Board of Directors Meeting

Virtual Meeting via Microsoft Teams

August 11, 2022 - 4:30 p.m.

Dial in #: 754-900-7480, Conference ID: 436 731 131#

Link to join meeting on the computer: *(copy and paste the link below)*
https://teams.microsoft.com/l/meetup-join/19%3ameeting_NTdiMzU1NDgtM2FjYS00ZTFmLWIxMmItNjc5MmZlMTA1YzM1%40thread.v2/0?context=%7b%22Tid%22%3a%227bbca740-f271-4428-aeec-f0585b3625b3%22%2c%22Oid%22%3a%2284103832-9a45-46d3-a945-76ea1c188b08%22%7d

1. Introductions / Roll Call — Chair

2. Approval of June 16, 2022 Minutes — Chair

3. Board Chair Report — Chair
   - 988 Update
   - Legislative Update
   - County Update
   - 10th Year Anniversary Event Updates

4. CEO Report — CEO
   - Amendment #56 Update
   - Approval of Eagles Haven
   - Uncompensated Services Reallocation of Funds FY 21-22
   - Carisk Update

5. BBHC Committees' Reports
   - Finance Committee — Larry Rein
     - Approval of Financial Statements – May 2022
   - Nominating Committee — Larry Davis
   - Recovery Oriented System of Care — Commissioner Lois Wexler
   - Consumer Advisory Council — Susan Nyamora
   - Provider Advisory Council — Paul Jaquith

6. Public Comments

7. Adjournment

Next Meeting Date: October 20, 2022

Board of Directors Meeting
Virtual Meeting via Microsoft Teams
June 16, 2022– 4:30 p.m.
MINUTES

The meeting was called to order by Board Chair, Commissioner Nan Rich at 4:32 p.m.

Board of Directors	Present	Excused	Absent	Board of Directors	Present	Excused	Absent
Pamela Africk			X	Commissioner Nan Rich ***Board Chair***	X		
Kimm Campbell			X	Mayor Michael Ryan			X
Larry Davis	X			Steve Ronik	X		
Senator Gary Farmer			X	Jackie Rosen			X
Representative Michael Gottlieb			X	David Scharf	X		
Debra Hixon	X			Nancy Gregoire Stamper	X		
Paul Jaquith	X			Tammy Tucker	X		
Robin Martin	X			Ana Valladares ***Secretary***			X
Neal McGarry ***Vice-Chair***			X	Commissioner Lois Wexler	X		
Susan Nyamora	X			Julie Klahr, BBHC Attorney	X		
Rosalind Osgood	X			Silvia Quintana, BBHC CEO	X		
Marta Prado	X						
Larry Rein ***Treasurer***	X						

BBHC Staff: Danica Mamby, Steve Zuckerman, Kerline Robinson, Stefania Pace
Carisk Staff: Jennifer Braham, Shirley Murdock
DCF Staff: Suzette Fleischmann, Frank Jowdy
Guests: Eugenia Nikitina, Kayla Calafiore

1. <u>Introductions/Roll Call</u>

Roll call was taken as noted above. Board Chair, Commissioner Nan Rich, ascertained that there was a quorum.

2. <u>Approval of May 19, 2022 Minutes</u>

Without any corrections to the minutes, a motion was made by Commissioner Lois Wexler and seconded by Ms. Nancy Stamper. The Board unanimously approved the May 19, 2022 meeting minutes.

3. Board Chair Report

- **County Update**
  - Commissioner Rich announced that the County Commission unanimously passed a Tenant's Bill of Rights at the last Commission Meeting. The bill requires residential landlords to provide "Notice of Rights" before executing or renewing a lease and specifies notice to tenants for late fees imposed under a rental agreement. The bill also requires landlords to provide tenants with a 60-day written notification period if the landlord intends to increase the rent on an annual lease by more than 5%. Leases are complicated documents which is why it is important to increase tenants' awareness. As the affordable housing crisis continues to escalate, these steps will help provide guidance and protections to vulnerable residents.

  - Commissioner Rich shared that the Commission held a budget workshop. This year, the county voted to use nonrecurring federal funds to build over 1,000 affordable housing units. The county has committed to work with Dr. Murray and the FIU Metropolitan Center to develop a strategic plan for affordable housing. In addition, it was proposed that 100% of the 2022-2023 sunsetting CRA dollars be placed in affordable housing. Previously, only 50% of those funds were earmarked for economic development. However, the business community agrees that affordable housing is an economic development issue.

  - As the County Commission works to build more affordable housing, we must determine a dedicated source of revenue. It is clear we cannot solely rely on state or federal funding.

- **Legislative Update**

No updates were given.

4. CEO Report

- **Approval of BBHC Business Plan**

Ms. Silvia Quintana presented the BBHC Business Plan. **A motion was made by Commissioner Lois Wexler and seconded by Mr. Larry Davis. The Board unanimously approved the BBHC Business Plan.**

- **Approval of BBHC Contracts**

Ms. Silvia Quintana presented the BBHC provider contracts for the 2022-2023 fiscal year and the allocated funding they will received. The two new providers, Evolutions Treatment Center, and Children's Harbor have gone through the prequalification process. One provider will focus on children's respite and the other provider will receive referrals from the family engagement program with BSO so individuals can get immediate assessments within 48 hours.

The following abstentions were made:

Board Member:	Affiliation(s):
Susan Nyamora	South Florida Wellness Network
David Scharf	Broward's Sheriff's Office
Nancy Stamper	North Broward Hospital
Tammy Tucker	Memorial Healthcare Systems United Way of Broward County
Paul Jaquith	Mental Health America of Southeast Florida House of Hope Inc. United Way of Broward County Broward Partnership for the Homeless
Commissioner Nan Rich	Broward Addiction Recovery Center
Steve Ronik	Henderson Mental Health Center

A motion was made by Mr. Larry Rein and seconded by Ms. Marta Prado. The Board unanimously approved the provider contracts for FY 22-23.

- **Approval of Amendment # 55**

  Mr. Larry Rein presented Amendment #55 which will allocate $103,213 into substance abuse TANF funding. **A motion was made by Mr. Larry Rein and seconded by Commissioner Lois Wexler. The Board unanimously approved Amendment #55.**

- **Approval of Amendment # 56**

  Amendment # 56 will provide the base funding for fiscal year 2022-2023. **A motion was made by Mr. Larry Rein and seconded by Commissioner Lois Wexler. The Board unanimously approved Amendment #56 pending fiscal review.**

- **Approval of Waiving the Procurement Process**

  Ms. Silvia Quintana stated that in order to expedite the immediate contracting of the programs that Amendment # 56 will have, the provider network is recommending that the Board approves waiving the procurement procedure. **A motion was made by Commissioner Lois Wexler and seconded by Senator Rosalind Osgood. The Board unanimously approved waiving the procurement procedure.**

- **Approval of $12.8 Million Allocation**

  Ms. Quintana stated that the $12.8 million allocation is a part of the $126 million recurrent funds approved by the governor to be used for teaming programs and work stabilization. The list of providers and their programs were presented to the board. **A motion was made by Commissioner Lois Wexler and seconded by Mr. Larry Rein. The Board unanimously approved the $12.8 million allocation into the provider contracts, contingent upon receipt from DCF of those funds and approval of Amendment #57.**

- **Approval of Amendment # 57**
  Amendment #57 will provide nine (9) months' worth of opioid funding and the $12.8 million allocation added into the budget. **A motion was made by Mr. Larry Rein and seconded by Commissioner Lois Wexler. The Board unanimously authorize and delegate the executive Committee to approve Amendment #57.**

- **Approval of Revised Credential Policy**
  Ms. Quintana stated that masters level students, at an accredited four-year college or university, studying in the mental/ behavioral health field, have the opportunity to work within our provider network, under the supervision of a licensed clinician, after successfully completing all necessary coursework. **A motion was made by Commissioner Lois Wexler and seconded by Mr. Larry Davis. The Board unanimously approved the Revised Credential Policy.**

- **Approval of FIT Team Provider**
  Ms. Silvia Quintana presented The Village South as the family intensive treatment team provider. **A motion was made by Commissioner Lois Wexler and seconded by Mr. Larry Rein. The Board unanimously approved the Village South as the new FIT Team Provider.**

- **Carisk Update**
  Ms. Jennifer Branham provided an update. Carisk is getting all of the contracts for the new fiscal year prepped to be sent out. Carisk has built in the new Locus and Cal locus into the current portal, which will help to access individuals into the appropriate levels of care within the network. All of the providers are currently FASAMS compliant.

5. <u>Committee Reports</u>

Finance Committee

- **Approval of Financial Statements – April 2022**
  Consulting Chief Financial Officer, Mr. Steve Zuckerman, presented the March 2022 Financial Statements. **On a motion made by Mr. Larry Rein and seconded by Mr. Paul Jaquith, the Board unanimously approved the April 2022 Financial Statements.**

Nominating Committee

- After discussion with the Board, Mr. Larry Davis recommended that Commissioner Nan Rich remain Board Chair, the rest of the slate will be decided at the August meeting. A discussion was held regarding meeting 6 times a year, and the possible creation of a bylaw committee. **On a motion made by Mr. Larry Davis and seconded by Senator Rosalind Osgood, the Board unanimously approved Commissioner Nan Rich remain the Board of Directors Chair.**

Recovery Oriented System of Care

- Commissioner Lois Wexler stated that the quarterly CQI report was reviewed.
- The statewide needs assessment is still under review and the updated version will be finalized on June 17th, 2022.

Consumer Advisory Council

- No new updates were given from the Consumer Advisory Council.
- Mr. David Scharf discussed the success of the co-responder model. It has expanded from Pompano Beach to Deerfield Beach and Oakland Park.

Provider Advisory Council

Ms. Vivian Demille chairs the Workforce Recruitment Subcommittee. The subcommittee created a survey monkey and discussed how the new recommendations can help with recruitment and retention.

6. Public Comments

- Ms. Susan Nyamora announced that South Florida Wellness Network opened a second RCO in Hollywood.
- Senator Rosalind Osgood thanked BSO and Henderson for the positive experience regarding a baker act for a family member.
- Mr. David Scharf requested more information regarding how the allocation of opioid funding will affect the county.
- Commissioner Nan Rich thanked the board for the vote of confidence.

7. Adjournment

The meeting adjourned at 5:50 p.m.

Minutes approved by: _____

Ana Valladares, BBHC Secretary

CEO REPORT
August 11, 2022

1. ITEMS FOR APPROVAL

a. Amendment #56 - funding amendment for FY 22-23.

2. CURRENT SIGNIFICANT ISSUES

A. Operations – No new updates.

B. Telehealth Services – Broward Behavioral Health Coalition, Inc. (BBHC) is in the final developmental phase of the *Let's Talk Interactive* (LTI) platform that will provide Care Coordination among Broward County Public Schools (BCPS), BBHC, and the Network providers. Program is being implemented in a phased manner with BCPS being the first one. BCPS and BBHC are working on the scheduling the training for school staff and network providers.

C. Staff – BBHC's workforce is stable at this time. BBHC held a Staff Retreat during the month of July. We collaborated with staff on team building activities and received input to create a strategic plan. COVID outbreaks continue to be reported by staff.

D. Effect Work Force shortage on the BBHC Provider Network – Provider Advisory Council created the attached report on this topic. Currently, the network continues to suffer the consequences of staff shortages. At this time, at least one residential program is closed to admission and multiple outpatient programs are not able to maintain the levels of admissions and treatment due to lack of staff.

E. Short-Term Residential Treatment (SRT) Beds
Henderson Behavioral Health has ten (10) beds operational at the SRT. Staff retention continues to be an issue, especially for nurses. They continue to interview to bring all 12 beds online.

F. 2022 Behavioral Health Needs Assessment
BBHC received the final 2022 Behavioral Health Needs Assessment, which was updated with most of the feedback and recommendations provided by BBHC. Please see attached report.

G. DCF Secretary Harris Meeting – The Quarterly Behavioral Health meeting will take place in Orlando on August 16th.

H. Child Abuse Death Review Committee (CADRC). The Child Abuse and Death Review Summit was held on July 28-29, 2022, in Orlando. BBHC's CEO attended.

3. UPDATES – CARISK RELATED

A. BBHC and Carisk – Ongoing weekly meetings are held to address issues, concerns, and policies.

4. UPDATES – DCF RELATED

A. Bi-Monthly Partnership Meetings - These meetings between DCF and BBHC are designed to facilitate collaboration, to address priority issues, and identify opportunities for improvement. Our next meeting will be on August 24, 2022.

B. Network Provider Contract – Provider contracts will be amended to realign with the DCF funding as soon as DCF amends BBHC's contracts.

5. UPDATES – GRANTS RELATED

A. Administration on Children, Youth and Families (ACYF)

a. Peer Pilot Program - A new Peer has been on-boarded through SFWN and is meeting with the team. The Peer will complete the Family CPR training in August and will begin taking cases.

B. One Community Partnership 3 (OCP3)

a. The year three (3) enrollment goal is to consent fifty-eight (58) young people in the evaluation. OCP3 has enrolled forty-four (44) young people in the evaluation (76% of the year 3 goal). OCP3 must enroll 14 more young people into the evaluation to meet the year 3 goal.
b. On June 9, 2022, OCP3 held a TIP Learning Community training on Strength Discovery for Life Coaches. In addition, on June 10, 2022 OCP3 hosted a TIP Services using Video Games training for Life Coaches as a way to engage young people in services and to help with their future goals.
c. On July 20, 2022 OCP3 participated in the Statewide Wraparound Learning Community with other Managing Entities and behavioral health providers in Florida.
d. On June 27, 2022, OCP3 partnered with the Children's Services Council to host the Cross Systems Training for frontline staff within the community. Presentations from Broward County Public Schools, ChildNet, the Department of Juvenile Justice, Behavioral Health System providers, Youth MOVE and Federation of Families, and other systems partners were provided.

C. Criminal Justice Mental Health Substance Abuse Reinvestment Planning Grant

a. BYRP2 launched on July 1, 2022. The year one (1) enrollment goal is to enroll fifty (50) youth.
b. In July 2022, BYRP2 enrolled three (3) youth and there are ten (10) youth in the process of being enrolled.
c. On July 15, 2022, Aileen Bernard, Clinical Care Integration Coordinator conducted a Lunch and Learn Presentation with Supervisors from the Department of Juvenile Justice (DJJ) Probation and shared updates and changes implemented for BYRP2. Another presentation will be conducted with the new group of incoming Juvenile Probation Officers (JPO's).

D. Children Service Council of Broward County (CSC) Funded Services

a. As the Nikolas Cruz sentencing trial continues, clinicians remain onsite at the courthouse to support the victims and families of the tragedy.

6. UPDATES – OPERATIONS RELATED

A. Care Coordination Teams (CCT)

a. BBHC's System of Care Manager attended the NAMI Broward Speaker Meeting on July 13, 2022, and facilitated topics for discussion including supportive resources and areas for family advocacy.
b. BBHC welcomed the COVID-19 Grant administrators from Department of Children and Families (DCF) for a tour of BBHC and to discuss area processes and resources. This visit included a tour of the COVID-19 Grant partner, South Florida Wellness Network, a meet and greet with their team and a tour was provided that included both RCO locations in Fort Lauderdale and Hollywood.
c. A Critical Time Intervention training was provided to Banyan for new Supervisors of the Care Coordination Team.

B. Care Coordination Teams - Child Welfare (CCT-CW)

a. On July 1st, the new contract for the Family Intensive Treatment Team with The Village South started. There were various meetings, including an on-site introduction at Childnet for the Dependency Case Managers, staff, and families to ask questions.

C. Medication Assisted Treatment (MAT)

a. Broward Health continues to increase the number of persons served in their Out-Patient IMatr program.
b. For this fiscal year, BBHC has only received a quarter of its MAT funding.

D. Child Welfare Integration Initiatives

a. Healthy Start/Bringing Babies Home Healthy Initiative has identified a gap in services for women that are pregnant and under community control. It was identified that if a pregnant woman was on probation, pregnant and had no other children in her care, if she tested positive for substances a report is called into the abuse hotline. Due to the mother having no other children in her care, the call would be screened out and no referrals for services are made. BBHC is working with the office of Probation to make direct referrals for service when a woman is pregnant, using substances and under community control.

b. Motivational Interviewing Training was held for the BBHC provider network on July 26th and July 27th.

E. Housing Initiative

a. The Florida Housing Finance Corporation RFA Pilot for High Utilizers of Public Behavioral Health Systems was due on July 12, 2022. CARRFOUR, BBHC and HBH group was not able to secure site control of a development property in time for submission of the RFA. Efforts will continue to identify and secure a development property in preparation for future RFA opportunities.
b. HomesUnited year-to date utilization (since July 1, 2022) is as followed, there are 16 individuals that have been placed in their Mental Health Respite beds and 3 in their Mental Health Transitional beds

F. SSI/SSDI Outreach, Access, and Recovery (SOAR) Statewide Initiative

Year to date, eighty-eight percent (88%) of Initial SOAR applications were approved. The final SOAR OAT's data for this fiscal year was due on August 7th. Provider agencies have until August 4th to enter their FY data. Ongoing technical support continues for Network Providers.

G. Supportive Employment

a. On July 8, 2022, a technical assistance session was provided to Footprint to Success on Individual Placement Support (IPS), in order to assist with increasing employment numbers and fidelity to the IPS model.
b. The Recovery Support Navigator is working with the Florida Division of Vocational Rehabilitation to plan an IPS Supported Employment and Vocational Rehabilitation (VR) crosswalk training on services offered through both programs. The training will strengthen collaboration between Employment Specialists and VR Counselors through the education on how both services work together. Moreover, the training will cover VR documentation, VR billing process, as well as address barriers to persons served receiving VR services.

H. Children System of Care Plan

a. BBHC continues the efforts to implement the Children System of Care Plan as mandated by HB945.
b. BBHC has launched the HB945 Broward County Children System of Care Meeting as a forum for children systems issues to be addressed at a high systemic level. BBHC is also working in bringing more direct services meeting in alignment with the overall plan.
c. BBHC continues to collaborate with identified providers to bring online the latest expansions of the Children's Care Coordination initiative – Family Support Teams and additional Children's Care Coordination Teams that work with the Mobile Response Team (MRT).
d. SIPP Children's Care Coordination – Our SIPP Care Coordinator has begun to build relationships with SIPPs throughout the state and inform them of the initiative.

e. BBHC has completed the trainings for Early Learning Coalition teachers and preschool staff regarding early identification of signs and symptoms of trauma. This training is part of the early detection and prevention for children as it aims to help preschool staff to be able to identify infants with issues as early as possible, preventing the escalation of the problems. The next step of developing a cohort of therapist fully trained in Infant Mental health has already started.

7. UPDATES – QUALITY RELATED

A. Complaints and Grievances – There was one complaint received during the month of June 2022. The complaint was regarding handicap accessibility at a residence partially funded by BBHC. The complaint was not substantiated. One complaint was received during the month of July. BBHC is finalizing the report.

B. Cultural Competency and Diversity Initiative – BBHC reviewed and updated the Cultural Competency and Diversity Plan for FY 22-23. BBHC will continue to ensure the Culturally and Linguistically Appropriate Services (CLAS) standards are being implemented throughout the network.

C. Recovery-Oriented System of Care (ROSC) Statewide Initiative – In July, DCF disseminated the ROSC toolkit to help organizations identify the necessary resources to develop and maintain a Recovery-Oriented System of Care. BBHC reviewed and updated the ROSC Action Plan for FY 22-23. Network providers will be monitored for ROSC implementation throughout the fiscal year.

D. Contract/Program Monitoring – All Network Providers were monitored during FY 21-22. There was no monitoring during the months of June and July. The risk assessment for FY 22-23 was completed to determine which Providers will receive a virtual/on-site monitoring. BBHC will continue to adhere to health and safety precautions due to the COVID-19 pandemic.

E. Performance Measures – At the end of FY 21-22, the BBHC Network was passing all except one of the performance measures. The failing measure is ***Percent of adults in mental health crisis who live in stable housing environment***. The majority of clients that are failing that measure are currently in jail. Once they are treated and discharged back to the jail that counts against us. Guidance Document 24 is still based on Pamphlet 155-2, Version 12. We have recommended to DCF that they update the Pamphlet to reflect Version 14 data reporting. Specifically, we recommended that discharges to jail should be a neutral exit and should not directly impact the performance measure.

F. Incident Reports – During the month of June, a total of eleven (11) IRAS reports were received and reviewed by BBHC staff. During the month of July, a total of twenty-three (23) IRAS reports were received and reviewed by BBHC staff.

G. Consumer Person Served Satisfaction Surveys (CPSSS) - A total of 4,940 CPSSS were received during FY 21-22. The overall satisfaction rate for the BBHC Network was 88%.

8. RISK AND COMPLIANCE UPDATE

No updates.

9. COMMUNITY RELATIONS

A. Coordinating Council of Broward (CCB)

a. BBHC continues to participate monthly. The last meeting was held on August 3, 2022. BBHC's CEO attended the meeting. At the meeting there was discussion regarding the LTRC, housing, 988, vaccination available to school children, and COVID-19 testing.
b. Information on Hurricane preparedness has been sent out to the community by the LTRC.

B. Florida Association for Managing Entities (FAME)

a. BBHC participates in weekly conference calls.
b. MEs are being interviewed by an external Data IT company to make recommendations of FASAMs issues
c. The $126 Million appropriation has been approved for release but only $104 million statewide. Tallahassee legislative staff has withheld $21 million of the appropriation impacting the funding of Care Coordination at the ME level as well as the provider level and some prevention intervention programs. The Care Coordination recurring funding was part of the proviso language by the legislature. This is a basic tool we use to reduce the number of Baker Acts and high utilizer of the system of care. FAME is working with the DCF Secretary on the release of the $21 million.

C. Funders Forum

a. The last meeting took place on August 5, 2022. BBHC presented on new programs that are part of the Children's System of Care.
b. BBHC is in the process of negotiating Eagles' Havens contract, as per the proviso.

D. Broward Suicide Prevention Coalition (BSPC)

a. The Broward Suicide Prevention Coalition (BSPC) did not meet in July. The next meeting will be on August 10, 2022.

E. BBHC Marketing and Educational Initiative

BBHC contracted with KIP Hunter Marketing for Communication and Outreach services. The 10th Year Anniversary Celebration plan is on its way. BBHC's Board Chair set up a 10th Anniversary Committee and appointed some Board Members to participate. A meeting took place in early July. We have been working on a logo for the annual celebration event. We are also working on obtaining sponsors for the event. The Celebration will have a kickoff event at the end of October or November. We will be culminating the celebration at the Annual Behavioral Health Conference, hosted by the United Way of Broward County in May 2023.

F. Stepping up Initiative Jail Diversion Project

We are waiting for the DCF contract amendment with these funds to hire a Director and contract with Fellowship House.

10. MATTERS FOR NOTING

A. FASAMS - Please see Carisk Partners' Report.

B. Susan B. Anthony Recovery Center (SBA) - The agreement pertaining to the storage of SBA's records is still pending legal finalizing it. We have identified a vendor that will store the records. The contract is being finalized.

WORKFORCE COMMITTEE FINDINGS

Eighteen (18) organizations responded to the survey put out by our workforce committee.

Based on their responses, we identified following number of open positions:

Psychiatrists: 9 open positions
Psychiatric APRNS: 4 open positions
Licensed Clinicians: 55 open positions
Masters Level Clinicians: 69 open positions
Case Managers: 34 open positions
Other Bachelors Level Positions: 51 open positions
BHTs: 60 open positions
Peer Specialists: 23 open positions
RNs: 18 open positions
LPNs: 11 open positions

TOTAL OPEN POSITIONS = 324

B. Open positions - % by position type:

38% Therapists
26% Case Managers & other bachelor's level
19% BHTs
9% Nurses
7% Peer Recovery Specialists
4% Psychiatrists/APRNS

C. Length of time positions are open:

Varies by organization, organization size, position and number of positions. Answers ranged from 30 days to over a year.

D. Recruitment strategies implemented:

Increased Salaries – 13 organizations responded yes
Used Recruiters - 8 organizations responded yes
Sign on Bonuses – 6 organizations responded yes
Referral Bonuses - 10 organizations responded yes
Flexible Schedules - 13 organizations responded yes

Response to “were these strategies effective?” Increased salaries are somewhat effective at recruiting and effective for some organizations with retention. Recruiters are used for specific positions and are not always effective. Sign on bonuses and referral bonuses have been somewhat effective for some and not effective for others. Flexible schedules have been somewhat effective.

Despite some effectiveness with all these strategies, there continues to be shortages in workforce. *Note: A few organizations mentioned they used recruiters for licensed clinicians but more so for psychiatrists, APRNs and RNs. For those organizations that used recruiters for licensed clinicians, recruiting companies would not recruit for staff if salary ranges were under $65-75,000+ as most clinicians in non-supervisory positions recruiting companies were speaking to were already gainfully employed in positions within that range of pay.*

E. OTHER In general, organizations responded that a reduction in administrative burden would be helpful in terms of retention of staff. Where possible, we are asking that our funders and regulators commit to reducing administrative burdens. We recognize that in this new workforce era, staff and potential staff are looking for work/life balance. Decreasing administrative burden and reducing the amount of direct service time will improve work/life balance. It will also have an impact on burnout which a primary cause for workforce turnover.

Some organizations reported that background screenings results are taking longer post pandemic, and as a result, some organizations losing people in between offer and start date. Other organizations reported time frames remain the same. However, there was a consensus that there is little that can be done to impact the speed of background screening.

The workgroup recommends seeking regulatory &/or other relief to temporarily allow for (i) use of LPNs in lieu or RNS for services including, but not limited to, residential level 1 and crisis stabilization; (ii) use of masters interns in lieu of masters level staff; and/or (iii) expanding educational and experience criteria for case managers so as to have a wider pool of eligible applicants.

It was also noted that recruitment strategies should include engaging universities in changing messaging regarding working within community behavioral health organizations to be viewed in a more positive light.

Summary:

Although the majority organizations have implemented several recruitment strategies, we continue to experience a workforce shortage. Organizations expressed that while shortages are less than what they were previously, they continue to have gaps in care. Our survey

demonstrates that workforce shortages are within all position types, but the greatest number or shortages are for therapists and case managers/bachelors level positions (64%).

It is important to note that we are not alone in this workforce crisis and that this workforce crisis is here to stay. In the U.S. in 2021, more than 47 million workers quit their jobs, many who are in search of improved work-life balance, flexibility and increased compensation. We currently have 11.3 million job openings in the US and only have 6 million unemployed workers. And, while we added 3.8 million jobs in 2021, we lost 2.2 million people from the workforce. As we continue to add jobs at a greater rate than increase in workforce, the workforce crisis will likely get worse. And, in some industries, including education, and health services, there are more unfilled job openings than unemployed workers with experience in their respective industry. (*https://www.uschamber.com/workforce/understanding-americas-labor-shortage*)

(*https://www.uschamber.com/workforce/understanding-americas-labor-shortage-the-most-impacted-industries#:~:text=In%202021%2C%20more%20than%2047,and%20a%20strong%20company%20culture.*)

To add to these concerns, South Florida specifically has the unique challenges involving housing. A recent analysis by FAU real estate economist has indicated that the South Florida housing market (ownership and rentals) is 30% overvalued which may result in a prolonged period of unaffordability. (Economist Ken Johnson). The outcome of this "unaffordability" is people leaving the area to seek jobs in a more affordable housing market which could lead to a continued increase in workforce shortages.

Although a solution is nowhere in sight, there are strategies we can implement that will attract more people to our profession and help us with retention.

Our workgroup recommends the following:

1. **Develop a multi-year strategy/plan to incrementally increase salaries to become more competitive with and attract more people to our profession.**

Although most organizations answered that they have increased their rates of pay, salaries need to increase further. When comparing salaries for clinicians with other professions (Ziprecruiter, salary.com, Indeed), masters level clinicians average $50,000 or less annually and licensed clinicians average mid $60,000's annually, while registered nurses and people with MBAs average $80,000+ (annually).

Newly hired teachers in Broward County make almost $50,000, while bachelor's level staff/case managers in behavioral health are making mid to high $30,000's on average, the same as what you can expect to earn at Amazon and Whole Foods without a degree or the level of responsibility our staff has.

Even within our profession, it is well known that community behavioral health salaries are lower than what the private sector, insurance companies and others offer. In order to become more competitive and continue to attract people to this profession into the future, we will need to address this salary disparity.

2. **Reduce administrative burdens and reduce the expectation of the number of hours spent in direct client care to reduce burnout and improve work-life balance.**

   It is commonly accepted that burnout is the leading cause of turnover in our profession and that today's workforce is highly values work-life balance. Turnover rates in our profession are upwards of 40%. Our workforce crisis is as much about keeping people as it is attracting people to our profession. (*https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4715798/).* There was unanimous consensus in our workgroup that a reduction in administrative burden would help to reduce burnout. In addition, we believe lowering expectations as a system of care as to how much time is spent in direct client care will also reduce burnout. This initiative will require a collaborative effort between funders and providers and a commitment to reduce administrative burdens to the extent we can. Reducing the expectation as to the number of hours spent in direct care will require an increase in rates which requires an increase in funding.

3. **Widen the scope of who can provide services to help us serve people who are currently going unserved.**

   As the workforce crisis is not disappearing any time soon, widening the criteria of who can provide services may be the only short-term solution to serve people who are currently going unserved. This initiative may require a statewide effort to advocate for regulatory change. Recommendations include using LPNs in lieu of/addition to RNs where RNs are typically required and masters level interns in lieu of/addition to masters level staff, as well as expanding criteria for case manager employment eligibility.

4. **Engage in a coordinated effort to collaborate with local universities to educate students on the pros of working with our organizations to improve students' perception of working in community behavioral health and attract new graduates.** Our workgroup recommends an ongoing effort to engage universities in strategies to attract graduating students to community behavioral health.

BROWARD BEHAVIORAL HEALTH COALITION, INC.
STATEMENT OF FINANCIAL POSITION
May 31, 2022

	MAY 2022	APRIL 2022
ASSETS		
CURRENT ASSETS		
Cash and Cash Equivalent	$ 13,509,980	$ 7,316,761
Grant Contract Receivable, net of Allowance for Doubtful Accounts of $-0-	$ 6,767,122	$ 13,245,836
Prepaid Expenses	$ 63,999	$ 91,091
TOTAL CURRENT ASSETS	$ 20,341,101	$ 20,653,688
FIXED ASSETS		
Computer Hardware	$ 26,128	$ 26,128
Furniture, Fixtures and Equipment	$ 8,852	$ 8,852
	$ 34,980	$ 34,980
Less: Accumulated Depreciation	$ 34,980	$ 34,980
Net Book Value	$ 0	$ 0
OTHER ASSETS		
Security Deposits	$ 7,746	$ 7,746
TOTAL ASSETS	$ 20,348,847	$ 20,661,434
LIABILITIES and NET ASSETS		
CURRENT LIABILITIES		
Accounts Payable - Subcontracted Services	$ 8,227,199	$ 6,605,116
PPP Loan Payable	$ 305,048	$ 305,048
Accrued Expenses Payable	$ 251,262	$ 220,535
Deferred Revenue	$ 11,537,527	$ 13,502,923
TOTAL CURRENT LIABILITIES	$ 20,321,035	$ 20,633,622
NET ASSETS		
Beginning of Year	$ 26,701	$ 26,701
Change in Net Assets	$ 1,111	$ 1,111
TOTAL NET ASSETS - END OF PERIOD	$ 27,812	$ 27,812
TOTAL LIABILITIES and NET ASSETS	$ 20,348,847	$ 20,661,434

BROWARD BEHAVIORAL HEALTH COALITION, INC.
Managing Entity for Substance Abuse and Mental Health Services
Income Statement
For the eleven months ended May 31, 2022

	May 2022	YTD Actual	YTD Budget	Variance Favorable (Unfavorable)	Approved FY 2021-2022 Budget
Revenues:					
DCF Revenue for Services	$ 7,743,834	$ 60,020,453	$ 65,813,047	$ (5,792,594)	$ 71,796,051
DCF Carry Forward for Services	$ 389,280	$ 1,899,832	$ 3,114,669	$ (1,214,837)	$ 3,397,821
DCF Revenue for Operations	$ 233,485	$ 1,906,201	$ 3,113,158	$ (1,206,957)	$ 3,396,172
DCF Carry Forward Revenue for Operations	$ -	$ 871,015	$ 911,692	$ (40,677)	$ 994,573
Other Income	$ 27,001	$ 383,866	$ 521,708	$ (137,842)	$ 569,136
OCP3 Grant	$ 82,560	$ 856,219	$ 853,252	$ 2,967	$ 930,820
Family - CPR Grant	$ 35,869	$ 486,194	$ 550,000	$ (63,806)	$ 600,000
BYRC Grant	$ 182,005	$ 523,582	$ 333,333	$ 190,249	$ 333,333
Total Revenue	$ 8,694,034	$ 66,947,362	$ 75,210,858	$ (8,264,607)	$ 82,017,906
Expenses from Provider Services	$ 8,133,114	$ 61,920,285	$ 69,332,247	$ 7,411,962	$ 75,635,179
Expenses from Operations:					
Total Salary and Wages	$ 199,179	$ 2,007,233	$ 2,260,041	$ 252,808	$ 2,465,499
			$ -		
Total Fringe Benefits	$ 37,350	$ 423,878	$ 533,704	$ 109,826	$ 582,222
			$ -		
Total Building Occupancy	$ 9,079	$ 95,663	$ 111,564	$ 15,901	$ 121,706
			$ -		
Total Professional Services	$ 78,774	$ 1,114,558	$ 1,701,649	$ 587,091	$ 1,826,042
			$ -		
Total Travel	$ 2,003	$ 24,702	$ 73,398	$ 48,696	$ 80,071
			$ -		
Total Equipment Costs	$ 6,254	$ 128,696	$ 209,504	$ 80,808	$ 228,550
			$ -		
Total Subcontracted Services - Carerisk	$ 56,416	$ 620,583	$ 620,583	$ 0	$ 677,000
			$ -		
Total Insurance	$ 3,725	$ 37,959	$ 42,319	$ 4,360	$ 46,166
			$ -		
Total Telephone Expense	$ 2,003	$ 23,615	$ 28,106	$ 4,491	$ 30,661
			$ -		
Total Operating Supplies	$ 2,204	$ 16,590	$ 38,663	$ 22,073	$ 42,178
			$ -		
Total Other Expenses	$ 163,933	$ 532,489	$ 259,079	$ (273,410)	$ 282,632
			$ -		
Total Expenditures Before Depreciation	$ 8,694,034	$ 66,946,251	$ 75,210,858	$ 8,264,606	$ 82,017,906
			$ -		
Total Depreciation	$ -	$ -	$ -	$ -	$ -
			$ -		
Total Expenditure After Depreciation	$ 8,694,034	$ 66,946,251	$ 75,210,858	$ 8,264,607	$ 82,017,906
Adjusted Change in Net Assets	$ -	$ 1,111	$ -	$ -	$ -

BROWARD BEHAVIORAL HEALTH COALITION, INC.

EXPLANATION OF BUDGET VARIANCES

May 2022

Revenue

- Managing Entity Contract – Services – ($7,007,431) – Below budget for reporting period including Carry Forward Funds from FY 20-21.
- Managing Entity Contract – Operations – ($1,247,634) – Below Budget for reporting period including Carry Forward Operational Funds from FY 20-21.
- Other Income –($137,842)– Below budget for reporting period due to Trauma Services from CSC, and Care Coordination Services from Wellpath.
- OCP3 Grant –$2,967 – Above budget for reporting period.
- Family – CPR Grant – ($63,806) – Below budget for reporting period.
- BYRC Grant – $190,249 – Above budget for reporting period due to recording of CSC In-Kind Match. This grant will expire April 30th and recommence in July 2022.

Expenses

- Provider Services – See Revenue explanation above
- Salaries – Below budget for reporting period.
- Fringe Benefits – Below budget for reporting period.
- Building Occupancy –Below budget for reporting period
- Professional Services – Below budget for reporting period.
- Travel – Below budget for reporting period.
- Equipment Costs –Below budget for reporting period.
- Subcontracted Provider Services – Breakeven for reporting period.
- Insurance Expense – Below budget for reporting period.
- Telephone Expense – Below budget for reporting period.
- Operating Supplies – Below budget for reporting period.
- Other Expenses/Community Events – Above budget for reporting period. This is the offset for Trauma Services and Care Coordination Services from Wellpath. Also includes the recording of In-Kind Match from CSC for BYRP Program.

BBHC
Board of Directors Update
August 2022

Network Management

- All contracts (40) were executed prior to the start of this fiscal year, July 1, 2022. This includes three (3) new providers this fiscal year. School Board contracts are pending at this time.
- All Risk Assessments were completed and finalized.
- All 4 quarterly meeting have been schedule and sent to the Providers for FY 22-23. First meeting will be August 26, 2022.
- Carisk has enhanced the Contract Module to better support the ME in the contract negotiation process and reduce time-consuming tasks.

Network Management Statistics FY 22-23

	July-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	22-23 YTD	Comments
Risk Assessments	36	--	--	--	--	--	--	--	--	--	--	--	36	
Executed Contracts	40												40	
Amendments	--													

Technical Assistance and Training YTD FY 22-23

Topic	Number of Trainings	Providers Represented
LOCUS/CALOCUS	0	0

Financial Management / Invoice Processing

- Carisk continues to process Subcontractors invoices in a timely manner (completed within 5 business days).
- Carisk continues sending weekly Bed Census and Daily Submission Status Reports to Crisis and Acute Care Services Providers.
- Carisk updated the Invoice to include new DCF OCAs.
- Carisk continues to work with the Providers needing additional training and technical assistance.

FY 22-23 Financial Management Statistics		July-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	22-23 YTD
# TANF Approval		**												
Number of invoices submitted	(A)	**												

*** Currently under review.*

Data Management and Reporting

- Carisk completed the enhancement of the Financial Reports to include the Statement of Funds from DCF.
- LOCUS/Ca-LOCUS's new platform is pending the certification phase.

FASAMS V 14 update:

Broward Behavioral Health Coalition (BBHC)	Acute Care Version 14	5113	5113	63175	63175	100%
	Client Version 14	15157	15144	30320	30294	100%
	Provider Version 14	50	50	10961	10950	100%
	Service Event version 14	460689	456905	460689	456905	99%
	Subcontract Version 14	50	50	1288	1244	100%
	Treatment Episode Version 14	16471	16390	721302	715472	100%
	Waiting List Version 14	54	54	54	54	100%
	Total	497584	493706	1287789	1278094	99%

(June 2022)

AGREEMENT

between

First Call for Help of Broward, Inc.
D/B/A 211 Broward

and

Broward Behavioral Health Coalition

For

First Responder Regional Supports **CFDA#: 93.958**
PROGRAM **CONTRACT # LH839**

This Agreement, entered into this 1st day of May 2022 by and between First Call for Help of Broward, Inc., hereinafter referred to as "211," and Broward Behavioral Health Coalition hereinafter referred to as "PROVIDER."

PURPOSE
211 is engaging the Provider for the purpose of **providing regional supports targeting behavioral health needs of first responders and their families in the Southeast Region.**

NOW, THEREFORE, the parties agree as follows:

I. TERMS OF AGREEMENT

The term of this agreement shall be for the period of **May 1, 2022 through April 30, 2023.**

PROVIDER understands and acknowledges that the funding will only be for the Agreement Term stated herein. This Agreement is renewable at the sole discretion of the 211, contingent upon but not limited to the following:

A. Continued demonstrated and documented need for the services or priority area of funding;
B. Satisfactory program performance by PROVIDER;
C. The availability of funds from 211; and
D. This Agreement may be terminated with cause or without cause in accordance with the provisions contained in Section V of this Agreement.

II. SCOPE OF WORK

A. PROVIDER agrees to provide the services and meet the performance measures set forth in Exhibit 1, Scope of Work.

B. Both parties acknowledge that each party is under contract with the Florida Department of Children and Families (DCF) for services required pursuant to each of these independent and distinct contracts. Each party confirms that it will comply with the terms of its contract with DCF. To the extent that the provisions of each party's contract with DCF is inconsistent with the other party's contract with DCF, each individual party shall only be obligated to comply with the terms and conditions expressed within its own contract with DCF.

III. FUNDING AND METHOD OF PAYMENT

A. The annual maximum amount payable by 211 to PROVIDER for FY 22/23 shall be **$200,000** ("Contract Amount").
B. 211 agrees to pay for units of service or other deliverables actually provided, invoiced and documented as specified in the Exhibit 1, Scope of Work. An original invoice, in the format prescribed by the 211, is due on or before the fifth (5^{th}) day of the month following the month in which services were rendered. 211 agrees to reimburse PROVIDER on a monthly billing basis.

C. All invoices must comply with the requirements set forth in this Agreement and must be submitted on the forms as prescribed by 211. Invoices and/or documentation returned to PROVIDER for corrections may be cause for delay in receipt of payment. Late submission may result in delay in receipt of payment. 211 shall pay PROVIDER within thirty (30) calendar days of receipt of PROVIDER'S properly submitted invoice.

D. PROVIDER shall submit a W-9 IRS form providing the name, address and Federal I.D. Number of the official payee to whom payment shall be made.

E. It is the responsibility of both parties to advise, the other party in writing, of changes in name, address and/or telephone number as set forth in Section XXVI below.

F. PROVIDER shall submit an actual expenditure report to 211 within 30 days after the contract end date. The expenditure report may be used to negotiate amendments to the current contract rate (s), monitoring, or to negotiate rates in future contracts.

IV. *MONITORING, REQUIRED RECORDS AND REPORTS*

A. MONITORING: PROVIDER agrees:

1. To assign appropriate staff as necessary to attend meetings with 211 staff to discuss issues and recommendations concerning PROVIDER's subcontractors' quality of service; service delivery systems, coordination of services, consumer satisfaction, records maintenance, and funding maximization as may apply to services rendered pursuant to this contract..
2. To provide full access at PROVIDER's offices for monitoring of any administrative and oversight functions related to this agreement, and accompany 211 on any visits to PROVIDER's subcontractors' administrative and service delivery sites during all announced and unannounced visits, for the purpose of examination of records and data covered by this Agreement as well as observation of service delivery, and consumer/PROVIDER staff interaction. 211and PROVIDER shall maintain the confidentiality of Client services and records in full accordance with any federal or state laws or federal regulations mandating such confidentiality. PROVIDER's accompanying of 211 to any PROVIDER subcontractor's facilities shall facilitate 211's monitoring efforts, rather than to obstruct such activities.
3. To make all records and files pertaining to Clients subject at all times to inspection, review and/or audit by 211, upon reasonable advanced notice.
4. That, if documentation is not readily available, then payments may be suspended until such time as PROVIDER has rescheduled another monitoring appointment to occur within thirty (30) days.
5. To respond to any monitoring findings within the period specified therein, that back-up documentation to be used to support the billings and outcomes provided shall be approved in writing by 211 staff.
6. That, findings of monitoring reports, responsiveness to corrective action, and all the performance requirements of this Agreement and timeliness of requested information shall be considered factors in evaluating future funding requests.
7. To facilitate 211 access to BBHC's subcontractors' records and client files developed relevant to this Agreement regarding assessment of Performance Measures beyond the expiration of this Agreement, as applicable.

V. *TERMINATION OF AGREEMENT AND NOTICE*

A. It is the intent of the 211 to assure consistent and orderly delivery of behavioral health services to first responders. It is the further intent of the 211 to terminate Agreements only in those situations where such action is essential for the protection of its interest and the interests of first responders, as determined by the 211.

B. This Agreement may be terminated by the PROVIDER without cause upon no less than forty-five (45) days written notice. Said notice shall be delivered by certified mail, return receipt requested, or in person with proof of delivery.

C. This Agreement may be terminated by the 211 without cause upon no less than forty-five (45) days written notice. Said notice shall be delivered by certified mail, return receipt requested, or in person with proof of delivery.

D. In the event that funds needed to finance this Agreement become unavailable, the 211 may terminate the contract upon no less that twenty-four (24) hours' notice in writing to the PROVIDER. Said notice shall be delivered by certified mail, return receipt requested, or in person with proof of delivery. The 211 shall endeavor, whenever possible and consistent with its legal obligations and principles of prudent management to provide 30 days' notice for Termination for Lack of Funds. The 211 shall be the final authority as to the availability of funds and extension of notice beyond the minimum time herein stated.

E. Said notice shall be delivered by certified mail, return receipt requested, or in person with proof of delivery. The 211 at its discretion may waive any breach by the PROVIDER in writing, but such waiver shall not constitute a waiver of any further

breaches, including breaches of the same type. Upon receipt of notice of termination, PROVIDER shall cease providing any services under this Agreement as of the date such termination is communicated to become effective. PROVIDER shall be compensated for all services rendered prior to receipt of notice of termination in the event of a 24 hour notice of termination or upon the effective date of the termination as otherwise stipulated in the notice received, whichever is later.

F. The above provision shall not limit either party's right to remedies at law or to damages.

VI. AUDIT RIGHT AND RETENTION OF RECORDS

211 shall have the right to audit the books, records, and accounts of PROVIDER relevant to this Agreement that are related to the Scope of Work under this Agreement. PROVIDER shall keep such books, records, and accounts as may be necessary in order to record complete and correct entries related to the Scope of Work under this Agreement. PROVIDER shall further require its subcontractors to keep such books, records, and accounts in their possession related to the Scope of Work under this Agreement for all purposes intended in this paragraph. However, the retention of such records shall be the obligation of PROVIDER's subcontractor and not of the PROVIDER.

VII. INDEPENDENT CONTRACTOR

PROVIDER is an independent contractor under this Agreement. Services provided by PROVIDER shall be by employees of PROVIDER and subject to supervision by PROVIDER, and not as officers, employees, or agents of 211. Employee compensation, personnel policies, tax responsibilities, social security and health insurance, employee benefits, travel, per diem policies and other similar administrative procedures applicable to services rendered under this Agreement shall be those of PROVIDER.

VIII. SUBCONTRACTING

As more fully set forth in the Scope of Work in Exhibit 1, it is understood and agreed that PROVIDER will not be providing direct services to individuals served, and will therefore perform such services as required hereunder through subcontractors on its provider network as more fully described in the Scope of Work set forth in Exhibit 1., except as otherwise stated,

IX. CONFIDENTIAL INFORMATION

The PROVIDER, its agents, employees or subgrantees will not use or disclose any information concerning a recipient of services under this Agreement for any purpose not in conformity with state statutes and any applicable federal regulations (45 CFR, Part 205.50) except upon written consent of the recipient, or his/her responsible parent or guardian when authorized by law.

X. SECURITY OBLIGATIONS

PROVIDER and its subcontractors shall maintain an appropriate level of data security for the information the PROVIDER or its subcontractors are collecting or using in the performance of this Agreement. This includes, but is not limited to, approving and tracking all of their employees that request or require system or information access in the performance of their duties associated with this Agreement and ensuring that user access has been removed from all terminated employees. PROVIDER and its subcontractors shall report any security breaches immediately to the 211 Chief Operations Officer.

XI. CLIENT RISK PREVENTION AND INCIDENT REPORTING

A. PROVIDER and its subcontractors shall immediately report knowledge or reasonable suspicion of abuse, neglect, or exploitation of a child, aged person, or disabled adult to the Florida Abuse Hotline on the statewide toll- free telephone number (1-800-96ABUSE). As required by Chapters 39 and 415, FLORIDA STATUTES, this is binding upon the PROVIDER, its subcontractors, and their employees.

B. In the event of critical incidents such as serious client accident, injury or death, PROVIDER shall advise the Chief Operations Officer immediately by phone and in writing within twelve (12) hours of its receipt of such information from its subcontractor. All pertinent information such as Agency Incident Reports, Police Reports, or actions taken, shall be furnished by the PROVIDER to the 211 Chief Operations Officer within twelve (12) hours of the incident, or receipt of such information.

XII. NONDISCRIMINATION

Programs receiving funding from the 211 shall not discriminate against an employee, volunteer, or participant of the PROVIDER or its subcontractor, on the basis of race, color, gender, sexual orientation, religion, national origin, citizenship, disability, or age except that programs may target services for specific participant groups as defined in the application. Additionally, agencies receiving funds shall demonstrate the standards, policies, and practices necessary to render services in a manner that respects the worth of the individual and protects and preserves the dignity of people of diverse cultures, classes, races, religions, sexual orientation, and ethnic backgrounds. The parties shall affirmatively comply with all applicable provisions of the Americans with Disabilities Act (ADA) in the course of providing any services funded by 211, including Titles I and II of the ADA (regarding nondiscrimination on the basis of disability), and all applicable regulations, guidelines, and standards. In addition, the parties shall take affirmative steps to ensure nondiscrimination in employment of persons with disabilities.

XIII. *INDEMNIFICATION CLAUSE*

To the extent permitted by law, PROVIDER shall at all times hereafter indemnify, hold harmless and, at 211's option in consultation and agreement by PROVIDER, defend or pay for legal representation to defend 211, its officers, agents, servants, and employees against any and all claims, losses, liabilities, and expenditures of any kind, including attorney fees (including at all levels of appeal), court costs, and expenses, caused by negligent act or omission of PROVIDER , its employees, agents, servants, or officers, or accruing, resulting from, or related to the subject matter of this Agreement including, without limitation, any and all claims, demands, or causes of action of any nature whatsoever resulting from injuries or damages sustained by any person or property.

The provision of this section shall survive the expiration or earlier termination of this Agreement. To the extent considered necessary by 211, any sums due PROVIDER under this Agreement may be retained by 211 until all of 211's claims for indemnification pursuant to this Agreement have been settled or otherwise resolved; and any amount withheld shall not be subject to payment of interest by 211. The parties agree that such indemnification obligations shall survive the expiration or termination of this Agreement. Nothing herein shall be construed to waive any sovereign immunity that may be applicable pursuant to law.

Notwithstanding the foregoing, pursuant to §§394.9082 and 768.28, Florida Statutes, and any other applicable provisions of law or equity, nothing herein is intended to waive sovereign immunity by PROVIDER to the extent such immunity shall apply.

XIV. *INSURANCE*

A. PROVIDER shall maintain in force for the term of this Agreement adequate liability insurance. . PROVIDER will maintain professional liability insurance in the minimum amount of five hundred thousand dollars ($500,000) per occurrence bodily injury and property damage combined single limit. Such policy will be evidenced by a Certificate of Insurance which reflects 211 Broward as additional insured and provides thirty (30) days prior written notice of cancellation.

B.

XV. *AMENDMENTS: ASSIGNMENTS*

A. No modification, amendment or alteration in the terms or conditions contained herein shall be effective unless contained in a written document executed with the same formality and of equal dignity herewith. However, the 211's CEO & President may sign a modification, amendment or alteration to the terms and conditions of this Agreement where there is a change to Exhibit 1, Scope of Services, to reduce the Contract Amount, or to change Performance Measures.

XVI. *WAIVER OR BREACH*

Waiver or breach of any provision of this Agreement shall not be deemed a waiver of any other subsequent breach and shall not be construed to be a modification of the terms of this Agreement.

XVII. *DEFAULT*

In the event that either party should breach this contract, the non-breaching party shall have the right to seek remedies in law or in equity.

XVIII. *REPRESENTATIONS AND ACKNOWLEDGMENTS*

A. PROVIDER represents to 211 that upon the execution of this Agreement and continuing throughout the Agreement Term the following are true and correct. In the event that any of the following representations become at any time not true, the PROVIDER shall immediately provide written notice of same to the 211 Chief Financial & HR Officer.

1. There have been no irregularities involving its management or employees that could have a material effect on PROVIDER'S operations or financial stability.
2. PROVIDER has committed no violations or possible violations of laws or regulations the effects of which should be considered by 211 prior to entering into this Agreement.
3. There are no material transactions that have not been properly recorded in the appropriate document(s) or disclosed.
4. Related party transactions as defined by generally accepted accounting principles and related amounts receivable or payable have been properly recorded or disclosed.
5. It maintains appropriate active license(s), which are all in good standing and have not been revoked or suspended, where PROVIDER is operating a facility or providing a service where any type of licensure is required, including, but not limited to federal, state, county and local law.
6. PROVIDER represents that all persons delivering the services required by this Agreement are required by the PROVIDER's subcontract to have the knowledge and skills, either by training, experience, education, or a combination thereof, to adequately and competently perform the duties, obligations, and services set forth in the Scope of Work and to provide and perform such services to 211'S satisfaction for the agreed compensation.
7. PROVIDER and its subcontractors shall perform its duties, obligations, and services under this Agreement in a skillful and respectable manner. The quality of PROVIDER'S performance and all interim and final product(s) provided to or on behalf of 211 shall be comparable to local state and national best practice standards.

XIX. *PUBLIC ENTITIES CRIMES ACT*

PROVIDER represents that the execution of this Agreement will not violate the Public Entities Crimes Act (Section 287.133, Florida Statutes), which essentially provides that a person or affiliate who is a contractor, consultant or other provider and who has been placed on the convicted vendor list following a conviction for a Public Entity Crime may not submit a bid on a contract to provide any goods or services to 211, may not submit a bid on a contract with 211 for the construction or repair of a public building or public work, may not submit bids on leases of real property to 211, may not be awarded or perform work as a contractor supplier, subcontractor, or consultant under a contract with 211, and may not transact any business with 211 in excess of the threshold amount provided in Section 287.017, Florida Statues, for category two purchases for a period of thirty-six (36) months from the date of being placed on the convicted vendor list. Violation of this section shall result in cancellation of this Agreement and recovery of all monies paid hereto, and may result in debarment from 211's competitive procurement activities.

XX. *GOVERNING LAW AND VENUE*

This Agreement shall be governed, construed, and controlled according to the laws of the State of Florida without regard to its conflict of laws provisions. Any claim, objection or dispute arising out of the terms of this Agreement shall be litigated in Broward County, Florida.

XXI. *COMPLIANCE WITH LAWS*

The parties shall comply with all federal, state, and local government laws, codes, ordinances, rules, and regulations in performing its duties, responsibilities, and obligations related to this Agreement.

XXII. *SEVERABILITY*

In the event a portion of this Agreement is found by a court of competent jurisdiction to be invalid, the remaining provisions shall continue to be effective unless 211 or PROVIDER elects to terminate this Agreement. An election to terminate this Agreement based upon this provision shall be made within seven (7) days after the finding by the court becomes final.

XXIII. *HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)*

Both parties agree to satisfy the standard for personal health information contained in the federal and state statutes and regulations, including, without limitation, any regulations promulgated under HIPAA (Health Insurance Portability and Accountability Act), as applicable. It is expressly understood by the parties that where 211 is funding services, and 211 personnel and/or its agents shall have access to protected health information (hereinafter known as "PHI") for the purposes of compliance monitoring, quality assurance activities, and auditing. These provisions do not preclude 211 from disclosing protected health information to report unlawful conduct in accordance with 45 C.F.R. 164.502(j) (as may be amended from time to time).

Where required, PROVIDER shall handle and secure such PHI in compliance with HIPAA and its related regulations and, if required by HIPAA or other laws, include in its "Notice of Privacy Practices" notice of PROVIDER and/or 211's uses of client's PHI. The requirements to comply with this provision and HIPAA shall survive the expiration or earlier termination of this Agreement. The parties to this Agreement do not believe that a business associate or trading partner relationship (as defined by the Health Insurance Portability and Accountability Act or "HIPAA") exists between PROVIDER and 211 with regard to this Agreement; however if the Programs Manager subsequently determines that such a relationship exists, the parties agree to enter into an appropriate agreement using the form of such agreement to be provided by Programs Manager in his/her sole and absolute discretion at that time.

XXIV. EMPLOYEE SCREENING

PROVIDER assures all staff employed by PROVIDER meets the provisions for employment screening under Appendix A: Section 4.14 of this Agreement. PROVIDER assures that it further requires that all staff employed by its subcontractors providing services pursuant to this Agreement shall meet the same employment screening requirements.

XXV. TRAVEL

Where applicable, all travel expenses related to the performance of this Agreement shall be in accordance with section 112.061, F.S.

XXVI. CONTACT REPRESENTATIVES

The name, address, telephone number and e-mail of 211's representative responsible for administration of the program under this Agreement (and primary point of contact) are:

Name: Francisco Isaza, Chief Operating Officer
Address: 3317 NW 10TH Terrace, Ste. 403
City: Fort Lauderdale, FL 33309
Phone: 954-818-3637
Email: franciscoisaza@211-broward.org

Name: Louisa Morris, Chief Financial & HR Officer
Address: 3317 NW 10TH Terrace, Ste. 403
City: Fort Lauderdale, FL 33309
Phone: 954-390-0493, ext. 8014
Email: lmorris@211-broward.org

The name, address, telephone number and e-mail of Provider's representative responsible for administration of the program under this Agreement (and primary point of contact) are:

Name: Silvia Quintana, CEO
Address: 3521 West Broward Boulevard, Suite 206
Lauderhill, FL 33312
Phone: (954) 622-8121
Email: silvia.quintana@browardbehavioralhc.org

Name: Danica Mamby, Director of Administration
Address: 3521 West Broward Boulevard, Suite 206
Lauderhill, FL 33312
Phone: (954) 622-8121
Email: dmamby@BBHCFlorida.org

EXHIBIT 1

SCOPE OF WORK

Agency Name**:** Broward Behavioral Health Coalition

SCOPE OF SERVICE
The Provider will work with their subcontracted partners to provide regional supports targeting behavioral health needs of first responders and their families to reduce the incidence of suicide or attempted suicide among employed or retired first responders, pursuant to s.14.2019(5), F.S.

MAJOR CONTRACT GOALS
The major goal of this contract is to provide behavioral health supports designed to encourage the target population to seek services to offset the impact of traumatic exposure in the workplace and long-term risks associated with trauma in the first response community.

SERVICE AREA,
Services shall be provided to individuals throughout Broward County, Florida.

CLIENTS TO BE SERVED
Individuals to be served are First Responders and their family members, as defined in **Exhibit 2, Section A-1.1.2**.

CLIENT ELIGIBILITY AND DETERMINATION
The Provider shall be responsible for following 211's eligibility for services administered under this Contract.

SERVICE TASKS
Refer to **Exhibit 2, Section C-1.5.** In addition, providing a list of providers to 211 who will be funded to deliver the appropriate behavioral health services, and ensuring those providers will utilize the funding for only persons served under this contract through an agreed upon referral process.

ADMINISTRATIVE TASKS
Refer to **Exhibit 2, Section C-2**

INVOICE AND REPORTING SCHEDULE
An original invoice and report, in the format prescribed by the 211, is due on or before the fifth (5^{th}) day of the month following the month in which services were rendered.

Service Unit
For the Behavioral Health services specified in **Exhibit 2, Section C-1.5**, a service unit is as defined in Ch. 65E- 14.021, F.A.C., for the specific covered service provided.

EQUIPMENT
The PROVIDER may utilize funding provided under this Agreement to purchase equipment necessary to perform and complete the services described herein, in accordance with the 211 approved budget, if applicable. Capital equipment is defined for the purpose of this Agreement, as items with an acquisition cost of $1,000 or more, and a life expectancy of more than one year. The use, management, and disposal of capital equipment acquired with federal funds shall be in accordance of 2 CFR 200.313 (c-e).

By signing this Contract, the parties agree that they have read and agree to the entire Contract.

IN WITNESS THEREOF, the parties hereto have caused this **29** page Contract to be executed by their undersigned officials as duly authorized.

PROVIDER: Broward Behavioral Health Coalition, Inc.

Signature: Silvia Quintana
Print/Type Name: Silvia Quintana
Title: CEO
Date: 7/1/2022

2-1-1 Broward

Signature: Sheila Smith
Print/Type Name: Sheila Smith
Title: CEO/President
Date: 7/5/2022

The parties agree that any future amendment(s) replacing this page will not affect the above execution.

The Remainder of this Page Intentionally Left Blank.

EXHIBIT 2 – SAMH PROGRAMMATIC STATE AND FEDERAL LAWS, RULES, AND REGULATIONS

The BBHC and its subcontractors shall comply with all applicable state and federal laws, rules, and regulations, as amended from time to time, that affect the subject areas of the Agreement. Authorities include but are not limited to the following:

A1-1 Federal Authority

A1-1.1 Block Grants Regarding Mental Health and Substance Abuse

A1-1.1.1 Block Grants for Community Mental Health Services

42 U.S.C. ss. 300x, et seq.

A1-1.1.2 Block Grants for Prevention and Treatment of Substance Abuse

42 U.S.C. ss. 300x-21 et seq.

45 CFR Part 96, Subpart L

A1-1.2 Department of Health And Human Services, General Administration, Block Grants

45 CFR Part. 96

A1-1.3 Charitable Choice Regulations Applicable to Substance Abuse Block Grant and PATH Grant

42 CFR Part 54

A1-1.4 Confidentiality Of Substance Use Disorder Patient Records

42 CFR Part 2

A1-1.5 Security and Privacy

45 CFR Part 164

A1-1.6 Supplemental Security Income for the Aged, Blind and Disabled

20 CFR Part 416

A1-1.7 Temporary Assistance to Needy Families (TANF)

42 U.S.C. ss. 601 - 619

45 CFR, Part 260

A1-1.8 Projects for Assistance in Transition from Homelessness (PATH)

42 U.S.C. ss. 290cc-21 – 290cc-35

A1-1.9 Equal Opportunity for Individuals with Disabilities (Americans with Disabilities Act of 1990)

42 U.S.C. ss. 12101 - 12213

A1-1.10 Prevention of Trafficking (Trafficking Victims Protection Act of 2000)

22 U.S.C. s. 7104

2 CFR Part 175

A1-1.11 Governmentwide Requirements for Drug-Free Workplace (Financial Assistance)

2 CFR Part 182

2 CFR Part 382

A1-2 Florida Statutes

A1-2.1 Child Welfare and Community Based Care

Ch. 39, F.S.	Proceedings Relating to Children
Ch. 402, F.S.	Health and Human Services: Miscellaneous Provisions

A1-2.2 Substance Abuse and Mental Health Services

Ch. 381, F.S.	Public Health: General Provisions
Ch. 386, F.S.	Particular Conditions Affecting Public Health
Ch. 394, F.S.	Mental Health
Ch. 395, F.S.	Hospital Licensing and Regulation
Ch. 397, F.S.	Substance Abuse Services
Ch. 400, F.S.	Nursing Home and Related Health Care Facilities
Ch. 414, F.S.	Family Self-Sufficiency
Ch. 458, F.S.	Medical Practice
Ch. 464, F.S.	Nursing
Ch. 465, F.S.	Pharmacy
Ch. 490, F.S.	Psychological Services
Ch. 491, F.S.	Clinical, Counseling, and Psychotherapy Services
Ch. 499, F.S.	Florida Drug and Cosmetic Act
Ch. 553, F.S.	Building Construction Standards
Ch. 893, F.S.	Drug Abuse Prevention and Control
S. 409.906(8), F.S.	Optional Medicaid Services – Community Mental Health Services

A1-2.3 Developmental Disabilities

Ch. 393, F.S.	Developmental Disabilities

A1-2.4 Adult Protective Services

Ch. 415, F.S.	Adult Protective Services

A1-2.5 Forensics

Ch. 916, F.S.	Mentally Ill And Intellectually Disabled Defendants
Ch. 985, F.S.	Juvenile Justice; Interstate Compact on Juveniles
S. 985.19, F.S.	Incompetency in Juvenile Delinquency Cases
S. 985.24, F.S.	Use of detention; prohibitions

A1-2.6 State Administrative Procedures and Services

Ch. 119, F.S.	Public Records
Ch. 120, F.S.	Administrative Procedures Act
Ch. 287, F.S.	Procurement of Personal Property and Services
Ch. 435, F.S.	Employment Screening

Ch. 815, F.S.	Computer-Related Crimes
Ch. 817, F.S.	Fraudulent Practices
S. 112.061, F.S.	Per diem and travel expenses of public officers, employees, and authorized persons; statewide travel management system
S. 112.3185, F.S.	Additional standards for state agency employees
S. 215.422, F.S.	Payments, warrants, and invoices; processing time limits; dispute resolution; agency or judicial branch compliance
S. 216.181(16)(b), F.S.	Advanced funds for program startup or contracted services

A1-3 Florida Administrative Code

A1-3.1 Child Welfare and Community Based Care

Ch. 65C-13, F.A.C.	Foster Care Licensing
Ch. 65C-14, F.A.C.	Child-Caring Agency Licensing
Ch. 65C-15, F.A.C.	Child-Placing Agencies

A1-3.2 Substance Abuse and Mental Health Services

Ch. 65D-30, F.A.C.	Substance Abuse Services Office
Ch. 65E-4, F.A.C.	Community Mental Health Regulation
Ch. 65E-5, F.A.C.	Mental Health Act Regulation
Ch. 65E-10, F.A.C.	Psychotic and Emotionally Disturbed Children - Purchase of Residential Services Rules
Ch. 65E-11, F.A.C.	Behavioral Health Services
Ch. 65E-12, F.A.C.	Public Mental Health Crisis Stabilization Units and Short Term Residential Treatment Programs
Ch. 65E-14, F.A.C.	Community Substance Abuse and Mental Health Services - Financial Rules
Ch. 65E-20, F.A.C.	Forensic Client Services Act Regulation
Ch. 65E-26, F.A.C.	Substance Abuse and Mental Health Priority Populations and Services

A1-3.3 Financial Penalties

Ch. 65-29, F.A.C.	Penalties on Service Providers

A1-4 MISCELLANEOUS

A1-4.1 Department of Children and Families Operating Procedures

CFOP 155-10 / 175-40	Services for Children with Mental Health and Any Other Co-Occurring Substance Abuse or Developmental Disability Treatment Needs in Out-of-Home Care Placements
CFOP 155-11	Title XXI Behavioral Health Network
CFOP 155-47	Processing Referrals From The Department Of Corrections
CFOP 215-6	Incident Reporting and Analysis System (IRAS)

A1-4.2 Standards applicable to Cost Principles, Audits, Financial Assistance and Administrative Requirements

S. 215.425, F.S.	Extra Compensation Claims prohibited; bonuses; severance pay
S. 215.97, F.S.	Florida Single Audit Act
S. 215.971, F.S.	Agreements funded with federal or state assistance
Ch. 69I-42, F.A.C.	Travel Expenses
Ch. 69I-5, F.A.C	State Financial Assistance
CFO's Memorandum No. 01	Contract and Grant Reviews and Related Payment Processing Requirements
CFO's Memorandum No. 02	Reference Guide for State Expenditures
Comptroller's Memorandum No. 04	Guidance on all Contractual Service Agreements Pursuant to Section 215.971, Florida Statutes
CFO's Memorandum No. 20	Compliance Requirements for Agreements
2 CFR, Part 180	Office of Management and Budget Guidelines to Agencies on Government Wide Debarment and Suspension (Non-procurement),
2 CFR, Part 200	Office of Management and Budget Guidance - Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, available at https://www.ecfr.gov/current/title-2/subtitle-A/chapter-II/part-200
2 CFR, Part 300	Department of Health and Human Services - Office of Management and Budget Guidance - Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, Adoption of 2 CFR Part 200
45 CFR, Part 75	Uniform Administration Requirements, Cost Principles, and Audit Requirements for HHS Awards

A1-4.3 Data Collection and Reporting Requirements

S. 394.74(3)(e), F.S.	Data Submission
S. 394.9082, F.S.	Behavioral health managing entities
S. 394.77, F.S.	Uniform management information, accounting, and reporting systems for providers
S. 397.321(3)(c), F.S.	Data collection and dissemination system
DCF PAM 155-2	Financial and Services Accountability Management System (FASAMS)

B1-1 Behavioral Health Services

The Provider shall connect persons served to Department-funded treatment services provided by the Broward Behavioral Health Coalition, Inc., including:

B-1.1 The Provider shall use a standardized methodology to identify individual behavioral health treatment needs and to identify existing third-party payor resources the individual may access to address treatment needs.

B-1.2 Where third-party payor resources are unavailable for the indicated treatment need or are insufficient to adequately address the treatment needs, the Provider shall assess the individual for eligibility for Department-funded services.

B-1.3 The Provider shall ensure efficient referral to Network Service Providers under subcontract with a Managing Entity for the delivery of appropriate treatment services.

B-1.4 The Provider shall ensure prompt invoicing, service validation, data outcome reporting, and payment processing of services provided with these funds.

B-1.5 The Provider shall develop a process for seamless transition of services to third-party payor resources for an individual's treatment needs exceeding the term of this Contract.

C-1 ADMINISTRATIVE TASKS

C-1.1 Staffing

The Provider shall maintain a culturally competent workforce with knowledge and expertise of the unique circumstances facing first responders and their families. The provider shall maintain the following minimum FTEs by any combination of direct, subcontracted, or in-kind staffing.

C-1.1.1 4.0 FTE First Responder Peer

C-1.1.2 1.0 FTE Behavioral Health Navigator

C-1.1.3 3.0 FTE Helpline Counselor

C-1.2 Professional Qualifications

C-1.2.1 The Provider shall be responsible for determining staffing qualifications for each position in the approved line-item budget.

C-1.2.2 The Provider shall ensure that all staff qualifications comply with applicable statutes, rules, licensing standards, and the Provider's qualifications.

C-1.2.3 The Provider shall ensure all staff receive training to meet the qualification requirements of their position, including but not limited to information and referral and crisis intervention.

C-1.2.3.1 First Responder Peers shall also receive training to meet peer specialist certification requirements.

C-1.2.3.2 The Behavioral Health Navigator shall receive specialized training regarding system coordination.

ATTACHMENT 1

The administration of resources awarded by 211 Broward to the BBHC may be subject to audits as described in this attachment.

MONITORING

In addition to reviews of audits conducted in accordance with 2 Code of Federal Regulations (CFR) §§ 200.500-200.521 and § 215.97, F.S., as revised, the Department may monitor or conduct oversight reviews to evaluate compliance with contract, management, and programmatic requirements. Such monitoring or other oversight procedures may include, but not be limited to, on-site visits by Department staff, agreed-upon procedures engagements as described in 2 CFR § 200.425 or other procedures. By entering into this agreement, the recipient agrees to comply and cooperate with any monitoring procedures deemed appropriate by the Department. In the event the Department determines that a limited scope audit of the recipient is appropriate, the recipient agrees to comply with any additional instructions provided by the Department regarding such audit. The recipient further agrees to comply and cooperate with any inspections, reviews, investigations, or audits deemed necessary by the Department's inspector general, the state's Chief Financial Officer or the Auditor General.

AUDITS

PART I: FEDERAL REQUIREMENTS

This part is applicable if the recipient is a State or local government, or a non-profit organization as defined in 2 CFR §§ 200.500-200.521.

In the event the recipient expends $750,000 or more in Federal awards during its fiscal year, the recipient must have a single or program-specific audit conducted in accordance with the provisions of 2 CFR §§ 200.500-200.521. The recipient agrees to provide a copy of the single audit to the Department's Single Audit Unit and its contract manager. In the event the recipient expends less than $750,000 in Federal awards during its fiscal year, the recipient agrees to provide certification to the Department's Single Audit Unit and its contract manager that a single audit was not required. In determining the Federal awards expended during its fiscal year, the recipient shall consider all sources of Federal awards, including Federal resources received from the Department of Children & Families, Federal government (direct), other state agencies, and other non-state entities. The determination of amounts of Federal awards expended should be in accordance with guidelines established by 2 CFR §§ 200.500-200.521. An audit of the recipient conducted by the Auditor General in accordance with the provisions of 2 CFR Part 200 §§ 200.500-200.521 will meet the requirements of this part. In connection with the above audit requirements, the recipient shall fulfill the requirements relative to auditee responsibilities as provided in 2 CFR § 200.508.

The schedule of expenditures should disclose the expenditures by contract number for each contract with the Department in effect during the audit period. The financial statements should disclose whether or not the matching requirement was met for each applicable contract. All questioned costs and liabilities due the Department shall be fully disclosed in the audit report package with reference to the specific contract number.

PART II: STATE REQUIREMENTS

This part is applicable if the recipient is a nonstate entity as defined by Section 215.97(2), F.S.

In the event the recipient expends $500,000 or more ($750,000 or more for fiscal years beginning on or after July 1, 2016) in state financial assistance during its fiscal year, the recipient must have a State single or project-specific audit conducted in accordance with Section 215.97, Florida Statutes; applicable rules of the Department of Financial Services; and Chapters 10.550 (local governmental entities) or 10.650 (nonprofit and for-profit organizations), Rules of the Auditor General. The recipient agrees to provide a copy of the single audit to the Department's Single Audit Unit and its contract manager. In the event the recipient expends less than $500,000 (less than $750,000 for fiscal years beginning on or after July 1, 2016) in State financial assistance during its fiscal year, the recipient agrees to provide certification to the Department's Single Audit Unit and its contract manager that a single audit was not required. In determining the state financial assistance expended during its fiscal year, the recipient shall consider all sources of state financial assistance, including state financial assistance received from the Department of Children &

Families, other state agencies, and other nonstate entities. State financial assistance does not include Federal direct or pass-through awards and resources received by a nonstate entity for Federal program matching requirements.

In connection with the audit requirements addressed in the preceding paragraph, the recipient shall ensure that the

audit complies with the requirements of Section 215.97(8), Florida Statutes. This includes submission of a financial reporting package as defined by Section 215.97(2), Florida Statutes, and Chapters 10.550 or 10.650, Rules of the Auditor General.

The schedule of expenditures should disclose the expenditures by contract number for each contract with the Department in effect during the audit period. The financial statements should disclose whether or not the matching requirement was met for each applicable contract. All questioned costs and liabilities due the Department shall be fully disclosed in the audit report package with reference to the specific contract number.

PART III: REPORT SUBMISSION

Any reports, management letters, or other information required to be submitted to the 211 pursuant to this agreement shall be submitted within 180 days after the end of the provider's fiscal year or within 30 (federal) or 45 (State) days of the recipient's receipt of the audit report, whichever occurs first, directly to each of the following unless otherwise required by Florida Statutes:

A. Chief Financial & HR Officer for this contract (1 copy)

PART IV: RECORD RETENTION

The recipient shall retain sufficient records demonstrating its compliance with the terms of this agreement for a period of six years from the date the audit report is issued and shall allow 211's Chief Financial & HR Officer access to such records upon request. The recipient shall ensure that audit working papers are made available to the 211's Chief Financial & HR Officer upon request for a period of three years from the date the audit report is issued, unless extended in writing by the Department.

ATTACHMENT 2

CERTIFICATION REGARDING LOBBYING

CERTIFICATION FOR CONTRACTS, GRANTS, LOANS AND COOPERATIVE AGREEMENTS

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or an employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with this federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Signature: DocuSigned by: Silvia Quintana 38C7D57E4C654C4... Date: 7/1/2022

Name of Authorized Individual Application or Contractor: Silvia Quintana

Address of Organization: 3521 W. Broward Blvd. Ste. 206 Lauderhill, FL 33312

ATTACHMENT 3

This Attachment contains the terms and conditions governing the Provider's access to and use of Protected Health Information and provides the permissible uses and disclosures of protected health information by the Provider, also called "Business Associate."

Section 1.Definitions

1.1 Catch-all definitions:

The following terms used in this Attachment shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required by Law, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

1.2 Specific definitions:

1.2.1 "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR § 160.103, and for purposes of this Attachment shall specifically refer to the Provider.

1.2.2 "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR § 160.103, and for purposes of this Attachment shall refer to the Department.

1.2.3. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and

Enforcement Rules at 45 CFR Part 160 and Part 164.

1.2.4. "Subcontractor" shall generally have the same meaning as the term "subcontractor" at 45 CFR § 160.103 and is defined as an individual to whom a business associate delegates a function, activity, service, other than in the capacity of a member of the workforce of such business associate.

Section 2.Obligations and Activities of Business Associate

2.1 Business Associate agrees to:

2.1.1 Not use or disclose protected health information other than as permitted or required by this Attachment or as required by law;

2.1.2 Use appropriate administrative safeguards as set forth at 45 CFR § 164.308, physical safeguards as set forth at 45 CFR § 164.310, and technical safeguards as set forth at 45 CFR § 164.312; including, policies and procedures regarding the protection of PHI and/or ePHI set forth at 45 CFR § 164.316 and the provisions of training on such policies and procedures to applicable employees, independent contractors, and volunteers, that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI and/or ePHI that the Provider creates, receives, maintains or transmits on behalf of the Department;

2.1.3 Acknowledge that (a) the foregoing safeguards, policies and procedures requirements shall apply to the Business Associate in the same manner that such requirements apply to the Department, and (b) the Business Associate's and their Subcontractors are directly liable under the civil and criminal enforcement provisions set forth at Section 13404 of the HITECH Act and section 45 CFR §§ 164.500 and 164.502(E) of the Privacy Rule (42 U.S.C. 1320d-5 and 1320d- 6), as amended, for failure to comply with the safeguards, policies and procedures requirements and any guidance issued by the Secretary of Health and Human Services with respect to such requirements and any guidance issued by the Secretary of Health and Human Services with respect to such requirements;

2.1.4 Report to covered entity any use or disclosure of protected health information not provided for by this Attachment of which it becomes aware, including breaches of unsecured protected health information as required at 45 CFR § 164.410, and any security incident of which it becomes aware;

2.1.5 Notify the Department's Security Officer, Privacy Officer, and the Contract Manager as soon as possible, but no later than five (5) business days following the determination of any breach or potential breach of personal and confidential departmental data;

2.1.6 Notify the Privacy Officer and Contract Manager within (24) hours of notification by the US Department of Health and Human Services of any investigations, compliance reviews or inquiries by the US Department of Health and Human Services concerning violations of HIPAA (Privacy, Security Breach).

2.1.7 Provide any additional information requested by the Department for purposes of investigating and responding to a breach;

2.1.8 Provide at Business Associate's own cost notice to affected parties no later than 45 days following the determination of any potential breach of personal or confidential departmental data as provided in section 501.171, F.S.;

2.1.9 Implement at Business Associate's own cost measures deemed appropriate by the Department to avoid or mitigate potential injury to any person due to a breach or potential breach of personal and confidential departmental data;

2.1.10 Take immediate steps to limit or avoid the recurrence of any security breach and take any other action pertaining to such unauthorized access or disclosure required by applicable federal and state laws and regulations regardless of any actions taken by the Department ;

2.1.11 In accordance with 45 CFR §§ 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the business associate agree to the same restrictions, conditions, and requirements that apply to the business associate with respect to such information. Business Associate's must attain satisfactory assurance in the form of a written contract or other written agreement with their business associate's or subcontractor's that meets the applicable requirements of 164.504(e)(2) that the Business Associate or Subcontractor will appropriately safeguard the information. For prior contracts or other arrangements, the provider shall provide written certification that its implementation complies with the terms of 45 CFR § 164.532(d);

2.1.12 Make available protected health information in a designated record set to covered entity as necessary to satisfy covered entity's obligations under 45 CFR § 164.524;

2.1.13 Make any amendment(s) to protected health information in a designated record set as directed or agreed to by the covered entity pursuant to 45 CFR § 164.526, or take other measures as necessary to satisfy covered entity's obligations under 45 CFR § 164.526;

2.1.14 Maintain and make available the information required to provide an accounting of disclosures to the covered entity as necessary to satisfy covered entity's obligations under 45 CFR § 164.528;

2.1.15 To the extent the business associate is to carry out one or more of covered entity's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the covered entity in the performance of such obligation(s); and

2.1.16 Make its internal practices, books, and records available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance with the HIPAA Rules.

Section 3. Permitted Uses and Disclosures by Business Associate

3.1 The Business associate may only use or disclose protected health information covered under this Attachment as listed below:

3.1.1 The Business Associate may use and disclose the Department's PHI and/or ePHI received or created by Business Associate (or its agents and subcontractors) in performing its obligations pursuant to this Attachment.

3.1.2 The Business Associate may use the Department's PHI and/or ePHI received or created by Business Associate (or its agents and subcontractors) for archival purposes.

3.1.3 The Business Associate may use PHI and/or ePHI created or received in its capacity as a Business Associate of the Department for the proper management and administration of the Business Associate if such use is necessary (a) for the proper management and administration of Business Associate or (b) to carry out the legal responsibilities of Business Associate.

3.1.4 The Business Associate may disclose PHI and/or ePHI created or received in its capacity as a Business Associate of the Department for the proper management and administration of the Business Associate if (a) the disclosure is required by law or (b) the Business Associate (1) obtains reasonable assurances from the person to whom the PHI and/or ePHI is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person and (2) the person agrees to notify the Business Associate of any instances of which it becomes aware in which the confidentiality and security of the PHI and/or ePHI has been breached.

3.1.5 The Business Associate may aggregate the PHI and/or ePHI created or received pursuant this Attachment with the PHI and/or ePHI of other covered entities that Business Associate has in its possession through its capacity as a Business Associate of such covered entities for the purpose of providing the Department of Children and Families with data analyses relating to the health care operations of the Department (as defined in 45 C.F.R. § 164.501).

3.1.6 The Business Associate may de-identify any and all PHI and/or ePHI received or created pursuant to this Attachment, provided that the de-identification process conforms to the requirements of 45 CFR § 164.514(b).

3.1.7 Follow guidance in the HIPAA Rule regarding marketing, fundraising and research located at Sections 45 CFR § 164.501, 45 CFR § 164.508 and 45 CFR § 164.514.

Section 4. Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions

4.1 Covered entity shall notify business associate of any limitation(s) in the notice of privacy practices of covered entity under 45 CFR § 164.520, to the extent that such limitation may affect business associate's use or disclosure of protected health information.

4.2 Covered entity shall notify business associate of any changes in, or revocation of, the permission by an individual to use or disclose his or her protected health information, to the extent that such changes may affect business associate's use or disclosure of protected health information.

4.3 Covered entity shall notify business associate of any restriction on the use or disclosure of protected health information that covered entity has agreed to or is required to abide by under 45 CFR § 164.522, to the extent that such restriction may affect business associate's use or disclosure of protected health information.

Section 5. Termination

5.1 Termination for Cause

5.1.1 Upon the Department's knowledge of a material breach by the Business Associate, the Department shall either:

5.1.1.1 Provide an opportunity for the Business Associate to cure the breach or end the violation and terminate the Agreement or discontinue access to PHI if the Business Associate does not cure the breach or end the violation within the time specified by the Department of Children and Families;

5.1.1.2 Immediately terminate this Agreement or discontinue access to PHI if the Business Associate has breached a material term of this Attachment and does not end the violation; or

5.1.1.3 If neither termination nor cure is feasible, the Department shall report the violation to the Secretary of the Department of Health and Human Services.

5.2 Obligations of Business Associate Upon Termination

5.2.1 Upon termination of this Attachment for any reason, business associate, with respect to protected health information received from covered entity, or created, maintained, or received by business associate on behalf of covered entity, shall:

5.2.1.1 Retain only that protected health information which is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities;

5.2.1.2 Return to covered entity, or other entity as specified by the Department or, if permission is granted by the Department, destroy the remaining protected health information that the Business Associate still maintains in any form;

5.2.1.3 Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information to prevent use or disclosure of the protected health information, other than as provided for in this Section, for as long as Business Associate retains the protected health information;

5.2.1.4 Not use or disclose the protected health information retained by Business Associate other than for the purposes for which such protected health information was retained and subject to the same conditions set out at paragraphs 3.1.3 and 3.1.4 above under "Permitted Uses and Disclosures By Business Associate" which applied prior to termination; and

5.2.1.5 Return to covered entity, or other entity as specified by the Department or, if permission is granted by the Department, destroy the protected health information retained by business associate when it is no longer needed by business associate for its proper management and administration or to carry out its legal responsibilities.

5.2.1.6 The obligations of business associate under this Section shall survive the termination of this Attachment.

Section 6. Miscellaneous

6.1 A regulatory reference in this Attachment to a section in the HIPAA Rules means the section as in effect or as amended.

6.2 The Parties agree to take such action as is necessary to amend this Attachment from time to time as is necessary for compliance with the requirements of the HIPAA Rules and any other applicable law.

6.3 Any ambiguity in this Attachment shall be interpreted to permit compliance with the HIPAA Rules.

VENDOR CERTIFICATION REGARDING SCRUTINIZED COMPANIES LISTS

Respondent Vendor Name: Silvia Quintana

Vendor FEIN: 45-3675836

Vendor's Authorized Representative Name and Title: Silvia Quintana, CEO

Address: 3521 W. Broward Blvd. Ste. 206

City: Lauderhill State: FL Zip: 33312

Phone Number: (954) 622-8121

Email Address: squintana@bbhcflorida.org

Pursuant to section 287.135, Florida Statutes, a company that is on the Scrutinized Companies that Boycott Israel List, created pursuant to section 215.4725, Florida Statutes is prohibited from submitting a proposal for, or entering into or renewing a contract with an agency or local governmental entity, for goods or services for any amount. A company may not bid on, submit a proposal for, or enter into or renew a contract for goods or services of $1 million or more if the company is on either the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List, created pursuant to section 215.473, Florida Statutes.

As the person authorized to sign on behalf of Respondent, I hereby certify that the company identified above in the section entitled "Respondent Vendor Name" is not listed on either the Scrutinized Companies that Boycott Israel List, Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List I understand that pursuant to section 287.135, Florida Statutes, the submission of a false certification may subject such company to civil penalties, attorney's fees, and/or costs and termination of the contract at the option of the awarding governmental entity.

Certified By: Silvia Quintana (*Print Name*) CEO (*Print Title*),

who is authorized to sign on behalf of the above referenced company.

Authorized Signature: DocuSigned by: Silvia Quintana.

Attachment

Contract No. LH839

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION CONTRACTS/SUBCONTRACTS

This certification is required by the regulations implementing Executive Order 12549, Debarment and Suspension, signed February 18, 1986. The guidelines were published in the May 29, 1987 Federal Register (52 Fed. Reg., pages 20360 - 20369).

INSTRUCTIONS

1. Each provider whose contract/subcontract equals or exceeds $25,000 in federal moneys must sign this certification prior to execution of each contract/subcontract. Additionally, providers who audit federal programs must also sign, regardless of the contract amount. The Department of Children and Families cannot contract with these types of providers if they are debarred or suspended by the federal government.
2. This certification is a material representation of fact upon which reliance is placed when this contract/subcontract is entered into. If it is later determined that the signer knowingly rendered an erroneous certification, the Federal Government may pursue available remedies, including suspension and/or debarment.
3. The provider shall provide immediate written notice to the contract manager at any time the provider learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.
4. The terms "debarred", "suspended", "ineligible", "person", "principal", and "voluntarily excluded", as used in this certification, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the department's contract manager for assistance in obtaining a copy of those regulations.
5. The provider agrees by submitting this certification that, it shall not knowingly enter into any subcontract with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this contract/subcontract unless authorized by the Federal Government.
6. The provider further agrees by submitting this certification that it will require each subcontractor of this contract/subcontract, whose payment will equal or exceed $25,000 in federal moneys, to submit a signed copy of this certification.
7. The Department of Children and Families may rely upon a certification of a provider that it is not debarred, suspended, ineligible, or voluntarily excluded from contracting/subcontracting unless it knows that the certification is erroneous.
8. This signed certification must be kept in the contract manager's contract file. Subcontractor's certification must be kept at the provider's business location.

CERTIFICATION

(1) The prospective provider certifies, by signing this certification, that neither he nor his principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this contract/subcontract by any federal department or agency.

(2) Where the prospective provider is unable to certify to any of the statements in this certification, such prospective provider shall attach an explanation to this certification.

DocuSigned by:
Silvia Quintana

Signature

7/1/2022

Date

Silvia Quintana

Name (type or print)

CEO

Title

CF 1125

Effective July 2015

(CF-1125-1516)

TO Broward Behavioral Health Coalition Inc. (BBHC) Recovery Oriented System of Care Committee, Finance Committee, Board of Directors

FROM Silvia Quintana, CEO

SUBJECT Contract with Jewish Adoption and Family Care Options (Eagles' Haven)

DATE August 9, 2022

BACKGROUND

Jewish Adoption and Family Care Options has acquired a special project appropriation ($600,000) through the Florida Legislature and the Governor's Office for Eagles' Haven Wellness Center.

Through the Antiterrorism and Emergency Assistance Project (AEAP) grant the center was funded by the Children Services County of Broward County (CSC) at $1,200,000. CSC will continue to fund Eagles' Haven Wellness Center at $600,000.

To contract with the provider for services, BBHC requested that they complete our prequalification packet as we are required to ensure our network service providers meet contractual requirements. These prequalification documents are a necessary part of our quality assurance process (fiscal and programmatic) to ensure a successful contractual relationship with our providers and to ensure accountability, viability, and quality of services.

SUMMARY

Eagles' Haven Wellness Center offer wellness services, case management, trauma education, & crisis intervention in one nurturing setting. Community members can call or drop into the center 7 days a week, free of charge. The Eagles' Haven Navigators provide clinical assessment and crisis support to all clients while also linking families to any needed service. The Center targets anyone impacted by the shooting at Marjory Stoneman Douglas High School in Parkland, Florida in 2018. While initially aimed at students, parents and teachers in the Parkland/Coral Springs community, the center has expanded to serve anyone suffering from trauma related to the shooting or otherwise.

RECOMMENATION

It is being recommended that the BBHC Board of Directors approve BBHC contracting with Jewish Adoption and Family Care Options (JAFCO) with the following conditions:

1. JAFCO submits a completed Prequalification Application
2. JAFCO submits an updated background screening for their Controller
3. JAFCO submits a budget for $1.2 Million for Eagles' Haven
4. JAFCO submits quarterly Return on Investment Reports
5. At the end of the year, JAFCO submits a Financial Audit

2022 Florida
Cultural Health Disparity
and Behavioral Health
Needs Assessment

An Analysis of the Managing Entities Behavioral Health System of Care

Sponsored by the Florida Department of Children and Families

THE FLORIDA SENATE
Tallahassee, Florida 32399-1100

COMMITTEES:
Agriculture, Chair
Appropriations
Appropriations Subcommittee on Health and Human Services
Banking and Insurance
Children, Families, and Elder Affairs
Judiciary
Reapportionment
Regulated Industries

SELECT SUBCOMMITTEE:
Select Subcommittee on Congressional Reapportionment

SENATOR DARRYL ERVIN ROUSON
19th District

June 30, 2022

To Whom It May Concern:

When I was elected to the Florida House of Representatives in 2008, I determined that "behavioral health" should be a top priority of the Legislature. In 2018, during my first term in the Florida Senate, I embarked on a seven-month statewide tour to learn first-hand about Florida's behavioral health system of care. From Miami to Pensacola, I visited the following with the seven managing entities, forty large and small mental health and substance abuse providers, and forty-two different support programs. But, most important, I personally spoke with more than one thousand individuals enrolled in programs and in recovery.

Because of my first-hand experience, I saw a successful safety-net system of care for individuals who do not have insurance or other means to pay for behavioral health services. In addition, I identified opportunities that needed to be addressed by the Legislature; such as safe and stable housing; systems care coordination; flexible background screening for peers; and access to services for underserved communities.

In my Senate tenure, I increased funding for systems Care Coordination and worked to pass peer specialist legislation. In the 2021 Legislative Session, I secured funding to the Department of Children and Families for the Managing Entities to facilitate and conduct a statewide assessment of cultural health disparities.

I am pleased so far with the 2022 Florida Cultural Health Disparity and Behavioral Health Needs Assessment partially completed by the Managing Entities. This comprehensive report identifies opportunities across Florida that together with the support of the Legislature, stakeholder and the Managing Entity strategies may be developed so Floridians will lead healthy lives.

I pledge to continue fighting for underserved communities so that they may have access to the highest quality of behavioral health services.

Sincerely yours,

Darryl E. Rouson
State Senator, District 19

REPLY TO:
☐ 535 Central Avenue, Suite 302, St. Petersburg, Florida 33701 (727) 822-6828
☐ 212 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5019

Senate's Website: www.flsenate.gov

WILTON SIMPSON
President of the Senate

AARON BEAN
President Pro Tempore

The 2022 Florida Cultural Health Disparity and Behavioral Health Needs would not have been accomplished without the collaboration of the Managing Entities and the Local Health Councils across the state. A special thank you to those who collected and analyzed the primary and secondary data, worked with community partners to distribute the surveys, and conducted the focus group research.

Broward Behavioral Health Coalition
Central Florida Behavioral Health Network
Central Florida Cares Health System, Inc.
Lutheran Health Systems
Northwest Florida Health Network
Southeast Florida Behavioral Health Network, Inc.
Thriving Mind South Florida

&

Broward Regional Health Planning Council, Inc.
Health Council of East Central Florida, Inc.
Health Council of South Florida, Inc.
Health Council of Southeast Florida, Inc.
Health Council of West Central Florida, Inc.
Health Planning Council of Southwest Florida, Inc.
Northwest Florida Health Council, Inc./Big Bend Health Council, Inc.
Suncoast Health Council, Inc.
WellFlorida Council, Inc.

Introduction

History

The Florida Legislature created a Managing Entity pilot program in 2008 to improve accountability within the state's substance abuse and mental health funding and its overall behavioral health system of care. The pilot produced positive outcomes by supporting the community's needs. As a result of this success, the model was implemented on a statewide basis in 2013, creating seven Managing Entities (ME) across Florida. The MEs continue to achieve successful management of the system of care by increasing service capacity, ensuring access to quality care, and being good stewards of state funding.

The Florida Association of Managing Entities (FAME), is a statewide organization representing Florida's seven behavioral health managing entities that guide, administer, and make accountable the federal, state, and local funding that supports the network of more than 300 behavioral health providers. The mission of FAME is to advance the recovery of individuals and their families so individuals can live healthy lives to their fullest potential.

In 1982 the Florida Legislature under Florida Statute Section 408.033, established local health councils (LHCs) as a network of non-profit agencies that conduct regional health planning and implementation activities. LHCs develop district health plans containing data, analysis, and recommendations that relate to healthcare status and needs in the community. The recommendations are designed to improve access to health care, reduce disparities in health status, assist state and local governments in the development of sound and rational health care policies, and advocate on behalf of the underserved. Local health councils also study the impact of various initiatives on the healthcare system, aid the public and private sectors, and create and disseminate materials designed to increase their communities understanding of healthcare issues.

The ME serving Brevard, Orange, Osceola, and Seminole counties, known as Central Florida Cares Health System (CFCHS), and the Health Council of East Central Florida, Inc., (HCECF) have worked together for the past nine years preparing the CFCHS tri-annual behavioral health needs assessments (BHNA). The most recent assessment was completed in 2019.

In late summer 2021, the report template used for the 2019 CFCHS BHNA was shared with all the MEs to determine the feasibility for creating a statewide document. A truly collaborative process was needed to accomplish this assessment in the time frame allotted. Having an agreed-upon document template was the first step in designing the assessment process. FAME, CFCHS, and HCECF took the lead in developing the assessment process knowing that it would require collaboration from not only the MEs but other community partners as well. Florida's Local Health Councils (LHC) are statutorily mandated to conduct regional health planning and create and disseminate materials designed to increase their communities understanding of healthcare issues. The skill set of the LHC's made them the perfect community partners to assist the ME's with this project. HCECF staff

merged the components together for a comprehensive statewide document that also included assessment reports for the seven MEs.

As not all MEs had previously worked with their local health councils on the behavioral health needs assessment, relationships had to be established for data to flow from the MEs to the LHCs for analysis. These organizations collaborated on all the assessment components and worked tirelessly to ensure all deliverable timelines were met. This is now a statewide model that can be used for future assessments, strategic health planning, and program evaluation to improve health outcomes across Florida.

Statewide Behavioral Health Needs Assessment

Behavioral Health Needs Assessment/Enhancement Plan

In 2016, the Florida Legislature required the managing entities to conduct a triennial needs assessment and yearly enhancement plans, Florida Statute 394.9082 (5) and (8):

(5) MANAGING ENTITY DUTIES. — A managing entity shall:

(b) Conduct a community behavioral health care needs assessment every 3 years in the geographic area served by the managing entity which identifies needs by subregion. The process for conducting the needs assessment shall include an opportunity for public participation. The assessment shall include, at a minimum, the information the department needs for its annual report to the Governor and Legislature pursuant to s. 394.4573. The assessment shall also include a list and descriptions of any gaps in the arrays of services for children or adolescents identified pursuant to s. 394.4955 and recommendations for addressing such gaps. The managing entity shall provide the needs assessment to the department.

(8) ENHANCEMENT PLANS. — By September 1 of each year, beginning in 2017, each managing entity shall develop and submit to the department a description of strategies for enhancing services and addressing three to five priority needs in the service area. The planning process sponsored by the managing entity shall include consumers and their families, community-based care lead agencies, local governments, law enforcement agencies, service providers, community partners and other stakeholders. Each strategy must be described in detail and accompanied by an implementation plan that specifies action steps, identifies responsible parties, and delineates specific services that would be purchased, projected costs, the projected number of individuals that would be served, and the estimated benefits of the services. All or parts of these enhancement plans may be included in the department's annual budget requests submitted to the Legislature.

Each year, the Florida Legislature has broadened the MEs scope of work due to the successful track record of enhancing the community behavioral health system of care. One of the ways this is accomplished is through the implementation of a behavioral health needs assessment process. Assessing the physical, social, and environmental health of a population identifies key health needs and assets within a community. Epidemiological, quantitative, and qualitative research components define the data-driven process designed to improve health outcomes with the goal of ensuring that community resources are used efficiently and effectively. The assessment serves as the foundation for developing a strategic action plan to lead the community from 'where we are' to 'where we want to be'.

Cultural Health Disparities Study

In 2021, the Florida Legislature allocated non-recurring funds to specifically assess cultural health disparities as stated below. This funding was the catalyst for exploring the feasibility of conducting a statewide needs assessment.

> *From funds in Specific Appropriation 369A, the nonrecurring sum of $500,000 from the General Revenue Fund, which was awarded, in part, under the Consent Judgement in State of Florida v. McKinsey & Company, shall be provided to the Department of Children and Families for the Managing Entities to facilitate community engagement in assessing cultural health disparities, to develop strategies that engage minority populations with community services, and to enhance the awareness of mental health and substance abuse services available to minority communities.*

Assessment Document

The 2022 BHNA document contains a state report followed by a report for each ME. All eight reports are designed to be stand-alone reports as well. Each report contains the data components as bulleted below:

- Demographic profile
- General Health Assessment
- Individuals Served Profile
- Homelessness Population Profile
- Homeless Individuals Served Profile
- Cost Center Descriptions, Expenditures, and Under/Over Production
- Cultural Health Disparity Survey Results
- Cultural Health Disparity Focus Group Summary
- No Wrong Door Survey Results
- ME Provider Focus Group Summary
- Individuals Served Survey
- Stakeholder Survey
- Recovery Community Peer Support Specialists Survey
- Recovery Support Resources

Methodology

Using the components of the 2019 CFCHS needs assessment as a foundation for the statewide behavioral health assessment project, each component was thoroughly reviewed to ensure the most relevant data was collected, analyzed, and reported accurately. All surveys were revised to capture data that supported the cultural health disparity objective of Specific Appropriation 369A.

- A demographic profile was constructed for the state and each ME service area. The profile included a 5-year population growth trend, most recent year racial and ethnic composition, age range, educational attainment, employment, and Federal Poverty Level (FPL) status. Indicators were reported as population percentages and compared to the state, when available. Indicators were chosen based on the available data for ME clients. This facilitated direct comparisons between the general population and those served by the MEs. Data was gathered from the U.S. Census Bureau American Community Survey (ACS) for 2016-2020, 5-Year Estimates. Single year data (ACS 2020) are experimental and should be interpreted with caution.

- A general health assessment was provided to present the overall health status at the state level and for the ME service areas. Blended ME service area rates for the Behavioral Risk Factor Surveillance System (BRFSS) indicators were provided by staff at the Florida Department of Health, Division of Community Health Promotion, Public Health Research

Section. State BRFSS data, child abuse rates, serious mental illness and disability rates were gathered from FLHealthCHARTS.gov. Crude death rates for the ME service areas were calculated from vital statistics data available from FLHealthCHARTS.gov. Domestic violence offences by county were provided by the Florida Department of Law Enforcement Uniform Crime Report 2020. Calculations were made for MEs serving more than one county. State and ME service area rates for indicators from the Florida Youth Substance Abuse Survey (FYSAS) were provided by staff at the Florida Department of Health Division of Community Health Promotion, Public Health Research Unit.

- An ME client demographic profile was constructed for the State and for each ME service area. The MEs provided de-identified client data by demographic component and program to the LHC staff for analysis. Client data were for FY20-21.

- A homeless population profile was constructed using state and local data available through the Department of Children and Families (2021). Data were tabulated for ME service areas.

- A homeless ME client profile was constructed for the state and for each ME service area. The MEs provided de-identified homeless client data by demographic component and program to the LHC staff for analysis. Client data was for FY20-21.

- Cost center descriptions, expenditures, and over/underproduction (FY20-21) were provided for ME services areas.

- The Cultural Health Disparity Survey was designed by the MEs. The survey consisted of 14 questions including demographics. To survey individuals most in need and at a high risk for disparity, the surveys were distributed in vulnerable communities using the CDC Social Vulnerability Index (CDC SVI). This index uses U.S. Census data to determine the social vulnerability of every census tract. The CDC SVI ranks each tract on 15 social factors, including poverty, lack of vehicle access, and crowded housing, and groups them into four related themes:
    - Socioeconomic Status
    - Household Composition
    - Race/Ethnicity/Language
    - Housing/Transportation

A census tract ZIP Code crosswalk was created to assist the MEs in identifying the most appropriate clients for this survey. The survey was in the field for 5 weeks and made available through an electronic link and QR code that could be emailed, texted, printed, or posted to social media. The survey was translated into 3 languages: English, Spanish, and Creole. LHC staff analyzed and reported the survey results for each ME service area. Results were cross tabulated to provide an understanding of the variables among racial and ethnic populations. All survey results were rolled up for a state level report.

- Cultural Health Disparity Focus Groups were conducted by LHC staff. The MEs identified participants for the groups. Each LHC conducted a minimum of two and a maximum of four focus groups. The focus group findings were summarized for each respective ME region.

- No Wrong Door (NWD) Survey was sent to ME providers. Providers shared information on referral and community awareness, person-centered counseling, eligibility for public programs, person-centered transition support, partnership and stakeholder involvement, and quality assurance and continuous improvement. The analyses of the survey results were conducted by the LHCs and reported for each respective ME region. All ME regional survey results were rolled up for a state level report.

- ME Provider Focus Groups were conducted by LHC staff to further explore the No Wrong Door survey results. Results were summarized for each respective ME region.

- The Individuals Served Survey was distributed to all ME contracted providers to distribute to their clients. The survey was in the field for 5 weeks and made available through an electronic link and QR code that could be emailed, texted, printed, or posted to social media. The survey was translated into 3 languages: English, Spanish, and Creole. LHC staff analyzed the results for each respective ME region. All ME regional results were rolled up for a state level report.

- The Stakeholder Survey was distributed by all MEs and LHCs to gather responses from stakeholders in various community sectors. The survey was in the field for 5 weeks and made available through an electronic link and QR code that could be emailed, texted, printed, or posted to social media. LHCs analyzed and reported the results for each respective ME region. All ME regional results were rolled up for a state level report.

- The Recovery Community Peer Support Specialist Survey was distributed by the MEs to their peer support service providers. The survey was in the field for 5 weeks and made available through an electronic link and QR code that could be emailed, texted, printed, or posted to social media. The survey was translated into 3 languages: English, Spanish, and Creole. The analyses of the survey results were conducted by the LHCs and reported for each respective ME region. All ME regional results were rolled up for a state level report.

- Recovery Resources for support services were identified by county and complied for each ME service area for populations suffering with Severe and Persistent Mental Illness (SPMI) and Serious Emotional Disturbance (SED).

Data Notes

- Some data limitations were encountered during the assessment process. We do not feel these limitations compromised the integrity of the assessment but should be revealed to the reader when generalizing the results to a larger population. Although ME client data was unduplicated, a small number of clients received services from more than one program, reported living in more than one county, stated having more than one gender, age, or residential status. In total, these duplications accounted for less than one percent of all clients.

- Data for this report were not available beyond the gender descriptors of male and female. Additionally, secondary data availability for race and ethnicity were limited to 'White' 'Black' and 'Hispanic'. Primary ME client data did include Hispanic origin and analyses were provided where applicable.

- Crude death rates for suicide were calculated for each ME service area. Calculating Age-Adjusted Death Rates for each ME service area was beyond the scope of this report.

- Estimated numbers of adults who are seriously mentally ill and emotionally disturbed were provided via FLHealthCHARTS.com and based on a formula developed by the Department of Health and Human Services in their 1996 report on Mental Health.

- Survey fatigue is a community issue which can prevent gathering information for future planning and policy making. Providers and stakeholders are surveyed throughout the year by funders, community partners, program management, public health agencies, schools, local government, and faith-based organizations, just to name a few. The focus of many surveys can be redundant and the questions duplicative. Respondents are very weary of this process that requires valuable time, yet direct benefit may not be realized for several years. Every effort was made to streamline survey design while maintaining relevancy to the assessment requirements as defined by the MEs. Distribution was undertaken by all MEs and LHCs staff and their community stakeholders using all social media platforms available.

- Not all FYSAS indicators were available for 2016, 2018, and 2020. The following indicators were added to the survey in 2020: "Vaped nicotine in lifetime," "Vaped nicotine in the past 30 days," "Vaped marijuana in lifetime," and "Vaped marijuana in the past 30 days." Additionally, Taylor County was a county-level refusal in 2018, so results for Taylor were not able to be added to District 1 and 2 region results.

- There was a small anomaly in the reporting of one homeless data indicator. Although Okeechobee County is in the Southeast Florida Behavioral Health Network, the DCF report used for these data points included this county in the region covered by the Central Florida Behavioral Health Network.

- Data from the 2021 Council on Homelessness Annual report states that the 2021 Point in Time (PIT) Count numbers are not comparable to the previous years' counts. Typically, Continuums of Care (CoCs) conduct a PIT Count of both sheltered and unsheltered households. This year, due to COVID-19 related safety concerns, only six of the 27 CoCs conducted such a count; 10 CoCs did not conduct an unsheltered count; and others conducted a modified form of the unsheltered count. All CoCs conducted a sheltered PIT count. For those that did not conduct an unsheltered count, the CoCs reported zero unsheltered persons, resulting in an undercount of homelessness.

Definitions

Agender - defined as not having a gender. Some agender people describe it as having a "lack of gender," while others describe themselves as being gender neutral.

AMH – Adult Mental Health

ASA – Adult Substance Abuse

Asexual – Often called "ace" for short, asexual refers to a complete or partial lack of sexual attraction or lack of interest in sexual activity with others. Asexuality exists on a spectrum, and asexual people may experience no, little, or conditional sexual attraction.

BBHC – Broward Behavioral Health Coalition

Bigender – A person who has two gender identities or a combination of two gender identities.

Bisexual – A person emotionally, romantically, or sexually attracted to more than one sex, gender or gender identity though not necessarily simultaneously, in the same way or to the same degree. Sometimes used interchangeably with pansexual.

BRFSS – The Behavioral Risk Factor Surveillance System (BRFSS) is the nation's premier system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. Established in 1984 with 15 states, BRFSS now collects data in all 50 states as well as the District of Columbia and three U.S. territories. BRFSS completes more than 400,000 adult interviews each year, making it the largest continuously conducted health survey system in the world.

BRHPC – Broward Regional Health Planning Council, Inc.

CFBHN – Central Florida Behavioral Health Network

CFCHS – Central Florida Cares Health System

Chronically Homeless - In general, a household that has been continually homeless for over a year, or one that has had at least four episodes of homelessness in the past 3 years, where the combined lengths of homelessness of those episodes is at least one year, and in which the individual has a disabling condition.

Cisgender – A term used to describe a person whose gender identity aligns with those typically associated with the sex assigned to them at birth.

CL – Clients

CMH – Child Mental Health

Continuum of Care (CoC) – A local geographic area designated by HUD and served by a local planning body, which is responsible for organizing and delivering housing and services to meet the

needs of people who are homeless as they move to stable housing and maximum self-sufficiency. The terms “CoC Governing Body” or “CoC Board” have the same meanings. In some contexts, the term “continuum of care” is also sometimes used to refer to the system of programs addressing homelessness.

CSA – Child Substance Abuse

FYSAS – The Florida Youth Substance Abuse Survey is a collaborative effort between the Florida departments of Health, Education, Children and Families, Juvenile Justice, and the Governor's Office of Drug Control. It is based on the "Communities That Care" survey, assessing risk and protective factors for substance abuse, in addition to substance abuse prevalence. The survey was first administered to Florida's middle and high school students during the 1999-2000 school year, and is repeated in the spring, annually. In the spring of even years, the survey is administered simultaneously with the Florida Youth Tobacco Survey, sampling enough students to generate data applicable at the county and DCF district level. In odd years the Youth Risk Behavior Survey and the Youth Physical Activity and Nutrition Survey are also added. All surveys are administered to a statewide sample of students.

Gay/Lesbian – A woman who is sexually attracted to other women.

Gender Fluid – A person who does not identify with a single fixed gender or has a fluid or unfixed gender identity.

Gender non-conforming/Gender variant – A broad term referring to people who do not behave in a way that conforms to the traditional expectations of their gender, or whose gender expression does not fit neatly into a category. While many also identify as transgender, not all gender non-conforming people do.

Genderqueer/Non-Binary – Genderqueer people typically reject notions of static categories of gender and embrace a fluidity of gender identity and often, though not always, sexual orientation. People who identify as "genderqueer" may see themselves as being both male and female, neither male nor female or as falling completely outside these categories. An adjective describing a person who does not identify exclusively as a man or a woman. Non-binary people may identify as being both a man and a woman, somewhere in between, or as falling completely outside these categories. While many also identify as transgender, not all non-binary people do. Non-binary can also be used as an umbrella term encompassing identities such as agender, bigender, genderqueer or gender-fluid.

HCECF- Health Council of East Central Florida, Inc.

HCSF- Health Council of South Florida, Inc.

HCSEF – Health Council of Southeast Florida, Inc.

HCWCF – Health Council of West Central Florida, Inc.

Heterosexual/Straight – Sexual desire or behavior directed toward a person or persons of the opposite sex.

Homemaker – Manages household for family members.

HPCSEF – Health Planning Council of Southwest Florida, Inc.

HUD-CoC – Department of Housing and Urban Development Continuum of Care funding granted to local homeless on a competitive basis to coordinate programs, provide housing interventions, and collect and manage data related to homelessness.

Intersex – Intersex people are born with a variety of differences in their sex traits and reproductive anatomy. There is a wide variety of difference among intersex variations, including differences in genitalia, chromosomes, gonads, internal sex organs, hormone production, hormone response, and/or secondary sex traits.

LSFHS – LSF Health Systems

ME – Managing Entity

Motels - Living in hotels or motels

NWFHN – Northwest Florida Health Network

NWFL & Big Bend – Northwest Florida & Big Bend Health Councils

Pansexual – Describes someone who has the potential for emotional, romantic, or sexual attraction to people of any gender though not necessarily simultaneously, in the same way or to the same degree. Sometimes used interchangeably with bisexual.

Questioning – A term used to describe people who are in the process of exploring their sexual orientation or gender identity.

SA – Service Area, refers to the geographical area served by the MEs.

Sheltered – Living in emergency or transitional shelters.

Sharing – Sharing the housing of other persons due to loss of housing, economic hardship or similar reason, “doubled -up”.

SEFBHN – Southeast Florida Behavioral Health Network

State Challenge – Funding appropriated by the State of Florida legislature, and allocated from the Local and State Government Housing Trust Fund, to provide a variety of homelessness-related services and housing.

State HUD-ESG – Federal Emergency Solutions Grant (ESG) funding allocated to the State of Florida by the Department of Housing and Urban Development, to be used for homeless related housing interventions, outreach, shelters, and more.

State HUD ESG-CV – Federal Emergency Solutions Grant Coronavirus-related (ESG-CV) funding allocated to the State of Florida by the Department of Housing and Urban Development, to be used for homeless-related housing interventions, outreach, shelters, and other activities to prevent, prepare for, and respond to the coronavirus.

State Staffing – Funding appropriated by the State of Florida legislature to build capacity in local homeless Continuums of Care (CoCs).

State TANF-HP – Federal Temporary Assistance to Needy Families (TANF) funding that is allocated to the State of Florida, which is utilized for Homelessness Prevention (HP) services.

Suncoast Health Council – Suncoast Health Council, Inc.

Third Sex – a category of people who do not identify as male or female but rather as neither, both or a combination of male and female genders.

TMSF – Thriving Mind South Florida

Transgender – An umbrella term for people whose gender identity and/or expression is different from cultural expectations based on the sex they were assigned at birth. Being transgender does not imply any specific sexual orientation. Therefore, transgender people may identify as straight, gay, lesbian, bisexual, etc.

Unpaid Family Worker – Persons who work without pay for 15 or more hours per week on a farm or in a business operated by a member of the household to whom they are related by birth or marriage.

Unsheltered – Living in cars, parks, campgrounds, public spaces, abandoned buildings, substandard housing, bus, or train stations.

WellFlorida – WellFlorida Council, Inc.

STATE OF FLORIDA EXECUTIVE SUMMARY

2022 Key Findings at the National Level

Mental Health America

To gain a comprehensive perspective of behavioral health at the state and local levels, a look at the national data that drives legislation and policies must be included. Mental Health America (MHA), supported by the Substance Abuse and Mental Health Administration (SAMHSA), the Centers for Disease Control and Prevention, and the Department of Education, produced *2022 The State of Mental Health in American* report. As stated in the report, the goal was to provide a snapshot of mental health status among youth and adults for policy and planning analysis and evaluation; track changes in prevalence of mental health issues and access to mental health care; and to increase dialogue to improve outcomes for individuals and families with mental health needs. Using 15 measures of mental health, the report provided an understating of the prevalence of mental health concerns, including access to insurance and treatment issues. Data was used from SAMHSA's *National Survey on Drug Use and Health* (NSDUH) and the CDC's Behavioral Risk Factor Surveillance System (BRFSS). These national survey data sets included large sample sizes and utilized statistical modeling to provide weighted estimates. These data are more representative of the general population with the exclusion of the homeless population, active-duty military, or those who are institutionalized.

The report included highlights of two MHA's policy priorities in 2021-2022: The implementation of 988 as the national three-digit suicide prevention and mental health crisis hotline and increasing mental health education and supports in schools, particularly for Black and Indigenous People of Color (BIPOC) youth.

- Suicidal Ideation and 988 Implementation: With the passage of the new 988 number for suicide prevention and mental health crises, there is an opportunity to create a continuum of crisis care with adequate funding that ensures mental health responses to mental health crises and prioritizes equity, particularly for Black, Indigenous, and People of Color (BIPOC) individuals. However, of the 13 states (ranked 39-51) with the highest rates of suicidal ideation among adults, only four have successfully passed state legislation to implement 988: Utah, Oregon, Indiana, and Colorado. Of these, only one currently includes user fees.
- Disparities in Mental Health Treatment for Youth of Color: White youth with depression were most likely to receive mental health treatment, and Asian youth were least likely to receive mental health care. Youth of color with depression, particularly Native American or American Indian, multiracial, and Black youth, were most likely to receive non-specialty mental health services in education settings. To create healthier

communities, and to better serve students of color who may only receive mental health services in educational settings, schools need long-term financial support to build up sustained and sufficient school infrastructure.

The National Council for Mental Wellbeing

The 2022 Access to Care Survey was conducted online within the United States by the Harris Poll on behalf of the National Council for Mental Wellbeing. Over 2,000 adults, ages 18 years and older. completed the survey tool from April 26-28, 2022. The purpose of the research was to obtain data on barriers to access for mental health and substance use treatment, along with how insurance/cost plays a role in looking for and receiving care.

Among those with unmet substance use needs, the survey found the following:

- 31% experienced cost-related issues that prevented getting care
- 31% were not able to find a provider that offered a visit format they felt comfortable with
- 28% were not able to get an appointment immediately when they needed care.

Even for those who received substance use care experienced difficulties in receiving care that included:

- 34% revealed that available appointment times were not convenient
- 27% revealed that the provider did not have a convenient location
- 26% had to reach out to several providers before finding one accepting new patients
- 26% revealed that it took too long to actually see a provider

Insurance played a major role in people not getting the care they needed. Many Americans believed it is easier to get care paying out of pocket.

- 3 in 5 Americans (60%) believed there was not enough mental health care providers available who accepted insurance.
- Nearly 3 in 5 Americans believed it was easier (59%) and Faster (59%) to get mental health or substance use care if you pay out of pocket versus using insurance.

The full survey results can be found on the National Council for wellbeing website at: www.thenationalcouncil.org.

2022 KEY FINDINGS AT THE STATE LEVEL

The MHA report ranked all 50 states and the District of Columbia using 15 measures of mental health as noted below:

1. Adults with Any Mental Illness (AMI)
2. Adults with Substance Use Disorder in the Past Year
3. Adults with Serious Thoughts of Suicide
4. Youth with at Least One Major Depressive Episode (MDE) in the Past Year
5. Youth with Substance Use Disorder in the Past Year
6. Youth with Severe MDE
7. Adults with AMI Who Did Not Receive Treatment
8. Adults with AMI Reporting Unmet need
9. Adults with AMI Who Are Uninsured
10. Adults with Cognitive Disability Who Could Not See a Doctor Due to Costs
11. Youth with MDE Who Did Not Receive Mental Health Services
12. Youth with Severe MDE Who Received Some Consistent Treatment
13. Children with Private Insurance that Did Not Cover Mental or Emotion Problems
14. Students Identified with Emotional Disturbance for an Individualized Education Program
15. Mental Health Workforce Availability

States were ranked 1 to 51 with 1 being the highest and 51 being the lowest. Higher rankings (1-13) indicated that there was a lower prevalence of mental illness and higher rates of access to care. Conversely states ranked 39-51 indicated that adults had a higher prevalence of mental illness and lower rates of access to care. The table below shows the rates for Florida by ranking indicator for years 2019 to 2022.

Ranking Indicator	FLORIDA				2022 Highest Ranked State (1)	2022 Lowest Ranked State (51)
	2019	2020	2021	2022		
Overall (includes all 15 measures)	32	32	35	28	Massachusetts	Nevada
Overall Adult (includes 7 measures)	26	24	25	25	New Jersey	Colorado
Overall Youth (includes 7 measures)	32	36	38	30	Pennsylvania	Nevada
Overall Prevalence of Mental Illness (includes 6 measures)	9	12	8	2	New Jersey	Oregon
Access to Care (includes 9 measures)	45	40	48	49	Vermont	Texas
Adult Prevalence of Mental Health	8	6	5	3	New Jersey	Utah
Adults with Substance Use Disorder in Past Year	14	11	3	1	Florida	DC
Adults with Serious Thoughts of Suicide	1	2	4	6	New Jersey	Utah
Youth Prevalence of Mental Illness	26	22	14	5	DC	Oregon
Youth with Substance Use Disorder in Past Year	17	33	37	14	Alabama	Oregon
Youth with Severe Major Depression Episode	28	32	20	11	DC	Wyoming
Adults with AMI Who Did Not Receive Treatment	45	37	46	49	Vermont	Hawaii
Adults with AMI Reporting Unmet Need	9	23	11	10	Hawaii	DC
Adults with AMI Who Are Uninsured	48	45	45	46	Massachusetts	Texas
Adults with Cognitive Disability Who Could Not See A Doctor Due to Cost	47	43	49	47	Rhode Island	Texas
Youth with MDE Who Did Not Receive MH Services	28	26	44	45	Maine	Texas
Youth with Severe MDE Who Received Some Consistent Treatment	37	39	47	46	Maine	Tennessee
Children with Private Insurance That Did Not Cover Mental or Emotional Problems	42	30	38	43	Massachusetts	Arkansas
Students Identified with Emotional Disturbance for an Individualized Education Plan	33	38	38	40	Vermont	Alabama
Mental Health Workforce Availability	42	42	42	42	Massachusetts	Alabama

MHA provides free, anonymous, and confidential screening tools that allow individuals to explore their mental health concerns and bring their results to a provider. The screening tools can be accessed at www.mhascreening.org. The complete report can be found at https://www.mentalhealthamerica.net/download-2019-state-mental-health-america-report

Looking at the rankings for Florida, great strides were made over the past three years regarding the prevalence of adult and youth mental illness. The indicators with lower rankings appear to be related in some way to the mental health workforce availability where the ranking of 42 has remained constant for the past four years.

Focus group research from providers and individuals served revealed that the shortage of mental health workers and support staff were major contributors to access barriers and long waitlists. Data from the Florida Department of Health showed that the number of behavioral health workers per 100,000 population (psychologists, licensed mental health counselors, and licensed clinical social workers) had increased from FY16-17 to FY20-21. Even though these healthcare workers are licensed in Florida, it does not mean that they are working in the state. Anecdotal evidence indicated that the increase in licensed behavioral health care workers may not have been sufficient to serve the increase in individuals in need of mental health services.

THE COVID-19 PANDEMIC

While the impact of the COVID-19 pandemic on the collective psyche of residents has been anecdotally understood, statistics are now becoming available that demonstrate the connection between the pandemic and mental/behavioral health and substance use. As the years post-pandemic continue to unfold, a more detailed understanding will continue to emerge. Current statistics were largely unavailable while the 2022 Florida Cultural Health Disparity and Behavioral Needs Assessment was in draft; however, several issue briefs and reports that highlight the pandemic's impact nationally and statewide are shared below.

In February 2021, the Kaiser Family Foundation (KFF) developed an issue brief entitled The Implications of the COVID-19 for Mental Health and Substance Use. The issue brief, based on analysis of the U.S. Census Bureau 2020-2022 near real-time Household Pulse Survey for anxiety and depression, found that approximately "4 out of 10 adults in the U.S. reported symptoms of anxiety or depressive disorder, a share that has been largely consistent, up from one in ten adults who reported these symptoms from January to June 2019." This statistic was further supported by an August 2020 Centers for Disease Control, Morbidity and Mortality Weekly Report (MMWR) entitled Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic. A separate July 2020 study from the KFF found an increase in negative impacts to adults in areas such as alcohol consumption and substance use by 12% and worsening chronic conditions by 12% due to anxiety over the pandemic. Key findings from the KFF brief were:

- Young adults, ages 18-24, reported a higher rate of anxiety and/or depressive disorder at 56%. Compared to all adults, young adults also reported higher degrees of substance use (25% vs. 13%) and suicidal thoughts (26% vs 11%).
- During the pandemic, adults who had lost jobs or who had lower incomes reported higher rates of the symptoms of mental illness than those who maintained jobs and income levels (53% vs. 32%). This was especially the case for adults in households earning less than $40,000 per year.
- The pandemic disproportionately affected the health and mental wellbeing of communities of color, communities which historically have faced greater difficulty in accessing behavioral health services. Non-Hispanic Black adults and Hispanic or Latino

adults were more likely to report symptoms of anxiety and/or depressive disorder (48% and 46% respectively) than Non-Hispanic White adults (41%).

- Workers deemed "essential" to the workforce during the pandemic also reported higher levels of anxiety and/or depressive disorder than non-essential workers (42% vs 30%), increased or started substance use (25% vs 11%) and suicidal thoughts (22% vs 8%).

The National Institute on Health (NIH)/National Institute on Drug Abuse (NIDA) similarly reported on provisional data that showed drug overdoses accelerated during the COVID-19 pandemic. Based on data from the Centers for Disease Control, the NIDA report summarized that "More than 93,000 drug overdose deaths were estimated to have occurred in the United States in 2020, the highest number of overdose deaths ever recorded in a 12-month period and a nearly 30% increase from 2019." While drug overdose deaths have been steadily on the rise in the U.S. since the 1980's, the acceleration rate increased during the pandemic due to compounding factors such as social isolation and stress, people using drugs alone and decreased access to substance use treatment, harm reduction services and emergency services. This applies to not only various forms of opioids, cocaine, and alcohol but cannabis use as well.

The Substance Abuse and Mental Health Services Administration (SAMHSA) released its 2020 National Survey on Drug Use and Health in October 2021, which also confirmed COVID's negative impact on substance abuse and mental health. Key findings from the 2020 survey concluded:

- Of the estimated 25.9 million past-year users of alcohol and 10.9 million past-year users of drugs other than alcohol reported that they used these substances "a little more or much more" than pre-pandemic.
- 4.9% of all adults aged 18 or older had serious thoughts of suicide, 1.3% made a suicide plan, and 0.5% attempted suicide in the past year.
- For people of mixed ethnicity, the percentages went up in all categories – 11% had serious thoughts of suicide, 3.3% made a suicide plan, and 1.2 % attempted suicide within the same timeframe.
- Adolescents, ages 12 – 17 years, also had elevated rates of suicide ideation – 12% had serious thoughts of suicide, 5.3% made a plan, and 2.5% attempted suicide within the same timeframe.

Residents within the State of Florida echoed the similar impacts of the COVID-19 pandemic on mental/behavioral health and substance use. According to Florida Department of Health, Bureau of Community Health Assessment 2020 data, age-adjusted deaths from drug poisoning (rate per 100,000 of the population) for the State of Florida increased from 22.9 in 2018 to 25.1 in 2019, and up to 34.6 in 2020.

As states above COVID-specific data was not available for this report; however, a few insights were gained through focus group research on some of the pandemic consequences, effects, and outcomes related to individuals served and providers alike.

Providers reported that services covered by resort dollars were cut due to the national and international lockdowns that drastically reduced tourism to the state. Once services were cut, staff were cut, and the number of clients that could be seen diminished along with the ability to bill for services, which affected the bottom lines of many organizations.

Although job growth is now accelerating in Florida, some industries are still unable to find qualified candidates to hire. Offering bonuses or increased salary ranges are not always viable options available to most providers. For organizations that were in a stronger financial position, hiring staff at higher salaries stripped those with limited budgets of critical personnel. During normal economic times, this may not have been a big issue, but when there was a very limited pool of potential employees, it reduced access as the smaller entities were forced to operate with less staff and limited services. These dynamics forced providers to be creative in how to deliver services outside the traditional brick and mortar settings.

Some organizations with smaller operating budgets made huge sacrifices to keep the doors open. Unplanned investments, such as telehealth, resulted in providers forgoing their salaries to embrace new technology so that they could continue to provide care during a time of restricted access.

The proverbial saying ‘every cloud has a silver lining’ can be applied to behavioral health care because of the COVID-19 pandemic. The MEs worked closely with the NSPs to covert an entire system of care to telehealth, open-setting services, COVID managed protocols in residential and crisis settings, etc. to ensure continuity of care for individuals in treatment. During the height of the coronavirus flu, weekly meetings kept everyone in the community informed and fostered honest discussions about what was working during this unprecedented time. As the flu cases decreased, the need for these meetings diminished as communities began to return to normal. Could a version of this be used now as new challenges continue to arise? How can we keep the discussion going post-COVID?

Focus group research revealed that a reduction in stigma and an increase of empathy occurred during the pandemic. This was due in part to the self-realization that even individuals that did not have mental health indicators were forced to recognize the effect the pandemic was having on their own mental health.

It will be years before the full impact of the COVID-19 pandemic is realized. New data and analysis will continually be released over the months and years to come. As communities across Florida continue to assess the behavioral health care system post COVID, it is hoped that that benefits will be maximized, and the detriments minimized.

FLORIDA BEHAVIORAL HEALTH PROFILE

In 2020, there was an estimated 676,982 adults with serious mental illness in the state. This number increased 3.5 percent since 2018. Additionally, there are 197,235 youth, ages 9-17 years, who are emotionally disturbed. This Managing Entity (ME) statewide report is a compilation of primary and secondary data that identifies behavioral health needs and the community assets available to advance the system of care to improve outcomes for all Floridians.

Population Demographics

From 2016 to 2020, Florida's population increased 7% adding over 1.4 million people over the past 5 years. The female to male ratio is approximately 1:1. The racial composition is primarily White (71.6%) with the Black population accounting for 15.9%, American Indian and Native Hawaiian (1.0%), Asian (2.8%) and Other or Two or more races at 3.3% and 6%, respectively. Ethnically, 25.8% of residents were Hispanic. Older adults over the age of 65 years, accounted for 20.5% of the population. Those below the age of 15 years represented 16.4% of residents and those 15-24 years of age represented 11.7%. The remaining 51.4% of the population percentages were split between two ages ranges: adults 25-44 years and adults 45-64 years.

Residents earning a high school diploma represented 88.5% of adults over the age of 25 years with 27% deciding not to pursue further education. The labor force participation rate was 58.4% (2020) with a 6.4% unemployment rate (2020).

During 2016 to 2020, residents living above 400% of the FPL accounted for 42.3% of the population while those living below 200% FPL represented 26.3% of residents.

General Health

Overall, 80% of Florida residents (ages 18-64 years) reported good to excellent health while 86.2% of adults reported good mental health (2017 to 2019). Among adult residents, the average number of unhealthy mental days during the past 30 days was 4.4 days. This was an increase from 2017 where the average number of unhealthy mental days was 3.9 days in the past month. For this report only the crude death rate for suicide was calculated. This death rate decreased 2.5/100,000 from 2018 to 2020. The rate among males was more than triple that of females as was the rate in the White population when compared to Black residents. Domestic violence decreased from 2017 to 2019 by 25.8/100,000 offenses. Rates of children experiencing child abuse and sexual abuse also decreased during the same period.

Mental Illness

The estimated number of seriously mentally ill adults increased 3.5% during the past 3 years (2018-2020) while estimated youth who are emotionally disturbed increased 3.0%. The rates of children (grades K-12) with an emotional/behavioral disability have remained steady at 0.5%.

Tobacco, Alcohol, and Marijuana Use

Floridians, who are current smokers, accounted for 14.8% of adults while 91.0% of middle and high school students reported having never smoked cigarettes and 98.2% did not smoke at all. Vaping nicotine on at least one occasion accounted for 7.7% of high school students.

Eighteen percent of Florida adults reported binge drinking in 2019 while this same behavior decreased 1% among students (2016-2020). The percentages of students living in Florida who did not consume alcohol during the past 30 days increased from 81.7% in 2016 to 85.2% in 2020. The percentage of students who did not consume alcohol on any occasions in their lifetime increased from 2016 to 2020. Florida high school students who had woken up after a night of drinking and were unable to remember things on at least 1-2 occasions accounted for 7.4% in 2020. Over 86% of students in the state reported never having had this experience.

The percentage of students in the state who had not used marijuana in their lifetimes increased slightly over the past 4 years from 78.7% in 2016 to 79.9% in 2020. In Florida, 2.8% of students reported vaping marijuana in the past 30 days on at least one occasion and 1.0% reported vaping this drug on 40 or more occasions.

Disability

The percentages of those with a disability (includes hearing, vision, cognitive, ambulatory, self-care, and independent living) were higher among older adults, ages 65 years and older, at 48.9% when compared to those ages 18-64 years at 44.1%. For the state, 13.6% of the population was estimated to have a disability.

Health Insurance

The percentage of residents (ages 18-64) reporting having had some type of health insurance in 2019 was 84.2%.

STATE ME CLIENT PROFILE

Client Demographics

Florida's ME-funded organizations served 280,025 clients in FY20-21. Central Florida Behavioral Health Network (CFBNH) had the largest client population (98,665 clients) accounting for 35.2%

of all ME clients in Florida while Broward Behavioral Health Coalition (BBHC) served the smallest population at 6.2%. Adults in ME programs accounted for 82.6% of the total client population with 56.5% enrolled in the Adult Mental Health (AMH) program and 26.1% in the Adult Substance Abuse program (ASA). The remaining clients were in the Child Mental Health (CMH) program at 12.9% and the Child Substance Abuse (CSA) program at 4.5%.

As in the general population, the male to female ratio was close to 1:1 for behavioral health programs. However, males accounted for more than 50% of clients in the adult and child substance use programs.

Racially, ME clients were more diverse when compared to the general population. The percentages of Black and multi-racial clients were higher when compared to the same population groups in the general population. The percent of all ME clients of Hispanic ethnicity, at 19.3 percent, was lower when compared to the Hispanic population in Florida, at 25.6 percent.

The age range distribution among ME clients did not represent that of the state population. Adults, ages 25-44 years of age, accounted for 46.3 percent of AMH clients and 62.7 percent of ASA clients. In comparison, adults in this age range represented 25.1 percent of the population in Florida. There was a higher percentage of older teens, ages 15-19 years of age, in the CSA program when compared to those in the CMH program.

Residential Status

AMH clients were more likely to live with relatives (either dependently or independently) when compared to ASA clients. Most clients in the CMH and CSA programs lived dependently with relatives.

Educational Attainment

Lower educational attainment was one of several factors that contributed to much higher levels of unemployment among adult ME clients when compared to unemployed Floridians. Unemployment ranged from 43.1% of AMH clients to 48.9% among ASA clients. The 5-year estimate for unemployment in Florida was 5.6% (2015-2019).

STATE HOMELESS POPULATION

In 2021, the Florida Council on Homelessness reported there were 21,218 homeless individuals living in Florida. There was a 14.4% decrease from the number of homeless in 2017 at 32,109 residents compared to 27,487 in 2020. Sheltered homeless individuals accounted for 63.6% of all homeless while 36.4% were unsheltered. Chronically homeless, defined as continually homeless for over a year, accounted for 2,778 individuals in 2021. Chronic homelessness increased in Florida from 5,120 individuals in 2017 to 5,182 people in 2020.

The Continuum of Care (CoC) funding award for Florida was $194,436,457.35 in SFY20-21 (Federal and state sources).

STATE HOMELESS CLIENT DEMOGRAPHIC PROFILE

Homeless Clients

Client data from the MEs revealed a total of 23,038 homeless individuals were enrolled in programs during the FY20-21. CFBHN and Central Florida Cares Health System (CFCHS) had the highest percentages of homeless clients at 26.5% and 21.6%, respectively. Males accounted for over 60% of homeless individuals in the AMH and ASA programs.

Homeless clients in the AMH and CMH programs were racially more diverse when compared to the state population but less diverse when compared to the state homeless population. Clients in the ASA programs more closely matched the racial distribution in the general population. Overall, homeless Hispanic clients accounted for 14.1% of the total client population. Most homeless clients were 25-44 years of age.

Among homeless clients, 60.6% attained a high school education. This was much lower when compared to the state where close to 90% earned a diploma. Most homeless clients (73.3%) had been terminated or were unemployed.

STATE COST CENTER DESCRIPTIONS, EXPENDITURES AND OVER/UNDER PRODUCTION

For cost descriptions, expenditures, and over/under production specific to the regions, refer to the respective ME report section.

CULTURAL HEALTH DISPARITY SURVEY

The survey was distributed by each ME specific to their region with 800 respondents giving their perceptions on their comfort levels regarding various behavioral health care settings. The goal of the survey is to gain insight from respondents regarding access, quality, and culturally appropriate treatment by defining the health care settings that are most comfortable to clients. The data from each ME survey was analyzed. Questions were developed to further validate the findings through focus group research. As each ME identified different focus areas to probe, a summary at the state level was not achievable based on the unique needs of each ME region across Florida However, the region-specific findings can be found in the respective ME report section.

The overall theme was most individuals comfortable seeking behavioral health care. Just over 60% trusted or strongly trusted that they would be treated with respect. Respondents were asked about their level of privacy and comfort. Respondents were asked to rank statements regarding their feelings about their behavioral health issues. When asked to respond to the statement that

this [regarding behavioral health issues] was a private issue that I keep to myself, respondents were split as 44.8% indicated this was most like how they felt, and 39.7% said this was unlike how they felt. Over half of the respondents felt this [regarding behavioral health issues] was a private issue that stayed in the family, while less than 30% said this was unlike how they felt. Results were similar regarding sharing challenges [regarding behavioral health issues] with others as just over 50% revealed this was most or somewhat like how they felt. Respondents were asked if they were more comfortable with people like them when it concerned their behavioral health issues. Close to a third of respondents declined to answer, a third were more comfortable with people like them, and slightly less said this was unlike how they felt.

The top three preferred settings where respondents were most comfortable discussing behavioral health issues were: private office with a doctor, hybrid telehealth (included some fact to face and some telehealth), and telehealth. Over 10% were comfortable with all the care setting options which also included speaking with a nurse practitioner and accessing a faith-based organization. The traditional physician office setting was preferred over a faith-based care setting by 65.0% of respondents. When given the option, individual therapy was preferred by respondents over group therapy. Ninety percent of respondents received services in the primary language. Less than 2% required an interpreter.

Demographics collected revealed that respondents were more racially and ethnically diverse when compared to ME client demographics, indicating that the voices of those most at risk for cultural disparity were captured. Region-specific findings of the cross tabulations among racial and ethnic populations can be found in the state and respective ME report sections.

NO WRONG DOOR SURVEY

The No Wrong Door (NWD) survey was distributed by the MEs to their Network Service Provider (NSP), of which 264 s participated by submitting their responses online. The purpose of the survey was to gather their perceptions related to care coordination, awareness, processes, advocacy, and evaluation. The data from each ME survey was compiled and analyzed. Questions were developed to further validate the findings through focus group research. As each ME identified different focus areas to probe, a summary at the state level was not achievable based on the unique needs of each ME region across Florida, however, the region-specific findings can be found in the respective ME report section.

NSP respondents represented 12 facility types with most working in adult and children outpatient settings. Close to 70% felt that the NWD model worked well within their respective organization. Most indicated that the organization has a NWD role as it relates to care coordination with warm handoffs, action to improve referrals, and linkages to intervention and support.

The majority of NSPs indicated that organizations promote its services as well as awareness of other available options/linkages to needed services.

Over 90% of NSPs reported that the organization provided patient-centered care and over 85% of respondents agreed that employees are culturally competent and sensitive to the individuals served.

Access remains a barrier as only 65.4% of respondents agreed that individuals could get the services they needed quickly and efficiently. NSPs were split on whether a standard intake process would add additional efficiency for accessing services. NSPs felt that partnerships with other community organizations helped ensure care coordination.

Just over 60% of respondents agreed or strongly agreed that individuals have equal access to care. The remaining 38.8% were either not sure or disagreed. ME NSPs participated in focus groups to further assess the issue. Some of the barriers to equal access are due to insurance status, socioeconomics of the individual that result in an inability to cover the cost associated with receiving care, or not meeting the funding stream criteria for a particular service. More details regarding equal access can be found in the individual ME reports that follow. Although 63.1% of NSPs reported that stakeholders help to address and advocate for equal access, almost 25% of respondents were not sure the organization was an advocate for equal access at the entry points.

NSPs overwhelming agreed that services were of high quality and evaluation was a continuous process undertaken to improve outcomes.

INDIVIDUALS SERVED SURVEY

The Individuals Served survey was completed by 1,348 respondents served by Florida ME NSPs. More detailed analyses are found in the respective ME reports that follow.

Most respondents were adults receiving services with parents of children, youth, and guardians represented by smaller percentages.

Close to 90% of respondents knew where to go for services or knew where to go sometimes. One third of respondents learned of behavioral health services through a family member or friend and 20% learned from an individual in treatment/recovery/peer. The remaining individuals learned about services primarily through ‘word of mouth’ and law enforcement.

Over half of respondents were aware of the 2-1-1 information and referral resources with slightly more than half of those calling for assistance. Of those who called, over 50% were helped and 28.6% were helped sometimes. The remaining 20% of respondents were not helped by the 2-1-1 resource.

Most respondents (80.6%) were able to get the services they needed when they needed them. The top three services needed were housing assistance, crisis stabilization/support, and case management. Close to 20% of respondents reported they were put on a waitlist.

Almost 75% of respondents indicated that services were patient-centered leaving 25.7% disagreeing that services were focused on their needs.

Most respondents (61.4%) received an appointment within two weeks or less. An additional 15.4% waited up to 4 weeks to be seen. Slightly more than 8% reported having never received an appointment.

Close to 75% of respondents were able to travel to services within 30 minutes or less and either drove themselves or were taken by a relative/friend. Using Medicaid/Medicare transportation accounted for 7.3% respondents. The remaining respondents relied on walking and public or private transportation.

The top five obstacles experienced by respondents to get the care they needed were not knowing where to go, lack of affordability, limited or no transportation, being put on a waitlist, and stigma.

STAKEHOLDER SURVEY

ME NSPs, Local Health Councils (LHCs), and community organizations participated in the distribution of this survey to measure awareness, linkages, accessibility, and define barriers. A total of 1,737 stakeholders across Florida participated by completing the Stakeholder Survey Tool.

Over 20 service sectors were represented in the survey. Many stakeholders served more than one service sector. Although 84.1% of stakeholders were aware of behavioral health services, only 60.6% were aware of the ME resources which showed close to 40% of respondents had no awareness of the ME that served their area. Only 35% of respondents had accessed ME resources in the past 6 months. Of these, close to 70% indicated that the ME was helpful when accessed.

Most respondents were aware of the 2-1-1 information and referral resource. However less than 30% accessed this service in the past 6 months. Of those who did contact 2-1-1, over 85% of respondents found it helpful or somewhat helpful. Most stakeholders (83.0%) directed individuals to contact this resource by calling or online.

There were multiple crisis response models in each area served by the MEs. Mobile Crisis Response Team, Mobile Response Team, and Behavioral Health Response Team were the top three models selected across the state.

The majority of stakeholders rated community awareness of behavioral health services as good (30.3%) or fair (34.3%). The remaining stakeholders were almost evenly split between rating community awareness as excellent/very good (18.2%) or poor (17.3%).

Slightly more than 50% of stakeholders agreed or strongly agreed that linkages to services were coordinated and well established across the system of care. More stakeholders (62.8%) agreed or strongly agreed that behavioral health care and peer services were accessible. Regarding the referral processes, 48.3% of respondents agreed this was easily accessible. More respondents strongly disagreed that the referral process was easily accessible (8%) when compared to stakeholders who strongly agreed at 5.7%. Stakeholders who agreed or strongly agreed that

programs and services were coordinated across the system of care accounted for 54.1% of respondents.

The top four barriers across all MEs included Not knowing where to go for services, No or very limited transportation, Lack of affordability, and Long waitlists.

Stakeholders were asked to list the resources and services that are needed but not available to improve patient-centered care and planning. There were common resources across all MEs as noted below. Region-specific findings can be found in the respective ME report section.

- Care Coordination
- Child Care
- Education/Awareness Campaign
- Homeless Shelters and Services
- Housing
- Language/Cultural Competence/Bilingual Providers
- Provider/Staff Shortages
- Long Waitlists
- School-based Services
- Services/Access for Uninsured
- Transportation
- Weekend/Evening Appointments

Below are the top three patient-centered resources and services for each ME that have improved the quality of life for individuals.

BBHC – Henderson Behavioral Health, South Florida Wellness, and 2-1-1

CFBHN – Behavioral Health Service Agencies, Care Management, and Access to Services

CFCHS – Peer Support Services, Case Management, and Crisis Intervention/MCRT

LSFHS – Counseling Services, Crisis Response Teams, and Access to Medication and Services

NWFHN – School-based Services, Mobile Crisis Response Services, and Community-based Services

SEFBHN – Basic Needs, Case Management & Coordination, and Access to Care

TMSF – Supportive Housing, Mental Health Services, and Peer Services

PEER RECOVERY COMMUNITY/SUPPORT SPECIALIST SURVEY

Across Florida, 389 peer recovery/support specialists responded to this survey designed to measure their experience, awareness, and coordination of peer support services in their county of residence.

Most peer respondents were adults with lived mental health, substance use, or co-occurring conditions who worked or volunteered at facilities providing treatment, recovery, or prevention services. Certified Recovery Peer Specialist (CRPS) accounted for 36.7% of respondents, 31.6% were not certified, and 20% were in the certification process. Close to 40% of peers had been employed at the same agency for more than 3 years and almost 60% of peer respondents worked 40 hours per week.

Recovery support peer services were used at 87.4% of the agencies represented and adhered to recovery support best practices. Peers worked or volunteered in program settings that included RCO, medication assistance treatment, family/peer grassroots and drop-in centers.

Personal fulfillment was the most cited reason peer respondents stayed with an organization/facility. Other reasons included commitment to recovery principles, and flexible work schedule or work hours. Salary was cited as the biggest barrier experienced in the hiring process by 41.1% of respondents. Other barriers included the screening process and limited employment opportunities.

Peer respondents were offered the opportunity to select trainings they would recommend to other peers. The analysis revealed that all fourteen trainings were important and recommended by peers for peers.

Most peers were aware of partnerships organizations providing recovery support as well as organizations that provided resources such as food pantries, housing, employment, etc.

Peer respondents (85.2%) had the ability to offer choices to the individuals served at the agency where they were employed/volunteered. The majority of peers indicated that their agency promoted recovery language to help reduce stigma.

Over 75% of peer respondents reported that peers were included in developing and promoting programs. Regarding the inclusion of persons in recovery in management and board meetings, most peers indicated this was practiced at their agency.

CONCLUSION

Behavioral Health Care Settings

Individuals indicated their preferences for care settings where they were most comfortable included the traditional physician office, hybrid of telehealth, and individual therapy. Behavioral health issues were private concerns for about 50% of the respondents surveyed and close to 50%

were not comfortable sharing their challenges with others. One-third of respondents were most comfortable with people like them when it concerned their behavioral health issues. Language was not identified as a barrier as 90% of respondents received services in their primary language.

Equal Access

Equal access was the biggest barrier identified by NSPs. Insurance status, lack of affordability, and funding stream criteria are just some of the issues that can hinder access to services. Results of focus group research, which further validated this issue for the seven ME service areas, can be found in the respective ME reports that follow.

Patient Centered Care

Perceptions of patient-centered care differed among the groups surveyed. Ninety percent of providers reported that their services were patient centered yet only 75% of individuals served felt they received focused treatment.

Awareness of Resources

The 2-1-1 information and referral resource was a known source by most individuals served and stakeholder respondents. However, only about half of these respondents accessed the resources and slightly more than half of those were helped.

Although 60% of stakeholder were aware of the ME as a resource, the remaining 40% of respondents were not knowledgeable of this source for behavioral health services.

Barriers

Although several barriers to care existed across the MEs, housing assistance was cited by individuals served and stakeholders as the most needed service that they were unable to obtain. Long waitlists, in part attributed to staff shortages, was another top issue that requires attention in the next planning cycle. Additionally, each ME has identified obstacles unique to their service areas which will also require action.

MOVING FROM WHERE WE ARE TO WHERE WE WANT TO BE

This assessment serves as the foundation for strategically addressing the behavioral health care needs as identified by providers, consumers, stakeholders, and peers. Enhanced planning efforts will be needed to address the defined obstacles while continually building upon the many strengths within in the current system of care. Developing measurable objectives with realistic action plans has the potential to achieve a comprehensive and seamless behavioral health system promoting recovery and resiliency.

The 2022 Florida Cultural Health Disparity and Behavioral Health Needs Assessment was designed and prepared by

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2022 Florida
Cultural Health Disparity
and Behavioral Health
Needs Assessment

State Report

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Managing Entities Regional Report Link

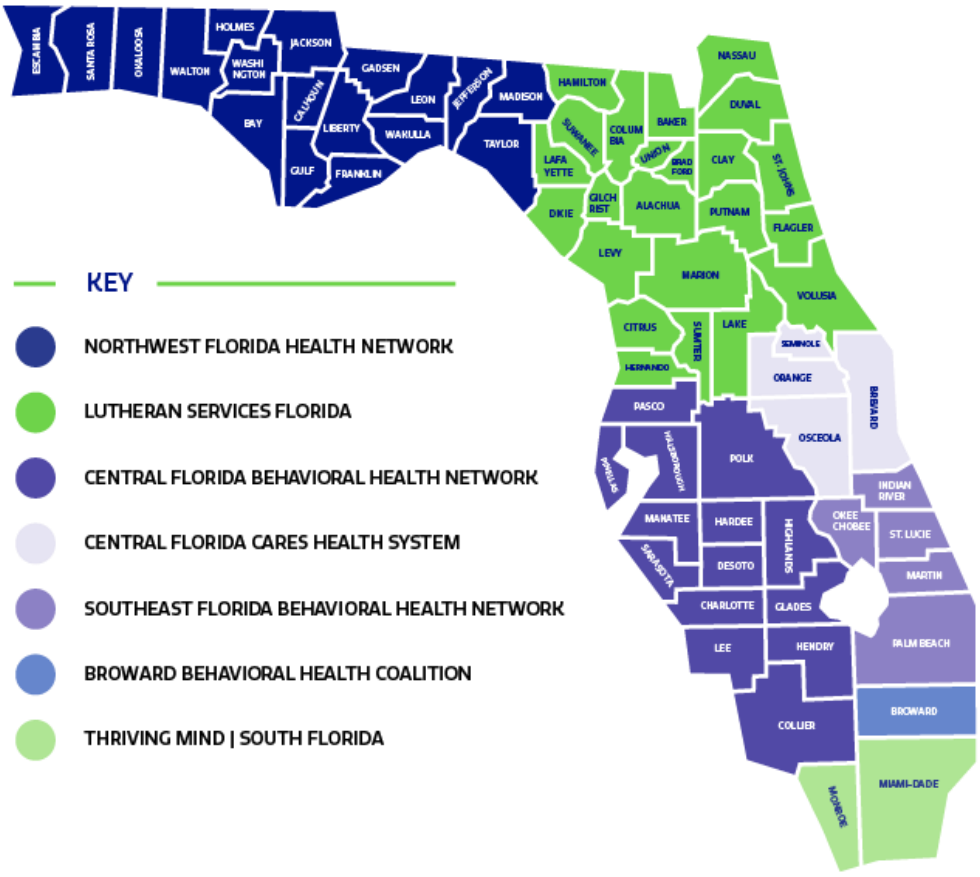
BROWARD BEHAVIORAL HEALTH COALITION, INC.
CENTRAL FLORIDA BEHAVIORAL HEALTH NETWORK, INC.
CENTRAL FLORIDA CARES HEALTH SYSTEM, INC.
LUTHERAN SERVICES FLORIDA HEALTH SYSTEMS
NORTHWEST FLORIDA HEALTH NETWORK
SOUTHEAST FLORIDA BEHAVIORAL HEALTH NETWORK
THRIVING MIND SOUTH FLORIDA

TABLE OF FIGURES

The Florida Association of Managing Entities (FAME) consists of the seven Managing Entities around the state and the FAME Chief Executive Officer. FAME's mission is to educate, promote, facilitate, collaborate, and advance the behavioral health recovery of individuals and their families in Florida.

Managing Entities are local, not-for-profit organizations with community boards that oversee the state and federal substance abuse and mental health (SAMH) system of care across Florida. The Florida Department of Children and Families contracts with the seven Managing Entities to ensure accountability of state and federal funds dedicated for substance use and mental health services.

Managing Entities work across systems of care, including child welfare, local governments, law enforcement, private care, state hospitals, courts, the Department of Corrections, the Department of Juvenile Justice, and school districts to name a few community partners.



FLORIDA DEMOGRAPHIC PROFILE

Population Demographics

The population in Florida increased 7% from 20,231,092 residents in 2016 to 21,640,766 residents in 2020. Over 1.4 million people were added to the population during the past 5 years.

Females accounted for slightly more than 50% of the population when compared to their male counterparts, at 48.9% (2020). This 1:1 ratio has remained stable over the past 5 years.

The racial composition in the state was predominately White, at 71.6%. The Black population accounted for 15.9% of the population. American Indian and Native Hawaiians represented less than 1% of Florida residents. Asian residents accounted for 2.8% of the population and people of two or more races accounted for 6%. Three percent of Florida residents were of another race.

Hispanic residents accounted for 25.8% of the population. Of these, 3.3% were Mexican, 5.4% Puerto Rican, 7.2% Cuban, and 9.8% were Other Hispanic.

Residents below the age of 15 years accounted for 16.4% of the population. Teens and young adults (ages 15-24 years) accounted for less than 12% of the total population. Adults 25-44 years of age represented 25.1% of Florida residents and those 45-64 years of age accounted for 26.3% of the population. Just over 20% of the population were older adults, those over the age of 65 years.

Education and Employment

Close to 90% of Florida residents earned a high school diploma. Of these, 27% did not attain additional education. Residents with some college education accounted for 19.8% of the population. Those with an undergraduate degree represented 29.3% of Florida residents while 11.3% of the population attained a graduate or professional degree.

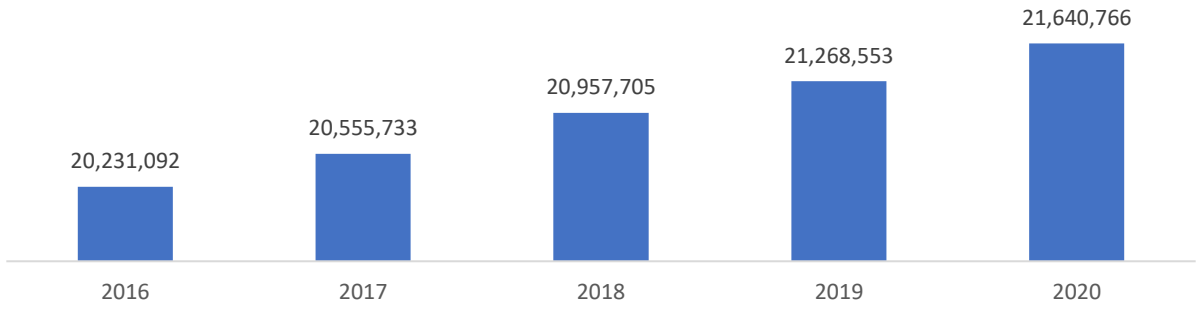
From 2016 to 2020 labor force participation remained stable. The 2020 rate was 58.4%, however, data for this single year is experimental and should not be compared with previous rates. The rate in 2019 was slightly higher at 59.3%. The same holds true for single year unemployment rates. The rate in 2019, at 4.7% was lower when compared to 6.4% in 2020.

Poverty Status

Residents living below 200% of the Federal Poverty Level (FPL) accounted for 26.3% of the population (2016 to 2020). Those at or above 200% FPL, but below 400% FPL, represented 31.4% of Floridians. Residents living above 400% of the FPL accounted for 42.3%.

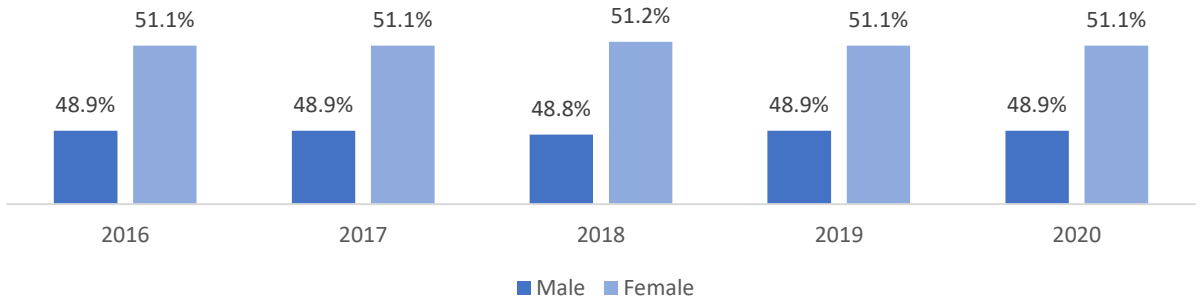
DEMOGRAPHIC CHARTS

Figure 1: Florida Population Estimates, 2016-2020



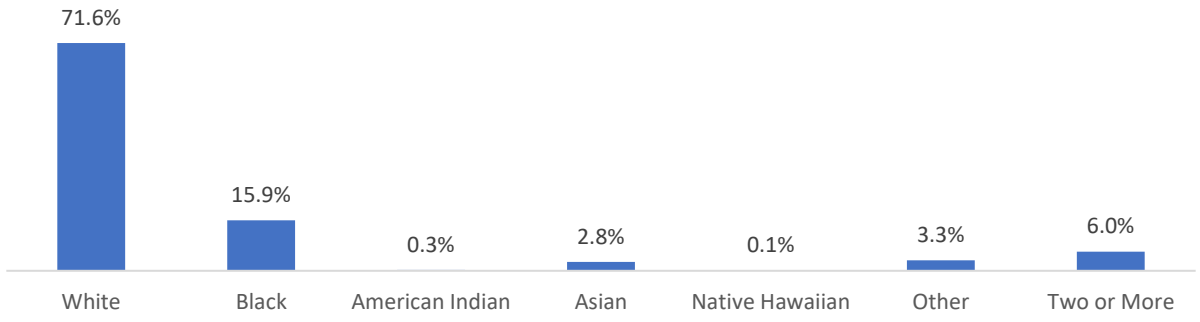
Source: Florida Legislature's Office of Economic and Demographic Research (EDR)

Figure 2: Florida Population by Gender, 2016-2020



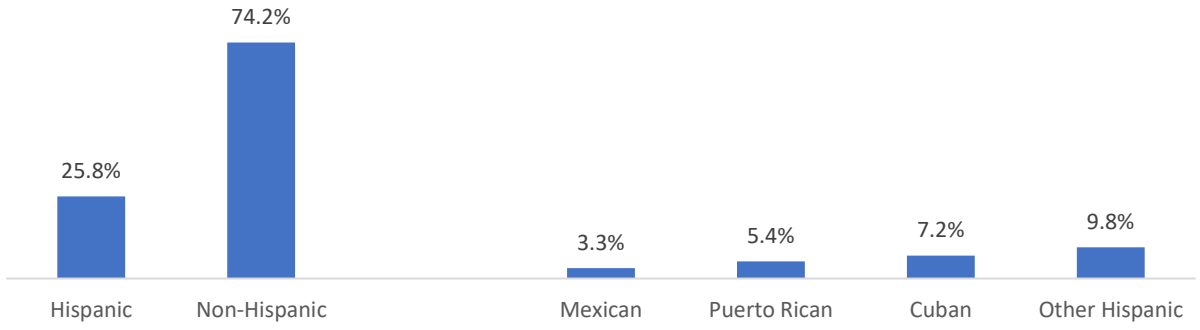
Source: Florida Legislature's Office of Economic and Demographic Research (EDR)

Figure 3: Florida Population by Race, 2016-2020 (5-Year Estimate)



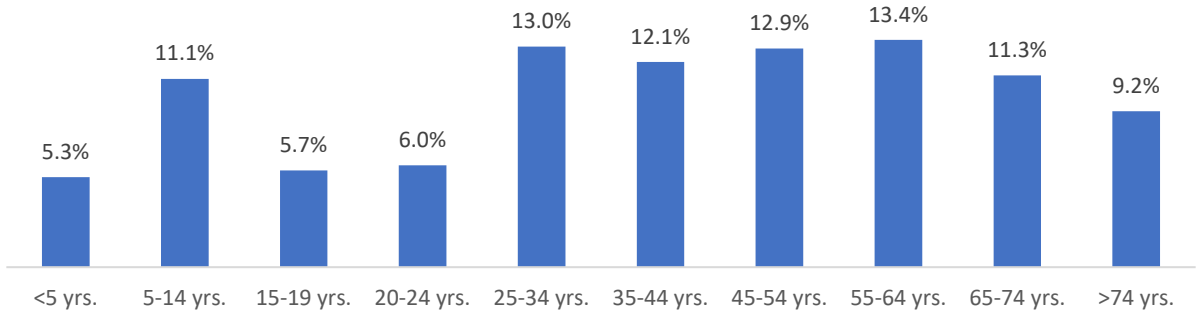
Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 4: Florida Population by Ethnicity, 2016-2020 (5-Year Estimate)



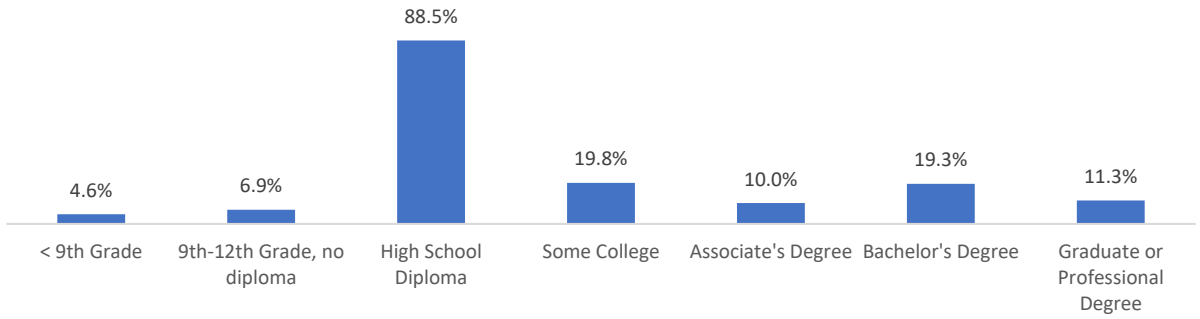
Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 5: Florida Population by Age Range, 2016-2020 (5-Year Estimate)



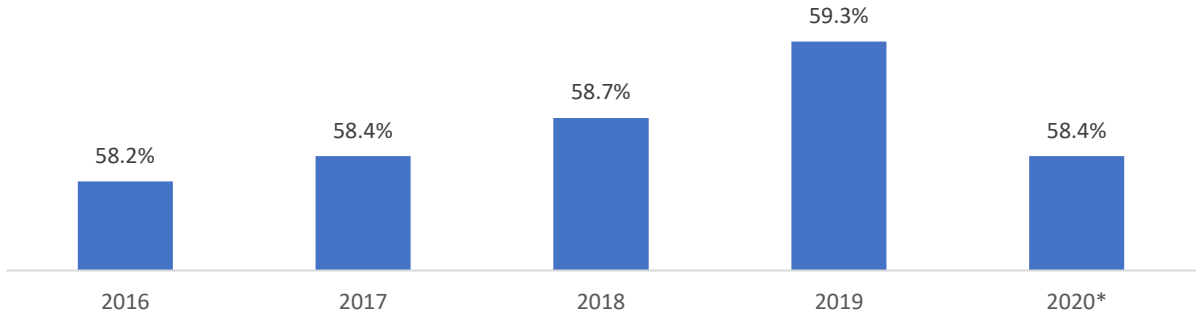
Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 6: Florida Population by Educational Attainment, 2016-2020 (5-Year Estimate)



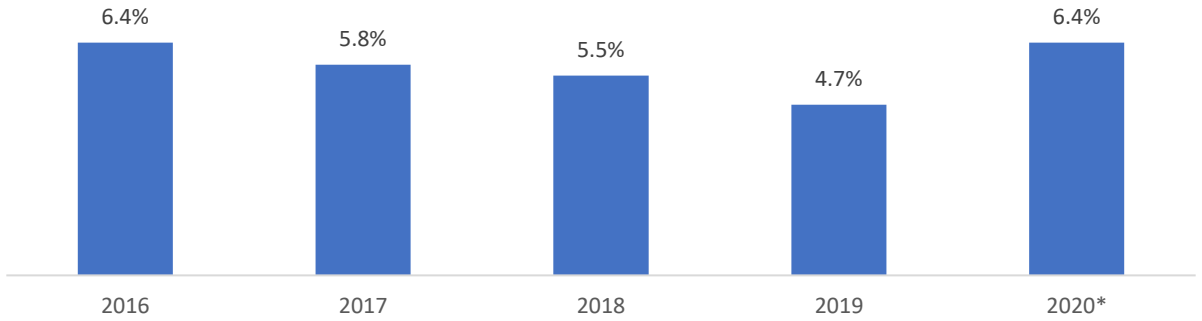
Source: U.S Census Bureau, American Community Survey, Table S1501

Figure 7: Florida Population Participation in Labor Force, 2016-2020 (1-Year Estimate)



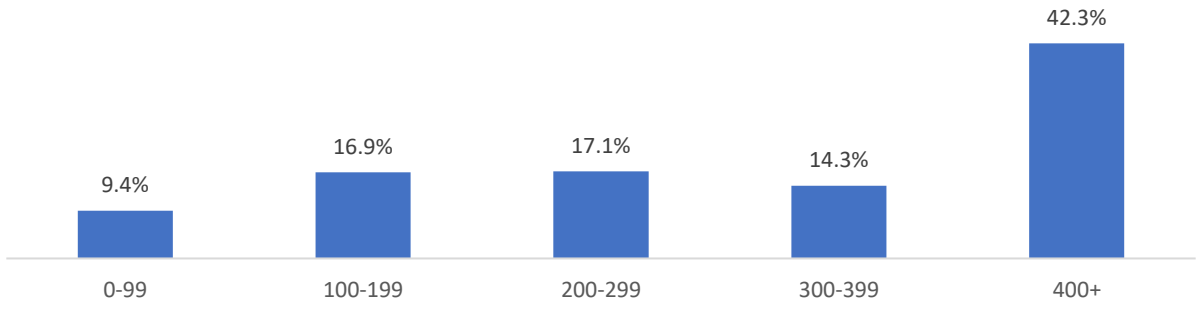
Source: U.S Census Bureau, American Community Survey, *2020 1-year estimates use an experimental estimation methodology and should not be compared with other American Community Survey data.

Figure 8: Florida Population Unemployment Rates, 2016-2020 (1-Year Estimate)



Source: U.S Census Bureau, American Community Survey, *2020 1-year estimates use an experimental estimation methodology and should not be compared with other American Community Survey data.

Figure 9: Florida Population Ratio of Income to Poverty Level of Families, 2016-2020 (5-Year Estimate)



Source: U.S Census Bureau, American Community Survey, Table B17026

FLORIDA GENERAL HEALTH STATUS

Overall, Health Status

Behavioral Risk Factor Surveillance System (BRFSS) data (2017-2019) estimates revealed 80.3% of Florida adults, ages 18-64 years of age, reported their overall health was “good” to “excellent”. This knowledge is a powerful tool for targeting and building health promotion activities. It also provides a way to see change in population health behaviors before morbidity or disease is apparent.

Mental Health

The percentage of adults reporting good mental health over the past 3 years was 86.2% percent, and the number of unhealthy mental days for the state was 4.4 days in the past 30 days. This was an increase from 2017 where the average number of unhealthy mental days was 3.9 days in the past month.

Suicide

The crude suicide death rate decreased from 16.98/100,000 in 2018 to 14.4/100,000 population in 2020. This represented a decrease of 2.5/100,000 suicide deaths. In 2020, the suicide death rate among males, at 22.7/100,000, was more than triple the death rate among females at 6.4/100,000. The suicide death rate among the White population (16.8/100,000) was more than triple the rate among Black residents at 5.3/100,000. It should be noted that the calculations required for the age-adjusted death rate for the ME service areas was beyond the scope of this project.

Violence and Abuse

The rate of total domestic violence offenses decreased in the state from 2017 to 2019. In Florida, the rate fell from 522.3/100,000 to 496.5/100,000 over the past 3 years. This represented a decrease of 25.8/100,000 domestic violence offenses.

According to data from the Department of Children and Families, Florida Safe Families Network Data Mart, the rate of children experiencing child abuse over the past 3 years (2017 to 2019) continuously decreased in Florida. Among children ages 5-11 years, the rate of child abuse fell from 857.9/100,000 in 2017 to 662.7/100,000 in 2019.

Child sexual abuse rates in the state also decreased each year of the past 2 years. The rate in 2017, at 59.6/100,000, dropped to 58.0/100,000 in 2018, and fell again in 2019 to 57.8/100,000 population.

Mental Illness

The estimated number of seriously mentally ill (SMI) adults increased by 3.5% (23,196) over the past 3 years. The estimated number of Florida adults with SMI was 676,982 in 2020.

Among youth, ages 9-17 years, the estimated number of those emotionally disturbed increased 3% from 2018 to 2020. The total estimated number in 2020 was 197,235 youth.

The Florida Department of Education (FLDOE) reported 0.5% of children in K-12 grades had an emotional/behavioral disability. These rates have been steady over the past 3 years.

Adult Tobacco and Alcohol Use

BRFSS results revealed that 14.8% of adults living in Florida were current smokers in 2019. Binge drinking is defined as 5 consecutive drinks for men and 4 consecutive drinks for women. For 2017 to 2019, the percentage of binge drinkers in the state was 18%.

High School Tobacco, Alcohol and Substance Use

Data from the Florida Youth Substance Abuse Survey (FYSAS) revealed that the percentage of middle and high school students who reported never having smoked cigarettes increased from 85.9% in 2016 to 91% in 2020. Just over 6% reported smoking once or twice, and less than 2% reported that they had smoked 'once in a while, but not regularly'.

When students were asked about smoking frequency, 98.2% of those living In Florida did not smoke at all (2020). The was an increase from 96.6% who reported not smoking in 2016.

Vaping questions were included in the 2020 FYSAS for the first time. In Florida, 7.7% of students reported vaping nicotine on at least one occasion in their lifetime. Almost 6% of students had vaped on 40 or more occasions. The percentage of students vaping nicotine during the past 30 days was much lower when compared to vaped in lifetime rates, indicating about half of those did not continue to vape after their first time. Overall, 88.6% of students had not vaped nicotine in the past 30 days.

The percentage of Florida students who did not consume alcoholic beverages on any occasions in their lifetime, ranged from 60.9% in 2016, to 64.7% in 2020. For those who did on 1-2 occasions, the percentage increased 0.2% from 2016 to 2020. The percentages of students consuming alcohol (2020) on more than two occasions, ranged from 7.6% on 3-5 occasions, to 2.4% for those consuming alcohol on at least 40 occasions.

Florida high school students were asked for the number of occasions in their lifetime when they had woken up after a night of drinking alcohol and were unable to remember the things they did or the places they went. The percentage of students reporting this event happening on at least 1-2 occasions in their lifetime (2020) was 7.4%. When looking at previously reported data, this was

a decrease from the percent reported in 2016 at 9.2%. Over 86% of students in the state reporting never having had this experience.

The percentages of students living in Florida, who did not consume alcohol during the past 30 days, increased from 81.7% in 2016 to 85.2% in 2020. The percentages of students who reported consuming alcohol on 1-2 occasions, during the past 30 days, decreased from 11.4% in 2016 to 9.6% in 2020.

The overall percentage of Florida students reporting binge drinking, defined as consuming five or more alcoholic drinks in a row in the past 2 weeks, decreased 1% over the past 4 years. This was a combined decrease for students who reported this behavior on one to more than 10 occasions.

The percent of students in the state who had not used marijuana in their lifetimes increased slightly over the past 4 years from 78.7% in 2016 to 79.9% in 2020. For those who did use marijuana on one to more than 40 occasions, the overall percentages decreased in the state when comparing 2016 at 21.3 percent, to 2020 at 20.1%. The percentages of students not using marijuana in the past 30 days, at 89.3% in 2020, was higher when compared to those who reported not using it in their lifetime. The percentages of students in the state who reported using marijuana in the past 30 days, on one or more occasions, decreased in the state. The percentages of students who reported vaping marijuana in their lifetimes on 1-2 occasions, at 5% was higher when compared to those who reporting vaping marijuana on 40 or more occasions at 3.2%. In Florida, 2.8% of students reported vaping marijuana in the past 30 days on at least one occasion, and 1% reported vaping this drug on 40 or more occasions.

Comparing the vaping of nicotine to marijuana, more students had vaped nicotine in their lifetime on 1-2 occasions (7.7%), when compared to vaping marijuana at 5% (lifetime and on 1-2 occasions). For vaping in the past 30 days, on 1-2 occasions, the percentage of those vaping nicotine (3.7%) was higher when compared to those vaping marijuana (2.8%).

Disability

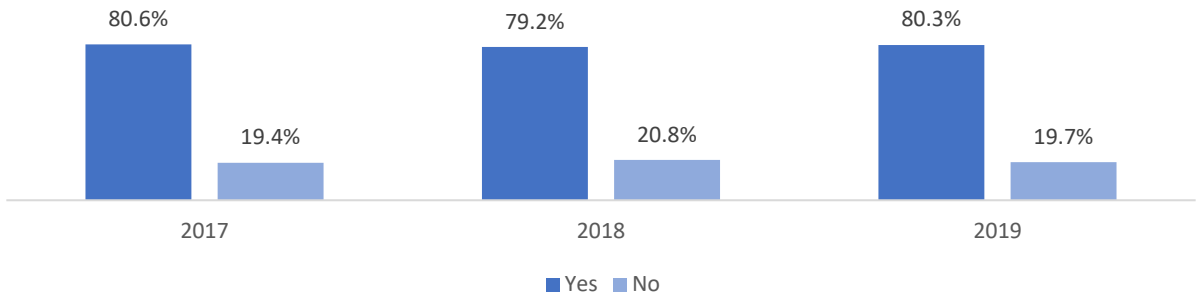
In Florida, 13.6% of the noninstitutionalized population, was estimated to have a disability (includes hearing, vision, cognitive, ambulatory, self-care, and independent living). The percentages of those with a disability were higher among older adults, ages 65 years and older, at 48.9%, when compared to those ages 18-64 years, at 44.1%.

Health Insurance Coverage

Most residents, ages 18-64 years, living in Florida reported having some type of health insurance coverage. The percentage of residents reporting having had some type of health insurance in 2019 was 84.2%.

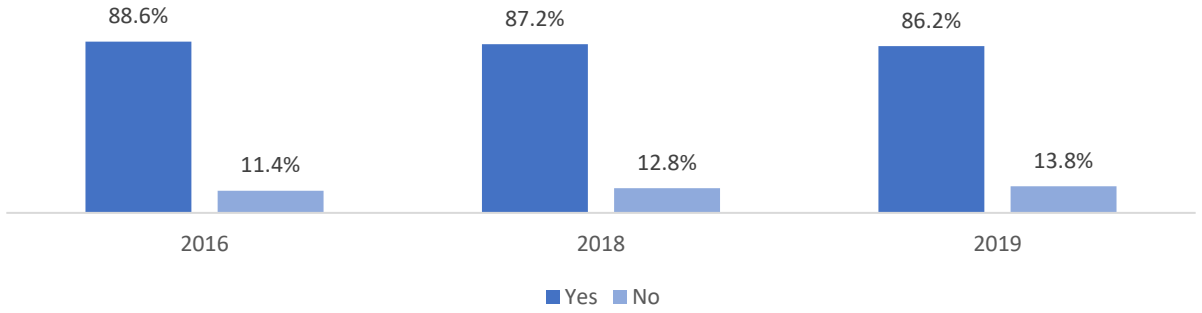
GENERAL HEALTH STATUS CHARTS

Figure 10: Florida Adults Who Said Their Overall Health Was "Good" to "Excellent"(2017-2019)



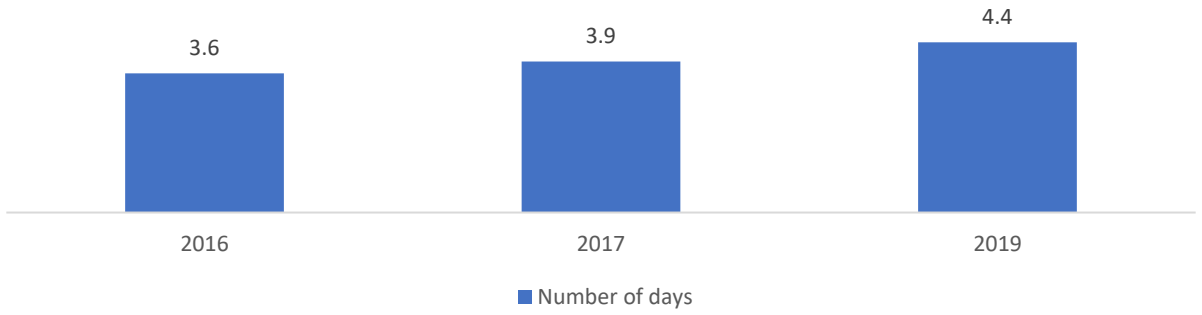
Source: Behavioral Risk Factor Surveillance System

Figure 11: Florida Adults with Good Mental Health for the Past 30 Days (2017-2019)



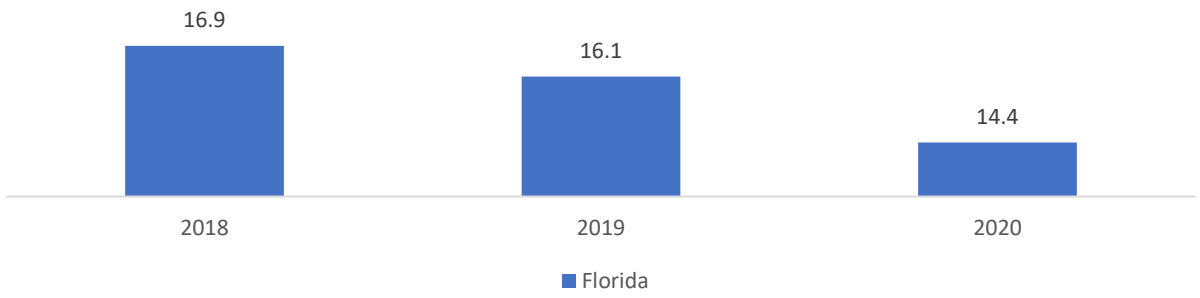
Source: Behavioral Risk Factor Surveillance System

Figure 12: Florida Adults Average Number of Unhealthy Mental Days in the Past 30 Days (2017-2019)



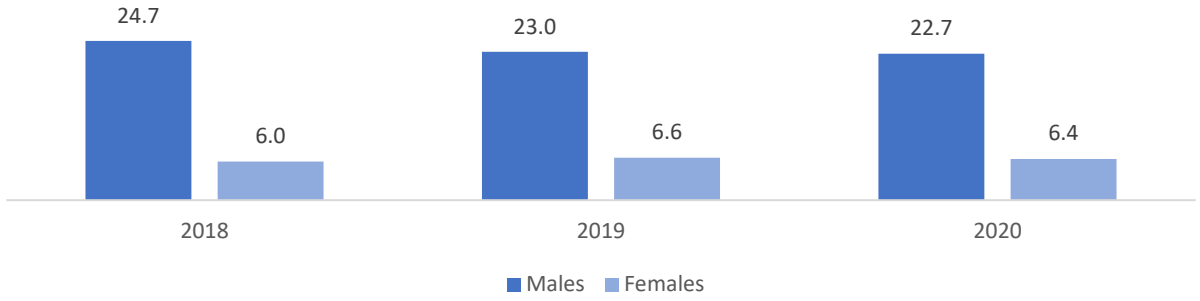
Source: Behavioral Risk Factor Surveillance System

Figure 13: Florida Crude Suicide Death Rates (2018-2020)



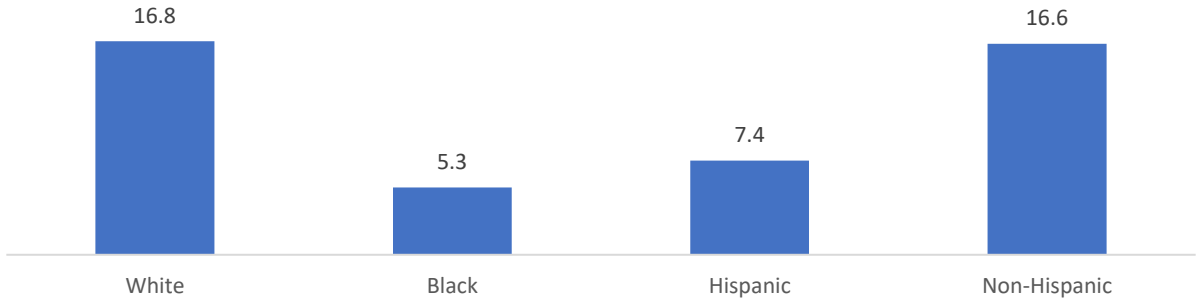
Source: Florida Department of Health, Bureau of Vital Statistics, Rate per 100,000

Figure 14: Florida Crude Suicide Death Rates by Gender (2020)



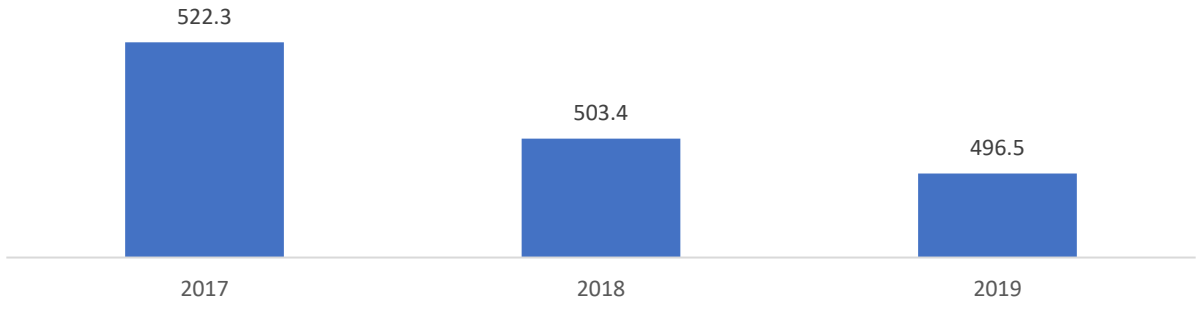
Source: Florida Department of Health, Bureau of Vital Statistics, Rate per 100,000

Figure 15: Florida Crude Suicide Death Rates by Race and Ethnicity (2020)



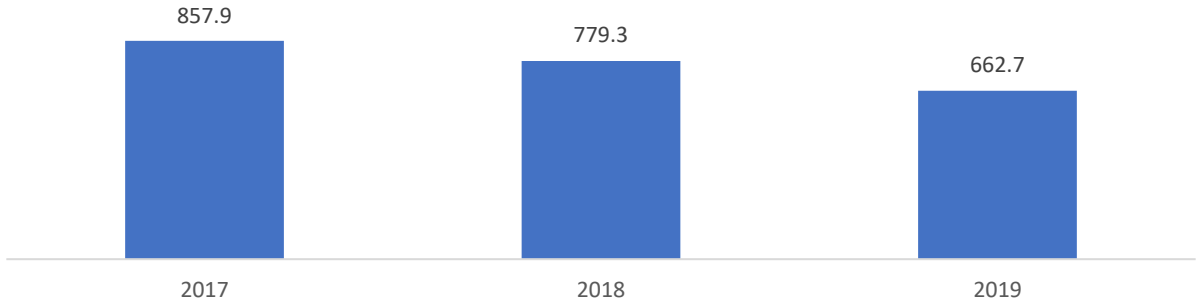
Source: Florida Department of Health, Bureau of Vital Statistics, Rate per 100,000

Figure 16: Florida Total Domestic Violence Offenses (2017-2019)



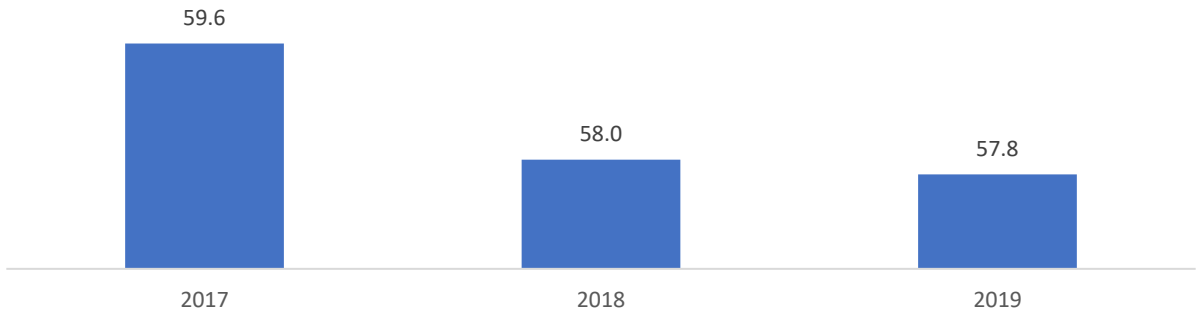
Source: Florida Department of Law Enforcement, Crime in Florida, Uniform Crime Report 2019, Rate per 100,000

Figure 17: Florida Rate of Children Experiencing Child Abuse, Ages 5-11 Years (2017-2019)



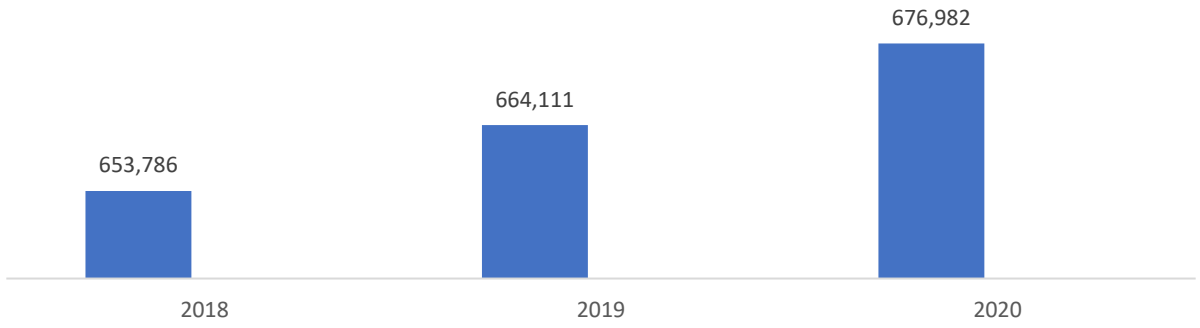
Source: Department of Children and Families, Florida Safe Families Network Data Mart, Rate per 100,000

Figure 18: Florida Rate of Children Experiencing Sexual Violence, Ages 5-11 Years (2017-2019)



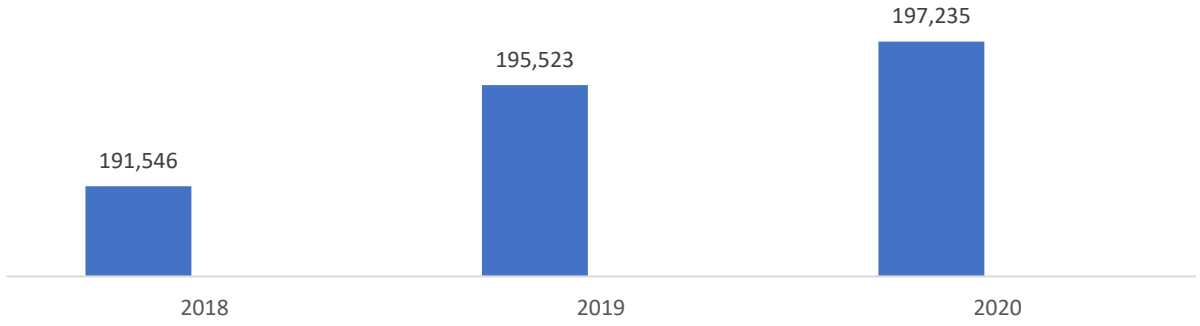
Source: Department of Children and Families, Florida Safe Families Network Data Mart, Rate per 100,000

Figure 19: Florida Estimated Number of Seriously Mentally Ill Adults (2018-2020)



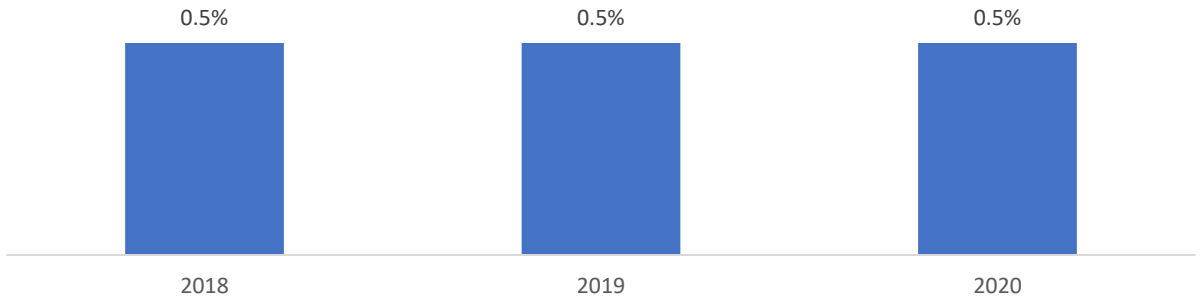
Source: Estimates based on Department of Health and Human Resource Report Mental Health U.S. 1995

Figure 20: Florida Estimated Number of Emotionally Disturbed Youth, Ages 9-17 Years (2018-2020)



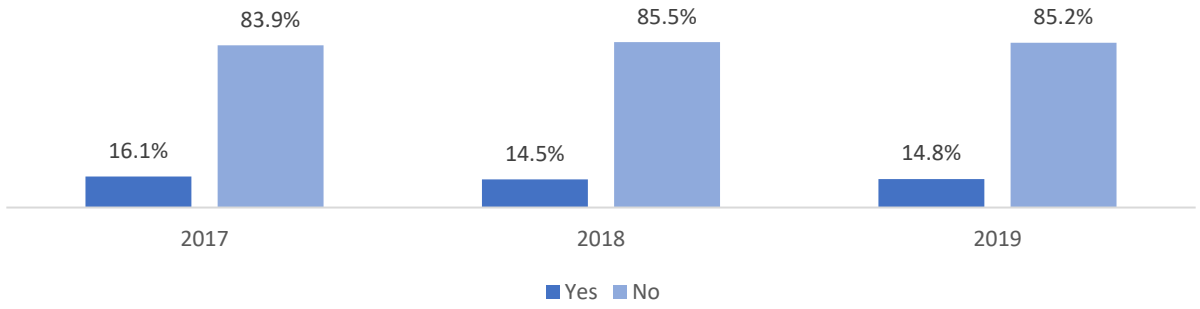
Source: Estimates based on Department of Health and Human Resource Report Mental Health U.S. 1995

Figure 21: Florida Percentage of Children with Emotional/Behavioral Disability, Grades K-12 (2018-2020)



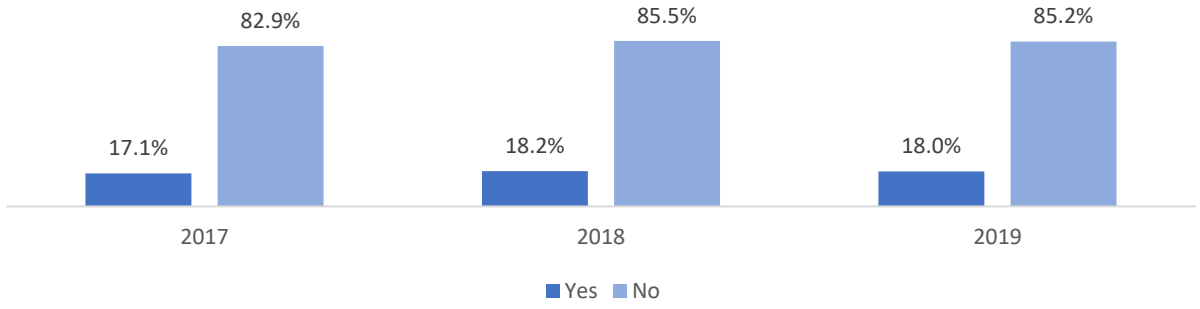
Source: Florida Department of Education, Education Information and Accountability Services (EIAS)

Figure 22: Florida Percentage of Adults Who Are Current Smokers (2017-2019)



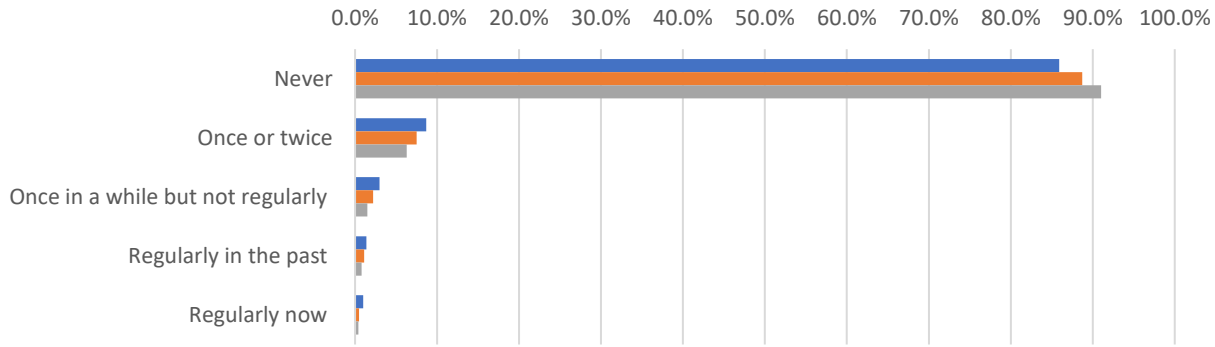
Source: Behavioral Risk Factor Surveillance System

Figure 23: Florida Percentage of Adults Who Engage in Heavy or Binge Drinking (2017-2019)



Source: Behavioral Risk Factor Surveillance System

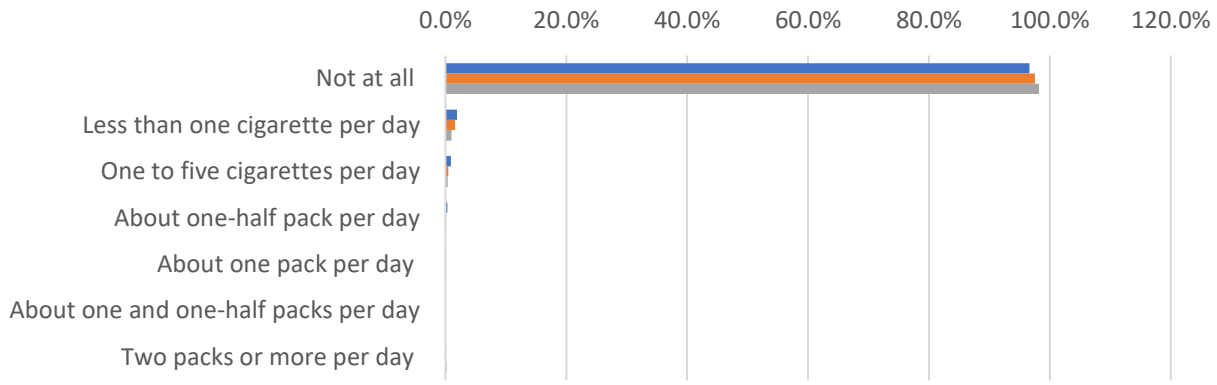
Figure 24: Florida Having Ever Smoked Cigarettes (MS&HS 2016-2020)



	Regularly now	Regularly in the past	Once in a while but not regularly	Once or twice	Never
2016	1.0%	1.4%	3.0%	8.7%	85.9%
2018	0.5%	1.1%	2.2%	7.5%	88.7%
2020	0.4%	0.8%	1.5%	6.3%	91.0%

Source: Florida Youth Substance Abuse Survey

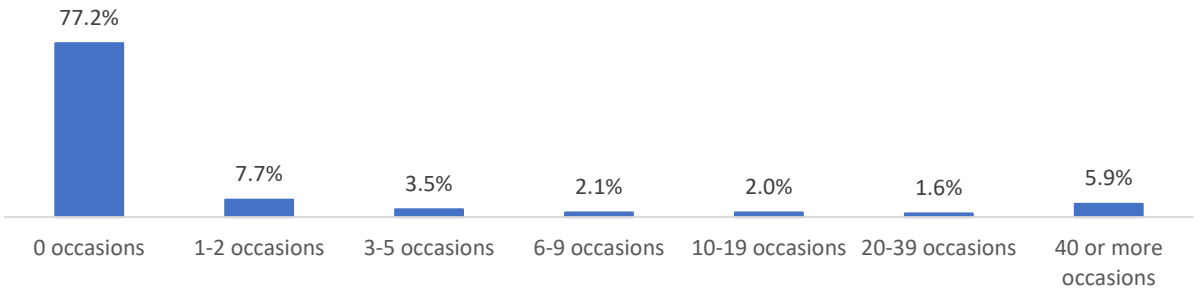
Figure 25: Florida – How Frequently Have You Smoked Cigarettes in the Past 30 Days? (MS&HS 2016-2020)



	Two packs or more per day	About one and one-half packs per day	About one pack per day	About one-half pack per day	One to five cigarettes per day	Less than one cigarette per day	Not at all
2016	0.1%	0.0%	0.1%	0.3%	0.9%	1.9%	96.6%
2018	0.1%	0.0%	0.1%	0.1%	0.5%	1.6%	97.5%
2020	0.2%	0.1%	0.1%	0.1%	0.4%	1.0%	98.2%

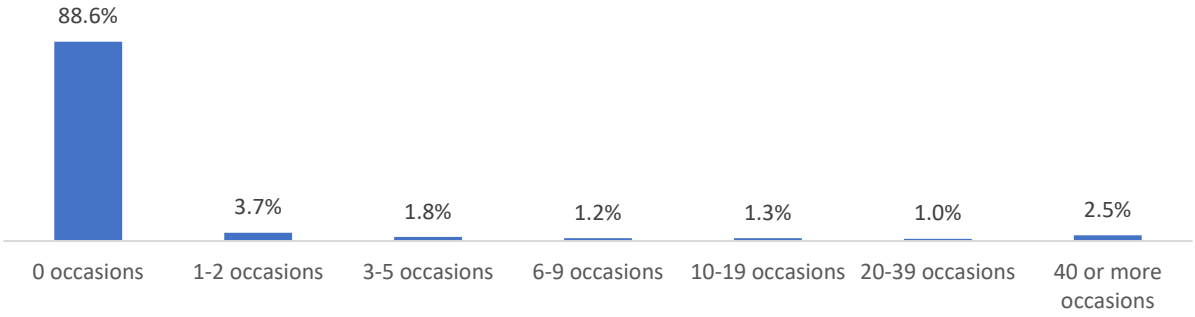
Source: Florida Youth Substance Abuse Survey

Figure 26: Florida – On How Many Occasions Have You Vaped Nicotine in Your Lifetime? (MS&HS 2020)



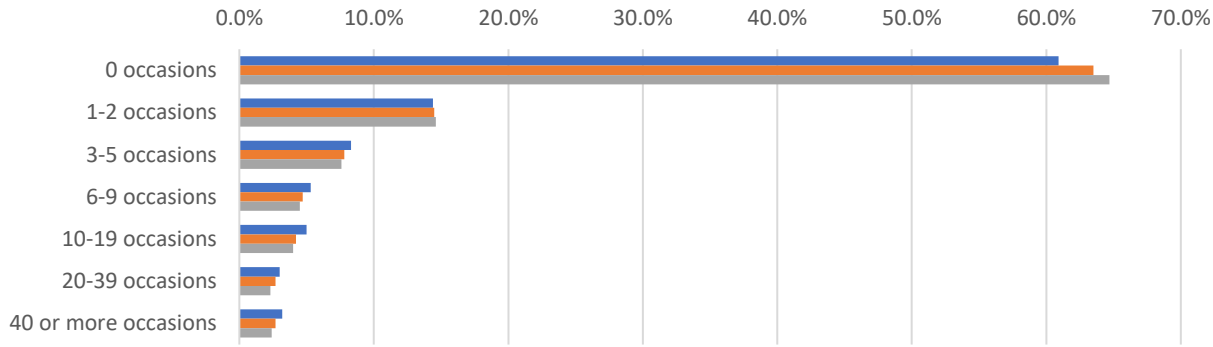
Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

Figure 27: Florida – On How Many Occasions Have You Vaped Nicotine During the Past 30 Days? (MS&HS 2020)



Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

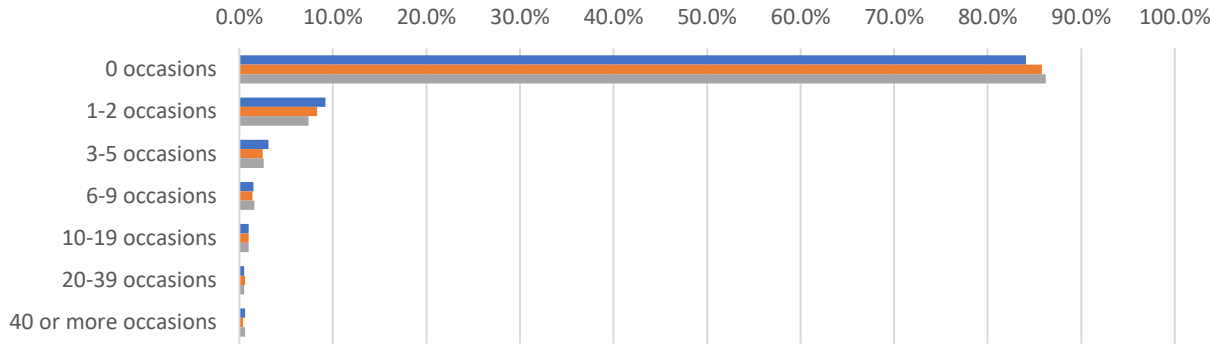
Figure 28: Florida – On How Many Occasions Have You Had Alcoholic Beverages to Drink in Your Lifetime? (MS&HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
2016	3.2%	3.0%	5.0%	5.3%	8.3%	14.4%	60.9%
2018	2.7%	2.7%	4.2%	4.7%	7.8%	14.5%	63.5%
2020	2.4%	2.3%	4.0%	4.5%	7.6%	14.6%	64.7%

Source: Florida Youth Substance Abuse Survey. Includes beer, wine, or hard liquor. More than a few sips.

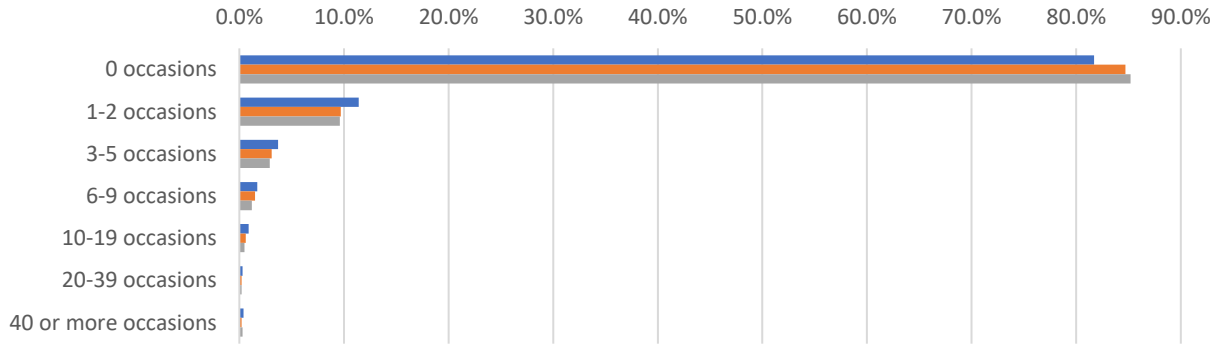
Figure 29: Florida – On How Many Occasions in Your Lifetime Have You Woken Up After a Night of Drinking Alcoholic Beverages and Not Been Able to Remember Things You Did or the Places You Went? (HS Only 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
2016	0.6%	0.5%	1.0%	1.5%	3.1%	9.2%	84.1%
2018	0.4%	0.6%	1.0%	1.4%	2.5%	8.3%	85.8%
2020	0.6%	0.5%	1.0%	1.6%	2.6%	7.4%	86.2%

Source: Florida Youth Substance Abuse Survey

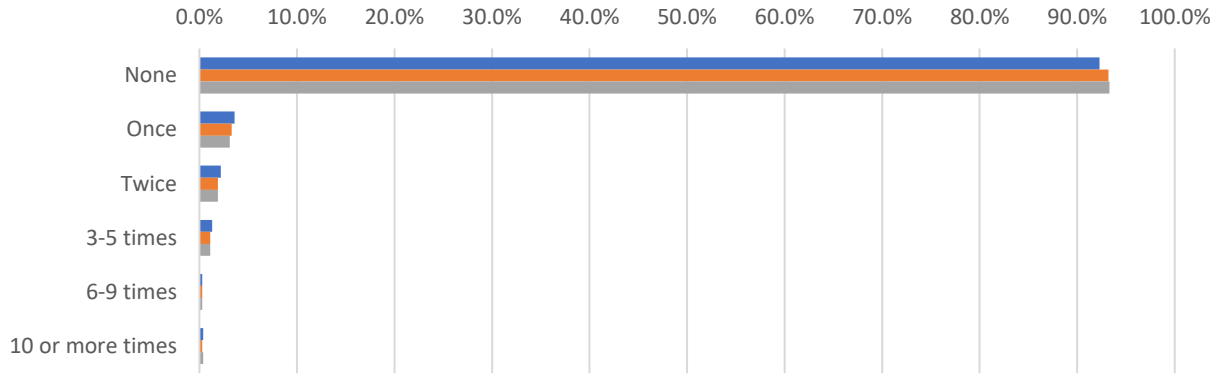
Figure 30: Florida – On How Many Occasions Have You Had Beer, Wine, or Hard Liquor in the Past 30 Days? (MS&HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
2016	0.4%	0.3%	0.9%	1.7%	3.7%	11.4%	81.7%
2018	0.2%	0.2%	0.6%	1.5%	3.1%	9.7%	84.7%
2020	0.3%	0.2%	0.5%	1.2%	2.9%	9.6%	85.2%

Source: Florida Youth Substance Abuse Survey

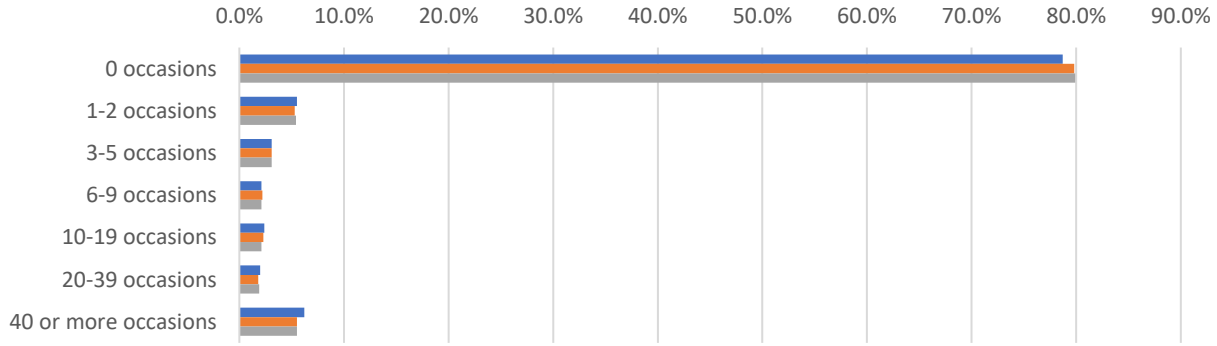
Figure 31: Florida – Think Back Over the Past 2 Weeks...How Many Times Have You Had Five or More Alcoholic Drinks in a Row? (MS&HS 2016-2020)



	10 or more times	6-9 times	3-5 times	Twice	Once	None
2016	0.4%	0.3%	1.3%	2.2%	3.6%	92.3%
2018	0.3%	0.3%	1.1%	1.9%	3.3%	93.2%
2020	0.4%	0.3%	1.1%	1.9%	3.1%	93.3%

Source: Florida Youth Substance Abuse Survey

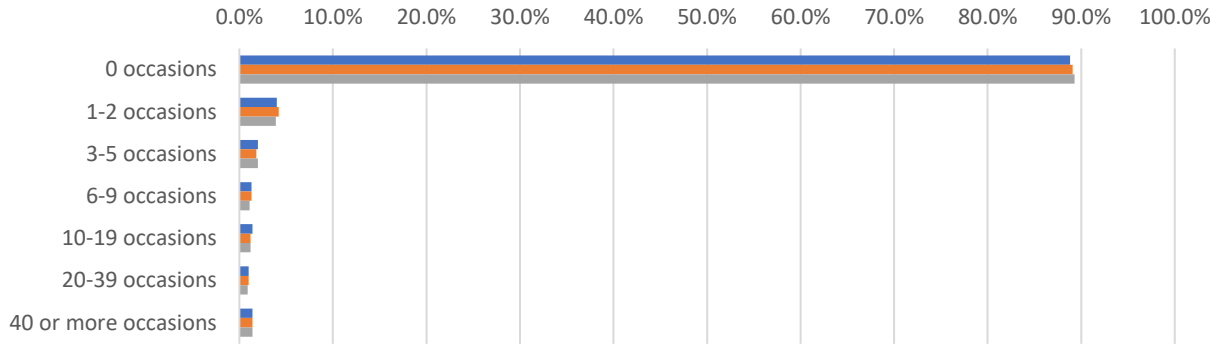
Figure 32: Florida – On How Many Occasions Have You Used Marijuana or Hashish in Your Lifetime? (MS&HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
2016	6.2%	2.0%	2.4%	2.1%	3.1%	5.5%	78.7%
2018	5.5%	1.8%	2.3%	2.2%	3.1%	5.3%	79.8%
2020	5.5%	1.9%	2.1%	2.1%	3.1%	5.4%	79.9%

Source: Florida Youth Substance Abuse Survey

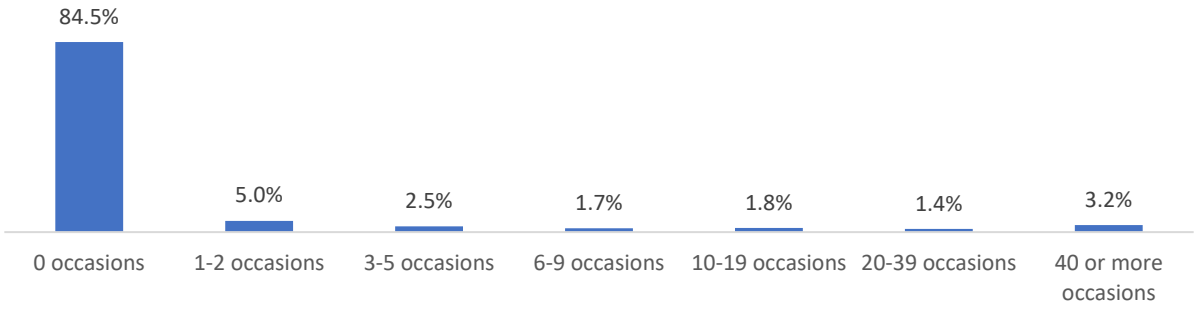
Figure 33: Florida – On How Many Occasions Have You Used Marijuana or Hashish During the Past 30 Days? (MS&HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
2016	1.4%	1.0%	1.4%	1.3%	2.0%	4.0%	88.8%
2018	1.4%	1.0%	1.2%	1.3%	1.8%	4.2%	89.1%
2020	1.4%	0.9%	1.2%	1.1%	2.0%	3.9%	89.3%

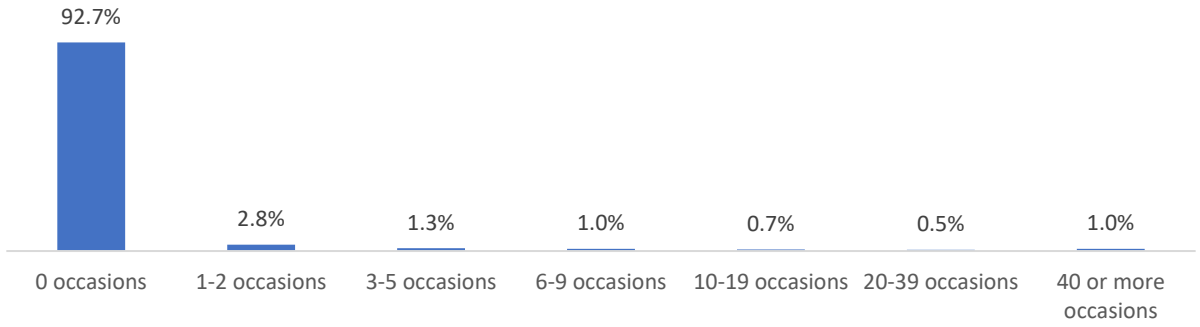
Source: Florida Youth Substance Abuse Survey

Figure 34: Florida – On How Many Occasions Have You Vaped Marijuana in Your Lifetime? (MS&HS 2016-2020)



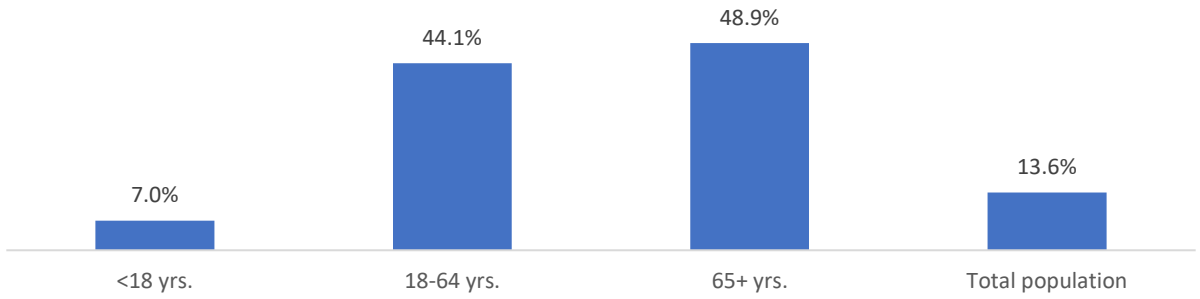
Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

Figure 35: Florida – On How Many Occasions Have You Vaped Marijuana in the Past 30 Days? (MS&HS 2016-2020)



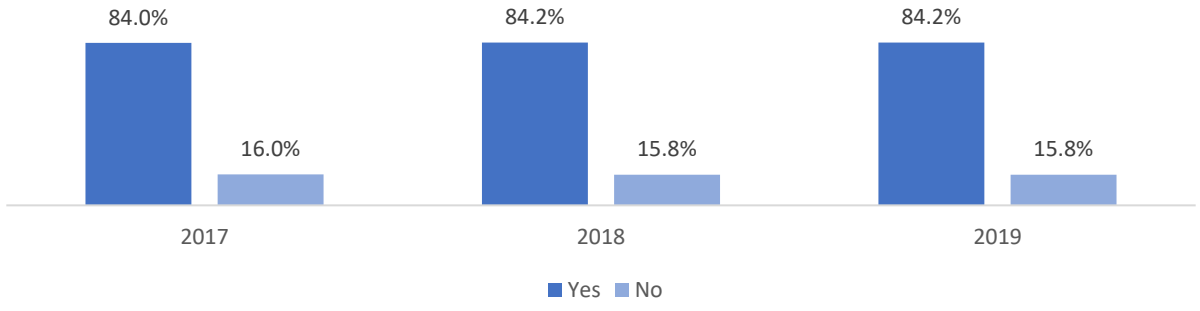
Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

Figure 36: Florida Civilian Noninstitutionalized Population with a Disability (2016-2020)



Source: U.S. Census Bureau, American Community Survey. Disability includes: Hearing, Vision, Cognitive, Ambulatory, Self-Care, and Independent Living

Figure 37: Florida Percentage of Adults with Any Type of Health Care Insurance Coverage (2013-2019)



Source: Behavioral Risk Factor Surveillance System

FLORIDA ME INDIVIDUALS SERVED DEMOGRAPHIC PROFILE

Individuals Served Population

Florida's ME-funded organizations had 280,025 individuals served in FY20-21. This number included a small amount of duplication (<2%) in that some individuals served moved from one county to another, were enrolled in more than one program, or changed residential status during the 1-year time frame. CFBNH had the largest individuals served population (98,665 individuals) accounting for 35.2% of all ME individuals served in Florida. LSFHS, having served 47,266 individuals accounted for 16.9% of the state's total. A total of 36,813 (13.1%) individuals served received services from NWFHN. CFCHS served 10.4% (29,813 individuals served) of Florida ME individuals, TMSF had 26,841 individuals served (9.6%), SEFBHN's individuals served (24,042) accounted for 8.6% of all individuals and BBHC had 17,268 individuals served (6.2%) in Broward County.

Adults in ME programs accounted for 82.6% of the total individuals served population, with 56.5% enrolled in the Adult Mental Health (AMH) program, and 26.1% in the Adult Substance Abuse program (ASA). The remaining individuals served were in the Child Mental Health (CMH) program at 12.9% and the Child Substance Abuse (CSA) program at 4.5%.

Gender

The male to female ratio was close to 1:1 for the adult and child mental health programs. In substance use programs, males accounted for 56.4% of ASA individuals served, and 63.3% of individuals served in the CSA program.

Race

Most ME individuals served were White (66%), which was much lower when compared to the state population at 71.6%. Conversely, Black ME individuals served accounted for 21% of the individuals served population, while representing 15.9% of the general population in Florida. ASA individuals served more closely matched the racial distribution of the general population in the state when compared to the racial distribution of individuals served in other programs. The percentage of multi-racial individuals served in all programs was higher when compared to the percentage of Floridians reporting more than once race category.

Ethnicity

The percentage of all ME individuals served of Hispanic ethnicity, at 19.3%, was less when compared to the percentage of the Hispanic population in Florida, at 25.8%. When comparing the ethnic distribution among programs, Hispanic individuals served in the CMH program, at 22.4%,

and the CSA program at 24.5%, were more representative of the ethnic distribution in the state. Among adult programs, Hispanic individuals served accounted for 19.5% of individuals served in the AMH program, and 14.8% of ASA individuals served.

Age Range

As expected, the age range distribution among ME individuals served did not represent that of the state population. Adults, ages 25-44 years of age, accounted for 46.3% AMH individuals served and 62.7% of ASA individuals served. In comparison, adults in this age range represented 25.1% of the population in Florida. Conversely, adults ages 65 years and older, accounted for a smaller percentage of individuals served (2.3%) when compared to those in the state population at 20.5%. Children under age 5 years accounted for less than 4% of individuals served in the CMH and CSA programs. There was a higher percentage of older teens, ages 15-19 years of age, in the CSA program when compared to those in the CMH program.

Residential Status

The percentage of ME individuals served living dependently (with relatives or non-relatives) was slightly higher among AMH individuals served (14.5%) compared to ASA individuals served (11.9%). Individuals served in the AMH and ASA programs who lived independently alone were similar at 22.7% and 20.9%, respectively. A higher percentage of AMH individuals served lived independently with relatives (29.9%) when compared to ASA individuals served at 24.2%. Most individuals served in the CMH, and CSA programs lived dependently with relatives. A slightly higher percentage of CMH youth lived independently with relatives (4.6%) when compared to their CSA counterparts at 1.7%.

Educational Attainment

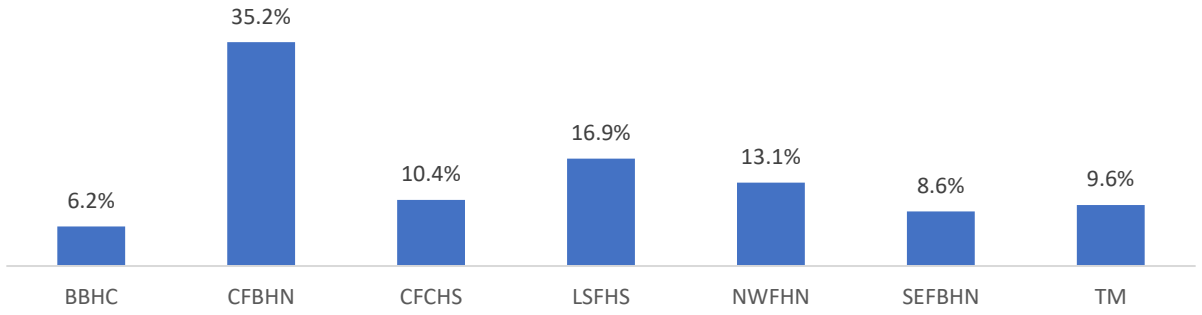
ME individuals served attained lower educational levels when compared to the adult state population. Among ME adults, 44.6% of AMH individuals served, and 43% of ASA individuals served did not attain more than a high school education. In the service area population, only 27% of residents did not go on to further education. Consequently, the percentages of adult individuals served who earned some college education (9.8%), or attained an undergraduate degree (10.8%), were below those for residents living in the state at 19.8% and 29.3%, respectively.

Employment Status

Lower educational attainment was one of several factors that contributed to much higher levels of unemployment among adult ME individuals served when compared to unemployed Floridians. Unemployment ranged from 43.1% of AMH individuals served to 48.9% among ASA individuals served. The unemployment rate in Florida was 6.4% (2020).

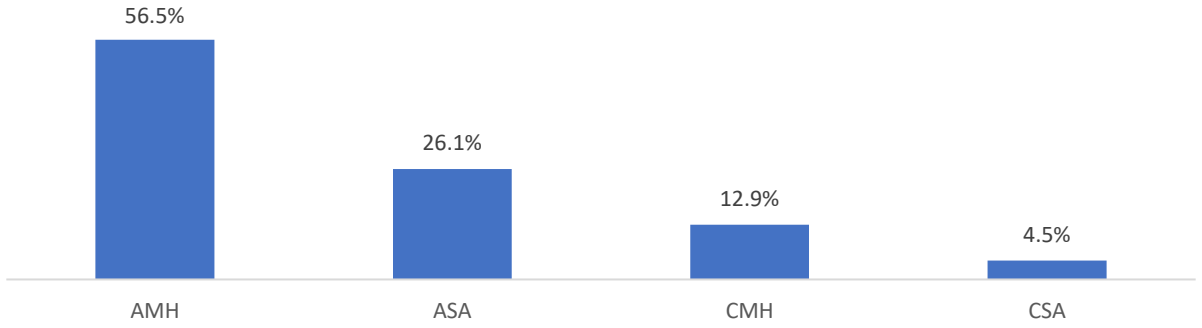
INDIVIDUALS SERVED DEMOGRAPHIC CHARTS

Figure 38: Florida Individuals Served by ME



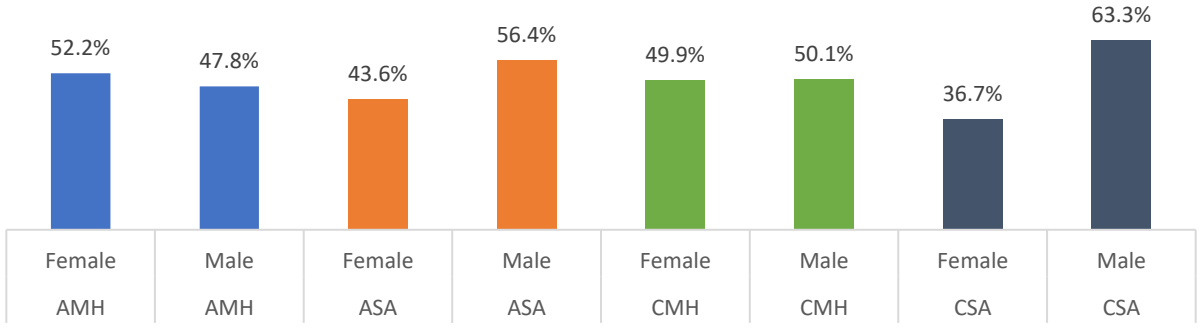
Source: Florida ME Individuals Served Data

Figure 39: Florida ME Individuals Served by Program



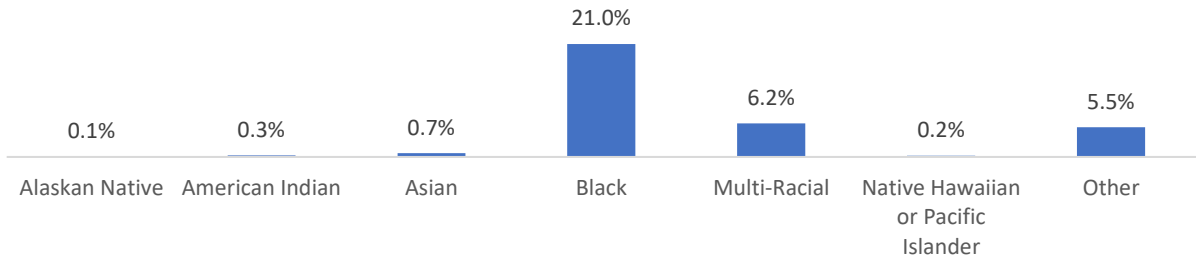
Source: Florida ME Individuals Served Data

Figure 40: Florida ME Individuals Served by Program and Gender



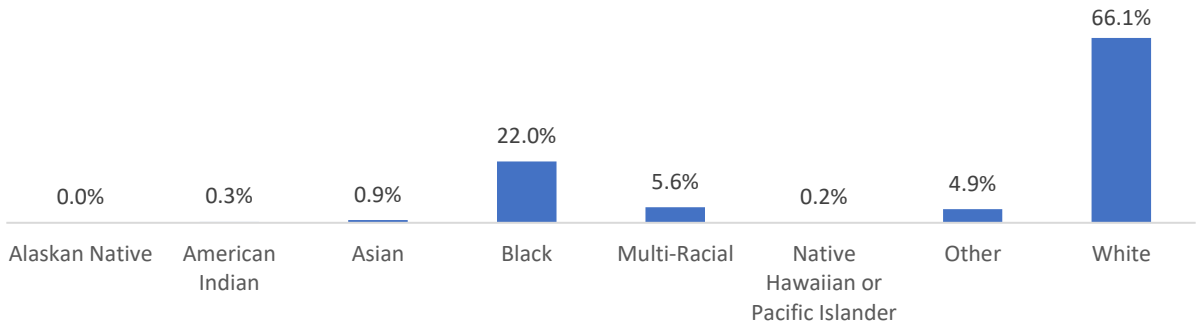
Source: Florida ME Individuals Served Data

Figure 41: Florida ME Individuals Served by Race



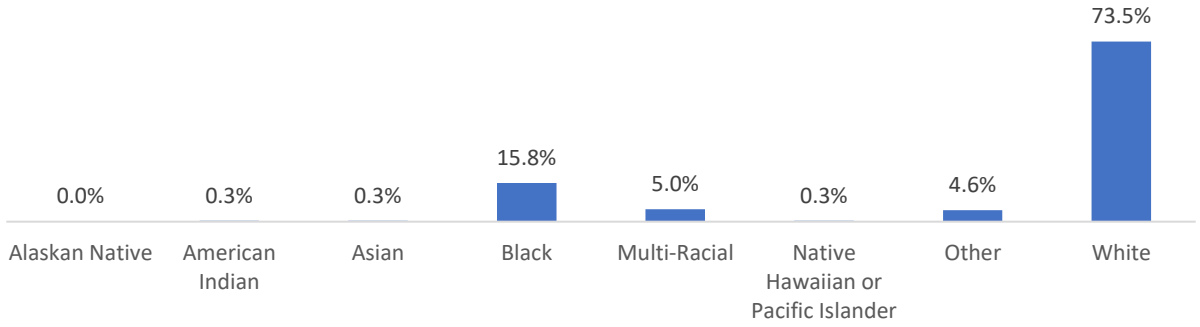
Source: Florida ME Individuals Served Data

Figure 42: Florida ME AMH Individuals Served by Race



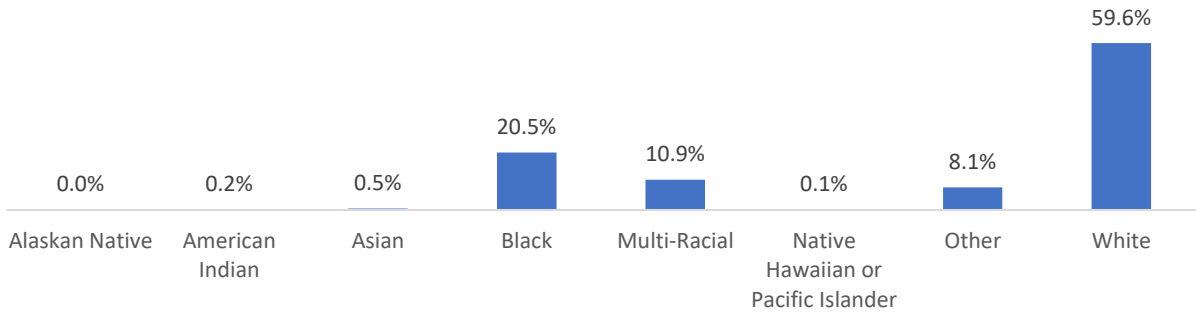
Source: Florida ME Individuals Served Data

Figure 43: Florida ME ASA Individuals Served by Race



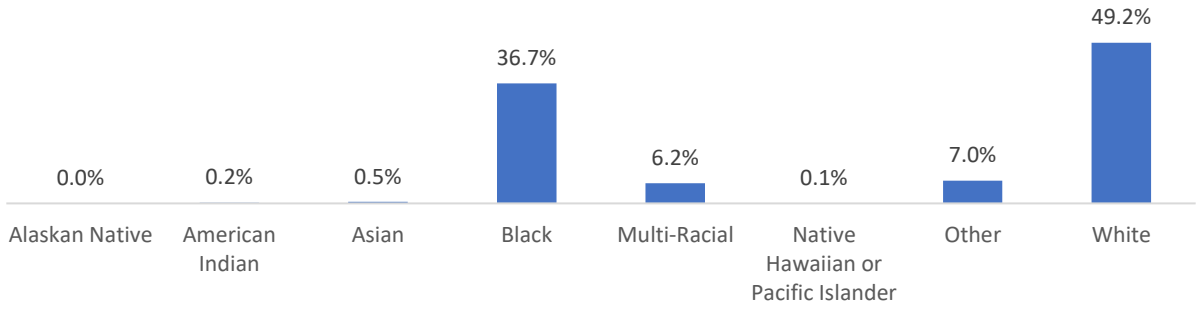
Source: Florida ME Individuals Served Data

Figure 44: Florida ME CMH Individuals Served by Race



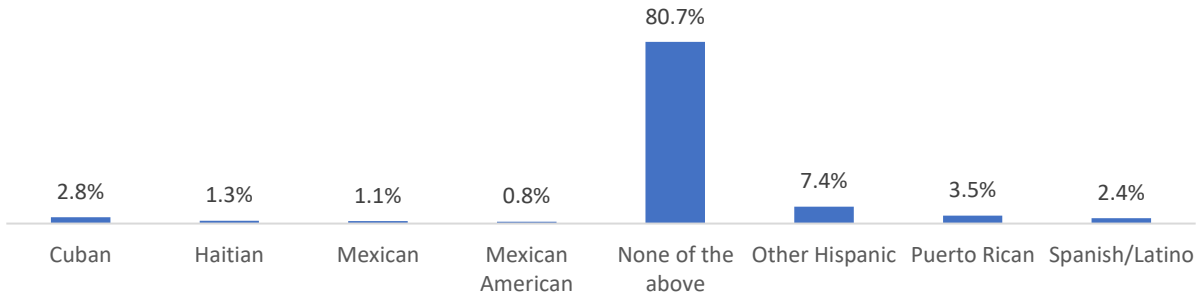
Source: Florida ME Individuals Served Data

Figure 45: Florida ME CSA Individuals Served by Race



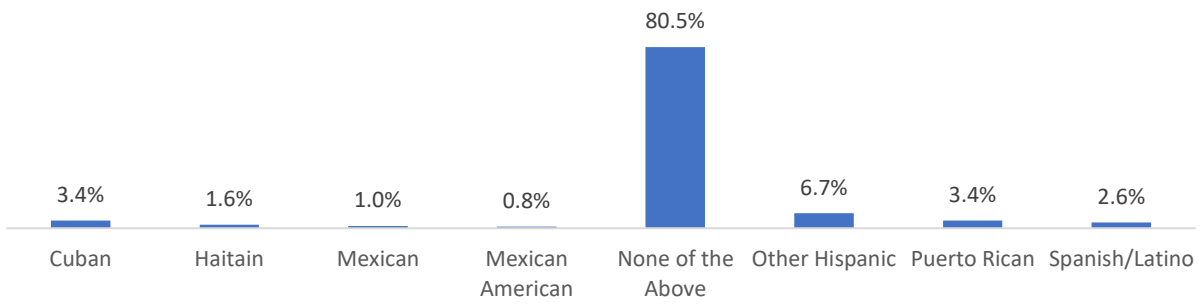
Source: Florida ME Individuals Served Data

Figure 46: Florida ME Individuals Served by Ethnicity



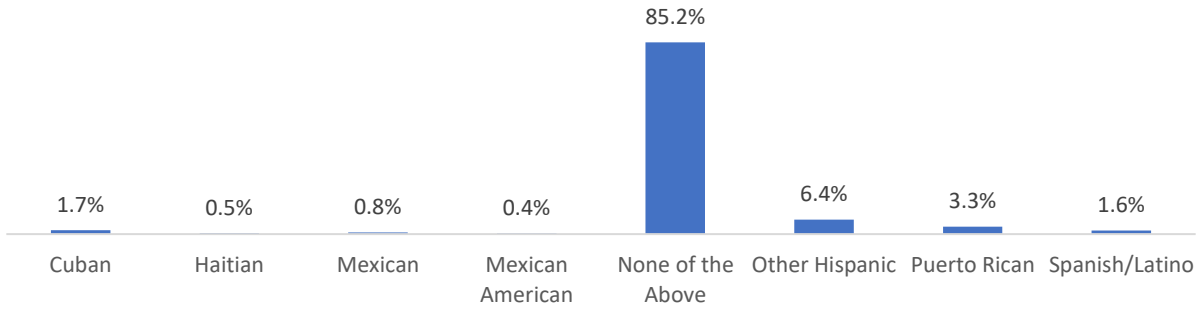
Source: Florida ME Individuals Served Data

Figure 47: Florida ME AMH Individuals Served by Ethnicity



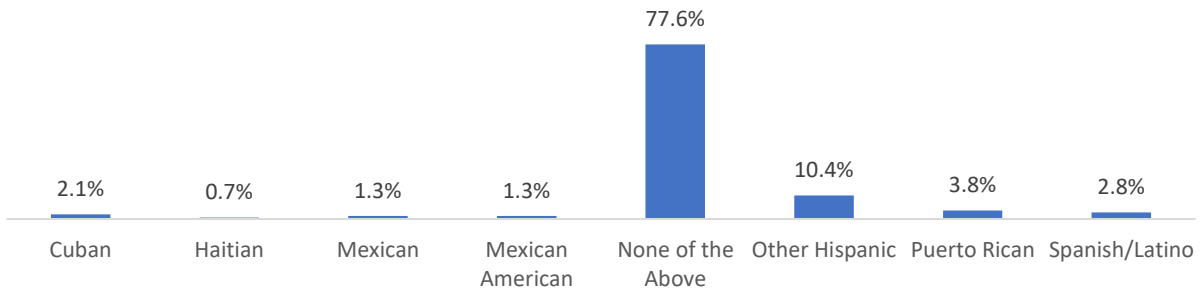
Source: Florida ME Individuals Served Data

Figure 48: Florida ME ASA Individuals Served by Ethnicity



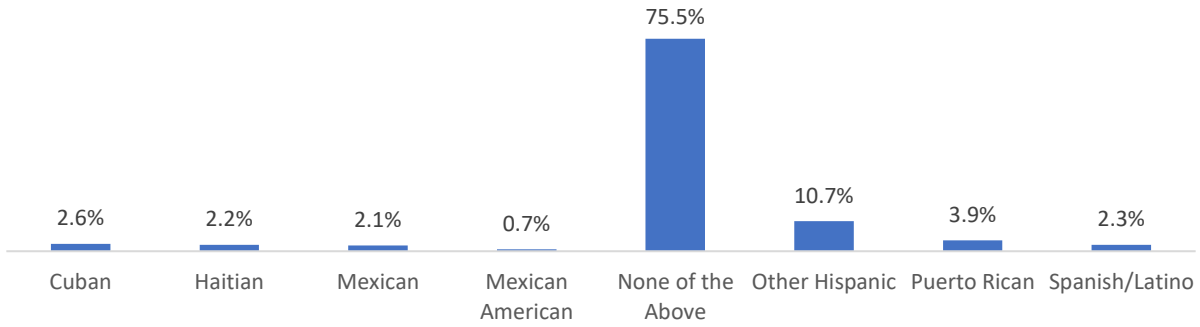
Source: Florida ME Individuals Served Data

Figure 49: Florida ME CMH Individuals Served by Ethnicity



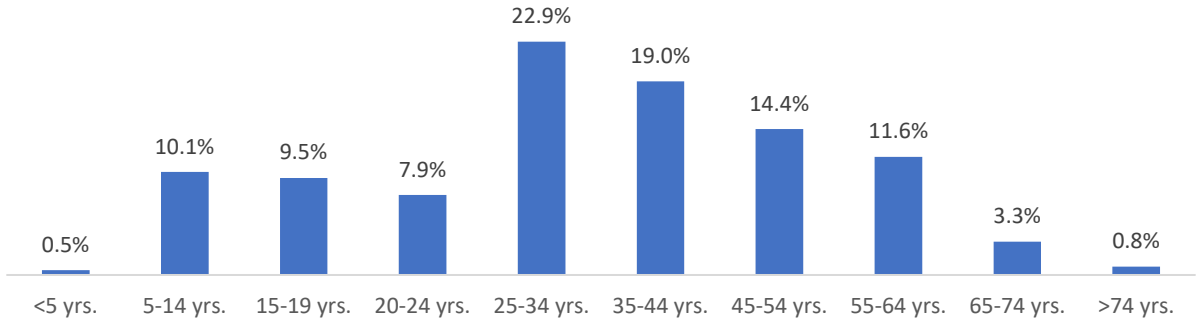
Source: Florida ME Individuals Served Data

Figure 50: Florida ME CSA Individuals Served by Ethnicity



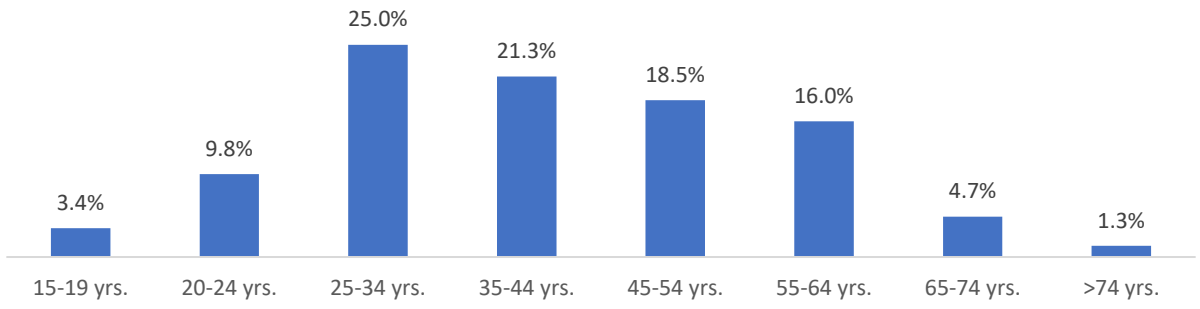
Source: Florida ME Individuals Served Data

Figure 51: Florida ME Individuals Served by Age Range



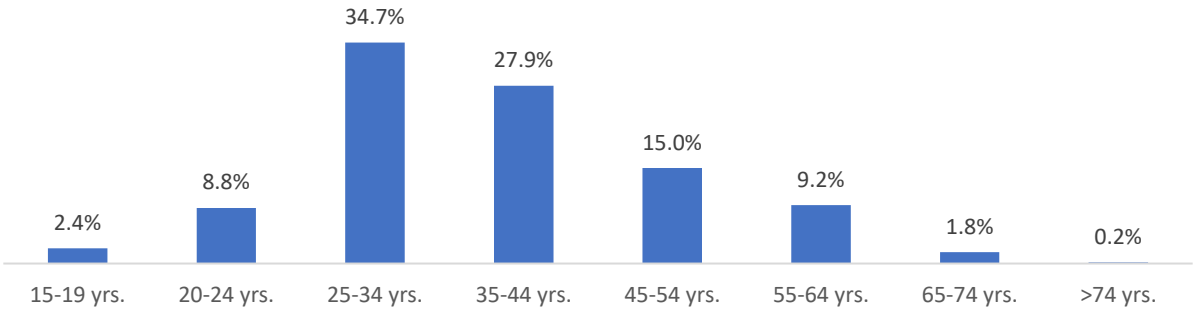
Source: Florida ME Individuals Served Data

Figure 52: Florida ME AMH Individuals Served by Age Range



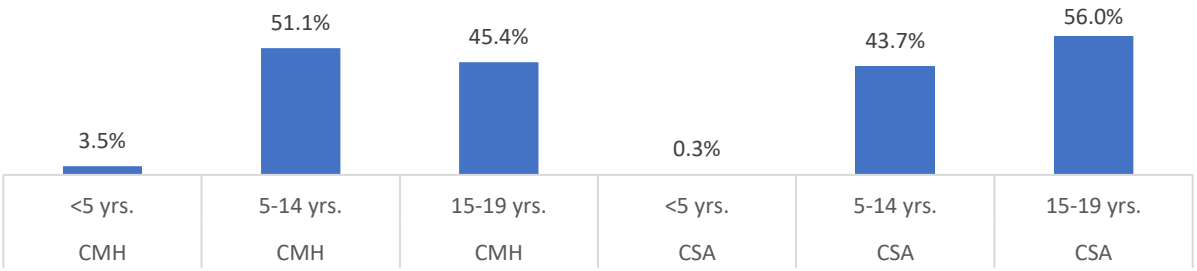
Source: Florida ME Individuals Served Data

Figure 53: Florida ME ASA Individuals Served by Age Range



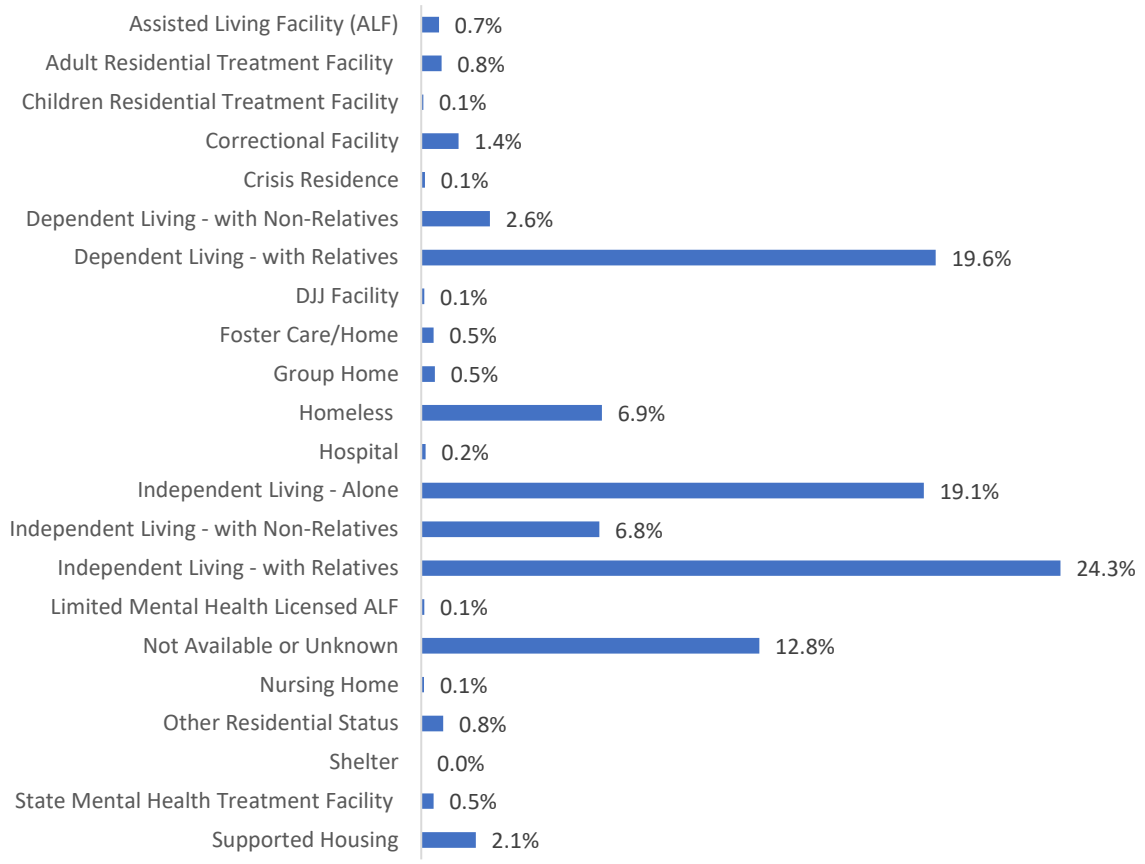
Source: Florida ME Individuals Served Data

Figure 54: Florida ME CMH and CSA Individuals Served by Age Range



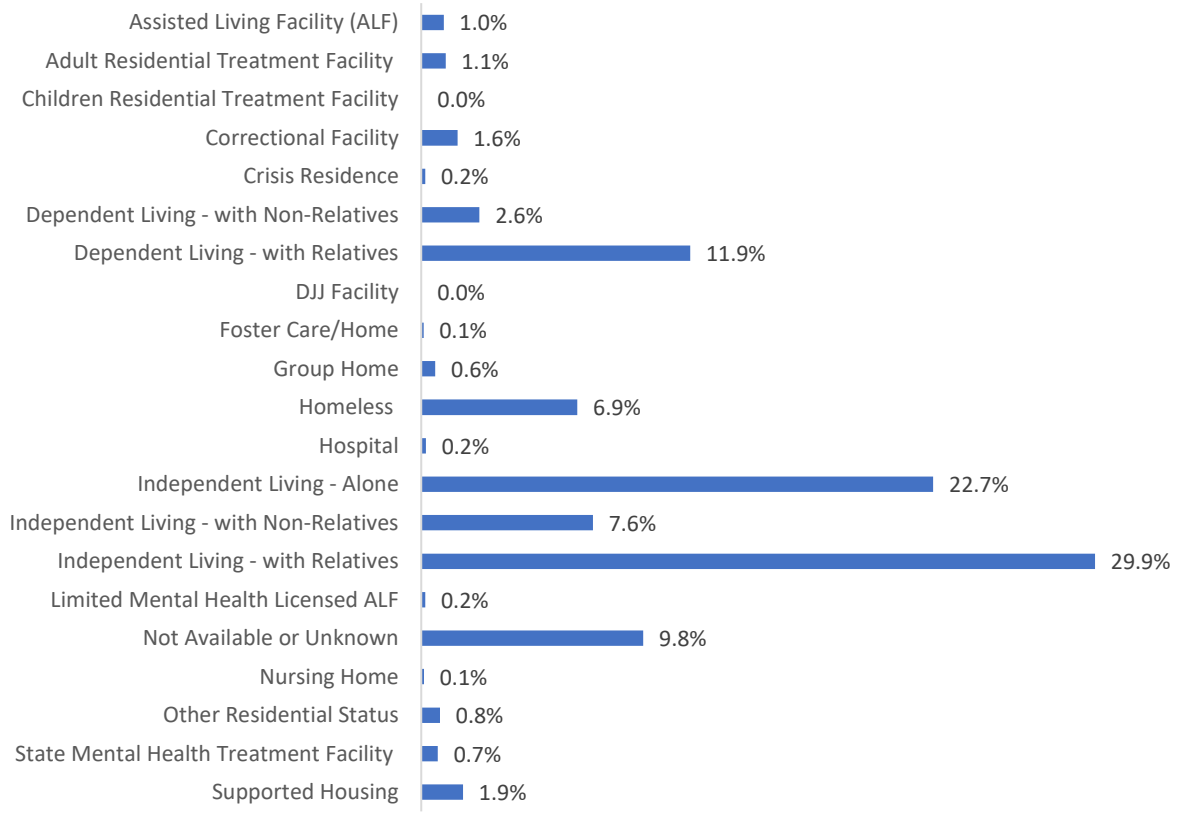
Source: Florida ME Individuals Served Data

Figure 55: Florida ME Individuals Served by Residential Status



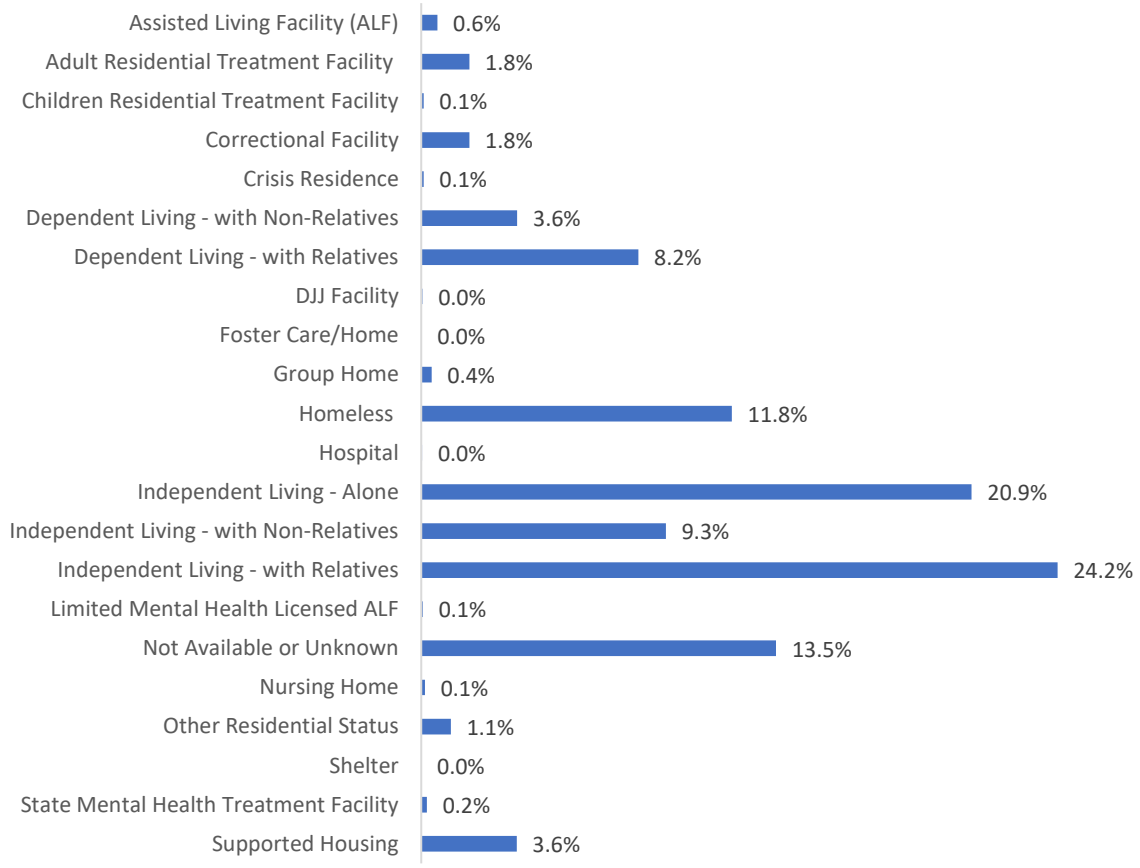
Source: Florida ME Individuals Served Data

Figure 56: Florida ME AMH Individuals Served by Residential Status



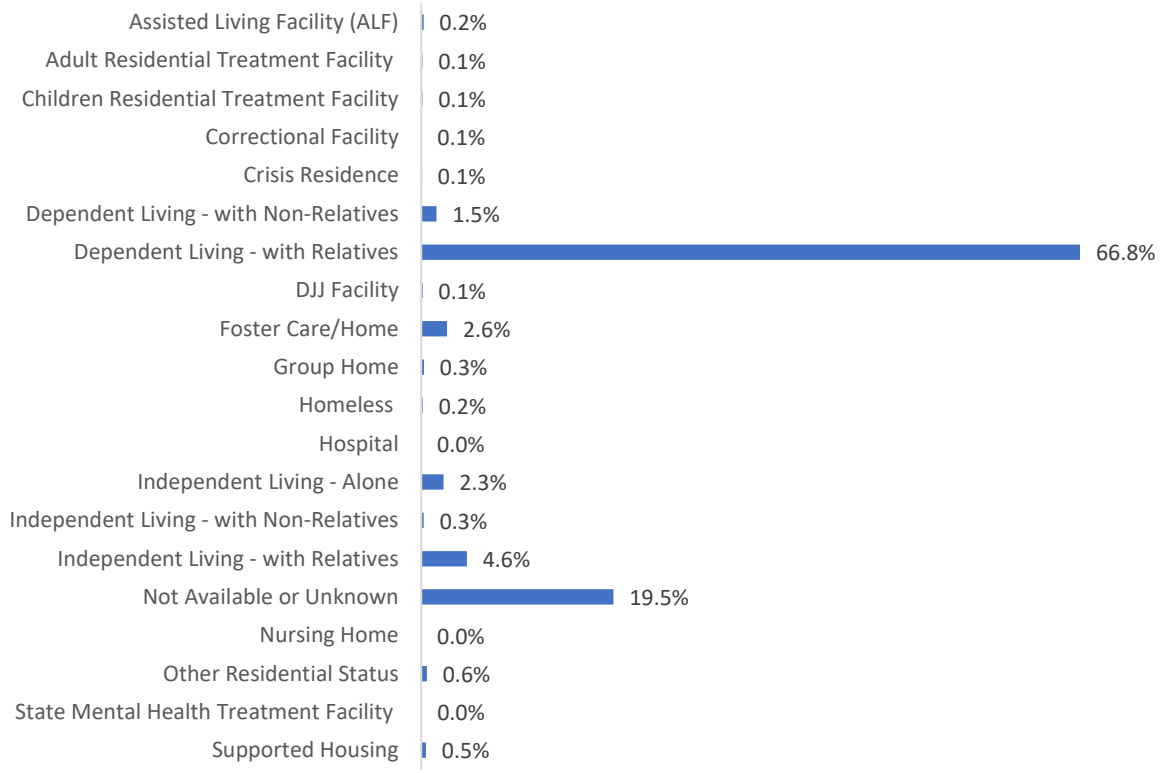
Source: Florida ME Individuals Served Data

Figure 57: Florida ME ASA Individuals Served by Residential Status



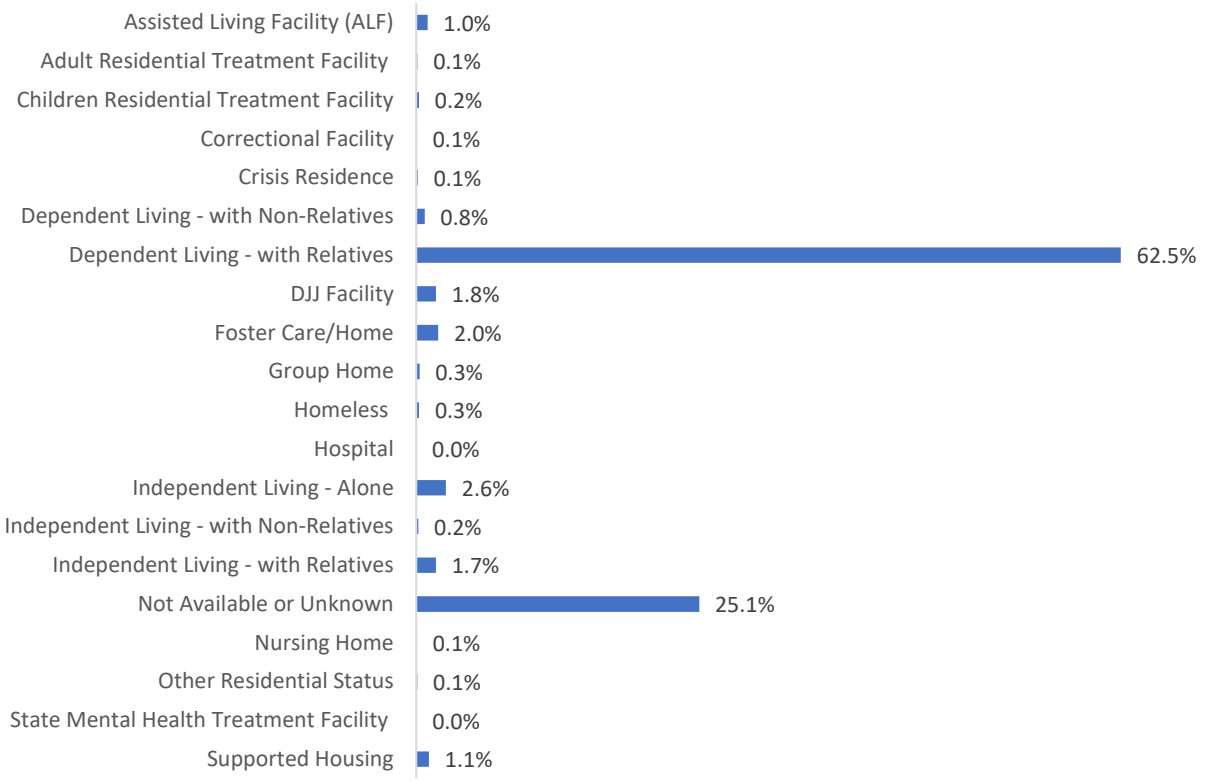
Source: Florida ME Individuals Served Data

Figure 58: Florida ME CMH Individuals Served by Residential Status



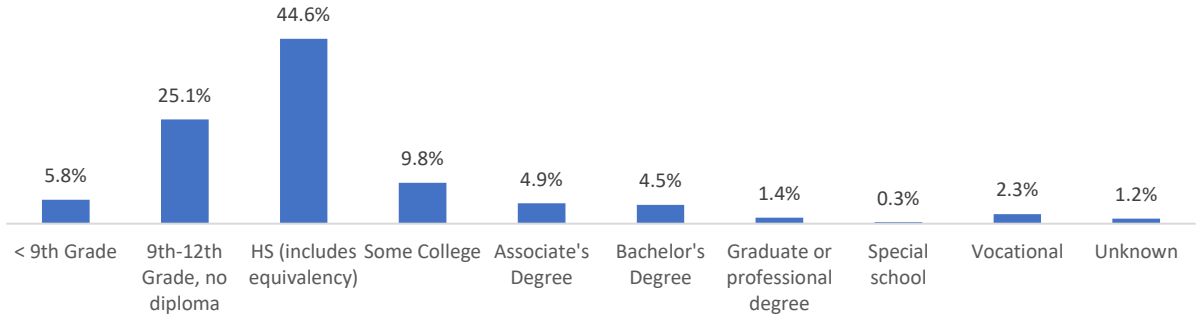
Source: Florida ME Individuals Served Data

Figure 59: Florida ME CSA Individuals Served by Residential Status



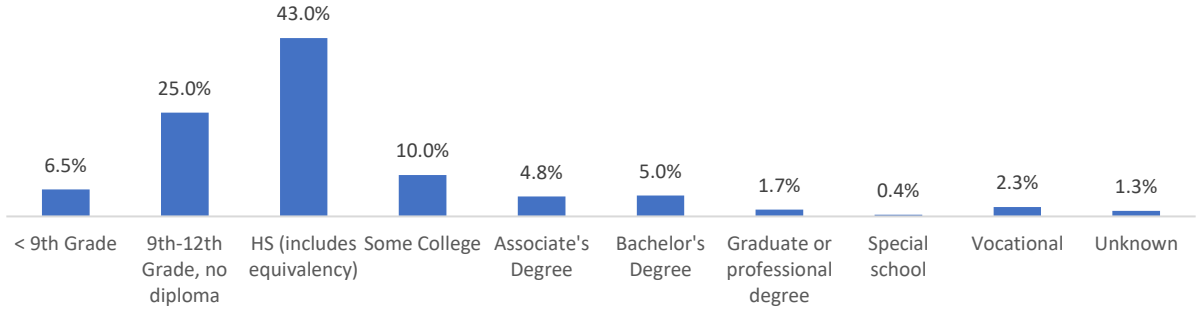
Source: Florida ME Individuals Served Data

Figure 60: Florida ME Individuals Served by Educational Attainment



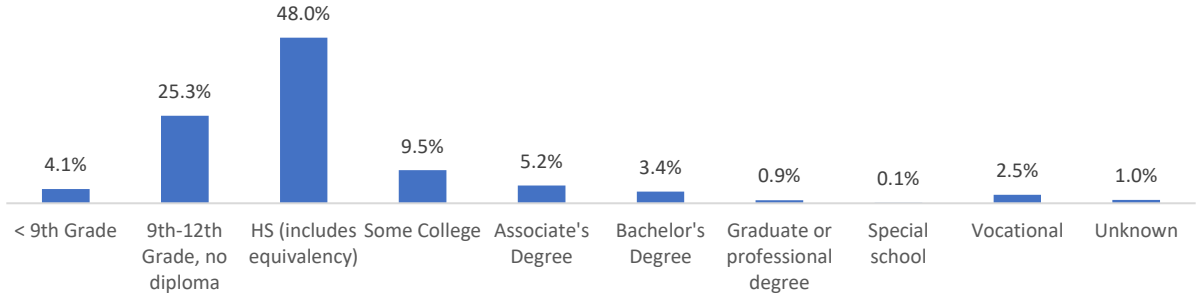
Source: Florida ME Individuals Served Data

Figure 61: Florida ME AMH Individuals Served by Educational Attainment



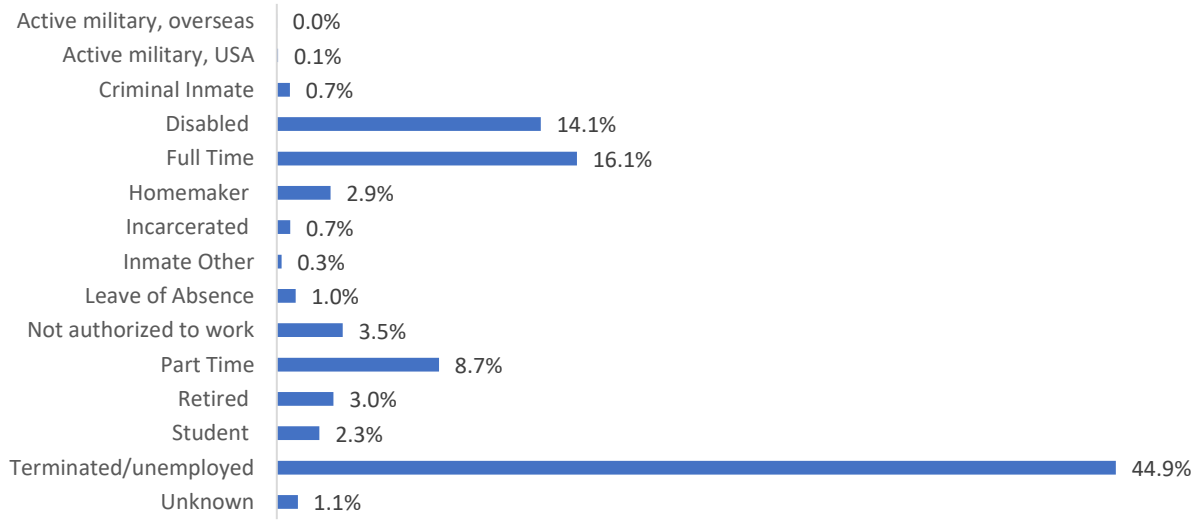
Source: Florida ME Individuals Served Data

Figure 62: Florida ME ASA Individuals Served by Educational Attainment



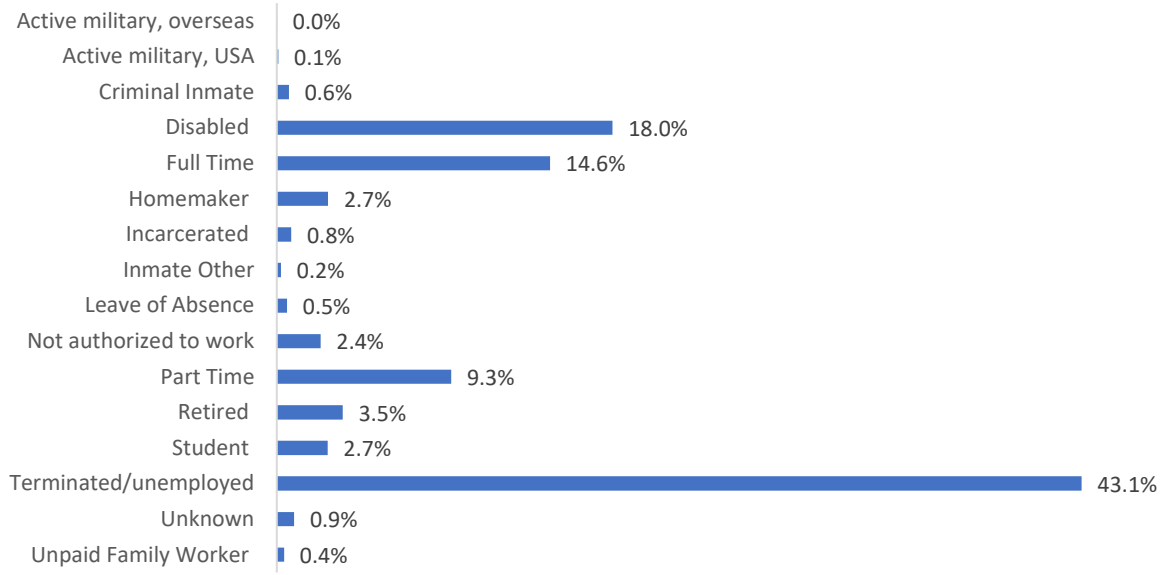
Source: Florida ME Individuals Served Data

Figure 63: Florida ME Individuals Served by Employment Status



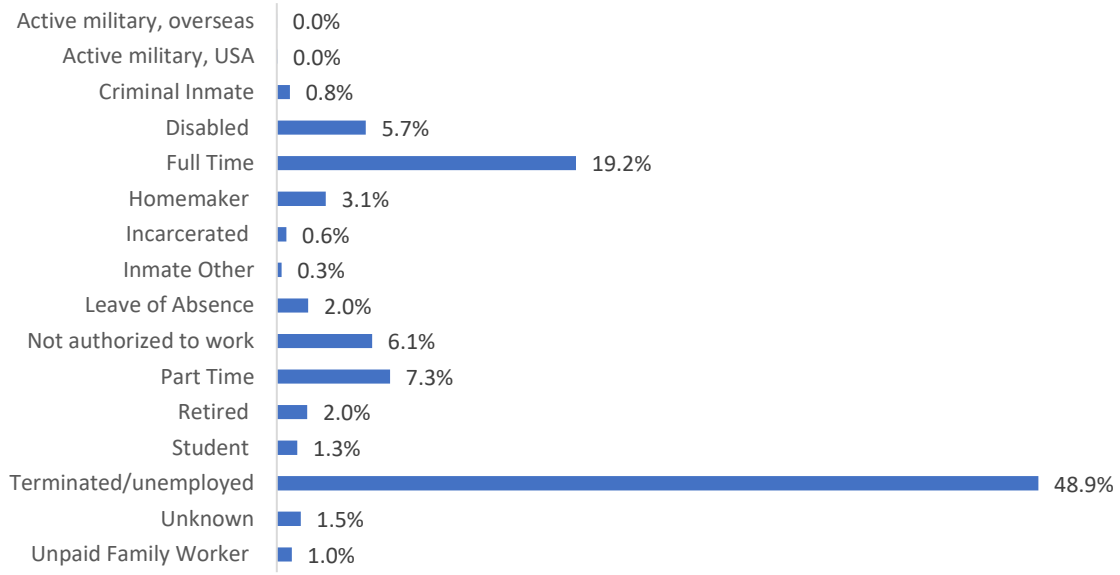
Source: Florida ME Individuals Served Data

Figure 64: Florida ME AMH Individuals Served by Employment Status



Source: Florida ME Individuals Served Data

Figure 65: Florida ME ASA Individuals Served by Employment Status



Source: Florida ME Individuals Served Data

FLORIDA HOMELESS POPULATION

The Continuum of Care (CoC) are a local geographic area designated by the U.S Department of Housing and Urban Development (HUD) and served by a local planning body, which is responsible for organizing and delivering housing and services to meet the needs of people who are homeless as they move to stable housing and maximum self-sufficiency. HUD requires CoCs to count the number of people experiencing homelessness in their geographic area through the Point in Time (PIT) Count on a given day. Conducted by most CoCs during the last ten days in January, the PIT Count includes people served in shelter programs every year, with every other year also including people who are un-sheltered. Data collected during the PIT Counts is critical to effective planning and performance management toward the goal of ending homelessness for each community and for the nation.

The 2021 Council on Homelessness Annual Report states that the PIT Count (PIT) data provides a snapshot of homelessness. **Due to the pandemic, the 2021 PIT Count is not directly comparable to prior years' counts.** This year, due to COVID-19 related safety concerns, only six of the 27 CoCs conducted such a count; 10 CoCs did not conduct an unsheltered count; and others conducted a modified form of the unsheltered count. All CoCs conducted a sheltered PIT count. For those that did not conduct an unsheltered count, the CoCs reported zero unsheltered persons, resulting in an undercount of total homelessness.

According to the report:

> "Housing is a significant determinant of health, and insufficient housing is a major public health issue. The COVID-19 pandemic has exacerbated housing instability especially for low-income households. In effect, the pandemic has triggered high rates of unemployment, worsened pre-existing behavioral health disorders, and increased stress, anxiety, and depression for others. Increased rates of unemployment also contribute to increasing the prevalence of behavioral health disorders, resulting in more suffering and deaths. Prior to the pandemic, America's affordable housing crisis was already expected to get worse. The ELI housing crisis is evidenced by the fact that people with disabilities are forced to live in segregated and institutional facilities (e.g., nursing homes, state institutions, etc.) and experience homelessness. Many of these individuals need Permanent Supportive Housing."
>
> (Please access the actual report for resources at: 2021CouncilReport.pdf (myflfamilies.com)

In 2021, the Florida Council on Homelessness reported there were 21,218 homeless individuals living in Florida. There was a 14.4% decrease from the number of homeless in 2017 at 32,109 residents compared to 27,487 in 2020. Sheltered homeless individuals accounted for 63.6% of all homeless, while 36.4% were unsheltered. Chronically homeless, defined as continually homeless

for over a year, accounted for 2,778 individuals in 2021. Chronic homelessness increased in Florida from 5,120 individuals in 2017 to 5,182 people in 2020. Homelessness among veterans decreased from 2,789 in 2017 to 2,436 in 2020. There were 2,153 homeless veterans in Florida in 2021. Families experiencing homelessness decreased 23.7% from 2017 to 2020. The number of homeless students, reported by the Florida Department of Education (FDOE), at 72,957 for the 2015-2016 school year, increased 9.6% to 79,949 in 2019-2020. Of those students who were homeless in 2019-2020, those in a sharing housing arrangement accounted for 74.5% while 11% were living in motels.

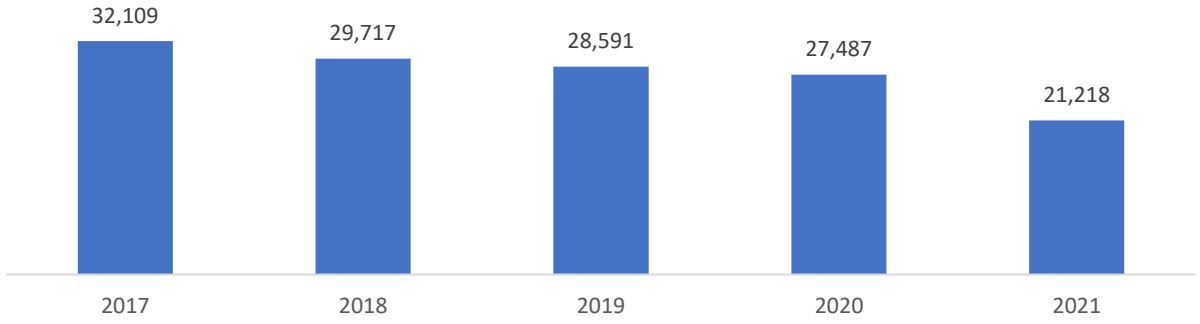
Due to the COVID-19 pandemic, this year saw an unprecedented infusion of federal funding to address homelessness and housing instability. With these funds appropriated by Congress, the State, local governments, CoCs, and partner agencies have invested in solutions to homelessness, including rent and utilities assistance, sheltering, outreach, supportive services and more. While these resources have increased Florida's capacity to prevent and end homelessness, the federal funds have strict restrictions on how the funds may be used; they are not interchangeable with the Challenge and Staffing grants provided to CoCs by the State of Florida. State funding remains critical to addressing homelessness in Florida, especially in rural areas and for the many programs that cannot be funded by federal resources due to their restrictions. State funding helps ensure a broad range of programs in Florida, as well as increase the capacity of the CoCs to administer the federal funding and other resources.

Figure 66: CoC Funding from Federal and State Sources, Florida (SFY20-21)

FUNDING SOURCE	FLORIDA
Total Funding Award	$194,436,457.35
HUD CoC FFY20	$98,991,639.00
State Total	$95,444,818.35
ESG-CV	$83,212,659.90
State Challenge	$3,181,500.00
Emergency Solutions Grant	$5,337,544.00
State Staffing	$2,892,856.95
State TANF-HP	$820,257.50

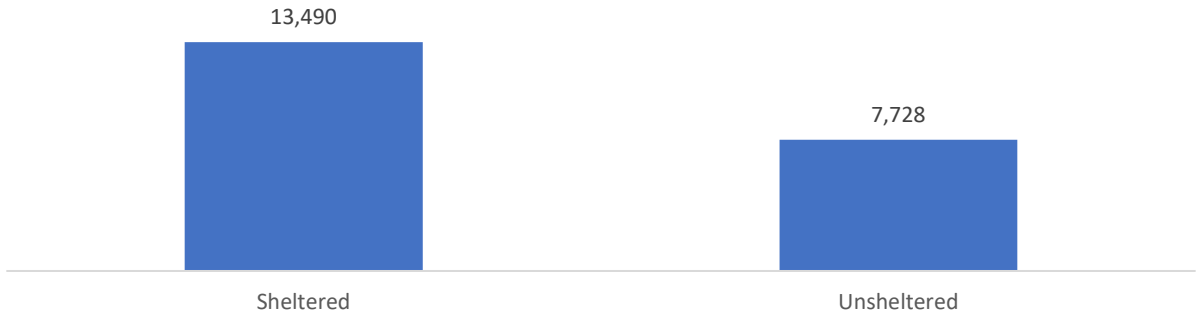
Source: 2021 Florida's Council on Homelessness Annual Report

Figure 67: Total Homeless Population, Florida (2017-2021)



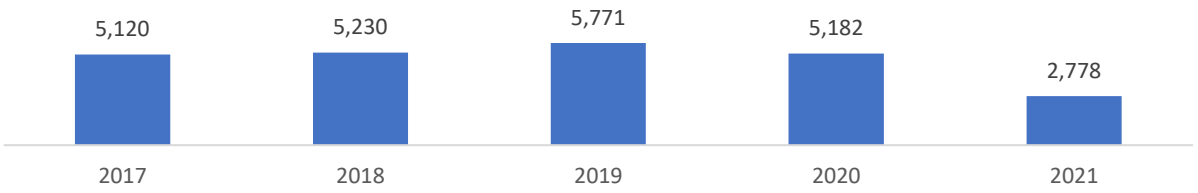
Source: 2021 Florida's Council on Homelessness Annual Report

Figure 68: Total Homeless Population Sheltered and Unsheltered, Florida (2021)



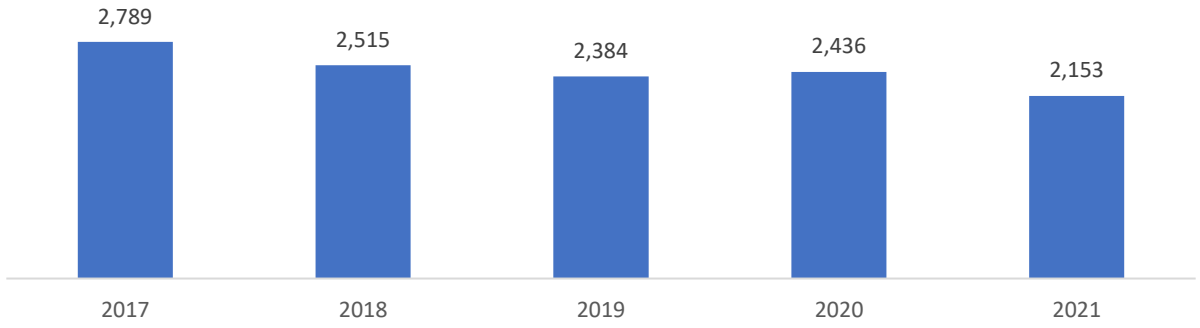
Source: 2021 Florida's Council on Homelessness Annual Report

Figure 69: Chronic Homelessness, Florida (2017-2021)



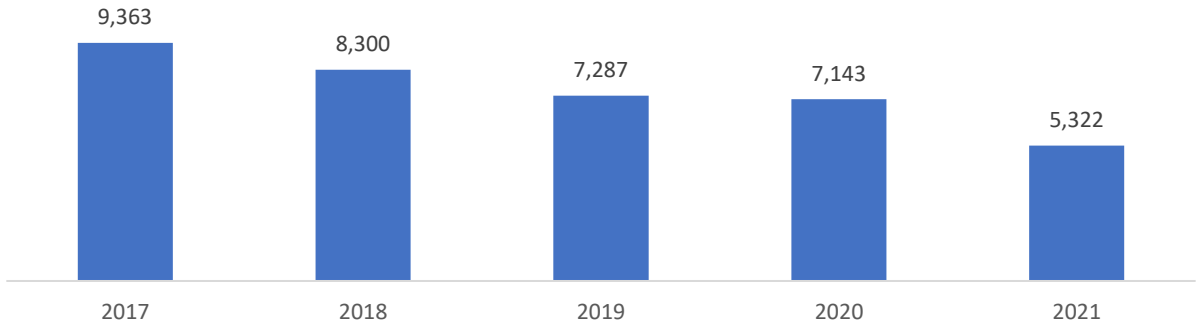
Source: 2021 Florida's Council on Homelessness Annual Report

Figure 70: Homelessness Among Veterans, Florida (2017-2021)



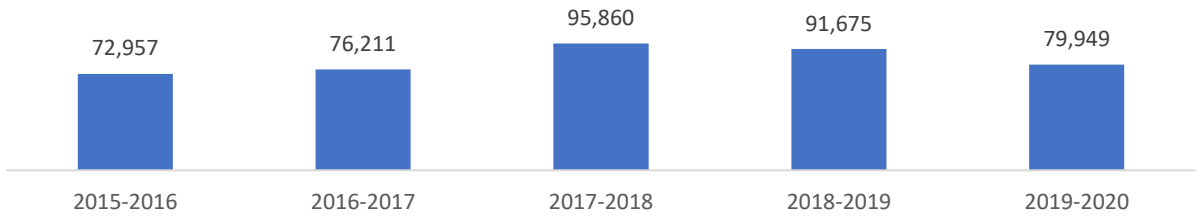
Source: 2021 Florida's Council on Homelessness Annual Report

Figure 71: Family Homelessness – Total Persons in Families with Children, Florida (2017-2021)



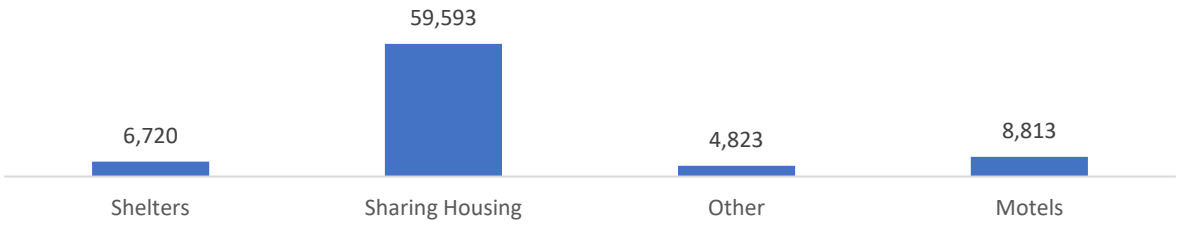
Source: 2021 Florida's Council on Homelessness Annual Report

Figure 72: Florida DOE – Reported Homeless Students in Public Schools, Florida (2015-2020)



Source: 2021 Florida's Council on Homelessness Annual Report

Figure 73: Reported Homeless Students in Public Schools by Living Situation, Florida (2019-2020)



Source: 2021 Florida's Council on Homelessness Annual Report

FLORIDA ME HOMELESS INDIVIDUALS SERVED PROFILE

Homeless Individuals Served Population

A total of 23,038 homeless individuals served were enrolled in adult and child programs in FY20-21. CFBHN and CFCHS had the highest percentages of homeless individuals served at 26.5% and 21.6%, respectively. Most homeless individuals served were in the adult programs, with 55.4% in the AMH program, and 44.2% in the ASA program. Homeless children accounted for 0.5% of all homeless individuals served.

Gender

Males accounted for 67.7% of homeless AMH individuals served and 68.6% of homeless ASA individuals served. Among the child programs, males represented 66.7% of homeless individuals served in the CSA program, and 52.5% in the CMH program. This is aligned with the gender distribution among all homeless in Florida where males represented 62.3% of the homeless population (2021). It should be noted that the number of homeless individuals served in the child programs were small and results should be interpreted with caution.

Race and Ethnicity

Homeless individuals served in the AMH and CMH programs were racially more diverse when compared to the state population, but less diverse when compared to the state homeless population. Black homeless individuals served accounted for 30.4% of those in the AMH program, and 33.3% of individuals served in the CMH program, while representing 15.9% of the state population. Among Florida's homeless population, 40.8% were Black. The racial distribution among homeless ASA and CSA individuals served more closely matched the distribution of the general state population, were homeless Black individuals served represented 16.9% ASA individuals served, and 14.3% of homeless Black CMH individuals served. Multi-racial homeless individuals served accounted for 6.4% of individuals served in all programs, 6.0% of the state population, and 3.0% of the state homeless population. Overall, homeless Hispanic individuals served accounted for 14.1% of the total individuals served population. In Florida, Hispanic's represented 25.8% of the state population but only 14.8% of the state's homeless population.

Age Range

Adults, ages 25-44 years, accounted for 55.9% of AMH individuals served, and 64% of ASA individuals served. This was much higher when compared to the state population where individuals, age 25-44 years, represented 25.1% of residents. Older homeless individuals served, those over 65 years of age, represented a much smaller percentage of homeless individuals served

(1.1%) when compared to those in the state at 20.5%. A comparison to Florida's homeless population by corresponding age ranges was not available.

Residential Status

All homeless individuals served reported their residential status as homeless.

Educational Attainment

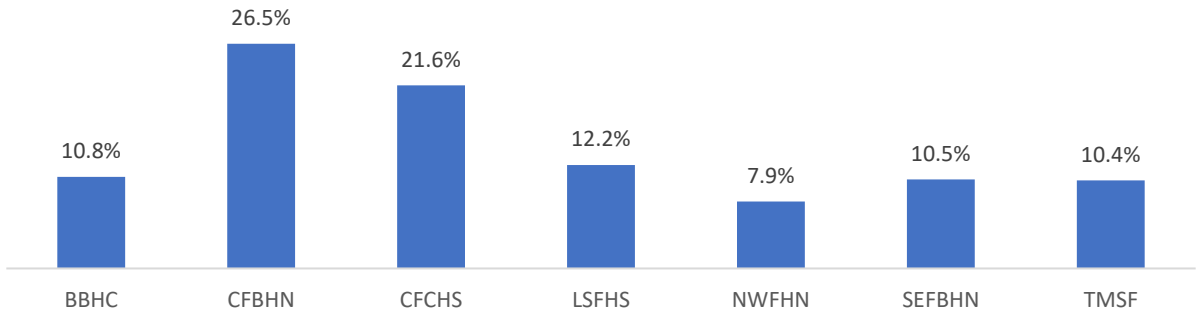
Among homeless individuals served, 60.6% attained a high school education. This statistic was much lower when compared to the state population where 88.5% of residents attainted a high school or equivalent education. Over 35% of homeless individuals served had not earned a high school diploma.

Employment Status

Only 9.6% of homeless individuals served were employed (part time or full time), and 73.3% had been terminated, or were unemployed. In comparison, the unemployment rate for Florida residents was 6.4% (2020).

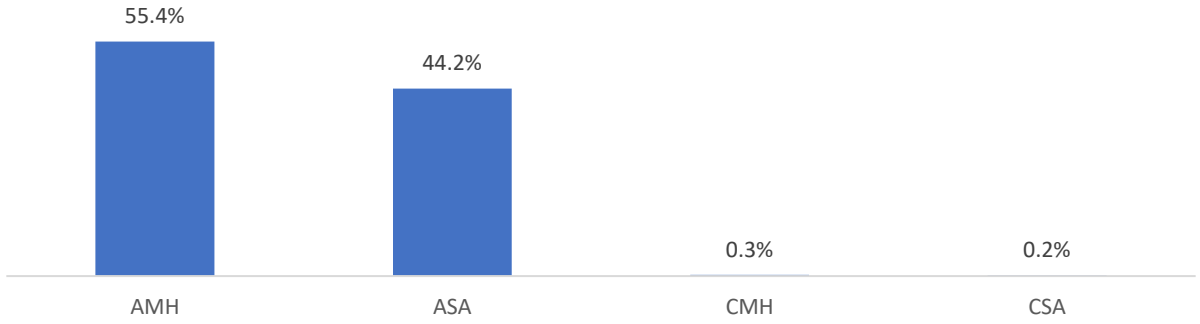
HOMELESS INDIVIDUALS SERVED CHARTS

Figure 74: Florida Homeless Individuals Served by ME



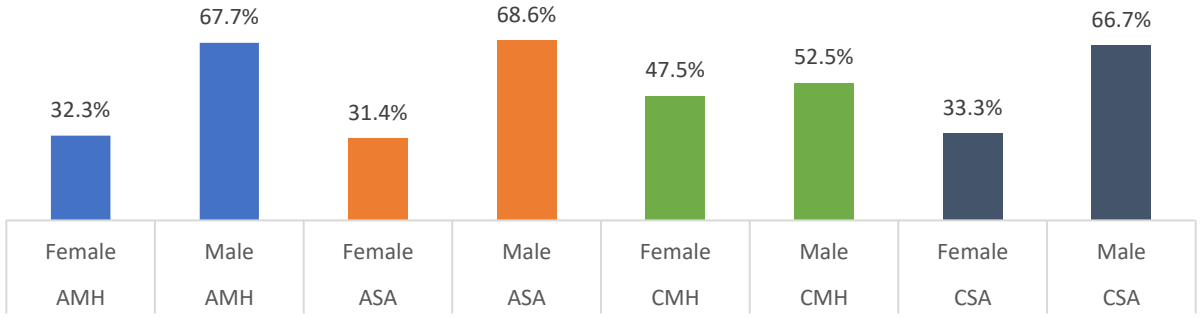
Source: Florida ME Individuals Served Data

Figure 75: Florida Homeless Individuals Served by Program



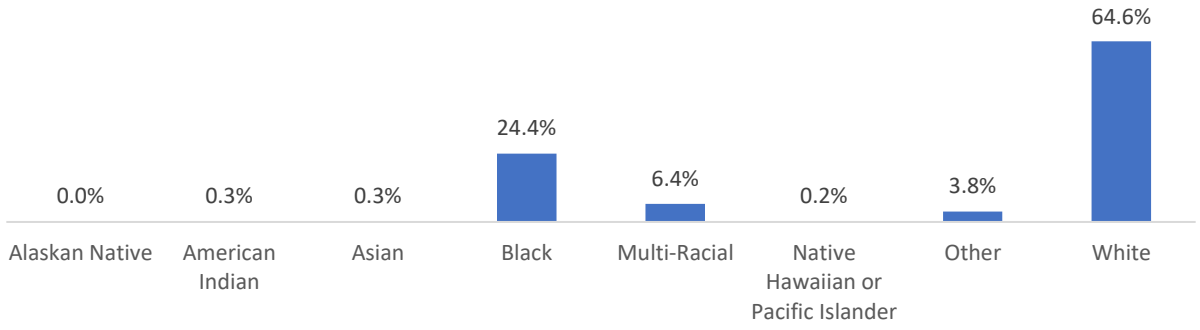
Source: Florida ME Individuals Served Data

Figure 76: Florida Homeless Individuals Served by Gender



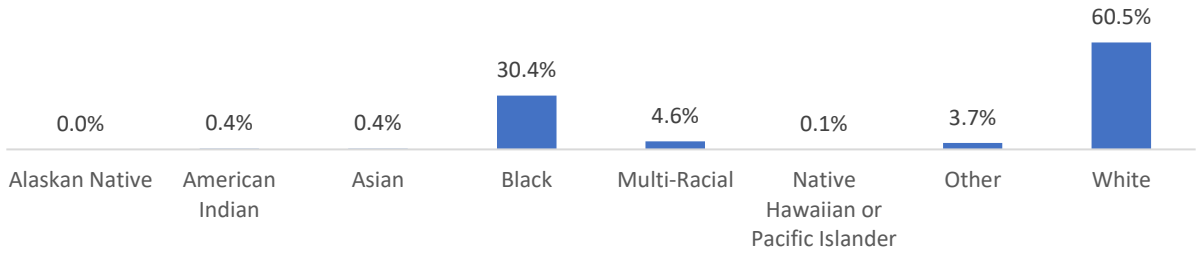
Source: Florida ME Individuals Served Data

Figure 77: Florida Homeless Individuals Served by Race



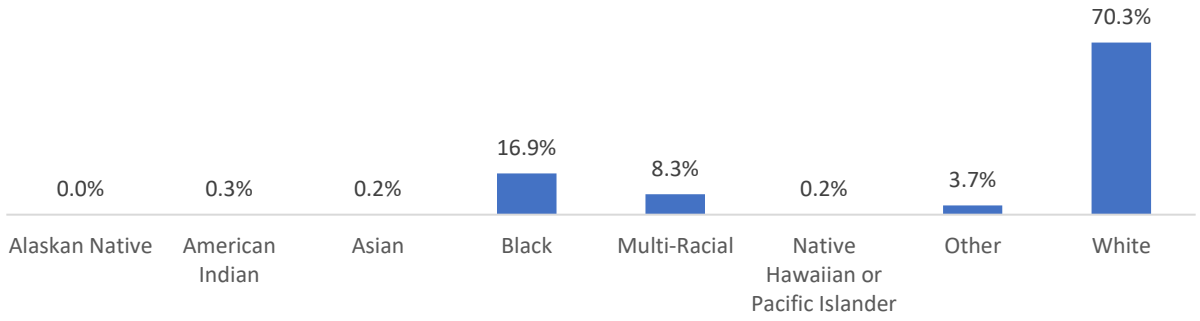
Source: Florida ME Individuals Served Data

Figure 78: Florida Homeless AMH Individuals Served by Race



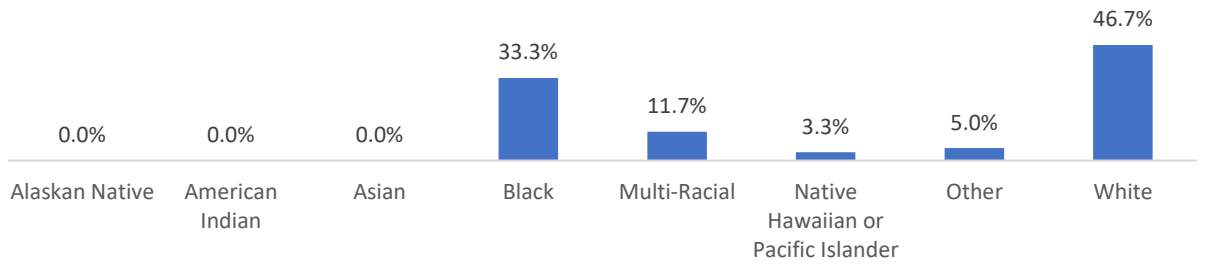
Source: Florida ME Individuals Served Data

Figure 79: Florida Homeless ASA Individuals Served by Race



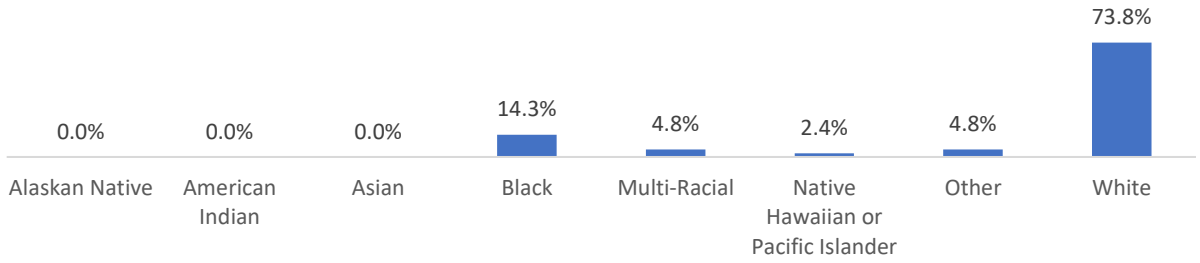
Source: Florida ME Individuals Served Data

Figure 80: Florida Homeless CMH Individuals Served by Race



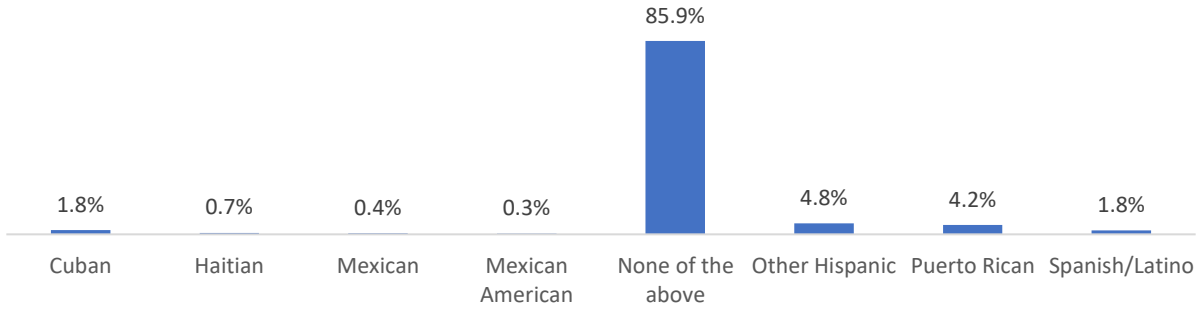
Source: Florida ME Individuals Served Data

Figure 81: Florida Homeless CSA Individuals Served by Race



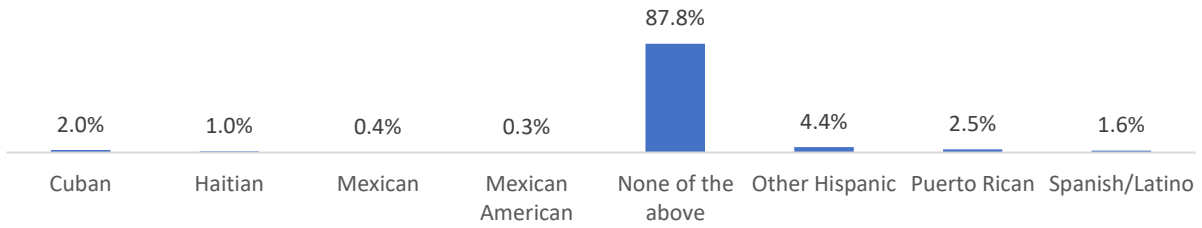
Source: Florida ME Individuals Served Data

Figure 82: Florida Homeless Individuals Served by Ethnicity



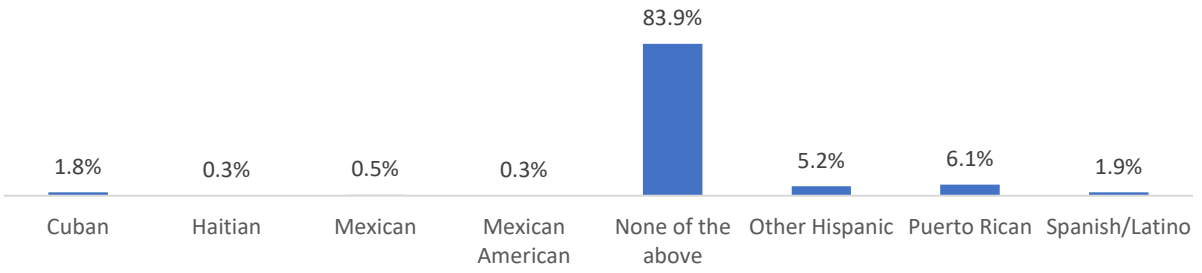
Source: Florida ME Individuals Served Data

Figure 83: Florida Homeless AMH Individuals Served by Ethnicity



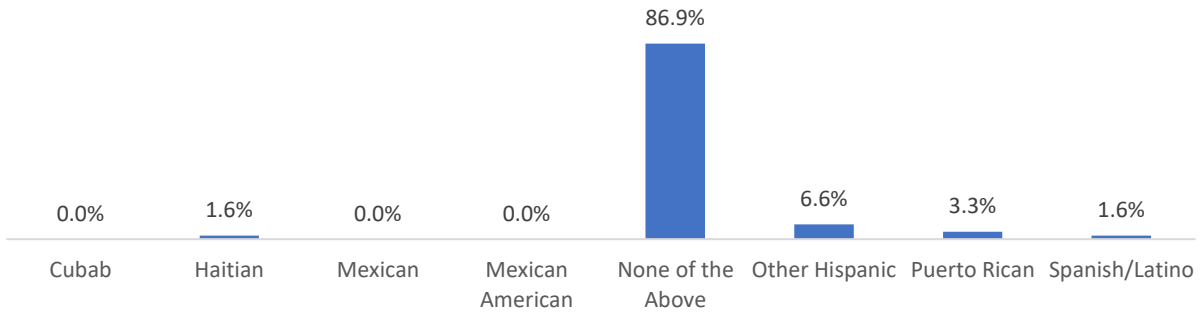
Source: Florida ME Individuals Served Data

Figure 84: Florida Homeless ASA Individuals Served by Ethnicity



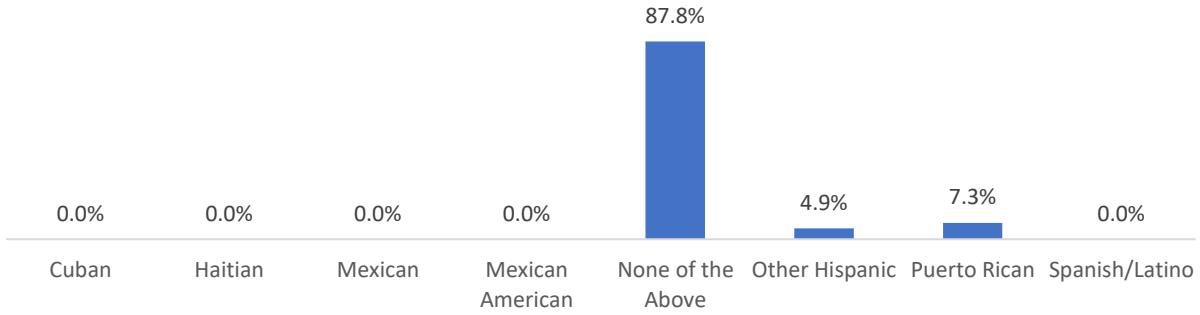
Source: Florida ME Individuals Served Data

Figure 85: Florida Homeless CMH Individuals Served by Ethnicity



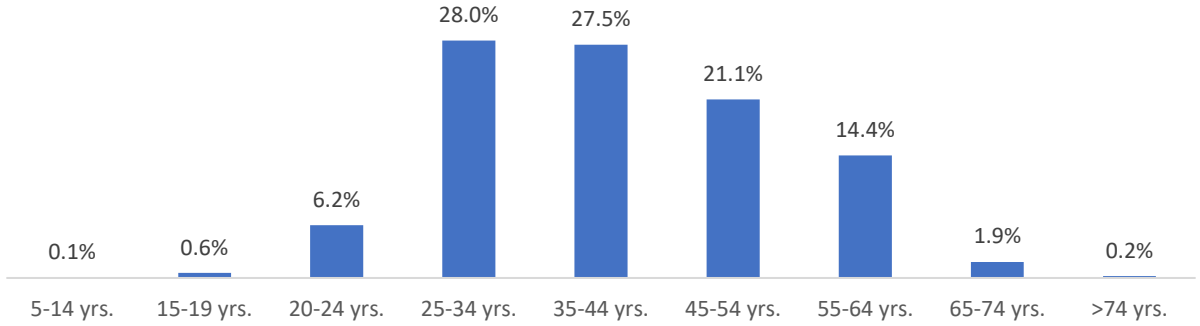
Source: Florida ME Individuals Served Data

Figure 86: Florida Homeless CSA Individuals Served by Ethnicity



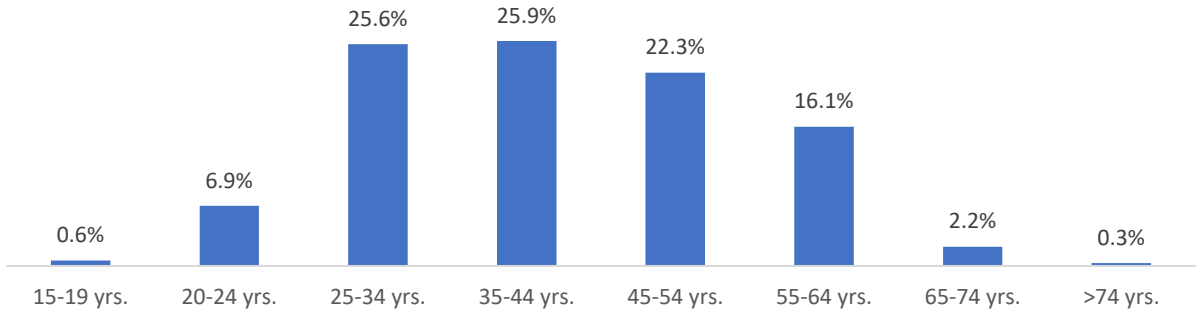
Source: Florida ME Individuals Served Data

Figure 87: Florida Homeless Individuals Served by Age Range



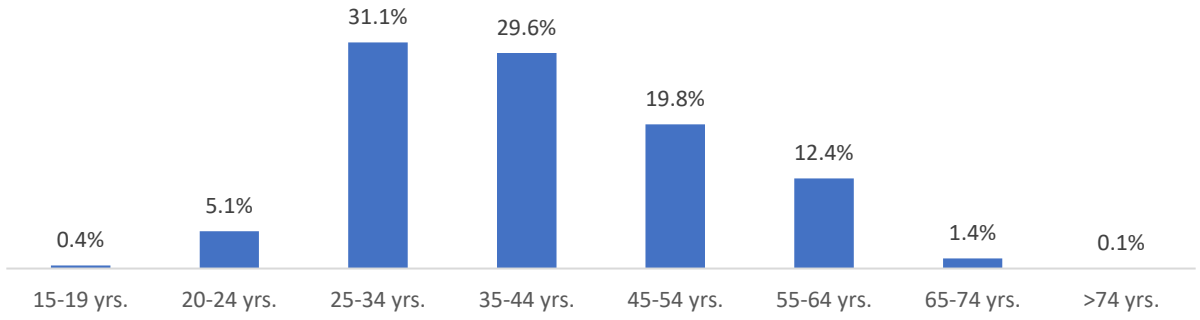
Source: Florida ME Individuals Served Data

Figure 88: Florida Homeless AMH Individuals Served by Age Range



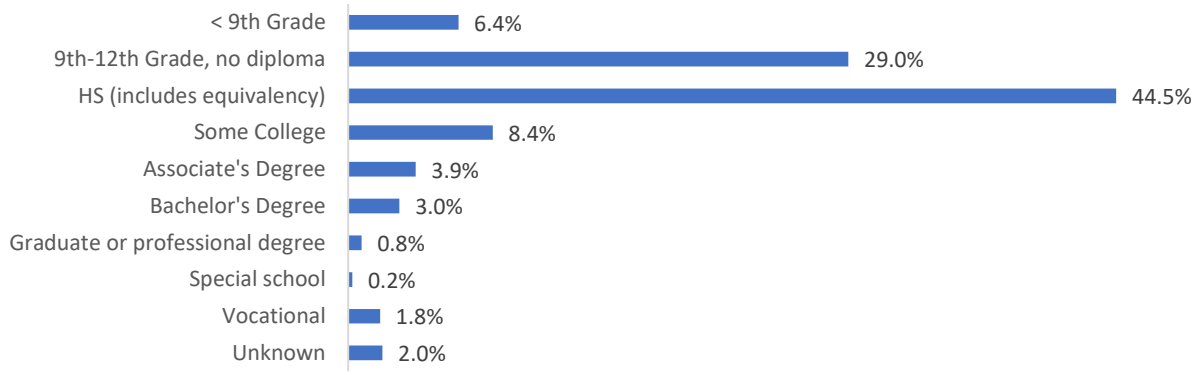
Source: Florida ME Individuals Served Data

Figure 89: Florida Homeless ASA Individuals Served by Age Range



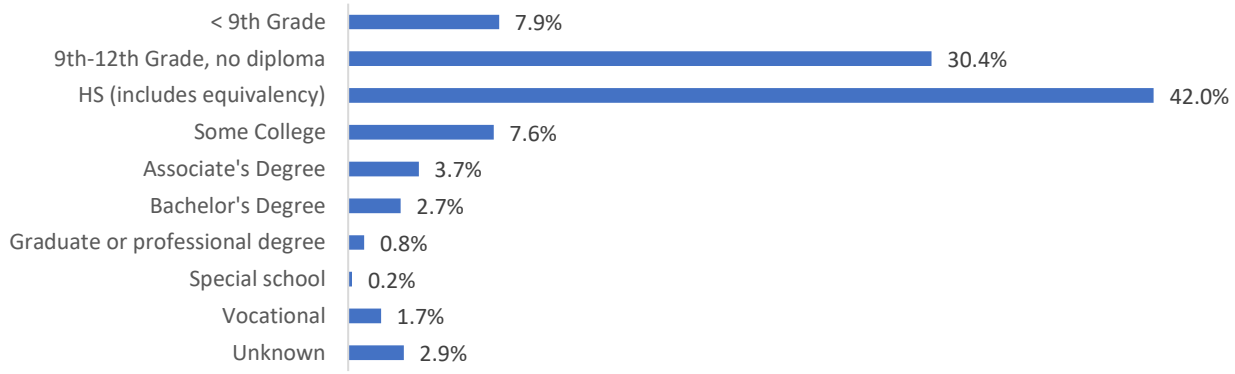
Source: Florida ME Individuals Served Data

Figure 90: Florida Homeless Individuals Served by Educational Attainment



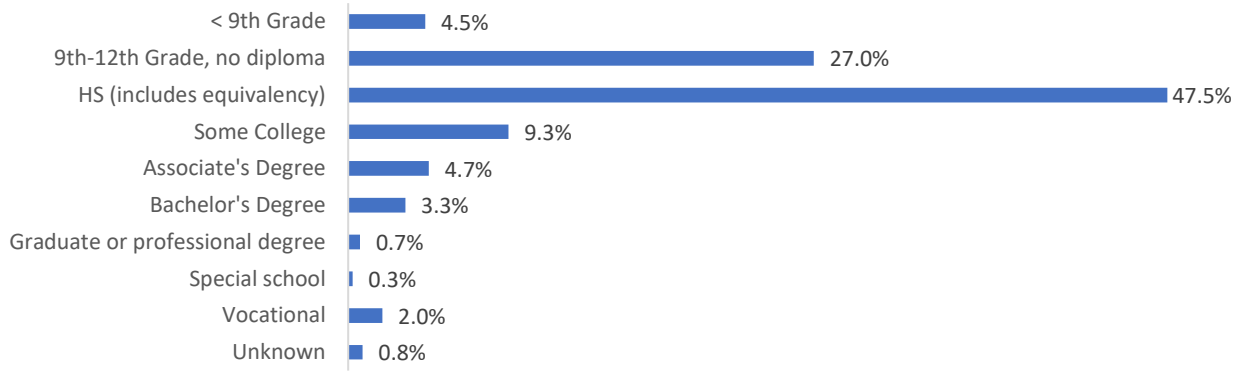
Source: Florida ME Individuals Served Data

Figure 91: Florida Homeless AMH Individuals Served by Educational Attainment



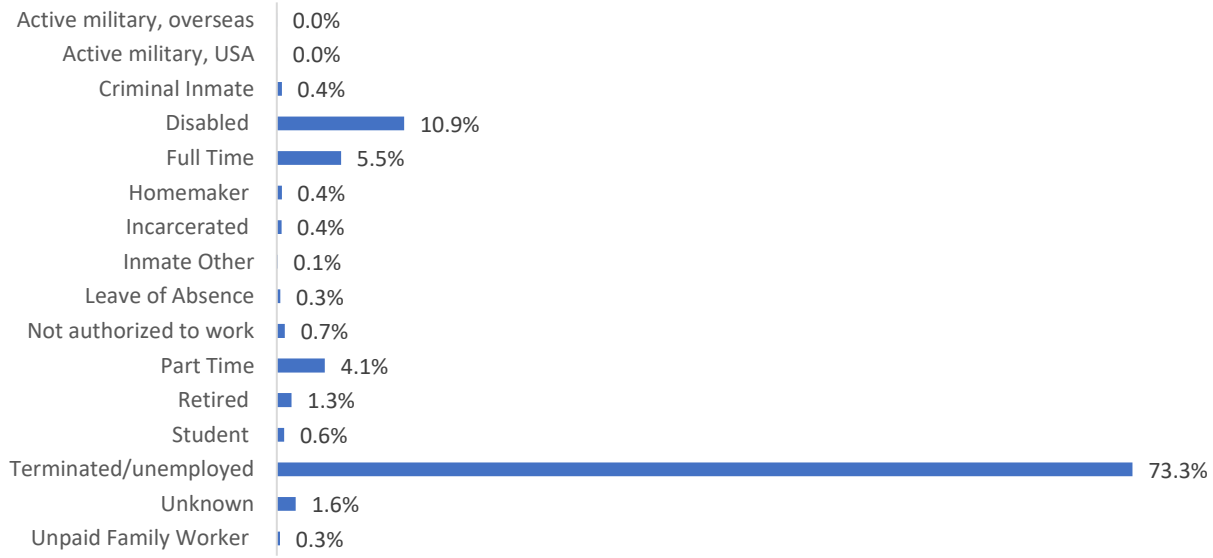
Source: Florida ME Individuals Served Data

Figure 92: Florida Homeless ASA Individuals Served by Educational Attainment



Source: Florida ME Individuals Served Data

Figure 93: Florida Homeless Individuals Served by Employment Status



Source: Florida ME Individuals Served Data

CULTURAL HEALTH DISPARITY SURVEY SUMMARY

The 14-question Cultural Health Disparity Survey administered for individuals most in need and at high risk for disparity was distributed in vulnerable communities using the CDC Social Vulnerability Index (CDC SVI). This index uses U.S. Census data to determine the social vulnerability of every census tract. The CDC SVI ranks each tract on 15 social factors, including poverty, lack of vehicle access, and crowded housing, and groups them into four related themes: Socioeconomic Status, Household Composition, Race/Ethnicity/Language, and Housing/Transportation.

A census tract ZIP Code crosswalk was created to assist the MEs in identifying the most appropriate individuals served for this survey. The survey was in the field for 5 weeks and made available through an electronic link and QR code that could be emailed, texted, printed, or posted to social media. The survey was translated into three languages: English, Spanish, and Creole.

The survey was distributed by each ME specific to their region with 800 respondents giving their perceptions on their comfort levels regarding various behavioral health care settings. The goal of the survey was to gain insight from respondents regarding access, quality, and culturally appropriate treatment by defining the health care settings that are most comfortable to individuals served. The data from each ME survey was analyzed by Local Health Council (LHC) staff. Questions were developed to further validate the findings through focus group research. As each ME identified different focus areas to probe, a summary at the state level was not achievable based on the unique needs of each ME region across Florida, however, the region-specific findings can be found in the respective ME report section.

The state summary of the survey revealed the vast majority (78.5%) of individuals surveyed indicated that they were comfortable seeking behavioral health care services. Only 20.7% of respondents were not comfortable seeking care. Just over 60% of respondents trusted or strongly trusted the behavioral health care system to treat them with respect. Of the remaining respondents, 19% distrusted or strongly distrusted that they would be treated with respect and 20.4% were neutral.

Respondents were asked to rank four statements that most closely describes their feelings regarding their behavioral health issues, with (1) being the best and (5) being the least.

- This is a private issue I keep to myself – Respondents were split regarding behavioral health issues as a private matter with 44.8% indicating that this is most like or somewhat how I feel, and 39.7% revealed this is most unlike or somewhat unlike how I feel. Those who were neutral accounted for 12.9% of respondents.
- This is a private issue that stays in the family – Behavioral health issues as a private matter that stays in the family, was most how I feel, or somewhat how I feel, for 51.8% of respondents. Neutral respondents accounted for 17%, and 28.6% responded that this was somewhat unlike, or most unlike how they feel.

- I am comfortable sharing my challenges with others (professionals, family members, friends, clergy, etc.) – More than half of respondents were comfortable sharing their challenges regarding with others, while 26.8% were not. Those with neutral feelings accounted for 16.9% of respondents.
- I am more comfortable with people like me – More respondents (33.8%) were more comfortable with people like them when compared to 21.6% who responded that this was somewhat unlike or most unlike how they feel. Those who were neutral accounted for 15.2% of respondents. It should be noted that 29.5% of respondents did not answer this question.

When asked to identify the settings which have been most comfortable discussing your behavioral health concerns, 31.8% responded that they were most comfortable in a private office with a doctor. A hybrid of telehealth and telehealth accounted for 18.8% and 15.7% of respondents, respectively. Speaking with a nurse practitioner was comfortable for 11.2% of respondents. About 10% chose all the settings offered. The traditional physician office was preferred 2:1 to faith-based behavioral healthcare services. Individuals Served were likely (23.6%) or very likely (17.5%) to be comfortable in group therapy. For the remaining respondents, 19.9% were very unlikely, and 15% were unlikely to be comfortable in this therapy setting. Almost one-quarter of respondents were neutral. More individuals served were likely or very likely (76.6%) to be comfortable in individual therapy. Only 8.2% would not be comfortable and 15.2% were neutral.

Ninety percent of respondents received services in their primary language. Of the remaining respondents receiving services in their primary language: 4.7% received them some of the time, 3.5% of received them a little of the time, and 1.7% of respondents needed an interpreter.

So that efforts could be best targeted to improve the availability of behavioral health care services within their communities, respondents were asked to provide some demographic information. Respondents were predominately female (57.9%) with males representing 38.4%. Less than 4% preferred not to answer this gender question. Regarding gender identity, 57% of respondents chose not to answer this question. Of those who responded, just over 20% identified as Cisgender, 8.3% as Agender, and 7.8% as Gender Fluid. The six remaining gender identity categories accounted for the remaining 5.5% of respondents. Over 60% of respondents reported their sexual orientation as Heterosexual/Straight. Bisexual accounted for 6.3% of respondents and 5.9% were asexual. Less than 40% indicated that their sexual orientation was not listed and 15.5% preferred not to answer.

Most respondents were White (54.9%) and 28.8% were Black. Multi-racial accounted for 4.8% of respondents while 4.6% preferred not to answer. Just over 30% of respondents were Hispanic with 11.5% being Spanish/Latino, 5.4% Cuban, 4.7% Haitian, 4.3% Puerto Rican, and 4.6% Other Hispanic. Mexican and Mexican American accounted for 3.3% of respondents. Close to 40% of respondents were 35-54 years of age. Those younger than 24 years accounted for 15.1% of

respondents while 16.3% were 25-34 years of age. Just over 17% of respondents were 55-64 years old. Those 65 years and older accounted for 7.9% of respondents.

Key Cultural Health Disparity Indicator Details from ME Surveys

Below are some of the highlights gleaned from the respective ME cultural health disparity survey results. This was the first step in identifying the extent of cultural health disparity among individuals served by the respective ME region. Most results were analyzed by service area which did not fully capture the disparity among the various racial, ethnic, and sexual identity groups. This is an ongoing process that will include additional analyses of the data so that the ME's can further identify the disparity within their service area. This will be the focus of their strategic planning efforts over the next two years. More comprehensive details from the cultural health disparity focus groups can be found in the ME region specific reports. This next section provides some key findings respective to each ME.

Broward Behavioral Health Care (BBHC)

Most respondents (70.8%) indicated that they usually feel comfortable seeking behavioral health care services. Just over half (54.2%) of respondents believe the behavioral health care system will treat them respectfully. Respondents preferred the private office with a doctor as the most comfortable setting to discuss behavioral health concerns. Telehealth and a hybrid of telehealth were preferred over speaking with a nurse practitioner (NP). As NP's are being used more extensively in the office setting, further analysis may be needed to identify "why this setting in not comfortable" for receiving behavioral health care services.

Although most respondents received services in their primary language, 10.1% said this was not available in most interactions with the health care system.

It is important to note almost half of the respondents identified themselves as cisgender, 31.7% preferred not to answer, and 19% were gender fluid. The majority of respondents (65.7%) identified as heterosexual/straight, 11.4% preferred not to answer, and 10% were asexual. Gender identity and sexual orientation could be explored to understand the impact on behavioral health concerns.

When asked about participating in group therapy, 38.9% were likely to participate, 34.7% were unlikely to participate, and 26.4% were neutral. To further understand what factors (stigma, time, need, etc.) affect interest in group therapy, which may lead to "why this setting is not comfortable.

Central Florida Behavioral Health Network (CFBHN)

In CFBHN's region when analyzing the respondents regarding, "how the individual feels about their behavioral health issues" provides insight into why they may not seek services when they need them. Keeping this a private issue "that is not shared" is the described feelings for 39.2% of

respondents. Feeling that their behaviors health issues are a private matter that stays in the family accounted for 25.4% of respondents. More respondents were comfortable sharing their behavioral issues with others when compared to those who were not comfortable sharing. However, when asked if they were more comfortable with people like them, 37.2% indicated this was how they felt, while 25.5 said this was unlike how they felt. This could be a barrier for those living in diverse communities with limited options for receiving services.

Central Florida Cares Health System (CFCHS)

In CFCHS's region although 61.4% trusted the behavioral health care system to treat them with respect, almost 40% did not. If individuals lack trust in the system, they will not seek services when they need them. Delaying care only intensifies the issues already present. Getting in to care when symptoms are noticeable ensures a lasting recovery. This is a good area to explore further to understand what factors (Stigma, setting, etc.) may be leading to the lack of trust.

Receiving behavioral health services in Individual therapy settings was reported as more comfortable for most respondents (81.9%) when compared to attending group therapy at 53.5%. The group therapy option offers benefits not available in individual therapy, such as receiving and giving support, the ability to model successful behaviors, and creating a broader safety net. Additionally, this option can help reduce the financial barriers associated with therapy. As noted above, further investigation should be explored to identify the obstacles in accessing care in a group setting.

Lutheran Services of Florida Health System (LSFHS)

In LSFHS's region most respondents (60%) felt that their behavioral health issues are private and stay in the family. Almost as many (57.7%) indicated that they are comfortable sharing their challenges with others. When asked if they were more comfortable with people like me, 70% did not respond. It is important to note that LSFHS's region consists of 23 counties and successfully collected 300 responses from 90 Zip Codes. In a service area with this many counties, the attitudes expressed can be widely varied thus skewing the results that have been rolled up to a service area level. For example, the respondent's attitude from Duval-to-Alachua-to-Volusia is vastly different. While some of the focus group participants had used telehealth services and found them convenient, others expressed that technology issues prevented a good experience. The focus group research found in the LSFHS regional report will further clarify the disparity in the service area.

Northwest Florida Health Network (NWFHN)

In NWFHN's region only 26.5% of respondents trusted the behavioral health care system to treat them with respect. More respondent indicated that this was an issue that individuals keep to themselves or stayed in the family when compared to those who felt differently. This indicates

that stigma regarding behavioral health issues can be the reason for those in need not to seek services. When looking across the service area results, more respondents were neutral when asked to share their feelings regarding behavioral health issues when compared to those chose a more definitive response. It appears that in the service area, individuals are less likely to be forth coming with their feeling, even when responding to an online survey. This area should be explored further to understand what factors (system, stigma, setting, etc.) may be leading to the lack of trust.

Southeast Florida Behavioral Health Network (SEFBHN)

In SEFBHN's region respondents' reported comfort in seeking behavioral health care services by race, it is significant to note that nearly half of all Black respondents indicated that they were not comfortable seeking behavioral health care services (47.6%), compared to about one-quarter (24.2%) of White respondents. Additionally, when looking at comfort by gender identity, it is important to note that 75% of respondents who identified as bigender did not feel comfortable seeking behavioral health care services, compared to 19.4% of those who identified as cisgender.

When describing their feelings regarding their behavioral health, 58.3% of participants felt that behavioral health is a private issue that they would keep to themselves (marked survey responses as "most how I feel" and "somewhat how I feel"). Importantly, 66.1% of Black respondents stated that they felt behavioral health is a private issue that they would keep to themselves, compared to 54.4% of White respondents.

Furthermore, 53.8% of participants felt that behavioral health issues are private issues that should stay in the family (marked survey response as "most how I feel" and "somewhat how I feel"). The percentage among Black respondents was greater, with 61.3% of Black respondents stating that behavioral health issues are private issues that should stay in the family, compared to 50% of White respondents. This is area should be explored further understand what factors (stigma, setting, culturally appropriate services, etc.) may be leading to the lack of trust.

Thriving Mind South Florida (TMSF)

In TMSF's region more than half (51.6%) of individuals felt that behavioral health issues were private and to be kept to themselves. A similar percentage (50.3%) believed it was a private issue to be kept within the family. Language barriers were identified in the TMSF service area as 23.8% used a formal interpreter, and 28.6% relied on a family or friend to interpret for them, as services were not offered in the individuals' primary language. More than half of participants (65.4%) felt most comfortable discussing their behavioral health concerns in a private office with a doctor. It is important to note that TMSF's Hispanic and Creole population is higher compared to the other ME regions. Current strategies should be reviewed, and new strategies explored for increasing culturally linguistic services.

CULTURAL HEALTH DISPARITY SURVEY CHARTS

Figure 94: Are you usually comfortable seeking behavioral health services?

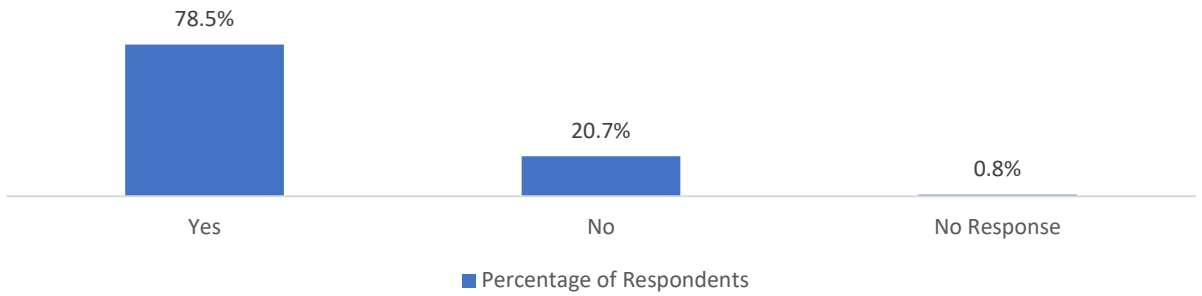


Figure 95: On a scale of 1 to 5, with 5 being 'strongly agree', how would you rate your trust in the behavioral health care system to treat you with respect?

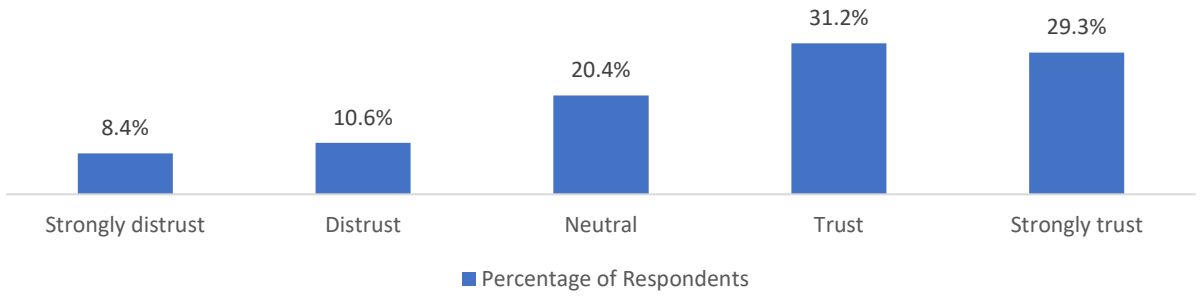


Figure 96: Please rank the statement below that most closely describe your feelings regarding your behavioral health issue, with (1) being the most and (5) being the least. "This is a private issue I keep to myself."

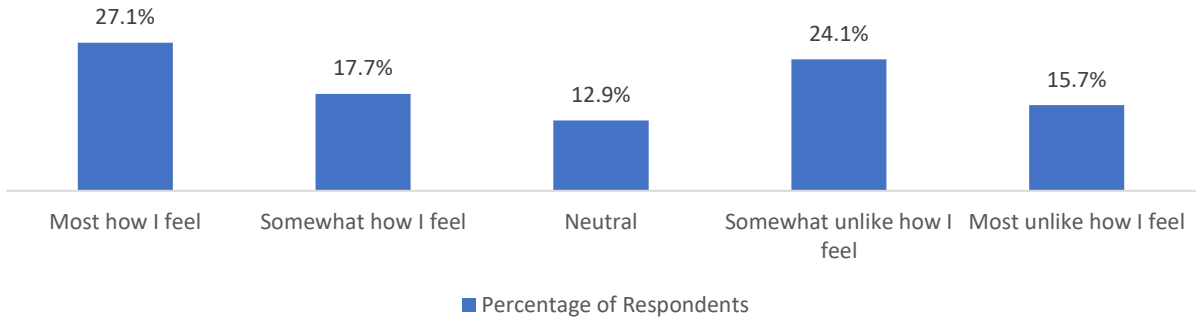


Figure 97: Please rank the statement below that most closely describes your feelings regarding your behavioral health issue, with (1) being the most and (5) being the least. "This is a private issue that stays in the family."

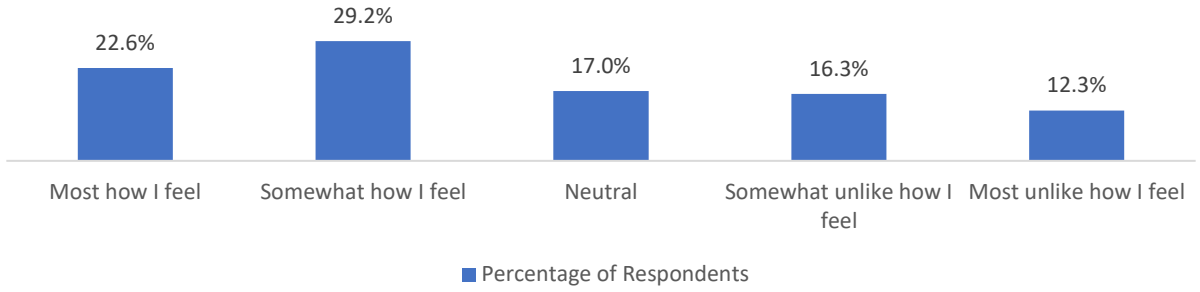


Figure 98: Please rank the following statement below that most closely describes your feelings regarding your behavioral health issue, with (1) being the most and (5) being the least. "I am comfortable sharing my challenges with others."

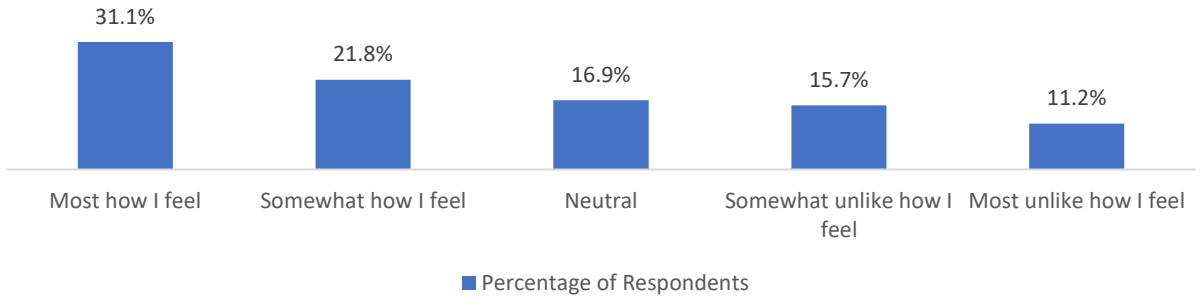


Figure 99: Please rank the following statement below that most closely describes your feelings regarding your behavioral health issue, with (1) being the most and (5) being the least. "I am more comfortable with people like me."

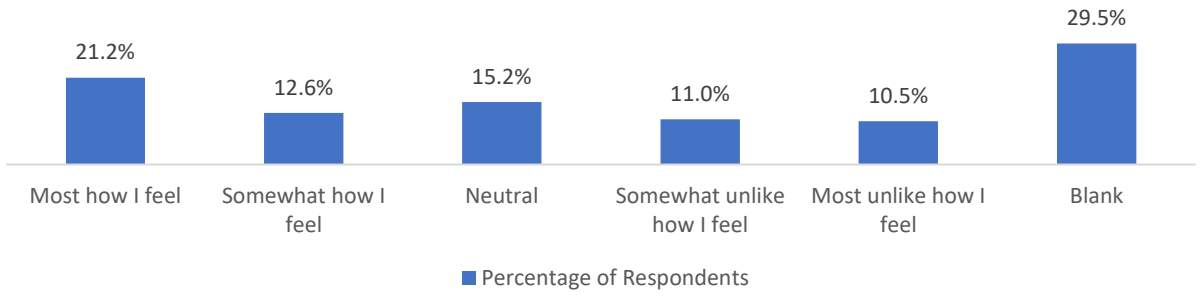


Figure 100: In which setting(s) have you been most comfortable discussing your behavioral health concerns? (Check all that apply)

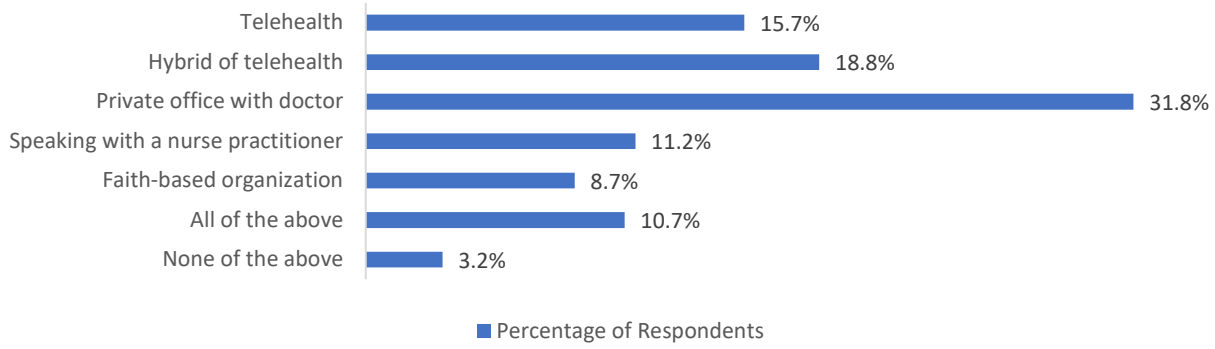


Figure 101: If given a choice for receiving behavioral health care services, would you be more comfortable going to a faith-based organization OR prefer the traditional physician office?

Figure 102: Now thinking about treatment options, on a scale of 1 to 5, with 5 being 'very likely', how comfortable would you be in group therapy?

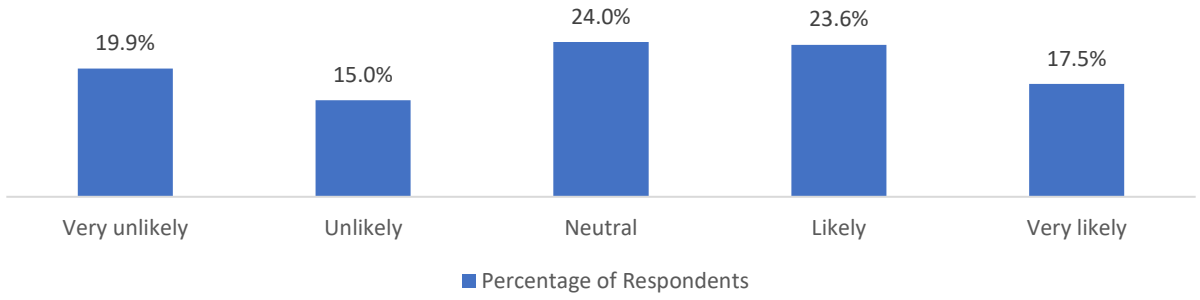


Figure 103: On a scale of 1 to 5, with 5 being 'very likely', how comfortable would you be in individual therapy?

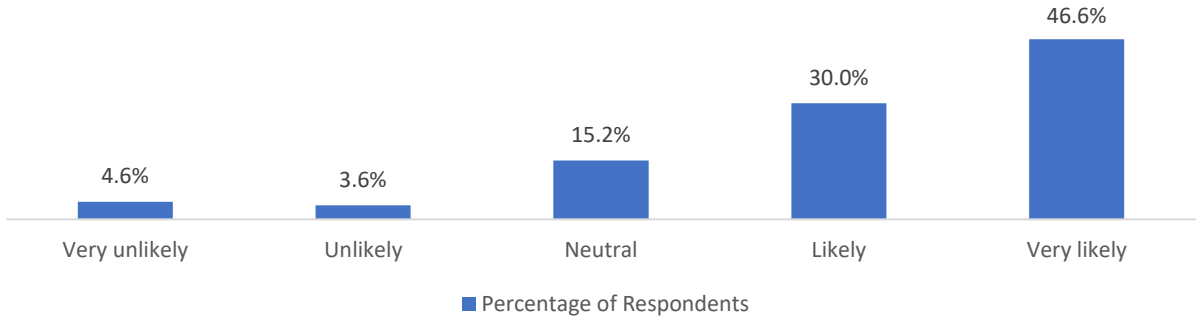


Figure 104: When you have received behavioral health care services in the past, were they mostly available in your primary language?

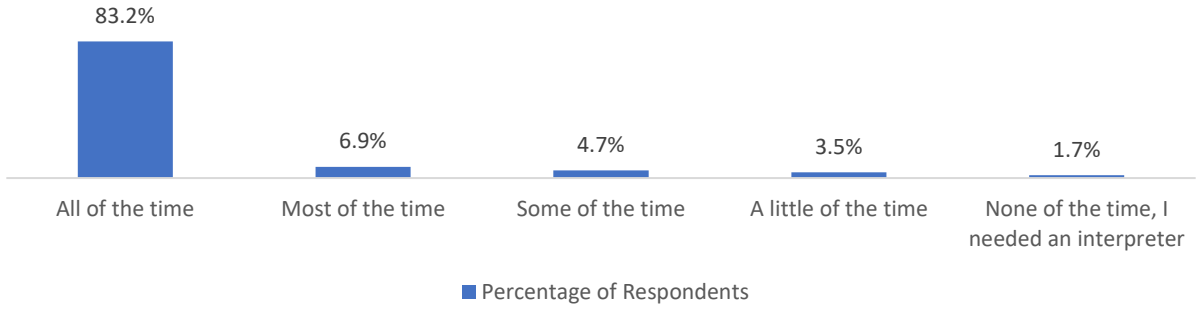


Figure 105: Which best describes your gender?

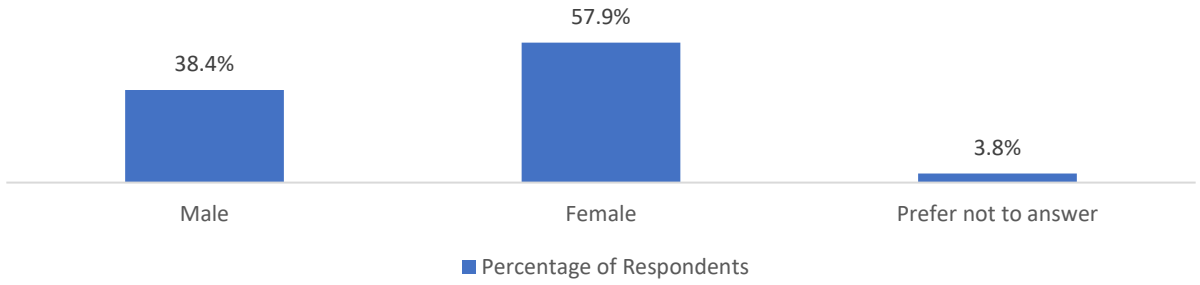


Figure 106: Which best describes your gender identity?

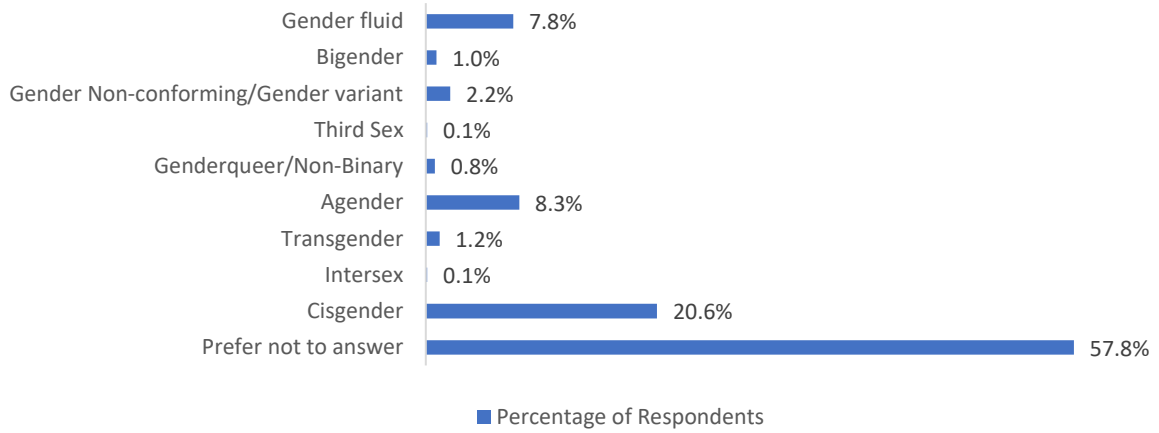


Figure 107: Which best describes your current sexual orientation? (Check all that apply)

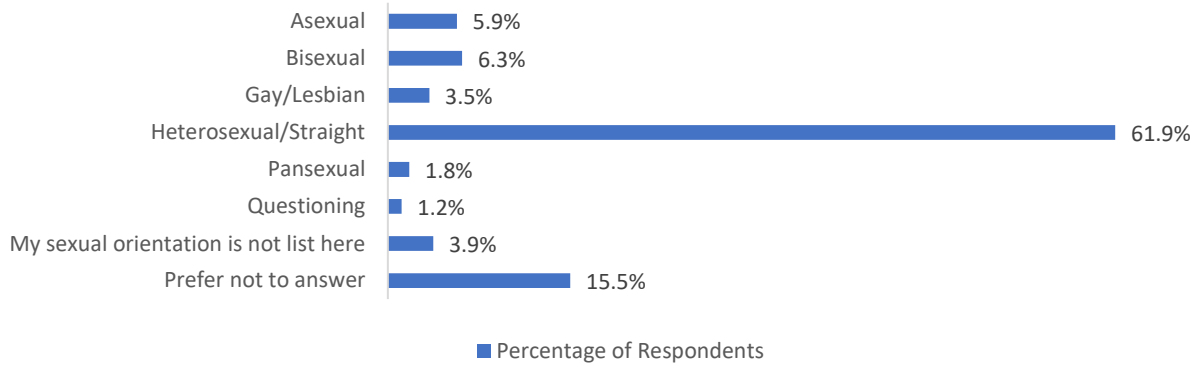


Figure 108: Which best describes your race?

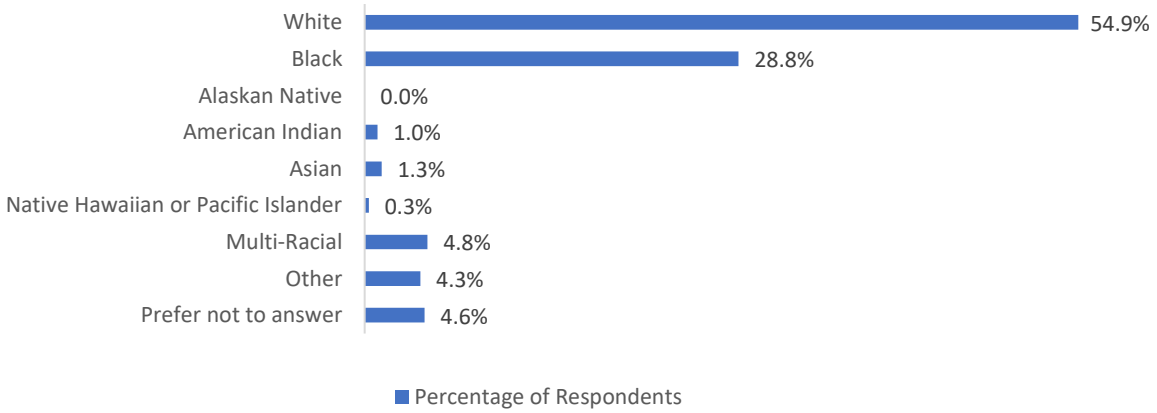


Figure 109: Which best describes your ethnicity?

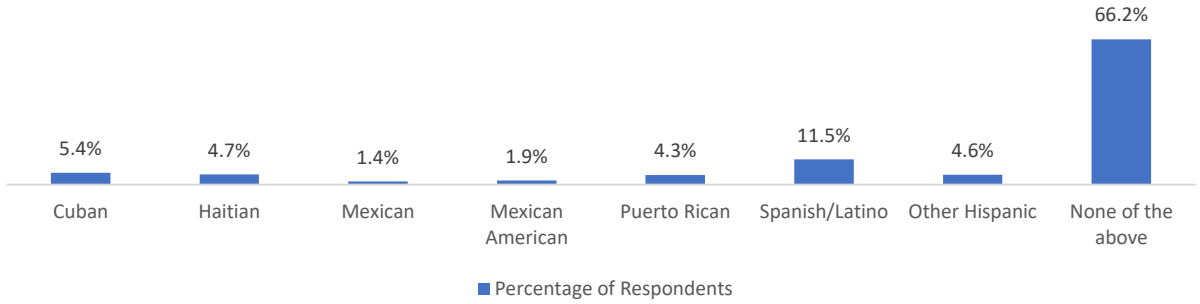
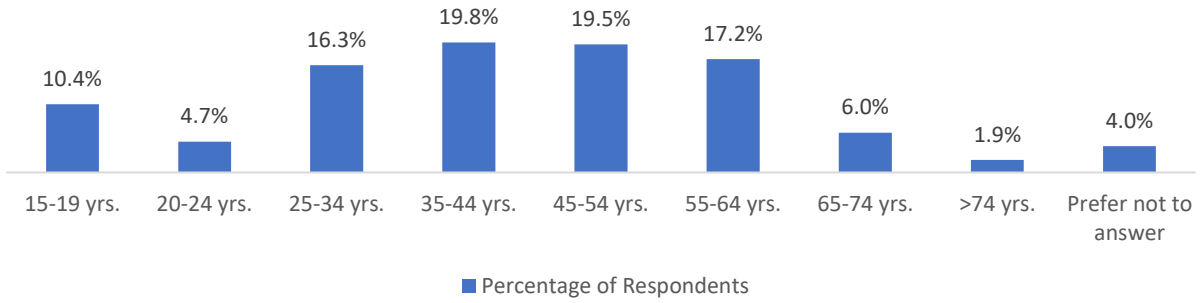


Figure 110: Please select your age range from the list below.



CULTURAL HEALTH DISPARITY SURVEY BY RACE AND ETHNICITY

The cultural health disparity survey was analyzed by race and ethnicity to further measure experience, awareness, and coordination of behavioral health services. This will help to facilitate focused strategic development and intervention implementation over the next three years.

Respondents were asked if they were comfortable seeking behavioral health care services. Black respondents were slightly more likely to be comfortable seeking care when compared to Hispanic and White respondents. Among Black respondents, 80.5% were comfortable while 19.5% were not. Among Hispanic and White respondents, the percentages of those comfortable seeking care were slightly lower at 72.6% and 79.4%, respectively.

When asked if they trust the behavioral health care system to treat them with respect, Black respondents were also more likely to trust (37.2%) or strongly trust (36.1%) the system to treat them with respect, (total 73.3%), when compared to Hispanic (62.2%), and White respondents (57.5%). Respondents who distrust or strongly distrust the behavioral health care system to treat them with respect accounted for 13.1% of Black, 18.3% of Hispanic, and 19% of White respondents.

Respondents were asked to describe their feelings regarding their behavioral health issues. When asked, if this was a private issue I keep to myself, close to half of Black respondents (48.7%) indicated this was most how I feel (31%) or somewhat how I feel at 17.7%. Slightly less than half (45.1%) indicated this is most unlike or somewhat unlike how I feel. Among Hispanic respondents, 55.1% indicated this is most or somewhat how I feel, while 36.2% indicated this is most unlike or somewhat unlike how I feel. More White respondents indicated this was most or somewhat how I feel (45.8%) when compared to those who indicated this was most unlike or somewhat unlike how I feel at 37.9%.

Regarding their behavioral health issues as a private matter that stays in the family, more Black respondents (48.2%) indicated this is most unlike or somewhat unlike how I feel when compared to Hispanic (37.7%) and White (34.9%) respondents. Percentages of respondents who indicated this is most or somewhat how I feel were higher among Hispanic (48.5%) and White (45.2%) when compared to Black respondents at 39.1%.

Most respondents were comfortable sharing their challenges with others. Among Black and White respondents, who indicated this was most or somewhat how I feel, accounted for 63.8% and 55.9%, respectively. For Hispanic respondents this percentage was lower at 48.6%, but still higher when compared to respondents who indicated this is most unlike or somewhat unlike how I feel at 37.6%.

When asked if they were more comfortable with people like them, the percentage of Black respondents who indicated this was most how I feel or somewhat like how I feel (63.4%) was higher when compared to Hispanic and White respondents at 51.2% and 50.4%, respectively.

Respondents who indicated this is most unlike or somewhat unlike how I feel, accounted for 22.3% of Black, 36.8% of Hispanic, and 25.4% of White respondents.

The most comfortable settings for discussing their behavioral health issues for all three population groups was a private office with a doctor, followed by either a hybrid of telehealth or telehealth. Black respondents who preferred a private office with a doctor accounted for 29.2%. A hybrid of telehealth (27%) was preferred over telehealth at 12.1%. Speaking with a nurse practitioner accounted for 9.6% of Black respondents while 9.8% preferred a faith-based organization. Among Hispanic respondents, 33.8% preferred a private office with a doctor, 17.4% indicated a hybrid of telehealth, followed by telehealth at 14.6%. Hispanic respondents preferred a faith-based organization at 11.6% when compared to speaking with a nurse practitioner at 10.1%. One-third of White respondents were more comfortable in a private office with a doctor when compared to telehealth (17%) and a hybrid of telehealth at 14.8%. White respondents who preferred speaking with a nurse practitioner accounted for 11.7% while 8.1% preferred a faith-based organization.

Although less than 12% of respondents indicated being comfortable receiving services at a faith-based organization in the previous question, 57.3% of Black, 43.4% of Hispanic, and 24.8% of White respondents preferred this option when the only other option was the traditional physician office.

Most Black respondents were likely or very likely (52.7%) to be comfortable in group therapy when compared to Hispanic (43.4%) and White (37.3%) respondents. When asked about their comfort in individual therapy, percentages of respondents who were likely or very likely to be comfortable in this setting were much higher at 79.2% of Black, 76.2% of Hispanic, and 80.32% of White respondents.

When asked if the behavioral health services they received in the past were mostly available in their primary language, 87.9% of Black, 80.3% of Hispanic, and 94.6% of White respondents received services in their primary language all or most of the time. Those who received services in their primary language some of the time or a little of the time accounted for less than 10% for all population groups. Respondents needing an interpreter to receive services accounted for 2% of Black, 3% of Hispanic, and 0.6% of White respondents.

CULTURAL HEALTH DISPARITY SURVEY BY RACE AND ETHNICITY CHARTS

Figure 111: Are you usually comfortable seeking behavioral health care services?

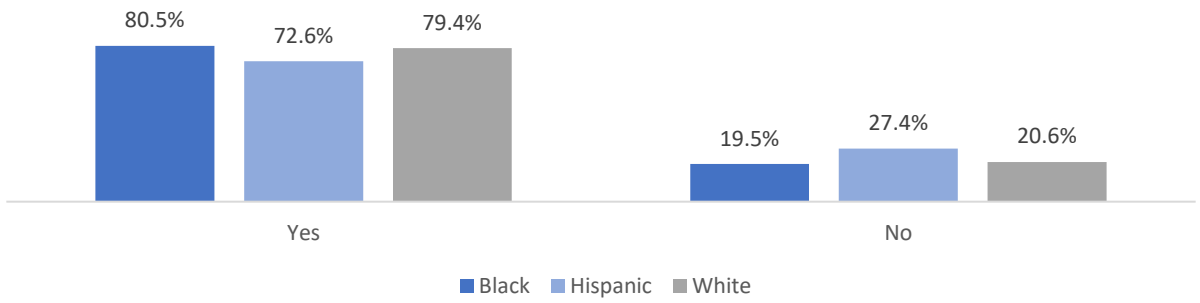


Figure 112: On a scale of 1 to 5, with 5 being 'strongly agree', how would you rate your trust in the behavioral health care system to treat you with respect?

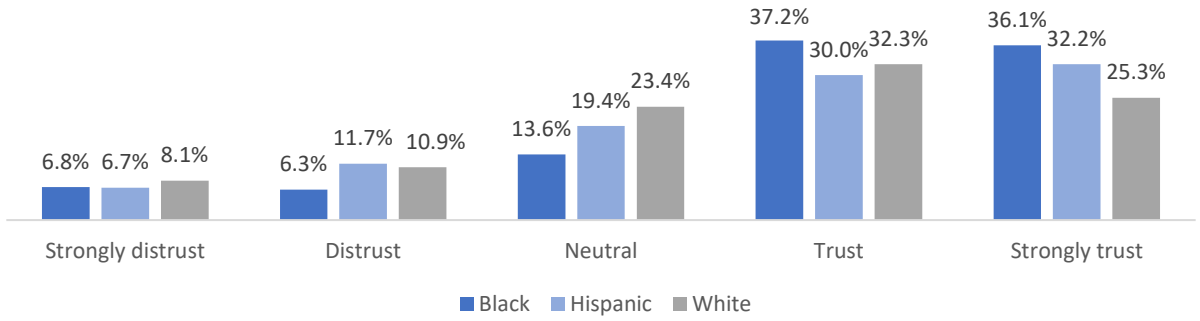


Figure 113: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. This is a private issue I keep to myself.

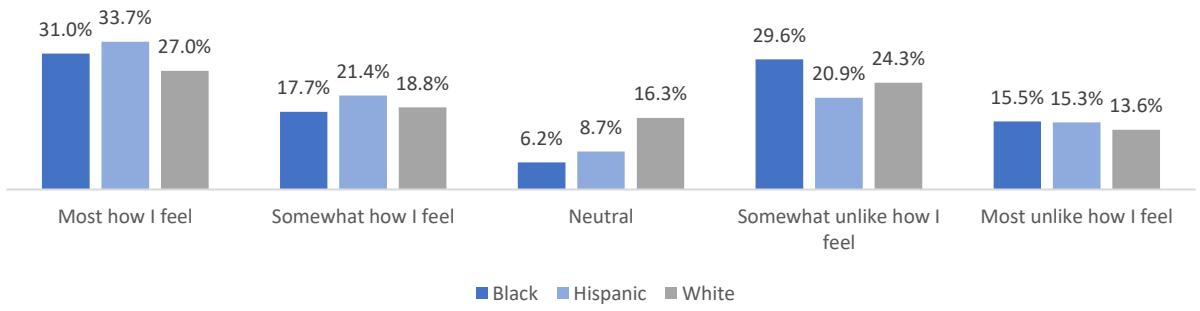


Figure 114: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the most and (5) being the least. This is a private issue that stays in the family.

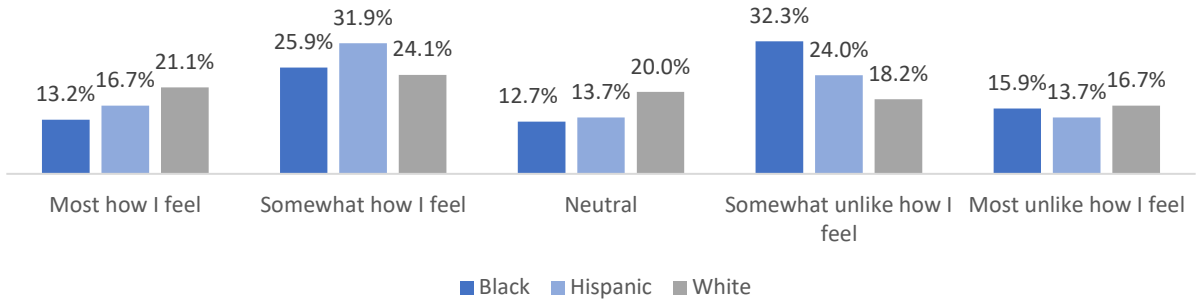


Figure 115: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. I am comfortable sharing my challenges with others.

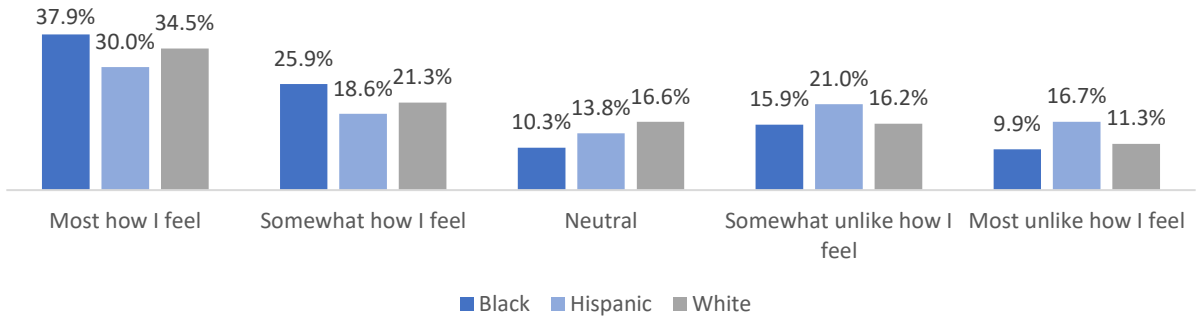


Figure 116: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. I am more comfortable with people like me.

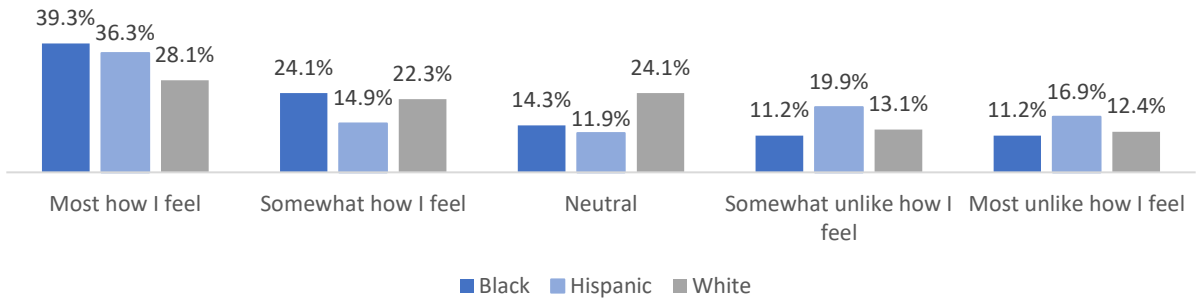


Figure 117: In which setting(s) have you been most comfortable discussing your behavioral health concerns? (Check all that apply)

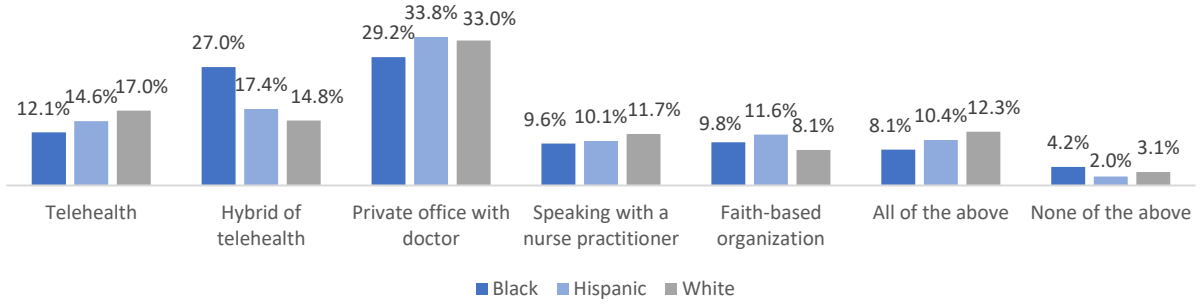


Figure 118: If given the choice for receiving behavioral health care services, would you be more comfortable going to a faith-based organization OR prefer the traditional physician office?

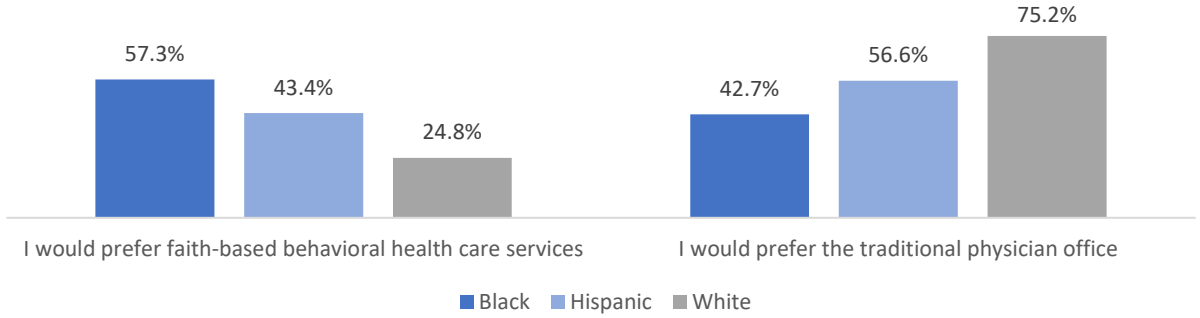


Figure 119: Now thinking about treatment options, on a scale of 1 to 5, with 5 being very likely, how comfortable would you be in group therapy?

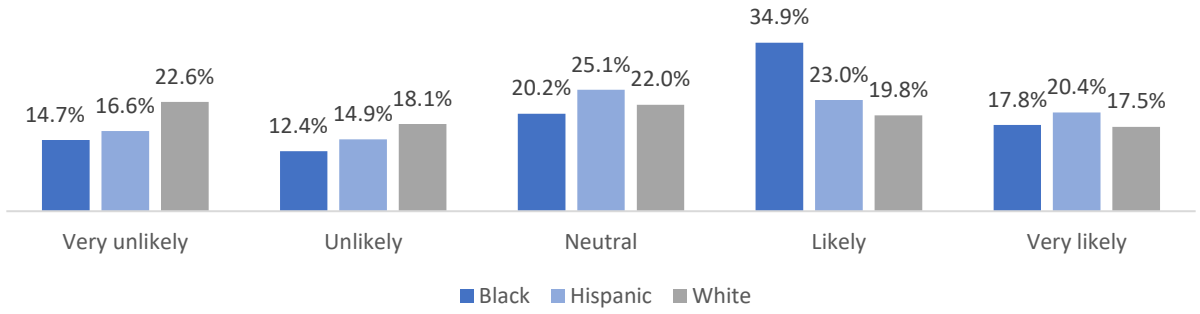


Figure 120: On a scale of 1 to 5, with 5 being very likely, how comfortable would you be in individual therapy?

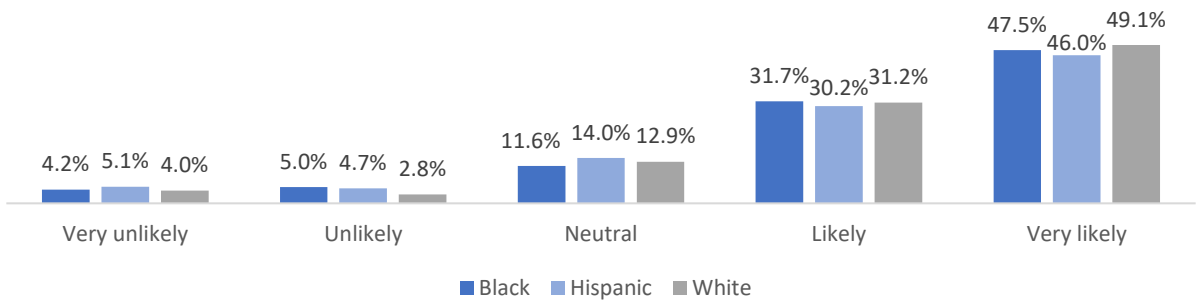
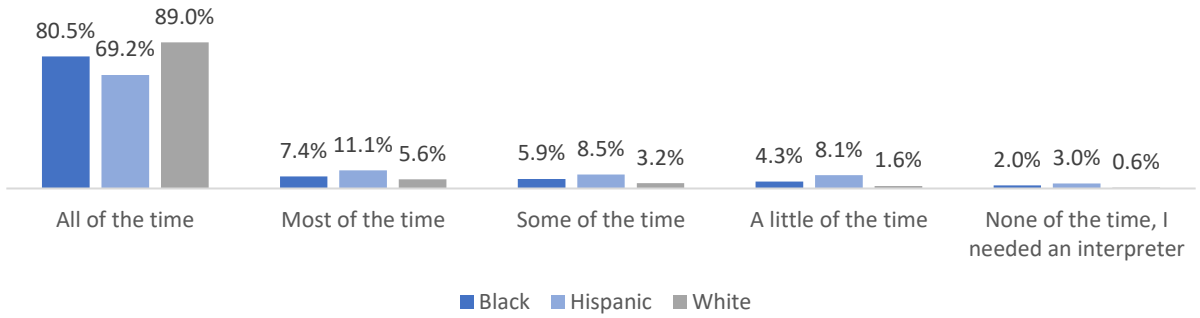


Figure 121: When you have received behavioral health care services in the past, were they mostly available in your primary language?



NO WRONG DOOR SURVEY SUMMARY

The No Wrong Door (NWD) survey was distributed by the MEs to their Network Service Provider (NSP), of which 264 participated by submitting their responses online. The purpose of the survey was to gather their perceptions related to care coordination, awareness, processes, advocacy, and evaluation. The data from each ME survey was compiled and analyzed. Questions were developed to further validate the findings through focus group research. As each ME identified different focus areas to probe, a summary at the state level was not achievable based on the unique needs of each ME region across Florida, however, the region-specific findings can be found in the respective ME report section.

The state summary of the survey results revealed that 30% of NSP respondents worked in an adult outpatient program and 15% worked in a children's outpatient program. Respondents working in an adult residential facility accounted for 10.7% of respondents, while 11.7% worked in peer recovery support. The remaining respondents represented adult crisis units, adult detox unit, adult mobile response, children's crisis unit, children's detox unit, children's residential facility, children's mobile response, and clubhouse drop-in center.

Most respondents (68.8%) felt that the NWD access worked well in the organization. Only 6.5% did not think it worked and 24.7% were not sure. Respondents (83.3%) overwhelming indicated that the organization has a role to play in the NWD access. The remaining respondents who were not sure accounted for 15.2%. Only 1.5% did not feel the organization played a role.

Close to 85% of respondents strongly agreed, or agreed, that the organization has a strong care coordination process that includes warm handoffs. Those not sure of this accounted for 8% of respondents while 7.3% disagreed or strongly disagreed with this statement. Over 80% of respondents strongly agreed or agreed that action was taken by the organization to improve the referral and care coordination process for the individuals served. Less than 5% disagreed or strongly disagreed. The remaining 12.8% of respondents were not sure this was undertaken at their facility.

Close to 30% of respondents strongly agreed that linkages to crisis interventions and support could be improved, while less than half (49%) of all respondents agreed with this statement. Of the remaining respondents, 16% were not sure, and 5.7% disagreed or strongly disagreed. Close to 90% of respondents agreed, or strongly agreed, that the organization engages in the promoting of services and resources. Regarding organizational promotion of available options to needed resources, 82.2% agreed or strongly agreed while 11.4% were not sure, and 6.5% disagreed.

Most respondents (92.4%) strongly agreed or agreed that person-centered care is provided by the organization. Of the remaining respondents, 6.1% not sure, and less than 2% of respondents disagreed. Over 85% of respondents agreed or strongly agreed that agency employees are

culturally sensitive and competent. Those who were not sure accounted for 8.7% of respondents and 4.5% disagreed.

Although 65.4% of respondents agreed that access to services is quick and efficient, 11% were not sure, and 23.6% disagreed or strongly disagreed. Respondents were split on if a standard intake and screening process would enable individuals to access services more quickly, as 54.2% thought it would, and 45.8 said no or were not sure. Most respondents (87.8%) strongly agreed or agreed that the organization works with other partners to ensure care coordination. Less than 1% strongly disagreed.

Thirty percent agreed and 29.3% strongly agreed that individuals have equal access. Respondents who disagreed or strongly disagreed accounted for 27%. Almost one-quarter of respondents were not sure that the organization advocated for equal access to care at entry points. Only 23.2% strongly agreed and 39.9% agreed with this statement. Those in disagreement accounted for 11% of respondents.

Over 90% of respondents agreed that services are of a high quality and meet the needs of individuals served. The remaining 9% were not sure or disagreed. Most respondents (84.1%) agreed that the organization undertakes quality improvement measures to enhance outcomes for individuals served. Of the remaining respondents, 11.7% were not sure, and 4.2% of respondents disagreed.

NO WRONG DOOR SURVEY CHARTS

Figure 122: I work in a/an...

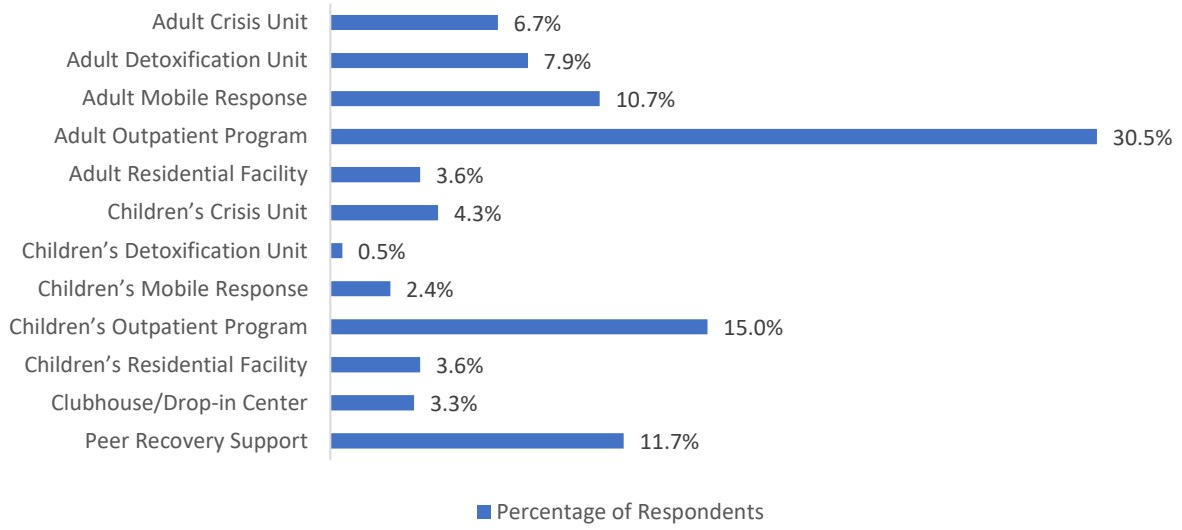


Figure 123: Do you think the "No Wrong Door" access works well within your organization?

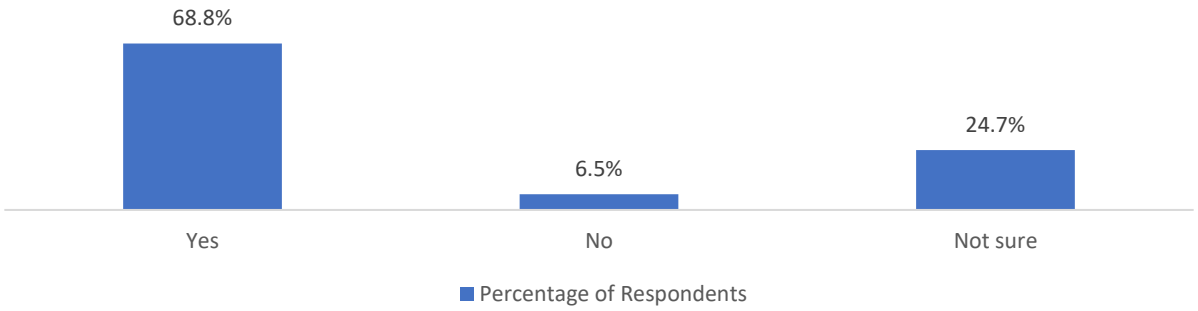


Figure 124: From your perspective your organization has a role to play in the "No Wrong Door" access.

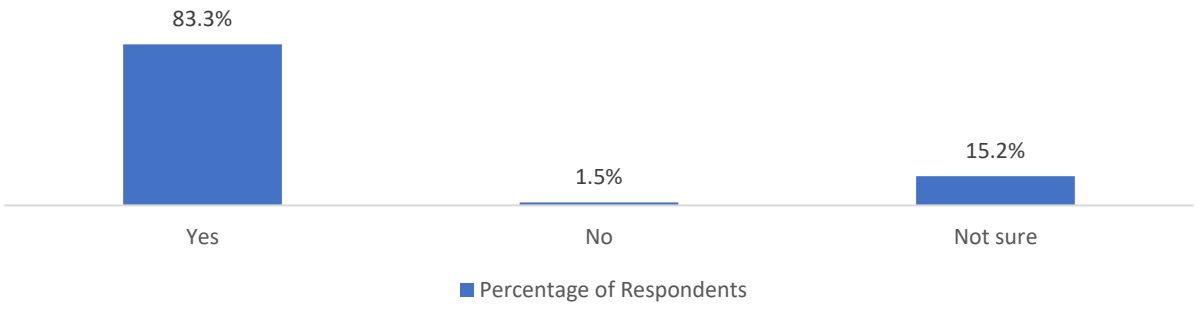


Figure 125: In your opinion, your organization has a strong care coordination process that includes warm handoffs to services and seamless care coordination.

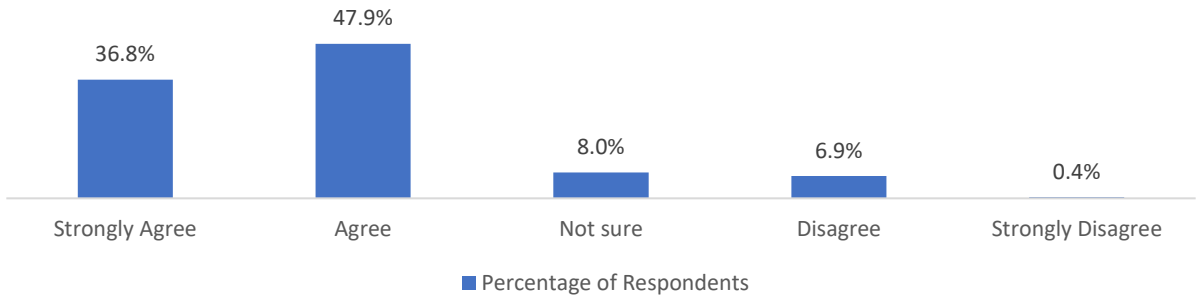


Figure 126: In your opinion, your organization has taken action to improve the referral and care coordination process for individuals served.

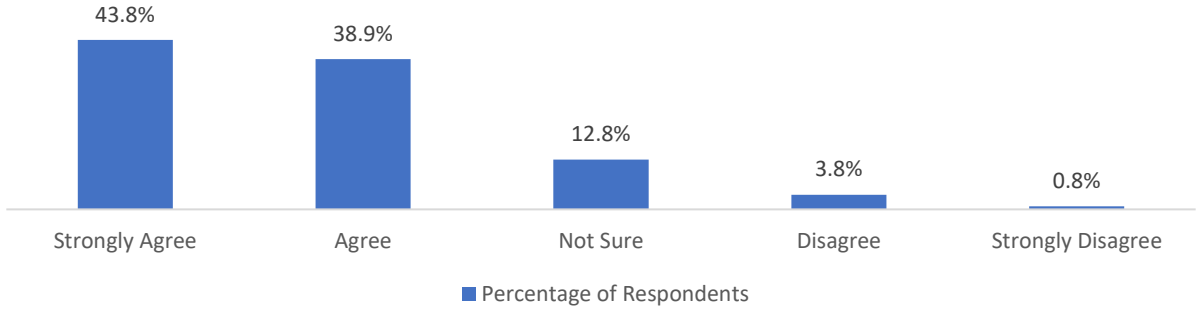


Figure 127: In your opinion, linkages to crisis intervention and support (like the Mobile Response Team, medication management, CRF, CIT Officer, BA, CSU, etc.) are occurring.

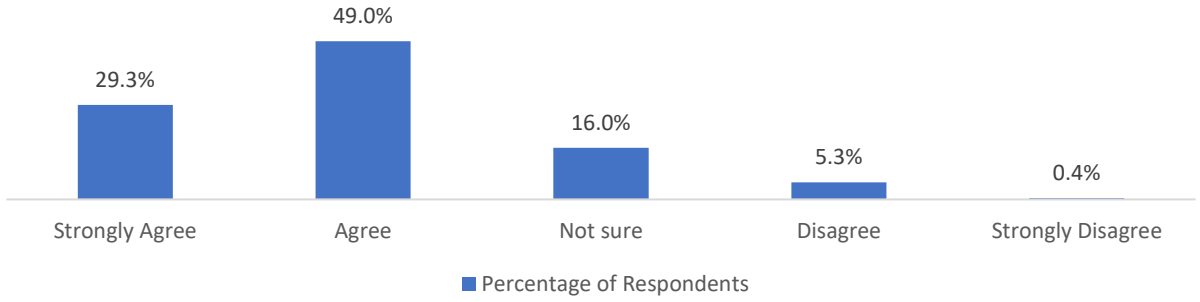


Figure 128: In your opinion, your organization promotes its services and resources very well.

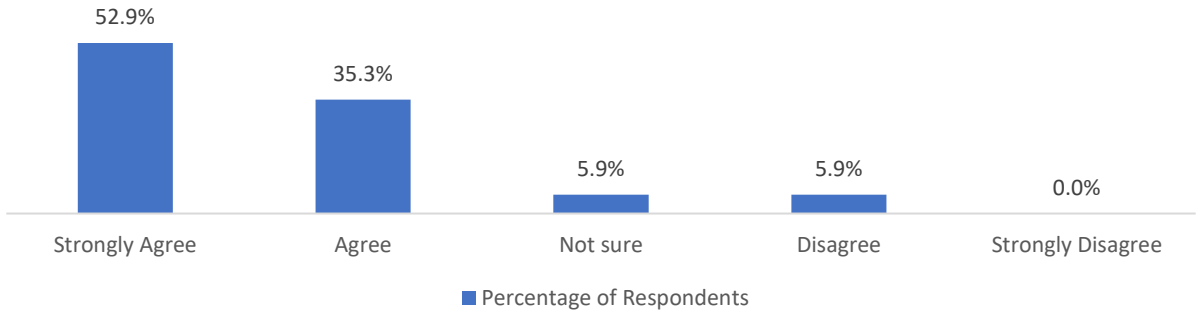


Figure 129: In your opinion, your organization promotes awareness of available options and linkages to need services.

