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BROWARD BEHAVIORAL HEALTH COALITION

Broward County, Florida

Community Behavioral Needs and Gaps Assessment

2025

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Executive Summary

The 2025 Broward Behavioral Health Community Needs and Gaps Assessment presents a comprehensive, evidence-based analysis of the county's behavioral health service delivery system. Conducted by the Broward Behavioral Health Coalition (BBHC), the state-designated managing entity for Broward County, this assessment draws upon longitudinal service utilization and waitlist data (2018–2024), integrated demographic and geographic analyses, and a robust participatory research process involving over 300 stakeholders. These included individuals with lived experience, peer specialists, family members, service providers, community leaders, and system administrators. The findings reflect a system that has made marked progress in alignment with recovery-oriented and culturally responsive principles but remains constrained by structural fragmentation, fiscal instability, and intensifying demand.

Broward County is home to nearly two million residents and is one of the most racially, ethnically, and linguistically diverse communities in the state. Its population is also characterized by deep disparities in income, insurance coverage, housing stability, and access to transportation, all of which shape behavioral health needs and access. BBHC oversees a network of 58 contracted providers delivering services across a continuum that includes prevention, outpatient treatment, care coordination, residential care, crisis stabilization, peer support, and other support services. While the geographic distribution of services has improved, gaps in access remain particularly pronounced for Hispanic and Haitian Creole-speaking communities, children under the age of 10, older adults, and individuals with co-occurring mental health and substance use disorders.

System utilization data reveal that adults with mental health diagnoses comprise 58% of all persons served across the network. Despite the implementation of several promising initiatives, such as mobile response teams, multidisciplinary coordination calls, and peer-led recovery hubs, waitlists remain, housing gaps continue to impede service transitions, and referral pathways are often confusing or inconsistent. The average wait time for adult outpatient behavioral health services exceeded 27 days in 2024, an increase from prior years that reflects the reduction of the Substance Abuse and Mental Health Supplemental Block Grant, along with an increased demand and workforce attrition.

The system has shown resilience in the face of substantial external shocks, particularly during and following the COVID-19 pandemic. Providers transitioned rapidly to telehealth platforms, and BBHC supported innovations in care coordination and community outreach. Yet the pandemic also exposed systemic vulnerabilities. Provider agencies reported staff turnover and burnout, and financial instability as service volume and acuity increased while reimbursement lagged from funding sources other than BBHC. The pandemic's disruption was compounded by long-standing challenges in the behavioral health workforce, including low compensation, limited advancement pathways, and stringent background screening requirements that disproportionately affect peer specialists and justice-involved individuals.

Stakeholder engagement in 2025 confirmed the system's philosophical alignment with recovery-oriented values but underscored barriers to operationalizing those values consistently across

agencies. Peer support was widely praised as a transformative component of the system, resulting in focus groups and survey data revealing insufficient peer capacity as compared to demand. Cultural mismatch between providers and service recipients was cited as a leading cause of treatment disengagement, especially among Black and Hispanic participants. Nearly 40% of survey respondents reported that they had dropped out of services due to feeling disrespected or misunderstood by providers, and a lack of multilingual service access remains a barrier for segments of the population.

One of the most urgent challenges identified in this assessment is the lack of affordable, recovery-oriented housing for individuals with behavioral health needs. From 2018 to 2024, Broward experienced an 18% increase in unsheltered homelessness, with more than 30% of this population meeting criteria for chronic behavioral health conditions. Stakeholders repeatedly described individuals being discharged from crisis units, jails, or detox centers into homelessness or unstable temporary housing due to the limited access to transitional or supported living options. These housing deficits result in avoidable recidivism, treatment non-adherence, and family separation, particularly for women on MAT and justice-involved parents. Providers and peers alike emphasized that without stable housing, behavioral health interventions often fail to achieve durable recovery outcomes.

Layered atop these longstanding system challenges is the destabilizing impact of recent federal legislation that has altered Medicaid eligibility and reduced Affordable Care Act (ACA) premium subsidies. In Broward County, estimates indicate that between 140,000 and 160,000 residents could lose Medicaid coverage, while an additional 25,000 individuals may be priced out of ACA marketplace plans in the coming three years. These changes are expected to significantly increase the demand for services, lengthen waitlists, and overwhelm the safety-net provider system funded by BBHC. The county's behavioral health infrastructure will be at risk of pushing beyond capacity.

The 2025 Needs Assessment offers a clear and urgent call to action. While the system has demonstrated innovation, adaptability, and a shared commitment to recovery, it requires structural realignment and strengthened interagency coordination to fulfill its potential. Recommendations outlined in the report include: developing a centralized digital referral and care navigation platform; expanding crisis and forensic diversion infrastructure; investing in patient-centered, responsive and linguistically accessible services; enhancing reentry and recovery housing; implementing urgent care alternatives for youth; strengthening the recovery-oriented system of care (ROSC) framework; supporting peer workforce development; and building geriatric behavioral health capacity; and explicitly addressing the behavioral health needs of individuals who will lose insurance coverage due to federal policy changes.

In conclusion, the 2025 Community Behavioral Health Needs Assessment confirms that BBHC has made significant gains in access, alignment, and engagement, even in the face of formidable structural challenges. Strategic and sustained investment, particularly in workforce, housing, and cross-system care coordination, will ensure that the system remains resilient to ongoing service disruptions. BBHC and its provider network remain uniquely positioned to lead the next phase of system transformation, grounded in recovery, resilience, and community partnership. This

assessment serves not only as a reflection of where the system has been, but as a roadmap for where it must go to ensure that every person in Broward County can access high-quality, person-centered, responsive, and recovery-aligned behavioral health care.

Introduction

History

In 2008, the Florida Legislature established a Managing Entity pilot program to enhance accountability for the state's funding of substance abuse and mental health services and improve the overall behavioral health system of care. The pilot produced positive outcomes by addressing the community's needs. Due to this success, the model was implemented statewide in 2013, creating seven Managing Entities (MEs) across Florida. These MEs continue to effectively manage the care system by increasing service capacity, ensuring access to quality care, and serving as responsible stewards of state funding. The Florida Association of Managing Entities (FAME) is a statewide organization representing Florida's seven behavioral health managing entities, guiding, administering, and ensuring accountability for the federal, state, and local funding that supports a network of over 300 behavioral health providers. FAME's mission is to advance the recovery of individuals and their families, enabling them to live healthy lives to their fullest potential. The Broward Behavioral Health Coalition (BBHC) is the Managing Entity serving Broward County.

In 2016, the Florida Legislature required managing entities to conduct a triennial needs assessment, as specified in Florida Statute 394.9082 (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, identifying needs by subregion. The process for conducting the needs assessment shall include opportunities 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. Additionally, the assessment shall include a list and descriptions of any gaps in the service arrays for children or adolescents identified under s. 394.4955, along with recommendations for addressing such gaps.*

This report outlines the data collection methodology and analysis, identifying community behavioral health needs and gaps in 2025. The report is divided into two main sections, with the first presenting the data components for 2025 as listed 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 and Focus Group Results
- No Wrong Door Survey and Focus Group Results
- Provider Focus Group Results
- Consumers Served Survey and Focus Group Results
- Stakeholder Survey and Focus Group Results
- Recovery Community Peer Support Specialists Survey and Focus Group Results

The second major section of the report presents a trend analysis of the past 10 years of community behavioral health data from Broward County. This analysis aims to identify trends in demographic profiles, project costs, and service needs to support community planning.

Methodology

Using the components from previous needs assessments as a foundation for the 2025 behavioral health assessment project, each element was thoroughly reviewed to ensure that the most relevant data were collected, analyzed, and reported accurately:

- A demographic profile was created for the BBHC service area. This profile included the most recent data on racial and ethnic composition, age range, educational attainment, employment, and Federal Poverty Level (FPL) status. Indicators were presented as population percentages and compared to the state, as well as Miami-Dade and Palm Beach Counties, when available. This allowed for direct comparisons between the general population and those served by BBHC. Data was sourced from the U.S. Census Bureau American Community Survey (ACS).

- A general health assessment was conducted to present the overall health status of the BBHC service area. The state Behavioral Risk Factor Surveillance System (BRFSS) data, child abuse rates, serious mental illness, and disability rates were collected from FLHealthCHARTS.gov. Crude death rates for Broward County were calculated using vital statistics data available from FLHealthCHARTS.gov. Domestic violence offenses were reported by the Florida Department of Law Enforcement's Uniform Crime Report.

- A demographic profile of BBHC clients was created for the service area. BBHC provided de-identified client data, categorized by demographic component and program, to the evaluation staff for analysis. The client data related to FY23-24.

- A profile of the homeless population was created using state and local data available through the Department of Children and Families (2024).

- A profile of a homeless BBHC client was created for the service area. BBHC provided de-identified data on homeless clients, categorized by demographic components and programs, to the evaluation staff for analysis. The client data pertains to FY23-24.

- Descriptions of cost centers, expenditures, and over/underproduction for the BBHC services area (FY23-24) were provided.

- The Cultural Health Disparity Survey included 14 questions, covering demographics. The Individuals Served Survey was distributed to all BBHC contracted providers for sharing with their clients. The surveys were available in the field for 5 weeks via an electronic link and a QR code that could be emailed, texted, printed, or posted on social media. The surveys were translated into three languages: English, Spanish, and Creole. Evaluation staff analyzed the results, and they conducted Consumer Focus Groups. BBHC identified the participants for these groups, with three focus groups held in total.

- The No Wrong Door (NWD) Survey was distributed to BBHC providers, who 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 evaluator analyzed the survey results, and evaluation staff organized a BBHC Provider Focus Group to further explore the No Wrong Door survey findings.

- BBHC distributed the Stakeholder Survey to gather responses from stakeholders across various community sectors. The survey was open for 5 weeks and could be accessed through an electronic link and QR code, which could be emailed, texted, printed, or shared on social media. The evaluator analyzed the data and reported the findings. During a focus group with the Recovery-Oriented System of Care subcommittee representing community stakeholders, information was gathered to gain a better understanding of the survey results.

- BBHC distributed the Recovery Community Peer Support Specialist Survey to its peer support service providers. The survey was conducted over five weeks and was accessible through an electronic link and QR code that could be emailed, texted, printed, or shared on social media. It was translated into three languages: English, Spanish, and Creole. The evaluator analyzed the survey results. During a focus group meeting, peer specialists identified recovery resources, needs, and gaps for support.

Data Notes

Some data limitations were encountered during the assessment process. We believe these limitations did not compromise the integrity of the assessment, but they should be disclosed to the reader when generalizing the results to a larger population.

- Although BBHC client data was unduplicated, a small number of clients received services from multiple programs, reported living in several counties, and indicated having more than one gender, age, or residential status. In total, these duplications accounted for less than one percent of all clients.

- The estimated number of adults who are seriously mentally ill and emotionally disturbed was provided by FLHealthCHARTS.com and is 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 that can hinder the collection of information necessary for future planning and policymaking. Throughout the year, providers and stakeholders are surveyed by funders, community partners, program management, public health agencies, schools, local government, and faith-based organizations, to name just a few. Many surveys are often redundant, and the questions tend to overlap. Respondents frequently feel weary of this process, which consumes valuable time, yet the direct benefits may not be recognized for several years. Every effort has been made to streamline survey design while keeping it relevant to the assessment requirements defined by BBHC. Distribution was managed by BBHC staff and their community stakeholders.

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2025 Broward County, Florida Service Area Demographics and Behavioral Health Services Utilization

BBHC Service Area Demographics

Population Demographics

Broward County, a vibrant coastal center in South Florida, is home to a significantly diverse population that continues to evolve considerably. According to the 2023 American Community Survey (ACS), Broward's population was recorded at **1,962,531**, with **projections for 2024 indicating an increase to 1,974,000** (Cubit Planning, 2025). This annual growth rate of 0.8% is notably less than Florida's overall migration-driven increase of 6.7% (U.S. Census Bureau, 2023), signifying Broward's status as a mature urban-suburban county characterized by high population density.

Regarding gender demographics, females account for **51.3%** of the population, surpassing Florida's statewide average of 50.7%. Males comprise the remaining **48.7%.** The median age in Broward County stands at 41.5 **years**, which is slightly lower than Florida's median age of **42.8 years. This** demographic suggests a relatively younger workforce than the adjacent Miami-Dade County, where the median age is 41.8 years. Conversely, Broward exhibits an older population relative to Palm Beach County, which has a median age of 45.2 years (ACS, 2023). Significantly, **16.5%** of residents in Broward are aged 65 and over, as opposed to **21.1% statewide; additionally**, **22.3% of the population falls** under 18. The consistent yet modest increase in senior and youth demographics highlights the imperative need for simultaneous investments in geriatric behavioral health services and youth mental health prevention programs.

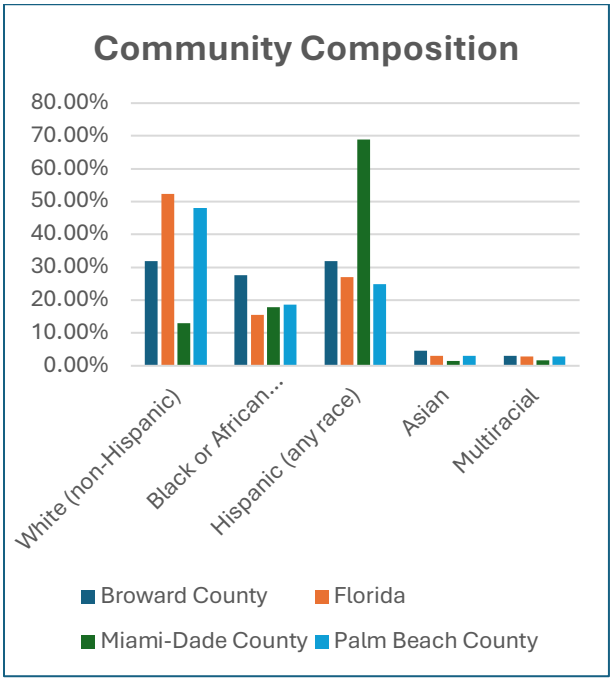
Category	Broward County	Florida	Miami-Dade County	Palm Beach County
2023 Population	1,962,531	22,590,000	2,673,837	1,543,912
2024 Estimate	1,974,000	22,950,000	2,695,000	1,560,000
Female (%)	51.3%	50.7%	51.5%	51.2%
Males (%)	48.7%	49.3%	48.5%	48.8%
Median Age (Years)	41.5	42.8	41.8	45.2
% Under 18	22.3%	20.4%	21.0%	19.2%
% Age 65+	16.5%	21.1%	17.5%	24.0%

Sources: ACS, 2023; Cubit Planning, 2025; U.S. Census Bureau, 2023.

Race and Ethnicity

Broward County's racial and ethnic composition constitutes a vibrant tapestry of cultures, effectively distinguishing it from the broader demographic profile of Florida. **As of 2023, the county comprises 31.9% White (non-Hispanic), 27.6% Black (non-Hispanic), 4.5% Asian, 3.0% multiracial, 0.3% American Indian, and 0.2% Native Hawaiian, with 31.9% of residents identifying as Hispanic (any race)** (ACS, 2023). Florida's demographic profile for 2023 was 52.3% White (non-Hispanic), 15.6% Black, and 27.1% Hispanic (ACS, 2023). Preliminary estimates for 2024 suggest that Broward's Hispanic population may have increased to 32.5% (Cubitt Planning, 2025), driven by ongoing migration from Latin America and the Caribbean. Miami-Dade County has a higher Hispanic population, at **69%**, while Palm Beach County reflects Broward's trends but has a slightly larger portion of White non-Hispanic residents, making up **48%**.

The racial and ethnic diversity present in Broward underscores the imperative need for a behavioral health system that is culturally and linguistically responsive. This system must provide Spanish, Haitian Creole, and Portuguese services while addressing the historical barriers Black, Haitian, and Caribbean communities encounter.



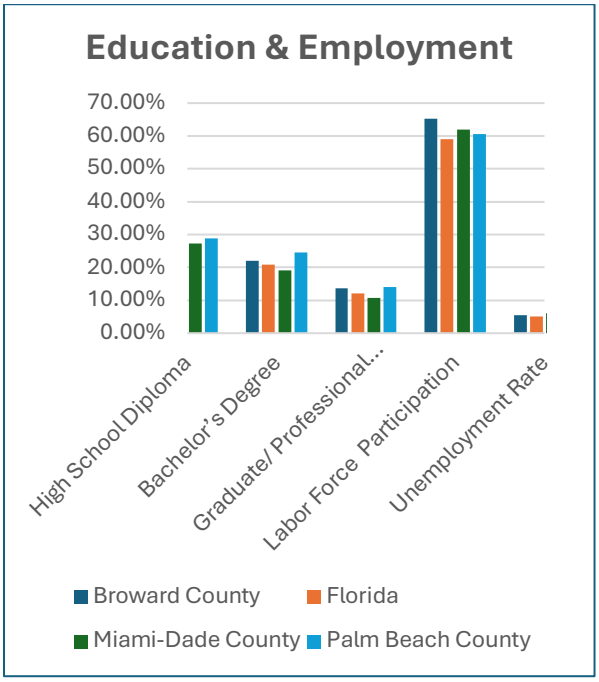
Sources: ACS, 2023; Cubit Planning, 2025.

Education and Employment

Broward County's educational attainment exceeds the average levels observed throughout Florida. According to data from the American Community Survey (ACS, 2023), this trend is particularly evident among residents aged 25 and older.

- 29.8% hold a high school diploma
- 22.7% have some college but no degree
- 22.1% possess a bachelor's degree
- 13.6% hold a graduate or professional degree

This comparison proves to be favorable when juxtaposed with the overall conditions of Florida, particularly with Miami-Dade County, where bachelor's degrees are recorded at a mere 19.2%, and Palm Beach County, which registers at 24.5% (ACS, 2023). The labor force participation in Broward remains robust at 65.2%, in contrast to the statewide figure of 59.1%. As of late 2023, the unemployment rate in Broward stood at 5.4%, slightly higher than the Florida average of **5.1%** but significantly lower than the 6.1% indicated for Miami-Dade.



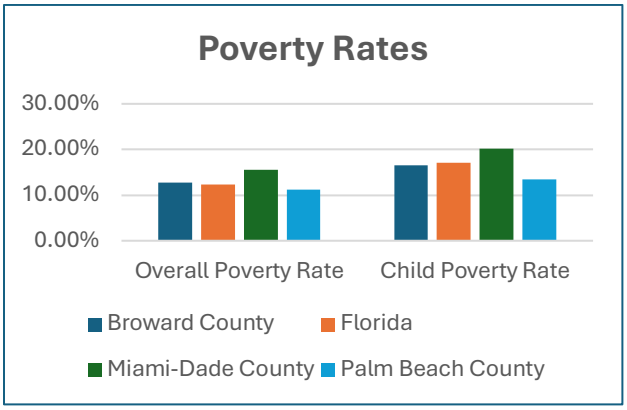
Sources: ACS, 2023; BLS, 2024.

Poverty Status

In 2023, the median household income in Broward County achieved a total of **$74,531**, which is marginally higher than Florida's median of **$73,311**. The per capita income recorded was **$42,074** (ACS, 2023). However, poverty continues to be a considerable factor influencing behavioral health needs in Broward County, affecting

12.7% of the population, which equates to 247,223 individuals. This includes a disproportionately affected 16.5% of children, surpassing Florida's overall poverty rate of **12.3%** (ACS, 2023). The economic conditions—characterized by stable employment for some in contrast to the precarious financial circumstances faced by others—play a pivotal role in fostering stress, anxiety, and substance use, particularly among families with low income.

The overall poverty rate in Broward County is comparable to the state of Florida's rate of **12.3%;** however, it remains lower than that of Miami-Dade County, which is recorded at **15.5%.** In contrast, Palm Beach County exhibits a marginally lower poverty rate of **11.2%** (ACS, 2023). Economic insecurity exacerbates access disparities in behavioral health services, particularly among uninsured and minority communities.

