Central Florida Behavioral Health Network, Inc.

Your Managing Entity

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ACKNOWLEDGEMENTS

This assessment could not be completed without the assistance and partnership of many throughout the community. The Central Florida Behavioral Health Network (CFBHN) would like to thank everyone who distributed surveys, participated in interviews, or focus groups, reviewed data and added information. CFBNH would like to acknowledge the following individuals and agencies for their participation in this process:

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Health Planning Council of Southwest Florida

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Healthy Start Coalition of Pinellas County

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West Central Florida Ryan White Care Council

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February 14, 2022

Dear Community, Partners and Stakeholders;

Thank you for the opportunity to complete the Needs Assessment survey this year.

This year Central Florida Behavioral Health Network collaborated with our local Health Councils to facilitate the 2022 Behavioral Health Needs Assessment for the Suncoast Region and Circuit 10. By measuring experiences, awareness, and coordination of treatment and services that currently exist and what needs remain, we will be able to help improve the behavioral health care system in our communities.

The survey was widely distributed within our fourteen counties of care and it took less than five minutes to complete. There was no personal information gathered during the process.

Central Florida Behavioral Health Network is a not for profit 501 (c) (3) corporation and a CARF International Accredited Network*, CFBHN contracts with community service organizations to provide a full array of publically funded mental health and substance abuse services in the SunCoast Region that includes the following counties: Charlotte, Collier, Desoto, Glades, Hardee, Hendry, Highlands, Hillsborough, Lee, Manatee, Pasco, Pinellas, Polk, and Sarasota. Range of services includes: acute care, residential treatment, housing, medical, outpatient, recovery support, and prevention.

CFBHN's transformational influence empowers local communities to develop, advocate for, and implement innovative solutions to social, economic, health, and wellness problems individuals may encounter that adversely impact lives. Mission is accomplished through seeking, developing, and nurturing partnerships with outstanding providers who offer high quality compassionate services. CFBHN continually meets the changing needs of the public safety net and manages all facets of the service delivery system providing oversight, education and training, implementation of treatment best practices, coordination with community partners and stakeholders as well as leading and encouraging inspirational advocacy support.

** CARF is the Commission on Accreditation of Rehabilitation Facilities*

Again, thank you for allowing us to conduct this valuable survey and we look forward to sharing the results.

Thank you,

Linda McKinnon
President & CEO

Central Florida Behavioral Health Network provides the right service, at the right time, in the right amount in order to save lives and ensure healthy communities."

719 South US Highway 301, Tampa, FL 33619 • phone: 813-740-4911 fax: 813-740-4821 • www.cfbhn.org

EXECUTIVE SUMMARY

In 2020, the estimated number of adults with serious mental illness was 193,039 in the 14-county service area comprised of Charlotte, Collier, DeSoto, Glades, Hardee, Hendry, Highlands, Hillsborough, Lee, Manatee, Pasco, Pinellas, Polk, and Sarasota Counties. This number has increased 4.4% over the past 3 years. This report, prepared for the Central Florida Behavioral Health Network (CFBHN), is a compilation of primary and secondary data that identifies behavioral health needs and the community assets available to advance the health care delivery system to improve outcomes for all residents.

DEMOGRAPHIC PROFILE

The population in the service area increased over the past five years to a total of 5,913,180 individuals. Racially, the service area is predominately White (83.1%), with the Black population accounting for 12.3%, Asian residents at 3.3%, and approximately 7% of individuals who are of other races or belong to more than one racial group. Hispanic individuals made up 20% of the area's population including 5.7% who identify as Mexican, 5.3% who identify as Puerto Rican, 3.7% who are Cuban, and 5.3% who identify as other Hispanic ethnicities.

Participation in the labor force (2015 to 2109) was at 56% and unemployment was 3%. The percentage of individuals living above 400% of the Federal Poverty Level (FPL) is 43.7% in the service area compared to 41.5% for the State of Florida.

GENERAL HEALTH STATUS

Behavioral Risk Factor Surveillance System (BRFSS) data (2017 to 2019) estimates revealed 80.4% of adults, ages 18-64 years of age, living in the service area said their overall health was "good" to "excellent". The average percentage of adults reporting good mental health over the past three years was 87.4%. Most residents (85.4%), ages 18-64 years, living in the Managing Entity (ME) service area reported having some type of health insurance coverage.

The crude suicide death rate decreased from 2018 to 2020, however, it should be noted that the suicide death rate for males in the ME service area was more than triple the rate among females. Additionally, the suicide death rate among the White population was double the rate for Black residents in the ME service area.

The rates of domestic violence and child abuse have decreased over the last 3 years in the service area and across the state. Meanwhile the percentage of adults who are smokers and who binge drink were higher in the service area than the state. High school tobacco, alcohol, and substance use continue to be issues for the area.

In the ME service area, 14.3% of the noninstitutionalized population was estimated to have a disability (includes hearing, vision, cognitive, ambulatory, self-care, and independent living).

CFBHN CLIENT DEMOGRAPHIC PROFILE

CFBHN-funded organizations served 95,157 clients in FY20-21. Approximately 24% of clients resided in Hillsborough County, followed by Pinellas County at 20.3%, Lee County at 12.1%, Polk County at 11.3%, Manatee County at 9.2%, Pasco County at 6.2%, Sarasota County at 6%, Charlotte County at 3.2%, Collier County at 2.6%, out-of-area at 2%, Highlands County at 1.6%, DeSoto at 0.7%, Hardee at 0.4%, Hendry County at 0.3%, and Glades County at 0.2%. It should be noted that 5.9% of clients reported their residential status as homeless across all counties in the service area.

Adults (age 15 and older) in CFBHN programs accounted for 85% of all clients with 74% enrolled in the Adult Mental Health (AMH) program and 26% in the Adult Substance Abuse program (ASA). The remaining clients were in the Child Mental Health (CMH) program at 15% and the Child Substance Abuse (CSA) program at 5%.

HOMELESS POPULATION

The effects of homelessness on individuals are numerous, complicated, and very costly. In addition to poor physical health, homeless community members are at an increased risk for mental illness, drug dependency, behavioral health issues, assault, and even premature death. In 2019, the Florida Council on Homelessness reported there were 7,781 individuals who were homeless in Central and Southwest Florida. Forty-two percent were unsheltered, and 18.8% were chronically homeless. In the ME service area, there were 1,894 people in families with children who were homeless. Among veterans, 742 were homeless in Central and Southwest Florida. The Florida Department of Education reported 24,536 students in Central and Southwest Florida were homeless in the 2017-2018 academic year.

HOMELESS CLIENT DEMOGRAPHIC PROFILE

A total of 6,113 homeless clients were only enrolled in adult programs with 57% in the AMH program and 42.6 in the ASA program. White homeless clients accounted for 67.2% of those in the AMH program and Black homeless clients represented 25% of clients in the same program. Black individuals accounted for 12.3% of the general population emphasizing that this population has been disproportionately impacted. Hispanic clients in both the AMH program, at 10.4%, and in the ASA, at 9.9%, were underrepresented when compared to the general population where 20% were Hispanic.

SERVICE UNITS AND RECORD COSTS

Total service costs for Fiscal Year 2020-21 were $119,466936.40; $13,829,837.89 reflected the costs for homeless services while $2,863,577.73 is attributed to out-of-service area costs. The majority of costs were in AMH (54.1%), followed by ASA (40.7%), CMH (2.8%), and CSA (2.4%).

NO WRONG DOOR ASSESSMENT-PROVIDER INTERVIEWS

A series of provider interview groups were conducted virtually to assess No Wrong Door access. Providers were invited to register for one of six virtual groups and then were sent a brief survey to complete. The interviews were used to gain qualitative understanding of the survey findings. Approximately 50 individuals participated.

Over 90% of survey respondents said that their agency has a role to play in the No Wrong Door access, with a little over 60% stating that it works well within their agency. The interviews showed that providers had multiple definitions to what No Wrong Door access means.

Interview respondents indicated that having relationships with individuals from various agencies in the area helped No Wrong Door access work well in their organization. A shortage in workforce and thus not enough capacity was also a common theme across all six group provider interviews.

CULTURAL HEALTH DISPARITY SURVEY

For the 2022 community assessment, a new survey was deployed to better understand the role of health disparities in behavioral health outcomes. Fifty-one participants completed a survey detailing their experiences and attitudes with respect to behavioral health. The survey assessed several focus areas including Comfort Seeking Care, Trust in the Behavioral Health System, Feelings Regarding Behavioral Health Issues, Behavioral Health Treatment Settings, and Language Needs.

IINDIVIDUALS SERVED SURVEY

Individuals served by CFBHN were surveyed during early 2022. Sixty-eight (68) responses were collected during the survey period. Data revealed the respondents were aware of where to go for mental health and substance use treatment when they needed them (82.1%) and that most respondents learned about services from a family member/friend (33.8%), another individual in treatment or recovery (33.8%) or by word of mouth (30.9%).

Most respondents indicated that they were able to receive the services they needed when they needed them (63%). Of those who were not able to get the services they needed, the most common responses were housing assistance (52.1%), case management (34.7%), crisis

stabilization/support (30.4%), alternative services (30.4%), and employment/job training assistance (30.4%).

Individuals were asked about the obstacles/barriers they encountered getting the care they needed, and 33.8% indicated there were long waitlists, they could not afford the services (19.1%), they did not know where to go for services (17.6%), that they had very limited or no transportation (17.6%), or that they did not meet the eligibility criteria (16.1%). Stigma, lack of evening/weekend appointments, and services not available in the county were also frequently mentioned as barriers.

STAKEHOLDER SURVEY

A survey of behavioral health stakeholders across the CFBHN service area yielded 463 responses. About 90% of respondents strongly agreed or agreed that they were aware of the availability of mental health and substance use services in their area. While 51% where aware of Central Florida Behavioral Health Network (CFBHN), 49% of people had accessed CFBHN's resources in the past six months. Majority of survey takers (58%) found the resources the CFBHN offered were helpful. When asked if they were aware of 2-1-1, most (92%) of the respondents said they were.

Over 50% of stakeholder respondents either strongly agree or agree that behavioral health care and peer services are accessible in the area. Respondents were split, 42% agreed, and 43% disagreed, if they believed the processes for referrals were easily accessible.

When asked to identify the barriers are for consumers accessing services in their community, the majority of stakeholder respondents said no or very limited transportation (13.4%), followed by long waitlists (12.9%), did not know where to go for services (11.5%), could not afford the services (11.2%), and stigma (10.2%).

RECOVERY COMMUNITY PEER SUPPORT SURVEY

Peer Support Specialist's (PSS) bridge gaps in services in the No Wrong Door care model to improve patient-centered care. PSS were surveyed to evaluate their engagement, barriers, and improvements they would like to see in the health system. PSS were used in various recovery support roles throughout the health care system and in the community. Hospital emergency rooms, drop-in centers, corrections facilities, child welfare, and Medication Assisted Treatment (MAT) were some of the programs supported or run by PSS.

CFBHN SERVICE AREA DEMOGRAPHIC PROFILE

Population Demographics

Population in the fourteen-county service area increased each year from 2015 to 2019. The total population growth for the 5-year period was 8.3%, added 454,151 residents.

In the service area and the state, females accounted for slightly more than 50% of the population when compared to their male counterparts.

The racial composition in the service area and state was predominately White at 83.1% and 75.1%, respectively. The Black population accounted for 12.3% of the service area population and 16.1% of the population in Florida. American Indian and Native Hawaiians represented less than 1% of residents in both population groups. The percentage of Asian residents, at 3.3% was higher in the service area when compared to the state at 2.7%. The service area was slightly more diverse when compared to the state with 3.2% having a race of Other and 2.6% of residents belonging to more than one racial group.

Ethnically, the service area had a lower percentage of Hispanic residents, at 20%, when compared to the state at 25.6%.

The CFBHN service area population was older when compared to the age distribution at the state level. Residents, 65 years of age or older, accounted for 23.6% of the population while in the state of Florida, 20.1% of residents were at least 65 years old.

Education and Employment

Data revealed the service area and state populations were very similar regarding education attainment. While slightly less residents in the state had a high school diploma (or equivalency) (88.2%), residents in the service area had higher percentages of individuals who attended or graduated from college. Graduate or professional degrees were held by 10.8% of the population.

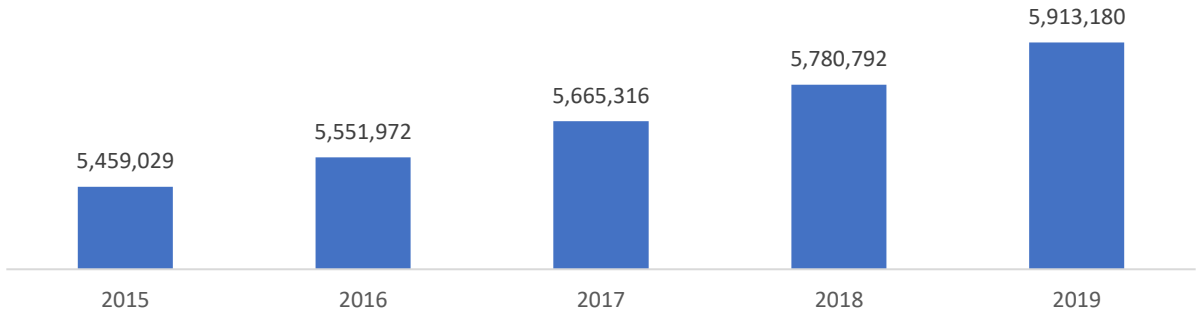
On average, 56% of the service area population participated in the labor force over the past 5 years. This was lower when compared to those employed in Florida at 58.8%. The unemployment rate for the service area was 3% compared to 5.6% for Florida.

Poverty Status

During 2015 to 2019, the service area had 9.2% of the population at or below 99% of the Federal Poverty Level (FPL) compared to 10% for Florida. Just over 43% of the service area was at or above 400% FPL compared to 41.5% for Florida.

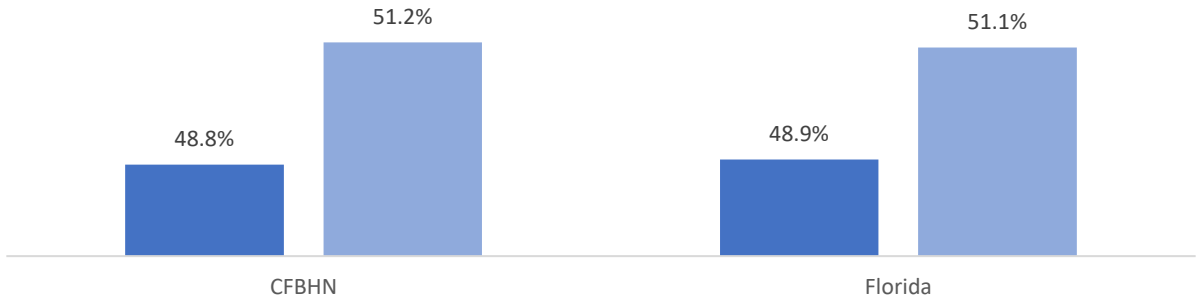
DEMOGRAPHIC CHARTS

Figure 1: CFBHN SA Population Estimates (2015-2019)



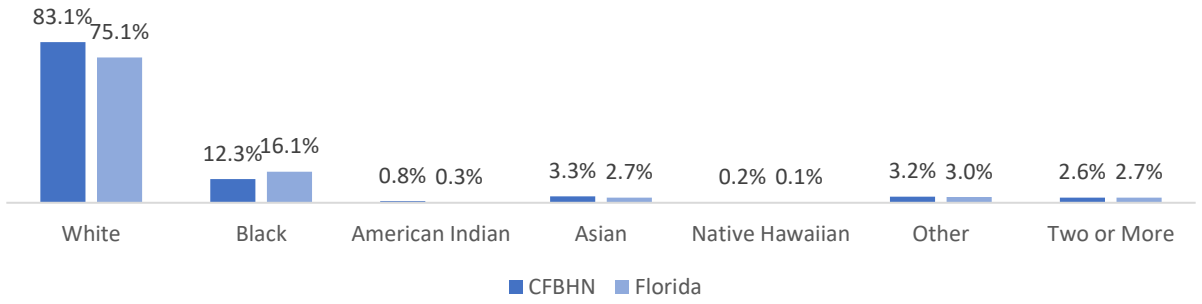
Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 2: CFBHN SA County Population by Gender (2015-2019)



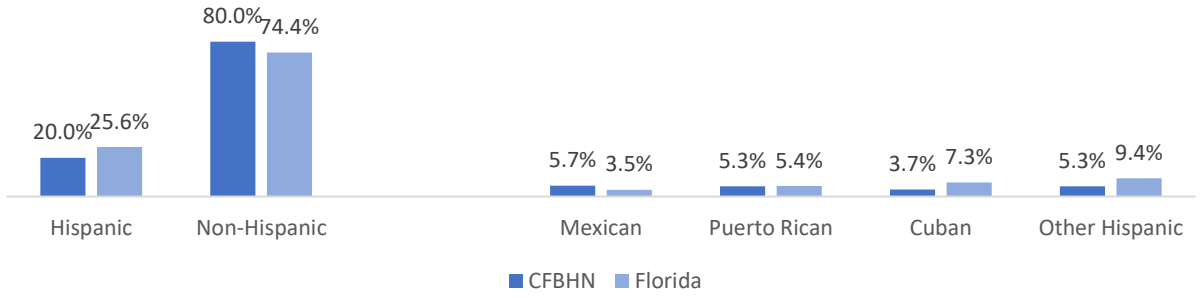
Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 3: CFBHN SA County Population by Race, 2015-2019 (5-Year Estimate)



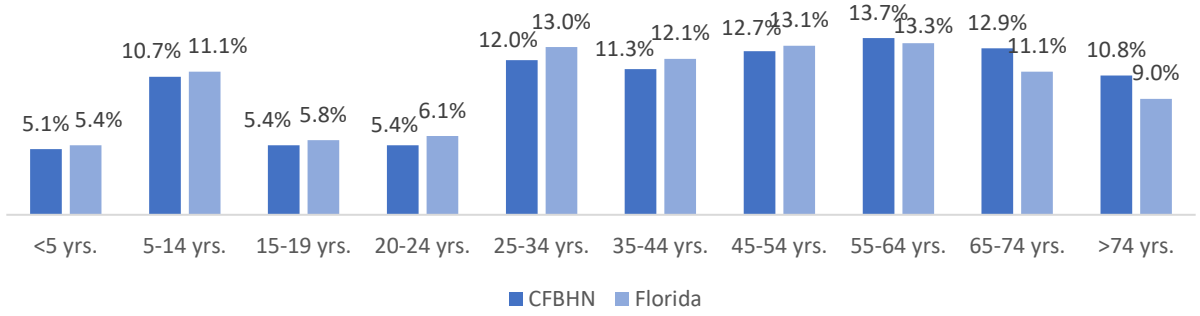
Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 4: CFBHN SA Population by Ethnicity, 2015-2019 (5-Year Estimate)



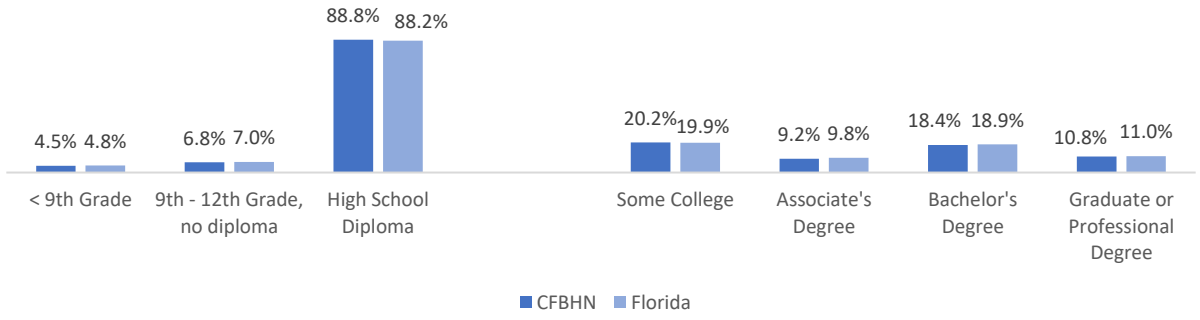
Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 5: CFBHN SA Population by Age Range, 2015-2019 (5-Year Estimate)



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

Figure 6: CFBHN SA Population by Educational Attainment, 2015-2019 (5-Year Estimate)

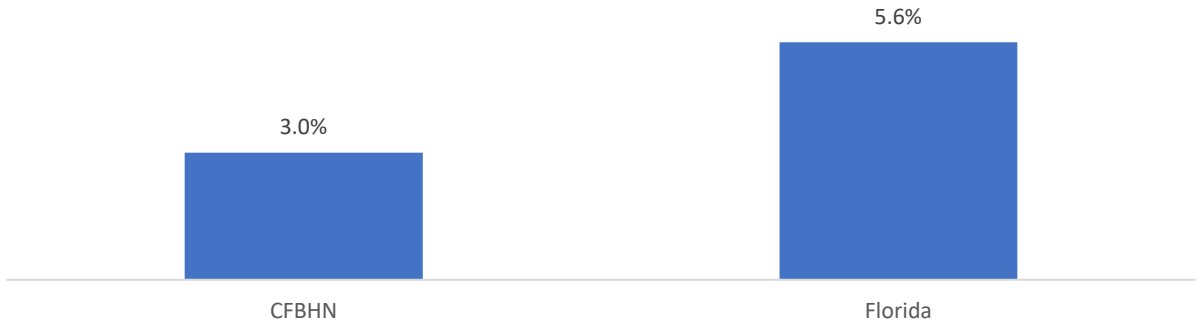


Source: U.S Census Bureau, American Community Survey, Table S1501

Figure 7: CFBHN SA Population Participation in Labor Force, 2015-2019 (5-Year Estimate)

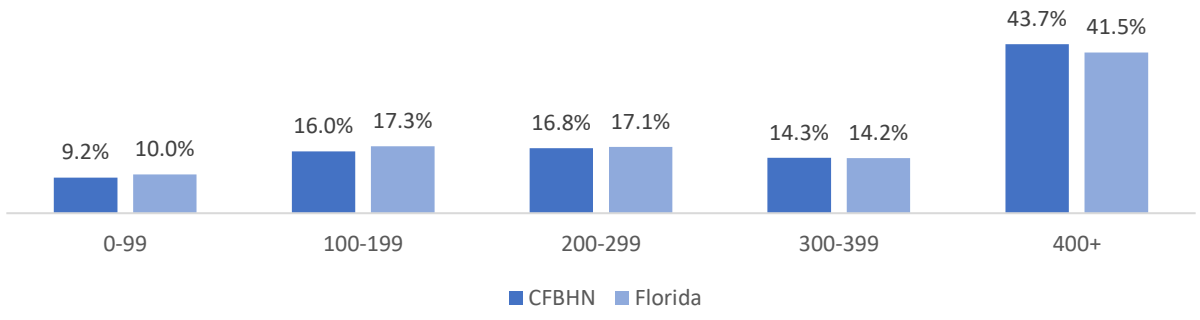
Source: U.S Census Bureau, American Community Survey, Table DP03

Figure 8: CFBHN SA Population Unemployment Rates, 2015-2019 (5-Year Estimate)



Source: U.S Census Bureau, American Community Survey, Table DP03

Figure 9: CFBHN SA Population Ratio of Income to Poverty Level of Families (2019)



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

CFBHN SERVICE AREA GENERAL HEALTH STATUS

Overall Health Status

BRFSS data (2017 to 2019) estimates revealed 80.4% of adults, ages 18-64 years of age, living in the service area said their overall health was “good” to “excellent”. For Florida, the rate was 80.3%. This knowledge is a powerful tool for targeting and building health promotion activities. It also provides a way to see change in population health behaviors before morbidity or disease is apparent.

Mental Health

The average percentage of adults reporting good mental health over the past 3 years, at 87.4% was just above the rate for the state at 86.2%. The number of unhealthy mental days for the service area population, at 3.9 days in the past 30 days, was just below the rate among all adult residents (ages 18-64 years) in Florida at 4.4 days in the past 30 days.