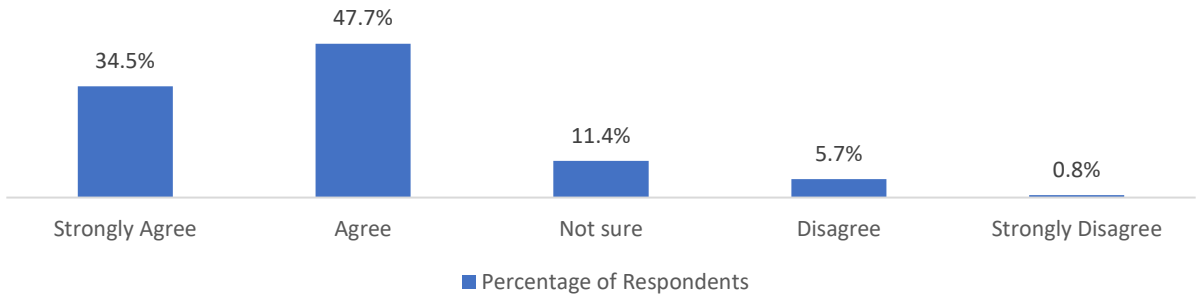


Figure 130: In your opinion, your organization provides person-centered care for all individuals served.

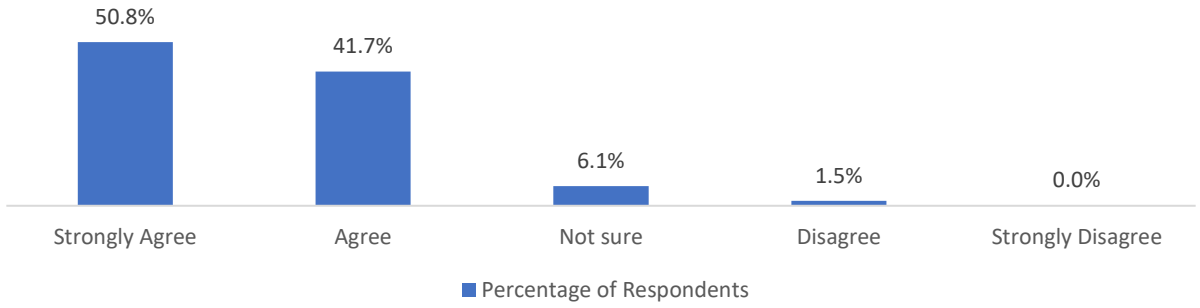


Figure 131: In your opinion, your agency hires employees who are culturally sensitive and culturally competent for the population served.

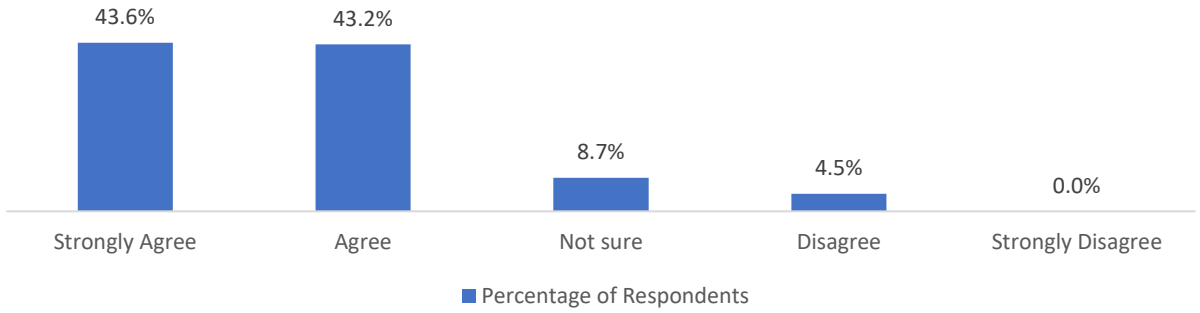


Figure 132: In your opinion, it's easy for individuals to access the services they need quickly and efficiently.

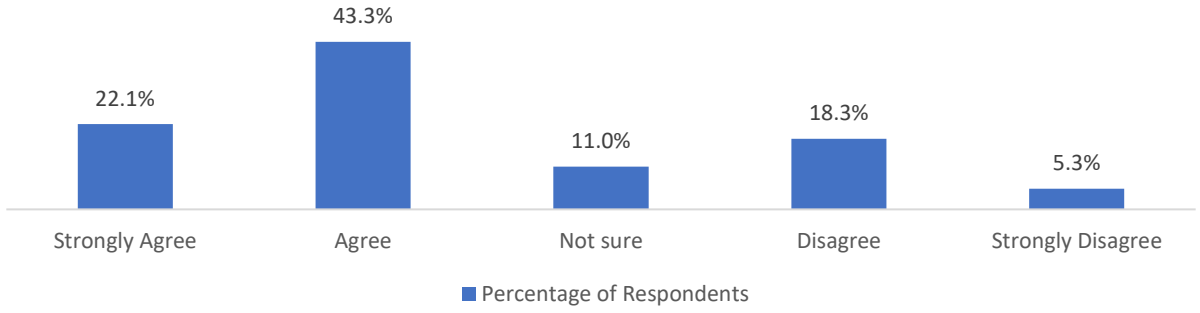


Figure 133: Do you think a standard intake and screening process for state agencies and community partners would help individuals get into services more quickly?

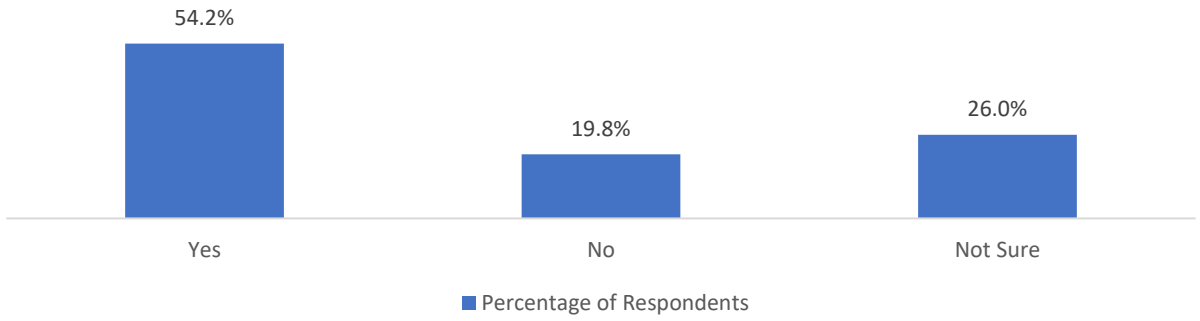


Figure 134: In your opinion, your organization encourages (promotes) working with other community partners to ensure care coordination.

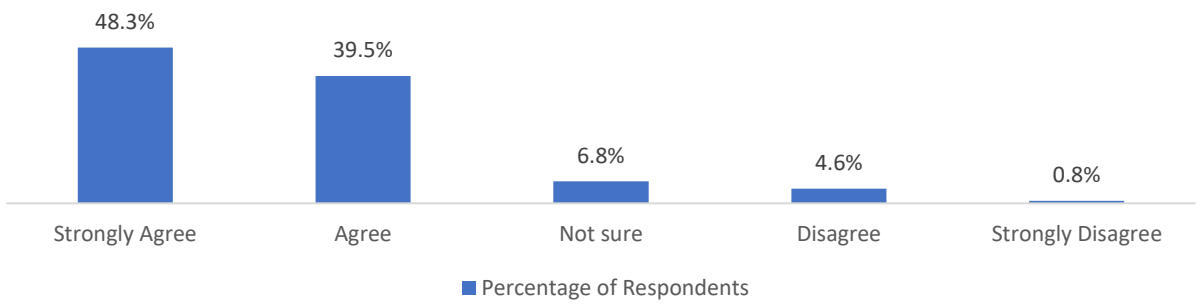


Figure 135: In your opinion, individuals in need of services have equal access to care.

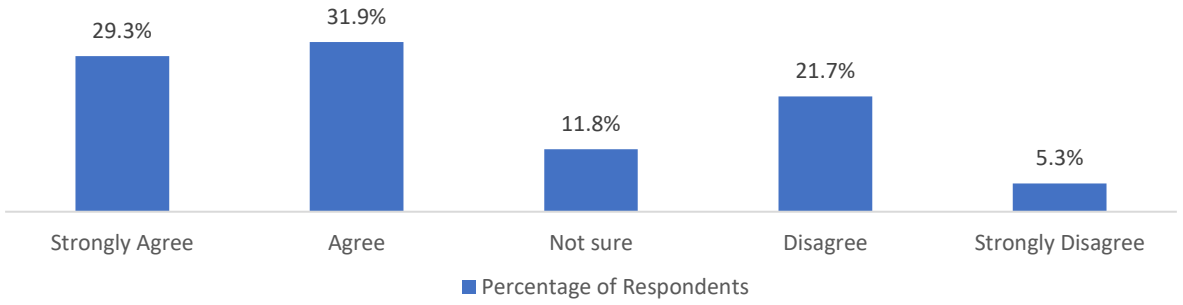


Figure 136: In your opinion, stakeholders help to address and advocate for equal access to care in system entry points.

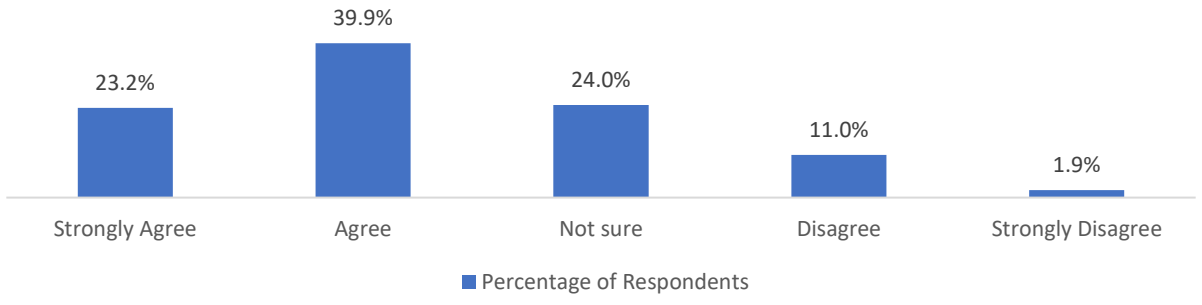


Figure 137: In your opinion, your organization ensures that services are of high quality and meet the needs of individuals served.

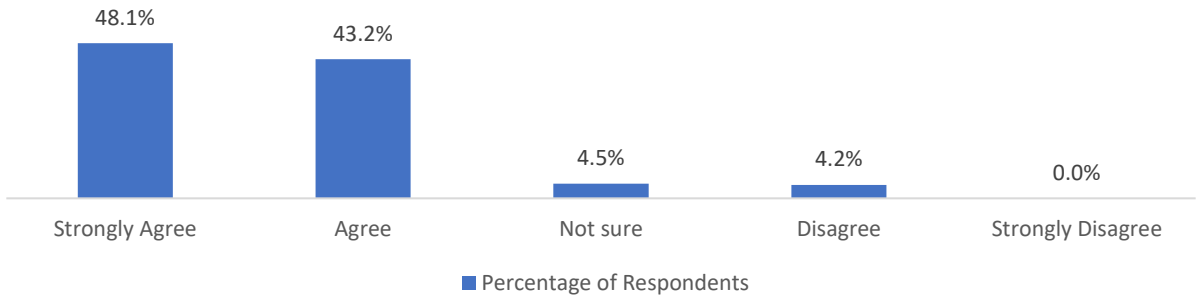
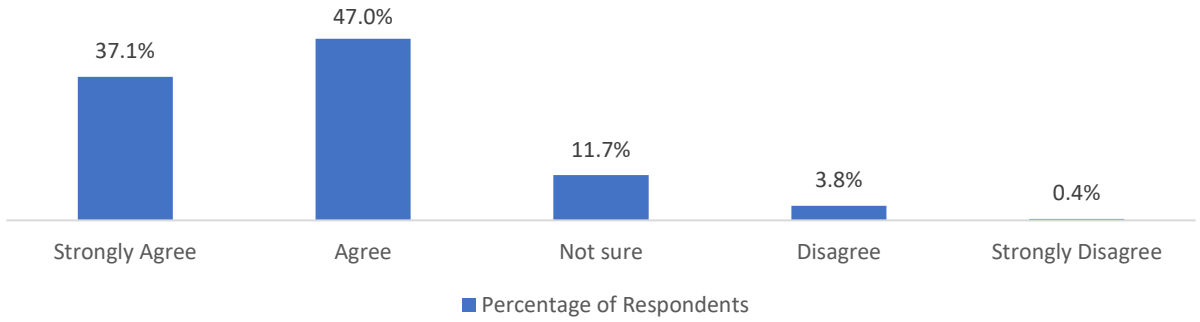


Figure 138: In your opinion, your organization tracks individuals served, services, performance, and cost to continually evaluate and improve outcomes.



INDIVIDUALS SERVED SURVEY SUMMARY

The Individuals Served survey was completed by 1,348 respondents served by the Florida ME NSP's. The results below have been aggregated for all ME's. Region-specific findings can be found in the respective ME report section. No personal identification information was gathered, and all respondents were completely anonymous.

Adults receiving services accounted for 67.2% of respondents while 17.8% were parents of a child receiving services. Youth receiving services accounted for 8% of respondents. The remaining 6.9% were guardians of individuals receiving services and caregivers who represented a person receiving services.

Adult mental health services were received by 38.8% of respondents and 27.4% received adult substance use services. Among children, 15.2% received mental health services while 2.3% received substance use services. Peer support services were received by 9.1% of respondents. Prevention services accounted for the remaining 7.2% of respondents. As multiple options were permitted, there was some overlap as respondents chose more than one response.

Respondents represented 46 of the 67 Florida Counties. Miami-Dade had the highest percentage of respondents at 10.9%. Volusia followed with 10.3% of respondents. Palm Beach County and Orange County had 9.3% and 9.1% of survey respondents, respectively. Just over 7% of respondents were from Osceola County and 6.5% lived in Brevard County. Respondents from all other counties accounted for less than 6% each.

Most respondents (80.3%) knew where to go for services when needed. Of the remaining 20%, 10.1% of respondents did not know where to go, and 9.6% knew where to go sometimes. Almost one-third of respondents (31%) learned of mental health and substance use treatment services from a family member or friend. Respondents learning from another individual in treatment/Recovery/Peer accounted for 19.3%. Those who learned through word of mouth accounted for 17.3% and 10.3% learned through law enforcement. The 2-1-1 information and referral source was sought by 5.3% of respondents. Social media (6.2%), Mobile Crisis Team (4%), and School at 6.6%, accounted for the remaining respondents. As multiple options were permitted, there was some overlap as respondents chose more than one response.

More respondents (54.8%) were aware of the 2-1-1 information and referral resource when compared to those who were not aware of the community resource at 45.2%. Although over 50% of respondents were aware of 2-1-1, only 27.3% ever called the resource for assistance. Of the respondents that called the resource, 52.2% indicated that they were helped with getting services they needed, and 28.6% were helped sometimes. The remaining 19.2% were not helped.

Among all respondents, 80.6% were able to get services when they needed them. Slightly less than 20% were not able to get services. Housing assistance (9.7%), Crisis Stabilization/Support (6.8%), and Case Management (6.2%) were the top three services that individuals needed but were not able to get. Other services included Aftercare/Follow-up (5.7%), Alternative Services (5.7%), and Assessment (5.5%). The complete list of services and percentages can be found in the chart section which follows. While 72.4% of respondents did received services when needed, 11.9% of respondents were not able to get services on one or two times in the past 12 months. Just over 7% indicated that they could not get services on three to four times, and 8.3% did not get services on five or more times in the past 12 months. Most respondents received services (72.3%), but 18.9% of respondents reported being put on a waitlist. Services that were needed but not available accounted for 8.9% of respondents.

Most respondents (74.3%) agreed or strongly agreed that services and planning were patient centered. Of the remaining respondents, 19.6% strongly disagreed that services were focused on their treatment needs, and 6.1% disagreed.

Most respondents (61.4%) were able to get an appointment within 1 to 2 weeks. An additional 15.4% waited 3 to 4 weeks to be seen and 9% waited over 1 month. Those waiting over 2 months accounted for 5.8% of respondents while 8.4% never received an appointment. Close to 75% of respondents were able to get to services, from their residence, within 30 minutes or less. Of those 44.6% revealed having a drive time of up to 15 minutes. Respondents traveling 31 minutes to 1 hour accounted for 17.4% and 7.8% of respondents drove more than 1 hour. Driving themselves represented 35.3% of respondents while 21.5% were driven by a relative or friend. Walking, or using the public bus system, accounted for 11.9% and 11.7% of respondents, respectively. Medicaid/Medicare transportation was used by 7.3% of respondents. The remaining respondents (12.3%) used a private transportation company.

The top five obstacles for respondents were: not knowing where to go for services (8.8%), not being able to afford services (8.4%), having limited or no transportation (8.1%), encountering long waitlists (7.8%), and stigma (5.1%).

INDIVIDUALS SERVED SURVEY CHARTS

Figure 139: Which best describes you?

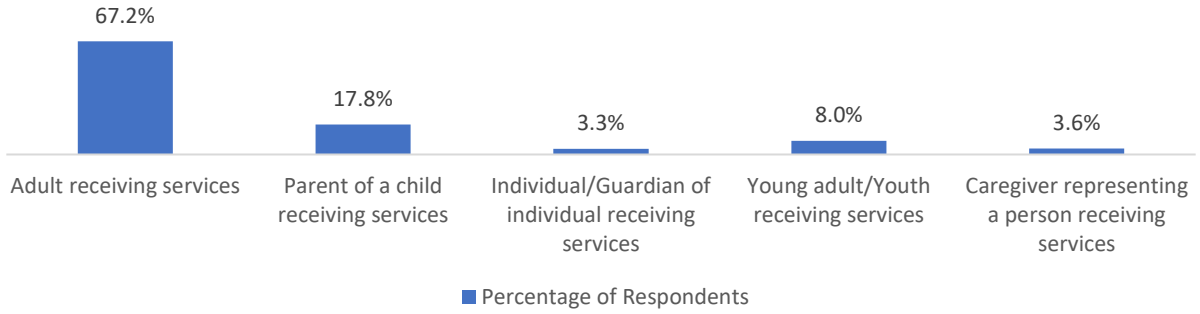


Figure 140: What type of service did you or the person you are representing receive?

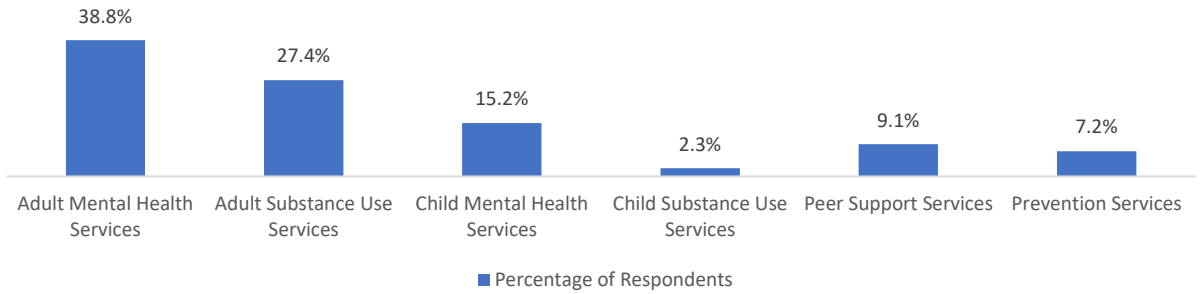


Figure 141: Which county do you live in?

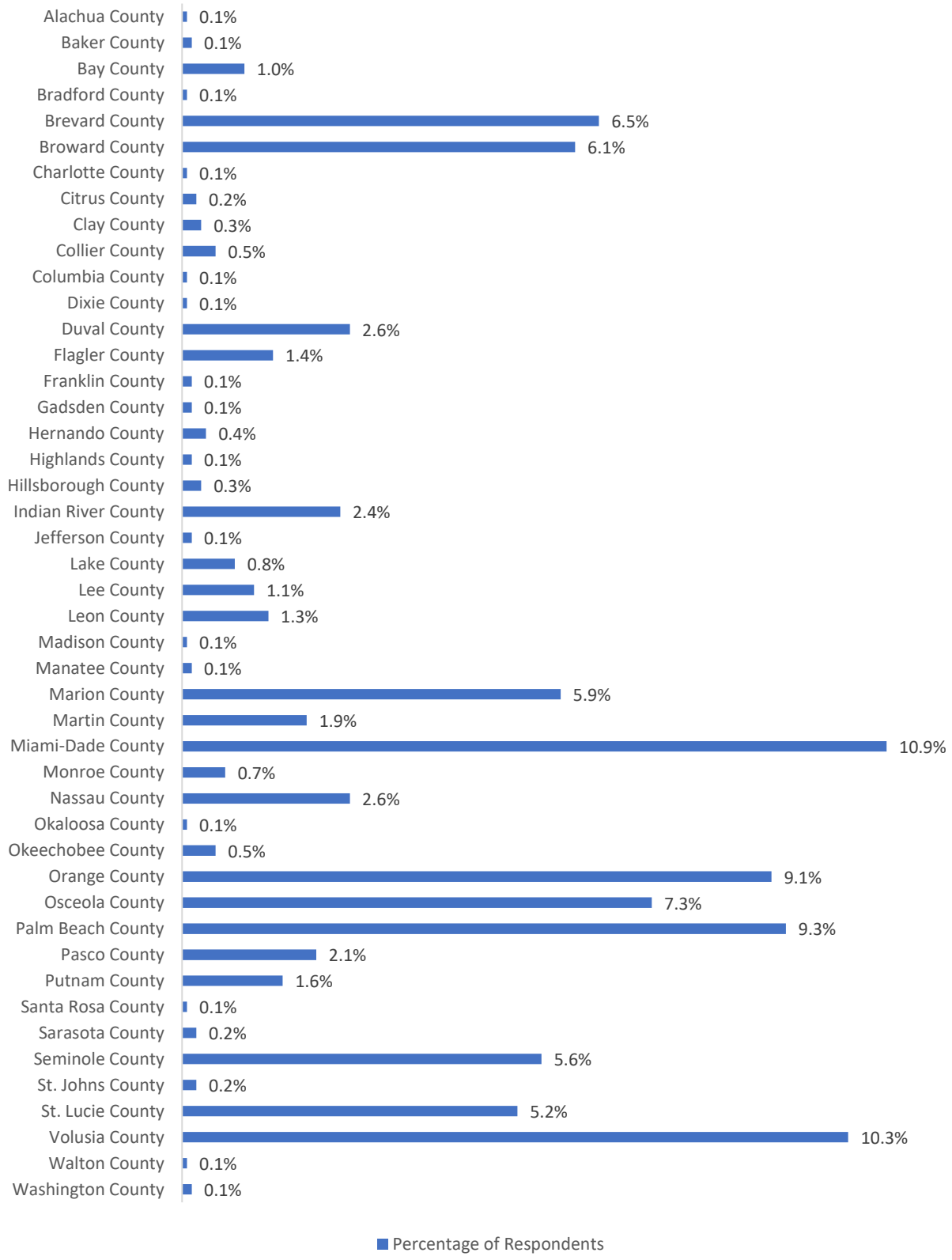


Figure 142: Did you know where to go for mental health and substance use treatment services when you needed them?

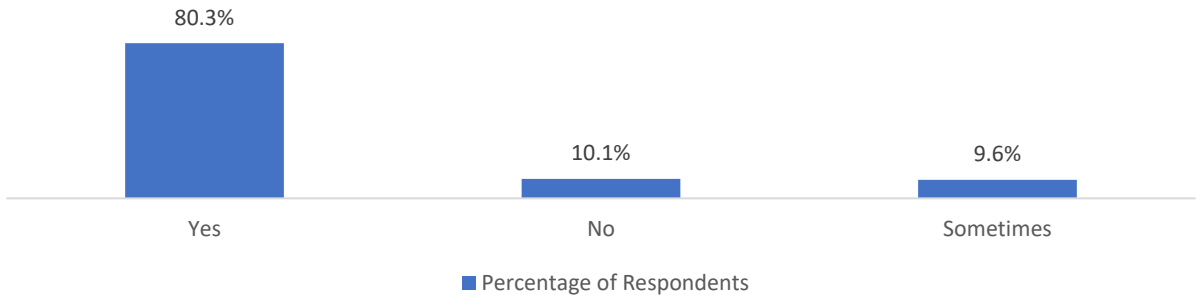


Figure 143: How did you learn about mental health and substance use treatment services when you needed them?

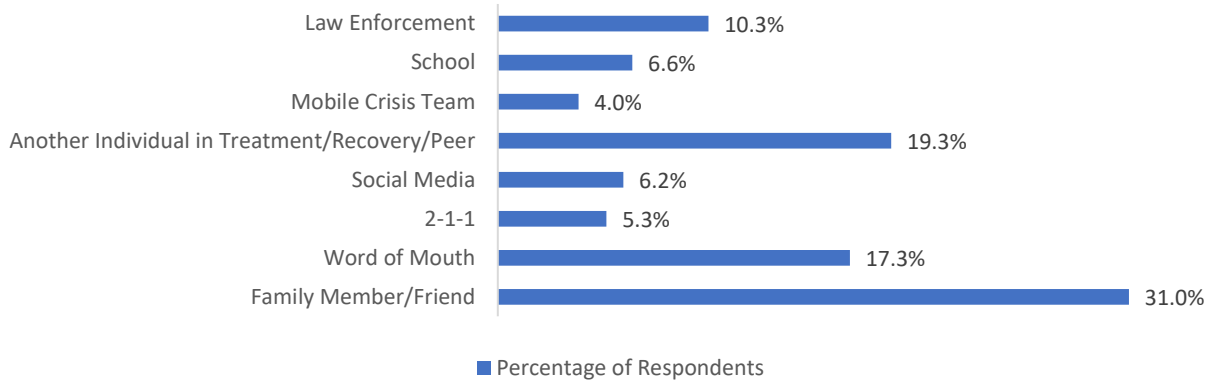


Figure 144: Are you aware of the 2-1-1 Information and Referral Resource in your community?

Figure 145: Have you ever called 2-1-1 Information and Referral Resource for assistance?

Figure 146: When you called the 2-1-1 Information and Referral Resource, were they helpful in getting you the services needed?

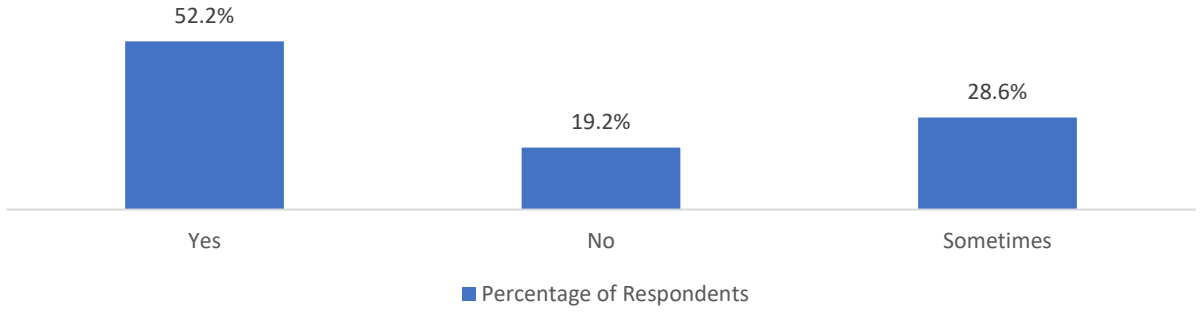


Figure 147: Were you able to get all the services you needed when you needed them?

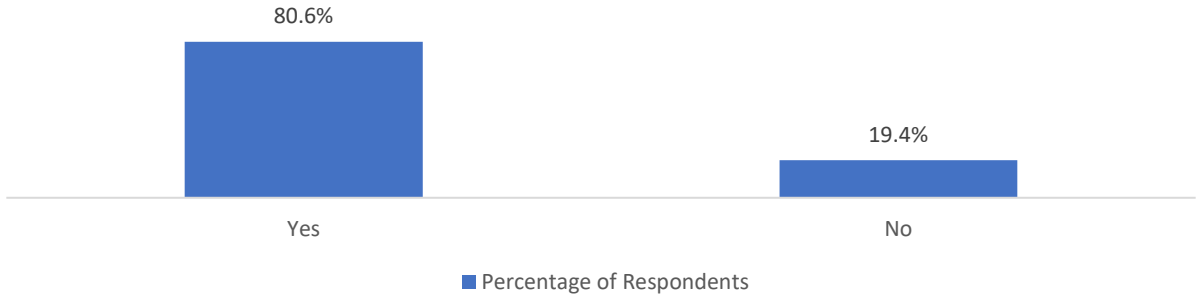


Figure 148: If no, please choose from the list below, the services you needed but were not able to get.

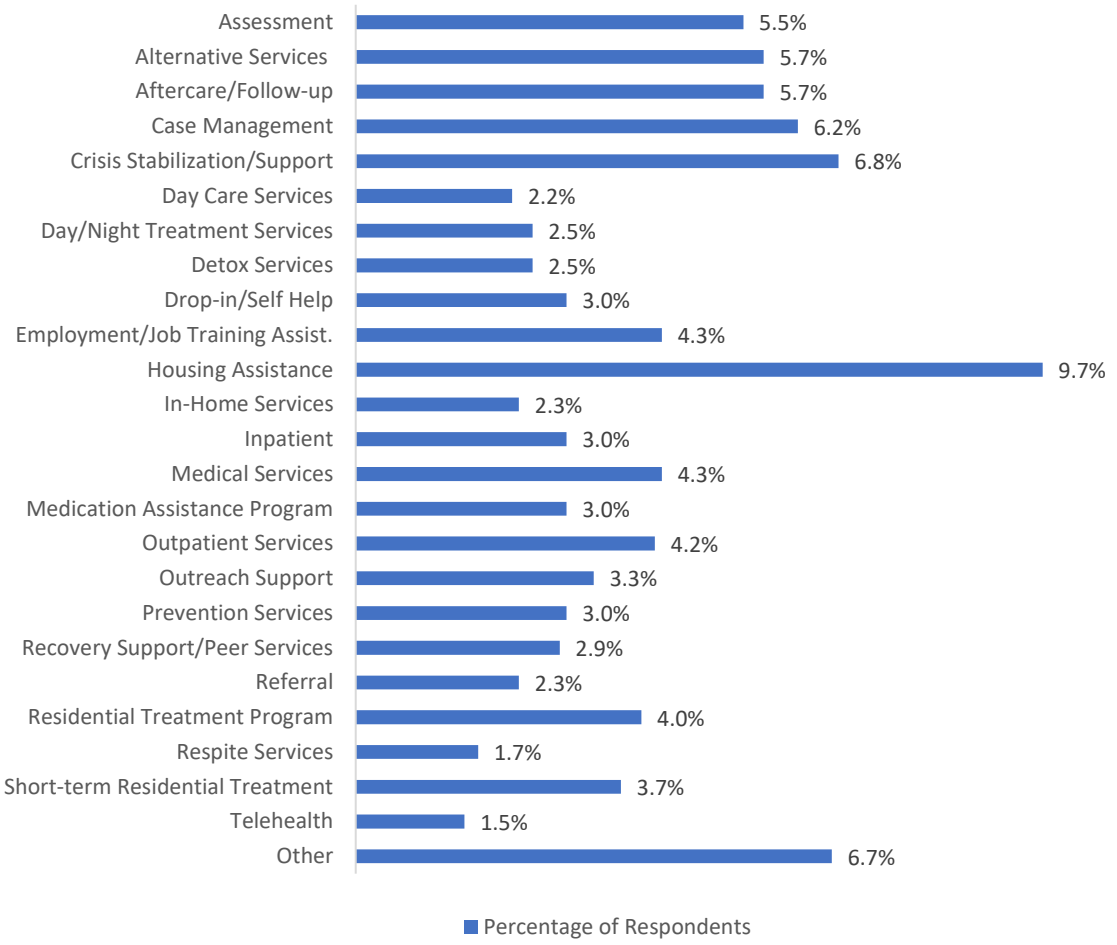


Figure 149: How many times during the last 12 months were you not able to get the services you needed?

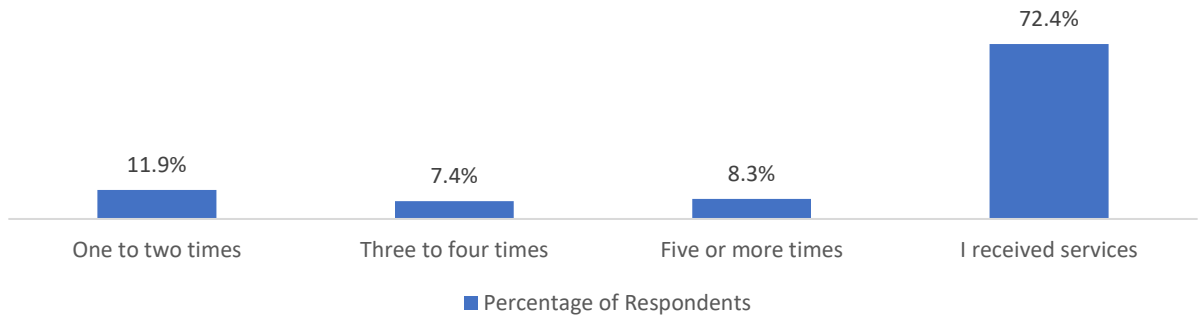


Figure 150: The services I needed were:

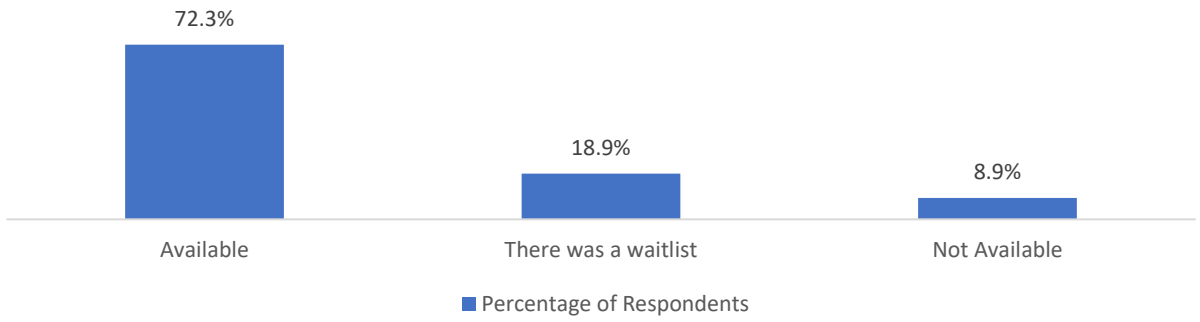


Figure 151: The services and planning I received were focused on my treatment needs (patient centered).

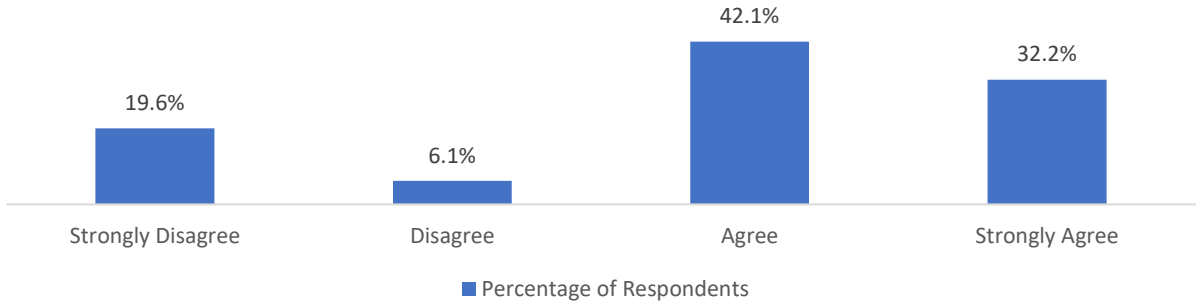


Figure 152: How long did it take from the time you requested an appointment for services to the time you received the services?

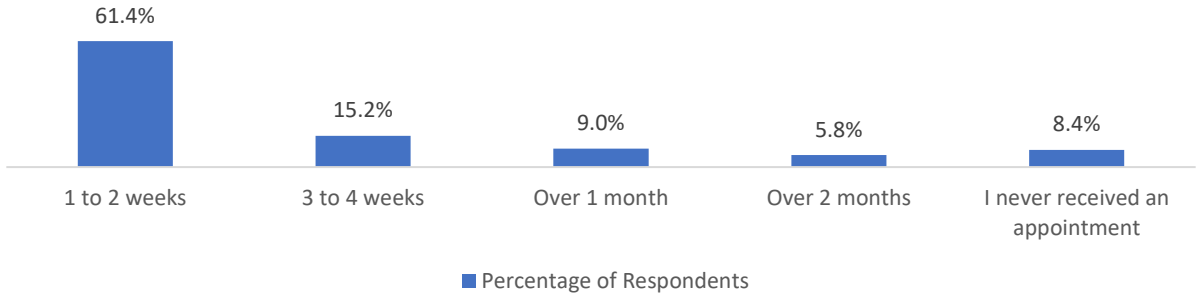


Figure 153: How long did it take to travel to the service?

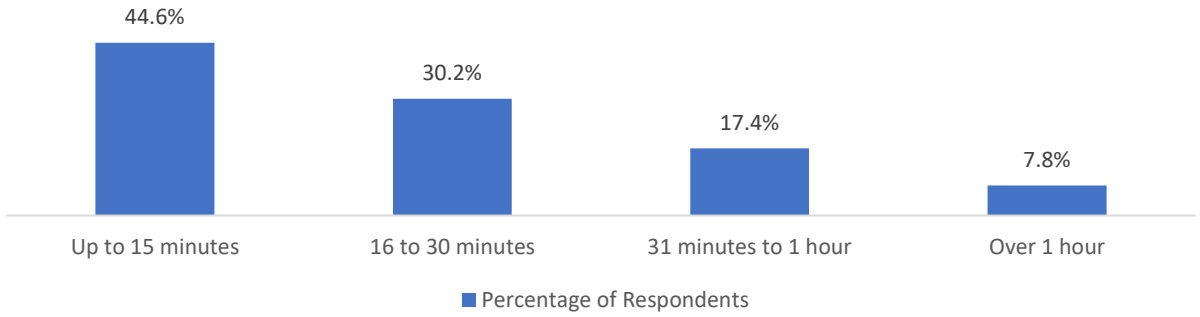
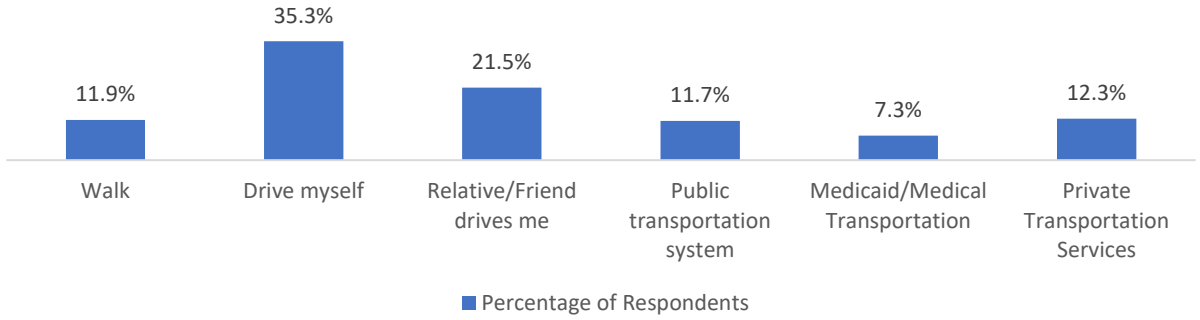
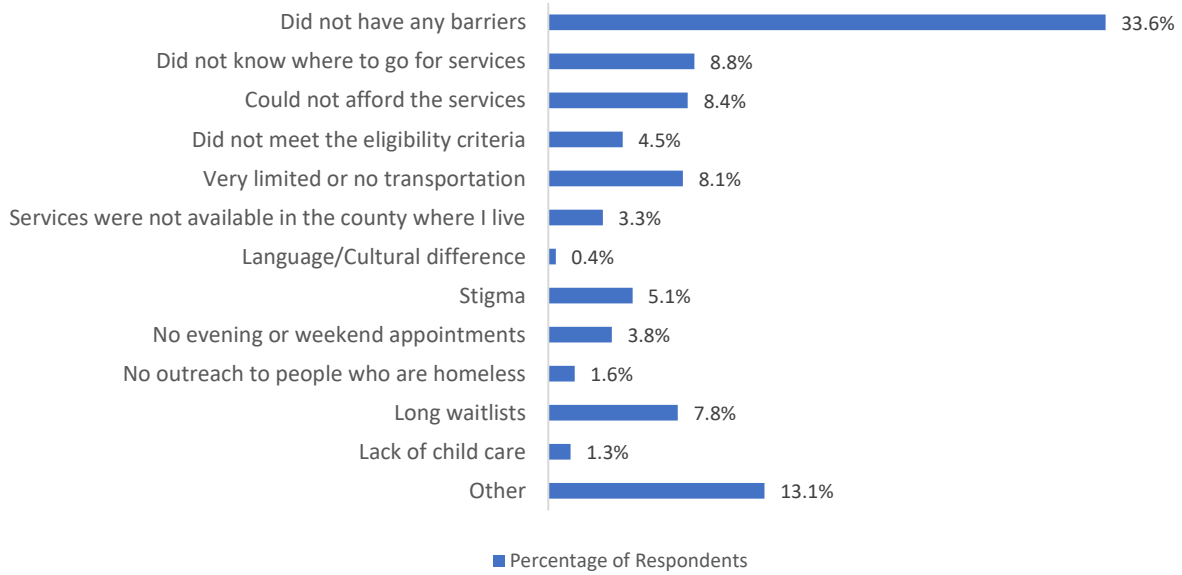


Figure 154: How do you travel to get services?



*Note-Private transportation includes Taxi, Uber, Lyft, TOPS, etc.

Figure 155: What were the obstacles you experienced getting the care you needed?



STAKEHOLDER SURVEY SUMMARY

ME NSP's, Local Health Councils (LHCs), and community organizations participated in the distribution of this survey to measure awareness, linkages, accessibility, and define barriers. A total of 1,737 stakeholders across Florida participated in completing the Stakeholder Survey Tool. The results below have been aggregated for all ME's. Region-specific findings can be found in the respective ME report section. No personal identification information was gathered, and all respondents were completely anonymous.

Over 20 service sectors participated in the stakeholder survey. Case management was represented by 9.4% of respondents. Child and Family Services accounted for 7.9%, Adult Mental Health Care at 7.7%, and Adult Substance Use Treatment at 6.3%. As this question allowed multiple answers, many organizations served more than one service sector.

All 67 counties were represented in the stakeholder survey. Representation ranged from 0.2% to 5.3% for the various counties. Broward, Palm Beach, Pinellas, St. Lucie, Miami-Dade, Monroe, and Hillsborough counties had over 100 stakeholders complete the survey. Many stakeholders served more than one county in Florida.

Most stakeholders (84.1%) agreed or strongly agreed that they were aware of the behavioral health services in their area. Only 12.3% were not aware and 3.6% were neutral.

Regarding awareness of ME resources, 60.6% of stakeholder respondents knew of these resources while 39.4% did not have this awareness. ME resources were accessed by 35% of stakeholders in the past 6 months. Close to 70% of stakeholders indicated that ME resources were helpful when accessed. Stakeholders who said resources were somewhat helpful accounted for 23% of all respondents. Stakeholders who directed individuals to access their ME by calling or online accounted for 39.4% of respondents while 60.6% did not direct individuals to contact this resource.

Most stakeholders (86.6%) revealed being familiar with the 2-1-1 information and referral resource. Although most stakeholders were aware of 2-1-1, only 29.8% accessed this resource in the past 6 months. Of the stakeholders who accessed the referral resource, 62.8% indicated that it was helpful while 25% said it was somewhat helpful. Those not finding 2-1-1 helpful accounted for 12.2% of respondents who had accessed the referral resource. Stakeholders directing individuals to contact 2-1-1 by calling or online accounted for 83% of respondents.

There were multiple crisis response models in each area served by the MEs. Mobile Crisis Response Team, Mobile Response Team, and Behavioral Health Response Team were the top three models selected across the state. Details can be found the chart section that follows as well as in the region-specific reports.

Stakeholders who rated awareness of mental health and substance use treatment services as excellent or very good accounted for 18.2% of respondents. Just over 30% felt awareness was good, 34.3% indicated it was fair, and 17.3% indicated awareness as being poor. Over 55% of stakeholders agreed or strongly agreed that linkages are coordinated across the system of care. Those who disagreed accounted for 33% of respondents while 8.7% strongly disagreed with the above statement. Most stakeholders (62.8%) either agreed or strongly agreed that services are accessible. Those who disagreed or strongly disagreed accounted for 35.4% of respondents. Stakeholders who agreed that referral processes are easily accessible accounted for 48.3% of respondents while 35.7% disagreed. More respondents strongly disagreed, at 8%, when compared to stakeholders who strongly agreed at 5.7%. Regarding the coordination of programs and services across the system of care, 54.1% of stakeholders either agreed, or strongly agreed with this statement. Those strongly disagreeing accounted for 8% while those who disagreed represented 34.8% of respondents.

The top four barriers across all MEs included: not knowing where to go for services, no or very limited transportation, lack of affordability, and long waitlists.

These are the resources and services that were not available to improve patient-centered care and planning, and that were common across all MEs. More details can be found in the region-specific reports. Resources not available: Care Coordination, Child Care, Education/Awareness Campaign, Homeless Shelters and Services, Housing, Language/Cultural Competence/Bilingual Providers, Provider/Staff Shortages, Long Waitlists, School-based Services, Services/Access for Uninsured, Transportation, Weekend/Evening Appointments.

The top three patient-centered care resources and services that have improved quality of life of individuals identified for ME are as follows.

BBHC: Henderson Behavioral Health, South Florida Wellness, and 2-1-1

CFBHN: Behavioral Health Service Agencies, Care Management, and Access to Services

CFCHS: Peer Support Services, Case Management, and Crisis Intervention/MRT

LSFHS: Counseling Services, Crisis Response Teams, and Access to Medication and Services

NWFHN: School-based Services, Mobile Crisis Response Services, and Community-based Services

SEFBHN: Basic Needs, Case Management & Coordination, and Access to Care

TMSF: Supportive Housing, Mental Health Services, and Peer Services

STAKEHOLDER SURVEY CHARTS

Figure 156: Percentage of respondents by organization service sector.

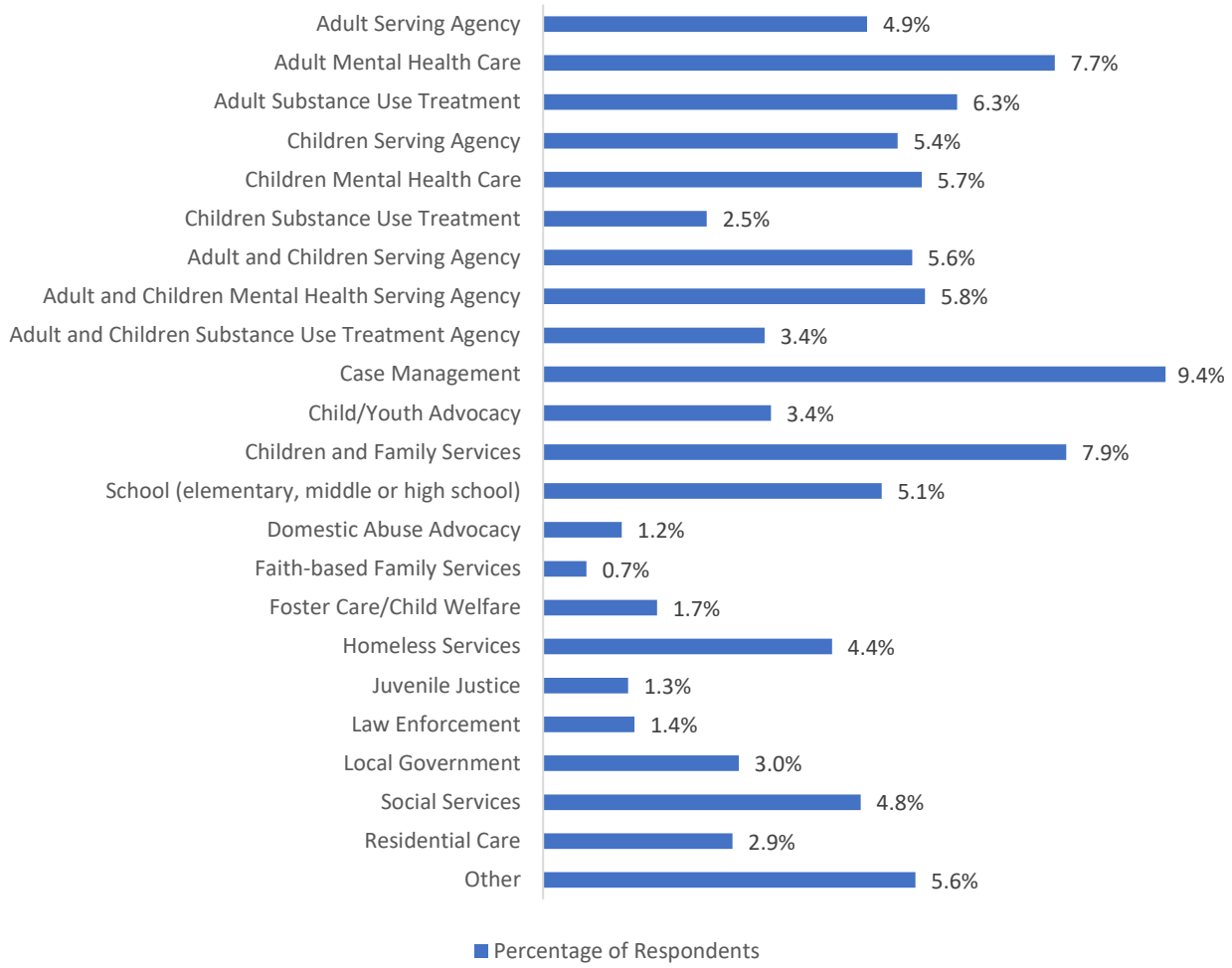


Figure 157: You are aware of the availability of mental health and substance use services in your area.

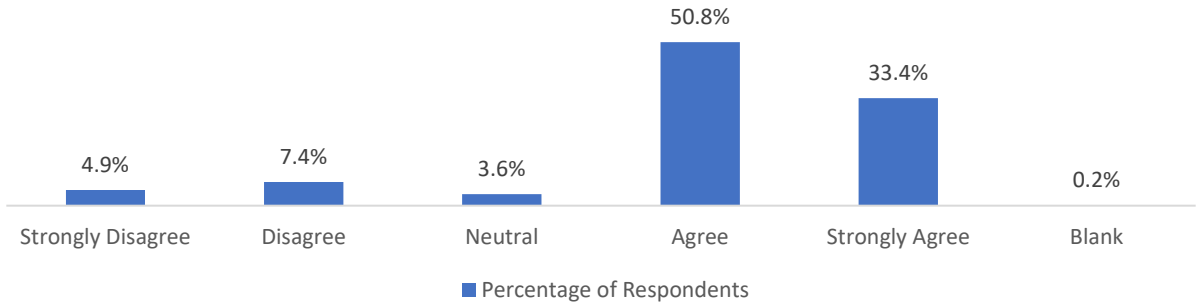


Figure 158: Are you aware of the Managing Entity resources?

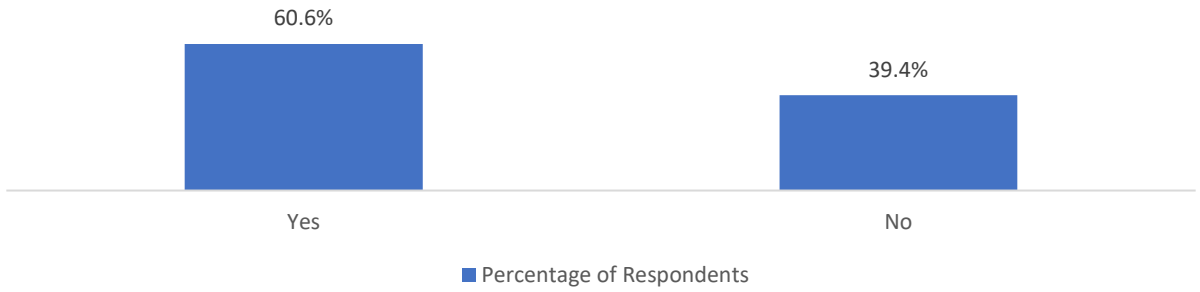


Figure 159: Have you accessed the Managing Entity resources in the past 6 months?

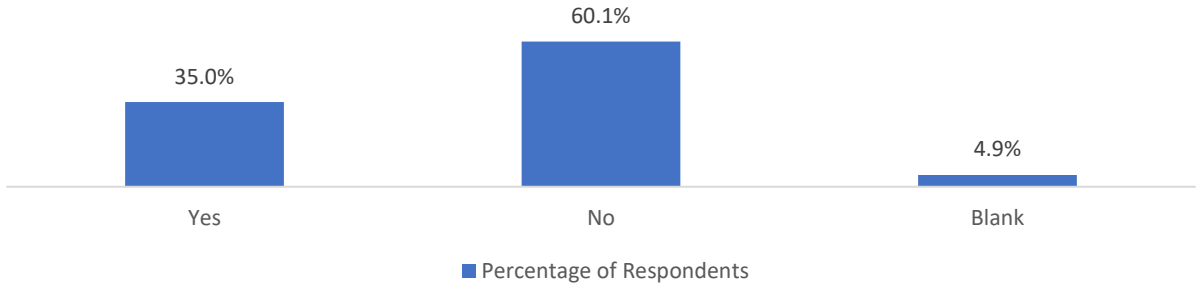


Figure 160: When you accessed the Managing Entity resources, was it helpful?

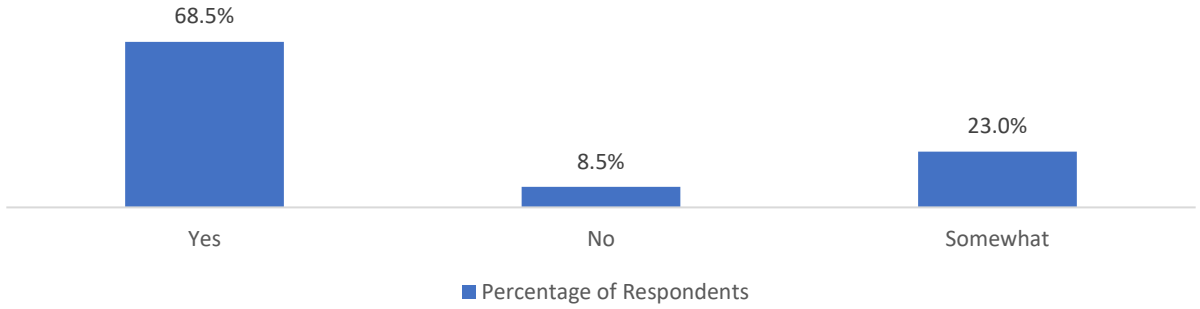


Figure 161: Have you ever directed individuals to access the Managing Entity by calling or online?

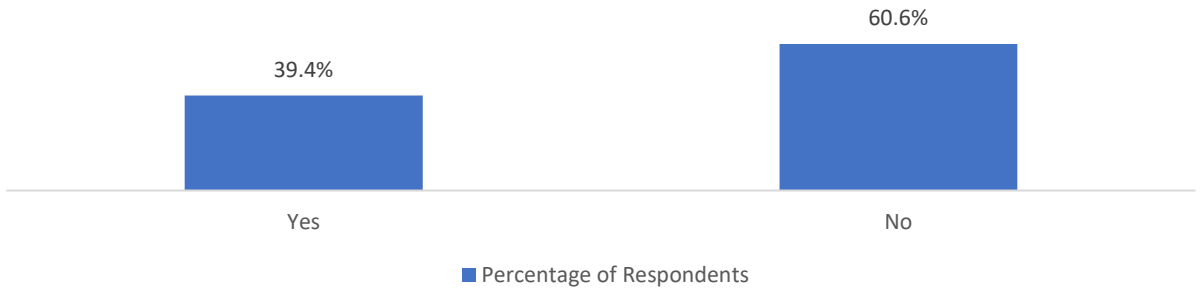


Figure 162: Are you aware of the 2-1-1 Information and Referral Resource?

Figure 163: Have you accessed the 2-1-1 Information and Referral Resource in the past 6 months?

Figure 164: When you accessed the 2-1-1 Information and Referral Resource, was it helpful?

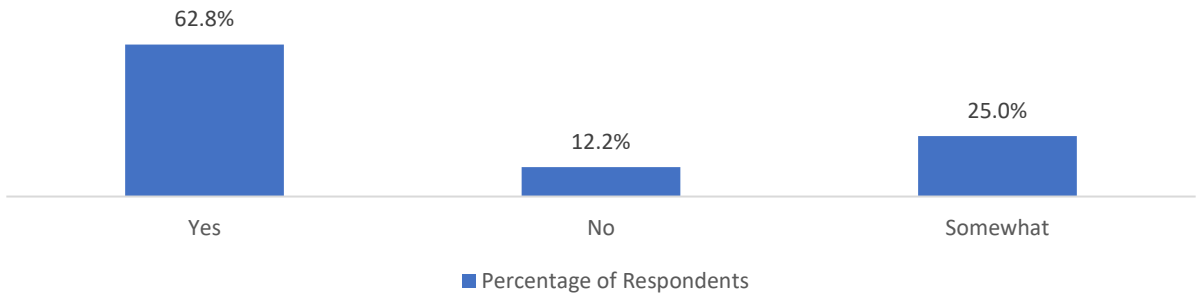


Figure 165: Have you ever directed individuals to access the 2-1-1 Information and Referral Resource by calling or online?

Figure 166: Select the crisis response model in your area. Select all that apply.

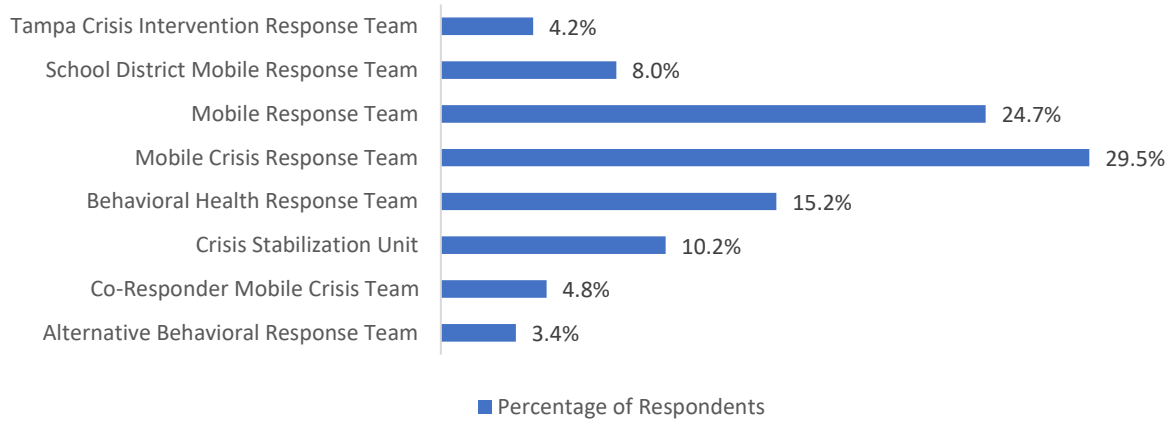


Figure 167: How would you rate community awareness of mental health and substance use treatment services in your area?

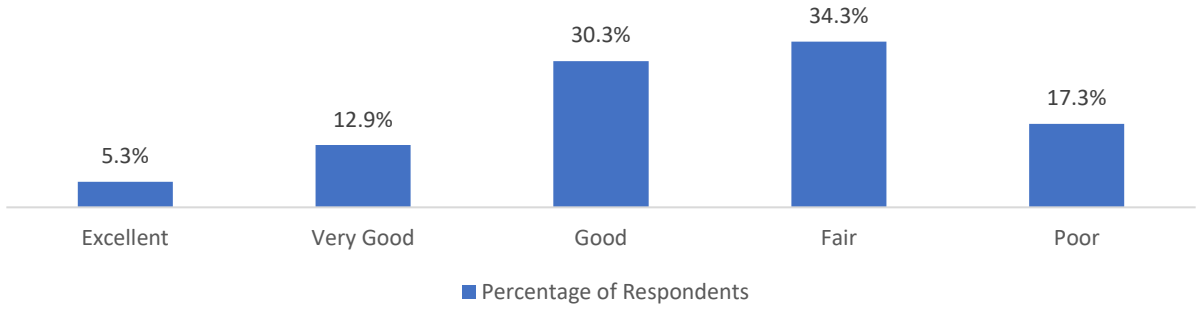


Figure 168: Linkages to needed services are coordinated and well established across the system.

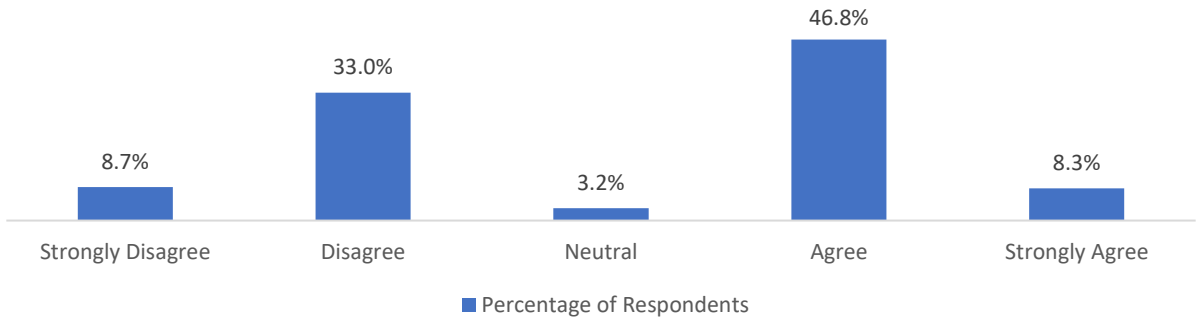


Figure 169: In general, behavioral health care and peer services are accessible in your area.

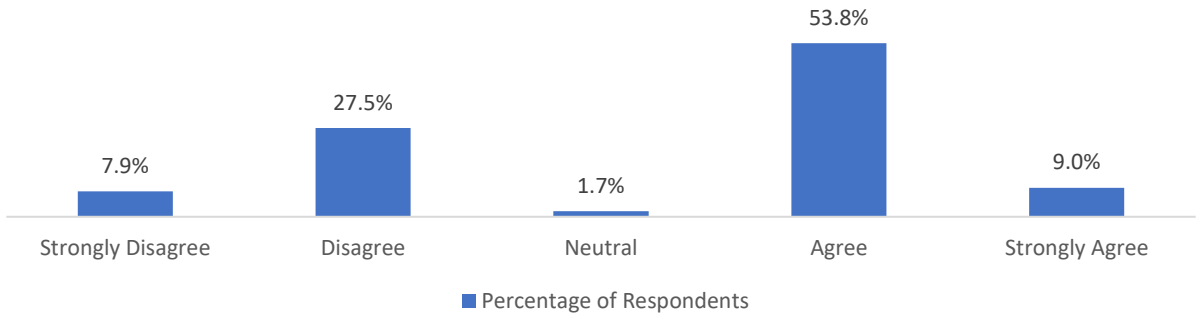


Figure 170: The process for referrals is easily accessible.

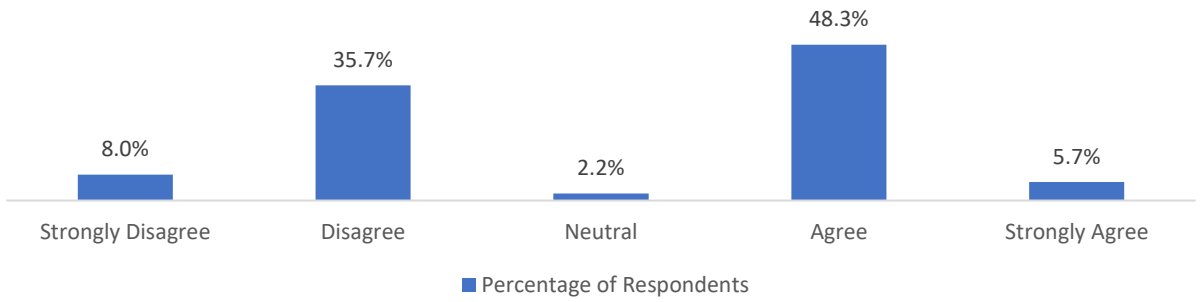


Figure 171: Programs and services are coordinated across the system of care.

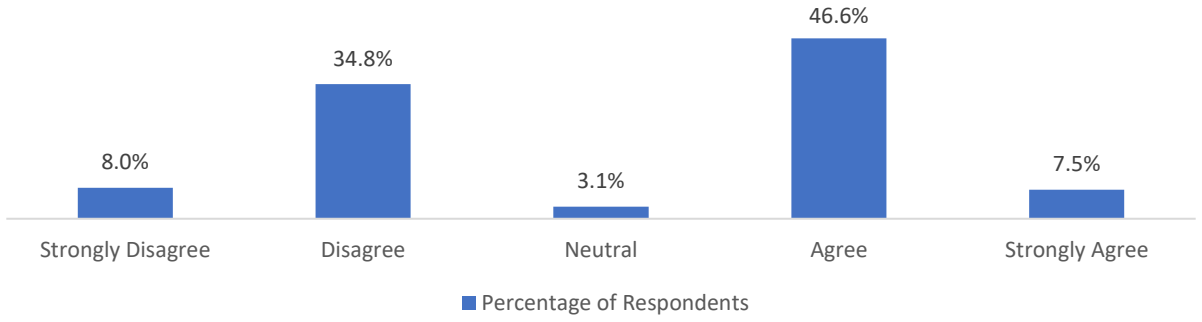
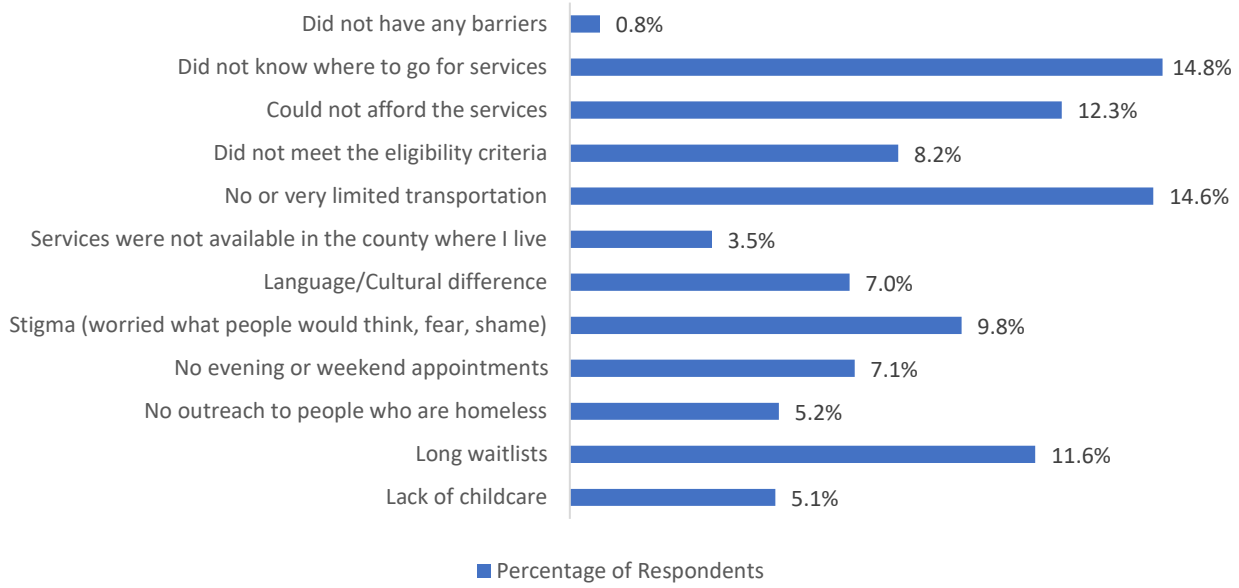


Figure 172: List the barriers for consumers accessing services in your community. (Check all that apply)



PEER RECOVERY COMMUNITY/SUPPORT SPECIALIST'S SURVEY SUMMARY

Across Florida, 389 peer recovery/support specialists responded to this survey designed to measuring their experience, awareness, and coordination of mental health and substance use (behavioral health) peer support services in their county of residence. More detailed analyses are found in the region-specific reports section. No personal identification information was gathered. All respondents were completely anonymous.

The experience for peer respondents were adults with lived mental health condition (31.1%), lived co-occurring condition (28.6%), or lived substance use condition at 21.8%. The remaining respondents had experience as a family member or friend, was a youth, or a veteran.

Peer respondents represented 44 of the 67 counties in Florida. Miami-Dade, Palm Beach, Broward, and Duval counties had the highest representation which ranged from 14.4% to 10.1% of respondents. The percentages of respondents from all other counties ranged from 0.3% to 4.4%.

Peers were employed or volunteered at agencies that provided peer services (20.5%), adult mental health services (19.3%), and adult substance use services at 18.3%. Recovery Community Organizations (RCO) accounted for 10.5% of respondents. Just less than 10% of respondents were employed with children's services. Those working in agencies providing prevention services, or family/peer organizations, represented 6.3% and 6.9% of respondents, respectively. Close to 40% of respondents had been employed at the same agency for more than 3 years. Those working at an agency for less than 6 months accounted for 19% of peers and 17.2% had been at the agency for 1 to 2 years. Peers working 40 hours per week accounted for 58% of respondents while 17.8% worked longer hours. Those working 20 hours per week accounted for 15.9%. and peers working up to 10 hours per week represented 8.4% of respondents.

Recovery support peer services were used at 87.4% of the agencies represented. Less than 7% were not sure if these services were utilized at their agency. Most peer respondents (86.7%) indicated that the agency where they worked adhered to recovery support best practices. Those who were not sure accounted for 9.2% of respondents.

Certified Recovery Peer Specialist (CRPS) accounted for 36.7% of respondents, 31.6% were not certified, and 20% had applied and were in the process for certification. Close to 12% of peers delivered services in Outpatient RCO's. Those working with Medication Assisted Treatment (MAT) accounted for 9.4% of respondents. Delivering services to Family/Peer Grassroots organizations were represented by 7.7% of peers and 7.2% provided services in Drop-in Centers.

Personal fulfillment was the reason cited for 25.4% of peer workers staying with their company. Commitment to recovery principles represented 19.1% of respondents. Flexible work schedule, or work hours, accounted for 18.4% and 14.3% of peer respondents, respectively. Only 7% indicated that salary was a reason for staying with the agency. Salary was cited as the biggest barrier

experienced in the hiring process by 41.1% of respondents. The exemption/background screening process was a challenge for 19.3% of peers, while limited employment opportunities were barriers for 17% of respondents. Peers recommending the 40-hour required training accounted for 10.3% of respondents. Having the option to choose all that applied, each responded chose an average of seven different trainings from the 14 options offered. This indicated that all trainings are recommended by peers for peers.

Most peers (69.2%) indicated there were existing partnerships among the peer recovery organizations. Respondents who were unsure of this accounted for 26%.

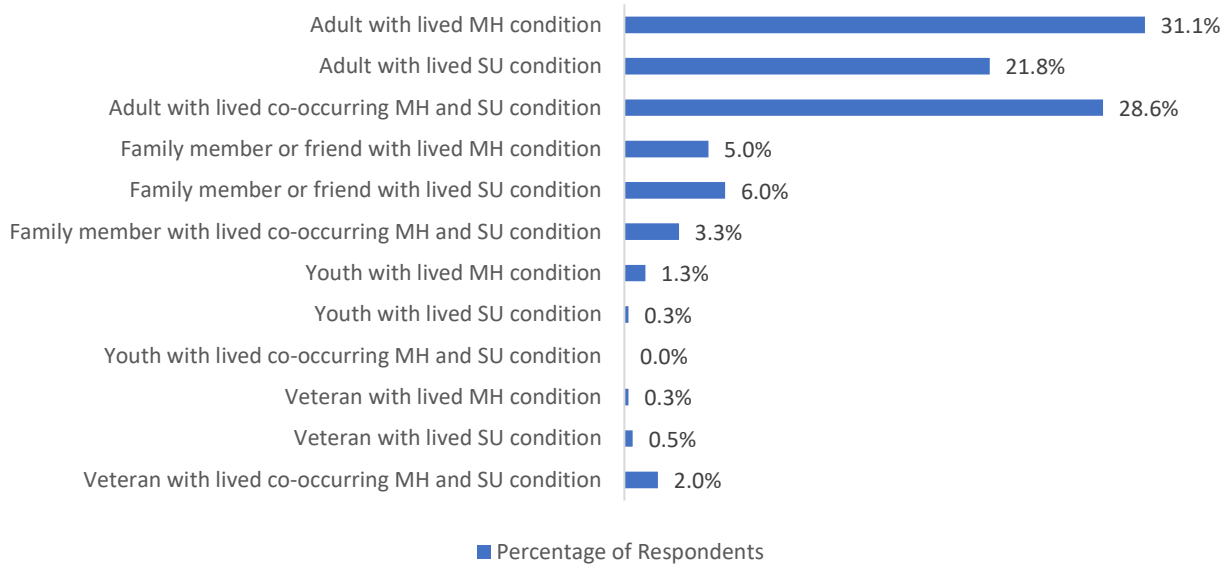
Over 10% of peer respondents were aware of partnerships with food pantries or meal programs. As each respondent was free to choose all that apply, an average of five resources were chosen by each respondent from the 13 options provided. This indicated that awareness of resources among peers was prevalent. Most peers (85.2%) had the ability to offer choices to the individuals served at the agency where they were employed/volunteered.

Over 83% of peers indicated that their agency promoted recovery language to help reduce stigma. Those unsure if this was used at their facility accounted for 10% of respondents while 6.2% indicated this was not used.

Over 75% of peer respondents reported that peers were included in developing and promoting programs. This did not happen for 11% of respondents at the agency where they were employed/volunteered, and 13.1% were unsure. Regarding the inclusion of persons in recovery in management and board meetings, 56% indicated this was practiced at their agency. Those unsure accounted for 27.2% while 16.7% of respondents revealed this did not happen at the agency where they were employed/volunteered.

PEER RECOVERY COMMUNITY/SUPPORT SPECIALIST'S SURVEY CHARTS

Figure 173: Which best describes your experience?



Note: Mental Health (MH) and Substance Use (SU)

Figure 174: Which county do you live in?

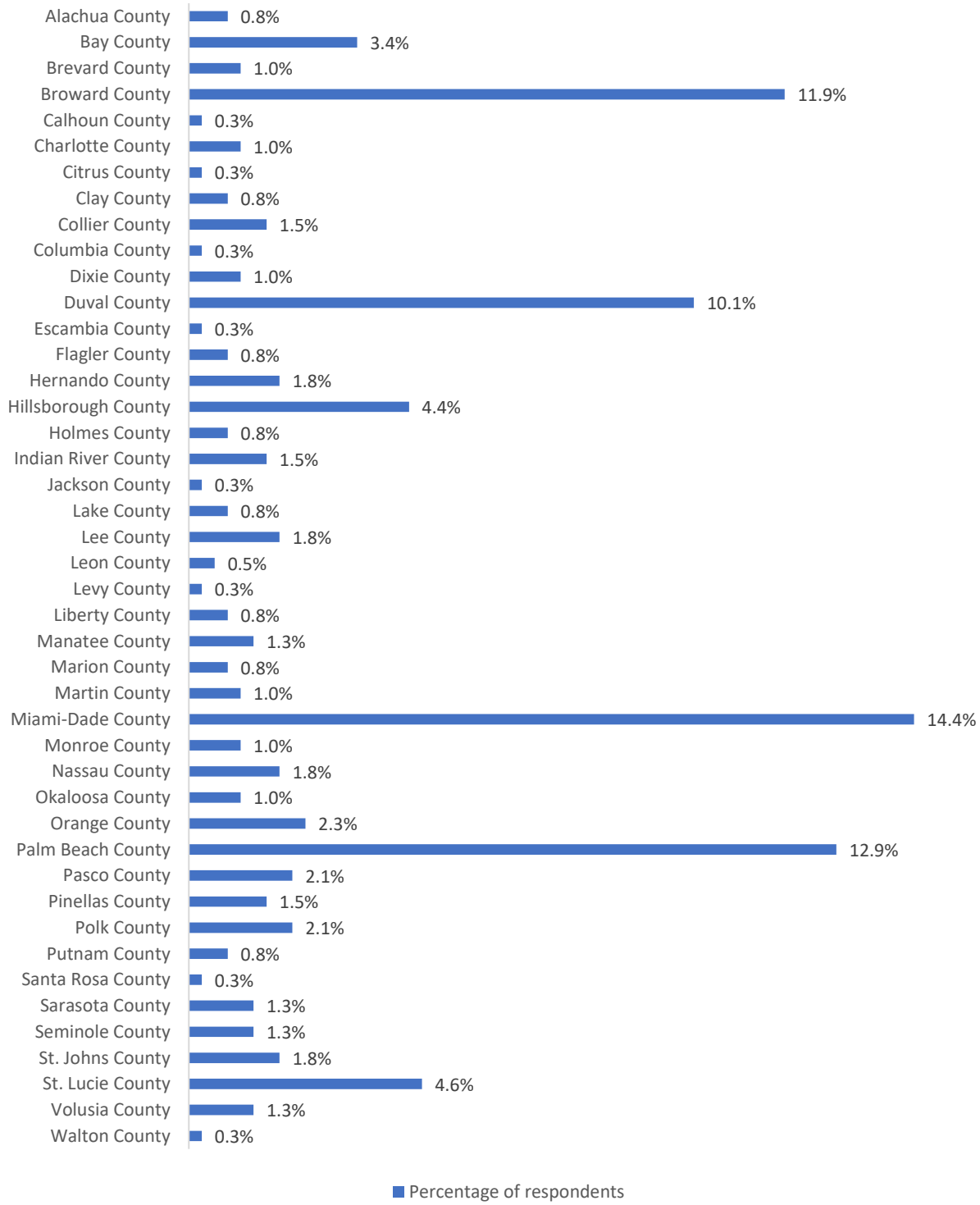


Figure 175: What type of service are you employed or volunteer with? (Check all that apply)

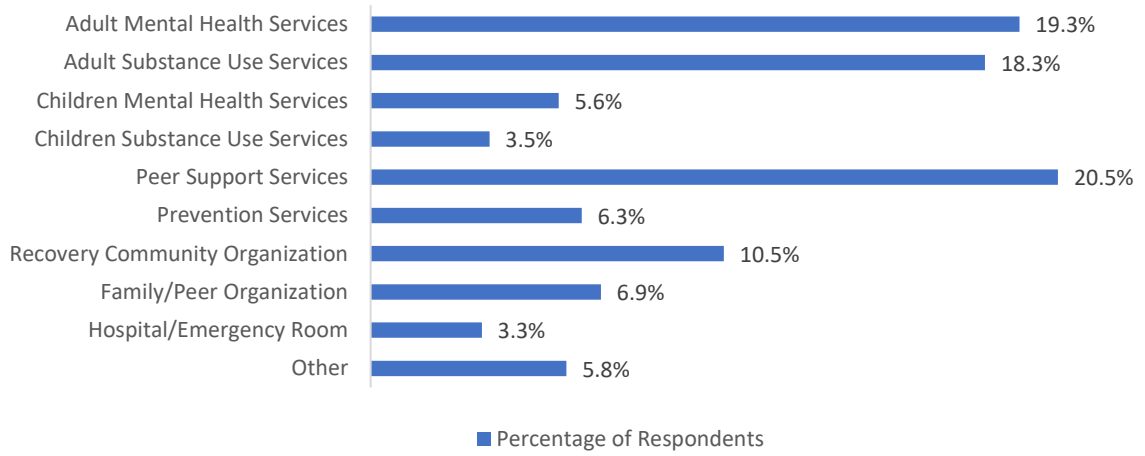


Figure 176: How long have you been employed/volunteered with the agency?

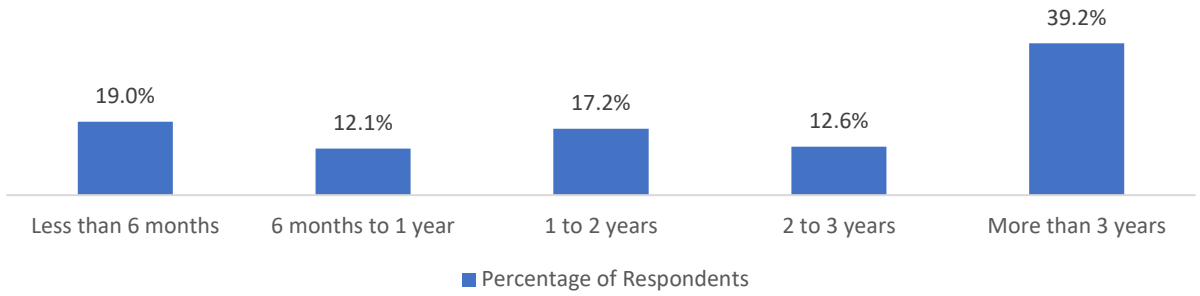


Figure 177: My work schedule averages...

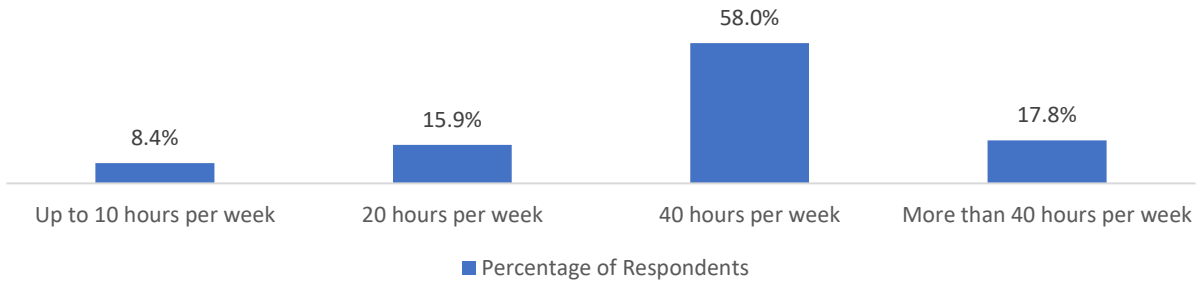


Figure 178: Does the agency where you are employed, or volunteer, utilize recovery peer support services within the services they provide in the community?

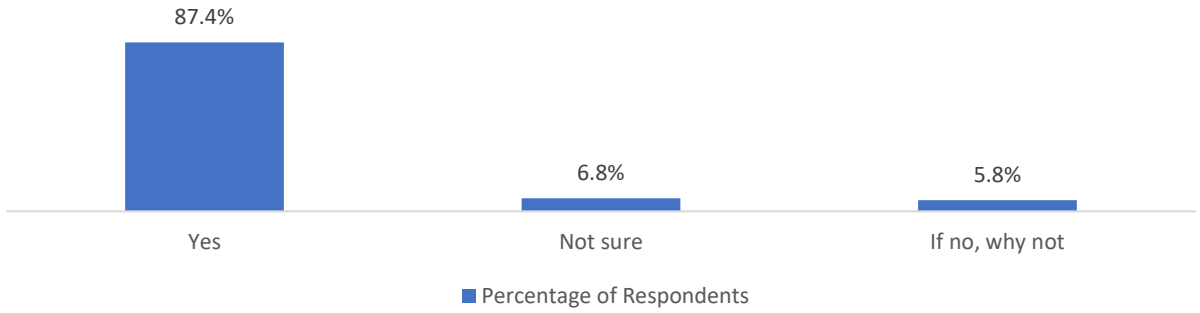


Figure 179: Does the agency where you are employed, or volunteer, adhere to recovery support best practices?

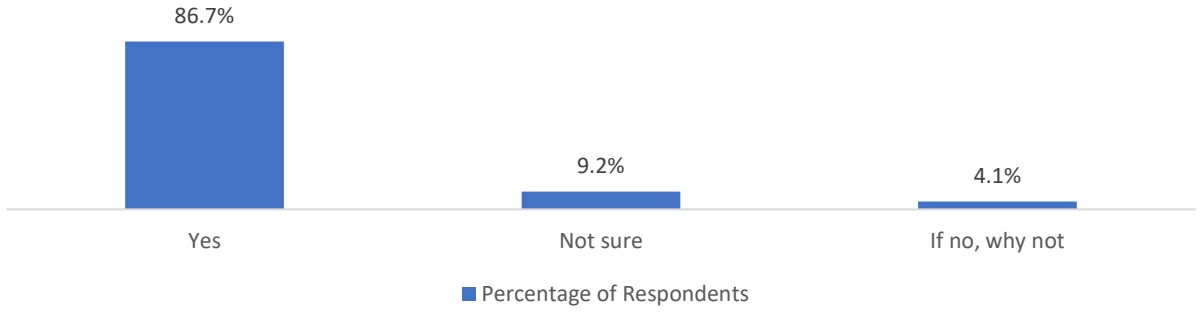


Figure 180: Please indicate the qualifications that best describe your status. (Check all that apply)

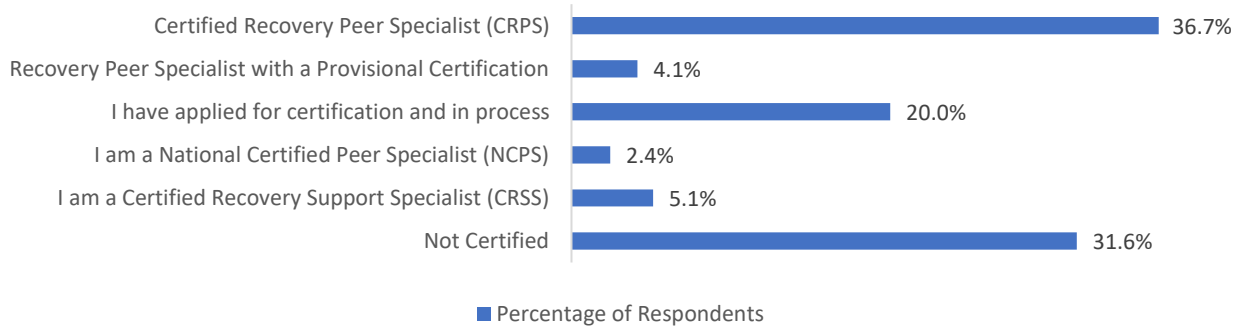
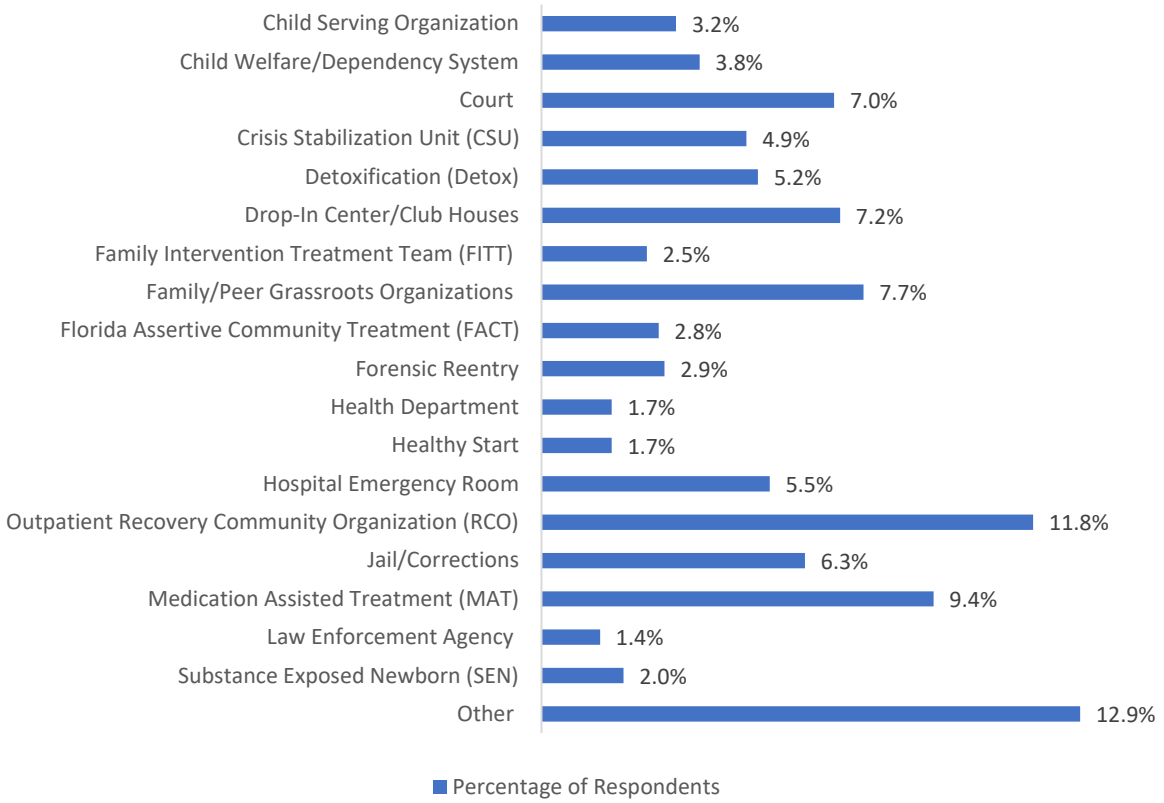


Figure 181: Please indicate the facility/program setting(s) that best describes where you deliver peer recovery support services. (Check all that apply)



Note: Family/Peer Grassroots Organizations includes the National Alliance on Mental Illness (NAMI), Federation of Families, etc.

Figure 182: What are the reasons/factors for staying with the company? (Check all that apply)

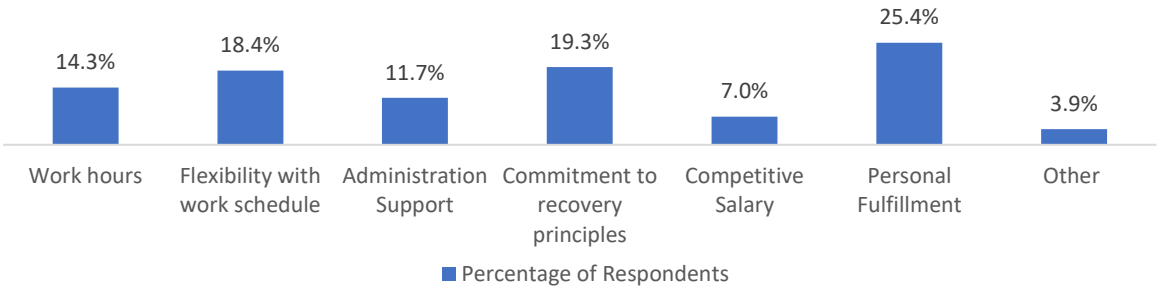


Figure 183: What barriers/challenges have you experienced in the hiring process? (Check all that apply)

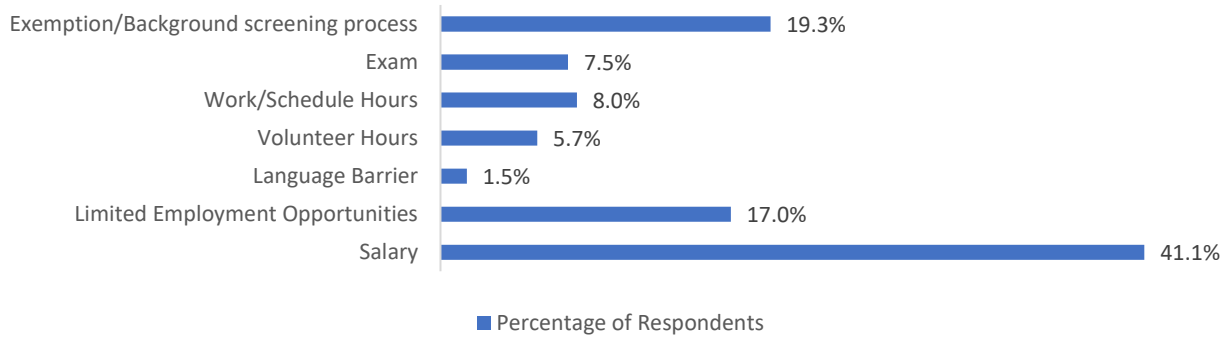
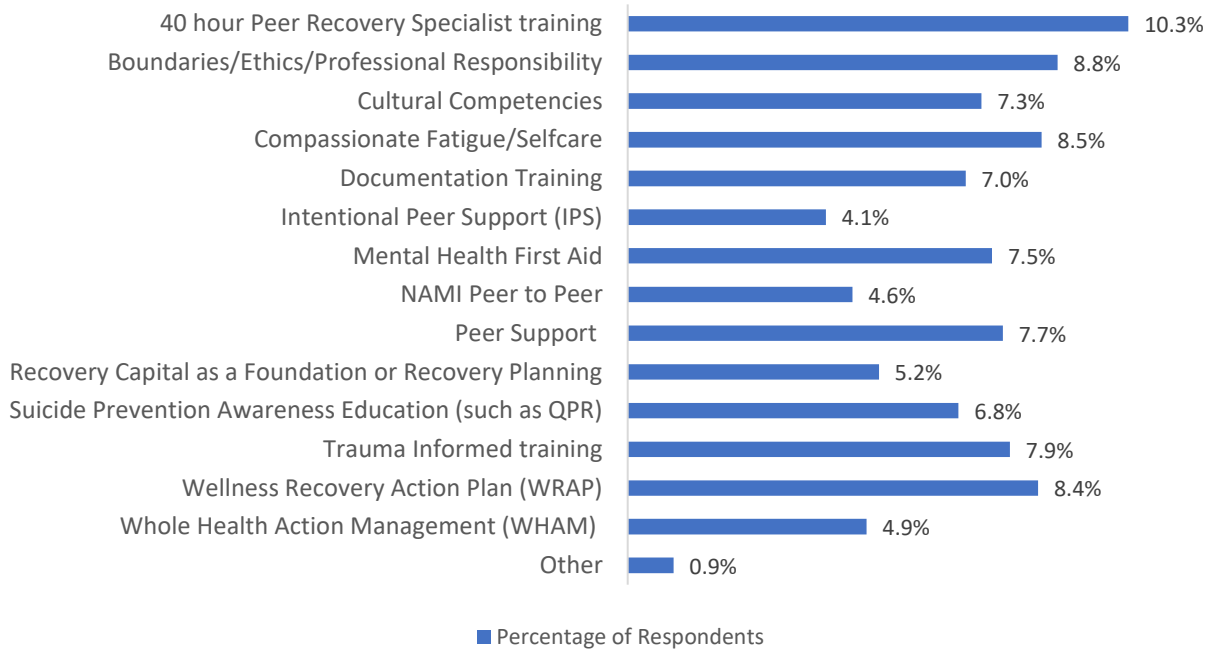


Figure 184: What training would you recommend for peers to have to help them provide peer support services? (Check all that apply)



Note: 40 hour required Peer Recovery Specialist training/Helping Others Heal

Figure 185: Are there partnerships that exist with peer support recovery programs, recovery community organizations, and other support groups?

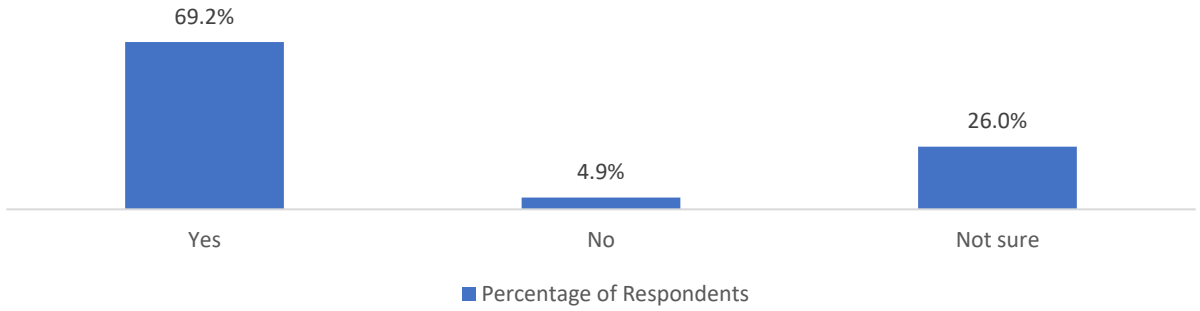


Figure 186: Are you aware of partnerships with other organizations that provide other resources such as: (Check all that apply)

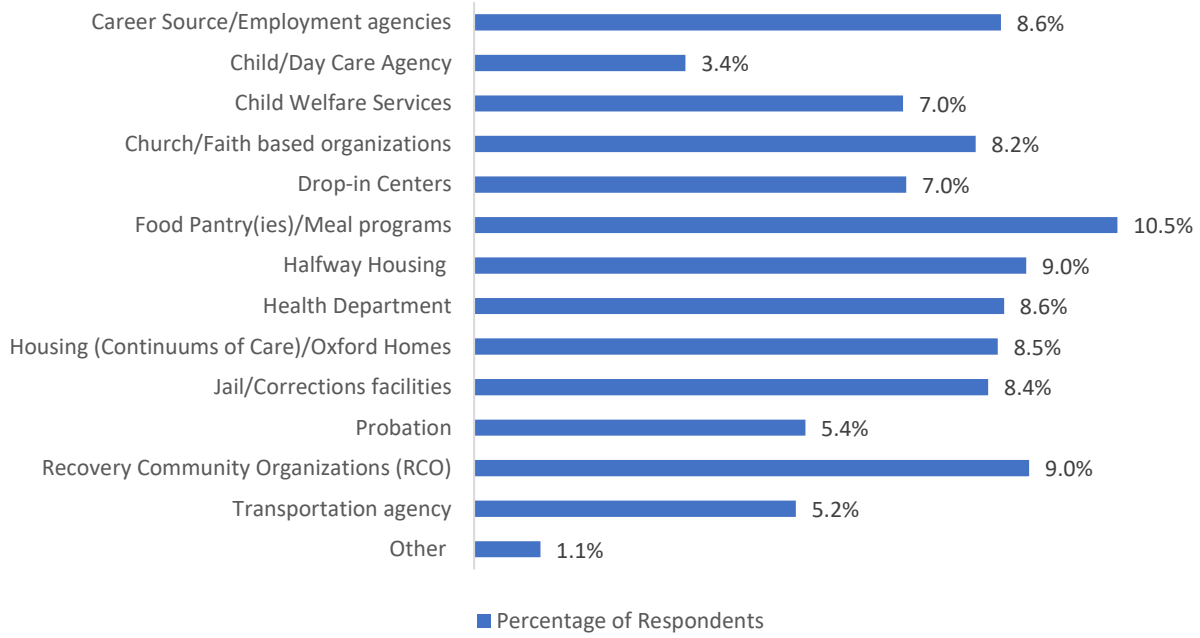


Figure 187: Do you have the ability to offer choices to the individuals where you serve at the agency you are employed/volunteer?

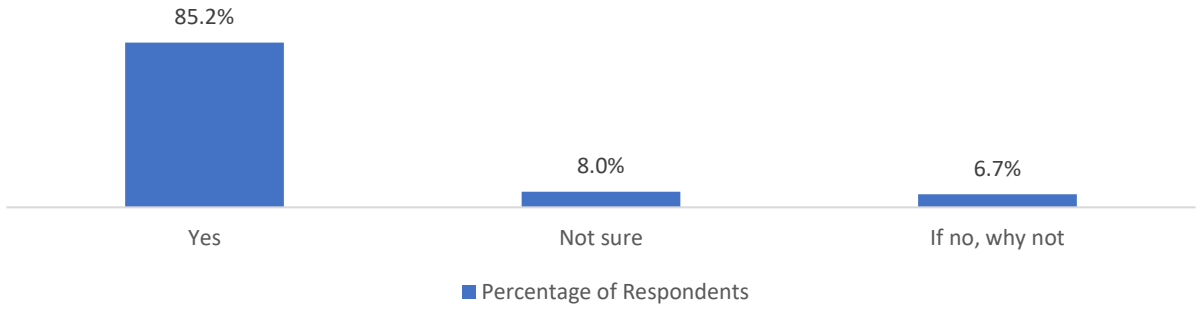


Figure 188: Does the organization where you are employed/volunteer with help to reduce stigma by promoting recovery language that is patient centered?

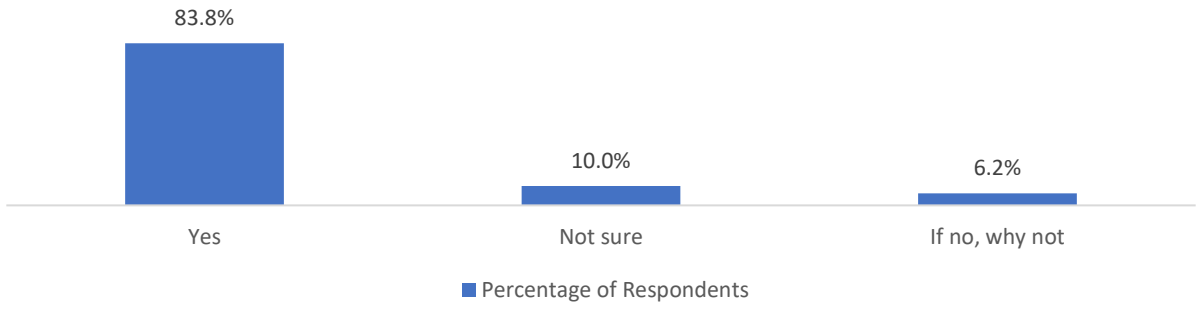


Figure 189: Does the agency where you are employed/volunteer include peers in developing and promoting effective program development, evaluation, and improvement?

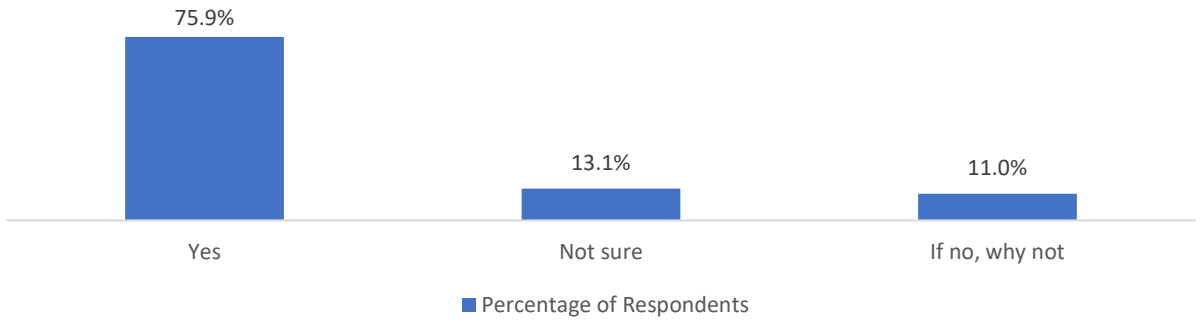
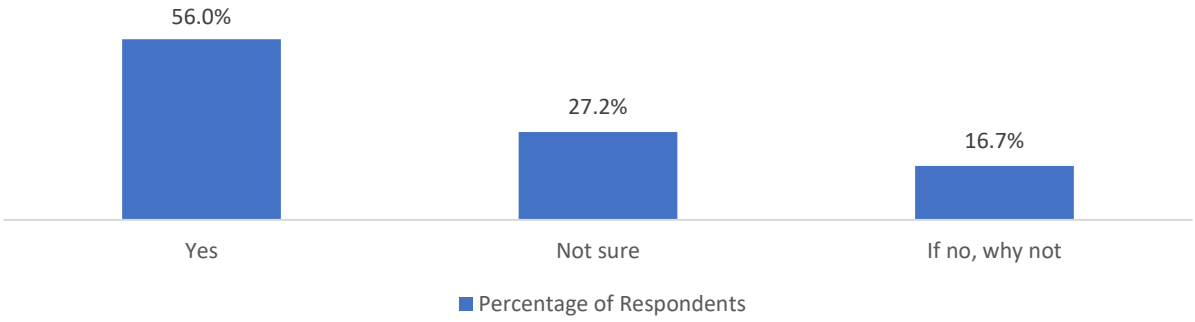


Figure 190: Does the agency where you are employed/volunteer with include persons in recovery management and board meetings?



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ACS Table S1810. Census - Table Results

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BBHC
BROWARD BEHAVIORAL HEALTH COALITION

2022

Florida Cultural Health Disparity & Behavioral Health Needs Assessment

BROWARD

Regional Report

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BROWARD BEHAVIORAL HEALTH COALITION
3521 W. Broward Blvd. Suite #206 Lauderhill, FL 33312 | (954) 622-8121 | www.bbhcflorida.org

May 30, 2022

Dear Valued Stakeholders:

Broward Behavioral Health Coalition, Inc. (BBHC) is Broward's local Managing Entity. Our Mission is to advocate and ensure an effective and efficient behavioral health system of care is available in Broward County. We are committed to ensuring a responsive and compassionate behavioral healthcare experience for individuals in our community. Our Values: Consumer driven, cultural competence, compassionate service, efficient management, innovative system, and fiscal integrity, serves as a guide as we support the provision of services.

We are responsible for the contracting, monitoring, clinical quality oversight, and performance improvement of the DCF/State funded behavioral health services. BBHC provides a comprehensive system of care for substance use, mental health, and co-occurring disorders for individuals and families in Broward County. As a non-profit organization, BBHC also manages local and national grants to develop evidence-based practices and practice improvement for Providers and persons served.

BBHC recently conducted our 2022 Behavioral and Cultural Health Disparity Needs Assessments. Stakeholder, Consumer, Peer, and Cultural Health Disparity surveys, and focus groups were conducted. We also reviewed local, state, and national data trends focused on behavioral health needs. The results from the surveys, focus groups, and research will be used to inform the community about needs and gaps in our system, develop strategic plans, leverage financial resources, and improve program effectiveness across the behavioral health care system and the continuum of services.

After reviewing the needs assessment, should you have any questions or areas that you would like BBHC to address, please let us know.

Sincerely,

Silva M. Quintana

Silva Quintana
Chief Executive Officer

ACKNOWLEDGEMENTS

Thank you to the awesome individuals and organizations who contributed to this report.

Footprint to Success Clubhouse

Broward Behavioral Health Coalition's Network Providers

Broward Behavioral Health Coalition Board of Directors, Committees, and Staff

Broward Behavioral Health Coalition Consumers

Broward County

Broward County Health Department

Broward County Public Schools

Broward Sheriff's Office – Child Protective Investigations

Broward Regional Health Planning Council

ChildNet

Children's Services Council of Broward County

Memorial Regional Hospital

Broward Behavioral Health Coalition, Inc., Consumer Advisory Council

Department of Children and Families – Adult Protective Services

NAMI Broward County, Inc.

Fort Lauderdale Independence, Training & Education (FLITE) Center

South Florida Wellness Network

City of Deerfield Beach

Center for Community Learning

Mujeres Latinas

Mental Health America

BBHC's Provider Advisory Council

Early Learning Coalition of Broward County, Inc.

State Representative Marie Woodson

Carisk Partners

South Florida Wellness Network

United Way of Broward County

Urban League of Broward County

EXECUTIVE SUMMARY

This report, prepared for the Broward Behavioral Health Coalition, Inc. (BBHC), is a compilation of primary and secondary data that identifies behavioral health needs and available community assets to advance health care delivery and improve outcomes for all residents.

SERVICE AREA POPULATION

The population in the service area (Broward County) increased by almost 30,000 individuals over the past 5 years to a total of 1,946,104. Racially, the service area is predominantly White (56.8%), followed by the Black population accounting for 28.6%, and Asian residents making up 3.6%. Ethnically, 30.2% of the service area population is Hispanic. When compared to Florida, our service area is much more racially and ethnically diverse. Females accounted for slightly more than half of the service area at 51.3%. Over 40% of individuals were between the ages of 25-54 years old. Most individuals attained a high school diploma. Participation in the labor force remained steady and was higher than the state. However, unemployment decreased between 2016 and 2020.

The effects of homelessness on individuals are numerous, complicated, and very costly. Addressing these requires community engagement dedicated to the long-term financial commitments and proven solutions that can bring an end to homelessness. In 2021, the Florida Council on Homelessness reported there were 2,561 homeless individuals in Broward County. Of these, 69% percent were unsheltered.

Overall, over 80% of residents reported good health and over 88% declared good mental health. Concurrently, suicide rates decreased in the service area between 2018 and 2020. In 2019, domestic violence increased from the 2018 rate. Children experiencing child abuse decreased by more than half between 2017 and 2019.

Among those in middle and high school, the percentage of students having never smoked increased from 2015 to 2019. Ninety-six percent of students had not vaped nicotine in the past 30 days. The percentage of students having never consumed alcoholic beverages in their lifetime also increased from 61.9% in 2016 to 69.8% in 2020.

BBHC CLIENT POPULATION

BBHC-funded organizations served 16,247 clients in FY20-21. Nearly all clients resided in Broward County. Most adults (60.5%) were enrolled in the Adult Mental Health (AMH) program. Adults enrolled in the ASA program accounted for 25.2%. The remaining 14.3% were comprised of children/youth clients in the Child Mental Health (CMH) program at 8.2% and the Child Substance Abuse (CSA) program at 6.1%.

BBHC clients were more racially and ethnically diverse when compared to the service area population. Clients in child/youth programs were even more racially and ethnically diverse overall when compared to adult clients. The highest percentage of clients were living independently with relatives and the second highest percentage of clients were living dependently with relatives. Among BBHC adult clients, most were unemployed.

A total of 2,492 homeless clients were enrolled in adult and child programs in FY20-21. There were more than twice the number of homeless men enrolled than women. Black homeless clients made up the majority in AMH programs while white homeless clients made up the majority in ASA programs. About 19% of homeless clients had less than a high school diploma and less than 10% of homeless clients were employed.

STAKEHOLDER SURVEY

Stakeholder respondents were asked questions regarding awareness, access to care, and barriers to behavioral health resources. More than 85% of stakeholders were aware of the behavioral health resources available in their county and over 95% had knowledge of the 2-1-1 informational resource. However, they did not feel that the overall community possessed the same level of awareness; only 57% rated awareness as good to excellent. Fortunately, of those who reported having used the 2-1-1 resource, the majority (55%) found it to be useful. Like consumers, stakeholders felt that linkages to services were well coordinated and accessible but were less confident in other aspects of the program. Stakeholders cited the lack of reliable transportation as the top barrier for access care. Long waitlists were number two and being unsure of where to go was the third biggest barrier to care. This identifies the need of additional resources to support the flow of consumers across the health care system. Respondents reported that housing needs, transportation needs, staff shortages, mental health resources, and more knowledge of available programs are needed resources and services.

CONSUMER SURVEY

Awareness of where to find services when needed was a challenge for about 17% of consumers. However, word of mouth was the most prominent method of learning of programs. More than half of the consumers indicated that they learned of the services they needed from family members, friends, or another person who used the services. Overall, more than 60% of consumers did identify that they received services when they needed them. Over 60% of consumers were aware of the 2-1-1 resource in their community. Most consumers also reported that they believed the provided services were focused. According to the responses, long waitlists, not knowing where to go for services, strict eligibility requirements, lack of transportation, stigma, and affordability were all top barriers for receiving necessary resources.

RECOVERY SURVEY

Adults living with co-occurring mental health and substance use conditions was the largest group of respondents in this survey, making up 47% of responses. Adults with lived mental health conditions were the second largest respondent group, followed by adults with lived substance use conditions and family member/friend of someone with lived mental health conditions.

Almost one-third of respondents worked/volunteered in either adult mental health services or substance use services; 23% were employed/volunteered with peer support services. Of the respondents, 40% have been employed/volunteered with the agency for more than 3 years. Personal fulfillment was a main reason for maintaining employment with the agency for over a quarter of respondents. Commitment to recovery principles and flexible work schedules were also among top reasons for maintaining employment. Top barriers in the hiring process included salary and the exemption/background screening process.

A large majority of responses indicated that agencies utilized peer support services, adhered to recovery support best practices, and reduced stigma by promoting person centered recovery language. Most respondents also identified that peers were included in program development stages as well as recovery management and board meetings. However, respondents were most aware of only a select few recovery partnerships.

CULTURAL HEALTH DISPARITIES

A cultural health disparities survey was sent to clients in Center for Disease Control and Prevention (CDC) identified vulnerable areas. They were asked a series of questions related to behavioral health care services and told to choose from responses ranging from strongly agree to strongly disagree. Question types ranged from demographic information to feelings/perception regarding behavioral health care services. There was a total of 72 survey respondents. Most (73%) of the respondents were female. When asked how they would rate their trust in the behavioral health care system to treat them with respect, 45% did not have trust.

NO WRONG DOOR

This assessment conducted among the BBHC providers revealed the mission to make all doors the right doors or even eliminate doors completely. This survey consisted of 81 respondents; over 20% of respondents worked in adult outpatient programs, followed by recovery support (20%), and adult detoxification units (14%). Most respondents (72.8%) felt the No Work Door (NWD) access worked well in their organizations.

Most participants (91.4%) felt their organization had a strong care coordination process, that linkages to crisis intervention and support were occurring (86.5%), and believed their organization encouraged community partners (92.6%). The majority also believed their organization provided person centered and culturally sensitive care. There were lower percentages of agreement

(65.4%) when asked if access to services were quick and efficient. Overall, more than three-quarters of respondents believed their organization worked well in improving patient outcomes.

MOVING FROM WHERE WE ARE TO WHERE WE WANT TO BE

This assessment serves as the foundation for strategically addressing the key behavioral health care needs as defined by consumers, stakeholders, and providers. This needs assessment will help identify pressing needs and challenges in the current system. This information is vital to developing measurable objectives in delivery of community mental health and substance use services, to improve access to care, to promote service continuity, to purchase services, and to support efficient and effective delivery of services to better support the needs of our community.

BROWARD COUNTY DEMOGRAPHIC PROFILE

Population Demographics

Population in the service area increased from 1,860,979 (2016) to 1,946,104 (2020). The total population growth for the 5-year period, at 4.6%, added 85,125 residents.

In the service area and the state, females accounted for slightly more than 50% of the population when compared to their male counterparts. Approximately 4% to 5% (if not higher) of residents are likely to be LGBTQ+ identified.

The racial composition in the service area and state was predominately White at 56.8% and 71.6%, respectively. The Black population accounted for 28.6% of the service area population and 15.9% of the population in Florida. American Indian and Native Hawaiians represented less than 1% of residents in both population groups. The percentage of Asian residents, at 3.6%, was higher in the service area when compared to the state at 2.8%. The service area was slightly more diverse when compared to the state, with 3.5% having a race of Other, and 7.1% of residents belonging to more than one racial group.

Ethnically, the service area had a slightly higher percentage of Hispanic residents, at 30.2%, when compared to the state at 25.8%.

The BBHC service area population was younger when compared to the age distribution at the state level. Residents, 65 years of age or older, accounted for 16.7% of the population while in the state of Florida, 20.5% of residents were at least 65 years old.

Education and Employment

Data revealed the service area and state populations were very similar regarding education attainment. Slightly more residents in service area (89.4%) had a high school diploma when compared to the state (88.5%). Residents in the service area had higher percentages of individuals who attended or graduated from college as well as those with graduate or professional degrees.

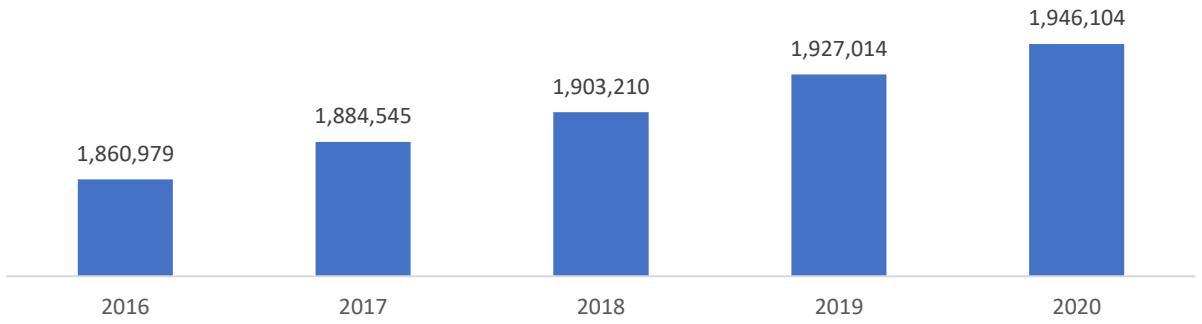
On average, 65.7% of the service area population participated in the labor force over the past 5 years. This was higher when compared to those employed in Florida at 58.9%. The 5-year unemployment rate estimate for the service area, at 5.9%, was higher than the state rate at 5.4%.

Poverty Status

During 2016 to 2020, the ratio of income to poverty rates for all categories were very similar for the service area and the state. The rates of those living >400% Federal Poverty Level (FPL), were 43% and 42.3%, respectively.

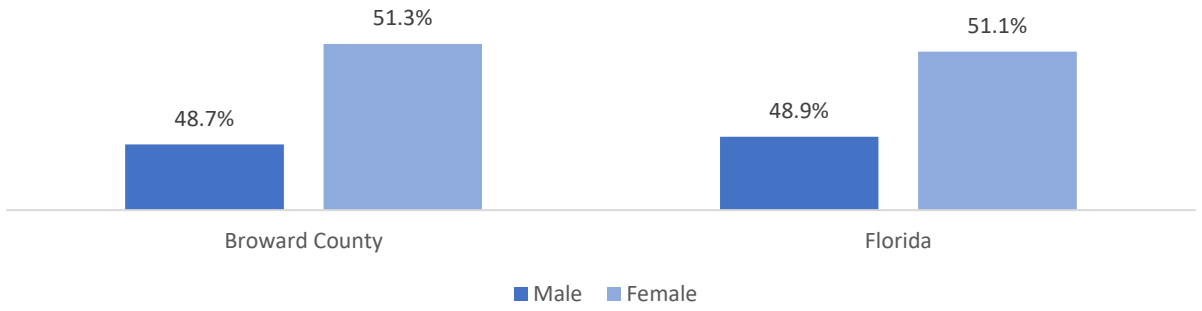
DEMOGRAPHIC CHARTS

Figure 1: Broward County Population Estimates (2016-2020)



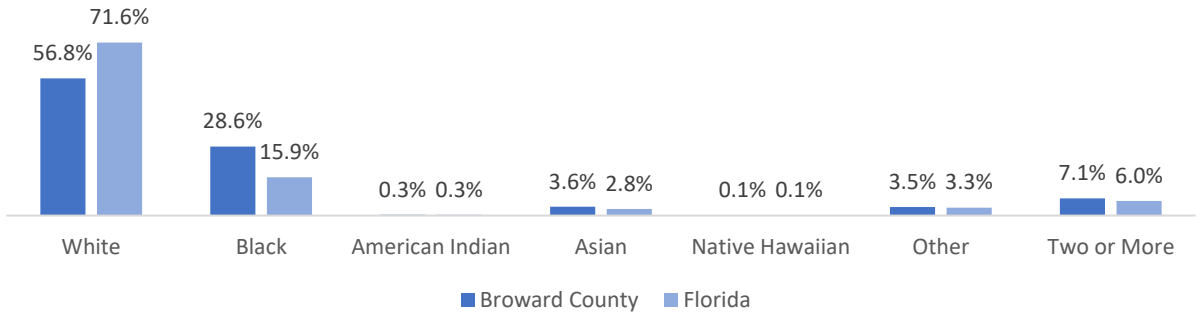
Source: Florida Legislature's Office of Economic and Demographic Research (EDR)

Figure 2: Broward County Population by Gender, 2016-2020 (5-Year Estimate)



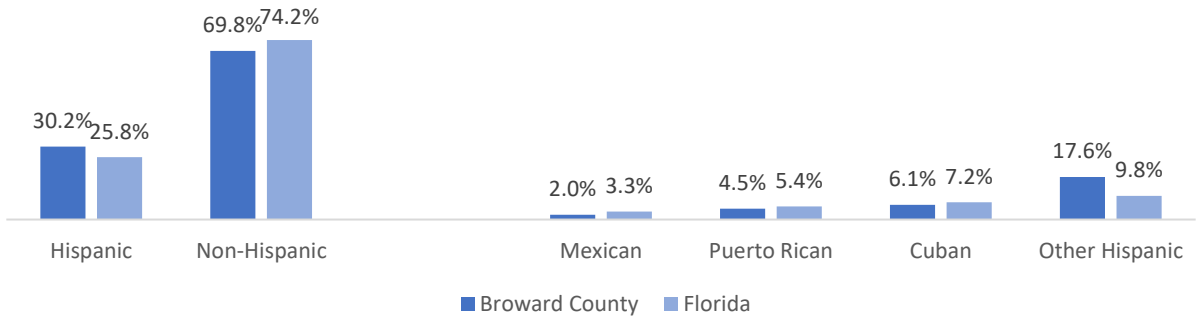
Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 3: Broward County Population by Race, 2016-2020 (5-Year Estimate)



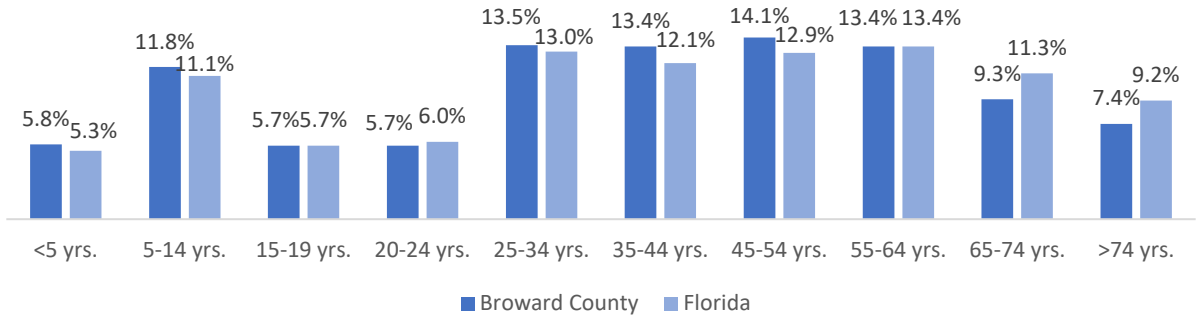
Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 4: Broward County Population by Ethnicity, 2016-2020 (5-Year Estimate)



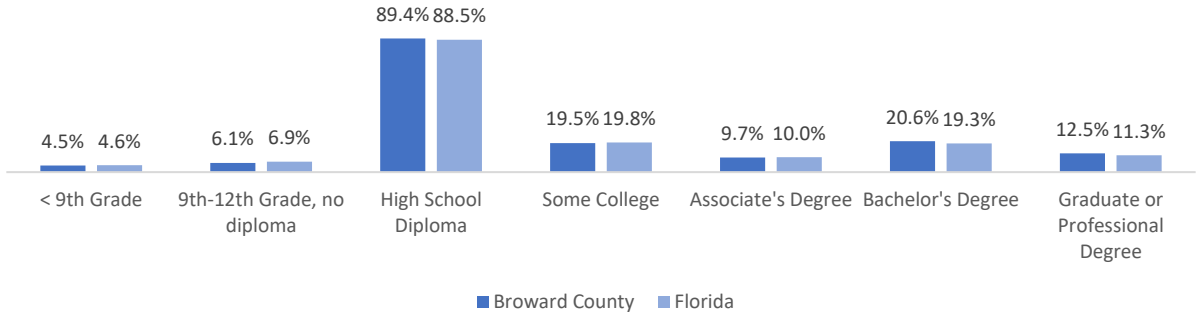
Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 5: Broward County Population by Age Range, 2016-2020 (5-Year Estimate)



Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 6: Broward County Population by Educational Attainment, 2016-2020 (5-Year Estimate)

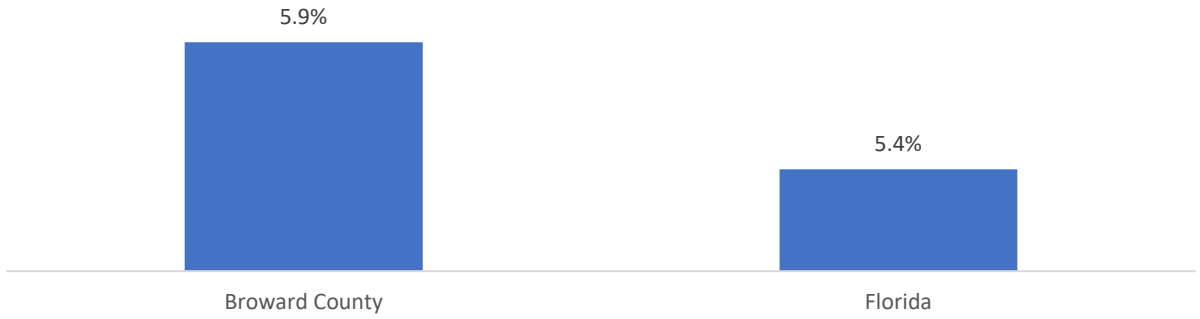


Source: U.S Census Bureau, American Community Survey, Table S1501

Figure 7: Broward County Population Participation in Labor Force, 2016-2020 (5-Year Estimate)

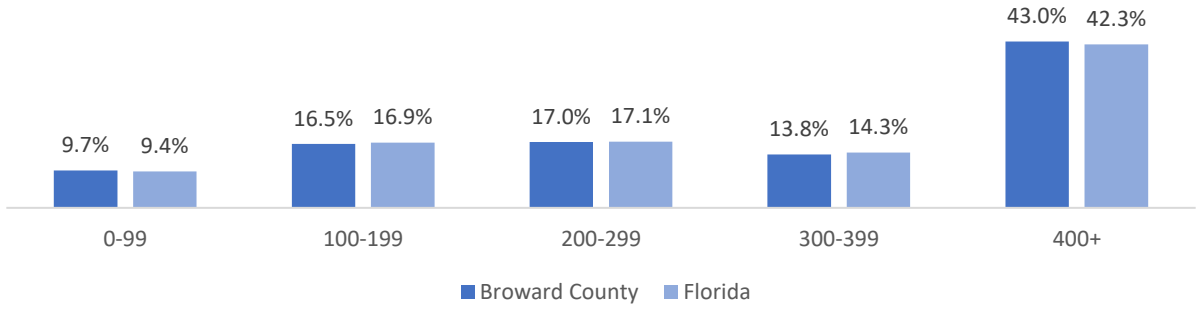
Source: U.S Census Bureau, American Community Survey, Table DP03

Figure 8: Broward County Population Unemployment Rates, 2016-2020 (5-Year Estimate)



Source: U.S Census Bureau, American Community Survey, Table DP03

Figure 9: Broward County Population Ratio of Income to Poverty Level of Families, 2016-2020 (5-Year Estimate)



Source: U.S Census Bureau, American Community Survey, Table B17026

BROWARD COUNTY GENERAL HEALTH STATUS

Overall, Health Status

Behavioral Risk Factor Surveillance System (BRFSS) data (2017 to 2019) estimates revealed 81.2% of adults, ages 18-64 years of age, living in the service area said their overall health was "good" to "excellent". For Florida, the rate was 80.3%. This knowledge is a powerful tool for targeting and building health promotion activities. It also provides a way to see change in population health behaviors before morbidity or disease is apparent.

Mental Health

The average percentage of adults reporting good mental health over the past 3 years, at 88.6% was above the rate for the state at 86.2%. The number of unhealthy mental days for the service area population, at 3.7 days in the past 30 days, was just below the rate among all adult residents (ages 18-64 years) in Florida at 4.4 days in the past 30 days.

Suicide

The crude suicide death rate decreased from 13.7/100,000 in 2018 to 11.4/100,000 population in 2020. This represents a decrease of 2.3/100,000 suicide deaths. At the state level, the suicide crude death rate decreased 2.5 deaths per 100,000 population during 2018 to 2020 but was also higher when compared to the Managing Entity (ME) service population. Among males, the suicide death rate for the ME service area and state were more than 3 times the rate among females. The suicide death rate among the White population was more than 4 times the rate for Black residents in the ME service area. It should be noted that the calculations required for the age-adjusted death rate for the ME service areas was beyond the scope of this project.

Violence and Abuse

The rate of total domestic violence offences decreased in the ME service area and the state from 2017 to 2019. In the ME service area, the rate fell from 297.1/100,000 to 293.5/100,000 over the past 3 years. This was much lower than the state rate of 496.5/100,000 in 2019.

The rate of children experiencing child abuse over the past 3 years (2017 to 2019) has continuously decreased in the ME service area and state. Among children ages 5-11 years, the rate of child abuse fell from 979.9/100,000 in 2017 to 430.5/100,000 in 2019. This trend was observed in the state rates which decreased from 857.9/100,000 to 662.7/100,000 during the same time.

Child sexual abuse rates changed very little from 2017 to 2019 but decreased from 2018 to 2019. In the ME service area, the 2019 sexual abuse rate for children 5-11 years was 26/100,000. This was much lower than the state rate at 57.8/100,000.

Mental Illness

The estimated number of seriously mentally ill (SMI) adults increased by 2.5% over the past 3 years. The rate of increase at the state level was 3.5%. The estimated number of SMI adults in the ME service area was 59,921 in 2020.

Among youth, ages 9-17 years, the estimated number of those emotionally disturbed increased by 1.4% from 2018 to 2020. This was lower when compared to the state increase at 3%.

The Florida Department of Education (FLDOE) reported 0.4% of children in K-12 grades had an emotional/behavioral disability in the ME service area. In the state, students with an emotional/behavioral disability accounted for 0.5%. These rates have been steady over the past 3 years.

Adult Tobacco and Alcohol Use

BRFSS results revealed the percentage of adults living in the ME service area who are current smokers, at 12.6% (2017 to 2019) was lower when compared to the state at 14.8%.

Binge drinking is defined as 5 consecutive drinks for men and 4 consecutive drinks for women. For 2017 to 2019, the percentage of binge drinkers in the ME service area was 16.7%. The percentage of binge drinkers in the state was slightly higher at 18%.

High School Tobacco, Alcohol, and Substance Use

Data from the Florida Youth Substance Abuse Survey (FYSAS) indicated that the percentage of middle and high school students who reported never having smoked cigarettes increased from 90.5% in 2016 to 92.3% in 2020. For middle and high school students in the state, the percentage of those having never smoked also increased over the past 4 years.

When students were asked about smoking frequency, 96.3% of those living in the ME service area did not smoke at all. The state rate was 98.2%.

Vaping questions were included in the 2020 FYSAS for the first time. In the ME service area, 14.2% of students reported vaping nicotine on at least one occasion in their lifetime. Two percent of students had vaped on 40 or more occasions. The percentage of students vaping nicotine during the past 30 days was much lower in the state when compared to vaped in lifetime rates. Ninety-six percent of students in the ME and 88.6% in the state had not vaped nicotine in the past 30 days.

The percentage of students who did not consume alcoholic beverages on any occasions in their lifetime ranged from 61.9% in 2016 to 69.8% in 2020. For those who did on 1-2 occasions, the percentage increased by a little over 0.5% from 2016 to 2020. The percentages of students in 2020 consuming alcohol on more than two occasions ranged from 3.8% for 3-5 occasions to 1.9% for those consuming alcohol on at least 40 occasions. The rates for the state were almost identical to those in the ME service area.

High school students were asked for the number of occasions in their lifetime when they had woken up after a night of drinking alcohol and were unable to remember the things they did or the places they went. The percentage of students reporting this event happening on no occasions in their lifetime (2020) in the ME service area and the state was 96.8% and 86.2%, respectively. When looking at previous reported data, this was an increase from the percentages reported in 2016 for the ME service area and the state.

The percentages of students living in the ME service area not consuming alcohol during the past 30 days increased from 81.7% in 2016 to 83% in 2020. The increase at the state level was greater when comparing percentages from 2016 (81.7%) to 2020, at 85.2%. The percentages of students who reported consuming alcohol on 1-2 occasions during the past 30 days decreased in the ME service area and state from 2016 to 2020.

The overall percentage of those binge drinking, defined as consuming five or more alcoholic drinks in a row in the past 2 weeks, decreased 1% over the past 4 years. This was a combined decrease for students in the ME service area and state who reported this behavior on one to more than 10 occasions.

The percentages of students who have not used marijuana in their lifetimes decreased over the past 4 years in the ME service area (76.9%-2020) and state (79.9%-2020). For those who did use marijuana on one to more than 40 occasions, the overall percentages increased in the ME service area from 19% in 2016 to 20% in 2020. The percentages of students not using marijuana in the past 30 days were higher when compared to those who reported not using it in their lifetime. The percentages of students who reported vaping marijuana in their lifetimes on one or more occasions was 0.2% lower in the ME service area when compared to the state. This was also true when comparing the two groups of students who had vaped marijuana in the past 30 days. In the ME service area, 6% of students had vaped marijuana in the past 30 days compared to 7.3% of students in the state.

Disability

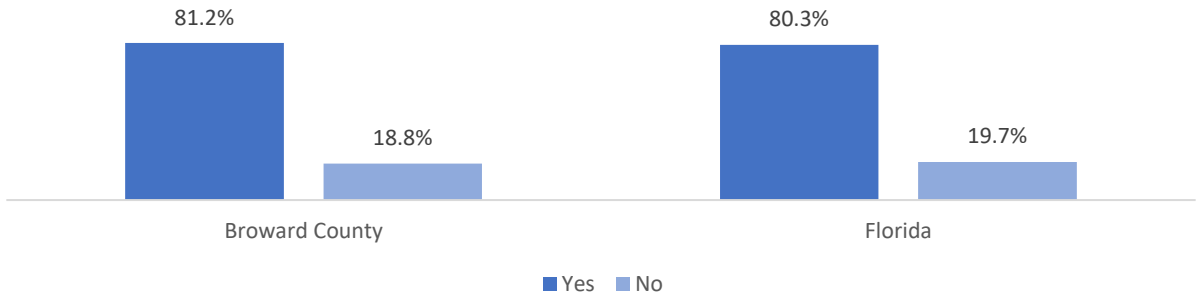
In the ME service area, 11% of the noninstitutionalized population was estimated to have a disability (includes hearing, vision, cognitive, ambulatory, self-care, and independent living). At the state level, 13.6% of residents had a disability. The percentages of those with a disability were much higher among older adults, ages 65 years and older, at 49.8% for the ME service area and 48.9% in the state.

Health Insurance Coverage

Over 82% of residents, ages 18-64 years, living in the ME service area and state reported having some type of health insurance coverage. The percentage of those with insurance in the state was slightly higher when compared to the ME service area at 84.2%.

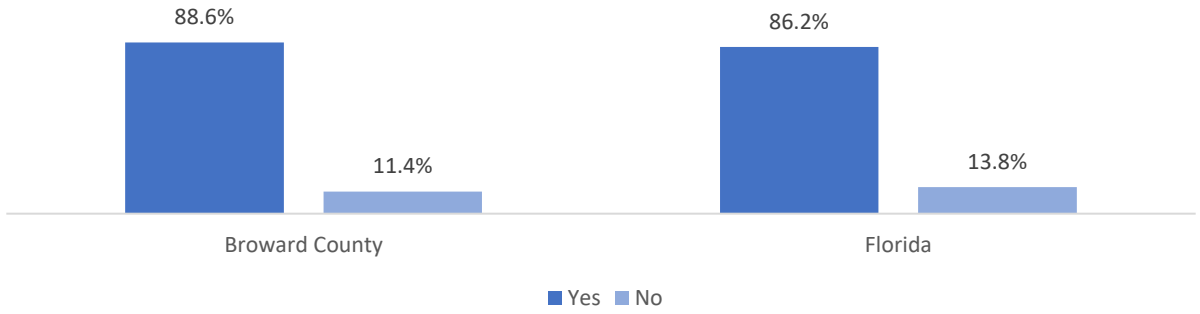
GENERAL HEALTH STATUS CHARTS

Figure 10: Broward County Adults Who Said Their Overall Health Was "Good" to "Excellent"(2017-2019)



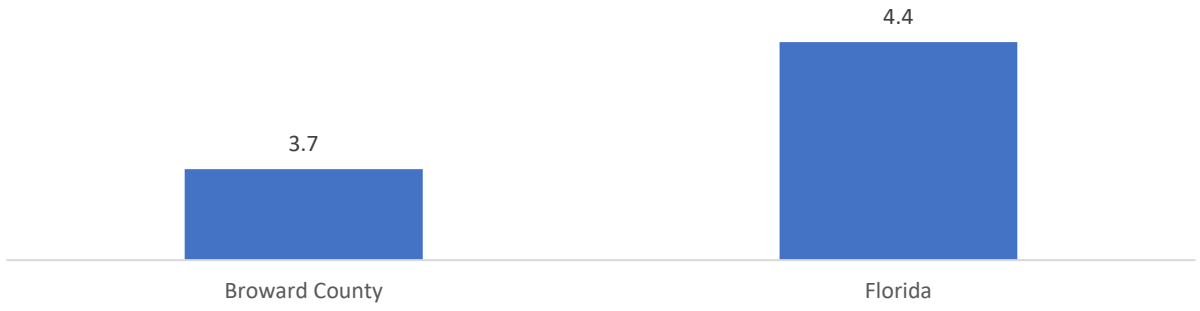
Source: Behavioral Risk Factor Surveillance System

Figure 11: Broward County Adults with Good Mental Health for the Past 30 Days (2017-2019)



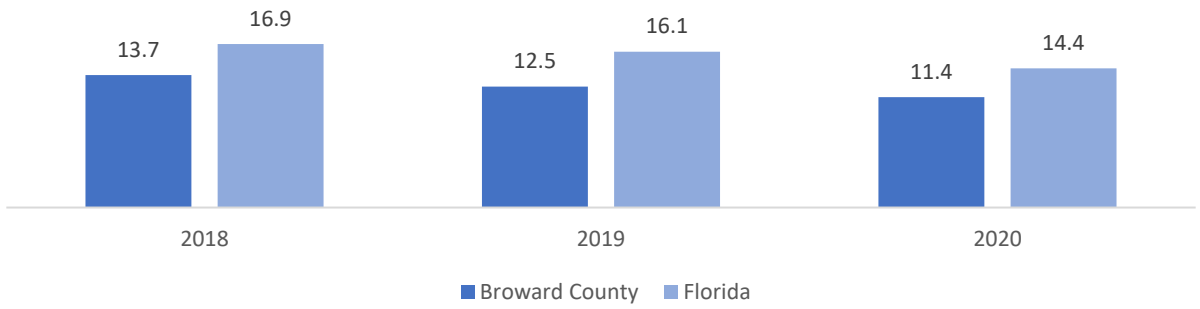
Source: Behavioral Risk Factor Surveillance System

Figure 12: Broward County Adults Average Number of Unhealthy Mental Days in the Past 30 Days (2017-2019)



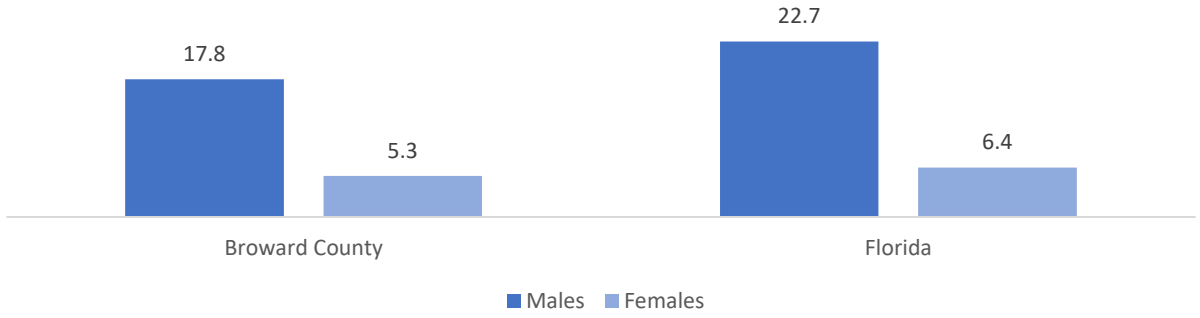
Source: Behavioral Risk Factor Surveillance System

Figure 13: Broward County Crude Suicide Death Rates (2018-2020)



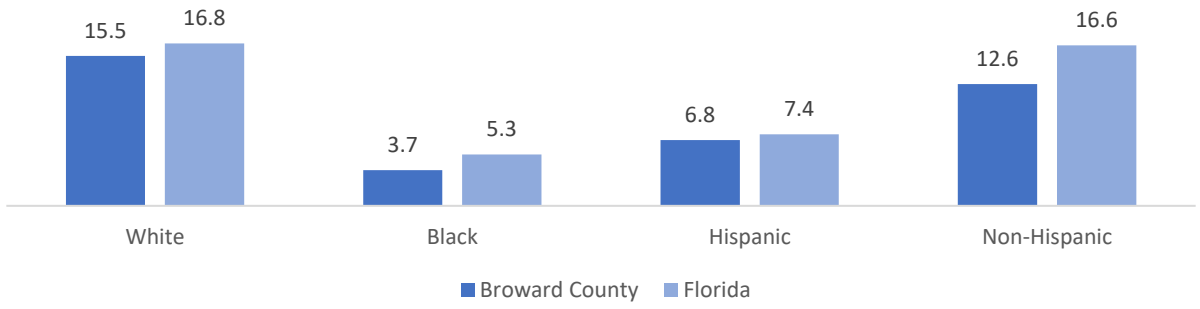
Source: Florida Department of Health, Bureau of Vital Statistics, Rates per 100,000

Figure 14: Broward County Crude Suicide Death Rates by Gender (2020)



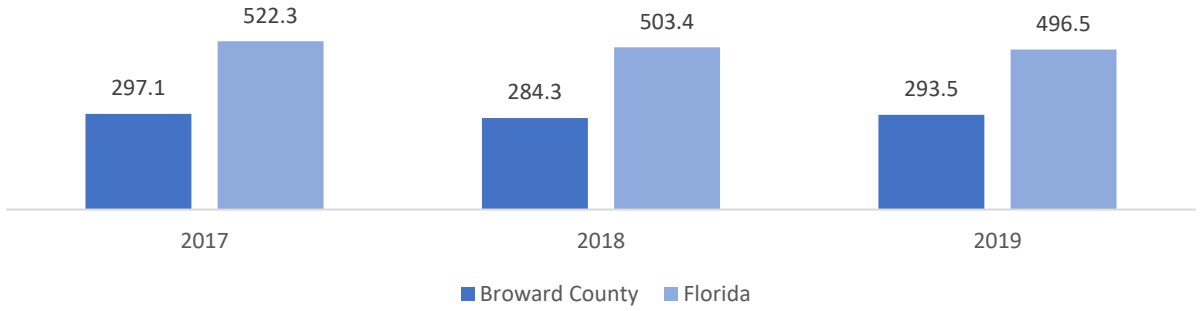
Source: Florida Department of Health, Bureau of Vital Statistics, Rate per 100,000

Figure 15: Broward County Crude Suicide Death Rates by Race and Ethnicity (2020)



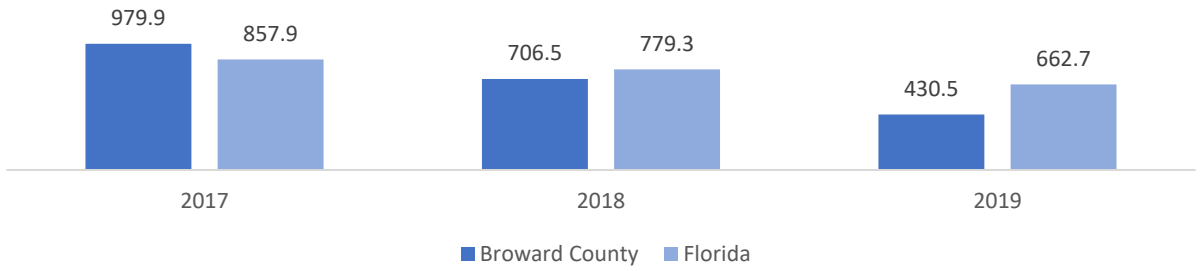
Source: Florida Department of Health, Bureau of Vital Statistics, Rate per 100,000

Figure 16: Broward County Total Domestic Violence Offenses (2017-2019)



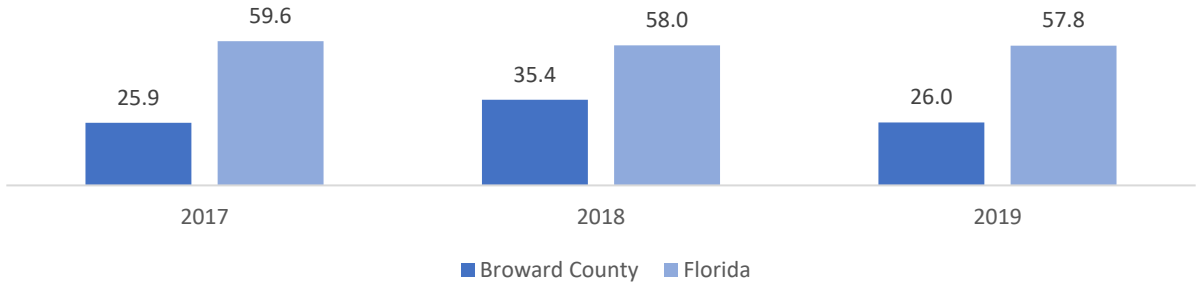
Source: Florida Department of Law Enforcement, Crime in Florida, Uniform Crime Report 2019, Rate per 100,000

Figure 17: Broward County Rate of Children Experiencing Child Abuse, Ages 5-11 Years (2017-2019)



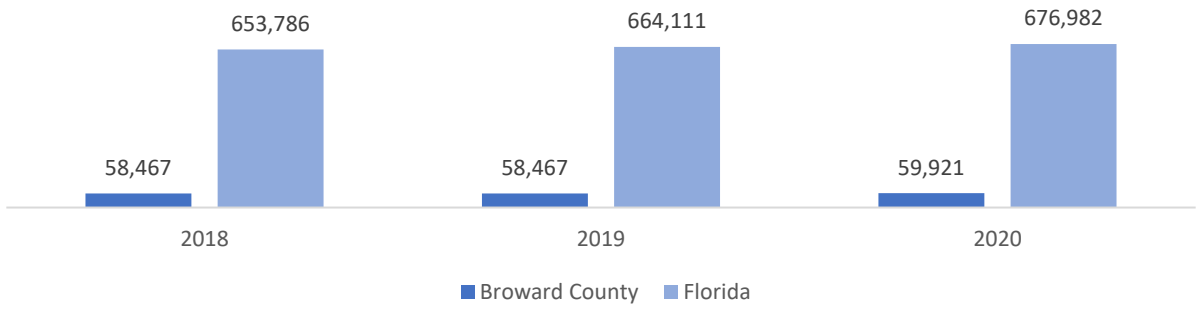
Source: Department of Children and Families, Florida Safe Families Network Data Mart, Rate per 100,000

Figure 18: Broward County Rate of Children Experiencing Sexual Violence, Ages 5-11 Years (2017-2019)



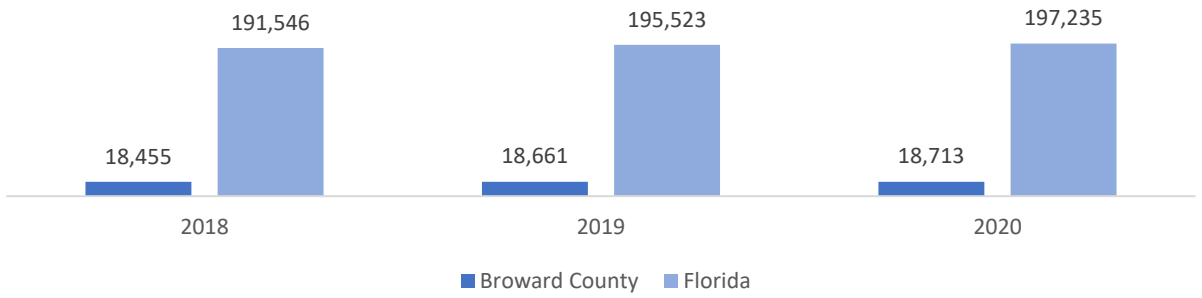
Source: Department of Children and Families, Florida Safe Families Network Data Mart, Rate per 100,000

Figure 19: Broward County Estimated Number of Seriously Mentally Ill Adults (2018-2020)



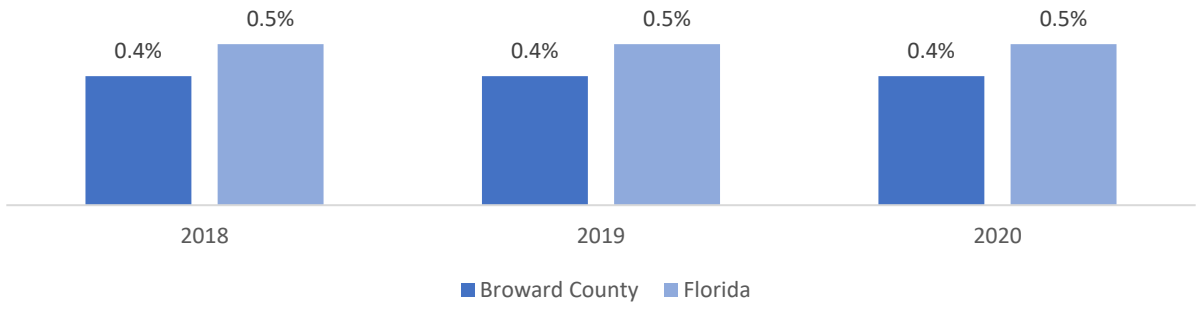
Source: Estimates based on Department of Health and Human Resource Report Mental Health U.S. 1995

Figure 20: Broward County Estimated Number of Emotionally Disturbed Youth, Ages 9-17 Years (2018-2020)



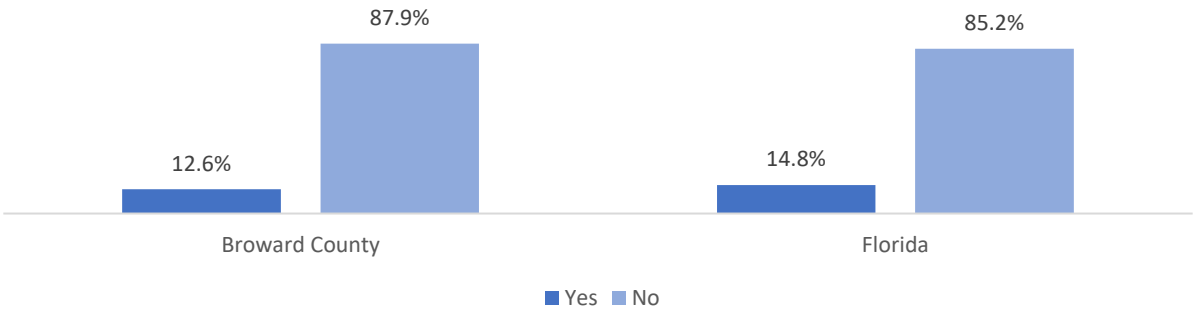
Source: Estimates based on Department of Health and Human Resource Report Mental Health U.S. 1995

Figure 21: Broward County Percentage of Children with Emotional/Behavioral Disability, Grades K-12 (2018-2020)



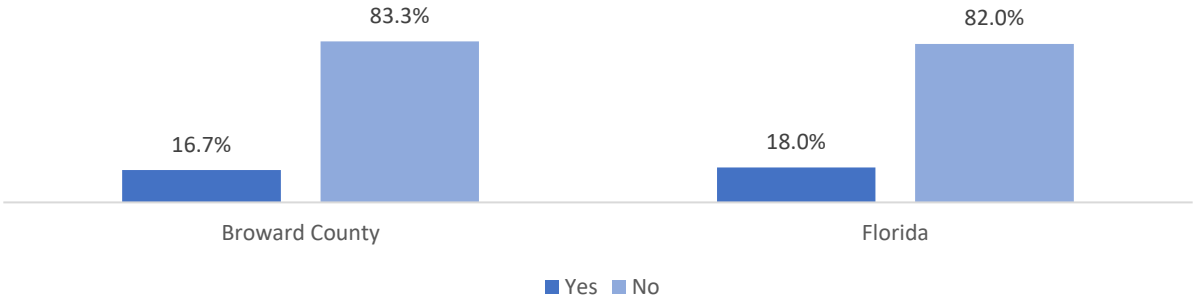
Source: Florida Department of Education, Education Information and Accountability Services (EIAS)

Figure 22: Broward County Percentage of Adults Who Are Current Smokers (2017-2019)



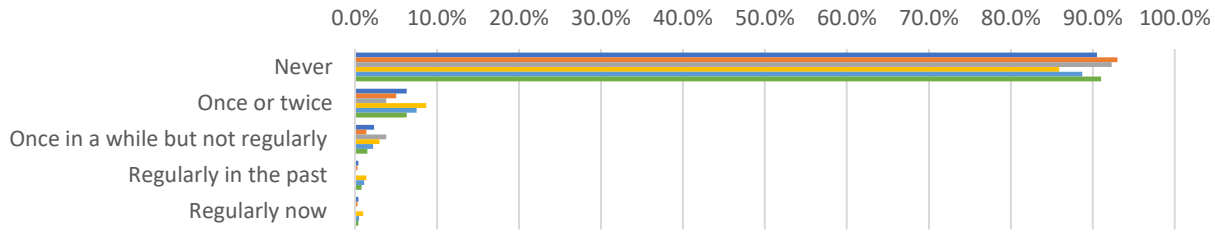
Source: Behavioral Risk Factor Surveillance System

Figure 23: Broward County Percentage of Adults Who Engage in Heavy or Binge Drinking (2017-2019)



Source: Behavioral Risk Factor Surveillance System

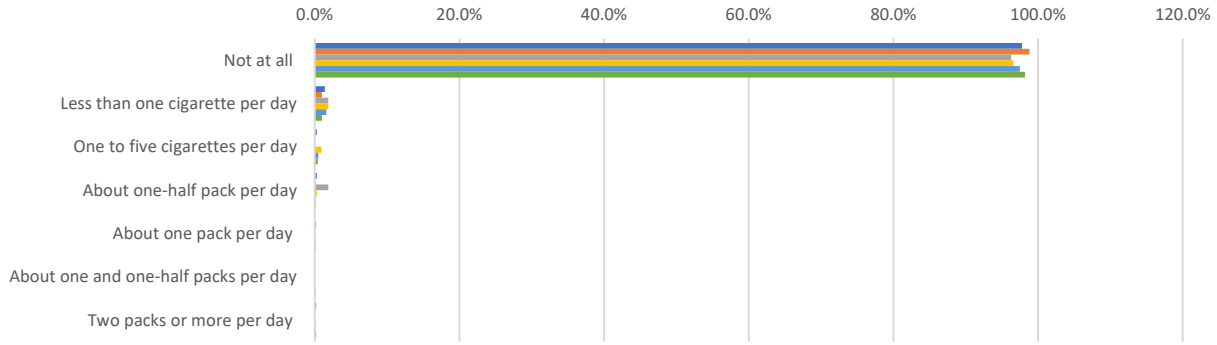
Figure 24: Broward County Having Ever Smoked Cigarettes (MS&HS 2016-2020)



	Regularly now	Regularly in the past	Once in a while but not regularly	Once or twice	Never
Broward County 2016	0.4%	0.4%	2.3%	6.3%	90.5%
Broward County 2018	0.3%	0.3%	1.4%	5.0%	93.0%
Broward County 2020	0.0%	0.0%	3.8%	3.8%	92.3%
Florida 2016	1.0%	1.4%	3.0%	8.7%	85.9%
Florida 2018	0.5%	1.1%	2.2%	7.5%	88.7%
Florida 2020	0.4%	0.8%	1.5%	6.3%	91.0%

Source: Florida Youth Substance Abuse Survey

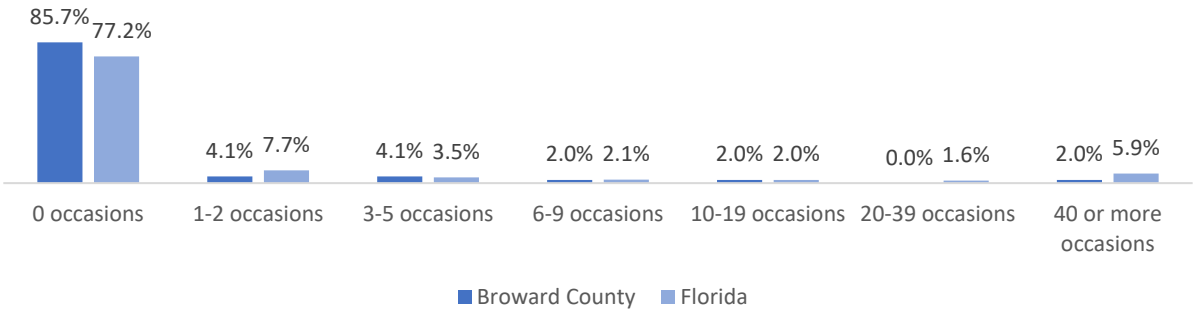
Figure 25: Broward County – How Frequently Have You Smoked Cigarettes in the Past 30 Days? (MS&HS 2016-2020)



	Two packs or more per day	About one and one-half packs per day	About one pack per day	About one-half pack per day	One to five cigarettes per day	Less than one cigarette per day	Not at all
Broward County 2016	0.2%	0.0%	0.0%	0.3%	0.3%	1.4%	97.8%
Broward County 2018	0.0%	0.0%	0.2%	0.0%	0.0%	1.0%	98.8%
Broward County 2020	0.0%	0.0%	0.0%	1.9%	0.0%	1.9%	96.3%
Florida 2016	0.1%	0.0%	0.1%	0.3%	0.9%	1.9%	96.6%
Florida 2018	0.1%	0.0%	0.1%	0.1%	0.5%	1.6%	97.5%
Florida 2020	0.2%	0.1%	0.1%	0.1%	0.4%	1.0%	98.2%

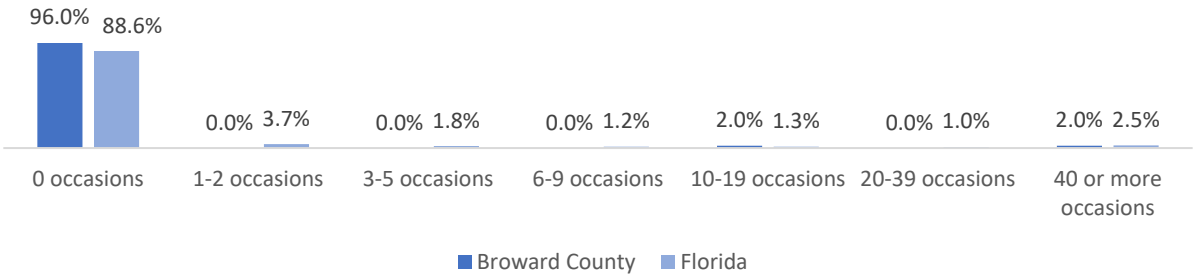
Source: Florida Youth Substance Abuse Survey

Figure 26: Broward County – On How Many Occasions Have You Vaped Nicotine in Your Lifetime? (MS&HS 2020)



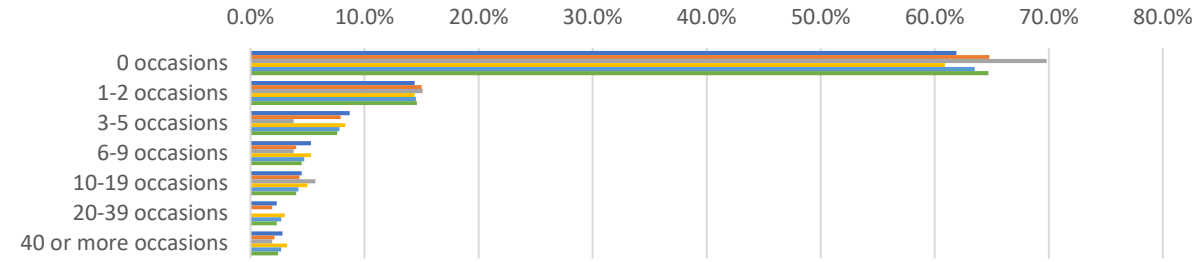
Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

Figure 27: Broward County – On How Many Occasions Have You Vaped Nicotine During the Past 30 Days? (MS&HS 2020)



Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

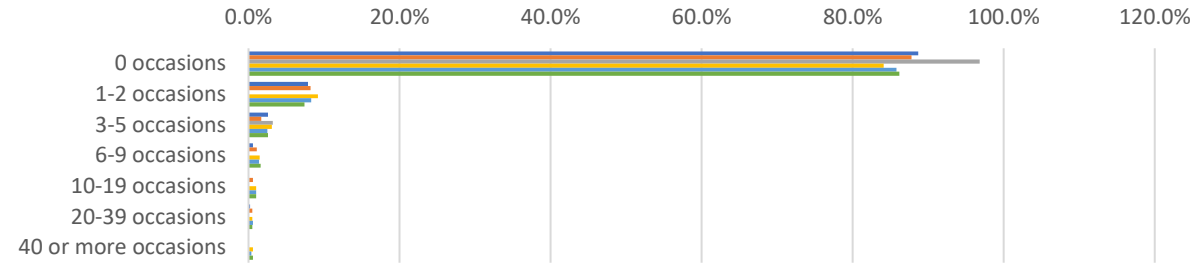
Figure 28: Broward County - On How Many Occasions Have You Had Alcoholic Beverages to Drink in Your Lifetime? (MS&HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
Broward County 2016	2.8%	2.3%	4.5%	5.3%	8.7%	14.4%	61.9%
Broward County 2018	2.1%	1.9%	4.3%	4.0%	7.9%	15.0%	64.8%
Broward County 2020	1.9%	0.0%	5.7%	3.8%	3.8%	15.1%	69.8%
Florida 2016	3.2%	3.0%	5.0%	5.3%	8.3%	14.4%	60.9%
Florida 2018	2.7%	2.7%	4.2%	4.7%	7.8%	14.5%	63.5%
Florida 2020	2.4%	2.3%	4.0%	4.5%	7.6%	14.6%	64.7%

Source: Florida Youth Substance Abuse Survey. Includes beer, wine, or hard liquor. More than a few sips.

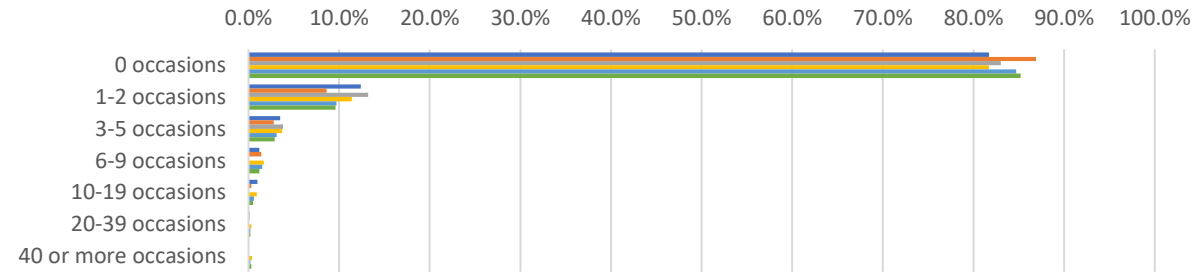
Figure 29: Broward County – On How Many Occasions in Your Lifetime Have You Woken Up After a Night of Drinking Alcoholic Beverages and Not Been Able to Remember Things You Did or the Places You Went? (HS Only 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
Broward County 2016	0.0%	0.2%	0.0%	0.6%	2.6%	7.9%	88.7%
Broward County 2018	0.0%	0.5%	0.6%	1.1%	1.7%	8.2%	87.8%
Broward County 2020	0.0%	0.0%	0.0%	0.0%	3.2%	0.0%	96.8%
Florida 2016	0.6%	0.5%	1.0%	1.5%	3.1%	9.2%	84.1%
Florida 2018	0.4%	0.6%	1.0%	1.4%	2.5%	8.3%	85.8%
Florida 2020	0.6%	0.5%	1.0%	1.6%	2.6%	7.4%	86.2%

Source: Florida Youth Substance Abuse Survey

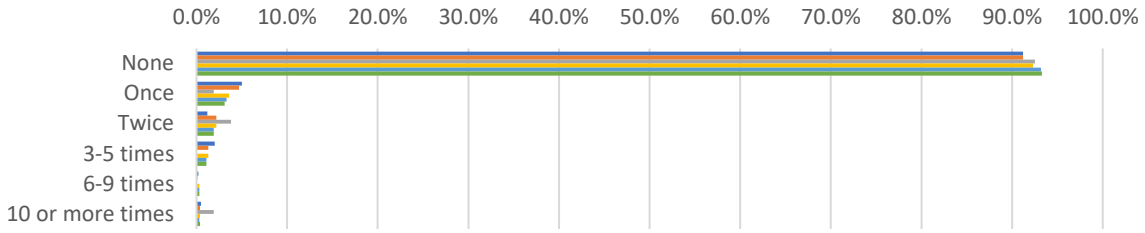
Figure 30: Broward County – On How Many Occasions Have You Had Beer, Wine, or Hard Liquor in the Past 30 Days? (MS&HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
Broward County 2016	0.0%	0.1%	1.0%	1.2%	3.5%	12.4%	81.7%
Broward County 2018	0.0%	0.1%	0.3%	1.4%	2.8%	8.6%	86.9%
Broward County 2020	0.0%	0.0%	0.0%	0.0%	3.8%	13.2%	83.0%
Florida 2016	0.4%	0.3%	0.9%	1.7%	3.7%	11.4%	81.7%
Florida 2018	0.2%	0.2%	0.6%	1.5%	3.1%	9.7%	84.7%
Florida 2020	0.3%	0.2%	0.5%	1.2%	2.9%	9.6%	85.2%

Source: Florida Youth Substance Abuse Survey

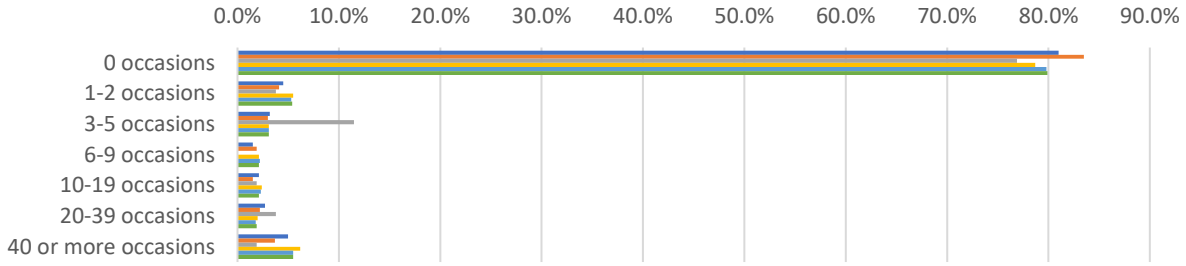
Figure 31: Broward County – Think Back Over the Past 2 Weeks...How Many Times Have You Had Five or More Alcoholic Drinks in a Row? (MS&HS 2016-2020)



	10 or more times	6-9 times	3-5 times	Twice	Once	None
Broward County 2016	0.5%	0.2%	2.0%	1.2%	5.0%	91.2%
Broward County 2018	0.4%	0.1%	1.3%	2.2%	4.7%	91.2%
Broward County 2020	1.9%	0.0%	0.0%	3.8%	1.9%	92.5%
Florida 2016	0.4%	0.3%	1.3%	2.2%	3.6%	92.3%
Florida 2018	0.3%	0.3%	1.1%	1.9%	3.3%	93.2%
Florida 2020	0.4%	0.3%	1.1%	1.9%	3.1%	93.3%

Source: Florida Youth Substance Abuse Survey

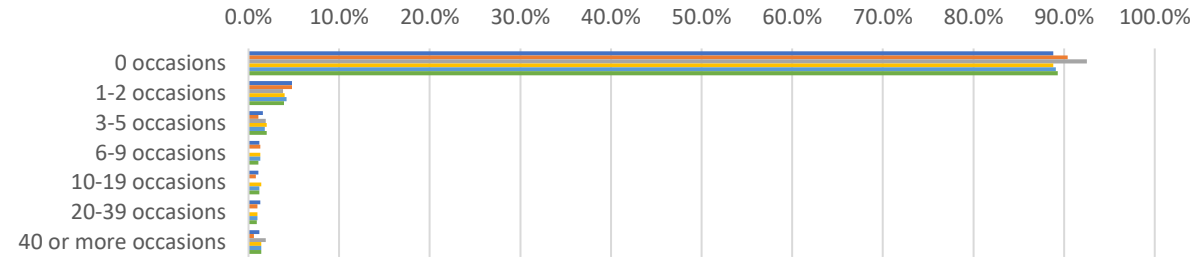
Figure 32: Broward County – On How Many Occasions Have You Used Marijuana or Hashish in Your Lifetime? (MS&HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
Broward County 2016	5.0%	2.7%	2.1%	1.5%	3.2%	4.5%	81.0%
Broward County 2018	3.7%	2.2%	1.5%	1.9%	3.0%	4.1%	83.5%
Broward County 2020	1.9%	3.8%	1.9%	0.0%	11.5%	3.8%	76.9%
Florida 2016	6.2%	2.0%	2.4%	2.1%	3.1%	5.5%	78.7%
Florida 2018	5.5%	1.8%	2.3%	2.2%	3.1%	5.3%	79.8%
Florida 2020	5.5%	1.9%	2.1%	2.1%	3.1%	5.4%	79.9%

Source: Florida Youth Substance Abuse Survey

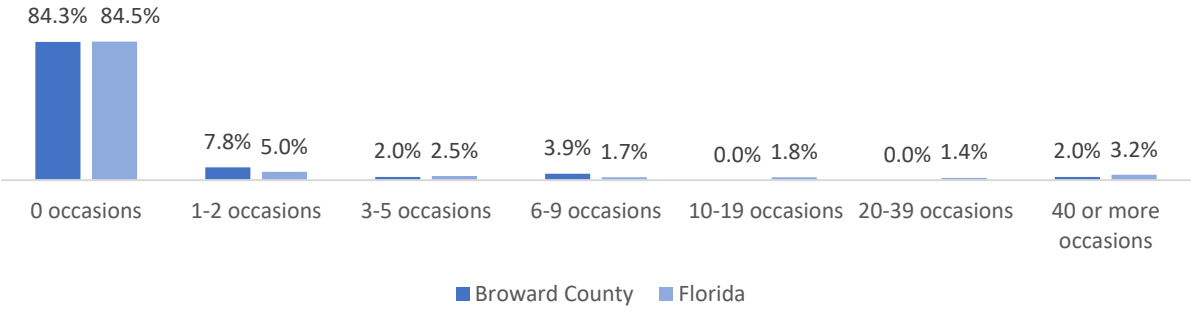
Figure 33: Broward County – On How Many Occasions Have You Used Marijuana or Hashish During the Past 30 Days? (MS&HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
Broward County 2016	1.2%	1.3%	1.1%	1.2%	1.6%	4.8%	88.8%
Broward County 2018	0.6%	1.0%	0.8%	1.3%	1.1%	4.8%	90.4%
Broward County 2020	1.9%	0.0%	0.0%	0.0%	1.9%	3.8%	92.5%
Florida 2016	1.4%	1.0%	1.4%	1.3%	2.0%	4.0%	88.8%
Florida 2018	1.4%	1.0%	1.2%	1.3%	1.8%	4.2%	89.1%
Florida 2020	1.4%	0.9%	1.2%	1.1%	2.0%	3.9%	89.3%

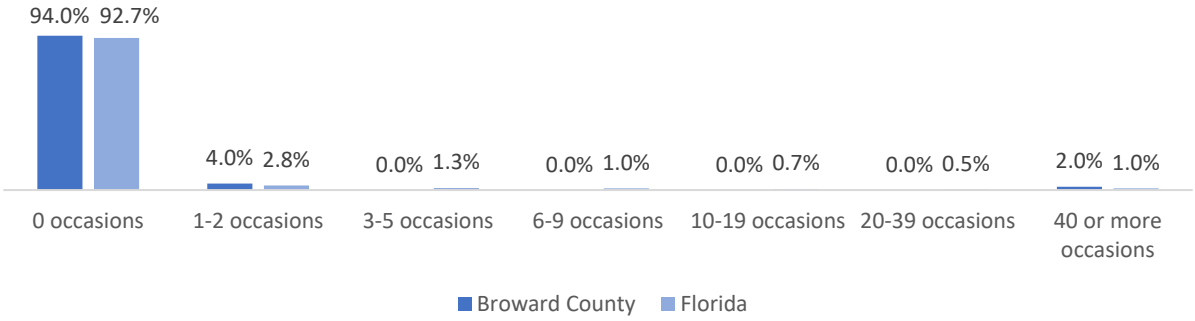
Source: Florida Youth Substance Abuse Survey

Figure 34: Broward County – On How Many Occasions Have You Vaped Marijuana in Your Lifetime? (MS&HS 2016-2020)



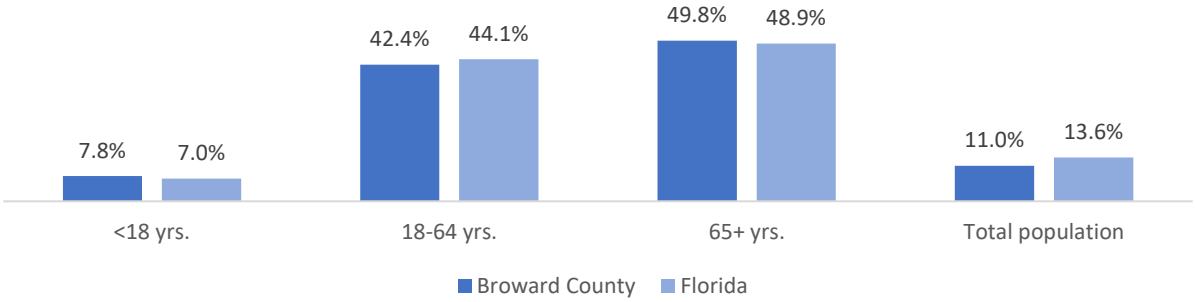
Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

Figure 35: Broward County – On How Many Occasions Have You Vaped Marijuana in the Past 30 Days? (MS&HS 2016-2020)



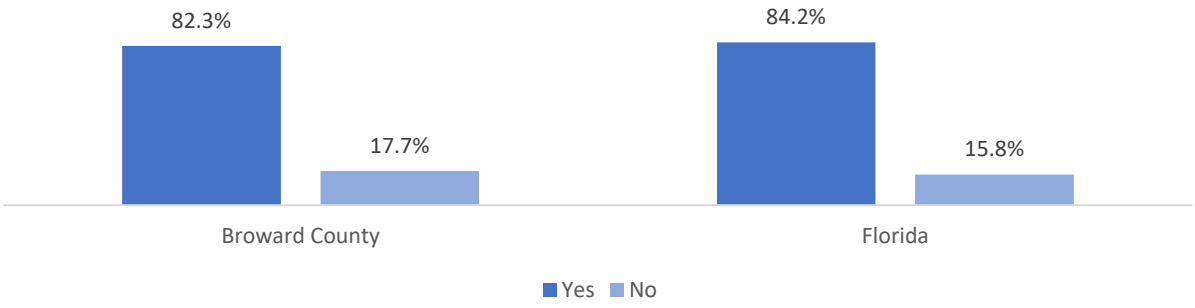
Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

Figure 36: Broward County Civilian Noninstitutionalized Population with a Disability (2016-2020)



Source: U.S. Census Bureau, American Community Survey. Disability includes: Hearing, Vision, Cognitive, Ambulatory, Self-Care, and Independent Living

Figure 37: Broward County Percentage of Adults with Any Type of Health Care Insurance Coverage (2013-2019)



Source: Behavioral Risk Factor Surveillance System

BBHC SERVICE AREA CLIENT DEMOGRAPHIC PROFILE

Client Population

BBHC-funded organizations served 16,247 clients in FY20-21. Over 90% of clients resided in Broward County (1,534 clients). Clients who reported living in another county accounted for nearly 3%. Just over 60% of adults were enrolled in the AMH program and 25.2% in the ASA program. The remaining clients were in the CMH program, at 8.2%, and the CSA program at 6.1%.

Gender

Males represented more than 50% of all clients in the AMH, ASA, CMH, and CSA programs ranging from 52% in the ASA program to 71% in the CSA program. Females accounted for 45% of clients in AMH program but only 36% of those in the ASA program. There were 10% more women enrolled in mental health programs (45%) than in substance abuse programs (35%).

Race

The majority of BBHC clients were White (45%). Black BBHC clients accounted for 40% of the total client population. The racial diversity among AMH clients was greater when compared to ASA clients where 57% of the population was White and 31% were Black. Clients in child programs followed the same trend with a more diverse racial distribution among CMH clients when compared the CSA clients.

Ethnicity

The percentage of Hispanics/Latino in the BBHC client population was 19.7%. This was less when compared to the Hispanic population in the service area at 30.2%. When comparing the ethnic distribution among programs, clients in the CMH program closely matched the service area where Hispanic/Latino clients accounted for 28%.

Age Range

Adults, ages 25-44 years of age, accounted for 45.1% AMH clients and 59.2% of ASA clients. Among these, adults ages 25-34 years, made up the largest proportion of both AMH and ASA clients when comparing age ranges. Children under age 5 years accounted for less than 0.5% of CSA clients but 11% of CMH clients. There was a higher percentage of older teens, ages 15-19 years of age, in the CSA (76.2%) program when compared to those in the CMH program (42.8%).

Residential Status

A higher percentage of AMH clients lived independently alone (18.5%) when compared to ASA clients at 12.2%. Eighty percent of clients in the CSA program lived dependently with relatives. This was higher when compared to the percentage of clients in the CMH program where 55.5% lived dependently with relatives.

Educational Attainment

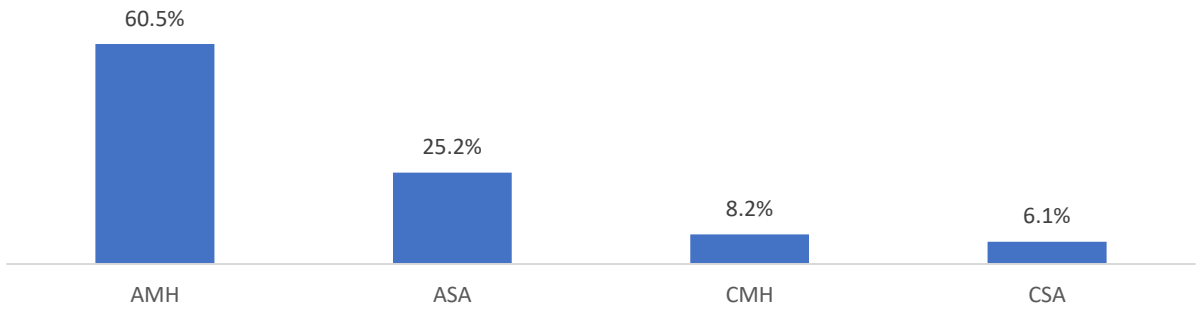
Among BBHC adults, 33.3% of clients were high school graduates who did not go on to further education. Over 40% of the total client population had less than a high school education. Among adult programs, 38.7% of AMH clients and 36.5% of ASA clients did not attain more than a high school education. The percentages of adult BBHC clients who earned an associate degree or bachelor's degree ranged from 10.7% for AMH clients to 13.1% for ASA clients.

Employment Status

Unemployment for BBHC clients was 41%. Full-time workers accounted for 10% of AMH client and 17.4% of ASA clients. For all BBHC clients, 8.9% were employed part time.

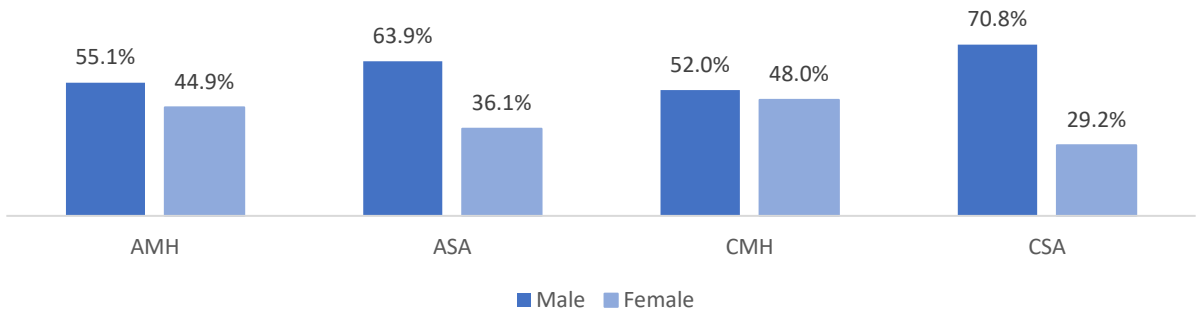
CLIENT DEMOGRAPHIC CHARTS

Figure 38: BBHC Clients by Program



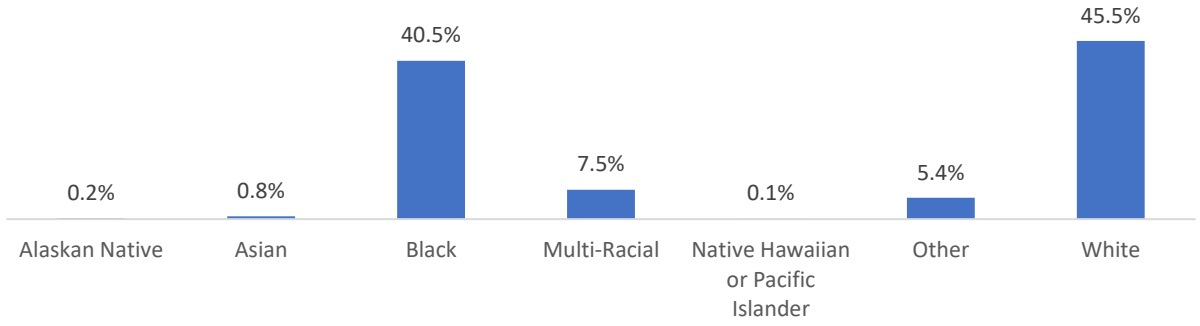
Source: BBHC Client Data

Figure 39: BBHC Clients by Program and Gender



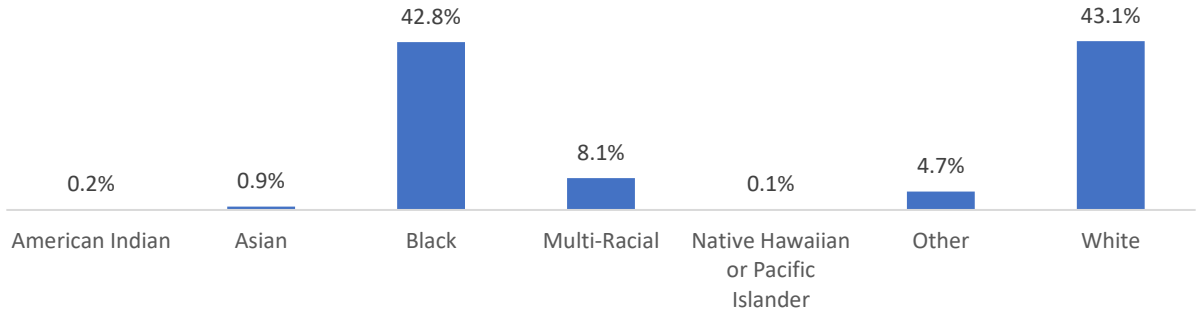
Source: BBHC Client Data

Figure 40: BBHC Clients by Race



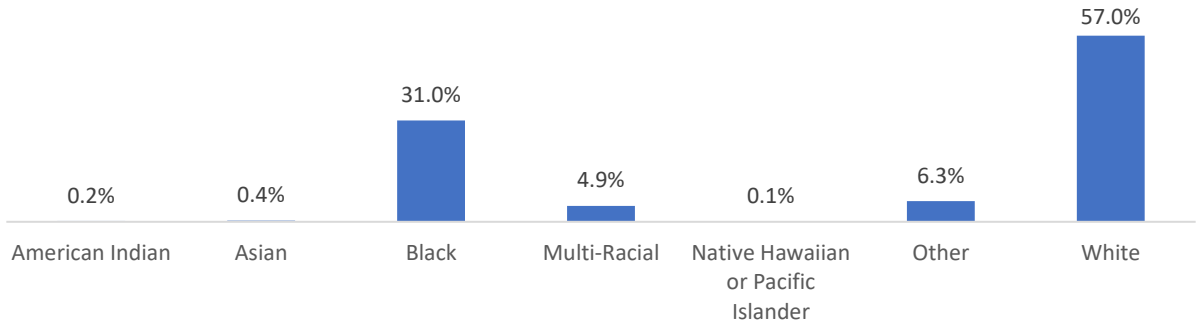
Source: BBHC Client Data

Figure 41: BBHC AMH Clients by Race



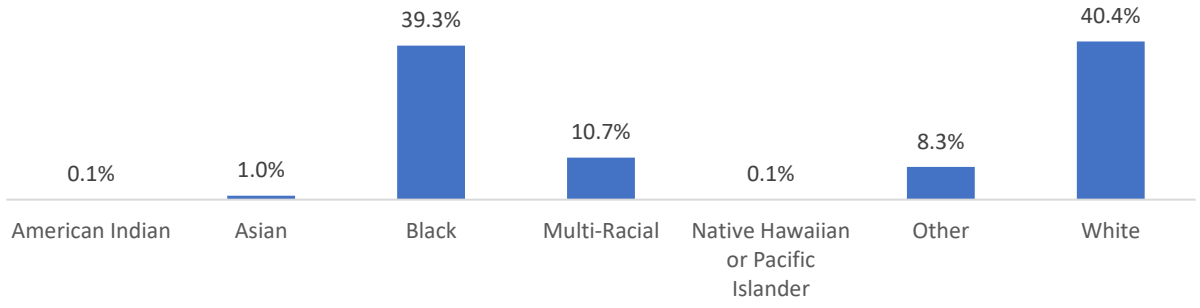
Source: BBHC Client Data

Figure 42: BBHC ASA Clients by Race



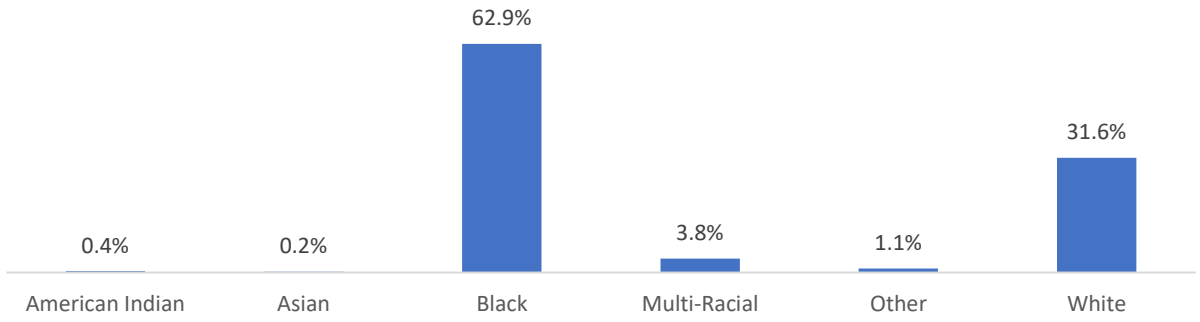
Source: BBHC Client Data

Figure 43: BBHC CMH Clients by Race



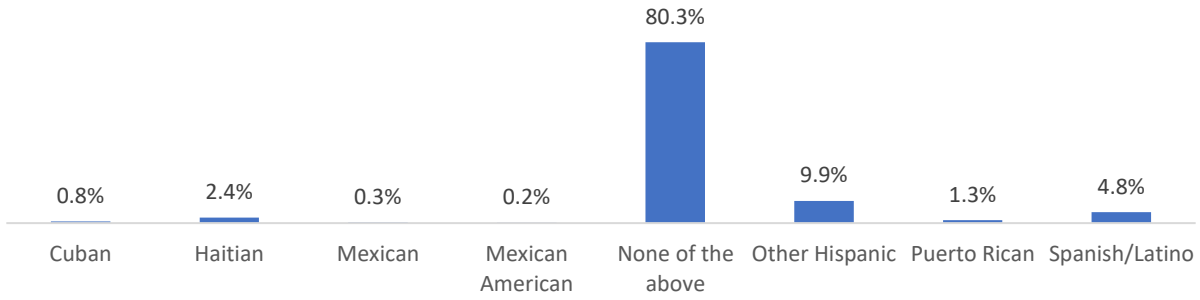
Source: BBHC Client Data

Figure 44: BBHC CSA Clients by Race



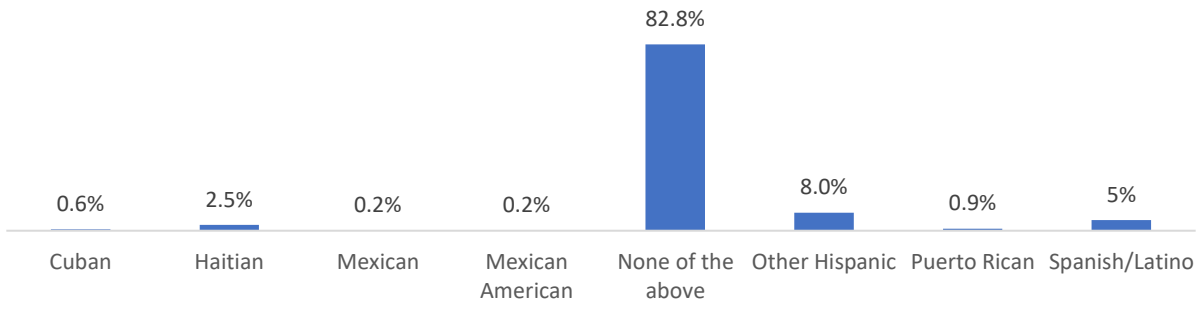
Source: BBHC Client Data

Figure 45: BBHC Clients by Ethnicity



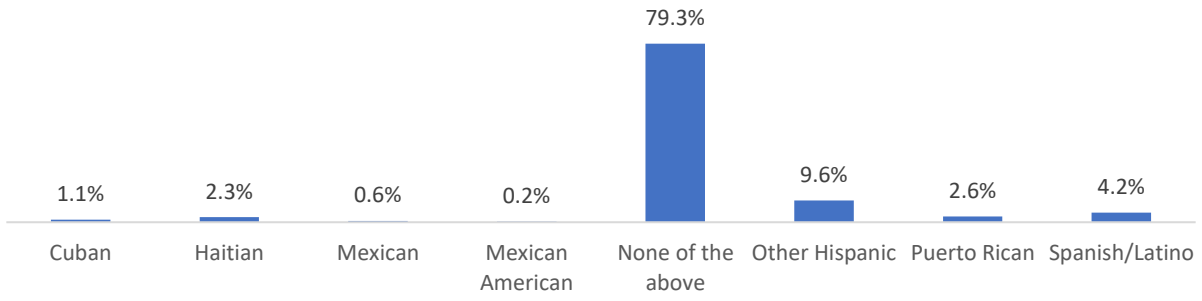
Source: BBHC Client Data

Figure 46: BBHC AMH Clients by Ethnicity



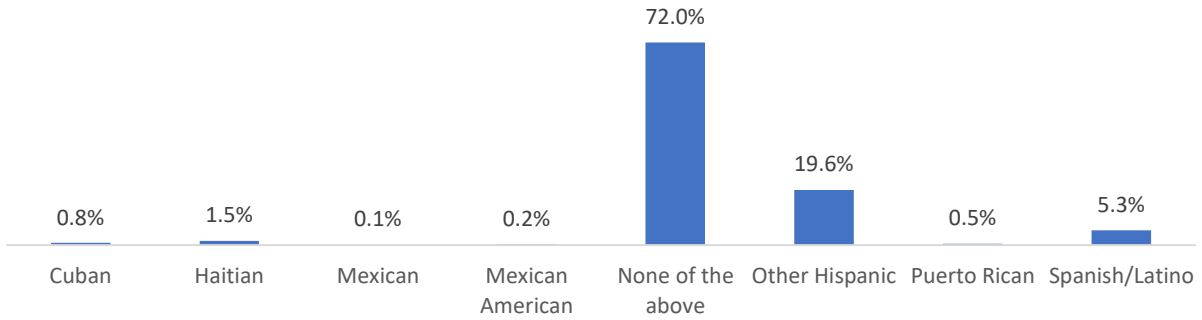
Source: BBHC Client Data

Figure 47: BBHC ASA Clients by Ethnicity



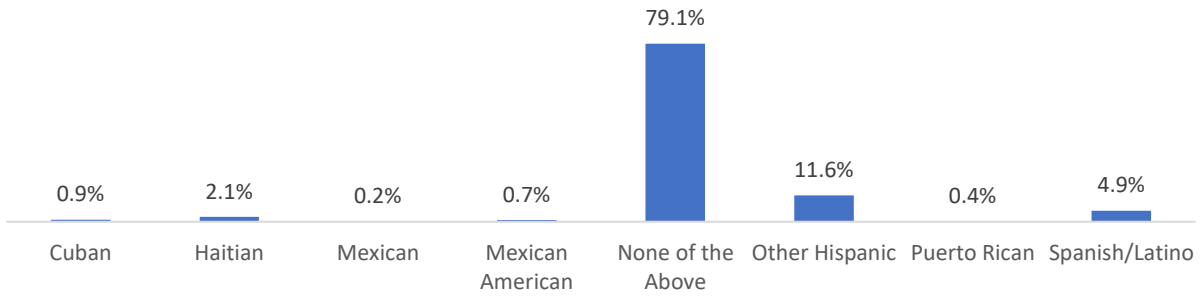
Source: BBHC Client Data

Figure 48: BBHC CMH Clients by Ethnicity



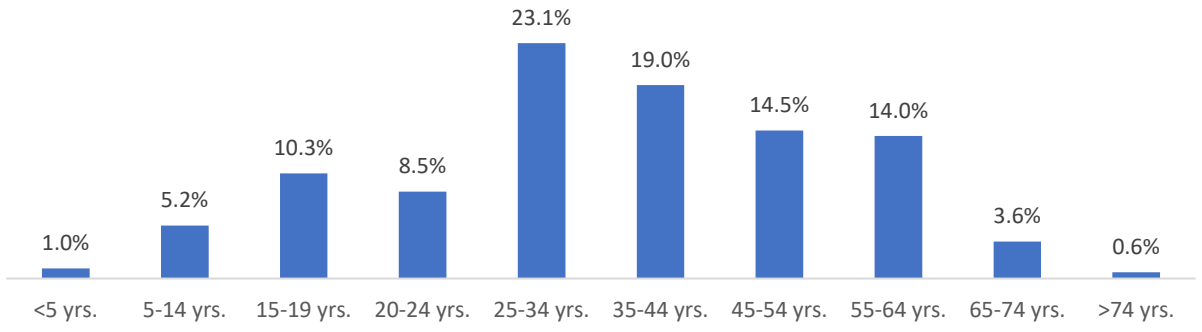
Source: BBHC Client Data

Figure 49: BBHC CSA Clients by Ethnicity



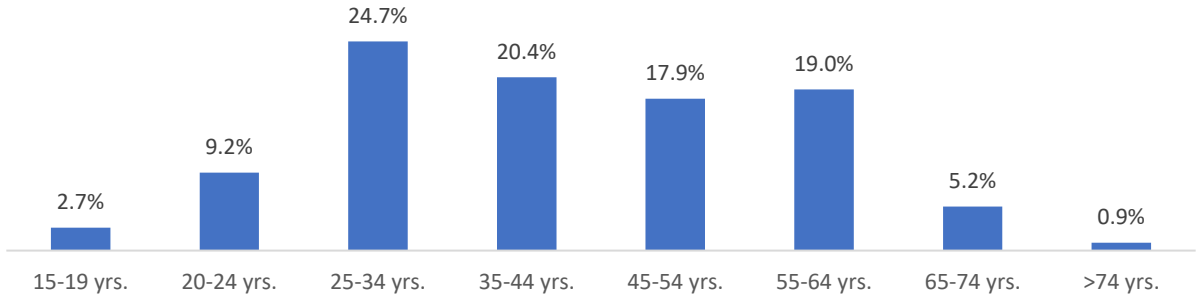
Source: BBHC Client Data

Figure 50: BBHC Clients by Age Range



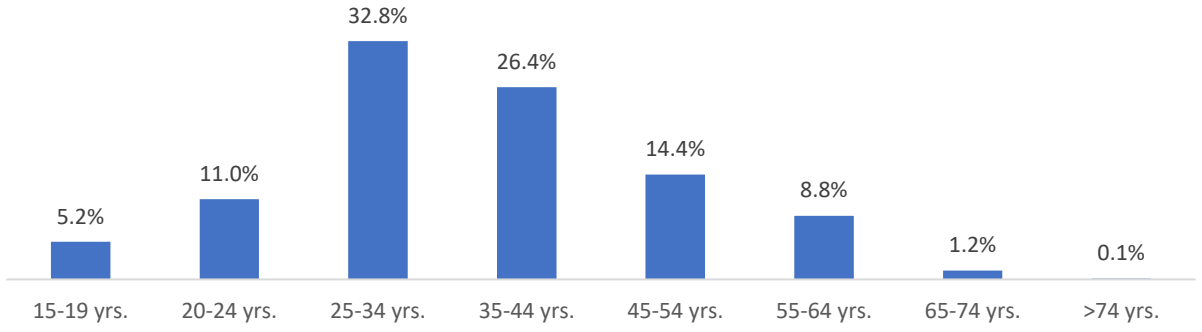
Source: BBHC Client Data

Figure 51: BBHC AMH Clients by Age Range



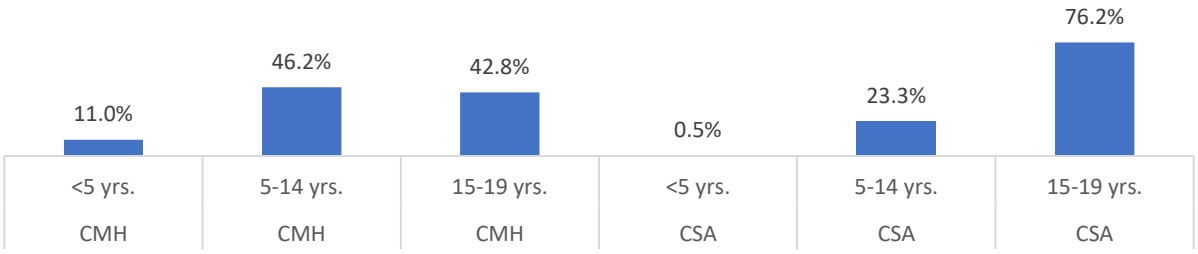
Source: BBHC Client Data

Figure 52: BBHC ASA Clients by Age Range



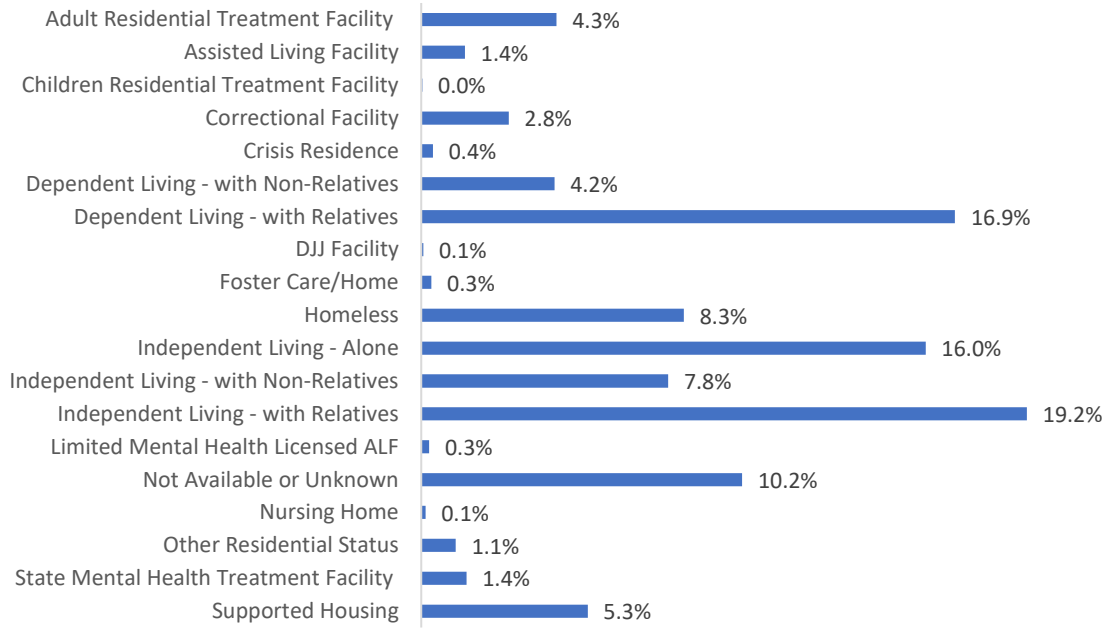
Source: BBHC Client Data

Figure 53: BBHC CMH and CSA Clients by Age Range



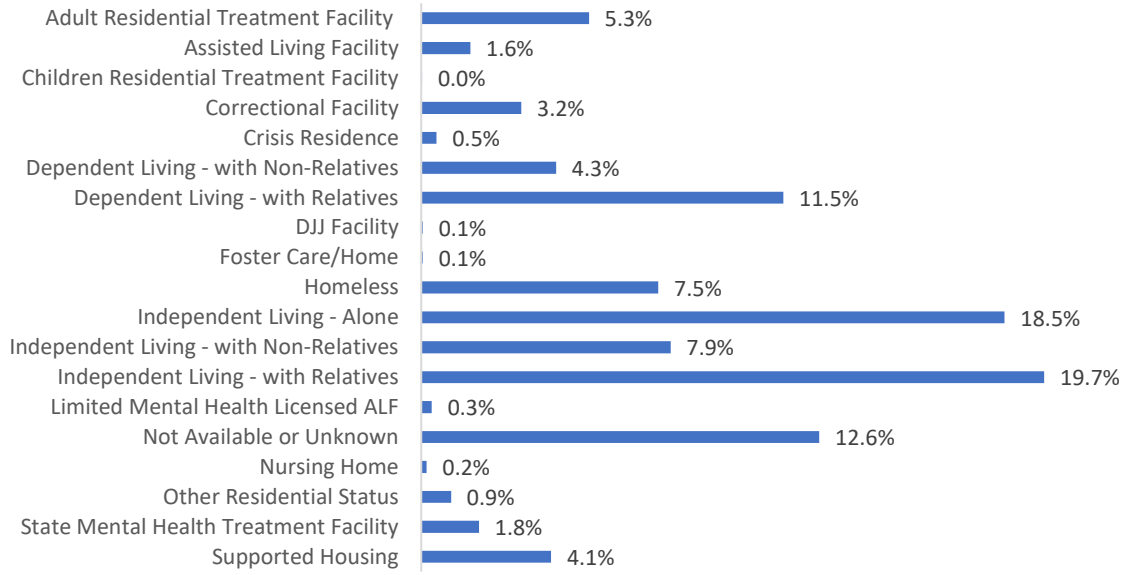
Source: BBHC Client Data

Figure 54: BBHC Clients by Residential Status



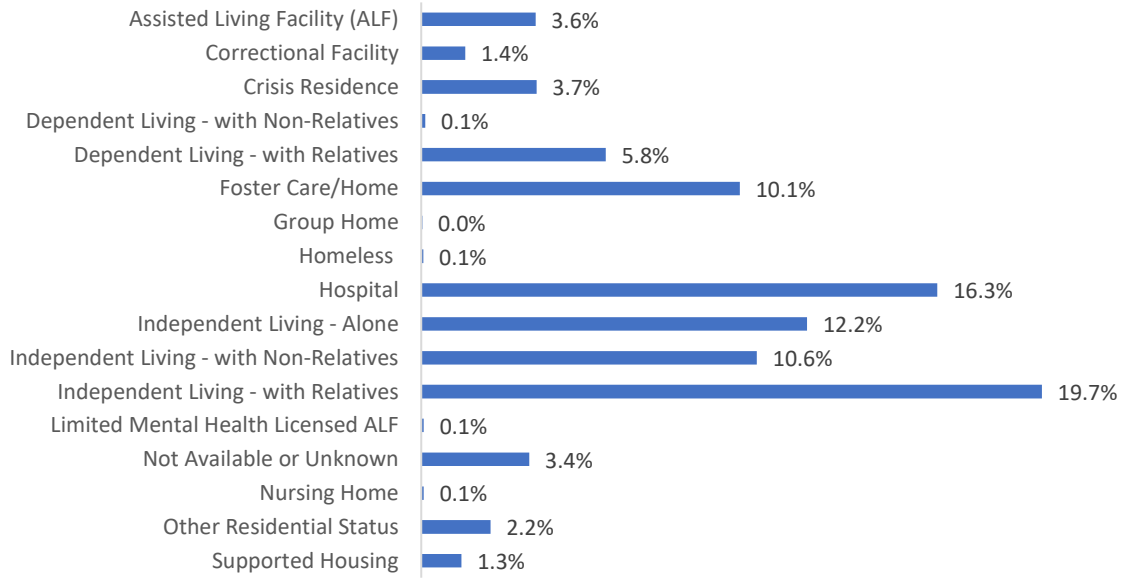
Source: BBHC Client Data

Figure 55: BBHC AMH Clients by Residential Status



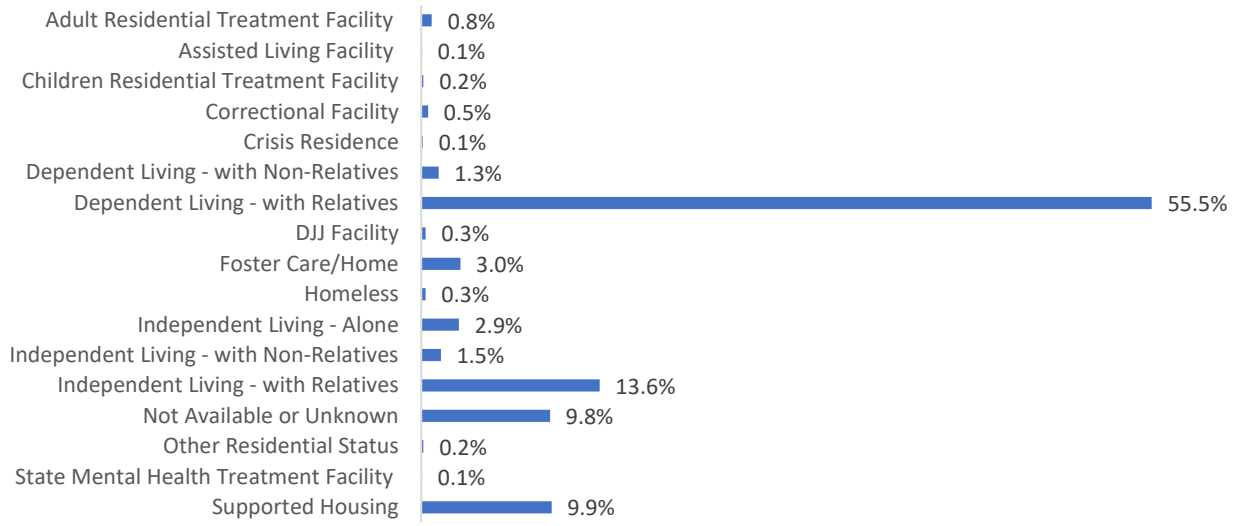
Source: BBHC Client Data

Figure 56: BBHC ASA Clients by Residential Status



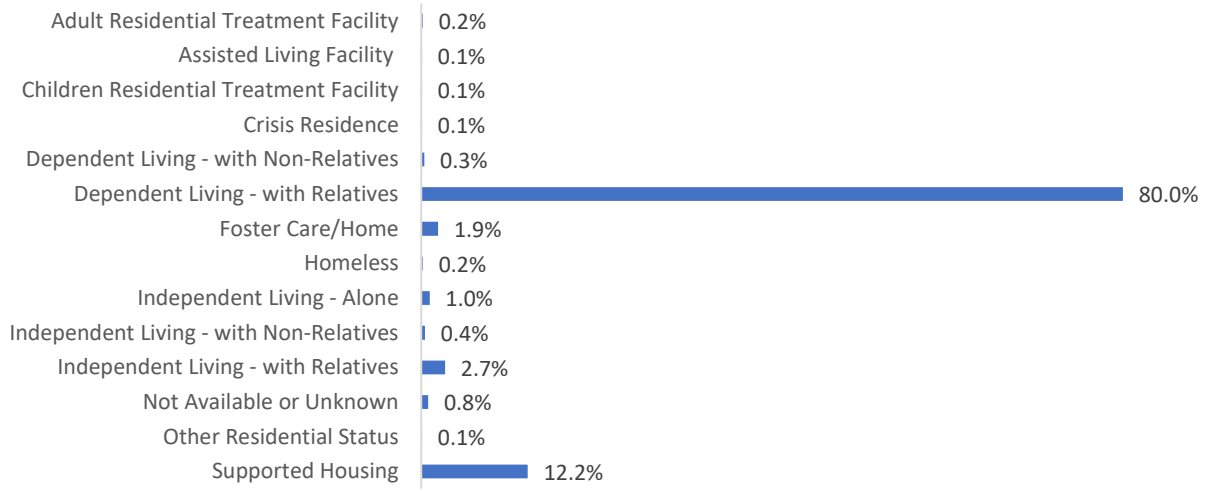
Source: BBHC Client Data

Figure 57: BBHC CMH Clients by Residential Status



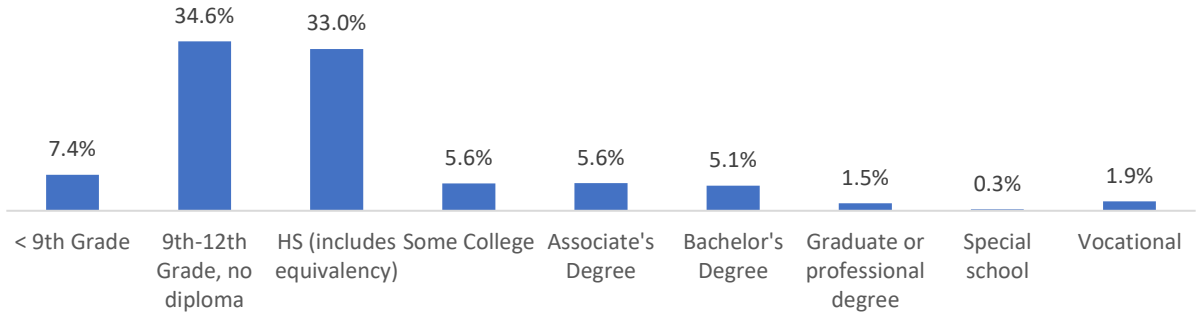
Source: BBHC Client Data

Figure 58: BBHC CSA Clients by Residential Status



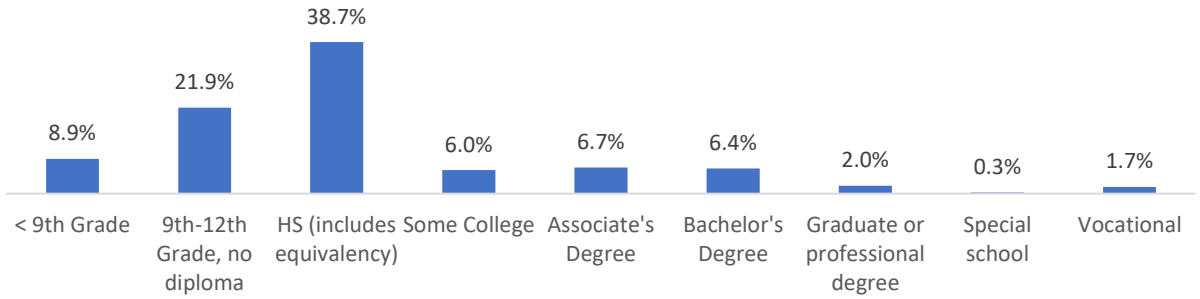
Source: BBHC Client Data

Figure 59: BBHC Clients by Educational Attainment



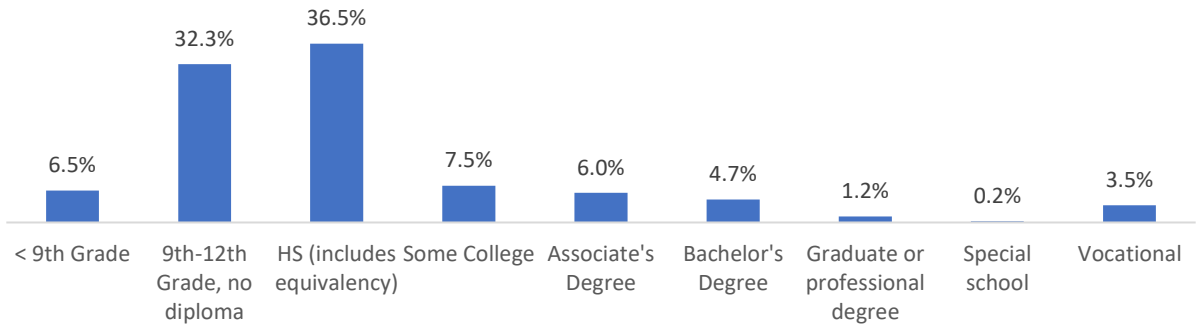
Source: BBHC Client Data

Figure 60: BBHC AMH Clients by Educational Attainment



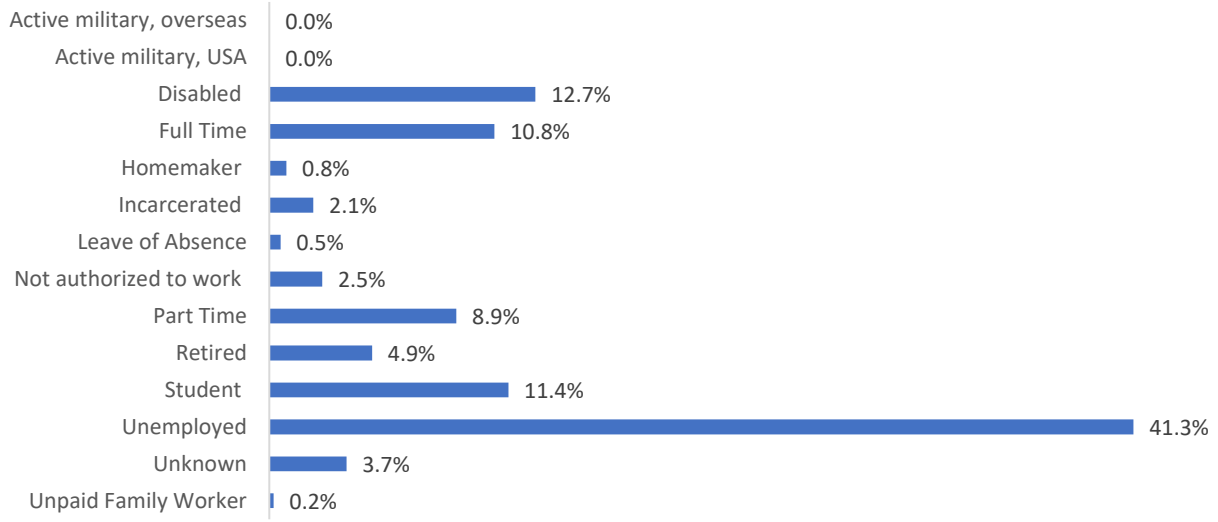
Source: BBHC Client Data

Figure 61: BBHC ASA Clients by Educational Attainment



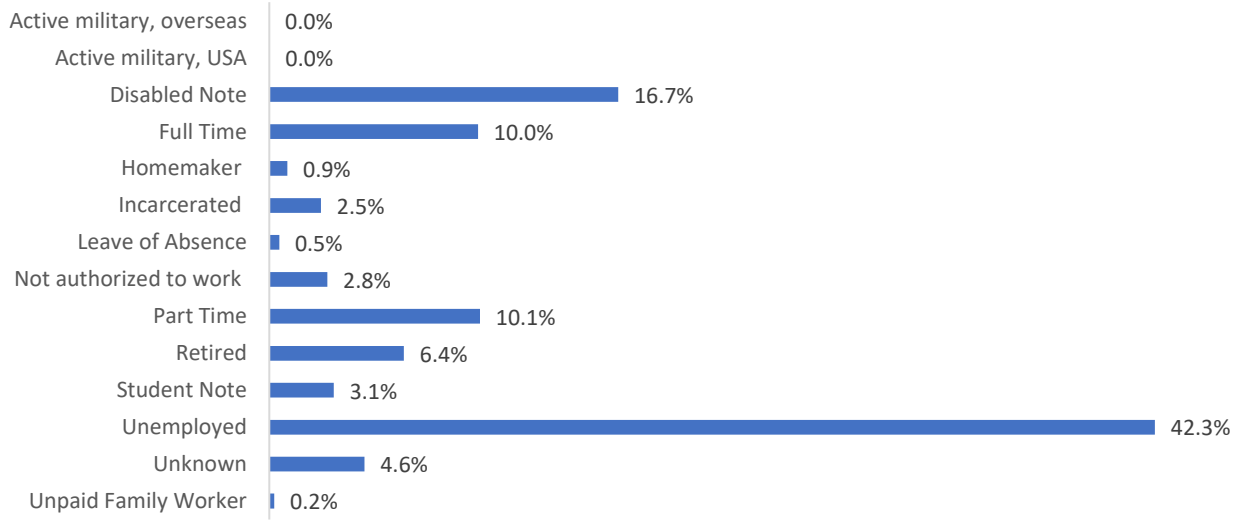
Source: BBHC Client Data

Figure 62: BBHC Clients by Employment Status



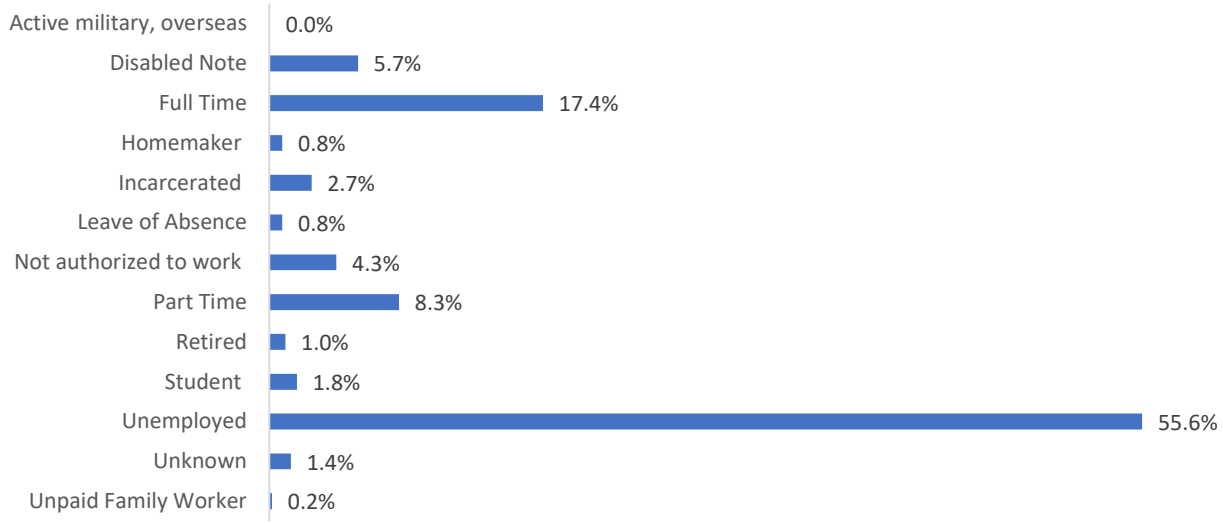
Source: BBHC Client Data

Figure 63: BBHC AMH Clients by Employment Status



Source: BBHC Client Data

Figure 64: BBHC ASA Clients by Employment Status



Source: BBHC Client Data

BROWARD COUNTY HOMELESS POPULATION

The 2021 Council on Homelessness Report states that the Point in Time Count (PIT) data provides a snapshot of homelessness. **Due to the pandemic, the 2021 PIT Count is not directly comparable to prior years' counts.** Typically, Continuums of Care (CoCs- A local geographic area designated by HUD and served by a local planning body, which is responsible for organizing and delivering housing and services to meet the needs of people who are homeless as they move to stable housing and maximum self-sufficiency) conduct a PIT Count of both sheltered and unsheltered households. This year, due to COVID-19 related safety concerns, only six of the 27 CoCs conducted such a count; 10 CoCs did not conduct an unsheltered count; and others conducted a modified form of the unsheltered count. All CoCs conducted a sheltered PIT count. For those that did not conduct an unsheltered count, the CoCs reported zero unsheltered persons, resulting in an undercount of total homelessness. According to the report:

> "Housing is a significant determinant of health, and insufficient housing is a major public health issue. The COVID-19 pandemic has exacerbated housing instability especially for low-income households. In effect, the pandemic has triggered high rates of unemployment, worsened pre-existing behavioral health disorders, and increased stress, anxiety, and depression for others. Increased rates of unemployment also contribute to increasing the prevalence of behavioral health disorders, resulting in more suffering and deaths. Prior to the pandemic, America's affordable housing crisis was already expected to get worse. The ELI housing crisis is evidenced by the fact that people with disabilities are forced to live in segregated and institutional facilities (e.g., nursing homes, state institutions, etc.) and experience homelessness. Many of these individuals need Permanent Supportive Housing."
>
> (Please access the actual report for more information at: 2021CouncilReport.pdf (myflfamilies.com))

Due to the COVID-19 pandemic, this year saw an unprecedented infusion of federal funding to address homelessness and housing instability. With these funds appropriated by Congress, the State, local governments, CoCs, and partner agencies have invested in solutions to homelessness, including rent and utilities assistance, sheltering, outreach, supportive services and more. While these resources have increased Florida's capacity to prevent and end homelessness, the federal funds have strict restrictions on how the funds may be used; they are not interchangeable with the Challenge and Staffing grants provided to CoCs by the State of Florida. State funding remains critical to addressing homelessness in Florida, especially in rural areas and for the many programs that cannot be funded by federal resources due to their restrictions. State funding helps ensure a broad range of programs in Florida, as well as increase the capacity of the CoCs to administer the federal funding and other resources.

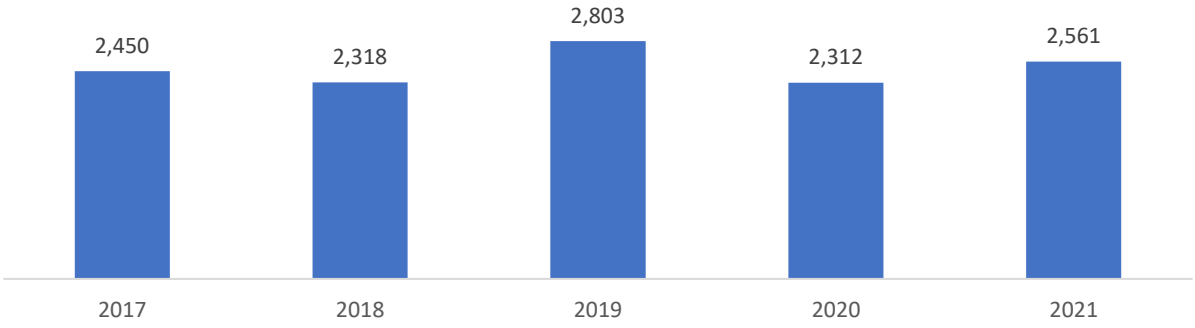
In 2021, the Florida Council on Homelessness reported there were 2,561 homeless individuals in Broward County. Of these, 794 individuals were sheltered and 1,767 were unsheltered. Chronically homeless, defined as continually homeless for over a year, decreased (64.2%) from 581 in 2017 to 208 in 2021. Homelessness among veterans decreased from 197 in 2017 to 182 in 2021. Families experiencing homelessness decreased 20.3% from 2017 to 2021. The number of homeless students, at 2,262 in (2015-2016) increased (125.2%) to 5,094 in the 2019-2020 school year. Of those students who were homeless, over 81.4% were in a sharing housing arrangement and 9% were living in motels.

Figure 65: CoC Funding from Federal and State Sources, District 10 (SFY20-21)

Source	District 10
Total Funding Award	$16,269,151.85
HUD CoC FFY20	$11,813,070.00
State Total	$4,456,081.85
State Challenge	$119,000.00
State ESG-CV	$4,035,920.00
State Staffing	$107,142.85
State Emergency Solutions Grant	$194,019.00

Source: 2021 Florida's Council on Homelessness Annual Report

Figure 66: Total Homeless Population, District 10 (2017-2021)

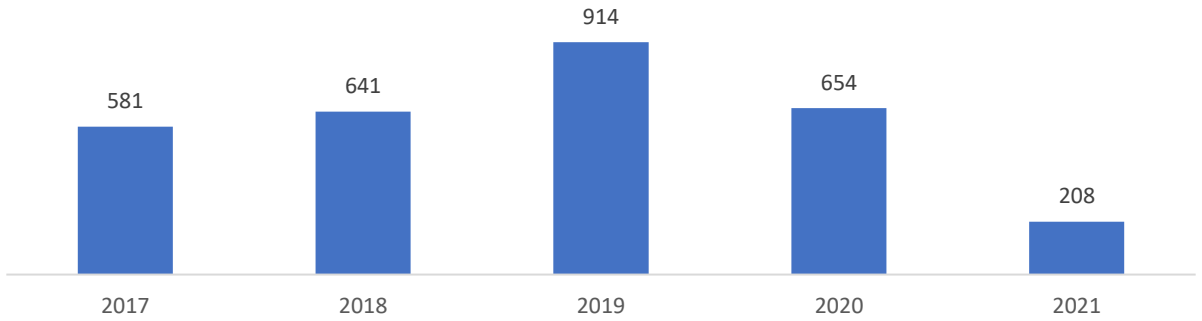


Source: 2021 Florida's Council on Homelessness Annual Report

Figure 67: Total Homeless Population Sheltered and Unsheltered, District 10 (2021)

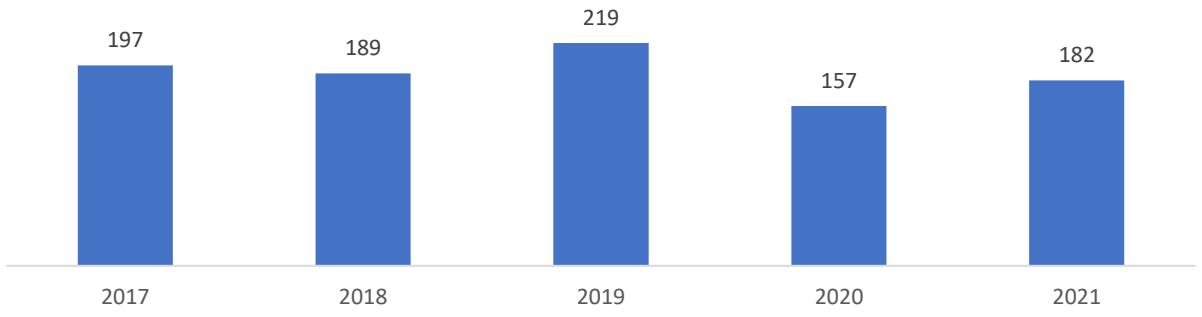
Source: 2021 Florida's Council on Homelessness Annual Report . Broward County conducted a modified unsheltered PIT Count.

Figure 68: Chronic Homelessness, District 10 (2017-2021)



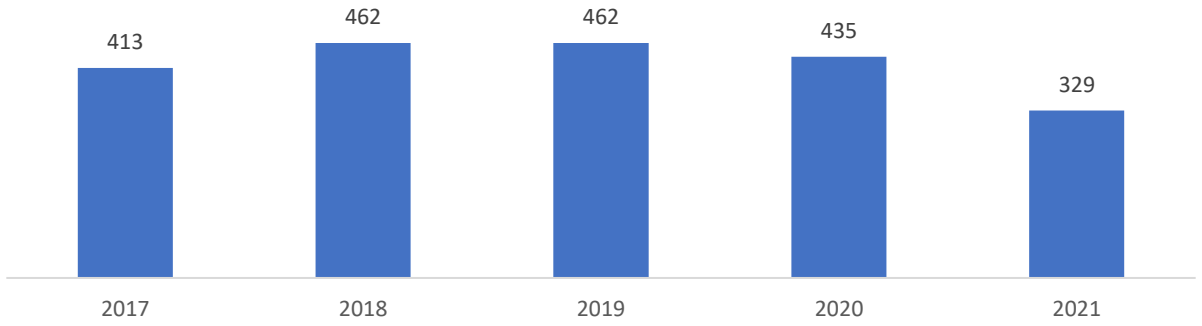
Source: 2021 Florida's Council on Homelessness Annual Report

Figure 69: Homelessness Among Veterans, District 10 (2017-2021)



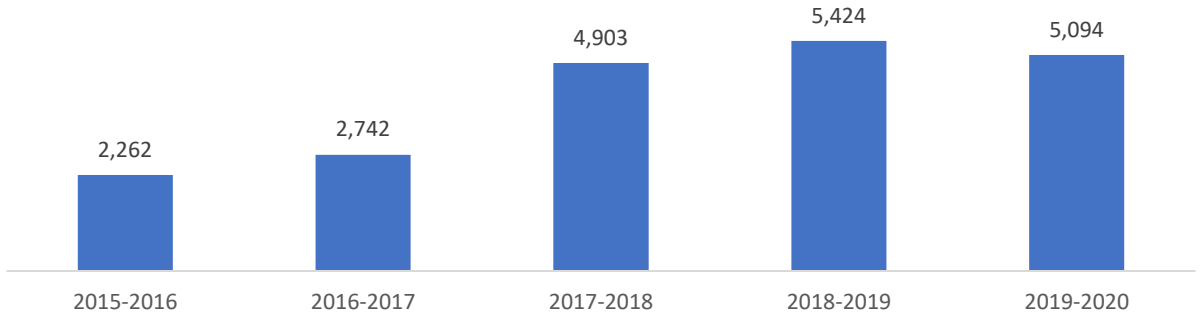
Source: 2021 Florida's Council on Homelessness Annual Report

Figure 70: Family Homelessness – Total Persons in Families with Children, District 10 (2017-2021)



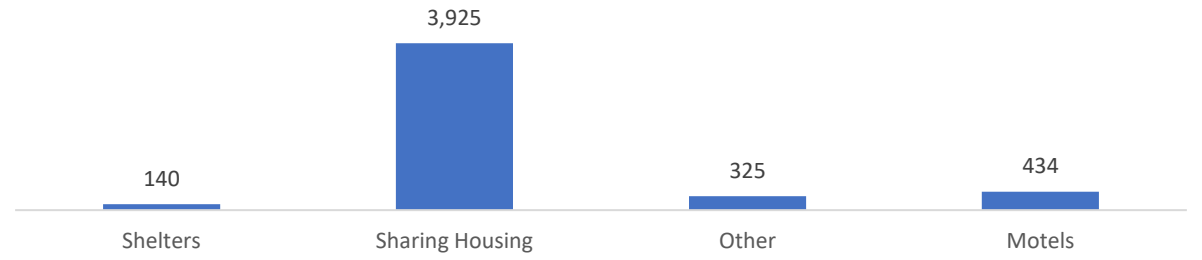
Source: 2021 Florida's Council on Homelessness Annual Report

Figure 71: Florida DOE – Reported Homeless Students in Public Schools, District 06 (2015-2020)



Source: 2021 Florida's Council on Homelessness Annual Report

Figure 72: Reported Homeless Students in Public Schools by Living Situation, District 06 (2019-2020)



Source: 2021 Florida's Council on Homelessness Annual Report

BBHC HOMELESS CLIENT PROFILE

Demographics

A total of 2,492 homeless clients were enrolled in adult and child programs in FY20-21. Of these, 59.6% were in the AMH program and 40% in the ASA program. Clients enrolled in child programs accounted for less than 0.5%. It should be noted that there may be a small percentage of overlap with some clients enrolled in both programs.

The number of homeless male clients (1,708) were more than double the number of homeless women (785). Males accounted for 67% of clients in the AMH and 72% of ASA homeless clients. There was a higher percentage of homeless male clients, at 69%, when compared to the general client population where males accounted for 58% of all clients. Among child programs, females accounted for 67% of CMH and 100% of CSA clients. It should be noted that the number of homeless clients in the CMH and CSA programs was very small so results should be interpreted with caution.

Black homeless clients accounted for 45.7% of those in the AMH program while White homeless clients accounted for 44%. White homeless clients represented the majority of ASA clients at 66.6%. Black homeless clients accounted for 83.3% of CMH participants. The percentage of homeless Hispanic/Latino clients in the AMH program, at 9.8%, was lower when compared to the Hispanic/Latino clients in the ASA at 15%. This was lower when compared to the general client population where 19.7% were Hispanic.

Adults, ages 25-44 years, accounted for 60.4% of ASA clients and 47.5% of AMH clients. Homeless clients 65 years and older accounted for less than 3% of the total homeless client population.

Residential Status

All homeless clients reported their residential status as homeless.

Educational Attainment

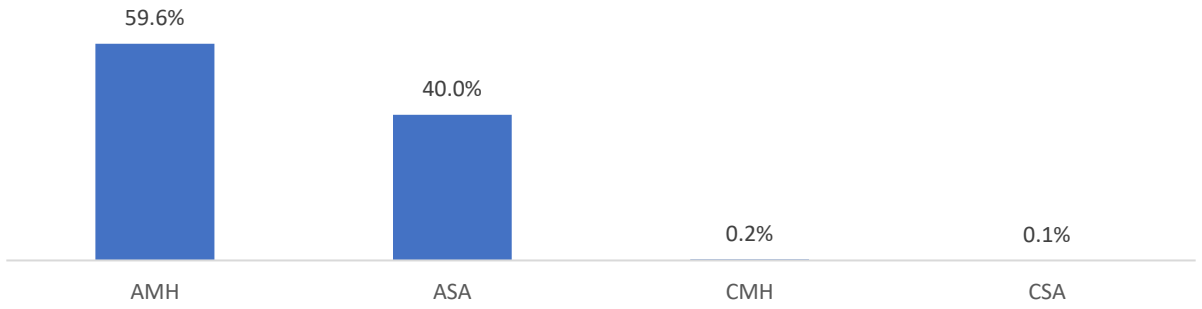
Among the homeless clients, close to 40% did not have a high school education and 33.6% completed their education at the high school level.

Employment Status

Less than 10% of homeless clients were employed (part or full time) and 65.3% were unemployed.

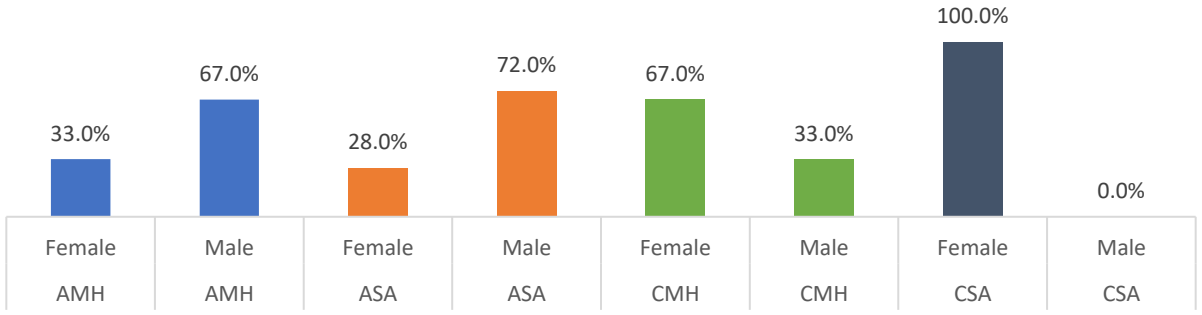
BBHC HOMELESS CLIENT CHARTS

Figure 73: BBHC Homeless Clients by Program



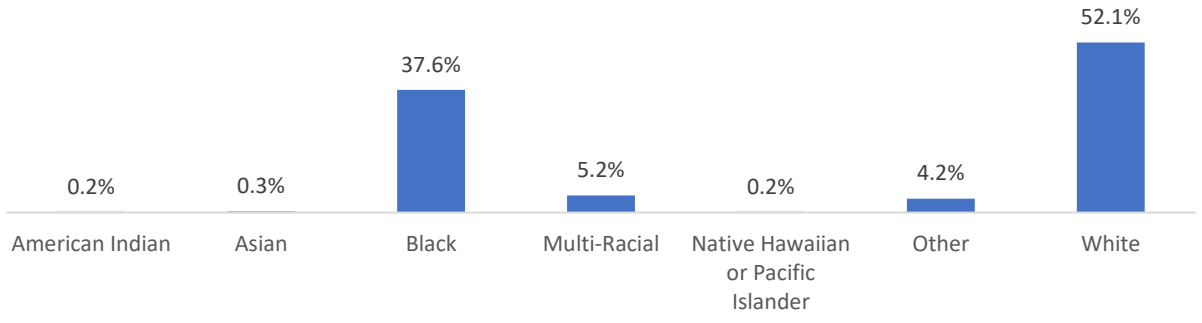
Source: BBHC Client Data

Figure 74: BBHC Homeless Clients by Gender



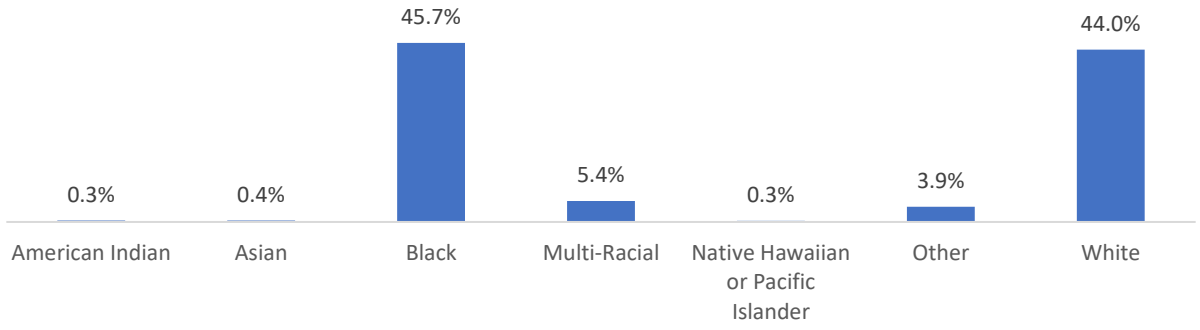
Source: BBHC Client Data

Figure 75: BBHC Homeless Clients by Race



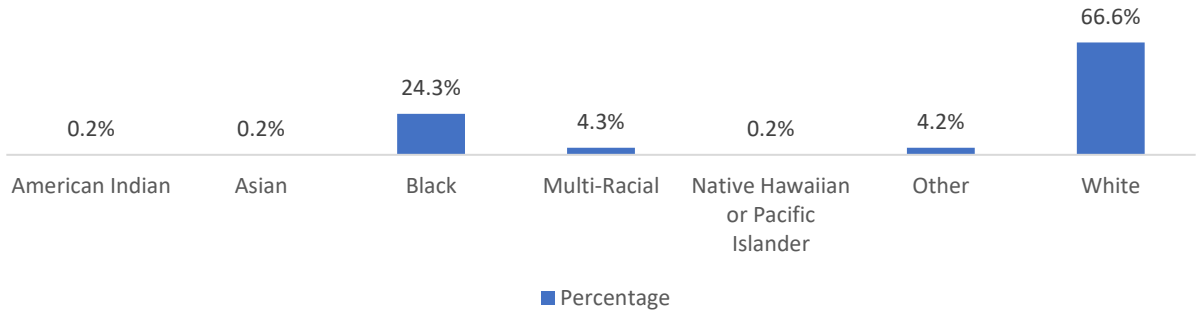
Source: BBHC Client Data

Figure 76: BBHC Homeless AMH Clients by Race



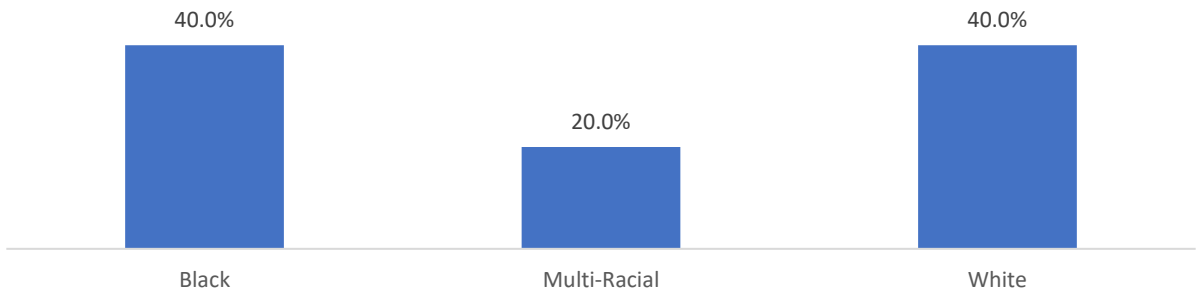
Source: BBHC Client Data

Figure 77: BBHC Homeless ASA Client by Race



Source: BBHC Client Data

Figure 78: BBHC Homeless CMH Clients by Race

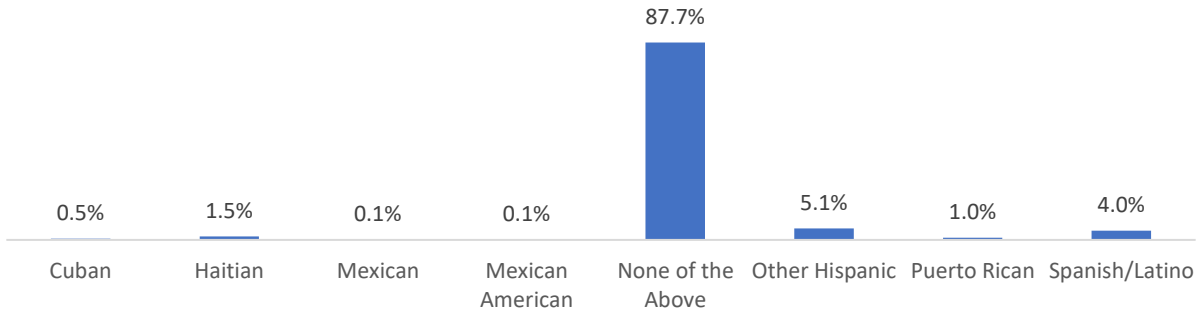


Source: BBHC Client Data

Figure 79: BBHC Homeless CSA Clients by Race

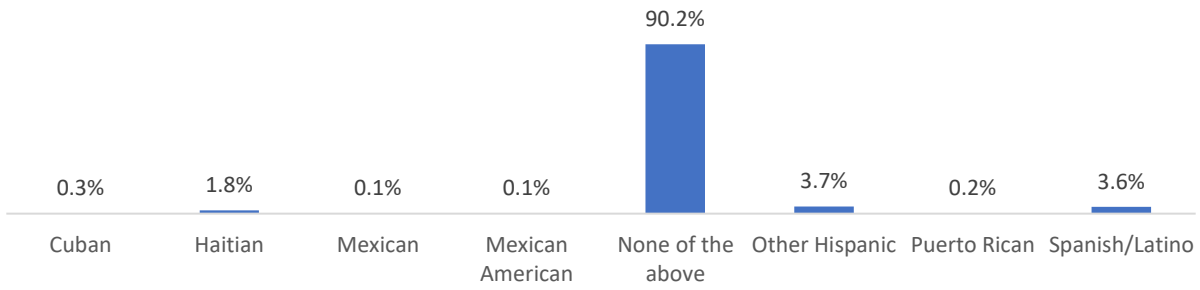
Source: BBHC Client Data

Figure 80: BBHC Homeless Clients by Ethnicity



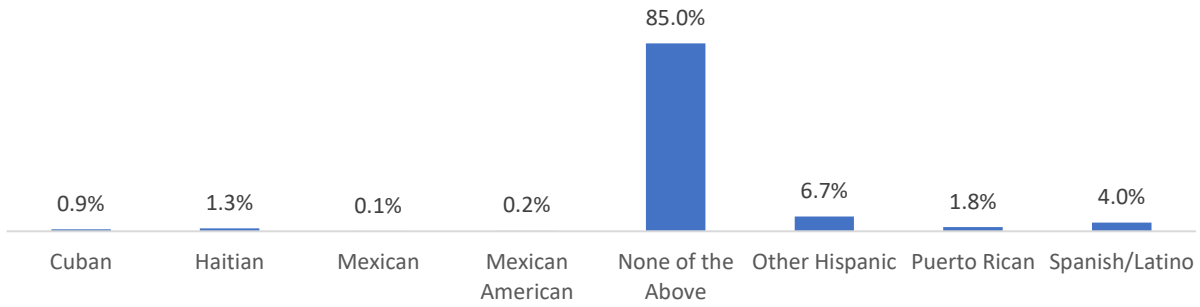
Source: BBHC Client Data

Figure 81: BBHC Homeless AMH Clients by Ethnicity



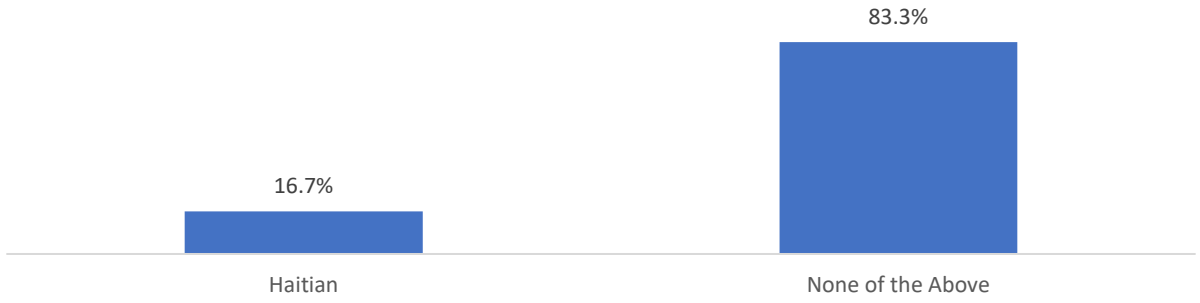
Source: BBHC Client Data

Figure 82: BBHC Homeless ASA Clients by Ethnicity



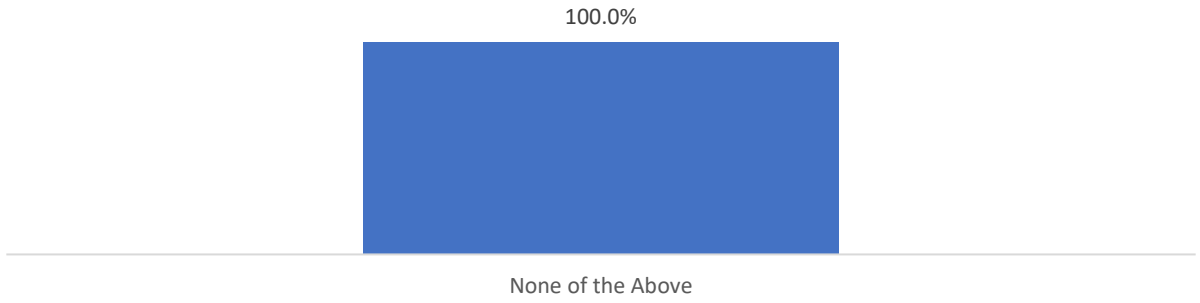
Source: BBHC Client Data

Figure 83: BBHC Homeless CMH Clients by Ethnicity



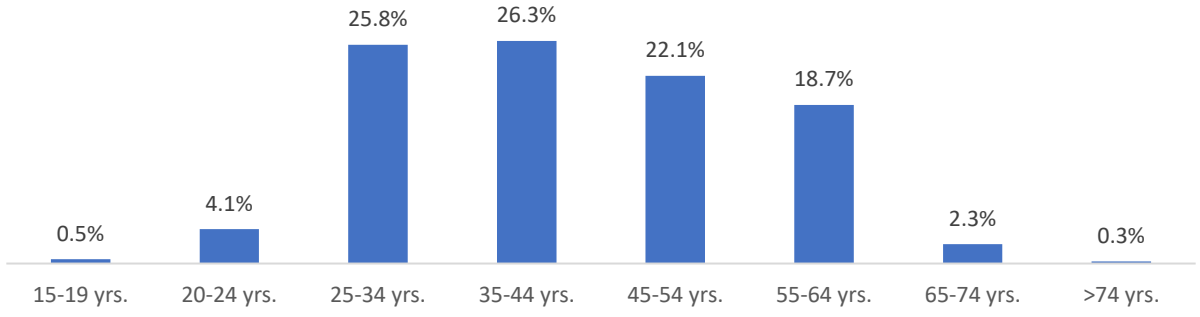
Source: BBHC Client Data

Figure 84: BBHC Homeless CSA Clients by Ethnicity



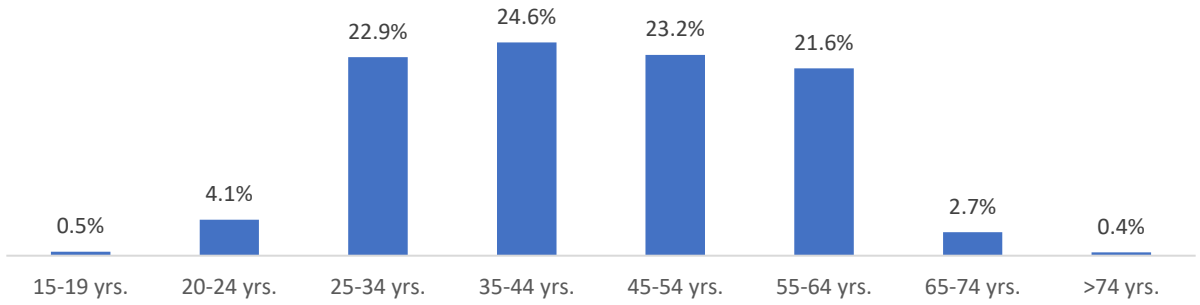
Source: BBHC Client Data

Figure 85: BBHC Homeless Clients by Age Range



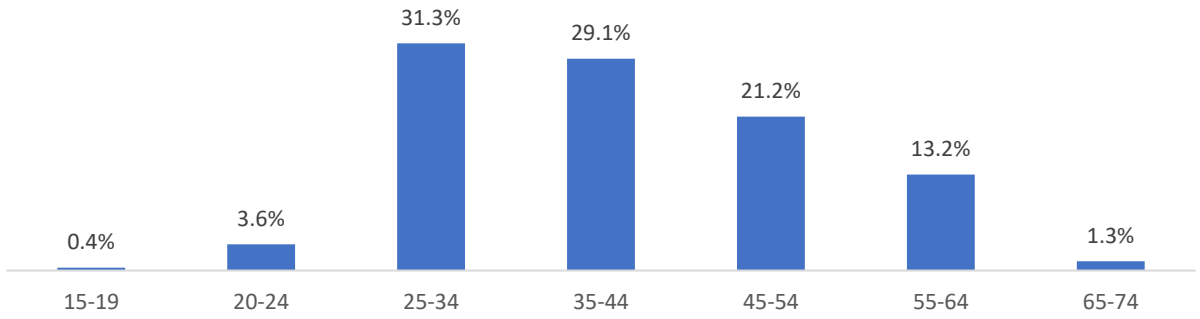
Source: BBHC Client Data

Figure 86: BBHC Homeless AMH Clients by Age Range



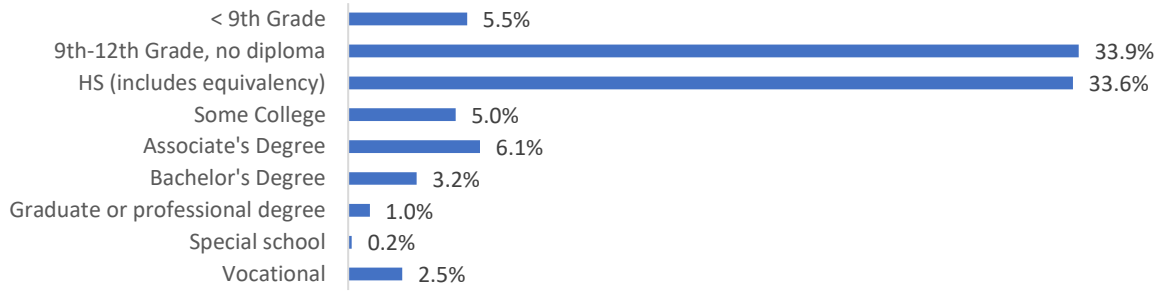
Source: BBHC Client Data

Figure 87: BBHC Homeless ASA Clients by Age Range



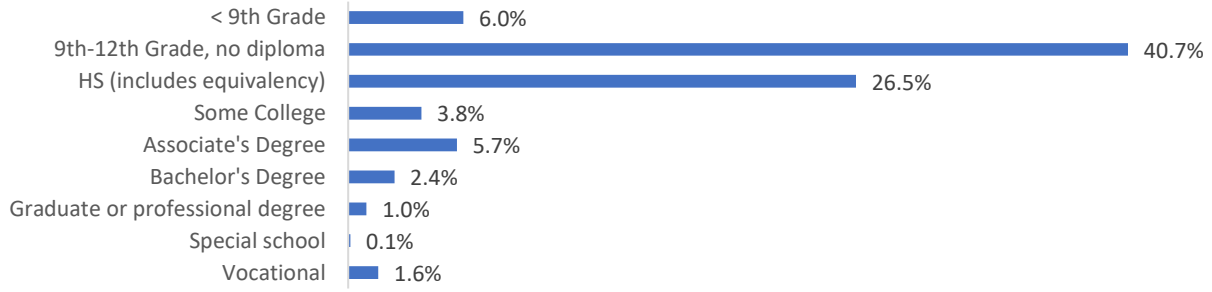
Source: BBHC Client Data

Figure 88: BBHC Homeless Clients by Educational Attainment



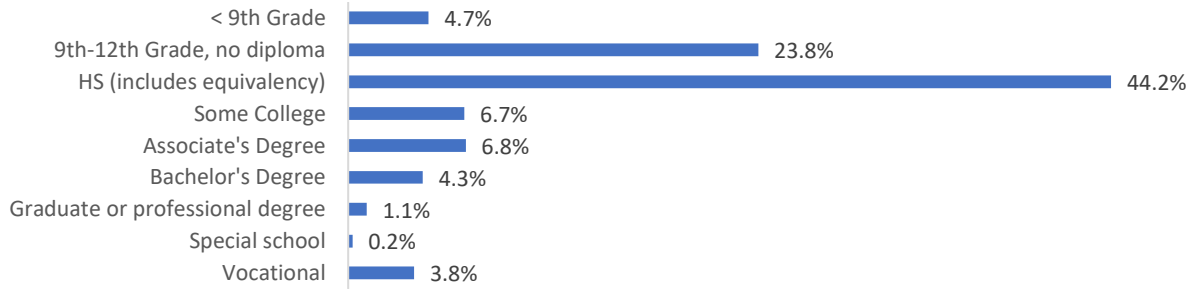
Source: BBHC Client Data

Figure 89: BBHC Homeless AMH Clients by Educational Attainment



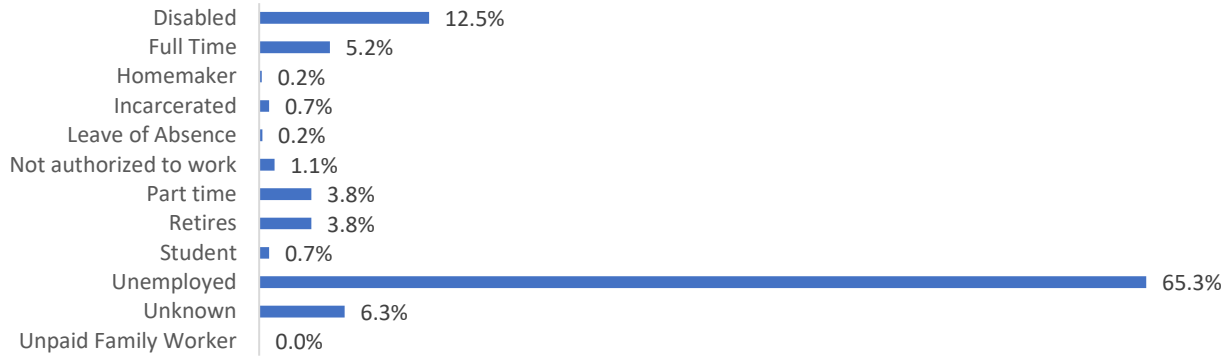
Source: BBHC Client Data

Figure 90: BBHC Homeless ASA Clients by Educational Attainment



Source: BBHC Client Data

Figure 91: BBHC Homeless Clients by Employment Status



Source: BBHC Client Data

COST CENTER DESCRIPTION, EXPENDITURES, AND OVER/UNDER PRODUCTION (FY20-21)

ADULT MENTAL HEALTH PROGRAM

Covered Service	Expenditures	Over/Under Production
Assessment	$270,592.94	$8,707.60
BNET	$0.00	$0.00
Case Management	$2,419,488.55	$64,134.84
CAT Team	$0.00	$0.00
Central Receiving System	$4,129,200.62	$72.16
Crisis Stabilization	$3,439,270.90	$0.00
Crisis Support/Emergency	$1,571,303.45	$987,822.97
Day Treatment	$150,048.56	$0.02
Drop-In/Self-Help Centers	$329,408.95	$27,717.91
FACT Team	$914,082.30	$3,428.71
First Episode Team	$749,243.00	$0.07
Forensic Multidisciplinary Team	$537,930.66	$2.19
Incidental Expenses	$2,062,859.17	$81,958.33
Indicated Prevention	$0.00	$0.00
Information and Referral	$83,333.99	$37,688.80
In-Home and On-Site	$41,949.42	$1.76
Intervention - Group	$0.00	$0.00
Intervention - Individual	$184,171.49	$33,055.68
Medical Services	$1,784,234.80	$53,579.49
Mental Health Clubhouse Services	$0.00	$0.00
Other Bundled Projects	$0.00	$0.00
Outpatient - Group	$402,996.80	$32,462.97
Outpatient - Individual	$786,015.35	$133,266.73
Outreach	$1,712,187.81	$717,239.81
Recovery Support - Group	$226.50	$0.00
Recovery Support - Individual	$398,493.79	$9,933.67
Residential Level I	$2,752,691.90	$8,757.81
Residential Level II	$1,195,424.46	$262,587.52
Residential Level III	$410,259.35	$1.83
Residential Level IV	$490,605.21	$0.39
Respite Services	$114,880.00	$0.00
Room and Board with Supervision Level I	$260,655.44	$1.47
Room and Board with Supervision Level II	$576,682.36	$18,463.28
Room and Board with Supervision Level III	$994,716.53	$56,650.91
Selective Prevention	$108,742.62	$15,194.87

Short-term Residential Treatment	$1,219,986.95	$0.00
Start-Up Cost Reimbursement	$12,095.32	$0.00
Supported Housing/Living	$345,540.13	$20,238.40
Supportive Employment	$584,795.18	$40,266.98
Sustainability Payment for COVID related funds/services	$0.00	$0.00
Universal Direct Prevention	$119,518.09	$0.00
Universal Indirect Prevention	$165,707.49	$88,441.32
TOTAL	**$31,319,340.08**	**$2,701,678.49**

Source: BBHC Program Data

ADULT SUBSTANCE ABUSE PROGRAM

Covered Service	Expenditures	Over/Under Production
Assessment	$87,163.60	$3,972.25
Case Management	$913,604.71	$68,161.92
Crisis Support/Emergency	$774,943.67	$57,199.30
Day Treatment	$154,376.90	$0.63
Federal Project Grant	$58,877.71	$0.00
FIT Team	$800,000.00	$663.99
Incidental Expenses	$854,068.97	$25,067.11
Indicated Prevention	$0.00	$0.00
Information and Referral	$137,712.66	$126,454.62
In-Home and On-Site	$456,321.43	$40,481.68
Intervention - Group	$0.00	$0.30
Intervention - Individual	$344,547.34	$30,810.75
Medical Services	$856,298.47	$34,015.31
Medication Assisted Treatment	$1,069,994.57	$408.46
Other Bundled Projects	$24,161.61	$0.00
Outpatient - Group	$561,029.65	$95,020.58
Outpatient - Individual	$1,198,722.36	$130,514.57
Outreach	$3,423,412.45	$124,330.09
Recovery Support - Group	$26,766.30	$5.01
Recovery Support - Individual	$665,171.38	$98,311.86
Residential Level II	$6,194,555.45	$318,313.12
Residential Level III	$519,362.65	$662.40
Residential Level IV	$0.00	$0.00
Respite Services	$164,199.99	$0.01
Room and Board with Supervision Level II	$0.00	$0.00
Selective Prevention	$227,694.84	$33,362.21
Start-Up Cost Reimbursement	$15,137.72	$0.00
Substance Abuse Inpatient Detoxification	$1,566,896.18	$121,595.02
Substance Abuse Outpatient Detoxification	$420,916.28	$0.00
Supported Housing/Living	$88,574.37	$216.36
Supportive Employment	$115,763.53	$4,992.59
Sustainability Payment for COVID related funds/services	$436,731.86	$0.00
Treatment Alternative for Safer Community	$11,523.89	$381.15
Universal Direct Prevention	$646,015.76	$23,871.95
Universal Indirect Prevention	$153,640.08	$75,172.26
TOTAL	**$22,968,186.38**	**$1,413,985.50**

Source: BBHC Program Data

CHILD MENTAL HEALTH PROGRAM

Covered Service	Expenditures	Over/Under Production
Assessment	$11,411.06	$8.30
Case Management	$14,728.41	$14,974.88
CAT Team	$629,039.32	$221.16
Crisis Stabilization	$75,000.00	$57,279.65
Crisis Support/Emergency	$1,278,206.33	$39,236.43
Day Treatment	$0.00	$0.00
Incidental Expenses	$567,804.69	$473.91
Indicated Prevention	$0.00	$0.00
Information and Referral	$1,060.09	$5.22
In-Home and On-Site	$166,050.77	$0.00
Inpatient	$18,166.88	$0.00
Intervention - Group	$512.05	$0.00
Intervention - Individual	$169,660.23	$4.91
Medical Services	$25,810.44	$963.48
Outpatient - Group	$1,525.92	$0.00
Outpatient - Individual	$226,189.49	$7,294.19
Outreach	$129,598.23	$341.81
Recovery Support - Group	$0.00	$0.00
Recovery Support - Individual	$144,786.31	$3,204.43
Residential Level I	$54,575.36	$0.00
Room and Board with Supervision Level I	$43,057.00	$0.00
Selective Prevention	$0.00	$0.00
Start-Up Cost Reimbursement	$187,500.00	$0.00
Supported Housing/Living	$95,412.85	$0.00
Supportive Employment	$490.26	$0.00
Sustainability Payment for COVID related funds/services	$0.00	$0.00
Universal Direct Prevention	$2,696.80	$1,031.81
Universal Indirect Prevention	$0.00	$0.00
TOTAL	**$3,843,282.49**	**$125,040.18**

Source: BBHC Program Data

CHILD SUBSTANCE ABUSE PROGRAM

Covered Service	Expenditures	Over/Under Production
Assessment	$28.10	$7.66
Case Management	$16,220.56	$4,090.15
Crisis Support/Emergency	$734,581.92	$199,282.95
Day Treatment	$0.00	$0.00
Incidental Expenses	$2,635.71	$271.29
Indicated Prevention	$0.00	$0.00
Information and Referral	$123,620.25	$157,959.12
In-Home and On-Site	$0.00	$0.00
Intervention - Group	$4,859.82	$0.00
Intervention - Individual	$269,043.45	$3.05
Medical Services	$198.44	$54.09
Outpatient - Group	$1,413.72	$0.00
Outpatient - Individual	$120,006.17	$1,003.76
Outreach	$56,532.85	$9,379.76
Recovery Support - Group	$0.00	$0.00
Recovery Support - Individual	$8,836.43	$2,506.58
Residential Level II	$6,347.04	$0.00
Selective Prevention	$0.00	$0.00
Substance Abuse Inpatient Detoxification	$197,797.72	$82,338.32
Supported Housing/Living	$12,756.47	$0.00
Sustainability Payment for COVID related funds/services	$0.00	$0.00
Universal Direct Prevention	$1,354,780.72	$53,647.73
Universal Indirect Prevention	$21,678.61	$3,471.22
TOTAL	**$2,931,337.98**	**$514,015.68**

Source: BBHC Program Data

BBHC All Cost Centers	Expenditures	Over/Under Production
Grand Total	$61,062,146.93	$4,754,719.85

CULTURAL HEALTH DISPARITY SURVEY SUMMARY

There were 72 respondents to this survey. Most of the respondents were female (72.5%). Almost half of the respondents identified themselves as cisgender, 31.7% preferred not to answer, and 19% were gender fluid. The majority of respondents (65.7%) identified as heterosexual/straight, 11.4% preferred not to answer, and 10% were asexual. Gender identity and sexual orientation could be explored to understand the impact on behavioral health concerns. Regarding race, 44.9% identified as White, followed by Black (34.8%), and Multiracial at 10.1%. More than 75% of respondents were Non-Hispanic, 8.7% were Other Hispanic, and 5.8% identified as Spanish/Latino. All other Hispanic ethnicities accounted for 3% or less. By age ranges, 71% of respondents were evenly distributed between ages 35-44 years, 45-54 years, and 55-64 years of age. Younger adults, those ages 25-34 years, accounted for 13% of respondents, and 10.1% were ages 65-74 years.

Of the respondents, 70.8% indicated that they usually feel comfortable seeking behavioral health care services. When asked to rate how strongly they believe the behavioral health care system will treat them respectfully, the majority (54.2%) stated that they trust or strongly trust the system; 16.7% had distrust for the system and 29.2% were neutral on the topic.

When asked about feelings regarding your behavioral health issues, 52.1% were comfortable sharing their challenges with others; 19.7% only liked to share with people like them, 18.3% felt this was a private matter that stays in the family or to themselves. When asked what setting felt most comfortable to discuss behavioral health concerns, 29.5% of respondents felt most comfortable in a private doctor's office; 36.4% felt most comfortable using telehealth services or a hybrid of telehealth services. All other settings received 10% or less of the responses. When asked about preference between faith-based health care services or traditional physician offices, 76.8% of respondents preferred the traditional setting. Regarding language, 84.1% of respondents stated that behavioral health services were available in their primary language all the time; 10.1% stated it was only available either some or a little of the time.

Questions on the type of preferred therapy revealed respondents were almost evenly split on their comfort with participating in group therapy. Of all respondents, 38.9% were likely to participate, 34.7% were unlikely to participate, and 26.4% were neutral. This may be a good concept to explore to further understand what factors (stigma, time, need, etc.) affect interest in group therapy. Conversely, 80.5% of respondents were either likely or very likely to attend individual therapy.

CULTURAL HEALTH DISPARITY SURVEY CHARTS

Figure 92: Are you usually comfortable seeking behavioral health services?

Figure 93: On a scale of 1 to 5, with 5 being 'strongly agree', how would you rate your trust in the behavioral health care system to treat you with respect?

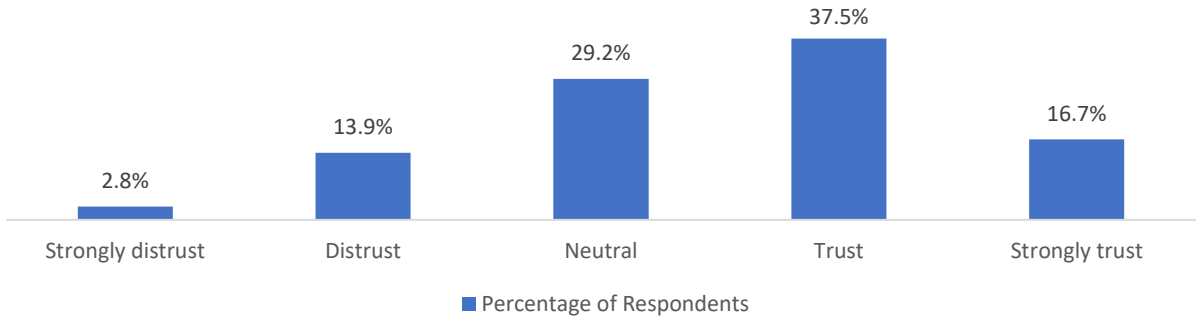


Figure 94: Please rank the statements below that most closely describe your feelings regarding your behavioral health issue, with (1) being the most and (5) being the least.

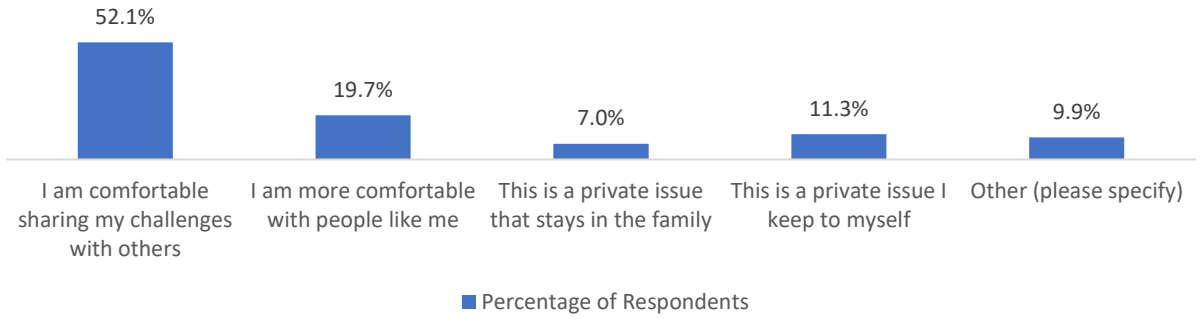
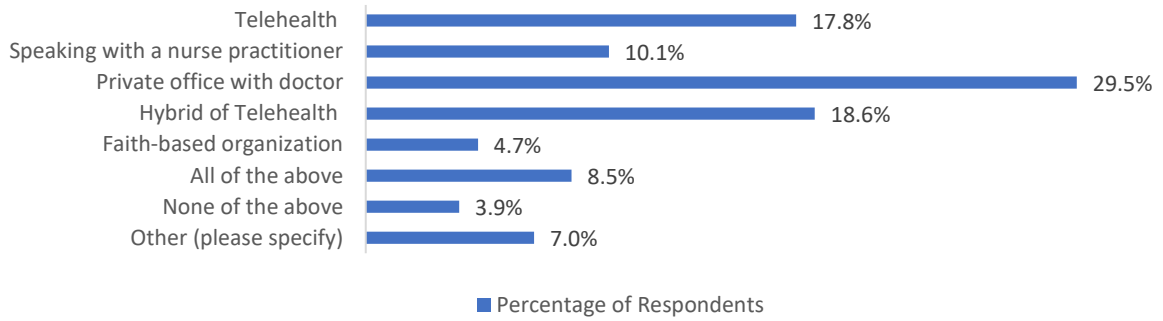


Figure 95: In which setting(s) have you been most comfortable discussing your behavioral health concerns? (Check all that apply)



SOURCE: Hybrid of Telehealth includes some face to face and some telehealth

Figure 96: If given a choice for receiving behavioral health care services, would you be more comfortable going to a faith-based organization OR prefer the traditional physician office?

Figure 97: Now thinking about treatment options, on a scale of 1 to 5, with 5 being 'very likely', how comfortable would you be in group therapy?

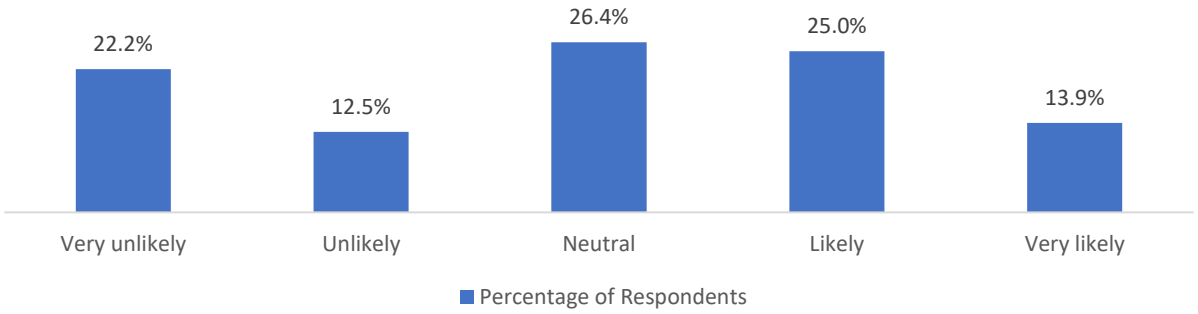


Figure 98: On a scale of 1 to 5, with 5 being 'very likely', how comfortable would you be in individual therapy?

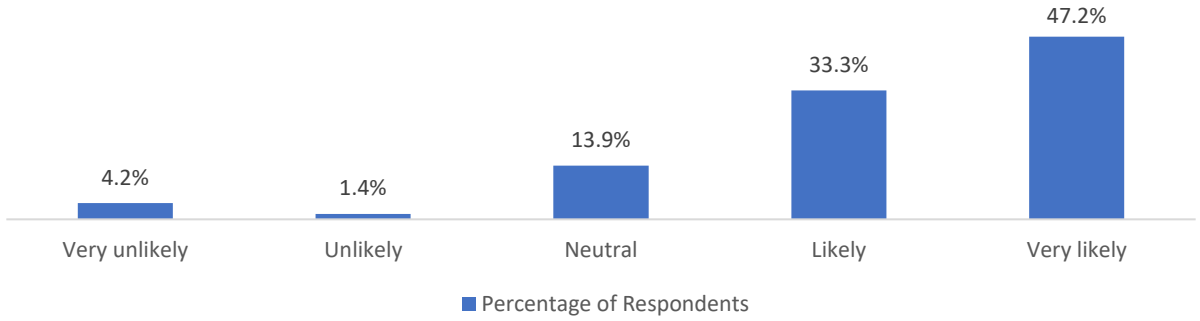


Figure 99: When you have received behavioral health care services in the past, were they mostly available in your primary language?

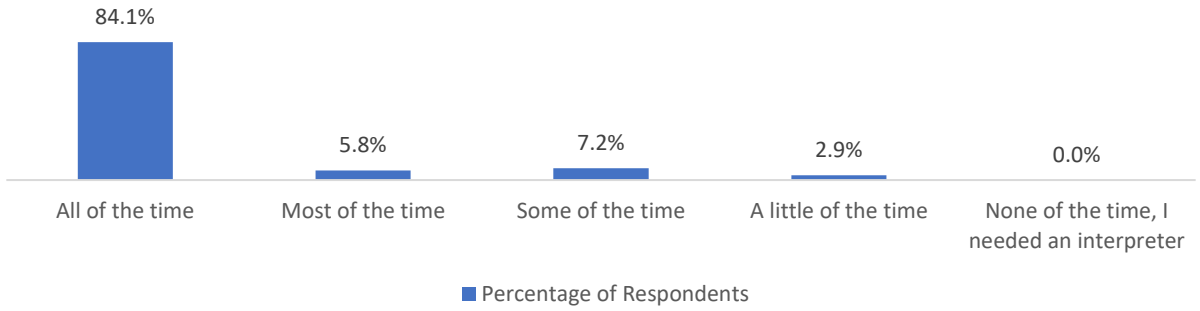


Figure 100: Which best describes your gender?

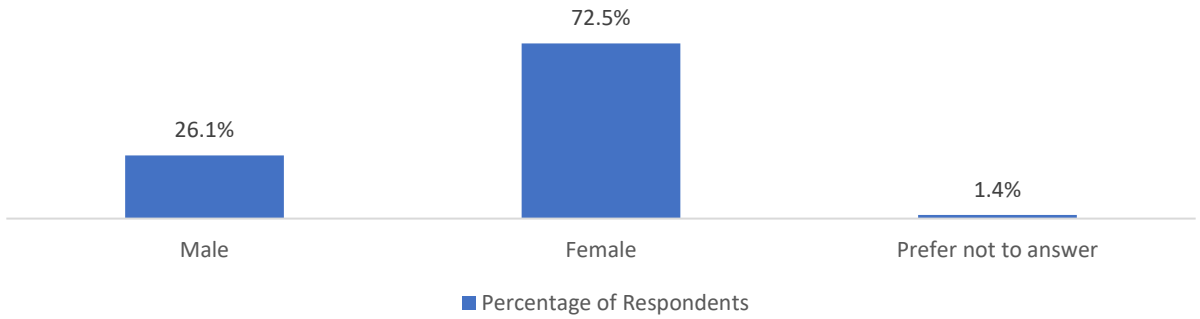


Figure 101: Which best describes your gender identity?

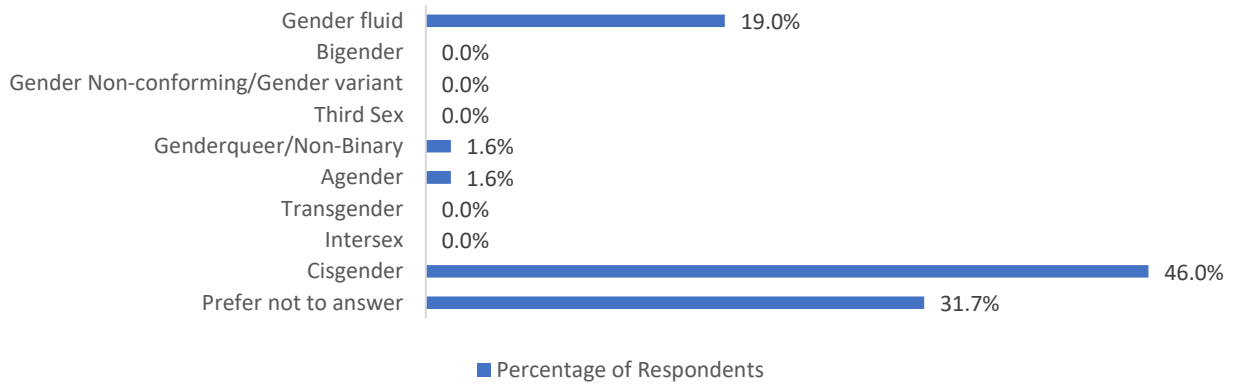


Figure 102: Which best describes your current sexual orientation? (Check all that apply)

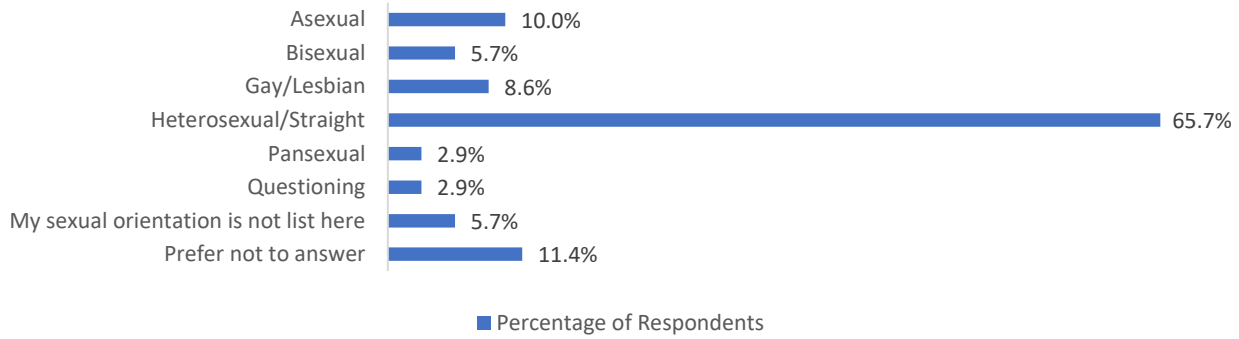


Figure 103: Which best describes your race?

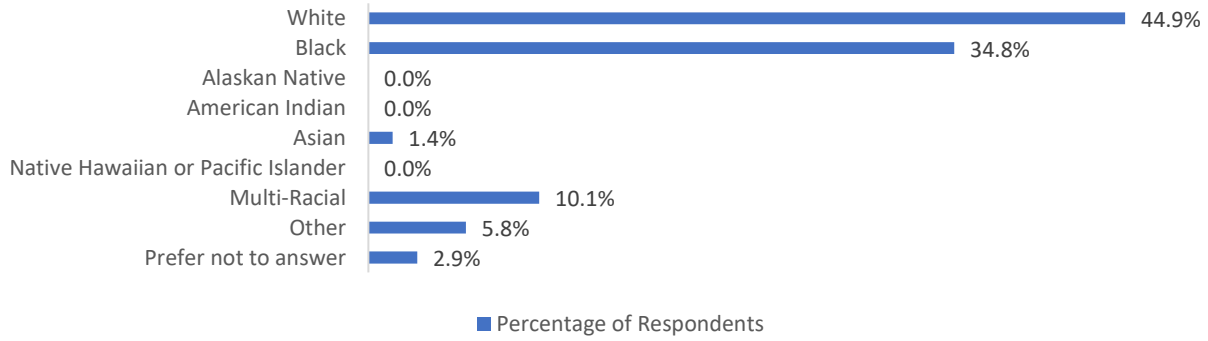


Figure 104: Which best describes your ethnicity?

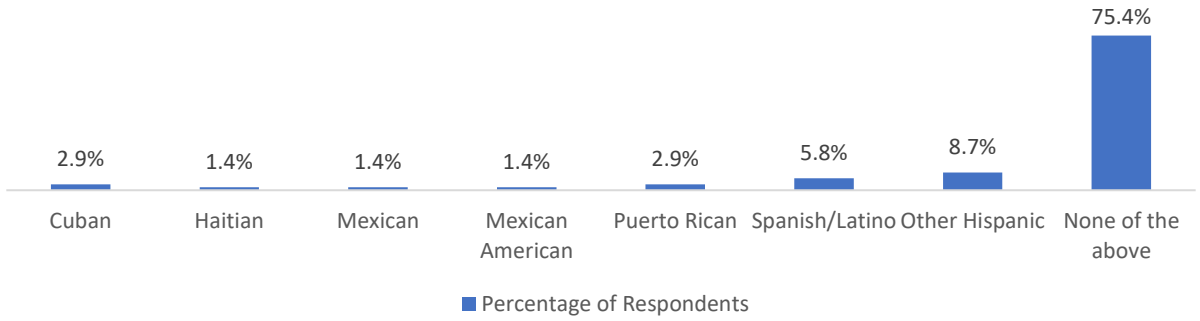
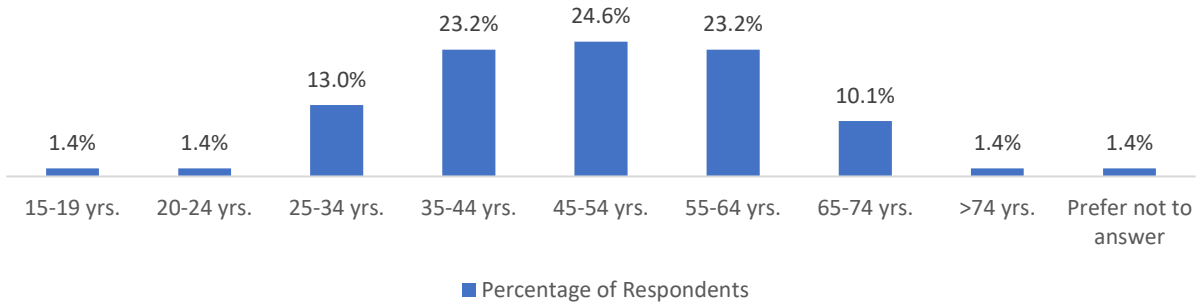


Figure 105: Please select your age range from the list below.



CULTURAL HEALTH DISPARITY SURVEY BY RACE AND ETHNICITY

The cultural health disparity survey was analyzed by race and ethnicity to further measure experience, awareness, and coordination of behavioral health services. This will help to facilitate focused strategic development and intervention implementation over the next three years.

More than 50% of respondents were comfortable seeking behavioral health care services. White respondents, at 82.4%, were more likely to be comfortable seeking care when compared to Black and Hispanic respondents at 66.7% and 56.3%, respectively.

When asked if they trust the health care system to treat them with respect, 54.2% of Black respondents trust, at 29.2%, or strongly trust, at 25%, they would be treated with respect. Among Hispanic respondents, 37.5% trust and 12.5% strongly trust they would be treated with respect. For White respondents, 44.1% trust or strongly trust, at 17.6%, that the health care system would treat them with respect. Less than 20% of Black and White respondents distrust or strongly distrust the behavioral health care system to treat them with respect. This was higher among Hispanic respondents at 21.9%

The most comfortable setting for discussing their behavioral health issues was in a private office with a doctor. Among respondents, 29.5% of Black, 44.9% of Hispanic, and 37.5% of White respondents preferred this setting. Among Black respondents, telehealth, at 20.5%, was preferred over a hybrid of telehealth (includes some face to face and some telehealth) at 18.2%. Receiving services from a nurse practitioner, at 15.9% was preferred over receiving services from a faith-based organization, at 4.5%. Among Hispanic respondents, a hybrid of telehealth, at 20.4%, was preferred over telehealth at 16.3%. The same percentage of Hispanic respondents, at 8.2%, indicated their preference for speaking with a nurse practitioner or receiving services from a faith-based organization. Among White respondents, 21.4% preferred a hybrid of telehealth over telehealth, at 17.9%. Receiving services from a faith-based organization, 5.4% indicated this was a comfortable setting for them. Less than 10% of respondents from each population group indicated all of the above (telehealth, hybrid of telehealth, private office with a doctor, speaking with a nurse practitioner and faith-based organization) were comfortable settings.

When asked for a preference between receiving services from a faith-based behavioral health care organization or the traditional physician office, most respondents preferred the traditional physician office. Among Black respondents, 60.9% preferred the traditional physician office compared to 39.1% who preferred faith-based behavioral health care services. Among Hispanic and White respondents, they preferred the traditional physician office at 71.9% and 87.92%, respectively. Only 12.1% of White and 28.1% of Hispanic respondents preferred a faith-based behavioral health care organization.

Fifty percent (50%) of Black respondents were neutral on their comfort in group therapy. Of the remaining respondents, more were likely or very likely to be comfortable in group therapy at

29.2% compared to 20.8% who were unlikely or very unlikely to be comfortable. Among Hispanic respondents, 62.5% were likely or very likely to be comfortable in group therapy while this was comfortable for 50% of White respondents. When asked about their comfort level regarding individual therapy, percentages were higher as 75% of Black, 90.6% of Hispanic, and 88.2% of White respondents indicated they were likely or very likely to be comfortable in individual therapy.

When asked if the behavioral health services they received in the past were mostly available in their primary language, 91.3% of Black and 93.9% of White respondents received services in their primary language all or most of the time. Among Hispanic respondents, 74.2% received services in the primary language all or most of the time (usually), while 16.1% indicated this only happened a little of the time. No respondents needed an interpreter to receive services.

CULTURAL HEALTH DISPARITY SURVEY BY RACE AND ETHNCITY CHARTS

Figure 106: Are you comfortable seeking behavioral health care services?

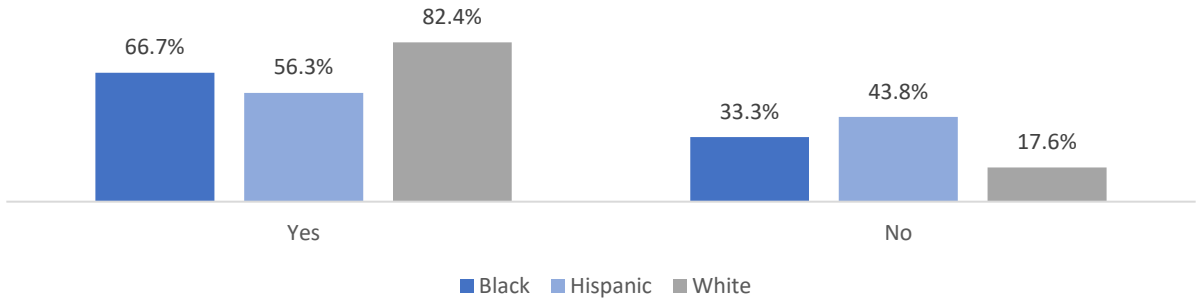


Figure 107: One a scale of 1 to 5, with 5 being "strongly agree', how would you rate your trust in the behavioral health care system to treat you with respect?

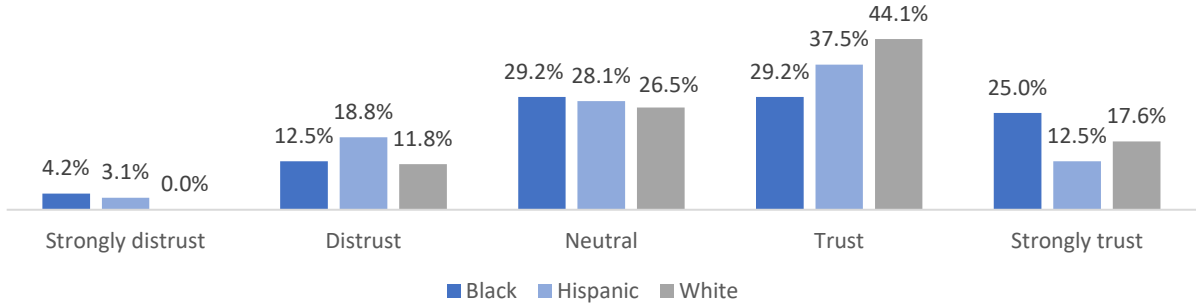


Figure 108: In which setting(s) have you been the most comfortable discussing your behavioral health concerns? (Check all that apply)

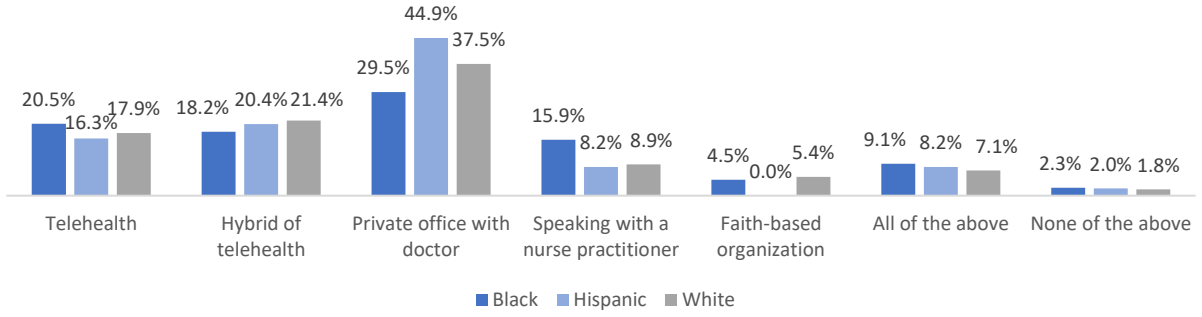


Figure 109: If given a choice for receiving behavioral health care services, would you be more comfortable going to a faith-based organization OR prefer the traditional physician office?

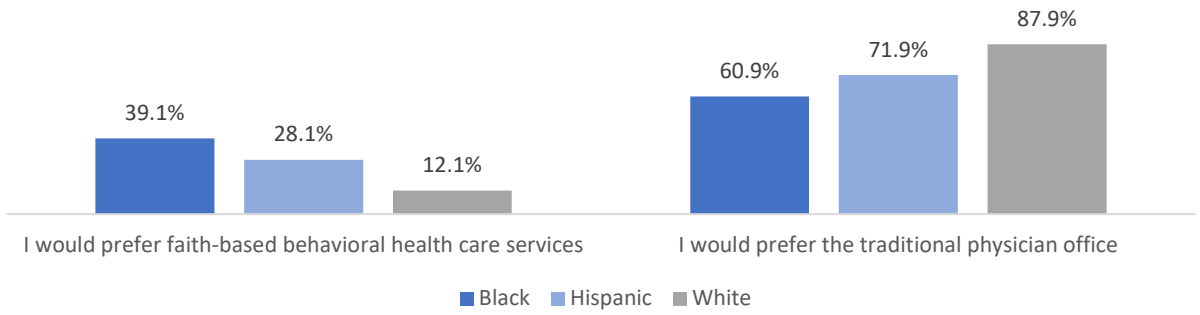


Figure 110: Now thinking about treatment options, on a scale of 1 to 5, with 5 being very likely, how comfortable would you be in group therapy?

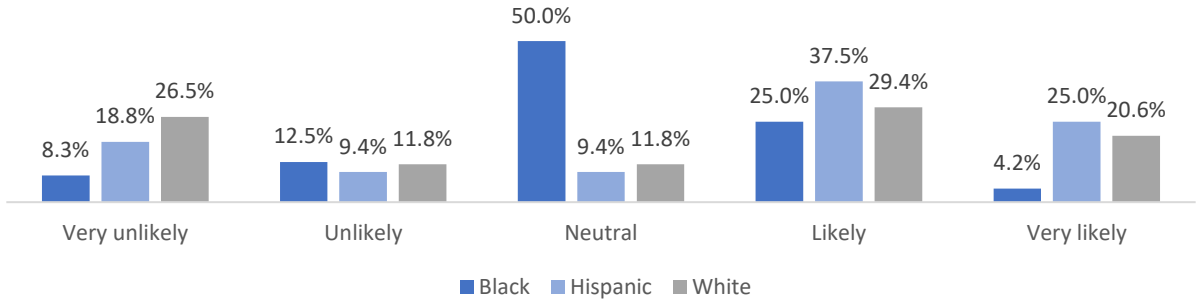


Figure 111: On a scale of 1 to 5, with 5 being very likely, how comfortable would you be in individual therapy?

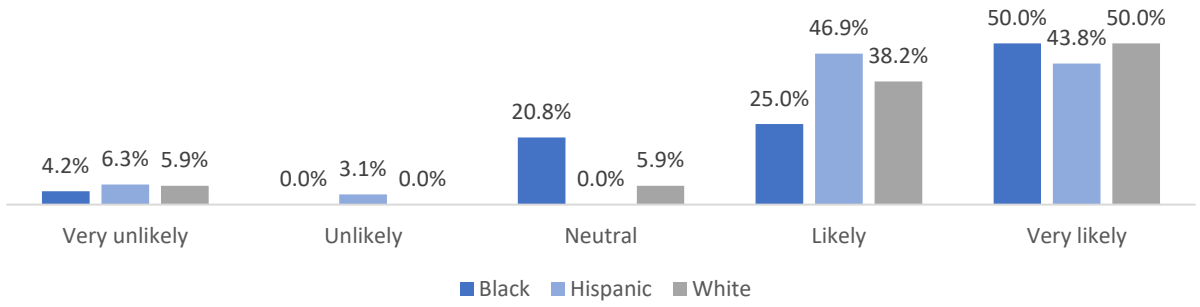
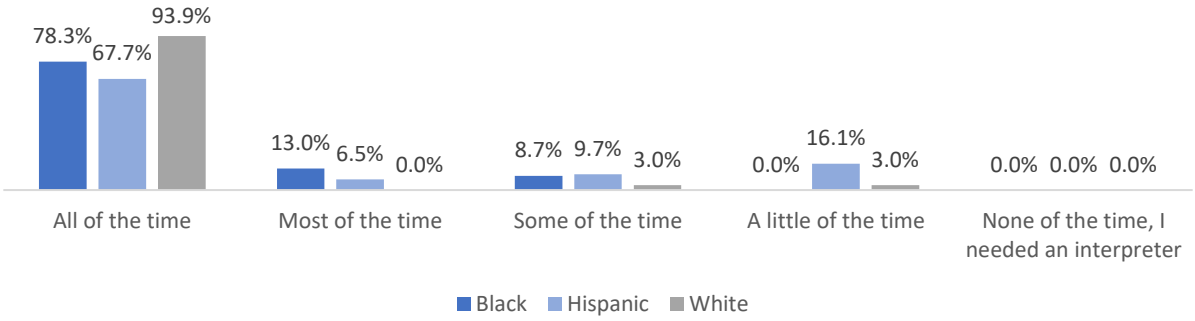


Figure 112: When you have received behavioral health care services in the past, were they mostly available in your primary language?



CULTURAL HEALTH DISPARITY FOCUS GROUP SUMMARY

BBHC Cultural Health Disparities Focus Groups: 4 Groups (41 Participants)

1. How do you feel when seeking behavioral health care services?

   Participants shared that at previous providers they were frustrated and did not feel that they were being helped and are "getting more from current Provider." Support/Kindness/Learned Skills/Work Experience are a few of the descriptions provided as to the type of care and services being provided in this program.

   Persons in attendance had attended or have been attending the Footprints program from 1 day to 9 years. Their overall experience is one of learning and respect from the provider. Participants enjoyed the range of activities and skill building that they received. The experience helped to overcome fears. Reclusiveness was shared by a participant who said that work allowed them to improve and to attend an upcoming training in Massachusetts. Staff is understanding of struggles.

   Participants who are court ordered and have struggled with addiction for 15 years shared that their experience within the drug court left them feeling like a criminal. Another participant shared that they have been straight for 14 months and shared that the program has helped them and is a blessing. Participants shared trauma, addiction, and that they have attended multiple programs prior to joining their current group and did not feel that their experience was what they now receive through this program. "If it wasn't for this place, I do not think I would have the strength to keep going." "This place saved my life." Participants feel validated. "Didn't really know how to love before." Participants talked about the sincerity of the care team. Participants also shared that providers with mental health experience who care about what they do was important. Having useful recovery tools, creative outlets, discharge planning, support, and community connections are necessary. Participants who have had a positive experience expressed that they love you back to health. Insurance concerns were raised within the groups as participants said that insurance blocks and prevents persons from accessing services. Mental health insurance transportation is inconsistent and was expressed as to not showing up 50% of the time. Costs involved and out-of-pocket expenses, high co-pay for medication, and not having the option of seeking a provider/physician that works best for the individual are barriers to care.

2. How strongly do you believe the behavioral health care system? Treated with respect and dignity?

   Yes. Participants shared that they are treated with respect and dignity. Transparency is important to the participants, and they are open to sharing experiences. In addition, sharing

behavioral health issues in an environment that is safe, welcoming, and caring can change the views held by person receiving services in a positive way.

3. How do you feel sharing your behavioral health issues? Where/who do you go to when you have issues? Faith based/traditional physician offices?
   Participants said that they feel comfortable with sharing behavioral health issues. The also shared that when they do not have a good day the team supports them. Participants also shared that they have been in other programs and the results/comfort level was not the same. "It is an uphill struggle." Participants shared that the staff did not listen to them at certain providers. If you try to talk especially with a speech impediment, they often do not take the time to understand what is being said.

4. Group therapy what does this experience look like? Individual/Group Therapy preference?
   The participants shared that therapy is viewed differently among providers. The programs may not offer traditional therapy and the term support group may be used. A Reach Out Program has been established for participants who have not attended the program/staying in contact through phone calls, birthday cards, and outreach. "Once a member always a member." Members are supportive to one another within their current space. When COVID-19 began the staff reached out and stayed connected and held virtual groups. The participants said the virtual groups were perfect. They shared that it was more "one on one." Another participant shared that with a speech impediment wearing a mask made if even more difficult for people to understand what was being said. Offering in person/virtual would provide options. Additional comments included that individual therapy is often preferred and participants felt safe in this type of setting. When talking about group therapy, participants also shared that smaller groups are better, and that individualized treatment should be provided.

   Are behavioral health services available in your primary language?
   Participants shared that they felt behavioral health services were available in their primary language. In addition, Spanish and Creole speaking staff are always needed.

5. What factors (stigma, time, need) affect interest in group therapy?
   Participants shared that people who are disrespectful at provider locations discourage an individual from sharing their need and experience. They also talked about arriving late for a program and not being permitted to attend. Participants who rely on transportation often cannot control arrival times. Participants shared that during group therapy one or two persons may dominate or monopolize the group and this does not allow for open discussion among all members.

   Mental health as shared by participants is taboo in many cultures. Training for family members in mental health, workshops, and partnering with community organizations could assist with education. In addition, suggestions of having drop-in services at churches, bus stops, food

pantries, Salvation Army, and services for single fathers may open the door to persons who may not seek out assistance otherwise.

Participants shared that support and guidance are needed as opposed to criticism.

THEMES IDENTIFIED

Cultural Health Disparities Focus Groups:

The themes identified during the Cultural Health Disparities focus groups as described by the participants are as follows.

- Importance of Being Heard
- Decrease Stigma and Judgement
- Trauma and Sensitivity Training
- The wait for services is “too long” “fall through the cracks while waiting”
- Limited Resources due to type of Insurance Coverage especially for Homeless individuals
- Additional Staff
- Feeling Safe
- Offer Group, Individual and Virtual Therapy – meet the need of the person
- Penalizing persons for arriving late when dependent upon transportation
- Education for the community
- Drop-in Centers
- Discharge Planning/Supportive Services
- Provider Availability
- Smaller Groups/Individualized Treatment
- Job Connections for persons with Disabilities
- Job and Life Training
- Strength Based/Judgement Free Zones

NO WRONG DOOR SURVEY SUMMARY

There were 81 respondents for the No Wrong Door (NWD) survey. Of the responses, 72.8% of survey participants thought (NWD) access works well within their organization; 24.7% were unsure. When asked if their organization had an important role in NWD access, 88.9% responded yes.

Stakeholders were asked to rate their agreement on statements about the delivery of health services of their organizations. Of the respondents, 91.4% of respondents either agreed or strongly agreed that their organization has a strong care coordination process that includes warm handoffs to services and seamless care coordination; 86.4% agreed that linkages to crisis intervention and support were occurring. Over 92% agreed or strongly believed that their organization encouraged partnerships with other community partners to ensure care coordination. When asked if their organization has taken action to improve their referral and care coordination process for individuals served, 88.8% agreed or strongly agreed.

Most respondents (88.9%) either agreed or strongly agreed that their organization promotes its services and resources very well and promotes awareness of available options and linkages to needed services. Most respondents (92.6%) believed their organization provide person-centered care; the majority "strongly agreed" to this statement. Additionally, 86.4% believe their agency hires culturally sensitive and culturally competent people for the population they are serving.

Most respondents strongly agreed that their organization ensures that services are of high quality and meet the needs of the individuals they serve. When asked if it's easy for individuals to access the services they need quickly and efficiently, 65.4% of respondents agreed or strongly agreed, however, more than 22% of respondents disagreed with this statement. This is nearly a quarter of the respondents and worth noting. Slightly more than half of the respondents (56.8%) answered "yes" when asked to respond whether standard intake and screening process for state agencies and community partners would help individuals get into services more quickly. However, a quarter of respondents chose "no" to this question while 18.5% were "unsure." Almost 70% believed individuals in need of services have equal access to care. However, 24.5% either disagreed or strongly disagree with this statement. Most respondents agreed or strongly agreed that stakeholders help to address and advocate for equal access to care in system entry points; less than 15% disagreed. Over 80% of survey participants believed their organization tracks individuals served, services, performance, and cost to continually evaluate and improve outcomes.

There were 81 respondents in the NWD Survey, however, when asked where respondents work, multiple responses were allowed; the following percentages are based off those 115 responses. Of these, 21.7% stated that they worked in Adult Outpatient Programs, followed by Peer Recovery Support (20%), Adult Residential Facilities (15.7%), and Adult Detoxification Unit (13.9%).

NO WRONG DOOR SURVEY CHARTS

Figure 113: I work in a/an...

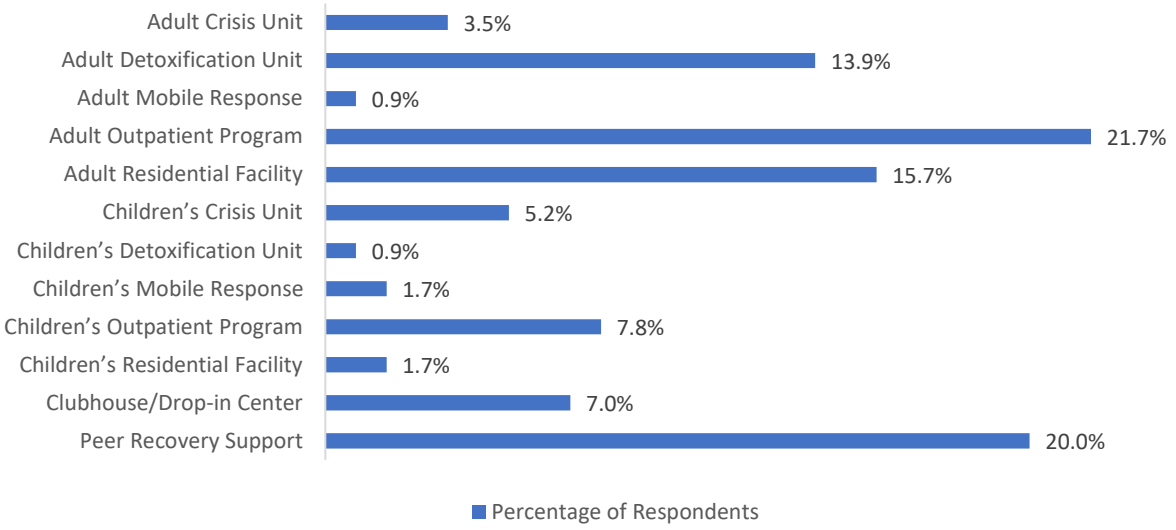


Figure 114: Do you think the "No Wrong Door" access works well within your organization?

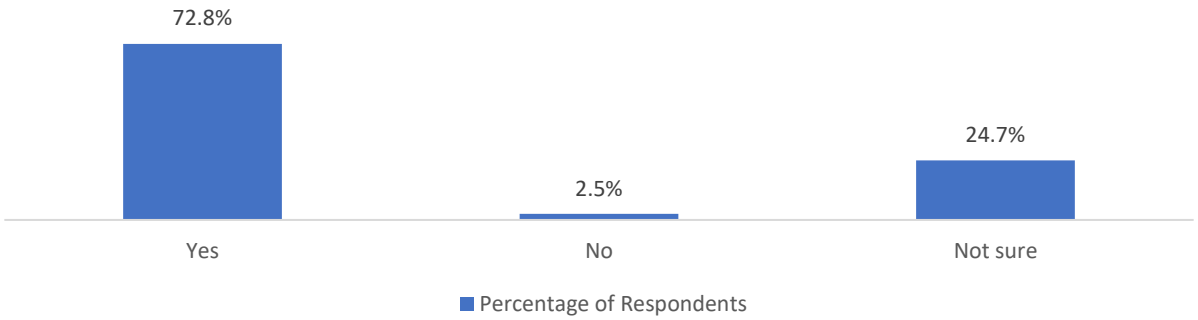


Figure 115: From your perspective your organization has a role to play in the "No Wrong Door" access.

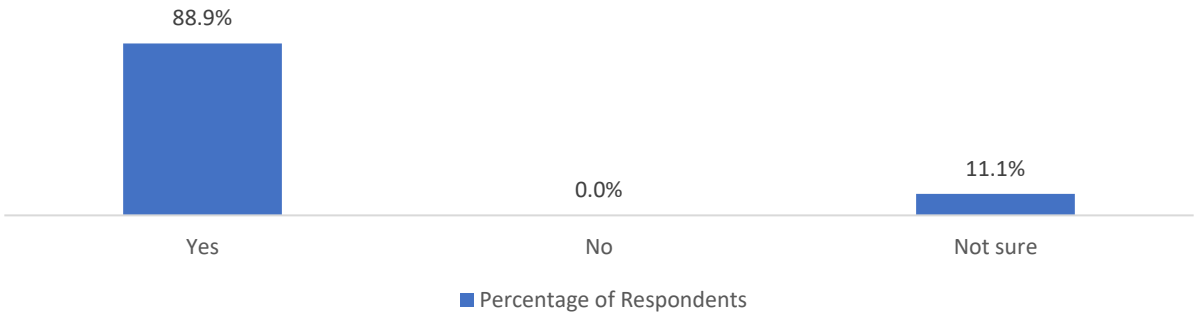


Figure 116: In your opinion, your organization has a strong care coordination process that includes warm handoffs to services and seamless care coordination.

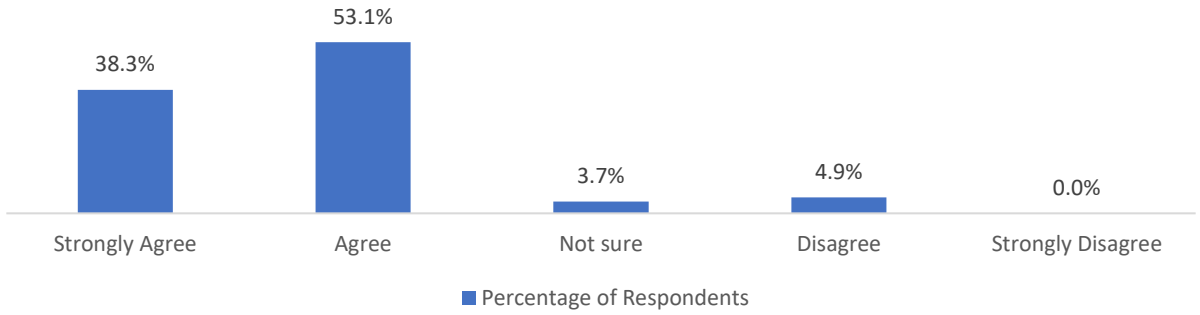


Figure 117: In your opinion, your organization has taken action to improve the referral and care coordination process for individuals served.

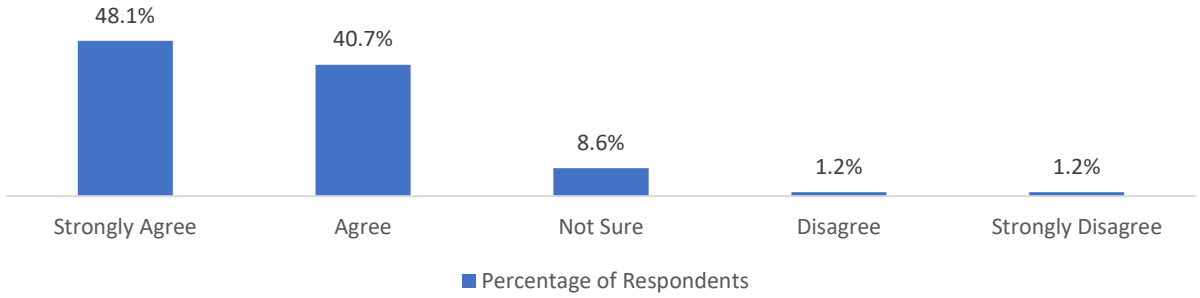


Figure 118: In your opinion, linkages to crisis intervention and support (like the Mobile Response Team, medication management, CRF, CIT Officer, BA, CSU, etc.) are occurring.

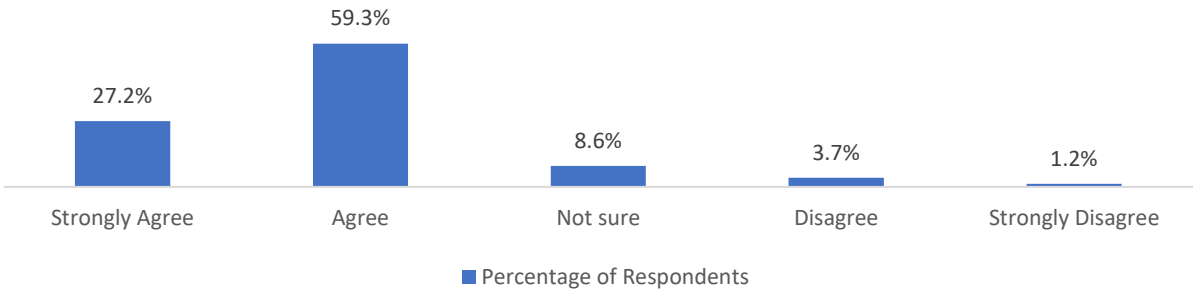


Figure 119: In your opinion, your organization promotes its services and resources very well.

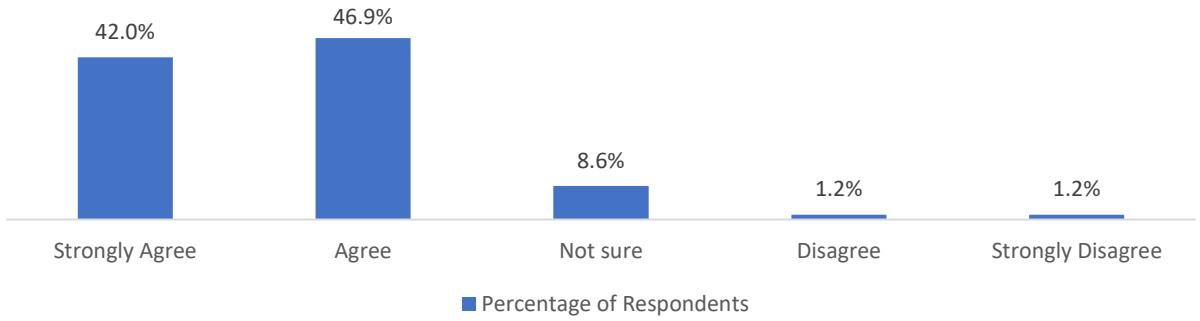


Figure 120: In your opinion, your organization promotes awareness of available options and linkages to need services.

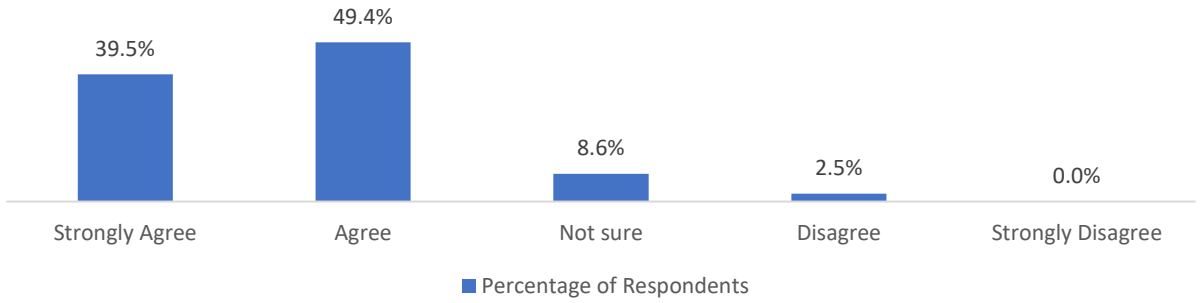


Figure 121: In your opinion, your organization provides person-centered care for all individuals served.

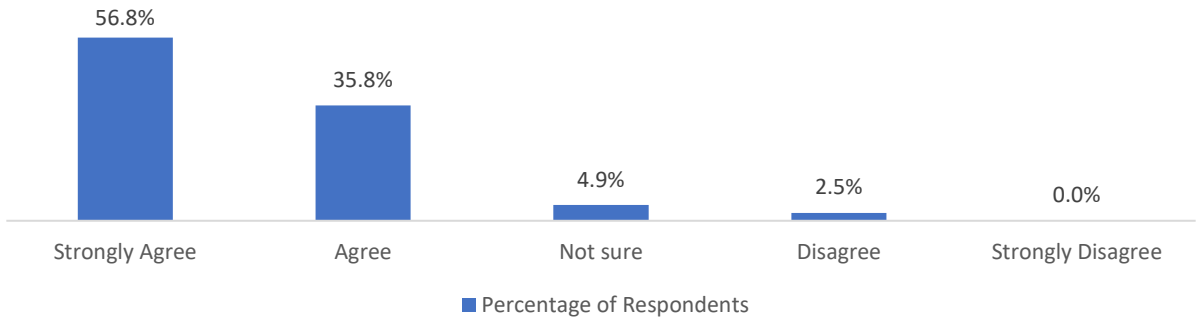


Figure 122: In your opinion, your agency hires employees who are culturally sensitive and culturally competent for the population served.

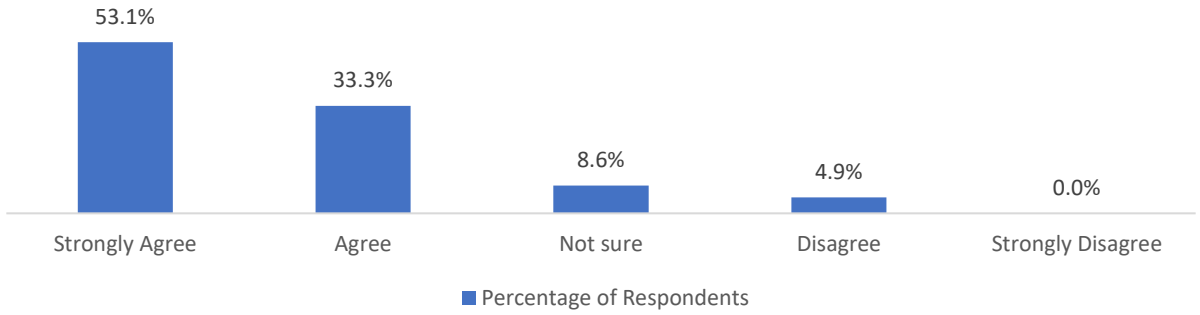


Figure 123: In your opinion, it's easy for individuals to access the services they need quickly and efficiently.

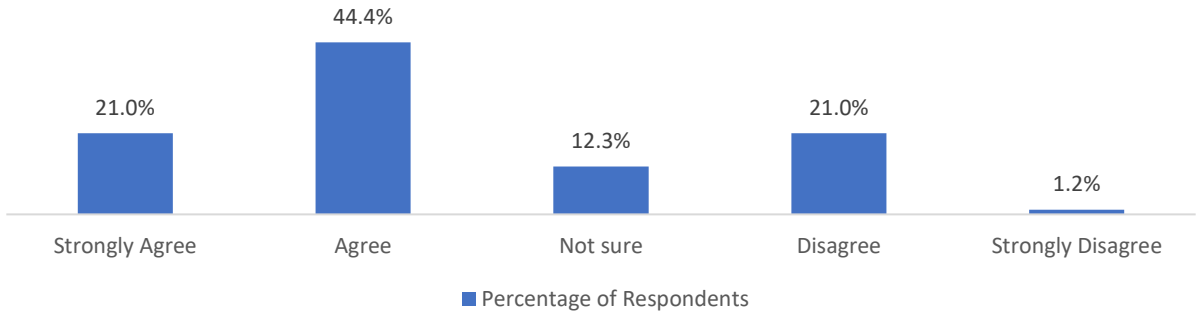


Figure 124: Do you think a standard intake and screening process for state agencies and community partners would help individuals get into services more quickly?

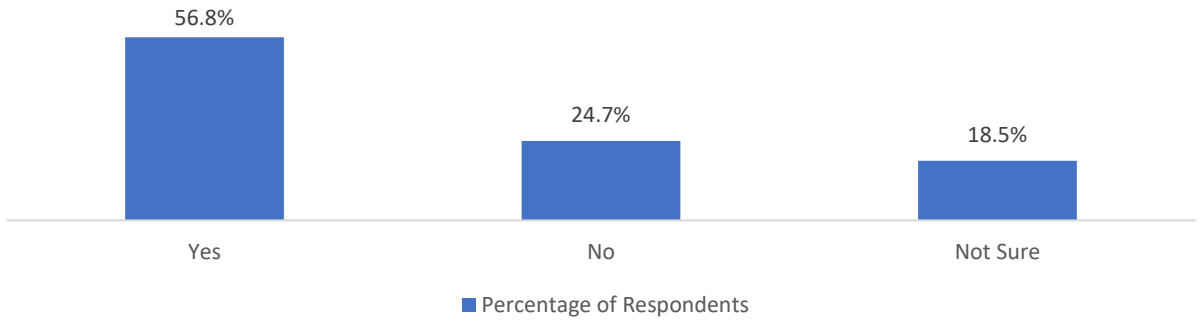


Figure 125: In your opinion, your organization encourages (promotes) working with other community partners to ensure care coordination.

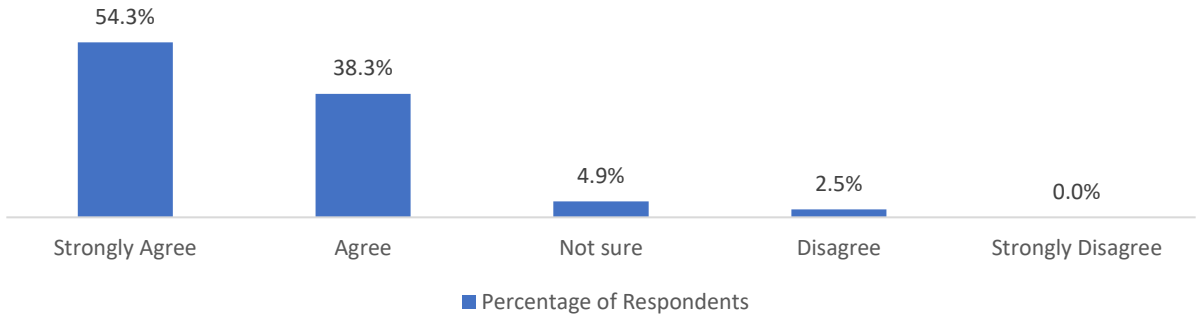


Figure 126: In your opinion, individuals in need of services have equal access to care.

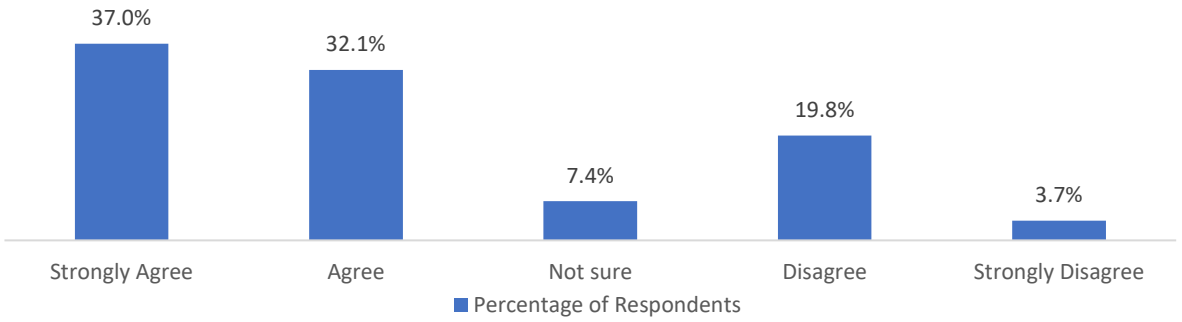


Figure 127: In your opinion, stakeholders help to address and advocate for equal access to care in system entry points.

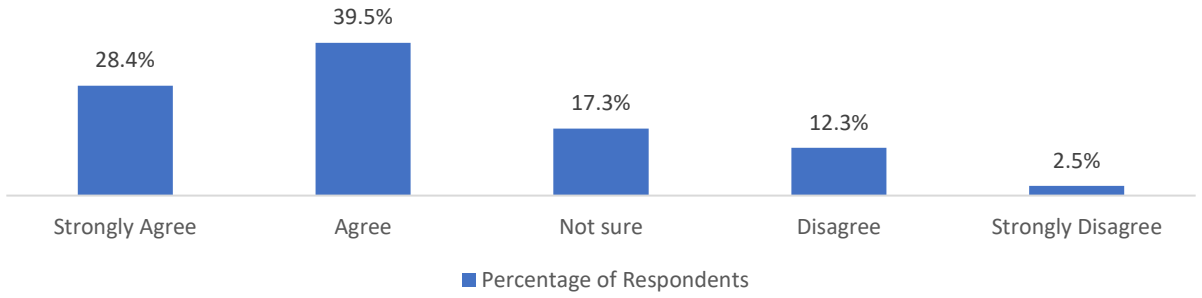


Figure 128: In your opinion, your organization ensures that services are of high quality and meet the needs of individuals served.

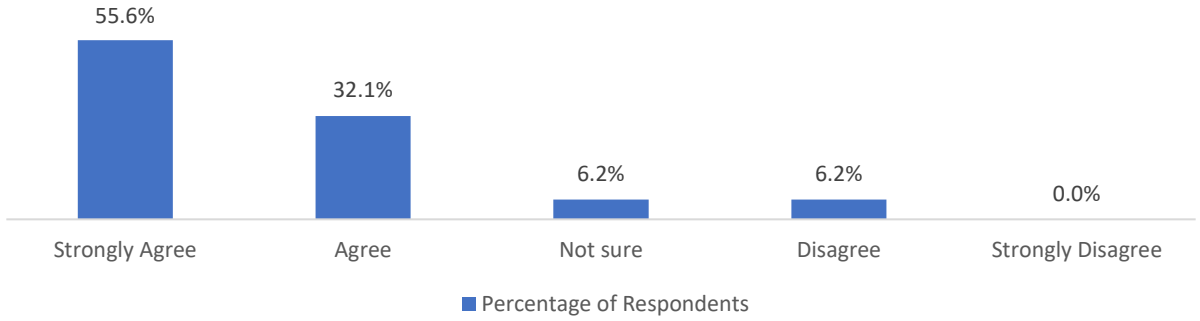
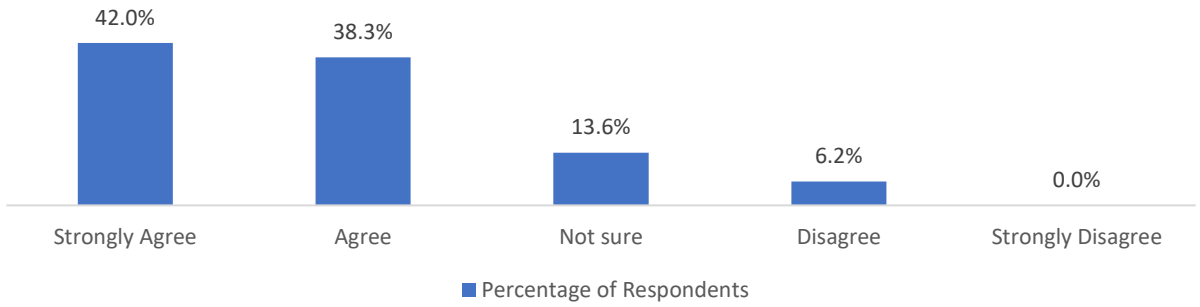


Figure 129: In your opinion, your organization tracks individuals served, services, performance, and cost to continually evaluate and improve outcomes.



NO WRONG DOOR BBHC PROVIDER FOCUS GROUP SUMMARY

BBHC No Wrong Door Provider Interview Questions 1 Group (12) Participants

Opening Question:

What does the term No Wrong Door Access mean to you?

Interview Questions to follow Q1:

Do you think the "No Wrong Door" access works well within your organization?

Tell us about your experience with No Wrong Door access within your organization.
Providers shared that they have a NWD policy for treatment, clients are assessed to determine criteria for treatment however, there are times when they are unable to accept a client/patient because they need a detox facility. Providers reach out on behalf of the client however, there are often no beds available.

Providers shared that they recently started a centralized scheduling department and that this will lend itself to the NWD by assisting clients/patients entering their system of care. Providers also shared that an assessment is completed by an intake specialist, and referrals are made according to client need.

The internal process includes a warm hand off/face to the name/engagement when clients are reluctant to care. The client is introduced to their contact person for enrollment, case management team works to build relationships with Providers and assists with linkage coordination on behalf of the client. This connection helps to build relationships/trust/connection with client and a more collaborative approach/team focused. Client's feel that they have advocates. Availability of additional beds would be helpful for the clients who would like to be in care and availability is limited. Also helpful was receiving updates from providers regularly. Creating a breakdown of services provided at each agency as a reference for the case management team would be useful.

Do you think your organization's current approach to "No Wrong Door" works well?
Yes.

What are some things that you think work well?
Providers shared that a centralized appointment scheduling system, referral process, case management team, warm hand offs and building relationships within the community are way that the agencies play a role in the NWD access.

What are some opportunities for improvement?

Providers shared that they have been struggling lately with clients who are homeless and in need of psychiatric care and placing them with a warm/hot hand off. Struggle with understanding what the other facilities do and linking these clients directly.

Interview Question to follow Q2:

From your perspective, your organization has a role to play in the No Wrong Door access.

What are the ways that your agency plays a role in the "No Wrong Door" access?

Providers shared that a centralized appointment scheduling system, referral process, case management team, warm hand offs, and building relationships within the community are way that the agencies play a role in the NWD access.

Interview Question to follow Q3:

In your opinion, your organization has taken action to improve the referral and care coordination process for individuals served.

In what specific ways can your agency improve on the referral and care coordination process for individuals served?

Providers shared that the coordination within the organization is important. The way it is managed can be fragmented at times and improvement would be helpful. Case managers are not utilized to coordinate services, but two case managers were hired recently for care coordination on behalf of clients. Not so much of a process change rather a staff issue/short in admissions and a real struggle to process clients in a timely manner. The average process time (1) door to (2) wings is Triage 2-3 days and a biopsychosocial in 2 weeks. The perfect situation would be 24 hours for triage and a biopsychosocial within 1 week. COVID 19 has played a role in the reduction of capacity, and this has not helped the availability of beds resulting in reduced capacity from 50 to 30.

Interview Question to follow Q4:

In your opinion, linkages to crisis intervention and support (like the Mobile Response Teams, medication management, CRF, CIT Officer, BA, CSU, etc.) occurring?

Have you or your agency identified any barriers or obstacles to becoming a part of the No Wrong Door System?

COVID 19: No longer require a COVID test; however, COVID testing is completed in house. If a client tests positive, they cannot complete the intake process as there is not enough space to separate appropriately. The agency is unable to quarantine negative and positive together.

INFORMATION, REFERRAL, AND COMMUNITY AWARENESS

Interview Question to follow Q5:

In your opinion, your organization promotes its services and resources very well.

Can you give examples of this?

Providers do not always promote services because they are already overwhelmed with patients, and they do not have the capacity for additional patients on the crisis side. Promotion is utilized and transportation for the youth services are limited. The community remains hesitant to return to pre-COVID events/resources.

Interview Questions to follow Q6:

In your opinion, your organization promotes awareness of available options and linkages to needed services.

How does your agency promote awareness of available options and linkages to needed services?

(Brochures, social media, billboards, website, handouts, etc.)

What else could be done to increase the level of awareness of behavioral health services in the community?

Two-fold: Determine level of awareness by the level of engagement. Stigma associated with mental health services within demographics. How the information is delivered and received plays a role in how a person understands what is being offered without feeling overwhelmed by the information.

Providers work with children and families from a very culturally diverse population and so when talking about behavioral health services it is important to factor in the culture of the population. In terms of reaching them, the cultural populations, the mode of communication used does not work well. Some populations may receive information from the radio rather than television; Religious organizations rather than someone from the outside; not wanting to use the term mental health. We must understand that one size will never fit all. The data shows the number of families coming into the behavioral health centers seeking help. The information must be broken down culturally.

Providers share stories through video among many demographics that are inspirational and that clients may relate to better especially persons who are hesitant. Mental health/behavioral health does not receive the same attention and should be brought to the forefront such as substance use and HIV services. The lived experience component is important. Push more within the school

system. How we reach the families will need us to go outside of the box to reach the populations that do not have access or do not receive the messaging.

PERSON-CENTERED CARE AND TRANSITIONAL SUPPORT

Interview Questions to follow Q7:

In your opinion, your organization provides person-centered care for all individuals served.

Describe how your agency implements a person-centered care system of care.

Peer Specialists: Clients are more engaged and relate in a different way-more connected.
Medical Case Manager/Behavioral Therapist: Allowing client to make the choice/comfort level.
Health care System: Pediatric side-organizational self-assessment Plain Tree (every 2 years) Family & Patient centered care.
Adult side: Patient and Family Centered Care self-assessment. Utilizing Peers on the adult side for decades. Peers for families are needed. Generate more opportunities for Peers.
Address Family Centered Care: Culturally the family can be quite extended/any relationship with the child/everyone who has a connection or impact becomes a part of the system.
The challenges with underlying beliefs of mental health services and effectiveness requires a great deal of education to even encourage them to engage. The success of the child relies within the family system. Many resources were lost during COVID and identifying what a client needs/level of care after detoxification must be overseen quickly. Collaborating with multiple providers post-detox to facilitate discharge planning so that the risk of post detoxification use does not occur.

What resources or supports would your agency need to improve person-centered care?
Interview Questions to follow Q8:

In your opinion your agency hires employees who are culturally sensitive and culturally competent for the population served. If not, are you aware of your agency doing anything to improve in this area? Is there anything your agency could do to improve?

The Providers responded that their agencies hire employees who are culturally sensitive and culturally competent.

STREAMLINED ACCESS AND ELIGIBILITY

Interview Questions to follow Q9:

In your opinion, it is easy for individuals to access the services they need quickly and efficiently.

If yes, what works well about the current process with individuals for accessing services? Yes and No. Get caught up with the diagnosis prior to engaging them in programs.

If no, what are the major barriers that keep individuals from accessing the services that they need?
It also depends on the services. Psychiatric services are even more challenging now. Young children access for psychiatric services is difficult because of the funding requirements. Focus on prevention and would like to see that children receive the services as young as possible to limit services needed at an older age. Using more telehealth as a tool, accessing services without the worry of transportation has changed the way business is being done. Insurance plans and types of insurance prevent certain services from being offered.

Interview Questions to follow Q10:
Do you think a standard intake and screening process for state agencies and community partners would help individuals get into services more quickly?

Why or why not?
Providers shared that a lot of times funding/accreditation drives the forms/processes in place and while there could be similar data in place it would be layering more work on the staff. Providers shared that there are many funders and requirements for each provider that make it challenging to create a universal process. Providers also shared that a standard intake would not be useful unless organizations could share data with one another. Providers talked about previous efforts to develop a virtual front door and conceptualized that an assessment would be provided and follow through to the next agency. How could this be worked out? MOU's? What platform would the assessment sit on? Maybe with technology it may be more possible. Would a core group be trained to complete assessments in a certain way? It is a great idea if it could happen.

What do you think would need to be accomplished to implement a standard intake and screening process for the region/state/system?
How could this be worked out? MOU's? What platform would the assessment sit on? Maybe with technology it may be more possible. Would a core group be trained to complete assessments in a certain way? It is a great idea – if it could happen.

PARTNERSHIPS AND COORDINATION OF EFFORTS

Interview Questions to follow Q11:

In your opinion, your organization encourages (promotes) collaborating with other community partners to ensure care coordination. Which partners do you work with most? What works well in these partnerships?

Yes, providers strive to collaborate with other community partners. Warm handoffs are challenging at times when the process is slowed down due to paperwork, insurance, and limited resources. Partnerships include pediatricians, social service agencies, and community platforms. Providers who obtain authorization with proper consents are important for the coordination effort and when in place the partnerships work well.

Interview Question to follow Q12:

In your opinion, individuals in need of services have equal access to care. Why? Why not? What works well?

The providers shared that mental health is not really set up for everyone to receive the same level of care due in part to insurance status/stigma/lack of resources. We do well in South Florida with the lack of resources however, there is still no parity. Someone with Medicaid may receive home therapy however, Medicare does not provide case management and the state is relied upon for assistance.

Interview Question to follow Q13:

In your opinion, do Stakeholders help to address and advocate for equal access to care in system entry points. If no, how can this be improved?

Providers shared that funding drives equity and while stakeholders help to address and advocate for equal access to care often, those services are reliant upon funding and type of Insurance coverage.

QUALITY ASSURANCE AND CONTINUOUS IMPROVEMENT

Interview Question to follow Q14:

In your opinion, your organization ensures that services are of high quality and meet the needs of individuals served.

If no, how can this be improved?

Providers shared that the utilize a robust quality incentive payment program and accreditation process to ensure that services are of high quality and meet the needs of individuals served. Training is emphasized and yet, expensive. Often, practitioners who have recently graduated and do not have firsthand experience require more training.

Interview Question to follow Q15:

In your opinion, your organization tracks individuals served, services, performance, and cost to continually evaluate and improve outcomes?

If no, how can this be improved?

Providers shared that data collection, the length of time a person has received services, compliance within those services and if the services were appropriate to the individual. Needs are utilized to track individuals' services, services, performance, and cost.

THEMES IDENTIFIED

The themes identified during the No Wrong Door provider group are as follows.

No Wrong Door Provider Group:

- Training for Fundamental Behavioral Health Services for Peers and Professional who can triage and support
- Ongoing Sensitivity Training is needed
- Additional Staff
- Socioeconomic Understanding
- Availability of Resources/Beds
- Community Resource Directory explaining services offered
- Referrals/Coordination
- Insurance Plan Barriers
- Stigma
- Engaging School System
- Telehealth
- Funding
- Lack of Resources

INDIVIDUALS SERVED SURVEY SUMMARY

BBHC INDIVIDUALS SERVED SURVEY RESULTS SUMMARY

All 81 survey respondents lived in Broward County. Of these, 55.3% of the respondents were enrolled in adult mental health services and 17.9% were enrolled in adult substance abuse services. Just under 14% were enrolled in peer support services and 11.4% in prevention services.

KNOWING WHERE TO GO FOR SERVICES

Knowing where to go for services is the first step in accessing health care. Among respondents, 82.7% indicated that they knew where to go for services if they needed them. Over half of consumers indicated they learned about services from family members, friends, or another person using services.

Regarding 2-1-1 awareness, almost two-thirds of respondents knew of this resource. However only 37% of those had previously called for assistance. Nearly 75% of those that did call 2-1-1 for support, found that it was only helpful sometimes or not at all.

SERVICES THAT WERE NEEDED BUT NOT RECEIVED

Close to 36% of respondents did not receive the services they needed. Of the services need, 9.6% were not able to get case management, 10.7% could not get housing assistance, and 11.9% responded 'other' services were needed. Fifteen percent of consumers stated that the services they needed we not available and 21.3% were placed on a waitlist. Close to one third of respondents stated they were not able to get services between 1-4 times. Overall, 63.8% of consumers received services when they needed them.

ACCESS AND PERCEPTION OF THE HEALTH CARE PROCESS

The majority of consumers agree that services were patient centered; 52.5% strongly agreed with this statement. Slightly over 40% of consumers waited 1-3 days for an appointment. Over 18% of consumers were able to get an appointment within a week. Only 3.8% were never able to get an appointment.

Over 80% of consumers were able to get to get to their services within 30 minutes. Almost half of the (46.1%) consumers were driven to services by themselves or a relative/friend. Respondents who used the public or private transportation services accounted for 35.3% of all consumers.

BARRIERS TO NEEDED SERVICES

Of all respondents, 28.3% indicated they did not face any barriers when seeking services. Among the responses, long waiting lists ranked as the top barrier prevented consumers from receiving

needed services. Not knowing where to go for services, not meeting the eligibility requirements, lack of transportation, stigma, and affordability were also in the top barriers for consumers.

INDIVIDUALS SERVED SURVEY CHARTS

Figure 130: Which best describes you?

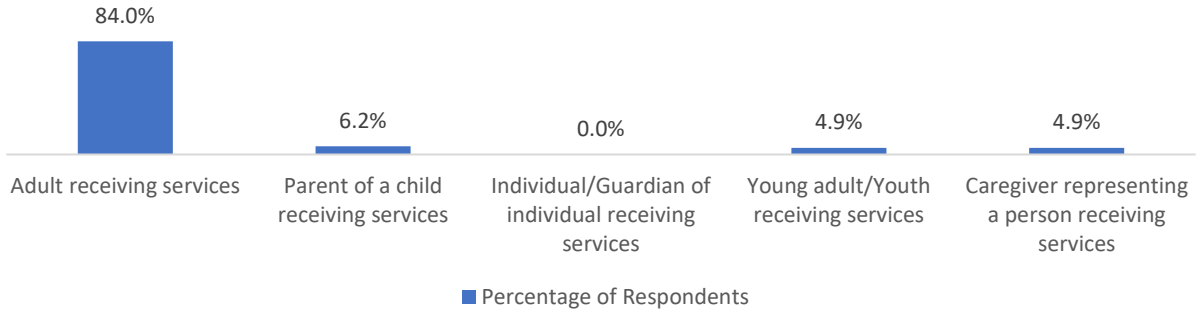


Figure 131: What type of service did you or the person you are representing receive?

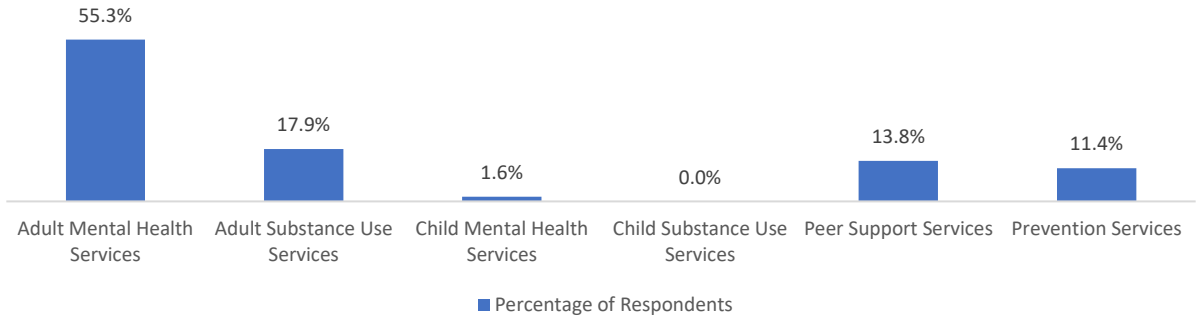


Figure 132: Which county do you live in?

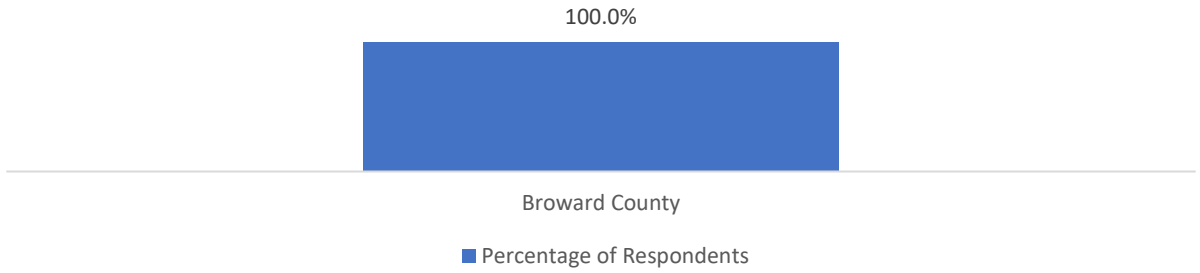


Figure 133: Did you know where to go for mental health and substance use treatment services when you needed them?

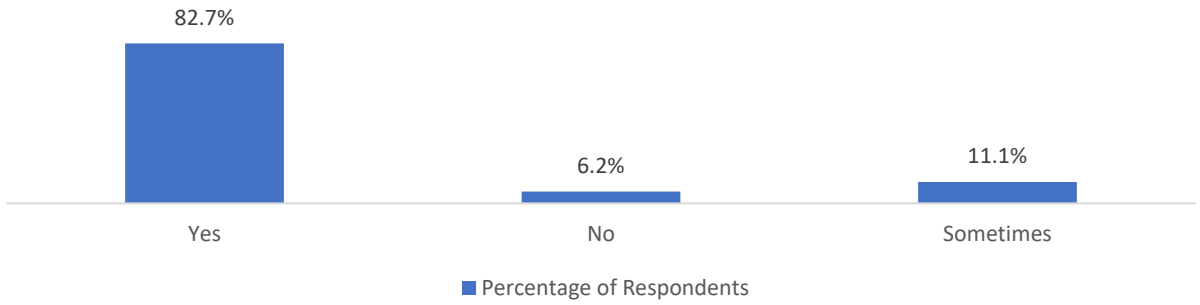


Figure 134: How did you learn about mental health and substance use treatment services when you needed them?

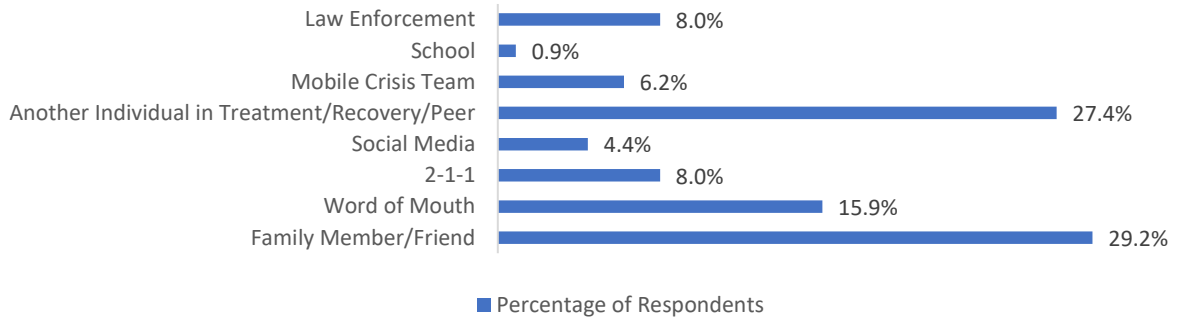


Figure 135: Are you aware of the 2-1-1 Information and Referral Resource in your community?

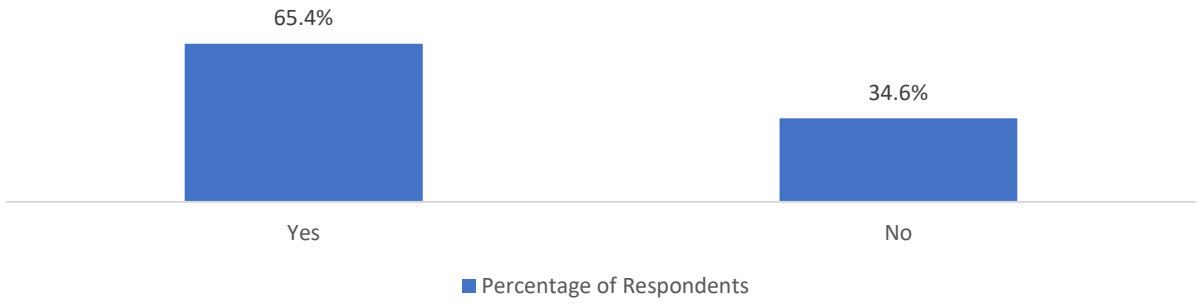


Figure 136: Have you ever called 2-1-1 Information and Referral Resource for assistance?

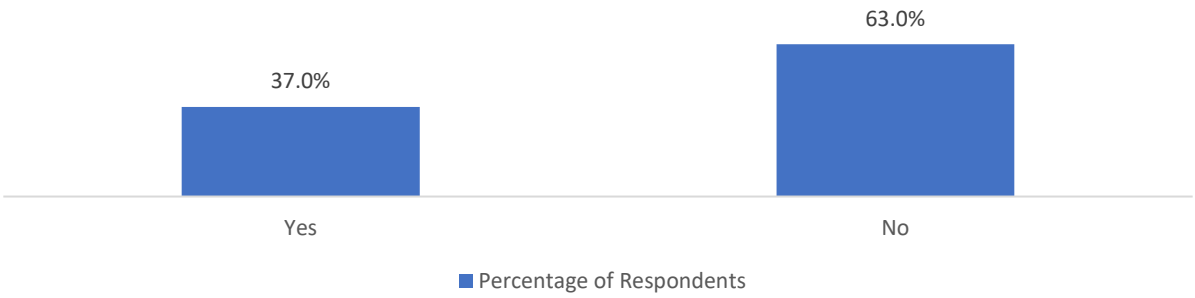


Figure 137: When you called the 2-1-1 Information and Referral Resource, were they helpful in getting you the services needed?

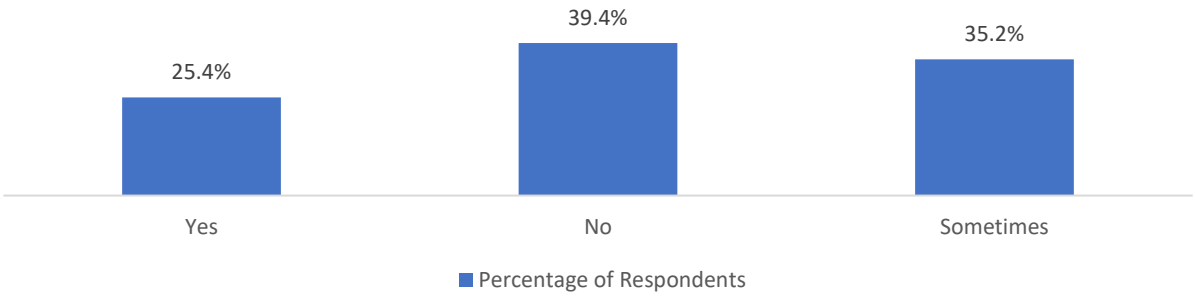


Figure 138: Were you able to get all the services you needed when you needed them?

Figure 139: If no, please choose from the list below, the services you needed but were not able to get.

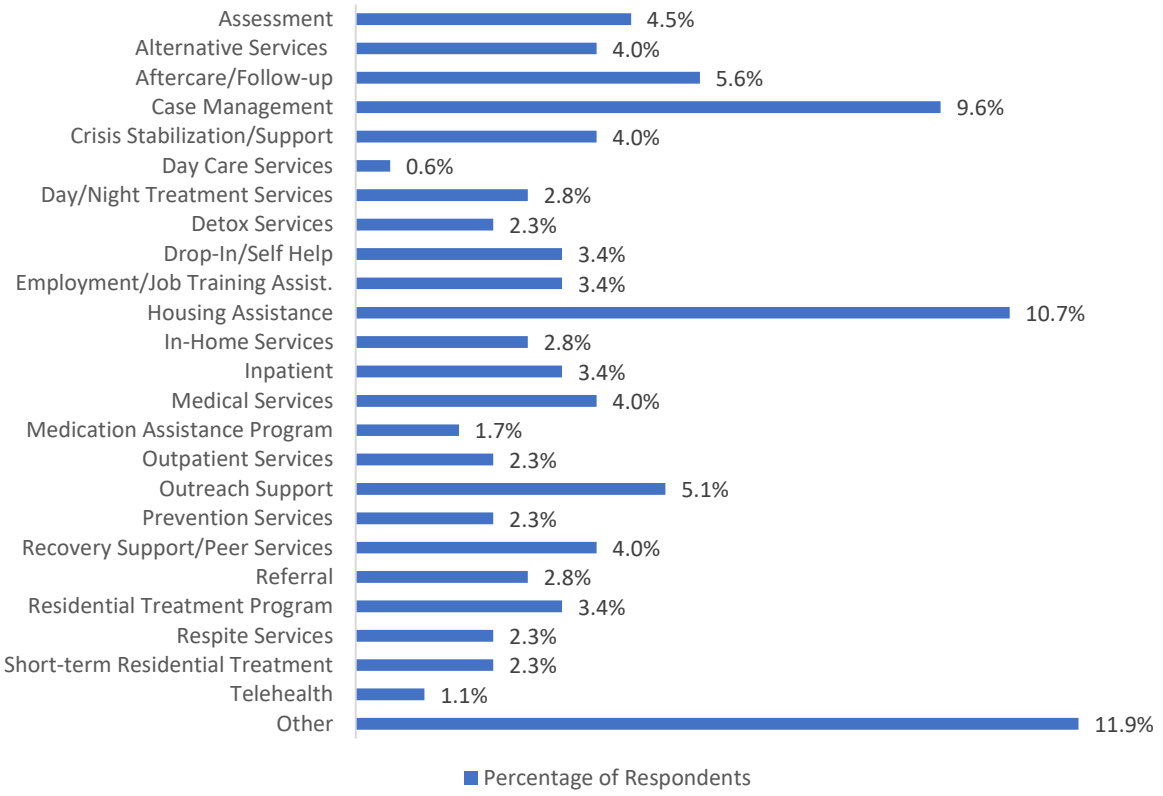


Figure 140: How many times during the last 12 months were you Not able to get the services you needed?

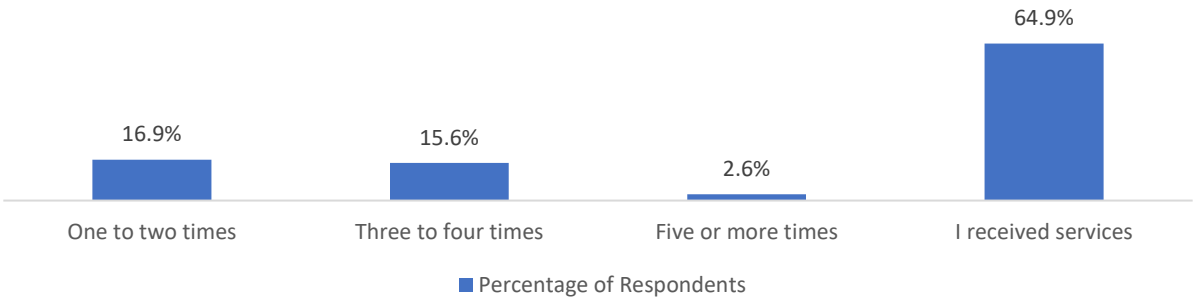


Figure 141: The services I needed were:

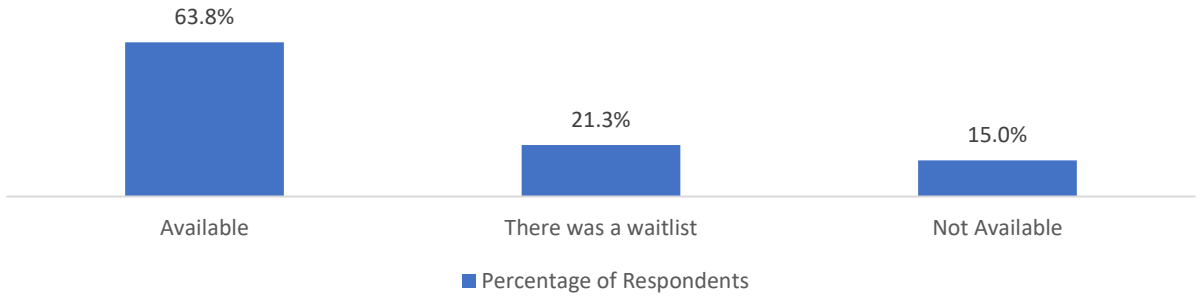


Figure 142: The services and planning I received were focused on my treatment needs (patient centered).

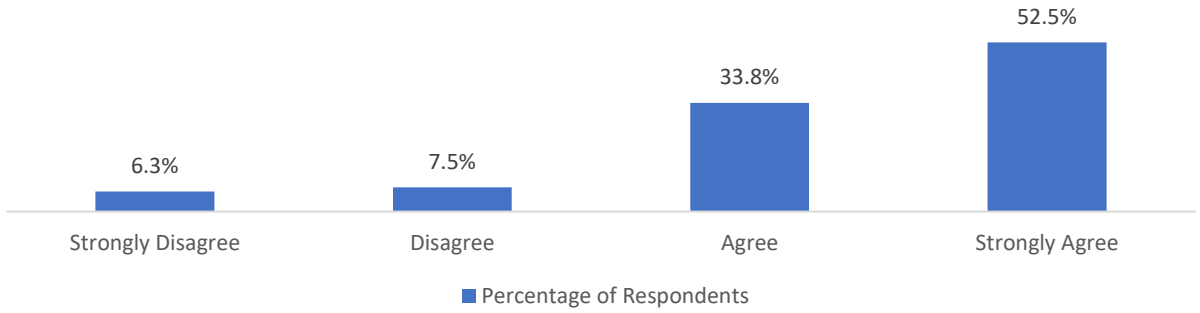


Figure 143: How long did it take from the time you requested an appointment for services to the time you received the services?

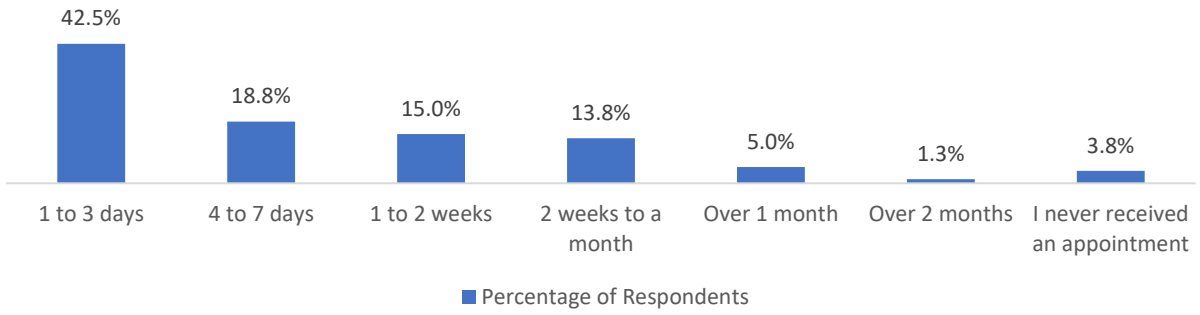


Figure 144: How long did it take to travel to the service?

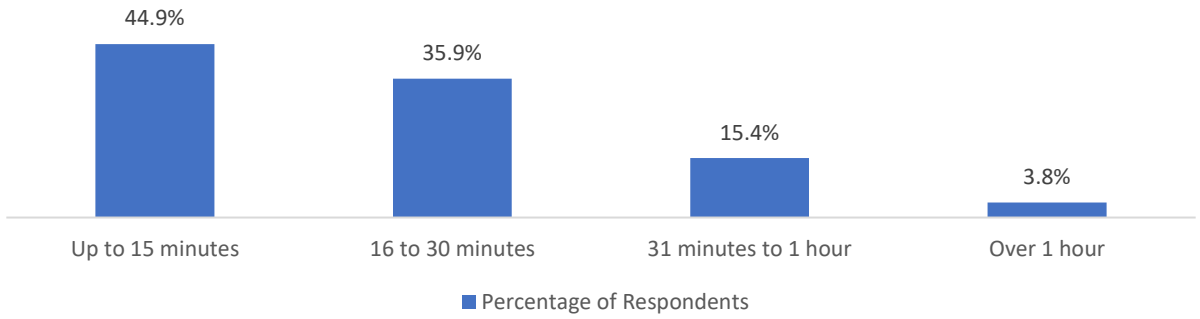
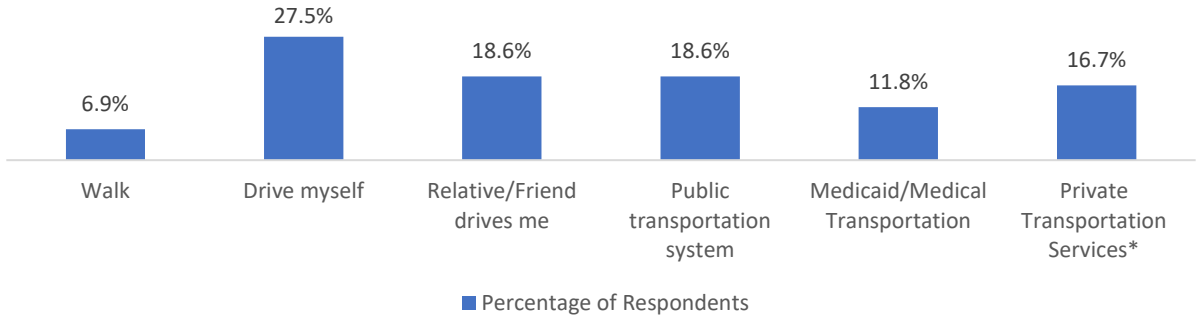
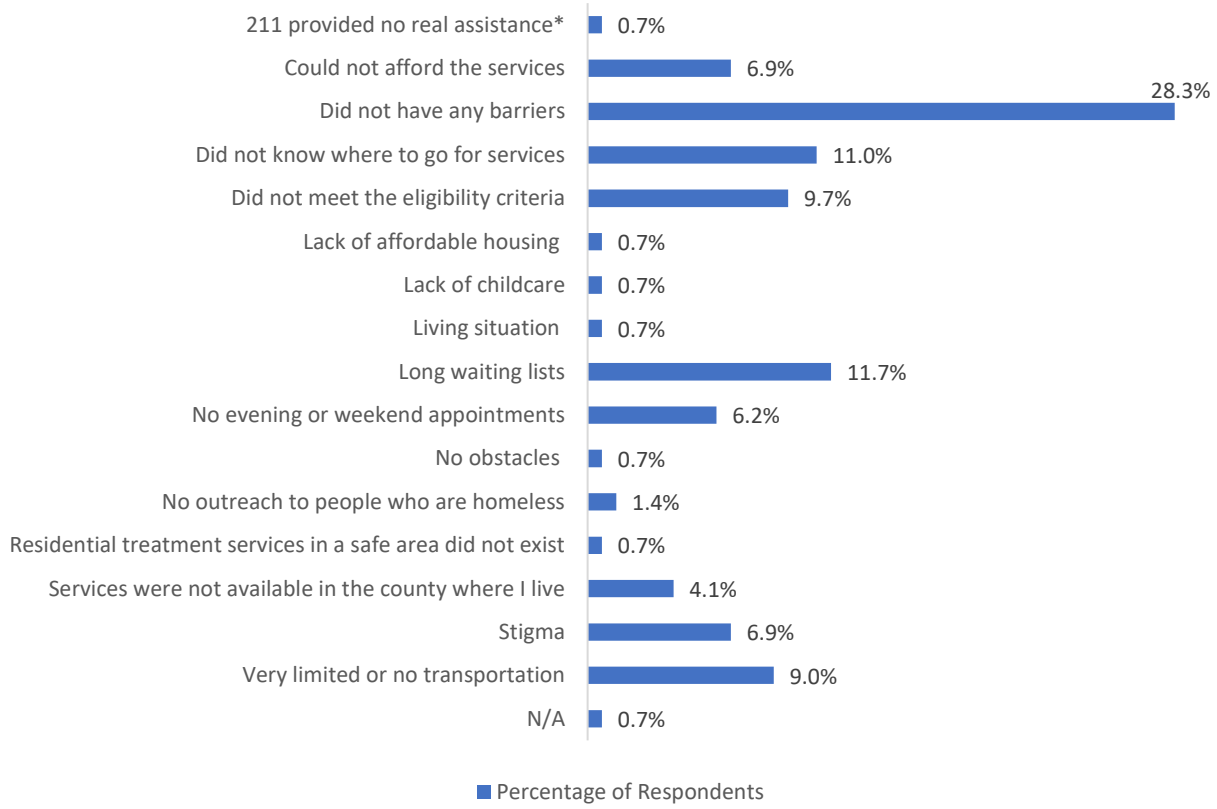


Figure 145: How do you travel to get services?



*Note-Private transportation includes Taxi, Uber, Lyft, TOPS, etc.

Figure 146: What were the obstacles you experienced getting the care you needed?



*2-1-1 no real assistance includes wait times are forever and they are poorly trained

STAKEHOLDER SURVEY SUMMARY

All 175 respondents for the stakeholder survey were from Broward County. Information was collected on awareness, access to care, and barriers to behavioral health resources. Broad representation was received from stakeholders in 22 service sectors. Respondents from adult substance use treatment services accounted for 11.4% of all respondents while 8.4% were from case management, 7.4% from adult serving agency, and 8.8% from unidentified other. All other services accounted for 6% or less. Additional Information: An additional Stakeholder survey was conducted for the BBHC Board members. Findings regarding the awareness of the behavioral health resources available in Broward County was consistent with the original Stakeholder survey with 85% of Board members agreeing or strongly agreeing that they were aware of behavioral health resources. The following resources and services that are needed, but not available to improve patient-centered care and planning include transportation, housing, childcare, shorter waitlists, more inpatient facilities, residential treatment for substance use conditions, mental health agencies serving non-insured, consumers knowing where to go for services, and more case management service locations to assist people applying for HUD and Section 8 housing. Board members identified the top barriers to treatment which included long wait lists, limited or no transportation to appointments, stigma, lack of awareness of programs, and lack of affordability of services.

AWARENESS

Most stakeholders (85.7%) agreed or strongly agreed that they were aware of the behavioral health resources available in their county. Seventy percent were aware of the ME resources, and 57.1% had accessed them. Of those who accessed the resources, 52% felt it was helpful, and 30.3% felt it was only somewhat helpful. The majority (60.6%) of respondents had not directed individuals to access ME resources by calling or online.

Regarding the 2-1-1 resource, 96% of respondents had knowledge of this information and referral source, but only 42.9% of those had accessed 2-1-1 in the past 6 months. Of those who accessed it, 54.9% found it to be useful, while 26.9% found it to be only somewhat useful. Of the respondents, 82.3% reported that they had directed individuals to access 2-1-1 by calling or online. Overall, only 20.6% of respondents felt community awareness for behavioral health resources was excellent or very good while 36.6% felt it was good.

ACCESS TO BEHAVIORAL HEALTH CARE SERVICES

Stakeholders were asked to rate their agreement on statements about the process of accessing behavioral health services. More than 75% of respondents agreed that behavioral health care and peer services were accessible. Regarding coordination, 60.6% agreed that programs and services

are coordinated across systems of care and 65.1% respondents agreed that the linkages to needed services are coordinated and well established. Most stakeholders (62.2 %) agreed that the referral process was accessible.

BARRIERS

The top 5 barriers for accessing services were no/limited transportation, long waitlists, being unsure about where to go for services, stigma, and being unable to afford the services. Transportation issues were identified as the number one barrier to accessing behavioral health care services by 14.9% of respondents. Other barriers were long waitlists (11.5%) and being unsure of where to go (12.2%). Percentages for all other barriers accounted for 10% or less of respondents.

According to respondents, the most needed resources and services were for housing (18%) and transportation (11.5%) needs. Ten percent of respondents believed there needs to be more education about available resources, and another 10% believed there needs to be a wider variety of services available. Of the respondents, 8.5% believed there was a greater need for mental health resources and 8.5% believed staff shortages and long waitlists needed to be addressed to improve the health system.

Respondents identified Henderson Behavioral Health, South Florida Wellness Network, and 2-1-1 as the top three patient-centered care resources that have improved individuals' quality of life.

STAKEHOLDER SURVEY CHARTS

Figure 147: Percentage of respondents by organization service sector.

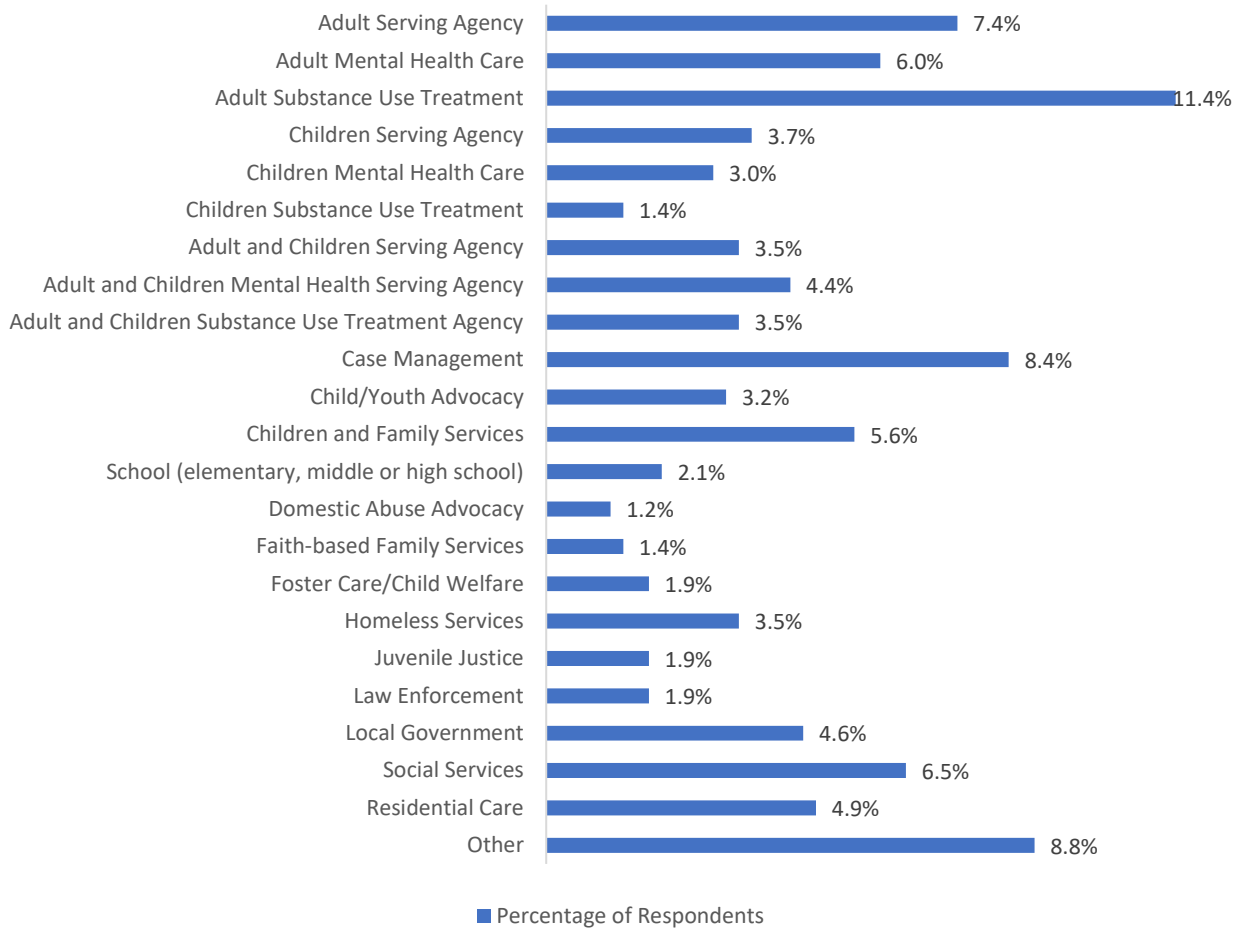


Figure 148: Percentage of stakeholder respondents by county.

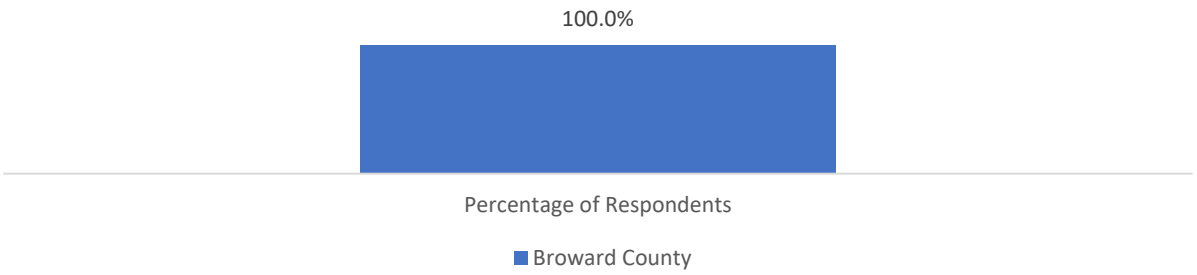


Figure 149: You are aware of the availability of mental health and substance use services in your area.

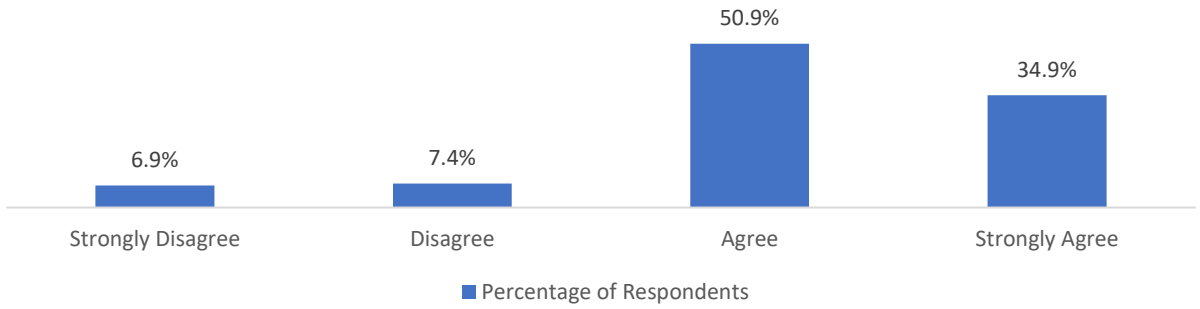


Figure 150: Are you aware of Broward Behavioral Health Coalition (Managing Entity) resources?

Figure 151: Have you accessed Broward Behavioral Health Coalition (Managing Entity) resources in the past 6 months?

Figure 152: When you accessed Broward Behavioral Health Coalition (Managing Entity) resources, was it helpful?

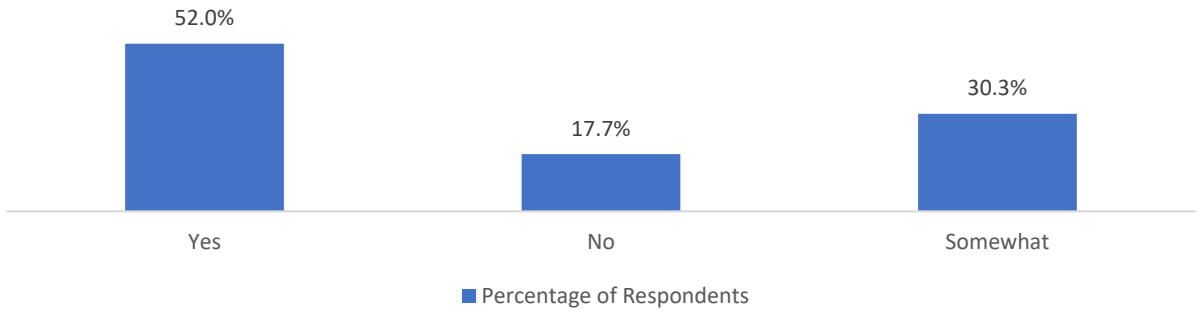


Figure 153: Have you ever directed individuals to access Broward Behavioral Health Coalition (Managing Entity) by calling or online?