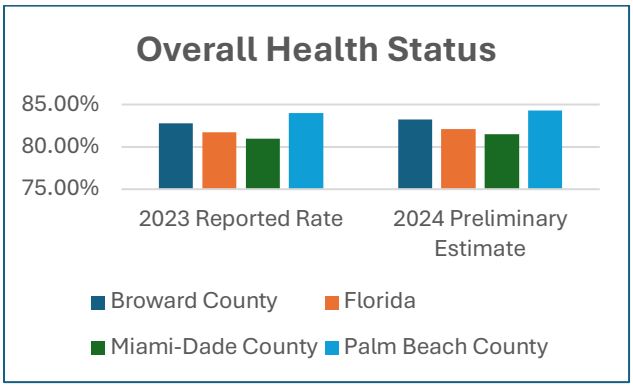


Source: ACS, 2023.

BBHC Service Area General Health Status Profile

Overall Health Status

Many residents in Broward County express favorable perceptions of their health. As of 2023, **82.8%** of adults aged 18 to 64 have assessed their health as "good," "very good," or "excellent," in comparison to Florida's **81.7%** (Behavioral Risk Factor Surveillance System [BRFSS], 2023). Preliminary data for 2024 indicate a slight increase to **83.2%** for Broward residents (BRFSS, 2024). These figures are comparable to those of Palm Beach County **(84.0%)** and marginally higher than those of Miami-Dade County **(81.0%)**. Notwithstanding this optimistic outlook, disparities remain evident. Lower-income, Black, Hispanic, and uninsured populations are considerably more likely to report adverse health outcomes. The ongoing socioeconomic and racial disparities imply that systemic barriers, including limited access to primary care, transportation, and culturally appropriate services, continue to inhibit equitable health outcomes (CDC, 2023)



Mental Health

Mental health in Broward County represents a narrative of advancement, albeit counterbalanced by escalating demands. In 2023:

- **89.5%** of adults reported experiencing good mental health (BRFSS, 2023).

- The average number of unhealthy mental health days per month was **3.4** in Broward, compared to **4.2** statewide.

This comparatively strong performance masks growing concerns:

- Serious Mental Illness (SMI) was estimated to affect approximately **63,100 adults** in 2023 (Substance Abuse and Mental Health Services Administration [SAMHSA], 2023).
- Projections suggest this figure will rise to **65,000 adults** in 2024 (United Way of Broward, 2024).

Among youth, emotional disturbances increased by **1.7%** through 2023, with **0.4%** of K–12 students formally recognized as having emotional or behavioral disabilities in 2024, closely corresponding with state figures (Florida Department of Health [DOH], 2023; Florida Department of Education [FLDOE], 2024).

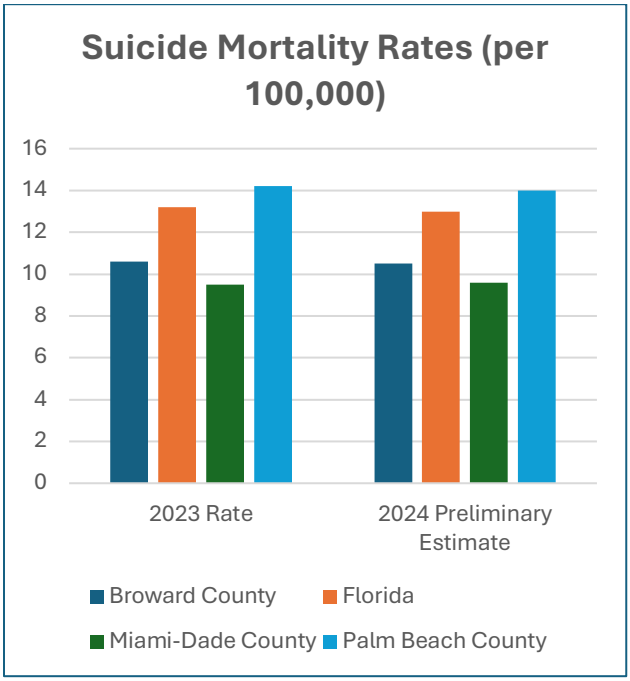
Mental Health Indicators	Broward County	Florida	Miami-Dade County	Palm Beach County
Adults Reporting Good Mental Health	89.5%	87.1%	88.3%	90.2%
Avg. Unhealthy Mental Health Days	3.4	4.2	3.7	3.3
Estimated Adults with SMI (2024)	65,000	N/A	79,000	55,000

Sources: BRFSS, 2023/2024; SAMHSA, 2023; United Way of Broward, 2024.

Suicide

The suicide rates in Broward County indicate a slight reduction; however, they continue to pose a substantial concern within the realm of behavioral health. Specifically, Broward County's crude suicide mortality rate has decreased from **11.4 per 100,000** in 2020 to **10.6 per 100,000** in 2023 (Florida DOH, 2023). Preliminary data for 2024 suggests stabilization at approximately **10.5 per 100,000**. In contrast, Florida's statewide suicide rate was recorded at **13.2 per 100,000** in 2023, while Miami-Dade County reported **9.5 per 100,000**, and Palm Beach County indicated a higher rate of **14.2 per 100,000**. Disparities continue to exist:

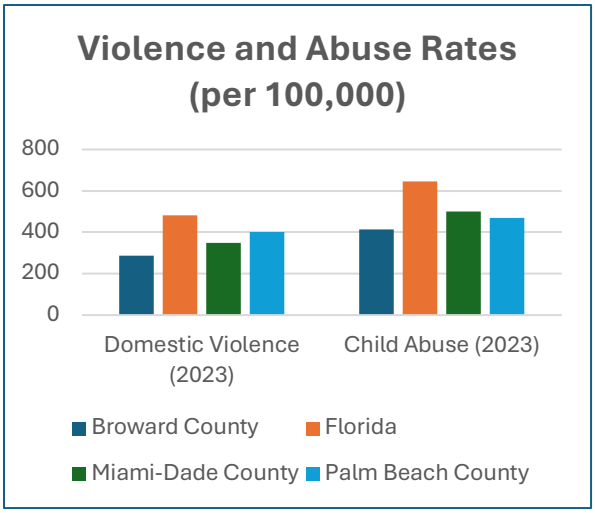
- Males in Broward are **3.6 times** more likely to die by suicide than females.
- White residents have suicide rates **four times** higher than Black residents.



Sources: Florida DOH, 2023/2024.

Violence and Abuse

The incidence of violence and abuse within Broward County has undergone a decline; however, it continues to pose a significant concern regarding public health. **Domestic violence offenses have** decreased from **293.5 per 100,000 individuals** in 2019 to **287.8 per 100,000 individuals** in 2023 (Florida Department of Law Enforcement [FDLE], 2023). Additionally, child abuse rates have diminished from **430.5 per 100,000 individuals** in 2019 to **412.7 per 100,000 individuals** in 2023, with projections indicating a further decline in 2024. Compared with regional counterparts, Broward's domestic violence rate is considerably lower than that of Miami-Dade County, which stands at **350.2 per 100,000 individuals** and is significantly lower than Palm Beach County's rate of **400.1 per 100,000 individuals** (FDLE, 2023).



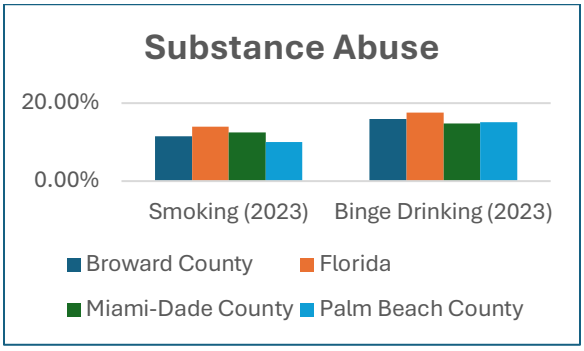
Sources: FDLE, 2023/2024; Florida DCF, 2023/2024.

Mental Illness

The burden of serious and persistent mental illness (SMI) remains significant across Broward County. In 2023, approximately **63,100 adults** were living with SMI, including schizophrenia, bipolar disorder, and major depressive disorders (SAMHSA, 2023). Projections indicate that this figure will rise to nearly **65,000 adults** in 2024 (United Way of Broward, 2024). Comparatively, Miami-Dade County had an estimated 79,000 adults with SMI, while Palm Beach County reported 55,000 cases. Driving factors include rising economic stressors, post-pandemic social isolation, and persistent stigma limiting timely engagement in mental health treatment.

Adult Tobacco and Alcohol Use

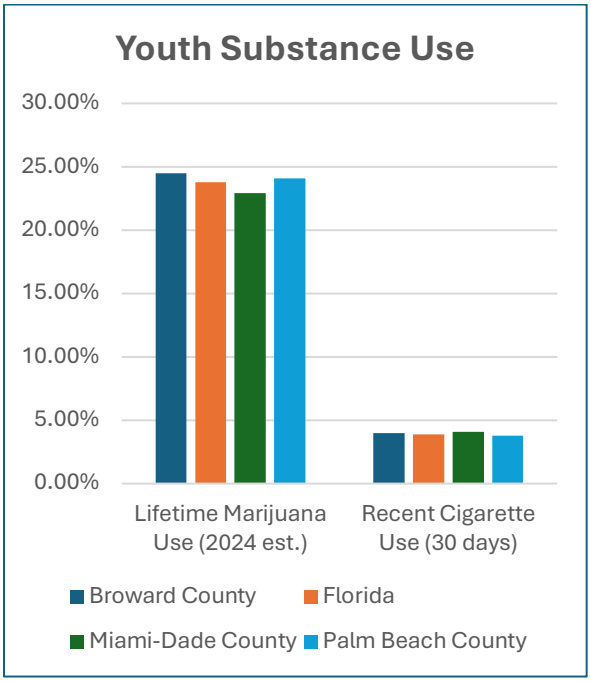
Behavioral health risk factors, including tobacco use and excessive alcohol consumption, exhibited a gradual decline; however, they remain prevalent. In 2023, nearly 12% **(11.5%)** of adults in Broward County identified as current smokers, a figure lower than the state average of 13.9% for Florida (BRFSS, 2023). Preliminary estimates for 2024 indicate a further decline to **11.2%**. Smoking rates in Broward County are lower than those in Miami-Dade County **(12.5%)** but slightly higher than those in Palm Beach County **(10.1%)** (BRFSS, 2023). Furthermore, **16.0%** of adults reported engaging in binge drinking in 2023, which decreased to **15.8%** in 2024.



Sources: BRFSS, 2023/2024.

High School Tobacco, Alcohol, and Substance Use

Substance use among youth in Broward County reflects national and state trends, highlighting a decline in tobacco and alcohol consumption alongside an increase in marijuana experimentation. By 2022, **93.4%** of middle and high school students in Broward reported never having smoked cigarettes (Florida Youth Substance Abuse Survey [FYSAS], 2022). However, lifetime marijuana use among youth rose from **23.0%** in 2022 to a projected **24.5%** in 2024 (FYSAS, 2024). Conversely, the rates of alcohol abstinence improved, with lifetime alcohol abstinence climbing to **71.5%, an increase** from 69% in 2020, and the 30-day alcohol abstinence rate reaching **84.5%**. The rising prevalence of youth marijuana use remains a significant concern, influenced by emerging legalization trends and evolving social norms. Broward County, like Florida and the nation, has seen an increase in adolescent vaping of nicotine and/or marijuana. Results indicate that adolescent vaping decreased among high school youth in Broward from 8% to 6%. The data suggests that 68% of Broward youth who vape nicotine also vape marijuana, and 59% of students who vape marijuana also vape nicotine. Interestingly, the majority of students who vape nicotine do not transition from smoking cigarettes; their vaping is independent of cigarette use. Only 4% of Broward County students in 2024 who vaped nicotine also smoked cigarettes (FYSAS, 2024).



Sources: FYSAS, 2022/2024.

Disability

As of 2023, 10.8% of the non-institutionalized population in Broward County reported living with a disability (ACS, 2023). This rate is significantly lower than the overall disability prevalence of 13.5% in Florida. Additionally, Palm Beach County indicates a slightly higher disability rate at 11.2%, while Miami-Dade County exhibits a lower rate at 9.4%. Disabilities commonly hindering access to behavioral health services encompass mobility impairments, cognitive challenges, and chronic mental health conditions, which frequently necessitate specialized intervention strategies.

Health Insurance Coverage

Insurance coverage continues to influence access to behavioral health services within Broward County. In 2023, **86.2%** of adults

aged 18 to 64 in Broward were insured (ACS, 2023). Most insured adults possessed employer-based coverage, amounting to 41%, followed by Medicaid at 14.5% and Medicare at 13%. Notably, private non-group plans comprise 17.5% of adult insurance in Broward. Miami-Dade County exhibits a slightly lower insured rate of **84.0%**, while Palm Beach County surpasses Broward with a coverage rate of 88.0%. Despite this comparatively robust insurance coverage, **13.8%** of Broward's working-age adults remain uninsured, a considerable barrier to early behavioral health intervention.

Social Determinants of Health

Broader community health conditions continue to affect behavioral health outcomes in Broward County. Food insecurity remains prevalent, impacting 13.5% of households, slightly above Florida's rate of 12.8% (Feeding Florida, 2024). **Housing costs** remain severe, with **55%** of renters allocating over 30% of their income towards housing expenses (ACS, 2023). **Transportation barriers** affect approximately **9%** of households lacking access to a personal vehicle, with immigrant and low-income families being disproportionately impacted.

The social determinants exacerbate behavioral health risks by heightening chronic stress, diminishing treatment adherence, and deteriorating recovery outcomes. Therefore, targeted interventions that address food access, housing stability, and transportation equity will be essential for enhancing overall behavioral health.

BBHC Service Area Homeless Population Profile

Homelessness Overview

Homelessness in Broward County constitutes a significant public health and behavioral health issue, impacting a wide range of populations, including families, veterans, and unaccompanied youth. The 2024 Point-in-Time (PIT) Count identified **2,800 homeless individuals** in Broward County, indicating a modest increase from **2,700** individuals in 2023 (Broward County PIT, 2024; HUD, 2024). In contrast, Miami-Dade County reported approximately **3,472** homeless individuals in 2024, while Palm Beach County reported approximately **1,350** homeless individuals in the same year.

The homelessness rate in Broward County, while lower in absolute numbers compared to that of Miami-Dade County, nonetheless exhibits significant challenges to housing affordability, which are further aggravated by behavioral health issues among the unsheltered population.

Sheltered and Unsheltered Homelessness

The distribution of homelessness across shelter status presents additional challenges. In 2024, **1,500 individuals (54%)** were sheltered in Broward, whereas **1,300 individuals (46%)** were unsheltered, residing in outdoor or uninhabitable locations. The unsheltered homelessness rate in Broward continues to be a matter of concern, particularly considering the documented increased risks of mental illness, victimization, and overdose among unsheltered populations.

Palm Beach County exhibits a higher shelter rate of 68%, in contrast to Miami-Dade, demonstrating a shelter distribution akin to Broward's.

Homelessness Distribution (2024)	Broward County	Miami-Dade County	Palm Beach County
Total Homeless Individuals	2,800	3,472	1,350
Sheltered	1,500 (54%)	1,890 (54%)	918 (68%)
Unsheltered	1,300 (46%)	1,582 (46%)	432 (32%)

Sources: Broward County PIT, 2024; HUD, 2024.

Subpopulations: Chronic Homelessness, Veterans, and Families

Among the homeless population in Broward County, chronic homelessness, defined as long-term or repeated homelessness combined with disabling conditions, impacted **840** individuals in 2024, representing a slight decrease from the 850 individuals recorded in 2023. Veteran homelessness experienced a modest decline to 175 individuals, indicating the effectiveness of intervention efforts. Family homelessness decreased by 10% from the previous year, resulting in 270 families in 2024. The trends in family homelessness in Broward County starkly contrast with the persistently high rates observed in Miami-Dade County, where an estimated 415 family households experience homelessness.

Youth homelessness persists as a significant issue, with 4,600 students identified as experiencing homelessness during the 2023–2024 academic year within Broward County Public Schools (FLDOE, 2024). In Florida, youth homelessness refers to children and youth lacking a fixed, regular, and adequate nighttime residence. **Seventy-seven** percent of these homeless students reside in shared housing or doubled-up situations, while **12%** occupy motels; a smaller proportion either resides in shelters or lives unsheltered.

Behavioral Health and Homelessness

Behavioral health conditions are profoundly interconnected with homelessness in Broward County. **Seventeen percent** of homeless adults are diagnosed with a serious mental illness, while **thirteen percent** are afflicted with a substance use disorder. These statistics reflect statewide trends in which co-occurring disorders frequently result in more complex service requirements and significantly decreased housing stability in the absence of integrated treatment options. Coordinated entry systems, permanent supportive housing models, and enhanced behavioral health outreach teams are essential for mitigating chronic homelessness among individuals experiencing behavioral health challenges.

Broward Behavioral Health Coalition System of Care Analysis

The Broward Behavioral Health Coalition (BBHC) contracts with a diverse and comprehensive network of 58 behavioral health providers strategically located throughout Broward County. The locations of the providers across the county are shown on the map:

The BBHC Network

This network comprises community-based organizations, county agencies, hospital-

affiliated programs, specialty treatment centers, and supportive centers. The table below illustrates the scope of this network, detailing provider names, locations, and the types of services they provide. Service categories are abbreviated and include AMH (Adult Mental Health), ASA (Adult Substance Abuse), CMH (Children's Mental Health), and CSA (Children's Substance Abuse), among others. This classification exemplifies BBHC's commitment to addressing behavioral health needs throughout the lifespan.

Provider Name	Services
Archways, Inc.	AMH ASA
Banyan Health Systems	AMH, ASA, CMH, CSA
Broward County Addiction Recovery Center	ASA
Broward County Crisis Intervention & Support Division	CMH
Broward County Sheriff's Office	CMH CSA
Broward Health	AMH ASA
Broward House, Inc.	AMH ASA
Broward Housing Solutions	AMH
Broward Partnership for the Homeless, Inc.	AMH
Camelot Community Care, Inc.	AMH CMH
Care Resource	AMH ASA
Carrfour Supportive Housing	AMH
Children's Harbor, Inc.	AMH CMH
Children's Home Society	AMH CMH
Citrus Health Network, Inc.	AMH CMH
CMET (Counseling, Medication Education and Treatment)	AMH CMH
Covenant House Florida, Inc.	AMH
Eagles Haven	AMH CMH
Evolutions Treatment Center	ASA
Fellowship House	AMH ASA
Fellowship Recovery Community Organization, Inc.	AMH ASA
FISP	AMH
Florida Initiative for Suicide Prevention, Inc.	AMH
Foot Print to Success Clubhouse, Inc.	AMH
Ft. Lauderdale Hospital	AMH ASA CMH CSA
Gulf Coast Jewish Family & Community Services, Inc.	AMH
Harmony Development Center	AMH
Healthy Mothers Healthy Babies	AMH
Here's Help Inc.	ASA
Henderson Behavioral Health, Inc.	AMH ASA CMH CSA
House of Hope, Inc.	ASA
Imperial Point	AMH
Jewish Family Services	CMH
Kids In Distress, Inc.	CMH
Memorial Healthcare System	AMH ASA CMH CSA
Mental Health America of Southeast Florida	AMH
Multicultural Alliance Health Care Solutions	CMH
NAMI Broward County, Inc.	AMH
Our Children, Our Future, Inc.	CMH
Silver Impact, Inc.	AMH
Smith Mental Health Associates, LLC.	AMH ASA CMH CSA
South Florida Wellness Network, Inc.	AMH ASA CMH CSA
SunServe	AMH ASA
Taskforce Fore Ending Homelessness, Inc.	AMH
The Chrysalis Center, Inc.	AMH CMH
The Village South	AMH ASA
Tomorrow's Rainbow	CMH

United Way of Broward County, Inc.	AMH ASA CMH CSA
Here's Help	ASA
Passageway	AMH
Adult Residential Communities, LLC	Transitional Housing
Boys Town South Florida, Inc.	Trauma Counseling
Broward Healthy Start Coalition	Peer Services
Center for Community Living	Trauma Counseling
CMET, LLC	Trauma Counseling
Dream Beyond Your Journey, Inc.	Transitional Housing
Eagles Haven	Trauma Counseling
FLITE Center	Education Support
Ft. Lauderdale Hospital	AMH, Crisis Support
Goodman Jewish Family Services of Broward County	Trauma Counseling
Healing Arts Institute of South Florida International, Inc.	Trauma Counseling
Homes United Ministries	Transitional Housing
Marriage and Family Services	Trauma Counseling
MissionExec	Transitional Housing
Multicultural Alliance Health Care Solutions, Inc.	Trauma Counseling
Soul Wellness, Social Support & Therapeutic Services	Trauma Counseling
The Journey Institute, Inc.	Education Support

Several key insights emerge from this distribution. First, there is a strong presence of integrated service providers offering a full array of mental health and substance use services for adults and children. This indicates a strategic alignment with BBHC's "No Wrong Door" philosophy and supports continuity of care within single agencies. Additionally, providers like Broward County Addiction Recovery Center, Memorial Healthcare System, and Henderson Behavioral Health underscore BBHC's emphasis on core treatment services, including crisis stabilization, detoxification, and residential care. Including specialized services highlights a commitment to ensuring crisis response capability and law enforcement collaboration throughout the system.