Suicide

The crude suicide death rate decreased from 18.7/100,000 in 2018 to 15.8/100,000 population in 2020. This represents a decrease of 2.9/100,000 suicide deaths. At the state level, the suicide crude death rate decreased 2.5 deaths per 100,000 population during the same time but was also higher when compared to the CFBHN service population. Among males, the suicide death rate for the ME service area and state were more than triple the rate among females. The suicide death rate among the White population was double the rate for Black residents in the ME service area. The same held true at the state level where White to Black suicide deaths revealed a 3.2:1.0 ratio. It should be noted that the calculations required for the age-adjusted death rate for the ME service areas was beyond the scope of this project.

Violence and Abuse

The rate of total domestic violence offences decreased in the ME service area and the state from 2017 to 2019. In the ME service area, the rate fell from 575.5/100,000 to 535.3/100,000 over the past 3 years. This was still higher than the state rate of 496.5/100,000 in 2019.

The rate of children experiencing child abuse over the past 3 years (2017-2019) has continuously decreased in the ME Service area and state. Among children ages 5-11 years, the rate of child abuse fell from 1053.4/100,000 in 2017 to 888.8/100,000 in 2019. This trend was observed in the state rates which decreased from 857.9/100,000 to 662.7/100,000 during the same time.

Child sexual abuse rates changed very little from 2017 to 2019 and decreased from 2018 to 2019. In the ME service area, the 2019 sexual abuse rate for children 5-11 years was 57.2/100,000. This was slightly lower than the state rate at 57.2/100,000.

Mental Illness

The estimated number of seriously mentally ill (SMI) adults increased by 4.4% over the past 3 years. The rate of increase at the state level was 3.5%. The estimated number of SMI adults in the ME service area was 193,069 in 2020.

Among youth, ages 9-17 years, the estimated number of those emotionally disturbed increased over 2% from 2018 to 2020. This was lower when compared to the state increase at 3%.

The Florida Department of Education (FLDOE) reported less than 0.5% of children in K-12 grades had an emotional/behavioral disability in the ME service area. In the state, students with an emotional/behavioral disability accounted for 0.5%. These rates have been steady over the past 3 years.

Adult Tobacco and Alcohol Use

BRFSS results revealed the percentage of adults living in the ME service area who are current smokers, at 16.7% (2017-2019) was higher when compared to the state at 14.8% (2019).

Binge drinking is defined as 5 consecutive drinks for men and 4 consecutive drinks for women. For 2017 to 2019, the percentage of binge drinkers in the ME service area was 18.6%. The percentage of binge drinkers in the state was slightly higher at 18.0% (2019).

High School Tobacco, Alcohol and Substance Use

Data from the Florida Youth Substance Abuse Survey (FYSAS) indicated that the percentage of middle and high school students who reported never having smoked cigarettes increased from 85.7% in 2016 to 92.1% in 2020. Slightly more than 5% of students smoked once or twice, and 3% reported that they had smoked 'once in a while'. For middle and high school students in the state, the percentage of those having never smoked also increased over the past 4 years.

When students were asked about smoking frequency, 96.6% of those living in the ME service area did not smoke at all. The state rate was 98.2%.

Vaping questions were included in the 2020 FYSAS for the first time. In the ME service area, 22.2% of students reported vaping nicotine on at least one occasion in their lifetime. Almost 6% of student had vaped on 40 or more occasions. Rates at the state level were similar for frequency occasions of vaping nicotine in their lifetime. The percentage of students vaping nicotine during

the past 30 days were much lower in the service area and the state when compared to vaped in lifetime rates. Slightly over 88% of students had not vaped nicotine in the past 30 days.

The percentage of students who did not consume alcoholic beverages on any occasions in their lifetime ranged from 60.7% in 2016 to 84.8% in 2020. For those who did on 1-2 occasions, the percentage decreased 4.5% from 2016 to 2020. The percentages of students in 2020 consuming alcohol on more than 2 occasions ranged from 3.2% for 3-5 occasions to 0.3% for those consuming alcohol on at least 40 occasions. The rates for the state were almost identical to those in the ME service area.

High school students were asked for the number of occasions in their lifetime when they had woken up after a night of drinking alcohol and were unable to remember the things they did or the places they went. The percentage of students reporting this event happening on at least 1-2 occasions in their lifetime (2020) in the ME service area and the state was 7.6% and 7.4%, respectively. When looking at previous reported data, this was a decrease from the percentages reported in 2016 for the ME service area and the state. Slightly over 86% of students in the service area and the state reported never having had this experience.

The percentages of students living in the ME service area not consuming alcohol during the past 30 days increased from 81.8% in 2016 to 84.8% in 2020. The increase at the state level was greater when comparing percentages from 2016 (81.7%) to 2020, at 85.2%. The percentages of students who reported consuming alcohol on 1-2 occasions during the past 30 days decreased in the ME Service area and state from 2016-2020.

The overall percentage of those binge drinking, defined as consuming 5 or more alcoholic drinks in a row in the past 2 weeks, increased 1% over the past 4 years. This was a combined decrease for students in the ME service area and state who reported this behavior on one to more than 10 occasions.

The percentages of students who have not used marijuana in their lifetimes increased over the past 4 years in the ME service area (80.0%-2020) and state (79.9%-2020). For those who did use marijuana on one to more than 40 occasions, the overall percentages decreased in the ME service area from 22.6% in 2016 to 20.0% in 2020. At the state level, the decrease was smaller when comparing 2016, at 21.3%, to 2020, at 20.1%. The percentages of students not using marijuana in the past 30 days was higher when compared to those who reported not using it in their lifetime. The percentages of students in the ME service area and state who reported using marijuana in the past 30 days on one or more occasions, increased slightly in the ME service area while decreasing in the state. The percentages of students who reported vaping marijuana in their lifetimes on one or more occasions was higher in the ME service area at 16.0% when compared to the state at 15.6%. This is different when comparing the two groups of students who had vaped marijuana in the past 30 days. In the ME service area, 7.2% of students had vaped marijuana in the past 30 days compared to 7.3% of students in the state.

Disability

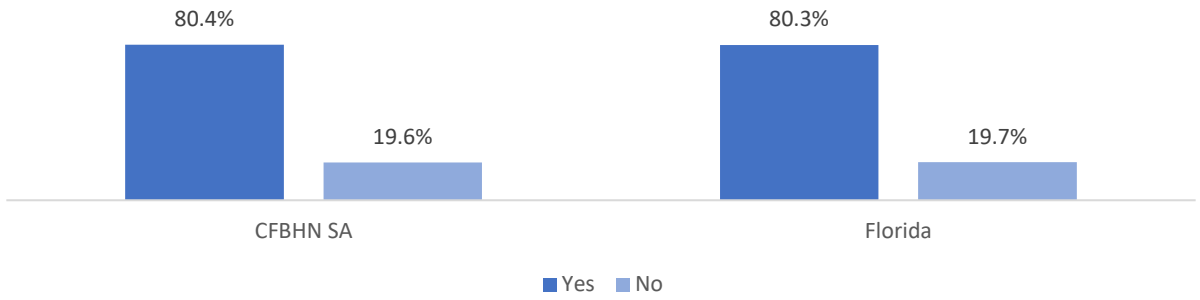
In the ME service area, 14.3% of the noninstitutionalized population was estimated to have a disability (includes hearing, vision, cognitive, ambulatory, self-care, and independent living). At the state level, 13.7% of residents had a disability. The percentages of those with a disability were much higher among older adults, ages 65 years and older, at 31.3% for the ME service area and 32.4% in the state.

Health Insurance Coverage

Most residents, ages 18-64 years, living in the ME service area and state reported having some type of health insurance coverage. The percentage of those with insurance in the state was slightly lower when compared to the ME service area at 85.4% and 82.4%, respectively.

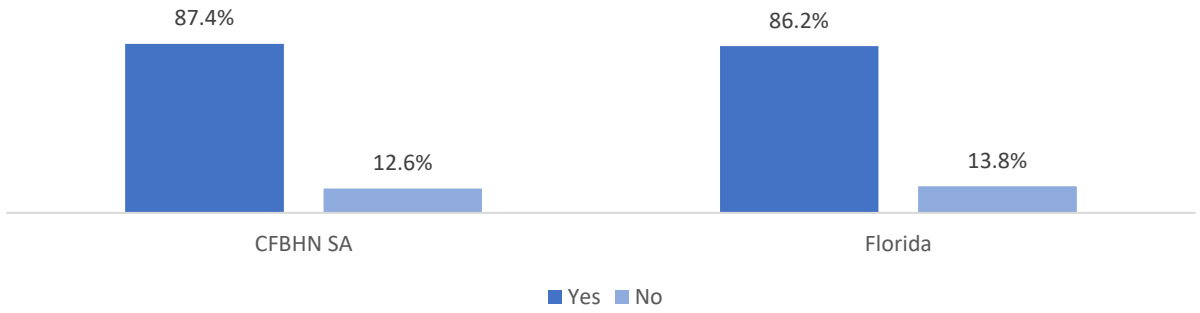
GENERAL HEALTH STATUS CHARTS

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



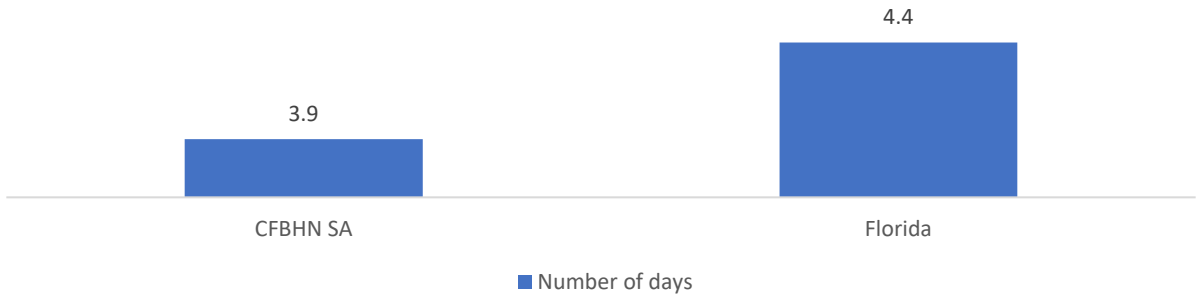
Source: Behavioral Risk Factor Surveillance System

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



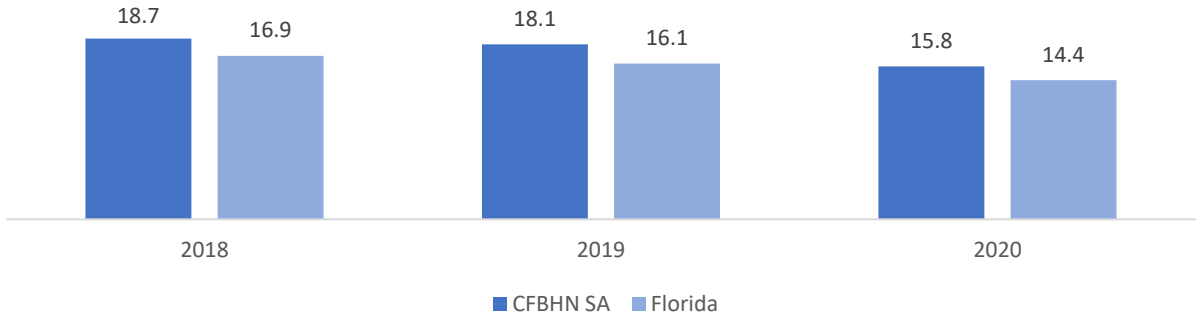
Source: Behavioral Risk Factor Surveillance System

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



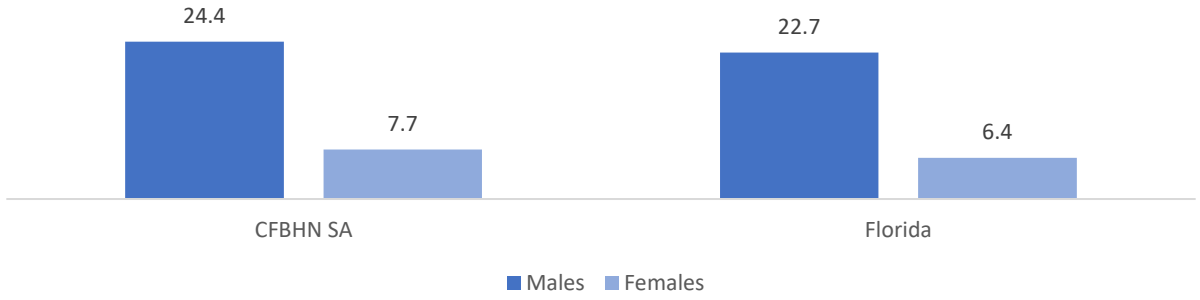
Source: Behavioral Risk Factor Surveillance System

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



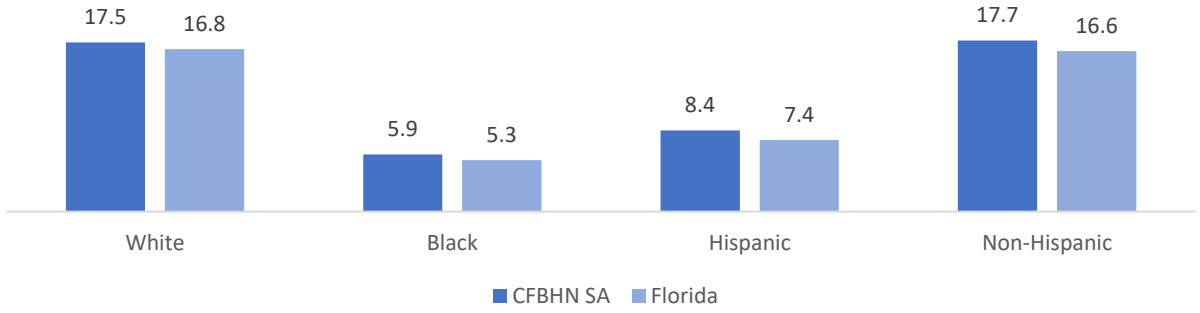
Source: Florida Department of Health, Bureau of Vital Statistics

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



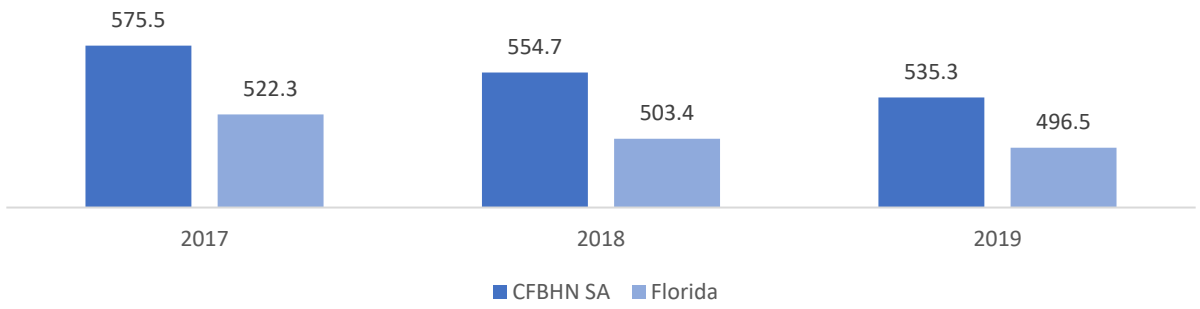
Source: Florida Department of Health, Bureau of Vital Statistics, Rate per 100,000

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



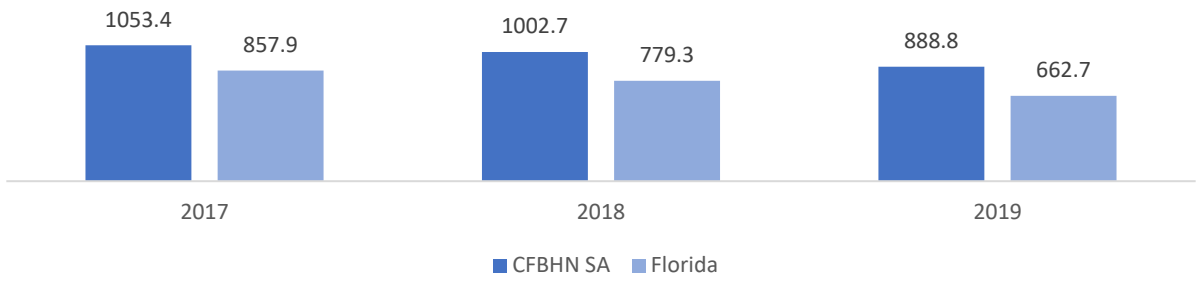
Source: Florida Department of Health, Bureau of Vital Statistics, Rate per 100,000

Figure 16: CFBHN SA Total Domestic Violence Offences (2017-2019)



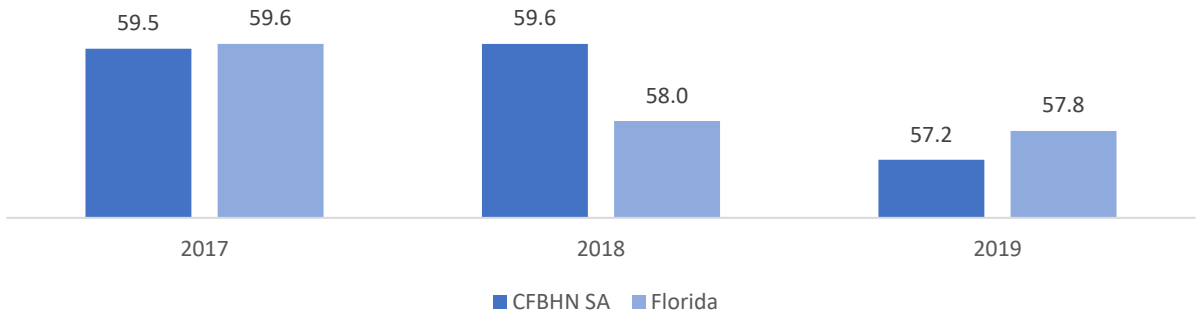
Source: Florida Department of Law Enforcement, Crime in Florida, Uniform Crime Report 2019, Rate per 100,000

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



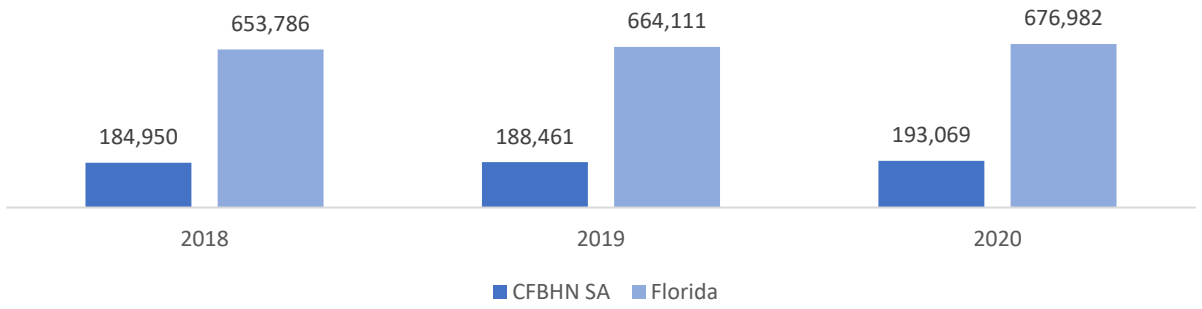
Source: Department of Children and Families, Florida Safe Families Network Data Mart, Rate per 100,000

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



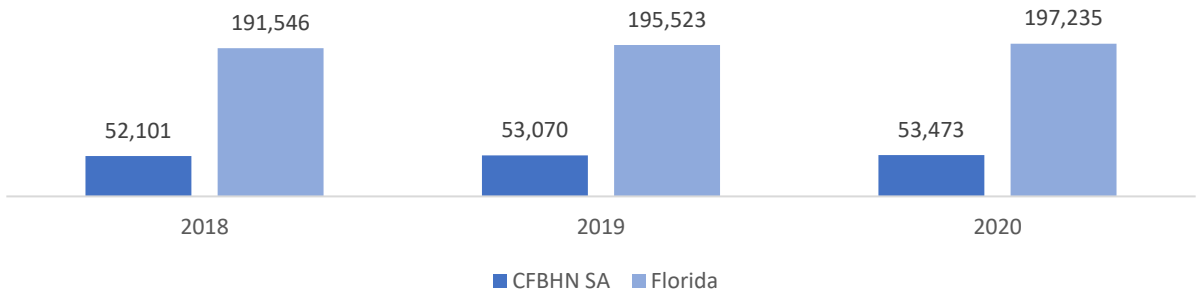
Source: Department of Children and Families, Florida Safe Families Network Data Mart, Rate per 100,000

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



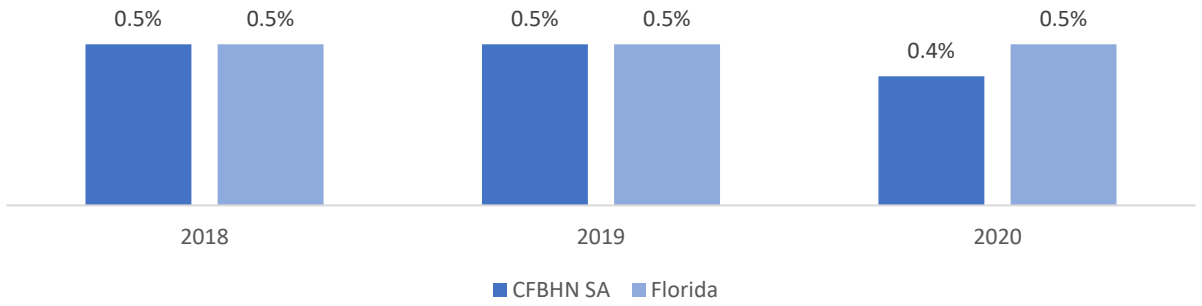
Source: Estimates based on Department of Health and Human Resource Report Mental Health U.S. 1995

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



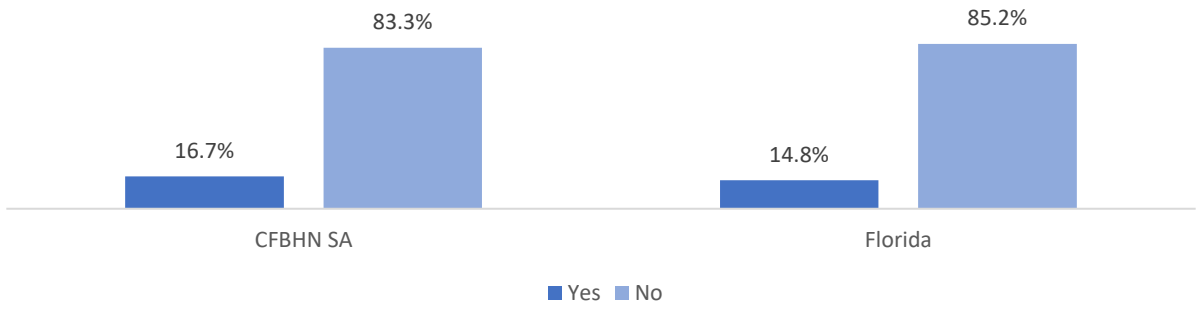
Source: Estimates based on Department of Health and Human Resource Report Mental Health U.S. 1995

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



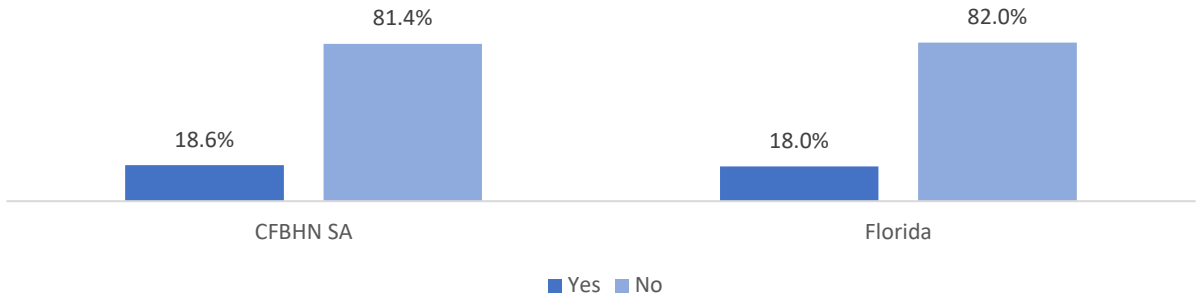
Source: Florida Department of Education, Education Information and Accountability Services (EIAS)