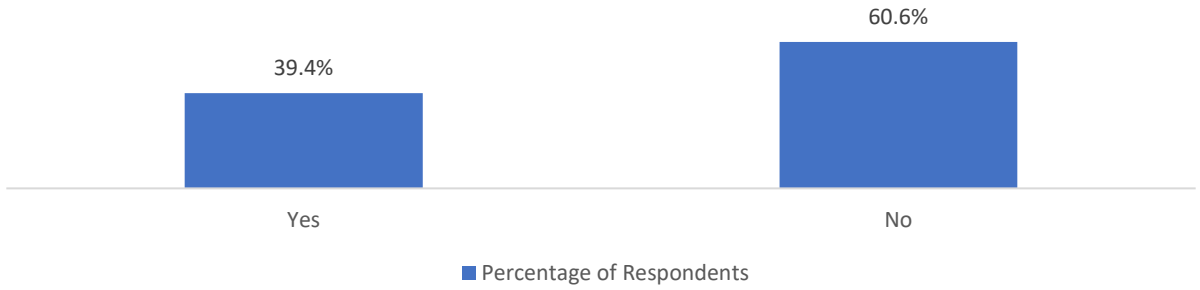


Figure 154: Are you aware of the 2-1-1 Information and Referral Resource?

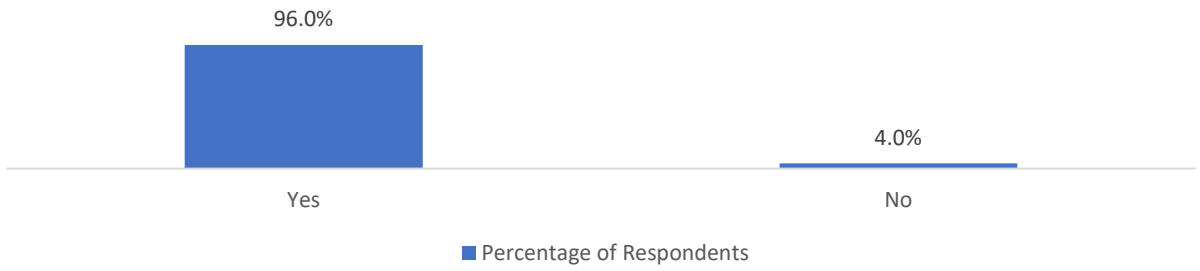


Figure 155: Have you accessed the 2-1-1 Information and Referral Resource in the past 6 months?

Figure 156: When you accessed the 2-1-1 Information and Referral Resource, was it helpful?

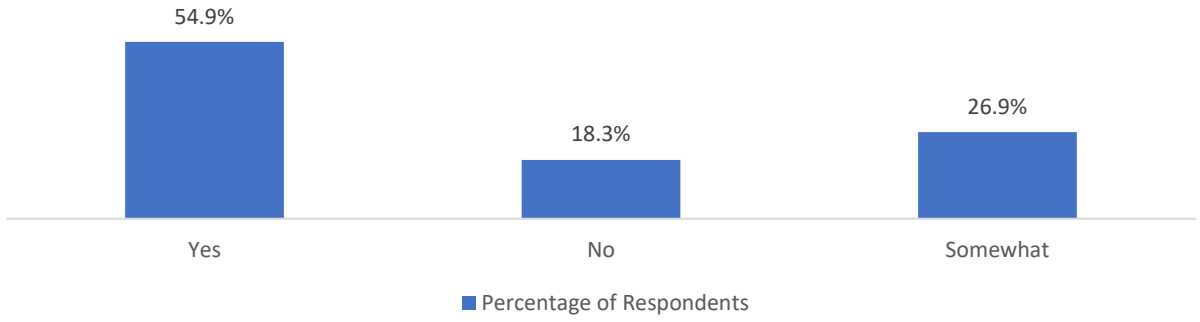


Figure 157: Have you ever directed individuals to access the 2-1-1 Information and Referral Resource by calling or online?

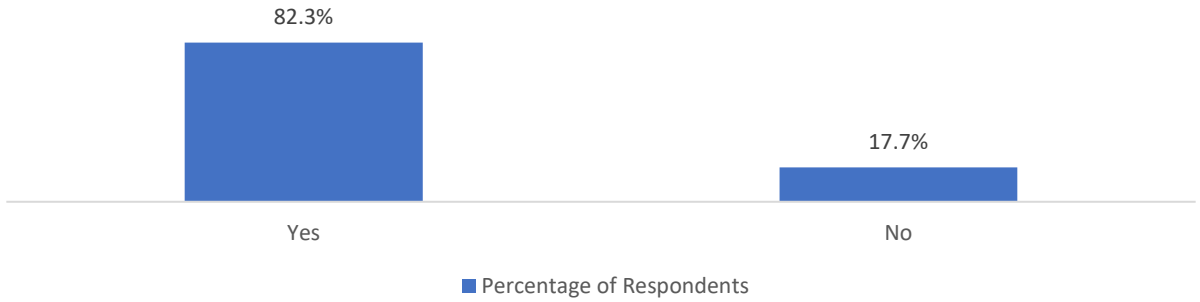


Figure 158: Select the crisis response model in your area. (Check all that apply)

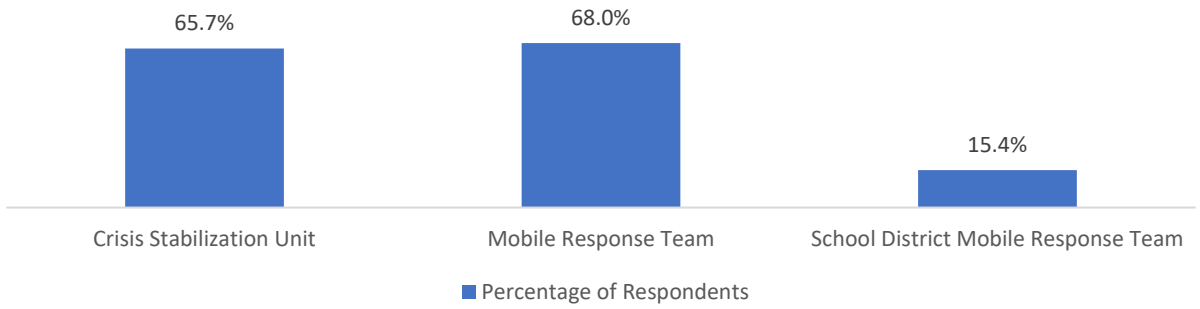


Figure 159: How would you rate community awareness of mental health and substance use treatment services in your area?

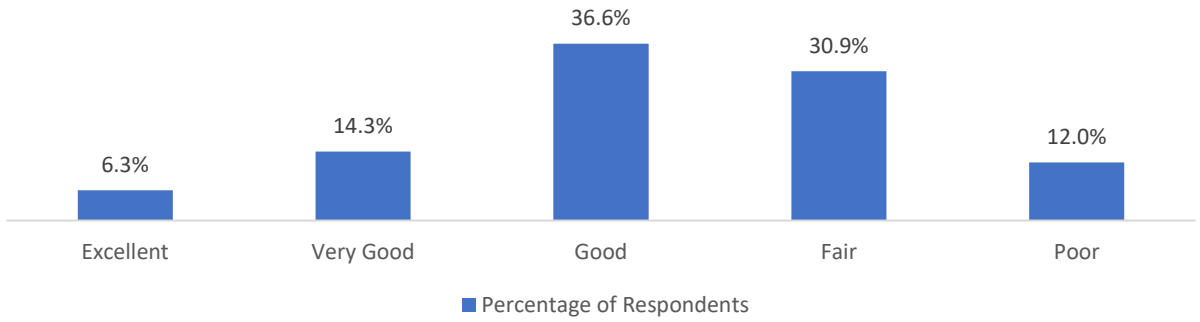


Figure 160: Linkages to needed services are coordinated and well established across the system.

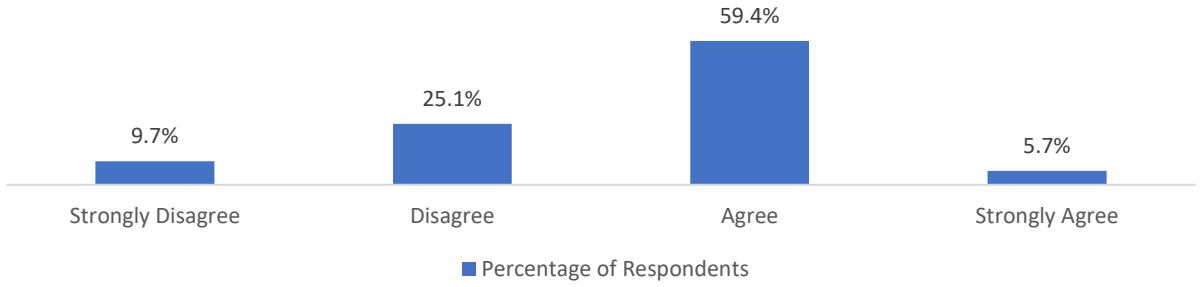


Figure 161: In general, behavioral health care and peer services are accessible in your area.

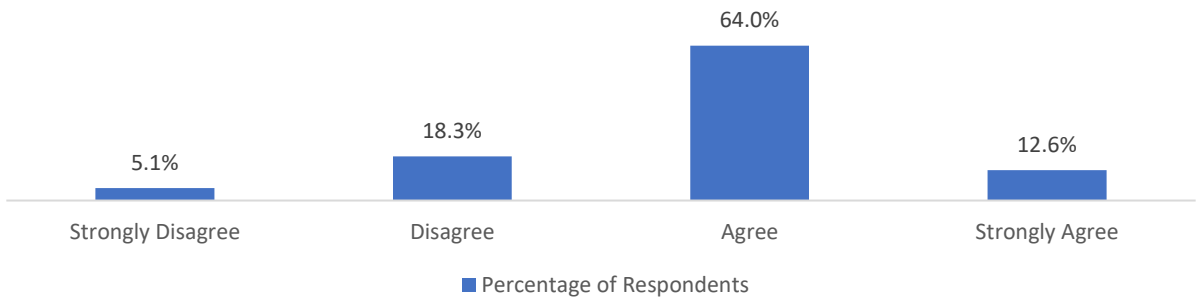


Figure 162: The process for referrals is easily accessible.

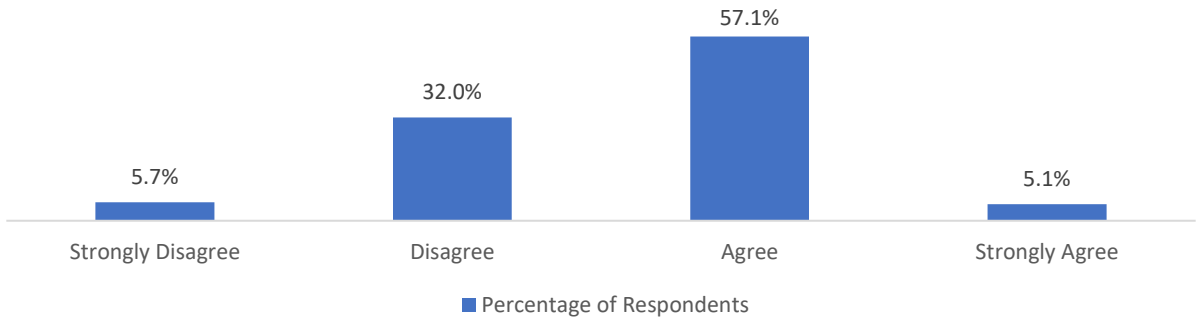


Figure 163: Programs and services are coordinated across the system of care.

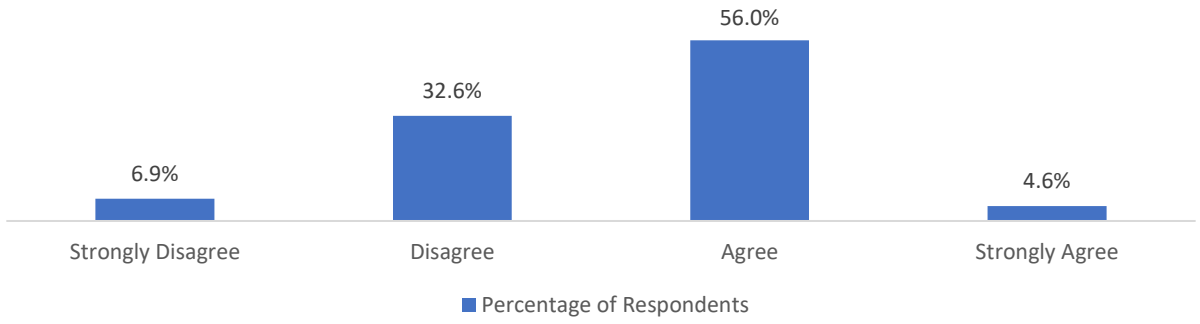


Figure 164: List the barriers for consumer accessing services in your community. (Check all that apply)

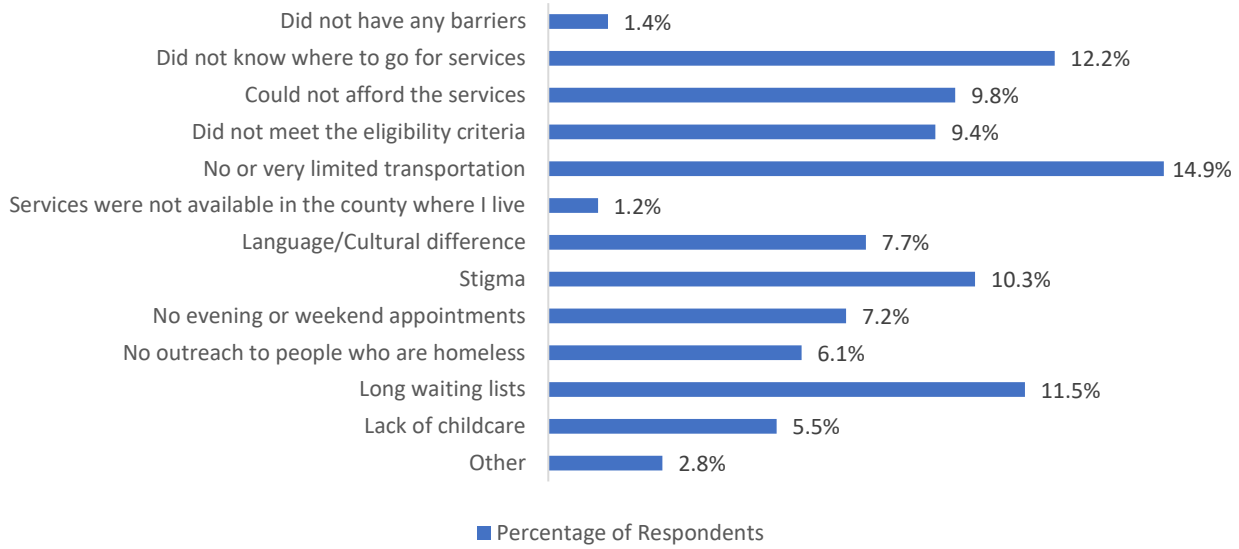


Figure 165: List the resources and services needed that are not available to improve patient-centered care and planning.

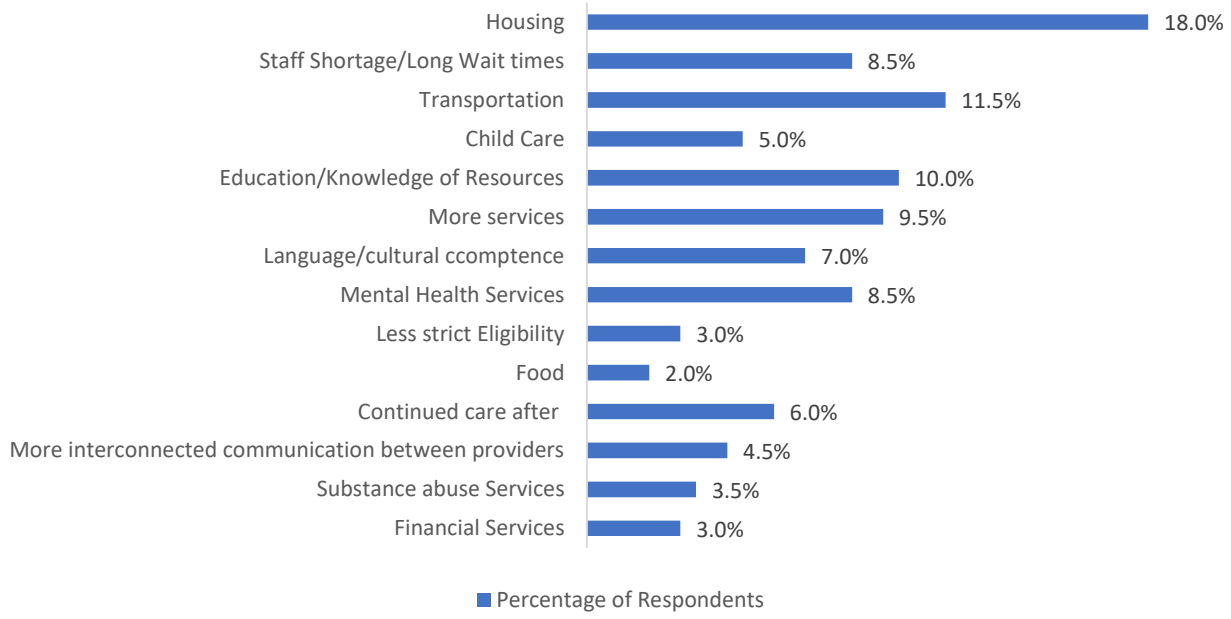


Figure 166: List the top three patient-centered care resources that have improved quality of life for individuals.

TOP THREE PATIENT-CENTERED RESOURCES
Henderson Behavioral Health
South Florida Wellness Network
2-1-1 Information and Referral Resource.

PEER RECOVERY COMMUNITY/SUPPORT SPECIALIST'S SURVEY SUMMARY

All 46 respondents lived in Broward County. The largest respondent demographic were adults living with co-occurring Mental Health and Substance Use condition (46.7%), followed by Adult with lived mental health conditions (24.4%), Adult with lived Substance use condition (13.3%), and family member or friend of someone with lived mental health conditions.

EMPLOYMENT

Respondents who worked/volunteered in either Adult mental health services or substance use services accounted for 31.5% of respondents, while 23.1% were employed or volunteered with peer support services, and 11.1% worked for Recovery Community Organization. All other service agencies employed less than 10% of respondents.

Forty percent of respondents have been employed/volunteered with the agency for more than 3 years; this was the largest demographic. Respondents who have been employed for 1-3 years accounted for 28.9% and 24.4% have been employed for less than 6 months. Most respondents (74.5%) have work schedules that average 40 hours/week.

Almost a quarter of respondents indicated that personal fulfillment was a reason for maintaining employment with the agency. Commitment to recovery principles and flexible work schedules were among the top responses. Conversely, respondents identified salary (23.4%), limited employment opportunities (42.6%), and the exemption/background screening processes (21.3%) as top barriers in the hiring process.

SERVICE DELIVERY

An overwhelming majority reported that their agency utilizes recovery peer support services within services they provide to the community (95.7%) and adhered to recovery support best practices (91.3%). Most respondents (85.1%) agreed that the organization they work/volunteer for help to reduce stigma by promoting person-centered recovery language. Close to 75% reported that peers are included in program development, promotion, evaluation, and improvement. However, only 57.4% responded that people were being included in recovery management and board meetings.

The setting of peer recovery report services varied; however, the most frequently reported locations include Outpatient Recovery Community Organization (RCO), Drop-in Centers/Club Houses, and Medication Assisted Treatment (MAT).

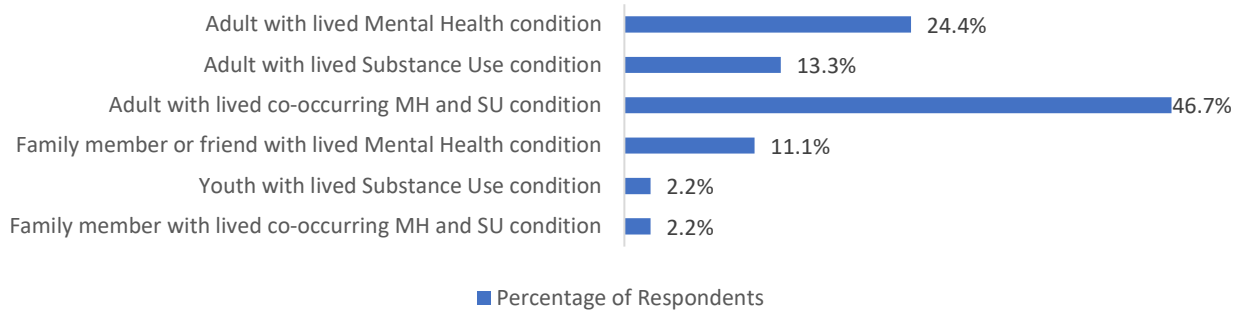
Respondents who are Certified Recovery Peer Specialists (CRPS) represented 44.4% of survey participants. Those who identified as "Not certified" accounted for 26.7% of respondents while

22.2% of respondents are in the process of acquiring certification. Respondents recommended trainings to help peers deliver peer support services. Among the top responses for trainings were 40-hour required Peer Recovery Specialist Training/Helping Others Heal, Wellness Recovery Action Plan (WRAP), Documentation Training, Boundaries/Ethics/Professional Responsibility, Cultural Competencies, and Mental Health First Aid.

Most respondents were aware that partnerships existed between recovery programs and support groups. Respondents were most aware of the following partnerships: Drop-in Centers, Food Pantries/Meal Programs, Halfway Housing, and RCOs.

PEER RECOVERY COMMUNITY/SUPPORT SPECIALIST'S SURVEY CHARTS

Figure 167: Which best describes your experience?



Note: Mental Health (MH) and Substance Use (SU)

Figure 168: Which county do you live in?

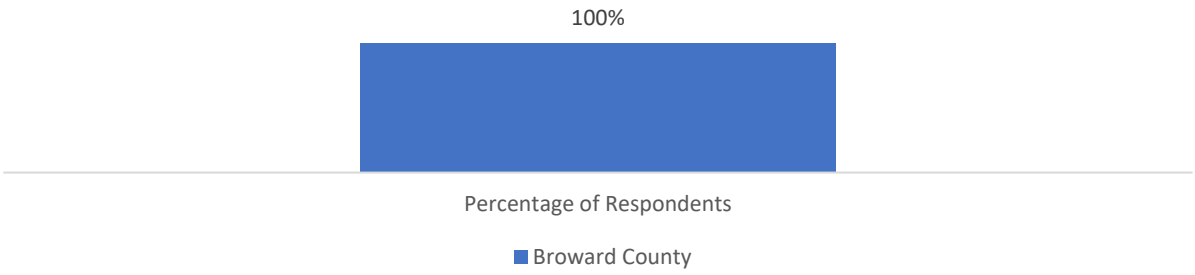


Figure 169: What type of service are you employed or volunteer with? (Check all that apply)

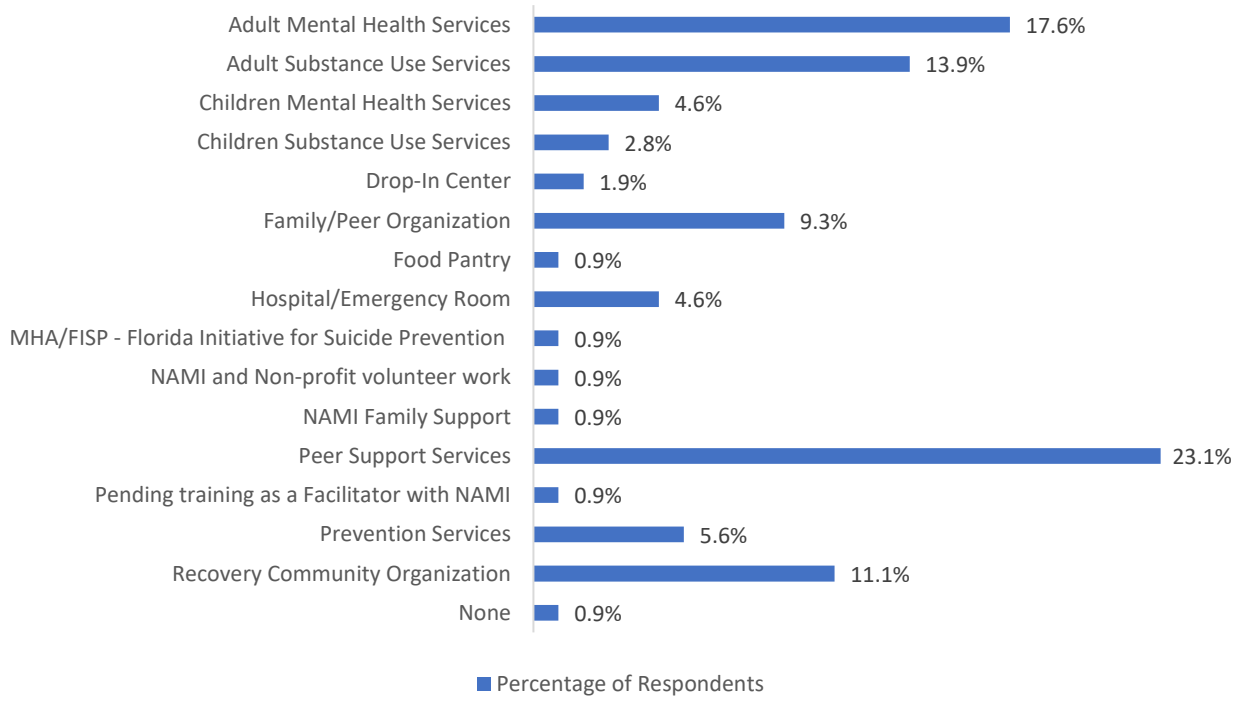


Figure 170: How long have you been employed/volunteered with the agency?

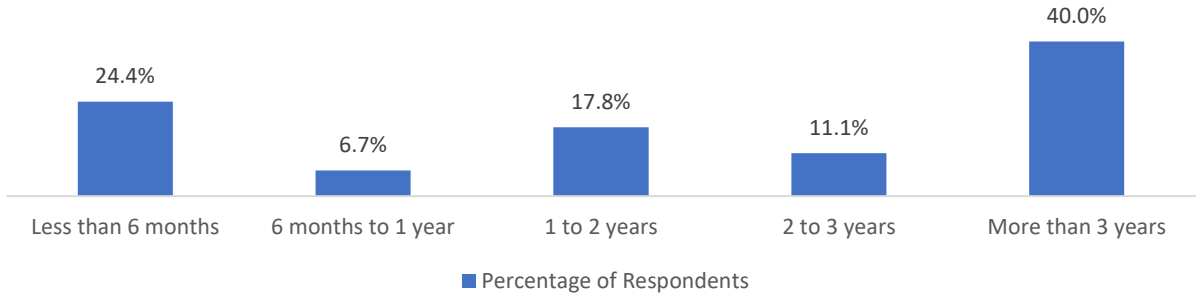


Figure 171: My work schedule averages...

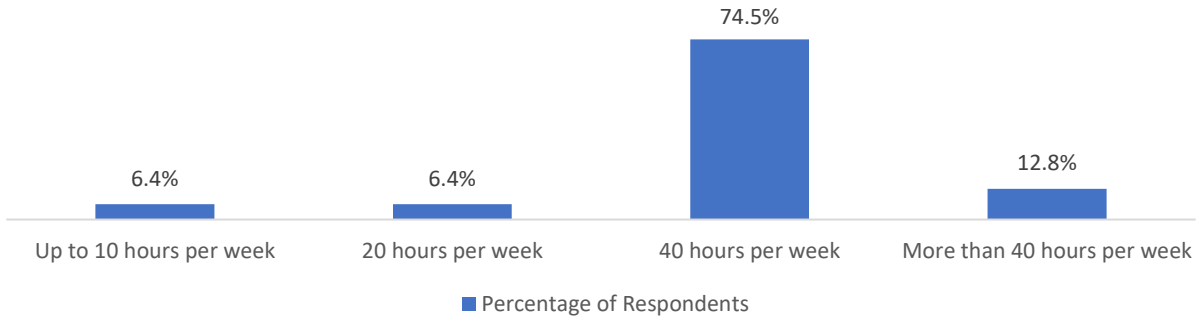


Figure 172: Does the agency where you are employed, or volunteer, utilize recovery peer support services within the services they provide in the community?

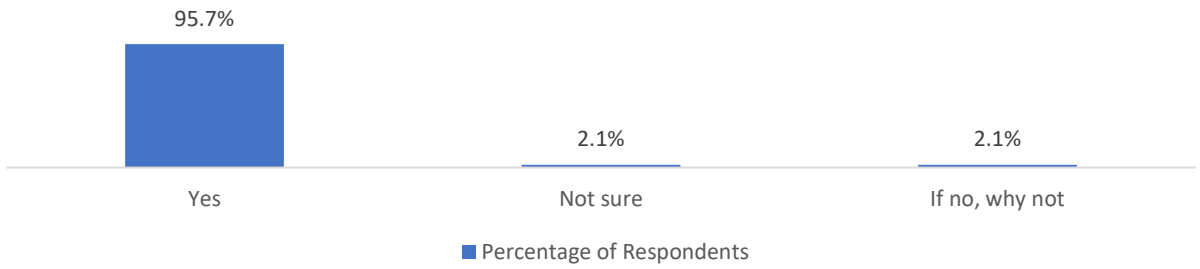


Figure 173: Does the agency where you are employed, or volunteer, adhere to recovery support best practices?

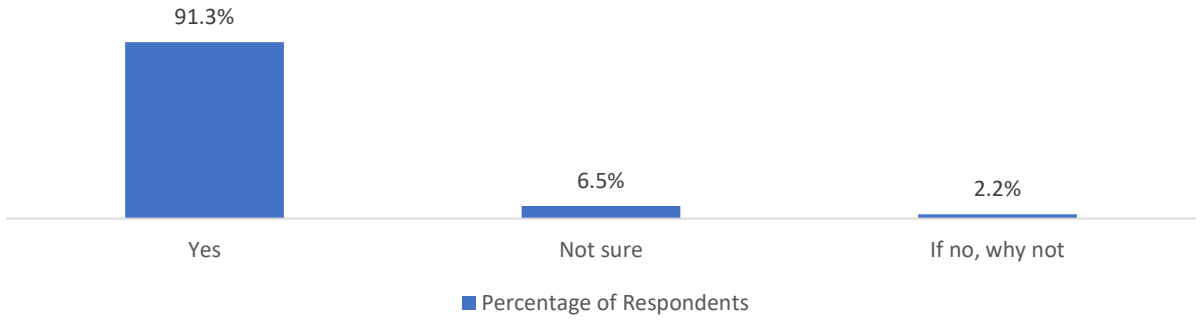


Figure 174: Please indicate the qualifications that best describe your status. (Check all that apply)

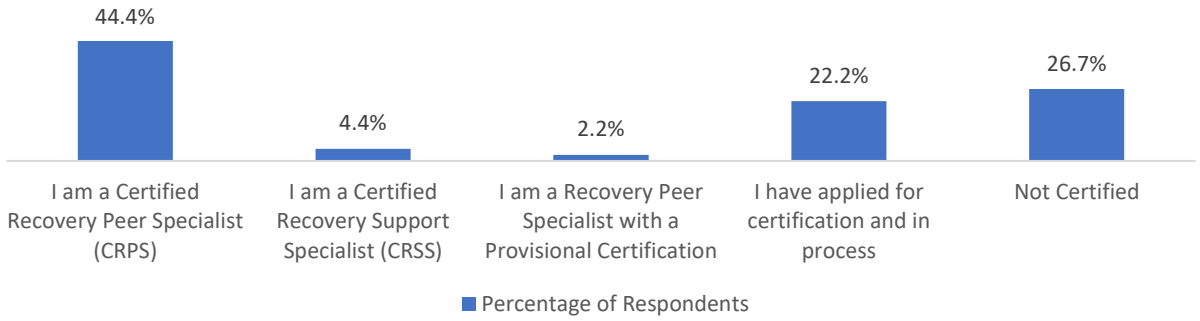
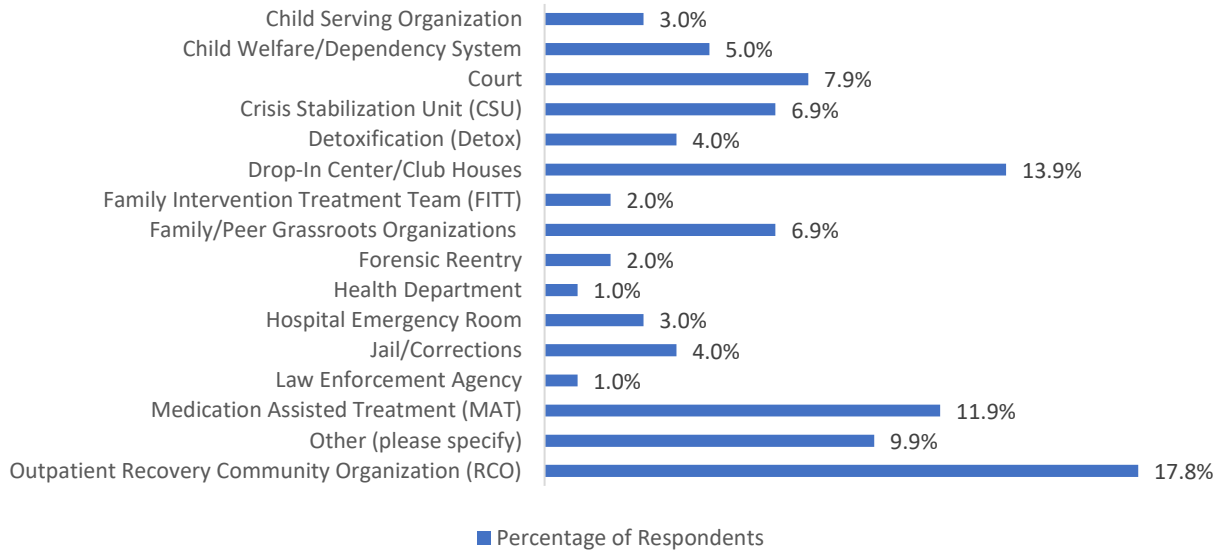


Figure 175: Please indicate the facility/program setting(s) that best describes where you deliver peer recovery support services. (Check all that apply)



Note: Family/Peer Grassroots Organizations (NAMI, Federation of Families, etc.)

Figure 176: What are the reasons/factors for staying with the company? (Check all that apply)

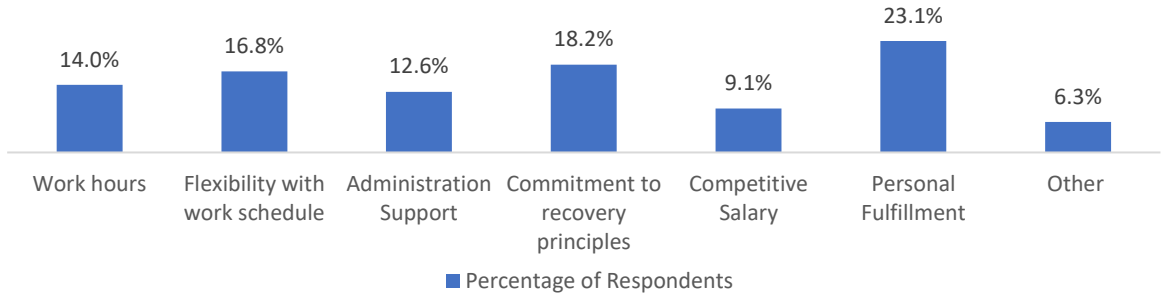


Figure 177: What barriers/challenges have you experienced in the hiring process? (Check all that apply)

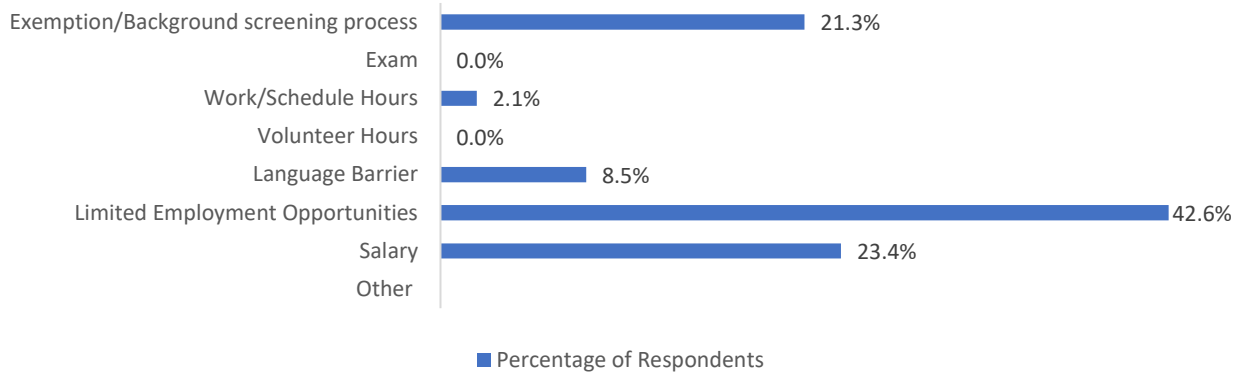
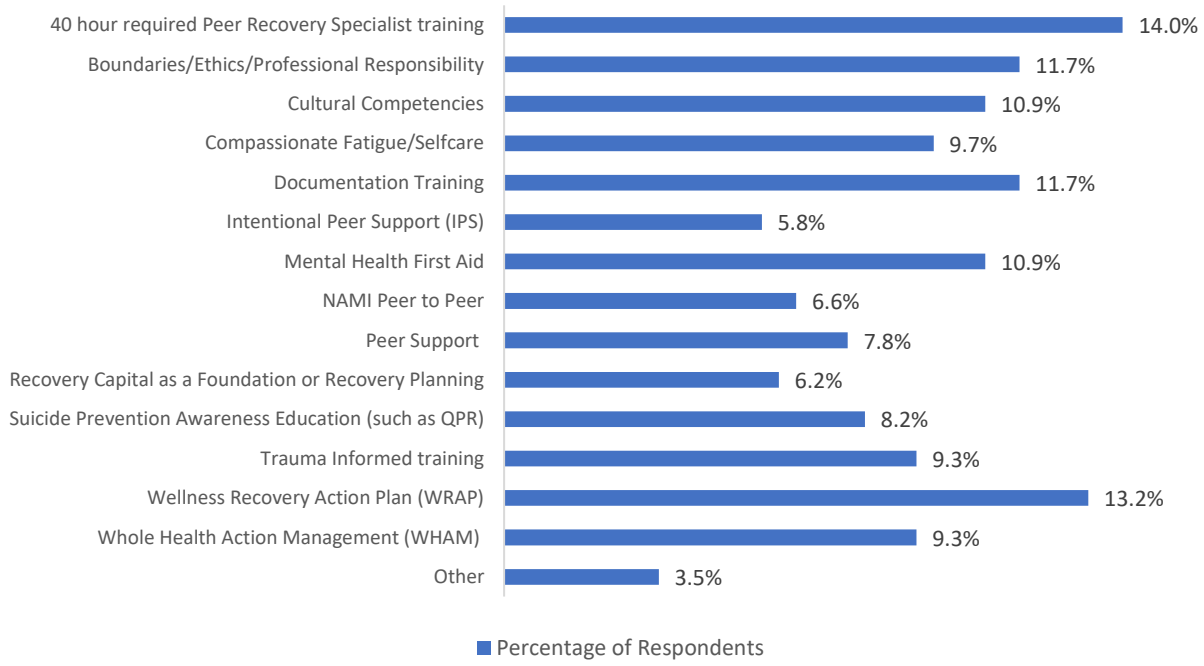


Figure 178: What training would you recommend for peers to have to help them provide peer support services? (Check all that apply)



Note: 40 hour required Peer Recovery Specialist training/Helping Others Heal

Figure 179: Are there partnerships that exist with peer support recovery programs, recovery community organizations, and other support groups?

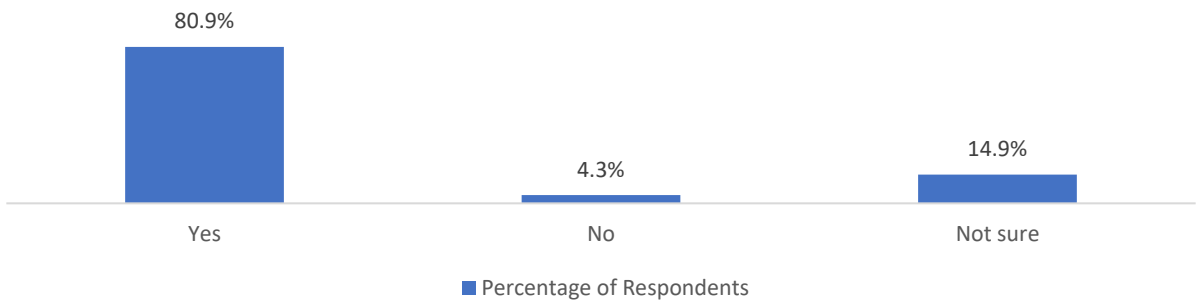


Figure 180: Are you aware of partnerships with other organizations that provide other resources such as: (Check all that apply)

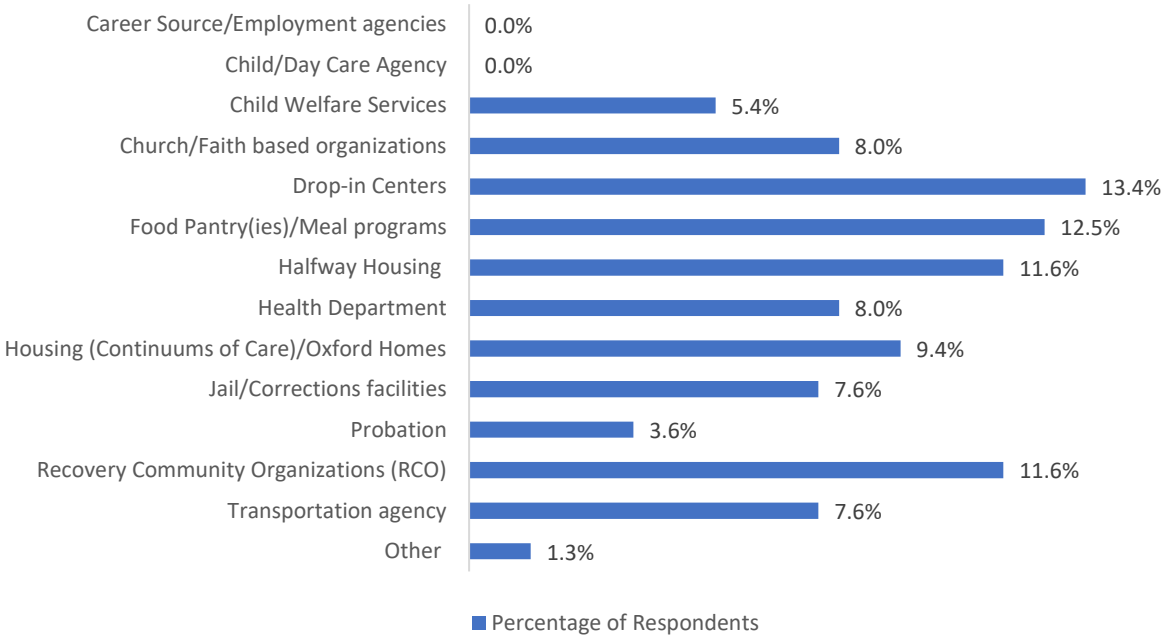


Figure 181: Do you have the ability to offer choices to the individuals where you serve at the agency you are employed/volunteer?

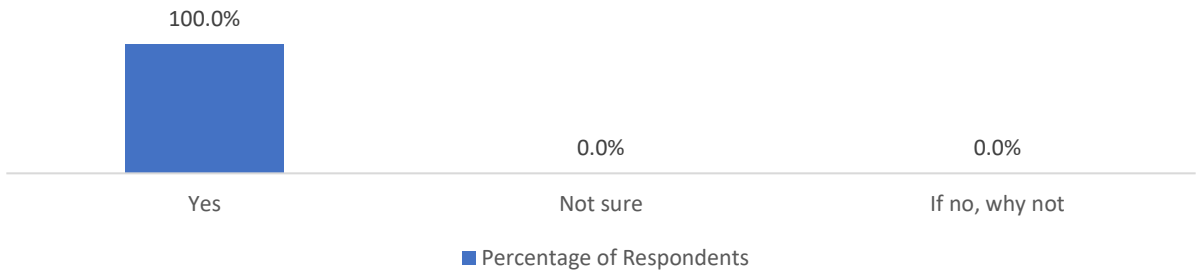


Figure 182: Does the organization where you are employed/volunteer with help to reduce stigma by promoting recovery language that is patient centered?

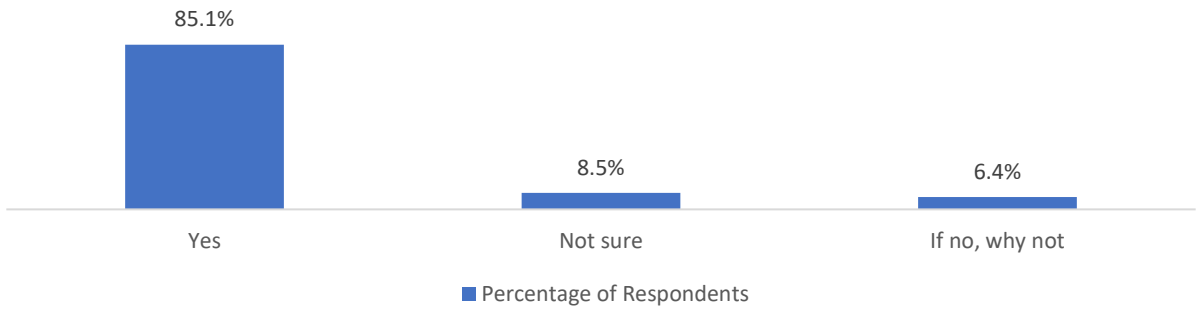


Figure 183: Does the agency where you are employed/volunteer include peers in developing and promoting effective program development, evaluation, and improvement?

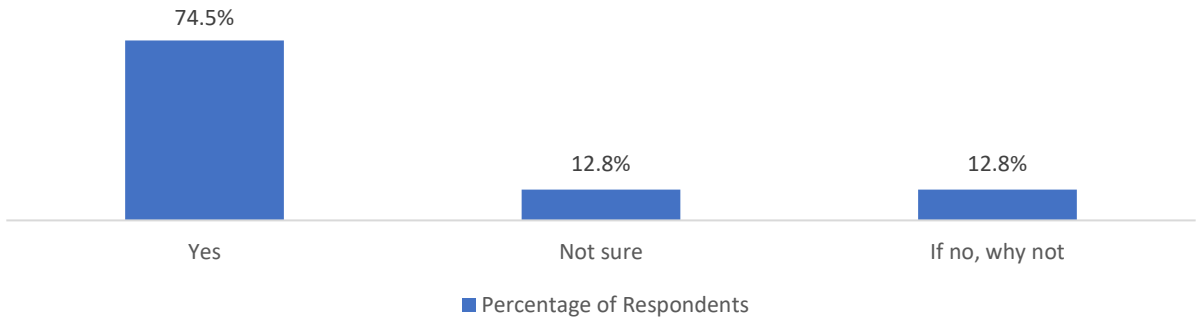
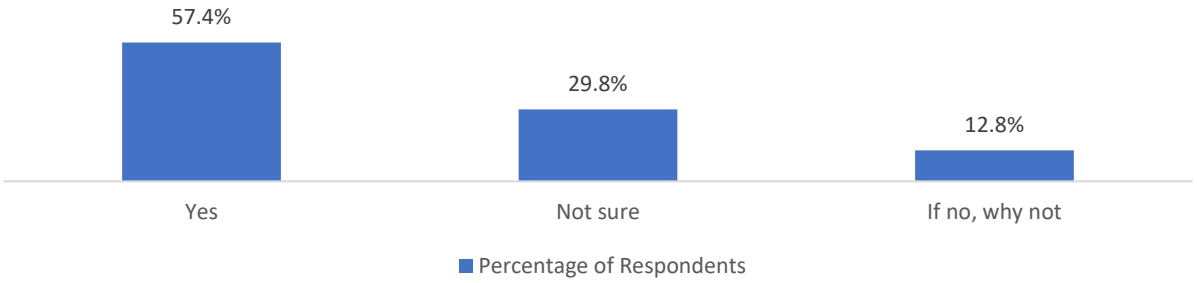


Figure 184: Does the agency where you are employed/volunteer with include persons in recovery management and board meetings?



CHILDREN SYSTEM OF CARE

BBHC completed a Children System of Care Plan which included an evaluation of needs. Below is the summary of the section that covered the needs.

BBHC has collaborated with a community-based workgroup specifically focused on the systemic needs and barriers plaguing Broward County and to support the successful realization of this plan. While we recognize that it is virtually impossible to account for every shortfall in a community as large and diverse as Broward County, we believe we have developed a plan that addresses the most prominent needs and barriers. This plan includes the aggregated feedback collected via needs assessments completed within the community served. In our summation, this feedback suggests that we must focus on the ongoing systemic issues affecting the way the current system of care functions and impediments to the successful implementation of this plan. These include many challenges and service gaps that affect individual treatment outcomes and overall systemic functioning.

The list is as follows:

Limited access to and availability of supportive, transitional, and permanent housing for people who do not have stable housing.

Limited access to and availability of evidence-based supported employment and education services for people that are unemployed.

Individuals in our community lack awareness of community resources available (including transportation) this includes not only potential consumers, but parents and support services professionals.

Limited access to and awareness of perinatal psychiatric and substance use disorder services.

People in our community have limited options regarding access to services because no one provider may meet all of a person's needs, such as time, location, and method, as applicable.

Limited focus on racial equity in access to services as well as cultural competency of service providers.

Lack of step-down options following crisis hospitalization discharge or Statewide Inpatient Psychiatric Program, such as crisis respite, Specialized Therapeutic Group Home (STGH) Special Therapeutic Foster Care (for community children) and children SRT.

Lack of authority on the part of the Managing Entity to implement this HB945 plan.

Absence of a universal level of care assessment and bio-psychosocial evaluations that can facilitate movement between funding sources and service providers.

Limited connection and collaboration between major organizations and systems that provide services to youth. This results in children having services duplicated and pertinent information lost between systems.

Lack of sufficient supervision at group homes that put youth at an increased risk of human trafficking (HT) or are formally or informally identified as HT hotspots.

Inadequate coordination of care/discharge planning when it comes to stepdown from Statewide Inpatient Psychiatric Program and placements back into the community.

Limited offerings and participation in best practices training and continuing education on the part of service providers to ensure quality-of-service delivery, an important example is significant shortage in Wraparound trained providers and availability across the BBHC network

Medicaid Reimbursement rates have not increased in more than 20 years and are especially low for innovative, evidence practices programs. This results additional burdens by the system in finding, hiring, and maintaining qualified staff as the employment outlook continues to be bleak and programs are faced with severe staffing shortages

The Broward Data Collaborative has been able to build out mature governance, technology, and research infrastructures. However, it lacks the necessary legal agreements to wholistically integrate data from the various educational and human service partners.

The successful implementation of this plan will require coordination across stakeholders within the system of care and high-level policy and decision-making entities.

RECOVERY ORIENTED SYSTEM OF CARE RESOURCES

RECOVERY ORIENTED SYSTEM OF CARE RESOURCES

2-1-1 Broward	Covenant House
Al-Anon Family Groups & Alateen	Faith Farm Ministries
Alcoholics Anonymous	Fellowship House
Archways	Footprints to Success Clubhouse
Banyan Health Systems	Florida (State Of) 17th Judicial Circuit Court
Broward Addiction Recovery Center (BARC)	Forest Park Drop-In Center
Broward County Public Schools	Gulf Coast Jewish Family and Community Services
North Broward Hospital District	Harmony Development Center
Broward House	Henderson Behavioral Health
Broward Outreach Centers	House of Hope Men/Stepping Stones
Broward Housing Solutions	Kids in Distress
Broward Partnership for the Homeless Initiative	Larkin Community Hospital Behavioral Health Services
Broward Sheriff's Office	Memorial Healthcare System
Camelot Community Care, Inc.	Mental Health America
Care Resource	NAMI of Broward County, Inc.
Catholic Charities of the Archdiocese of Miami	Narcotics Anonymous
Center for Hearing and Communication	Nova Southeastern University
Citrus Health Network	Our Children Our Future
Chrysalis Health	Pace Center for Girls

RECOVERY ORIENTED SYSTEM OF CARE RESOURCES

Salvation Army	The Village South
Schott Communities	Tomorrow's Rainbow
Silver Impact	Total Intervention Early Services
Smith Mental Health Associates	United Way of Broward County
South Florida Recovery Community Respite	University Hospital
South Florida Wellness Network	Urban League
Sunserve	Volunteers of America

Source: SAMHSA

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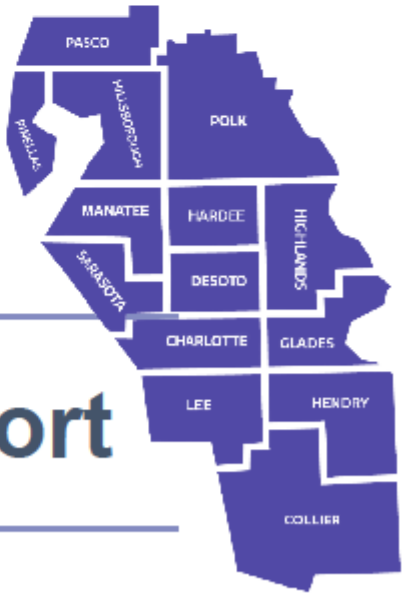
Central Florida Behavioral Health Network, Inc.
Your Managing Entity

2022

Florida Cultural Health Disparity & Behavioral Health Needs Assessment



Regional Report

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ACKNOWLEDGEMENTS

This assessment could not be completed without the assistance and partnership of many throughout the community. The Central Florida Behavioral Health Network (CFBHN) would like to thank everyone who distributed surveys, participated in interviews, or focus groups, reviewed data and added information. CFBNH would like to acknowledge the following individuals and agencies for their participation in this process:

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Health Planning Council of Southwest Florida

Healthy Bones Tampa Bay

Healthy Start Coalition of Pasco County

Healthy Start Coalition of Pinellas County

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Pinellas County Ending the HIV Epidemic

Pinellas County Opioid Task Force

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Stephanie Jones, Department of Children and Families

West Central Florida Ryan White Care Council

Central Florida
Behavioral Health
Network, Inc.
Your Managing Entity

February 14, 2022

Dear Community, Partners and Stakeholders;

Thank you for the opportunity to complete the Needs Assessment survey this year.

This year Central Florida Behavioral Health Network collaborated with our local Health Councils to facilitate the 2022 Behavioral Health Needs Assessment for the Suncoast Region and Circuit 10. By measuring experiences, awareness, and coordination of treatment and services that currently exist and what needs remain, we will be able to help improve the behavioral health care system in our communities.

The survey was widely distributed within our fourteen counties of care and it took less than five minutes to complete. There was no personal information gathered during the process.

Central Florida Behavioral Health Network is a not for profit 501 (c) (3) corporation and a CARF International Accredited Network*, CFBHN contracts with community service organizations to provide a full array of publically funded mental health and substance abuse services in the SunCoast Region that includes the following counties: Charlotte, Collier, Desoto, Glades, Hardee, Hendry, Highlands, Hillsborough, Lee, Manatee, Pasco, Pinellas, Polk, and Sarasota. Range of services includes: acute care, residential treatment, housing, medical, outpatient, recovery support, and prevention.

CFBHN's transformational influence empowers local communities to develop, advocate for, and implement innovative solutions to social, economic, health, and wellness problems individuals may encounter that adversely impact lives. Mission is accomplished through seeking, developing, and nurturing partnerships with outstanding providers who offer high quality compassionate services. CFBHN continually meets the changing needs of the public safety net and manages all facets of the service delivery system providing oversight, education and training, implementation of treatment best practices, coordination with community partners and stakeholders as well as leading and encouraging inspirational advocacy support.

* *CARF is the Commission on Accreditation of Rehabilitation Facilities*

Again, thank you for allowing us to conduct this valuable survey and we look forward to sharing the results.

Thank you,

Linda McKinnon
President & CEO

Central Florida Behavioral Health Network provides the right service, at the right time, in the right amount in order to save lives and ensure healthy communities."

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EXECUTIVE SUMMARY

In 2020, the estimated number of adults with serious mental illness was 193,039 in the 14-county service area comprised of Charlotte, Collier, DeSoto, Glades, Hardee, Hendry, Highlands, Hillsborough, Lee, Manatee, Pasco, Pinellas, Polk, and Sarasota Counties. This number has increased 4.4% over the past 3 years. This report, prepared for the Central Florida Behavioral Health Network (CFBHN), is a compilation of primary and secondary data that identifies behavioral health needs and the community assets available to advance the health care delivery system to improve outcomes for all residents.

DEMOGRAPHIC PROFILE

The population in the service area increased over the past five years to a total of 6,098,052 individuals. Racially, the service area is predominately White (78%), with the Black population accounting for 10.9%, Asian residents at 2.7%, and approximately 8.1% of individuals who are of other races or belong to more than one racial group. Hispanic individuals made up 20.4% of the area's population including 5.5% who identify as Mexican, 5.4% who identify as Puerto Rican, 3.8% who are Cuban, and 5.7% who identify as other Hispanic ethnicities.

Participation in the labor force (2016 to 2020) was at 48.6% and unemployment was 1.9%. The percentage of individuals living above 400% of the Federal Poverty Level (FPL) is 44.4% in the service area compared to 42.3% for the State of Florida.

GENERAL HEALTH STATUS

Behavioral Risk Factor Surveillance System (BRFSS) data (2017 to 2019) estimates revealed 80.4% of adults, ages 18-64 years of age, living in the service area said their overall health was "good" to "excellent". The average percentage of adults reporting good mental health over the past three years was 87.4%. Most residents (85.4%), ages 18-64 years, living in the Managing Entity (ME) service area reported having some type of health insurance coverage.

The crude suicide death rate decreased from 2018 to 2020, however, it should be noted that the suicide death rate for males in the ME service area was more than triple the rate among females. Additionally, the suicide death rate among the White population was double the rate for Black residents in the ME service area.

The rates of domestic violence and child abuse have decreased over the last 3 years in the service area and across the state. Meanwhile the percentage of adults who are smokers and who binge drink were higher in the service area than the state. High school tobacco, alcohol, and substance use continue to be issues for the area.

In the ME service area, 14.3% of the noninstitutionalized population was estimated to have a disability (includes hearing, vision, cognitive, ambulatory, self-care, and independent living).

CFBHN CLIENT DEMOGRAPHIC PROFILE

CFBHN-funded organizations served 95,157 clients in FY20-21. Approximately 24% of clients resided in Hillsborough County, followed by Pinellas County at 20.3%, Lee County at 12.1%, Polk County at 11.3%, Manatee County at 9.2%, Pasco County at 6.2%, Sarasota County at 6%, Charlotte County at 3.2%, Collier County at 2.6%, out-of-area at 2%, Highlands County at 1.6%, DeSoto at 0.7%, Hardee at 0.4%, Hendry County at 0.3%, and Glades County at 0.2%. It should be noted that 5.9% of clients reported their residential status as homeless across all counties in the service area.

Adults (age 15 and older) in CFBHN programs accounted for 85% of all clients with 74% enrolled in the Adult Mental Health (AMH) program and 26% in the Adult Substance Abuse program (ASA). The remaining clients were in the Child Mental Health (CMH) program at 15% and the Child Substance Abuse (CSA) program at 5%.

HOMELESS POPULATION

The effects of homelessness on individuals are numerous, complicated, and very costly. In addition to poor physical health, homeless community members are at an increased risk for mental illness, drug dependency, behavioral health issues, assault, and even premature death. In 2021, the Florida Council on Homelessness reported there were 5,740 individuals who were homeless in Central and Southwest Florida. Individuals who were unsheltered accounted for 33.9%, and 14.7% were chronically homeless. In the ME service area, there were 1,404 people in families with children who were homeless. Among veterans, 640 were homeless in Central and Southwest Florida. The Florida Department of Education reported 20,687 students in Central and Southwest Florida were homeless in the 2019-2020 academic year.

HOMELESS CLIENT DEMOGRAPHIC PROFILE

A total of 6,113 homeless clients were only enrolled in adult programs with 57% in the AMH program and 42.6 in the ASA program. White homeless clients accounted for 67.2% of those in the AMH program and Black homeless clients represented 25% of clients in the same program. Black individuals accounted for 12.3% of the general population emphasizing that this population has been disproportionately impacted. Hispanic clients in both the AMH program, at 10.4%, and in the ASA, at 9.9%, were underrepresented when compared to the general population where 20.4% were Hispanic.

SERVICE UNITS AND RECORD COSTS

Total service costs for Fiscal Year 2020-21 were $119,466936.40; $13,829,837.89 reflected the costs for homeless services while $2,863,577.73 is attributed to out-of-service area costs. The majority of costs were in AMH (54.1%), followed by ASA (40.7%), CMH (2.8%), and CSA (2.4%).

NO WRONG DOOR ASSESSMENT-PROVIDER INTERVIEWS

A series of provider interview groups were conducted virtually to assess No Wrong Door (NWD) access. Providers were invited to register for one of six virtual groups and then were sent a brief survey to complete. The interviews were used to gain qualitative understanding of the survey findings. Approximately 50 individuals participated.

Over 90% of survey respondents said that their agency has a role to play in the NWD access, with a little over 60% stating that it works well within their agency. The interviews showed that providers had multiple definitions to what NWD access means.

Interview respondents indicated that having relationships with individuals from various agencies in the area helped NWD access work well in their organization. A shortage in workforce and thus not enough capacity was also a common theme across all six group provider interviews.

CULTURAL HEALTH DISPARITY SURVEY

For the 2022 community assessment, a new survey was deployed to better understand the role of health disparities in behavioral health outcomes. Fifty-one participants completed a survey detailing their experiences and attitudes with respect to behavioral health. The survey assessed several focus areas including Comfort Seeking Care, Trust in the Behavioral Health System, Feelings Regarding Behavioral Health Issues, Behavioral Health Treatment Settings, and Language Needs.

IINDIVIDUALS SERVED SURVEY

Individuals served by CFBHN were surveyed during early 2022. Sixty-eight (68) responses were collected during the survey period. Data revealed the respondents were aware of where to go for mental health and substance use treatment when they needed them (82.1%) and that most respondents learned about services from a family member/friend (33.8%), another individual in treatment or recovery (33.8%) or by word of mouth (30.9%).

Most respondents indicated that they were able to receive the services they needed when they needed them (63%). Of those who were not able to get the services they needed, the most common responses were housing assistance (52.1%), case management (34.7%), crisis stabilization/support (30.4%), alternative services (30.4%), and employment/job training assistance (30.4%).

Individuals were asked about the obstacles/barriers they encountered getting the care they needed, and 33.8% indicated there were long waitlists, they could not afford the services (19.1%), they did not know where to go for services (17.6%), that they had very limited or no transportation (17.6%), or that they did not meet the eligibility criteria (16.1%). Stigma, lack of evening/weekend appointments, and services not available in the county were also frequently mentioned as barriers.

STAKEHOLDER SURVEY

A survey of behavioral health stakeholders across the CFBHN service area yielded 463 responses. About 90% of respondents strongly agreed or agreed that they were aware of the availability of mental health and substance use services in their area. While 51% where aware of Central Florida Behavioral Health Network (CFBHN), 49% of people had accessed CFBHN's resources in the past six months. Majority of survey takers (58%) found the resources the CFBHN offered were helpful. When asked if they were aware of 2-1-1, most (92%) of the respondents said they were.

Over 50% of stakeholder respondents either strongly agree or agree that behavioral health care and peer services are accessible in the area. Respondents were split, 42% agreed, and 43% disagreed, if they believed the processes for referrals were easily accessible.

When asked to identify the barriers are for consumers accessing services in their community, the majority of stakeholder respondents said no or very limited transportation (13.4%), followed by long waitlists (12.9%), did not know where to go for services (11.5%), could not afford the services (11.2%), and stigma (10.2%).

RECOVERY COMMUNITY PEER SUPPORT SURVEY

Peer Support Specialist's (PSS) bridge gaps in services in the NWD care model to improve patient-centered care. PSS were surveyed to evaluate their engagement, barriers, and improvements they would like to see in the health system. PSS were used in various recovery support roles throughout the health care system and in the community. Hospital emergency rooms, drop-in centers, corrections facilities, child welfare, and Medication Assisted Treatment (MAT) were some of the programs supported or run by PSS.

CFBHN SERVICE AREA DEMOGRAPHIC PROFILE

Population Demographics

Population in the fourteen-county service area increased each year from 2016 to 2020. The total population growth for the 5-year period was 7.9%, added 448.981 residents.

In the service area and the state, females accounted for slightly more than 50% of the population when compared to their male counterparts.

The racial composition in the service area and state was predominately White at 78% and 71.6%, respectively. The Black population accounted for 10.9% of the service area population and 15.9% of the population in Florida. American Indian and Native Hawaiians represented less than 1% of residents in both population groups. The percentage of Asian residents, at 2.7%, in the service area was similar when compared to the state at 2.8%. The service area was slightly less diverse when compared to the state with 2.9% having a race of Other and 5.2% of residents belonging to more than one racial group. In the state, 3.3% reported a race of Other and 6% belonged to more than one racial group.

Ethnically, the service area had a lower percentage of Hispanic residents, at 20.4%, when compared to the state at 25.8%.

The CFBHN service area population was older when compared to the age distribution at the state level. Residents, 65 years of age or older, accounted for 24% of the population while in the state of Florida, 20.5% of residents were at least 65 years old.

Education and Employment

Data revealed the service area and state populations were very similar regarding education attainment. While slightly less residents in the state had a high school diploma (or equivalency) (88.5%), when compared to the service area at 89.1%, residents in the service area had lower percentages of individuals who attended or graduated from college. Graduate or professional degrees were held by 11.1% of the service area population when compared to the state at 11.3%.

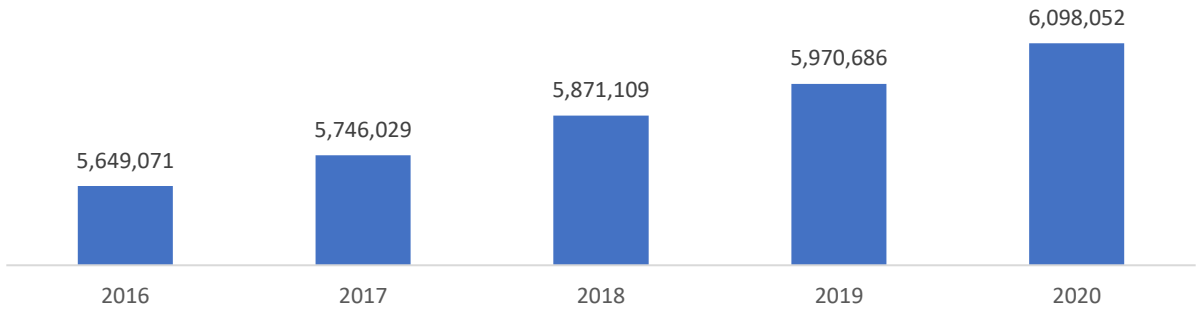
On average, 48.6% of the service area population participated in the labor force over the past 5 years. This was lower when compared to those employed in Florida at 58.98%. The unemployment rate for the service area was 1.3% compared to 5.4% for Florida.

Poverty Status

During 2016 to 2020, the service area had 8.7% of the population at or below 99% of the Federal Poverty Level (FPL) compared to 9.4% for Florida. Just over 44% of the service area was at or above 400% FPL compared to 42.3% for Florida.

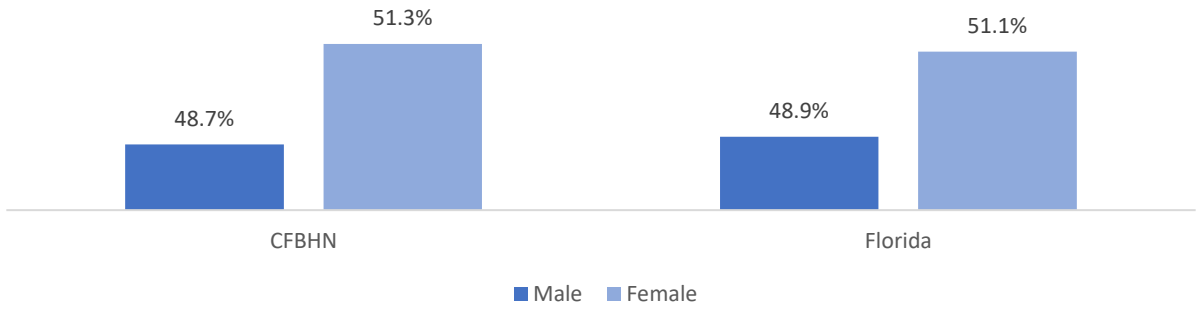
DEMOGRAPHIC CHARTS

Figure 1: CFBHN SA Population Estimates (2016-2020)



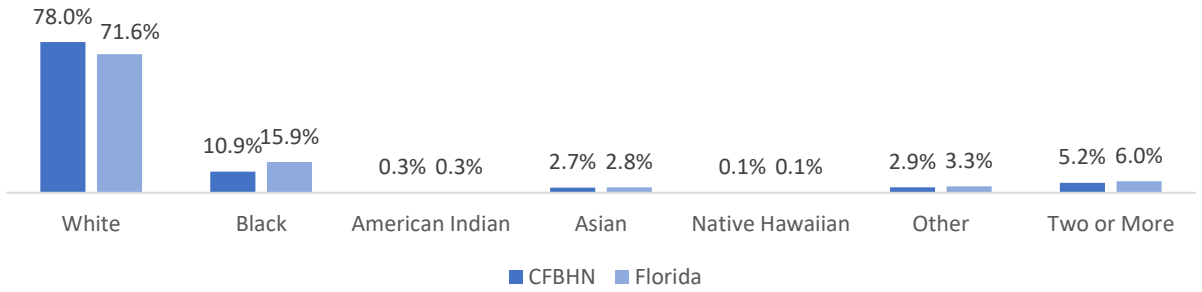
Source: Florida Legislature's Office of Economic and Demographic Research (EDR)

Figure 2: CFBHN SA County Population by Gender (2016-2020)



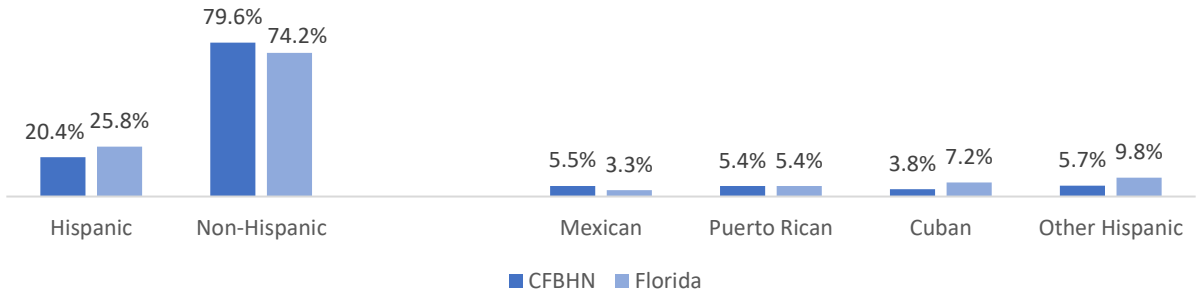
Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 3: CFBHN SA County Population by Race, 2016-2020 (5-Year Estimate)



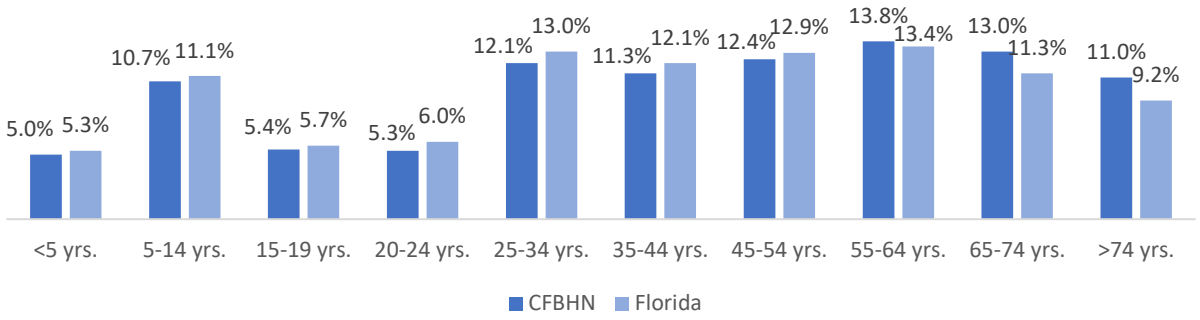
Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 4: CFBHN SA Population by Ethnicity, 2016-2020 (5-Year Estimate)



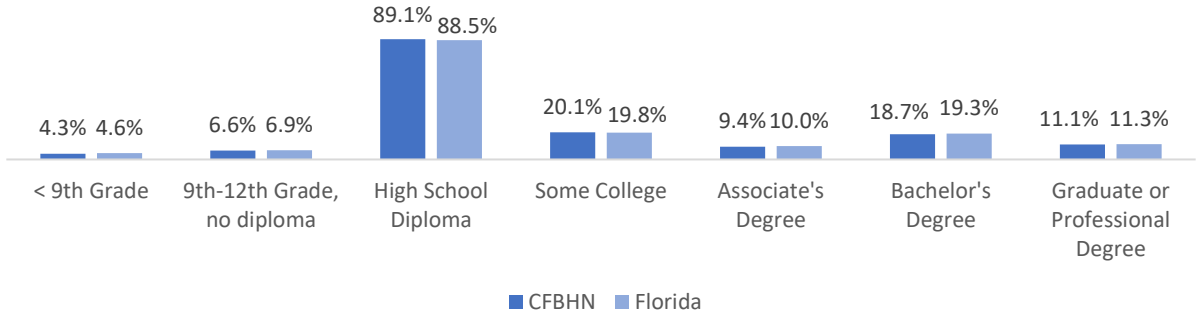
Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 5: CFBHN SA Population by Age Range, 2016-2020 (5-Year Estimate)



Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 6: CFBHN SA Population by Educational Attainment, 2016-2020 (5-Year Estimate)

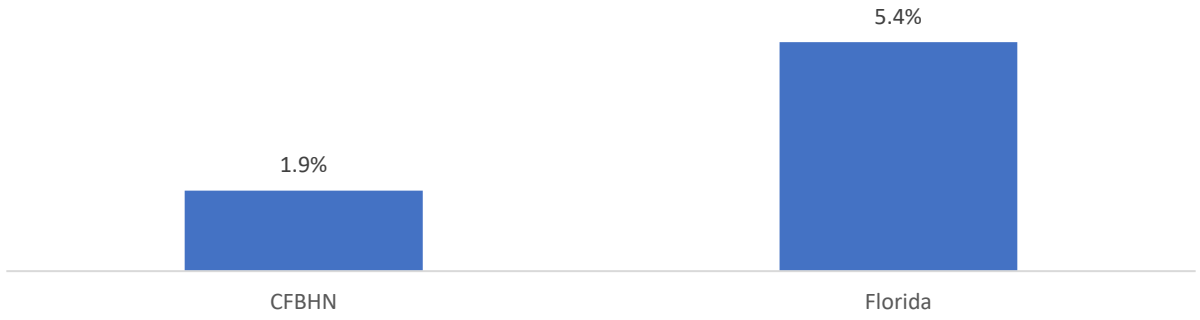


Source: U.S Census Bureau, American Community Survey, Table S1501

Figure 7: CFBHN SA Population Participation in Labor Force, 2016-2020 (5-Year Estimate)

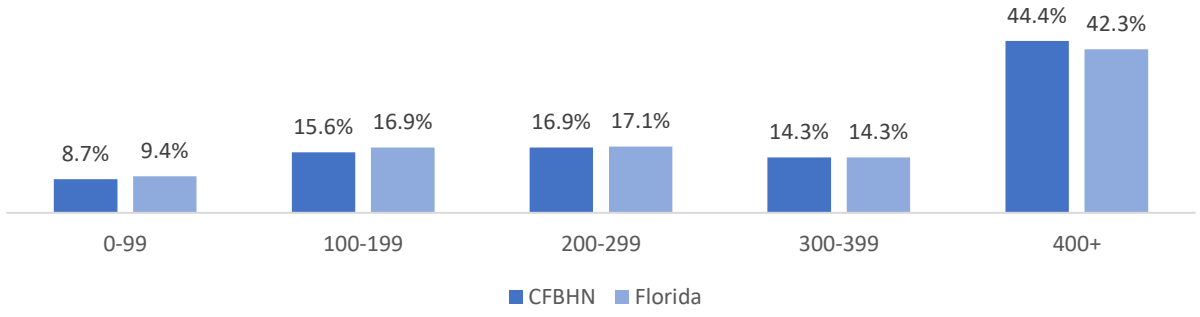
Source: U.S Census Bureau, American Community Survey, Table DP03

Figure 8: CFBHN SA Population Unemployment Rates, 2016-2020 (5-Year Estimate)



Source: U.S Census Bureau, American Community Survey, Table DP03

Figure 9: CFBHN SA Population Ratio of Income to Poverty Level of Families, 2016-2020 (5-Year Estimate)



Source: U.S Census Bureau, American Community Survey, Table B17026

CFBHN SERVICE AREA GENERAL HEALTH STATUS

Overall, Health Status

BRFSS data (2017 to 2019) estimates revealed 80.4% of adults, ages 18-64 years of age, living in the service area said their overall health was “good” to “excellent”. For Florida, the rate was 80.3%. This knowledge is a powerful tool for targeting and building health promotion activities. It also provides a way to see change in population health behaviors before morbidity or disease is apparent.

Mental Health

The average percentage of adults reporting good mental health over the past 3 years, at 87.4% was just above the rate for the state at 86.2%. The number of unhealthy mental days for the service area population, at 3.9 days in the past 30 days, was just below the rate among all adult residents (ages 18-64 years) in Florida at 4.4 days in the past 30 days.

Suicide

The crude suicide death rate decreased from 18.7/100,000 in 2018 to 15.8/100,000 population in 2020. This represents a decrease of 2.9/100,000 suicide deaths. At the state level, the suicide crude death rate decreased 2.5 deaths per 100,000 population during the same time but was also higher when compared to the CFBHN service population. Among males, the suicide death rate for the ME service area and state were more than triple the rate among females. The suicide death rate among the White population was double the rate for Black residents in the ME service area. The same held true at the state level where White to Black suicide deaths revealed a 3.2:1.0 ratio. It should be noted that the calculations required for the age-adjusted death rate for the ME service areas was beyond the scope of this project.

Violence and Abuse

The rate of total domestic violence offences decreased in the ME service area and the state from 2017 to 2019. In the ME service area, the rate fell from 575.5/100,000 to 535.3/100,000 over the past 3 years. This was still higher than the state rate of 496.5/100,000 in 2019.

The rate of children experiencing child abuse over the past 3 years (2017-2019) has continuously decreased in the ME Service area and state. Among children ages 5-11 years, the rate of child abuse fell from 1053.4/100,000 in 2017 to 888.8/100,000 in 2019. This trend was observed in the state rates which decreased from 857.9/100,000 to 662.7/100,000 during the same time.

Child sexual abuse rates changed very little from 2017 to 2019 and decreased from 2018 to 2019. In the ME service area, the 2019 sexual abuse rate for children 5-11 years was 57.2/100,000.

Mental Illness

The estimated number of seriously mentally ill (SMI) adults increased by 4.4% over the past 3 years. The rate of increase at the state level was 3.5%. The estimated number of SMI adults in the ME service area was 193,069 in 2020.

Among youth, ages 9-17 years, the estimated number of those emotionally disturbed increased over 2% from 2018 to 2020. This was lower when compared to the state increase at 3%.

The Florida Department of Education (FLDOE) reported less than 0.5% of children in K-12 grades had an emotional/behavioral disability in the ME service area. In the state, students with an emotional/behavioral disability accounted for 0.5%. These rates have been steady over the past 3 years.

Adult Tobacco and Alcohol Use

BRFSS results revealed the percentage of adults living in the ME service area who are current smokers, at 16.7% (2017-2019) was higher when compared to the state at 14.8% (2019).

Binge drinking is defined as 5 consecutive drinks for men and 4 consecutive drinks for women. For 2017 to 2019, the percentage of binge drinkers in the ME service area was 18.6%. The percentage of binge drinkers in the state was slightly lower at 18% (2019).

High School Tobacco, Alcohol and Substance Use

Data from the Florida Youth Substance Abuse Survey (FYSAS) indicated that the percentage of middle and high school students who reported never having smoked cigarettes increased from 85.7% in 2016 to 92.1% in 2020. Slightly more than 5% of students smoked once or twice, and 3% reported that they had smoked 'once in a while'. For middle and high school students in the state, the percentage of those having never smoked also increased over the past 4 years.

When students were asked about smoking frequency, 96.6% of those living in the ME service area did not smoke at all. The state rate was 98.2%.

Vaping questions were included in the 2020 FYSAS for the first time. In the ME service area, 22.2% of students reported vaping nicotine on at least one occasion in their lifetime. Almost 6% of student had vaped on 40 or more occasions. Rates at the state level were similar for frequency occasions of vaping nicotine in their lifetime. The percentage of students vaping nicotine during the past 30 days were much lower in the service area and the state when compared to vaped in lifetime rates. Slightly over 88% of students had not vaped nicotine in the past 30 days.

The percentage of students who did not consume alcoholic beverages on any occasions in their lifetime ranged from 60.7% in 2016 to 84.8% in 2020. For those who did on 1-2 occasions, the percentage decreased 4.5% from 2016 to 2020. The percentages of students in 2020 consuming alcohol on more than 2 occasions ranged from 3.2% for 3-5 occasions to 0.3% for those consuming alcohol on at least 40 occasions. The rates for the state were almost identical to those in the ME service area.

High school students were asked for the number of occasions in their lifetime when they had woken up after a night of drinking alcohol and were unable to remember the things they did or the places they went. The percentage of students reporting this event happening on at least 1-2 occasions in their lifetime (2020) in the ME service area and the state was 7.6% and 7.4%, respectively. When looking at previous reported data, this was a decrease from the percentages reported in 2016 for the ME service area and the state. Slightly over 86% of students in the service area and the state reported never having had this experience.

The percentages of students living in the ME service area not consuming alcohol during the past 30 days increased from 81.8% in 2016 to 84.8% in 2020. The increase at the state level was greater when comparing percentages from 2016 (81.7%) to 2020, at 85.2%. The percentages of students who reported consuming alcohol on 1-2 occasions during the past 30 days decreased in the ME Service area and state from 2016-2020.

The overall percentage of those binge drinking, defined as consuming 5 or more alcoholic drinks in a row in the past 2 weeks, increased 1% over the past 4 years. This was a combined decrease for students in the ME service area and state who reported this behavior on one to more than 10 occasions.

The percentages of students who have not used marijuana in their lifetimes increased over the past 4 years in the ME service area (80%-2020) and state (79.9%-2020). For those who did use marijuana on one to more than 40 occasions, the overall percentages decreased in the ME service area from 22.6% in 2016 to 20% in 2020. At the state level, the decrease was smaller when comparing 2016, at 21.3%, to 2020, at 20.1%. The percentages of students not using marijuana in the past 30 days was higher when compared to those who reported not using it in their lifetime. The percentages of students in the ME service area and state who reported using marijuana in the past 30 days on one or more occasions, increased slightly in the ME service area while decreasing in the state. The percentages of students who reported vaping marijuana in their lifetimes on one or more occasions was higher in the ME service area at 16% when compared to the state at 15.6%. This is different when comparing the two groups of students who had vaped marijuana in the past 30 days. In the ME service area, 7.2% of students had vaped marijuana in the past 30 days compared to 7.3% of students in the state.

Disability

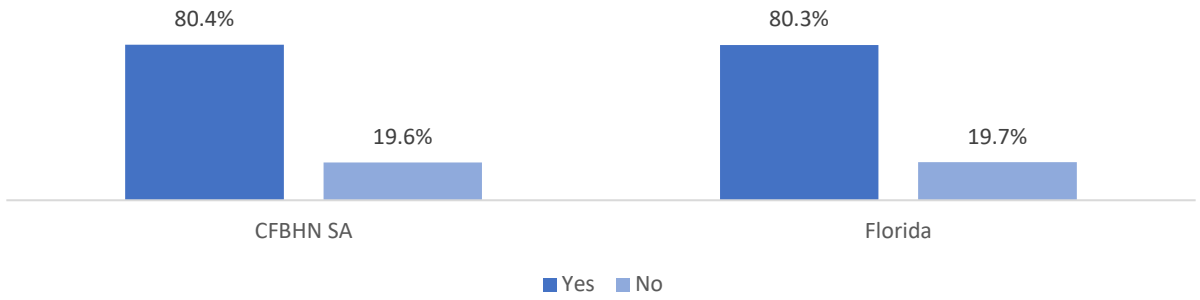
In the ME service area, 14.5% of the noninstitutionalized population was estimated to have a disability (includes hearing, vision, cognitive, ambulatory, self-care, and independent living). At the state level, 13.6% of residents had a disability. The percentages of those with a disability were higher among older adults, ages 65 years and older, at 51.5% for the ME service area and 48.3% in the state.

Health Insurance Coverage

Most residents, ages 18-64 years, living in the ME service area and state reported having some type of health insurance coverage. The percentage of those with insurance in the state was slightly lower when compared to the ME service area at 85.4% and 82.4%, respectively.

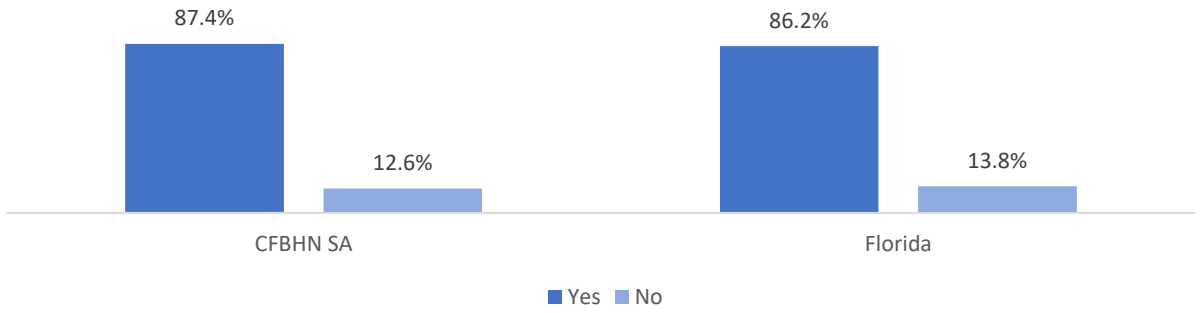
GENERAL HEALTH STATUS CHARTS

Figure 10: CFBHN SA Adults Who Said Their Overall Health Was "Good" to "Excellent"(2017-2019)



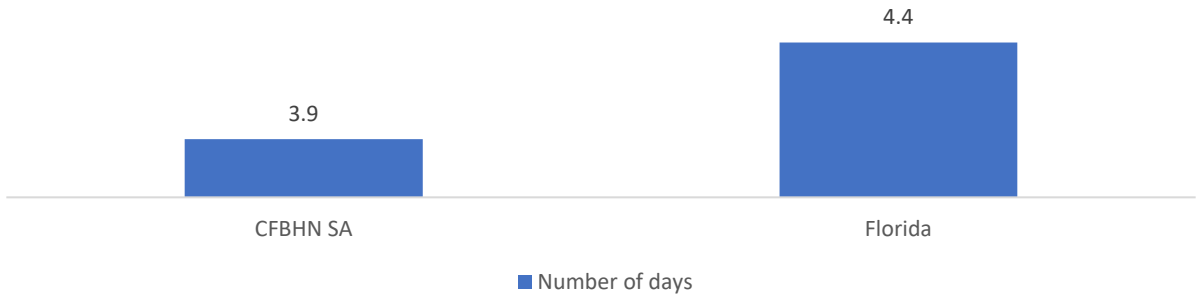
Source: Behavioral Risk Factor Surveillance System

Figure 11: CFBHN SA Adults with Good Mental Health for the Past 30 Days (2017-2019)



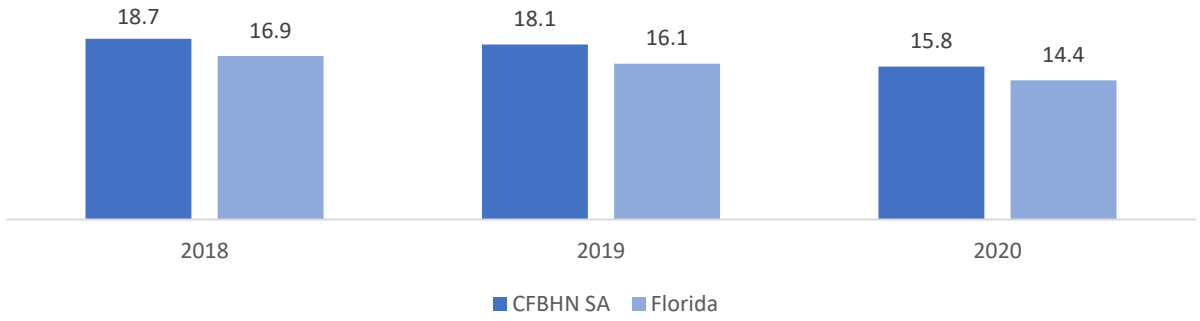
Source: Behavioral Risk Factor Surveillance System

Figure 12: CFBHN SA Adults Average Number of Unhealthy Mental Days in the Past 30 Days (2017-2019)



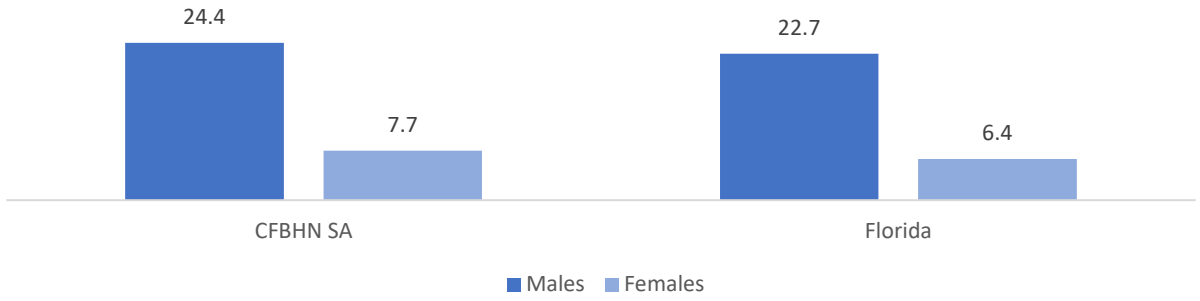
Source: Behavioral Risk Factor Surveillance System

Figure 13: CFBHN SA Crude Suicide Death Rates (2018-2020)



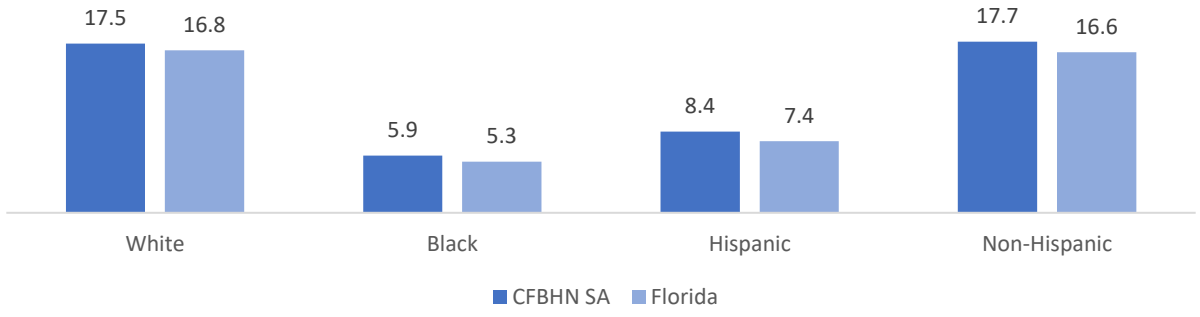
Source: Florida Department of Health, Bureau of Vital Statistics, Rate per 100,000

Figure 14: CFBHN SA Crude Suicide Death Rates by Gender (2020)



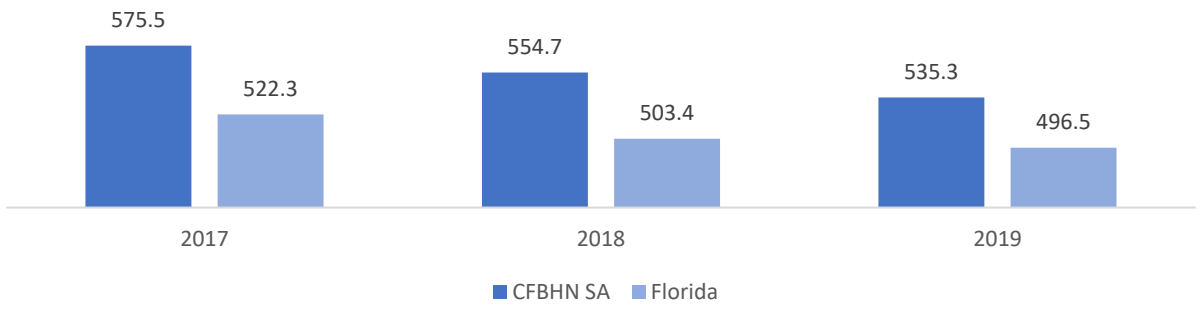
Source: Florida Department of Health, Bureau of Vital Statistics, Rate per 100,000

Figure 15: CFBHN SA Crude Suicide Death Rates by Race and Ethnicity (2020)



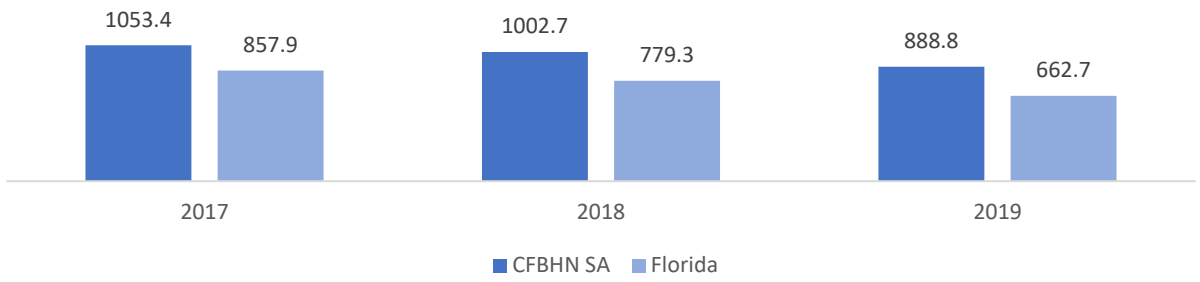
Source: Florida Department of Health, Bureau of Vital Statistics, Rate per 100,000

Figure 16: CFBHN SA Total Domestic Violence Offenses (2017-2019)



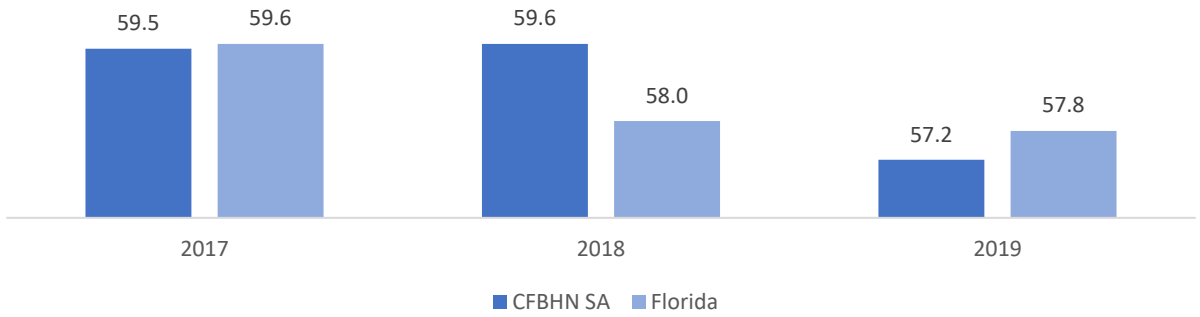
Source: Florida Department of Law Enforcement, Crime in Florida, Uniform Crime Report 2019, Rate per 100,000

Figure 17: CFBHN SA Rate of Children Experiencing Child Abuse, Ages 5-11 Years (2017-2019)



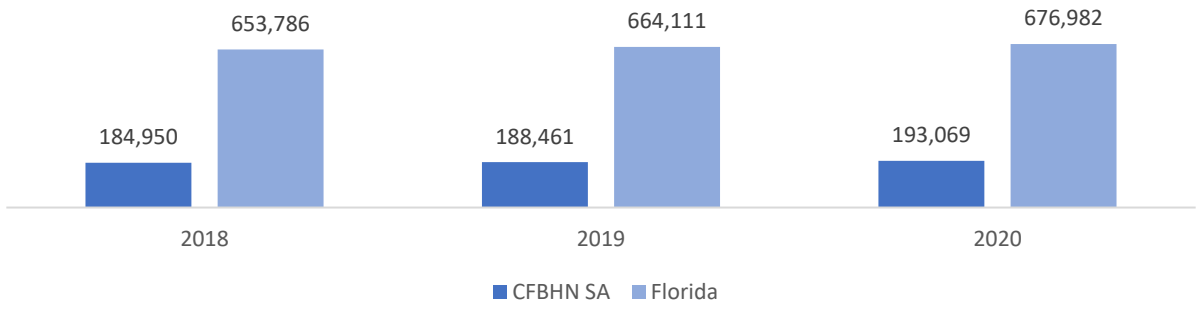
Source: Department of Children and Families, Florida Safe Families Network Data Mart, Rate per 100,000

Figure 18: CFBHN SA Rate of Children Experiencing Sexual Violence, Ages 5-11 Years (2017-2019)



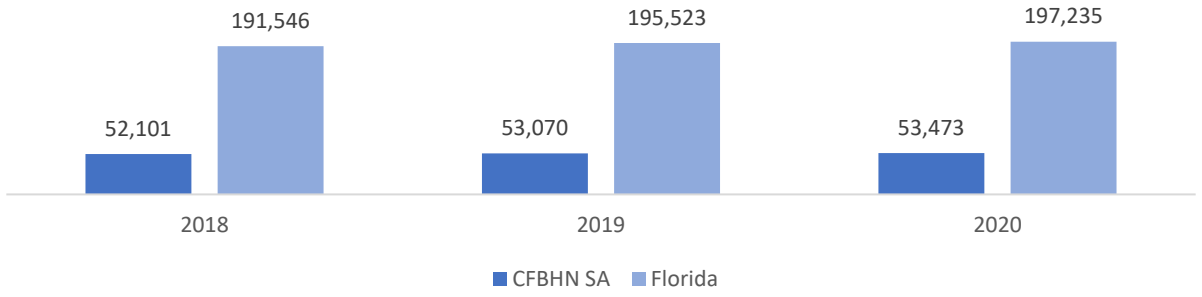
Source: Department of Children and Families, Florida Safe Families Network Data Mart, Rate per 100,000

Figure 19: CFBHN SA Estimated Number of Seriously Mentally Ill Adults (2018-2020)



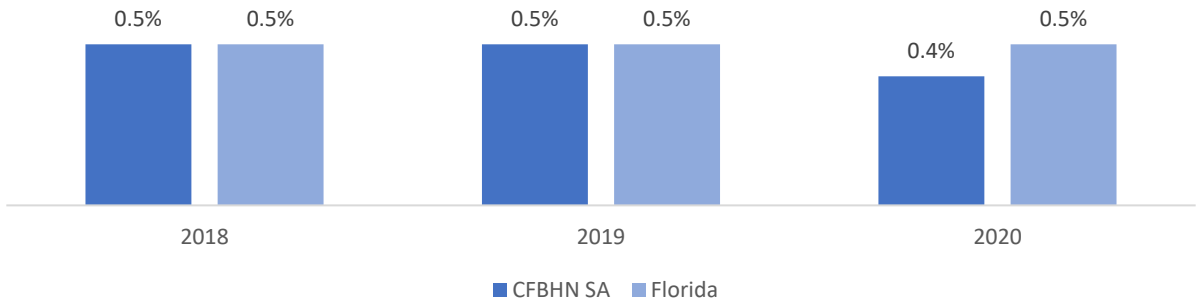
Source: Estimates based on Department of Health and Human Resource Report Mental Health U.S. 1995

Figure 20: CFBHN SA Estimated Number of Emotionally Disturbed Youth, Ages 9-17 Years (2018-2020)



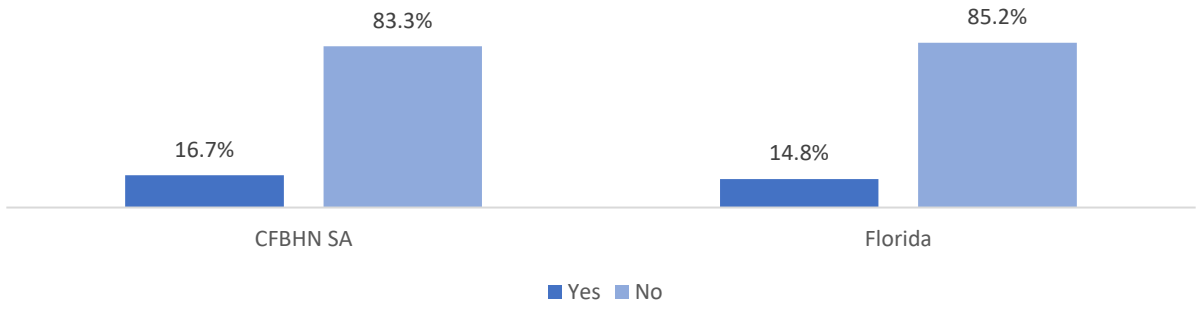
Source: Estimates based on Department of Health and Human Resource Report Mental Health U.S. 1995

Figure 21: CFBHN SA Percentage of Children with Emotional/Behavioral Disability, Grades K-12 (2018-2020)



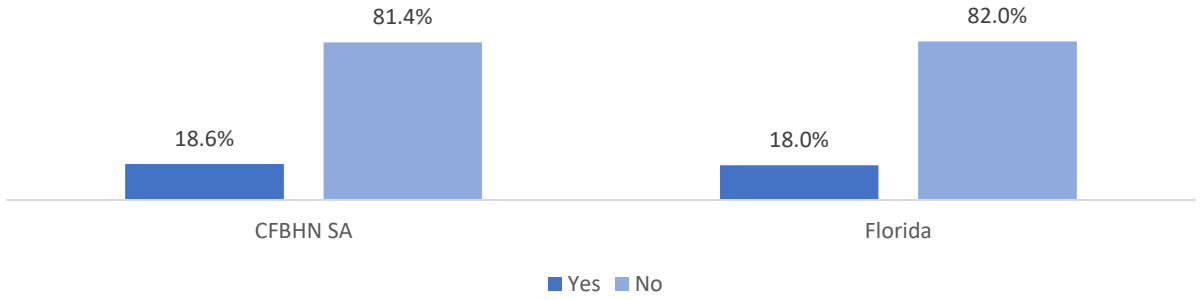
Source: Florida Department of Education, Education Information and Accountability Services (EIAS)

Figure 22: CFBHN SA Percentage of Adults Who Are Current Smokers (2017-2019)



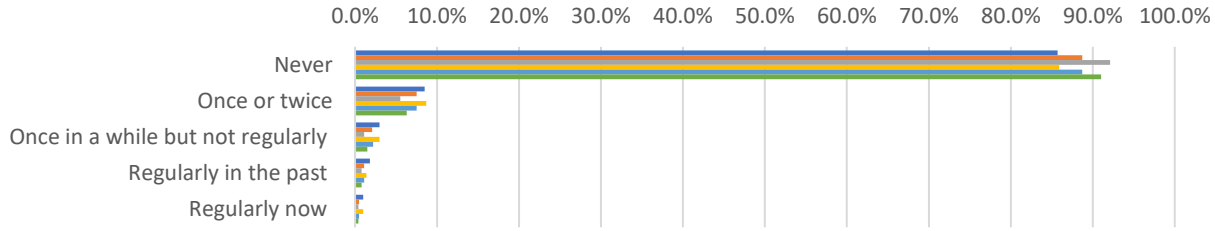
Source: Behavioral Risk Factor Surveillance System

Figure 23: CFBHN SA Percentage of Adults Who Engage in Heavy or Binge Drinking (2017-2019)



Source: Behavioral Risk Factor Surveillance System

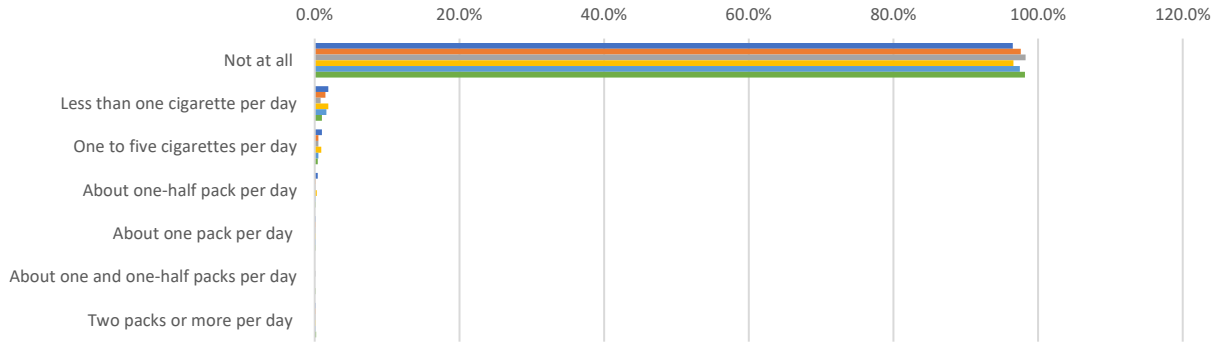
Figure 24: CFBHN SA Having Ever Smoked Cigarettes (MS&HS 2016-2020)



	Regularly now	Regularly in the past	Once in a while but not regularly	Once or twice	Never
CFBHN SA 2016	1.0%	1.8%	3.0%	8.5%	85.7%
CFBHN SA 2018	0.5%	1.1%	2.1%	7.5%	88.7%
CFBHN SA 2020	0.4%	0.8%	1.1%	5.5%	92.1%
Florida 2016	1.0%	1.4%	3.0%	8.7%	85.9%
Florida 2018	0.5%	1.1%	2.2%	7.5%	88.7%
Florida 2020	0.4%	0.8%	1.5%	6.3%	91.0%

Source: Florida Youth Substance Abuse Survey

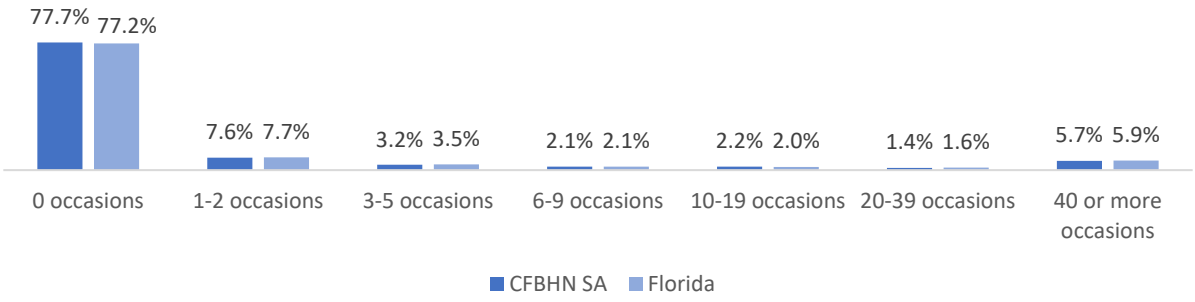
Figure 25: CFBHN SA – How Frequently Have You Smoked Cigarettes in the Past 30 Days? (MS&HS 2016-2020)



	Two packs or more per day	About one and one-half packs per day	About one pack per day	About one-half pack per day	One to five cigarettes per day	Less than one cigarette per day	Not at all
CFBHN SA 2016	0.1%	0.0%	0.1%	0.4%	1.0%	1.9%	96.5%
CFBHN SA 2018	0.1%	0.0%	0.1%	0.1%	0.5%	1.5%	97.6%
CFBHN SA 2020	0.1%	0.1%	0.1%	0.1%	0.5%	0.8%	98.3%
Florida 2016	0.1%	0.0%	0.1%	0.3%	0.9%	1.9%	96.6%
Florida 2018	0.1%	0.0%	0.1%	0.1%	0.5%	1.6%	97.5%
Florida 2020	0.2%	0.1%	0.1%	0.1%	0.4%	1.0%	98.2%

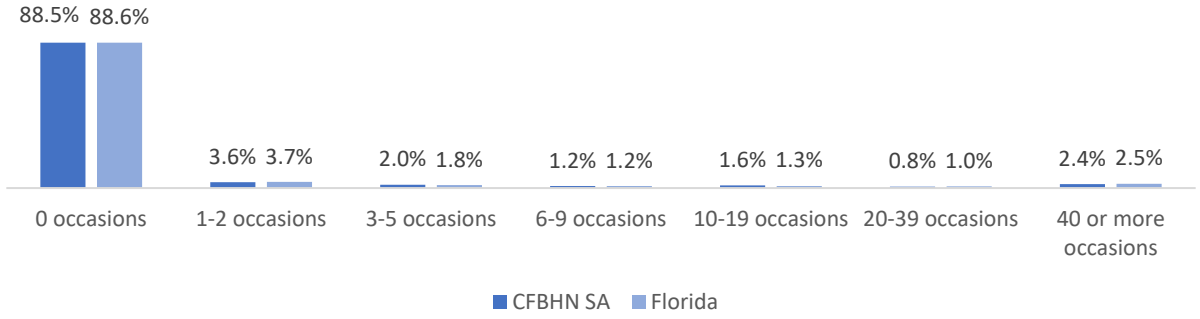
Source: Florida Youth Substance Abuse Survey

Figure 26: CFBHN SA – On How Many Occasions Have You Vaped Nicotine in Your Lifetime? (MS&HS 2020)



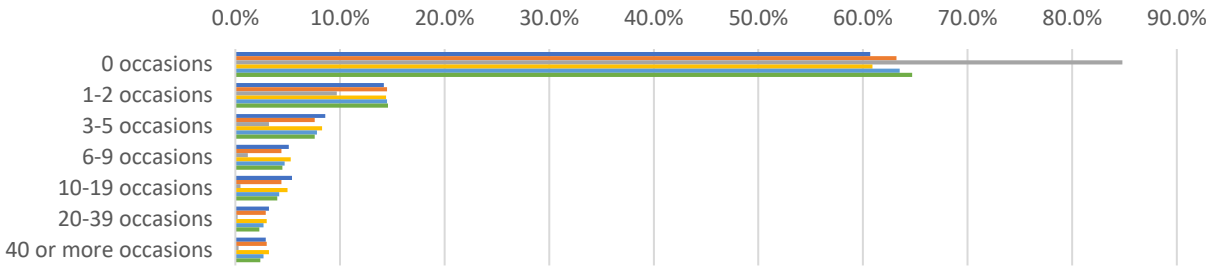
Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

Figure 27: CFBHN SA – On How Many Occasions Have You Vaped Nicotine During the Past 30 Days? (MS&HS 2020)



Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

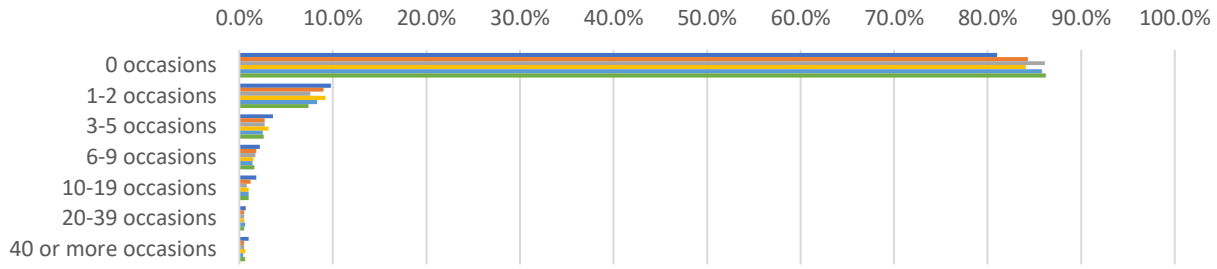
Figure 28: CFBHN SA – On How Many Occasions Have You Had Alcoholic Beverages to Drink in Your Lifetime? (MS&HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
CFBHN SA 2016	2.9%	3.2%	5.4%	5.1%	8.6%	14.2%	60.7%
CFBHN SA 2018	3.0%	2.9%	4.4%	4.4%	7.6%	14.5%	63.2%
CFBHN SA 2020	0.3%	0.2%	0.5%	1.2%	3.2%	9.7%	84.8%
Florida 2016	3.2%	3.0%	5.0%	5.3%	8.3%	14.4%	60.9%
Florida 2018	2.7%	2.7%	4.2%	4.7%	7.8%	14.5%	63.5%
Florida 2020	2.4%	2.3%	4.0%	4.5%	7.6%	14.6%	64.7%

Source: Florida Youth Substance Abuse Survey. Includes beer, wine, or hard liquor. More than a few sips.

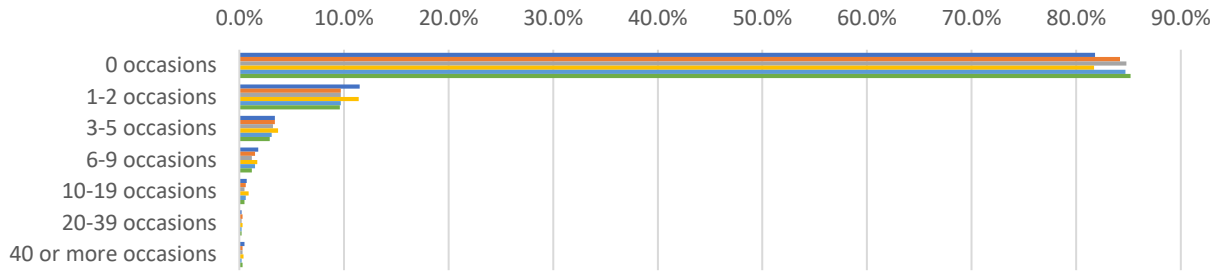
Figure 29: CFBHN SA – On How Many Occasions in Your Lifetime Have You Woken Up After a Night of Drinking Alcoholic Beverages and Not Been Able to Remember Things You Did or the Places You Went? (HS Only 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
CFBHN SA 2016	1.0%	0.7%	1.8%	2.2%	3.6%	9.8%	81.0%
CFBHN SA 2018	0.5%	0.5%	1.2%	1.8%	2.7%	9.0%	84.3%
CFBHN SA 2020	0.5%	0.5%	0.8%	1.7%	2.7%	7.6%	86.1%
Florida 2016	0.6%	0.5%	1.0%	1.5%	3.1%	9.2%	84.1%
Florida 2018	0.4%	0.6%	1.0%	1.4%	2.5%	8.3%	85.8%
Florida 2020	0.6%	0.5%	1.0%	1.6%	2.6%	7.4%	86.2%

Source: Florida Youth Substance Abuse Survey

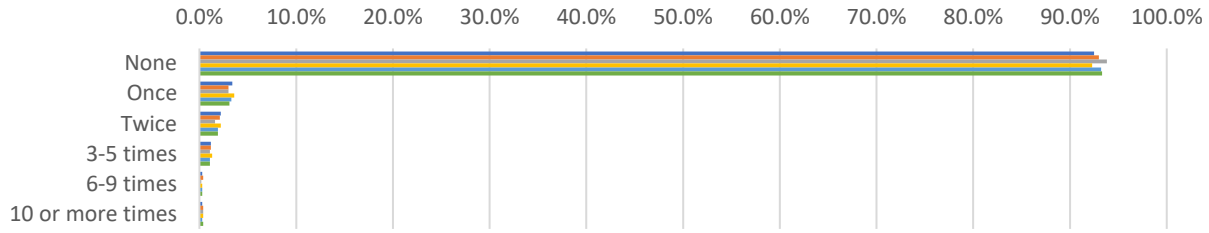
Figure 30: CFBHN SA – On How Many Occasions Have You Had Beer, Wine, or Hard Liquor in the Past 30 Days? (MS&HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
CFBHN SA 2016	0.5%	0.2%	0.7%	1.8%	3.4%	11.5%	81.8%
CFBHN SA 2018	0.3%	0.3%	0.6%	1.5%	3.4%	9.7%	84.2%
CFBHN SA 2020	0.3%	0.2%	0.5%	1.2%	3.2%	9.7%	84.8%
Florida 2016	0.4%	0.3%	0.9%	1.7%	3.7%	11.4%	81.7%
Florida 2018	0.2%	0.2%	0.6%	1.5%	3.1%	9.7%	84.7%
Florida 2020	0.3%	0.2%	0.5%	1.2%	2.9%	9.6%	85.2%

Source: Florida Youth Substance Abuse Survey

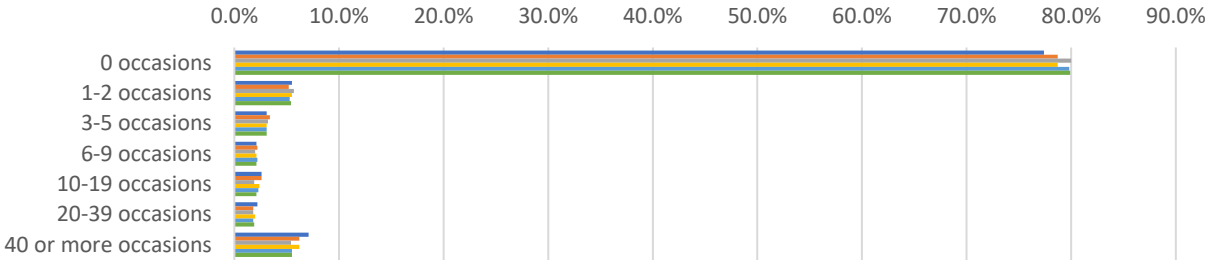
Figure 31: CFBHN SA – Think Back Over the Past 2 Weeks...How Many Times Have You Had Five or More Alcoholic Drinks in a Row? (MS&HS 2016-2020)



	10 or more times	6-9 times	3-5 times	Twice	Once	None
CFBHN SA 2016	0.3%	0.3%	1.2%	2.2%	3.4%	92.5%
CFBHN SA 2018	0.4%	0.4%	1.2%	2.1%	3.0%	93.0%
CFBHN SA 2020	0.4%	0.2%	1.1%	1.6%	3.0%	93.8%
Florida 2016	0.4%	0.3%	1.3%	2.2%	3.6%	92.3%
Florida 2018	0.3%	0.3%	1.1%	1.9%	3.3%	93.2%
Florida 2020	0.4%	0.3%	1.1%	1.9%	3.1%	93.3%

Source: Florida Youth Substance Abuse Survey

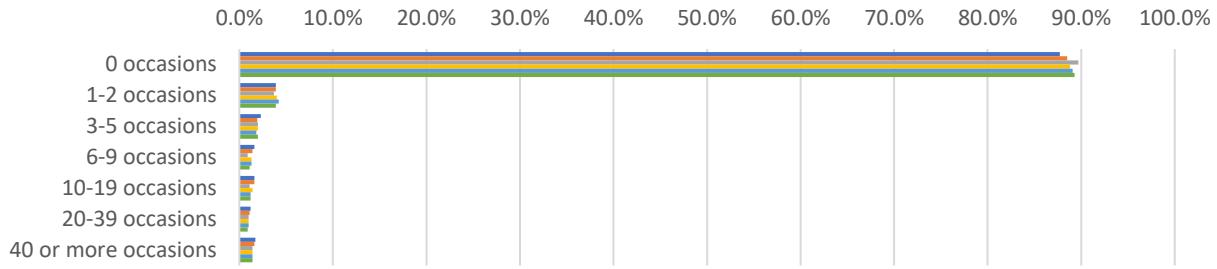
Figure 32: CFBHN SA – On How Many Occasions Have You Used Marijuana or Hashish in Your Lifetime? (MS&HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
CFBHN SA 2016	7.1%	2.2%	2.6%	2.1%	3.1%	5.5%	77.4%
CFBHN SA 2018	6.2%	1.8%	2.6%	2.2%	3.4%	5.2%	78.7%
CFBHN SA 2020	5.4%	1.8%	1.9%	2.0%	3.2%	5.7%	80.0%
Florida 2016	6.2%	2.0%	2.4%	2.1%	3.1%	5.5%	78.7%
Florida 2018	5.5%	1.8%	2.3%	2.2%	3.1%	5.3%	79.8%
Florida 2020	5.5%	1.9%	2.1%	2.1%	3.1%	5.4%	79.9%

Source: Florida Youth Substance Abuse Survey

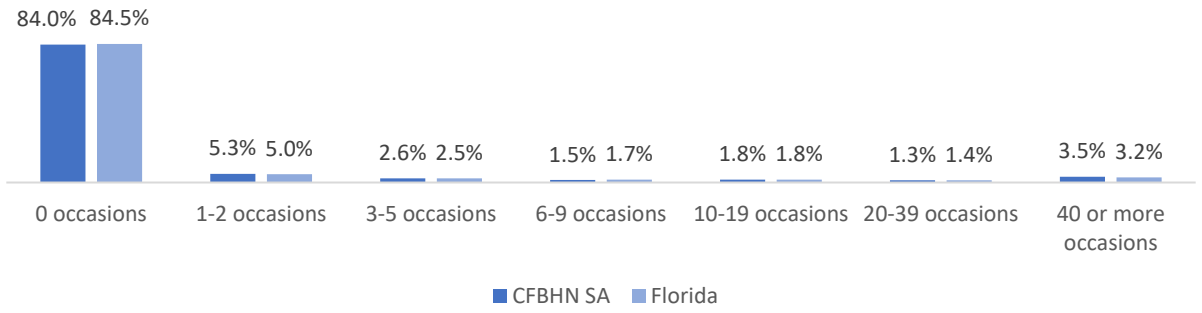
Figure 33: CFBHN SA – On How Many Occasions Have You Used Marijuana or Hashish During the Past 30 Days? (MS&HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
CFBHN SA 2016	1.7%	1.2%	1.6%	1.6%	2.3%	3.9%	87.7%
CFBHN SA 2018	1.6%	1.1%	1.6%	1.4%	1.9%	3.9%	88.5%
CFBHN SA 2020	1.4%	1.0%	1.1%	0.9%	2.0%	3.7%	89.7%
Florida 2016	1.4%	1.0%	1.4%	1.3%	2.0%	4.0%	88.8%
Florida 2018	1.4%	1.0%	1.2%	1.3%	1.8%	4.2%	89.1%
Florida 2020	1.4%	0.9%	1.2%	1.1%	2.0%	3.9%	89.3%

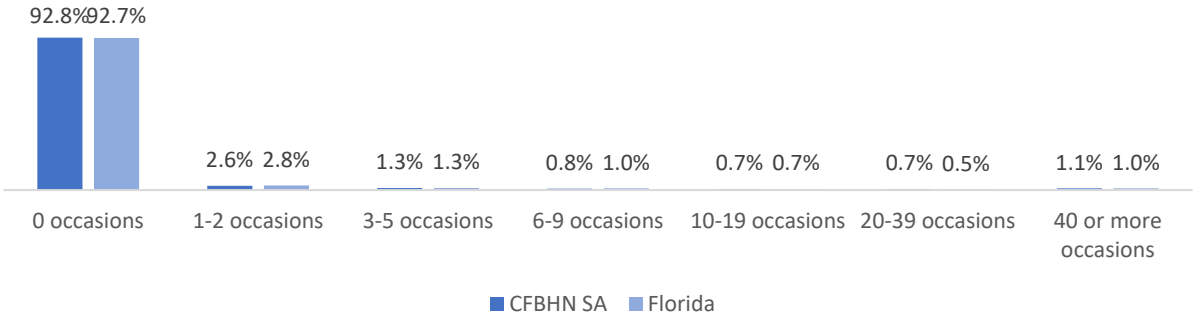
Source: Florida Youth Substance Abuse Survey

Figure 34: CFBHN SA - On How Many Occasions Have You Vaped Marijuana in Your Lifetime? (MS&HS 2016-2020)



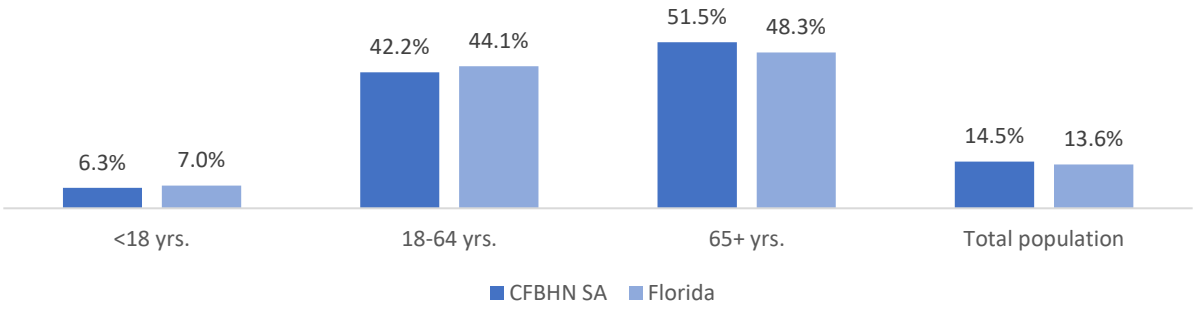
Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

Figure 35: CFBHN SA – On How Many Occasions Have You Vaped Marijuana in the Past 30 Days? (MS&HS 2016-2020)



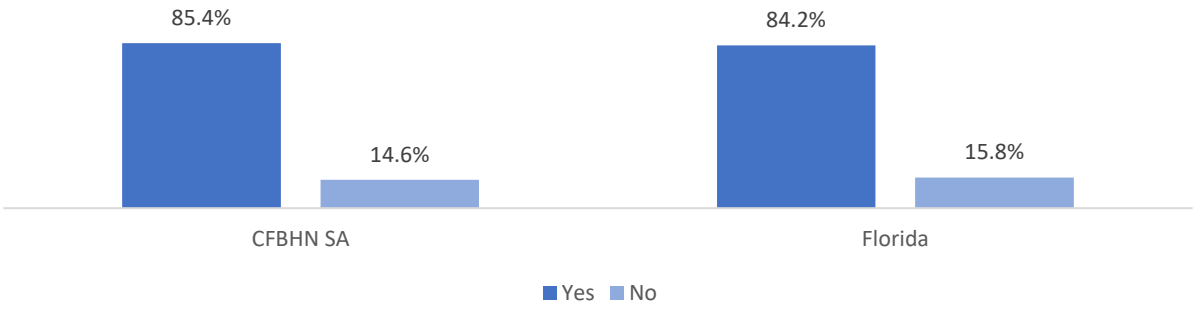
Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

Figure 36: CFBHN SA Civilian Noninstitutionalized Population with a Disability (2016-2020)



Source: U.S. Census Bureau, American Community Survey. Disability includes: Hearing, Vision, Cognitive, Ambulatory, Self-Care, and Independent Living

Figure 37: CFBHN SA Percentage of Adults with Any Type of Health Care Insurance Coverage (2013-2019)



Source: Behavioral Risk Factor Surveillance System

CFBHN SERVICE AREA CLIENT DEMOGRAPHIC PROFILE

Client Population

CFBHN-funded organizations served 95,157 clients in FY20-21. This number may include a small amount of duplication in that some clients moved from one county to another, were enrolled in more than one program or changed residential status during the one-year period. Approximately 24% of clients resided in Hillsborough County (22,760 clients), followed by Pinellas County at 20.3% (19,310 clients), Lee County at 12.1% (11,522 clients), Polk County at 11.3% (10,781 clients), Manatee County at 9.2% (8,709 clients), Pasco County at 6.2% (5,918 clients), Sarasota County at 6% (5,731 clients), Charlotte County at 3.2% (3,003 clients), Collier County at 2.6% (2,484 clients), out-of-area at 2% (1,937 clients), Highlands County at 1.6% (1,494 clients), DeSoto at 0.7% (648 clients), Hardee at 0.4% (398 clients), Hendry County at 0.3% (263 clients), and Glades County at 0.2% (199 clients). It should be noted that 5.9% clients reported their residential status as homeless across all counties in the service area.

Adults (age 15 and older) in CFBHN programs accounted for 85% of all clients with 74% enrolled in the Adult Mental Health (AMH) program and 26% in the Adult Substance Abuse program (ASA). The remaining clients were in the Child Mental Health (CMH) program at 15% and the Child Substance Abuse (CSA) program at 5%.

Gender

Females represented 55% of all clients in the AMH, and 65% in CSA programs. Males represented 55% in ASA, and males and females were evenly represented in CMH services at 50% each. Resident population in the service area is 51.3% female and 48.7% male.

Race

The majority of CFBHN clients were White (70%) which was lower than the percentage in the service area population at 78%. Conversely, Black CFBHN clients accounted for 17% of the client population while representing only 10.9% of the population in the service area. AMH racial makeup closely followed the total client percentages. Whites were a larger percentage of ASA clients than in any other service at 80%, with Blacks at their lowest percentage in any service at 11%. CMH and CSA were more diverse when compared with AMA and ASA, with Blacks representing 19% in CMH and 23% in CSA. Multi-race represented 16% of CMH clients and 14% of CSA clients. Whites in CMH and CSA had their lowest percentages at 59% and 58% respectively.

Ethnicity

The percentage of Hispanics in the CFBHN client population (21%) was reflective of the percent of Hispanics in the service area at 20.4% each. The ethnic composition of the CFBHN client population was lower for Cubans (2% vs. 3.8%), Puerto Rican (5% vs 5.4%), and other Hispanic (7% vs. 5.7%) when compared with resident population. CFBHN client population also reported 7% Mexican American but no similar measure was available for the service area population.

Age Range

As expected, the age range distribution among CFBHN clients did not mimic that of the service area population. Adults 25-34 years of age, accounted for 23.7% of those in the AMH and 34.8% in the ASA programs while representing only 12.1% of the population in the service area. Adults 35-44 years of age accounted for 20.3% of AMH and 29.8% of ASA clients while representing 11.3% of the population in the service area. Teens and young adults ages 15-19 years of age accounted for 5.4% of those living in the service area population and children ages 5-14 years made up 10.7%. Among those enrolled in child/youth programs, 62.1% of clients in the CMH program were 5-14 years of age and 78.3% of clients in the CSA program were 15-19 years old.

Residential Status

The majority of CFBHN adults resided in one of three types of living conditions: independent with relatives, dependent living with relatives, or independent alone. Among AMH clients, 5.7% reported their status as homeless, as did 11.6% of those in the ASA program. Those in children/youth programs lived dependently with relatives.

Educational Attainment

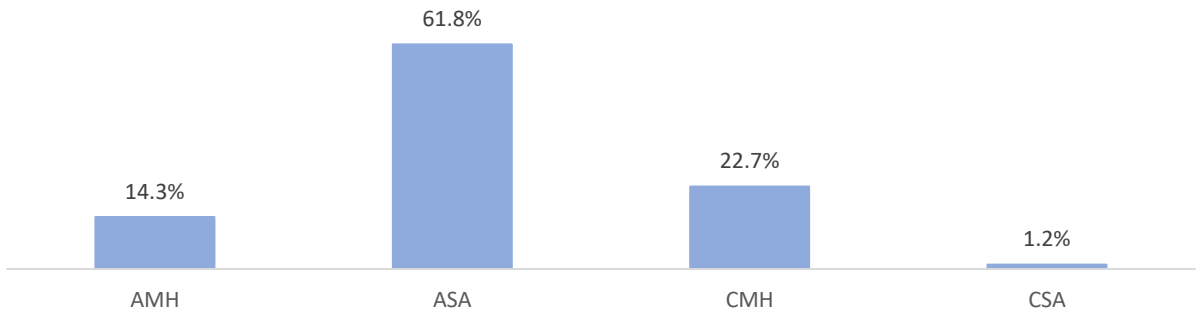
CFBHN clients attained lower educational levels when compared to those in the service area population. Among CFBHN adults, educational attainment was limited to high school for 47.8% of AMH clients and 38% of ASA clients. This compares to 89.1% of residents in the service area who had a high school education. Consequently, the percentages of adult CFBHN clients who earned college degrees were well below those for residents living in the service area.

Employment Status

Lower educational attainment was one of several factors that contributed to much higher levels of unemployment among CFBHN clients when compared to those in the service area. Among AMH client 35.7% were not employed and 50.2% of ASA clients were not employed. In the service area 1.9% of residents were unemployed.

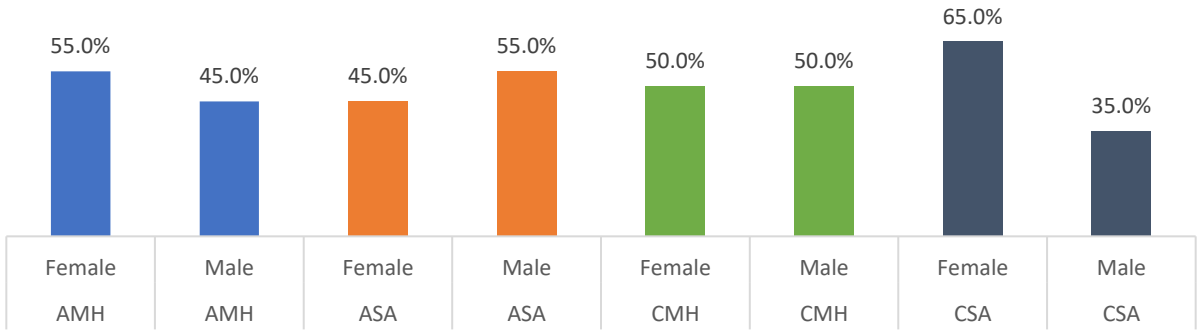
CLIENT DEMOGRAPHIC CHARTS

Figure 38: CFBHN Clients by Program



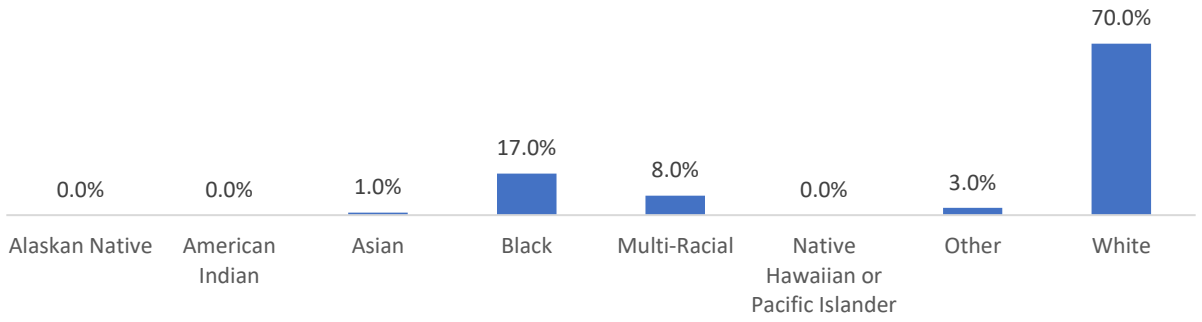
Source: CFBHN Client Data

Figure 39: CFBHN Clients by Program and Gender



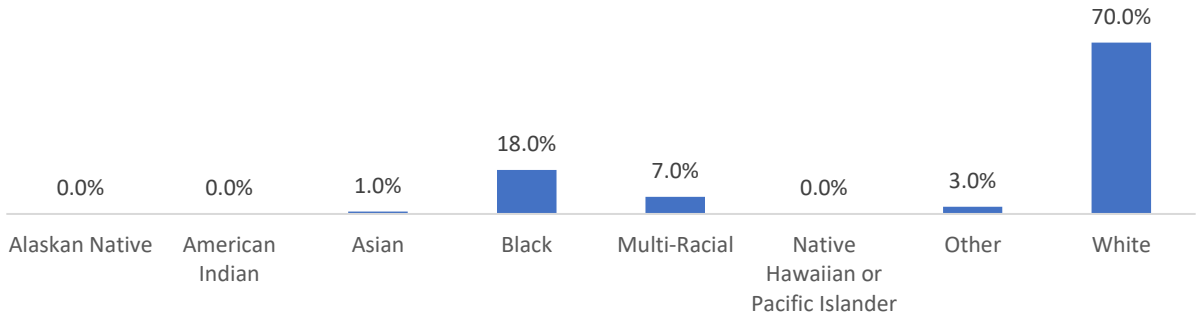
Source: CFBHN Client Data

Figure 40: CFBHN Clients by Race



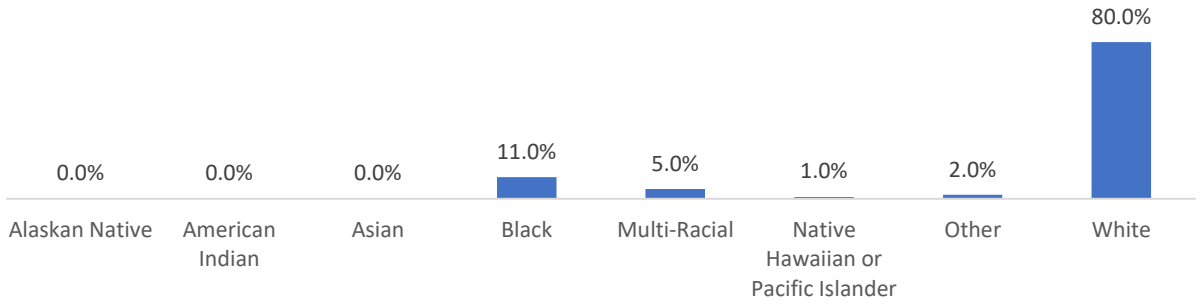
Source: CFBHN Client Data

Figure 41: CFBHN AMH Clients by Race



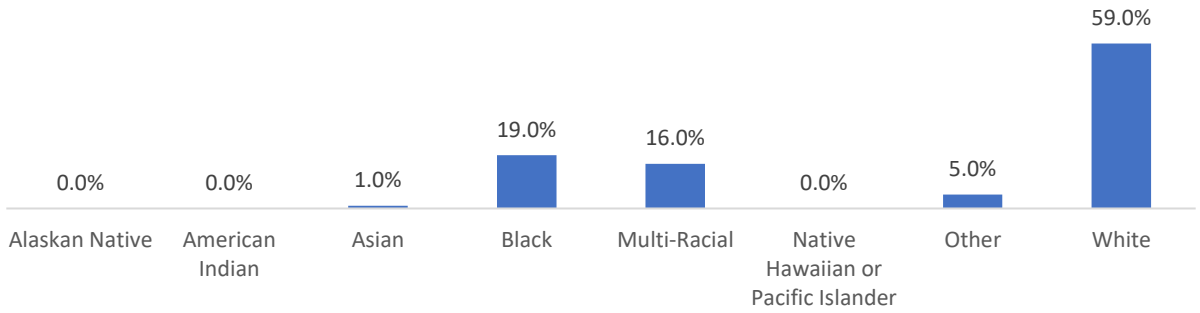
Source: CFBHN Client Data

Figure 42: CFBHN ASA Clients by Race



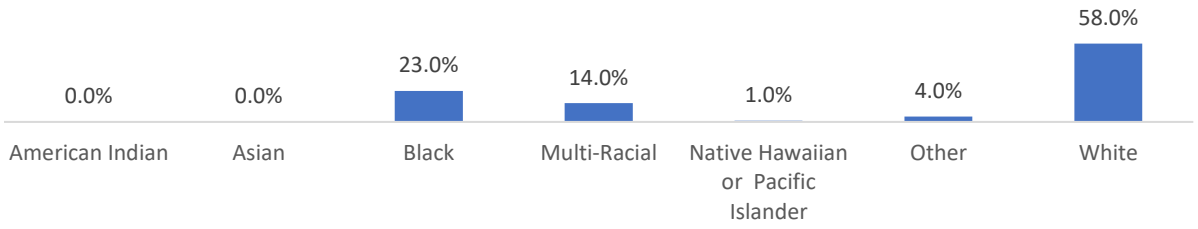
Source: CFBHN Client Data

Figure 43: CFBHN CMH Clients by Race



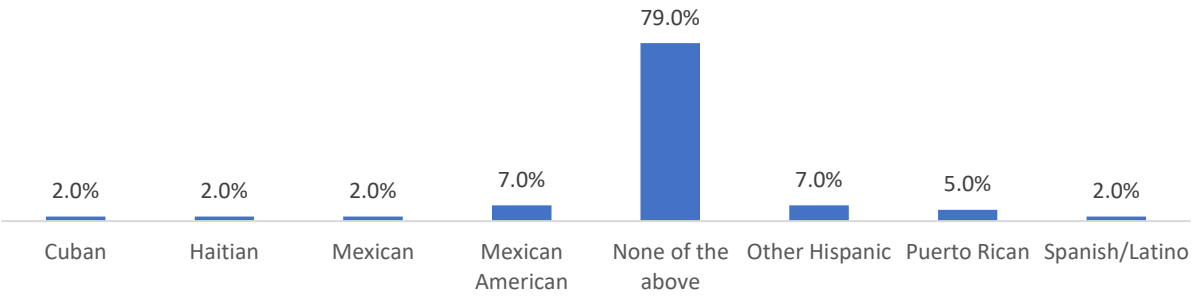
Source: CFBHN Client Data

Figure 44: CFBHN CSA Clients by Race



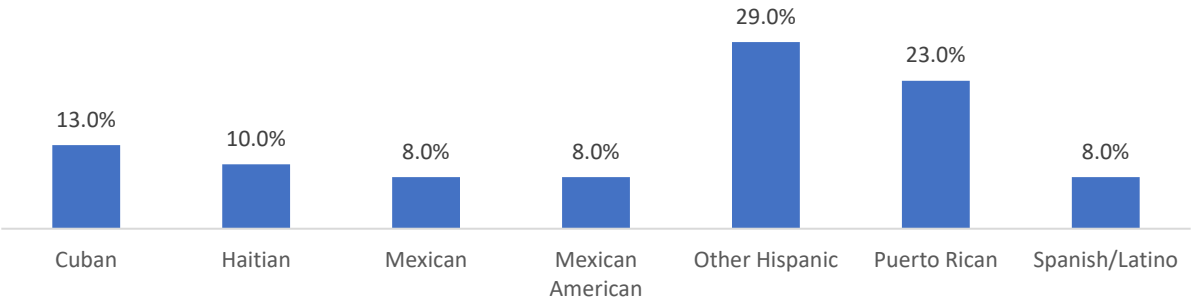
Source: CFBHN Client Data

Figure 45: CFBHN Clients by Ethnicity



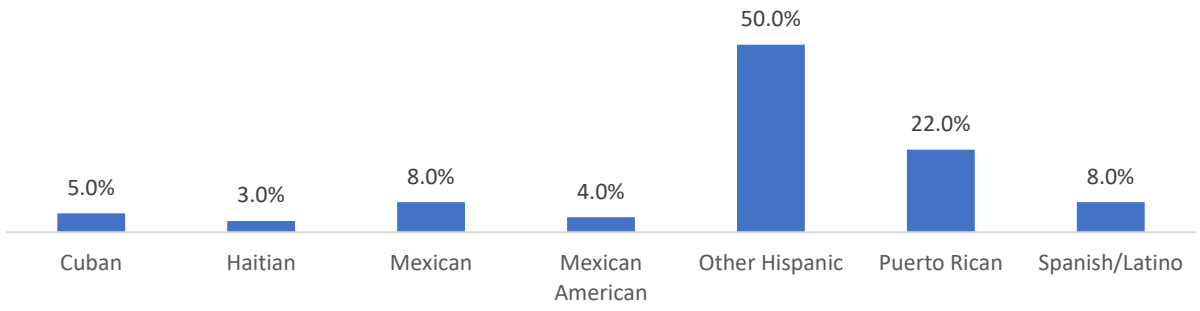
Source: CFBHN Client Data

Figure 46: CFBHN AMH Clients by Ethnicity



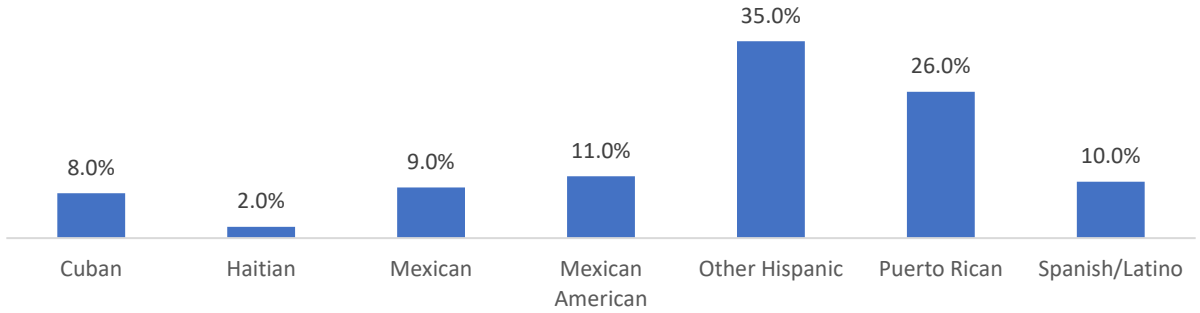
Source: CFBHN Client Data

Figure 47: CFBHN ASA Clients by Ethnicity



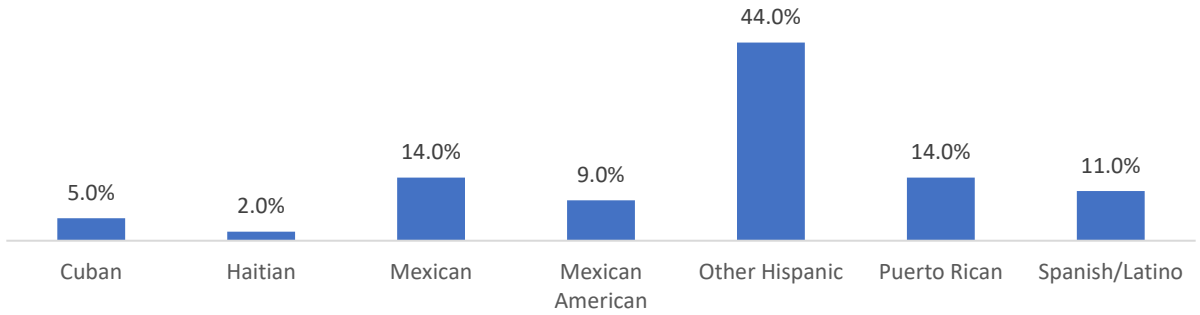
Source: CFBHN Client Data

Figure 48: CFBHN CMH Clients by Ethnicity



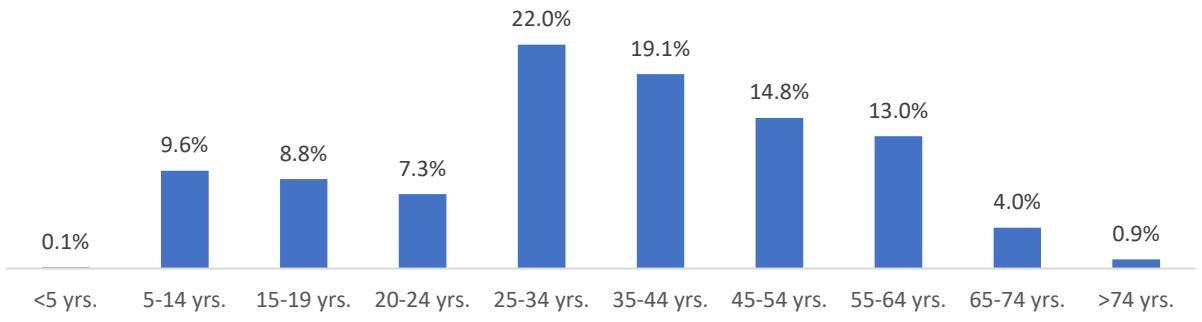
Source: CFBHN Client Data

Figure 49: CFBHN CSA Clients by Ethnicity



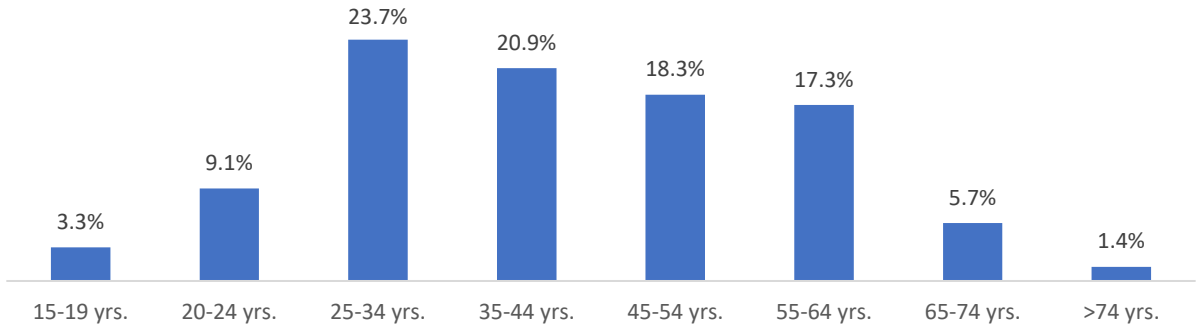
Source: CFBHN Client Data

Figure 50: CFBHN Clients by Age Range



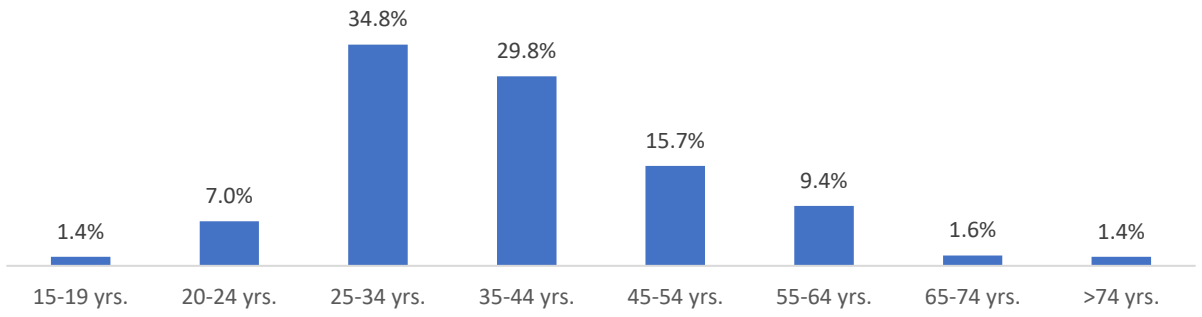
Source: CFBHN Client Data

Figure 51: CFBHN AMH Clients by Age Range



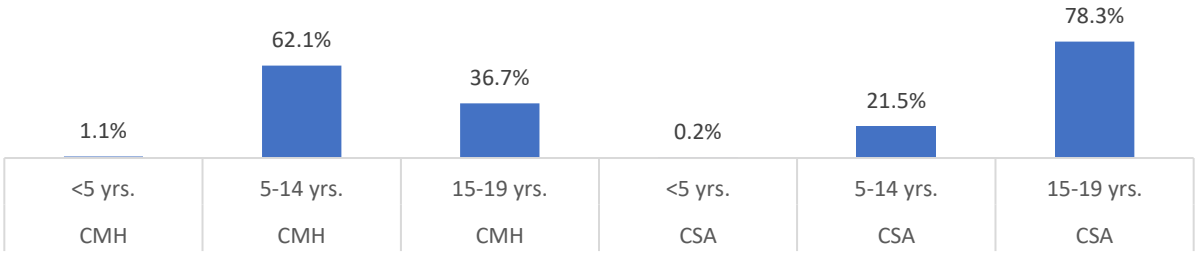
Source: CFBHN Client Data

Figure 52: CFBHN ASA Clients by Age Range



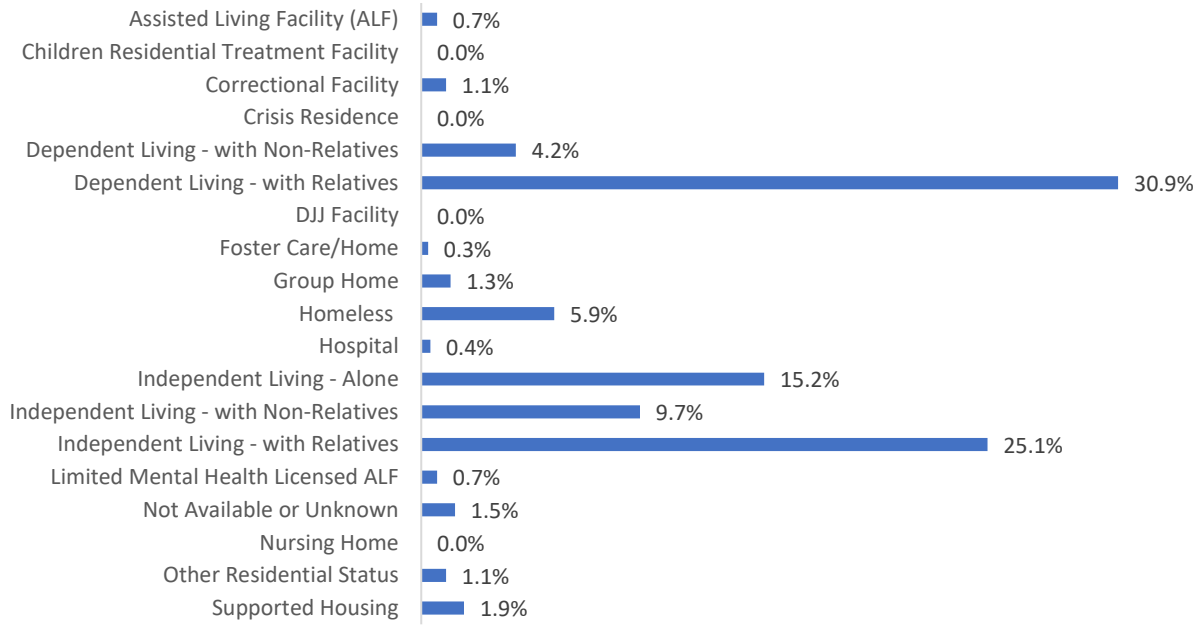
Source: CFBHN Client Data

Figure 53: CFBHN CMH and CSA Clients by Age Range



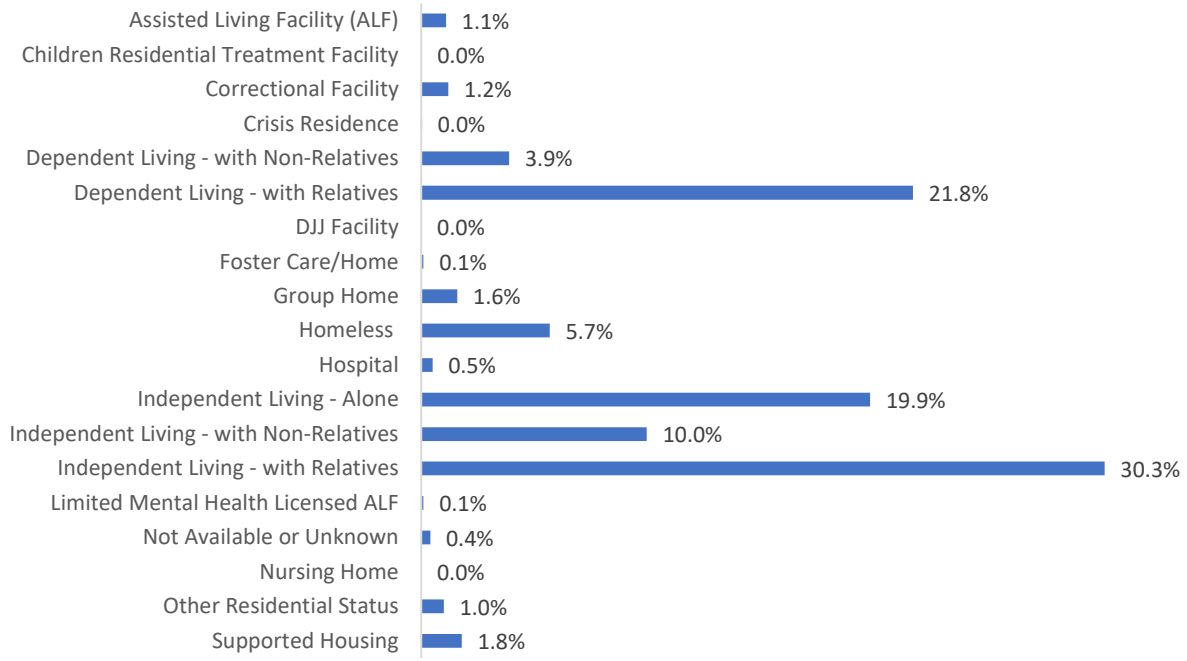
Source: CFBHN Client Data

Figure 54: CFBHN Clients by Residential Status



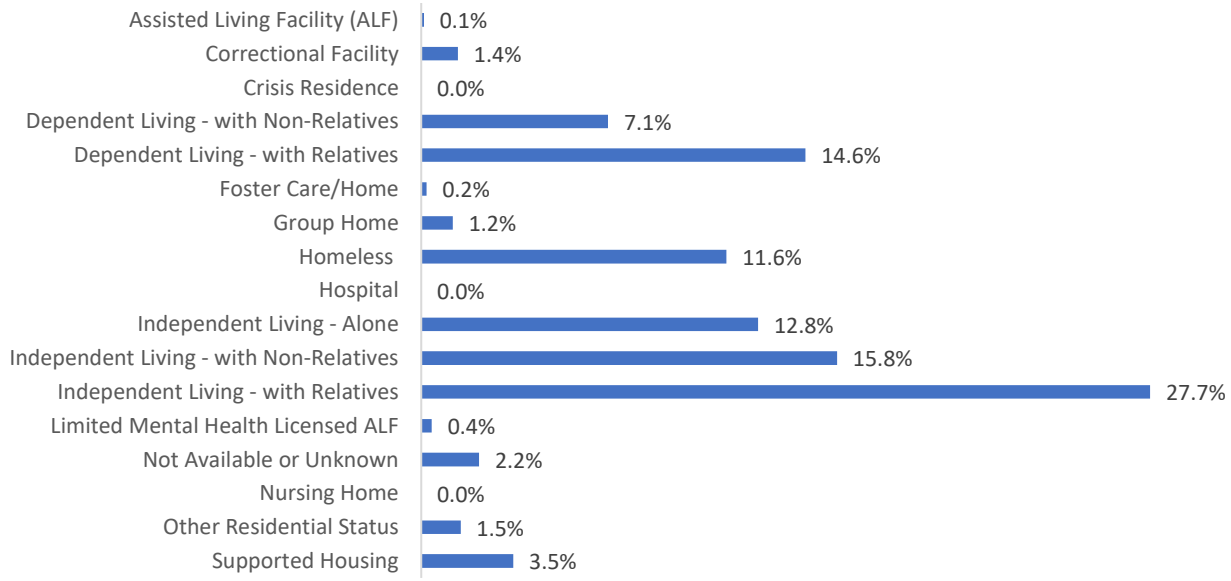
Source: CFBHN Client Data

Figure 55: CFBHN AMH Clients by Residential Status



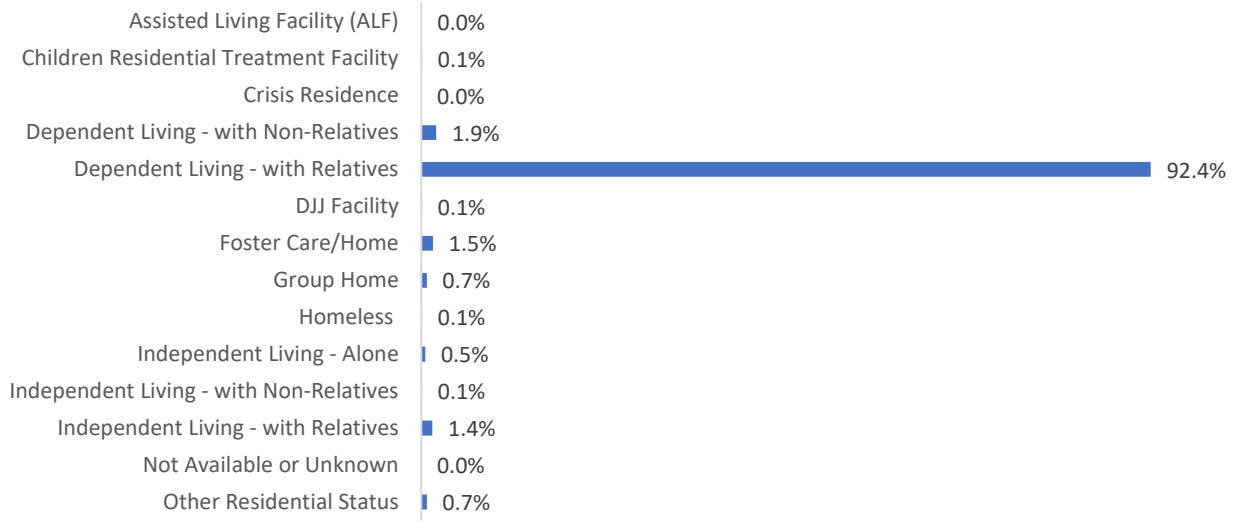
Source: CFBHN Client Data

Figure 56: CFBHN ASA Clients by Residential Status



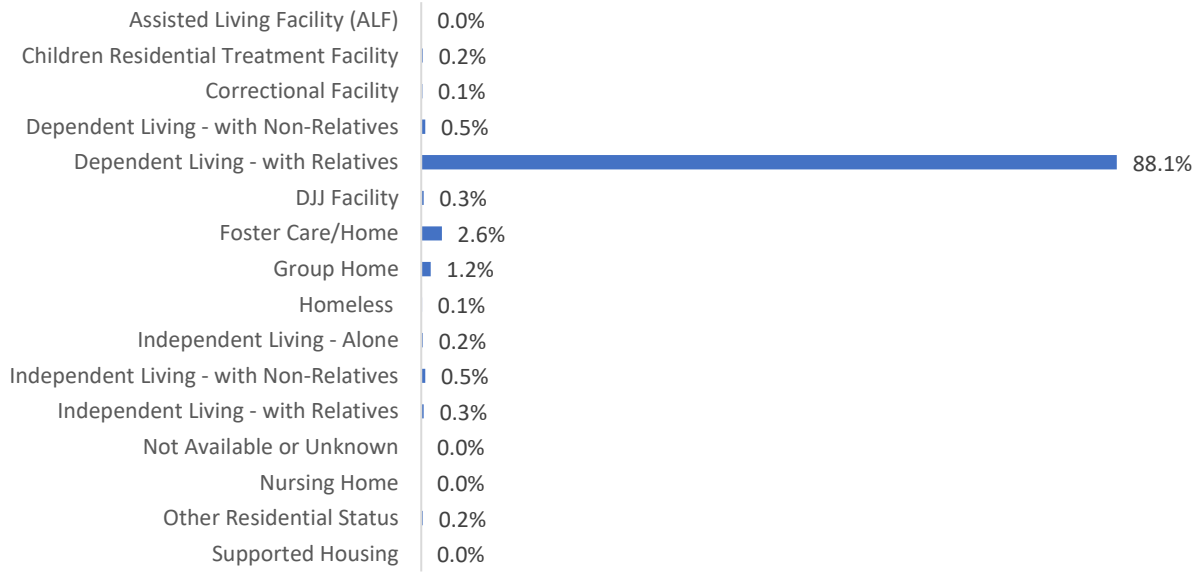
Source: CFBHN Client Data

Figure 57: CFBHN CMH Clients by Residential Status



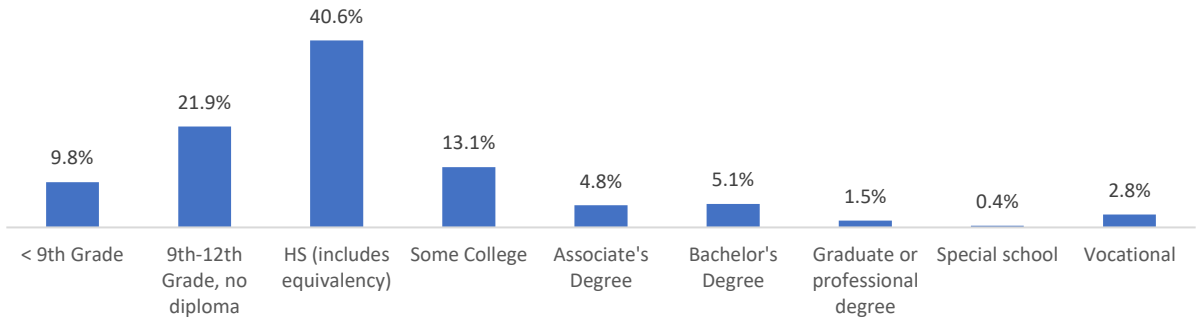
Source: CFBHN Client Data

Figure 58: CFBHN CSA Clients by Residential Status



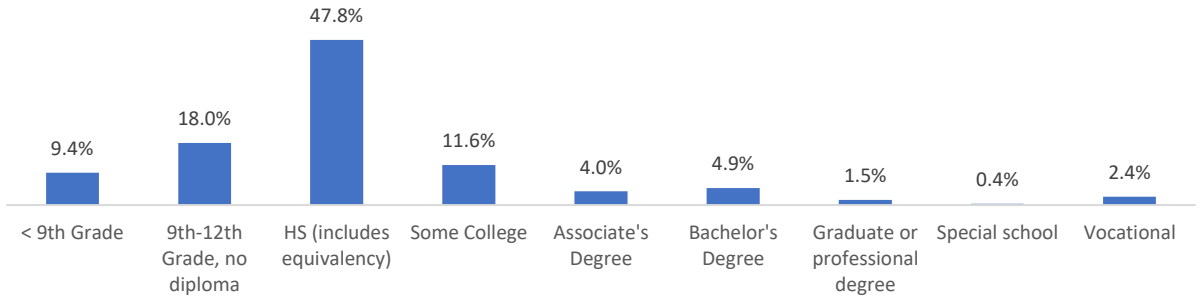
Source: CFBHN Client Data

Figure 59: CFBHN Clients by Educational Attainment



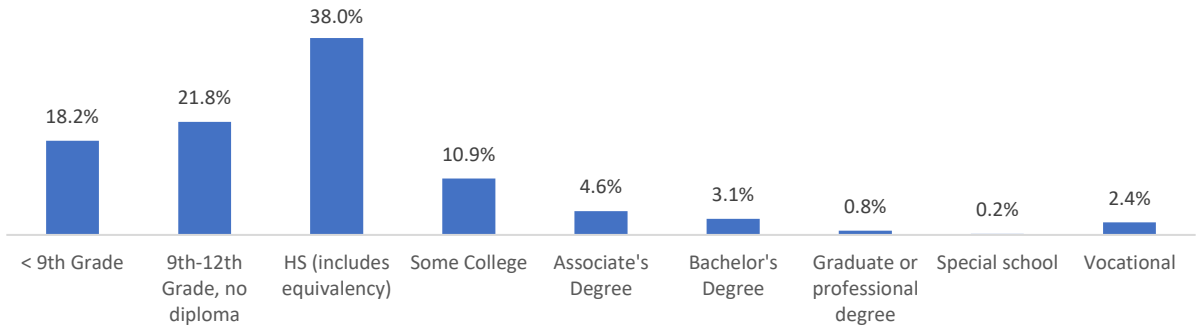
Source: CFBHN Client Data

Figure 60: CFBHN AMH Clients by Educational Attainment



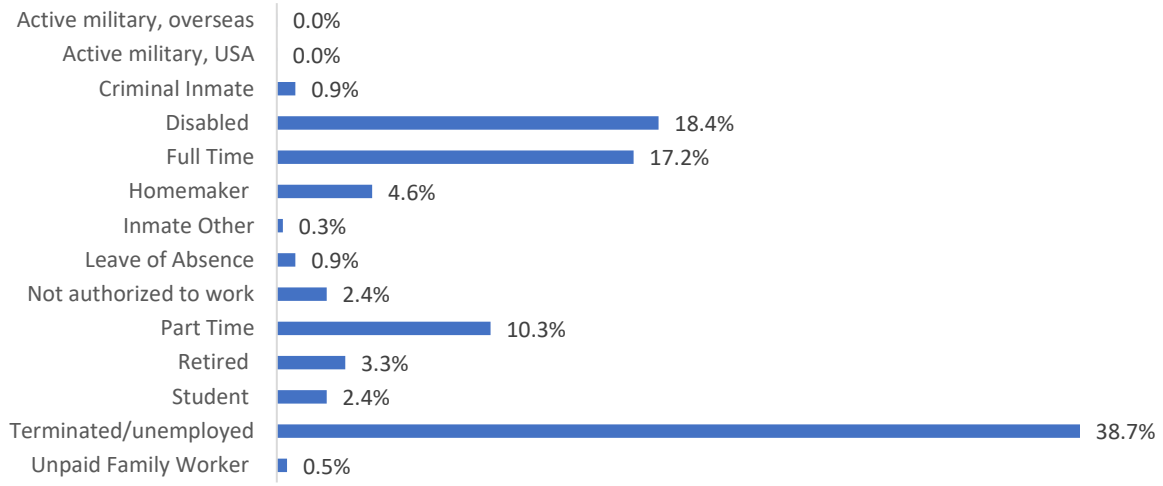
Source: CFBHN Client Data

Figure 61: CFBHN ASA Clients by Educational Attainment



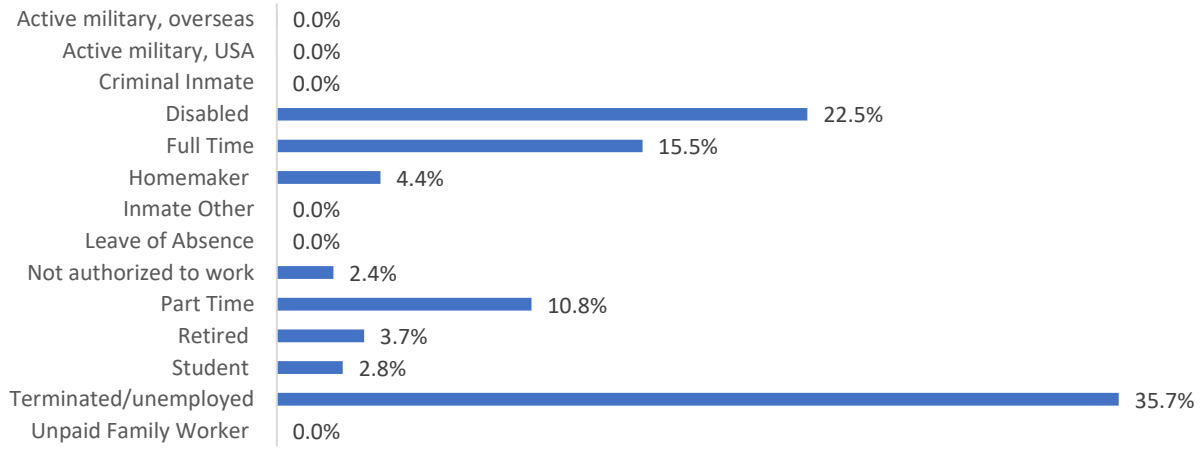
Source: CFBHN Client Data

Figure 62: CFBHN Clients by Employment Status



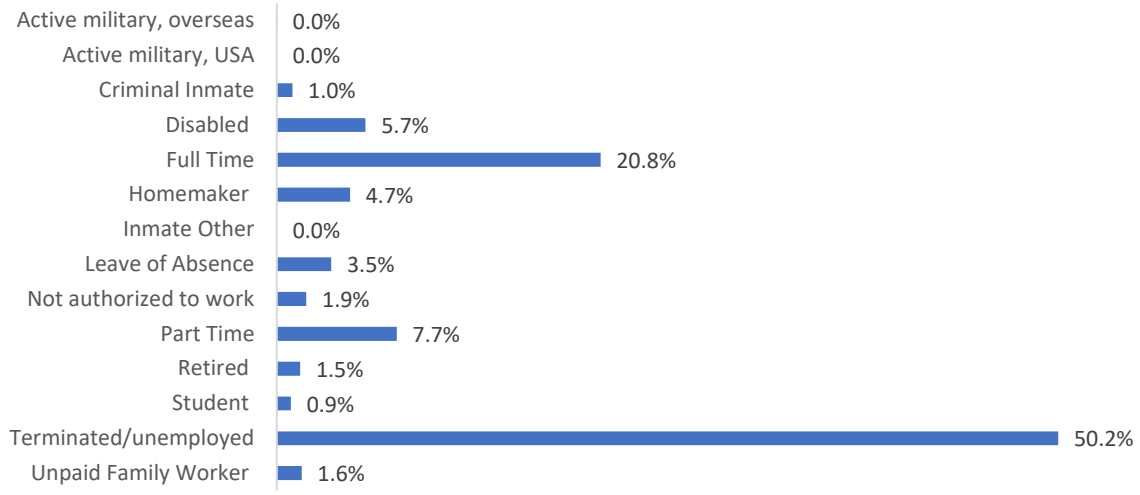
Source: CFBHN Client Data

Figure 63: CFBHN AMH Clients by Employment Status



Source: CFBHN Client Data

Figure 64: CFBHN ASA Clients by Employment Status



Source: CFBHN Client Data

CFBHN SERVICE AREA HOMELESS POPULATION

The 2021 Council on Homelessness Report states that the Point in Time Count (PIT) data provides a snapshot of homelessness. **Due to the pandemic, the 2021 PIT Count is not directly comparable to prior years' counts.** Typically, Continuums of Care (CoCs- A local geographic area designated by HUD and served by a local planning body, which is responsible for organizing and delivering housing and services to meet the needs of people who are homeless as they move to stable housing and maximum self-sufficiency) conduct a PIT Count of both sheltered and unsheltered households. This year, due to COVID-19 related safety concerns, only six of the 27 CoCs conducted such a count; 10 CoCs did not conduct an unsheltered count; and others conducted a modified form of the unsheltered count. All CoCs conducted a sheltered PIT count. For those that did not conduct an unsheltered count, the CoCs reported zero unsheltered persons, resulting in an undercount of total homelessness. According to the report:

> "Housing is a significant determinant of health, and insufficient housing is a major public health issue. The COVID-19 pandemic has exacerbated housing instability especially for low-income households. In effect, the pandemic has triggered high rates of unemployment, worsened pre-existing behavioral health disorders, and increased stress, anxiety and depression for others. Increased rates of unemployment also contribute to increasing the prevalence of behavioral health disorders, resulting in more suffering and deaths. Prior to the pandemic, America's affordable housing crisis was already expected to get worse. The ELI housing crisis is evidenced by the fact that people with disabilities are forced to live in segregated and institutional facilities (e.g., nursing homes, state institutions, etc.) and experience homelessness. Many of these individuals need Permanent Supportive Housing."
>
> (Please access the actual report for resources at: 2021CouncilReport.pdf (myflfamilies.com)

For this report, Okeechobee County is included in the data totals as it is part of the Continuum of Care (CoC) # FL-517. Okeechobee County is outside of the CFBHN ME service area. In 2021, the Florida Council on Homelessness reported there were 5,740 individuals who were homeless in Central and Southwest Florida (Charlotte, Collier, DeSoto, Glades, Hardee, Hendry, Highlands, Hillsborough, Lee, Manatee, Okeechobee, Pasco, Pinellas, Polk, and Sarasota counties). Of those, 33.9% were unsheltered and 14.7% were chronically homeless. In the ME service area, there were 1,404 people in families with children who were homeless. Among veterans, 640 were homeless in Central and Southwest Florida. The Florida Department of Education reported 20,687 students in Central and Southwest Florida were homeless in the 2019-2020 academic year. Seventy-five percent of homeless students resided in a shared housing environment, 12.1% lived in motels, 8.9% were sheltered, and 4.4% were living in other housing situations.

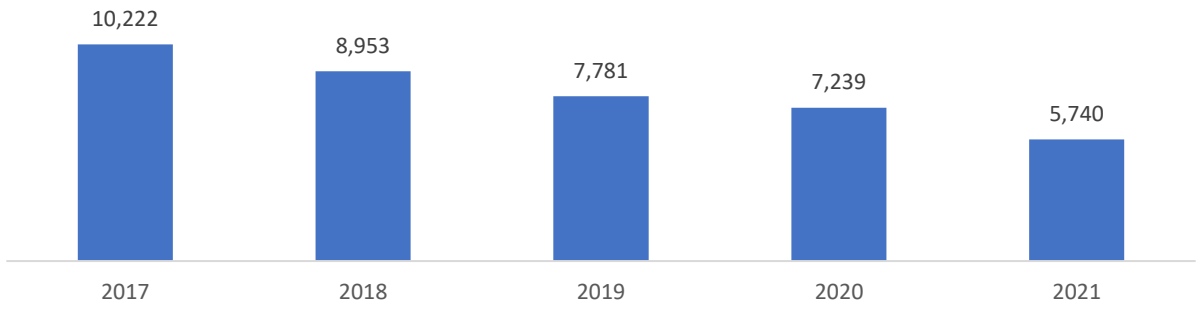
Due to the COVID-19 pandemic, this year saw an unprecedented infusion of federal funding to address homelessness and housing instability. With these funds appropriated by Congress, the State, local governments, CoCs, and partner agencies have invested in solutions to homelessness, including rent and utilities assistance, sheltering, outreach, supportive services and more. While these resources have increased Florida's capacity to prevent and end homelessness, the federal funds have strict restrictions on how the funds may be used; they are not interchangeable with the Challenge and Staffing grants provided to CoCs by the State of Florida. State funding remains critical to addressing homelessness in Florida, especially in rural areas and for the many programs that cannot be funded by federal resources due to their restrictions. State funding helps ensure a broad range of programs in Florida, as well as increase the capacity of the CoCs to administer the federal funding and other resources.

Figure 65: CoC Funding from Federal and State Sources, District 5, 6, & 8 (SFY20-21)

Source	District 5, 6, & 8
Total Funding Award	$39,348,592.82
HUD CoC FFY20	$16,324,036.00
State Total	$20,685,090.82
State Challenge	$941,500.00
Emergency Solutions Grant	$1,326,525.00
State Staffing	$857,142.80
State TANF-HP	$177,746.00
ESG-CV	$18,382,177.02

Source: 2021 Florida's Council on Homelessness Annual Report

Figure 66: Total Homeless Population, District 5, 6, & 8 (2017-2021)

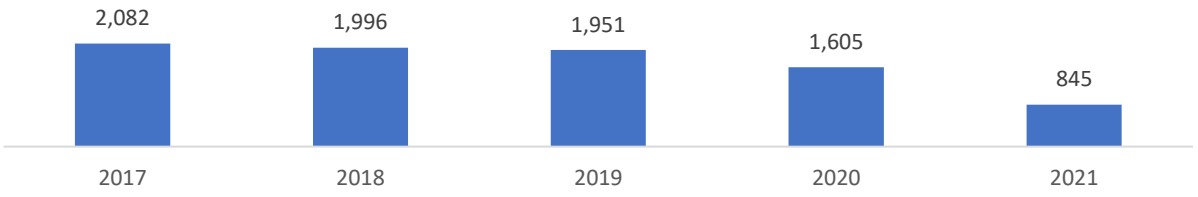


Source: 2021 Florida's Council on Homelessness Annual Report

Figure 67: Total Homeless Population Sheltered and Unsheltered, District 5, 6, & 8 (2021)

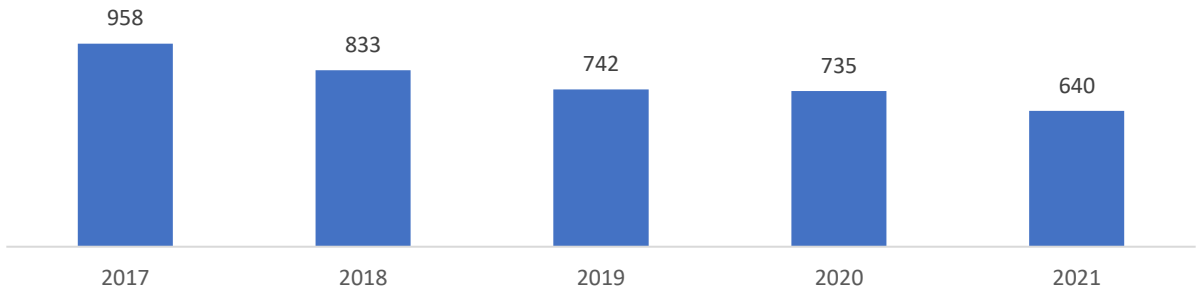
Source: 2021 Florida's Council on Homelessness Annual Report. Manatee, Sarasota, Hillsborough, Desoto, Glades, Hardee, Hendry, Highlands, and Okeechobee counties did not conduct an unsheltered PIT Count. Pinellas, Charlotte, and Lee counties conducted a modified unsheltered PIT count. Pasco and Collier counties conducted a full unsheltered PIT count.

Figure 68: Chronic Homelessness, District 5, 6, & 8 (2017-2021)



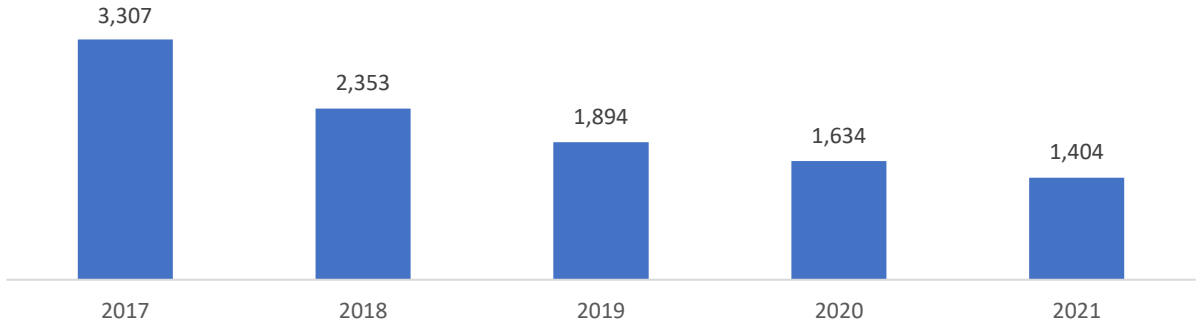
Source: 2021 Florida's Council on Homelessness Annual Report

Figure 69: Homelessness Among Veterans, District 5, 6, & 8 (2017-2021)



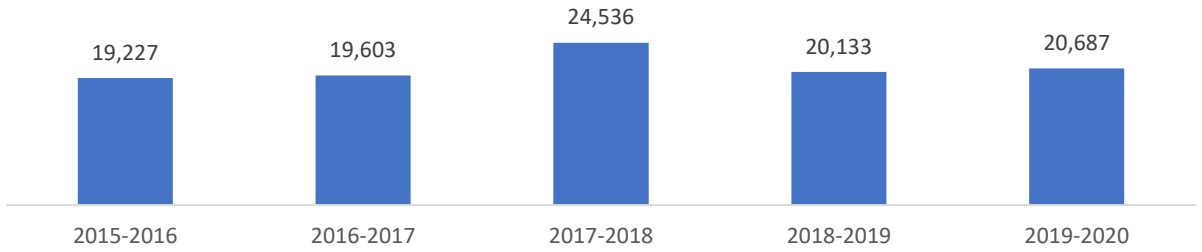
Source: 2021 Florida's Council on Homelessness Annual Report

Figure 70: Family Homelessness – Total Persons in Families with Children, District 5, 6, & 8 (2017-2021)



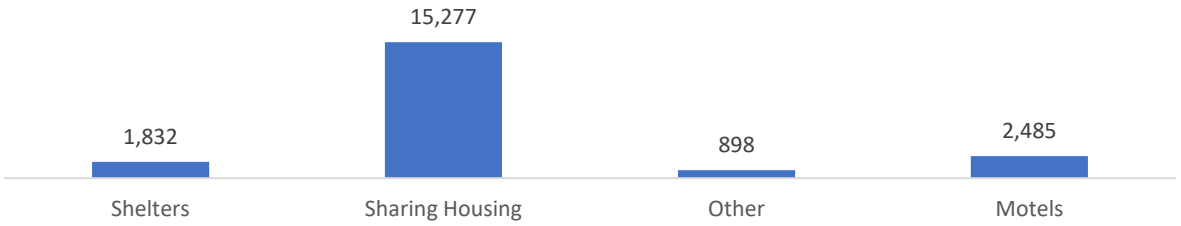
Source: 2021 Florida's Council on Homelessness Annual Report

Figure 71: Florida DOE – Reported Homeless Students in Public Schools (2015-2020)



Source: 2021 Florida's Council on Homelessness Annual Report. School Districts: 8, 11, 14, 22, 25, 26, 28, 29, 36, 41, 51, 52, 53, & 58

Figure 72: Reported Homeless Students in Public Schools by Living Situation (2019-2020)



Source: 2021 Florida's Council on Homelessness Annual Report. School Districts: 8, 11, 14, 22, 25, 26, 28, 29, 36, 41, 51, 52, 53, & 58

CFBHN HOMELESS CLIENT PROFILE

Demographics

A total of 6,113 homeless clients were enrolled in adult programs with 57% in the AMH program and 42.6 in the ASA program.

Males accounted for larger percentages of clients in the AMH and ASA programs at 66.7% and 70.7%, respectively.

Homeless clients in the AMH program were racially more diverse when compared to the general service population while those in the ASA program were representative of the 14-county area. White homeless clients accounted for 67.2% of those in the AMH program and Black homeless clients represented 25% of clients in the same program. In the general population, Blacks accounted for 10.9% of the total population. Multi-racial individuals also accounted for a larger percentage of clients in the AMH (4.7%) and ASA (6.4%) programs when compared to the service area population at 5.2%. Hispanic clients in both the AMH program, at 10.4%, and in the ASA, at 9.9%, were underrepresented when compared to the general population where 20.4% were Hispanic.

Adults, ages 25-44 years, accounted for 25.5% of AMH clients and 23.9% of ASA clients. Older homeless clients in the ASA program were very underrepresented, at 2%, when compared the general population at 23.4%.

Residential Status

All homeless clients reported their residential status as homeless.

Educational Attainment

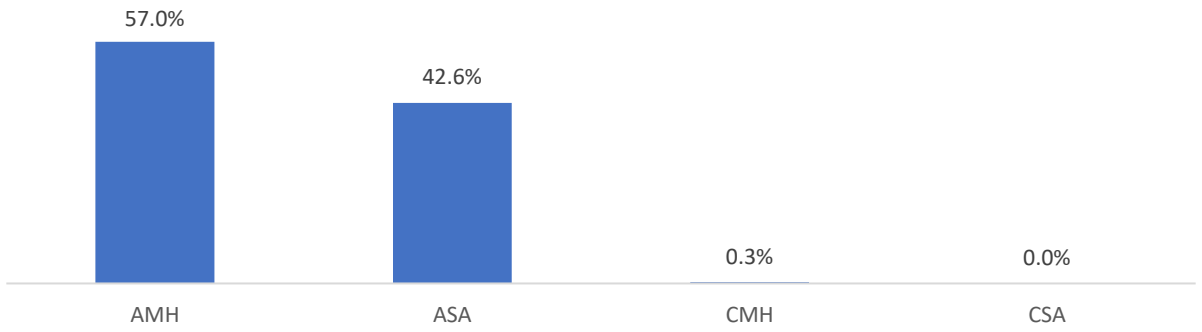
Among the homeless, 81.1% of AMH clients and 77.9% of ASA clients did not have more than a high school education. Of these, 39.8% of AMH clients and 34.4% of ASA clients did not have a diploma.

Employment Status

Only 9.1% of homeless clients were employed (full time and part time) and over 70% had been terminated.

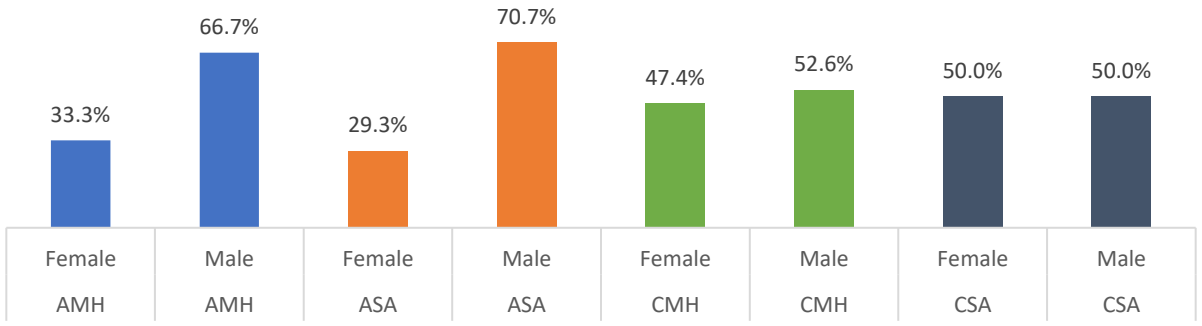
CFBHN HOMELESS CLIENT CHARTS

Figure 73: CFBHN Homeless Clients by Program



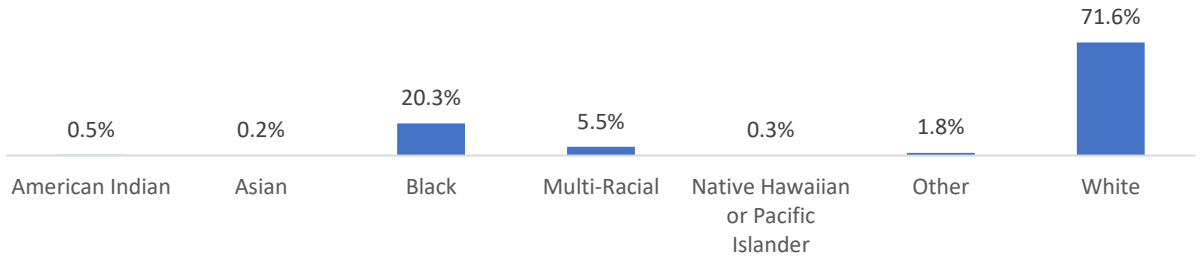
Source: CFBHN Client Data

Figure 74: CFBHN Homeless Clients by Gender



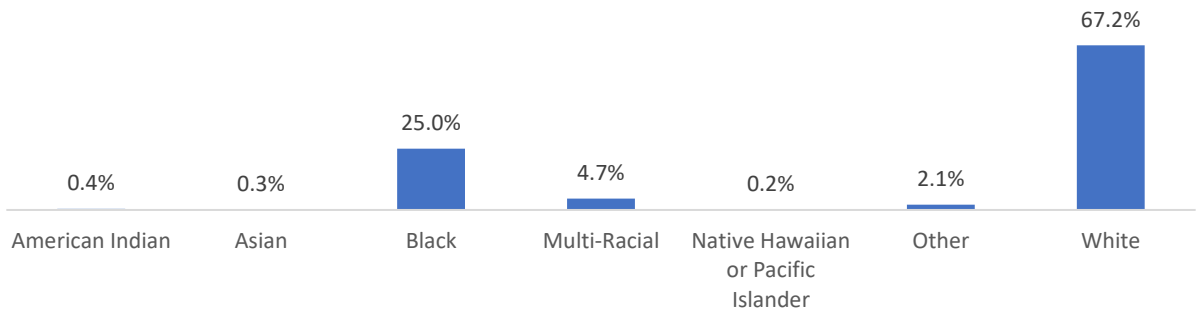
Source: CFBHN Client Data

Figure 75: CFBHN Homeless Clients by Race



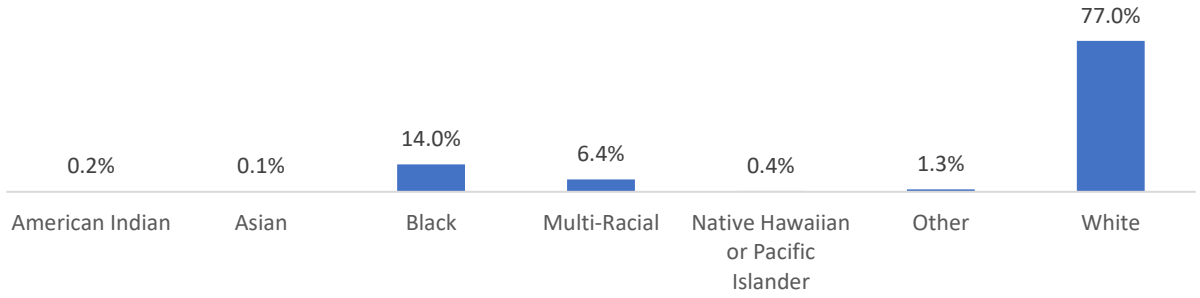
Source: CFBHN Client Data

Figure 76: CFBHN Homeless AMH Clients by Race



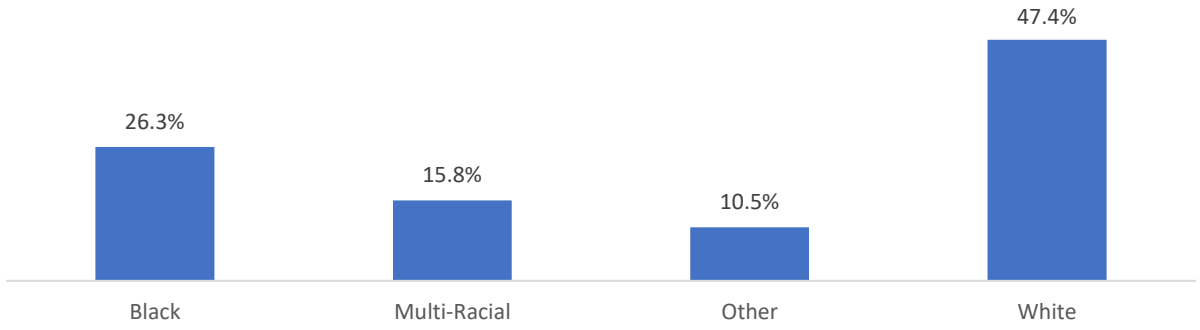
Source: CFBHN Client Data

Figure 77: CFBHN Homeless ASA Client by Race



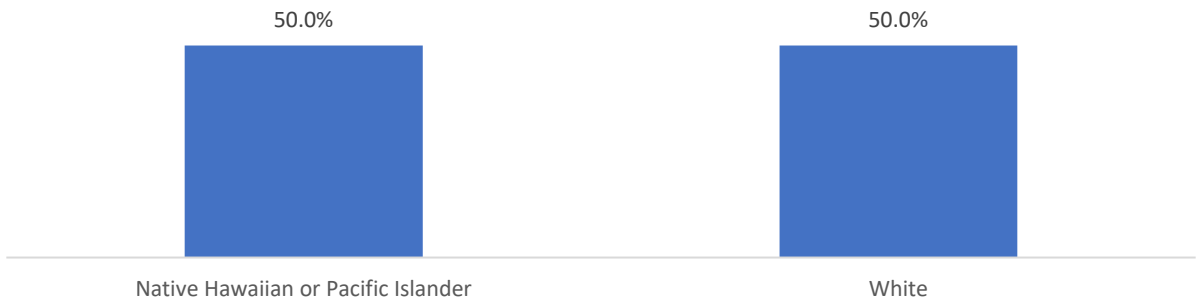
Source: CFBHN Client Data

Figure 78: CFBHN Homeless CMH Clients by Race



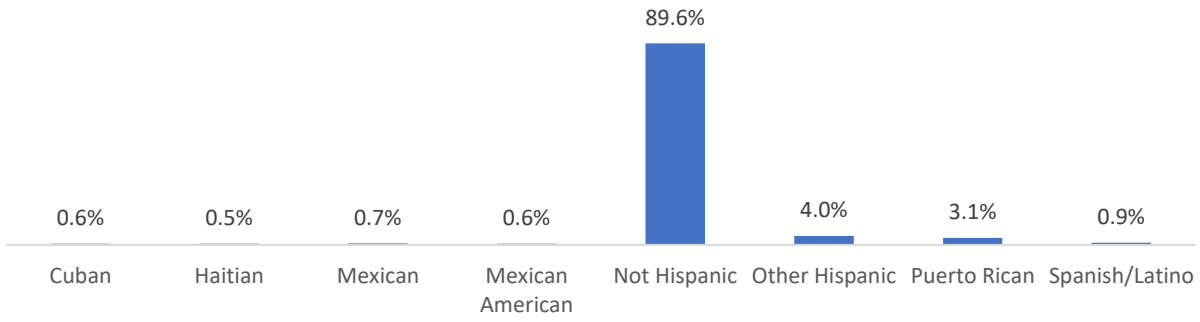
Source: CFBHN Client Data

Figure 79: CFBHN Homeless CSA Clients by Race



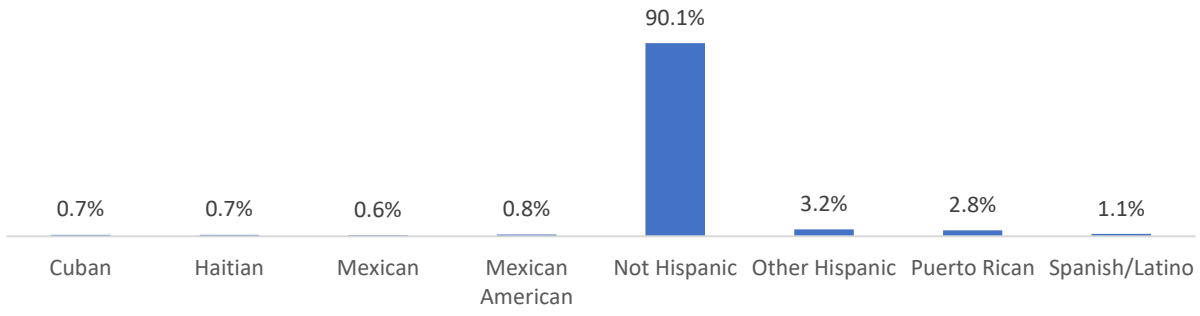
Source: CFBHN Client Data

Figure 80: CFBHN Homeless Clients by Ethnicity



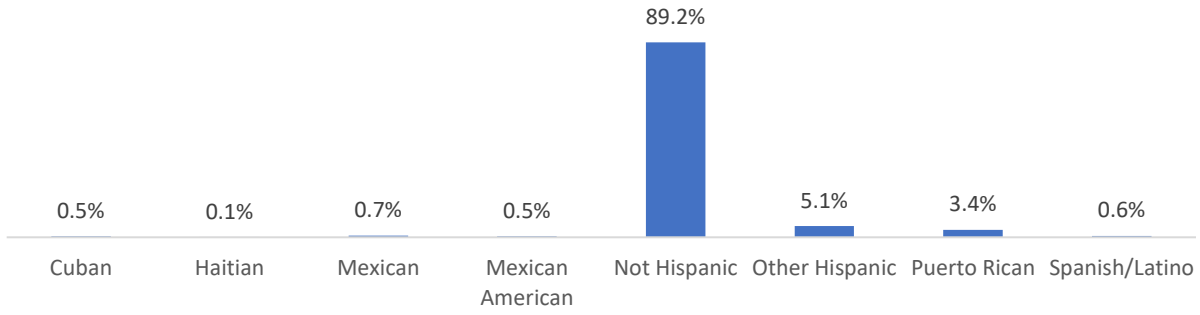
Source: CFBHN Client Data

Figure 81: CFBHN Homeless AMH Clients by Ethnicity



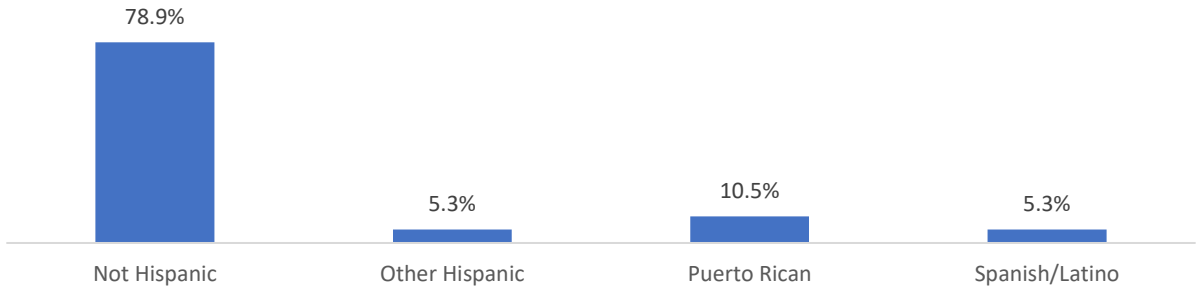
Source: CFBHN Client Data

Figure 82: CFBHN Homeless ASA Clients by Ethnicity



Source: CFBHN Client Data

Figure 83: CFBHN Homeless CMH Clients by Ethnicity

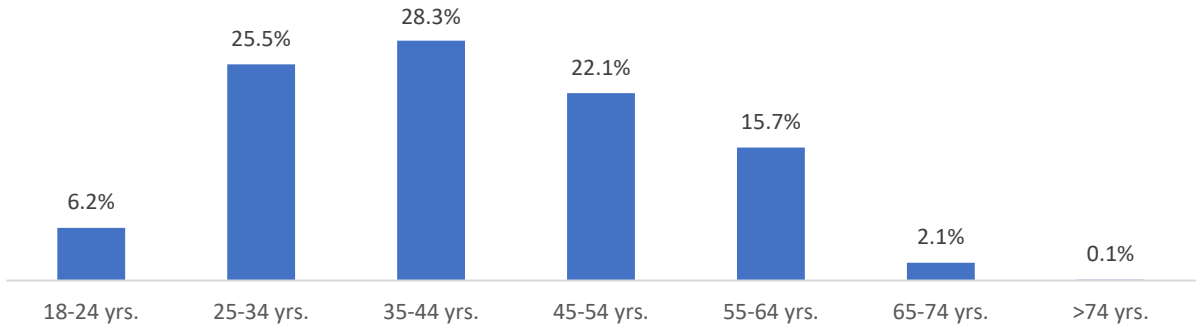


Source: CFBHN Client Data

Figure 84: CFBHN Homeless CSA Clients by Ethnicity

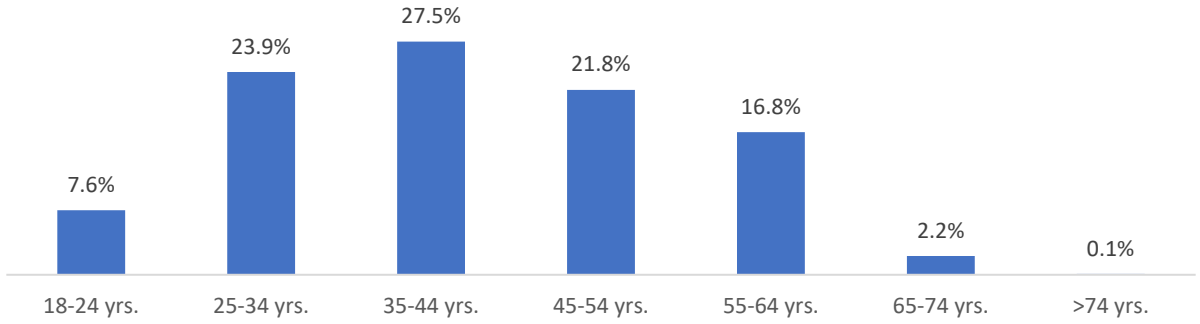
Source: CFBHN Client Data

Figure 85: CFBHN Homeless Clients by Age Range



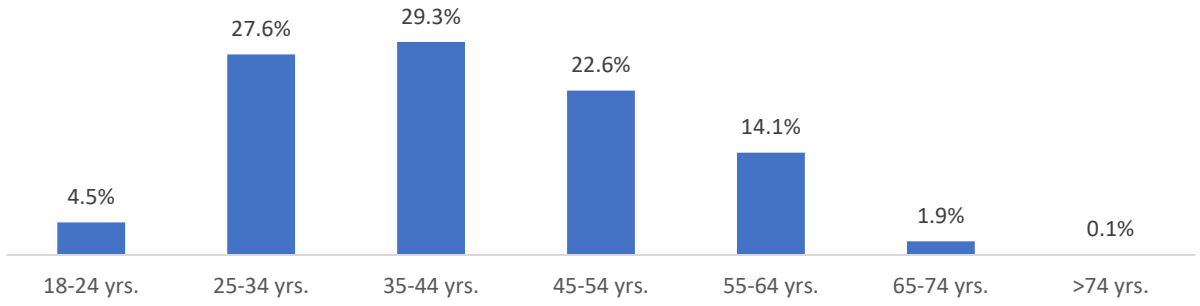
Source: CFBHN Client Data

Figure 86: CFBHN Homeless AMH Clients by Age Range



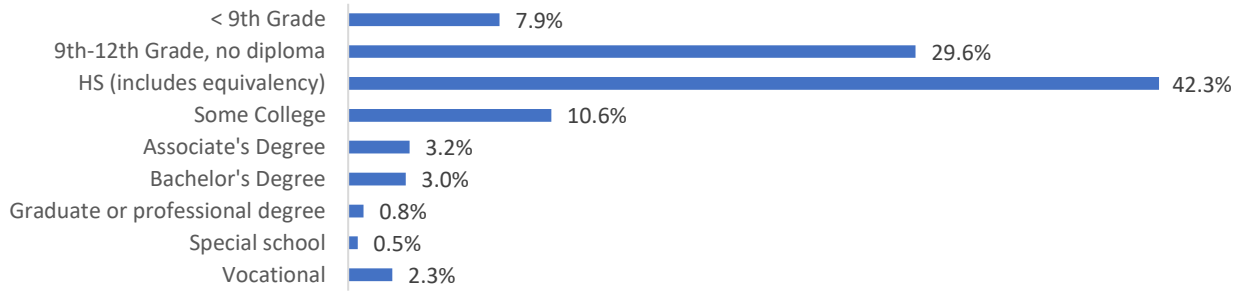
Source: CFBHN Client Data

Figure 87: CFBHN Homeless ASA Clients by Age Range



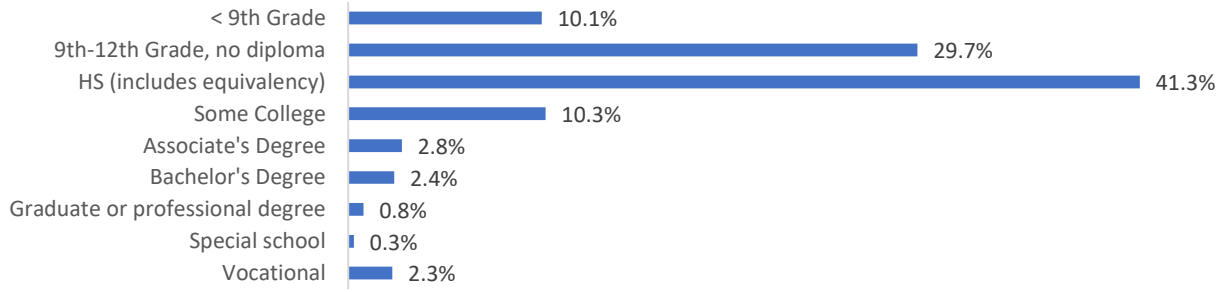
Source: CFBHN Client Data

Figure 88: CFBHN Homeless Clients by Educational Attainment



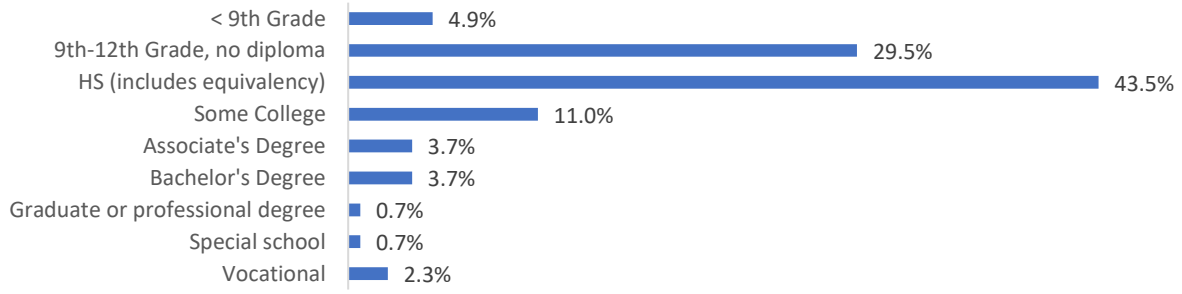
Source: CFBHN Client Data

Figure 89: CFBHN Homeless AMH Clients by Educational Attainment



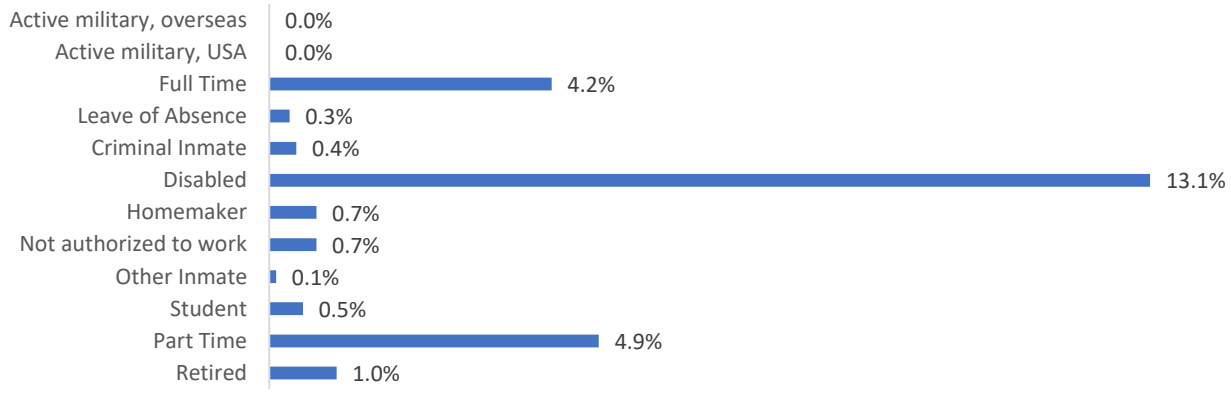
Source: CFBHN Client Data

Figure 90: CFBHN Homeless ASA Clients by Educational Attainment



Source: CFBHN Client Data

Figure 91: CFBHN Homeless Clients by Employment Status



Source: CFBHN Client Data. The following categories are not in the labor force: Criminal Inmate, Disabled, Homemaker, Other Inmate, and student.

COST CENTER DESCRIPTION, EXPENDITURES, AND OVER/UNDER PRODUCTION (FY20-21)

ADULT MENTAL HEALTH PROGRAM

Cost Center Description	Expenditures	Over/Under Production
Assessment	$907,245.77	$10,772.45
Case Management	$7,675,013.65	$589,801.73
Crisis Stabilization	$18,822,679.42	$1,130,592.00
Crisis Support/Emergency	$1,092,909.16	$269,057.11
Day-Night	$549,689.70	$38.78
In-home & On-site	$80,366.82	$26,936.91
Intensive Case Mgmt.	$149,550.58	$13,700.44
Intervention	$1,227,580.97	$153,921.05
Medical Services	$6,972,546.66	$138,528.83
Outpatient-Individual	$3,701,866.76	$83,285.32
Outreach	$65,911.51	$0.00
Residential 1	$2,086,938.20	$38,416.02
Residential 2	$2,768,948.31	$188,620.02
Residential 3	$393,855.00	$120,551.25
Residential 4	$2,369,306.41	$15,452.25
Supported Employment	$266,311.64	$815.68
Supported Housing	$2,670,068.24	$38,584.57
Incidental Expenses	$2,163,044.00	$808,432.53
Outpatient-Group	$203,806.82	$1,257.08
Rm & Bd w/Supervision Level 2	$5,131,982.77	$200,799.35
Short-Term Residential	$1,810,056.11	$0.00
Intervention Group	$3,063.82	$0.00
CCST - Individual	$35,384.70	$2,228.87
CCST - Group	$137.35	$137.35
SARSS - Individual	$2,136.37	$2,136.37
SARSS - Group	$30.72	$30.72
TOTAL	**$61,150,431.46**	**$3,834,096.68**

Source: CFBHN Program Data

ADULT SUBSTANCE ABUSE PROGRAM

Cost Center Description	Expenditures	Over/Under Production
Assessment	$259,675.45	$13,958.26
Case Management	$2,977,481.15	$59,401.77
Crisis Support/Emergency	$54,789.95	$187.07
Day Care (Tx)	$34,760.92	$5.60
Day-Night	$131,719.57	$0.00
In-home & On-site	$889.20	$889.20
Intervention	$2,013,379.91	$11,066.91
Medical Services	$3,539,916.05	$213,821.09
Methadone Maintenance	$4,803,139.56	$5,827.72
Outpatient-Individual	$2,306,409.05	$107,939.94
Outreach	$31,435.40	$20.26
Residential 1	$2,190,748.31	$48.45
Residential 2	$9,277,944.56	$136,475.66
Residential 3	$2,195,454.61	$375,347.20
Residential 4	$358,823.74	$0.00
SA Detox	$5,730,081.07	$130,476.88
Supported Housing	$286,671.61	$716.07
Incidental Expenses	$2,163,772.00	$17,082.83
Aftercare	$13,577.81	$306.45
Outpatient Detox	$6.60	$6.60
Outpatient-Group	$709,228.22	$16,403.06
Rm & Bd w/Supervision, Level 2	$497,106.87	$0.33
Rm & Bd w/Supervision, Level 3	$180,321.99	$2.52
Intervention Group	$135,107.99	$3,205.95
Aftercare Group	$42,944.92	$333.19
SARSS - Individual	$354,630.20	$674.33
SARSS - Group	$188,639.52	$329.42
TOTAL	**$40,478,656.23**	**$1,094,526.76**

Source: CFBHN Program Data

CHILD MENTAL HEATH PROGRAM

Cost Center Description	Expenditures	Over/Under Production
Assessment	$231,508.97	$147,357.50
Case Management	$4,563,225.52	$3,184,109.40
Crisis Stabilization	$547,446.24	$11,863.18
Crisis Support/Emergency	$495,904.02	$135,751.05
In-home & On-site	$543,977.49	$440,260.08
Intervention	$6,970.24	$0.00
Medical Services	$562,564.28	$240,782.98
Outpatient-Individual	$1,030,445.41	$574,704.43
Incidental Expenses	$84,116.00	$29,115.00
Outpatient-Group	$5,664.87	$4,970.34
CCST - Individual	$0.00	$0.00
CCST - Group	$15.15	$15.15
SARSS - Individual	$692.10	$692.10
SARSS - Group	$12.68	$12.68
TOTAL	**$8,072,542.97**	**$4,769,633.89**

Source: CFBHN Program Data

CHILD SUBSTANCE ABUSE PROGRAM

Cost Center Description	Expenditures	Over/Under Production
Assessment	$13,407.04	$707.84
Case Management	$44,034.37	$395.34
Crisis Support/Emergency	$6,941.24	$0.00
In-home & On-site	$9,480.51	$9,480.51
Intervention	$253,853.41	$904.25
Medical Services	$114,070.02	$0.08
Outpatient-Individual	$63,542.32	$2,639.29
Residential 2	$2,131,332.16	$80,174.78
Residential 4	$27,139.36	$4,094.30
SA Detox	$184,478.27	$0.00
TASC	$9,895.21	$6.24
Incidental Expenses	$3,050.00	$0.00
Aftercare	$604.71	$36.28
Outpatient-Group	$6,508.88	$466.34
Intervention Group	$658.66	$27.72
SARSS - Individual	$48.12	$0.00
SARSS - Group	$36.09	$0.00
TOTAL	**$2,869,080.37**	**$98,932.97**

Source: CFBHN Program Data

CFBHN All Cost Centers	Expenditures	Over/Under Production
Grand Total	$112,570,711.03	$9,797,190.30

CULTURAL HEALTH DISPARITY SURVEY SUMMARY

For the 2022 community assessment, a new survey was deployed to better understand the role of health disparities in behavioral health outcomes. Fifty-one (51) participants completed a survey detailing their experiences and attitudes with respect to behavioral health. The survey was offered in English, Spanish and Creole. Two participants completed the survey in Spanish.

Survey participants were asked to indicate their level of comfort in seeking care for their behavioral health needs. Thirty-nine participants (76.5%) selected 'Yes' specifying that they do feel comfortable seeking the care they need. Eleven (21.6%) revealed that they do not feel comfortable, and one participant left the question blank.

On a scale of 1 to 5, where 5 is "strongly agree," participants were asked to rate their trust in the behavioral health system to treat them with respect. All participants answered the question with the majority (31.4%) responding that they "strongly trust" they will be respected. The least elected option was "strongly distrust,'" chosen by two participants (3.9%). Fifteen of the participants (29.4%) remained "neutral," to the question, while 12 (23.5%) indicated that they "trust" the behavioral health system will treat them with respect. The remaining six participants (11.8%), "distrust," the system. The responses indicate that when combined, 55% "trust," rather than "distrust" (15.2%) the behavioral health system to treat them with respect.

The following series of questions asked participants to indicate how they feel about sharing issues they consider to be private. Participants were able to select a range of five choices from "Most how I feel" (1) to "Most unlike how I feel" (5).

The following statements were provided for participants to respond to,

- This is a private issue I keep to myself
- This is a private issue that stays in the family
- I am comfortable sharing my challenges with others (professionals, family members, friends, clergy, etc.)
- I am more comfortable with people like me

Thirty-nine of the 51 (76.5%) participants provided a response to "this is a private issue I keep to myself." "Most how I feel" and "Somewhat unlike how I feel," were each selected by 11 participants (21.5%). Four participants selected "Neutral" and another four selected "Most unlike how I feel," to this question. The remaining nine (17.6%) selected "Somewhat how I feel."

When asked to respond to "This is a private issue that stays in the family," 41 participants responded and 10 selected "Somewhat unlike how I feel," and another 10 chose, "Most unlike how I feel" for a combined total of 39.2%. Eight (15.7%) selected "Neutral" and the remaining 13 (25.4%) selected either "Somewhat how I feel" (nine, 17.6%) or "Most how I feel" (4, 7.8%).

“I am comfortable sharing my challenges with others,” was the next statement posed to participants and 41 provided a response. Fourteen participants (27.5%) indicated as “Most how they feel,” which is more than for any other question or choice. Eleven (21.6%) selected “Neutral”, seven participants (13.7%) selected “Somewhat unlike how I feel”, and four (7.8%) chose “Most unlike how I feel.” The final five participants (9.8%) selected “Somewhat how I feel,” as their response.

A total of 43 participants provided responses to the statement “I am more comfortable with people like me.” Eleven participants indicated “Neutral’ as their selection (21.6%), more than the other choices provided. Eight (15.7%) indicated “Somewhat unlike how I feel,” and five (9.8%) “Most unlike how I feel,” was selected by five participants (9.8%), the lowest choice represented. A combined total of 19 participants (37.2%) selected “Most how I feel’ with nine responses, and 10 chose “Somewhat how I feel.”

Behavioral health treatment is conducted in a variety of settings and the survey asked participants to select where they feel most comfortable discussing their behavioral health concerns. They were instructed to select “all that apply” yielding 91 selections from the 51 participants.

“Private office with doctor,” was selected by 29 participants (31.9%), more than any other option. Twenty-four participants (26.4%) indicated a preference for “Telehealth,” as a close second. “Hybrid of telehealth” was the third most preferred option, selected by 14 (15.4%) participants. Nine participants indicated their preference of “Speaking with a nurse practitioner,” and six (6.6%) preferred a “Faith-based organization.” Another six participants indicated “All of the above,” while the remaining three selected “None of the above.”

The next question asked participants to indicate their preference of faith-based health care services or the traditional physician office. All 51 participants answered the question, where 45 (88.2%) prefer the “traditional physician office” and the remaining six prefer “faith-based health care services.”

Participants were asked to respond to the question “thinking about treatment options, on a scale of 1 to 5, with 5 being “Very likely” and 1 being “Very unlikely”, how comfortable would you be in group therapy? The majority, fifteen (29.4%) of participants selected “Very unlikely.” Responses of “Unlikely” and “Very likely” were each selected by nine (17.6%) participants. Eleven (21.6%) expressed their feelings as “Neutral” regarding group therapy and the final seven (13.7%) were “Likely” to be comfortable with group therapy.

The question regarding how comfortable they would you be in individual therapy was asked of participants. Again, they were provided with a range from one to five, where five is “Very likely” and one is “Very unlikely.” Most participants indicated they were “Likely” (20, 39.2%), or “Very Likely” (22, 43.1%) to be comfortable with induvial therapy, combined total of 42 or (82.3%). “Very unlikely” and “Unlikely” were each selected by one participant each for a combined 4% of the 51 participants. Seven participants indicated a “Neutral” response regarding their comfort with individual therapy.

Survey participants were asked if behavioral health care services they have received in the past were available in their primary language. Forty-nine (96.1%) stated they were able to receive services in their primary language. The other 2 participants (3.9%) indicated services were never available in their primary language and they needed a translator.

Participants were asked to answer several questions regarding their demographics. Thirty-four (66.7%) of the participants selected female, 16 (31.4%) chose male, and one indicated a preference to not answer.

Five participants did not select any gender identity when asked, and 20 (39.2%) indicated a preference to not answer the question. Cisgender was selected by 19 (37.3%) participants, followed by six (11.8%) that identified as Gender fluid. The final participant selected Agender as their preferred gender identity.

Sexual orientation was asked of survey participants where four did not provide a response and two indicated their preference was not to respond. Thirty-six (76.6%) indicated a sexual orientation of Heterosexual/Straight. One participant indicated their sexual orientation is Asexual, and no one selected Gay/Lesbian, or my sexual orientation is not listed here. Pansexual and Bisexual were each selected by three (6.4%) of the participants. Two participants selected Questioning, as their sexual orientation.

Most participants indicated White as their race (40, 80%), and four (8%) selected Black. American Indian, Asian, Multi-Racial, and Other were each selected by one participant, for a total of four participants totaling 8% of the sample. Two participants preferred not to answer the question, and one did not respond.

Participants were asked to select their ethnicity from a list provided. Forty-three (84.3%) responded “none of the above.” Three participants indicated their ethnicity is Spanish/Latino, the second most represented ethnic group. Cuban, Mexican, Mexican American, Puerto Rican, and Other Hispanic, we each selected by one participant for a total of 10%.

Age was the final question posed to participants. Most participants (34, 66.7%) selected ages between 25-54 years old. One participant selected the youngest age group of 15-19 years old, and two (3.9%) were 20-24 years old. The 55–64-year-old group included eight (15.7 participants), and there were four participants (7.8%) from age 65-74. Only one participant indicated they were older than 74 years of age and another preferred not to answer the question.

CULTURAL HEALTH DISPARITY SURVEY CHARTS

Figure 92: Are you usually comfortable seeking behavioral health services?

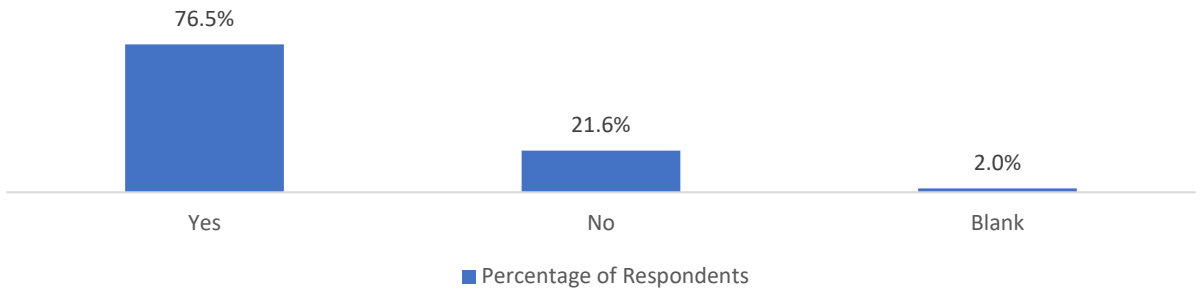


Figure 93: On a scale of 1 to 5, with 5 being 'strongly agree', how would you rate your trust in the behavioral health care system to treat you with respect?

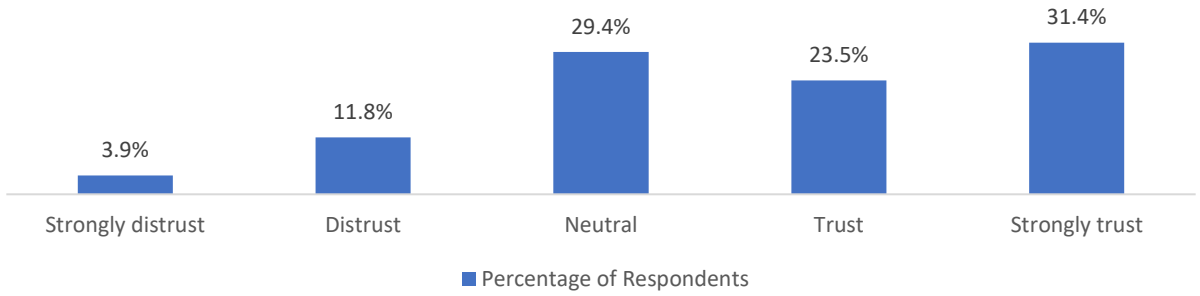


Figure 94: Please rank statement that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. "This is a private issue I keep to myself."

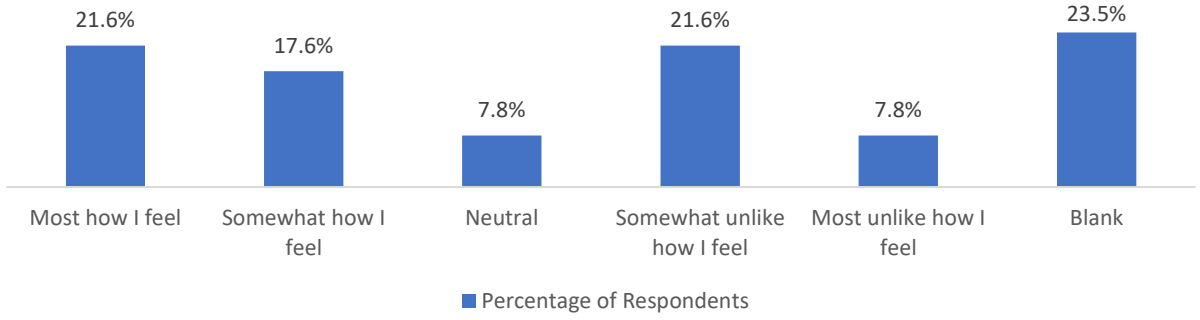


Figure 95: Please rank the statement that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. "This is a private issue that stays in the family."

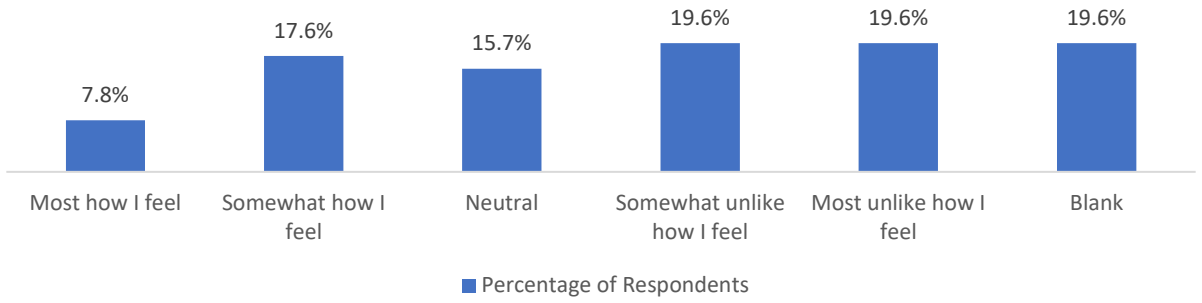


Figure 96: Please rank the statement that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. "I am comfortable sharing my challenges with others."

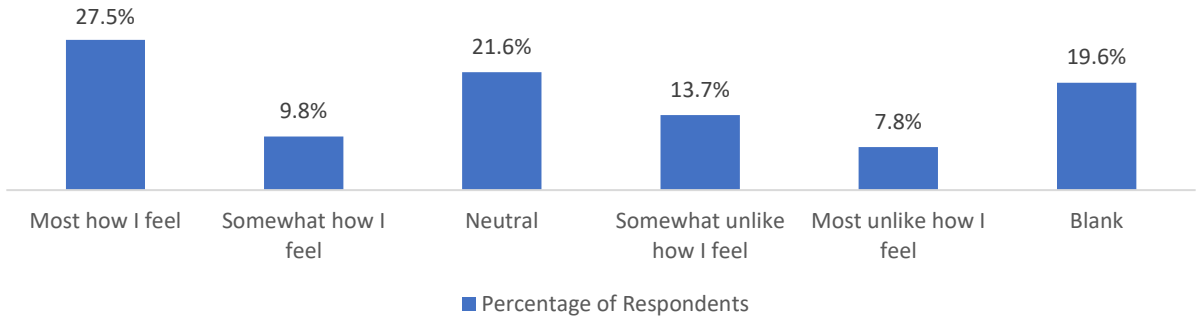


Figure 97: Please rank the statement that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. "I am more comfortable with people like me."

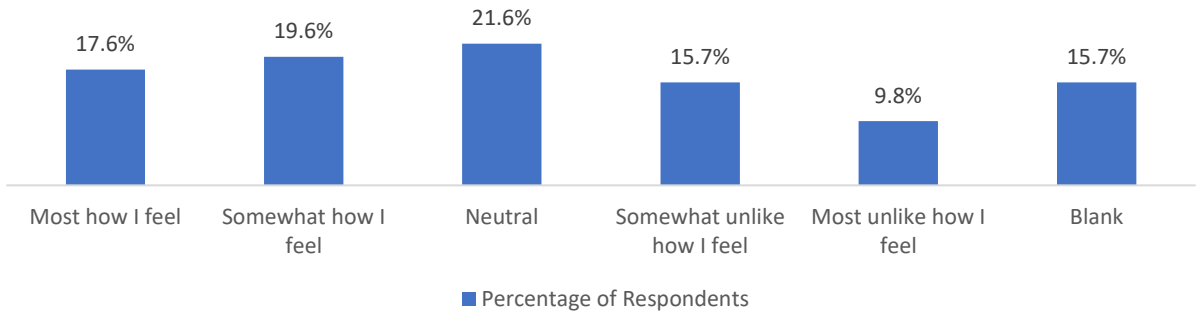


Figure 98: In which setting(s) have you been most comfortable discussing your behavioral health concerns? (Check all that apply)

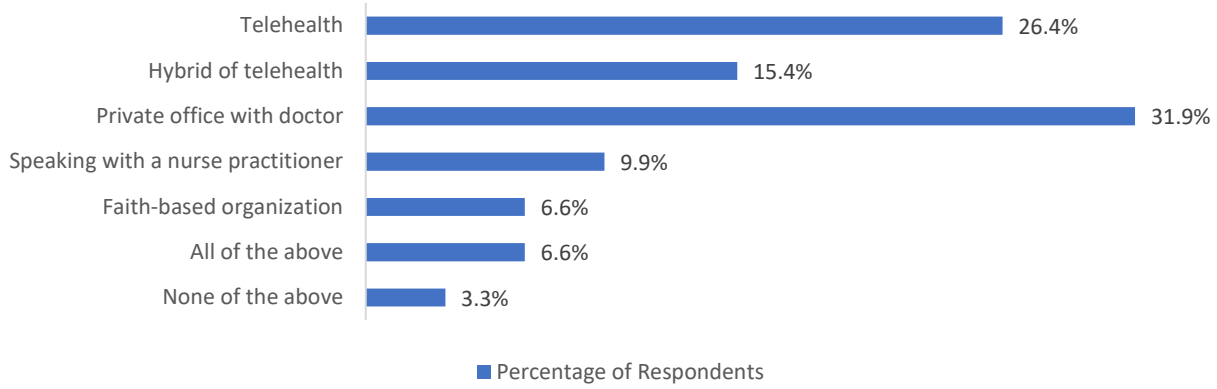


Figure 99: If given a choice for receiving behavioral health care services, would you be more comfortable going to a faith-based organization OR prefer the traditional physician office?

Figure 100: Now thinking about treatment options, on a scale of 1 to 5, with 5 being 'very likely,' how comfortable would you be in group therapy?

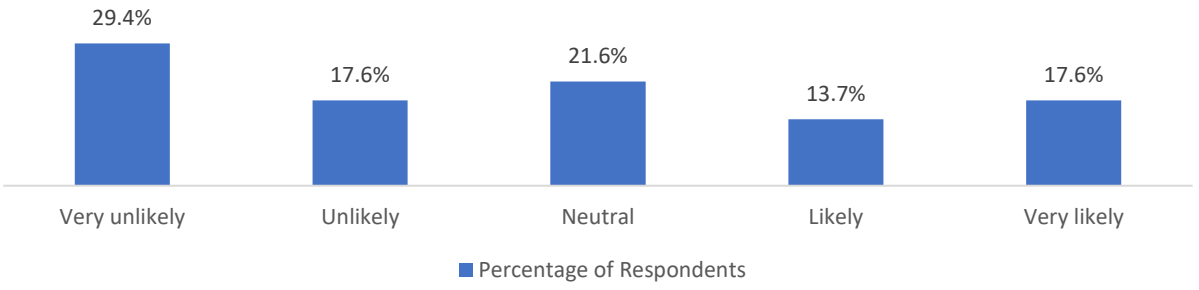


Figure 101: On a scale of 1 to 5, with 5 being 'very likely,' how comfortable would you be in individual therapy?

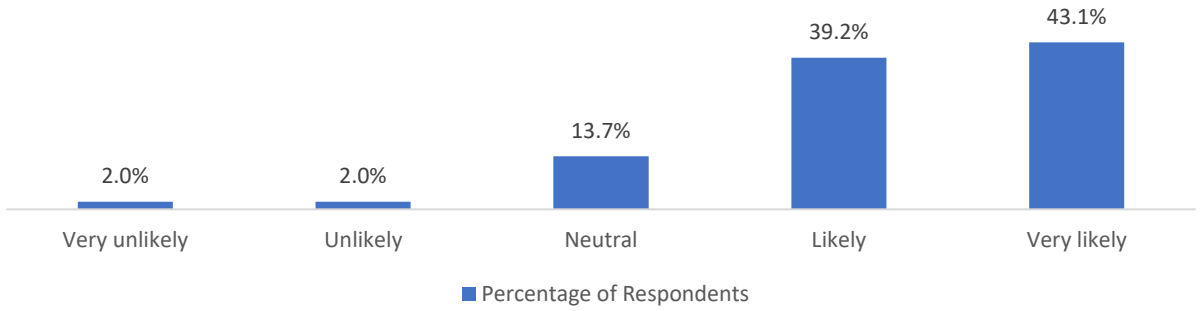


Figure 102: When you have received behavioral health care services in the past, were they mostly available in your primary language?

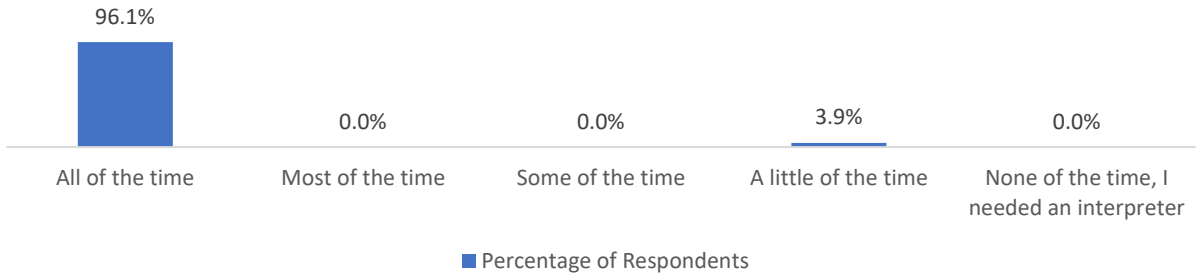


Figure 103: Which best describes your gender?

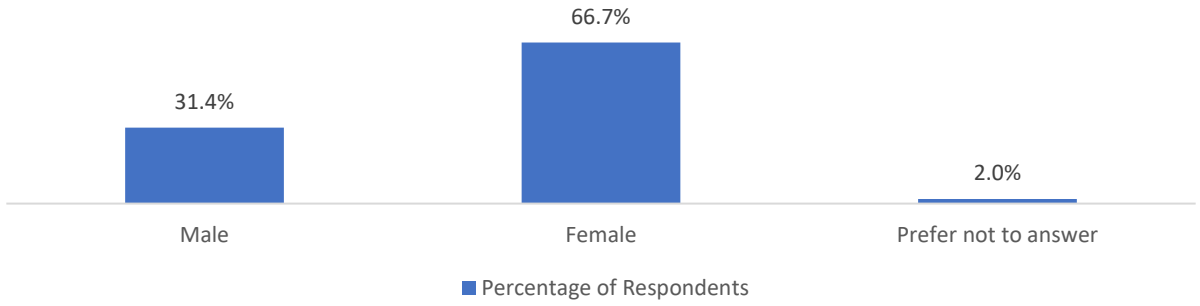


Figure 104: Which best describes your gender identity?

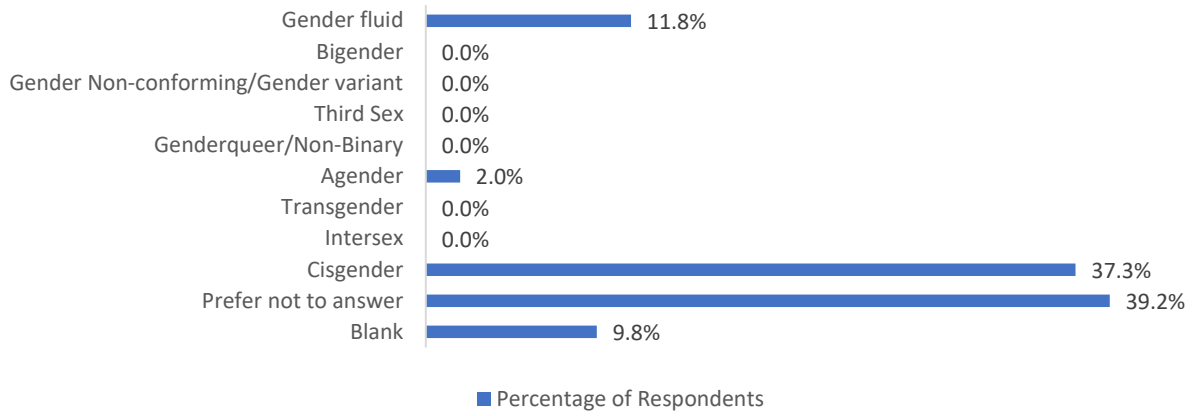


Figure 105: Which best describes your current sexual orientation? (Check all that apply)

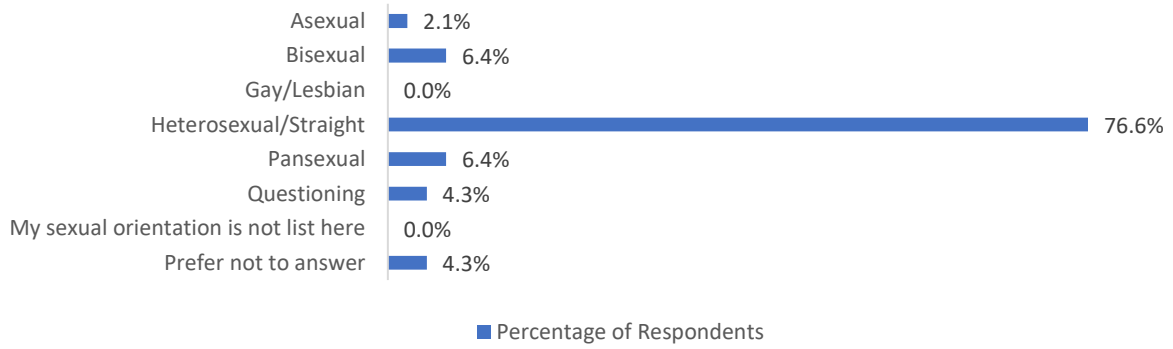


Figure 106: Which best describes your race?

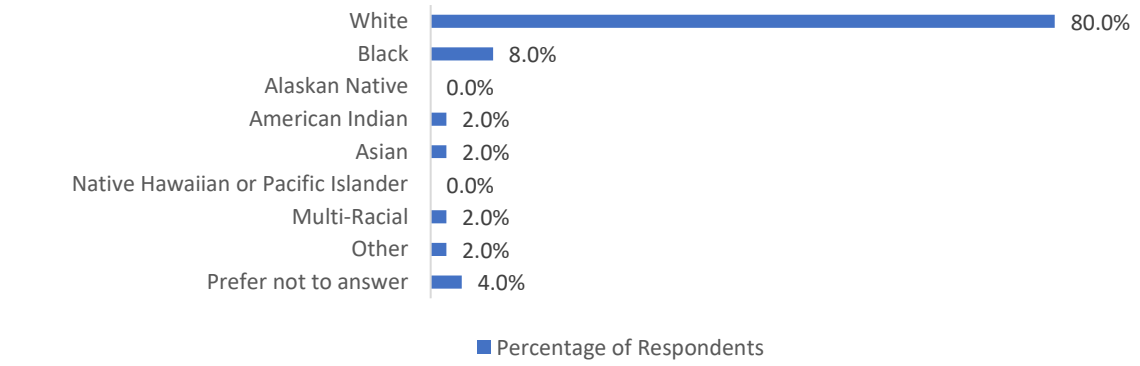


Figure 107: Which best describes your ethnicity?

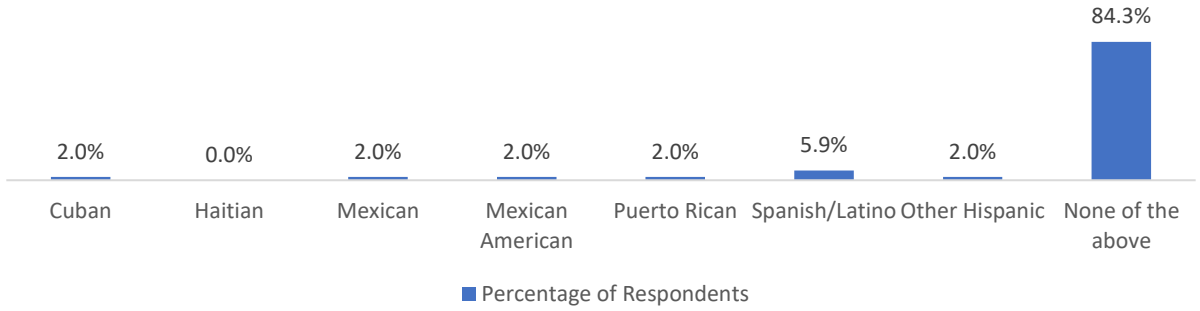
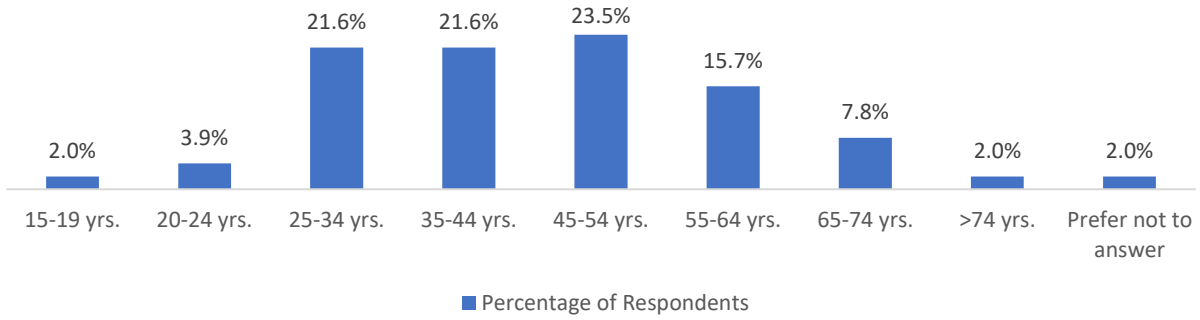


Figure 108: Please select your age range from the list below.



CULTURAL HEALTH DISPARITY SURVEY BY RACE AND ETHNICITY

The cultural health disparity survey was analyzed by race and ethnicity to further measure experience, awareness, and coordination of behavioral health services. This will help to facilitate focused strategic development and intervention implementation over the next three years.

Respondents were asked if they were comfortable seeking behavioral health care services. Among Black respondents, 50% were comfortable while 50% were not. Among Hispanic and White respondents, the percentages of those comfortable seeking care were higher at 72.5% and 82.1%, respectively.

When asked if they trust the health care system to treat them with respect, 75% of Black respondents trust (25%) or strongly trust (50%) to be treated with respect. The remaining 25% were neutral. These percentages were higher when compared to other demographic groups. Among Hispanic respondents, 33.3% distrust the behavioral health care system to treat them with respect, 33.3% were neutral, and the remaining 33.3% did trust or strongly trust to be treated with respect. More than half (57.5%) of White respondents trust (27.5%) or strongly trust (30%) that the health care system would treat them with respect. White respondents who were neutral accounted for 32.1%.

Respondents were asked to describe their feelings regarding their behavioral health issues. When asked, is this was a private issue I keep to myself, most Black (66.7%) and Hispanic (71.4%) respondents indicated that this is most how they feel. One-third of Black respondents indicated this is somewhat unlike how they feel. Among Hispanic respondents, 28.6% indicated this is most unlike how they feel. White respondents were split on behavioral health issues being a private matter I keep to myself as 20% indicated this was most how I feel, 26.7% said this is somewhat how I feel, and 33.3% indicated this is somewhat unlike how I feel.

Regarding their behavioral health issues as a private matter that stays in the family, 50% of Black and Hispanic respondents indicated this was somewhat how I feel. The remaining 50% of Black respondents indicated this is most unlike how I feel. Among Hispanic respondents, 37.5% indicated this is somewhat unlike how I feel while 12.5% said this is most unlike how I feel. White respondents were split on responses to this question as 12.1% indicated this was most how they feel, 18.2% said this is somewhat how I feel, 24.2% were neutral, 21.2% indicated this is somewhat unlike how I feel, and 24.2% said it was most unlike how I feel.

Regarding comfort sharing their challenges with others, 100% of Black respondents were neutral. Among Hispanic respondents, 66.6% indicated this is somewhat unlike or most unlike how I feel. Among White respondents, 35.3% indicated this is most how they feel, 23.5% were neutral, and 20.6% said this is somewhat unlike how I feel.

When asked if they were more comfortable with people like them, 66.6% of Black respondents indicated this is somewhat unlike how I feel or most unlike how I feel. Fifty percent of Hispanic

respondents were neutral, and 25% indicated this is somewhat unlike how I feel. Among White respondents, 31.4% were neutral, 25.7% indicated this is somewhat how I feel, and 17.1% said this is most how I feel.

The most comfortable setting for discussing their behavioral health issues for Black respondents was in a private office with a physician at 28.6%. Telehealth, a hybrid of telehealth, speaking with a nurse practitioner, and faith-based organization each accounted for 14.3% of Black respondents. Among Hispanic respondents, 21.4% preferred a hybrid or telehealth, 21.4% said a private office with a doctor, and 14.3% preferred a faith-based organization. White respondents preferred a private office with a doctor at 34.8%. Telehealth, at 29%, was preferred over a hybrid of telehealth at 15.9%. Only 4.3% of White respondents selected a faith-based organization for receiving behavioral health services.

When asked to choose between faith-based or the traditional physician office, results were different from the results in the preceding question for Hispanic respondents as 55.6% indicated their preference for a faith-based organization. Most Black (75%) and White (87.5%) respondents indicated they would be more comfortable in a private office with a physician.

Among Black respondents, 50% were very likely to be comfortable in group therapy. The remaining 50% were either very unlikely or unlikely to be comfortable in group therapy. For Hispanic respondents, 44.4% were neutral and 44.4% were very likely to be comfortable in group therapy. White respondents were split as 27.5% were very unlikely to be comfortable in group therapy, 20% were unlikely, 20% were neutral, 15% were likely, and 17.5% were very likely to be comfortable in group therapy. When asked about their comfort in individual therapy, 100% of Black and 90% of White respondents were likely or very likely to be comfortable. Among Hispanic respondents, 44.4% were neutral and 55.6% were likely or very likely to be comfortable in individual therapy.

When asked if the behavioral health services they received in the past were mostly available in their primary language, 75% of Black respondents, 77.8% of Hispanic respondents, and 100% of White respondents received services in their primary language all of the time. Those who received services in the primary language only a little of the time accounted for 25% of Black and 11.1% of Hispanic respondents. No respondents needed an interpreter.

CULTURAL HEALTH DISPARITY SURVEY BY RACE AND ETHNICITY CHARTS

Figure 109: Are you usually comfortable seeking behavioral health care services?

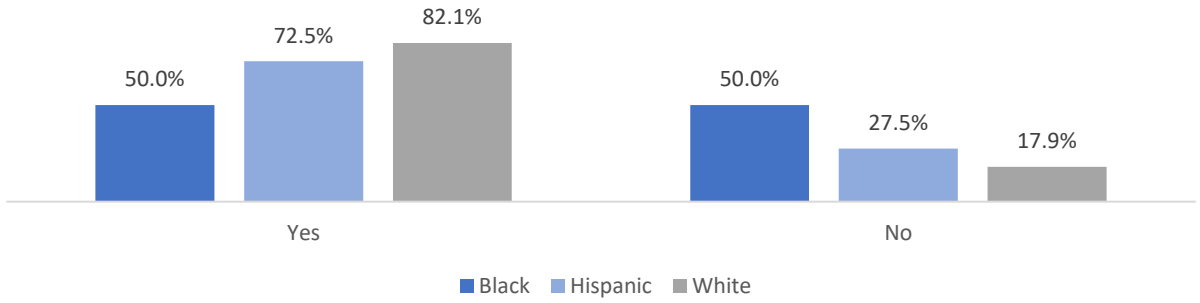


Figure 110: On a scale of 1 to 5, with 5 being 'strongly agree', how would you rate your trust in the behavioral health care system to treat you with respect?

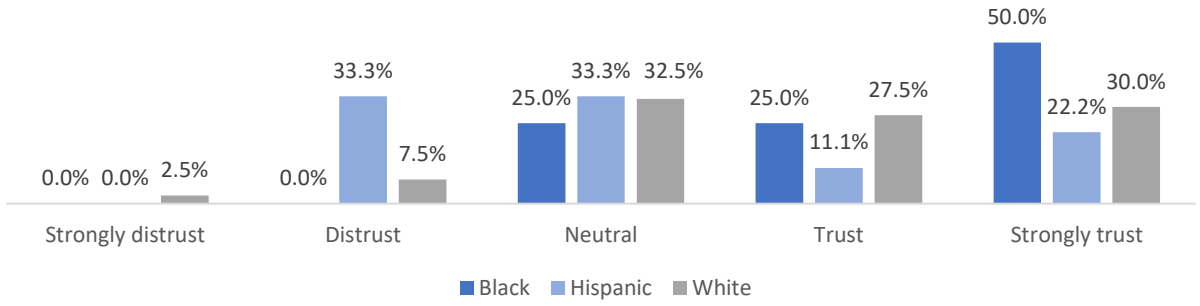


Figure 111: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. This is a private issue I keep to myself.

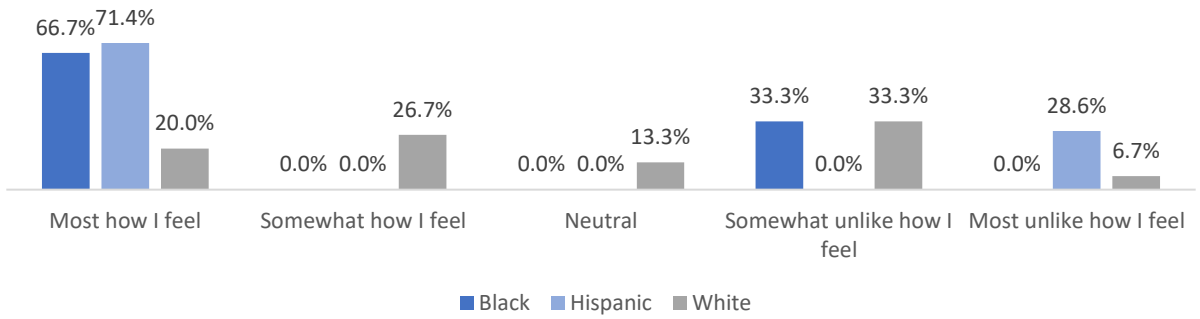


Figure 112: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the most and (5) being the least. This is a private issue that stays in the family.

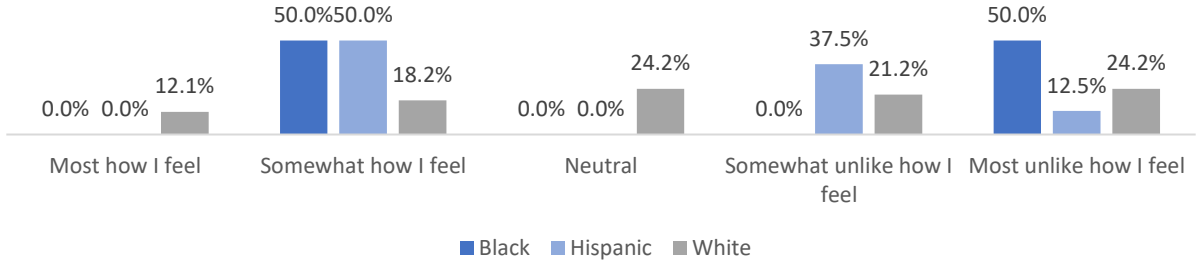


Figure 113: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. I am comfortable sharing my challenges with others.

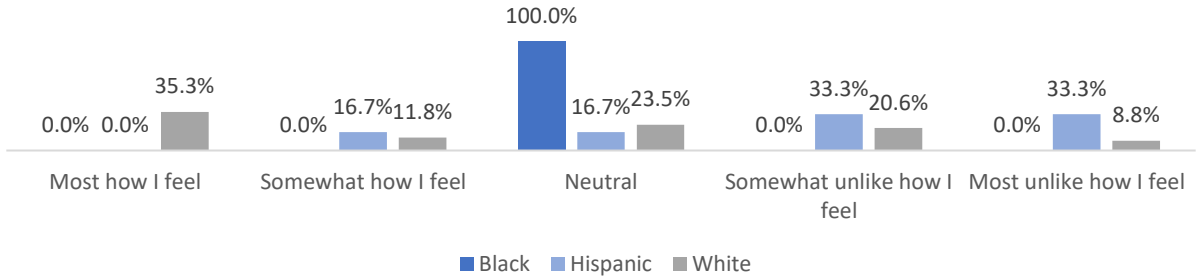


Figure 114: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. I am more comfortable with people like me.

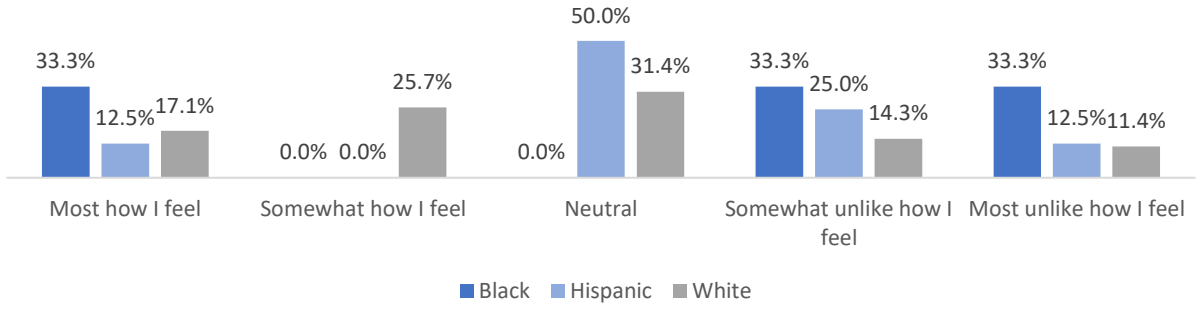


Figure 115: In which setting(s) have you been most comfortable discussing your behavioral health concerns? (Check all that apply)

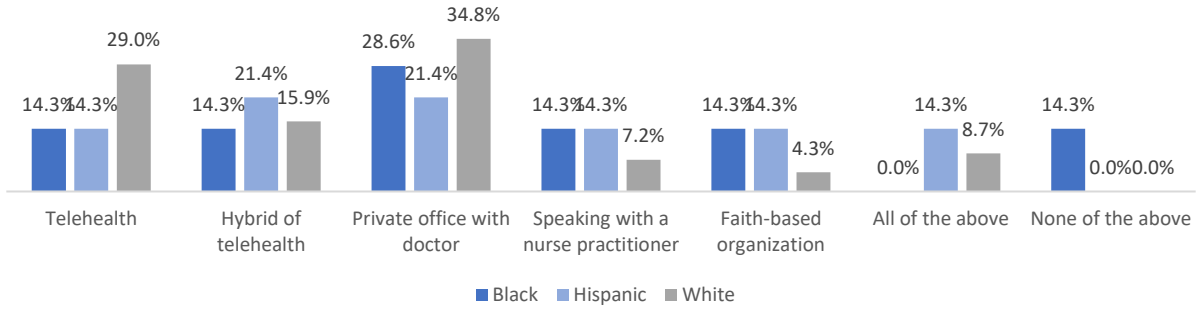


Figure 116: If given a choice for receiving behavioral health care services, would you be more comfortable going to a faith-based organization OR prefer the traditional physician office?

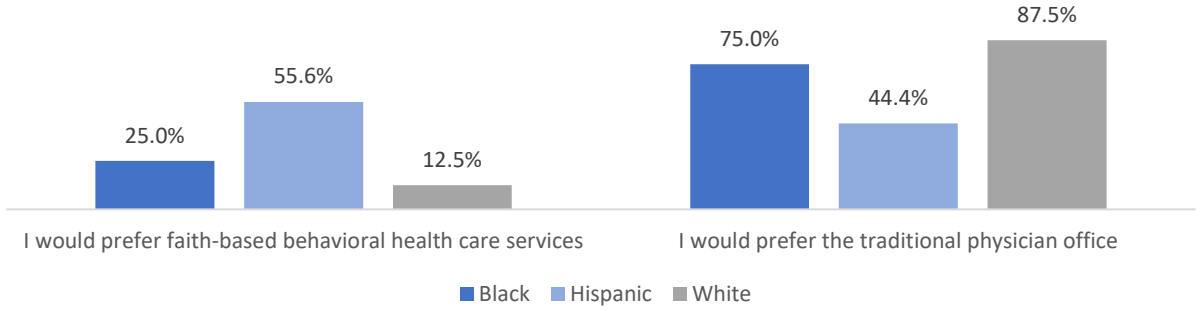


Figure 117: Now thinking about treatment options, on a scale of 1 to 5, with 5 being very likely, how comfortable would you be in group therapy?

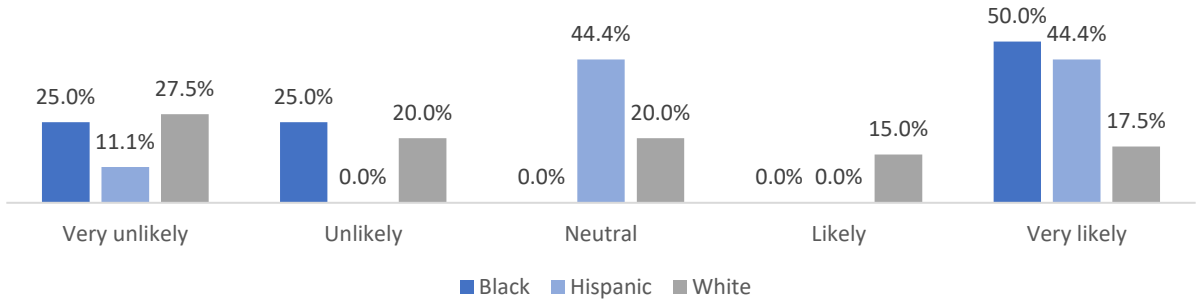


Figure 118: On a scale of 1 to 5, with 5 being very likely, how comfortable would you be in individual therapy?

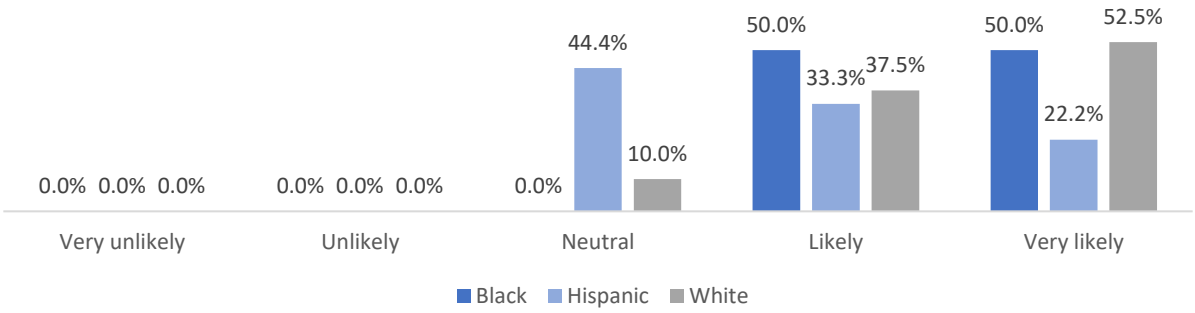
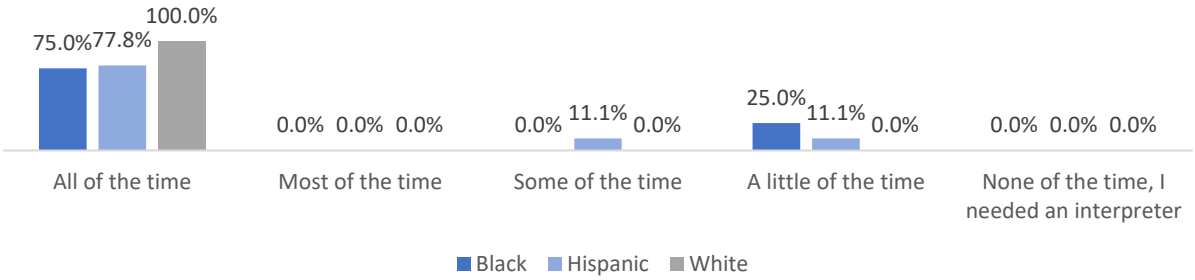


Figure 119: When you have received behavioral health care services in the past, were they mostly available in your primary language?



CULTURAL HEALTH DISPARITY FOCUS GROUP SUMMARY

Focus groups were held with individuals that receive or have experiences with the behavioral health network across the region. Two focus groups were held virtually and one in-person resulting in a total of 22 participants.

GENERALLY, HOW COMFORTABLE ARE YOU TALKING ABOUT BEHAVIORAL HEALTH?

Community members were primarily comfortable talking about behavioral health and mental illness in all settings and with whomever will engage in conversation. Discomfort discussing their own behavioral health occurred in the workplace, expressing professional settings are "more restrictive", and not always the appropriate place despite the fact that mental illness affects their work capacity. The stigma associated with behavioral health makes conversations with family and others difficult. Sometimes individuals felt the need to apologize when talking about mental health too much.

WHO DO YOU USUALLY GO TO WHEN YOU NEED SUPPORT?

Participants identified support systems consisting of spouses, family members, and friends as people they rely on. Peer support specialists and peers in support groups they attend through National Alliance on Mental Illness (NAMI) and Club Success were described as second families with similar experiences. Participants also listed professionals such as therapist, counselors, and resource centers with in-person and virtual wellness tools.

ARE YOU USUALLY COMFORTABLE SEEKING AND RECEIVING BEHAVIORAL HEALTH SERVICES?

Being comfortable seeking and receiving behavioral health services related to familiarity with the system. In the early stages of seeking treatment participants experienced long waitlists during times of crisis. As community members became more aware of the resources available and individuals within the behavioral health system their comfort increased. Participants noted that it takes time and persistence to find the right providers and resources. The process of finding providers is daunting and tedious especially when looking for providers that have experience with youth and populations of color.

HOW DO YOU LIKE TO RECEIVE BEHAVIORAL HEALTH CARE SERVICES?

In-person individual and group services were the overwhelming preference for community members. Solo in-person services feel more secure and help create a connection with the provider. Virtual services fill the gap and most participants have attended sessions but expressed issues with privacy, building trust with their provider, and providers not attending the

appointment. Virtual services are beneficial for the flexibility of scheduling, access to services for those without transportation, or the ability to leave the home.

WHAT ARE SOME BARRIERS THAT MAKE IT MORE CHALLENGING TO RECEIVE BEHAVIORAL HEALTH SERVICES?

Barriers to care include but are not limited to long waitlists, transportation, shortage of providers, stigma, and lack of awareness. The shortage and turnover of staff within agencies has resulted in extended waits to receive services. Participants reported negative encounters with staff that are inexperienced and uneducated on how to assist people with mental illness, listing stigma, and lack of awareness of resources as examples. Transportation to receive services is limited but some organizations provide transportation or bus passes for community members. Payment of services is a barrier for those who are uninsured or have private insurance. Difficulty getting time off from work, the high cost of appointments, and medication have resulted in delays of treatment. While virtual services reduced some barriers, access to an internet enabled device and knowledge of technology use have become an additional barrier.

ADDITIONAL COMMENTS

Community members shared a need for better integration of mental health and clinical services to improve the continuity of care. Increased care coordination of social services to help with transitional support and navigating clients through the system is of high need. Cost and coverage of behavioral health services are dependent on insurance with Medicaid providing the most assistance. There is limited availability and access to services through private insurance plans. Continuing to bring awareness of behavioral health services and mental illness through education for community members, behavioral health staff, and community groups would help decrease stigma and make more people comfortable with behavioral health.

NO WRONG DOOR SURVEY AND FOCUS GROUP SUMMARY

CFBHN PROVIDER INTERVIEWS

Provider interviews were held with various behavioral health providers across the region to gather additional feedback regarding the No Wrong Door (NWD) process and entry into care. Six focus group provider interviews were held virtually from February through March 2022 resulting in approximately 50 participants. Prior to the provider interviews participants were asked to complete the NWD survey. For the survey and throughout the interviews NWD was defined as "a model for the delivery of acute care services to persons who have mental health or substance use disorders, or both, which optimizes access to care, regardless of the entry point to the behavioral health care system". The results of the NWD survey were used to guide each of the six group provider interviews. Depending on the survey results not all questions from the interview guide may have been used during that specific group interview.

NO WRONG DOOR SURVEY SUMMARY

When asked where they work, the respondents gave the following top three responses: adult outpatient program (28%), children's outpatient program (16%), and adult residential facility (14%). Over 90% of respondents said that their agency has a role to play in the NWD access with a little over 60% stating that it works well within their agency. Eighty-three percent of the survey takers either strongly agreed or agreed that their organization has taken action to improve the referral and care coordination for individuals served. Of those that either strongly agreed or agreed (87%) believed that linkages to crisis intervention and support are occurring. When asked if they believed that their organization promotes awareness of available options and linkages to needed services, 90% strongly agreed or agreed. A little over 40% of respondents either disagreed or strongly disagreed that it's easy for individuals to access the services they need quickly and efficiently. Over 90% strongly agreed or agreed that their organization ensures that services are of high quality and meet the needs of individuals served.

WHAT DOES THE TERM "NO WRONG DOOR ACCESS" MEAN TO YOU?

Providers had multiple definitions to what NWD Access means. One definition was that wherever a family or client enters, there would be a warm handoff to whatever services they are seeking. Another definition provided was that for a patient or individual that is wanting or seeking assistance, there is no wrong place to receive and seek services regardless of the access point (emergency room, central intake, or detox services). This should also be done regionally, regardless of the person's county of residence. For providers, this coordinated entry is the goal for any person that is looking to access services. Not all systems talk to each other so some people seeking services do fall through the cracks. In "behavioral health there are so many different access

points and even then, an individual in the community may not be aware of all the resources available."

DO YOU THINK THE "NO WRONG DOOR" ACCESS WORKS WELL WITHIN YOUR ORGANIZATION?

How well the NWD access works varies. There is successful access when the resources in the community are available such as the availability of nurses and beds. Also, it varies by facility type and how the person enters the system. When a person is seeking services there tends to be a long wait time. After an individual is assessed their "stories" do not necessarily follow them when being transferred to different agencies. Some providers do not utilize a health information exchange while some others do.

WHAT ARE SOME THINGS THAT YOU THINK WORK WELL?

The formation of relationships with individuals from various agencies in the area are beneficial. These relationships are useful when connecting clients to services that may not be available at the initial facility the person entered. Having a point person at an agency that is familiar with various available programs also helps. The crisis mobilization teams work well when inpatient is at capacity.

WHAT ARE SOME OPPORTUNITIES FOR IMPROVEMENT?

A shortage in workforce and thus not enough capacity was a common theme across all six focus group provider interviews. Creating a community information system for all agencies to access is an opportunity for improvement. For example, this system could include where this person has received services and what services they have received. When having to refer outside of an agency there is an issue with care coordination and people falling through the cracks when referrals are made. Operationalizing technology to expediate moving people through the system and getting them where they need to be. There is a need for an increase in services to get patients to services in a timely manner.

IN WHAT SPECIFIC WAYS CAN YOUR AGENCY IMPROVE ON THE REFERRAL AND CARE COORDINATION PROCESS FOR INDIVIDUALS SERVED?

Creating a unified platform or using one that is already in existence and having all agencies/facilities updating it. Having more agencies getting onboard to using a unified platform will increase the succession of care coordination. The addition of more Florida Assertive Community Treatment (FACT) teams would be an improvement. One of the largest barriers to care coordination is the funding source, so having an unrestricted funding source can help to reduce this barrier. Current restrictive funding can only pay for certain services limiting access. Increase in community outreach so community members and other agencies in the area can learn about

what an agency offers would be an improvement. An increase in staff and funding for staff are needed to improve on the referral and care coordination process for individuals served.

HAVE YOU OR YOUR AGENCY IDENTIFIED ANY BARRIERS OR OBSTACLES TO BECOMING A PART OF THE NO WRONG DOOR SYSTEM?

Currently, there is a lack of fiscal and staff resources. Not being able to pay a competitive salary to attract the right people is a large barrier. More people are asking for help than ever before, but there are less staff available. Staff shortages affect the safety of workers and clients at various times of the day, especially at night.

IN YOUR OPINION, YOUR ORGANIZATION PROMOTES ITS SERVICES AND RESOURCES VERY WELL. CAN YOU GIVE EXAMPLES OF THIS?

A YouTube channel was created to offer a way for people to participate in a certain program if they could not physically come to the center. Conducting fundraisers and outreach events for promotion. The COVID-19 pandemic paused a lot of outreach activities to the community.

HOW DOES YOUR AGENCY PROMOTE AWARENESS OF AVAILABLE OPTIONS AND POSSIBLE LINKAGES TO NEEDED SERVICES?

Advisory committee meetings are helpful to promote awareness of available options. Use billboards with co-branding of services to promote linkages to care.

WHAT ELSE COULD BE DONE TO INCREASE THE LEVEL OF AWARENESS OF BEHAVIORAL HEALTH SERVICES IN THE COMMUNITY?

Some suggestions to increase awareness of behavioral health services in the community include social-media campaigns, tabling events, stuff intake envelopes with different providers information, have a walk (like a 3K/5K), and physically handing out pamphlets at local provider offices. People who work in the behavioral health field know about the resources, but that knowledge doesn't transfer to community members. There is an issue with funding as a large portion of funds that an agency receives cannot be used for marketing. Ensuring that all marketing materials can be translated and are culturally appropriate since there are a variety of different cultures and languages being spoken in the region. A consistent message that was shared among the six focus group provider interviews were the worry of promoting services when agencies would not be able to fulfill the needs of everyone due to staff shortages.

IN YOUR OPINION, YOUR ORGANIZATION PROVIDES PERSON-CENTERED CARE FOR ALL INDIVIDUALS SERVED.

DESCRIBE HOW YOUR AGENCY IMPLEMENTS PERSON-CENTERED CARE.

Entities strive to provide person-centered care, but this can be hindered due to funding issues (using multiple streams of funding for one client). Care is not dictated; choices are offered to patients. Agencies must meet the individuals where they are at in their journey. There are very few restrictions for telehealth as to who can or cannot receive telehealth services, which helps with person-centered care.

WHAT RESOURCES OR SUPPORTS WOULD YOUR AGENCY NEED TO IMPROVE PERSON-CENTERED CARE?

A change in the Baker Act criteria can be helpful to remove barriers created by the act. Continue to provide education to staff and community members to help with removing stigma. Investing in trauma informed care would be beneficial.

IN YOUR OPINION YOUR AGENCY HIRES EMPLOYEES WHO ARE CULTURALLY SENSITIVE AND CULTURALLY COMPETENT FOR THE POPULATION SERVED.

IF NOT, ARE YOU AWARE OF YOUR AGENCY DOING ANYTHING TO IMPROVE IN THIS AREA?

There are employees who are culturally sensitive but there remains a need to address cultural competency. Some agencies have open discussions about cultural competency and how to aid patients from different backgrounds, which is vital to providing person-centered care. Over the past couple of years some agencies were working to hire a diverse staff, but this has become difficult due to shortages, and lack of salary funding. A few agencies have implemented diversity, equity, and inclusion (DEI) training. Another agency has made cultural competency training mandatory for senior management. There are several agencies that have these trainings but it's not a requirement for staff to participate.

IS THERE ANYTHING YOUR AGENCY COULD DO TO IMPROVE?

Having better access to translators and/or translation services could improve outcomes for patients served. There is a need for more cultural sensitivity training. This type of training should be implemented as a part of the new hiring process. Usually, once people begin their work, they are too busy to take time off to attend training, or they are not paid for their time to attend training outside of normal work hours/days.

IN YOUR OPINION, IT'S EASY FOR INDIVIDUALS TO ACCESS THE SERVICES THEY NEED QUICKLY AND EFFICIENTLY.

IF YES, WHAT WORKS WELL ABOUT THE CURRENT PROCESS WITH INDIVIDUALS FOR ACCESSING SERVICES?

Many agencies have created walk-in access which gives individuals an easy access point to start receiving services. The addition of telehealth services is another great option for patients to access

services. Telehealth has made it easier for those with individuals that don't have reliable transportation to continue accessing services.

IF NO, WHAT ARE THE MAJOR BARRIERS THAT KEEP INDIVIDUALS FROM ACCESSING THE SERVICES THAT THEY NEED?

Stigma is still a huge barrier for patients to access services they need. Even if someone has insurance, they are still experiencing some issues accessing services, including certain places not taking the insurance, and the overall cost. Staffing challenges and paying for staff was a barrier that was consistently brought up through all the focus group interviews. Without sufficient staff there are long waitlists for individuals to gain access to services. Cultural and language barriers are also a consistent issue. There is a need for more bilingual staff/providers. Also, people want access to a provider that looks like them and knows their culture. Transportation to services continues to be a large barrier for individuals to access services, especially if they are in a rural area. Some services are only offered during normal business hours as people who work during the day cannot access most services due to work schedules. Parents and clients do not always know where to go, how to pay for services, and which services they have access to.

DO YOU THINK A STANDARD INTAKE AND SCREENING PROCESS FOR STATE AGENCIES AND COMMUNITY PARTNERS WOULD HELP INDIVIDUALS GET INTO SERVICES MORE QUICKLY?

Among all focus group provider interviews the consensus was that a standard system could help but there are some reservations. It is understood that a system would take a lot of manpower to keep it updated and that sufficient training would be required. A central hub so the different systems could "talk to each other". Having a standard intake and screening process could benefit clients in multiple ways. For example, a client wouldn't have to tell their story over and over during the process, and they could reach out and make new connections.

WHAT DO YOU THINK WOULD NEED TO BE ACCOMPLISHED TO IMPLEMENT A STANDARD INTAKE AND SCREENING PROCESS FOR THE REGION/STATE/SYSTEM?

There is a lack of knowledge of HIPAA. It can be interpreted differently by various departments, agencies, and facilities. There would need to be an agreement on which tools would be used across all systems. A barrier to having a standard intake and screening process is the various funding sources agencies have as the data reporting requirements can vary greatly.

IN YOUR OPINION, YOUR ORGANIZATION ENCOURAGES (PROMOTES) WORKING WITH OTHER COMMUNITY PARTNERS TO ENSURE CARE COORDINATION.

WHICH PARTNERS DO YOU WORK WITH MOST? WHAT WORKS WELL IN THESE PARTNERSHIPS?

There are partnerships between agencies but having personal relationships with staff at other agencies works best. The community is about using social capital to get clients where they need to be, but this is not sustainable. Virtual meetings are primarily used to share information but could be used to help problem solve issues that agencies are facing.

IN YOUR OPINION, INDIVIDUALS IN NEED OF SERVICES HAVE EQUAL ACCESS TO CARE.

WHY? WHY NOT? WHAT WORKS WELL?

There are a lot of socioeconomic issues that prevent someone from having equal access to care. Some examples include not having access to reliable transportation, being uninsured, having insurance (public or private) that doesn't cover everything, and not having a provider speak your primary language. "Just because you have access to private insurance does not mean you can afford copays, or the costs associated with receiving care." Not having the adequate funding to aid clients and relying on certain funding streams that have limited criteria, means many people are left out of the system.

IN YOUR OPINION, YOUR ORGANIZATION TRACKS INDIVIDUALS SERVED, SERVICES, PERFORMANCE, AND COST TO CONTINUALLY EVALUATE AND IMPROVE OUTCOMES?

IF NOT, HOW CAN THIS BE IMPROVED?

This information is tracked more particularly for care coordination, Crisis Stabilization Unit (CSU), and outpatient services. Some funding requires this information for deliverables. Agencies utilize the data in the best ways possible and are required to monitor multiple measures.

NO WRONG DOOR SURVEY CHARTS

Figure 120: I work in a/an...

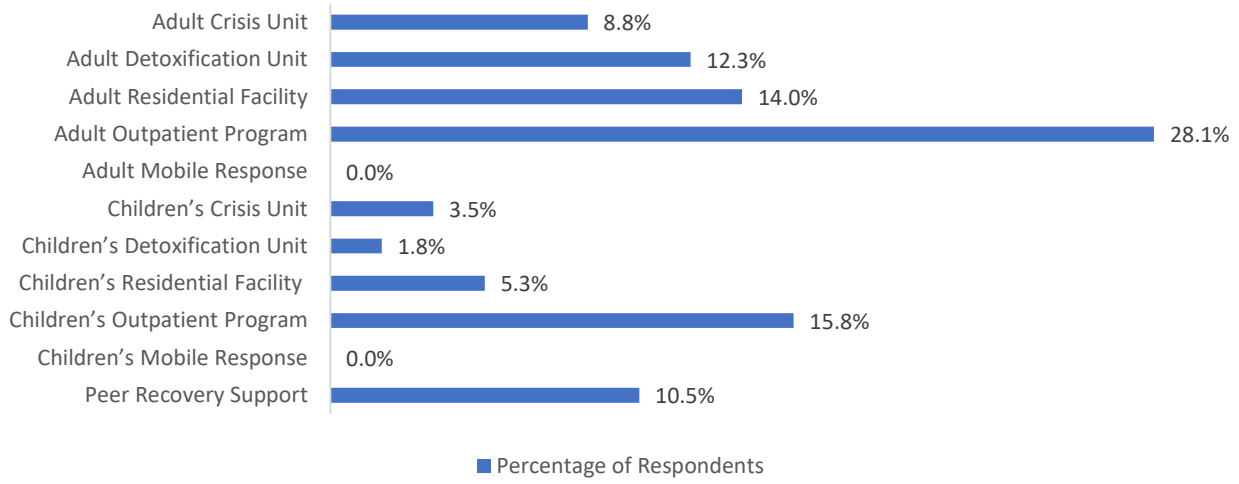


Figure 121: Do you think the "No Wrong Door" access works well within your organization?

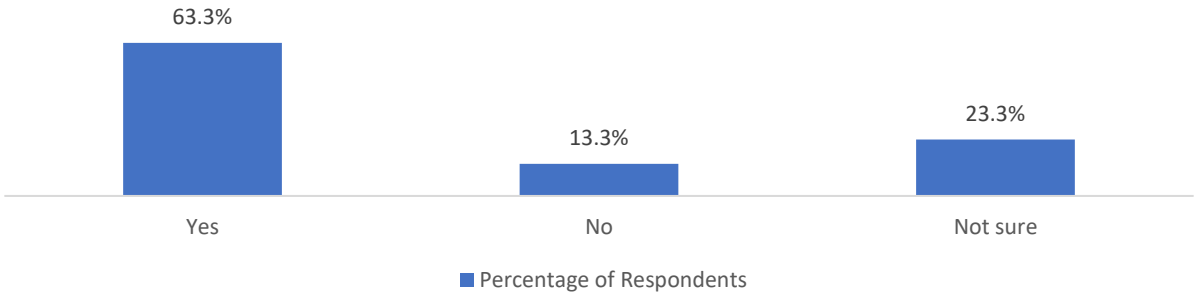


Figure 122: From your perspective your organization has a role to play in the "No Wrong Door" access.

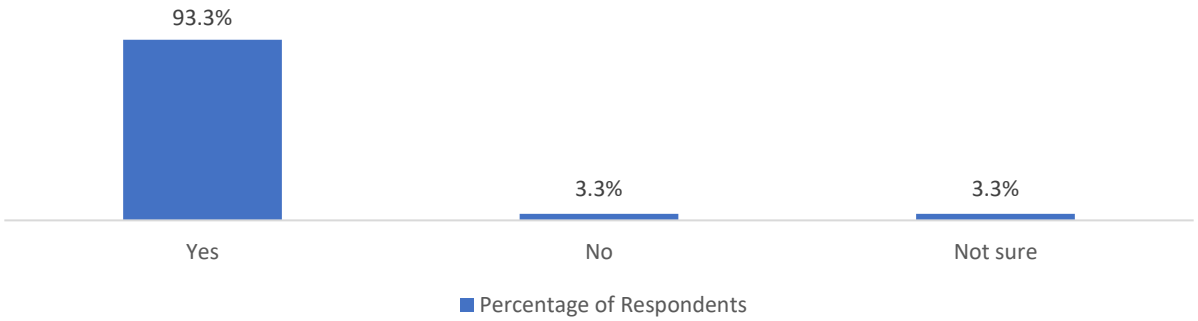


Figure 123: In your opinion, your organization has a strong care coordination process that includes warm handoffs to services and seamless care coordination.

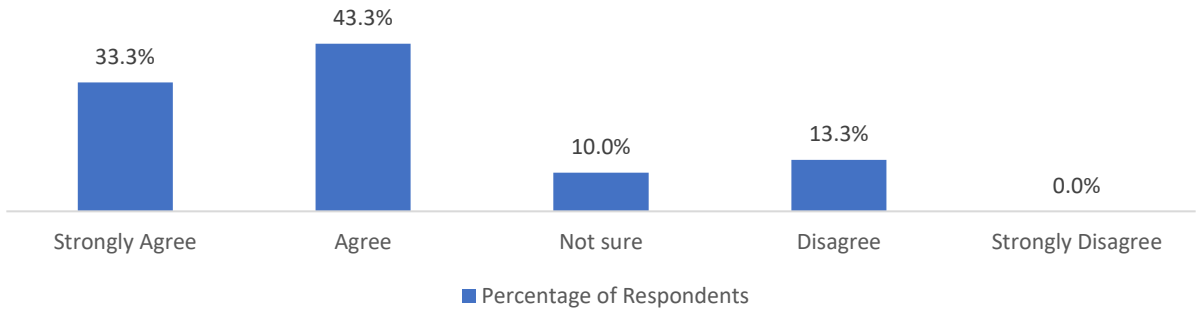


Figure 124: In your opinion, your organization has taken action to improve the referral and care coordination process for individuals served.

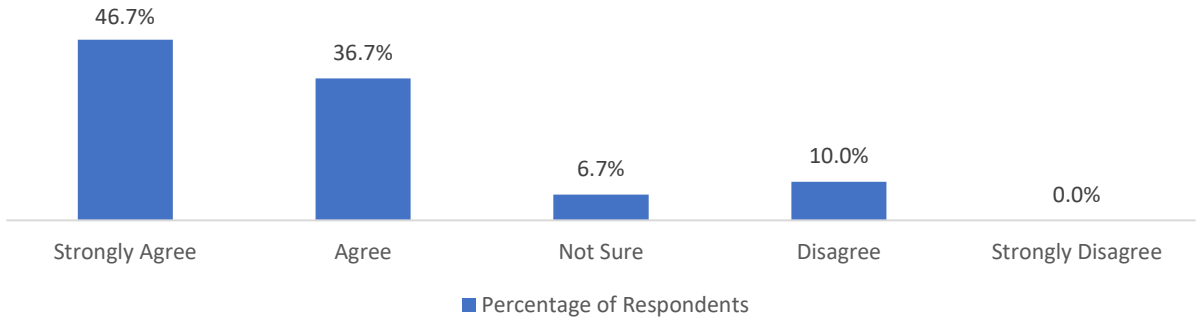


Figure 125: In your opinion, linkages to crisis intervention and support (like the Mobile Response Team, medication management, CRF, CIT Officer, BA, CSU, etc.) are occurring.

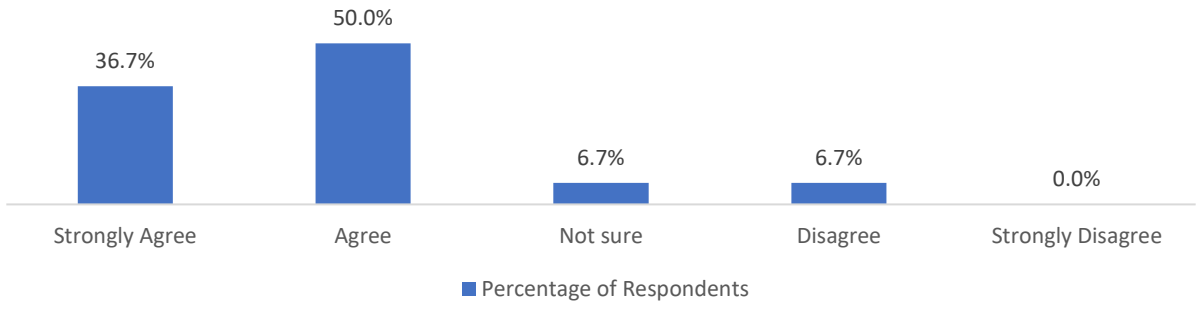


Figure 126: In your opinion, your organization promotes its services and resources very well.

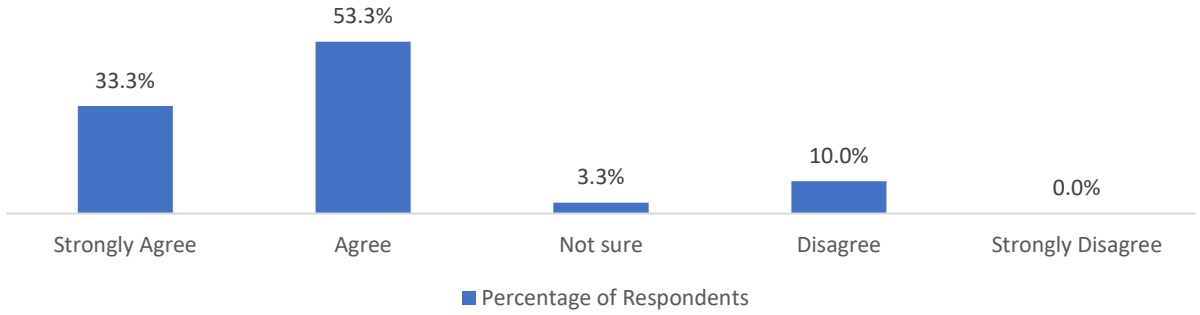


Figure 127: In your opinion, your organization promotes awareness of available options and linkages to need services.

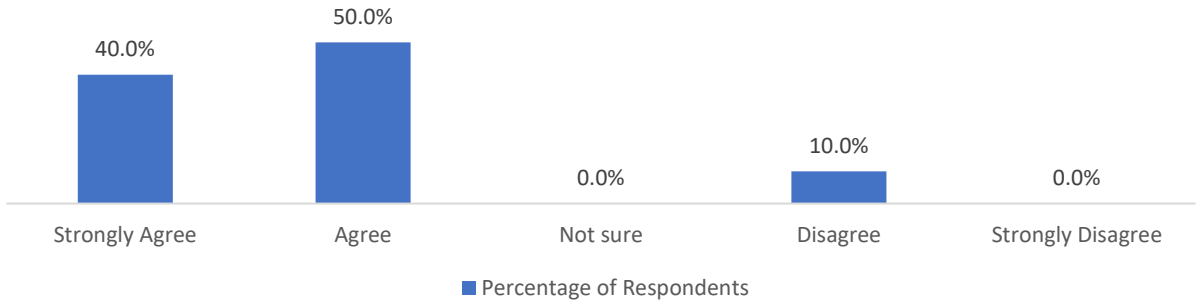


Figure 128: In your opinion, your organization provides person-centered care for all individuals served.

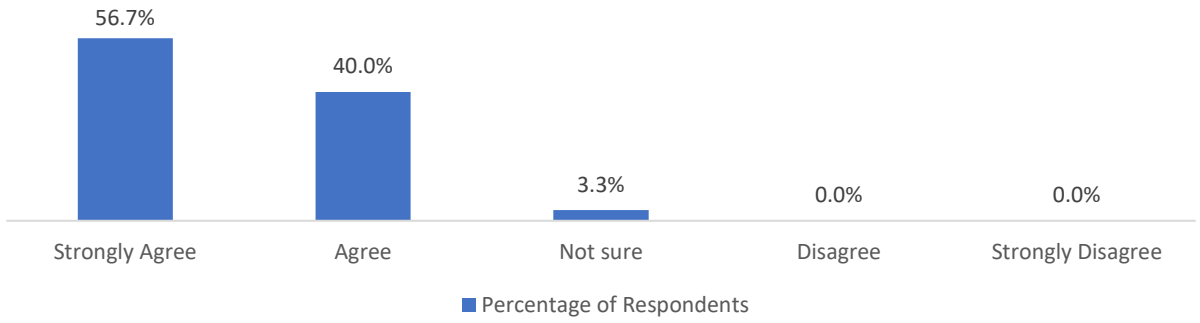


Figure 129: In your opinion, your agency hires employees who are culturally sensitive and culturally competent for the population served.

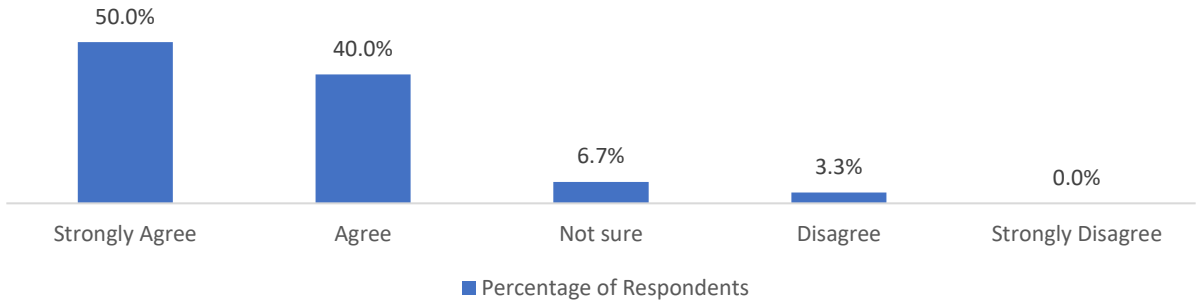


Figure 130: In your opinion, it's easy for individuals to access the services they need quickly and efficiently.

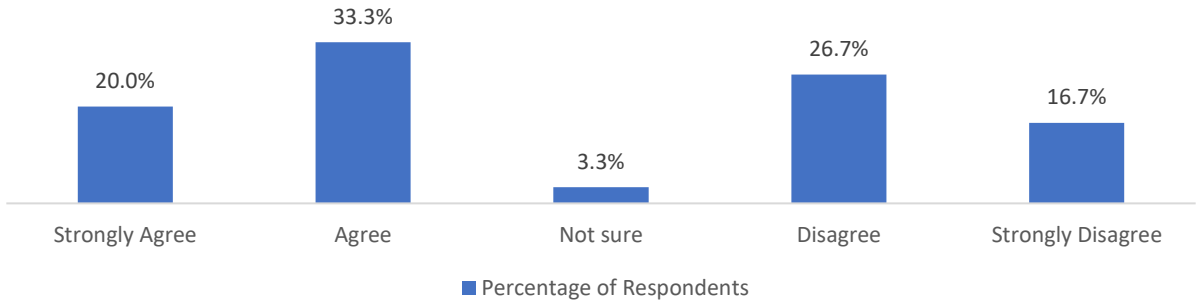


Figure 131: Do you think a standard intake and screening process for state agencies and community partners would help individuals get into services more quickly?

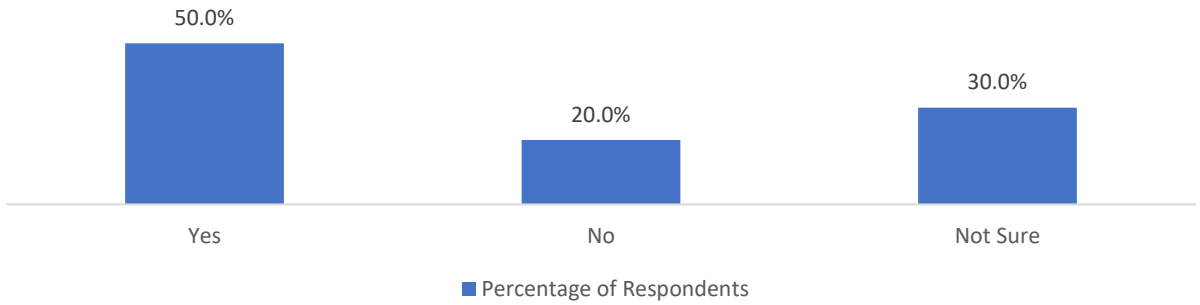


Figure 132: In your opinion, your organization encourages (promotes) working with other community partners to ensure care coordination.

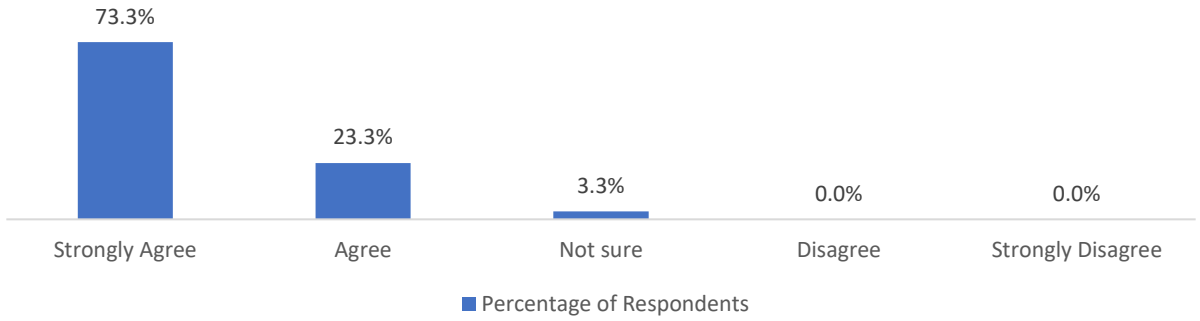


Figure 133: In your opinion, individuals in need of services have equal access to care.

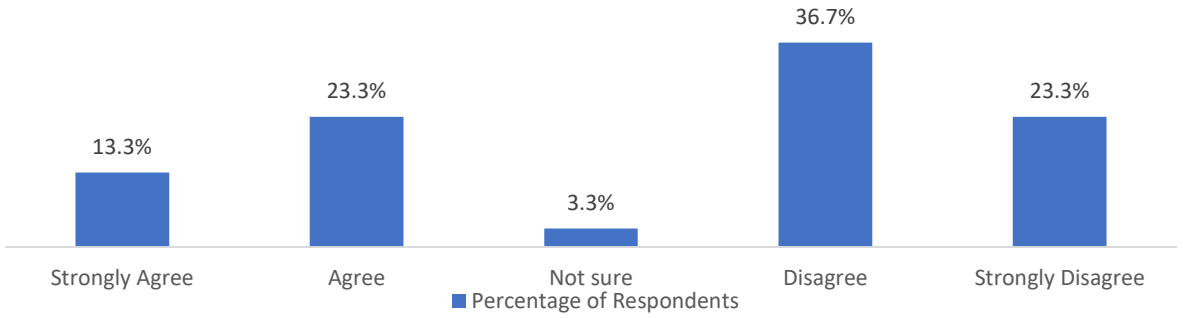


Figure 134: In your opinion, stakeholders help to address and advocate for equal access to care in system entry points.

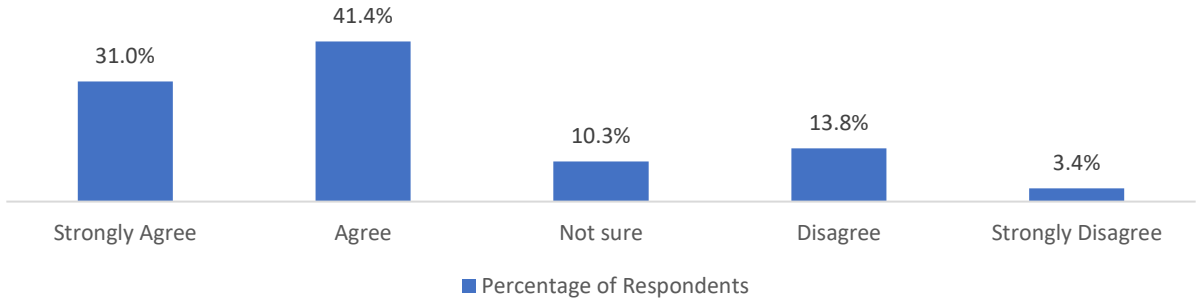


Figure 135: In your opinion, your organization ensures that services are of high quality and meet the needs of individuals served.

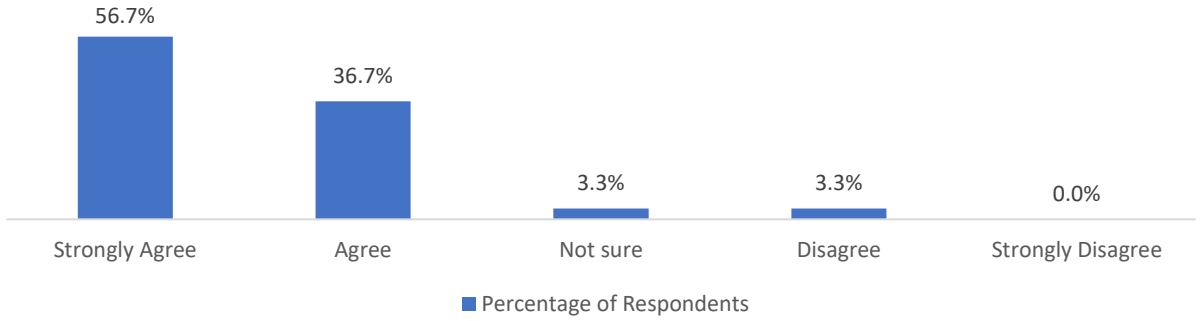
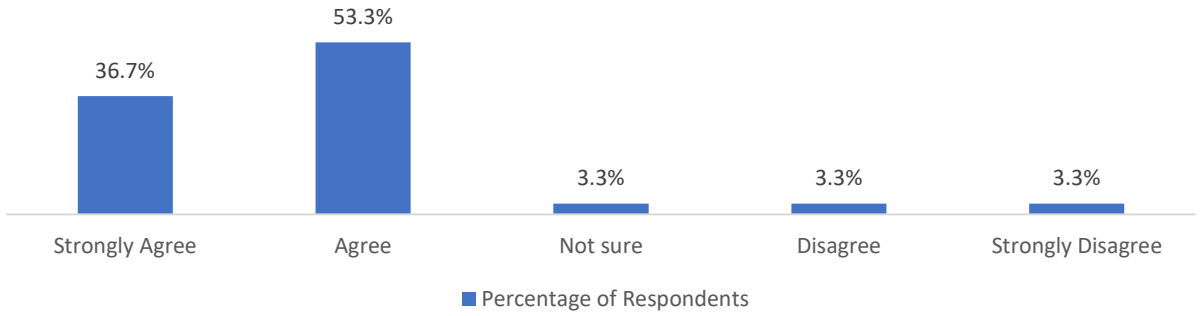


Figure 136: In your opinion, your organization tracks individuals served, services, performance, and cost to continually evaluate and improve outcomes.



INDIVIDUALS SERVED SURVEY SUMMARY

BACKGROUND

The Behavioral Health Needs Assessment Consumer/Client survey was available from January 7-February 14, 2022. It was distributed by Central Florida Behavioral Health Network and their community partners via email along with flyers that contained the survey information and a QR code. The survey was available in English, Spanish, and Haitian Creole.

Sixty-eight (68) responses were collected during the survey period. Most respondents (70.6%) were adults who were receiving services, followed by 11.8% who were the parent of a child receiving services, and caregivers representing a person receiving services (7.4%).

Survey respondents indicated they were receiving adult mental health services (72.1%), adult substance use services (32.4%), peer support services (23.5%), child mental health services (18.4%), prevention services (11.8%), or child substance use services (1.5%).

Ten out of 14 counties in the service area were represented in the responses. The largest percentage of respondents were from Pasco County (41.2%), followed by Lee County (22.1%), Collier County (10.3%), and Hillsborough County (5.9%). The following counties did not have any respondents: Glades, Hardee, Hendry, and Polk.

AWARENESS OF LOCAL RESOURCES

Data revealed the respondents were aware of where to go for mental health and substance use treatment when they needed them (82.1%) and that most respondents learned about services from a family member/friend (33.8%), another individual in treatment or recovery (33.8%), or by word of mouth (30.9%).

Client respondents indicated that they were aware of the 2-1-1 information and referral resources in their county (70.6%), while 29.4% had called, and 47.8% found the 2-1-1 service helpful.

SERVICE NEEDS & BARRIERS

The majority of respondents indicated that they were able to receive the services they needed when they needed them (63.1%). Of those who were not able to get the services they needed, the most common responses were housing assistance (52.2%), case management (34.8%), crisis stabilization/support (30.4%), alternative services (30.4%), and employment/job training assistance (30.4%).

Most respondents noted that the services they needed were available (56.1%). However, over 40.4% indicated that there was a waitlist for the services they needed.

The wait time from requesting an appointment for services to the time the client received the services varied with respondents indicating it took 1-2 weeks (26.8%) or over 2 months (26.8%), while 12.5% indicated that they never received an appointment.

Clients were asked about the obstacles/barriers they encountered getting the care they needed, and 33.8% indicated there were long waitlists, they could not afford the services (19.1%), they did not know where to go for services (17.7%), that they had very limited or no transportation (17.7%) or that they did not meet the eligibility criteria (16.2%). Stigma, lack of evening/weekend appointments, and services not available in the county were also frequently mentioned as barriers. Additionally, 30.9% of respondents indicated they did not have any barriers.

INDIVIDUALS SERVED SURVEY CHARTS

Figure 137: Which best describes you?

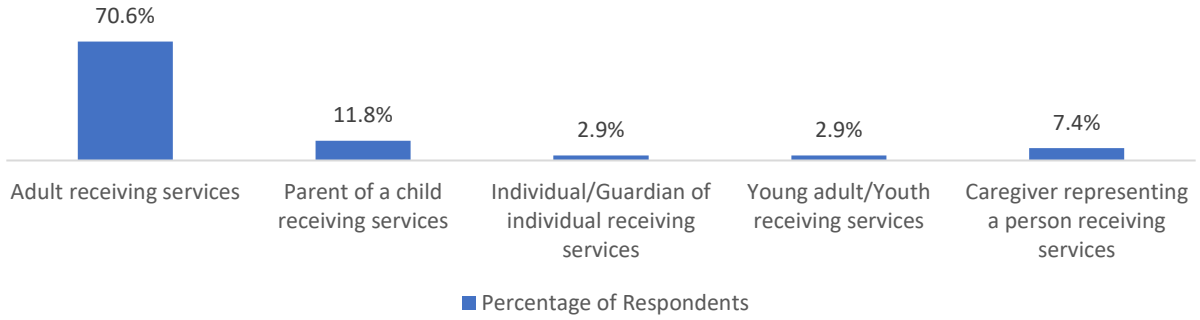


Figure 138: What type of service did you or the person you are representing receive?

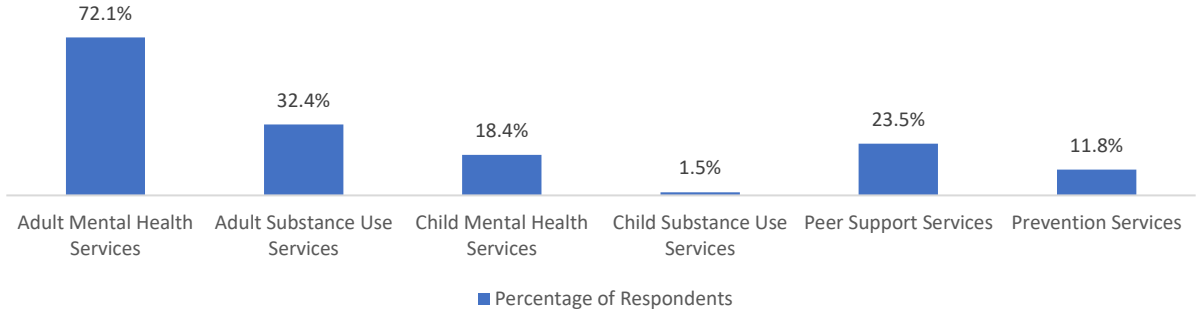


Figure 139: Which county do you live in?

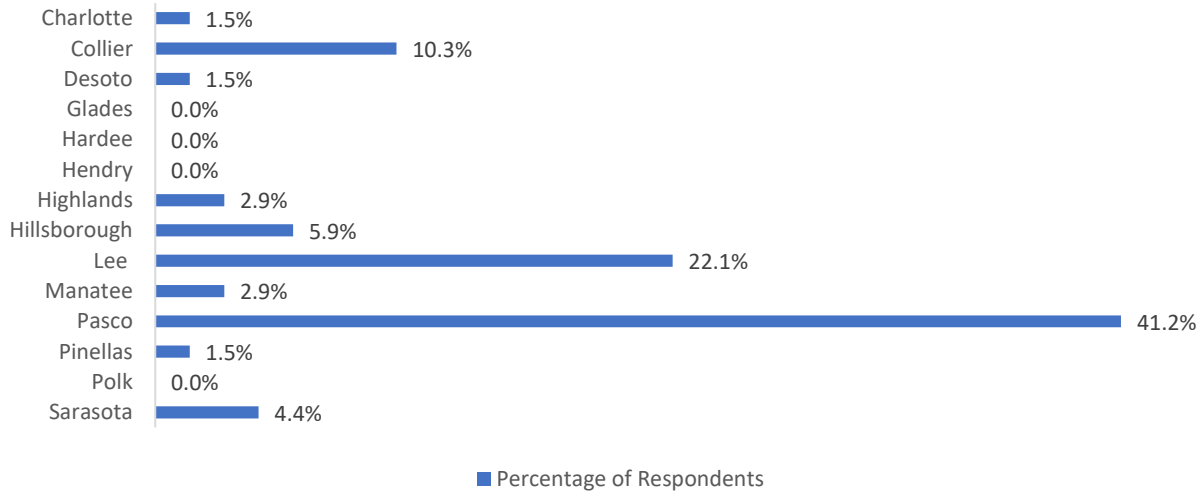


Figure 140: Did you know where to go for mental health and substance use treatment services when you needed them?

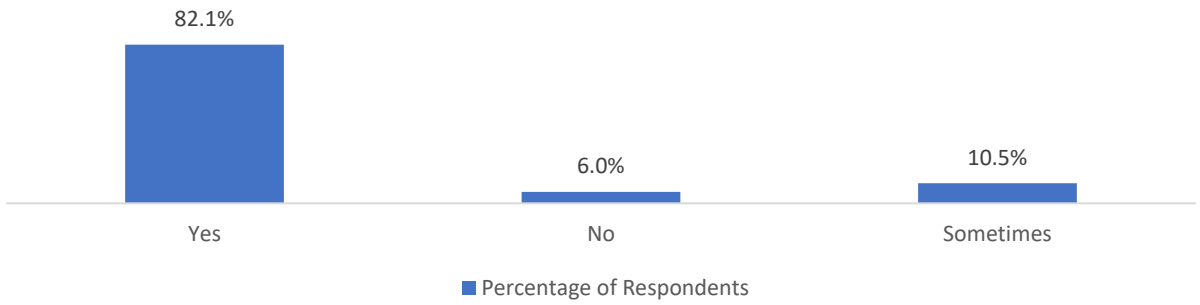


Figure 141: How did you learn about mental health and substance use treatment services when you needed them?

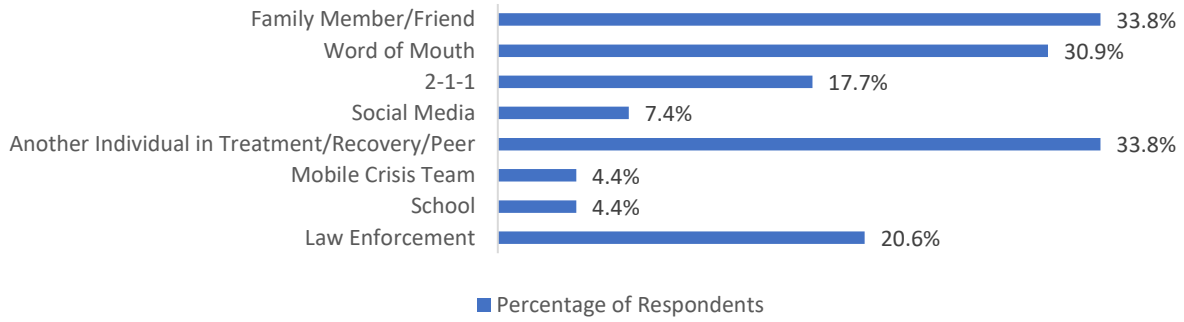


Figure 142: Are you aware of the 2-1-1 Information and Referral Resource in your community?

Figure 143: Have you ever called 2-1-1 Information and Referral Resource for assistance?

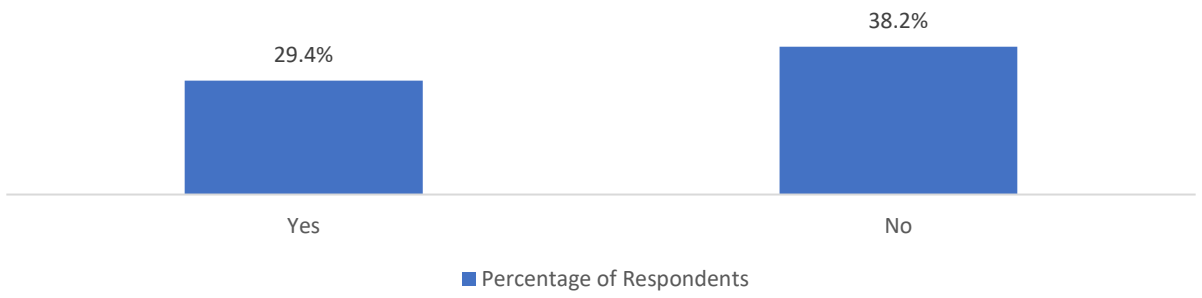


Figure 144: When you called the 2-1-1 Information and Referral Resource, were they helpful in getting you the services needed?

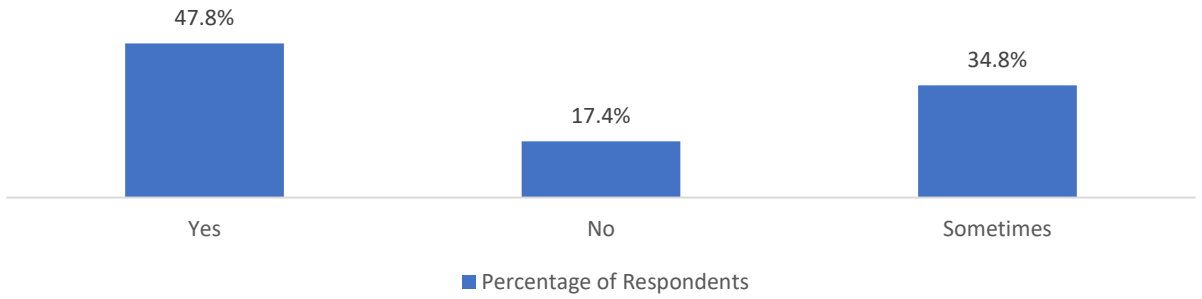


Figure 145: Were you able to get all the services you needed when you needed them?

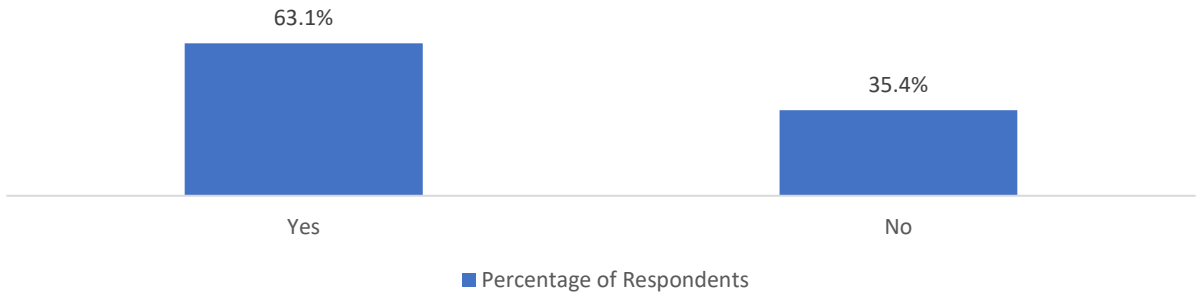


Figure 146: If no, please choose from the list below, the services you needed but were not able to get.

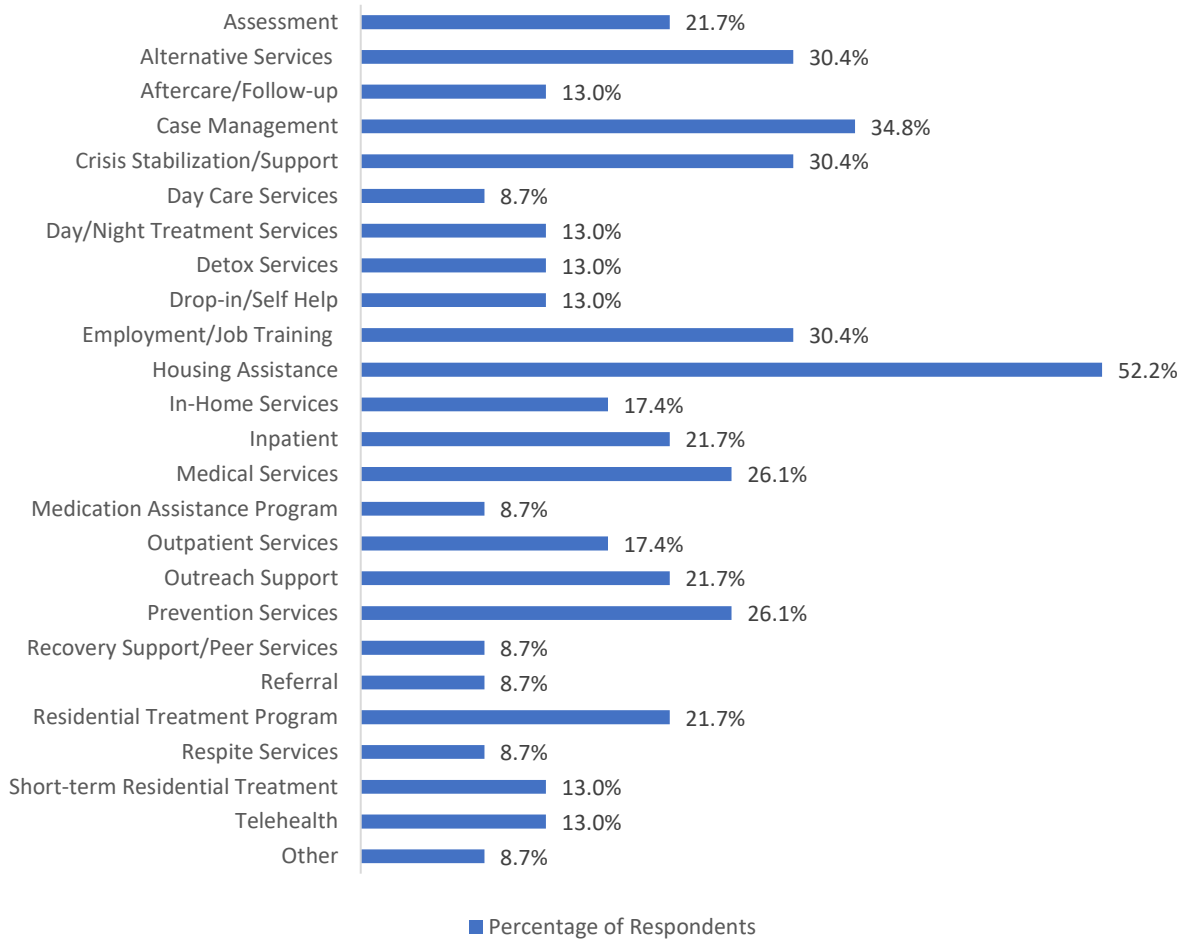


Figure 147: How many times during the last 12 months were you not able to get the services you needed?

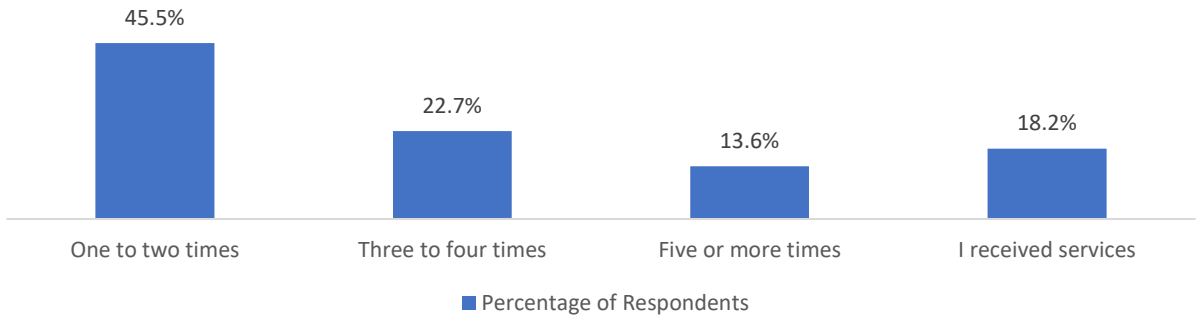


Figure 148: The services I needed were:

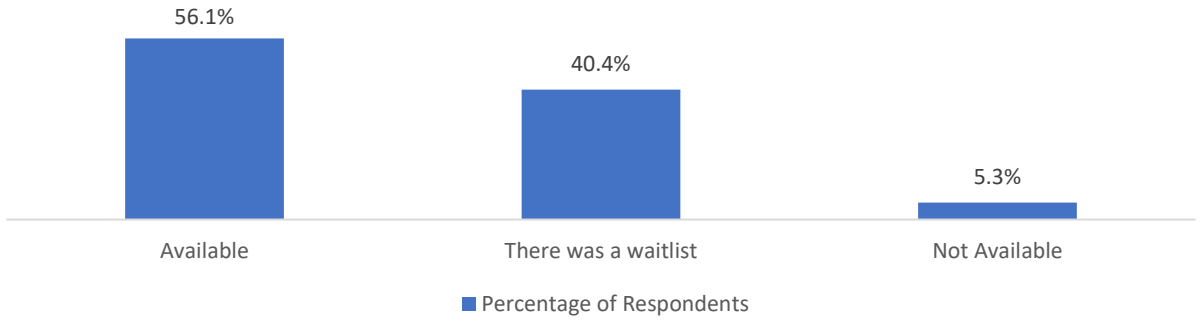


Figure 149: The services and planning I received were focused on my treatment needs (patient centered).

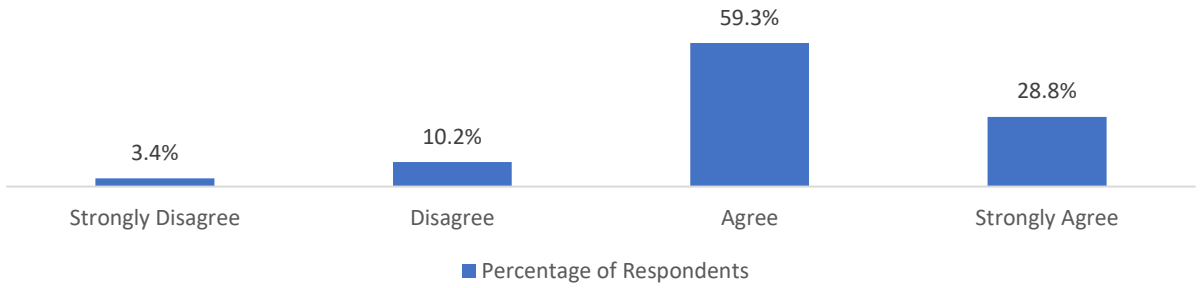


Figure 150: How long did it take from the time you requested an appointment for services to the time you received the services?

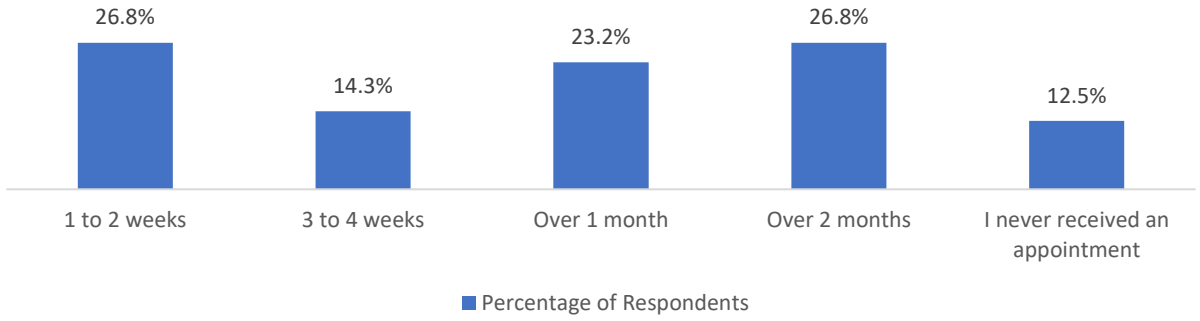


Figure 151: How long did it take to travel to the service?

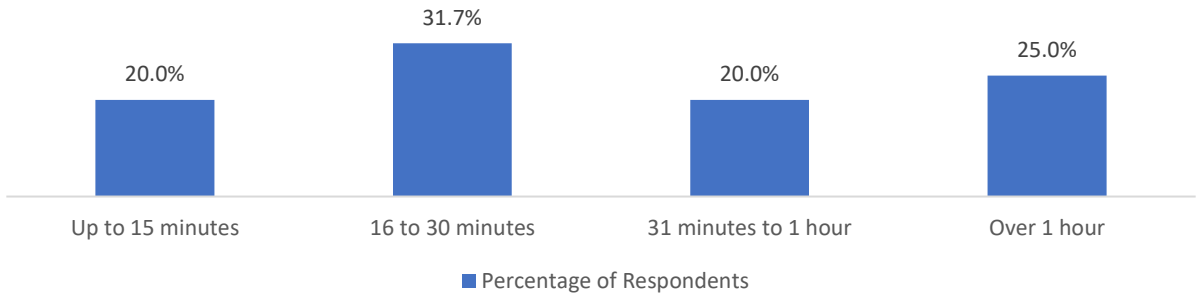
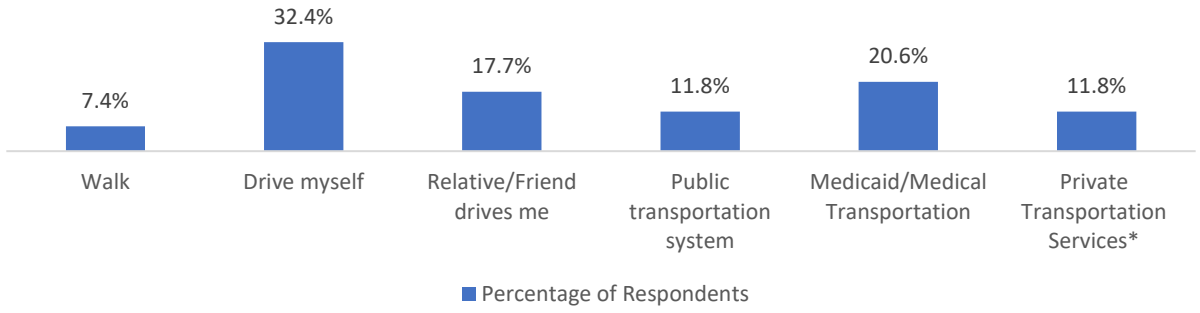
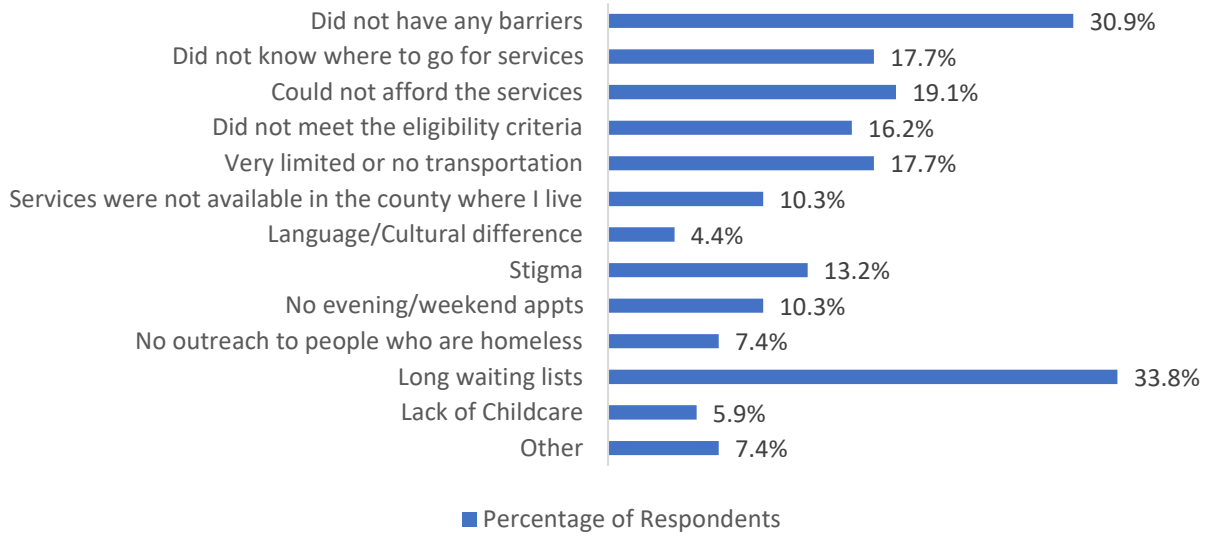


Figure 152: How do you travel to get services?



*Note-Private transportation includes Taxi, Uber, Lyft, TOPS, etc.

Figure 153: What were the obstacles you experienced getting the care you needed?



STAKEHOLDER SURVEY SUMMARY

BACKGROUND

The Behavioral Health Needs Assessment Stakeholder Survey was available from January 7-February 14, 2022. It was distributed by Central Florida Behavioral Health Network and their community partners via email along with flyers that contained the survey information and a QR code. The survey was available in English, Spanish, and Haitian Creole.

Over 460 responses were collected during the survey period. The top five service sectors that had the highest percentage of respondents were: case management (10.2%), other (8.4%), children and family services (7.8%), social services (7.6%), and adult mental health care (7.1%).

All 14 counties in the service area were represented in the responses. The highest percentage of respondents were from Pinellas County (13.4%), followed by Hillsborough County (12.3%), Manatee County (9.1%), Pasco County (8.6%), and Lee County (8.5%).

SURVEY RESPONSES

About 90% of respondents strongly agreed or agreed that they were aware of the availability of mental health and substance use services in their area. While 51% were aware of Central Florida Behavioral Health Network (CFBHN), 49% of people had accessed CFBHN's resources in the past 6 months. Most survey takers (58%) found the offered CFBHN resources were helpful. When asked if they ever directed individuals to access CFBHN by calling or online, 59% of respondents said no.

The majority (92%) of respondents were aware of the 2-1-1 information and referral resource. Although most of survey takers were aware of the 2-1-1 resource, 62% had not accessed 2-1-1 in the past 6 months. For those who accessed the 2-1-1 information and referral resource, 60% of respondents found it helpful. Eighty-eight percent of respondents had directed individuals to access 2-1-1 by either calling or online. The top three crisis response models in the service area were the Mobile Crisis Response Team (37.3%), Behavioral Health Response Team (20.6%), and Tampa Crisis Intervention Response Team (11.9%).

Survey takers were asked to rate the community's awareness of mental health and substance use treatment services using a scale from excellent to poor. Forty percent of respondents rated the awareness as fair. Over 40% of respondents indicated that the linkages to need services were not being coordinated and established across the system of care. Over 50% of respondents either strongly agree or agree that behavioral health care and peer services were accessible in the area. Respondents were split with 42% who agreed and 43% who disagreed on if the processes for referrals were easily accessible. Most respondents (56%) either disagreed or strongly disagreed that programs and services are coordinated across the system of care.

When asked to identify barriers for consumers accessing services in their community, most respondents said no or very limited transportation (13.4%), followed by long waitlists (12.9%), did not know where to go for services (11.5%), could not afford the services (11.2%), and stigma (10.2%). Survey takers were asked to list resources and services to improve patient-centered care and planning that are not available. There were over 260 responses to this question. Some of the responses included: shortage of providers/staff including peer specialists, transportation, affordable housing, bilingual providers, access to services in a timely manner, care coordination, increased access to certain behavioral and substance use treatment on the weekend, and increased access for uninsured patients. There were 565 different patient-centered care resources and services that were provided by survey respondents. Responses included names of specific service agencies/organizations, care management, and access to services.

STAKEHOLDER SURVEY CHARTS

Figure 154: Percentage of respondents by organization service sector.

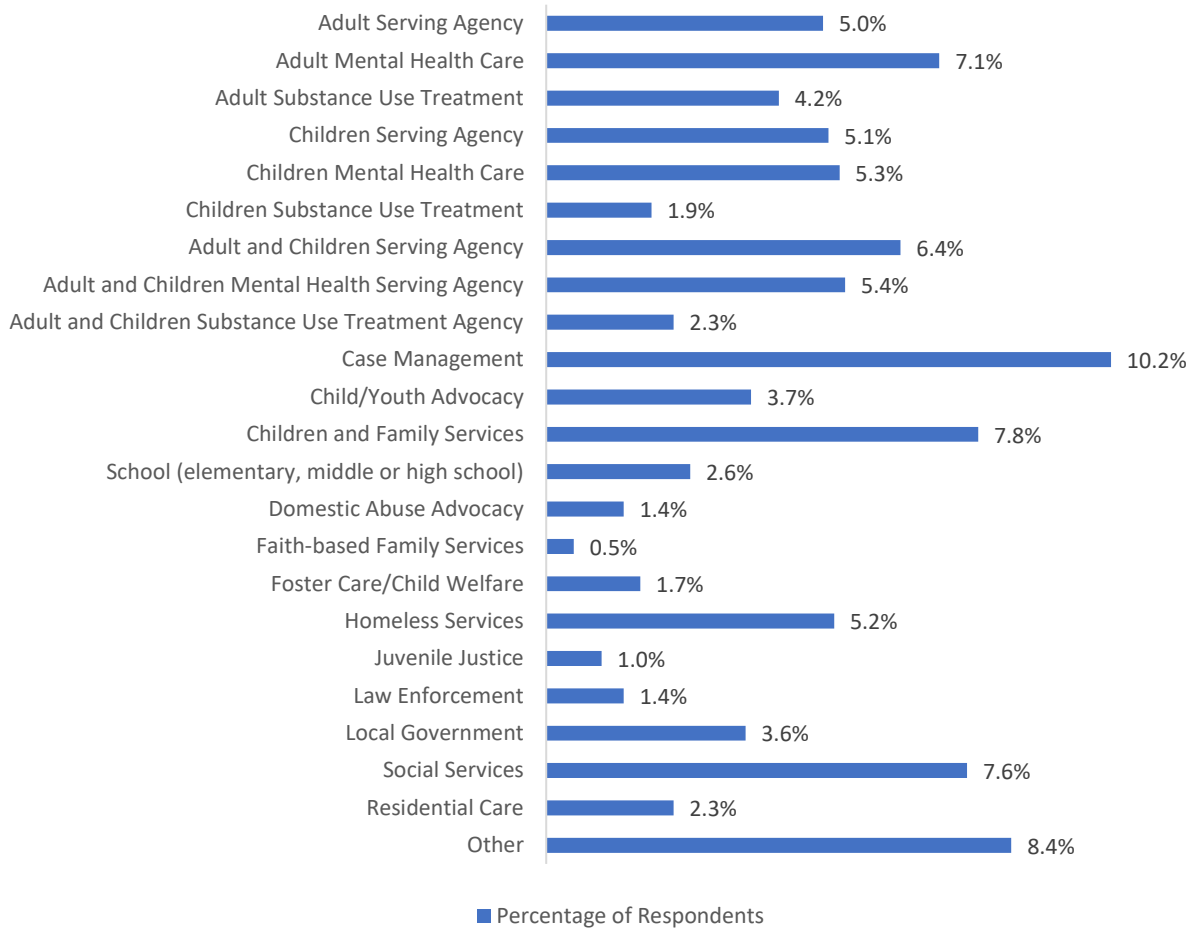


Figure 155: Percentage of stakeholder respondents by county.

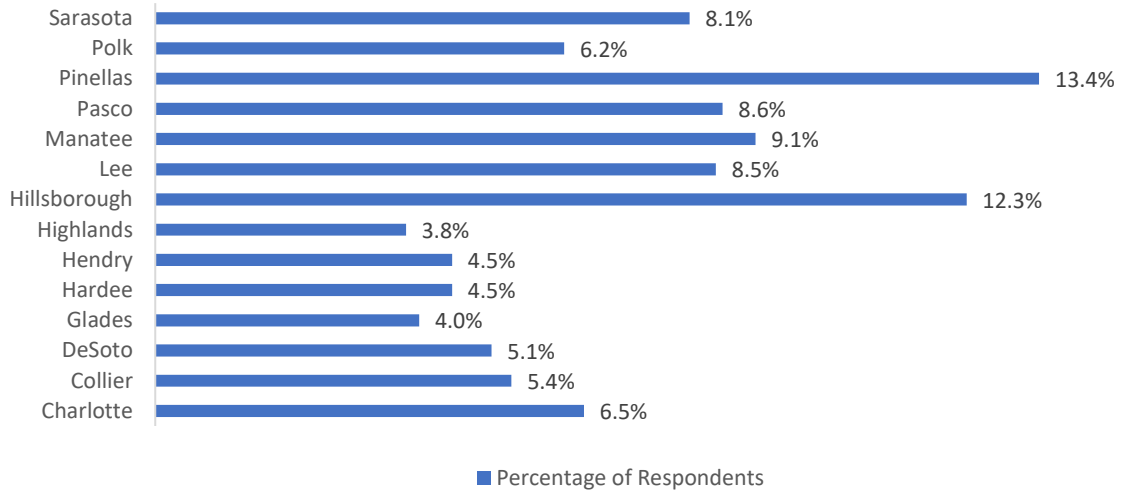


Figure 156: You are aware of the availability of mental health and substance use services in your area.

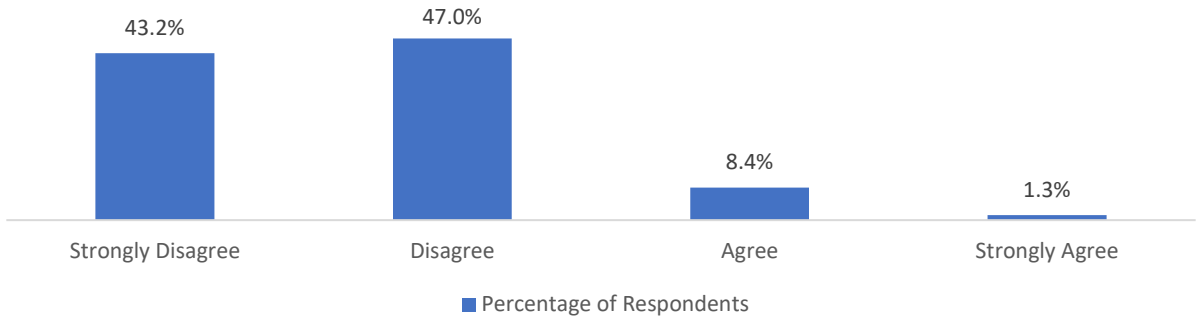


Figure 157: Are you aware of Central Florida Behavioral Health Network (Managing Entity) resources?

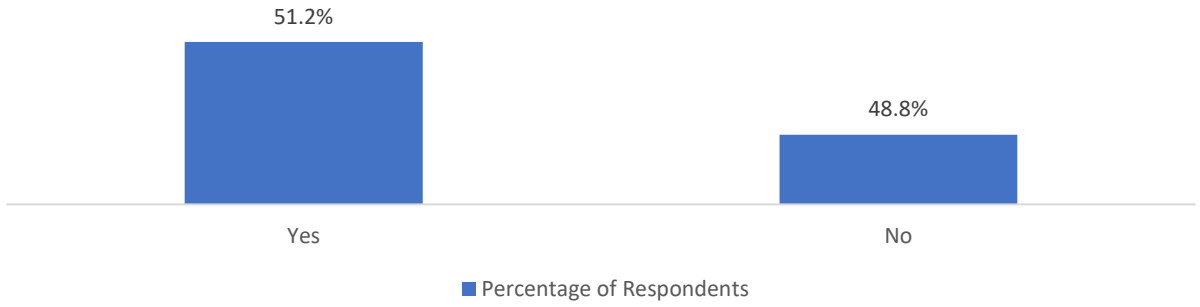


Figure 158: Have you accessed Central Florida Behavioral Health Network (Managing Entity) resources in the past 6 months?

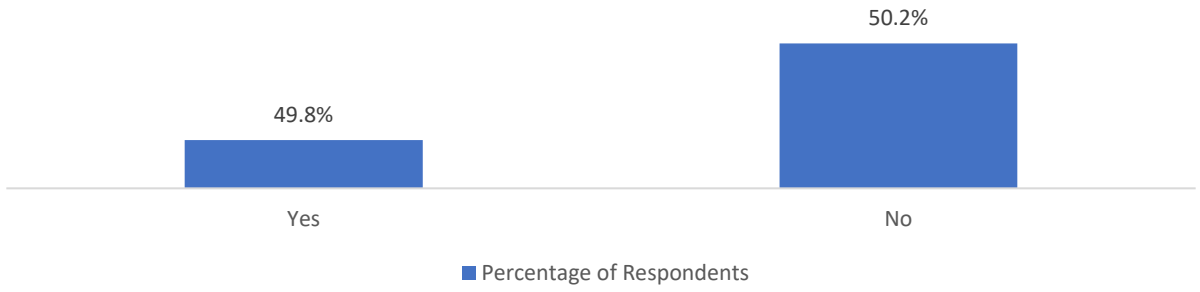


Figure 159: When you accessed Central Florida Behavioral Health Network (Managing Entity) resources, was it helpful?

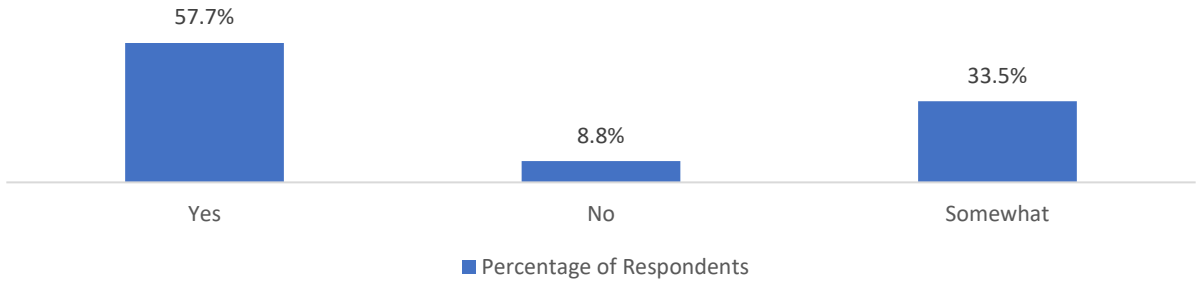


Figure 160: Have you ever directed individuals to access Central Florida Behavioral Health Network (Managing Entity) by calling or online?

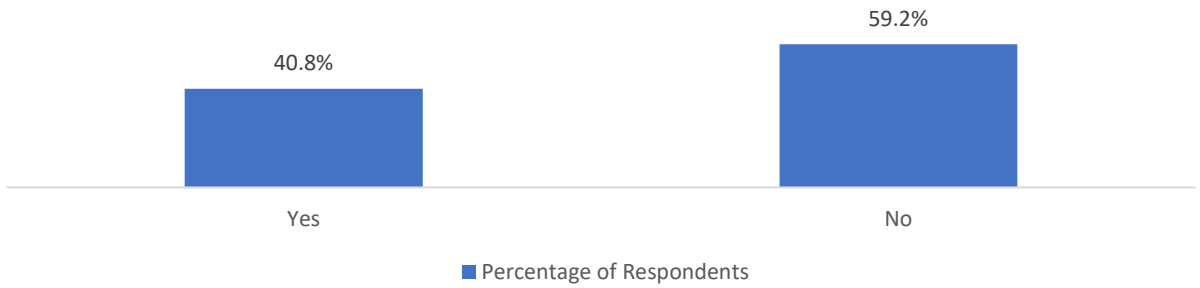


Figure 161: Are you aware of the 2-1-1 Information and Referral Resource?

Figure 162: Have you accessed the 2-1-1 Information and Referral Resource in the past 6 months?

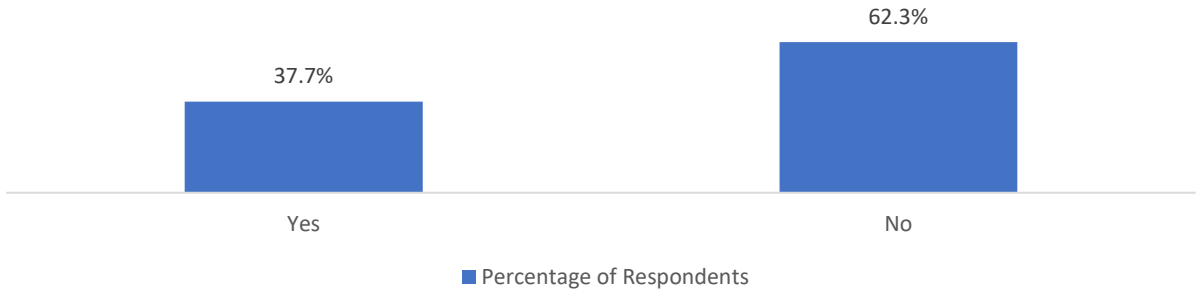


Figure 163: When you accessed the 2-1-1 Information and Referral Resource, was it helpful?

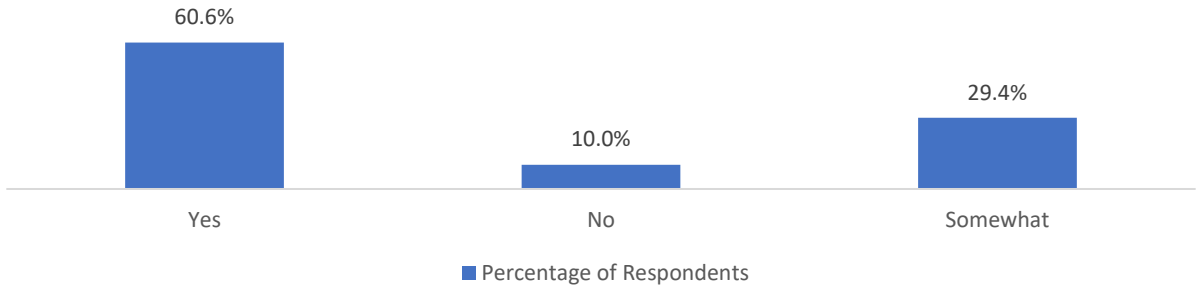


Figure 164: Have you ever directed individuals to access the 2-1-1 Information and Referral Resource by calling or online?

Figure 165: Select the crisis response model in your area. (Check all that apply)

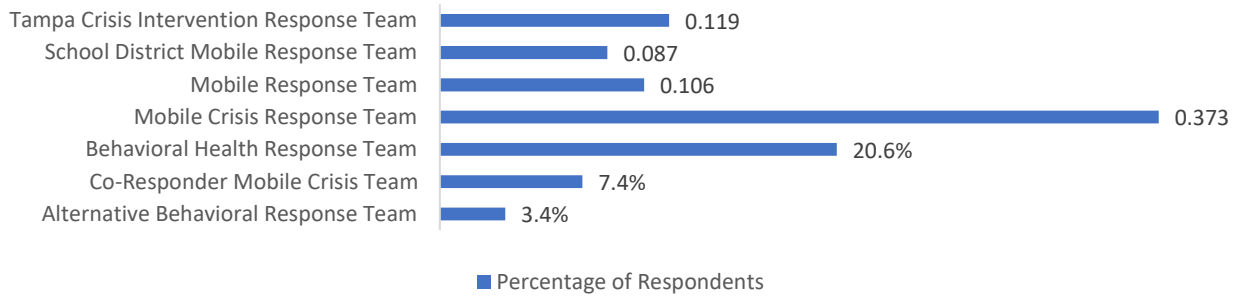


Figure 166: How would you rate community awareness of mental health and substance use treatment services in your area?

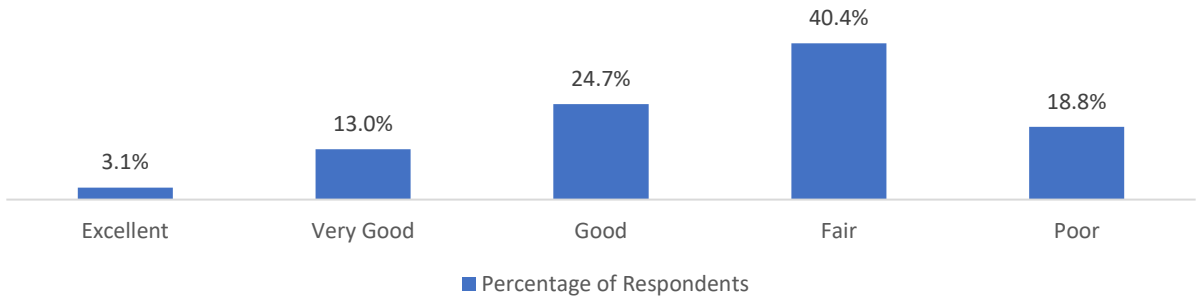


Figure 167: Linkages to needed services are coordinated and well established across the system.

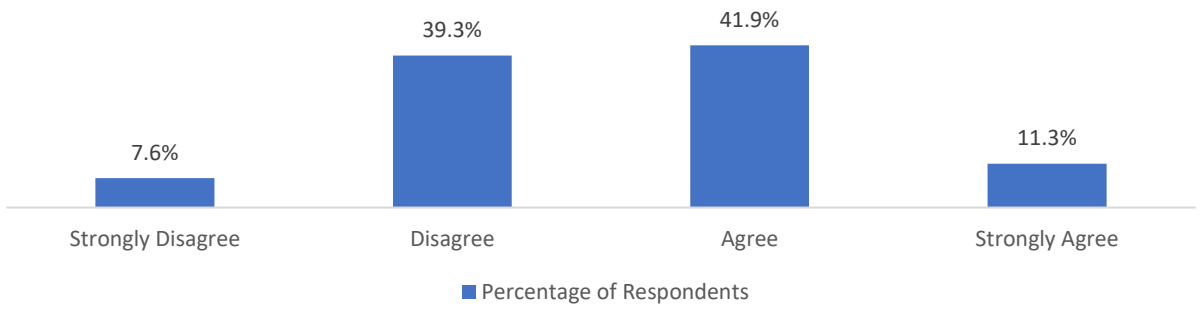


Figure 168: In general, behavioral health care and peer services are accessible in your area.

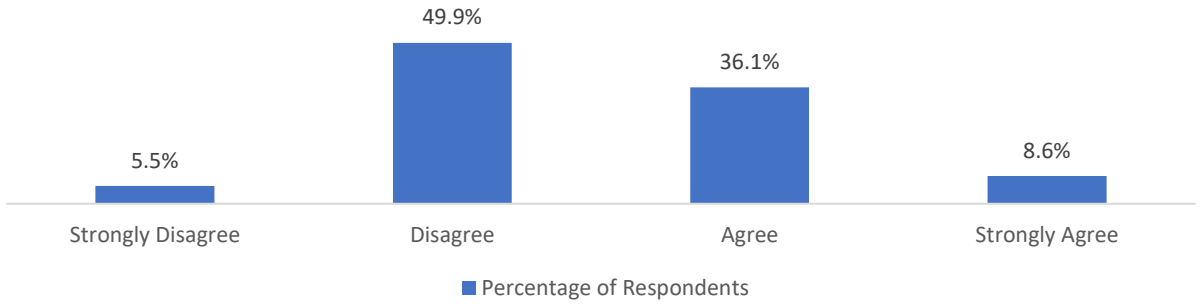


Figure 169: The process for referrals is easily accessible.

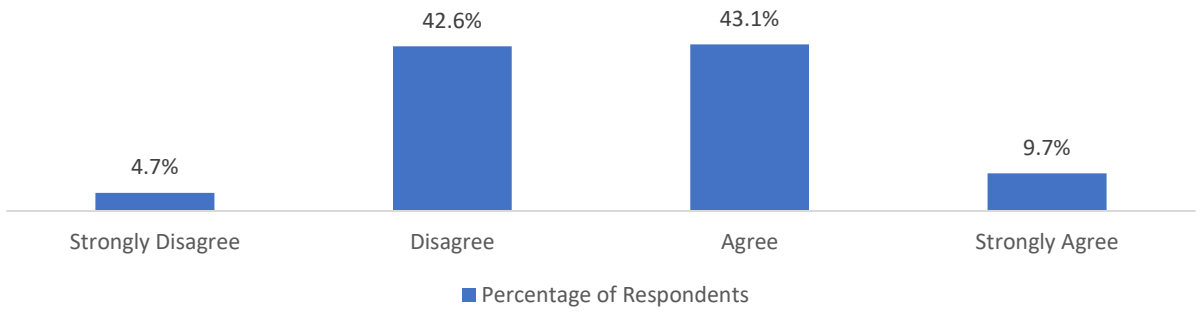


Figure 170: Programs and services are coordinated across the system of care.

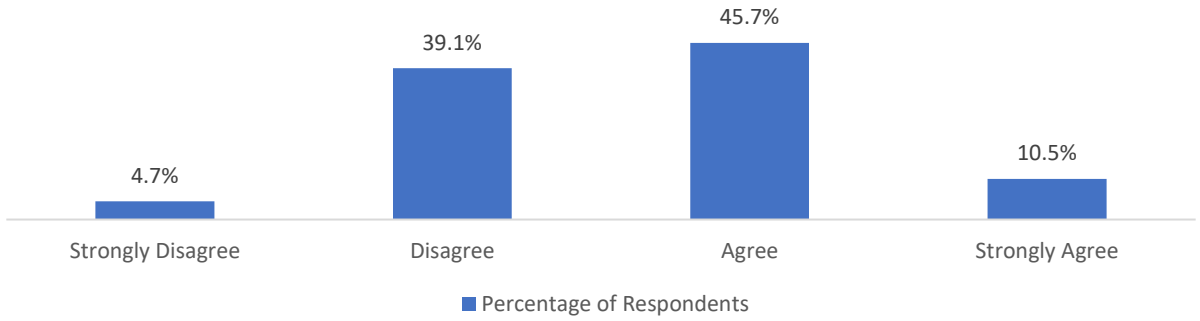


Figure 171: List the barriers for consumers accessing services in your community. (Check all that apply)

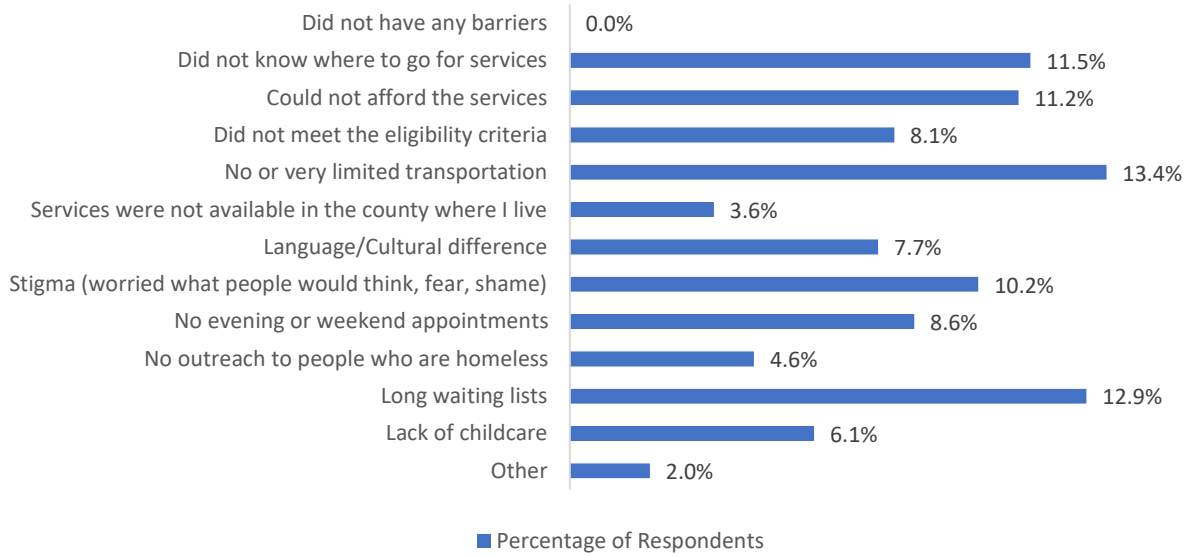


Figure 172: List the resources and services needed that are not available to improve patient-centered care and planning.

Needed Resources and Services
Shortage of providers and staff
More peer specialists
Aid in transportation
Affordable housing
Bilingual providers
Access to services in a timely manner
Weekend access to behavioral health services
Increased access for uninsured patients
Care coordination

Figure 173: List the top three patient-centered care resources that have improved quality of life for individuals.

TOP THREE PATIENT-CENTERED RESOURCES
Behavioral Health Service Agencies
Case Management
Access to Services

PEER RECOVERY COMMUNITY/SUPPORT SPECIALIST'S SURVEY SUMMARY

PEER SUPPORT SPECIALISTS IN THE CENTRAL FLORIDA BEHAVIORAL HEALTH NETWORK

Peer Support Specialists (PSS) bridge gaps in services in the NWD care model to improve patient-centered care. PSS were surveyed to evaluate their engagement, barriers, and improvements they would like to see in the health system. Sixty-six PSS responded to the survey, 30.3% were adults with a lived substance use condition, and an additional 30.3% were adults with lived co-occurring mental health and substance use conditions. Of the 14 counties with CFBHN locations, Hillsborough County was the most represented at 25.8% with Pasco and Polk County tied as the second most at 12.1% each. Other counties represented were Lee County (10.6%), Pinellas and Collier County (9.1% respectively), Manatee and Sarasota County (7.6% respectively), and Charlotte County (6.1%). PSS are employed at a variety of agencies ranging from mental health and substance use for adults and children to community and family/peer organizations. They may be employed or volunteer for one or multiple agencies. Approximately 48.5% of PSS have been involved for more than 3 years and 63.6% of all respondents have a work schedule averaging 40 hours per week, 15.2% exceed the 40-hour schedule.

Peer Specialists were evaluated for the certifications they hold for peer specialists and recovery support specialists. Approximately 22.7% of respondents were not certified. Individuals who have applied for and are in the process of receiving certification made up 16.7% of respondents while 6.1% held a provisional certification as a recovery peer specialist. Exactly 50% of all respondents were Certified Recovery Peer Specialists (CRPS) and 4.6% were Certified Recovery Support Specialists (CRSS). Only 3% of respondents were Nationally Certified Peer Specialists (NCPS).

WHAT TYPES OF PROGRAMS DO PSS SUPPORT?

PSS were used in various recovery support roles throughout the health care system and in the community. Hospital emergency rooms, drop-in centers, corrections facilities, child welfare, and Medication Assisted Treatment (MAT) were some of the programs supported or run by PSS. Peer recovery support roles assisted families through grassroots organizations like National Alliance on Mental Illness (NAMI) and Family Intervention Treatment Team (FITT).

Partnerships with agencies outside of the health care system were heavily recognized by specialists. PSS can connect their patients with social services related to food pantries, halfway housing, Recovery Community Organizations (RCO), employment agencies, and child welfare services to aid in recovery.

STRENGTHS EXPEREINCED BY PSS

Approximately 95% of PSS reported that their organization utilizes person-centered recovery language to help reduce stigma. Over 75% responded that their organization included peers in developing, evaluating, and improving programs. Strength of peer support materials, programs, and best practices included inviting individuals in recovery to management and board meetings.

BARRIERS TO RECRUITING/EMPLOYING PSS

Multiple barriers were mentioned regarding the employment and recruiting of PSS. The length of hiring and screening processes were among the top barriers cited. PSS expressed experiences with significant delays for background checks and exemptions. Additionally, salary and pay were the most selected barriers with PSS indicating that the lack of raises does not compensate for the cost of living.

TRAINING NEEDS THAT MAY ASSIST IMPLEMENTING PSS SERVICES

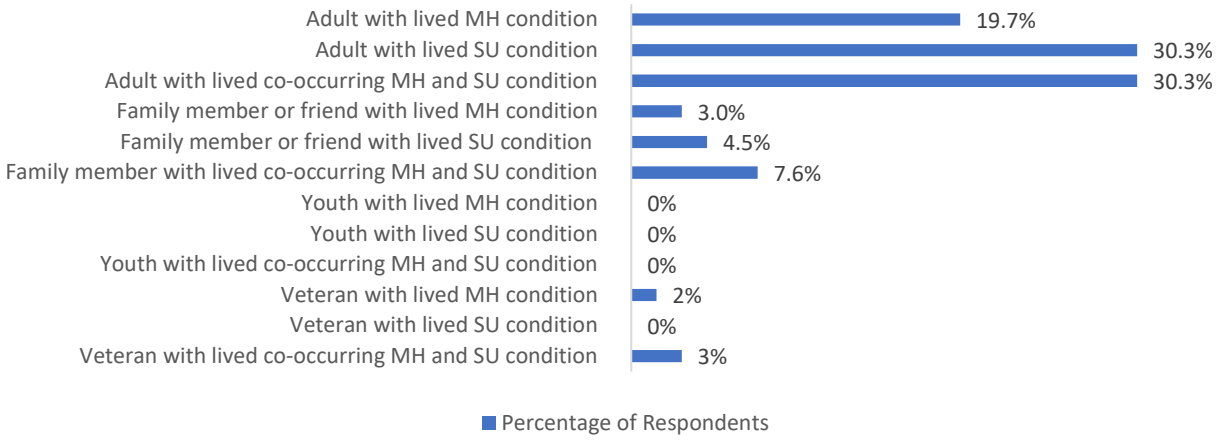
PSS prioritized Peer Recovery Specialists training, Wellness Recovery Action Plan (WRAP), trauma informed training, and professional responsibility/ethics as areas of need. Mental health first aid was identified and aims to benefit those serving both adults and children. Peer Recovery Specialists Training should require at least 40 hours to maintain and improve the skills of specialists along with peer support training within organizations.

RECOMMENDATIONS TO IMPROVE THE IMPLEMENTATION OF PSS

Peer Support Specialists found it was important to include peers in recovery during all stages of the process for the development of effective programs. Documentation training would aid in improving the continuity of care to ensure patient notes and progress are updated for better communication among providers. PSSs suffer from compassion fatigue, limited employment opportunities, and extended work hours. Selfcare is vital to PSSs success in supporting patients. As an employee, flexible work schedules, support from administration, and work hours reaffirm their commitment to supporting their patients. PSS are dedicated to their work gaining personal fulfillment and committed to recovery principles when helping their community.

PEER RECOVERY COMMUNITY/SUPPORT SPECIALISTS SURVEY CHARTS

Figure 174: Which best describes your experience?



Note: Mental Health (MH) and Substance Use (SU)

Figure 175: Which county do you live in?

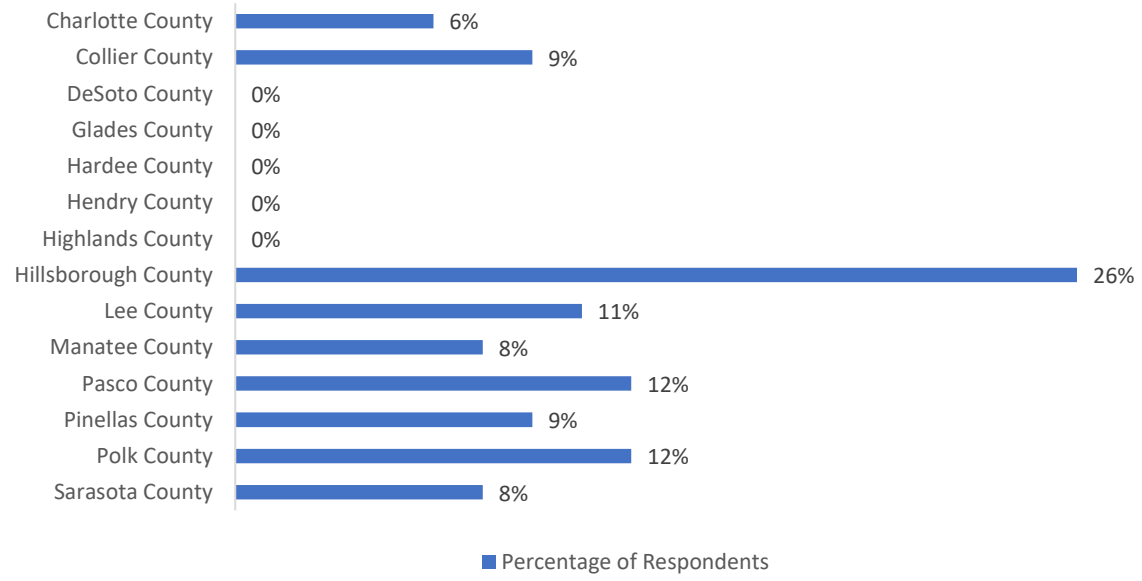


Figure 176: What type of service are you employed or volunteer with? (Check all that apply)

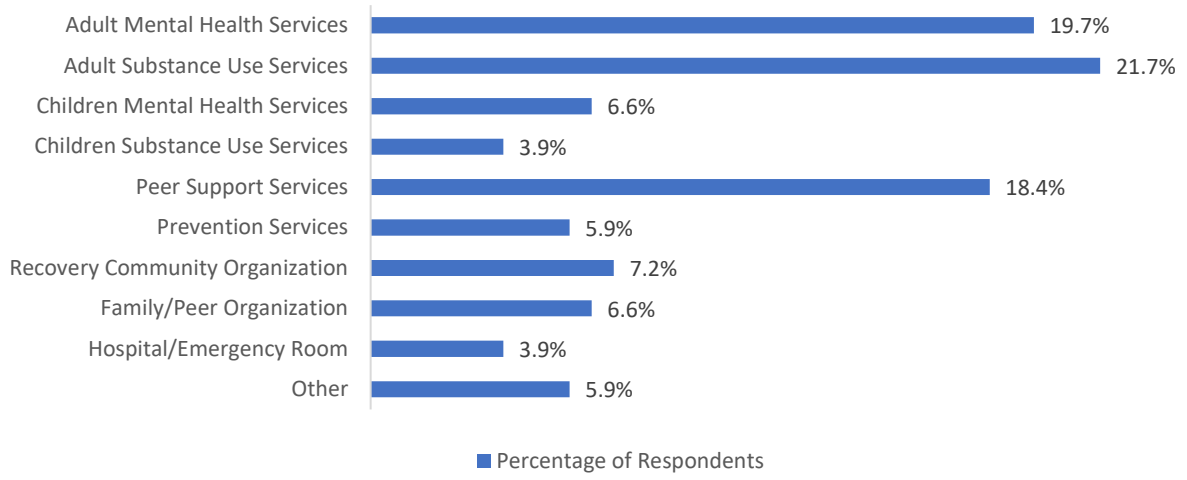


Figure 177: How long have you been employed/volunteered with the agency?

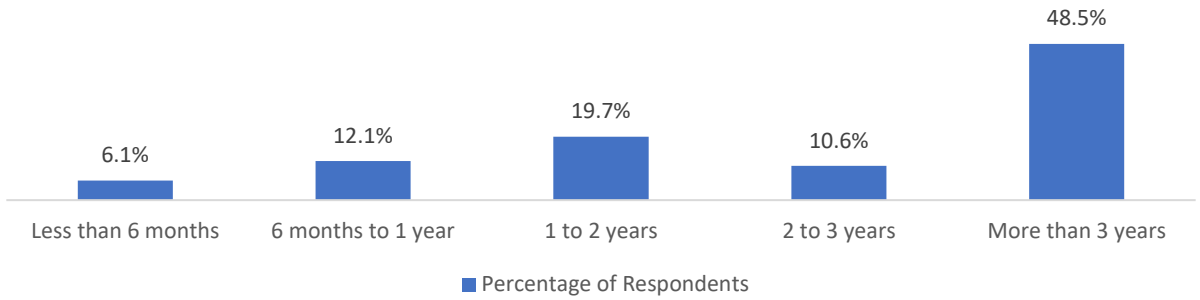


Figure 178: My work schedule averages...

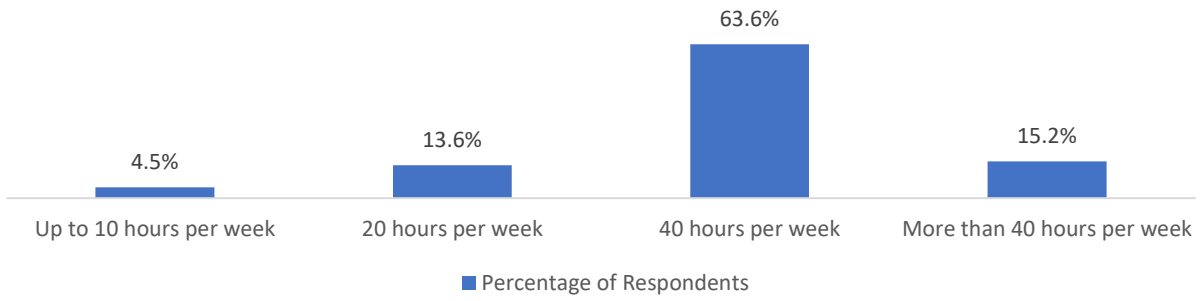


Figure 179: Does the agency where you are employed, or volunteer, utilize recovery peer support services within the services they provide in the community?

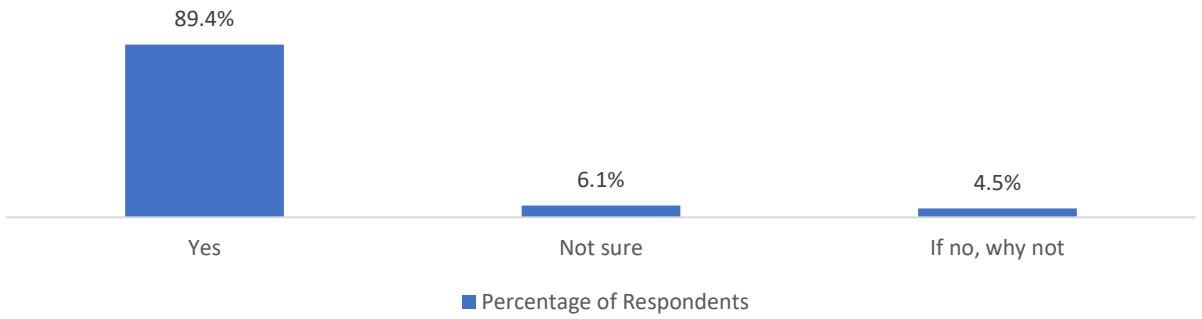


Figure 180: Does the agency where you are employed, or volunteer, adhere to recovery support best practices?

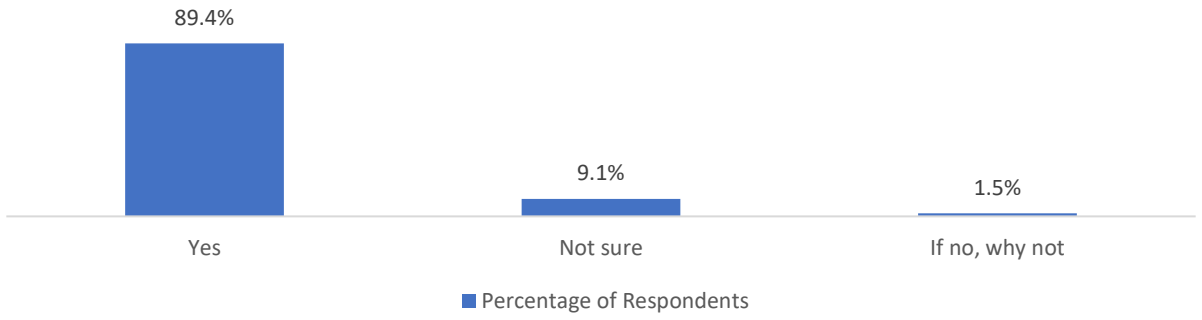


Figure 181: Please indicate the qualifications that best describe your status. (Check all that apply)

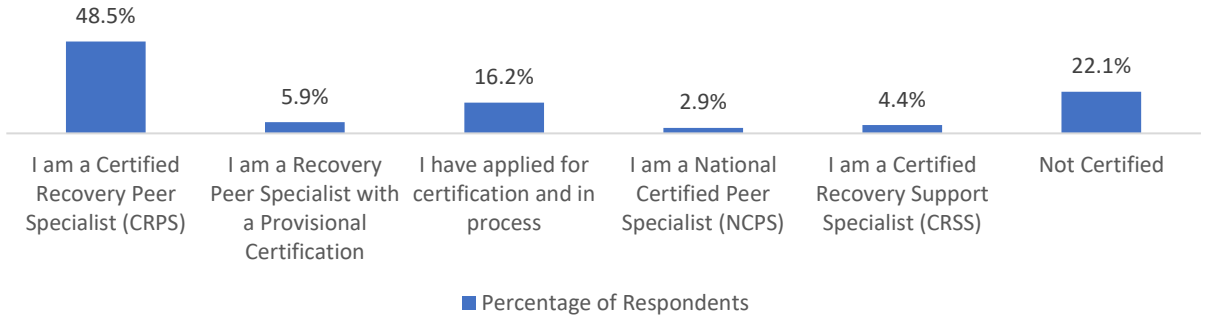
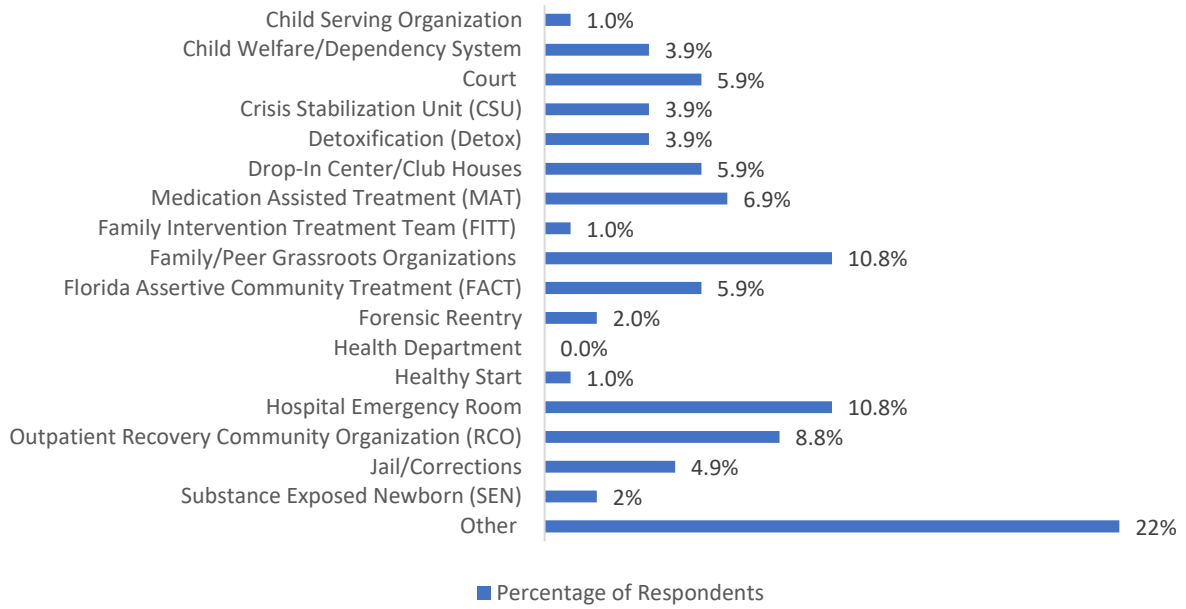


Figure 182: Please indicate the facility/program setting(s) that best describes where you deliver peer recovery support services. (Check all that apply)



Note: Family/Peer Grassroots Organizations (NAMI, Federation of Families, etc.)