This geographic and service-based dispersion reflects an intentional effort by BBHC to ensure access and avoid service deserts. It further reveals a layered and redundant system structure, allowing for resiliency in care delivery in the face of staffing shortages, funding changes, or public health emergencies. This redundancy is particularly critical in a large, demographically diverse county such as Broward, where transportation challenges and social determinants of health may otherwise impede access to care.

Additionally, the integration of evidence-based practices (EBPs) across these providers further enhances the quality and consistency of care delivered. The table below confirms the widespread implementation of more than thirty EBPs across the network. These include structured psychotherapies such as Cognitive Behavioral Therapy, Dialectical Behavior Therapy, and Trauma-Focused Cognitive Behavioral Therapy, as well as systemic interventions like Assertive Community Treatment (ACT), Wraparound, and Family Psychoeducation. Equally important are peer-centered approaches such as eCPR, Whole Health Action Management (WHAM), Wellness Recovery Action Plan (WRAP), and peer support integration, all of which align with national movements toward recovery-oriented systems of care.

The BBHC provider network also implements innovative and specialized interventions aimed at prevention and early intervention. The use of Screening, Brief Intervention, Referral & Treatment (SBIRT), Mental Health First Aid, and Question, Persuade, Refer (QPR) Suicide Prevention represents a population health approach, integrating behavioral health into broader public health strategies. Further, tools such as the Services Prioritization Decision Assistance Tool (SPDAT) for prioritization and the SSI/SSDI Outreach, Access, and Recovery (SOAR) model for navigating SSI/SSDI benefits speak to BBHC's commitment to supporting the social determinants of recovery, particularly for those experiencing homelessness, co-occurring disorders, or justice involvement.

List of Evidence-Based Practices Utilized Across the BBHC Provider Network

Acceptance and Commitment Therapy (ACT)	Assertive Community Treatment	Cognitive Behavioral Therapy
Critical Time Intervention	Dialectical Behavior Therapy	eCPR
Family Centered Treatment	Family Psychoed.	Housing First Model
Harm Reduction	International Center for Clubhouse Development	Illness (Wellness) Management and Recovery
Integrated Treatment for Co-Occurring Disorders	IPS Supported Employment/ Education	Mental Health First Aud (Adult/Youth)
Moral Reconation Therapy	Motivational Enhancement Therapy	Motivational Interviewing
Peer Support Services	Permanent Housing	QPR: Question, Persuade, Refer Suicide Prevention
Rational, Emotional Behavioral Treatment	SBIRT – Screening, Brief Intervention and Referral to Treatment	Seeking Safety
SOAR	Solution Focused Brief Treatment	Service Prioritization Decision Assistance Tool (SPDAT)
Trauma-Focused cognitive Behavioral Therapy	TIP – Transition to Indep. Process	Trauma Incident Reduction/ Resolution
Trauma Incident Reduction	Trauma Informed Care	Team Up for Families (TUFF)
WHAM – Whole Health Action Mgmt.	WRAP – Wellness Recovery Action Plan	Wraparound Case Management

The structure of BBHC's provider network and the distribution of EBPs within it form the backbone of a highly coordinated and adaptable behavioral health system. This system not only ensures the delivery of appropriate care but also supports innovation, workforce development, and continuous quality improvement. BBHC's intentional design and oversight of this network position it as a model of regional behavioral health governance capable of responding dynamically to both routine community needs and emergent crises.

The following data presentations and analyses reflect the utilization of services,

costs, and demographic profiles of clients receiving services within the BBHC network of providers.

BBHC Clients – Demographic Profile (FY 2023–2024)

Client Population

During the Fiscal Year 2023–2024, the Broward Behavioral Health Coalition (BBHC) network rendered services to **20,695 unduplicated individuals** across its core program areas. The predominant segment was **Adult Mental Health (AMH)**, which accounted for **11,920 clients (58%)**, followed by **Adult Substance Abuse (ASA)** with **5,103 clients (25%)**. Furthermore, the **Children's Mental Health (CMH)** programs served **2,347 children (11%)**, while the **Children's Substance Abuse (CSA)** programs assisted **1,325 children (6%)**.

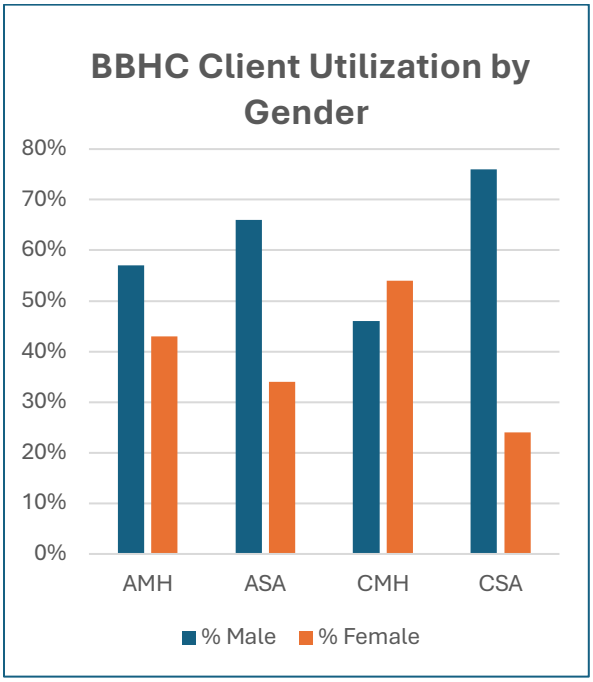
This distribution shows a service system mainly for adult clients, especially in mental health. Services for children make up 17% of BBHC's clients, reflecting Florida's youth behavioral health funding. Most Florida children using publicly funded mental health or substance use services are covered by Medicaid or KidCare, with about 2.7 million enrolled in 2024. Most youth services are reimbursed through these programs (AHCA, 2024; Georgetown University, 2023). The smaller share of children in BBHC's data shows funding structure, not lack of need. Still, the data highlights the need for ongoing investment in early intervention, system coordination, and capacity to ensure timely care for children, especially those not covered or missing systemic support.

Program Area	Clients Served (FY 23–24)	% of Total*
Adult Mental Health (AMH)	11,920	58%
Adult Substance Abuse (ASA)	5,103	25%
Children's Mental Health (CMH)	2,347	11%
Children's Substance Abuse (CSA)	1,325	6%
Total	**20,695**	**100%**

*Children under 18 have greater access to Medicaid and Kidcare health insurance.

Gender

Overall, the client population of BBHC exhibits a slight male predominance (52.6%) across all programs. The distribution of gender demonstrates considerable variation by service line:



The significant male predominance in **ASA and CSA programs aligns** with substantial epidemiological evidence suggesting that

males exhibit a higher propensity for engaging in substance use behaviors, which consequently results in increased treatment admissions. In contrast, the heightened **female participation** in children's mental health services may indicate both the augmented prevalence of diagnosed internalizing disorders (e.g., anxiety, depression) among girls and a tendency towards more pronounced help-seeking behaviors.

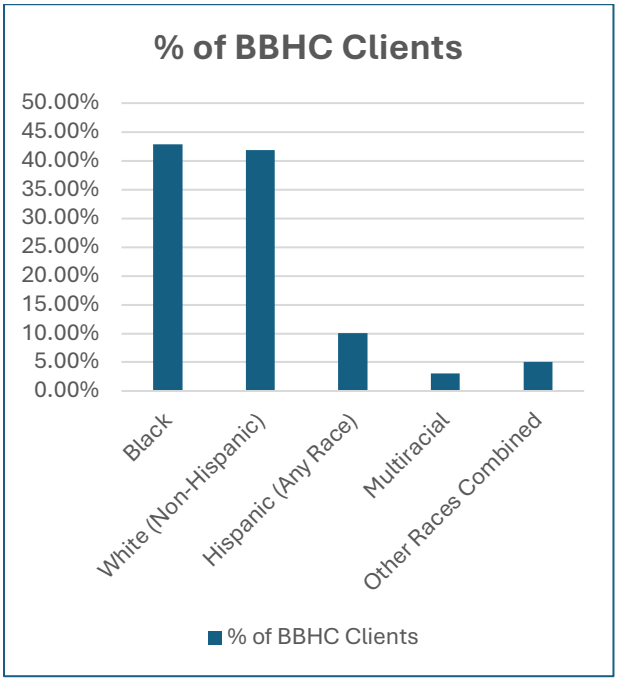
This gender trend signifies substantial implications for program design, particularly concerning gender-responsive services within substance abuse treatment, as well as the requirement for trauma-informed care models that effectively address gender-specific risks and experiences.

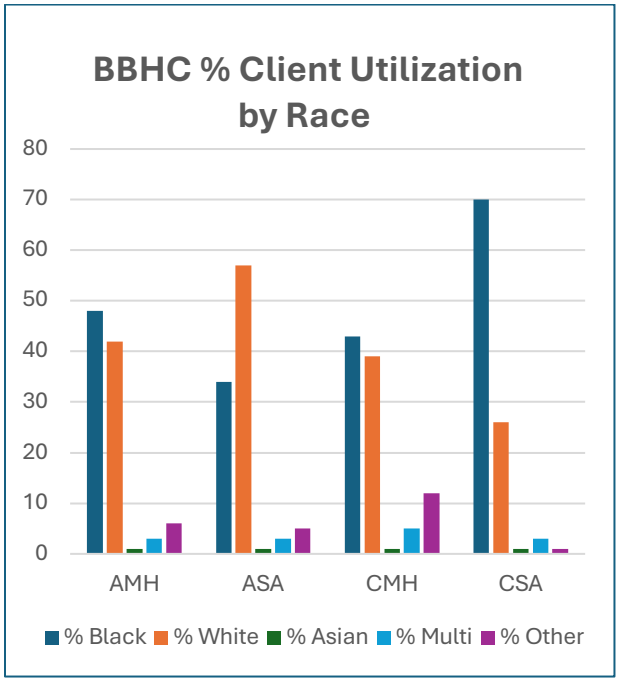
Race and Ethnicity

The racial and ethnic composition of the clients at BBHC demonstrates a considerable degree of diversity. It underscores notable disparities in access to and usage of services when contrasted with the larger population of Broward County. Among the clientele of BBHC:

- **Black or African American individuals** comprised **42.9%** of the population, substantially higher than the Broward County Black population of **27.6%** (ACS, 2023).
- **White individuals** accounted for **41.9%**.
- **Multiracial individuals** represented **3%**
- **Asian, American Indian, and Native Hawaiian/Pacific Islander individuals** collectively represented **less than 1%** of the population.

The **Hispanic ethnicity**, which is classified independently from race, indicated that **10.1%** of BBHC clients identified as Hispanic or Latino. This percentage significantly underrepresents the countywide Hispanic population estimate for Broward, which is **32.5%** (Cubit Planning, 2025). This discrepancy suggests potential obstacles to accessing care for Hispanic residents, including linguistic barriers, stigma associated with behavioral health care, and insufficient availability of culturally and linguistically appropriate services.

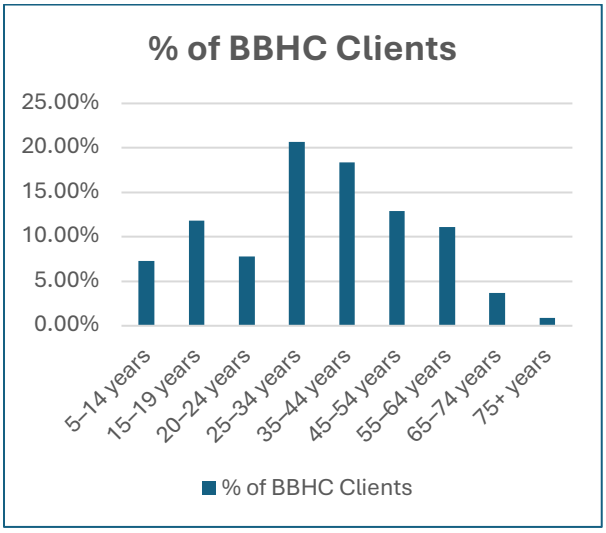




The disproportionate representation of Black residents within the client population of the BBHC Network may also signify historical inequities related to social determinants of health, such as housing, employment, and access to early preventive care. These factors contribute to elevated behavioral health needs and increased involvement with the system. Consequently, programs must prioritize culturally competent practices to address these communities' needs effectively.

Age Range

The age distribution of BBHC's clients demonstrates a pronounced **concentration among young and middle-aged adults**, which carries substantial implications for service planning. Again, it is noted that children and youth have increased access to Medicaid and KidCare



The predominant client cohorts consist of **young adults aged 25 to 34** (20.7%) and **middle-aged adults between the ages of 35 and 44** (18.4%). These two age groups collectively constitute nearly **40%** of BBHC's client population.

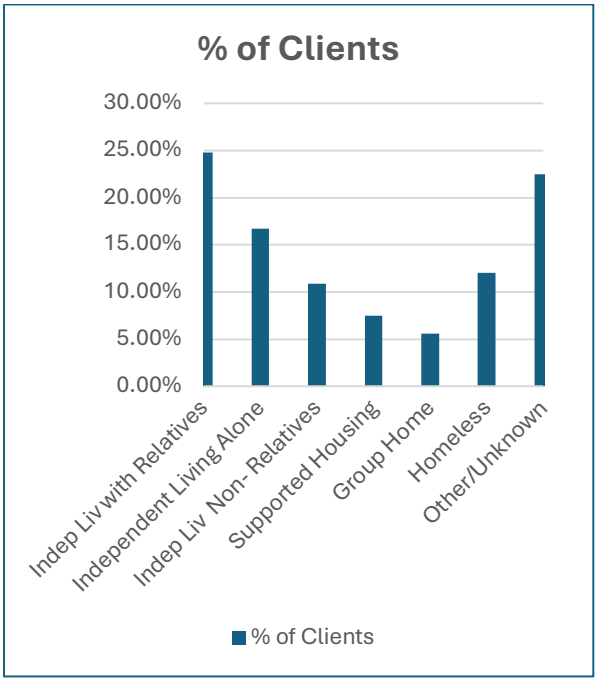
Children between the ages of 5 and 14 constitute 3% of total clients despite accounting for approximately 12% of Broward's general population. It is noted that the majority of youth receiving behavioral health services in Florida access Medicaid and KidCare for service payment.

Individuals aged **65 and older** constitute a mere 4.6% of clients despite representing over 16% of Broward's population (ACS, 2023). This underrepresentation highlights the necessity to enhance access to geriatric behavioral health services, particularly for those experiencing dementia, depression, and social isolation.

Residential Status

The residential status of the client further exemplifies the structural challenges

encountered by individuals receiving behavioral health care under BBHC:

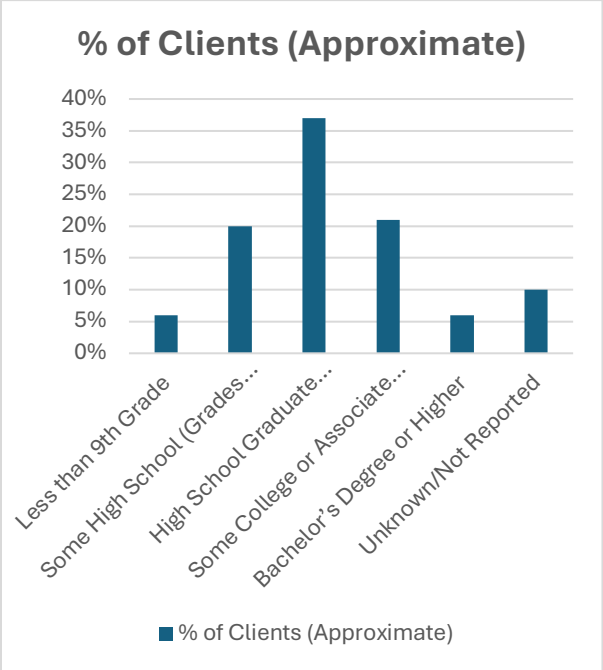


More than half (52.4%) of BBHC clients reside independently, whether with family, roommates, or alone. This phenomenon is an encouraging indicator of functional autonomy; however, it concurrently raises concerns: individuals living alone may encounter elevated risks of isolation, relapse, and reliance on emergency services should adequate community support be deficient.

It is noteworthy that 12% of all clients were identified as experiencing homelessness at the time of service engagement. This figure is significantly higher than Broward's general homelessness rate of approximately 0.14% (HUD PIT Count, 2024). This observation underscores the critical intersection between housing instability and behavioral health, necessitating intensive case management, supported housing initiatives, and integrated housing-behavioral health strategies.

Educational Attainment

The educational attainment of the adult clients of BBHC indicates challenges that are likely to contribute to their overall vulnerability in terms of behavioral health outcomes:



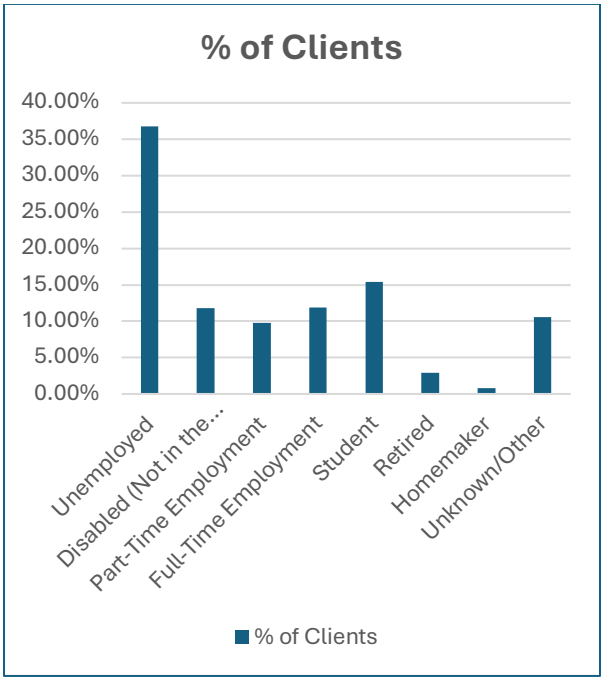
Approximately **twenty-six percent** of adult clients did not complete their high school education, while **thirty-seven percent** graduated from high school without pursuing higher education. Although these statistics do not markedly differ from Florida's overall educational attainment rates, individuals with lower levels of education experience increased difficulties in securing stable employment, maneuvering through healthcare systems, and maintaining long-term engagement in treatment. The minuscule percentage of clients possessing a bachelor's degree or higher (6%) indicates that many BBHC clients encounter educational, economic, and social

disadvantages, which intensify their behavioral health difficulties.