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



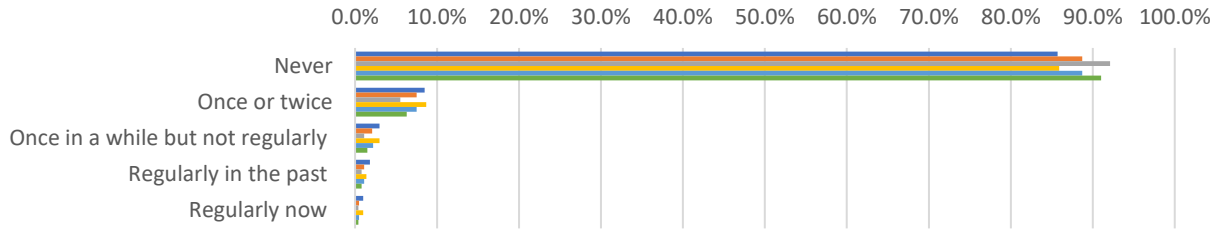
Source: Behavioral Risk Factor Surveillance System

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



Source: Behavioral Risk Factor Surveillance System

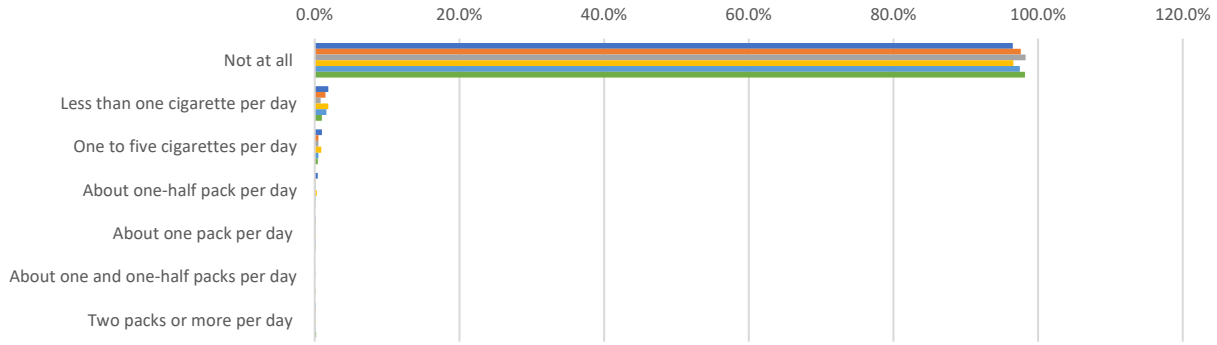
Figure 24: CFBHN SA Having Ever Smoker Cigarettes (MS&HS-2016-2020)



	Regularly now	Regularly in the past	Once in a while but not regularly	Once or twice	Never
CFBHN SA 2016	1.0%	1.8%	3.0%	8.5%	85.7%
CFBHN SA 2018	0.5%	1.1%	2.1%	7.5%	88.7%
CFBHN SA 2020	0.4%	0.8%	1.1%	5.5%	92.1%
Florida 2016	1.0%	1.4%	3.0%	8.7%	85.9%
Florida 2018	0.5%	1.1%	2.2%	7.5%	88.7%
Florida 2020	0.4%	0.8%	1.5%	6.3%	91.0%

Source: Florida Youth Substance Abuse Survey

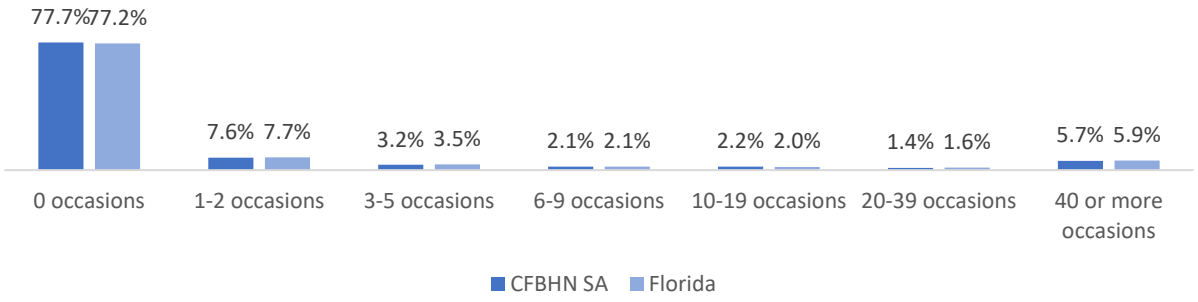
Figure 25: CFBHN SA-How Frequently Have You Smoked Cigarettes in the Past 30 Days? (MS&HS-2016-2020)



	Two packs or more per day	About one and one-half packs per day	About one pack per day	About one-half pack per day	One to five cigarettes per day	Less than one cigarette per day	Not at all
CFBHN SA 2016	0.1%	0.0%	0.1%	0.4%	1.0%	1.9%	96.5%
CFBHN SA 2018	0.1%	0.0%	0.1%	0.1%	0.5%	1.5%	97.6%
CFBHN SA 2020	0.1%	0.1%	0.1%	0.1%	0.5%	0.8%	98.3%
Florida 2016	0.1%	0.0%	0.1%	0.3%	0.9%	1.9%	96.6%
Florida 2018	0.1%	0.0%	0.1%	0.1%	0.5%	1.6%	97.5%
Florida 2020	0.2%	0.1%	0.1%	0.1%	0.4%	1.0%	98.2%

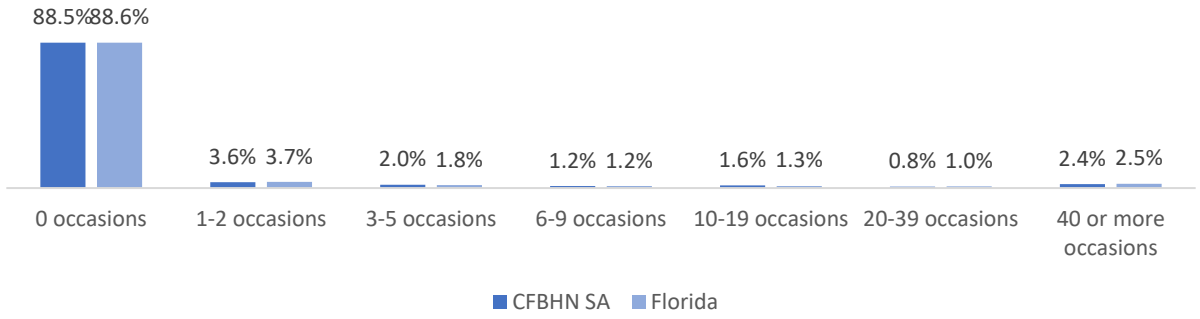
Source: Florida Youth Substance Abuse Survey

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



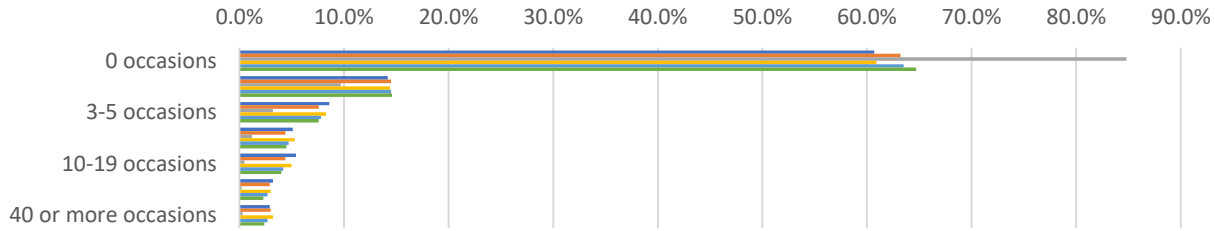
Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

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



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

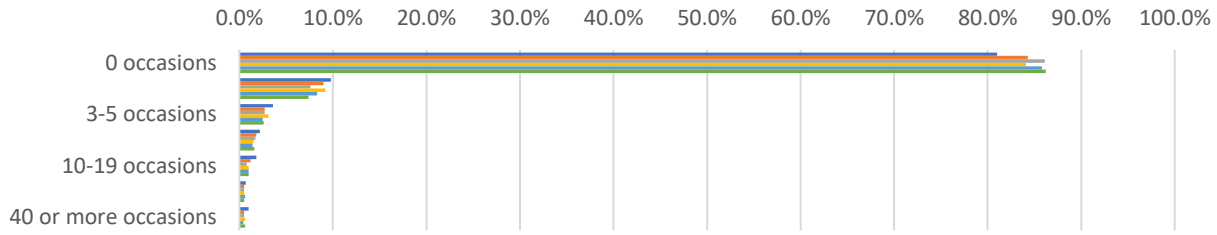
Figure 28: CFBHN SA-On How Many Occasions Have You Had Alcoholic Beverages to Drink in Your Lifetime? (MS&HS-2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
CFBHN SA 2016	2.9%	3.2%	5.4%	5.1%	8.6%	14.2%	60.7%
CFBHN SA 2018	3.0%	2.9%	4.4%	4.4%	7.6%	14.5%	63.2%
CFBHN SA 2020	0.3%	0.2%	0.5%	1.2%	3.2%	9.7%	84.8%
Florida 2016	3.2%	3.0%	5.0%	5.3%	8.3%	14.4%	60.9%
Florida 2018	2.7%	2.7%	4.2%	4.7%	7.8%	14.5%	63.5%
Florida 2020	2.4%	2.3%	4.0%	4.5%	7.6%	14.6%	64.7%

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

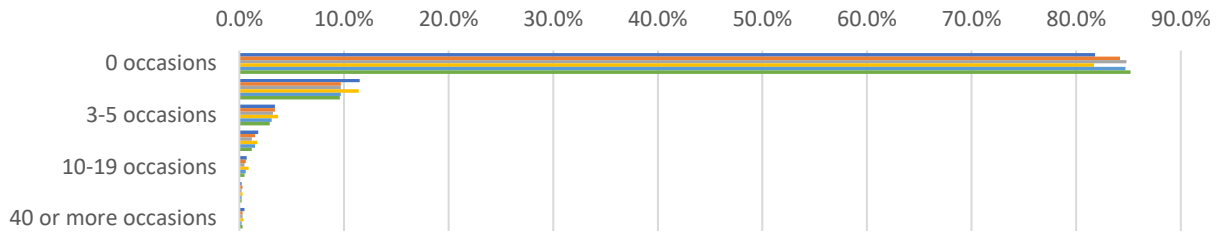
Figure 29: CFBHN SA-On How Many Occasions in Your Lifetime Have You Woken Up After a Night of Drinking Alcoholic Beverages and Not Been Able to Remember Things You Did or the Places You Went? (HS Only-2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
CFBHN SA 2016	1.0%	0.7%	1.8%	2.2%	3.6%	9.8%	81.0%
CFBHN SA 2018	0.5%	0.5%	1.2%	1.8%	2.7%	9.0%	84.3%
CFBHN SA 2020	0.5%	0.5%	0.8%	1.7%	2.7%	7.6%	86.1%
Florida 2016	0.6%	0.5%	1.0%	1.5%	3.1%	9.2%	84.1%
Florida 2018	0.4%	0.6%	1.0%	1.4%	2.5%	8.3%	85.8%
Florida 2020	0.6%	0.5%	1.0%	1.6%	2.6%	7.4%	86.2%

Source: Florida Youth Substance Abuse Survey

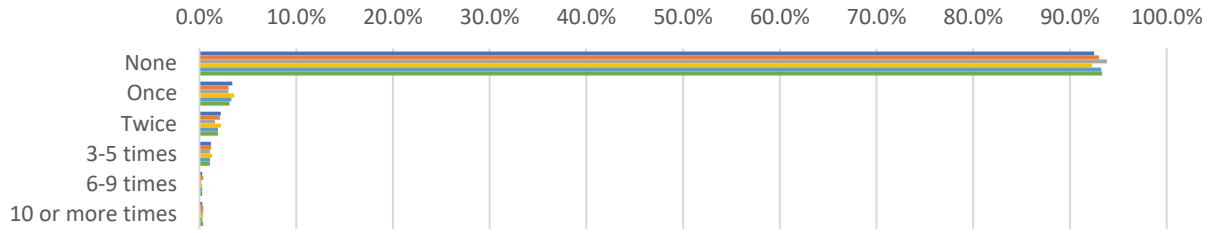
Figure 30: CFBHN SA-On How Many Occasions Have You Had Beer, Wine, or Hard Liquor in the Past 30 Days? MS&HS-2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
CFBHN SA 2016	0.5%	0.2%	0.7%	1.8%	3.4%	11.5%	81.8%
CFBHN SA 2018	0.3%	0.3%	0.6%	1.5%	3.4%	9.7%	84.2%
CFBHN SA 2020	0.3%	0.2%	0.5%	1.2%	3.2%	9.7%	84.8%
Florida 2016	0.4%	0.3%	0.9%	1.7%	3.7%	11.4%	81.7%
Florida 2018	0.2%	0.2%	0.6%	1.5%	3.1%	9.7%	84.7%
Florida 2020	0.3%	0.2%	0.5%	1.2%	2.9%	9.6%	85.2%

Source: Florida Youth Substance Abuse Survey

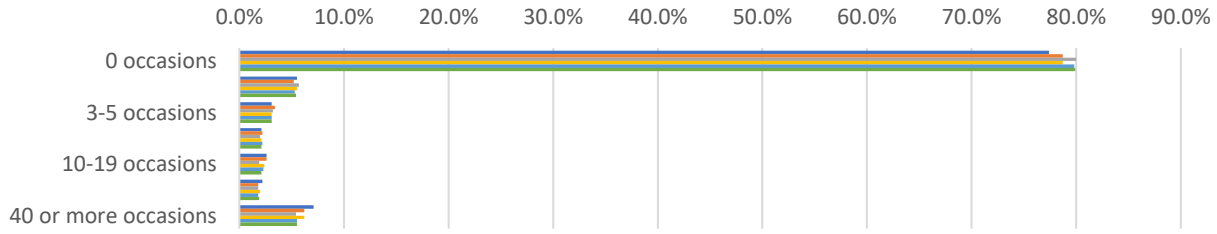
Figure 31: CFBHN SA-Think Back Over the Past Two Weeks...How Many Times Have You Had Five or More Alcoholic Drinks in a Row? (MS&HS-2016-2020)



	10 or more times	6-9 times	3-5 times	Twice	Once	None
CFBHN SA 2016	0.3%	0.3%	1.2%	2.2%	3.4%	92.5%
CFBHN SA 2018	0.4%	0.4%	1.2%	2.1%	3.0%	93.0%
CFBHN SA 2020	0.4%	0.2%	1.1%	1.6%	3.0%	93.8%
Florida 2016	0.4%	0.3%	1.3%	2.2%	3.6%	92.3%
Florida 2018	0.3%	0.3%	1.1%	1.9%	3.3%	93.2%
Florida 2020	0.4%	0.3%	1.1%	1.9%	3.1%	93.3%

Source: Florida Youth Substance Abuse Survey

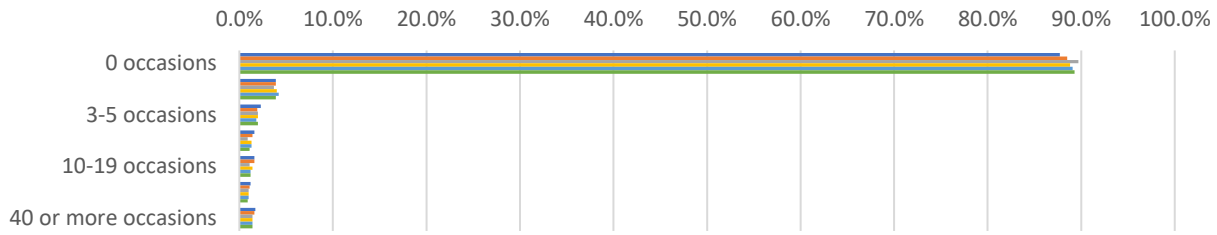
Figure 32: CFBHN SA-On How Many Occasions Have You Used Marijuana or Hashish in Your Lifetime? MS&HS-2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
CFBHN SA 2016	7.1%	2.2%	2.6%	2.1%	3.1%	5.5%	77.4%
CFBHN SA 2018	6.2%	1.8%	2.6%	2.2%	3.4%	5.2%	78.7%
CFBHN SA 2020	5.4%	1.8%	1.9%	2.0%	3.2%	5.7%	80.0%
Florida 2016	6.2%	2.0%	2.4%	2.1%	3.1%	5.5%	78.7%
Florida 2018	5.5%	1.8%	2.3%	2.2%	3.1%	5.3%	79.8%
Florida 2020	5.5%	1.9%	2.1%	2.1%	3.1%	5.4%	79.9%

Source: Florida Youth Substance Abuse Survey

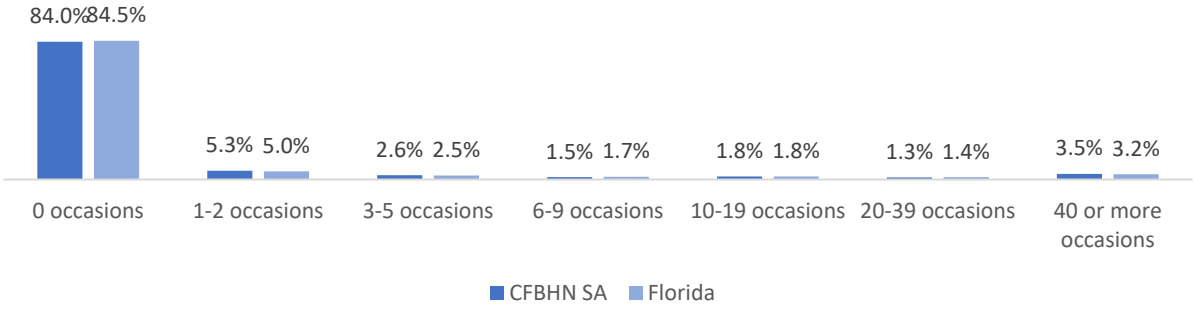
Figure 33: CFBHN SA-On How Many Occasions Have You Used Marijuana or Hashish During the Past 30 Days? (MS&HS-2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
CFBHN SA 2016	1.7%	1.2%	1.6%	1.6%	2.3%	3.9%	87.7%
CFBHN SA 2018	1.6%	1.1%	1.6%	1.4%	1.9%	3.9%	88.5%
CFBHN SA 2020	1.4%	1.0%	1.1%	0.9%	2.0%	3.7%	89.7%
Florida 2016	1.4%	1.0%	1.4%	1.3%	2.0%	4.0%	88.8%
Florida 2018	1.4%	1.0%	1.2%	1.3%	1.8%	4.2%	89.1%
Florida 2020	1.4%	0.9%	1.2%	1.1%	2.0%	3.9%	89.3%

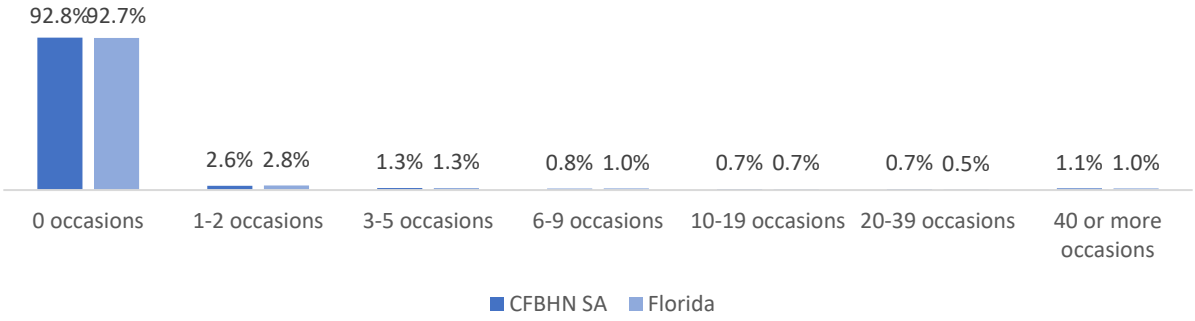
Source: Florida Youth Substance Abuse Survey

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



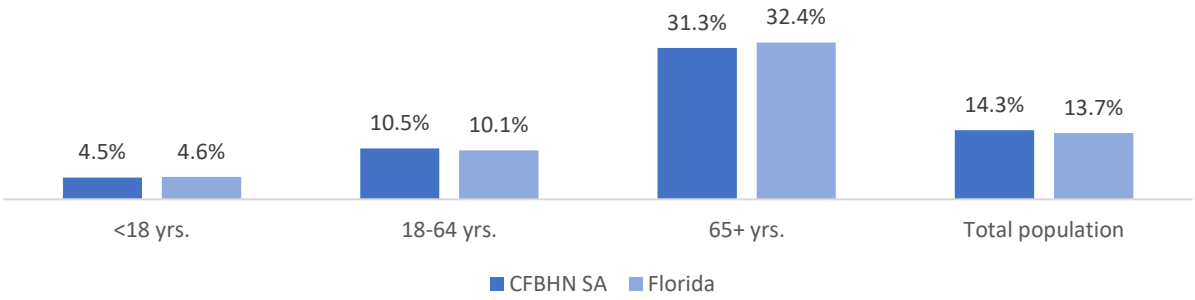
Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

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



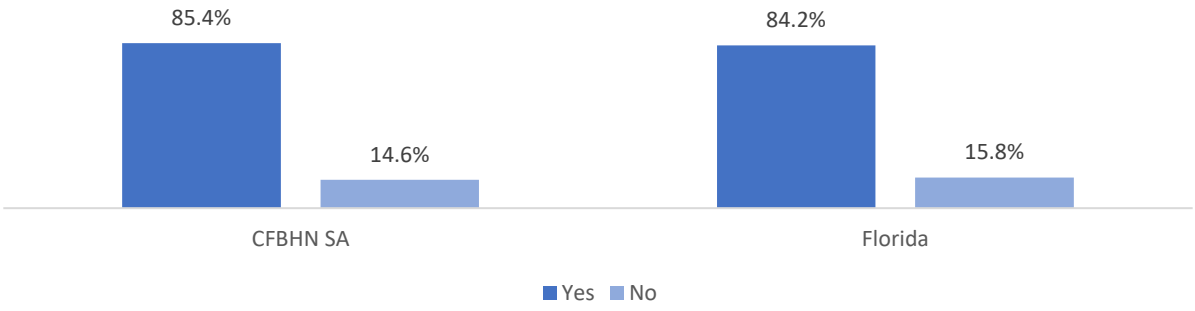
Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

Figure 36: CFBHN SA Civilian Noninstitutionalized Population with a Disability (2015-2019)



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

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



Source: Behavioral Risk Factor Surveillance System

CFBHN SERVICE AREA CLIENT DEMOGRAPHIC PROFILE

Client Population

CFBHN funded organizations that served 95,157 clients in FY20-21. This number may include a small amount of duplication in that some clients moved from one county to another, were enrolled in more than one program or changed residential status during the one-year period. Approximately 24% of clients resided in Hillsborough County (22,760 clients), followed by Pinellas County at 20.3% (19,310 clients), Lee County at 12.1% (11,522 clients), Polk County at 11.3% (10,781 clients), Manatee County at 9.2% (8,709 clients), Pasco County at 6.2% (5,918 clients), Sarasota County at 6% (5,731 clients), Charlotte County at 3.2% (3,003 clients), Collier County at 2.6% (2,484 clients), out-of-area at 2% (1,937 clients), Highlands County at 1.6% (1,494 clients), DeSoto at 0.7% (648 clients), Hardee at 0.4% (398 clients), Hendry County at 0.3% (263 clients), and Glades County at 0.2% (199 clients). It should be noted that 5.9% clients reported their residential status as homeless across all counties in the service area.

Adults (age 15 and older) in CFBHN programs accounted for 85% of all clients with 74% enrolled in the Adult Mental Health (AMH) program and 26% in the Adult Substance Abuse program (ASA). The remaining clients were in the Child Mental Health (CMH) program at 15% and the Child Substance Abuse (CSA) program at 5%.

Gender

Females represented 55% of all clients in the AMH, and 65% in CSA programs. Males represented 55% in ASA, and males and females were evenly represented in CMH services at 50% each. Resident population in the service area is 51.2% female and 48.8% male.