Figure 183: What are the reasons/factors for staying with the company? (Check all that apply)

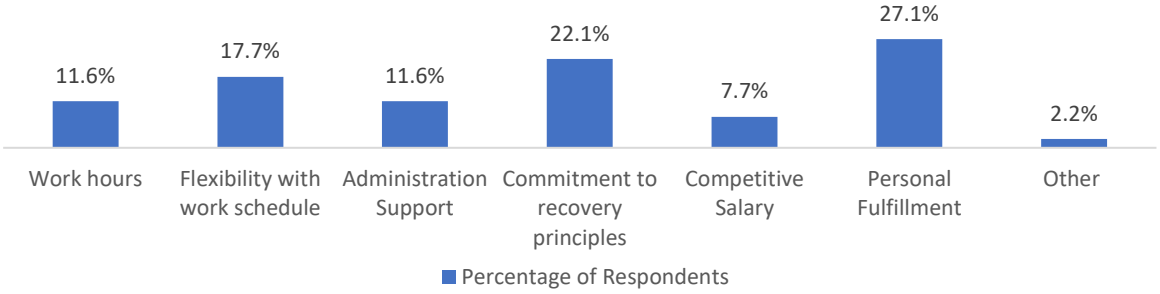


Figure 184: What barriers/challenges have you experienced in the hiring process? (Check all that apply)

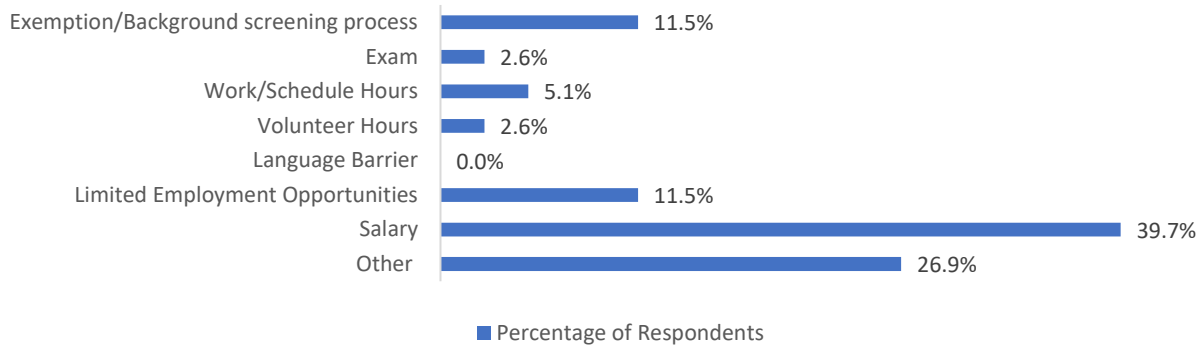
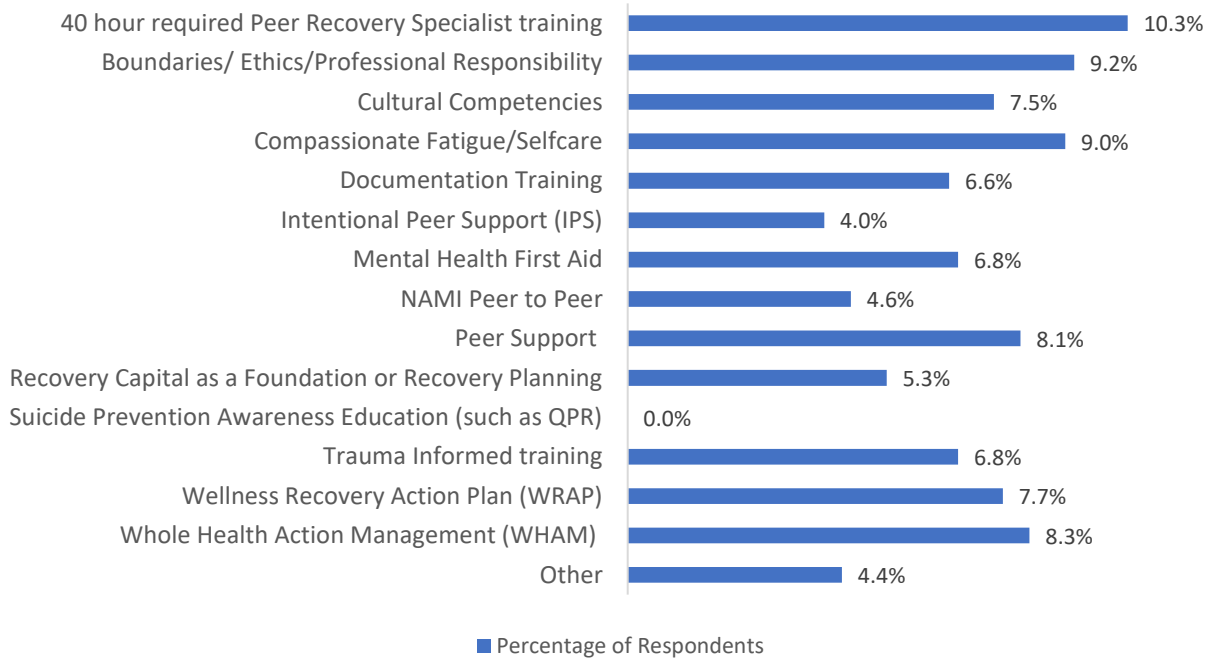


Figure 185: What training would you recommend for peers to have to help them provide peer support services? (Check all that apply)



Note: 40 hour required Peer Recovery Specialist training/Helping Others Heal

Figure 186: Are there partnerships that exist with peer support recovery programs, recovery community organizations, and other support groups?

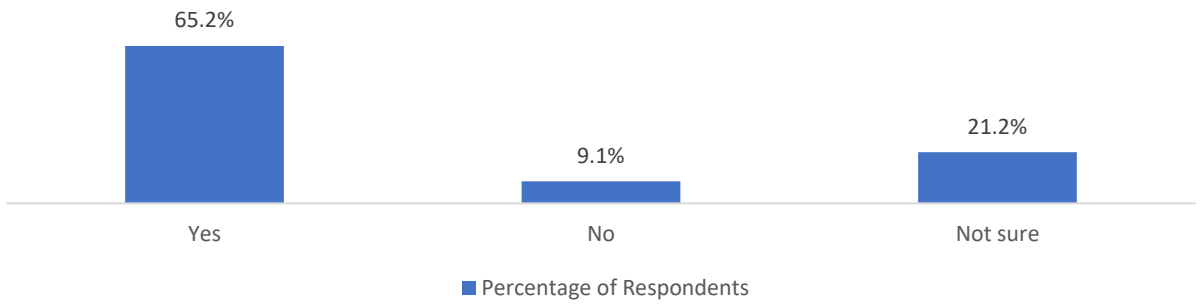


Figure 187: Are you aware of partnerships with other organizations that provide other resources such as: (Check all that apply)

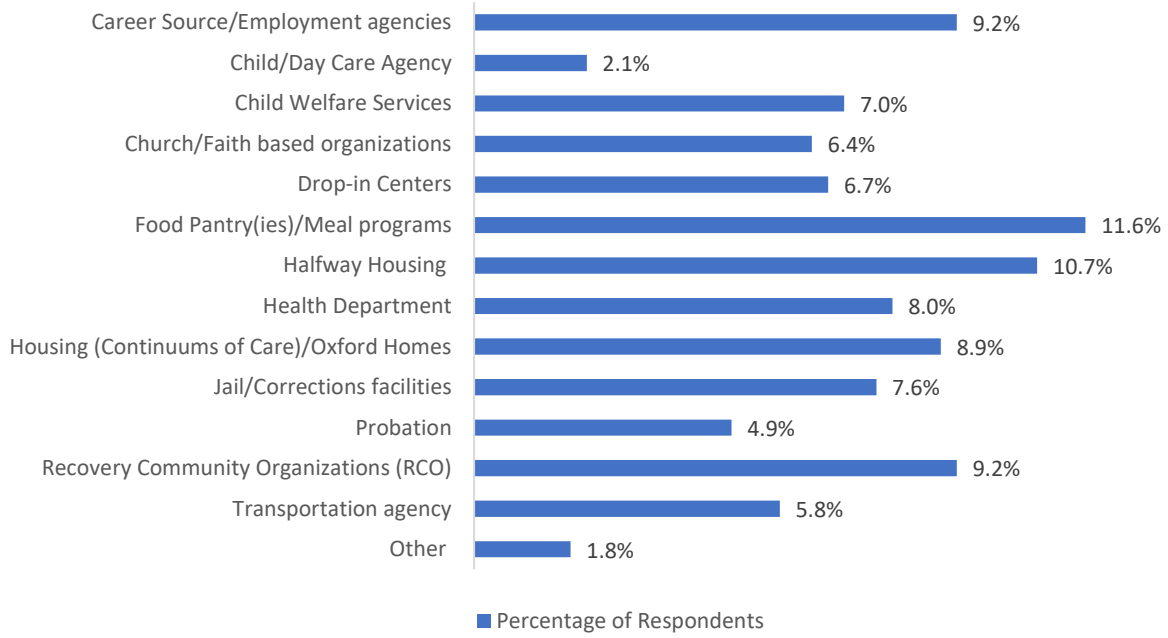


Figure 188: Do you have the ability to offer choices to the individuals where you serve at the agency you are employed/volunteer?

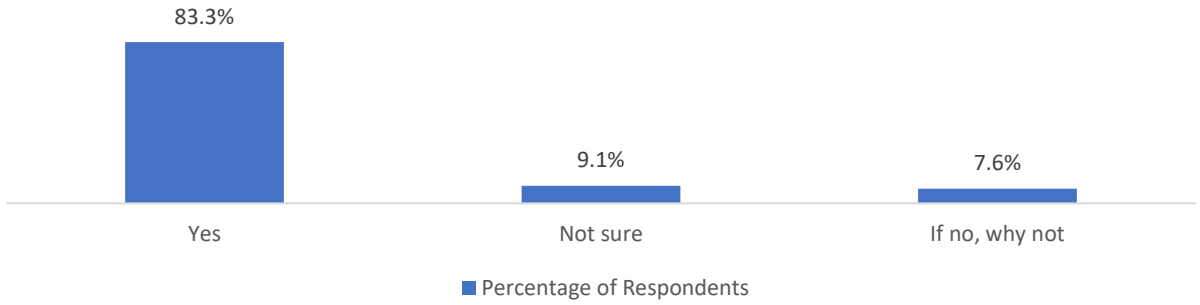


Figure 189: Does the organization where you are employed/volunteer with help to reduce stigma by promoting recovery language that is patient centered?

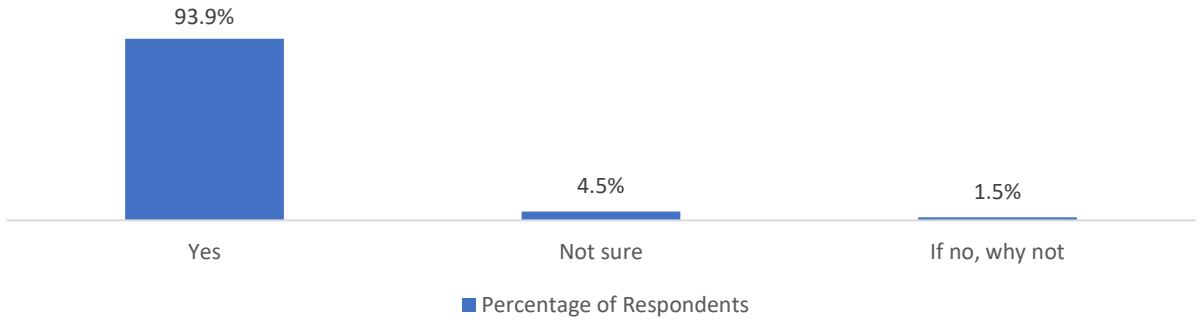


Figure 190: Does the agency where you are employed/volunteer include peers in developing and promoting effective program development, evaluation, and improvement?

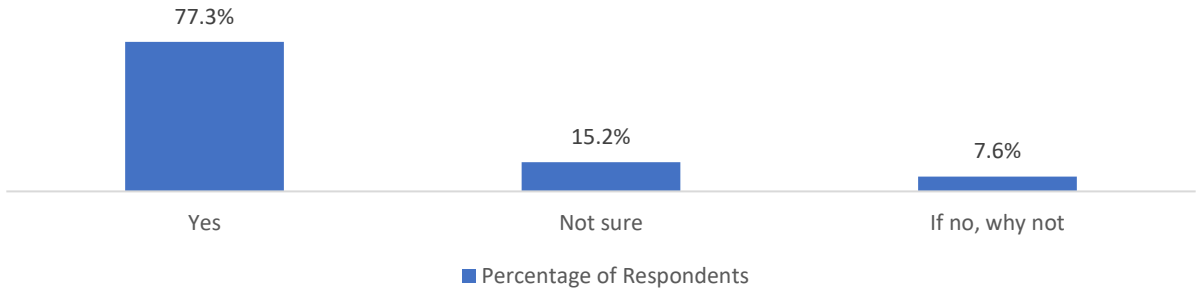
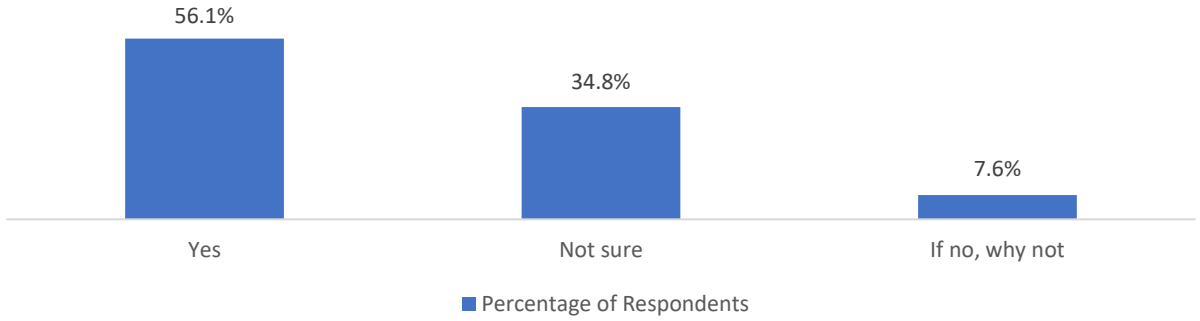


Figure 191: Does the agency where you are employed/volunteer with include persons in recovery management and board meetings?



RECOVERY ORIENTED SYSTEM OF CARE RESOURCES

CFBHN
RECOVERY ORIENTED SYSTEM OF CARE RESOURCES

ACTS Adult Addiction Receiving Facility	Florida Treatment for Change
ACTS Juvenile Addiction Receiving Facility	Footprints Beachside Recovery
ACTS Thonotosassa Youth Residential	Frankies Place Counseling & Prevention Services
Agency for Community Treatment Services (ACTS)	Gracepoint Adult Outpatient & Assessment Center
Alternatives in Behavioral Health	Hazelden Betty Ford Foundation
Calusa Recovery	Lakeland Centers
Centerstone of Florida Sawyer Road	Lifeworks Substance Abuse Services
Coalition Recovery	Multiple Innovations to Recovery 7 Summit Pathways
Cove Behavioral Health Medication Assisted Treatment Program	Naples Metro Treatment Center of Florida
Cove Behavioral Health Outpatient & Opiate Addiction Treatment Services	Nextep
Crossing Bridges of the Palm Beaches	North Tampa Behavioral Health
Detox of South Florida	Operation PAR Highpoint
Dignity Healing	Operation PAR Therapeutic Community

Fairwinds Treatment Center Residential	Park Royal Hospital
River Oaks Treatment Center	Tri-County Human Services Agape Halfway House
SalusCare Transitional Living Center	Tri-County Human Services/5-Bed Project FL Center
Sarasota County DUI & Drug Court	Tri-County Human Services/RASUW Center for Women
Solutions	White Sands Alcohol & Drug Rehab
Spencer Recovery Centers Florida	White Sands Alcohol & Drug Rehab Fort Myers
Tampa Crossroads Non-Residential Counseling Services	White Sands Treatment Center
Tampa Crossroads Rose Manor Women's Residential Program	White Sands Treatment Center Clearwater Alcohol & Drug Rehab
Terrace Landing Finest Medical Center	White Sands Treatment Center Sarasota Alcohol & Drug Rehab
Tranquil Shores	White Sands Treatment Center Alcohol & Drug Rehab
Tri County Human Services Detox Unit	The Willough at Naples

Source: SAMHSA

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ACS Table S1810. Census - Table Results

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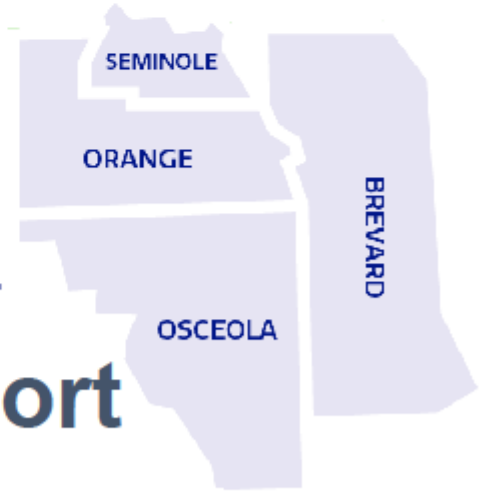
Central Florida Cares Health System

2022

Florida Cultural Health Disparity & Behavioral Health Needs Assessment



Regional Report

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Brevard 2-1-1
AdventHealth
Aspire Health Partners
Brevard C.A.R.E.S.
Brevard Family Partnership
CFSATC, Inc.
Children's Home Society
Circles of Care
Community Counseling Center of Central Florida, LLC
Devereux
Eckard Connects
Gulf Coast Jewish Family and Community Services
Heart of Florida United Way
House of Freedom
IMPOWER
Informed Families
LifeStream Behavioral Center
Mental Health Resource Center
Metro Treatment of Florida, L.P.
Orlando Health/The Healing Tree
Park Place Behavioral Health Care
Peer Support Space, Inc.
Project Opioid
Recovery Connections of Central Florida
Space Coast Health Centers
Space Coast Recovery
Specialized Treatment, Education, and Prevention Services, Inc. (STEPS)
The RASE Project
The Transition House
University Behavioral Center
Volunteers of America
Wayne Densch Center
&
Allison Griswold – Behavioral Risk Factor Surveillance System Florida Department of Health
Central Florida Cares Individuals Served
Karla Pease – Central Florida Cares Health System, Inc.
Justine Gunderson – Division of Community Health Promotion FDOH
Focus Group Facilitators
Focus Group Participants

May 30, 2022

To Our Valuable Stakeholders,

Central Florida Cares Health System, Inc. (CFCHS) is pleased to announce the release of the 2022 Behavioral Health and Cultural Disparity Needs Assessment (BHCD). This needs assessment was successfully conducted with input from persons served, community stakeholders, and data from multiple state and private sectors. The 2022 BHCD process for CFCHS' region included survey input from individuals served, community stakeholders, provider organizations, peer recovery community, and cultural disparity; persons-served focus groups; and interviews with provider organizations. The 2022 BHCD analyzes the service capacity, identifies gaps and opportunities in our region.

Central Florida Cares Health System, Inc., Managing Entities, is a not-for-profit organization contracted by the Department of Children and Families to oversee state-funded mental health and substance abuse treatment services in Circuits 9 and 18 (Brevard, Orange, Osceola, and Seminole counties). As a managing entity, CFCHS is a behavioral health administrative and management organization with a primary focus to promote a comprehensive, seamless system of recovery and resiliency to those individuals in the community who are in need of these services.

This needs assessment will serve as the foundation for developing a strategic plan to address the behavioral health needs for our community. Participation in the development and execution of a data-driven process has the potential to enhance program effectiveness, leverage limited financial resources, and strengthen the public health system. Collaboration among community partners can lead to improved health outcomes for our community.

After reviewing the needs assessment, should you have any questions or areas that you would like CFCHS to address, please let us know.

Sincerely,

Maria Bledsoe
Chief Executive Officer

Maria Bledsoe, Chief Executive Officer, Central Florida Cares Health System, Inc. | 407-985-3560 | 707 Mendham Blvd., Suite 201 | Orlando, FL 32825

www.CentralFloridaCares.org

EXECUTIVE SUMMARY

INTRODUCTION

Central Florida Cares Health System, Inc. (CFCHS) is one of seven Managing Entities (ME) in Florida which serve as regional systems of care. This structure enables the ME to tailor funding to meet the specific behavioral health needs in various regions throughout Florida. Since July 2012, Central Florida Cares has managed state and federal funds for substance use and mental health services (also known as behavioral health services) for Brevard, Orange, Osceola, and Seminole counties. CFCHS is a CARF International Accredited Services Management Network organization. CFCHS funds a services network comprised of many organizations offering various levels of treatment options. These options include prevention, interventions, crisis support, residential treatment, and outpatient services, and opioid MAT services for adults, children, and families. CFCHS' mission is to manage an affordable, high-quality behavioral health care system for persons with mental health and/or substance use disorders, with a vision to achieve a comprehensive and seamless behavioral health system promoting recovery and resiliency. CFCHS is dedicated to serving persons in need of mental health and/or substance use services by providing the best possible information, options, and resources available in our community. CFCHS' primary objective to ensure that all individuals are given their "first step towards success" by putting the person served "first" in all aspects of our operation.

This report, prepared for CFCHS, is a compilation of primary and secondary data that identifies behavioral health needs, and the community assets available to advance the health care delivery system to improve outcomes for all residents.

HB945 Children's Mental Health

It should be noted in addition to this statewide assessment which includes the CFCHS report, House Bill 945 (Children's Mental Health) went into effect in July 2020 requiring Managing Entities to lead the development of a plan promoting a coordinated system of care which: (1) integrates services provided through providers funded by the state's child-serving systems, and (2) facilitates access by children and adolescents, as resources permit, to needed mental health treatment and services at any point of entry regardless of the time of year, intensity, or complexity of the need, and other systems with which such children and adolescents are involved, as well as treatment and services available through other systems for which they would qualify.

The planning process shall include: examining children and adolescents with behavioral health needs and their families, behavioral health service providers, law enforcement agencies, school districts or superintendents, the multiagency network for students with emotional or behavioral disabilities, the Florida Department of Children and Families, representatives of the child welfare and juvenile justice systems, early learning coalitions, the Agency for Health Care Administration

(AHCA), Medicaid managed medical assistance plans, the Agency for Persons with Disabilities, the Department of Juvenile Justice, and other community partners. An organization receiving state funding must participate in the planning process if requested by the managing entity. In addition, state agencies shall provide reasonable staff support to the planning process if requested by the ME.

The planning process considered the geographical distribution of the population, needs, and resources, and created separate plans on an individual county or multi-county basis, as needed, to maximize collaboration and communication at the local level.

Priorities were developed for each of the four counties served by CFCHS. They were grouped into Mental Health and Substance Use categories. CFCHS will collaborate with community partners in reviewing current funding resources to realign or expand services in addressing the opportunities for improvement outlined in this plan as well as those identified in the 2022 Behavioral Health Needs Assessment.

SERVICE AREA POPULATION

The population in the service area increased an average of 2.4% from 2016 to 2020. This added 264,087 residents to the CFCHS service area population. The total population in 2020 grew over the past 5 years to a total of 2,899,334 individuals. Racially, the service area is predominately White (67.3%), with the Black population accounting for 15.8%, Asian residents at 4.2%, 5.6% of residents are of other races, and 6.8% belong to more than one racial group. The Hispanic population represented 28.8% of the service area population which was slightly higher when compared to the state at 25.8%. Participation in the labor force was 6.4% (2016 to 2020). Unemployment, at 3.4%, was slightly lower than the state at 5.6%. The percentage of individuals living below 200% of the Federal Poverty Level (FPL) was 26.4% while those living above 400% FPL was 42.4%.

Overall, 80% of residents reported good health and 86.8% reported good mental health. The number of unhealthy mental days in the past 30 days, at 4.2, was below 4.4 days for the state. The crude suicide rate decreased from 13.8/100,000 in 2018 to 11.9/100,000 in 2020. Suicides among males at 19.1/100,000 were more than triple the rate among females at 5.1/100,000. The suicide rates for the White population, at 14.1/100,000, exceeded the rate among the Black population (5.3/100,000), and the Hispanic population (5.8/100,000). Suicide rates in the state were higher among White and Hispanic populations, but similar for the Black population.

The estimated numbers of seriously mentally ill adults, and emotionally disturbed youth, increased from 2018 to 2020.

Only 12.8% of adults reported being a current smoker. Binge drinking affected 17% of adults. Among middle and high school students, 91% reported never smoking, and 90.2% reported never vaping nicotine. When asked about having alcoholic drinks in their lifetime, 64.7% had not had

any. Close to 80% of students had not smoked marijuana in their lifetimes and 89.3% reported never vaping marijuana.

The percentage of the civilian noninstitutionalized population with a disability was 12.6% (2016-2020). Disability includes hearing, vision, cognitive, ambulatory, self-care, and independent living. Of those with a disability, 9.4% were ages 18 years and younger while 40.8% were ages 65 years and older. This was lower that the state rate for this population group at 48.9%. The percentages of adults with any type of health insurance in the service area, and the state, were almost identical at 82.4% and 84.2%, respectively.

HOMELESS POPULATION IN THE SERVICE AREA

The Department of Housing and Urban Development (HUD) requires Continuum of Care's (CoC) to count the number of people experiencing homelessness in their geographical area through the Point in Time (PIT) count. CoCs are geographically designated by HUD and served by a local planning body which is responsible for organizing and delivering housing and services to meet the needs of people who are homeless. In 2021, the Florida Council on Homelessness reported there were 1,976 homeless individuals in Central Florida (Brevard, Orange, Osceola, and Seminole counties). Although all were sheltered, due to COVID-19 Brevard did not conduct an unsheltered PIT Count, and Orange, Osceola and Seminole counties conducted a modified PIT count. Chronically homeless, defined as continually homeless for over 1 year, increased from 335 individuals in 2017 to 734 people in 2020. There were 192 chronically homeless individuals in 2021. Homelessness among veterans decreased during the same period from 405 in 2017 to 309 in 2020. Families experiencing homelessness also decreased during 2015 to 2019. The number of homeless students, 14,286 in the 2015-2016 academic year 2013-2014, decreased 25.5% to 10,641, in 2019-2020. Of those students who were homeless in 2019-2020, close to 70% were in a sharing housing arrangement, and 24.4% were living in motels.

CFCHS INDIVIDUALS SERVED POPULATION

CFCHS-funded organizations served 27,681 individuals in FY20-21. Over 40% of individuals resided in Orange County, followed by Brevard County at 29.4%, Seminole County at 14.2%, and Osceola County at 9.9%. Individuals who reported their county as homeless accounted for 4,974 individuals.

Adults in CFCHS programs accounted for 81.7% of all individuals, with 41.2% enrolled in the Adult Mental Health (AMH) program, and 40.5% in the Adult Substance Abuse program (ASA). The remaining 18.3% of individuals were children/youth in the Child Mental Health (CMH) program (7%), and the Child Substance Abuse (CSA) program at 11.3%.

CFCHS population were more racially and ethnically diverse when compared to the service area population. The percentage of multi-racial individuals in all programs was higher when compared to the population in the service area.

Child/youth programs were more racially and ethnically diverse when compared to adults and the service area population, especially among those in the CSA program where nearly 40% of youth were Black.

Most individuals lived independently either with relatives, non-relatives, or alone. CFCHS adult population had lower educational attainment when compared to adults in the service area. The unemployment rate was at least eight times higher than the rate in the service area population.

HOMELESS INDIVIDUALS SERVED POPULATION

A total of 4,974 homeless individuals were enrolled in adult and child programs in FY20-21. Of these, 39.9% were in the AMH program, and 59.4% in the ASA program. Homeless individuals in the AMH and ASA programs were racially more diverse when compared to the general service population. Adults, ages 25-44 years, accounted for 55.9% of AMH, and 64% of ASA individuals. Among the homeless individuals, 78.8% did not have more than a high school education. Over 30% of homeless individuals had not earned a high school diploma.

CULTURAL HEALTH DISPARITY SURVEY AND FOCUS GROUP

A cultural health disparity survey was conducted for the first time for this assessment. The goal of the survey was to gain insight from respondents regarding access, quality, and culturally appropriate treatment, by defining the health care settings that are most comfortable for individuals served. The survey consisted of 14 questions including demographics. To survey individuals most in need and at a high risk for disparity, the surveys were distributed in vulnerable communities using the CDC Social Vulnerability Index (CDC SVI). This index uses U.S. Census data to determine the social vulnerability of every census tract.

The data from the survey was analyzed. Questions were developed to further validate the findings through focus group research. Most respondents were comfortable seeking behavioral health services and trusted the system to treat them with respect. Close to 30% of respondents preferred receiving services in a private office with a doctor and 27% were comfortable with telehealth and hybrid telehealth settings. Over 90% of respondents received services in their primary language all or most of the time.

The NO WRONG DOOR MODEL SURVEY AND FOCUS GROUP

For the assessment, CFCHS Network Service Providers (NSPs) completed a 16-question survey on the key elements of the No Wrong Door (NWD) model. NSP's were offered the opportunity to participate in a focus group to further investigate the challenges revealed in the survey data.

Most survey respondents worked with adult programs (residential and outpatient), and peer recovery support. About one-quarter of respondents worked with children in residential and outpatient settings. Most NSP's promoted awareness of options and linkages to needed services,

agreed that services were patient centered and culturally competent, and that the services provided were of high quality, with continuous evaluation undertaken to improve outcomes. Providers were divided on whether all individuals have equal access to services and how effective stakeholders were in helping to advocate for equal access.

Focus group discussion revealed that all organizations are a door while continually striving to be the right door. NSP's use many tools to help individuals plan their pathway to recovery. Each recovery plan that is developed is as individual as the individual themselves.

One of the biggest barriers to getting individuals into care was the lack of available staff. NSP's shared that most applicants are not qualified when they apply for the position. A lack of support staff, such as kitchen and cleaning, causes beds to remain empty. With such a limited pool of workers to select from, the competition between organizations is intense. There are those who can offer bonuses or promotions to attract potential employees. Those who cannot make such offers struggle with too few staff that quickly become overworked.

Equal access was further investigated based on the survey data analyzed. NSP's identified several reasons why access may not always be equal. Insurance companies with their ever-changing networks, lack of affordable housing, living in a geographic location with limited resources, lack of transportation, and referral and funding restrictions were some of the issues that prevented individuals from getting the care they needed when they needed it. Waitlists also contributed to inequality.

NSP's offered ideas on how the system could be improved. Suggestions included: funding and program expansion, increased autonomy, eliminating some insurance barriers, and having state funding cover additional expenses for those without insurance.

INDIVIDUALS SERVED SURVEY

The Individuals Served Survey was distributed by CFCHS NSP's. The survey was designed to measure the experience, awareness, and coordination of behavioral health services for those served by CFCHS NSP's.

Awareness of services among individuals served in CFCHS service area increased over the past 3 years. Close to 60% of individuals served were aware of the 2-1-1 information and referral resource in their community, and over half of those who accessed 2-1-1, found it to be helpful. Housing, aftercare/follow up, and crisis stabilization were the three most needed services that individuals were not able to receive. Waitlists prevented 16.5% of respondents from getting the services they needed and was one of the biggest obstacles to obtaining care. Other obstacles included staff turnover with lack of transition, lack of phone call response, and not taking on new patients. Most respondents received services and planning that was patient centered. Close to 60% of respondents were able to access services within a 15-minute travel time.

STAKEHOLDER SURVEY

CFCHS staff, NSP's, the Health Council of East Central Florida, Inc. (HCECF), and community organizations participated in the distribution of this survey to measure awareness, linkages, accessibility, and define barriers to behavioral health services.

Stakeholder respondents represented 24 community sectors in CFCHS service area. When asked specifically about CFCHS, 78% were aware of the resources provided by the managing entity. Of those that accessed CFCHS services, 90.5% reported that the agency's resources were helpful.

Over 95% of stakeholders had knowledge of the 2-1-1 resource. This was an increase from 80% in 2019. Less than 20% of stakeholders reported that community awareness of behavioral health services was good to excellent. Less than 50% of stakeholders felt that links to services were well coordinated and established. Stakeholders were split on whether referrals were easy with 32% disagreeing, 29.5% were neutral, and 38.6% agreed. Lack of transportation remained the number one barrier to accessing services. Unaffordability, and not knowing where to go for services, were also among the top barriers. Stakeholders indicated that affordable housing is desperately needed for improving patient-centered care and planning. There were also provider shortages that have resulted in understaffed offices. This was one of the identified contributors to long waitlists for services. Among the top three patient-centered care resources that have improved the quality of life, stakeholders identified peer support, case management, and mobile response.

PEER RECOVERY COMMUNITY/SUPPORT SPECIALIST SURVEY

A recovery system that builds on the strengths of individuals, using the full range of community support services required to achieve substance use abstinence, will improve the mental health, physical health, wellness, and quality of life for those with or at risk of drug or alcohol problems. The Peer Recovery Community/Support Specialists survey respondents represented agencies that provide mental health services, peer support, transitional shelter, family dependency drug court, human trafficking survivors, and crisis stabilization units. Most agencies adhere to recovery support best practices and organizations are effective in reducing stigma by promoting recovery language that is patient centered. One-third of respondents were a Certified Recovery Peer Specialist. The biggest barriers encountered during the hiring process were attributed to salary and the exemption/background screening process. Respondents reported that partnerships existed with peer support recovery programs as well as with other organizations that provided needed resources. In most organizations, peers were included in developing and promoting effective management evaluation.

MOVING FROM WHERE WE ARE TO WHERE WE WANT TO BE

A comprehensive, seamless, and culturally competent behavioral health system that promotes recovery, while ensuring equal access, can be developed with measurable objectives tied to realistic action plans. This assessment serves as the foundation for strategically addressing the key

behavioral health care needs as defined by individuals served, peers, NSP's, and stakeholders. Planning efforts should be undertaken to address the identified barriers while continually building upon the many strengths within the current system of care.

CFCHS SERVICE AREA DEMOGRAPHIC PROFILE

Population Demographics

Population in the service area increased an average of 2.4% each year from 2016 to 2020. The total population growth for the 5-year period, at 10%, added 264,087 residents.

In the service area and the state, females accounted for slightly more than 50% of the population when compared to their male counterparts.

The racial composition in the service area and state was predominately White at 67.3% and 71.6%, respectively. The Black population accounted for 15.8% of the service area population and 15.9% of the population in Florida. American Indian and Native Hawaiians represented less than 1% of residents in both population groups. The percentage of Asian residents, at 4.2%, was higher in the service area when compared to the state at 2.8%. The service area was slightly more diverse when compared to the state with 5.6% having a race of Other and 6.8% of residents belonging to more than one racial group.

Ethnically, the service area had a slightly higher percentage of Hispanic residents, at 28.8%, when compared to the state at 25.8%.

The CFCHS service area population was younger when compared to the age distribution at the state level. Residents, 65 years of age or older, accounted for 15.2% of the population while in the state of Florida 20.5% of residents were at least 65 years old.

Education and Employment

Data revealed the service area and state populations were very similar regarding education attainment. Slightly more residents in the service area attained a high school diploma (90.1%) when compared to the state at 88.5%. Residents in the service area also had higher percentages of individuals who graduated from college (23.8%) or held graduate or professional degrees (11.8%), when compared to the state at 29.3% and 11.3%, respectively.

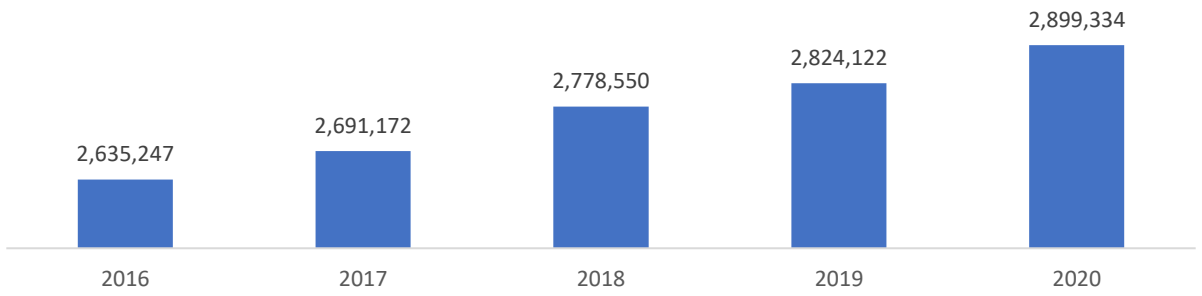
On average, 64% of the service area population participated in the labor force over the past 5 years. This was higher when compared to those employed in Florida at 58.9%. The 5-year unemployment rate estimate for the service area, at 3.4%, was below the state rate at 5.4%.

Poverty Status

During 2016 to 2020, the ratio of income to poverty rates for all categories were almost identical for the service area and the state. The rates of those living <200% of the Federal Poverty Level (FPL) were 26.4% and 26.3%, respectively.

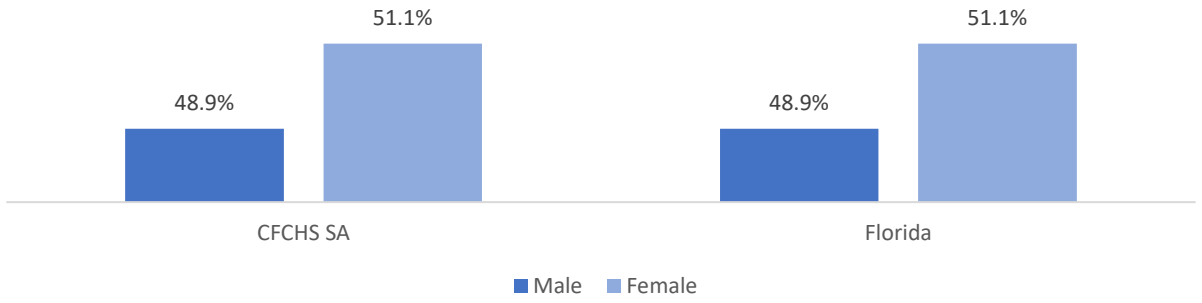
DEMOGRAPHIC CHARTS

Figure 1: CFCHS Service Area Population Estimates (2016-2020)



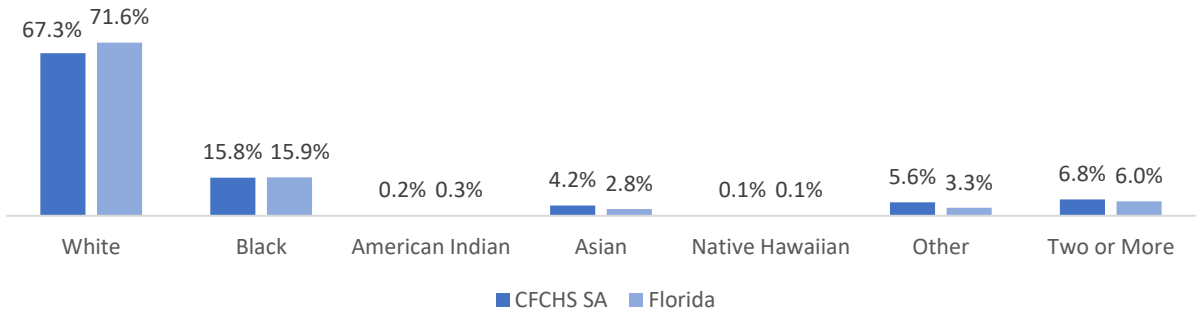
Source: Florida Legislature's Office of Economic and Demographic Research (EDR)

Figure 2: CFCHS Service Area County Population by Gender (2016-2020)



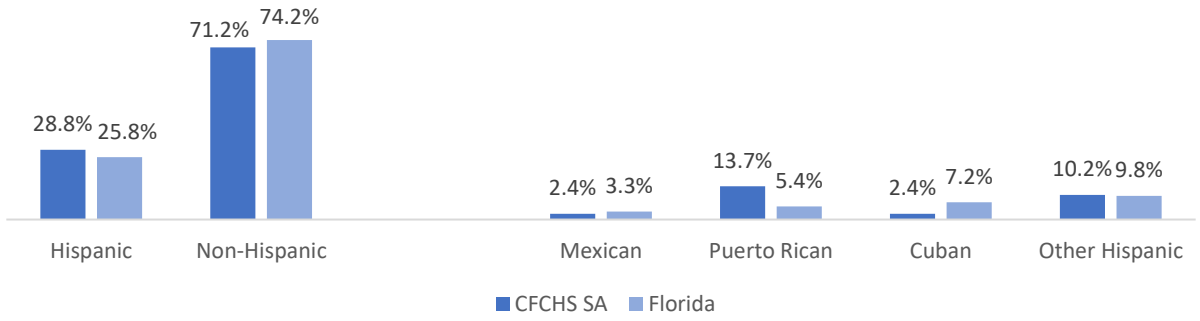
Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 3: CFCHS Service Area County Population by Race, 2016-2020 (5-Year Estimate)



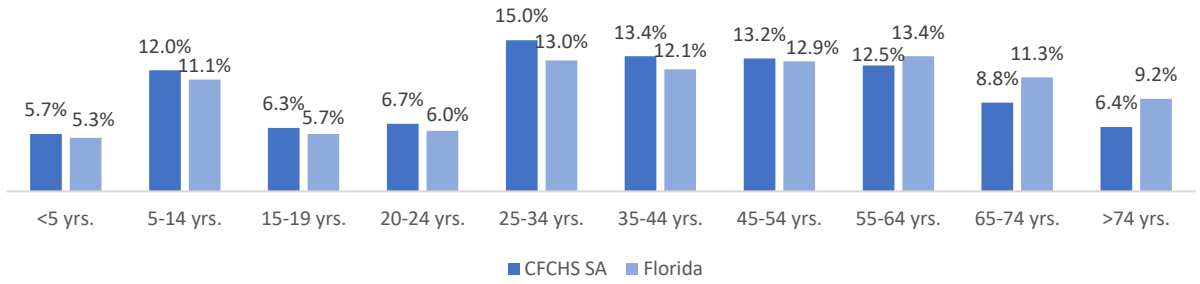
Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 4: CFCHS Service Area Population by Ethnicity, 2016-2020 (5-Year Estimate)



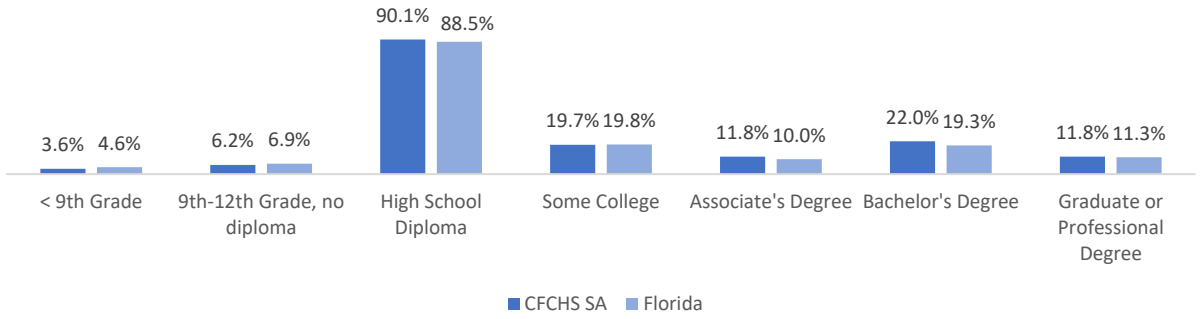
Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 5: CFCHS Service Area Population by Age Range, 2016-2020 (5-Year Estimate)



Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 6: CFCHS Service Area Population by Educational Attainment, 2016-2020 (5-Year Estimate)

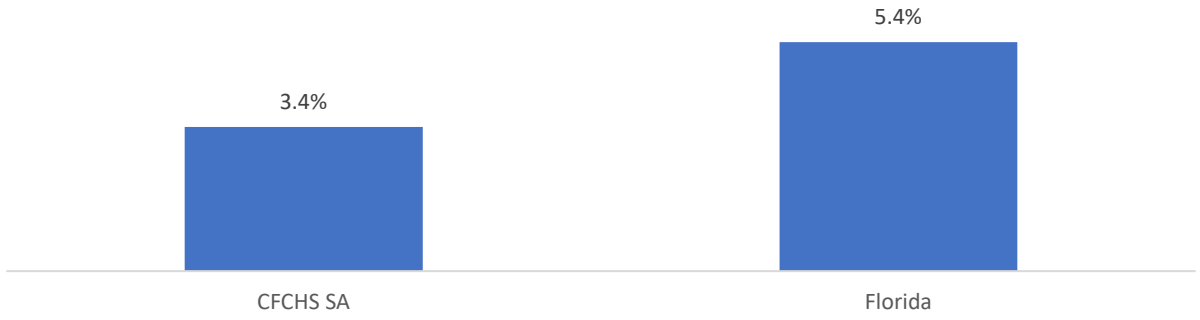


Source: U.S Census Bureau, American Community Survey, Table S1501

Figure 7: CFCHS Service Area Population Participation in Labor Force, 2016-2020 (5-Year Estimate)

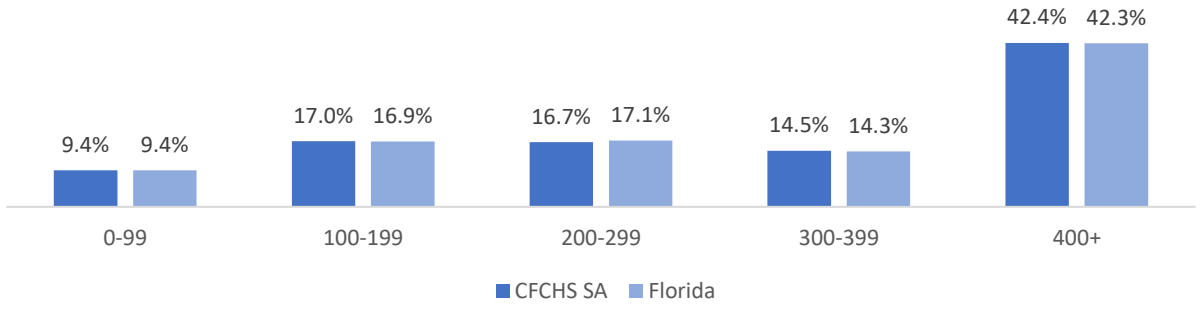
Source: U.S Census Bureau, American Community Survey, Table DP03

Figure 8: CFCHS Service Area Population Unemployment Rates, 2016-2020 (5-Year Estimate)



Source: U.S Census Bureau, American Community Survey, Table DP03

Figure 9: CFCHS Service Area Population Ratio of Income to Poverty Level of Families, 2016-2020 (5-Year Estimate)



Source: U.S Census Bureau, American Community Survey, Table B17026

CFCHS SERVICE AREA GENERAL HEALTH STATUS

Overall, Health Status

The Behavioral Risk Factor Surveillance System (BRFSS) is the nation's premier system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. BRFSS data estimates revealed 79.8% of adults, ages 18-64 years of age, living in the CFCHS service area said their overall health was "good" to "excellent" (2017 to 2019). For Florida, the rate was 80.3%. This knowledge is a powerful tool for targeting and building health promotion activities. It also provides a way to see change in population health behaviors before morbidity or disease is apparent.

Mental Health

The average percentage of adults in the CFCHS service area reporting good mental health over the past 3 years, at 86.8%, was just above the rate for the state at 86.2% (2017 to 2019). The number of unhealthy mental days for the service area population, at 4.2 days in the past 30 days, was just below the rate among all adult residents (ages 18-64 years) in Florida at 4.4 days in the past 30 days.

Suicide

The CFCHS service area crude suicide death rate decreased from 13.8/100,000 in 2018 to 11.9/100,000 population in 2020. This represents a decrease of 1.9/100,000 suicide deaths. At the state level, the suicide crude death rate decreased 2.5/100,000 population during the same time. Among males, the suicide death rate for the service area and state was more than triple the rate among females. The suicide death rate among the White population was almost three times the rate for Black residents in the CFCHS service area. The same held true at the state level where White to Black suicide deaths revealed a 3.2:1.0 ratio. It should be noted that the calculations required for the age-adjusted death rate for the service areas was beyond the scope of this project.

Violence and Abuse

According to the Department of Law Enforcement Uniform Crime Report 2019, the rate of total domestic violence offenses decreased in the CFCHS service area and the state from 2017 to 2019. The rate fell from 633.8/100,000 to 585.0/100,000 over the past 3 years. This was still higher than the state rate of 496.5/100,000 in 2019.

The rate of children experiencing child abuse over the past 3 years (2017 to 2019) continually decreased in the service area and state. Among children ages 5-11 years, the rate of child abuse fell from 758.4/100,000 in 2017 to 534.8/100,000 in 2019. This trend was observed in the state

rates, which also decreased from 857.9/100,000 to 662.7/100,000 during the same time (Department of Children and Families, Florida Safe Network Data Mart).

Child sexual abuse rates changed very little from 2017 to 2018 but increased from 2018 to 2019. In the service area, the 2019 sexual abuse rate for children 5-11 years was 59.0/100,000. This was higher than the state rate at 57.8/100,000 (Department of Children and Families, Florida Safe Network Data Mart).

Mental Illness

The estimated number of seriously mentally ill (SMI) adults in the CFCHS service area increased by almost 5% over the past 3 years. The rate of increase at the state level was 3.5%. The estimated number of SMI adults in the service area was 88,991 in 2020.

Among youth, ages 9-17 years, the estimated number of those emotionally disturbed increased over 4% from 2018 to 2020. This was higher when compared to the state increase of 3%.

According to the Florida Department of Education (FLDOE), service area children in grades K-12 who had an emotional/behavioral disability, decreased from 0.4% to 0.3%, during the past 3 years (2018 to 2020). In the state, students with an emotional/behavioral disability accounted for 0.5%. These rates have been steady over the past 3 years.

Adult Tobacco and Alcohol Use

BRFSS results revealed the percentage of adults living in the service area who are current smokers, at 12.8% (2017 to 2019), was lower when compared to the state at 14.8%.

Binge drinking is defined as 5 consecutive drinks for men and 4 consecutive drinks for women. For 2017 to 2019, the percentage of binge drinkers in the service area was 17%. The percentage of binge drinkers in the state was slightly higher at 18%.

High School Tobacco, Alcohol and Substance Use

The Florida Youth Substance Abuse Survey is a collaborative effort between the Florida departments of Health, Education, Children and Families, Juvenile Justice, and the Governor's Office of Drug Control. It is based on the "Communities That Care" survey, assessing risk and protective factors for substance abuse, in addition to substance abuse prevalence. Data FYSAS indicated that the percentage of middle and high school students in the CFCHS service area, who reported never having smoked cigarettes, increased from 88.6% in 2016 to 92.6% in 2020. In 2020, less than 5% of students smoked once or twice and less than 2% reported that they had smoked once in a while. For middle and high school students in the state, the percentage of those having never smoked also increased over the past 4 years.

When students were asked about smoking frequency, 98% of those living in the service area did not smoke at all. The state rate was 98.2%.

Vaping questions were included in the 2020 FYSAS for the first time. In the service area, 20.3% of students reported vaping nicotine on at least one occasion in their lifetime. Of these, 5% of students had vaped on 40 or more occasions. Rates at the state level were similar for frequency occasions of vaping nicotine in their lifetime. The percentage of students vaping nicotine during the past 30 days were much lower in the service area and the state when compared to vaped in lifetime rates. Over 90% of students had not vaped nicotine in the past 30 days.

The percentage of students who did not consume alcoholic beverages on any occasions in their lifetime ranged from 63.1% in 2016 to 64.6% in 2020. For those who did on 1-2 occasions, the percentage increased 1% from 2016 to 2020. The percentages of students consuming alcohol on more than 2 occasions ranged from 7.6% for 3-5 occasions to 2.3% for those consuming alcohol on at least 40 occasions (2020). The rates for the state were almost identical to those in the service area.

High school students were asked for the number of occasions in their lifetime when they had woken up after a night of drinking alcohol and were unable to remember the things they did or the places they went. The percentage of students reporting this event happening on at least 1-2 occasions in their lifetime (2020) in the CFCHS service area and the state was 7.5% and 7.4%, respectively. When looking at previously reported data, this was a decrease from the percentages reported in 2016 for the service area and the state. Over 85% of students in the service area and the state reporting never having this experience.

The percentages of students living in the CFCHS service area not consuming alcohol during the past 30 days increased from 83.8% in 2016 to 85.7% in 2020. The increase at the state level was greater when comparing percentages from 2016 (81.7%) to 2020, at 85.2%. The percentages of students who reported consuming alcohol on 1-2 occasions during the past 30 days decreased in the CFCHS service area and state from 2016-2020.

The overall percentage of those binge drinking, defined as consuming five or more alcoholic drinks in a row in the past 2 weeks, decreased a total of 1% over the past 4 years.

The percentages of students who had not used marijuana in their lifetimes increased over the past 4 years in the service area from 80.6% (2016) to 83.5% in 2020. For those who did use marijuana on one to more than 40 occasions, the overall percentages decreased in the service area from 19.5% in 2016 to 16.5% in 2020. At the state level, the decrease was smaller when comparing 2016, at 21.3%, to 2020 at 20.1%. The percentages of students not using marijuana in the past 30 days was higher when compared to those who reported not using it in their lifetime. The percentages of students in the service area and state who reported using marijuana in the past 30 days on one or more occasions, increased slightly in the service area while decreasing in the state. The percentages of students who reported vaping marijuana in their lifetimes on one or more occasions was lower in the service area, at 13.9%, when compared to the state at 15.6%. This was

also true when comparing the two groups of students who had vaped marijuana in the past 30 days. In the service area, 6.6% of students had vaped marijuana in the past 30 days compared to 7.3% of students in the state.

Disability

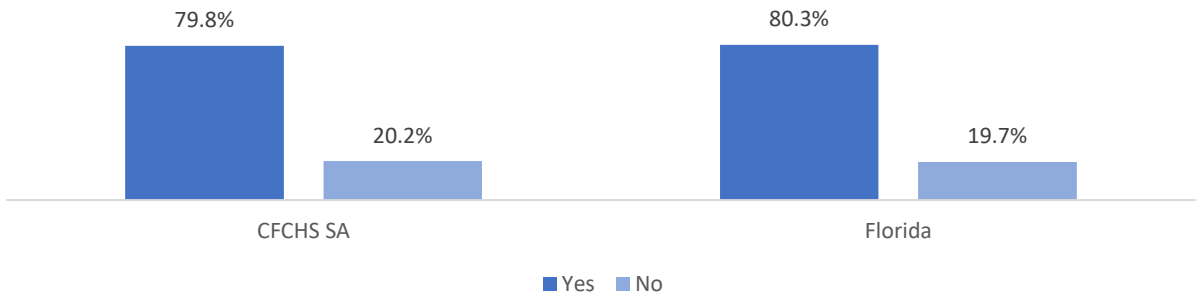
In the CFCHS service area, 12.6% of the noninstitutionalized population was estimated to have a disability (includes hearing, vision, cognitive, ambulatory, self-care, and independent living). At the state level, 13.6% of residents had a disability. The percentages of those with a disability among older adults, ages 65 years and older, was 40.8% for the service area and 48.9% in the state.

Health Insurance Coverage

Most residents, ages 18-64 years, living in the CFCHS service area and state reported having some type of health insurance coverage. The percentage of those with insurance in the state was slightly higher when compared to the service area at 84.2% and 82.4%, respectively.

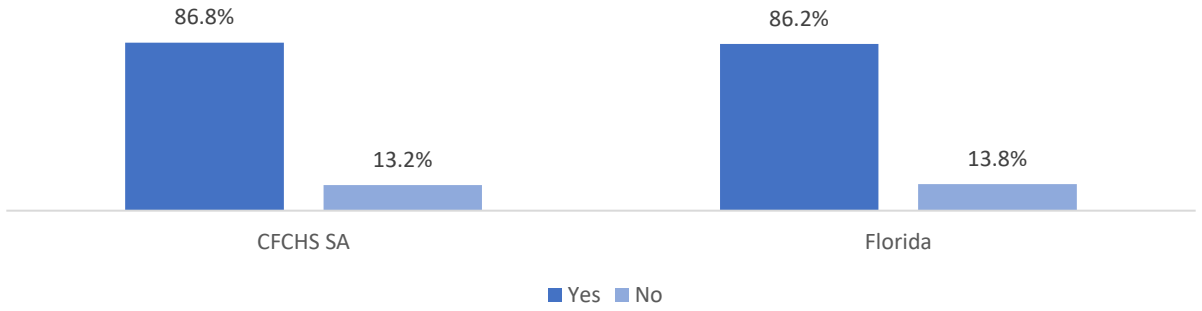
GENERAL HEALTH STATUS CHARTS

Figure 10: CFCHS Service Area Adults Who Said Their Overall Health Was "Good" to "Excellent"(2017-2019)



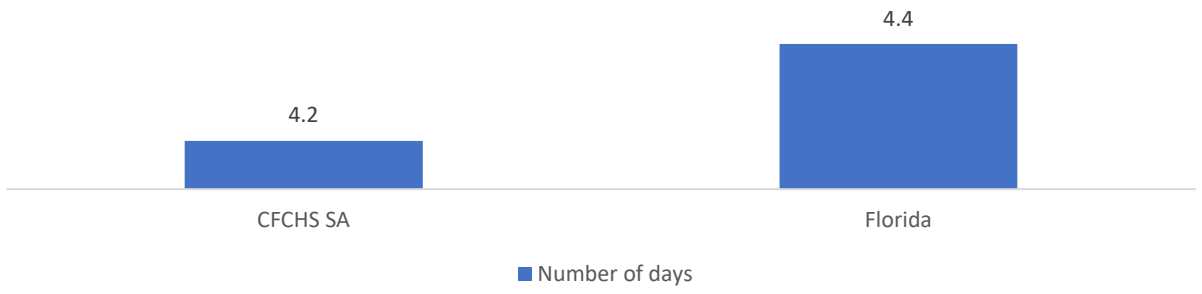
Source: Behavioral Risk Factor Surveillance System

Figure 11: CFCHS Service Area Adults with Good Mental Health for the Past 30 Days (2017-2019)



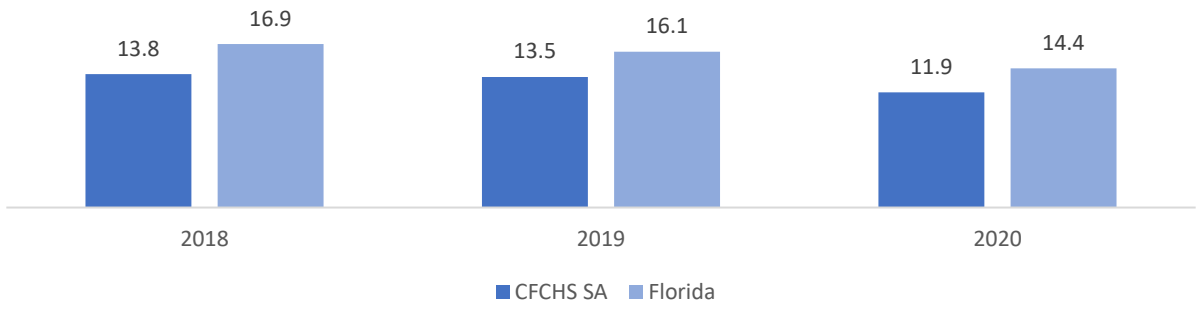
Source: Behavioral Risk Factor Surveillance System

Figure 12: CFCHS Service Area Adults Average Number of Unhealthy Mental Days in the Past 30 Days (2017-2019)



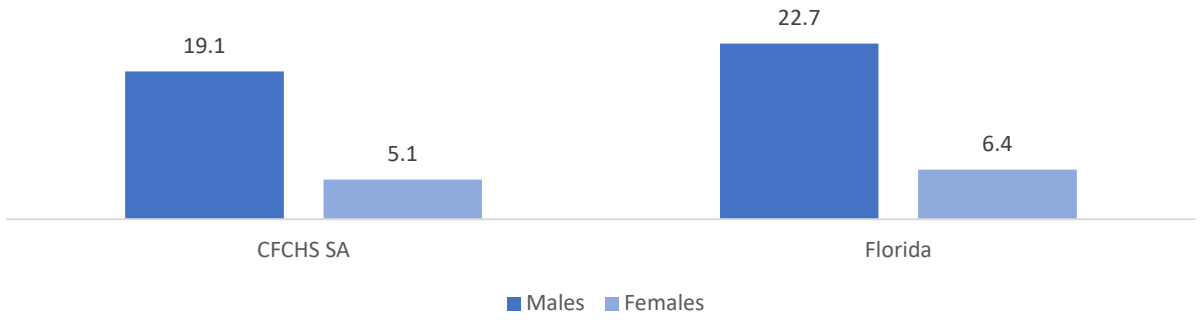
Source: Behavioral Risk Factor Surveillance System

Figure 13: CFCHS Service Area Crude Suicide Death Rates (2018-2020)



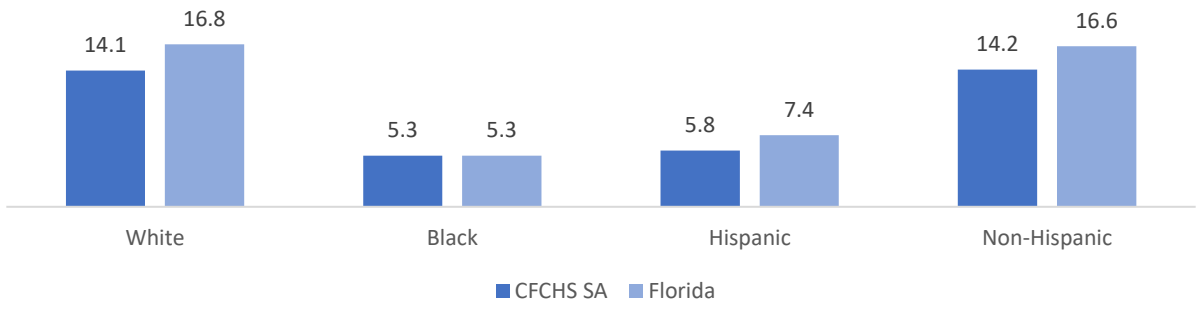
Source: Florida Department of Health, Bureau of Vital Statistics, Rate per 100,000

Figure 14: CFCHS Service Area Crude Suicide Death Rates by Gender (2020)



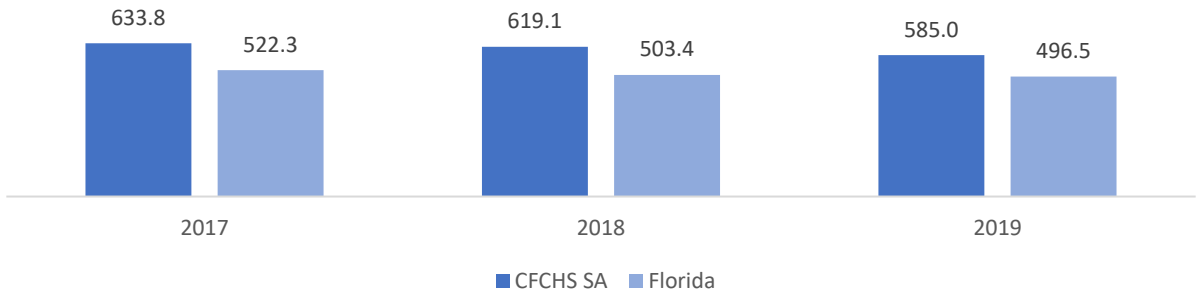
Source: Florida Department of Health, Bureau of Vital Statistics, Rate per 100,000

Figure 15: CFCHS Service Area Crude Suicide Death Rates by Race and Ethnicity (2020)



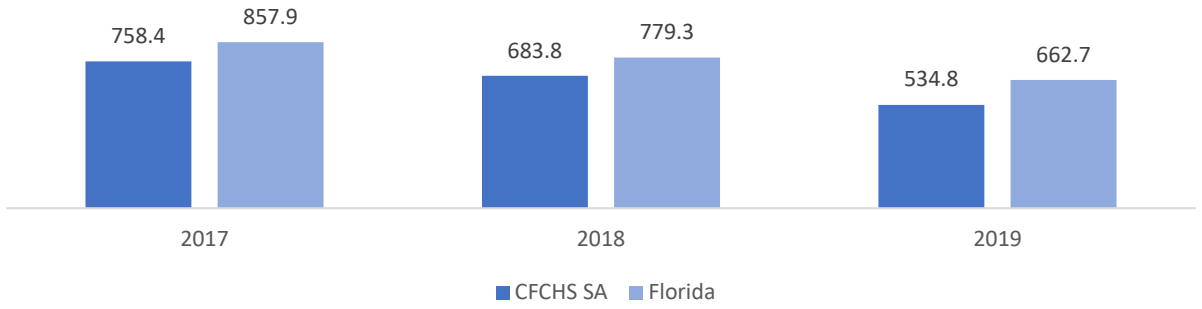
Source: Florida Department of Health, Bureau of Vital Statistics, Rate per 100,000

Figure 16: CFCHS Service Area Total Domestic Violence Offenses (2017-2019)



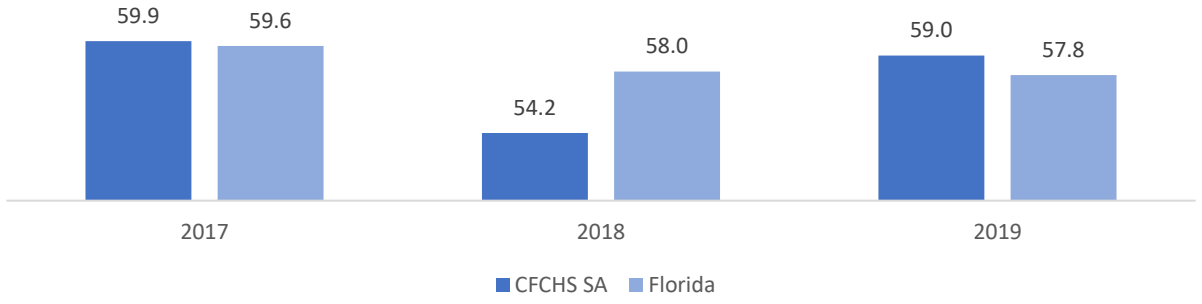
Source: Florida Department of Law Enforcement, Crime in Florida, Uniform Crime Report 2019, Rate per 100,000

Figure 17: CFCHS Service Area Rate of Children Experiencing Child Abuse, Ages 5-11 Years (2017-2019)



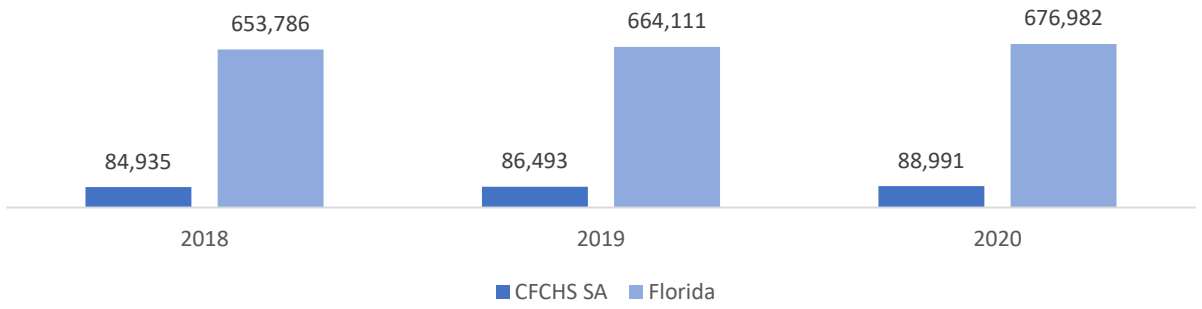
Source: Department of Children and Families, Florida Safe Families Network Data Mart, Rate per 100,000

Figure 18: CFCHS Service Area Rate of Children Experiencing Sexual Violence, Ages 5-11 Years (2017-2019)



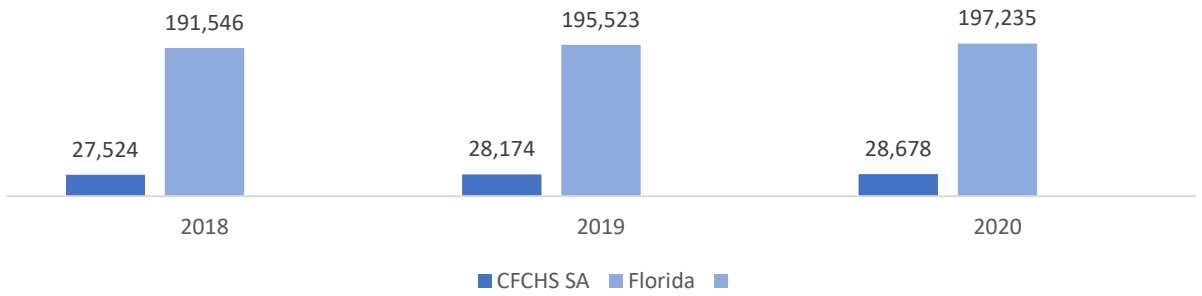
Source: Department of Children and Families, Florida Safe Families Network Data Mart, Rate per 100,000

Figure 19: CFCHS Service Area Estimated Number of Seriously Mentally Ill Adults (2018-2020)



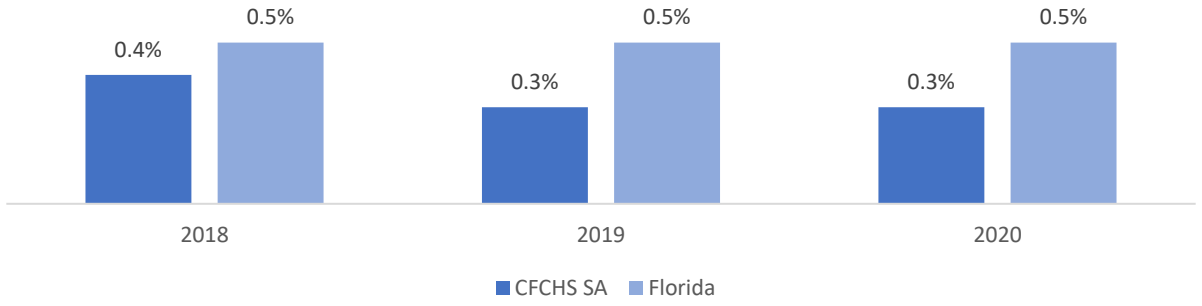
Source: Estimates based on Department of Health and Human Resource Report Mental Health U.S. 1995

Figure 20: CFCHS Service Area Estimated Number of Emotionally Disturbed Youth, Ages 9-17 Years (2018-2020)



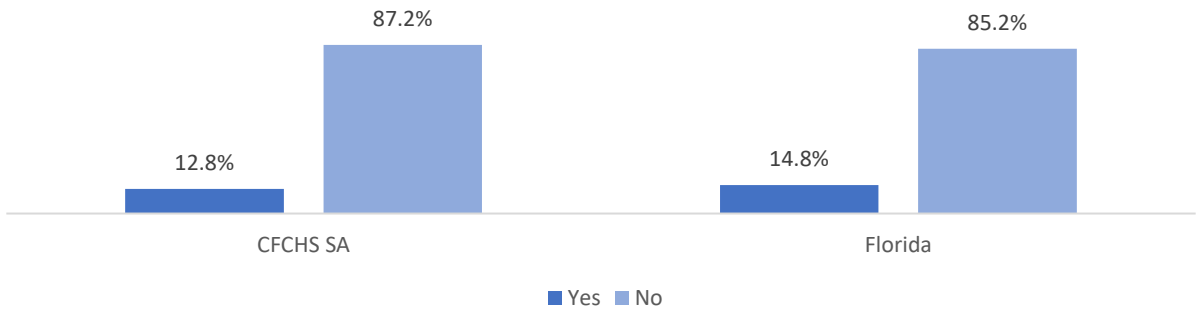
Source: Estimates based on Department of Health and Human Resource Report Mental Health U.S. 1995

Figure 21: CFCHS Service Area Percentage of Children with Emotional/Behavioral Disability, Grades K-12 (2018-2020)



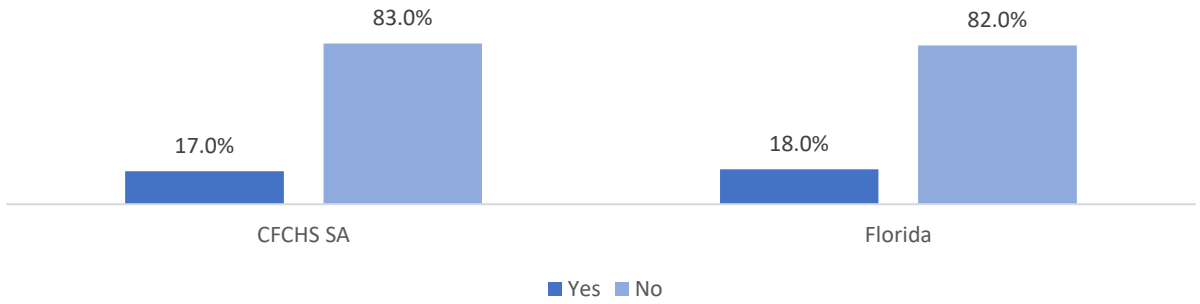
Source: Florida Department of Education, Education Information and Accountability Services (EIAS)

Figure 22: CFCHS Service Area Percentage of Adults Who Are Current Smokers (2017-2019)



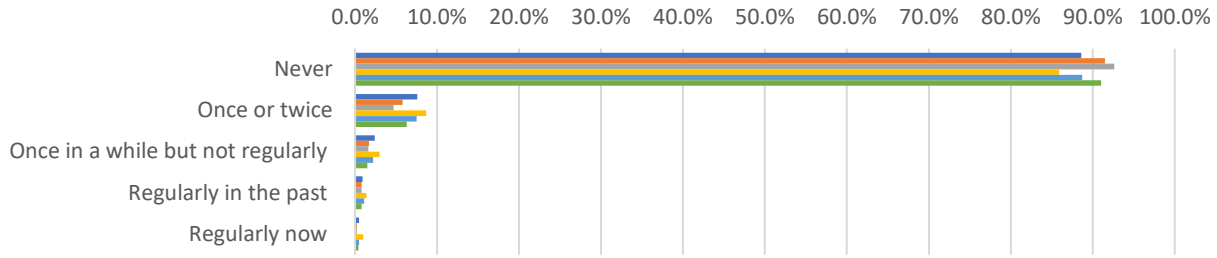
Source: Behavioral Risk Factor Surveillance System

Figure 23: CFCHS Service Area Percentage of Adults Who Engage in Heavy or Binge Drinking (2017-2019)



Source: Behavioral Risk Factor Surveillance System

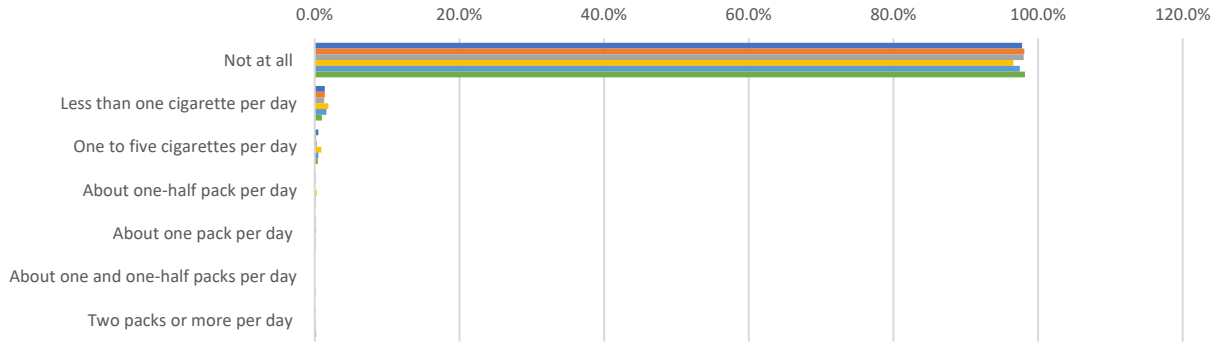
Figure 24: CFCHS Service Area Having Ever Smoked Cigarettes (MS&HS 2016-2020)



	Regularly now	Regularly in the past	Once in a while but not regularly	Once or twice	Never
CFCHS SA 2016	0.5%	0.9%	2.4%	7.6%	88.6%
CFCHS SA 2018	0.2%	0.8%	1.7%	5.8%	91.5%
CFCHS SA 2020	0.2%	0.8%	1.6%	4.7%	92.6%
Florida 2016	1.0%	1.4%	3.0%	8.7%	85.9%
Florida 2018	0.5%	1.1%	2.2%	7.5%	88.7%
Florida 2020	0.4%	0.8%	1.5%	6.3%	91.0%

Source: Florida Youth Substance Abuse Survey

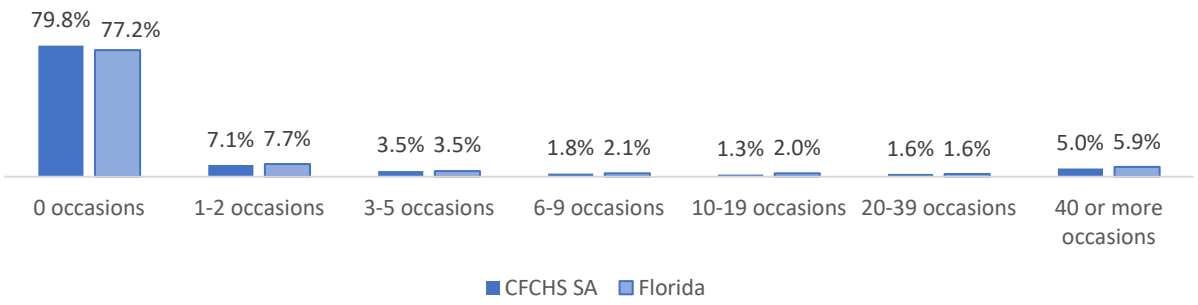
Figure 25: CFCHS Service Area – How Frequently Have You Smoked Cigarettes in the Past 30 Days? (MS&HS 2016-2020)



	Two packs or more per day	About one and one-half packs per day	About one pack per day	About one-half pack per day	One to five cigarettes per day	Less than one cigarette per day	Not at all
CFCHS SA 2016	0.0%	0.0%	0.1%	0.1%	0.5%	1.4%	97.8%
CFCHS SA 2018	0.1%	0.0%	0.1%	0.1%	0.2%	1.4%	98.1%
CFCHS SA 2020	0.0%	0.0%	0.2%	0.0%	0.3%	1.3%	98.0%
Florida 2016	0.1%	0.0%	0.1%	0.3%	0.9%	1.9%	96.6%
Florida 2018	0.1%	0.0%	0.1%	0.1%	0.5%	1.6%	97.5%
Florida 2020	0.2%	0.1%	0.1%	0.1%	0.4%	1.0%	98.2%

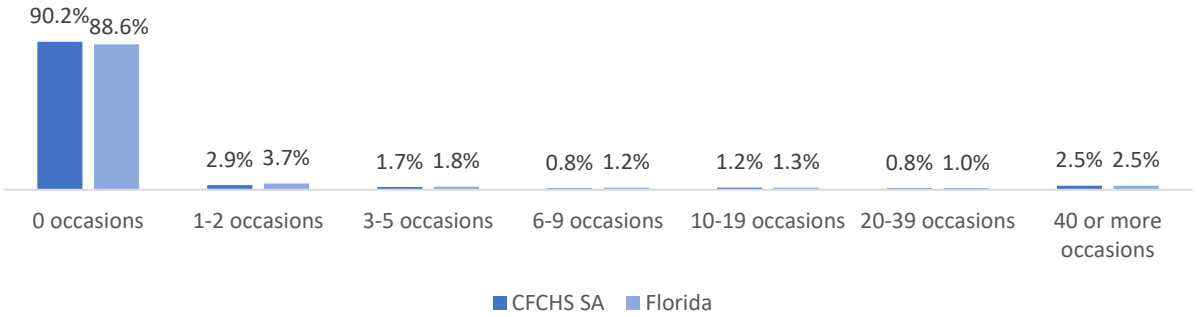
Source: Florida Youth Substance Abuse Survey

Figure 26: CFCHS Service Area – On How Many Occasions Have You Vaped Nicotine in Your Lifetime? (MS&HS 2020)



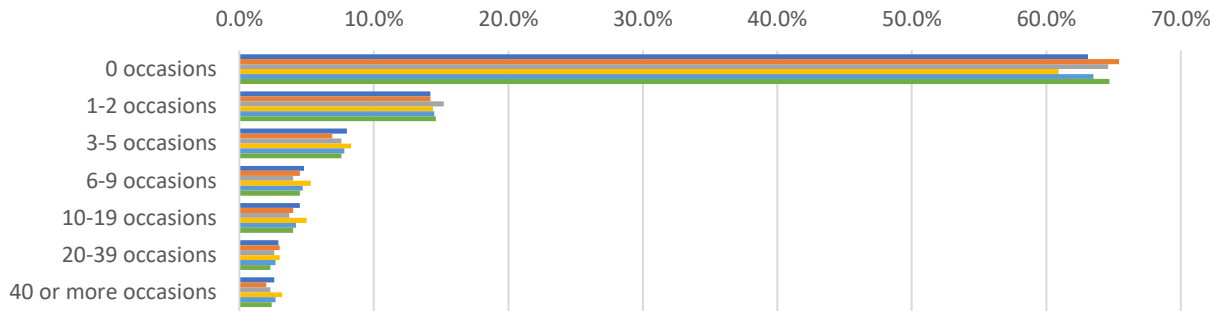
Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

Figure 27: CFCHS Service Area – On How Many Occasions Have You Vaped Nicotine During the Past 30 Days? (MS&HS 2020)



Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

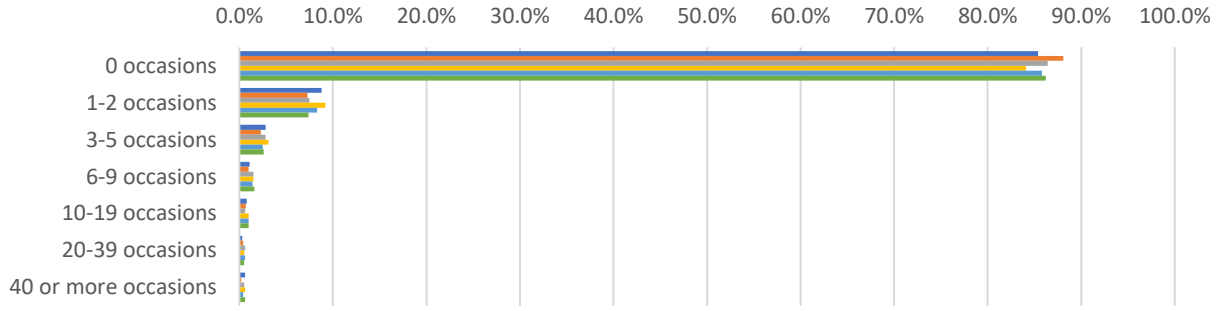
Figure 28: CFCHS Service Area – On How Many Occasions Have You Had Alcoholic Beverages to Drink in Your Lifetime? (MS&HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
CFCHS SA 2016	2.6%	2.9%	4.5%	4.8%	8.0%	14.2%	63.1%
CFCHS SA 2018	2.0%	3.0%	4.0%	4.5%	6.9%	14.2%	65.4%
CFCHS SA 2020	2.3%	2.6%	3.7%	4.0%	7.6%	15.2%	64.6%
Florida 2016	3.2%	3.0%	5.0%	5.3%	8.3%	14.4%	60.9%
Florida 2018	2.7%	2.7%	4.2%	4.7%	7.8%	14.5%	63.5%
Florida 2020	2.4%	2.3%	4.0%	4.5%	7.6%	14.6%	64.7%

Source: Florida Youth Substance Abuse Survey. Includes beer, wine, or hard liquor. More than a few sips.

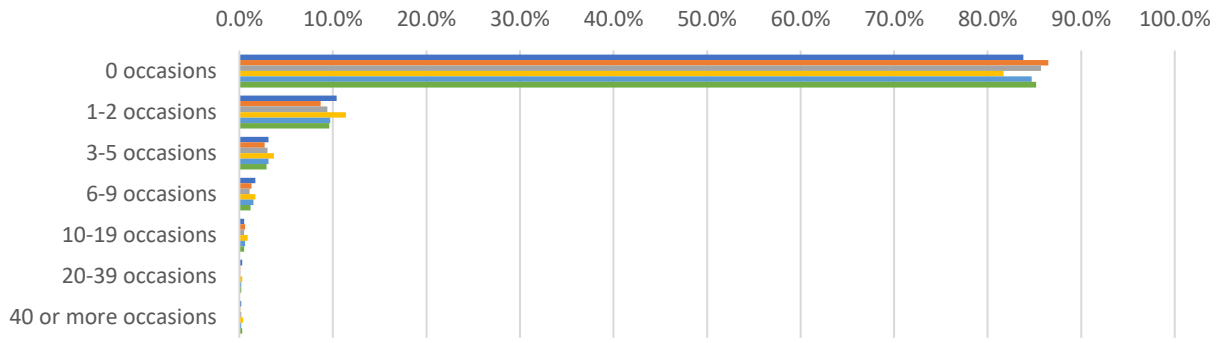
Figure 29: CFCHS Service Area – On How Many Occasions in Your Lifetime Have You Woken Up After a Night of Drinking Alcoholic Beverages and Not Been Able to Remember Things You Did or the Places You Went? (HS Only 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
CFCHS SA 2016	0.6%	0.3%	0.8%	1.1%	2.8%	8.8%	85.4%
CFCHS SA 2018	0.2%	0.4%	0.7%	1.0%	2.3%	7.3%	88.1%
CFCHS SA 2020	0.5%	0.6%	0.6%	1.5%	2.8%	7.5%	86.4%
Florida 2016	0.6%	0.5%	1.0%	1.5%	3.1%	9.2%	84.1%
Florida 2018	0.4%	0.6%	1.0%	1.4%	2.5%	8.3%	85.8%
Florida 2020	0.6%	0.5%	1.0%	1.6%	2.6%	7.4%	86.2%

Source: Florida Youth Substance Abuse Survey

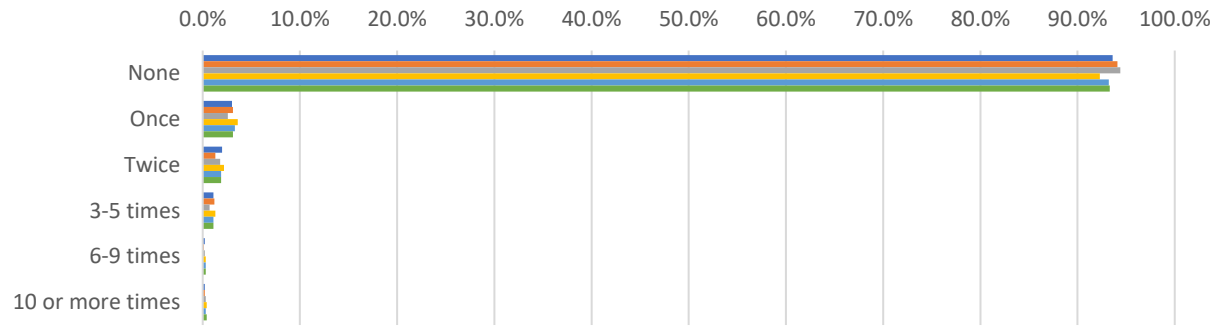
Figure 30: CFCHS Service Area – On How Many Occasions Have You Had Beer, Wine, or Hard Liquor in the Past 30 Days? (MS&HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
CFCHS SA 2016	0.2%	0.3%	0.5%	1.7%	3.1%	10.4%	83.8%
CFCHS SA 2018	0.1%	0.1%	0.6%	1.3%	2.7%	8.7%	86.5%
CFCHS SA 2020	0.2%	0.1%	0.5%	1.1%	3.0%	9.4%	85.7%
Florida 2016	0.4%	0.3%	0.9%	1.7%	3.7%	11.4%	81.7%
Florida 2018	0.2%	0.2%	0.6%	1.5%	3.1%	9.7%	84.7%
Florida 2020	0.3%	0.2%	0.5%	1.2%	2.9%	9.6%	85.2%

Source: Florida Youth Substance Abuse Survey

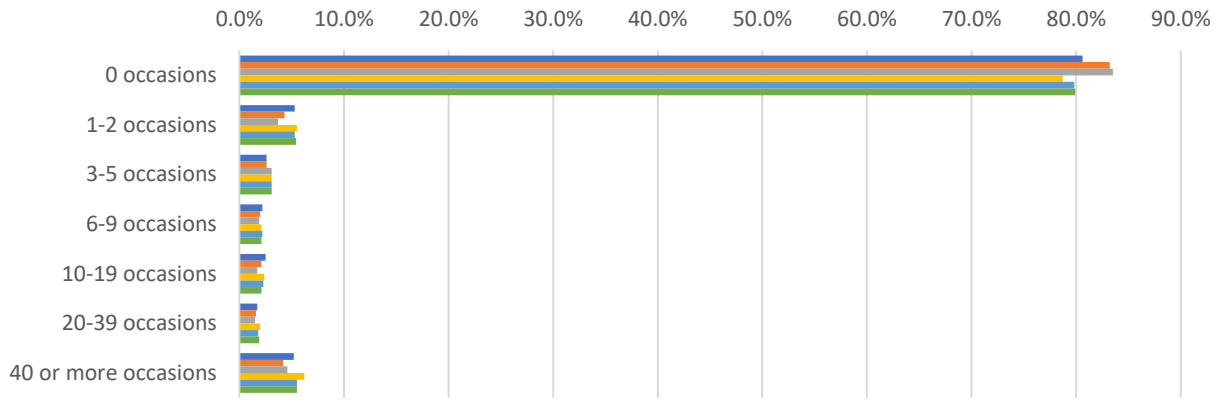
Figure 31: CFCHS Service Area – Thinking Back Over the Past 2 Weeks...How Many Times Have You Had Five or More Alcoholic Drinks in a Row? (MS&HS 2016-2020)



	10 or more times	6-9 times	3-5 times	Twice	Once	None
CFCHS SA 2016	0.2%	0.2%	1.1%	2.0%	3.0%	93.6%
CFCHS SA 2018	0.2%	0.1%	1.2%	1.3%	3.1%	94.1%
CFCHS SA 2020	0.3%	0.2%	0.7%	1.8%	2.6%	94.4%
Florida 2016	0.4%	0.3%	1.3%	2.2%	3.6%	92.3%
Florida 2018	0.3%	0.3%	1.1%	1.9%	3.3%	93.2%
Florida 2020	0.4%	0.3%	1.1%	1.9%	3.1%	93.3%

Source: Florida Youth Substance Abuse Survey

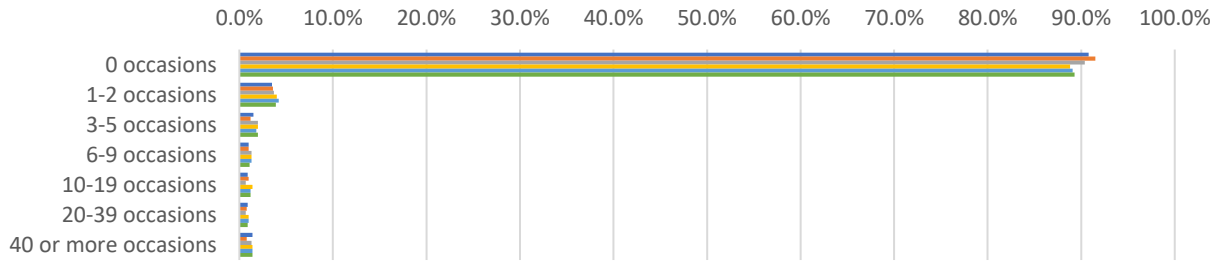
Figure 32: CFCHS Service Area – On How Many Occasions Have You Used Marijuana or Hashish in Your Lifetime? (MS&HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
CFCHS SA 2016	5.2%	1.7%	2.5%	2.2%	2.6%	5.3%	80.6%
CFCHS SA 2018	4.2%	1.6%	2.1%	2.0%	2.6%	4.3%	83.2%
CFCHS SA 2020	4.6%	1.5%	1.7%	1.9%	3.1%	3.7%	83.5%
Florida 2016	6.2%	2.0%	2.4%	2.1%	3.1%	5.5%	78.7%
Florida 2018	5.5%	1.8%	2.3%	2.2%	3.1%	5.3%	79.8%
Florida 2020	5.5%	1.9%	2.1%	2.1%	3.1%	5.4%	79.9%

Source: Florida Youth Substance Abuse Survey

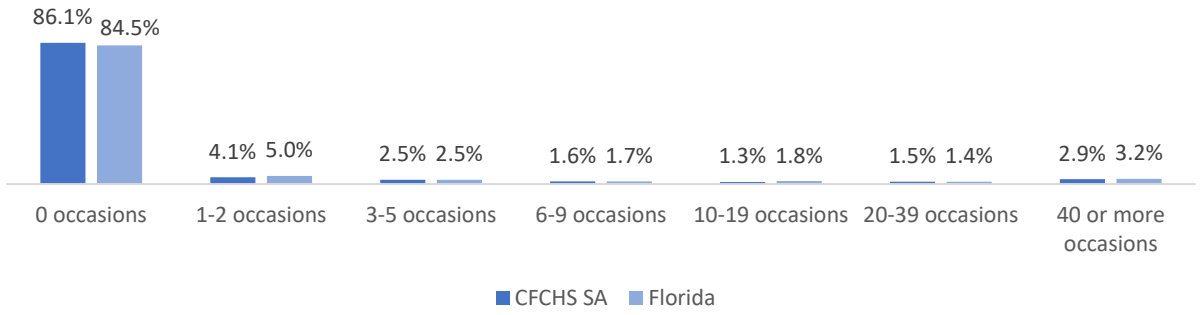
Figure 33: CFCHS Service Area – On How Many Occasions Have You Used Marijuana or Hashish During the Past 30 Days? (MS&HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
CFCHS SA 2016	1.4%	0.9%	0.9%	1.0%	1.5%	3.5%	90.8%
CFCHS SA 2018	0.8%	0.8%	1.0%	1.0%	1.2%	3.6%	91.5%
CFCHS SA 2020	1.3%	0.7%	0.7%	1.3%	2.0%	3.7%	90.4%
Florida 2016	1.4%	1.0%	1.4%	1.3%	2.0%	4.0%	88.8%
Florida 2018	1.4%	1.0%	1.2%	1.3%	1.8%	4.2%	89.1%
Florida 2020	1.4%	0.9%	1.2%	1.1%	2.0%	3.9%	89.3%

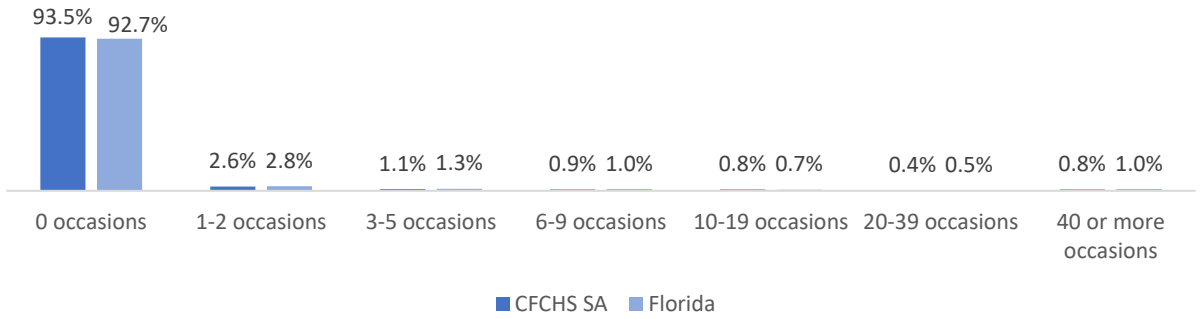
Source: Florida Youth Substance Abuse Survey

Figure 34: CFCHS Service Area – On How Many Occasions Have You Vaped Marijuana in Your Lifetime? (MS&HS 2016-2020)



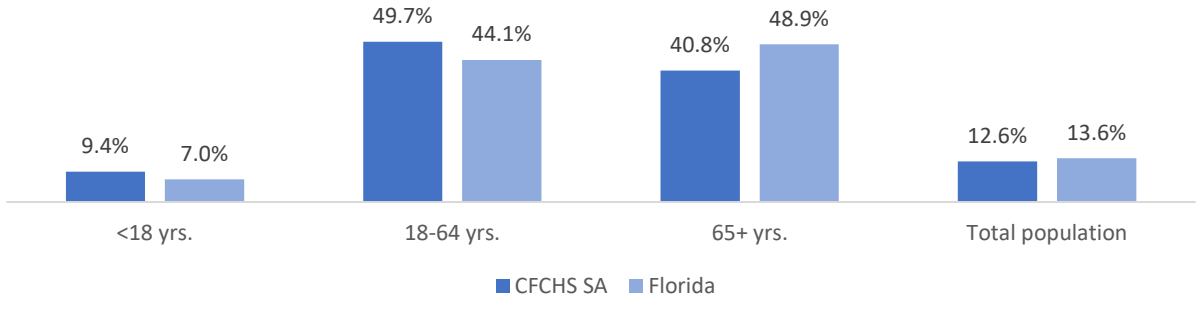
Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

Figure 35: CFCHS Service Area – On How Many Occasions Have You Vaped Marijuana in the Past 30 Days? (MS&HS 2016-2020)



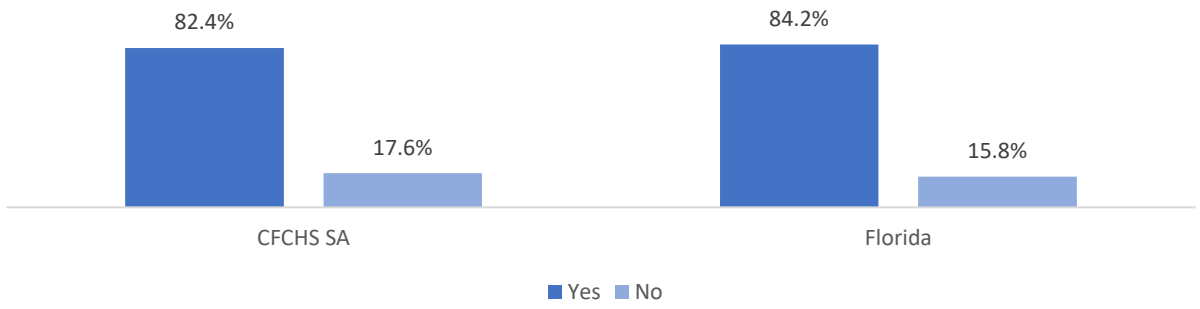
Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

Figure 36: CFCHS Service Area Civilian Noninstitutionalized Population with a Disability (2016-2020)



Source: U.S. Census Bureau, American Community Survey. Disability includes Hearing, Vision, Cognitive, Ambulatory, Self-Care, and Independent Living

Figure 37: CFCHS Service Area Percentage of Adults with Any Type of Health Care Insurance Coverage (2013-2019)



Source: Behavioral Risk Factor Surveillance System

CFCHS INDIVIDUALS SERVED DEMOGRAPHIC PROFILE

Individuals Served Population

CFCHS-funded organizations served 27,681 individuals in FY20-21. This number included a small amount of duplication (<1%) in that some individuals served moved from one county to another, were enrolled in more than one program, or changed residential status during the 1-year time frame. Over 40% of individuals served resided in Orange County (11,195 individuals), followed by Brevard County at 29.4% (8,132 individuals), Seminole County at 14.2% (3,937 individuals), and Osceola County at 9.9% (2,746 individuals). Individuals who reported living in another county accounted for 6% of all individuals.

Adults in CFCHS programs accounted for 81.7% of all individuals, with 41.2% enrolled in the Adult Mental Health (AMH) program, and 40.5% in the Adult Substance Abuse program (ASA). The remaining individuals were in the Child Mental Health (CMH) program, at 7%, and the Child Substance Abuse (CSA) program at 11.3%.

Gender

Males represented more than 50% of all individuals in the AMH, ASA, and CSA programs, ranging from 60.6% in the CSA program, to 54.4% in the AMH program. Males accounted for 47.9% of CMH individuals. Females accounted for 45.6% of individuals in AMH program, but only 39.4% of those in the CSA program.

Race

The majority of CFCHS individuals were White (60%), which was lower than the percentage in the CFCHS service area population at 67.3%. Conversely, Blacks accounted for 23.3% of individuals served population while representing only 15.8% of the population in the service area. ASA individuals more closely matched the racial distribution of the general population when compared to individuals served in other programs. The percentage of multi-racial individuals in the AMH, ASA and CMH programs was higher when compared to the population in the service area.

Ethnicity

The percentage of Hispanics in the CFCHS individuals served population, at 19.5%, was lower when compared to the percentage of the Hispanic population in the service area, at 28.8%. When comparing the ethnic distribution among programs, Hispanic individuals in the CMH programs, at 29.6%, were more representative of the service area population. Hispanic individuals served in the AMH, ASA, and CSA programs ranged from 15.8% in the ASA program to 19.6% in the AMH program.

Age Range

As expected, the age range distribution among CFCHS individuals served did not mimic that of the service area population. Adults, ages 25-44 years of age, accounted for 52.6% of AMH and 60.4% of ASA individuals served. In comparison, adults in this age range represented 28.4% of the population in the service area. Conversely, adults aged 65 years and older accounted for a smaller percentage of individuals (2.3%) when compared to those in the service area population at 15.2%. Children under 5 years accounted for less than 10% of individuals in the CMH and CSA programs. There was a higher percentage of older teens, ages 15-19 years of age, in the CSA program when compared to those in the CMH program.

Residential Status

The percentage of individuals living dependently (with relatives or non-relatives) was similar when comparing AMH and ASA. A higher percentage of AMH individuals lived independently alone (32.8%) when compared to ASA individuals at 20.7%. Over 90% of individuals served in the CSA program lived dependently with relatives. This was higher than the percentage in the CMH program where 74.6% lived dependently with relatives. Youth living independently alone also varied when comparing the two programs. CMH served accounted for 12.6% of those living alone while only 1.9% of individuals in the CSA program lived by themselves.

Educational Attainment

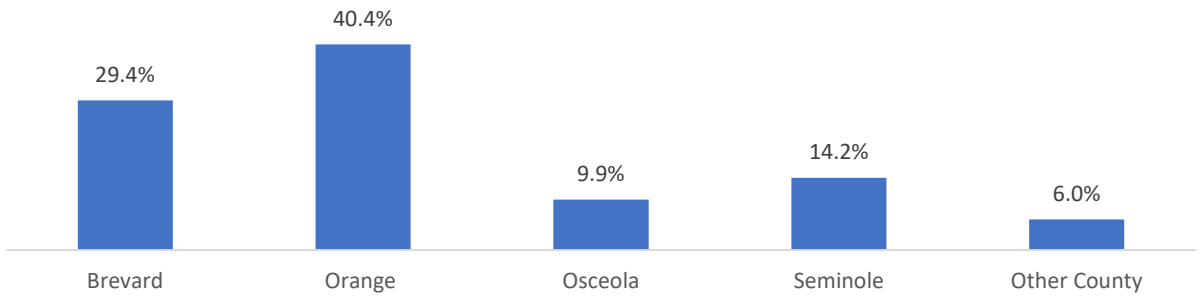
CFCHS individuals served attained lower educational levels when compared to those in the service area population. Among CFCHS adults, 44.7% of AMH, and 45.9% of ASA, did not attain more than a high school education. In the service area population, only 24.7% of residents did not go on to further education. Consequently, the percentages of CFCHS adults served who earned some college education, or attained a college degree, were well below those for residents living in the service area.

Employment Status

Lower educational attainment was one of several factors that contributed to much higher levels of unemployment among CFCHS adults served when compared to those in the service area. Unemployment ranged from 39.5% of ASA to 52.4% among AMH individuals served. The 5-year estimate for unemployment in the service area was 3.4% (2016-2020).

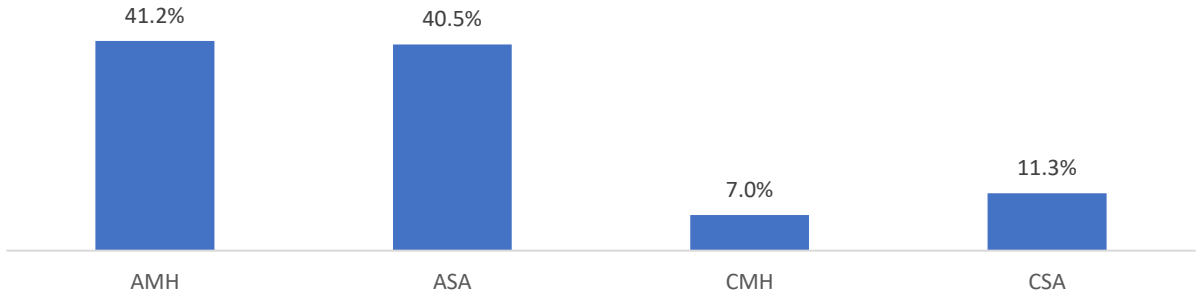
IINDIVIDUALS SERVED DEMOGRAPHIC CHARTS

Figure 38: CFCHS Individuals Served by County



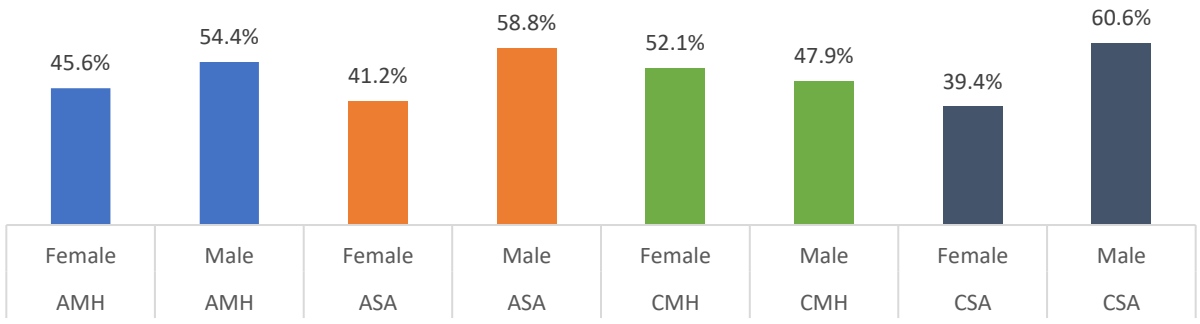
Source: CFCHS Individuals Served Data

39: CFCHS Individuals Served by Program



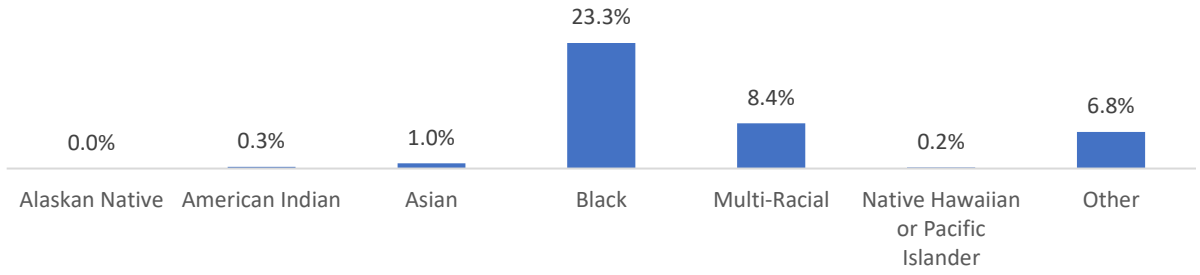
Source: CFCHS Individuals Served Data

Figure 40: CFCHS Individuals Served by Program and Gender



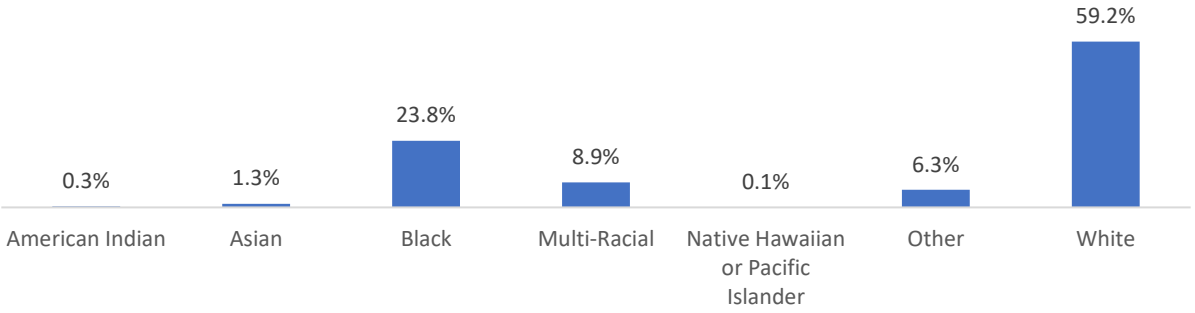
Source: CFCHS Individuals Served Data

Figure 41: CFCHS Individuals Served by Race



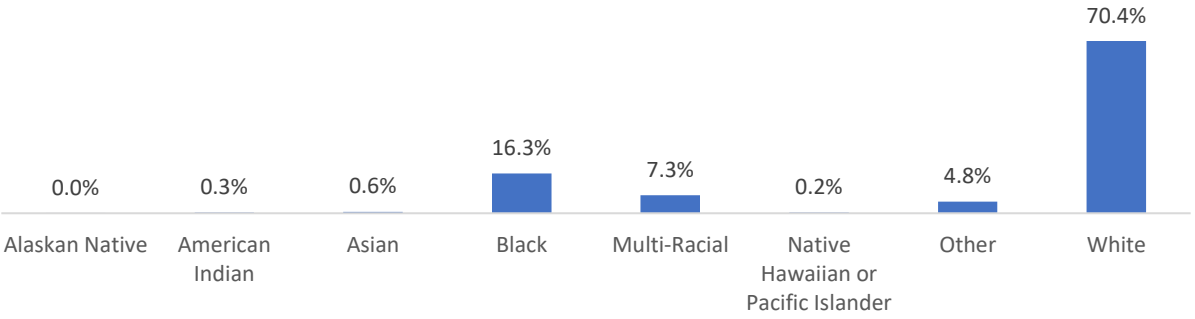
Source: CFCHS Individuals Served Data

Figure 42: CFCHS AMH Individuals Served by Race



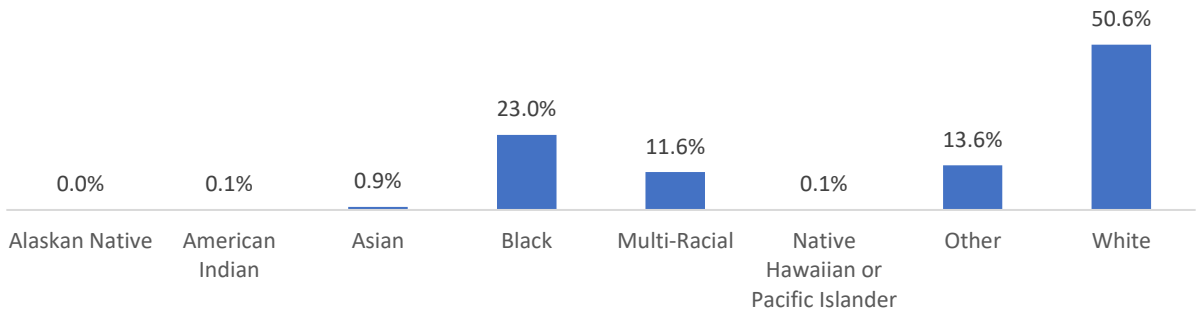
Source: CFCHS Individuals Served Data

Figure 43: CFCHS ASA Individuals Served by Race



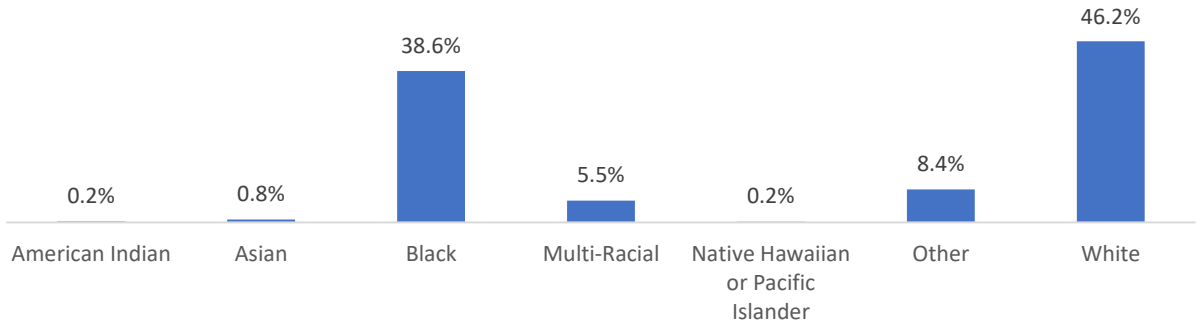
Source: CFCHS Individuals Served Data

Figure 44: CFCHS CMH Individuals Served by Race



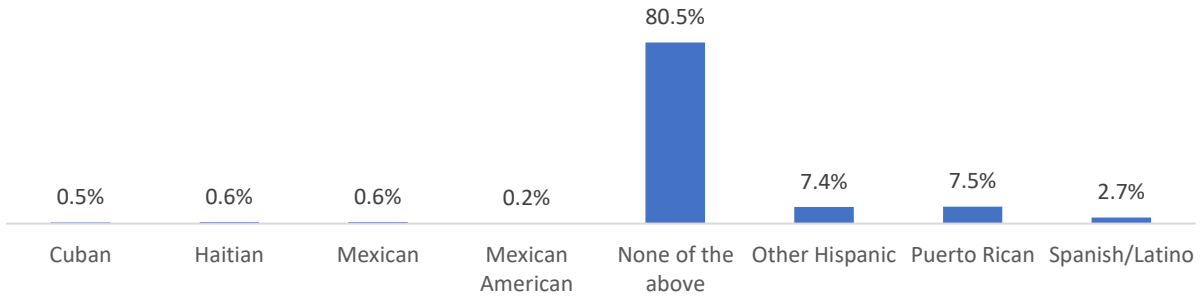
Source: CFCHS Individuals Served Data

Figure 45: CFCHS CSA Individuals Served by Race



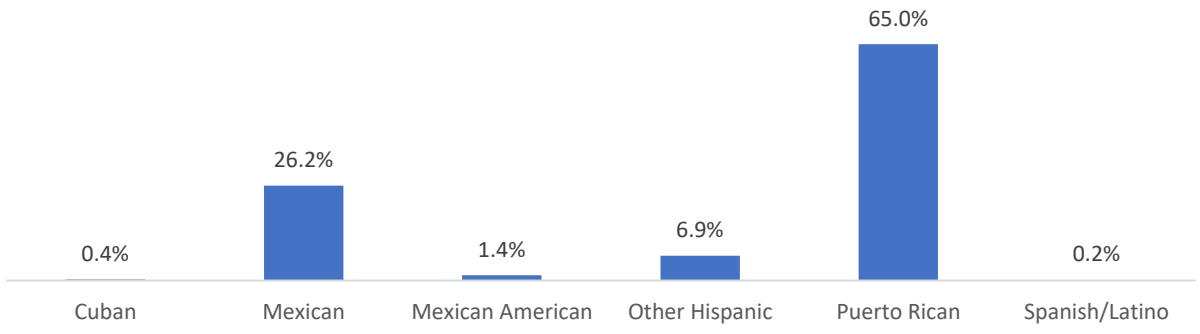
Source: CFCHS Individuals Served Data

Figure 46: CFCHS Individuals Served by Ethnicity



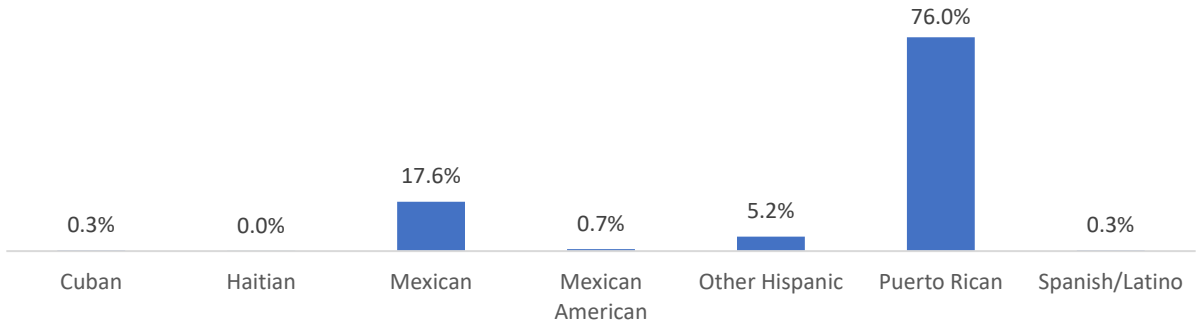
Source: CFCHS Individuals Served Data

Figure 47: CFCHS AMH Individuals Served by Ethnicity



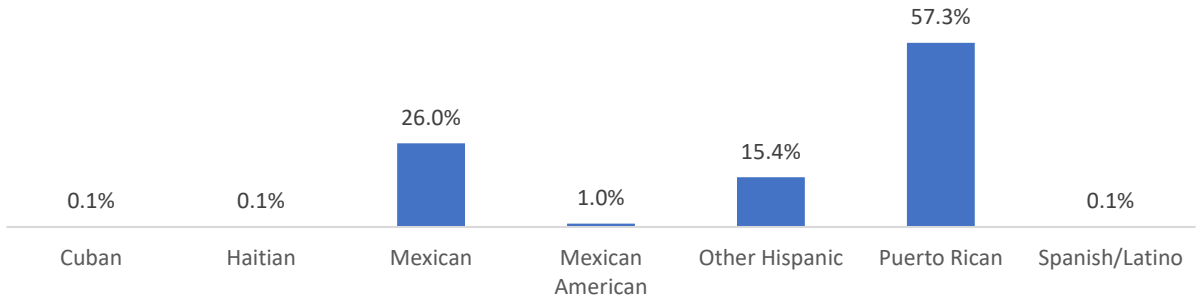
Source: CFCHS Individuals Served Data

Figure 48: CFCHS ASA Individuals Served by Ethnicity



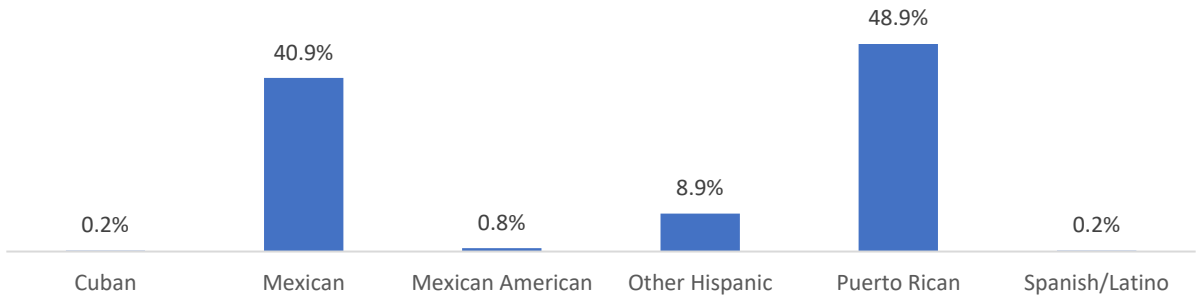
Source: CFCHS Individuals Served Data

Figure 49: CFCHS CMH Individuals Served by Ethnicity



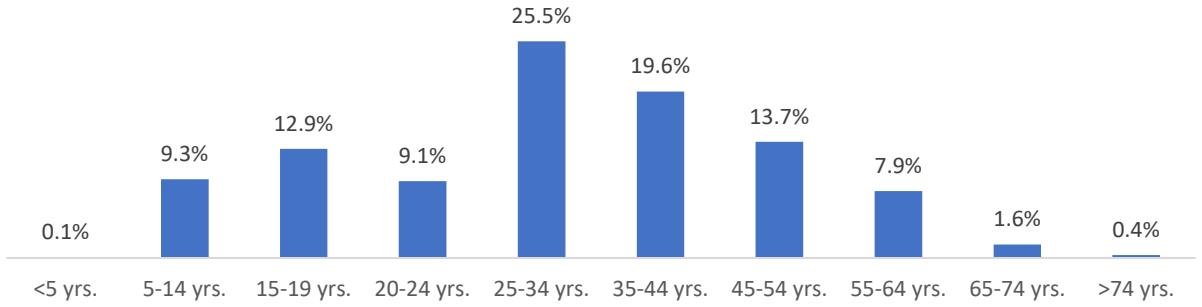
Source: CFCHS Individuals Served Data

Figure 50: CFCHS CSA Individuals Served by Ethnicity



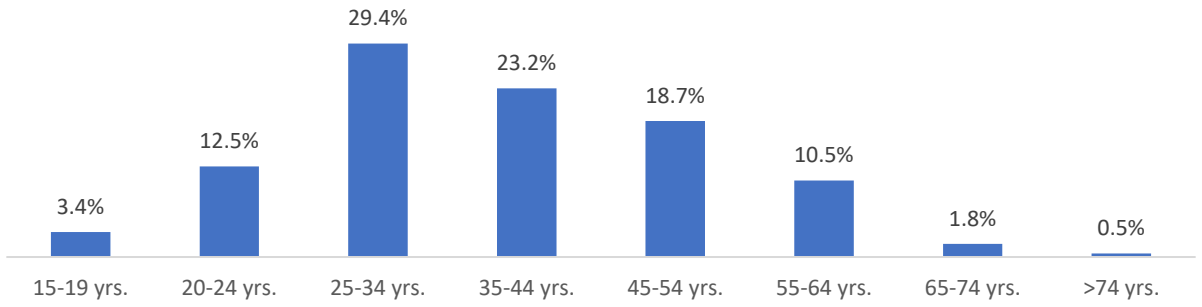
Source: CFCHS Individuals Served Data

Figure 51: CFCHS Individuals Served by Age Range



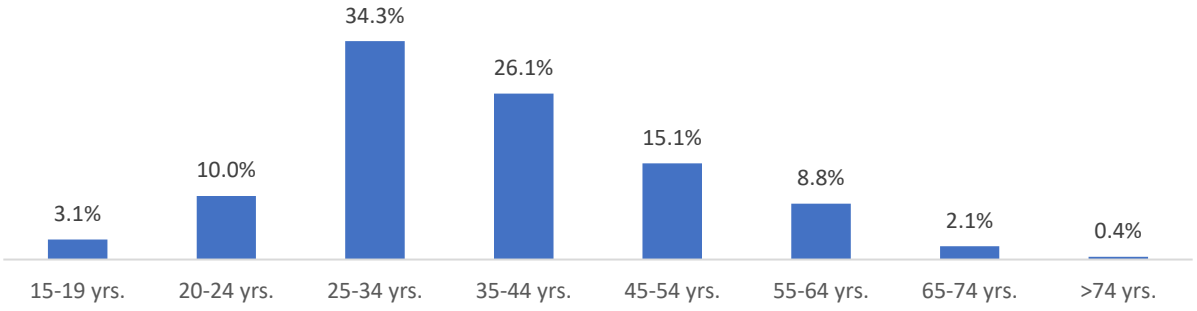
Source: CFCHS Individuals Served Data

Figure 52: CFCHS AMH Individuals Served by Age Range



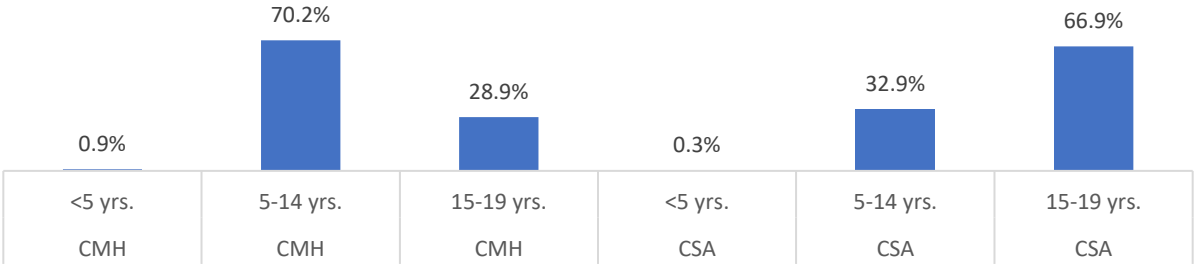
Source: CFCHS Individuals Served Data

Figure 53: CFCHS ASA Individuals Served by Age Range



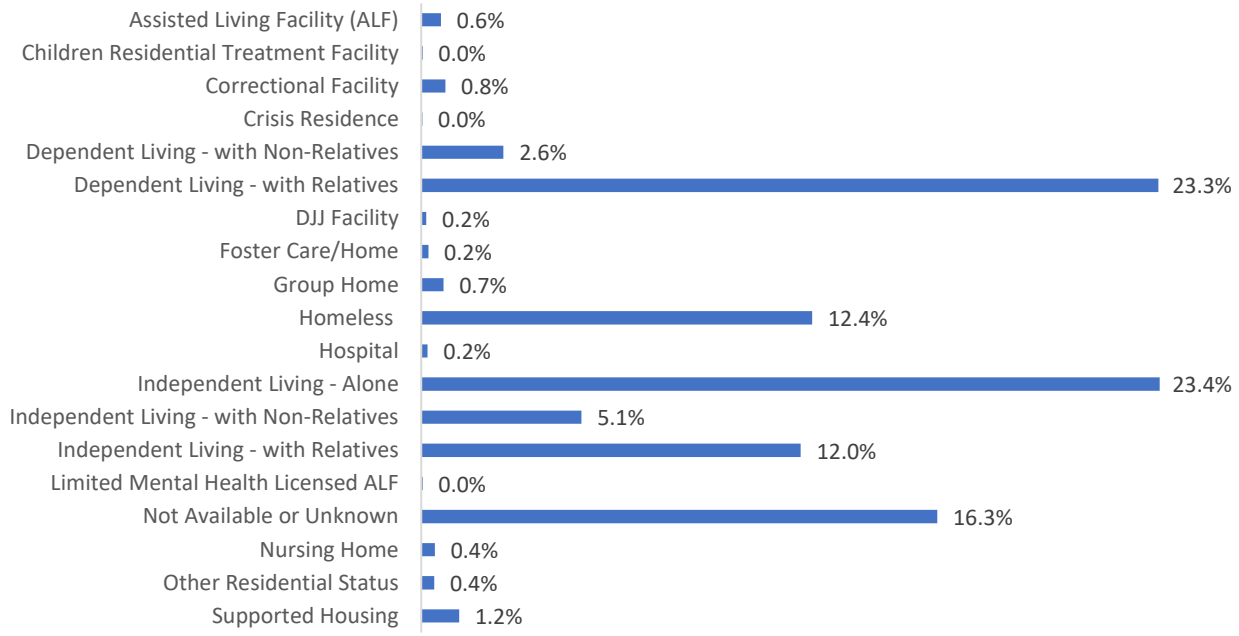
Source: CFCHS Individuals Served Data

Figure 54: CFCHS CMH and CSA Individuals Served by Age Range



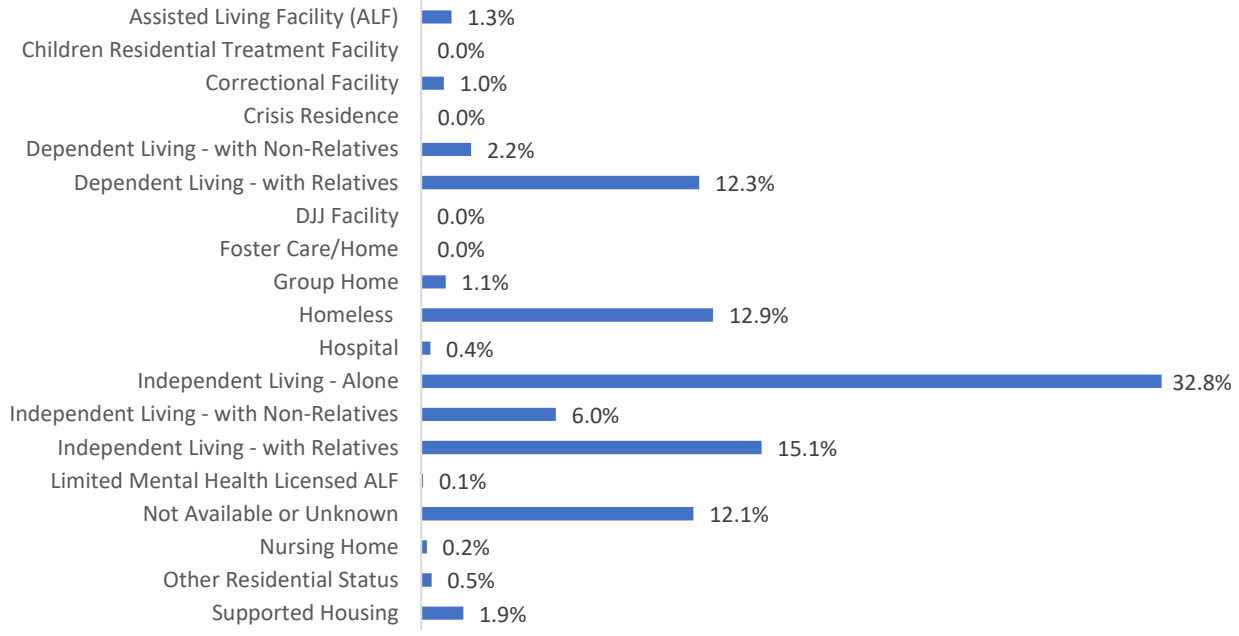
Source: CFCHS Individuals Served Data

Figure 55: CFCHS Individuals Served by Residential Status



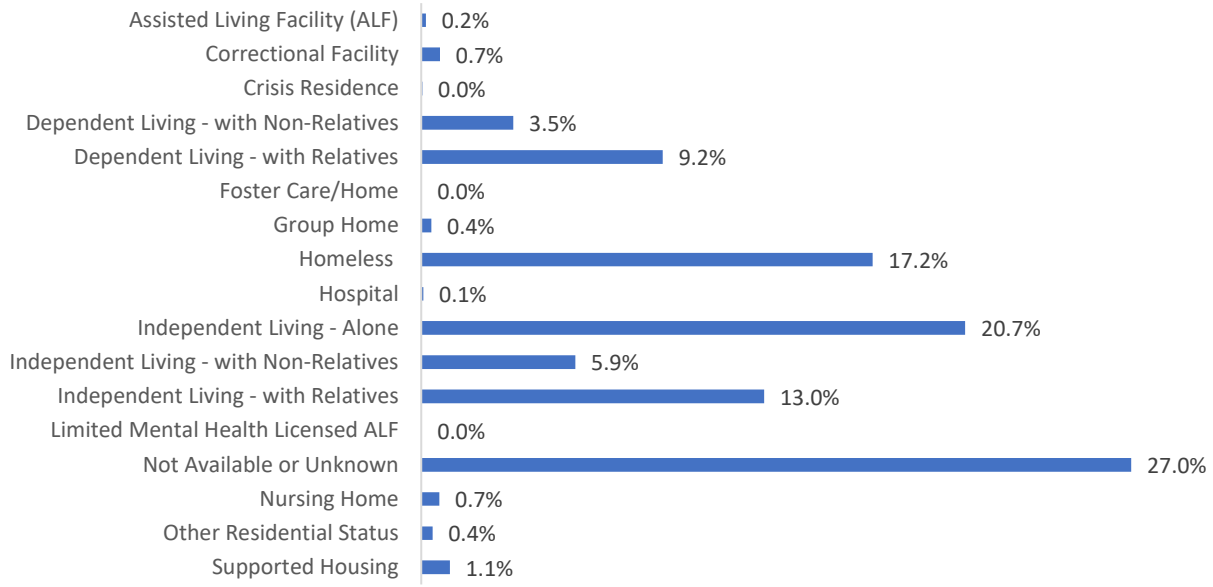
Source: CFCHS Individuals Served Data

Figure 56: CFCHS AMH Individuals Served by Residential Status



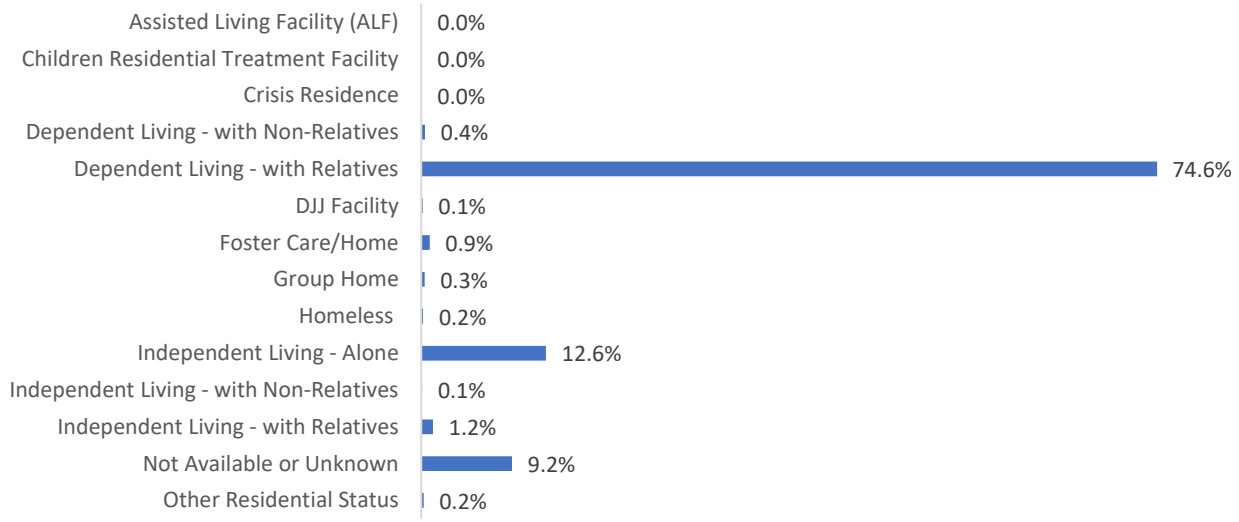
Source: CFCHS Individuals Served Data

Figure 57: CFCHS ASA Individuals Served by Residential Status



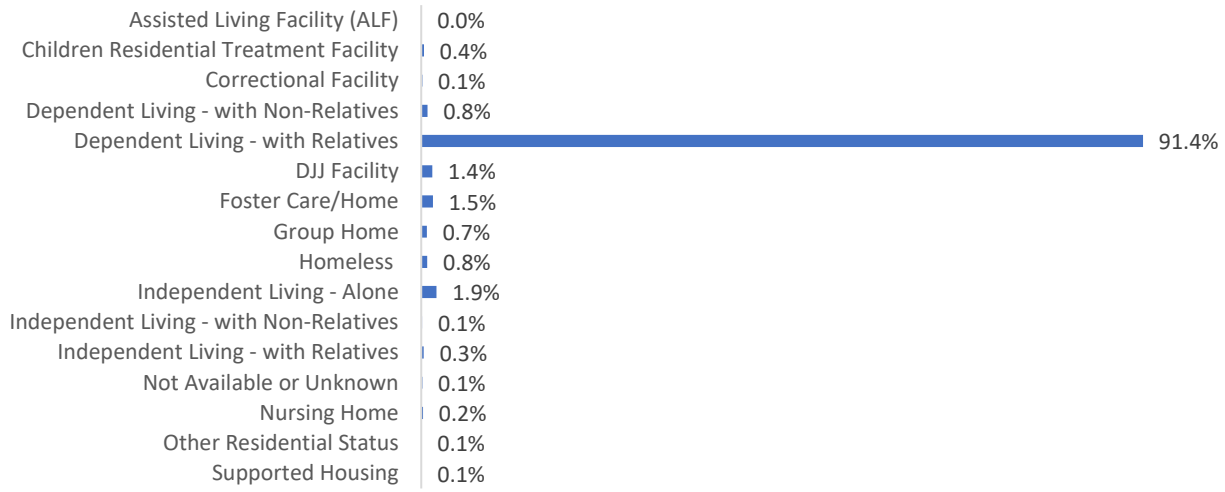
Source: CFCHS Individuals Served Data

Figure 58: CFCHS CMH Individuals Served by Residential Status



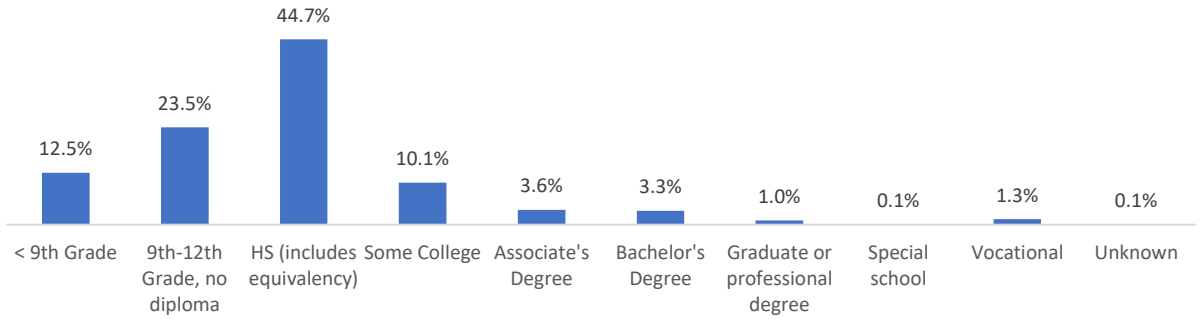
Source: CFCHS Individuals Served Data

Figure 59: CFCHS CSA Individuals Served by Residential Status



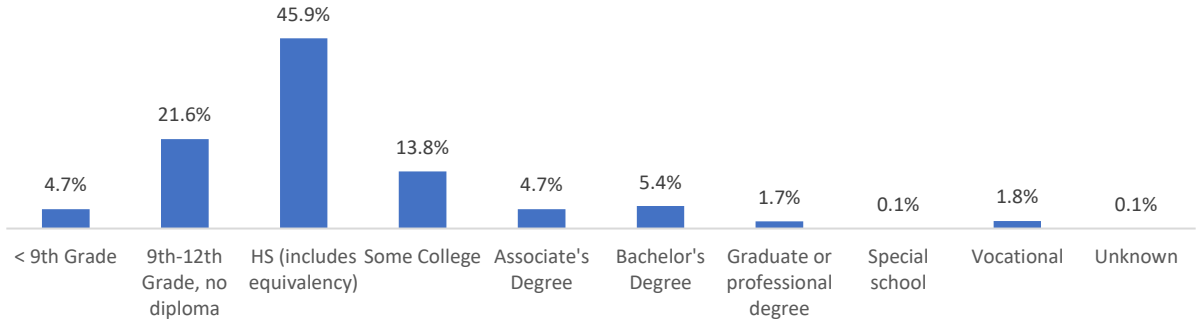
Source: CFCHS Individuals Served Data

Figure 60: CFCHS Individuals Served by Educational Attainment



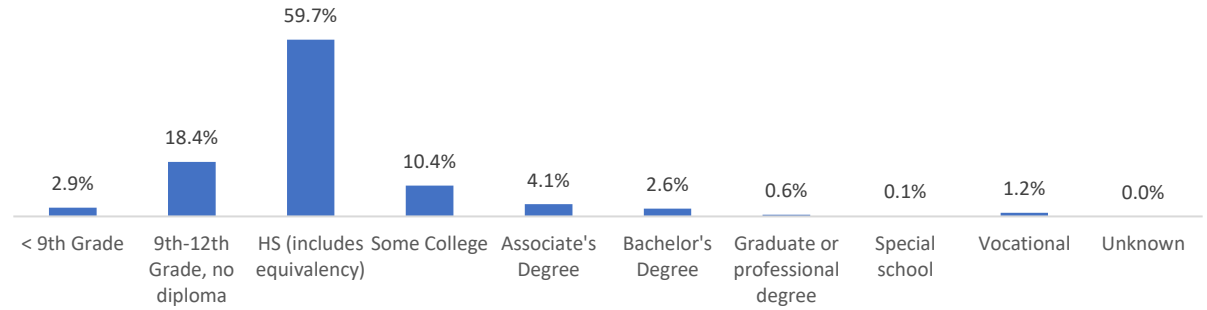
Source: CFCHS Individuals Served Data

Figure 61: CFCHS AMH Individuals Served by Educational Attainment



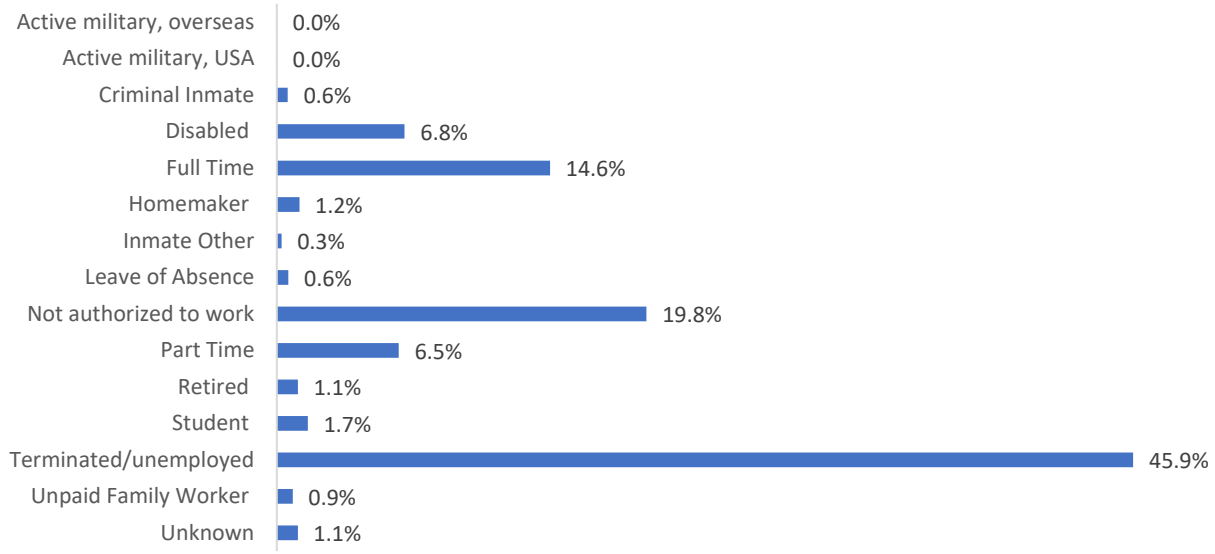
Source: CFCHS Individuals Served Data

Figure 62: CFCHS ASA Individuals Served by Educational Attainment



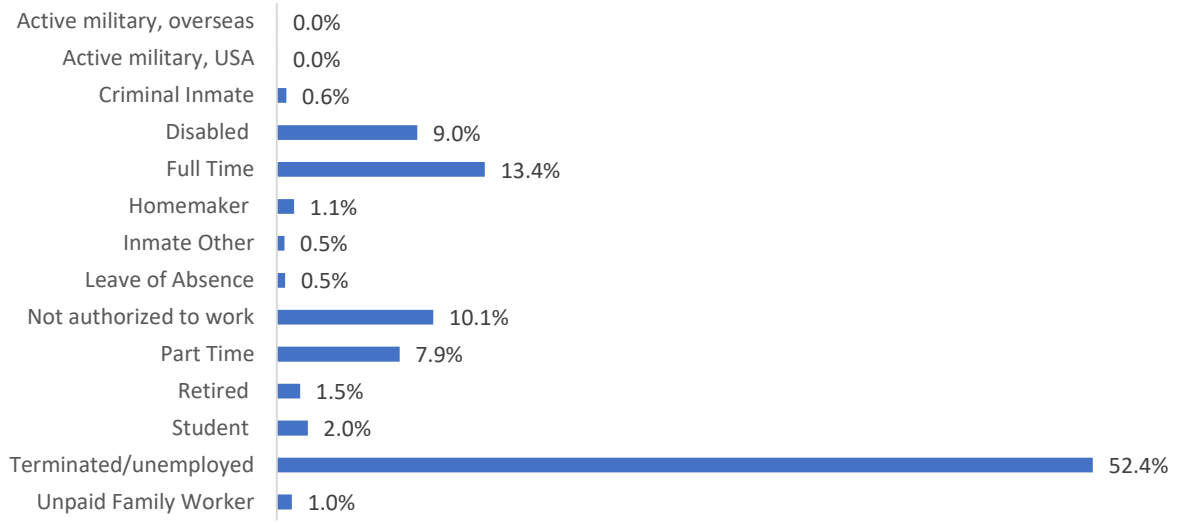
Source: CFCHS Individuals Served Data

Figure 63: CFCHS Individuals Served by Employment Status



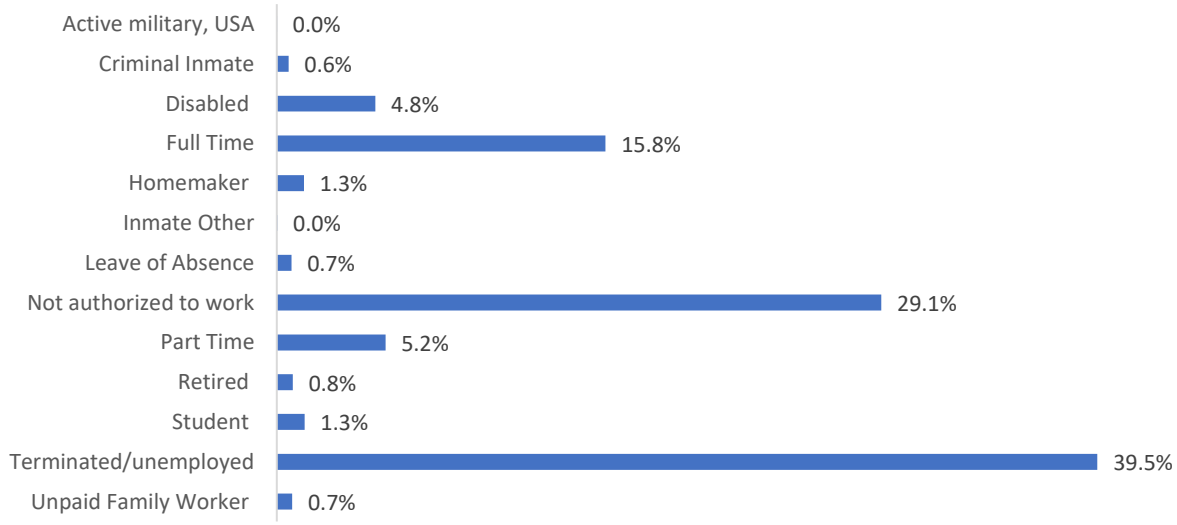
Source: CFCHS Individuals Served Data

Figure 64: CFCHS AMH Individuals Served by Employment Status



Source: CFCHS Individuals Served Data

Figure 65: CFCHS ASA Individuals Served by Employment Status



Source: CFCHS Individuals Served Data

CFCHS SERVICE AREA HOMELESS POPULATION

The 2021 Council on Homelessness Report states that the Point in Time Count (PIT) data provides a snapshot of homelessness. **Due to the pandemic, the 2021 PIT Count is not directly comparable to prior years' counts.** Typically, Continuums of Care (CoCs - A local geographic area designated by HUD and served by a local planning body, which is responsible for organizing and delivering housing and services to meet the needs of people who are homeless as they move to stable housing and maximum self-sufficiency) conduct a PIT Count of both sheltered and unsheltered households. This year, due to COVID-19 related safety concerns, only six of the 27 CoCs conducted such a count; 10 CoCs did not conduct an unsheltered count; and others conducted a modified form of the unsheltered count. All CoCs conducted a sheltered PIT count. For those that did not conduct an unsheltered count, the CoCs reported zero unsheltered persons, resulting in an undercount of total homelessness. According to the report:

> "Housing is a significant determinant of health, and insufficient housing is a major public health issue. The COVID-19 pandemic has exacerbated housing instability, especially for low-income households. In effect, the pandemic has triggered high rates of unemployment, worsened pre-existing behavioral health disorders, and increased stress, anxiety, and depression for others. Increased rates of unemployment also contribute to increasing the prevalence of behavioral health disorders, resulting in more suffering and deaths. Prior to the pandemic, America's affordable housing crisis was already expected to get worse. The ELI housing crisis is evidenced by the fact that people with disabilities are forced to live in segregated and institutional facilities (e.g., nursing homes, state institutions, etc.) and experience homelessness. Many of these individuals need Permanent Supportive Housing."
>
> (Please access the actual report for resources at: 2021CouncilReport.pdf (myflfamilies.com)

In 2021, the Florida Council on Homelessness reported there were 1,976 homeless individuals in Central Florida (Brevard, Orange, Osceola, and Seminole counties). Although all were sheltered, Brevard County did not conduct an unsheltered PIT Count, and Orange, Osceola, and Seminole counties conducted a modified PIT Count. Chronically homeless, defined as continually homeless for over 1 year, increased from 335 individuals in 2017 to 734 people in 2020. Homelessness among veterans decreased during the same period from 405 to 309 (2017 to 2019). Families experiencing homelessness also decreased (17.6%) from 2017 to 2020. The number of homeless students, reported by the Florida Department of Education (FDOE), at 14,286 for the 2015-2016 academic year, decreased 25.5% to 10,641 in 2019-2020. Of those students who were homeless in 2019-2020, close to70% were in a sharing housing arrangement, and 24.4% were living in motels.

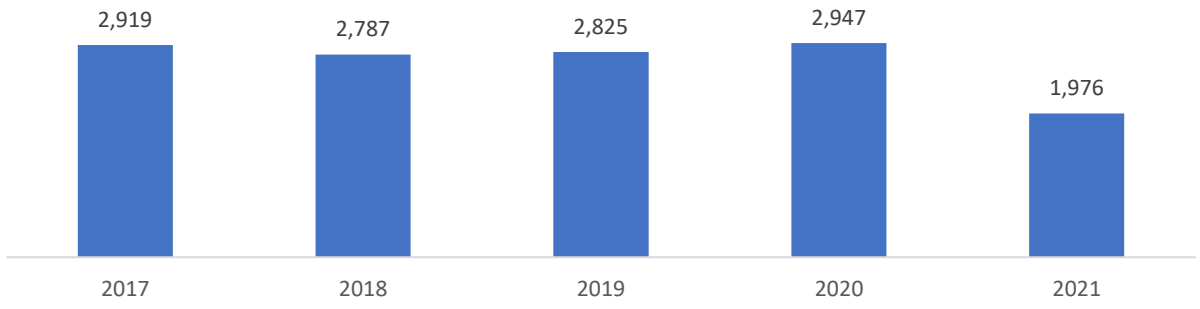
Due to the COVID-19 pandemic, this year saw an unprecedented infusion of federal funding to address homelessness and housing instability. With these funds appropriated by Congress, the State, local governments, CoCs, and partner agencies have invested in solutions to homelessness, including rent and utilities assistance, sheltering, outreach, supportive services and more. While these resources have increased Florida's capacity to prevent and end homelessness, the federal funds have strict restrictions on how the funds may be used; they are not interchangeable with the Challenge and Staffing grants provided to CoCs by the State of Florida. State funding remains critical to addressing homelessness in Florida, especially in rural areas and for the many programs that cannot be funded by federal resources due to their restrictions. State funding helps ensure a broad range of programs in Florida, as well as increase the capacity of the CoCs to administer the federal funding and other resources.

Figure 66: CoC Funding from Federal and State Sources, District 7 (SFY20-21)

Source	District 7
Total Funding Award	$22,090,742.72
HUD CoC FFY20	$10,257,750.00
State Total	$11,832,992.72
State Challenge	$267,500.00
State ESG-CV	$10,815,375.02
Emergency Solutions Grant	$457,000.00
State Staffing	$214,285.70
State TANF-HP	$78,832.00

SOURCE: Council on Homelessness Annual Report (2021)

Figure 67: Total Homeless Population, District 7 (2017-2021)

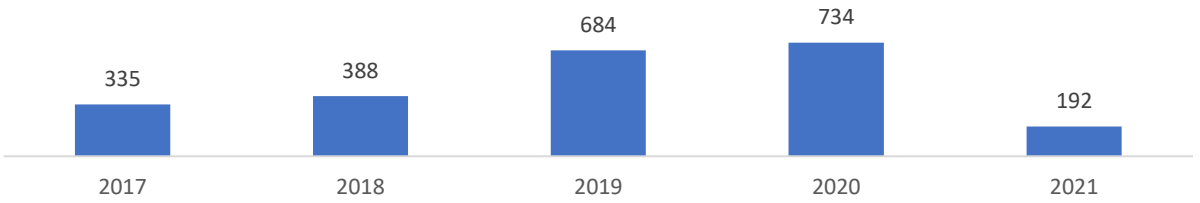


SOURCE: Council on Homelessness Annual Report (2019)

Figure 68: Total Homeless Population Sheltered and Unsheltered, District 7 (2021)

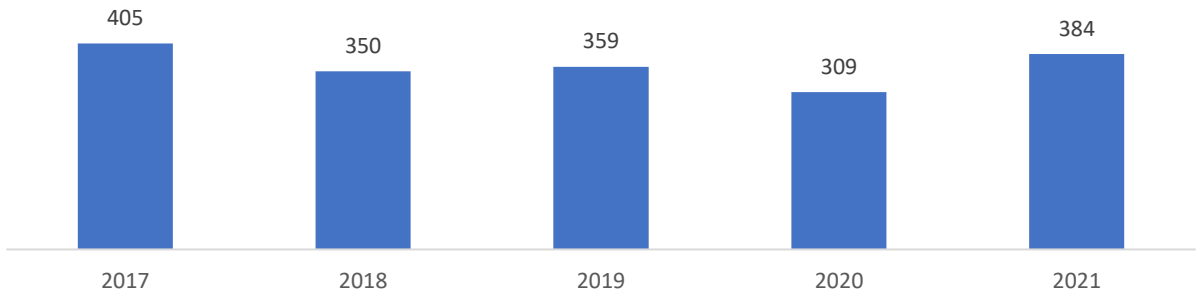
SOURCE: Council on Homelessness Annual Report (2021)

Figure 69: Chronic Homelessness, District 7 (2017-2021)



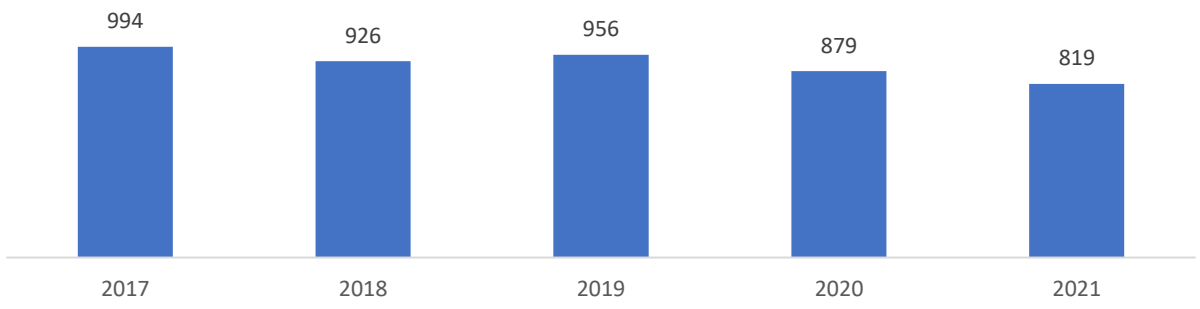
SOURCE: Council on Homelessness Annual Report (2021)

Figure 70: Homelessness Among Veterans, District 7 (2017-2020)



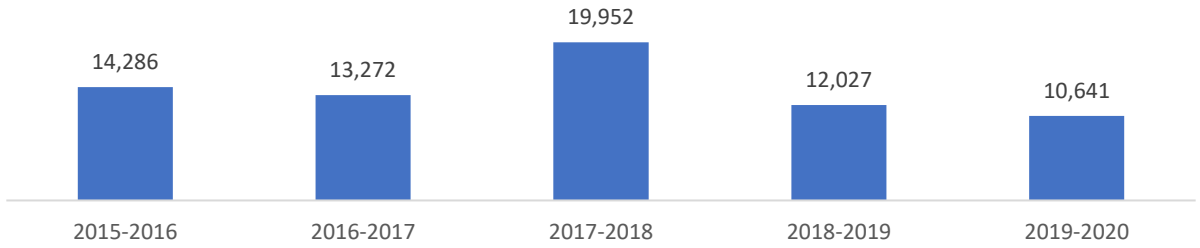
SOURCE: Council on Homelessness Annual Report (2021)

Figure 71: Family Homelessness – Total Persons in Families with Children, District 7 (2017-2021)



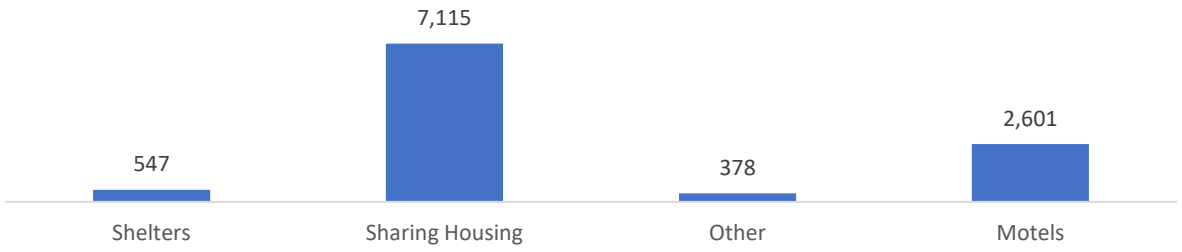
SOURCE: Council on Homelessness Annual Report (2021)

Figure 72: Florida DOE – Reported Homeless Students in Public Schools (2015-2020)



SOURCE: Council on Homelessness Annual Report (2021). School Districts 5, 48, 49, & 59.

Figure 73: Reported Homeless Students in Public Schools by Living Situation (2019-2020)



SOURCE: Council on Homelessness Annual Report (2021). School Districts 5, 48, 49, & 59.

CFCHS HOMELESS INDIVIDUALS SERVED PROFILE

Homeless Individuals Served Demographics

A total of 4,974 homeless individuals served were enrolled in adult and child programs in FY20-21. Of these, 39.8% were in the AMH program, and 59.4% in the ASA program. It should be noted that there may be a small percentage of overlap with some individuals enrolled in both programs. Homeless children accounted for less than 1% of homeless.

Gender

Males accounted for larger percentages of individuals served in the AMH and ASA programs, at 71.3% and 65.2%, respectively. Among the child programs, females accounted for 80% of CMH program, but only 30.3% in the CSA program. It should be noted that the number of homeless individuals in the CMH was very small, and results should be interpreted with caution.

Race

Homeless individuals in the AMH and ASA programs were racially more diverse when compared to the CFCHS service area population. White homeless individuals accounted for 56.6% of those in the AMH program and Black homeless individuals represented 31.7% in the same program. In the service area population, 67.3% of residents were White, and 15.8% were Black. Multi-racial individuals also accounted for a larger percentage of AMH (7.4%) and ASA (14.5%) programs when compared to the service area population at 6.8%.

Ethnicity

The percentage of homeless Hispanic individuals in the AMH program, at 14.8%, was lower when compared to the Hispanic individuals in the ASA at 23.08%. In the service area population, 28.8% were Hispanic. Only 3.1% of homeless individuals in the child programs were Hispanic.

Age Range

Adults, ages 25-44 years, accounted for 55.9% of AMH and 64% of ASA individuals served. Older homeless individuals, those over 65 years of age, represented a much smaller percentage of homeless individuals (1.1%) when compared to those in the service area at 15.2%.

Residential Status

All homeless individuals served reported their residential status as homeless.

Educational Attainment

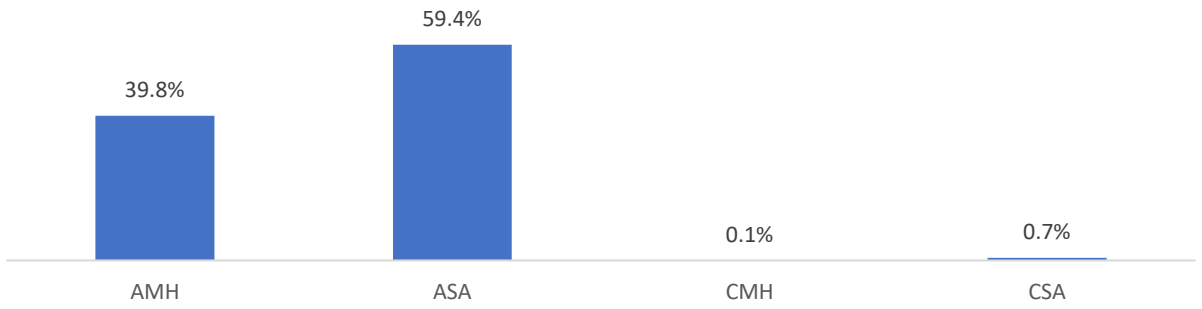
Among the homeless individuals served, 78.8% did not have more than a high school education. Over 30% of homeless individuals did not have an HS diploma.

Employment Status

Only 11.3% of homeless individuals were employed (part or full time) and 78.4% had been terminated or were unemployed.

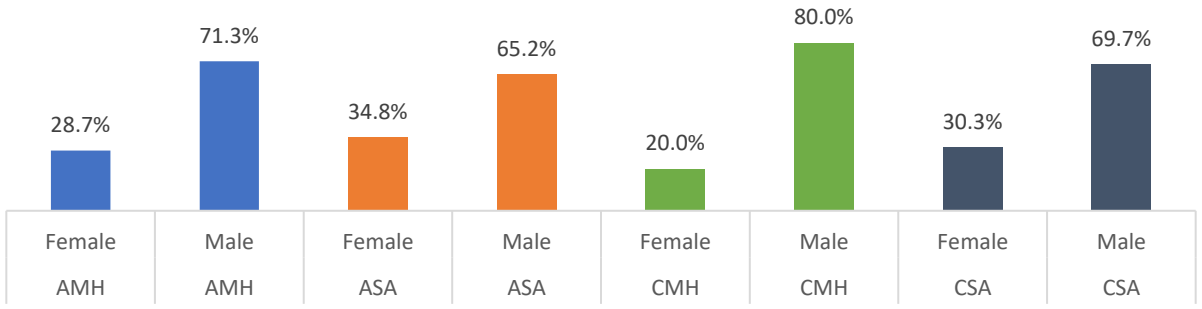
CFCHS HOMELESS INDIVIDUALS SERVED CHARTS

Figure 74: CFCHS Homeless Population by Program



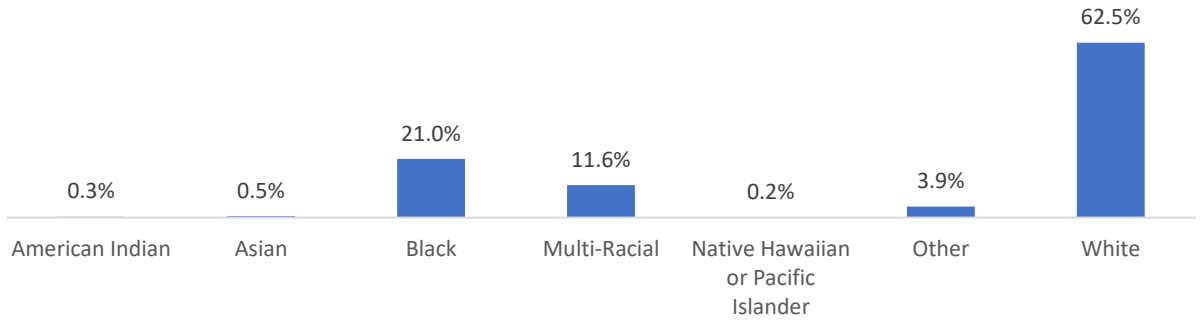
Source: CFCHS Individuals Served Data

Figure 75: CFCHS Homeless Individuals Served by Gender



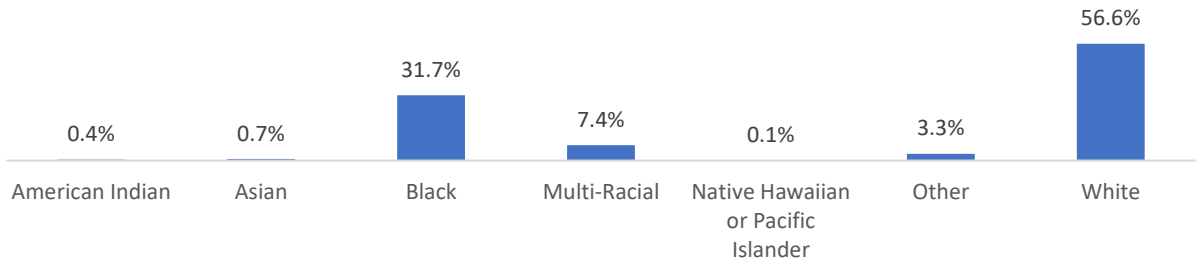
Source: CFCHS Individuals Served Data

Figure 76: CFCHS Homeless Individuals Served by Race



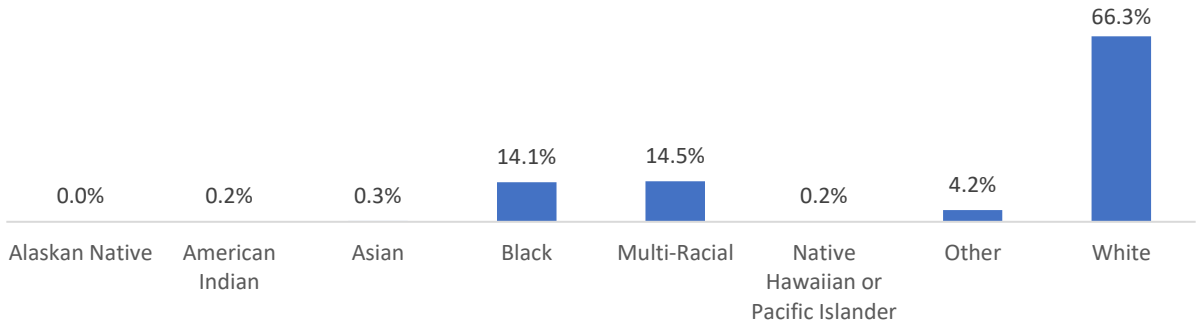
Source: CFCHS Individuals Served Data

Figure 77: CFCHS Homeless AMH Individuals Served by Race



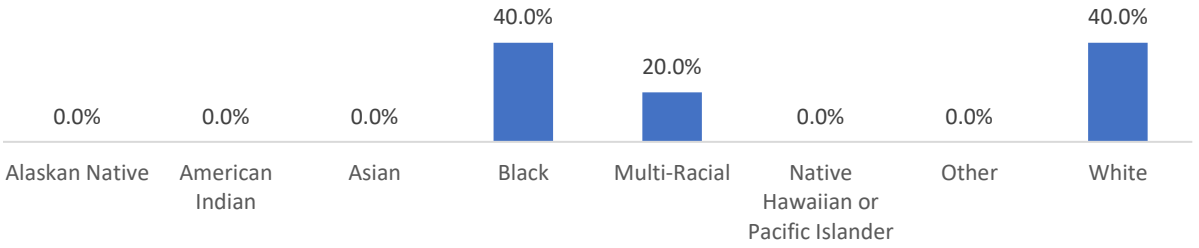
Source: CFCHS Individuals Served Data

Figure 78: CFCHS Homeless ASA Individuals Served by Race



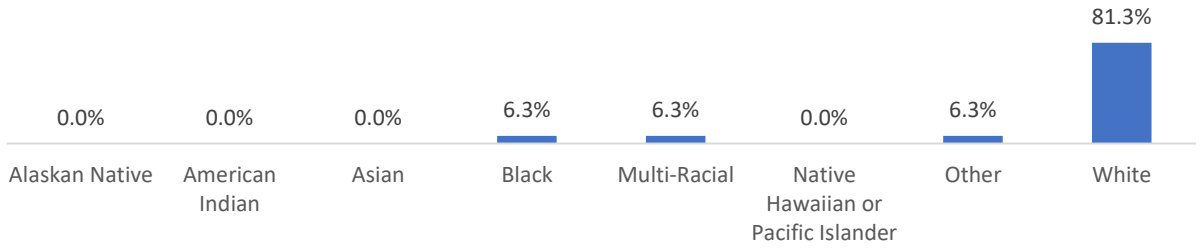
Source: CFCHS Individuals Served Data

Figure 79: CFCHS Homeless CMH Individuals Served by Race



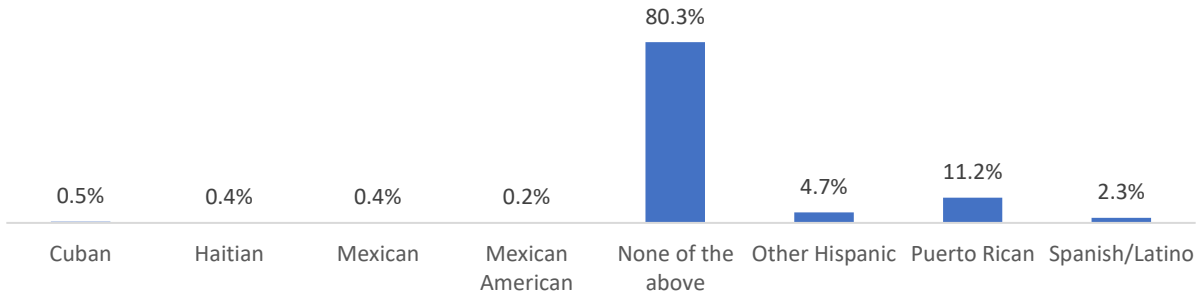
Source: CFCHS Individuals Served Data

Figure 80: CFCHS Homeless CSA Individuals Served by Race



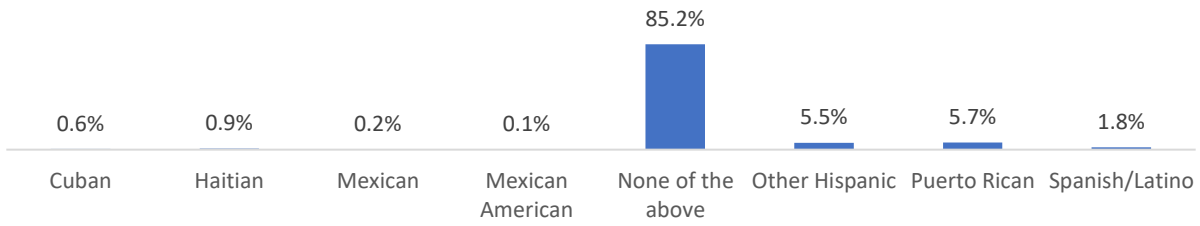
Source: CFCHS Individuals Served Data

Figure 81: CFCHS Homeless Individuals Served by Ethnicity



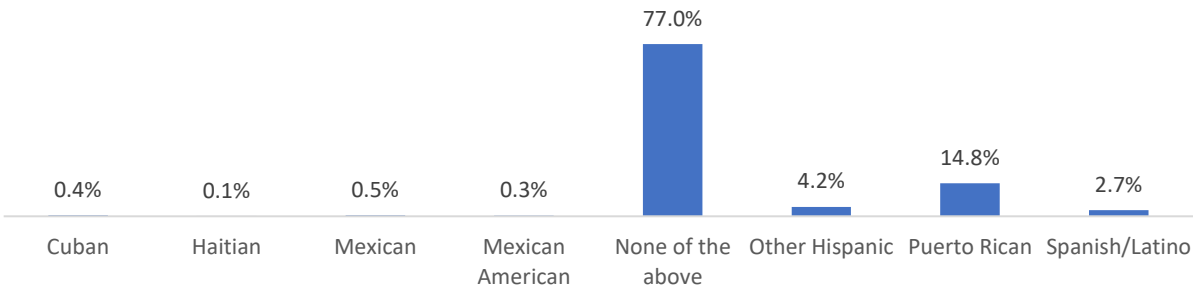
Source: CFCHS Individuals Served Data

Figure 82: CFCHS Homeless AMH Individuals Served by Ethnicity



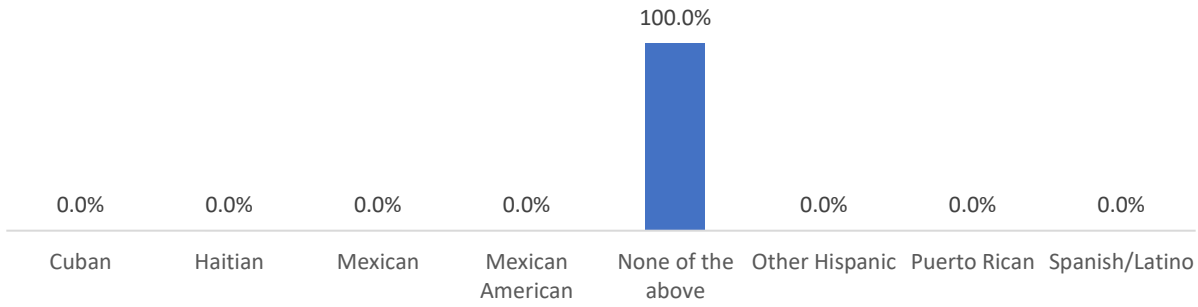
Source: CFCHS Individuals Served Data

Figure 83: CFCHS Homeless ASA Individuals Served by Ethnicity



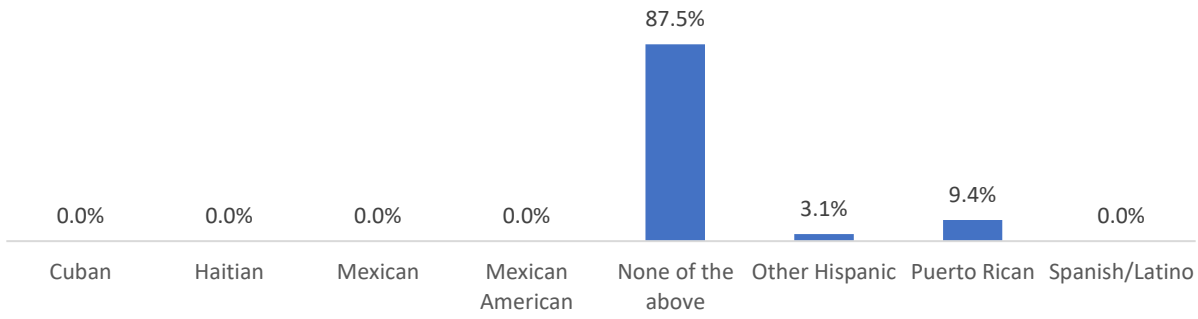
Source: CFCHS Individuals Served Data

Figure 84: CFCHS Homeless CMH Individuals Served by Ethnicity



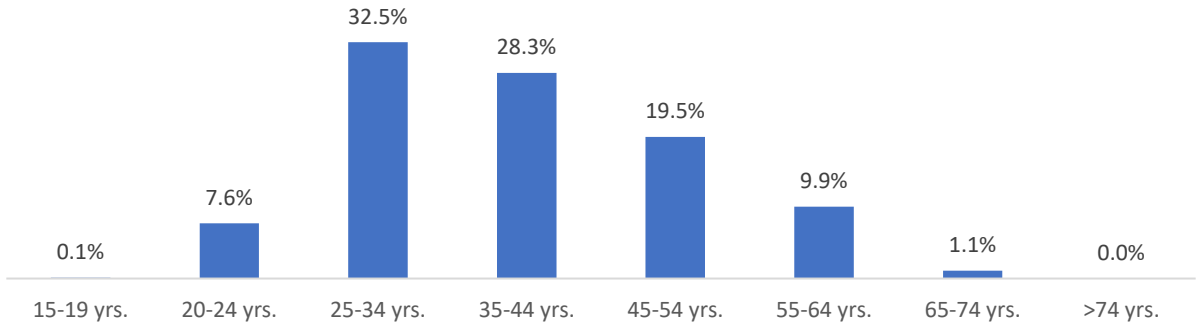
Source: CFCHS Individuals Served Data

Figure 85: CFCHS Homeless CSA Individuals Served by Ethnicity



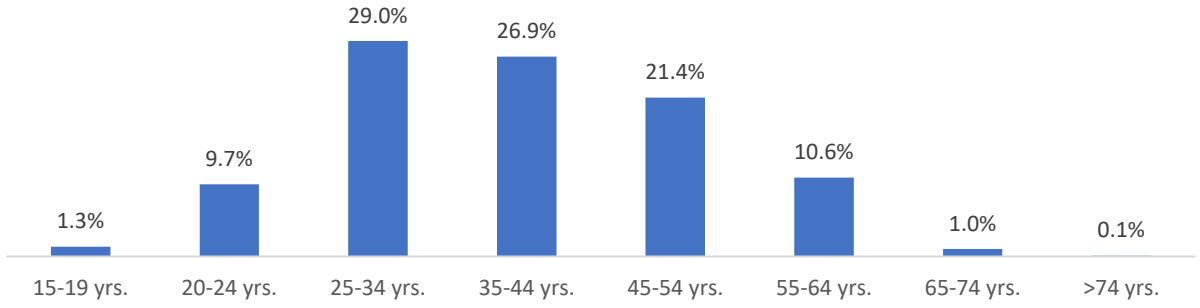
Source: CFCHS Individuals Served Data

Figure 86: CFCHS Homeless Individuals Served by Age Range



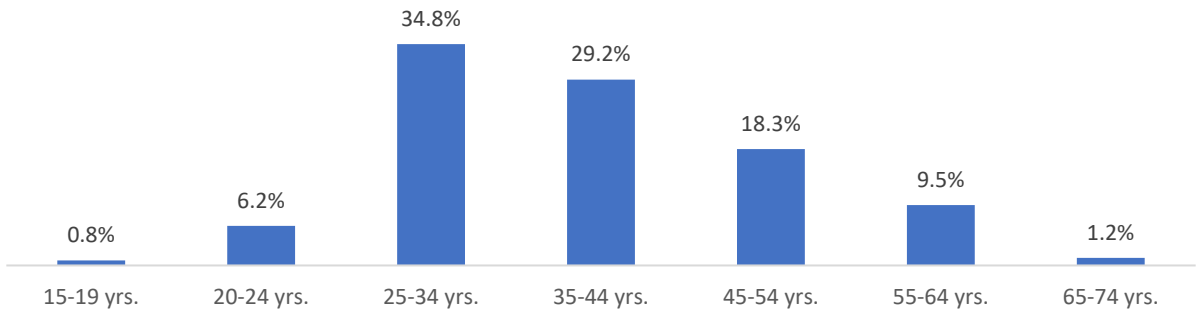
Source: CFCHS Individuals Served Data

Figure 87: CFCHS Homeless AMH Individuals Served by Age Range



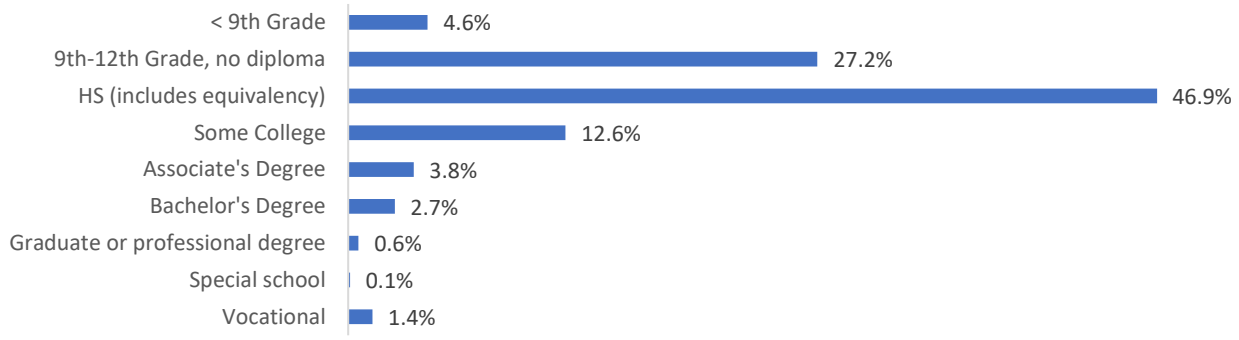
Source: CFCHS Individuals Served Data

Figure 88: CFCHS Homeless ASA Individuals Served by Age Range



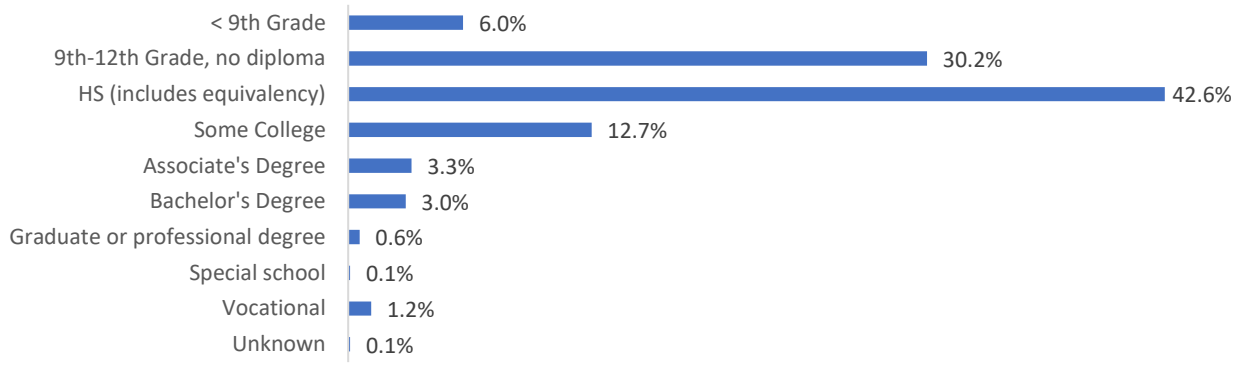
Source: CFCHS Individuals Served Data

Figure 89: CFCHS Homeless Individuals Served by Educational Attainment



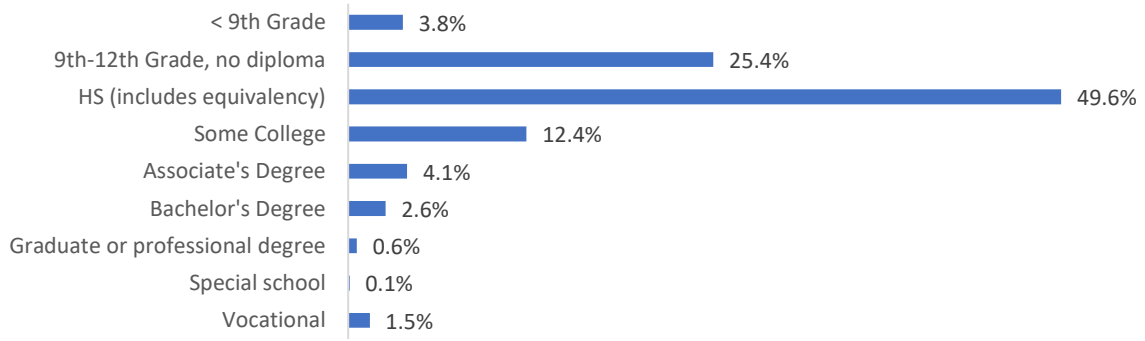
Source: CFCHS Individuals Served Data

Figure 90: CFCHS Homeless AMH Individuals Served by Educational Attainment



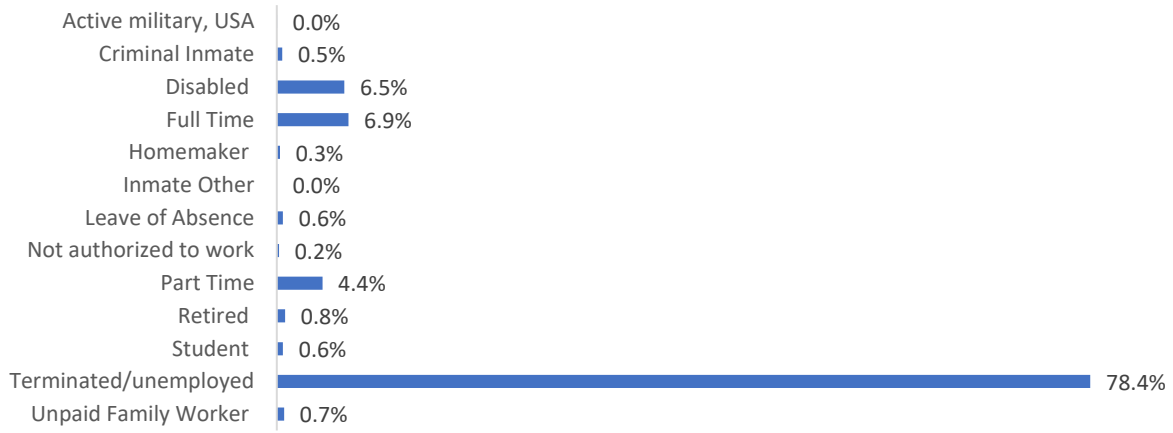
Source: CFCHS Individuals Served Data

Figure 91: CFCHS Homeless ASA Individuals Served by Educational Attainment



Source: CFCHS Individuals Served Data

Figure 92: CFCHS Homeless Individuals Served by Employment Status



Source: CFCHS Individuals Served Data

COST CENTER DESCRIPTION, EXPENDITURES, AND OVER/UNDER PRODUCTION (FY20-21)

ADULT MENTAL HEALTH PROGRAM

Cost Center Description	Expenditures	Over/Under Production
Assessment	$117,076.43	$69,471.10
Case Management	$2,037,253.35	$9,562.91
Crisis Stabilization	$8,390,914.81	$1,773,357.17
Crisis Support/Emergency	$5,010,073.73	-$8,012.48
Information and Referral	$299,273.19	$115,286.20
In-Home and On-Site Services	$190,018.05	$1,782.15
Inpatient	$294,509.00	$1,924,330.00
Intensive Case Management	$158,735.64	-$0.03
Intervention	$28,750.84	$632.50
Medical Services	$1,901,279.77	$258,118.47
Mental Health Clubhouse	$732,772.11	$207,886.57
Outpatient - Group	$180,624.83	$560.07
Outpatient - Individual	$868,711.13	$230,873.85
Outreach	$402,432.45	$26,177.67
Recovery Support - Group	$20,612.27	$0.04
Recovery Support - Individual	$4,912.39	$0.16
Residential Level 2	$545,581.86	$3,783.84
Residential Level 4	$176,840.28	$0.00
Room & Board Level 2	$2,243,358.47	$62,692.01
Room & Board Level 3	$1,794,252.18	$111,778.40
Short-term Residential TX	$2,830,725.28	-$137,565.52
Supported Housing/Living	$386,094.15	-$0.06
TOTAL	**$28,614,802.20**	**$4,650,715.04**

SOURCE: CFCHS Program Data

ADULT SUBSTANCE ABUSE PROGRAM

Cost Center Description	Expenditures	Over/Under Production
Assessment	$116,417.09	$427.43
Case Management	$703,461.19	$168,959.34
Crisis Support/Emergency	$1,431,800.57	$0.13
Day Treatment (Day/Night)	$172,055.19	$27.89
In-Home and On-Site Services	$10,615.86	$5,152.75
Intervention	$1,077,319.53	$531.52
Intervention - Group	$11,731.41	$0.01
Medical Services	$1,146,079.95	$3,999.15
Methadone Maintenance	$1,640,277.91	$16,488.89
Outpatient - Group	$252,675.93	$6,803.68
Outpatient - Individual	$1,286,584.58	$19,903.43
Outreach	$603,024.98	$36,521.78
Recovery Support - Group	$35,119.04	$1.96
Recovery Support - Individual	$471,969.73	$96,127.52
Residential Level 1	$1,628,473.98	$63,244.41
Residential Level 2	$7,844,562.75	$317,372.70
Residential Level 3	$709,783.92	$1,723.53
Residential Level 4	$247,172.78	$6,850.01
Room & Board Level 2	$146,827.93	$0.00
Substance Abuse Detoxification	$5,367,750.05	$53,590.73
Supported Housing/Living	$42,838.78	-$0.28
TASC	$337,442.65	-$0.07
TOTAL	**$25,283,985.78**	**$797,726.51**

SOURCE: CFCHS Program Data

CHILD MENTAL HEALTH PROGRAM

Cost Center Description	Expenditures	Over/Under Production
Assessment	$25,507.52	$239.80
Case Management	$634,257.42	$1,056.58
Crisis Stabilization	$390,963.16	$104,191.21
Crisis Support/Emergency	$672,753.87	$557,574.45
Information and Referral	$80,955.00	$22,716.16
In-Home and On-Site Services	$220,494.07	$9,440.66
Intervention	$215,272.51	$8,002.82
Medical Services	$19,024.01	$3,226.71
Outpatient - Group	$1,878.75	$0.00
Outpatient - Individual	$140,667.05	$13,876.01
Outreach	$164,197.21	-$0.17
Residential Level 1	$68,304.85	-$0.84
Respite Services	$17,578.56	$885.00
Room & Board Level 2	$37,521.87	$38,751.21
TOTAL	**$2,689,375.85**	**$759,959.59**

SOURCE: CFCHS Program Data

CHILD SUBSTANCE ABUSE PROGRAM

Cost Center Description	Expenditures	Over/Under Production
Assessment	$74.02	$0.00
Crisis Support/Emergency	$195,281.36	$0.15
Intervention	$680,145.34	$4,216.37
Intervention - Group	$7,258.44	-$0.06
Medical Services	$2,350.41	$0.00
Outpatient - Individual	$12,307.63	-$0.41
Residential Level 2	$879,068.32	$2,627.01
Substance Abuse Detoxification	$298,325.50	-$289,799.79
TASC	$986,412.04	-$0.02
TOTAL	**$3,061,223.06**	**-$282,956.76**

SOURCE: CFCHS Program Data

CFCHS All Cost Centers	Expenditures	Over/Under Production
Grand Total	$59,649,386.89	$5,925,444.38

CULTURAL HEALTH DISPARITY SURVEY SUMMARY

The 14-question Cultural Health Disparity Survey administered for individuals most in need and at high risk for disparity was distributed in vulnerable communities using the CDC Social Vulnerability Index (CDC SVI). This index uses U.S. Census data to determine the social vulnerability of every census tract. The CDC SVI ranks each tract on 15 social factors, including poverty, lack of vehicle access, and crowded housing, and groups them into four related themes: Socioeconomic Status, Household Composition, Race/Ethnicity/Language, and Housing/Transportation. A census tract ZIP Code crosswalk was created to assist CFCHS NSPs in identifying the most appropriate individuals for this survey. The survey was in the field for 5 weeks and made available through an electronic link and QR code that could be emailed, texted, printed, or posted to social media. The survey was translated into three languages: English, Spanish, and Creole.

CFCHS received 59 total respondents for the cultural health disparity survey. Of these, 75% (44 respondents) lived in ZIP Codes identified by the CDC Social Vulnerability Index. For the purposes of this project, this summary is based on the responses of the respondents living in vulnerable communities. It should be noted that a comparison of the percentages from the total number of participants and those of the 44 respondents were very similar.

Almost 80% of respondents were comfortable seeking behavioral health care services and 61.4% trusted or strongly trusted the system to treat them with respect. Respondents were asked to rank statements that most closely described their feelings regarding their behavioral health concerns. Asked if this was a private issue, I keep to myself, 48.8% of respondents said this was somewhat unlike or most unlike how I feel while 37.2% did in fact feel this was a private issue. Privacy was further explored when asked if this was a private issue that stays in the family. Over 50% of respondents revealed this was somewhat or most unlike how they felt. Just over 30% of respondents did feel this was an issue that stays in the family. Over 67% of respondents were comfortable sharing their challenges with others (professionals, family members, friends, clergy, etc.) while 25.6% were not comfortable. Almost 50% of respondents were more comfortable with people like me and just over 30% were neutral. Although respondents were offered a category of Other, no one chose this option.

To help identify the settings in which respondents were most comfortable receiving services, the survey offered five options (telehealth, hybrid of telehealth, private office with a doctor, speaking with a nurse practitioner, faith-based organization, all of the above, and none of the above) where the respondent could choose more than one option. Multiple responses were received per respondent, therefore the results reported are based on the total number of all responses. All five options were comfortable settings for 21.6% of the responses. Almost 30% preferred a private office with a doctor but only 10.8% were comfortable with speaking with a nurse practitioner. Telehealth and hybrid telehealth were popular settings among the respondents receiving 27% of the responses. Just over 10% of the responses chose the faith-based setting and less than 3% did

not find any of the care setting options comfortable. Respondents were provided an option to explain another setting that was most comfortable. Sharing with close friends who have had similar experiences and not being face-to-face with the therapist were offered. When options were limited to faith-based or traditional, respondents preferred the traditional setting in a ratio of 2:1. Respondent's comfort level was highest in the individual therapy setting where 81.8% of respondents were likely or very likely to be comfortable. Group therapy was a likely or very likely comfortable treatment option for 53.5% of respondents.

Over 90% of respondents received behavioral health care services in their primary language all or most of the time. Just less than 5% received services in their primary language some or a little of the time while 4.8% of respondents needed an interpreter.

Almost 60% of respondents were female. When asked for their gender identity, 54.5% preferred not to answer and 15.9% provided no response. Regarding sexual orientation, 75% of respondents were heterosexual, 4.5% pansexual, 4.5% gay/lesbian, 2.3% asexual, 2.3% bisexual, and 2.3% responded that their sexual orientation was not listed. Nine percent of respondents preferred not to answer this question.

Respondents were more racially and ethnically diverse when compared to the CFCHS service area population and CFCHS individuals served population as 54.5% were white, 20.5% were Black, and 11.4% were multi-racial. Among ethnicity, 34.9% were Hispanic. Most respondents were between 25-54 years of age.

CULUTRAL HEALTH DISPARITY SURVEY CHARTS

Figure 93: Are you usually comfortable seeking behavioral health services?

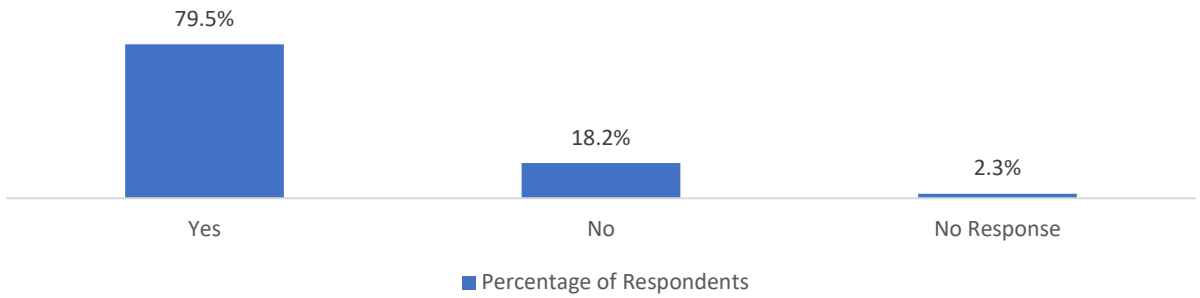


Figure 94: On a scale of 1 to 5, with 5 being 'strongly agree', how would you rate your trust in the behavioral health care system to treat you with respect?

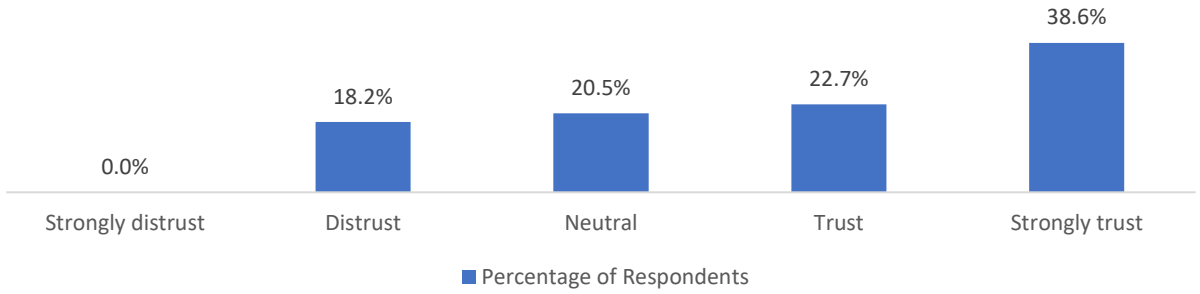


Figure 95: Please rank the statement below that most closely describe your feelings regarding your behavioral health issue, with (1) being the most and (5) being the least. "This is a private issue I keep to myself."

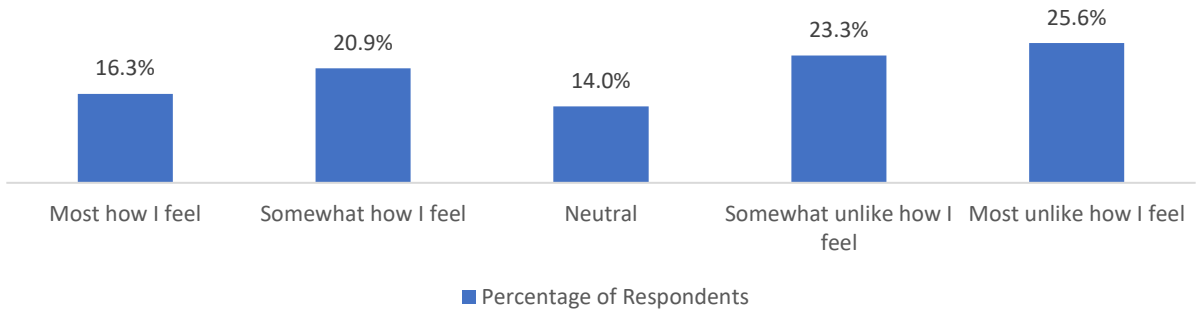


Figure 96: Please rank the statement below that most closely describes your feelings regarding your behavioral health issue, with (1) being the most and (5) being the least. "This is a private issue that stays in the family."

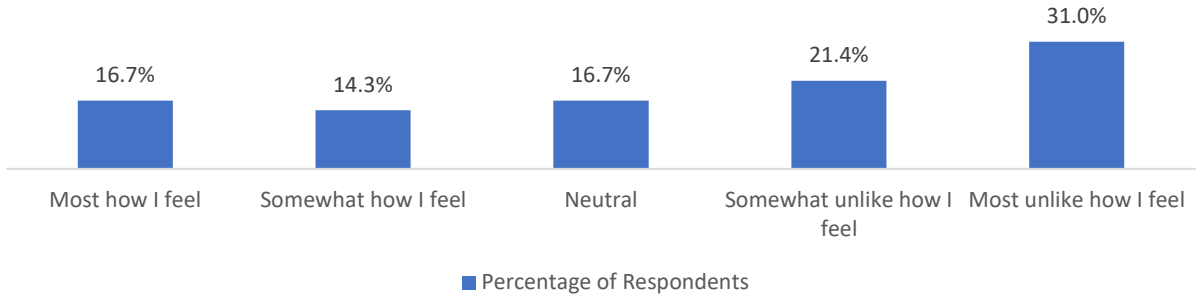


Figure 97: Please rank the statement below that most closely describes your feelings regarding your behavioral health issue, with (1) being the most and (5) being the least. "I am comfortable sharing my challenges with others."

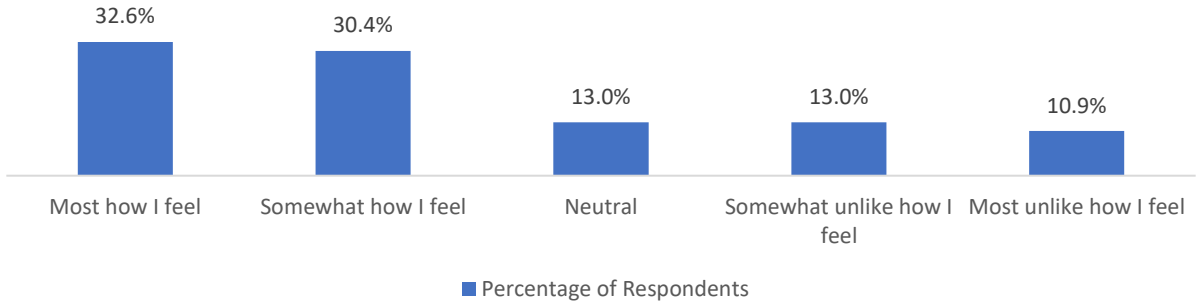


Figure 98: Please rank the statement below that most closely describes your feelings regarding your behavioral health issue, with (1) being the most and (5) being the least. "I am more comfortable with people like me."

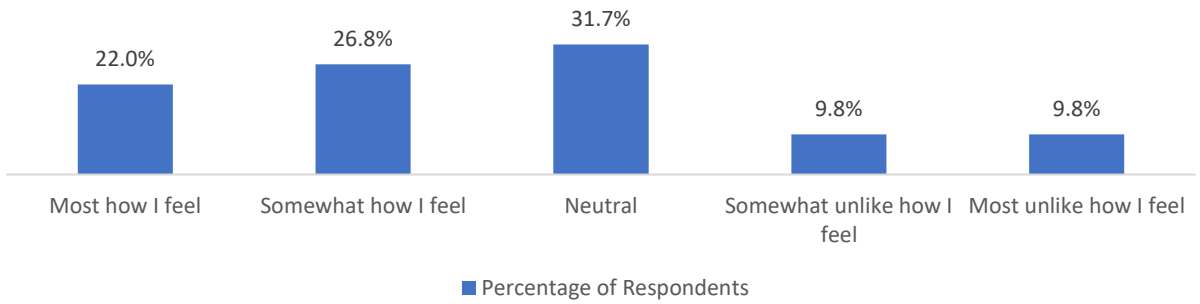


Figure 99: In which setting(s) have you been most comfortable discussing your behavioral health concerns? (Check all that apply)

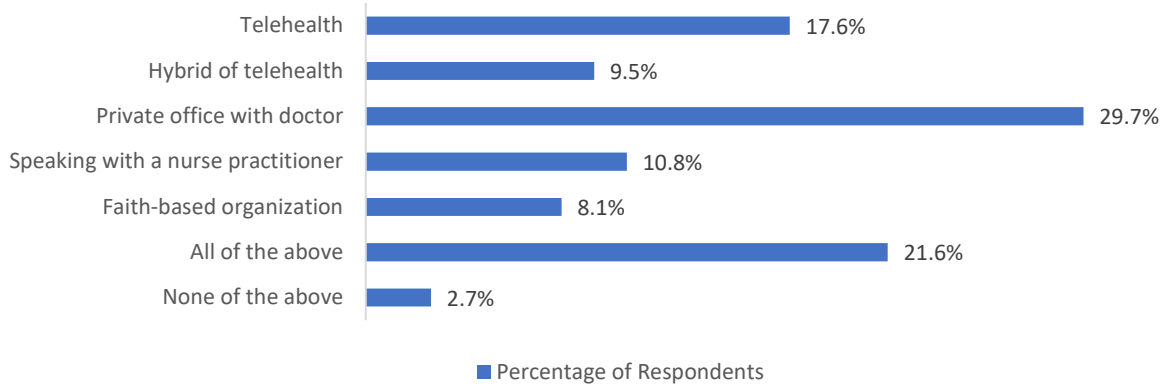


Figure 100: If given a choice for receiving behavioral health care services, would you be more comfortable going to a faith-based organization OR prefer the traditional physician office?

Figure 101: Now thinking about treatment options, on a scale of 1 to 5, with 5 being 'very likely', how comfortable would you be in group therapy?

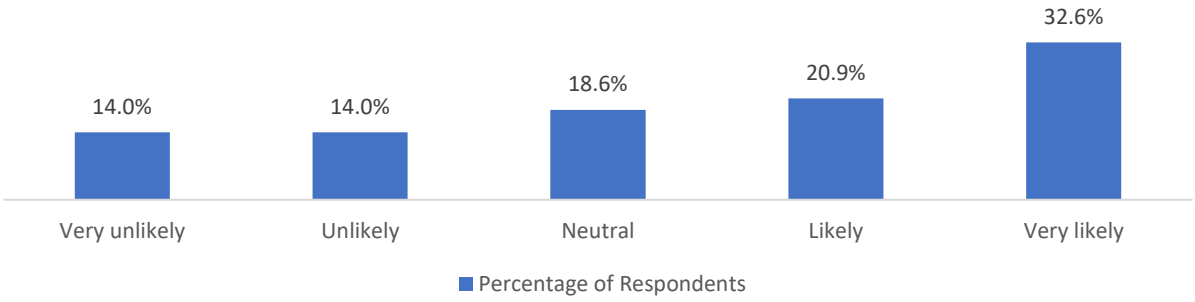


Figure 102: On a scale of 1 to 5, with 5 being 'very likely', how comfortable would you be in individual therapy?

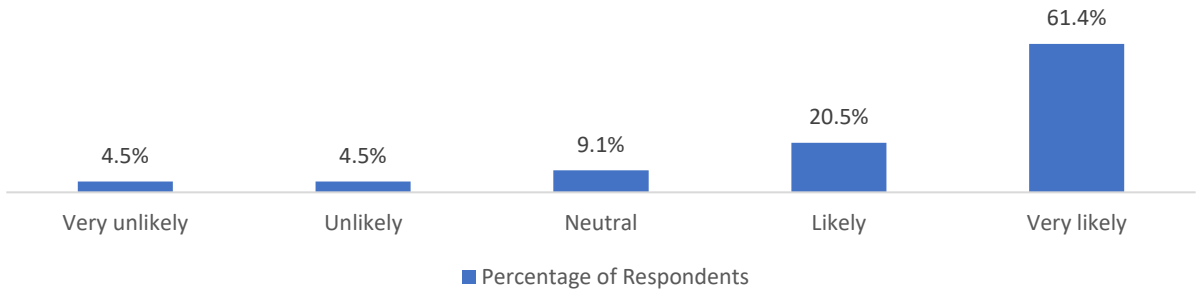


Figure 103: When you have received behavioral health care services in the past, were they mostly available in your primary language?

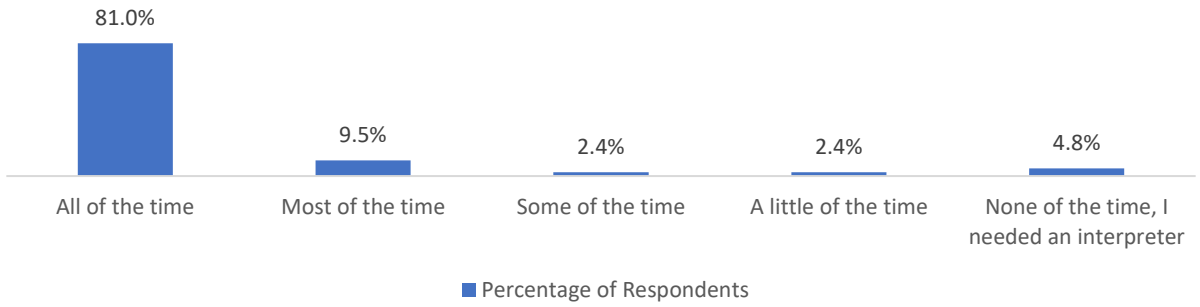


Figure 104: Which best describes your gender?

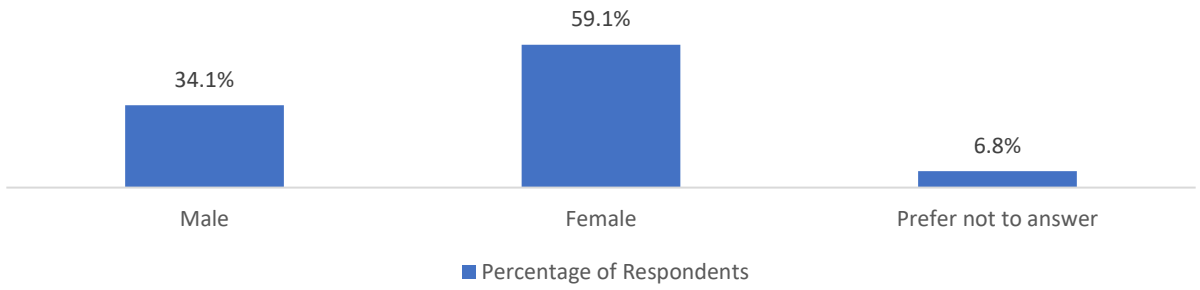


Figure 105: Which best describes your gender identity?

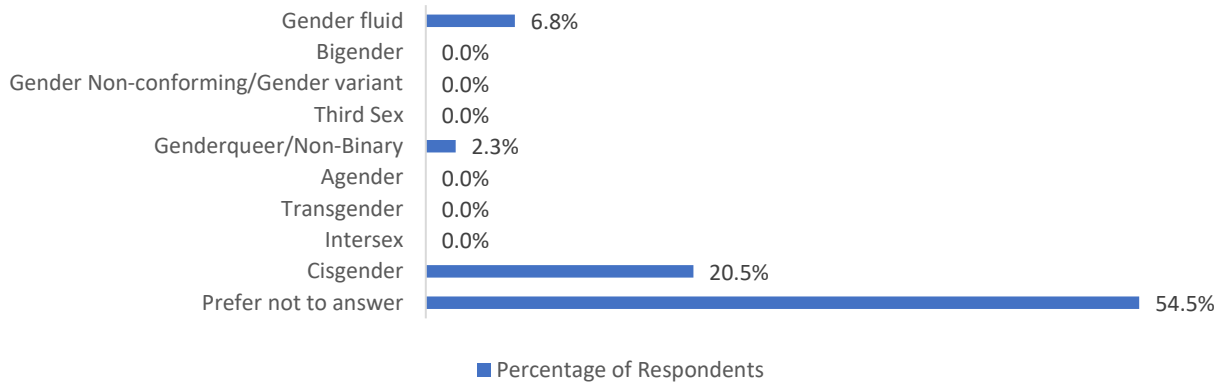


Figure 106: Which best describes your current sexual orientation? (Check all that apply)

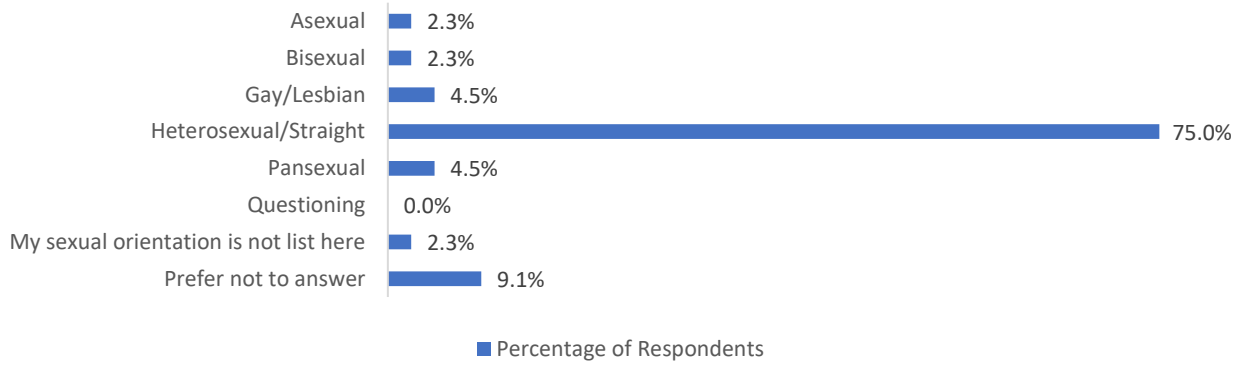


Figure 107: Which best describes your race?

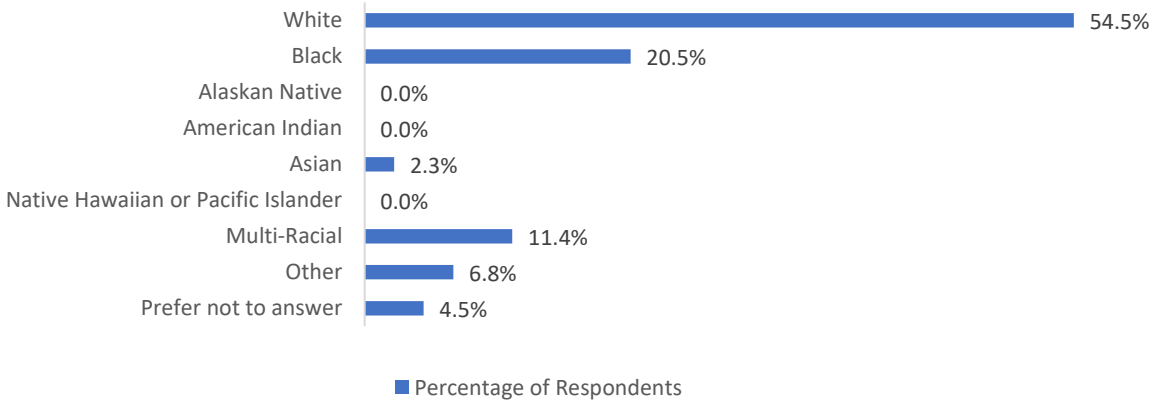


Figure 108: Which best describes your ethnicity?

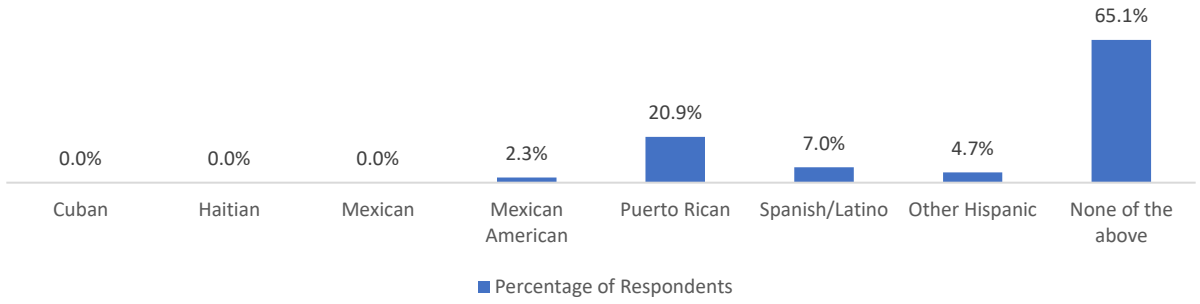
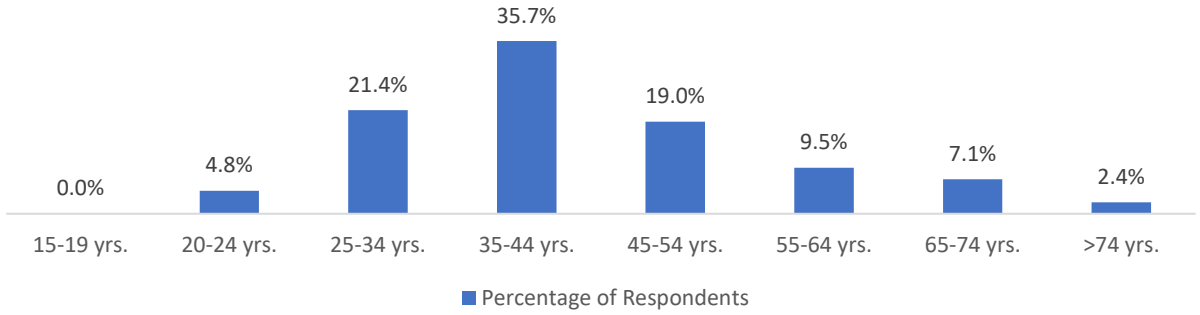


Figure 109: Please select your age range from the list below.



CULTURAL HEALTH DISPARITY SURVEY BY RACE AND ETHNICITY

The cultural health disparity survey was analyzed by race and ethnicity to further measure experience, awareness, and coordination of behavioral health services. This will help to facilitate focused strategic development and intervention implementation over the next three years.

Respondents were asked if they were comfortable seeking behavioral health care services. Among Black respondents, 50% were comfortable while 50% were not. Among Hispanic and White respondents, the percentages of those comfortable seeking care were higher at 72.5% and 82.1%, respectively.

When asked if they trust the health care system to treat them with respect, 75% of Black respondents trust (25%) or strongly trust (50%) to be treated with respect. The remaining 25% were neutral. These percentages were higher when compared to other demographic groups. Among Hispanic respondents, 33.3% distrust the behavioral health care system to treat them with respect, 33.3% were neutral, and the remaining 33.3% did trust or strongly trust to be treated with respect. More than half (57.5%) of White respondents trust (27.5%) or strongly trust (30%) that the health care system would treat them with respect. White respondents who were neutral accounted for 32.1%.

Respondents were asked to describe their feelings regarding their behavioral health issues. When asked, if this was a private issue I keep to myself, most Black (66.7%) and Hispanic (71.4%) respondents indicated that this is most how they feel. One-third of Black respondents indicated this is somewhat unlike how they feel. Among Hispanic respondents, 28.6% indicated this is most unlike how they feel. White respondents were split on behavioral health issues being a private matter I keep to myself as 20% indicated this was most how I feel, 26.7% said this is somewhat how I feel, and 33.3% indicated this is somewhat unlike how I feel.

Regarding their behavioral health issues as a private matter that stays in the family, 50% of Black and Hispanic respondents indicated this was somewhat how I feel. The remaining 50% of Black respondents indicated this is most unlike how I feel. Among Hispanic respondents, 37.5% indicated this is somewhat unlike how I feel while 12.5% said this is most unlike how I feel. White respondents were split on responses to this question as 12.1% indicated this was most how they feel, 18.2% said this is somewhat how I feel, 24.2% were neutral, 21.2% indicated this is somewhat unlike how I feel, and 24.2% said it was most unlike how I feel.

Regarding comfort sharing their challenges with others, 100% of Black respondents were neutral. Among Hispanic respondents, 66.6% indicated this is somewhat unlike or most unlike how I feel. Among White respondents, 35.3% indicated this is most how they feel, 23.5% were neutral, and 20.6% said this is somewhat unlike how I feel.

When asked if they were more comfortable with people like them, 66.6% of Black respondents indicated this is somewhat unlike how I feel or most unlike how I feel. Fifty percent of Hispanic

respondents were neutral, and 25% indicated this is somewhat unlike how I feel. Among White respondents, 31.4% were neutral, 25.7% indicated this is somewhat how I feel, and 17.1% said this is most how I feel.

The most comfortable setting for discussing their behavioral health issues for Black respondents was in a private office with a physician at 28.6%. Telehealth, a hybrid of telehealth, speaking with a nurse practitioner, and faith-based organization each accounted for 14.3% of Black respondents. Among Hispanic respondents, 21.4% preferred a hybrid or telehealth, 21.4% said a private office with a doctor, and 14.3% preferred a faith-based organization. White respondents preferred a private office with a doctor at 34.8%. Telehealth, at 29%, was preferred over a hybrid of telehealth at 15.9%. Only 4.3% of White respondents selected a faith-based organization for receiving behavioral health services.

When asked to choose between faith-based or the traditional physician office, results were different from the results in the preceding question for Hispanic respondents as 55.6% indicated their preference for a faith-based organization. Most Black (75%) and White (87.5%) respondents indicated they would be more comfortable in a private office with a physician.

Among Black respondents, 50% were very likely to be comfortable in group therapy. The remaining 50% were either very unlikely or unlikely to be comfortable in group therapy. For Hispanic respondents, 44.4% were neutral and 44.4% were very likely to be comfortable in group therapy. White respondents were split as 27.5% were very unlikely to be comfortable in group therapy, 20% were unlikely, 20% were neutral, 15% were likely, and 17.5% were very likely to be comfortable in group therapy. When asked about their comfort in individual therapy, 100% of Black and 90% of White respondents were likely or very likely to be comfortable. Among Hispanic respondents, 44.4% were neutral and 55.6% were likely or very likely to be comfortable in individual therapy.

When asked if the behavioral health services they received in the past were mostly available in their primary language, 75% of Black respondents, 77.8% of Hispanic respondents, and 100% of White respondents received services in their primary language all of the time. Those who received services in the primary language only a little of the time accounted for 25% of Black and 11.1% of Hispanic respondents. No respondents needed an interpreter.

CULTURAL HEALTH DISPARITY SURVEY BY RACE AND ETHNICITY CHARTS

Figure 110: Are you usually comfortable seeking behavioral health care services?

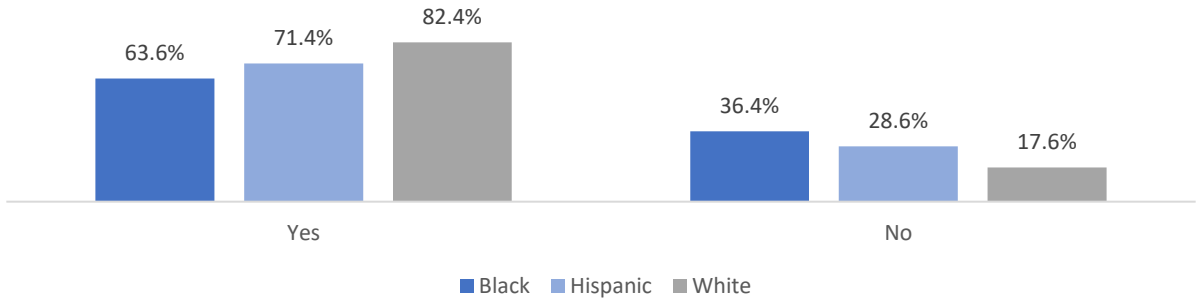


Figure 111: On a scale of 1 to 5, with 5 being 'strongly agree', how would you rate your trust in the behavioral health care system to treat you with respect?

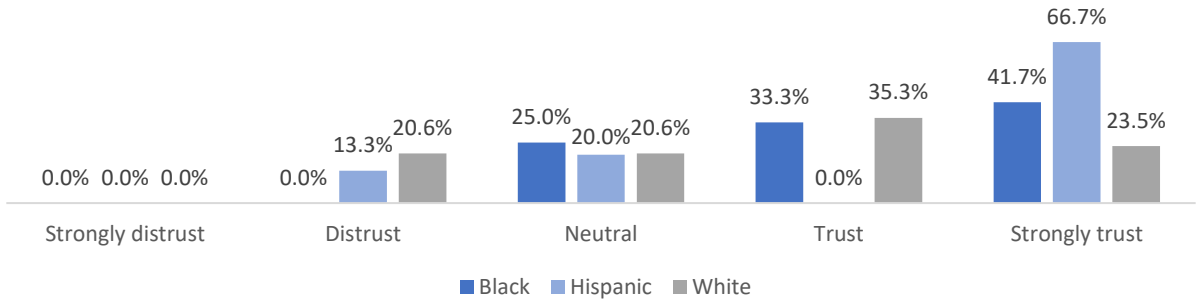


Figure 112: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues with (1) being the best and (5) being the least. This is a private issue I keep to myself.

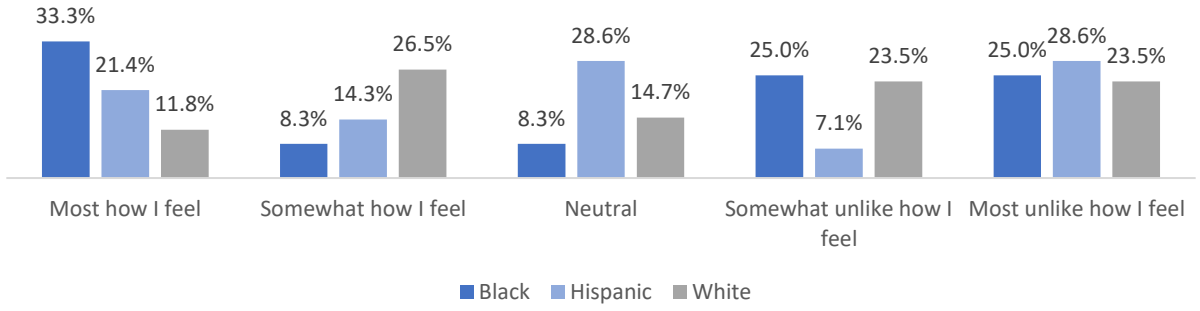


Figure 113: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues with (1) being the best and (5) being the least. This is a private issue that stays in the family.

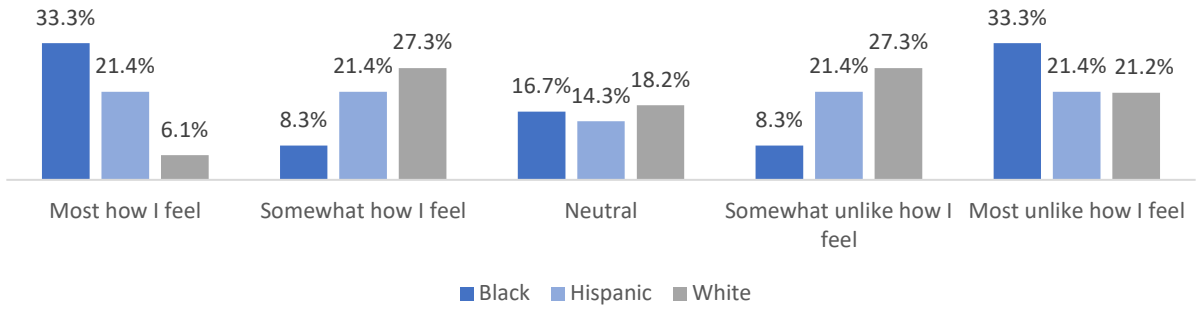


Figure 114: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. I am comfortable sharing my challenges with others.

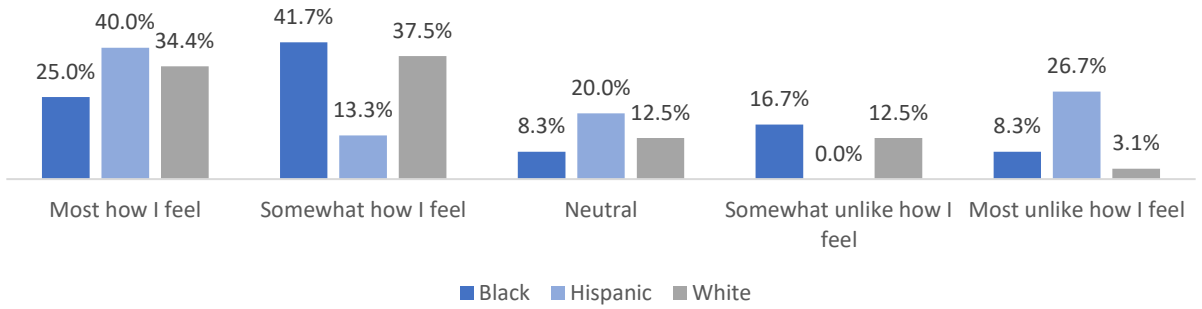


Figure 115: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. I am more comfortable with people like me.

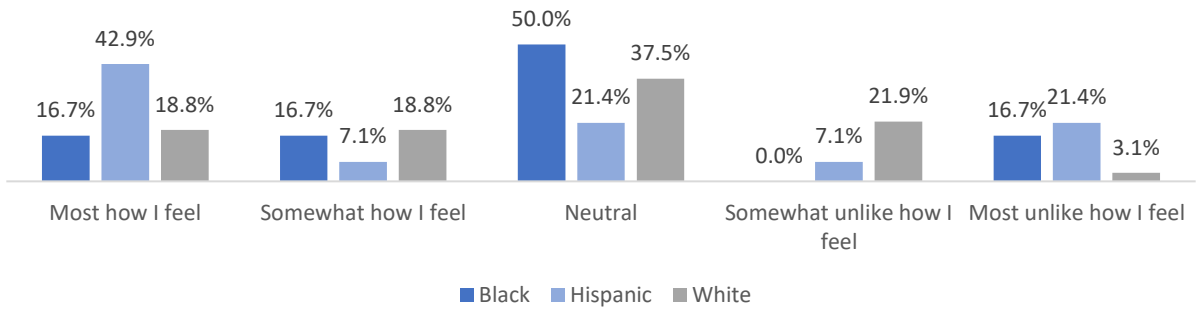


Figure 116: In which setting(s) have you been the most comfortable discussing your behavioral health concerns? (Check all that apply)

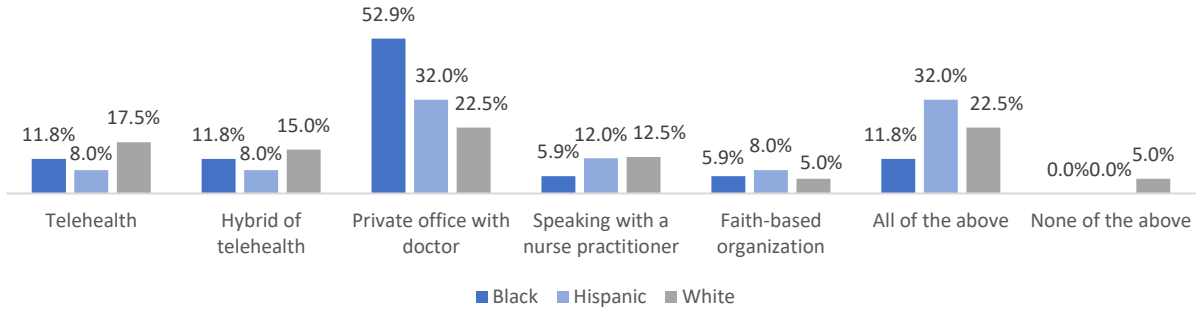


Figure 117: If given a choice for receiving behavioral health care services, would you be more comfortable going to a faith-based organization OR prefer the traditional physician office?

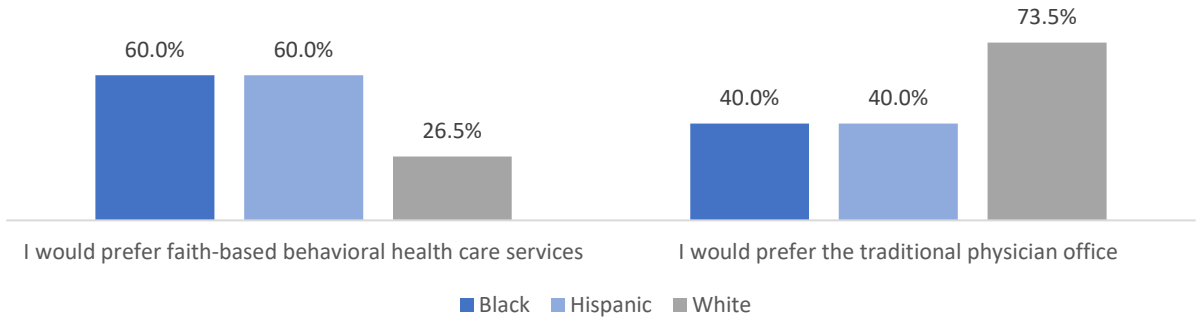


Figure 118: Now thinking about treatment options, on a scale of 1 to 5, with 5 being very likely, how comfortable would you be in group therapy?

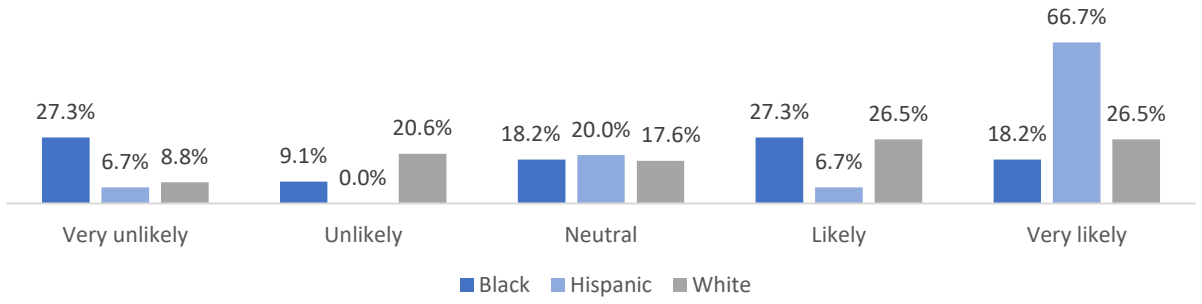


Figure 119: On a scale of 1 to 5, with 5 being very likely, how comfortable would you be in individual therapy?

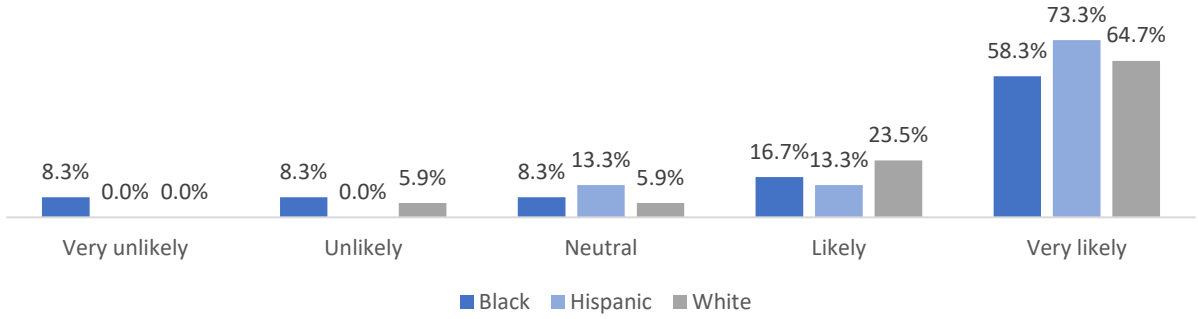
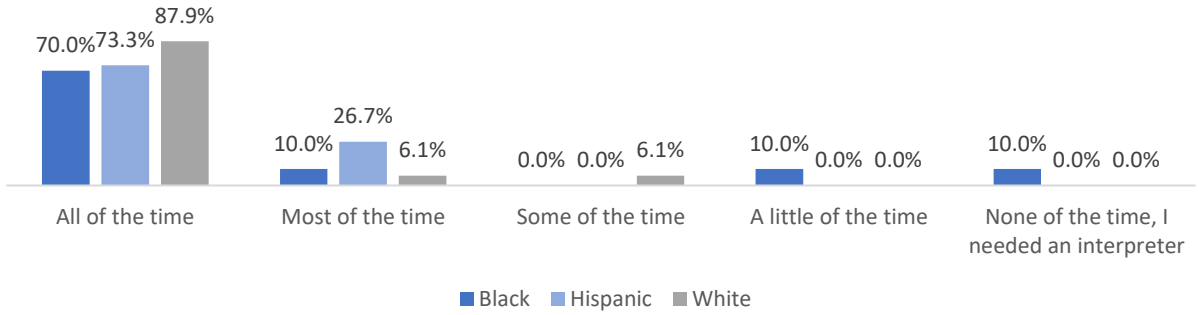


Figure 120: When you have received behavioral health care services in the past, were they mostly available in your primary language?



CULTURAL HEALTH DISPARITY FOCUS GROUP SUMMARY

CFCHS conducted 14 focus groups with community members. There was an average of eight participants per group. The participating organizations were as follows:

- Advent Health Hope & Healing
- Aspire Health Partners
- Brevard FACT/MHRC
- Brevard Family Partnership
- Central Florida Treatment Center/CFSATC
- Eckerd Connects
- Federation of Families of Central Florida
- House of Freedom
- Kissimmee FACT/MHRC
- New Season/Metro Treatment of Central Florida
- STEPS
- The RASE Project
- University Behavioral Center
- Volunteers of America
- Wayne Densch Center

Participants were asked five questions regarding their expereinces accessing behavioral health services, payment, quality, linkages, and to share other thoughts that had not been discussed. The information gathered from these groups will be an integral data component to the strategic planning process that will follow later this year. Responsess from all groups have been summarized for the reader.

TELL US ABOUT (DESCRIBE) YOUR EXPERIENCE IN ACCESSING MENTAL HEALTH SERVICES:

What was the process like?

When describing the process participants encountered accessing services, there was a wide range of experiences. Some participants expressed receiving an immediate and supportive response. The respondents were made to feel comfortable, hope and inspiration provided, started down the right path, taught life skills to avoid future problems, were respectful and genuine, and were treated as people, not as a number. Others shared that their insurance company played a role in connecting them to services without issues. Participants received warm handoffs to services which

contributed to their continued recovery. Participants shared that access to medications were provided, sometimes at no charge, and on an as-needed basis.

Other respondents explained how difficult the process was for them. Not all organizations were able to provide the needed services which led participants to seek alternatives on their own. This was a long process where phone calls were not returned in a timely manner, counselors who had been providing services left the organization, residential detox beds were not readily available, there was a waitlist for services, insurance was not accepted, and eligibility requirements left individuals unable to access services. In addition to having their health insurance rejected, changing insurance companies changed the providers that the respondents were currently using. This resulted in seeking out new providers which disrupted the continuity of care. For homeless individuals the process was even more challenging. Those in need of behavioral health services often experienced delays in receiving needed care.

Participants expressed their frustration with the current health care system. Patients do not get to see the doctor, only the nurse/nurse practitioner. They expressed their concern over the lack of history the nurse has in treating the patients when compared to the doctor. There was also a lack of personal interaction by the medical staff who spent most of the appointment time on the computer. Patients expressed the need for more education regarding medications, patient rights, and managing expectations. Participants highlighted the lack of communication between multiple doctors involved in their treatment, which led to conflicts in care. Medication conflicts also existed with participants who used multiple pharmacies to fulfill prescriptions.

Adding to access issues are the social or self-perceived constraints that further hinder access to services such as stigma, embarrassment, what happens in the family stays in the family, and misunderstandings regarding mental illness within the corrections system. The uninsured individuals did not feel secure seeking services. They felt services would be less adequate due to their inability to pay. The perception that individuals received from some organizations left them feeling as if they were “junkies”.

Individuals moving to Florida for services shared that behavioral health resources are difficult to find when there is no family member to help guide them through the process. They encountered many steps during the process (required referrals, intake, social worker, and case manager) before receiving an appointment for the first visit. Many participants shared that they did their own research to find services due to a lack of one-stop shopping for resources.

How long did you wait to begin services?

The length of time spent waiting to begin services depended on many factors. Those who were in the hospital seemed to get services quicker than others who accessed services from the outside. Also, peers played a big role in connecting to services more rapidly. Individuals under the Baker Act needed to wait for referrals before being transferred to treatment services. Those new to

Florida seemed to have the longest wait times for services, which in some cases, took over one year to access. On average, the wait times expressed by the participants ranged from 2 weeks to 4 months.

Were you provided/offered other services in a timely fashion?

Participants indicated a lack of providers, coordination, not knowing where to go for services, and insurance complications (whether you have it or not, there can be problems). There was frustration when referring to the 2-1-1 information and referral resource as focus group participants felt they were directed to the resource simply because no one knew where else to send them. The paperwork required for some services was difficult to complete. Services for children were harder to obtain and took longer to receive. There is a shortage of psychiatrists, psychologists, counselors, and peers to serve the Central Florida population.

PLEASE SHARE WITH US HOW YOU PAID FOR THE SERVICES YOU RECEIVED.

Please share with us any eligibility barriers you experienced in paying for or qualifying for service.

Some counseling services were limited for individuals with 3rd party insurance who had to wait for availability. Other barriers included: those on a sliding fee scale or flat rate for all, having services covered by the program itself, limited grant funding, payment methods for telehealth, inability to afford the insurance co-pay or meet the deductible, had to forgo medications due to the cost, funds limited to cover those in crisis only, encountered a Medicaid cap (where the organization has a limit on the number of cases that can be accepted for reimbursement), justification for needing the service which is dependent up the diagnosis, limited housing, and no transportation to access services outside of the community.

Participants reported that Medicaid was difficult to navigate, and providers were no longer offering services, although they were listed in the handbook. For those without any insurance, one may be able to see the doctor for free but couldn't afford the medications. Insurance-provided transportation got the individual to services but pick up for the return trip home took up to several hours.

DO YOU FEEL THE QUALITY OF SERVICES YOU RECEIVED WAS HELPFUL TOWARDS RECOVERY?

Can you share your experiences in developing treatment goals?

Most participants felt they received quality services and expressed positive experiences in developing their treatment goals. Many felt the support they received connected them to the staff, provided stability in their recovery, and needs were accommodated. They had much praise

for their counselors who helped them define tangible steps toward attaining the bigger goal. There was a lot of team collaboration developing treatment goals.

Participants indicated that treatment goals need to be realistic while accounting for everyday life. Having a mentor or support group helped with meeting established goals. Staff changes had a definite impact on outcomes. Care coordination with medical providers would help to improve outcomes.

The COVID-19 pandemic did have an impact on receiving in-person services. Virtual (telehealth) visits were not a one-size-fits-all solution.

Participants expressed their dissatisfaction regarding child services. Issues were raised regarding the lack of engagement of providers, over medicating, true needs not being addressed, family issues creating additional stress, poverty was a challenging dynamic, and families do not always feel that their voices are heard.

PLEASE SHARE WITH US YOUR PAST EXPERIENCES WITH AND BEING LINKED/CONNECTED TO SERVICES.

Linkages do not always connect to the right place or the right services at the time they are needed most. Participants with bad experiences lose trust in the system. With limited resources, there is no place to turn. Choices are limited if you are in the legal system with court ordered services.

Individuals without discharge plans felt like they were locked in the system and questioned the model of care. Recovery support services were needed to prevent undoing years of progress gained through treatment. Some participants would prefer to have therapy before being offered drugs to address their issues.

Access to the same treatment varies according to the organization. This can take up to 1 day at one facility but up to 2 months at another facility. Completing applications to apply for services was delayed when individuals required assistance due to reading and writing challenges.

IS THERE ANYTHING YOU WOULD LIKE TO SHARE WITH US ABOUT TODAYS THAT WE HAVEN'T DISCUSSED?

- Make 30-day programs longer, let individuals stay longer if they need to, individuals are referred for discharge too soon
- Better transportation to meetings and services, medical transportation lacking in reliability
- More staff, more education for staff to know referral and support services (related to high staff turnover)
- Improved phone system for vision impaired, need to personalize message so individuals know they are calling the correct person

- Create a personal space in residential for individuals to work on needs, provide support places for individuals to go who are trying to break the habit
- Improved transitions from one facility to another
- Resources lists are often outdated and unattainable, finding resources on your own is extremely challenging
- Social support systems needed for parents of children with mental health needs, housing, respite, job security, after-school programs, children not eligible for certain programs due to diagnosis
- Holistic services should be added to programs, nutrition, more food pantries
- Corrections system not trained to effectively respond to those with mental illness

NO WRONG DOOR SURVEY SUMMARY

The No Wrong Door (NWD) survey was distributed by CFCHS to their Network Service providers (NSPs). The purpose of the survey was to gather their perceptions related to care coordination, awareness, processes, advocacy, and evaluation. Questions were developed to further validate the findings through focus group research. The survey received 17 respondents, who represented slightly less than half of all NSP's serving in the CFCHS region. The survey was in the field for 5 weeks and made available through an electronic link and QR code that could be emailed, texted, printed, or posted to social media.

Respondents represented those working in adult residential facilities (32%), Adult Outpatient Program (28%), Peer Support (20%), and Children's Outpatient program at 12%.

Over 80% of respondents indicated that the NWD access works well, while 18.8% of respondents were not sure. Most respondents (88.2%) agreed that their organization has a role to play with the NWD access and that warm handoffs were part of their care coordination process.

When asked if they had taken action to improve referral and care coordination, 78.9% of respondents strongly agreed or agreed that this action was taken by their organization. While no respondents disagreed, 21.1% were unsure. According to the participating providers, 70.6% revealed that linkages to crisis interventions were occurring, 23.5% were not sure, and 5.9% disagreed this was an action taking place at their organization.

Awareness promotion of available options and linkages to needed services was undertaken by 88.2% of the respondents that participated in the survey. All NSP's strongly agreed or agreed that services were patient centered and culturally competent. Regarding the ease of accessing services, 76.5% of respondents strongly agreed or agreed that this is a quick and efficient process. However, 53.3% of respondents replied that they did not think standardizing the intake and screening process would help individuals get into services more quickly. An additional 20% were not sure this would work. Respondents (94.1%) felt overwhelmed that their organizations encouraged partnerships to ensure care coordination.

Regarding equal access, 47.1% of respondents disagreed that all individuals in need of services have the same access, while 52.9% of respondents agreed or strongly agreed with this statement. Respondents were divided on whether stakeholders help to address and advocate for equal access with 41.7% who strongly agreed, 17.6% who agreed, 23.5% were not sure, and 17.6% disagreed. Further probing is needed to address this access issue.

All respondents agreed that the services provided by their organizations are of high quality and 94.1% agreed that continuous evaluation is undertaken to improve outcomes.

NO WRONG DOOR SURVEY CHARTS

Figure 121: I work in a/an...

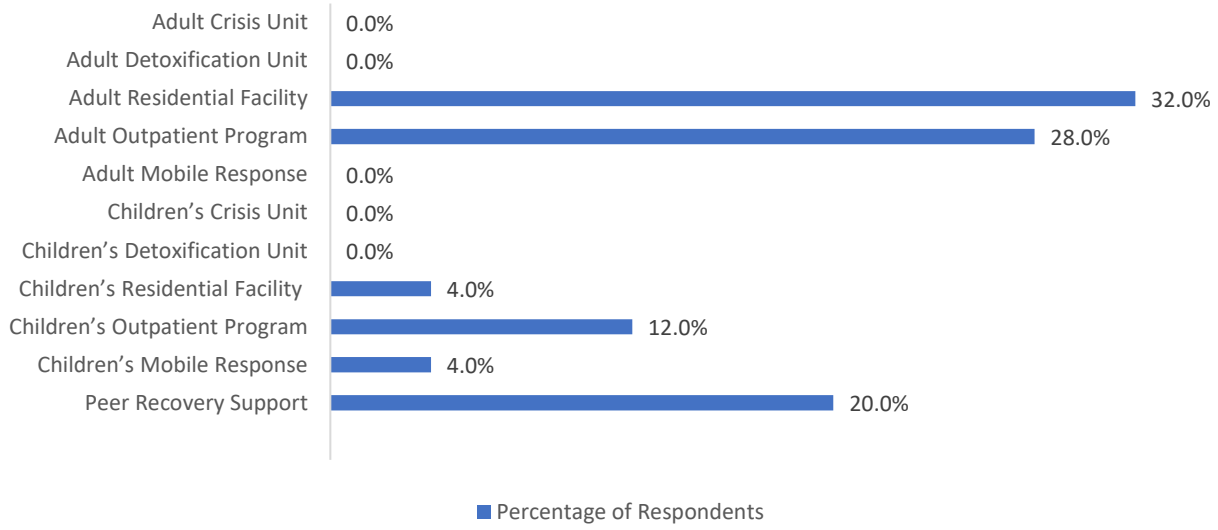


Figure 122: Do you think the "No Wrong Door" access works well within your organization?

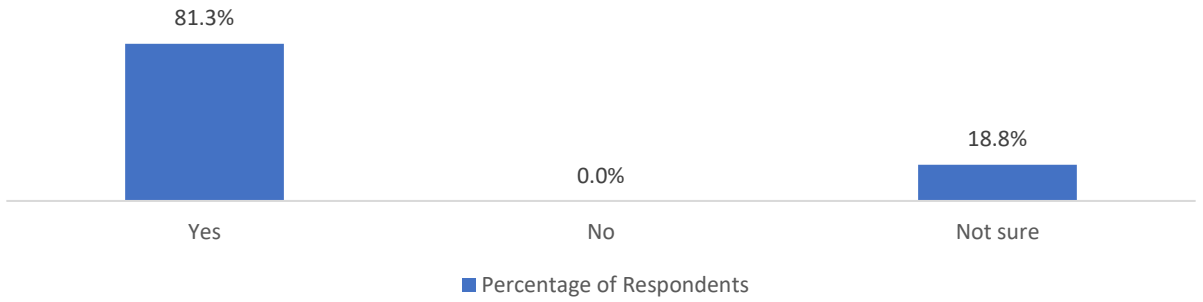


Figure 123: From your perspective your organization has a role to play in the "No Wrong Door" access.

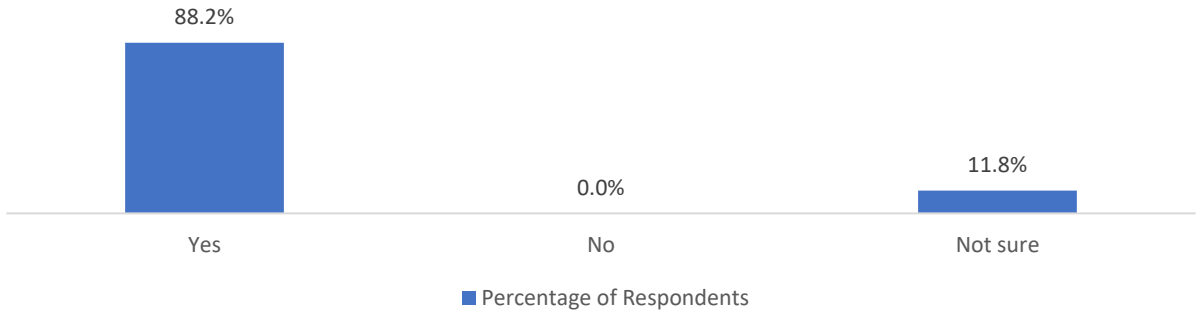


Figure 124: In your opinion, your organization has a strong care coordination process that includes warm handoffs to services and seamless care coordination.

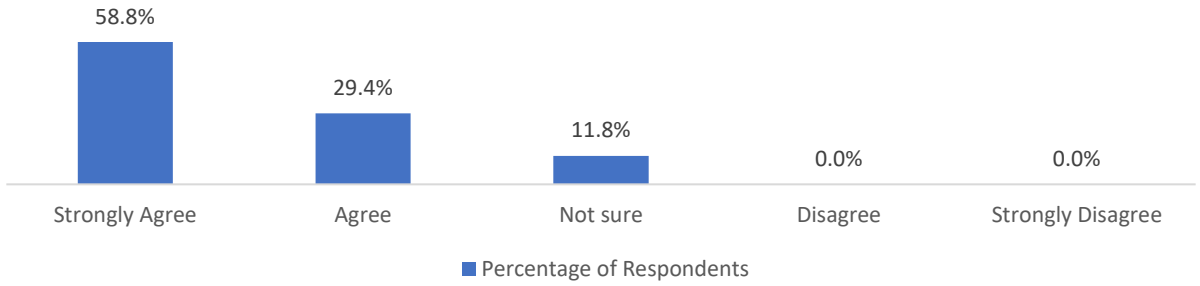


Figure 125: In your opinion, your organization has taken action to improve the referral and care coordination process for individuals served.

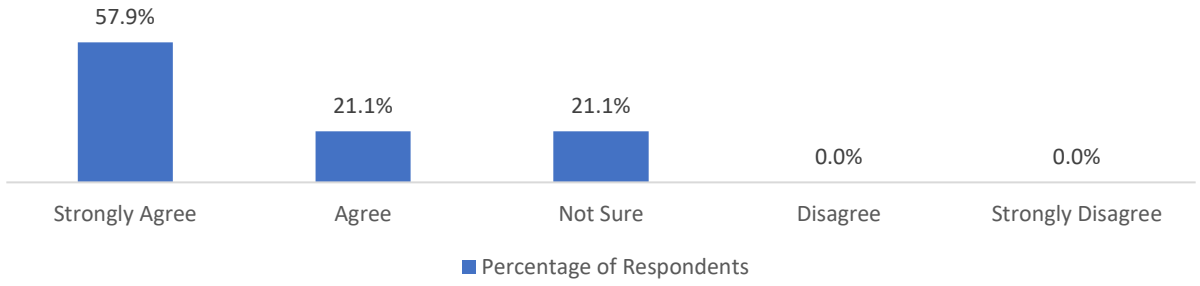


Figure 126: In your opinion, linkages to crisis intervention and support (like the Mobile Crisis Response Team, medication management, CRF, CIT Officer, BA, CSU, etc.) are occurring.

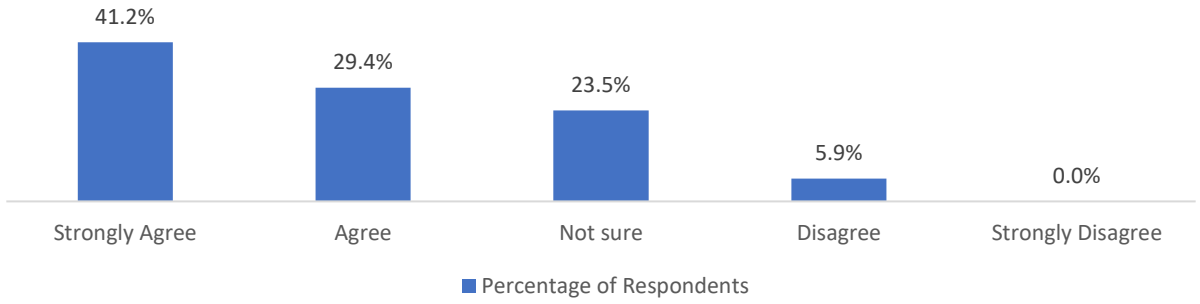


Figure 127: In your opinion, your organization promotes its services and resources very well.

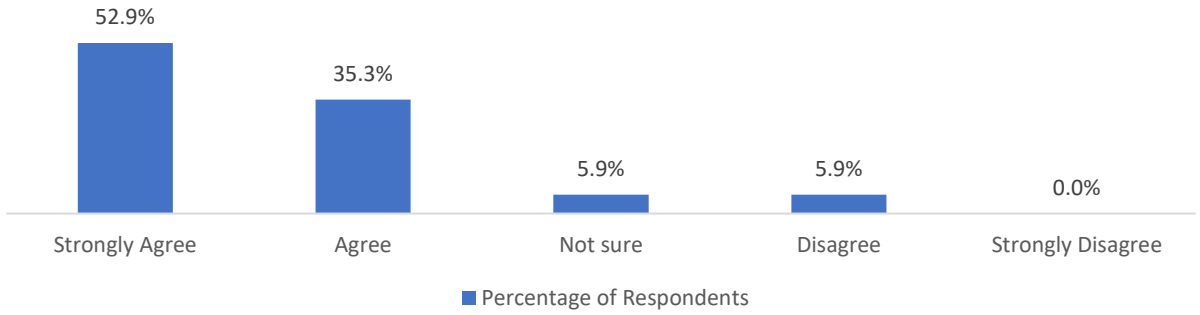


Figure 128: In your opinion, your organization promotes awareness of available options and linkages to need services.

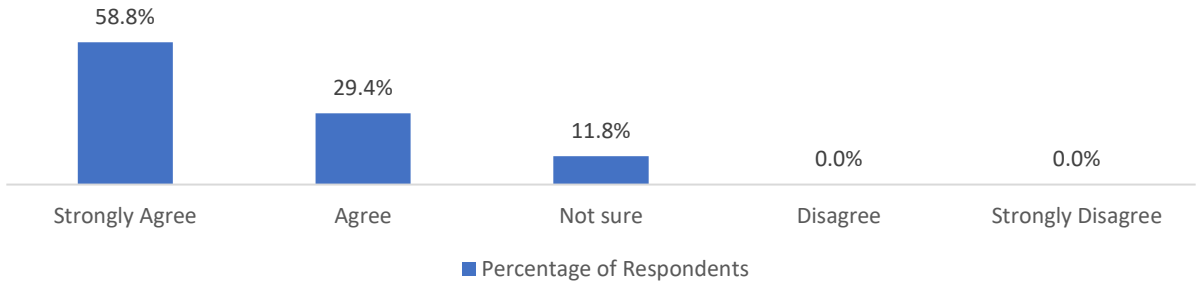


Figure 129: In your opinion, your organization provides person-centered care for all individuals served.

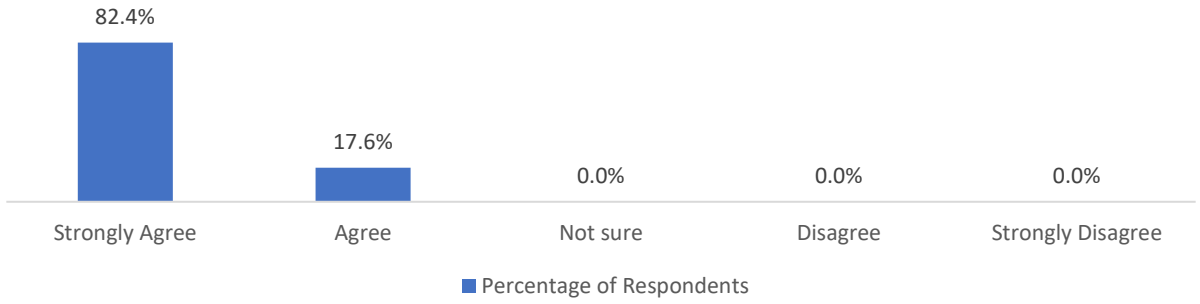


Figure 130: In your opinion, your agency hires employees who are culturally sensitive and culturally competent for the population served.

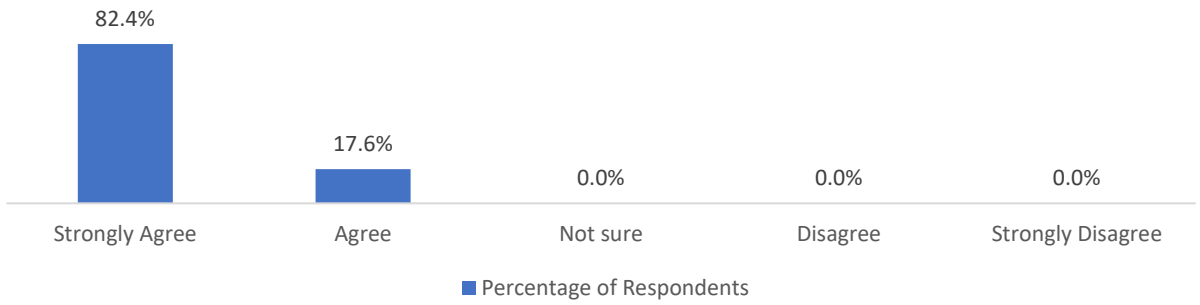


Figure 131: In your opinion, it's easy for individuals to access the services they need quickly and efficiently.

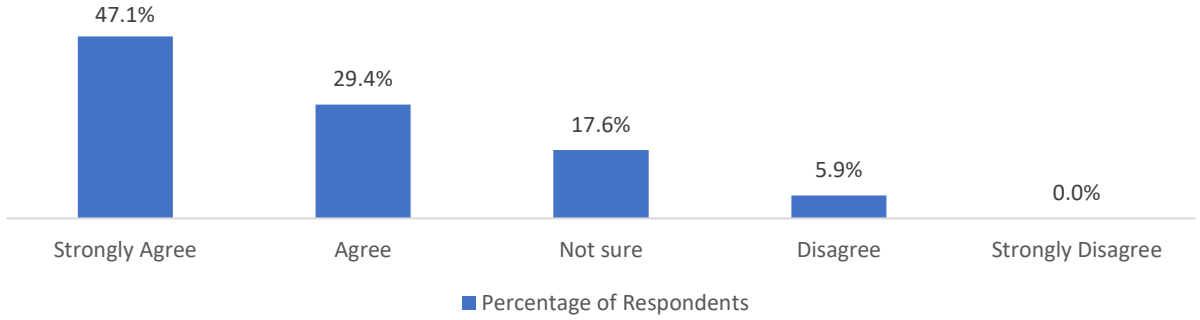


Figure 132: Do you think a standard intake and screening process for state agencies and community partners would help individuals get into services more quickly?

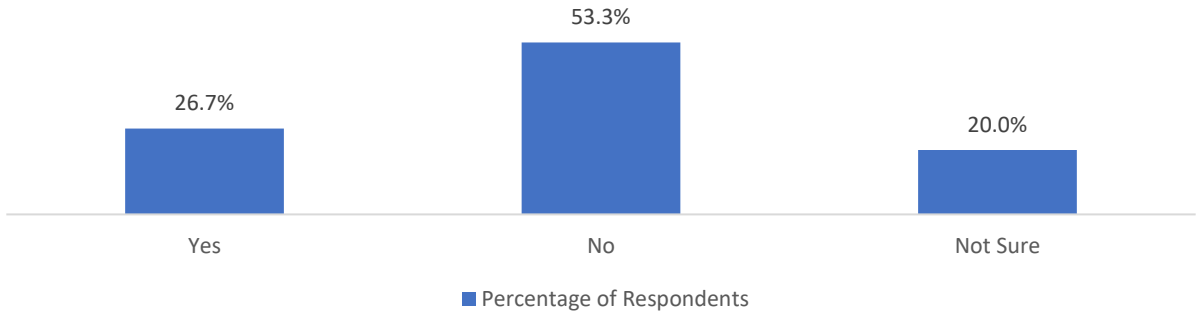


Figure 133: In your opinion, your organization encourages (promotes) working with other community partners to ensure care coordination.

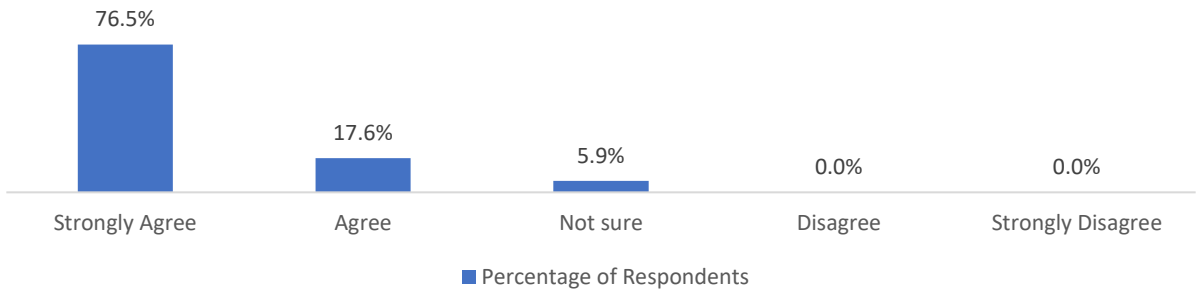


Figure 134: In your opinion, individuals in need of services have equal access to care.

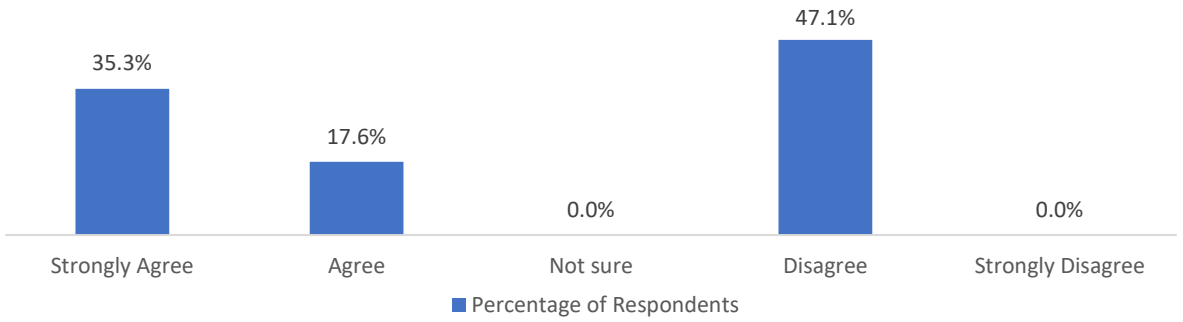


Figure 135: In your opinion, stakeholders help to address and advocate for equal access to care in system entry points.

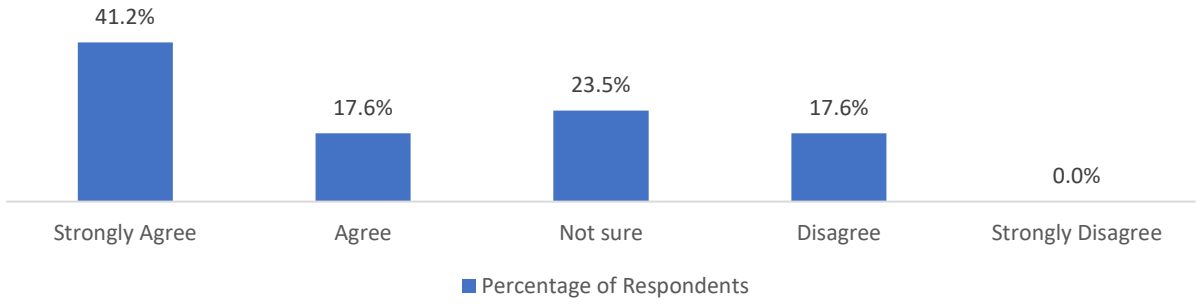


Figure 136: In your opinion, your organization ensures that services are of high quality and meet the needs of individuals served.

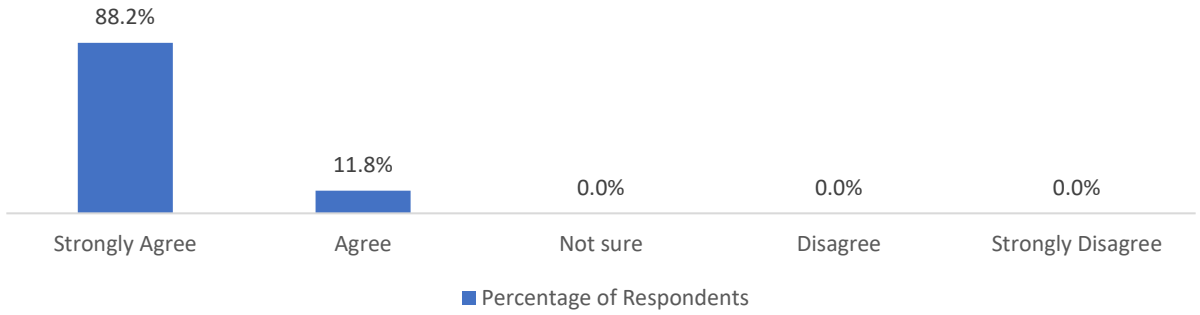
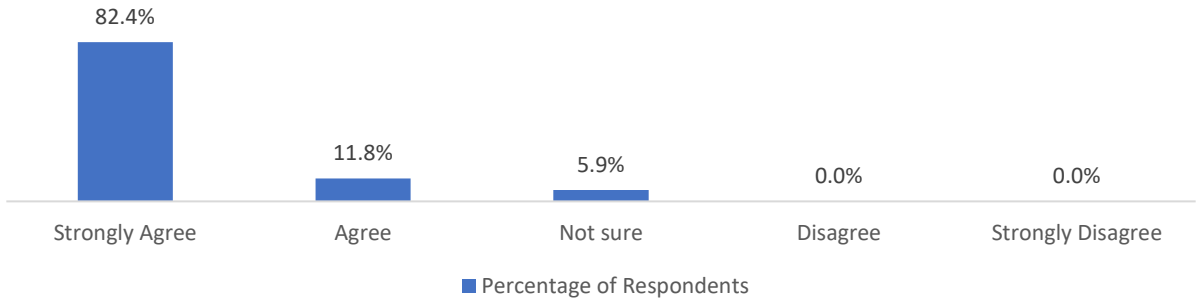


Figure 137: In your opinion, your organization tracks individuals served, services, performance, and cost to continually evaluate and improve outcomes.



NO WRONG DOOR CFCHS PROVIDER FOCUS GROUP SUMMARY

CFCHS NSP's participated in focus groups to further investigate the findings from the No Wrong Door (NWD) survey. The results have been summarized for the reader.

Please tell us how the "No Wrong Door" model works, or not, within your organization:

All organizations are a "door" and strive to serve as a no wrong door model. Whether individuals are physically walking through the door, entering through an online portal, or accessing the 24/7 on-call coverage, the no wrong door concept is working among the NSP's. Staff are trained to make appropriate referrals and participate in warm handoffs to ensure a smooth transition to services. Even if the services needed are not provided, staff will work to get the individual to where they need to be.

We'd like to hear your thoughts on how your organization provides person-centered care for all individuals served:

NSP's are committed to providing patient-centered care as it builds on individual strengths, promotes engagement, and adherence. With the support of family, attainment of the desired goals leads to improvement in the individuals' quality of life, and health outcomes. NSP's and their staff are focused and trained in applying person-centered care to individuals served. Organizations work to understand the unique needs and how they can best serve individuals. Recovery plans are as individual as the individuals themselves. The NSP's share their knowledge of the many pathways that can be taken to attain personal objectives, while supporting the individual's choices and decisions that lead to obtaining their desired goals. Working with supportive family members or guardians helps to ensure successful outcomes. Patient-centered care planning enables NSP's to connect those served with the community resources that are tailored to their needs. Daily interaction between the NSP and the individual keeps the individual on track, while also serving as an alert for a possible misstep.

Organizations have many ways of helping the individual develop their recovery plan. Assessments are one tool that helps to facilitate the discussions that lead to identifying realistic and achievable goals. When presented with their options, individuals plot their own pathways to recovery.

Meeting individuals where they are required, taking into consideration the myriad of environmental influences that play a role in recovery. Staff are trained to provide service delivery in ways that are responsible, honest, upbeat, empathic, and caring.

Motivational Interviewing (MI) is a patient-centered tool to elicit change in an individual's behavior. MI and person-centered care intersect in the strategies of reflective listening and

improving overall interactions between behavioral health care team members and the individuals served.

Evidenced-based models and strengths-based approaches enable individuals to recognize and develop skills that lead to a fulfilling life.

Please share with us how your organization attempts to hire employees who are culturally sensitive and culturally competent for the population served:

Organizations do their very best to align staff with the individual's culture. Cultural competency training, starting with the on-boarding process, continuing through supervision stage, and ongoing annually, enables NSP's to serve individuals in a sensitive and competent manner. Finding the right staff requires a comprehensive interview process, where the potential employee can be evaluated in several settings to ensure they are the best fit for the organization, and the individuals served. Being committed to promoting an inclusive and affirming environment for service delivery fosters strong and healthy individuals.

We are interested in hearing how your organization works to assure that individuals served have quick and efficient access to the services they need:

NSP's recognized that the window of opportunity is limited. Not acting immediately when an individual is ready may be the only chance to get them into care. Based on the organizational structure and service delivery models, triage, assessment, and referrals were some of the tools used to get individuals where they needed to be as quickly as possible (24-48 hours). Some NSP's offer 24/7 call coverage or are open 24/7/365 so that services are received the same day, or the next day. Other NSP's were in the position to offer transportation for individuals without a ride. Still other NSP's are completely virtual with almost limitless access.

One of the biggest barriers in getting individuals connected to services is the lack of staff, which has resulted in part from the COVID-19 pandemic. Although hundreds of job applications may be received, only a couple are qualified to apply for the position. Most organizations are not in a financial position to offer the bonuses being provided by larger corporations. Competition for staff has increased tremendously in the past year.

We'd be interested in hearing how your organization encourages and promotes working with other community partners to ensure care coordination:

NSP's participated in many opportunities that enabled them to promote services, provide education, conduct outreach, build partnerships, address challenges, and expand services. The goal is to understand the best way to connect individuals to services that are appropriate and received in a timely manner.

What are your thoughts on individuals in need of services currently having equal access to care?

- How is equal access to care defined? NSP's agreed that all individuals, regardless of background, insurance, or financial status, should have access to the same level of care and treatment that is currently available.
- Is access to care equal for all individuals? If not, why not? Access to care is not equal for all individuals. Depending on where you live, and the services you need, shortages of NSP's and staff may exist that limit access to care. Lack of transportation or access to a transportation system, lack of affordable housing (that restricts an individual's ability to pay), funding source restrictions (can delay or deny care), individuals not possessing needed identification to receive services, as well as multiple referrals each having their own restrictions, are some of the access issues related to receiving equal care. Although NSP's make every effort to provide needed services, passion doesn't pay the bills, and care is not free.
- What role does health coverage play in equal access to services? Regardless of whether the individual has a commercial or governmental health insurance plan, no two plans are the same. Provider networks, co-pays, benefits, drug formularies, and participating pharmacies can all be different. The plan used in 2021 can change in 2022, forcing individuals to find new providers and pharmacies which results in delayed care. This affects Medicaid as well as commercial plans.

  It was revealed that Medicaid plans have larger networks and behavioral health care is covered for a longer period, when compared to commercial plans that have limited access, and services are covered for a shorter period. Additionally, some NSP's reported that Medicaid recipients do not like their care coordinated, and adult Medicaid recipients do not see the value in preventive health care. This could be an educational opportunity for both the Medicaid insured as well as the NSP. Further investigation should be undertaken into these topics to truly understand the individuals' perceptions as it relates to the current system of care.

  Further complicating the process is the sale of health insurance "de jour," where individuals are enticed to purchase a plan that they don't understand, are not able to navigate, and which may not fit their needs. The case manager is the one who is often tasked with fixing it. Those without insurance, or who are underinsured, face more challenges in finding providers, affordable treatment, and medication.
- How do waitlists for services contribute to inequity? Since the COVID-19 pandemic, NSP's have experienced a lack of personnel looking for work, so less people are available for hire. This affects direct and indirect services such as the kitchen and

cleaning staff in a facility with open Baker Act beds. Without these staff, the highly sought beds remain empty. Additionally, when organizations are not optimally staffed, the burden of the work falls on current staff who quickly become overburdened. This results in high caseloads that impact access and could create a waitlist. Lack of staff is not always the barrier to receiving services. Sometimes the insurance company is the one responsible for the delay in approving services.

As stated earlier, the opportunity to provide care to an individual may be limited to just one window of time. Being put on a waitlist can close that window causing further deterioration of the individuals' condition, where care options are extremely limited, if they can help at all. Although NSP's do everything to avoid placing individuals on such a list, some have opportunities to offer alternative resources that will support the individuals' recovery in the interim. One of the care options that can be attributed to COVID-19 is the growth of telehealth. It has helped address access, transportation, stigma, and waitlist barriers for those willing to participate in this care setting.

- How could the system of care be improved to ensure equal access?
    - Program and funding expansions
    - Reduce staffing shortages and recruitment challenges
    - More affordable housing options
    - Additional funding for indigent beds
    - Medicaid expansion
    - Continue weekly meetings similar to what was done during the COVID-19 pandemic
    - Ability to increase salaries and offer higher pay to get quality people
    - Need solutions when organizations offering higher pay strip other organizations of their personnel, which recreates a system that was in existence, instead of filling the gaps.
    - NSP's should be given more autonomy when individuals are on the line for qualifying for services…need some flexibility
    - Eliminate insurance barriers
    - Allow state funding to cover co-pays and high deductibles for those without insurance
    - Increase Medicaid rates for behavioral health services to account for the expense of providing those services…some service rates have not changed in 25 years
    - Managed Medicaid needs to have adequate provider networks and commensurate reimbursement for provider services
    - Fund services that lack consistent availability or minimally exist such as intensive outpatient programs, partial hospitalization programs, drop-in centers, and outpatient psychiatric services for those with limited resources.

How would you rate stakeholder's success in helping to address and advocate for equal access to care in system entry points?

- What role do stakeholders play in addressing and advocating for equal access? Stakeholders should have conversations that identify the fundamental barriers that impact equal access to care. Consideration needs to be given to the importance of basic needs (food, shelter, transportation, etc.) and the role they play in achieving good health outcomes. Conducting educational awareness campaigns that focus on stigma and the perceptions of mental illness and substance use, could help address some barriers associated with equal access. Communication must include agencies at the top so that they know what is happening on the ground. NSP's should embrace the secret shopper concept to see and experience the gaps in real time. Community stakeholders need to educate state government stakeholders, who have never run services, and do not understand how the systems work. The continual sharing of information and challenges among all stakeholders is needed to identify solutions that will support equal access.
- What improvements could be made to ensure equal access to care at the service entry points?
    - Increased funding for services
    - Increase the number of community centers which serve as entry points
    - Funding for training needs to be all inclusive (cover costs associated with case consultations, qualified supervision, etc.)
    - Consider unit cost reimbursement rather than salary for services with 24-hour hotlines
    - Funding for telehealth – this was not in most NSP budgets yet needed to be done during COVID-19 to stay in business

INDIVIDUALS SERVED SURVEY SUMMARY

The survey was in the field for 5 weeks and made available through an electronic link and QR code that could be emailed, texted, printed, or posted to social media. The survey was translated into three languages: English, Spanish, and Creole. There were 388 individuals who completed the survey measuring experiences, awareness, and coordination of behavioral health care services.

Most respondents were either adults receiving services (47.9%) or parents of a child receiving services (37.8%). The remaining respondents were guardians of individuals (5.2%), young adults/ youth receiving services (5.5%), or a care giver representative (3.6%). The services received were predominantly for mental health, either adult (38.1%) or child (36.6%). Substance use services accounted for 14.1% of respondents that included adults (12.3%) and children (1.8%). Peer support services were received by 6.6% of respondents and prevention services accounted for less than 5% of respondents.

Among the four-county service area, 32.1% of respondents resided in Orange County, 25.6% in Osceola County, 22.7% lived in Brevard County, and 19.6% were from Seminole County.

Close to 70% of respondents knew where to go for behavioral health services when they needed them. This was higher when compared to responses from the 2019 survey, at 65.6%. Those not knowing where to go were similar for both surveys (2019 and 2022) at about 17%. The percentage of individuals who sometimes knew where to go decreased from 17.6% in 2019 to 12.5% in 2020. This indicated that awareness of services among individuals served in the CFCHS increased over the past 3 years.

Individuals served learned about services from family and friends (23.4%), word of mouth (14.4%), and another individual in treatment/recovery/peer (10.4%). Other responses included internet research, case manager, doctor, insurance company, and other social service organizations. When asked about their awareness of the 2-1-1 information and referral resource, 58.2% of respondents indicated they were familiar with this community resource. This was lower than the percentage of respondents indicating awareness in 2019 at 63.8%. Less than 40% of those who were aware of 2-1-1 had called for help. Of those that did call, 51.2% of respondents found 2-1-1 to be helpful. This was higher than the percentage of respondents in 2019 where only 43.3% indicated that 2-1-1 was helpful in directing them to needed services. Most respondents (78%) were able to get all the services when they needed them.

Housing, aftercare/follow up, and crisis stabilization were the three most needed services that individuals were not able to get. Although 78.9% of individuals responded that they received services, 9.5% were not able to get them on five or more times during the past 12 months. These services were not available for 13.2% of respondents. Over 16% indicated that there was a waitlist for the services they needed. When asked if services and planning were focused on treatment needs (patient centered), 66.8% agreed or strongly agreed. Less than 20% disagreed or strongly

disagreed, and 14.5% of respondents were neutral on whether services and planning were focused on their needs.

Over 56% of respondents waited 1 to 2 weeks for an appointment. Just over 18% waited up to 1 month to receive services from the time they requested an appointment. Ten percent of individuals never received an appointment for services. Travel time to services ranged from 15 minutes for 57.7% of respondents to up to 30 minutes for 20.8% of respondents. Twelve percent of respondents traveled up to 1 hour to access services. Less than 10% of respondents traveled over 1 hour to receive services. When asked how they traveled to services, 48.1% indicated that they drove themselves. Just over 21% had a friend or relative drive them. Eleven percent of respondents walked to services, 6.8% used public buses, 6.6% relied on provide transportation, and 5.6% used Medicare/Medicaid transportation to access services.

Not knowing where to go for services and long waitlists were the biggest obstacles for respondents. Affordability and services not available in the county of residence were also barriers to care. Other obstacles included staff turnover with lack of transition, lack of phone call response, and not taking on new patients.

INDIVIDUALS SERVED SURVEY CHARTS

Figure 138: Which best describes you?

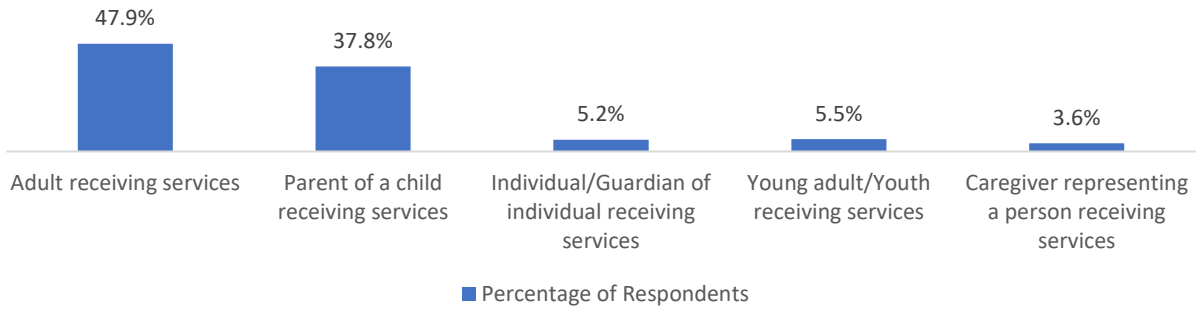


Figure 139: What type of service did you or the person you are representing receive?

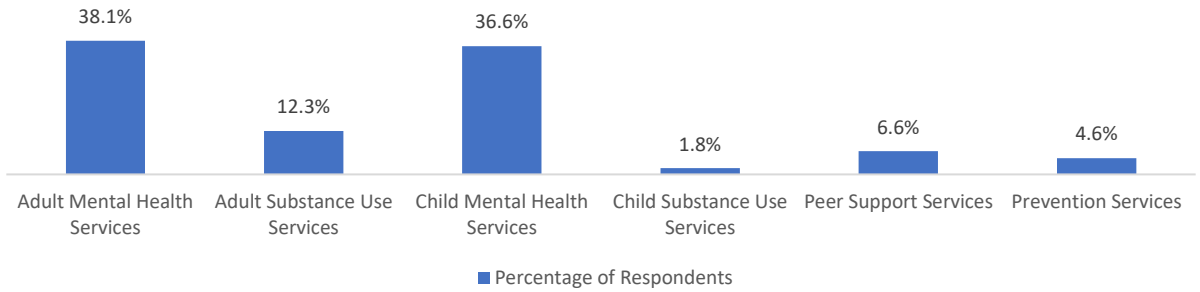


Figure 140: Which county do you live in?

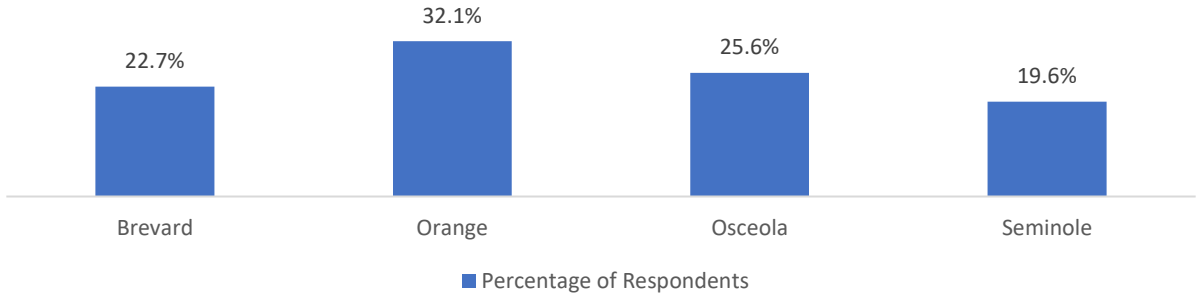


Figure 141: Did you know where to go for mental health and substance use treatment services when you needed them?

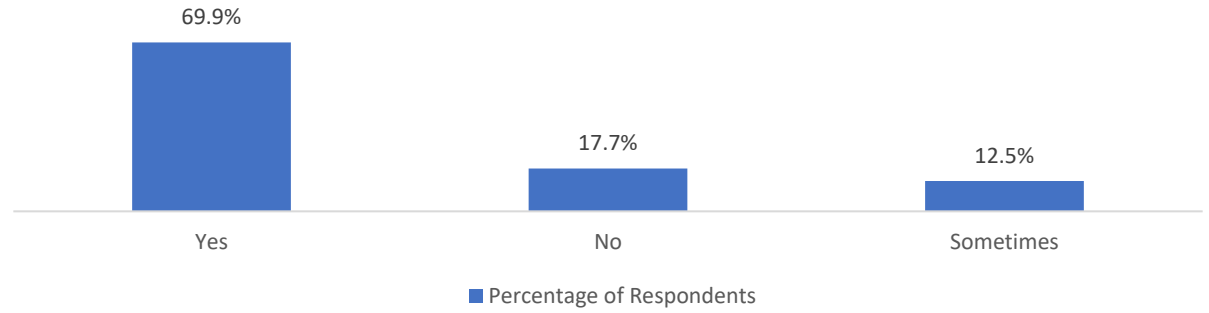


Figure 142: How did you learn about mental health and substance use treatment services when you needed them?

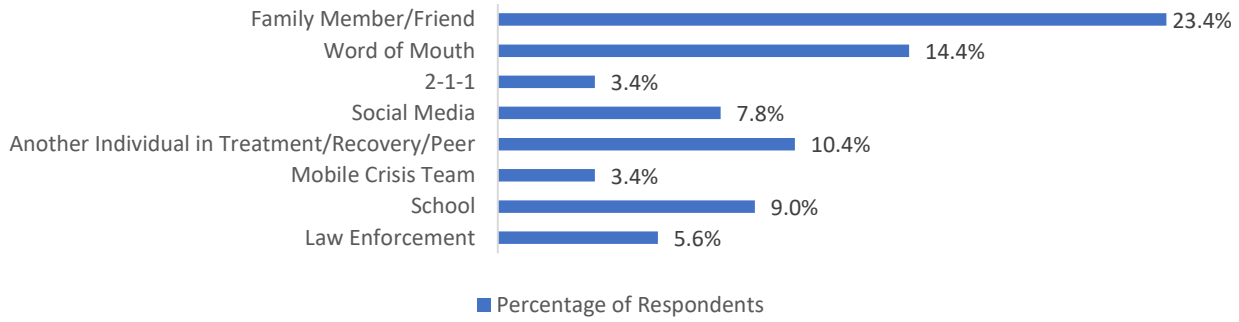


Figure 143: Are you aware of the 2-1-1 Information and Referral Resource in your community?

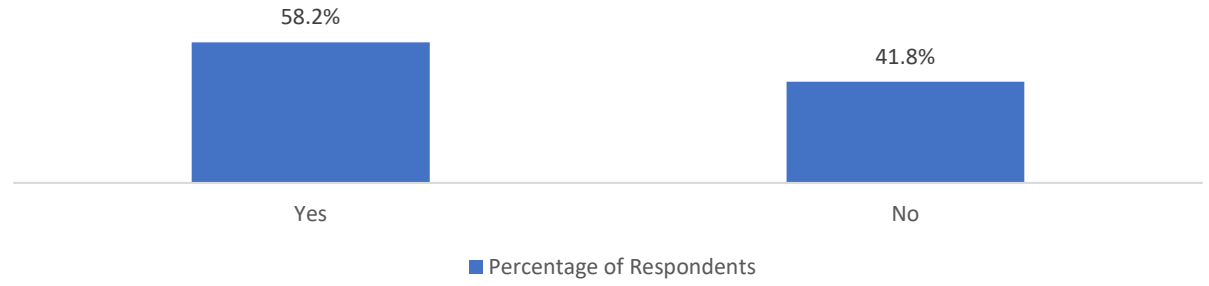


Figure 144: Have you ever called 2-1-1 Information and Referral Resource for assistance?

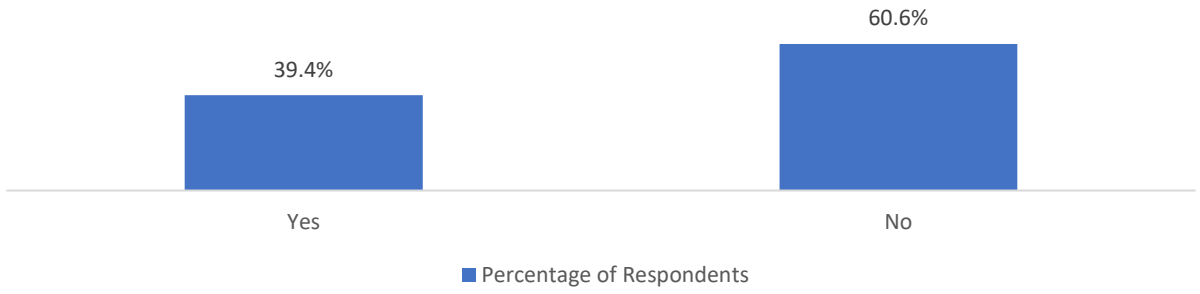


Figure 145: When you called the 2-1-1 Information and Referral Resource, were they helpful in getting you the services needed?

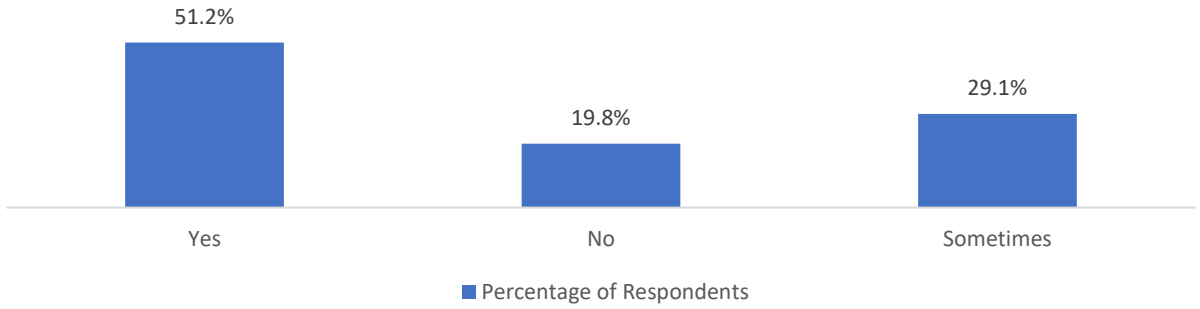


Figure 146: Were you able to get all the services you needed when you needed them?

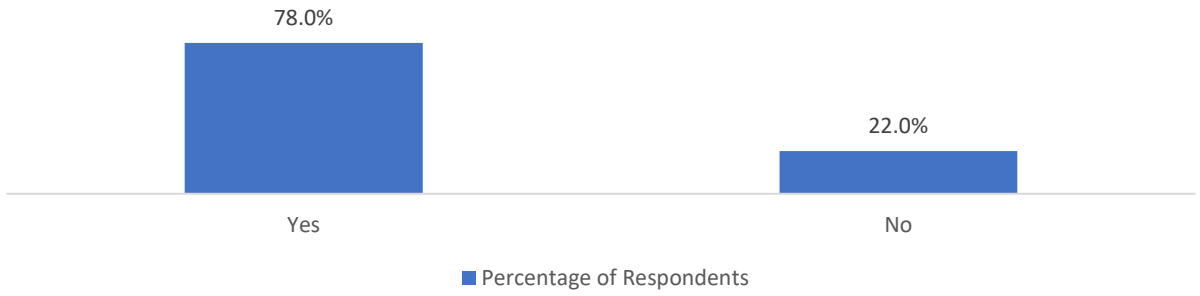


Figure 147: If not, please choose from the list below the services you needed but were not able to get.

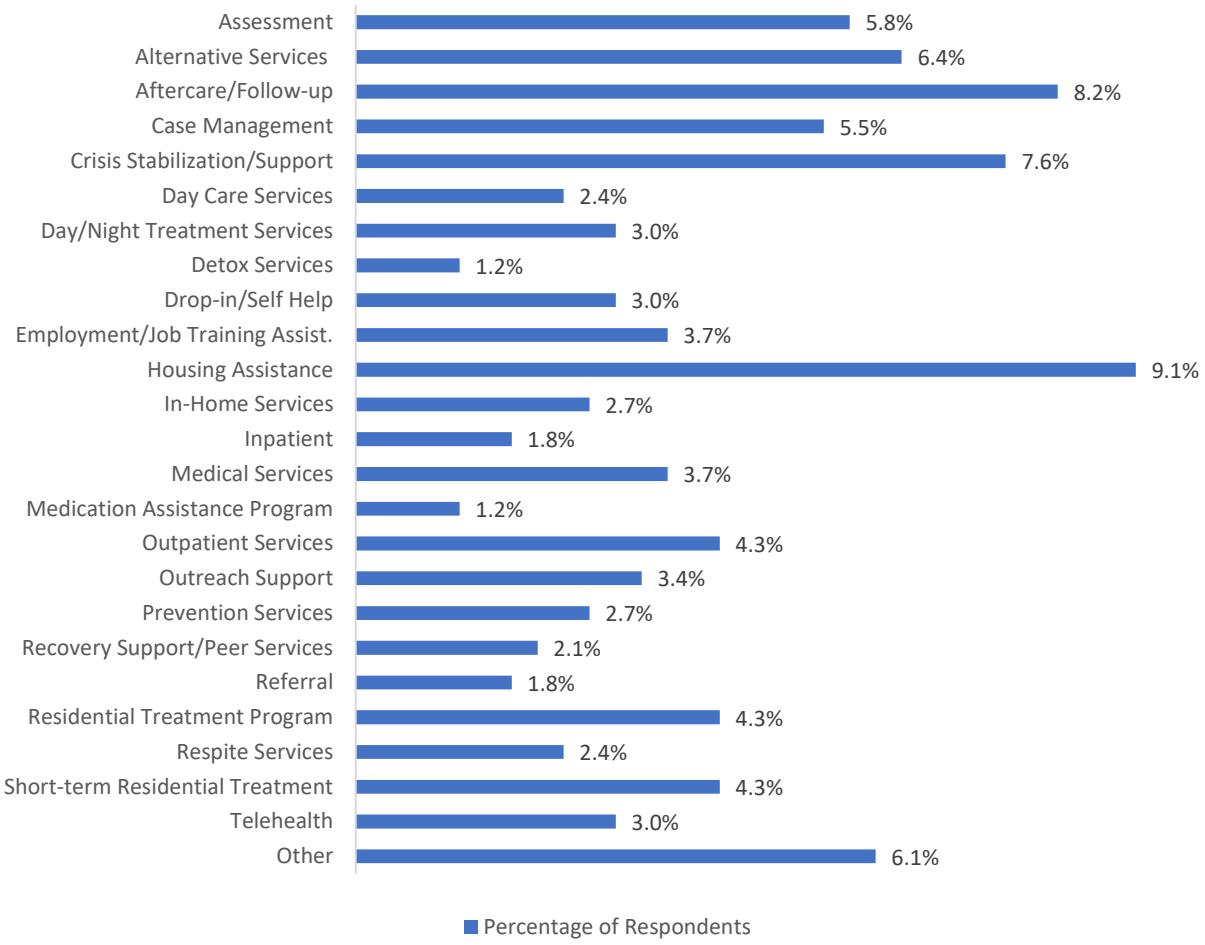


Figure 148: How many times during the last 12 months were you not able to get the services you needed?

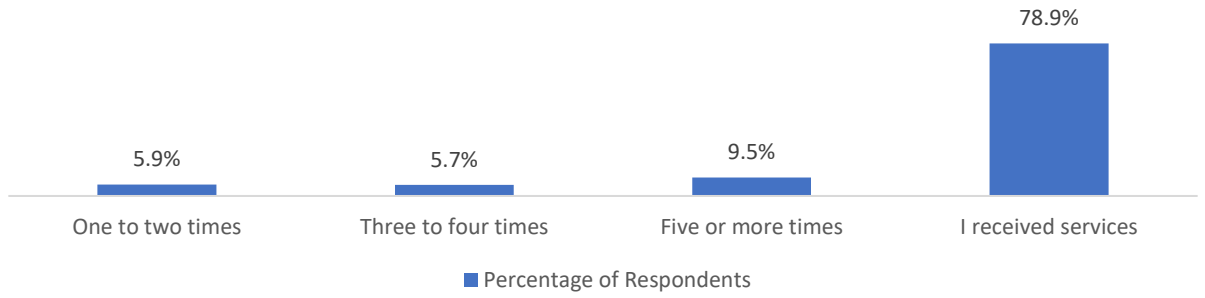


Figure 149: The services I needed were:

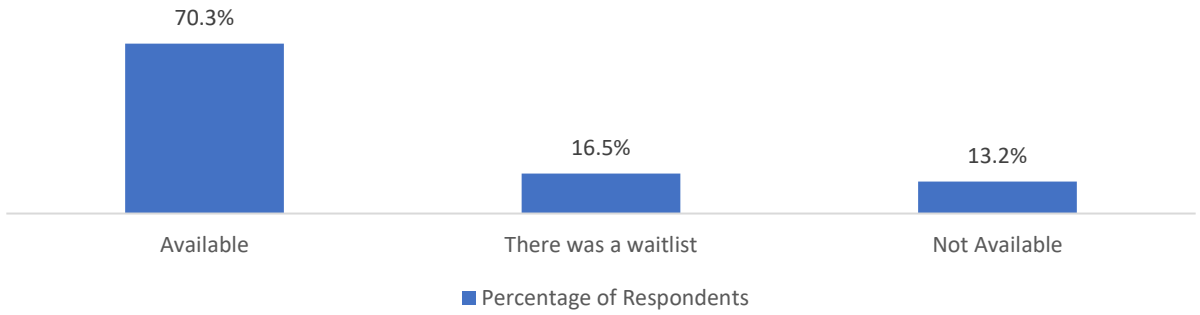


Figure 150: The services and planning I received were focused on my treatment needs (patient centered).

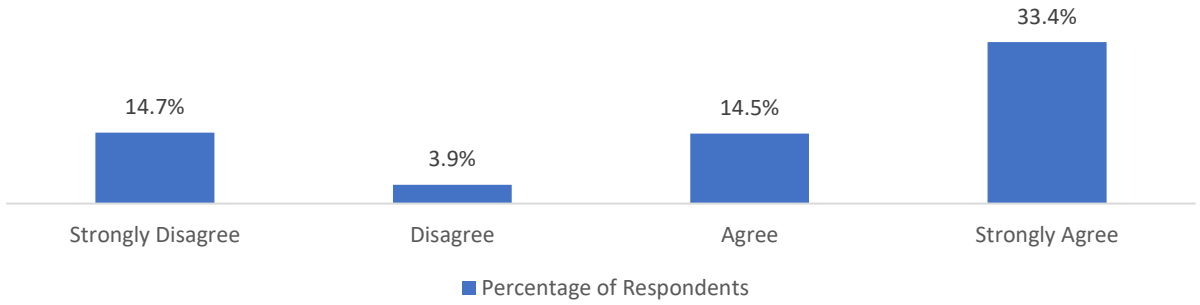


Figure 151: How long did it take from the time you requested an appointment for services to the time you received the services?

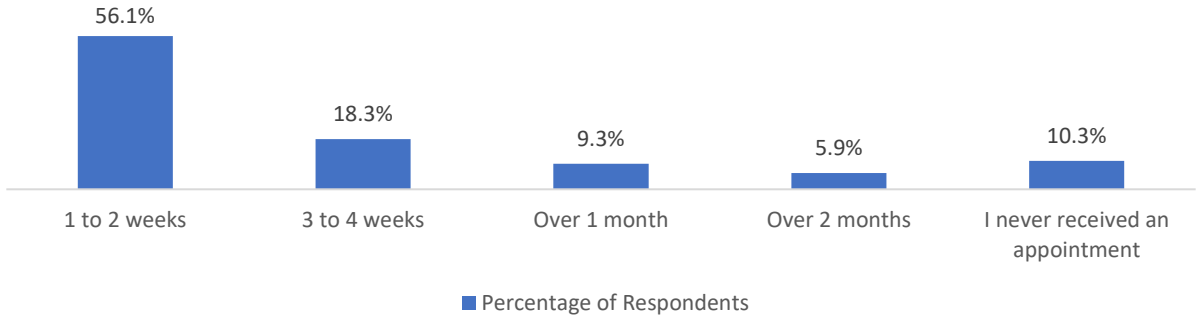


Figure 152: How long did it take to travel to the service?

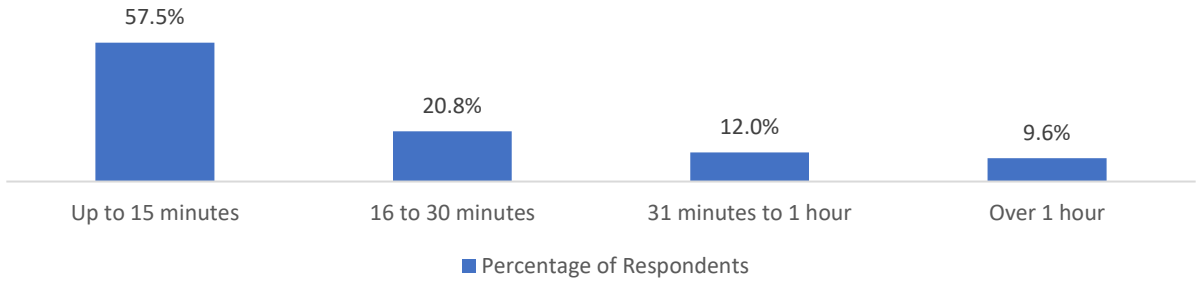
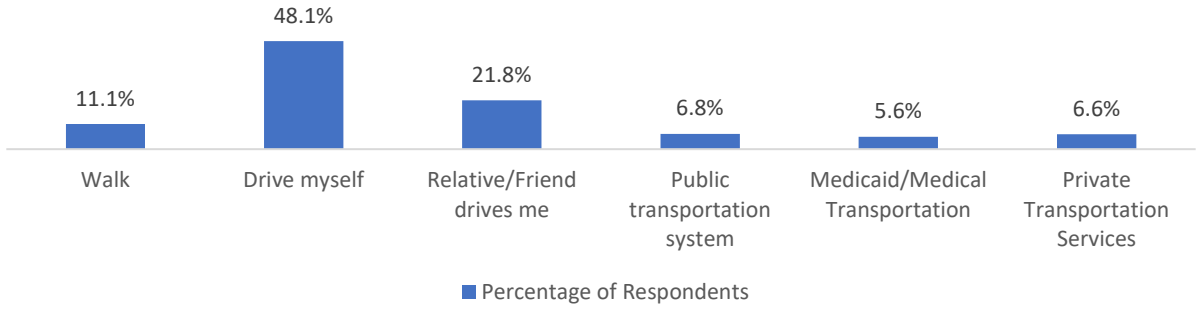
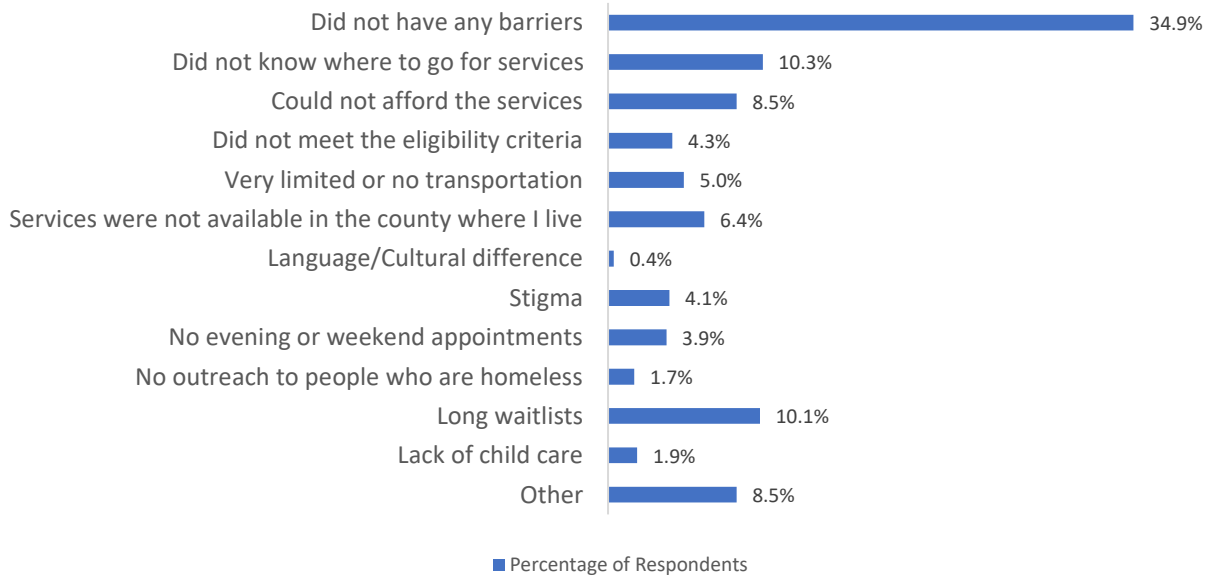


Figure 153: How do you travel to get services?



*Note-Private transportation includes Taxi, Uber, Lyft, TOPS, etc.

Figure 154: What were the obstacles you experienced getting the care you needed?



STAKEHOLDER SURVEY SUMMARY

The survey was distributed by CFCHS Staff, NSP's, the Health Council of East Central Florida, Inc. to gather responses from stakeholders in various community sectors. The survey was in the field for 5 weeks and made available through an electronic link and QR code that could be emailed, texted, printed, or posted to social media.

There were 123 individuals who completed the stakeholder survey in the CFCHS service area. Brevard County accounted for 24% of respondents and 19% of respondents lived in Orange County. Just over 12% of the respondents were from Osceola County while 7.4% represented Seminole County. There was some overlap regarding where stakeholders provided services. This was mostly in the tri-county area that includes Orange, Osceola, and Seminole counties.

There were 24 organizational service sectors represented in the survey results. Almost 12% of respondents provided adult mental health care. Close to 10% provided case management and 9.1% provided adult substance use treatment. The remaining service sector categories had representation that ranged from 2.4% to 6.8%. Details are found in the charts that follow.

When asked if they were aware of the behavioral health services in their area, 86.2% indicated awareness. When asked specifically about CFCHS, 78% were aware of the resources provided by the ME. Respondents who accessed CFCHS resources in the past 6 months accounted for 34.1%. Of these, 90.5% reported that the agency's resources were helpful. Close to 60% of stakeholders had directed individuals to access CFCHS resources by calling or online. Over 95% of respondents were aware of the 2-1-1 information and referral resource. Of these, 30.5% had accessed 2-1-1 in the past 6 months, and of those, 78% found it helpful. Over 87% of respondents had directed individuals to call or contact 2-1-1 online.

Assessing crisis response models in the service area, 34.3% selected the Mobile Crisis Response Team and 25.4% of respondents selected the Behavioral Health Response Team. The Mobile Crisis Response Team was chosen by 15.4% of respondents, while 11.8% selected Co-Responder Mobile Crisis Teams, and 10.1% chose the Alternative Behavioral Response Team model.

Less than 20% of respondents felt community awareness of behavioral health services was excellent or very good. One-third of respondents felt it was good and 30.3% thought it was fair. Less than 20% reported community awareness as poor.

Regarding whether linkages were well coordinated and established, 41% of respondents agreed or strongly agreed with this statement. Close to 30% were neutral and 29.5% disagreed or strongly disagreed. Close to 50% of respondents agreed or strongly agreed that services were accessible, while 27.9% disagreed or strongly disagreed, and 23.8% were neutral on the topic. Respondents were split on whether referrals were easy with 32% disagreeing, 29.5% were neutral, and 38.6% agreed. These percentages were very similar to those respondents who provided their assessment on the coordination of programs and services across the system of care.

Stakeholders were asked to select the barriers that consumers encountered in accessing services. Multiple responses were permitted for this question. Each respondent chose approximately five barriers. The biggest barrier identified (14.6%) was the lack of or limited transportation needed to get to the service. Combining all responses, 13.9% of respondents cited the unaffordability of the service, and 12.4% indicated that consumers did not know where to go for services. Other top barriers included consumers not meeting the eligibility criteria, stigma, and long waitlists. The Other category revealed the need for more incidentals for substance use individuals served, no centralized service location, and limited options for those without health insurance.

Stakeholders were asked to identify resources and services that were not available to improve patient-centered care and planning. The overwhelming majority felt that affordable housing is desperately needed. Stakeholders indicated there is a shortage of providers, provider offices are understaffed which is related to the long waitlists for services. Resources cited were detox beds, outpatient counseling, as well as psychiatric services.

Stakeholders identified the top three patient-centered care resources that have improved the quality of life of individuals as Peer support, Case Management, and Mobile Response.

STAKEHOLDER SURVEY CHARTS

Figure 155: Percentage of respondents by organization service sector.

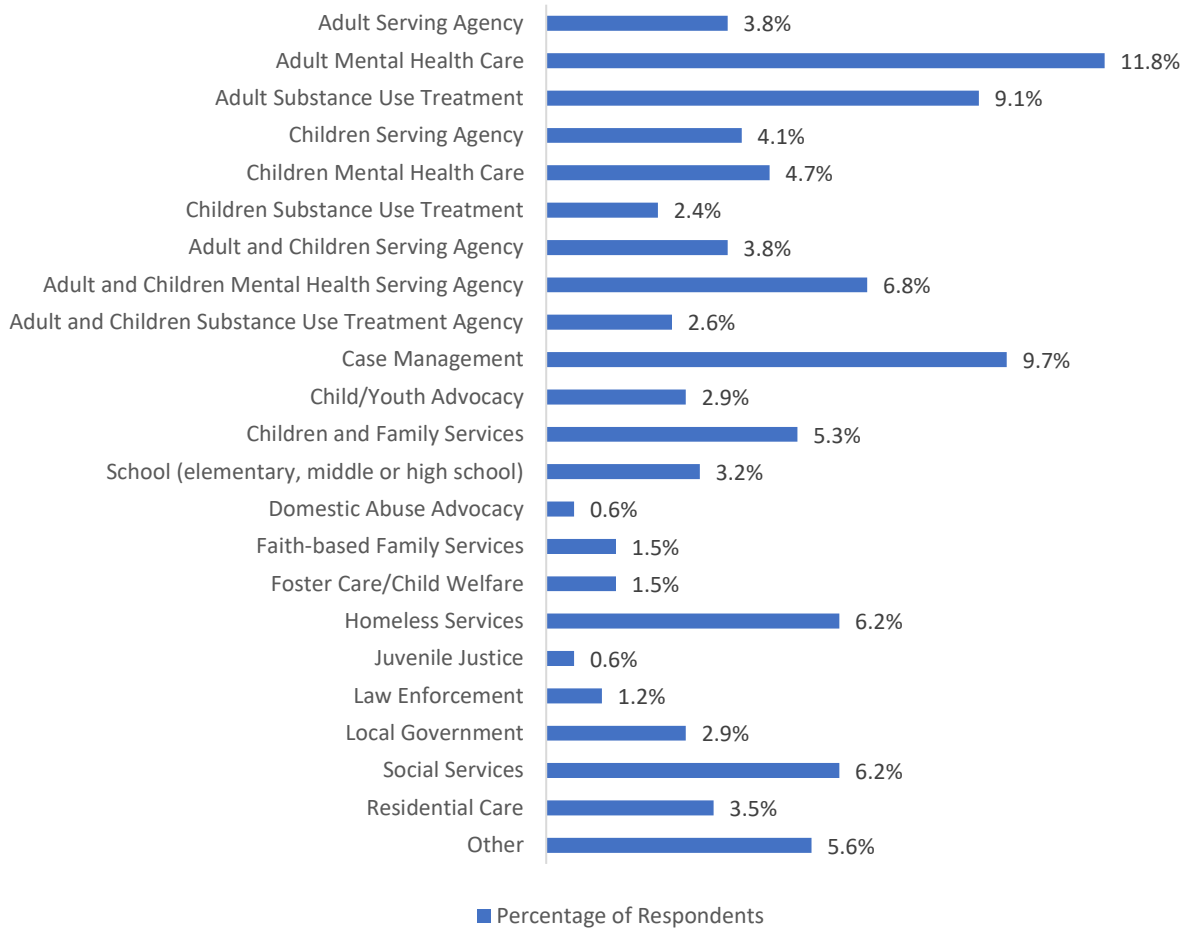
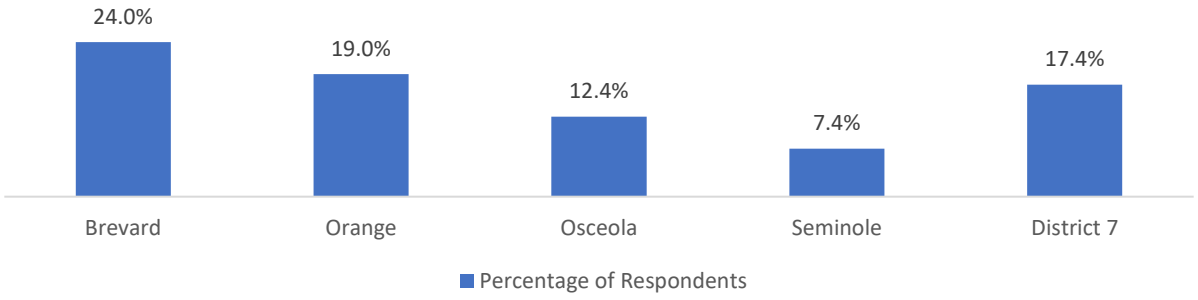


Figure 156: Percentage of stakeholder respondents by county.



NOTE: Stakeholders in District 7 served in all four counties.

Figure 157: You are aware of the availability of mental health and substance use services in your area.

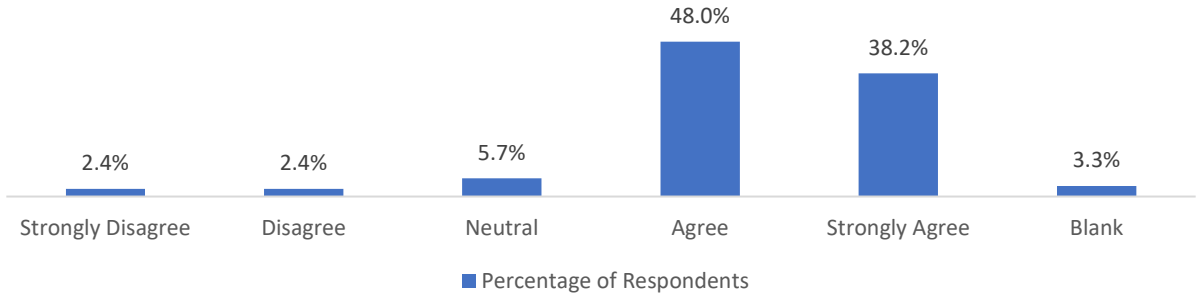


Figure 158: Are you aware of Central Florida Cares Health System (Managing Entity) resources?

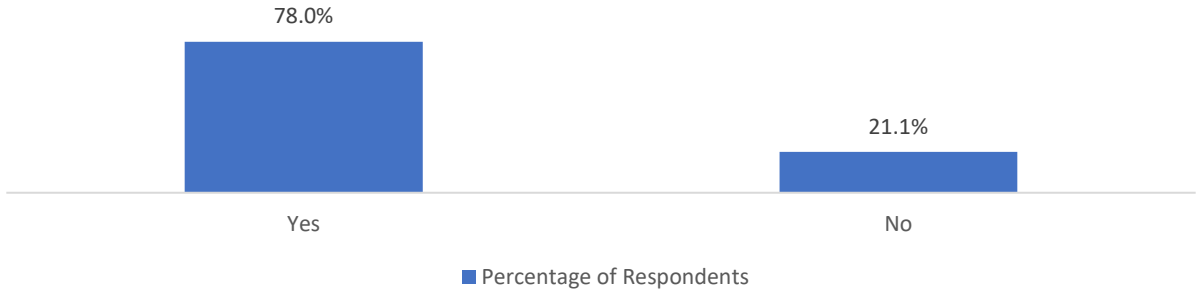


Figure 159: Have you accessed Central Florida Cares Health System (Managing Entity) resources in the past 6 months?

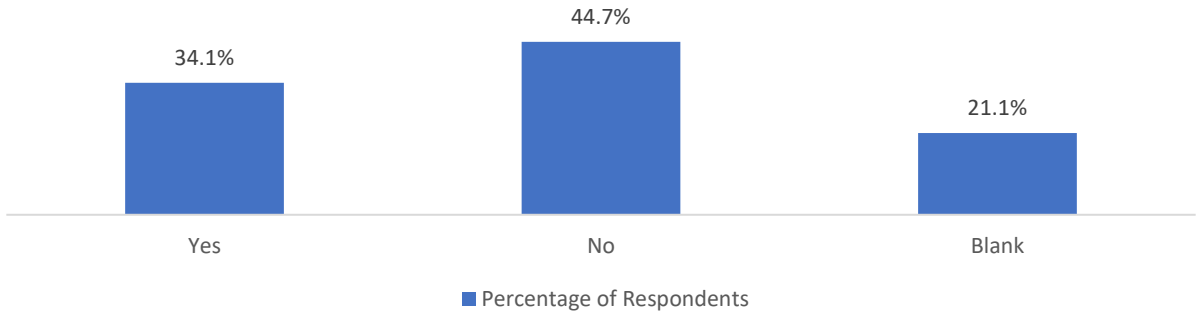


Figure 160: When you accessed Central Florida Cares Health System (Managing Entity) resources, was it helpful?

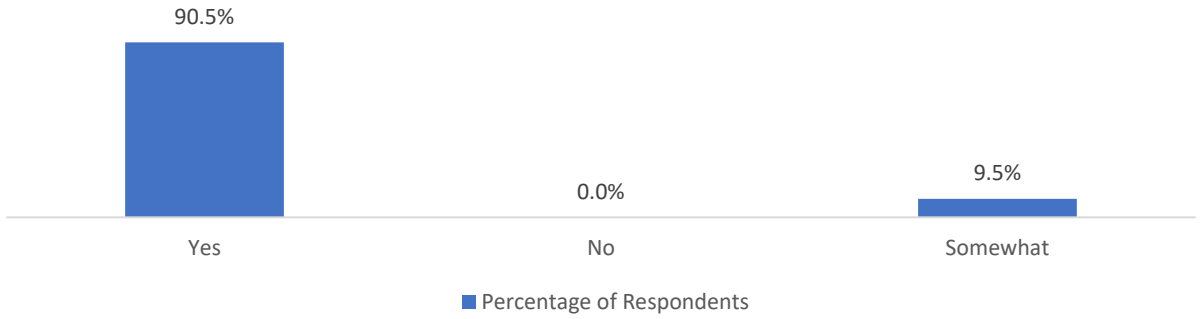


Figure 161: Have you ever directed individuals to access Central Florida Cares Health System (Managing Entity) by calling or online?

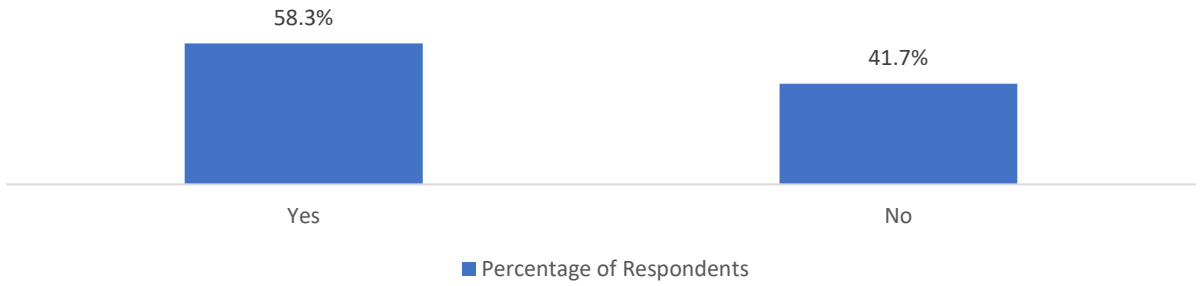


Figure 162: Are you aware of the 2-1-1 Information and Referral Resource?

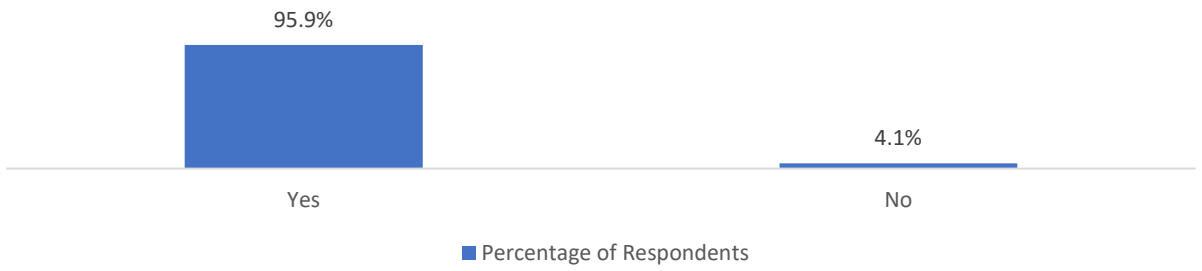


Figure 163: Have you accessed the 2-1-1 Information and Referral Resource in the past 6 months?

Figure 164: When you accessed the 2-1-1 Information and Referral Resource, was it helpful?

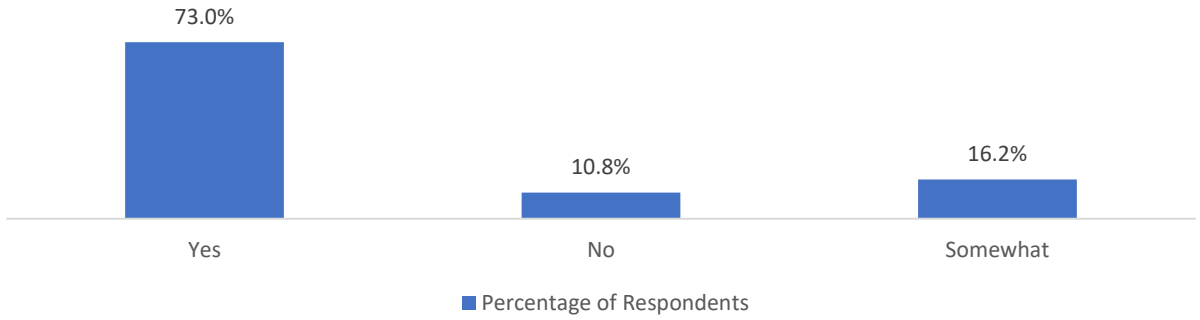


Figure 165: Have you ever directed individuals to access the 2-1-1 Information and Referral Resource by calling or online?

Figure 166: Select the crisis response model in your area. (Check all that apply)

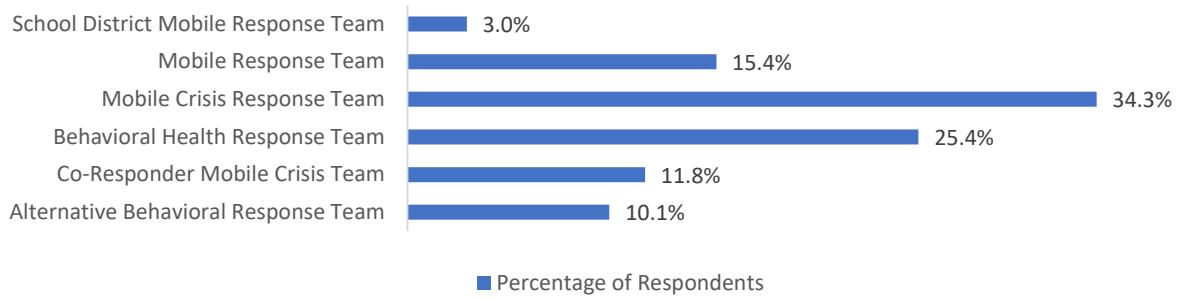


Figure 167: How would you rate community awareness of mental health and substance use treatment services in your area?

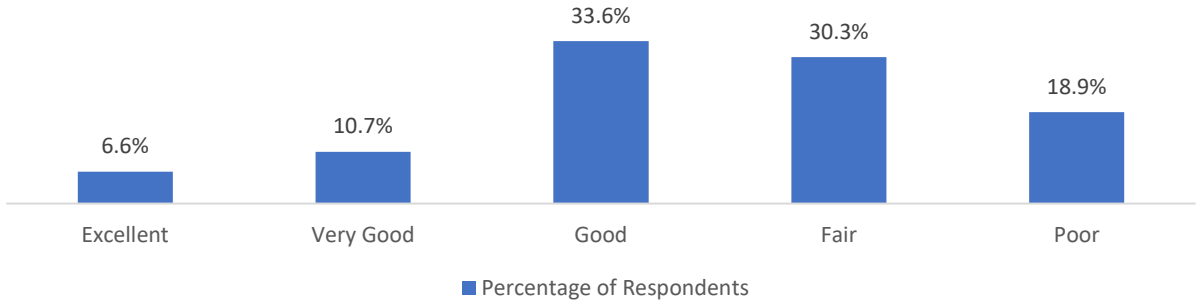


Figure 168: Linkages to needed services are coordinated and well established across the system.

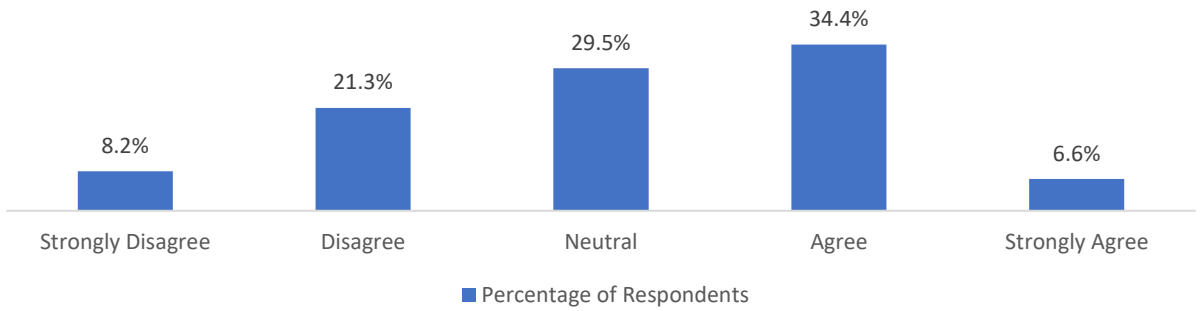


Figure 169: In general, behavioral health care and peer services are accessible in your area.

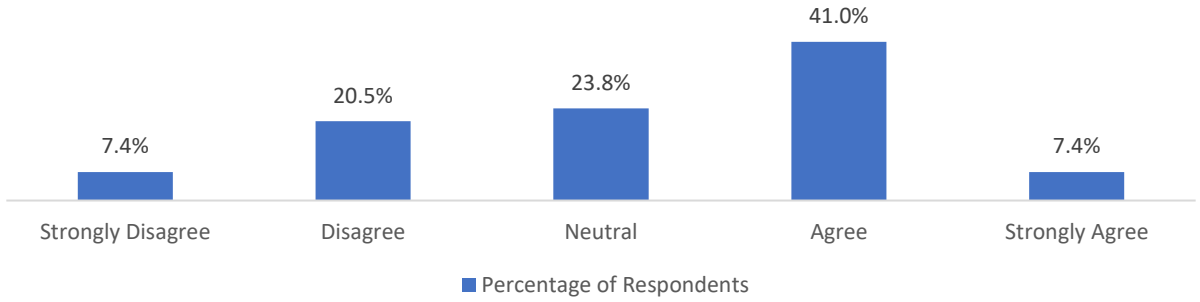


Figure 170: The process for referrals is easily accessible.

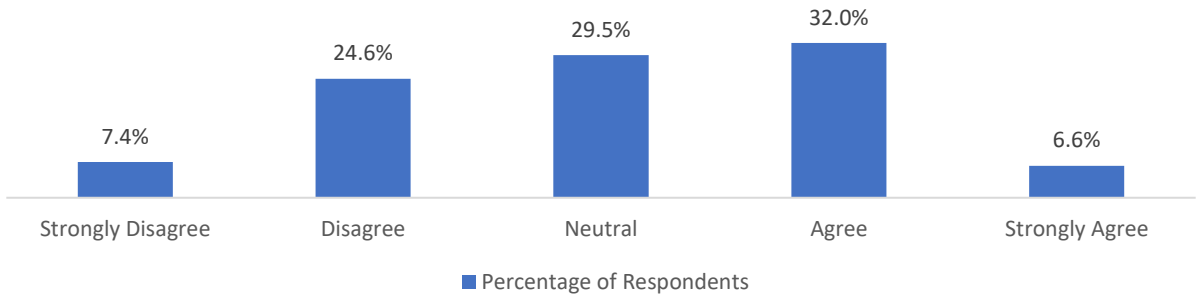


Figure 171: Programs and services are coordinated across the system of care.

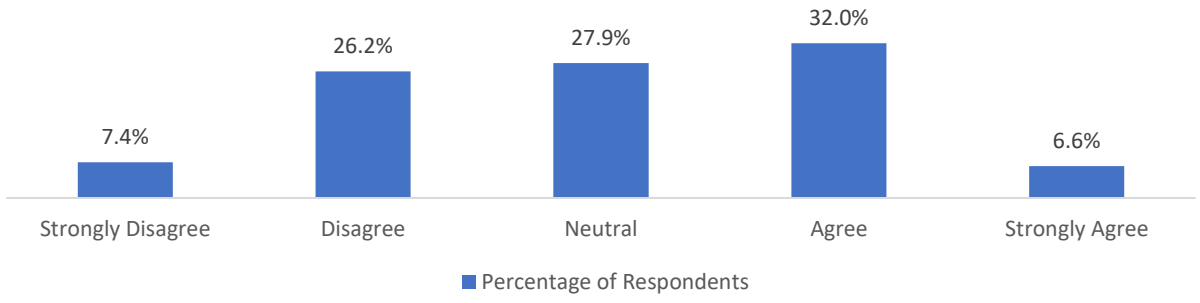


Figure 172: List the barriers for consumers accessing services in your community. (Check all that apply)

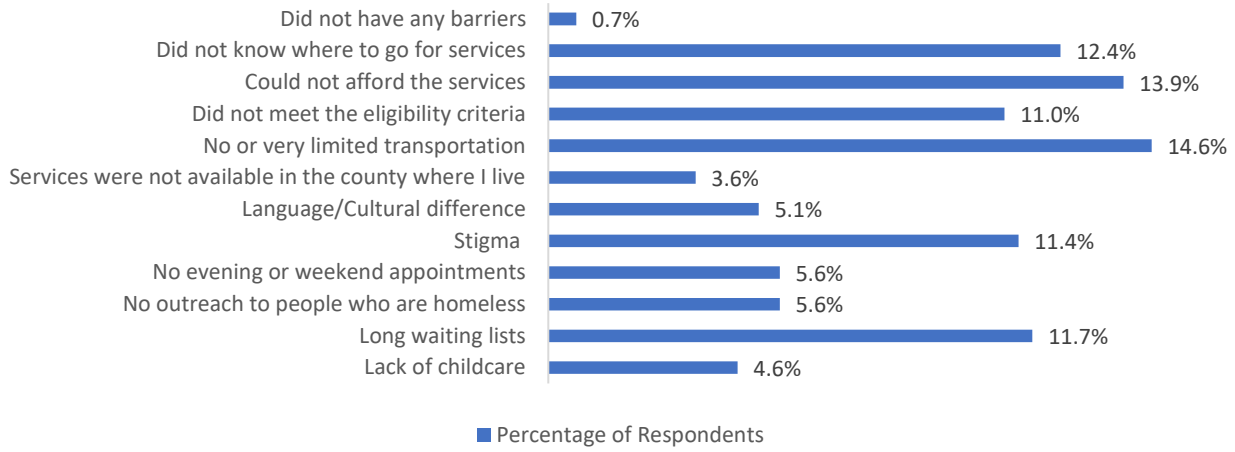


Figure 173: List the resources and services needed that are not available to improve patient-centered care and planning.

NEEDED SERVICES AND RESOURCES
Affordable Housing
Providers
Fully Staffed Provider Offices
Detox Beds
Outpatient Counseling
Psychiatric Services

Figure 174: List the top three patient-centered care resources that have improved quality of life for individuals.

TOP THREE PATIENT-CENTERED RESOURCES
School-based Services
Crisis Response Services
Community-based Providers

PEER RECOVERY COMMUNITY/SUPPORT SPECIALIST'S SURVEY SUMMARY

The survey was distributed by CFCHS to their peer support service community. The survey was in the field for 5 weeks and made available through an electronic link and QR code that could be emailed, texted, printed, or posted to social media. The survey was translated into three languages: English, Spanish, and Creole.

There were 20 individuals who completed the survey measuring experiences, awareness, and coordination of behavioral health care services as it relates to peer recovery community and support specialists. Most (65%) respondents were adults with lived substance use condition. Adults with lived co-occurring mental health and substance use conditions accounted for 15% of all respondents. Ten percent of survey participants were family members or friends with a lived substance use condition. The remaining 10% were adults or youth with mental health conditions. Fifty percent of respondents resided in Orange County, 27.8% lived in Seminole County, and 22.2% were from Brevard County. There were no respondents from Osceola County.

Thirty percent of respondents were from agencies that provided adult mental health services. Just over 15% worked in peer support service agencies. Recovery community organizations were represented by 10.9% of respondents, and 10% accounted for other agencies which included men's transitional shelter, family dependency drug court, human trafficking survivors, and crisis stabilization units.

Close to one-third of respondents were employed at their agency for the past 2 to 3 years. Just over 20% had joined the agency within the past 6 months and 26.3% worked at the agency for at least 6 months but less than 1 year. Respondents who had been employed at the same agency for 1 to 2 years accounted for 10.5% of respondents. Only 10.5% of respondents were employed at the same agency for more than 3 years.

The majority of respondents (66.7%) worked a full 40-hour work week. Just over 11% worked more than 40 hours per week. The remaining respondents worked part time, with 16.7% working up to 10 hours per week, and 5.6% who worked a 20-hour work week.

When asked if the agency utilizes peer recovery services within the services they provide, 65% responded yes. Just less than one-third did not provide peer services. One agency did not require their facilitators to take peer recovery training.

Seventy-five percent of respondents indicated that the agency does adhere to recovery support best practices. The remaining 25% were not sure.

When asked about their qualifications, 33.3% of respondents were a Certified Recovery Peer Specialist, 19% had applied for certification and were in the process, and 38.1% were not certified.

Regarding the program setting where respondents deliver peer support services, 15.2% were in Medication Assisted Treatment (MAT) and 15.2% were in an outpatient Recovery Community Organization (RCO). Detoxification and Flexible Assertive Community Treatment (FACT) each accounted for 9.1% of respondents. Just over 12% were in other settings which included Seminole Collaborative Opioid Response Efforts (SCORE), family dependency drug court, residential treatment, and work therapy programs.

Twenty percent of respondents stayed with the company due to flexible work schedules and another 20% stayed because they were committed to the recovery principles. Thirty percent stayed with their employer due to personal fulfillment. Only 4% of respondents stayed due to a competitive salary.

The biggest barriers encountered during the hiring process were attributed to salary, at 33.3%, and exemption/background screening process, also 33.3% of responses. Over 22% of respondents indicated that limited employment opportunities were a barrier in the hiring process.

The top three recommended training for peers by peers were the cultural competency training, the 40-hour required Peer Recovery Specialist training, and the boundaries/ethnics/professional responsibility training. Respondents recommended a combination of training courses based on their experiences. The complete accounting for training is found in the chart that follows in the next section of this document.

Slightly more than 50% of respondents said there were partnerships that existed with peer support recovery programs, recovery community organizations, and other support groups. The remaining respondents were not sure.

All respondents were aware of partnerships with organizations that provided other needed resources. These partnerships included RCO's, career source/employment agencies, church/faith-based organizations, housing, and food pantries.

Most respondents (77.8%) indicated that the agency where they work has the ability to offer choices to the individuals served. The remaining 16.7% were not sure, and 5.6% indicated that that level of information was not available to them.

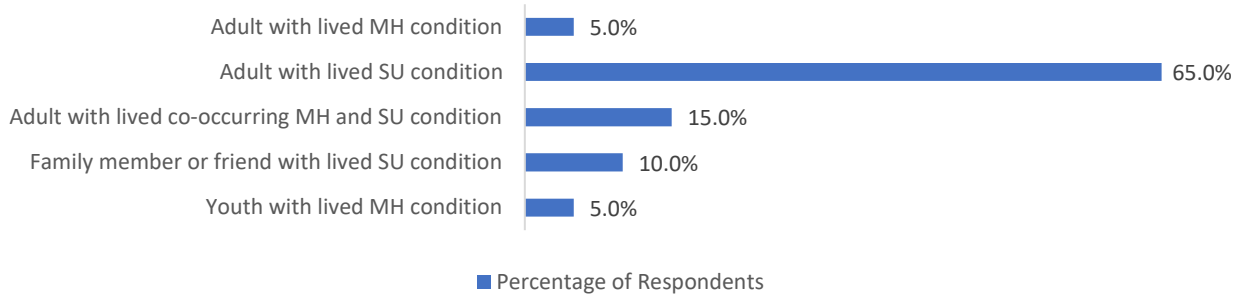
Almost 74% of respondents indicated that the organization where they work reduces stigma by promoting recovery language that is patient centered. The remaining 26.3% were not sure of this.

When asked if peers were included in developing and promoting effective program management, evaluation, and improvement, 64.7% replied yes. Close to 30% were not sure. One respondent indicated that the organization was housing focused, so this did not apply.

Just over 50% of respondents indicated that people in recovery were included in management and board meetings. In some organizations there is not an actual peer position, so this is not possible. Forty percent of respondents were unsure if peers were included in management and board meetings.

PEER RECOVERY COMMUNITY/SUPPORT SPECIALIST'S SURVEY CHARTS

Figure 175: Which best describes your experience?



Note: Mental Health (MH) and Substance Use (SU)

Figure 176: Which county do you live in?

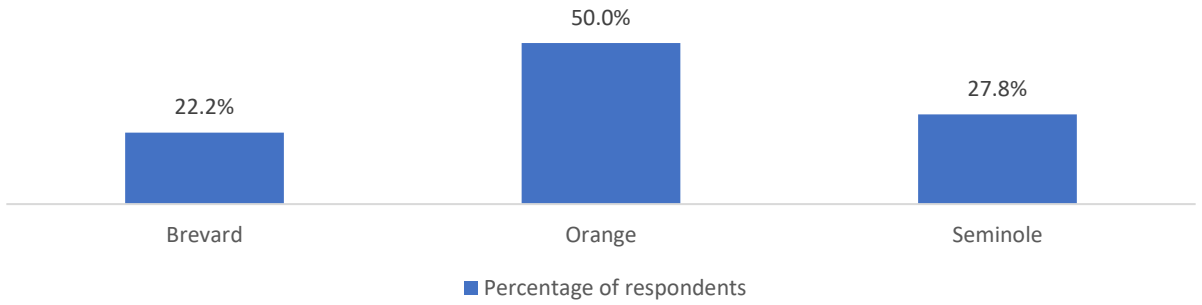


Figure 177: What type of service are you employed or volunteer with? (Check all that apply)

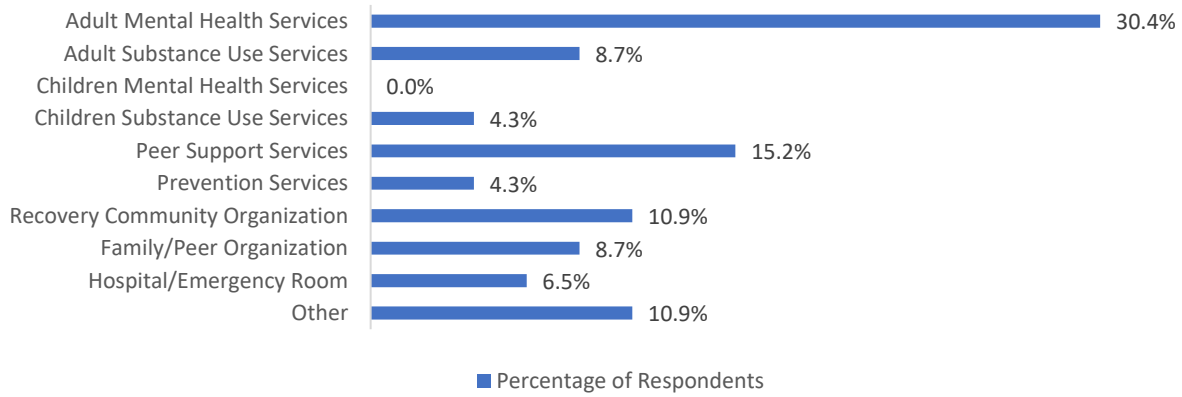


Figure 178: How long have you been employed/volunteered with the agency?

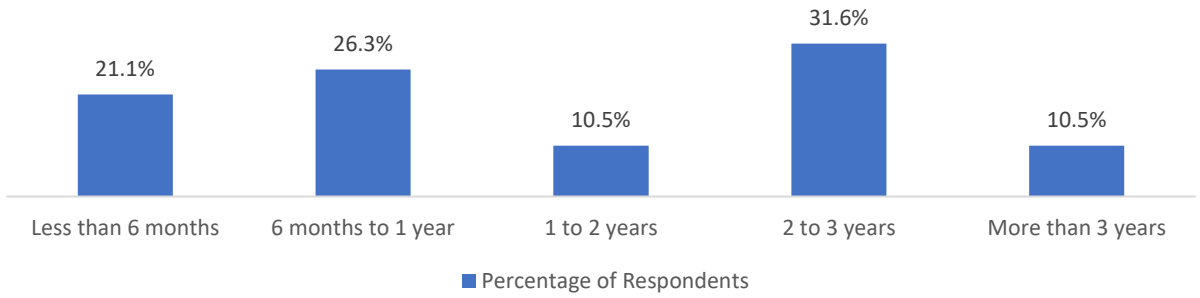


Figure 179: My work schedule averages...

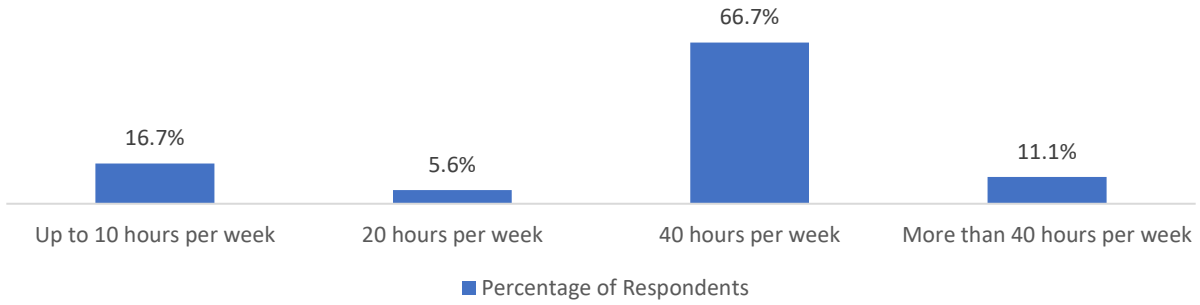


Figure 180: Does the agency where you are employed, or volunteer, utilize recovery peer support services within the services they provide in the community?

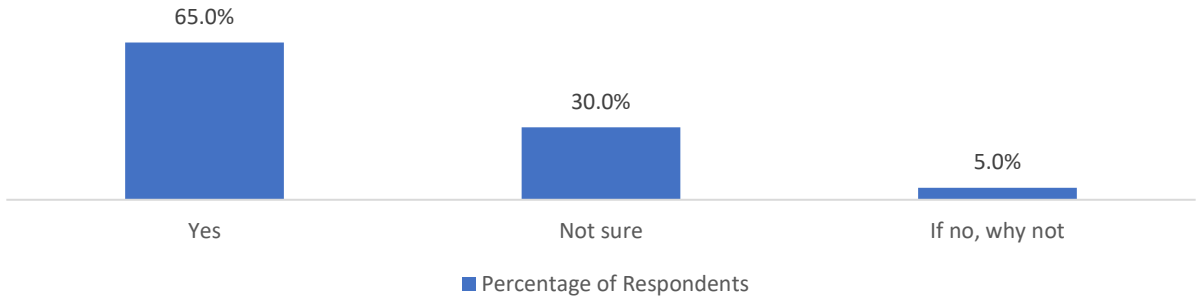


Figure 181: Does the agency where you are employed, or volunteer, adhere to recovery support best practices?

Figure 182: Please indicate the qualifications that best describe your status. (Check all that apply)

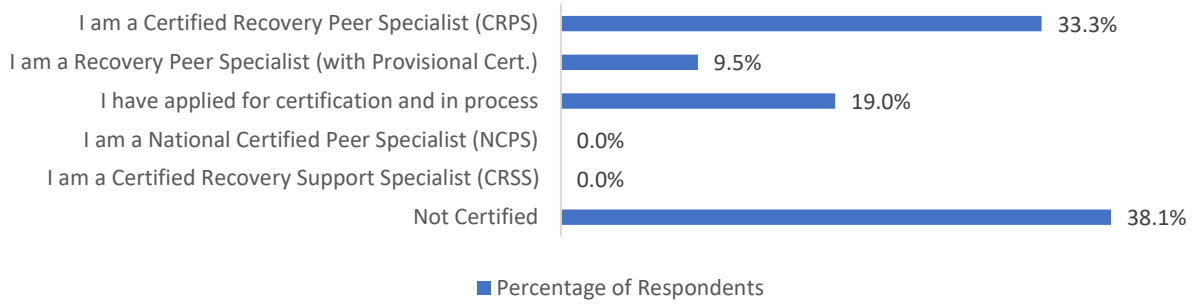
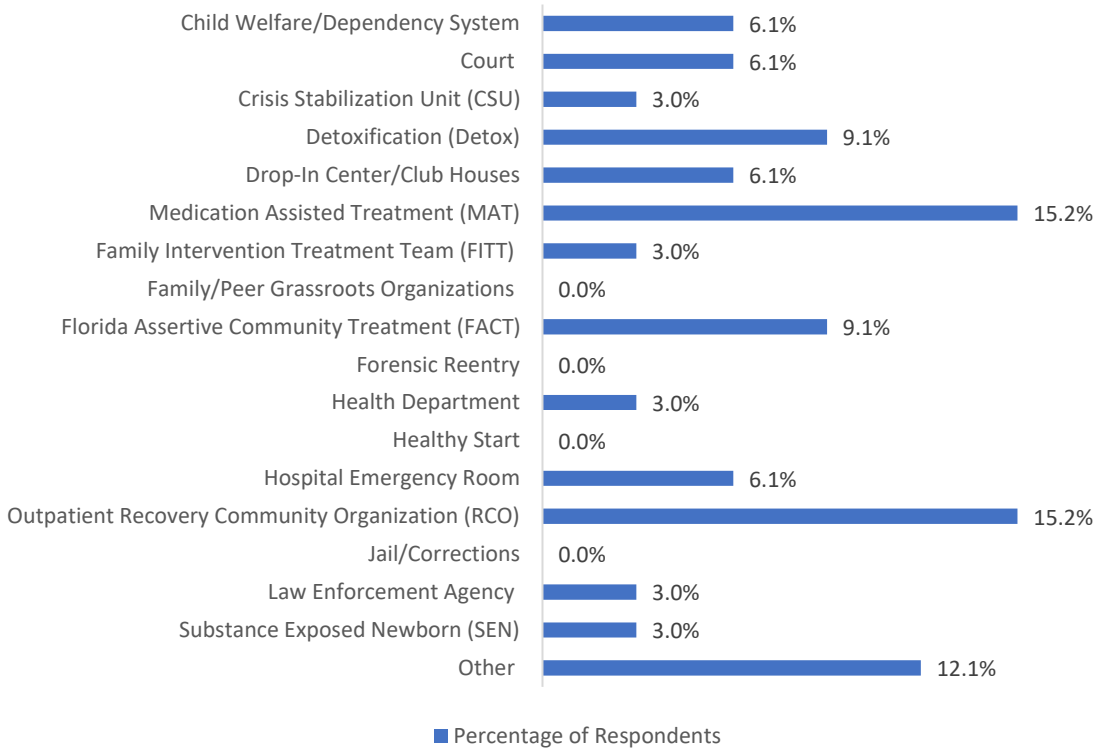


Figure 183: Please indicate the facility/program setting(s) that best describes where you deliver peer recovery support services. (Check all that apply)



Note: Family/Peer Grassroots Organizations includes the National Alliance on Mental Illness (NAMI), Federation of Families, etc.

Figure 184: What are the reasons/factors for staying with the company? (Check all that apply)

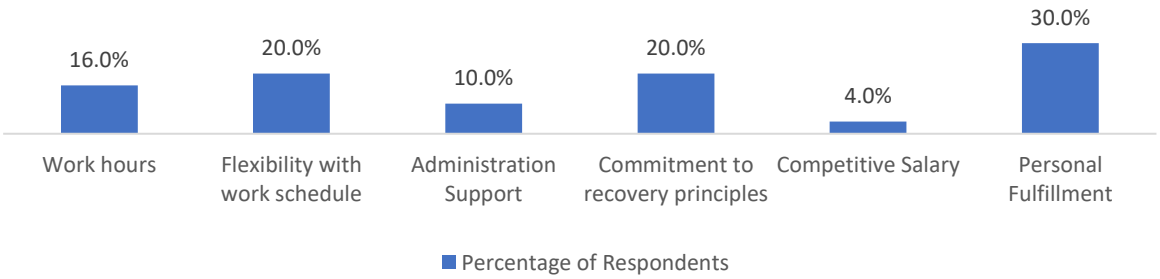


Figure 185: What barriers/challenges have you experienced in the hiring process? (Check all that apply)

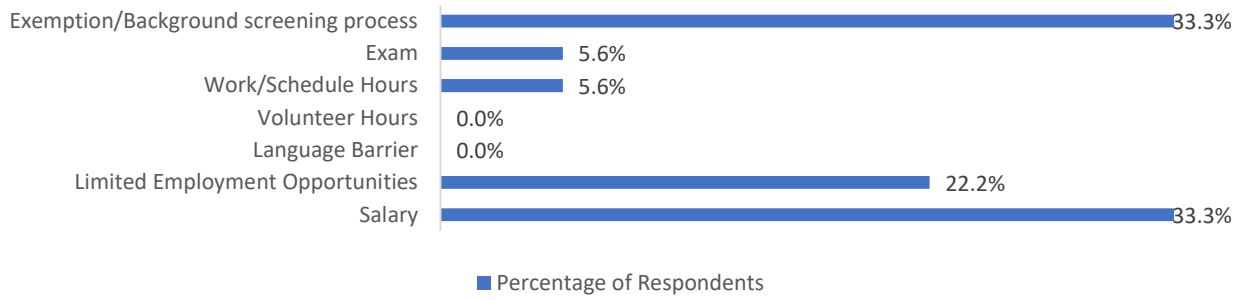
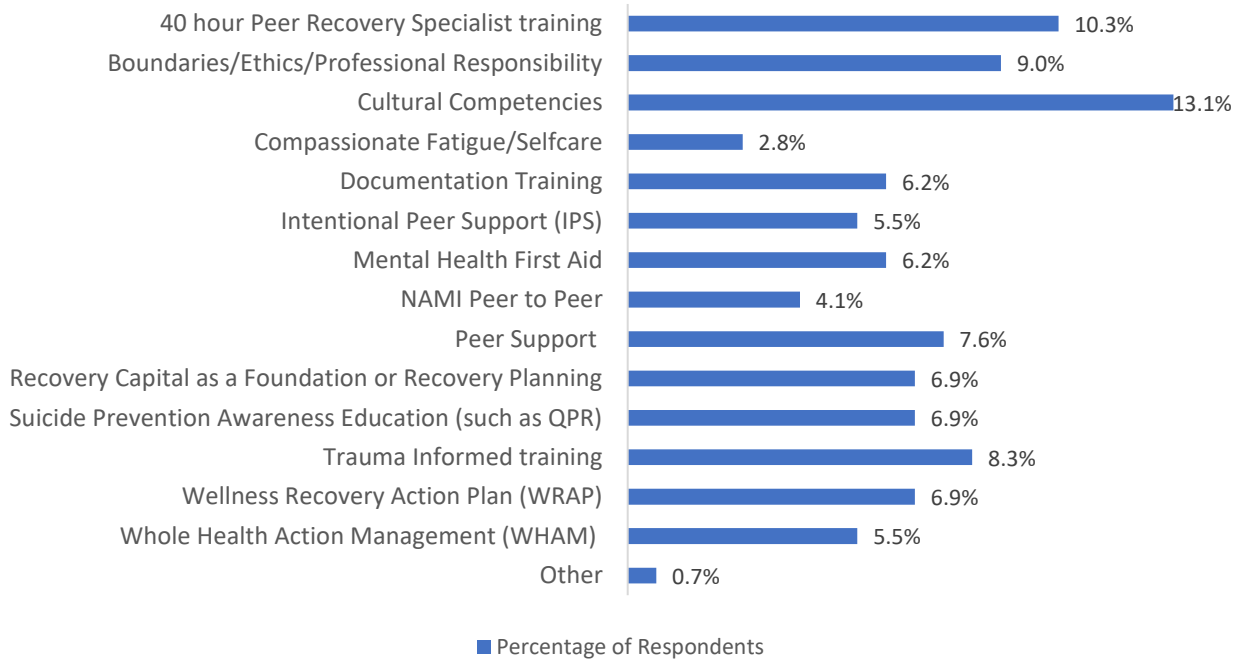


Figure 186: What training would you recommend for peers to have to help them provide peer support services? (Check all that apply)



Note: 40 Hour required Peer Recovery Specialist training/Helping Others Heal

Figure 187: Are there partnerships that exist with peer support recovery programs, recovery community organizations, and other support groups?

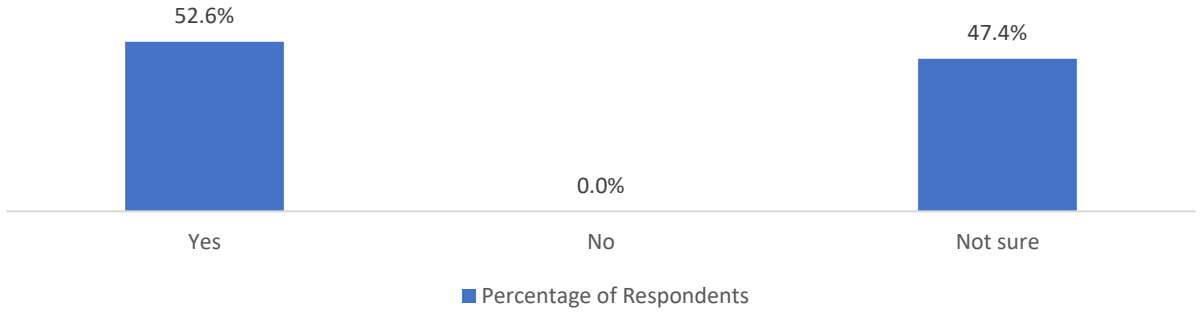


Figure 188: Are you aware of partnerships with other organizations that provide other resources such as: (Check all that apply)

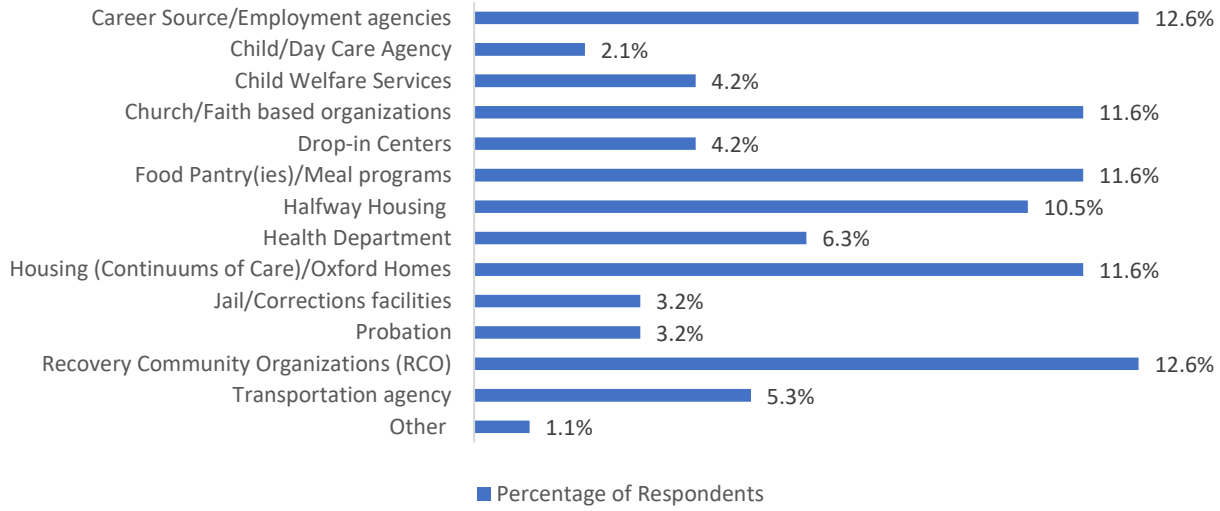


Figure 189: Do you have the ability to offer choices to the individuals where you serve at the agency you are employed/volunteer?

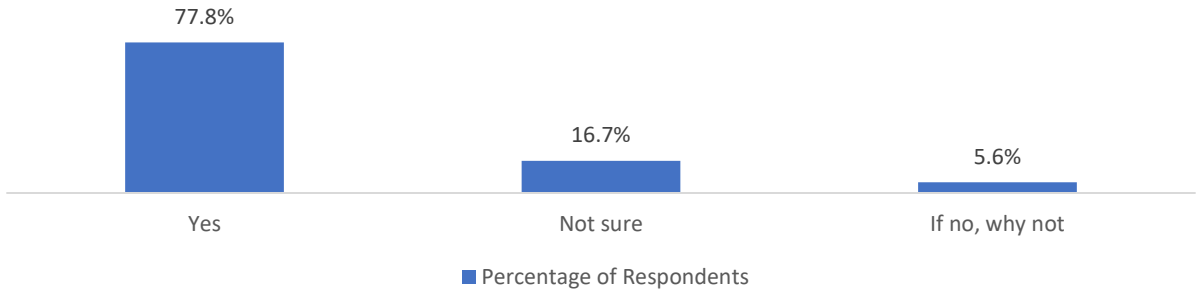


Figure 190: Does the organization where you are employed/volunteer help to reduce stigma by promoting recovery language that is patient centered?

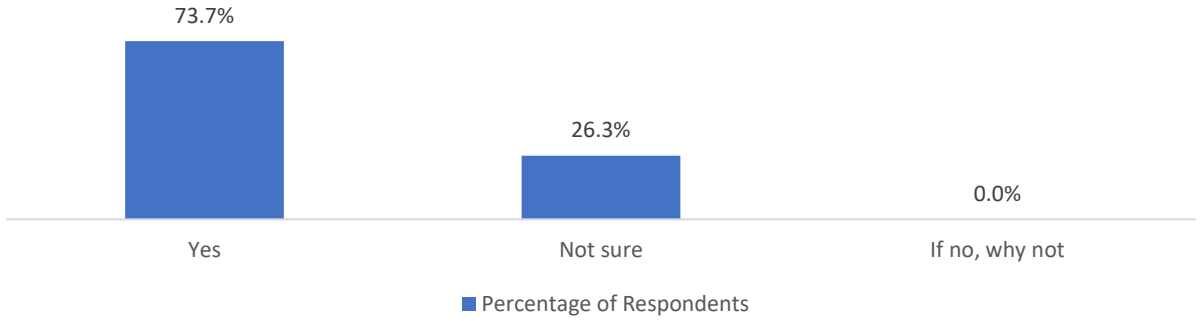


Figure 191: Does the agency where you are employed/volunteer include peers in developing and promoting effective program development, evaluation, and improvement?

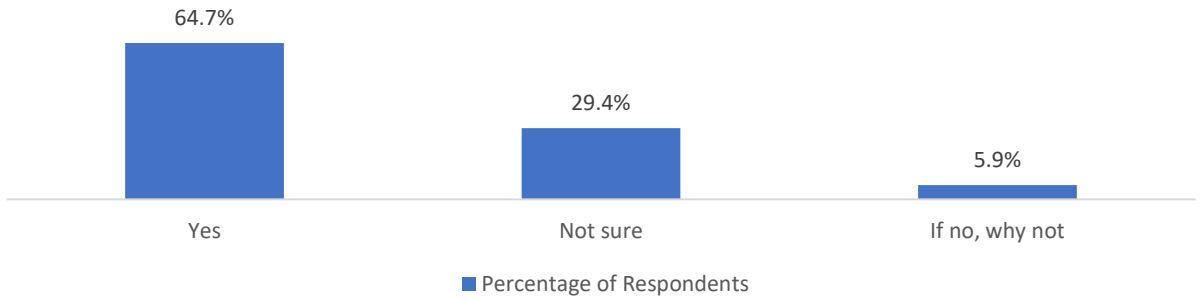
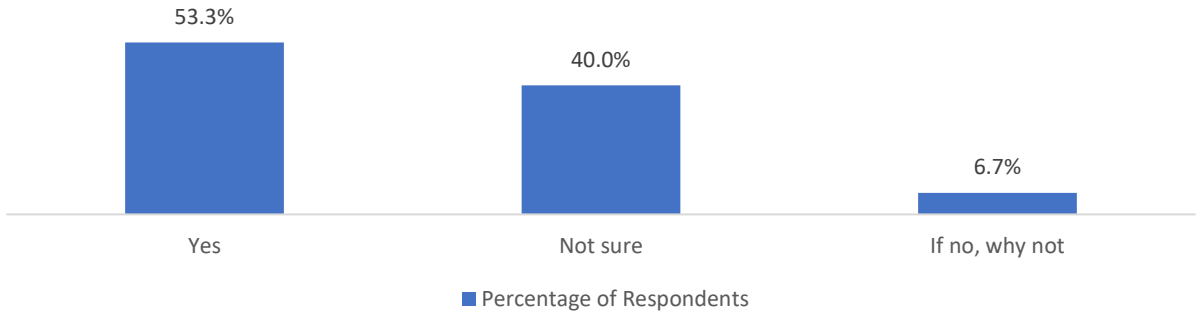


Figure 192: Does the agency where you are employed/volunteer with include persons in recovery management and board meetings?



CFCHS RECOVERY ORIENTED SYSTEM OF CARE RESOURCES

2-1-1 Brevard, Inc.	Brevard Services Navigation
A New Hope Recovery Services	Bridges of America Inc
Adapt Behavioral Services	Care Clinic
Addictions Counseling Services, Inc.	Center for Discovery
Advent Health Hope and Healing Center	Central Florida Behavioral Hospital
All Family Resource Center LLC	Central Florida Recovery Centers
Aspire Health Partners	Central Florida Substance Abuse Treatment Center
Bell Eve Treatment Center	Central Florida Treatment Center
Blackberry Center	Children's Home Society of Florida
Boys Town Central Florida	Circles of Care
Brevard C.A.R.E.S	Circle of Friends Services Kissimmee
Brevard Community Family Resource Tool	Community Counseling Center of Central Florida
Brevard Family Partnership	Comprehensive Addiction Solutions
Brevard Outpatient Alt Treatment	Devereux

Devereux Florida Viera Campus	La Amistad Behavioral Health Servs
Devereux Inpatient Psychiatric Program	Lake Baldwin OPC
Devereux (MRT)	Lake Mary Counseling LLC
Devereux Orange Counseling Center	LifeStream Behavioral Center
Eckerd Youth Alternatives, Inc./Eckerd Connects	Lifetime Counseling Center
Esperanza Behavioral Services	Lotus Behavioral Health
Everyone's Counseling Center Inc (ECC)	Management Consulting Services
Fresh Start Ministries of Central Florida	Mental Health Resource Center (MHRC)
Grove	Metro Treatment of Florida, L.P.
Gulf Coast Jewish Family and Community Services	Mosaico Mental Health Center
Heart of Florida United Way 2-1-1	Neurotherapeutic Addiction Associates
Hope for Tomorrow Mental Health Services	Orlando Health/The Healing Tree
House of Freedom Inc	Orlando Methadone Treatment Center
IMPOWER	Orlando Recovery Center
Informed Families - FL Family Partnership	Orlando VAMC
Kinder Konsulting and Parents Too, Inc.	Palm Point Behavioral Health Hospital

Kissimmee CBOC	Pan American Behavioral Health
Park Place Behavioral Healthcare	Statewide Inpatient Psychiatric Program
Peace Club	STEPS Inc.
Peer Support Space	Stress and Anxiety Center LLC
Project Opioid	Sunrise Detox
RASE Project	Sunspire Health Florida LLC
Recovery Connections of Central Florida	Tele Med Clinix LLC
Recovery House of Central Florida	Total Health Guidance LLC
Renaissance Healthcare Group LLC	The Transition House Inc
Riverside Counseling Services LLC	TTHI Counseling Center
Saint John's Recovery Place	Turning Point Counseling/Consulting
SCCD/Crossroads of Sanford	University Behavioral Center
Serving Children and Reaching Families	Volunteers of America
Space Coast Health Centers	Wayne Densch Center
Space Coast Recovery Inc	White Sands Treatment Center
SP Behavioral LLC, Inc./Sandy Pines	

Source: SAMHSA

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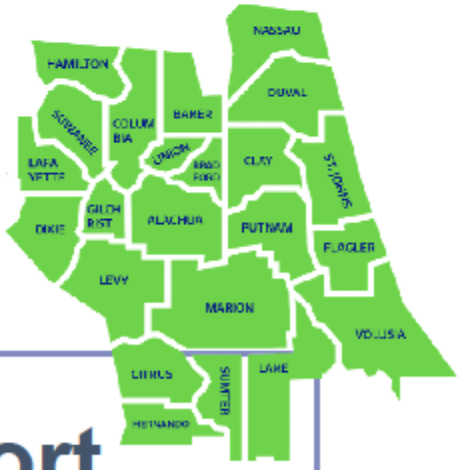
LUTHERAN SERVICES FLORIDA

2022

Florida Cultural Health Disparity & Behavioral Health Needs Assessment



Regional Report

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Greetings Community Members,

LSF Health Systems, your behavioral health Managing Entity for the Northeast and North Central region, proudly announces the completion of our 2022 Triennial Needs Assessment. As the second largest Managing Entity in the state, we serve 23 counties in Northeast and North Central Florida. This includes both urban and rural areas with diverse populations and unique needs. LSF Health Systems contracts with the Department of Children and Families to manage state-funded behavioral health services for those vulnerable citizens who are indigent, uninsured, or underinsured. This includes children, adults, and families who lack the financial resources to afford behavioral health care. Our goal is to provide the right service at the right time in the right setting. This supports our vision to create a world of safe children, strong families, and vibrant communities where every child, adult, and family have access to behavioral health services they need to live well and be well.

We would like to acknowledge Senator Darryl Rouson who embodies our vision and values. His legislative advocacy resulted in the inclusion of the health disparities focus on our assessment. Health disparities are often interpreted to mean racial or ethnic disparities; however, many dimensions of disparity exist in the United States, particularly in health. When health differences are seen to a greater or lesser extent between populations, there is disparity. Race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location all contribute to an individual's ability to achieve good health. LSF Health Systems appreciates Senator Rouson's recognition of the impact that social determinants have on health outcomes of specific populations.

The purpose of conducting a needs assessment every three years is to determine needs, gaps, barriers, and strengths in the behavioral health system of care. LSF Health Systems will use this report as a call to action, engaging providers, consumers, stakeholders, and community members in creating effective programs, policies, and community collaborations to bring positive change to our communities. The long-term goal of a community health needs assessment is to identify health priorities and develop impact strategies with all health-related stakeholders in the community. This report will serve to inform the development of the LSF Health Systems' Strategic Plan for 2022-2025 as well as the annual enhancement plans submitted to the Department of Children and Families to address unmet needs. Town Hall meetings with providers and stakeholders will be scheduled in each of the circuits served by LSF Health Systems to discuss the results of the Triennial Needs Assessment. We thank our communities for engaging in the needs assessment and assisting LSF Health Systems with implementing strategies to enhance the behavioral health system of care in our region.

Sincerely,

Dr. Christine Cauffield

Dr. Christine Cauffield
Chief Executive Officer
Executive Vice President - SAMH
LSF Health Systems, Inc.

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A special thank you to all those who participated in the needs assessment process including:

LSF Health Systems network service providers and community partners who promoted the Individual's Served Survey, Cultural Health Disparity Survey, Recovery Community Peer Specialist Survey, Stakeholder Survey, and No Wrong Door Survey.

LSF Health Systems network services providers who participated in the No Wrong Door Survey and Focus Groups.

Community members who completed the Individual's Served Survey, Cultural Health Disparity Survey, Recovery Community Peer Specialist Survey, and Stakeholder Survey.

Community members who participated in focus groups.

A special thank you to the professional staff at LSF Health Systems who served as the Steering Committee and leadership team for the behavioral health needs assessment:

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EXECUTIVE SUMMARY

SERVICE AREA POPULATION

LSF Health Systems (LSFHS) serves a 23-county region in Northeast and North Central Florida which includes the counties of Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Hernando, Lake, Lafayette, Levy, Marion, Nassau, Putnam, St. Johns, Sumter, Suwannee, Union, and Volusia. In 2020, the estimated number of adults with serious mental health conditions was 127,850 in the 23-county service area. This number has increased 4.5% over the past 3 years. This report, prepared for LSFHS, is a compilation of primary and secondary data that identifies behavioral health needs and the community assets available to advance the health care delivery system to improve outcomes for all residents.

DEMOGRAPHIC PROFILE

The population in the service area increased (7.5%) over the past 5 years to a total of 4,067.330 individuals. Racially, the service area is predominately White (75.2%), with the Black population accounting for 15.4%, Asian residents at 2.7%, American Indians and Native Hawaiians represented less than 1%, and 2.2% of individuals who are of other races. Hispanic individuals make up 11% of the area's population, which is less than the percentage of Hispanic individuals in Florida (25.8%). This varies by county/circuit and that some show higher rates.

LSFHS service area population is slightly younger when compared to the age distribution of Florida. In the service area 54.6% of the population participated in the labor force over the past 5 years. The ratio of income and poverty levels in the service area mirrors that of Florida. The percentage of individuals in the service area living below the Federal Poverty Level (FPL), according to 5-year estimates from 2016 to 2020, was 9.1% (9.4% in Florida) with 16.7% living between 100 and 199% of FPL (17.1% in Florida), and 41.3% living at 400% or more of poverty (42.3% in Florida).

GENERAL HEALTH STATUS

Behavioral Risk Factor Surveillance System (BRFSS) data (2017 to 2019) estimates revealed 78.6% of adults, ages 18-64 years of age, living in the service area said their overall health was "good" to "excellent", compared to 80.3% in Florida overall. The average percentage of adults reporting good mental health over the past 3 years was 84.9% in the service area compared to 86.2% in Florida overall. Most residents (85.4%), ages 18-64 years, living in the ME service area reported having some type of health insurance coverage which is slightly higher than Florida overall (84.2%).

The crude suicide death rate decreased from 21.2/100,000 in 2018 to 18.7/100,000 in 2020; however, it should be noted that the suicide death rate for males in the Managing Entity (ME) service area was more than three times the rate among females. Additionally, the suicide death rate among the White population was three times the rate for Black residents in the ME service area.

The rates of domestic violence and child abuse have decreased over the last 3 years in the service area and across the state. The percentage of adults who are smokers and who binge drink are lower in the service area than the state. High school tobacco, alcohol, and substance use in the service area closely mirror the state.

In the ME service area, 15.7% of the noninstitutionalized population is estimated to have a disability (includes hearing, vision, cognitive, ambulatory, self-care, and independent living) compared to 13.6% in the state.

CLIENT DEMOGRAPHIC PROFILE

LSFHS-funded organizations served 49,928 individuals in FY20-21. Slightly more than 22% of those served resided in Volusia County (11,185 individuals), followed by Duval County at 19.5% (9,756 individuals), Marion County at 8.6% (4,290 individuals), and Clay County at 6.9% (3,445 individuals). Adults in LSFHS programs accounted for 86.5% of all persons served with 53.2% enrolled in the Adult Mental Health (AMH) program and 33.3% in the Adult Substance Abuse program (ASA). The remaining individuals were in the Child Mental Health (CMH) program at 9.4% and the Child Substance Abuse (CSA) program at 4.1%.

Adults, ages 25-44 years of age, accounted for 48.6% of all LSFHS persons served by LSFHS providers while representing 23.7% of the population in the service area. Adults, ages 65 years and older, accounted for only 3% of the individuals served by LSFHS providers while representing 22.5% of the service area population.

HOMELESSNESS

The effects of homelessness on individuals are numerous, complicated, and very costly. In addition to poor physical health, homeless community members are at an increased risk for mental health conditions, drug dependency, behavioral health issues, assault, and even premature death. In 2021, the Florida Council on Homelessness reported there were 4,232 individuals who experienced homelessness in District 3 (includes the 23-county LSFHS service area). Sheltered individuals represented 58.5% of those experiencing homelessness population, while 41.5% of the individuals experiencing homelessness were unsheltered. Among veterans, 484 experienced homelessness in the LSFHS service area. The Florida Department of Education reported 14,992 students in the LSFHS service area experienced homelessness in the 2019-2020 academic year.

HOMELESSNESS PROFILE

A total of 2,728 individuals served by LSFHS providers experienced homelessness, representing 5.5% of all those served by LSFHS. Of the 2,728 individuals who experienced homelessness, 67.6% were enrolled in the AMH program, 31.8% in the ASA program, 0.4% were enrolled in the CMH program, and 0.1% were enrolled in the CSA program.

Almost 70% of individuals experiencing homelessness served by LSFHS providers were White, 20.2% were Black, 3.1% were Multi-Racial, and 6.2% identified as "Other" race.

Adults, ages 25-44 years, accounted for 59.7% of individuals experiencing homelessness served by LSFHS providers and only 48.6% of the overall number of individuals served by LSFHS providers.

NO WRONG DOOR ASSESSMENT PROVIDER INTERVIEWS

Three provider interview focus groups were conducted virtually to assess No Wrong Door (NWD) access. Providers were invited to participate in the focus groups after completing a brief NWD survey (80 responses). The interviews were used to gain qualitative understanding of the survey findings. Approximately 15 individuals participated.

Over 80% of survey respondents said that their agency has a role to play in NWD access, with 65% stating that it works well within their agency. The interviews showed that providers have worked internally and externally to improve NWD access. As expected with Florida ranked #49 in the nation for behavioral health spending per capita, providers noted funding limitations as a concern.

Interview respondents indicated that having relationships with individuals from various agencies in the area helped NWD access work well in their organization. A shortage in workforce and not enough capacity was also a common theme across all three focus group provider interviews.

CULTURAL HEALTH DISPARITY SURVEY

For the 2022 needs assessment, a new survey was deployed to better understand the role of health disparities in behavioral health outcomes. A total of 300 participants completed a survey detailing their experiences and attitudes with respect to behavioral health. The survey assessed several focus areas including Comfort Seeking Care, Trust in the Behavioral Health System, Feelings Regarding Behavioral Health Issues, Behavioral Health Treatment Settings, and Language Needs.

INDIVIDUAL'S SERVED SURVEY

An individual's served survey was conducted during early 2022 with 388 responses collected during the survey period. Data revealed the respondents were aware of where to go for mental health and substance use treatment when they needed them (90%), that most respondents

learned about services from a family member/friend (31.6%), another individual in treatment or recovery (21.9%), law enforcement (15.3%), or by word of mouth (14.9%).

Most respondents indicated that they were able to receive the services they needed when they needed them (81%). Those who were unable to get the services they needed were asked a follow-up question to list the services they needed but did not receive. The service needed and not received most was "housing assistance" (10.7%) followed by "other" (9.8%), and "medication assistance program" (6.8%).

When asked, "What were the obstacles you experienced getting the care you needed respondents said, "no or very limited transportation" (10.5%), "long waitlists" (9.8%), followed by "could not afford the service" (8.9%), "did not know where to go for services" (7.3%), and nearly 29% (28.9%) did not have any barriers.

STAKEHOLDER SURVEY

A survey of behavioral health stakeholders across the 23-county LSFHS service area yielded 387 responses. All 23 counties were represented in the survey. Nearly 88% of respondents strongly agreed or agreed that they were aware of the availability of mental health and substance use services in their area. While only 56% of respondents were aware of LSFHS, it is possible respondents were aware of LSFHS service providers, but not aware of the managing entity network in Florida and LSFHS' role as a managing entity. Although nearly 76% of respondents were familiar with 2-1-1, only 15.3% of respondents had used the 2-1-1 service in the past 6 months.