This underscores the necessity of continuing to incorporate General Educational Development (GED) programs, vocational training, and supported educational services within behavioral health interventions, particularly for young adults experiencing early-onset mental illnesses or substance use disorders.

Employment Status

The employment status of BBHC clients further underscores the substantial socioeconomic challenges confronted by this demographic:



Only **22%** of adult BBHC clients, including part-time and full-time participants, are employed. In contrast, **nearly 50% of this demographic is** either unemployed or categorized as disabled and not seeking employment opportunities. This lack of workforce participation is significantly correlated with an increased dependence on public benefits, unstable housing circumstances, detrimental health outcomes, and an elevated risk of hospitalization.

A notable **15.4%** of the students were enrolled in post-secondary or vocational training programs. Nevertheless, difficulties in managing behavioral health may jeopardize their educational trajectories without sufficient support.

In summary, the demographic, socioeconomic, and functional profiles of BBHC's clients highlight the complex array of needs that go beyond conventional clinical treatment. Over the next three years, coordinated investments in employment services, housing supports, culturally responsive care, and educational access initiatives will facilitate these individuals' recovery, resilience, and community integration.

BBHC Homeless Clients Demographic Profile

Demographics

In Fiscal Year 2023–2024, 2,479 clients served by BBHC were classified as experiencing homelessness at the time of intake. This population constitutes approximately 12% of all BBHC clients, reflecting a rate nearly 100 times greater than the estimated 0.13% prevalence of homelessness within the general Broward County population (HUD PIT, 2024).

Homeless Clients by Service Area:

Program	Number of Homeless Clients Served in Program	% of Total Homeless Clients*
Adult Mental Health (AMH)	1,266	51.0%
Adult Substance Abuse (ASA)	1,394	56.2%
Children's Mental Health (CMH)	6	0.2%
Children's Substance Abuse (CSA)	3	0.1%

**The total of 2,479 reflects unduplicated clients experiencing homelessness across the BBHC system. Program-specific counts indicate the number of clients who received services in each program area. Because clients may participate in more than one program, the figures by program cannot be summed to equal the total. They instead demonstrate the distribution of homeless clients across different types of services.*

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The majority of BBHC's homeless clientele comprises adults utilizing mental health or substance abuse services. The occurrence of child and adolescent homelessness within BBHC's service framework is comparatively low. However, educational homelessness statistics from Broward Public Schools reveal that a considerable number of children experience hidden homelessness (e.g., couch-surfing or temporary motel accommodations), often unacknowledged by clinical service systems.

Residential Status

Within the homeless clientele of BBHC, the living conditions exhibit a broad spectrum of instability, encompassing situations ranging from outright street homelessness to provisional accommodations in communal facilities.

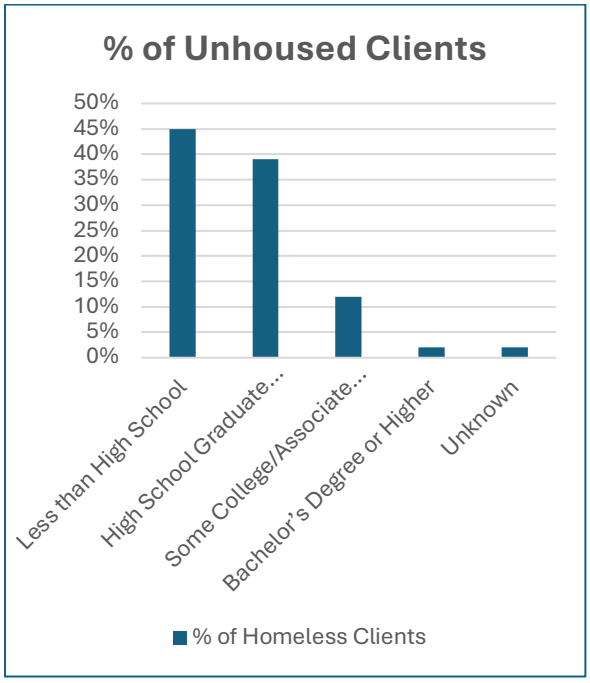
Homeless Client Residential Status

Residential Status	Number of Clients	% of Homeless Clients at Intake
Independent Living - With Non-Relatives	1,198	48.3%
Homeless (Unsheltered or Emergency Shelter)	2,479	100%
Adult Residential Treatment Facility (Group Home)	355	14.3%
Supported Housing	334	13.5%
Crisis Residence	100	4.0%
Other/Unknown	492	19.8%

While 100% of this cohort met the definition of homelessness at the time of intake, **only approximately fifty percent subsequently continued to reside in unsheltered or emergency shelter conditions**. The transition into supported housing, crisis facilities, or treatment group homes was frequently facilitated following intake, illustrating the BBHC's commitment to stabilizing its most vulnerable clients.

Educational Attainment

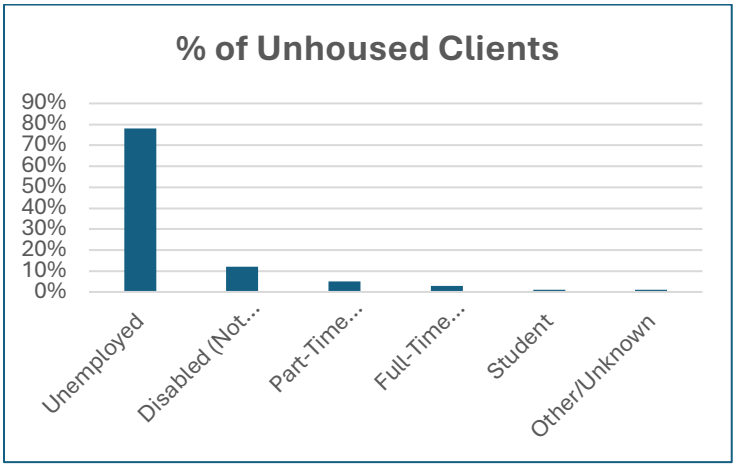
The educational attainment of clients experiencing homelessness at BBHC markedly highlights the prevalence of cumulative disadvantage.



Nearly **half** of the homeless clientele had not attained a high school diploma. This deficiency in educational qualifications considerably hampers employment opportunities, financial stability, and sustained recovery from behavioral health issues.

Employment Status

The employment rate among BBHC's unhoused clients remains critically low. A mere **8%** indicated any form of active employment, encompassing both full-time and part-time positions.



The unemployment rate among unhoused clients, **78%**, significantly surpasses the 3.6% rate in Broward County. An 8% unemployment rate was observed within BBHC's general population of clients. This profound economic vulnerability contributes to the persistence of homelessness, food insecurity, and difficulties adhering to medication regimens and appointments. Employment support services, which include supported employment and vocational rehabilitation, are essential; they represent vital components of long-term recovery for individuals experiencing homelessness.

BBHC Service Access: Waitlist Trends and Analysis

An examination of BBHC's FY 2024–2025 waitlist data offers critical insights into the accessibility of behavioral health services and underlying capacity challenges across the system of care. Waitlist trends, particularly those associated with outpatient and residential modalities, serve as key indicators of unmet demand and structural bottlenecks.

The FY 24–25 data reveal that **outpatient and residential services for adults** experience the most significant waitlist

activity. Notably, **108 adults** remained on waitlists for **outpatient mental health services**, with an average wait time of **27.5 days**, a maximum wait of **131 days**, and a median wait of **18.5 days**. **Residential mental health services** also faced pressure, with **189 individuals** waitlisted and an average delay of **40 days**. The longest recorded wait time for residential mental health care was **165 days**.

Similarly, **adult residential substance use services** reported the highest waitlist volume, with **296 individuals** awaiting placement. Although the average wait time was **24 days**, individual wait periods extended up to **129 days**, signaling strain on the residential SUD system. **Outpatient SUD services** for adults showed somewhat lower demand, with **30 individuals** waitlisted and an average delay of **8 days**.

Among children, the most pronounced delays were seen in **outpatient mental health services**, where **70 youth** were waitlisted with an average wait time of **20.6 days**. The maximum wait recorded for a child in this category was **100 days**. In contrast, **no children were on waitlists for substance use disorder services**, suggesting either lower demand or more immediate placement availability for youth in this category.

Notably, **pregnant women and individuals who inject drugs** are not reflected in the FY 24–25 waitlist, supporting the conclusion that system-level prioritization for these federally designated special populations continues to function effectively.

BBHC FY 2024 Waitlist Activity by Population and Service Type

Population	Service Type	Clients Waitlisted	Average Wait (Days)	Max Wait	Min Wait	Median Wait
Children (Mental Health)	Outpatient	70	20.6	100	2	16.5
Children (Substance Use)	Outpatient	0	0	0	0	0
Adults (Mental Health)	Outpatient	108	27.5	131	1	18.5
Adults (Substance Use)	Outpatient	30	8.0	27	1	7.0
Adults (Mental Health)	Residential	189	40.0	165	1	27.0
Adults (Substance Use)	Residential	296	24.0	129	1	18.0
Pregnant Women	All Services	0	0	0	0	0
Individuals Who Inject Drugs	All Services	0	0	0	0	0

Source: BBHC FY 2023–2024 Waitlist Report

From a system-level planning perspective, the data indicate that **adult residential and outpatient mental health services** face the most significant access challenges. The high volume of waitlisted clients, particularly for residential care, signals persistent infrastructure gaps. Likewise, **youth mental health services** require targeted investment, given that dozens of children continue to face delays of up to three months.

The complete absence of waitlist activity among **pregnant women** and **individuals who inject drugs** reflects the continued effectiveness of BBHC's prioritization and placement protocols for high-need populations. However, the system must address growing demand among the general population, who are more likely to face

prolonged wait times and subsequent risks of clinical deterioration, crisis events, and system disengagement.

As BBHC continues to review its provider networks and community needs, these quantitative indicators can serve as a guide for service expansion and contract negotiation strategies, especially in outpatient mental health and substance use treatment. This analysis also emphasizes the importance of examining staffing limitations, provider reimbursement rates, and program infrastructure, which contribute to systemic access issues.

Involuntary Baker Act Examinations

In Fiscal Year 2023–2024, Broward County recorded 9,842 involuntary examinations under the Baker Act, with a population of approximately 1,987,884 residents. This figure corresponds to a rate of roughly 4.95 examinations per 1,000 residents (Florida Department of Children and Families, 2024). Statewide, Florida conducted over 161,000 Baker Act exams, with nearly 18% involving children (≈ 29,612) (LaGrone, 2025), and 25% of those children experience repeat Baker Acts, underscoring the need for system coordination and prevention strategies (Florida Department of Children and Families, 2024; LaGrone, 2025).

Utilization and Financial Analysis Across BBHC's Service Area

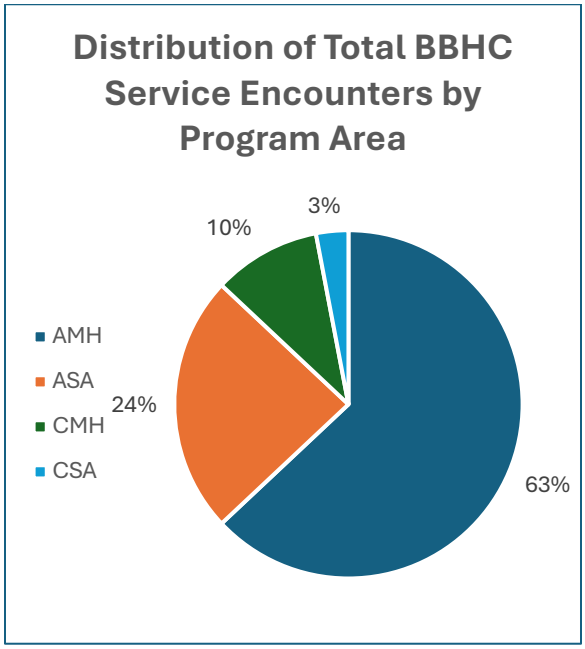
During fiscal year 2023–2024, BBHC's provider network documented **44,707 distinct service encounters** across its four principal program areas: Adult Mental Health (AMH), Adult Substance Abuse (ASA), Children's Mental Health (CMH), and Children's Substance Abuse (CSA). Service utilization remains heavily concentrated in adult services, with **AMH and ASA services accounting for 87%** of all encounters, **AMH at 63%** and **ASA at 24%. CMH and CSA comprise 10%** and **3%, respectively**.

This pattern reflects the enduring intensity of behavioral health needs among adults in Broward County, particularly in the context of post-COVID mental health deterioration, rising housing instability, and untreated serious mental illness (SMI). While children's services represent a smaller proportion of total encounters, demand continues to grow in specialized areas such as mobile response and crisis diversion, particularly as pressures on the child welfare and school-based systems increase.

Care coordination programs also documented steady service engagement, with total enrollment rising from **388 individuals in Q1** to **601 individuals in Q4**, reflecting a **55% increase over the fiscal year**. These programs served a cross-section of high-risk individuals, including those with repeat crisis utilization, criminal justice involvement, and children with complex behavioral needs. Notably, crisis stabilization utilization remained low among those engaged in care coordination, with CSU readmission rates consistently under **1.3%**.

Mobile Response Teams (MRT) responded to a total of **3,915 crisis calls** across the year, with peak activity in Q3 (**1,300 calls**). The rate of school-based crisis calls surged in Q2 and Q3 (over 48% of all calls), before falling back to **11%** in Q4. Approximately **31%** of all MRT calls in FY 23–24 resulted in a Baker Act. In comparison, **67% were successfully diverted** from involuntary

examination, affirming the system's effectiveness in triaging community-based crises without resorting to hospitalization.



Financial Expenditures

Broward Behavioral Health Coalition (BBHC) serves as the state-designated managing entity for behavioral health services in Broward County, overseeing the delivery of publicly funded mental health and substance use services. In this capacity, BBHC functions as the county's behavioral health safety-net provider network, managing care for individuals who are uninsured or underinsured. BBHC does not administer or reimburse services for individuals with coverage through Medicaid, Medicare, Florida KidCare, or private insurance plans. As such, its financial expenditures and service utilization patterns reflect the needs of those residents who face the most significant systemic barriers to accessing care, including individuals without third-party coverage, those with limited income, and those navigating complex social determinants such as homelessness, justice involvement, or co-occurring behavioral health conditions.

The total revenue earned across all DCF programs in the fiscal year 2023-2024 was **$70.2 million**, with **AMH** services generating **$36.1 million, ASA $27.1 million, CMH $3.3 million and CSA $3.7 million**.

BBHC Service Area Financial Summary, FY 23-24

Program Area	Earned Revenue
AMH	$36,138,435
ASA	$27,086,362
CMH	$3,301,233
CSA	$3,681,013
Total	**$70,207,043**

(Source: BBHC Financial Data, FY 23-24)

Several insights emerge from the fiscal year 2023-2024 utilization and financial analysis.

First, the concentration of utilization in AMH and ASA services suggests that adult populations remain the highest-cost, highest-need demographic within the BBHC system. This is consistent with the elevated rates of untreated mental illness, comorbid substance use, and lack of stable housing among adults in Broward County. Uninsured care is particularly burdensome in these categories, as adults without stable insurance coverage disproportionately rely on BBHC-funded services. (American Community Survey, 2023).

Second, although **Children's Mental Health** services make up a smaller portion of overall service delivery, this is to be expected

given that most children and youth accessing behavioral health services are enrolled in Medicaid, KidCare, or private insurance.

Third, despite the increasing complexity of client needs, BBHC sustained a **low administrative overhead rate of 3.6%**, well under the state-mandated 8% cap. This demonstrates the organization's continued fiscal discipline and prioritization of resource allocation toward direct client services and system coordination.

Finally, utilization data across multidisciplinary programs, such as CAT, FACT, and CCT, highlight a consistent pattern of system engagement, with improvements in family functioning, school attendance, and stable housing among participants. These programs provide essential support for complex cases and continue to produce positive outcomes that reduce the need for higher-cost services such as residential or inpatient psychiatric care.

The four DCF-funded categories together totaled **$70.2 million**, or **94% of all revenue** for the fiscal year. This reflects BBHC's primary role as a managing entity under state contract, charged with delivering the publicly funded behavioral health safety net across Broward County.

Beyond DCF allocations, BBHC's network also receives revenues from **non-DCF sources**, totaling approximately **$4.6 million**. These funds supported wraparound, integrated care, and coordination services across specialized populations and program models with funding from local government and school system partners, including the Children's Services Council, Wellpath, and other contributors. These resources supported collaborative initiatives spanning criminal justice, education, and youth-serving systems, helping to fill critical gaps not addressed through traditional funding. Additionally, state and federal grant-supported programs such as Family CPR, BYRP, OCP, and Healthy Connections provided vital support for service coordination, peer recovery services, and transitional care. These non-traditional revenue sources played an essential role in strengthening system responsiveness, supporting high-risk populations, and enabling flexible interventions beyond the scope of core treatment programs.

Summary

Broward County's behavioral health landscape reflects a dynamic, diverse, and steadily evolving region. With nearly 2 million residents and modest population growth, Broward stands as one of the most demographically varied counties in Florida. Its racial and ethnic composition includes an almost equal distribution of White non-Hispanic (31.9%) and Hispanic (31.9%) populations, alongside a significant Black population (27.6%). This diversity underscores the importance of a responsive system of care that offers linguistically appropriate services and is focused on the county's unique sociocultural landscape.

The county performs relatively well on certain health and education indicators, with a higher-than-average rate of adults reporting good mental health, fewer mentally unhealthy days than the state average, and higher levels of post-secondary education. Nonetheless, structural inequities persist. Roughly 12.7% of the population lives in poverty, and children remain disproportionately impacted. These economic vulnerabilities are compounded by

housing instability, transportation limitations, and food insecurity, each of which directly affects access to behavioral health services. While the uninsured rate in Broward has decreased, 13.8% of adults aged 18–64 remain without coverage, posing challenges for behavioral health service continuity and affordability.

BBHC's behavioral health infrastructure includes 58 network providers offering a wide spectrum of services across the lifespan. These agencies deploy more than 30 evidence-based practices, ranging from Cognitive Behavioral Therapy and Motivational Interviewing to specialized peer-led models like WRAP and WHAM. The system is supported by assessment tools and interventions such as SOAR and SPDAT, which facilitate connections to income supports and stable housing.

In FY 2023–2024, BBHC served 20,695 unduplicated clients. Adults represented the majority, with 58% receiving Adult Mental Health (AMH) services and 25% receiving Adult Substance Abuse (ASA) treatment. Children's services accounted for 17% of the total caseload. Importantly, these figures reflect funding structures, particularly Medicaid and KidCare eligibility, rather than the overall demand for children's behavioral health services.

Client demographics reveal that 52.6% were male, and a notable 42.9% identified as Black, a figure significantly higher than their proportion in the general population. In contrast, Hispanic individuals were underrepresented, comprising just 10.1% of clients, despite making up nearly one-third of the county population. These disparities suggest ongoing access barriers, likely related to insurance status, perceptions of care, and availability of bilingual providers.

Additionally, adults aged 25–44 were the most frequently served age group, with both youth under 15 and older adults over 65 comprising only a small percentage of the client base. This distribution points to potential unmet needs in both younger and older populations, possibly driven by payor service barriers, eligibility restrictions, system navigation difficulties, or lack of age-specific programming.

Housing insecurity emerges as a central theme in the report. Approximately 12% of BBHC clients were identified as experiencing homelessness at intake, a rate vastly higher than the county's general population, which sits at approximately 0.14%. The 2024 Point-in-Time count identified 2,800 individuals experiencing homelessness, with 46% unsheltered and significant representation among families, veterans, and youth. Nearly 17% of adults experiencing homelessness were identified as having serious mental illness, and 13% had substance use disorders. These figures highlight the deep interconnection between behavioral health challenges and housing instability, as well as the need for continued investment in permanent supportive housing and coordinated case management strategies.