Race

The majority of CFBHN clients were White (70%) which was lower than the percentage in the service area population at 83.1%. Conversely, Black CFBHN clients accounted for 17% of the client population while representing only 12.3% of the population in the service area. AMH racial makeup closely followed the total client percentages. Whites were a larger percentage of ASA clients than in any other service at 80%, with Blacks at their lowest percentage in any service at 11%. CMH and CSA were more diverse when compared with AMA and ASA, with Blacks representing 19% in CMH and 23% in CSA. Multi-race represented 16% of CMH clients and 14% of CSA clients. Whites in CMH and CSA had their lowest percentages at 59% and 58% respectively.

Ethnicity

The percentage of Hispanics in the CFBHN client population was reflective of the percent of Hispanics in the service area at 20% each. The ethnic composition of the FBHN client population was lower for Cubans (2.0% vs. 3.7%), Puerto Rican (5.0% vs 5.3%), and other Hispanic (7.0% vs. 5.3%) when compared with resident population. CFBHN client population also reported 7.0% Mexican American but no similar measure was available for the service area population.

Age Range

As expected, the age range distribution among CFBHN clients did not mimic that of the service area population. Adults 25-34 years of age, accounted for 23.7% of those in the AMH and 34.8% in the ASA programs while representing only 12.0% of the population in the service area. Adults 35-44 years of age accounted for 20.3% of AMH and 29.8% of ASA clients while representing 11.3% of the population in the service area. Teens and young adults ages 15-19 years of age accounted for 28% of those living in the service area population and children ages 5-14 years made up 10.7%. Among those enrolled in child/youth programs, 62.1% of clients in the CMH program were 5-14 years of age and 78.3% of clients in the CSA program were 15-19 years old.

Residential Status

The majority of CFBHN adults resided in one of three types of living conditions: independent with relatives, dependent living with relatives, or independent alone. Among AMH clients, 5.7% reported their status as homeless, as did 11.6% of those in the ASA program. Those in children/youth programs lived dependently with relatives.

Educational Attainment

CFBHN clients attained lower educational levels when compared to those in the service area population. Among CFBHN adults, educational attainment was limited to high school for 47.8% of AMH clients and 38.0% of ASA clients. This compares to 88.8% of residents in the service area who had a high school education. Consequently, the percentages of adult CFBHN clients who earned college degrees were well below those for residents living in the service area.

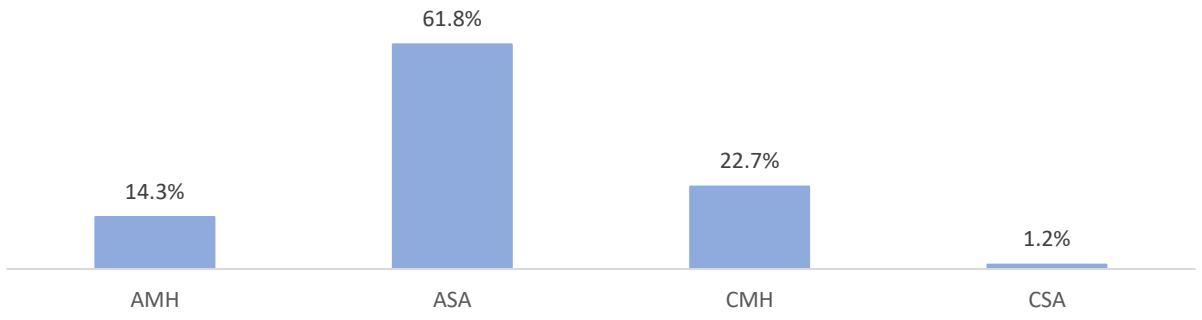
Employment Status

Lower educational attainment was one of several factors that contributed to much higher levels of unemployment among CFBHN clients when compared to those in the service area. Among AMH

client 35.7% were not employed and 50.2% of ASA clients were not employed. In the service area 3% of residents were unemployed.