Respondents were not in agreement regarding the availability and accessibility of behavioral health care and peer services. Respondents were also not in agreement regarding the referral process with 46% indicating the process for referrals is not easily accessible.

Barriers for accessing services included not being aware of where to go for services (53.4%), affordability (17.9%), and transportation barriers (14.7%). Respondents were asked to "List the resources and services needed that are not available to improve patient-centered care and planning that are not available." Write in responses included: providers, professionals, clinicians, therapists, transportation, housing, waitlist reduction, crisis stabilization services, residential services, case management services and case management coordination, Baker Act receiving facilities, school-based support services, Medicaid payment acceptance and expansion of Medicaid services, behavioral health support services, therapies, and childcare.

RECOVERY COMMUNITY PEER SUPPORT SURVEY

Peer Support Specialists' (PSS) bridge gaps in services in the NWD care model to improve patient-centered care. PSS were surveyed to evaluate their engagement, barriers, and improvements they would like to see in the health system. In total, 95 responses from peers were collected,

representing 15 of the 23 counties in the service area. PSS participate in various recovery support roles throughout the health care system and in the community. Hospital emergency rooms, drop-in centers, corrections facilities, child welfare, and Medication Assisted Treatment (MAT) were some of the programs supported or run by PSS.

The participation and integration of PSS is evidence-based practice. In the LSFHS service area, peers overwhelmingly (81.1%) reported their agencies use person-centered language that helps reduce stigma. Nearly three-quarters of respondents indicated that peers are included in developing, promoting, evaluating, and improving programs. Nearly 60% of respondents said that persons in recovery participate in management and board meetings.

LSFHS SERVICE AREA DEMOGRAPHIC PROFILE

Population Demographics

From 2016 to 2020, the estimated population in the 23-county service has increased from 3,784,476 to 4,067,330 (7.5%).

In the service area and the state, females accounted for slightly more than 50% of the population when compared to their male counterparts.

The racial composition in the service area varies slightly from the state. White residents account for 75.2% in the service area and 71.6% in Florida. The Black population accounted for 15.4% of the service area population and 15.9% of the population in Florida. American Indian and Native Hawaiians represented less than 1% of residents in both population groups. The percentage of Asian residents in the service area and the state was 2.7% and 2.8%, respectively. Those with a race of Other accounted for 2.2% of the service area population and 3.3% in the state.

Ethnically, the service area had a much lower percentage of Hispanic residents, at 11%, when compared to the state at 25.8%.

The LSFHS service area population was slightly younger when compared to the age distribution at the state level. Residents, 65 years of age or older, accounted for 22.5% of the population while in the state of Florida, 20.5% of residents were at least 65 years old.

Education and Employment

Data revealed the service area and state populations were very similar regarding education attainment. In the LSFHS service area and in Florida, approximately 10% of the population have associate degrees. In the service area 17.1% have bachelor's degrees compared to 19.3% in Florida. Graduate or professional degrees were held by 9.8% of the LSFHS service area and by 11.3% of Florida residents.

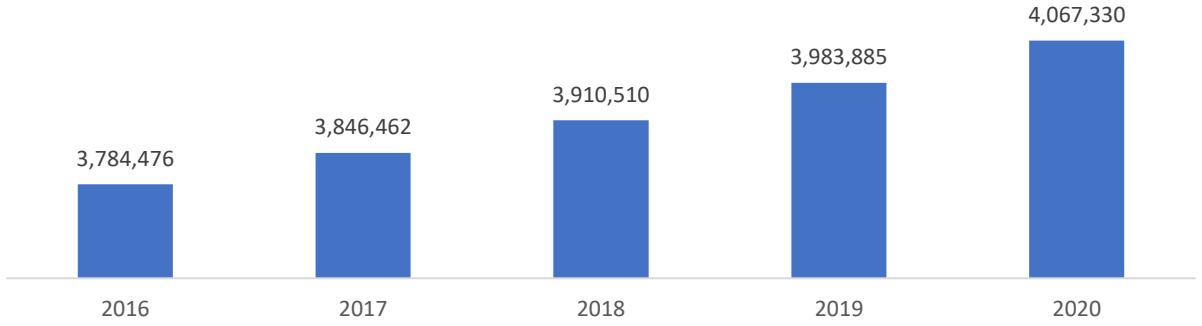
On average, 54.6% of the service area population participated in the labor force over the past 5 years. This was lower when compared to those employed in Florida at 58.9%. The unemployment rate for the service area during that same period was 3% compared to 5.4% in Florida.

Poverty Status

During 2016 to 2020, the ratio of income to poverty in LSFHS service area closely mirrored that of the state of Florida. The percent of residents living at < 200% of the Federal Poverty Level (FPL) was 25.8% in the LSFHS service area compared to 26.3% in Florida and those living at 400% the Federal Poverty Level in the LSFHS service area was 41.3% compared to 42.3% in Florida.

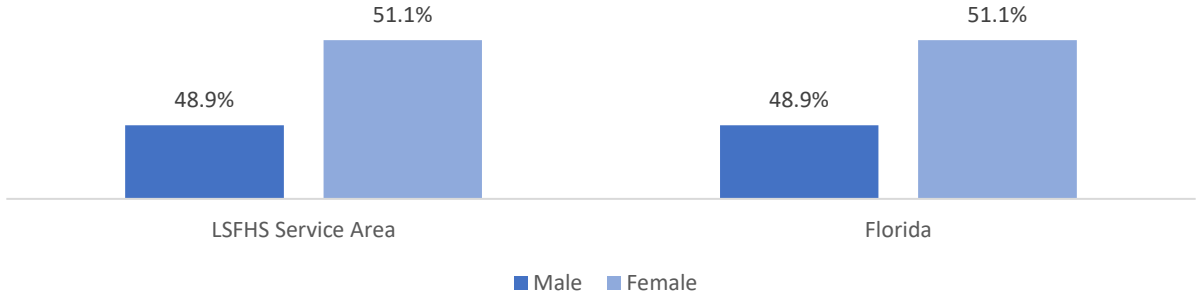
DEMOGRAPHIC CHARTS

Figure 1: LSFHS Service Area Population Estimates (2016-2021)



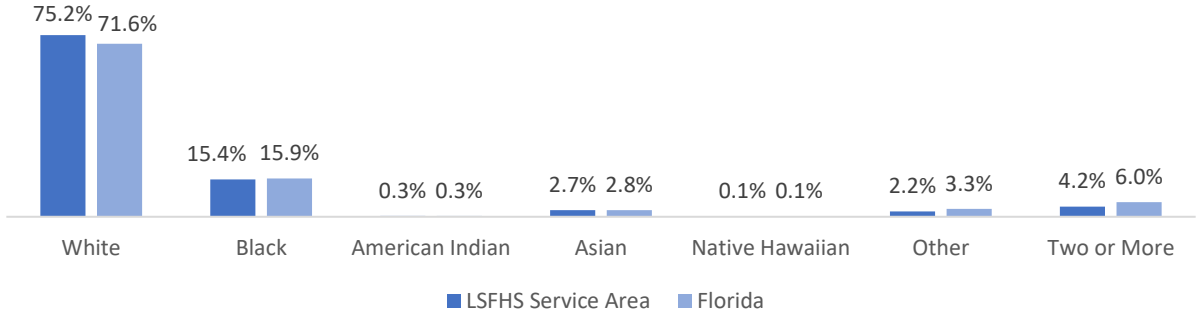
Source: Florida Legislature's Office of Economic and Demographic Research (EDR)

Figure 2: LSFHS Service Area County Population by Gender (2016-2020)



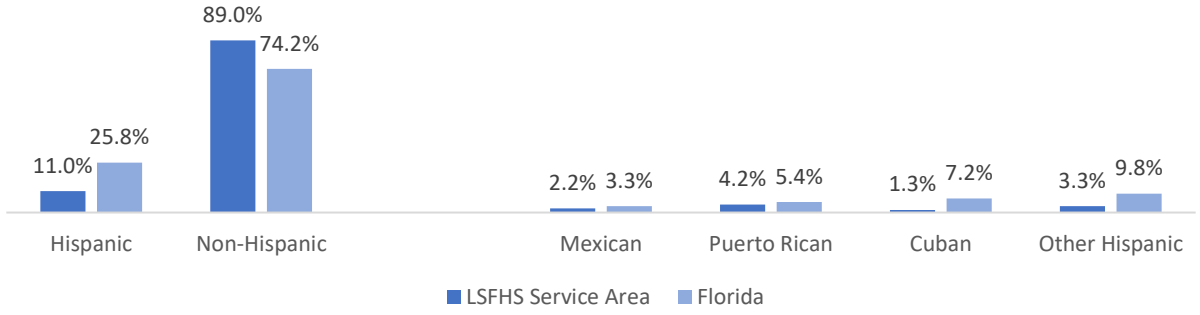
Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 3: LSFHS Service Area County Population by Race, 2016-2020 (5-Year Estimate)



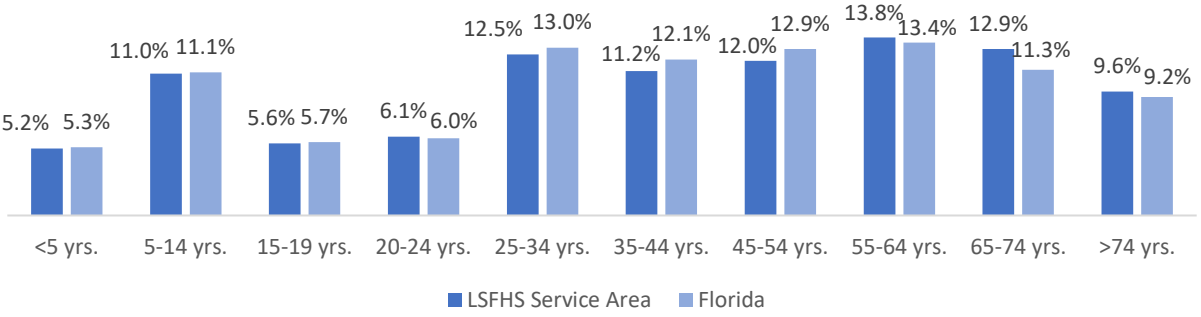
Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 4: LSFHS Service Area Population by Ethnicity, 2016-2020 (5-Year Estimate)



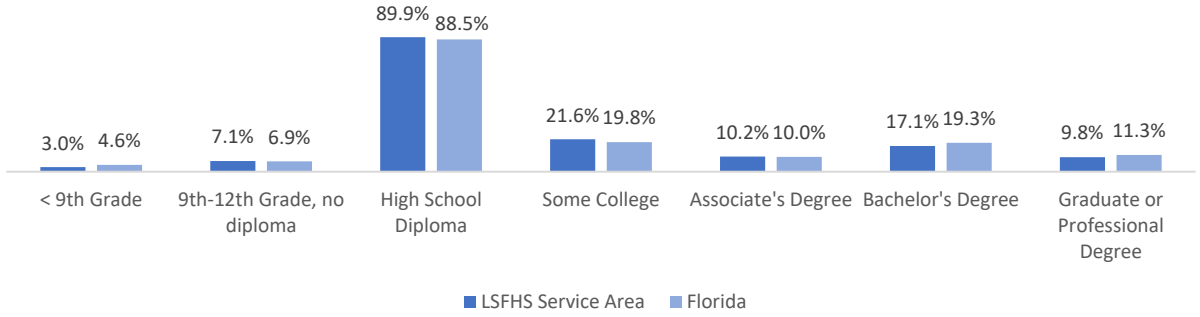
Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 5: LSFHS Service Area Population by Age Range, 2016-2020 (5-Year Estimate)



Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 6: LSFHS Service Area Population by Educational Attainment, 2016-2020 (5-Year Estimate)



Source: U.S Census Bureau, American Community Survey, Table S1501

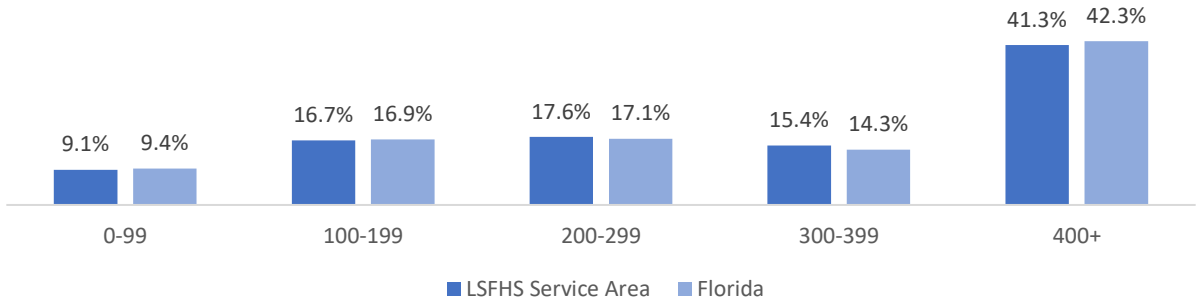
Figure 7: LSFHS Service Area Population Participation in Labor Force, 2016-2020 (5-Year Estimate)

Source: U.S Census Bureau, American Community Survey, Table DP03

Figure 8: LSFHS Service Area Population Unemployment Rates, 2016-2020 (5-Year Estimate)

Source: U.S Census Bureau, American Community Survey, Table DP03

Figure 9: LSFHS Service Area Population Ratio of Income to Poverty Level of Families, 2016-2020 (5-Year Estimate)



Source: U.S Census Bureau, American Community Survey, Table B17026

LSFHS SERVICE AREA GENERAL HEALTH STATUS

Overall, Health Status

Behavioral Risk Factor Surveillance System (BRFSS) data (2017 to 2019) estimates revealed 78% of adults, ages 18-64 years of age, living in the service area said their overall health was "good" to "excellent." For Florida, the rate was 80.3%. This knowledge is a powerful tool for targeting and building health promotion activities. It also provides a way to see change in population health behaviors before morbidity or disease is apparent.

Mental Health

The average percentage of adults reporting good mental health over the past 3 years at 84.9% was below the rate for the state at 86.2%. The number of unhealthy mental days for the service area population, at 4.6 days in the past 30 days, was just above the rate among all adult residents (ages 18-64 years) in Florida at 4.4 days in the past 30 days.

The estimated number of adults with a seriously mental health condition in the LSFHS service area was 127,850 in 2020 compared to 122,517 in 2018. This represents an increase of 4.5% over the past 3 years. The estimated number of adults with a serious mental health condition in the state also increased by 3.5% from 2018 to 2020.

Among youth in the LSFHS service area, ages 9-17 years, the estimated number of those who experienced an emotionally disturbance increased nearly 3% from 2018 to 2020, (35,046 in 2018 and 36,067 in 2020). This was slightly lower that the state percentage increase.

The Florida Department of Education (FLDOE) reported 0.7% of children in K-12 grades had an emotional/behavioral disability in the LSFHS service area. In the state, students with an emotional/behavioral disability accounted for 0.5%. These rates have been steady over the past 3 years.

Suicide

The crude suicide death rate decreased from 21.2/100,000 in 2018 to 18.7/100,000 population in 2020. This represents a decrease of 2.5/100,000 suicide deaths. At the state level, the suicide crude death rate decreased 2.5 deaths per 100,000 population during the same period but was lower when compared to the LSFHS service population (16.9/100,000 in 2018 and 14.4/100,000 in 2020 in Florida). Among males, the suicide death rate for the ME service area and state were more than three times the rate among females (29.6/100,000 compared to 8.2/100,000, respectively). The suicide death rate among the White population was three times the rate for Black residents in the ME service area (21.8/100,000 compared to 7.0/100,000, respectively). The

same held true at the state level where White to Black suicide deaths revealed a 3.2:1.0 ratio. It should be noted that the calculations required for the age-adjusted death rate for the ME service areas was beyond the scope of this project.

Violence and Abuse

The rate of total domestic violence offences decreased in the ME service area and the state from 2017 to 2020. In the ME service area, the rate fell from 643.7/100,000 to 594.8/100,000 over the past 3 years. This was still higher than the state rate of 496.5/100,000 in 2020.

The rate of children experiencing child abuse over the past 3 years (2017-2019) has continuously decreased in the ME Service area and state. Among children ages 5-11 years, the rate of child abuse fell from 873.4/100,000 in 2017 to 684.9/100,000 in 2019. This trend was observed in the state rates which decreased from 857.9/100,000 to 662.7/100,000 during the same period.

Child sexual abuse rates for children ages 5-11 decreased slightly from 2017 to 2019 in the LSFHS service area from 62.8/100,000 in 2017 to 60.8/100,000 in 2019. The Florida child sexual abuse rates for children ages 5-11 decreased from 59.6/100,00 in 2017 to 57.8/100,00 in 2019.

Adult Tobacco and Alcohol Use

BRFSS results revealed the percentage of adults living in the ME service area who are current smokers at 12.8% (2017-2019) was lower when compared to the state at 14.8%.

Binge drinking is defined as five consecutive drinks for men and four consecutive drinks for women. For 2017-2019, the percentage of binge drinkers in the ME service area was 17%. The percentage of binge drinkers in the state was slightly higher at 18%.

High School Tobacco, Alcohol and Substance Use

Data from the Florida Youth Substance Abuse Survey (FYSAS) indicated that the percentage of middle and high school students in the LSFHS service area who reported never having smoked cigarettes increased from 84.3% in 2016 to 91% in 2020. In 2020, 6.3% of students smoked once or twice and 2.2% reported that they had smoked once in a while. For middle and high school students in the state, the percentage of those having never smoked also increased over the past 4 years. The state has slightly higher rates when compared to the LSFHS service area.

When students were asked about smoking frequency, 97.5% of those living in the ME service area did not smoke at all compared to 98.2% in the state of Florida.

Vaping questions were included in the 2020 FYSAS for the first time. In the LSFHS service area, 25.2% of students reported vaping nicotine on at least one occasion in their lifetime. Slightly more

than 7% of student had vaped on 40 or more occasions. Rates at the state level were similar for frequency occasions of vaping nicotine in their lifetime. The percentage of students vaping nicotine during the past 30 days was lower in the service area and the state (12.6% compared to 11.4%, respectively). However, in the LSFHS service area, 3.1% of students reported vaping 40 or more occasions during the past 30 days as compared to 2.4% in the state.

The percentage of students who did not consume alcoholic beverages on any occasions in their lifetime ranged from 60.5% in 2016 to 63.5% in 2020, which is slightly lower than the state percentage of 64.7%. For those who did consume alcoholic beverages on 1-2 occasions, the percentage ranged from a low of 14.4% to a high of 15% from 2016 to 2020. In the LSFHS service area, the percentages of students in 2020 consuming alcohol on more than 2 occasions ranged from 7.8% for 3-5 occasions to 2.7% for those consuming alcohol on at least 40 occasions. The LSFHS service area consumption percentages closely mirrored those of the state.

High school students were asked for the number of occasions in their lifetime when they had woken up after a night of drinking alcohol and were unable to remember the things they did or the places they went. The percentage of students reporting this event happening on at least 1-2 occasions in their lifetime (2020) in the ME service area and the state was 7.9% and 7.4%, respectively. When looking at previous reported data, this was a decrease from the percentages reported in 2016 for the ME service area and the state. In 2020, 84.5% of students in the service area reported never having had this experience, compared to the state at 86.2%.

The percentages of students living in the ME service area not consuming alcohol during the past 30 days increased from 80.7% in 2016 to 84.2% in 2020. The increase at the state level was higher when comparing percentages from 2016 (81.7%) to 2020, at 85.2%. The percentages of students who reported consuming alcohol on 1-2 occasions during the past 30 days decreased in the ME Service area and state from 2016-2020.

The overall percentage of those binge drinking, defined as consuming five or more alcoholic drinks in a row in the past 2 weeks, varied from 8% in 2016 to 7.1% in 2018, and 7.7% in 2020. Florida experienced a decrease in the percent of students who participated in binge drinking from 7.7% to 6.7% in 2020.

The percentages of students who have not used marijuana in their lifetimes has varied over the past 4 years in the LSFHS service area (77.7% in 2016, 78.7% in 2019 and 77.2% in 2020) while the state percentage has increased from 78.7% in 2016 to 79.9% in 2020. For those who did use marijuana on one to more than 40 occasions in their lifetime, the overall percentages decreased in the LSFHS service area from 6.7% in 2016 to 6.6% in 2020. At the state level, the rate decreased from 2016 (6.2%) to 2020 (5.5%). The percentages of students not using marijuana in the past 30 days was higher when compared to those who reported not using it in their lifetime. The percentages of students in the LSFHS service area and state who reported using marijuana in the past 30 days on one or more occasions, was 12.3% and 10.7% in 2020, respectively. The percentages of students who reported vaping marijuana in their lifetimes on one or more

occasions was higher in the ME service area at 16.6% when compared to the state at 15.6%. This was also true when comparing the two groups of students who had vaped marijuana in the past 30 days. In the ME service area, 8% of students had vaped marijuana in the past 30 days compared to 7.3% of students in the state.

Disability

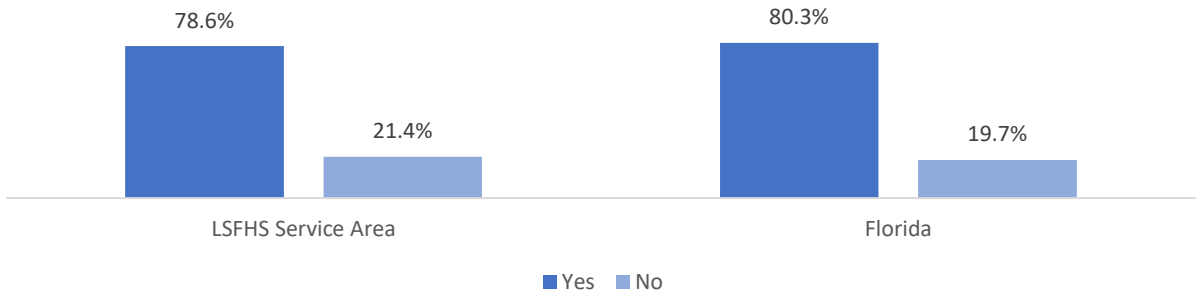
In the ME service area, 15.7% of the noninstitutionalized population is estimated to have a disability (includes hearing, vision, cognitive, ambulatory, self-care, and independent living). At the state level, 13.6% of residents had a disability. The percentages of those with a disability were much higher among older adults, ages 65 years and older, at 48.3% for the LSFHS service area and the state.

Health Insurance Coverage

Most residents, ages 18-64 years, living in the LSFHS service area and state reported having some type of health insurance coverage. The percentage of those with insurance in the LSFHS service area was slightly higher when compared to the state at 85.4 percent and 84.2 percent, respectively.

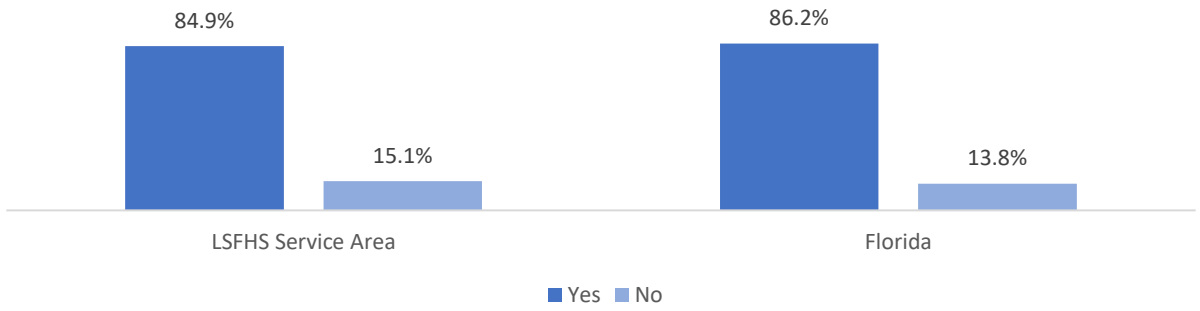
GENERAL HEALTH STATUS CHARTS

Figure 10: LSFHS Service Area Adults Who Said Their Overall Health Was "Good" to "Excellent"(2017-2019)



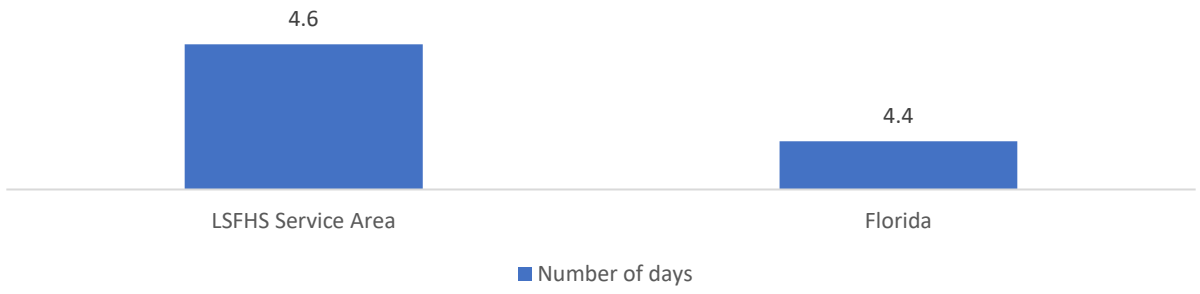
Source: Behavioral Risk Factor Surveillance System

Figure 11: LSFHS Service Area Adults with Good Mental Health for the Past 30 Days (2017-2019)



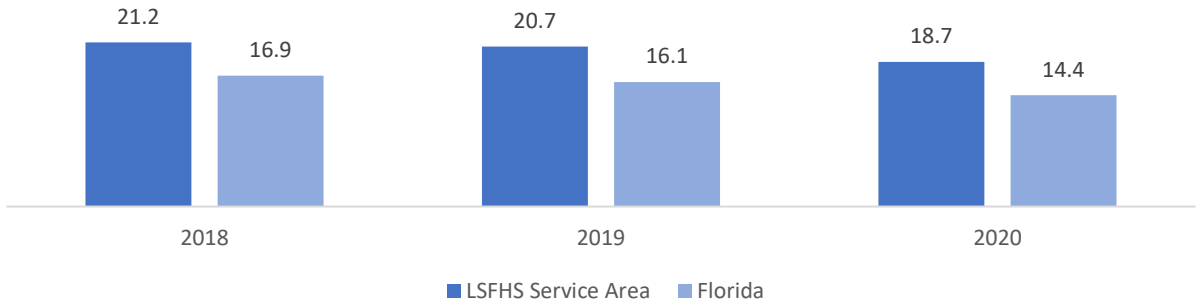
Source: Behavioral Risk Factor Surveillance System

Figure 12: LSFHS Service Area Adults Average Number of Unhealthy Mental Days in the Past 30 Days (2017-2019)



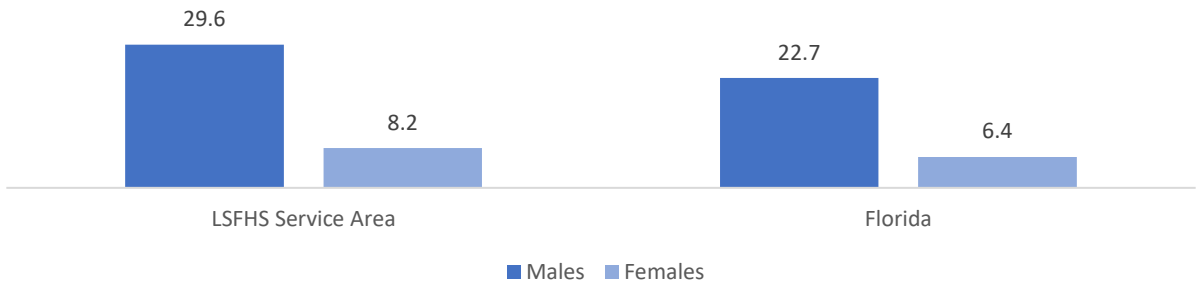
Source: Behavioral Risk Factor Surveillance System

Figure 13: LSFHS Service Area Crude Suicide Death Rates (2018-2020)



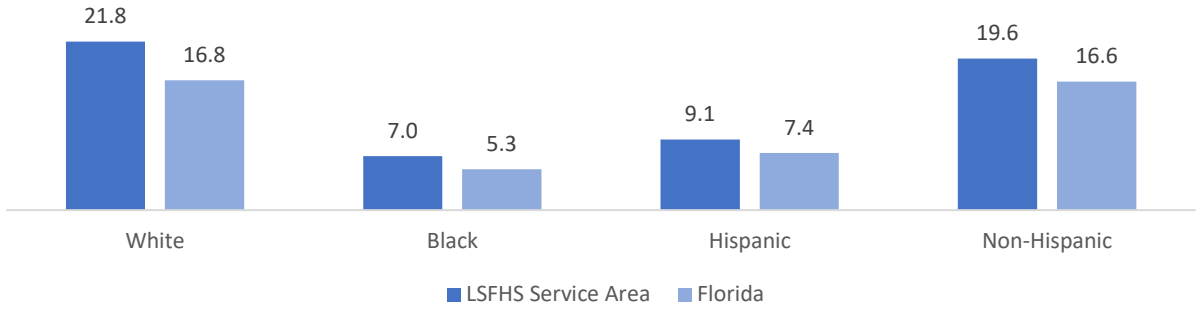
Source: Florida Department of Health, Bureau of Vital Statistics, Rate per 100,000

Figure 14: LSFHS Service Area Crude Suicide Death Rates by Gender (2020)



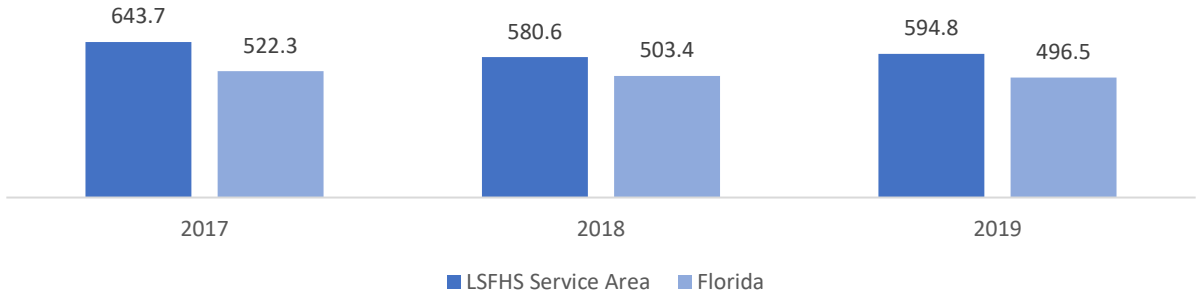
Source: Florida Department of Health, Bureau of Vital Statistics, Rate per 100,000

Figure 15: LSFHS Service Area Crude Suicide Death Rates by Race and Ethnicity (2020)



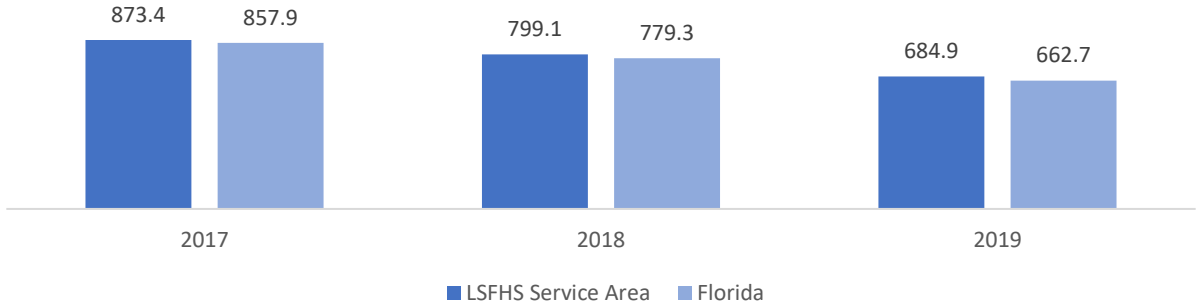
Source: Florida Department of Health, Bureau of Vital Statistics, Rate per 100,000

Figure 16: LSFHS Service Area Total Domestic Violence Offenses (2017-2019)



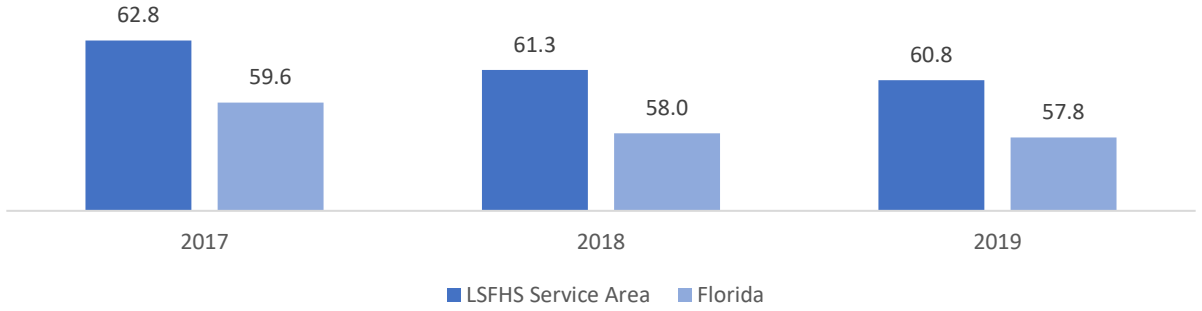
Source: Florida Department of Law Enforcement, Crime in Florida, Uniform Crime Report 2019, Rate per 100,000

Figure 17: LSFHS Service Area Rate of Children Experiencing Child Abuse, Ages 5-11 Years (2017-2019)



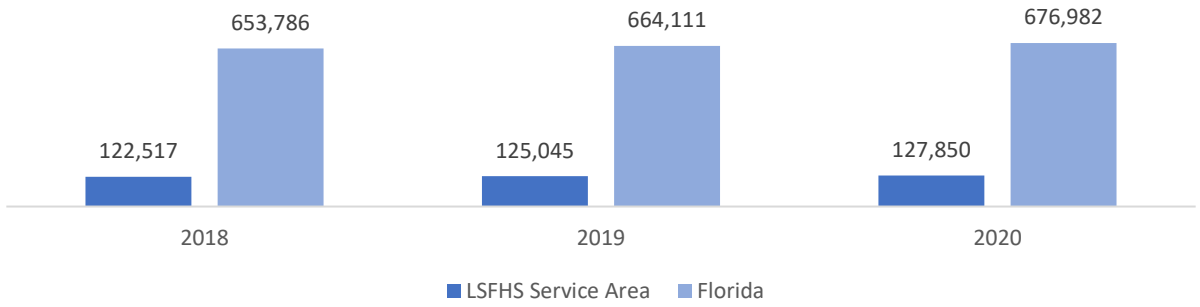
Source: Department of Children and Families, Florida Safe Families Network Data Mart, Rate per 100,000

Figure 18: LSFHS Service Area Rate of Children Experiencing Sexual Violence, Ages 5-11 Years (2017-2019)



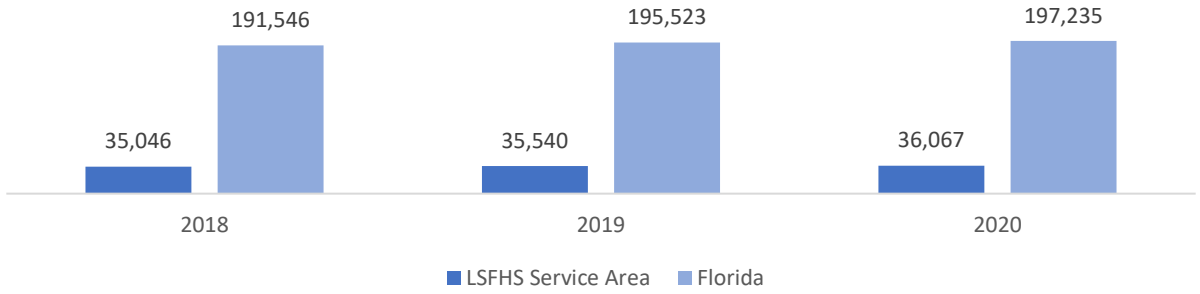
Source: Department of Children and Families, Florida Safe Families Network Data Mart, Rate per 100,000

Figure 19: LSFHS Service Area Estimated Number of Seriously Mentally Ill Adults (2018-2020)



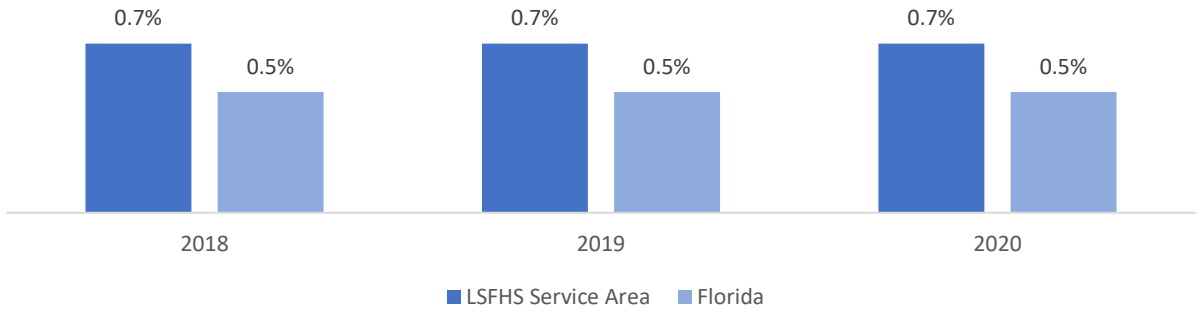
Source: Estimates based on Department of Health and Human Resource Report Mental Health U.S. 1995

Figure 20: LSFHS Service Area Estimated Number of Emotionally Disturbed Youth, Ages 9-17 Years (2018-2020)



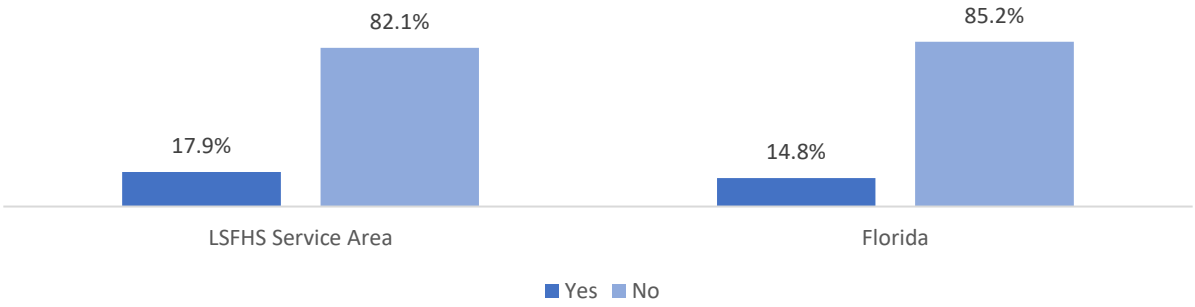
Source: Estimates based on Department of Health and Human Resource Report Mental Health U.S. 1995

Figure 21: LSFHS Service Area Percentage of Children with Emotional/Behavioral Disability, Grades K-12 (2018-2020)



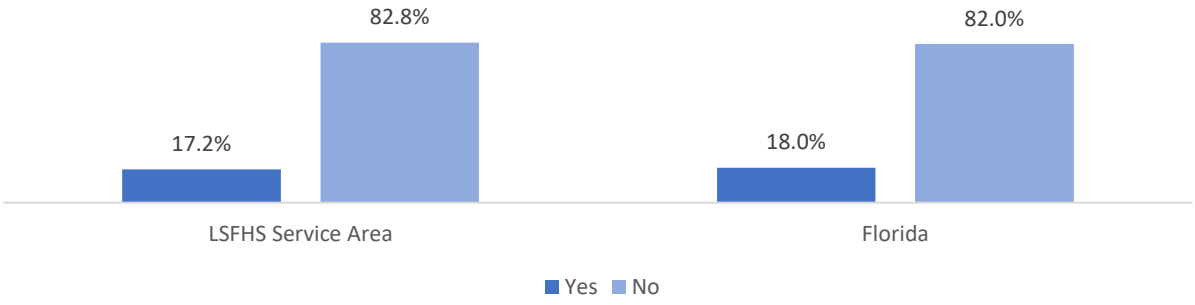
Source: Florida Department of Education, Education Information and Accountability Services (EIAS)

Figure 22: LSFHS Service Area Percentage of Adults Who Are Current Smokers (2017-2019)



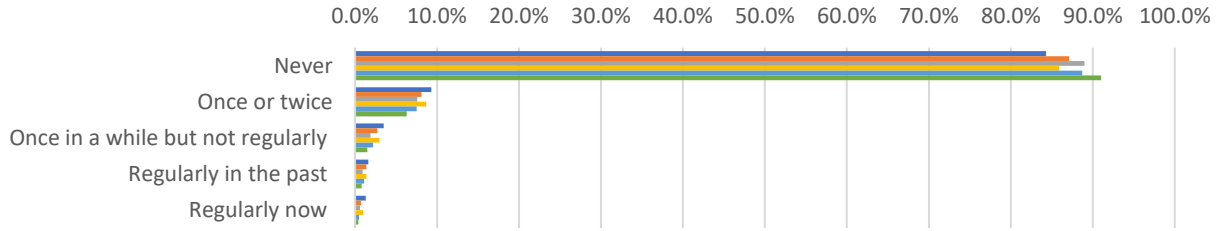
Source: Behavioral Risk Factor Surveillance System

Figure 23: LSFHS Service Area Percentage of Adults Who Engage in Heavy or Binge Drinking (2017-2019)



Source: Behavioral Risk Factor Surveillance System

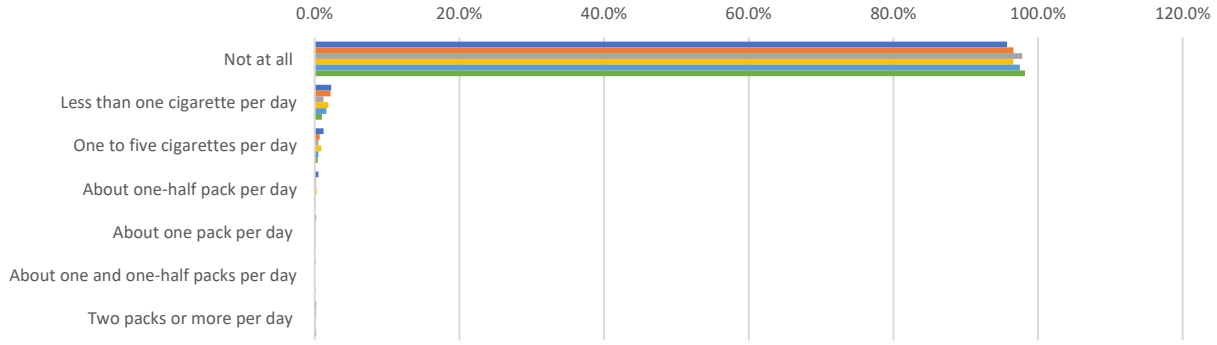
Figure 24: LSFHS Service Area Having Ever Smoked Cigarettes (MS&HS 2016-2020)



	Regularly now	Regularly in the past	Once in a while but not regularly	Once or twice	Never
LSFHS Service Area 2016	1.3%	1.6%	3.5%	9.3%	84.3%
LSFHS Service Area 2018	0.7%	1.4%	2.7%	8.1%	87.1%
LSFHS Service Area 2020	0.6%	0.9%	1.9%	7.6%	89.0%
Florida 2016	1.0%	1.4%	3.0%	8.7%	85.9%
Florida 2018	0.5%	1.1%	2.2%	7.5%	88.7%
Florida 2020	0.4%	0.8%	1.5%	6.3%	91.0%

Source: Florida Youth Substance Abuse Survey

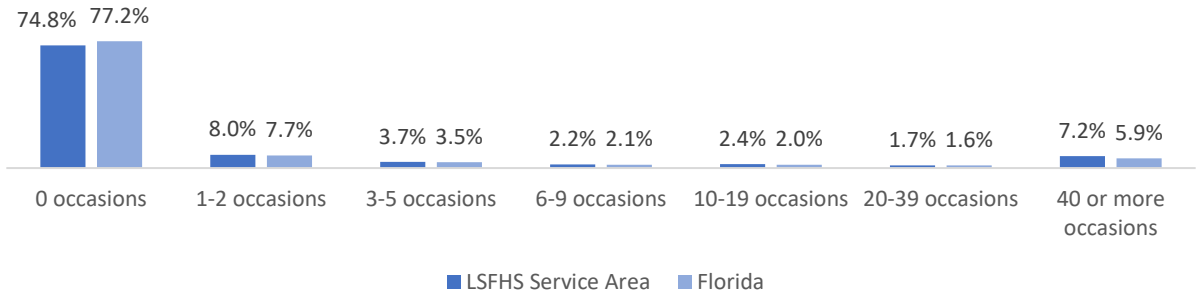
Figure 25: LSFHS Service Area – How Frequently Have You Smoked Cigarettes in the Past 30 Days? (MS&HS 2016-2020)



	Two packs or more per day	About one and one-half packs per day	About one pack per day	About one-half pack per day	One to five cigarettes per day	Less than one cigarette per day	Not at all
LSFHS Service Area 2016	0.2%	0.1%	0.2%	0.5%	1.2%	2.3%	95.7%
LSFHS Service Area 2018	0.2%	0.0%	0.1%	0.2%	0.7%	2.2%	96.6%
LSFHS Service Area 2020	0.2%	0.0%	0.1%	0.2%	0.5%	1.2%	97.8%
Florida 2016	0.1%	0.0%	0.1%	0.3%	0.9%	1.9%	96.6%
Florida 2018	0.1%	0.0%	0.1%	0.1%	0.5%	1.6%	97.5%
Florida 2020	0.2%	0.1%	0.1%	0.1%	0.4%	1.0%	98.2%

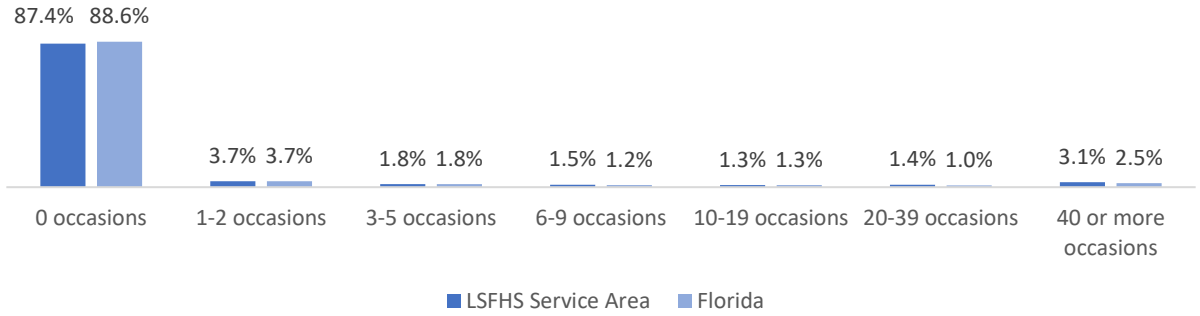
Source: Florida Youth Substance Abuse Survey

Figure 26: LSFHS Service Area – On How Many Occasions Have You Vaped Nicotine in Your Lifetime? (MS&HS 2020)



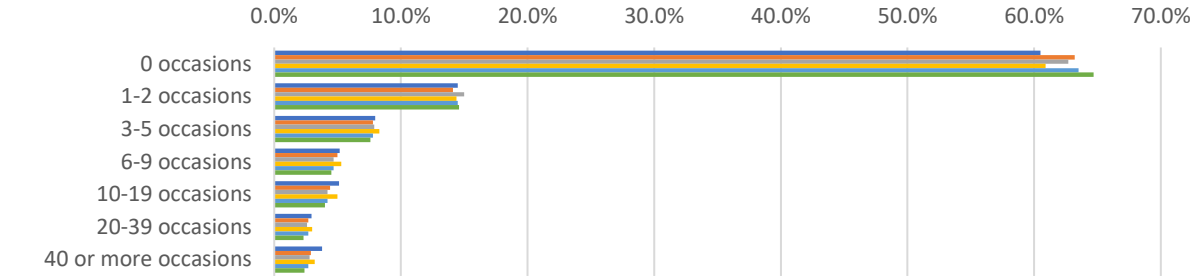
Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

Figure 27: LSFHS Service Area – On How Many Occasions Have You Vaped Nicotine During the Past 30 Days? (MS&HS 2020)



Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

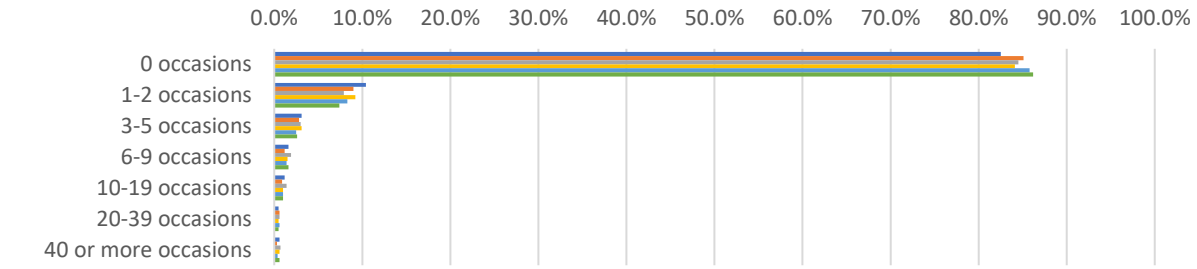
Figure 28: LSFHS Service Area – On How Many Occasions Have You Had Alcoholic Beverages to Drink in Your Lifetime? (MS&HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
LSFHS Service Area 2016	3.8%	2.9%	5.1%	5.2%	8.0%	14.5%	60.5%
LSFHS Service Area 2018	2.9%	2.7%	4.4%	5.0%	7.8%	14.1%	63.2%
LSFHS Service Area 2020	2.8%	2.6%	4.2%	4.7%	7.9%	15.0%	62.7%
Florida 2016	3.2%	3.0%	5.0%	5.3%	8.3%	14.4%	60.9%
Florida 2018	2.7%	2.7%	4.2%	4.7%	7.8%	14.5%	63.5%
Florida 2020	2.4%	2.3%	4.0%	4.5%	7.6%	14.6%	64.7%

Source: Florida Youth Substance Abuse Survey. Includes beer, wine, or hard liquor. More than a few sips.

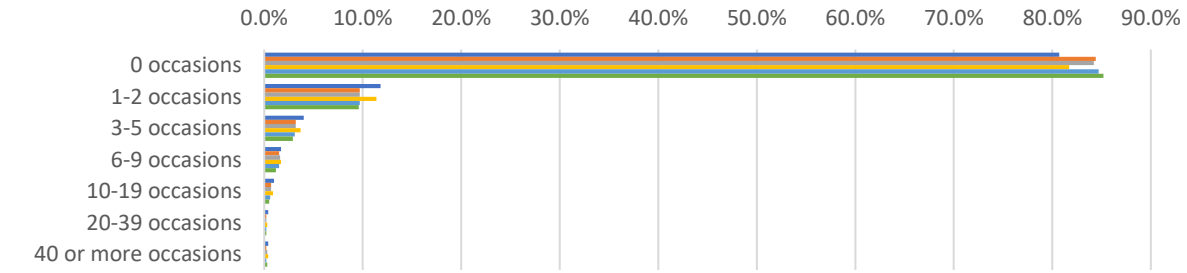
Figure 29: LSFHS Service Area – On How Many Occasions in Your Lifetime Have You Woken Up After a Night of Drinking Alcoholic Beverages and Not Been Able to Remember Things You Did or the Places You Went? (HS Only 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
LSFHS Service Area 2016	0.6%	0.5%	1.2%	1.6%	3.1%	10.4%	82.5%
LSFHS Service Area 2018	0.3%	0.6%	0.9%	1.2%	2.8%	9.0%	85.1%
LSFHS Service Area 2020	0.7%	0.6%	1.4%	1.9%	3.0%	7.9%	84.5%
Florida 2016	0.6%	0.5%	1.0%	1.5%	3.1%	9.2%	84.1%
Florida 2018	0.4%	0.6%	1.0%	1.4%	2.5%	8.3%	85.8%
Florida 2020	0.6%	0.5%	1.0%	1.6%	2.6%	7.4%	86.2%

Source: Florida Youth Substance Abuse Survey

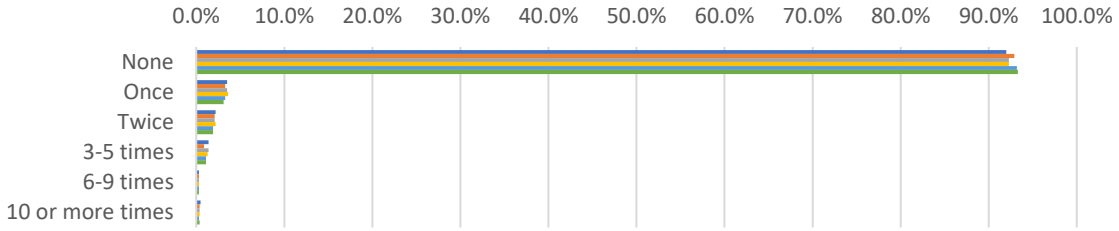
Figure 30: LSFHS Service Area – On How Many Occasions Have You Had Beer, Wine, or Hard Liquor in the Past 30 Days? (MS&HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
LSFHS Service Area 2016	0.4%	0.4%	1.0%	1.7%	4.0%	11.8%	80.7%
LSFHS Service Area 2018	0.2%	0.2%	0.7%	1.5%	3.2%	9.7%	84.4%
LSFHS Service Area 2020	0.3%	0.2%	0.7%	1.6%	3.2%	9.7%	84.2%
Florida 2016	0.4%	0.3%	0.9%	1.7%	3.7%	11.4%	81.7%
Florida 2018	0.2%	0.2%	0.6%	1.5%	3.1%	9.7%	84.7%
Florida 2020	0.3%	0.2%	0.5%	1.2%	2.9%	9.6%	85.2%

Source: Florida Youth Substance Abuse Survey

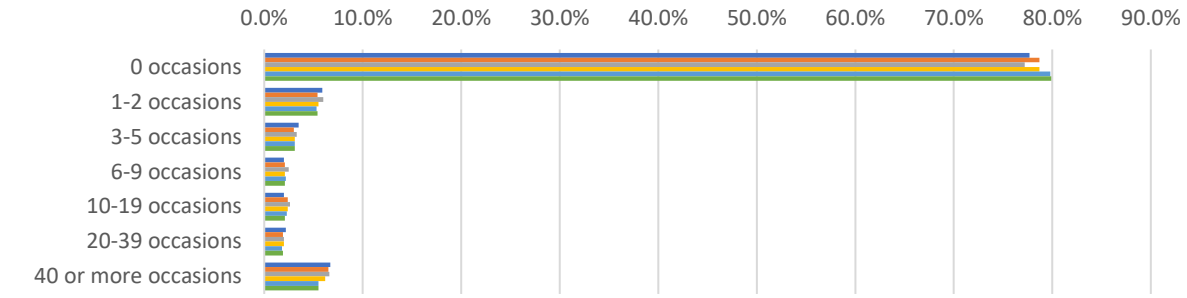
Figure 31: LSFHS Service Area – Think Back Over the Past 2 Weeks...How Many Times Have You Had Five or More Alcoholic Drinks in a Row? (MS&HS 2016-2020)



	10 or more times	6-9 times	3-5 times	Twice	Once	None
LSFHS Service Area 2016	0.5%	0.3%	1.4%	2.2%	3.5%	92.0%
LSFHS Service Area 2018	0.4%	0.3%	0.9%	2.1%	3.3%	92.9%
LSFHS Service Area 2020	0.4%	0.3%	1.4%	2.1%	3.5%	92.3%
Florida 2016	0.4%	0.3%	1.3%	2.2%	3.6%	92.3%
Florida 2018	0.3%	0.3%	1.1%	1.9%	3.3%	93.2%
Florida 2020	0.4%	0.3%	1.1%	1.9%	3.1%	93.3%

Source: Florida Youth Substance Abuse Survey

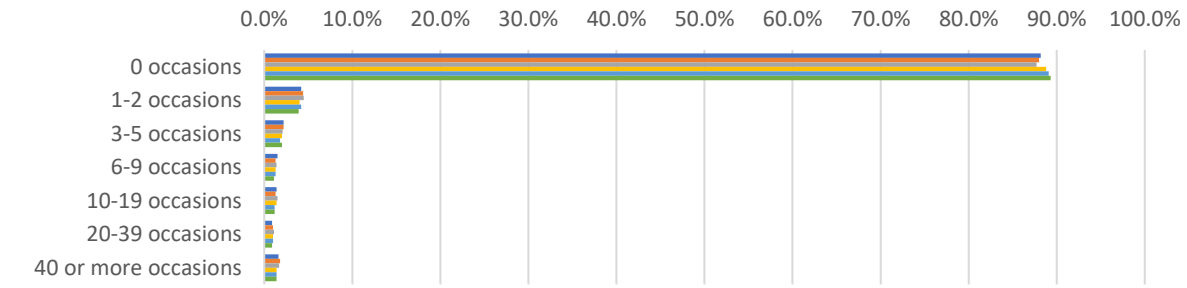
Figure 32: LSFHS Service Area – On How Many Occasions Have You Used Marijuana or Hashish in Your Lifetime? (MS&HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
LSFHS Service Area 2016	6.7%	2.2%	2.0%	2.0%	3.5%	5.9%	77.7%
LSFHS Service Area 2018	6.5%	1.9%	2.4%	2.1%	3.0%	5.4%	78.7%
LSFHS Service Area 2020	6.6%	2.0%	2.6%	2.5%	3.3%	6.0%	77.2%
Florida 2016	6.2%	2.0%	2.4%	2.1%	3.1%	5.5%	78.7%
Florida 2018	5.5%	1.8%	2.3%	2.2%	3.1%	5.3%	79.8%
Florida 2020	5.5%	1.9%	2.1%	2.1%	3.1%	5.4%	79.9%

Source: Florida Youth Substance Abuse Survey

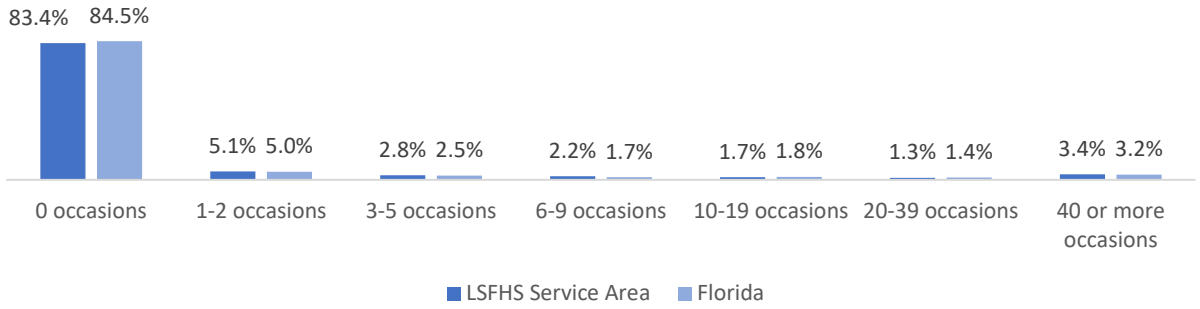
Figure 33: LSFHS Service Area – On How Many Occasions Have You Used Marijuana or Hashish During the Past 30 Days? (MS&HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
LSFHS Service Area 2016	1.6%	0.9%	1.4%	1.5%	2.2%	4.2%	88.2%
LSFHS Service Area 2018	1.8%	1.0%	1.3%	1.3%	2.2%	4.4%	88.0%
LSFHS Service Area 2020	1.7%	1.1%	1.5%	1.4%	2.1%	4.5%	87.7%
Florida 2016	1.4%	1.0%	1.4%	1.3%	2.0%	4.0%	88.8%
Florida 2018	1.4%	1.0%	1.2%	1.3%	1.8%	4.2%	89.1%
Florida 2020	1.4%	0.9%	1.2%	1.1%	2.0%	3.9%	89.3%

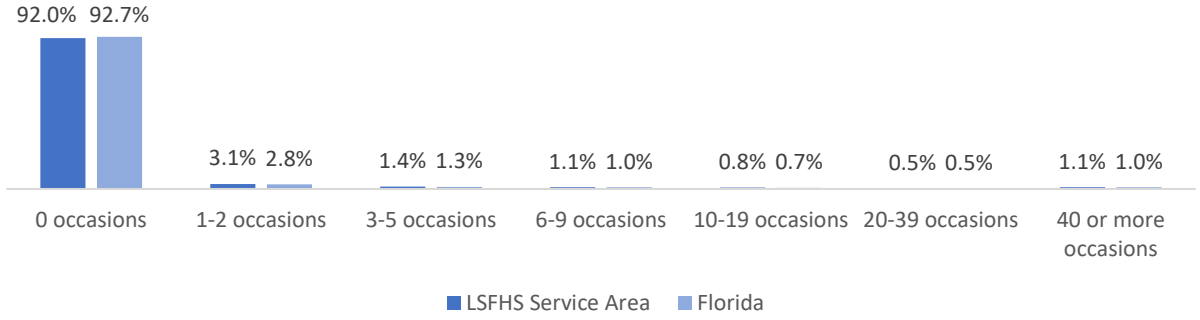
Source: Florida Youth Substance Abuse Survey

Figure 34: LSFHS Service Area – On How Many Occasions Have You Vaped Marijuana in Your Lifetime? (MS&HS 2016-2020)



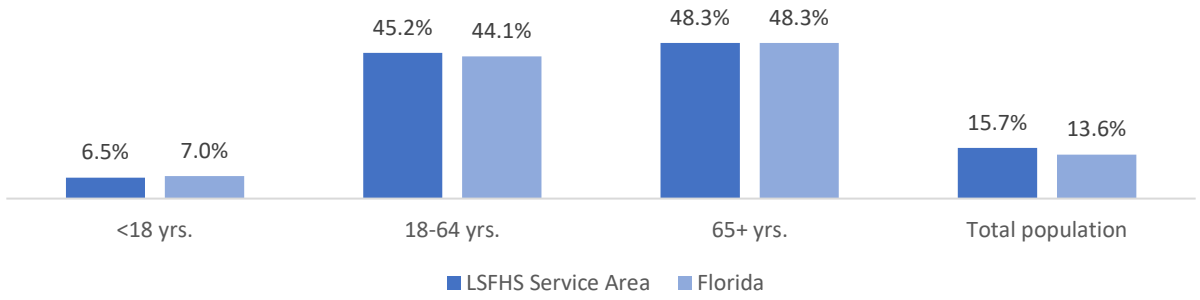
Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

Figure 35: LSFHS Service Area – On How Many Occasions Have You Vaped Marijuana in the Past 30 Days? (MS&HS 2016-2020)



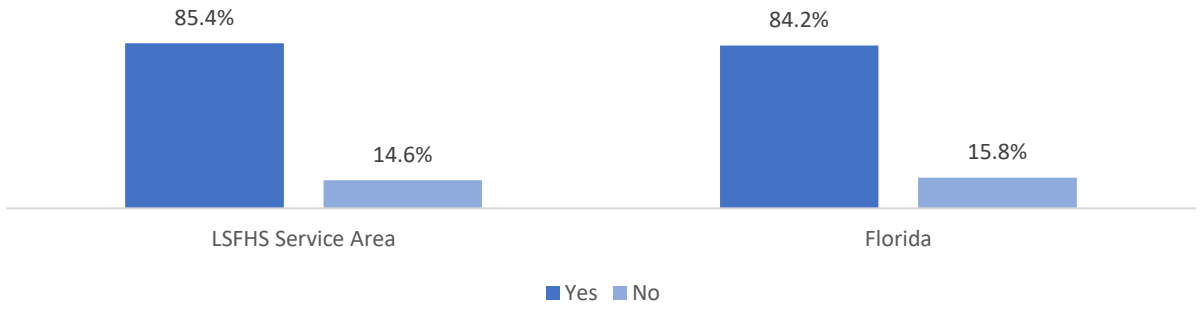
Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

Figure 36: LSFHS Service Area Civilian Noninstitutionalized Population with a Disability (2016-2020)



Source: U.S. Census Bureau, American Community Survey. Disability includes: Hearing, Vision, Cognitive, Ambulatory, Self-Care, and Independent Living

Figure 37: LSFHS Service Area Percentage of Adults with Any Type of Health Care Insurance Coverage (2013-2019)



Source: Behavioral Risk Factor Surveillance System

LSFHS SERVICE AREA: DEMOGRAPHIC PROFILE OF INDIVIDUALS SERVED

Individuals Receiving Services Population Statistics

LSFHS-funded organizations served 49,928 individuals in FY20-21. This number may include a small amount of duplication in that some people moved from one county to another, were enrolled in more than one program or changed residential status during the one-year time frame. Over 22% of people served resided in Volusia County (11,185 individuals), followed by Duval County at 19.5% (9,756 individuals), Marion County at 8.6% (4,290 individuals), and Clay County at 6.9% (3,445 individuals). People who reported living in another county accounted for 2.7% of all persons served.

Adults in LSFHS programs accounted for 86.5% of all persons served with 53.2% enrolled in the Adult Mental Health (AMH) program and 33.3% in the Adult Substance Abuse program (ASA). The remaining individuals were in the Child Mental Health (CMH) program at 9.4% and the Child Substance Abuse (CSA) program at 4.1%.

Gender

Males represented 50.1% of people served in the AMH program, 51.7% in the ASA program, 50.4% in the CMA program, and 68.3% in the CSA program. Females accounted for 49.9% of persons served in AMH program and 49.6% of those in the CMH program. Females accounted for 48.3% in the ASA program and 31.7% in the CSA program.

Race

The majority of persons served were White (71.8%), which was a little lower than the percentage in the service area population at 75.2%. Conversely, Black LSFHS individuals accounted for 16.8% of the those served while representing 15.9% of the population in the 23-county service area. The percentage of Multi-Racial individuals in adult programs (ranged from 3.1% to 3.8%) were lower when compared to the service area (4.2%). Among child programs, the percentages of multi-racial individuals were higher (ranged from 4.4% to 6.6%) when compared to the service area.

Ethnicity

The percentage of Hispanics in the LSFHS population at 8%, was less when compared to the percentage of the Hispanic population in the service area at 11%. The percentage of Hispanic

individuals in all LSFHS programs ranged from 7.4% to 9.8%. Individuals identifying as "Other Hispanic", and "Puerto Rican" received more services than those identifying as Cuban, Haitian, Mexican, Mexican American, and Spanish/Latino.

Age Range

As expected, the age range distribution among individuals served by LSFHS providers did not mimic that of the service area population. Adults, ages 25-44 years of age, accounted for 48.6% of all individuals served. Those younger than 20 years of age represented 15.7% of those served. Adults, ages 25-44 years of age, accounted for 49.7% of those who participated in AMH programs and 66.4% of those who participated ASA programs. In comparison, adults in this age range represented 23.7% of the population in the 23-county area. Conversely, adults ages 65 years and older, accounted for a far less percentage of persons served (3%) when compared to those in the service area population at 22.5%. Children, under age 5 years, accounted for 1.1% and 0.4% of participants in the CMH and CSA programs, respectively. There was a higher percentage of older teens, ages 15-19 years of age, in the CSA program (62.6%) when compared to those in the CMH program (32.4%).

Residential Status

The percentage of individuals living independently-alone was higher for those in AMH programs (40.2%) as compared to those participating in ASA program (34.9%). Individuals living independently-with relatives was similar for AMH and ASA programs. People participating in AMH programs were more likely to experience homelessness than those participating in ASA programs (6.9% compared to 5.1%, respectively), however, residential status was missing for 17.4% of individuals in AMH programs and 20.4% of those in ASA programs. Residential status for children was missing for 79.2% of those in CMH programs and 79.8% of those in CSA programs.

Educational Attainment

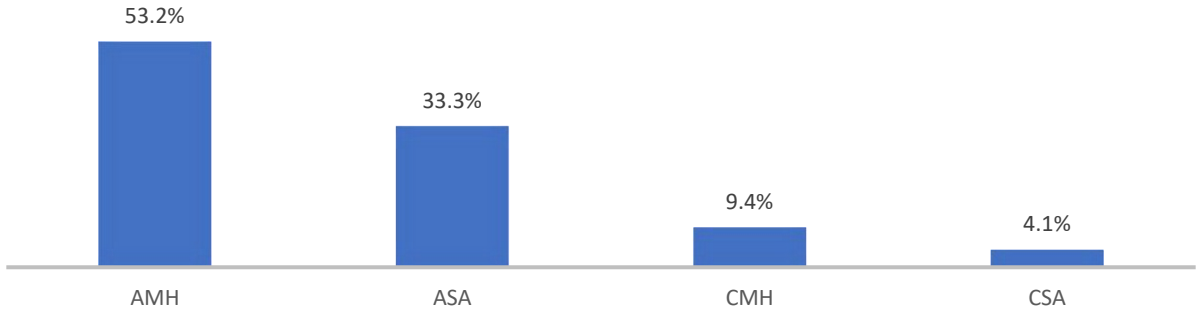
Individuals served by LSFHS providers attained lower educational levels when compared to the general population in the service area. Among adults served, 77.7% did not attain more than a high school education, and 23.9% of those attained a 9th-12th grade education without receiving a diploma. Only 18.9% of the population served by LSFHS providers went on for further education beyond high school. Among the general population in the LSFHS service area, 17.1% of adults ages 25 and older have a bachelor's degree compared to 2.9% of individuals receiving services from LSFHS providers.

Employment Status

Lower educational attainment was one of several factors that contributed to much higher levels of unemployment among adults served by LSFHS providers when compared to those in the service area. Unemployment ranged from 54.6% of those participating in AMH programs to 55.1% among those in ASA programs. The 5-year estimate for unemployment in the service area was 3.0% (2016 to 2020).

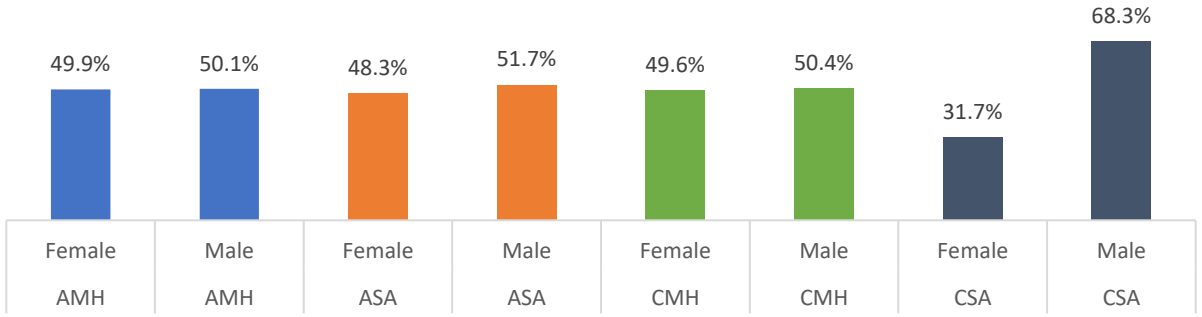
INDIVIDUALS SERVED DEMOGRAPHIC CHARTS

Figure 38: LSFHS Individuals Served by Program



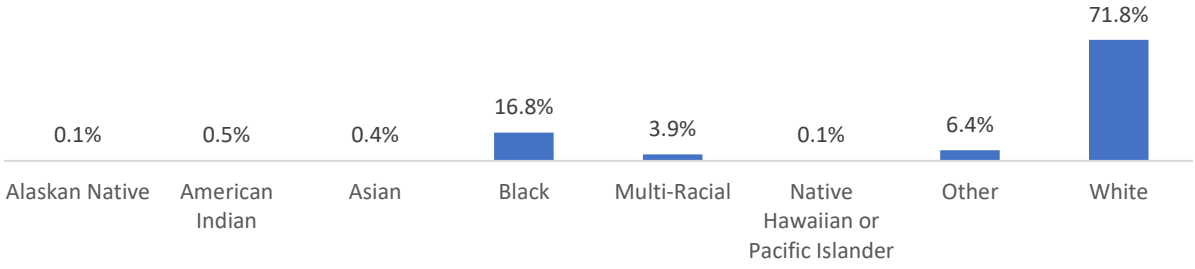
Source: LSFHS Individuals Served Data

Figure 39: LSFHS Individuals Served by Program and Gender



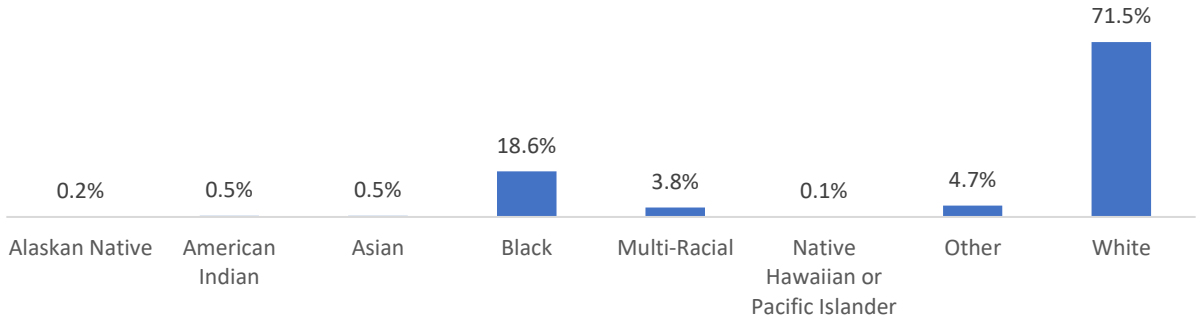
Source: LSFHS Individuals Served Data

Figure 40: LSFHS Individuals Served by Race



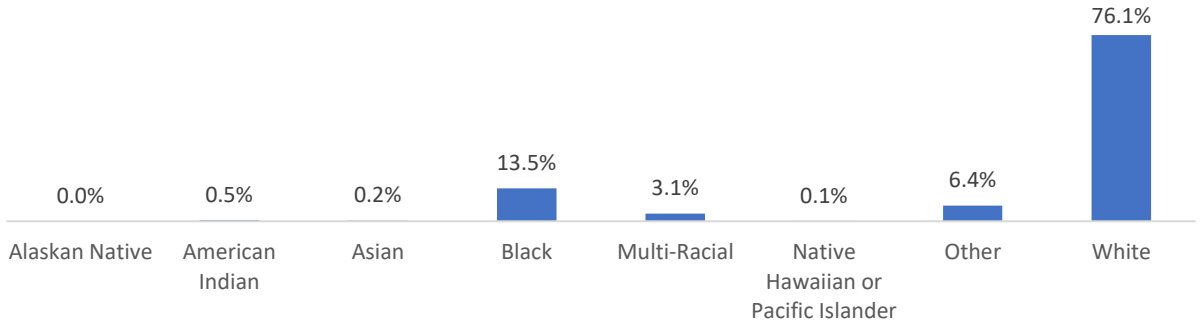
Source: LSFHS Individuals Served Data

Figure 41: LSFHS AMH Individuals Served by Race



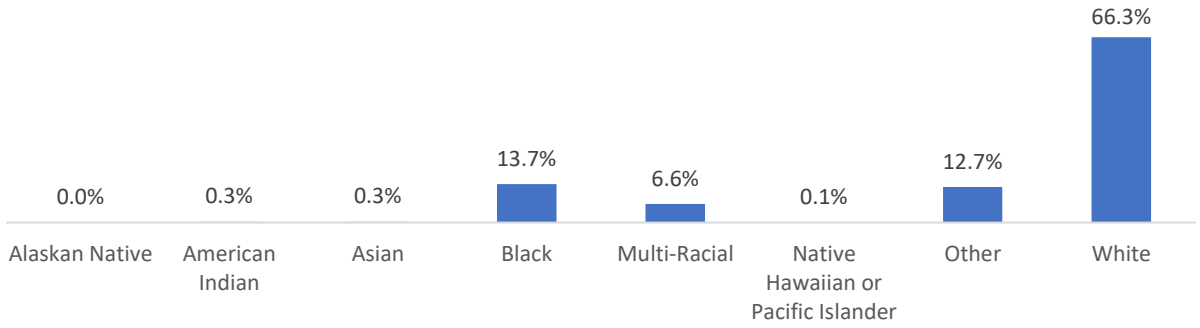
Source: LSFHS Individuals Served Data

Figure 42: LSFHS ASA Individuals Served by Race



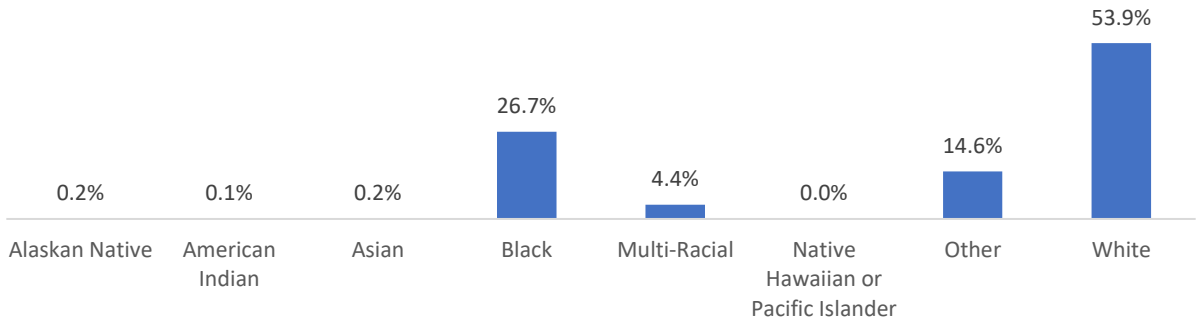
Source: LSFHS Individuals Served Data

Figure 43: LSFHS CMH Individuals Served by Race



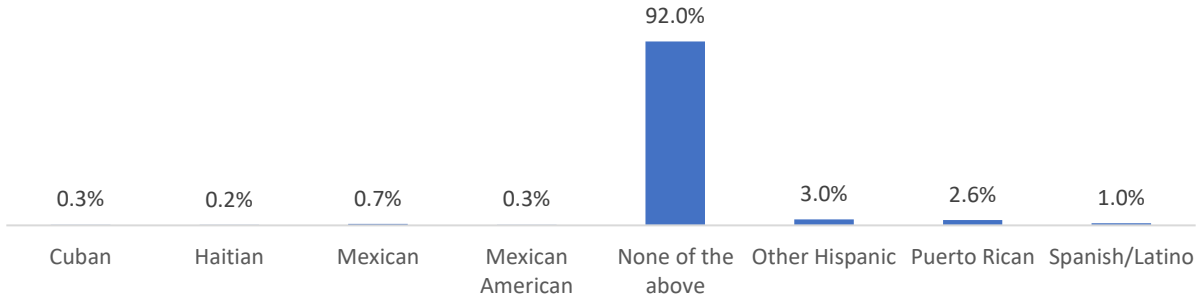
Source: LSFHS Individuals Served Data

Figure 44: LSFHS CSA Individuals Served by Race



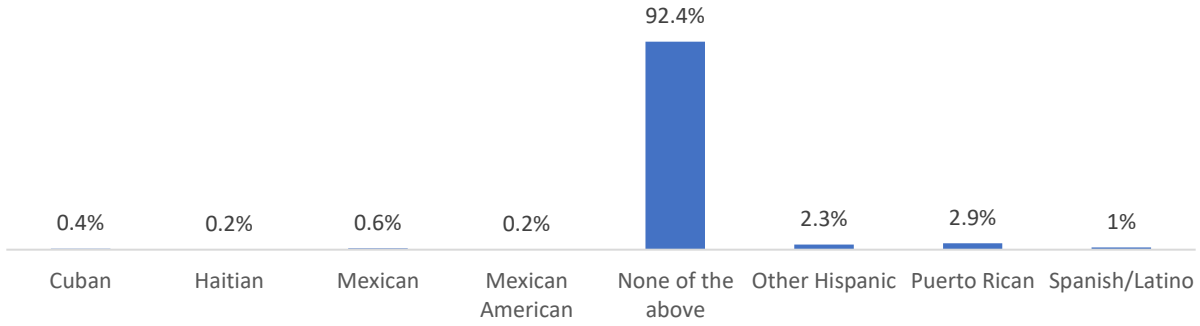
Source: LSFHS Individuals Served Data

Figure 45: LSFHS Individuals Served by Ethnicity



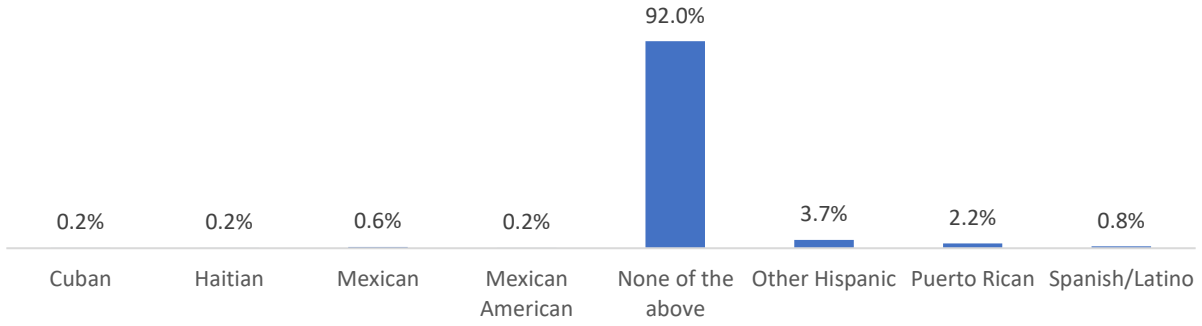
Source: LSFHS Individuals Served Data

Figure 46: LSFHS AMH Individuals Served by Ethnicity



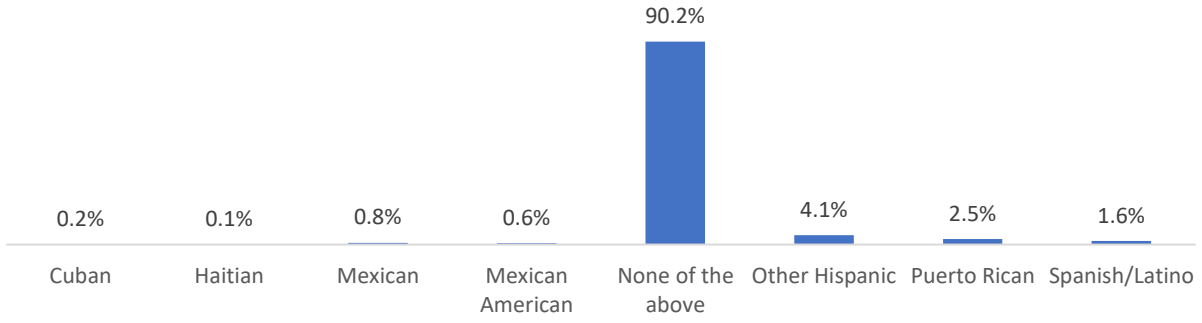
Source: LSFHS Individuals Served Data

Figure 47: LSFHS ASA Individuals Served by Ethnicity



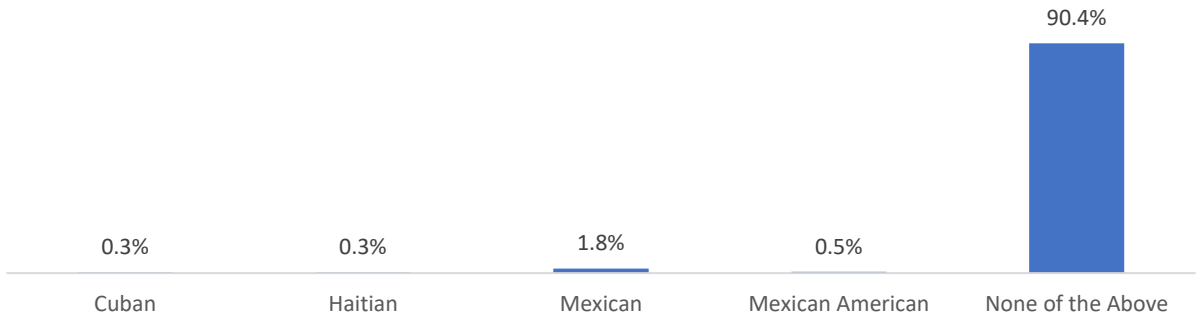
Source: LSFHS Individuals Served Data

Figure 48: LSFHS CMH Individuals Served by Ethnicity



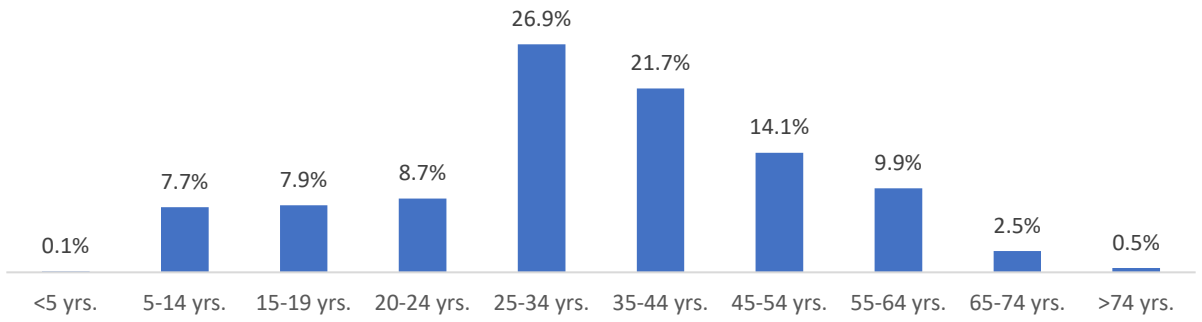
Source: LSFHS Individuals Served Data

Figure 49: LSFHS CSA Individuals Served by Ethnicity



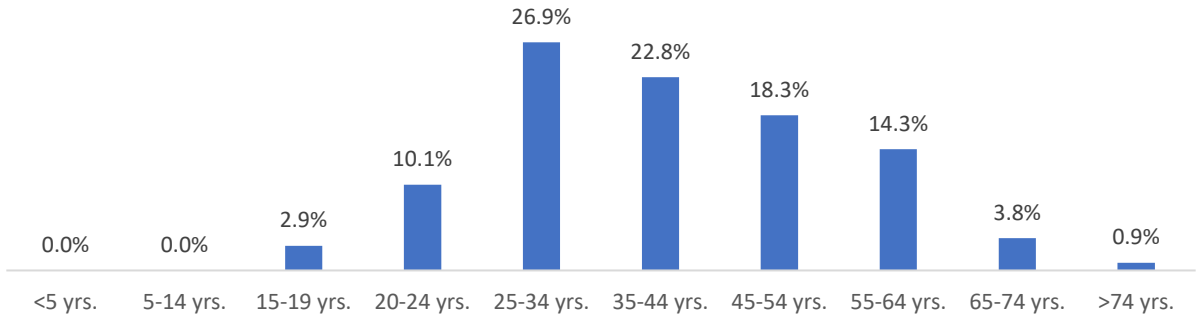
Source: LSFHS Individuals Served Data

Figure 50: LSFHS Individuals Served by Age Range



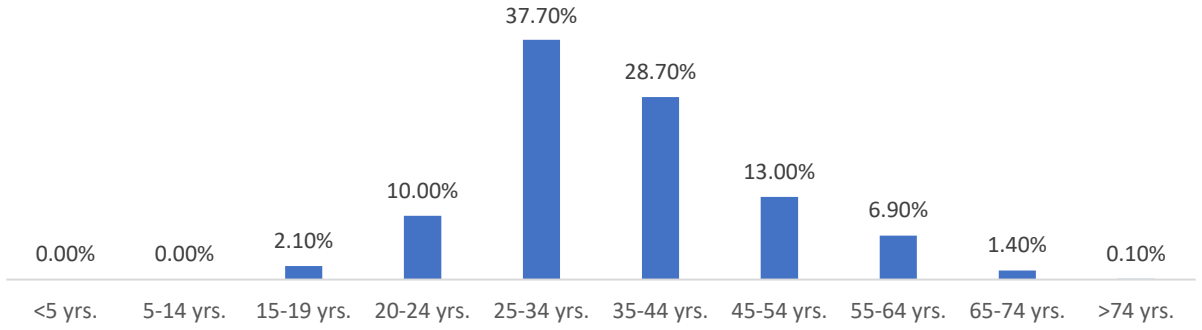
Source: LSFHS Individuals Served Data

Figure 51: LSFHS AMH Individuals Served by Age Range



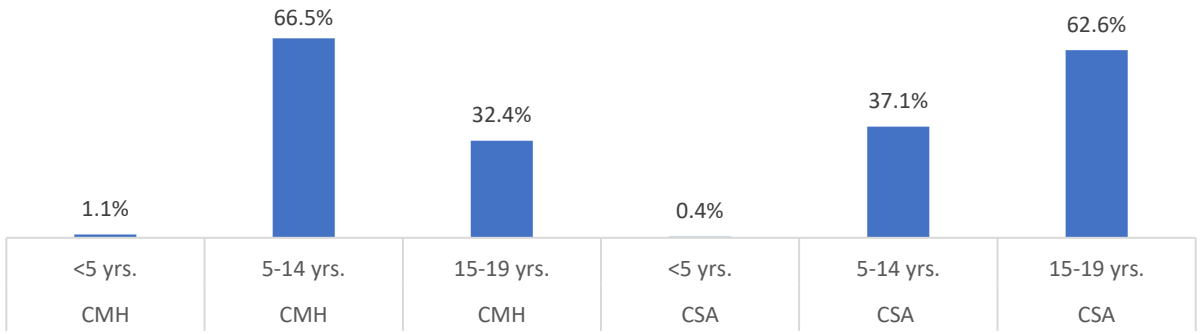
Source: LSFHS Individuals Served Data

Figure 52: LSFHS ASA Individuals Served by Age Range



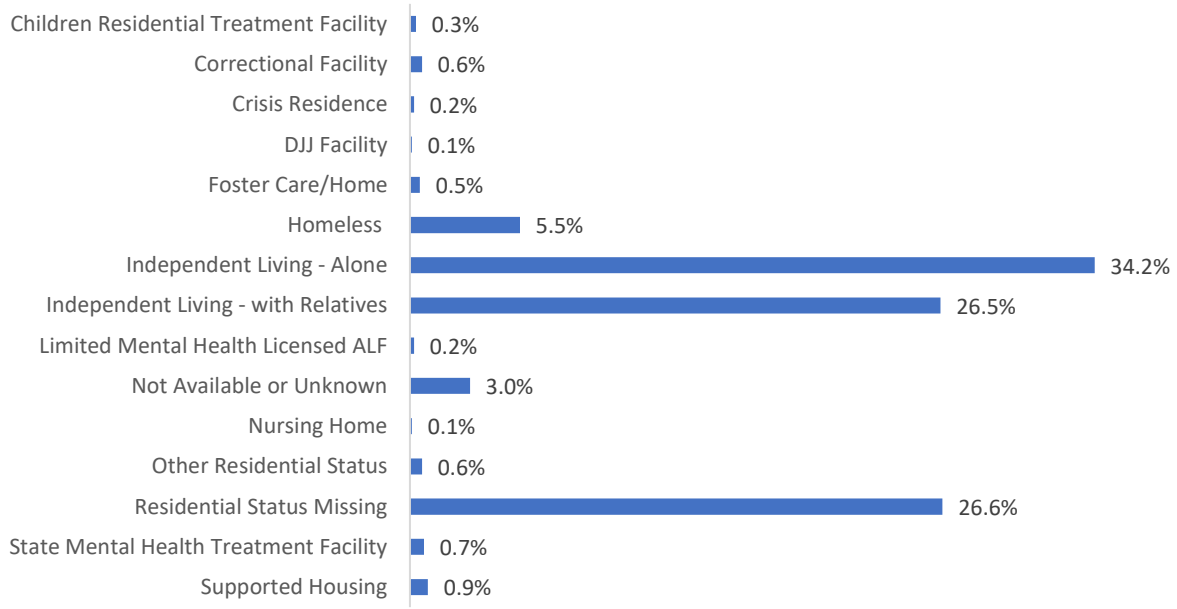
Source: LSFHS Individuals Served Data

Figure 53: LSFHS CMH and CSA Individuals Served by Age Range



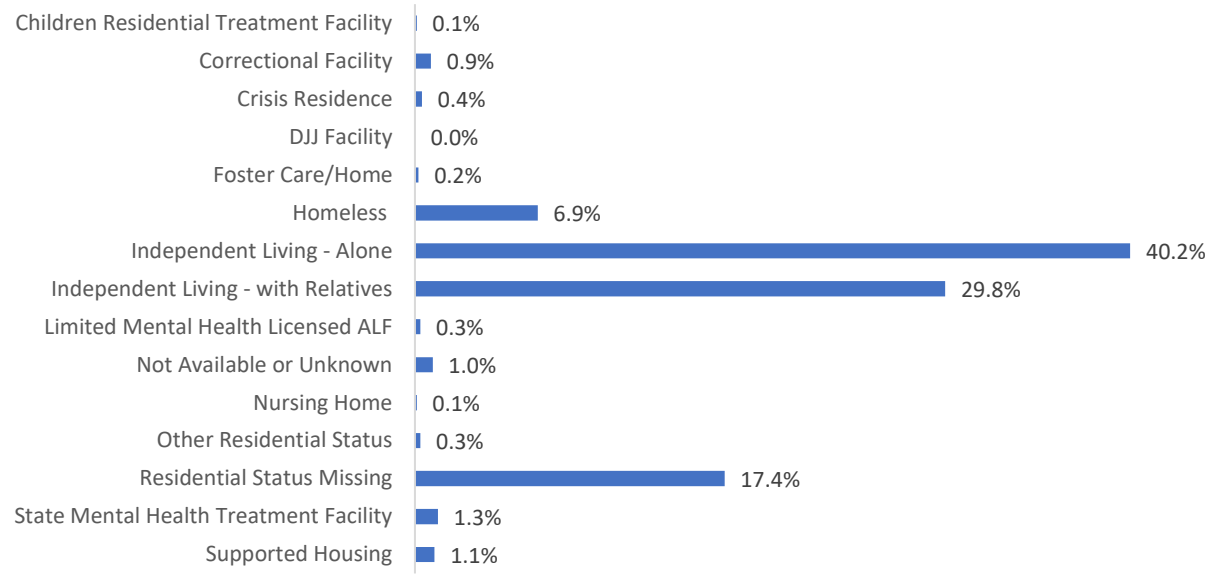
Source: LSFHS Individuals Served Data

Figure 54: LSFHS Individuals Served by Residential Status



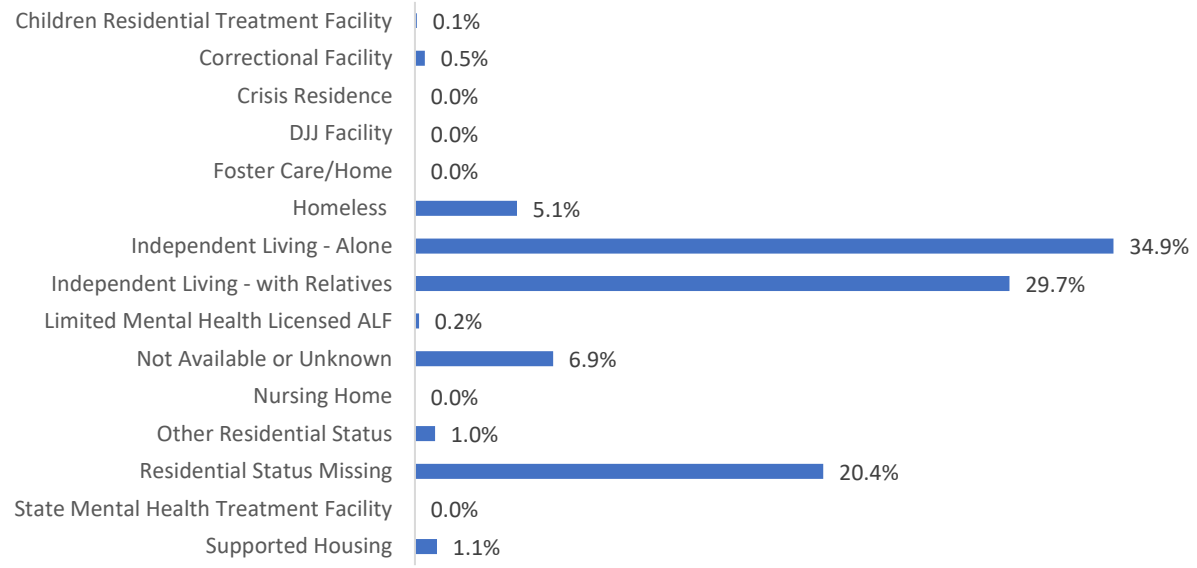
Source: LSFHS Individuals Served Data

Figure 55: LSFHS AMH Individuals Served by Residential Status



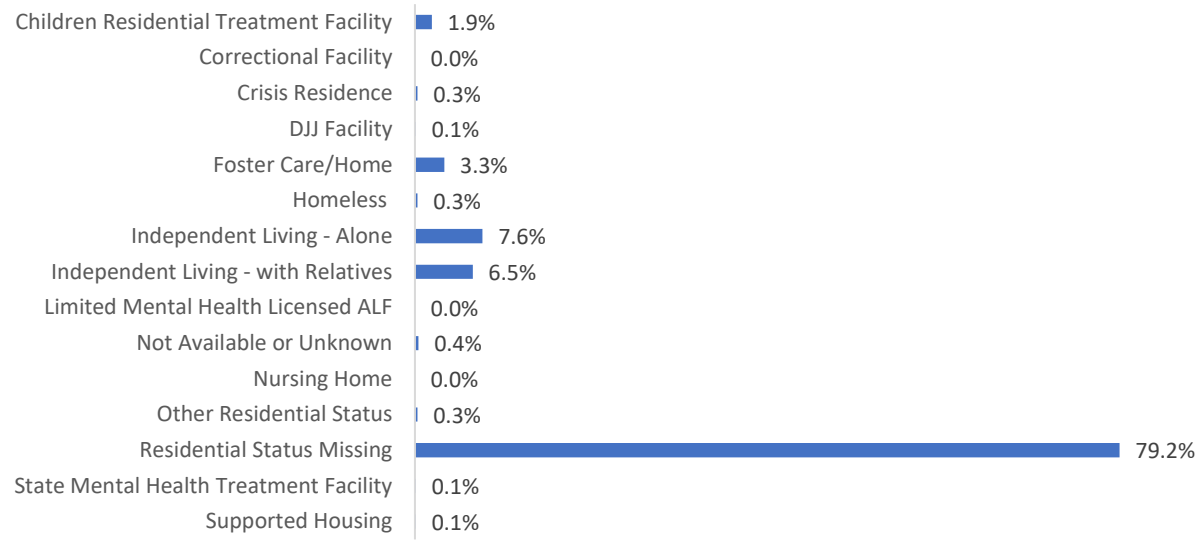
Source: LSFHS Individuals Served Data

Figure 56: LSFHS ASA Individuals Served by Residential Status



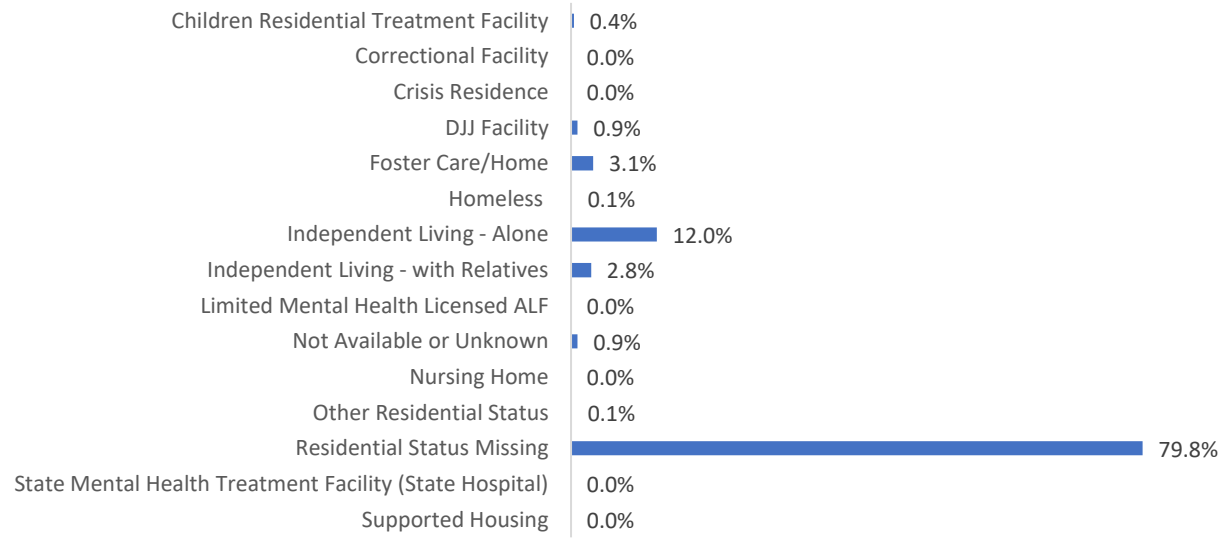
Source: LSFHS Individuals Served Data

Figure 57: LSFHS CMH Individuals Served by Residential Status



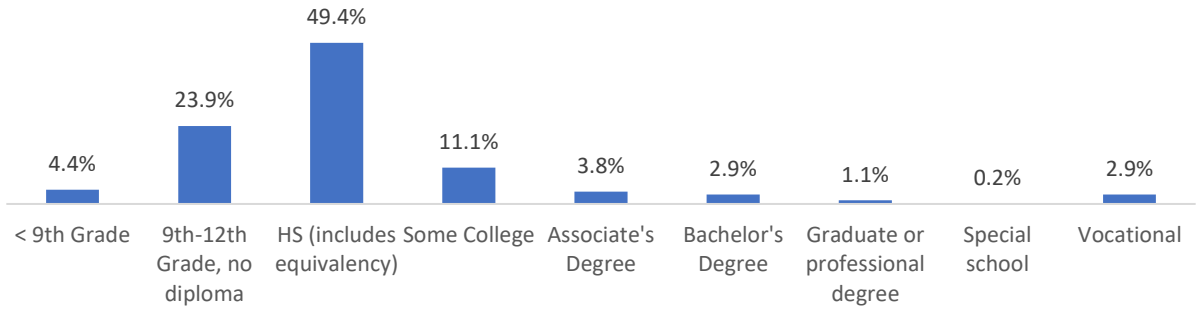
Source: LSFHS Individuals Served Data

Figure 58: LSFHS CSA Individuals Served by Residential Status



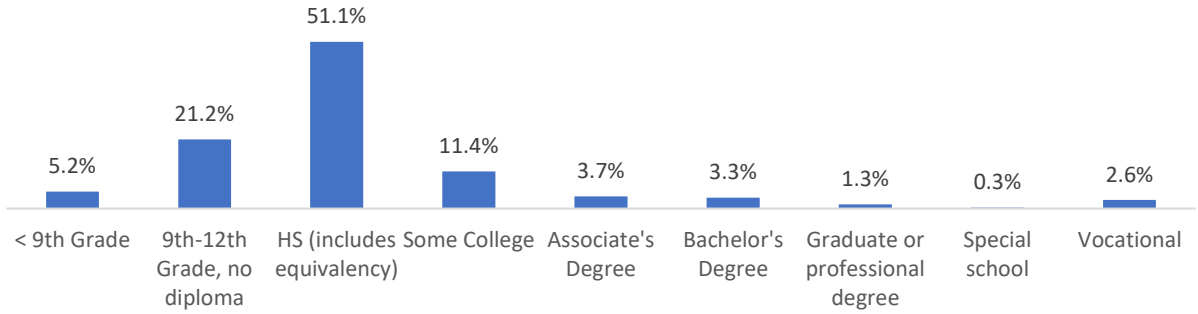
Source: LSFHS Individuals Served Data

Figure 59: LSFHS Individuals Served by Educational Attainment



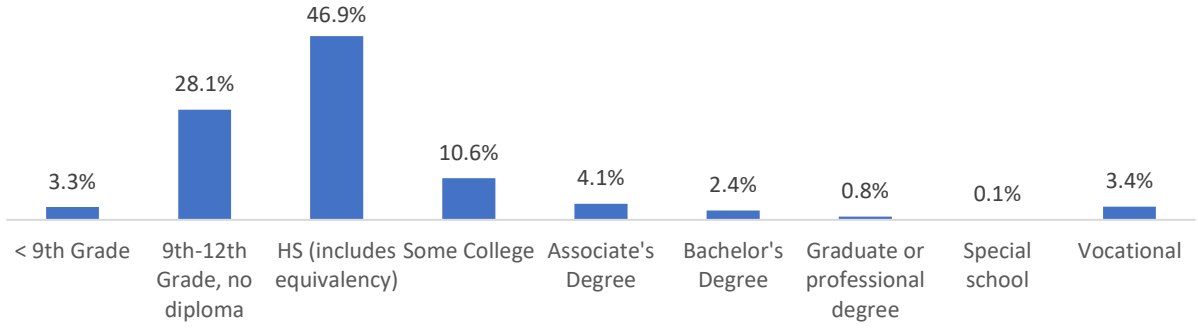
Source: LSFHS Individuals Served Data

Figure 60: LSFHS AMH Individuals Served by Educational Attainment



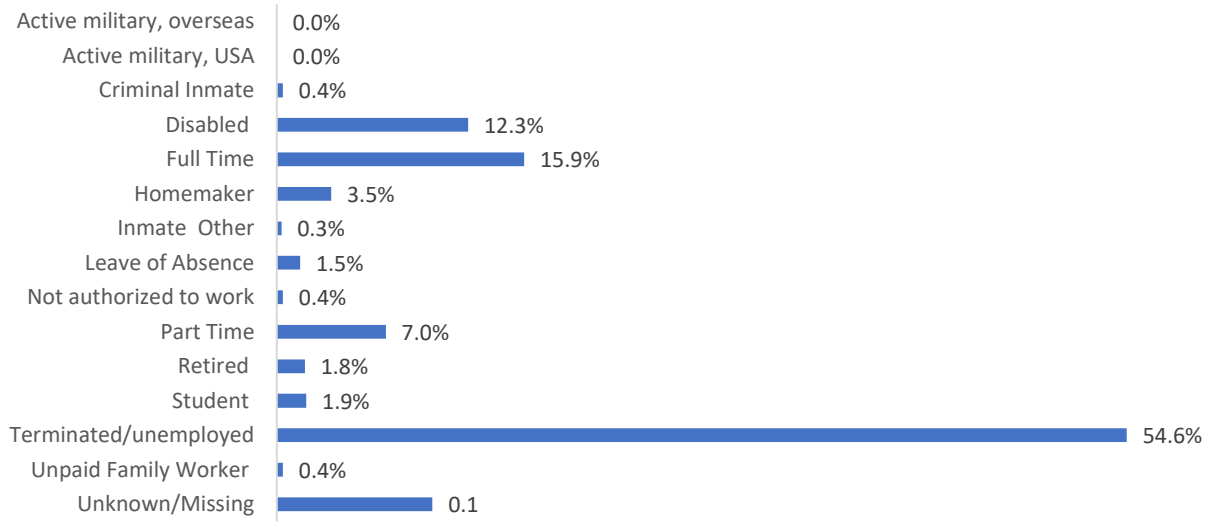
Source: LSFHS Individuals Served Data

Figure 61: LSFHS ASA Individuals Served by Educational Attainment



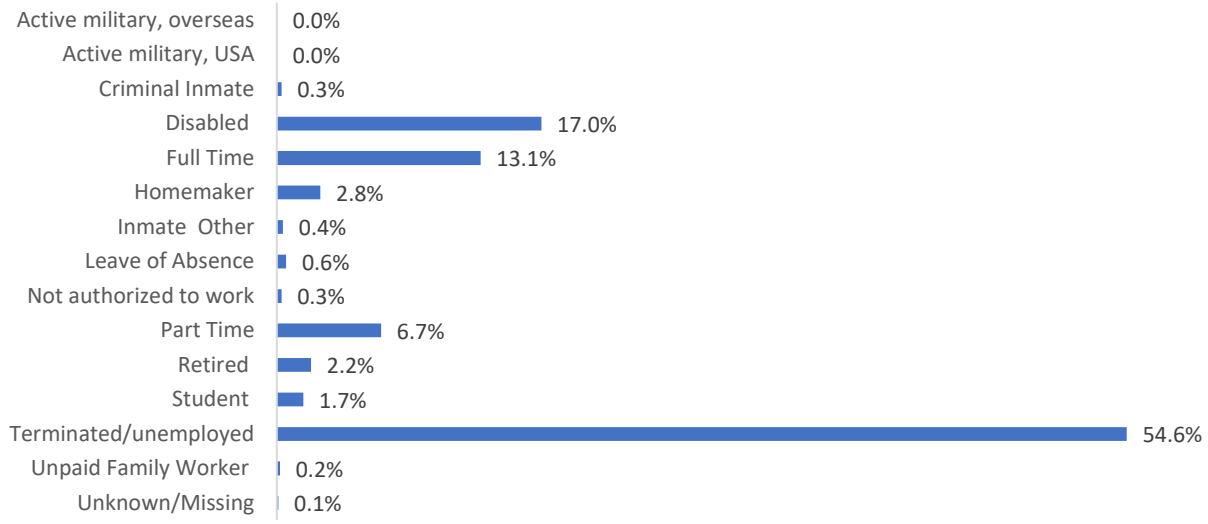
Source: LSFHS Individuals Served Data

Figure 62: LSFHS Individuals Served by Employment Status



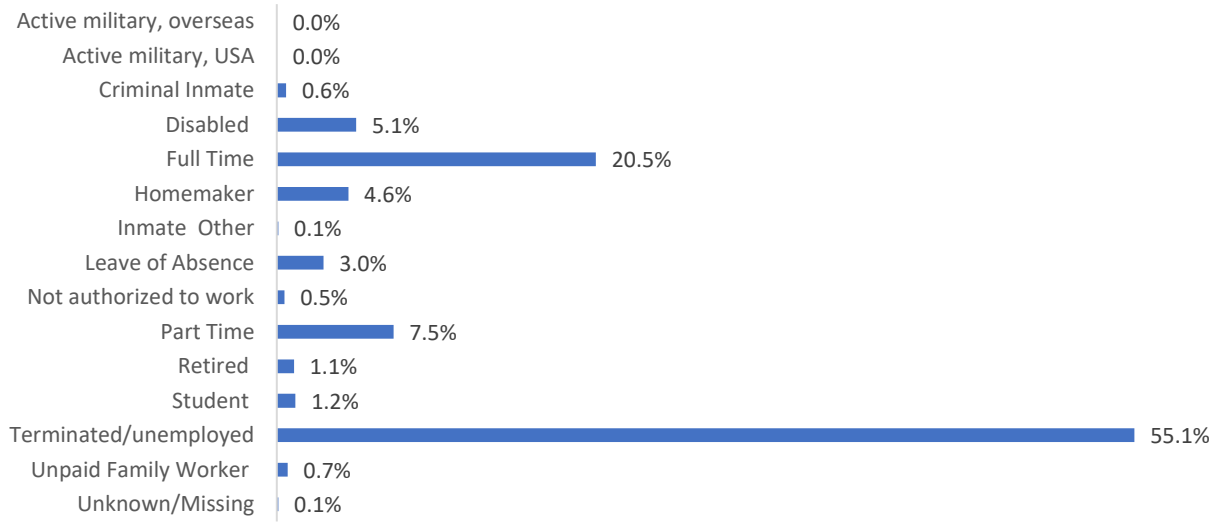
Source: LSFHS Individuals Served Data

Figure 63: LSFHS AMH Individuals Served by Employment Status



Source: LSFHS Individuals Served Data

Figure 64: LSFHS ASA Individuals Served by Employment Status



Source: LSFHS Individuals Served Data

LSFHS SERVICE AREA: INCIDENCE OF HOMELESSNESS

The 2021 Council on Homelessness Report states that the Point in Time Count (PIT) data provides a snapshot of homelessness. **Due to the pandemic, the 2021 PIT Count is not directly comparable to prior years' counts.** Typically, Continuums of Care (CoCs- A local geographic area designated by HUD and served by a local planning body, which is responsible for organizing and delivering housing and services to meet the needs of people who are homeless as they move to stable housing and maximum self-sufficiency) conduct a PIT Count of both sheltered and unsheltered households. This year, due to COVID-19 related safety concerns, only six of the 27 CoCs conducted such a count; 10 CoCs did not conduct an unsheltered count; and others conducted a modified form of the unsheltered count. All CoCs conducted a sheltered PIT count. For those that did not conduct an unsheltered count, the CoCs reported zero unsheltered persons, resulting in an undercount of total homelessness. According to the report:

> "Housing is a significant determinant of health, and insufficient housing is a major public health issue. The COVID-19 pandemic has exacerbated housing instability especially for low-income households. In effect, the pandemic has triggered high rates of unemployment, worsened pre-existing behavioral health disorders, and increased stress, anxiety, and depression for others. Increased rates of unemployment also contribute to increasing the prevalence of behavioral health disorders, resulting in more suffering and deaths. Prior to the pandemic, America's affordable housing crisis was already expected to get worse. The ELI housing crisis is evidenced by the fact that people with disabilities are forced to live in segregated and institutional facilities (e.g., nursing homes, state institutions, etc.) and experience homelessness. Many of these individuals need Permanent Supportive Housing."
>
> (Please access the actual report for resources at: 2021CouncilReport.pdf (myflfamilies.com)

In 2021, the Florida Council on Homelessness reported there were 4,232 individuals who had experienced homelessness in Districts 3 and 4 (includes the 23-county LSFHS service area), *however, please note, this count does not include data for Baker, Dixie, or Union counties.* Sheltered homeless individuals represented 58.5% of the homeless population, while 41.5% of the homeless population were unsheltered. Individuals experiencing chronic homelessness, defined as continually homeless for over a year, decreased from 908 individuals in 2017 to 668 people in 20202. The number of those experiencing chronic homelessness in 2021 was 477 individuals. Homelessness among veterans increased during the same period from 515 in 2017 to 538 in 2020 with 484 veterans experiencing homelessness in 2021. Families experiencing homelessness in 2021 accounted for 993 individuals.

The number of homeless students, 16,335 in 2015-2016, decreased 8.2% to 14,992 in the 2019-2020 academic year. *Please note, data was not available for Gilchrist County.* Of those students

who were homeless in 2019-2020, over 80% were in a sharing housing arrangement and 9.1% were living in motels. *Please note, totals for "Shelters" were not available for Baker County, Hamilton County, Lafayette County, Sumter County, and Union County. Totals for "Sharing Housing" data was also not available for Gilchrist County. The same applies to "Other" totals were unavailable for Baker County, Bradford County, Dixie County, Gilchrist County, Hamilton County, Levy County, Sumter County, Suwannee County, and Union County. "Motels" totals were not available for Baker County, Dixie County, Gilchrist County, and Levy County.*

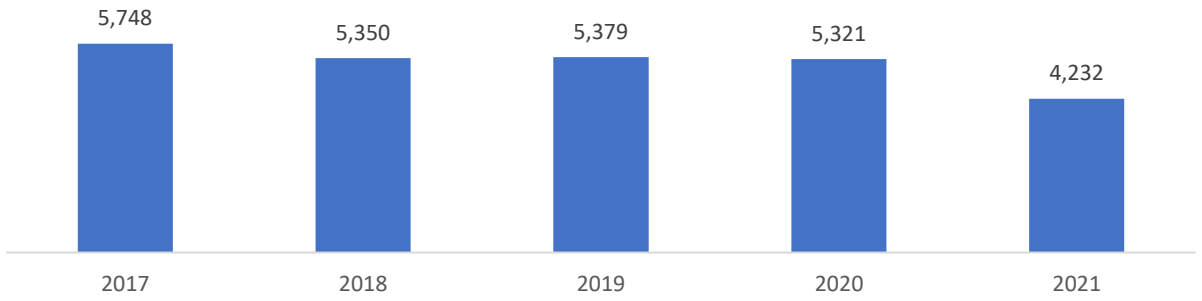
Due to the COVID-19 pandemic, this year saw an unprecedented infusion of federal funding to address homelessness and housing instability. With these funds appropriated by Congress, the State, local governments, CoCs, and partner agencies have invested in solutions to homelessness, including rent and utilities assistance, sheltering, outreach, supportive services and more. While these resources have increased Florida's capacity to prevent and end homelessness, the federal funds have strict restrictions on how the funds may be used; they are not interchangeable with the Challenge and Staffing grants provided to CoCs by the State of Florida. State funding remains critical to addressing homelessness in Florida, especially in rural areas and for the many programs that cannot be funded by federal resources due to their restrictions. State funding helps ensure a broad range of programs in Florida, as well as increase the capacity of the CoCs to administer the federal funding and other resources.

Figure 65: CoC Funding from Federal and State Sources, District 3 & 4 (SFY20-21)

Source	Districts 3 & 4
Total Funding Award	$27,720,389.31
HUD CoC FFY20	$9,943,554.00
State Total	$23,646,835.31
State Challenge	$793,000.00
State ESG-CV	$20,291,170.86
State Staffing	$749,999.95
State TANF-HP	$271,664.50
Emergency Solutions Grant	$1,541,000.00

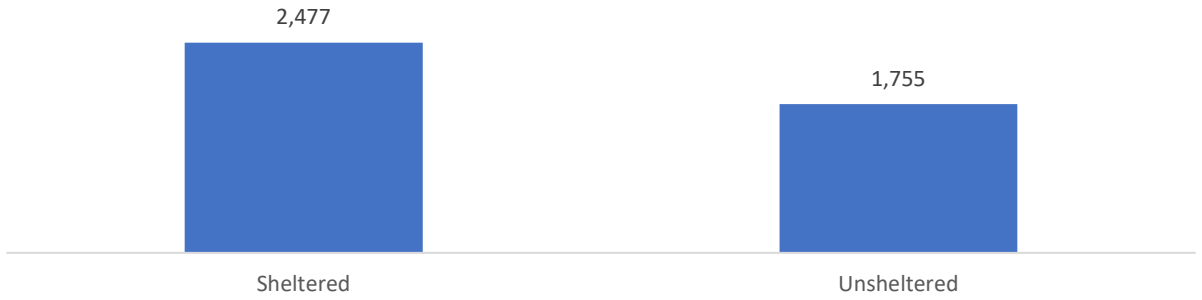
Source: 2021 Florida's Council on Homelessness Annual Report

Figure 66: Total Homeless Population, District 3 & 4 (2017-2021)



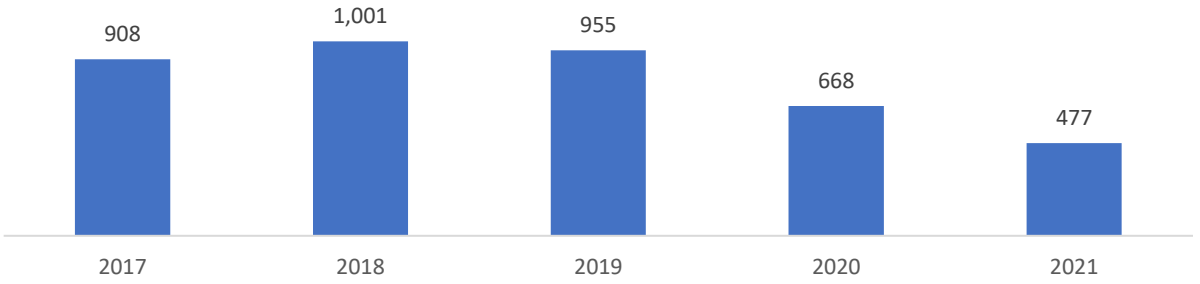
Source: 2021 Florida's Council on Homelessness Annual Report

Figure 67: Total Homeless Population Sheltered and Unsheltered, District 3 & 4 (2021)



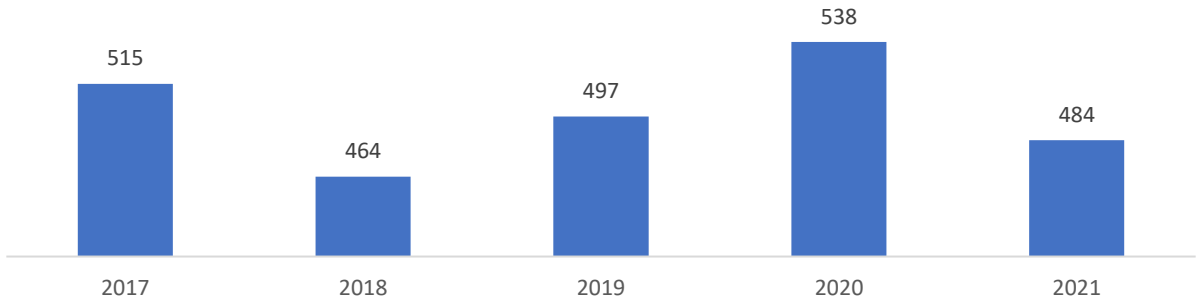
Source: 2021 Florida's Council on Homelessness Annual Report. FL-518 did not conduct an unsheltered PIT count. FL-504, FL-510, FL-512, and FL-514 conducted a modified unsheltered count. FL-508 and FL-520 conducted a full unsheltered count.

Figure 68: Chronic Homelessness, District 3 & 4 (2017-2021)



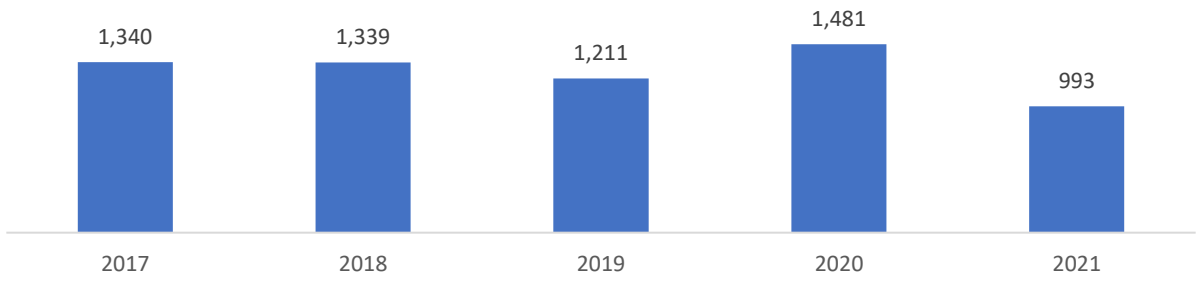
Source: 2021 Florida's Council on Homelessness Annual Report

Figure 69: Homelessness Among Veterans, District 3 & 4 (2017-2021)



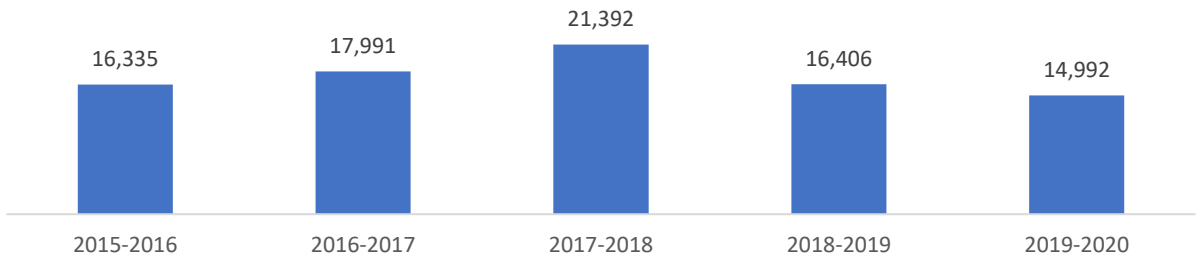
Source: 2021 Florida's Council on Homelessness Annual Report

Figure 70: Family Homelessness – Total Persons in Families with Children, District 3 & 4 (2017-2021)



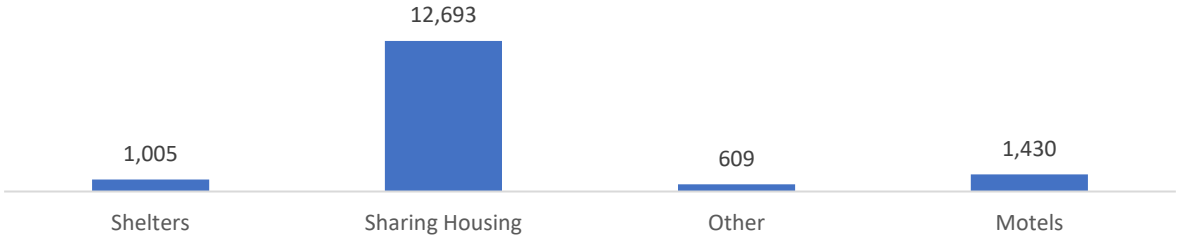
Source: 2021 Florida's Council on Homelessness Annual Report

Figure 71: Florida DOE – Reported Homeless Students in Public Schools (2015-2020)



Source: 2021 Florida's Council on Homelessness Annual Report. School Districts: 01, 02, 04, 09, 10, 12, 15, 16, 18, 21, 24, 27, 34, 35, 38, 42, 45, 54, 55, 60, 61, 63, & 64

Figure 72: Reported Homeless Students in Public Schools by Living Situation (2019-2020)



Source: 2021 Florida's Council on Homelessness Annual Report. School Districts: 01, 02, 04, 09, 10, 12, 15, 16, 18, 21, 24, 27, 34, 35, 38, 42, 45, 54, 55, 60, 61, 63, & 64

LSFHS HOMELESSNESS DATA

Homelessness Population Statistics

A total of 2,728 individuals served by LSFHS providers experienced homelessness, representing 5.5% of all those served. Of the 2,728 individuals who experienced homelessness, 67.6% were enrolled in AMH programs, 31.8% in ASA programs, 0.4% in CMH programs, and 0.1% in CSA programs.

Males accounted for 65.6% of LSFHS individuals experiencing homelessness compared to 34.4% females. Almost 70% of LSFHS individuals experiencing homelessness were White, 20.2% were Black, 3.1% were Multi-Racial, and 6.2% identified as "Other" race. In the general LSFHS client population, 71.8% of LSFHS individuals served were White, 16.8% were Black, Multi-Racial was 3.9%, and Other was 6.4%. Disparities exist for Black and Multi-Racial individuals when comparing the general LSFHS individuals served to LSFHS individuals experiencing homelessness. The percentages of Black and Other Race LSFHS individuals experiencing homelessness were higher when compared to White and Other LSFHS individuals experiencing homelessness.

White LSFHS individuals served represented 71.5% of AMH participants and 56.6% of LSFHS individuals experiencing homelessness. Black LSFHS individuals served represented 18.6% AMH participants and 24.4% of LSFHA individuals experiencing homelessness. White LSFHS individuals served represented 76.1% of all ASA participants and 78.8% of LSFHS individuals experiencing homelessness. Black LSFHS individuals served represented 13.5% of ASA participants and 12.1% LSFHS individuals experiencing homeless. Hispanic LSFHS individuals served represented 8% of participating in LSFHS programs and 3.4% of LSFHS individuals experiencing homelessness.

Adults, ages 25-44 years, accounted for 59.7% of LSFHS individuals experiencing homelessness, and 48.6% of the LSFHS individuals served. Adults, ages 25-44 years, accounted for 56.5% of AMH individuals experiencing homelessness and 66.8% of ASA individuals experiencing homelessness.

Residential Status

All individuals experiencing homelessness reported their residential status as homeless.

Educational Attainment

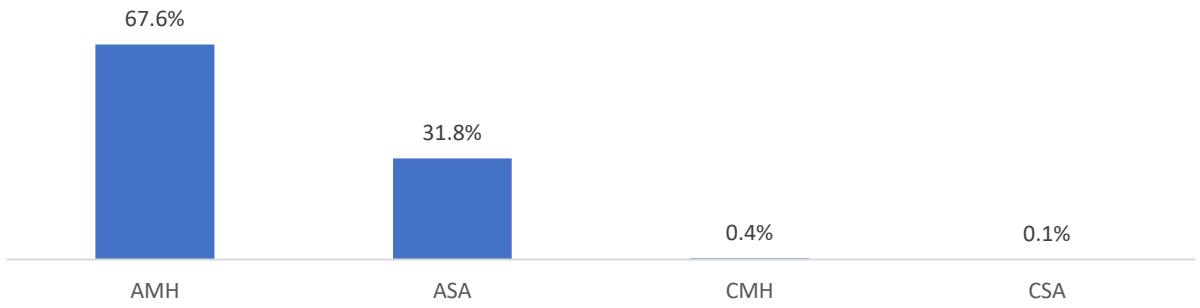
Among individuals experiencing homelessness, 82.7% of those in the AMH program and 83.3% of those in the ASA program did not have more than a high school education. Of these, 25.9% of AMH individual experiencing homelessness and 27.9% of ASA individuals experiencing homelessness did not have a diploma. Among individuals experiencing homelessness, 2.3% in the AMH program and 2.7% in the ASA program attained a bachelor's degree.

Employment Status

Of individuals experiencing homelessness, 5.7% were employed full time, 3.7% employed part time, and over 78% had been terminated/unemployed with 9.4% being disabled and unable to work.

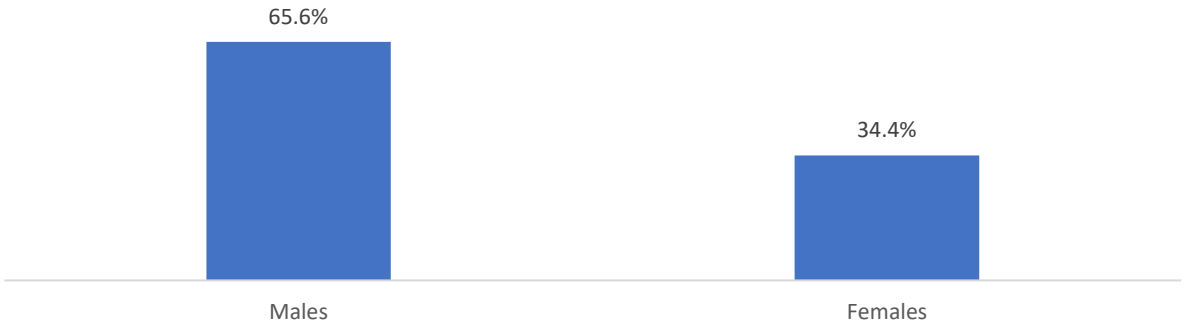
LSFHS HOMELESSNESS CHARTS

Figure 73: LSFHS Homelessness by Program



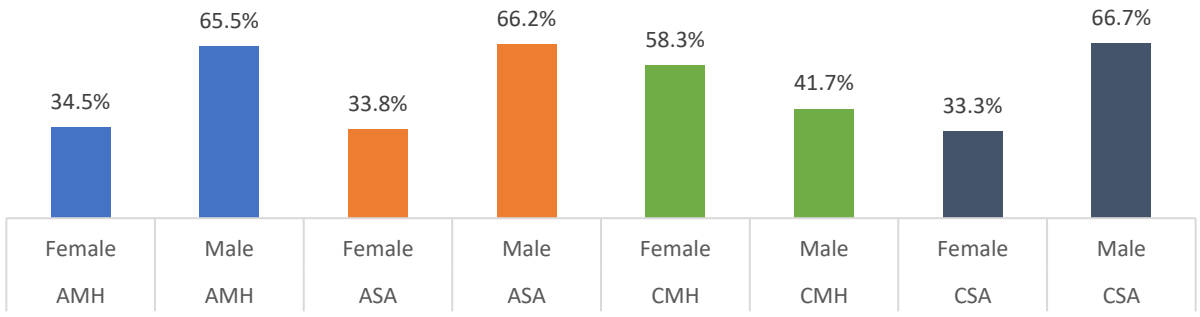
Source: LSFHS Individuals Served Data

Figure 74: LSFHS Homelessness Gender



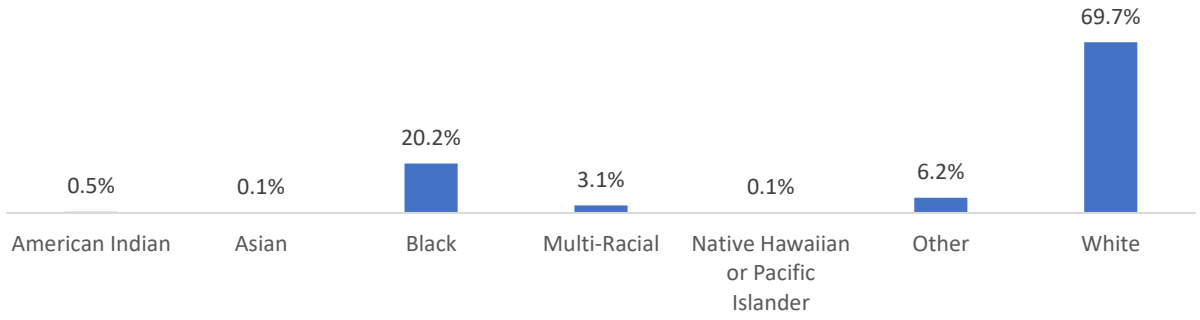
Source: LSFHS Individuals Served Data

Figure 75: LSFHS Homelessness by Program and Gender



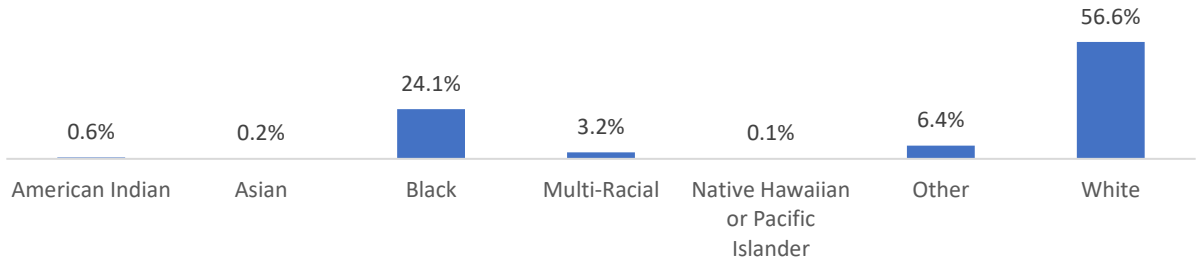
Source: LSFHS Individuals Served Data

Figure 76: LSFHS Homelessness by Race



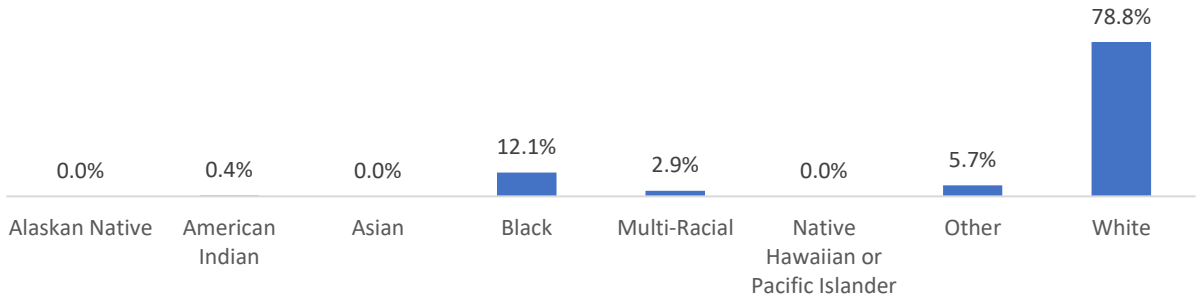
Source: LSFHS Individuals Served Data

Figure 77: LSFHS Homelessness AMH by Race



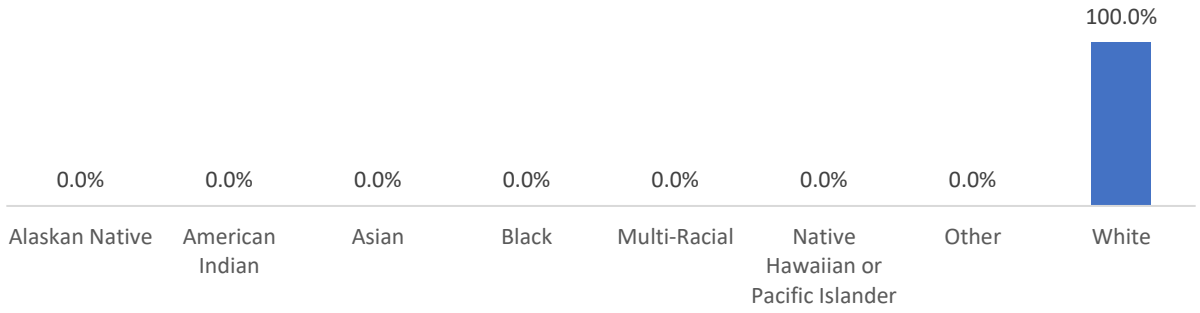
Source: LSFHS Individuals Served Data

Figure 78: LSFHS Homelessness ASA by Race



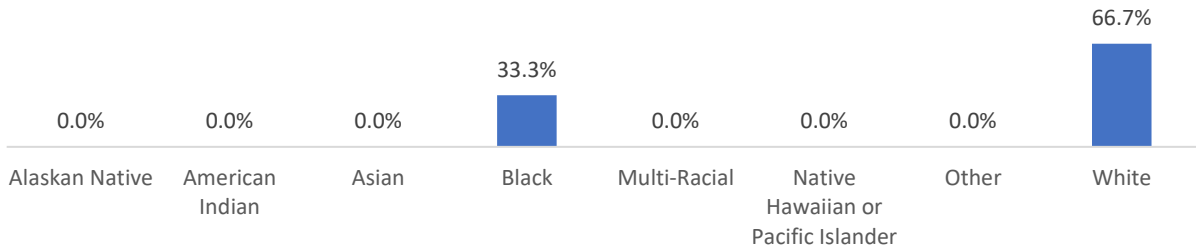
Source: LSFHS Individuals Served Data

Figure 79: LSFHS Homelessness CMH by Race



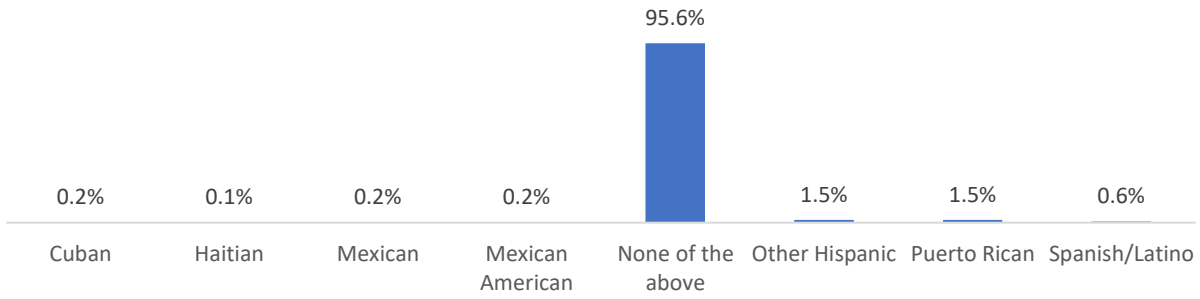
Source: LSFHS Individuals Served Data

Figure 80: LSFHS Homelessness CSA by Race



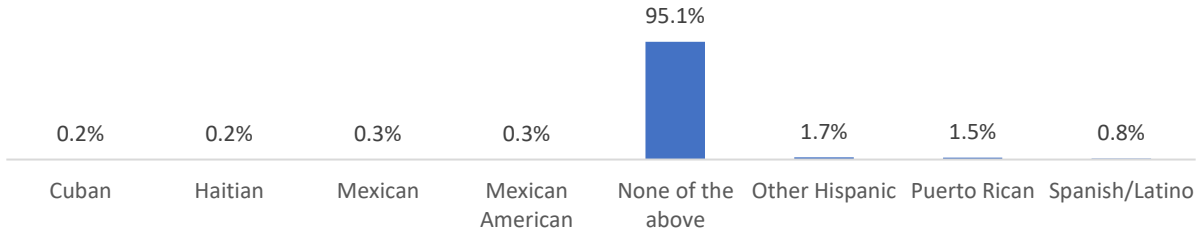
Source: LSFHS Individuals Served Data

Figure 81: LSFHS Homelessness by Ethnicity



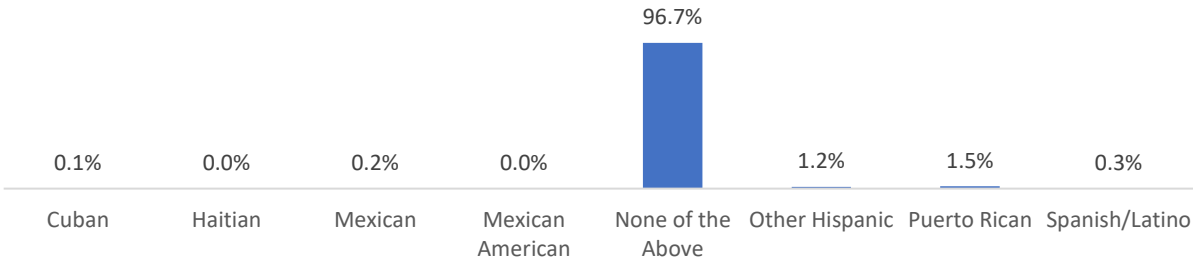
Source: LSFHS Individuals Served Data

Figure 82: LSFHS Homelessness AMH by Ethnicity



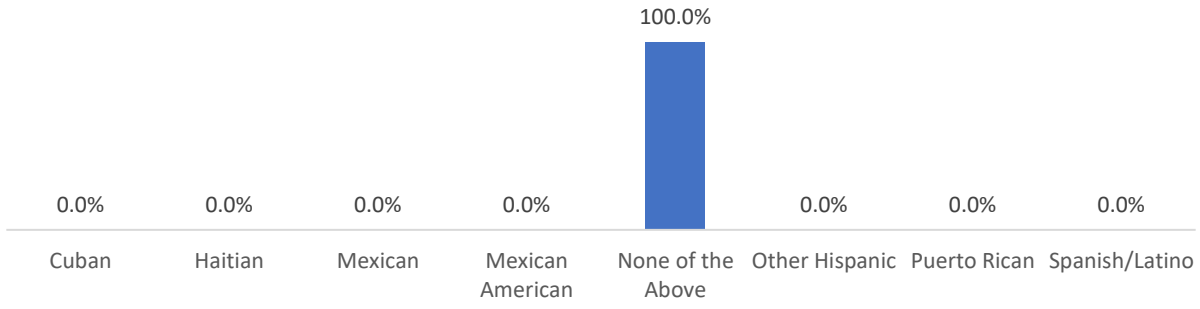
Source: LSFHS Individuals Served Data

Figure 83: LSFHS Homelessness ASA by Ethnicity



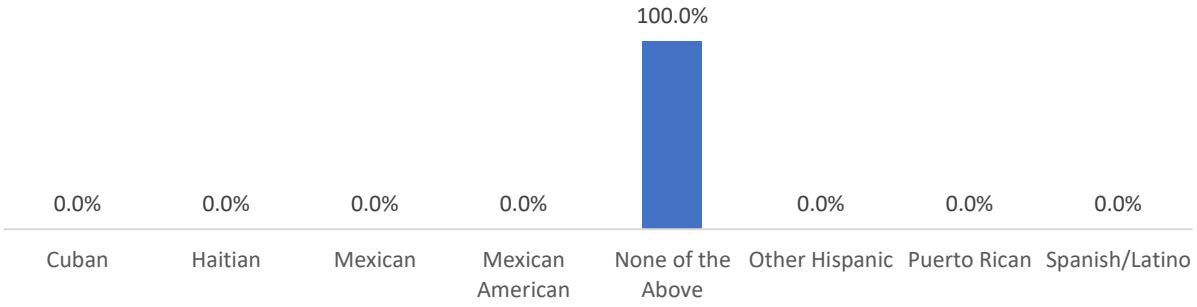
Source: LSFHS Individuals Served Data

Figure 84: LSFHS Homelessness CMH by Ethnicity



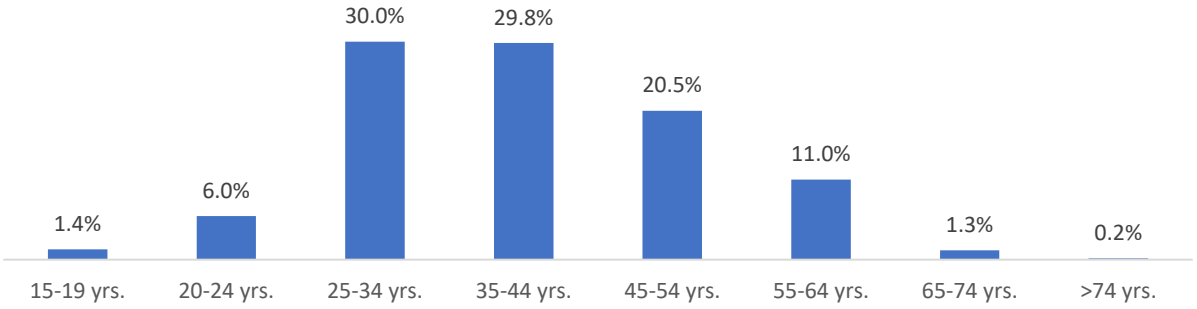
Source: LSFHS Individuals Served Data

Figure 85: LSFHS Homelessness CSA by Ethnicity



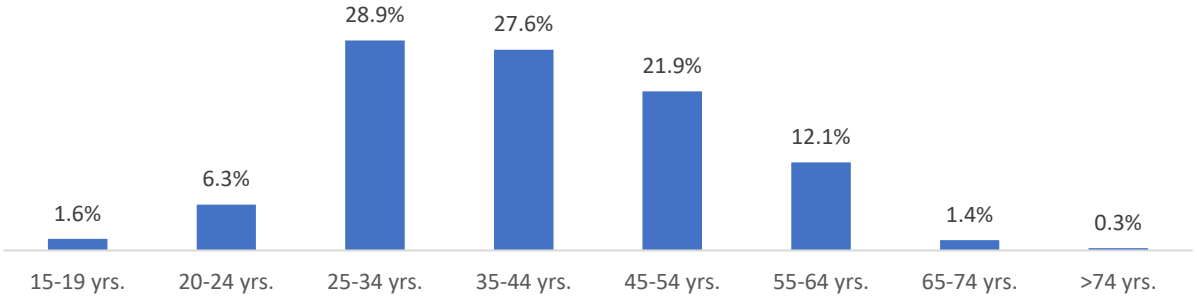
Source: LSFHS Individuals Served Data

Figure 86: LSFHS Homelessness by Age Range



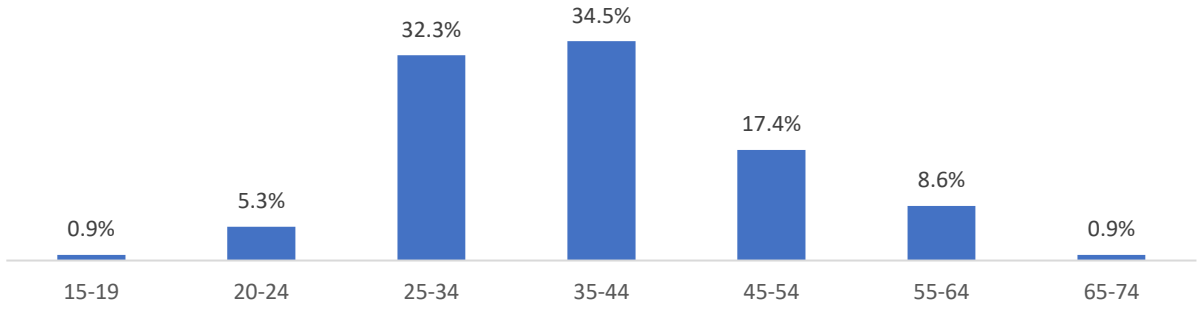
Source: LSFHS Individuals Served Data

Figure 87: LSFHS Homelessness AMH by Age Range



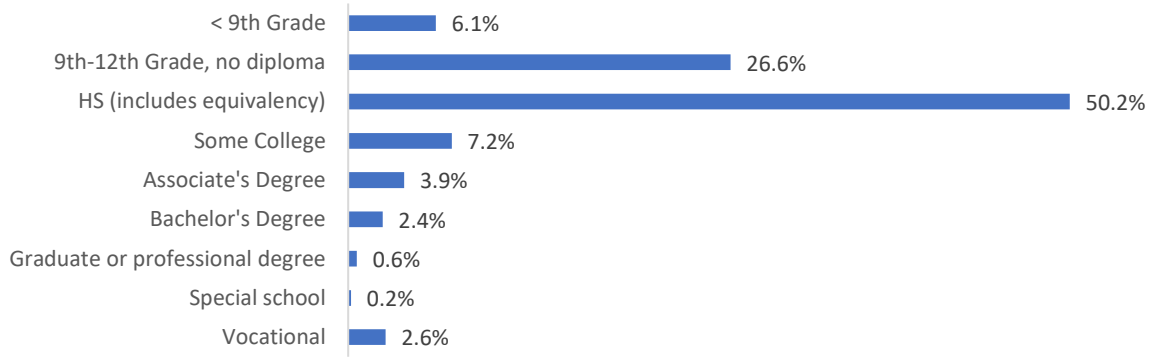
Source: LSFHS Individuals Served Data

Figure 88: LSFHS Homelessness ASA by Age Range



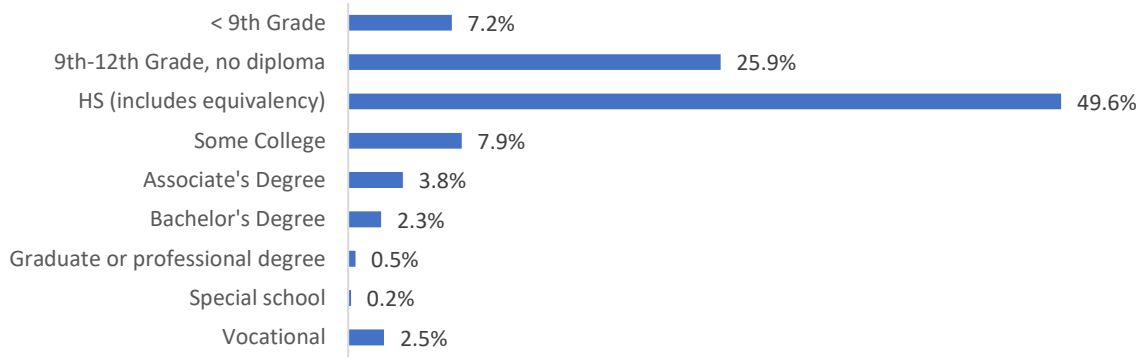
Source: LSFHS Individuals Served Data

Figure 89: LSFHS Homelessness by Educational Attainment



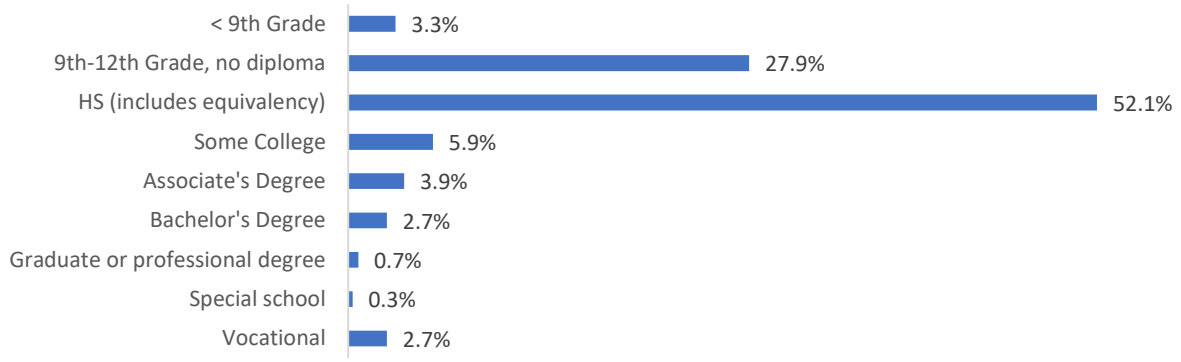
Source: LSFHS Individuals Served Data

Figure 90: LSFHS Homelessness AMH by Educational Attainment



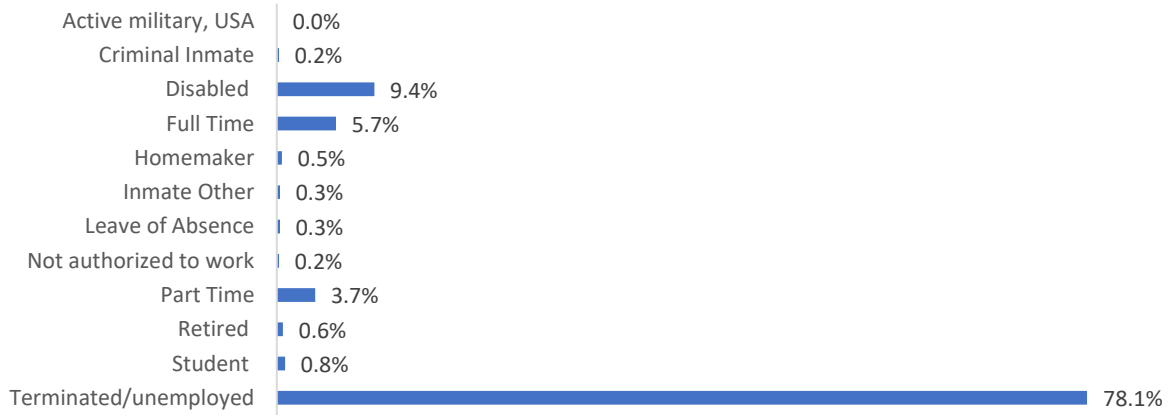
Source: LSFHS Individuals Served Data

Figure 91: LSFHS Homelessness ASA by Educational Attainment



Source: LSFHS Individuals Served Data

Figure 92: LSFHS Homelessness by Employment Status



Source: LSFHS Individuals Served Data

COST CENTER DESCRIPTION, EXPENDITURES, AND OVER/UNDER PRODUCTION (FY20-21)

ADULT MENTAL HEALTH PROGRAM

Cost Center Description	Expenditures	Over/Under Production
Assessment	$176,218.72	$17,597.39
Case Management	$2,299,553.87	$175,992.12
Crisis Stabilization Units	$16,052,987.11	$1,467,429.93
Crisis Support/Emergency	$4,523,168.22	$2,771,697.04
Day Care	$5,477.30	$14.58
Day Treatment	$114,818.43	$70,921.63
Detoxification Services - SA Detox Beds	$112,398.10	$0.00
Drop-in/Self-Help Centers	$547,962.08	$156,892.88
Information & Referral	$105,265.76	$172,894.48
In-Home and On-site Services	$150,040.93	$5,101.07
Inpatient	$691,957.98	$514,254.65
Intensive Case Management	$60,394.92	$23,619.05
Intervention - Group	$864.27	$0.00
Intervention - Individual	$132,053.53	$5,076.81
Medical Services	$2,050,514.66	$639,795.47
Mental Health Clubhouse Services	$892,007.32	$68,869.58
Outpatient - Group	$131,246.58	$7,714.80
Outpatient - Individual	$1,059,425.60	$158,702.25
Outreach	$1,008,227.26	$167,298.12
Recovery Support - Group	$11,949.34	$3,240.26
Recovery Support - Individual	$81,103.65	$42,567.04
Residential Level II	$796,952.42	$15,642.91
Residential Level II - (Enhanced Rate)	$62,368.64	$0.00
Residential Level II (Enhanced Rate)	$217,920.00	$0.00
Residential Level III	$31,082.68	$3,655.80
Residential Level IV	$431,336.55	$25,841.55
Respite Services	$330,142.18	$53,048.82
Room and Board Level II	$1,126,050.59	$238,595.56
Room and Board Level III	$734,893.79	$24,381.21
Room and Board Level III (Enhanced Rate)	$46,784.00	$0.00
Supported Employment	$397,482.52	$50,064.56
Supported Housing/Living	$200,920.40	$16,291.23
Supportive Housing/Living - Monthly	$115,310.50	$79,793.50
TOTAL	**$34,698,879.90**	**$6,976,994.28**

Source: LSFHS Program Data

ADULT SUBSTANCE ABUSE PROGRAM

Cost Center Description	Expenditures	Over/Under Production
Aftercare - Group	$38,327.28	$3,604.49
Aftercare - Individual	$78,373.81	-$760.04
Assessment	$282,852.95	$12,774.92
Case Management	$588,819.62	$33,069.20
Crisis Support/Emergency	$1,798,311.86	$173,515.25
Day Care	$30,469.90	$11.44
Detoxification Services - SA Detox Beds	$5,950,850.38	$390,747.76
Information & Referral	$154,047.62	$4,381.11
Intervention - Group	$3,476.74	$361.17
Intervention - Individual	$179,993.02	$944.44
Medical Services	$1,597,276.33	$36,564.12
Medication Assisted Treatment – Enhanced	$1,313,035.78	$62,285.06
Medication-Assisted Treatment	$2,693,439.38	$48,618.98
Outpatient - Group	$295,096.10	$11,941.24
Outpatient - Individual	$952,589.59	$50,600.63
Outreach	$481,789.91	$61,997.09
Prevention - Indicated	$24,447.04	$4,553.16
Prevention - Selective	$1,920.34	-$516.77
Prevention - Universal Direct	$245,362.65	$19,092.35
Prevention - Universal Indirect	$737,385.60	$80,090.40
Recovery Support - Group	$14,583.66	$2,281.96
Recovery Support - Individual	$68,424.23	$5,552.03
Residential Level II	$3,530,014.31	$485,385.50
Residential Level II - (Enhanced Rate)	$860,792.35	$62.69
Respite Services	$95.92	$0.00
Room and Board Level II	$101,423.67	$2.33
TOTAL	**$22,023,200.04**	**$1,487,160.50**

Source: LSFHS Program Data

CHILD MENTAL HEALTH PROGRAM

Cost Center Description	Expenditures	Over/Under Production
Assessment	$19,290.81	-$152.17
Case Management	$109,896.33	$37,827.77
Crisis Stabilization Units	$1,614,786.80	$2,599,801.71
Crisis Support/Emergency	$2,839,302.43	$567,170.48
Day Treatment	$372,504.74	$11,082.11
FSPT - Information & Referral	$129,852.63	$67,114.34
FSPT - Intervention - Individual	$192,998.16	$96,960.29
Information & Referral	$160,520.27	$629.57
In-Home and On-site Services	$7,875.13	$3,458.21
Intensive Case Management	$88,281.05	$3,512.30
Intervention - Individual	$44.93	$0.00
Medical Services	$35,220.31	$3,336.14
Outpatient - Group	$105.11	$35.12
Outpatient - Individual	$76,206.23	$15,671.01
Outreach	$198,739.56	$12,931.25
Room & Board Level II	$4,093.32	$0.00
Room & Board Level II STGC - B	$49,354.30	$0.00
Room & Board Level II STGC - N	$16,740.00	$0.00
Room and Board Level I	$108,255.00	$0.00
TOTAL	**$6,024,067.11**	**$3,419,378.13**

Source: LSFHS Program Data

CHILD SUBSTANCE ABUSE PROGRAM

Cost Center Description	Expenditures	Over/Under Production
Alachua - Prevention - Universal Direct	$150,000.00	$650.00
Case Management	$938.67	$802.79
Clay Baker Bradford - Prevention - Universal Direct	$150,000.00	$537.50
Crisis Support/Emergency	$442,924.81	$81,531.52
Dixie Gilchrist Levy - Prevention - Universal Direct	$150,000.00	$162.50
Information & Referral	$157,263.77	$0.00
Intervention - Group	$31,938.37	$9,030.63
Intervention - Individual	$123,727.67	$33,757.65
Outpatient - Group	$228.80	$0.00
Outpatient - Individual	$1,204.16	$822.31
Outreach	$215,877.72	$15,726.79
Prevention - Indicated	$334,668.80	$2,282.90
Prevention - Selective	$159,411.91	$6,797.95
Prevention - Universal Direct	$2,458,215.17	$171,308.33
Prevention - Universal Indirect	$1,157,810.37	$117,537.63
Putnam - Prevention - Universal Direct	$150,000.00	$437.50
Residential Level II	$1,001,923.80	$198,839.55
Residential Level II - (Enhanced Rate)	$53,647.56	$2,288.44
TOTAL	**$6,739,781.58**	**$642,513.98**

Source: LSFHS Program Data

LSF All Cost Centers	Expenditures	Over/Under Production
Grand Total	$69,485,928.63	$12,526,046.89

CULTURAL HEALTH DISPARITY SURVEY SUMMARY

BACKGROUND

The Behavioral Health Needs Assessment Cultural Health Disparity survey was available in January thru February 2022. It was distributed by LSFHS and their providers to peer specialists throughout the 23-county service region with the intent of reaching individuals served in ZIP Codes with high CDC social vulnerability index scores (SVI). This was used to identify LSFHS individuals served who were at a high risk for experiencing cultural health disparity.

SURVEY RESPONSES

In total, 300 responses were collected during the survey period from residents in 90 ZIP Codes. Slightly more than 62% of respondents were female, and 35% were male, 8% preferred not to answer. Most respondents were heterosexual/straight (54.8%), preferred not to answer (16.2%), asexual (9.6%), bisexual (4.6%), with 8.6% of respondents selecting "my sexual orientation is not listed here." Nearly 57% of respondents were White, 29% Black, 4.7% Multi-Racial and 5.7% preferred not to answer. The majority of respondents were not Hispanic (87.3%); however, 6% were Puerto Rican, 2.7% Spanish/Latino, and 1% Haitian. Age of respondents varied from 15-19 years (14.7%), 20-24 years (5%), 25-34 years (13%), 35-44 years (16.3%), 45-54 years (19.3%), 55-64 years (14.7%), 65-74 years (5.7%), and older than 74 years at 3%. Adults with lived substance use conditions accounted for 22% of respondents, 15% were adults with lived mental health conditions, and 15% were family members or friends with someone with lived experience. Respondents represented 15 of the 23 counties in the service area including: Alachua, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Hernando, Lake, Levy, Marion, Nassau, Putnam, St. Johns, and Volusia counties. Duval County respondents represented 41.1% of all respondents with Hernando and St. Johns counties each having 7.4% of respondents.

Most respondents (83%) reported usually being comfortable seeking behavioral health care services and 16% reporting not being comfortable seeking behavioral health care services. Respondents were asked to rate their trust in the behavioral health care system to treat them with respect on a 1 to 5 scale with 5 being "strongly trust" and 1 being "strongly distrust." Of all respondents, 66.8% of respondents "strongly trust" or "trust" the behavioral health care system to treat them with respect while 16.4% "strongly distrust" or "distrust" the system.

Respondents were asked a series of questions about their feelings regarding their behavioral health issues. More than 20% of respondents feel their behavioral health issues are private issues they keep to themselves; 35% of respondents feel it is a private issue that stays in the family, 34.7% feel comfortable sharing challenges with others, and 8% were comfortable sharing with people like themselves.

Respondents were asked, “In which settings have you been the most comfortable discussing your behavioral health concerns?” Respondents were most comfortable with a hybrid of telehealth (29.4%), private office with doctor (27.1%), all the options (18.3%), and telehealth (14%). If given a choice for receiving behavioral health care services at faith-based organization or a traditional physician office, 58.3% preferred the traditional setting compared to 39.7% who preferred a faith-based setting. Only 45.7% of respondents would be comfortable in group therapy (selected “likely” or “very likely”) and 36% would not be comfortable (selected “unlikely” or “very unlikely”). Comfort in individual therapy was higher with 82.7% of respondents being “likely” or “very likely” comfortable in individual therapy. Most respondents (92%) said services were available in their primary language all of the time and 3.7% said most of the time.

CULTURAL HEALTH DISPARITY SURVEY CHARTS

Figure 93: Are you usually comfortable seeking behavioral health services?

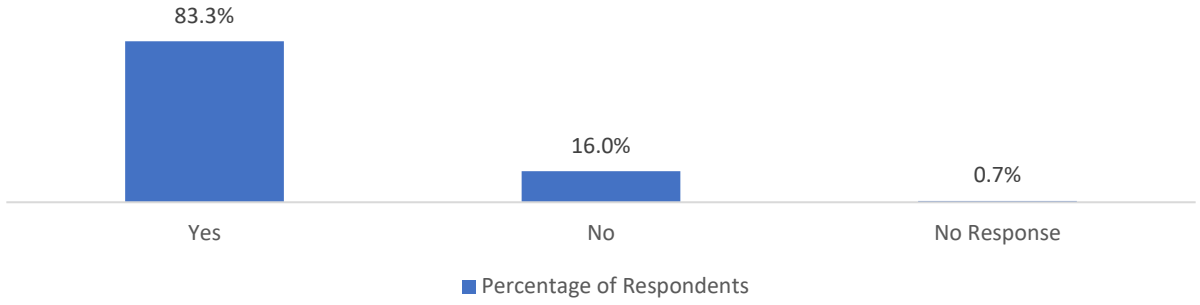


Figure 94: On a scale of 1 to 5, with 5 being 'strongly agree', how would you rate your trust in the behavioral health care system to treat you with respect?

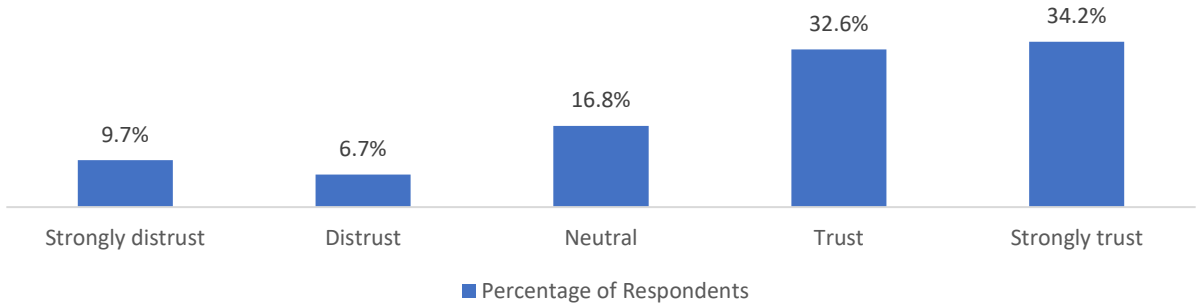


Figure 95: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. "This is a private issue I keep to myself."

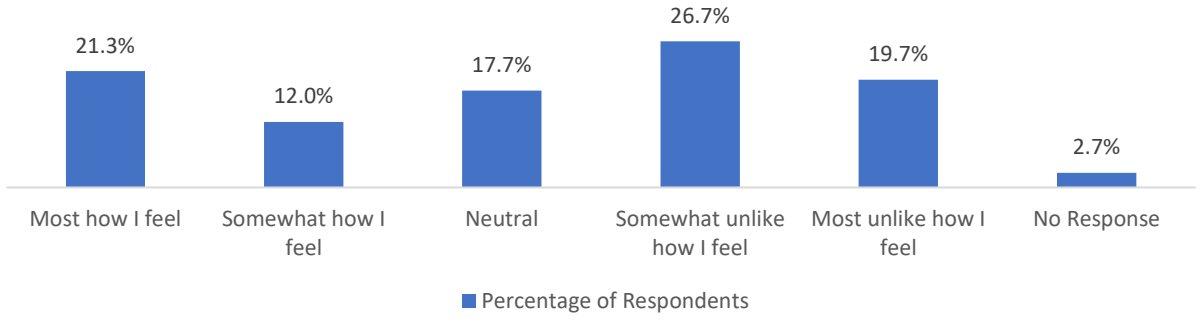


Figure 96: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. "This is a private issue that stays in the family."

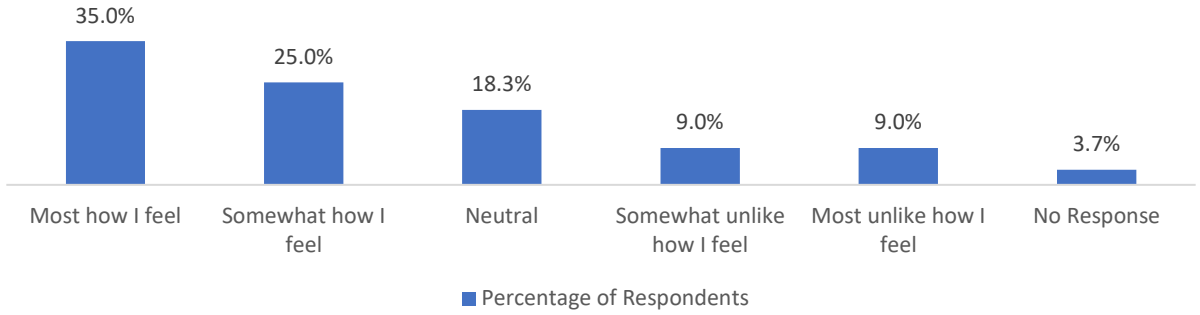


Figure 97: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. "I am comfortable sharing my challenges with others."

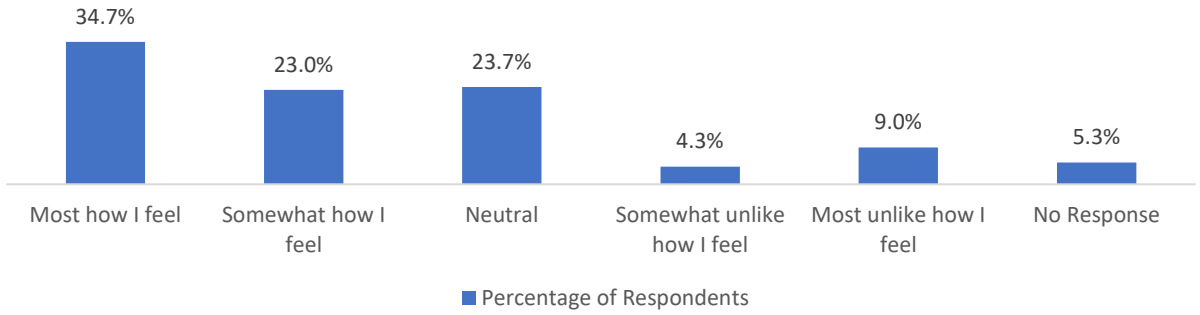


Figure 98: Please rank the statement below that most closely describes your feelings regarding your behavioral health issue, with (1) being the best and (5) being the least. "I am more comfortable with people like me."

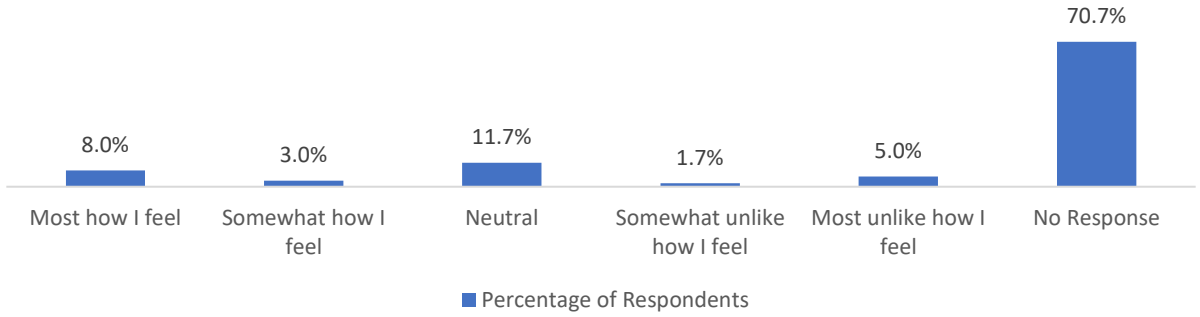


Figure 99: In which settings have you been the most comfortable discussing your behavioral health concerns? (Check all that apply)

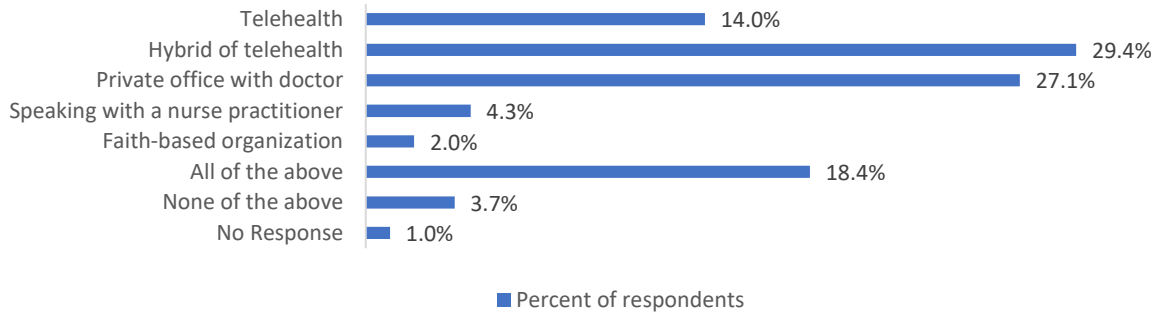


Figure 100: If given a choice for receiving behavioral health care services, would you be more comfortable going to a faith-based organization OR prefer the traditional physician office?

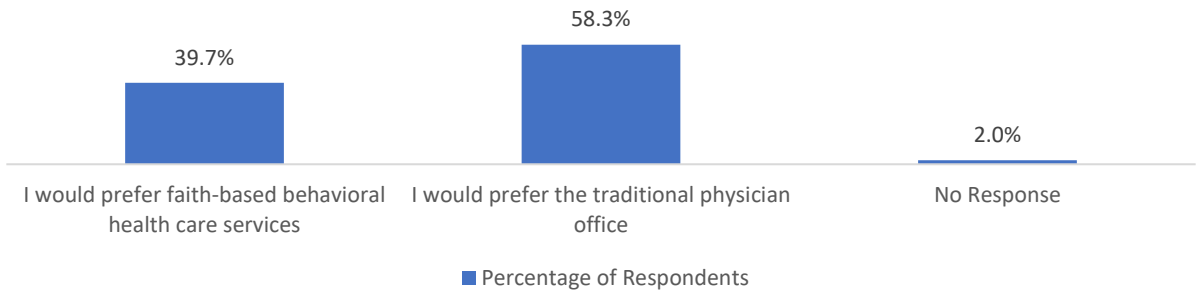


Figure 101: Now thinking about treatment options, on a scale of 1 to 5, with 5 being 'very likely', how comfortable would you be in group therapy?

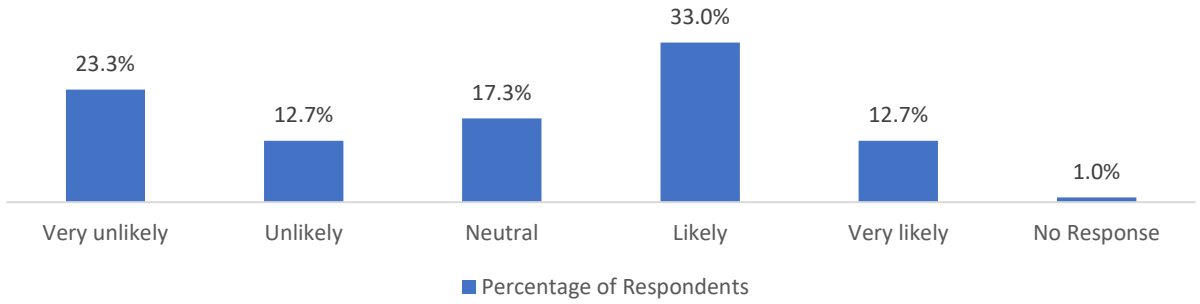


Figure 102: On a scale of 1 to 5, with 5 being 'very likely', how comfortable would you be in individual therapy?

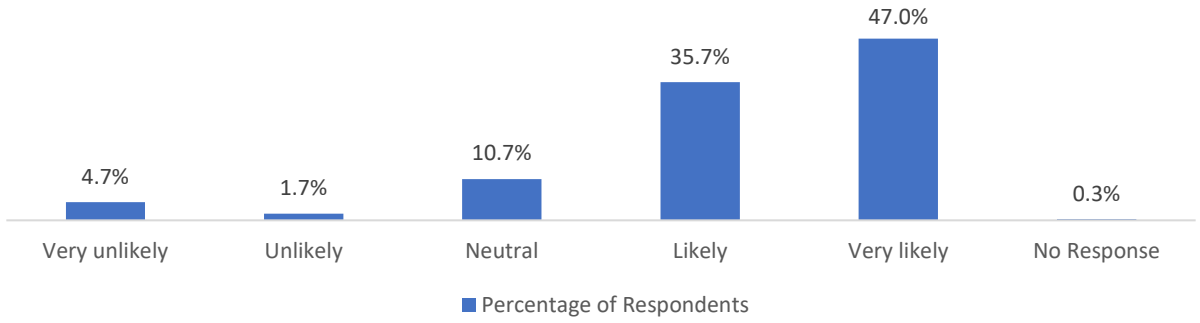


Figure 103: When you have received behavioral health care services in the past, were they mostly available in your primary language?

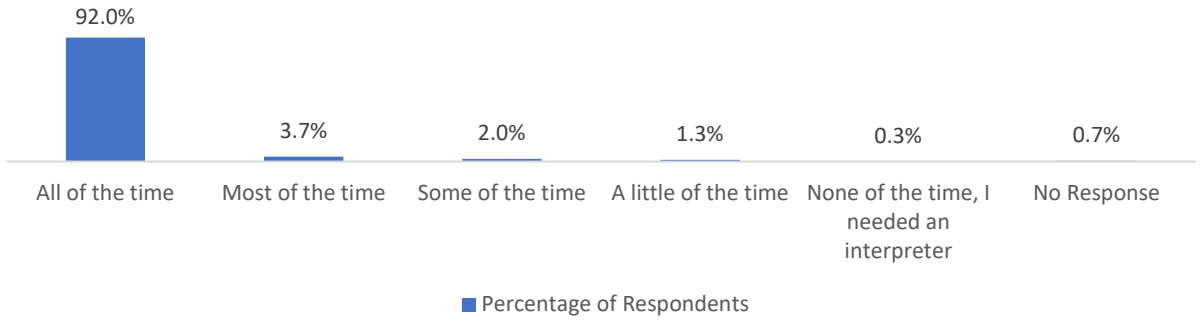


Figure 104: Which best describes your gender?

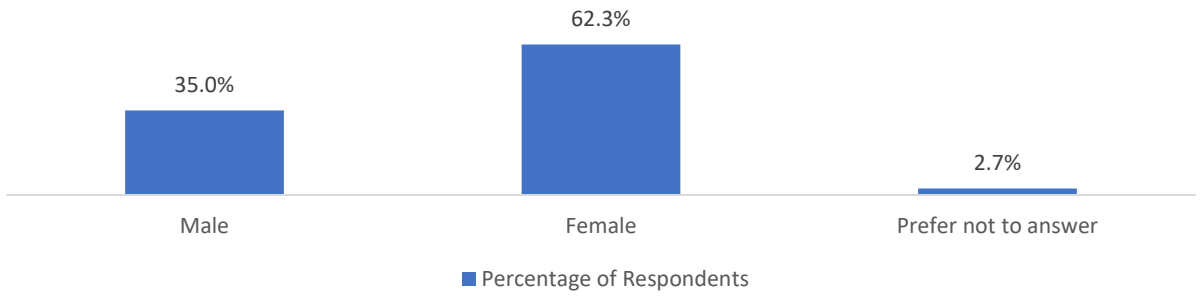


Figure 105: Which best describes your gender identity?

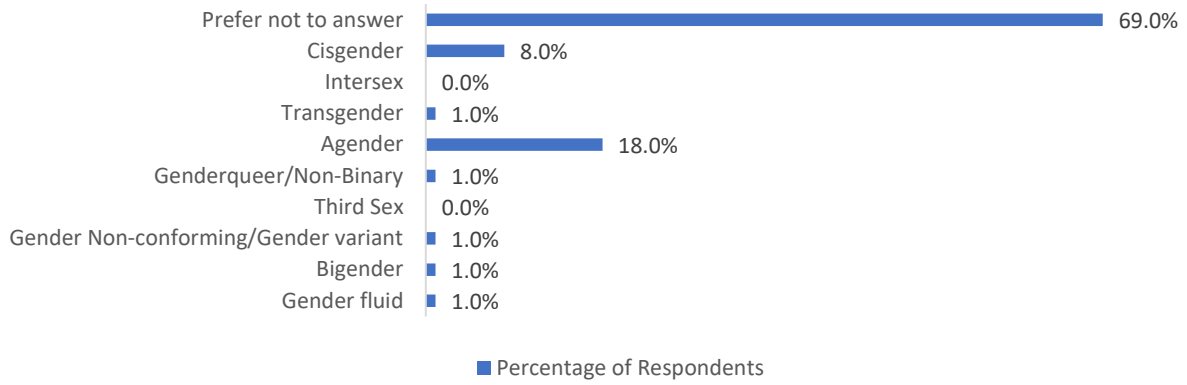


Figure 106: Which best describes your current sexual orientation? (Check all that apply)

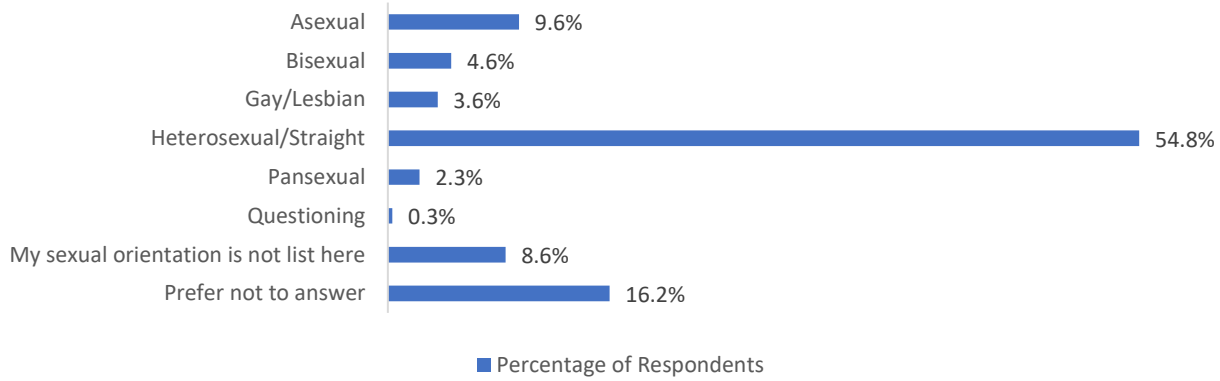


Figure 107: Which best describes your race?

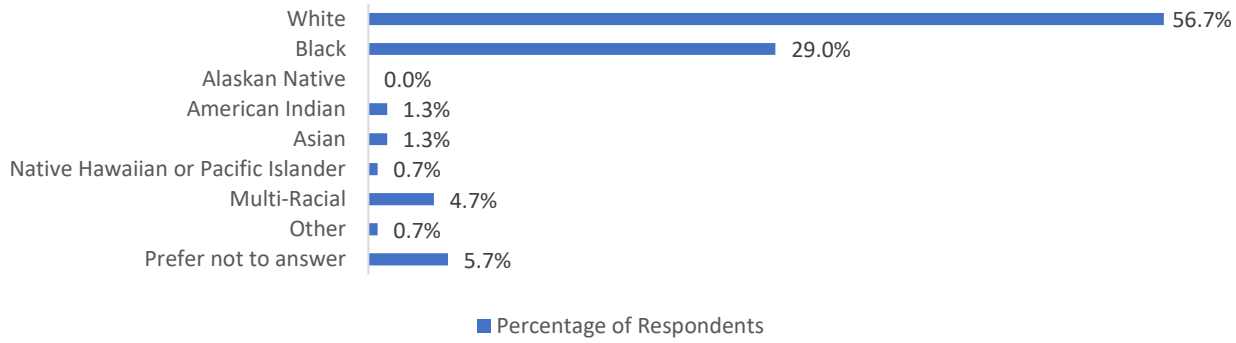


Figure 108: Which best describes your ethnicity?

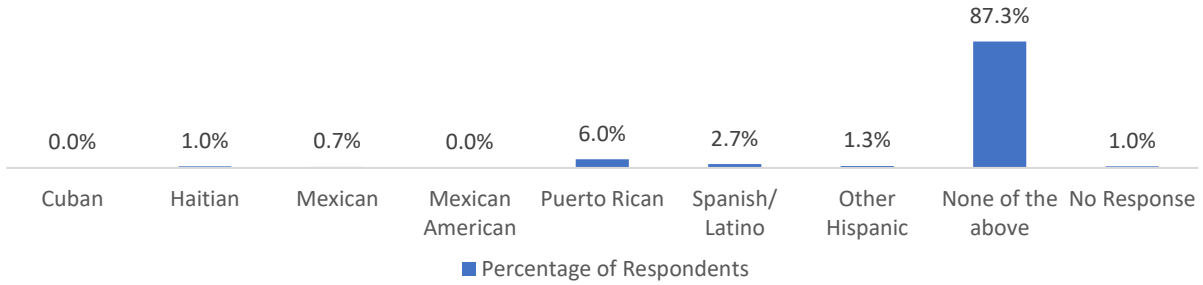
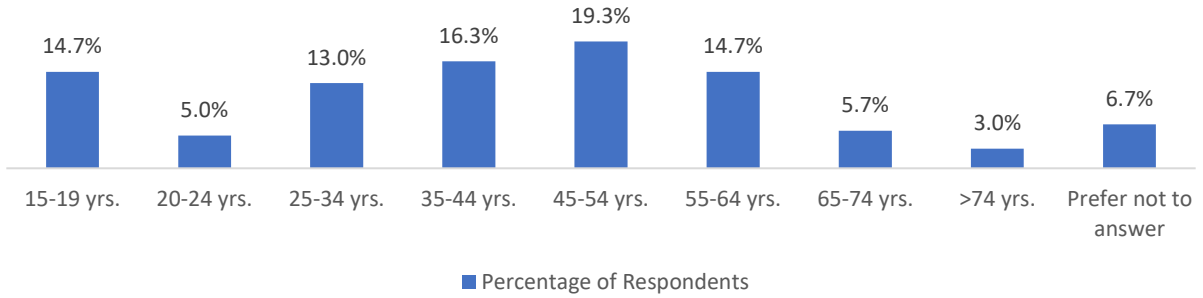


Figure 109: Please select your age range from the list below.



CULTURAL HEALTH DISPARITY SURVEY BY RACE AND ETHNICITY

The cultural health disparity survey was analyzed by race and ethnicity to further measure experience, awareness, and coordination of behavioral health services. This will help tailor outreach and treatment options based on the unique needs and preferences of individuals over the next three years.

Most respondents were comfortable seeking behavioral health care services. Black respondents (96.6%) were more likely to be comfortable seeking care when compared to Hispanic (82.9%) and White respondents (78.6%).

When asked if they trust the health care system to treat them with respect, 88.5% of Black participants responded positively. Specifically, 40.2% trusted and 48.3% strongly trusted they would be treated with respect. These percentages were higher when compared to other demographic groups. Among Hispanic respondents, 42.9% trusted and 31.4% strongly trusted they would be treated with respect. Slightly more than half (55.4%) of White respondents trusted (25.6%) or strongly trusted (29.8%) that the health care system would treat them with respect.

Respondents were asked to describe their feelings regarding their behavioral health issues. When asked if this was "a private issue I keep to myself", Black respondents (26.7%) indicated that this was most how I feel (18.6%) or somewhat how I feel (8.1%). Among Hispanic respondents (44.1%), indicated this was most (20.6%) or somewhat how they feel (14.7%). White respondents (39.8%) were more likely to feel this was a private issue kept to themselves as 14.9% indicated this was somewhat or most how they feel (24.8%).

Regarding their behavioral health issues as a private matter that stays in the family, a greater percentage of Black and Hispanic respondents indicated this was unlike how they feel while a greater percentage of White respondents indicated this was most how they feel. Among Black respondents73.3% indicated this was somewhat unlike or most unlike how I feel. Only 34.4% of White respondents indicated this was somewhat or most unlike how they feel while 41.7% indicated this was most or somewhat how they feel.

Most respondents were comfortable sharing their challenges with others. Among Black respondents, 37.2% indicated this was most how they feel or somewhat how they feel (38.4%). Hispanic respondents who most feel this way accounted for 31.4% while 17.1% indicated this was somewhat how they feel. Among White respondents, 37.7% indicated this was most how they feel or somewhat how they feel (19.8%).

Black respondents (82.4%) were likely to be more comfortable with people like them when compared to Hispanic (65.7%) and White respondents (51.3%). Among Black respondents, 50.6% indicated this was most how they feel or somewhat how they feel (31.8%). For Hispanic respondents, 40% indicated that this most how they feel or somewhat how they feel (25.7%).

Among White respondents, 29.7% indicated this was most how they feel, and 21.5% indicated this was somewhat how they feel.

The most comfortable setting for discussing their behavioral health issues for Black respondents was a hybrid of telehealth at 64%. In a private office with a doctor accounted for 14% of Black respondents and 14% indicated all of the above were comfortable settings. Hispanic respondents preferred to be in a private office with a doctor (38.2%) or a hybrid of telehealth at 32.4%. Over 20% indicated all of the above were also comfortable settings. White respondents also preferred a private office with a doctor at 33.3%. Among White respondents, 19% were comfortable with telehealth and 19.6% were comfortable with all settings. No Black or Hispanic respondents chose faith-based organizations as a comfortable setting and only 3% of White respondents selected this option.

When asked to choose between faith-based or the traditional physician office, results were opposite of the results in the preceding question. Most Black respondents (73.8%) indicated they would be more comfortable going to a faith-based organization. Among Hispanic respondents, 45.5% were comfortable in a faith-based setting and 54.5% were comfortable in a traditional physician office. Only 22.8% of White respondents indicated they were comfortable in a faith-based organization while 77.2% preferred the traditional physician office. Network Service Providers (NSP) may be able to offer insight on this contradiction.

Among Black respondents, 80.2% were likely or very likely to be comfortable in group therapy. This was much higher when compared to Hispanic and White respondents at 41.2% and 31.5%, respectively. When asked about their comfort in individual therapy, more than 75% of respondents from all three population groups were comfortable in this setting. Among respondent groups, 96.6% of Black respondents indicated they would be comfortable in individual therapy, along with 82.9% of Hispanic respondents, and 76.9% of White respondents.

When asked if the behavioral health services they received in the past were mostly available in their primary language, 90.8% of Black respondents, 82.4% of Hispanic respondents, and 95.2% of White respondents received services in their primary language all of the time. Those needing an interpreter accounted for 2.9% of Hispanic respondents, and 1.1% of Black respondents.

CULTURAL HEALTH DISPARITY SURVEY BY RACE AND ETHNICITY CHARTS

Figure 110: Are you usually comfortable seeking behavioral health care services?

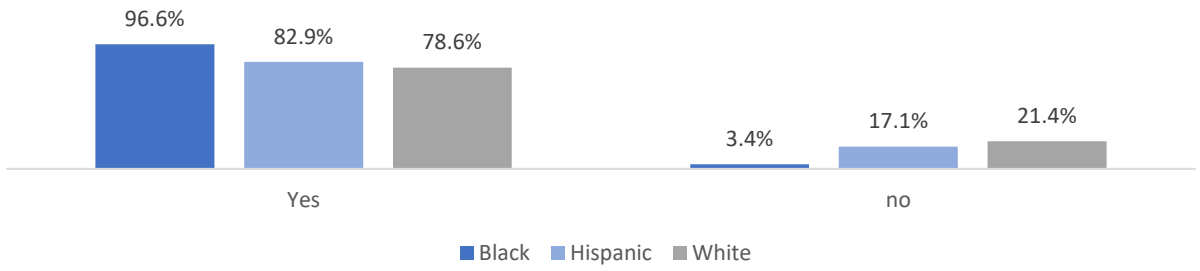


Figure 111: On a scale of 1 to 5, with 5 being 'strongly agree', how would you rate your trust in the behavioral health care system to treat you with respect?

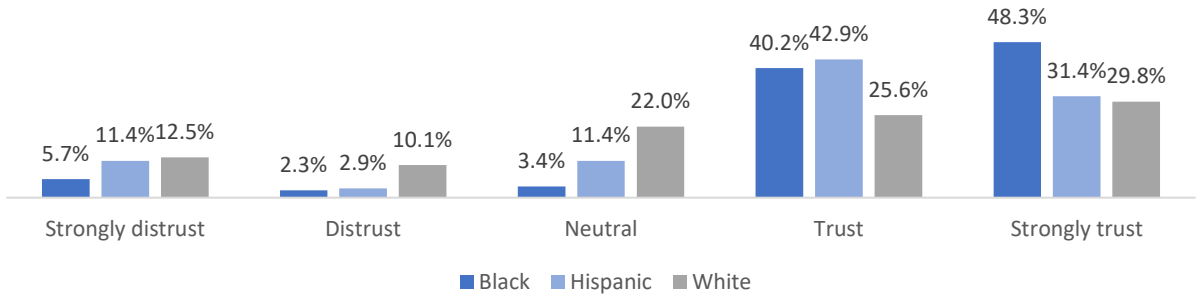


Figure 112: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. This is a private issue I keep to myself.

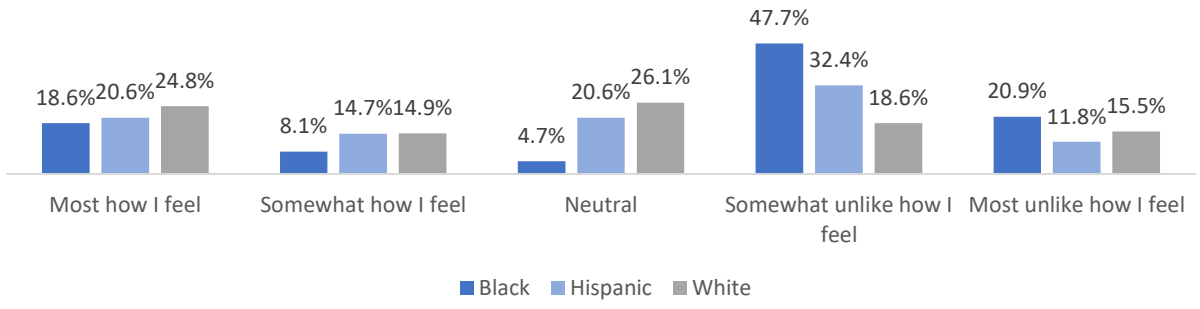


Figure 113: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. This is a private issue that stays in the family.

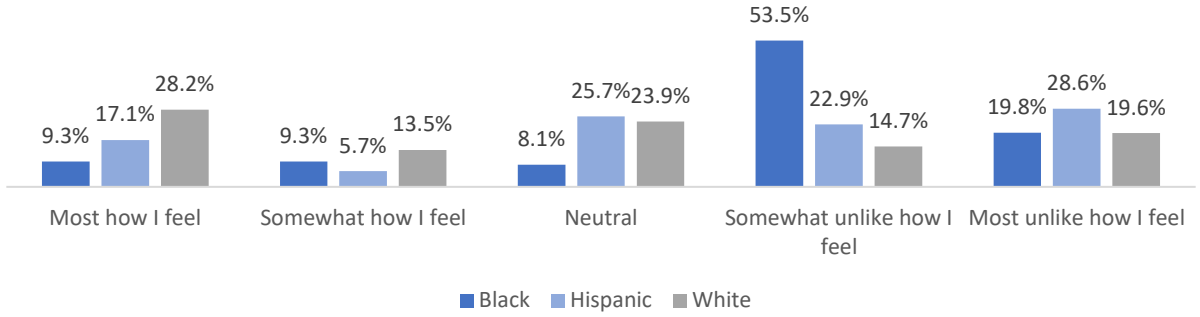


Figure 114: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. I am comfortable sharing my challenges with others.

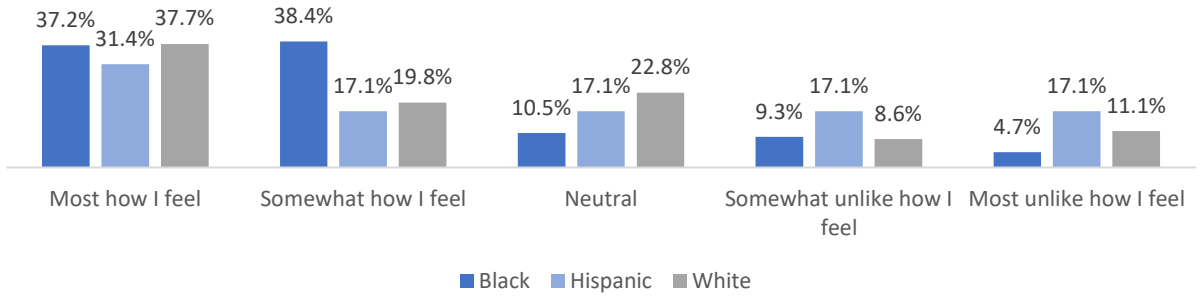


Figure 115: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. I am more comfortable with people like me.

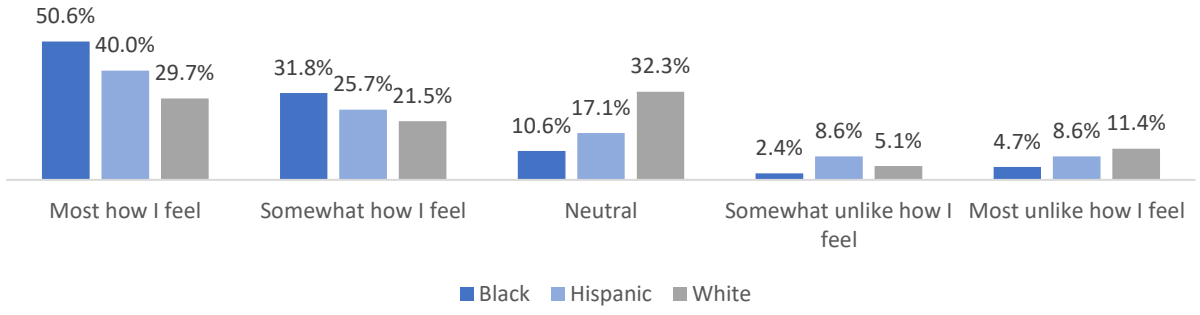


Figure 116: In which setting(s) have you been the most comfortable discussing your behavioral health concerns? (Check all that apply)

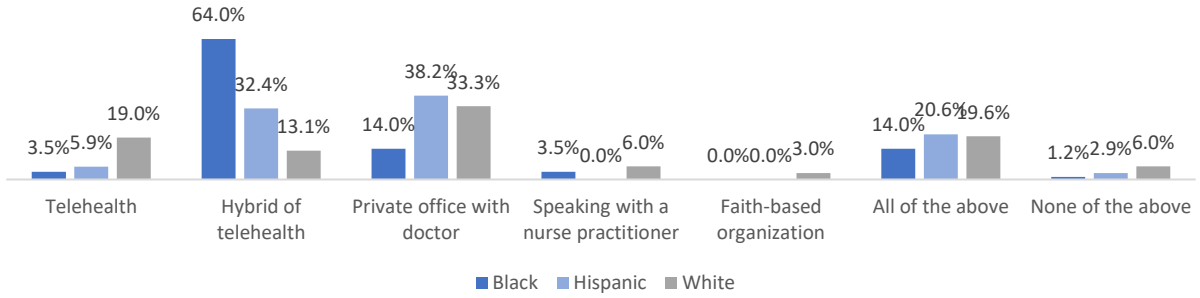


Figure 117: If given a choice for receiving behavioral health care services, would you be more comfortable in a faith-based organization OR prefer the traditional physician office?

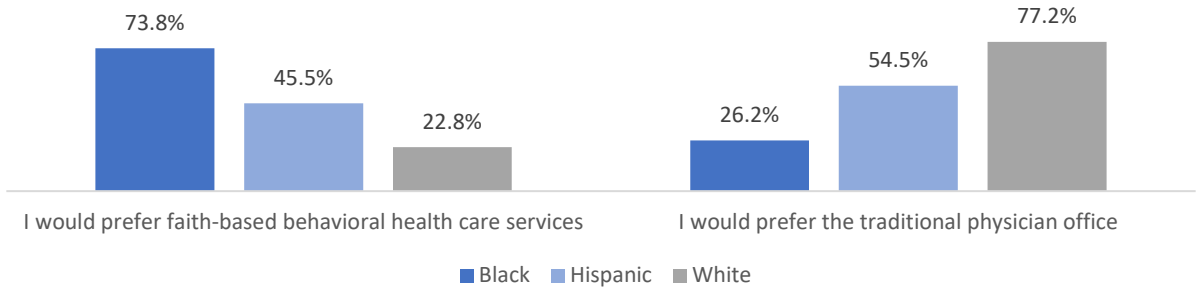


Figure 118: Now thinking about treatment options, on a scale of 1 to 5, with 5 being very likely, how comfortable would you be in group therapy?

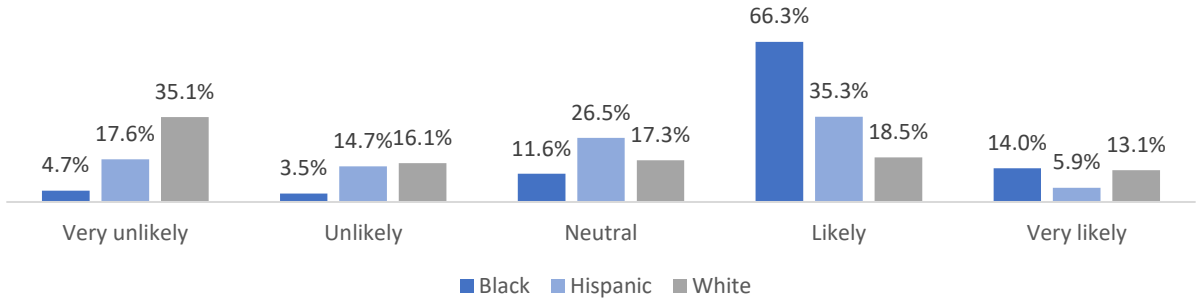


Figure 119: On a scale of 1 to 5, with 5 being very likely, how comfortable would you be in individual therapy?

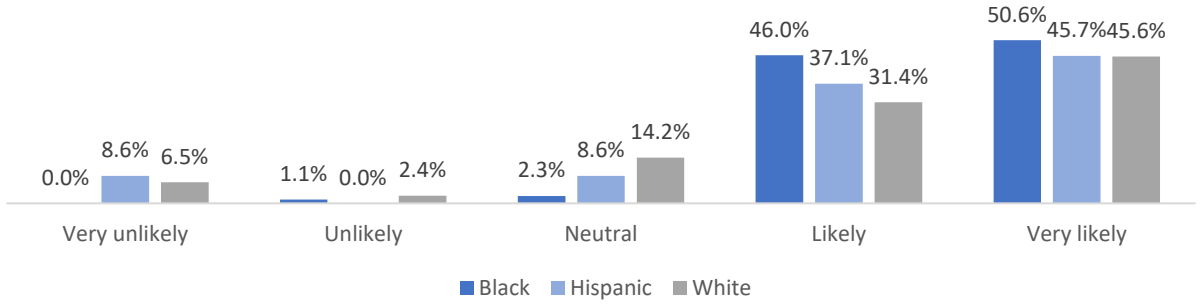
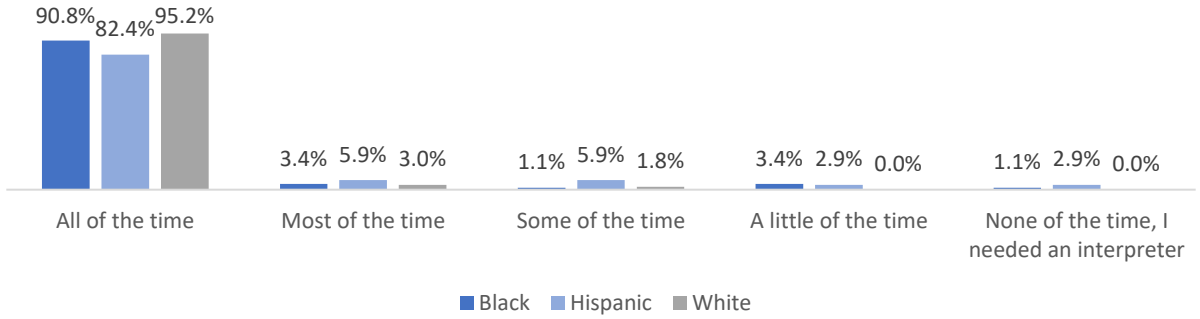


Figure 120: When you have received behavioral health care services in the past, were they mostly available in your primary language?



CULTURAL HEALTH DISPARITY FOCUS GROUP SUMMARY

FOCUS GROUP METHODOLOGY

LSF Health Systems is one of seven behavioral health Managing Entities (ME) contracted by the Florida Department of Children and Families to manage the state-funded system of behavioral health care for people who face poverty and are without insurance. LSF Health Systems serves a 23-couty region in Northeast and North Central Florida which includes the counties of Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Hernando, Lake, Lafayette, Levy, Marion, Nassau, Putnam, St. Johns, Sumter, Suwannee, Union, and Volusia.

Lutheran Services of Florida recruited and provided access to a total 36 number of behavioral health clients and stakeholders to participate in four separate behavioral health services focus groups. The eligibility criteria for participating in the focus groups was that participants were 18 years or older and lived in the LSF Health Systems service area. Focus group sessions were held for two hours each and were facilitated by WellFlorida staff via the Zoom platform. The script of ten questions (see below) about behavioral health services in the managing entity service area was utilized to obtain the feedback from the participants. A summary of the respondents' input is provided below.

SCHEDULE OF FOCUS GROUP SESSIONS

Date (2022)	Time	Number of Participants
March 14	10:00 - 11:30 am	11
March 14	2:30 - 4:00 pm	8
March 18	10:00 - 11:30 am	8
March 22	10:00 -11:30 am	9

FOCUS GROUP SUMMARY

Each of the four focus groups followed the same focus group script. The following pages present summaries of the focus group participants' responses to each question. A summary of the responses across the four groups for each of the ten questions is provided.

Question 1: Tell us about your most recent experience seeking behavioral health services? (Prompts: how did you learn about the provider, were you referred by someone?) Tell us about how you choose or selected your current (or most recent) behavioral health services provider?

Summary of Responses: Various experiences prompted focus group participants to access behavior health services. Across the four focus groups no clients expressed an inability to find

services. However, a common comment from focus group participants was that services were not so much personally sought but accessed as a result of being court ordered, placement in a detoxification unit, or having been released from jail. Other participants expressed that they sought out specific providers such as a pediatric provider, one who accepted their insurance, or provided telehealth services to meet their schedule demand or transportation barriers.

List of Responses (paraphrased focus group participant responses):

- Had to find a service without a long wait list
- Found provider on insurance website
- Court ordered
- Veteran's Administration referral
- Detox admission and discharges
- Jail discharge
- Needed pediatric specialist
- Telehealth services available

Question 2: Did you experience barriers or obstacles when seeking behavioral health services? If so, what were the barriers and how did you overcome them? Were there barriers you could not overcome? If so, what were the barriers and what would have helped you overcome them?

Summary of Responses: Answers depended on the focus group participant's life situation. For example, for single parents, persons with limited incomes, and those on Medicaid, there were housing, childcare, Medicaid acceptance, and transportation barriers. COVID-19 also presented barriers as participants expressed that the pandemic seemed to create a shortage of providers. Some participants did not want to go to one-on-one therapy during the pandemic. Those who relied on telehealth services expressed frustrations with technology issues, including internet access or specific computer issues that forced them to use their cell phones for telehealth services.

List of Responses (paraphrased focus group participant responses):

- Wait time
- Medicaid has a limited set of providers
- Technology issues
- Transportation including price of gas
- Staff turnover impact ability to establish client provider relations
- Finding one to fit my schedule
- Financial barriers
- Chose by what insurance offers
- Needed to get housing, childcare, and employment first
- Difficult for single parents to get childcare to attend appointments
- During pandemic there was a shortage of providers
- During pandemic did not want to go in person so had to find a provider that offered telehealth services

Question 3: What makes you feel comfortable getting behavioral healthcare services? (Prompts: person understands you, values of your culture, is a part of your community, know your privacy is maintained, etc.)

Summary of Responses: A common experience among focus group participants was that building trust and not being judged are essential to feeling comfortable with a provider. Other key items discussed that contribute to participants feeling comfortable were having a provider who understood their behavioral health traumas and or individual histories and backgrounds. Participants expressed that providers who are interested in client progress and not just checking on medication status made them comfortable, made them feel the provider cared about their progress and understood them. Having consistency with a provider as well as the recognition that behavioral health is an integral to overall health and well-being was important to participants.

List of Responses (paraphrased focus group participant responses):

- Feeling comfortable with the provider
- Trusting the provider
- Ability of provider to understand participant's type of trauma/behavior health issue
- Non-judgmental providers
- Ability to establish rapport with provider
- Provider who helps maintain progress
- Provider interested in your progress and not just your medications
- Maintaining consistency with provider because building trust and progress takes time
- Understanding that behavioral health is part of overall health and wellness in general

Question 4: What helps build a good provider-client relationship?

Summary of Responses: Provider competency was a common topic of discussion. Competency could include the ability to develop a trusting client-provider relationship. Within the client-provider relationship, the ability of the provider to mirror the client's situation, hold the client accountable for their responsibilities to achieve progress in identifying the specific behavioral health issue(s), and for there to be a bit of humor in therapy as humor were cited as helpful. A few respondents expressed they prefer a provider of a specific gender.

List of Responses (paraphrased focus group participant responses):

- Provider competency
- Time to develop relationship
- Trust
- Humor
- Building a partnership with the provider
- Providers who hold a client accountable
- Gender of provider in some cases
- Ability to mirror client, to put themselves in the same role as client (peer)
- Ability to get to the real problem

- Maintenance of confidentiality

Question 5: What services have you been satisfied with and why? Any services that you've been dissatisfied with or that need improvement and if yes, why? (Prompt or example of family involvement as part of satisfaction).

Summary of Responses: Participants expressed that good case management which includes coordination of care from primary care physicians to empathetic trusting providers, proper medication management, availability of providers, and a good patient to provider ratio are service characteristics they have been satisfied with. Other services participants were satisfied with included being able to reach providers by telephone and providers who hold the client accountable.
Services participants were dissatisfied with were predominantly centered around crisis care including hospital and inpatient admissions and Baker Act admissions. Crisis management discussions highlighted the damage caused by Baker Act admissions for children, emergency services that inappropriately medicate clients, and the lack of training among law enforcement officers to properly aid clients and families in crisis. A suggestion was made that emergency room health workers could benefit from training about behavioral health and crisis management. Other services participants expressed dissatisfaction with was the ability to receive primary and dental care and unreliability of transportation at times.

List of Responses (paraphrased focus group participant responses):
Satisfied

- Good case management
- Proper medication management
- Therapist who holds client accountable
- Good patient provider ration
- Provider who takes the patient seriously

Dissatisfied

- Crisis management, particularly for children
- Care coordination after incarceration
- Law enforcement interactions when officers not trained in crisis intervention
- Coordination of discharge from jail
- Too much process and time to move from detox centers to residential can sometimes cause relapse to detox.
- Baker Act admissions of children can cause permanent harm
- Mismedication
- Dental and primary care is needed and is expensive
- Transportation not on schedule
- Difficult to get intervention for a client who is deteriorating, not wait for a crisis leading to hospitalization
- Emergency crisis care

Question 6. How many of you have received behavioral health services through telehealth? How was that experience? Would you like to continue it? For those who haven't tried telehealth, would you like to try it? If not, why?

Summary of Responses: A few participants in the focus group sessions had used telehealth services. Overall, they found it convenient, especially for medicine assessments. Telehealth users found telehealth convenient, saved on transportation costs, and found it a mechanism to receive care consistently and continuously. Participants thought telehealth services can be a good way to receive behavioral health services if there are no technology issues. Telehealth services also were found to be a way to overcome wait times for appointments and expedite service. On-telehealth servicer users in the groups said they would give telehealth a try but expressed they would prefer to initially meet the provider in person.

List of Responses (paraphrased focus group participant responses):
Responses from Those Who had Used Telehealth Services: about 15 total for all groups

- For medication checkup it was fine but not for therapy
- Love telehealth. It is convenient
- Other people in room or area can listen to conversations (lack of privacy, security, and confidentiality
- Some technology issues at times
- Awkward to do
- Good if you have a busy life and with a full-time job can't take time off work
- Easy and convenient to schedule
- Saves on driving or depending on transportation

Responses from Those Who had Not Used Telehealth Services:

- Would absolutely try
- Would like to meet the provider prior to using

Question 7: What is appealing or unappealing about group therapy? Why would or wouldn't you go to group therapy?

Summary of Responses: A small number of participants had participated in group therapy and overall found it helpful. Hearing and learning from others and making friends was cited as beneficial. Participants who choose not to or have never used group therapy or find it unappealing had concerns about confidentiality. Participants expressed that if a client has difficult, complex issues to overcome, one-on-one therapy would be better than group therapy. Private people or those with difficulty talking also find group therapy unappealing.

List of Responses (paraphrased focus group participant responses):

Appealing Aspect of Group Therapy:

- Would be ok if you are with people with shared experiences
- Voluntary clients are more invested, but some court-ordered participants just show up because they must
- If in a group, you're not going to be judged
- It's a way to make friends
- Hearing other's stories makes you feel you are not alone
- Group trust is necessary

Non-appealing Aspects of Group Therapy:

- Concerns about confidentiality if people talk outside of the group
- Have trouble just talking one-on-one with the therapist, never mind talking in a group
- Private people don't want to share their issues with strangers
- I have a lot to work through that I am not comfortable exposing to others
- Can be invasive

Question 8: What services do you think are most important for people living with behavioral health needs? What services are needed but not available?

Summary of Responses: There were a variety of responses to this question. Many of the needs expressed were conveyed throughout the entire focus group sessions in response to other questions posed. The focus group participants clearly expressed the need for medication management, case coordination, improved crisis services and transportation. Participants also voiced needs for supportive services such as housing, parenting classes, trauma-informed care, services specific for domestic violence victims, services for persons upon discharge from residential treatment facilities, specific services for children, peer services in schools, food at day treatment facilities, and primary, vision and dental care. Participants summarized that services need to be available for everyone and not just limited to the specific needs or behavioral issues of certain individuals.

List of Responses (paraphrased focus group participant responses):

Most important service needs:

- Medication management
- Medication and talk therapy in tandem, individually they don't work
- Case coordination
- Crisis services
- Psychiatric urgent care
- Community supervision
- Housing, residential facility
- Expansion of FACT team services

- Transportation to services

Services not available:

- Supportive housing, residential
- Separate facilities for children
- School therapists only serve females – need the same service for males
- Peer services, particularly in schools
- Wrap-around services – FACT team, MAT team; more services in the community to help those who come out of residential treatment
- Parenting class for those whose children go to residential, to stop the cycle, help the whole family
- Trauma-informed care for adopted children and parents of adopted children
- Service for everyone, not just limited to certain individuals
- Vision services
- Primary and dental care
- Group for women who are victims of domestic violence. (Some centers have counseling but can go to regular providers through Meridian)
- No food services at social rehab (day treatment that lasts all day), have to bring in own food, snacks in morning

Question 9: Are there groups of people who have a difficult time getting the behavioral health services they need? If so, who are those people and why is it more difficult for them to access the services.

Summary of Responses: The responses to this question about groups of people who have a difficult time getting behavioral health services are reflective of many of the barrier issues discussed by the focus group participants throughout the sessions. Participants expressed that there many groups and individuals who face disparities caused by their environment and various social determinants of health including lack of health insurance, race, poverty, education, housing deficiencies, income, and language barriers.

List of Responses (paraphrased focus group participant responses):

- People who don't have transportation
- Low-income persons can't get gas, or don't have a car
- People who have social anxiety to get treatment
- Hard to get into a van full of people if you have social anxiety
- People with language barriers
- People with different types of abilities (physical, behavioral, intellectual, developmental)
- People without resources
- People out of jail or state hospitals
- Groups that have difficult time include children. Services not available especially if you don't have health insurance

- Homeless people, people who don't know how or where, might be scared or intimidated
- Hard to get help until you get in trouble and incarcerated
- Those that must go to detox first to get help
- Detox is more for alcoholics, not for cocaine, other drugs
- Insurance, drug of choice, stable housing are issues, getting arrested or negative act gets you to services
- Those in poverty and people of color, it's (services) not as open to them, not as offered to them as often as it is to others.
- Persons who suffer addiction remain in poverty if they are unable to maintain steady employment
- People not educated about mental health, parents are addicted, I had to wait till I was older to make my own decisions, environment makes it difficult to access services
- Homeless population needs services, but they can't access it, community services are needed

Question 10: If there was anything you could change about behavioral health services, what would it be?

Summary of Responses: While many of the responses to this question reflect needs for improvements in the delivery and availability of behavioral health services for many groups and individuals, participants expressed that many people need services. Focus group participants expressed that mainstreaming behavioral/mental health care by removing stigmas and elevating acceptance, compassion, and competencies of medical providers to treat and coordinate care will provide opportunities for everyone to have a chance to succeed and achieve mental and physical wellbeing.

List of Responses (paraphrased focus group participant responses):

- Remove barriers so everyone has a chance to receive services barriers
- Increase supply of services. There is such a demand and low supply
- Improved coordination between the providers
- Information sharing between facilities and providers
- Continuum of care increasing staff, weekend appointments, wrap around services, including housing and weekend hours
- Improve the criminal justice system role in behavioral health care
- Competence of providers
- Integrated care, therapist like a primary care doctor, medicines
- Training for medical personnel such as primary care physicians
- Compassion and understanding from providers
- Safe transportation
- Remove stigma, need ER staff nurses and doctors to take mental health seriously
- Get help with the different types of little problems and get the proper help, proper medications
- Services are segmented

- Better diagnosis
- Improved services for children and adolescents to prevent Baker Act admissions and related crisis
- Insurance

NO WRONG DOOR SURVEY SUMMARY

BACKGROUND

The Behavioral Health Needs Assessment No Wrong Door (NWD) survey was available in March 2022 for several weeks. It was distributed by LSFHS to staff at funded providers via email.

The NWD Survey included 17 questions. The purpose of the survey was to access the extent to which providers have implemented six criteria adopted from the Administration for Community Living as the integrated system with key consideration of: information, referral, and community awareness, person-centered counseling, eligibility determination, person-centered transition support, partnerships and stakeholder involvement, and quality assurance and continuous improvement.

A total of 80 responses were collected during the survey period. Providers who responded worked in a variety of settings (providers could select all that applied) including:

- Adult Crisis Unit (8.9%)
- Adult Detoxification Unit (2.4%)
- Adult Residential Facility (4.9%)
- Adult Residential Facility (4.9%)
- Adult Outpatient Program (46.3%)
- Adult Mobile Response (4.9%)
- Children's Crisis Unit (3.3%)
- Children's Detoxification Unit (0%)
- Children's Residential Facility (2.4%)
- Children's Outpatient Program (18.7%)
- Children's Mobile Response (4.1%)
- Peer Recovery Support (2.4%)

Most respondents worked in organizations that provide Adult Outpatient Programs or Children's Outpatient Programs.

SURVEY RESPONSES

The following narrative summarizes responses to each survey question. The survey question is provided in Italics and is followed with the responses according to percentage.

Question: *Do you think the "No Wrong Door" access works well within your organization?*

- Yes (65%)

- No (6.3%)
- Not Sure (28.8%)

Question: *From your perspective, your organization has a role to play in the "No Wrong Door" access.*

- Yes (81.3%)
- No (1.3%)
- Not Sure (17.5%)

Most respondents agreed their organization has a role to play in NWD access.

Question: *In your opinion, your organization has a strong care coordination process that includes warm handoffs to services and seamless care coordination.*

- Strongly Agree (37.5%)
- Agree (45%)
- Not Sure (6.3%)
- Disagree (7.5%)
- Strongly Disagree (1.3%)
- No Response (2.5%)

More than 82% of providers "strongly agreed" or "agreed" their organization has a strong care coordination process that provides warm handoffs to services, yet 8.8% disagreed or strongly disagreed.

Question: *In your opinion, your organization has taken action to improve the referral and care coordination process for individuals served.*

- Strongly Agree (47.5%)
- Agree (36.3%)
- Not Sure (12.5%)
- Disagree (1.3%)
- Strongly Disagree (1.3%)
- No Response (1.3%)

According to respondents, 83.8% of organizations have improved the referral and care coordination process for individuals served while 2.6% of respondents did not believe their organization had improved the referral and care coordination process. Given these responses,

there may be room for continued improvement, however, organizations have already made strides in improvement efforts.

Question: *In your opinion, linkages to crisis intervention and support (like the Mobile Response Teams, medication management, CRF, CIT Officer, BA, CSU, etc.) are occurring.*

- Strongly Agree (30%)
- Agree (45%)
- Not Sure (20%)
- Disagree (5%)
- Strongly Disagree (0%)

Given that nearly 20% of respondents were "Not Sure", providers may need more information regarding linkages to crisis intervention and support services in their service area.

Question: *In your opinion, your organization promotes its services and resources very well.*

- Strongly Agree (33.8%)
- Agree (41.3%)
- Not Sure (11.3%)
- Disagree (8.8%)
- Strongly Disagree (3.8%)
- No Response (1.3%)

More than three-quarters of respondents "agreed" or "strongly agreed" that their organization promotes its services and resources well. Twelve percent "disagreed" or "strongly disagreed" which indicates an opportunity for improving the promotion of services and resources.

Question: *In your opinion, your organization promotes awareness of available options and linkages to needed services?*

- Strongly Agree (38.8%)
- Agree (38.8%)
- Not Sure (13.8%)
- Disagree (6.3%)
- Strongly Disagree (2.5%)

More than three-quarters of survey respondents "agreed" or "strongly agreed" that awareness of available options and linkages to needed services were promoted by their organizations. However,

more than 20% were “not sure” or “disagreed” to some extent, indicating that more can be done for such promotion and linkages.

Question: *In your opinion, your organization provides person-centered care for all individuals served.*

- Strongly Agree (50%)
- Agree (40%)
- Not Sure (7.5%)
- Disagree (2.5%)
- Strongly Disagree (0%)

Ninety percent of respondents “agreed” or “strongly disagreed” that their organization provides person-centered care for all individuals served with 2.5% who ‘disagreed” indicating a high confidence in the provision of person-centered care.

Question: *In your opinion your agency hires employees who are culturally sensitive and culturally competent for the population served?*

- Strongly Agree (42.5%)
- Agree (43.8%)
- Not Sure (12.5%)
- Disagree (1.3%)
- Strongly Disagree (0%)

Overall, respondents believed their organization hires culturally sensitive and culturally competent staff.

Question: *In your opinion, it is easy for individuals to access the services they need quickly and efficiently.*

- Strongly Agree (23.8%)
- Agree (36.3%)
- Not Sure (12.5%)
- Disagree (20%)
- Strongly Disagree (7.5%)

Sixty percent of respondents believed it is easy for individuals to access the services they need quickly and efficiently while 27% of respondents “disagree” or “strongly disagree.” The result points to the need for further assessment of how individuals access services.

Question: *Do you think a standard intake and screening process for state agencies and community partners would help individuals get into services more quickly?*

- Yes (55%)
- No (12.5%)
- Not Sure (32.5%)

Respondents' opinions regarding a standard intake process were mixed. While some respondents believed a standard intake process would help (50%), many were unsure (32.5%) or did not think it would help (12.5%).

Question: *In your opinion, your organization encourages working with other community partners to ensure care coordination.*

- Strongly Agree (43.8%)
- Agree (41.3%)
- Not Sure (8.8%)
- Disagree (5%)
- Strongly Disagree (0%)
- No Response (1.3%)

Most respondents "strongly agreed" or "agreed" their organization works well with community partners ensuring care coordination.

Question: *In your opinion, individuals in need of services have equal access to care.*

- Strongly Agree (38.8%)
- Agree (23.8%)
- Not Sure (15%)
- Disagree (18.8%)
- Strongly Disagree (3.8%)

Many respondents (22.5%) "disagreed" or "strongly disagreed" that individuals in need of services have equal access while 15% of respondents were "not sure."

Question: *In your opinion, Stakeholders help to address and advocate for equal access to care in system entry points.*

- Strongly Agree (13.8%)
- Agree (38.8%)
- Not Sure (35%)
- Disagree (10%)
- Strongly Disagree (2.5%)

Slightly more than half of the respondents “strongly agreed” or “agreed” that stakeholders help to address and advocate for equal access to care in system entry points while (35%) of respondents were “not sure.”

Question: *In your opinion, your organization ensures that services are of high quality and meet the needs of individuals served.*

- Strongly Agree (42.5%)
- Agree (47.5%)
- Not Sure (6.3%)
- Disagree (3.8%)
- Strongly Disagree (0%)

Survey respondents were in strong agreement (90%) that their organizations ensure high quality services are delivered and that they meet the needs of individuals.

Question: *In your opinion, your organization tracks individuals served, services, performance, and costs to continually evaluate and improve outcomes?*

- Strongly Agree (31.3%)
- Agree (52.5%)
- Not Sure (15%)
- Disagree (1.3%)
- Strongly Disagree (0%)

More than 80% of respondents “strongly agreed” or “agreed” their organization tracks individuals served, services, performance, and costs to continually evaluate and improve outcomes indicating continuous improvement is a strong component of provider organizations’ processes.

NO WRONG DOOR SURVEY CHARTS

Figure 121: I work in a/an...

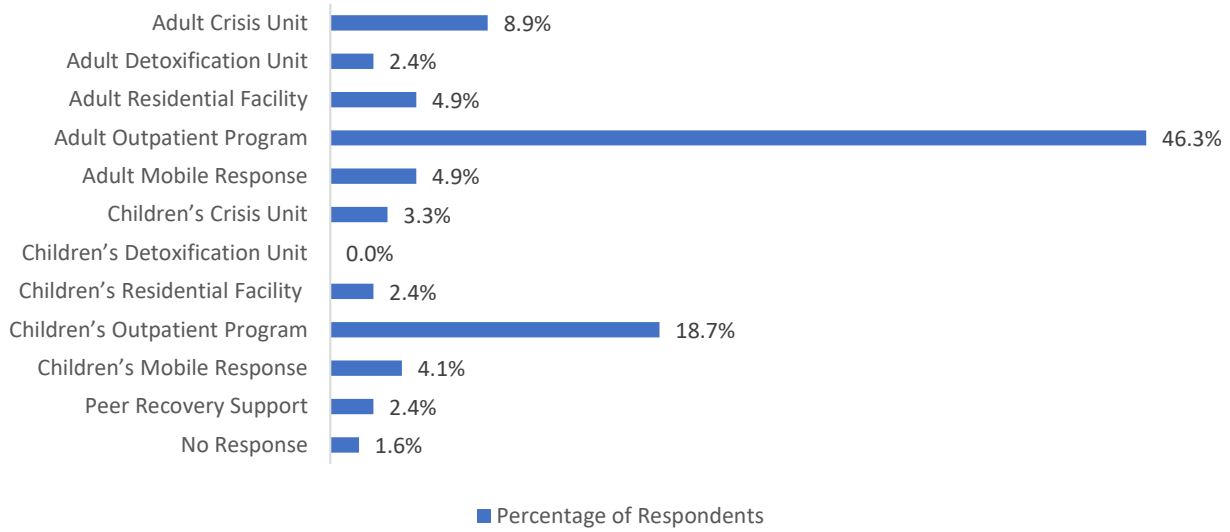


Figure 122: Do you think the "No Wrong Door" access works well within your organization?

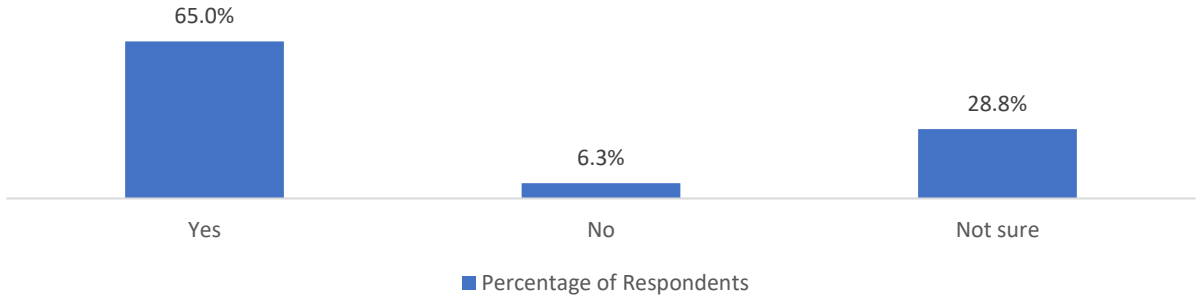


Figure 123: From your perspective your organization has a role to play in the "No Wrong Door" access.

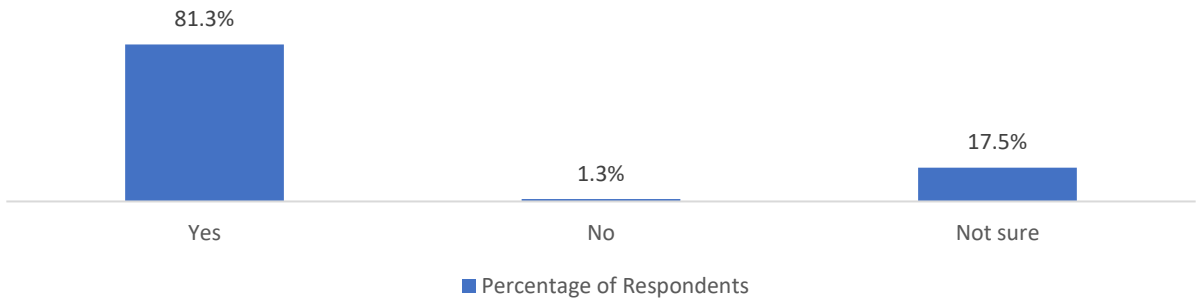


Figure 124: In your opinion, your organization has a strong care coordination process that includes warm handoffs to service and seamless care coordination.

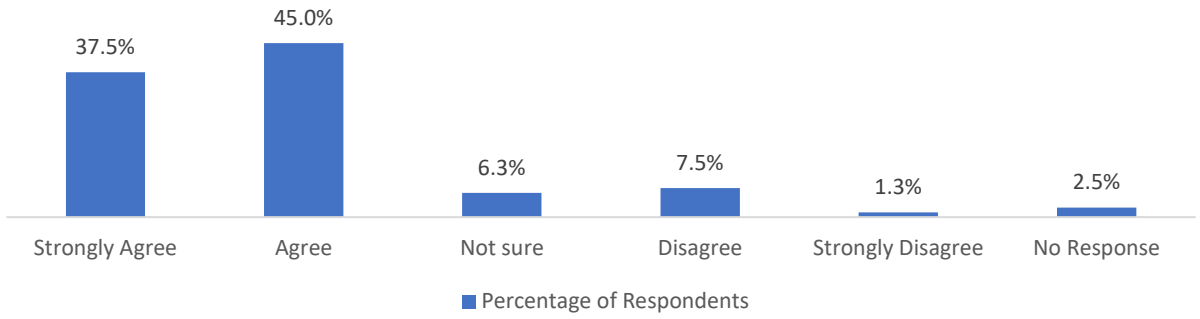


Figure 125: In your opinion, your organization has taken action to improve the referral and care coordination process for individuals served.

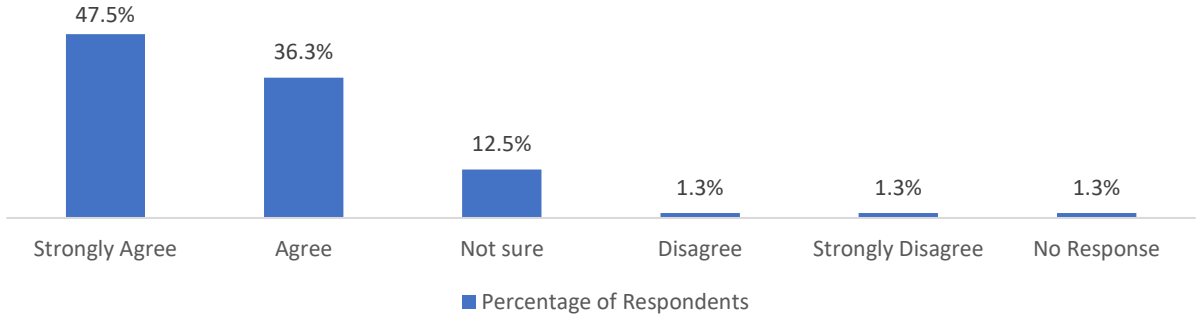


Figure 126: In your opinion, linkages to crisis intervention and support (like the Mobile Response Team, medication management, CRF, CIT Officer, BA, CSU, etc.) are occurring.

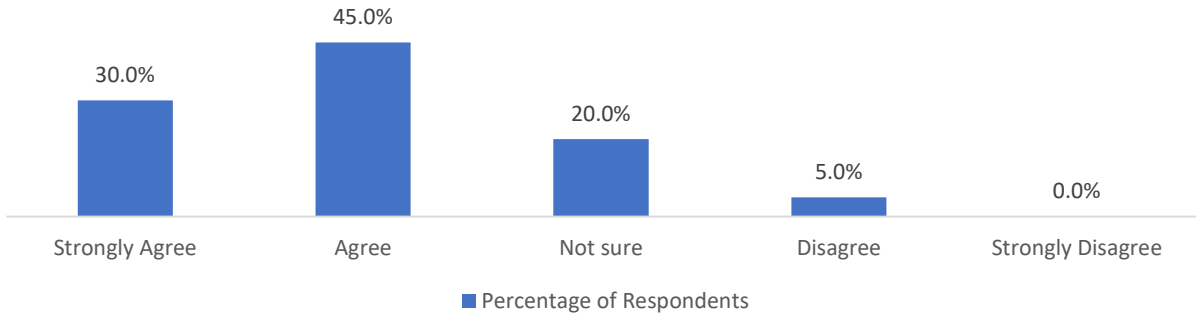


Figure 127: In your opinion, your organization promotes its services and resources very well.

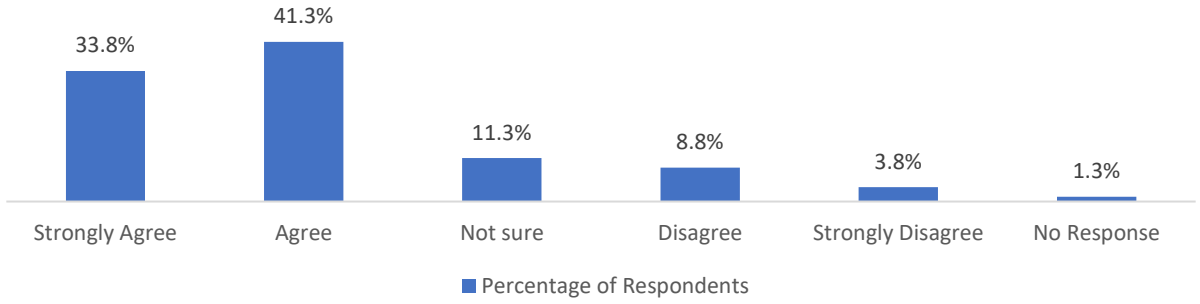


Figure 128: In your opinion, your organization promotes awareness of available options and linkages to needed services.

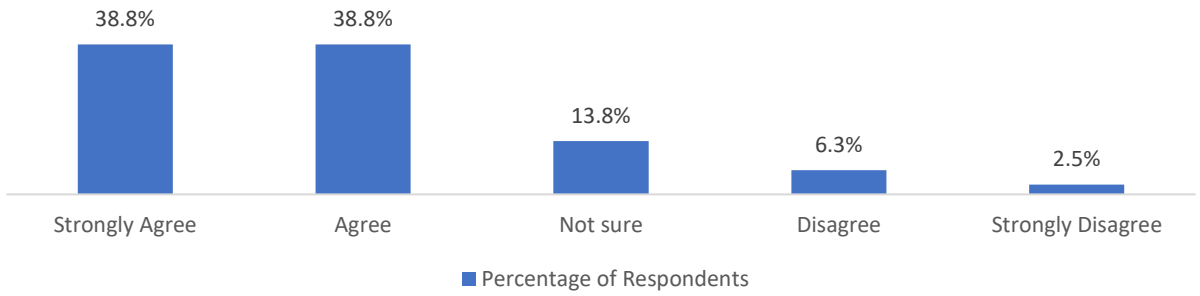


Figure 129: In your opinion, your organization provides person-centered care for all individuals served.

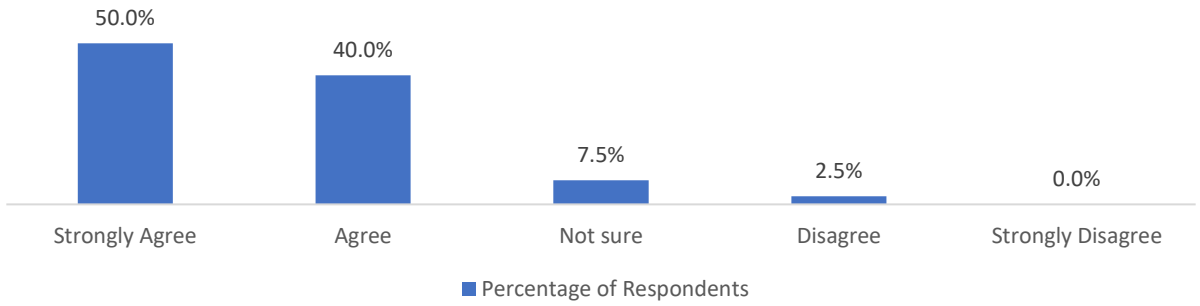


Figure 130: In your opinion, your agency hires employees who are culturally sensitive and culturally competent for the population served.

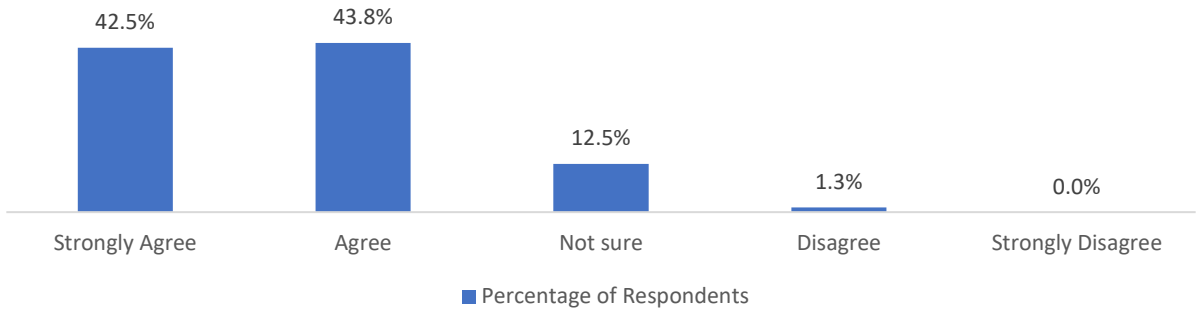


Figure 131: In your opinion, it's easy for individuals to access the services they need quickly and efficiently.

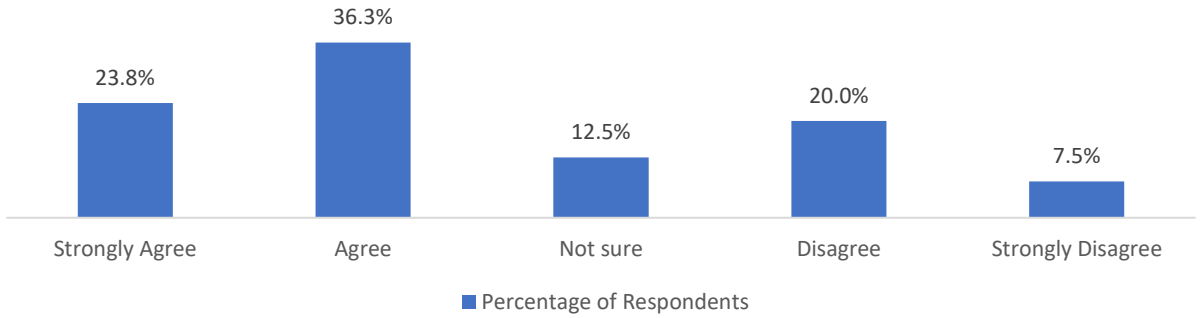


Figure 132: Do you think a standard intake and screening process for the state agencies and community partners would help individuals get into services more quickly?

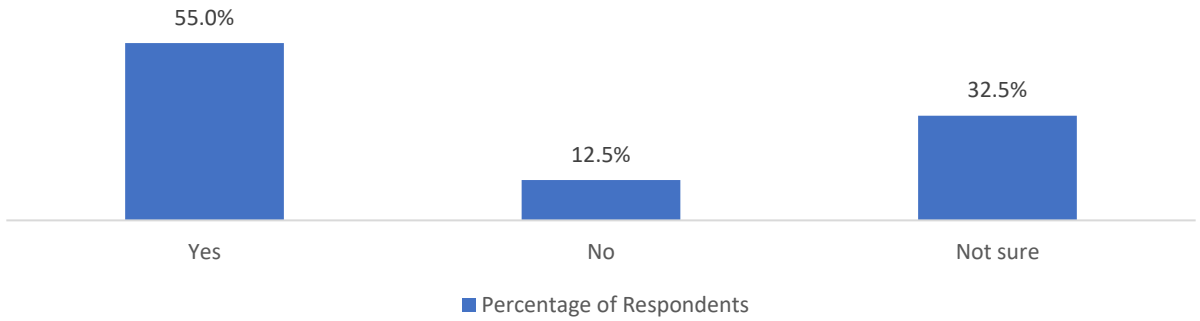


Figure 133: In your opinion, your organization encourages (promotes) working with other community partners to ensure care coordination.

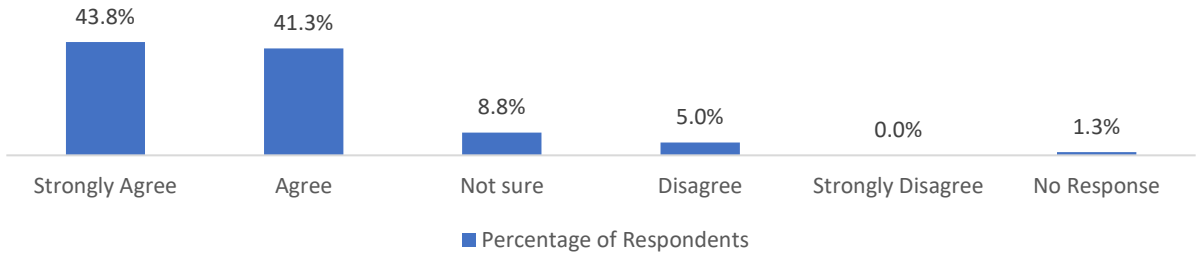


Figure 134: In your opinion, individuals in need of services have equal access to care.

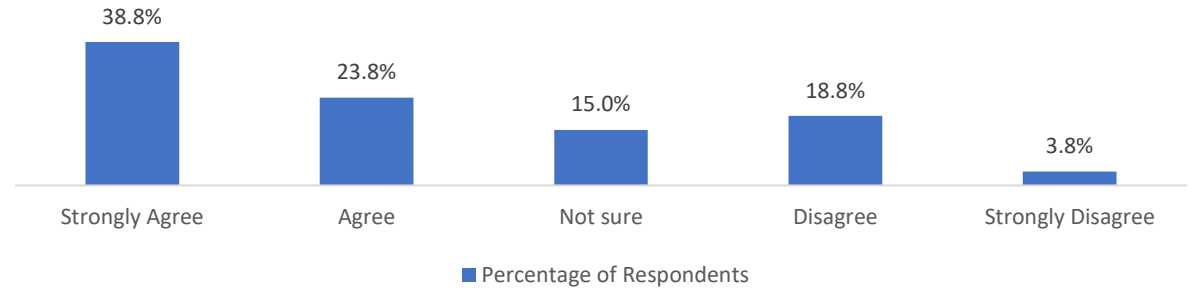


Figure 135: in your opinion, stakeholders help to address and advocate for equal access to care in system entry points.

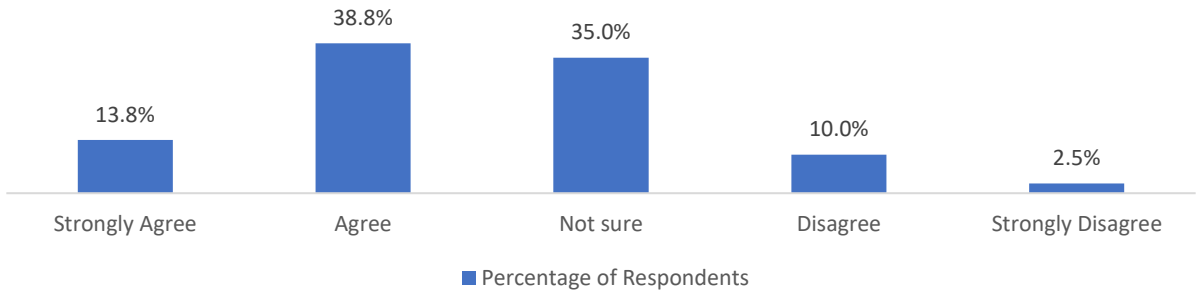


Figure 136: In your opinion, your organization ensures that services are of high quality and meet the needs of individuals served.

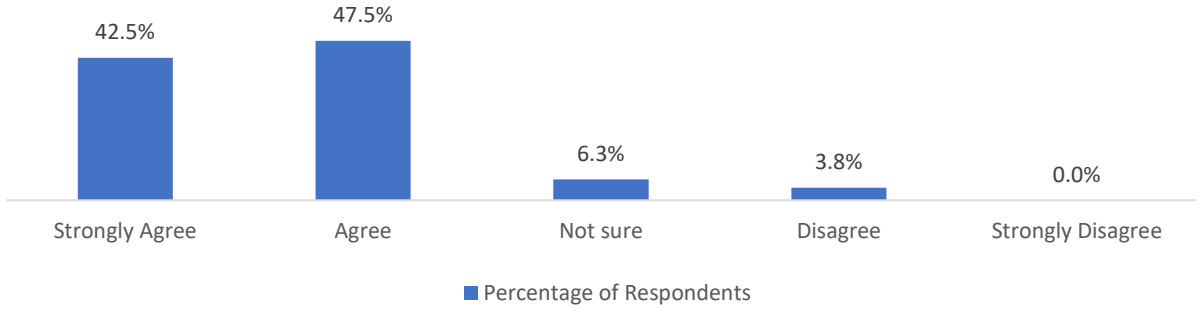
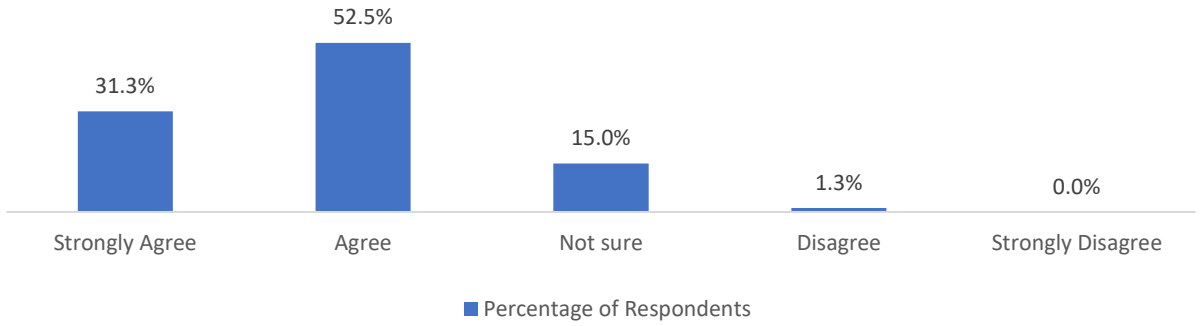


Figure 137: In your opinion, your organization tracks individuals served, services, performances, and costs to continually evaluate and improve outcomes.



NO WRONG DOOR LSFHS PROVIDER FOCUS GROUP SUMMARY

FOCUS GROUP METHODOLOGY

LSFHS is one of seven behavioral health Managing Entities (ME) contracted by the Florida Department of Children and Families to manage the state-funded system of behavioral health care for people who face poverty and are without insurance. LSFHS serves a 23-county region in Northeast and North Central Florida which includes the counties of Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Hernando, Lake, Lafayette, Levy, Marion, Nassau, Putnam, St. Johns, Sumter, Suwannee, Union, and Volusia.

LSFHS promoted the NWD Provider focus groups to contracted provider leaders. Three focus groups were facilitated by WellFlorida Council via the Zoom Platform and each focus group was one hour in length. The script of six questions (see below) about behavioral health services in the managing entity service area was utilized to obtain the feedback from the participants. A summary of the respondents' input is provided below.

SCHEDULE OF FOCUS GROUP SESSIONS

Date (2022)	Time	Estimated Number of Participants
April 22	1:00 - 2:00 pm	5
April 25	12:00 - 1:00 pm	8
April 26	9:00 - 10:00 am	5

FOCUS GROUP SUMMARY

Each of the three focus groups followed the same focus group script. The following pages present summaries of the focus group participants' responses to each question. A summary of the responses across the three groups for each of the six questions is provided. The summaries are followed by themes that were identified.

Question 1: In what ways has your organization improved referral and care coordination? What are suggestions for continued improvement?

Summary of Responses: Referrals are now accessible online for convenience and providers work with many partners to promote services and remove barriers to services. To remove direct access barriers, providers meet individuals where they are, such as in the home, school, community locations, etc. The online referral form allows anyone to refer individuals served from anywhere.

Some providers have incorporated monthly meetings with care coordination teams. These meetings provide a regular opportunity to examine referral sources, 30-day readmission rates, and other metrics to improve services and processes. Provision of services in additional locations has improved referral and care coordination. One provider shared his experience working with LSF for technical assistance related to improving referrals and care coordination. In his opinion, improvements based on the technical assistance received made a noticeable difference in referrals and care coordination. A provider expressed that many changes in the intake process occurred including assigning an assistant to manage phone calls and communications for referrals and care coordination. This organization now completes the formalized intake process in person. This required hiring additional staff and finding grants to fund those new staff positions geared at improving the referral process and care coordination.

List of Responses (Paraphrased focus group participant responses):

- Online referral forms
- Meeting individuals served in person in locations that are convenient to them such as in schools, their home, community organizations, etc.
- Improved referral processes with partnering community organizations
- Monthly meetings to review referrals and success and challenges
- Difficult to engage the parents and without their engagement children are often not referred or treated
- Paperwork takes four times the amount of time than the time to work with people
- LSF helped our organization improve and streamline our services. Noticeable improvements have been made in a short time.
- Hired additional staff to assist with referrals and care coordination
- Applied to grants and received additional funding to support additional referral and care coordination staff
- Formalized intake as an in-person process
- Staff offer in-home services to maintain contact with individuals served
- Continual improvements occurring

Question 2: How does your agency promote awareness of available options and possible linkages to needed services? What else can be done to increase awareness of behavioral health services?

Summary of Responses: Agencies expressed a variety of promotional activities including community outreach to the public and organizations, internet-based promotion, speaking engagements, resource guides, and social media, however, most respondents agreed that their expertise is not in marketing and that efforts could most likely be improved. Restricted funding creates challenges for the availability of services especially for persons in need of services who are commercially insured as many of the programs are not reimbursed by commercial insurances. For example: If a person does not have insurance, they have access to programs, but it is difficult to

provide care coordination for individuals served with commercial insurance when their insurance does not cover the services provided. MOUs with partners has improved care coordination.

List of Responses (Paraphrased focus group participant responses):

How does your agency promote awareness of available options and possible linkages to needed services?

- Social Media
- Community Outreach
- Speaking engagements
- Paid advertising
- Resource Guides (being listed in)
- Communication team assigned to promote awareness of services
- Care coordinators will soon be located at juvenile care centers in Volusia
- Partnerships with other organizations
- Provide trainings to school guidance counselors

What else can be done to increase awareness of behavioral health services?

- Continued outreach
- Improved overall marketing (efforts guided by someone with marketing expertise)
- Ability to serve all individuals with the services that are the best fit for their needs regardless of insurance status and ability to pay

Question 3: What resources or supports does your agency need to improve person-centered care?

Summary of Responses: Common themes among focus group participants for needed resources or supports were additional funding for existing funded/allowable services, funding for services that are not currently allowable under Medicaid, the ability to recruit, hire and maintain staff, ability to seek and receive reimbursement for all best practices, and an increase in Medicaid reimbursement rates.

List of Responses (Paraphrased focus group participant responses):

- Additional funding
- Funding to cover the cost of services for persons with private insurance
- Difficult to recruit and hire new staff, difficult to retain staff
- Lack of individuals who want to work in publicly funded behavioral health due to lower salaries than those in private practice
- Young professionals want to earn more money than they can earn in behavioral health, so they are not entering the behavioral health field.

- Need access to free training on evidence-based practices
- Need increased Medicaid reimbursement rates to ensure we can provide adequate services
- Funding for non-funded services that are best practices

Question 4: What does your organization do or provide that helps people access services quickly and easily? What barriers prevent easy and quick access to services?

Summary of Responses: Providers responded that telehealth, mobile buses, walk-in availability, peers, working closely with law enforcement, 24/7 response teams, and low cost or no cost services (for those who qualify) help people access services quickly and easily. Providers responded that limited internet access, transportation, paperwork, lack of staff, fear, stigma, language barriers, and awareness of available services were barriers to quick and easy access to services.

List of Responses (Paraphrased focus group participant responses):

What does your organization do or provide that helps people access services quickly and easily?

- Telehealth allows us to leverage staff from one area to serve individuals in a different area. Expansion of that service is expected because it helps reduce the waiting time for individuals served.
- Purchased a mobile bus
- Open access – people come in/walk in and are immediately able to see a clinician and have an assessment and treatment plan.
- Telehealth
- Walk-ins are able to see a clinician and have an assessment, receive a treatment plan, and go to a group session that day if the client wants. People can have their first treatment session in 4 days.
- Peers in the emergency room allows individuals served to immediately receive treatment and the peers see anyone, regardless of opioid use disorder.
- Work closely with the police department on crisis cases and get through the crisis before burdening individuals served with paperwork. Paperwork can be time intensive, so we worked with insurance companies to determine what part of the paperwork is absolutely necessary.
- 24/7 response team and emergency screening
- 24/7 access center to accept referrals and coordinate intake
- Peers
- Low cost or no cost services for persons who qualify

What barriers prevent easy and quick access to services?

- Telehealth can be a barrier when internet service is limited or not strong

- Transportation
- Paperwork
- Lack of staffing
- Fear
- Stigma
- Language barriers
- Barriers for persons with limited hearing
- Provider capacity
- People in the community not knowing about the services available and the affordability of those services (some people qualify for free or reduced cost services)
- Limited funding

Question 5: What would a standard intake and screening process for state agencies and community partners look like?

Summary of Responses: Providers expressed concerns related to a standard intake and screening process. Concerns centered on the volume of paperwork needed by various agencies and the inability to limit the standard intake and screening process in a way that will reduce paperwork burdens on individuals served and providers. Redundancy in collecting information from individuals served is frustrating for providers and individuals, but not all providers require the same information from persons served. Providers found value in a more streamlined process for individuals served and providers, especially given the high volume of paperwork required. Providers also expressed a desire to share information more quickly with other providers especially related those who utilize behavioral health services frequently throughout the state. Paperwork required by providers is often determined by accrediting bodies and funding sources and these vary at each provider causing significant challenges in creating a standard intake and screening process. Providers stressed the need to negotiate with funders about required forms and to limit what is collected to only the items that providers can justify. Forms are complicated and hard to understand making it difficult for individuals to fill out forms accurately and quickly.

List of Responses (Paraphrased focus group participant responses):

- Standard process would be ideal but highly unlikely
- Release of information forms allow us to see records, but it often takes a long time to receive the records. Having access to the records would be helpful and a standard process may help with that accessibility
- A standard intake and screening that could be shared between providers would require all providers to use the same electronic record system
- Standard screening tools may be possible, but standard intake and processes overall will be provider specific

- FASAMS (Financial and Services Accountability Management System) could be part of the solution, however, it isn't fully working yet.
- Accrediting bodies all have different standards and providers must comply with those standards
- We need a process that isn't 20-pages long, forms that can be filled out and understood by someone with a 5th grade reading level so our services can start as quickly as possible
- Medicaid requires some information and LSF requires something else
- Is any other state using a standard intake and screening process?
- We need to ask funders: "Why do you need to know this information?" If they cannot justify the request, we should not be required to provide it.

Question 6. Are there individuals in need of services who do not have equal access to care? If so, who are those individuals and what makes it harder for them to have access to care?

Summary of Responses: Providers responded that there are people in services without equal access to care including those with limited transportation, limited internet access, those who have a severe and persistent mentally health condition, those who are involved with the criminal justice system, those with limited health literacy, those living below the poverty line, those with insufficient insurance and high copays, those with disabilities, people of color, LGBTQ+, and other groups who frequently experience health disparities.

List of Responses (Paraphrased focus group participant responses):

- Those involved in the criminal justice system
- People who have a severe and persistent mental health condition
- Lower economic status
- Those in poverty and living below the poverty line
- People who do not trust the system
- People who do not have access to a provider who looks like them
- People of color
- LGBTQ+
- Children with parents lacking resources or unwilling to seek assistance
- Transportation disadvantaged
- People who do not meet the eligibility criteria for funded services
- People with private insurance with high copays
- Rural residents
- Lack of childcare
- Deaf and hard of hearing
- Persons with disabilities
- Persons with limited English proficiency

Additional comments of note:

- It is important for legislatures to know how the system works, that we are seeing the tip of the iceberg for mental health, suicide, overdoes, opioids. This is not going to get better without doing more to provide services and support the peers and providers. These issues impact everything else: child welfare, education, family well-being, everything. When we talk about the staff shortage, how do we get more people in this field and licensed? What will the state do to encourage or incentivize people to go into this field in Florida? How do we identify people in our treatment programs who can become providers?
- Florida is near the bottom of the country in per capita funding for mental health and substance misuse services. The state has been pouring more money into MHSA and it is helping, but it must continue if we are to be in the middle of the nation for resources. We have been woefully underfunded for so long that it takes a while to catch up. How do we sustain the profession of MHSA? Why do I need to be in abject poverty to do this work? Stigma continues to be a barrier for this profession. We have to message our profession differently and people need to value it and we need comparable salaries to recruit new professionals. People feel valued by what they get paid. If you are educated with a master's degree and a license, but you are not making a livable salary, why go into that profession?
- Reduce complexity in billing and paperwork
- Politics has become more important than people and that should change
- Stop persecuting innocent people and start valuing human life
- We need better coordination between the child welfare system and behavioral health system

INDIVIDUALS SERVED SURVEY SUMMARY

BACKGROUND

The Behavioral Health Needs Assessment Individuals Served survey was available in January thru February 2022. It was distributed by LSFHS and their providers to individuals served through various distribution methods including flyers, emails, and word of mouth. To be eligible to complete the survey, respondents must have received a service through a LSFHS funded provider and be at least 18 years of age at the time of the survey. Parents of children individuals served were eligible to respond on behalf of services received by their children.

The survey received 388 responses during the survey period with 16 of the 23 counties in the LSFHS service area represented. Volusia (35.8 %) and Marion (20.4%) counties had the most representation.

Respondents received one of the following service types: adult mental health services, adult substance use services, child mental health services, child substance use services, peer support services, and/or prevention services. The largest percent of responses were from adults who received or receive adult substance use serves (49.9%) followed by adult mental health services at 25.7% of respondents. Responses for child mental health services (7.7%) and child substance use services (2.6%) were limited. Peer support services represented 6.9% of responses and prevention services represented 6.4% of responses.

SURVEY RESPONSES

Ninety percent of respondents know where to go for mental health and substance use treatment services, 4.6% were not aware of where to go for those services, and 3.6% said they know where to go “sometimes.” Respondents were asked, “How did you learn about mental health and substance use treatment services when you needed them?” The majority of respondents learned through a family member or friend (31.6%), another individual in treatment/recovery/peer (21.9%), law enforcement (15.3%), and word of mouth (14.9%). Of the remaining respondents, 2.3% learned of services through 2-1-1, social media (5.3%), school, and the mobile crisis team (3.6% each). Less than half (47.9%) of respondents were familiar with 2-1-1 referral line and 59 respondents (15.2%) had ever called 2-1-1. Of those who called the 2-1-1 referral line, 36 respondents found it helpful, seven respondents did not find it helpful, and 16 respondents said it was helpful “sometimes.”

Respondents were asked, “Were you able to get all the services you needed when you needed them?” and nearly 81% responded “Yes” and 19% responded “No.” Those who were unable to get the services they needed were asked a follow-up question to list the services they needed but did not receive. The service needed and not received most was “housing assistance” (10.7%) followed

by “other” (9.8%) and “medication assistance program” (6.8%). Respondents were also asked, “How many times during the last 12 months were you not able to get the services you needed?” Respondents who did not receive services one to two times accounted for 36.7%, 15.2% of respondents did not received services three to four times, and 11.5% of respondents did not receive services five or more times in the last 12 months.

Respondents were asked about the availability of needed services. Sixty-one percent of respondents said the service needed was available, 12% said there was a waitlist, and slightly more than 2% of respondents said the service needed was not available. Most (78%) respondents said the services received were focused on their individual needs, while close to 20% of respondents did not believe the services received were focused on their individual needs.

Survey respondents were asked, “How long did it take from the time you requested an appointment for services to the time you received the services?” The majority of respondents waited 1 to 2 weeks for an appointment (55.9%), 15% waited 3 to 4 weeks, 8.5% reporting never receiving an appointment, and 17% waited over 1 to 2 months for an appointment. Most respondents (69.3%) traveled 30 minutes or less to their appointments with 21.1% traveling 31-60 minutes to their appointments. Respondents drove themselves to the appointment accounted for 31.1%. Those driven by a relative or friend represented 23% of respondents, 9% of respondents walked to their appointment, and 14.2% used the public bus system.

When asked, “What were the obstacles you experienced getting the care you needed?”, respondents said no or very limited transportation (10.5%), long waitlists (9.8%), could not afford the service (8.9%), and 7.3% did not know where to go for services. Those with no barriers accounted for 28.9% of respondents.

INDIVIDUALS SERVED SURVEY CHARTS

Figure 138: Which best describes you?

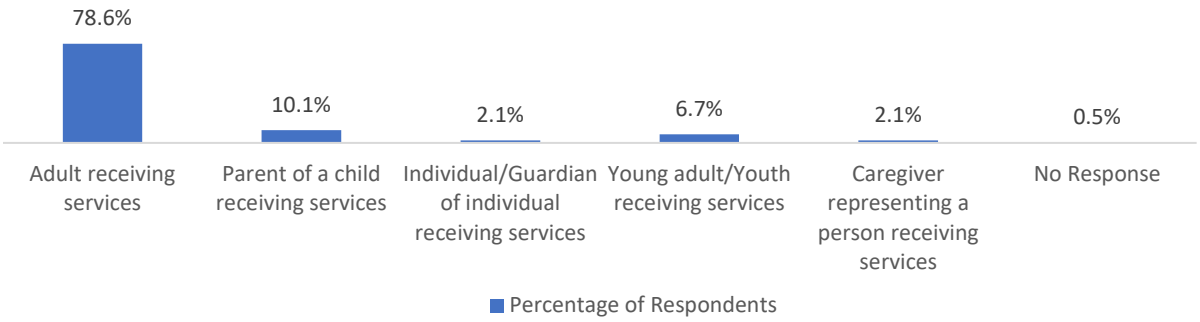


Figure 139: What type of service did you or the person you are representing receive? (Check all that apply)

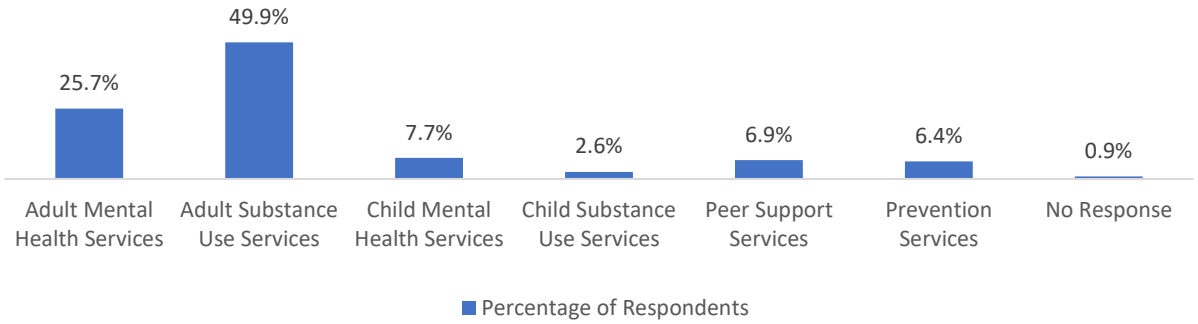


Figure 140: Which county do you live in?

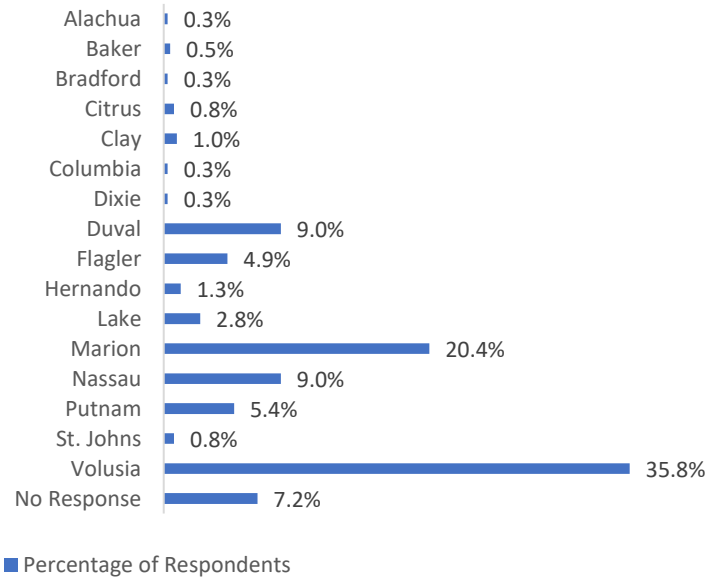


Figure 141: Did you know where to go for mental health and substance use treatment services when you needed them?

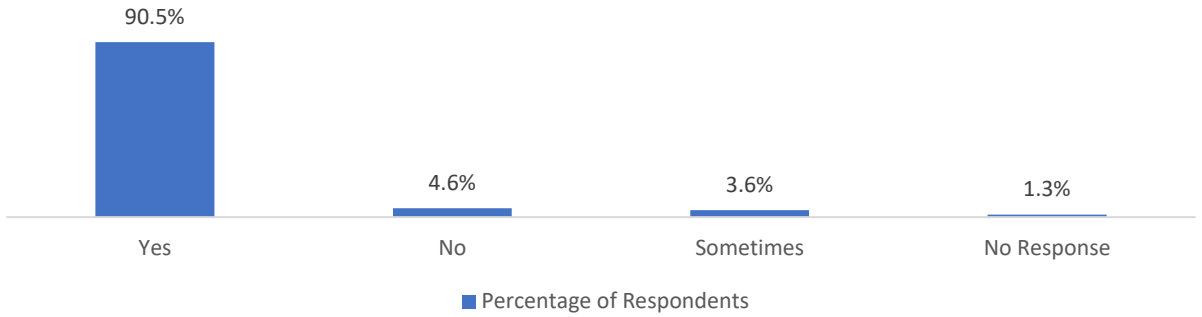


Figure 142: How did you learn about mental health and substance use treatment services when you needed them? (Check all that apply)

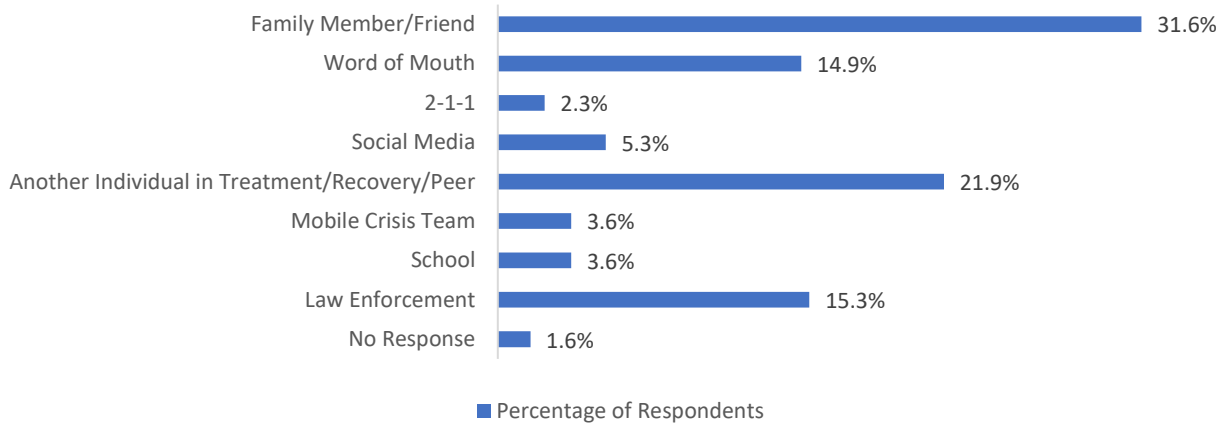


Figure 143: Are you aware of the 2-1-1 Information and Referral Resource in your community?

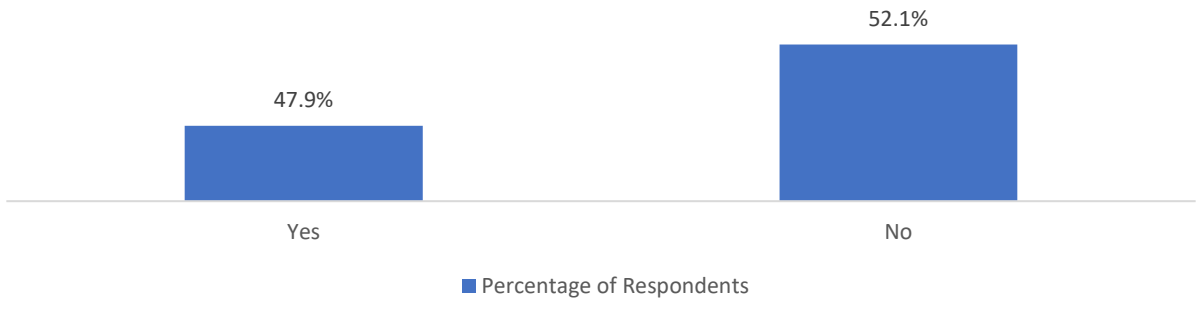


Figure 144: Have you ever called 2-1-1 Information and Referral Resource for assistance?

Figure 145: When you called the 2-1-1 Information and Referral Resource, were they helpful in getting you the services needed?

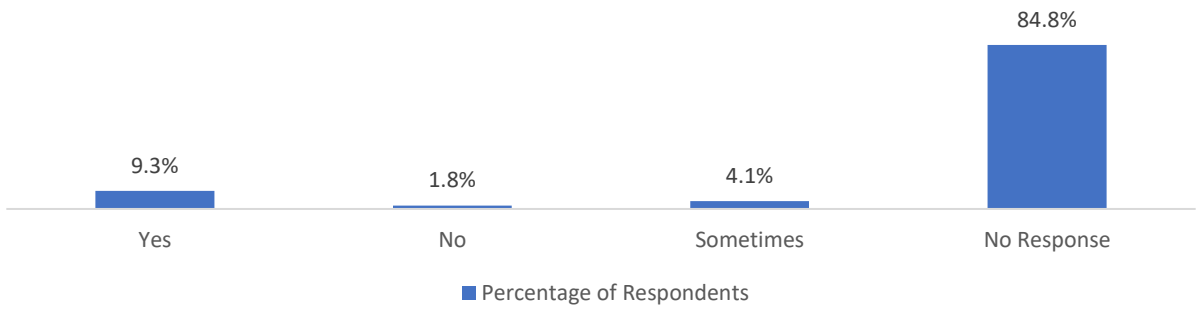


Figure 146: Were you able to get all the services you needed when you needed them?

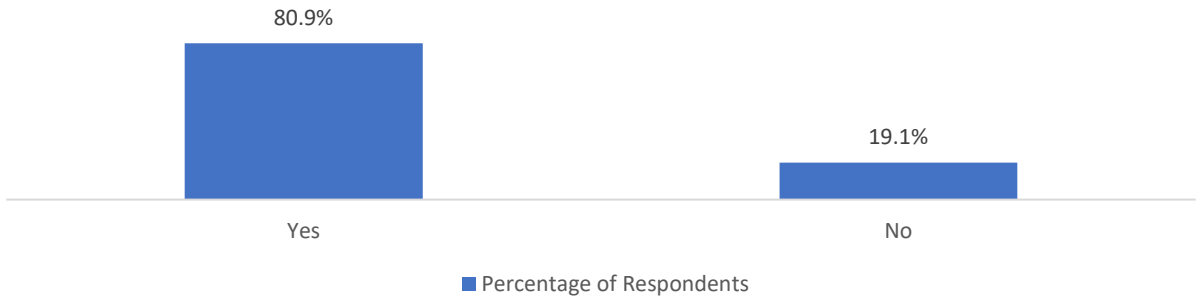


Figure 147: If no, please choose from the list below, the services you needed but were not able to get.

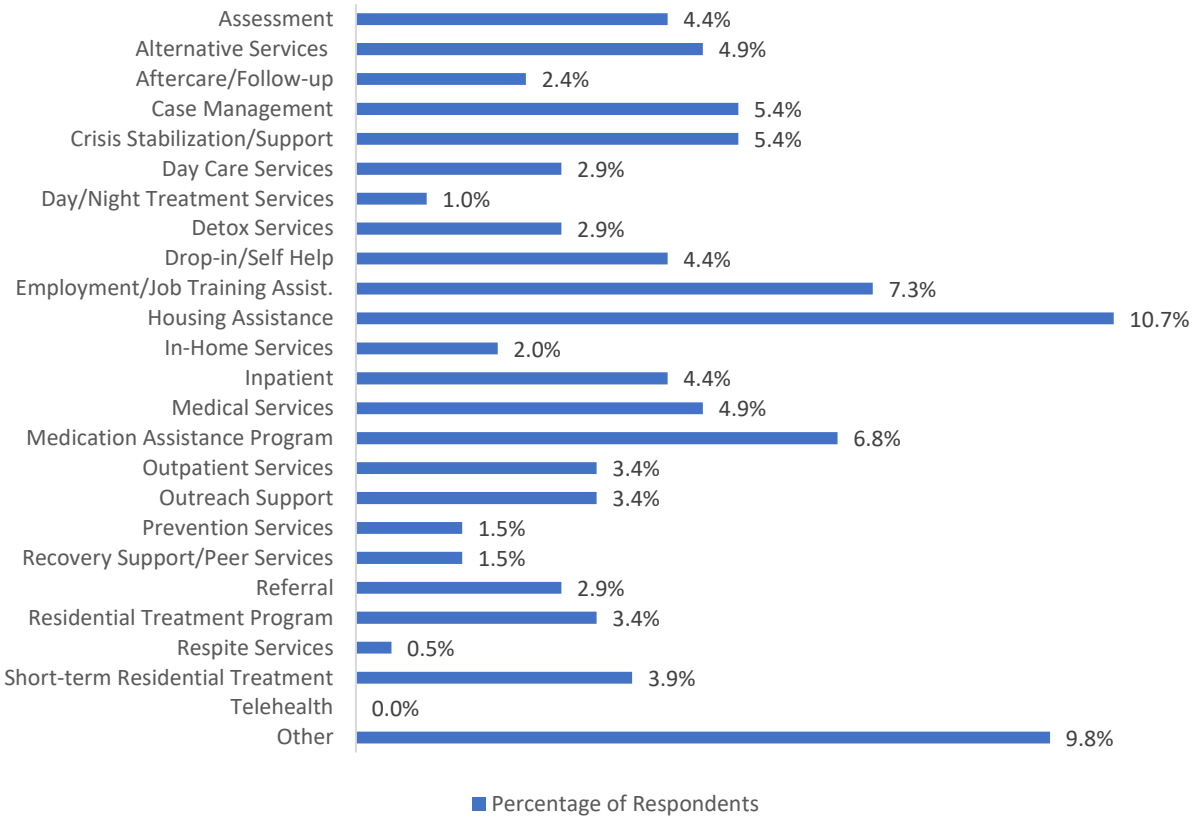


Figure 148: How many times during the last 12 months were you not able to get the services you needed?

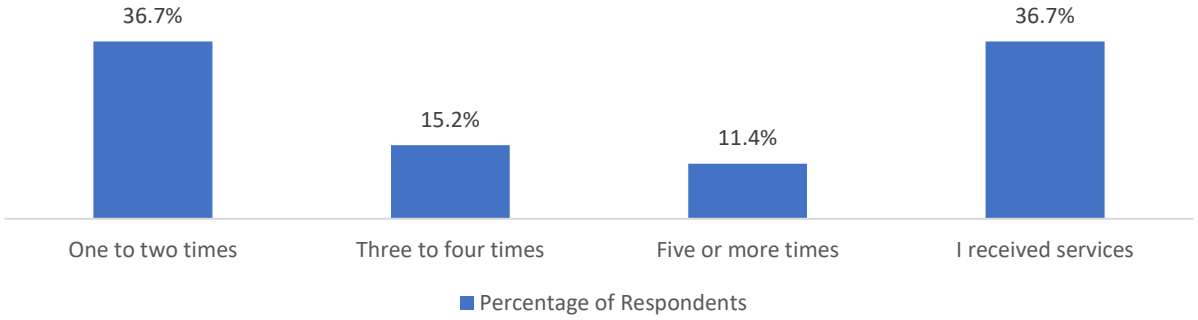


Figure 149: The services I needed were:

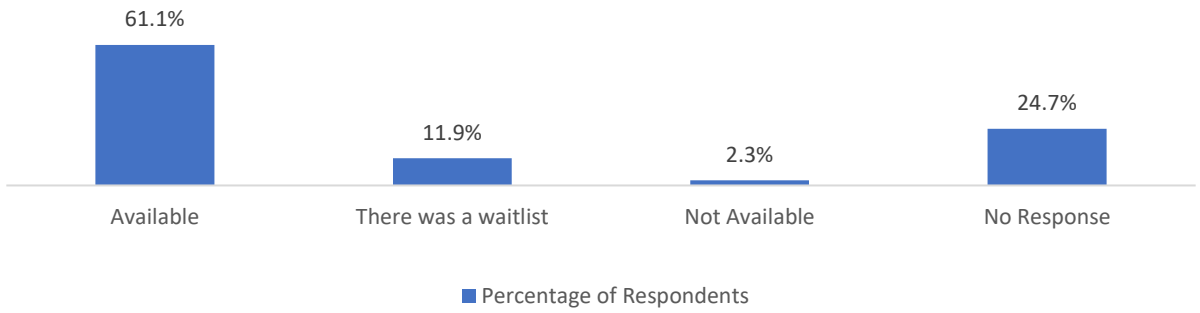


Figure 150: The services and planning I received were focused on my treatment needs (patient centered)

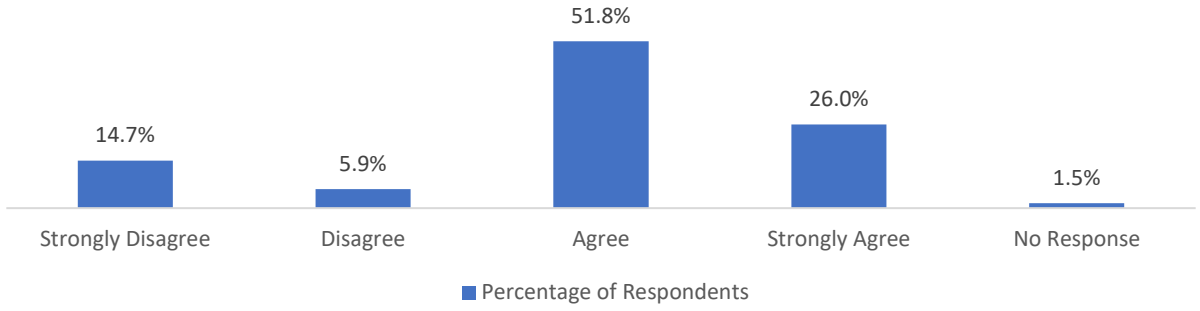


Figure 151: How long did it take from the time you requested an appointment for services to the time you received the services?

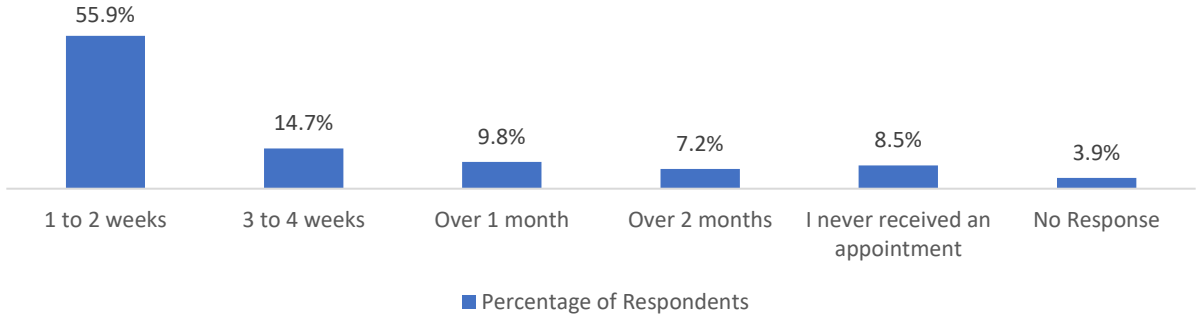


Figure 152: How long did it take you to travel to the service?

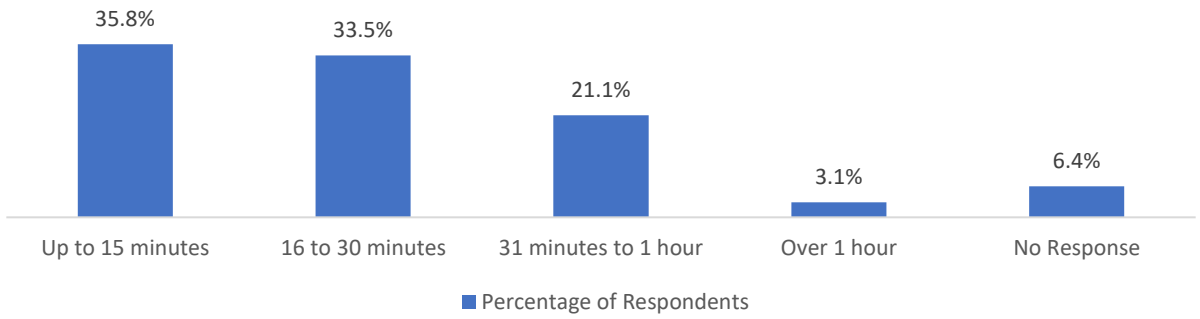
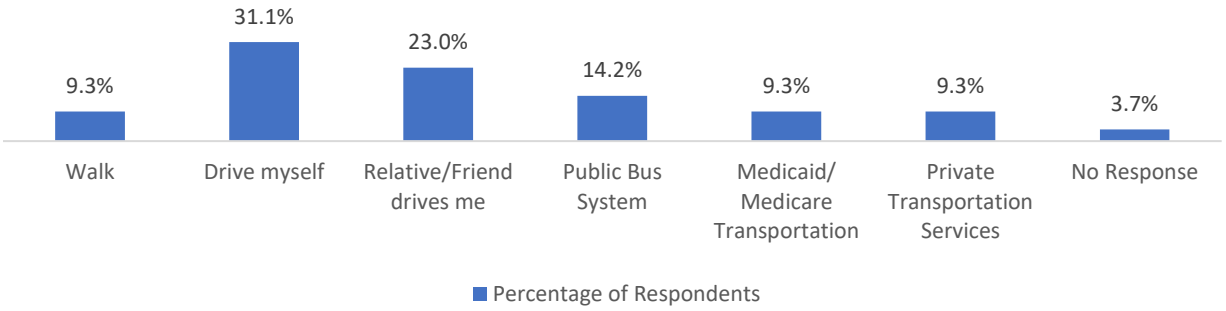
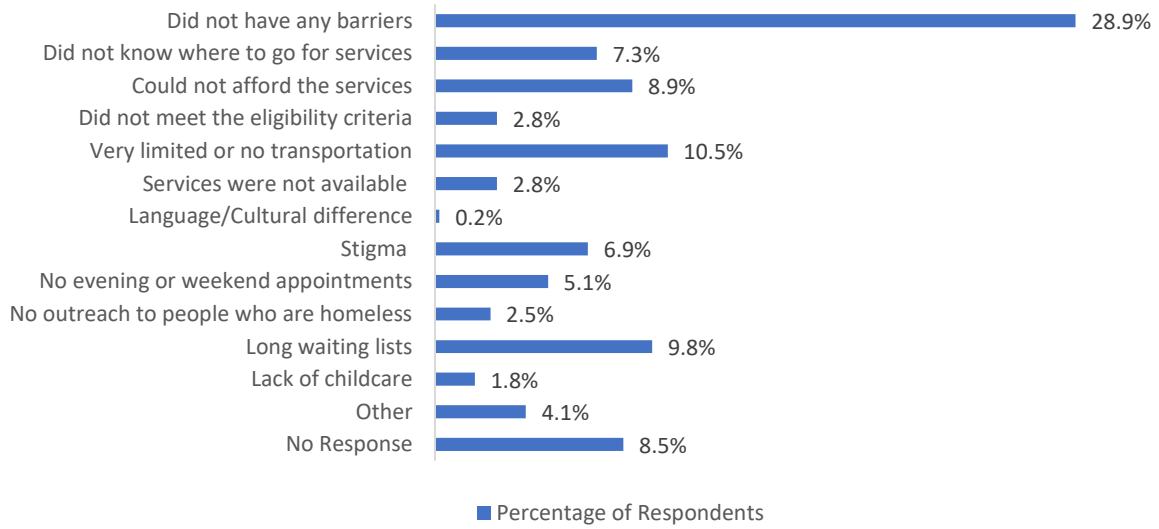


Figure 153: How do you travel to get to services? (Check all that apply)



Note-Private transportation includes Taxi, Uber, Lyft, TOPS, etc.

Figure 154: What were the obstacles you experienced getting the care you needed? (Check all that apply)



Note-Services were not available in the county where I live

STAKEHOLDER SURVEY SUMMARY

BACKGROUND

The Behavioral Health Needs Assessment Stakeholder survey was available in January thru February 2022. It was distributed by LSFHS, their providers, and community partners through various distribution methods including flyers, emails, and word of mouth. The intent of the survey was to better understand the perspectives of community partners and organizations serving in the 23-county region.

SURVEY RESPONSES

In total, 387 responses were collected during the survey period. Respondents were asked to select the service sector which best described their organization. Respondents of children and family services organizations accounted for 11.5% case management organizations (9.3%), children mental health care organizations (7.7%), and adult mental health care organizations (6.4%). All 23 counties in the LSFHS service area were represented in the survey, with respondents providing services in St. Johns at 7.6%, Marion (7.5%), Citrus (6%) and Hernando County at 6.1%. Respondents we asked to rate their level of agreement to the statement, "You are aware of the availability of mental health and substance use services in your area?" Most (88%) responded, "agree" or "strongly agree." Those not aware of services accounted for 12% of respondents. When respondents were also asked if they were aware of LSFHS resources, 56% said "yes" and 44% said "no." It is possible that respondents are aware of LSFHS service providers, but not aware of LSFHS and the managing entity network in Florida. Respondents who had accessed LSFHS services in the past 6 months accounted for 24.6% while 75.5% had not accessed services. Of those who accessed services in the past 6 months, the majority said the services were helpful (74 out of 95), 20 said "somewhat helpful" and one respondent said "no." When respondents were asked if they have ever directed someone else to LSFHS services, 28.7% said "yes" and 70% responded "no."

The 2-1-1 information and referral resource can be utilized to find resources by speaking with an operator. Nearly 76% of respondents were familiar with 2-1-1, and 15.3% of respondents (59 respondents) had used the 2-1-1 service in the past 6 months. Of the 59 respondents who used 2-1-1 in the past 6 months, 34 said the service was helpful, 20 said the service was somewhat helpful, and five said the service was not helpful. Although most respondents did not use 2-1-1 in the past 6 months, 58% had directed others to 2-1-1.

Survey respondents were asked to select the Crisis Response Model in their area. The most selected models were Mobile Crisis Response Team (23.3%), Mobile Response Team (15.4%), and Behavioral Health Response Team (13.5%). The remaining 37% of respondents did not answer this question. The question did not include an "I don't know" response option, so it is possible

respondents who did not respond were unaware of what type of crisis response model is in their area.

When respondents were asked to rate the awareness of mental health and substance use treatment services in their area 11.6% rated it “excellent” or “very good,” 30% rated it “good,” and 58.4% rated it “fair” or “poor.” Linking people to needed services and coordinating care is an important component of success in service delivery systems. Respondents were asked if linkages to needed services are coordinated and well established across the system of care. Respondents were equally split as 49.1% “strongly agree” or “agree,” and 50.1% “strongly disagreed” or “disagreed.”

Respondents were asked if behavioral health care and peer services are accessible in your area. More respondents “strongly agree” or “agree” (55.1%) while 44.5% of respondents “strongly disagree” or “disagree.”

Respondents were also split on if the processes for referral are easily accessible as 52% “strongly agree” or “agree,” and 46.2% either “strongly disagreed” or disagreed.”

More than half of the respondents did not believe programs and services are coordinated across the system of care (51.7%).

Barriers for accessing services included not being aware of where to go for services (53.4%), affordability (17.9%), and transportation barriers (14.74%). Respondents were asked to list the resources and services needed that are not available to improve patient-centered care and planning. Write-in responses included: providers, professionals, clinicians, therapists, transportation, housing, waitlist reduction, crisis stabilization services, residential services, case management services and case management coordination, Baker Act receiving facilities, school-based support services, Medicaid payment acceptance, expansion of Medicaid services, behavioral health support services, therapies, and childcare.

Respondents were asked to list the top three patient-centered care resources and services that have improved quality of life of individuals. These were counseling services, crisis response teams, and access to medication and medication services.

STAKEHOLDER SURVEY CHARTS

Figure 155: Please select the service sector which best describes your organization? (Check all that apply)

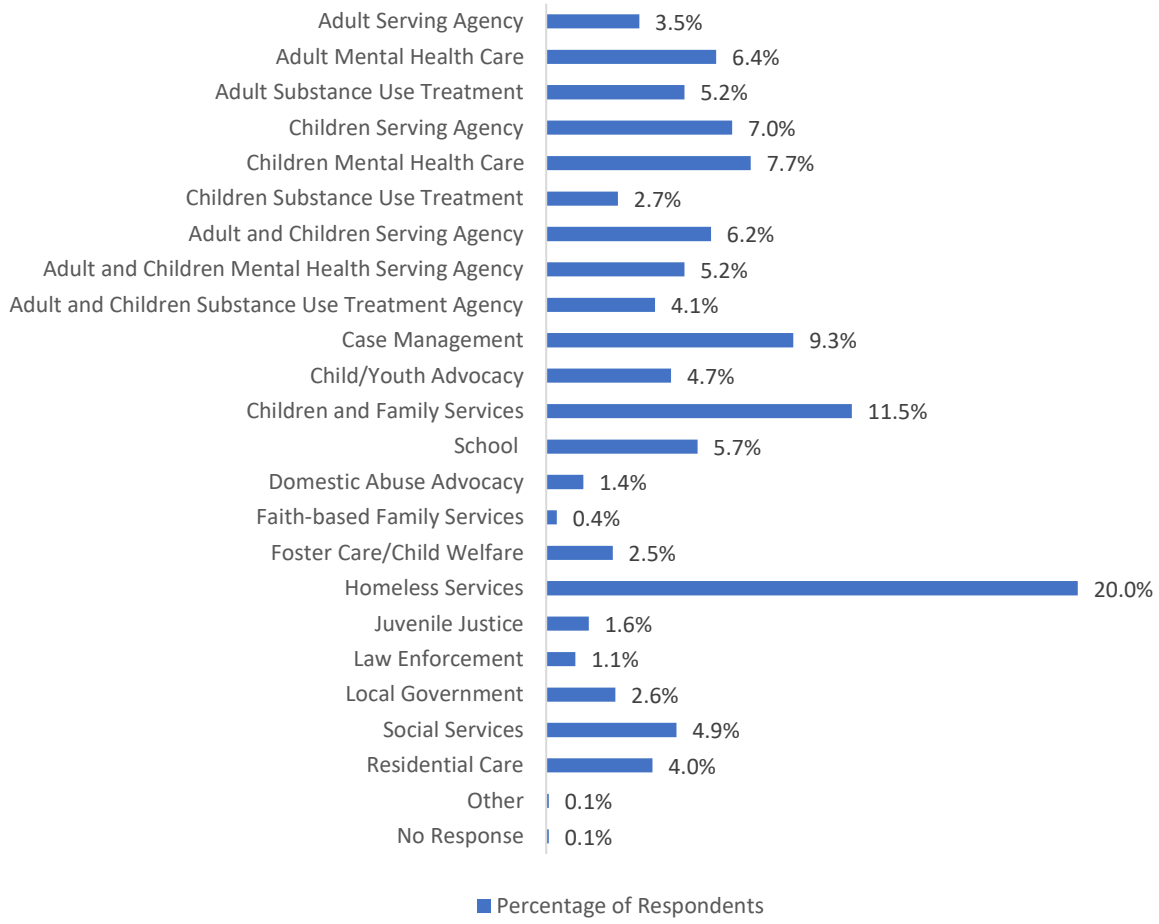


Figure 156: In which county do you provide services? (Check all that apply)

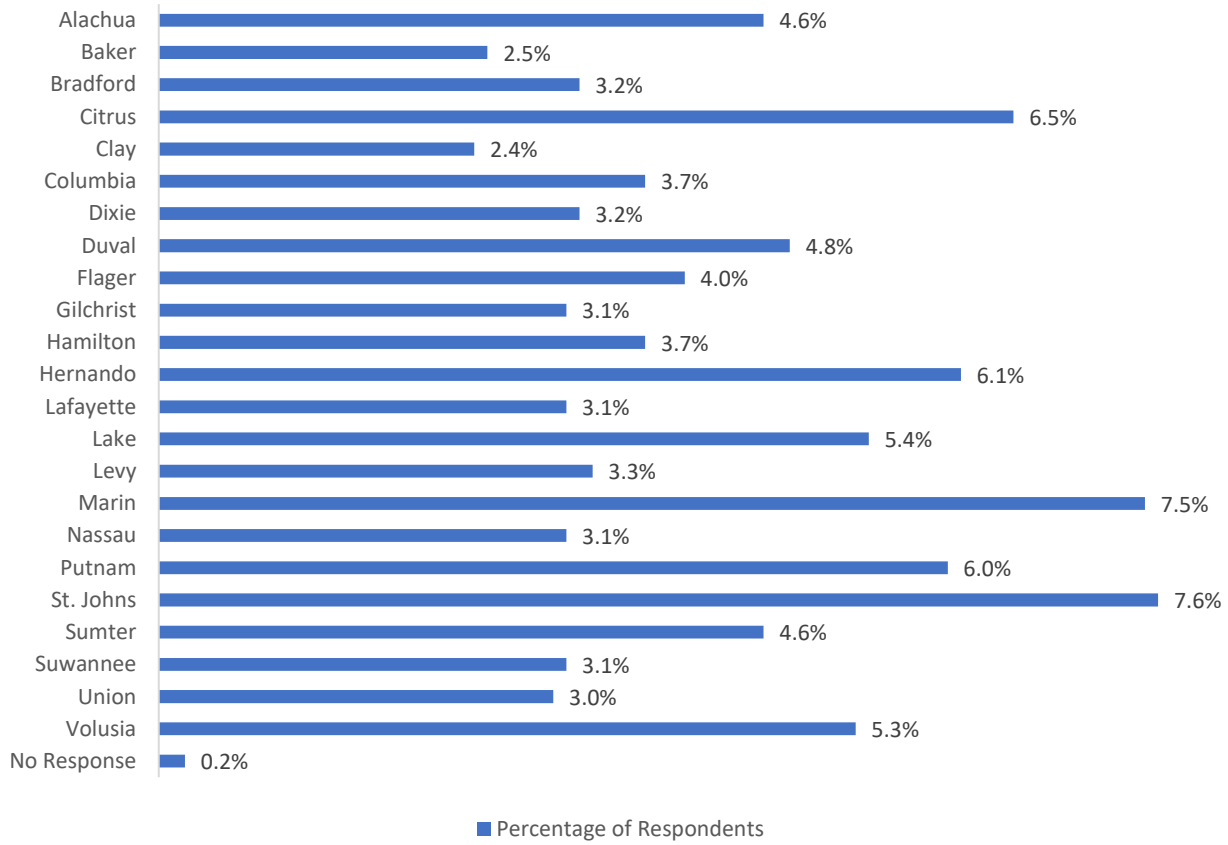


Figure 157: You are aware of the availability of mental health and substance use services in your area.

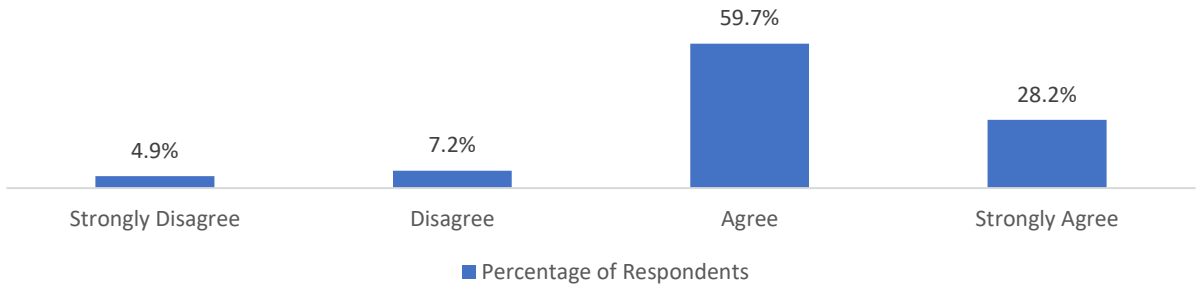


Figure 158: Are you aware of LSF Health Systems (Managing Entity) resources?

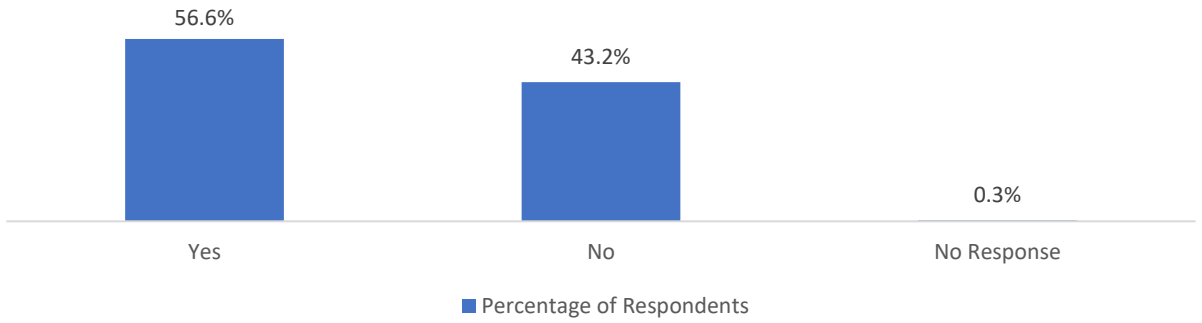


Figure 159: Have you accessed LSF Health Systems (Managing Entity) resources in the past 6 months?

Figure 160: When you accessed LSF Health Systems (Managing Entity) resources, was it helpful?

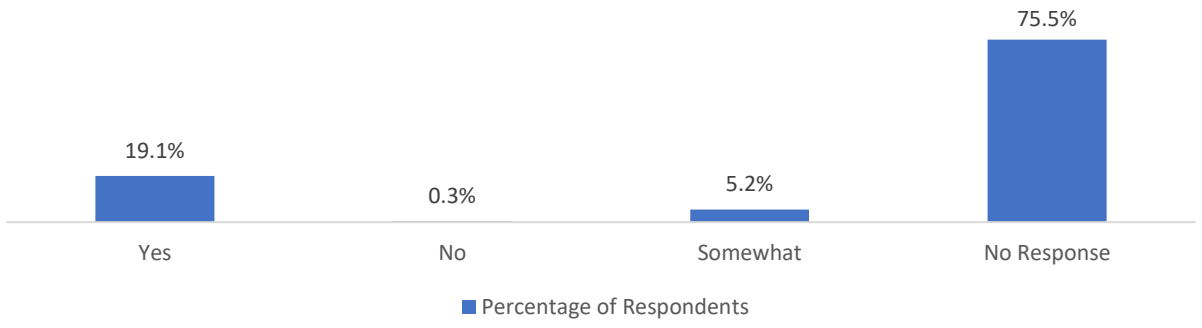


Figure 161: Have you ever directed individuals to access LSF Health Systems (Managing Entity) by calling or online?

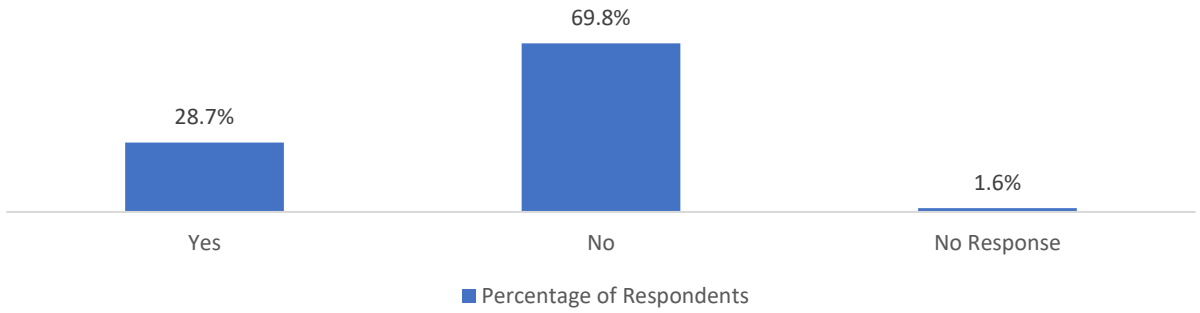


Figure 162: Are you aware of the 2-1-1 Information and Referral Resource?

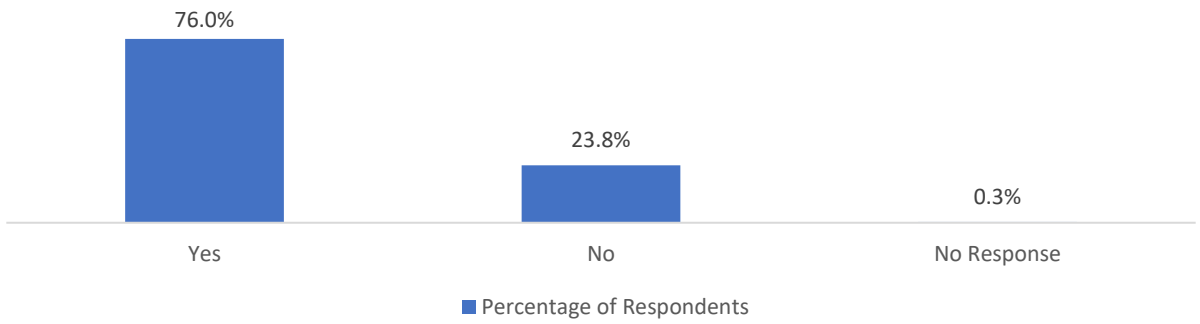


Figure 163: Have you accessed the 2-1-1 Information and Referral Resource in the past 6 months?

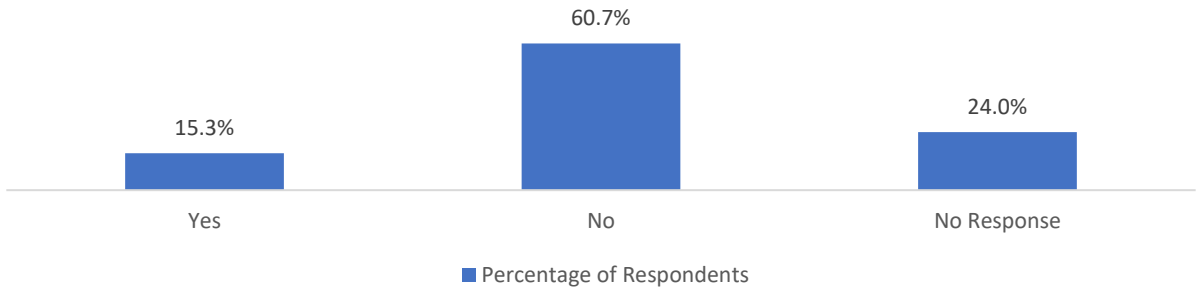


Figure 164: When you accessed the 2-1-1 Information and Referral Resource, was it helpful?

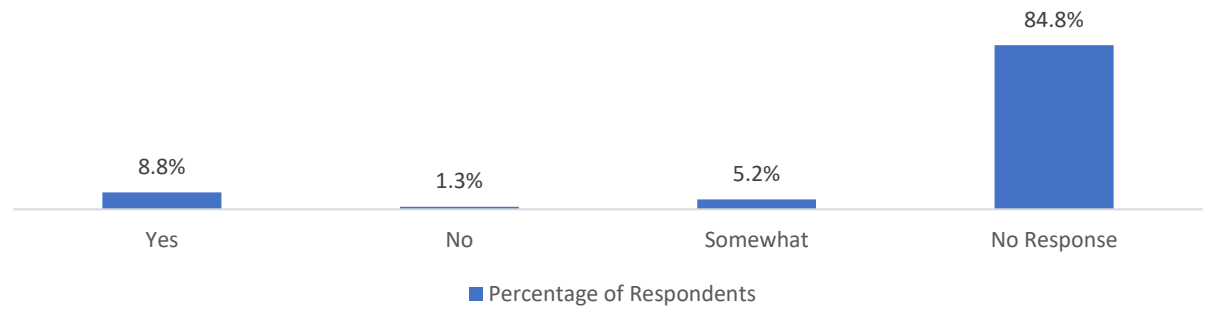


Figure 165: Have you ever directed individuals to access the 2-1-1 Information and Referral Resource by calling or online?

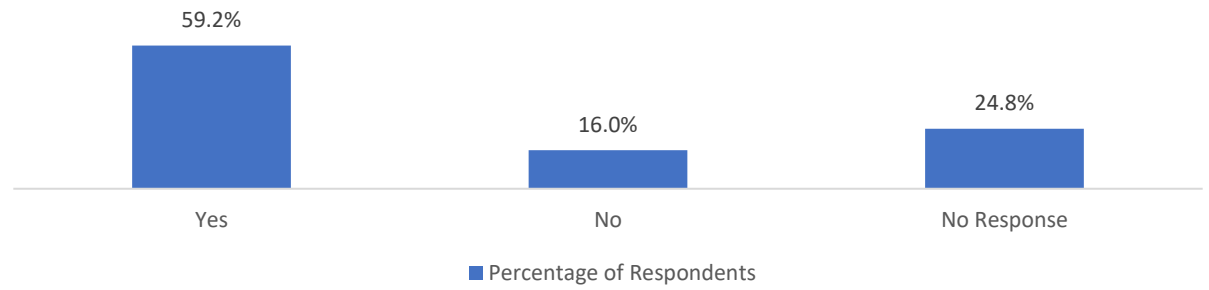


Figure 166: Select the crisis response model in your area. (Check all that apply)

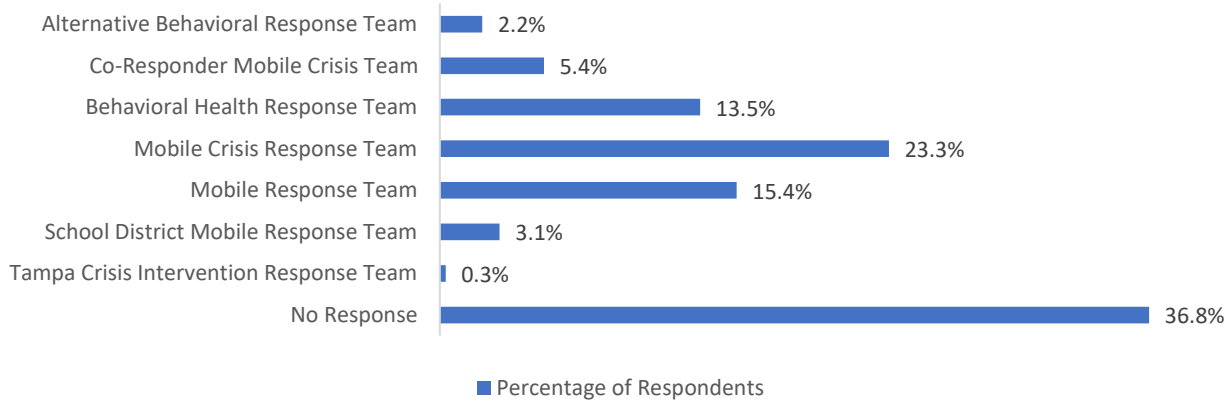


Figure 167:How would you rate community awareness of mental health and substance use treatment services in your area?

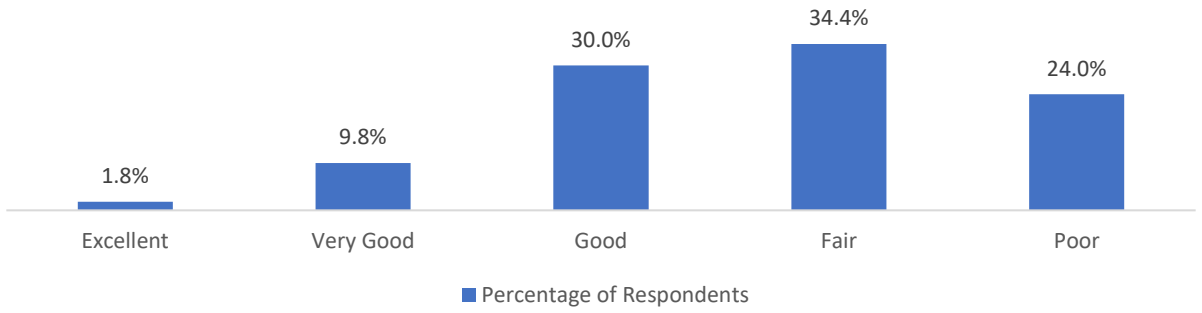


Figure 168: Linkages to needed services are coordinated and well established across the system.

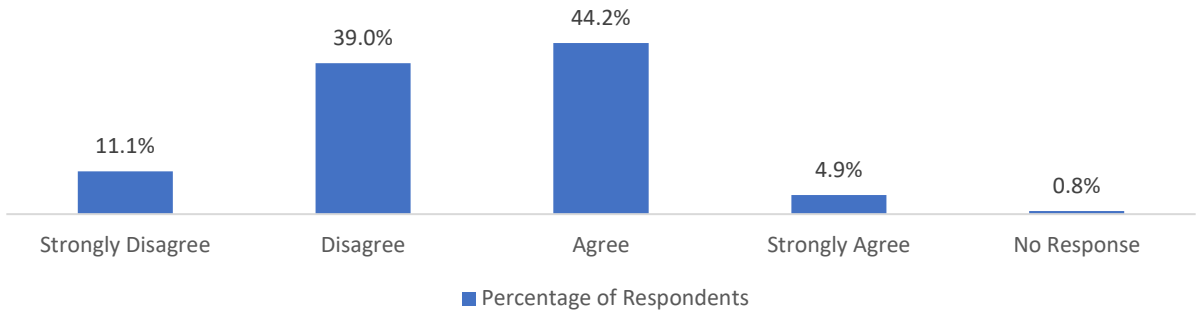


Figure 169: In general, behavioral health care and peer services are accessible in your area?

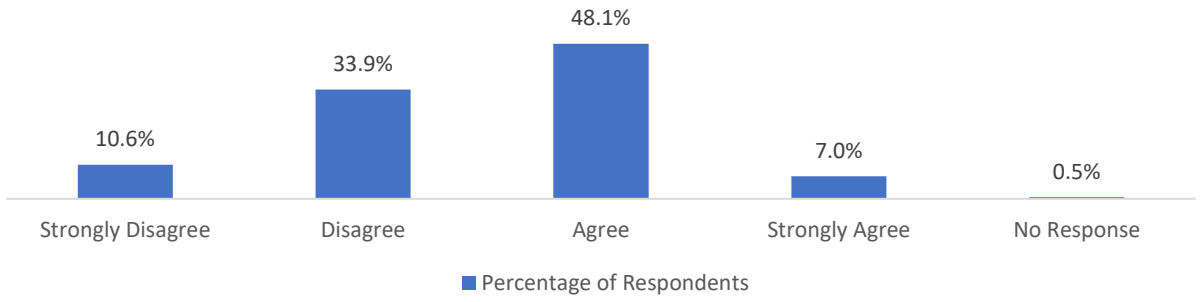


Figure 170: The process for referrals is easily accessible.

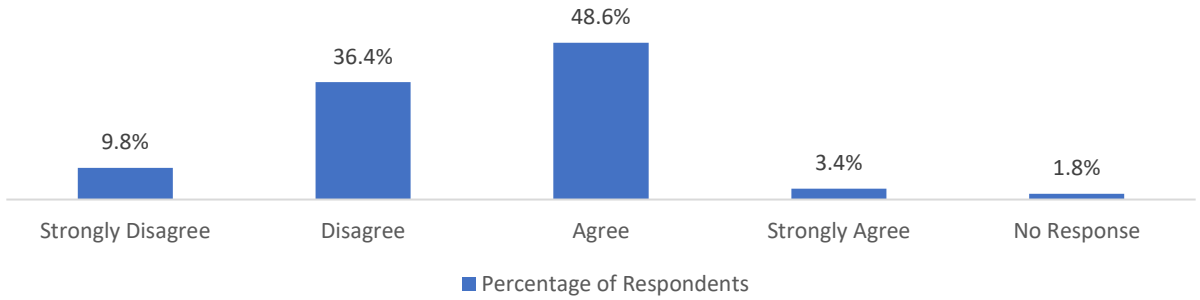


Figure 171: Programs and services are coordinated across the system of care.

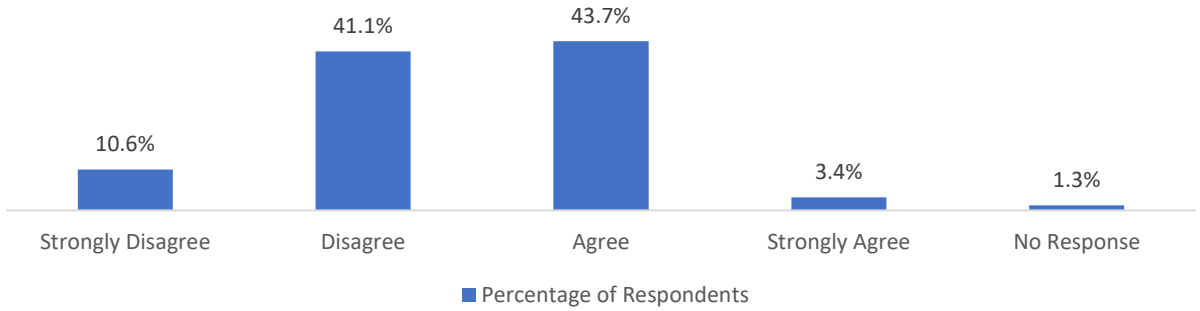


Figure 172: List the barriers for consumers accessing services in your community. (Check all that apply)

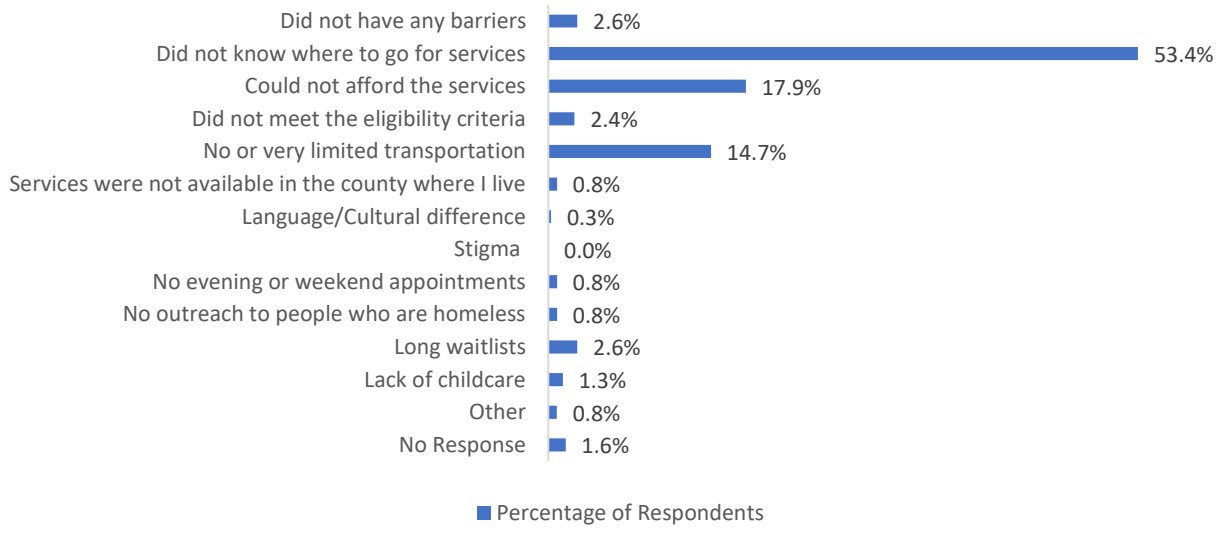


Figure 173: List the resources and services needed that are not available to improve patient-centered care and planning.

Needed Resources and Services
Providers, Professionals, Clinicians, Therapists
Transportation
Housing
Wait List Reduction
Crisis Stabilization Services
Residential Services
Case Management Services and Case Management Coordination
Baker Act Receiving Facilities
School-Based Support Services
Medicaid Payment Acceptance and Expansion of Medicaid Services
Behavioral Health Support Services
Therapies
Childcare

Figure 174: List the top three patient-centered care resources that have improved quality of life for individuals.

TOP THREE PATIENT-CENTERED RESOURCES
Counseling Services
Crisis Response Teams
Access to Medication and Medication Services

PEER RECOVERY COMMUNITY/SUPPORT SPECIALIST'S SURVEY SUMMARY

BACKGROUND

The Behavioral Health Needs Assessment Recovery Community Peer Specialist survey was available in January thru February 2022. It was distributed by LSFHS and their providers to peer specialists throughout the 23-county service region. The intent of the survey was to better understand the perspectives of peer specialists who serve in the 23-county region.

SURVEY RESPONSES

In total, 95 responses were collected during the survey period. Of the respondents, 43.2% were adults with lived co-occurring mental health and substance use conditions, 22.1% were adults with lived substance use conditions, 14.7% were adults with lived mental health conditions, and 14.8% were family members or friends with someone with lived experience. Respondents represented 15 of the 23 counties in the service area which included, Alachua, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Hernando, Lake, Levy, Marion, Nassau, Putnam, St. Johns, and Volusia counties. Duval County respondents represented 41.1% of all respondents with Hernando and St. Johns counties each accounting for 7.4% of respondents.

Respondents were employed by a variety of service agency types including: adult mental health service agencies (12.7%), adult substance use service agency (18.6%), peer support service agency (22.3%), recovery community organization (13.2%), children mental health service agency (6.4 %), children substance use service agency (5%), hospital/emergency room (4.1%), prevention services (7.7%), family/peer organizations (5%), and other (1.4%) which included DCF, Family Dependency Drug court, state government, not employed. Of the respondents, 31.6% have been employed by the agency for more than 3 years, 25.3% were with the agency for less than 6 months, and 17.9% were at the agency for 1 to 2 years. Nearly half of respondents (46.3%) work 40 or more hours per week while 23.2% work more than 40 hours per week, and 28.7% work 20 hours or less per week. Nearly 95% of respondents reported their agency utilizes peer support services with 8.4% of respondents unsure if peer support services are provided by their agency. Respondents overwhelmingly believe their agency adheres to recovery support best practices (87.4%), while 9.5% were unsure.

Qualifications varied as Certified Recovery Peer Specialists accounted for 32.4% of respondents, Certified Recovery Support Specialists (9.8%), applied for certification and in process (27.5%), Recovery Peer Specialist with Provisional Certification (3.9%), National Certified Peer Specialist (2.9%), and not certified (21.6%). Respondents provide peer specialist services in a variety of

settings with the most frequent settings being outpatient recovery community organization (12.5%), court (10.9%), medication assisted treatment (10.3%), and jail/corrections (8.7%).

Peer specialist respondents were asked why they stayed with the company. Responses varied as personal fulfillment accounted for 24.6% of respondents, commitment to recovery principles (20.4%), flexibility with work schedule (20%), and work hours (13.1%). Barriers to hiring presented challenges for peer specialists. The most common barriers included: Exemption/background screening process (21.8%), salary (32.3%), limited employment opportunities (18%), and work/schedule hours (9%). Write-in responses included court costs, lack of disability awareness, and long hiring process.

Peers recommended a variety of trainings to assist in implementing peer support services including compassion fatigue/self-care, 40 hour required peer recovery specialist training, boundaries/ethics/professional responsibility, mental health first aid, trauma informed training, and others.

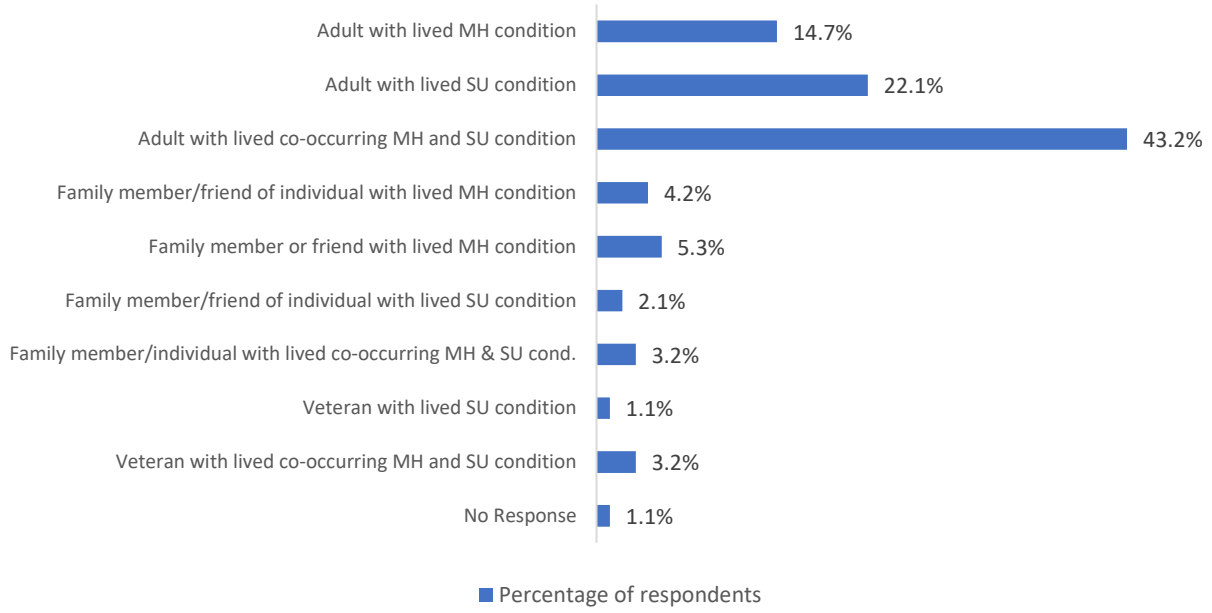
Partnerships existed between peer support recovery programs, recovery community organizations and other organizations as reported by 67.4% of respondents. Partnerships with organizations that provide other types of services were reported and included Career Source, daycare, child welfare, faith-based, drop-in centers, food panties, housing, Florida Department of Health, jail/corrections, probation, and transportation agencies.

Peers (81.1%) reported their agencies use person-centered language that helps reduce stigma with only 5.3% reporting their agencies do not use person-centered language. One write-in response indicated that clinical language is used more than person-centered language. Another write-in response indicated that the agency uses person-centered language, but some "staff struggle to put it into practice."

Nearly three-quarters of respondents indicated that peers are included in developing, promoting, evaluating, and improving programs. Nearly 60% of respondents said that persons in recovery participate in management and board meetings. Of those who reported that persons in recovery do not participate in management and board meetings, write-in responses for "why not" included: hierarchy that only includes clinicians/medical professionals, peers without a bachelor's degree, higher education is not considered important except when they are "required to be employed to qualify for certain grants," and traditional hierarchy.

PEER RECOVERY COMMUNITY/SUPPORT SPECIALIST'S SURVEY CHARTS

Figure 175: Which best describes your experience?



Note-Mental Health (MH) and Substance Use (SU)

Figure 176: Which county do you live in?

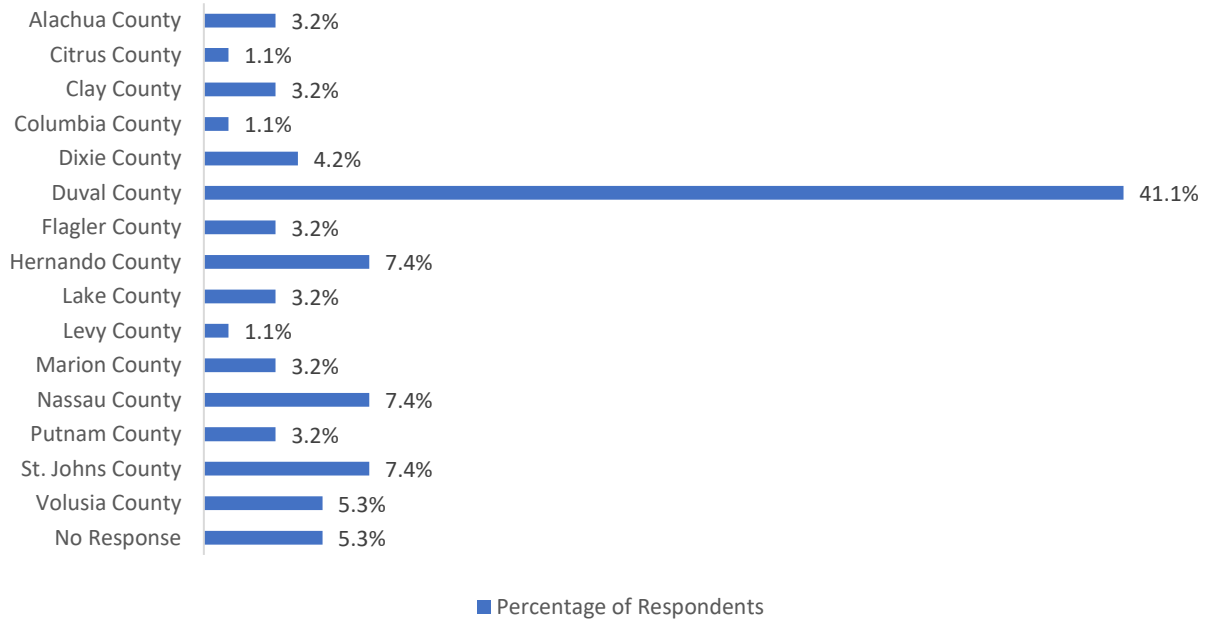


Figure 177: What type of service are you employed or volunteer with? (Check all that apply)

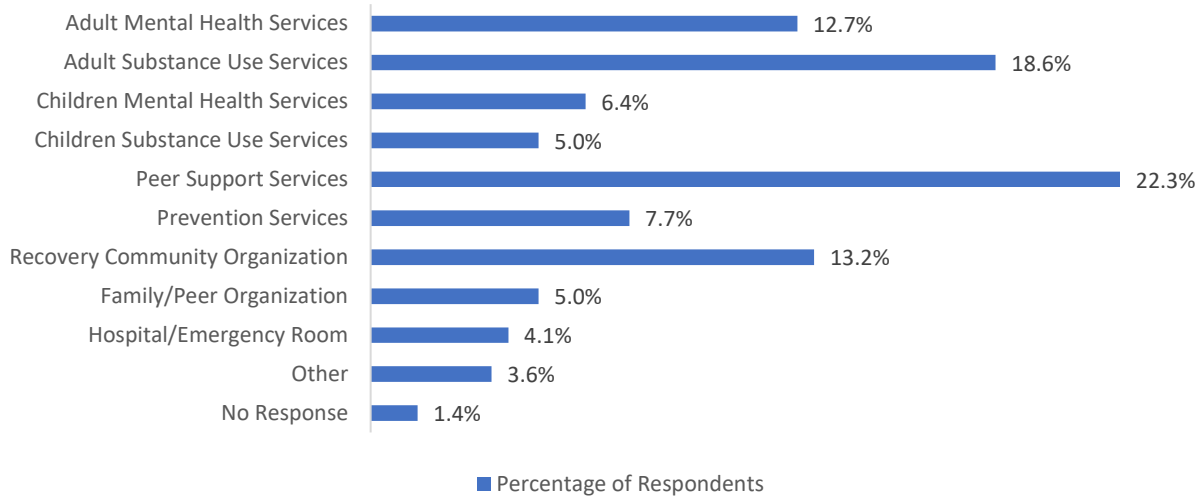


Figure 178: How long have you been employed/volunteered with the agency?

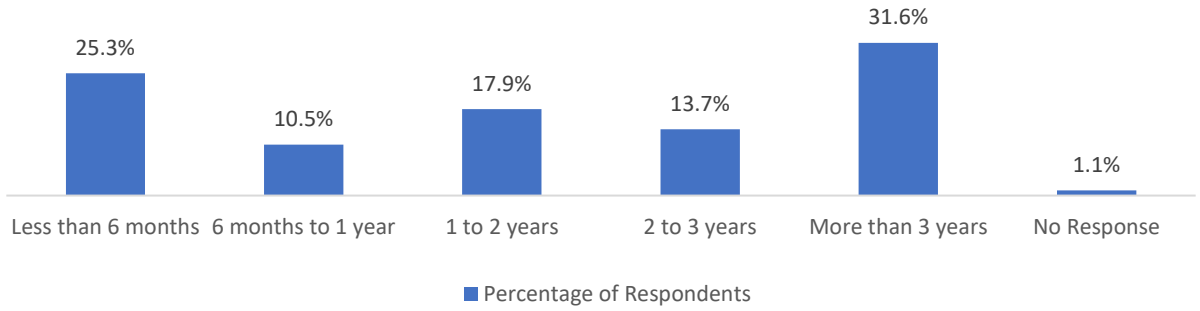


Figure 179: My work schedule averages...

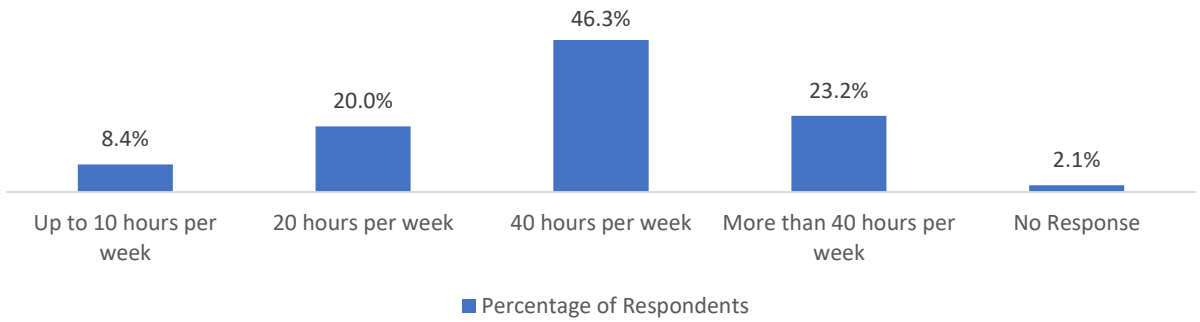


Figure 180: Does the agency where you are employed, or volunteer, utilize recovery peer support services within the services they provide in the community?

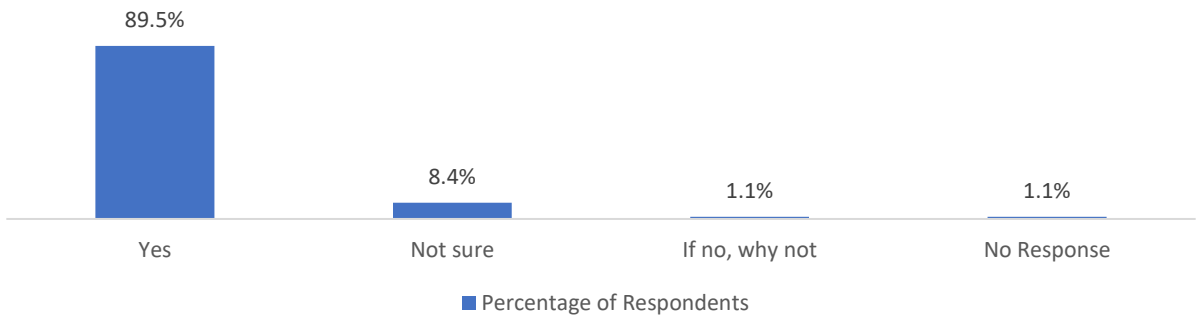


Figure 181: Does the agency where you are employed, volunteer, adhere to recovery support best practices?

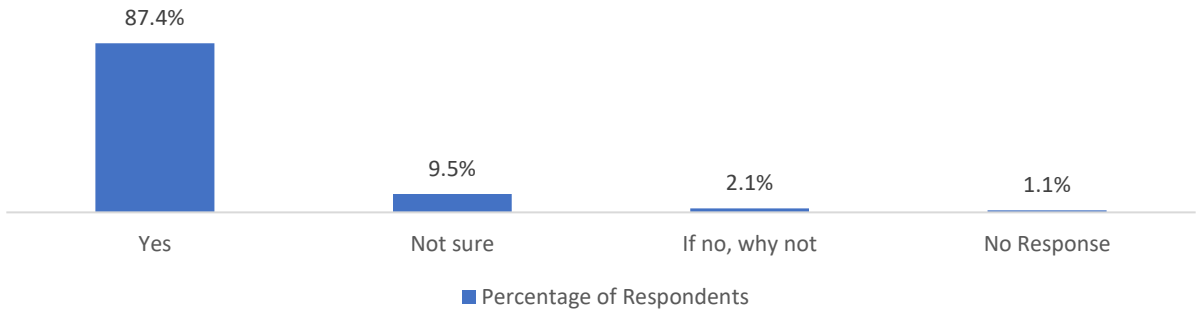


Figure 182: Please indicate the qualifications that best describe your status. (Check all that apply)

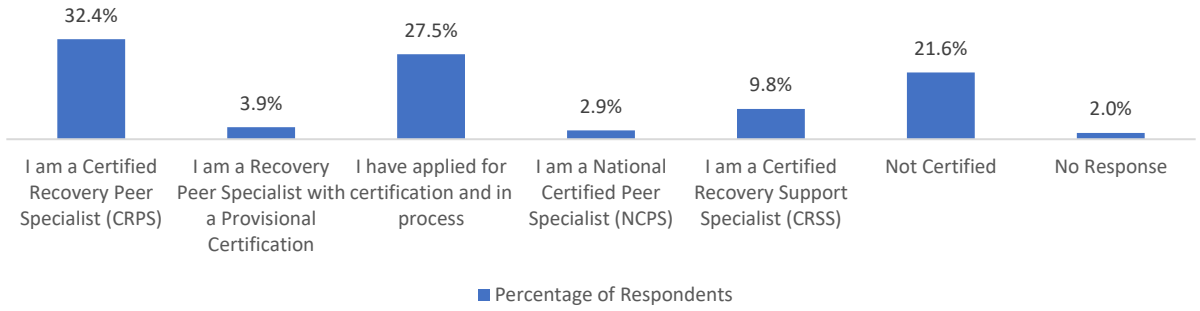


Figure 183: Please indicate the facility/program setting(s) that best describes where you deliver peer recovery support services. (Check all that apply)

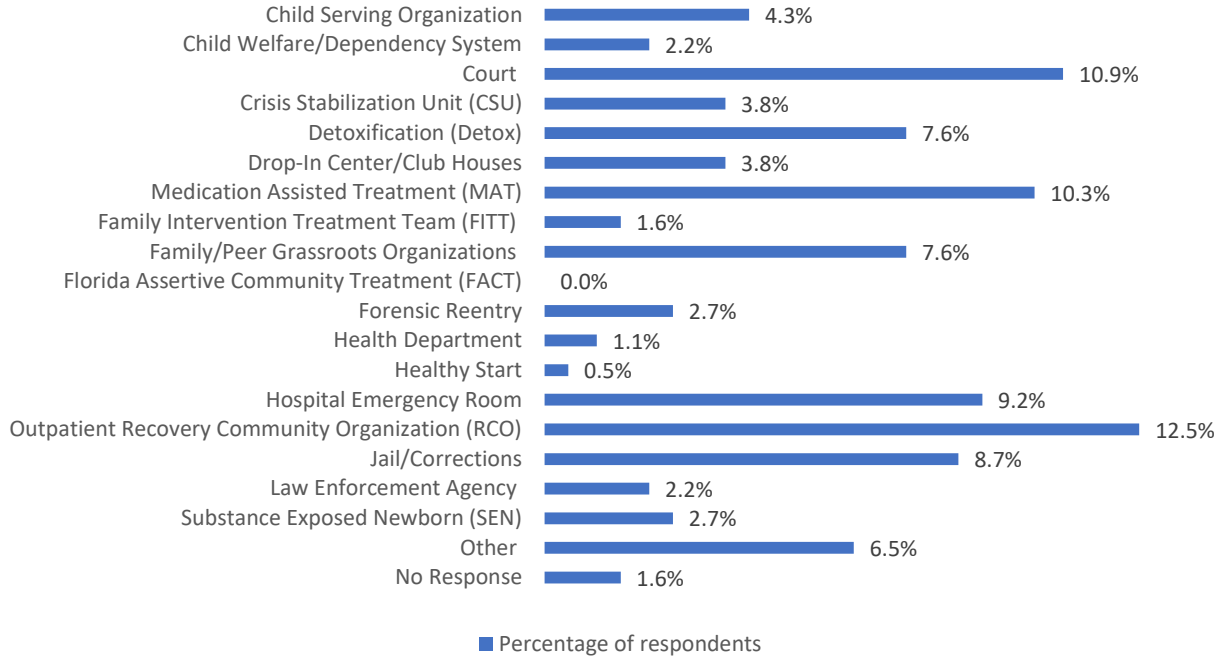


Figure 184: What are the reasons/factors for staying with the company? (Check all that apply)

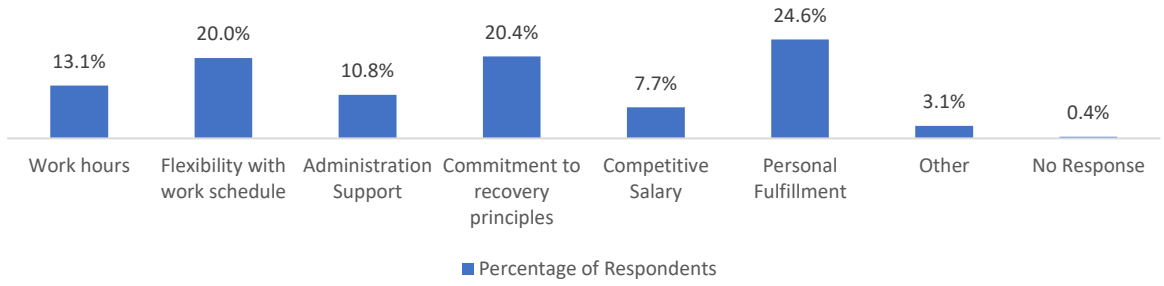


Figure 185: What barriers/challenges have you experienced in the hiring process? (Check all that apply)

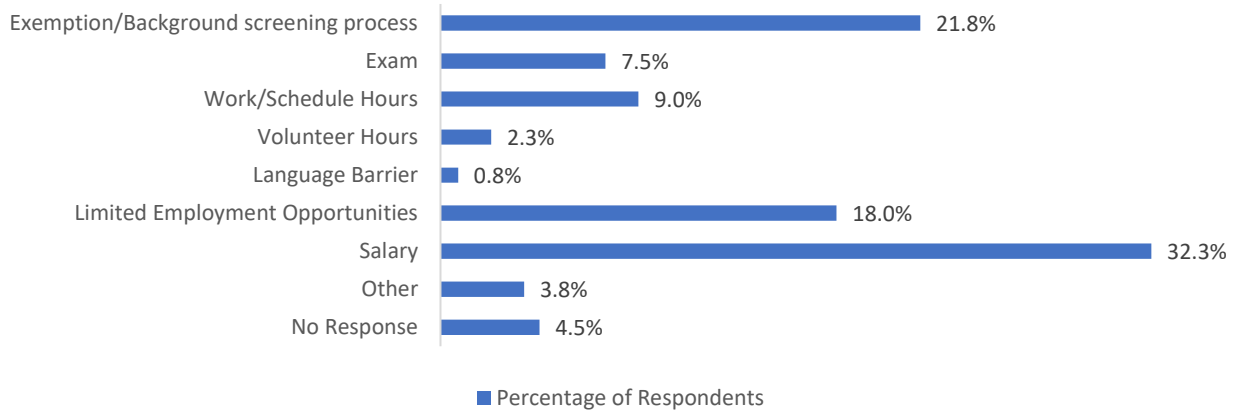


Figure 186: What training would you recommend for peers to have to help them provide Peer Support Services? (Check all that apply)

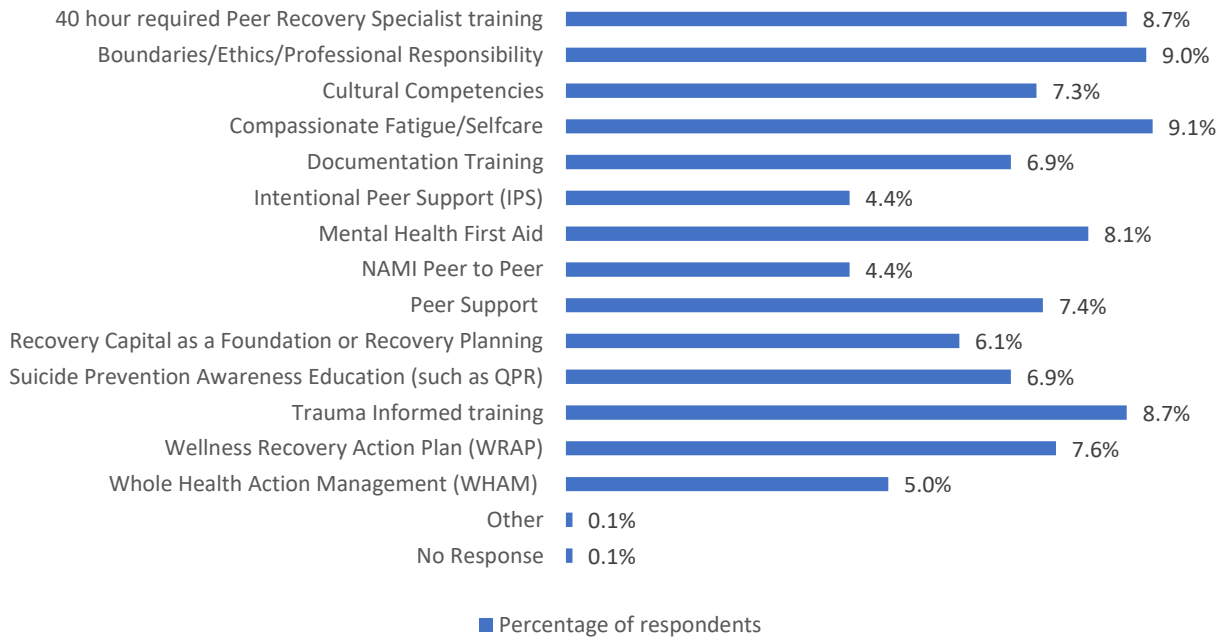


Figure 187: Are there partnership that exist with peer support recovery programs, recovery community organizations, and other support groups?

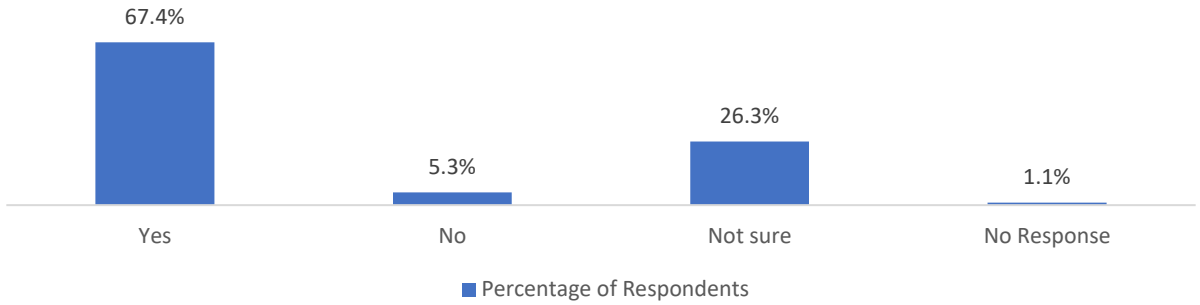


Figure 188: Are you aware of partnerships with other organizations that provide other resources such as: (Check all that apply)

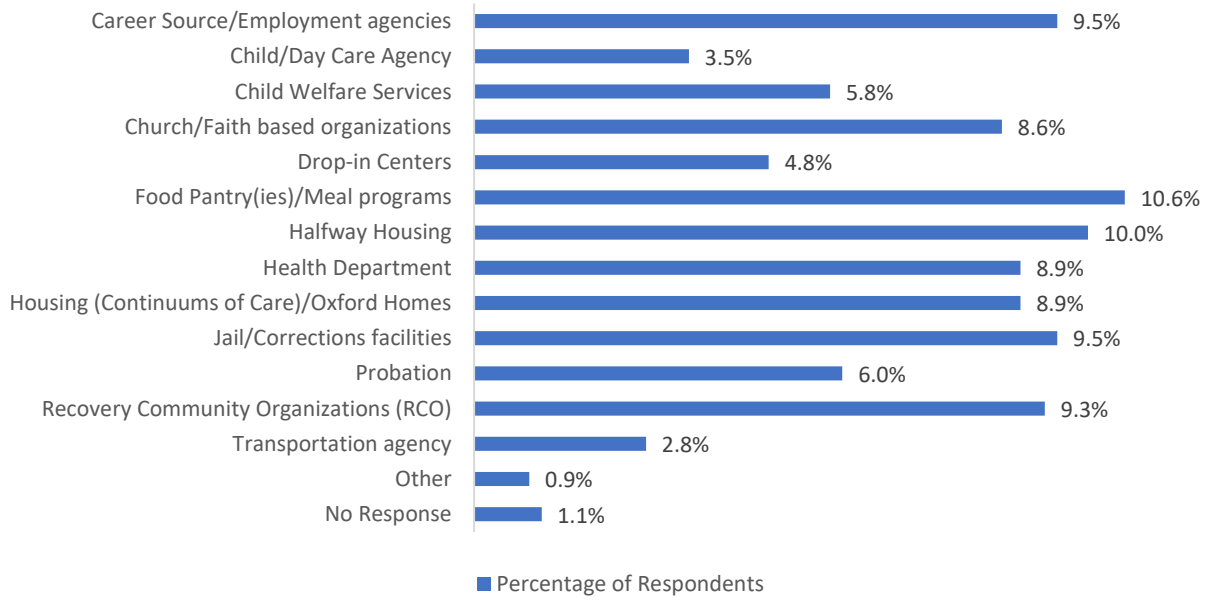


Figure 189: Do you have the ability to offer choices to the individuals where you serve at the agency you are employed/volunteer?

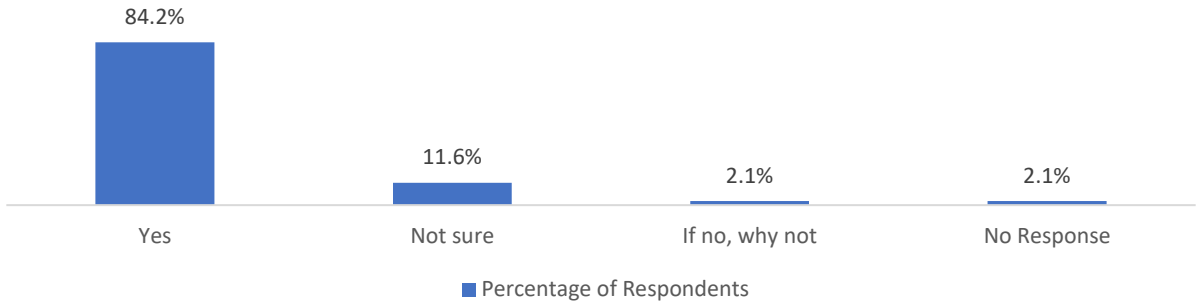


Figure 190: Does the organization where you are employed/volunteer with help to reduce stigma by promoting recovery language that is patient centered?

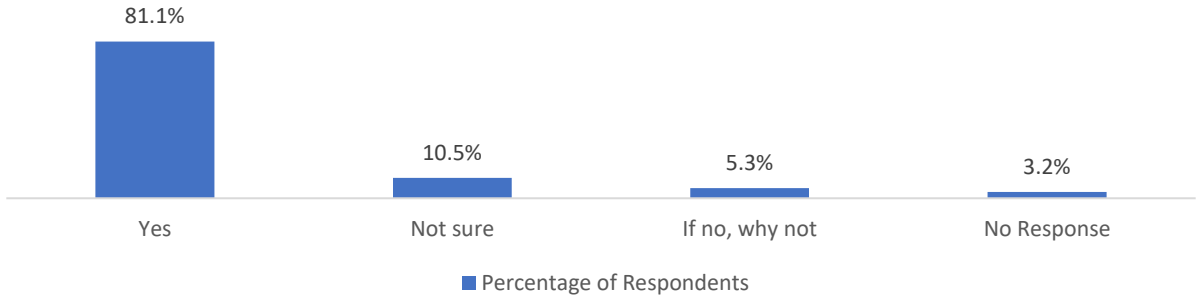


Figure 191: Does the agency where you are employed/volunteer include peers in developing and promoting effective program development, evaluation, and improvement?

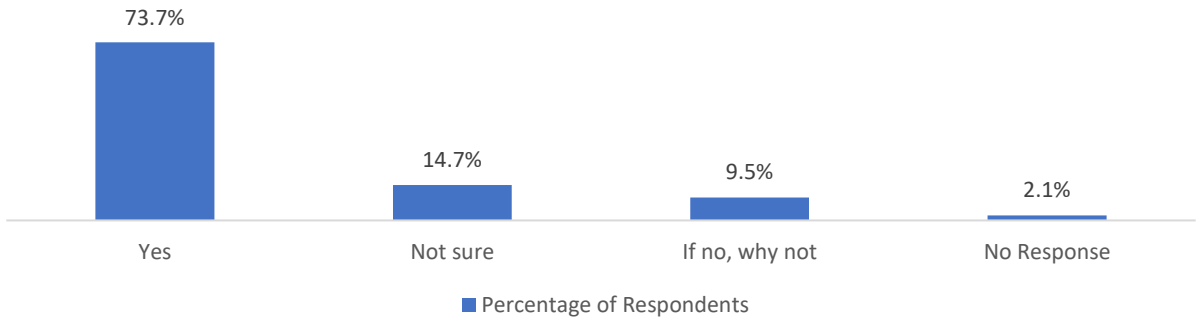
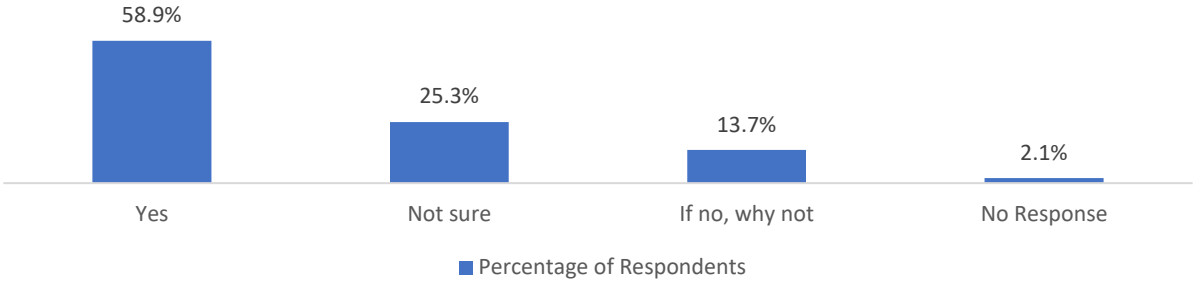


Figure 192: Does the agency where you are employed/volunteer with include persons in recovery in management and board meetings?



RECOVERY ORIENTED SYSTEM OF CARE RESOURCES

LSFHS
RECOVERY SYSTEM OF CARE RESOURCES

Addiction Recovery Lakeside	Awakening-Nassau
Addiction Recovery Live Oak	Beaches Recovery
Addiction Recovery of Brooksville	Breakthroughs Counseling and Recovery
Addiction Recovery of Citrus Hills	DeLand Addiction Recovery
Addiction Recovery of Citrus Springs	Drug and Alcohol Rehab Experts
Addiction Recovery of Inverness	Drug and Alcohol Rehab Advisers
Addiction Recovery of Lake City	Drug and Alcohol Rehab Advisers Lake City
Addiction Recovery of Macclenny	Drug and Alcohol Rehab Experts
Addiction Recovery of Orange City	Drug Rehab and Alcohol Detox Recovery Center Starke, Fl
Addiction Recovery of St. Augustine South	Drug Rehab and Suboxone Clinic Recovery Center Jacksonville, Fl
Addiction Recovery Starke	Drug Rehab Spring Hill
Alachua Addiction Recovery	Drug Treatment
Atlantic Recovery Center	Drug Rehab and Alcohol Detox Jacksonville, Fl Inpatient Recovery Center
Augustine Recovery	Epic Recovery Center
Fernandina Beach Addiction Recovery	Jasper Drug and Alcohol Rehab List
Flagler Beach Addiction Recovery	Journey to Independence Recovery
Fleming Island Addiction Recovery	Lifestream Behavioral Center

Florida Recovery Center	Live Oak Opioid Addiction Treatment Centers
Gateway Steps to Recovery	Mayo Drug and Alcohol Rehab List
Harmony Hills	Meridian - Suwannee County Counseling Center
Haven Recovery Center	Meridian - Union County Clinic, Lake Butler
Inpatient Cocaine, Drug, and Alcohol Rehab Helpline Cross City	Meridian Behavioral Healthcare Levy County
Inpatient Cocaine, Drug, and Alcohol Rehab Helpline Starke	New Hope Opioid Addiction Treatment Centers
Inpatient Cocaine, Drug, and Alcohol Rehab Helpline White Springs	New Paths Recovery Center
Inpatient Drug Alcohol Rehab Advisers	Ocala Addiction Recovery
Inpatient Drug and Alcohol Center	Palatka Addiction Recovery
Inpatient Drug Detox Centers	Pathways to Recover
Inpatient Drug, Alcohol, Cocaine Rehab Advisers Chiefland	Quantum's Oceanside Recovery
Inpatient Drug, Alcohol, Cocaine Rehab Advisers Tavares	Recovery Counseling and More, Inc.
Inpatient Drug Alcohol Rehab Advisers	Recovery Solutions
Jasper Addiction Recovery	Recovery Keys
Ridge Manor Addiction Recovery	Tavares Inpatient Drug Alcohol Rehab Advisers
Road Center	TDC Substance Abuse Treatment
Serenity Springs Recovery Center	TDC Substance Abuse Treatment
Smart Recovery Gainesville	TDC Substance Abuse Treatment
Spencer Recovery Center	The Centers
Spring Hill Addiction Recovery	The Drug Detox Center Ocala

Springs Gardens Detox and Recovery	The Recovery Village Drug and Alcohol Rehab
Starting Point Behavioral Healthcare	Vince Carter Sanctuary
Substance Abuse of East Palatka	Volusia County Comprehensive Treatment Center
Substance Abuse of Fleming Island	Yulee Addiction Recovery
Substance Abuse of Gainesville	Substance Abuse of San Mateo
Substance Abuse of Jennings	Tavares Addiction Recovery
Substance Abuse of Live Oak	
Substance Abuse of Macclenny	
Substance Abuse of Otter Creek	

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NWF Health Network

2022

Florida Cultural Health Disparity & Behavioral Health Needs Assessment

Regional Report

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NWF Health Network

June 14, 2022

Dear Community Stakeholders

I am pleased to announce NWF Health Network has completed its 2022 Behavioral Health and Cultural Disparity Needs Assessment. The Needs Assessment will help determine the types of resources needed and how best to deploy them across our network of behavioral health providers in our 18-county Northwest Florida coverage area.

This is the fourth formal Needs Assessment NWF Health Network has distributed since we assumed responsibility for the substance use disorder and mental health system of care through a Managing Entity (ME) contract award from the Department of Children and Families (DCF) in April of 2013.

We used a series of surveys to gather feedback from providers, stakeholders, consumers and their families, as well as the peer specialist/recovery communities. The Needs Assessment will help us better understand the current behavioral health system of care and support our mission to provide the highest quality child protection and behavioral health services to children, adults, and their families within their communities through a managed network of accredited providers.

The completed surveys included: consumer, cultural health disparity, peer review, stakeholder, and the No Wrong Door access system surveys. These surveys targeted specific groups which will allow the Managing Entity to develop programming in our provider network to meet the needs of the community.

We appreciate the assistance we have received in completing this year's Behavioral Health and Cultural Disparity Needs Assessment. We look forward to continuing the work with our partners and community stakeholders to serve the families and children of northwest Florida.

Sincerely,

Mike Watkins, CEO
NWF Health Network

525 N. Martin Luther King Jr. Blvd | Tallahassee, FL 32301 | 850-410-1020
NWFHealthNetwork.com

ACKNOWLEDGEMENTS

We want to thank and acknowledge the ongoing contributions of our providers
and express gratitude for your participation and support.

2-1-1 Northwest Florida
2-1-1 Big Bend
Ability 1st
Apalachee Center
Baptist Health Care
Bay County District Schools
Bay County Sheriff
Big Bend AHEC
Boys Town North Florida
Bridgeway Center
CARE
CDAC Behavioral Health Care
DISC Village
Fort Walton Beach Medical Center
Franklin County Sheriff
Lakeview Center/Chautauqua Healthcare Services
Leon County Courts/A Life
Leon County Sheriff
Life Management Center
Mental Health Association of Okaloosa and Walton Counties
Okaloosa County Board of County Commissioners
PanCare Health
Panhandle Behavioral Services
Tallahassee Public Defender
Turn About

Thank you to all those who participated in surveys, interviews, and focus groups.
Your invaluable input continues to inspire our commitment to provide access to high quality,
affordable behavioral health care services in Northwest Florida.

Special Thanks to Central Florida Cares
for their leadership in spearheading this needs assessment.
&
Northwest Florida & Big Bend Health Councils
for planning, data analysis, and technical assistance.

EXECUTIVE SUMMARY

In 2020, there were an estimated 47,465 adults with serious mental illness and 15,058 youth (ages 9-17) with a serious emotional disturbance in the 18-county service area comprised of Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Taylor, Santa Rosa, Wakulla, Walton, and Washington counties. Between 2018 and 2020 the rates increased among adults (by <1%) and among youth (by 9.1%).

This report, prepared for the Northwest Florida Health Network (NWFHN), is a compilation of primary and secondary data that describe behavioral health care needs of individuals and their families and the assets available to meet those needs.

SERVICE AREA POPULATION

From 2016 to 2020, population in the service area increased by 74,076 (3.8%) to a total of 1,541,100 residents. The fastest growth occurred in Walton and Santa Rosa counties which grew by 15.7% and 10.8%, respectively. Other counties grew more slowly, and some, for example Gulf and Jackson counties decreased by 11.2% and 7%, respectively.

Adults 65 years of age or older accounted for 16.6% of the service area population and females accounted for slightly less than 50% of the population.

The racial composition in the service area was predominately White at 72%, slightly less than the state rate of 71.6%. The Black population accounted for 18.8% of the service area population and 15.9% of Florida's population. American Indian and Native Hawaiians represented less than 1% of the service area and state population. The percentage of Asian residents, at 2.4%, was similar to the state rate at 2.8%. The service area was slightly less diverse when compared to the state, with 1.8% identifying with a race of Other, and 4.5% identifying with more than one racial group. In the state, 3.3% of the population identified as Other, and 6% identified with more than one racial group.

From 2016 to 2020, a total of 59% of the service area population participated in the labor force, and the rate of unemployment was 3.1%. The population with incomes less than 100% of the poverty level accounted for 9.7% and 15.8% had incomes between 100 and 199% poverty.

According to the Behavioral Risk Factor Surveillance System (BRFSS) Survey conducted between 2017 and 2020, an estimated 80.6% of adults (ages 18-64) living in the service area said their overall health was "good" to "excellent". More than 86.1% reported good mental health.

The overall suicide rate increased slightly between 2018 and 2020. The rate among males was more than triple the rate among females, while the rate among Whites was five times the rate among Blacks.

Although the rate of total domestic violence offenses decreased in the service area between 2017 and 2019, by 2019 it was still significantly higher than the state rate.

The rate of children (ages 5-11) experiencing child abuse decreased in the service area between 2017 and 2019. However, by 2019 the rate was still more than 1.5 times the state rate. Child sexual abuse rates changed very little from 2017 to 2019, except for briefly decreasing in 2018; by 2019 the rate in the service area was 1.8 times the state rate.

From 2017 to 2019, the average rate of current smokers among adults living in the service area was 19.1%, and the average rate of adult binge drinkers was 18.3%.

According to the Florida Youth Substance Abuse Survey (FYSAS), by 2020, there were increased rates of middle and high school students who reported never having smoked cigarettes, marijuana, or having consumed alcohol.

From 2015 to 2019, an estimated 16% of the civilian noninstitutionalized population in the NWFHN service area, and 13.7% in the state had a disability (including disabilities related to hearing, vision, cognitive, ambulatory, self-care, and independent living).

Between 2017 and 2019, an average of 83.6% of adults (ages 18-64 years) reported having some type of health insurance coverage.

NWFHN CLIENT POPULATION

NWFHN-funded organizations that served 33,313 clients in FY20-21, including 792 clients from outside of the catchment area. The greatest percentage of clients resided in Escambia County 31%, followed by Bay County 14.8%, Okaloosa County 12.4%, Leon County 9.7%, and Santa Rosa County 9.5%. Nearly 5% of clients reported their residential status as unhoused.

Adult Mental Health (AMH) programs served 20,863 clients, and the Adult Substance Use Disorder (ASUD) programs served 7,690. An additional 6,881 clients were in the Child Mental Health (CMH) programs and 1,397 were in the Child Substance Use Disorder (CSUD) programs.

While females represented 56.5% of all NWFHN clients, and 54.2% of AMH clients, males accounted for a majority of clients in ASUD (52.8%), CMA (52.9%), and CSUD (51.5%) programs.

Most NWFHN clients were White (70%). This represents a lower percentage than in the service area population at 72.9%. Black NWFHN clients accounted for 22.8% of the client population, but only 18.9% of the population in the 18-county service area.

The percentage of Hispanics residing in the service area (6.4%) was higher than the rate of Hispanics in NWFHN programs (3.9%). The percentages of Hispanic clients in AMH and ASUD programs were slightly less than 4%, while the percentages in CMH and CSUD programs were 4.6% and 5.7%, respectively.

Adults, 25-44 years of age, accounted for 40.9% of clients in AMH and ASUD programs. This was nearly twice the percentage of adults in that age range in the service area (22.7%). Teen and young adult clients, 15-24 years of age, accounted for 16.4% of NWFHN clients which was slightly less than the percentage of those living in the service area at 17.9%. Among those enrolled in child/youth programs, 72% of clients in the CMH program were 5-14 years of age, and 46.3% of clients in the CSUD program were 15-19 years old.

The majority of NWFHN adults (55.3%) resided in one of three types of independent living conditions: with relatives (28.9%), with non-relatives (9.8%), or alone at 16.6%. Among AMH clients, 5.8% reported their status as unhoused, as did 7.8% of those in the ASUD program. Children/Youth lived dependently with relatives with CMH clients accounting for 87.6% and CSUD clients at 95%.

Overall, NWFHN clients attained lower educational levels when compared to those in the service area population, contributing to higher levels of unemployment among NWFHN clients than others in the service area. More than 41% of AMH clients and nearly 46% of ASUD clients were not employed while the unemployment rate was less than 4% in the service area and state.

NO WRONG DOOR PROVIDER INTERVIEWS

Providers are committed to No Wrong Door (NWD) Access to ensure that services or linkages to services are provided to everyone who comes in for help. Person-centered, trauma-informed care is built into organizational cultures. Providers are sensitive to emerging trends regarding language and other cultural issues consistent with inclusive and welcoming environments. The NWD Access is facilitated and supported by extensive training, discussions among leadership and staff, strong case management teams, and close-knit staffs. Having a variety of programs within an organization improves efficiency by streamlining protocols that connect clients with needed services, resulting in enhanced effectiveness by ensuring synergistic effects of coordinated care.

In some areas, disruptions in the aftermath of Hurricane Michael, (e.g., structural damages, high staff turnover) impeded prioritization and implementation of the NWD Access policies, trainings, and practices. In some areas, recovery is still in progress.

Although time is of the essence when someone expresses the need for help, providers are not always able to respond within a small window of opportunity. Barriers include waitlists, worsening staff shortages, bifurcation of funding, and inconsistent diagnostic standards for substance use and mental health. Because substance use and mental health diagnoses are frequently co-occurring disorders, additional funding is needed for specialty care (i.e., psychiatry). Ready access to additional specialty services should be available to all substance use and mental health clients/patients. A standardized intake and screening process, including a comprehensive referral and feedback form/process with all necessary information that is easy to transmit to other

programs and providers, are needed to expedite access to services. The biggest unmet need is for legislative and gubernatorial action to change funding structures and rates.

CONSUMER SURVEY

Most respondents said they know where to go for behavioral health services, and they were aware of the 2-1-1 information and referral resource in their respective counties. Nearly two-thirds of respondents were able to get the services they needed when they needed them. From a comprehensive list of services, the most frequently mentioned services that were hard to get were crisis stabilization support, assessment, and short-term residential treatment. The most frequently identified obstacles were related to affordability, stigma, and access (i.e., long waitlists, no evening or weekend appointments, eligibility criteria, and lack of knowledge regarding where to go for services).

STAKEHOLDER SURVEY

Stakeholder respondents represented 20 behavioral health service sectors. The most frequently cited sectors were, schools (elementary, middle, or high school), unhoused services, case management, children serving agencies, adult mental health care, and social services. Every county in the service area is provided with behavioral health services, and 82.5% of respondents were aware of the availability of mental health and substance use services in their area.

More than half (51.5%) indicated they were aware of NWFHN resources. Of the seventeen respondents who had accessed NWFHN resources in the previous six months, sixteen said the services were helpful. When asked if they had ever directed an individual to access NWFHN by calling or online, 22.7% said they had.

While 59.8% of respondents indicated they were aware of the 2-1-1 information and referral service, 22 (22.7%) had accessed this service in the previous six months. Of those 22, 12 said it was helpful, and 38 (39.2% of all respondents) said they have directed individuals to 2-1-1 by calling or on-line.

Most respondents rated community awareness of behavioral health treatment services in their area as very good (13.4%), good (26.8%), or fair (40.2%).

Nearly two-thirds of respondents agreed or strongly agreed that linkages to needed services are coordinated and well established across the system of care. More than two-thirds agreed or strongly agreed that behavioral health care and peer services are accessible in the service area. Two-thirds agreed or strongly agreed that the processes for referrals are easily accessible.

The most frequently cited barrier to access was no or very limited transportation at 73.2%. Additionally, 57.7% said consumers did not know where to go for services, 57.6% said consumers

could not afford the services, and 38.1% cited stigma (worried what people would think, fear, shame) and long waitlists. More than two-thirds, 69.1%, cited two or more barriers. Respondents described a wide range of resources and services needed to facilitate integration of behavioral health care, primary care, specialty care, dental health care, transportation, safe housing, and follow up (via navigation and wrap-around services), especially in minority, rural, and low-income communities. Specific unmet needs included Medication Assisted Treatment (MAT [especially in rural areas]), assistance with Social Security Disability Insurance (SSDI), Medicaid, Affordable care Act (ACA) applications, and other needed services (e.g., housing, transportation, food, employment, etc.). Adequate funding was also needed to recruit and retain quality providers, including diverse providers that "look like" consumers. The types of patient-centered care resources and services that have improved quality of life of individuals include school-based services, crisis response services, and community-based providers.

CULTURAL HEALTH DISPARITIES SURVEY

Individuals who have received behavioral care services described their personal experiences and preferences related to those services. Although most respondents, 71.4%, indicated they are usually comfortable seeking behavioral health care services, only 26.5% indicated they trusted or strongly trusted the behavioral health care system to treat them with respect. While many respondents are uncomfortable discussing behavioral health issues at all, most respondents indicated that they have been most comfortable in a private office with a doctor (55.1%), speaking with a nurse practitioner (26.5%), or via telehealth (22.4%). The majority identified more than one setting in which they have been most comfortable.

A majority of respondents (59.2%) indicated they would be more comfortable going to a traditional physician office than to faith-based care. Nearly half, 48.9%, said they would be unlikely or very unlikely to be comfortable in group therapy, while 67.3% would be likely or very likely to be comfortable in individual therapy.

Nearly all, 95.9% of respondents, indicated that when they received behavioral health care services, those services were available in their primary language all the time or most of the time.

Demographically, most respondents described their gender as female but 71.4% did not disclose their gender identity at all, and 30.6% did not disclose their current sexual orientation.

Most respondents (85.7%) identified their race as White, 4.1% as Black, 6.1% as multi-racial, and 93.9% identified as non-Hispanic/Latino or did not disclose their ethnicity at all.

Those in the age range 35-44 accounted for 38.8% of survey respondents. The next largest groups were adults 55-64 year of age (18.4%), followed by those 45-54 years (12.2%) and 25-34 years (12.2%).

PEER RECOVERY COMMUNITY SURVEY

Members of the Recovery Community and Certified Peer Recovery Community Specialists use their lived experience and skills learned in training to help others achieve and maintain recovery and wellness from mental health and/or substance use conditions. Of the 30 peers who responded to this survey, 63.3% described their behavioral health experience as adults with lived mental health conditions, and 13.3% described their experience as adults with lived co-occurring mental health and substance use conditions. Others described themselves as veterans with lived co-occurring mental health and substance use conditions, family members, or friends with lived (behavioral health) conditions.

A majority, 53.3%, said they are Certified Recovery Peer Specialists (CRPS), and an additional 30% said they have applied for certification and are in process.

Most respondents, 60%, cited personal fulfillment as one of the reasons/factors for staying with their current company. Forty percent said flexibility with work schedule, 33.3% indicated commitment to recovery principles were important factors. Work hours (30%), administrative support (23.3%), and competitive salary (16.7%) were also identified as important factors. Nearly half, 46.6%, identified two or more reasons/factors.

The most frequently identified barriers/challenges experienced in the hiring process were salary (56.7%), volunteer hours (26.7%), limited employment opportunities (23.3%), and exemption/background screening process (10%). Six respondents identified two or more barriers/challenges.

Respondents were asked to identify what training they would recommend for a peer to have to help them provide peer support services. From a list of 14 types of training, 11 types were identified by more than 50% of respondents. The most frequently cited trainings were the 40-hour required Peer Recovery Specialist Training/Helping Others Heal (90%), Wellness Recovery Action Plan (WRAP [80%]), Compassionate Fatigue/Selfcare (76.7%), and Mental Health First Aid (70%). All respondents cited two or more trainings they would recommend for a peer to have.

Nearly two-thirds of respondents said that partnerships exist with peer support recovery programs, recovery community organizations, and other support groups. Nearly three-fourths said their organization helps reduce stigma by promoting person-centered recovery language.

MOVING FROM WHERE WE ARE TO WHERE WE WANT TO BE

This assessment can serve as the foundation for strategically addressing key behavioral health care needs as defined by consumers and their providers. Next steps include developing a comprehensive behavioral health care plan to enhance access and quality while mitigating barriers and weaknesses. Articulating and implementing measurable objectives and realistic action steps can help ensure a system that promotes individual, family, and community wellbeing and

resilience. We hope that this needs assessment will help make those efforts more fruitful and effective.

NWFHN SERVICE AREA DEMOGRAPHIC PROFILE

Population Demographics

NWFHN's 18-county service area includes Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton, and Washington Counties. Demographic data in this section are based in 5-year estimates from 2016-2020.

Total population of the service area increased by 3.8% between 2016 and 2020, from 1,484,226 to 1,541,100. This increase added 56,874 residents to the service area.

In the service area females accounted for slightly less than 50% of the population while they accounted for 51.1% of the statewide population.

The racial composition in the service area was predominately White at 72%, slightly less than the state rate of 71.6%. The Black population accounted for 18.8% of the service area population and 15.9% of Florida's population. American Indian and Native Hawaiians represented less than 1% of the service area and state population. The percentage of Asian residents, at 2.4%, was similar to the state rate at 2.8%. The service area was slightly less diverse when compared to the state, with 1.8% identifying with a race of Other, and 4.5% identifying with more than one racial group. In the state, 3.3% of the population identified as Other, and 6% identified with more than one racial group.

Ethnically, the service area's percentage of Hispanic residents was 6.5%, significantly lower than the state rate of 25.8%.

The age distribution of the service area population was somewhat younger than the state's population. Residents, 65 years of age or older, accounted for 16.6% of the service area's population, while in the state, 20.5% of residents were at least 65 years old.

Education and Employment

Service area and state populations over the age of 25 years were very similar regarding educational attainment. Nearly 90% of residents in the service area and the state over 25 years of completed high school. The service area rate of 89.7% was slightly higher than the state rate of 88.5%.

In the service area, 17.7% of those over the age of 25 received a bachelor's degree, lower than the state rate of 19.3%. Graduate or professional degrees were held by 11% of those over the age of 25 in the service area compared to 11.3% statewide.