Youth and adult behavioral health trends in the county show progress in certain areas, including declines in adult smoking and alcohol use, and shifting patterns of youth substance use, such as decreased alcohol and cigarette use. However, the rise in vaping and marijuana experimentation, particularly among youth who do not concurrently use tobacco products, signals a new frontier in prevention efforts.

Behavioral health-related crises also remain prominent. In FY 2023–2024, Broward recorded 9,842 Baker Act examinations,

equating to 4.95 per 1,000 residents. The county's Mobile Response Teams (MRTs) played a crucial role in crisis diversion, with approximately two-thirds of calls successfully diverted from involuntary examination. School-based crises were particularly prevalent in the second and third quarters of the fiscal year.

Access challenges are also reflected in BBHC's waitlist data for FY 2024–2025. The longest delays were observed in adult residential services for substance use, where 296 individuals faced average waits of 24 days. In adult mental health residential services, 189 individuals were on the waitlist for an average of 40 days. Youth services, while lower in volume, also experienced delays, especially in outpatient mental health treatment, with 70 children waiting an average of 21 days. Conversely, system prioritization appears to be functioning well for federally designated priority populations, such as pregnant women and individuals who inject drugs, neither of whom experienced placement on waitlists during the reporting period.

From a fiscal standpoint, BBHC reported $70.2 million in revenue for FY 2023–2024, of which 94% was sourced through contracts with the Florida Department of Children and Families. The remaining 6%, approximately $4.6 million, came from local government contributions, federal grants, and carry-forward funds. These non-DCF revenues supported service coordination, peer recovery support, jail-based services, and family-focused programs like Family CPR. Administrative costs remained low at 3.6%, reinforcing the system's efficiency and commitment to directing funds toward direct service provision. While uncompensated care remains a persistent challenge, BBHC continues to leverage its multi-source funding approach to strengthen provider capacity and expand access, particularly for high-risk populations.

Overall, the data presented demonstrates a robust and responsive behavioral health system that is adapting to evolving population needs and addressing longstanding service gaps. BBHC's data-informed planning, diverse provider network, and strategic resource allocation position the system well for ongoing progress.

Lived Experiences and Perceptions from the Community

Survey and Focus Group Results

The report section presents an integrated analysis of quantitative surveys and qualitative focus groups conducted as part of the Community Needs Assessment. Designed to capture the experiences and perspectives of a diverse cross-section of system users and providers, including consumers, peer specialists, behavioral health professionals, and community stakeholders, these data sources offer a multidimensional understanding of the assets and challenges within the county's behavioral health landscape.

This analysis synthesizes patterns across populations, highlights systemic barriers, and identifies opportunities for strategic improvement. The combined use of structured survey instruments and thematic focus group interviews ensures that the findings quantify trends and contextualize them through the lived experiences of those navigating and delivering care. This approach provides a strong foundation for data-driven planning, equity-informed service enhancements, and long-term system transformation.

Stakeholder Survey and Focus Group

The human service systems, community organizations, and providers in Broward County participated in distributing this survey to measure awareness, linkages, accessibility, and to define barriers. A total of 152 stakeholders from across Broward County completed the Stakeholder Survey Tool. This focus group was convened as part of BBHC's Recovery-Oriented System of Care (ROSC) initiative to provide context for findings from a recent stakeholder survey.

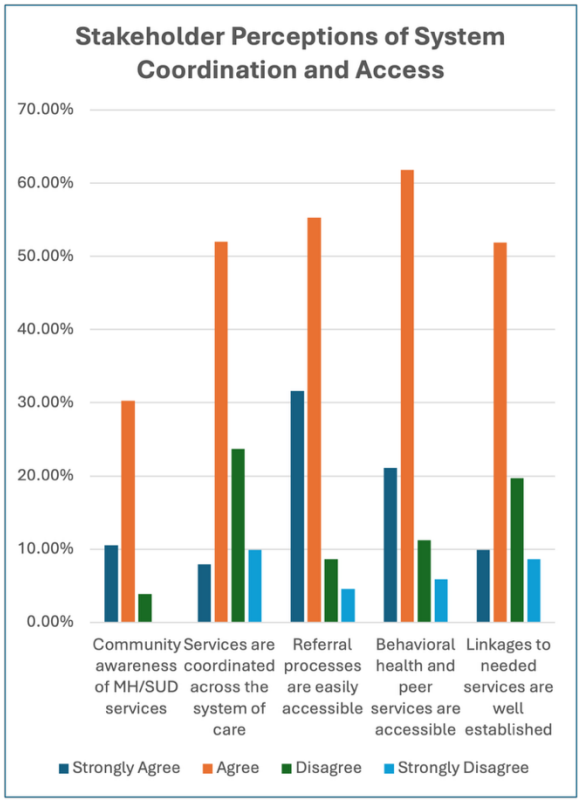
The session included 52 participants representing agencies, peer specialists, administrators, and community advocates, spanning the behavioral health continuum. Utilizing a generic qualitative research approach grounded in thematic analysis, this report synthesizes key findings, identifies core challenges, and highlights promising innovations. The goal was to collect data points and surface context-rich insights that reflect the complexity and interdependence of behavioral health service delivery in Broward County. These methods offer a panoramic view of a system marked by resource density and fragmentation, innovation and inequity, and an underlying call for system coherence grounded in cultural responsiveness and whole-person care.

Survey Results and System Performance Indicators

The stakeholder survey captured the views of a diverse group of providers, advocates, administrators, and peer leaders. Results indicated a generally high awareness of BBHC's resources and core functions, with 90.8% of respondents reporting familiarity with the coalition's offerings and 71.7% stating they had accessed BBHC-funded services in the previous six months. Among those who engaged with BBHC, 76.3% found the experience helpful, while 16.4% described it as "somewhat helpful," and only 7.2% rated it negatively.

The data also confirmed that knowledge of behavioral health navigation tools, such as 2-

1-1, is widespread, with 96.1% of respondents aware of the resource. However, direct engagement was notably lower: only 43.4% had accessed 2-1-1 recently, and satisfaction varied, with only 52.6% finding the experience helpful. This finding, while not alarming by itself, suggested potential weaknesses in service integration or the consistency of referral follow-up. Stakeholders were asked to rate system components related to coordination, access, and community awareness. These are summarized below.



These results reveal that while most stakeholders view general access as relatively strong, opinions regarding system coordination and linkages vary significantly. A majority believe that services are coordinated, and nearly 20% disagree.

Structural Barriers and Resource Gaps

Survey respondents were asked to describe barriers to care and identify resources that are lacking in the current service array. Among the most frequently reported barriers were waiting lists, mismatches in language and culture, insufficient transportation, stigma, and limited availability of evening and weekend appointments. These findings are reflected in the following summary.

Most Frequently Reported Barriers to Access

Barrier	Frequency
Long waiting lists	High
Stigma	High
Lack of transportation	Moderate
Language/cultural mismatch	Moderate
No evening or weekend appointments	Moderate

Respondents identified specific unmet needs through open-ended prompts. The most frequently mentioned themes related to housing (primarily respite, recovery, and supported living), care coordination, low-cost outpatient counseling, and child and family-centered services. Keyword analysis of these responses revealed "housing" as the most dominant unmet need, followed by "transportation" and "child services." It should be noted that Medicaid primarily serves children and youth presenting for services.

Understanding System Drivers

We modeled the predictors of satisfaction and perceived system coordination using logistic regression. The analysis found that the actual use of BBHC

services and awareness of BBHC were the strongest predictors of stakeholder satisfaction. In contrast, the county's general awareness of behavioral health services was a weak predictor of satisfaction or confidence in system coordination. These findings confirm that direct organizational engagement and relational familiarity are key drivers of perceived system quality, emphasizing the importance of consistent, high-touch engagement between BBHC and the broader provider community.

The ROSC Subcommittee focus group, which included 52 participants, added a vivid, lived-experience dimension to the survey data. The discussion revealed six dominant themes.

First, service fragmentation and poor inter-agency communication emerged as a persistent systemic flaw. Stakeholders described a system in which providers often make referrals without fully understanding what other agencies do, leading to duplicated efforts or missed care opportunities. One participant noted, "We sometimes refer people for services they already have. It's not just inefficient—it confuses the client."

Second, participants highlighted logistical and social barriers to access. This included transportation, cost (Medicaid and insurance co-payments), and the stigma of entering recognizable behavioral health facilities. "Do I want my neighbors seeing me walk into Henderson? Everyone knows what that building means," shared one clinician.

Third, the group identified high-need subpopulations that remain underserved, including seniors (especially after the closure of geriatric case management), Spanish-speaking residents (due to a lack of bilingual clinicians), and justice-involved individuals (who are often discharged without a care plan or medication). "People are being discharged from jail straight into the streets," one stakeholder reported, "with no plan, no meds, no follow-up."

Fourth, staff turnover and burnout eroded institutional knowledge and weakened system navigation. The consensus was that the frontline workforce lacks sufficient pay, training, and retention support. "We're losing the people who really know how to make the system work," said one administrator.

Fifth, peer support and community innovations received universal acclaim. Programs like the South Florida Wellness Network and the Deerfield Community Health Hub were commended for their accessibility, reliability, and integrated care approach. "Peers know the system, they live it. Their referrals count," one stakeholder explained.

Finally, participants pointed out a lack of coordinated system planning. While many meetings occur, they often remain insular and provider-centric. "We have meetings, but not a common voice. There's no shared strategy," said a senior systems leader. There was a strong call for genuinely cross-sector planning spaces that include unaffiliated community leaders and individuals with lived experience.

In summary, the survey and focus group collectively present a compelling picture. BBHC is well-regarded, especially among its service users. However, satisfaction levels vary, and perceptions of coordination are weak in some system areas. The gap between awareness and accessibility underscores the necessity of providing services and ensuring

they are well-structured, coordinated, and supported by cultural humility and logistical accessibility. Peer workers and community-led models emerge as successful engagement and service continuity mechanisms. Similarly, the workforce infrastructure, compensation, and organizational memory need targeted support to prevent attrition and burnout.

What stands out most is the universal desire for system coherence. Broward has numerous programs but lacks a unified strategy to unite municipalities, providers, funders, community members, and system users around a shared agenda for recovery-oriented, trauma-informed, and accessible care.

Provider "No Wrong Door" Survey and Focus Group

The No Wrong Door (NWD) model aims to ensure that individuals seeking behavioral health care encounter seamless, coordinated, and compassionate services, regardless of where they enter the system. The "No Wrong Door" approach organizes services to guarantee that those seeking help can access various support and services without being shuffled from one place to another. It aims to create a streamlined system where individuals are connected to the right resources, no matter their initial point of contact. This approach simplifies access to services, reduces confusion, and empowers individuals to make informed choices.

To assess the extent to which this model has been adopted and operationalized in South Florida, a provider survey (N=93) and a provider advisory council focus group were conducted in Spring 2025. The survey yielded 93 responses and analyzed provider perspectives using structured quantitative items. A subsequent focus group with providers, held during the Provider Advisory Council meeting, provided context to the quantitative survey results. The focus group employed a generic qualitative research methodology. This report synthesizes both data sources to offer a multidimensional assessment of system strengths, barriers, and priorities for action.

Organizational Commitment to NWD Principles:

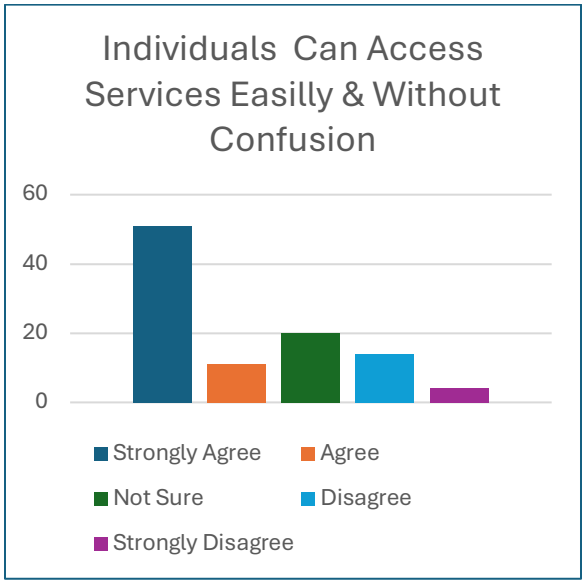
The survey showed strong organizational alignment with NWD values. Over 90% of respondents agreed that their organization raises awareness of behavioral health issues, promotes cross-system collaboration, and hires staff with cultural competence and lived experience. For example:

While respondents articulated an explicit philosophical endorsement of NWD values, focus group participants stressed that **implementation varies widely**. One provider cautioned, "There's this ongoing

confusion, even among providers, about what we do. We know our job in-house, but how it relates to everyone else is fuzzy." This sentiment reveals that despite cultural buy-in, the absence of structural clarity across agencies weakens consistent application of NWD principles.

Access and Navigation Challenges

emerged as an area of concern. Only 61.3% of survey respondents agreed that clients can access services "easily and without confusion." Approximately 25% were unsure or disagreed.

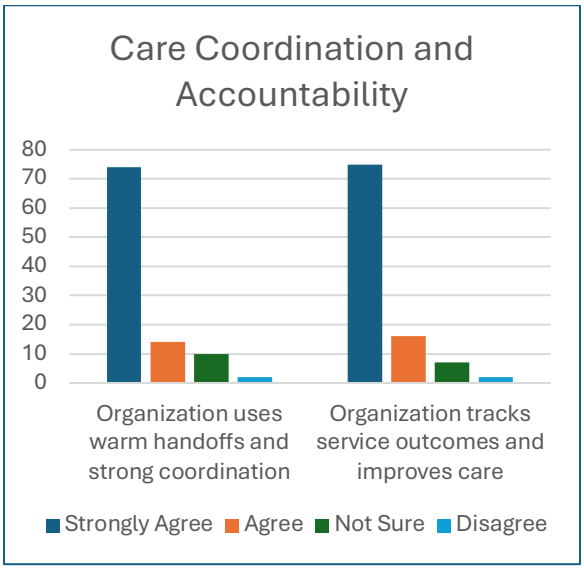


Focus group participants provided powerful accounts of the real-world barriers clients face. These included waitlists for psychiatric evaluations, outdated referral directories, fragmented eligibility processes, and a lack of warm handoffs. One participant shared, "If a client needs a psych eval and can't get it for weeks, then everything else is delayed." Another added, "We keep referring people to each other, but sometimes we're just passing them around with no resolution."

These findings emphasize a central theme: navigating the system remains challenging for many, despite the availability of services. The gap lies not in the existence of services, but in the ability of clients to effectively connect to them with support, timeliness, and continuity.

Care coordination and accountability

were among the most positively rated domains. Approximately 88% of respondents agreed that their organization employs strong coordination and warm handoffs. A similarly high percentage indicated that their organization tracks service connections and utilizes outcome data to enhance care.



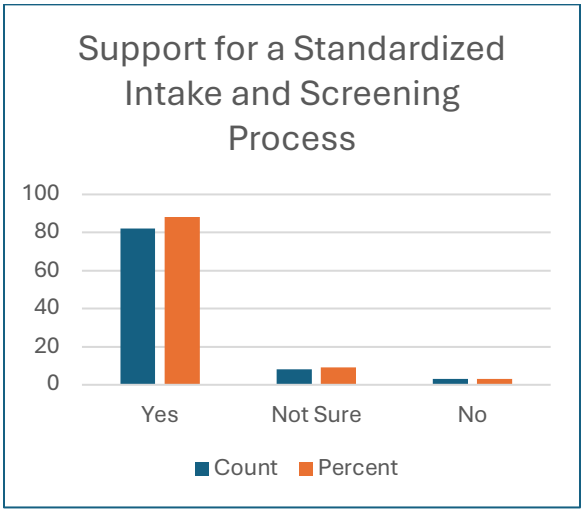
In contrast, focus group participants described an accountability vacuum among agencies. One provider said, *"Once we refer them, there's no follow-up. No one's really tracking whether that person got what they needed."* Others noted the absence of feedback loops: *"We need a shared tracking system that lets us know what happened after the referral."* Others mentioned that even

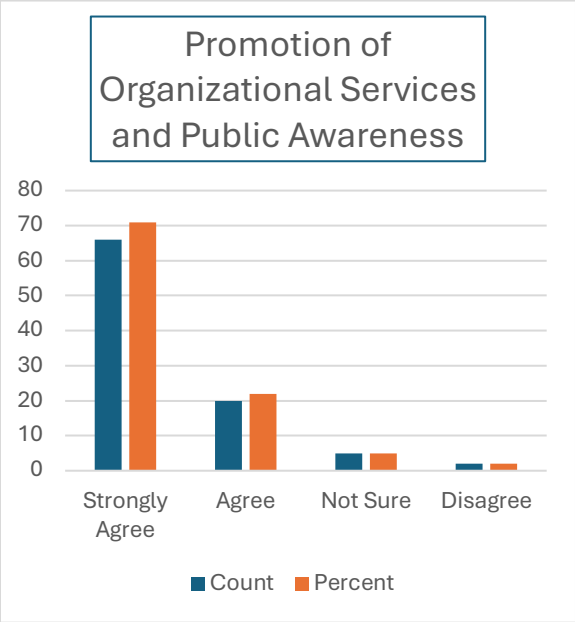
with access to information, navigation remains difficult: "It's not just about knowing what services are available—it's about knowing how to actually get your client through the door." Another participant emphasized that information portals or resource directories are often outdated or inaccessible, leading to frustration among both staff and clients

These conflicting perceptions suggest that although agencies may track outcomes internally, cross-agency continuity and shared care accountability still represent significant weaknesses in the system. The data indicates that ease of access is not about availability but about usability, coordination, and follow-through.

System Infrastructure and Capacity

survey results showed strong support for a unified intake process, with 88% of respondents in favor. Respondents also believed their agency promotes service awareness (92.5%).



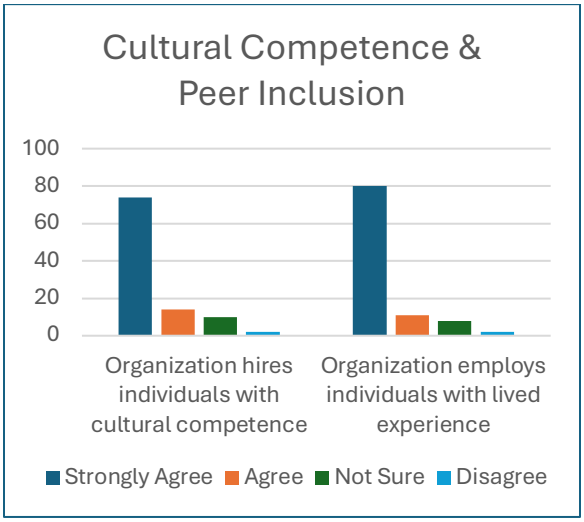


Participants expressed that services often operate in silos, with limited accountability for ensuring a client's full continuum of care. "Once we refer them, there's no follow-up. No one's really tracking whether that person got what they needed," one provider lamented. Another added, "We need a feedback loop—some kind of shared tracking system that lets us know what happened after we made the referral." These quotes reveal a lack of system-wide accountability mechanisms, reinforcing the need for unified intake, shared care coordination, and interagency governance protocols. This aligns with the 91.4% of survey respondents who said their own agency tracks service connections, although these tracking practices are not yet integrated across the network.

A consistent concern was insufficient system capacity to meet client needs. Participants pointed to gaps in psychiatric care, detox availability, peer support, and housing. Providers emphasized that logistical issues like transportation, childcare, and

identification documentation access remain unaddressed, acting as de facto barriers that prevent people from accessing care. This aligns with the quantitative finding that 58.1% of providers agreed individuals could navigate the system easily, underscoring that structural deficits, not just coordination failures, are a critical barrier to proper access.

Cultural Competence and Peer Inclusion were endorsed by more than 90% of providers.