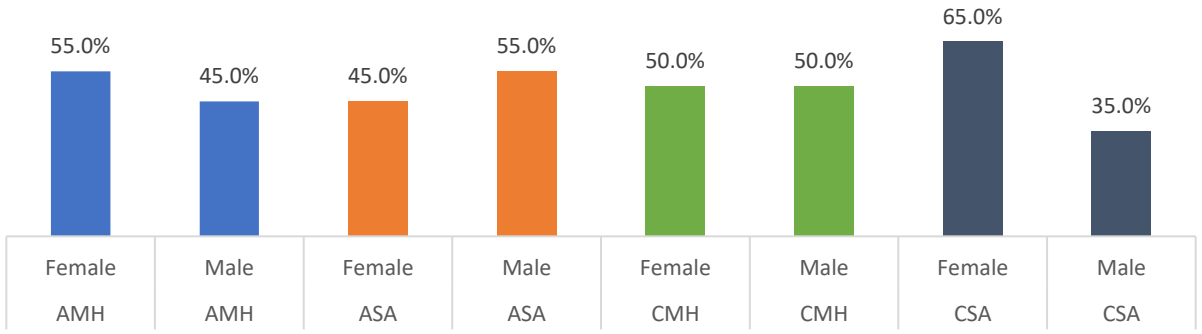
CLIENT DEMOGRAPHIC CHARTS

Figure 38: CFBHN Clients by Program



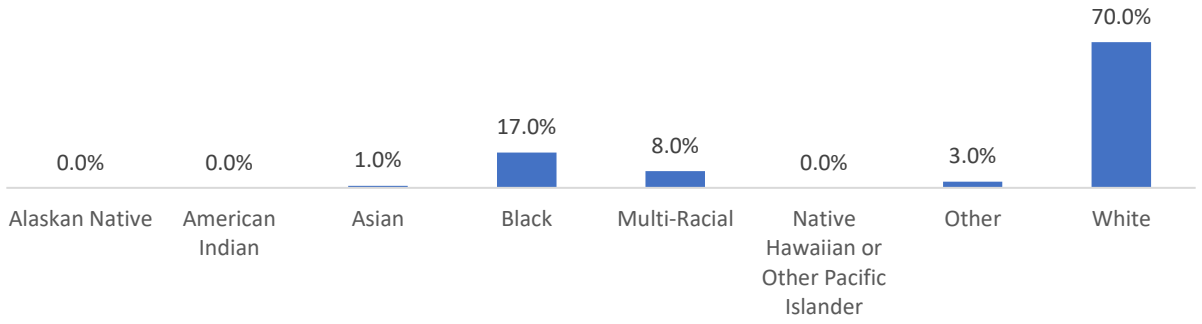
Source: CFBHN Client Data

Figure 39: CFBHN Clients by Program and Gender



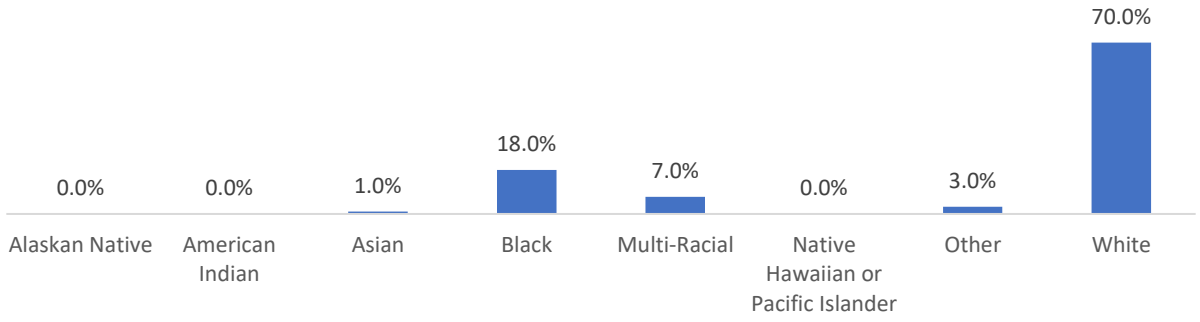
Source: CFBHN Client Data

Figure 40: CFBHN Clients by Race



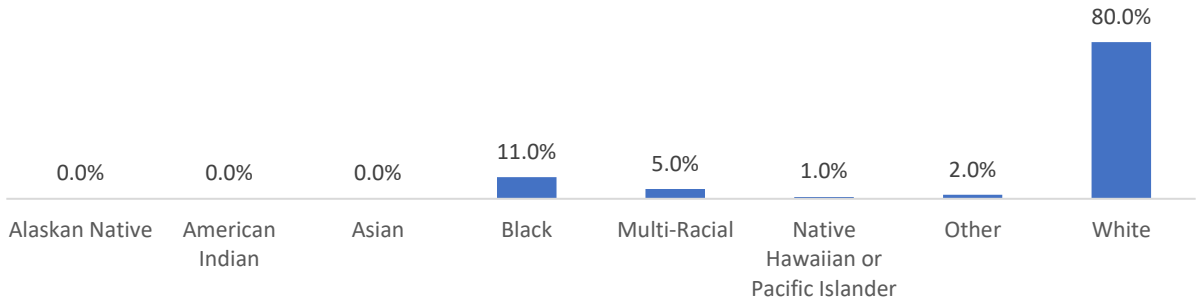
Source: CFBHN Client Data

Figure 41: CFBHN AMH Clients by Race



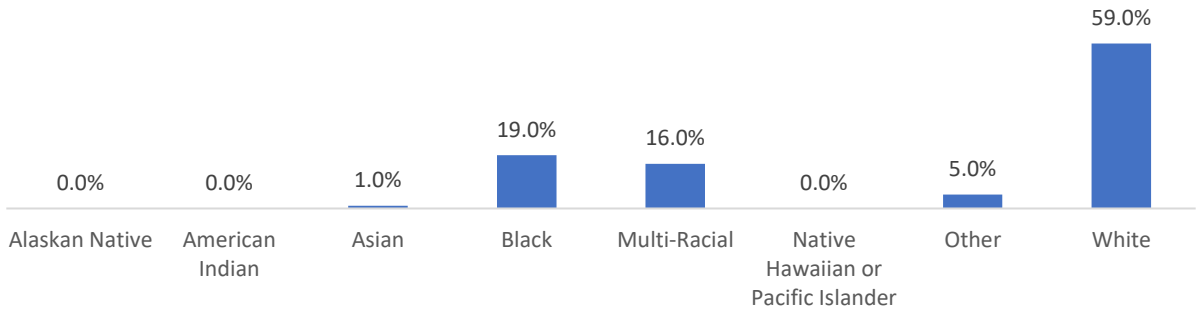
Source: CFBHN Client Data

Figure 42: CFBHN ASA Clients by Race



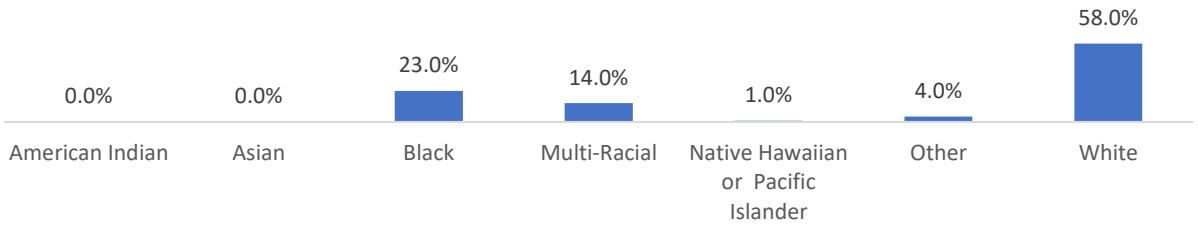
Source: CFBHN Client Data

Figure 43: CFBHN CMH Clients by Race



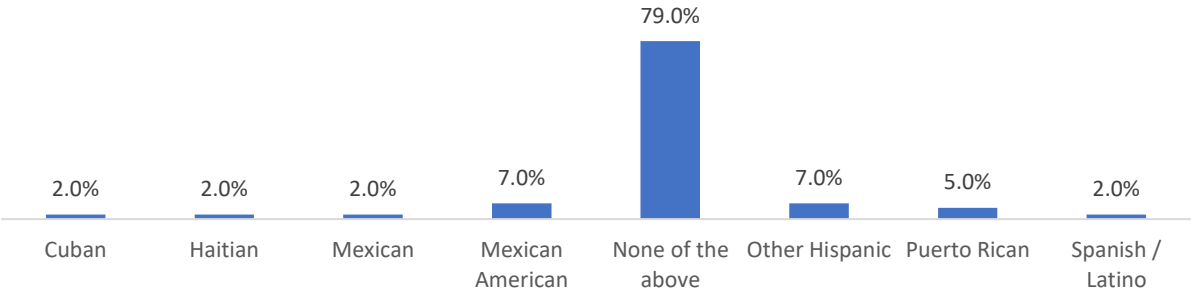
Source: CFBHN Client Data

Figure 44: CFBHN CSA Clients by Race



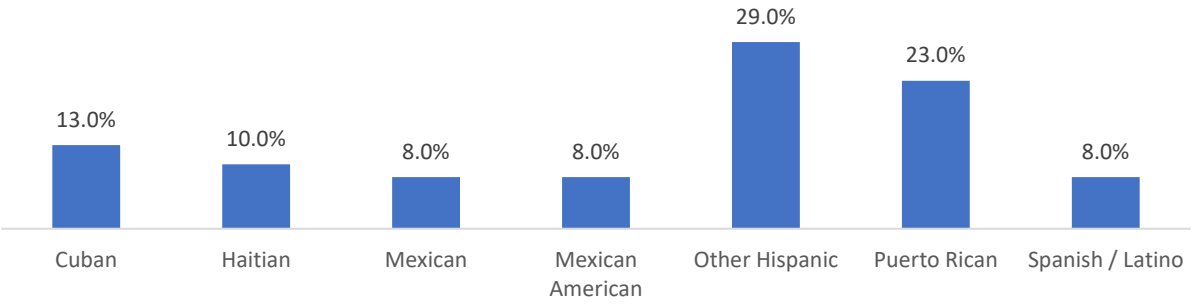
Source: CFBHN Client Data

Figure 45: CFBHN Clients by Ethnicity



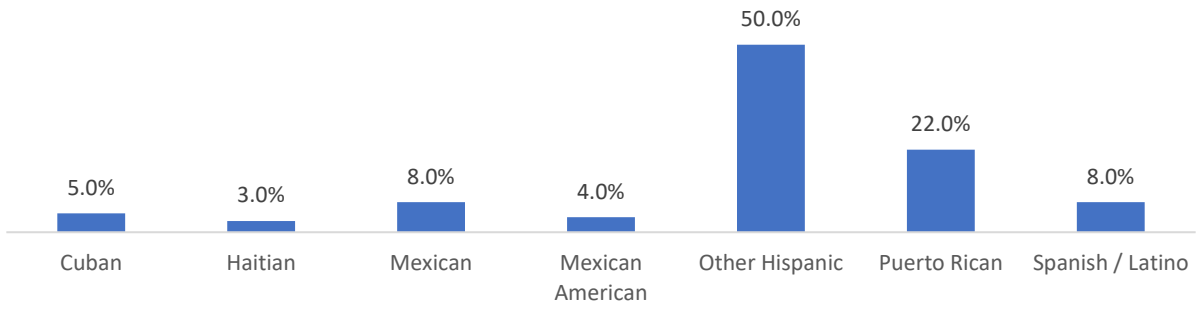
Source: CFBHN Client Data

Figure 46: CFBHN AMH Clients by Ethnicity



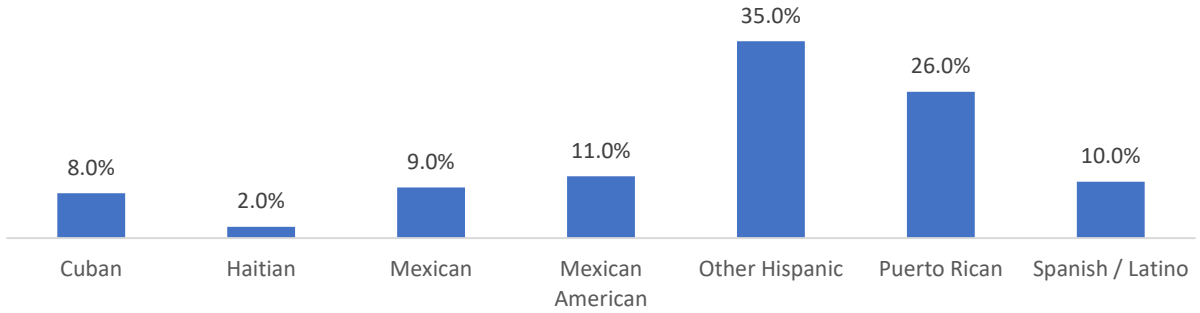
Source: CFBHN Client Data

Figure 47: CFBHN ASA Clients by Ethnicity



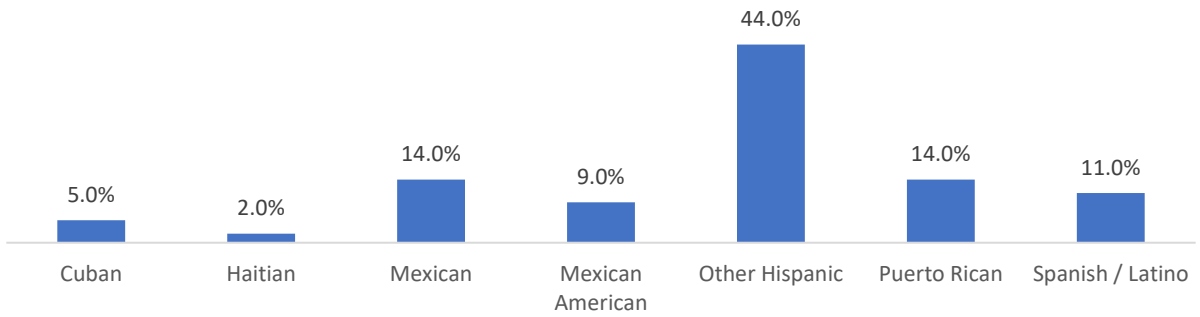
Source: CFBHN Client Data

Figure 48: CFBHN CMH Clients by Ethnicity



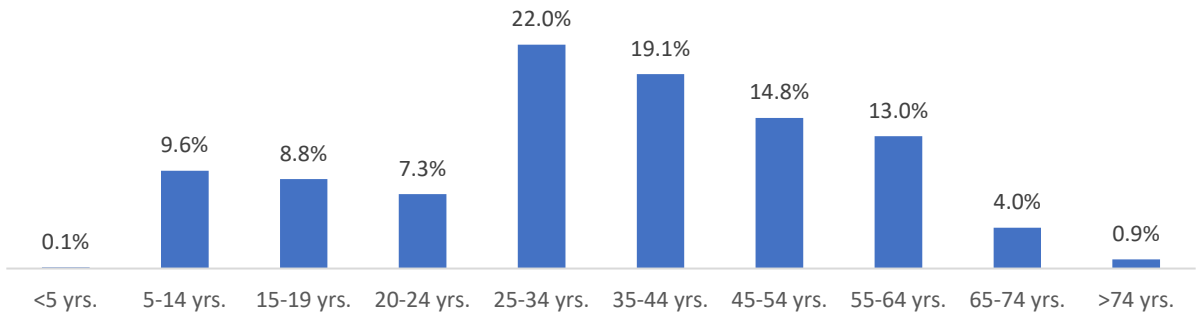
Source: CFBHN Client Data

Figure 49: CFBHN CSA Clients by Ethnicity



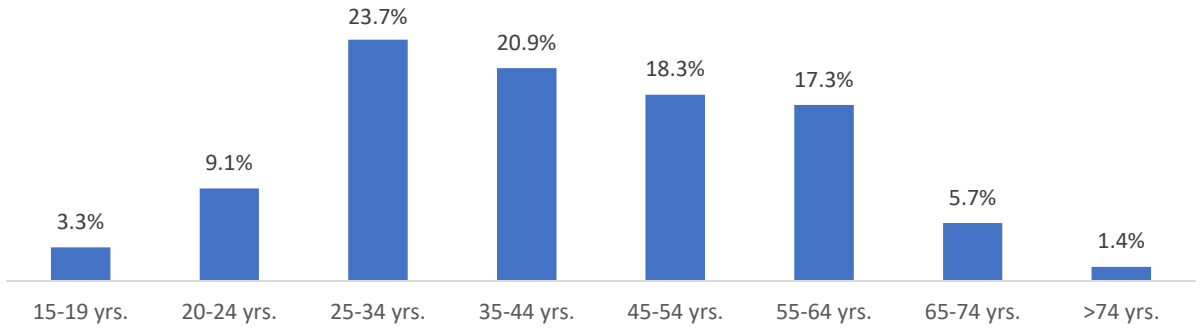
Source: CFBHN Client Data

Figure 50: CFBHN Clients by Age Range



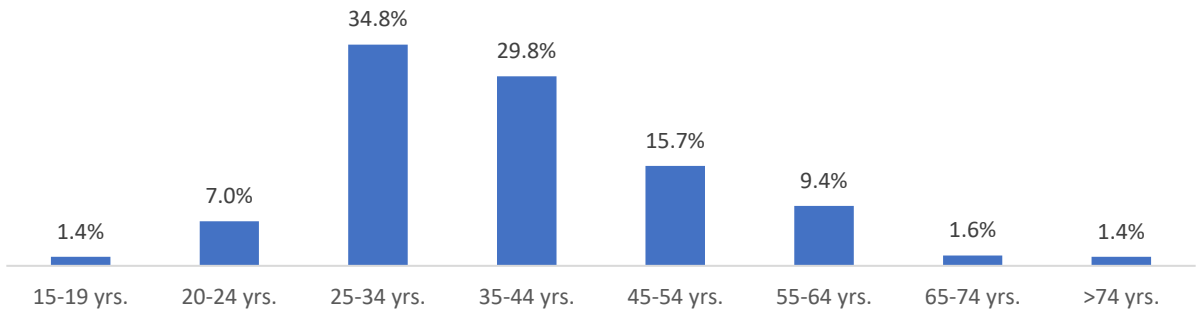
Source: CFBHN Client Data

Figure 51: CFBHN AMH Clients by Age Range



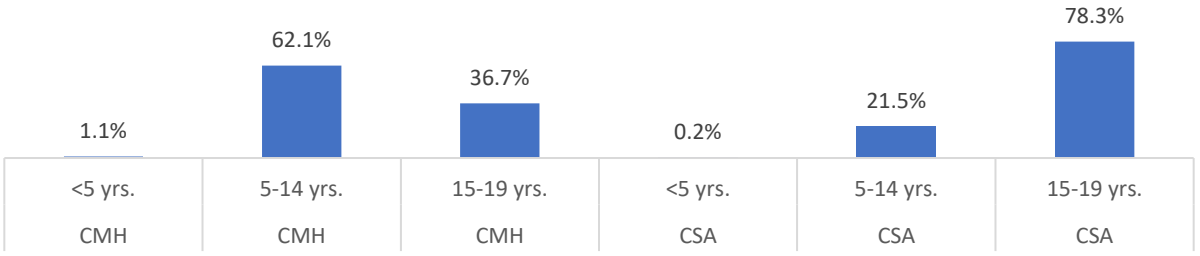
Source: CFBHN Client Data

Figure 52: CFBHN ASA Clients by Age Range



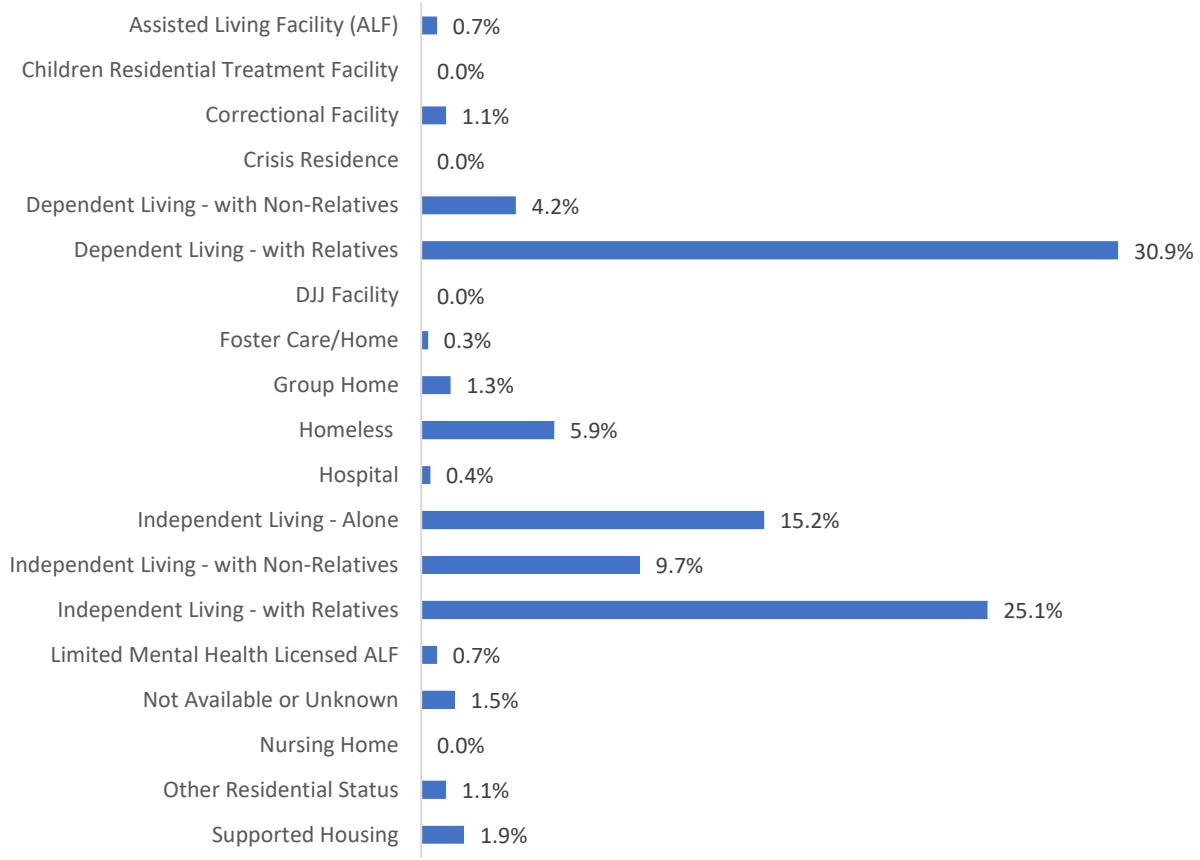
Source: CFBHN Client Data

Figure 53: CFBHN CMH and CSA Clients by Age Range



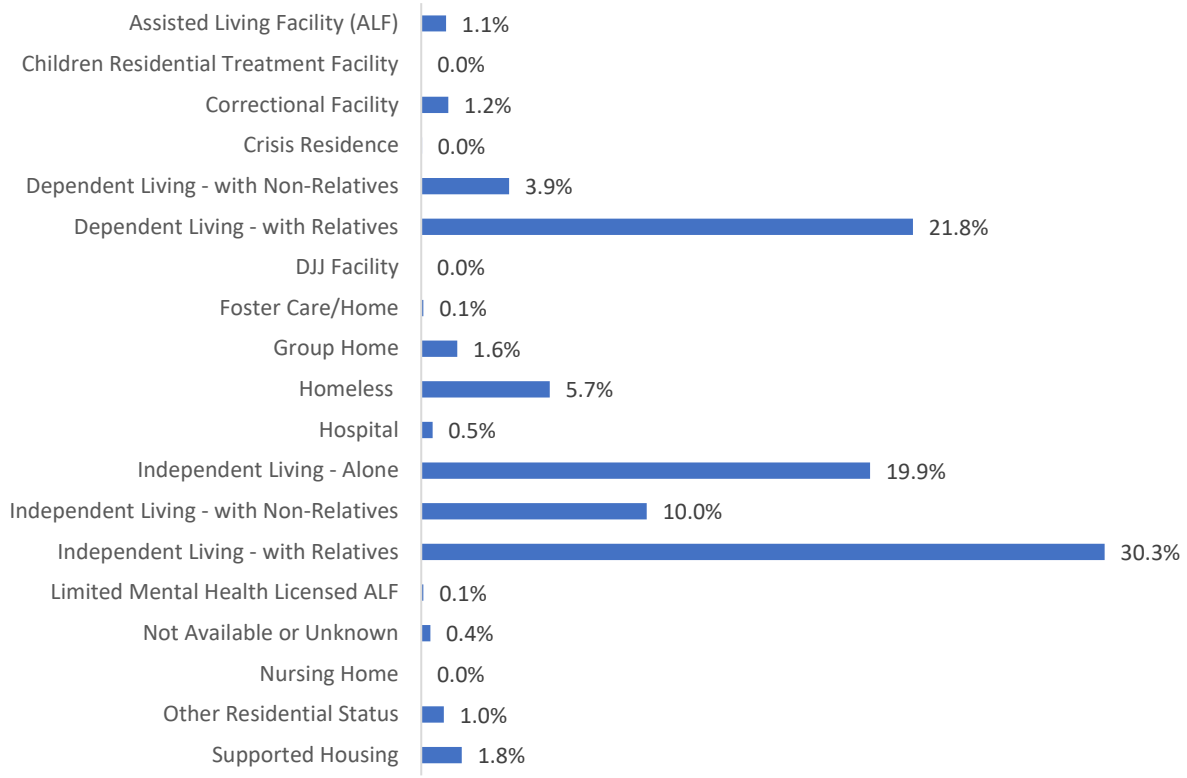
Source: CFBHN Client Data

Figure 54: CFBHN Clients by Residential Status



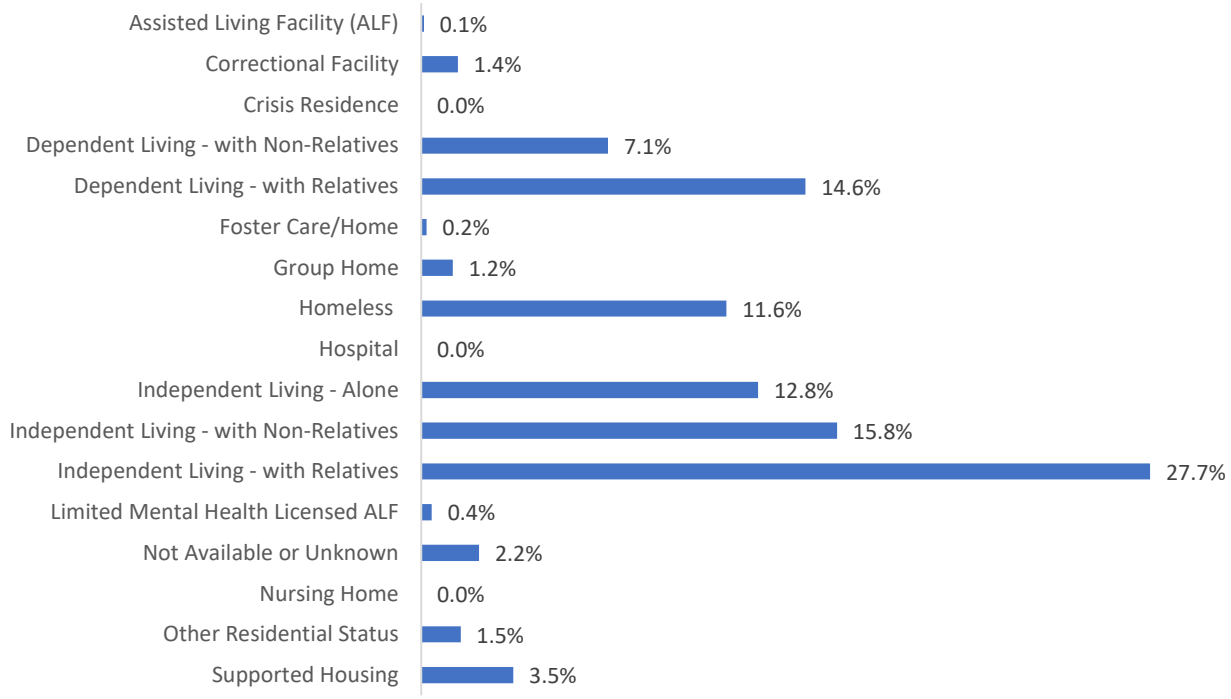
Source: CFBHN Client Data

Figure 55: CFBHN AMH Clients by Residential Status



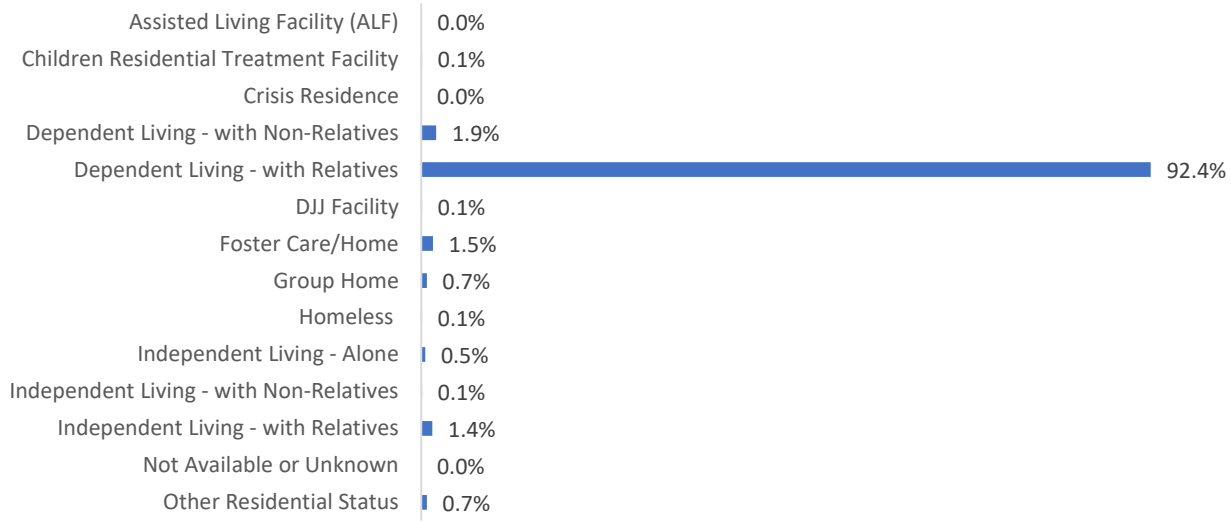
Source: CFBHN Client Data

Figure 56: CFBHN ASA Clients by Residential Status



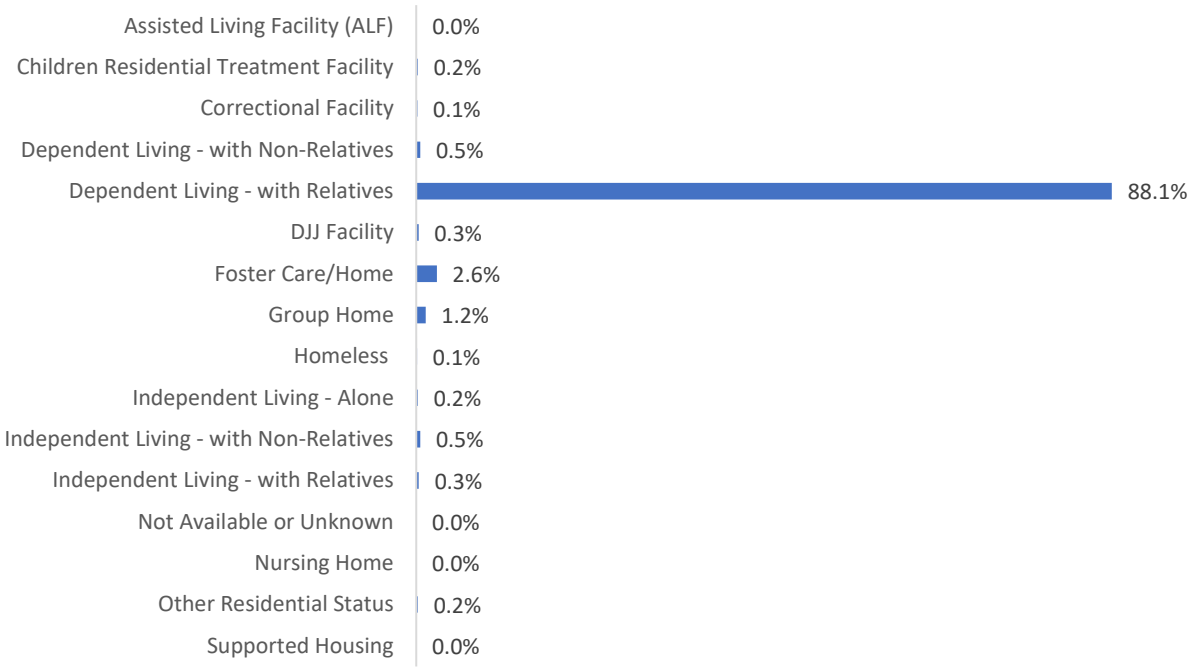
Source: CFBHN Client Data

Figure 57: CFBHN CMH Clients by Residential Status



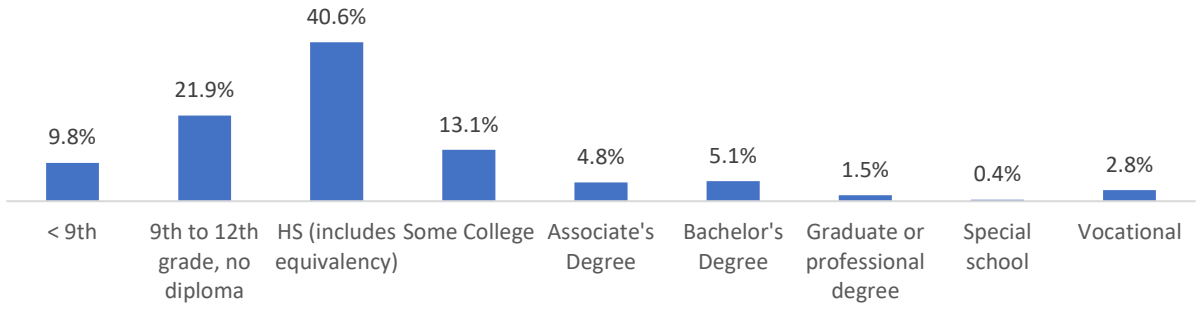
Source: CFBHN Client Data

Figure 58: CFBHN CSA Clients by Residential Status



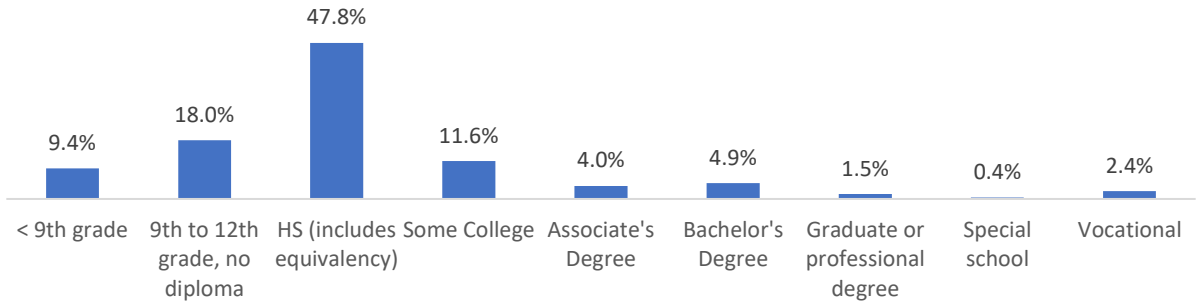
Source: CFBHN Client Data

Figure 59: CFBHN Clients by Educational Attainment



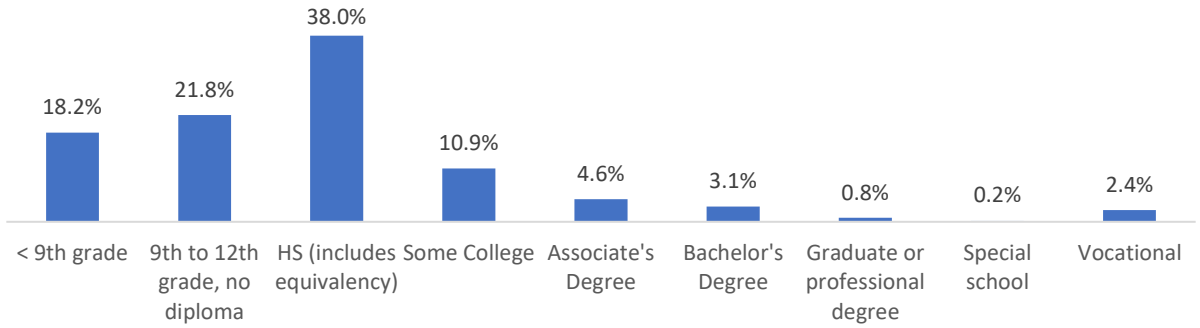
Source: CFBHN Client Data

Figure 60: CFBHN AMH Clients by Educational Attainment



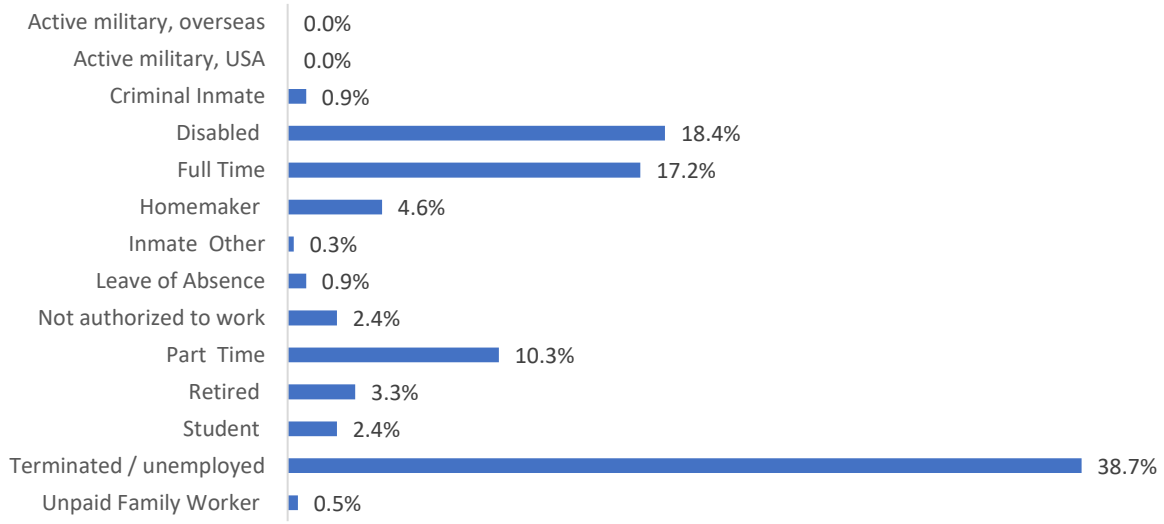
Source: CFBHN Client Data

Figure 61: CFBHN ASA Clients by Educational Attainment



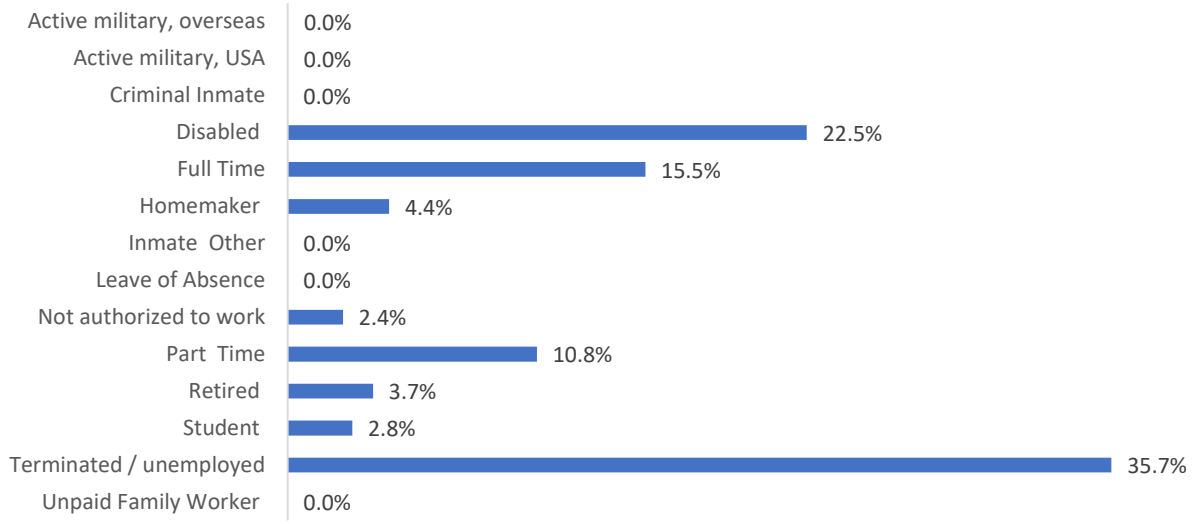
Source: CFBHN Client Data

Figure 62: CFBHN Clients by Employment Status



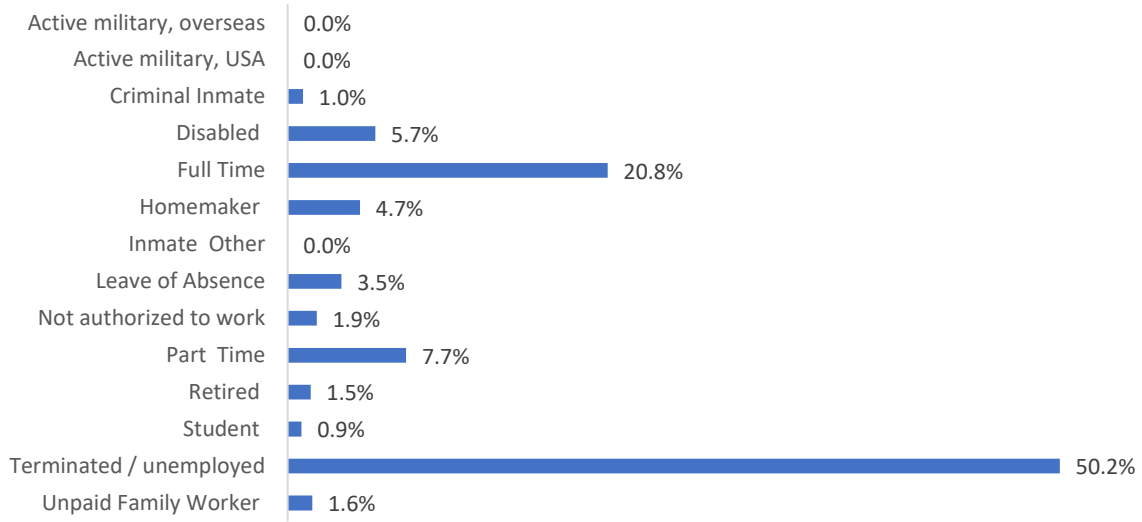
Source: CFBHN Client Data

Figure 63: CFBHN AMH Clients by Employment Status



Source: CFBHN Client Data

Figure 64: CFBHN ASA Clients by Employment Status



Source: CFBHN Client Data

CFBHN SERVICE AREA HOMELESS POPULATION

The effects of homelessness on individuals are numerous, complicated, and very costly. In addition to poor physical health, homeless community members are at an increased risk for mental illness, drug dependency, behavioral health issues, assault, and even premature death. The causes for homelessness such as unemployment, lack of affordable housing, domestic violence, or aging out of foster care are complex societal problems. Addressing these requires community engagement dedicated to the long-term financial commitments and proven solutions that can bring an end to homelessness.

For this report, Okeechobee County is included in the data totals as it is part of CoC # FL-517. Okeechobee County is outside of the CFBHN ME service area. In 2019, the Florida Council on Homelessness reported there were 7,781 individuals who were homeless in Central and Southwest Florida (Charlotte, Collier, DeSoto, Glades, Hardee, Hendry, Highlands, Hillsborough, Lee, Manatee, Okeechobee, Pasco, Pinellas, Polk, and Sarasota counties). Forty-two percent were unsheltered and 18.8% were chronically homeless. In the ME service area, there were 1,894 people in families with children who were homeless. Among veterans, 742 were homeless in Central and Southwest Florida. The Florida Department of Education reported 24,536 students in Central and Southwest Florida were homeless in the 2017-2018 academic year. Seventy-five percent of homeless students resided in a shared housing environment, 12.1% lived in motels, 9.8% were sheltered, and 2.9% were living in other housing situations.