On average, 59% of the service area population participated in the labor force between 2015 and

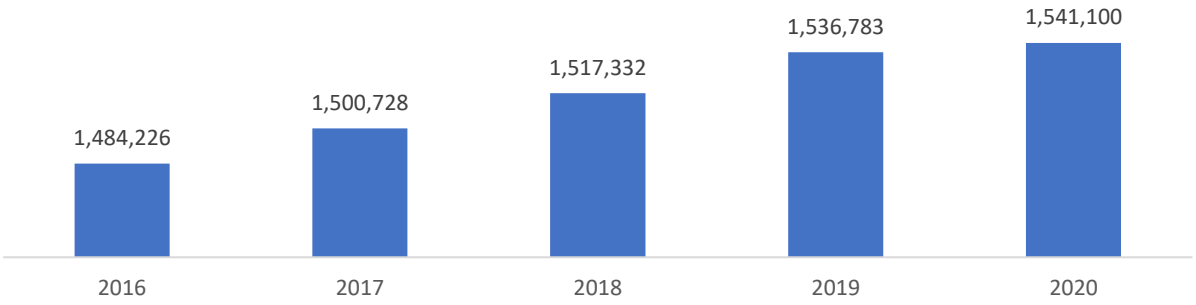
2019, slightly higher than the statewide rate at 58.9%. During the same period, the average rate of unemployment in the service area was 3.1%, lower than the state rate of 5.4%.

Poverty Status

The ratios of income to poverty of residents in the service area and the state were very similar. The population of the area and the state with incomes less than 100% of the poverty level, accounted for 9.7% and 9.4%, respectively. Those with incomes between 100-199% of poverty accounted for 15.8% of the area, and 16.9% of the state population.

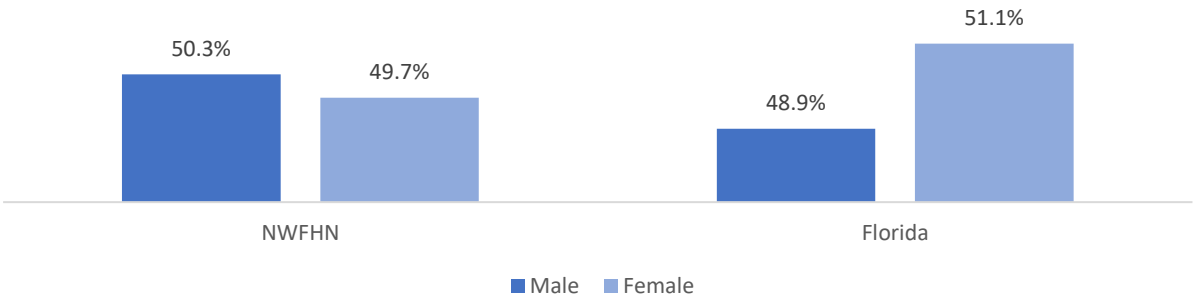
DEMOGRAPHIC CHARTS

Figure 1: NWFHN SA Population Estimates (2016-2020)



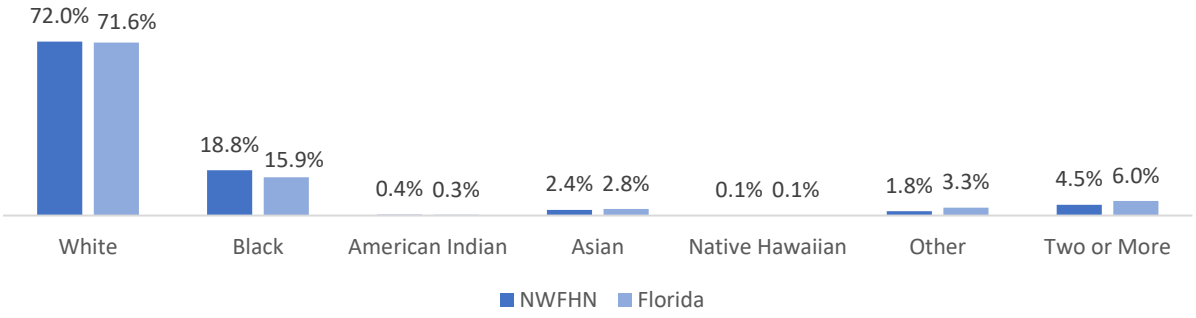
Source: Florida Legislature, Office of Economic and Demographic Research (EDR)

Figure 2: NWFHN SA County Population by Gender (2016-2020)



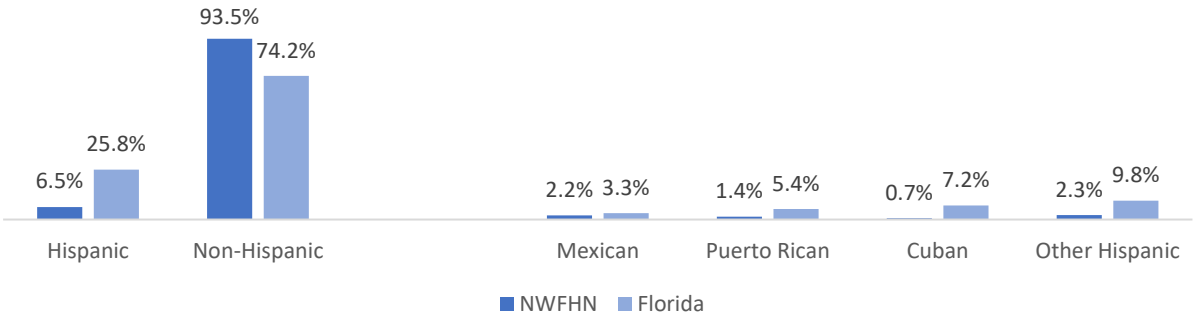
Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 3: NWFHN SA County Population by Race, 2016-2020 (5-Year Estimate)



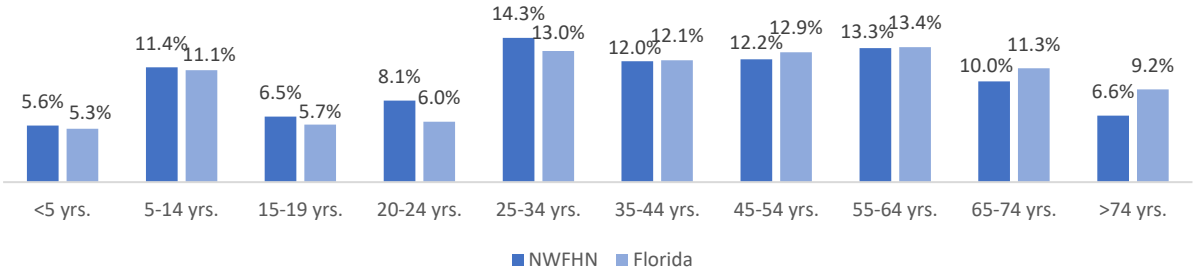
Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 4: NWFHN SA Population by Ethnicity, 2016-2020 (5-Year Estimate)



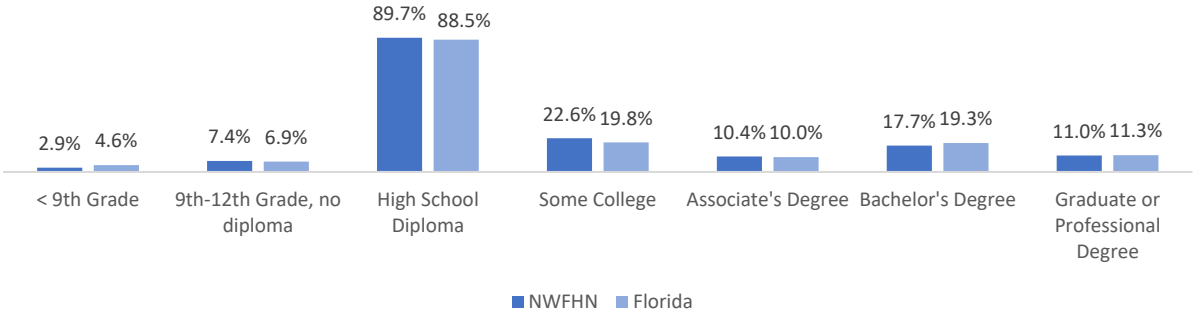
Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 5: NWFHN SA Population by Age Range, 2016-2020 (5-Year Estimate)



Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 6: NWFHN SA Population by Educational Attainment, 2016-2020 (5-Year Estimate)

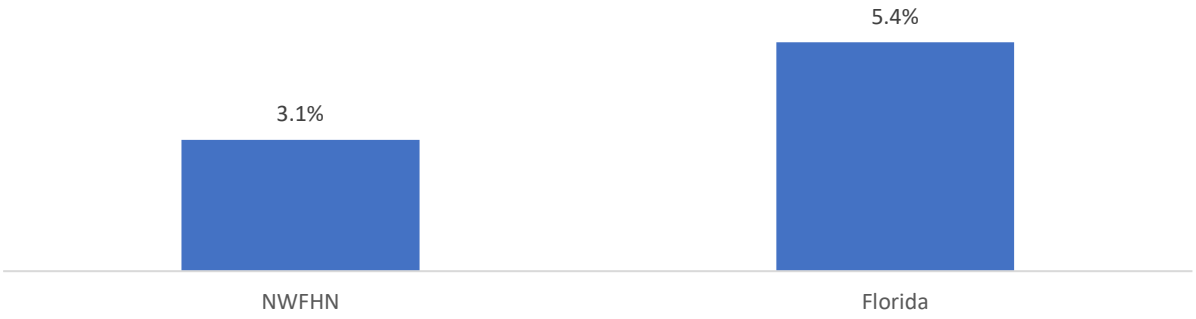


Source: U.S Census Bureau, American Community Survey, Table S1501

Figure 7: NWFHN SA Population Participation in Labor Force, 2016-2020 (5-Year Estimate)

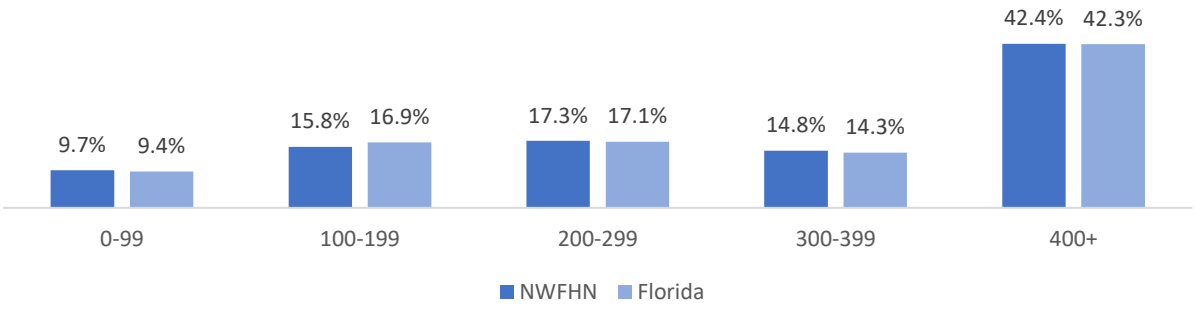
Source: U.S Census Bureau, American Community Survey, Table DP03

Figure 8: NWFHN SA Population Unemployment Rates, 2016-2020 (5-Year Estimate)



Source: U.S Census Bureau, American Community Survey, Table DP03

Figure 9: NWFHN SA Population Ratio of Income to Poverty Level of Families, 2016-2020 (5-Year Estimate)



Source: U.S Census Bureau, American Community Survey, Table B17026

NWFHN SERVICE AREA GENERAL HEALTH STATUS

Overall, Health Status

According to Behavioral Risk Factor Surveillance System (BRFSS) surveys conducted between 2017 and 2020, an estimated 80.6% of adults (ages 18-64) living in the service area said their overall health was "good" to "excellent". For Florida, the rate was slightly lower at 80.3%.

Mental Health

The average percentage of adults, ages 18-64 years, in the service area who reported good mental health from 2017 to 2019, at 86.1%, was slightly lower than the state average of 86.2%. During the same time, adults in the NWFHN service area and the state reported 4.4 days of unhealthy mental days during the previous 30 days.

Suicide

The crude suicide death rate increased from 18.5/100,000 in 2018 to 19.2/100,000 population in 2020, representing an increase of 0.7/100,000 suicide deaths. At the state level, the suicide crude death rate decreased 2.5 deaths per 100,000 population during the same time and was lower throughout 2018 to 2020 when compared to the NWFHN service area population. Among males, the suicide death rates in the service area (29.4/100,000), and state (22.7/100,000), were more than triple the rates among females. The suicide death rate among White residents in the service area (23.7/100,000) was more than five times the rate for Black residents (4.7/100,000). This disparity was greater than at the state level where rate of White suicide deaths was more than triple that of Blacks. It should be noted that the calculations required for the age-adjusted death rate for the NWFHN service areas was beyond the scope of this project.

Violence and Abuse

The rate of total domestic violence offenses decreased in the service area and the state between 2017 and 2019. During this time, the service area rate fell from 627.5/100,000 population to 608.1/100,000, but by 2019 was still significantly higher than the state rate of 496.5/100,000.

The rate of children (ages 5-11 years) experiencing child abuse, during 2017 to 2019, decreased in the NWFHN service area, falling from 1,117.7/100,000 in 2017 to 1,016.1/100,000 in 2019. During this same period, the state rate decreased from 857.9/100,000 to 662.7/100,000. By 2019, the service area rate

was still more than 1.5 times the state rate.

Child sexual abuse rates changed very little from 2017 to 2019, except for briefly decreasing in 2018. In the NWFHN service area, the 2019 sexual abuse rate for children 5-11 years was 104.4/100,000. This was 1.8 times higher than the state rate of 57.8/100,000.

Mental Illness

The estimated number of adults with serious mental illness in the NWFHN service area increased by less than 1%, from 47,047 in 2018 to 47,465 in 2020. This was lower than the rate of increase at the state level of 3.5%.

Between 2018 and 2020, the estimated number of youth with an emotional disturbance (ages 9-17) in the NWFHN service area, increased by 9.1%, from 13,801 in 2018 to 15,058 in 2020. This was higher than the state increase of 3%.

The Florida Department of Education reported that 0.6% of K-12 grade children in the service area had an emotional/behavioral disability, slightly higher than the state rate of 0.5%. Service area rates and state rates were steady from 2018 to 2020.

Adult Tobacco and Alcohol Use

According to BRFSS survey data, between 2017 and 2019, 19.1% of adults living in the service area said they were current smokers, higher than the state rate of 14.8%.

The BRFSS survey defines binge drinking as five consecutive drinks for men and four consecutive drinks for women. From 2017 to 2019, the percentage of binge drinkers in the NWFHN service area was 18.3%, slightly higher than the state rate of 18%.

High School Tobacco, Alcohol and Substance Use

Numerous questions in the Florida Youth Substance Abuse Survey (FYSAS) relate to tobacco, alcohol, and substance use among middle and high school students. Data in this section are estimates from FYSAS 2016-2020.

The percentage of middle and high school students who reported never having smoked cigarettes increased from 80.7% in 2016 to 87.4% in 2020. By 2020, 8.2% of students reported they had smoked once or twice, 2.5% reported that they smoked ‘once in a while’, and 0.6% said they smoked regularly. Overall, for middle and high school students in NWFHN service area and the state, the percentage of those who had never smoked increased.

In 2020, when students were asked about current smoking frequency, 97.2% of those living in the NWFHN service area did not smoke at all, while the state rate was slightly higher at 98.2%.

Questions relevant to vaping were included in the FYSAS for the first time in 2020. In the NWFHN service area, 26% of students reported vaping nicotine on at least one occasion in their lifetime, and 7.8% of students had vaped on 40 or more occasions. Rates at the state level were somewhat lower with 22.8% reporting vaping at least once and 5.9% vaping on 40 or more occasions. Rates of current nicotine vaping during the previous 30 days were much lower in the service area and the state when compared to lifetime rates. While 74% of students in the service area and 77.2% of the students in state had never vaped nicotine, 87% in the service area, and 88.6% in the state had not done so in the past 30 days.

The percentage of students in the service area who had not consumed alcoholic beverages on any occasions in their lifetimes increased from 60.7% in 2016 to 66.3% in 2020. The lifetime consumption of alcohol on 1-2 occasions, increased slightly from 13.8% in 2016 to 14.1% in 2020, while the rates of consuming alcohol on least 40 occasions decreased from 4% in 2016 to 2.8% in 2020. State rates and trends were very similar to those in the NWFHN service area. Overall, lifetime drinking decreased from 2016 to 2020 in the NWFHN service area and the state.

High school students were asked for the number of occasions in their lifetime when they had woken up after a night of drinking alcohol and were unable to remember the things they did or the places they went. The percentage of students in the service area who said this never happened increased from 81.6% in 2016 to 85.1% in 2020, while the state rate increased from 84.1% to 86.2%. In 2020, 7.6% of NWFHN service area students reported that this event happened on at least 1-2 occasions, nearly identical to the state rate of 7.4%.

The percentages of students living in the NWFHN service area not consuming alcohol during the previous 30 days increased from 81% in 2016 to 85.5% in 2020. This was very similar to the state rates and trend. The percentages of students who reported consuming alcohol on 1-2 occasions during the previous 30 days, decreased in the service area from 11.1% in 2016 to 9.1% in 2020, nearly identical to the state rates and trend.

The overall percentage of those binge drinking, defined as consuming 5 or more alcoholic drinks in a row in the past two weeks, decreased in the NWFHN service area from 8.9% in 2016 to 6.5% in 2020. In the state, there was a decrease from 7.8% in 2016 to 6.8% in 2020. These decreases in binge drinking were consistent with the overall increase in no binge drinking at all. Specifically, by 2020 93.5% in the NWFHN service area reported no binge drinking, which was almost identical to the state rate of 93.3%.

Between 2016 and 2020, the percentages of NWFHN service area students who had not used marijuana in their lifetimes increased slightly from 79% to 79.7%, almost identical to the state increase from 78.7% to 79.9%. For those who did use marijuana on one or more occasions, the overall percentages decreased slightly in the NWFHN service area from 21% in 2016 to 20.3% in

2020. At the state level, the decrease was similar when comparing 2016 at 21.3% to 2020 at 20.1%.

In 2020, the percentages of students not using marijuana in the previous 30 days (90.6%) was higher when compared with those who reported not using it at all in their lifetimes at 79.7%. These rates are almost identical to statewide rates.

In 2020, the percentage of students who reported vaping marijuana in their lifetimes on one or more occasions was lower in the NWFHN service area, at 14.6%, when compared to the state rate of 15.6%. This was also true when comparing the two groups of students who had vaped marijuana in the previous 30 days. In the NWFHN service area, 6.6% of students had vaped marijuana in the previous 30 days compared to 7.3% of students in the state.

Disability

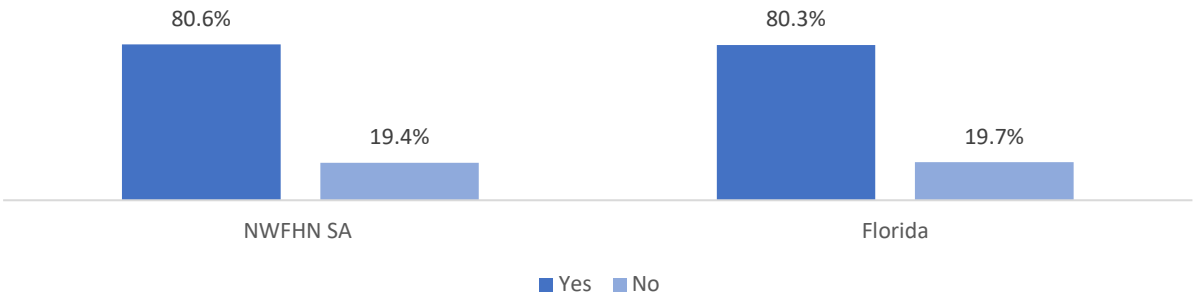
From 2016 to 2020, an estimated 16.1% of the civilian noninstitutionalized population in the NWFHN service area, and 13.6% in the state had a disability (including disabilities related to hearing, vision, cognitive, ambulatory, self-care, and independent living). The rates of disability among older adults, ages 65 years and older, at 39.9% were less when compared to the state at 48.9%.

Health Insurance Coverage

Between 2017 and 2019, most residents ages 18-64 years, living in the NWFHN service area and state, reported having some type of health insurance coverage. The state rate was slightly higher when compared to the NWFHN service area at 84.2% and 83.6%, respectively.

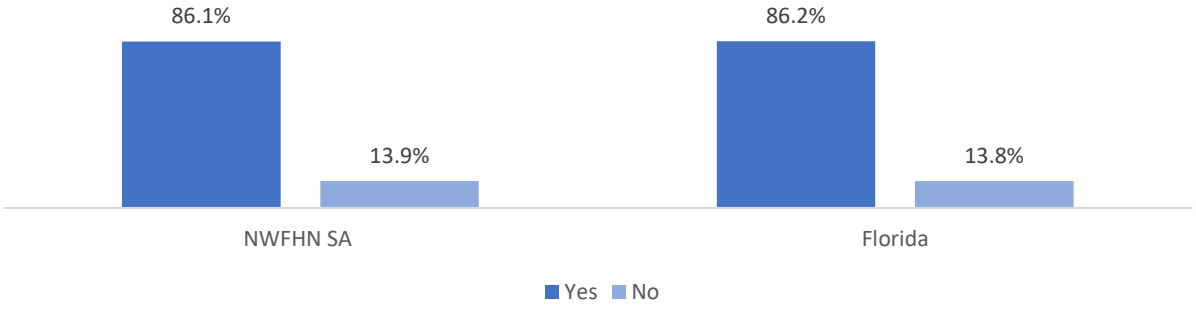
GENERAL HEALTH STATUS CHARTS

Figure 10: NWFHN SA Adults Who Said Their Overall Health Was "Good" to "Excellent" (2017-2019)



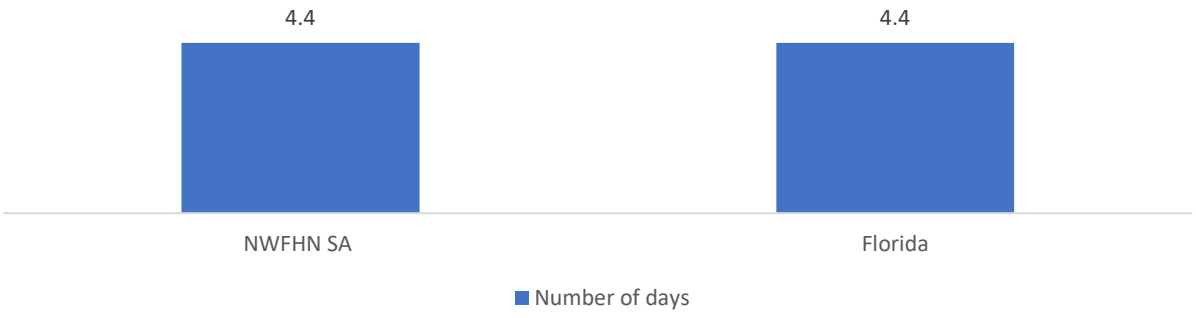
Source: Behavioral Risk Factor Surveillance System

Figure 11: NWFHN SA Adults with Good Mental Health for the Past 30 Days (2017-2019)



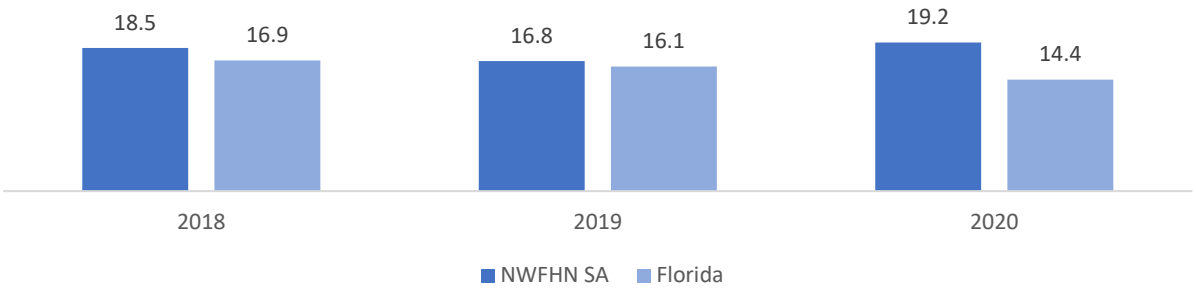
Source: Behavioral Risk Factor Surveillance System

Figure 12: NWFHN SA Adults Average Number of Unhealthy Mental Days in the Past 30 Days (2017-2019)



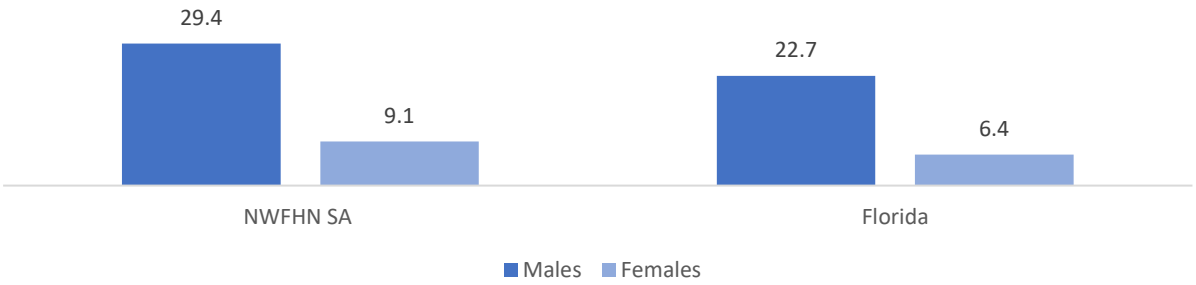
Source: Behavioral Risk Factor Surveillance System

Figure 13: NWFHN SA Crude Suicide Death Rates (2018-2020)



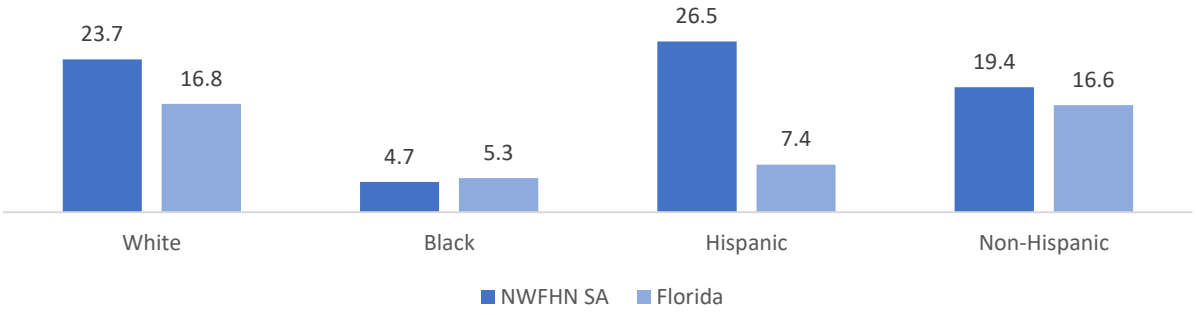
Source: Florida Department of Health, Bureau of Vital Statistics, Rate per 100,000

Figure 14: NWFHN SA Crude Suicide Death Rates by Gender (2020)



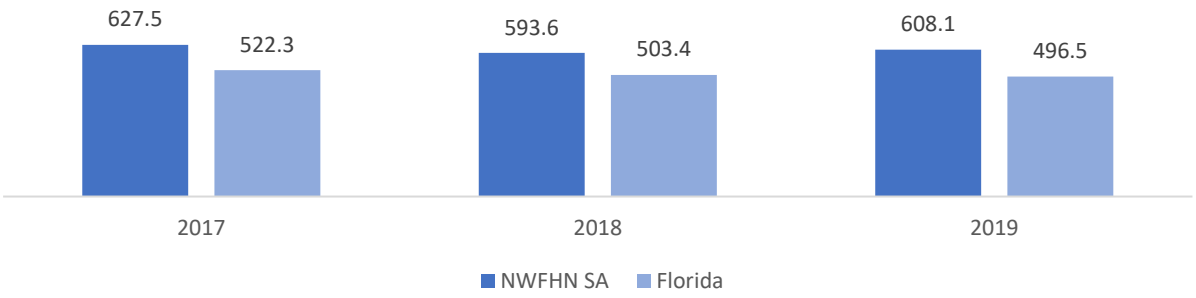
Source: Florida Department of Health, Bureau of Vital Statistics, Rate per 100,000

Figure 15: NWFHN SA Crude Suicide Death Rates by Race and Ethnicity (2020)



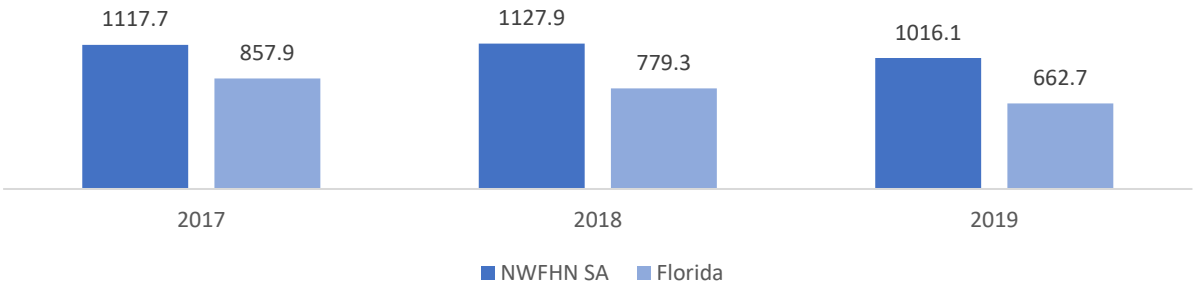
Source: Florida Department of Health, Bureau of Vital Statistics, Rate per 100,000

Figure 16: NWFHN SA Total Domestic Violence Offenses (2017-2019)



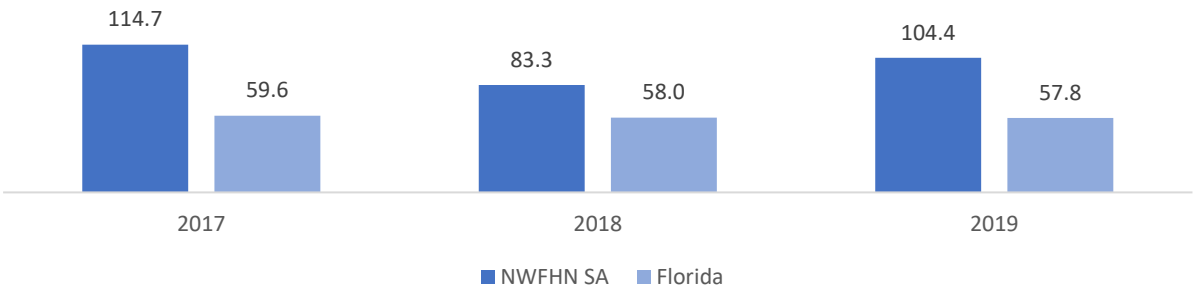
Source: Florida Department of Law Enforcement, Crime in Florida, Uniform Crime Report 2019, Rate per 100,000

Figure 17: NWFHN SA Rate of Children Experiencing Child Abuse, Ages 5-11 Years (2017-2019)



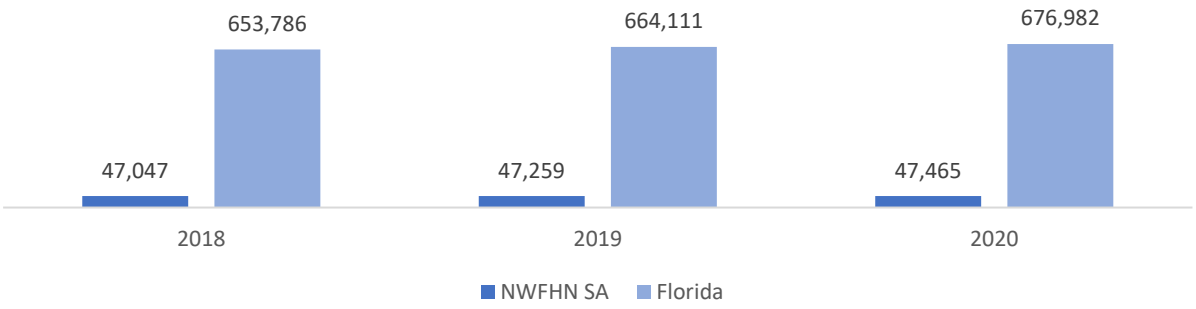
Source: Department of Children and Families, Florida Safe Families Network Data Mart, Rate per 100,000

Figure 18: NWFHN SA Rate of Children Experiencing Sexual Violence, Ages 5-11 Years (2017-2019)



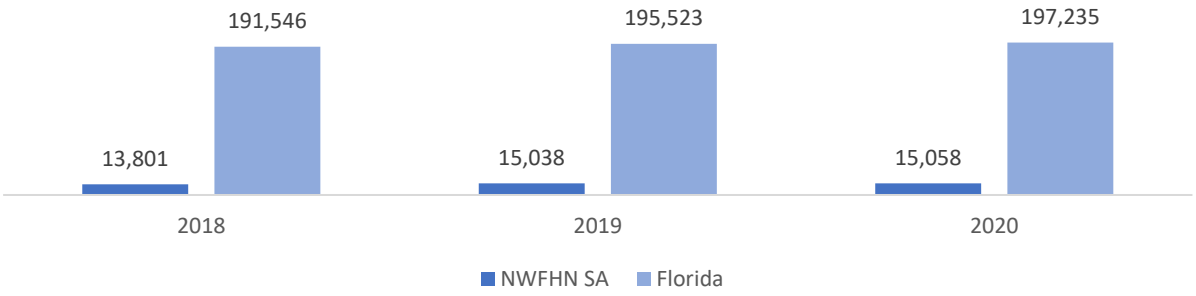
Source: Department of Children and Families, Florida Safe Families Network Data Mart, Rate per 100,000

Figure 19: NWFHN SA Estimated Number of Seriously Mentally Ill Adults (2018-2020)



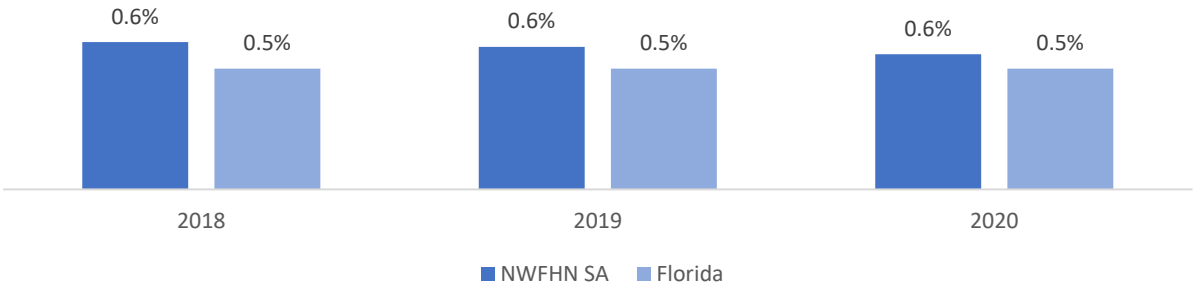
Source: Estimates based on Department of Health and Human Resource Report Mental Health U.S. 1995

Figure 20: NWFHN SA Estimated Number of Emotionally Disturbed Youth, Ages 9-17 Years (2018-2020)



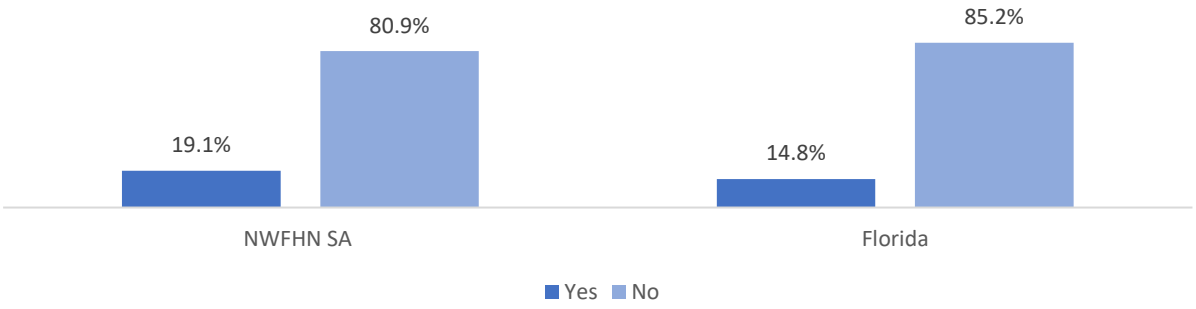
Source: Estimates based on Department of Health and Human Resource Report Mental Health U.S. 1995

Figure 21: NWFHN SA Percentage of Children with Emotional/Behavioral Disability, Grades K-12 (2018-2020)



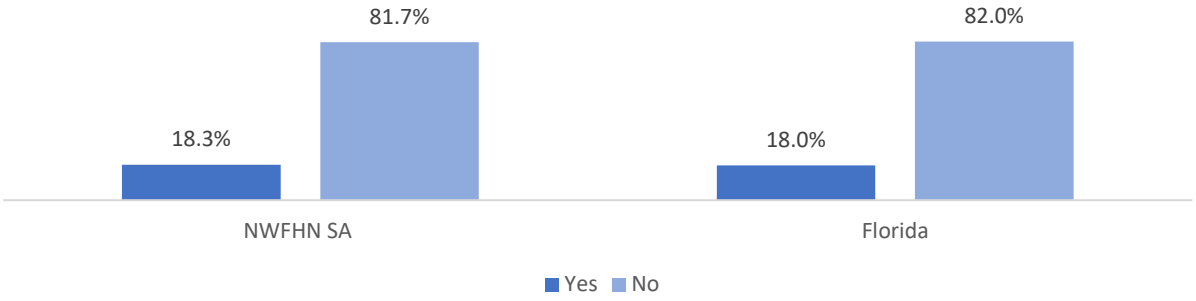
Source: Florida Department of Education, Education Information and Accountability Services (EIAS)

Figure 22: NWFHN SA Percentage of Adults Who Are Current Smokers (2017-2019)



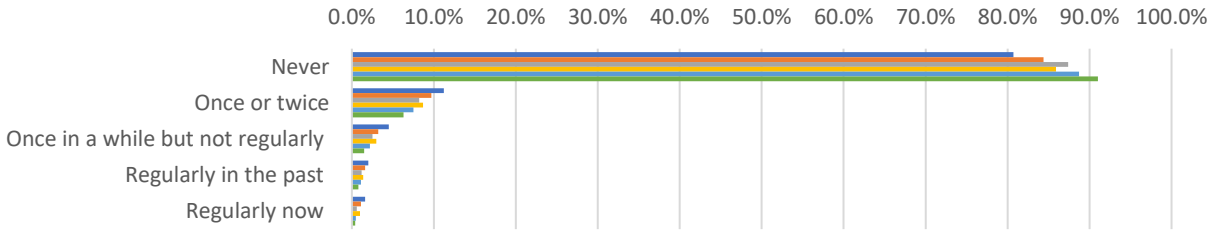
Source: Behavioral Risk Factor Surveillance System

Figure 23: NWFHN SA Percentage of Adults Who Engage in Heavy or Binge Drinking (2017-2019)



Source: Behavioral Risk Factor Surveillance System

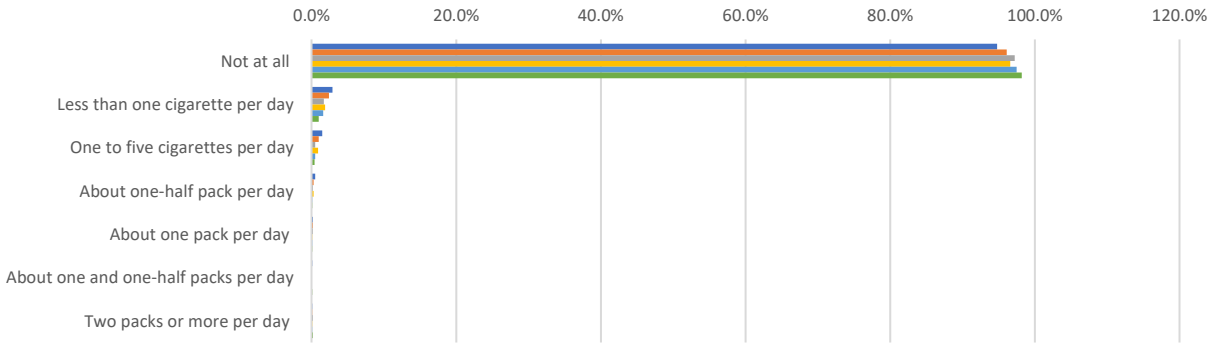
Figure 24: NWFHN SA Having Ever Smoked Cigarettes (MS&HS 2016-2020)



	Regularly now	Regularly in the past	Once in a while but not regularly	Once or twice	Never
NWFHN SA 2016	1.6%	2.0%	4.5%	11.2%	80.7%
NWFHN SA 2018	1.1%	1.6%	3.2%	9.7%	84.4%
NWFHN SA 2020	0.6%	1.2%	2.5%	8.2%	87.4%
Florida 2016	1.0%	1.4%	3.0%	8.7%	85.9%
Florida 2018	0.5%	1.1%	2.2%	7.5%	88.7%
Florida 2020	0.4%	0.8%	1.5%	6.3%	91.0%

Source: Florida Youth Substance Abuse Survey

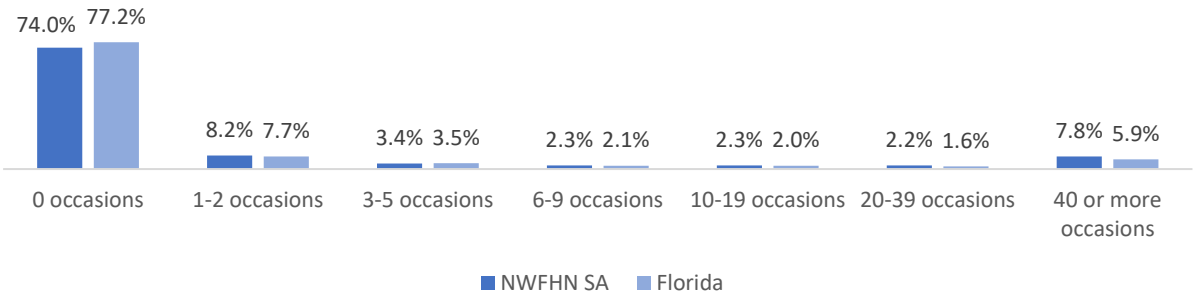
Figure 25: NWFHN SA – How Frequently Have You Smoked Cigarettes in the Past 30 Days? (MS&HS 2016-2020)



	Two packs or more per day	About one and one-half packs per day	About one pack per day	About one-half pack per day	One to five cigarettes per day	Less than one cigarette per day	Not at all
NWFHN SA 2016	0.1%	0.1%	0.2%	0.5%	1.5%	2.9%	94.8%
NWFHN SA 2018	0.1%	0.0%	0.2%	0.3%	1.0%	2.4%	96.1%
NWFHN SA 2020	0.2%	0.0%	0.2%	0.2%	0.5%	1.7%	97.2%
Florida 2016	0.1%	0.0%	0.1%	0.3%	0.9%	1.9%	96.6%
Florida 2018	0.1%	0.0%	0.1%	0.1%	0.5%	1.6%	97.5%
Florida 2020	0.2%	0.1%	0.1%	0.1%	0.4%	1.0%	98.2%

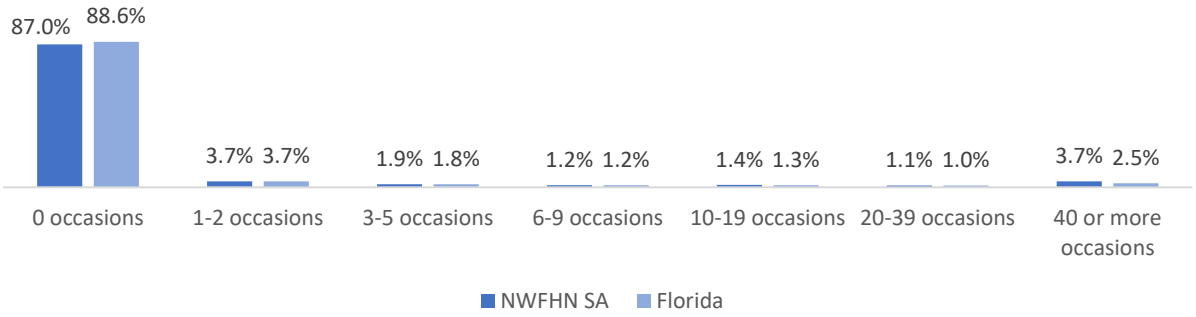
Source: Florida Youth Substance Abuse Survey

Figure 26: NWFHN SA – On How Many Occasions Have You Vaped Nicotine in Your Lifetime? (MS&HS 2020)



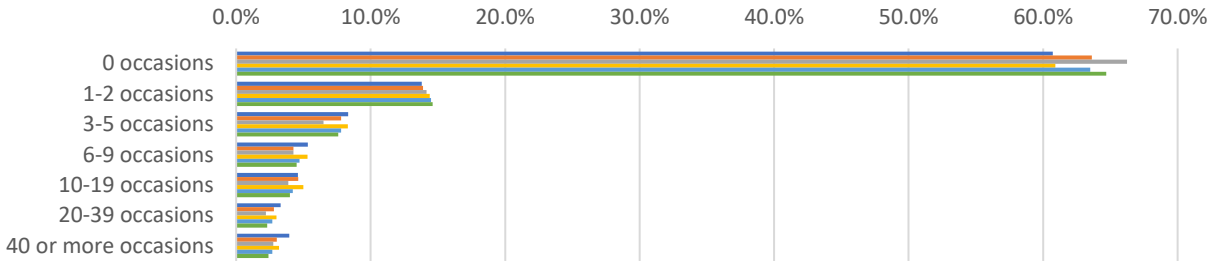
Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

Figure 27: NWFHN SA – On How Many Occasions Have You Vaped Nicotine During the Past 30 Days? (MS&HS 2020)



Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

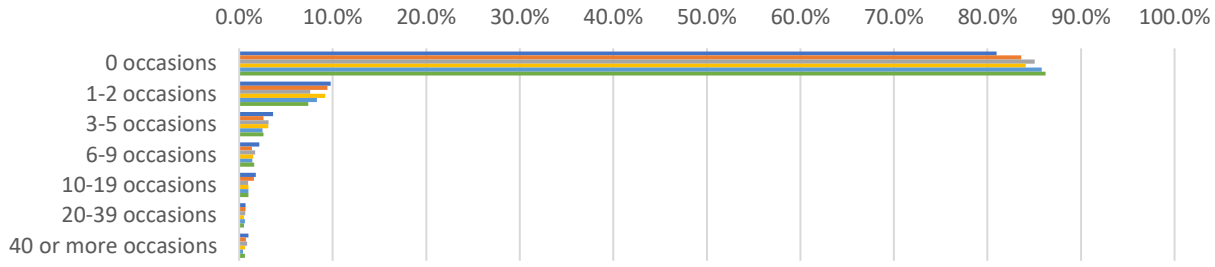
Figure 28: NWFHN SA – On How Many Occasions Have You Had Alcoholic Beverages to Drink in Your Lifetime? (MS&HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
NWFHN SA 2016	4.0%	3.3%	4.6%	5.3%	8.3%	13.8%	60.7%
NWFHN SA 2018	3.0%	2.8%	4.6%	4.3%	7.8%	13.9%	63.6%
NWFHN SA 2020	2.8%	2.2%	3.9%	4.3%	6.5%	14.1%	66.3%
Florida 2016	3.2%	3.0%	5.0%	5.3%	8.3%	14.4%	60.9%
Florida 2018	2.7%	2.7%	4.2%	4.7%	7.8%	14.5%	63.5%
Florida 2020	2.4%	2.3%	4.0%	4.5%	7.6%	14.6%	64.7%

Source: Florida Youth Substance Abuse Survey. Includes beer, wine, or hard liquor. More than a few sips.

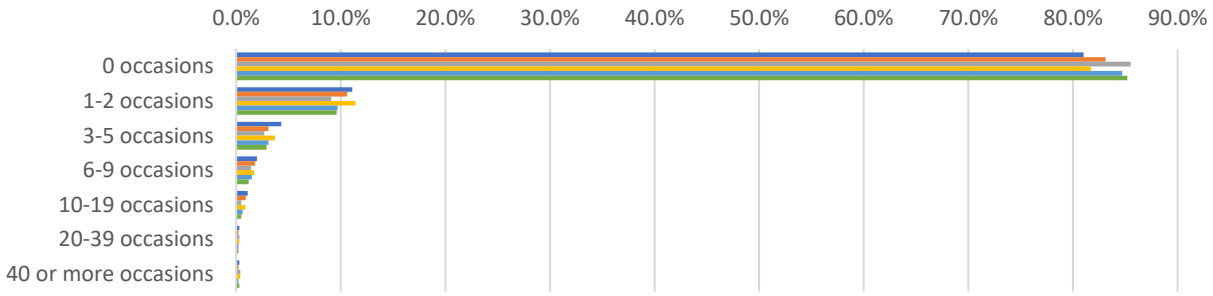
Figure 29: NWFHN SA – On How Many Occasions in Your Lifetime Have You Woken Up After a Night of Drinking Alcoholic Beverages and Not Been Able to Remember Things You Did or the Places You Went? (HS Only 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
NWFHN SA 2016	1.0%	0.7%	1.8%	2.2%	3.6%	9.8%	81.0%
NWFHN SA 2018	0.7%	0.7%	1.6%	1.4%	2.6%	9.4%	83.6%
NWFHN SA 2020	0.9%	0.7%	0.9%	1.7%	3.2%	7.6%	85.1%
Florida 2016	0.6%	0.5%	1.0%	1.5%	3.1%	9.2%	84.1%
Florida 2018	0.4%	0.6%	1.0%	1.4%	2.5%	8.3%	85.8%
Florida 2020	0.6%	0.5%	1.0%	1.6%	2.6%	7.4%	86.2%

Source: Florida Youth Substance Abuse Survey

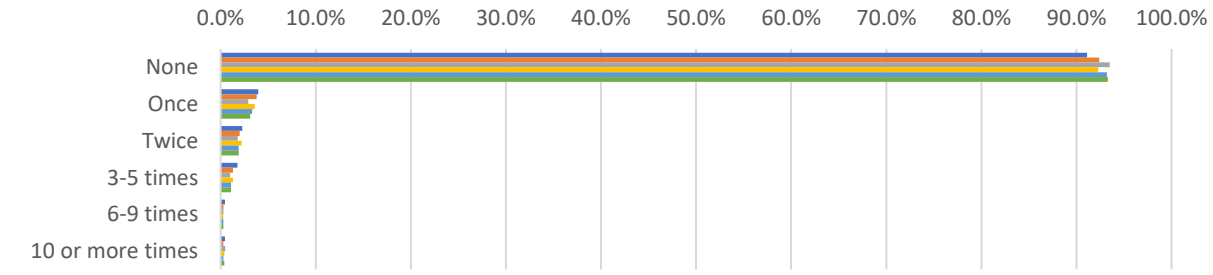
Figure 30: NWFHN SA – On How Many Occasions Have You Had Beer, Wine, or Hard Liquor in the Past 30 Days? (MS&HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
NWFHN SA 2016	0.3%	0.3%	1.1%	2.0%	4.3%	11.1%	81.0%
NWFHN SA 2018	0.2%	0.2%	0.9%	1.8%	3.1%	10.6%	83.1%
NWFHN SA 2020	0.4%	0.3%	0.5%	1.4%	2.7%	9.1%	85.5%
Florida 2016	0.4%	0.3%	0.9%	1.7%	3.7%	11.4%	81.7%
Florida 2018	0.2%	0.2%	0.6%	1.5%	3.1%	9.7%	84.7%
Florida 2020	0.3%	0.2%	0.5%	1.2%	2.9%	9.6%	85.2%

Source: Florida Youth Substance Abuse Survey

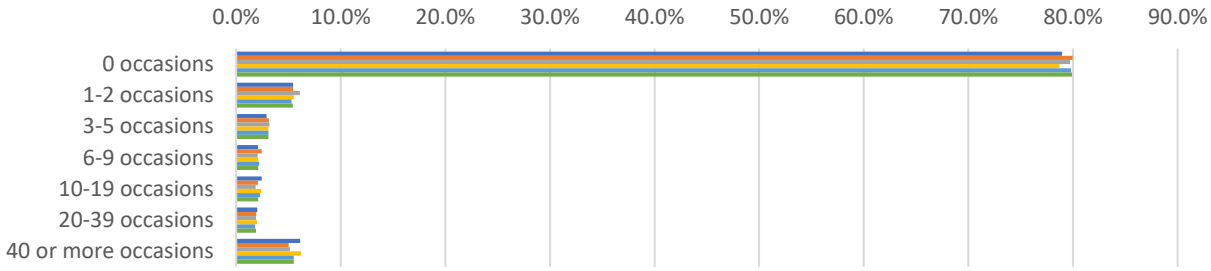
Figure 31: NWFHN SA – Think Back Over the Past 2 Weeks...How Many Times Have You Had Five or More Alcoholic Drinks in a Row? (MS&HS 2016-2020)



	10 or more times	6-9 times	3-5 times	Twice	Once	None
NWFHN SA 2016	0.4%	0.4%	1.8%	2.3%	3.9%	91.1%
NWFHN SA 2018	0.3%	0.3%	1.3%	2.0%	3.8%	92.4%
NWFHN SA 2020	0.5%	0.3%	1.0%	1.8%	2.9%	93.5%
Florida 2016	0.4%	0.3%	1.3%	2.2%	3.6%	92.3%
Florida 2018	0.3%	0.3%	1.1%	1.9%	3.3%	93.2%
Florida 2020	0.4%	0.3%	1.1%	1.9%	3.1%	93.3%

Source: Florida Youth Substance Abuse Survey

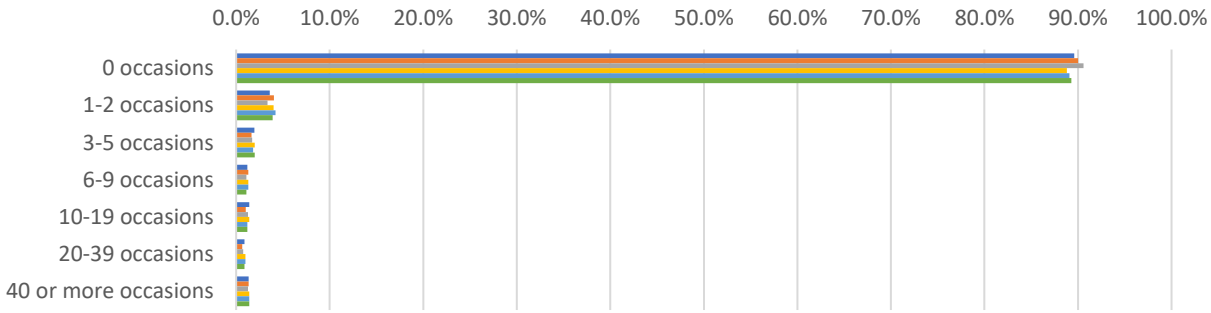
Figure 32: NWFHN SA – On How Many Occasions Have You Used Marijuana or Hashish in Your Lifetime? (MS&HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
NWFHN SA 2016	6.1%	2.0%	2.4%	2.1%	2.9%	5.4%	79.0%
NWFHN SA 2018	5.0%	1.9%	2.1%	2.5%	3.1%	5.4%	80.0%
NWFHN SA 2020	5.2%	1.9%	1.9%	2.1%	3.2%	6.1%	79.7%
Florida 2016	6.2%	2.0%	2.4%	2.1%	3.1%	5.5%	78.7%
Florida 2018	5.5%	1.8%	2.3%	2.2%	3.1%	5.3%	79.8%
Florida 2020	5.5%	1.9%	2.1%	2.1%	3.1%	5.4%	79.9%

Source: Florida Youth Substance Abuse Survey

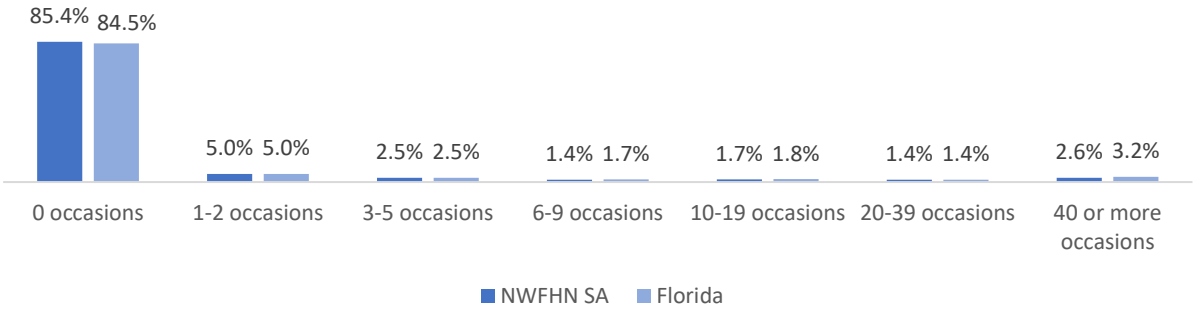
Figure 33: NWFHN SA – On How Many Occasions Have You Used Marijuana or Hashish During the Past 30 Days? (MS&HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
NWFHN SA 2016	1.3%	0.9%	1.4%	1.2%	2.0%	3.6%	89.6%
NWFHN SA 2018	1.3%	0.6%	1.0%	1.3%	1.6%	4.0%	90.0%
NWFHN SA 2020	1.3%	0.8%	1.3%	1.1%	1.7%	3.4%	90.6%
Florida 2016	1.4%	1.0%	1.4%	1.3%	2.0%	4.0%	88.8%
Florida 2018	1.4%	1.0%	1.2%	1.3%	1.8%	4.2%	89.1%
Florida 2020	1.4%	0.9%	1.2%	1.1%	2.0%	3.9%	89.3%

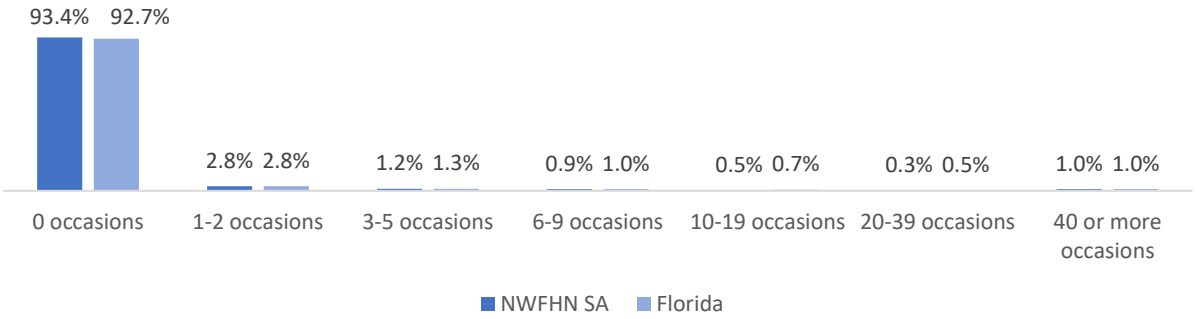
Source: Florida Youth Substance Abuse Survey

Figure 34: NWFHN SA – On How Many Occasions Have You Vaped Marijuana in Your Lifetime? (MS&HS 2016-2020)



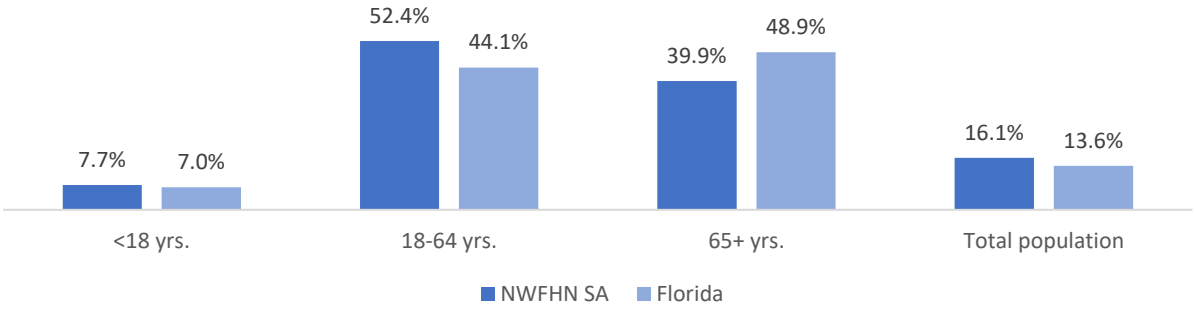
Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

Figure 35: NWFHN SA – On How Many Occasions Have You Vaped Marijuana in the Past 30 Days? (MS&HS 2016-2020)



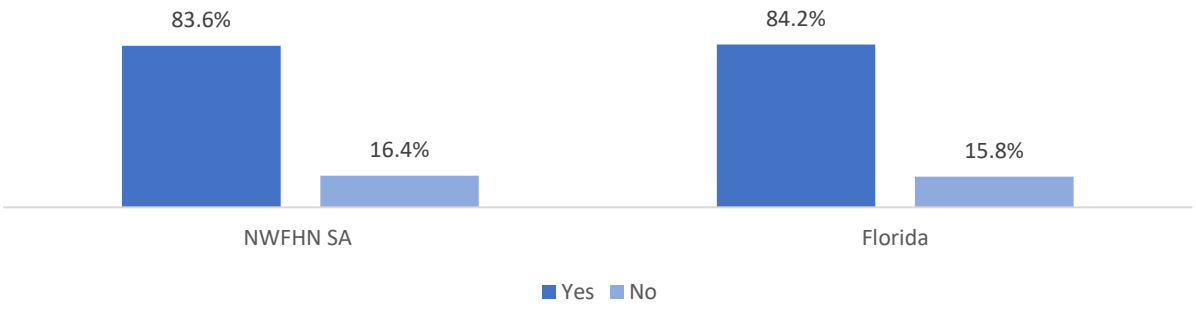
Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

Figure 36: NWFHN SA Civilian Noninstitutionalized Population with a Disability (2016-2020)



Source: U.S. Census Bureau, American Community Survey. Disability includes: Hearing, Vision, Cognitive, Ambulatory, Self-Care, and Independent Living.

Figure 37: NWFHN SA Percentage of Adults with Any Type of Health Care Insurance Coverage (2013-2019)



Source: Behavioral Risk Factor Surveillance System

NWFHN SERVICE AREA CLIENT DEMOGRAPHIC PROFILE

Client Population

NWFHN-funded organizations served 33,313 clients in FY20-21. This included 792 clients (2.4%) from out of the catchment area as well as residents from all 18 counties in the service area. The highest percentage of clients were from Escambia County (31%, 10,331 clients), followed by Bay County at 14.8% (4,928 clients), Okaloosa County at 12.4% (4,120 clients), Leon County at 9.7% (3,232 clients), and Santa Rosa County at 9.5% (3,152 clients). Nearly 5% of clients (1,526) reported their residential status as unhoused.

The Adult Mental Health (AMH) program served 56.6% (20,863 clients) and the Adult Substance Use Disorder (ASUD) program served 20.9% (7,690 clients). An additional 22.2% of clients were in children's programs with 18.7% (6,881 clients) in the Child Mental Health (CMH) program, and 3.8% (1,397 clients) in the Child Substance Use Disorder (CSUD) program.

Gender

Females represented 56.5% of all NWFHN clients and 54.2% of AMH clients. Males accounted for the majority of clients in ASUD (52.8%), CMH (52.9%), and CSUD (51.5%) programs.

Race

Most NWFHN clients were White (70%), a slightly lower percentage of the population of than service area population at 72.9%. Black NWFHN clients accounted for 22.8% of the client population, while representing only 18.8% of the population in the 18-county service area. Overall, 7.2% of all clients identified their race as other than White or Black, including 3.3% multi-racial and 2.5% other.

Ethnicity

The percentage of Hispanics residing in the 18-county service area, at 6.5%, was higher than the rates of Hispanics in NWFHN programs (3.9%). The percentages of Hispanic clients in AMH and ASUD programs were slightly lower, while the rates in CMH and CSUD programs were slightly higher.

Age Range

Adults, 25-44 years of age, accounted for 40.9% of clients in AMH and ASUD programs. This was nearly twice the percentage of adults in that age range in the 18-county area (26.3%). Teen and young adult clients, 15-24 years of age, accounted for 16.4% of NWFHN clients, which was slightly lower than the percentage of those living in the service area at 14.6%. Among those enrolled in child/youth programs, 72% of clients in the CMH program were 5-14 years of age, and 53.5% of clients in the CSUD program were 5-14 years old.

Residential Status

The majority of NWFHN adults (55.3%) resided in one of three types of independent living conditions: with relatives (28.9%), with non-relatives (9.8%), or alone at 16.6%. Among AMH clients, 5.8% reported their status as unhoused, as did 7.8% of those in the ASUD program. Children/Youth living dependently with relatives accounting for 87.6% of CMH clients and 95% of CSUD clients.

Educational Attainment

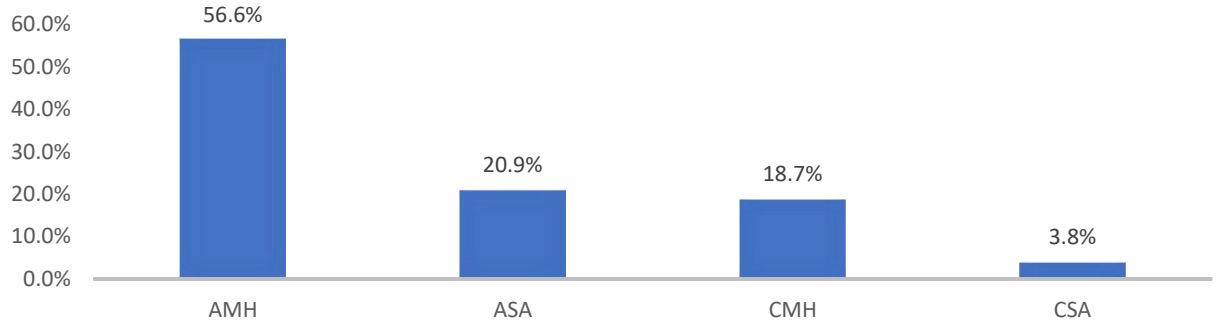
NWFHN clients attained lower educational levels when compared to those in the service area as a whole. Among NWFHN clients, educational attainment at the high school level was 58.4% of AMH clients and 61.2% for ASUD clients. This was significantly lower than 89.7% of residents who graduated high school in the 18-county service area. The percentage of adult NWFHN clients who earned a college degree (2.5%) was well below the overall rate for residents living in the service area (39.1%).

Employment Status

Lower educational attainment was one of several factors contributing to much higher levels of unemployment among NWFHN clients when compared to the overall rate of the service area population. Unemployment ranged from 41.7% among AMH clients, to 45.9% among ASUD clients, while the unemployment rate in the service area and state was 3.1%.

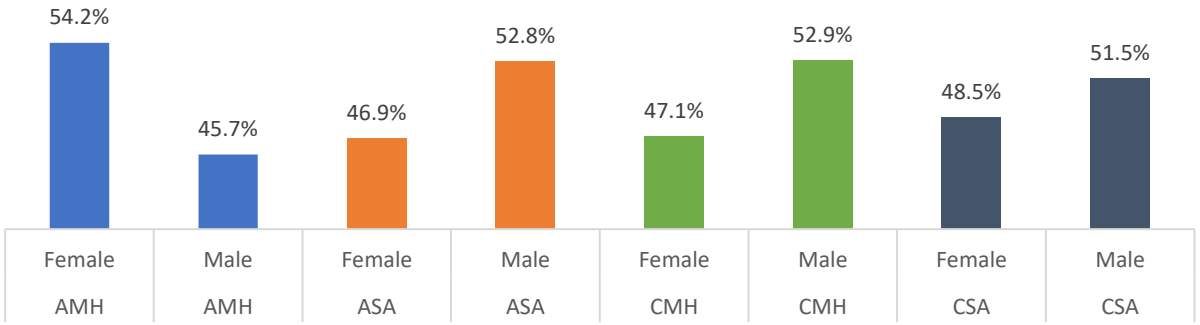
CLIENT DEMOGRAPHIC CHARTS

Figure 38: NWFHN Clients by Program



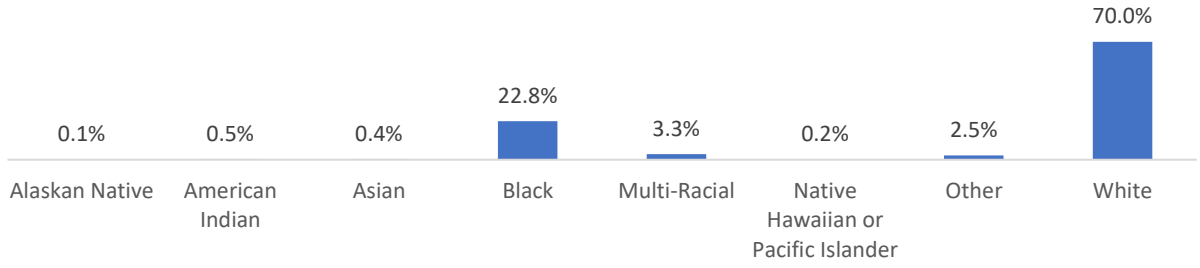
Source: NWFHN Client Data

Figure 39: NWFHN Clients by Program and Gender



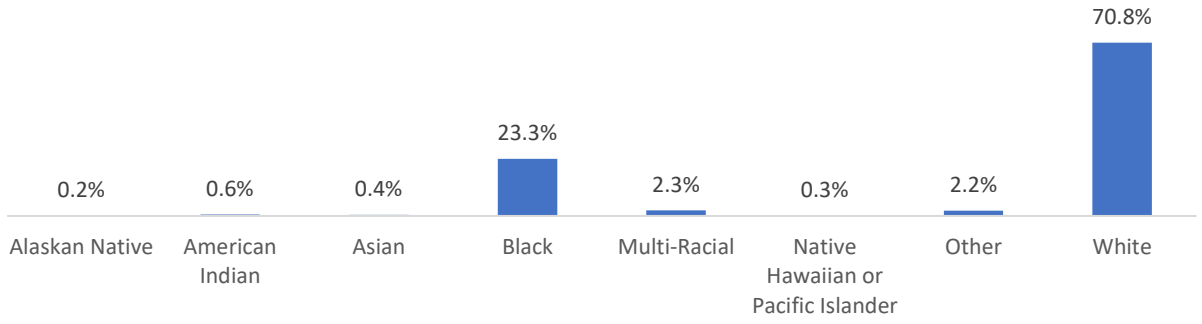
Source: NWFHN Client Data

Figure 40: NWFHN Clients by Race



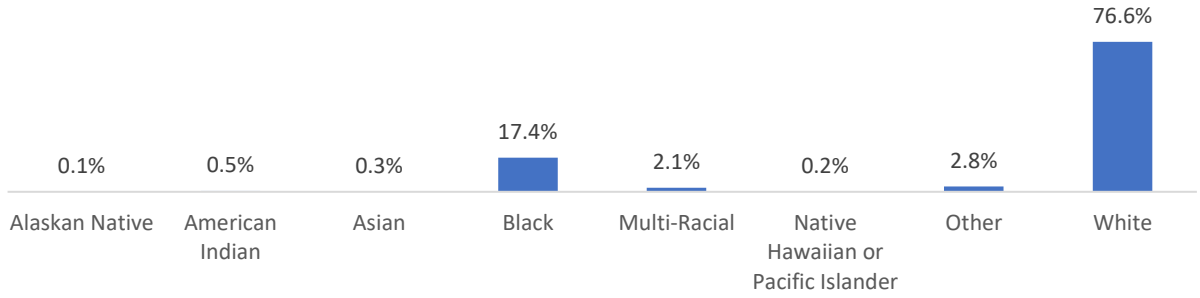
Source: NWFHN Client Data

Figure 41: NWFHN AMH Clients by Race



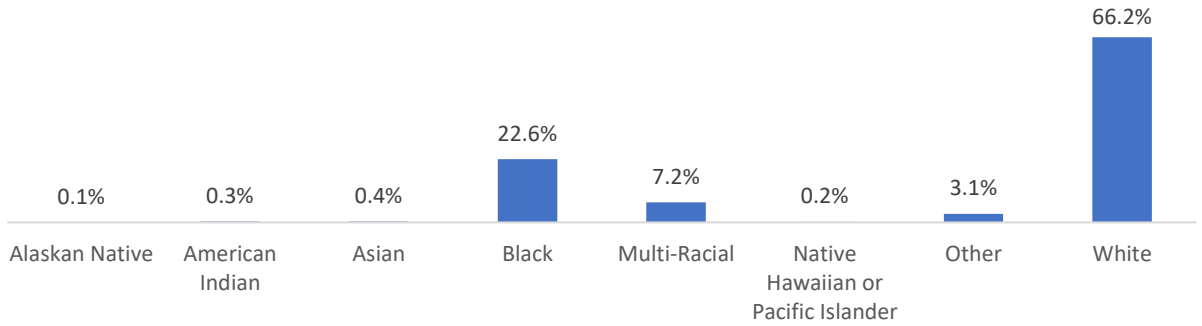
Source: NWFHN Client Data

Figure 42: NWFHN ASUD Clients by Race



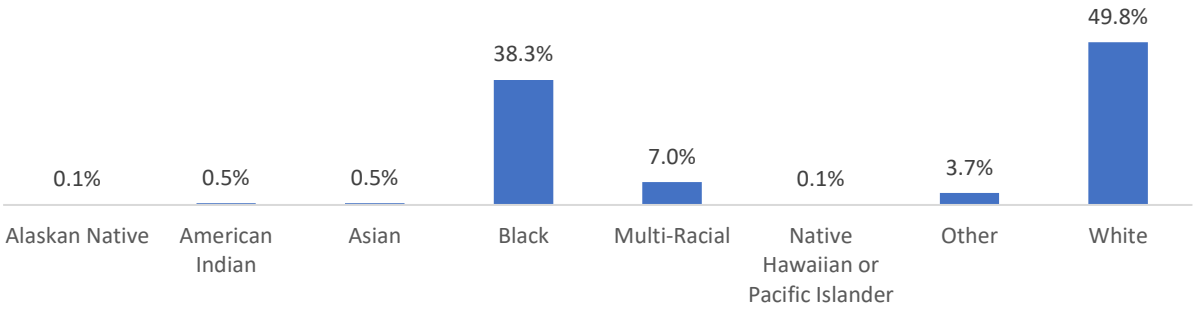
Source: NWFHN Client Data

Figure 43: NWFHN CMH Clients by Race



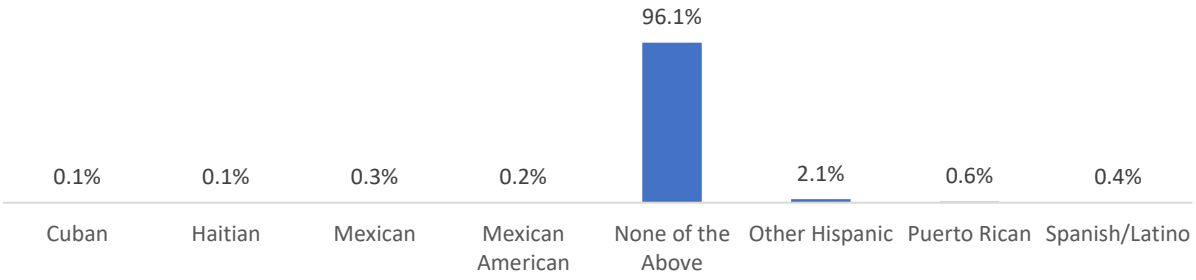
Source: NWFHN Client Data

Figure 44: NWFHN CSUD Clients by Race



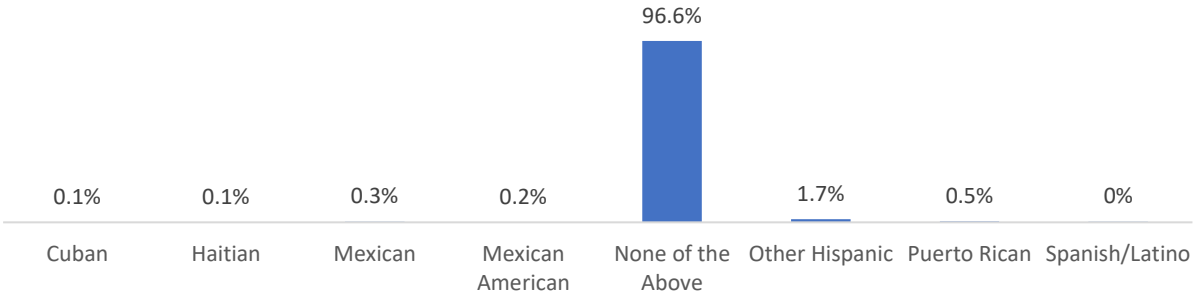
Source: NWFHN Client Data

Figure 45: NWFHN Clients by Ethnicity



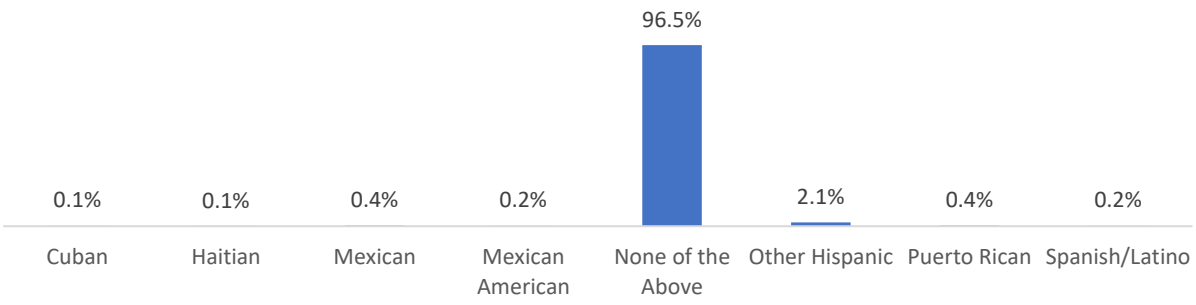
Source: NWFHN Client Data

Figure 46: NWFHN AMH Clients by Ethnicity



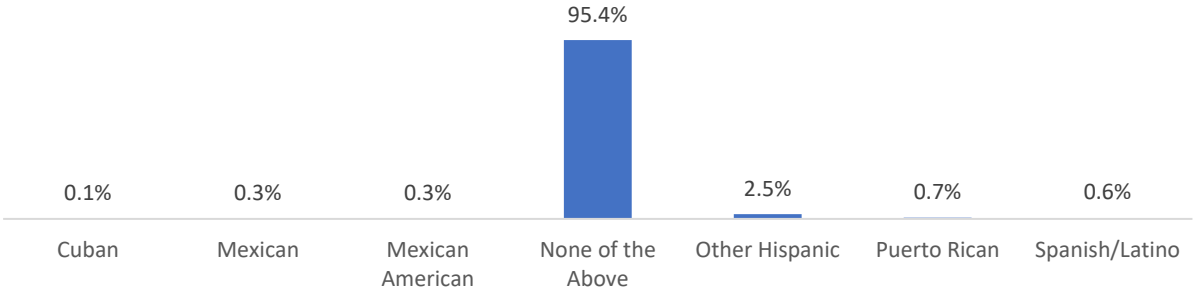
Source: NWFHN Client Data

Figure 47: NWFHN ASUD Clients by Ethnicity



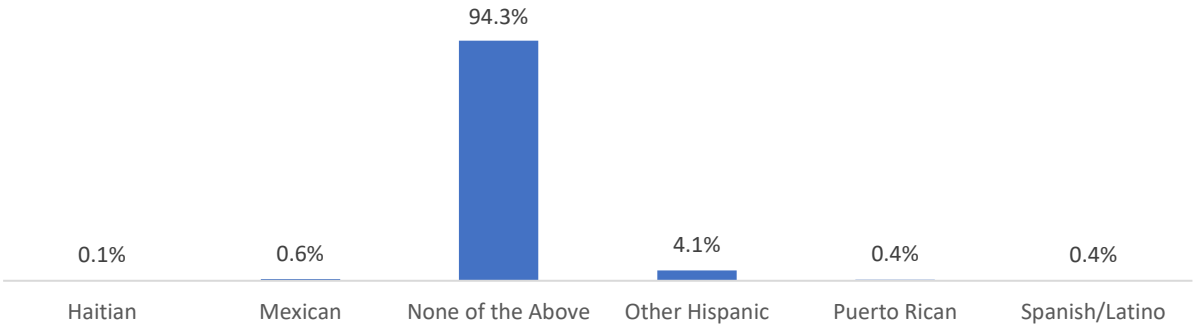
Source: NWFHN Client Data

Figure 48: NWFHN CMH Clients by Ethnicity



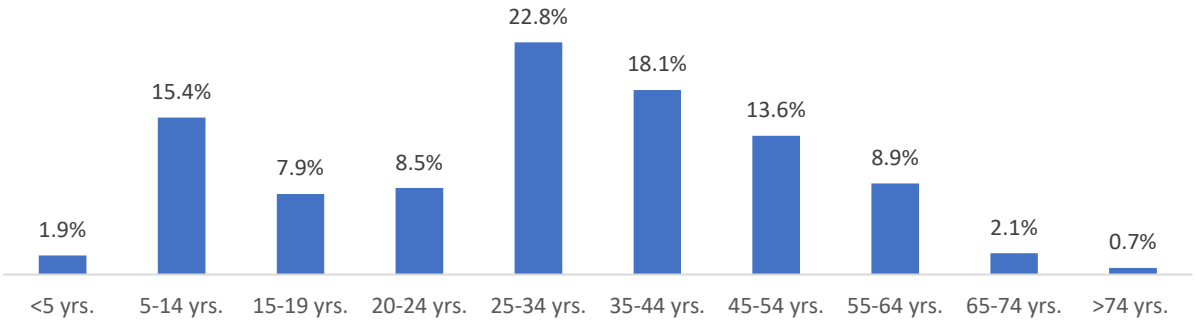
Source: NWFHN Client Data

Figure 49: NWFHN CSUD Clients by Ethnicity



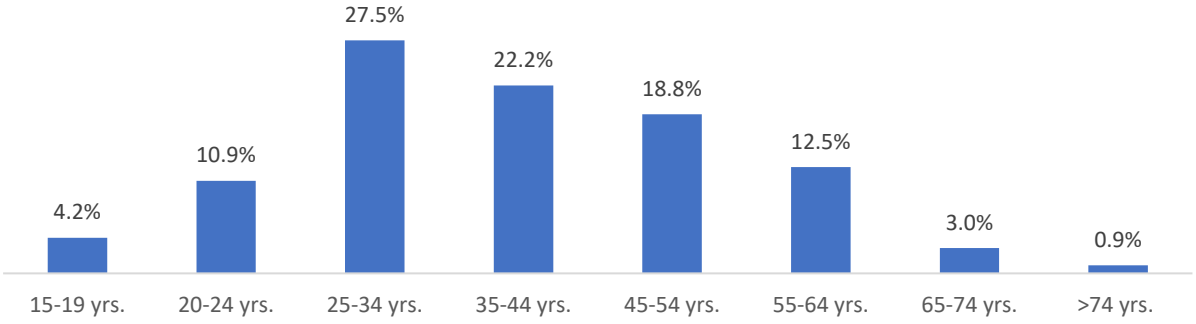
Source: NWFHN Client Data

Figure 50: NWFHN Clients by Age Range



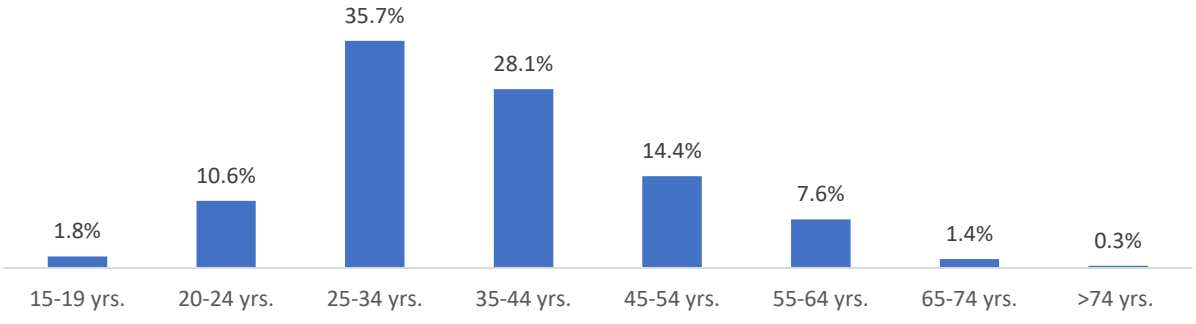
Source: NWFHN Client Data

Figure 51: NWFHN AMH Clients by Age Range



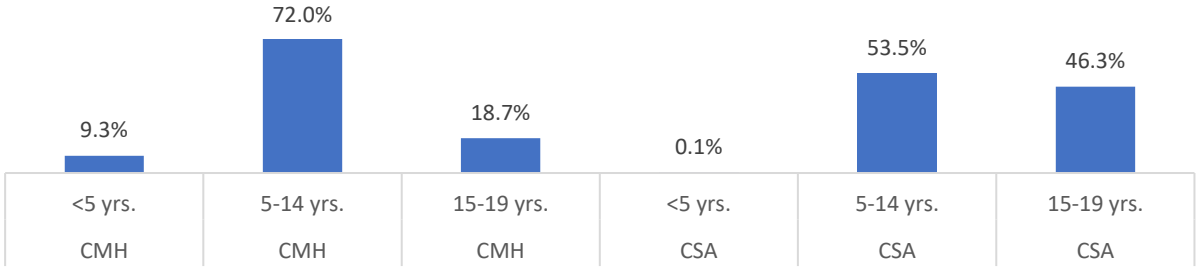
Source: NWFHN Client Data

Figure 52: NWFHN ASUD Clients by Age Range



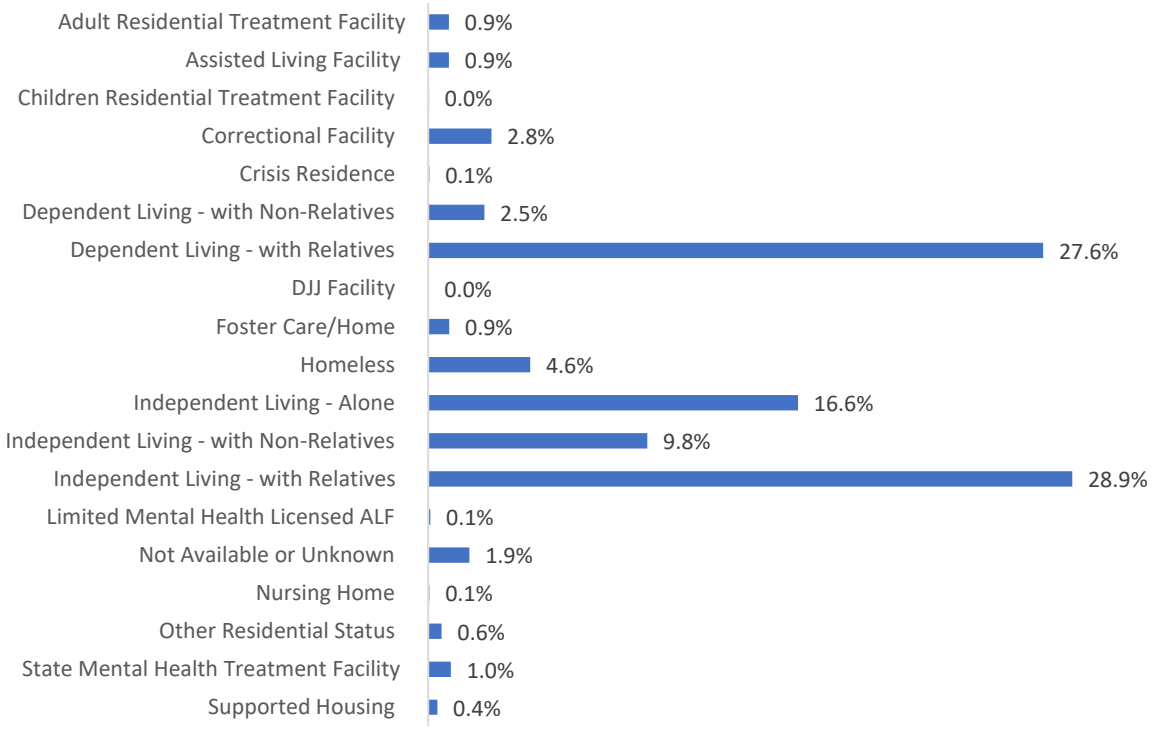
Source: NWFHN Client Data

Figure 53: NWFHN CMH and CSUD Clients by Age Range



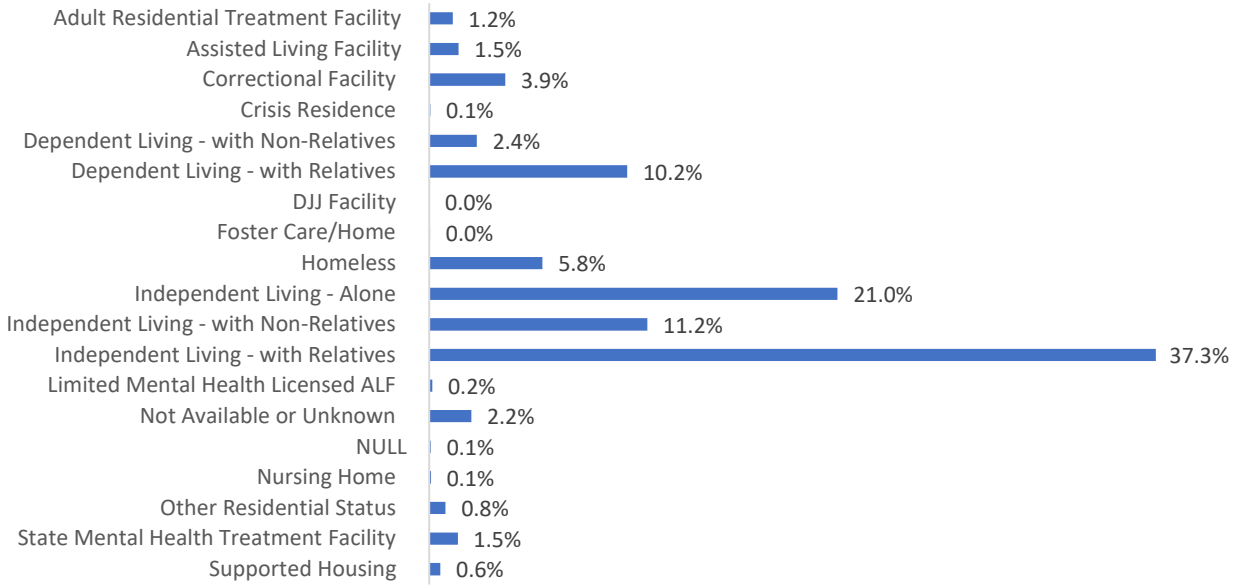
Source: NWFHN Client Data

Figure 54: NWFHN Clients by Residential Status



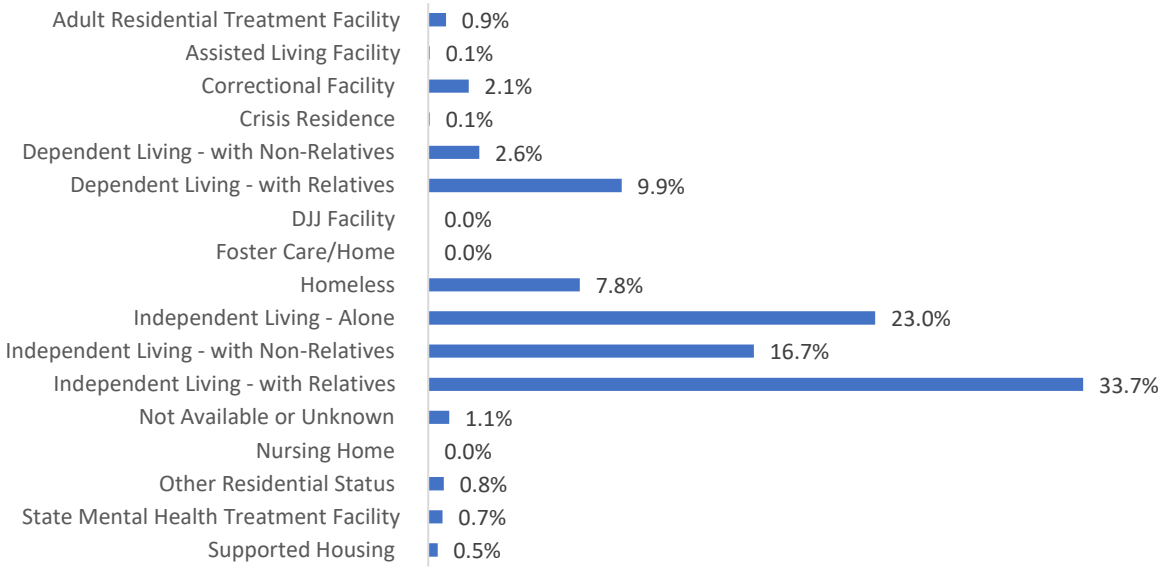
Source: NWFHN Client Data

Figure 55: NWFHN AMH Clients by Residential Status



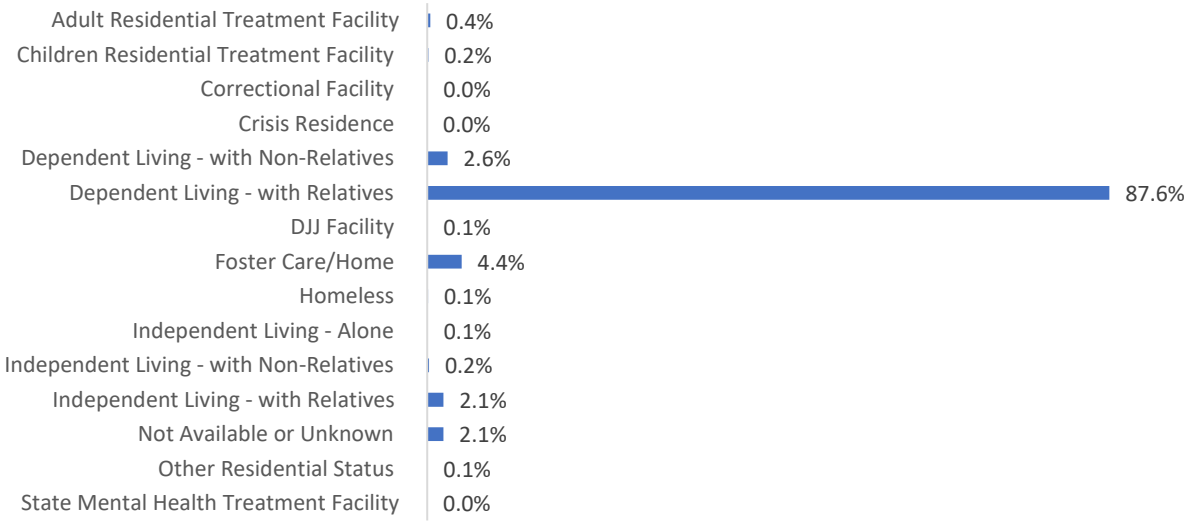
Source: NWFHN Client Data

Figure 56: NWFHN ASUD Clients by Residential Status



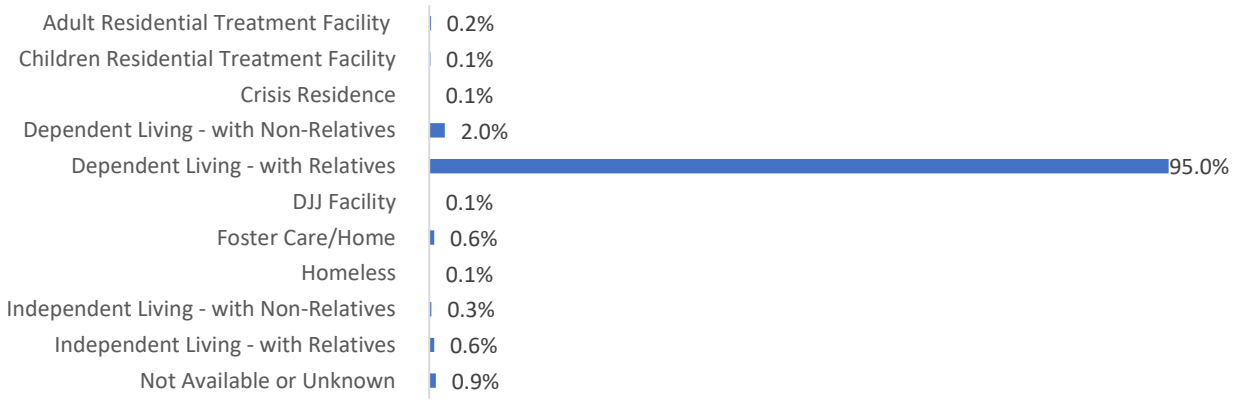
Source: NWFHN Client Data

Figure 57: NWFHN CMH Clients by Residential Status



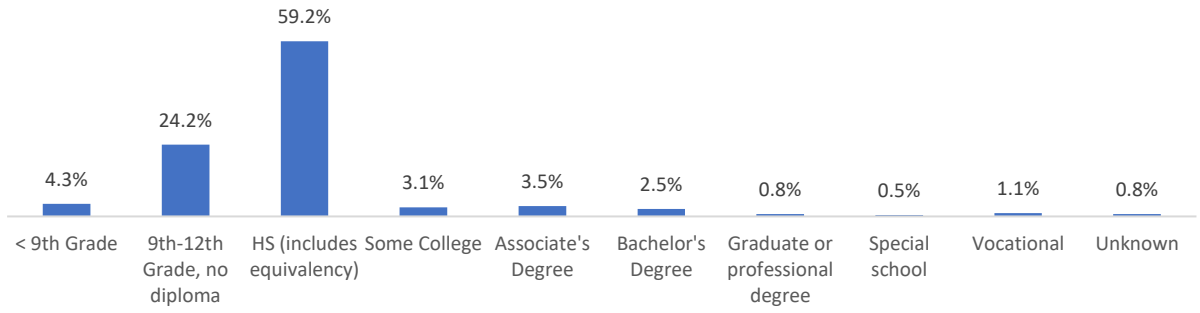
Source: NWFHN Client Data

Figure 58: NWFHN CSUD Clients by Residential Status



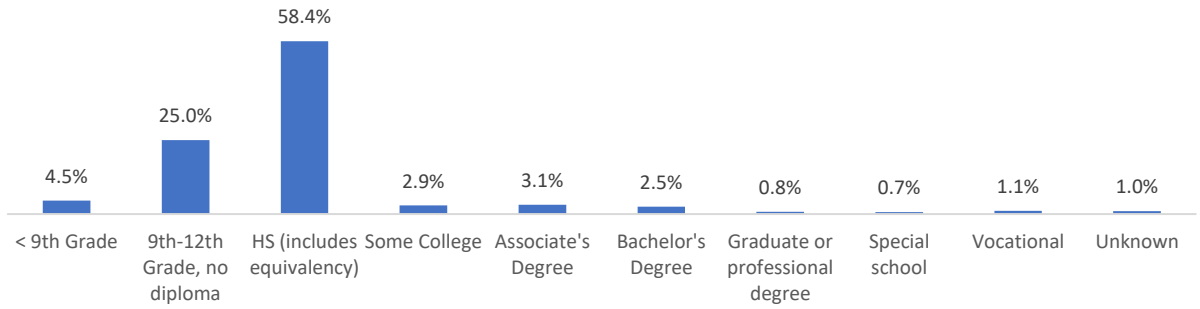
Source: NWFHN Client Data

Figure 59: NWFHN Clients by Educational Attainment



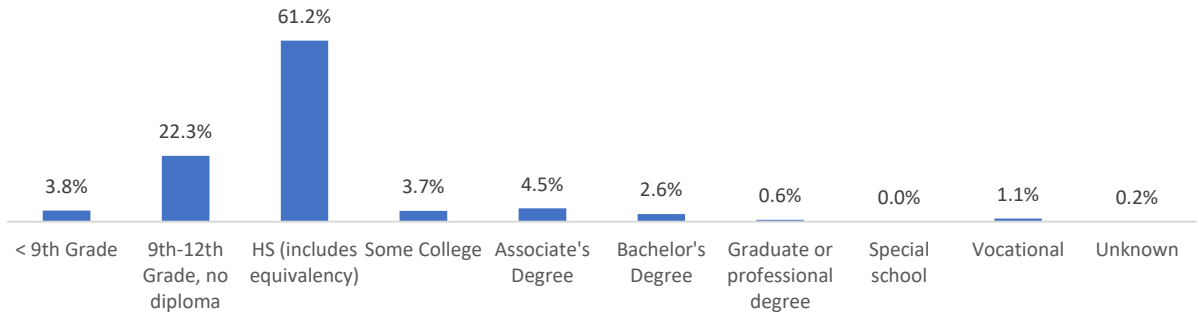
Source: NWFHN Client Data

Figure 60: NWFHN AMH Clients by Educational Attainment



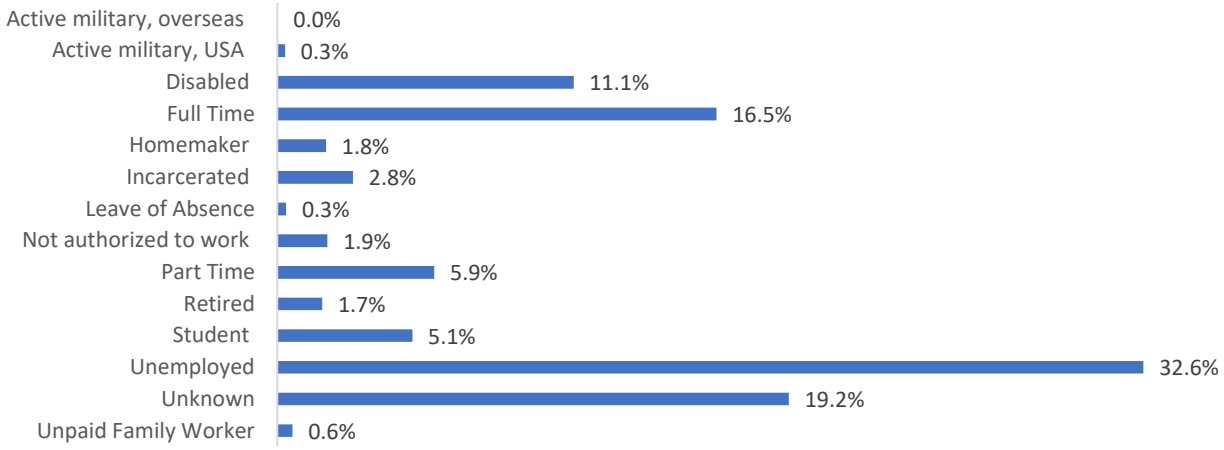
Source: NWFHN Client Data

Figure 61: NWFHN ASUD Clients by Educational Attainment



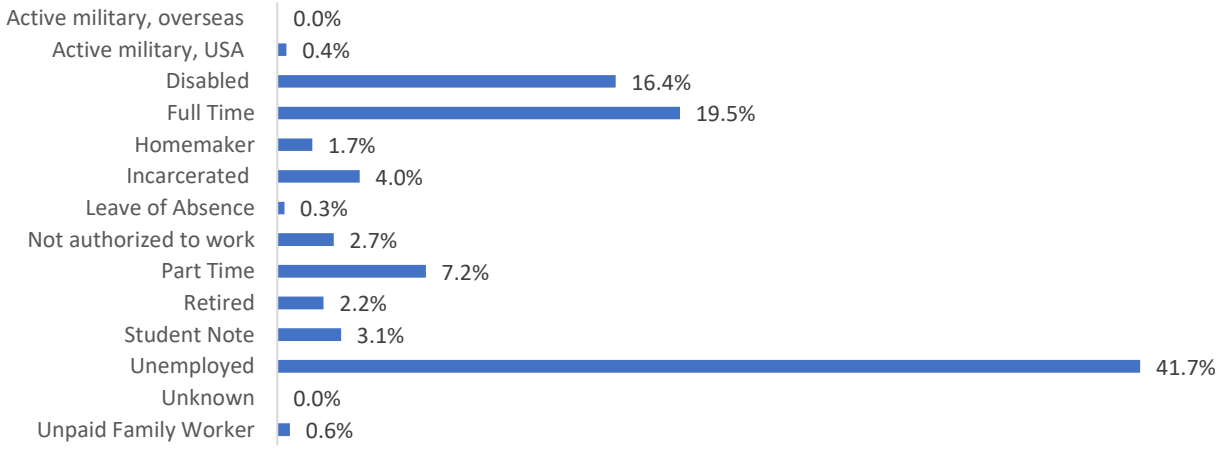
Source: NWFHN Client Data

Figure 62: NWFHN Clients by Employment Status



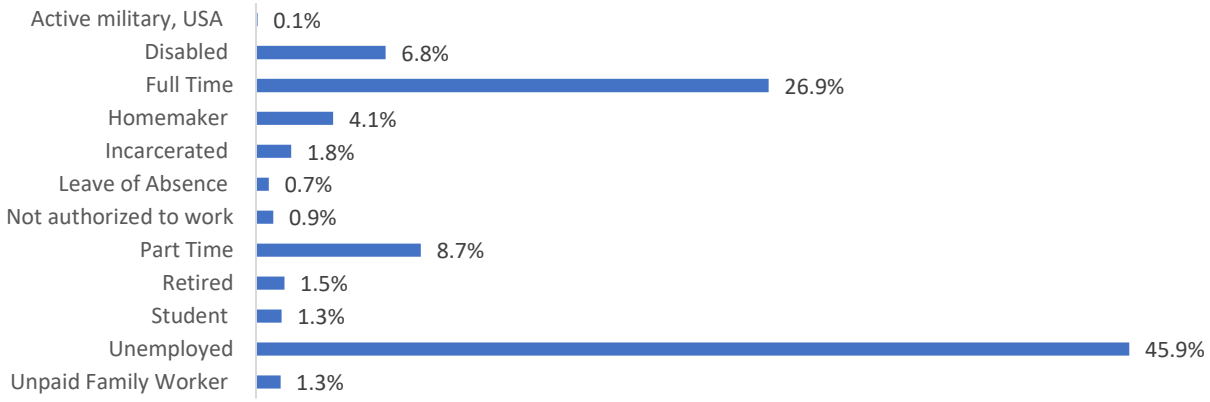
Source: NWFHN Client Data

Figure 63: NWFHN AMH Clients by Employment Status



Source: NWFHN Client Data

Figure 64: NWFHN ASUD Clients by Employment Status



Source: NWFHN Client Data

NWFHN SERVICE AREA UNHOUSED POPULATION

The 2021 Council on Homelessness Report states that the Point in Time Count (PIT) data provides a snapshot of homelessness. **Due to the pandemic, the 2021 PIT Count is not directly comparable to prior years' counts.** Typically, Continuums of Care (CoCs- A local geographic area designated by HUD and served by a local planning body, which is responsible for organizing and delivering housing and services to meet the needs of people who are homeless as they move to stable housing and maximum self-sufficiency) conduct a PIT Count of both sheltered and unsheltered households. This year, due to COVID-19 related safety concerns, only six of the 27 CoCs conducted such a count; 10 CoCs did not conduct an unsheltered count; and others conducted a modified form of the unsheltered count. All CoCs conducted a sheltered PIT count. For those that did not conduct an unsheltered count, the CoCs reported zero unsheltered persons, resulting in an undercount of total homelessness. According to the report:

> "Housing is a significant determinant of health, and insufficient housing is a major public health issue. The COVID-19 pandemic has exacerbated housing instability especially for low-income households. In effect, the pandemic has triggered high rates of unemployment, worsened pre-existing behavioral health disorders, and increased stress, anxiety, and depression for others. Increased rates of unemployment also contribute to increasing the prevalence of behavioral health disorders, resulting in more suffering and deaths. Prior to the pandemic, America's affordable housing crisis was already expected to get worse. The ELI housing crisis is evidenced by the fact that people with disabilities are forced to live in segregated and institutional facilities (e.g., nursing homes, state institutions, etc.) and experience homelessness. Many of these individuals need Permanent Supportive Housing."
>
> (Please access the actual report for resources at: 2021CouncilReport.pdf (myflfamilies.com)

In 2021, the Florida Council on Homelessness reported there were 1,589 unhoused individuals in Northwest Florida (Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton, and Washington counties). Nearly 57.6% (1,514) were sheltered and 42.2% (857) were unsheltered. Chronically unhoused, defined as continually unhoused for over a year, increased from 374 individuals in 2017 to 602 people in 2020. Unhoused veterans decreased during the same time from 288 in 2017 to 203 in 2020. Families with children experiencing homelessness decreased by 36.5% from 606 in 2017 to 385 in 2020.

The number of unhoused students in public schools increased 94.1% from 8,357 in 2015-2016 to 16,219 in the 2018-2019 school year. Of the 16,219 students who were unhoused in 2018-2019, more than 71.1% were in a shared housing arrangement and 7.2% were living in motels.

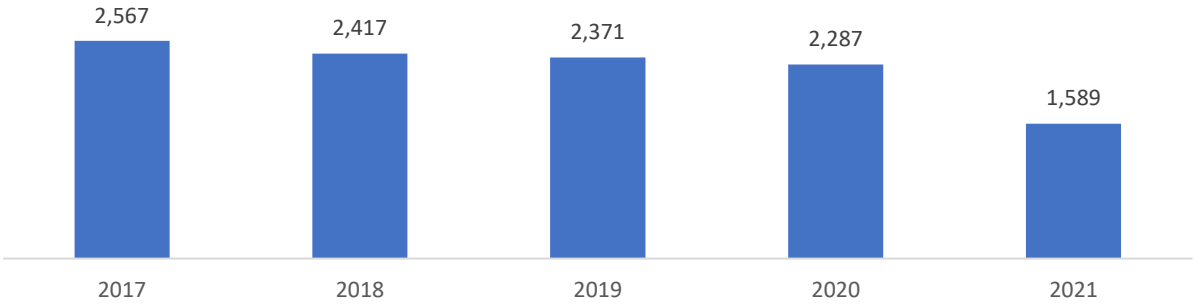
Due to the COVID-19 pandemic, this year saw an unprecedented infusion of federal funding to address homelessness and housing instability. With these funds appropriated by Congress, the State, local governments, CoCs, and partner agencies have invested in solutions to homelessness, including rent and utilities assistance, sheltering, outreach, supportive services and more. While these resources have increased Florida's capacity to prevent and end homelessness, the federal funds have strict restrictions on how the funds may be used; they are not interchangeable with the Challenge and Staffing grants provided to CoCs by the State of Florida. State funding remains critical to addressing homelessness in Florida, especially in rural areas and for the many programs that cannot be funded by federal resources due to their restrictions. State funding helps ensure a broad range of programs in Florida, as well as increase the capacity of the CoCs to administer the federal funding and other resources.

Figure 65: CoC Funding from Federal and State Sources, NWFHN Service Area (SFY20-21)

Source	NWF Service Area
Total Funding Award	$18,025,694.40
HUD CoC FFY20	$3,371,435.00
State Total	$14,654,259.40
State Challenge	$439,500.00
Emergency Solutions Grant	$890,000.00
ESG-CV	$12,755,688.00
State Staffing	$428,571.40
State TANF-HP	$140,500.00

Source: 2021 Florida's Council on Homelessness Annual Report

Figure 66: Total Unhoused Population, NWFHN Service Area (2017-2021)

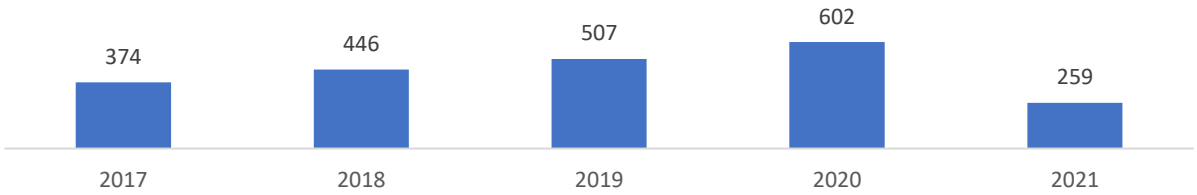


Source: 2021 Florida's Council on Homelessness Annual Report

Figure 67: Total Unhoused Population Sheltered and Unsheltered, NWFHN Service Area (2021)

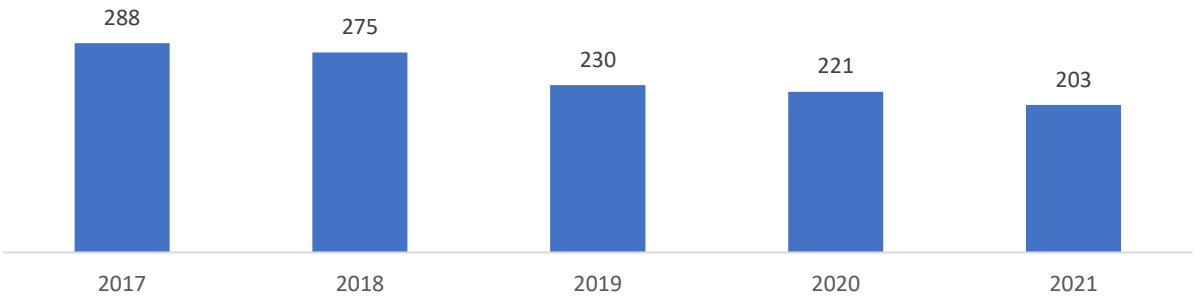
Source: 2021 Florida's Council on Homelessness Annual Report . FL-515 did not conduct an unsheltered PIT Count. FL-504 and FL-511 conducted a modified PIT Count. FL-506 conducted a full PIT Count.

Figure 68: Chronic Unhoused, NWFHN Service Area (2017-2021)



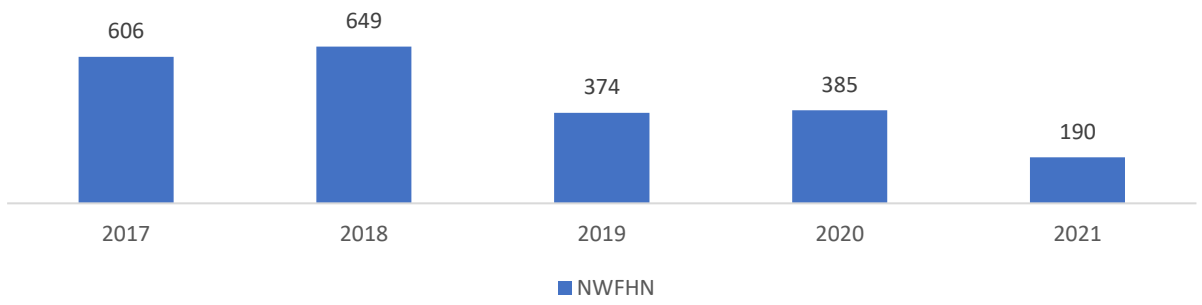
Source: 2021 Florida's Council on Homelessness Annual Report

Figure 69: Unhoused Veterans, NWFHN Service Area (2017-2021)



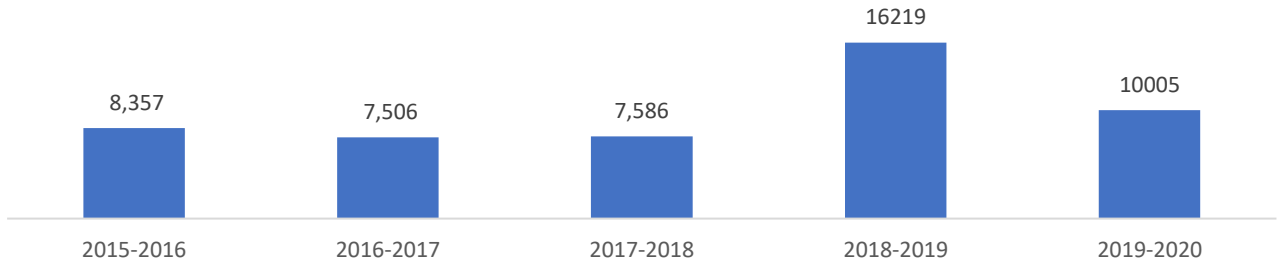
Source: 2021 Florida's Council on Homelessness Annual Report

Figure 70: Unhoused Families – Total Persons in Families with Children, NWFHN Service Area (2017-2021)



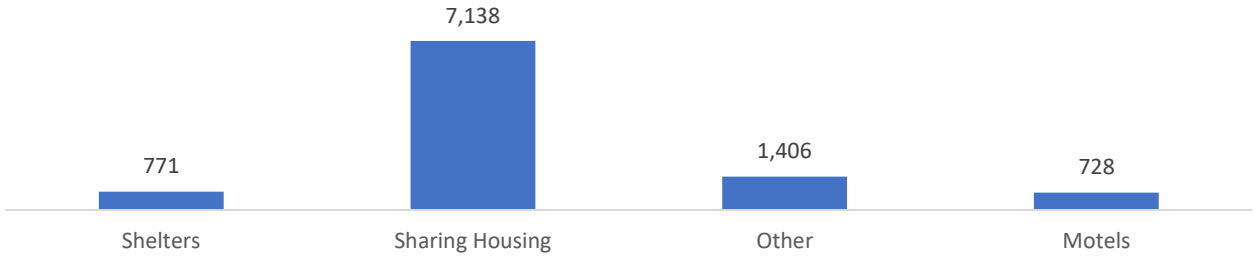
Source: 2021 Florida's Council on Homelessness Annual Report

Figure 71: Florida DOE – Reported Unhoused Students in Public Schools, NWFHN Service Area (2015-2020)



Source: 2021 Florida's Council on Homelessness Annual Report

Figure 72: Reported Unhoused Students in Public Schools by Living Situation, NWFHN Service Area (2019-2020)



Source: 2021 Florida's Council on Homelessness Annual Report

NWFHN UNHOUSED CLIENT PROFILE

Of the 33,313 clients served during FY20-21, 4.6% (1,526) were unhoused. While NWFHN served unhoused clients in every county, the highest numbers of unhoused clients resided in Escambia (541 clients), Leon (411 clients), Bay (191 clients), and Okaloosa (142 clients), accounting for 1,289 clients, 84.5% of all unhoused clients in the NWF service area.

Nearly two-thirds (63.2%) of all unhoused clients were male, 65.9% of unhoused males were in the AMH program and 61.4% were in the ASUD program. Three-fourths (75%) of unhoused male children were in CMH and 100% were in CSUD.

Most unhoused clients were White (1,026, 67.2%), 409 (26.8%) were Black, and 91 (9.4%) were other races. This was similar to the rates for all NWFHN clients; 70% were White, 22.8% were Black, and 7.2% were other races.

Of the 1,526 unhoused clients, 42 (2.8%) were Hispanic, compared to 3.9% of all clients, and 6.5% of the service area population as a whole.

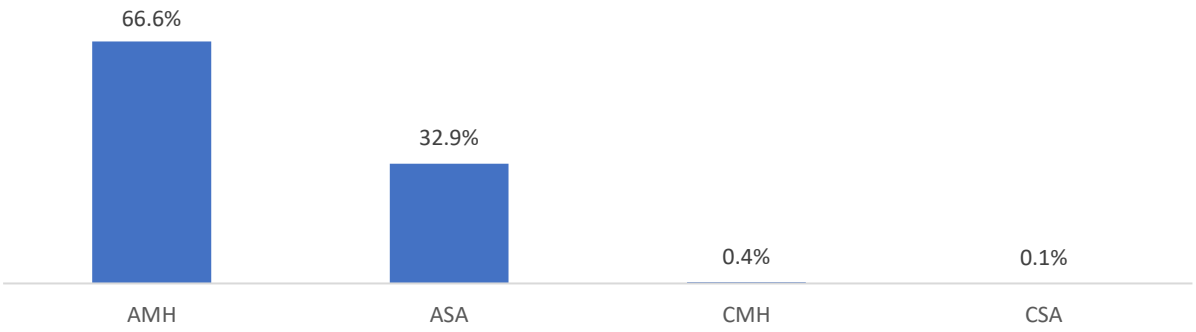
Overall, 75.1% of adult unhoused clients were 25-54 years of age. Among all NWFHN clients, 54.5% were in this age range. Additionally, 13.5% unhoused clients were 55-64 years, 7.6% were 20-24 years, and 3.2% were in other age ranges. These ranges were fairly consistent in adult and children's programs.

Most adult unhoused clients completed high school (59.7%), while 27.4% completed 9th-12th grade with no diploma. More than 3% completed some college, and nearly 2% completed an associate degree. These rates were similar for clients in AMH and ASUD programs, for those who were unhoused and for all clients.

Overall, 62.9% of adult unhoused clients were unemployed, 10.4% were employed full time, and 2.5% were employed part time.

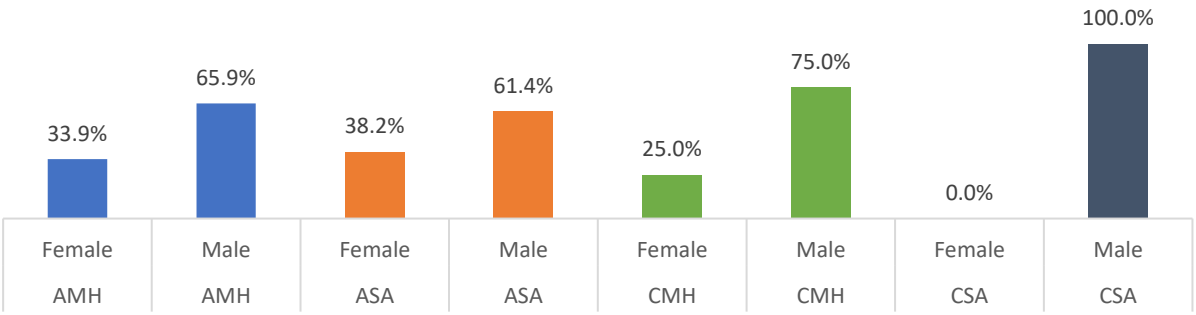
NWFHN UNHOUSED CLIENT CHARTS

Figure 73: NWFHN Unhoused Clients by Program



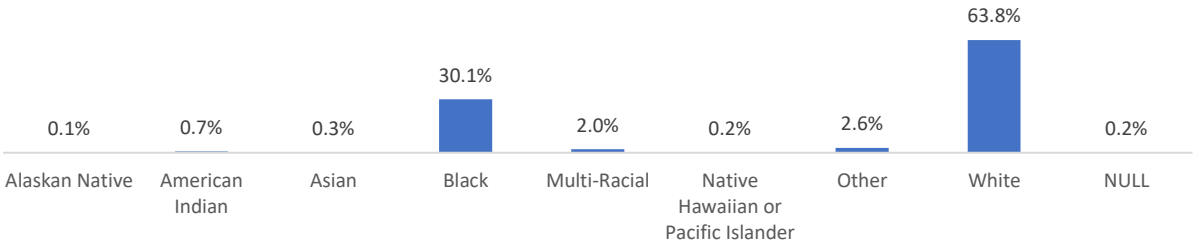
Source: NWFHN Client Data

Figure 74: NWFHN Unhoused Clients by Gender



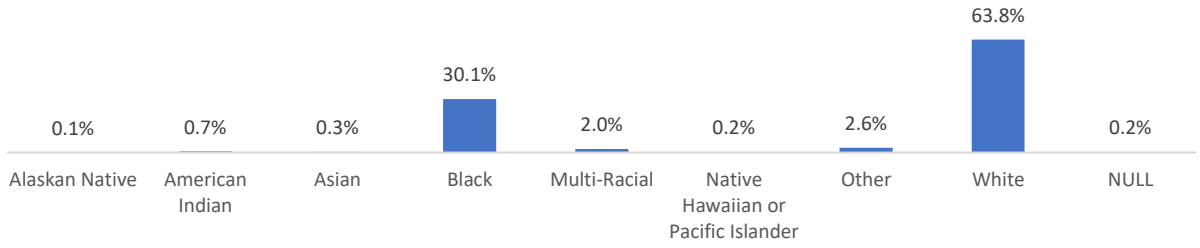
Source: NWFHN Client Data

Figure 75: NWFHN Unhoused Clients by Race



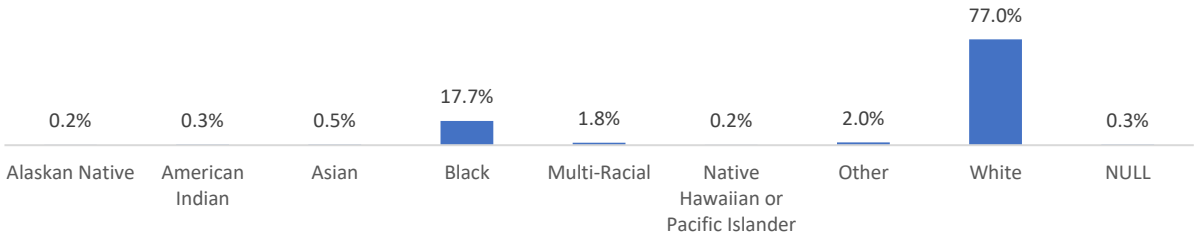
Source: NWFHN Client Data

Figure 76: NWFHN Unhoused AMH Clients by Race



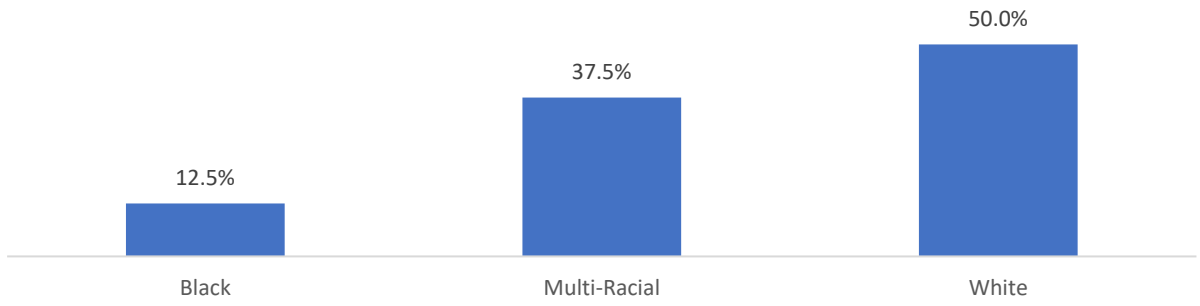
Source: NWFHN Client Data

Figure 77: NWFHN Unhoused ASUD Client by Race



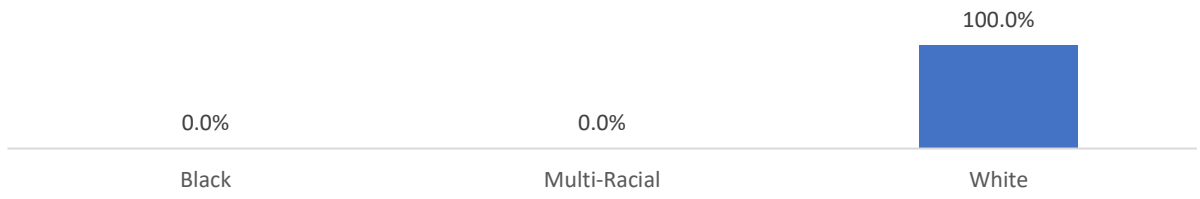
Source: NWFHN Client Data

Figure 78: NWFHN Unhoused CMH Clients by Race



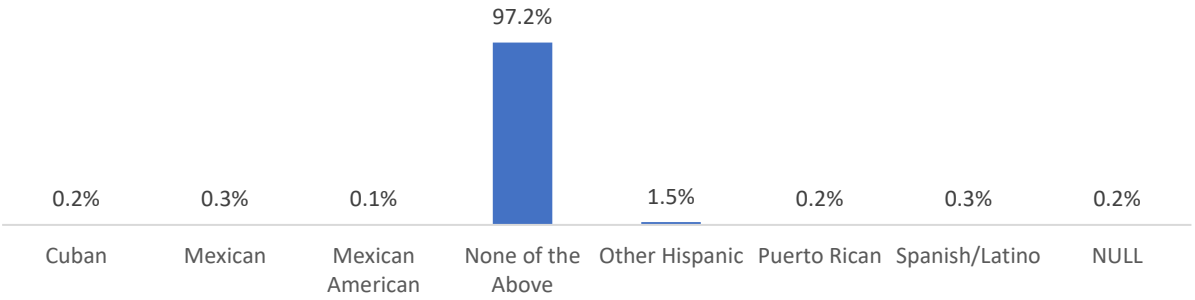
Source: NWFHN Client Data

Figure 79: NWFHN Unhoused CSUD Clients by Race



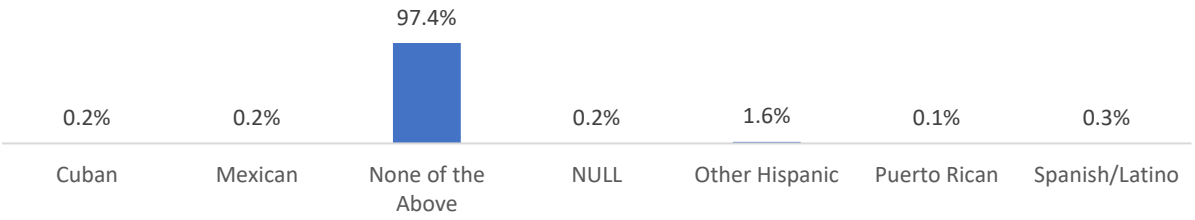
Source: NWFHN Client Data

Figure 80: NWFHN Unhoused Clients by Ethnicity



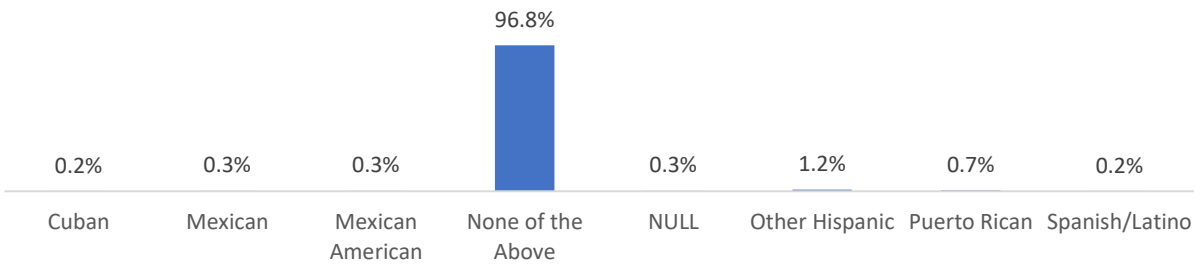
Source: NWFHN Client Data

Figure 81: NWFHN Unhoused AMH Clients by Ethnicity



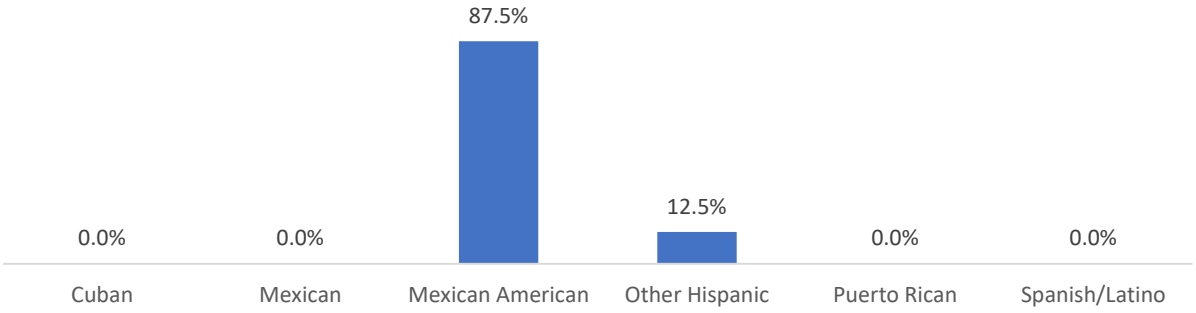
Source: NWFHN Client Data

Figure 82: NWFHN Unhoused ASUD Clients by Ethnicity



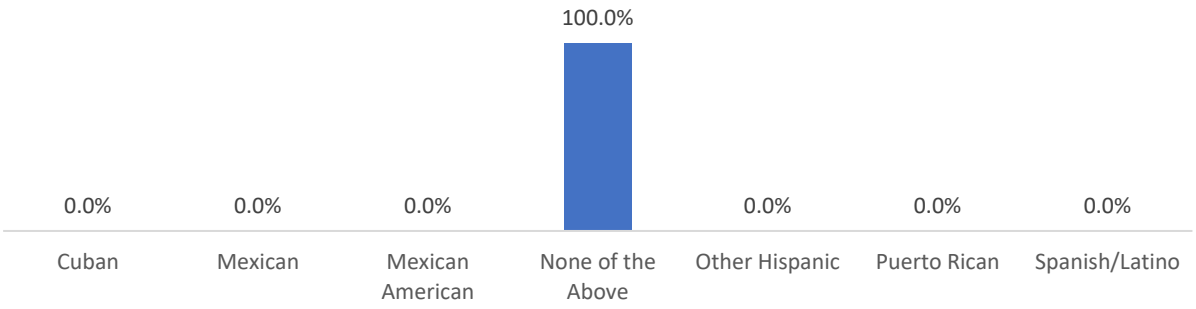
Source: NWFHN Client Data

Figure 83: NWFHN Unhoused CMH Clients by Ethnicity



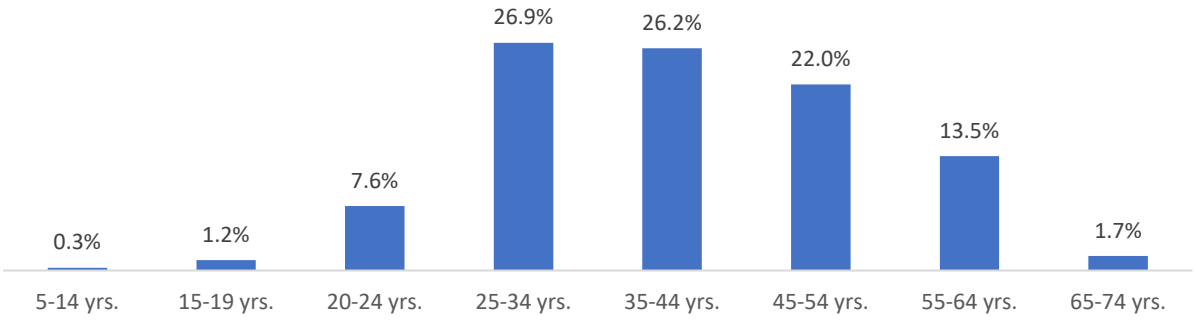
Source: NWFHN Client Data

Figure 84: NWFHN Unhoused CSUD Clients by Ethnicity



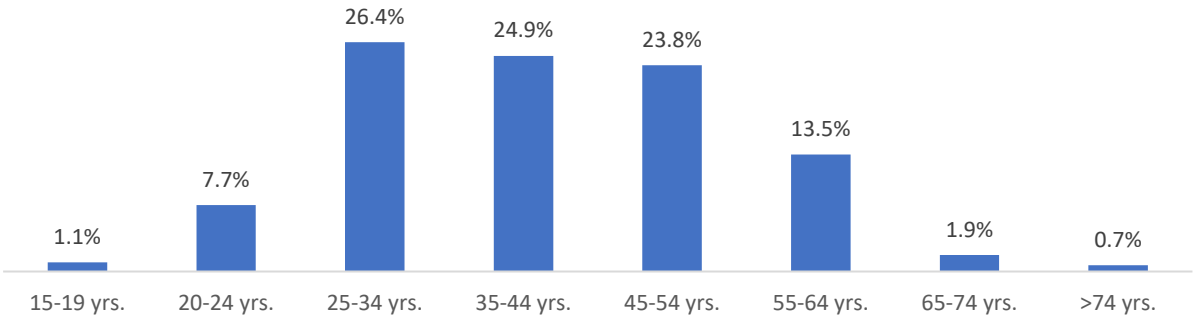
Source: NWFHN Client Data

Figure 85: NWFHN Unhoused Clients by Age Range



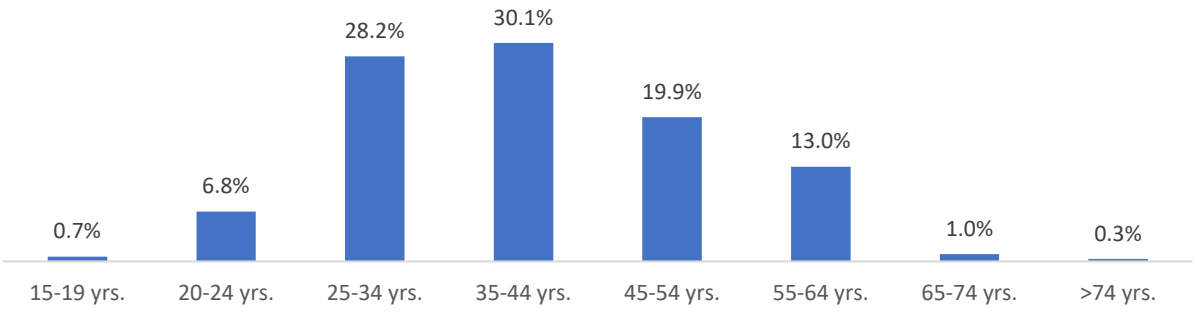
Source: NWFHN Client Data

Figure 86: NWFHN Unhoused AMH Clients by Age Range



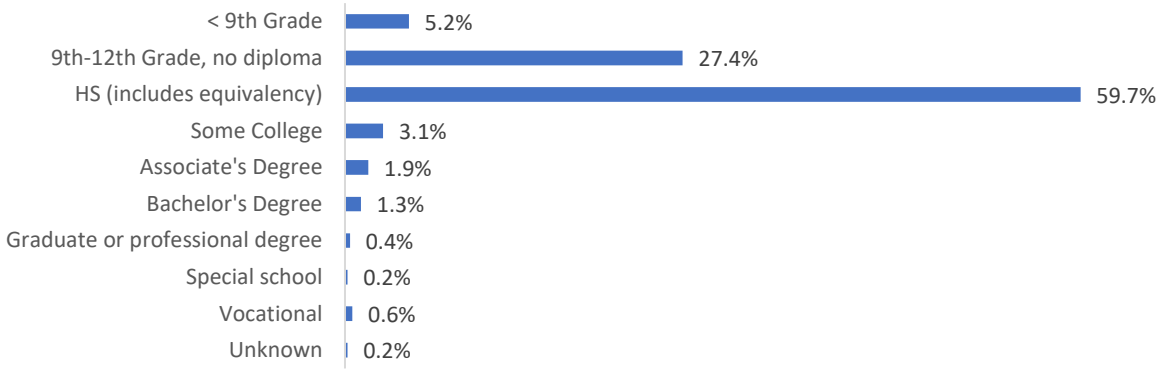
Source: NWFHN Client Data

Figure 87: NWFHN Unhoused ASUD Clients by Age Range



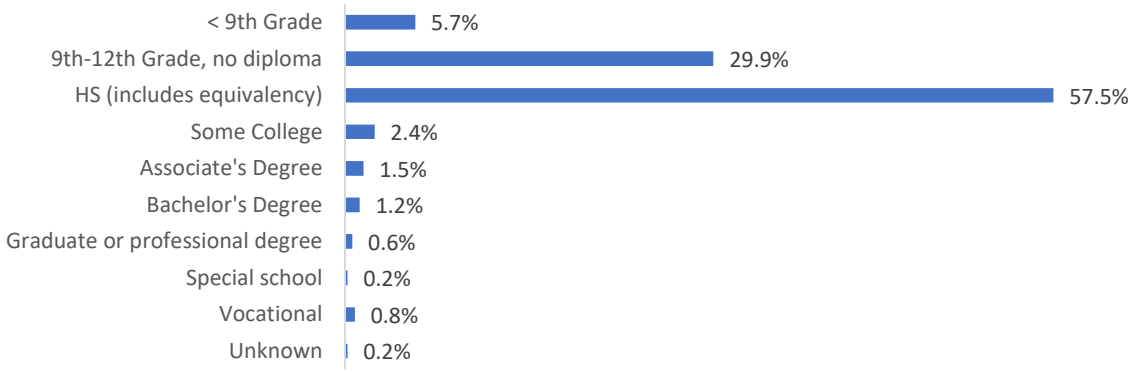
Source: NWFHN Client Data

Figure 88: NWFHN Unhoused Clients by Educational Attainment



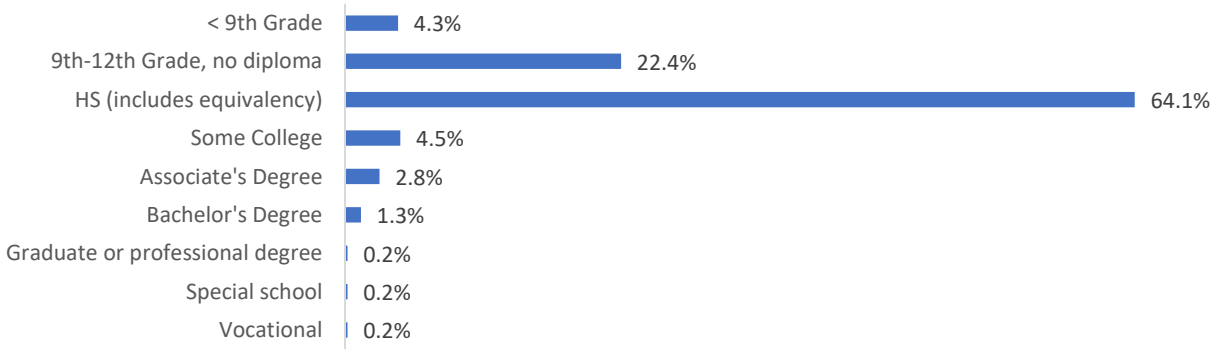
Source: NWFHN Client Data

Figure 89: NWFHN Unhoused AMH Clients by Educational Attainment



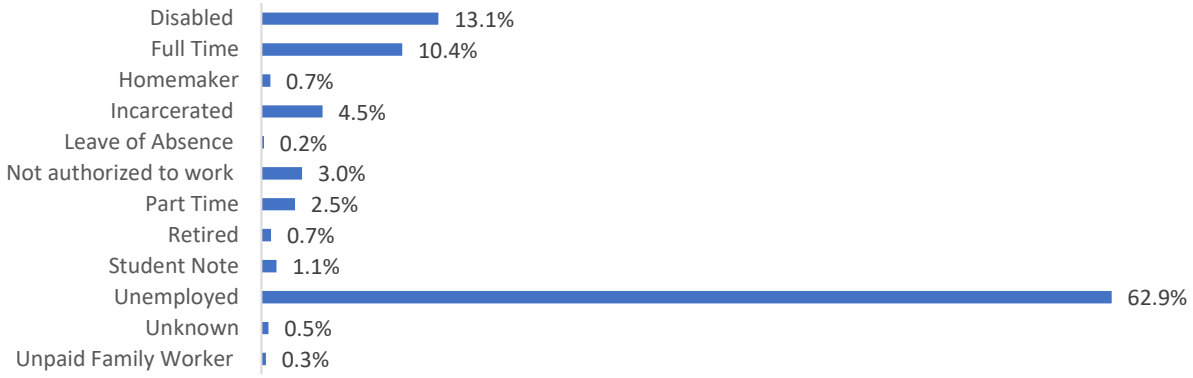
Source: NWFHN Client Data

Figure 90: NWFHN Unhoused ASUD Clients by Educational Attainment



Source: NWFHN Client Data

Figure 91: NWFHN Unhoused Clients by Employment Status



Source: NWFHN Client Data

COST CENTER DESCRIPTION, EXPENDITURES, AND OVER/UNDER PRODUCTION (FY20-21)

MENTAL HEALTH PROGRAM

Cost Center Description	Expenditures	Over/Under Production
Assessment	$12,643.84	$0.00
Case Management	$2,154,476.27	$119,681.36
Day Treatment	$25,726.00	$403,540.07
Drop-In/Self Health Centers	$69,402.96	$0.00
In-Home & Onsite	$151,377.85	$0.01
Intervention (Individual)	$191,815.95	$64,381.87
Medical Services	$3,372,931.06	$212,516.92
Outpatient-Individual	$1,558,583.52	$1,404,272.43
Outreach	$170,839.69	$42,502.68
Residential II	$152,934.00	$0.00
Residential III	$346,500.00	$966,854.61
Residential IV	$156,312.00	$0.00
Supported Employment	$0.00	$0.00
Supportive Housing/Living	$319,226.75	$2,070.29
Supported Employment	$238,332.75	$10,768.00
Information and Referral	$152,195.25	$42,460.12
Outpatient (Group)	$477,956.58	$0.00
R&B with Sup. II	$448,357.82	$0.00
Intervention Group	$8,184.06	$4,546.65
TOTAL	**$10,007,796.34**	**$3,273,595.01**

Source: NWFHN Program Data

SUBSTANCE USE PROGRAM

Cost Center Description	Expenditures	Over/Under Production
Assessment	$51,087.21	$0.00
Case Management	$1,258,513.72	$76,956.19
Crisis Support/Emergency	$28.89	$0.00
Day Treatment	$232,603.27	($0.00)
In-Home & Onsite	$71.37	$0.00
Intervention (Individual)	$438,918.81	$31,807.73
Medical Services	$1,079,513.21	$63,964.21
Medication-Assisted Tx	$12,045.00	$0.00
Outpatient-Individual	$1,708,783.56	$87,116.45
Outreach	$636,798.41	$57,831.40
Residential II	$3,509,125.89	$241,200.33
Residential III	$445,000.00	$11,855.27
Residential IV	$67,159.88	$0.00
Supportive Housing/Living	$324.85	$0.00
TASC	$127,790.59	$9,212.91
Supported Employment	$921,064.68	$65,464.87
Supportive Housing/Living	$158,411.73	$0.00
Information and Referral	$69,139.00	$86,650.16
Outpatient (Group)	$360,857.73	$33,128.63
R&B with Sup. II	$168,723.39	$0.00
Intervention Group	$32,519.70	$14,191.05
Recovery Support (Individual)	$42,725.75	$0.00
Recovery Support (Group)	$37,709.81	$2,026.38
TOTAL	**$11,358,916.43**	**$781,405.59**

Source: NWFHN Program Data

NWFHN All Cost Centers	Expenditures	Over/Under Production
Grand Total	$21,366,712.77	$4,055,000.60

CULTURAL HEALTH DISPARITY SURVEY SUMMARY

INTRODUCTION

To help improve the behavioral health system of care, NWFHN developed and distributed a survey to elicit feedback from consumers focusing on awareness and experience concerning behavioral health care services in the service area, specifically consumers' levels of trust and comfort regarding service settings and providers. The 14-question survey was structured as yes/no, single- and multi- select multiple choice, and Likert Scale items.

Ordinarily, this type of survey would be conducted in person throughout the community. However, due to concerns and limitations attributable to COVID-19, NWFHN decided that online data collection from a convenience sample would be more appropriate at this time. A link to the online survey was emailed to providers, who in turn, distributed it broadly to their consumers. A total of 49 consumers responded to this survey.

Survey data were downloaded into an Excel spreadsheet and analyzed by the planning team. Descriptive frequencies were calculated by dividing the number of responses by the total number of respondents. Numerous tables and graphs were developed to illustrate the data. Findings were presented to and discussed with NWFHN and integrated into the assessment.

SUMMARY OF FINDINGS

Although most respondents, 71.4%, indicated they are usually comfortable seeking behavioral health care services, only 26.5% indicated they trusted or strongly trusted the behavioral health care system to treat them with respect.

Respondents were asked to rank the statements that most closely describe their feelings regarding their behavioral health issues. Less than half, 42.8%, indicated they mostly or somewhat felt it was a private issue they keep to themselves; 40.8% indicated they mostly or somewhat felt this is a private issue that stays in the family; 42.9% said they mostly or somewhat felt comfortable sharing their challenges with others (professionals, family members, friends, clergy, etc.), and 26.5% said they mostly or somewhat were more comfortable with people like themselves. For each statement, the most frequently mentioned descriptions of their feelings regarding their behavioral health issues were "neutral" and "no response".

Most respondents indicated that they have been most comfortable discussing behavioral health concerns in a private office with a doctor (55.1%), speaking with a nurse practitioner (26.5%), or hybrid of telehealth (22.4%). All of the above was mentioned by 16.3% of respondents and 8.2% indicated, "none". The majority (55.1%) identified more than one setting in which they have been most comfortable.

Most respondents, 59.2%, indicated they would be more comfortable going to the traditional physician office, and 38.8% would prefer faith-based behavioral health care services.

Nearly half, 48.9%, said they would be unlikely or very unlikely to be comfortable in group therapy, while 67.3% would be likely or very likely to be comfortable in individual therapy.

Nearly all, 95.9% of respondents, indicated that when they received behavioral health care services, those services were available in their primary language all of the time or most of the time.

Most respondents (81.6%) described their gender as female, 12.2% as male, and 6.1% preferred not to answer this question.

When asked to describe their gender identity, most respondents (71.4%) preferred not to answer, or did not respond to this question at all. More than 16% described themselves as cisgender and 12.2% as gender fluid.

When asked to describe their current sexual orientation, 61.2% responded heterosexual/straight, 8.2% responded asexual, and 30.6% preferred not to answer, or did not respond at all.

Most respondents (85.7%) described themselves as White, 4.1% as Black, and 6.1% as Multi-Racial.

Four percent described their ethnicity as Mexican American, 2% as Spanish/Latino, and 93.9% said none of the above, or did not respond at all.

Nineteen respondents, 38.8%, were ages 35-44 years. The second largest age group consisted of those 55-64 years of age (18.4%), followed by those 45-54 years (12.2%), and 25-34 years (12.2%).

CULTURAL HEALTH DISPARITY SURVEY CHARTS

Figure 92: Are you usually comfortable seeking behavioral health services?

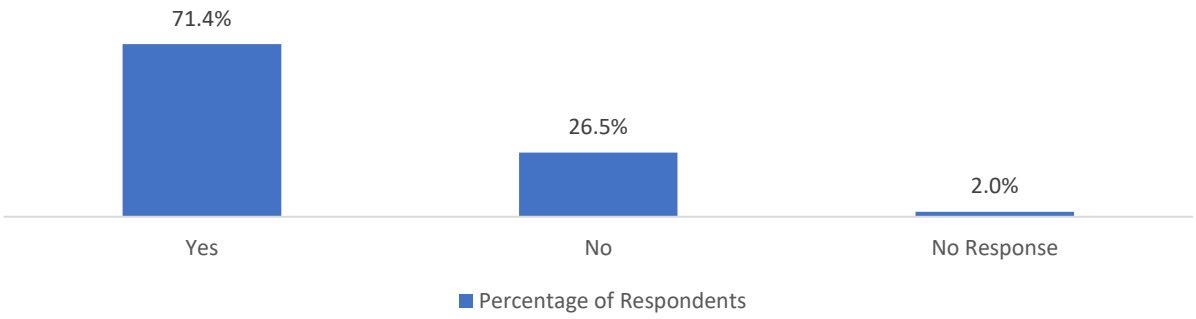


Figure 93: On a scale of 1 to 5, with 5 being 'strongly agree', how would you rate your trust in the behavioral health care system to treat you with respect?

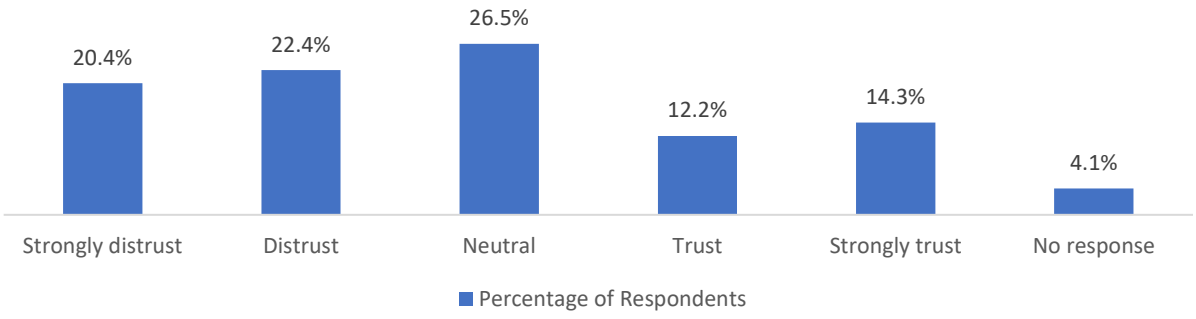


Figure 94: Please rank the statement below that most closely describe your feelings regarding your behavioral health issue, with (1) being the most and (5) being the least. "This is a private issue I keep to myself."

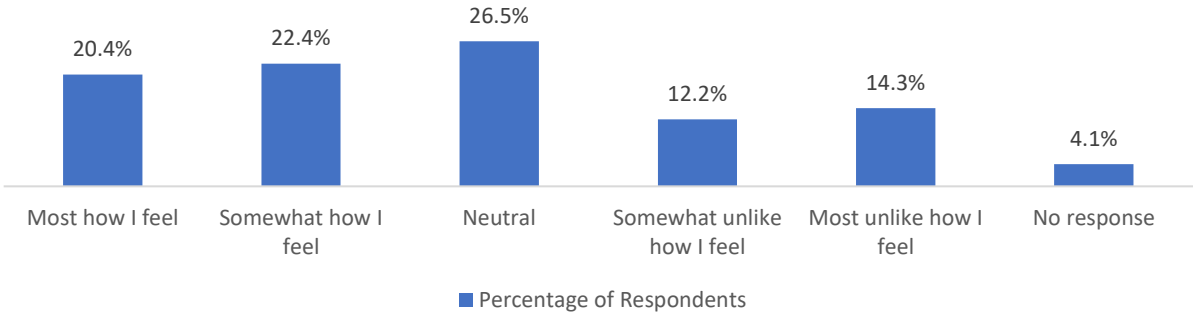


Figure 95: Please rank the statement below that most closely describe your feelings regarding your behavioral health issue, with (1) being the most and (5) being the least. "This is a private issue that stays in the family."

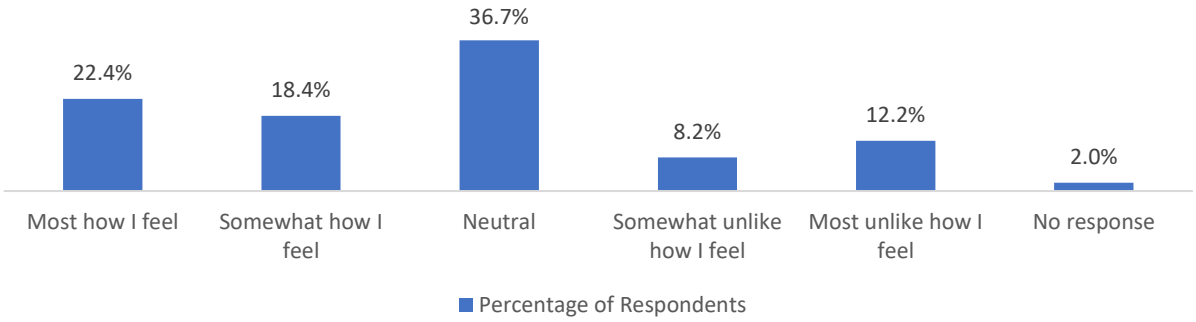


Figure 96: Please rank the statement below that most closely describe your feelings regarding your behavioral health issue, with (1) being the most and (5) being the least. "I am comfortable sharing my challenges with others."

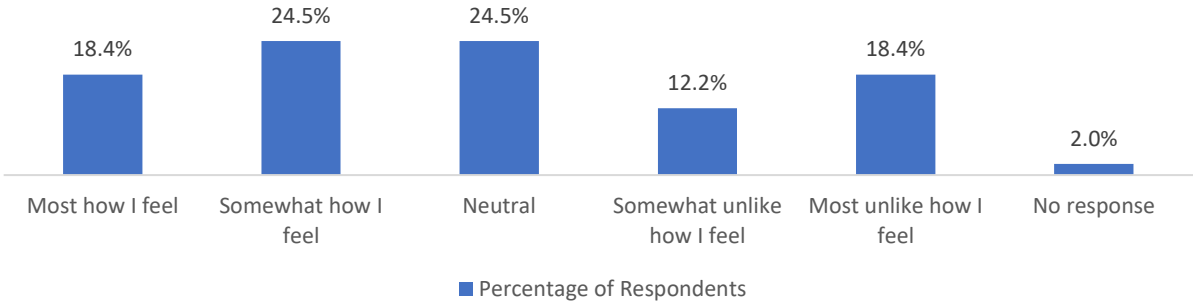


Figure 97: Please rank the statement below that most closely describe your feelings regarding your behavioral health issue, with (1) being the most and (5) being the least. "I am more comfortable with people like me."

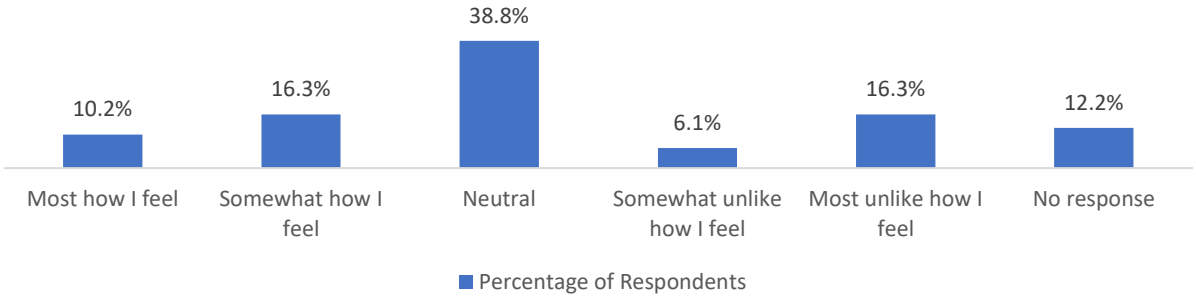


Figure 98: In which setting(s) have you been most comfortable discussing your behavioral health concerns? (Check all that apply)

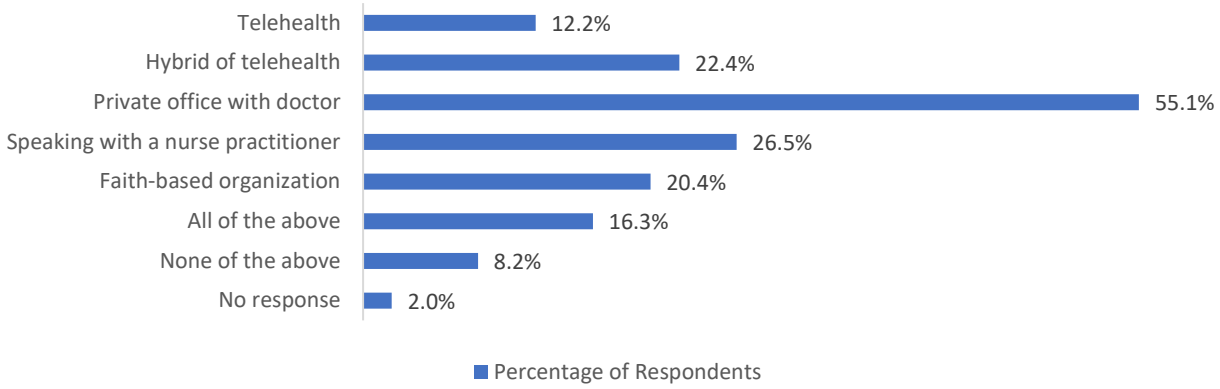


Figure 99: If given a choice for receiving behavioral health care services, would you be more comfortable going to a faith-based organization OR prefer the traditional physician office?

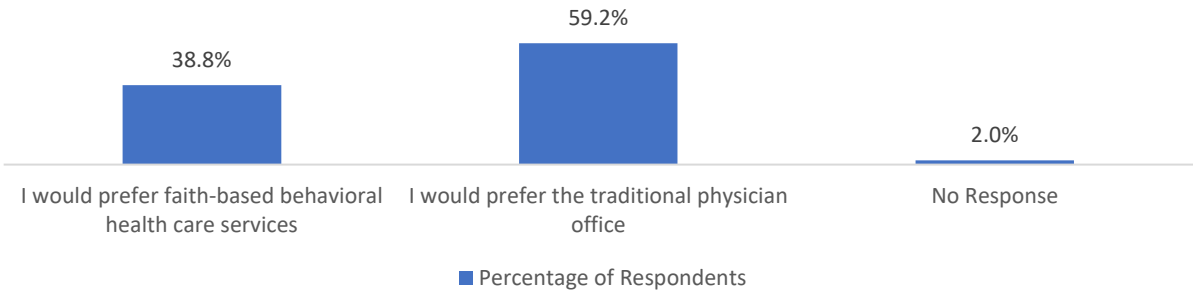


Figure 100: Now thinking about treatment options, on a scale of 1 to 5, with 5 being 'very likely', how comfortable would you be in group therapy?

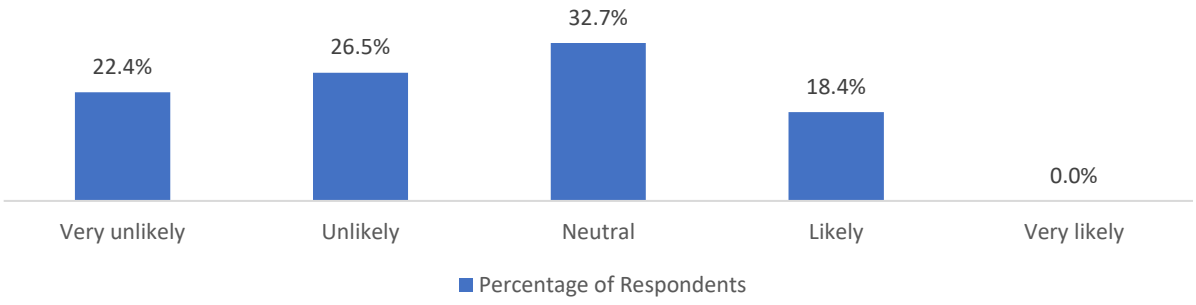


Figure 101: On a scale of 1 to 5, with 5 being 'very likely', how comfortable would you be in individual therapy?

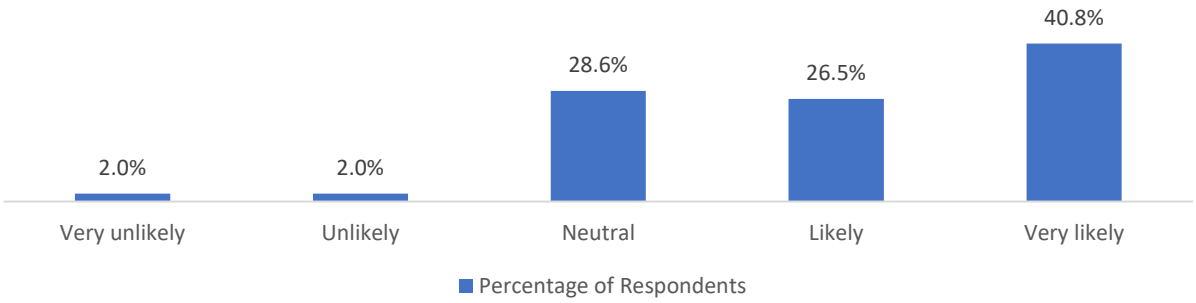


Figure 102: When you have received behavioral health care services in the past, were they mostly available in your primary language?

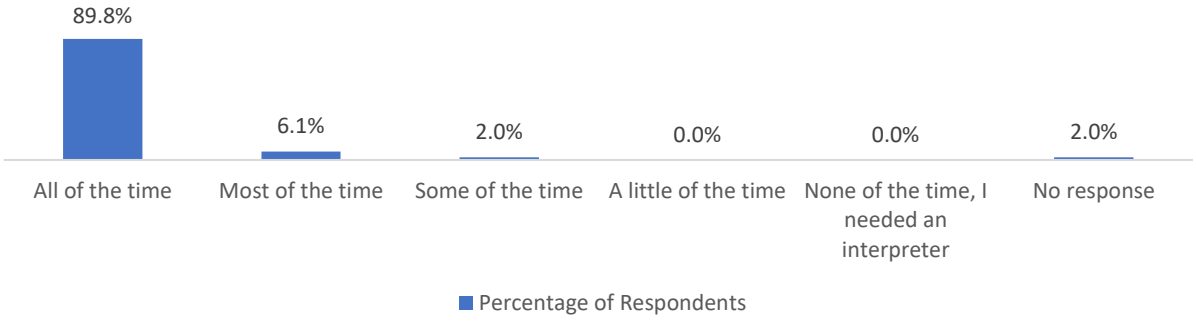


Figure 103: Which best describes your gender?

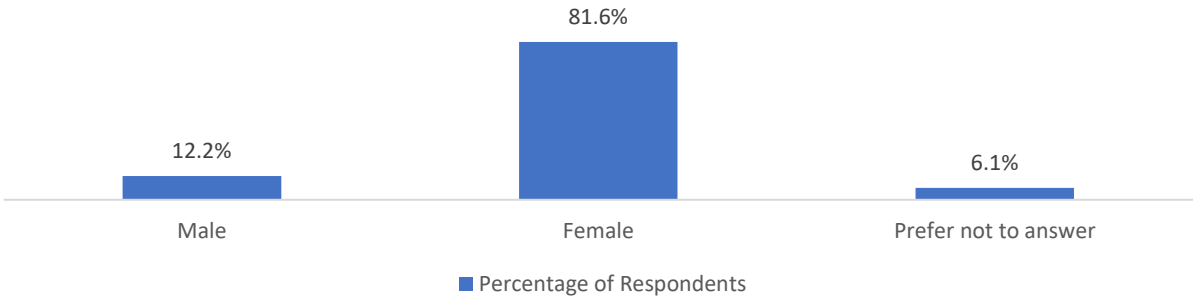


Figure 104: Which best describes your gender identity?

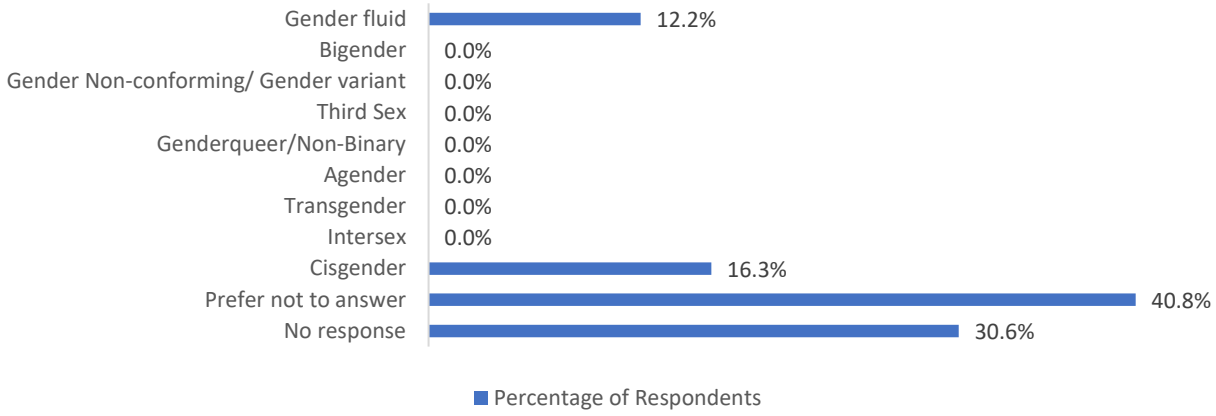


Figure 105: Which best describes your current sexual orientation? (Check all that apply)

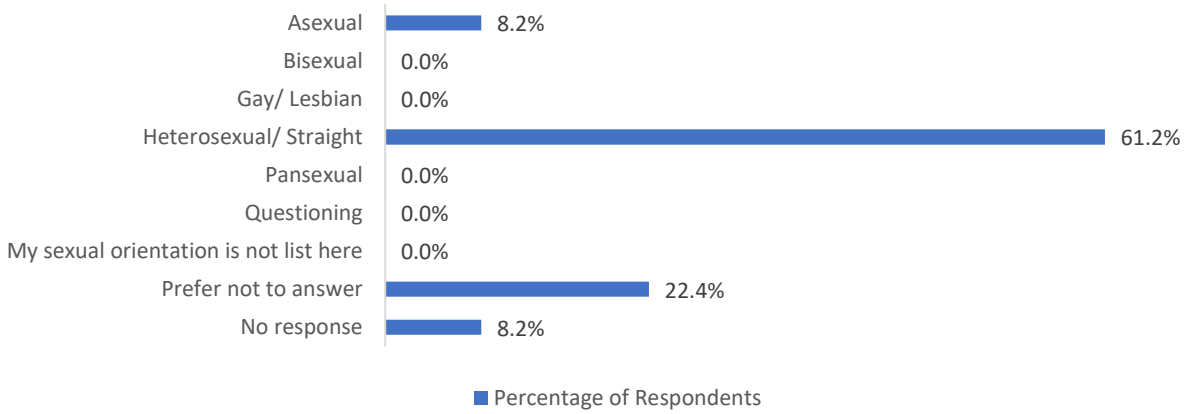


Figure 106: Which best describes your race?

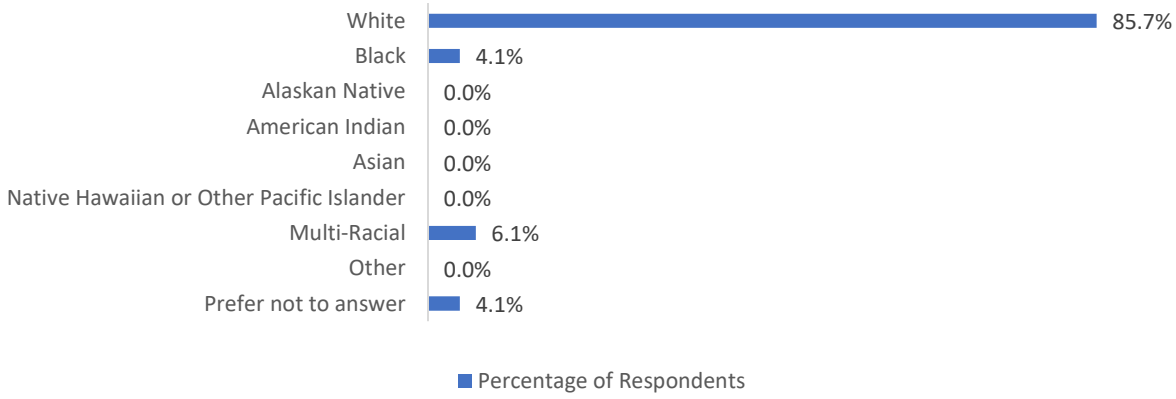


Figure 107: Which best describes your ethnicity?

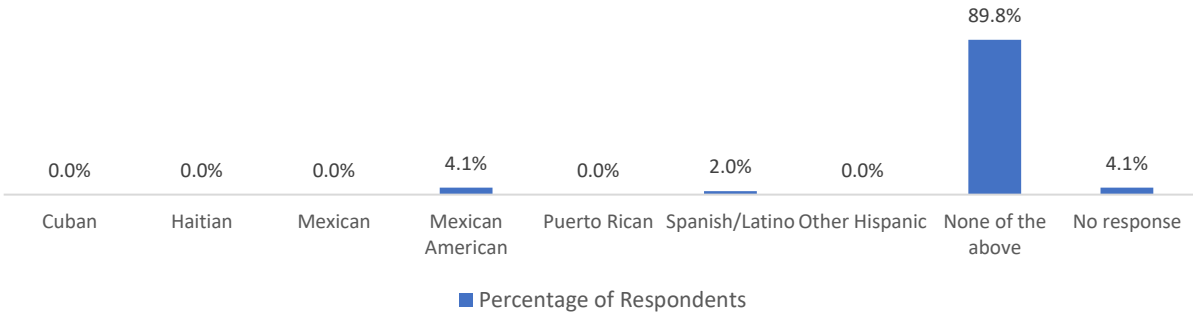
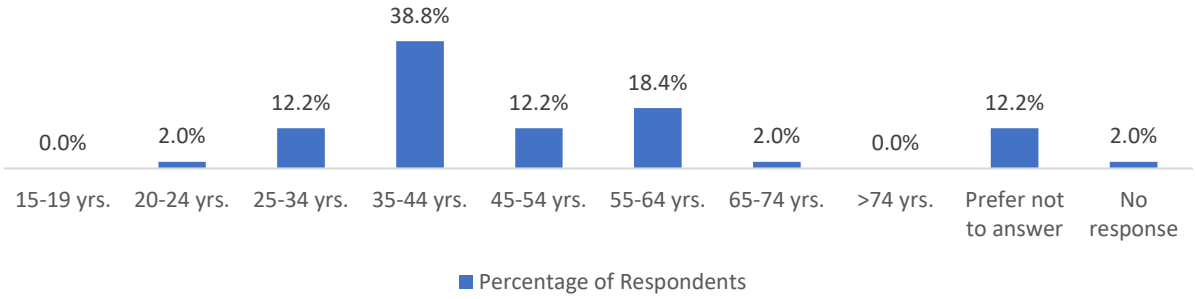


Figure 108: Please select your age range from the list below.



CULTURAL HEALTH DISPARITY SURVEY BY RACE AND ETHNICITY

The cultural health disparity survey was analyzed by race and ethnicity to further measure experience, awareness, and coordination of behavioral health services. This will help to facilitate focused strategic development and intervention implementation over the next three years. It should be noted that there were less than five respondents for the Black and Hispanic population groups.

Respondents were asked if they were comfortable seeking behavioral health care services. Most respondents were comfortable as 100% of Black, 66.7% of Hispanic, and 72.5% of White respondents selected yes to this question. Among Hispanic and White respondents, the percentages of those not comfortable seeking care were lower at 33.3% and 27.5%, respectively.

When asked if they trust the health care system to treat them with respect, 50% of Black respondents were neutral, and 50% trust to be treated with respect. Among Hispanic respondents, 33.3% were neutral, 33.3% trust, and 33.3% strongly trust to be treated with respect. More than half (56.1%) of White respondents, trust (41.5%) or strongly trust (14.6%), that the health care system would treat them with respect. White respondents who were neutral accounted for 31.7%.

Respondents were asked to describe their feelings regarding their behavioral health issues. When asked, is this is a private issue I keep to myself, 50% of Black respondents were neutral, and 50% indicated this is somewhat unlike how I feel. Among Hispanic respondents, 33.3% indicated this is somewhat how I feel, and 66.6% said this is somewhat or most unlike how I feel. White respondents were split on behavioral health issues being a private matter I keep to myself as 47.5% indicated this was most or somewhat how I feel, 30% were neutral, and 22.5% said this is somewhat or most unlike how I feel.

Regarding their behavioral health issues as a private matter that stays in the family, 50% of Black respondents indicated this is somewhat how they feel, and 50% were neutral. Hispanic respondents were split as 33.3% indicated this was somewhat how I feel, 33.3% were neutral, and 33.3% said this is most unlike how I feel. White respondents were also split on responses to this question as 43.9% indicated this was most or somewhat how I feel, 36.6% were neutral, and 19.5% indicated this is somewhat or most unlike how I feel.

Regarding comfort sharing their challenges with others, 100% of Black respondents indicated this is most or somewhat how I feel. Among Hispanic respondents, 33.3% indicated this is somewhat how I feel, 33.3% were neutral, and 33.3% said this was most unlike how I feel. Among White respondents, 42.5% indicated this is most or somewhat how I feel, 27.5% were neutral, and 30% said this is somewhat or most unlike how I feel.

When asked if they were more comfortable with people like them, Black respondents were split as 50% indicated this is somewhat how I feel, and 50% said this is somewhat unlike how I feel. Fifty percent of Hispanic respondents were neutral and 50% indicated this is most unlike how I feel.

Among White respondents, 47.4% were neutral, 31.6% indicated this is most or somewhat how I feel, and 21.1% said this is somewhat or most unlike how I feel.

The most comfortable setting for discussing their behavioral health issues for Black respondents was a hybrid of telehealth (40%). Telehealth, private office with a doctor, and speaking with a nurse practitioner accounted for 20% each of Black respondents. Among Hispanic respondents, 60% preferred a private office with a doctor, and the remaining 40% were split evenly between telehealth and a hybrid of telehealth. White respondents preferred a private office with a doctor at 34.3%. A hybrid of telehealth (12.9%) was preferred over telehealth. Speaking with a nurse practitioner accounted for 15.7%, 11.4% preferred faith-based, and 11.4% indicated all of the above.

When asked to choose between faith-based or the traditional physician office, 100% of Black and Hispanic respondents indicated the traditional physician office. Among White respondents, 42.5% indicated they would be more comfortable with faith-based care, and 57.5% preferred the traditional physician office.

Among Black respondents, 50% were very unlikely to be comfortable in group therapy, and 50% were neutral. For Hispanic respondents, 66.7% were likely to be comfortable in group therapy, and 33.3% were neutral. Over half of White respondents (53.7%) were very unlikely or unlikely to be comfortable in group therapy, 29.3% were neutral, and 17.1% were likely to be comfortable in group therapy. When asked about their comfort in individual therapy, 50% of Black, 66.7% of Hispanic, and 73.2% White respondents were likely or very likely to be comfortable in this setting.

When asked if the behavioral health services they received in the past were mostly available in their primary language, 100% of Black, 100% of Hispanic, and 90.2% of White respondents received services in their primary language all of the time. No respondents needed an interpreter.

CULTURAL HEALTH DISPARITY SURVEY BY RACE AND ETHNICITY CHARTS

Figure 109: Are you usually comfortable seeking behavioral health care services?

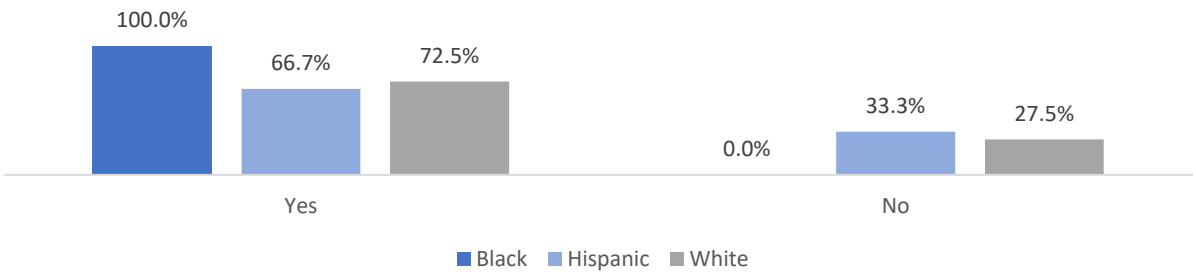


Figure 110: On a scale of 1 to 5, with 5 being 'strongly agree', how would you rate your trust in the behavioral health care system to treat you with respect?

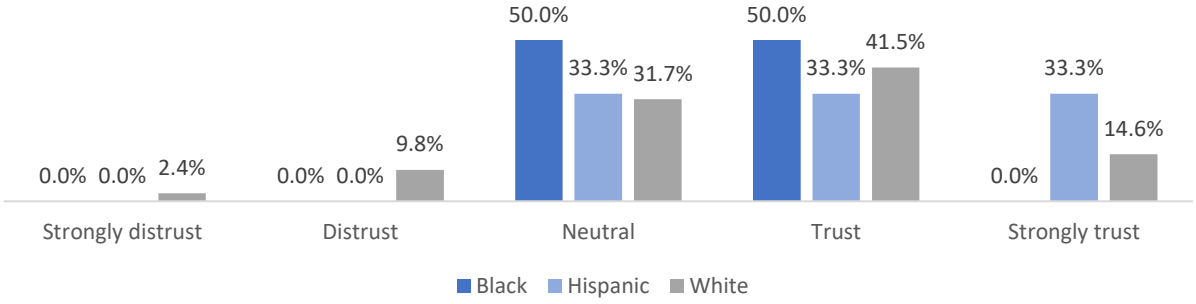


Figure 111: Please rank the statement below that most closely describes your feelings regarding your behavioral health issue, with (1) being the best and (5) being the least. This is a private issue I keep to myself.

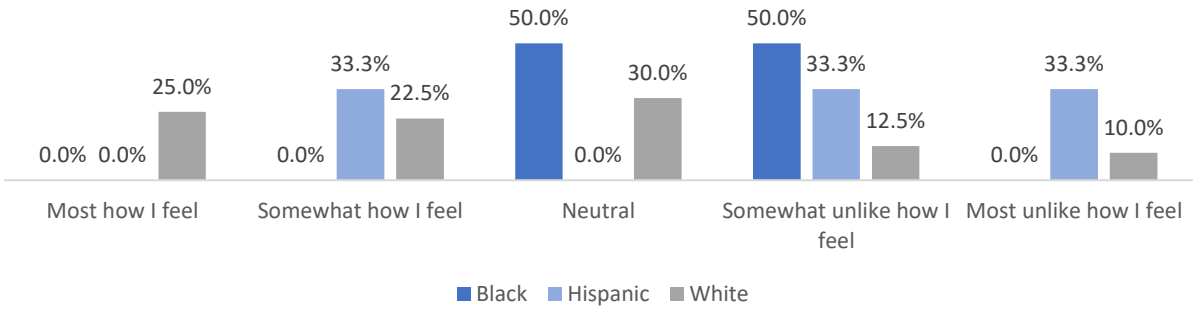


Figure 112: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the most and (5) being the least. This is a private issue that stays in the family.

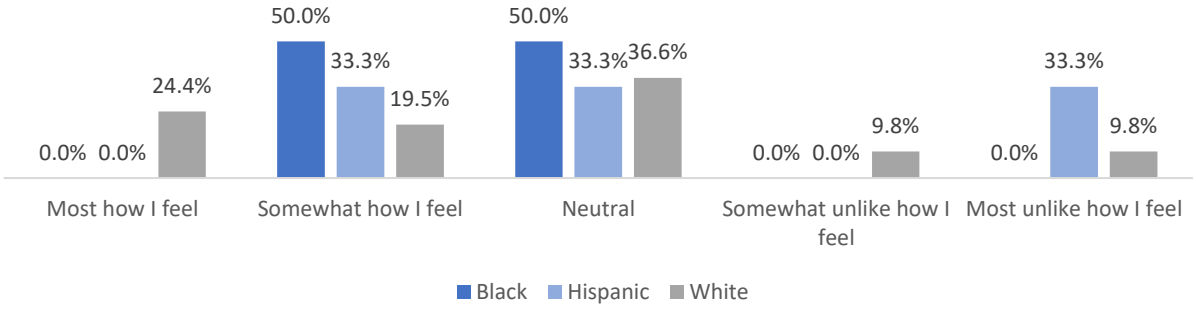


Figure 113: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. I am comfortable sharing my challenges with others.

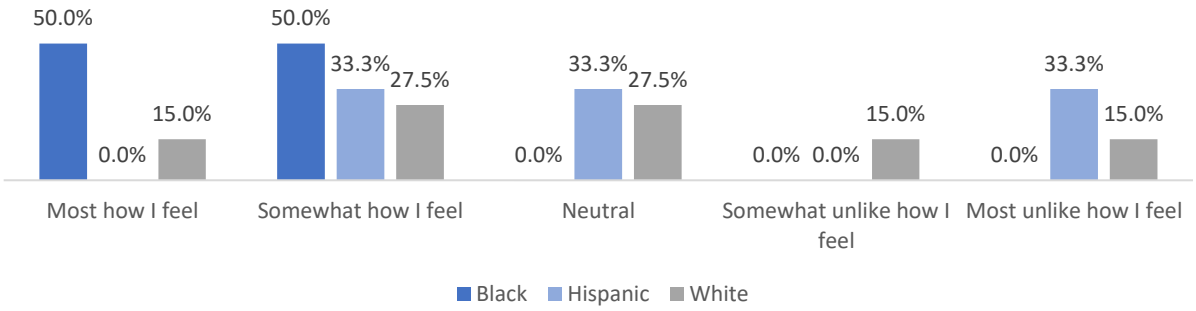


Figure 114: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. I am more comfortable with people like me.

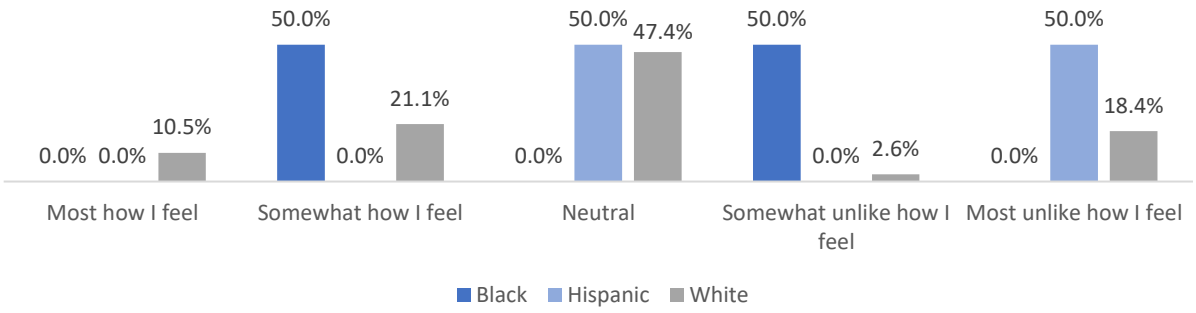


Figure 115: In which setting(s) have you been the most comfortable discussing your behavioral health concerns? (Check all that apply)

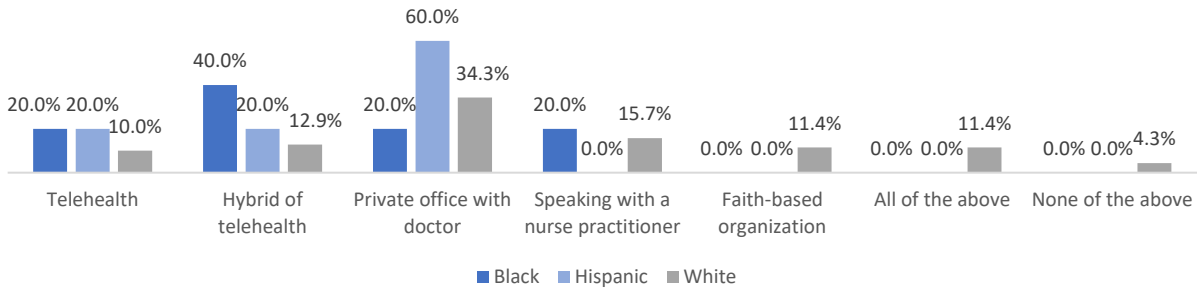


Figure 116: If given a choice for receiving behavioral health care services, would you be more comfortable going to a faith-based organization OR the traditional physician office?

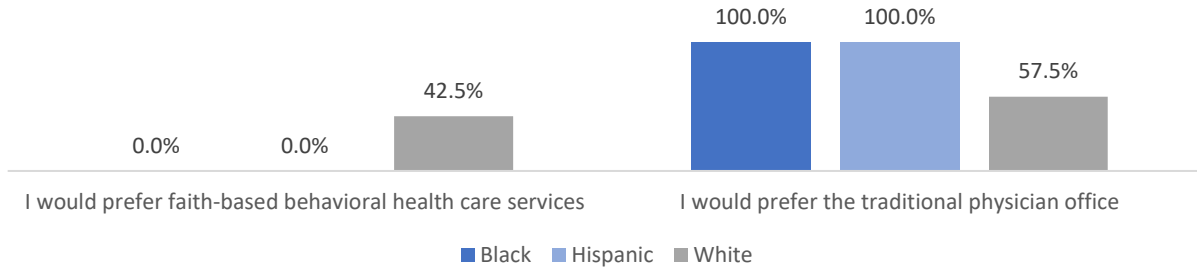


Figure 117: Now thinking about treatment options, on a scale of 1 to 5, with 5 being very likely, how comfortable would you be in group therapy?

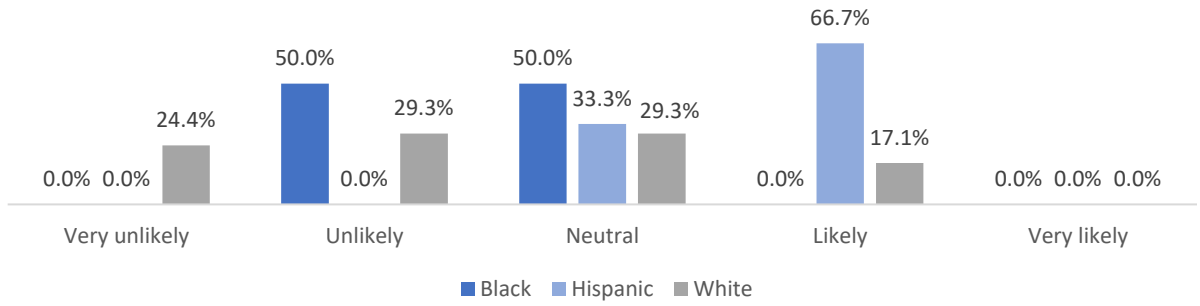


Figure 118: On a scale of 1 to 5, with 5 being very likely, how comfortable would you be in individual therapy?

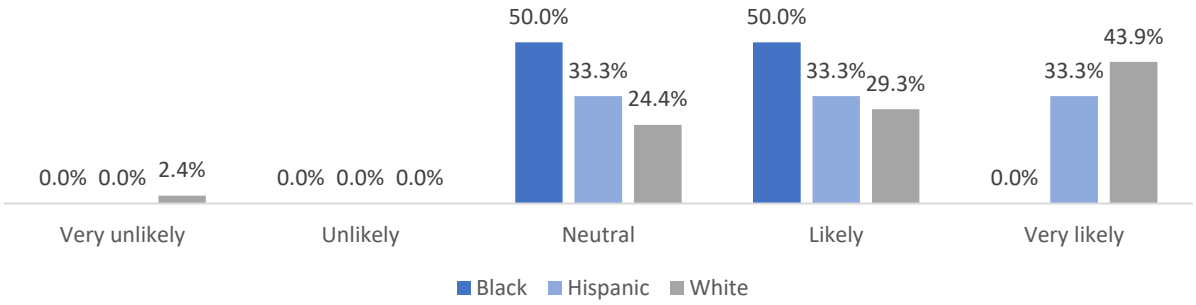
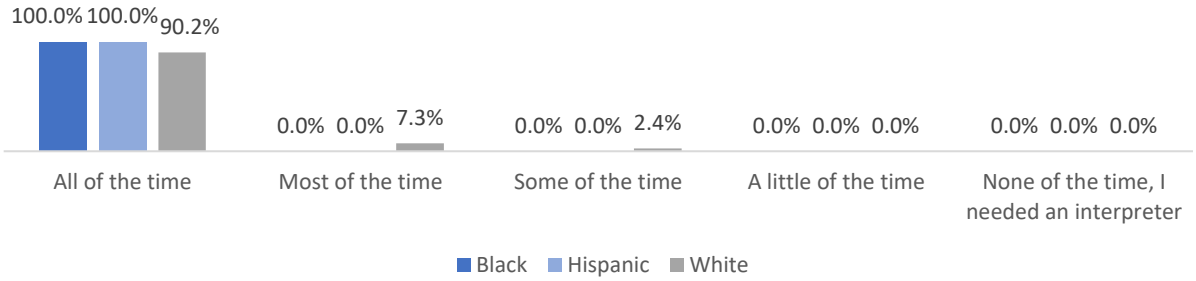


Figure 119: When you have received behavioral health care services in the past, were they available in your primary language?



CULTURAL HEALTH DISPARITY FOCUS GROUP SUMMARY

After analyzing the Cultural Health Disparities Survey responses, two focus groups were convened to elicit more detailed input from individuals who have had direct experience with the behavioral health system in NWFHN's service area. Focus group participants shared their behavioral health care experiences from one or more of the following perspectives:

- Those who needed and received services for themselves
- Those whose family member or close friend needed and received services
- Foster parents whose foster children needed and received services
- Those who provided services as a peer support specialist

The scope of focus group discussions included questions from the Cultural Health Disparities Survey as well as follow-up questions to the survey questions. Discussions included topics related to access, affordability, continuity of care, trust and respect, therapeutic settings and modalities, providers, and language barriers.

Focus group discussions were recorded and electronically transcribed. In this section, key findings are summarized. Sometimes, key findings and participants' comments were addressed during more than one question but are listed as part of only one section. These findings are intended to express the complexities of personal perspectives and experiences.

Survey Question 1. Are you usually comfortable seeking behavioral health care services?

Key Findings:

Discussions regarding this question focused on challenges with access, affordability, and continuity of care. Participants expressed the need for a broader range of options. Barriers included affordability, restrictive third-party payors (i.e., private insurance, Medicaid, funding for children in foster care), complexity of the system, and the lack of qualified providers (especially for children).

Accessing services within the complex behavioral health system is exacerbated by a general lack of knowledge regarding available resources.

Learning how to advocate for self and family requires tenacity and persistence to navigate the system and access needed care. This is extremely difficult for individuals and families amid a behavioral health crisis or during prolonged chronic behavioral health situations.

Complexities and delays in the system along with a lack of providers impede access to care for traumatized children in foster care, undermining the stability of placements. Extensive waiting

periods for services and inconsistency with providers lead to interruptions in care, exacerbation of symptoms, and disrupted placements.

Survey Question 2: On a scale of 1 to 5, with 5 being "strongly agree", how would you rate your trust in the behavioral health care system to treat you with respect?

Key Findings:

Mutual trust and respect can help resolve conflicts between families (who need to be informed and involved), providers (who must prioritize therapeutic needs of patients), and patients (whose privacy rights must be honored).

There is widespread lack of awareness of and access to early intervention, aftercare, peer support, and communication with consumers and their identified support networks. Providers and consumers need education regarding the role of peer support specialists.

Survey Question 3: Please rank the statements below that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least.

____This is a private issue I keep to myself

____This is a private issue that stays in the family

____I am comfortable sharing my challenges with others (professionals, family members, friends, clergy, etc.)

____I am more comfortable with people like me

____Other

Please explain_____

Key Findings:

Implicit trust and comfort with peers, (i.e., people with shared experiences), encourages meaningful discussions regarding behavioral health issues without fear of judgement or stigma.

Survey Question 4: In which settings have you been the most comfortable discussing your behavioral health concerns? (Choose all that apply)

____Telehealth (Talking to a health care provider over your phone or computer. This may include using a video)

____Hybrid of Telehealth (includes some face to face and some telehealth)

____Private office with doctor

____Speaking with a nurse practitioner

____Faith-based organization

____All of the above

____None of the above

____Other

Please explain: _____

Key Findings:

Confidentiality as well as a private and safe physical environment influence the preference for in-person individual therapy. Although there is a value in telehealth, there is a higher value in in-person interaction.

Participants prioritized providers who are experienced working with people who have experienced trauma, have shared values, and welcome individuals who identify with marginalized groups.

For a supporter of a loved one receiving services, it's important that the provider is receptive to the supporter and the loved one and cultivates a therapeutic rapport with the client/patient. It's important that providers engage in a manner that builds trust, so that the loved one can experience the dignity of self-determination and select a provider that they are comfortable with. This in turn helps to dispel fear and provide comfort for the supporter.

Survey Question 5: If given a choice for receiving behavioral health care services, would you be more comfortable going to a faith-based organization OR prefer the traditional physician office?

Key Findings:

Some clients need services that are faith-based, but for some, faith-based services are unacceptable and are not viewed as safe or supportive. Some clients would prefer hybrid services that are open to both perspectives.

Survey Question 6: On a scale of 1 to 5, with 5 being very likely, how comfortable would you be in group therapy? (For the purpose of this discussion, “group therapy” refers to any services provided in a group setting, including fellowship, support groups, and any services outside of individual/couples/family sessions.)

Survey Question 7: On a scale of 1 to 5, with 5 being very likely, how comfortable would you be in individual therapy?

1. Very unlikely

2. Unlikely

3. Neutral

4. Likely

5. Very Likely

Key Findings:

Participants expressed a wide range of views regarding preferences for group therapy, individual therapy, or both. Most were open to both modalities under certain circumstances. Many who had experience with both saw value in both. Critical issues of concern regarding group therapy included privacy, confidentiality, and the suitability of group therapy for specific issues. Critical issues for *both* modalities included competence of the therapist and a safe and comfortable environment. Foster parents explained why group therapy had not been appropriate for the children in foster care in their homes.

Survey Question 8: When you have received behavioral health care services in the past, were they mostly available in your primary language?

Key Findings:

More accessible translation services are needed. Translators should be trained to translate regarding all health care issues, including behavioral health care issues.

Spanish is the most frequently cited language in need of translation. Spanish-speaking providers would be more effective than translators in communicating with patients/clients, their families, and their support networks.

It's very difficult to access translation services and Spanish-speaking services for children in foster care for all needed services, especially for behavioral health services.

NO WRONG DOOR SURVEY SUMMARY

INTRODUCTION

To help improve the behavioral health system of care, Northwest Florida Health Network developed and distributed a survey to elicit feedback from providers focusing on No Wrong Door (NWD) Access in the service area. Survey questions focused on how intake and referral for health services are streamlined across multiple agencies and departments so that no matter where people enter the system, they can easily gain access to behavioral health care services.

The 16-question survey was structured as yes/no and single- and multi-select multiple choice items. Ordinarily, this type of survey would be conducted in person throughout the community. However, due to concerns and limitations attributable to COVID-19, NWFHN decided that online data collection would be more appropriate at this time. A link to the online survey was emailed to all NWFHN providers. A total of five providers responded to this survey.

Survey data were downloaded into an Excel spreadsheet and analyzed by the planning team. Descriptive frequencies were calculated, and numerous tables and graphs were developed to illustrate the data. Findings were presented to and discussed with NWFHN and integrated into the assessment.

KEY FINDINGS

Survey respondents indicated they worked in one or more of the following:

- Adult Crisis Unit
- Adult Detoxification Unit
- Adult Mobile Response
- Adult Outpatient Program
- Children's Crisis Unit
- Children's Mobile Response
- Children's Outpatient Program
- Children's Residential Facility

The most frequently mentioned program was Adult Crisis Unit (26.7%) followed by Adult Mobile Response (20%). All but one respondent worked in more than one type of program.

When asked if No Wrong Door Access works well within their organization, 60% said, "yes" and 40% said they weren't sure.

Most respondents (60%) agreed that from their perspective their organization has a role to play in No Wrong Door Access. Forty percent weren't sure.

Respondents were asked if they agreed that their organization has a strong care coordination process that includes warm handoffs to services and seamless care coordination. Fifty percent agreed and 50% strongly agreed.

All respondents either agreed (60%), or strongly agreed (40%), that their organization has taken action to improve the referral and care coordination process for individuals served.

Most respondents, (80%), strongly agreed that linkages to crisis intervention and support (i.e., the Mobile Response Teams, medication management, CRF, CIT Officer, BA, CSU, etc.) are occurring; 20% disagreed.

All respondents either agreed (60%), or strongly agreed (40%), that their organization promotes its services and resources very well, promotes awareness of available options, and linkages to needed services.

When asked if their organization provides person-centered care for all individuals served, 40% agreed, and 60% strongly agreed.

All respondents agreed or strongly agreed, that their agency hires employees who are culturally sensitive, and culturally competent for the population served.

All who responded to this question agreed that it's easy for individuals to access the services they need quickly and efficiently.

When asked if they think a standard intake and screening process for state agencies and community partners would help individuals get into services more quickly, one respondent (20%) said, "yes", one (20%) said, "no", and three (60%) were not sure?

When asked if, in their opinion, their organization encourages (promotes) working with other community partners to ensure care coordination, 60% strongly agreed and 40% agreed.

Providers were asked if individuals in need of services have equal access to care. Of those who responded, 50% agreed and 50% strongly agreed.

When providers were asked if stakeholders help to address and advocate for equal access to care in system entry points, 60% strongly agreed, and 40% were not sure.

All respondents either agreed, (40%), or strongly agreed, (60%), that their organization ensures that services are of high quality and meet the needs of individuals served. All either agreed (60%) or strongly agreed (40%) that tracking individuals served, services, performance, and costs were undertaken to continually evaluate and improve outcomes.

NO WRONG DOOR SURVEY CHARTS

Figure 120: I work in a/an...

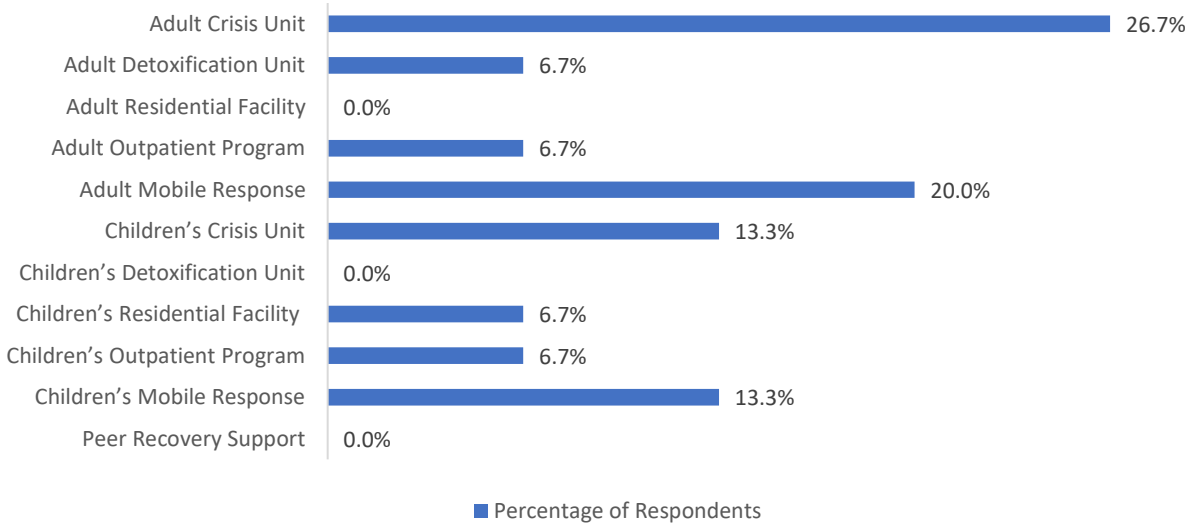


Figure 121: Do you think the "No Wrong Door" access works well within your organization?

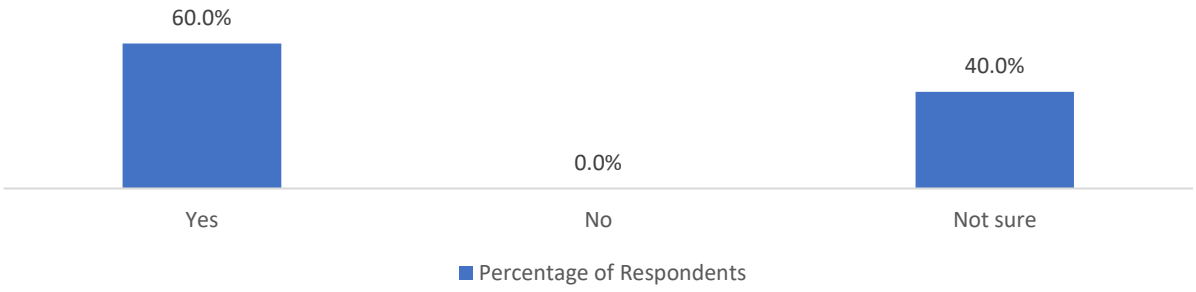


Figure 122: From your perspective your organization has a role to play in the "No Wrong Door" access.

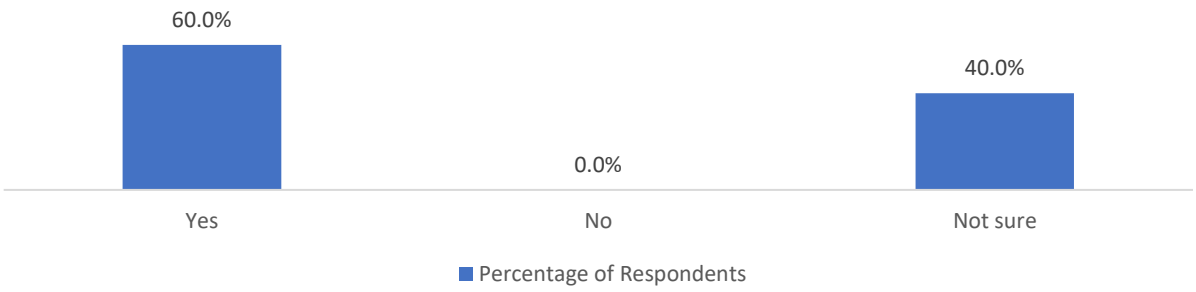


Figure 123: In your opinion, your organization has a strong care coordination process that includes warm handoffs to services and seamless care coordination.

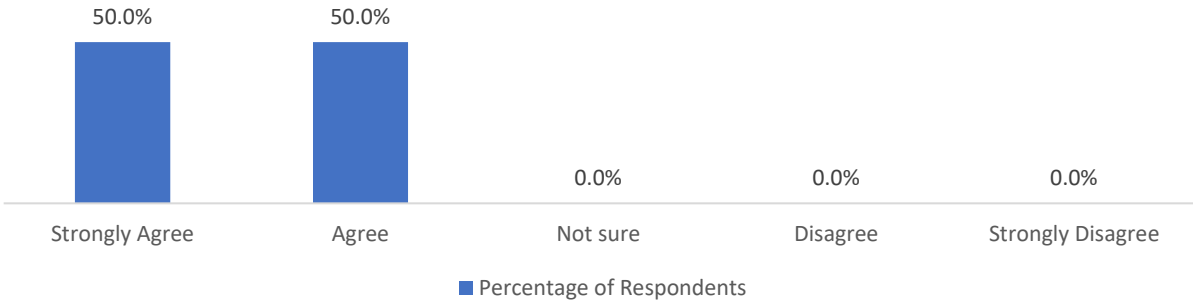


Figure 124: In your opinion, your organization has taken action to improve the referral and care coordination process for individuals served.

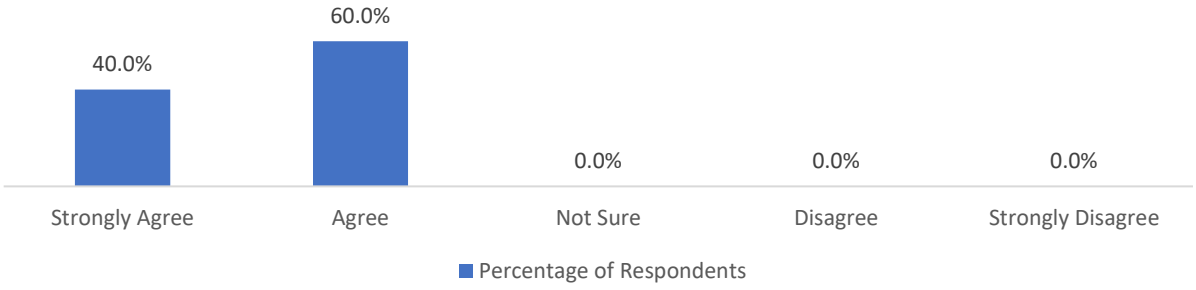


Figure 125: In your opinion, linkages to crisis intervention and support (like the Mobile Response Team, medication management, CRF, CIT Officer, BA, CSU, etc.) are occurring.

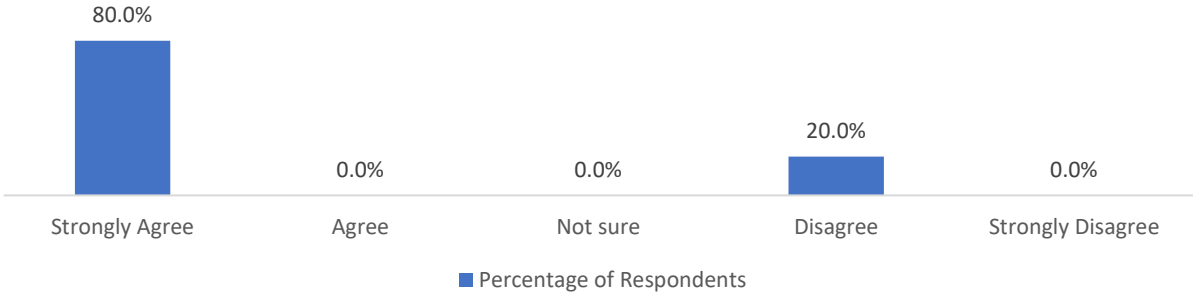


Figure 126: In your opinion, your organization promotes its services and resources very well.

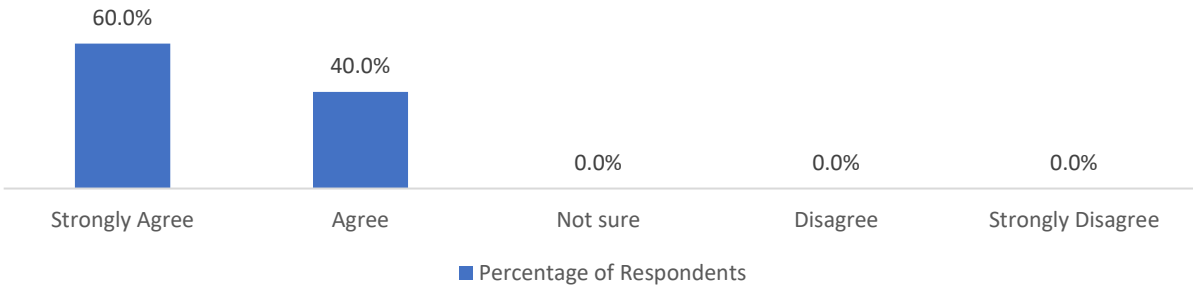


Figure 127: In your opinion, your organization promotes awareness of available options and linkages to need services.

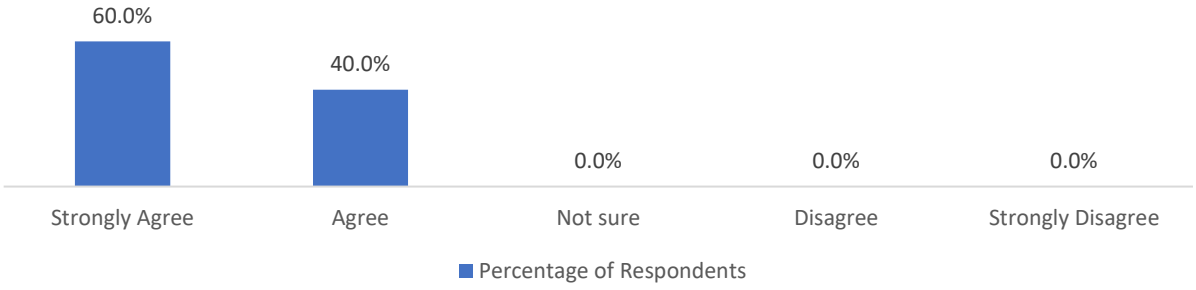


Figure 128: In your opinion, your organization provides person-centered care for all individuals served.

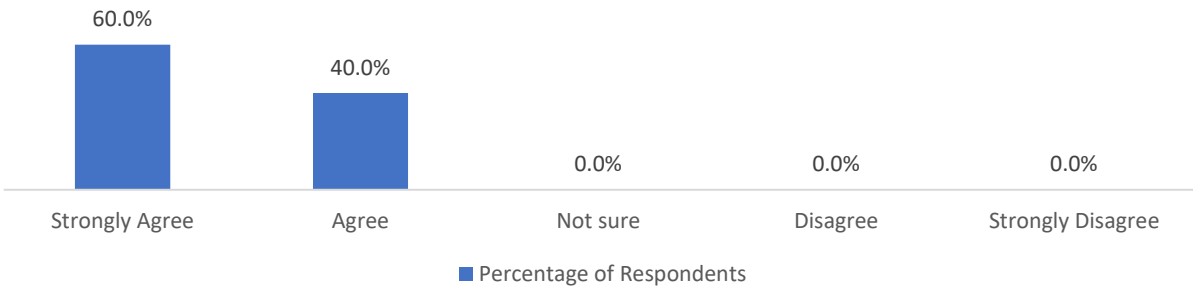


Figure 129: In your opinion, your agency hires employees who are culturally sensitive and culturally competent for the population served.

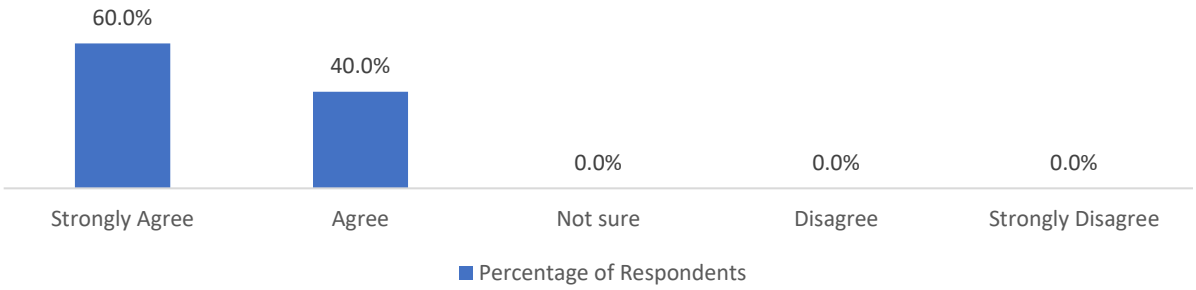


Figure 130: In your opinion, it's easy for individuals to access the services they need quickly and efficiently.

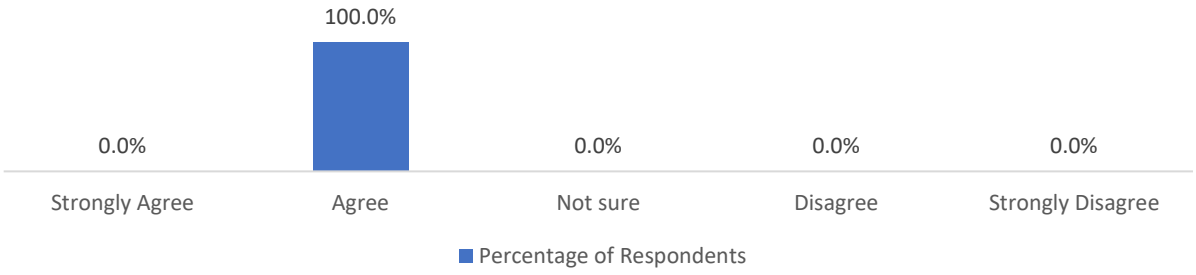


Figure 131: Do you think a standard intake and screening process for state agencies and community partners would help individuals get into services more quickly?

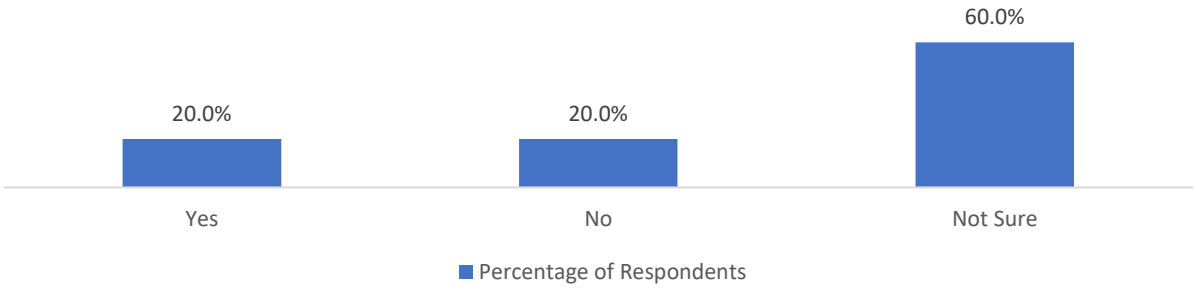


Figure 132: In your opinion, your organization encourages (promotes) working with other community partners to ensure care coordination.

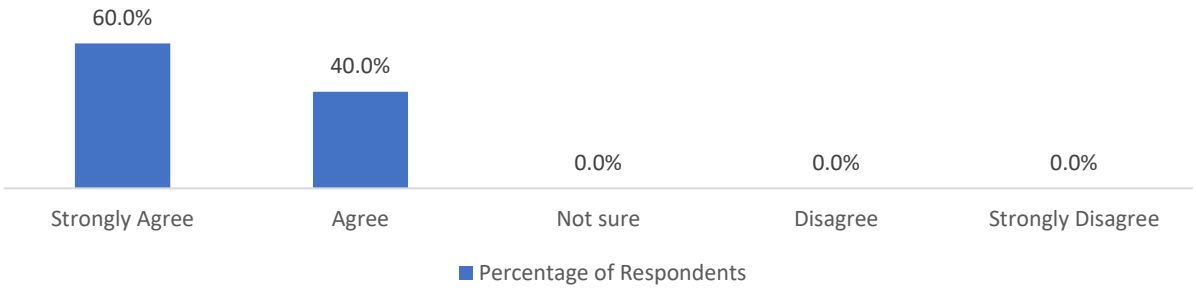


Figure 133: In your opinion, individuals in need of services have equal access to care.

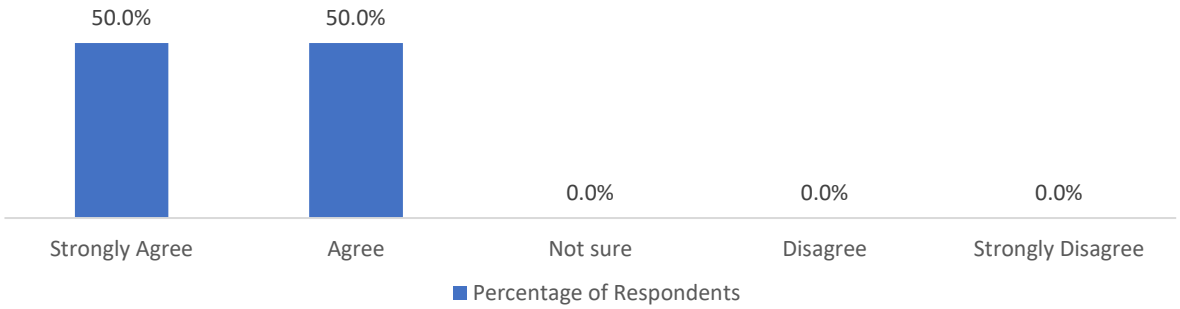


Figure 134: In your opinion, stakeholders help to address and advocate for equal access to care in system entry points.

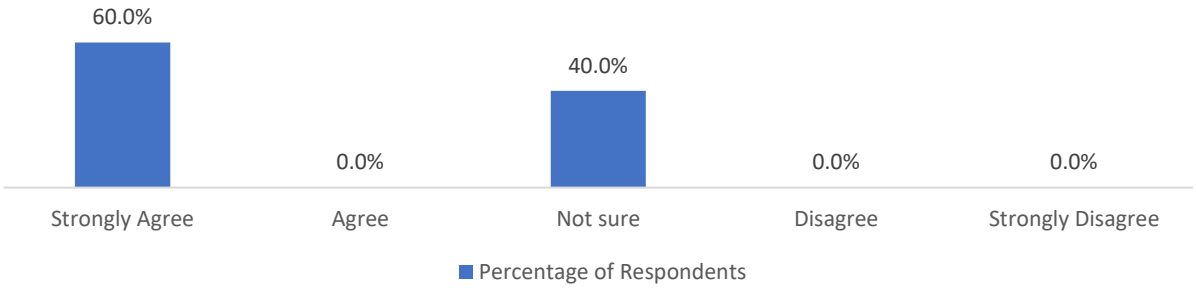


Figure 135: In your opinion, your organization ensures that services are of high quality and meet the needs of individuals served.

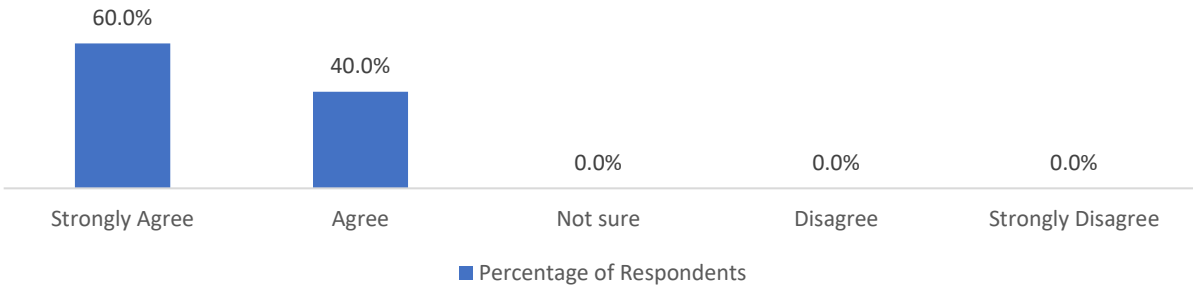
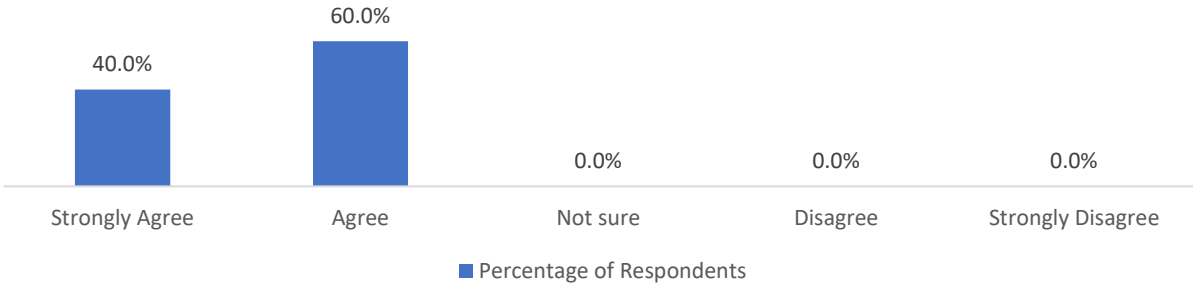


Figure 136: In your opinion, your organization tracks individuals served, services, performance, and cost to continually evaluate and improve outcomes.



NO WRONG DOOR NWFHN PROVIDER FOCUS GROUP SUMMARY

After analyzing the No Wrong Door (NWD) Access Survey responses, interviews were scheduled to elicit more detailed input from providers who have had direct experience with the behavioral health system in NWFHN's service area.

The scope of interviews included questions from the NWD Access Survey as well as follow-up questions. Discussions included topics related to the following:

- NWD Access
- Information, Referral, and Community Awareness
- Person-Centered Care and Transitional Support
- Streamlined Access and Eligibility
- Partnerships and Coordination of Efforts
- Quality Assurance and Continuous Improvement

In this section, selected survey questions, follow-up questions, and key findings are summarized. Sometimes, key findings were addressed during more than one question but are articulated in only one section. All names of individuals and providers were omitted to encourage candor and protect privacy.

Opening Question. What does No Wrong Door Access mean to you?

Survey Question 1. Do you think "No Wrong Door Access" works well within your organization?
Follow-up Interview Questions:

Tell us about your experience with No Wrong Door Access within your organization. Do you think your organization's current approach to No Wrong Door Access works well? What are some things that you think work well? What are some opportunities for improvement?

Key Findings:

Providers' understanding of NWD Access includes making sure they provide services or a linkage to services to everyone who comes in for help. It's important to make sure people who are seeking help get the help they need. This helps to ensure people in need are not sent back out feeling helpless or hopeless.

NWD Access is a part of the organization's culture. When someone walks on campus seeking services, it is a best practice to walk people to warm handoffs, and ensure folks are in the right space.

NWD Access is facilitated and supported by extensive training and discussions among leadership and staff.

Disruptions in the aftermath of Hurricane Michael, (e.g., structural damages, high staff turnover, etc.) impeded prioritization and implementation of NWD Access policies, trainings, and practices. While collaboration and integration are effective and necessary, some immediate issues may need to be addressed in other ways. Recovery from the distractions caused by Hurricane Michael is still in progress.

Bifurcation of funding and inconsistent diagnostic standards for substance use and mental health create barriers to NWD Access.

Having a variety of programs within an organization improves efficiency by streamlining protocols to connect clients with needed services. This results in enhanced effectiveness by ensuring and supporting the synergistic effects of coordinated care.

Opportunities for Improvement:

NWD Access" can be facilitated by streamlining processes for appointments, intake, screening, aftercare, etc.

Telehealth has improved access as providers and consumers have adapted well to the new normal of telehealth, Zoom availability, etc.

NWD Access can be facilitated by training across all behavioral health services and providers to coordinate, plan, and implement assessment, treatment, and aftercare to meet accreditation standards such as the Commission on Accreditation of Rehabilitation Facilities (CARF).

Survey Question 2. From your perspective, your organization has a role to play in "No Wrong Door Access".

Follow-up Interview Question:

What are the ways that your agency plays a role in No Wrong Door Access?

Key Finding:

A strong case management team and a close-knit staff facilitate NWD Access.

Survey Question 4. In your opinion, what action has your agency taken to improve the referral and care coordination process for individuals served?

Follow-up Interview Question:

In what specific ways can your agency improve on the referral and care coordination process for individuals served?

Key Findings:

Providers should continue to develop coordinated services with Crisis Stabilization Units (CSU) to facilitate intensive care coordination for high utilizers.
Providers should continue to develop processes to expedite referrals from outpatient to specialty teams, including referrals from Community Action Teams to adult services.

Funding and staff shortages result in some substance use providers running deficits due to large numbers of referrals.

Some providers receive funding for Medication Assisted Treatment (MAT) but are unable to provide needed services due to lack of capacity (i.e., shortage of providers).

Survey Question 5. In your opinion, are linkages to crisis intervention and support (e.g., Mobile Response Teams, medication management, Crisis Intervention Teams, Baker Act, Crisis Stabilization Units., etc.) occurring?

Follow-up Interview Question:

Have you or your agency identified any barriers or obstacles to becoming a part of the No Wrong Door Access system?

Key Finding:

Because substance use and mental health diagnoses are frequently identified as co- occurring disorders, additional funding is needed for specialty care (i.e., psychiatry). Ready access to additional specialty services should be available to all substance use and mental health clients/patients.

INFORMATION, REFERRAL, AND COMMUNITY AWARENESS

Survey Question 6. In your opinion, does your organization promote its services and resources very well.

and

Survey Question 7. In your opinion, does your organization promotes awareness of available options and linkages to needed services?

Follow-up questions:

Can you give examples? How does your agency promote awareness of available options and possible linkages to needed services (e.g., brochures, social media, billboards, website, handouts,

etc.)? What else could be done to increase the level of awareness of behavioral health services in the community?

Key Findings:

Providers, community partners, and NWFHN collaborate to conduct community-based activities promoting prevention services and resources.

Providers participate in community-based meetings to identify and analyze strengths and weaknesses in the current system of care and develop strategies to manage strategic issues.

Providers' public relations specialists promote behavioral health wellness and treatment services through marketing efforts such as community outreach via print, broadcast, and electronic media. Messages are often tailored to address issues relevant to holiday seasons, specific community needs, and specialty programs.

All the above-mentioned activities could be expanded and increased via social media.

Expand awareness of resources to address critical issues such as Medication Assisted Treatment (MAT) for opioid use disorder.

PERSON-CENTERED CARE AND TRANSITIONAL SUPPORT

Survey Question 8. In your opinion, does your organization provides person-centered care for all individuals served?

Follow-up Interview Question:

Describe how your agency implements a person-centered system of care.

Key Findings:

Providers implement person-centered Recovery Oriented System of Care (ROSC) training and policies.

Person-centered, trauma-informed care is built into organizational cultures. Providers are sensitive to emerging trends regarding language and other cultural issues to ensure inclusive and welcoming environments.

Providers' emphasis on person-centered care and trauma-informed care as best practices have been internalized and is promoted throughout leadership and treatment teams.

Providers routinely ask consumers where and when they want services to prioritize patients' convenience. Providers' values include client safety, flexibility to meet client needs, autonomy, and choice regarding clients' therapeutic goals.

Providers elicit and are responsive to client feedback.

Follow-up Interview Question:

What resources or supports would your agency need to improve person-centered care?

Key Findings:

Develop protocols (e.g., staff peer mentoring/review) to ensure that each client is treated as an individual, rather than generically with "one size fits all" assessments, treatment plans, etc.

Fund ongoing trainings and mentoring to ensure leadership and staff, including new staff, understand values and practices associated with person-centered care. This is especially important due to high staff turnover.

Fund frequent trainings regarding Mental Health First Aid (MHFA).

Partner with other providers or Managing Entities to develop cost effective lending libraries of training materials.

Survey Question 9. In your opinion does your agency hires employees who are culturally sensitive and culturally competent for the population served?

Follow-up Interview Questions:

If not, are you aware of your agency doing anything to improve in this area? Is there anything your agency could do to improve?

Key Findings:

Provide training to new employees and current employees.

Facilitate trainings with other providers to promote the beneficial exchange of information.

Allocate funds for training including guest speakers and cost-effective virtual training.

Recent Cultural Competency Audit included anonymous survey and identified the need for additional training, especially regarding cultural competency. Identified issues of concern are addressed in quarterly trainings and include topics such as:

- Recognition of the professional and organizational strength developed by a commitment to serving families/clients of different cultures.
- Recognition of the strength developed by a commitment to developing a diverse staff.
- Developing and distributing printed materials to reflect the importance of diversity and cultural sensitivity and competence.
- The need for leadership development and advancement to cultivate diversity.
- Recognition of the importance of training to promote cultural sensitivity and competence specific to LGBTQ+ clients.
- The need for additional training to increase awareness of clients' cultures and beliefs, and how to appropriately translate awareness into best practices.

STREAMLINED ACCESS AND ELIGIBILITY

Survey Question 10. In your opinion, it's easy for individuals to access the services they need quickly and efficiently.

Follow-up Interview Questions:

If yes, what works well about the current process with individuals for accessing services? If no, what are the major barriers that keep individuals from accessing the services that they need?

Key Finding:

Time is of the essence when someone expresses the need for help, but providers are not always able to respond within the small window of opportunity. Barriers include waitlists and staffing shortages.

Survey Question 11. Do you think a standard intake and screening process for state agencies and community partners would help individuals get into services more quickly?

Follow-up Interview Questions:

Why or why not? What do you think would need to be accomplished to implement a standard intake and screening process for the region/state/system?

Key Findings:

A standard intake and screening process, including a comprehensive referral and feedback form/process, with all necessary information that is easy to transmit to other programs and providers, is needed.

Judicial Circuit 14 has developed an effective form for services related to child welfare.

Because of billing protocols and standardized processes, Federally Qualified Healthcare Centers (FQHC) may be able to provide services more efficiently and effectively.

PARTNERSHIPS AND COORDINATION OF EFFORTS

Survey Question 12. In your opinion, your organization encourages (promotes) working with other community partners to ensure care coordination.

Follow-up Questions:

Which partners do you work with most? What works well in these partnerships?

Key Findings:

Working well across the region requires effective communication and an overall respect for the importance of NWD Access.

Leadership and staff training promotes professional standards and practices.

Training to elicit a shift in perspective helps providers empathize with clients seeking services.

Working closely with schools (e.g., through weekly staffing meetings with school leadership and providers) to ensure wraparound services and individualized solutions for youth in crisis, are available.

Having long term collaborative relationships with NWFHN and providers is necessary to develop mutual respect and understanding. This will help to foster respect for the multiple perspectives and roles necessary to achieve beneficial outcomes.

Reengage communities to resume communication after Hurricane Michael and COVID-19 eliminated many meetings. There is a need to restart some meetings to increase direct communication among similar providers.

Survey Question 13. In your opinion, individuals in need of services have equal access to care.

Follow-up Interview Questions: Why? Why not? What works well?

Key Findings:

All clients can receive services because access to services is not based on the ability to pay. Providers welcome all people in need.

Providers are committed to universal equal access.

The current funding system favors service provision to some in a more expedited way than for others. Shifting to universal equal access will require additional funding and staffing.

Survey Question 14. In your opinion, stakeholders help to address and advocate for equal access to care in system entry points.

Follow-up Interview Question

If not, how can this be improved?

Key Findings

Stakeholders advocate for individuals who are seeking services by sharing information directly with providers, helping people transcend seemingly insurmountable barriers in the system.

QUALITY ASSURANCE AND CONTINUOUS IMPROVEMENT?

Survey Question 16. In your opinion, your organization tracks individuals served, services, performance, and cost to continually evaluate and improve outcomes.

Follow-up Interview Question:

If not, how can this be improved?

Key Findings:

There are already a multitude of monitoring systems and standards, regarding services, finances, facilities, staffing, etc.

Biggest need is legislative and gubernatorial action to change funding structure and rates.

INDIVIDUALS SERVED SURVEY SUMMARY

INTRODUCTION

To help improve the behavioral health system of care, NWFHN developed and distributed a survey to elicit feedback from consumers. The focus of this survey is consumer awareness and experience concerning behavioral health care services in the service area.

The survey instrument was comprised of 17 questions regarding county of residence, awareness of, access to, and utilization of available services, quality of care, and service gaps. Responses were structured as yes/no, multiple choice, and Likert Scale options.

Ordinarily, this type of survey would be conducted in person throughout the community. However, due to concerns and limitations attributable to COVID-19, NWFHN decided that online data collection from a convenience sample would be more appropriate at this time. A link to the online survey was emailed to providers, who in turn distributed it broadly to their consumers. A total of 46 consumers responded.

Survey data were downloaded into an Excel spreadsheet and analyzed by the planning team. Descriptive frequencies were calculated by dividing the number of responses by the total number of respondents. Tables and graphs were developed to illustrate the data. Findings were presented to and discussed with NWFHN and integrated into the assessment.

SUMMARY OF FINDINGS

Nineteen (41.3%) respondents identified as adults receiving services, 12 (26.1%) as caregivers representing a person receiving services, and 9 (19.6%) as parents of a child receiving services.

Adult Mental Health Services were received by 52.2% of respondents (or the person they are representing) and 32.6% received Child Mental Health Services. Adult Substance Use Services were received by 23.9% of respondents. Twelve (26.1%) received two or more types of services.

While the majority of respondents were residents of Leon or Bay Counties (39.1% and 28.3%, respectively), 61.1% of the service area's 18 counties had at least one respondent.

When asked if they know where to go for behavioral health services, 67.4% said yes, 13% said no, and 19.6% said sometimes.

While nearly two-thirds of respondents said they are aware of the 2-1-1 information and referral resource in their county, only 17.4% had ever called for assistance. Among those who called, when asked if 2-1-1 was helpful in getting them to the services they needed, 75% said yes, and 25% said sometimes.

Nearly two-thirds, 63%, said they were able to get the services they needed when they needed them.

From a comprehensive list of services, 13 respondents identified 22 specific services they needed but were unable to get. The most frequently mentioned services were crisis stabilization support (38.5%), assessment (30.8%), and short-term residential treatment (30.8%). Ten respondents identified two or more specific services they were unable to get.

When asked how many times they were unable to get the services they needed during the previous 12 months, 2 said one to two times, 3 said three to four times and 2 said five or more times. Altogether, 84.8% did not indicate they had been unable to get services they needed during the previous twelve months.

Most respondents, 63%, indicated that the services they needed were available, 17.4% said there was a waitlist for needed services, and 10.9% said the services they needed were not available.

More than two-thirds, 69.6%, agreed or strongly agreed that the services and planning they received were focused on their treatment needs.

Fewer than half (43.5%) had to wait 1 to 2 weeks to receive services, 21.7% had to wait 3 to 4 weeks, 17.4% had to wait more than a month, and 8.7% had to wait more than two months.

While most respondents traveled less than 30 minutes to access services (34.8%, up to 15 minutes; 37%, 16 to 30 minutes), 8.7% traveled 31 minutes to 1 hour, and 15.2% traveled more than an hour.

Driving myself or relative/friend drives me were the most frequently identified means of transportation to getting the care they needed, 65.2% and 32.6%, respectively.

From a comprehensive list of obstacles, 28 respondents identified a total of 13 barriers that they experienced while trying to get the care they needed. Sixteen respondents identified more than one. The most frequently identified obstacles were related to affordability (i.e., could not afford the services, 23.9%), stigma (i.e., worried what people would think, fear, shame, 19.6%), and access (i.e., long waitlists, 13%; no evening or weekend appointments, 13%; did not meet eligibility criteria, 13%; did not know where to go for services, 13%). In addition to the obstacles listed in the survey, each of six respondents specified an additional another obstacle they encountered: amount of time before I could get an appt; had to pay out of pocket because insurance didn't cover the service. Providers that took insurance had no availability; no legitimate evaluations; good providers not covered by insurance; handicap inaccessible; lack of attention to critical need.

INDIVIDUALS SERVED SURVEY CHARTS

Figure 137: Which best describes you?

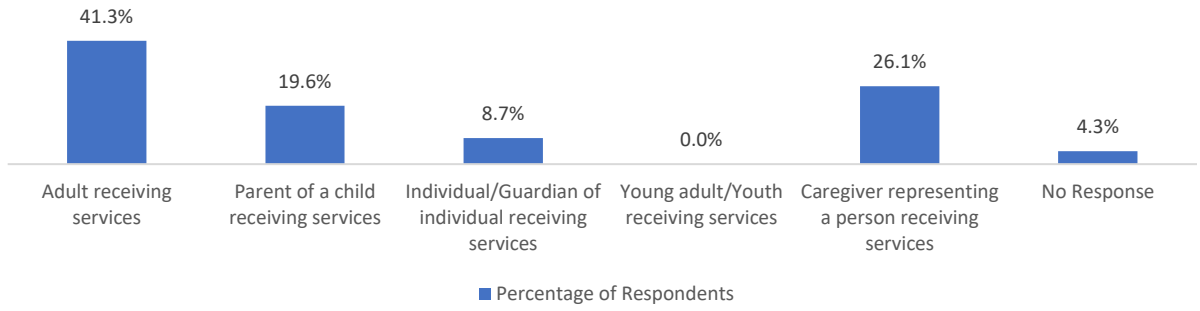


Figure 138: What type of service did you or the person you are representing receive?

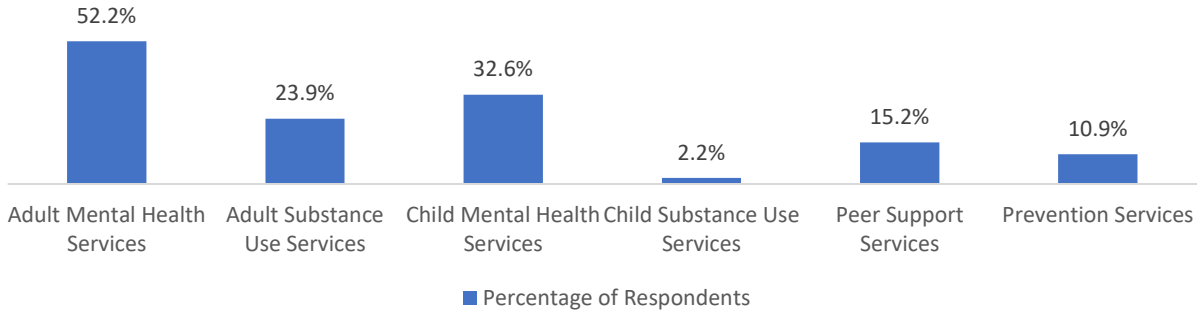


Figure 139: Which county do you live in?

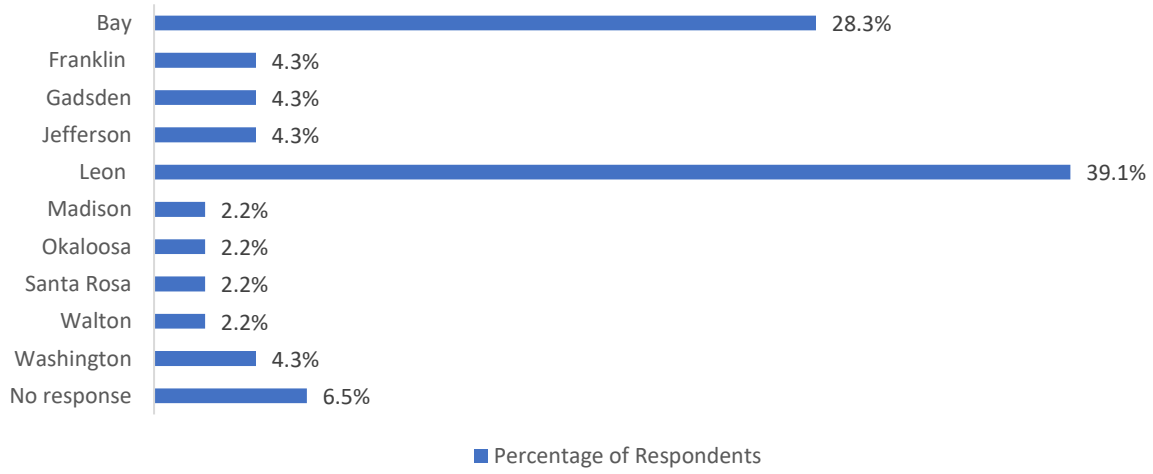


Figure 140: Did you know where to go for mental health and substance use treatment services when you needed them?

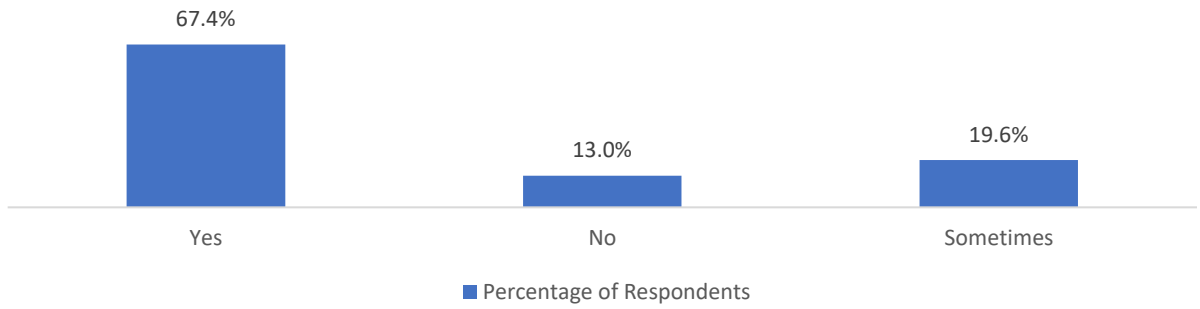


Figure 141: How did you learn about mental health and substance use treatment services when you needed them?

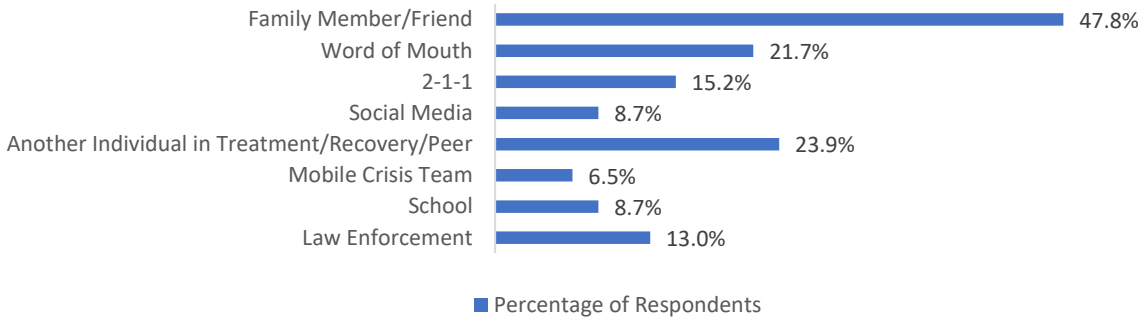


Figure 142: Are you aware of the 2-1-1 Information and Referral Resource in your community?

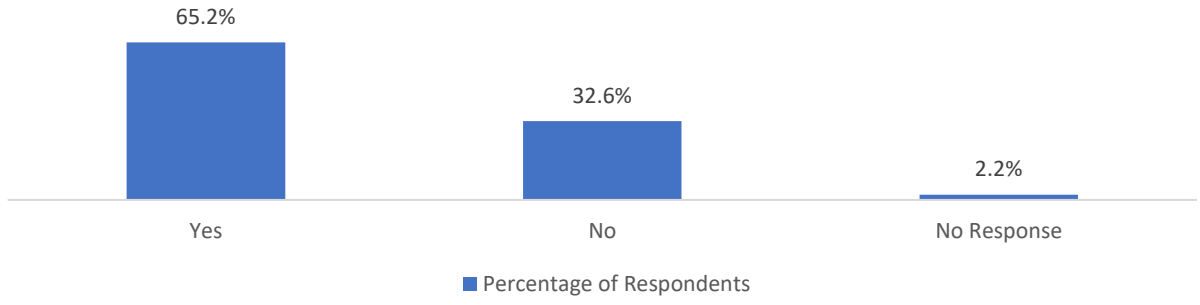


Figure 143: Have you ever called 2-1-1 Information and Referral Resource for assistance?

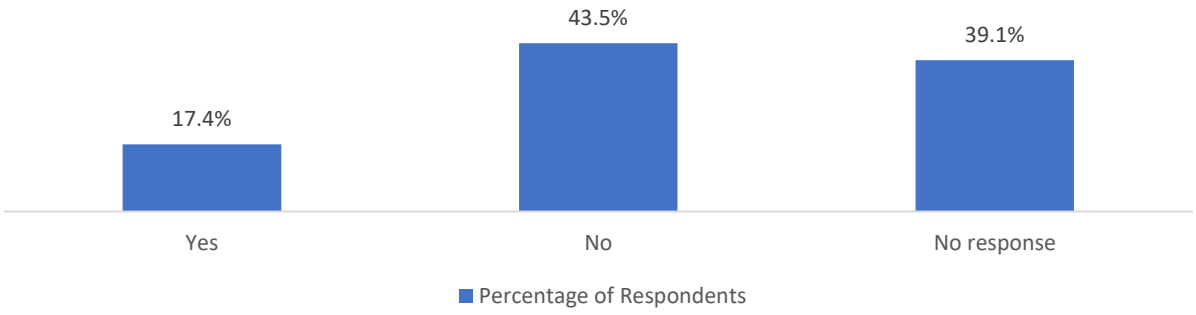


Figure 144: When you called the 2-1-1 Information and Referral Resource, were they helpful in getting you the services needed?

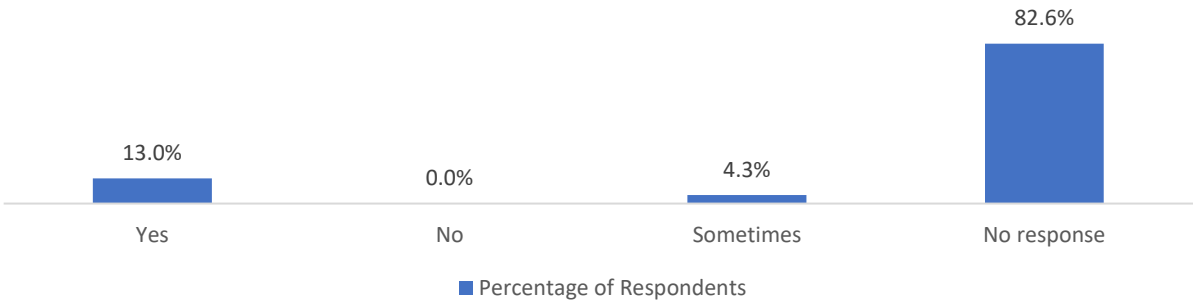


Figure 145: Were you able to get all the services you needed when you needed them?

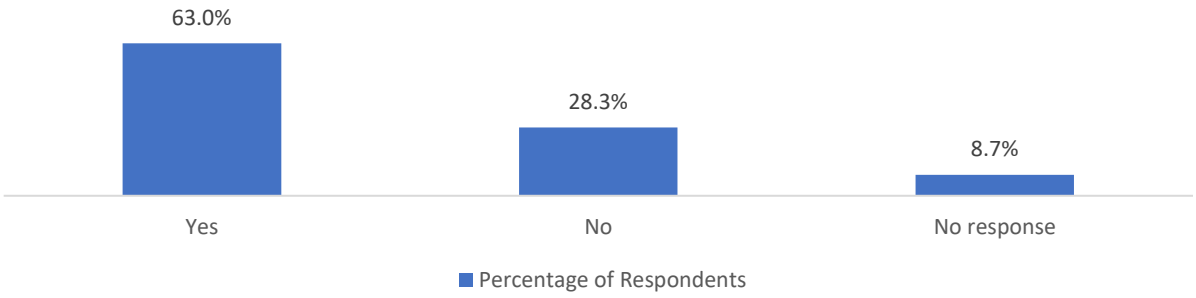


Figure 146: If no, please choose from the list below, the services you needed but were not able to get.

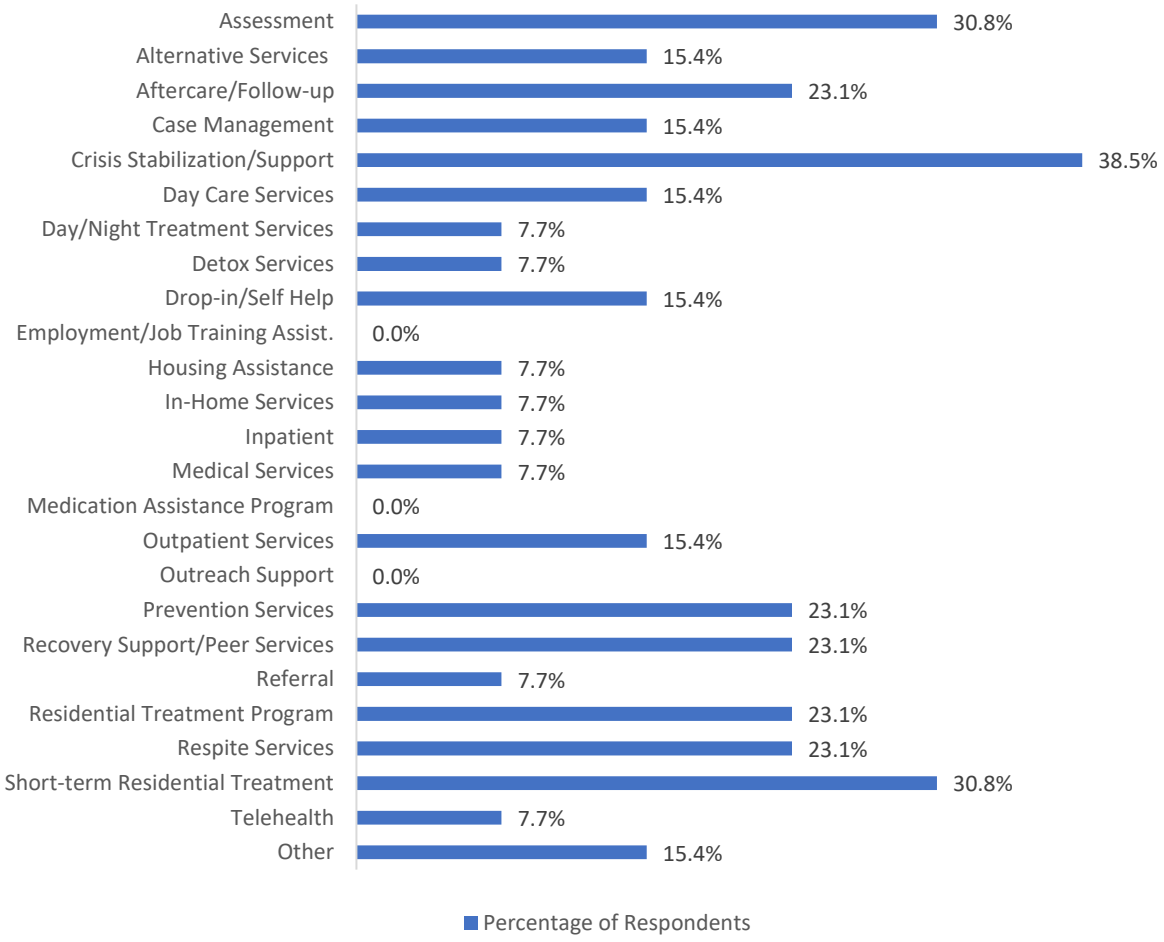


Figure 147: How many times during the last 12 months were you not able to get the services you needed?

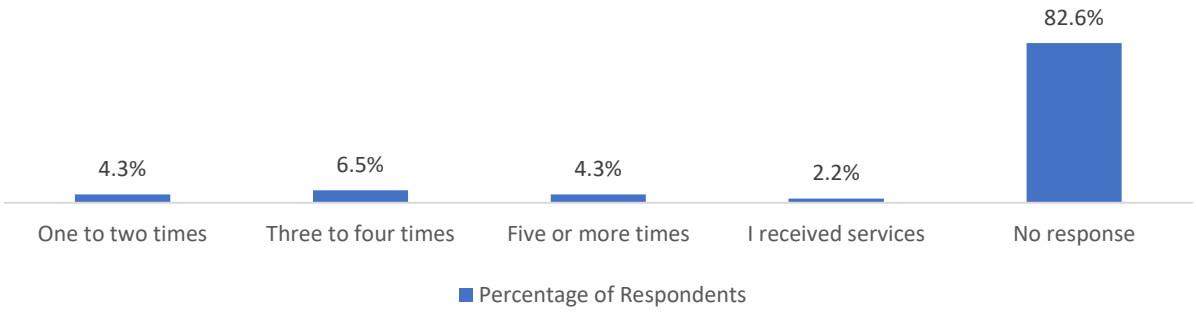


Figure 148: The services I needed were:

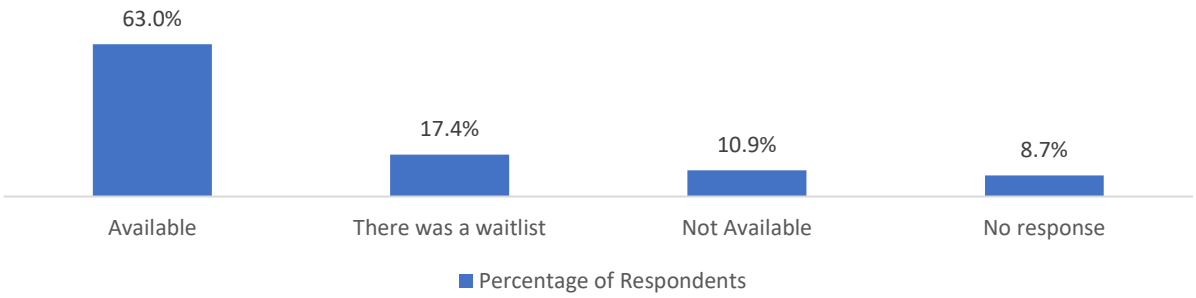


Figure 149: The services and planning I received were focused on my treatment needs (patient centered).

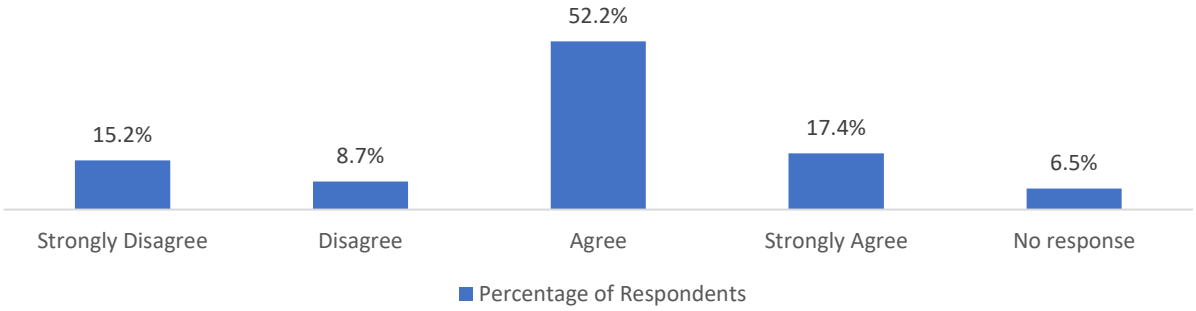


Figure 150: How long did it take from the time you requested an appointment for services to the time you received the services?

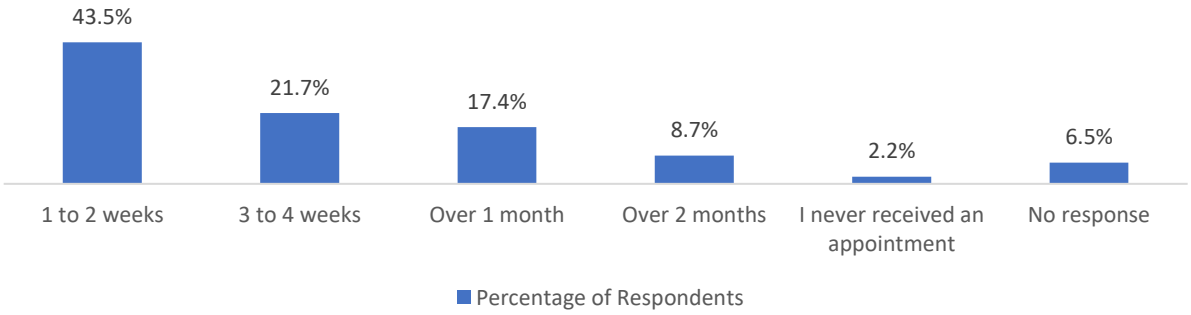


Figure 151: How long did it take to travel to the service?

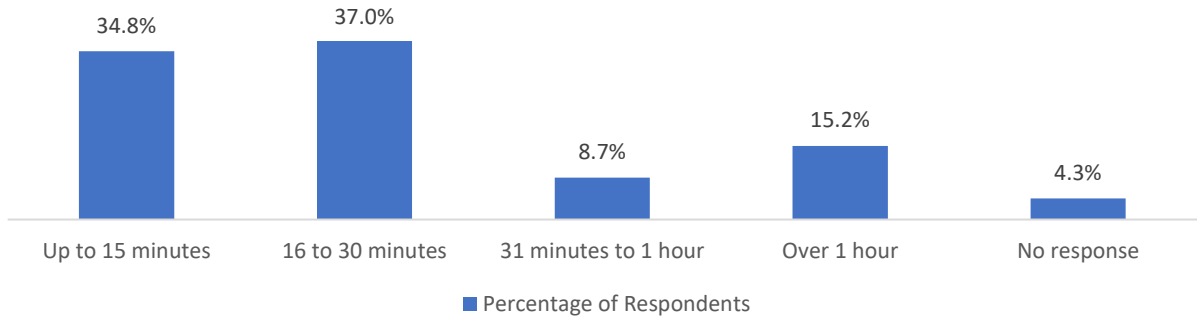


Figure 152: How do you travel to get services?

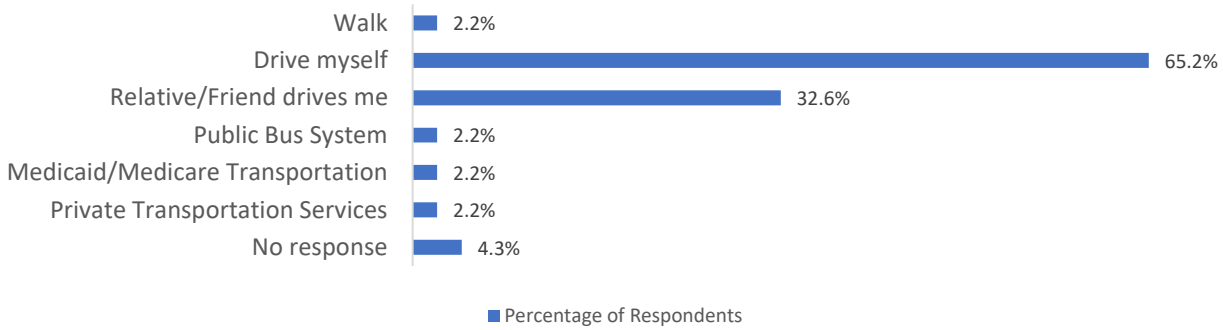
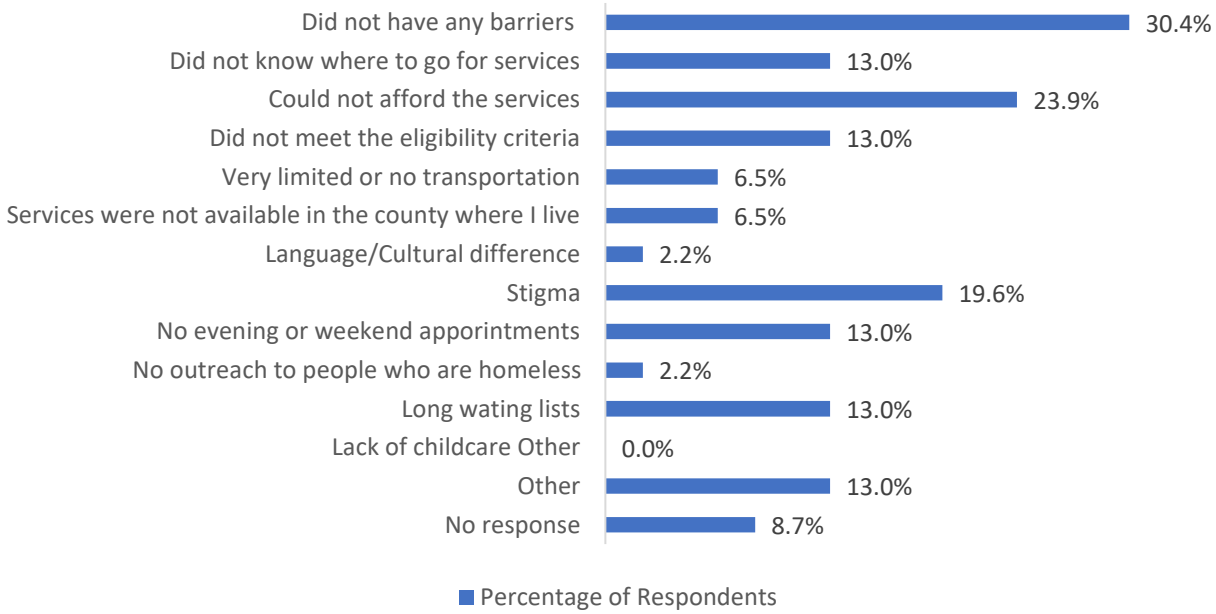


Figure 153: What were the obstacles you experienced getting the care you needed?



STAKEHOLDER SURVEY SUMMARY

INTRODUCTION

To help improve the behavioral health system of care, NWFHN developed and distributed a survey to elicit feedback from a wide range of stakeholders including health care providers as well as state, local, and community organizations and agencies. The focus of this survey was stakeholder awareness and experience concerning behavioral health care services in the service area.

The survey instrument was comprised of 20 questions regarding the scope of available services, awareness of, access to, and utilization of available services, quality of care, and service gaps. Responses were structured as yes/no, single- and multi- select multiple choice, and Likert Scale items.

Ordinarily, this type of survey would be conducted in person throughout the community. However, due to concerns and limitations attributable to COVID-19, NWFHN decided that online data collection from a convenience sample would be more appropriate at this time. A link to the on-line survey was emailed to a broad range of stakeholders and a total of 97 responded.

Survey data were downloaded into an Excel spreadsheet and analyzed by the planning team. Descriptive frequencies were calculated, numerous tables, and graphs were developed to illustrate the data. Findings were presented to and discussed with NWFHN and integrated into the assessment.

SUMMARY OF FINDINGS

When respondents were asked to select the service sector(s) which best describes their respective organizations, they identified 20 service sectors. The most frequently selected sectors were school (elementary, middle, or high school) at 13.9%, unhoused services (12.4%), case management (10.4%), and children serving agency (7.7%). Smaller percentages of respondents cited a wide range of sectors such as adult mental health care and social services. More than a quarter, 25.8%, selected (but did not specify) other sectors that were not included in the survey list. It should be noted that many stakeholders provided services to more than one sector. The denominator was the total number of responses not the total number of respondents.

Respondents indicated that every county in the service area is provided behavioral health services and stakeholders served more than just one county. There were more services available in Bay and Calhoun counties when compared to other counties in the service area. Among counties with the least services were Escambia, Gadsden, Jefferson, Leon, Santa Rosa, and Taylor.

Most respondents, 82.5%, agreed or strongly agreed that they are aware of the availability of mental health and substance use services in their area.

Slightly more than half of respondents, 51.5%, indicated they are aware of NWFHN resources, 17.7% had accessed NWFHN resources in the past 6 months, and 16.5% said the resources were helpful. Of the 17 who said they had accessed NWFHN resources in the previous six months, 16 said the services were helpful. When asked if they had ever directed an individual to access NWFHN by calling or online, 22.7% said they had.

Nearly 60% of respondents indicated they are aware of 2-1-1 information and referral service, 22% had accessed this service in the previous 6 months, and 17.6% said it was helpful. Of the 22 who said they had accessed 2-1-1 in the previous six months, 17 said the service was helpful. When asked if they had ever directed individuals to 2-1-1 by calling or online, 39.2% of all respondents (65.5% of those who were aware of 2-1-1) said they had done so.

The most frequently identified crisis response models in respondents' respective areas were mobile response teams (43.3%), behavioral health response teams (28.9%), mobile crisis response team (21.6%), and school district mobile response teams (16.5%). Sixteen respondents cited more than one response model and 25 did not respond to this question.

Most respondents, a total of 80.4%, rated community awareness of behavioral health treatment services in their area as very good (13.4%), good (26.8%), or fair (40.2%).

Nearly two-thirds of respondents, a total of 61.9%, agreed or strongly agreed that linkages to needed services are coordinated and well established across the system of care. More than two-thirds, a total of 68%, agreed or strongly agreed that behavioral health care and peer services are accessible in their area.

Two-thirds, 65.9%, agreed or strongly agreed that the processes for referrals are easily accessible, and nearly two-thirds, 62.9%, agreed or strongly agreed that programs and services are coordinated across the system of care.

From a list eleven barriers to access, the most frequently cited barriers included the following: no or very limited transportation at 73.2%; 57.7% said consumers did not know where to go for services; 52.6% said consumers could not afford the services; 38.1% cited stigma (worried what people would think, fear, shame), and long waitlists. Only 10 (10.3%) respondents identified only one barrier and 4 respondents said they did not have any barriers.

Respondents described a wide range of resources and services needed to facilitate integration of behavioral health care, primary care, specialty care, dental health care, transportation, safe housing, follow up via navigation, and wrap-around services, especially in minority, rural, and low-income communities. Specific services included Medication Assisted Treatment (especially in rural areas), assistance with SSDI, Medicaid, and ACA applications. Other needed services included housing, transportation, food, and employment. Also, adequate funding is needed to recruit and retain quality providers, including diverse providers that "look like" consumers.

The types of patient-centered care resources and services that have improved quality of life of individuals included, school-based services, mobile crisis response services, and community-based providers.

STAKEHOLDER SURVEY CHARTS

Figure 154: Percentage of respondents by organization service sector.

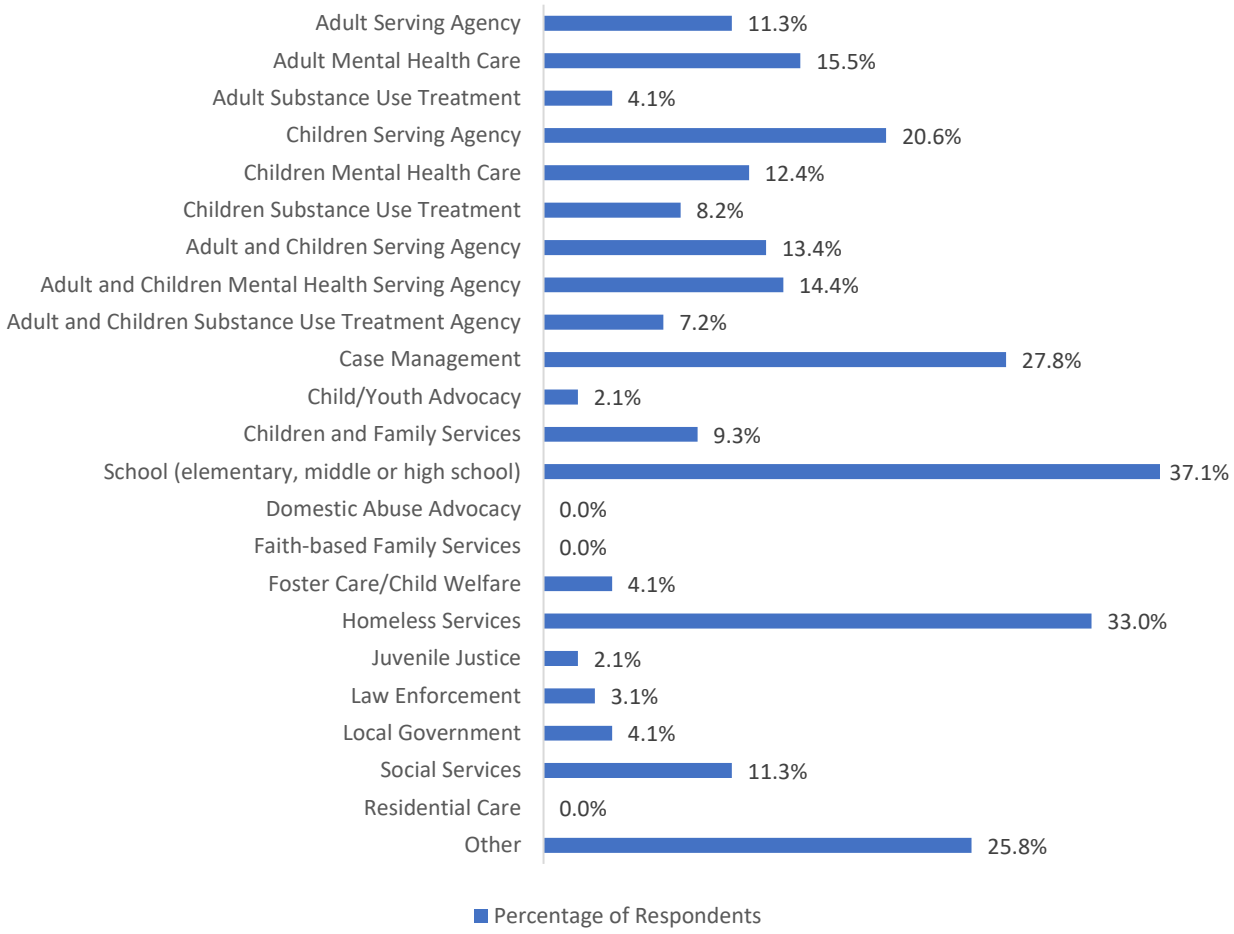


Figure 155: Percentage of stakeholder respondents by county.

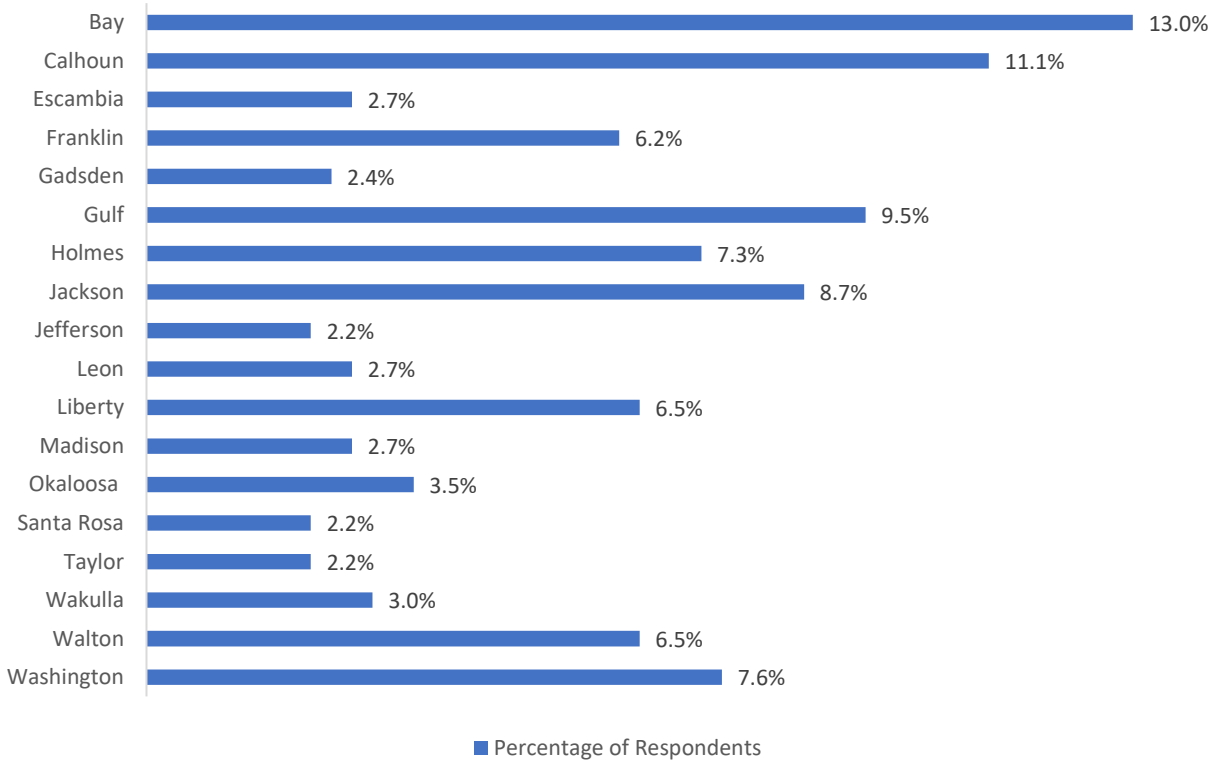


Figure 156: You are aware of the availability of mental health and substance use services in your area.

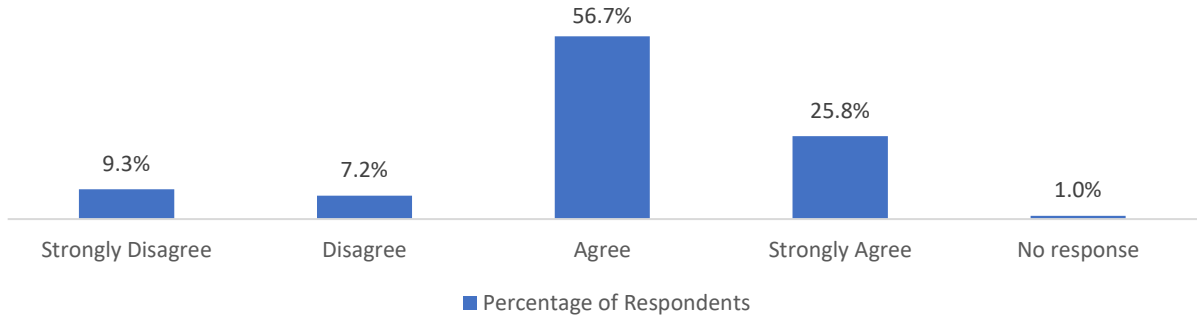


Figure 157: Are you aware of Northwest Florida Health Network (Managing Entity) resources?

Figure 158: Have you accessed Northwest Florida Health Network (Managing Entity) resources in the past 6 months?

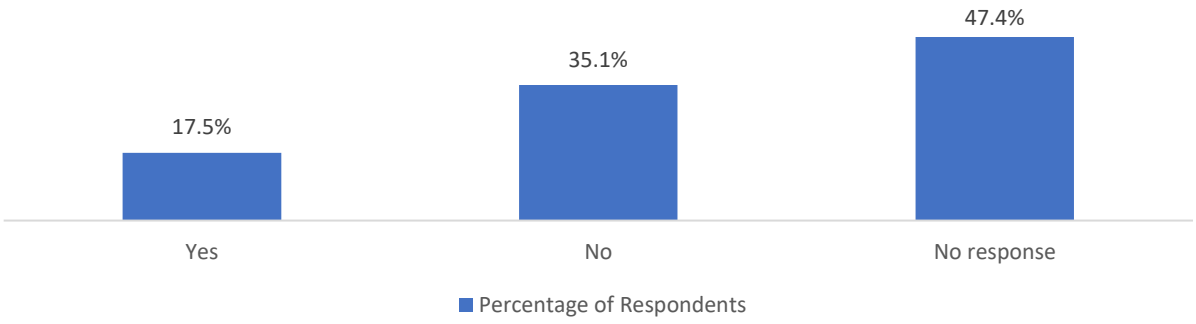


Figure 159: When you accessed Northwest Florida Health Network (Managing Entity) resources, was it helpful?

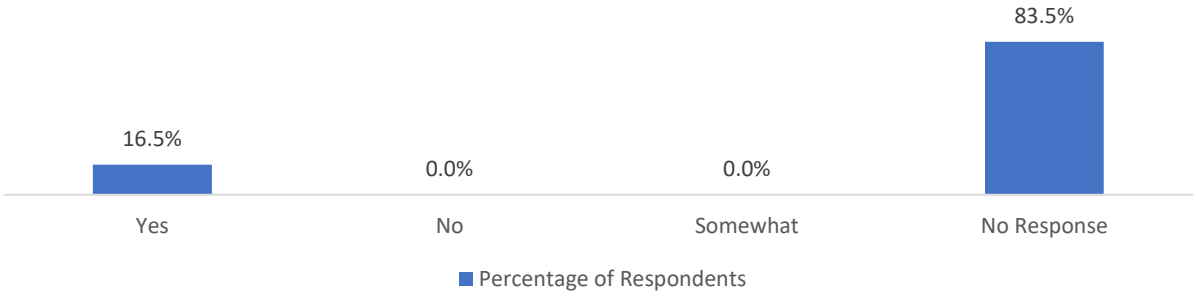


Figure 160: Have you ever directed individuals to access Northwest Florida Health Network (Managing Entity) by calling or online?

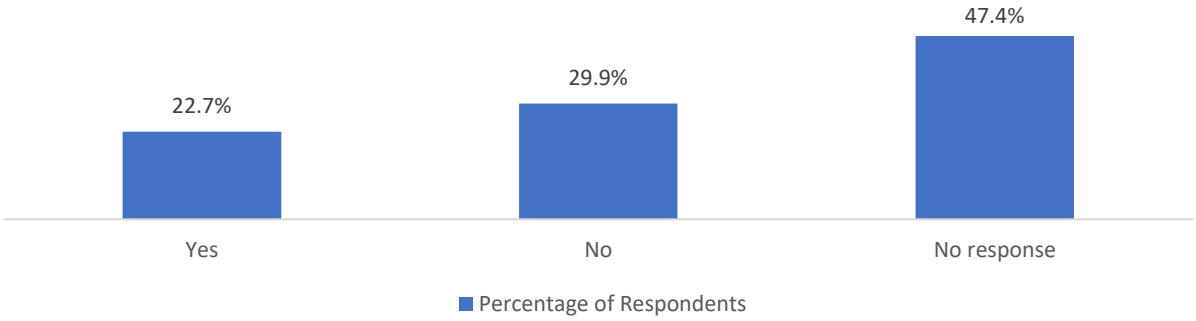


Figure 161: Are you aware of the 2-1-1 Information and Referral Resource?

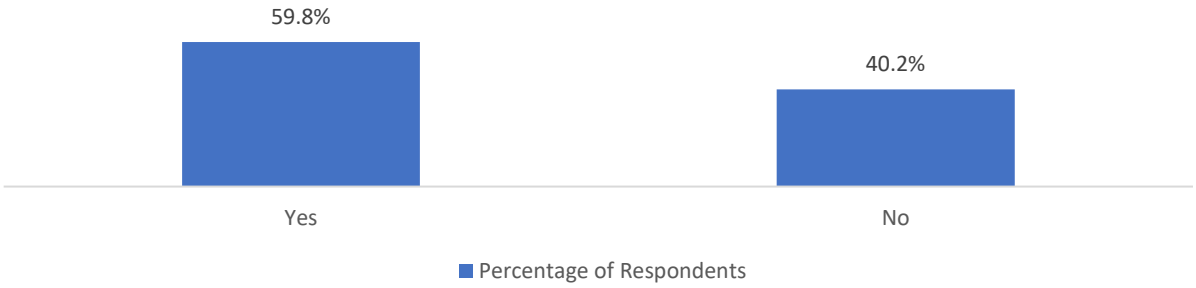


Figure 162: Have you accessed the 2-1-1 Information and Referral Resource in the past 6 months?

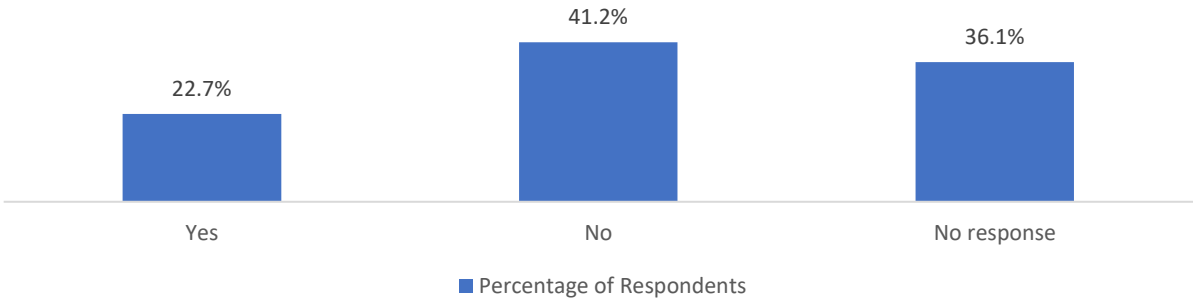


Figure 163: When you accessed the 2-1-1 Information and Referral Resource, was it helpful?

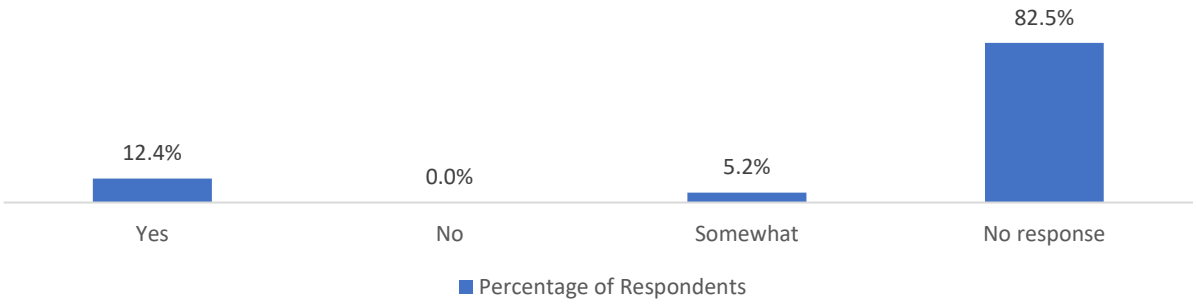


Figure 164: Have you ever directed individuals to access the 2-1-1 Information and Referral Resource by calling or online?

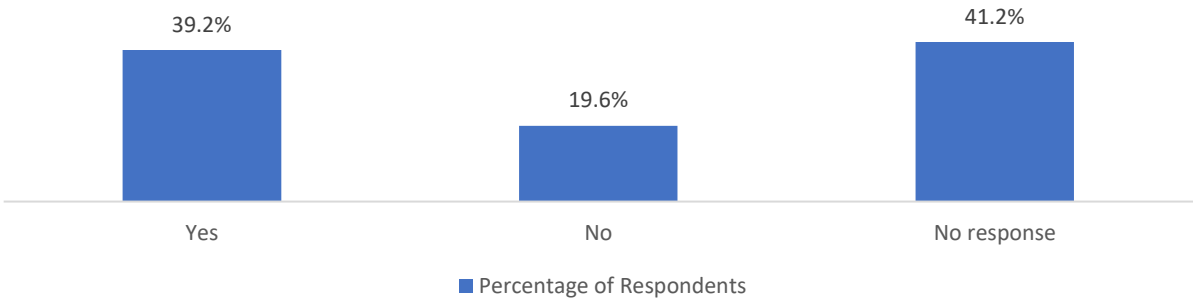


Figure 165: Select the crisis response model in your area. (Check all that apply)

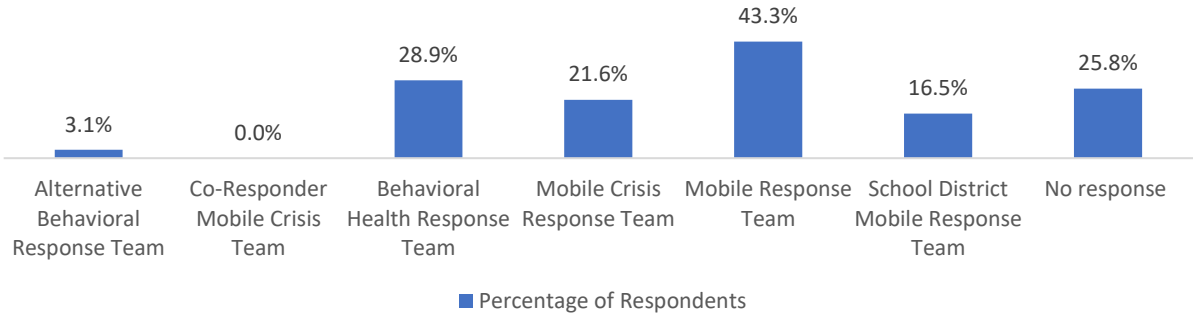


Figure 166: How would you rate community awareness of mental health and substance use treatment services in your area?

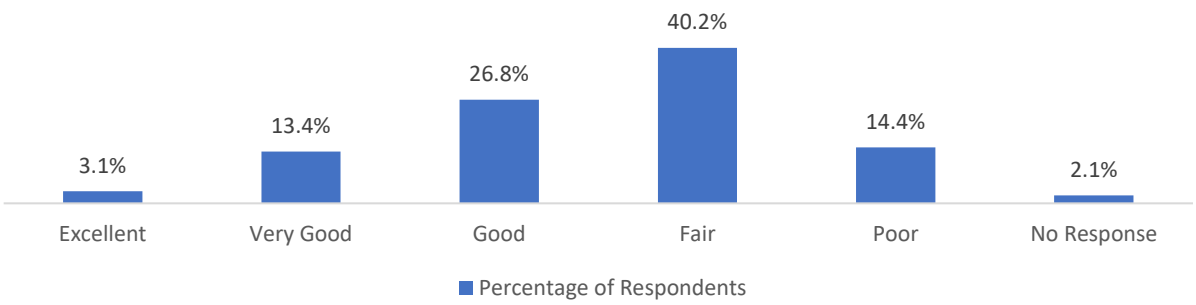


Figure 167: Linkages to needed services are coordinated and well established across the system.

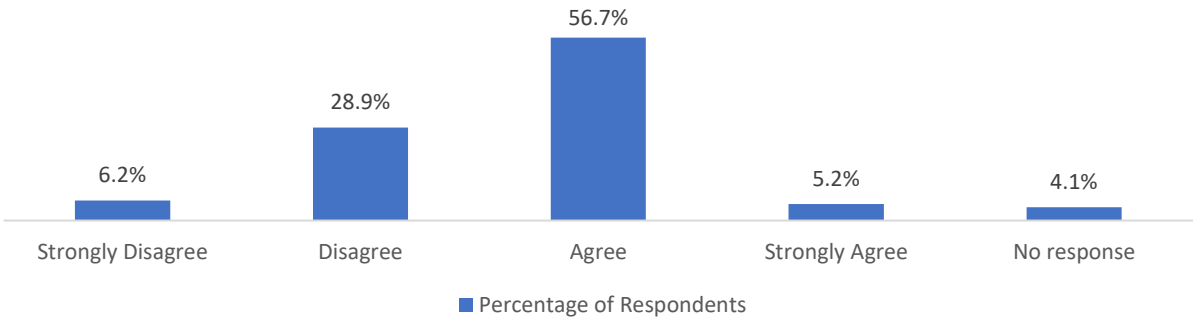


Figure 168: In general, behavioral health care and peer services are accessible in your area.

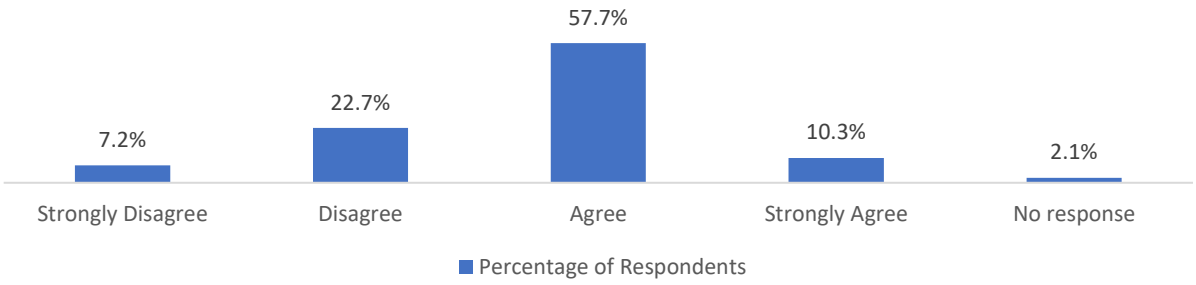


Figure 169: The process for referrals is easily accessible.

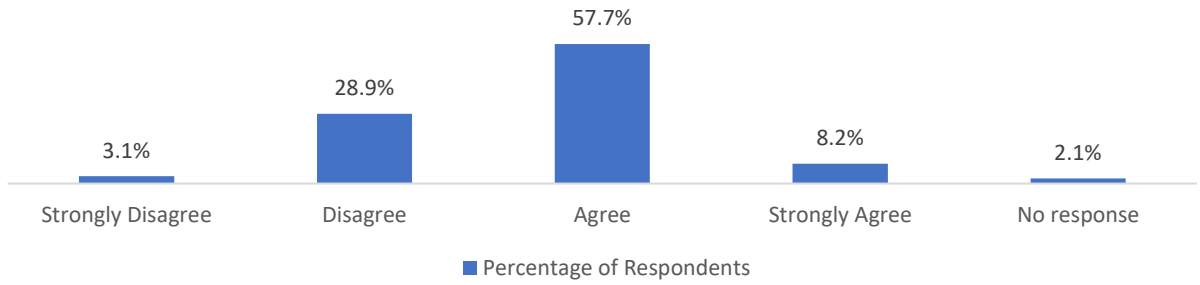


Figure 170: Programs and services are coordinated across the system of care.

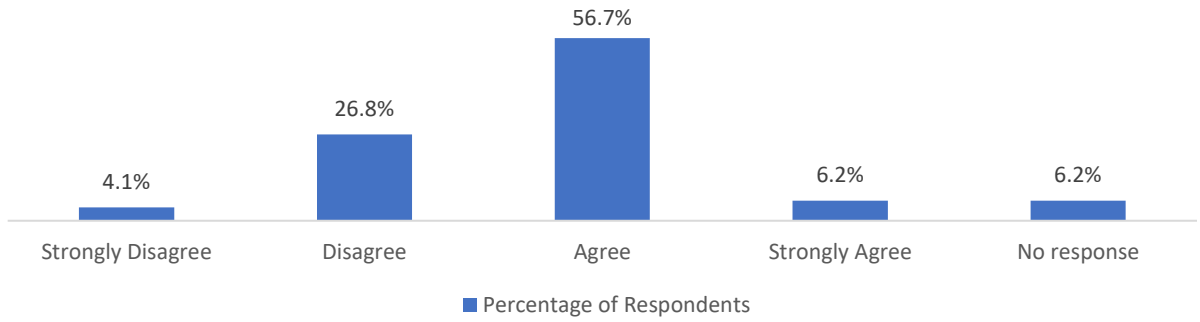


Figure 171: List the barriers for consumers accessing services in your community. (Check all that apply)

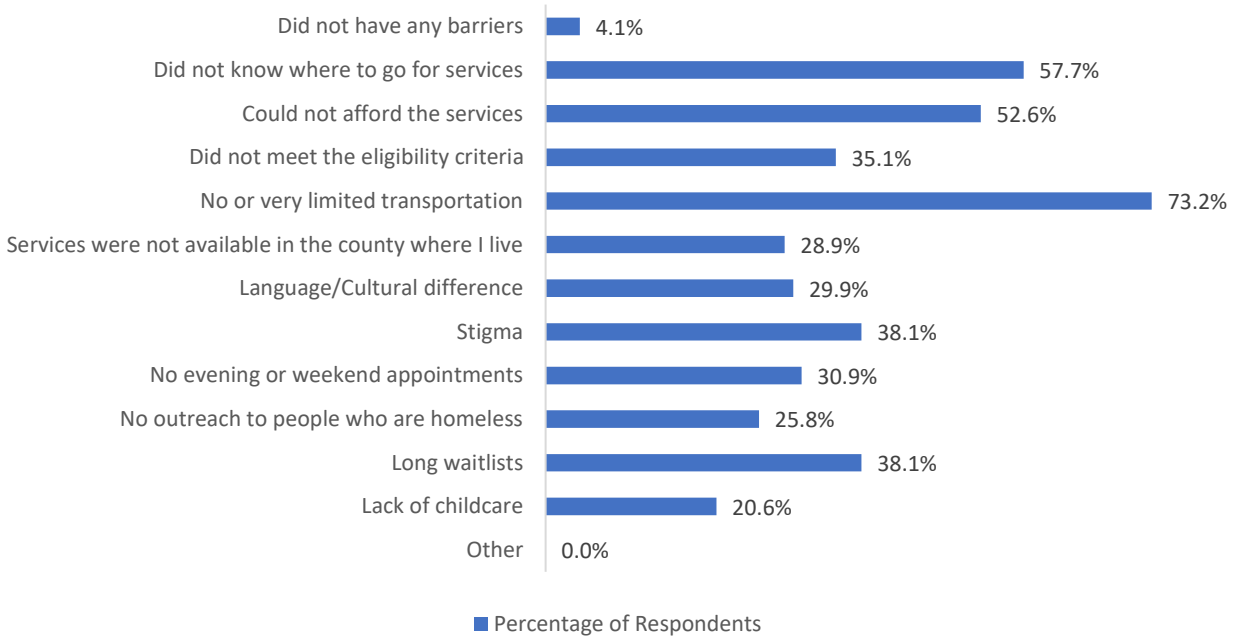


Figure 172: List the resources and services needed that are not available to improve patient-centered care and planning.

Needed Resources and Services
Medication Assisted Treatment (MAT)
Community-based services other than telehealth
Accessible up-to-date information regarding available services, especially in rural areas.
Adequate access to services in minority, rural, and low-income communities.
Safe, affordable housing
Assistance with SSDI, Medicaid, ACA applications and other needed services (e.g., housing, transportation, food, employment, etc.).
Services for families with children, e.g., behavioral analysis, intensive outpatient, residential treatment, inpatient substance use treatment for teens, Autism screening and treatment, human trafficking resources and support for teens, outreach via schools, respite for parents.
Medicaid and other funding for providers to integrate behavioral health care, primary care, specialty care, dental health care, and follow-up via navigation and wrap-around services.
Adequate funding to recruit and retain quality providers, including diverse providers that "look like" consumers.
Integration of behavioral health care, primary care, specialty care, dental health care, transportation, housing, and follow-up via navigation and wrap-around services, especially in minority, rural, and low-income communities.

Figure 173: List the top three patient-centered care resources that have improved quality of life for individuals.

TOP THREE PATIENT-CENTERED RESOURCES
School-based Services
Mobile Crisis Response Services
Community-based Providers

PEER RECOVERY COMMUNITY/SUPPORT SPECIALIST'S SURVEY SUMMARY

INTRODUCTION

To help improve the behavioral health system of care, NWFHN developed and distributed a survey to elicit feedback from peer recovery community/support specialists. Learning from their experiences and perspectives will help to improve the behavioral health system of care in Northwest Florida.

The 18-question survey was structured as yes/no, single- and multi- select multiple choice, and Likert Scale items. Ordinarily, this type of survey would be conducted in person. However, due to concerns and limitations attributable to COVID-19, NWFHN decided that online data collection would be more appropriate at this time. A link to the on-line survey was emailed to peer recovery community/peer support specialists. A total of 30 peer specialists responded to this survey.

Survey data were downloaded into an Excel spreadsheet and analyzed by the planning team. Descriptive frequencies were calculated by dividing the number of responses by the total number of respondents; numerous tables, and graphs were developed to illustrate the data. Findings were presented to and discussed with NWFHN and integrated into the assessment.

SUMMARY OF FINDINGS

Most survey respondents, 63.3%, described their behavioral health experience as adults with lived mental health condition, and 13.3% described their experience as adults with lived co-occurring mental health and substance use condition. Smaller percentages described their experience as veteran with lived co-occurring mental health and substance use condition, or family member or friend with lived (behavioral health) condition(s). Because this question asked for respondents to select the type of experience that best describes their experience, these data do not describe whether respondents have had more than one type of experience.

The largest percentages of respondents lived in Bay County (43.3%), Okaloosa County (13.3%), and Holmes and Liberty Counties (10% each). Smaller percentages lived in Calhoun, Escambia, Jackson, Leon, Santa Rosa, and Walton counties.

Respondents were asked to describe all the types of service agencies by which they are employed/ volunteered. Thirteen respondents identified more than one type of service agency. The most frequently mentioned types of agencies were adult mental health services (50%), followed by peer support services (43.3%), and adult substance use services (30%). Prevention services and recovery community organizations were each mentioned by 23.3% of respondents. Smaller percentages of respondents identified child mental health services, family/peer organizations, and other types of agencies.

Nearly half, 46.7%, of respondents indicated they have been employed/volunteered with their agency more than 3 years. An additional 30% indicated they have been employed or volunteered with their agency 1 to 2 years.

Two-thirds, 66.7%, of respondents' work schedules average 40 hours per week. An additional 20% worked more than 40 hours per week, 13.3% worked 20 hours per week or less, and 10% work up to 10 hours per week.

Most respondents, 83.3%, indicated that the agency where they are employed/volunteered, utilize recovery peer support services within the services they provide in the community. Another 10% were not sure if recovery peer support services were utilized. When asked if their agency adheres to recovery support best practices, 70% said yes, and 13.3% were not sure.

When asked to describe their qualification status, 53.3% said they were a Certified Recovery Peer Specialist (CRPS). An additional 30% said they applied for certification and were in process.

When asked to select the facility/program setting that best describes where they deliver services, respondents identified 26 different settings, and eight respondents mentioned two or more settings. The most frequently cited settings were, Outpatient Recovery Community Organization (RCO) at 23.3%, followed by child serving organization at 16.7%, and family/peer grassroots organizations at 16.7%. Detoxification and medication assisted treatment settings were each mentioned by 13.3% of respondents. In addition to those listed in the survey question, "Other" facilities/programs mentioned were, Transitional Resource Center, CAT, CDAC, EPIC, in-home case management, 90% of the above, MHA, school and private, and state government.

Most respondents, 60%, cited personal fulfillment as one of the reasons/factors for staying with their current company. Forty percent said flexibility with work schedule and 33.3% indicated commitment to recovery principles. Work hours (30%), administrative support (23.3%), and competitive salary (16.7%), were also identified as important factors. Nearly half, 46.6%, identified two or more reasons/factors.

The most frequently identified barriers/challenges experienced in the hiring process were salary (56.7%), volunteer hours (26.7%), limited employment opportunities (23.3%), and exemption/background screening process (10%). Six respondents identified two or more barriers/challenges.

Respondents were asked to identify what training they would recommend for a peer to have to help them provide peer support services. From a list of fourteen types of training, all types were identified by at least 30% of respondents and eleven types were identified by more than 50% of all respondents. The most frequently cited trainings were 40-hour required Peer Recovery Specialist training/Helping Others Heal (90%), Wellness Recovery Action Plan (WRAP) 80%), Compassionate Fatigue/Selfcare (76.7%), and Mental Health First Aid (70%). All respondents cited two or more trainings.

When asked if there are partnerships that exist with peer support recovery programs, recovery community organizations and other support groups, 63.3% said yes, 6.7% said no, and 30% said they

weren't sure.

Respondents were asked about partnerships with other organizations that provide resources. Most respondents were aware of two or more of the thirteen types of resources listed in the survey question. The most frequently identified resources were food pantry/meal programs and church/faith-based organizations identified by 56.7% of respondents, Career source/employment agencies by 50%, child welfare services by 46.7%, health department and Recovery Community Organizations (RCOs) by 43.3%, and housing (halfway housing, 30% and Oxford Homes 36.7%).

Nearly two-thirds, 63.3%, of respondents said they have the ability to offer choices to the individuals they serve at the agency at which they are employed/volunteer, 23.3% said they cannot, and 13.3% said they aren't sure.

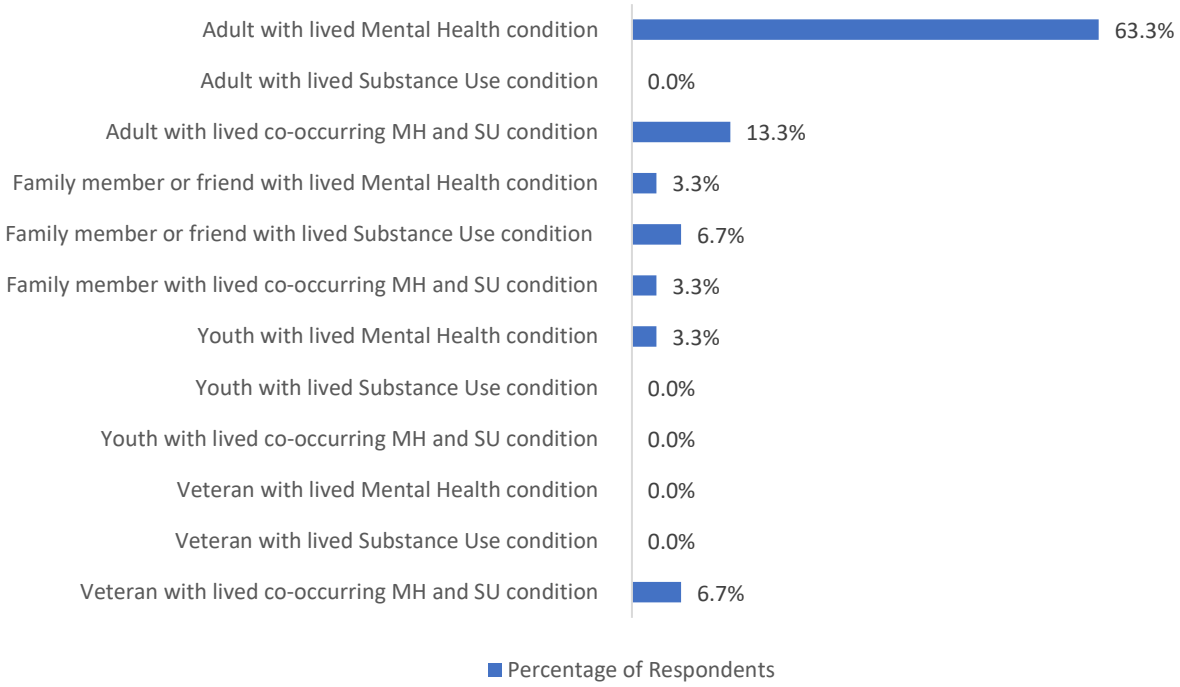
When asked if the organization where they are employed/volunteer helps reduce stigma by promoting recovery language that is patient centered, 73.3% said yes, 6.7% said no, and 20% said they are not sure.

Most respondents, 60%, said that the agency where they are employed/volunteer includes peers in developing and promoting affective program development, evaluation, and improvement; 20% said no, and 20% said they are not sure.

When asked if the agency where they are employed/volunteer includes persons in recovery in management and board meetings, less than half, 43.3%, said yes, 26.7% said no, and 30% said they are not sure.

PEER RECOVERY COMMUNITY/SUPPORT SPECIALISTS SURVEY CHARTS

Figure 174: Which best describes your experience?



Note: Mental Health (MH) and Substance Use (SU)

Figure 175: Which county do you live in?

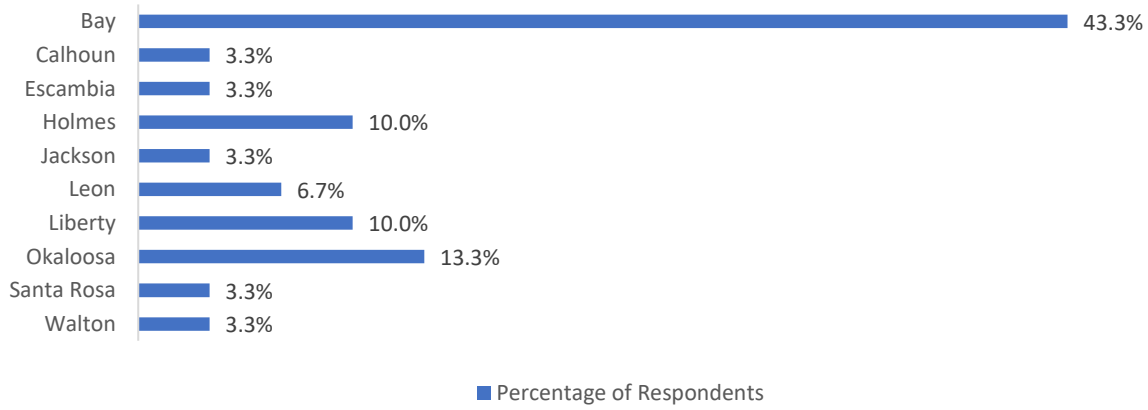


Figure 176: What type of service are you employed or volunteer with? (Check all that apply)

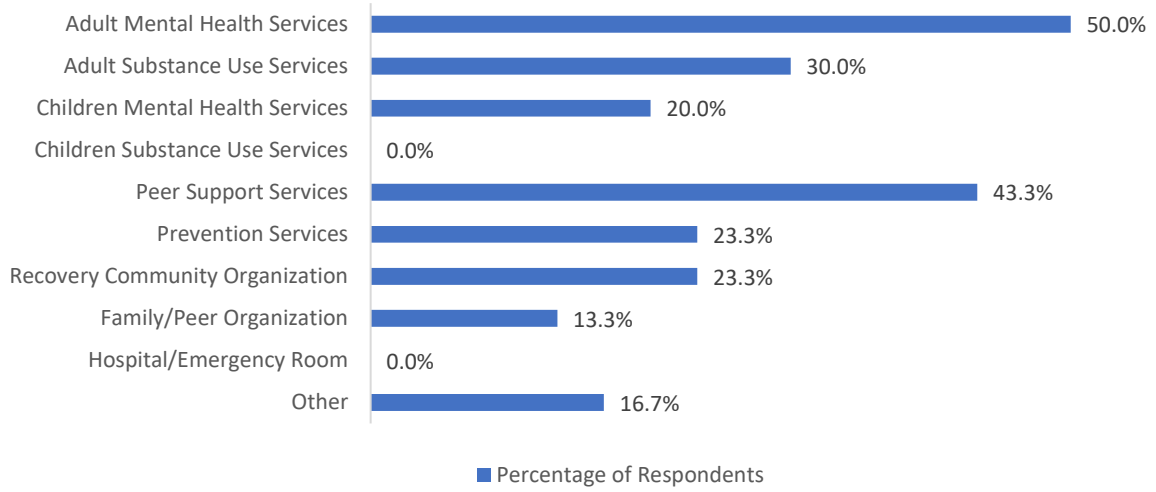


Figure 177: How long have you been employed/volunteered with the agency?

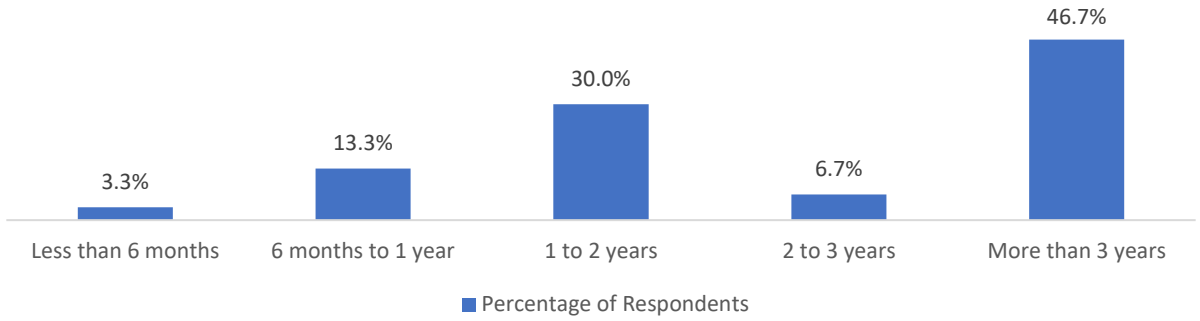


Figure 178: My work schedule averages...

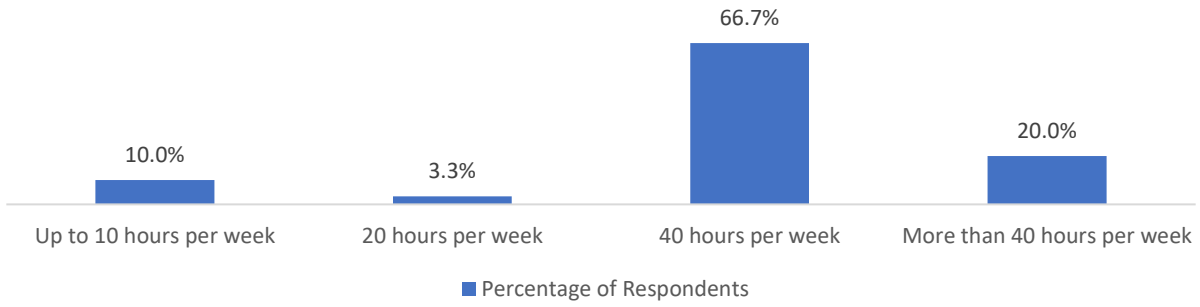


Figure 179: Does the agency where you are employed, or volunteer, utilize recovery peer support services within the services they provide in the community?

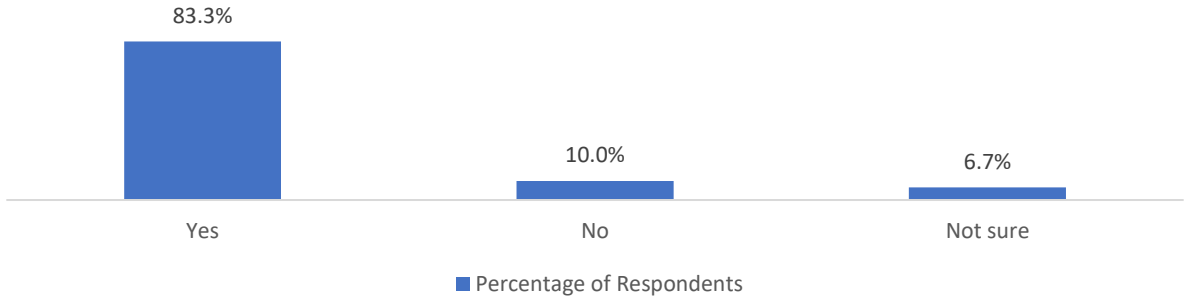


Figure 180: Does the agency where you are employed, or volunteer, adhere to recovery support best practices?

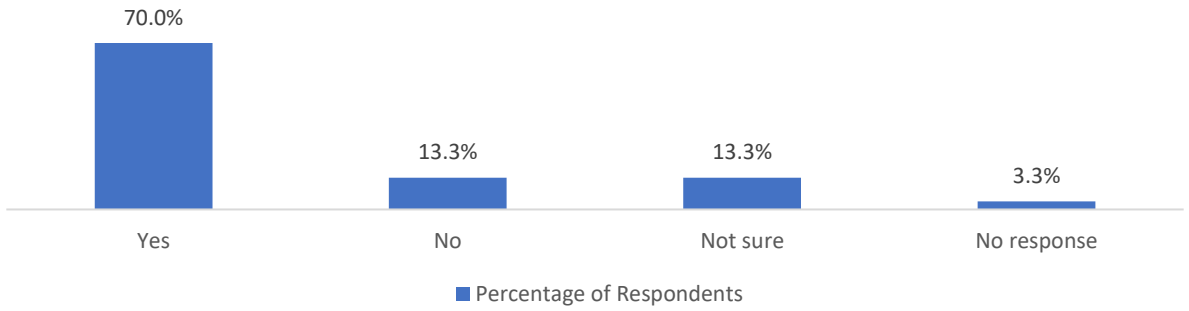


Figure 181: Please indicate the qualifications that best describe your status. (Check all that apply)

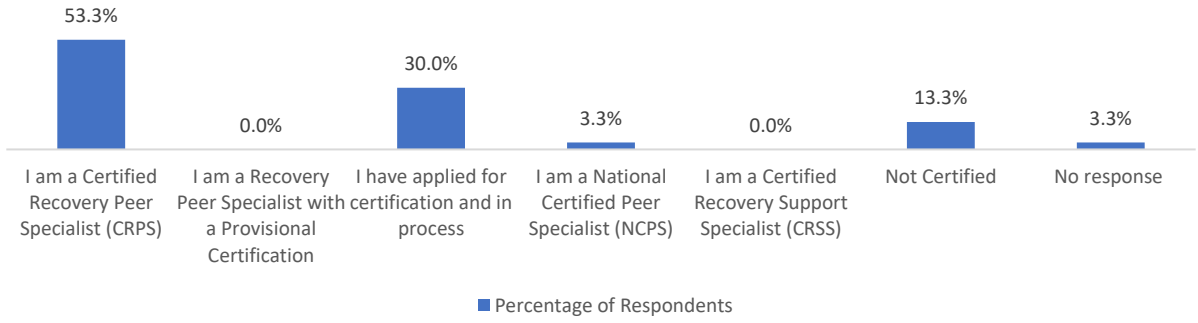


Figure 182: Please indicate the facility/program setting(s) that best describes where you deliver peer recovery support services. (Check all that apply)

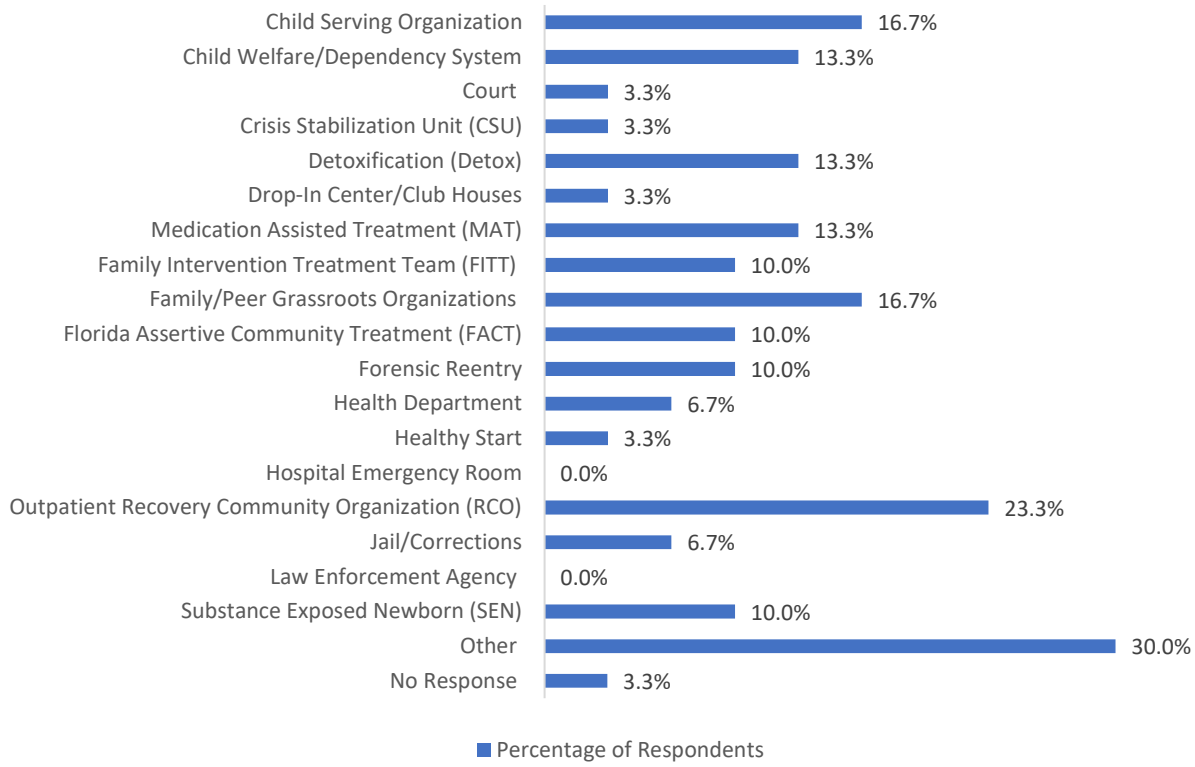


Figure 183: What are the reasons/factors for staying with the company? (Check all that apply)

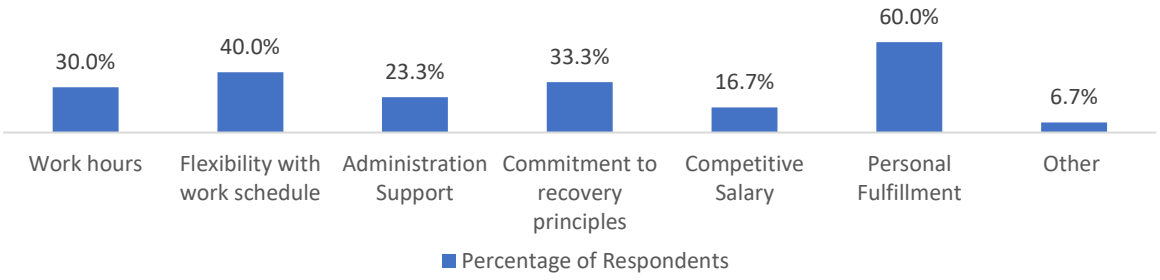


Figure 184: What barriers/challenges have you experienced in the hiring process? (Check all that apply)

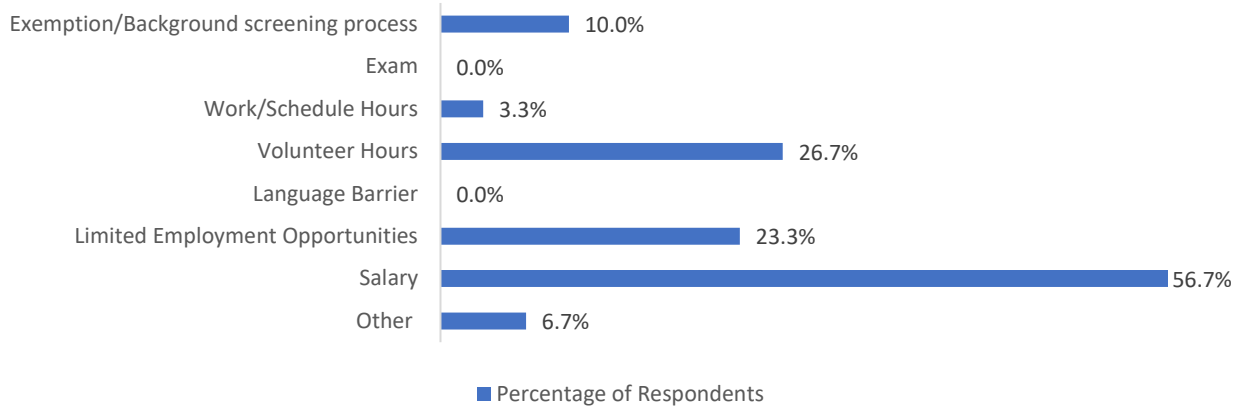
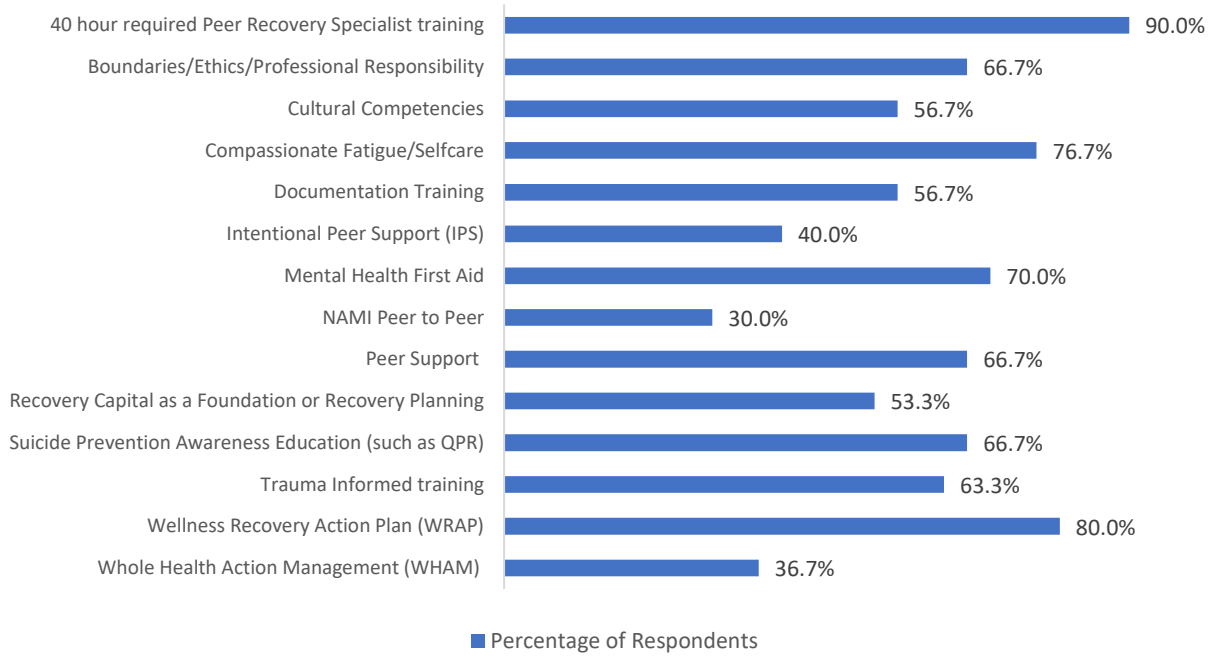


Figure 185: What training would you recommend for peers to have to help them provide peer support services? (Check all that apply)



Note: 40 hour required Peer Recovery Specialist Training/Helping Others Heal

Figure 186: Are there partnerships that exist with peer support recovery programs, recovery community organizations, and other support groups?

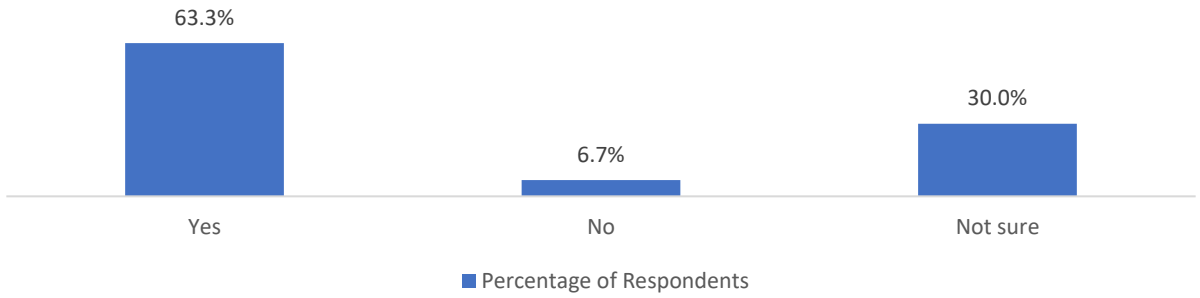


Figure 187: Are you aware of partnerships with other organizations that provide other resources such as: (Check all that apply)

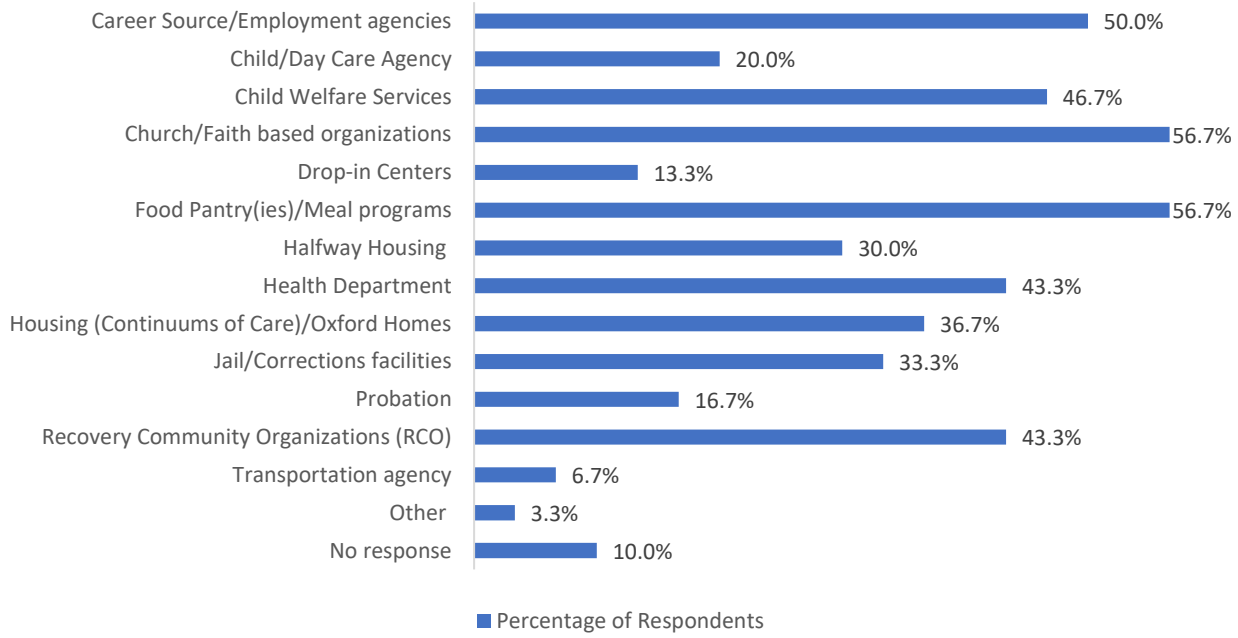


Figure 188: Do you have the ability to offer choices to the individuals where you serve at the agency you are employed/volunteer?

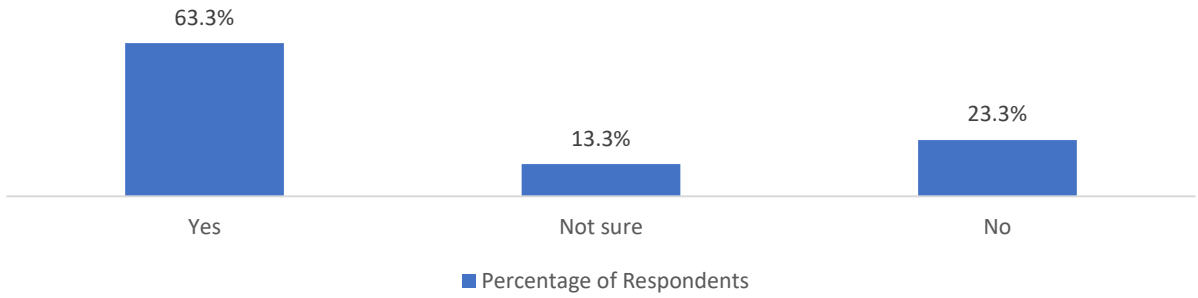


Figure 189: Does the organization where you are employed/volunteer with help to reduce stigma by promoting recovery language that is patient centered?

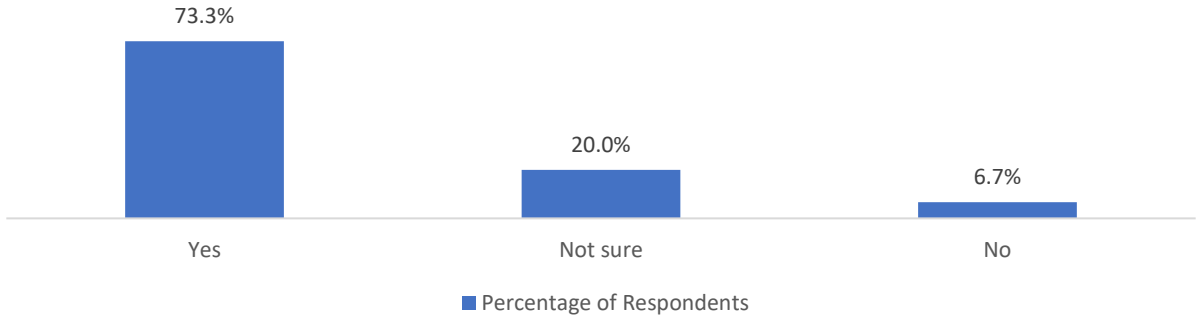


Figure 190: Does the agency where you are employed/volunteer include peers in developing and promoting effective program development, evaluation, and improvement?

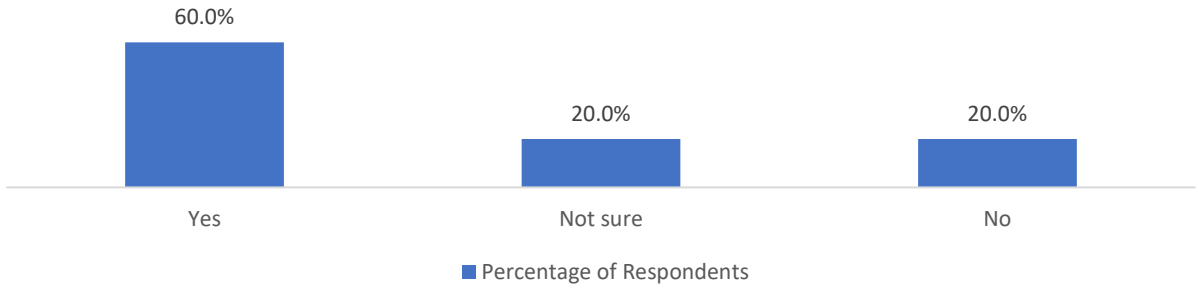
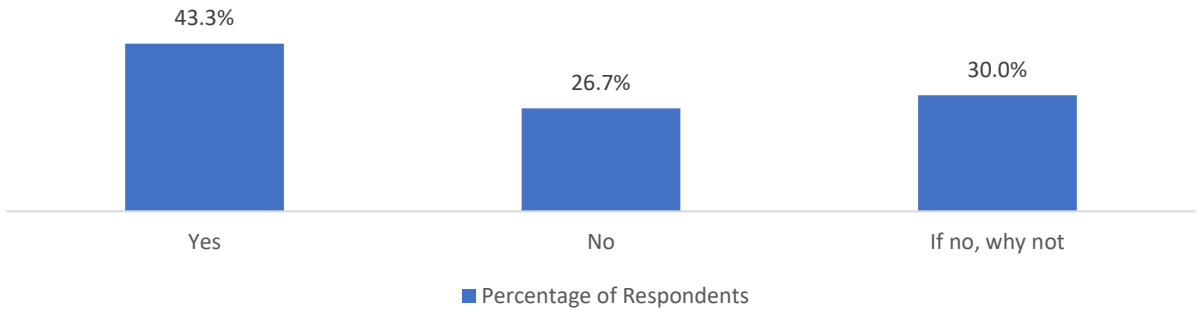


Figure 191: Does the agency where you are employed/volunteer with include persons in recovery management and board meetings?



RECOVERY RESOURCES

RECOVERY RESOURCES IN THE NORTHWEST REGION

Apalachee Center Inc	Florida Therapy Services
Avalon Center of Lakeview	JourneyPure
Baptist Hospital	Lakeview Center Inc
Bayshore Retreat LLC	Life Management Center
Blue Spring Outpatient Center	New Season Treatment Center
Bridgeway Center Inc	New Season Pensacola
Century Clinic	Okaloosa Outpatient Center
Chemical Addictions Recovery Effort	Panhandle Comprehensive Treatment Center
Children's Home Society of Florida	Senior Enrichment
DISC Village Inc	Treatment Center of Panama City
Gulf Breeze Recovery	Turn About Inc of Tallahassee
Gulf Coast Addiction Medicine LLC	Twelve Oaks Recovery
Emerald Coast Behavioral Hospital	

If you are looking for more specific resources in your area, please contact 2-1-1.

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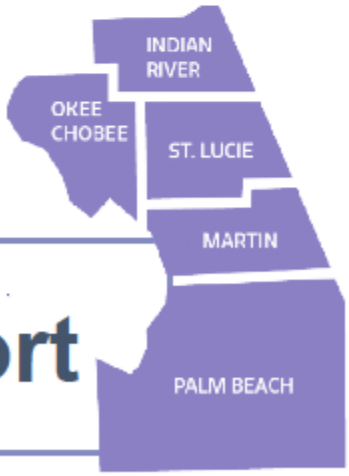
Southeast Florida
BEHAVIORAL HEALTH NETWORK

2022

Florida Cultural Health Disparity & Behavioral Health Needs Assessment



Regional Report

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ACKNOWLEDGEMENTS

Thank you to all the wonderful people who contributed to this report:

Southeast Florida Behavioral Health Network (SEFBHN) Board of Directors

SEFBHN personnel and staff who contributed to the project:
Ann Berner
Becky Walker
Daniel Oria

All Provider Network Agencies of the SEFBHN for Circuits 15 and 19, with special thanks to the following agencies for their help and contributions:
Helping People Succeed
Counseling and Recovery Center
Drug Abuse Foundation
Drug Abuse Treatment Association
National Alliance on Mental Illness (NAMI) of Palm Beach County
211 Palm Beach and Treasure Coast
New Horizons of the Treasure Coast
South County Mental Health Center

Systems Partners:
ChildNet
Communities Connected for Kids (CCKids)
Children's Services Council of St. Lucie County
Department of Juvenile Justice
Palm Beach County Fire Rescue
Martin County Sheriff's Office
Martin County School District
Palm Beach County School District

Southeast Florida
BEHAVIORAL HEALTH NETWORK

February 18, 2022

Dear Community Stakeholders and Survey Participants,

In February of 2022, a large-scale, community-wide needs assessment was completed by Southeast Florida Behavioral Health Network (SEFBHN), in partnership with the Florida Managing Entities of Florida (FAME) and the Health Council of Southeast Florida (HCSEF). SEFBHN worked collaboratively in a comprehensive effort to create and develop the Statewide Behavioral Health Needs Assessment and a Cultural Health Disparities Survey. The Statewide Behavioral Health Needs Assessment and the Cultural Health Disparities Survey were intended to find both areas of strength and opportunities of improvement for our network of providers and the regional system of care.

SEFBHN is the managing entity for Circuit 15 (Palm Beach County) and Circuit 19 (Indian River, Martin, Okeechobee, and St. Lucie Counties). The overall mission of SEFBHN is to develop, support, and manage an integrated network of behavioral health services to promote the emotional well-being and drug-free living of children and adults in the southeast region. To achieve this mission, SEFBHN has contracted with a network of service providers which includes forty-five (45) private and non-profit agencies. These contracted agencies provide a wide array of Adult and Children's Mental Health and Substance Abuse services that strive to provide evidence-based supports as part of a coordinated system of care. As a leader in the community of behavioral health providers, SEFBHN has also spearheaded, or worked in partnership with, many community initiatives and activities, with the goal of implementing a Recovery-Oriented System of Care that embraces the principles of recovery in all aspects of service delivery.

To further strengthen this connected system of services and support, SEFBHN will utilize the Statewide Behavioral Health Needs Assessment and the Cultural Health Disparities Survey to continue our extensive existing efforts to implement a wide array of behavioral health services that are specific to the needs of the community and that embody our vision of a seamless, accessible, recovery-oriented system of behavioral health care, driven by the individuals who live and work in the communities that we proudly serve.

Sincerely,

Ann M. Berner
Chief Executive Officer
Southeast Florida Behavioral Health Network

1070 E Indiantown Road, Suite 408, Jupiter, FL 33477
561.203.2485 / FX 561.203.2487 www.sefbhn.org

EXECUTIVE SUMMARY

As a part of a statewide effort to enhance Florida's behavioral health system of care, Florida's Managing Entities implemented a behavioral health needs assessment for each service area. Included in this report is the Southeast Florida Behavioral Health Network (SEFBHN) Managing Entity's assessment of general health and behavioral health inequities in SEFBHN's five-county service area, including Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie counties, compiled, and facilitated by SEFBHN's Local Health Council, the Health Council of Southeast Florida. The goal of this assessment is to evaluate SEFBHN's Service Area population's physical, social, and environmental health, an important step towards identifying the community's assets and areas of greatest need. This assessment is also the foundation for the development of a strategic plan to address behavioral health inequities in SEFBHN's Service Area and, ultimately, the state overall.

This behavioral health assessment report includes both primary and secondary data collected and analyzed at the county level and was compiled to represent the collective service area when applicable. Components include a Demographic Profile, General Health Status Profile, Managing Entity Client Demographic Profile, Homeless Population Profile, Homeless Client Demographic Profile, Service Units and Record Costs, No Wrong Door (NWD) Assessment, Evidence-Based Practices Assessment, Cultural Health Disparity Survey, Consumer Survey, Stakeholder Survey, Recovery Community Peer Support Survey, and List of Recovery Oriented Support Services. Each section's description and key findings are listed below.

DEMOGRAPHIC PROFILE

The Demographic Profile includes data on key demographic information on residents in SEFBHN's five-county service area population, including Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie Counties. Indicators outline characteristics related to the overall population, gender, race, ethnicity, age range, educational attainment, employment status, and poverty status.

- The service area is diverse in terms of race although most residents identified as White (72.5%), and this was followed by residents who identify as Black (17%), two or more races (5.1%), another race (2.7%), Asian (2.4%), American Indian (0.3%), and Native Hawaiian (0.1%).
- The service area was also diverse in terms of ethnicity, with just over one-fifth identifying as Hispanic (20.8%).
- The service area has an aging population, with 25.1% aged 65 years and older.
- Regarding education attainment, 88.7% of service area residents completed their high school education. Of those with a high school diploma or higher, 12.8% held a graduate or professional degree.

- The average unemployment rate for the service area from was 3.3%.
- More than half the families in the service area (52.5%) are living with a ratio of income to poverty level below 400% of the Federal Poverty Level (FPL).

GENERAL HEALTH STATUS PROFILE

The General Health Status Profile provides information on SEFBHN's 5-county service area related to: overall health status; mental health; suicide; violence and abuse; mental illness; adult tobacco and alcohol use; high school tobacco, alcohol, and substance use; disability; and health insurance coverage.

- A majority of the service area adults said their overall health was "good" to "excellent" (81.3%).
- A majority of adults reported good mental health in the past 30 days (89.1%).
- The crude suicide death rate decreased from over time, with the rate being three times higher among males compared to females and four times higher among White residents compared to Black residents.
- Based on treatment facility enrollment data analyzed by the Substance Abuse and Mental Health Services Administration (SAMHSA), the estimated number of seriously mental ill adults increased by almost 5% from 2018 to 2020.

MANAGING ENTITY CLIENT DEMOGRAPHIC PROFILE

The Managing Entity Client Demographic Profile includes data on key demographic information on SEFBHN clients, including details on the overall client population, gender, race, ethnicity, age range, residential status, educational attainment, and employment status.

- SEFBHN-funded organizations that served 23,409 clients in FY20-21.
- Over 50% of clients resided in Palm Beach County, followed by St. Lucie County (23.2%), Martin County (8.1%), Indian River County (7.3%), and Okeechobee County (3.6%).
- Adults, 18 years or older, in SEFBHN programs accounted for 76.3% of all clients, while children represented 23.7%.
- The majority of SEFBHN clients identified as White (55.3%), followed by those who identified as Black (22.2%), Other (15.4%), Multi-Racial (6%), Asian (0.5%), American Indian (0.3%), and Native Hawaiian or Other Pacific Islander (0.2%). In addition, the majority of SEFBHN clients were non-Hispanic (92.9%).
- Among SEFBHN clients, over one-third were unemployed or terminated (37.6%). Additionally, 17.6% were students, 13.3% had full-time employment, 10.6% were disabled, and 9.2% had part-time employment.

HOMELESS POPULATION PROFILE

The Homeless Population Profile provides insight into characteristics of the homeless population living in SEFBHN's five-county service area, where possible, including the number of homeless residents, homeless sheltered (in homeless shelters or transitional housing) and unsheltered residents, residents experiencing chronic homelessness, homeless veterans, families with children experiencing homelessness, homeless students in public schools, homeless students in public schools by living situation, and homeless funding sources and dollar amounts for Continuums of Care (CoCs). In this report, CoCs refer to all stakeholders within a specific geographic area (as determined by local communities and the US Department of Housing and Urban Development) that are: 1) working to address homelessness with a focus on individuals who are experiencing literal homelessness; and 2) navigating them through the CoC's crisis response team. Thus, the CoC is not only made up of non-profits that serve people experiencing homelessness, but also philanthropists, local governments, businesses, housing developers, health care systems, and businesses, among other entities. As a note, Okeechobee County was excluded in the calculations for all indicators, except those related to students, as it falls outside of CoC District and within a CoC that covers additional counties outside of SEFBHN's service area.

- In 2021, the Florida Council on Homelessness reported there were 1,270 homeless individuals in Indian River, Martin, Palm Beach, and St. Lucie counties.
- Among all homeless residents, 54.5% unsheltered 2021.
- The number of chronically homeless residents decreased from 386 to 286 from 2017 to 2020.

HOMELESS CLIENT DEMOGRAPHIC PROFILE

The Homeless Client Demographic Profile outlines key information on SEFBHN's homeless client population, including overall demographics, such as total population, gender, race, ethnicity, and age, residential status, educational attainment, and employment status.

- A total of 2,421 homeless clients were enrolled in adult and child programs in FY20-21.
- The majority of SEFBHN's homeless clients were White (63.8%), followed by Black (22.8%), Other (8.5%), and Multi-Racial (4.2%).
- Non-Hispanic clients accounted for 87.5% of SEFBHN's total homeless client population, while 12.5% were Hispanic.
- Most homeless clients were unemployed (75.3%) and just under 10% were disabled.

NO WRONG DOOR ASSESSMENT

The No Wrong Door (NWD) Assessment was designed to assess how NWD works, how person-centered care is provided, and about partnerships and care coordination within direct-service provider organizations in SEFBHN's five-county service area.

PROVIDER INTERVIEWS

Interviews were conducted with seven different SEFBHN direct-service provider organizations, with eight representatives, over the course of 9 days.

- While all providers stated their organization's current approach to "No Wrong Door" works well, the majority also noted challenges and opportunities for improvement.
- Providers most commonly reported that, in order to increase the level of awareness in behavioral health services in the community, their organizations must stay up to date on partner services and keeping resource lists updated.
- Importantly, the majority of providers mentioned that mental health-related stigma must be addressed and described this as a bigger issue than lack of awareness of services. This is because even if people know about services, they will not seek them if stigma persists. "Removing stigma is what it comes down to – we have to let people realize that it's ok and this is the norm," stated one provider.
- Providers mentioned that ensuring everyone has access to their services, never denying anyone care, and offering a variety of services helps them provide equal access among those who seek their services.
- Several providers stated that people do not have equitable access to care due to outside barriers, including transportation, stigma, lack of representation, insurance, and the lack of devices and internet needed to access telehealth services.

NWD SURVEY

The NWD Survey was a multiple-choice survey completed by 39 different direct-service providers. Similarly, this survey was conducted to assess provider perspectives on how "No Wrong Door" access is working within their organizations.

- A majority (59%) believed that "No Wrong Door" access works well within their organization.
- Almost all of the survey respondents agreed (69.2%) or strongly agreed (17.9%) that their organization provides person-centered care for all individuals served.
- A majority of respondents felt that their organizations ensure that services are of high quality and meet the needs of individuals served (92.4%).

CULTURAL HEALTH DISPARITY SURVEY

The Cultural Health Disparity Survey was given to community members to assess experiences and awareness of local mental and substance use services and resources.

- The majority of survey respondents identified as female (55.4%). When asked to describe their gender identity, 46.6% preferred not to answer, 27.8% identified as cisgender, 11.7% identified as gender fluid, and 5.8% identified as gender non-conforming or gender variant.
- Approximately half of the survey respondents identified as Heterosexual/Straight (50.4%), while nearly one-quarter (24.8%) preferred not to answer when asked to describe their current sexual orientation.
- Over half of the survey respondents identified as White (51.4%), over one-quarter identified as Black (27.9%), 6.3% identified as Multi-Racial, and 5% identified as Other.
- The majority of participants were non-Hispanic (61%).
- Of all survey respondents, 75.8% stated that they were usually comfortable seeking behavioral health care services.
- However, of the Black respondents, nearly half indicated that they were not comfortable seeking behavioral health care services (47.6%), compared to about one-quarter (24.2%) of White respondents.
- Of the respondents who identified as bigender, 75% did not feel comfortable seeking behavioral health care services, compared to 19.4% of those who identified as cisgender. However, 88.9% of those who identified as gender fluid or genderqueer/non-binary stated they felt comfortable seeking services, compared to 80.6% of those who identified as cisgender.

CULTURAL HEALTH DISPARITY FOCUS GROUPS

The Cultural Health Disparity Focus Groups were conducted with the goal of understanding community perspectives on what it is like to access mental and behavioral health services in the SEFBHN service area. Twenty-one focus groups were conducted, 20 in English and one in Spanish, with 267 participants virtually via Zoom.

- Participants expressed the major behavioral health issues and areas of need in their communities were substance use, mental health disorders, and inability to access to care, including mental health care, behavioral health care, and medical care.
- Participants emphasized the two groups that experience the greatest mental health challenges are: youth, due to external, societal pressures and challenges youth have with expressing themselves during major transitional periods in life, and elderly and disabled individuals, due to isolation, loneliness, financial issues, and decreasing health status as a result of aging.

- Participants shared the most common barriers to accessing behavioral health services in their communities were related to socioeconomic factors, discrimination, stigma, a lack of understanding and awareness of services, and provider availability or trustworthiness.
- When participants were asked to consider changes they would make to the behavioral health system, they suggested reducing the cost of services, increasing access in rural communities, increasing options for telehealth, and increasing the diversity of the provider workforce.

CONSUMER SURVEY

The Consumer Survey was designed to assess individuals' experiences and awareness of local mental health and substance use resources and services. It was provided to individuals who had received services within the SEFBHN service area.

- The majority of survey respondents were adults receiving services (67.3%), followed by young adults or youth receiving services (15.2%), and parents of a child receiving services (11.4%).
- At the time of the survey, most of the services received were related to adult mental health services (33.9%) or adult substance use services (28.6%).
- Most survey respondents lived in Palm Beach County (47.9%) or Saint Lucie County (26.6%), with additional representation from Indian River County (12.5%), Martin County (9.9%), and Okeechobee County (2.7%).
- More than three-quarters of participants indicated that they knew where to go for mental health and substance use treatment services (82.5%).
- Approximately one-quarter of survey respondents reported having ever called 2-1-1 for assistance at some point (28.9%).
- Almost 90% of survey respondents indicated that they were able to get the services they needed when they needed them (86.3%).

STAKEHOLDER SURVEY

The Stakeholder Survey measured awareness and coordination of behavioral health care and resources, particularly those funded by Southeast Florida Behavioral Health Network (SEFBHN). Survey participants were asked various questions related to their organization and the services they provide, 2-1-1 hotline and online resource, community awareness of services, and care coordination.

- Respondents indicated they provide services in Palm Beach County (31.8%), followed by Saint Lucie County (20.5%) and Martin County (19.5%).
- More than three-quarters of stakeholders (83.3%) agreed or strongly agreed that they were aware of the availability of mental health and substance use services in their area.

- Over one-quarter of stakeholders indicated they had accessed behavioral health care resources funded by SEFBHN in the past 6 months (38%), and among these respondents, the vast majority found services helpful (84.8%).
- Stakeholders rated community awareness of available mental health and substance use treatment services as either 'good' (32.1%) or 'fair' (31.2%).
- Stakeholders most commonly reported the barriers for individuals accessing services in their community were 'no or very limited transportation' (14.2%), individuals 'did not know where to go for services' (12.5%), they 'could not afford the services' (12.4%), 'long waitlists (11.2%), and 'stigma' (9.6%).

RECOVERY COMMUNITY PEER SUPPORT SURVEY

The Recovery Community Peer Support Survey assessed the experiences and awareness of local mental health and substance use services and resources of individuals specifically in a Peer Support role.

- Overall, a large majority of the respondents reported that their agency utilizes recovery peer support services (89.9%) and adheres to recovery support best practices (87.3%).
- Most respondents stated that they were able to support voice and choice principles (i.e., respecting individual choice and self-determination) for the individuals served at their agency (91.1%), and a majority also stated that their agency does help to reduce stigma by promoting recovery language that is person centered (87.34%).
- More than three-quarters of respondents also indicated that their agency includes peers in processes, including program development, promotion, evaluation, and improvement (81%).

LIST OF RECOVERY ORIENTED SUPPORT SERVICES

The List of Recovery Oriented Support Services, located at the end of this report, includes organizations providing services in SEFBHN's 5-county service area that are a part of the Recovery Oriented System of Care (ROSC). This model focuses on providing individuals and families a wide variety of services and supports to facilitate the journey towards recovery and overall wellness.

SEFBHN SERVICE AREA DEMOGRAPHIC PROFILE

POPULATION DEMOGRAPHICS

The population in the 5-county service area increased an average of 1.4% each year from 2016 to 2020. The total population growth for the 5-year period at 5.9%, added 119,478 residents.

With respect to resident sex in the service area and the state, females accounted for slightly more than 50% of the population when compared to their male counterparts.

In both the service area and the state, White residents accounted for the highest proportion of the population (72.5% and 71.6%, respectively), followed by Black or African American residents (17% and 15.9%, respectively), while Asian residents accounted for lower proportions (2.4% and 2.8%, respectively). Moreover, 2.7% of residents in the service area were of some other race, 5.1% of residents were multiracial, and less than 1% were American Indian and Native Hawaiian (0.3%, 0.1%), respectively, and less than 1% in the state. Moreover, ethnically, the service area had a lower percentage of Hispanic residents (20.8%), compared to the state (25.8%).

The SEFBHN service area population was slightly older, compared to the age distribution at the state level. In the service area, 25.1% of residents were aged 65 years or older, compared to 20.5% of residents in Florida.

EDUCATION AND EMPLOYMENT

Data revealed the service area and state populations were very similar regarding education attainment. A similar proportion of residents in both the service area and the state attained a high school diploma at 88.7% and 88.5%, respectively. Residents in the service area had higher percentages of individuals who attended or graduated from college. Graduate or professional degrees were held by over 12.8% of the population.

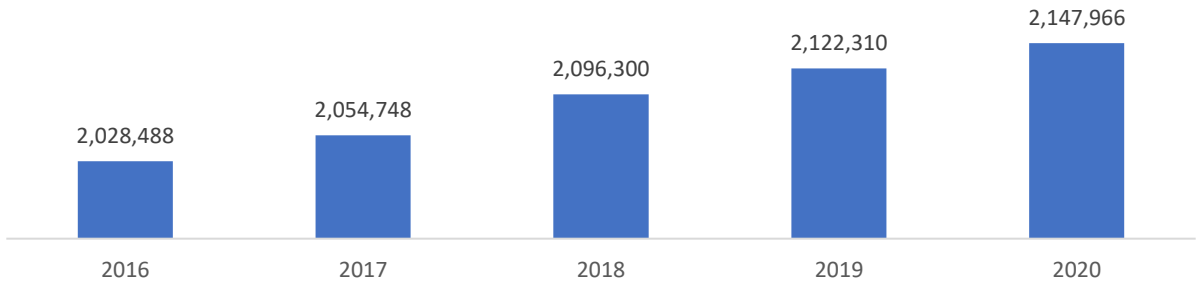
On average, 57% of the service area population participated in the labor force over the past 5 years. In comparison, Florida had a higher proportion of employed residents (58.9%). The average unemployment rate for the service area in the past 5 years was 3.3%, which was lower than the state, which had a rate of 5.4%.

POVERTY STATUS

The Federal Poverty Level (FPL) is the total amount of annual household income, below which a household would be eligible to receive certain welfare and income benefits. Residents in the service area living <400% of the Federal Poverty Level (FPL) had a lower income-to-poverty ratio that residents across the state. However, the ratio was considerably higher among those living at or above 400% of the FPL.

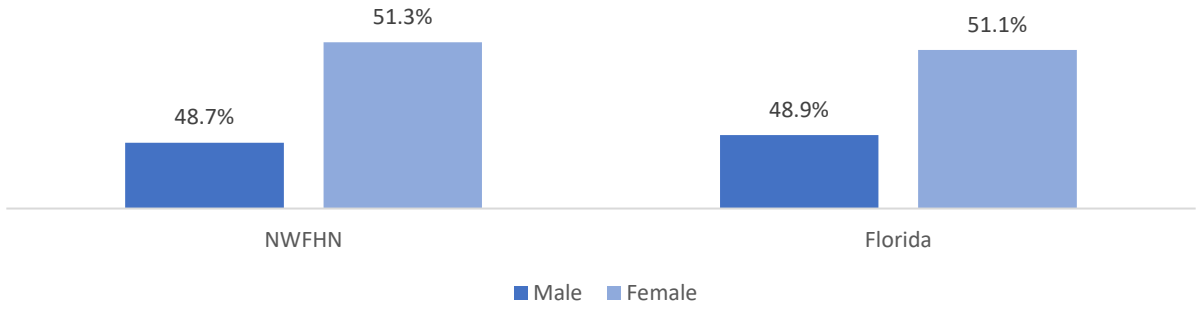
DEMOGRAPHIC CHARTS

Figure 1: SEFBHN SA Population Estimates (2016-2020)



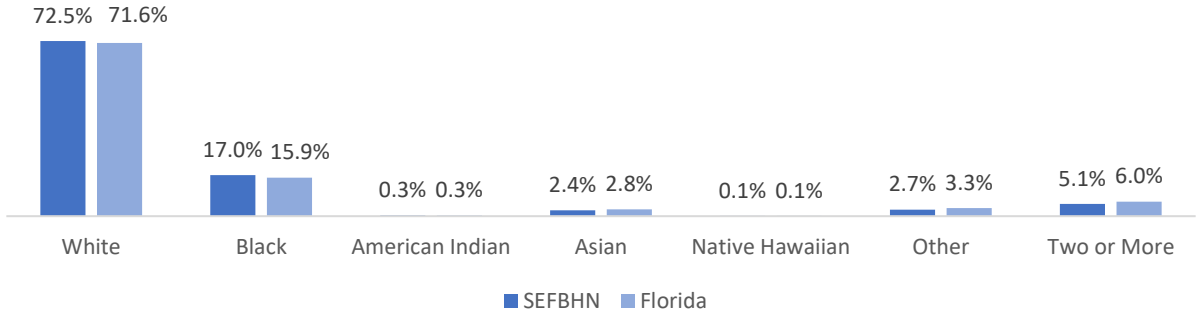
Source: Florida Legislature's Office of Economic and Demographic Research (EDR)

Figure 2: SEFBHN SA County Population by Gender (2016-2020)



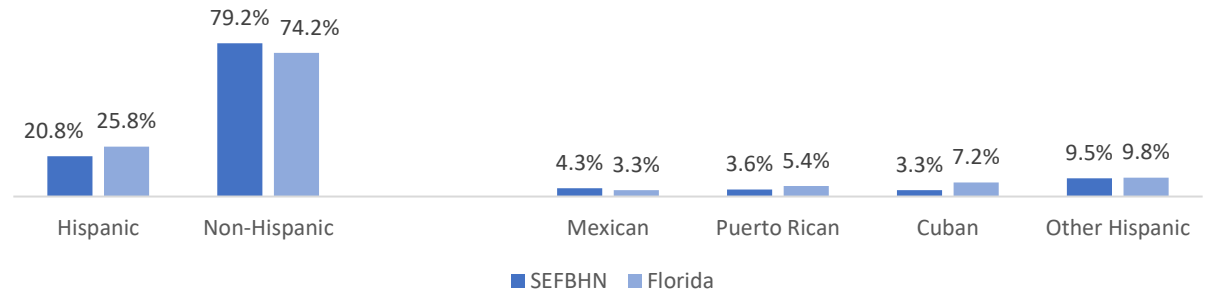
Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 3: SEFBHN SA County Population by Race, 2016-2020 (5-Year Estimate)



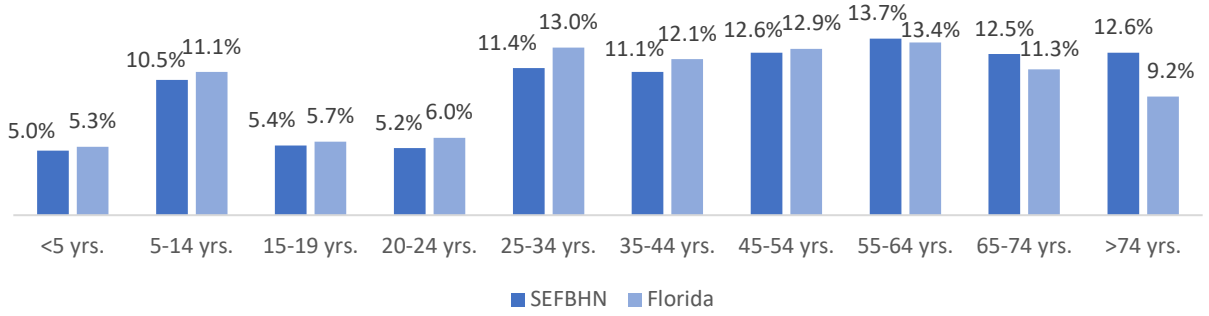
Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 4: SEFBHN SA Population by Ethnicity, 2016-2020 (5-Year Estimate)



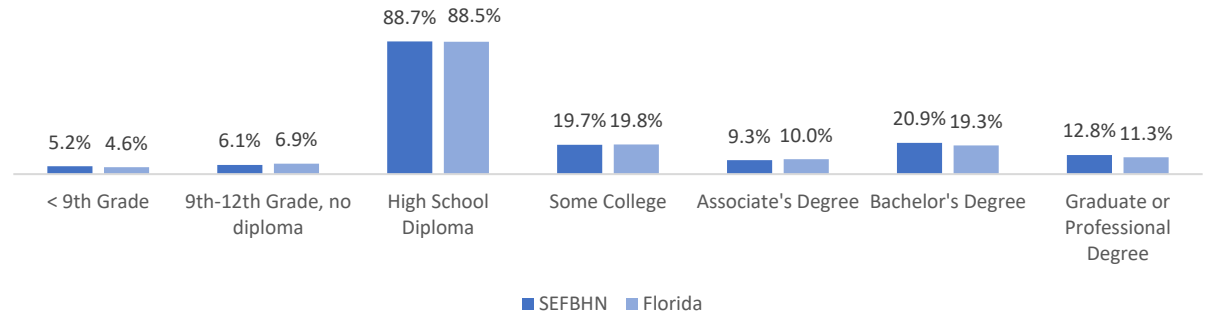
Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 5: SEFBHN SA Population by Age Range, 2016-2020 (5-Year Estimate)



Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 6: SEFBHN SA Population by Educational Attainment, 2016-2020 (5-Year Estimate)

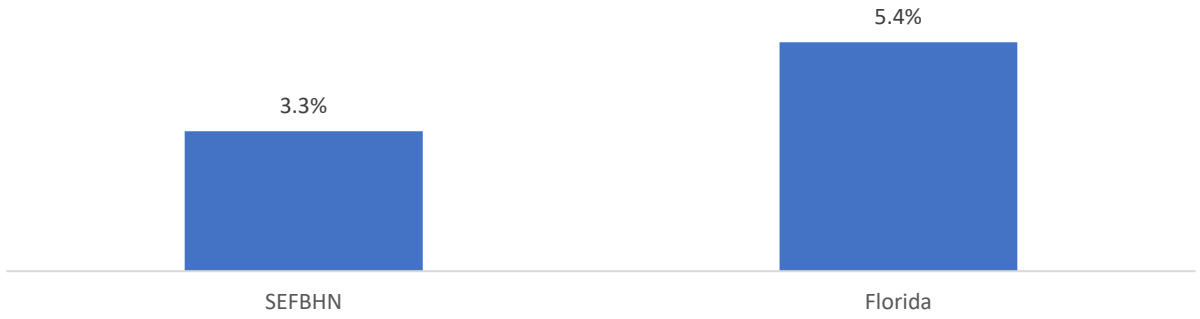


Source: U.S Census Bureau, American Community Survey, Table S1501

Figure 7: SEFBHN SA Population Participation in Labor Force, 2016-2020 (5-Year Estimate)

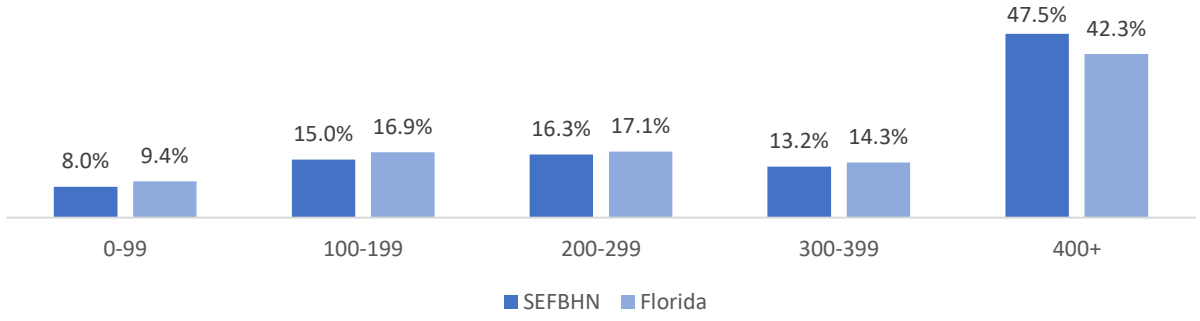
Source: U.S Census Bureau, American Community Survey, Table DP03

Figure 8: SEFBHN SA Population Unemployment Rates, 2016-2020 (5-Year Estimate)



Source: U.S Census Bureau, American Community Survey, Table DP03

Figure 9: SEFBHN SA Population Ratio of Income to Poverty Level of Families, 2016-2020 (5-Year Estimate)



Source: U.S Census Bureau, American Community Survey, Table B17026

SEFBHN SERVICE AREA GENERAL HEALTH STATUS

OVERALL, HEALTH STATUS

Behavioral Risk Factor Surveillance System (BRFSS) is the nation's health-related telephone survey that collects state-level data about U.S. residents regarding their health-related behaviors, chronic health conditions, and use of preventative services. BRFSS data estimates revealed that 81.3% of adults aged 18-64 years living in the service area said their overall health was "good" to "excellent," compared to 80.3% of adults in Florida (2017 to 2019). This knowledge is a powerful tool for targeting and building health promotion activities. It also provides a way to see change in population health behaviors before morbidity or disease is apparent.

MENTAL HEALTH

Data indicates that the mental health status of residents in the service area is better than that of residents across the state. For instance, the average proportion of adults reporting good mental health over the past 3 years was higher in the service area compared to the state (89.8% and 86.2%, respectively). Moreover, the number of unhealthy mental days reported among adults aged 18-64 years in the service area was lower compared to the state (3.3 days and 4.4 days, respectively).

SUICIDE

In the service area, the crude suicide death rate decreased by 29% from 18.2/100,000 in 2018 to 12.9/100,000 population in 2020, a decrease of 5.3/100,000 suicide deaths; whereas, at the state level, the suicide crude death rate decreased by just 2.5 deaths per 100,000 population. With respect to resident sex, the suicide death rate among males in both the SEFBHN service area and state was more than triple the rate among females. Moreover, when looking at race, the suicide death rate among the White population was almost four times the rate among Black residents in the SEFBHN service area.

VIOLENCE AND ABUSE

The rate of total domestic violence offenses increased in the SEFBHN service area and the state from 2017 to 2019. In the SEFBHN service area, the rate rose from 345.4/100,000 to 369.4/100,000 over the 3-year period. However, this was 1.3 times lower than the state rate of 496.5/100,000 in 2019.

Additionally, the rates of children experiencing child abuse from 2017 to 2019 has continuously decreased in the SEFBHN service area and state. Among children ages 5-11 years, the rate of child abuse significantly decreased by 17.5% from 630.8/100,000 in 2017 to 520.5/100,000 in 2019. This decreasing trend was also observed in the state, with the rate decreasing by 22.8% from 857.9/100,000

to 662.7/100,000 during the same time.

Moreover, child sexual abuse rates decreased from 2017 to 2019 as well. In the SEFBHN service area, the sexual abuse rate for children 5-11 years, decreased from 63.1/100,000 in 2017 to 48.2/100,000 in 2019. This was almost 20% lower than the state rate at 57.8/100,000 in 2019.

MENTAL ILLNESS

The estimated number of seriously mentally ill (SMI) adults increased by almost 5% over the past 3 years. The rate of increase at the state level was 3.5%. The estimated number of SMI adults in the SEFBHN service area was 68,114 in 2020.

Among youth, ages 9-17 years, the estimated number of those emotionally disturbed increased by just 0.6% from 2018 to 2020. This was much lower when compared to the state's increase of 3%.

Moreover, the Florida Department of Education (FLDOE) reported 0.4% of children in K-12 grades had an emotional/behavioral disability in the SEFBHN service area. Similarly, the proportion in the state was 0.5%. Both in the service area and the state, the proportion has decreased over the past three years.

ADULT TOBACCO AND ALCOHOL USE

BRFSS data revealed that 12.6% of adults in the SEFBHN service area were current smokers, compared to 14.8% of adults in the state (2017-2019).

Binge drinking is defined as five consecutive drinks for men and four consecutive drinks for women. From 2017 to 2019, 16.3% of SEFBHN service area adults were binge drinkers, compared to 18% of adults in the state.

HIGH SCHOOL TOBACCO, ALCOHOL AND SUBSTANCE USE

Data from the Florida Youth Substance Abuse Survey (FYSAS) indicated that the percentage of middle and high school students who reported never having smoked cigarettes increased from 87.6% in 2016 to 92% in 2020. In 2020, 6.3% of students smoked once or twice and 1% reported that they had smoked once in a while but not regularly. For middle and high school students in the state, the percentage of those having never smoked also increased over the past 4 years.

When students were asked about smoking frequency, 98.8% of those living in the SEFBHN service area stated that they did not smoke at all in 2020, compared to 98.2% of students in Florida.

Vaping questions were included in the 2020 FYSAS for the first time. In the SEFBHN service area, 22.7% of students reported vaping nicotine on at least one occasion in their lifetime. Almost 6% of students had vaped on 40 or more occasions. State level proportions were similar in terms of

frequency of occasions that students ever vaped nicotine. However, the proportion of students vaping nicotine in the past 30 days was much lower compared to the proportion of students who had ever vaped. In the SEFBHN service area, 87.1% of students had not vaped nicotine in the past 30 days.

The percentage of students who did not consume alcoholic beverages on any occasions in their lifetime ranged from 60.9% in 2016 to 65.2% in 2020 in the SEFBHN service area. For those who did on 1-2 occasions, the percentage decreased 0.9% from 2016 to 2020. The percentages of students in 2020 consuming alcohol on more than 2 occasions ranged from 8.1% for 3-5 occasions to 2.5% for those consuming alcohol on at least 40 occasions. The proportions in the state were similar.

High school students were asked about the number of occasions in their lifetime when they had woken up after a night of drinking alcohol and were unable to remember the things they did or the places they went. The percentage of students reporting this event happening on at least 1-2 occasions in their lifetime (2020) in the SEFBHN service area and the state was 9.2% and 7.4%, respectively. This was an increase from the percentage reported in 2016 for the SEFBHN service area and a decrease from the percentage for the state. Over 84% of students in the service area and the state reporting never having had this experience.

The percentages of students living in the SEFBHN service area who did not consume alcohol during the past 30 days increased from 80.8% in 2016 to 84.9% in 2020. The increase at the state level was smaller when comparing percentages from 2016 (81.7%) to 2020 (85.2%). The percentages of students who reported consuming alcohol on 1-2 occasions during the past 30 days decreased in the SEFBHN service area and state from 2016 to 2020.

The overall percentage of those binge drinking, defined as consuming five or more alcoholic drinks in a row in the past two weeks, decreased less than 1% over the past four years in the SEFBHN service area. The state percentage decreased exactly 1% during this same timeframe.

The proportion of students who have not used marijuana in their lifetimes increased over the past four years in the SEFBHN service area from 80.1% in 2016 to 81.4% in 2020. The state followed a similar trend with an increase from 78.7% in 2016 to 79.9% in 2020. For those who did use marijuana on one or more than 40 occasions, the overall percentages decreased in the SEFBHN service area from 19.9% in 2016 to 18.6% in 2020. The state saw a similar decrease in the proportion from 21.3% in 2016 to 20.1% in 2020. The proportion of students who reported using marijuana in the past 30 days on one or more occasion decreased slightly in both the SEFBHN service area and the state. The percentages of students who reported vaping marijuana in their lifetimes, on one or more occasions, was higher in the SEFBHN service area at 17.2% when compared to the state at 15.6%. This was also true when comparing the two groups of students who had vaped marijuana in the past 30 days. In the SEFBHN service area, 8.1% of students had vaped marijuana in the past 30 days compared to 7.3% of students in the state.

DISABILITY

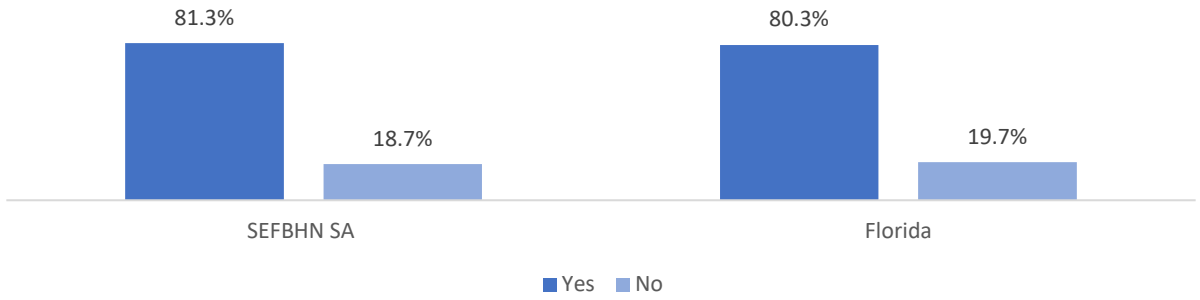
In the SEFBHN service area, 13.5% of the noninstitutionalized population is estimated to have a disability (includes hearing, vision, cognitive, ambulatory, self-care, and independent living). At the state level, 13.6% of residents had a disability. The percentages of those with a disability were much higher among older adults, ages 65 years and older, at 51.6% for the SEFBHN service area and 48.3% in the state.

HEALTH INSURANCE COVERAGE

Most residents, ages 18-64 years, living in the SEFBHN service area and state reported having some type of health insurance coverage. The percentage of those with insurance in the state was slightly lower when compared to the SEFBHN service area at 84.5% and 84.6%, respectively.