Participants highlighted the need for greater cultural and linguistic responsiveness throughout the system. "We're not doing enough to reach Haitian Creole-speaking clients," one provider noted, while another described the struggles of serving undocumented clients who fear legal consequences. There was a consensus that agencies need training and support to more effectively assist marginalized populations, particularly those facing language barriers, immigration concerns, or trauma histories.

The importance of peer involvement was also emphasized, albeit with caveats. While most agencies engage peer specialists, participants noted variability in their training, supervision, and inclusion in decision-making. "We have peers on staff, but they're not always respected as part of the team," shared one provider. These insights echo survey findings in which 90% of respondents affirmed hiring individuals with lived experience. Still, qualitative data suggest that peer integration needs to be connected to training, support, and cultural change.

In summary, the integrated results of the No Wrong Door Provider Survey and Advisory Council Focus Group reveal a system poised for transformation but still challenged by fragmentation, access bottlenecks, and inconsistent accountability. Providers show a strong commitment to NWD values and a willingness to collaborate. However, they also require more explicit role definitions and referral ownership, shared tracking systems and follow-up mechanisms, investments in infrastructure (beds, transportation, psychiatry), and practical equity and peer workforce development tools. To realize the promise of the No Wrong Door model, system leaders must bridge the gap between principle and practice by investing in structures, improving communication, and creating cross-agency tools that promote shared care and ensure seamless access.

Recovery Peer Specialists Survey and Focus Group

The Recovery Peer Support Specialist Survey was conducted among peer professionals and volunteers at recovery-oriented agencies in South Florida. A total of 65 responses were collected. A follow-up focus group was held with the BBHC Consumer Advisory Council to provide context and detail for the quantitative survey results. Integrating the quantitative survey results with qualitative

thematic findings offers a comprehensive understanding of the county's strengths, challenges, and opportunities facing peer support specialists.

Lived Experience and Role Identity

The foundation of peer support lies in lived experience, and the survey findings affirm the diversity of such experiences among peer professionals. Among the 65 survey respondents, 40.0% identified as having co-occurring mental health and substance use disorders, while an additional 24.6% reported mental health conditions only, and 21.5% reported substance use conditions only. These data indicate that over 85% of the workforce comprises individuals with direct experience of behavioral health challenges, lending authenticity and empathy to their roles.

Focus group participants elaborated on how their lived experiences translate into professional value, especially when supporting complex populations, such as individuals involved in the justice system or those with co-occurring disorders. Several participants expressed concern that, despite their extensive recovery and relevant experience, background checks continue to exclude highly qualified peers from employment and housing opportunities.

Geographic and Organizational Landscape

The geographic composition of the peer workforce provides critical insight into the contextual relevance of these findings. Among respondents, 87.7% reported residing in Broward County, while the remaining individuals came from Miami-Dade (4.6%), Palm Beach (3.1%), or other unspecified counties (4.6%). This concentrated regional representation ensures that the findings are especially pertinent to the local South Florida behavioral health system, offering a solid basis for county-specific planning and program development.

Respondents indicated working across various service types. Notably, 78.5% were involved in adult mental health services, 55.4% in substance use treatment programs, 50.8% in peer-specific services, and 41.5% in recovery community organizations. These outcomes illustrate the peer workforce's range and its integration within traditional and nontraditional care systems.

Empowerment and Organizational Inclusion: Empowerment and shared decision-making are hallmarks of recovery-oriented systems. Survey results indicated that 86.2% of peer specialists reported being able to offer clients choices, while 96.9% noted their organizations use person-centered, stigma-reducing language.

However, a closer examination reveals that not all peer roles are implemented uniformly. Approximately 13.8% were uncertain about their authority to offer choices, indicating that role clarity remains challenging. Similarly, although 83.1% of respondents reported being included in program development and 81.5% noted inclusion in leadership governance, qualitative data revealed concerns about the depth and authenticity of that participation.

Hiring and Retention Barriers

Quantitative data indicate low compensation and restrictive hiring policies significantly hinder recruitment and retention efforts. Among respondents, 34.4% identified low pay as a barrier to hiring, while 25% cited it as a reason their peers leave the profession. Focus group participants elaborated on this issue, emphasizing that many qualified candidates are excluded due to criminal background checks, even when these individuals have extensive recovery histories and strong qualifications. Such limiting policies undermine workforce development and contradict the principle of lived experience as a source of professional legitimacy.

Credentialing and Training Needs: Credentialing continues to evolve within the peer workforce, with 66.2% of respondents identified as Certified Recovery Peer Specialists and 18.5% actively pursuing certification. While the 40-hour foundational training received broad support, focus group participants emphasized the need for additional training in trauma-informed care, boundary setting, and culturally responsive approaches. Concerns were especially pronounced for peers working with Haitian communities, women with children, and justice-involved populations, highlighting the importance of training that addresses the diversity and complexity of service environments.

Service Integration and Interagency Partnerships

Coordinated systems of care bolster peer specialists' ability to support recovery effectively. Survey data revealed that 87.7% of respondents believe their agencies utilize peer services, and 86.2% affirmed alignment with best practices. However, narratives from focus groups indicated that agency partnerships are often challenging. Peers reported discrepancies between publicly listed services and availability, creating barriers for staff and clients. Peers recommended that reentry and care coordination begin before individuals are discharged from jails or hospitals.

Systemic Housing Gaps and Social Determinants of Health

Access to safe and stable housing was identified as a foundational barrier in both data sources. This is a systemic issue that is not limited to Broward County. Peers described situations where parents lost custody of their children due to homelessness, and women were frequently excluded from transitional or respite housing. Survey respondents noted that agencies maintain partnerships with housing providers and support services; however, these affiliations often lack the operational strength needed to ensure access.

Focus group participants stressed that housing for co-occurring or justice-involved individuals is virtually nonexistent, with one

participant stating, 'We don't have true co-occurring services. No housing for co-occurring. No mental health housing outside of an ALF.' These structural barriers limit recovery not only for clients but also for the peer specialists supporting them.

In sum, the analysis highlights a resilient peer support workforce. There is a high level of demand for these services despite limited capacity across systems. The survey strongly aligns with recovery values, deep professional commitment, and a growing credentialed workforce. In contrast, the focus group emphasizes a more complex reality: structural inequities, limited compensation, training gaps, and superficial inclusion undermine the impact and sustainability of peer roles.

To tackle these issues, agencies and systems will need to invest in higher compensation, inclusive hiring practices for justice-involved individuals, expanded training in trauma-informed and culturally responsive care, and improved interagency coordination.

Consumer Experience Survey and Focus Groups

Quantitative data were collected through the Cultural Health Disparities Survey (N = 99) and a broader Consumer Experience Survey (N = 80). These surveys were distributed to adults who were either receiving or had recently attempted to access mental health and substance use services.

To complement this quantitative data, three focus groups were conducted with a total of 37 adult participants, ranging in age from 25 to 97 years, most of whom were living with serious mental illness (SMI). Using a generic qualitative analysis approach, emergent themes from the focus groups were examined alongside the quantitative findings to generate a comprehensive view of consumer-reported access, quality, cultural responsiveness, and barriers to behavioral health care.

Participants in the surveys and focus groups came from diverse backgrounds, reflecting the racial, cultural, and economic complexity of Broward County. In the Cultural Health Disparities Survey, 68.9% of respondents identified as Black or African American, 20% as White, and 11.1% as multiracial or other—approximately 30% of participants identified as Hispanic. Most participants were aged 25 to 54, a demographic typically showing higher engagement with the behavioral health system. The Consumer Experience Survey also included a mix of direct service users and caregivers, with services encompassing adult mental health, substance use treatment, and children's mental health programs. In the focus groups, participants reflected these demographics, representing a broad spectrum of ages, races, and lived experiences, including reentry from incarceration, homelessness, and co-occurring disorders.

Service Navigation and System Complexity

Quantitative results indicated that 85.5% of survey respondents knew where to find services, but many still encountered substantial delays or systemic barriers. Only 27.5% had ever contacted the 2-1-1 referral system, indicating a disconnect between awareness and effective use of available navigation tools.

Focus group data expanded on these findings. Participants described the system as

fragmented and burdensome, particularly during times of need. One participant stated, "They told me to call back in two weeks. Then when I called back, they said my name wasn't even in the system anymore. I had to start all over again." Another added, "Nobody tells you what the next step is. You just kind of float between appointments hoping someone will help." These accounts suggest the need for embedded system navigators and improved referral coordination.

Timeliness and Transportation Barriers

Survey data revealed that while most consumers received services within 10 days, about 20% waited more than two weeks. Most travel times were under 30 minutes for the majority; however, access remained inconsistent for marginalized subgroups. The Cultural Health Survey found that 50% of respondents deemed services unaffordable.

Focus group participants discussed how geography and transit influence their experiences. "I had to take two buses to get there, and when I missed the second one, they said I had to reschedule. That was three more weeks," shared one individual. These experiences indicate that close proximity to services does not ensure true accessibility, especially for those dependent on public transit or residing in underserved neighborhoods.

Cultural Misalignment and Respect:

According to the Cultural Health Disparities Survey, only 37.5% of respondents stated that their providers "always" respected their culture, while another 25% indicated "most of the time." However, over 37% ended treatment due to feeling misunderstood. Subgroup analysis revealed that multiracial and gender-fluid participants were more likely to report this misalignment.

Focus group participants highlighted this disconnect. "It's not just about race. It's about how we grow up, how we cope. They don't get it, and they don't ask," said one participant. Others recounted experiences where emotional expression or dialects were misinterpreted as non-compliance or lack of engagement. These narratives emphasize the need for more intersectional training in cultural humility, rather than solely focusing on diversity.

Peer Support as a Catalyst for Trust

Survey data revealed that 24% of participants had interacted with a Peer Support Specialist, even though their positive impact on engagement was evident. Focus group responses underscored the importance of these relationships. "My peer mentor didn't judge me. She didn't look at me like a chart," one consumer explained. Another shared, "When I felt like giving up, my peer support reminded me I wasn't alone." These perspectives highlight the necessity of continuously improving the integration of peer support at every service level, from crisis response to outpatient recovery planning.

Service Satisfaction and Continuity

Many survey and focus group participants appreciated supportive providers despite structural barriers. The Consumer Experience Survey found that most felt their treatment addressed personal needs. One focus group member recalled, "He stayed on the phone

with me through my panic attack. I didn't think anyone would do that."

These provider relationships built loyalty and helped participants address systemic deficiencies. However, satisfaction often relied on the actions of individual providers rather than the overall system, emphasizing the need for consistency in trauma-informed, person-centered care.

Conclusion and Summary of Survey & Focus Group Outcomes

The synthesized findings from surveys and focus groups with stakeholders, providers, peer specialists, and service consumers yield a comprehensive and nuanced portrait of the behavioral health system's strengths, limitations, and opportunities.

Across surveys and focus groups, there is widespread acknowledgment of the availability of behavioral health services in the county. Providers consistently reported high levels of organizational commitment to No Wrong Door (NWD) principles, cultural competence, and inclusion of peer support staff. Most respondents demonstrated familiarity with BBHC's role and services, and many had directly accessed or referred clients to its programs. However, the ability to navigate the system effectively and ensure consistent service access remains a challenge. Consumers and providers alike reported that even when services exist, they are often challenging to connect with due to waitlists, lack of warm handoffs, inconsistent follow-up, outdated referral systems, and transportation limitations.

The data presented also illustrates the unique challenges associated with serving high-need and high-utilizing individuals. These clients frequently cycle through multiple systems, justice, housing, behavioral health, and emergency care, without stable support or comprehensive care coordination. Focus group participants emphasized that individuals discharged from jails or hospitals are often released without a clear plan, necessary medications, or a connection to ongoing care. This contributes to a revolving door effect, where individuals in crisis are repeatedly stabilized but not sustained in recovery. The lack of system-wide accountability for follow-up care exacerbates this issue. While some providers track internal outcomes, few systems are integrated across agencies, leaving a vacuum in shared care responsibility.

Care coordination services, when available, are seen as essential to supporting high-need clients and achieving continuity of care. Peer-led and community-based innovations were repeatedly cited as examples of effective system navigation and engagement. Programs such as the South Florida Wellness Network and community health hubs were praised for their accessibility, trustworthiness, and ability to maintain engagement with clients who might otherwise disengage from care. Peer support was also viewed as a powerful tool for trust-building, especially among clients with histories of trauma and incarceration. However, despite widespread endorsement of peer involvement, challenges related to training, integration, and compensation persist. Peer specialists often report feeling underutilized or excluded from decision-making and hiring policies, including background check requirements, which frequently disqualify individuals with lived experience who are otherwise well-qualified for these roles.

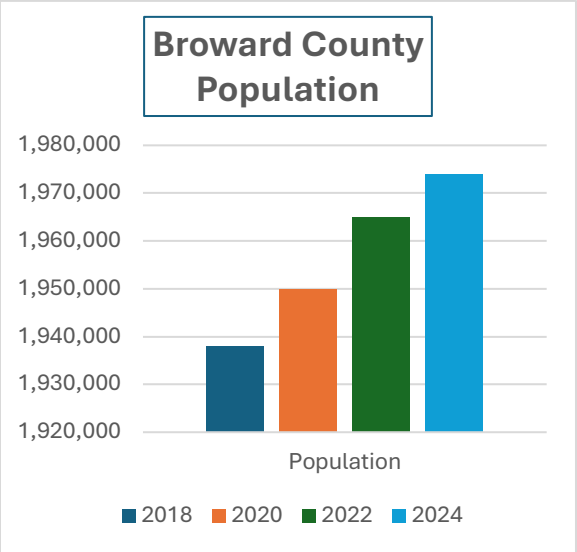
Structural barriers continue to be a persistent theme. The most frequently cited obstacles to care include waiting lists, transportation limitations, language and cultural mismatches, and the lack of evening and weekend service hours. Geographic disparities and affordability also contribute, especially for populations living in high-poverty neighborhoods or relying on public transportation.

In summary, the community feedback collected for this report portrays a behavioral health system that is recognized for its assets and philosophical commitments but still struggles with operational coherence. There is broad agreement that services exist and that BBHC plays a vital role in funding and coordinating care. Yet, the system's fragmentation, lack of shared accountability, and insufficient infrastructure impede its ability to function as a seamless continuum, particularly for high-need clients. Care coordination, peer involvement, and responsive engagement models are widely supported as strategies for bridging this gap. Strengthening these components, along with investing in infrastructure, workforce support, and cross-agency communication systems, will be essential for realizing the full potential of a No Wrong Door, recovery-oriented system in Broward County.

Behavioral Health Trends in Broward County (2018–2024)

Population and Demographic Trends (2018–2024)

Between 2018 and 2024, the population of Broward County experienced consistent and moderate growth, increasing from approximately **1,938,000 residents in 2018 to an estimated 1,974,000 residents in 2024** (U.S. Census Bureau, 2023; Cubit Planning, 2025). This cumulative increase of 1.86% stands in contrast to Florida's overall more rapid population expansion, which is primarily driven by migration and economic opportunities. During this timeframe, **Broward's median age rose from 40.7 years in 2018 to 41.5 years in 2024,** indicating a gradually aging population, yet it remains younger than Florida's median age (U.S. Census Bureau, 2023).



The county's racial and ethnic diversity has intensified over this period. **In 2018, White non-Hispanic residents constituted 35.2% of the population, which decreased to 31.9% by 2023, while the Hispanic population grew from 28.6% to 32.5%** (ACS, 2018; ACS, 2023). Black non-Hispanic residents consistently represented approximately 27–28%, although there was a slight increase in absolute numbers, corresponding with the overall population growth.

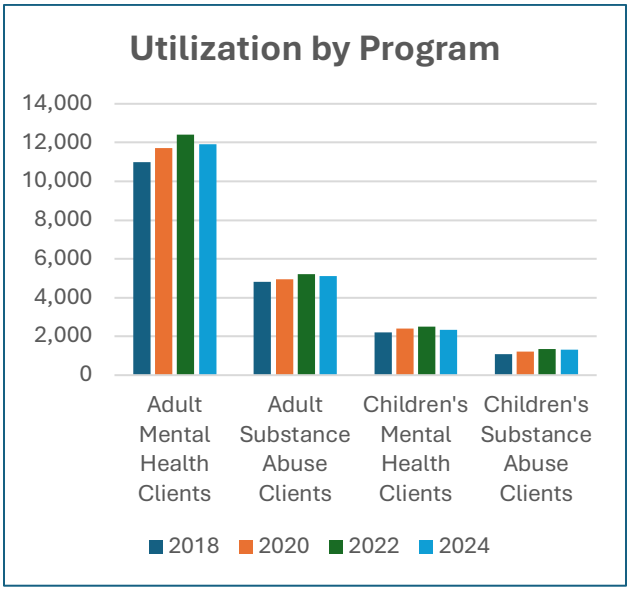
The gradual demographic shifts, particularly the increasing racial and ethnic diversity, along with a modestly aging population, indicate that future behavioral health services must be substantially more culturally responsive while also preparing for an augmented demand for geriatric mental health support.

Service Utilization Patterns

The utilization of behavioral health services in Broward County exhibited significant variations during the designated timeframe. Adult mental health (AMH) and adult substance abuse (ASA) services continually served as the primary segments for clientele. From 2018 to 2024, programs funded by the Broward Behavioral Health Coalition (BBHC) rendered services to an annual population ranging from 15,000 to 17,000 individuals across AMH and ASA service categories, with a modest increase in utilization observed each year (BBHC Service Reports, 2018–2024).

The services related to children's mental health (CMH) and children's substance abuse (CSA) catered to approximately 3,500 to 4,000 youth on an annual basis during this timeframe. Notably, outpatient service utilization among all demographics experienced a significant increase in 2021–2022, indicative of the heightened mental health requirements following the pandemic and the enhanced availability of telehealth services.

Crisis stabilization admissions have also experienced an increase, particularly among adults, reflecting a 12% rise in admissions between 2020 and 2023. This trend is likely attributed to the escalating acuity of mental health issues exacerbated by economic and social stressors (BRFSS, 2023).

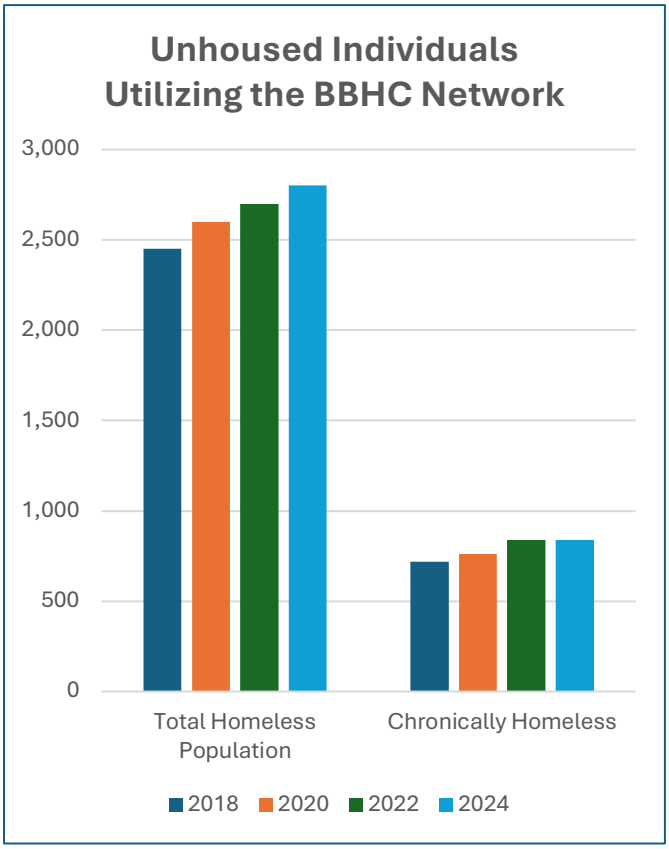


Utilization growth reflects both the community's needs and the system's responsiveness. Nevertheless, the expansion of outpatient services must be proportional to staffing, resource scaling, and sustainability strategies, especially within school-based settings.