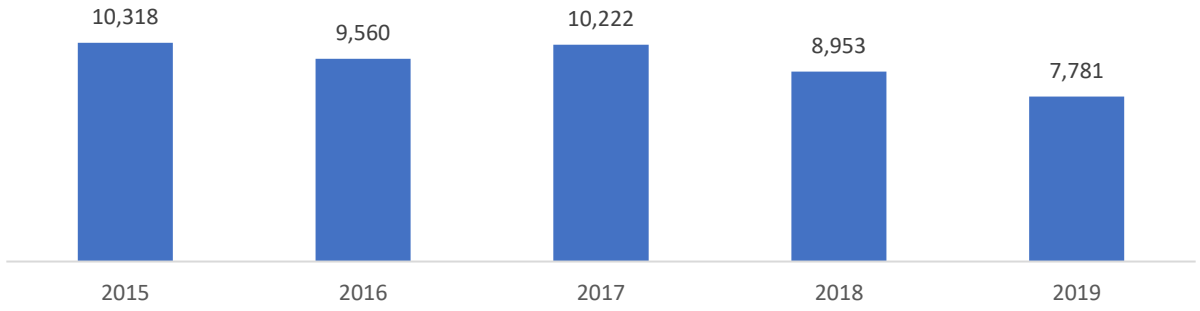
According to the annual report produced by the Council on Homelessness, federal funding from HUD CoC increased (5.5% from 2017) in 2018. As stated in the report, even with the additional dollars, funding is barely adequate to address the level of shortfalls related to years of decreased funding. Additionally, organizations are faced with ever increasing rent costs, limited affordable housing options, and lack of increased monies needed for health and human services that support the homeless population. The table below depicts the homeless funding sources and dollars amounts by county for 2019.

Figure 65: CoC Funding from Federal and State Sources, District 5, 6, & 8

Source	District 5, 6, & 8
Total Funding Award	$17,816,286.54
HUD CoC	$13,964,822.00
State Total	$3,851,734.54
State Challenge	$902,501.24
State HUD-ESG	$1,876,063.50
State Staffing	$857,142.80
State TANF-HP	$252,000.00

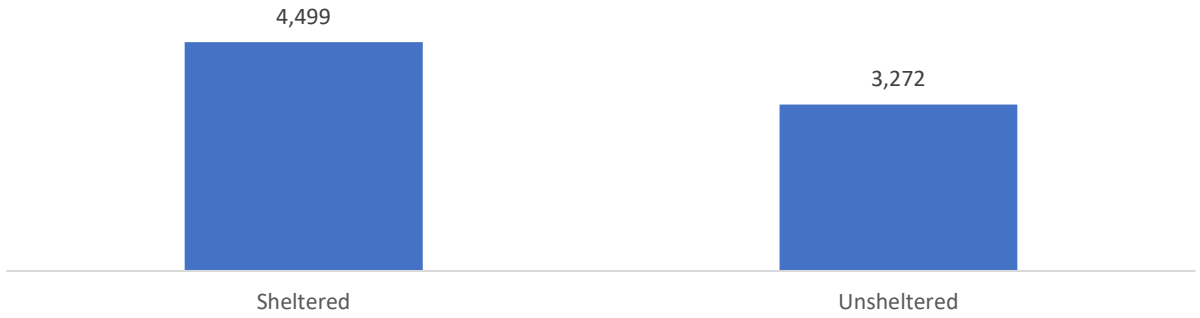
SOURCE: Council on Homelessness Annual Report (2019)

Figure 66: Total Homeless Population, District 5, 6, & 8 (2015-2019)



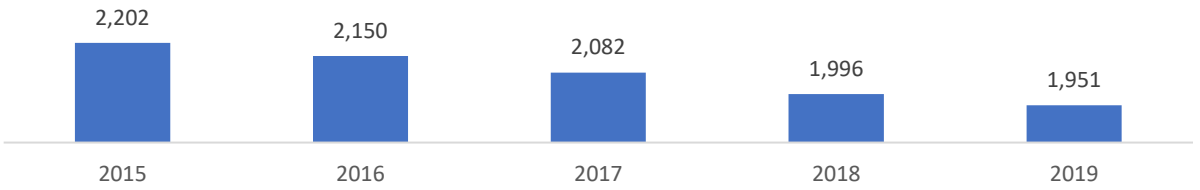
SOURCE: Council on Homelessness Annual Report (2019)

Figure 67: Total Homeless Population Sheltered and Unsheltered, District 5, 6, & 8 (2019)



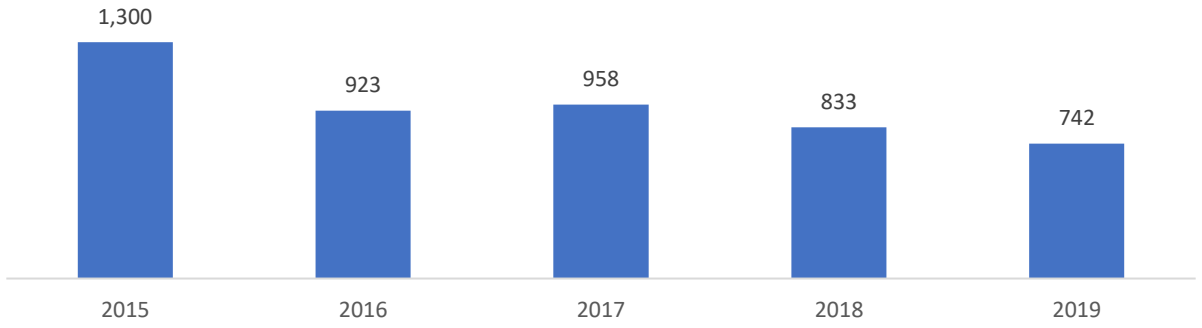
SOURCE: Council on Homelessness Annual Report (2019)

Figure 68: Chronic Homelessness, District 5, 6, & 8 (2015-2019)



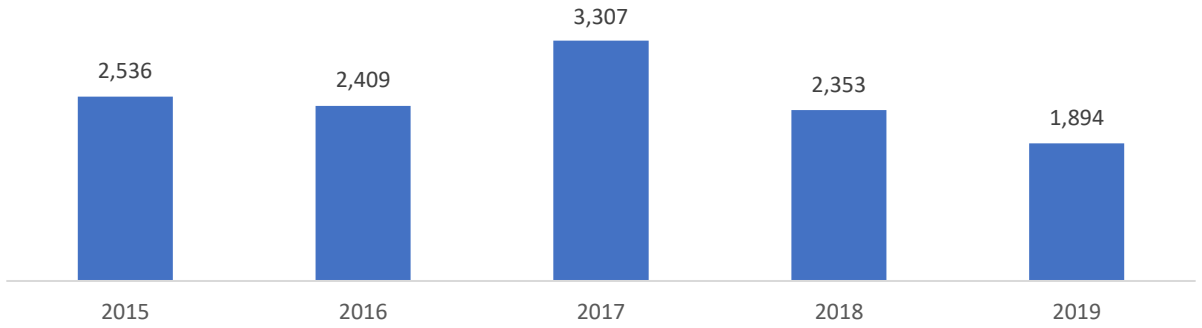
SOURCE: Council on Homelessness Annual Report (2019)

Figure 69: Homelessness Among Veterans, District 5, 6, & 8 (2015-2019)



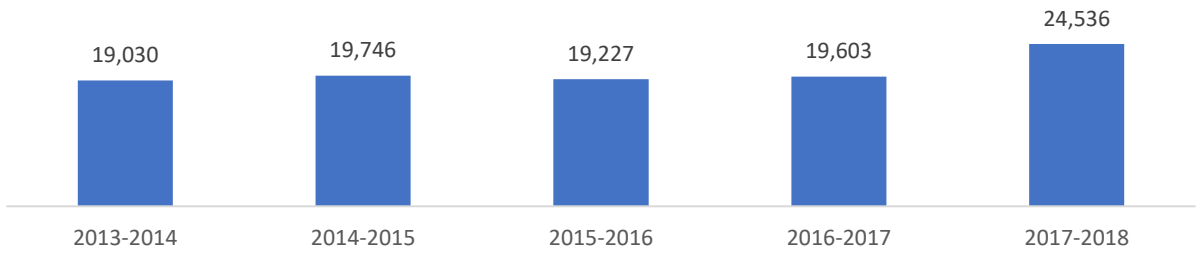
SOURCE: Council on Homelessness Annual Report (2019)

Figure 70: Family Homelessness-Total Persons in Families with Children, District 5, 6, & 8 (2015-2019)



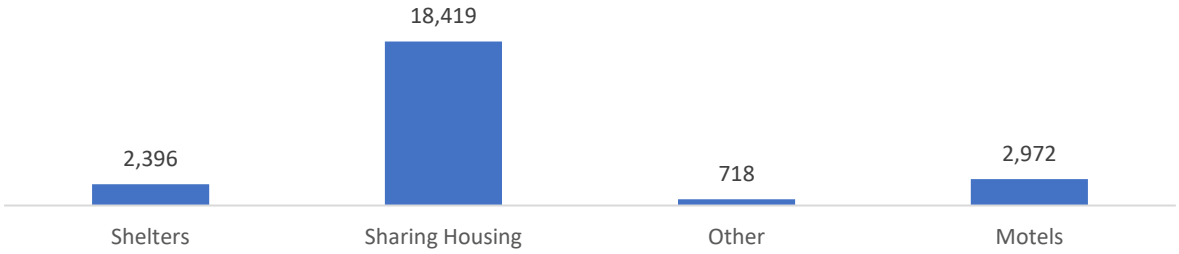
SOURCE: Council on Homelessness Annual Report (2019)

Figure 71: Florida DOE-Reported Homeless Students in Public Schools (2013-2018)



SOURCE: Council on Homelessness Annual Report (2019). School Districts: 8, 11, 14, 22, 25, 26, 28, 29, 36, 41, 51, 52, 53, & 58

Figure 72: Reported Homeless Students in Public Schools by Living Situation (2017-2018)



SOURCE: Council on Homelessness Annual Report (2019). School Districts: 8, 11, 14, 22, 25, 26, 28, 29, 36, 41, 51, 52, 53, & 58

CFBHN HOMELESS CLIENT PROFILE

Demographics

A total of 6,113 homeless clients were enrolled in adult programs with 57.0% in the AMH program and 42.6 in the ASA program.

Males accounted for larger percentages of clients in the AMH and ASA programs at 66.7% and 70.7%, respectively.

Homeless clients in the AMH program were racially more diverse when compared to the general service population while those in the ASA program were representative of the 14-county area. White homeless clients accounted for 67.2% of those in the AMH program and Black homeless clients represented 25.0% of clients in the same program. In the general population, Blacks accounted for 12.3% of the total population. Multi-racial individuals also accounted for a larger percentage of clients in the AMH (4.7%) and ASA (6.4%) programs when compared to the service area population at 2.6%. Hispanic clients in both the AMH program, at 10.4%, and in the ASA, at 9.9%, were underrepresented when compared to the general population where 20.0% were Hispanic.

Adults, ages 25-44 years, accounted for 25.5% of AMH clients and 23.9% of ASA clients. Older homeless clients in the ASA program were very underrepresented, at 2.0%, when compared the general population at 23.7%.

Residential Status

All homeless clients reported their residential status as homeless.

Educational Attainment

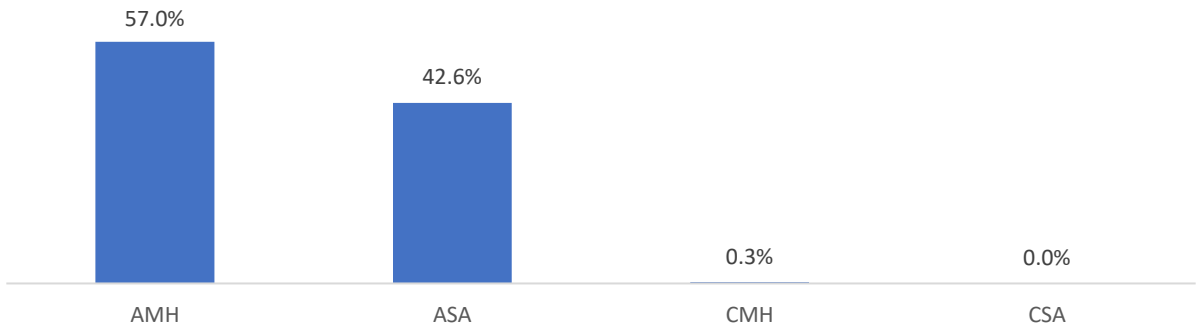
Among the homeless, 81.1% of AMH clients and 77.9% of ASA clients did not have more than a high school education. Of these, 39.8% of AMH clients and 34.4% of ASA clients did not have a diploma.

Employment Status

Only 9.1% of homeless clients were employed (full time and part time) and over 70% had been terminated.