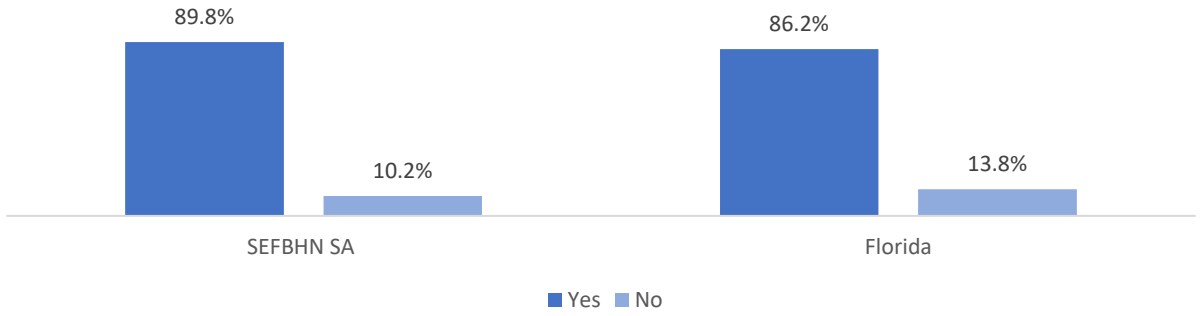
GENERAL HEALTH STATUS CHARTS

Figure 10: SEFBHN SA Adults Who Said Their Overall Health Was "Good" to "Excellent"(2017-2019)



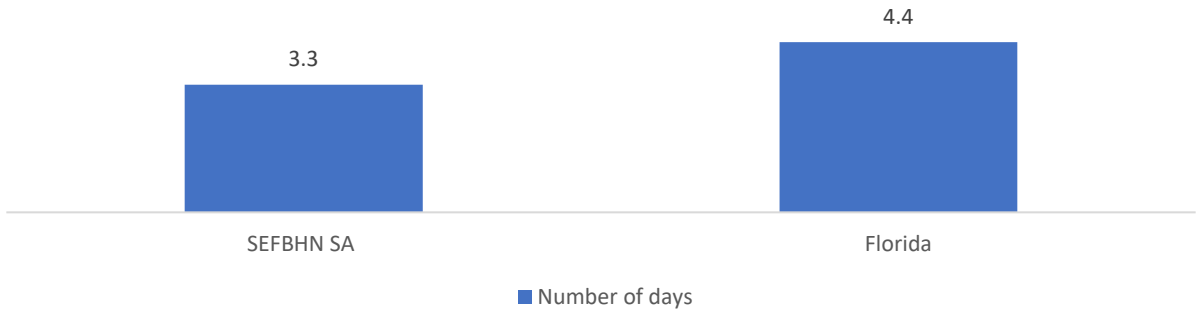
Source: Behavioral Risk Factor Surveillance System

Figure 11: SEFBHN SA Adults with Good Mental Health for the Past 30 Days (2017-2019)



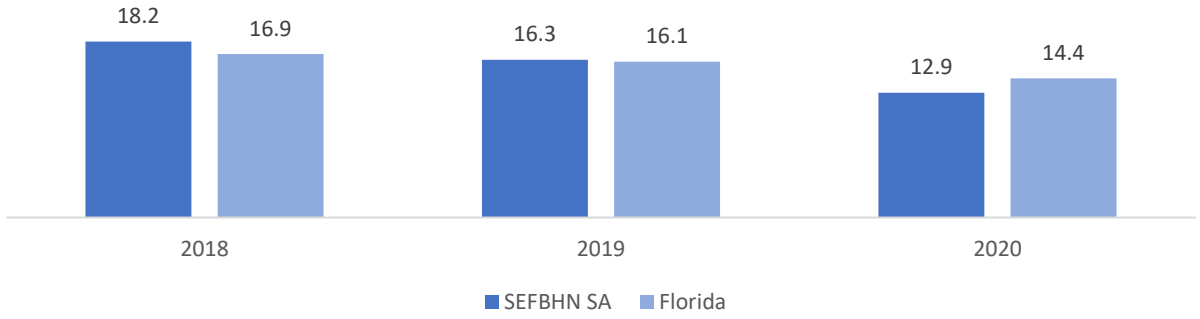
Source: Behavioral Risk Factor Surveillance System

Figure 12: SEFBHN SA Adults Average Number of Unhealthy Mental Days in the Past 30 Days (2017-2019)



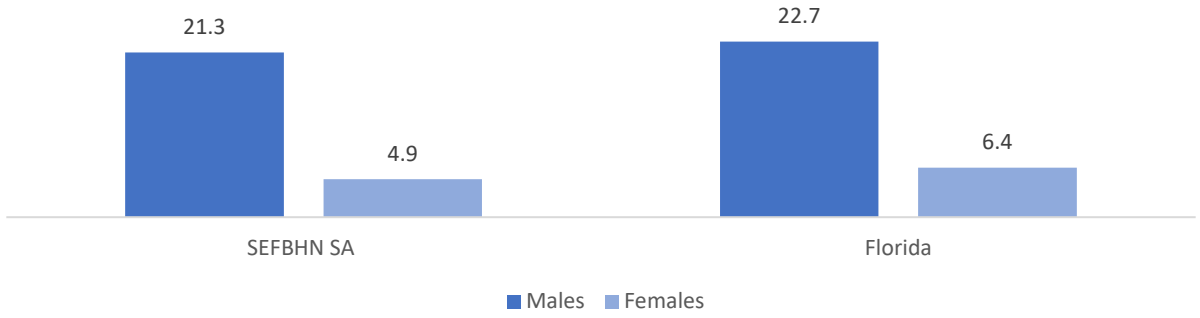
Source: Behavioral Risk Factor Surveillance System

Figure 13: SEFBHN SA Crude Suicide Death Rates (2018-2020)



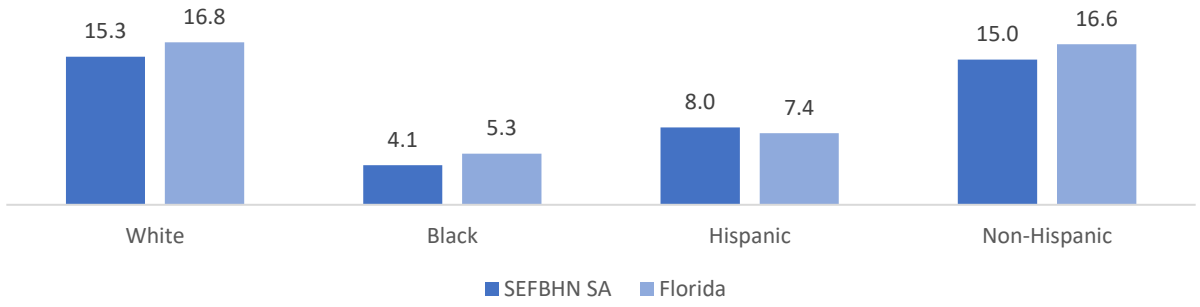
Source: Florida Department of Health, Bureau of Vital Statistics. Rate per 100,000

Figure 14: SEFBHN SA Crude Suicide Death Rates by Gender (2020)



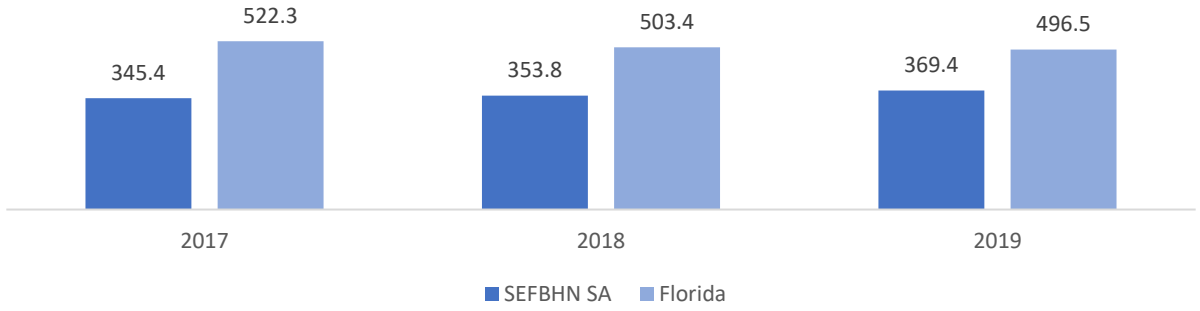
Source: Florida Department of Health, Bureau of Vital Statistics, Rate per 100,000

Figure 15: SEFBHN SA Crude Suicide Death Rates by Race and Ethnicity (2020)



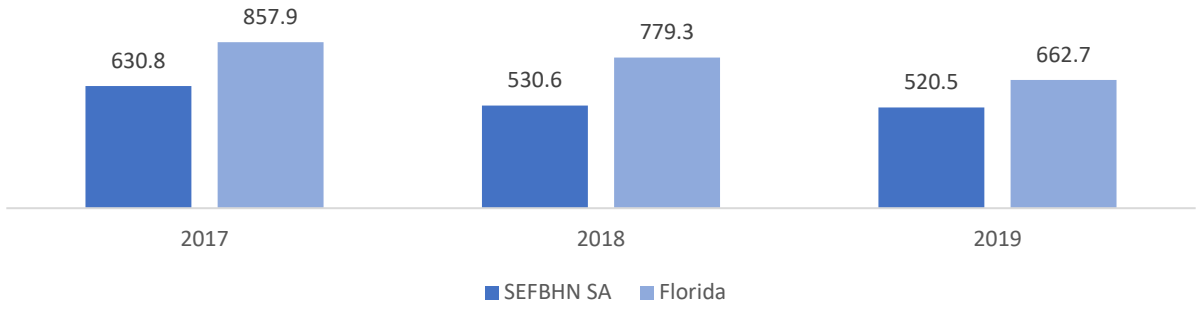
Source: Florida Department of Health, Bureau of Vital Statistics, Rate per 100,000

Figure 16: SEFBHN SA Total Domestic Violence Offenses (2017-2019)



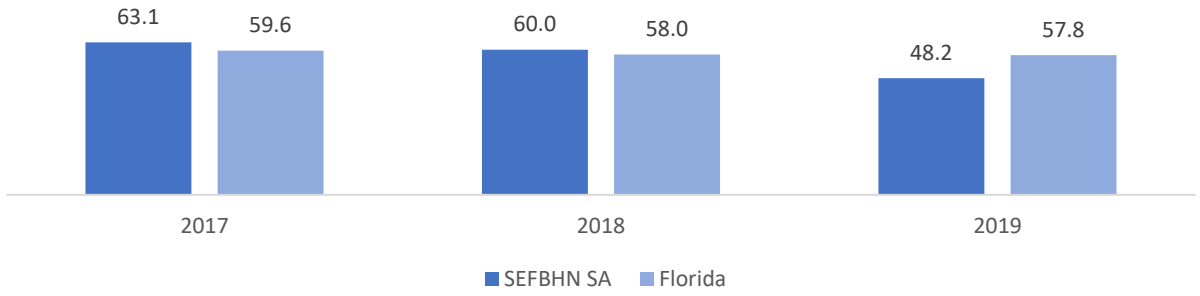
Source: Florida Department of Law Enforcement, Crime in Florida, Uniform Crime Report 2019, Rate per 100,000

Figure 17: SEFBHN SA Rate of Children Experiencing Child Abuse, Ages 5-11 Years (2017-2019)



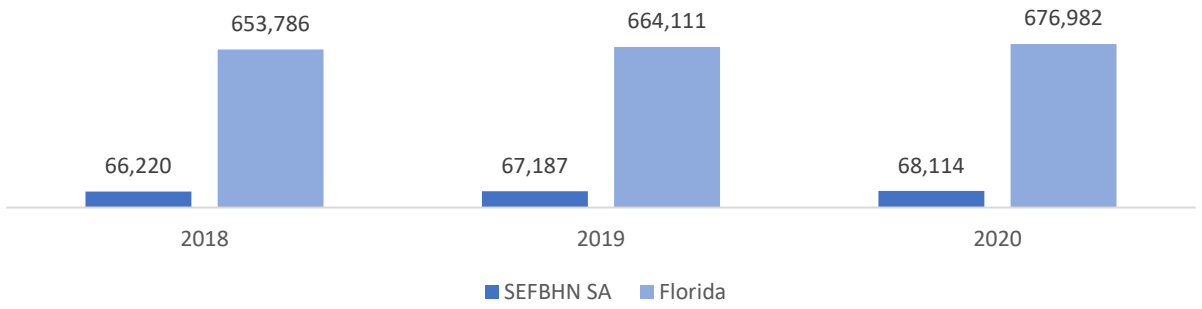
Source: Department of Children and Families, Florida Safe Families Network Data Mart, Rate per 100,000

Figure 18: SEFBHN SA Rate of Children Experiencing Sexual Violence, Ages 5-11 Years (2017-2019)



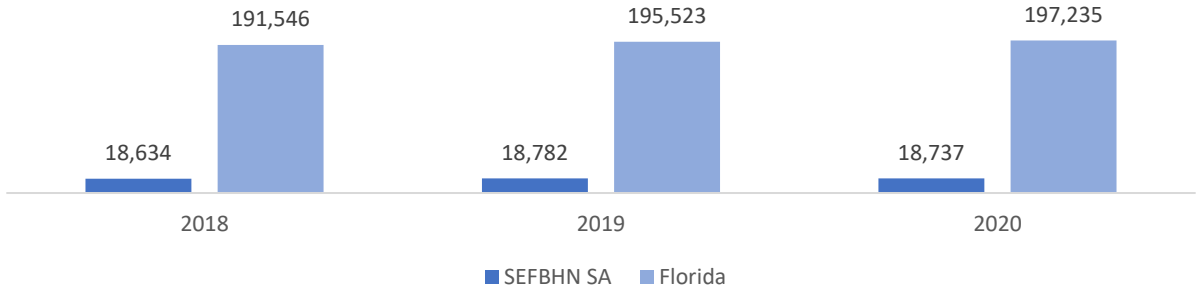
Source: Department of Children and Families, Florida Safe Families Network Data Mart, Rate per 100,000

Figure 19: SEFBHN SA Estimated Number of Seriously Mentally Ill Adults (2018-2020)



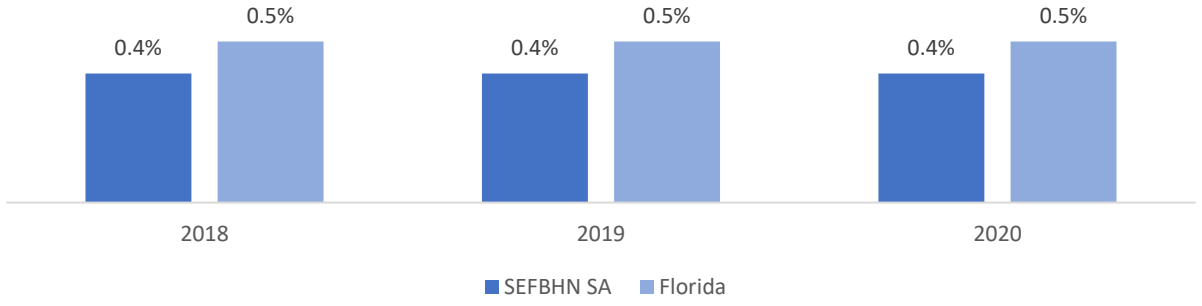
Source: Estimates based on Department of Health and Human Resource Report Mental Health U.S. 1995

Figure 20: SEFBHN SA Estimated Number of Emotionally Disturbed Youth, Ages 9-17 Years (2018-2020)



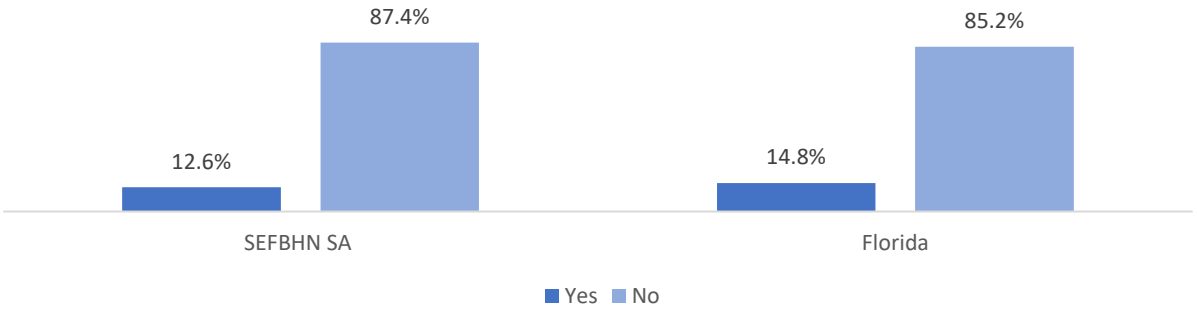
Source: Estimates based on Department of Health and Human Resource Report Mental Health U.S. 1995

Figure 21: SEFBHN SA Percentage of Children with Emotional/Behavioral Disability, Grades K-12 (2018-2020)



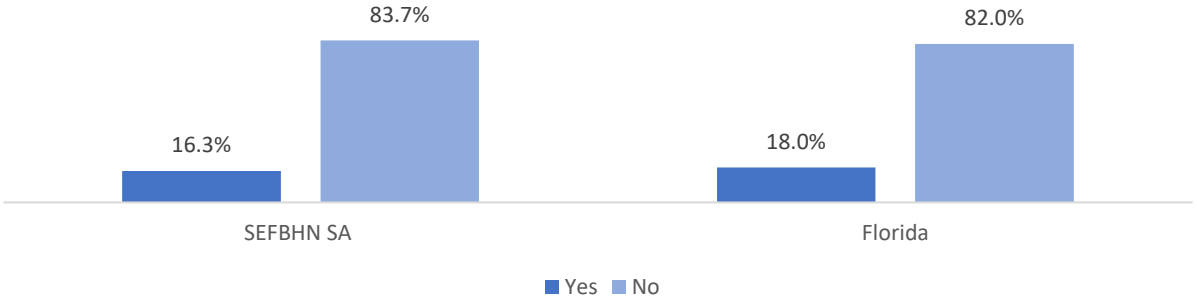
Source: Florida Department of Education, Education Information and Accountability Services (EIAS)

Figure 22: SEFBHN SA Percentage of Adults Who Are Current Smokers (2017-2019)



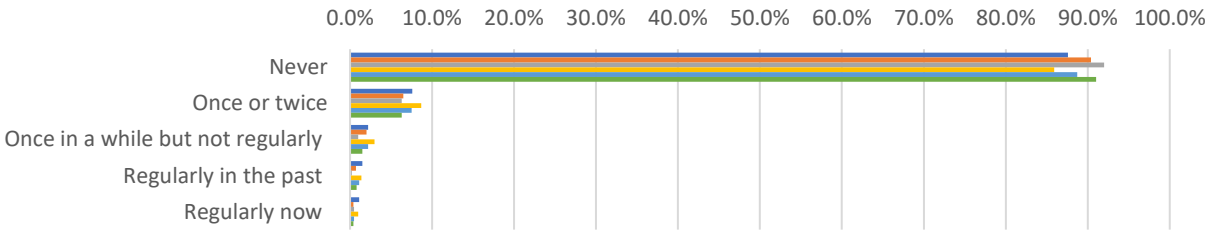
Source: Behavioral Risk Factor Surveillance System

Figure 23: SEFBHN SA Percentage of Adults Who Engage in Heavy or Binge Drinking (2017-2019)



Source: Behavioral Risk Factor Surveillance System

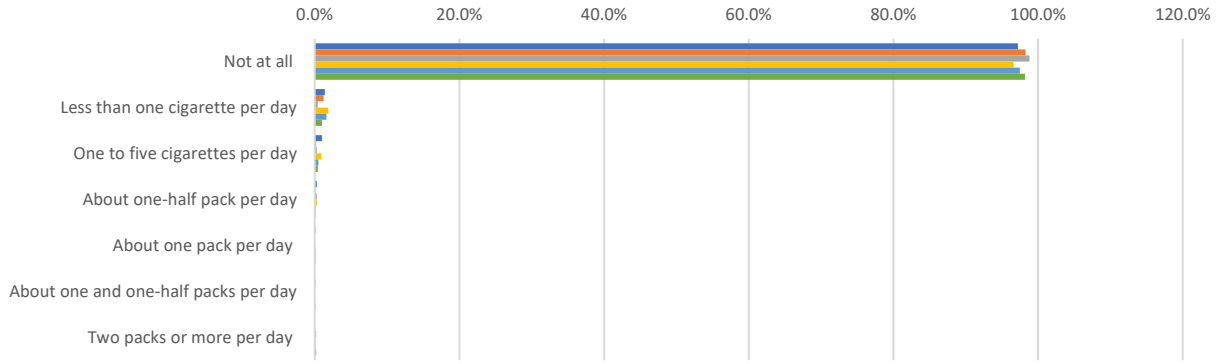
Figure 24: SEFBHN SA Having Ever Smoked Cigarettes (MS&HS 2016-2020)



	Regularly now	Regularly in the past	Once in a while but not regularly	Once or twice	Never
SEFBHN SA 2016	1.1%	1.5%	2.2%	7.6%	87.6%
SEFBHN SA 2018	0.4%	0.7%	2.0%	6.5%	90.4%
SEFBHN SA 2020	0.5%	0.2%	1.0%	6.3%	92.0%
Florida 2016	1.0%	1.4%	3.0%	8.7%	85.9%
Florida 2018	0.5%	1.1%	2.2%	7.5%	88.7%
Florida 2020	0.4%	0.8%	1.5%	6.3%	91.0%

Source: Florida Youth Substance Abuse Survey

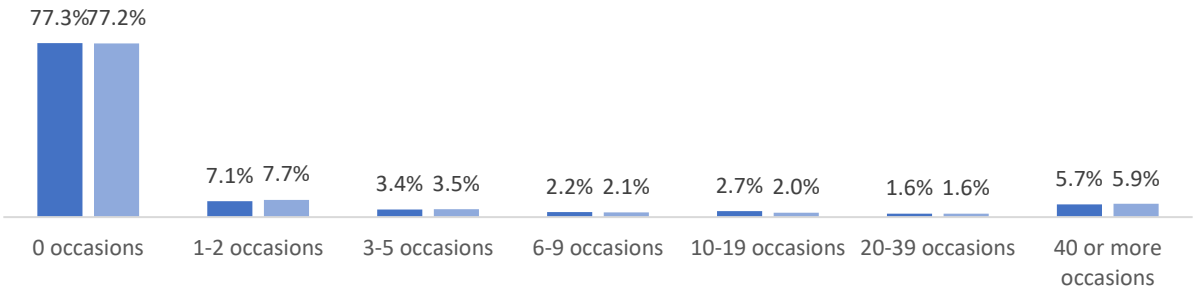
Figure 25: SEFBHN SA – How Frequently Have You Smoked Cigarettes in the Past 30 Days? (MS&HS 2016-2020)



	Two packs or more per day	About one and one-half packs per day	About one pack per day	About one-half pack per day	One to five cigarettes per day	Less than one cigarette per day	Not at all
SEFBHN SA 2016	0.0%	0.0%	0.1%	0.3%	1.0%	1.4%	97.2%
SEFBHN SA 2018	0.0%	0.1%	0.0%	0.1%	0.2%	1.2%	98.3%
SEFBHN SA 2020	0.2%	0.0%	0.0%	0.3%	0.3%	0.4%	98.8%
Florida 2016	0.1%	0.0%	0.1%	0.3%	0.9%	1.9%	96.6%
Florida 2018	0.1%	0.0%	0.1%	0.1%	0.5%	1.6%	97.5%
Florida 2020	0.2%	0.1%	0.1%	0.1%	0.4%	1.0%	98.2%

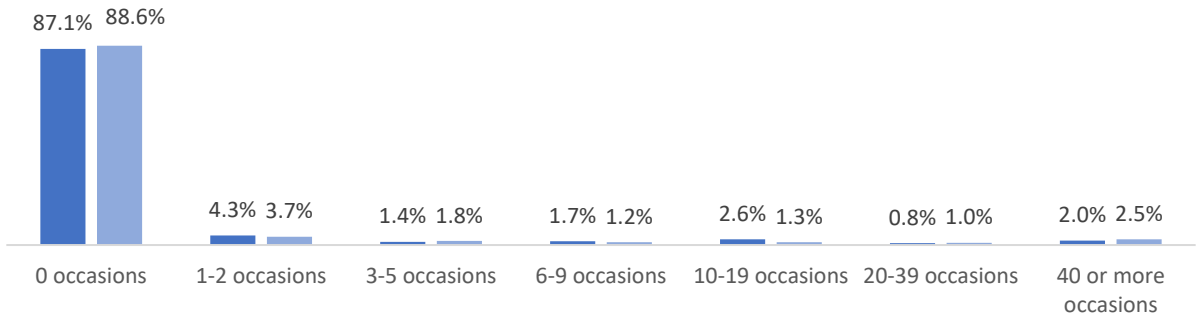
Source: Florida Youth Substance Abuse Survey

Figure 26: SEFBHN SA – On How Many Occasions Have You Vaped Nicotine in Your Lifetime? (MS&HS 2020)



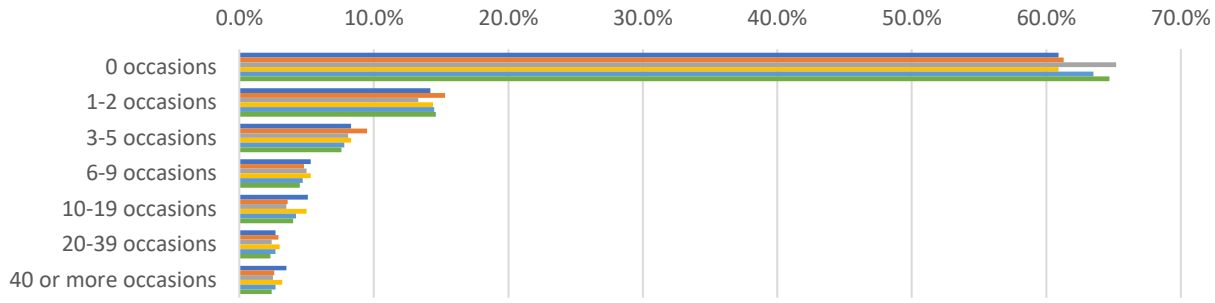
Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

Figure 27: SEFBHN SA – On How Many Occasions Have You Vaped Nicotine During the Past 30 Days? (MS&HS 2020)



Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

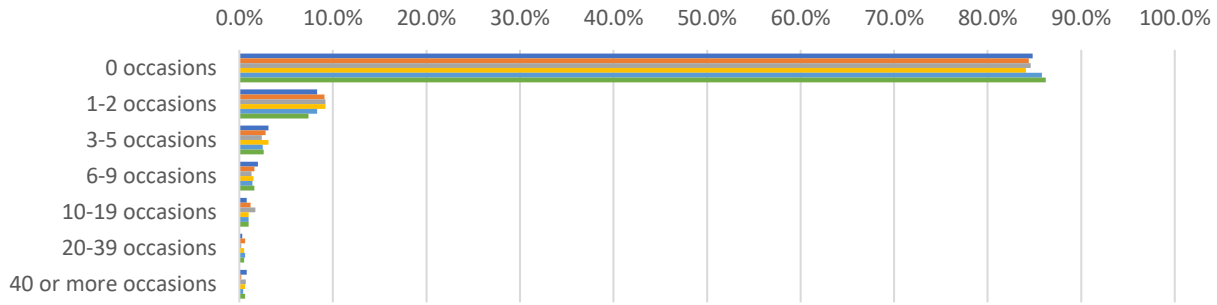
Figure 28: SEFBHN SA – On How Many Occasions Have You Had Alcoholic Beverages to Drink in Your Lifetime? (MS&HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
SEFBHN SA 2016	3.5%	2.7%	5.1%	5.3%	8.3%	14.2%	60.9%
SEFBHN SA 2018	2.6%	2.9%	3.6%	4.8%	9.5%	15.3%	61.3%
SEFBHN SA 2020	2.5%	2.4%	3.5%	5.0%	8.1%	13.3%	65.2%
Florida 2016	3.2%	3.0%	5.0%	5.3%	8.3%	14.4%	60.9%
Florida 2018	2.7%	2.7%	4.2%	4.7%	7.8%	14.5%	63.5%
Florida 2020	2.4%	2.3%	4.0%	4.5%	7.6%	14.6%	64.7%

Source: Florida Youth Substance Abuse Survey. Includes beer, wine, or hard liquor. More than a few sips.

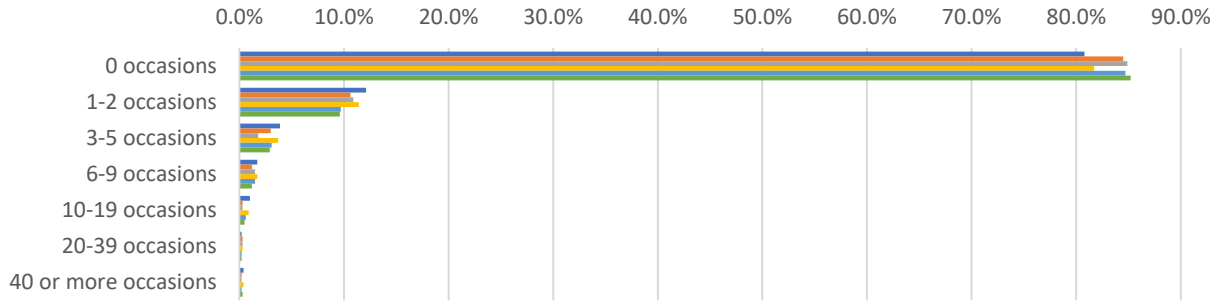
Figure 29: SEFBHN SA – On How Many Occasions in Your Lifetime Have You Woken Up After a Night of Drinking Alcoholic Beverages and Not Been Able to Remember Things You Did or the Places You Went? (HS Only 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
SEFBHN SA 2016	0.8%	0.3%	0.8%	2.0%	3.1%	8.3%	84.8%
SEFBHN SA 2018	0.2%	0.6%	1.2%	1.6%	2.8%	9.1%	84.4%
SEFBHN SA 2020	0.7%	0.2%	1.7%	1.3%	2.4%	9.2%	84.6%
Florida 2016	0.6%	0.5%	1.0%	1.5%	3.1%	9.2%	84.1%
Florida 2018	0.4%	0.6%	1.0%	1.4%	2.5%	8.3%	85.8%
Florida 2020	0.6%	0.5%	1.0%	1.6%	2.6%	7.4%	86.2%

Source: Florida Youth Substance Abuse Survey

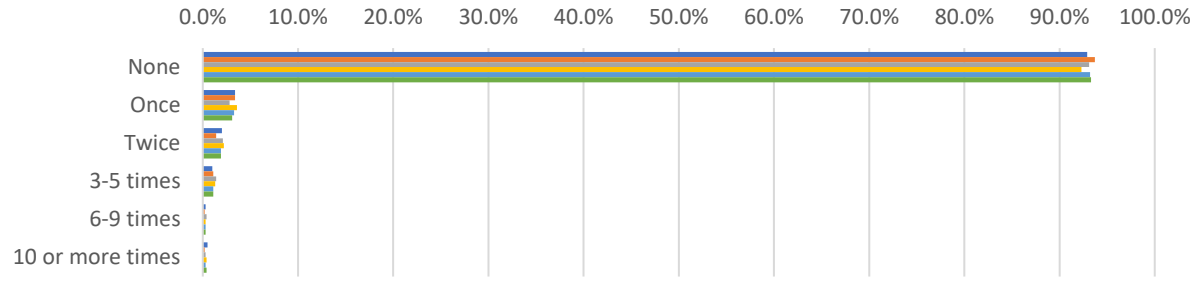
Figure 30: SEFBHN SA – On How Many Occasions Have You Had Beer, Wine, or Hard Liquor in the Past 30 Days? (MS&HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
SEFBHN SA 2016	0.4%	0.2%	1.0%	1.7%	3.9%	12.1%	80.8%
SEFBHN SA 2018	0.2%	0.3%	0.3%	1.2%	3.0%	10.6%	84.5%
SEFBHN SA 2020	0.2%	0.3%	0.3%	1.5%	1.8%	10.9%	84.9%
Florida 2016	0.4%	0.3%	0.9%	1.7%	3.7%	11.4%	81.7%
Florida 2018	0.2%	0.2%	0.6%	1.5%	3.1%	9.7%	84.7%
Florida 2020	0.3%	0.2%	0.5%	1.2%	2.9%	9.6%	85.2%

Source: Florida Youth Substance Abuse Survey

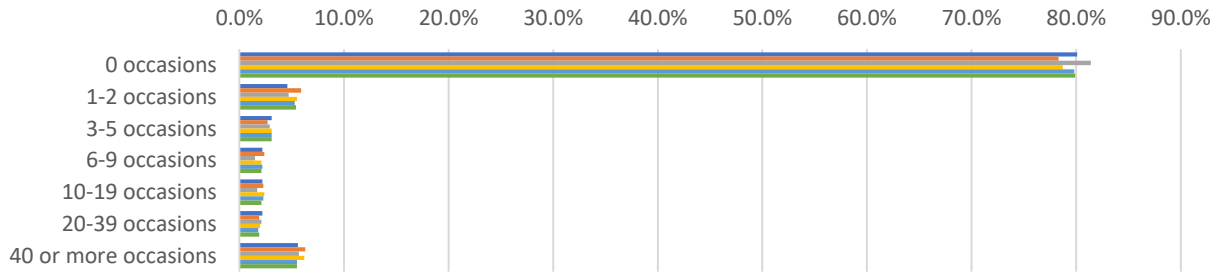
Figure 31: SEFBHN SA – Think Back Over the Past 2 Weeks...How Many Times Have You Had Five or More Alcoholic Drinks in a Row? (MS&HS 2016-2020)



	10 or more times	6-9 times	3-5 times	Twice	Once	None
SEFBHN SA 2016	0.5%	0.3%	1.0%	2.0%	3.4%	92.9%
SEFBHN SA 2018	0.2%	0.2%	1.1%	1.4%	3.4%	93.7%
SEFBHN SA 2020	0.3%	0.4%	1.4%	2.1%	2.8%	93.1%
Florida 2016	0.4%	0.3%	1.3%	2.2%	3.6%	92.3%
Florida 2018	0.3%	0.3%	1.1%	1.9%	3.3%	93.2%
Florida 2020	0.4%	0.3%	1.1%	1.9%	3.1%	93.3%

Source: Florida Youth Substance Abuse Survey

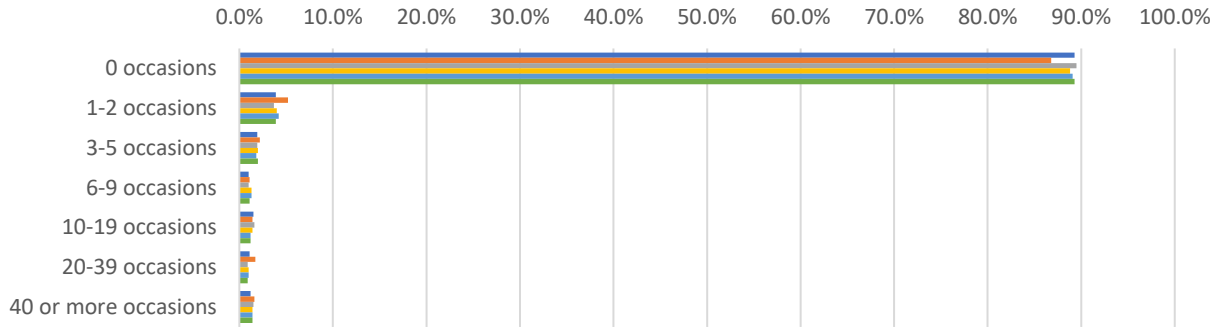
Figure 32: SEFBHN SA – On How Many Occasions Have You Used Marijuana or Hashish in Your Lifetime? (MS&HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
SEFBHN SA 2016	5.6%	2.2%	2.2%	2.2%	3.1%	4.6%	80.1%
SEFBHN SA 2018	6.3%	1.9%	2.3%	2.4%	2.7%	5.9%	78.3%
SEFBHN SA 2020	5.7%	2.1%	1.7%	1.5%	2.9%	4.7%	81.4%
Florida 2016	6.2%	2.0%	2.4%	2.1%	3.1%	5.5%	78.7%
Florida 2018	5.5%	1.8%	2.3%	2.2%	3.1%	5.3%	79.8%
Florida 2020	5.5%	1.9%	2.1%	2.1%	3.1%	5.4%	79.9%

Source: Florida Youth Substance Abuse Survey

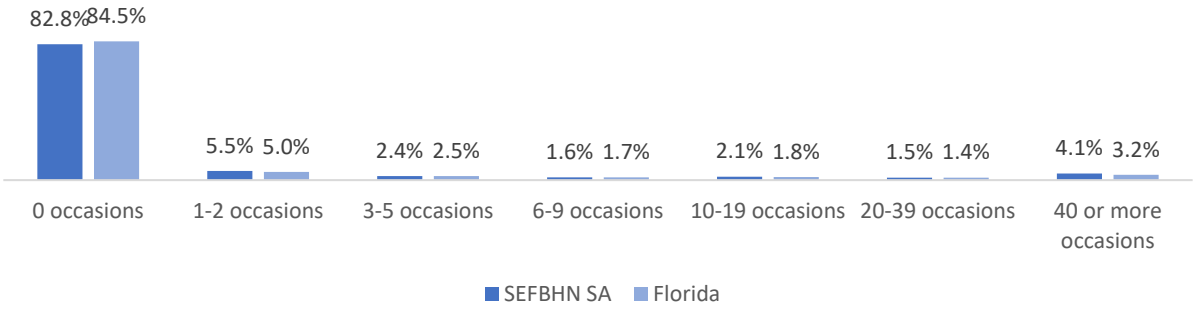
Figure 33: SEFBHN SA – On How Many Occasions Have You Used Marijuana or Hashish During the Past 30 Days? (MS&HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
SEFBHN SA 2016	1.2%	1.1%	1.5%	1.0%	1.9%	3.9%	89.3%
SEFBHN SA 2018	1.6%	1.7%	1.4%	1.1%	2.2%	5.2%	86.8%
SEFBHN SA 2020	1.5%	0.9%	1.6%	1.0%	1.9%	3.7%	89.5%
Florida 2016	1.4%	1.0%	1.4%	1.3%	2.0%	4.0%	88.8%
Florida 2018	1.4%	1.0%	1.2%	1.3%	1.8%	4.2%	89.1%
Florida 2020	1.4%	0.9%	1.2%	1.1%	2.0%	3.9%	89.3%

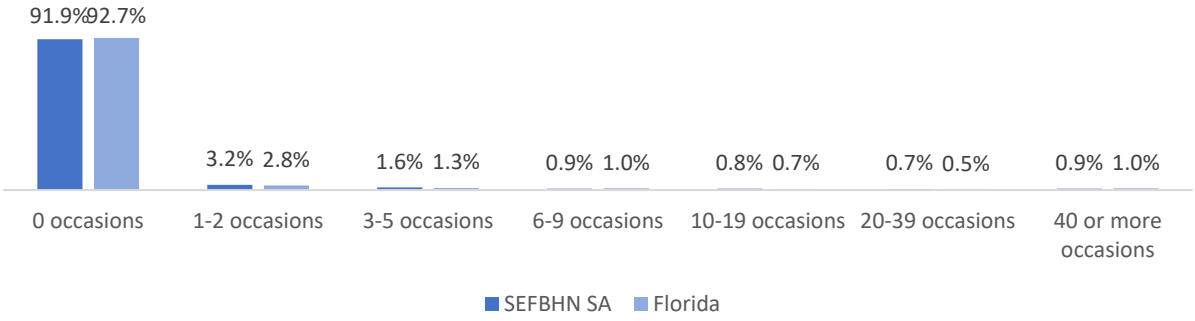
Source: Florida Youth Substance Abuse Survey

Figure 34: SEFBHN SA – On How Many Occasions Have You Vaped Marijuana in Your Lifetime? (MS&HS 2016-2020)



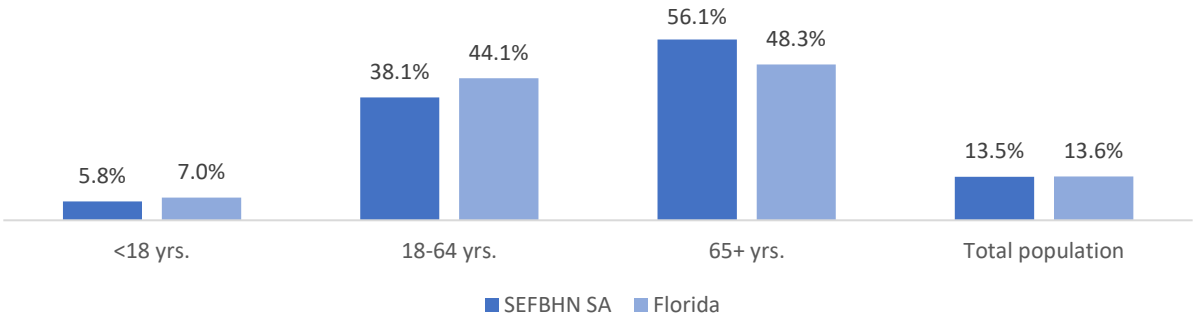
Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

Figure 35: SEFBHN SA – On How Many Occasions Have You Vaped Marijuana in the Past 30 Days? (MS&HS 2016-2020)



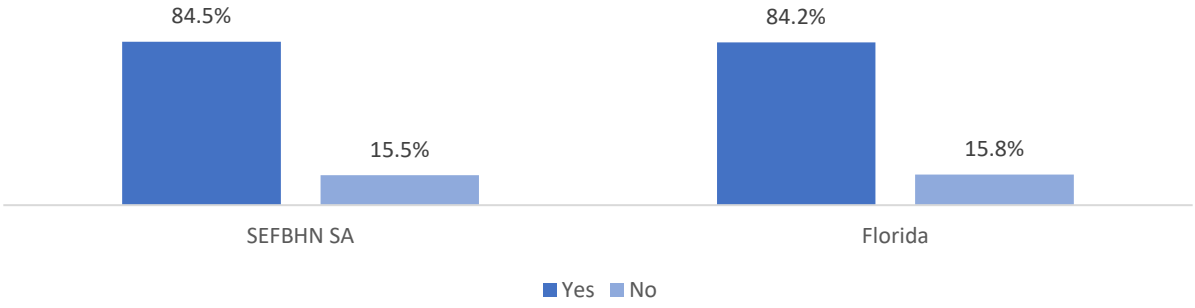
Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

Figure 36: SEFBHN SA Civilian Noninstitutionalized Population with a Disability (2016-2020)



Source: U.S. Census Bureau, American Community Survey. Disability includes: Hearing, Vision, Cognitive, Ambulatory, Self-Care, and Independent Living

Figure 37: SEFBHN SA Percentage of Adults with Any Type of Health Care Insurance Coverage (2013-2019)



Source: Behavioral Risk Factor Surveillance System

SEFBHN SERVICE AREA CLIENT DEMOGRAPHIC PROFILE

CLIENT POPULATION

SEFBHN-funded organizations that served 23,409 clients in FY20-21. This number included a small amount of duplication (<1%) in that some clients moved from one county to another, were enrolled in more than one program, or changed residential status during the one-year time frame. Over 50% of clients resided in Palm Beach County (12,985 clients), followed by St. Lucie County at 23.2% (5,746 clients), Martin County at 8.1% (1,997 clients), Indian River County at 7.3% (1,796 clients), and Okeechobee County at 3.6% (885 clients). Clients who reported living out of state accounted for 2.7% of clients, and those who reported living in another county accounted for 2.6% of all clients.

Adults in SEFBHN programs accounted for 76.3% of all clients with 51.3% enrolled in the Adult Mental Health (AMH) program and 25% in the Adult Substance Abuse program (ASA). The remaining clients were in the Child Mental Health (CMH) program at 15.7% and the Child Substance Abuse (CSA) program at 8%.

GENDER

Males represented more than 50% of all clients in the ASA and CSA programs, ranging from 57.2% in the ASA program, to 62% in the CSA program. Females accounted for more than 50% of all clients in the AMH and CMH programs, at 52.8% of the CMH clients, and 52.4% of the AMH clients. Females accounted for 38% of those in the CSA program.

RACE

The majority of SEFBHN clients were White (55.3%), which was much lower than the percentage in the service area population at 72.5%. Conversely, Black SEFBHN clients accounted for 22.2% of the client population, while representing only 17% of the population in the 5-county service area. ASA clients more closely matched the racial distribution of the general population when compared to clients in other programs. The CSA program had the largest proportion of Black clients (35.6%), compared to the other programs. Moreover, the proportion of multi-racial clients was higher compared to the proportion of multi-racial residents in the SEFBHN service area.

ETHNICITY

The percentage of Hispanics in the SEFBHN client population, at 17.1%, was slightly less when compared to the percentage of the Hispanic population in the service area, at 20.8%. When comparing the ethnic distribution among programs, Hispanic clients comprised 35.3% of CSA clients, 16.5% of CMH clients, 16.3% of AMH clients, and 12% of ASA clients.

AGE RANGE

As expected, the age range distribution among SEFBHN clients did not mimic that of the service area population. Adults, ages 25-44 years of age, accounted for 44.8% AMH clients and 64.3% of ASA clients. In comparison, adults in this age range represented 22.5% of the population in the 5-county area. Conversely, adults ages 65 years and older, accounted for a far less percentage of clients (5.4%) when compared to those in the service area population at 25.1%. Children under age 5 years accounted for less than 5% of clients in the CMH and CSA programs. There was over double the percentage of older teens, ages 15-19 years of age, in the CSA program (61.5%) when compared to those in the CMH program (29.1%).

RESIDENTIAL STATUS

The percentage of clients living dependently (with relatives or non-relatives) was similar when comparing AMH and ASA clients. A higher percentage of ASA clients lived independently alone (19.3%) when compared to AMH clients (15%). Additionally, a higher percentage of ASA clients were homeless (13%) when compared to AMH clients (5.8%). Over 80% of clients in the CSA program lived dependently with relatives. This was far higher than the percentage of clients in the CMH program, where 71.7% lived dependently with relatives. Youth living independently with relatives also varied when comparing clients in the two programs. CMH clients accounted for 16.8% of those living independently with relatives, while only 1.3% of clients in the CSA program lived independently with relatives. In the CSA program, 7.2% of youth lived in a DJJ facility, and 5.9% lived in an assisted living facility, both much higher percentages than youth in the CMH program.

EDUCATIONAL ATTAINMENT

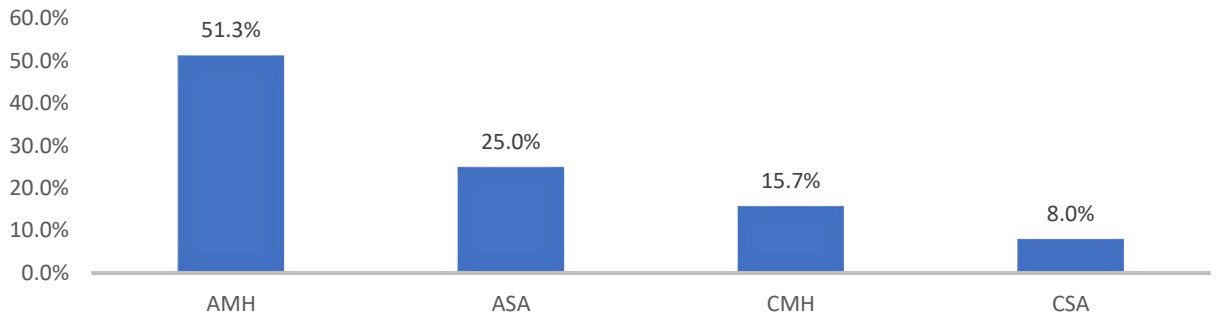
SEFBHN clients attained lower educational levels when compared to service area residents. Among SEFBHN adult clients, 69.4% of AMH clients, and 70.3% of ASA clients did not attain more than a high school education. In the service area population, only 26% of residents did not go on to further education. Consequently, the percentages of adult SEFBHN clients who earned some college education, or attained a college degree, were well below those among residents living in the service area.

EMPLOYMENT STATUS

Unemployment ranged from 40.8% of AMH clients to 50.9% among ASA clients. The 5-year estimate for unemployment in the service area was 303% (2016 to 2020). Additionally, 16.1% of AHM clients and 4.3% of ASA clients were disabled. Of those employed, 27.6% of AMH clients and 27.2% of ASA clients had either part or full-time employment.

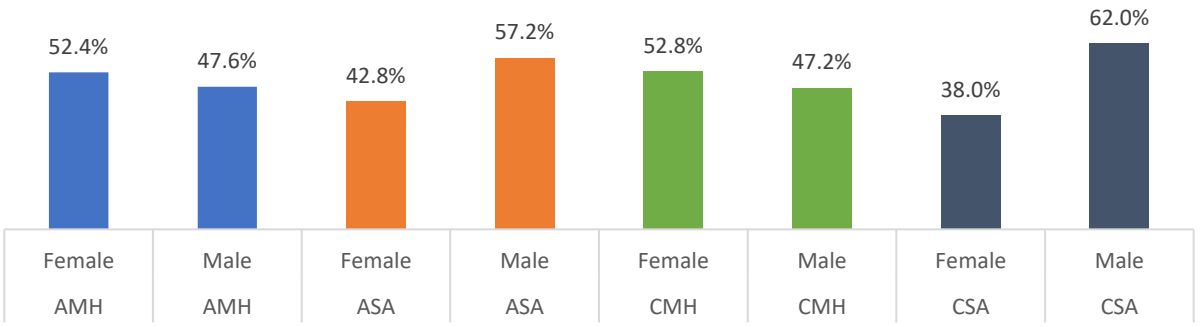
CLIENT DEMOGRAPHIC CHARTS

Figure 38: SEFBHN Clients by Program



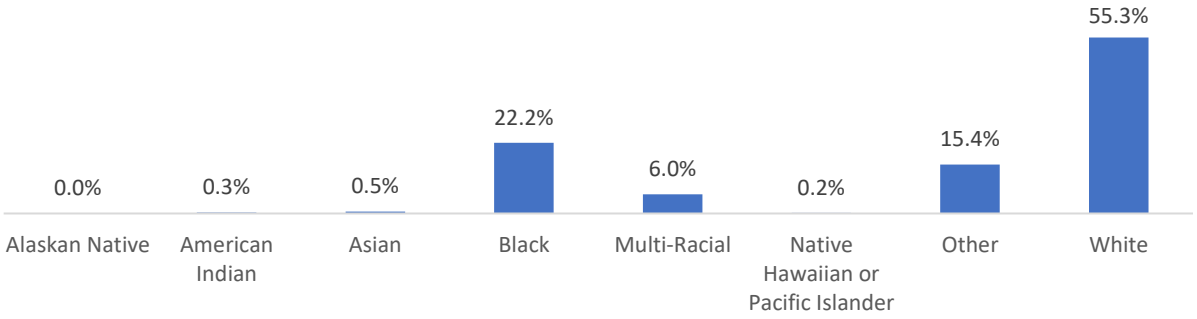
Source: SEFBHN Client Data

Figure 39: SEFBHN Clients by Program and Gender



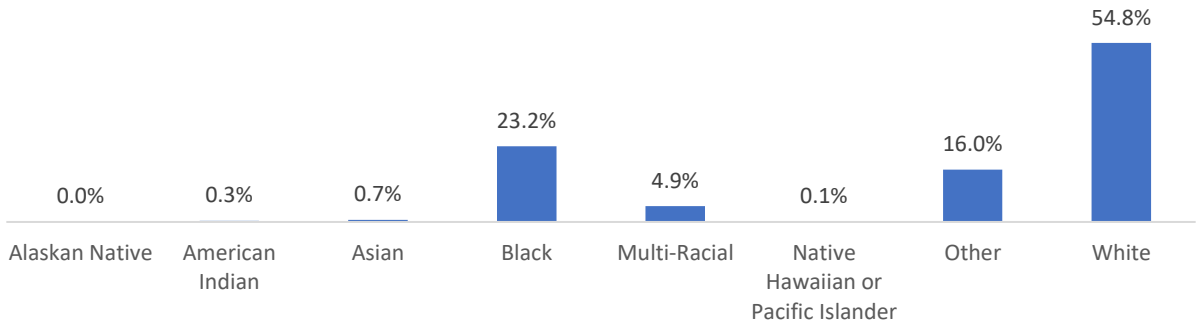
Source: SEFBHN Client Data

Figure 40: SEFBHN Clients by Race



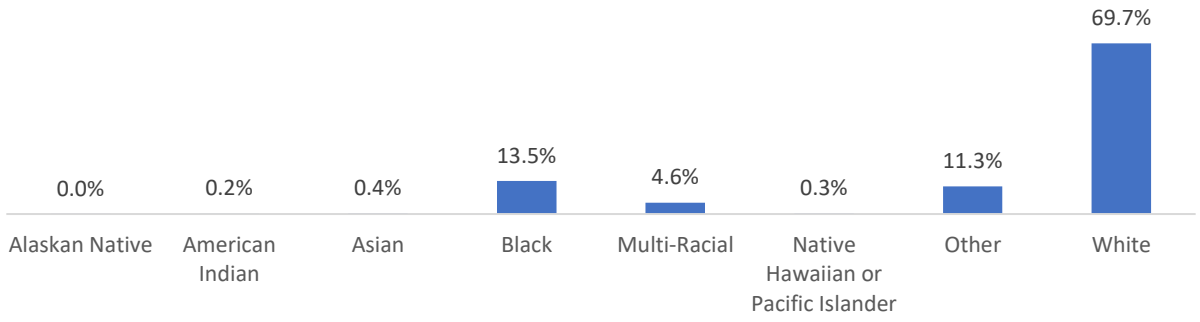
Source: SEFBHN Client Data

Figure 41: SEFBHN AMH Clients by Race



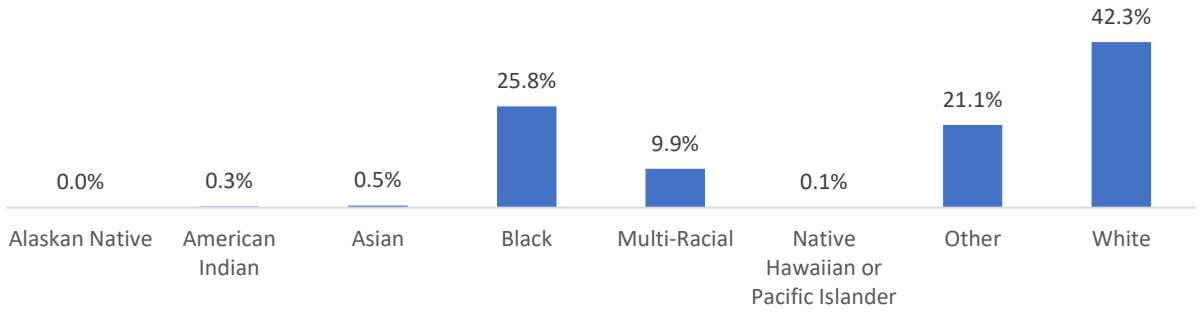
Source: SEFBHN Client Data

Figure 42: SEFBHN ASA Clients by Race



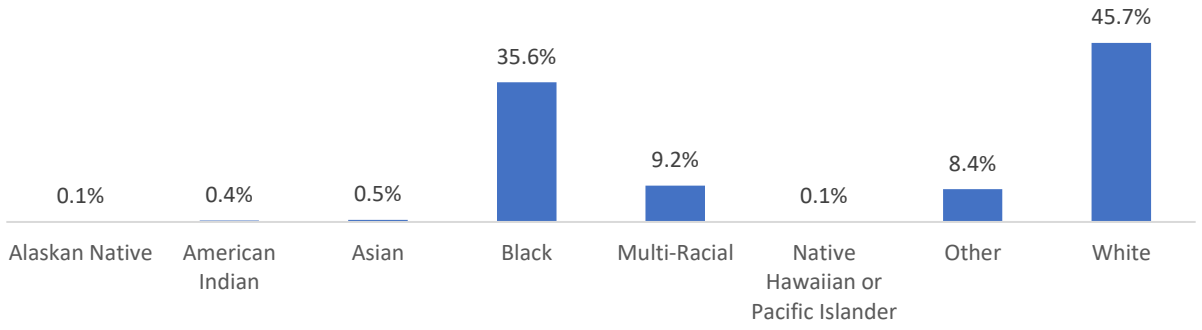
Source: SEFBHN Client Data

Figure 43: SEFBHN CMH Clients by Race



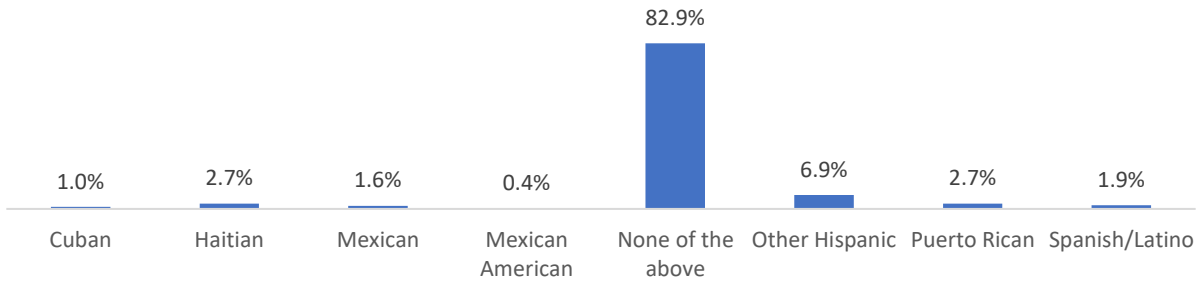
Source: SEFBHN Client Data

Figure 44: SEFBHN CSA Clients by Race



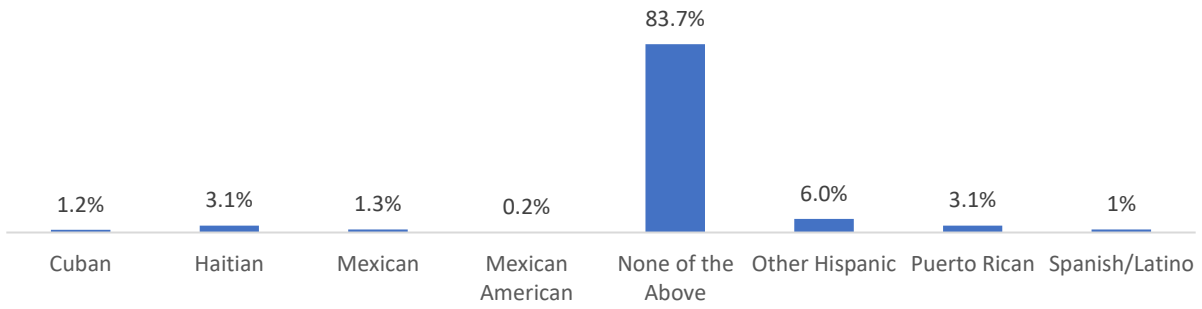
Source: SEFBHN Client Data

Figure 45: SEFBHN Clients by Ethnicity



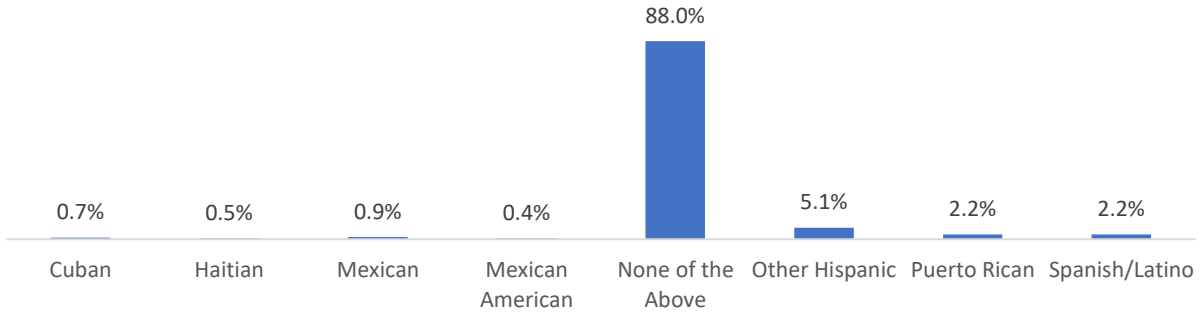
Source: SEFBHN Client Data

Figure 46: SEFBHN AMH Clients by Ethnicity



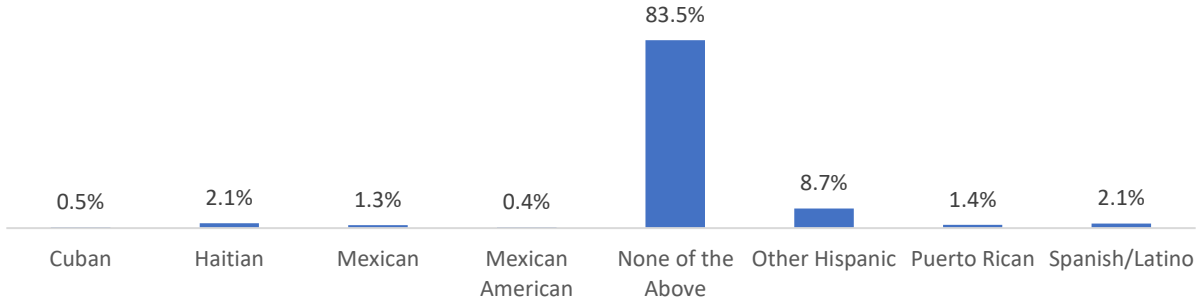
Source: SEFBHN Client Data

Figure 47: SEFBHN ASA Clients by Ethnicity



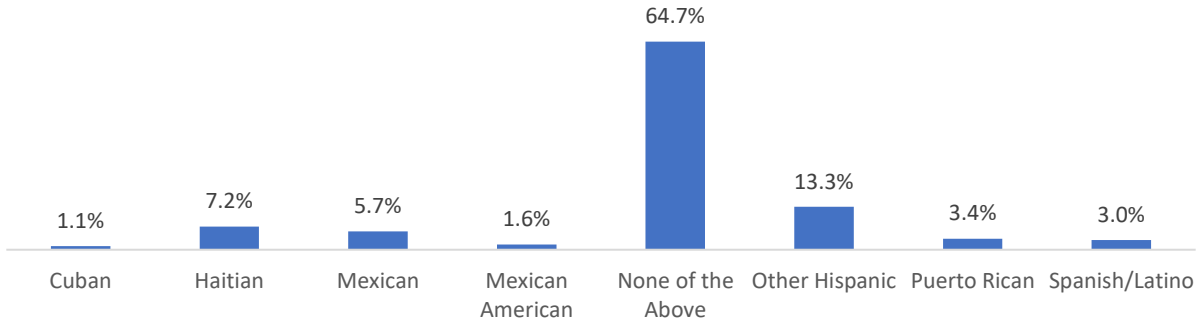
Source: SEFBHN Client Data

Figure 48: SEFBHN CMH Clients by Ethnicity



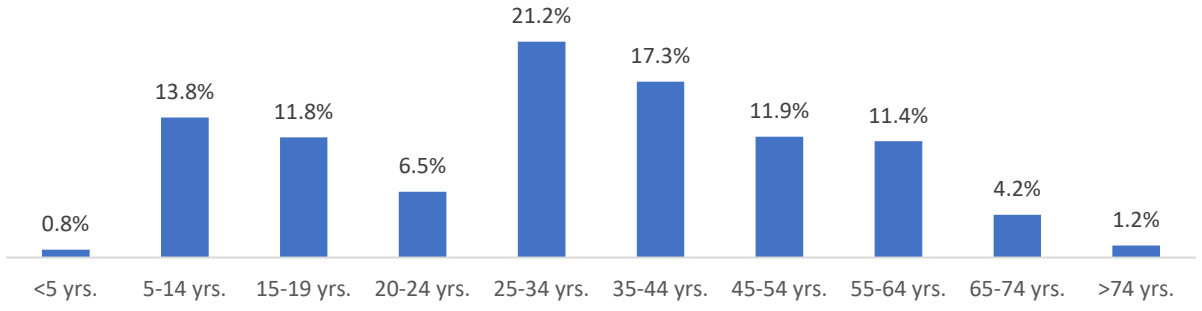
Source: SEFBHN Client Data

Figure 49: SEFBHN CSA Clients by Ethnicity



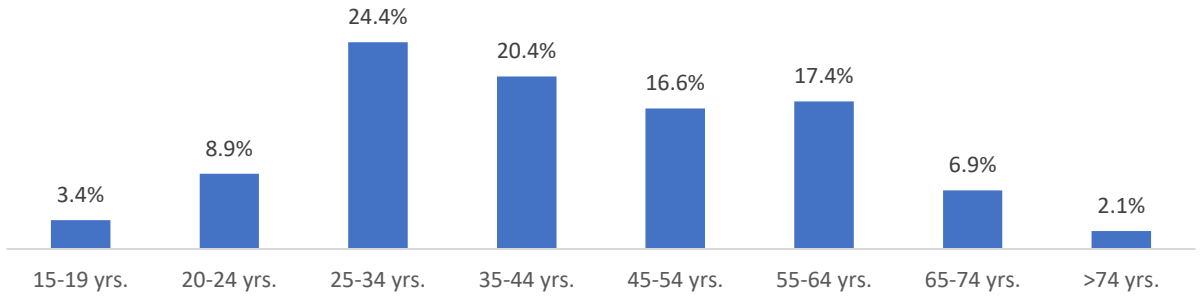
Source: SEFBHN Client Data

Figure 50: SEFBHN Clients by Age Range



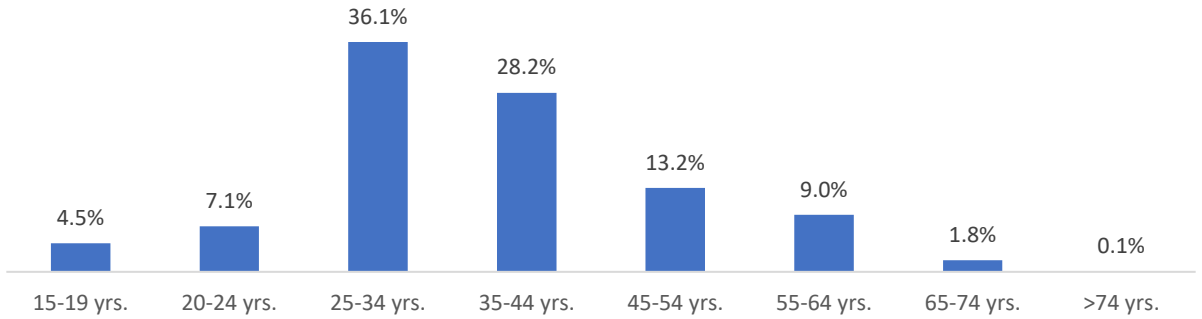
Source: SEFBHN Client Data

Figure 51: SEFBHN AMH Clients by Age Range



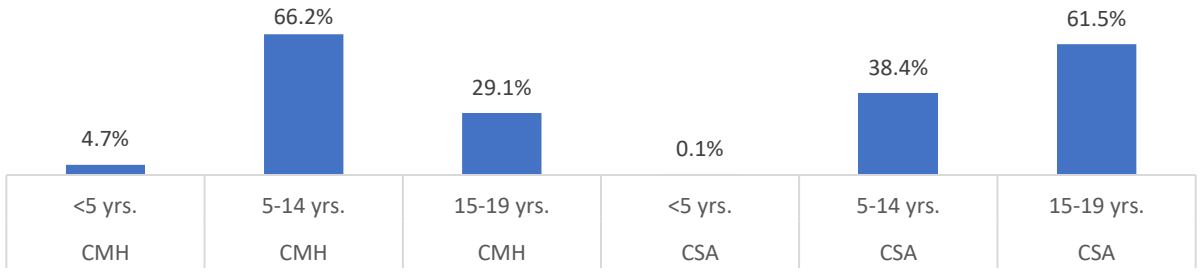
Source: SEFBHN Client Data

Figure 52: SEFBHN ASA Clients by Age Range



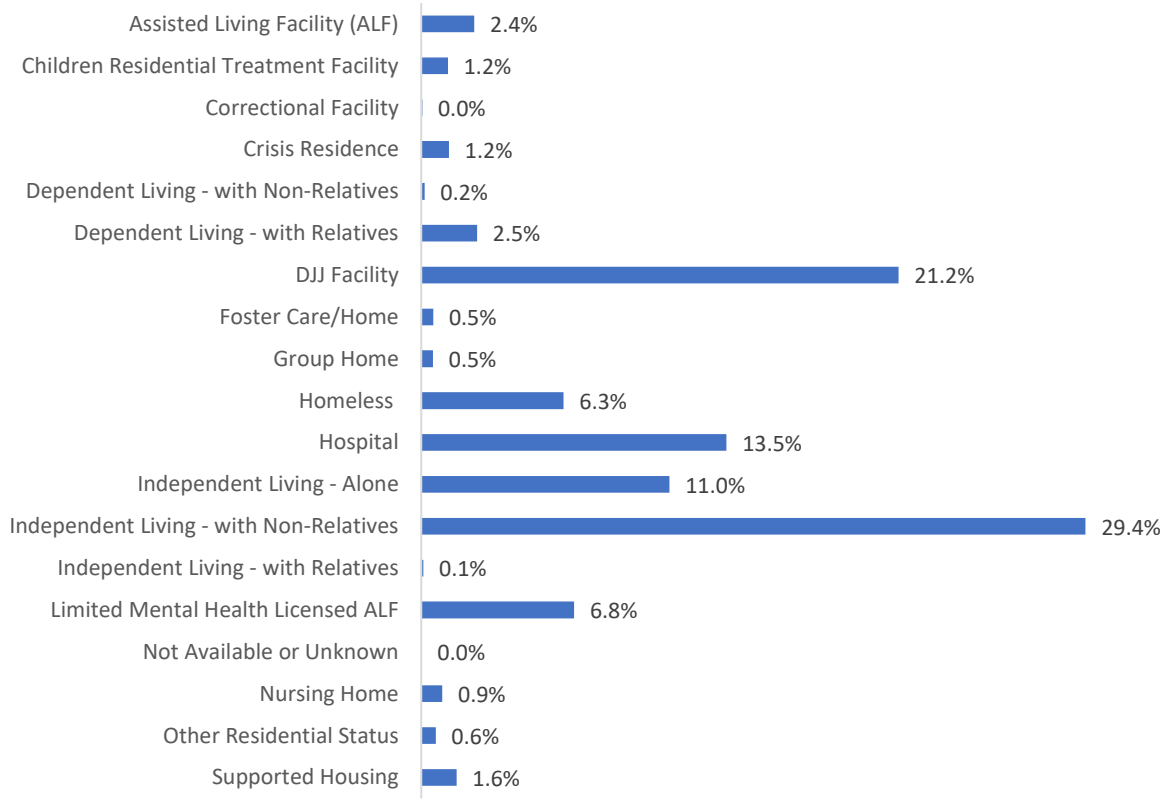
Source: SEFBHN Client Data

Figure 53: SEFBHN CMH and CSA Clients by Age Range



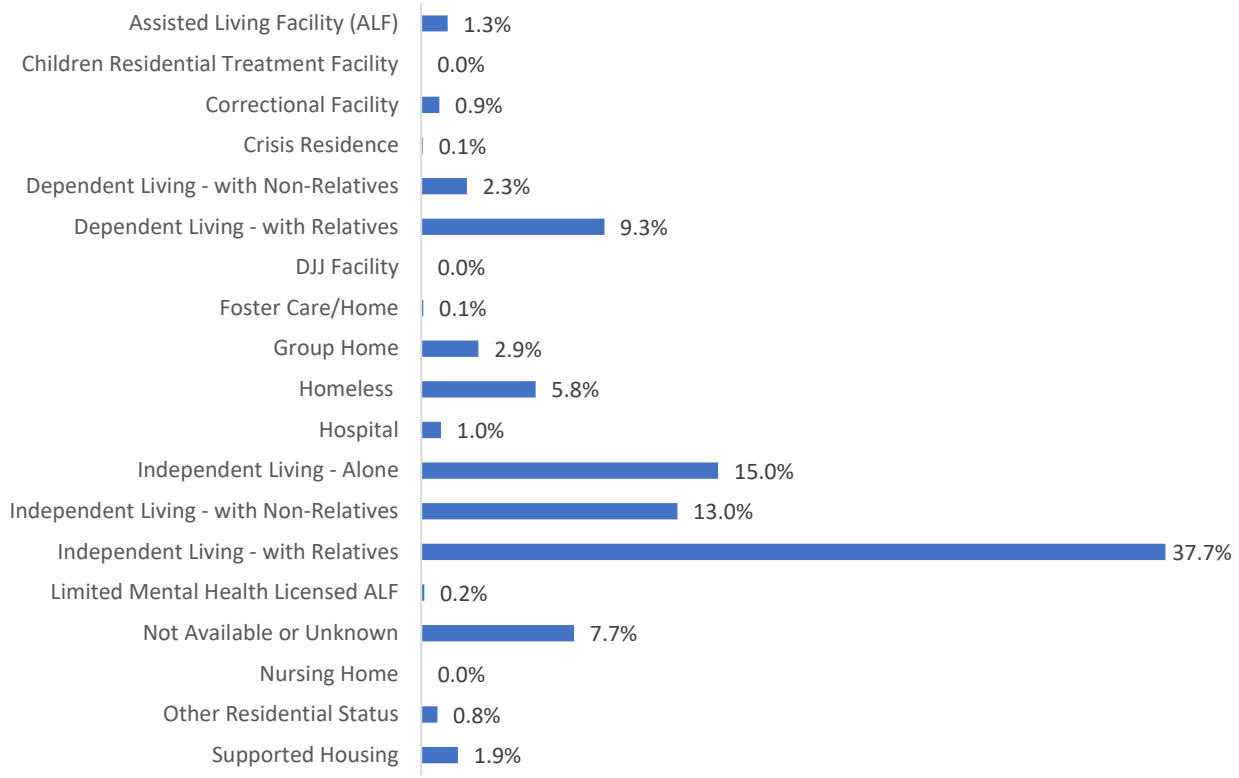
Source: SEFBHN Client Data

Figure 54: SEFBHN Clients by Residential Status



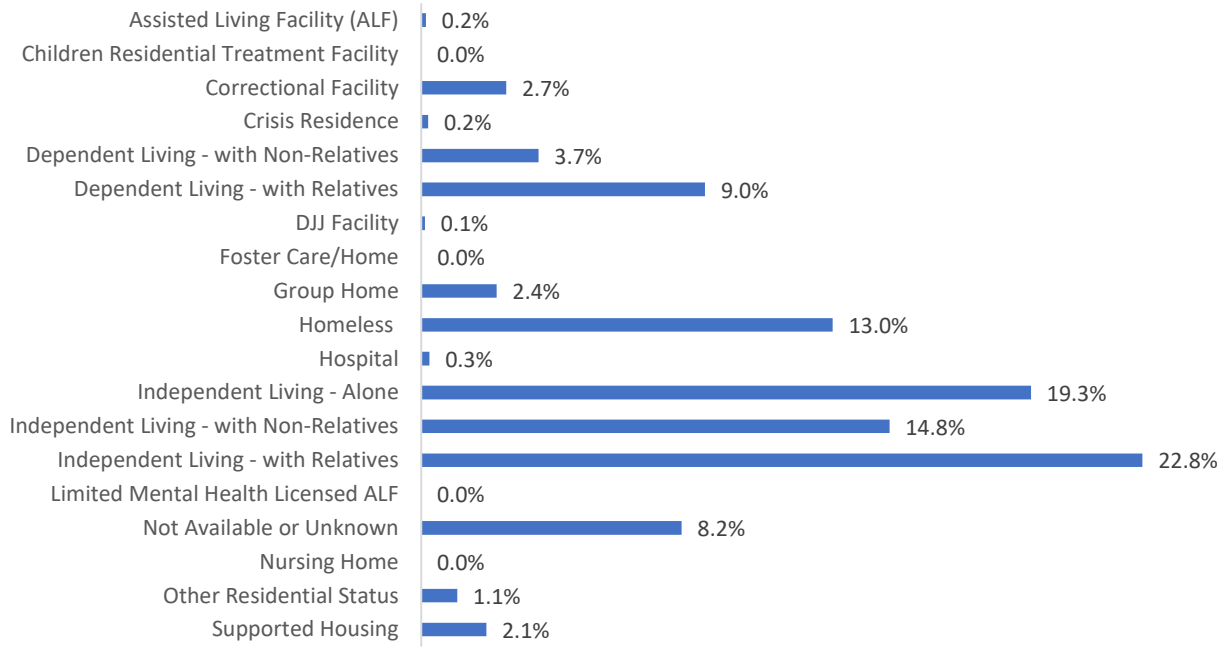
Source: SEFBHN Client Data

Figure 55: SEFBHN AMH Clients by Residential Status



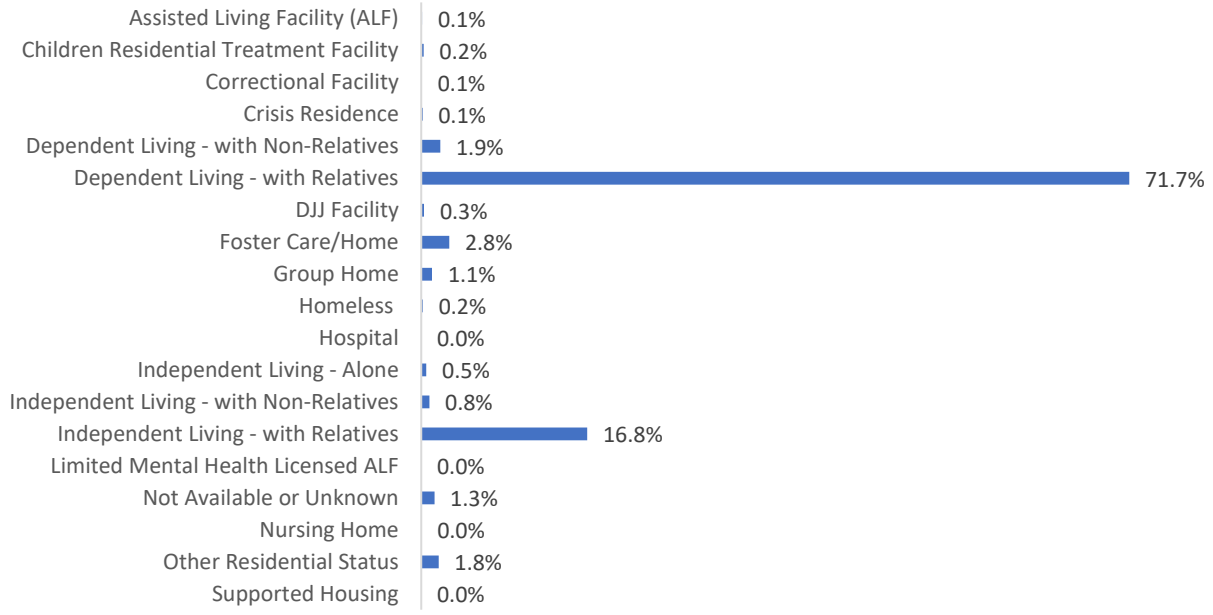
Source: SEFBHN Client Data

Figure 56: SEFBHN ASA Clients by Residential Status



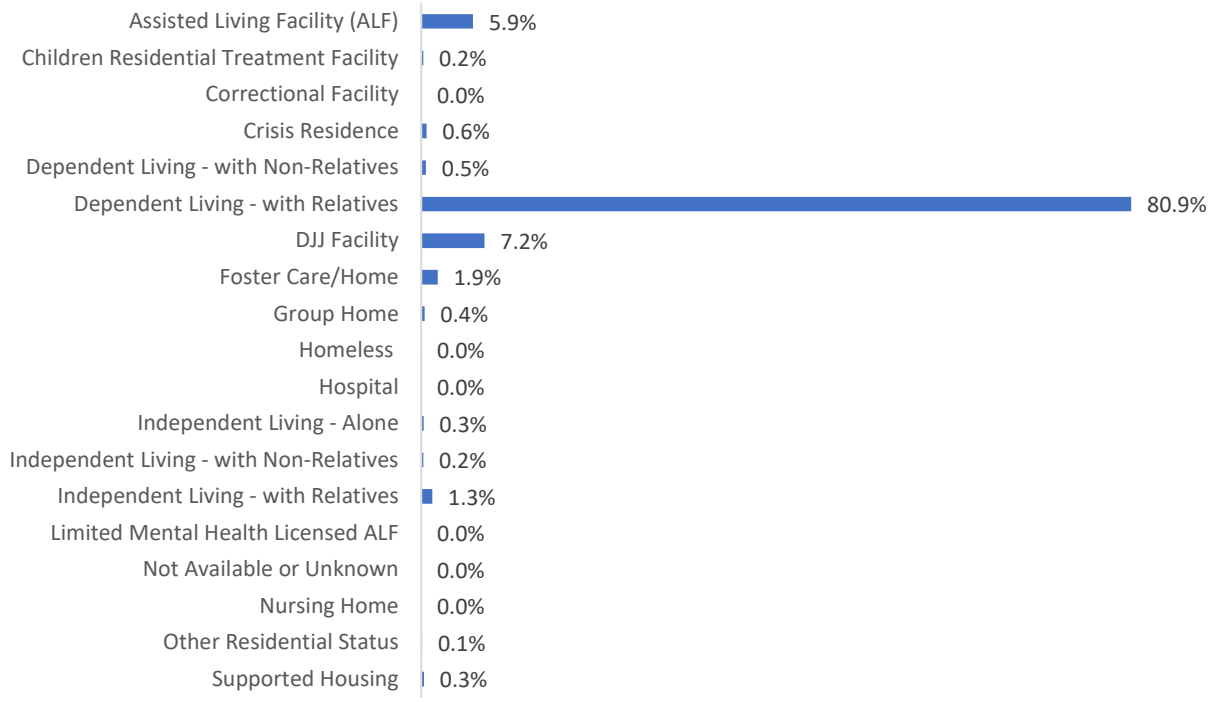
Source: SEFBHN Client Data

Figure 57: SEFBHN CMH Clients by Residential Status



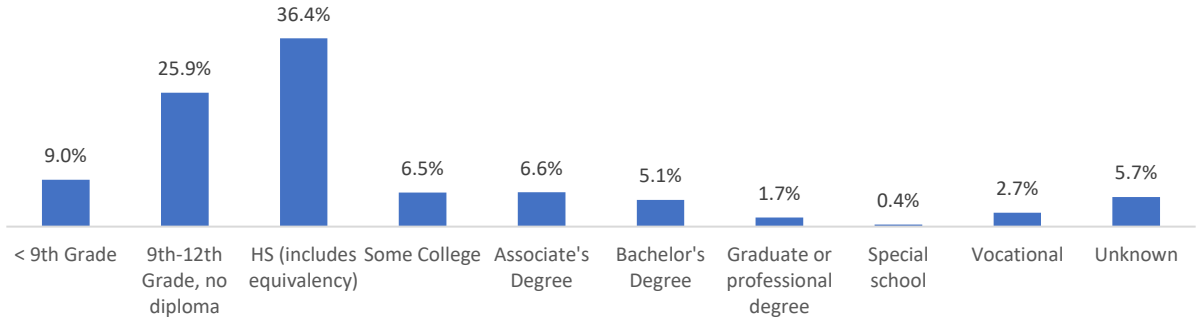
Source: SEFBHN Client Data

Figure 58: SEFBHN CSA Clients by Residential Status



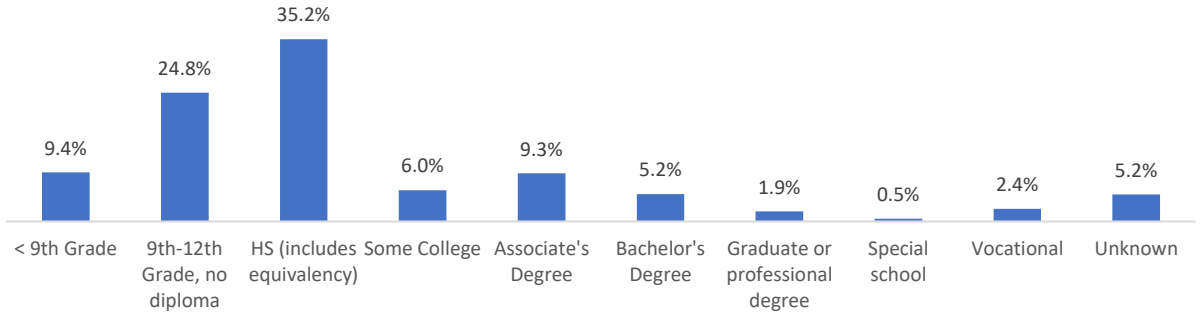
Source: SEFBHN Client Data

Figure 59: SEFBHN Clients by Educational Attainment



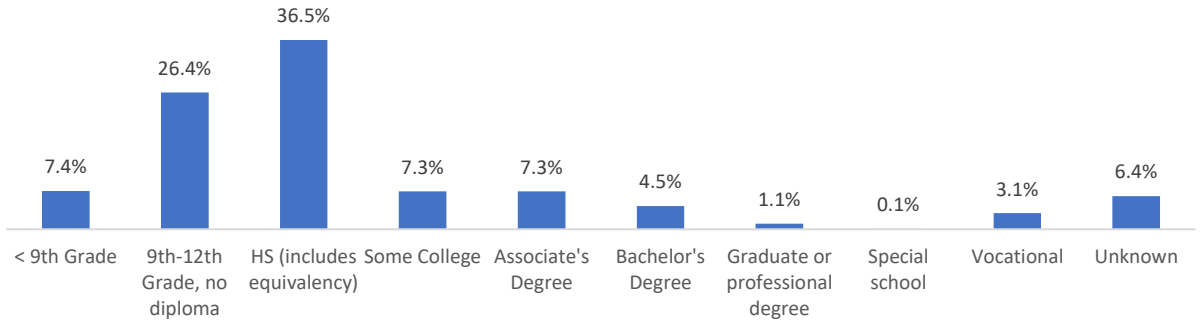
Source: SEFBHN Client Data

Figure 60: SEFBHN AMH Clients by Educational Attainment



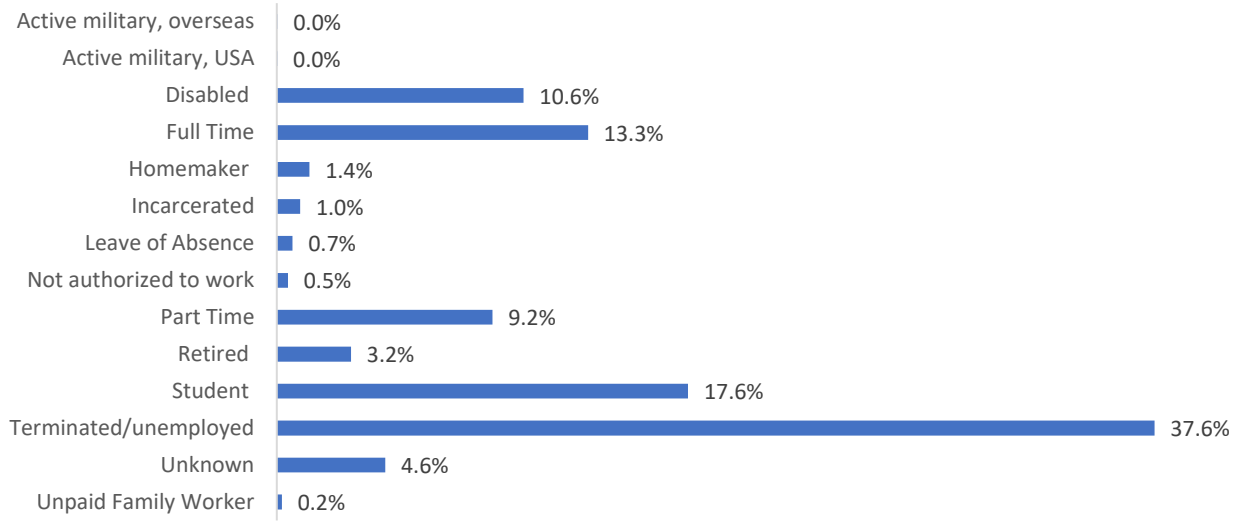
Source: SEFBHN Client Data

Figure 61: SEFBHN ASA Clients by Educational Attainment



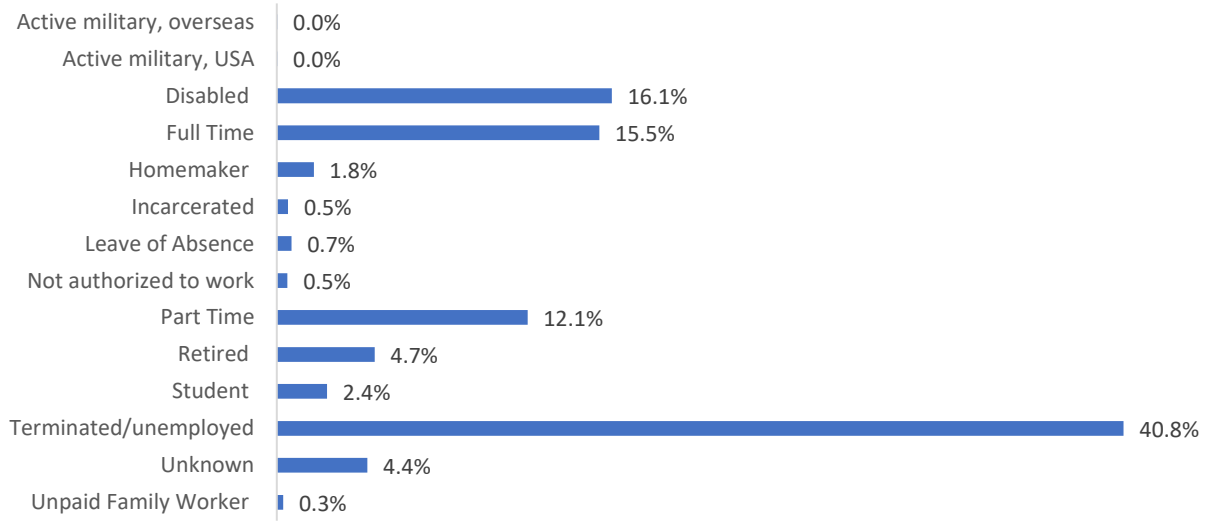
Source: SEFBHN Client Data

Figure 62: SEFBHN Clients by Employment Status



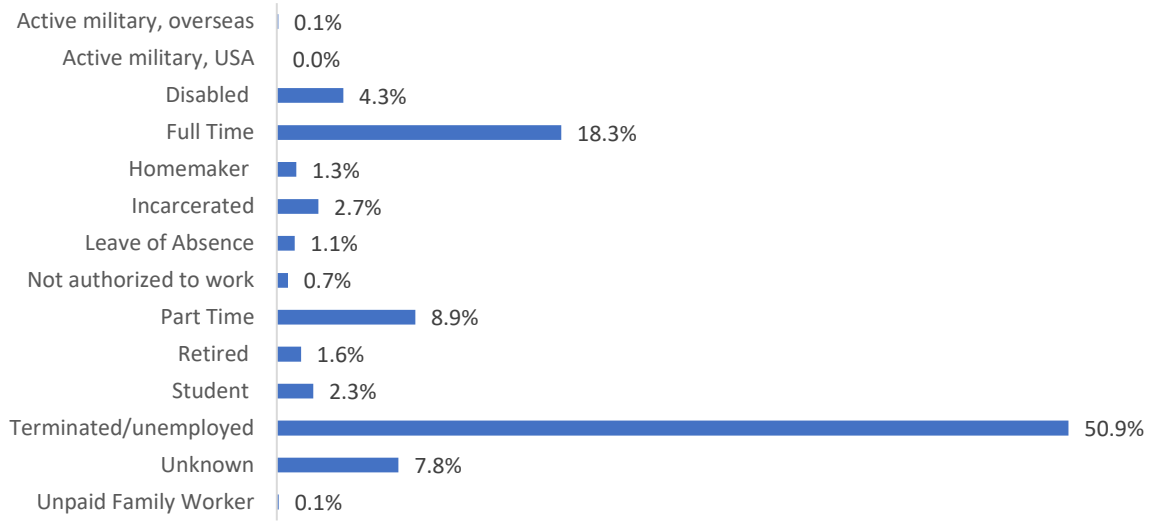
Source: SEFBHN Client Data

Figure 63: SEFBHN AMH Clients by Employment Status



Source: SEFBHN Client Data

Figure 64: SEFBHN ASA Clients by Employment Status



Source: SEFBHN Client Data

SEFBHN SERVICE AREA HOMELESS POPULATION

The 2021 Council on Homelessness Report states that the Point in Time Count (PIT) data provides a snapshot of homelessness. **Due to the pandemic, the 2021 PIT Count is not directly comparable to prior years' counts.** Typically, Continuums of Care (CoCs- A local geographic area designated by HUD and served by a local planning body, which is responsible for organizing and delivering housing and services to meet the needs of people who are homeless as they move to stable housing and maximum self-sufficiency) conduct a PIT Count of both sheltered and unsheltered households. This year, due to COVID-19 related safety concerns, only six of the 27 CoCs conducted such a count; 10 CoCs did not conduct an unsheltered count; and others conducted a modified form of the unsheltered count. All CoCs conducted a sheltered PIT count. For those that did not conduct an unsheltered count, the CoCs reported zero unsheltered persons, resulting in an undercount of total homelessness. According to the report:

> "Housing is a significant determinant of health, and insufficient housing is a major public health issue. The COVID-19 pandemic has exacerbated housing instability especially for low-income households. In effect, the pandemic has triggered high rates of unemployment, worsened pre-existing behavioral health disorders, and increased stress, anxiety, and depression for others. Increased rates of unemployment also contribute to increasing the prevalence of behavioral health disorders, resulting in more suffering and deaths. Prior to the pandemic, America's affordable housing crisis was already expected to get worse. The ELI housing crisis is evidenced by the fact that people with disabilities are forced to live in segregated and institutional facilities (e.g., nursing homes, state institutions, etc.) and experience homelessness. Many of these individuals need Permanent Supportive Housing."
>
> (Please access the actual report for resources at: 2021CouncilReport.pdf (myflfamilies.com)

In 2021, the Florida Council on Homelessness reported there were 1,270 homeless individuals in Indian River, Martin, Palm Beach, and St. Lucie counties. While SEFBHN's service area also includes Okeechobee County, we were unable to include it in this and following calculations as the county was included within a Continuum of Care (CoC) in the Council's 2021 Annual Report that covers additional counties outside of SEFBHN's service area. For this reason, it was excluded from all calculations aside from those on students mentioned below. As previously mentioned, in this report, CoCs refer to all stakeholders within a specific geographic area (as determined by local communities and the US Department of Housing and Urban Development) that are: 1) working to address homelessness with a focus on individuals who are experiencing literal homelessness; and 2) navigating them through the CoC's crisis response team. Thus, the CoC is not only made up of non-profits that serve people experiencing homelessness, but also philanthropists, local governments, businesses, housing developers, health care systems, and businesses, among other

entities.

In Indian River, Martin, Palm Beach, and St. Lucie counties, 54.5% of homeless individuals were unsheltered and 45.5% were sheltered. Chronically homeless, defined as continually homeless for over a year, decreased by 25.9% from 386 individuals in 2017 to 286 people in 2020. Homelessness among veterans increased by 22.6% during the same time from 137 in 2017 to 168 in 2020. Families experiencing homelessness decreased 35.3% from 2017 to 2020. The number of homeless students in School Districts 31, 43, 47, 50, and 56 was 5,428 in the 2015-2016 school year and increased 37.8% to 7,479 in the 2019-2020 school year. Of those students who were homeless in 2019-2020, over 82% were in a sharing housing arrangement, 7.4% were living in motels, and 6.4% were living in shelters.

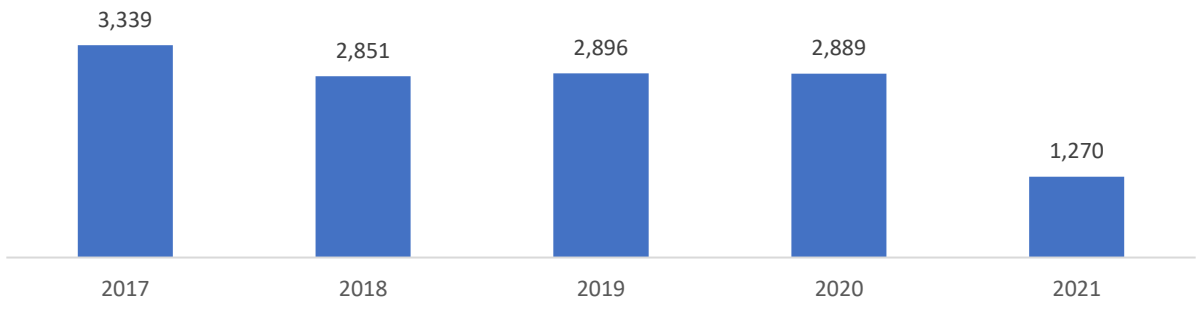
Due to the COVID-19 pandemic, this year saw an unprecedented infusion of federal funding to address homelessness and housing instability. With these funds appropriated by Congress, the State, local governments, CoCs, and partner agencies have invested in solutions to homelessness, including rent and utilities assistance, sheltering, outreach, supportive services and more. While these resources have increased Florida's capacity to prevent and end homelessness, the federal funds have strict restrictions on how the funds may be used; they are not interchangeable with the Challenge and Staffing grants provided to CoCs by the State of Florida. State funding remains critical to addressing homelessness in Florida, especially in rural areas and for the many programs that cannot be funded by federal resources due to their restrictions. State funding helps ensure a broad range of programs in Florida, as well as increase the capacity of the CoCs to administer the federal funding and other resources.

Figure 65: CoC Funding from Federal and State Sources, District 9 (SFY20-21)

Source	District 9 (excluding Okeechobee County)
Total Funding Award	$12,711,407.70
HUD CoC FFY2020	$7,790,599.00
State Total	$4,920,808.70
State Challenge	$234,500.00
State ESG-CV	$4,134,023.00
State Staffing	$214.285.70
Emergency Solutions Grant	$300,000.00
State TANF-HP	$38,000.00

Source: 2021 Florida's Council on Homelessness Annual Report

Figure 66: Total Homeless Population, District 9 (2017-2021)

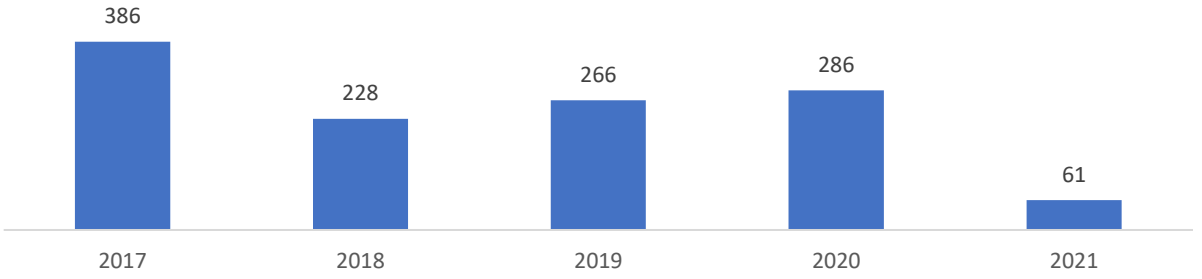


Source: 2021 Florida's Council on Homelessness Annual Report

Figure 67: Total Homeless Population Sheltered and Unsheltered, District 9 (2021)

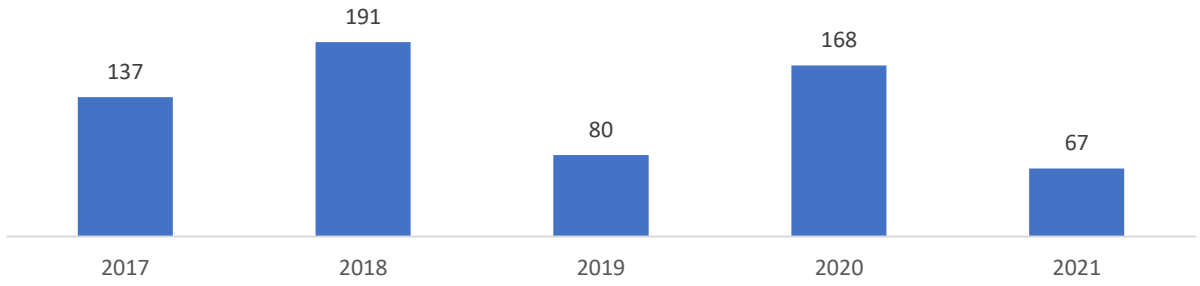
Source: 2021 Florida's Council on Homelessness Annual Report . FL-509 conducted a modified unsheltered PIT Count. FL-605 did not conduct an unsheltered PIT Count.

Figure 68: Chronic Homelessness, District 9 (2017-2021)



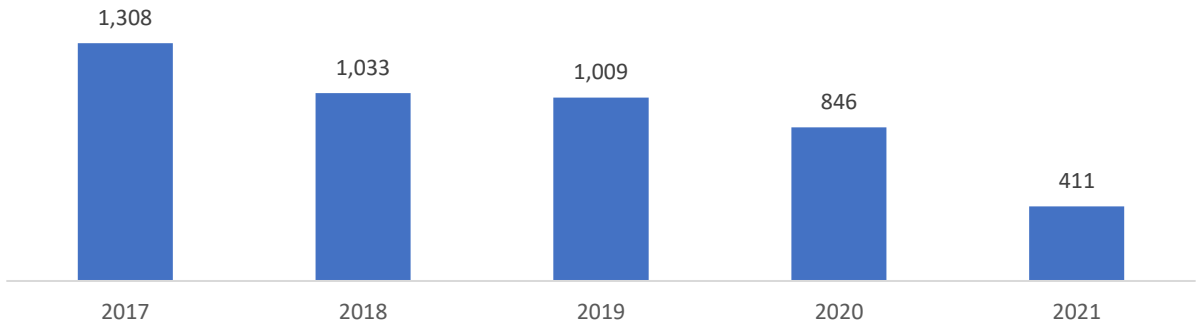
Source: 2021 Florida's Council on Homelessness Annual Report

Figure 69: Homelessness Among Veterans, District 9 (2017-2020)



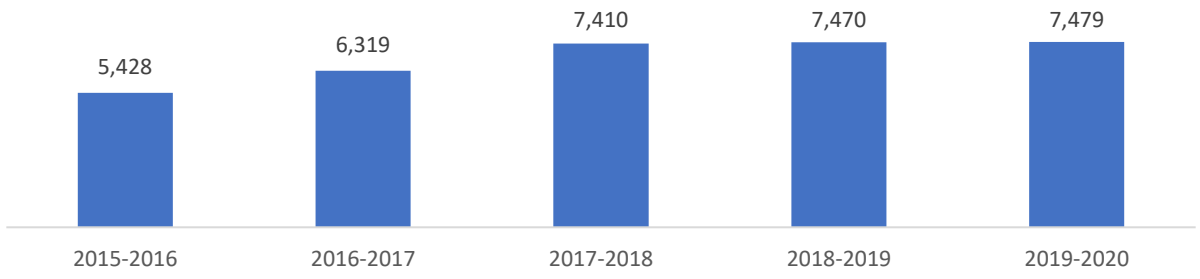
Source: 2021 Florida's Council on Homelessness Annual Report

Figure 70: Family Homelessness – Total Persons in Families with Children, District 9 (2017-2021)



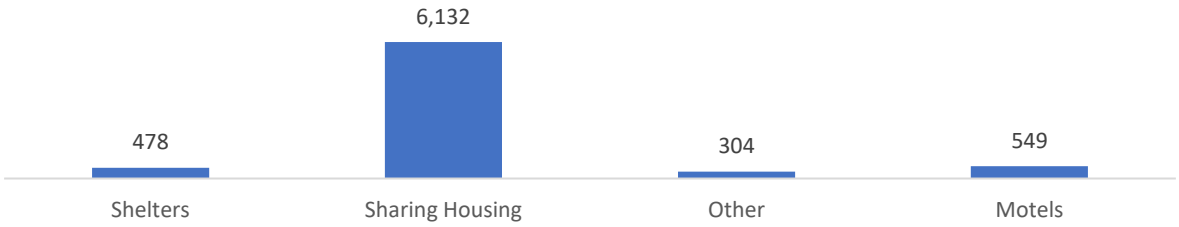
Source: 2021 Florida's Council on Homelessness Annual Report

Figure 71: Florida DOE – Reported Homeless Students in Public Schools (2015-2020)



Source: 2021 Florida's Council on Homelessness Annual Report. School Districts include: 31, 43, 47, 50, & 56.

Figure 72: Reported Homeless Students in Public Schools by Living Situation (2019-2020)



Source: 2021 Florida's Council on Homelessness Annual Report. School Districts include: 31, 43, 47, 50, & 56.

SEFBHN HOMELESS CLIENT PROFILE

DEMOGRAPHICS

A total of 2,421 homeless clients were enrolled in adult and child programs in FY20-21. Of these, 50.2% were in the AMH program and 49.4% in the ASA program. It should be noted that there may be a small percentage of overlap with some clients enrolled in both programs. Homeless children accounted for less than 10% of homeless clients.

Males accounted for larger percentages of clients in the AMH and ASA programs at 61.9% and 69.1%, respectively. Among the child programs, females accounted for 14.3% of clients in the CMH program. There were no female clients in the CSA program. It should be noted that the number of homeless clients in the CMH was very small and results should be interpreted with caution.

Homeless clients in the AMH and ASA programs were racially more diverse when compared to the general service population. White homeless clients accounted for 56.7% of those in the AMH program and Black homeless clients represented 31.2% of clients in the same program. In the general population of the 5-county service area, 75.7% of residents were White, and 17% were Black. Multi-racial individuals also accounted for a larger percentage of clients in the AMH (4.1%) and ASA (4.3%) programs when compared to the service area population (2.2%). The percentage of homeless Hispanic clients in the AMH program, at 14%, was higher when compared to the Hispanic clients in the ASA at 10.1%. In the general population, 20.6% were Hispanic. There were no homeless clients in the child programs that were Hispanic.

Adults, ages 25-44 years, accounted for 49.7% of AMH clients and 66% of ASA clients. Older homeless clients, those over 65 years of age, represented a much smaller percentage of homeless clients (3.1%) when compared to those in the service area at 20.1%.

RESIDENTIAL STATUS

All homeless clients reported their residential status as homeless.

EDUCATIONAL ATTAINMENT

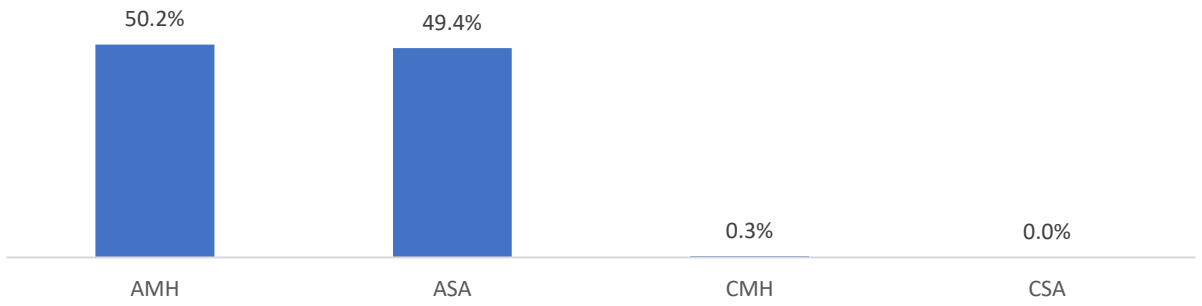
Among the homeless clients, 24.4% had more than a high school education, while 75.6% did not. Moreover, while 30% of homeless clients did not have a HS diploma, almost 5% had a Bachelor's degree or higher (4.8%).

EMPLOYMENT STATUS

Only 11.3% of homeless clients were employed (part time or full time) and 75.3% had been terminated or were unemployed. Additionally, 9.8% of homeless clients were disabled.

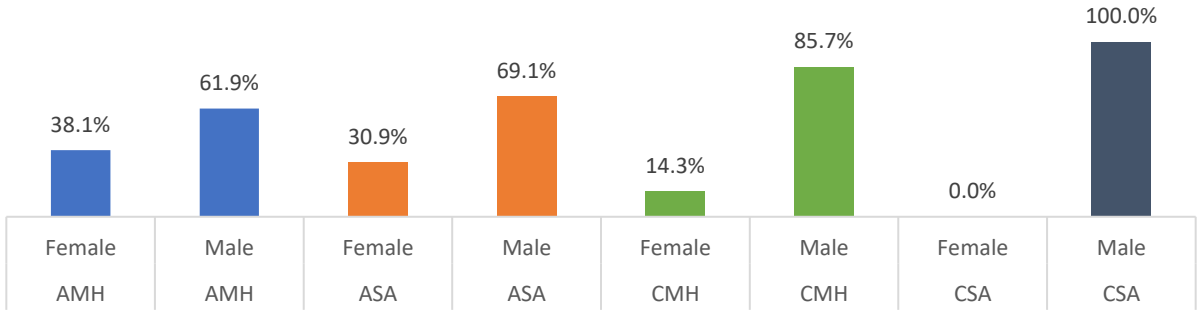
SEFBHN HOMELESS CLIENT CHARTS

Figure 73: SEFBHN Homeless Clients by Program



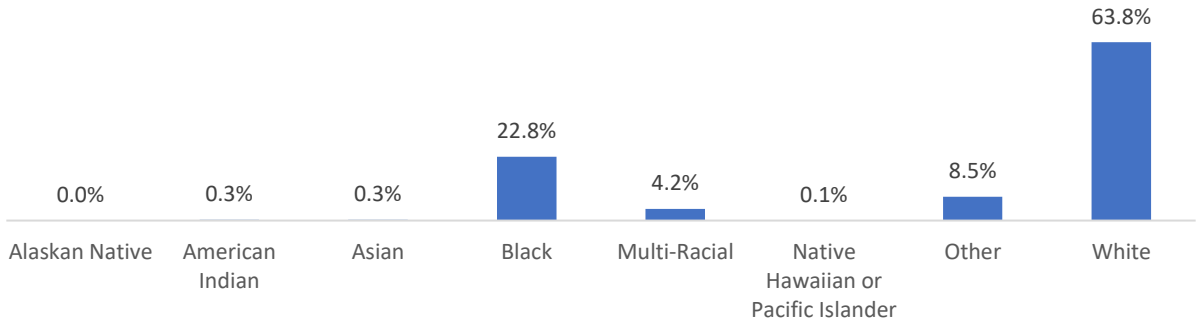
Source: SEFBHN Client Data

Figure 74: SEFBHN Homeless Clients by Gender



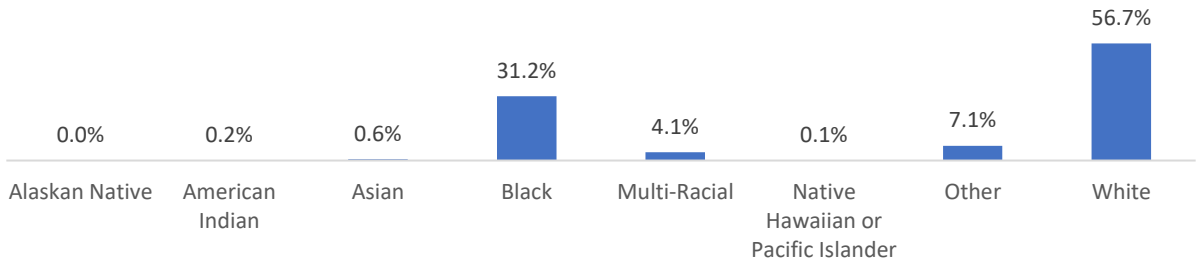
Source: SEFBHN Client Data

Figure 75: SEFBHN Homeless Clients by Race



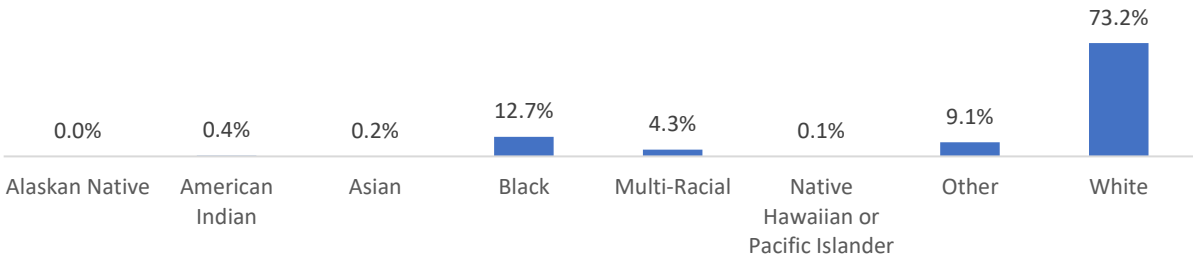
Source: SEFBHN Client Data

Figure 76: SEFBHN Homeless AMH Clients by Race



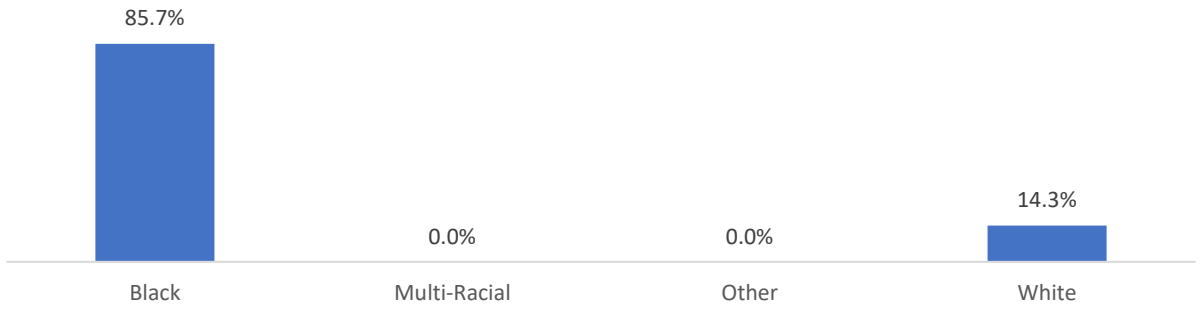
Source: SEFBHN Client Data

Figure 77: SEFBHN Homeless ASA Client by Race



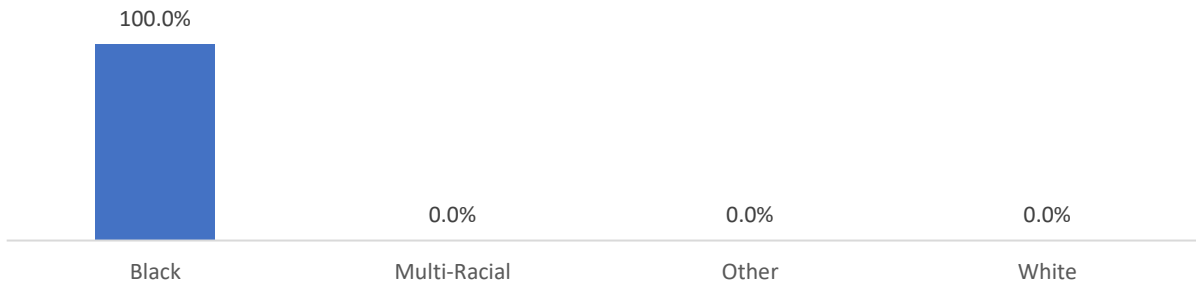
Source: SEFBHN Client Data

Figure 78: SEFBHN Homeless CMH Clients by Race



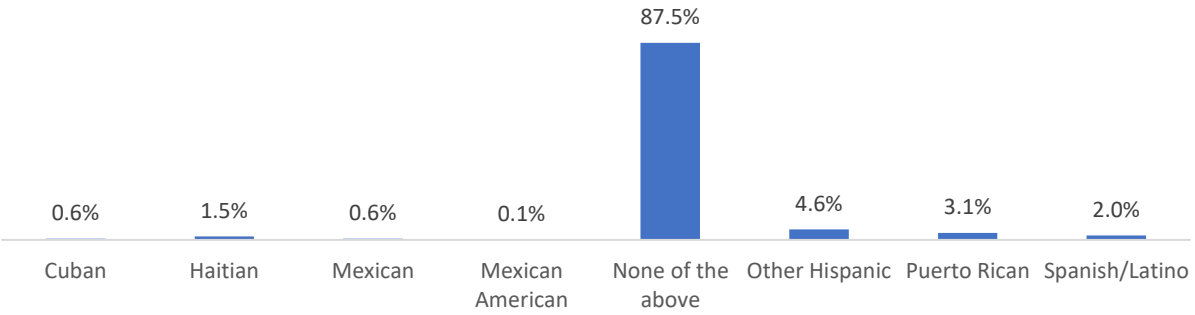
Source: SEFBHN Client Data

Figure 79: SEFBHN Homeless CSA Clients by Race



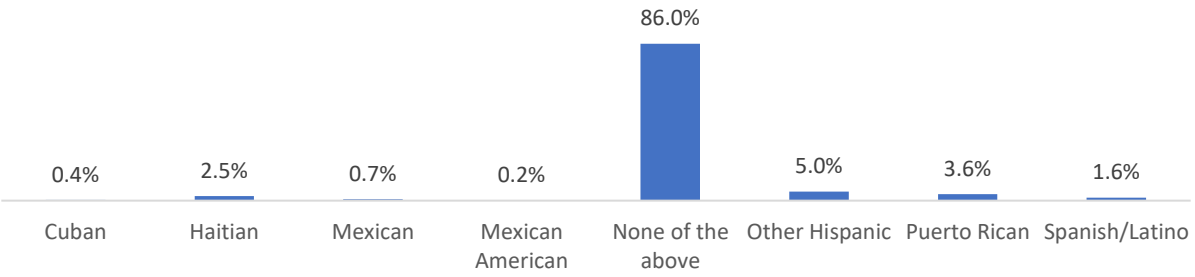
Source: SEFBHN Client Data

Figure 80: SEFBHN Homeless Clients by Ethnicity



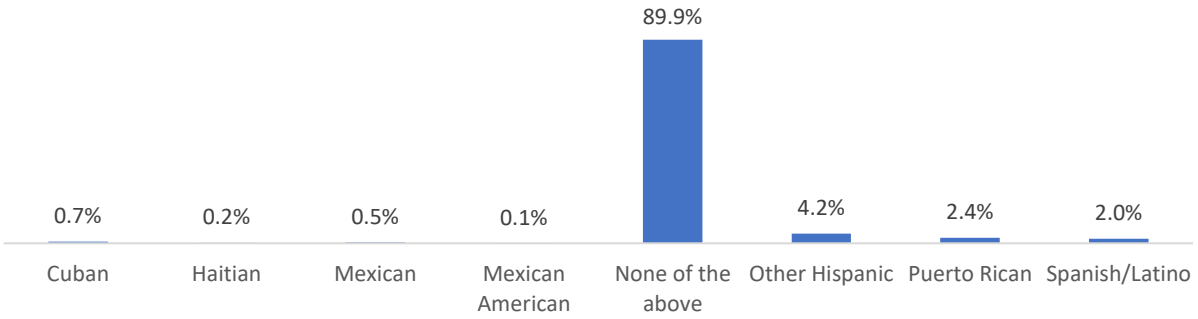
Source: SEFBHN Client Data

Figure 81: SEFBHN Homeless AMH Clients by Ethnicity



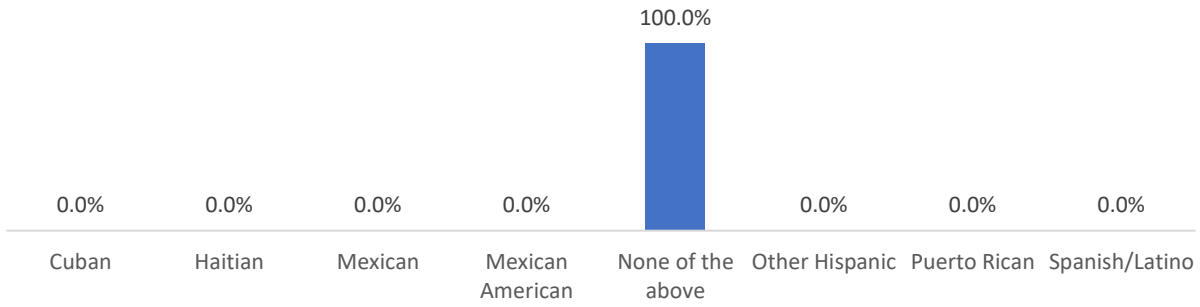
Source: SEFBHN Client Data

Figure 82: SEFBHN Homeless ASA Clients by Ethnicity



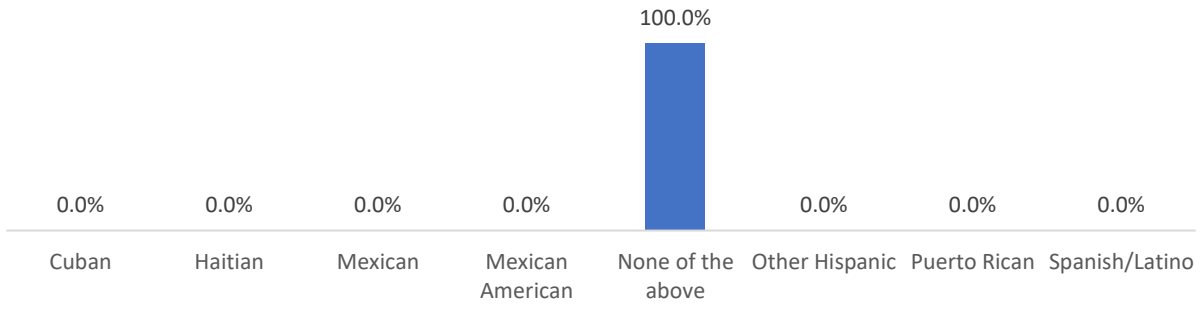
Source: SEFBHN Client Data

Figure 83: SEFBHN Homeless CMH Clients by Ethnicity



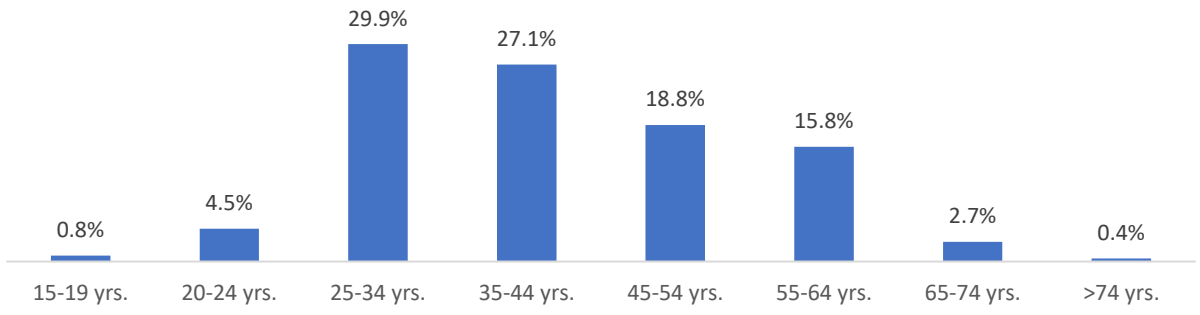
Source: SEFBHN Client Data

Figure 84: SEFBHN Homeless CSA Clients by Ethnicity



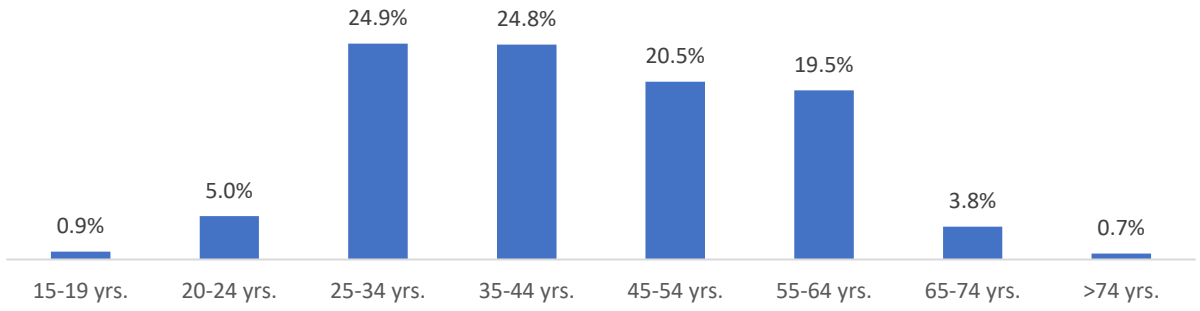
Source: SEFBHN Client Data

Figure 85: SEFBHN Homeless Clients by Age Range



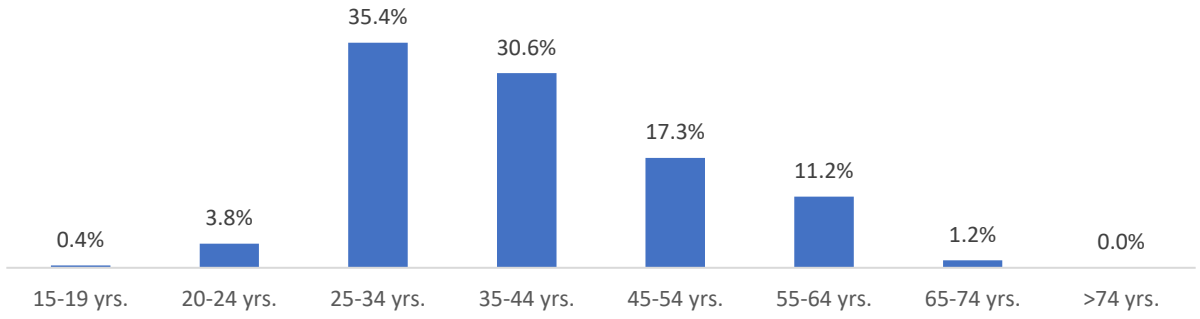
Source: SEFBHN Client Data

Figure 86: SEFBHN Homeless AMH Clients by Age Range



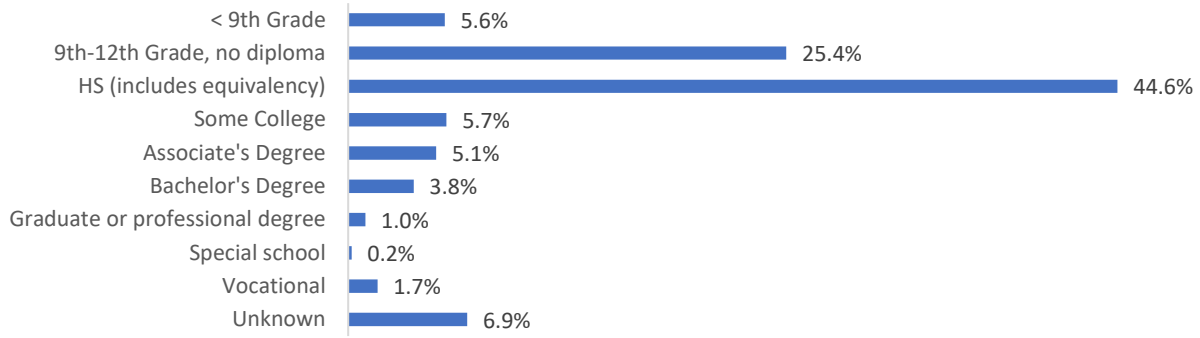
Source: SEFBHN Client Data

Figure 87: SEFBHN Homeless ASA Clients by Age Range



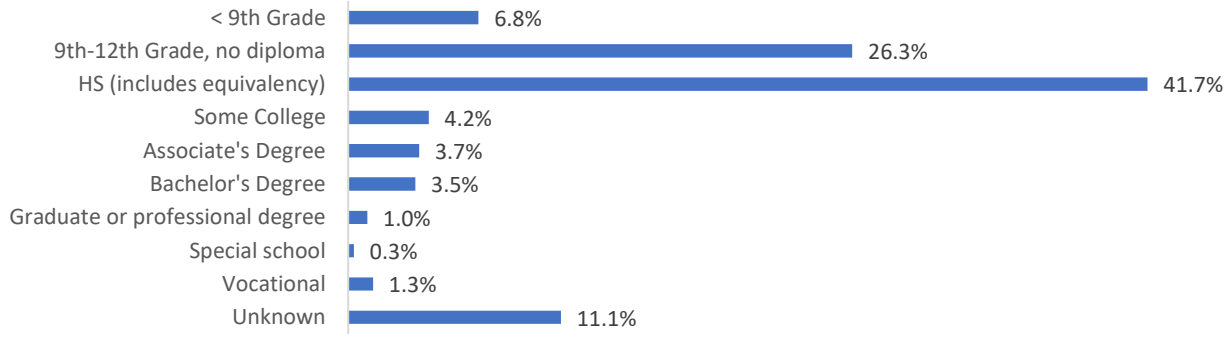
Source: SEFBHN Client Data

Figure 88: SEFBHN Homeless Clients by Educational Attainment



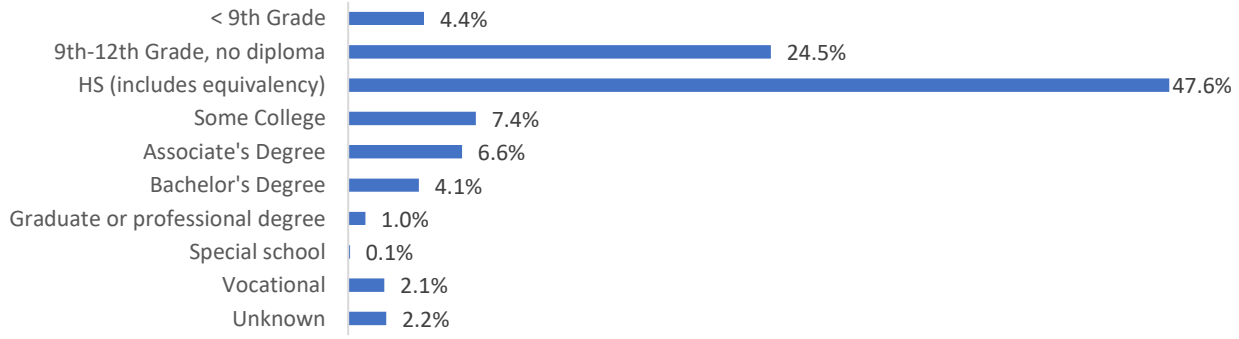
Source: SEFBHN Client Data

Figure 89: SEFBHN Homeless AMH Clients by Educational Attainment



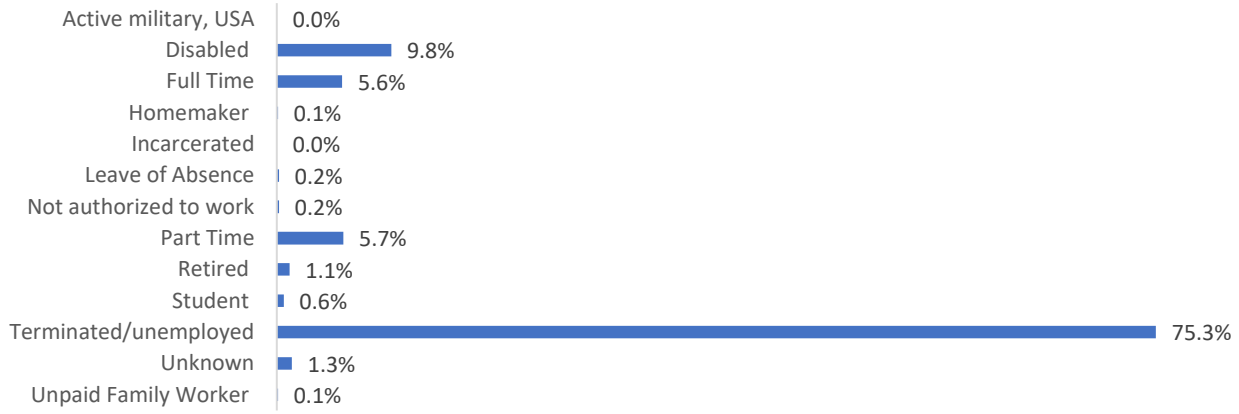
Source: SEFBHN Client Data

Figure 90: SEFBHN Homeless ASA Clients by Educational Attainment



Source: SEFBHN Client Data

Figure 91: SEFBHN Homeless Clients by Employment Status



Source: SEFBHN Client Data

COST CENTER DESCRIPTION, EXPENDITURES, AND OVER/UNDER PRODUCTION (FY20-21)

ADULT MENTAL HEALTH PROGRAM

Cost Center Description	Expenditures	Over/Under Production
Aftercare - Individual	$0.00	$0.00
Assessment	$279,865.29	$0.27
Care Coordination	$400,000.92	$0.00
Case Management	$1,998,076.46	$7,650.56
Comprehensive Community Service Team - Group	$338,770.80	$0.00
Comprehensive Community Service Team - Individual	$352,103.75	$0.00
Crisis Stabilization	$6,980,476.63	$209.24
Crisis Support/Emergency	$2,649,979.54	$3,173.53
Day Treatment	$192,903.61	$0.00
Drop-In/Self-Help Centers	$573,314.90	$0.00
FACT Team	$3,330,250.22	$92,678.52
First Episode Team	$750,000.00	$56,328.46
Incidental Expenses	$3,124,845.56	$79,105.78
Information and Referral	$35,622.56	$0.00
In-Home and On-Site	$12,105.63	$0.00
Intensive Case Management	$703,012.58	$10,883.37
Intervention - Individual	$14,033.70	$0.00
Medical Services	$1,730,710.79	$0.00
Mental Health Clubhouse Services	$51,350.25	$0.00
Outpatient - Group	$412,869.00	$0.00
Outpatient - Individual	$1,293,700.37	$2.24
Outreach	$548,968.35	$27,925.61
Recovery Support - Group	$48,569.34	$0.00
Recovery Support - Individual	$112,621.14	$3,121.77
Residential Level I	$1,315,010.84	$0.00
Residential Level II	$338,655.66	$0.00
Residential Level IV	$483,320.14	$5,143.84
Room and Board with Supervision Level II	$760,585.44	$0.00
Room and Board with Supervision Level III	$1,320.00	$0.00
Start-Up Cost Reimbursement	$23,639.90	$0.00
Supported Housing/Living	$641,846.50	$2.06
Supportive Employment	$218,707.72	$167.67
Sustainability Payment for COVID related funds/services	$415,029.31	$0.00
TOTAL	**$30,132,266.90**	**$286,392.92**

Source: SEFBHN Program Data

ADULT SUBSTANCE ABUSE PROGRAM

Cost Center Description	Expenditures	Over/Under Production
Aftercare - Group	$0.00	$0.00
Aftercare - Individual	$33,977.51	$0.00
Assessment	$256,219.17	$10,163.98
Care Coordination	$123,810.96	$0.00
Case Management	$491,355.72	$1,618.16
Crisis Support/Emergency	$1,391,664.31	$308,229.29
Day Treatment	$1,211,429.98	$55.38
Federal Project Grant	$473,930.27	$6,389.15
FIT Team	$1,200,000.00	$0.00
Incidental Expenses	$499,420.38	$1,945.72
Indicated Prevention	$0.00	$0.00
Information and Referral	$134,266.56	$0.00
In-Home and On-Site	$36,278.76	$2,376.12
Intervention - Group	$0.00	$0.00
Intervention - Individual	$554,527.50	$13,081.96
Medical Services	$1,456,774.43	$6,516.77
Medication Assisted Treatment	$1,551,293.85	$0.00
Outpatient - Group	$556,721.73	$22,968.64
Outpatient - Individual	$1,395,634.28	$29,599.56
Outreach	$727,011.31	$16.31
Recovery Support - Group	$145,783.21	$0.00
Recovery Support - Individual	$755,914.55	$72.00
Residential Level II	$3,539,557.43	$212,630.57
Residential Level IV	$388,202.15	$0.00
Room and Board with Supervision Level II	$129,126.32	$19,857.68
Room and Board with Supervision Level III	$447,979.07	$27.99
Substance Abuse Inpatient Detoxification	$2,997,516.95	$151,833.05
Supported Housing/Living	$12,572.38	$0.00
Supportive Employment	$14,600.32	$0.00
Sustainability Payment for COVID related funds/services	$1,288,355.05	$8,059.21
Treatment Alternative for Safer Community	$24,874.63	$1,169.37
Universal Direct Prevention	$32,446.30	$0.00
Universal Indirect Prevention	$6,156.27	$0.00
TOTAL	**$21,877,401.35**	**$796,610.91**

Source: SEFBHN Program Data

CHILD MENTAL HEALTH PROGRAM

Cost Center Description	Expenditures	Over/Under Production
Assessment	$14,177.11	$0.17
BNET	$364,116.72	$26,089.36
Care Coordination	$80,000.00	$0.00
Case Management	$329,673.07	$0.58
CAT Team	$1,600,000.00	$0.00
Comprehensive Community Service Team - Individual	$0.00	$0.00
Crisis Stabilization	$458,584.84	$52.26
Crisis Support/Emergency	$697,394.91	$0.00
Day Treatment	$0.00	$0.00
Incidental Expenses	$49,146.69	$0.31
Information and Referral	$35,622.45	$0.11
In-Home and On-Site	$63,507.20	$0.00
Intensive Case Management	$322,273.10	$0.00
Intervention - Individual	$145,176.44	$0.00
Medical Services	$107,279.80	$0.00
Outpatient - Group	$4,635.99	$0.00
Outpatient - Individual	$596,545.26	$2.17
Outreach	$172,348.88	$1.14
Recovery Support - Individual	$0.00	$0.00
Residential Level I	$252,152.88	$956.08
Residential Level II	$36,809.08	$0.00
Residential Level IV	$0.00	$0.00
Respite Services	$135,988.00	$0.00
Room and Board with Supervision Level II	$3,768.00	$0.00
Substance Abuse Outpatient Detoxification	$0.00	$0.00
Supported Housing/Living	$28.75	$0.00
Sustainability Payment for COVID related funds/services	$62,026.11	$0.00
Universal Direct Prevention	$51,008.91	$0.00
Universal Indirect Prevention	$250,000.00	$0.00
TOTAL	**$5,832,264.19**	**$27,102.18**

Source: SEFBHN Program Data

CHILD SUBSTANCE ABUSE PROGRAM

Cost Center Description	Expenditures	Over/Under Production
Assessment	$0.00	$0.00
Case Management	$0.00	$0.00
Crisis Support/Emergency	$234.50	$98.00
Day Treatment	$0.00	$0.00
Incidental Expenses	$253,252.79	$402.22
Indicated Prevention	$171,250.85	$22,310.90
Information and Referral	$109,266.40	$0.19
In-Home and On-Site	$489,959.60	$29,506.49
Intervention - Individual	$36,339.09	$0.00
Medical Services	$4,293.00	$0.00
Medication Assisted Treatment	$0.00	$0.00
Outpatient - Group	$0.00	$0.00
Outpatient - Individual	$226,561.06	$17,229.29
Outreach	$828,998.53	$27,588.61
Recovery Support - Group	$0.00	$0.00
Recovery Support - Individual	$0.00	$0.00
Residential Level II	$1,164,480.00	$0.00
Sustainability Payment for COVID related funds/services	$884,695.98	$0.00
Treatment Alternative for Safer Community	$360,163.28	$20,845.25
Universal Direct Prevention	$2,742,252.47	$398,645.44
Universal Indirect Prevention	$522,828.12	$6,646.48
TOTAL	**$7,794,575.67**	**$523,272.87**

Source: SEFBHN Program Data

SEFBHN All Cost Centers	Expenditures	Over/Under Production
Grand Total	$65,636,508.11	$1,633,378.88

CULTURAL HEALTH DISPARITY SURVEY SUMMARY

1. Are you usually comfortable seeking behavioral health care services?

Overall, 75.8% of survey respondents stated that they were usually comfortable seeking behavioral health care services. Less than one-quarter of respondents reported that they were not comfortable seeking these services (23.3%).

When looking at respondents' comfort in seeking behavioral health care services by race, it is significant to note that nearly half of all Black respondents indicated that they were not comfortable seeking behavioral health care services (47.6%), compared to about one-quarter (24.2%) of White respondents. Additionally, when looking at comfort by gender identity, it is important to note that 75% of respondents who identified as bigender did not feel comfortable seeking behavioral health care services, compared to 19.4% of those who identified as cisgender.

An individual's community is also important to assess to consider areas with higher behavioral health service needs. When looking at where respondents reside, the ZIP Codes where most individuals who indicated that they did not feel generally comfortable with seeking behavioral health services live included 33430 – Belle Glade (13.5%), 32967 – Vero Beach (9.6%), 34950 – Fort Pierce (9.6%), 34956 - Indiantown (7.7%), and 33404 – Riviera Beach (5.8%).

2. On a scale of 1 to 5, with 5 being 'strongly agree', how would you rate your trust in the behavioral health care system to treat you with respect?

When reporting their level of trust in the behavioral health care system to treat them with respect, a majority of survey respondents felt as though they "trust" (34.7%), or "strongly trust" (27.5%) the system to treat them with respect. It is important to note, however, that 10.4% of respondents felt "distrust", and 8.6% of respondents felt "strong distrust."

It is significant to note that among Black respondents, 22.6% felt "distrust" or "strong distrust" in the behavioral health care system to treat them with respect. A similar sentiment was shared among White respondents, with 21.1% of White respondents stating that they felt "distrust" or "strong distrust" in the behavioral health care system to treat them with respect.

When looking at where respondents live, the ZIP Codes where most individuals who indicated they "distrust" or "strongly distrust" the behavioral health care system to treat them with respect reside included 33430 – Belle Glade (11.9%), 34950 – Fort Pierce (9.5%), 34956 – Indiantown (7.1%), and 33458 – Jupiter (7.1%).

3. Please rank the statements below that most closely describe your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least.

When describing their feelings regarding their behavioral health, 58.3% of participants felt that behavioral health is a private issue that they would keep to themselves (marked survey responses as "most how I feel" and "somewhat how I feel"). Importantly, 66.1% of Black respondents stated

that they felt behavioral health is a private issue that they would keep to themselves, compared to 54.4% of White respondents.

Furthermore, 53.8% of participants felt that behavioral health issues are private issues that should stay in the family (marked survey response as "most how I feel" and "somewhat how I feel"). The percentage among Black respondents was greater, with 61.3% of Black respondents stating that behavioral health issues are private issues that should stay in the family, compared to 50% of White respondents.

Survey respondents reported mixed feelings related to their comfort in sharing challenges with others, such as professionals, family members, friends, or clergy members. Among those surveyed, 48.9% described feeling comfortable sharing their challenges with others as "most how [they] feel" or "somewhat how [they] feel," compared to 51.4% who described this as "somewhat unlike how [they] feel" or "most unlike how [they] feel."

The largest difference in reported feelings was seen when participants were asked to describe how they felt about the statement, "I am more comfortable with people like me." Among respondents, 63.2% felt that was "most how [they] feel" or "somewhat how [they] feel" compared to 37.2% of participants who felt that was "somewhat unlike how [they] feel" or "most unlike how [they] feel." A similar proportion was seen among racial demographics, with 62.9% of Black respondents who felt more comfortable with people like themselves (marked survey response as "most how I feel" and "somewhat how I feel") compared to 65.8% of White respondents.

4. In which setting(s) have you been the most comfortable discussing your behavioral health concerns? (Check all that apply)

Participants shared a variety of settings in which they are most comfortable discussing their behavioral health concerns. Participants indicated that the settings they felt most comfortable in included: a private office with a doctor (27.2%), a hybrid of telehealth (including some face to face and some telehealth) (15.3%), telehealth (talking to a health care provider over the phone or computer) (12.8%), faith-based organizations (12.8%), and speaking with a nurse practitioner (12.3%). Other responses included family, friends, clinical supports, support groups, case workers, and more.

Among the participants who indicated that they felt most comfortable discussing behavioral health concerns in a faith-based organization setting, the majority were Black (52.9%). Additionally, the ZIP Codes where the majority of these individuals lived included: 32960 – Vero Beach, 33404 – Riviera Beach, 33415 – West Palm Beach, and 33430 – Belle Glade (each 11.8%).

5. When receiving behavioral health care services, would you be more comfortable going to a faith-based organization OR prefer a traditional doctor's office?

When asked if they would prefer to receive behavioral health care services in a faith-based organization or a traditional doctor's office, 35.4% of respondents indicated they would prefer faith-based behavioral health care services, while 64.1% preferred a traditional physician's office.

It is significant to note that among Black respondents, over half (56.5%) stated they would prefer faith-based behavioral health care services compared to a traditional doctor's office setting. Among White respondents, less than a quarter (23.7%) would prefer faith-based services compared to a traditional doctor's office setting. Faith-based services were also preferred by half of all Cuban and Haitian respondents, and by three-quarters of all Puerto Rican respondents. Among those who preferred faith-based services, the most commonly reported ZIP Codes of residence included 33430 – Belle Glade (13.9%), 34956 – Indiantown (8.9%), 32960 – Vero Beach (7.6%), and 34950 – Fort Pierce (6.3%).

6. Thinking about treatment options, on a scale of 1 to 5, with 5 being very likely, how comfortable would you be in group therapy?

Overall, a total of 32.7% of participants reporting being "likely" (16.1%) or "very likely" (16.6%) to be comfortable using group therapy as a treatment option. Alternatively, 37.2% of participants were "unlikely" (17%) or "very unlikely" (20.2%) to use this method of treatment. Over a quarter of respondents were neutral in their comfort level with using group therapy as a treatment option (29.6%).

It is significant to note that among Black respondents, less than one-quarter (24.2%) felt "likely" or "very likely" to be comfortable in group therapy, compared to 35.1% of White respondents. Additionally, among those who were "unlikely" or "very unlikely" to be comfortable in group therapy, the most commonly reported ZIP Codes of residence were 33430 – Belle Glade (10.8%), 32967 – Vero Beach (6%), and 34950 – Fort Pierce (6%).

7. On a scale of 1 to 5, with 5 being very likely, how comfortable would you be in individual therapy?

A majority (68.5%) of respondents reported feeling "very likely" (43.7%) or "likely" (24.8%) to be comfortable in individual therapy. Alternatively, 14% of respondents felt "very unlikely" (5.9%) or "unlikely" (8.1%) to be comfortable in individual therapy. Less than a quarter of respondents felt neutral towards using individual therapy (17.6%).

It is significant to note that among Black respondents, 59.7% were "likely" or "very likely" to be comfortable in individual therapy, compared to 74.6% of White respondents. Additionally, among those who were "unlikely" or "very unlikely" to be comfortable in individual therapy, the most commonly reported ZIP Codes of residence were 33430 – Belle Glade (16.1%) and 34950 – Fort Pierce (12.9%).

8. When you have received behavioral health care services in the past, were they mostly available in your primary language?

Among respondents, 2.7% found that behavioral health care services were never available in their primary language, requiring them to use an interpreter to receive services. Additionally, 14.3% reported that services were available "some of the time" (8.5%) or "a little of the time" (5.8%) in

their primary language. However, 82.5% of respondents indicated that services were available in their primary language "all of the time" (72.6%) or "most of the time" (9.9%).

It is significant to note that among respondents who identified as Mexican, 50% reported that behavioral health care services were only available in their primary language "some of the time." Additionally, among the respondents who indicated that these services were only available in their primary language "some of the time," the most commonly reported ZIP Codes of residence included 34981 – Fort Pierce (15.8%), 33407 – West Palm Beach (10.5%), and 34956 – Indiantown (10.5%).

9. Which best describes your gender?

Among survey respondents, 55.4% reported their gender as female, 41.4% reported their gender as male, and 3.2% indicated a preference not to answer the question.

10. Which best describes your gender identity?

Among survey respondents, 46.6% preferred not to answer this question. However, over one-quarter of participants identified as cisgender (27.8%) and one quarter of participants identified as non-binary (24.9%). Among those who identified as non-binary, 11.7% identified as gender fluid, 5.8% identified as gender non-conforming or gender variant, 1.8% identified as bigender, 0.4% identified as a third sex, 0.4% identified as genderqueer/non-binary, 2.2% identified as agender, 2.2% identified as transgender, and 0.4% identified as intersex.

11. Which best describes your current sexual orientation? (Check all that apply)

Nearly one-quarter (24.8%) of participants preferred not to answer this question. However, approximately half of the survey respondents identified as Heterosexual/Straight (50.4%). Other respondents identified as Bisexual (10.6%), Asexual (5.3%), Gay/Lesbian (3.1%), Pansexual (1.3%), and Questioning (2.2%). Additionally, 2.2% of participants stated that their sexual orientation was not listed as an option.

12. Which best describes your race?

Over half of the survey respondents identified as White (51.4%), and over one-quarter identified as Black (27.9%), while 6.3% identified as multi-racial and 5% identified as "other." Very few respondents identified as American Indian (0.5%), Asian (0.9%), and Native Hawaiian or Pacific Islander (0.5%). No respondents identified as "Alaskan Native" and 7.7% of respondents preferred not to answer.

13. Which best describes your ethnicity?

A majority of participants (61%) did not identify as Cuban, Haitian, Mexican, Mexican American, Puerto Rican, Spanish/Latino, or "other Hispanic" when defining their ethnicity. Among survey respondents, 9.9% identified as Haitian, 3.6% identified as Cuban, 1.8% identified as Mexican, 4.9%

identified as Mexican American, 1.8% identified as Puerto Rican, 4.9% identified as Spanish/Latino, and 11.7% identified as "Other Hispanic."

14. Please select your age range from the list below.

Approximately two-thirds of the survey respondents (75.8%) were between the ages of 25 years old and 74 years old. The largest percentage of respondents were aged 25-35 years old (20.6%), followed by those aged 45-54 years (17.9%), 35-44 years (16.6%), 55-64 years (14.3%), 15-19 years (13.9%), 65-74 years (6.3%), 20-24 years (4.9%), and over 74 years (1.3%). A small number of participants indicated that they preferred not to answer this question (3.6%).

CULTURAL HEALTH DISPARITY SURVEY CHARTS

Figure 92: Are you usually comfortable seeking behavioral health services?

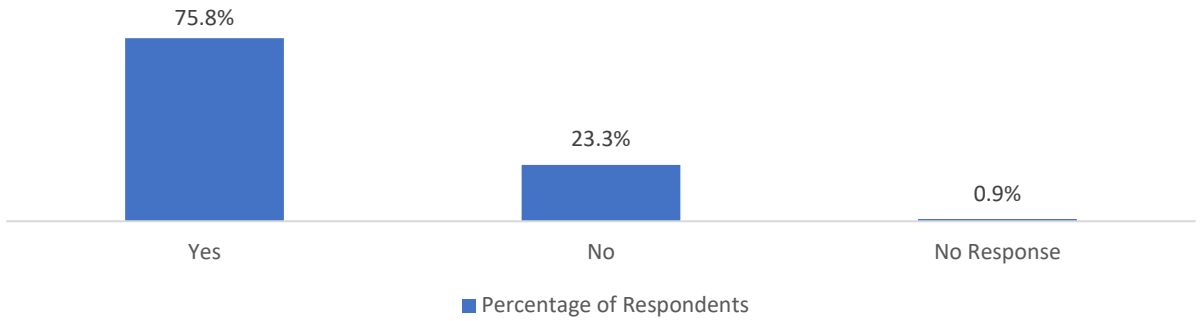


Figure 93: On a scale of 1 to 5, with 5 being 'strongly agree', how would you rate your trust in the behavioral health care system to treat you with respect?

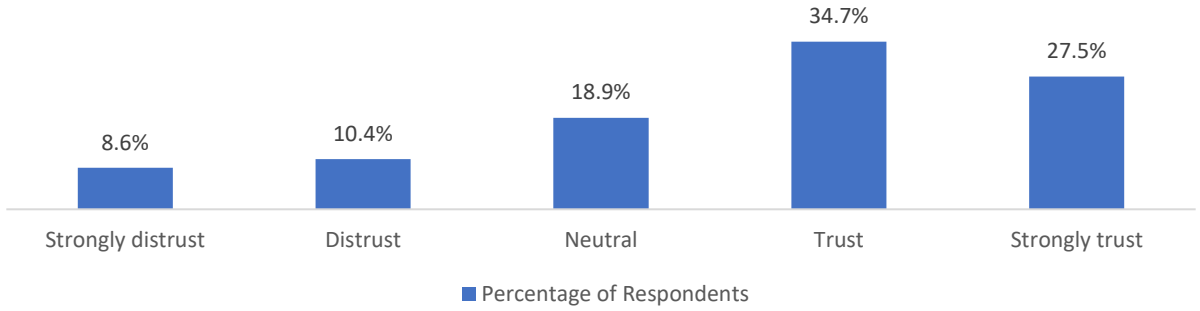


Figure 94: Please rank the statement below that most closely describe your feelings regarding your behavioral health issue, with (1) being the most and (5) being the least. "This is a private issue I keep to myself."

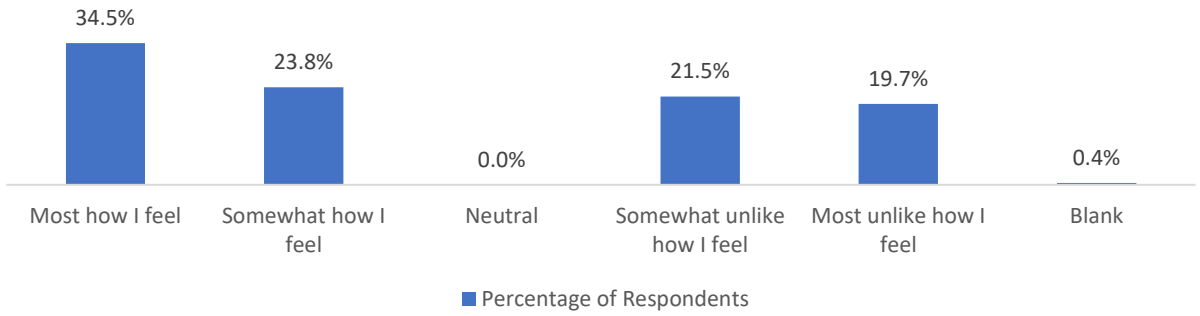


Figure 95: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. "This is a private issue that stays in the family."

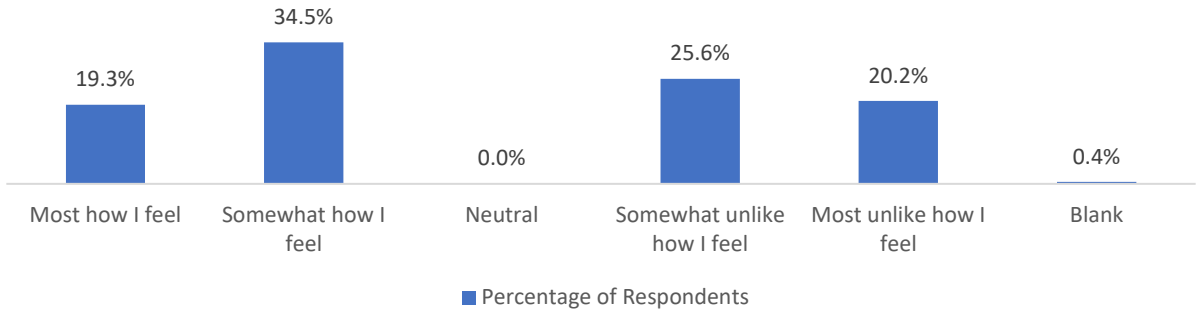


Figure 96: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. "I am comfortable sharing my challenges with others."

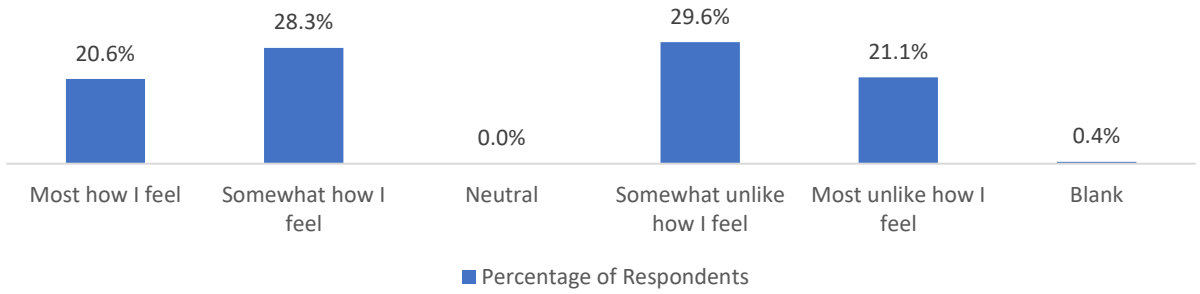


Figure 97: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. "I am more comfortable with people like me."

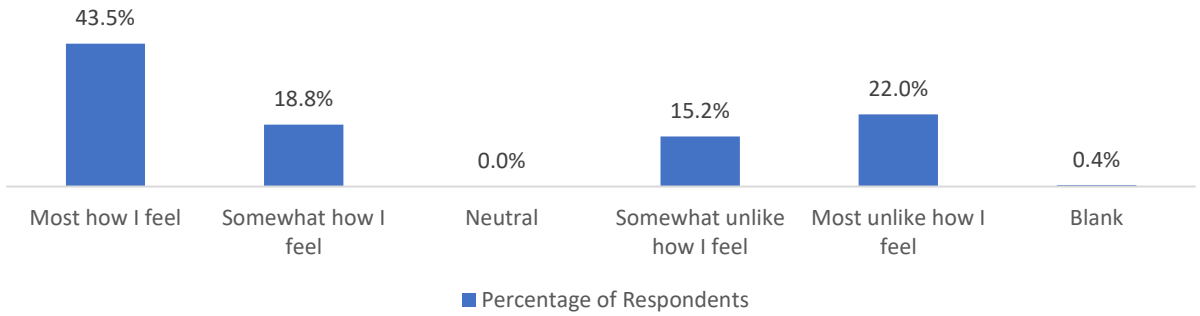


Figure 98: In which setting(s) have you been most comfortable discussing your behavioral health concerns? (Check all that apply)

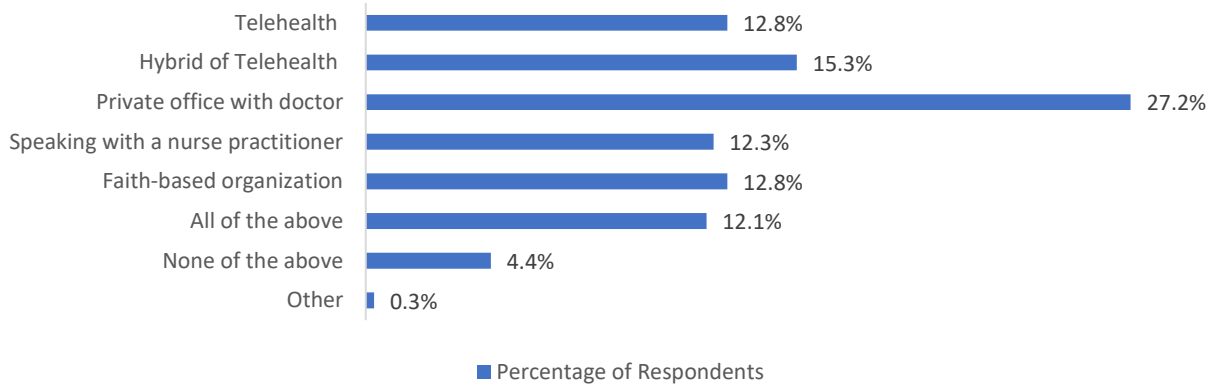


Figure 99: If given a choice for receiving behavioral health care services, would you be more comfortable going to a faith-based organization OR prefer the traditional physician office?

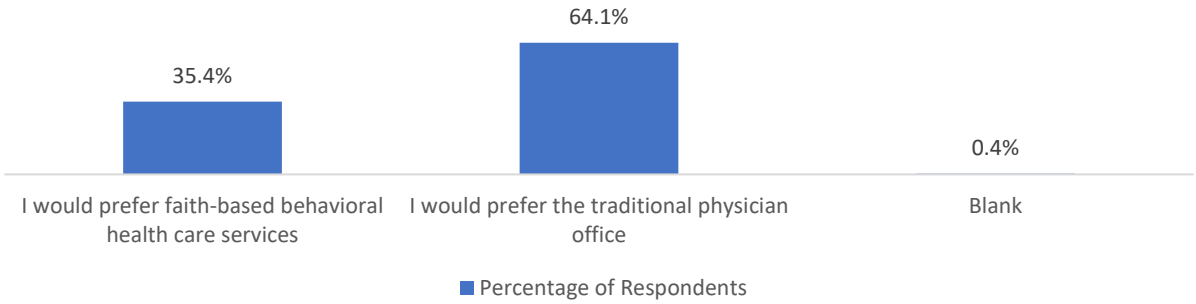


Figure 100: Now thinking about treatment options, on a scale of 1 to 5, with 5 being 'very likely', how comfortable would you be in group therapy?

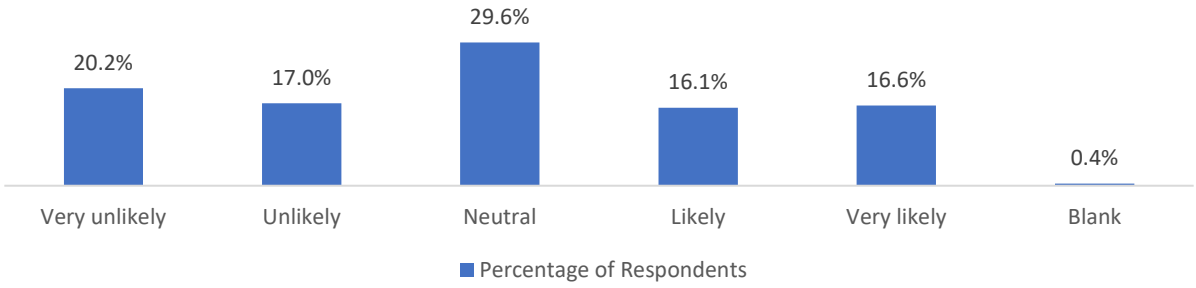


Figure 101: On a scale of 1 to 5, with 5 being 'very likely', how comfortable would you be in individual therapy?

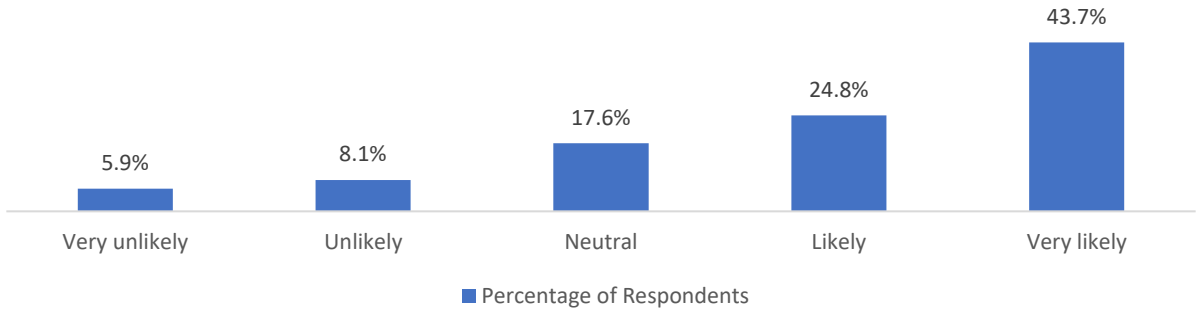


Figure 102: When you have received behavioral health care services in the past, were they mostly available in your primary language?

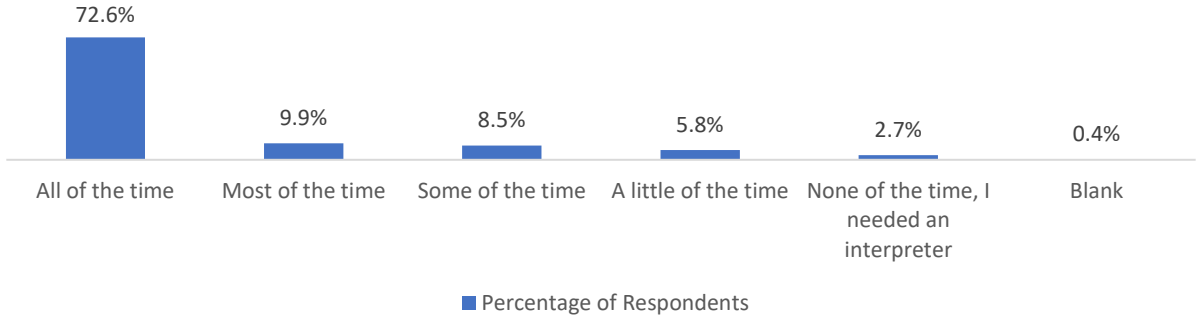


Figure 103: Which best describes your gender?

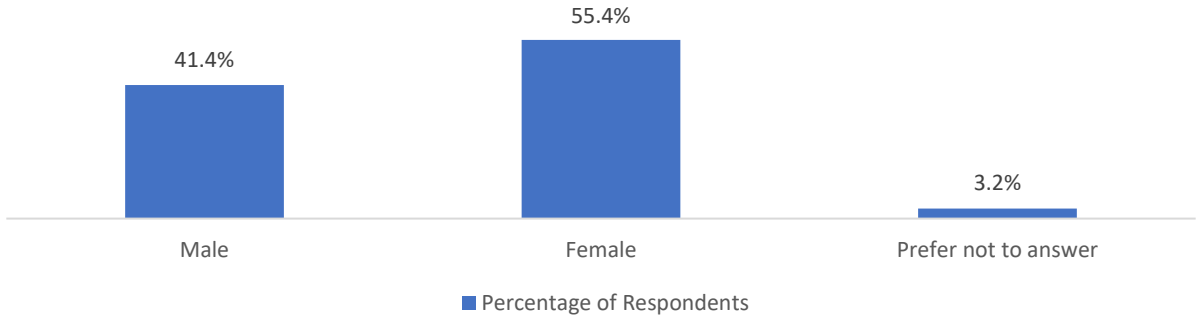


Figure 104: Which best describes your gender identity?

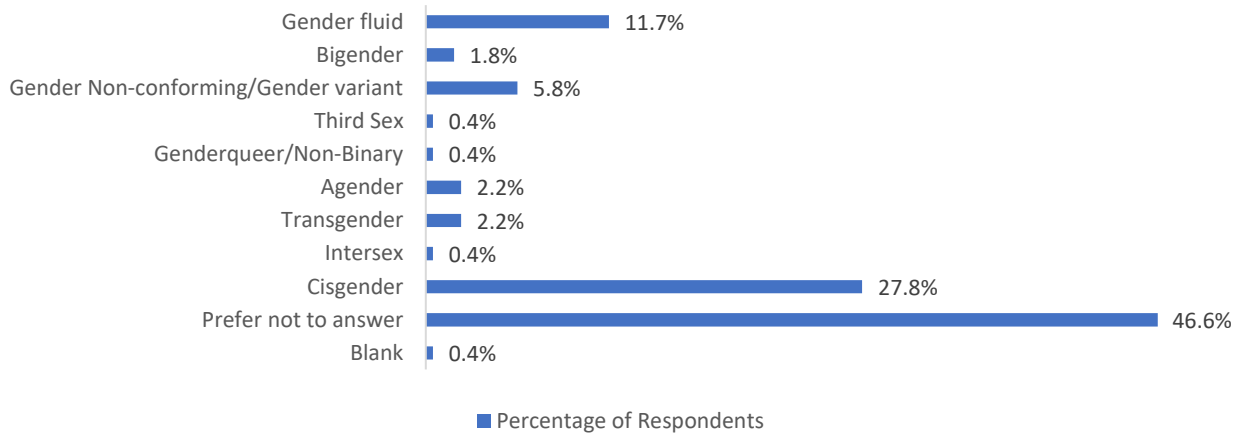


Figure 105: Which best describes your current sexual orientation? (Check all that apply)

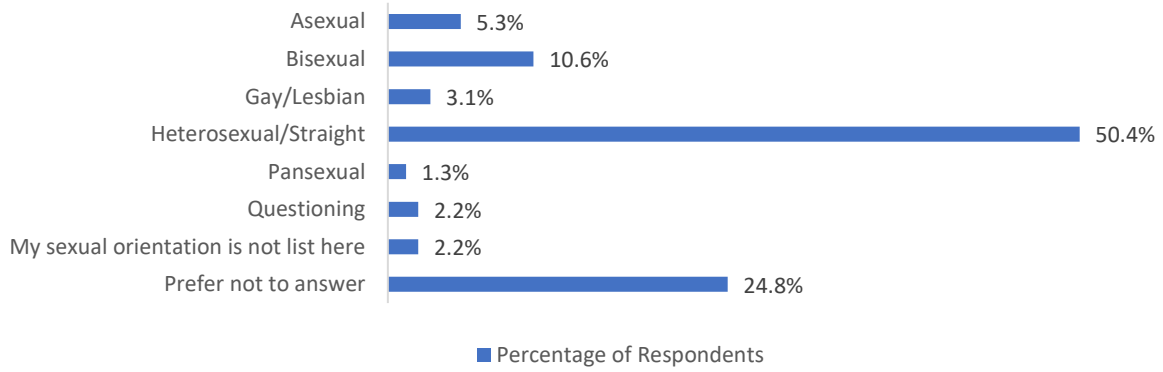


Figure 106: Which best describes your race?

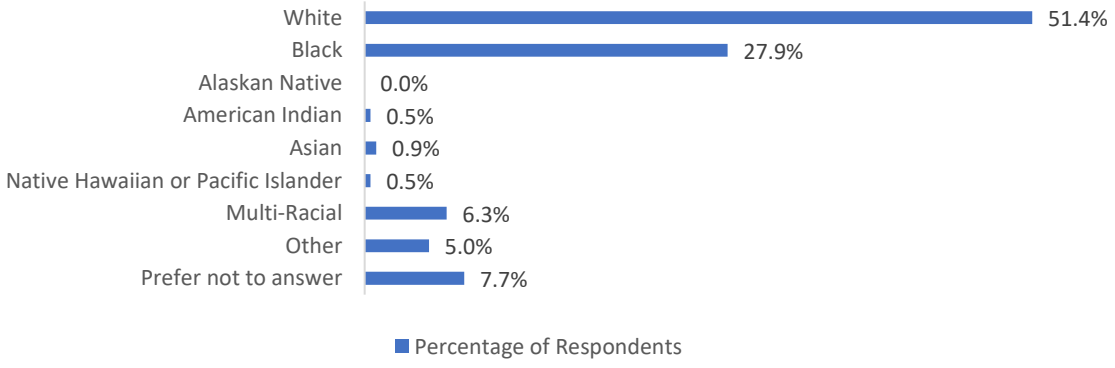


Figure 107: Which best describes your ethnicity?

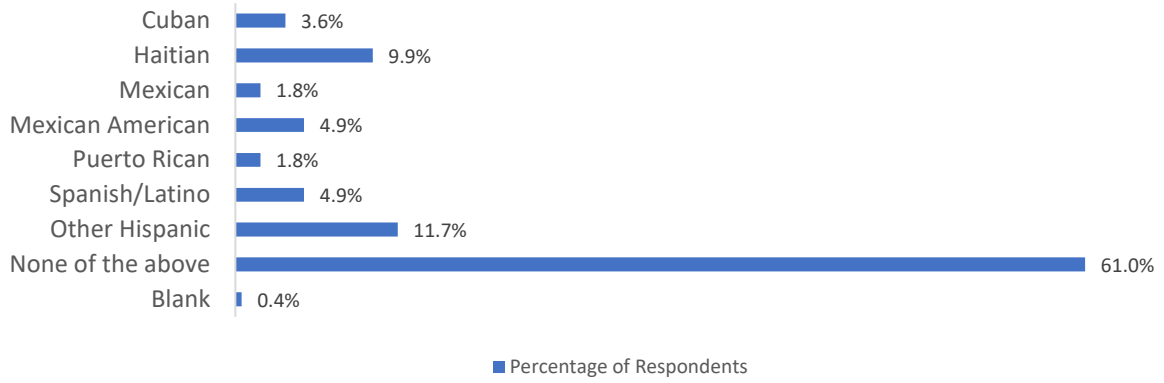
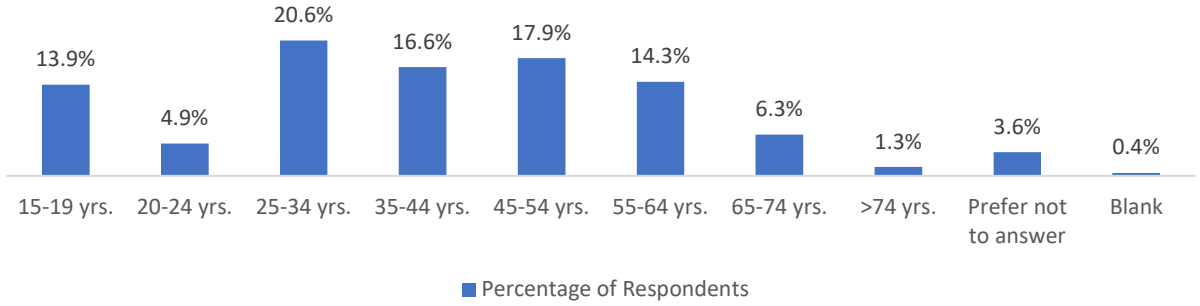


Figure 108: Please select your age range from the list below.



CULTURAL HEALTH DISPARITY SURVEY BY RACE AND ETHNICITY

The cultural health disparity survey was analyzed by race and ethnicity to further measure experience, awareness, and coordination of behavioral health services. The seven counties represented were, Broward, Glades, Indian River, Martin, Okeechobee, Palm Beach and St. Lucie. Survey collection started on January 12, 2022 and was completed on February 18, 2022. The results of the cross tabulations will help to facilitate focused strategic development and intervention implementation over the next three years. Being aware of an individual's comfort level in various behavioral health care settings will enable providers to tailor services that best meet the social, cultural, and linguistic needs of those served. The analysis below serves as the foundation for identifying disparity and opportunities for network improvement.

Respondents were asked if they were comfortable seeking behavioral health care services. Among Black respondents, 67.7% were comfortable while 32.3% were not. Among Hispanic and White respondents, the percentages of those comfortable seeking care were higher at 76.7% and 80.5%, respectively.

When asked if they trust the behavioral health care system to treat them with respect, 59.7% of Black and 59.6% of White respondents, trust or strongly trust to be treated with respect. Trust was slightly higher among Hispanic respondents at 64%. About 20% of respondents from all population groups distrust or strongly distrust the system to treat them with respect. This is an opportunity for improvement for Network Service Providers (NSP).

Respondents were asked to describe their feelings regarding their behavioral health issues. When asked, if this was a private issue I keep to myself, higher percentages of Black (66.1%) and Hispanic (62.8%) respondents indicated that this is most or somewhat how I feel. White respondents were split on behavioral health issues being a private matter I keep to myself as 54.4% indicated this was somewhat or most how I feel and 45.6% said this is somewhat unlike or most unlike how I feel. This may explain why some individuals are hesitant to access behavioral health care services when they need them.

Regarding their behavioral health issues as a private matter that stays in the family, 61.3% of Black respondents indicated this was somewhat or most how I feel. Among Hispanic and White respondents, close to fifty percent indicated this is somewhat or most how I feel while the remaining 50% said this is somewhat unlike or most unlike how I feel.

Regarding comfort sharing their challenges with others, Black and Hispanic respondents were almost evenly split on their comfort level. Half of respondents indicated this is most or somewhat how they feel, and half indicated this is somewhat unlike or most unlike how they feel. Among White respondents, 41.9% indicated this was most or somewhat how I feel while 58.1% said this was somewhat unlike or most unlike how I feel. Providers should continue to be sensitive to the individual's comfort level when asked to share their challenges.

When asked if they were more comfortable with people like them, most respondents indicated this was most or somewhat how I feel for 62.9% of Black, 55.8% of Hispanic, and 65.8% of White respondents.

The most comfortable settings for discussing their behavioral health issues for Black respondents was in a faith-based organization at 22.5% and private office with a doctor at 21.6%. A hybrid of telehealth, (defined as including some face to face and some telehealth) at 13.7%, was preferred over telehealth (11.8%) for Black respondents. Speaking with a nurse practitioner accounted for 10.8% of Black respondents. Among Hispanic respondents, 31.4% preferred a private office with a doctor and 20.4% preferred a faith-based organization. Telehealth (19.7%) was preferred over a hybrid of telehealth at 18.2%. White respondents also preferred a private office with a doctor at 30.4%. A hybrid of telehealth, at 16.7%, was preferred over telehealth at 12.7%. Only 8.8% of White respondents selected a faith-based organization for receiving behavioral health services.

Faith based health care services were preferred over a traditional physician office by more than half of Black and Hispanic respondents, while three-quarters of White respondents indicated a preference for traditional physician office.

Among Black respondents, 50% were very unlikely or unlikely to be comfortable in group therapy while 41.9% of Hispanic respondents felt the same way. White respondents were split as 31.6% were very unlikely or unlikely to be comfortable in group therapy, 33.3% were neutral, and 35.1% were likely or very likely to be comfortable. When asked about their comfort in individual therapy, 59.7% of Black, 68.6% of Hispanic, and 74.6% of White respondents were likely or very likely to be comfortable. When providing services

When asked if the behavioral health services they received in the past were mostly available in their primary language, 80.6% of Black, 74.4% of Hispanic, and 89.5% of White respondents received services in their primary language all or most of the time.

CULTURAL HEALTH DISPARITY SURVEY BY RACE AND ETHNICITY CHARTS

Figure 109: Are you usually comfortable seeking behavioral health care services?

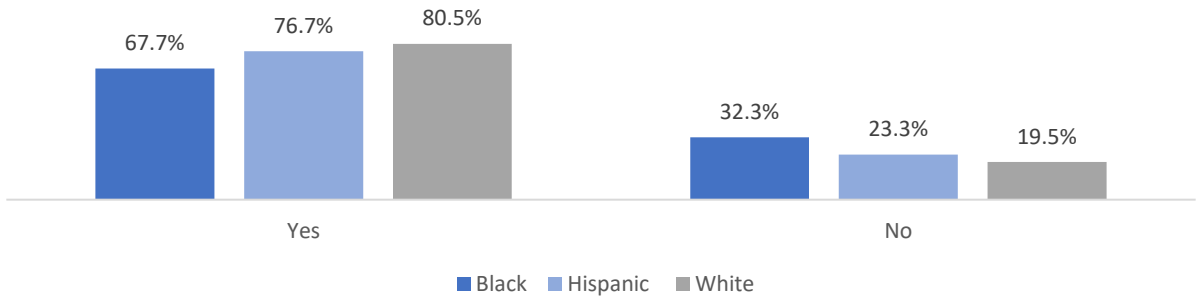


Figure 110: On a scale of 1 to 5, with 5 being 'strongly agree', how would you rate your trust in the behavioral health care system to treat you with respect?

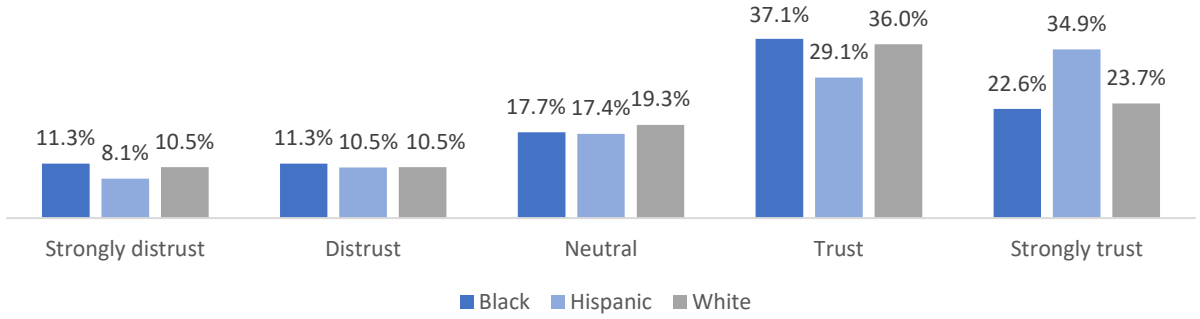


Figure 111: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. This is a private issue I keep to myself.

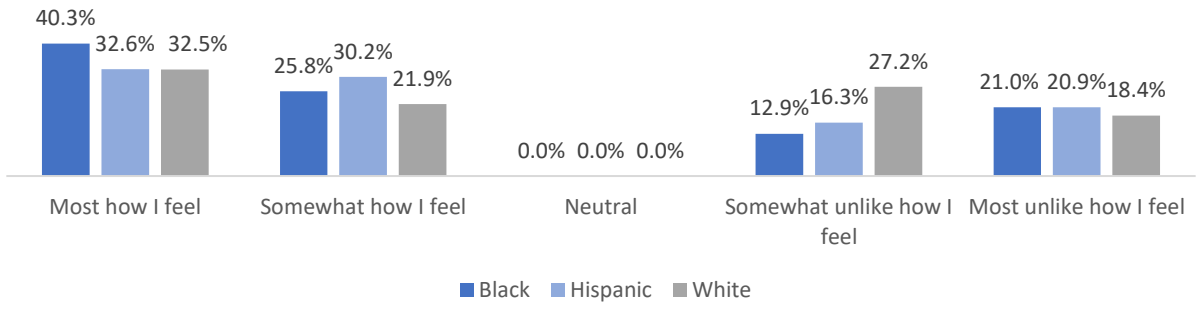


Figure 112: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the most and (5) being the least. This is a private issue that stays in the family.

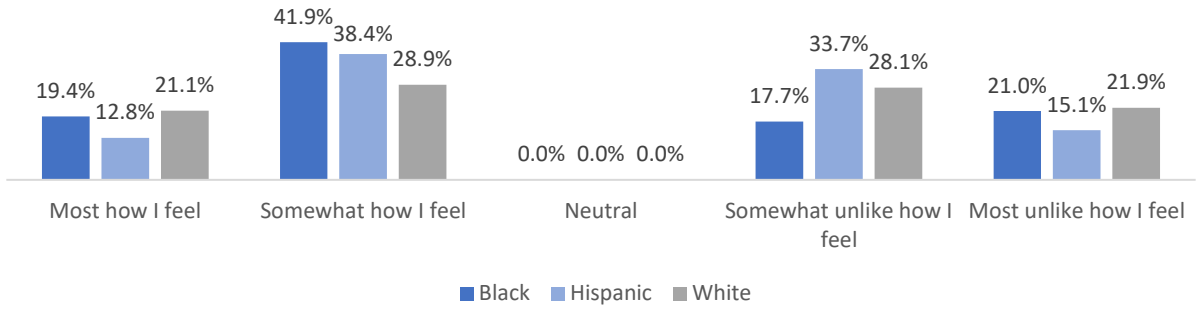


Figure 113: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. I am comfortable sharing my challenges with others.

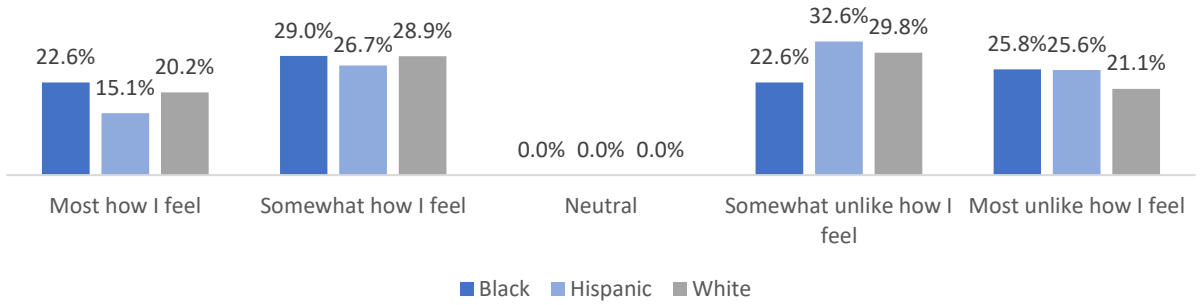


Figure 114: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. I am more comfortable with people like me.

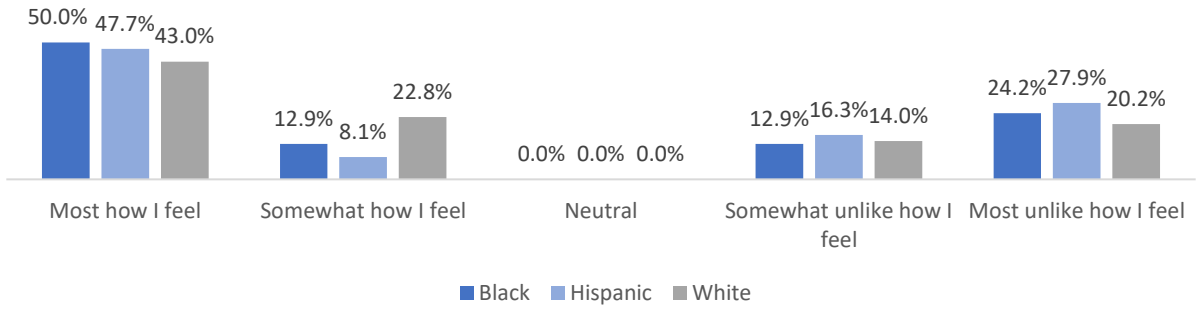


Figure 115: In which setting(s) have you been the most comfortable discussing your behavioral health concerns? (Check all that apply)

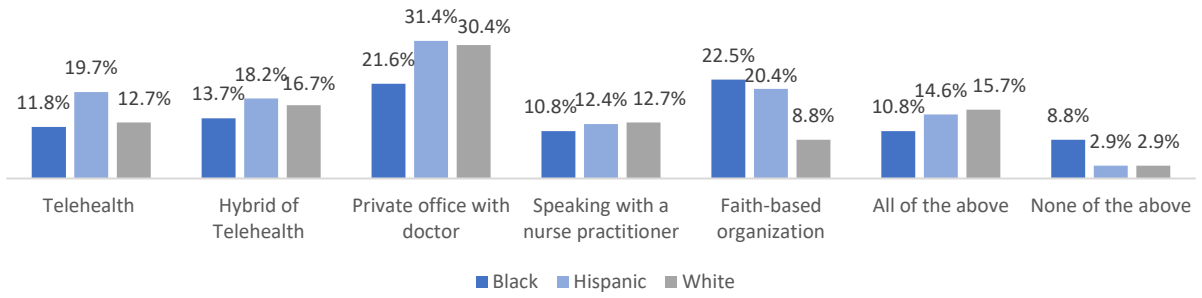


Figure 116: If given a choice for receiving behavioral health care services, would you be more comfortable going to a faith-based organization OR prefer the traditional physician office?

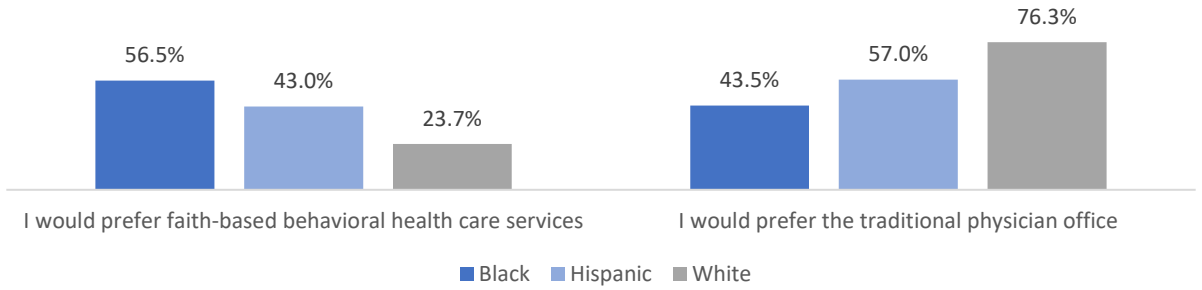


Figure 117: Now thinking about treatment options, on a scale of 1 to 5, with 5 being very likely, how comfortable would you be in group therapy?

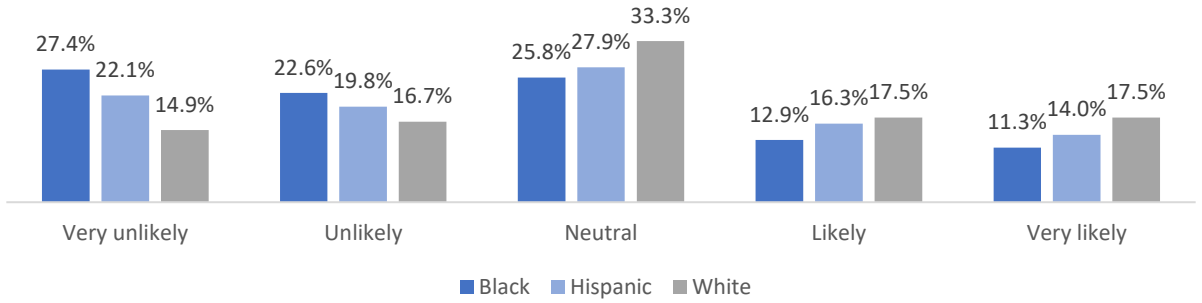


Figure 118: On a scale of 1 to 5, with 5 being very likely, how comfortable would you be in individual therapy?

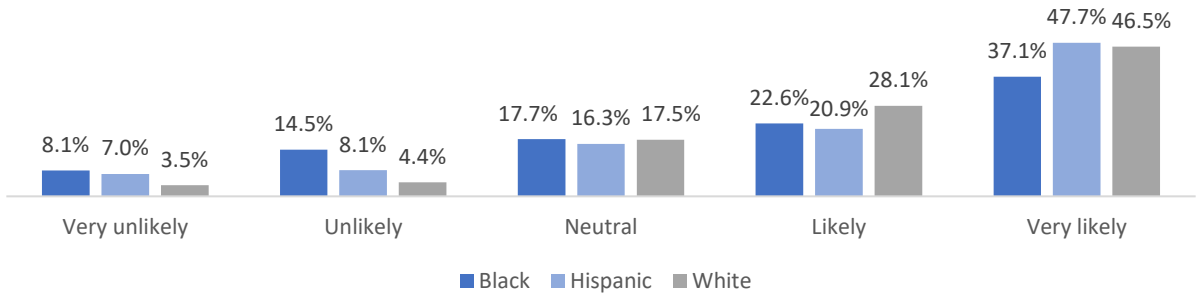
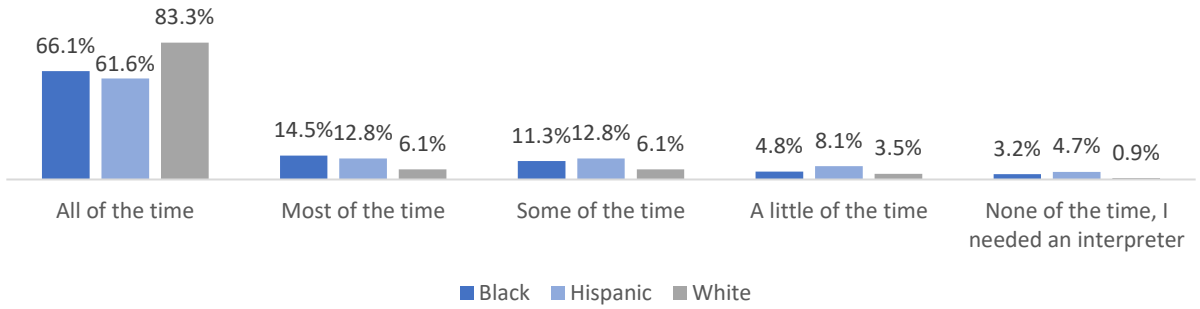


Figure 119: when you have received behavioral health care services in the past, were they mostly available in your primary language?



CULTURAL HEALTH DISPARITY FOCUS GROUP SUMMARY

Focus Group Methodology

The Cultural Health Disparity Focus Groups were conducted with the goal of understanding community experiences related to mental and behavioral health and perspectives on what it is like to access mental and behavioral health services in the SEFBHN service area. The Health Council of Southeast Florida (HCSEF) conducted 21 focus groups with 267 participants via Zoom over the course of six dates, including March 10, 2022, March 14, 2022, March 16, 2022, March 17, 2022, March 22, 2022, and March 31, 2022. The session on March 31, 2022, was facilitated in Spanish.

Focus group recruitment took place through local partnerships and social media outreach. Concerted efforts were made to ensure adequate representation of the 5-county service area, which is comprised of Indian River County, Martin County, Okeechobee County, Palm Beach County, and St. Lucie County. Participants were required to register through the Zoom meeting platform, and quality assurance was completed to ensure participants resided within the SEFBHN service area. HCSEF also conducted additional quality assurance to confirm self-reported demographic details via direct email communication.

Focus Group Participant Demographics

Most focus group participants identified as male (60.7% compared to 39% female). This is higher than the SEFBHN service area's overall demographics, where 48.7% of residents are male and 51.3% are female. However, this was in line with a key focus area, as there was particular interest in exploring what men in the service area need to encourage them to seek mental and behavioral health services.

With respect to county of residence, most participants reported living in Palm Beach County (69.7%), followed by St. Lucie County (12.4%), Indian River County (6.4%), Martin County (6.4%), and Okeechobee County (5.2%). This was representative of the SEFBHN service area population, where 68.4% of the 5-county service area population resided in Palm Beach County in 2020, followed by 14.7% in St. Lucie County, 7.4% in Indian River County, 7.5% in Martin County, and 2% in Okeechobee County.

When looking at the age of participants, there was some diversity, but a large proportion were young adults. A majority were between the ages of 25 to 35 years old (61%), followed by those ages 35 to 44 years old (15.4%), 20 to 24 years old (15%), 45 to 54 years old (5.6%), 55 to 64 years old (1.9%), and, finally, those ages 65 to 74 years old (0.4%). Participants were required to be over the age of 18 years to participate in the focus groups.

In terms of participant race, nearly half of all focus group participants were Black or African American (48.7%), followed by White (34.8%). Other focus group participants reported their race

as “two or more races” (4.9%), American Indian, Alaskan Native, or Indigenous (4.1%), Asian (2.6%), Native Hawaiian or Other Pacific Islander (2.2%), and “other” (2.2%). Representation within the focus groups was much more diverse than the SEFBHN service area, where 17% of residents are Black and 75.7% of residents are White.

When looking at participant ethnicity, most focus group participants were non-Hispanic (85.4%) compared to those identifying as Hispanic or Latino (14.2%). This is similar to the ethnic makeup of the service area, where 79.4% of residents identify as non-Hispanic and 20.6% as Hispanic.

In terms of educational attainment, most participants reported obtaining a bachelor’s degree (57.3%), followed by those with a master’s degree (12.4%), Associate’s Degree (10.1%), some college but no degree (9.7%), Doctorate (6%), High School Diploma or equivalent (2.2%), and less than a high school diploma (1.9%). In the SEFBHN service area, 20.7% of the population has a bachelor’s degree and 88.2% of the population has a High School Diploma, while 6.3% completed some high school but have no diploma, and 5.4% completed less than 9th grade.

Additionally, the majority of participants were employed in some capacity, with over half of all focus group participants employed full time (55.4%), followed by those who are self-employed (19.9%), part-time employed (17.6%), and those who are working two or more jobs (0.4%). Less commonly reported employment statuses included students (3%), homemakers (1.5%), participants who are unemployed and currently looking for work (1.1%), participants who are retired (0.4%), and participants who are unable to work (0.4%).

With respect to insurance status, most participants reported utilizing Medicaid and/or Medicare coverage (74.5%), or private insurance coverage (14.6%), followed by those who did not have health insurance coverage and used cash to pay for health services (9%). Less commonly reported health insurance statuses included Military Care/VA/TRICARE (0.4%) and other, unspecified options (1.1%).

Focus Group Analysis

1. Engagement Question: When you hear the term “behavioral health,” what comes to mind?

Participants associated the term “behavioral health” with drug use, mental health, and the overall influence of behavior on one’s wellbeing. Among those who mentioned mental health, they highlighted key mental health issues, including anxiety, depression, “*dealing with difficult issues*,” mental stability, rational decision making, and self-awareness. Many participants also spoke to holistic wellness when thinking of behavioral health, associating the balance of mind, body, and spirit with the term.

2. Engagement Question: What are the most important behavioral health issues or needs that you see in your community?

Participants expressed several behavioral health issues and areas of need that they saw in their communities. These included substance use and mental health disorders, access to care, and population-specific issues. Emergent themes are described below:

Participants frequently reported substance use and addiction to drugs and alcohol, with prescription pain relievers being commonly mentioned. Many considered substance use issues to be predecessors to additional behavioral health issues, such as depression and anxiety. In line with this, participants mentioned several mental health conditions that they saw as prevalent in their communities, including: depression, anxiety, panic disorder, schizophrenia, bipolar disorder, eating disorders, post-traumatic stress disorder, and personality disorders. Throughout the focus groups, participants emphasized root causes to these issues, such as COVID-19 related stress, discrimination, racism, social unrest, the economy, community-based violence, and the lack of financial capital. Several social determinants of health were highlighted in these responses, with participants emphasizing the role that stability (such as stable housing and income) plays in a person's mental health and their ability to seek help when needed. Participants also stated the role these mental health disorders and root causes play in furthering social isolation and stress, creating a web of compounding issues for residents.

Participants also described access to care as an issue in the community. Access to care issues spanned the areas of access to quality medical care, mental health care, and behavioral health care. Many associated the lack of specialists with limited access to care and the ways in which residents seek (or don't seek) treatment. Participants emphasized the need for affordable and quality behavioral health specialists "when people need them," such as in immediate crisis moments, evenings, and weekends. Participants also stressed the need to reduce stigma to increase access for those who are hesitant to seek services.

In addition, participants highlighted issues among specific populations, including: depression among the elderly due to social isolation; depression and suicide ideation among school-age children due to issues with self-image, self-esteem, peer pressure, academic pressure, and social media use; and depression among lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) youth due to confusion, identity, and stigma. According to participants, each of these issues were exacerbated by COVID-19 lockdowns and isolation.

3. Need: Are there some groups of people in your community who face more mental health challenges than others, e.g., older people, women, parents, adolescents? Describe how mental health needs differ by group.

Participants noted several groups in their communities that face more mental health challenges than others throughout the discussions.

Participants placed great emphasis on youth, adolescents, and teenagers in their concern over those groups most affected, noting heightened familial pressure, peer pressure, and academic pressure. Participants highlighted that youth experience critical life turning points and are working to discover themselves and define their futures and that this may be particularly challenging for those who are navigating sexual identity, such as LGTBQ+ teens. In addition to the added stress and pressure, participants stated that these groups may be less likely to seek mental health help because they fear judgement or being "*outed*." Additionally, participants shared that the COVID-19 pandemic exacerbated these issues for all youth, adolescents, and teens who faced isolation during lockdowns and virtual learning. Across many focus groups, participants emphasized that social media was a contributing factor to worsening mental health among younger residents.

Participants also shared that elderly and disabled residents face depression due to isolation, loneliness, financial issues, such as fixed incomes, and overall decreasing health status because of aging. Participants noted that the loss of independence, diminished physical ability, and discrimination faced by older community members were contributing factors to poor mental health. To illustrate this theme, one participant shared the experience of an aging friend who developed ALS, leading to increased feelings of depression and anxiety as she felt "*she had nothing left*." This participant described how the isolation due to being unable to live independently, which was further limited by poor public transportation systems in her rural community, was a contributing factor to her friend's declining mental health. Furthermore, the participant shared that this experience took a toll on the friend's family and friends who served as caregivers, impacting their overall mental and behavioral health.

Additionally, participants mentioned other groups, including those who are uninsured or underinsured, homeless populations, women and pregnant women, the African American and Black communities, residents in jail, refugees, HIV/AIDS patients, parents, low-income populations, unemployed residents, and LGBTQ residents. Notably, multiple participants also stated that individuals who tested positive for COVID-19 faced increased mental health issues, due to additional stigmas and pressures.

4. <u>Availability:</u> What resources (programs and services) does the community currently have that address mental/behavioral health?

Participants listed several resources, programs, and services available in their communities that address mental and behavioral health. The following list summarizes the groups' responses. It is important to note that a large portion of the focus group participants remained quiet during this question or openly expressed a lack of awareness or knowledge of any available services in their own communities. This may imply that while some resources do exist in the community, portions of the population are unaware of where to go or how to access these resources.

- Mental health advocates
- Rehabilitation centers

- Psychologists
- Hypnotists
- Therapists
- Primary health care centers and public health centers
- Counseling programs, counseling centers, and counseling groups
- Mental health facilities, such as psychiatric hospitals, with crisis support systems
- Youth programs and educational opportunities, such as drug prevention programs
- Community centers with mental health classes
- Call centers
- Medicare-based free therapy and counseling sessions
- School-based programs, such as counseling, therapy and crisis support systems
- Sliding-scale facilities and providers to offer affordable care options
- Several specific agencies were also highlighted by numerous participants, including Our Village Okeechobee, Suncoast Behavioral Health, New Horizons, Florida Community Health Center, 211, and the Kane Center

a. What resources (programs and services) are needed that may not be currently available?

When thinking of resources, programs, and services that are needed that are not currently available in their communities, the themes that emerged among participant responses included the following:

- Free mental health awareness programs, educational sessions, and campaigns, including a centralized website where residents can find information and resources in one spot. Participants also suggested targeted outreach to specific populations, such as pregnant women, to offer services and information
- Low-cost, government-funded mental health facilities and programs that require minimal fees and are easily accessible, as compared to the expensive private facilities that often have long waitlists. Many participants indicated that a fear of high costs served as a barrier to seeking and/or accessing needed care
- Smaller settings for mental and behavioral health care. Suggestions included community-based programs and church programs, as many participants stated that the clinical setting can be intimidating
- Programs and services focused on prevention instead of treatment. One participant stated, *"we have a lot of treatment centers, but not a lot of preventative programs and services"*
- Increased numbers of qualified providers. Many participants stated that additional counselors, therapists, specialists, and other qualified mental and behavioral health providers are needed based on the current lack of availability and long waitlists

experienced in the community. Many participants shared experiences of being unable to successfully obtain an appointment when they were seeking behavioral health care

- Increased hours of operation, such as services available in the evenings or on the weekends
- Financial resources and assistance programs to help address the barrier of cost for residents
- Additional rehabilitation facilities and programs
- Enhanced incorporation of telehealth options to increase access to care and privacy in seeking services
- Mental health services targeted for specific groups, such as the LGBTQ+ population and elderly residents
- Additional counseling programs and services throughout the community, including school counseling programs on-site at each school
- Guidance in identifying, accessing, and successfully navigating services. Many participants spoke about systematic barriers, such as navigating the health care system and insurance networks, that prevented them from getting the care they needed when they needed it. This included a need for increased wrap-around services to help residents navigate the system and obtain the full range of care that they need
- Increased information dissemination and awareness campaigns are needed to educate residents on their options for low-cost, accessible services. As one participant stated, *"it's as good as not having it if we don't know about it."* Numerous participants emphasized that while there may be availability in the community in terms of programs and services, there is not much awareness

b. How do you feel about mental and behavioral health services being provided via telehealth versus in-person? Comfort level? Ability to improve access?

Participants were fairly divided on their preferences for telehealth versus in-person mental and behavioral health services. Many expressed that telehealth is an effective way to make it so that more people are comfortable speaking about mental health concerns, while others shared that they believed it took away from the full mental and behavioral health service experience.

Among those participants who preferred telehealth, convenience, privacy, confidentiality, increased availability (such as nights, weekends, or in a crisis situation), and time/transportation savings were commonly highlighted. Participants shared experiences of being able to access providers who may not normally be available in their communities or time preferences by utilizing telehealth platforms. Participants also mentioned that telehealth led to decreased wait times, allowing them to receive the care they needed in a timely fashion. As one participant shared, *"My particular therapist works at a couple different locations so she is only available two days a week at my location – with telehealth, I have more access to her. When you are having a crisis, that immediate connection is a big thing."* Participants also expressed increased comfort in using

telehealth platforms, stating that it was a less intimidating experience for them to join a telehealth session in the safety and comfort of their home as compared to traveling to a clinic and sharing their feelings face-to-face with a provider they are not yet familiar with. As one participant shared, *"for me, when it comes to sharing personal information like mental issues, I would prefer online because I don't have to sit in the same room as the person. I feel more comfortable behind the computer or phone."* Across groups, participants also highlighted the elimination of transportation barriers, associated costs and stress, when using telehealth options. Notably, some participants shared a preference for telehealth because they could work with providers from outside of their community, increasing their sense of privacy as compared to seeing a provider that lives and works in their community and may share acquaintances.

Among those who preferred in-person services, participants felt that they were better able to convey their feelings and to establish trust and a better relationship with the provider. Many stated a preference for seeing facial expressions and body language, which may indicate a preference for video-based telehealth services when in-person services are not available. These participants also felt that the focus of the provider was decreased during telehealth sessions, as they may be checking other messages or multi-tasking during appointments when the client is not physically in front of them. Distractions experienced by the patients, such as phone notifications or interruptions at home, were also seen as a negative factor in using telehealth, driving a preference for in-person services.

Additionally, participants felt that in-person services were better for the elderly or those without reliable access to internet services or smart devices. To further illustrate, one participant shared:

> *"My mother can't access the computer or texts at all – so that's the big problem... In Okeechobee, there isn't much transportation to get to offices, but there are also residents who don't have internet access, smart devices, or the training on how to use virtual telehealth."*

Areas within the SEFBHN service area such as Okeechobee County present a conflict in which telehealth would immensely aid in increasing access to care by eliminating transportation barriers and increasing the number of providers available for residents (two major barriers shared by these participants), but the residents in these rural communities, are also disproportionately affected by the digital divide and decreased access to smart devices and reliable internet connection. Participants shared that this makes telehealth unrealistic for them unless those digital divide barriers are addressed. Another participant shared similar sentiments, stating:

> *"It is a useful tool for people who have transportation issues. But we still have people in Okeechobee without the tools to get online (like no home computer) and internet access is lacking in some areas. Depending on the age, the face-to-face connection would benefit. But I do like the availability that telehealth provides in overcoming transportation barriers."*

Other participants preferred a blended approach, where they could work with the provider in person to establish a foundational relationship, and then utilize the convenience of telehealth

options. A number of participants felt that for smaller-scale issues or for follow-up appointments, telehealth would be a good option, but in-person services would be preferred for more extensive issues.

c. What types of services would encourage an individual or the community to be more likely to seek help when needed?

Participants shared various ideas regarding services that would encourage an individual or the community to be more likely to seek help when needed, including strategies to increase awareness and education, solutions to address current barriers, and characteristics to improve services. Participants expressed that education related to identifying signs and symptoms would be particularly beneficial, along with subsequent local provider and resource connections.

Participants suggested strategies to increase awareness and education, including a coordinated mental health screening event or health fair to provide no-cost education, resources, and early identification of issues, as well as a "one-stop" website where residents could access resources and educational information at any time. Participants also suggested social media campaigns to reduce stigma and share local resources and information. In general, a number of participants highlighted the need for increased communication channels to help residents understand what services are available and what services they may qualify for (especially those seeking low to no-cost services). Additionally, participants suggested campaigns in which a person with lived experience shared their story to reduce stigma and normalize seeking services in the community.

Moreover, participants shared solutions to address current barriers, including the enhancement of low-cost or no-cost services to help residents overcome financial barriers, as well as transportation solutions for those who may not have reliable transportation or those who live in rural areas without public transportation. Notably, one participant shared a positive experience of having several of her behavioral health services and pharmacy co-located in the same medical complex, making it easy for her to get everything she needed in one trip. Additionally, participants suggested the implementation of free *"navigators"* who were available to help residents connect with services, make appointments, and ultimately obtain the array of services they need. Participants noted that this was a way to help individuals who may feel overwhelmed, may not know where to start in seeking care, and those who may face barriers in navigating the health care and insurance system. Participants also emphasized the need for increased service options, especially those that are located closer to residential areas, to help address current waitlists and access issues related to provider proximity and transportation.

Additionally, participants noted specific factors that would improve services, including enhanced privacy and confidentiality, utilization of remote patient monitoring, the enhancement of wraparound services, and a focus on warm handoffs to help successfully link residents to needed services. Participants also focused on characteristics of services that would make residents more comfortable in seeking services, such as enhancing partnerships with faith-based providers to help increase trust among community members and increasing opportunities for peer support groups.

Participants mentioned that by including trusted individuals, such as faith leaders and peers who can relate to the individual, residents would be more likely to seek services.

Participants also valued culturally competent services from professionals of various religions, backgrounds, gender identities, languages, races, ethnicities, and lived experiences, emphasizing the benefit of being able to connect with a provider that *"looks like [them]."* Many participants expressed that adequate representation of the population rendering services would encourage residents to seek help when needed, as this enhances inclusivity, trust, and comfort in obtaining services. As one participant stated, it is critical to have *"people who are available who look and sound like the people who are seeking help"* when working to encourage those who need them to seek services. Provider diversity and lived experience was very important to participants, with one participant summarizing the general theme by saying that having a provider that looks like them or has had similar experiences increases "*acceptability and accessibility."* Participants also highlighted the value of incorporating the family unit or support network in an individual's care, stating that the involvement of a person's support network would encourage someone to seek services because they felt like they were not on their own and, in turn, they would have those people encouraging them to continue their treatment or care.

Lastly, participants spoke to the attitude and characteristics of individual providers when discussing the types of services that would encourage individuals or the community to be more likely to seek services. As one participant stated, *"in the initial visit, if you feel like you are valued and listened to, you would be more likely to go back."* Participants shared experiences of facing racism, discrimination, or *"rude"* provider interactions throughout the discussion. In these instances, the participants stated that they felt discouraged and even rejected when seeking care, leading them and their networks to develop a distrust in the system as a whole based on these negative reviews or experiences.

5. Perceptions/Barriers: What are some things that might make it challenging or difficult for people to access behavioral health services in your community?

Participants shared experiences and thoughts on barriers related to socioeconomic factors, discrimination, stigma, a lack of understanding and awareness, and provider availability or trustworthiness.

To start, participants highlighted barriers related to socioeconomic status, including the high cost of services, which were exacerbated for those without medical insurance but also present for those with health insurance when services were not covered or required large co-pays. As one participant shared, *"the issue of cost is the biggest issue in my community. Not everyone who is going through a hard time has the ability to pay for services. The finances are a true barrier – they may want it but they step back [due to cost]."* Participants stated that language barriers and transportation barriers were also an issue. According to participants, internet and smart device availability remained a barrier in accessing telehealth services that were intended to address

access issues related to transportation or provider proximity and availability for those in low-income or rural communities. Participants also emphasized health literacy, as many participants discussed the challenges faced in navigating the system and understanding the issues.

Additionally, participants shared that discrimination played a role in creating challenges for those seeking access to behavioral health services in several ways. Participants spoke to racial, ethnic, and gender identity discrimination as they sought to obtain services. In speaking to racial inequities in the system, one participant stated, *"White residents tend to be attended to first before the Black residents."* Another participant stated, *"White providers see White patients first."* A lack of diverse provider representation contributed to this issue according to participants. Other participants spoke about citizenship status as a barrier for accessing care. One participant shared, "*undocumented residents are scared to seek help. Many undocumented people also do not know where to seek help."*

Furthermore, participants stated that stigma and fear of judgement continued to be a major barrier. Many participants spoke to the uneasy feelings that came from *"talking about myself to a stranger,"* stating *"feeling like you don't know this person and you are about to share your most personal feelings and thoughts with them – it can be scary."* Many participants faced a fear of negative feedback and judgement from friends and family, sharing feelings or experiences of being treated differently after their networks found out they were seeking behavioral health treatment or therapy. Participants also shared experiences of being rejected by friends after seeking care, making them feel even worse about themselves on top of struggling with their behavioral health concerns.

In addition, participants shared that a lack of general understanding of the system or awareness of resources available to them compounded issues in seeking care. Many participants shared experiences of being unable to navigate the health care system, leading them to delay or ultimately skip care. Participants also shared experiences related to a lack of knowledge related to the signs and symptoms of behavioral health issues, with one stating *"when you are not aware that you have a problem, you can't seek help for it."*

Lastly, participants highlighted provider availability and trustworthiness as additional barriers that made it difficult for people to access behavioral health services in the community. Participants spoke about long waitlists, reduced availability of therapists in the community, and the lack of facilities near them. As one participant shared, *"rural areas [in the service area] often have few to no mental health providers at all, let alone providers with specialties."* In addition to the limited availability, participants emphasized the importance of having trustworthy providers who would not breach confidentiality practices and would be reliable in continuing care.

a. Why do you think some people do not get help for behavioral health issues?

According to research, nearly half of all Americans living with mental health conditions go without any treatment. Treatment rates for substance use fair even worse, with a mere 10% of those affected receiving treatment according to the American Medical Association. Participants

provided a wide range of insight as to why some people do not get help for behavioral health issues, noting that time, cost, language barriers, and trust were common reasons. Other consistent barriers shared by participants included a lack of provider availability in the area, a lack of reliable and trustworthy providers, and a lack of awareness as to where to go or what services exist. According to participants, the challenging process of finding available and appropriate help was also seen as a barrier, with participants sharing experiences of frustration in navigating the health care system and challenges with connecting with providers. Many participants stated that they experienced instances of not receiving calls back from providers.

Participants also shared negative experiences related to poor treatment from providers, or testimonies of such incidents, citing these as a major deterrent for seeking care. In some cases, participants experienced challenges in referral processes and issues with being sent to the wrong providers when they were seeking help. Several reported instances of racial discrimination from providers towards patients and shared that *"most immigrants are not granted services like citizens. Immigrants are also afraid to seek services [because of a fear it will] result in deportation."* Lastly, patients expressed experiences of providers being selective in terms of which patients they took on. In these instances, participants shared experiences where providers took a selective approach in scheduling by conducting screenings, ultimately leading to limited access for certain populations, such as those with violent pasts or more complex mental and behavioral health issues.

Finally, participants noted personal feelings and stigma as reasons that people do not get help for behavioral health issues. Many shared that feelings of hopelessness, negative perceptions related to seeking help, low self-esteem, fear, and shame were common. Participants also shared that in some instances, those in need may minimize their situation, feeling that others *"have it worse"* and their issue is not *"as bad"* as others' situations. Participants expressed experiences of feeling that they couldn't be helped because it is *"too late"* or *"it isn't worth it."* Participants also indicated that some residents may not know they have a problem or may feel that they do not need professional help and that they can *"work it out on [their] own."* In addition, participants also identified misinformation about behavioral health, or a lack of education and health literacy related to mental health problems. Notably, some participants mentioned the role of culturally-based stigmas. Participants shared experiences where mental and behavioral health topics were taboo or highly sensitive because of their culture or religion. In these cases, participants stated that cultural norms enhanced stigma around mental and behavioral health beyond the traditional stigmas, further compounding barriers on the personal level. All of these examples may suggest a need for education on signs and symptoms of behavioral and mental health issues.

b. What contributes to the lack of trust with seeking services?

When speaking to the lack of trust with seeking services, many participants noted the influence that negative reviews or negative experiences had on their decisions to seek or not seek services. Participants noted both negative experiences with providers, and negative personal experiences

in which someone is betrayed by a peer or other confidant, leading them to be hesitant to open up and share with anyone else. Participants emphasized that they have seen people struggle accessing appropriate and successful care, leading to a distrust in the system as a whole.

Participants also shared comments surrounding stigma, noting fear of judgement, fear of being exposed or having their problems exposed, and a fear of being *"seen differently"* by friends and family after seeking help. One participant shared:

> *"I work with special needs children and other people make fun of them – it really does upset them. Who wants to say something if you are being made fun of? Kids have a hard time getting over that judgement so they won't say something."*

Multiple participants stated that it was difficult for them to trust a provider who they didn't know, emphasizing the need for relationship development and awareness campaigns. Participants also noted worry about having a mental health issue formally on their medical record, stating that they feared *"having a dent in [their] history to be able to get a good job and have good relationships."*

Lastly, participants stated that providers and programs where other contributing factors to the lack of trust when seeking services. Participants noted that poor clinician relationships, experiences with or fear of breaches of confidentiality, racism, discrimination, gender discrimination, fear of abandonment from providers after establishing a relationship, lack of follow up from providers, and experiences with reaching health care providers who were unable to assist (such as those not participating in No Wrong Door practices) were problematic. Notably, when speaking of racism and discrimination from providers, one participant stated, *"most Black people complain of racial abuse they get while trying to get services."*

c. How can we improve trust and comfort among men seeking services?

According to research, mental illness is often overlooked in males. This is indicated by the overall prevalence of mental illness being typically lower in men, despite the fact that men die by suicide at a rate four times higher than women. Males are also reported to die to due to alcohol-related causes at a much higher rate compared to their female counterparts. Additionally, men are two to three times more likely to misuse drugs compared to women. For these reasons, it is important to identify how we can improve trust and comfort among men seeking services. Focus group participants ultimately viewed confidentiality and provider sex as key factors in males' comfort and trust in seeking behavioral health services. Participants valued family-centered solutions, family support, and positive relationships with providers as ways in which trust and comfort in seeking services can be improved for men in the community. Many participants cited a need for anonymous services and private sessions (such as telehealth options) to increase trust, due to the stigma surrounding men and mental health. In comments on provider sex, many participants indicated that males would be more comfortable speaking with male providers *"who look like [them]."* Throughout the discussion, participants highlighted the need for credible health professionals of the same sex, race, and cultural background, who speak the same language.

Participants also emphasized the need to reduce overall stigma around men seeking services. Increasing awareness and understanding of issues among the male population and creating campaigns *"to end this idea that someone is less of a man for seeking help"* were highlighted. As one participant shared, "*society teaches us to be strong, to show no sign of weakness. To be in the position to ask for help, men see it as a sign of weakness or vulnerability. There should be more encouragement to open up."* Participants felt that media campaigns featuring male leaders would help reduce stigma and bring awareness to the issue of mental health experienced by men in the community. Additionally, participants saw value in creating awareness at younger stages of life to begin diminishing stigmas early. As one participant shared:

> *"I feel everyone should know that it's okay to feel down, that a man can be depressed and seek help, a man can feel addicted and it's not a weakness. They should be reminded that they are human and can speak about issues without feeling weak or of low esteem."*

d. How much of a barrier is the lack of services provided in an individual's native language?

According to the U.S. Census, within the five-county service area (Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie counties), over 11 percent of residents reported speaking English "less than very well," with Palm Beach County reporting the highest percentage (13.5 percent). The service area's growing diversity, coupled with the following qualitative insights from the focus groups, indicated a need for additional services provided in an individual's native language to increase access to care and enhance outcomes.

Participants viewed the lack of services provided in an individual's native language as a major barrier to finding, accessing, and maintaining behavioral health services in their communities. For residents who do not speak English as a primary language, participants noted that seeking services was seen as intimidating, and participating in sessions was confusing as these patients struggled to fully express themselves, convey their feelings, and, in turn, understand feedback from providers. Participants stated that this made residents feel shy or not confident in their attempts to seek or receive care, creating a barrier that ultimately dissuaded them from getting the care they need. Participants emphasized that barriers that already exist in seeking or receiving care, such as finding the right provider, making appointments, and accessing these appointments, are ultimately compounded when the added barrier of language differences was included. Participants also expressed that many behavioral health appointments are sensitive, leading these residents to feel apprehensive about bringing a family member or friend to translate. Additionally, participants shared that when translators were present, there were sometimes errors in interpretation or meanings of the conversations, given the different meaning and cultural implications of certain words when translating from one language to another.

Additionally, participants emphasized the tie between culture and language, noting that speaking in the same language allowed patients and providers to relate better and create meaningful connections that made the therapy or treatment much more successful. One participant shared

the experience of her grandmother, who found an agency and provider that spoke her native language. The participant shared that her grandmother was instantly put at ease when she heard the provider speak in her native language at the reception area, and it ultimately led to better communication between the grandmother and her provider. According to the participant, this was because her grandmother felt that she could connect with the provider since they came from the same region, establishing an immediate relationship and rapport. The participant stated that her grandmother was freer to express herself in her native language, instead of struggling to find the right English words as she spoke. In addition to this specific example, participants emphasized the nuances in languages that make direct translation challenging. In these cases, even individuals who may be able to speak limited English had a hard time finding the right words or truly conveying their thoughts when direct translations of words were not possible. Focus group participants indicated that there was a lack of providers who spoke languages other than English in the community and that there is a need for bi-lingual providers.

e. What are some possible solutions to addressing these barriers?

Participants shared several possible solutions to address identified barriers. Participants saw awareness and education campaigns as a valuable method to both increase awareness of available services and programs and to reduce stigma in the community. Many residents were unaware of available services throughout the sessions, indicating a potential need for this education to take place. Participants saw an opportunity for improvement in communication channels used to disseminate this information, suggesting the use of “one-stop” websites and applications to feature community-wide resources, services, and educational materials. Many participants expressed concern over where to find information and services, and this suggestion would work to address those gaps. Participants also highlighted culturally relevant education and awareness campaigns focused on destigmatizing mental health.

As language was identified as a major barrier across the focus group sessions, participants highlighted the need for providers versed in languages that are representative of the community, along with free translation services. According to participants, these solutions were seen as ways to increase health literacy, access, and patient satisfaction among groups that speak a language other than English because they increase understanding and the effectiveness of communication between the provider and patient.

Participants also posed structural solutions, including an increase in low-to-no-cost services, reduced service costs, and the establishment of additional behavioral health centers and providers in rural areas. Participants noted that transportation options, especially for rural areas, were highlighted as a solution to reduce transportation barriers and associated cost burdens when limited provider availability existed in the community. Some participants viewed government intervention as a solution, noting a need for increased community-based, low-cost health centers near residential areas with added providers to meet the needs of the community and reduce waitlists.

Focus group participants also focused solutions on ways in which providers can better serve those in need. According to participants, continuing education and professional development for providers, increased focus on provider-patient confidentiality, and enhanced provider *"bedside manner"* offered opportunities to increase patient satisfaction, reduce stigma, and encourage the use of behavioral health services. Participants also emphasized a need for providers to focus treatment on the needs and wants of patients, emphasizing patient-centered care practices, and to reduce instances of provider discrimination based on race, ethnicity, or sexual identity.

6. Perceptions/Facilitators: What about the existing system makes it easier for people to access care in your area?

It is important to examine the mental and behavioral health system in the context of the social determinants of health and upstream factors that either inhibit or support an individual's ability to access services. Upstream factors act as "fundamental" causes that impact health through social factors, which ultimately impact behavior. Understanding which of these factors individuals see as barriers and, alternatively, as supportive can inform future work designed to improve policies, systems, and environmental factors aimed at increasing access to mental and behavioral health services.

When participants were asked what about existing system makes it easier for people to access care, they described the general availability of services, the quality of the health care workforce, and the guarantee of confidentiality. In terms of general availability of services, participants specifically mentioned that the number of centers in their area, specialty options for care, health care facilities in close proximity to their home, and centers that are open 24 hours a day all increase ease of access for their communities. Among the participants who explained that the quality of health care workers also positively contributed to accessibility of services, many described the health care workforce and providers they saw as free of bias, friendly, qualified, experienced, and *"highly professional."* Many participants also mentioned the assurance of confidentiality makes it easier for people to access care. In addition to these factors, one participant described that, *"there is a good referral system in place. Providers know where to refer people in need, and 2-1-1 is a wonderful portal for resources that people need."* Another participant explained that there is *"a whole lot of support from governmental and private organizations."*

While many participants described aspects of the existing system that make it easy to access care, as mentioned above, many also described barriers associated with accessing care in their communities. This could have been because they do not believe the system is necessarily easy to navigate, as has been the sentiment for many of the previous questions.

7. Intentions: How do people deal with behavioral health concerns in your community? If you or someone you knew were struggling with a mental or behavioral health issue, how would you approach seeking care or advise them on seeking care?

Participants were asked how people deal with behavioral health concerns in their community and, in response, a number of participants shared various coping mechanisms. They explained that that people dealing with mental and behavioral health issues in their community turn to substance use, specifically prescription drugs, and self-harm. A few participants also noted suicide. Notably, one participant mentioned meditation as a specific tool used to manage mental and behavioral health concerns. This participant explained they have *"seen a lot of people using that tool to get rid of stress and anxiety,"* and they have *"seen it help a lot of people."* Additionally, many participants mentioned that people in their community actively seek care at community-based and health care clinics, where counseling and therapy services are available.

Participants were also asked to describe how they would approach seeking care if they were struggling or how they would advise someone they knew to seek care if someone they knew were struggling with a mental or behavioral health issue. This question is especially important, because it shows whether or not participants understand what to do in a mental or behavioral health crisis and how to utilize the mental and behavioral health system at the individual level if they or someone they knew needed help. The large majority of participants explained that they would refer the person in need to a health care professional or health care facility and would also assist them in the process of accessing care. *"People are more comfortable seeking help from professionals,"* one participant stated. Many participants also described offering various types of additional interpersonal support they would provide, through ongoing communication and follow up, love, encouragement, and open-mindedness. Participants described how listening to the person, avoiding stigmatization, and building trust is very important in these situations. One participant advised, *"treat them with care and provide a safe space for trust."*

Participants also explained that it would be beneficial to increase awareness of services and the signs and symptoms of a mental or behavioral health crisis. This type of information would help communities understand what to look for, how to respond, and where to seek additional information for care. A few participants explained situations in which someone didn't understand they had an issue or didn't have accountability from a health care provider and the issue became worse. Participants emphasized that seeking help from a mental or behavioral health professional is very important.

a. If a loved one were to approach you with a behavioral health issue, what would you do?

More specifically, participants were asked what they would do in a situation where a loved one approached them with a behavioral health issue. Among the participants who answered this question, many emphasized the importance of quickly assisting the loved one, recommending them to the appropriate resources, offering options for self-management, and providing personal support. Participants explained they would specifically recommend the loved one to a health care professional or direct them to a health care facility, such as a hospital, counseling facility, or care center for care. Alternatively, some participants explained they would advise the loved one to start

with self-management through healthy habits and building a healthy routine. Providing encouragement and being patient, compassionate, and free of judgement were emphasized in many instances as personal support mechanisms to assist loved ones in need of assistance. Many participants also stated that, in these situations, it is important to make sure the loved one knows that they are not alone, others experience the same issues, they should seek help from a professional, and they will overcome what they are experiencing.

b. What can be done to encourage people to seek help when they need it?

Participants provided several suggestions on what could be done to encourage people to seek help when they need it. Suggestions included increasing awareness, personal testimonials, reducing the cost, and guaranteeing fair and quality services.

To start, many participants mentioned increasing awareness of available resources and emphasizing the need to seek help in a timely manner. One participant noted that they would *"advise them that their health is life, and it is very important they are alive."* A large portion of participants also mentioned that testimonials and personal stories from people who have experienced similar mental or behavioral health issues would be useful strategies for encouraging people to seek help when they need it. This was also noted as a way to reduce the stigma associated with accessing services, which would ultimately encourage people to seek care.

Additionally, participants mentioned that reducing the cost of services would encourage people to seek help when they need it. Several participants shared that subsidizing costs, offering an initial free consultation, or providing free services during certain months of the year would greatly encourage people to seek help when they need it.

Lastly, participants mentioned that ensuring high quality services would encourage their community to seek care. There was an emphasis on guaranteeing confidentiality and fair, equal, non-discriminatory treatment, with many specifically mentioning gender and race equity. Participants also described the importance of positive first experiences with trustworthy providers would encourage residents to come back for and stay engaged in care for as long as they need it.

8. Experience: If you are comfortable, please share some of your own experiences seeking behavioral health services.

Many participants remained silent when asked to share their own experience seeking behavioral health services. The participants who were open to sharing their experiences emphasized that they intentionally searched for a provider who was a well-trained professional, one they could *"rely on"* and build rapport with through shared experiences. One participant noted that the cost of services didn't matter as long as the provider was *"well-known and well-trained."* When describing the process of seeking services, a few participants explained that the experience was smooth and not challenging. However, one participant described a situation in which they experienced racial discrimination from providers when trying to access services, stating *"I once*

faced discrimination when I tried to access services. Health care providers didn't want to attend to me because they were kind of racist towards me." Two participants described specific reasons for seeking services, including marital issues and issues caused by poor treatment from others.

a. What influenced your decision to seek help?

Participants were asked to share what influenced their decision to seek help. Of those participants who were comfortable sharing, the majority explained they were influenced by external factors. Participants described how they were influenced by individuals they trust, such as family members, friends, and individuals from religious organizations, who provided encouragement. One participant specifically explained a situation in which a friend not only provided encouragement, but also booked a therapy appointment for them. Several participants noted that testimonials from individuals who experienced similar situations influenced them to seek help, one further stating that her "*community gave a good review about where they sought care at*." While the majority of participants mentioned external factors that influenced their decision to seek help, many who answered this question also described intrinsic factors and self-motivation, with one stating he was *"doing what's best for myself*."

b. Where did you go?

Participants mentioned a wide variety of places they turned to for care when seeking help, including health care facilities, online or virtual sources, and specific community organizations. Of the participants who mentioned a health care facility, many cited health centers, and hospitals. Notably, several participants specifically mentioned Suncoast Behavioral Health, Tykes & Teens, and 2-1-1.

Many participants also described seeking care online and or virtually through telehealth. Of note, one participant explained their preference for this environment was because they felt they could express themselves and speak openly about their experiences without inhibition. One participant stated:

> *"I prefer getting my services online because I believe it's where I could share my experience freely. I do have meetings with my therapist and counselor online and the services are really helpful. I was really excited that a total stranger could understand my plight and make me feel good."*

c. Were the services helpful? What happened as a result of you seeking care?

When participants were asked if the services they received were helpful and what happened as a result of seeking care, all who responded agreed that the services were very helpful. While all participants who answered this question found the services helpful, many described situations in which they were initially reluctant or hesitant to ask for help and seek care but also noted that the outcome was ultimately positive. One participant described that *"the services were helpful, because it helped me break the stigma of the condition of anxiety and depression."* Another explained, *"I felt relief, calm, and free from stresses, especially when talking with someone that*

understands." Additionally, many participants spoke positively of their provider, describing them as a *"good listener,"* patient, and trustworthy. Notably, one participant explained how the services *"helped revive"* their family.

d. How did you feel about talking to someone about your mental and behavioral health?

Participants were then asked how they felt about talking to someone about their mental and behavioral health. Among the participants who answered this question, many described a mix of emotions. Many described feeling comfortable, relaxed, relieved, and valued being able to personally connect with someone who really understood their situation. One participant explained they felt *"refreshed."* Many participants also mentioned that they experienced initial feelings of hesitation, skepticism, struggle, reluctance, discomfort, and shyness due to fear of judgement, but that the end result was positive. Importantly, one participant attributed their positive experience to not being discriminated against. Overall participants, again, shared that the services they received were helpful.

A few participants described negative experiences when talking to someone about their mental and behavioral health and explained situations in which they felt discouraged and feared stigmatization. One participant explained they regretted seeking help entirely, because it made them feel *"they were a very different person in society."*

9. Setting: In which setting do you feel most comfortable talking to someone about your mental and behavioral health?

Participants were asked in which type of setting they feel most comfortable talking to someone about their mental and behavioral health. Participants mentioned a wide range of settings such as virtual, in-person, one-on-one and group settings. Regardless of setting, participants explained that relating to their provider in terms of age, gender, race, or experiences is very important.

Many participants stated they prefer to speak with someone about their mental and behavioral health virtually through telehealth. Participants emphasized that having the ability to speak with someone over the phone specifically was important. A few participants noted that having the option to seek care anonymously was critical, explaining that seeking services virtually provides this option in most cases. One participant explained they would rather speak with someone they can't see, again emphasizing the importance and preference towards telehealth.

While many participants stated they prefer a virtual environment for seeking mental and behavioral health care, many also prefer speaking with someone in-person, either one-on-one or in a group setting. Participants shared that being able to physically see someone and being with someone face-to-face helps them observe body language and feel more comfortable sharing their experiences. Of the participants who preferred one-on-one settings, many described environmental factors such as having a private, quiet space, as being very important. They

explained that this helps them feel more comfortable and assures confidentiality. Notably, one participant said this is important *"to avoid being looked down on."* Specific locations, such as a doctor's office or faith-based setting, for individual, one-on-one settings were also mentioned by participants.

In-person, group settings were also preferred by many participants. Many shared that they feel most comfortable and prefer talking to someone in an in-person, group setting, because this setting allows them to personally connect with others through shared experiences, grow with others, and speak in a roundtable setting. Participants explained that in-person, group settings *"always give someone [the] courage to speak out"* and can be *"a breakthrough for many people."*

a. Who would you prefer to speak with about your mental and behavioral health?

When participants were asked who they would prefer to speak with about their mental and behavioral health, participants mentioned the following:

- Health care professional, such as a doctor
- Mental health professional, such as a counselor, psychologist, therapist, or mental or behavioral health specialist
- Family member, such as a parent or a spouse
- Friend
- Someone with shared life experiences
- Someone of the same race
- Someone who is experienced
- A trusted individual who will ensure confidentiality

Participants also mentioned important personal characteristics, such as trustworthiness, kindness, politeness, and professionalism.

- How do you or people in your community feel about faith-based mental and behavioral health services?

Faith-based communities offer individuals the opportunity to connect with others through shared values and beliefs and, oftentimes, provide additional support services for community members. This question explored participants' feelings towards seeking mental and behavioral health services in a faith-based setting. Participants expressed a mix of sentiments when asked how people in their community feel about faith-based mental and behavioral health services, describing how services in this setting can be either very helpful or, alternatively, biased, strict, and judgmental.

Among the participants who described faith-based services as helpful, many mentioned this would be the case if someone has a strong faith or religious background. *"If that's your core belief, it affects your thoughts and how you feel, so it is everything,"* said one participant. Many participants said that faith-based services provide alternative methods of motivation for those that need help. Participants also described this as being positively influential. One participant shared, "*Religion*

gives people something to believe in, provides a sense of structure, and typically offers a group of people the opportunity to connect over similar beliefs." Many participants also described religious leaders as good options for support and a connection to other services. Some participants also explained that these services would be beneficial mainly for the elderly population or those with spiritual health problems.

As mentioned, many participants also expressed negative sentiments regarding faith-based mental and behavioral health services. Participants mentioned hesitation for faith-based services, because they believed their pastor or someone in the religious organization might share their problems after they confide in them. Many participants also shared their fear of judgement in the religious community, specifically with substance use issues, saying that the community is very biased in this case. One participant explained,

> *"There is a huge stigma on substance abuse and certain mental illness[es] in the religious world. A lot of faith-based services don't encourage the use of medication. I have found that stigma in groups where they say 'because I am on suboxone I am not clean.' There is a lot of stereotyping and judgement. Those stereotypes have not kept up with the world we live in today."*

There were some participants that expressed indifference, saying that they aren't religious so it wouldn't necessarily help them. However, they acknowledged that faith-based services may help other community members or someone who prefers to share things with their religious leader. Participants also mentioned that these services may be a good starting point for seeking care, but ultimately someone should seek services from a health care professional.

10. Suggestions: Thinking about the future of our behavioral health system, if you could change or implement a new program, service, or policy, what would it be?

When participants were asked to think about the future of the behavioral health system in their community and what new program, service, or policy they would change or implement, many suggestions were shared. Themes that emerged from participant responses are listed below:

- Reduce the cost of services, making them more affordable or free in some cases
- Ensure accessibility in rural communities
- Increase awareness of and provide more options for telehealth services; This was seen as a solution for the high cost of services, for those who live far away from a provider, or those who feel more comfortable seeking services this way
- Improve health center facilities, specifically to accommodate larger groups for group therapy
- Increase the diversity of providers; One participant mentioned a need for *"professionals of different cultures, races, and backgrounds that speak different languages"*
- Improve access to and availability of interpretation services

- Eliminate racism, discrimination, and biases among providers, and provide inclusive environments for patients to seek care; participants described that services should be more accessible to all groups and individuals should be encouraged to speak up no matter their age, gender, or race
- Create LGBTQ specific centers, so this population can seek care without judgement
- Focus on reducing unemployment rates
- Focus on preventative services
- Increase the awareness of available services, where to go for what types of services, what to do in a mental or behavioral health crisis, and encourage the community to reduce the stigma associated with seeking care for mental and behavioral health services
- Create a more robust linkage system, including a referral system, with communication between providers
- Increase accessibility to trained mental health professionals in schools specifically
- Notably, one participant stated, *"There should be less punishment for less crimes and more rehabs and treatments, maybe substance use treatment, for people that have low criminal records. There should not be serious consequences because of depression or alcohol and drugs. They should be given a chance. I support there should be low punishment for individuals who are influenced by their mental health issues."*

11. Closing Question: Is there anything else that we did not ask about behavioral health? What final thoughts would you like to share?

Of note, when asked for final thoughts, the majority of participants remained silent. Of the few that shared additional closing remarks, participants specifically suggested the need for more support groups and counseling services. One participant specifically noted that these services increase access to individuals and offer an opportunity for them to talk about their issues.

NO WRONG DOOR SURVEY SUMMARY

I work in a/an …

Among all providers who participated in the survey, the majority worked in Outpatient Programs, with 28% in Adult Outpatient Programs, 26% in Children's Outpatient Programs, and Peer Recovery Support programs (20%). Other respondents worked in Adult Detoxification Units (6%), Adult Mobile Response Units (6%), Children's Crisis Units (6%), Children's Mobile Response Units (6%), and Adult Residential Facilities (2%). There were no participants who worked in Adult Crisis Units, Children's Detoxification Units, or Children's Residential Facilities. As a note, providers were able to choose more than one option.

1. Do you think the "No Wrong Door" access works well within your organization?

Among the survey respondents, a majority believe that No Wrong Door access works well within their organization (59%). Notably, 15.4% of respondents did not think it worked well in their organization. Approximately one-quarter or respondents were not sure (25.6%).

2. From your perspective, your organization has a role to play in the "No Wrong Door" access.

A majority of survey respondents believe that their organization had a role to play in No Wrong Door access (64.1%), whereas a few respondents felt that their organization does not have a role to play (5.1%). Over one-quarter of respondents were not sure (30.8%).

3. In your opinion, your organization has a strong care coordination process that includes warm handoffs to services and seamless care coordination.

Almost three-quarters of respondents indicated that their organization has a strong care coordination process that includes warm handoffs to services and seamless care coordination, with 25.6% of respondents strongly agreeing to the statement, and 48.7% of respondents agreeing. However, some respondents indicated that they were not sure (17.9%), and a few respondents disagreed (7.7%). No respondents strongly disagreed with the statement.

4. In your opinion, your organization has taken action to improve the referral and care coordination process for individuals served.

Most survey respondents indicated that their organization has taken action to improve the referral and care coordination process for individuals served, stating that they strongly agreed (15.4%) or agreed (43.6%) with the statement. However, a few respondents indicated that their organization has not taken action to improve the referral and care coordination process, stating that they disagreed with the proposed statement (12.8%). Over one-quarter of survey respondents were not sure (28.2%).

5. In your opinion, are linkages to crisis intervention and support (like the Mobile Response Teams, medication management, CRF, CIT Officer, BA, CSU, etc.) occurring?

Most survey respondents indicated that linkages to crisis intervention and support were occurring, stating that they strongly agreed (10.3%), or agreed (48.7%) with the proposed statement. However, one-third of respondents were not sure (33.3%), and a few respondents indicated that they disagree with the statement (7.7%).

6. In your opinion, your organization promotes its services and resources very well.

A majority of respondents indicated that their organization promoted its services and resources very well, stating that they strongly agreed (2.6%), or agreed (64.1%) with the proposed statement. Notably, 12.8% of respondents indicated that they disagreed with this statement. One-fifth of respondents were not sure (20.5%).

7. In your opinion, your organization promotes awareness of available options and linkages to needed services?

Most survey respondents agreed with the statement that their organization promoted awareness of available options and linkages to needed services (66.7%). Nearly one-quarter of survey respondents were not sure (23.1%) and 10.3% of the respondents disagreed with this statement. Notably, no participants indicated that they strongly agreed with this statement.

8. In your opinion, your organization provides person-centered care for all individuals served.

Almost all of the survey respondents indicated that their organization provided person-centered care for all individuals serviced, stating that they strongly agreed (17.9%), or agreed (69.2%) with the proposed statement. Few respondents indicated that they were not sure (12.8%), and notably, no respondents disagreed or strongly disagreed with the proposed statement.

9. In your opinion your agency hires employees who are culturally sensitive and culturally competent for the population served.

Over three-quarters of all respondents indicated that their agency hired employees who were culturally sensitive and culturally competent for the populations served, with 2.6% of respondents strongly agreeing with the statement, and 74.4% of respondents agreeing with the statement. Few respondents indicated that they were not sure (10.3%), while 12.8% disagreed with the statement.

10. In your opinion, it's easy for individuals to access the services they need quickly and efficiently.

Most survey respondents indicated that it was easy for individuals to access the services they needed quickly and efficiently, with 10.3% of respondents strongly agreeing with the statement and 61.5% of respondents agreeing with the statement. Few participants were not sure (10.3%). Notably, a small portion of respondents did not believe this to be true, stating that they either disagreed (12.8%) or strongly disagreed (5.1%) with the proposed statement.

11. Do you think a standard intake and screening process for state agencies and community partners would help individuals get into services more quickly?

A majority of respondents indicated that a standard intake and screening process for state agencies and community partners would help individuals get into services more quickly (71.8%). Some respondents did not feel that this would help individuals get into services more quickly (12.8%), while 15.4% of respondents were not sure.

12. In your opinion, your organization encourages (promotes) working with other community partners to ensure care coordination.

Most respondents indicated that they strongly agreed (5.1%) or agreed (64.1%) that their organization encourages and promotes working with other community partners to ensure care coordination. Notably, some participants indicated that they strongly disagreed (5.1%) or disagreed (12.8%) with this statement. Few participants were not sure (12.8%).

13. In your opinion, individuals in need of services have equal access to care.

Most respondents indicated that they believed individuals in need of services had equal access to care, with 59% of respondents agreeing with this statement. Notably, nearly one-quarter of respondents were not sure (23.1%). Among those who did not agree with this statement, 15.4% disagreed and 2.6% strongly disagreed.

14. In your opinion, Stakeholders help to address and advocate for equal access to care in system entry points.

While most survey respondents indicated that they agreed that stakeholders help to address and advocate for equal access to care in system entry points (7.7% strongly agreed and 59% agreed). A small portion of respondents indicated that they disagree (10.3%) with this statement. Additionally, nearly one-quarter of respondents were not sure (23.1%).

15. In your opinion, your organization ensures that services are of high quality and meet the needs of individuals served.

A majority of respondents felt that their organizations ensure that services are of high quality and meet the needs of individuals served, with 10.3% of respondents strongly agreeing with this statement, and 82.1% of respondents agreeing. Few respondents were not sure (2.6%) or disagreed with the statement (5.1%).

16. In your opinion, your organization tracks individuals served, services, performance, and cost to continually evaluate and improve outcomes?

Most respondents strongly agreed (17.9%) or agreed (61.5%) that their organization tracks individuals served, services, performance, and cost to continually evaluate and improve outcomes. Some participants were not sure (15.4%) and a few disagreed with this statement (5.1%).

NO WRONG DOOR SURVEY CHARTS

Figure 120: I work in a/an...

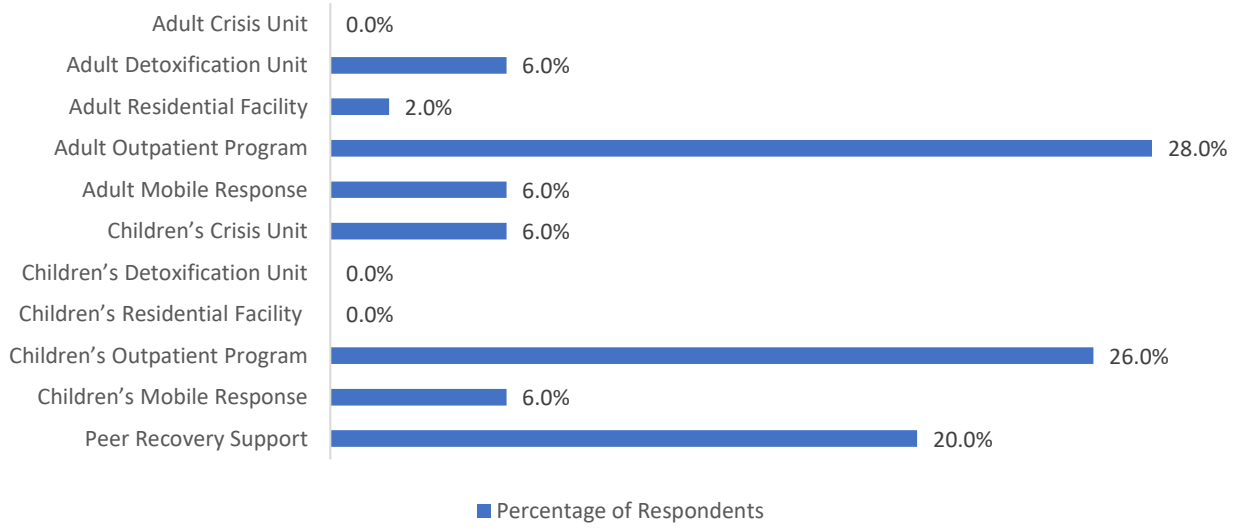


Figure 121: Do you think the "No Wrong Door" access works well within your organization?

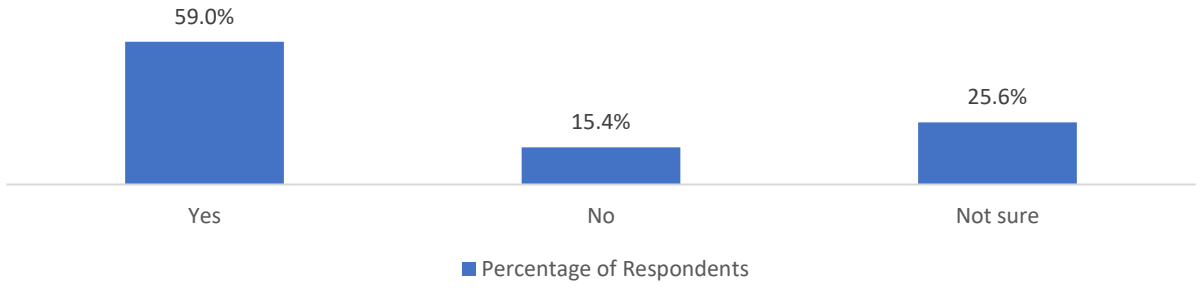


Figure 122: From your perspective your organization has a role to play in the "No Wrong Door" access.

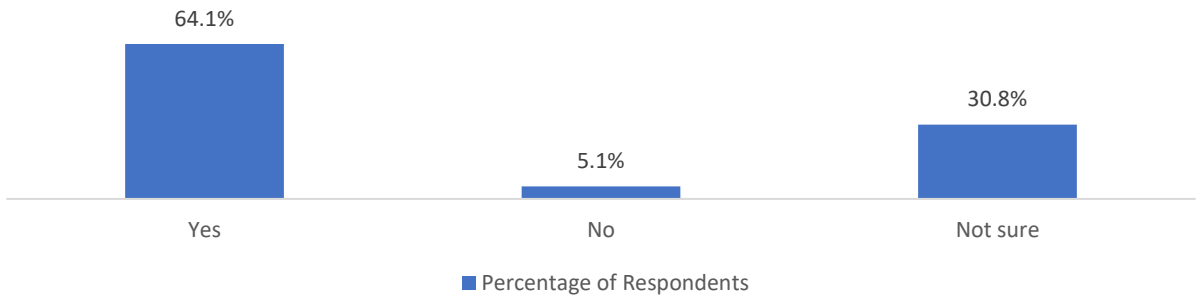


Figure 123: In your opinion, your organization has a strong care coordination process that includes warm handoffs to services and seamless care coordination.

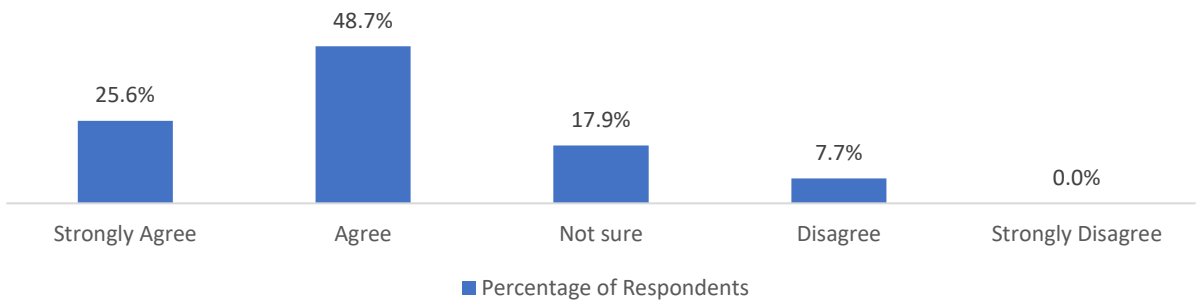


Figure 124: In your opinion, your organization has taken action to improve the referral and care coordination process for individuals served.

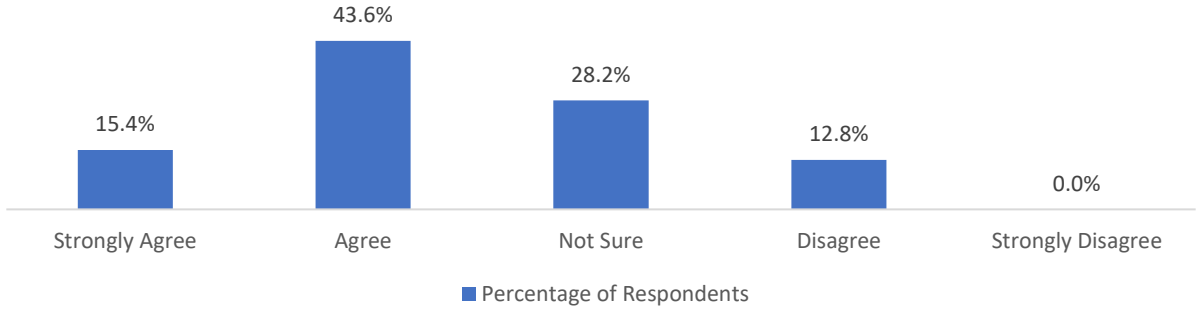


Figure 125: In your opinion, linkages to crisis intervention and support (like the Mobile Response Team, medication management, CRF, CIT Officer, BA, CSU, etc.) are occurring.

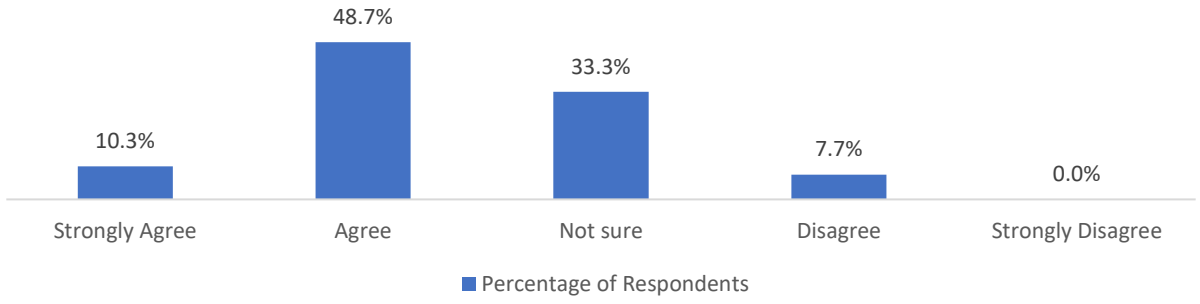


Figure 126: In your opinion, your organization promotes its services and resources very well.

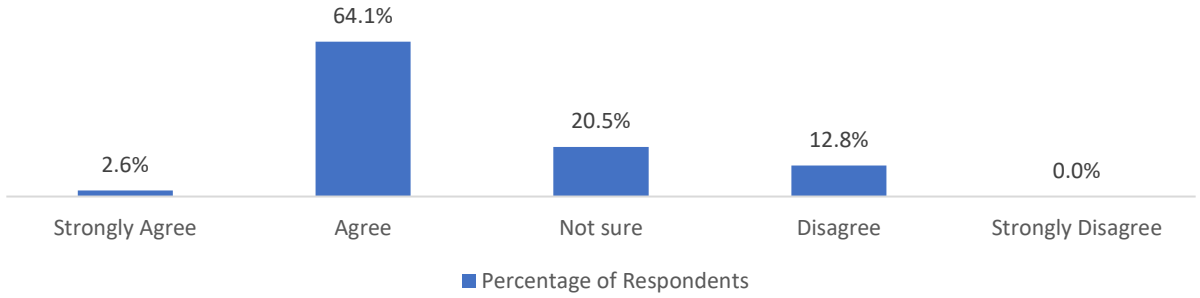


Figure 127: In your opinion, your organization promotes awareness of available options and linkages to need services.

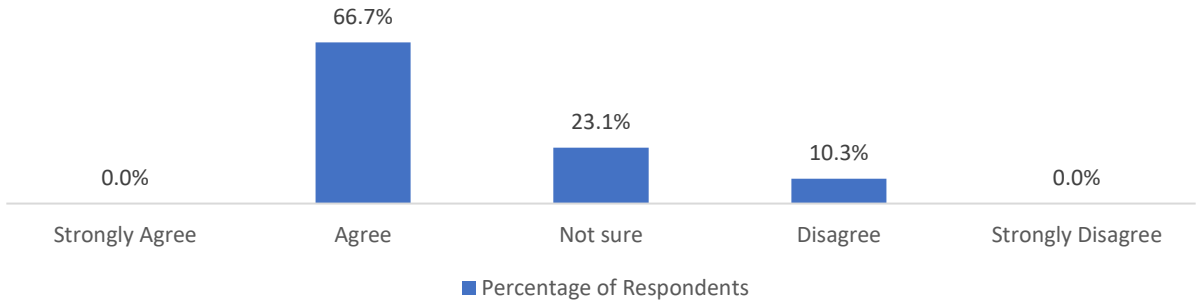


Figure 128: In your opinion, your organization provides person-centered care for all individuals served.

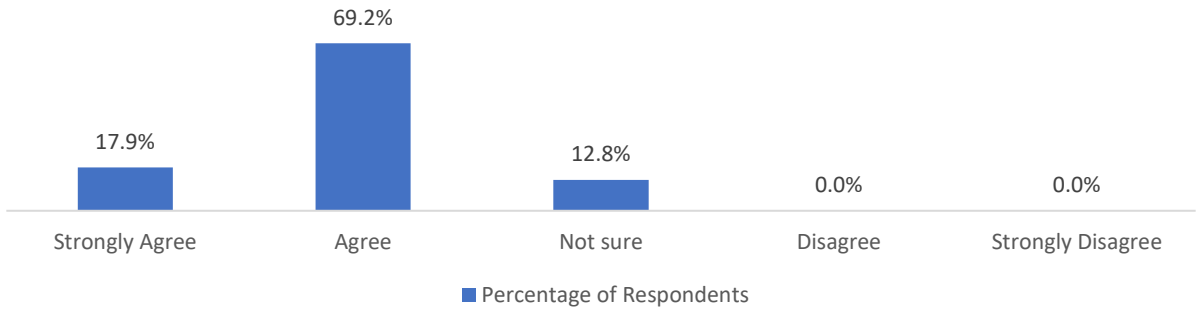


Figure 129: In your opinion, your agency hires employees who are culturally sensitive and culturally competent for the population served.

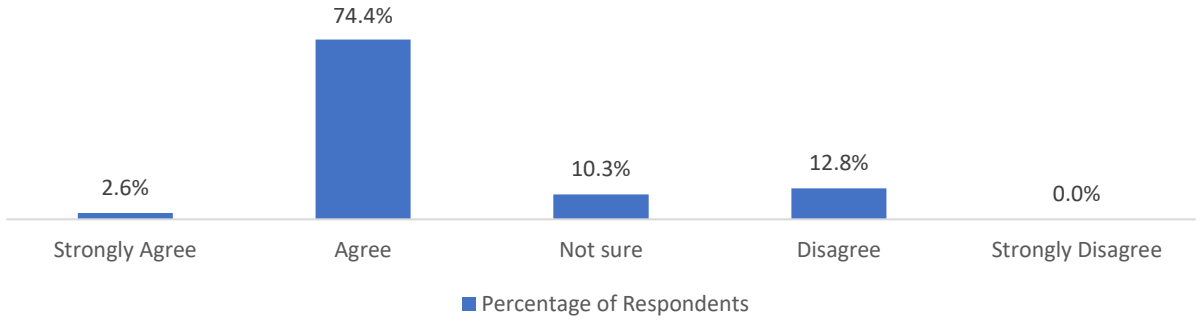


Figure 130: In your opinion, it's easy for individuals to access the services they need quickly and efficiently.

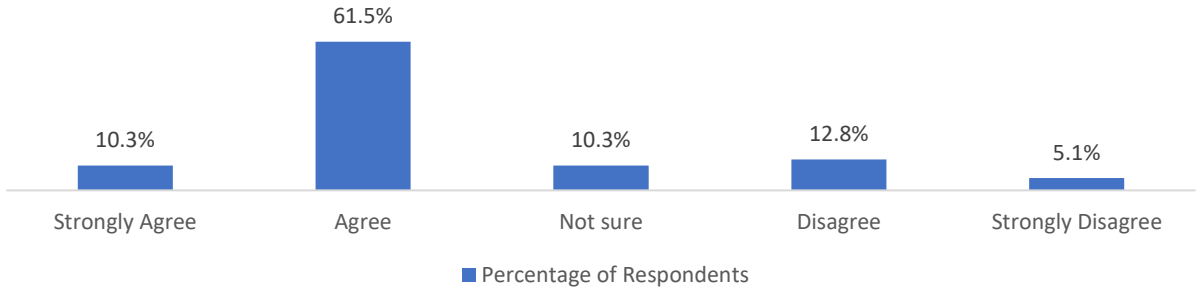


Figure 131: Do you think a standard intake and screening process for state agencies and community partners would help individuals get into services more quickly?

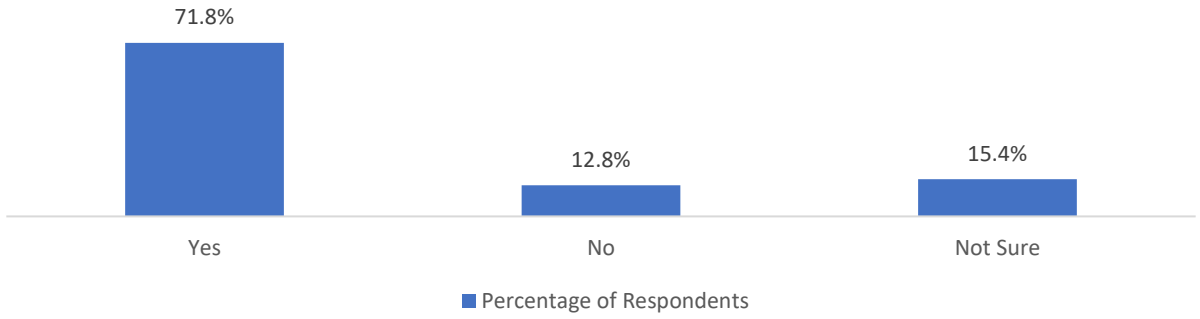


Figure 132: In your opinion, your organization encourages (promotes) working with other community partners to ensure care coordination.

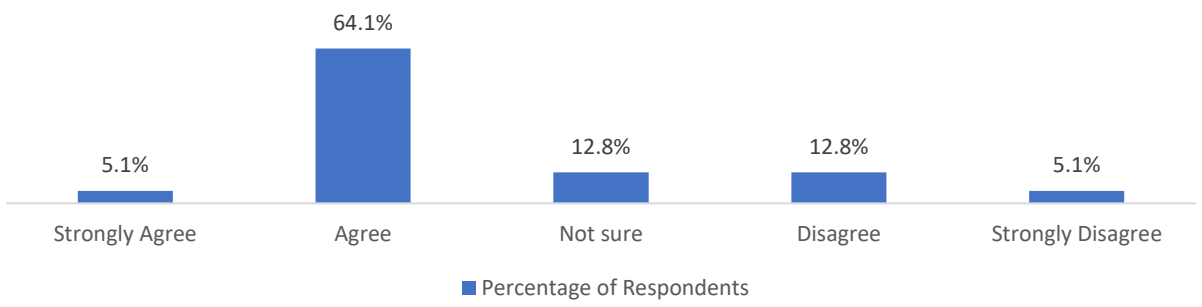


Figure 133: In your opinion, individuals in need of services have equal access to care.

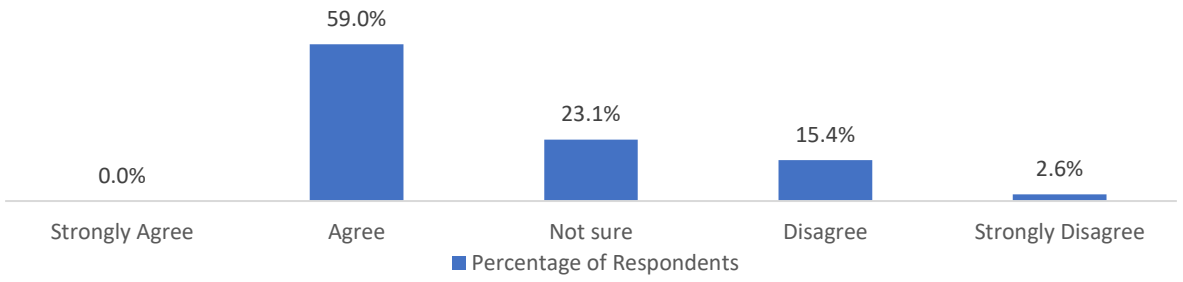


Figure 134: In your opinion, stakeholders help to address and advocate for equal access to care in system entry points.

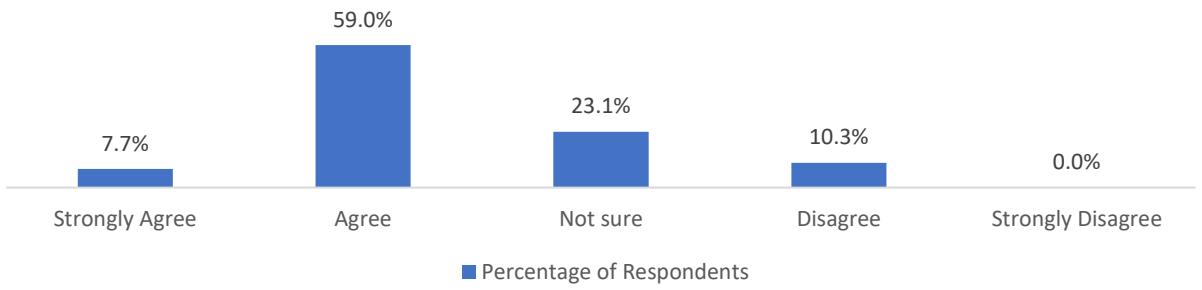


Figure 135: In your opinion, your organization ensures that services are of high quality and meet the needs of individuals served.

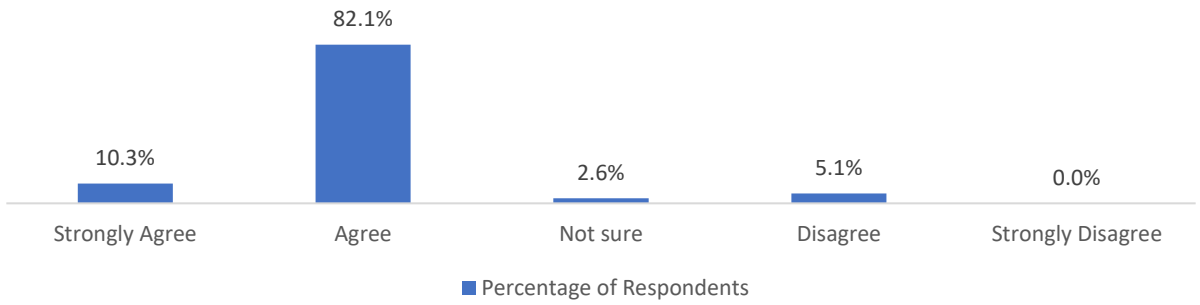
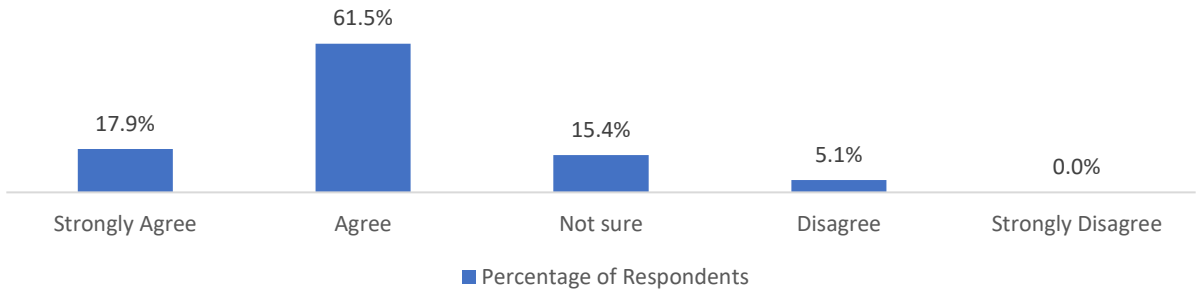


Figure 136: In your opinion, your organization tracks individuals served, services, performance, and cost to continually evaluate and improve outcomes.



NO WRONG DOOR SEFBHN PROVIDER FOCUS GROUP SUMMARY

Interviews were conducted with seven different SEFBHN direct-service provider organizations, with eight representatives, over the course of nine days to assess No Wrong Door, which is a policy that ensures that, no matter where people enter the behavioral health system, they can easily gain access to services. Interviews included a series of questions related to No Wrong Door access, how it works within each organization, how person-centered care is provided, how effective partnerships are maintained, how care coordination is provided, and how quality assurance takes place.

What does the term "No Wrong Door Access" mean to you?

Providers associated No Wrong Door Access with clients never being turned away, being given what they need, and being able to easily access services regardless of where they enter the system. Providers also described that, with No Wrong Door, if there is a service that they do not or cannot provide, clients are linked directly via warm handoffs to a provider who does and can. Providers shared that this ensures patients are efficiently and effectively connected with the array of services they need.

Do you think the "No Wrong Door" access works well within your organization?

Overall, providers stated that No Wrong Door access works well within their organization. Most providers described the full array of services and the ability to connect clients directly to services that they provide internally. One provider mentioned "*We see everyone and make sure they have care*" and another stated "*our organization alone has so many doors*." Several providers also described their process for referring clients for services that they are not able to provide, with one mentioning their partnership with 2-1-1, which helps address a variety of client needs through their referral service.

Tell us about your experience with "No Wrong Door" access within your organization.

Providers largely expressed positive experiences with No Wrong Door access within their organizations. Several described that their organization has the necessary and established structures in place to provide needed services, with the ability to provide the majority of services in-house, serving as a "one-stop shop." The majority of providers also described the great work that specific staff do to ensure quality care and service provision. Staff who were specifically mentioned included referral specialists, case managers, care coordinators, emergency receiving staff, and a Mobile Response Team. A couple providers also described the way they have implemented a client-centered approach, listening to their clients, and providing the services that they need and want in their care plan.

Do you think your organization's current approach to "No Wrong Door" works well?

Providers, for the most part, stated that their organization's current approach to No Wrong Door works well. However, a majority also described challenges and barriers. Providers stated waitlists, workforce capacity, staffing issues due to COVID-19, and client attrition as the major challenges. One provider stated:

"*The reality of not really being able to meet the needs gets in the way of [clients] feeling that they are going to be able to get something from us, maybe something we can't provide – this creeps into the work more than we would like*."

What are some things that you think work well?

Providers described a variety of things that they think work well with their organization's approach to No Wrong Door access. Several providers mentioned that their teams were skilled in reaching the community, due to the trust that they have established, and their ability to meet clients exactly where they are. Providers also stated that their agencies have trained staff who know about available community resources and who are able to successfully link clients as appropriate. Additionally, the majority of providers described their mission-driven and compassionate staff, with one stating "*we have a lot of dedicated people who really care about their clients*."

What are some opportunities for improvement?

Providers listed several opportunities for improvement. Citing transportation access and availability of services in certain geographic areas as a major area for improvement. One provider stated:

"*We don't have all kinds of levels of care in the community itself in rural areas. There are times when we have to send people out of their safety zone when they are from these rural areas – away from their support network and to another county to receive services. This isn't ideal.*"

Providers also stated that there is a need for more trained staff with the ability to consistently follow up with clients. Additionally, providers mentioned the need for constantly updated and maintained resource directories to ensure efficient and effective linkages between agencies.

From your perspective, your organization has a role to play in the "No Wrong Door" access.

Providers unanimously stated that their organization has a role to play in the No Wrong Door access. The ways that their agencies play a role are described below.

What are the ways that your agency plays a role in the "No Wrong Door" access?

Providers described several ways that their agencies play a role in No Wrong Door access. The most commonly reported was their ability to provide individualized care for individuals through a multitude of services provided in-house and their ability to address client needs through direct service provision or warm handoffs to other providers. Several providers also mentioned that they do well with training all employees on both mental health and substance use. Notably, two

providers mentioned how they work to address proximity and accessibility issues with one provider stating they accommodate their clients by offering telehealth services, and two others stating that they provide many transportation services for their clients, to and from appointments.

In your opinion, your organization has taken action to improve the referral and care coordination process for individuals served.

Providers largely agreed that their organizations have taken action to improve the referral and care coordination process for individuals served through: 1. enhanced care coordination and follow up; 2. standardized policies and procedures; and 3. increased partnerships and engagement with other providers so "*if [they] aren't the right door, [they] are working together to get the client to where they need to be*." However, the majority also mentioned that there is room for improvement and that they are constantly working to improve their processes.

In what specific ways can your agency improve on the referral and care coordination process for individuals served?

Providers mentioned several ways that their agency can improve on the referral and care coordination process for individuals served. The most commonly reported was to increase outreach to other service providers, including the mental health court, probation officers, and other agencies. For clients outside of their service area, one provider stated, "*we don't have a seamless, continuous and regimented process for interagency referrals*." Some providers also mentioned that, with care coordination, follow up is challenging especially when their clients are constantly moving and changing contact information. One provider specifically mentioned providing more services tailored for men.

In your opinion, are linkages to crisis intervention and support (like the Mobile Response Teams, medication management, CRF, CIT Officer, BA, CSU, etc.) occurring?

Overall, providers agreed that linkages to crisis intervention and support are occurring. Several mentioned the importance of relationships with officers and collaborating with different agencies who have appointment openings. A couple of providers also stated that they provide training onsite to Crisis Intervention Team (CIT) officers, so they understand how services are provided, how they handle restraints, and how to refer individuals to specific services. However, two providers were critical of some entities who receive those who are Baker Acted, citing the lack of follow up, support, and warm handoffs, and the poor quality of care provided.

Have you or your agency identified any barriers or obstacles to becoming a part of the No Wrong Door System?

All providers but one stated that their agency faced no major barriers or obstacles to becoming a part of the No Wrong Door System. However, several providers mentioned the barriers they do face with service provision. These barriers included the lack of people in the workforce which contributes to long wait times and waitlists, the siloed approach to service provision when there are a lot of agencies involved, the obstacles that come with trying to get clients what they need

through referrals, the limited accountability among specific entities, and transportation challenges.

INFORMATION, REFERRAL, AND COMMUNITY AWARENESS

In your opinion, your organization promotes its services and resources very well.

All providers agreed that their agency promotes its services and resources very well. Some providers mentioned how COVID-19 has impacted their ability to engage in community events, but also described how their agencies have managed to continue to get the word out. Examples of how each organization promotes its services and resources are described below.

Can you give examples of this?

Providers mentioned a variety of examples for how their organization promotes their services and resources. The most commonly reported method was through direct community engagement through local events, including speaking engagements, job fairs, network lunch-and-learn sessions, community wide meetings, community and partner outreach events, and interagency meetings. Providers also described their use of online marketing through both their websites and social media platforms, which provides the ability for them to share up-to-date information. Additionally, providers emphasized the importance of being well known in the community and the power of word of mouth. One provider stated, "*Our best marketing is our clients – they network for us, sharing with friends and family.*"

In your opinion, your organization promotes awareness of available options and linkages to needed services.

All providers agreed that their organization promotes awareness of available options and linkages to needed services. Ways in which such promotion occurs are described below.

How does your agency promote awareness of available options and possible linkages to needed services? (Brochures, social media, billboards, website, handouts, etc.)

Providers described a variety of ways that their agency promotes the awareness of available options and possible linkages to needed services. The most commonly reported was through online marketing, including via social media platforms or organizational websites. The majority of partners also mentioned the distribution of printed collateral with programmatic information, including brochures, posters, rack cards, and flyers, which they distribute both throughout community events and as part of a client's discharge in the event they need additional services in the future. Additionally, several providers stated that they promote awareness through speaking engagements at provider learning collaboratives and staff meetings.

What else could be done to increase the level of awareness of behavioral health services in the community?

Providers mentioned several actions that could be taken to further increase the level of awareness of behavioral health services in the community, mentioning the need to stay up to date on the services that other partners and agencies are providing, and to keep their resource lists consistently updated for referral and client education purposes. However, to a majority of providers, mental health-related stigma is a bigger issue than the level of awareness, because even if people know about services, they will not seek them if stigma persists. One provider stated, "*Removing stigma is what it comes down to – we have to let people realize that it's ok and this is the norm*."

Person-Centered Care and Transitional Support

In your opinion, your organization provides person-centered care for all individuals served.

All providers agreed that their organization provides person-centered care for all individuals served. Ways in which their agencies implement person-centered care systems of care are described below.

Describe how your agency implements a person-centered care system of care.

Providers described how their agencies implement a person-centered care system of care. Many providers emphasized the need to let clients drive, make informed decisions, and to provide the information and guidance for them to do so. One provider stated:

"*The clients are involved and guide their treatment planning. They have a big voice in what services they go into…if they say it isn't for them, we say ok. It is strictly client voice/client choice, but we try to use positive encouragement and involve them in planning*."

Several providers mentioned that they provide navigation assistance as the client makes their treatment decisions, because the system can be difficult to navigate. These providers described how their staff provide consistent support and warm handoffs each step of the way. In addition to this system-based support, providers stated that they also involve outside support as a safety net, including churches, support groups, families, and friends. Lastly, providers specifically mentioned that they apply the Strength, Needs, Abilities, and Preferences (SNAP) framework for developing treatment plans for their clients with their clients. The SNAP framework is a person-centered approach meant to leverage elements in a client's life used to help them cope with stressful situations, to promote a client's success with reaching their goals, and to prioritize what the client wants in terms of treatment.

What resources or supports would your agency need to improve person-centered care?

Providers mentioned a few resources or supports that their agencies would need to improve person-centered care. The most commonly stated was the need for more staff trainings, including trainings related to developing treatment plans, Medicaid requirements, and developing specific, measurable, attainable, relevant, and time-bound (S.M.A.R.T.) objectives. Several providers also mentioned the need for additional services in their area and more transportation services. One

provider stated, "*I think we need more of what other areas have so people don't have to drive so far…some rural places have nothing.*" Although not commonly reported, other notable mentions include language services, additional staff, more financial resources, affordable housing services, and services geared towards individuals who are undocumented.

In your opinion your agency hires employees who are culturally sensitive and culturally competent for the population served.

Most providers agreed that their agencies hire employees who are culturally sensitive and culturally competent for the population served. The majority of providers mentioned the cultural sensitivity, competency, and diversity trainings they require for staff to complete, which cover how to communicate with different cultures, and how to approach service provision with cultural humility, or self-reflection to gain a deeper understanding of cultural differences to improve the way individuals are treated. Several providers also mentioned their efforts to ensure their staff are representative of the communities they serve, from peer specialists to those in leadership positions. One provider stated:

"We have representative staff – we are international. We have people from many different cultures on staff. Our board of directors is also representative of the cultures and populations we serve. Annually, we do a civil rights compliance checklist to identify the staff and board of directors' cultures and the cultures of the persons served. We go into the demographics in our area so we can be sure we are actually representative."

However, a few providers mentioned that they try their best to ensure adequate representation, but that it has been difficult to recruit. They described ways in which they are trying to improve in this area, specifically around how to attract more staff from specific populations to join their organization.

If not, are you aware of your agency doing anything to improve in this area? Is there anything your agency could do to improve?

Providers mentioned a few ways that their agencies could improve in this area. The most commonly reported was the need to stay updated with the latest trends and being proactive with their approach, especially when it comes to the trainings. For instance, one provider mentioned that, a decade ago, gender pronouns were not part of the discussion, but now it is a very important component. In addition, one provider mentioned that they could provide more Diversity, Equity, and Inclusion trainings for staff.

STREAMLINED ACCESS AND ELIGIBILITY

In your opinion, it's easy for individuals to access the services they need quickly and efficiently.

Providers generally agreed that it's easy for individuals to access the services they need quickly and efficiently, although almost all of them also mentioned waitlists as a barrier. The general sentiment was that services are available, but there are staffing shortages, especially for specific

providers such as therapists and behavioral analysts, and that that has contributed to longer waitlists and wait times.

If yes, what works well about the current process with individuals for accessing services?

Providers mentioned several things that are currently working well with respect to the process with individuals for accessing services. The most commonly reported was the variety of services that are provided, the staff knowledge of available services, the ability for clients to access many of them in a timely manner (within 24-48 hours), and the warm handoffs completed when linking clients to these services. Additionally, a couple of providers also mentioned having a centralized person who is able to triage clients appropriately for intakes and/or referrals.

If no, what are the major barriers that keep individuals from accessing the services that they need?

Although providers generally agreed that it is easy for clients to access services they need quickly and efficiently, several also mentioned that there are a few major barriers that keep individuals from accessing the services that they need. Barriers included lack of availability of providers and waitlists, lack of transportation and proximity of services, language barriers among Spanish-speakers, and those from the Guatemalan Mayan community. Notably, several providers mentioned that telehealth and virtual platforms have helped with addressing some of these barriers, though initial contact must be made to initiate such virtual services. There is a lack of internet and device access among certain pockets of the communities served.

Do you think a standard intake and screening process for state agencies and community partners would help individuals get into services more quickly? Why or why not?

Providers had different opinions on if a standard intake and screening process for state agencies and community partners would help individuals get into services more quickly. The majority did not believe it would help because it would be difficult to develop a standardized tool across statewide providers and different programs, it may cause more confusion, and it may result in either too many or too little details being collected. However, one provider thought it would absolutely help, but only "*if everyone was onboard*." This provider mentioned the standardized electronic health records that is currently in place in other states works well. Notably, one provider mentioned that instead of considering a standardized intake, increasing staff capacity should be prioritized. This provider stated, "*Honestly, what I think would help [individuals get into services more quickly] is being fully staffed. Before asking for money or anything else, we need the staff*."

What do you think would need to be accomplished to implement a standard intake and screening process for the region/state/system?

Providers mentioned several things that would need to be accomplished to implement a standard intake and screening process. By far, the most commonly reported was the need to have buy-in and input from all stakeholders, agencies, and providers. They specifically mentioned the need to include what each agency needs to assess for their specific programs and services. One provider

mentioned that a crosswalk of all regulations and requirements would help inform a standardized screening process, while another mentioned that the only way for this to successfully roll out would be to make it mandatory. Additionally, one provider mentioned that setting it up electronically would help, with the ability to move through different tabs for specific intake components and the ability to select referral organizations and services, filtering by eligibility requirements. However, another provider maintained that it would not be feasible and that statewide processes haven't proven to be as efficient in the past.

PARTNERSHIPS AND COORDINATION OF EFFORTS

In your opinion, your organization encourages (promotes) working with other community partners to ensure care coordination.

All providers agreed that their organizations encourage and promote working with other community partners to ensure care coordination. Descriptions of partnerships are included below.

Which partners do you work with most?

Providers listed several providers that they work with the most. The below list includes the partners that providers mentioned.

- Behavior Basics
- CARD
- CAT Team Chrysalis
- CC Kids
- Child welfare providers
- Cleveland Clinic
- Compass Health
- Drug Abuse Foundation
- Drug Abuse Treatment Association
- Family Preservation (for referrals)
- HCA (Arc for inpatient referrals)
- Indian River State College
- Inpatient Baker Act Receiving Units
- JFK North Hospital
- Judicial Drug Court
- Mental Health Court
- New Horizons of the Treasure Coast
- Health District of Palm Beach County
- Probation Offices
- Substance Awareness Center of Indian River County
- Sequel Care

- South County Mental Health Center
- The School System
- The Sheriff's Office
- Suncoast
- Tykes and Teens
- Village for Change
- Wayside House

What works well in these partnerships?

Providers mentioned several things that work well in these partnerships. Almost all providers mentioned the importance of collaboration and communication, being able to openly discuss issues and determine appropriate strategies together. Several providers also mentioned the importance of having built and maintaining trust with these agencies over time. One provider stated:

"*It's best when you have an established relationship and trust, so you can pick up the phone and say 'this is what we need.' It's lovely and makes things efficient. It's harder to accomplish, but having investment and coordinating is a huge positive*."

Other notable mentions include location and proximity to partners and establishing expectations to foster a culture of "follow through."

In your opinion, individuals in need of services have equal access to care. Why? Why not? What works well?

Providers felt differently about whether individuals in need of services have equal access to care, although the majority of them stated that they agreed within the context of their specific organization. Providers mentioned that ensuring that everyone has access to their services, never denying anyone care, and providing a variety of services helps them provide equal access among those who seek their services. However, several providers stated that not everyone has equitable access to care due to several outside barriers, including transportation, stigma, lack of representation, insurance, and the lack of devices and internet needed to access telehealth services.

In your opinion, Stakeholders help to address and advocate for equal access to care in system entry points.

In general, providers agreed that stakeholders help to address and advocate for equal access to care in system entry points. Providers specifically mentioned police officers, the school system, hospitals, receiving facilities, main funders, and client family members as stakeholders who serve as advocates for equal access. One partner stated, "*I feel like that is happening, but there is a lot of room to grow. It will be an ongoing process and we have to be part of the solution*."

If no, how can this be improved?

One provider mentioned a key opportunity for improvement, emphasizing the need for increased empathy for individuals who are seeking services. This provider stated that financial stakeholders may look at equal access as a check box to guarantee they continue to get funded, but that it should be approached with an empathetic lens instead, ensuring that the best, comprehensive, and equal care is provided to those in need.

QUALITY ASSURANCE AND CONTINUOUS IMPROVEMENT

In your opinion, your organization ensures that services are of high quality and meet the needs of individuals served.

All providers agreed that their organizations ensure that services are of high quality and meet the needs of individuals served. The majority of providers described their quality assurance and continuous improvement processes, which included conducting chart, peer, and fidelity reviews, providing administrative and clinical supervision, tracking outcome measures, implementing client and staff satisfaction and feedback surveys, and carrying out quarterly clinical reviews. Several providers also mentioned staff quality assurance meetings, workgroup meetings, and Clinical Quality Improvement Committee meetings where quality assurance, evaluation, and program monitoring activities take place. One provider also mentioned that they are in the process of hiring a Quality Improvement Manager to carry out this work continually.

In your opinion, your organization tracks individuals served, services, performance, and cost to continually evaluate and improve outcomes?

All providers agreed that their organizations track individuals served, services, performance, and cost to continually evaluate and improve outcomes. Several providers described how they consistently run reports from electronic health records and check performance outcomes measures. Providers also mentioned reviewing the outcomes of calls, discharges, and implementing ways to follow up with discharged clients on a periodic basis. Additionally, a couple providers also stated that they track higher level costs and have sound business models in place.

If no, how can this be improved?

Although all providers agreed that their organizations track individuals served, services, performance, and cost to continually evaluate and improve outcomes, two providers also mentioned opportunities for improvement. One provider mentioned that they should actually do something with the data, implement improvement strategies, and make changes, rather than using it to check boxes as part of a protocol. The other provider mentioned that they want to collect more data and spend time processing the data to assess where they currently are and where they want to be.

INDIVIDUALS SERVED SURVEY SUMMARY

1. Which best describes you? Age Group and Dynamics

Among survey respondents, most were adults receiving services (67.3%), followed by young adults or youth receiving services (15.2%), and parents of a child receiving services (11.4%). Few respondents were individuals/guardians of individuals receiving services (3.8%) or caregivers representing a person receiving services (1.9%).

2. What type of service did you or the person you are representing receive? (Check all that apply)

Most of the services received at the time of the survey were related to adult mental health services (33.9%) or adult substance use services (28.6%). Other services received included peer support services (13.5%), prevention services (10.7%), child mental health services (9.7%), and child substance use services (3.6%).

3. What county do you live in?

Most survey respondents lived in Palm Beach County (47.9%) or Saint Lucie County (26.6%). Other survey respondents lived in Indian River County (12.5%), Martin County (9.9%), and Okeechobee County (2.7%). One participant did not respond (0.4%) to the question.

4. Do you know where to go for mental health and substance use treatment services when you need them?

When asked if they knew where to go for mental health and substance use treatment services when needed, most participants stated that they did know where to go (82.5%). Some participants stated they only knew where to go “sometimes” (11%), and 6.1% of participants stated that they did not know where to go when they needed services. One participant did not respond (0.4%) to the question.

5. How did you learn about mental health and substance use treatment services when you needed them? (Check all that apply)

When services were needed, participants learned about them through family members or friends (20.5%), word of mouth (18.2%), another individual in treatment/recovery/peer (15.6%), or through other avenues, such as a hospital or outpatient facility, job coach, Mental Health of America, caseworkers, online research, outreach persons, Rebel Recovery, Tykes and Teens, Ritelife Services, teachers and learning centers, Catholic churches, VA centers, workplaces, or other social service agencies (14.8%). Additional sources of information included 2-1-1 (8.4%), school (8.2%), law enforcement (6.9%), social media (3.8%), or a mobile crisis team (3.6%).

6. Are you aware of the 2-1-1 information, crisis intervention, and referral hotline in your county?

Over three-quarters of survey respondents were aware of the 2-1-1 information, crisis intervention, and referral hotline in their county (78.7%). Notably, 20.9% of respondents were not aware of this resource. One participant did not respond (0.4%) to the question.

6A. Are You aware that 2-1-1 can dispatch a Mobile Response Team (MRT) that can meet you and provide crisis intervention/assistance wherever you are?

A majority of survey respondents were aware that 2-1-1 can dispatch a Mobile Response Team (MRT) to provide crisis intervention or assistance wherever they are (62.4%), while 37.3% were not. One participant did not respond to this question (0.4%).

7. Have you ever called 2-1-1 for assistance?

Approximately one-quarter of survey respondents had called 2-1-1 for assistance at some point (28.9%). Notably, a significant portion had never called 2-1-1 (70.7%). One participant did not respond (0.4%) to the question.

8. When you called 2-1-1, were they helpful in getting you to the services needed?

Most respondents who had called 2-1-1 found that the agency was helpful in getting them the services they needed (18.3%). However, 7.2% of respondents stated that the agency was only helpful "sometimes", and 3% of respondents stated that the agency was not helpful. A significant portion of respondents had never called 2-1-1 and thus marked the question not applicable (71.1%).

9. Were you able to get all the services you needed when you needed them?

A majority of survey respondents found that they were able to get the services they needed when they needed them (86.3%). However, 13.3% of respondents found that they were not able to get the services they needed when they needed them. One participant did not respond (0.4%) to the question.

10. If no, please choose from the list below the services you needed but were not able to get (Check all that apply)

Among services needed that were not received, housing assistance (8.8%), alternative services (such as acupuncture, art therapy, meditation, etc.) (8%), crisis stabilization/support (8%), detox services (8%), aftercare/follow up (7.1%), and outpatient services (6.2%) were the most reported. Other services that were needed but not received included assessment (4.4%), day/night treatment services (3.5%), medical services (3.5%), medication assistance programs (3.5%), prevention services (3.5%), recovery support/peer services (3.5%), residential treatment programs (3.5%), short-term resident treatment programs (3.5%), drop-in/self-help services (2.7%), employment/job training assistance (2.7%), inpatient services (2.7%), referral services (2.7%), case management (1.8%), outreach support (1.8%), respite services (1.8%), and daycare services (0.9%).

11. How many times during the last 12 months were you not able to get the services you needed?

Most respondents reported receiving the services they needed (89.4%). However, 4.2% of respondents found that they were not able to get the services they needed in five or more instances in the last 12 months. Additionally, 2.3% of respondents found that they were not able to get the services they needed three to four times in the past 12 months, and 3.8% of respondents found that they were not able to get the services they needed one to two times in the past 12 months.

12. The services I needed were:

For nearly one-fifth of survey respondents, the service they needed had a waitlist (18.6%). However, while 7.6% of respondents found that they service they needed were not available, most participants stated that the service they needed was available (73.4%). One participant did not respond (0.4%) to the question.

12A. If there was a waitlist for services, were you offered other services you could receive while you waited?

Among those who indicated that there was a waitlist for services, 39.6% said that they were offered other services while on the waitlist, and 35.4% said that they were not. Additionally, 18.8% stated that they were told about other services, but that no one had directly connected them. One respondent stated that they needed medical services and another mentioned that they understood why they were on a waitlist because they needed homeless-related services.

12B. About how long were you on the waitlist for services?

When it came to waiting for services, 38.4% of respondents indicated that this did not apply to them. Among those who indicated that there was a waitlist for services, the majority waited less than one week (26.6 of all respondents), followed by those who waited 1 to 2 weeks (9.1% of all respondents). There was an equal number of respondents who indicated that they waited 3 to 4 weeks and over 1 month (7.2% of all respondents), but following closely behind, 6.5% had indicated that they waited over 2 months to receive services. Importantly, 4.6% of respondents mentioned that they never received the service(s) that they were on the waitlist for. One participant did not respond to this question (0.4%).

13. On a scale of 1 to 4, with 4 being “strongly agree,” how much do you agree with the following statement: “the services and planning I received were focused on my treatment needs.”

A majority of respondents felt that the services and planning they received were focused on their treatment needs (44.9% stating strongly agree and 38% stating agree). However, nearly 20% of respondents felt that the services and planning received was not focused on their individual treatment needs (5.3% reporting they disagreed with the statement and 11.4% reporting they strongly disagreed with the statement). One participant did not respond (0.4%) to the question.

14. How long did it take from the time you requested an appointment for services to the time you received the services?

Over half of all respondents received services within 1 to 7 days of requesting an appointment (59.3%). However, some participants had to wait 1 to 2 weeks (12.9%) or 2 weeks to a month (9.5%). A portion of participants had to wait over 1 month (6.5% waiting over 1 month and 1.9% waiting over 2 months) and some participants never received an appointment (9.5%). One participant did not respond (0.4%) to the question.

15. How long did/does it take you to travel to the services?

Most respondents traveled 15 minutes (44.9%) to 30 minutes (27.8%) to access services. A significant portion traveled between 31 minutes and 1 hour (17.9%), and 9.1% of respondents traveled over 1 hour to receive services. One participant did not respond (0.4%) to the question.

16. How did/do you travel (get) to services? (check all that apply)

The most commonly reported transportation methods used to travel to services among consumers included private transportation services such as a taxi, Uber, Lyft, or TOPS (25.3%), driving themselves (23.5%), walking (19.6%), and having relative or friend drive (18.5%). Respondents also indicated using the public bus system (9.4%) or Medicaid/Medicare transportation (3.7%).

17. What, if any, were the obstacles you experienced to getting to the care you needed? (check all that apply)

The most commonly reported obstacles experienced among consumers included very limited or no transportation (9%), not knowing where to go for services (8.1%), not being able to afford services (7.7%), and not meeting eligibility criteria (3.4%). Many respondents also cited other barriers, such as stigma, a lack of available specialists, COVID restrictions, denial, fear, lack of childcare, language/cultural difference, long waitlists or lack of provider availability, trust, and scheduling conflicts (no weekend or evening appointment availability). Notably, 34.2% of respondents indicated that no barriers were present.

18. Are there any services, resources, or supports that you think are needed in our community, but that are not currently provided?

Overall, participants saw utility in enhanced transportation resources, detoxification centers, resource awareness campaigns, housing assistance and affordability, homeless shelters and resources, and programs and providers focused special populations. Respondents mentioned the following special populations: youth (child psychiatry services), pregnant women, children with disabilities, incarcerated individuals, and domestic violence survivors.

19. In your opinion, are there any services, supports, agencies, or resources that you think were exceptionally helpful to you and/or your family?

Consumers listed a wide range of services, supports, agencies and resources that were exceptionally helpful to them and/or their families. These included: 2-1-1, ABA services, school services, Boys Town, case management, Catholic Charities, Community Partners of South Florida, Peer Place Clubhouses, South County Mental Health Center (for Baker Act situations), Comprehensive Wellness Center Group Therapy, CRC, DATA, school based programs and therapists, Fern Street Clubhouses, LAHIA, MAT, MHA, Midway Crisis Line, NAMI, La Amistad, JFK North, New Horizons, Project LIFT, SAC, SEFBHN, Federation of Families, The Grant, Tykes and Teens, Urban League, Lewis Center, DCF, Rebel Recovery, Recovery Research Network, and the Salvation Army.

Notably, multiple consumers mentioned how specific service providers assisted them in their time of need. Participants stated, “Rebel Recovery listened to all of my needs. They helped with the ones they could and assisted me to find additional resources even sending referrals when needed” and “Rebel Recovery was so amazing at being there for me when it seemed no one else was.” Additionally, one participant stated, “Boys Town was very helpful and supportive in guiding our family through the steps to better communication and mental health. They were very knowledgeable in all the local services for our needs. We greatly appreciate their services and support.” Another participant shared, “Fern Street Clubhouse is about one of the most helpful places I've attended in the past few years. I feel MHA is positive and constructive.”

INDIVIDUALS SERVED SURVEY CHARTS

Figure 137: Which best describes you?

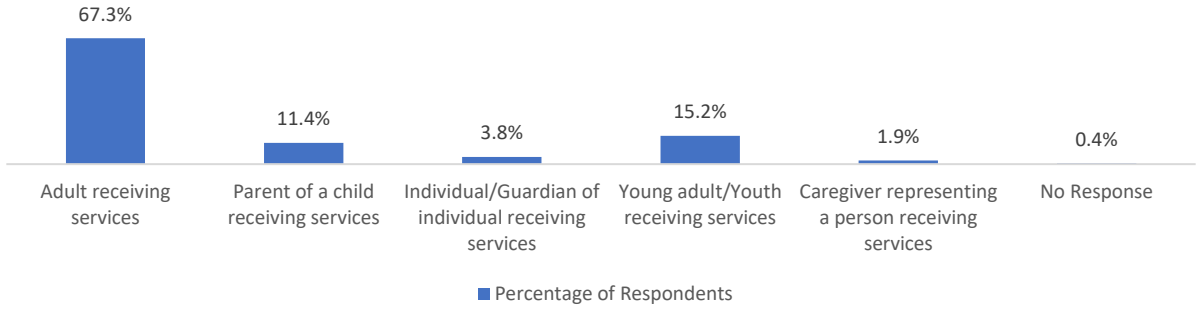


Figure 138: What type of service did you or the person you are representing receive?

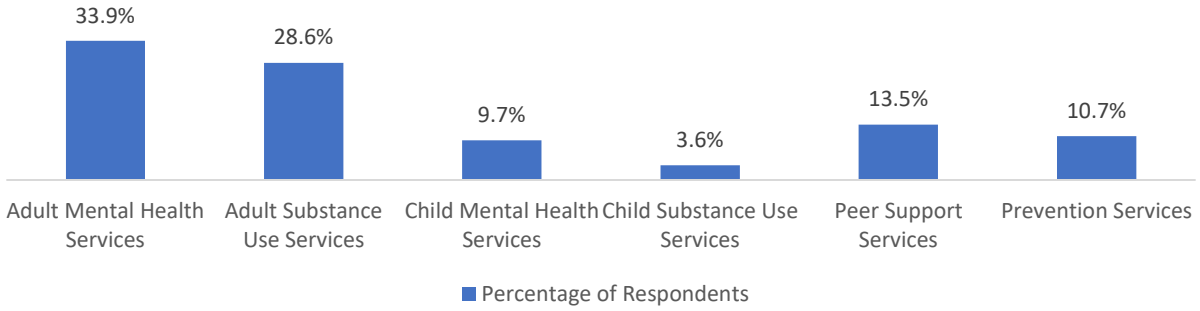


Figure 139: Which county do you live in?

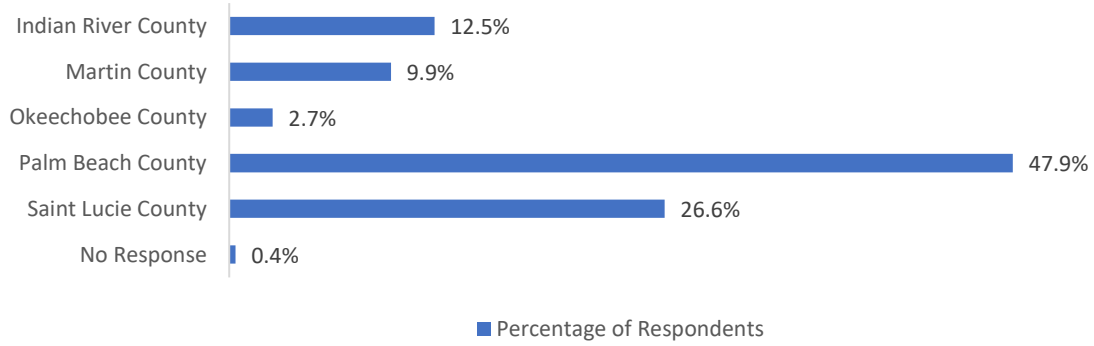


Figure 140: Did you know where to go for mental health and substance use treatment services when you needed them?

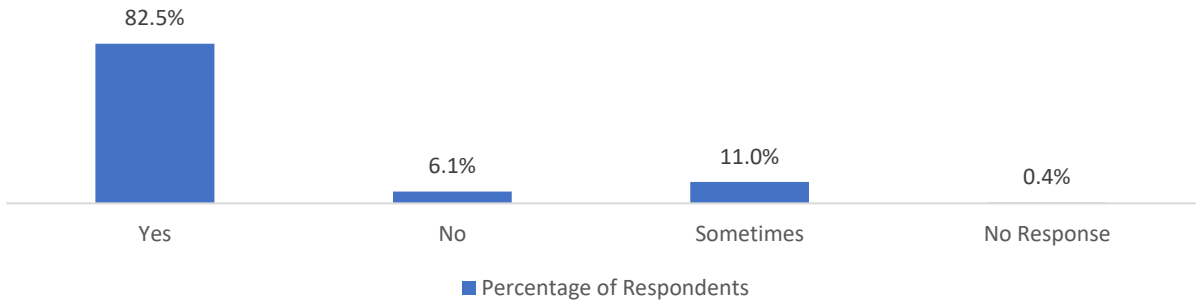


Figure 141: How did you learn about mental health and substance use treatment services when you needed them?

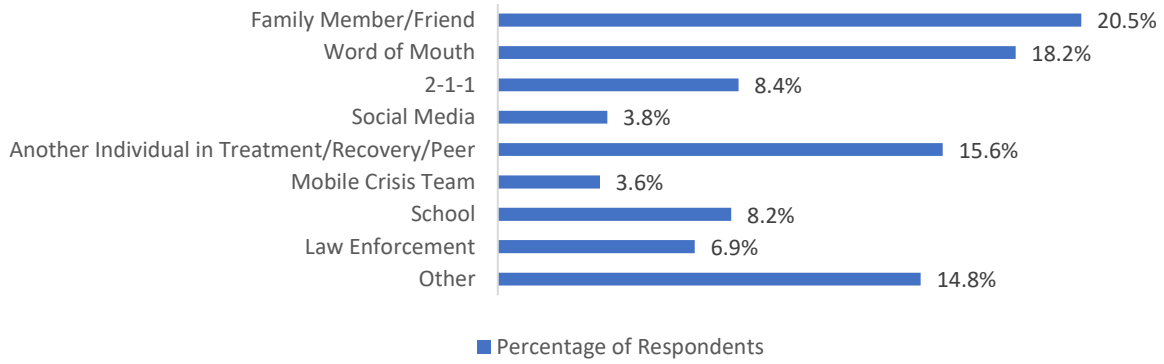


Figure 142: Are you aware of the 2-1-1 Information and Referral Resource in your community?

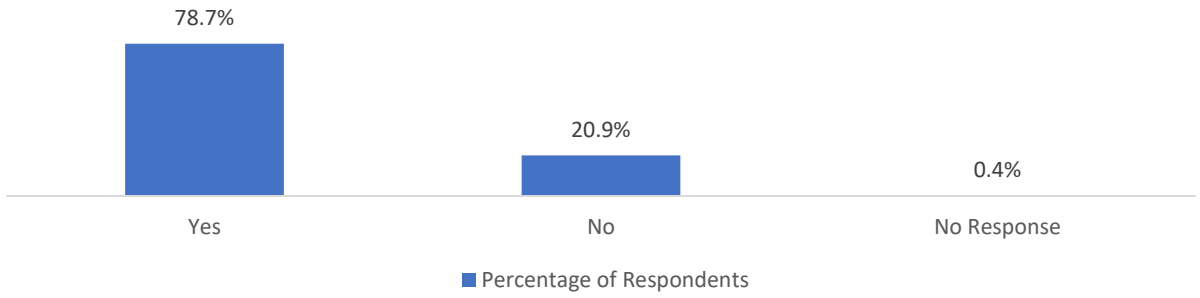


Figure 143: Are you aware that 2-1-1 can dispatch a Mobile Response Team (MRT) that can meet you and provide crisis intervention/assistance wherever you are?

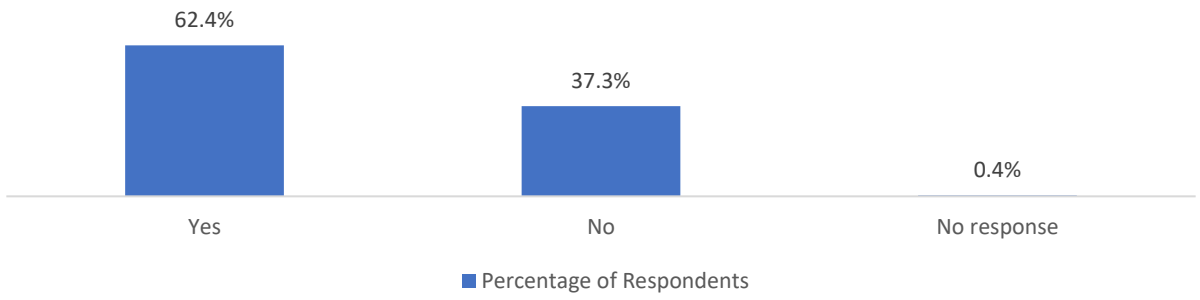


Figure 144: Have you ever called 2-1-1 Information and Referral Resource for assistance?

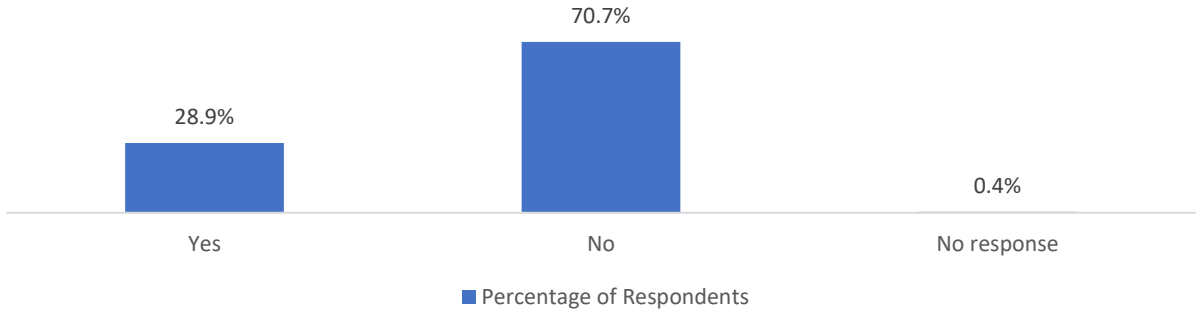


Figure 145: When you called the 2-1-1 Information and Referral Resource, were they helpful in getting you the services needed?

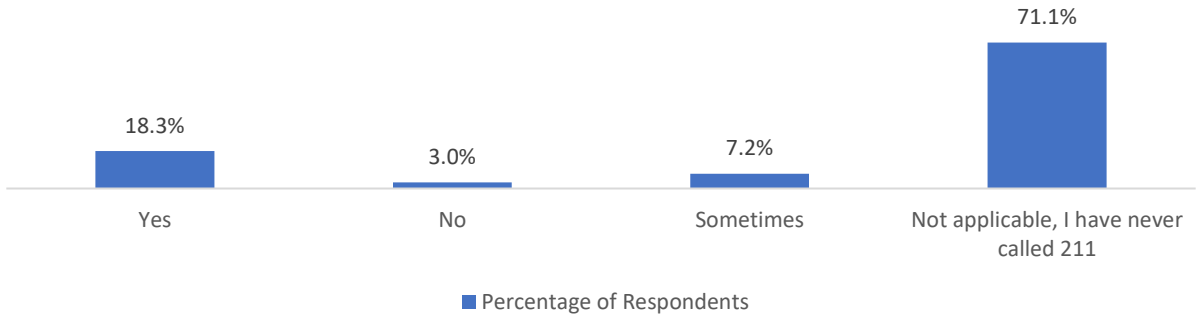


Figure 146: Were you able to get all the services you needed when you needed them?

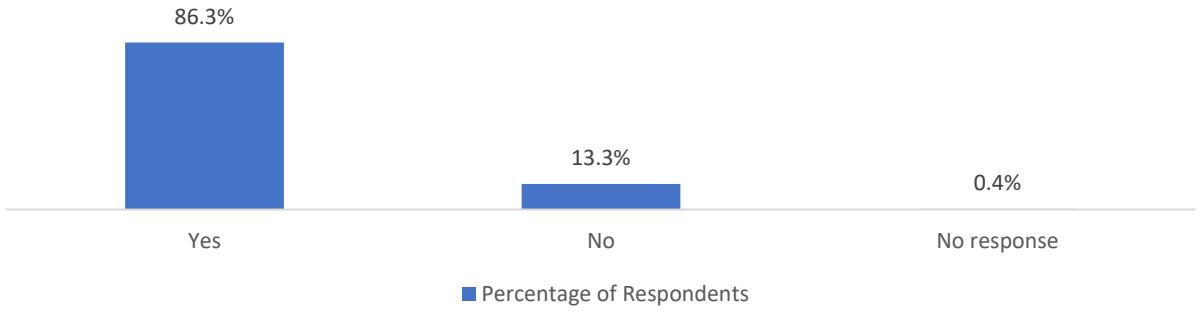


Figure 147: If no, please choose from the list below, the services you needed but were not able to get.

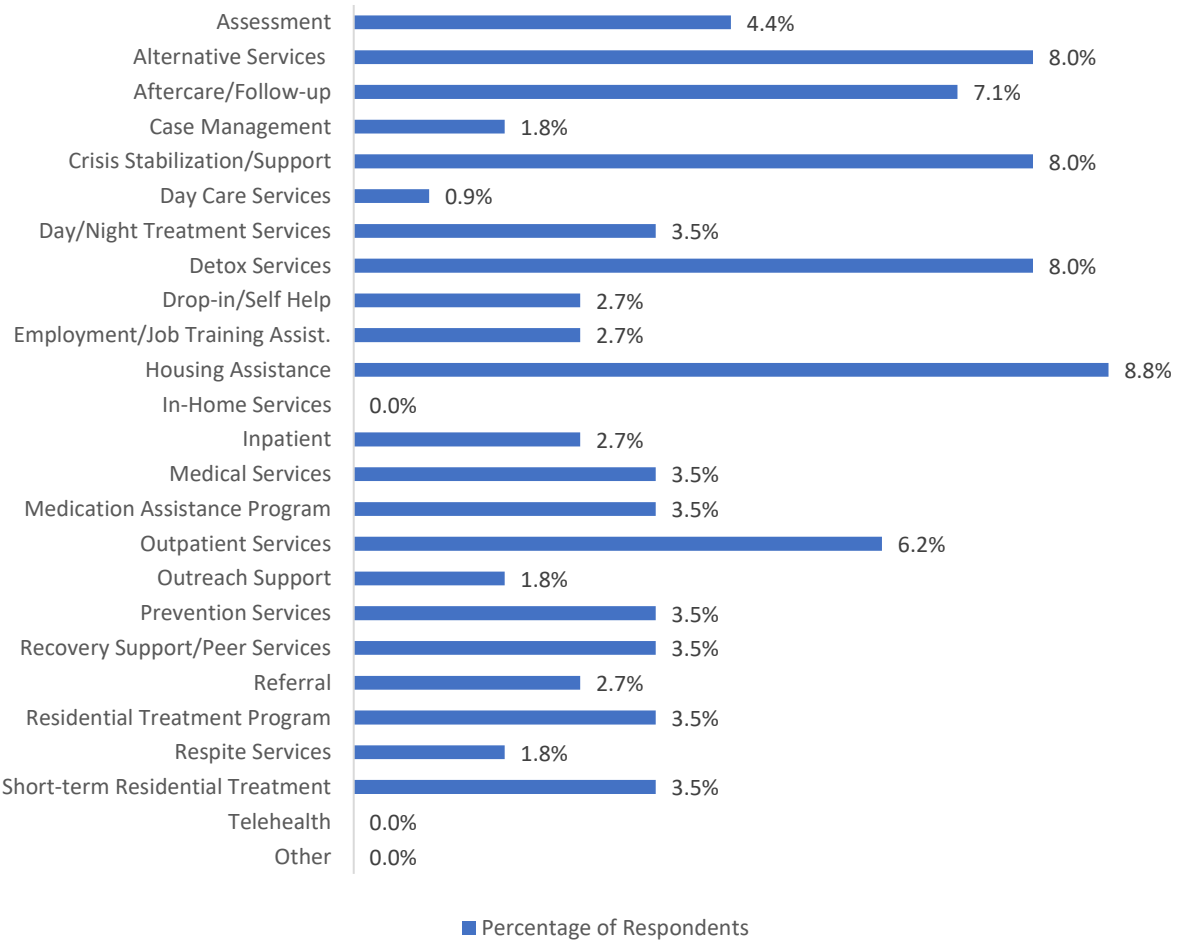


Figure 148: How many times during the last 12 months were you Not able to get the services you needed?

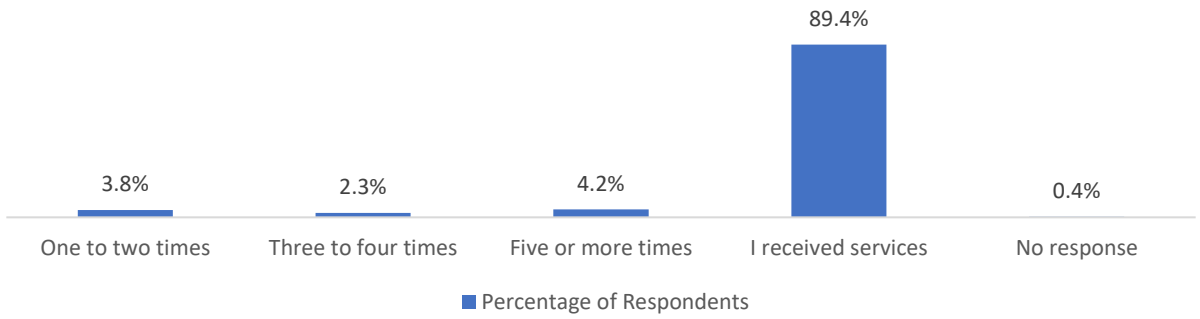


Figure 149: The services I needed were:

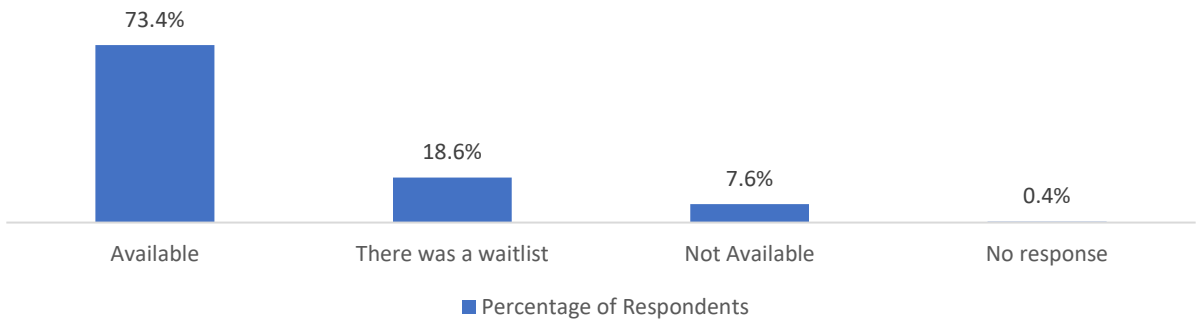


Figure 150: If there was a waitlist for services, were you offered other services you could receive while you waited?

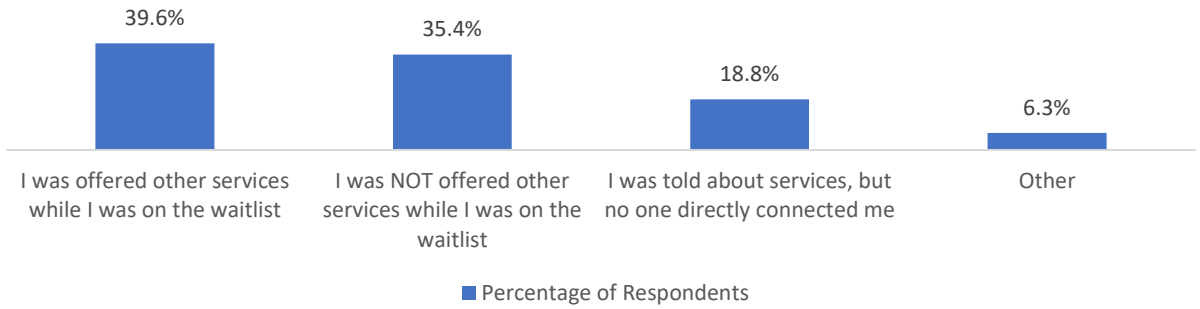


Figure 151: About how long were you on the waitlist for services?

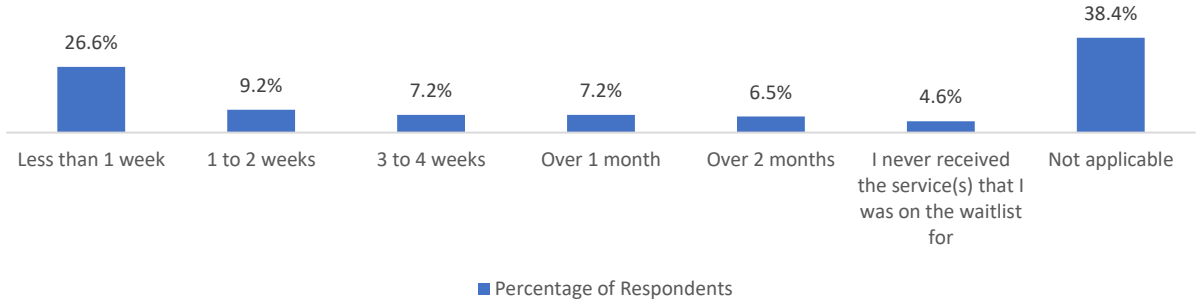


Figure 152: The services and planning I received were focused on my treatment needs (patient centered).

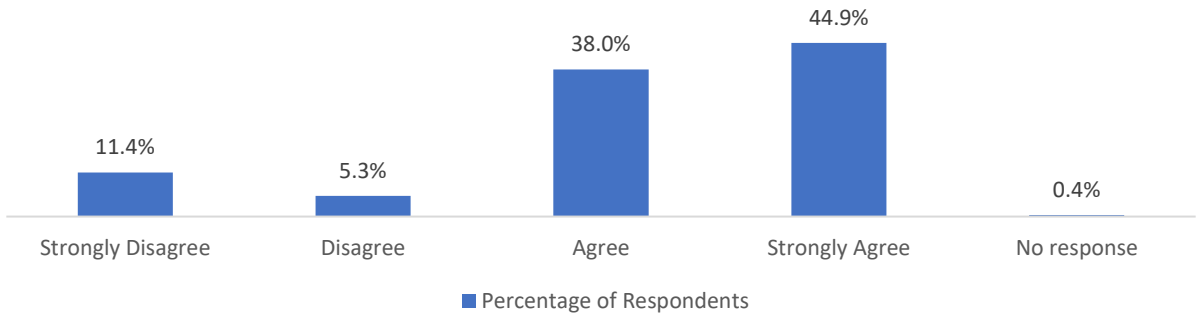


Figure 153: How long did it take from the time you requested an appointment for services to the time you received the services?

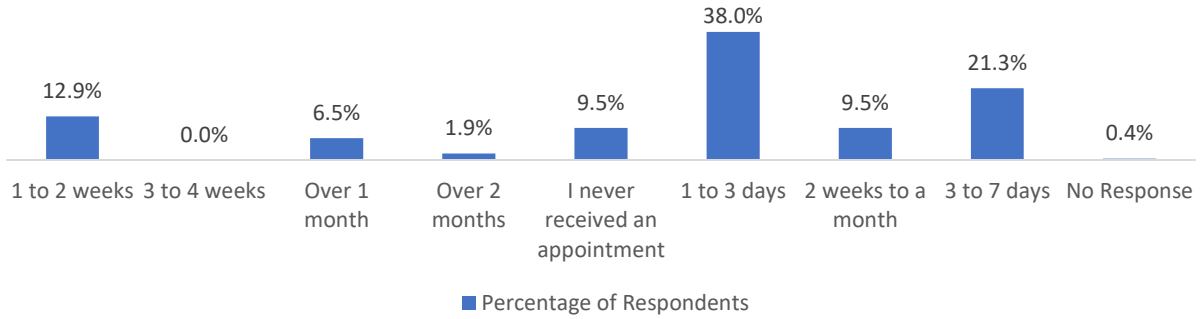


Figure 154: How long did it take to travel to the service?

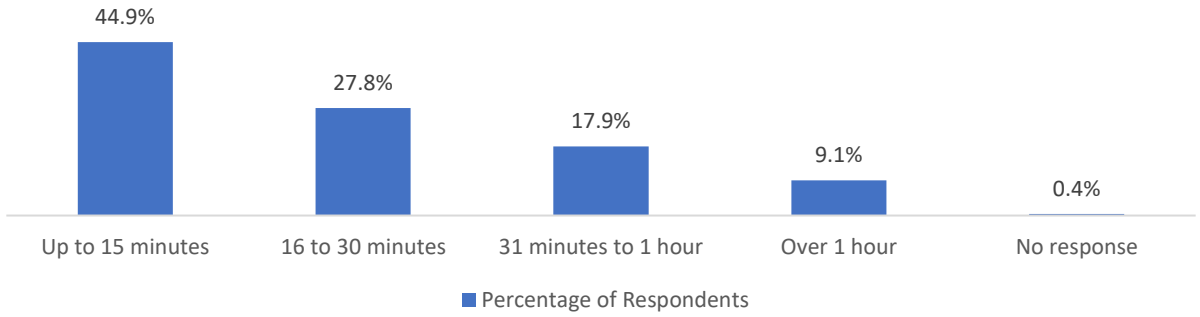
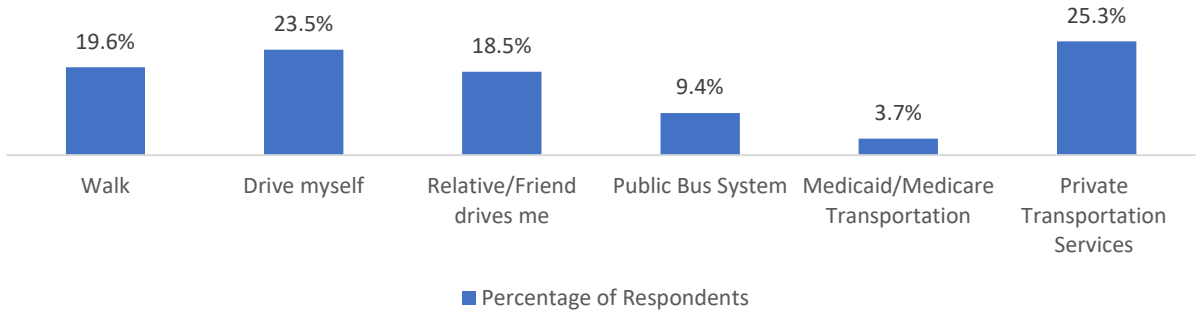
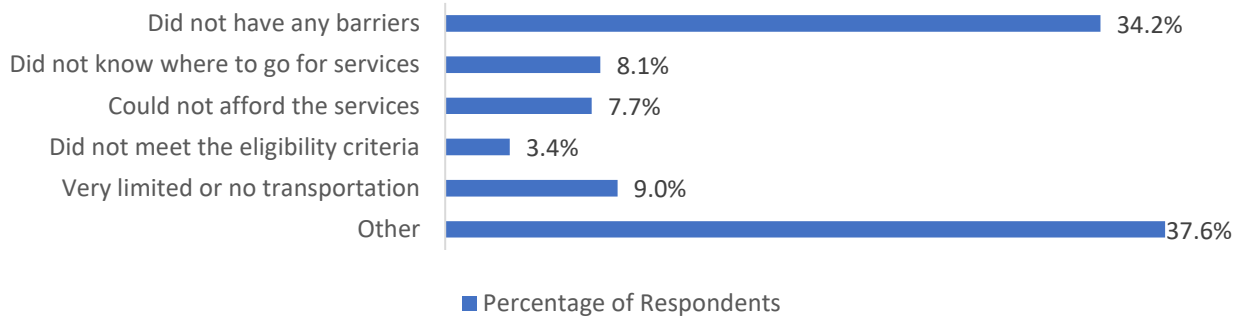


Figure 155: How do you travel to get services?



***Note-Private transportation includes Taxi, Uber, Lyft, TOPS, etc.**

Figure 156: What were the obstacles you experienced getting the care you needed?



STAKEHOLDER SURVEY SUMMARY

1. Please select the service sector which best describes your organization (Check all that apply)

Among stakeholders, there was diversity in terms of their organizational service sector, with the range of proportions among all sectors being from 1% to 9.5%. The top five most commonly reported organizational service sectors were Case Management (9.5%), Child and Family Services (8.2%), Social Services (7.3%), Elementary, Middle, or High School (7%), and Adult Substance Use Treatment (6.9%). The least commonly reported sectors included Juvenile Justice, Law Enforcement, and Faith-based Family Services (each 1%).

2. in which county do you provide services? (Check all that apply)

There was diversity when it came to where stakeholders provided services. Most survey respondents provide services in Palm Beach County (31.8%), followed by Saint Lucie County (20.5%), and Martin County (19.5%). Lower proportions of stakeholders provide services in Indian River County (14.4%) and Okeechobee County (13.9%).

3. On a scale of 1 to 4, with 4 being "strongly agree," how much do you agree with the following statement: "I am aware of the availability of mental health and substance use services in my area."

When asked about their awareness of the availability of mental health and substance use services in their area, the majority of stakeholders agreed that they were aware (53.7%), followed by those who strongly agreed (29.6%). Approximately 9% of respondents disagreed that they are aware of such services, while 7.4% strongly disagreed. Less than 1% of participants did not respond to this question (0.3%).

4. were you AWARE that Southeast Florida behavioral health network has a network of service providers which offers a variety of services and resources at no cost to eligible individuals?

When asked about their awareness of the SEFBHN no-cost services and resources, the majority of stakeholders indicated that they were aware (64.2%), while 35.5% indicated that they were not. Less than 1% of participants did not respond to this question (0.3%).

5. Have you accessed Southeast Florida Behavioral Health Network resources in the past 6 months?

When asked if they had accessed Southeast Florida Behavioral Health Network resources in the past 6 months, the majority of stakeholder respondents said they had not (61.7%). Just under 38% said they had, while less than 1% did not respond to this question (0.3%).

6. When you accessed Southeast Florida Behavioral Health Network resources, was it helpful?

Among those who had accessed Southeast Florida Behavioral Health Network resources in the past 6 months, the vast majority responded that they found the services helpful (84.8%). This was

followed by those who found the services somewhat helpful (13.6%). Only 1.6% of respondents indicated that they did not find the services to be helpful.

7. Have you ever directed individuals to access Southeast Florida Behavioral Health Network by calling or online?

The majority of stakeholders indicated that they had not ever directed individuals to access Southeast Florida Behavioral Health Network by calling or online (62.7%). However, 37% indicated that they had. Less than 1% of participants did not respond to this question (0.3%).

8. Are you aware of the 2-1-1 information, crisis intervention and referral hotline and online resource?

Almost all stakeholders indicated that they were aware of the 2-1-1 information, crisis intervention, and referral hotline, and online resource (97.8%), while only 1.9% indicated that they were not. Less than 1% of participants did not respond to this question (0.3%).

8A. Are you aware that 2-1-1 can dispatch a Mobile Response Team (MRT) that can met you and provide crisis intervention/assistance wherever you are?

A majority of stakeholders were aware that 2-1-1 can dispatch a Mobile Response Team (MRT) to provide crisis intervention/assistance wherever a person is in need (77.5%), while 22.2% were not. Less than 1% of participants did not respond to this question (0.3%).

9. Have you called or accessed the 2-1-1 in the past 6 months?

Among the stakeholders who were aware of 2-1-1, only 22.8% had accessed it in the past 6 months, while the vast majority had not (76.9%). Less than 1% of participants did not respond to this question (0.3%).

10. When you called or accessed 2-1-1, was it helpful?

Among the stakeholders who had accessed the 2-1-1 information and referral resource in the past 6 months, the vast majority found it to be helpful (74.7%), followed by those who found it somewhat helpful (20%). Only 4% of stakeholders did not find the 2-1-1 helpful when they accessed it.

11. Have you ever directed individuals to access 2-1-1 by calling or accessing the 2-1-1 website?

The majority of stakeholders indicated that they had ever directed individuals to access the 2-1-1 resource by calling or online (82.1%), while a minority indicated that they had not (17.6%). Less than 1% of participants did not respond to this question (0.3%).

12. Base on your knowledge, select which of the following is the crisis response model in your area. (Check all that apply)

The most commonly reported crisis response model in the stakeholders' areas was Mobile Crisis Response Team (46.4%). This was followed by the Mobile Response Team (19.5%), Behavioral Health Response Team (14.5%), and School District Mobile Response Team (12.4%) crisis response

models. The least commonly reported models included the Alternative Behavioral Response Team (4.4%) and Co-Responder Mobile Crisis Team (2.7%).

13. How would you rate community awareness of mental health and substance use treatment services available in your area?

When it came to rating community awareness of mental health and substance use treatment services in their areas, the majority of stakeholders (54.6%) rated it as Good to Excellent, while 32.1% rated it as Fair (31.2%), and just 14% rated it as Poor. Less than 1% of participants did not respond to this question (0.3%).

14. Please rate your level of agreement with the following statement: Linkages to needed services are well coordinated and well established across the system of care.

Stakeholders were asked to indicate their level of agreement with the statement "Linkages to needed services are well coordinated and well established across the system of care." Approximately 60% of respondents agreed with the statement (50.6% agreed and 10% strongly agreed), while 40% indicated some level of disagreement (33.3% disagreed and 6.2% strongly disagreed). Less than 1% of participants did not respond to this question (0.3%).

15. Please rate your level of agreement with the following statement: In general, behavioral health care and peer services are accessible in our area?

Stakeholders were asked to indicate their level of agreement with the statement "In general, behavioral health care and peer services are accessible in our area." The vast majority of stakeholders agreed with the statement, with 62.4% indicating they agreed and 12% stating that they strongly agreed. Just over a quarter of respondents disagreed with the statement, with 20.7% indicating that they disagreed and 4.6% indicating that they strongly disagreed.

16. Please rate your level of agreement with the following statement: The processes for referral are easily accessible.

Stakeholders were asked to indicate their level of agreement with the statement "The processes for referral are easily accessible." The majority of stakeholders agree with the statement, with 48.8% indicating that they agreed and 7.7% indicating that they strongly agreed. However, 43.2% of respondents disagreed with the statement, with 36.7% indicating that they disagreed and 6.5% indicating that they strongly disagreed. Less than 1% of participants did not respond to this question (0.3%).

17. Please rate your level of agreement with the following statement: Program and services are coordinated across the system of care.

Stakeholders were asked to indicate their level of agreement with the statement "Programs and services are coordinated across the system of care." A majority of stakeholders agreed with the statement, with 54.3% indicating that they agreed and 9.3% indicating that they strongly agreed. However, over one-third of participants disagreed with the statement, with 29.9% indicating that

they disagreed and 6.2% indicating that they strongly disagreed. Less than 1% of participants did not respond to this question (0.3%).

18. What are the barriers to accessing services that individuals in your community experience. (Check all that apply)

Among stakeholders, the most commonly reported barriers for individuals accessing services in their community included no or very limited transportation (14.2%), that individuals did not know where to go for services (12.5%), that they could not afford the services (12.4%), long waitlists (11.2%), and stigma (worried what people would think, fear, or shame) at 9.6%. Notably, some stakeholders also indicated that individuals experienced barriers related to language or cultural differences (7.7%) and that some individuals did not meet the eligibility criteria (7.7%). Only 0.4% of stakeholders indicated that individuals did not have any barriers.

19. What are the resources and services you feel are needed but are not available in your area?

Stakeholders listed resources and services central to addressing the social determinants of health and providing comprehensive, wrap-around, and coordinated care. To further illustrate, stakeholders specifically mentioned the need for housing (housing assistance, affordable housing, homeless services, and shelters), education (school services, programs, educational and awareness campaigns), transportation (transportation assistance and/or expanded options), and culturally competent service provision (linguistically and culturally competent providers along with treatment options available in multiple languages).

Notably, stakeholders also mentioned the need for additional and affordable behavioral health services. Responses included the need for increased availability, more diverse providers, and specific programs (therapists, child psychiatrists, grief support, trauma-informed care for youth, residential facilities, substance use programs, mental health providers, respite care, child and teen programs, dual-diagnosis services, detox, walk-in clinics, and specialty care programs). One stakeholder also mentioned the need for "Community Navigators to help connect the residents to services and follow up to ensure a successful connection to service providers."

20. List the top 3 patient-centered care resources and services that have improved quality of life of individuals.

Among those reported by stakeholders, the top three patient-centered care resources and services that have improved the quality of life of individuals include: 1) services that address basic needs (e.g., housing assistance, food/SNAP assistance, financial assistance, Medicaid and low-cost service assistance, and other necessities such as clothing, diapers, etc.); 2) case management and care coordination; and 3) the availability of services and access to care.

STAKEHOLDER SURVEY CHARTS

Figure 157: Percentage of respondents by organization service sector.

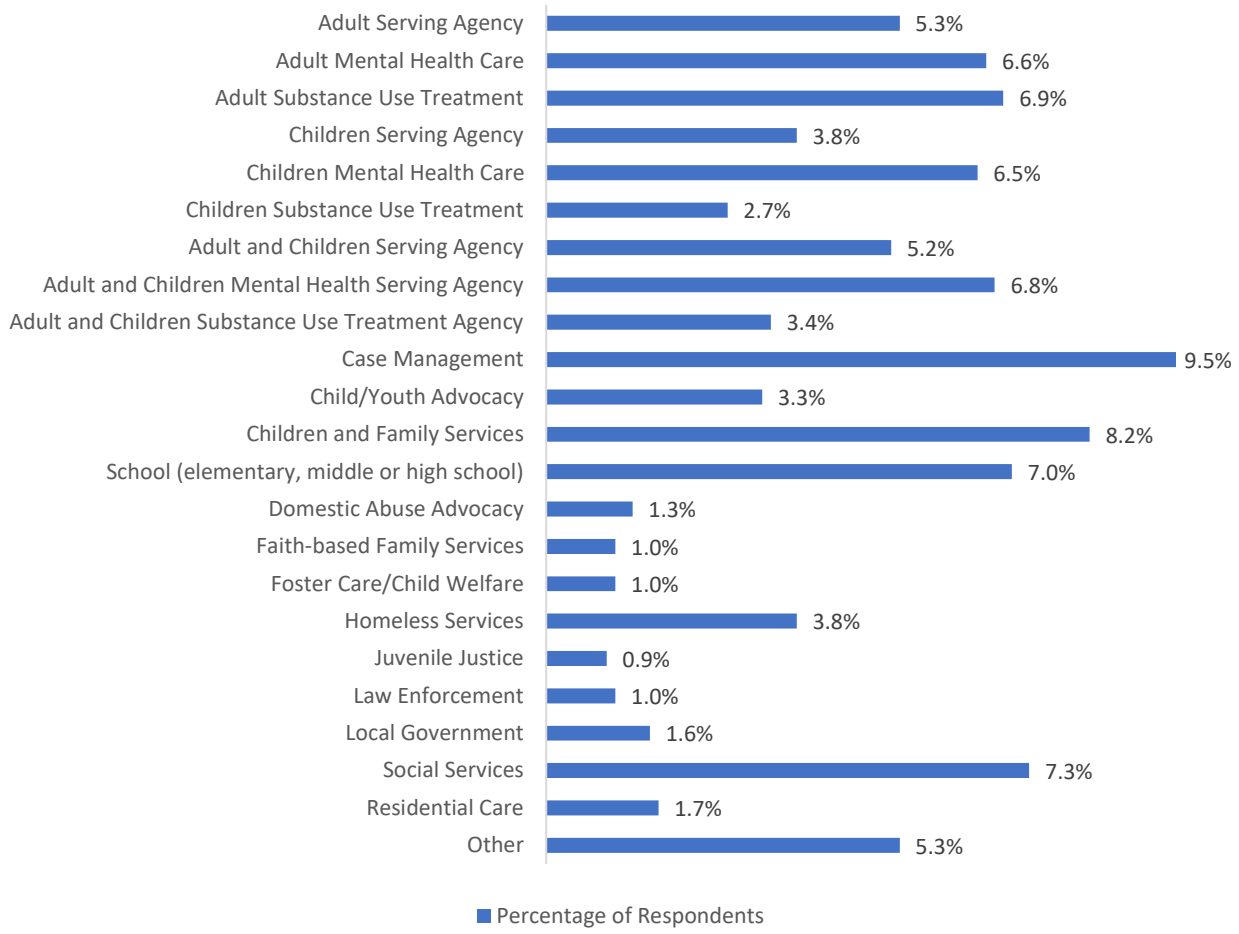


Figure 158: Percentage of stakeholder respondents by county.

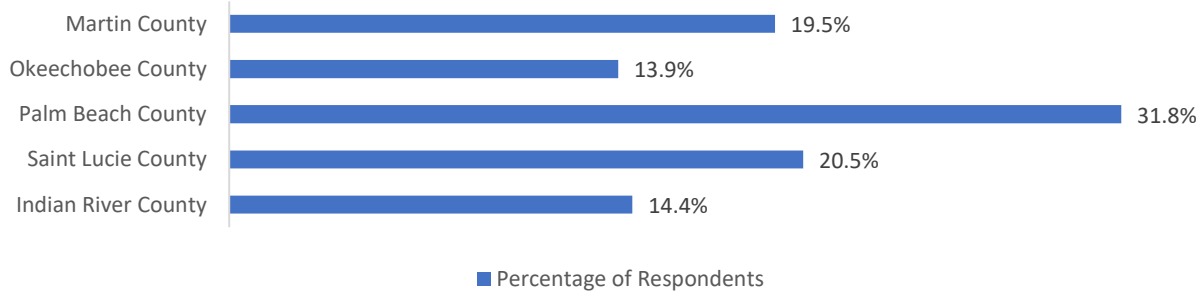


Figure 159: You are aware of the availability of mental health and substance use services in your area.

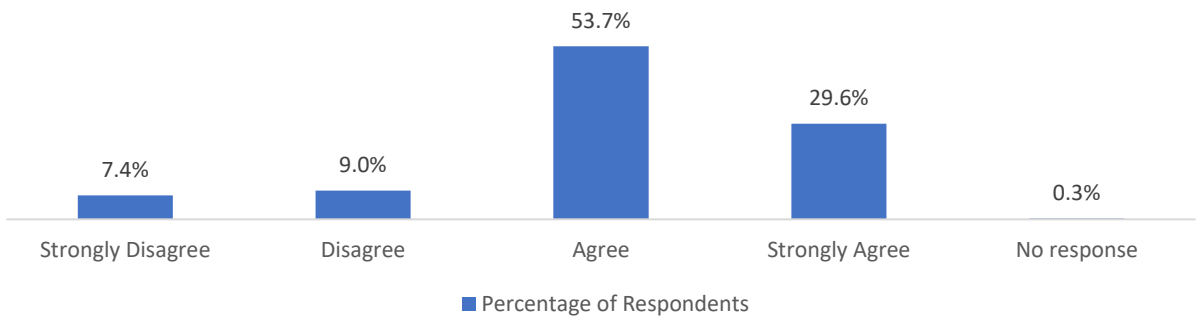


Figure 160: Are you aware of Southeast Florida Behavioral Health Network (Managing Entity) resources?

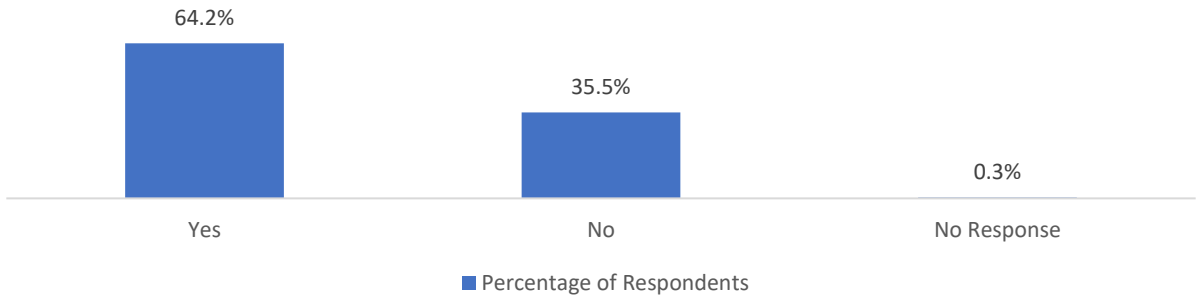


Figure 161: Have you accessed Southeast Florida Behavioral Health Network (Managing Entity) resources in the past 6 months?

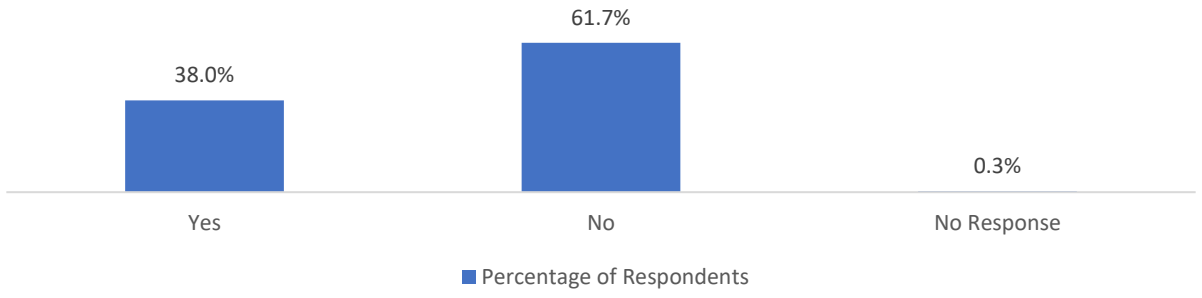


Figure 162: When you accessed Southeast Florida Behavioral Health Network (Managing Entity) resources, was it helpful?

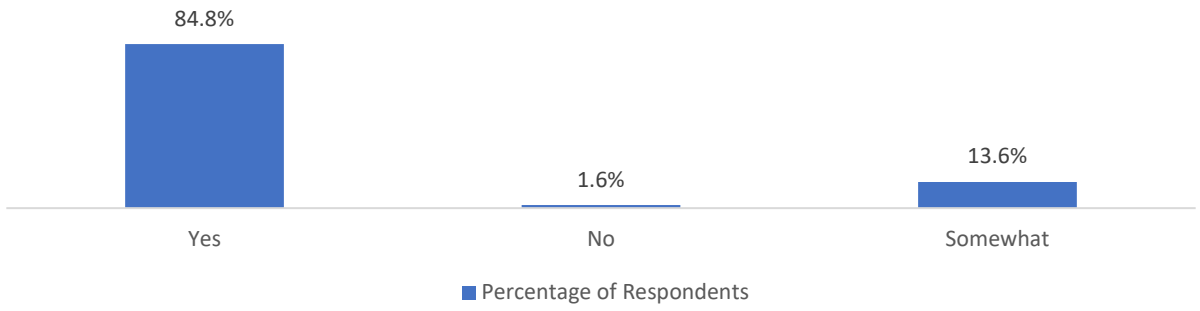


Figure 163: Have you ever directed individual to access Southeast Florida Behavioral Health Network (Managing Entity) by calling or online?

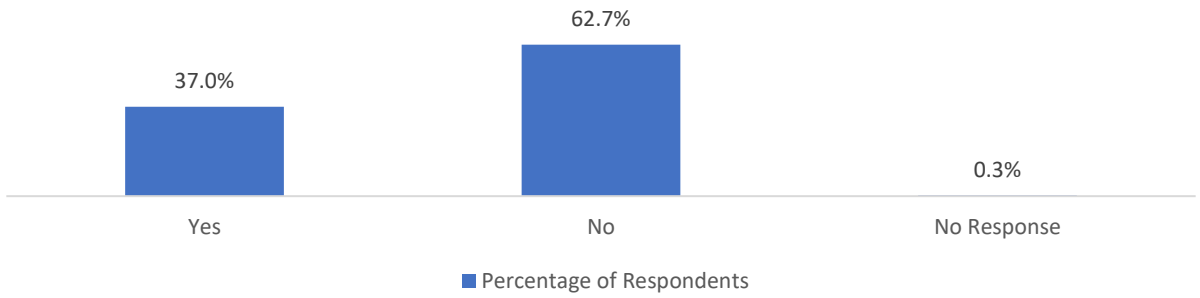


Figure 164: Are you aware of the 2-1-1 Information and Referral Resource?

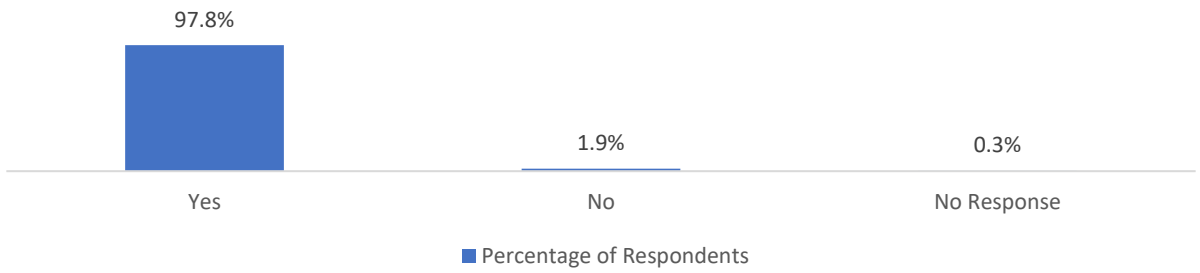


Figure 165: Are you aware that 2-1-1 can dispatch a Mobile Response Team (MRT) that can meet you and provide crisis intervention/assistance wherever you are?

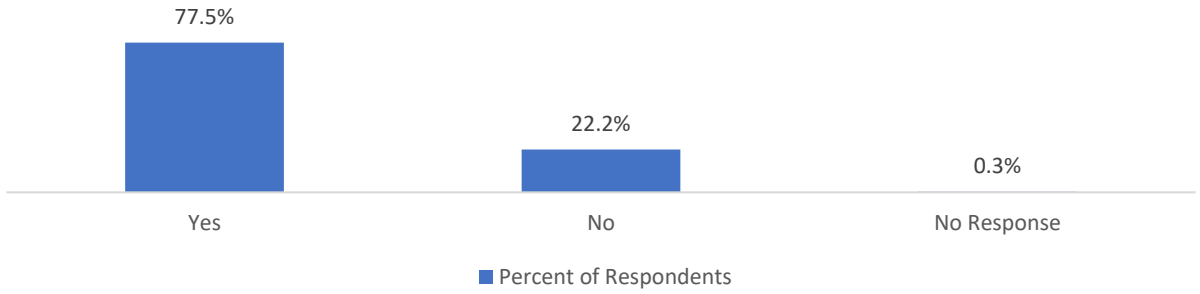


Figure 166: Have you accessed the 2-1-1 Information and Referral Resource in the past 6 months?

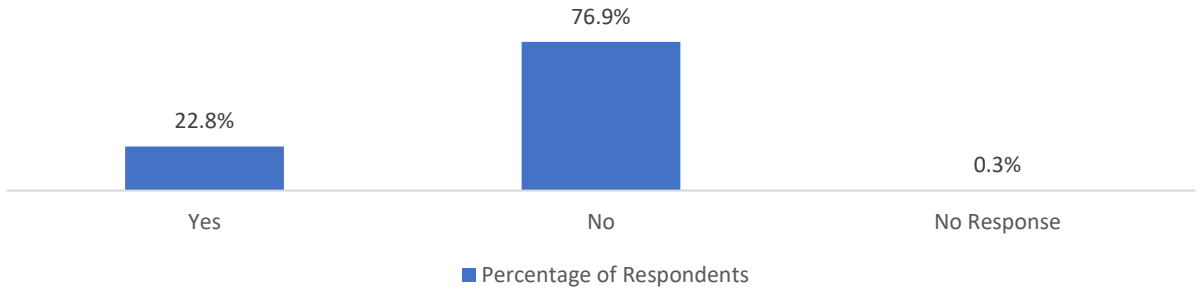


Figure 167: When you accessed the 2-1-1 Information and Referral Resource, was it helpful?

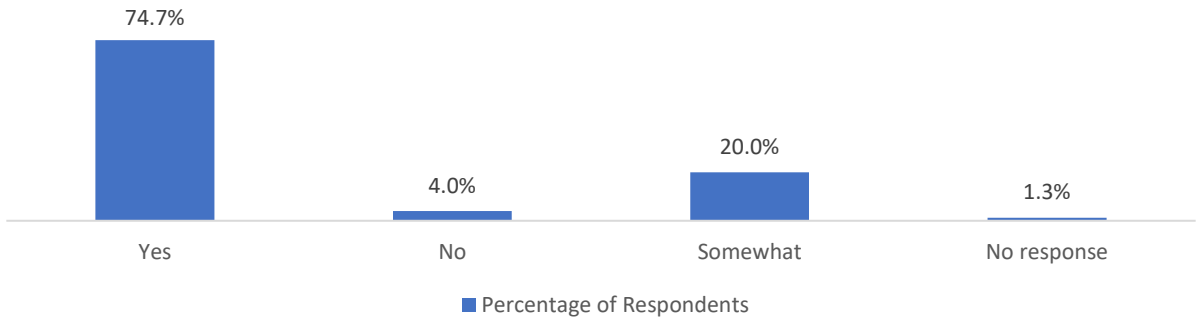


Figure 168: Have you ever directed individuals to access the 2-1-1 Information and Referral Resource by calling or online?

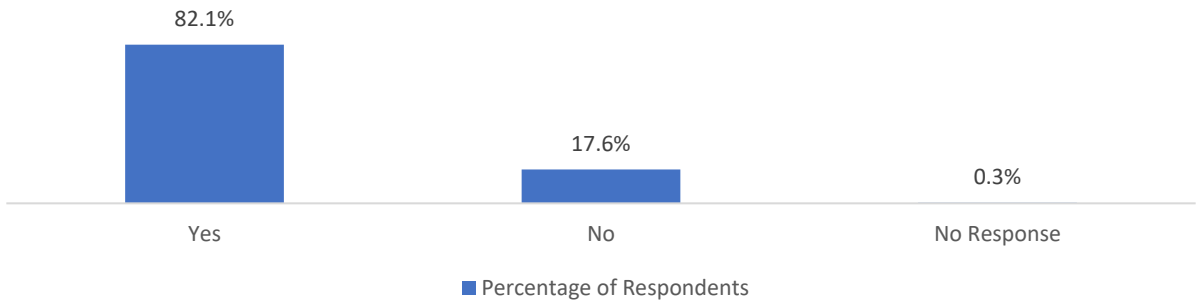


Figure 169: Select the crisis response model in your area. (Check all that apply)

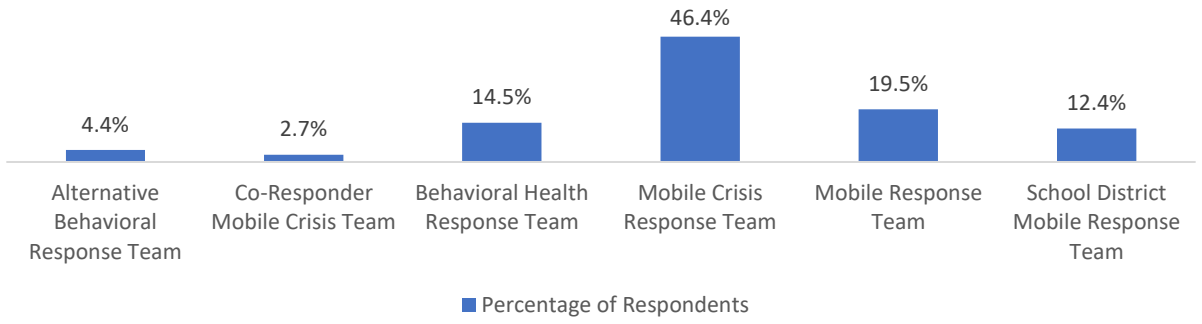


Figure 170: How would you rate community awareness of mental health and substance use treatment services in your area?

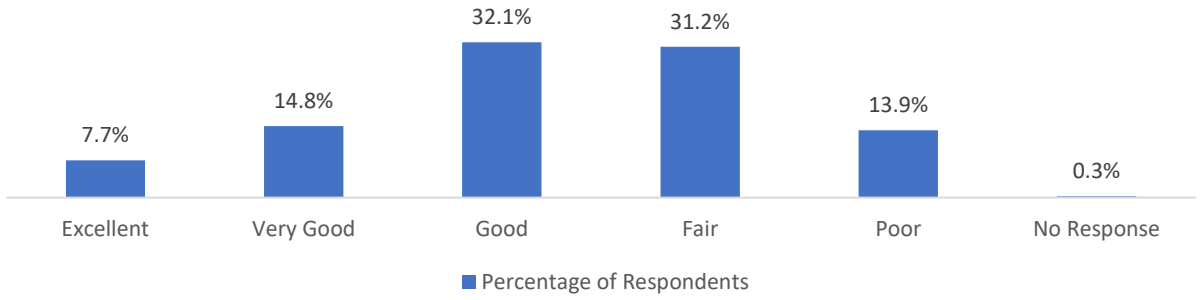


Figure 171: Linkages to needed services are coordinated and well established across the system.

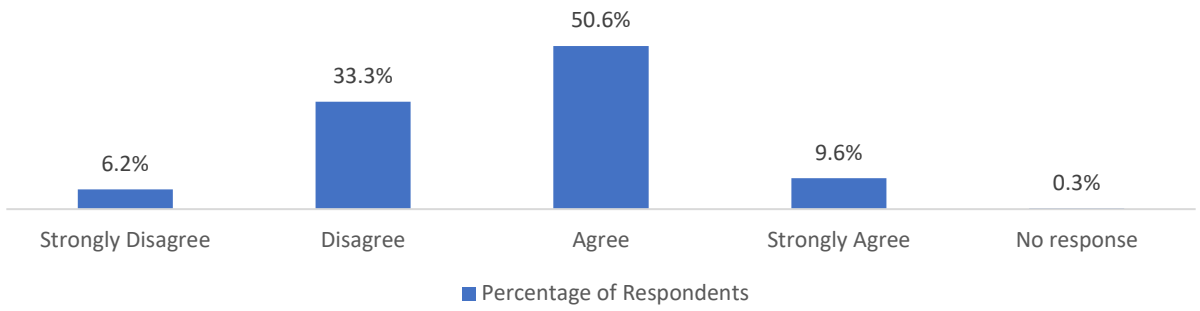


Figure 172: In general, behavioral health care and peer services are accessible in your area.

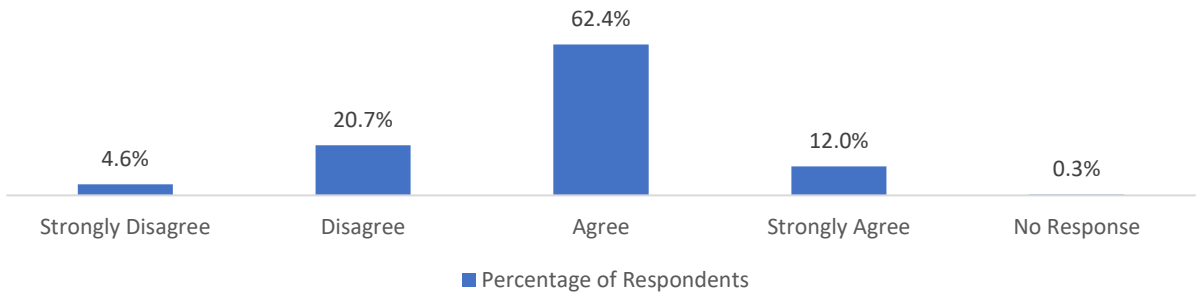


Figure 173: The process for referrals is easily accessible.

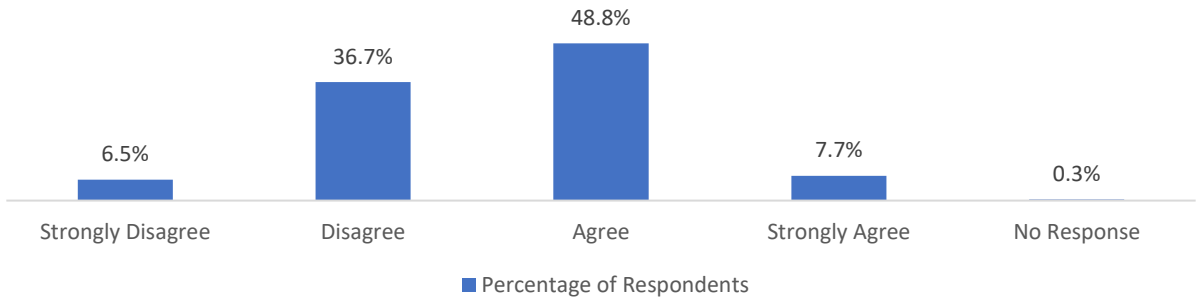


Figure 174: Programs and services are coordinated across the system of care.

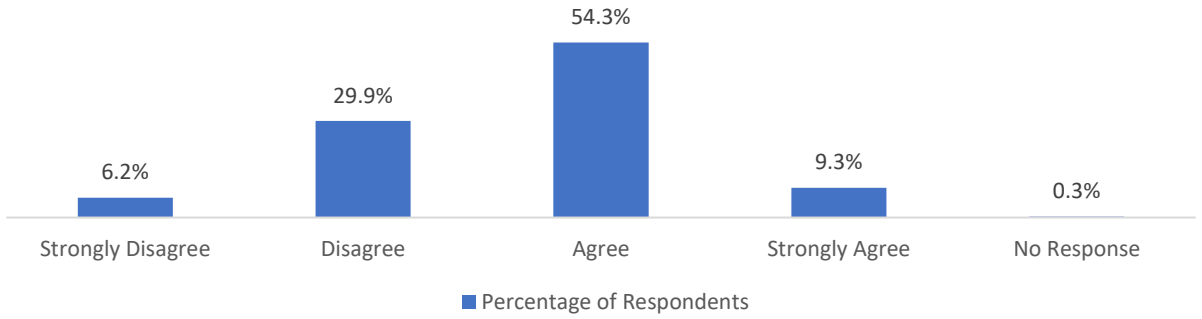


Figure 175: List the barriers for consumers accessing services in your community. (Check all that apply)

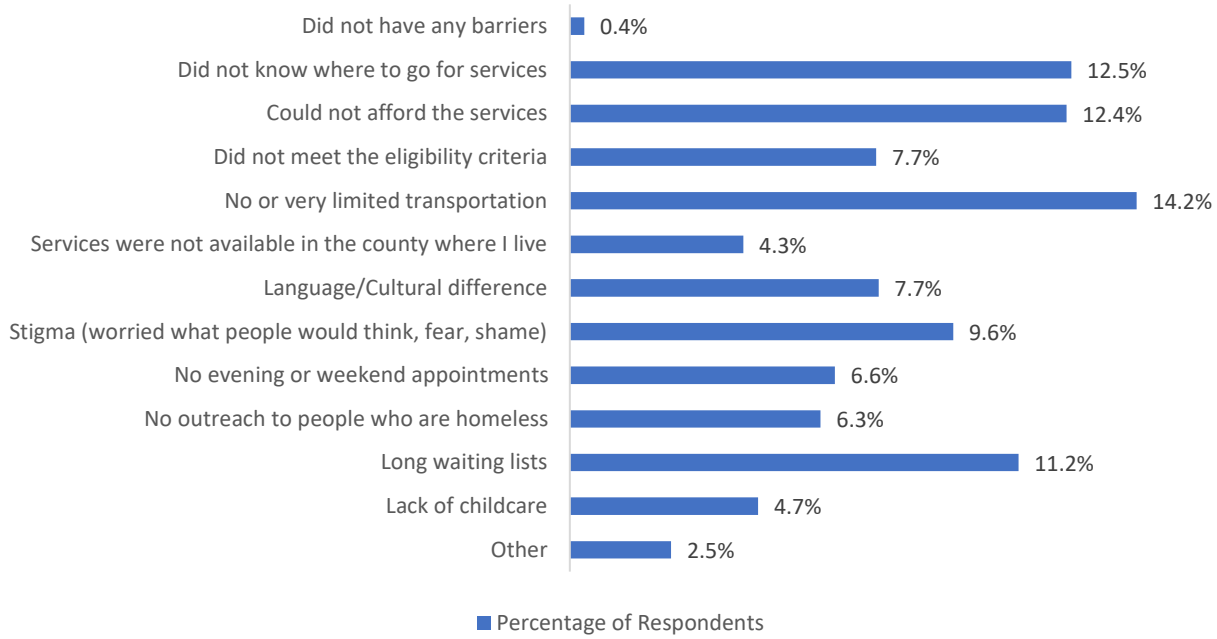


Figure 176: List the resources and services needed that are not available to improve patient-centered care and planning.

Needed Resources
Housing
Education
Transportation
Culturally Competent Service Provision

Figure 177: List the top three patient-centered care resources that have improved quality of life for individuals.

TOP THREE PATIENT-CENTERED RESOURCES
Basic Needs
Case Management & Case Coordination
Availability of Services/Access to Care

PEER RECOVERY COMMUNITY/SUPPORT SPECIALIST'S SURVEY SUMMARY

1. Which best describes your experience?

Most survey respondents had experience with adults with lived mental health conditions (35.4%), lived substance use conditions (22.8%), or lived co-occurring mental health and substance use conditions (17.7%). Other respondents included those with experience with family members or friends who had had lived mental health conditions (10.1%), lived substance use conditions (6.3%), or lived co-occurring mental health and substance use conditions (3.8%), and veterans with lived mental health conditions (1.3%), substance use conditions (1.3%), and lived co-occurring mental health and substance use conditions (1.3%). None of the survey respondents were youth with lived mental health conditions, lived substance use conditions, or lived co-occurring mental health and substance use conditions.

2. Which County do you live in?

Respondents resided in Palm Beach County (63.3%), Saint Lucie County (22.8%), Martin County (8.9%), and Indian River County (7.6%). No participants reported living in Okeechobee County; however, one participant did not share their county of residence.

3. What type of service agency are you employed or volunteer with? (Check all that apply)

Most respondents were employed or volunteered with agencies that offered peer support services (20.8%), adult mental health services (18%), adult substance use services (17.4%), recovery community organizations (11.2%), or family/peer organizations (10.7%). Other types of service agencies included children mental health services (5.6%), prevention services (5.6%), children substance use services (2.3%), and hospitals or emergency rooms (2.3%). Respondents also included those who worked or volunteered at homeless service organizations, transitional housing agencies, or nonprofits, such as The Lord's Place.

4. how long have you been employed, or volunteered, with the agency?

Overall, a majority of the respondents have been employed or volunteered with the agency for 3 years or less (65.2%). Notably, a quarter of respondents have been employed or volunteered with the agency for less than 6 months (25.3%).

5. Your work, or volunteer, schedule averages

Most work or volunteer schedules among respondents averaged 40 hours per week (63.3%). Respondents also reported working or volunteering more than 40 hours per week (15.2%), 20 hours per week (11.4%), and up to 10 hours per week (1.3%). Some respondents reported a varying schedule (7.6%).

6. Does the agency where you are employed, or volunteer, utilize recovery peer support services within the mental health or substance use services they provide in the community?

Overall, a large majority of the respondents reported that their agency utilizes recovery peer support services (89.9%). However, a few respondents were unsure (7.6%), and one respondent stated that this was not used. When asked why recovery peer support services were not used, this respondent stated that they did not know.

7. Does the agency where you are employed, or volunteer, adhere to recovery support best practices?

Most respondents (87.3%) stated that their agency adheres to recovery support best practices. Some respondents were unsure (10.1%), and one respondent stated that their agency did not adhere to recovery support best practices. When asked why these best practices were not used, this respondent stated that they did not know.

8. Please indicate the qualifications that best describe your status. (Check all that apply)

A majority of survey respondents reported being a Certified Recovery Peer Specialist (CRPS) (34.1%) or not certified (42.4%). Importantly, 14.1% of respondents have applied for certification and are in the process of obtaining certification. Other respondents were Recovery Peer Specialists with a Provision Certification (3.5%), National Certified Peer Specialists (NCPS) (3.5%), or Certified Recovery Support Specialists (CRSS) (1.2%).

9. Please indicate the facility/program setting that best describes where you deliver peer recovery support services. (Check all that apply)

Survey respondents worked in a variety of settings, often overlapping. Among all responses, family/peer grassroots organizations such as NAMI or Federation of Families were most reported (10.8%), followed by outpatient Recovery Community Organizations (RCO) at 10.1%, Medication Assisted Treatment (MAT)at 8.6%, and jail/corrections (8.6%). Other less commonly reported program settings included drop-in centers or club houses (5.8%), courts (5%), Crisis Stabilization Units (CSU) at 5.1%, Florida Assertive Community Treatment (FACT) at 4.3%, child serving organizations (3.6%), detoxification (3.6%), forensic reentry (3.6%), Healthy Start (3.6%), hospital emergency rooms (3.6%), the health department (3%), child welfare/dependency system (2.9%), Family Intervention Treatment Team (FITT) at 2.9%, law enforcement agencies (1.4%), and Substance Exposed Newborn (SEN) agencies (0.7%).

10. What are the reasons/factors for you in staying with the agency? (Check all that apply)

Among respondents, personal fulfillment (24.7%), commitment to recovery principles (18.6%), flexibility with work schedule (17.7%), work hours (16.3%), and administration support (13.5%) were the most popular reasons for staying with an agency. Interestingly, only a few respondents listed competitive salary (5.1%). Survey respondents also noted belief in the mission, supportive

leadership, teammates and organizations, love of the job, helping people, and the need for income as other reasons of staying with their agency.

11. What barriers/challenges have you experienced in the hiring (or volunteering) process to become a Peer? (Check all that apply)

Respondents faced multiple barriers and challenges in the hiring or volunteering process to become a peer, the most of which focused on salary (33.3%), followed by the exemption and background screening process (11.5%), the exam (11.5%), limited employment opportunities (11.5%), volunteer hours (6.3%), work schedules/hours (5.2%), and language barriers (2.1%). Other barriers noted by the respondents included a need to go back to school and challenges within the application process. It is important to note that many respondents also indicated that they did not face any barriers, with 16.7% of respondents selecting the "none" category.

12. What trainings would you recommend in assisting Peers in delivering effective Peer Support Services? (Check all that apply)

Survey respondents saw value in a number of different trainings to assist peers in developing effective peer support services. The most popular trainings among respondents included trainings such as the 40-hour required Peer Recovery Specialist training/Helping Others Heal (10.2%), Boundaries/Ethics, Professional Responsibility (9.4%), and Compassion Fatigue/Self-care (9.2%). Other trainings recommended by survey respondents included Trauma Informed training (8.6%), Wellness Recovery Action Plan (WRAP) training (7.8%), Cultural Competencies (7.6%), Peer Support (7.6%), documentation training (6.8%), Suicide Prevention Awareness Education (such as QPR) (6.6%), Mental Health First Aid (6.5%), NAMI Peer to Peer (5.3%), Whole Health Action Management (WHAM) at 5.3%, Recovery Capital as a Foundation or Recovery Planning (4.7%), and Intentional Peer Support (IPS) at 3.3%. Respondents also shared other training recommendations, such as motivational interviewing, eCPR, training to help with substance use, and training in identifying true nature of addiction/alcoholism.

13. Does your agency have any existing partnerships with other peer support recovery programs, recovery community organizations and general community support groups?

Nearly three-quarters of respondents stated their agency has existing partnerships with other peer support recovery programs, recovery community organizations, and general community groups (74.7%). Many respondents were unsure (20.3%), and some respondents stated that these partnerships did not exist (3.8%).

14. Are you aware of any other partnerships that your agency may have with organizations that provide resources, such as: (Check all that apply)

Nearly all survey respondents were aware of other agency partnerships that provide services. Those services included RCO (10%), Housing (Continuum of Care)/Oxford Homes (10%), Career Source/employment agencies (9.7%), food pantries/meal programs (9.7%), and jail or corrections facilities (9.1%). Other agencies included halfway housing (8.6%), child welfare services (8%), the

health department (8%), drop-in centers (7.4%), and church or faith-based organizations (6.3%). Less participants reported known partnerships with probation (4.6%), transportation (4.3%), or child or daycare agencies (2.9%). Some respondents shared other agency partnerships, such as the Department of Children and Families, inpatient treatment centers, and hospitals.

15. Are you able to support voice and choice principles (i.e., respecting individual choice and self-determination) for the individuals that you serve at your agency?

Most respondents stated that they were able to support voice and choice principles for the individuals served at their agency (91.1%). Some respondents were unsure (6.3%), and one respondent stated that this was not used at their agency. When asked why voice and choice principles were not used, this participant stated that they did not know.

16. Does the organization you are employed, or volunteer, with help to reduce stigma by promoting recovery language that is person centered?

A majority of respondents stated that their agency does help to reduce stigma by promoting recovery language that is person centered (87.3%). Some respondents were unsure (10.1%), and one respondent stated that this was not done at their agency. When asked why stigma reduction initiatives such as promoting recovery language that is person centered was not used, this participant stated that they did not know.

17. Does the agency where you are employed, or volunteer, with include Peers in the process of program development, promotion, evaluation, and improvement.

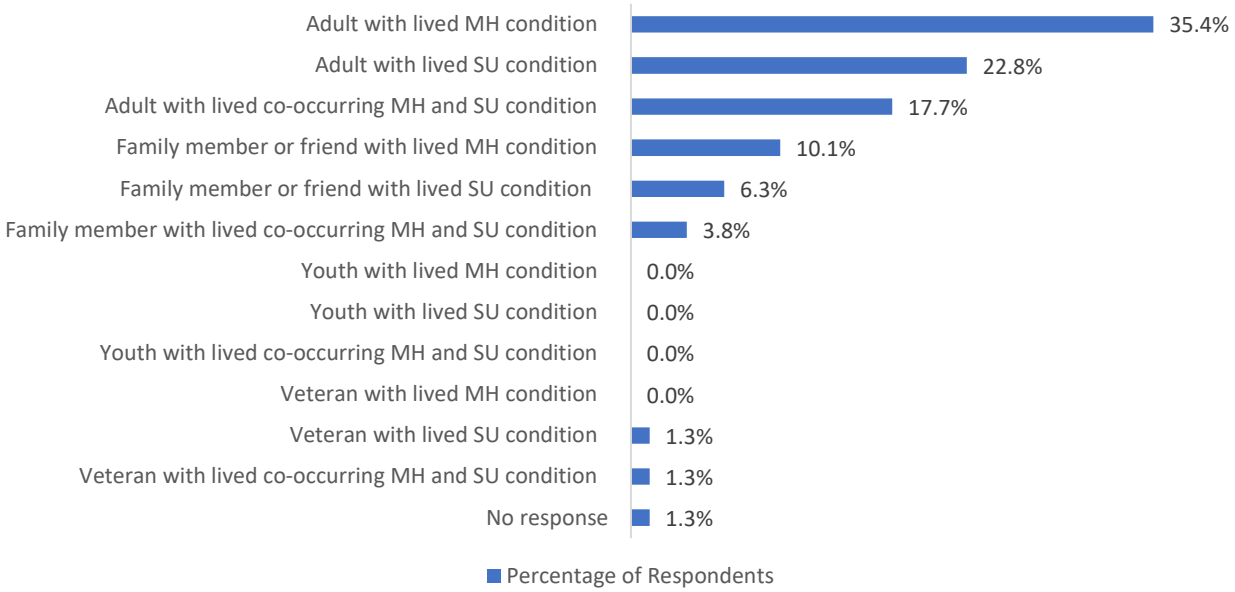
A majority of respondents stated that their agency includes peers in the process of program development, promotion, evaluation, and improvement (81%). Notably, 6.3% of respondents stated that this was not done in their agency, and 11.4% were unsure. Among those who stated that peers were not included in the process of program development, promotion, evaluation, and improvement, most stated they were not sure or that management utilized a top-down structure.

18. Does the agency where you are employed/volunteer with include persons in recovery in management and board meetings.

Over half of respondents stated that their agency includes persons in recovery in management and board meetings (57%) compared to 11.4% who stated that these persons were not included in such meetings. Over one-quarter of respondents were not sure (30.4%).

PEER RECOVERY COMMUNITY/SUPPORT SPECIALIST'S SURVEY CHARTS

Figure 178: Which best describes your experience?



Note: Mental Health (MH) and Substance Use (SU)

Figure 179: Which county do you live in?

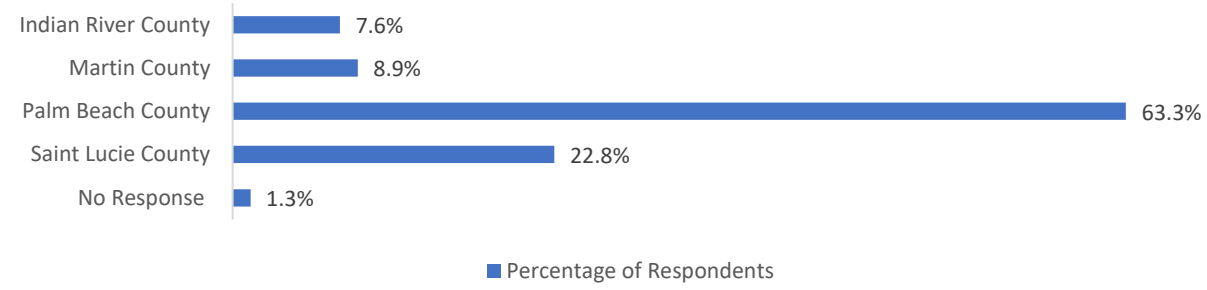


Figure 180: What type of service are you employed or volunteer with? (Check all that apply)

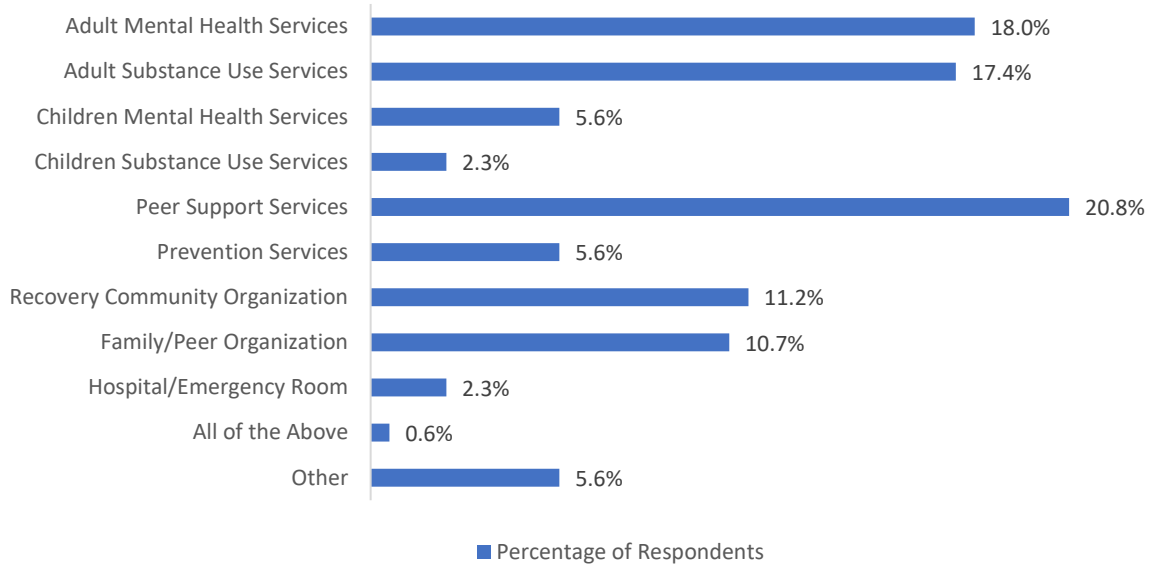


Figure 181: How long have you been employed/volunteered with the agency?

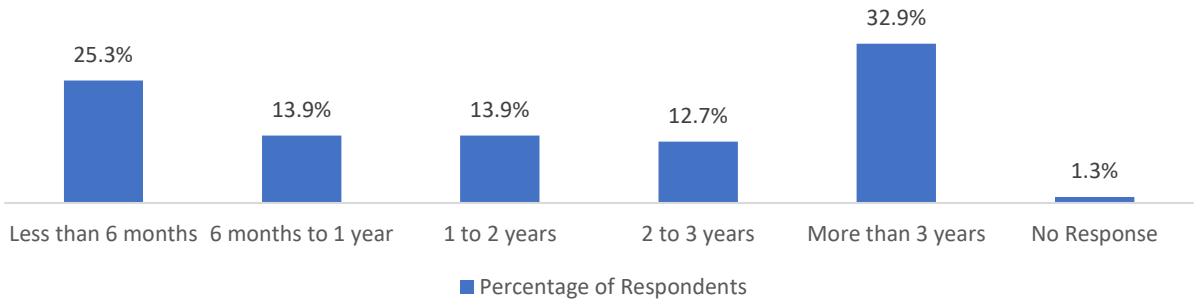


Figure 182: My work schedule averages...

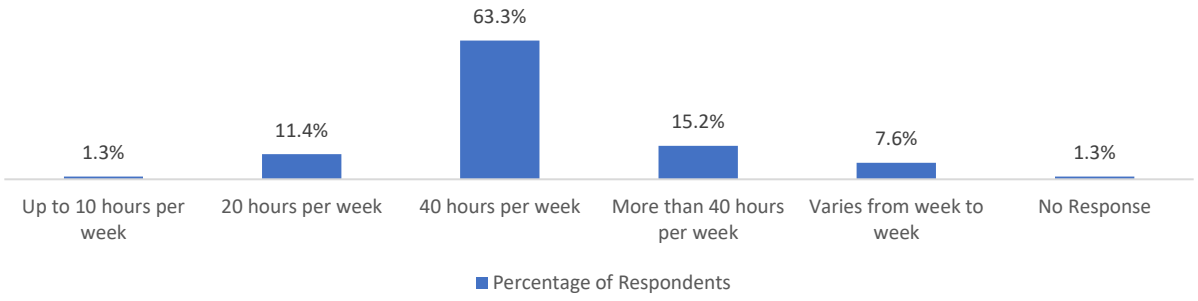


Figure 183: Does the agency where you are employed, or volunteer, utilize recovery peer support services within the services they provide in the community?

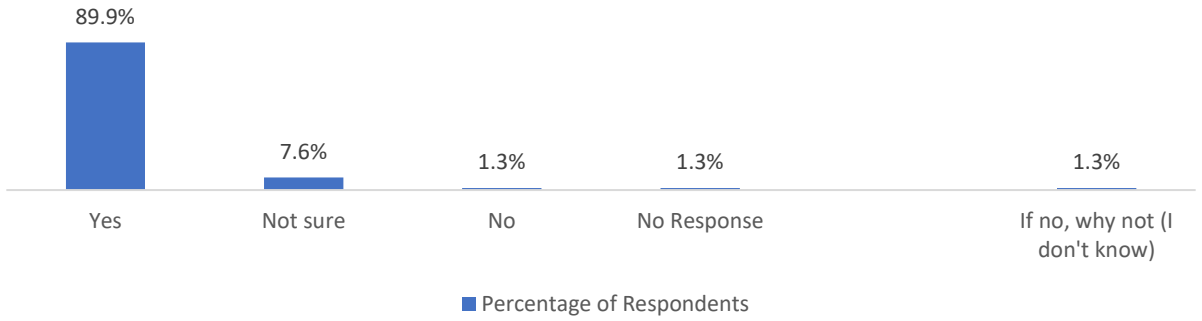


Figure 184: Does the agency where you are employed, or volunteer, adhere to recovery support best practices?