Homelessness Trends

The statistics regarding homelessness in Broward County have fluctuated yet ultimately demonstrated **an increase from 2,450 individuals in 2018 to 2,800 in 2024**, signifying an overall escalation of 14% (Broward PIT Count, 2024). Although the number of individuals experiencing sheltered homelessness has remained comparatively stable, the incidence of unsheltered homelessness has surged by nearly 18% throughout this six-year interval.

Significantly, the population of chronically homeless individuals, defined as those enduring long-term homelessness frequently exacerbated by behavioral health conditions, has also increased, accounting for approximately 30% of the homeless population by the year 2024 (Florida Council on Homelessness, 2024).



Rising homelessness, particularly among individuals experiencing co-occurring mental health and substance use disorders, underscores an urgent necessity for BBHC and its collaborators to enhance affordable housing capacity in Broward County, establish assertive community treatment

(ACT) teams, and implement integrated care models.

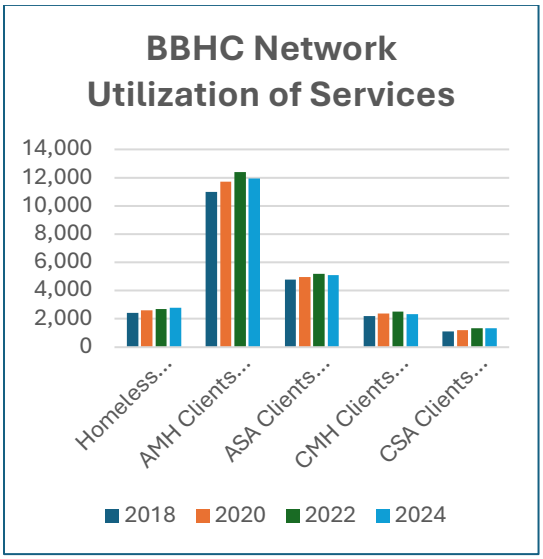
Gender Distribution Trends

The gender distribution among behavioral health clients has remained relatively consistent from 2018 to 2024. Within the program areas of AMH, ASA, CMH, and CSA, approximately 52% of all clients have been male, while 48% have been female annually. Nonetheless, slight yet notable patterns have emerged.

- Adult substance abuse programs have consistently catered to a high number of males, comprising approximately 66 to 68 percent of the participants, aligning with increased substance abuse incidence rates among males as compared to females.
- The services provided for Children's Mental Health demonstrated a nearly equal distribution; however, there has been a modest increase in female engagement, rising from 47% to 50% over the observed period. These subtle shifts may indicate a changing social acceptance among young females regarding the pursuit of behavioral health care and persistent gendered patterns in adult substance use rates.

Targeted outreach focused on gender, especially for underserved female populations within adult substance abuse services, has the potential to enhance outcomes. Additionally, addressing the emerging mental health needs of young females should inform the development of future Community Mental Health programming.

Visual Snapshot of Broward Behavioral Health Trends



Waitlist Historical Trends

Between 2018 and 2025, the behavioral health system in Broward County significantly reduced the number of individuals placed on waitlists for residential and outpatient services across nearly all demographic segments. This trend indicates targeted investments within the system, the implementation of prioritization protocols, and potentially enhanced access pathways. Data from the BBHC Network for the fiscal years 2018–2019 and 2023–2025 substantiate this assertion.

Waitlist Trends Table

Population & Service Area	FY18–19 WL Count	FY18–19 Avg Wait Days	FY24–25 WL Count	FY24–25 Avg Wait Days
MH Children Outpatient	11	N/A	70	20.6
SA Children Outpatient	0	0	0	0
MH Adult Outpatient	105	19.6	108	27.5
SA Adult Outpatient	92	12.8	30	8.0
MH Residential	428	36.04	189	24.0
SA Residential	159	N/A	296	24.0

An integrated review of BBHC's waitlist data across FY 2018–2019 and FY 2024–2025 reveals a complex but instructive evolution of service demand and access delays, particularly across outpatient and residential services for both youth and adult populations. While the number of individuals on waitlists has shifted across categories, changes in average wait times further illuminate where systemic improvements have been made and where barriers to timely access persist.

In **children's mental health outpatient services**, the number of individuals on the waitlist rose from 11 in FY 2018–2019 to 70 in FY 2024–2025. While no historical average wait time was available, the current average wait of 20.6 days suggests moderate delays in care. This increase likely reflects a growing recognition and diagnosis of pediatric mental health needs, coupled with rising clinical complexity and limited provider availability. However, it is important to recognize that many children receiving behavioral health services in Florida are covered under Medicaid or KidCare, which means their treatment is reimbursed through those systems and not reflected in BBHC waitlists. BBHC, as the safety-net managing entity, funds care only for uninsured or underinsured populations. For children with substance use needs, there were no individuals waitlisted in either year, which may indicate low service volume, strong diversion strategies, or adequate service continuum across the many service payors.

For **adult mental health outpatient services**, the number of individuals on waitlists remained relatively constant, 105 in FY 18–19 and 108 in FY 24–25. However, the average wait time increased from 19.6 to 27.5 days. This rise in delay, despite flat volume, suggests that while demand has stabilized, provider availability or throughput may have declined, potentially due to staffing shortages or growing clinical complexity.

The **adult outpatient substance use** category exhibited one of the most significant improvements: the waitlist declined from 92 to 30 individuals, and the average wait time dropped from 12.8 to 8.0 days. These trends suggest meaningful gains in outpatient SUD treatment access, likely stemming from system-wide investments in community-based service delivery and triage protocols.

In contrast, **residential treatment services** experienced divergent trends. For **mental health residential care**, the number of individuals waitlisted declined from 428 in FY 18–19 to 189 in FY 24–25, with the average wait time remaining consistent at 40 days. This indicates enhanced efficiency in managing high-acuity placements and possibly greater residential treatment availability or more effective diversion to alternative levels of care. However, the most dramatic shift occurred in **residential**

substance use treatment, where waitlisted individuals increased from 159 in FY 18–19 to 296 in FY 24–25, an 86% rise. While the average wait time is now 24.0 days, the surge in volume suggests escalating demand for high-intensity SUD treatment. It highlights the urgent need for expanded residential capacity and enhanced upstream outpatient and recovery support.

In summary, BBHC has demonstrated measurable progress in reducing wait times for outpatient substance use services and improving the efficiency of adult mental health residential placements. However, rising volumes in outpatient mental health services for children, particularly those without Medicaid, KidCare, or other insurance coverage, and increased demand for residential substance use disorder (SUD) placements among adults highlight service gaps within the safety-net system. Because the majority of insured children access care through reimbursable systems outside of BBHC, the observed increase in waitlisted uninsured youth underscores the vulnerability of those without coverage. Strategic investments to strengthen outpatient mental health capacity, expand residential treatment infrastructure, and better align provider resources with uncovered demand will be essential to ensuring equitable access and maintaining system responsiveness for all high-need, uninsured, or underinsured populations.

Financial Expenditures

Between FY 2018–2019 and FY 2023–2024, total behavioral health expenditures managed by the Broward Behavioral Health Coalition (BBHC) rose significantly, from $60.7 million to $108 million, reflecting a 66% increase over six years. This steady expansion signals BBHC's growing role as the managing entity responsible for serving uninsured and underinsured individuals in Broward County's behavioral health system. The funding structure, composed of core state allocations from the Florida Department of Children and Families (DCF) and a diverse range of supplemental revenue streams, has enabled BBHC to expand service delivery capacity, stabilize essential programs, and respond to rising population demand.

Core program expenditures, which include Adult Mental Health (AMH), Adult Substance Abuse (ASA), Children's Mental Health (CMH), and Children's Substance Abuse (CSA), represented the majority of BBHC's annual investments across all years. AMH remained the largest funding category, rising from $30.5 million in FY 2018–2019 to $45.1 million in FY 2023–2024. ASA expenditures increased from $20.3 million to nearly $36.8 million in the same timeframe, while CMH grew from $3.8 million to $6.0 million. CSA allocations fluctuated modestly but showed overall growth, from $3.3 million to $4.4 million by FY 2023–2024. Together, these four categories accounted for over 95% of DCF-funded behavioral health services in each fiscal year.

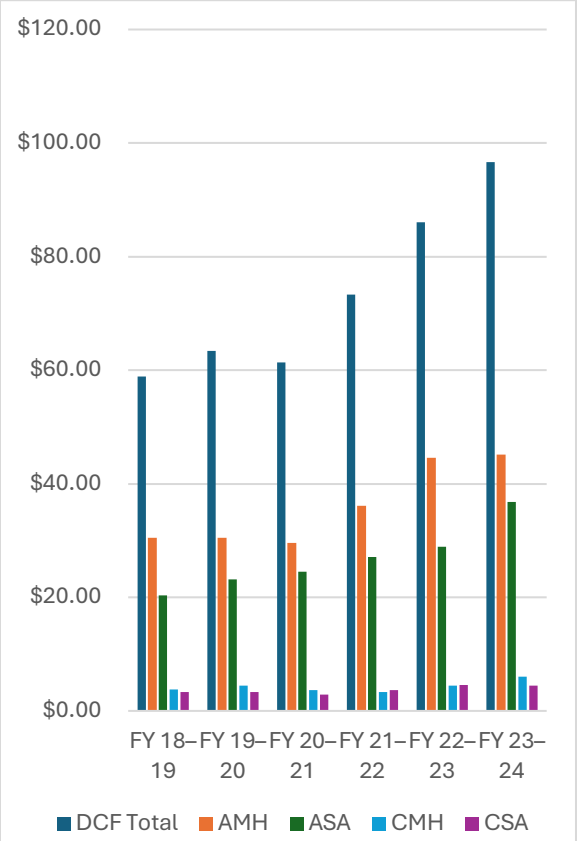
The proportion of funding dedicated to adult services (AMH and ASA combined) consistently exceeded 80% of total program expenditures, underscoring the high acuity and complex service needs of Broward's uninsured adult population. In contrast, children's services (CMH and CSA) remained a smaller segment, reflecting the broader structural reality that most children are covered under Medicaid or KidCare and therefore receive services outside the BBHC-managed system. However, the increase in CMH funding by more than 57% over the

review period signals a growing recognition of youth mental health needs within the safety-net population.

Beyond core DCF allocations, **supplemental investments** contributed to the growth of BBHC's system of care. These included carry-forward funds from prior fiscal years, as well as targeted grants and local appropriations. For example, initiatives such as the Broward Youth Reentry Project (BYRP), Family CPR, and Healthy Connections were sustained through designated federal grants and state reentry funding streams, providing critical services such as peer support, transitional care, and coordination for justice-involved and high-need populations. In FY 2023–2024 alone, over $4.2 million in carry-forward resources and $1 million in BYRP funding supplemented BBHC's direct service system.

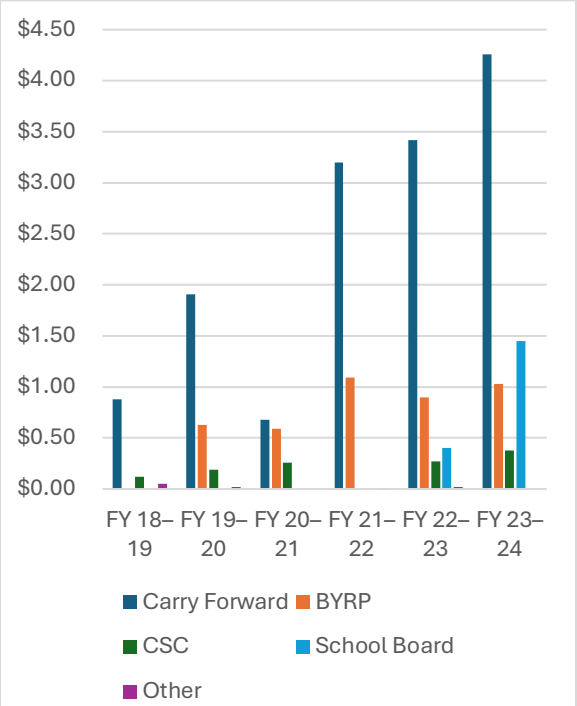
Local partnerships further enhanced capacity. The Children's Services Council (CSC) contributed more than $375,000 in FY 2023–2024 to support youth behavioral health coordination. The School Board invested over $1.4 million in that same year to expand school-based services and mental health prevention efforts. Wellpath contributed approximately $68,675 to support forensic and jail-based treatment efforts. While smaller in proportion to DCF funding, these sources played an essential role in bridging service gaps and reinforcing cross-sector collaboration. The table below summarizes financial expenditures across funding sources for the six years:

DCF Core Program Expenditures (in Millions)



Fiscal Year	DCF Total	AMH	ASA	CMH	CSA
FY 18–19	$58.9M	$30.5M	$20.3M	$3.8M	$3.3M
FY 19–20	$63.4M	$30.5M	$23.2M	$4.5M	$3.3M
FY 20–21	$61.4M	$29.6M	$24.5M	$3.7M	$2.9M
FY 21–22	$73.3M	$36.1M	$27.1M	$3.3M	$3.7M
FY 22–23	$86.1M	$44.6M	$28.9M	$4.5M	$4.6M
FY 23–24	$96.6M	$45.1M	$36.8M	$6.0M	$4.4M

Supplemental Investment Expenditures (in Millions)



Fiscal Year	Carry Forward	BYRP	CSC	School Board	Other
FY 18–19	$0.88M	$0.00M	$0.12M	$0.00M	$0.05M
FY 19–20	$1.91M	$0.63M	$0.19M	$0.00M	$0.02M
FY 20–21	$0.68M	$0.59M	$0.26M	$0.00M	$0.00M
FY 21–22	$3.20M	$1.09M	$0.32M	$0.00M	$0.01M
FY 22–23	$3.42M	$0.90M	$0.27M	$0.40M	$0.02M
FY 23–24	$4.26M	$1.03M	$0.38M	$1.45M	$0.03M

Source: BBHC Financial Reports, 2018–2024.

This integrated analysis of BBHC's financial trends highlights the breadth and evolution of Broward County's behavioral health safety-net. The system has grown in both scale and diversification of funding, ensuring that essential services remain accessible for uninsured and underinsured residents. Continued strategic alignment between core funding and targeted local investments will be necessary to sustain this momentum and advance equitable access to care across the lifespan.

Strategic Implications for Financial Planning

The financial data from FY 2018–2019 through FY 2023–2024 reveals several critical strategic implications for financial planning within the BBHC system of care, particularly in its role as a safety-net behavioral health network serving uninsured and underinsured residents of Broward County.

First, the consistent and substantial increases in **total DCF allocations**, rising from $58.9 million in FY 18–19 to $96.6 million in FY 23–24 (a 64% increase), indicate a reliable expansion of the state's investment in safety-net behavioral health infrastructure. The **Adult Mental Health (AMH)** and **Adult Substance Abuse (ASA)** categories account for most of the funding, with AMH growing from $30.5 million to $45.1 million and ASA from $20.3 million to $36.8 million during this same period. This adult orientation reflects real system demands, such as co-occurring disorders, chronic homelessness, and reentry populations.

Second, while funding for **Children's Mental Health (CMH)** and **Children's Substance Abuse (CSA)** also increased, their proportions remain comparatively small. The CMH budget rose from $3.8 million in FY 18–19 to $6.0 million in

FY 23–24, and CSA from $3.3 million to $4.4 million.

Third, the year-over-year increases across all core categories, particularly the sharp increases in FY 21–22 through FY 23–24, suggest that **BBHC is scaling its provider network** in response to complex drivers such as rising acuity, housing instability, and justice-system involvement. However, continued reliance on categorical funding (e.g., AMH vs. CMH) may limit cross-system coordination unless more flexible financing models are implemented.

From a financial planning standpoint, BBHC must remain attentive to the balance between adult stabilization investments and earlier-stage interventions for children and adolescents. Strategic reinvestment of carry-forward funds and grant revenues should target service gaps, especially in outpatient care, youth behavioral health, and transition-age populations that are often under-identified. At the same time, the escalating reliance on high-cost adult care services may require BBHC to prioritize workforce development, service integration, and value-based payment reforms to enhance sustainability.

Finally, the expansion of funding itself brings increased operational responsibility. As BBHC's system budget approaches $200 million annually, maintaining **fiscal oversight**, ensuring **resource allocation**, and building **capacity for data-driven contracting** will be central to sustaining accountability and efficiency. Proactive planning, especially during periods of federal or state policy transition, will be critical to mitigate volatility in non-recurring or supplemental funding streams and to secure the long-term solvency of the provider network.

Summary

Between 2018 and 2024, Broward County experienced modest population growth and increasing demographic diversity, contributing to changing behavioral health service needs. The population rose by 1.86%, while the county became more racially and ethnically diverse and gradually aged. These changes highlight a growing need for culturally responsive care and expanded geriatric mental health services.

Behavioral health service utilization has increased across all age groups, particularly in adult mental health and substance use services. **Outpatient care showed the most substantial growth**, especially following the COVID-19 pandemic, due to heightened demand for mental health care and the expansion of telehealth. **Crisis stabilization admissions rose by 12%** from 2020 to 2023, reflecting the increasing acuity of services.

Homelessness also increased during this period, with a **14% rise in the overall homeless population and an 18% increase in unsheltered homelessness.** Notably, by 2024, chronically homeless individuals, many with co-occurring behavioral health conditions, constituted 30% of this population. These trends highlight an urgent need for expanded supportive housing and integrated behavioral health interventions.

Gender distribution in service use remained stable overall, with males making up most adult substance use clients. A significant increase in female participation in children's mental health services may indicate greater

social acceptance of behavioral health care among youth.

Waitlist data revealed a significant decline in individuals placed on residential and outpatient waitlists by 2024. However, the average duration of wait times for outpatient services increased, indicating that while triage and prioritization improved, actual system capacity remained strained. **For example, outpatient wait times for adults rose from 19.6 days in 2018 to 27.5 days in 2024.**

The data highlights achievements and increasing vulnerabilities within Broward County's behavioral health system. Reductions in waitlist volume, expanded outpatient access, and heightened awareness indicate progress. However, increased service acuity and ongoing housing challenges suggest that coordinated, sustainable strategies will be essential for maintaining and enhancing the system over the next decade.

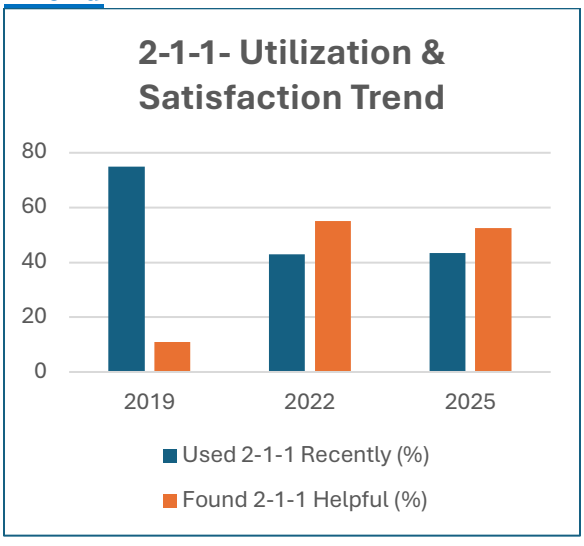
Stakeholder Input Across the Years

Over the past decade, the Broward Behavioral Health Coalition (BBHC) has carried out periodic community needs assessments to evaluate the strengths, challenges, and evolution of the behavioral health system in Broward County. This report synthesizes key findings from the 2019, 2022, and 2025 assessments, integrating quantitative survey results with qualitative focus group insights. The analysis examines systemic patterns, persistent barriers, and emerging innovations through a longitudinal lens. It also places these trends in the context of the COVID-19 pandemic, which brought a series of cascading disruptions that continue to affect the delivery and accessibility of care across the county. The following findings reflect the internal dynamics of Broward's system.