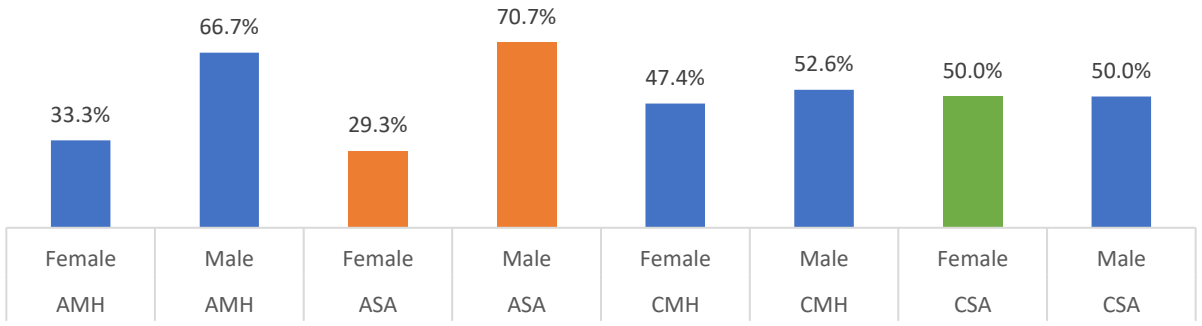
CFBHN HOMELESS CLIENT CHARTS

Figure 73: CFBHN Homeless Clients by Program



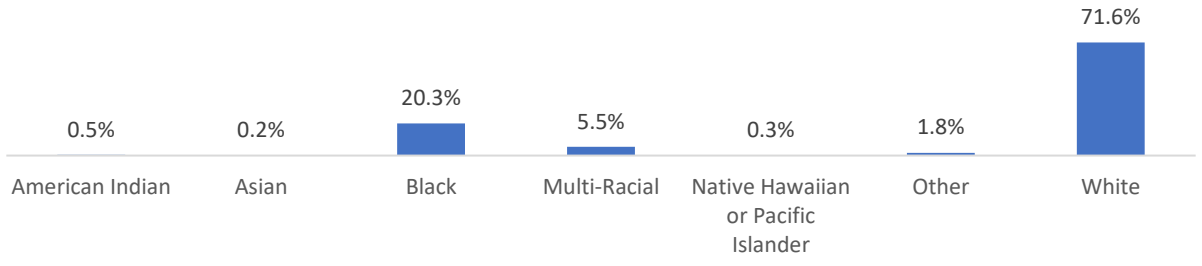
SOURCE: CFBHN Client Data

Figure 74: CFBHN Homeless Clients by Gender



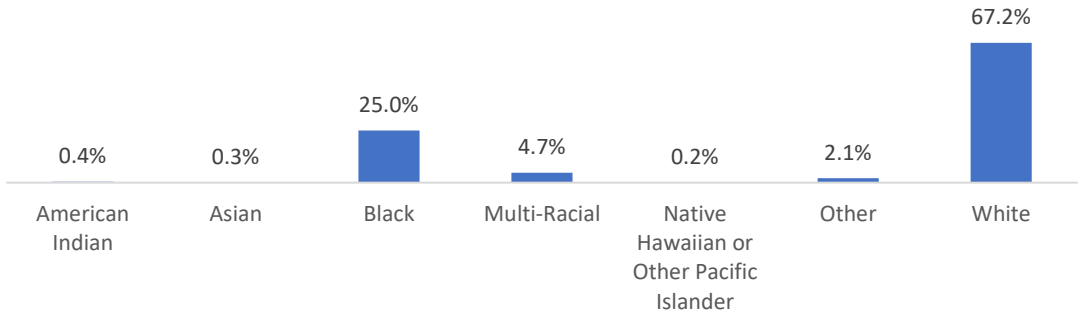
SOURCE: CFBHN Client Data

Figure 75: CFBHN Homeless Clients by Race



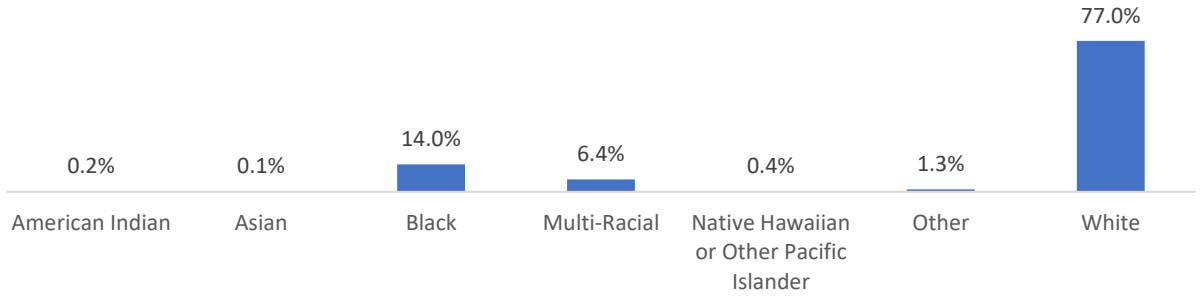
SOURCE: CFBHN Client Data

Figure 76: CFBHN Homeless AMH Clients by Race



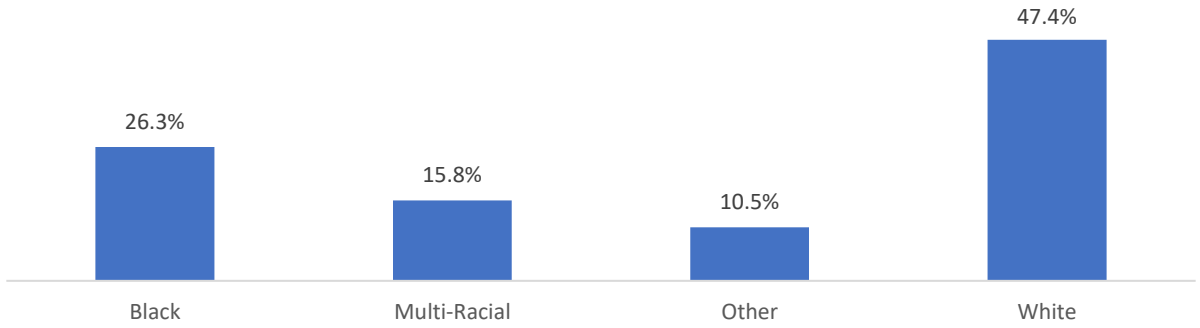
SOURCE: CFBHN Client Data

Figure 77: CFBHN Homeless ASA Client by Race



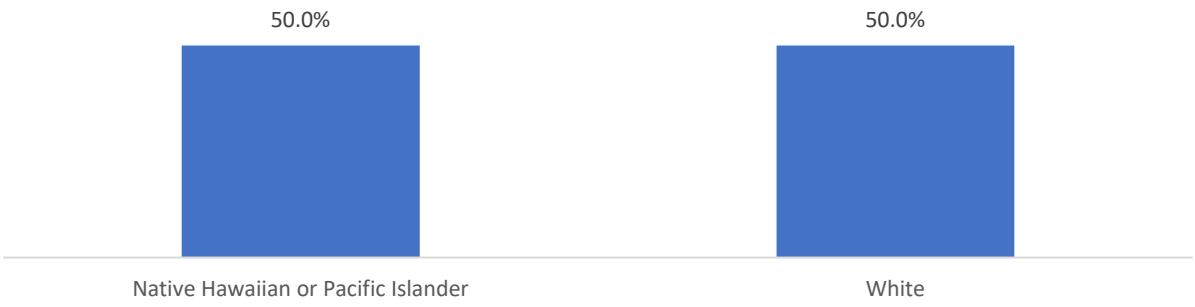
SOURCE: CFBHN Client Data

Figure 78: CFBHN Homeless CMH Clients by Race



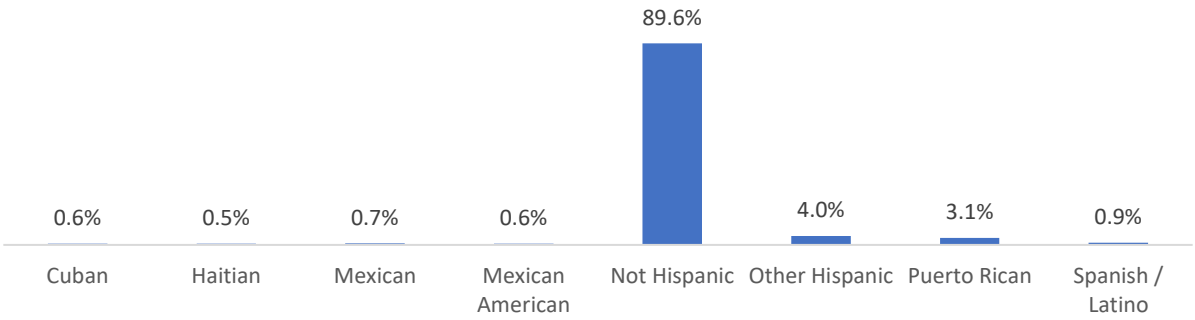
SOURCE: CFBHN Client Data

Figure 79: CFBHN Homeless CSA Clients by Race



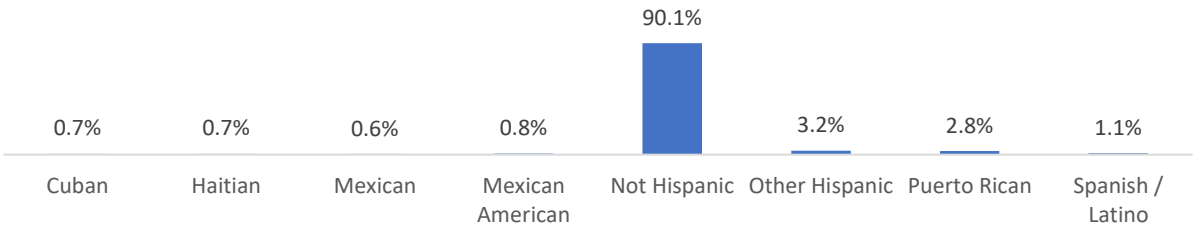
SOURCE: CFBHN Client Data

Figure 80: CFBHN Homeless Clients by Ethnicity



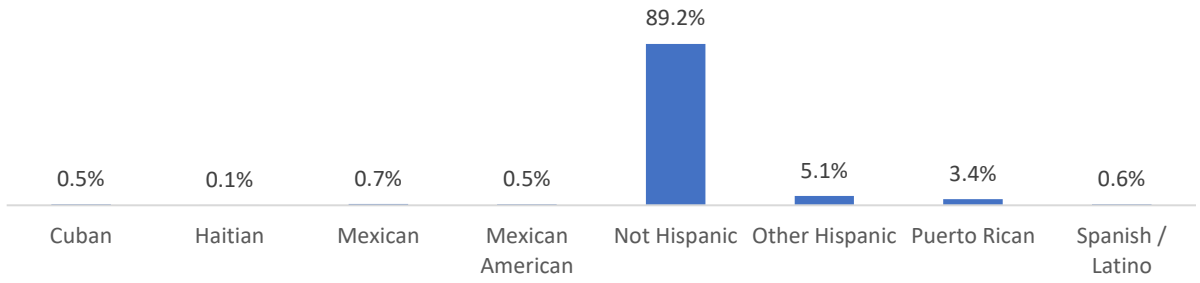
SOURCE: CFBHN Client Data

Figure 81: CFBHN Homeless AMH Clients by Ethnicity



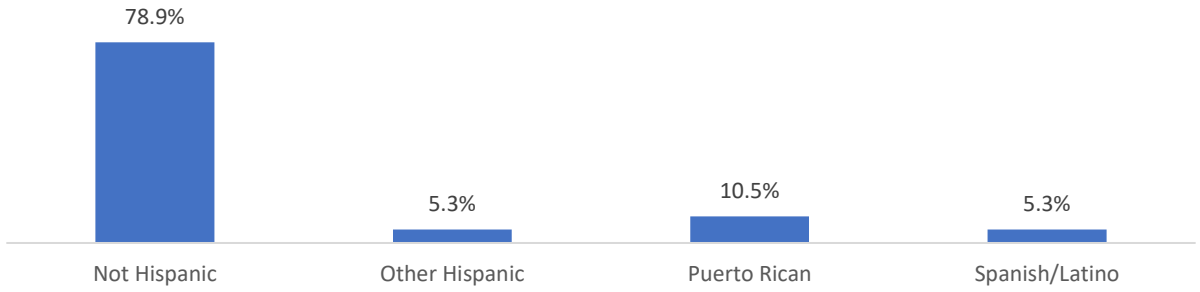
SOURCE: CFBHN Client Data

Figure 82: CFBHN Homeless ASA Clients by Ethnicity



SOURCE: CFBHN Client Data

Figure 83: CFBHN Homeless CMH Clients by Ethnicity

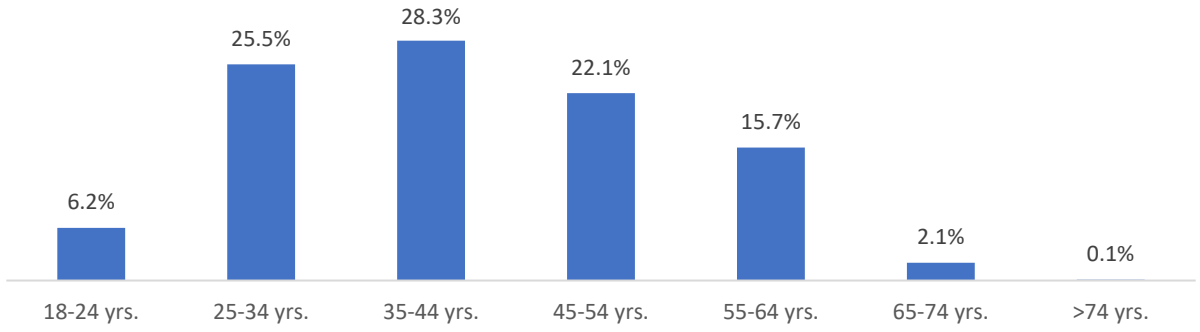


SOURCE: CFBHN Client Data

Figure 84: CFBHN Homeless CSA Clients by Ethnicity

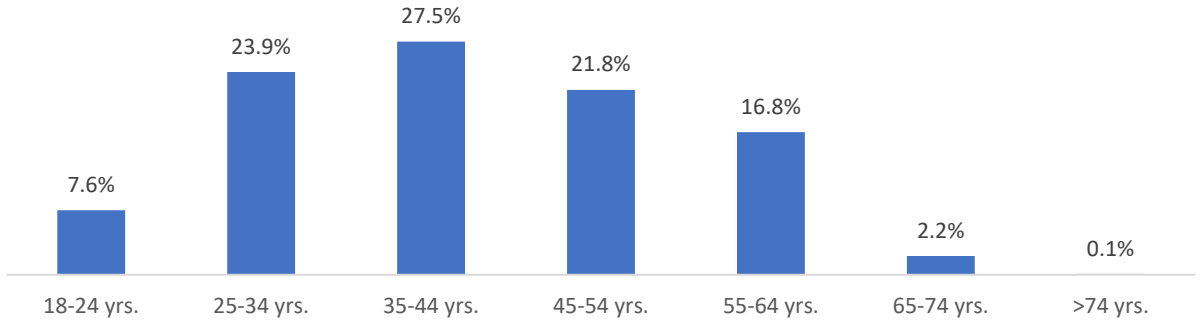
SOURCE: CFBHN Client Data

Figure 85: CFBHN Homeless Clients by Age Range



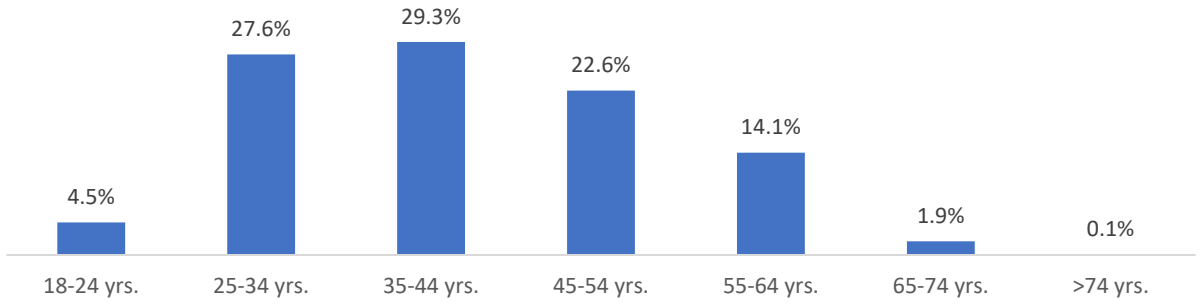
SOURCE: CFBHN Client Data

Figure 86: CFBHN Homeless AMH Clients by Age Range



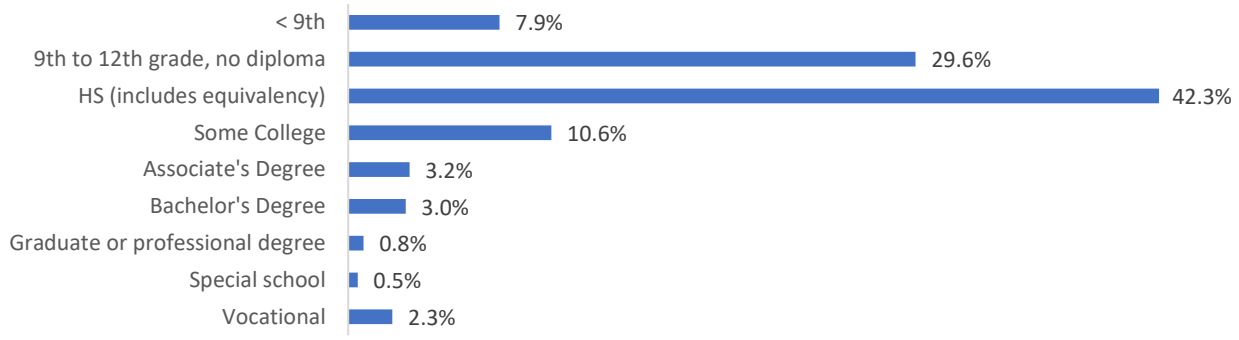
SOURCE: CFBHN Client Data

Figure 87: CFBHN Homeless ASA Clients by Age Range



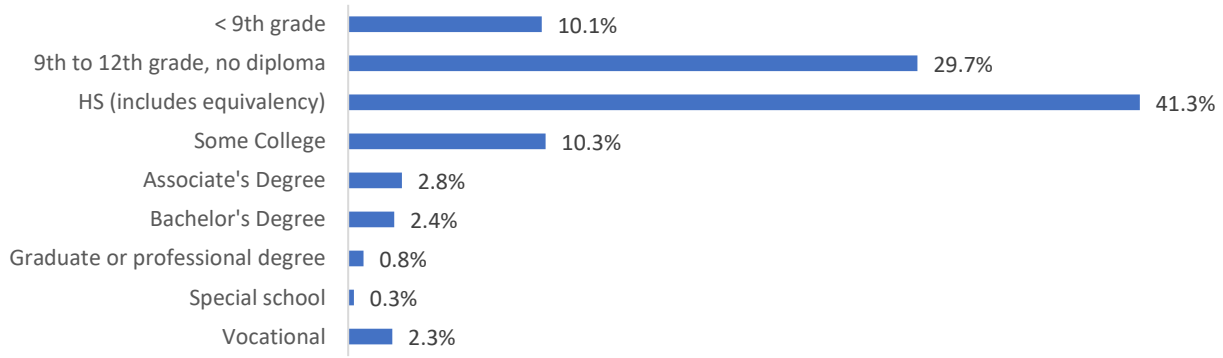
SOURCE: CFBHN Client Data

Figure 88: CFBHN Homeless Clients by Educational Attainment



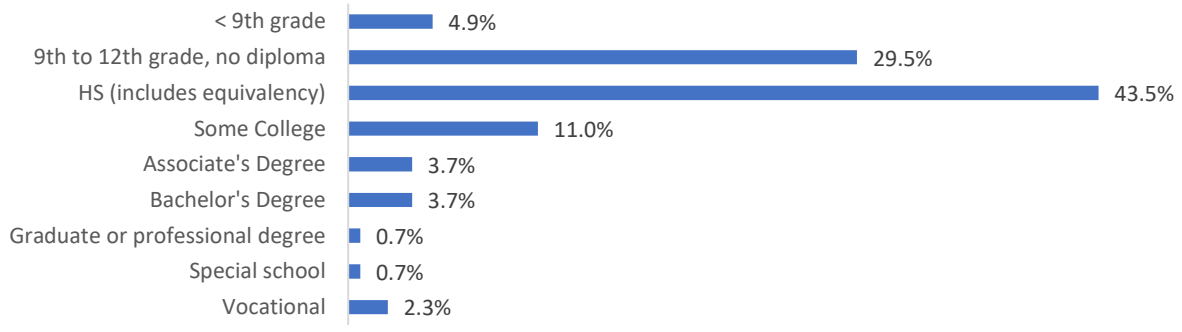
SOURCE: CFBHN Client Data

Figure 89: CFBHN Homeless AMH Clients by Educational Attainment



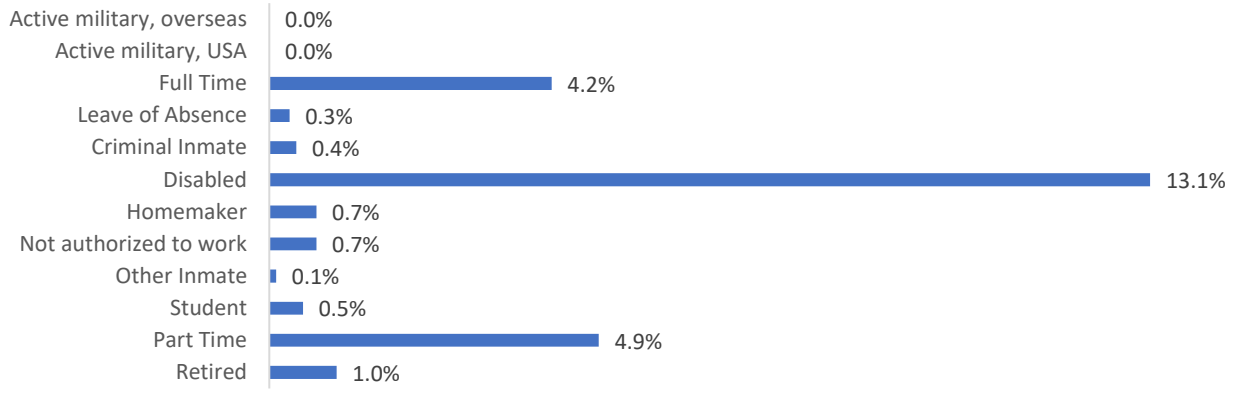
SOURCE: CFBHN Client Data

Figure 90: CFBHN Homeless ASA Clients by Educational Attainment



SOURCE: CFBHN Client Data

Figure 91: CFBHN Homeless Clients by Employment Status



SOURCE: CFBHN Client Data. The following categories are not in the labor force: Criminal Inmate, Disabled, Homemaker, Other Inmate, and student.

COST CENTER DESCRIPTION, EXPENDITURES, AND OVER/UNDER PRODUCTION

ADULT MENTAL HEALTH PROGRAM

Cost Center Description	Expenditures	Over/Under Production
Assessment	$907,245.77	$10,772.45
Case Management	$7,675,013.65	$589,801.73
Crisis Stabilization	$18,822,679.42	$1,130,592.00
Crisis Support/Emergency	$1,092,909.16	$269,057.11
Day-Night	$549,689.70	$38.78
In-home & On-site	$80,366.82	$26,936.91
Intensive Case Mgmt.	$149,550.58	$13,700.44
Intervention	$1,227,580.97	$153,921.05
Medical Services	$6,972,546.66	$138,528.83
Outpatient-Individual	$3,701,866.76	$83,285.32
Outreach	$65,911.51	$0.00
Residential 1	$2,086,938.20	$38,416.02
Residential 2	$2,768,948.31	$188,620.02
Residential 3	$393,855.00	$120,551.25
Residential 4	$2,369,306.41	$15,452.25
Supported Employment	$266,311.64	$815.68
Supported Housing	$2,670,068.24	$38,584.57
Incidental Expenses	$2,163,044.00	$808,432.53
Outpatient-Group	$203,806.82	$1,257.08
Rm & Bd w/Supervision Level 2	$5,131,982.77	$200,799.35
Short-Term Residential	$1,810,056.11	$0.00
Intervention Group	$3,063.82	$0.00
CCST - Individual	$35,384.70	$2,228.87
CCST - Group	$137.35	$137.35
SARSS - Individual	$2,136.37	$2,136.37
SARSS - Group	$30.72	$30.72
TOTAL	**$61,150,431.46**	**$3,834,096.68**

SOURCE: CFBHN Program Data

ADULT SUBSTANCE ABUSE PROGRAM

Cost Center Description	Expenditures	Over/Under Production
Assessment	$259,675.45	$13,958.26
Case Management	$2,977,481.15	$59,401.77
Crisis Support/Emergency	$54,789.95	$187.07
Day Care (Tx)	$34,760.92	$5.60
Day-Night	$131,719.57	$0.00
In-home & On-site	$889.20	$889.20
Intervention	$2,013,379.91	$11,066.91
Medical Services	$3,539,916.05	$213,821.09
Methadone Maintenance	$4,803,139.56	$5,827.72
Outpatient-Individual	$2,306,409.05	$107,939.94
Outreach	$31,435.40	$20.26
Residential 1	$2,190,748.31	$48.45
Residential 2	$9,277,944.56	$136,475.66
Residential 3	$2,195,454.61	$375,347.20
Residential 4	$358,823.74	$0.00
SA Detox	$5,730,081.07	$130,476.88
Supported Housing	$286,671.61	$716.07
Incidental Expenses	$2,163,772.00	$17,082.83
Aftercare	$13,577.81	$306.45
Outpatient Detox	$6.60	$6.60
Outpatient-Group	$709,228.22	$16,403.06
Rm & Bd w/Supervision, Level 2	$497,106.87	$0.33
Rm & Bd w/Supervision, Level 3	$180,321.99	$2.52
Intervention Group	$135,107.99	$3,205.95
Aftercare Group	$42,944.92	$333.19
SARSS - Individual	$354,630.20	$674.33
SARSS - Group	$188,639.52	$329.42
TOTAL	**$40,478,656.23**	**$1,094,526.76**

SOURCE: CFBHN Program Data

CHILD MENTAL HEATH PROGRAM

Cost Center Description	Expenditures	Over/Under Production
Assessment	$231,508.97	$147,357.50
Case Management	$4,563,225.52	$3,184,109.40
Crisis Stabilization	$547,446.24	$11,863.18
Crisis Support/Emergency	$495,904.02	$135,751.05
In-home & On-site	$543,977.49	$440,260.08
Intervention	$6,970.24	$0.00
Medical Services	$562,564.28	$240,782.98
Outpatient-Individual	$1,030,445.41	$574,704.43
Incidental Expenses	$84,116.00	$29,115.00
Outpatient-Group	$5,664.87	$4,970.34
CCST - Individual	$0.00	$0.00
CCST - Group	$15.15	$15.15
SARSS - Individual	$692.10	$692.10
SARSS - Group	$12.68	$12.68
TOTAL	**$8,072,542.97**	**$4,769,633.89**

SOURCE: CFBHN Program Data

CHILD SUBSTANCE ABUSE PROGRAM

Cost Center Description	Expenditures	Over/Under Production
Assessment	$13,407.04	$707.84
Case Management	$44,034.37	$395.34
Crisis Support/Emergency	$6,941.24	$0.00
In-home & On-site	$9,480.51	$9,480.51
Intervention	$253,853.41	$904.25
Medical Services	$114,070.02	$0.08
Outpatient-Individual	$63,542.32	$2,639.29
Residential 2	$2,131,332.16	$80,174.78
Residential 4	$27,139.36	$4,094.30
SA Detox	$184,478.27	$0.00
TASC	$9,895.21	$6.24
Incidental Expenses	$3,050.00	$0.00
Aftercare	$604.71	$36.28
Outpatient-Group	$6,508.88	$466.34
Intervention Group	$658.66	$27.72
SARSS - Individual	$48.12	$0.00
SARSS - Group	$36.09	$0.00
TOTAL	**$2,869,080.37**	**$98,932.97**

SOURCE: CFBHN Program Data

CFBHN All Cost Centers	Expenditures	Over/Under Production
Grand Total	$112,570,711.03	$9,797,190.30

CULTURAL HEALTH DISPARITY SURVEY SUMMARY

HEALTH DISPARITIES

For the 2022 community assessment, a new survey was deployed to better understand the role of health disparities in behavioral health outcomes. Fifty-one participants completed a survey detailing their experiences and attitudes with respect to behavioral health. The survey was offered in English and Spanish, and two participants completed it in Spanish.

SEEKING CARE

Survey participants were asked to indicate their level of comfort in seeking care for their behavioral health needs. Thirty-nine (76.5%) selected 'Yes' specifying that they do feel comfortable seeking the care they need. Eleven (21.6%) revealed that they do not feel comfortable, and one participant left the question blank.

TRUST

On a scale of 1 to 5, where 5 is "strongly agree," participants were asked to rate their trust in the behavioral health system to treat them with respect. All 51 participants answered the question and the majority (31.4%) specified they "strongly trust" they will be respected. The least elected option was "strongly distrust,'" chosen by two participants (3.9%). Fifteen of the participants (29.4%) remained "neutral," to the question, while 12 (23.5%) indicated that they "trust" the behavioral health system will treat them with respect. The remaining six participants (11.8%), "distrust," the system. The responses indicate that when combined, 55% "trust," rather than "distrust" (15.2%) the behavioral health system to treat them with respect.

FEELINGS REGARDING BEHAVIROAL HEALTH ISSUES

The following series of questions asked participants to indicate how they feel about sharing issues they consider to be private. Participants were able to select a range of five choices from "Most how I feel" (1) to "Most unlike how I feel" (5).

The following statements were provided for participants to respond to,

- This is a private issue I keep to myself
- This is a private issue that stays in the family
- I am comfortable sharing my challenges with others (professionals, family members, friends, clergy, etc.)
- I am more comfortable with people like me

Thirty-nine of the 51 participants provided a response to “this is a private issue I keep to myself.” “Most how I feel” and “Somewhat unlike how I feel,” were each selected by 11 participants (21.5%). Four participants selected “Neutral” and another four selected “Most unlike how I feel,” to this question. The remaining nine (17.6%) selected “Somewhat how I feel.”

When asked to respond to “This is a private issue that stays in the family,” 41 participants responded and 10 selected “Somewhat unlike how I feel,” and another 10 chose, “Most unlike how I feel” for a combined total of 39.2%. Eight (15.7%) selected “Neutral” and the remaining 13 (25.4%) selected either “Somewhat how I feel” (nine, 17.6%) or “Most how I feel” (4, 7.8%).

“I am comfortable sharing my challenges with others,” was the next statement posed to participants and 41 provided a response. Fourteen participants (27.5%) indicated as “Most how they feel,” which is more than for any other question or choice. Eleven (21.6%) selected “Neutral”, seven participants (13.7%) selected “Somewhat unlike how I feel”, and four (7.8%) chose “Most unlike how I feel.” The final five participants (9.8%) selected “Somewhat how I feel,” as their response.

A total of 43 participants provided responses to the statement “I am more comfortable with people like me.” Eleven participants indicated “Neutral’ as their selection (21.6%), more than the other choices provided. Eight (15.7%) indicated “Somewhat unlike how I feel,” and five (9.8%) “Most unlike how I feel,” was selected by five participants (9.8%), the lowest choice represented. A combined total of 19 participants (37.2%) selected “Most how I feel’ with nine responses, and 10 chose “Somewhat how I feel.”

TREATMENT SETTING

Behavioral health treatment is conducted in a variety of settings and the survey asked participants to select where they feel most comfortable discussing their behavioral health concerns. They were instructed to select “all that apply” yielding 91 selections from the 51 participants.

“Private office with doctor,” was selected by 29 participants (31.9%), more than any other option. Twenty-four participants (26.4%) indicated a preference for “Telehealth,” as a close second. “Hybrid of telehealth” was the third most preferred option, selected by 14 (15.4%) participants. Nine participants indicated their preference of “Speaking with a nurse practitioner,” and six (6.6%) preferred a “Faith-based organization.” Another six participants indicated “All of the above,” while the remaining three selected “None of the above.”

The next question asked participants to indicate their preference of faith-based health care services or the traditional physician office. All 51 participants answered the question, where 45 (88.2%) prefer the “traditional physician office” and the remaining six prefer “faith-based health care services.”

Participants were asked to respond to the question "thinking about treatment options, on a scale of 1 to 5, with 5 being "Very likely" and 1 being "Very unlikely", how comfortable would you be in group therapy? The majority, fifteen (29.4%) of participants selected "Very unlikely." Responses of "Unlikely" and "Very likely" were each selected by nine (17.6%) participants. Eleven (21.6%) expressed their feelings as "Neutral" regarding group therapy and the final seven (13.7%) were "Likely" to be comfortable with group therapy.

The question regarding how comfortable they would you be in individual therapy was asked of participants. Again, they were provided with a range from one to five, where five is "Very likely" and one is "Very unlikely." Most participants indicated they were "Likely" (20, 39.2%), or "Very Likely" (22, 43.1%) to be comfortable with induvial therapy, combined total of 42 or (82.3%). "Very unlikely" and "Unlikely" were each selected by one participant each for a combined 4% of the 51 participants. Seven participants indicated a "Neutral" response regarding their comfort with individual therapy.

LANGUAGE

Survey participants were asked if behavioral health care services they have received in the past were available in their primary language. Forty-nine (96.1%) stated they were able to receive services in their primary language. The other 2 participants (3.9%) indicated services were never available in their primary language and they needed a translator.

PARTICIPANT DEMOGRAPHICS

Participants were asked to answer several questions regarding their demographics. Thirty-four (66.7%) of the participants selected female, 16 (31.4%) chose male, and one indicated a preference to not answer.

Five participants did not select any gender identity when asked, and 20 (39.2%) indicated a preference to not answer the question. Cisgender was selected by 19 (37.3%) participants, followed by six (11.8%) that identified as Gender fluid. The final participant selected Agender as their preferred gender identity.

Sexual orientation was asked of survey participants where four did not provide a response and two indicated their preference not to respond. Thirty-six (76.6%) indicated a sexual orientation of Heterosexual/Straight, with more responses than the other choices. One participant indicated their sexual orientation is Asexual, and no one selected Gay/Lesbian, or my sexual orientation is not listed here. Pansexual and Bisexual were each selected by three (6.4%) of the participants. Two participants selected Questioning, as their sexual orientation.

Most participants indicated White as their race (40, 80%), and four (8%) selected Black. American Indian, Asian, Multi-Racial, and Other were each selected by one participant, for a total of four

participants totaling 8% of the sample. Two participants preferred not to answer the question, and one did not respond.

Participants were asked to select their ethnicity from a list provided. Forty-three (84.3%) responded “none of the above.” Three participants indicated their ethnicity is Spanish/Latino, the second most represented ethnic group. Cuban, Mexican, Mexican American, Puerto Rican, and Other Hispanic, we each selected by one participant for a total of 10%.

Age was the final question posed to participants. Most participants (34, 66.7%) selected ages between 25-54 years old. One participant selected the youngest age group of 15-19 years old, and two (3.9%) were 20-24 years old. The 55–64-year-old group included eight (15.7 participants), and there were four participants (7.8%) from age 65-74. Only one participant indicated they were older than 74 years of age and another preferred not to answer the question.

CULUTRAL HEALTH DISPARITY SURVEY CHARTS

Figure 92: Are you usually comfortable seeking behavioral health services?