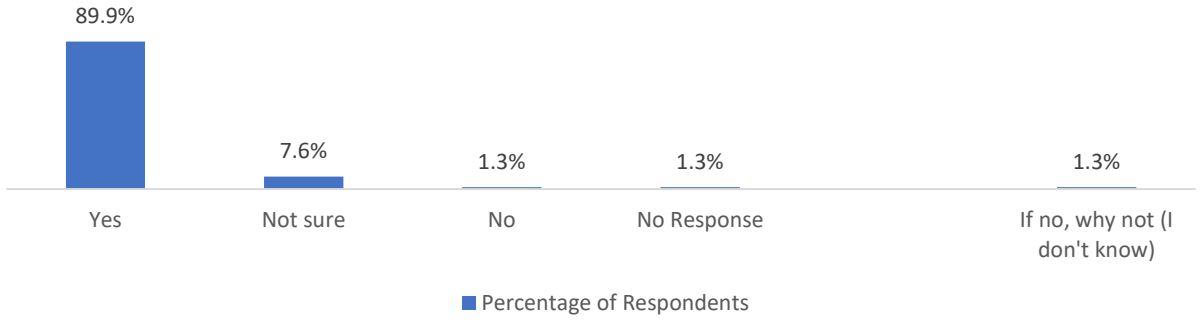


Figure 185: Please indicate the qualifications that best describe your status. (Check all that apply)

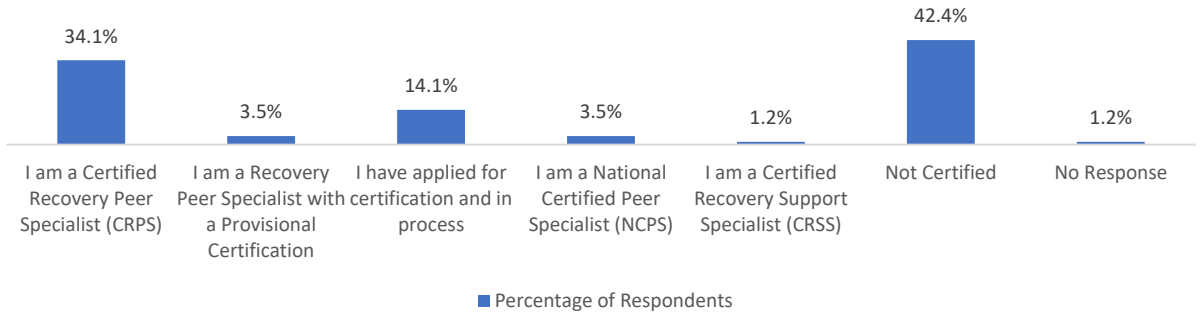


Figure 186: Please indicate the facility/program setting(s) that best describes where you deliver peer recovery support services. (Check all that apply)

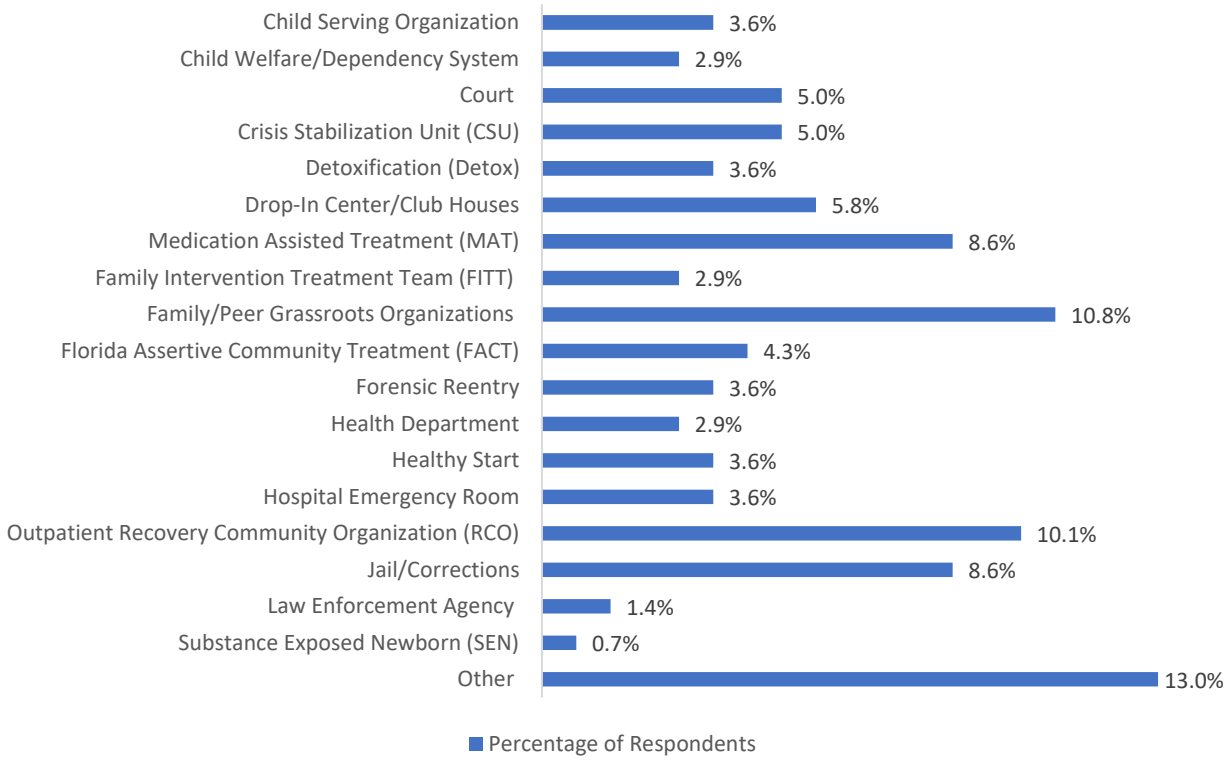


Figure 187: What are the reasons/factors for staying with the company? (Check all that apply)

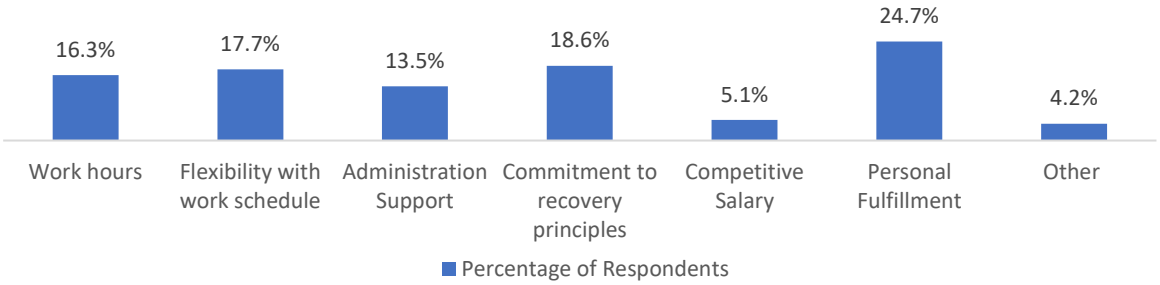


Figure 188: What barriers/challenges have you experienced in the hiring process? (Check all that apply)

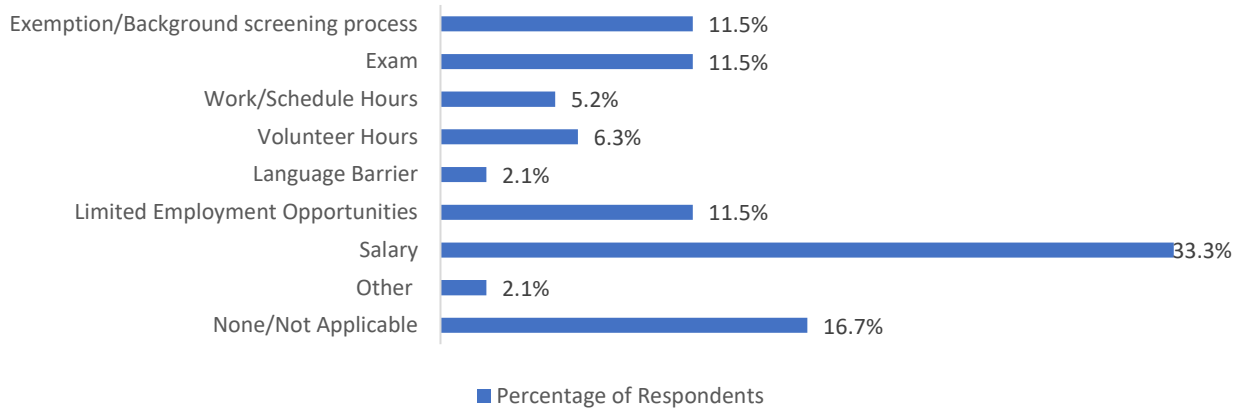
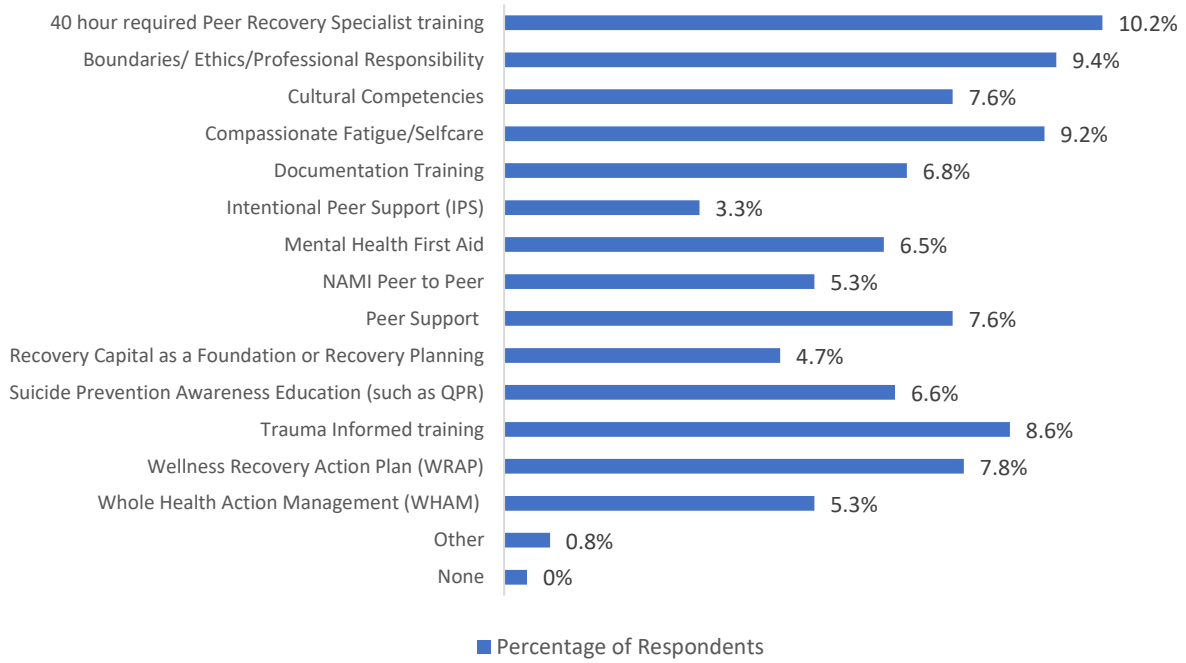


Figure 189: What training would you recommend for peers to have to help them provide peer support services? (Check all that apply)



Note: 40 hour required Peer Recovery Specialist training/Helping Others Heal

Figure 190: Are there partnerships that exist with peer support recovery programs, recovery community organizations, and other support groups?

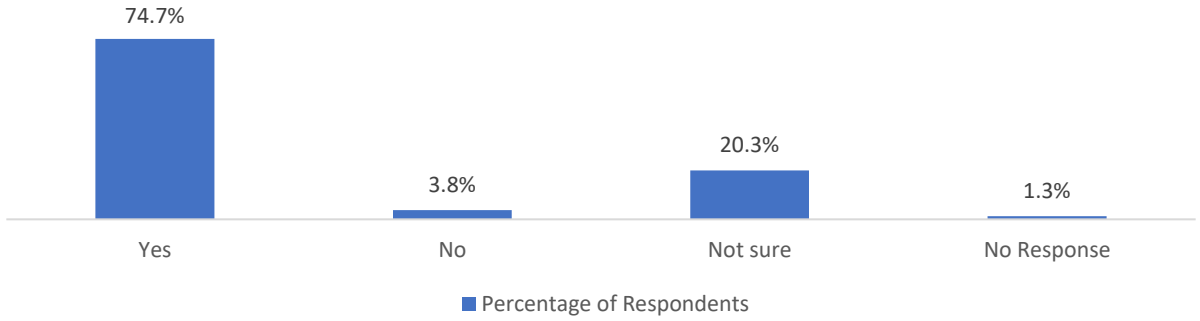


Figure 191: Are you aware of partnerships with other organizations that provide other resources such as: (Check all that apply)

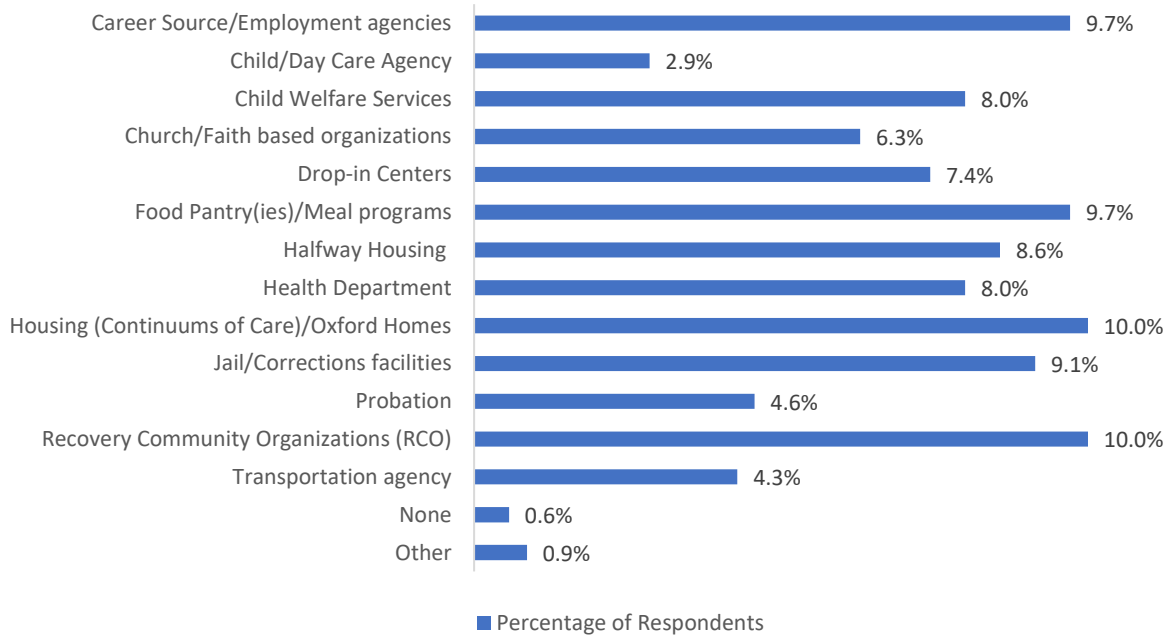


Figure 192: Do you have the ability to offer choices to the individuals where you serve at the agency you are employed/volunteer?

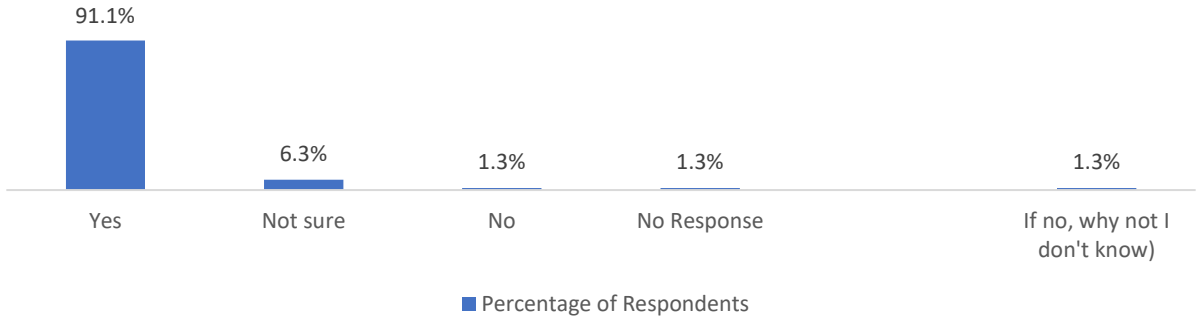


Figure 193: Does the organization where you are employed/volunteer with help to reduce stigma by promoting recovery language that is patient centered?

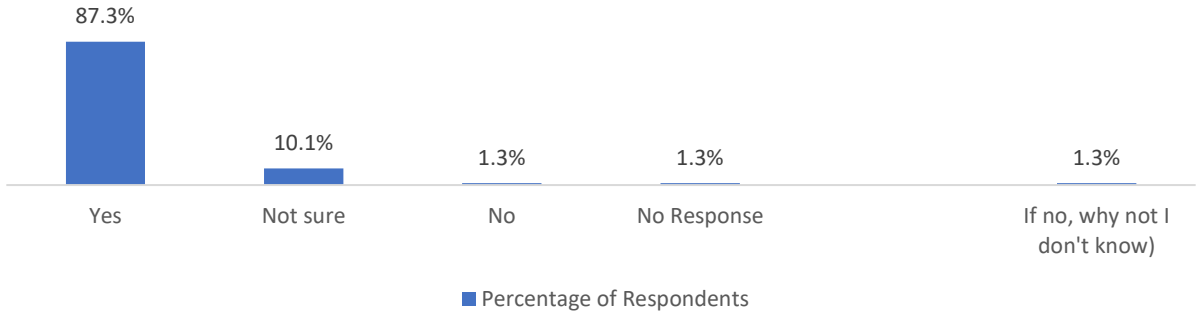


Figure 194: Does the agency where you are employed/volunteer include peers in developing and promoting effective program development, evaluation, and improvement?

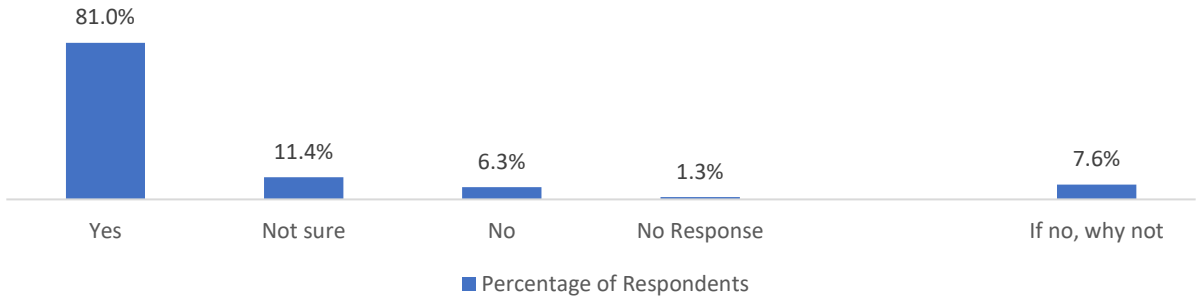
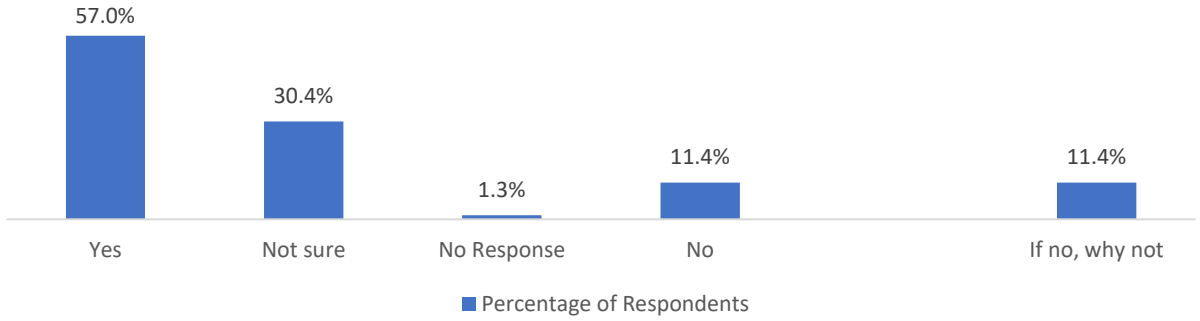


Figure 195: Does the agency where you are employed/volunteer with include persons in recovery management and governance?



RECOVERY ORIENTED SYSTEM OF CARE RESOURCES

Behavioral Health Resources and Supports for Circuits 15 and 19

211 Palm Beach/Treasure Coast, Inc.*	Lawnwood Pavilion Behavioral Health Services
2nd Chance Mental Health Center	Legacy Behavioral Health Center, Inc. – Belle Glade*
Access Recovery Solutions*	Legacy Behavioral Health Center, Inc. – Indiantown*
ADAP Counseling Services	Legacy Behavioral Health Center, Inc. – Okeechobee*
All in Solutions Counseling Center, LLC (AISOL)	Legacy Behavioral Health Center, Inc. – Port Saint Lucie*
Alternatives in Treatment, LLC	Legacy Behavioral Health Center, Inc. – Vero Beach*
Ambrosia of the Palm Beaches	Legacy Behavioral Health Center, Inc. – West Palm Beach*
Ambrosia Treatment Center	Lifeskills South Florida Outpatient
Amethyst Recover Center, LLC	Lighthouse Recovery Institute
Archstone Behavioral Health	Love and Hope in Action, Inc.*
Awareness Counseling Agency, LLC	Lumiere Detox Center
Banyan Boca	Mandala Healing Center*

Banyan Stuart	Map to Health DBA Recovery Unplugged
Beachcomber Family Treatment Center	Marion Stamm Abusive Partners
Beachside Detox	Medical Center North Campus*
Beachway Therapy Center, LLC	Mental Health Association of Palm Beach County, Inc.*
Beachway Therapy Center, LLC Residential and Detox	Multilingual Psychotherapy Center*
Behavioral Health of the Palm Beaches DBA Ctr for Alcohol and Drug Studies	NAMI Palm Beach County, Inc.*
Behavioral Health of the Palm Beaches DBA Seaside of the Palm Beaches	NeuroPsychiatric Addiction Clinic
Believe Drug and Alcohol Treatment Center	Neuroscience Research Institute
Best Life Counseling	New Horizons of the Treasure Coast, Detox*
Boca Counseling Center	New Horizons of the Treasure Coast – Fort Pierce*
Boca Detox Center	New Horizons of the Treasure Coast Inc Mental Health Services*
Boca Recovery Center	New Horizons of the Treasure Coast – Okeechobee*
Boys Town South Florida*	New Horizons of the Treasure Coast Residential Program Level 2 – Fort Pierce*

Brighter Family Center*	New Horizons of the Treasure Coast – Stuart*
Caron of Florida	New Horizons of the Treasure Coast – Vero Beach*
Catholic Charities of the Diocese of Palm Beach, Inc.*	New Path Halfway House, Inc.
Center for Discovery Palm Beach	New Reflections Counseling, Inc.
Center for Family Services of Palm Beach County, Inc.*	New Reflections Counseling Inc Boynton Beach
Central Florida Treatment Center Fort Pierce OP MAT	North Palm Beach Recovery Center
Central Florida Treatment Center Lake Worth OP MAT	Olympic Behavioral Health LLC
Changes Wellness Center LLC	Palm Beach County Substance Abuse Coalition, Inc.*
Chapel Hill Medical Detox	Palm Beach Habilitation Center, Inc.*
Chrysalis Health*	Palm Beach Institute
Clean and Sober Recovery Center Inc Better Tomorrow Treatment Center	Pendulum Detox DBA 1 Solution Detox
Cleveland Clinic Indian River Hospital Behavioral Health Center	Phoenix Rising Wellness Center

Coastal Detox, Inc.	Pivot Treatment and Wellness Centers
Compass Health Systems Boynton Beach Clinic	Port Saint Lucie Hospital
Comprehensive Wellness Centers*	Pride Recovery Center
Cotler Children and Family Services	Public Defenders Office, Nineteenth Judicial Circuit*
Counseling and Recovery Center, Inc.*	Rebel Recovery Florida*
Counseling Services of Lake Worth	RECO Intensive
Crossing Bridges of the Palm Beaches	Recovery by the Sea
Delray Center for Recovery	Recovery Team, Inc.
Detox Center II	Relax Behavioral Health
Detox Center of Boca Raton	Relax Medical Center
Detox of South Florida	Remedy Therapy
Dignity Healing	Reprieve LLC
Drug Abuse Foundation of Palm Beach County*	Retreat Behavioral Health Service Ctr Lake Worth
Drug Abuse Foundation of Palm Beach County/Detox Program*	Retreat Behavioral Health Service Ctr Palm Beach County

Drug Abuse Foundation of Palm Beach County/Halfway House*	Roundtable of St. Lucie County, Inc.*
Drug Abuse Foundation of Palm Beach County/Outpatient*	Saint Lucie Medical Center
Drug Abuse Treatment Association, Inc. (DATA)/Outpatient*	Sandy Pines Hospital*
Drug Abuse Treatment Association, Inc. (DATA)/Data Outpatient Services*	Seaside Palm Beach
Drug Abuse Treatment Association, Inc. (DATA)/Residential*	Serenity Counseling Services
Drug Abuse Treatment Association, Inc. (DATA)/Walter D Kelly Treatment Center*	Serenity House Detox Palm Beach
Ebb Tide Treatment, LLC*	Serenity Counseling Services
Essentials Recovery	Serenity House Detox Palm Beach
Fair Oaks Pavilion	Singer Island Health
Fair Oaks Pavilion at Delray Medical Center	South County Mental Health Center, Inc.*
Family Center for Recovery	Substance Awareness Center of Indian River County*
Faulk Center for Counseling	Substance Abuse Free Indian River Coalition

Federations of Families*	Success TMS Depression Treatment Specialists
Ferd and Gladys Alpert Jewish Family Services*	Summit Detox, Inc.
Florida Recovery Group, LLC	Suncoast Mental Health Center Okeechobee
Foundations Wellness Center	Suncoast Mental Health Center – Fort Pierce
Futures of Palm Beach	Suncoast Mental Health Center - Stuart
Hanley Center Foundation, Inc.*	Suncoast Mental Health Center – Vero Beach
Harm Reduction Center, LLC	Sunlight Recovery
Harmony Treatment and Wellness	Sunrise Detoxification Center, LLC
Helping People Succeed, Inc.*	Sunset House, Inc.*
Henderson Behavioral Health FACT*	Sunspire Health Florida, LLC WhiteSands Alcohol and Drug Rehab
Henderson Behavioral Health, Port Saint Lucie/CM Wrap Around*	The Chrysalis Center, Inc.*
Hibiscus Children's Center	The Lord's Place*
Holistix Treatment Centers: We Level Up Lake Worth	The Recovery Research Network Foundation, Inc.*

HomeSafe Libra Girls	The Recovery Research Network Foundation, Inc. (Jail Program)*
Housing Partnership, Inc. d/b/a Community Partners of South Florida*	Transformations Treatment Center, Inc.
iKare Treatment Center, LLC	Treasure Coast Counseling Center, Inc.
Immersion Recovery Center	Treasure Coast Counseling Center – Port Saint Lucie
Immersion Residential	Tribe Intensive, LLC
Inpatient Drug & Alcohol Centers	Tykes and Teens, Inc.*
Inpatient Drug Detox Centers	Veterans Affairs Medical Center Substance Abuse Program
Inspire Recovery, LLC*	Wayside House, Inc.*
Intrepid Detox Residential	Wellness Counseling and Residential Detox Servs, LLC
iRecovery LLC	Wellness Resource Center
Jeff Industries, Inc.*	West Palm Beach Treatment Center Metro Treatment of Florida LP
JFK Medical Center Limited Partnership d/b/a JFK*	West Palm Beach VAMC Mental Hygiene (116A)
Just Believe Recovery Center	West Palm Beach VAMC Port St Lucie PTSD Clinic

Just Believe Recovery Center Port Saint Lucie	
Lawnwood Reg Med Center and Heart Institute	

*SEFBHN-Contracted Entities

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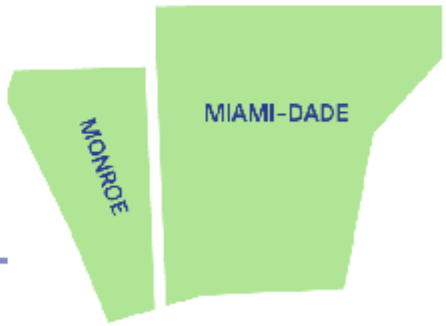
THRIVING MIND
SOUTH FLORIDA®

2022

Florida Cultural Health Disparity & Behavioral Health Needs Assessment



Regional Report

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May 30, 2022

THRIVING MIND
SOUTH FLORIDA®
A network of exceptional mental health and substance use treatment providers.
Contracting as South Florida Behavioral Health Network, Inc.

7205 Corporate Center Drive, Suite 200
Miami, Florida 33126
(305) 858-3335
ThrivingMind.org

To Our Community,

Thriving Mind South Florida is pleased to announce the release of the 2022 Behavioral Health and Cultural Disparity Needs Assessment (BHCD). This needs assessment was successfully conducted with broad input from individuals served, community stakeholders, peers, families, and network service providers (NSPs). It also included data from multiple state and local sources. The 2022 BHCD process used surveys, interviews and focus groups to gain insights from individuals served, community stakeholders, NSPs, and the peer recovery community. The process also sought to understand the potential role of cultural disparities on access to care and quality. The 2022 BHCD analyzed service capacity, identified gaps and opportunities, and will be used to inform our Strategic Plan and Priorities.

Thriving Mind South Florida (contracting as South Florida Behavioral Health Network, Inc.) is the nonprofit Managing Entity (ME) that funds and oversees a safety net of mental health and substance use disorder treatment and prevention services for uninsured and underinsured adults and children in Miami-Dade County (Circuit 11) and Monroe County (Circuit 16), supported by Florida's Department of Children and Families (DCF) and other public and private sources. Thriving Mind provides administrative, quality improvement and care coordination support, as well as collection and analysis of systemwide data for a network of around 40 treatment and prevention healthcare provider organizations. Thriving Mind is a cost-effective, evidence-based payer that operates with administrative overhead of less than 3.5%, to maintain safety net services for a catchment area of approximately 3 million residents. Our mission is to ensure that families and individuals affected by mental health and substance use disorders in Miami-Dade and Monroe counties can readily access innovative, effective, and compassionate services that lead to health and recovery.

As part of Thriving Mind's contractual commitments to DCF, a triannual comprehensive behavioral health needs assessment is completed. This needs assessment serves as a blueprint to guide planning for services offered through a coordinated system of behavioral health care. To assist in the current needs assessment, Thriving Mind engaged Health Council of South Florida (HCSF) and Behavioral Science Research Institute (BSRI). As in past years, this needs assessment will serve as a foundation for modifications to our strategic plan that help us to best support behavioral health needs in our community. After reviewing the results of this needs assessment, if you have any questions or comments that you would like Thriving Mind to address, please let us know.

Sincerely,

John W. Newcomer, M.D.; President & CEO

Thriving Mind South Florida is a managing entity contracted with the Department of Children and Families. Thriving Mind receives additional support from other Federal, State, County, and private sources.

EXECUTIVE SUMMARY

In 2020, Florida was ranked #48 in per capita funding for mental health treatment. According to the 2020 National Survey on Drug Use and Health (NSDUH), serious mental illnesses (SMI) and substance use disorders (SUD) affected 5.6% and 15.4% of the U.S. adult population, respectively. In addition, both SMI and SUD are strongly associated with poverty. For those living below 200% of the Federal Poverty Level (FPL), the estimated prevalence is even higher, with at least 25% of that population having some form of SMI or SUD. South Florida, comprised of Miami-Dade and Monroe counties, has a known population of 2.8 million, with the total population including both documented and undocumented individuals estimated at more than 3 million. In 2020, over 1 million individuals across Miami-Dade and Monroe counties were below 200% of the FPL.

According to the NSDUH, in 2020 there was an estimated 262,190 individuals with SMI/SUD service needs in the Managing Entity (ME), Thriving Mind South Florida's, service area comprised of Miami-Dade and Monroe counties. In addition, according to a Department of Health and Human Services report, for youth ages 9-17 years, the estimated number of children considered to have serious emotional disturbances (SED) increased over 2% in Thriving Mind's service area from 2018 to 2020.

This statewide behavioral health needs assessment has been prepared using a compilation of primary and secondary data that identify mental health and substance use treatment needs in the community as well as assets to advance health care delivery that support health and well-being for residents.

SERVICE AREA POPULATION

Population in the two-county service area increased an average of 1.3% each year from 2016 to 2020. The total population growth for the 5-year period, added 152,275 residents.

In the service area and the state, women accounted for slightly more than 50% of the population when compared to their male counterparts. The racial composition in the service area and state was predominately White at 66.4% and 71.6%, respectively. The Black population accounted for 16.7% of the service area population and 15.9% of the population in Florida. American Indian and Native Hawaiians represented less than 1% of residents in both population groups. The percentage of Asian residents at 1.6% was lower in the service area when compared to the state at 2.8%. In the service area 4.6% of the population indicated having some other race and 10.5% of residents indicated they belonged to more than one racial group. Ethnically, the service area had a much larger percentage of Hispanic residents, at 67% when compared to the state at 25.8%.

About 78% of residents reported "good" to "excellent" health, which is slightly less than the state average of 80.3%. Suicide rates in the service area decreased by 8% from 2017 to 2020. For men,

the rate was more than quadruple the rate for women. The rate of total domestic violence offences decreased in the Thriving Mind service area and the state from 2017 to 2020.

NO WRONG DOOR SURVEY

Twelve individuals were selected to complete the No Wrong Door Survey by Thriving Mind South Florida given their executive experience and diverse organizational service offerings. All respondents believed they had a role to play in the No Wrong Door access and most (83.3%) believed that warm-handoff referrals were occurring. Key highlights from survey responses included:

- All participants believe that the No Wrong Door access works well within the organization and that their organization has a role to play within the No Wrong Door access.
- Stakeholders believe services are high quality and coordinated across the systems of care
- Fifty percent of respondents believe that the No Wrong Door access works to improve outcomes, linkages, and referral care coordination.

CULTURAL HEALTH DISPARITY SURVEY

A total of 190 respondents completed the individual/consumer served needs assessment survey with each question having between 163-190 responses. Below is a list of key takeaways from survey results:

- The behavioral health setting most often selected (65.4%) as being preferred was a private office with a doctor. The other settings chosen included telehealth (27.7%), hybrid of telehealth, in-person visits (25.5%), speaking with a nurse practitioner (23.9%), and speaking with a faith-based organization (16.5%).
- About 80% of residents confirmed they could access behavioral health services when they needed them.
- Common barriers cited included: concerns about cost (35.3%), not knowing where to go (20%), services were not covered by insurance (19.4%), and transportation challenges (19.4%).

PEER RECOVERY SUPPORT SURVEY

A total of 61 respondents completed the peer recovery support survey with each question having between 58-61 responses. Most peer respondents were adults with mental health experience. Key points from the survey response were:

- The most common reasons for staying with an agency included flexibility with work schedule (43.3%) and commitment to recovery principles (40%).
- The reason least selected for individuals staying with an agency was competitive salary (15.0%).
- Approximately half of participants have been employed or volunteered with their agency for three or more years.

CONSUMER SURVEY

A total of 166 respondents completed the individual/consumer served needs assessment survey with each question having between 148-166 responses. Snapshot of results are outlined below:

- About 80% of survey respondents received behavioral health services.
- Most survey respondents received services in Miami (94.2%) compared to Monroe County (5.8%).
- Most participants (88.2%) agreed that services and planning they received were focused on their treatment needs (patient-centered).

STAKEHOLDER SURVEY

A total of 181 respondents completed the individual/consumer served needs assessment survey with each question having between 177-181 responses. Key highlights from the survey are outlined below:

- More than half of respondents were aware of Thriving Mind South Florida (68.9%); 35.2% accessed its resources in the past 6 months.
- Two-thirds (67%) of respondents found behavioral health services in their communities to be accessible, while one-third of respondents (33%) did not.
- Assessing the top five barriers to access to behavioral health services (more than one option could be selected), 58.1% of respondents indicated they had no or very limited transportation, 53.6% indicated there were long waiting lists, 49.2% indicated they did not know where to go to access services, 46.4% indicated they could not afford services, and 45.3% were concerned about the stigma of behavioral health and what others would think.

FOCUS GROUPS

Six (6) Focus Groups were conducted in both Miami-Dade and Monroe counties to assess the behavioral health needs in these communities and facilitate pathways for all residents to access behavioral health prevention, treatment, and recovery services. Overall, a total of 104 participants comprised of residents from the two counties, Thriving Mind sub-contracted mental health providers, and other behavioral health professionals attended the focus groups sessions.

Participants were asked a series of questions which were developed following evidence-based practices and findings from surveys implemented that included the Cultural Health Disparity Survey.

The following items contain a few common themes that were consistent in both Miami-Dade and Monroe counties:

SOLUTIONS TO OVERCOME BARRIERS TO CARE:

- Expand Health Insurance Coverage
- Increase communication between different service providers
- Culturally competent and LGBTQ-friendly staff
- Expand STS (Special Transportation Services) for behavioral health services
- Increase number of Psychosocial rehabilitation centers across South Florida

BEHAVIORAL HEALTH NEEDS:

- Prevention and early intervention services
- Program/service proximity
- Affordable services
- Peer driven support
- Culturally competent workforce
- Educational resources and provider engagement

BARRIERS TO ACCESS:

- Stigma and discrimination
- Lack of treatment options
- Long wait times
- Insurance coverage issues and affordability
- Program/service proximity

VULNERABLE GROUPS:

- Undocumented immigrants
- Homeless people
- Young adults
- Low-income individuals
- Minorities

COVID-19 PANDEMIC EFFECT:

- Increased flexibility due to Telehealth

- Increased awareness of behavioral health and services
- Reduced capacity in behavioral health facilities
- Lack of in-person services

THRIVING MIND SERVICE AREA DEMOGRAPHIC PROFILE

Population Demographics

Population in the two-county service area increased an average of 1.3% each year from 2016 to 2020. The total population growth for the 5-year period at 5.5%, added 152,275 residents.

In the service area and the state, females accounted for slightly more than 50% of the population when compared to their male counterparts.

The racial composition in the service area and state was predominately White at 66.4% and 71.6%, respectively. The Black population accounted for 16.7% of the service area population and 15.9% of the population in Florida. American Indian and Native Hawaiians represented less than 1% of residents in both population groups. The percentage of Asian residents, at 1.6% was lower in the service area when compared to the state at 2.8%. The service area was slightly more diverse when compared to the state with 4.6% of some other race and 10.5% of residents belonging to more than one racial group.

Ethnically, the service area had a higher percentage of Hispanic residents, at 67%, when compared to the state at 25.8%.

Residents, 65 years of age or older, accounted for 16.4% of the population while in the state of Florida, 20.5% of residents were at least 65 years old.

Education and Employment

Data revealed the service area and state populations were very similar regarding education attainment. Slightly more residents in the state attained a high school diploma, (88.5%) when compared to the service area at 82.1%. Percentages of those with a college education were very similar for the service area and state. This held true for those who attained a graduate or professional degree at 11.4% for the service area and 11.3% for the state.

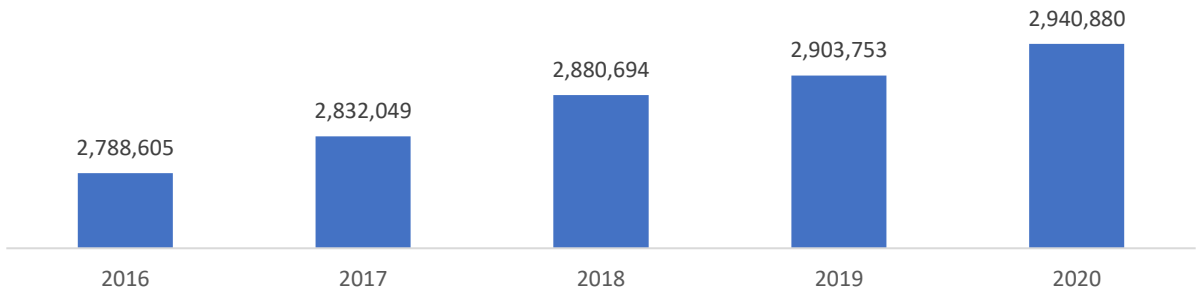
The 5-year estimate for labor force participation, at 63.1%, was higher when compared to the state at 58.9% during 2016 to 2020. The 5-year unemployment rate estimate for the service area, at 3.2% was below the state rate at 5.4%.

Poverty Status

During 2016 to 2020, the ratio of income to poverty rates for those below 300% of the Federal Poverty Level (FPL) were higher for the service area than the state. The rates of those living <200% FPL, were 35% and 26.3%, respectively.

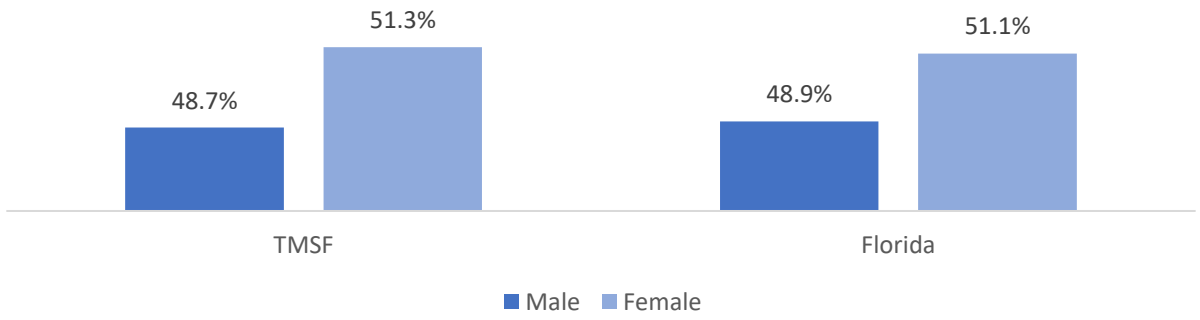
DEMOGRAPHIC CHARTS

Figure 1: Thriving Mind SA Population Estimates (2016-2020)



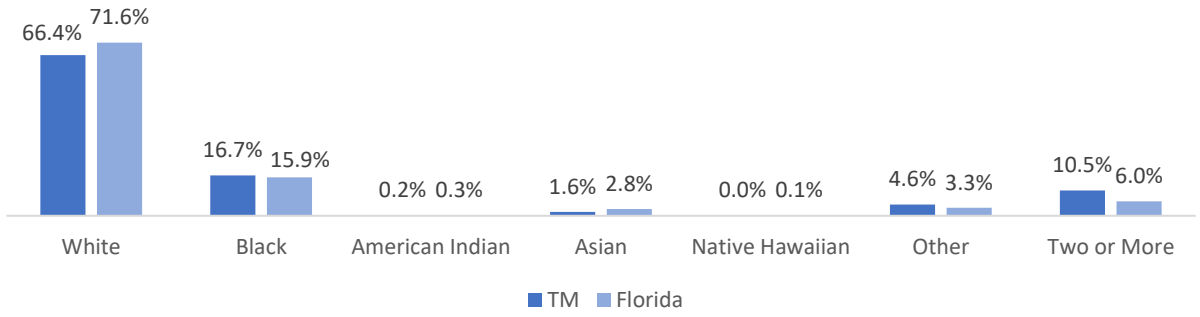
Source: Florida Legislature's Office of Economic and Demographic Research (EDR)

Figure 2: Thriving Mind SA County Population by Gender (2016-2020)



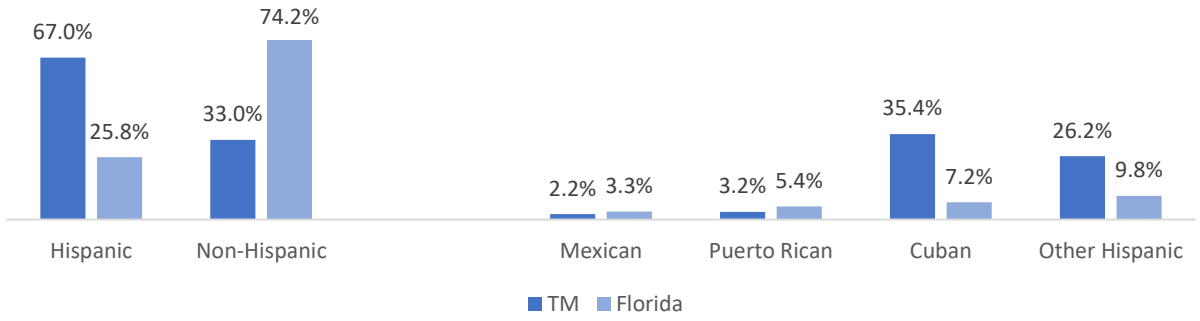
Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 3: Thriving Mind SA County Population by Race, 2016-2020 (5-Year Estimate)



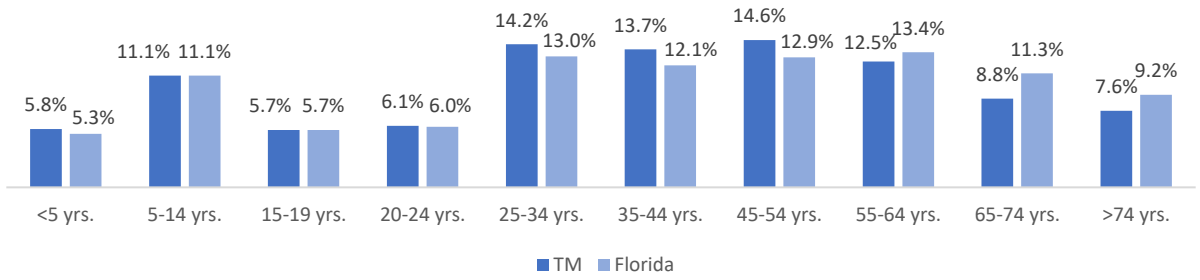
Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 4: Thriving Mind SA Population by Ethnicity, 2016-2020 (5-Year Estimate)



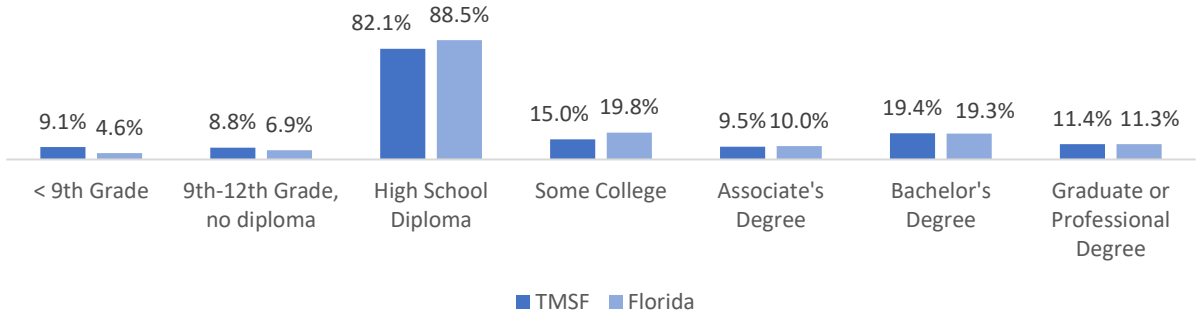
Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 5: Thriving Mind SA Population by Age Range, 2016-2020 (5-Year Estimate)



Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 6: Thriving Mind SA Population by Educational Attainment, 2016-2020 (5-Year Estimate)

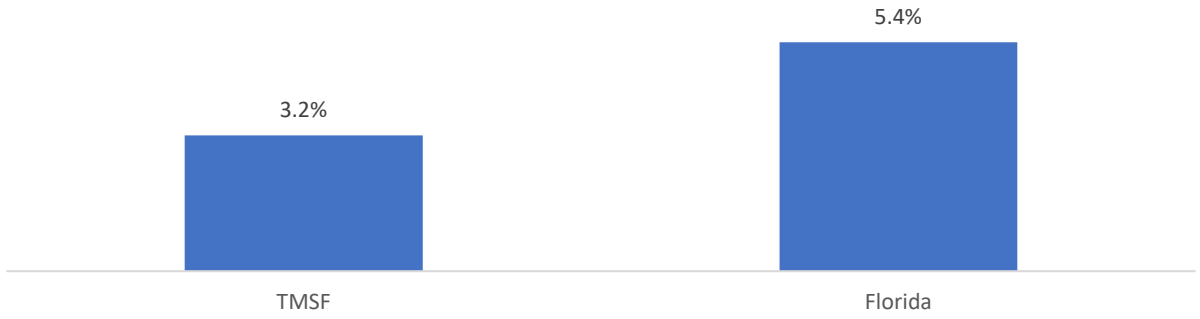


Source: U.S Census Bureau, American Community Survey, Table S1501

Figure 7: Thriving Mind SA Population Participation in Labor Force, 2016-2020 (5-Year Estimate)

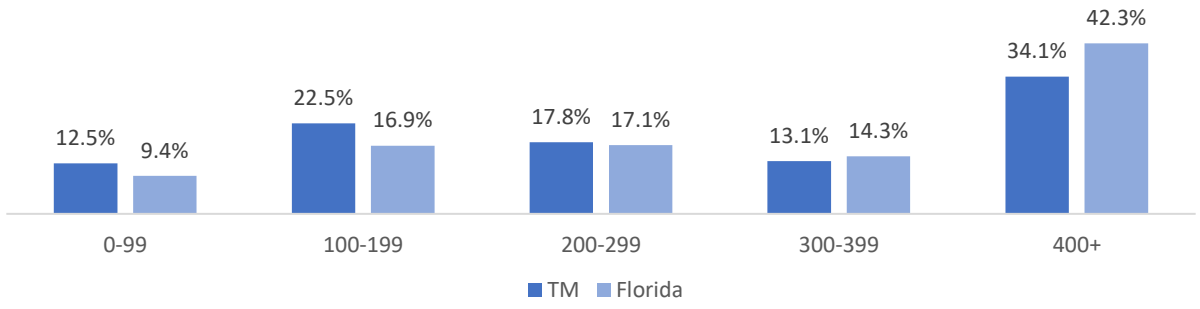
Source: U.S Census Bureau, American Community Survey, Table DP03

Figure 8: Thriving Mind SA Population Unemployment Rates, 2016-2020 (5-Year Estimate)



Source: U.S Census Bureau, American Community Survey, Table DP03

Figure 9: Thriving Mind SA Population Ratio of Income to Poverty Level of Families, 2016-2020 (5-Year Estimate)



Source: U.S Census Bureau, American Community Survey, Table B17026

THRIVING MIND SERVICE AREA GENERAL HEALTH STATUS

Overall, Health Status

The Behavioral Risk Factor Surveillance System (BRFSS) is the nation's premier system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. BRFSS data (2017 to 2019) estimates revealed 77.6% of adults, ages 18-64 years of age, living in the service area said their overall health was "good" to "excellent". For Florida, the rate was 80.3%. This knowledge is a powerful tool for targeting and building health promotion activities. It also provides a way to see change in population health behaviors before morbidity or disease is apparent.

Mental Health

Over the past 3 years, an average of 87.3% of adults reported good mental health just above the rate for the state at 86.2%. The number of unhealthy mental days for the service area population, at 3.8 days in the past 30 days, was just below the rate among all adult residents (ages 18-64 years) in Florida at 4.4 days in the past 30 days.

Suicide

The crude suicide death rate decreased from 14.8/100,000 in 2018 to 11.8/100,000 population in 2020. This represents a decrease of 3.0/100,000 suicide deaths. At the state level, the suicide crude death rate decreased 2.5 deaths per 100,000 population during the same time but was also higher when compared to the Thriving Mind service population. Among males, the suicide death rate for the ME service area and state were more than quadruple the rate among females. The suicide death rate among the White population was almost twice the rate for Black residents in the ME service area. The same held true at the state level where White to Black suicide deaths revealed a 3.2:1.0 ratio. It should be noted that the calculations required for the age-adjusted death rate for the ME service areas were beyond the scope of this project.

Violence and Abuse

The rate of total domestic violence offences decreased in the ME service area and the state from 2017 to 2019. In the ME service area, the rate fell from 338.4/100,000 to 294.4/100,000 over the past three years. This was lower than the state rate of 496.5/100,000 in 2019.

The rate of children experiencing child abuse over the past three years (2017-2019) has continuously decreased in the ME Service area and state. Among children ages 5-11 years, the rate of child abuse fell from 366.6./100,000 in 2017 to 222.9/100,000 in 2019. This trend was observed in the state rates which decreased from 857.9/100,000 to 662.7/100,000 during the same time.

Child sexual abuse rates changed very little from 2017 to 2019 and increased from 2018 to 2019. In the ME service area, the 2019 sexual abuse rate for children 5-11 years was 35.5/100,000. This was lower than the state rate at 57.8/100,000.

Serious Mental Illness, Substance Use Disorders and Serious Emotional Disturbances

The estimated number of seriously mentally ill (SMI) adults increased by almost 2 % over the past 2 years. The rate of increase at the state level was 3.5% over the past 3 years. According to the 2020 National Survey on Drug Use and Health (NSDUH), the estimated number of SMI adults in the ME service area was 83,352 in Miami-Dade County and 1,490 in Monroe County for a total of 84,842 in 2020.

According to the 2020 NSDUH, the estimated number of adults with substance use disorders in the ME service area 174,233 in Miami-Dade and 3,115 in Monroe County for a total of 177,348 in 2020.

Among youth, ages 9-17 years, the estimated number of those with serious emotional disturbances (SED) increased over 2% from 2018 to 2020. This was lower when compared to the state increase at 3%.

The Florida Department of Education (FLDOE) reported less than 0.5% of children in K-12 grades had an emotional/behavioral disability in the ME service area. In the state, students with an emotional/behavioral disability accounted for 0.5%. These rates have been steady over the past 3 years.

Adult Tobacco and Alcohol Use

BRFSS results revealed the percentage of adults living in the ME service area who are current smokers, at 12.1% (2017 to 2019) was lower when compared to the state at 14.8%.

Binge drinking is defined as 5 consecutive drinks for men and 4 consecutive drinks for women. For 2017 to 2019, the percentage of binge drinkers in the ME service area was 18.3%. The percentage of binge drinkers in the state was slightly lower at 18.0%.

High School Tobacco, Alcohol and Substance Use

The Florida Youth Substance Abuse Survey (FYSAS) is a collaborative effort between the Florida departments of Health, Education, Children and Families, Juvenile Justice, and the Governor's Office of Drug Control. It is based on the "Communities That Care" survey, assessing risk and protective factors for substance abuse, in addition to substance abuse prevalence. Data from the FYSAS indicated that the percentage of middle and high school students who reported never having smoked cigarettes increased from 88.6% in 2016 to 91.5% in 2020. Less than 7% of students smoked once or twice and less than 2% reported that they had smoked 'once in a while'. For middle and high school students in the state, the percentage of those having never smoked also increased over the past four years.

When students were asked about smoking frequency, 98.2% of those living in the ME services area did not smoke at all, which is the same as the state rate.

Vaping questions were included in the 2020 FYSAS for the first time. In the ME service area, 9.6% of students reported vaping nicotine on at least one occasion in their lifetime compared to 7.7% at the state level and just under 5% of students had vaped on 40 or more occasions in the ME service area compared to 5.9% at the state level. The percentage of students vaping nicotine during the past 30 days were much lower in the service area than the state when compared to vaped in lifetime rates. Over 90% of students had not vaped nicotine in the past 30 days.

The percentage of students who did not consume alcoholic beverages on any occasions in their lifetime ranged from 59.7% in 2016 to 62.7% in 2020. For those who did on 1-2 occasions, the percentage increased 1% from 2016 to 2020. The percentage of students in 2020 consuming alcohol on more than two occasions was 7.4%, while 0.9% consumed alcohol on at least 40 occasions. The rates for the state were almost identical to those in the ME service area.

High school students were asked for the number of occasions in their lifetime when they had woken up after a night of drinking alcohol and were unable to remember the things they did or the places they went. The percentage of students reporting this event happening on at least 1-2 occasions in their lifetime was 9.7% in the ME service area and 7.4% in the state. When looking at previously reported data, this was an increase from the percentages reported in 2016 for the ME service area and the state. Over 85% of students in the service area and the state reported never having had this experience.

The percentages of students living in the ME service area not consuming alcohol during the past 30 days increased from 81.3% in 2016 to 82.9% in 2020. The increase at the state level was greater when comparing percentages from 2016 (81.7%) to 2020, at 85.2%. The percentages of students who reported consuming alcohol on 1-2 occasions during the past 30 days decreased in the ME service area and state from 2016-2020.

The overall percentage of those binge drinking, defined as consuming 5 or more alcoholic drinks in a row in the past 2 weeks, decreased 1% over the past 4 years. This was a combined decrease

for students in the ME service area and state who reported this behavior on one to more than 10 occasions.

The percentages of students who have not used marijuana in their lifetimes increased over the past 4 years in the ME service area (83.1%-2020) and state (79.9%-2020). For those who did use marijuana on one to more than 40 occasions, the overall percentages decreased in the ME service area from 3.1% in 2016 to 2.8% in 2020. At the state level, the decrease was larger when comparing 2016, at 21.3%, to 2020, at 20.1%. The percentages of students not using marijuana in the past 30 days was higher when compared to those who reported not using it in their lifetime. The percentages of students in the ME service area and state who reported using marijuana in the past 30 days on one or more occasions, decreased slightly in the ME service area while increasing in the state. The percentages of students who reported vaping marijuana in their lifetimes on one or more occasions was lower in the ME service area at 13.9% when compared to the state at 15.6%. This was also true when comparing the two groups of students who had vaped marijuana in the past 30 days. In the ME service area, 6.6% of students had vaped marijuana in the past 30 days compared to 7.3% of students in the state.

Disability

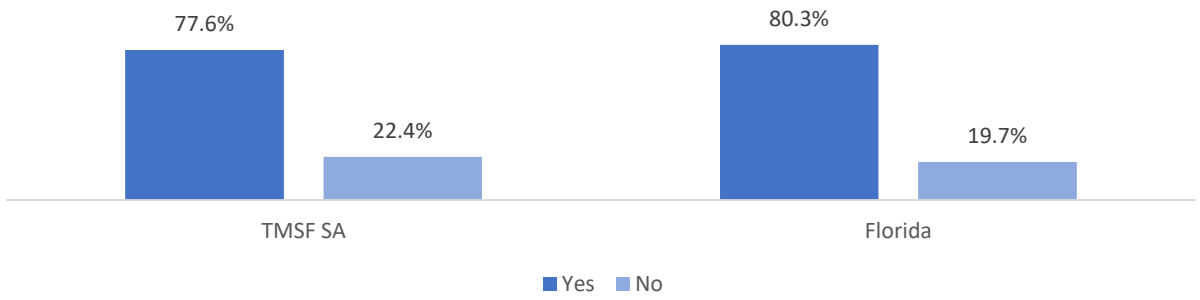
In the ME service area, 10.2% of the noninstitutionalized population is estimated to have a disability (includes hearing, vision, cognitive, ambulatory, self-care, and independent living). At the state level, 13.3% of residents had a disability. The percentages of those with a disability were much higher among older adults, ages 65 years and older, at 51.87% for the ME service area and 48.9% in the state.

Health Insurance Coverage

Most residents, ages 18-64 years, living in the ME service area and state reported having some type of health insurance coverage. The percentage of those with insurance in the state was slightly higher when compared to the ME service area at 84.2% and 83.0%, respectively.

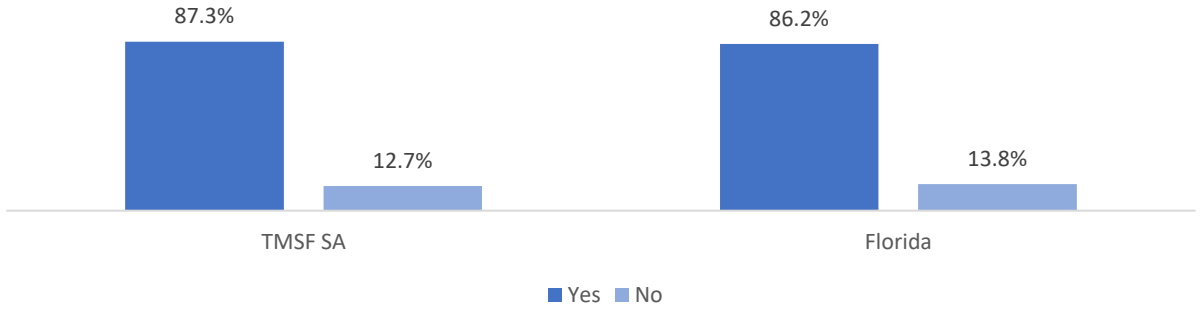
GENERAL HEALTH STATUS CHARTS

Figure 10: Thriving Mind SA Adults Who Said Their Overall Health Was "Good" to "Excellent"(2017-2019)



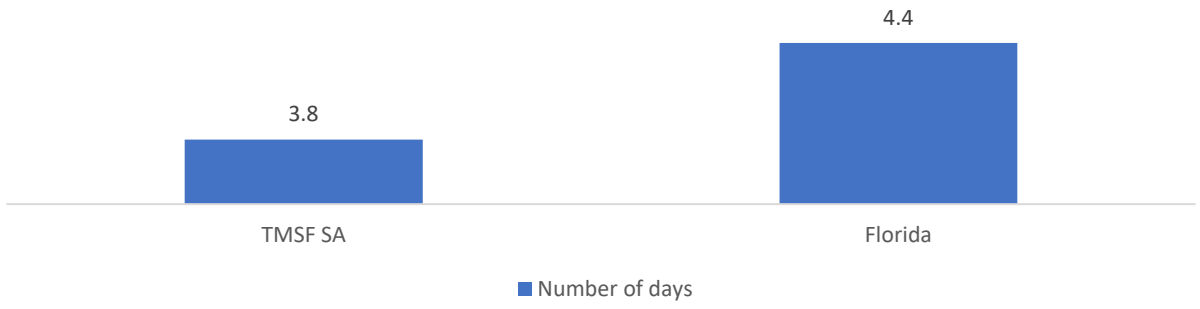
Source: Behavioral Risk Factor Surveillance System

Figure 11: Thriving Mind SA Adults with Good Mental Health for the Past 30 Days (2017-2019)



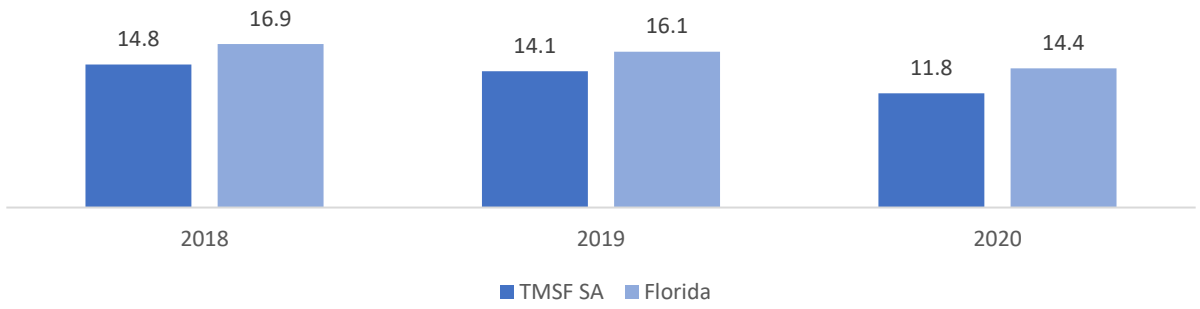
Source: Behavioral Risk Factor Surveillance System

Figure 12: Thriving Mind SA Adults Average Number of Unhealthy Mental Days in the Past 30 Days (2017-2019)



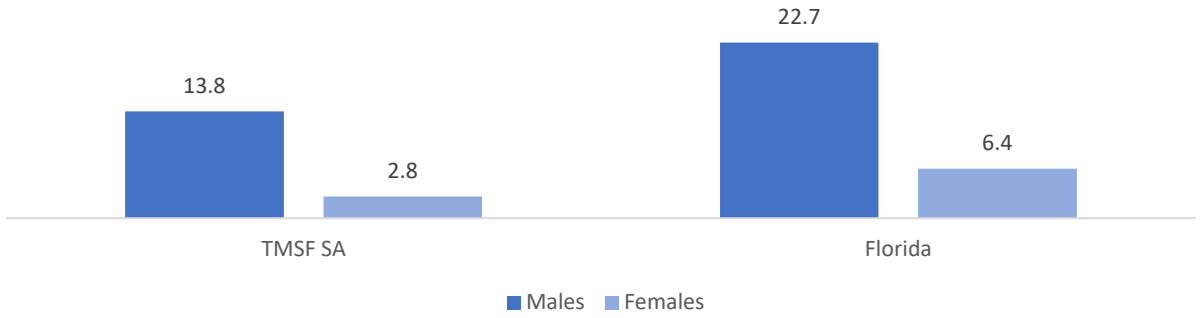
Source: Behavioral Risk Factor Surveillance System

Figure 13: Thriving Mind SA Crude Suicide Death Rates (2018-2020)



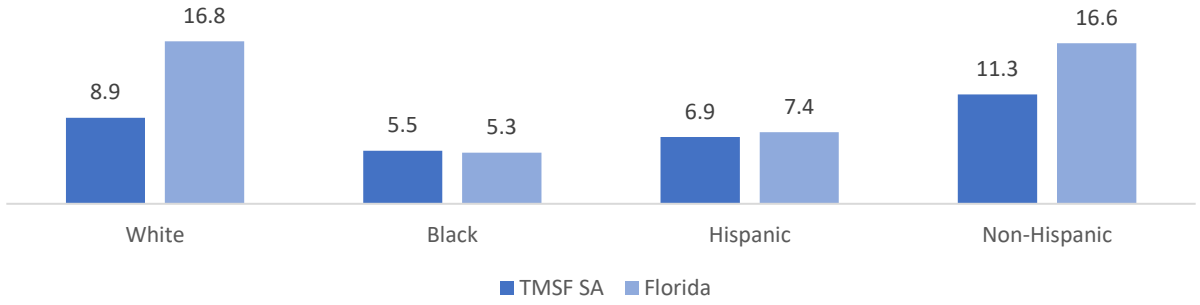
Source: Florida Department of Health, Bureau of Vital Statistics. Rate per 100,000

Figure 14: Thriving Mind SA Crude Suicide Death Rates by Gender (2020)



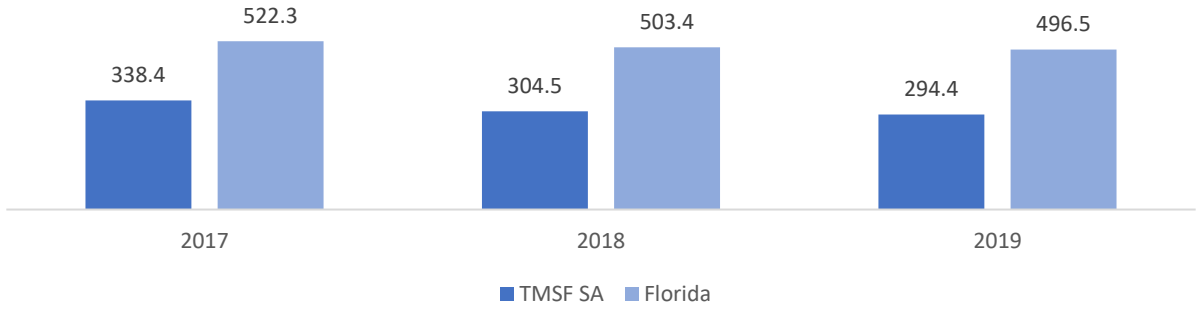
Source: Florida Department of Health, Bureau of Vital Statistics, Rate per 100,000

Figure 15: Thriving Mind SA Crude Suicide Death Rates by Race and Ethnicity (2020)



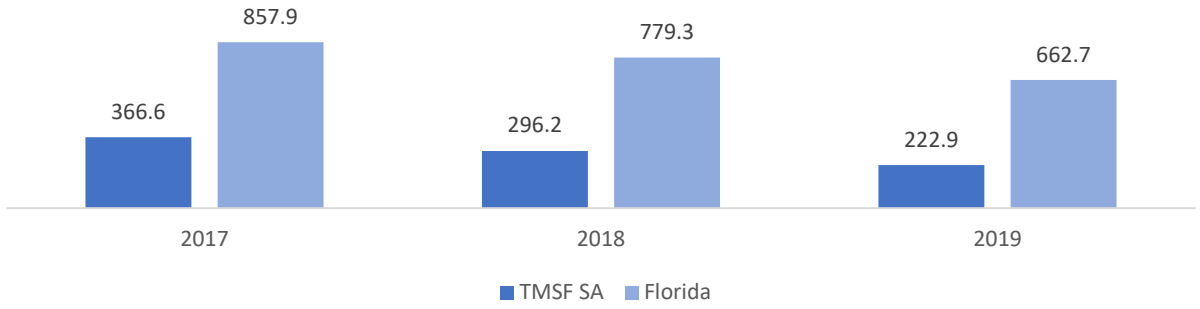
Source: Florida Department of Health, Bureau of Vital Statistics, Rate per 100,000

Figure 16: Thriving Mind SA Total Domestic Violence Offenses (2017-2019)



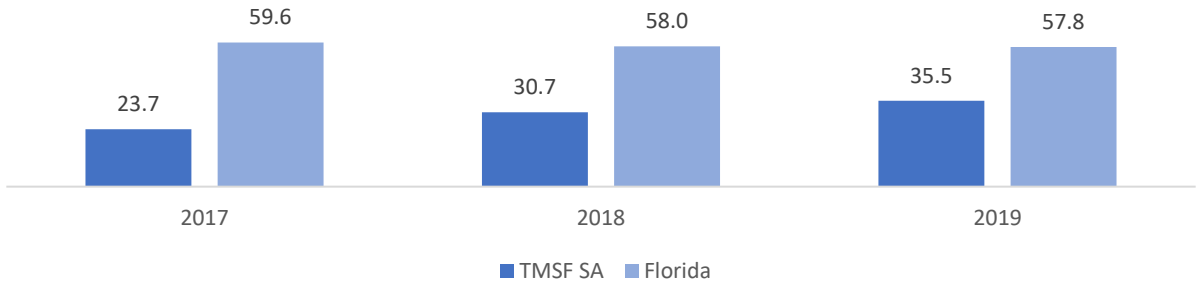
Source: Florida Department of Law Enforcement, Crime in Florida, Uniform Crime Report 2019, Rate per 100,000

Figure 17: Thriving Mind SA Rate of Children Experiencing Child Abuse, Ages 5-11 Years (2017-2019)



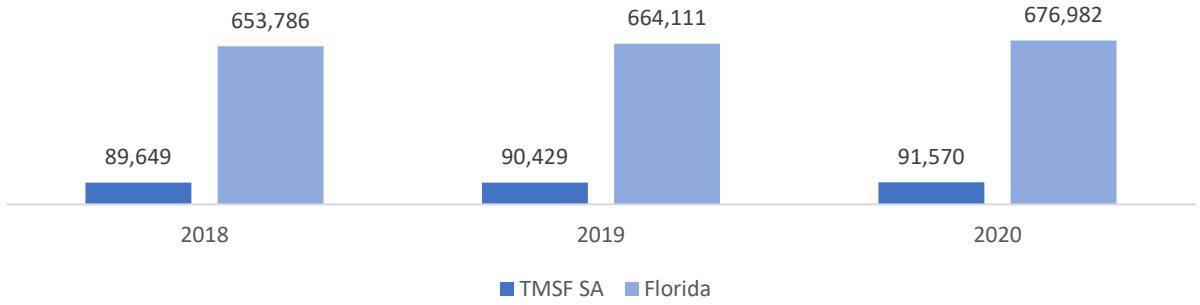
Source: Department of Children and Families, Florida Safe Families Network Data Mart, Rate per 100,000

Figure 18: Thriving Mind SA Rate of Children Experiencing Sexual Violence, Ages 5-11 Years (2017-2019)



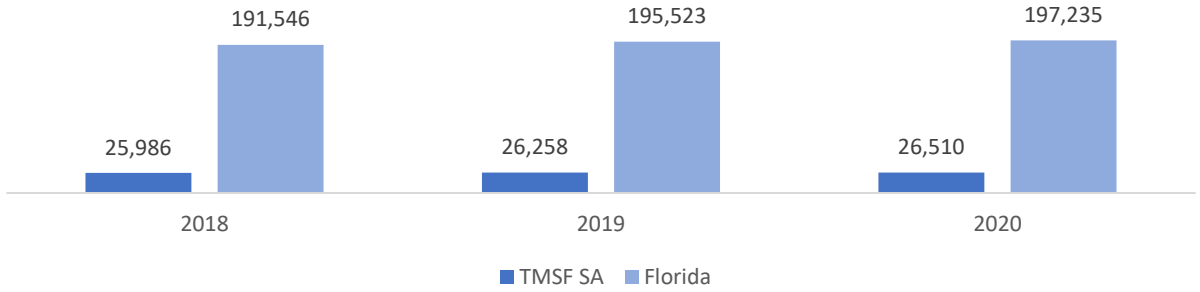
Source: Department of Children and Families, Florida Safe Families Network Data Mart, Rate per 100,000

Figure 19: Thriving Mind SA Estimated Number of Seriously Mentally Ill Adults (2018-2020)



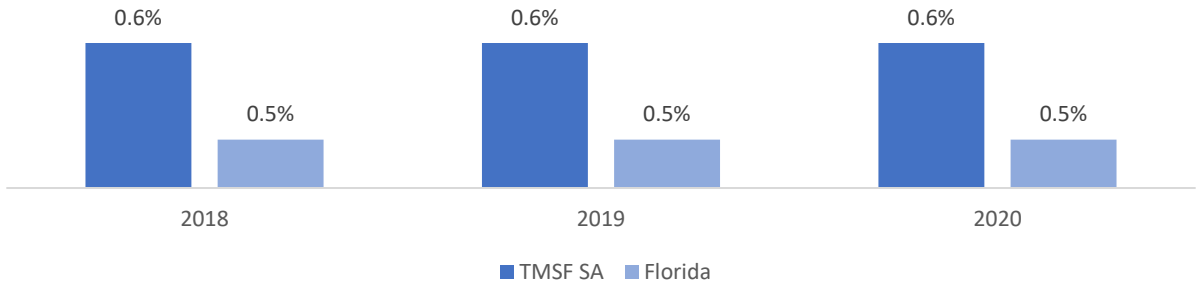
Source: Estimates based on Department of Health and Human Resource Report Mental Health U.S. 1995

Figure 20: Thriving Mind SA Estimated Number of Emotionally Disturbed Youth, Ages 9-17 Years (2018-2020)



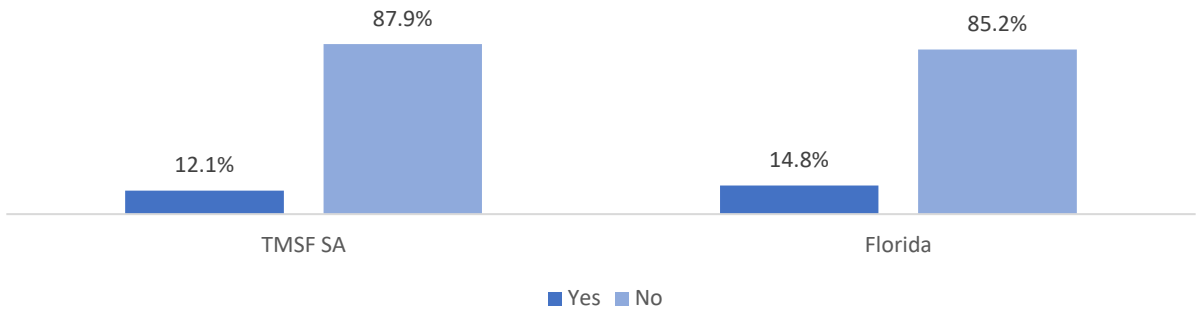
Source: Estimates based on Department of Health and Human Resource Report Mental Health U.S. 1995

Figure 21: Thriving Mind SA Percentage of Children with Emotional/Behavioral Disability, Grades K-12 (2018-2020)



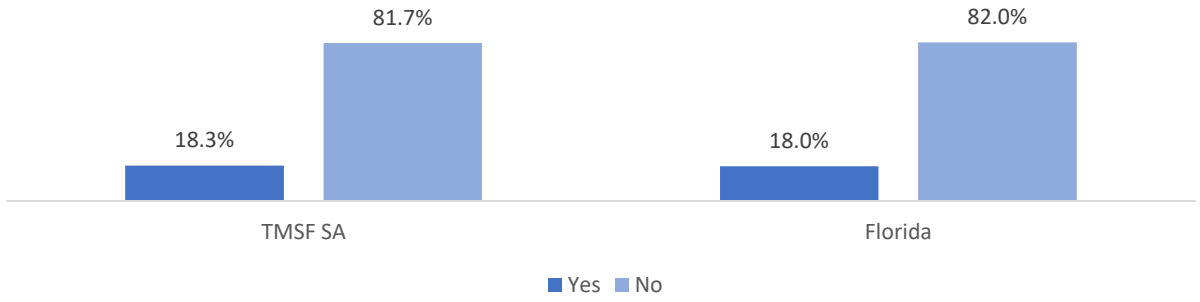
Source: Florida Department of Education, Education Information and Accountability Services (EIAS)

Figure 22: Thriving Mind SA Percentage of Adults Who Are Current Smokers (2017-2019)



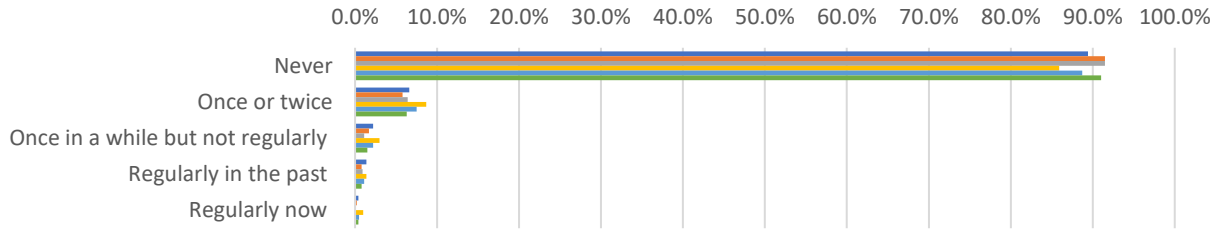
Source: Behavioral Risk Factor Surveillance System

Figure 23: Thriving Mind SA Percentage of Adults Who Engage in Heavy or Binge Drinking (2017-2019)



Source: Behavioral Risk Factor Surveillance System

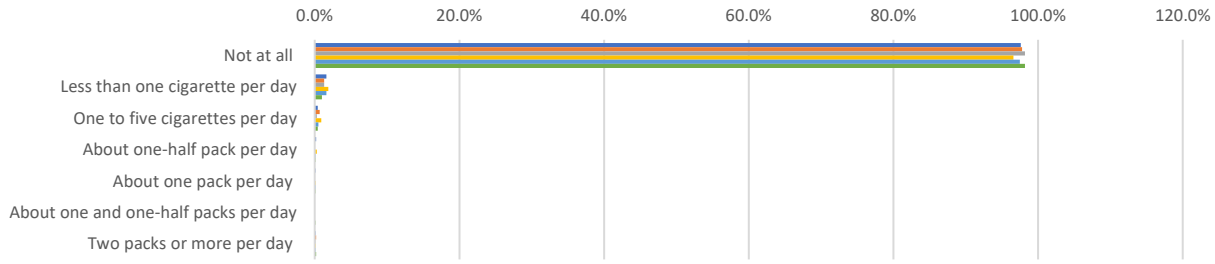
Figure 24: Thriving Mind SA – Having Ever Smoked Cigarettes (MS&HS 2016-2020)



	Regularly now	Regularly in the past	Once in a while but not regularly	Once or twice	Never
TMSF SA 2016	0.4%	1.4%	2.2%	6.6%	89.4%
TMSF SA 2018	0.2%	0.8%	1.7%	5.8%	91.5%
TMSF SA 2020	0.1%	0.9%	1.1%	6.4%	91.5%
Florida 2016	1.0%	1.4%	3.0%	8.7%	85.9%
Florida 2018	0.5%	1.1%	2.2%	7.5%	88.7%
Florida 2020	0.4%	0.8%	1.5%	6.3%	91.0%

Source: Florida Youth Substance Abuse Survey

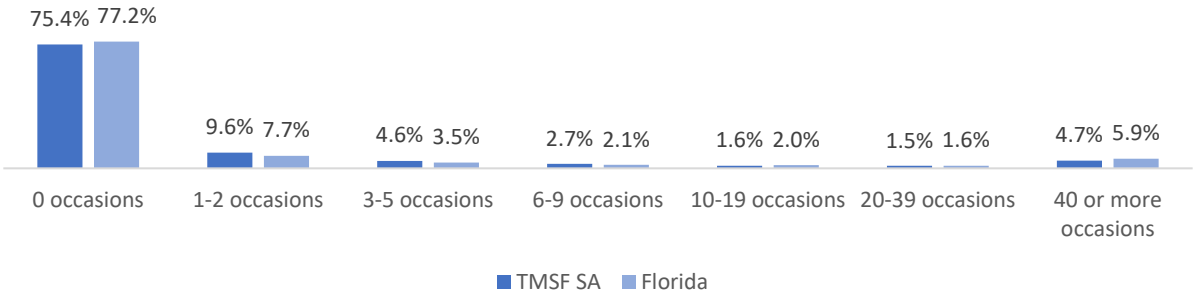
Figure 25: Thriving Mind SA – How Frequently Have You Smoked Cigarettes in the Past 30 Days? (MS&HS 2016-2020)



	Two packs or more per day	About one and one-half packs per day	About one pack per day	About one-half pack per day	One to five cigarettes per day	Less than one cigarette per day	Not at all
TMSF SA 2016	0.1%	0.0%	0.1%	0.2%	0.4%	1.6%	97.6%
TMSF SA 2018	0.2%	0.0%	0.0%	0.0%	0.7%	1.3%	97.8%
TMSF SA 2020	0.1%	0.0%	0.0%	0.0%	0.3%	1.3%	98.2%
Florida 2016	0.1%	0.0%	0.1%	0.3%	0.9%	1.9%	96.6%
Florida 2018	0.1%	0.0%	0.1%	0.1%	0.5%	1.6%	97.5%
Florida 2020	0.2%	0.1%	0.1%	0.1%	0.4%	1.0%	98.2%

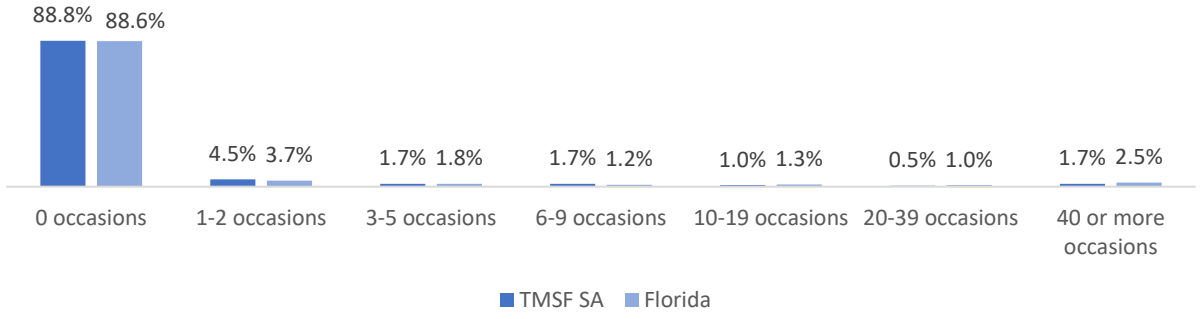
Source: Florida Youth Substance Abuse Survey

Figure 26: Thriving Mind SA – On How Many Occasions Have You Vaped Nicotine in Your Lifetime? (MS&HS 2020)



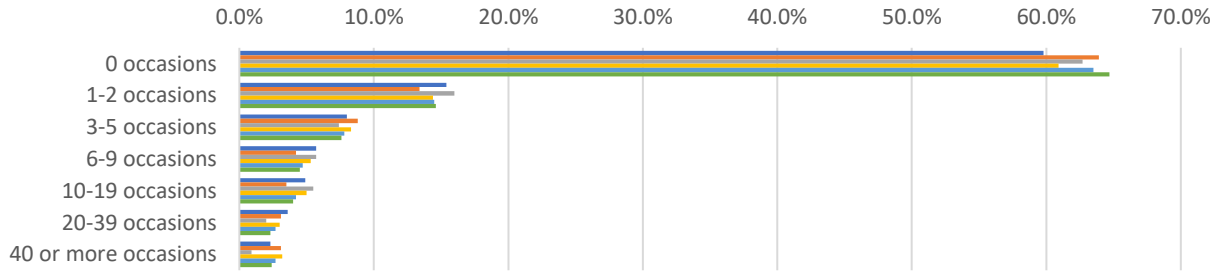
Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

Figure 27: Thriving Mind SA – On How Many Occasions Have You Vaped Nicotine During the Past 30 Days? (MS&HS 2020)



Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

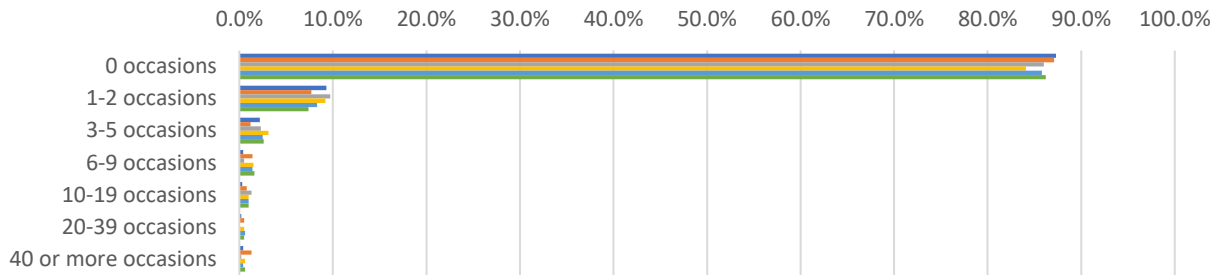
Figure 28: Thriving Mind SA – On How Many Occasions Have You Had Alcoholic Beverages to Drink in Your Lifetime? (MS&HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
TMSF SA 2016	2.3%	3.6%	4.9%	5.7%	8.0%	15.4%	59.8%
TMSF SA 2018	3.1%	3.1%	3.5%	4.2%	8.8%	13.4%	63.9%
TMSF SA 2020	0.9%	2.0%	5.5%	5.7%	7.4%	16.0%	62.7%
Florida 2016	3.2%	3.0%	5.0%	5.3%	8.3%	14.4%	60.9%
Florida 2018	2.7%	2.7%	4.2%	4.7%	7.8%	14.5%	63.5%
Florida 2020	2.4%	2.3%	4.0%	4.5%	7.6%	14.6%	64.7%

Source: Florida Youth Substance Abuse Survey. Includes beer, wine, or hard liquor. More than a few sips.

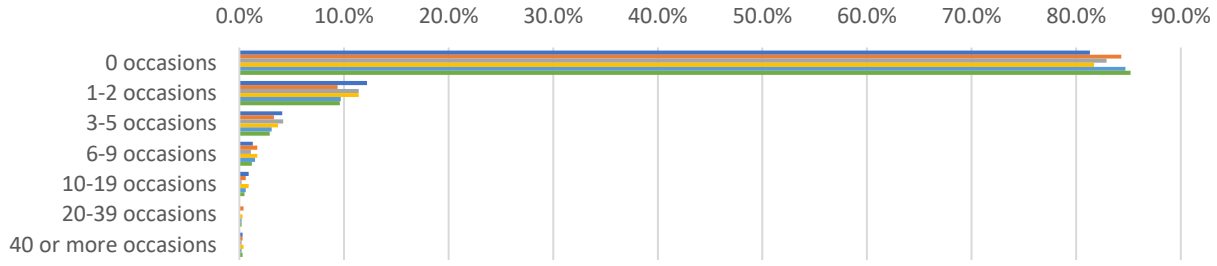
Figure 29: Thriving Mind SA – On How Many Occasions in Your Lifetime Have You Woken Up After a Night of Drinking Alcoholic Beverages and Not Been Able to Remember Things You Did or the Places You Went? (HS Only 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
TMSF SA 2016	0.4%	0.2%	0.3%	0.4%	2.2%	9.3%	87.3%
TMSF SA 2018	1.3%	0.5%	0.8%	1.4%	1.2%	7.7%	87.1%
TMSF SA 2020	0.2%	0.0%	1.3%	0.5%	2.3%	9.7%	86.0%
Florida 2016	0.6%	0.5%	1.0%	1.5%	3.1%	9.2%	84.1%
Florida 2018	0.4%	0.6%	1.0%	1.4%	2.5%	8.3%	85.8%
Florida 2020	0.6%	0.5%	1.0%	1.6%	2.6%	7.4%	86.2%

Source: Florida Youth Substance Abuse Survey

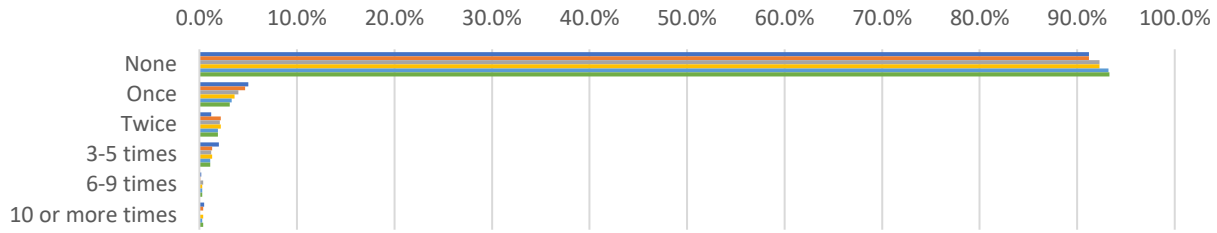
Figure 30: Thriving Mind SA – On How Many Occasions Have You Had Beer, Wine, or Hard Liquor in the Past 30 Days? (MS&HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
TMSF SA 2016	0.3%	0.0%	0.9%	1.3%	4.1%	12.2%	81.3%
TMSF SA 2018	0.3%	0.4%	0.6%	1.7%	3.3%	9.4%	84.3%
TMSF SA 2020	0.2%	0.0%	0.2%	1.1%	4.2%	11.4%	82.9%
Florida 2016	0.4%	0.3%	0.9%	1.7%	3.7%	11.4%	81.7%
Florida 2018	0.2%	0.2%	0.6%	1.5%	3.1%	9.7%	84.7%
Florida 2020	0.3%	0.2%	0.5%	1.2%	2.9%	9.6%	85.2%

Source: Florida Youth Substance Abuse Survey

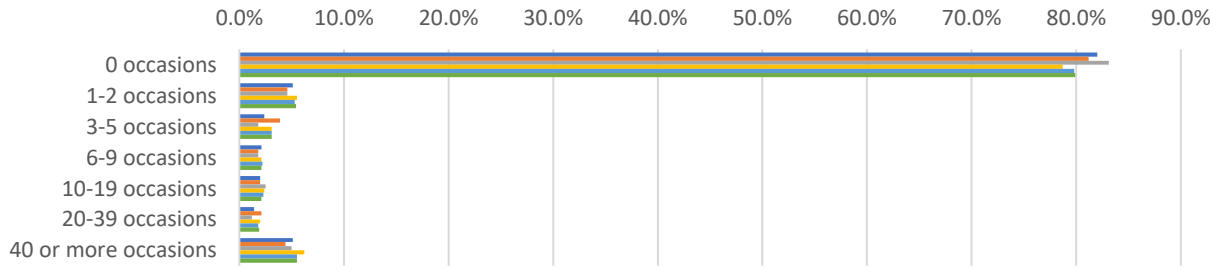
Figure 31: Thriving Mind SA – Think Back Over the Past 2 Weeks...How Many Times Have You Had Five or More Alcoholic Drinks in a Row? (MS&HS 2016-2020)



	10 or more times	6-9 times	3-5 times	Twice	Once	None
TMSF SA 2016	0.5%	0.2%	2.0%	1.2%	5.0%	91.2%
TMSF SA 2018	0.4%	0.1%	1.3%	2.2%	4.7%	91.2%
TMSF SA 2020	0.0%	0.4%	1.2%	2.1%	4.0%	92.3%
Florida 2016	0.4%	0.3%	1.3%	2.2%	3.6%	92.3%
Florida 2018	0.3%	0.3%	1.1%	1.9%	3.3%	93.2%
Florida 2020	0.4%	0.3%	1.1%	1.9%	3.1%	93.3%

Source: Florida Youth Substance Abuse Survey

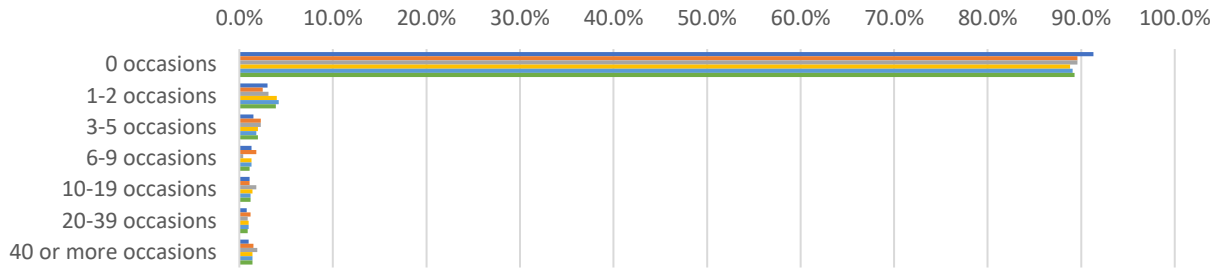
Figure 32: Thriving Mind SA – On How Many Occasions Have You Used Marijuana or Hashish in Your Lifetime? (MS&HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
TMSF SA 2016	5.1%	1.4%	2.0%	2.1%	2.4%	5.1%	82.0%
TMSF SA 2018	4.4%	2.1%	2.0%	1.8%	3.9%	4.6%	81.2%
TMSF SA 2020	5.0%	1.2%	2.5%	1.8%	1.8%	4.6%	83.1%
Florida 2016	6.2%	2.0%	2.4%	2.1%	3.1%	5.5%	78.7%
Florida 2018	5.5%	1.8%	2.3%	2.2%	3.1%	5.3%	79.8%
Florida 2020	5.5%	1.9%	2.1%	2.1%	3.1%	5.4%	79.9%

Source: Florida Youth Substance Abuse Survey

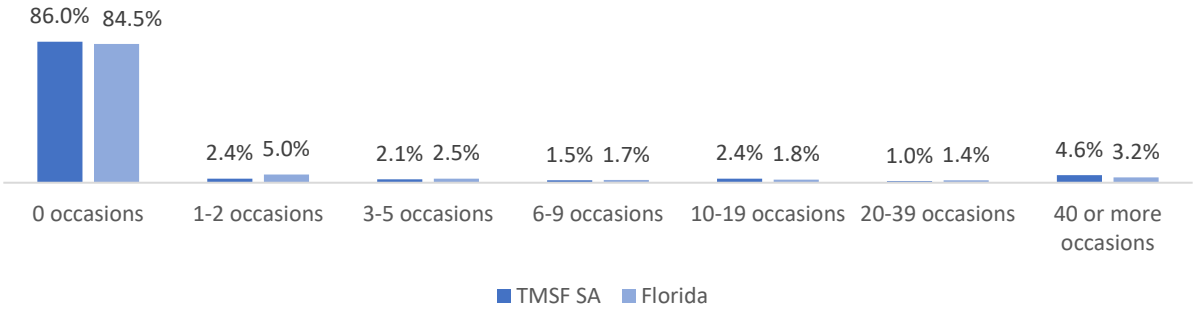
Figure 33: Thriving Mind SA – On How Many Occasions Have You Used Marijuana or Hashish During the Past 30 Days? (MS&HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
TMSF SA 2016	1.0%	0.8%	1.1%	1.3%	1.5%	3.0%	91.3%
TMSF SA 2018	1.5%	1.2%	1.1%	1.8%	2.3%	2.5%	89.6%
TMSF SA 2020	1.9%	0.9%	1.8%	0.4%	2.3%	3.1%	89.6%
Florida 2016	1.4%	1.0%	1.4%	1.3%	2.0%	4.0%	88.8%
Florida 2018	1.4%	1.0%	1.2%	1.3%	1.8%	4.2%	89.1%
Florida 2020	1.4%	0.9%	1.2%	1.1%	2.0%	3.9%	89.3%

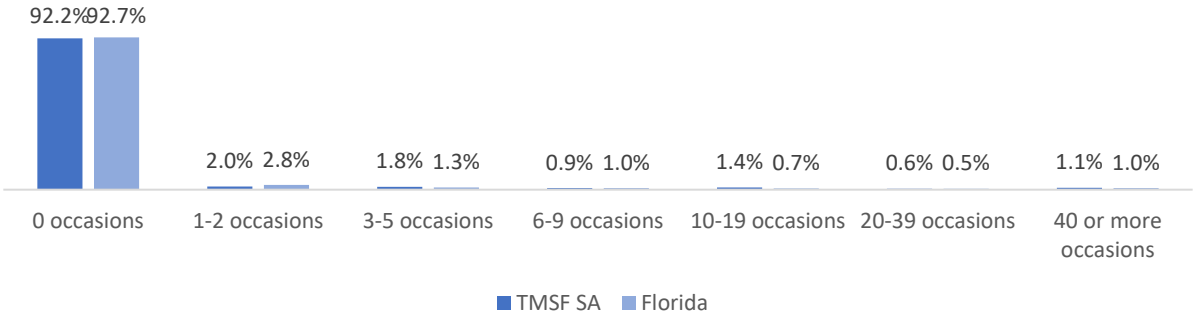
Source: Florida Youth Substance Abuse Survey

Figure 34: Thriving Mind SA – On How Many Occasions Have You Vaped Marijuana in Your Lifetime? (MS&HS 2016-2020)



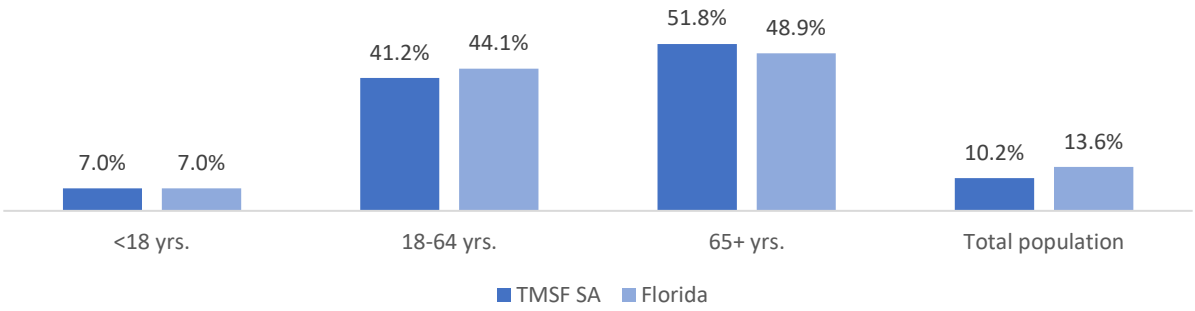
Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

Figure 35: Thriving Mind SA – On How Many Occasions Have You Vaped Marijuana in the Past 30 Days? (MS&HS 2016-2020)



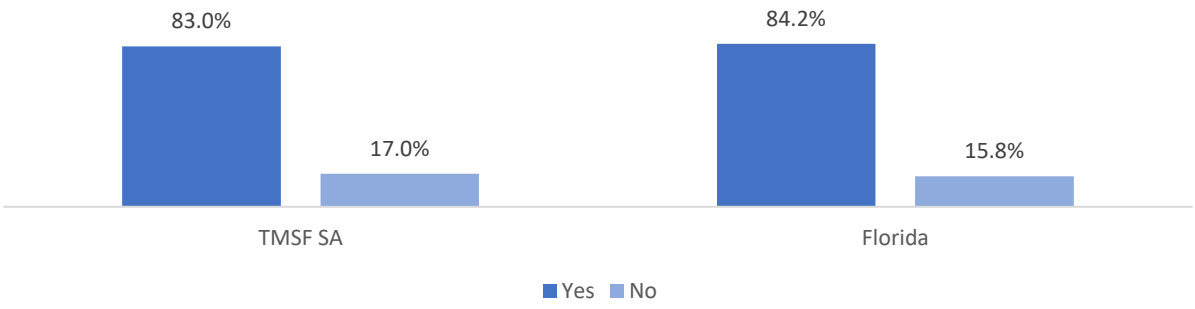
Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

Figure 36: Thriving Mind SA Civilian Noninstitutionalized Population with a Disability (2016-2020)



Source: U.S. Census Bureau, American Community Survey. Disability includes Hearing, Vision, Cognitive, Ambulatory, Self-Care, and Independent Living

Figure 37: Thriving Mind SA Percentage of Adults with Any Type of Health Care Insurance Coverage (2013-2019)



Source: Behavioral Risk Factor Surveillance System

THRIVING MIND SOUTH FLORIDA SERVICE AREA CLIENT DEMOGRAPHIC PROFILE

Client Population

Thriving Mind-funded organizations served 26,849 clients in treatment services for FY20-21. Not counted in these treatment services, during FY20-21, the Thriving Mind Prevention System served 1,173,480 individuals. Of these, 121,749 were individuals receiving direct services, and 1,039,577 were served through community education, outreach, and media impressions. Over 40% of clients resided in Miami-Dade County (23,672 clients) and Monroe County at 12.1% (3,248 clients). Clients who reported living in another county accounted for 0.7% of all clients.

Adults in Thriving Mind programs accounted for 81.7% of all clients with 61.5% enrolled in the Adult Mental Health (AMH) program and 19.2% in the Adult Substance Abuse program (ASA). The remaining clients were in the Child Mental Health (CMH) program at 12.7% and the Child Substance Abuse (CSA) program at 6.5%.

Gender

Males represented more than 50% of all clients in the AMH, ASA and CSA programs ranging from 67.6% in the CSA program to 49.3% in the AMH program. Males accounted for 47.7% of CMH clients. Females accounted for 50.7% of clients in AMH program but only 32.4% of those in the CSA program.

Race

The majority of Thriving Mind clients were White (64.8%) which was lower than the percentage in the service area population at 66.4%. Conversely, Black Thriving Mind clients accounted for 24.5% of the client population while representing only 16.7% of the population in the two-county service area. ASA clients more closely matched the racial distribution of the general population when compared to clients in other programs. The percentage of multi-racial clients in all programs was lower when compared to population in the ME service area.

Ethnicity

The percentage of Hispanics in the Thriving Mind client population at 50.9%, was less when compared to the percentage of the Hispanic population in the service area, at 67%. When

comparing the ethnic distribution among programs, Other Hispanic clients accounted for 33.8% of those in the CMH program.

Age Range

As expected, the age range distribution among Thriving Mind clients did not mimic that of the service area population. Adults, ages 25-44 years of age, accounted for 33.6% AMH clients and 48.4% of ASA clients. In comparison, adults in this age range represented 27.9% of the population in the two-county service area. Conversely, adults ages 65 years and older, accounted for a far less percentage of clients (5.5%) when compared to those in the service area population at 16.4%. Children under age 5 years accounted for less than 2% of clients in the CMH and CSA programs. There was a higher percentage of older teens, ages 15-19 years of age, in the CSA program when compared to those in the CMH program.

Residential Status

The percentage of clients living dependently (with relatives or non-relatives) was similar when comparing AMH and ASA clients. A lower percentage of AMH clients lived independently alone (15%) when compared to ASA clients at 21%. Youth living independently alone varied when comparing clients in the two programs. CMH clients were less than 1% of those living alone while only 1% of clients in the CSA program lived by themselves. It should be noted that DCF allows a value for not available/unknown for living arrangement, which our providers chose for most of this population.

Educational Attainment

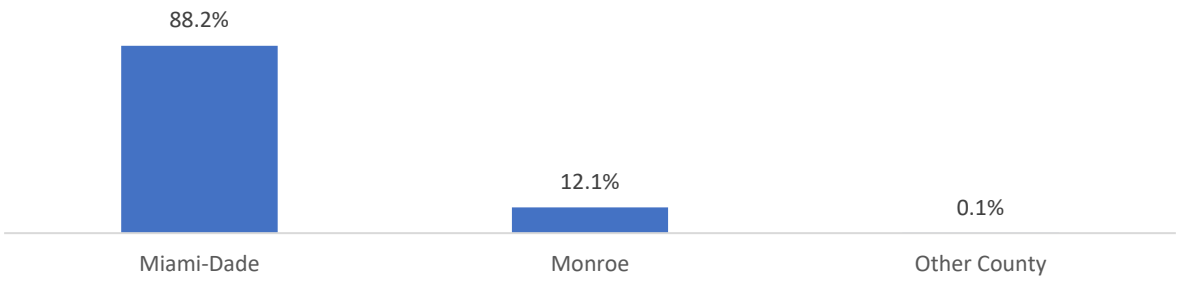
Thriving Mind clients attained lower educational levels when compared to those in the service area population. Among Thriving Mind adult clients, 42.3% of AMH clients and 33.2% of ASA clients did not attain more than a high school education. For all Thriving Mind adult clients, 31.1% did not attain more than a high school education. This rate was much lower compared to the rate for all residents living in the service area.

Employment Status

Lower educational attainment was one of several factors that contributed to much higher levels of unemployment among adult Thriving Mind clients when compared to those in the service area. Unemployment ranged from 44.3% of ASA clients to 49.9% among AMH clients. The 5-year estimate for unemployment in the service area was 3.2% (2016-2020).

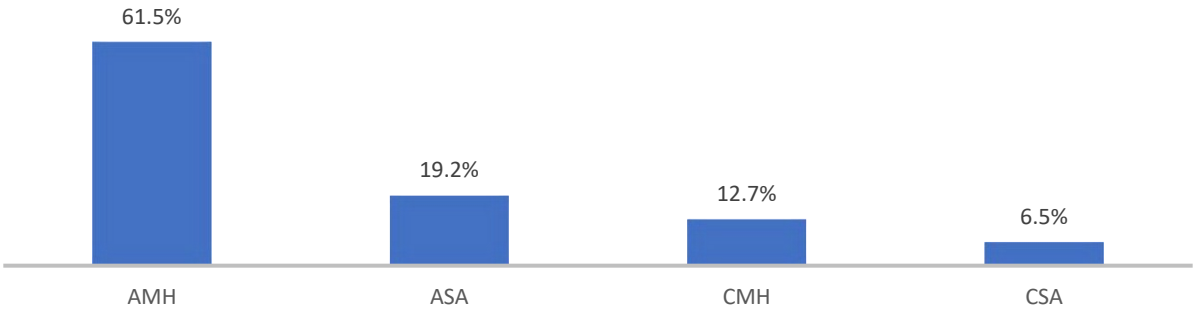
CLIENT DEMOGRAPHIC CHARTS

Figure 38: Thriving Mind Clients by County



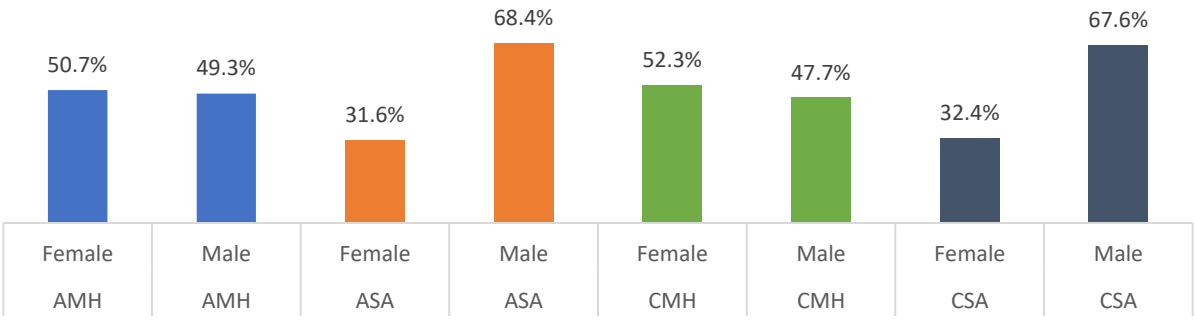
Source: Thriving Mind Client Data

Figure 39: Thriving Mind Clients by Program



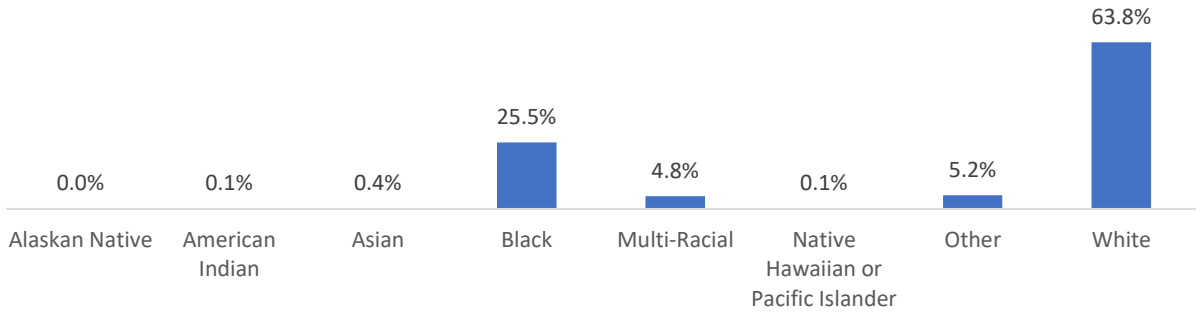
Source: Thriving Mind Client Data

Figure 40: Thriving Mind Clients by Program and Gender



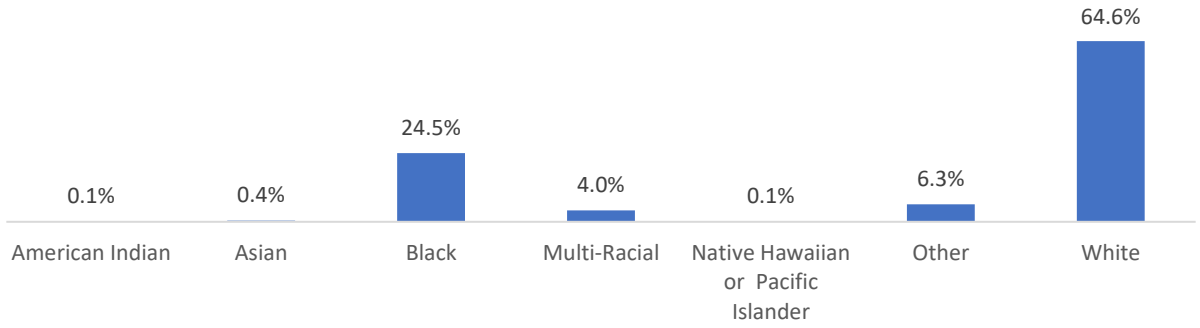
Source: Thriving Mind Client Data

Figure 41: Thriving Mind Clients by Race



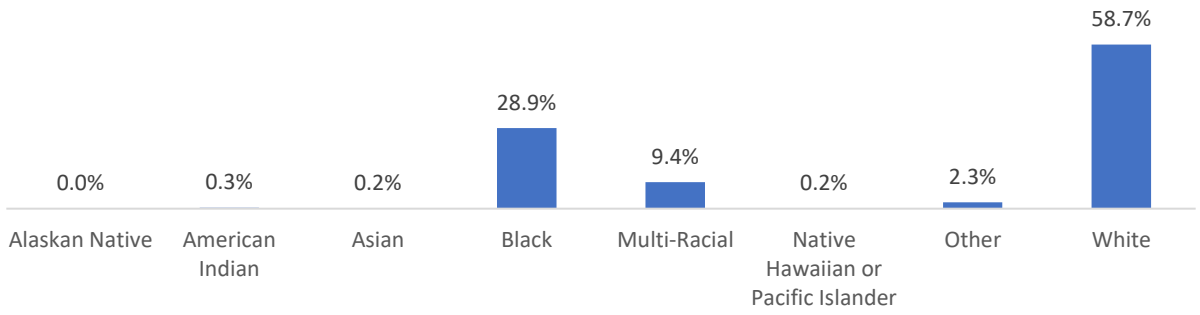
Source: Thriving Mind Client Data

Figure 42: Thriving Mind AMH Clients by Race



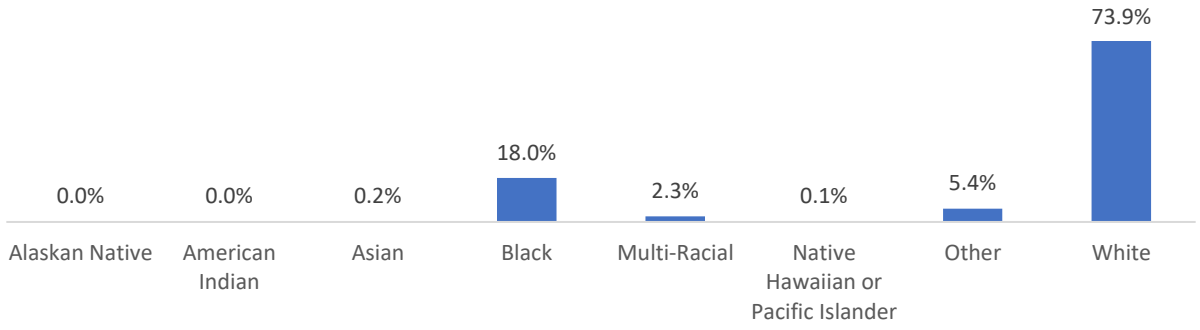
Source: Thriving Mind Client Data

Figure 43: Thriving Mind ASA Clients by Race



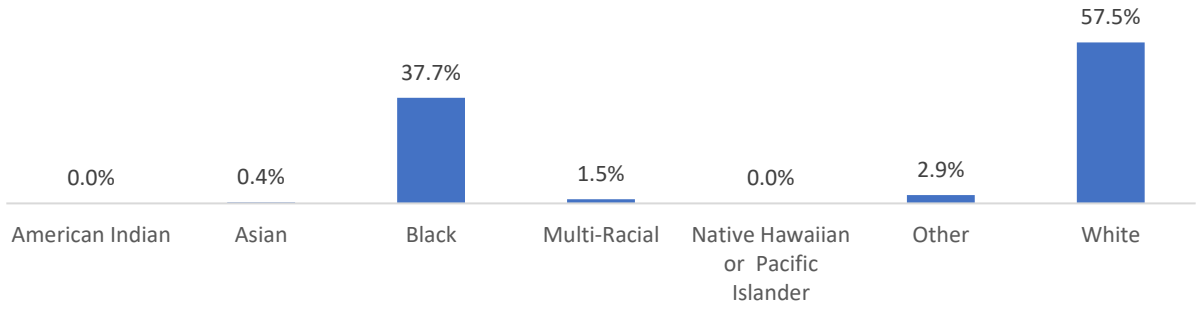
Source: Thriving Mind Client Data

Figure 44: Thriving Mind CMH Clients by Race



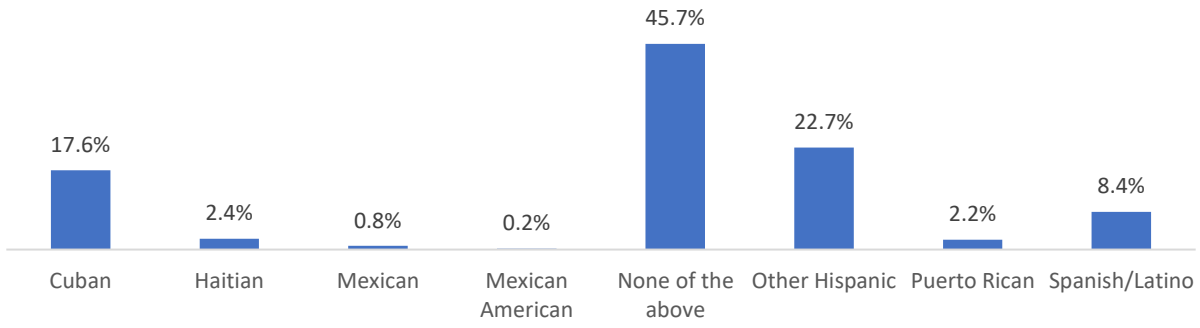
Source: Thriving Mind Client Data

Figure 45: Thriving Mind CSA Clients by Race



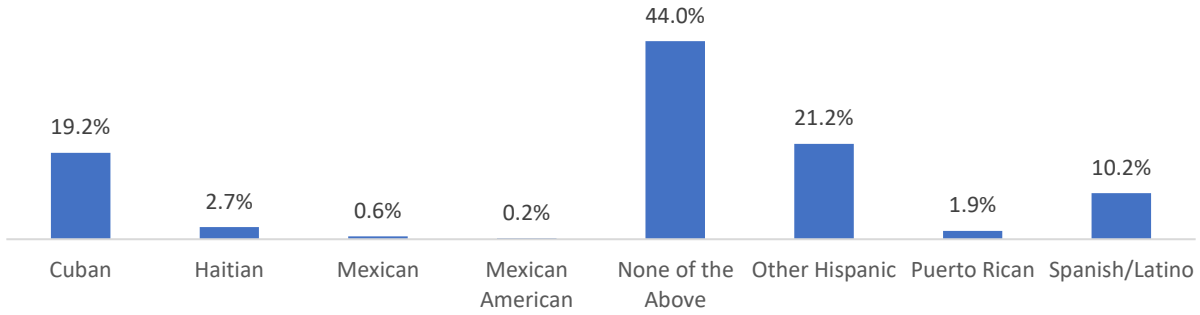
Source: Thriving Mind Client Data

Figure 46: Thriving Mind Clients by Ethnicity



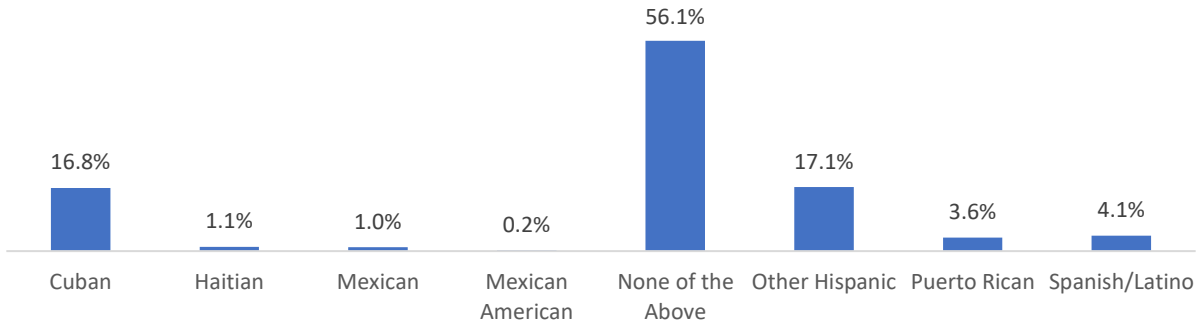
Source: Thriving Mind Client Data

Figure 47: Thriving Mind AMH Clients by Ethnicity



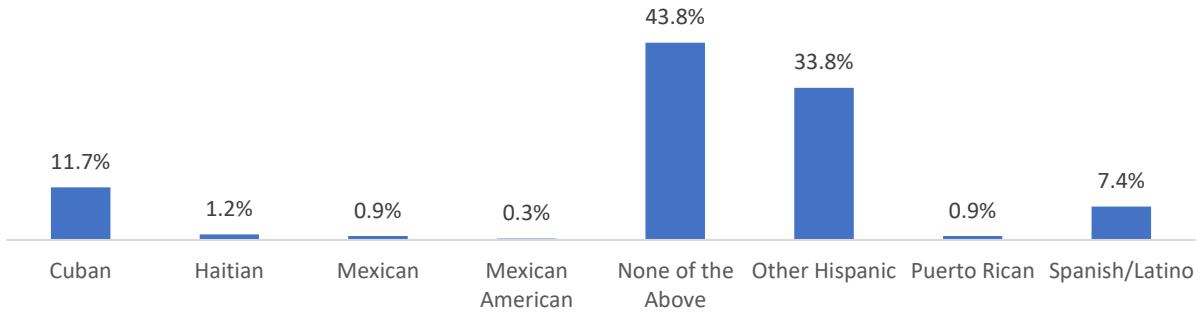
Source: Thriving Mind Client Data

Figure 48: Thriving Mind ASA Clients by Ethnicity



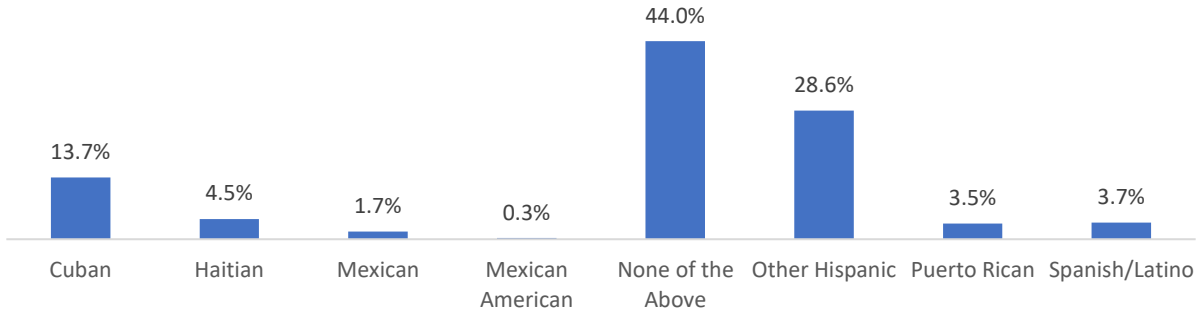
Source: Thriving Mind Client Data

Figure 49: Thriving Mind CMH Clients by Ethnicity



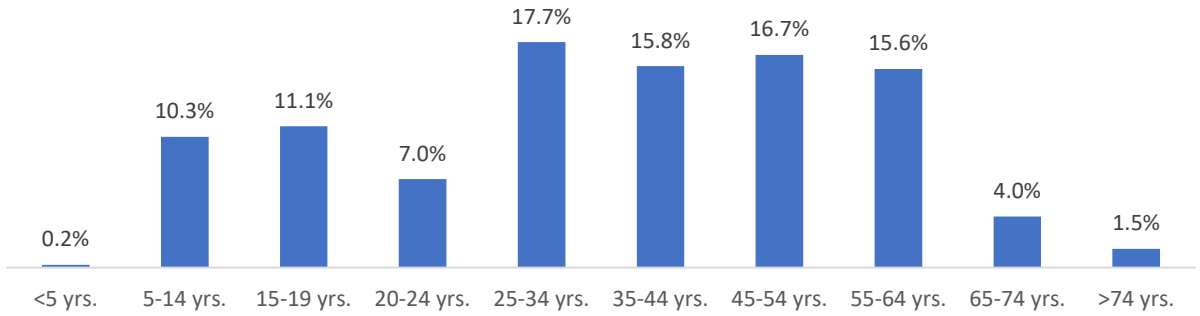
Source: Thriving Mind Client Data

Figure 50: Thriving Mind CSA Clients by Ethnicity



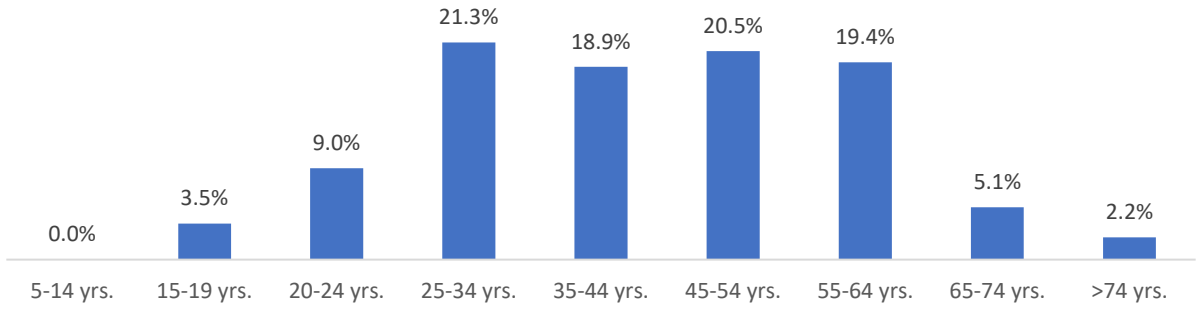
Source: Thriving Mind Client Data

Figure 51: Thriving Mind Clients by Age Range



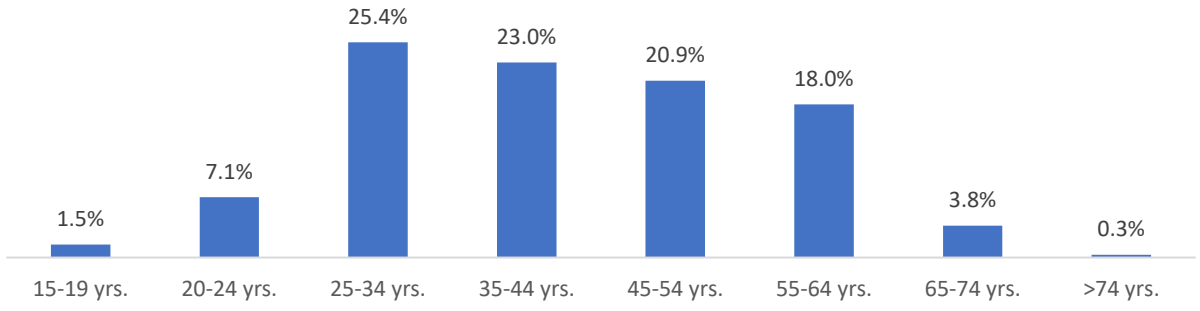
Source: Thriving Mind Client Data

Figure 52: Thriving Mind AMH Clients by Age Range



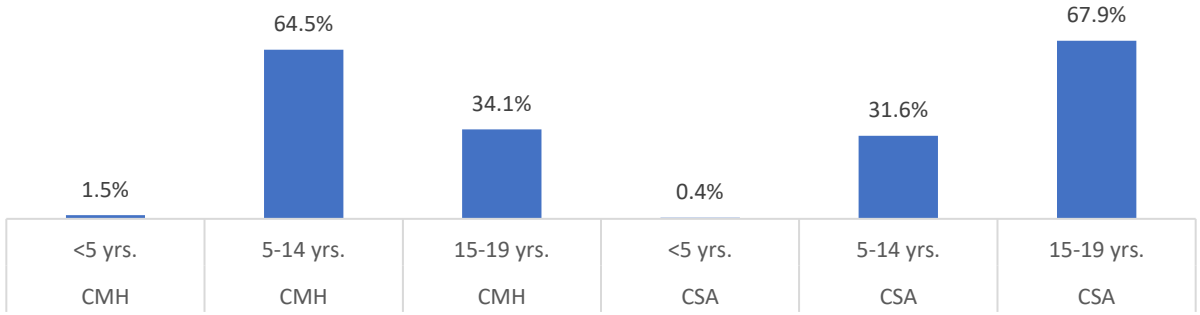
Source: Thriving Mind Client Data

Figure 53: Thriving Mind ASA Clients by Age Range



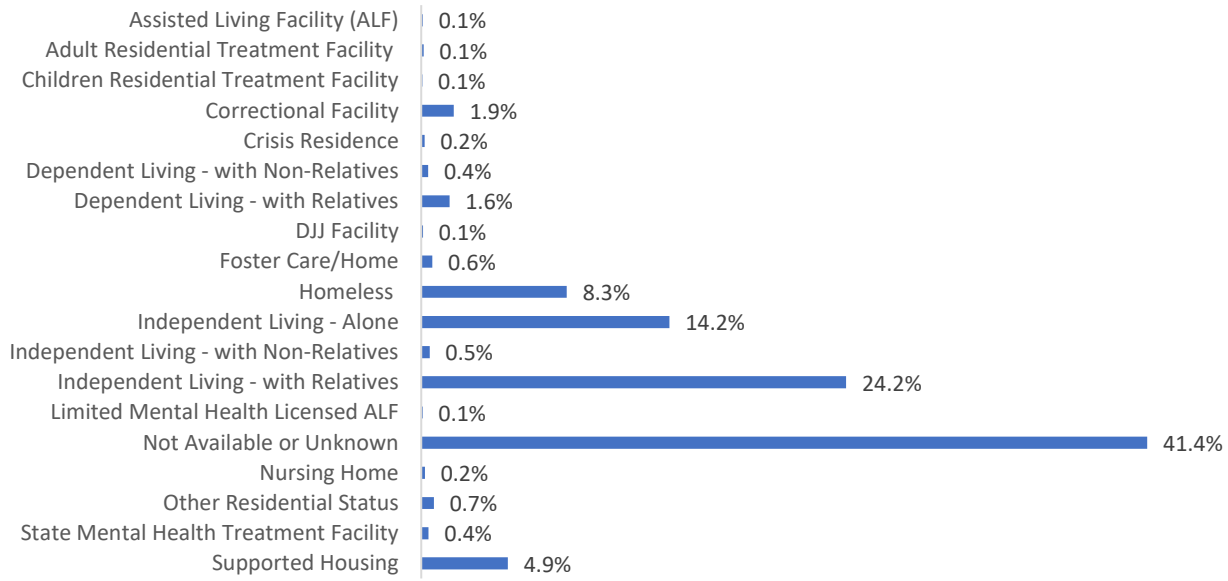
Source: Thriving Mind Client Data

Figure 54: Thriving Mind CMH and CSA Clients by Age Range



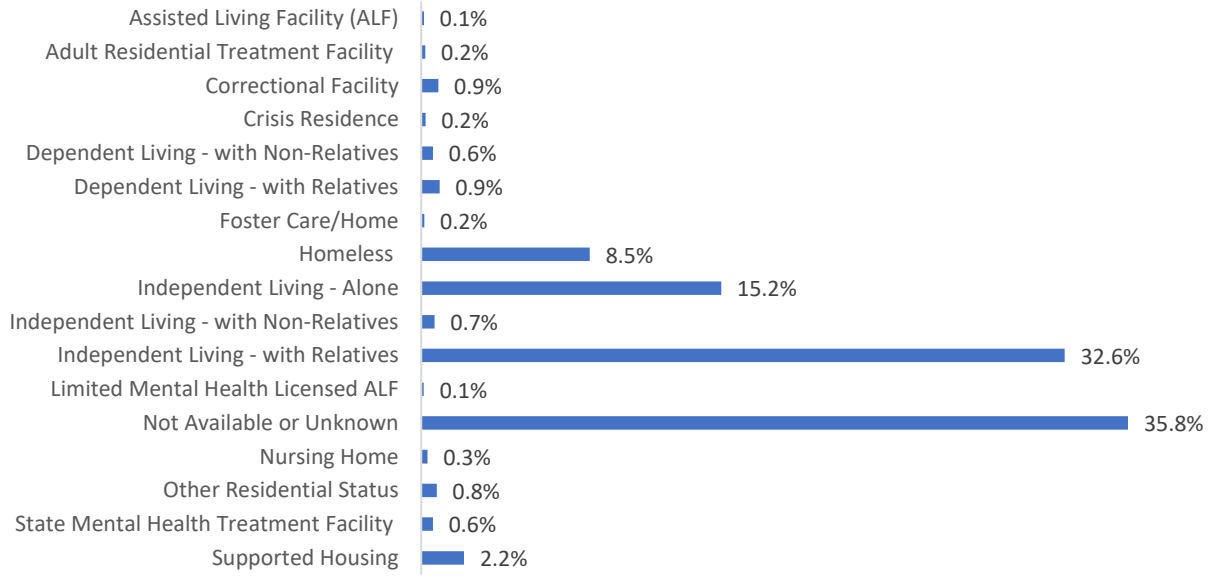
Source: Thriving Mind Client Data

Figure 55: Thriving Mind Clients by Residential Status



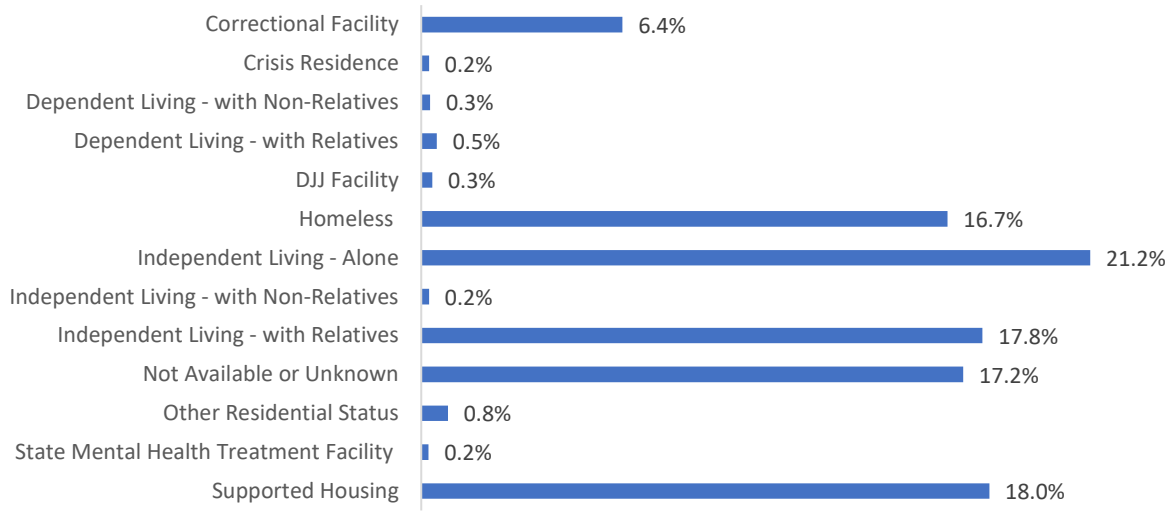
Source: Thriving Mind Client Data

Figure 56: Thriving Mind AMH Clients by Residential Status



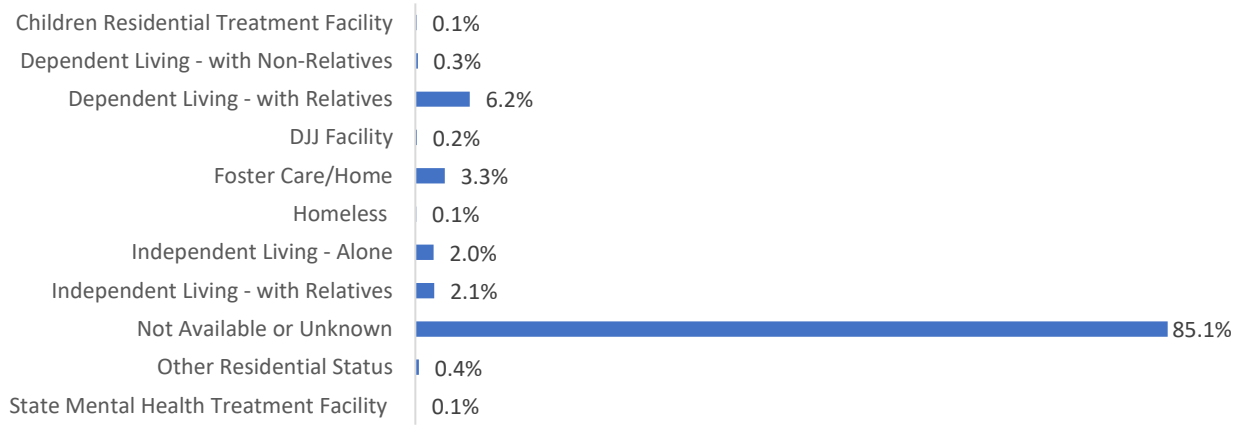
Source: Thriving Mind Client Data

Figure 57: Thriving Mind ASA Clients by Residential Status



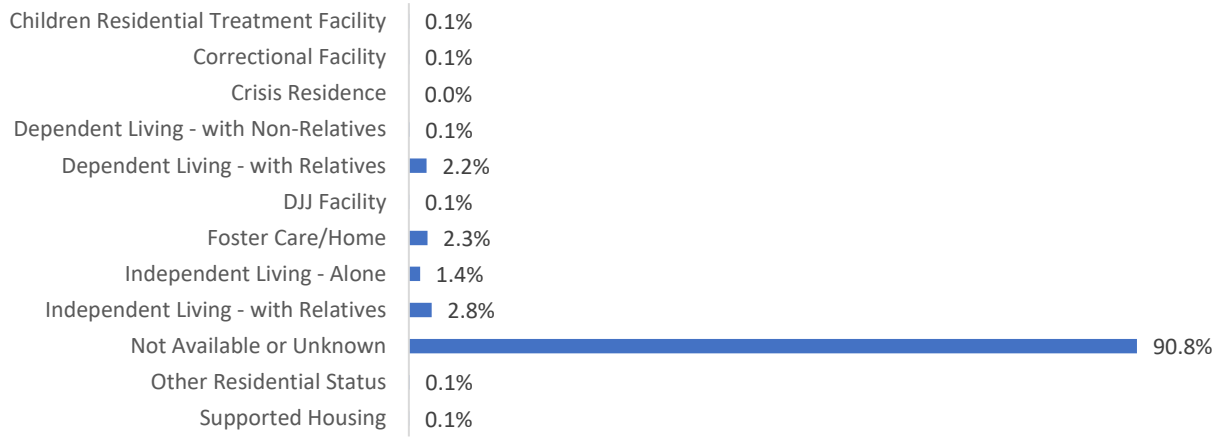
Source: Thriving Mind Client Data

Figure 58: Thriving Mind CMH Clients by Residential Status



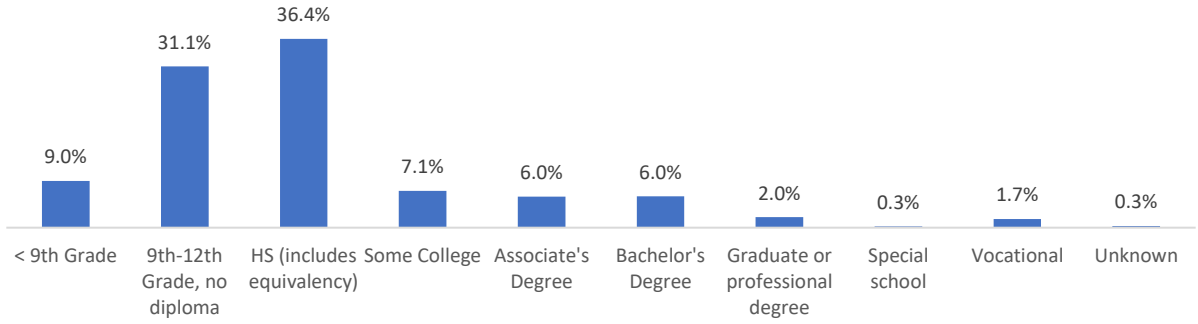
Source: Thriving Mind Client Data

Figure 59: Thriving Mind CSA Clients by Residential Status



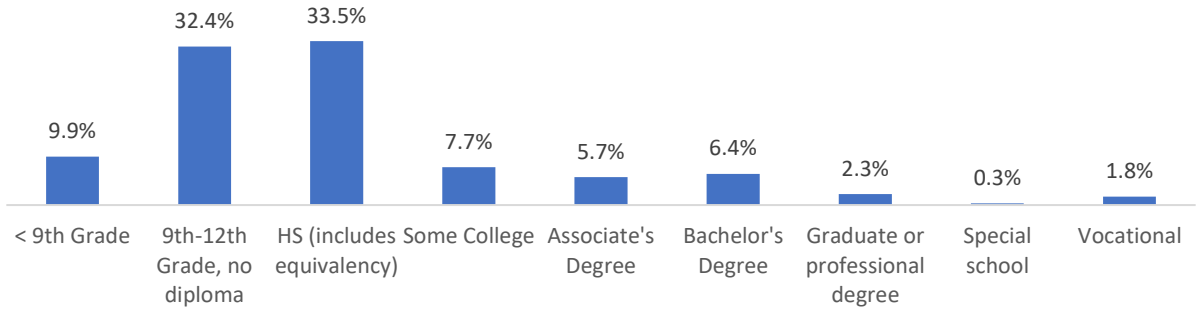
Source: Thriving Mind Client Data

Figure 60: Thriving Mind Clients by Educational Attainment



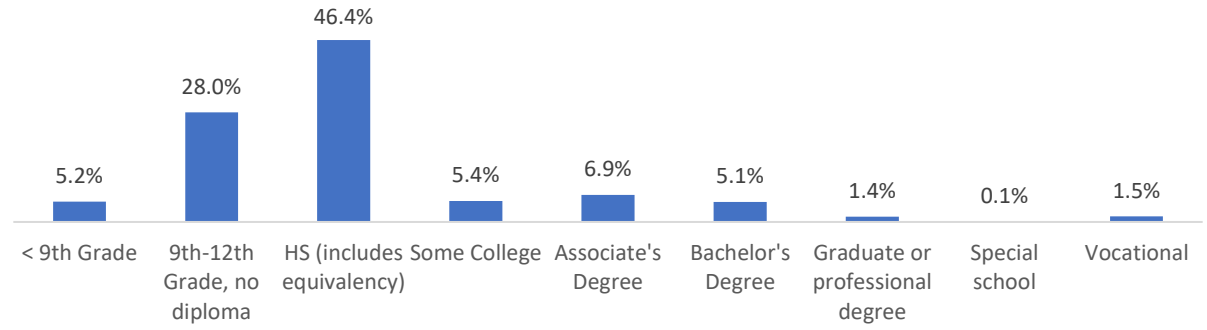
Source: Thriving Mind Client Data

Figure 61: Thriving Mind AMH Clients by Educational Attainment



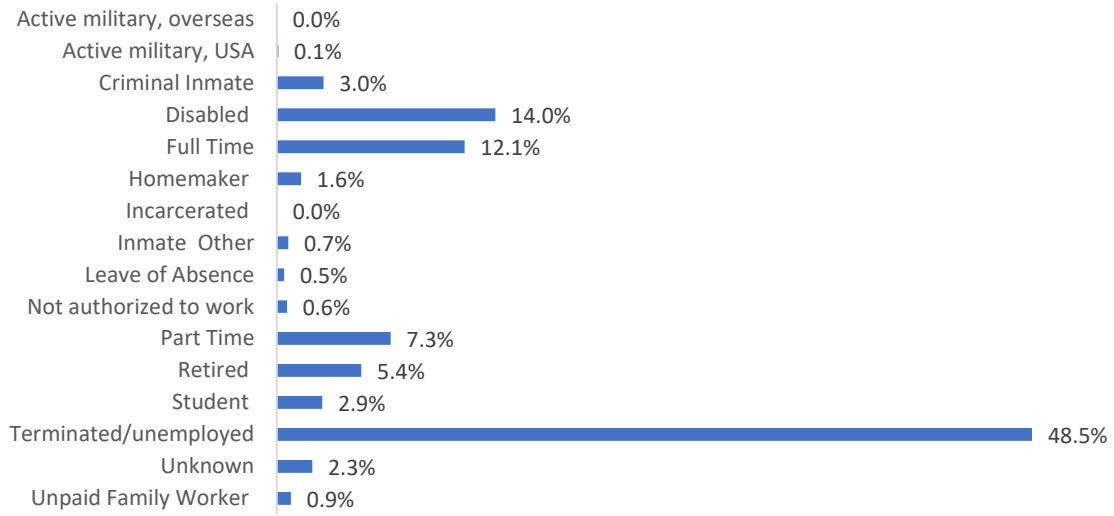
Source: Thriving Mind Client Data

Figure 62: Thriving Mind ASA Clients by Educational Attainment



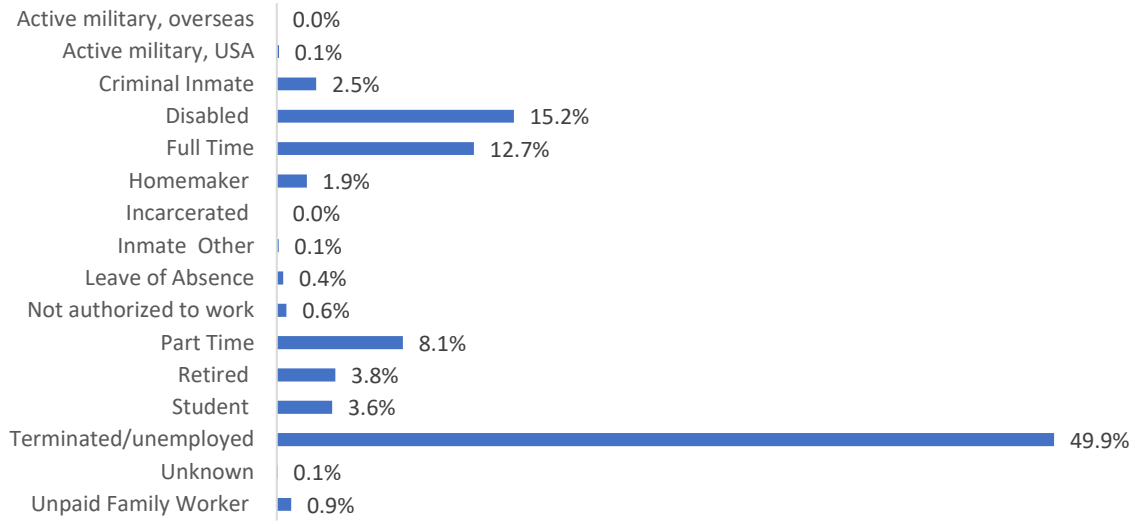
Source: Thriving Mind Client Data

Figure 63: Thriving Mind Clients by Employment Status



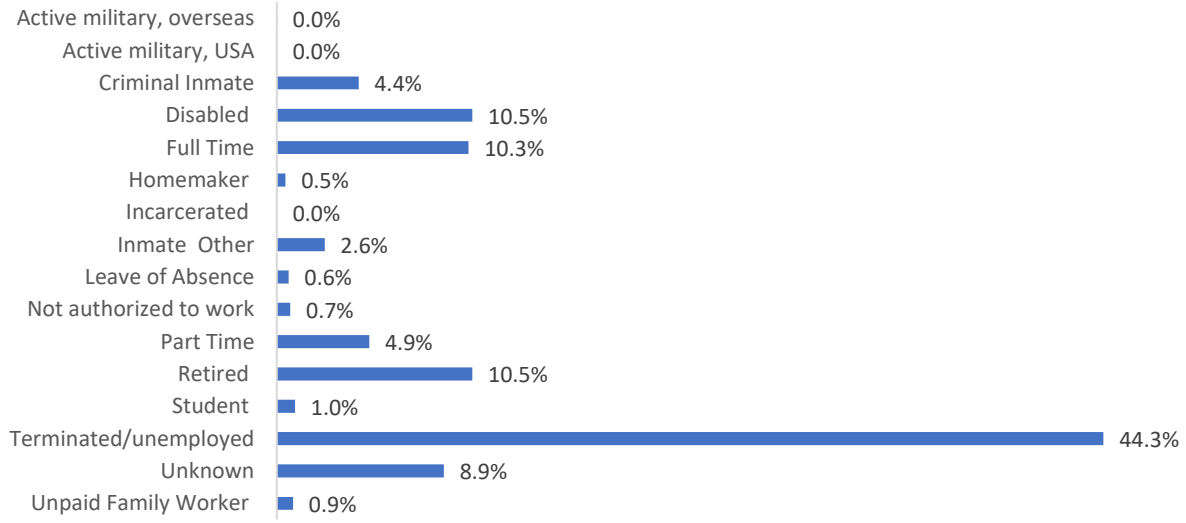
Source: Thriving Mind Client Data

Figure 64: Thriving Mind AMH Clients by Employment Status



Source: Thriving Mind Client Data

Figure 65: Thriving Mind ASA Clients by Employment Status



Source: Thriving Mind Client Data

THRIVING MIND SERVICE AREA HOMELESS POPULATION

The 2021 Council on Homelessness Report states that the Point in Time Count (PIT) data provides a snapshot of homelessness. **Due to the pandemic, the 2021 PIT Count is not directly comparable to prior years' counts.** Typically, Continuums of Care (CoCs- A local geographic area designated by HUD and served by a local planning body, which is responsible for organizing and delivering housing and services to meet the needs of people who are homeless as they move to stable housing and maximum self-sufficiency) conduct a PIT Count of both sheltered and unsheltered households. This year, due to COVID-19 related safety concerns, only six of the 27 CoCs conducted such a count; 10 CoCs did not conduct an unsheltered count; and others conducted a modified form of the unsheltered count. All CoCs conducted a sheltered PIT count. For those that did not conduct an unsheltered count, the CoCs reported zero unsheltered persons, resulting in an undercount of total homelessness. According to the report:

> "Housing is a significant determinant of health, and insufficient housing is a major public health issue. The COVID-19 pandemic has exacerbated housing instability especially for low-income households. In effect, the pandemic has triggered high rates of unemployment, worsened pre-existing behavioral health disorders, and increased stress, anxiety, and depression for others. Increased rates of unemployment also contribute to increasing the prevalence of behavioral health disorders, resulting in more suffering and deaths. Prior to the pandemic, America's affordable housing crisis was already expected to get worse. The ELI housing crisis is evidenced by the fact that people with disabilities are forced to live in segregated and institutional facilities (e.g., nursing homes, state institutions, etc.) and experience homelessness. Many of these individuals need Permanent Supportive Housing."
>
> (Please access the actual report for resources at: 2021CouncilReport.pdf (myflfamilies.com)

In 2021, the Florida Council on Homelessness reported there were 3,466 homeless individuals in South Florida (Miami-Dade and Monroe counties) or District 11. Over 67% were sheltered and 25.7% unsheltered. Chronically homeless, defined as continually homeless for over a year, increased from 377 individuals in 2017 to 555 people in 2020 in District 11. Homelessness among veterans decreased during the same time from 254 in 2017 to 224 in 2020. Families experiencing homelessness decreased by 8% from 2017 to 2020. The number of homeless students, 6,490 in 2015-2016 increased 49.7% to 9,714 in the 2019-2020 school year. Of those students who were homeless in 2019-2020, over 70% were in a sharing housing arrangement and 5.4% were living in motels.

Due to the COVID-19 pandemic, this year saw an unprecedented infusion of federal funding to address homelessness and housing instability. With these funds appropriated by Congress, the

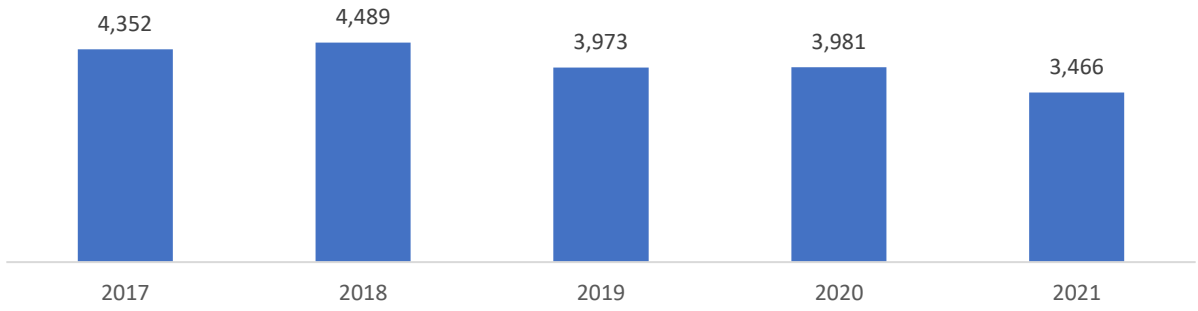
State, local governments, CoCs, and partner agencies have invested in solutions to homelessness, including rent and utilities assistance, sheltering, outreach, supportive services and more. While these resources have increased Florida's capacity to prevent and end homelessness, the federal funds have strict restrictions on how the funds may be used; they are not interchangeable with the Challenge and Staffing grants provided to CoCs by the State of Florida. State funding remains critical to addressing homelessness in Florida, especially in rural areas and for the many programs that cannot be funded by federal resources due to their restrictions. State funding helps ensure a broad range of programs in Florida, as well as increase the capacity of the CoCs to administer the federal funding and other resources.

Figure 66: CoC Funding from Federal and State Sources, District 11 (SFY20-21)

Source	District 11
Total Funding Award	$48,258,807.70
HUD CoC FFY20	$35,870,160.00
State Total	$12,388,647.70
State Challenge	$267,500.00
State HUD-ESG	$11,371,030.00
State Staffing	$267,500.00
Emergency Solutions Grant	$457,000.00
State TANF-HP	$78,832.00

Source: 2021 Florida's Council on Homelessness Annual Report

Figure 67: Total Homeless Population, District 11 (2017-2021)

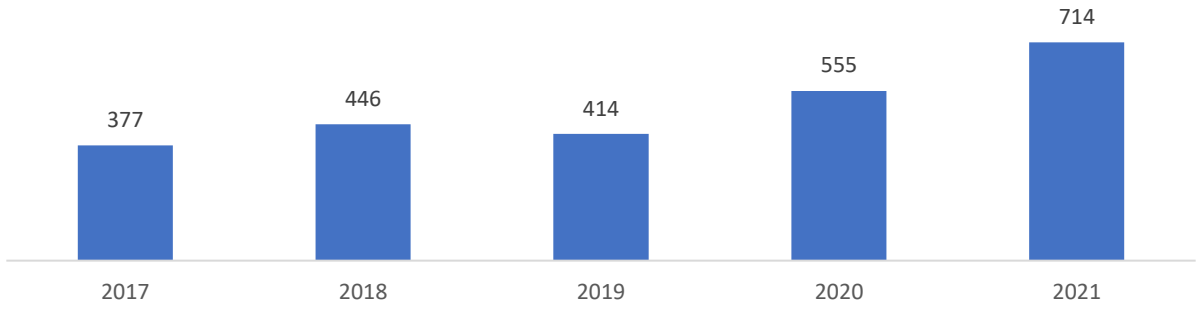


Source: 2021 Florida's Council on Homelessness Annual Report

Figure 68: Total Homeless Population Sheltered and Unsheltered, District 11 (2021)

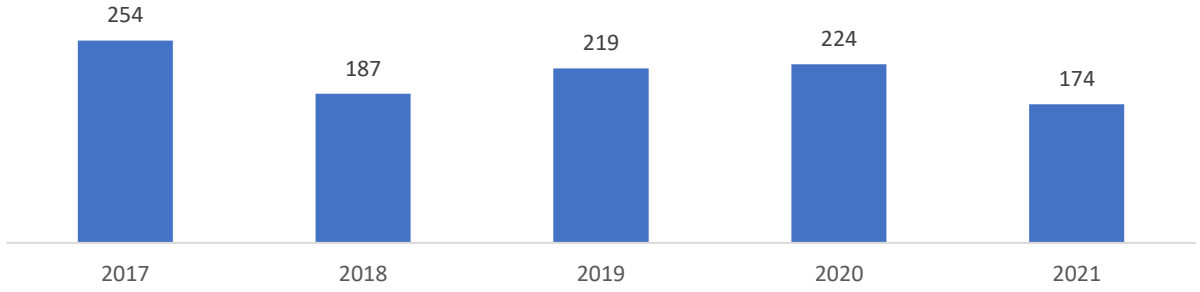
Source: 2021 Florida's Council on Homelessness Annual Report

Figure 69: Chronic Homelessness, District 11 (2017-2021)



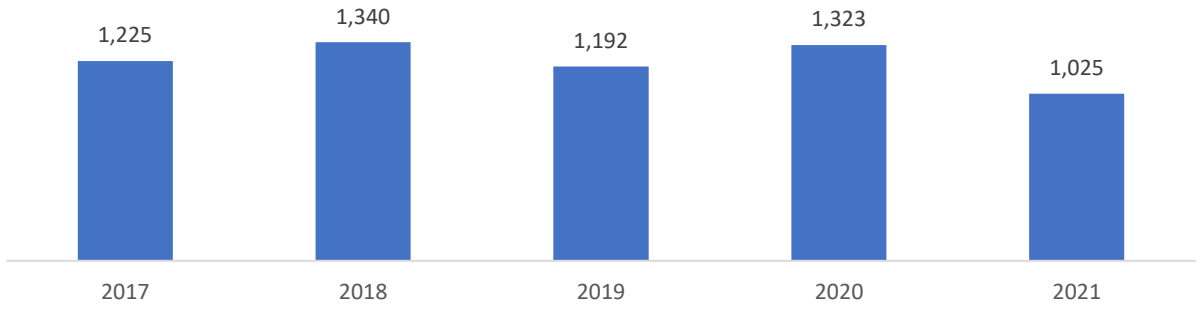
Source: 2021 Florida's Council on Homelessness Annual Report

Figure 70: Homelessness Among Veterans, District 11 (2017-2021)



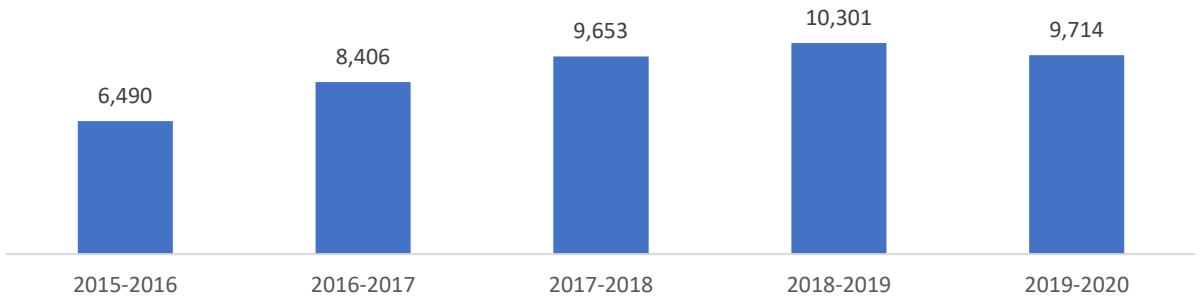
Source: 2021 Florida's Council on Homelessness Annual Report

Figure 71: Family Homelessness – Total Persons in Families with Children, District 11 (2017-2021)



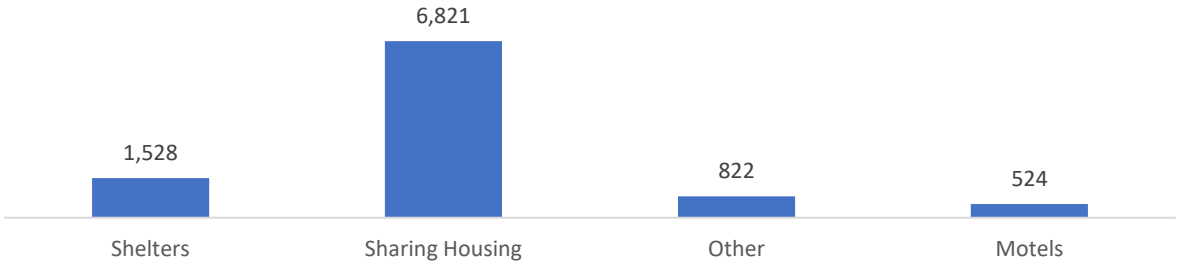
Source: 2021 Florida's Council on Homelessness Annual Report

Figure 72: Florida DOE – Reported Homeless Students in Public Schools, District 16 & 20 (2015-2020)



Source: 2021 Florida's Council on Homelessness Annual Report

Figure 73: Reported Homeless Students in Public Schools by Living Situation, District 16 & 20 (2019-2020)



Source: 2021 Florida's Council on Homelessness Annual Report

THRIVING MIND HOMELESS CLIENT PROFILE

Demographics

A total of 2,567 homeless clients were enrolled in adult and child programs in FY20-21. Of these, 39.2% were in the AMH program and 60.7% in the ASA program. It should be noted that there may be a small percentage of overlap with some clients enrolled in both programs. Homeless children accounted for less than 10% of homeless clients.

Males accounted for larger percentages of clients in the AMH and ASA programs at 56.2% and 24.4%, respectively. Among the child programs, females accounted for 14.5% of clients in the CMH program but only 4.6% in the CSA program. It should be noted that the number of homeless clients in the CSA was small, and results should be interpreted with caution.

Homeless clients in the AMH and ASA programs were racially more diverse when compared to the general service population. White homeless clients accounted for 64.5% of those in the AMH program and Black homeless clients represented 24.5% of clients in the same program. In the general population, 66.4% of residents were White and 16.7% were black. Multi-racial individuals also accounted for a lower percentage of clients in the AMH (4%) and ASA (9.4%) programs when compared to the service area population at 10.5%. The percentage of homeless Hispanic clients in the AMH program, at 11.4%, was lower when compared to the Hispanic clients in the ASA, at 14.2%. In the general population, 67% were Hispanic. Only 3.1% of homeless clients in the child programs were Hispanic.

Adults, ages 25-44 years, accounted for 45.8% of AMH clients and 50.9% of ASA clients. Older homeless clients, those over 65 years of age, represented a much smaller percentage of homeless clients (3.1%) when compared to those in the service area at 16.4%.

Residential Status

Majority of Thriving Mind homeless clients reported their residential status as unknown, living independently with relatives with a shared cost, supported housing, or living alone. It should be noted that DCF allows a value for not available/unknown for living arrangement, which our providers chose for some of this population.

Educational Attainment

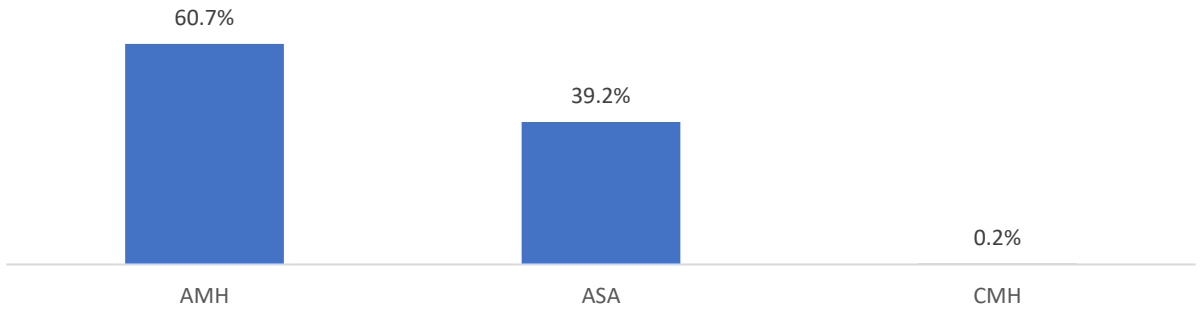
Among the homeless clients, 30% had not received a high school diploma and 81.5% had not attained more than a high school education.

Employment Status

Only 4.8% of homeless clients were employed (part time or full time) and 69.8% had been terminated or were unemployed.

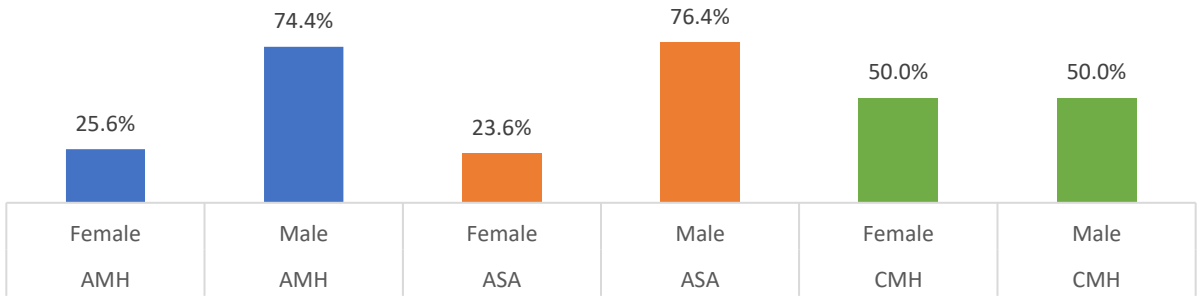
THRIVING MIND SOUTH FLORIDA HOMELESS CLIENT CHARTS

Figure 74: Thriving Mind Homeless Clients by Program



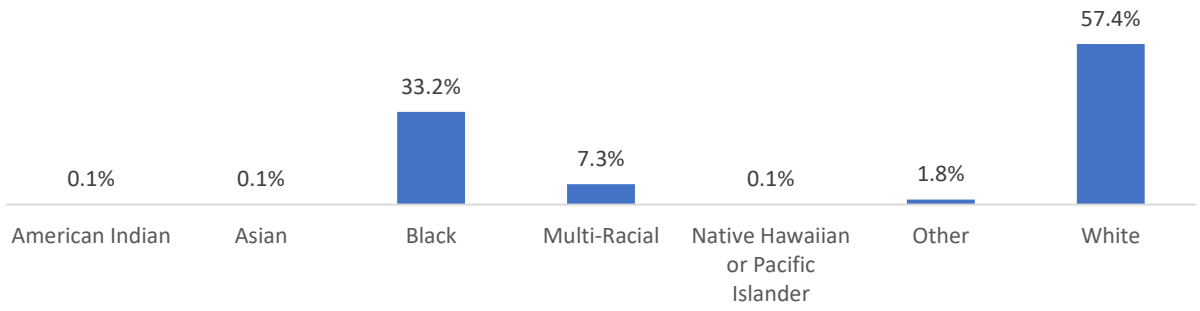
Source: Thriving Mind Client Data

Figure 75: Thriving Mind Homeless Clients by Gender



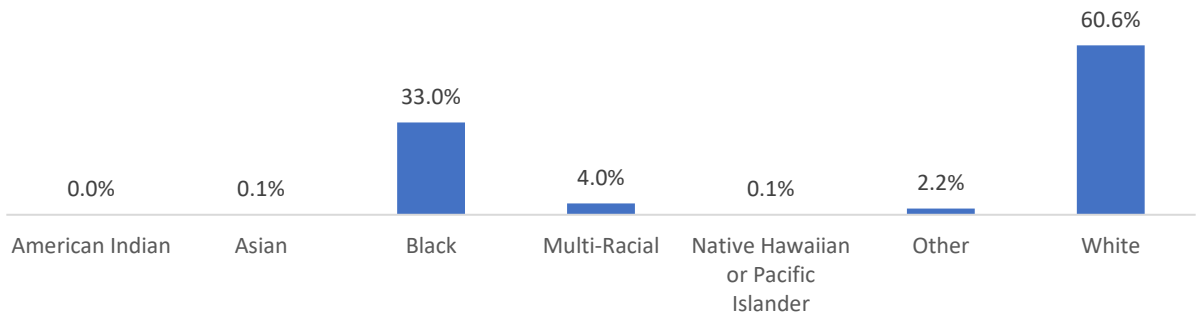
Source: Thriving Mind Client Data

Figure 76: Thriving Mind Homeless Clients by Race



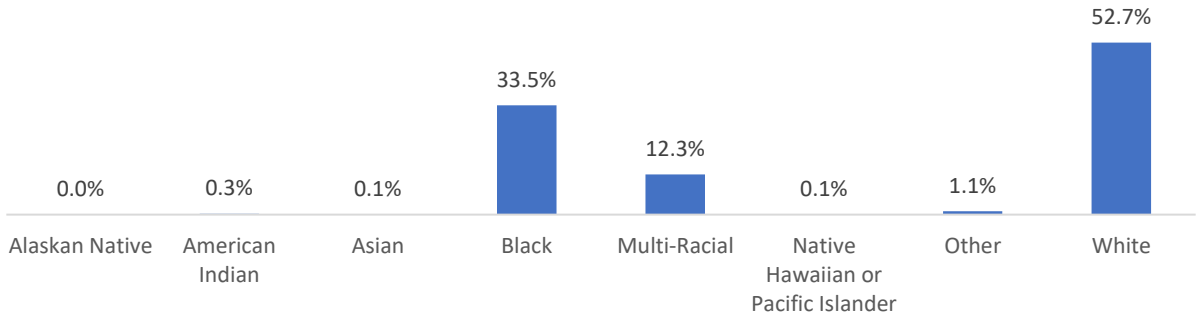
Source: Thriving Mind Client Data

Figure 77: Thriving Mind Homeless AMH Clients by Race



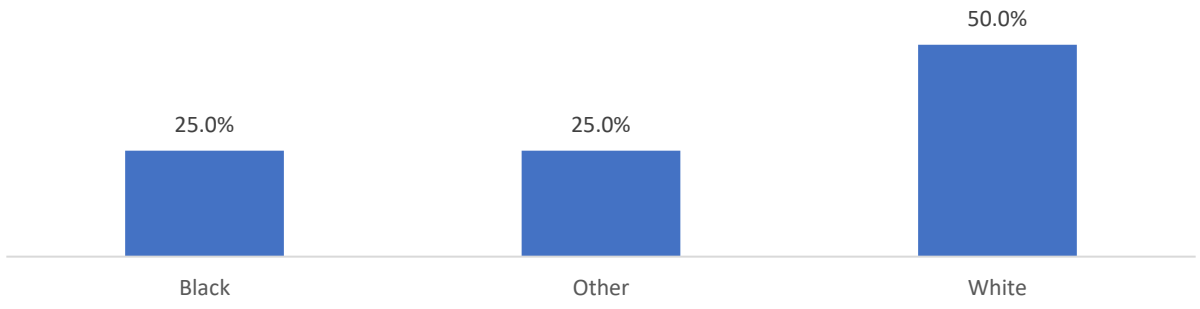
Source: Thriving Mind Client Data

Figure 78: Thriving Mind Homeless ASA Client by Race



Source: Thriving Mind Client Data

Figure 79: Thriving Mind Homeless CMH Clients by Race



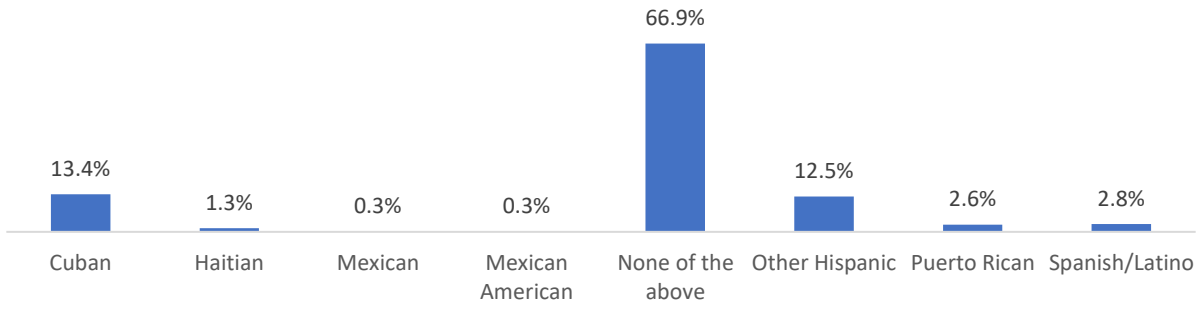
Source: Thriving Mind Client Data

Figure 80: Thriving Mind Homeless CSA Clients by Race

There were no homeless clients in the CSA Program.

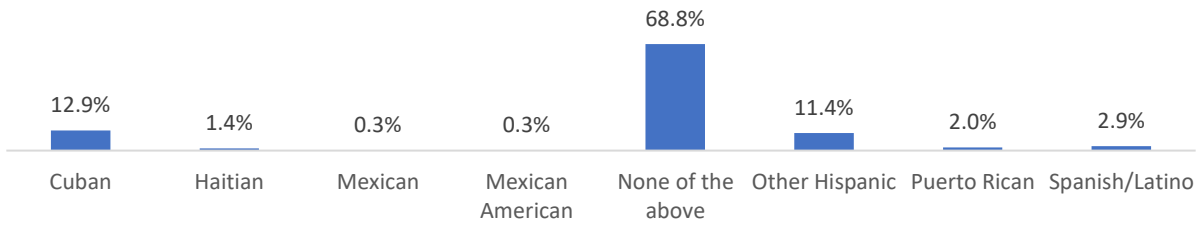
Source: Thriving Mind Client Data

Figure 81: Thriving Mind Homeless Clients by Ethnicity



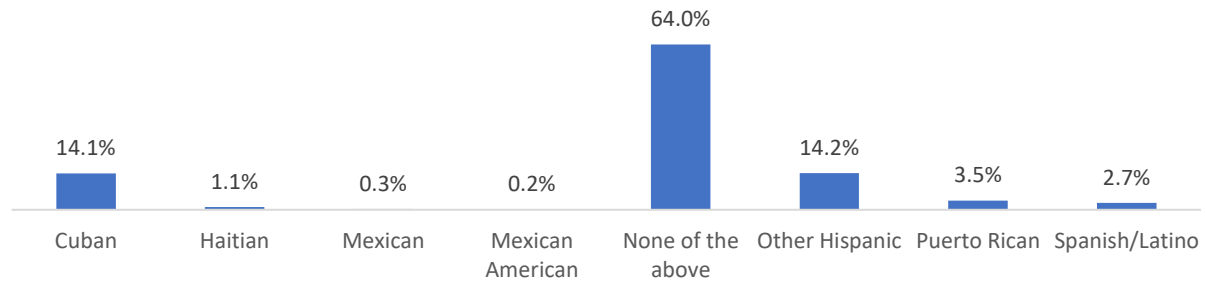
Source: Thriving Mind Client Data

Figure 82: Thriving Mind Homeless AMH Clients by Ethnicity



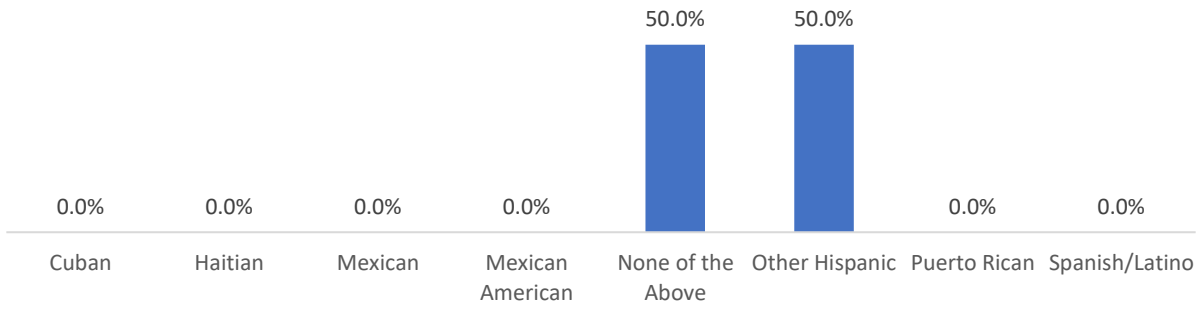
Source: Thriving Mind Client Data

Figure 83: Thriving Mind Homeless ASA Clients by Ethnicity



Source: Thriving Mind Client Data

Figure 84: Thriving Mind Homeless CMH Clients by Ethnicity



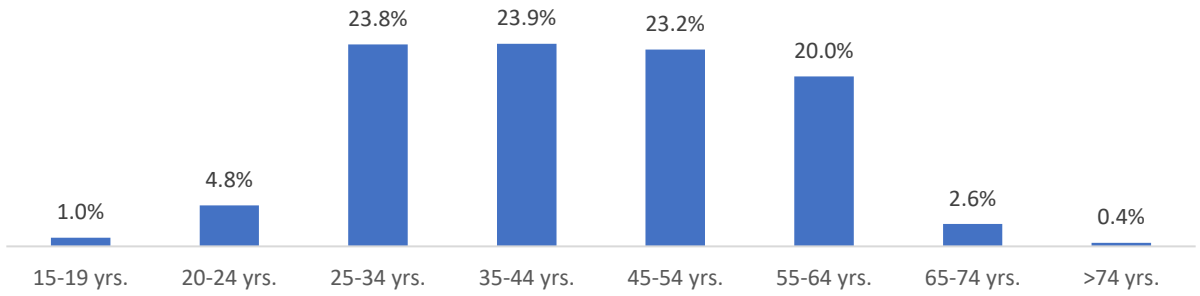
Source: Thriving Mind Client Data

Figure 85: Thriving Mind Homeless CSA Clients by Ethnicity

There were no homeless clients in the CSA Program.

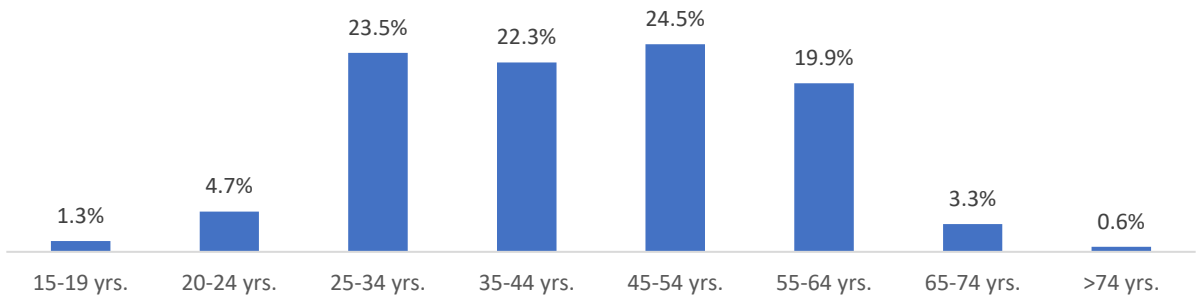
Source: Thriving Mind Client Data

Figure 86: Thriving Mind Homeless Clients by Age Range



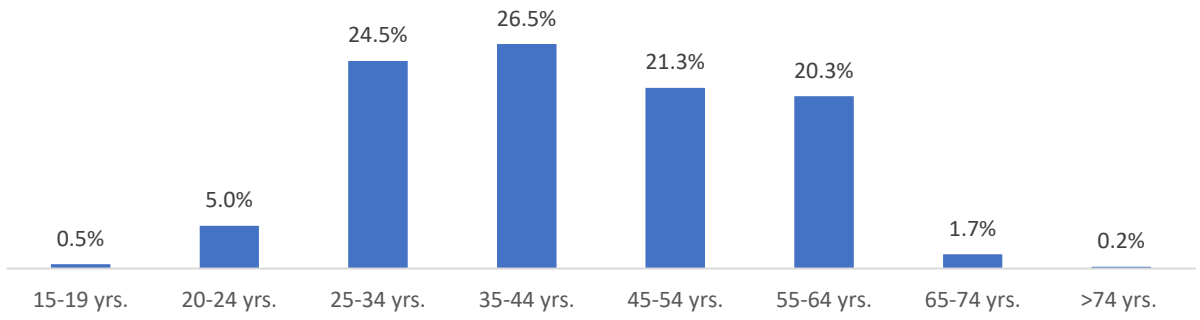
Source: Thriving Mind Client Data

Figure 87: Thriving Mind Homeless AMH Clients by Age Range



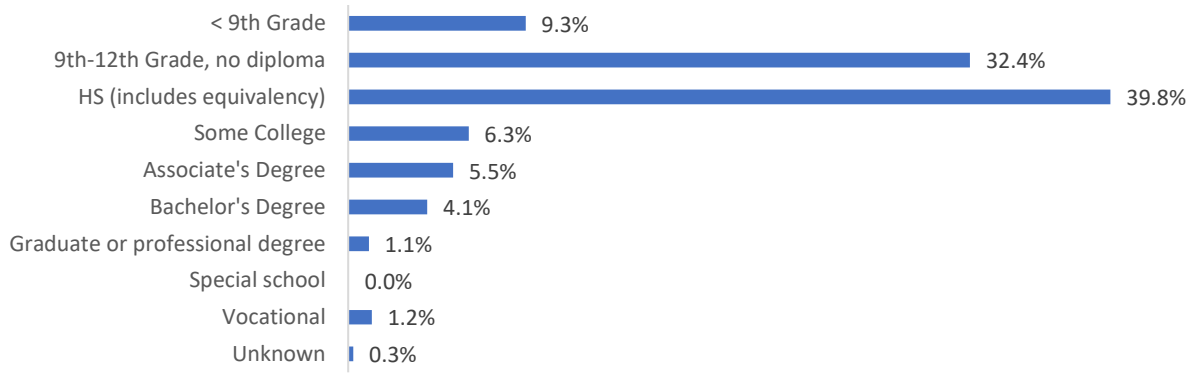
Source: Thriving Mind Client Data

Figure 88: Thriving Mind Homeless ASA Clients by Age Range



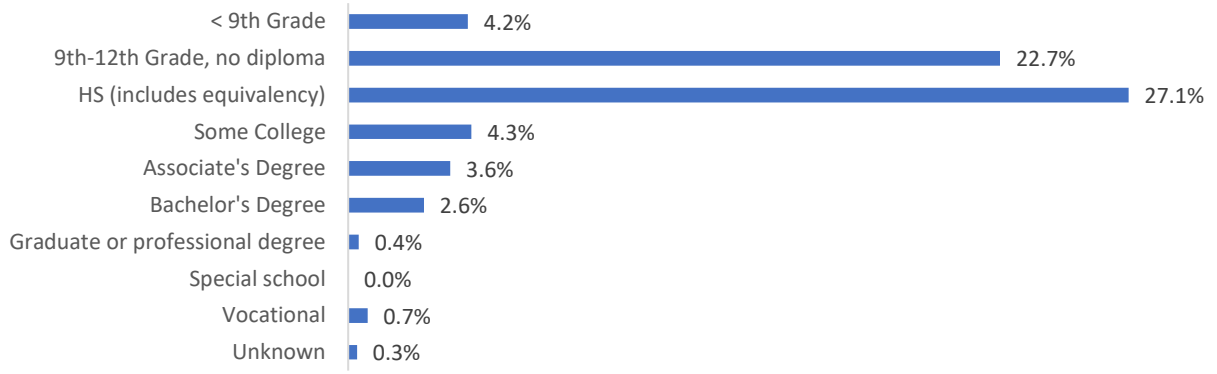
Source: Thriving Mind Client Data

Figure 89: Thriving Mind Homeless Clients by Educational Attainment



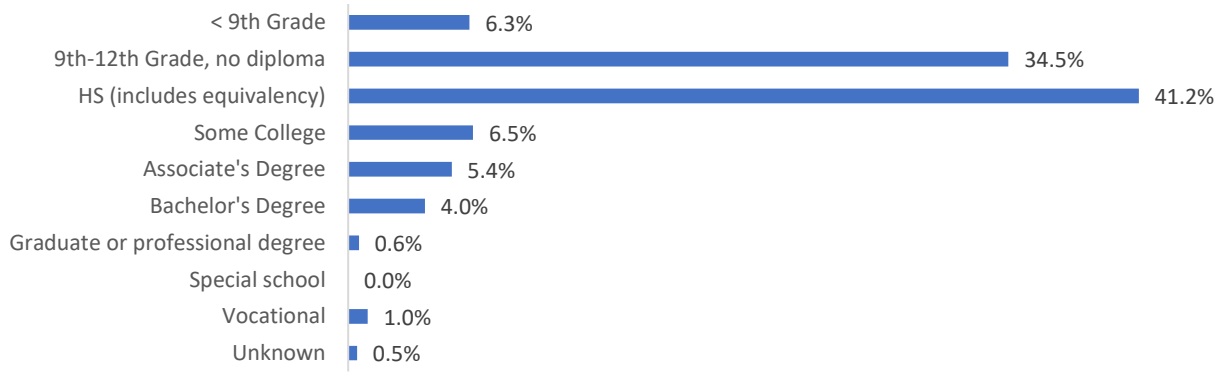
Source: Thriving Mind Client Data

Figure 90: Thriving Mind Homeless AMH Clients by Educational Attainment



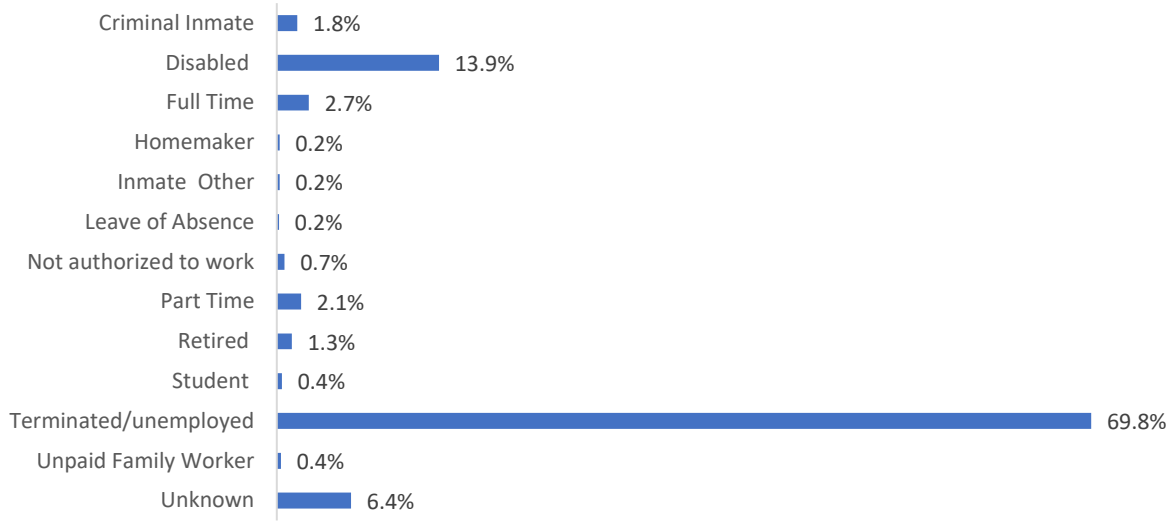
Source: Thriving Mind Client Data

Figure 91: Thriving Mind Homeless ASA Clients by Educational Attainment



Source: Thriving Mind Client Data

Figure 92: Thriving Mind Homeless Clients by Employment Status



Source: Thriving Mind Client Data

COST CENTER DESCRIPTION, EXPENDITURES, AND OVER/UNDER PRODUCTION (FY20-21)

ADULT MENTAL HEALTH PROGRAM

Cost Center Description	Expenditures	Over/Under Production
Assessment	$352,076.00	$83,233.00
Case Management	$3,341,624.00	$749,402.00
Crisis Stabilization	$7,608,771.00	$2,438,120.00
Crisis Support/Emergency	$3,373,898.00	$1,001,271.00
Day Treatment	$259,572.00	$0.00
Drop-In/Self Help Centers	$613,522.00	$109,135.00
In-Home & Onsite	$177,241.00	$127,708.00
Intervention (Individual)	$567,294.00	$34,199.00
Medical Services	$2,303,860.00	$726,595.00
Medication-Assisted Tx	$198,210.00	$0.00
Outpatient - Individual	$1,939,963.00	$273,749.00
Outreach	$1,343,708.00	$163,621.00
Residential I	$36,764.00	$0.00
Residential II	$2,215,374.00	$57,045.00
Residential III	$62,406.00	$0.00
Residential IV	$690,508.00	$14,961.00
Inpatient Detoxification	$0.00	$0.00
Supported Employment	$83,210.00	$6,180.00
Supportive Housing/Living	$4,830.00	$0.00
Incidental Expenses	$2,102,807.00	$35,500.00
FACT Team	$1,526,814.00	$1,392.00
Outpatient (Group)	$9,211.00	$0.00
R&B with Sup. II	$1,457,882.00	$113,154.00
R&B with Sup. III	$2,142,362.00	$361,541.00
Short-term Residential	$2,844,870.00	$159,846.00
MH Clubhouse	$548,902.00	$191,143.00
CCST (Individual)	$621,438.00	$395,401.00
Recovery Support (Individual)	$25,657.00	$4,311.00
Prevention – Universal Indirect	$162,054.00	$0.00
TOTAL	**$36,614,828.00**	**$7,047,507.00**

Source: Thriving Mind Program Data

ADULT SUBSTANCE USE PROGRAM

Cost Center Description	Expenditures	Over/Under Production
Assessment	$116,437.00	$11,588.00
Case Management	$655,916.00	$31,462.00
Crisis Support/Emergency	$324,007.00	$149,374.00
Day Treatment	$962,003.00	$423,117.00
In-Home & Onsite	$2,155,508.00	$4,410.00
Intervention (Individual)	$821,398.00	$11,840.00
Medical Services	$270,978.00	$10,726.00
Medication-Assisted Tx	$486,361.00	$0.00
Outpatient - Individual	$647,631.00	$131,498.00
Outreach	$397,406.00	$8,891.00
Residential II	$12,445,439.00	$322,852.00
Residential IV	$273,977.00	$0.00
Inpatient Detoxification	$1,991,209.00	$328,751.00
Supported Employment	$167,482.00	$0.00
Aftercare (Individual)	$33,391.00	$0.00
Information and Referral	$69,586.00	$382,650.00
FACT Team	$0.00	$0.00
Outpatient (Group)	$152,230.00	$0.00
R&B with Sup. II	$165,620.00	$0.00
CCST (Individual)	$26,219.00	$0.00
Recovery Support (Individual)	$90,972.00	$0.00
TOTAL	**$22,253,770.00**	**$1,817,159.00**

Source: Thriving Mind Program Data

CHILD MENTAL HEALTH PROGRAM

Cost Center Description	Expenditures	Over/Under Production
Assessment	$94,594.00	$17,922.00
Case Management	$261,649.00	$15,914.00
Crisis Stabilization	$1,099,414.00	$0.00
Crisis Support/Emergency	$1,631,262.00	$513,841.00
In-Home & Onsite	$342,135.00	$71,221.00
Intervention (Individual)	$50,000.00	$31,274.00
Medical Services	$65,814.00	$30,392.00
Outpatient - Individual	$257,454.00	$5,849.00
Outreach	$49,390.00	$26,414.00
Residential I	$321,000.00	$1,538.00
Residential II	$141,472.00	$0.00
Incidental Expenses	$24,213.00	$0.00
Information and Referral	$7,994.00	$0.00
CCST (Individual)	$337,958.00	$0.00
TOTAL	**$4,684,349.00**	**$714,365.00**

Source: Thriving Mind Program Data

CHILD SUBSTANCE ABUSE PROGRAM

Cost Center Description	Expenditures	Over/Under Production
Assessment	$164,742.00	$11,178.00
Case Management	$11,611.00	$0.00
Crisis Support/Emergency	$88,000.00	$33,502.00
In-Home & Onsite	$1,821,641.00	$18,890.00
Intervention (Individual)	$206,420.00	$44,458.00
Outpatient - Individual	$11,327.00	$0.00
Outreach	$120,070.00	$67,500.00
Residential II	$292,569.00	$0.00
Inpatient Detoxification	$943,802.00	$0.00
TASC	$41,805.00	$0.00
Information and Referral	$238,852.00	$872,237.00
Outpatient (Group)	$6,706.00	$0.00
CCST (Individual)	$146,773.00	$26,220.00
Prevention – Indicated	$322,738.00	$3,649.00
Prevention – Selective	$2,205,860.00	$24,716.00
Prevention – Universal Direct	$801,092.00	$38,482.00
Prevention – Universal Indirect	$501,589.00	$31,595.00
TOTAL	**$7,925,597.00**	**$1,172,427.00**

Source: Thriving Mind Program Data

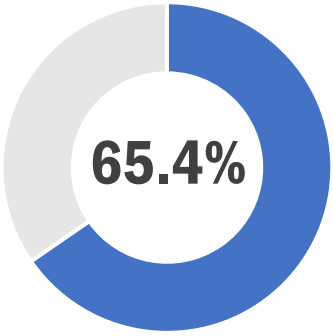
Thriving Mind All Cost Centers	Expenditures	Under/Over Production
Grand Total	$71,478,544.00	$10,751,458.00

CULTURAL HEALTH DISPARITY SURVEY SUMMARY

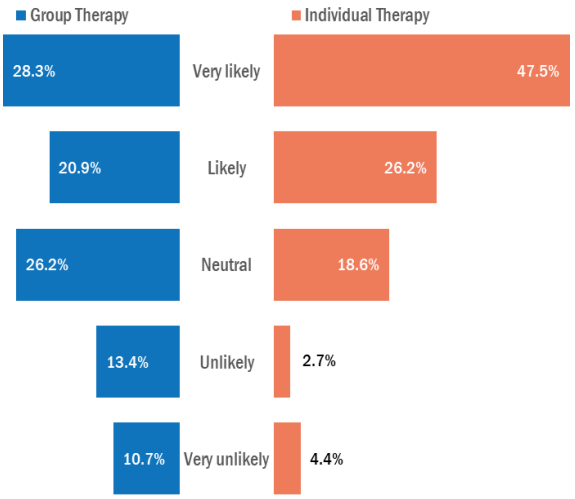
A total of 190 respondents completed the cultural health disparities needs assessment survey with each question having between 163-190 responses. Demographic questions, asked at the end of the survey can be found below.

Gender	Male	102	60.0%
	Female	74	43.5%
	Prefer not to answer	12	7.1%
	Gender fluid	1	0.6%
	Transgender	1	0.6%
Age (years)	15-19	16	8.6%
	20-24	10	5.4%
	25-34	26	14.1%
	35-44	30	16.2%
	45-54	33	17.8%
	55-64	41	22.2%
	65-74	8	4.3%
	>74	2	1.1%
Ethnicity	Spanish/Latino	68	38.4%
	Cuban	35	19.8%
	Haitian	14	7.9%
	Mexican	4	2.3%
	Puerto Rican	3	1.7%
Race	White	79	43.2%
	Black	74	40.4%
	Other	18	9.8%
	American Indian	3	1.6%
	Asian	3	1.6%
Sexual orientation	Heterosexual/ Straight	153	84.1%
	Prefer not to answer	15	8.2%
	Bisexual	13	7.1%
	Gay/ Lesbian	7	3.8%
	Asexual	1	0.5%
	Questioning	1	0.5%

More than half of participants (65.4%) felt most comfortable discussing their behavioral health concerns in a private office with a doctor.



Fewer participants are likely to go to group therapy compared to individual therapy.



Of respondents, 80.5% confirmed they could access behavioral health services when they needed them. For those who could not, common barriers cited included: concerns about cost (35.3%), not knowing where to go (20%), services were not covered by insurance (19.4%), and transportation challenges (19.4%). In open text, one individual commented that the length of time for an assessment is 4 hours, and they could not give that much time.

More than half (51.6%) of individuals felt that behavioral health issues were private and to be kept to themselves. A similar percentage (50.3%) believed it was a private issue to be kept within the family.

Individuals were most likely to prefer discussing behavioral health in a private office with a doctor, and more than one-fourth preferred telehealth (27.7%) or a hybrid in-person telehealth combination (25.5%). More than three-fourths had services delivered in their primary language all the time. For those who did not answer affirmatively, 23.8% used a formal interpreter, 28.6% used family or friend to interpret, and

21.4% had an interpreter offered but did not use one. Fewer than 5% reported using an interpreter but being unsatisfied with the experience.

CULTURAL HEALTH DISPARITY SURVEY CHARTS

Figure 93: This is a private issue I keep to myself (describes feelings regarding behavioral health issues)

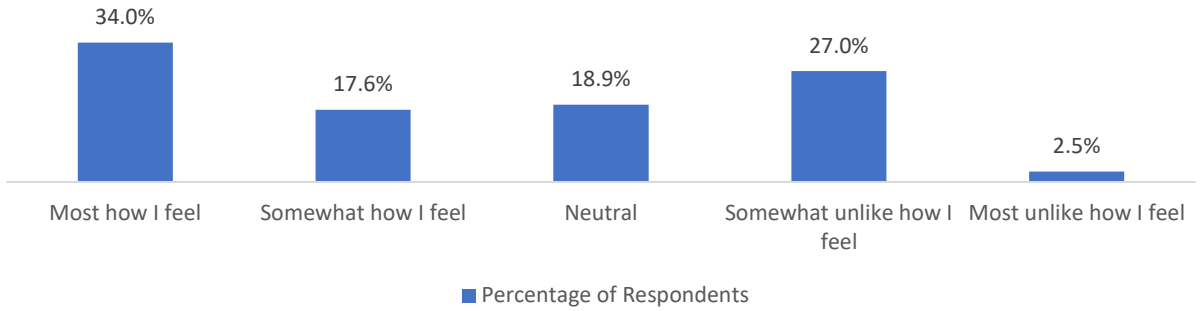


Figure 94: This is a private issue that stays in the family (describes feelings regarding behavioral health issues)

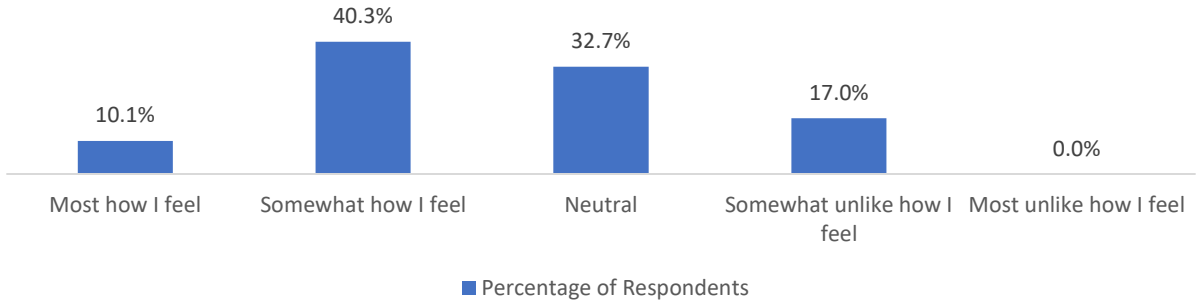


Figure 95: I am comfortable sharing my challenges with others such as professionals, family members, friends, clergy, etc. (describes feelings regarding behavioral health issues)

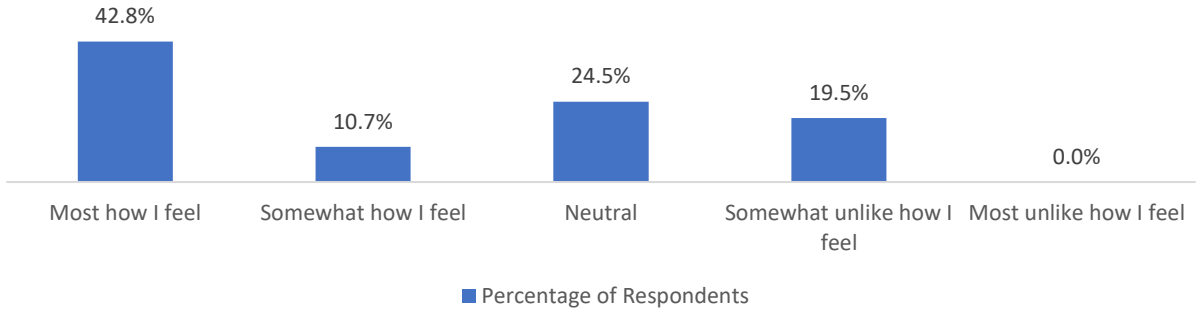


Figure 96: I am more comfortable with people like me (describes feelings regarding behavioral health issues)

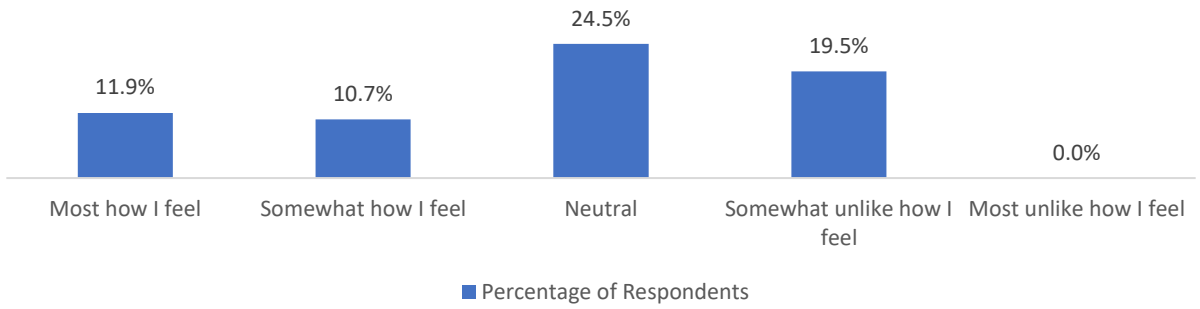


Figure 97: In which setting(s) have you been most comfortable discussing your behavioral health concerns? (Check all that apply)

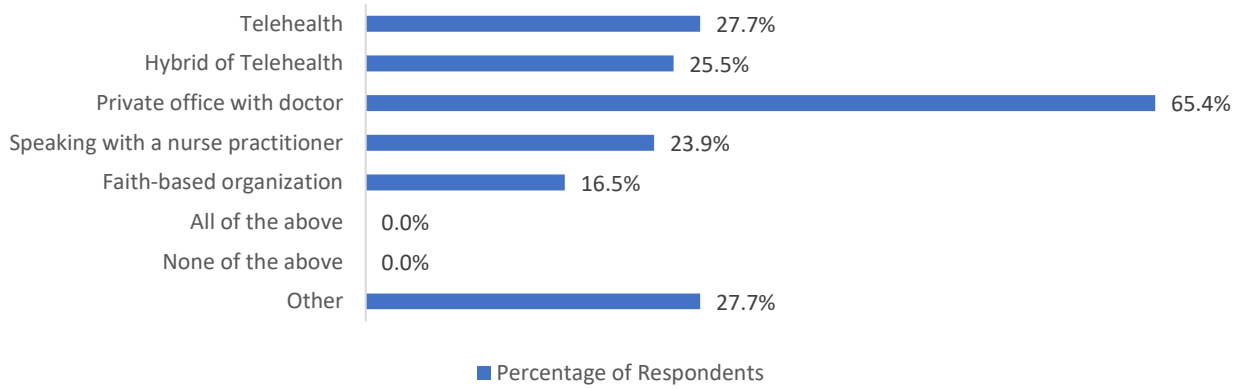


Figure 98: If given a choice for receiving behavioral health care services, would you be more comfortable going to a faith-based organization OR prefer the traditional physician office?

Figure 99: Now thinking about treatment options, on a scale of 1 to 5, with 5 being 'very likely', how comfortable would you be in group therapy?

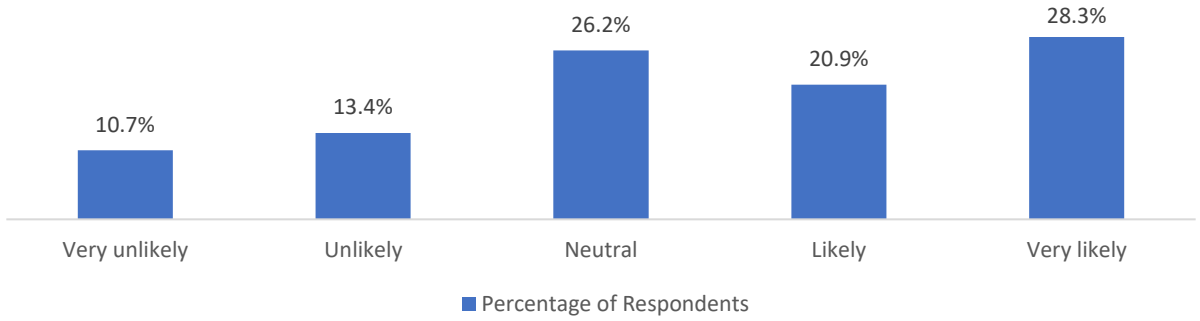


Figure 100: On a scale of 1 to 5, with 5 being 'very likely', how comfortable would you be in individual therapy?

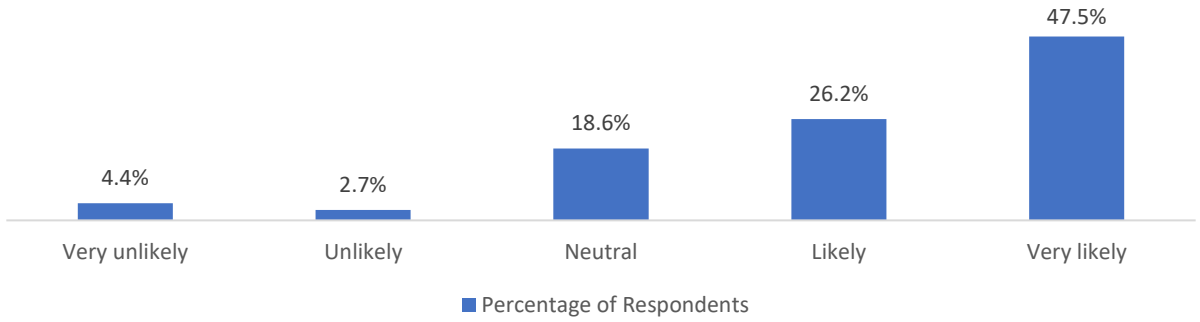


Figure 101: When you have received behavioral health care services in the past, were they mostly available in your primary language?

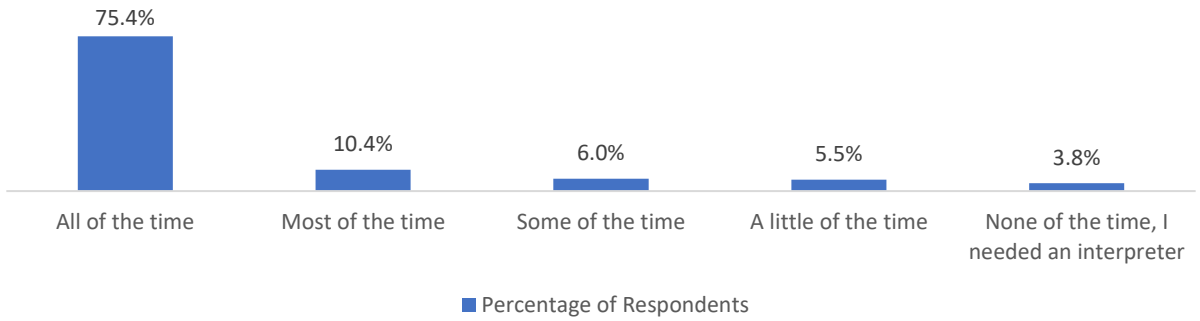


Figure 102: Which best describes your gender?

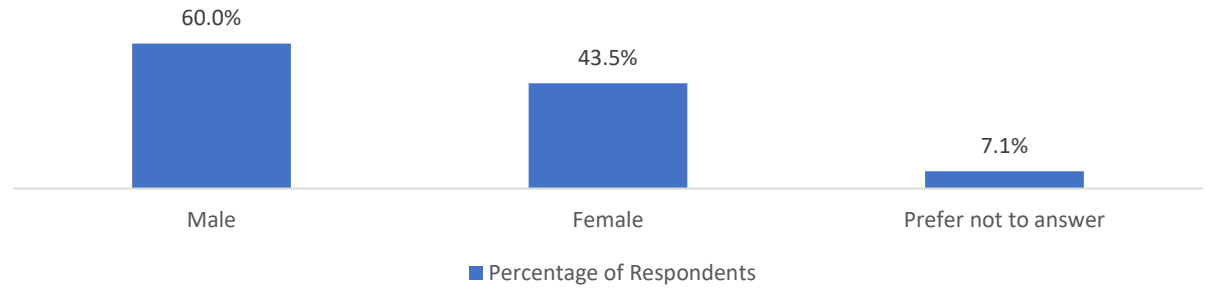


Figure 103: Which best describes your gender identity?

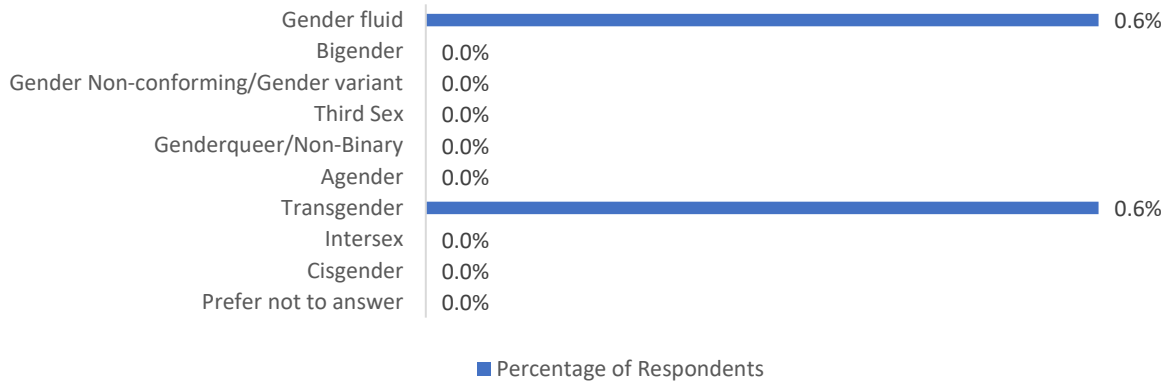


Figure 104: Which best describes your current sexual orientation? (Check all that apply)

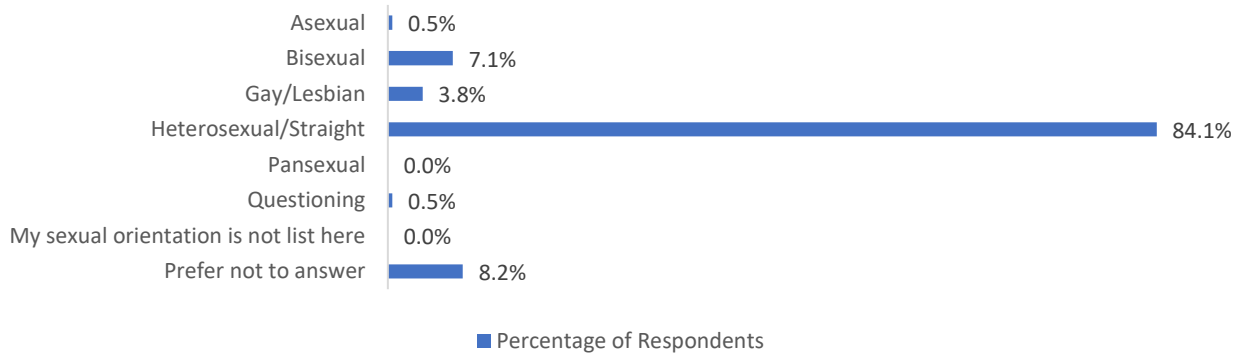


Figure 105: Which best describes your race?

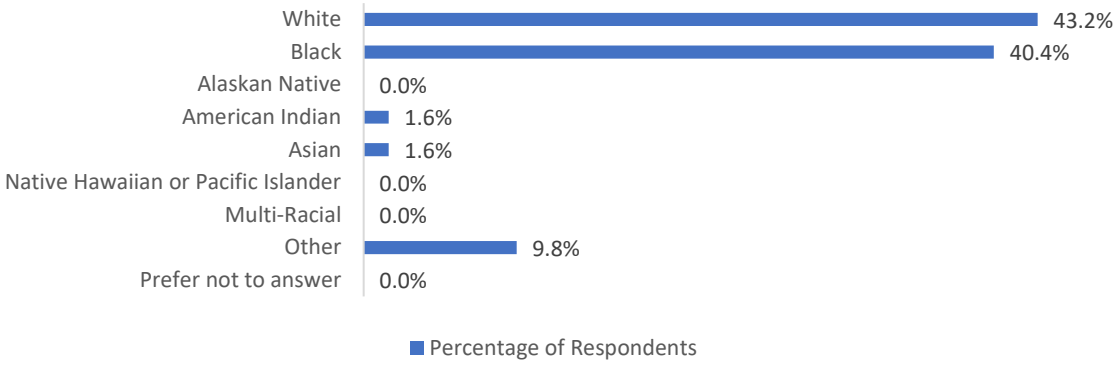


Figure 106: Which best describes your ethnicity?

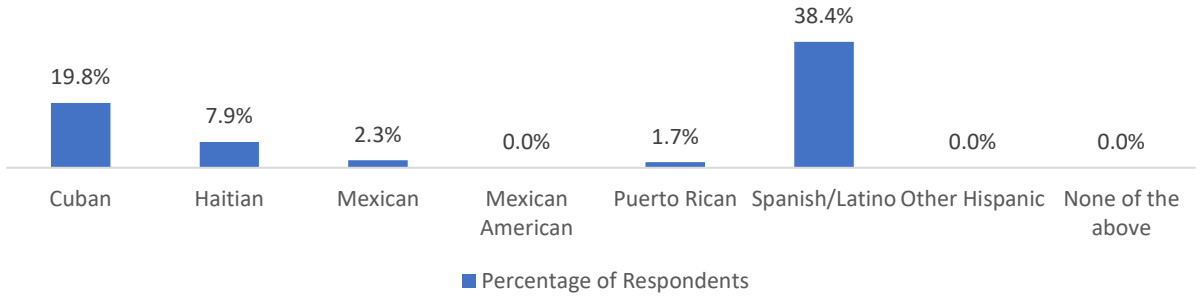
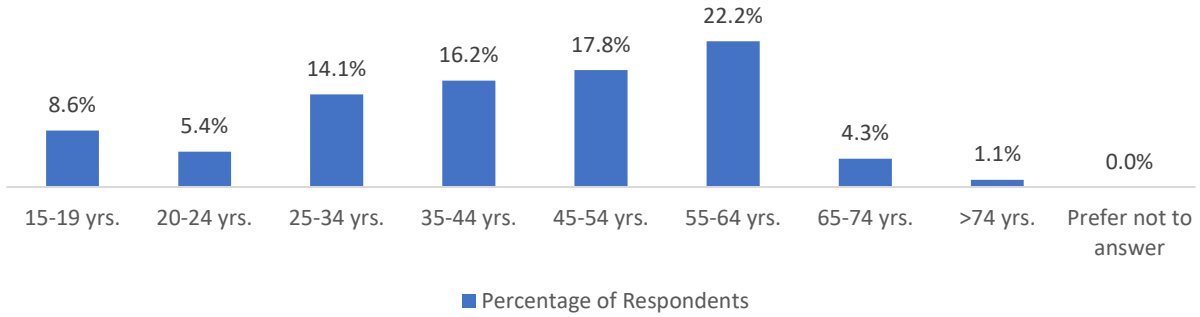


Figure 107: Please select your age range from the list below.



CULTURAL HEALTH DISPARITY SURVEY BY RACE AND ETHNICITY

The Cultural Health Disparity survey was analyzed by race and ethnicity to further measure experience, awareness, and coordination of behavioral health services. This will help to facilitate focused strategic development and intervention implementation over the next three years aimed at improving the delivery of treatment services.

Respondents were asked to describe their feelings regarding their behavioral health issues. When asked if this was a private issue that they keep to themselves, (60.7%) of Black respondents expressed agreement with this sentiment with 32.1% indicating that this was most how they feel, and 28.6% indicating it was somewhat how they feel. Hispanic respondents felt similarly with 58% responding that this was most (42%) or somewhat (16.0%) how they feel about their behavioral health issues. White respondents were less likely (47.1%) to feel this was a private issue they kept to themselves with 33.8% indicating this was most how they felt and 13.2% indicating this was somewhat how they felt.

Regarding their behavioral health issues as a private matter that stays in the family, most respondents indicated this was somewhat how they feel or were neutral. A higher percentage of White respondents (47.1%) indicated this was somewhat how they feel when compared to Black respondents (35.7%) and Hispanic respondents (44%.) Respondents who were neutral ranged from approximately 32% among Black and Hispanic respondents to 33.8% for White respondents.

Most respondents were comfortable sharing their challenges with others. Among Black respondents, 46.4% indicated this was most how they feel while 5.4% indicated this was somewhat how they feel (5.4%).36% of Hispanic respondents indicated this was most how they feel, while 12% indicated this was somewhat how they feel. Among White respondents, 44.1% indicated this was most how they feel while 11.8% indicated this was somewhat how they feel.

Respondents were split when asked if they were more comfortable with people like me when it came to describing their feelings regarding their behavioral health issues. Among Black respondents, 41.1% indicated this was either most (12.5%) or somewhat (28.6%) how they feel. More Hispanic respondents (44%) indicated that this was either somewhat unlike how they feel (40%) or most unlike how they feel (4%). For White respondents, 38.2% indicated they either mostly feel this way or somewhat feel this way, while 36.8% said this was either somewhat unlike (32.4%) or most unlike how they feel (4.4%).

Overall, respondents indicated the most comfortable setting for discussing their behavioral health issues was in a private office with a doctor. Nearly half (47.4%) of Black respondents, 40% of Hispanic respondents, and 36.1% of White respondents preferred this setting. Among Black respondents, telehealth (15.8%) was preferred over a hybrid of telehealth and in-person services at 14.7%. Receiving services from a faith-based organization, at 8.4%, was slightly less favored when compared to speaking with a nurse practitioner at 10.5%. Among Hispanic respondents, a

hybrid of telehealth (16.2%) was preferred over telehealth at 15.2%. The same percentage of Hispanic respondents (13.3%) indicated their preference for speaking with a nurse practitioner or receiving services from a faith-based organization. Among White respondents, 18.1% equally indicated that speaking with a nurse practitioner or telehealth was their preferred choice, while a hybrid of telehealth was favored by 11.8% of White respondents. Regarding receiving services from a faith-based organization, 15.3% indicated this was a comfortable setting for them.

When asked to choose between faith-based or the traditional physician office, results were opposite of the preceding question. Most Black respondents (67.9%) still preferred the traditional physician office when compared to faith-based behavioral health care services at 32.1%. Among Hispanic and White respondents, more preferred faith-based services at 55.6% and 52.2%, respectively, compared to the traditional physician office.

The majority of Black (55.1%) and White (54.8%) respondents indicated they were likely or very likely to be comfortable in group therapy. Among Hispanic respondents, 44.6% indicated they were likely or very likely to be comfortable in a group therapy session. When asked about their comfort level regarding individual therapy, percentages were higher as 76.5% of Black respondents and 76.3% of Hispanic respondents indicated they were likely or very likely to be comfortable in this setting. Among White respondents, 88.7% indicated they were likely or very likely to be comfortable in individual therapy.

When asked if the behavioral health services they received in the past were mostly available in their primary language, 86.8% of Black respondents, 82.1% of Hispanic respondents, and 90.4% of White respondents received services in their primary language all or most of the time. Those needing an interpreter accounted for 3.6% of Hispanic respondents, 2.7% of White respondents, and 1.5% of Black respondents.

CULTURAL HEALTH DISPARITY SURVEY BY RACE AND ETHNICITY CHARTS

Figure 108: This is a private issue I keep to myself (describes feelings regarding behavioral health issues)

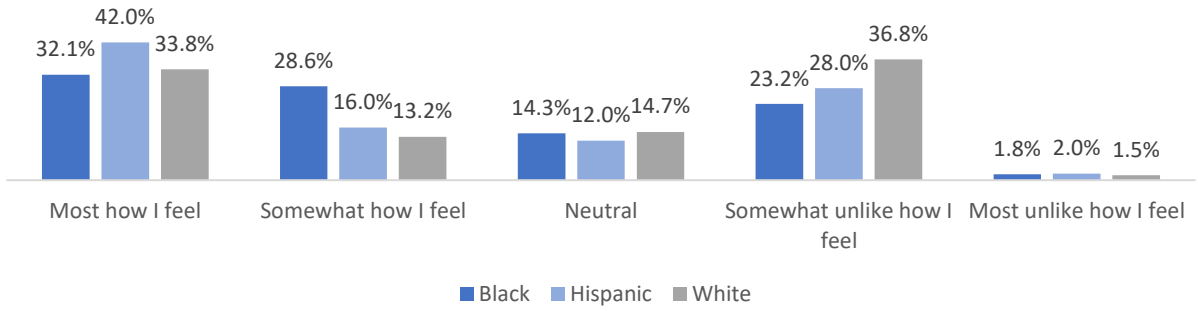


Figure 109: This is a private issue that stays in the family (describes feelings regarding behavioral health issues)

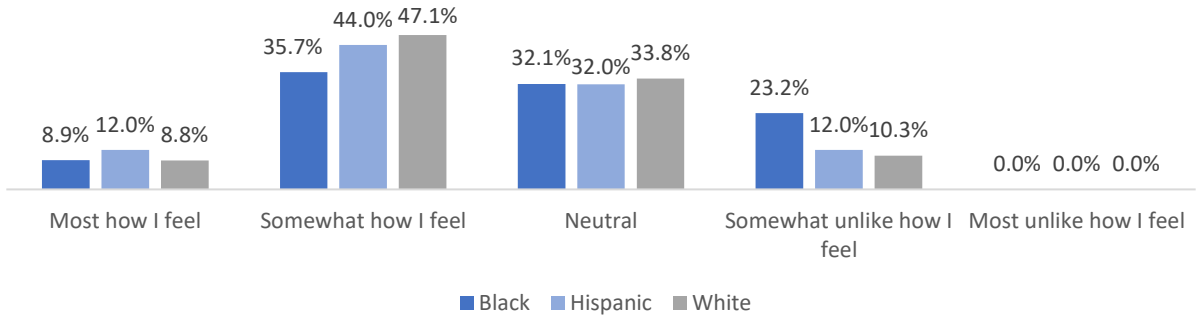


Figure 110: I am comfortable sharing my challenges with others such as professionals, family members, friends, clergy, etc. (describes feelings regarding behavioral health issues)

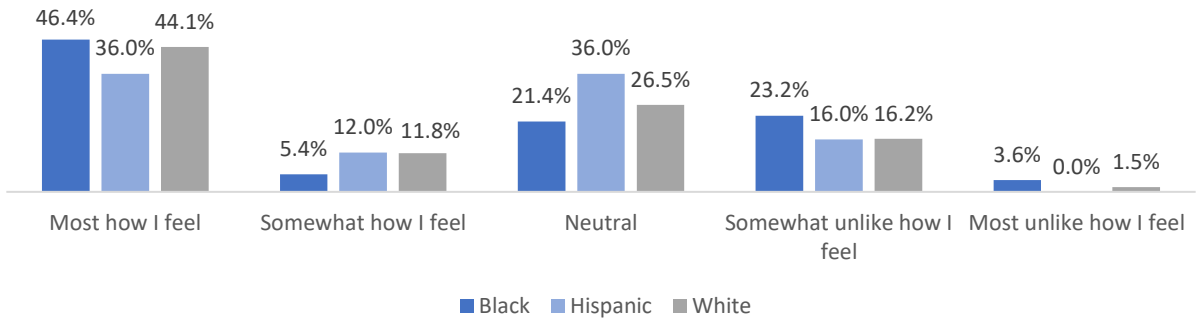


Figure 111: I am comfortable with people like me (describes feelings regarding behavioral health issues)

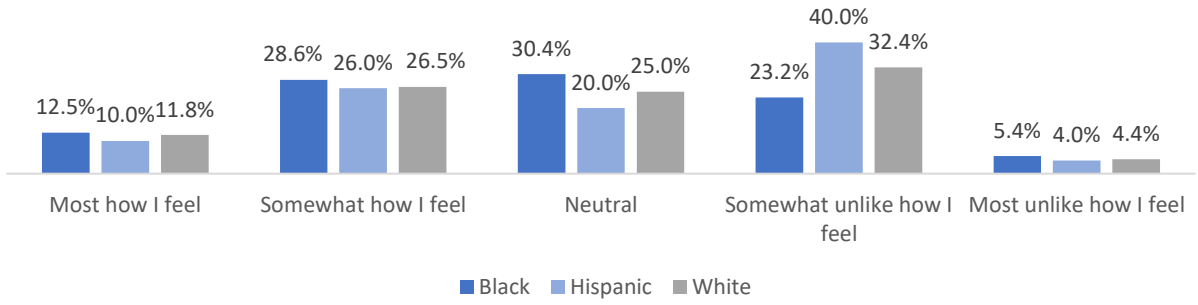


Figure 112: In which setting(s) have you been most comfortable discussing your behavioral health concerns? (Check all that apply).

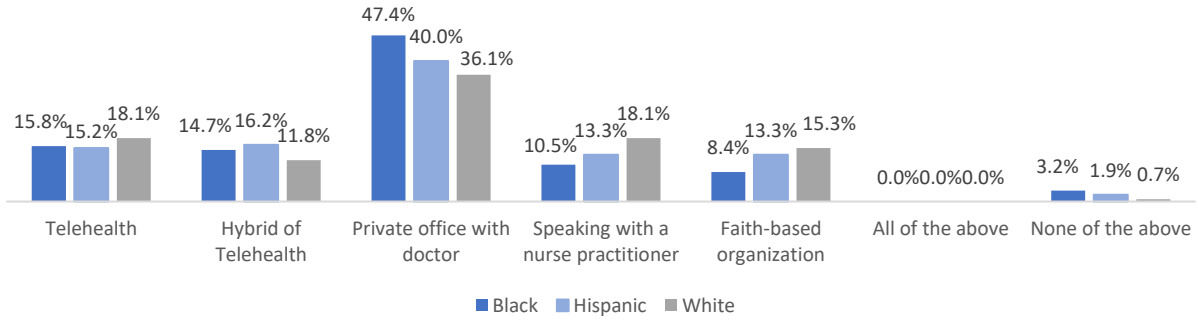


Figure 113: If given a choice for receiving health care services, would you be more comfortable going to a faith-based organization OR prefer the traditional physician office?

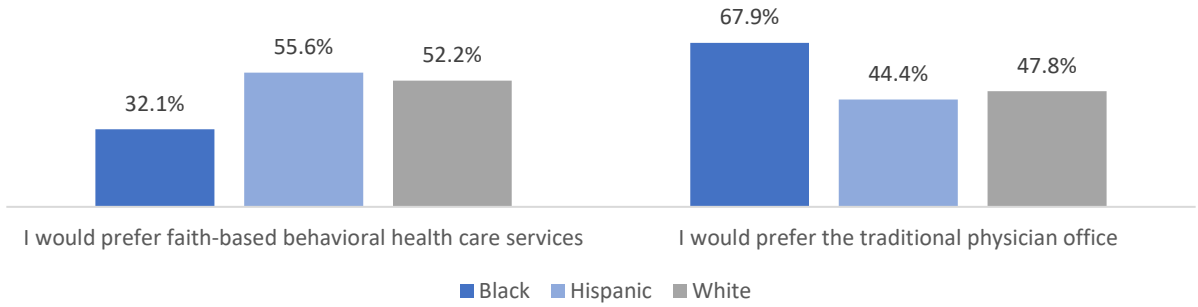


Figure 114: Now thinking about treatment options, on a scale of 1 to 5, with 5 being very likely, how comfortable would you be in group therapy?

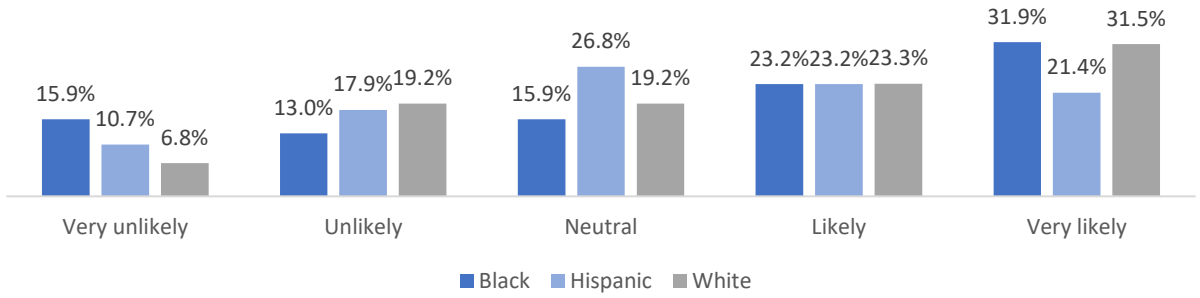


Figure 115: On a scale of 1 to 5, with 5 being very likely, how comfortable would you be in individual therapy?

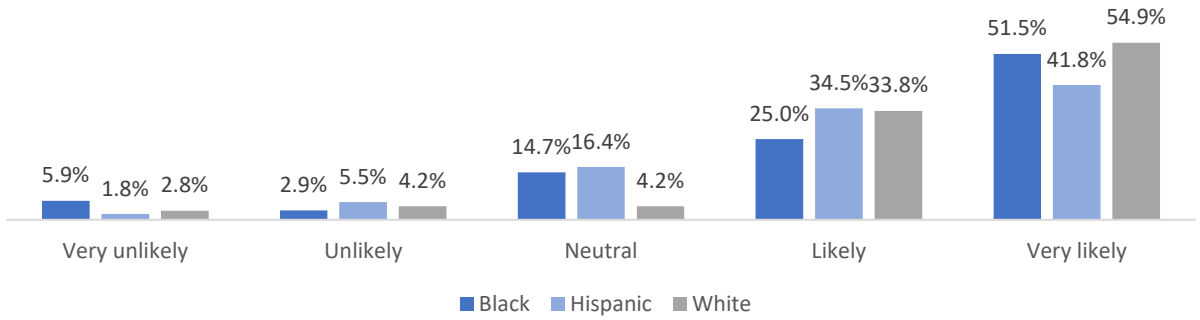
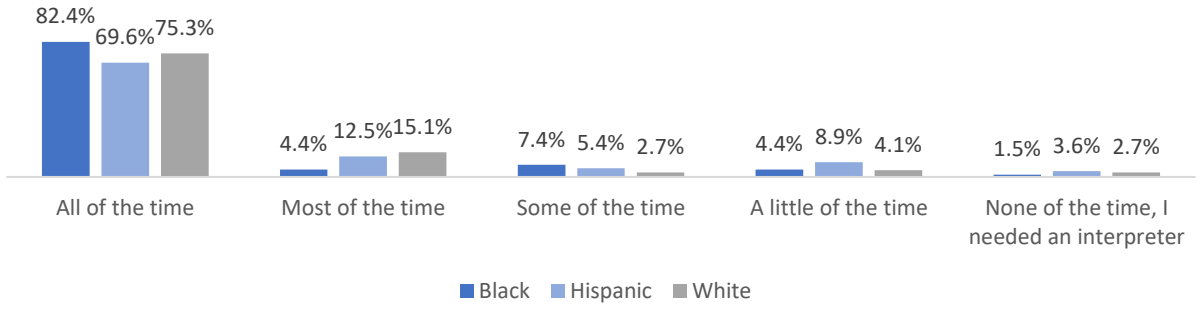


Figure 116: When you have received behavioral health care services in the past, were they mostly available in your primary language?



CULTURAL HEALTH DISPARITY FOCUS GROUP SUMMARY

Background

The Behavioral Health Needs Assessment Focus Group sessions were conducted as a follow-up to a series of surveys administered by Thriving Mind South Florida (Thriving Mind) and Behavioral Science Research Institute (BSRI). Thriving Mind partnered with the Health Council of South Florida, Inc., (HCSF) to facilitate focus group sessions and develop a brief analysis for inclusion in the statewide Behavioral Health Needs Assessment report.

Focus Group Profile

In April of 2022, the HCSF on behalf of Thriving Mind facilitated six (6) community forums to gain insight from Miami-Dade and Monroe County residents on different issues associated with mental health and substance use/abuse. These focus group sessions were conducted at various locations, both in-person and virtually, in Miami-Dade and Monroe counties (see table below). A total of one hundred four (104) Miami-Dade and Monroe County participants attended the focus groups sessions. Even though the questions were designed for consumers, providers, caregivers, and residents at large were also invited to attend with participants comprising of Miami-Dade and Monroe County residents, Thriving Mind sub-contracted mental health providers, and other behavioral health professionals. The focus group sessions were heavily promoted through marketing strategies, such as flyers, social media, email blasts, word of mouth, and other community partner networks. All the conversations were recorded and transcribed to identify major themes across all six focus group sessions facilitated.

Community Focus Group Sessions

Date/Time	County	Format	Location
April 4th @ 10:00 am	Miami-Dade	Virtual	Online
April 4th @ 6:00 pm	Miami-Dade	Virtual	Online
April 5th @ 10:00 am	Monroe	In-person	Guidance Care Center
April 6th @ 10:00 am	Miami-Dade	In-person	Citrus Health Network
April 7th @ 6:00 pm	Miami-Dade	Virtual	Online
April 8th @ 11:00 am	Monroe	Virtual	Online

Overview

Thriving Mind recognizes behavioral health as a vital aspect to overall well-being and works closely with partners to ensure all community residents within its service areas have access to care which is incorporated within the scope of health promotion and public health prevention activities. Behavioral health is defined as the promotion of mental health, resilience, and wellbeing; the treatment of mental and substance use disorders; and the support of those who experience and/are in recovery from these conditions along with their families and communities. [1] The term 'behavioral health" will be inclusive of both mental and substance use when mentioned in this document.

Findings

The following sections describe participants' perceptions of behavioral health or mental health and substance use, including their beliefs related to the drivers and the impacts of limited mental and behavioral health services. Findings related to barriers and solutions to accessing mental health and substance use care and treatment and recovery were described at the individual and community level. Recommendations are outlined regarding approaches that community organizations can implement to improve overall mental health and substance use care among Miami-Dade and Monroe County, Florida residents. Throughout this document, content under each section heading incorporates a summation of participants key discussion themes regarding mental health and substance use from focus group participants. Direct quotes are italicized to communicate the community's perspective.

General Perceptions of Behavioral Health

Questions asked by moderator:

When you hear the words "mental health," what comes to mind?
When you hear the words "substance use," what comes to mind?

Mental Health

Participants mentioned a variety of topics related to mental health including mental wellness, mental health services, emotional well-being, anxiety, and various mental health conditions. In addition, a few participants mentioned the importance of addressing the increased needs of society regarding mental health issues because it is a serious and complex issue that does not have an easy solution.

[1] SAMHSA. https://www.samhsa.gov/sites/default/files/samhsa-behavioral-health-integration.pdf

"Emotional wellbeing Is not a constant, it can be treated but it is a lifelong issue, almost like diabetes and other chronic diseases"- Miami-Dade County participant.

Substance Use

Participants mentioned a variety of topics related to substance use including addiction, drugs, coping mechanisms, medicine, mental and physical illness, and recovery. In addition, a few participants expressed the importance of understanding the complexity behind substance use and the negative connotation that substance use has.

" It is negative…people think about it as a user, drug addict and all the other clichés about substance use…we have been trying for many years to change the idea of this negative connotation…substance use has a genetic and environmental component to it…people think you can just say no…most people with substance use issues have to consider that there are mental health issues attached to it…they are often intertwined"- Miami-Dade County participant

Additionally, some participants expressed that many individuals use substances in the absence of adequate coping mechanisms for the stressors in life. Individuals mentioned the exacerbation of substance use issues in the community by medical practitioners who prescribe addictive drugs too easily. Participants also mentioned the increased need to combat substance use issues in the community.

Extent of Behavioral Health Concerns in Community

Questions asked by moderator:

To what extent are mental health and mental illness concerns in your community? Why?
To what extent is substance use a concern in your community? Why?

Mental Health

Participants voiced the following concerns regarding mental health care and services:

- Lack of resources and provider engagement
- Difficulties accessing services
- Many services not covered by insurance
- Homelessness
- Stigma and discrimination
- High suicide rate

One participant shared that they were a student searching for healthy coping mechanisms, but they were not able to find the proper resources to address the mental health concerns they had.

A participant from a Monroe County focus group noted that mental health was a very serious concern in her community and that there is a high suicide rate there.

"High suicide rate…very serious… mental health is very important and serious in the community and people still wrestle with it" – Monroe County participant

Participants from Miami-Dade County acknowledged that homelessness was a big issue and that there was a connection between homelessness and mental health issues. They noted that many homeless people will not acknowledge their illness which makes it difficult to engage with them to seek treatment. They added that more mental health professionals on the ground may help to serve these individuals.

When asked why mental health and mental illness was such a concern in the community, many participants from Monroe and Miami-Dade counties mentioned a lack of resources to combat mental health issues. They also mentioned the difficulty in accessing resources.

"What resources there are, people aren't aware of how to access them. There is a lot of misunderstanding. The system is too broad and there are too many separate entities involved, so it is hard to find resources for Mental Health"- Miami-Dade County participant.

Substance Use

Substance use is a problem that affects everyone regardless of their background, culture, or ethnicity. It is a prevalent issue in the southern region and was described as having a negative connotation in the community. There has been a significant increase in opioid use with a specific increase in opioid related deaths. Concerns about substance use include:

- High rates of substance use
- Lack of treatment options
- Long wait times
- Domestic violence
- Stigma and discrimination
- Lack of affordable housing
- High suicide rate

Substance use issues tend to be a very serious concern in Monroe County as reported by participants:

"Bigger issue than it used to be. Schools are seeing it more often and are having to lock bathrooms to decrease prevalence in school groups. Rise in younger use" – Monroe County participant

"Serious issue with methamphetamines. Substance use is extremely prevalent in Monroe County. There was an OD in front of the girls' softball field last week"- Monroe County participant

"Substance abuse is high in Monroe County. For example, alcohol – in Monroe we have among the highest rates of binge drinking. Oftentimes we have the highest rates each year"- Monroe County participant

Along with these key observations from participants in Monroe County, it was also mentioned that there was no substance use treatment center located in the county, only a detox clinic. It was expressed that this lack of treatment options is not helping the substance use issues in Monroe County.

In Miami-Dade County, participants noted that there are extensive waitlist times and not enough resources to combat the substance use crisis in the county.

One participant noted how the pandemic simply highlighted the issues related to substance use which already existed:

"Pandemic showcased the issues we were already experiencing! Fear of seeking help, domestic violence, trauma, bullying in schools. It is a community pandemic – kids, peer pressure, wanting to be accepted, emulating basketball stars, people are afraid to be alone or don't know how to cope with isolation. Also, not having the education and awareness to know what's going on or how to access resources" – Miami-Dade County participant

Others from Miami-Dade and Monroe Counties mentioned that it was important to get rid of the stigma attached to substance use because it does not help in promoting treatment options to those suffering from substance use issues.

Most Important Behavioral Health Care Needs

Questions asked by moderator:

What do you think are the most important mental health issues and/or needs of the community?
What do you think are the reasons for these issues/needs?
What do you think are the most important substance use issues and/or needs of the community?
What do you think are the reasons for these issues/needs?

Mental Health

The most important needs related to mental health services include:

- Peer driven support
- Prevention and early intervention services
- Specialized, responsive, and culturally competent workforce
- Community mobile services
- Educational resources
- Program/service proximity

- Affordable services
- Appointment availability during non-business hours

A Monroe County participant shared that affordable mental health services for young adults was a real need in the community. They added that once an individual graduates high school, resources become more difficult to access due to costs being too high, especially if they lack family support.

Multiple participants from Monroe County also shared that having long term after-care, certified treatment centers, and affordable housing are major needs in the community. Many participants emphasized the importance of having Mobile Response Units to aid in providing service to all Monroe County residents since the Florida Keys Island chain located in Monroe County geographically extends over 90 miles.

Some Monroe County participants shared:

"Heron House which is good and accepts SSI and Food stamps in Marathon (Assisted Living Facility) accepts people with mental illness but a lot of these types of facilities don't...there is also a huge waiting list…" – Monroe County participant

"COVID has made mental health worse. High cost of living and housing issues in Monroe County leads to high suicide rate. Also, alcohol and opiate use has also been exacerbated by COVID and has left the county very vulnerable."- Monroe County participant

A participant in Miami-Dade County mentioned that enough services were available but navigating the health care system to access those services was difficult:

"Enough services are available but if you are not aware or know how to navigate the healthcare system, it is then difficult to access these services. If people are not in systems (schools, work) that promote these services, you won't know"- Miami-Dade County Participant

A Miami-Dade County participant noted that it was very important to practice cultural sensitivity when dealing with others such as the Haitian population in Miami-Dade County because mental health is seen very differently in Haiti.

Substance Use

The most important needs related to substance use services include:

- Suicide prevention
- Increase substance use treatment and recovery facilities
- Prevention and early intervention services
- Reduction of liquor licenses
- Educational resources
- Program/service proximity

In Monroe County, participants indicated that the community suffers from some of the highest suicide rates in the country due to numerous factors including alcohol and opiate use, natural disasters/hurricanes, and high housing costs.

"High cost of living and housing issues in Monroe County leads to high suicide rate. Also, alcohol and opiate use also being exacerbated by COVID has made the County very vulnerable. This is in addition to Natural disasters/hurricanes which add stress"- Monroe County Participant

Participants in Monroe County also expressed concerns about the amount of liquor licenses in the County with numbers being among the highest in the country. Additional concerns surrounded the potential legalization of Marijuana and the effects that may have on residents regarding both Mental Health and Substance Use.

Miami-Dade County participants mentioned that there was a large need for more beds and more capacity in Substance Use Treatment Facilities. A participant mentioned the wait time was usually 6 weeks because the wait list is very long.

Participants from both Miami-Dade and Monroe Counties mentioned a need for more substance use treatment and recovery facilities.

Populations Most Vulnerable to Behavioral Health Issues

Questions asked by moderator:

Are there some groups of people in your community who face more mental health challenges than others?

Are there some groups of people in your community who face more substance use challenges than others?

Mental Health

Some of the groups mentioned that were most vulnerable to mental health issues were:

- Undocumented immigrants
- Homeless people
- Young adults
- Low-income individuals
- Minorities

In both Miami-Dade and Monroe Counties they identified undocumented immigrants as being a group of people in the community who face more mental health challenges than others due to lack of insurance and apprehension in seeking treatment for fear of being deported.

Young adults were also mentioned as a group that faces more mental health challenges than others. Primarily after finishing high school, many young adults were said to experience a vulnerable period where they are no longer covered by their family's health insurance policy. A participant also mentioned that this is also a period where the brain is still in development and all treatment options must be thoroughly considered because they had once received medication which caused further mental health issues during this critical time in their life.

Both Counties mentioned homeless people and people struggling to pay housing costs as groups of people that suffer mental health issues at a higher rate than others due to the stress involved in securing shelter.

Monroe County residents mentioned that there are many individuals who work part time but are still homeless because they cannot afford rent. It was also mentioned that traditional housing providers and homeless shelters are full in Monroe County.

Individuals from cultural backgrounds where mental health is still not talked about, particularly Jamaicans and Haitians also were said to suffer from mental health issues at a higher rate due to the stigma attached to mental health and the lack of discussion on the topic in their household growing up.

Substance Use

Some of the groups mentioned that were most vulnerable to substance use issues were:

- Homeless people
- Young adults
- Low-income individuals
- Teenagers

Young adults were said to experience more substance use challenges than other groups due to the ease of accessibility to alcohol and drugs. Middle school students were also mentioned as a group that faces more substance use challenges than other groups due to them being at an age were addiction can really take hold.

Perceived Fairness of Treatment for Behavioral Health Services

Questions asked by moderator:

Within the past 12 months, when seeking mental health services, do you feel that your experiences were worse than, the same as, or better than for people of other races?
Within the past 12 months, when seeking substance use services, do you feel that your experiences were worse than, the same as, or better than for people of other races?

In a Monroe County Focus group, a participant from Haiti indicated that they had experienced discrimination when seeking treatment due to being "black." It was also mentioned that a lack of cultural awareness and feeling of inclusion from the provider created a barrier when seeking treatment.

Many individuals from both Counties stated that there were disparities in treatment based on the income level of the patient rather than race. Contrarily, most individuals did not perceive any difference in treatment.

Impact of COVID-19 on Behavioral Health Services

Questions asked by moderator:

How would you describe how mental health services have changed since the beginning of the COVID-19 pandemic? What do you think about these changes?
How would you describe how substance use services have changed since the beginning of the COVID-19 pandemic? What do you think about these changes?

Participants mentioned a number of aspects of behavioral health services changed during the COVID-19 pandemic:

- Increased flexibility due to Telehealth
- Increased awareness of behavioral health and services
- Decreased capacity in behavioral health facilities
- Lack of in-person services

Much of the feedback received from participants from both Miami-Dade and Monroe Counties indicated that although the COVID-19 pandemic has exacerbated the mental health issues in the community, telehealth has become a useful tool for providers to assist residents throughout the different Counties.

Some of the comments were:

"…telehealth has been a plus and has allowed being able to access services from even in your living room" – Miami-Dade County participant

"Telehealth has allowed for more mental health sessions, than before" – Monroe County participant

Individuals noted that the promotion of telehealth services for mental health has helped tear down the stigma regarding mental health.

Nevertheless, individuals acknowledged that many of the homeless and older residents in the community still lack internet access. In addition, a few individuals in Monroe County mentioned the necessity for in-person sessions for individuals who suffer from more serious mental health conditions. Service is sometimes available but not covered by most insurances.

Participants also noted that since COVID-19 rates have declined, some telehealth options are no longer available. Concerns were expressed over the transition back to pre-pandemic treatment options.

Many participants indicated they enjoyed the flexibility offered by telehealth but are concerned about how this will change post-pandemic. Participants have noticed more federal funding has been invested into addressing these issues, which goes a long way in opening the communication channels regarding substance use.

A participant in Miami-Dade County noted that the capacity of the treatment center he attended was limited to 50% capacity in addition to some services being restricted.

Perceived Barriers to Behavioral Health Care

Questions asked by moderator:

Have you faced any barriers when trying to access mental health services?
Have you faced any barriers when trying to access substance use services?

Mental Health

When participants were asked about barriers related to accessing mental health services, they mentioned:

- Far distance to services
- Limited information and access to resources
- Lack of Mobile Response Team units
- High out-of-pocket costs

In Monroe County, many participants indicated that the distance to get to services was a barrier as the Florida Keys in Monroe County stretch over 100 miles and service locations are sparse. Many participants also mentioned that the lack of Mobile Response Team units can cause long waits for emergency services which leads to having to call police officers to deal with mental health crises. A woman described her daughter being arrested when all she needed was treatment for a

mental health issue. This woman also described a lack of communication by County officials regarding all available treatment options for mental health issues.

A few participants also mentioned that the out-of-pocket costs for doctors who do not accept Medicaid is a barrier.

Substance Use

Common barriers to accessing substance use services included:

- Lack of insurance coverage
- Limited information and access to resources
- Lack of substance use treatment facilities
- Lack of communication between agencies and providers

Lack of insurance coverage, and residential treatment facilities were mentioned as some of the biggest barriers to substance use services among all focus groups.

A woman from Monroe County mentioned there was no methadone clinic in the Florida Keys, so she had to go to Miami-Dade County.

Many participants from both Miami-Dade and Monroe Counties shared that the lack of communication between agencies and providers created a huge barrier when trying to access both substance use and mental health services.

Solutions to Overcome Behavioral Health Service Barriers

Questions asked by moderator:

What are some possible solutions to overcome these barriers?

In producing solutions to overcome the barrier's participants face regarding Behavioral Health issues in Miami-Dade and Monroe County, participants proposed a number of ideas:

- Provider one-stop shops which house all behavioral health services and where patients can come to learn about how to access these services
- Mandatory mental health days similar to PTO (Paid Time Off)
- More funding for Behavioral Health services
- Increase programs that support obtaining affordable housing
- Increase programs aimed at de-stigmatizing behavioral health issues
- Increase communication and information shared between different Emergency Health Services to increase understanding of clients and promote healthy interactions

- Increase funding for Public Health organizations to increase salaries of workforce to aid in retention and reduce turnover which can stifle public health efforts
- Increase funding for Public Health initiatives in rural communities
- Promote safe spaces free of discrimination for the LGBTQ community
- Increase community sites where non-religious spiritual services are offered along with meditation, yoga, and more
- Promote Behavioral Health education in communities with greatest needs
- Rewrite Baker Act to be more flexible
- Expand STS (Special Transportation Services) for behavioral health services
- Increase number of Psychosocial rehabilitation centers across South Florida
- Increase communication and shared information between all healthcare facilities to aid in tailoring care to patient's individual needs
- Provide more opportunities for care for those with a criminal background
- Communication between Public Health organizations to lobby against gentrification and rising housing costs in South Florida

A participant mentioned:

"The rent jumped from 1000 to 1600 on Christmas eve because an investor bought a building where many working-class families lived. Miami Workers Union is working on trying to create a bill which mandates landlords to inform tenants of rent increase at least 4 months ahead "- Miami-Dade Focus Group Participant

Community Engagement for Positive Behavioral Health Outcomes

Questions asked by moderator:

How can these entity's support mental health for those who live in the community? (a) schools (b) churches (c) hospitals and/or clinics (d) law enforcement (e) citizens

Schools

- Have classes on behavioral health to teach children about mental health and substance use issues while providing healthy coping mechanisms that can be used to effectively relieve stress
- Provide a space for parents, teachers, and students to gather and discuss behavioral health issues in the community
- Promote campaigns which de-stigmatize behavioral health issues
- Colleges can promote sobriety and offer "Sober Tailgating" for sporting events, as FIU (Florida International University) currently does
- Conduct open houses which educate and provide resources for behavioral health

- Address any bullying that may be going on and provide direct help to students who suffer from bullying

Churches

- Providing Ministry leaders with training and references so they can guide the congregation to seek behavioral health services when needed
- Provide spaces for community to gather and discuss mental health and substance use issues

Hospitals and Clinics

- Provide easy access to behavioral health and substance use services
- Provide resources and information regarding insurance coverage and access to care
- Increase communication and shared information between health care facilities to expedite and improve patient care
- Administer training for staff regarding cultural competence

Law Enforcement

- Provide all officers with CIT (Crisis Intervention Team) training and ensure police officers are competent to deal with behavioral health crises
- Have jail diversion programs to avoid placing those with mental health and substance use issues into the Criminal Justice system
- Partner with other agencies to promote continued education for law enforcement officers on behavioral health issues

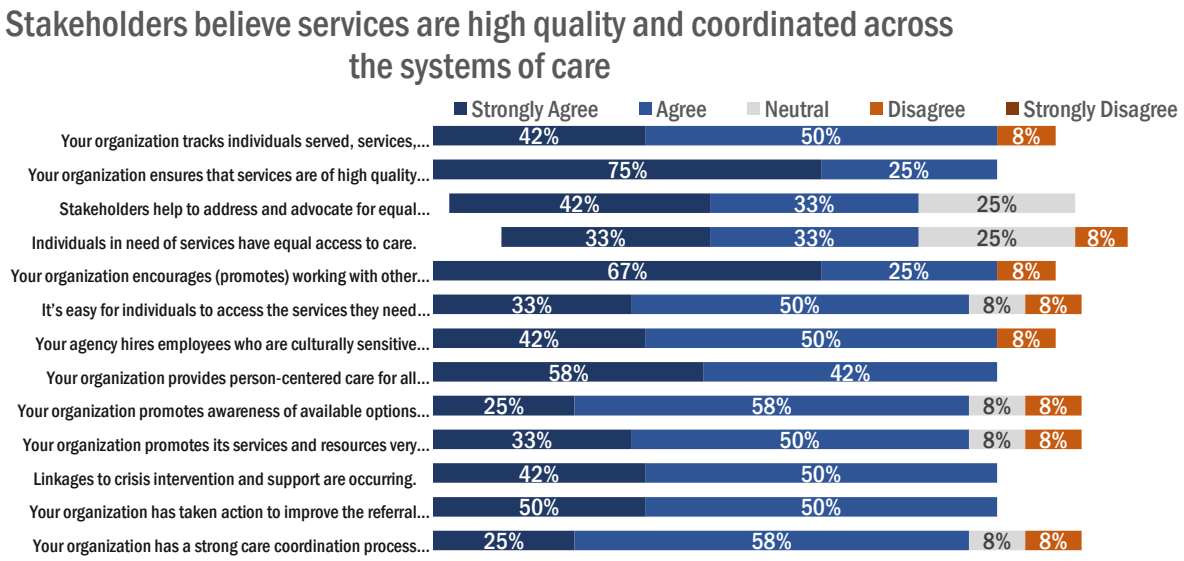
Citizens

- Communicate with providers and/or legislators to inform them of areas which have no behavioral health service centers
- Practice and promote positive communication regarding behavioral health issues to end the stigma surrounding mental health and substance use
- Contact providers and legislators regarding affordable housing options for those in substance use treatment programs because many of the housing options are in neighborhoods with high amounts of drug use and distribution
- Seek resources to educate oneself on techniques to improve mental health and prevent substance use issues
- Encourage others to seek help for mental health or substance use issues

NO WRONG DOOR SURVEY SUMMARY

Twelve individuals were selected to complete the No Wrong Door (NWD) Survey by Thriving Mind South Florida given their executive experience and diverse organizational service offerings. All respondents believed they had a role to play in the NWD access, that it worked well at their organizations and most (83.3%) believed that warm handoff referrals were occurring.

Results (per below) indicate high levels of confidence in NWD service provision across the systems of care.



NO WRONG DOOR SURVEY CHARTS

Figure 117: I work in a/an...

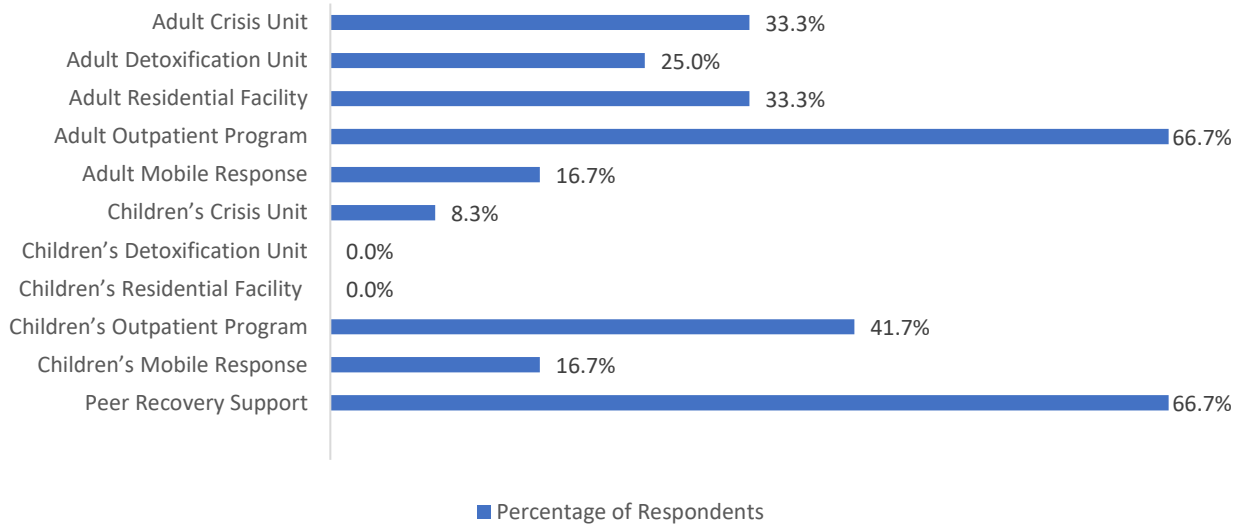


Figure 118: Do you think the "No Wrong Door" access works well within your organization?

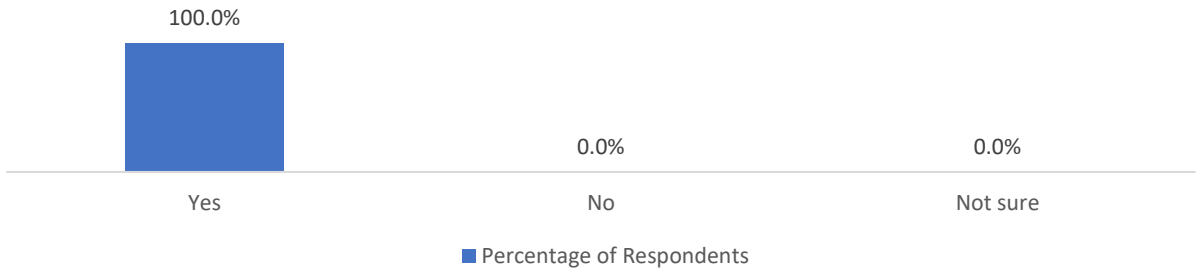


Figure 119: From your perspective your organization has a role to play in the "No Wrong Door" access.

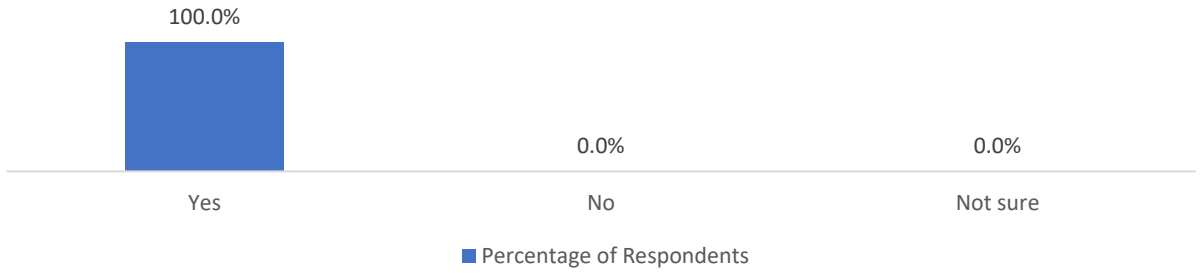


Figure 120: In your opinion, your organization has a strong care coordination process that includes warm handoffs to services and seamless care coordination.

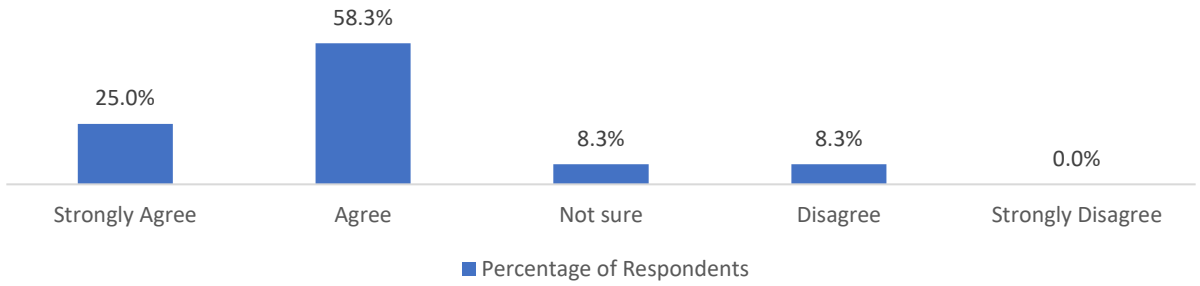


Figure 121: In your opinion, your organization has taken action to improve the referral and care coordination process for individuals served.

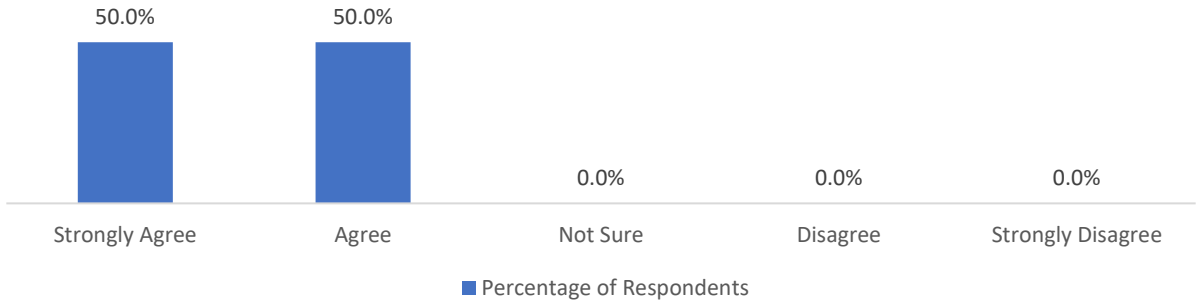


Figure 122: In your opinion, linkages to crisis intervention and support (like the Mobile Response Team, medication management, CRF, CIT Officer, BA, CSU, etc.) are occurring.

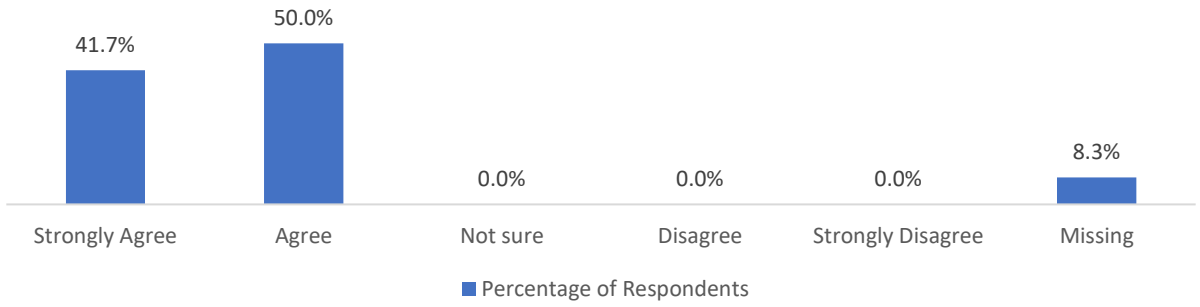


Figure 123: In your opinion, your organization promotes its services and resources very well.

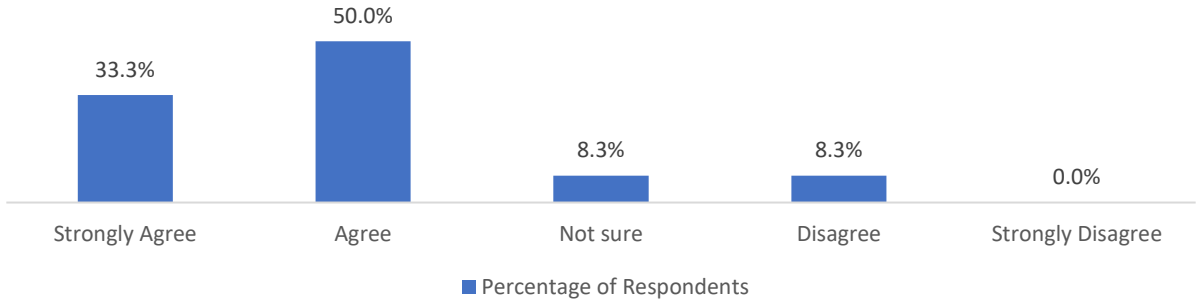


Figure 124: In your opinion, your organization promotes awareness of available options and linkages to need services.

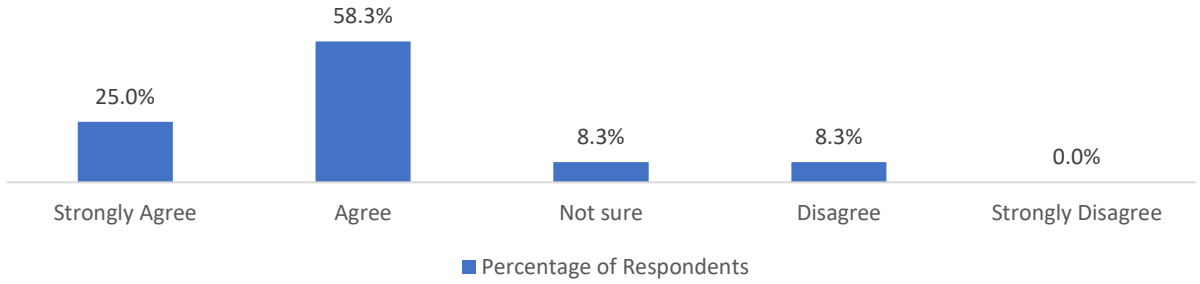


Figure 125: In your opinion, your organization provides person-centered care for all individuals served.

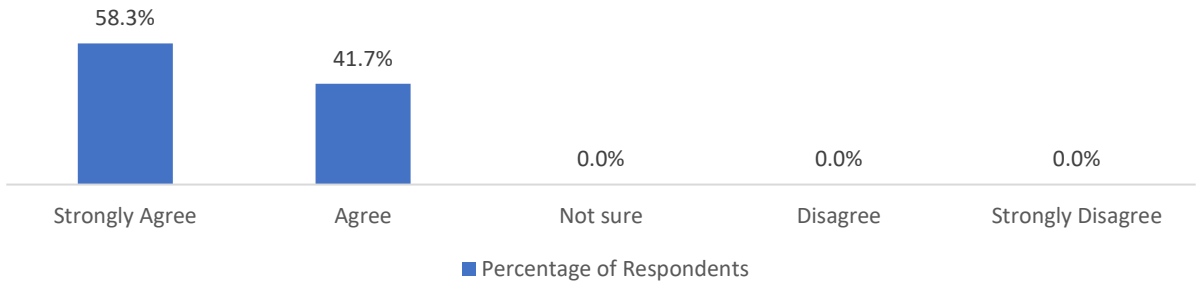


Figure 126: In your opinion, your agency hires employees who are culturally sensitive and culturally competent for the population served.

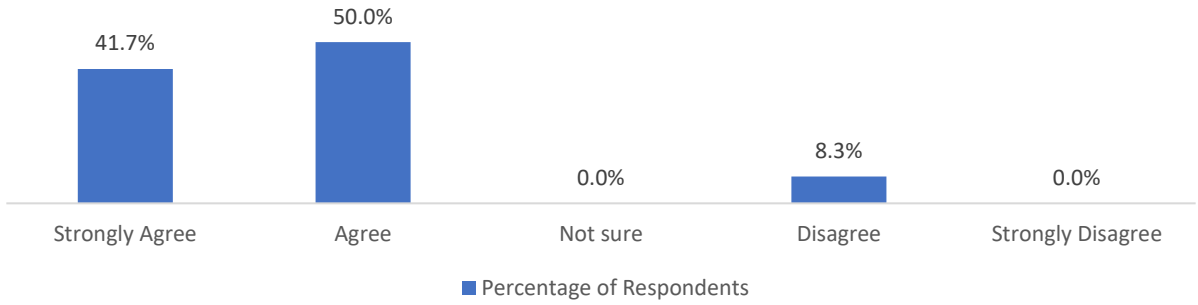


Figure 127: In your opinion, it's easy for individuals to access the services they need quickly and efficiently.

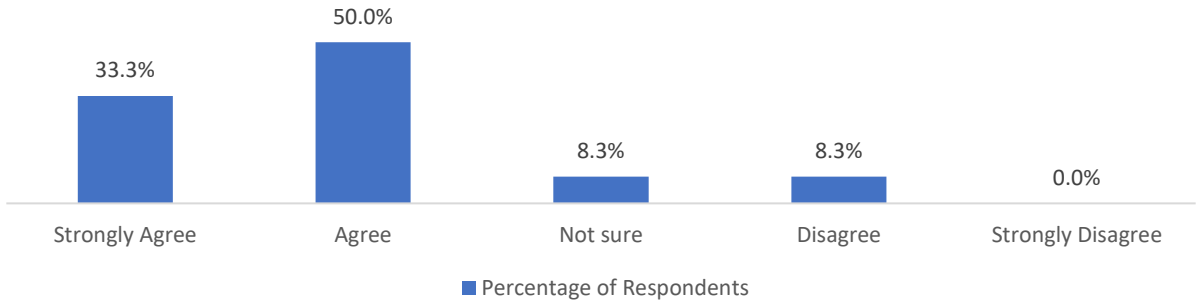


Figure 128: Do you think a standard intake and screening process for state agencies and community partners would help individuals get into services more quickly?

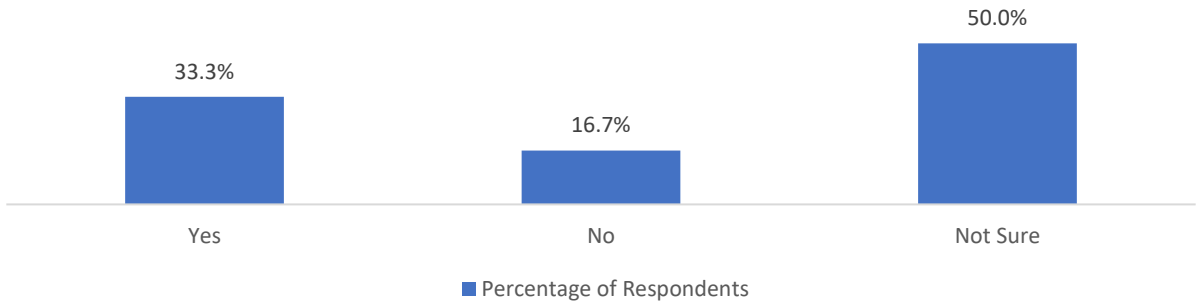


Figure 129: In your opinion, your organization encourages (promotes) working with other community partners to ensure care coordination.

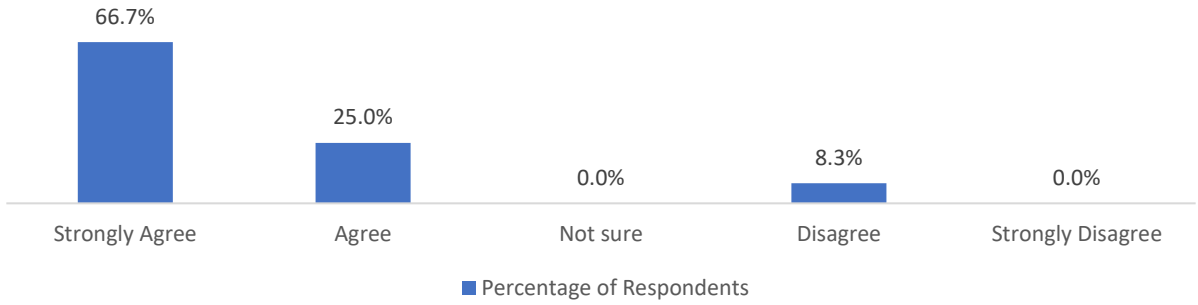


Figure 130: In your opinion, individuals in need of services have equal access to care.

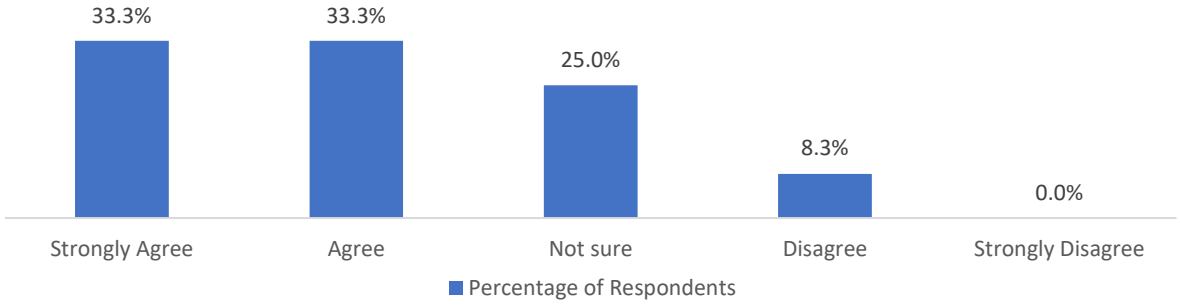


Figure 131: In your opinion, stakeholders help to address and advocate for equal access to care in system entry points.

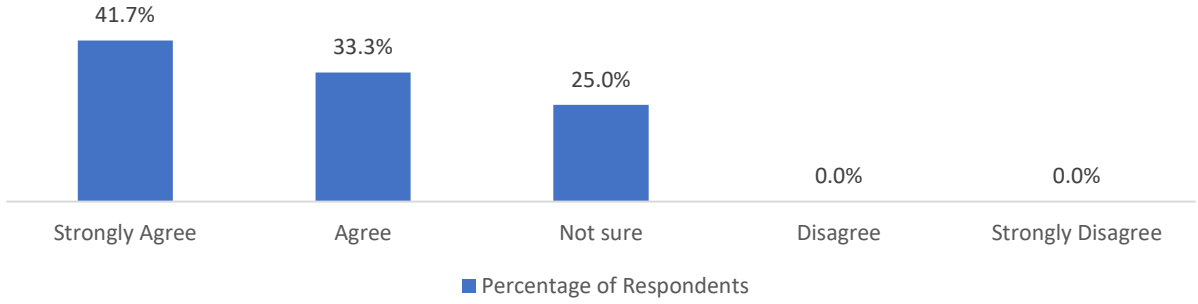


Figure 132: In your opinion, your organization ensures that services are of high quality and meet the needs of individuals served.

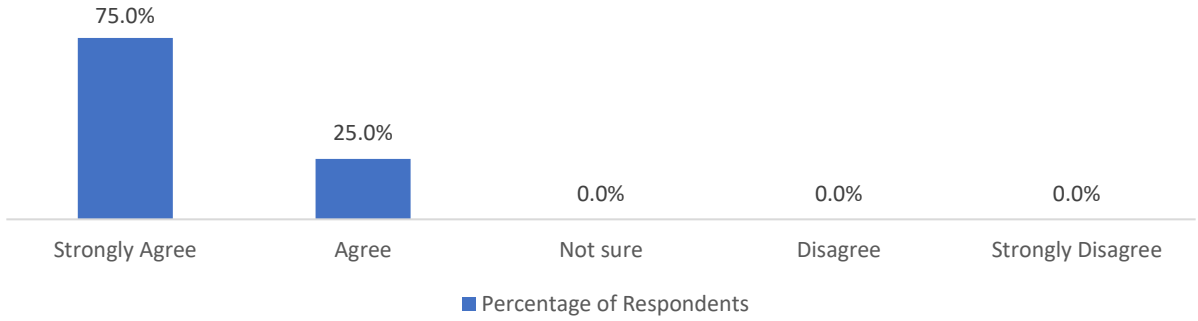
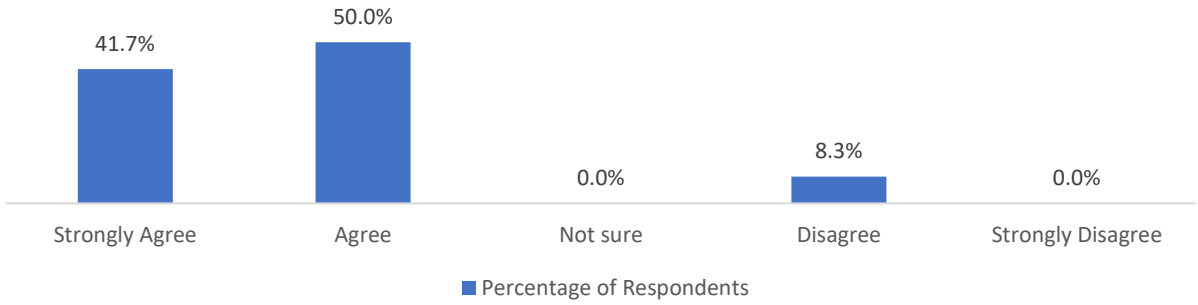


Figure 133: In your opinion, your organization tracks individuals served, services, performance, and cost to continually evaluate and improve outcomes.



No Wrong Door Needs Assessment Interviews Summary

During February and March 2022, two researchers / evaluators from Behavioral Science Research Institute (BSRI) conducted hour-long semi-structured interviews with C-level executives from 12 behavioral health providers in South Florida. Those C-level executives, and their associated organizations, were selected based on their participation in surveys for the No Wrong Door Needs Assessment as directed by Thriving Mind South Florida. The interviews were recorded and transcribed. BSRI then used thematic coding techniques to discover patterns in the data and search for 'saturation' - topics, feelings, descriptions, or explanations that indicate overarching sentiments across different experiences (in this case, organizational experiences with No Wrong Door in South Florida).

The most common areas of saturation are described below.

THE "NO WRONG DOOR" (NWD) ECOSYSTEM IN SOUTH FLORIDA

Interviewees used the following key terms and phrases to define NWD:

> "Regardless of where a client ends up, we are trying to serve them and make sure they're getting the services they need." | "The access points to bring someone into care are really unlimited." | "No Wrong Door is the ability to access service from any level of care." | "We determine whether they [the patients] are a fit for a service that we provide, or if it's a service that we're not able to provide in-house, then we refer that case to an outside agency."

Despite some similarities in their responses to what defines NWD, the organizations perceived role in NWD differed depending on their size. Larger organizations were often imagined as "one-stop-shops" while smaller organizations offered more targeted care and often focused on one type of service.

Larger Organizations	Smaller Organizations
"My organization is a very large organization with a lot of breadth to what we do, and so there's a lot of ways people can come to us and be referred to us and get into services, as well as receive a lot of different services."	"We work with primarily substance use disorders, but some people need to go to detox first, some people need to go to treatment first.[So,] we try to connect them with that and stay connected throughout the whole way."
'We're creating an integrated model - we're a one-stop-shop - we were primarily behavioral health and now we're adding primary care, and we're going to also look at other specialties in the future.' (Paraphrased from multiple sentences in same interview section)	"We are primarily a service provider to individuals with chronic and persistent mental illness. But, we could have somebody that comes here seeking treatment for marital discord... we'd sit down and help them by making some calls and finding out what appropriate agencies could be available to serve them."
"So we are a pretty broad agency. We do behavioral health, we do primary care... We're trying to make sure that we're receiving and connecting all the services... So no matter how they start trying to access our agency or our care, we facilitate that."	"We are a peer-run organization. Let's say someone homeless walks in here and they have a need, we're going to do a warm handoff for that person to the right place, or the closest access point to get the help that they need. We're not here to hold on to someone."

The interviewees observed many inequities and inequalities in terms of healthcare access. As one respondent broadly stated:

"You know what? I think that there is elitism within the community. I think that those who have more will get better, quicker access. Imagine if Halle Berry was laying out there on the road and I'm laying out there too, who do you think the ambulance is going to pick up? It shouldn't be that way, but [it is that way.]"

Thematic analysis helped identify three, more finite areas of inequity and inequality that people face when trying to access healthcare in general, and which may contribute to why they 'end up' at the wrong services in the first place. The first two pertain to common misunderstandings or inexperience with the system:

Confusion with the system	Not knowing the right people
"I think a normal person walking in that has no idea about healthcare, I do believe it's difficult wherever you go. I'm in healthcare, so I have a little bit of knowledge on what to do... and I'm sometimes confused."	"If somebody doesn't know, they're just calling a number off the street, it's a lot more difficult for them to seek services. A lot of times it is if you know the right person that can call the right person to get you in."

The third has to do with meeting admission criteria, and the challenges with overlapping services or difficult cases in general.

'Difficult Cases'	
"I feel like providers sometimes don't wanna take on the difficult cases. For example, all substance abuse providers have to do co-occurring, but it's either mental health with a little substance abuse, or substance abuse with a little mental health. There's levels of SUD [but] I don't think there's a place for that severe SUD with SMI."	"Sex offender. That's another one. A registered sex offender is not gonna be able to get housing in this community, no matter what they do. A person who has a history of difficult behavior is gonna be bounced around before they have direct access depending on what level of services that it is."

To help navigate these inequities and inequalities and help ensure a NWD ecosystem across South Florida, many organizations acknowledged certain **opportunities** and some common **strategies**.

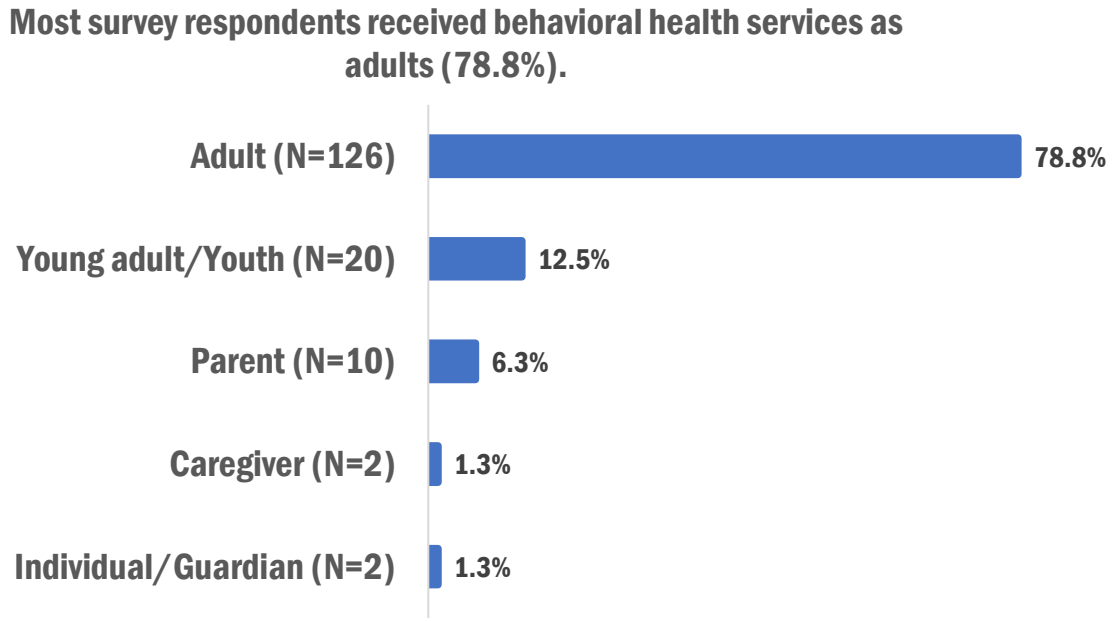
FOUNDATION FOR NWD IN SOUTH FLORIDA

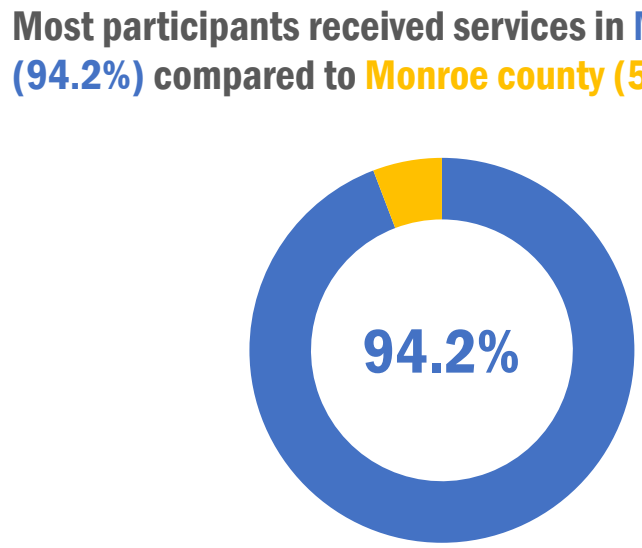
Decades-long experiences in this industry have helped many organizations develop strong community partnerships.

Decades-Long Experience	**Strong Community Partnerships**
"We have long-standing relationships with resources in the community since we've been in business for 43 years, we are very well aware of the service provider network that might be most appropriate."	"We've been in the community for almost 50 years. We have the entire continuum of care... We also do a lot of community-based services, so we've got all of our counselors and therapists co-located at the schools, we've got a program for substance abuse treatment in the jail, and then we're working closely with the Department of Children and Families with their child welfare services."
*Interestingly, only one interviewee discussed negative experiences with community partnerships, suggesting that an already existing vibrant and supportive framework may lay the foundation for future improvement.	

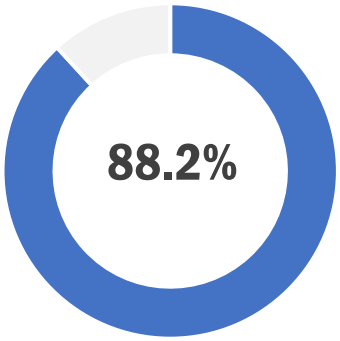
INDIVIDUALS SERVED SURVEY SUMMARY

A total of 166 respondents completed the individual/consumer served needs assessment survey with each question having between 148-166 responses. Just over half (55.9%) of responses came from individuals identifying as female, although males, gender fluid, bigender, gender queer, and transgender individuals were also represented. Nearly two-thirds (62.3%) identified as Hispanic, 58.6% identified as White, and 29.9% identified as Black. Adult mental health services were most common among respondents (83.1%).

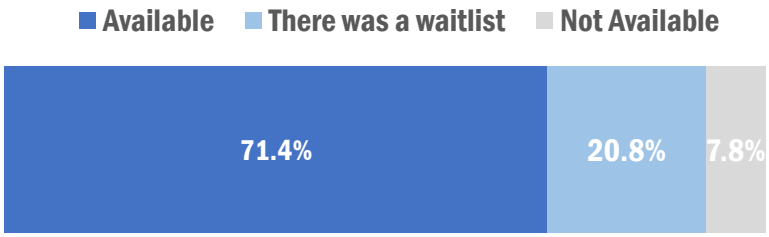




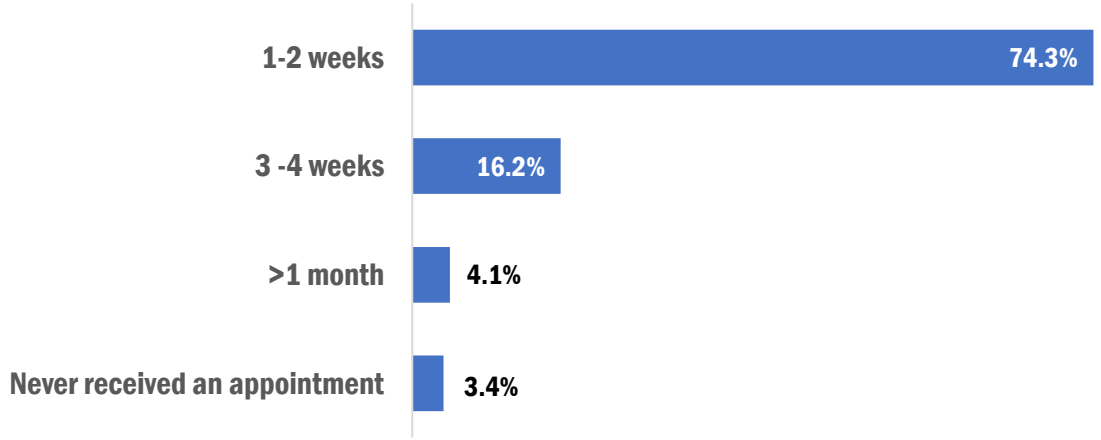
Most participants (88.2%) agreed that services and planning they received were focused on their treatment needs (patient-centered).



Most participants cited that services were available when needed.

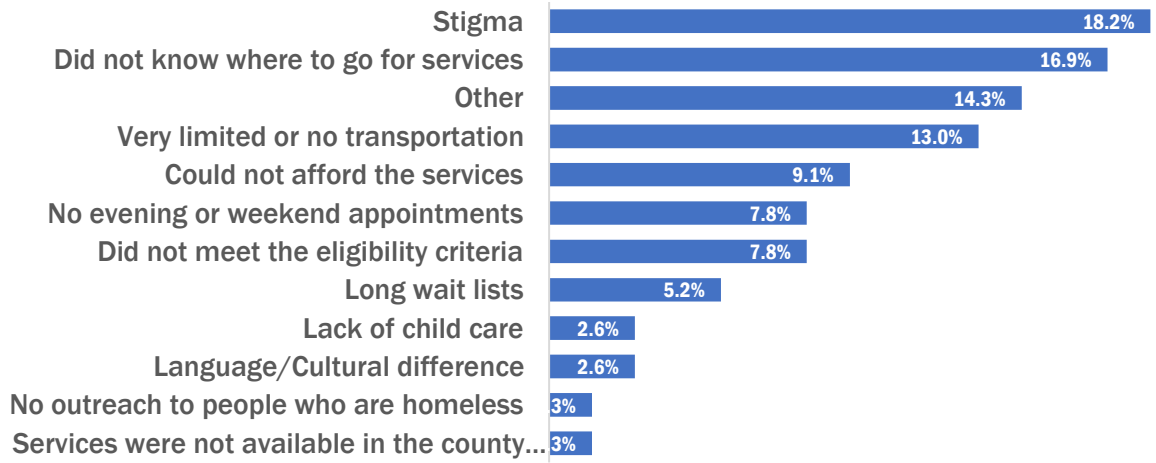


Most participants (74.3%) waited 1-2 weeks from the time they requested an appointment for services to the time they received the services.



Two-thirds of respondents (66.9%) reported travel time of 30 minutes or less to receive services, with an additional 13.6% citing they were only engaged in virtual services. One in five (19.9%) relied on public transportation, 39.7% drove themselves, and 22.1% had a family member or friend drive them. Fewer than half (46.5%) were aware of the 211 resource.

Of participants who faced obstacles in getting the care they needed (N=77) most cited stigma or not knowing where to go for services.



INDIVIDUALS SERVED SURVEY CHARTS

Figure 134: Which best describes you?

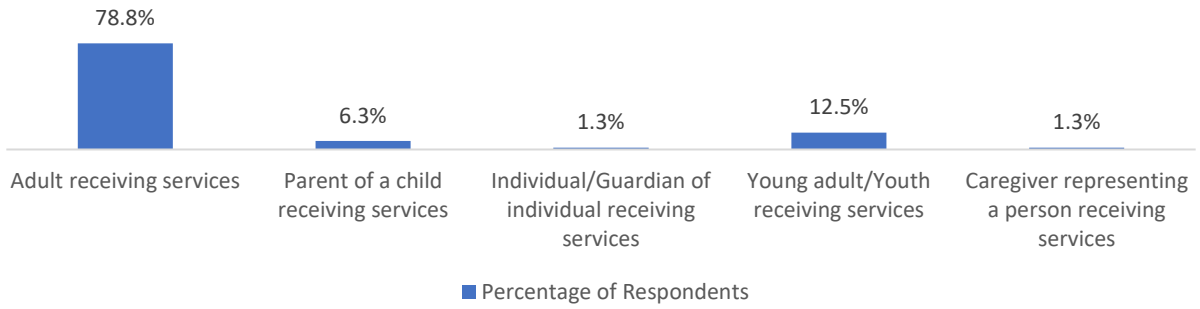


Figure 135: What type of service did you or the person you are representing receive?

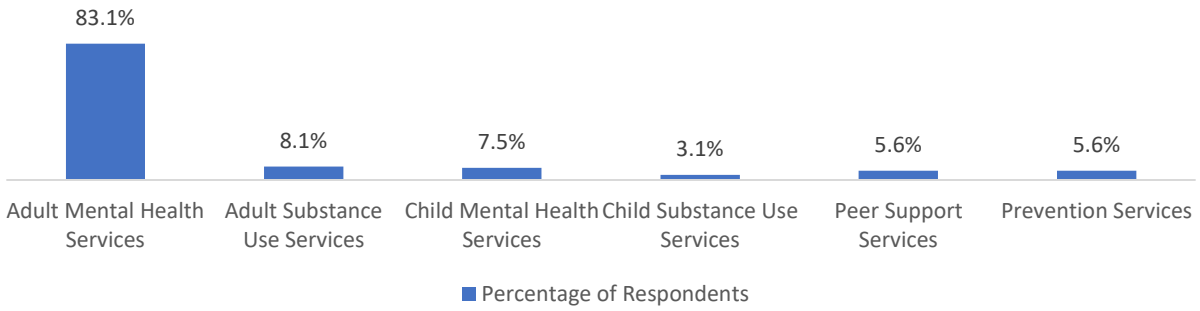


Figure 136: Which county do you live in?

Figure 137: Did you know where to go for mental health and substance use treatment services when you needed them?

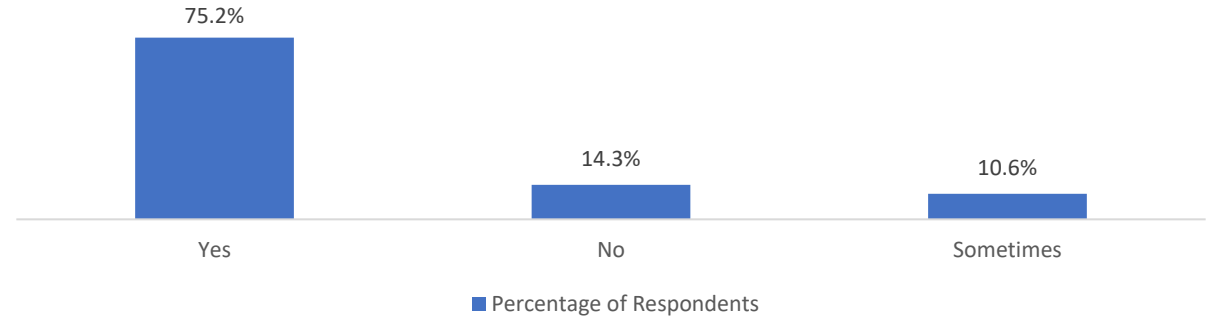


Figure 138: How did you learn about mental health and substance use treatment services when you needed them?

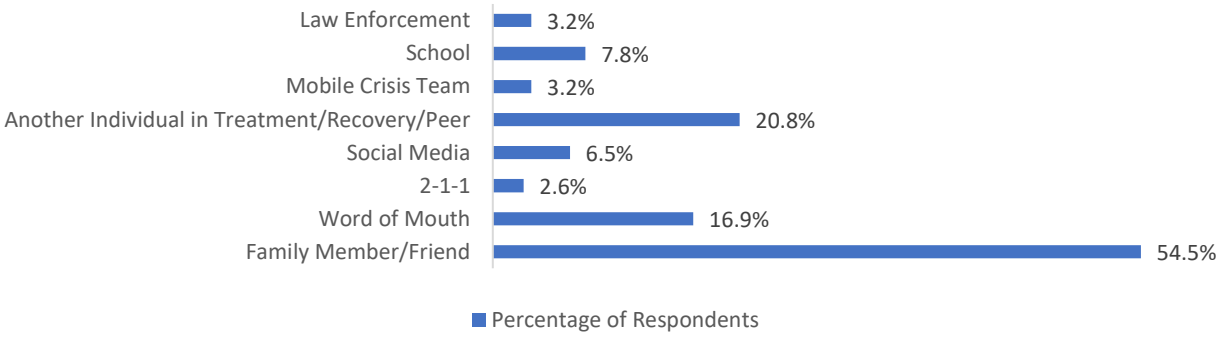


Figure 139: Are you aware of the 2-1-1 Information and Referral Resource in your community?

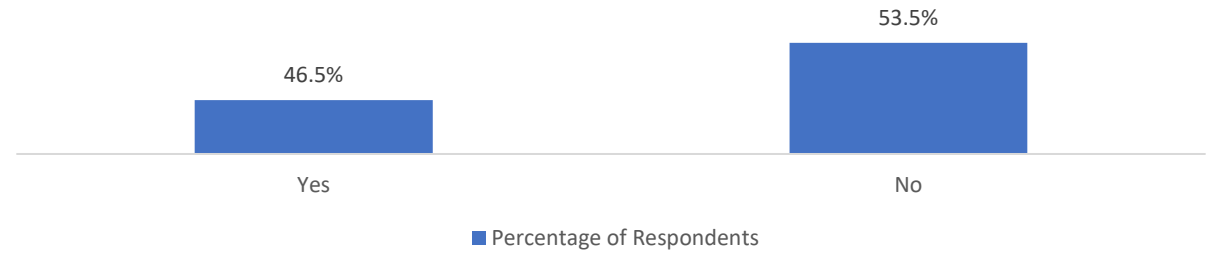


Figure 140: Have you ever called 2-1-1 Information and Referral Resource for assistance?

Figure 141: When you called the 2-1-1 Information and Referral Resource, were they helpful in getting you the services needed?

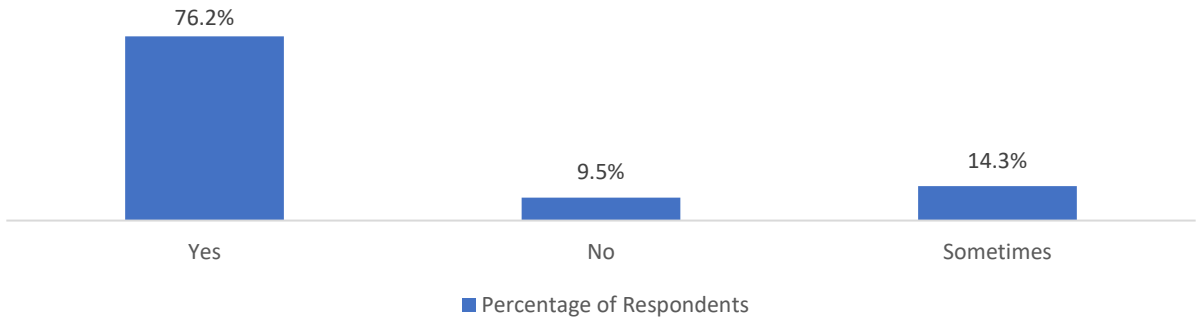


Figure 142: Were you able to get all the services you needed when you needed them?

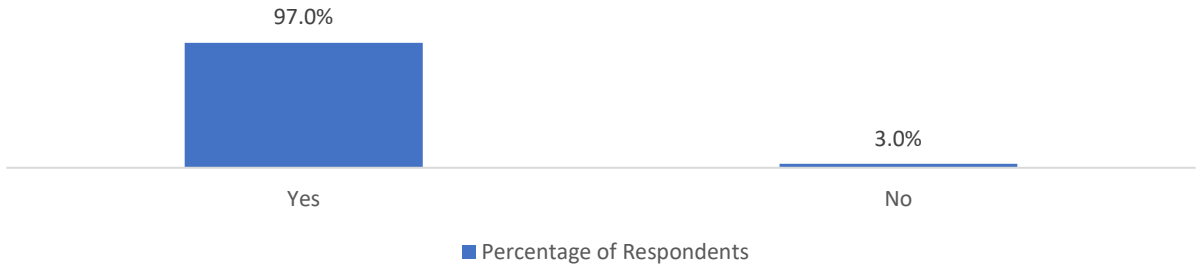


Figure 143: If no, please choose from the list below, the services you needed but were not able to get.

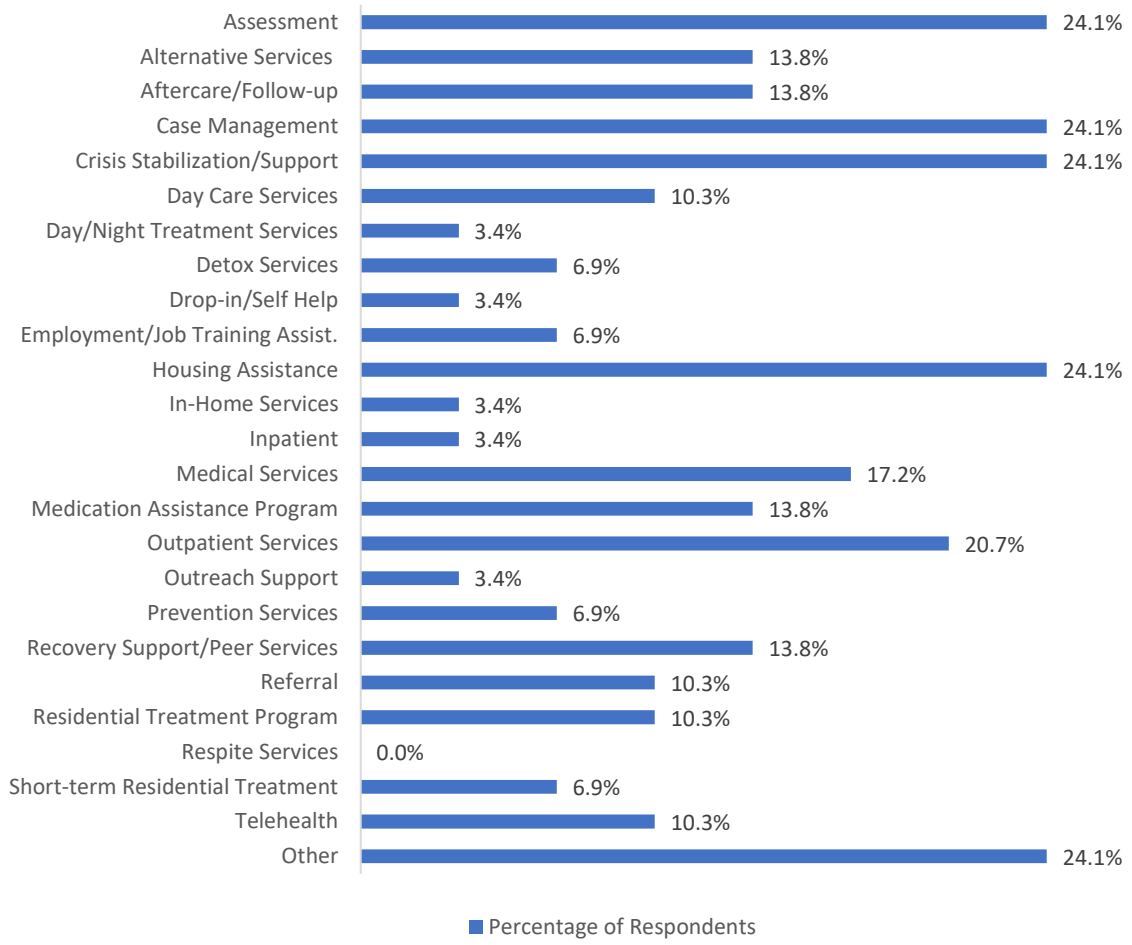


Figure 144: How many times during the <u>last 12 months</u> were you not able to get the services you needed?

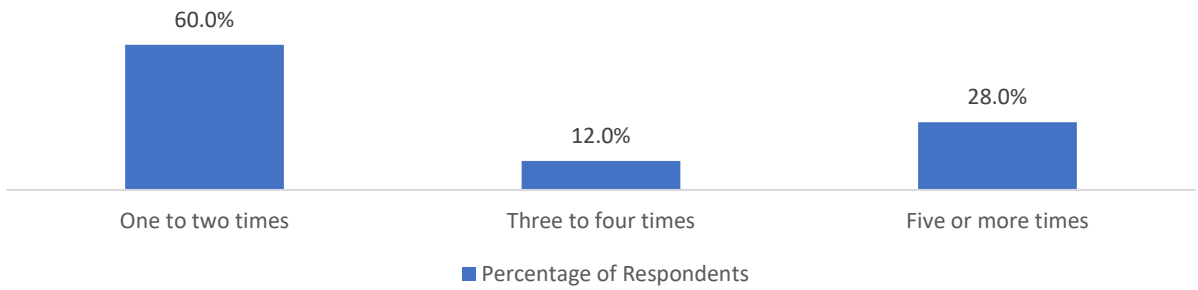


Figure 145: The services I needed were:

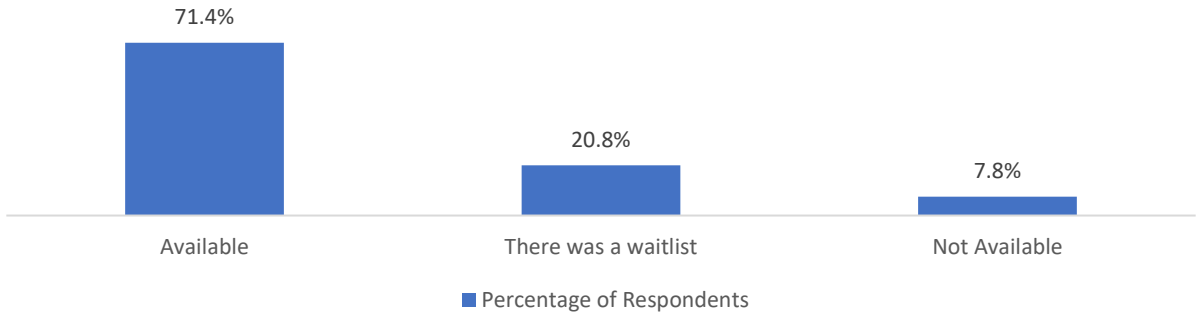


Figure 146: The services and planning I received were focused on my treatment needs (patient centered).

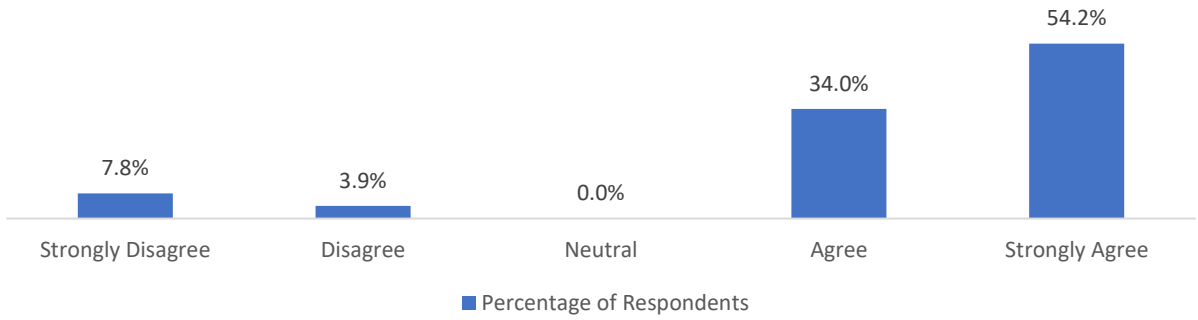


Figure 147: How long did it take from the time you requested an appointment for services to the time you received the services?

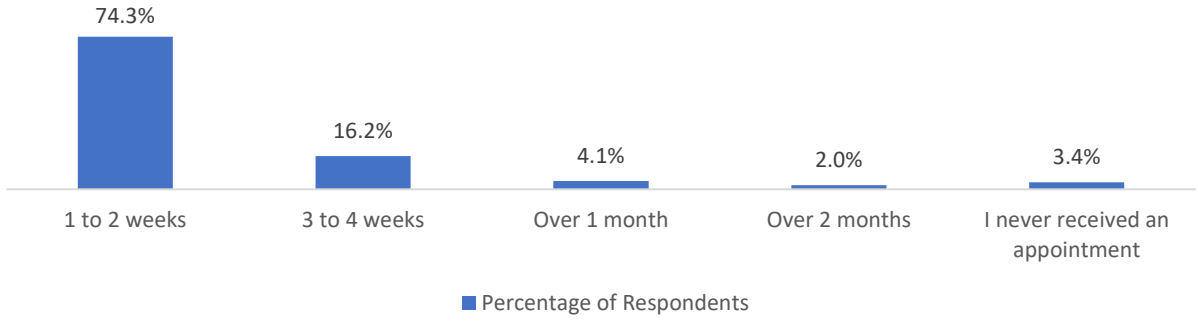


Figure 148: How long did it take to travel to the service?

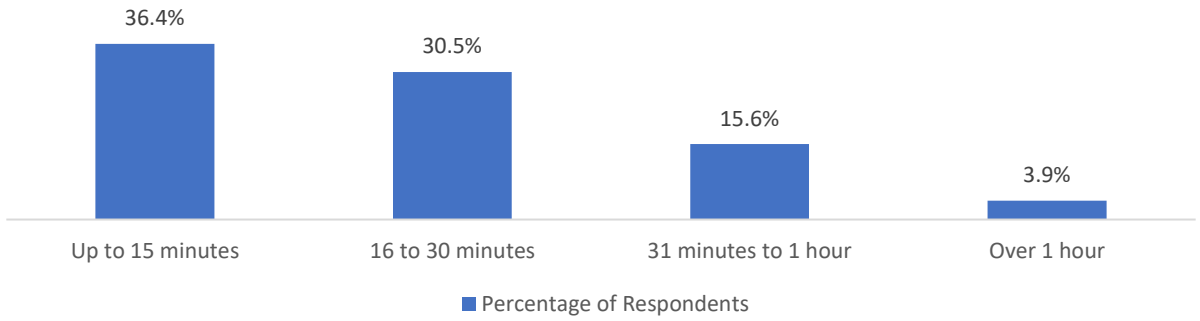
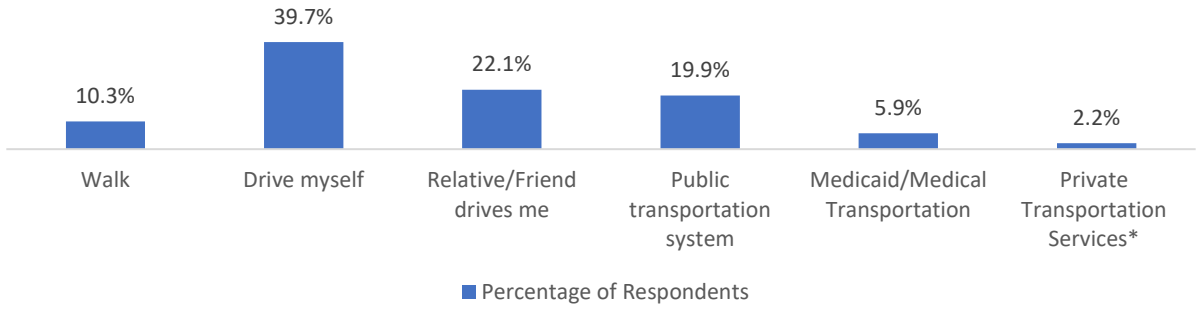
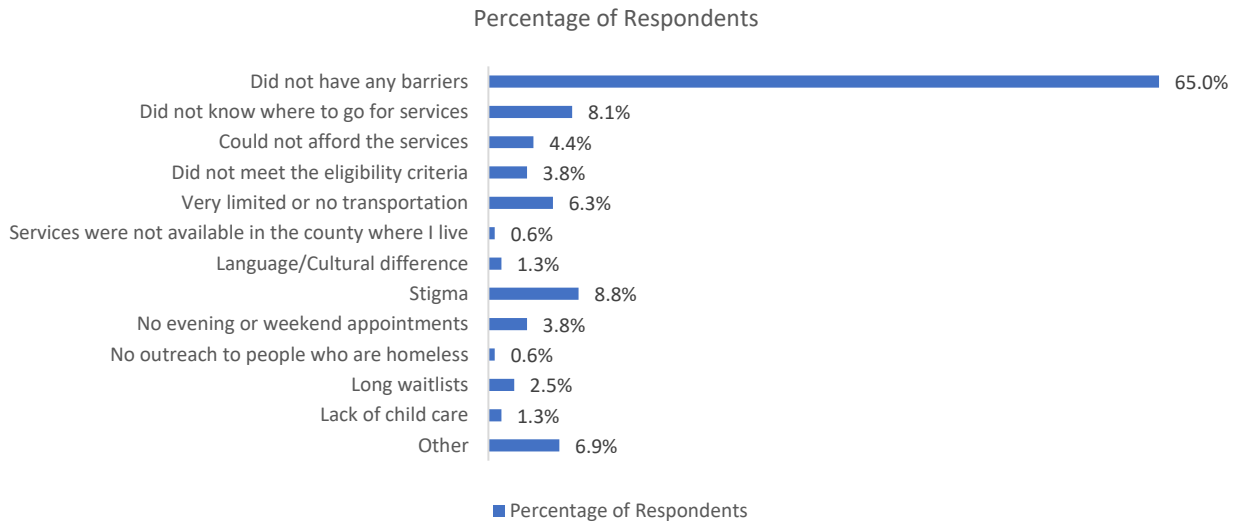


Figure 149: How do you travel to get services?



*Note-Private transportation includes Taxi, Uber, Lyft, TOPS, etc.

Figure 150: What were the obstacles you experienced getting the care you needed?



STAKEHOLDER SURVEY SUMMARY

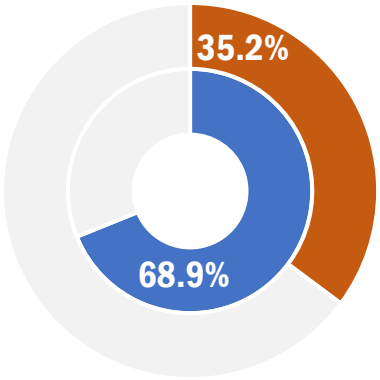
A total of 181 respondents completed the stakeholder served needs assessment survey with each question having between 177-181 responses. More than two-thirds (68%) of respondents worked in the substance use or mental health fields but fewer than half (42.8%) reported working for an organization funded by the managing entity.

Of the 35.2% who accessed Thriving Mind South Florida resources in the past 6 months, three-fourths (74.4%) found the resources helpful, and 57.7% directed someone else to their resources. Reasons for using Thriving Mind resources included: trainings and events, the consumer and family manual, identifying referral options for providers in the network, assisting parents of children in need of services, and for assisting petitioners in Marchman court.

More stakeholders were aware of the 2-1-1 resource when compared to Thriving Mind resources (71.7%), however, fewer accessed 2-1-1 (23.2%).

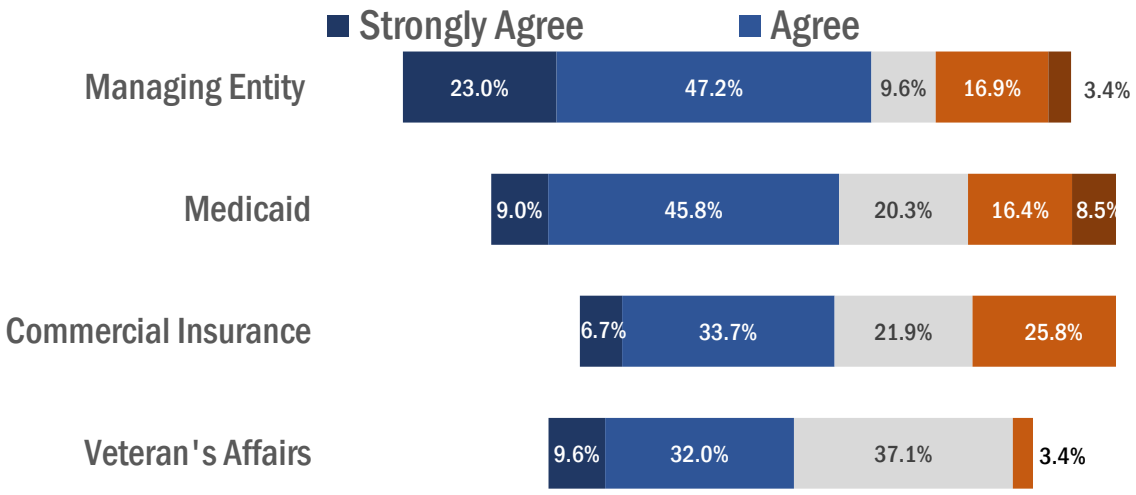
There was a greater number of patients served in Miami-Dade compared to Monroe County.

More than half of partipcant were aware of Thriving Mind South Florida, however just 35.2% accessed it in the past 6 months.



In terms of rating community awareness of behavioral health services respondents agreed that service providers had the greatest awareness, followed by persons needing services. Only 12.5% of general population rated community awareness as excellent. Despite these perceptions of lower awareness, 69.3% of respondents believed linkages within the system of care were well coordinated, and 67% believed services were accessible to those in need.

Stakeholders thought the managing entity had the most coordinated systems of care.



STAKEHOLDER SURVEY CHARTS

Figure 151: Percentage of respondents by organization service sector.

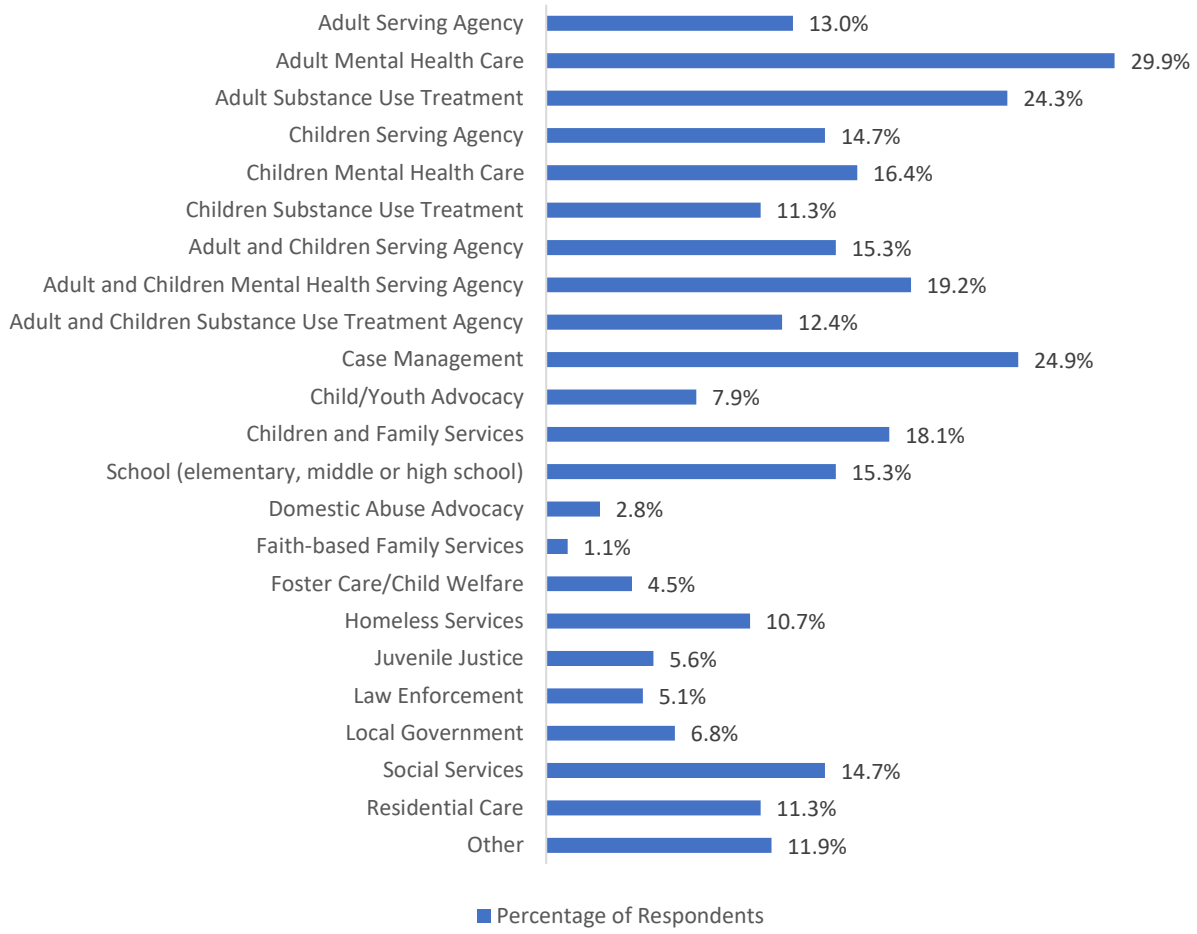


Figure 152: Percentage of stakeholder respondents by county.

Figure 153: You are aware of the availability of mental health and substance use services in your area.

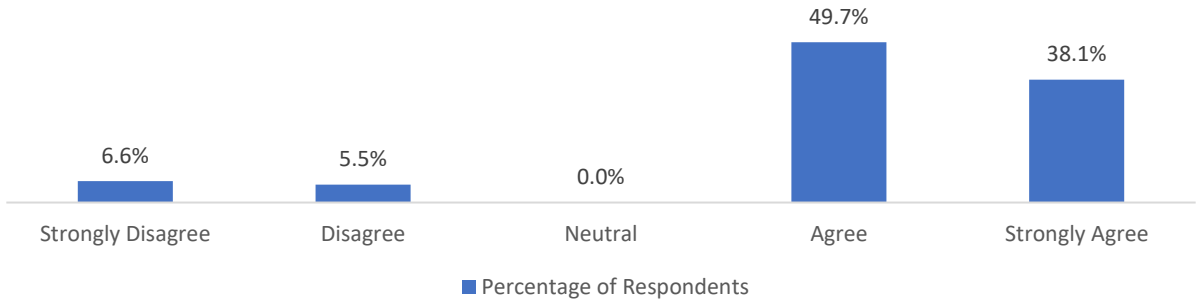


Figure 154: Are you aware of Thriving Mind South Florida (Managing Entity) resources?

Figure 155: Have you accessed Thriving Mind South Florida (Managing Entity) resources in the past 6 months?

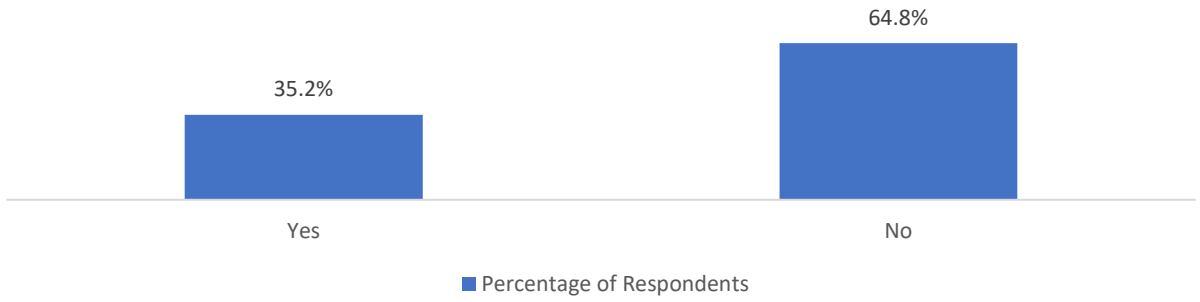


Figure 156: When you accessed Thriving Mind South Florida (Managing Entity) resources, was it helpful?

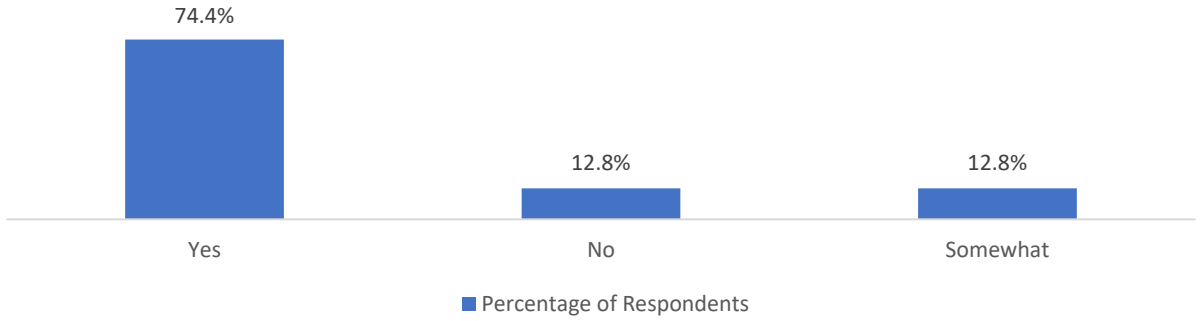


Figure 157: Have you ever directed individual to access Thriving Mind South Florida (Managing Entity) by calling or online?

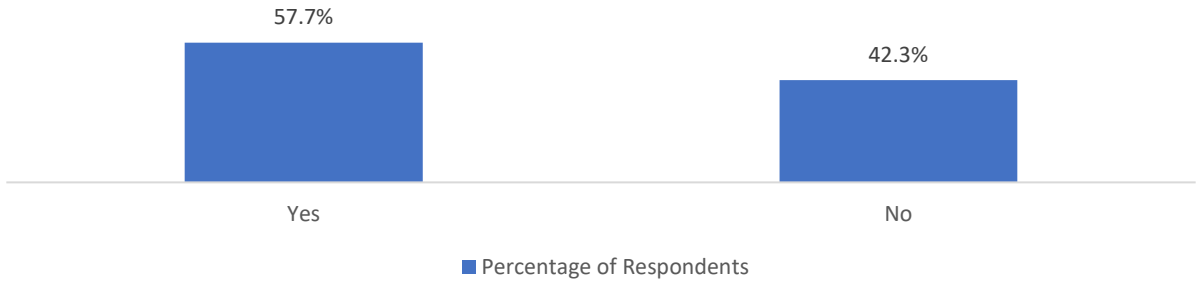


Figure 158: Are you aware of the 2-1-1 Information and Referral Resource?

Figure 159: Have you accessed the 2-1-1 Information and Referral Resource in the past 6 months?

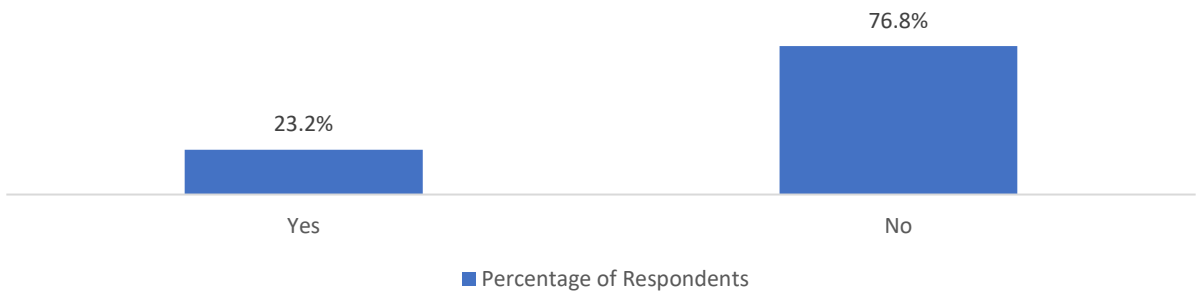


Figure 160: When you accessed the 2-1-1 Information and Referral Resource, was it helpful?

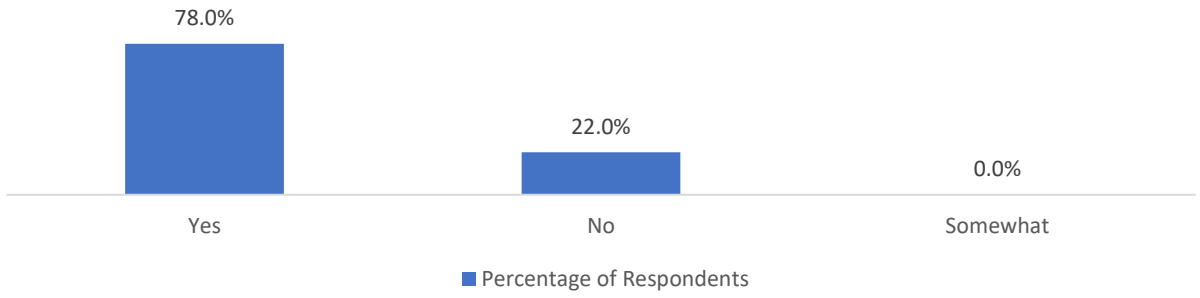


Figure 161: Have you ever directed individuals to access the 2-1-1 Information and Referral Resource by calling or online?

Figure 162: Select the crisis response model in your area. Select all that apply.

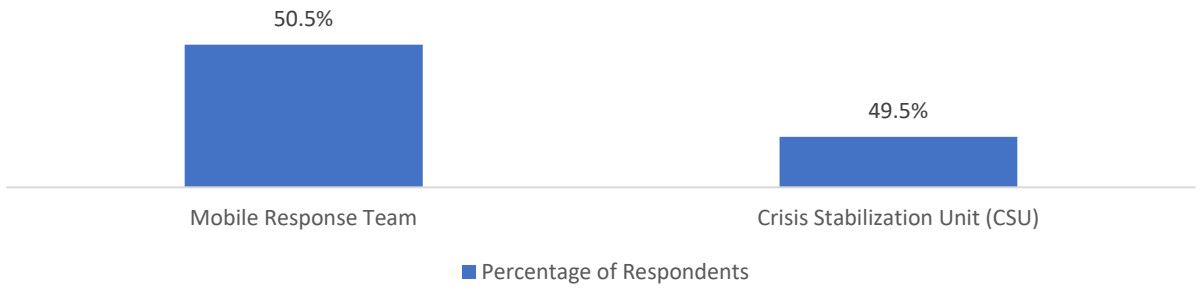


Figure 163: How would you rate community awareness of mental health and substance use treatment services in your area?

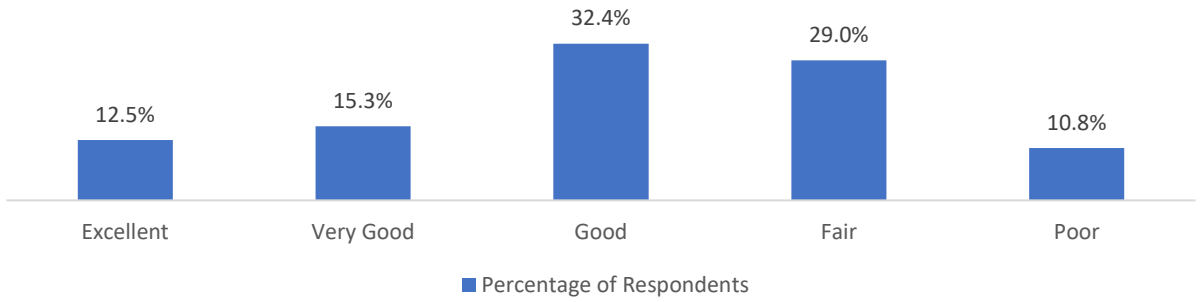


Figure 164: Linkages to needed services are coordinated and well established across the system.

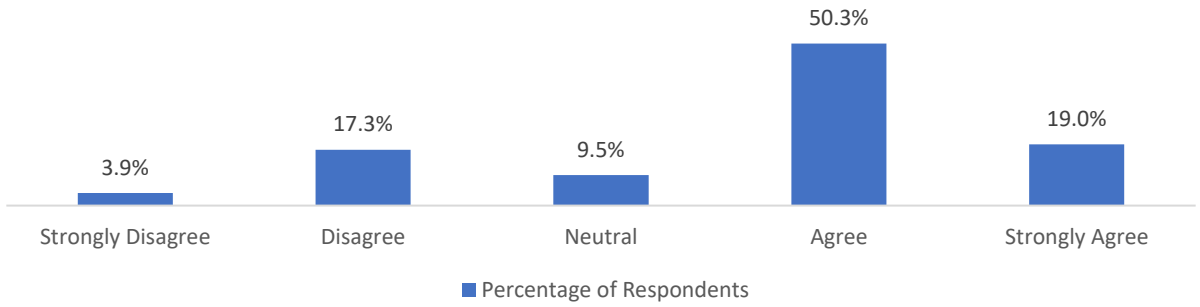


Figure 165: In general, behavioral health care and peer services are accessible in your area.

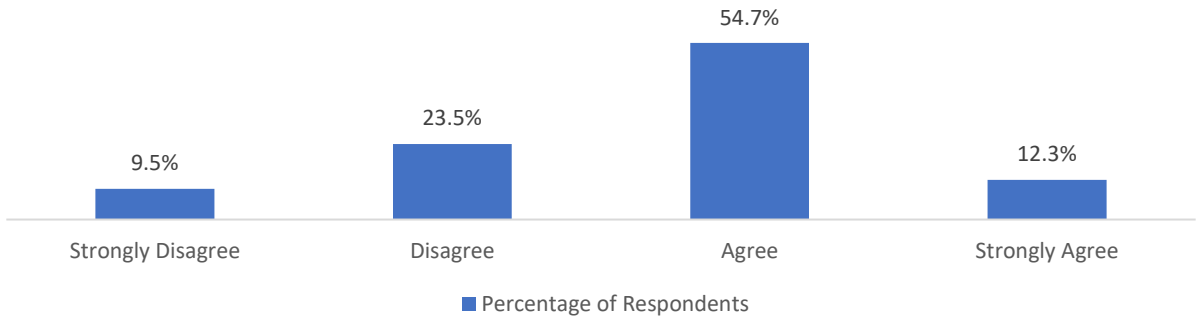


Figure 166: The process for referrals is easily accessible.

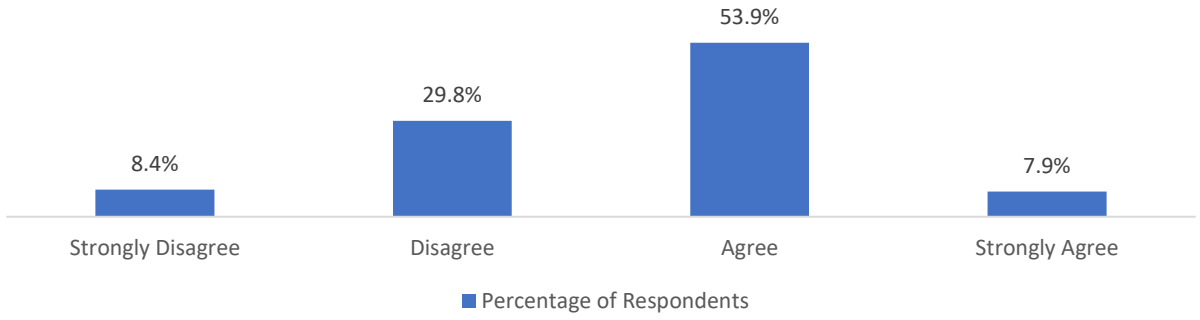


Figure 167: Programs and services are coordinated across the system of care.

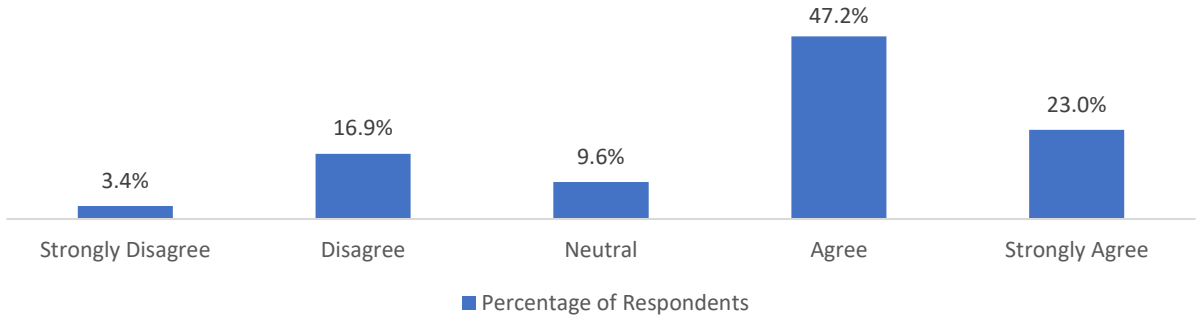


Figure 168: List the barriers for consumers accessing services in your community. (Check all that apply)

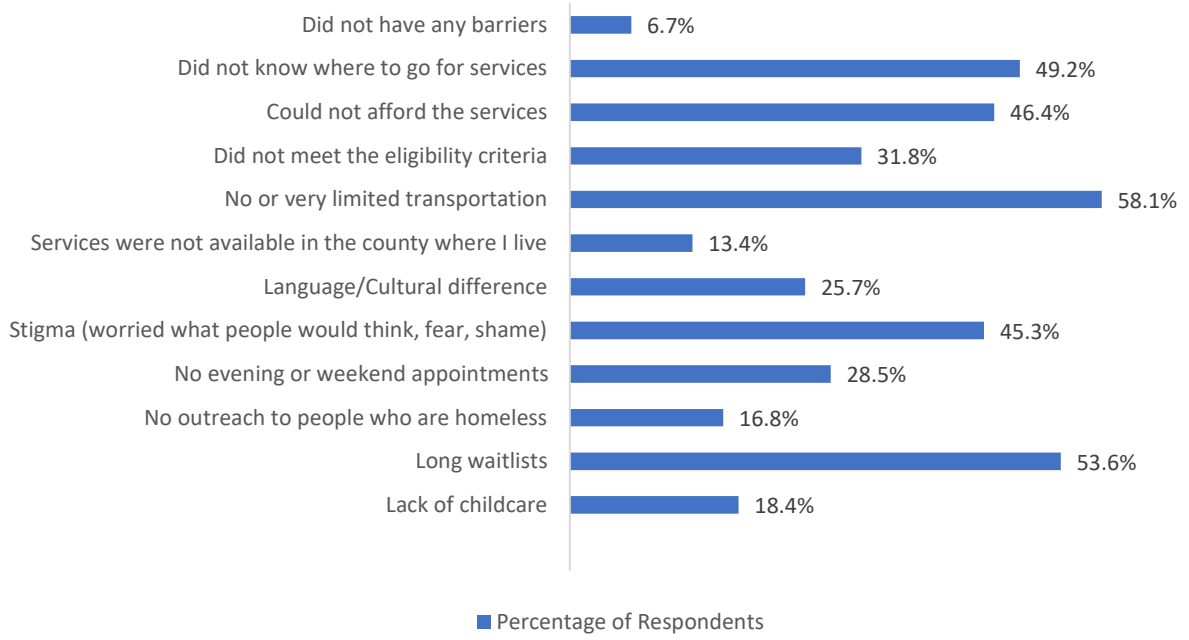


Figure 169: List the resources and services needed that are not available to improve patient-centered care and planning.

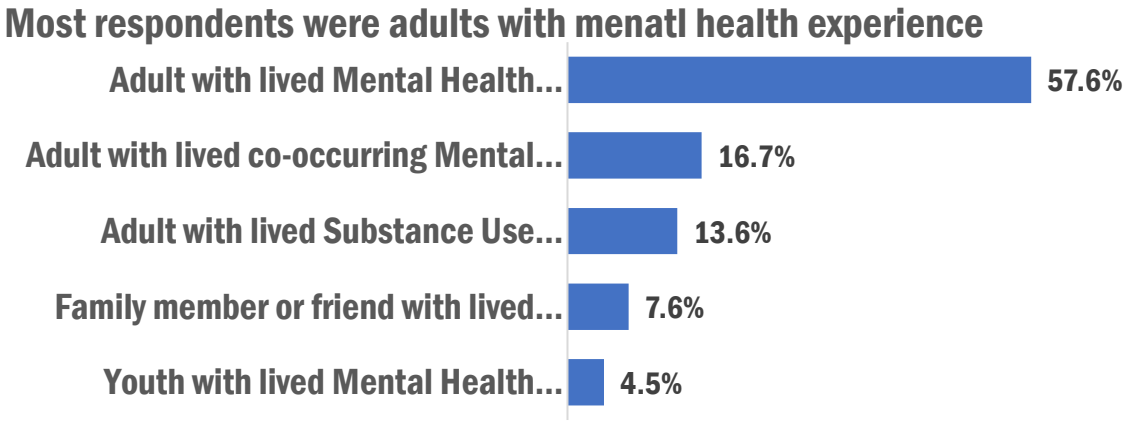
NEEDED RESOURCES
Lack of adequate housing
Need additional staff/doctors/other health care professionals
User-friendly health provider directory

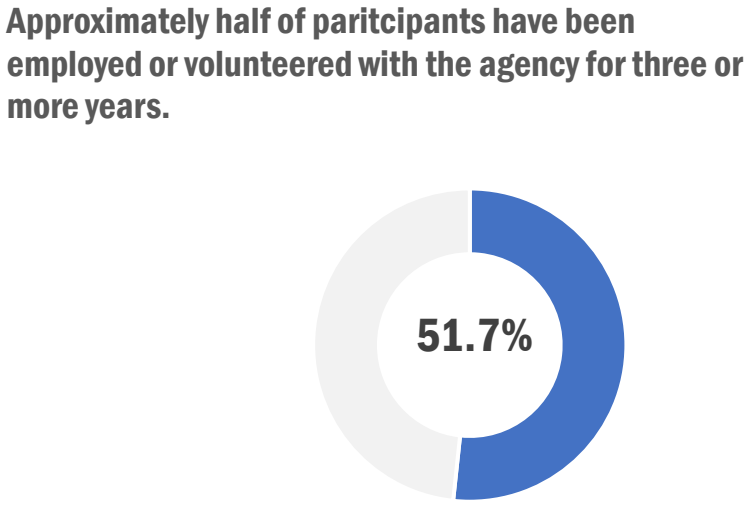
Figure 170: List the top three patient-centered care resources that have improved quality of life for individuals.

TOP THREE PATIENT-CENTERED RESOURCES
Supportive Housing
Mental Health Services
Peer Services

PEER RECOVERY COMMUNITY/SUPPORT SPECIALIST'S SURVEY SUMMARY

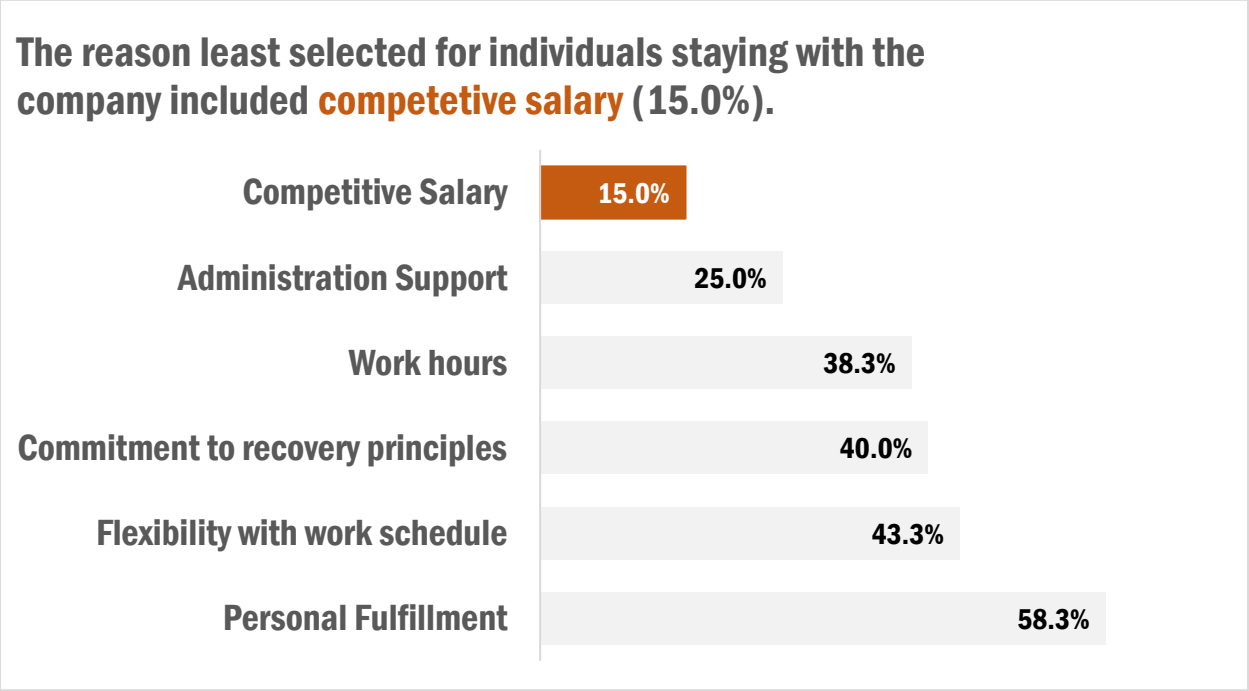
A total of 61 respondents completed the peer recovery support survey with each question having between 58-61 responses. Responses came from 16 organizations with an additional 6 individuals not entering the organization they work with; 90% of respondents worked in Miami-Dade. Respondents were two-thirds female (64.4%) with 50.8% identifying as white and 35.6% identifying as black. Nearly half (44.8%) identified as Hispanic.





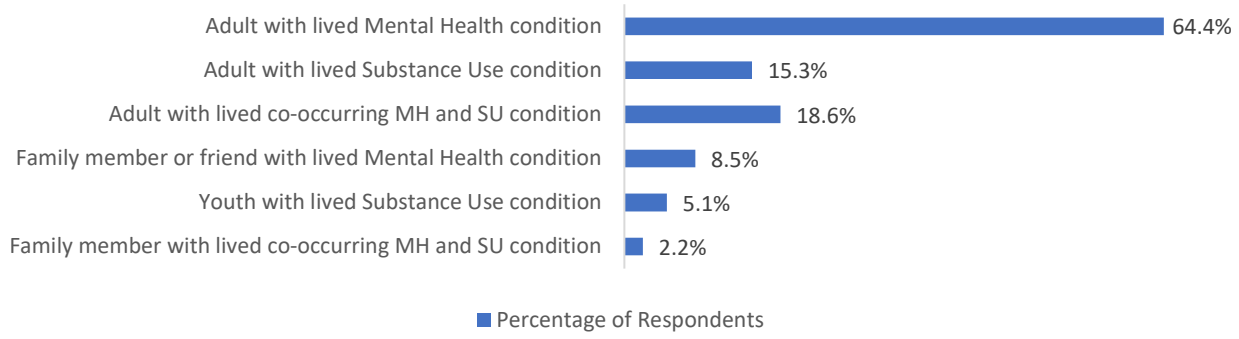
More than half of respondents (55.9%) reported being non-certified peer specialists; 22% were currently certified and an additional 19% had applied for certification. Unfortunately, peers discussed salary as being a barrier in the hiring process and was the least endorsed reason for staying with an organization. The most common reasons for staying included flexibility with work schedule (43.3%)

and commitment to recovery principles (40.0%). Finally, respondents believed strongly that person-centered principles and peer input was valued at their organization across policies and services.



PEER RECOVERY COMMUNITY/SUPPORT SPECIALIST'S SURVEY CHARTS

Figure 171: Which best describes your experience?



Note: Mental Health (MH) and Substance Use (SU)

Figure 172: Which county do you live in?

Figure 173: What type of service are you employed or volunteer with? (Check all that apply)

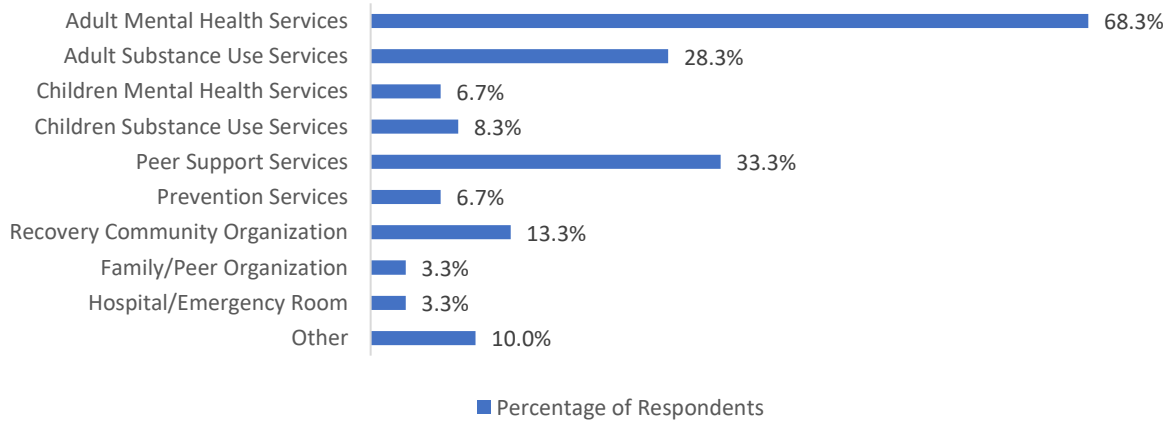


Figure 174: How long have you been employed/volunteered with the agency?

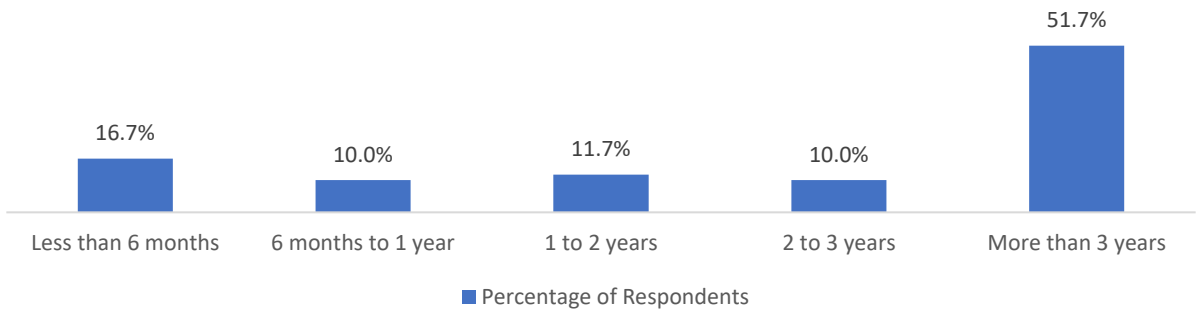


Figure 175: My work schedule averages...

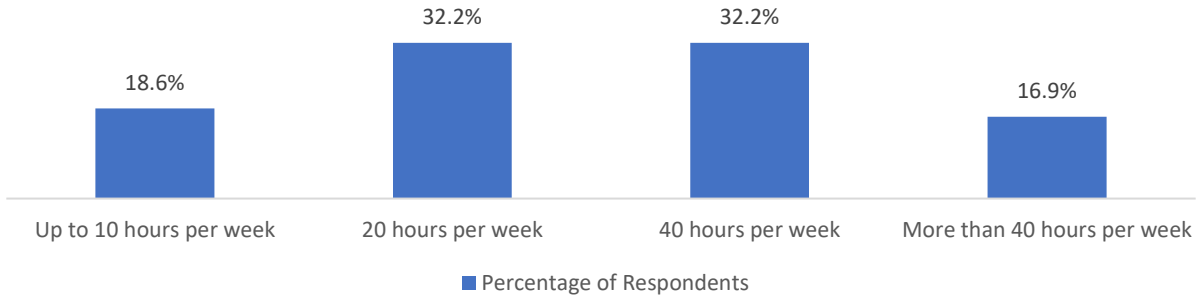


Figure 176: Does the agency where you are employed, or volunteer, utilize recovery peer support services within the services they provide in the community?

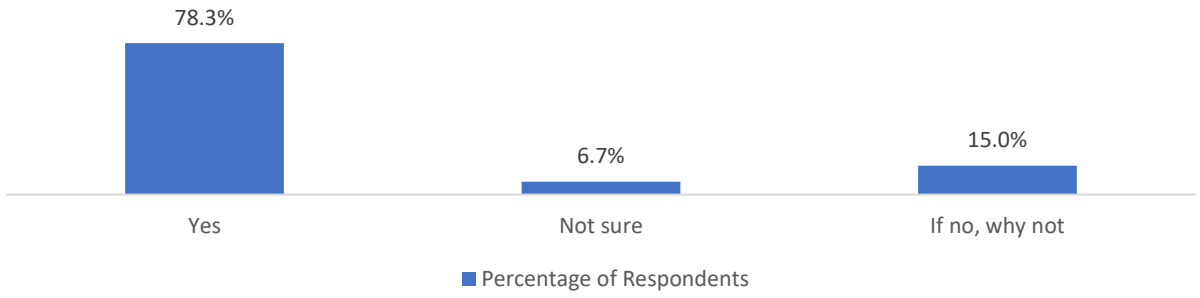


Figure 177: Does the agency where you are employed, or volunteer, adhere to recovery support best practices?

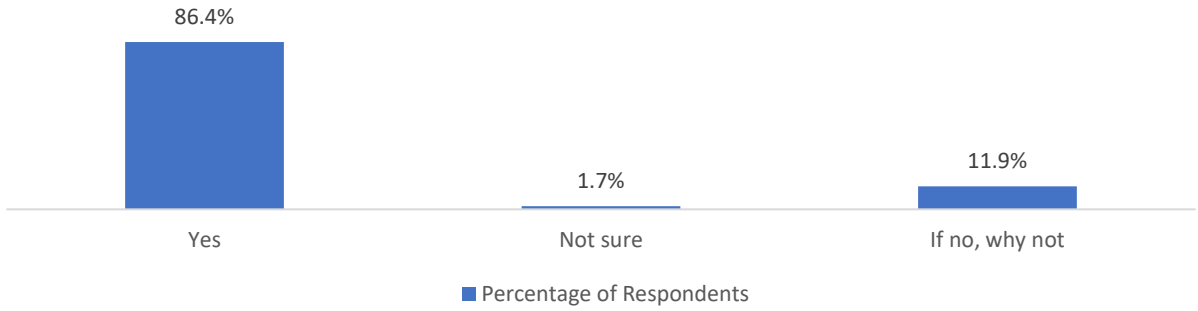


Figure 178: Please indicate the qualifications that best describe your status. (Check all that apply)

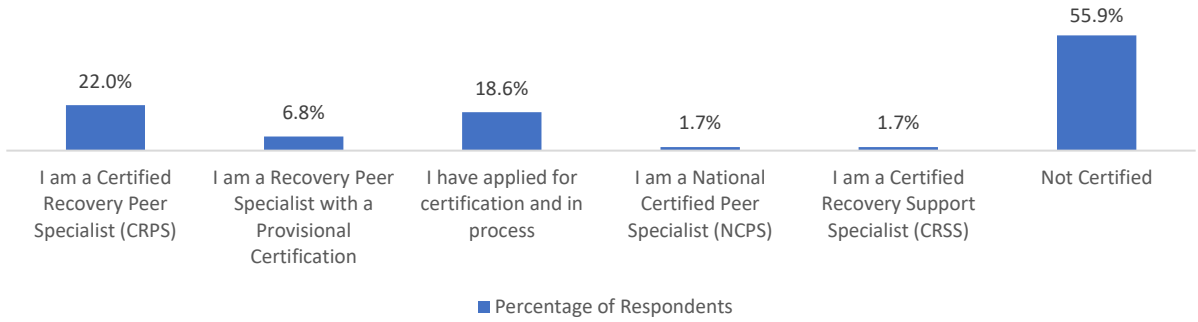


Figure 179: Please indicate the facility/program setting(s) that best describes where you deliver peer recovery support services. (Check all that apply)

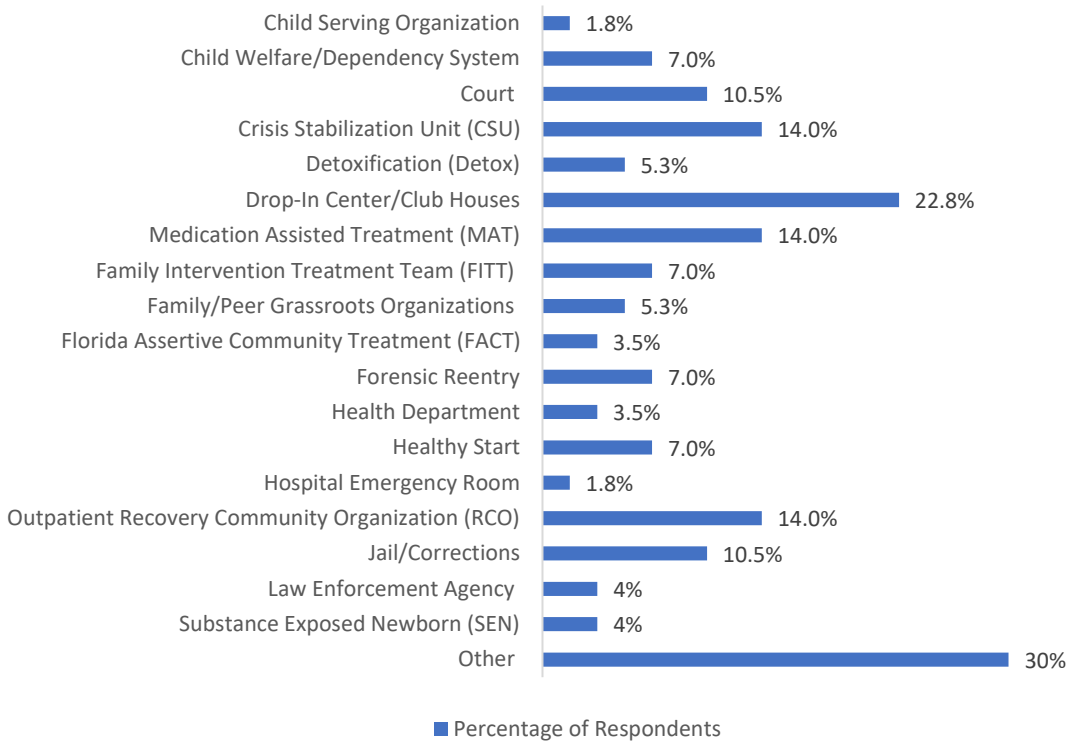


Figure 180: What are the reasons/factors for staying with the company? (Check all that apply)

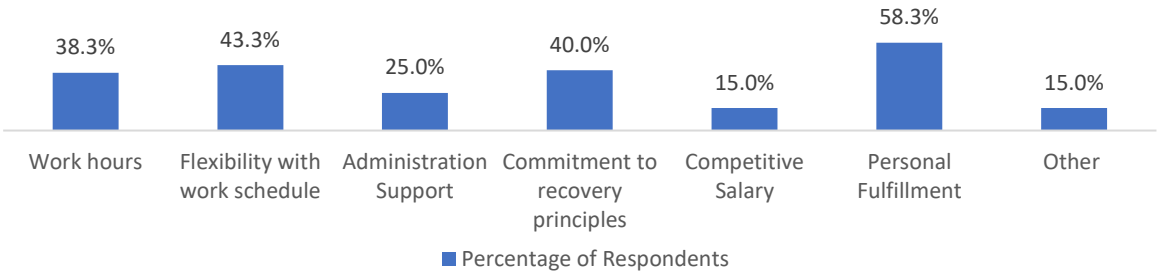


Figure 181: What barriers/challenges have you experienced in the hiring process? (Check all that apply)

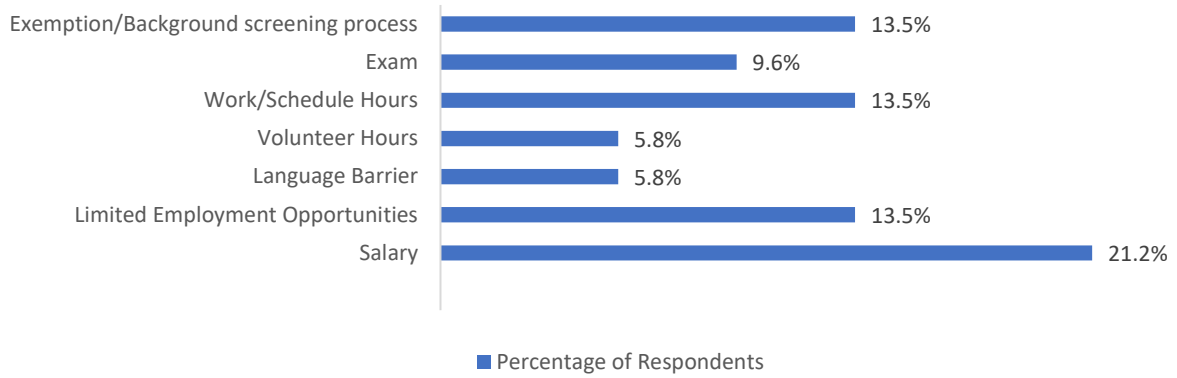
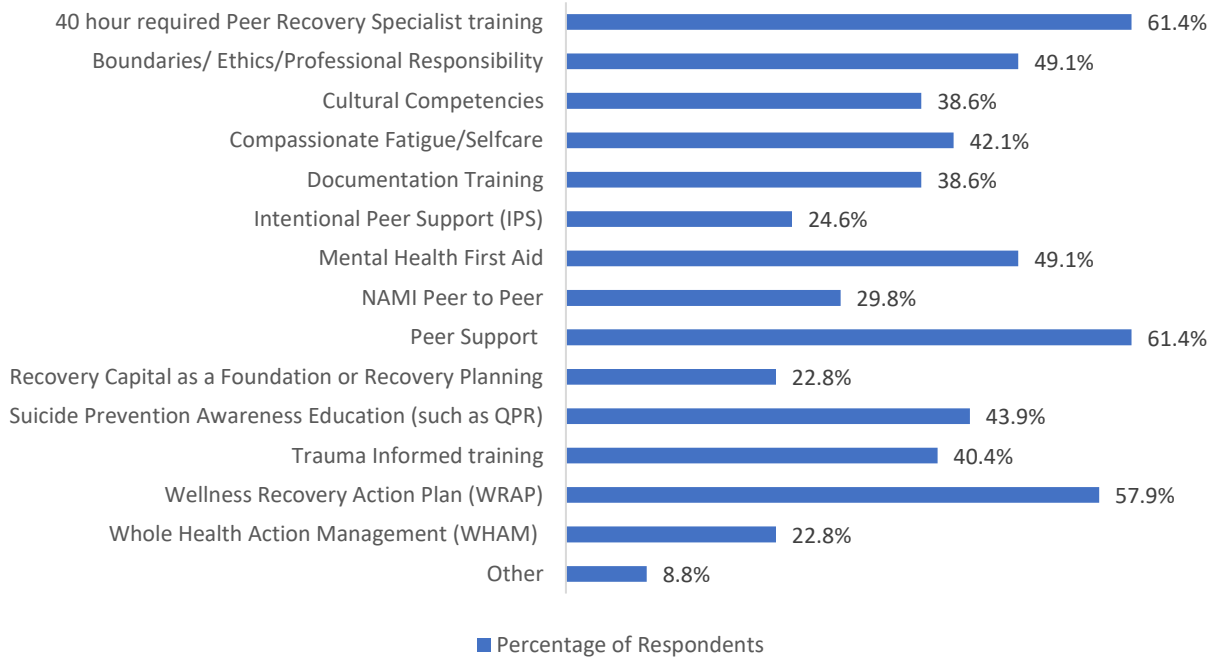


Figure 182: What training would you recommend for peers to have to help them provide peer support services? (Check all that apply)



Note: 40 hour required Peer Recovery Specialist training/Helping Others Heal

Figure 183: Are there partnerships that exist with peer support recovery programs, recovery community organizations, and other support groups?

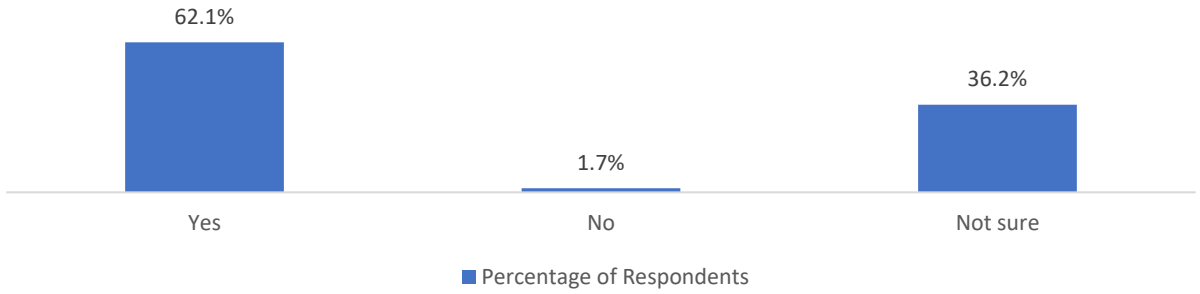


Figure 184: Are you aware of partnerships with other organizations that provide other resources such as: (Check all that apply)

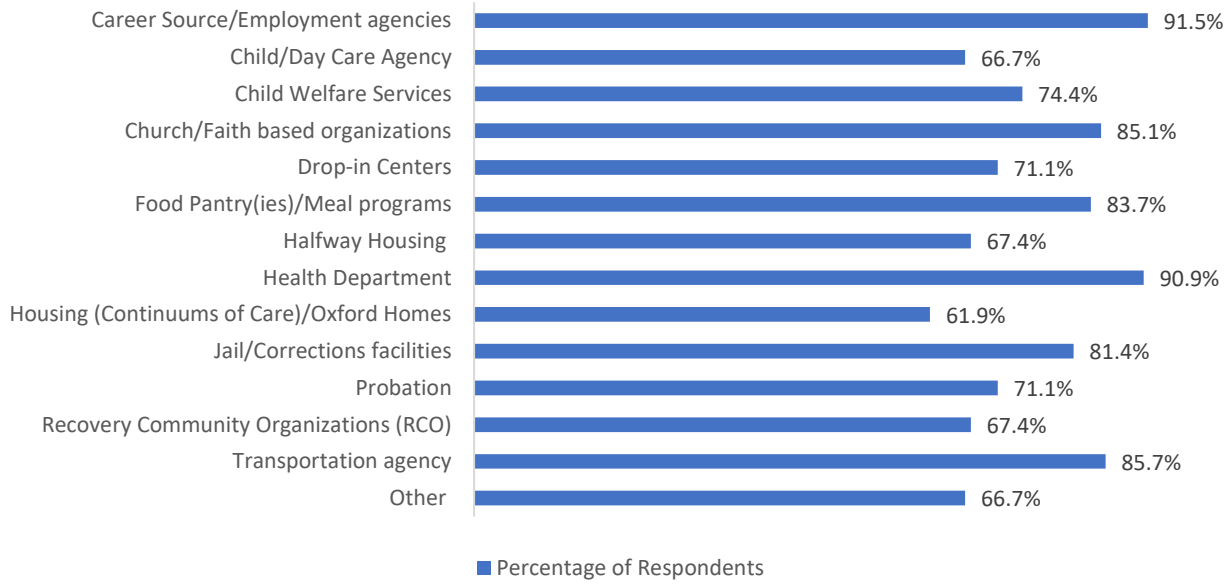


Figure 185: Do you have the ability to offer choices to the individuals where you serve at the agency you are employed/volunteer?

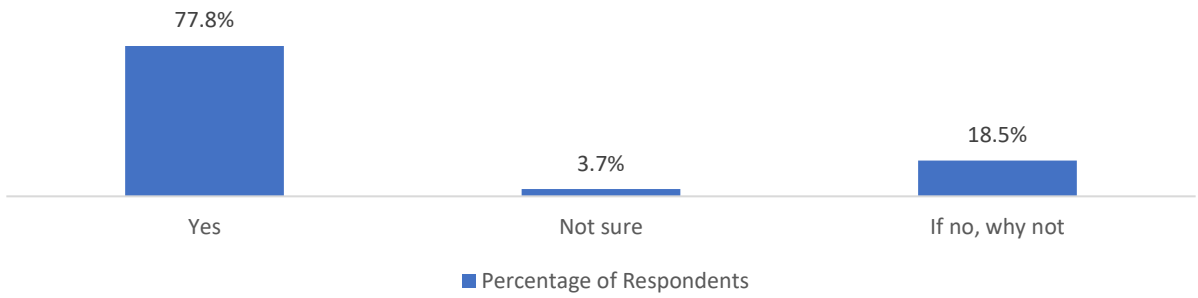


Figure 186: Does the organization where you are employed/volunteer with help to reduce stigma by promoting recovery language that is patient centered?

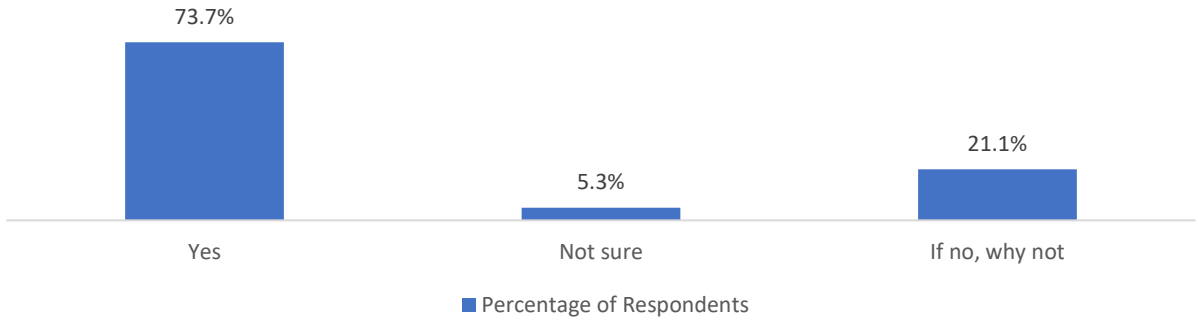


Figure 187: Does the agency where you are employed/volunteer include peers in developing and promoting effective program development, evaluation, and improvement?

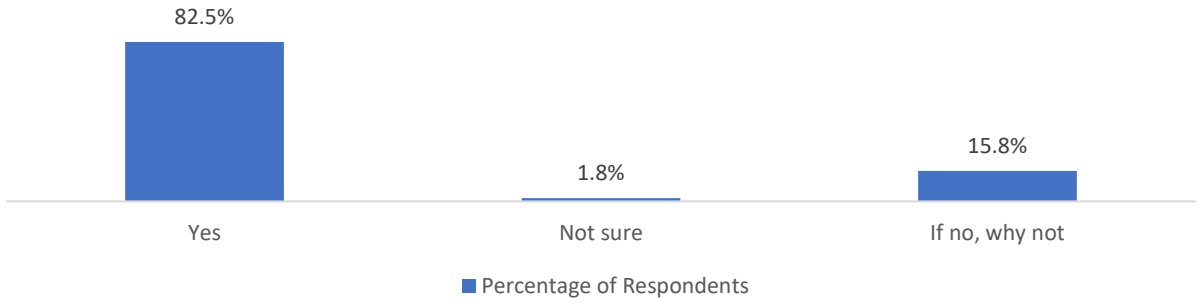
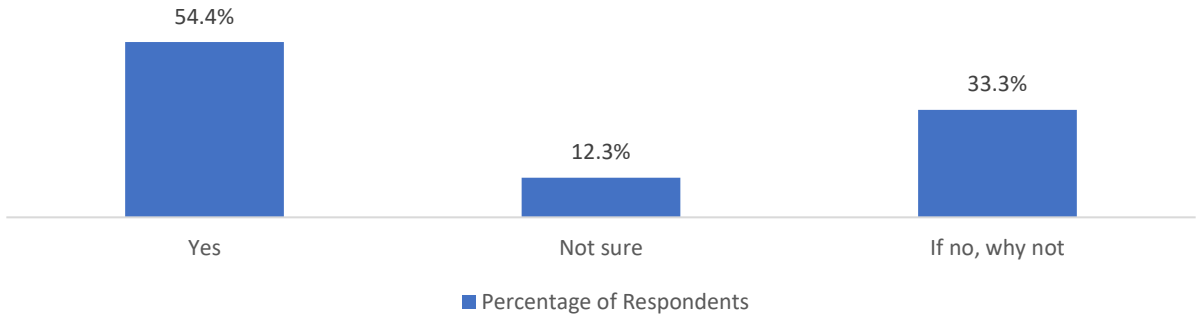


Figure 188: Does the agency where you are employed/volunteer with include persons in recovery management and board meetings?



RECOVERY ORIENTED SYSTEM OF CARE RESOURCES

Thriving Mind South Florida
RECOVERY ORIENTED SYSTEM OF CARE RESOURCES

Adaptive Fitness Center	Jackson Memorial Hospital
Advocate Program – South Dade Office	Jackson South Community Hospital
Agape Network	Jessie Trice Community Health Center
All Wellness Community Center Inc	Jewish Community Services of South Florida
Alliance for Psychological Services	Kedem Counseling Center Inc
Ascend Behavioral Health Services	Key Bridge Inc
Banyan Health Systems	Kinder in the Keys Treatment
Behavioral Aid Solutions Inc.	Kristi House Inc.
Better Way of Miami Inc.	Lower Keys Medical Center
Borinquen Behavioral Health Center	Meraki Wellness and Healing
Brave Health	Miami Dade Community Services Inc
Camillus House	Miami Dade Rehab Services Bureau
Care Resource Comm Health Centers	Miami VA Healthcare System
Catholic Charities of Miami	Millennium Clinic of Dade Inc.
Chase Center	Mobile Crisis Team in South Florida
Citrus Health Center	Morning Star Centers Inc.
Chrysalis Health	Mount Sinai Medical Center
Community Health of South Florida Inc.	National Suicide Prevention Lifeline
Compass Health Systems	New Hope CORPS

Comprehensive Psychiatric Center	New Horizons Community MH Center
Coral CMHC	Nicklaus Children's Hospital
Center for Family and Child Enrichment	Paramount Counseling Services Inc.
Dade Family Counseling CMHC Inc	PsychSolutions Inc
Douglas Gardens CMHC	Regis House
Edgar Pena LMHC CAP and Associates	Retreat Behavioral Health Service Center
Equilibrium Centro Terapeutico	Safe Future LLC
Face to Face Mental Health Servs LLC	Safe Landing
Fellowship House	Safe Landing Recovery
Global Institutes on Addictions (GIA)	Serenity Behavioral Health Services
Golden Glades Treatment Center	South Miami Recovery Inc.
Golden Palms Residential Treatment Facility	Southern Winds Hospital
Guidance Care Center Inc.	Summer House
Harbor Village, Inc.	Tamiami Wellness Club
Here's Help Inc.	Thriving Mind Consumer Hotline
Homestead Behavioral Clinic	TLC Recovery Center of South FL LLC
Improving Lives Community Mental	Total Rehab Services
Institute for Child and Family Health	Veterans Affairs Miami Medical Center
Integrity Behavioral Health LLC	West Miami CMHC Inc.
Jackson Community Mental Health Center	

Source: SAMHSA

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TO Broward Behavioral Health Coalition Inc. (BBHC) Recovery Oriented System of Care Committee, Finance Committee, Board of Directors

FROM Silvia Quintana, CEO

SUBJECT Prequalification - Jewish Adoption and Family Care Options (Eagles' Haven)

DATE August 9, 2022 – **Updated: August 10, 2022**

BACKGROUND

Jewish Adoption and Family Care Options (JAFCO) has acquired a special project appropriation ($600,000) through the Florida Legislature and the Governor's Office for Eagles' Haven Wellness Center. These funds have been added to BBHC's contract with the Department of Children and Families.

Through the Antiterrorism and Emergency Assistance Project (AEAP) grant the center was funded by the Children Services County of Broward County (CSC) at $1,200,000. CSC will continue to fund Eagles' Haven Wellness Center at $600,000.

To contract with the provider for services, BBHC requested that they complete our prequalification packet as we are required to ensure our network service providers meet contractual requirements. These prequalification documents are a necessary part of our quality assurance process (fiscal and programmatic) to ensure a successful contractual relationship with our providers and to ensure accountability, viability, and quality of services.

SUMMARY

Eagles' Haven Wellness Center offer wellness services, case management, trauma education, & crisis intervention in one nurturing setting. Community members can call or drop into the center 7 days a week, free of charge. The Eagles' Haven Navigators provide clinical assessment and crisis support to all clients while also linking families to any needed service. The Center targets anyone impacted by the shooting at Marjory Stoneman Douglas High School in Parkland, Florida in 2018. While initially aimed at students, parents and teachers in the Parkland/Coral Springs community, the center has expanded to serve anyone suffering from trauma related to the shooting or otherwise.

RECOMMENATION

It is being recommended that Jewish Adoption and Family Care Options (JAFCO) be added to the BBHC Provider Network, with the following conditions:

1. JAFCO submits a budget for $1.2 Million for Eagles' Haven
2. JAFCO submits quarterly Return on Investment Reports
3. At the end of the year, JAFCO submits a Financial Audit

TO: Broward Behavioral Health Coalition Inc. (BBHC) Recovery Oriented System of Care Committee, Finance Committee and Board of Directors

FROM: Silvia Quintana, CEO

SUBJECT: Proposed Uncompensated Units Purchase

DATE: August 9, 2022

SUMMARY

Table 1 (BBHC Uncompensated Units Purchase) shows the proposed distribution of uncompensated funds to network providers for services rendered during FY21-22.

BBHC Uncompensated Units Purchase		
Providers	**Services Purchased**	
Henderson Behavioral Health, Inc	$	350,000
Memorial Healthcare System	$	350,000
South Florida Wellness Network Inc.	$	350,000
United Way of Broward County Inc.	$	350,000
Archways, Inc	$	338,171
Banyan Health Systems	$	276,430
House of Hope, Inc	$	268,439
Broward Health	$	258,983
Care Resource	$	183,331
The Village South	$	57,482
211 Broward via the United Way of Broward County	$	50,543
Fort Lauderdale Hospital	$	46,500
Foot Print to Success Clubhouse, Inc.	$	43,743
Gulf Coast Jewish Family & Community Services, Inc.	$	42,033
Broward County Addiction Recovery Center- BARC	$	31,514
NAMI Broward County, Inc.	$	30,825
Broward County Sheriff's Office	$	28,222
Broward Housing Solutions	$	24,291
Broward House Inc.	$	13,026
Silver Impact, Inc	$	12,148
Broward County Elderly & Veterans Services Division	$	10,702
Task Force Fore Ending Homelessness, Inc.	$	1,830
Grand Total	**$**	**3,118,213**

Table 2 (**Purchase of Services**) shows the list of services purchased from network services providers delivered during FY21-22.

Purchase of Services	
Service Type	**Purchased Amounts**
Ambulatory/Community Services (Non-24 Hour Care)	$ 1,372,508
Residential Services (24 Hour Care)	$ 849,460
Detoxification Services	$ 546,246
Prevention Services	$ 350,000
Grand Total	**$ 3,118,213**

Table 3 (**Funds Returned to DCF**) shows the funds that were not utilized by the providers during FY21-22. These are federal funds so they cannot be carried forward to be utilized during FY22-23.

Funds Returned to DCF

OCA Code	OCA Titles	Returned Funds
MS922	FY22 ME Broward Health - Integrated Medication Assisted Treatment Response	$393,152
MSSM3	FY22 ME State Opioid Response SVCS-MAT - Year 3	$371,702
MH0BN	FY22 ME MH Title XXI Children's Health Insurance Program (Behavioral Health Network)	$226,190
MS023	FY22 ME SA HIV Services	$177,068
MHCAS	FY21 ME Children's Care Coordination – CARES ACT-Direct Client Services	$132,289
MSTVS	FY22 ME SA Transitional Vouchers SAPT Supplemental 1	$96,056
MSSM2	FY22 ME State Opioid Response SVCS-MAT - Year 2	$64,673
MSSP3	FY22 ME State Opioid Response Disc Grant SVCS-Prevent - Year 3	$9,816
	Total	**$1,470,945**

RECOMMENATION

It is being recommended that the BBHC Board of Directors approve the proposed distribution of funds to network providers for uncompensated services, based on the above information.