Trends in System Awareness and Navigation

Stakeholder awareness of behavioral health resources in Broward County has consistently remained high. In 2025, 90.8% of respondents reported familiarity with BBHC's offerings, reflecting similarly strong awareness levels in 2019 and 2022 (BBHC, 2019; 2022; 2025). However, high general awareness levels did not consistently lead to effective service navigation or successful linkage to care. The county's utilization of 2-1-1, one of the County's referral resource, dropped significantly after 2019. As shown below, the use of 2-1-1 declined from 75% in 2019 to 43% in 2022 and remained stagnant in 2025. Satisfaction with the tool increased from 11% in 2019 to 52.6% in 2025, but nearly half of the users reported it was only "somewhat helpful" or not helpful.

2-1-1 Utilization and Satisfaction Trend



This decline in utilization and mixed satisfaction aligns with national disruptions to information and referral systems during the COVID-19 pandemic. According to the National Alliance to End Homelessness (2021), 2-1-1 systems nationwide were overwhelmed with COVID-related inquiries, housing emergencies, and service redirections, which likely diminished reliability and discouraged subsequent use in Broward.

Access Barriers and Structural Constraints

The persistence of **waitlists** continues to be one of the most significant challenges across all assessment years. Forty-six percent (46%) of consumers in 2019 cited waitlists as a barrier, a rate that decreased to 12% in 2022 but re-emerged as a "high frequency" concern in 2025.

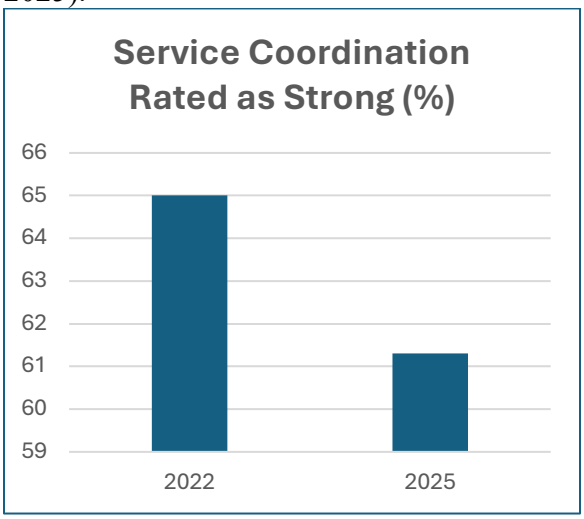
This trend is likely due to pandemic-driven workforce attrition. The American Psychological Association (2022) reported that more than 60% of providers were unable to meet post-pandemic mental health demand due to burnout and staff shortages, conditions mirrored in Broward's provider network, especially in detoxification and psychiatric services.

Transportation, though not the most frequently cited barrier, remains a persistent obstacle to access for vulnerable groups. In 2019, 26% of consumers identified it as a barrier; by 2022, this number declined to 15%, and it was still considered a "moderate" barrier in 2025, particularly impacting low-income populations and those with mobility impairments.

COVID-19 has worsened the enduring impact of these structural barriers. Many community-based programs previously providing transportation or mobile services were paused or closed during the pandemic and have not fully recovered. The Substance Abuse and Mental Health Services Administration (SAMHSA, 2021) notes that while telehealth increased access for some, it left behind many who lacked digital connectivity or technological literacy.

Service Coordination and System Fragmentation

One trend over the past decade has been the **decline in perceptions regarding system coordination**. In 2022, 65% of stakeholders agreed that services were coordinated across care systems. By 2025, this figure dropped to 61.3%, with nearly 20% disagreeing (BBHC, 2025).



This erosion of confidence in coordinated care marks a significant characteristic of pandemic-era service fragmentation. Rapid transitions to remote operations, workforce turnover, and isolated data systems have disrupted care continuity. Focus group participants in 2025 cited frequent instances

of duplicated referrals, missed handoffs, and a lack of communication between providers, echoing concerns raised in the National Council for Mental Wellbeing (2021).

Discharge Planning and High-Need Populations

Across all three assessments, discharge planning barriers, particularly for justice-involved individuals, older adults, and those with co-occurring disorders, have been a recurring issue. In 2025, stakeholders reported that individuals were being released from incarceration or inpatient care without medications, housing, or referrals. This problem became more pronounced during the pandemic, when transitional programs were suspended or permanently closed. The Urban Institute (2021) found that behavioral health clients were disproportionately affected by housing instability and lacked adequate discharge supports during COVID-19, which aligns with trends identified in Broward.

Peer Support and Community-Led Innovation

A significant growth area has been the role and visibility of peer support services. In 2019, peer services were recognized as emerging supports. By 2022, peer-led organizations were acknowledged for enhancing the quality of life. In 2025, peer involvement was identified as essential for system navigation and recovery success. However, qualitative data continued to reveal barriers for peer support workers, including low compensation, limited supervision, and exclusionary background screening policies.

During the pandemic, peer specialists became essential bridges for consumers confronting digital divides or institutional mistrust. The Mental Health America (2022) report confirmed that peer roles were crucial in maintaining engagement and reducing stigma during the crisis, a conclusion echoed in Broward's 2025 focus groups.

Housing as the Central Unmet Need

Housing has consistently been the primary unmet need across all three assessment years. In 2019, the absence of step-down and transitional housing was noted as a factor delaying discharges and overcrowding residential beds. **By 2022 and 2025, "housing" emerged as the most frequently mentioned keyword in open-ended stakeholder responses, highlighting acute concerns regarding recovery housing, respite care, and accommodations for co-occurring disorders.** The pandemic only worsened this issue. Economic strain, reduced shelter capacity, and the reallocation of housing funds to the COVID-19 response contributed to a housing crisis for individuals with behavioral health needs (National Alliance to End Homelessness, 2021).

Summary

The historical trends report offers a comprehensive view of the evolution of Broward County's behavioral health system between 2018 and 2024, capturing significant demographic, clinical, financial, and operational developments. During these six years, the county experienced modest population growth and increasing racial and ethnic diversity, with a total population increase of 1.86% and a notable rise in Hispanic residents. Concurrently, the median age increased slightly, reflecting a gradual

demographic shift that underscores the need for both culturally responsive care and expanded geriatric mental health resources.

Behavioral health service utilization has grown steadily, particularly in adult mental health (AMH) and adult substance abuse (ASA) categories, which served between 15,000 and 17,000 individuals annually. Outpatient service volume increased most significantly following the COVID-19 pandemic due to rising mental health demand and the expansion of telehealth access. However, this growth in demand has also coincided with increasing clinical acuity, as evidenced by a 12% rise in crisis stabilization admissions between 2020 and 2023. Children's services, while more limited due to their reimbursement through Medicaid and KidCare, also showed increased engagement, especially in outpatient mental health.

Homelessness emerged as a growing concern, with the overall number of individuals experiencing homelessness increasing by 14% and unsheltered homelessness rising by 18% over the six years. By 2024, approximately 30% of Broward's homeless population met the criteria for chronic homelessness, a status closely tied to co-occurring behavioral health needs. These trends highlight the urgent need for expanded available housing and integrated service models such as Assertive Community Treatment (ACT) teams.

Waitlist trends reflected a complex dynamic. While the number of individuals placed on waitlists for many services decreased, average wait times for outpatient care, particularly for adult mental health, increased, suggesting persistent bottlenecks in provider availability. Children's outpatient mental health waitlists rose, but it is important to contextualize this in light of BBHC's limited purview over Medicaid-covered populations; those appearing on the waitlist represent only uninsured or underinsured youth. In contrast, adult substance use outpatient services demonstrated notable gains in access, with both volume and average wait times declining substantially.

Financially, BBHC's system of care experienced a 65% increase in expenditures from FY 2018–2019 to FY 2023–2024, rising from $119.5 million to $197.3 million. Core program areas, AMH, ASA, CMH, and CSA, accounted for most DCF-funded services, with adult programs consistently representing more than 80% of expenditures. While children's services remained a smaller share, investments in children's mental health rose by over 57%, reflecting growing awareness of youth behavioral health needs within the safety-net population. Supplemental funds from federal grants, carry-forward resources, and local partners such as the Children's Services Council (CSC) and the School Board further diversified BBHC's financial portfolio and supported cross-sector innovations in care.

Taken together, the data reflect both measurable progress and persistent challenges. Reductions in waitlist volume, increases in outpatient access, and the diversification of funding streams point to a more responsive and adaptive system. Future system planning must prioritize infrastructure expansion, workforce stabilization, housing integration, and more flexible financing mechanisms to maintain equity, access, and continuity of care across the BBHC network.

Current State of the System of Care in Broward County: Needs, Gaps & Recommendations

Current State of the System of Care in Broward County: Advances, Gaps, and Pandemic Impact

Between 2018 and 2025, Broward County's behavioral health system has evolved into a more coordinated and responsive continuum of care. Through the leadership of the Broward Behavioral Health Coalition (BBHC) and its diverse network of safety-net providers, the system has demonstrated resilience, innovation, and a deepening commitment to person-centered, recovery-oriented care. While serious challenges remain, particularly in the wake of pandemic disruptions and federal policy shifts, the system's trajectory is marked by notable gains in access, coordination, and person-centered approaches.

BBHC has made substantial investments in infrastructure and system navigation tools that prioritize the needs of individuals with the highest acuity. Mobile response teams have been deployed countywide, offering timely and trauma-informed crisis response services that reduce emergency room visits and unnecessary law enforcement involvement. These teams, composed of clinicians and certified peer specialists, embody the system's shift toward integrated, real-time, community-based engagement. Data from 2023-2024 indicates that these mobile units successfully diverted over 1,200 individuals from hospitalization or incarceration, instead linking them to outpatient or community-based supports (BBHC, 2025b).

The expansion of care coordination teams has further reinforced the system's capacity to manage complex, multi-system cases. Programs operated by Henderson Behavioral Health, Memorial Healthcare System, Camelot Community Care, and others now participate in weekly interdisciplinary coordination calls. These efforts have improved discharge planning, reduced fragmentation, and built collaborative pathways across behavioral health, child welfare, education, and justice systems. Particularly in the youth system, care coordination has been instrumental in reducing readmissions following Baker Acts and increasing engagement in wraparound services.

The integration of peer support is the most transformative change in the system. Certified peer specialists now operate within nearly every level of care, from outreach and crisis stabilization to reentry and recovery housing. Peer-run organizations such as South Florida Wellness Network and Rebel's Drop-In Center provide person-centered, non-clinical recovery environments that are trusted by consumers and respected by providers. Over 66% of the peer workforce is now certified, with 85% having lived experience. Their contributions are linked to reduced inpatient utilization, greater satisfaction with care, and improved long-term outcomes (SAMHSA, 2022).

Emerging Challenges and Unmet Needs

Yet, persistent and well-documented challenges remain. The system continues to grapple with service fragmentation, wait times, and insufficient housing for people with complex needs. The 2025 provider survey revealed that 61.3% of respondents believed the system was well-coordinated, and 45% felt that clients could easily navigate available services (BBHC, 2025a).

These figures highlight ongoing difficulties in achieving seamless care across agencies, particularly for individuals involved in multiple systems or transitioning from institutional settings.

The availability of affordable, recovery-oriented housing remains the most significant structural barrier. Between 2018 and 2024, the number of unsheltered homeless individuals in Broward County increased by 18%, with over 30% identified as chronically homeless and experiencing co-occurring disorders (Florida Council on Homelessness, 2024). Peer focus groups emphasized the lack of transitional, step-down, and gender-responsive housing, especially for women with children and justice-involved parents. Despite Housing First policies, implementation is often stymied by zoning restrictions, stigma, and inadequate operational funding.

The COVID-19 pandemic deepened these challenges while simultaneously accelerating essential reforms. In-person service closures, staff attrition, and surging demand created a backlog that still lingers. Wait times for adult outpatient mental health services, for example, increased from an average of 19.6 days in 2018 to 27.5 days by 2024 (BBHC, 2025b). Yet, these difficulties also catalyzed innovation: virtual service delivery expanded, mobile engagement was normalized, and system leaders became more responsive to social determinants of health. The pandemic clarified the importance of coordinated responses to trauma, housing instability, and access to recovery-oriented, appropriate care.

The recent passage of federal legislation has introduced new economic pressures on the safety-net system, particularly as changes to Medicaid redetermination processes and the rollback of Affordable Care Act subsidies unfold. Broward County, home to approximately 10% of the state's Medicaid enrollees, is projected to lose coverage for 150,000 to 160,000 individuals. At the same time, enhanced ACA premium supports that made marketplace plans affordable for low-income working families are being reduced. Local estimates suggest that as many as 25,000 Broward County residents with marketplace insurance may no longer be able to afford their plans, effectively increasing the uninsured rate in a region already struggling with uncompensated care. This projected loss of coverage threatens to overwhelm already burdened providers, increase demand for indigent services, and widen disparities in access to care.

Despite these stressors, the Broward behavioral health system continues to demonstrate resilience. Providers are adapting through flexible service models, peer-led outreach, and system-wide discussions about access, collaboration, and sustainability. BBHC's leadership in facilitating cross-agency communication, standardizing outcome metrics, and creating space for community voices positions the system to navigate these changes while maintaining its commitment to high-quality, recovery-oriented care.

In summary, Broward County's system of care has progressed from a fragmented network of providers into a more integrated and responsive continuum, shaped by evidence, experience, and community voice. It has demonstrated the capacity to expand access, elevate the role of peers, and respond to crisis with innovation. Continued advancement will depend on strategic investment, policy alignment, and a system-wide commitment to addressing persistent inequities with urgency and integrity. The current moment, while challenging, presents an opportunity to consolidate gains,

reinvest in what works, and fulfill the vision of a truly inclusive and resilient behavioral health system.

Strategic Recommendations for 2025–2028: Advancing a Resilient System of Care

As Broward County looks ahead to the next three years of developing its behavioral health system, the insights gained from the 2025 Community Needs Assessment and historical trend analysis pave the way with solid evidence and real stakeholder experiences. To address ongoing issues the system needs to embrace reforms that are integrated and focused on access. These reforms will help stabilize the workforce, enhance the infrastructure, and foster collaborative practices. The following recommendations spotlight key priorities for transforming the system from 2025 to 2028.

- Broward County should **establish a centralized referral and care coordination platform** that enables real-time service navigation and ensures agency continuity. The lack of a shared referral infrastructure leads to duplication, delayed services, and fragmented care pathways. An interoperable digital referral system with real-time capacity tracking and closed-loop communication between providers would effectively address these gaps. National models have shown that centralized coordination systems can significantly reduce referral drop-off and enhance care engagement, particularly for high-acuity populations (Center for Health Care Strategies, 2021).

- **Crisis and Forensic Continuum of Care:** Broward County continues to lead the state in both civil and forensic commitments to state mental health treatment facilities, highlighting a systemic need for local forensic diversion options. A **Forensic Alternative Center** would address this by serving as a secure, cost-efficient alternative to state forensic hospitals for individuals deemed Incompetent to Proceed (ITP) on non-violent charges. This aligns with trends indicating overcrowding in forensic units and an increase in jail days for individuals awaiting placement. **Short-term Residential Treatment (SRT) beds for jail diversion** also remain insufficient despite their recognized cost-effectiveness and alignment with best practices under the Stepping-Up Initiative, which emphasizes diversion and early linkage to community-based services (Stepping Up, 2022; SAMHSA, 2017).

- **Integrated Reentry and Housing Needs**: Justice-involved individuals face significant barriers, including lack of pre-release planning, access to housing services, and trauma-informed care. Peer focus groups highlighted that parents, especially women on MAT and fathers with criminal histories, are losing custody due to housing instability. Available reentry programs are underfunded and lack consistent coordination. These findings support SAMHSA GAINS Center and National Reentry Resource Center guidelines, which recommend housing-first reentry models and care continuity from incarceration to community reentry (NRRC, 2023; SAMHSA GAINS, 2017).

  The county must invest in **housing infrastructure that aligns with behavioral health recovery goals.** Housing instability, especially among individuals with co-occurring conditions and those involved in the justice system, was the most frequently cited unmet need across all focus groups in 2025. This reflects national findings that associate stable housing with decreased emergency service utilization and improved treatment adherence (National Alliance to End Homelessness, 2021). Recommended strategies include increasing the number of low-barrier transitional beds, expanding peer-supported

respite programs, and allocating county and state funds to recovery housing connected to outpatient care and wraparound supports.

- **Youth Crisis, Recidivism, and Baker Act Trends**: Implementing a shared database would address recurring youth crises by integrating real-time data sharing to ensure follow-up and coordination for Baker Acted children. In FY 2023–2024, Broward County recorded 9,842 involuntary examinations under the Baker Act, reflecting a rate of 4.95 per 1,000 residents. Approximately 18% of statewide exams involved children, and 25% of those children experience repeat Baker Acts, underscoring the need for system coordination and prevention strategies (Florida Department of Children and Families, 2024; LaGrone, 2025). Legislative reforms in 2024 have enabled law enforcement discretion, encouraging fewer involuntary holds in favor of community-based crisis stabilization (Florida Legislature, 2024). Stakeholders support this shift, noting the importance of enhanced parental guidance, multilingual consent procedures, and data-informed discharge planning.

- **Child and Family System Improvements:** Expanding Community Action Treatment (CAT) teams to support children ages 0–10 would help address the lack of intensive in-home supports for younger children with co-occurring conditions. This aligns with feedback from cross-sector stakeholders who highlighted the importance of earlier interventions to reduce residential placements. The model is supported by SAMHSA and DCF as an evidence-based method for preserving families and lowering reliance on more costly institutional care (DCF, 2024).

- BBHC and its partners need to **expand and formalize peer workforce development pipelines.** Although peer support is a strength of the system, peer specialists report inconsistent supervision, low pay, limited career opportunities, and unnecessary exclusion due to criminal background checks. Recommendations include creating regional certification hubs, funding peer-led training institutes, and integrating peers into interdisciplinary treatment teams with decision-making power. Research shows that peer providers reduce inpatient admissions and improve treatment satisfaction when fully supported and integrated (Substance Abuse and Mental Health Services Administration, 2022).

- System-level planning must explicitly address the **behavioral health needs of older adults,** particularly given the county's aging population. Geriatric mental health services have been consistently identified as underdeveloped, especially since several programs were lost during the pandemic. As life expectancy increases and the number of residents aged 65 and older rises, the system should develop age-specific outreach, home-based therapy options, and caregiver support programs. The Administration for Community Living (ACL, 2022) identifies integrated behavioral health and aging services as a national priority, recommending interagency planning and co-located care delivery for older populations.

- BBHC should **continue to strengthen the recovery-oriented system of care (ROSC) framework at the policy level** and align all network contracts, funding, and outcome metrics accordingly. ROSC principles emphasize person-centered care, community inclusion, and resilience over pathology. While the system already incorporates many recovery-aligned elements, strengthening ROSC will ensure consistency across programs and guard against the re-medicalization of care during future crises. The ROSC model has been adopted in multiple states and is backed by extensive evidence demonstrating its role in enhancing long-term recovery outcomes and system efficiency (SAMHSA, 2010).

- Finally, federal policy changes affecting **Medicaid and ACA subsidies** are projected to leave up to 160,000 Broward County residents uninsured, including many with behavioral health needs. Implementing a coordinated mitigation strategy will preserve access for this growing population. This includes expanding indigent care capacity, prioritizing uninsured individuals in safety-net services, and establishing flexible funding mechanisms. Additionally, reviewing partnership agreements with FQHCs, hospitals, and community organizations will help develop referral pathways and public education efforts. Incorporating predictive modeling to monitor disenrollment trends will help align system capacity with need and ensure that mobile crisis, outpatient, and peer support services remain accessible despite surging demand. Without targeted adaptation, coverage loss will overwhelm the system and reverse hard-won progress in access and equity.

In summary, the next phase of behavioral health system development in Broward County must concentrate on structural and sustainable reforms that consolidate the achievements of the past decade while directly addressing the gaps intensified by the pandemic. By strategically implementing these recommendations, the system can move beyond stabilization to transformation, creating a continuum of care that is community-informed and grounded in resilience and recovery.

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