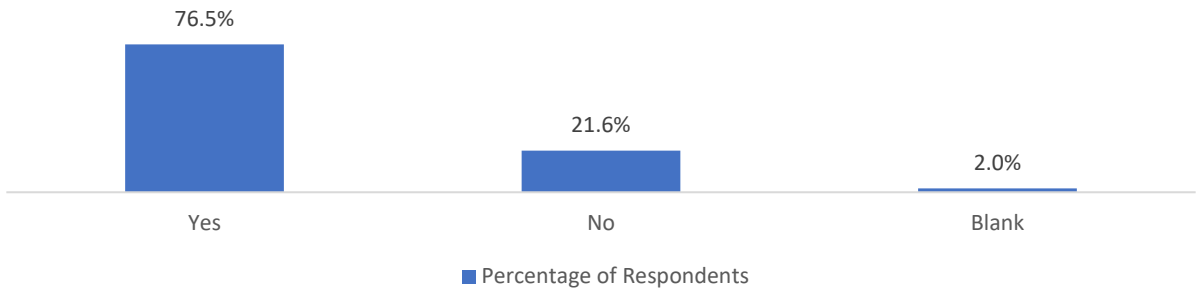


Figure 93: On a scale of 1 to 5, with 5 being 'strongly agree', how would you rate your trust in the behavioral health care system to treat you with respect?

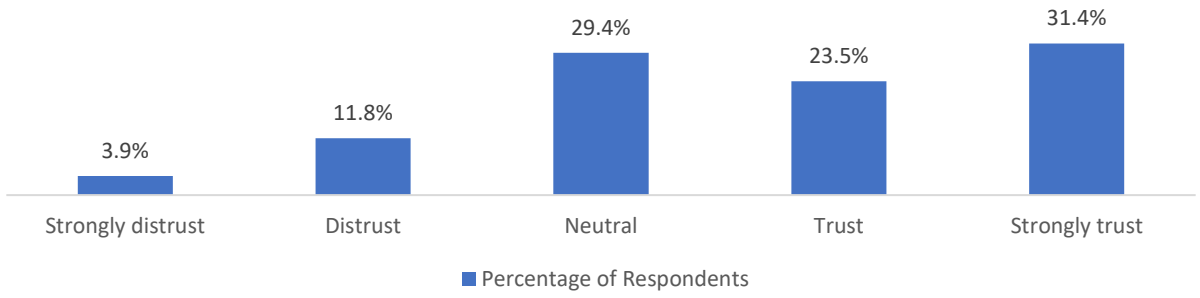


Figure 94: Please rank statement that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. "This is a private issue I keep to myself."

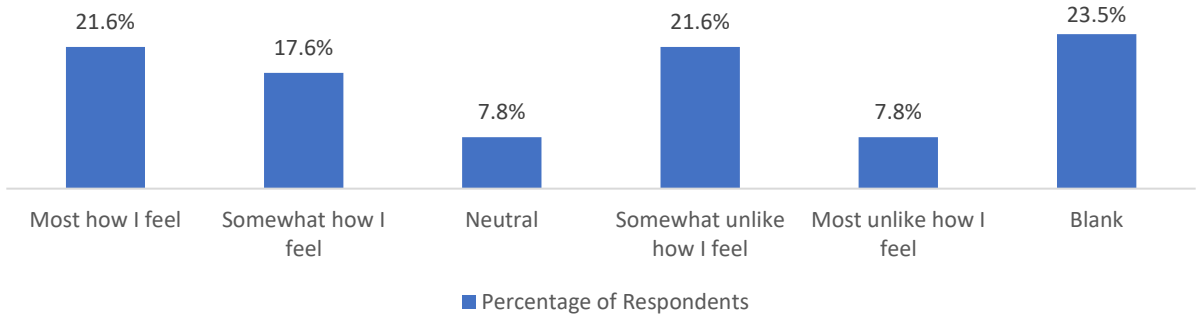


Figure 95: Please rank the statement that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. "This is a private issue that stays in the family."

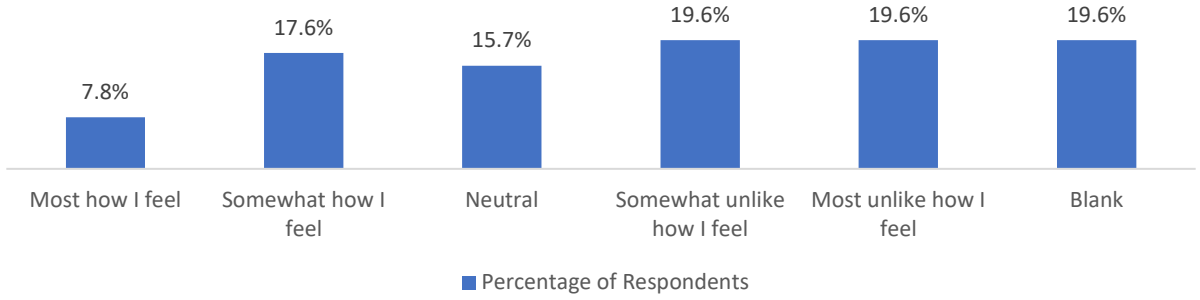


Figure 96: Please rank the statement that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. "I am comfortable sharing my challenges with others."

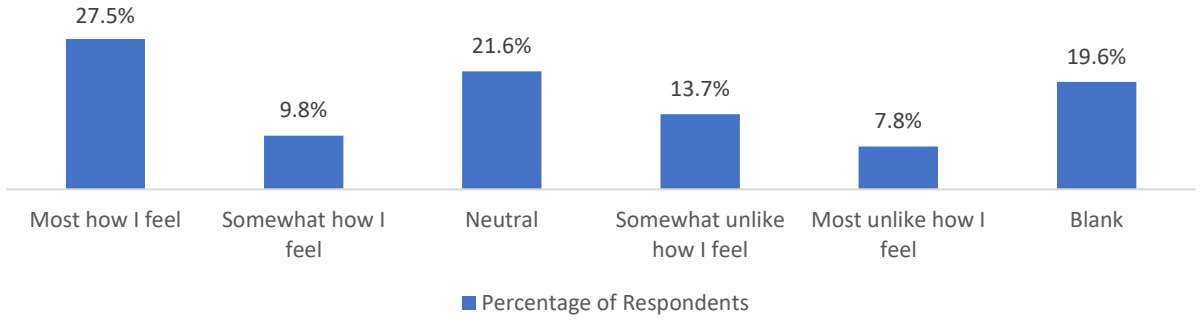


Figure 97: Please rank the statement that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. "I am more comfortable with people like me."

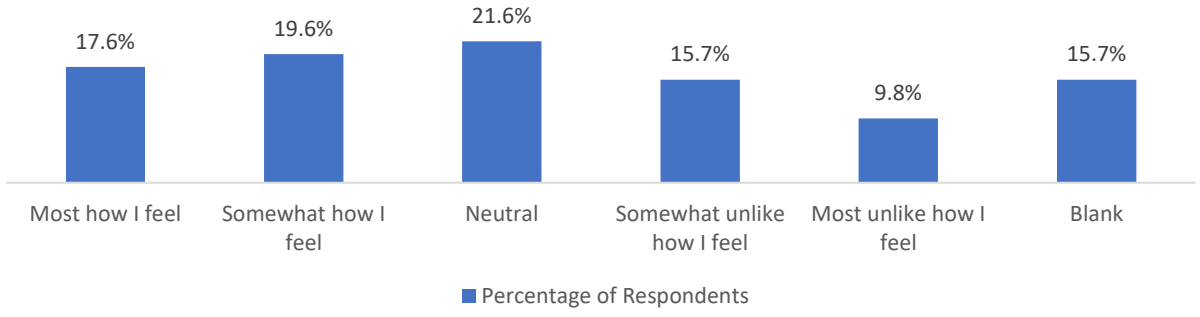


Figure 98: In which setting(s) have you been most comfortable discussing your behavioral health concerns? (Check all that apply)

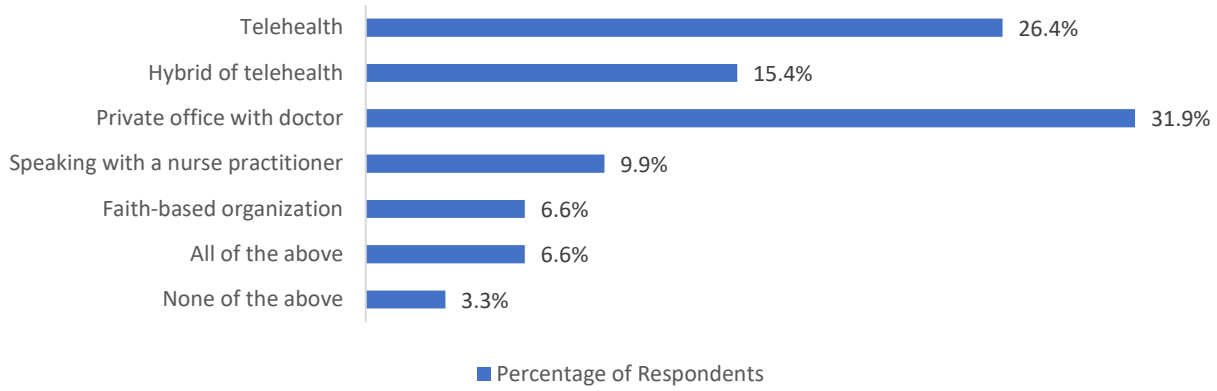


Figure 99: If given a choice for receiving behavioral health care services, would you be more comfortable going to a faith-based organization OR prefer the traditional physician office?

Figure 100: Now thinking about treatment options, on a scale of 1 to 5, with 5 being 'very likely', how comfortable would you be in group therapy?

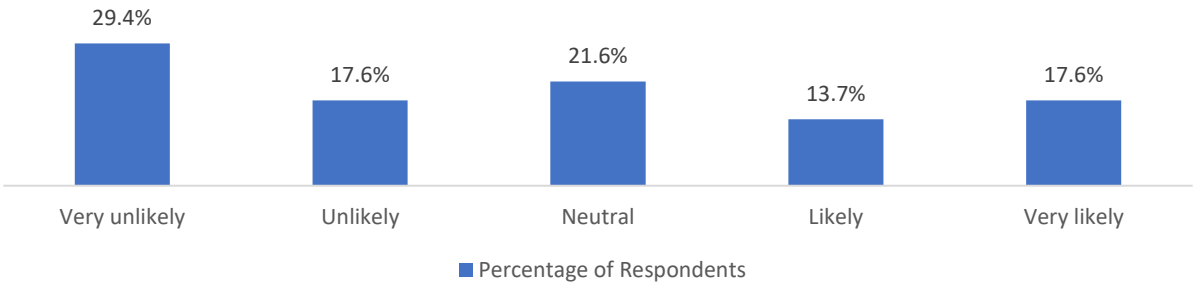


Figure 101: On a scale of 1 to 5, with 5 being 'very likely', how comfortable would you be in individual therapy?

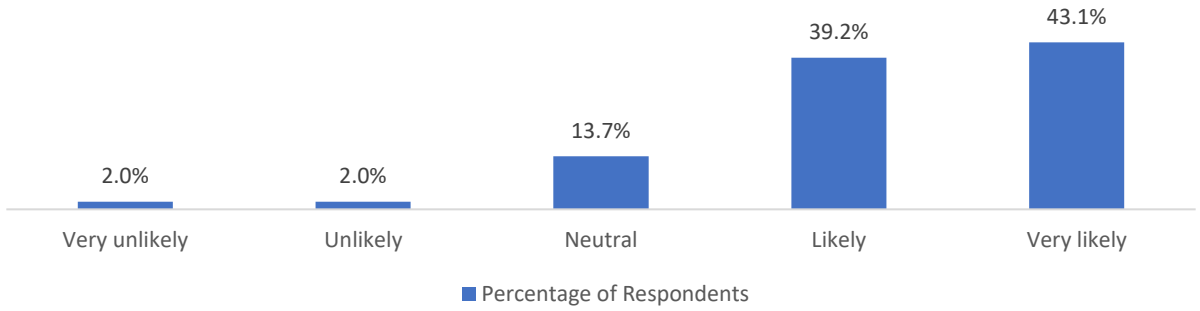


Figure 102: When you have received behavioral health care services in the past, were they mostly available in your primary language?

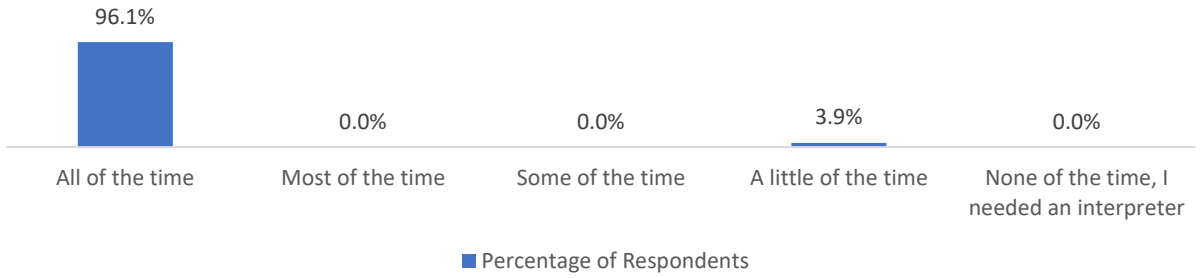


Figure 103: Which best describes your gender?

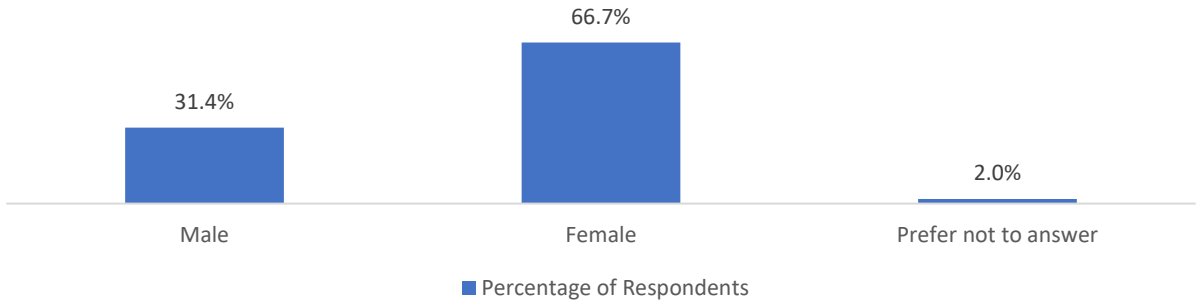


Figure 104: Which best describes your gender identity?

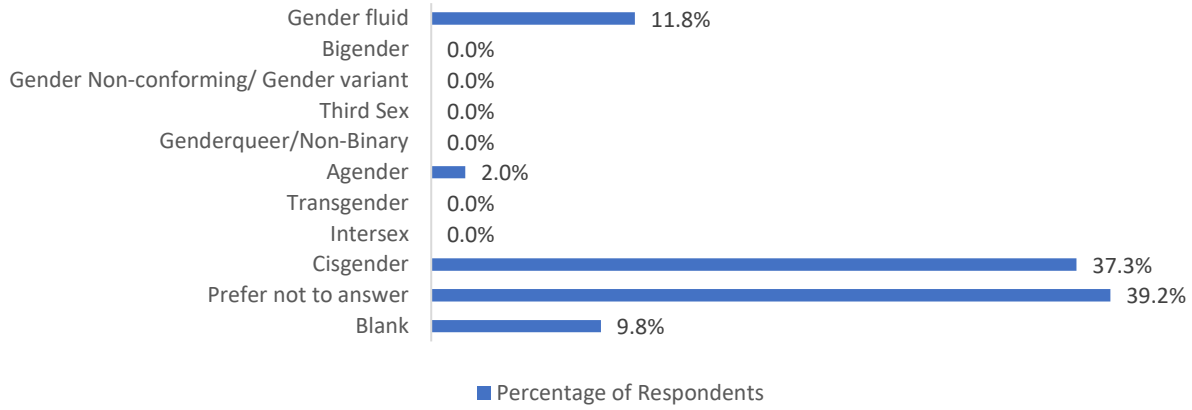


Figure 105: Which best describes your current sexual orientation? (Check all that apply)

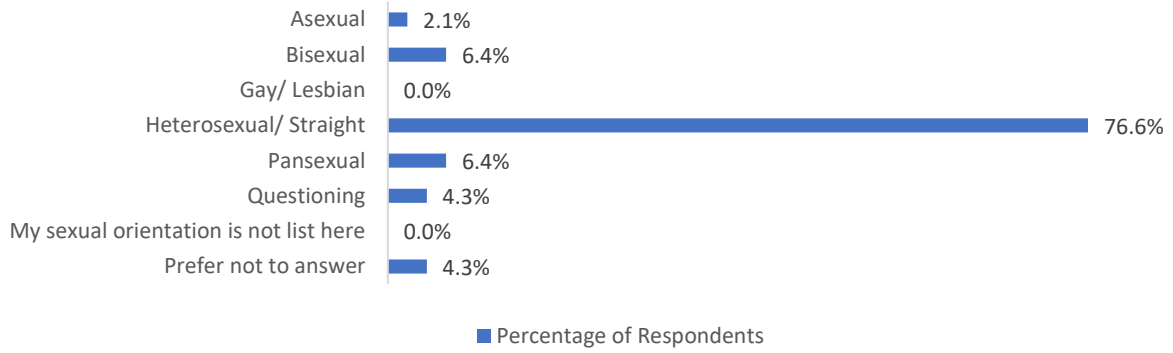


Figure 106: Which best describes your race?

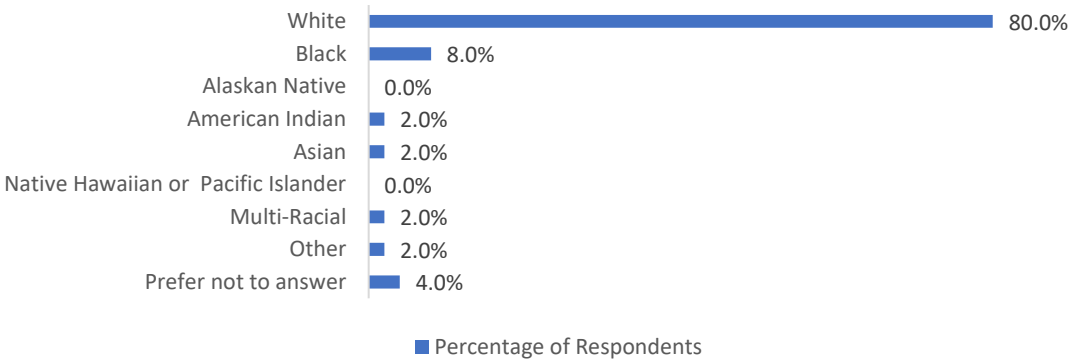


Figure 107: Which best describes your ethnicity?

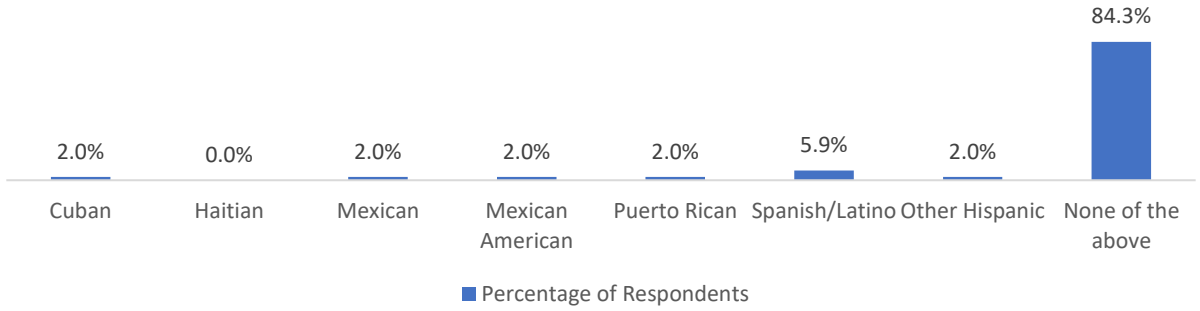
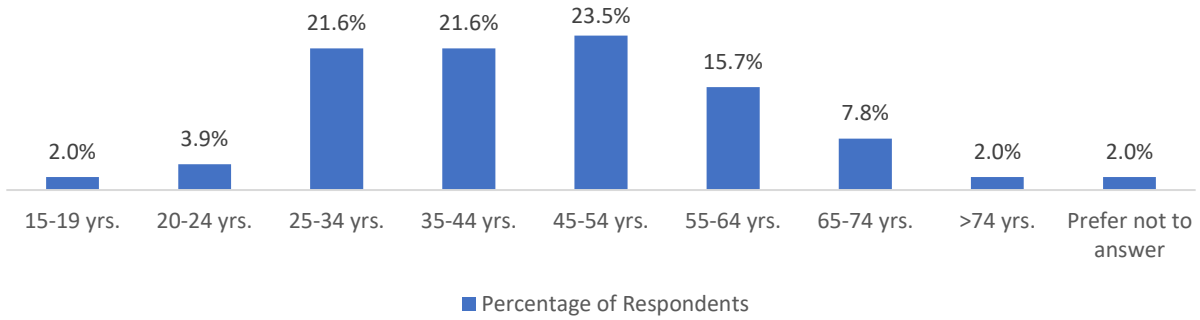


Figure 108: Please select your age range from the list below.



CULTURAL HEALTH DISPARITY FOCUS GROUP SUMMARY

Focus groups were held with individuals that receive or have experiences with the behavioral health network across the region. Two focus groups were held virtually and one in-person resulting in a total of 22 participants.

GENERALLY, HOW COMFORTABLE ARE YOU TALKING ABOUT BEHAVIORAL HEALTH?

Community members were primarily comfortable talking about behavioral health and mental illness in all settings and with whomever will engage in conversation. Discomfort discussing their own behavioral health occurred in the workplace, expressing professional settings are "more restrictive", and not always the appropriate place despite the fact that mental illness affects their work capacity. The stigma associated with behavioral health makes conversations with family and others difficult. Sometimes individuals felt the need to apologize when talking about mental health too much.

WHO DO YOU USUALLY GO TO WHEN YOU NEED SUPPORT?

Participants identified support systems consisting of spouses, family members, and friends as people they rely on. Peer support specialists and peers in support groups they attend through National Alliance on Mental Illness (NAMI) and Club Success were described as second families with similar experiences. Participants also listed professionals such as therapist, counselors, and resource centers with in-person and virtual wellness tools.

ARE YOU USUALLY COMFORTABLE SEEKING AND RECEIVING BEHAVIORAL HEALTH SERVICES?

Being comfortable seeking and receiving behavioral health services related to familiarity with the system. In the early stages of seeking treatment participants experienced long waitlists during times of crisis. As community members became more aware of the resources available and individuals within the behavioral health system their comfort increased. Participants noted that it takes time and persistence to find the right providers and resources. The process of finding providers is daunting and tedious especially when looking for providers that have experience with youth and populations of color.

HOW DO YOU LIKE TO RECEIVE BEHAVIORAL HEALTH CARE SERVICES?

In-person individual and group services were the overwhelming preference for community members. Solo in-person services feel more secure and help create a connection with the

provider. Virtual services fill the gap and most participants have attended sessions but expressed issues with privacy, building trust with their provider, and providers not attending the appointment. Virtual services are beneficial for the flexibility of scheduling, access to services for those without transportation, or the ability to leave the home.

WHAT ARE SOME BARRIERS THAT MAKE IT MORE CHALLENGING TO RECEIVE BEHAVIORAL HEALTH SERVICES?

Barriers to care include but are not limited to long waitlists, transportation, shortage of providers, stigma, and lack of awareness. The shortage and turnover of staff within agencies has resulted in extended waits to receive services. Participants reported negative encounters with staff that are inexperienced and uneducated on how to assist people with mental illness, listing stigma, and lack of awareness of resources as examples. Transportation to receive services is limited but some organizations provide transportation or bus passes for community members. Payment of services is a barrier for those who are uninsured or have private insurance. Difficulty getting time off from work, the high cost of appointments, and medication have resulted in delays of treatment. While virtual services reduced some barriers, access to an internet enabled device and knowledge of technology use have become an additional barrier.

ADDITIONAL COMMENTS

Community members shared a need for better integration of mental health and clinical services to improve the continuity of care. Increased care coordination of social services to help with transitional support and navigating clients through the system is of high need. Cost and coverage of behavioral health services are dependent on insurance with Medicaid providing the most assistance. There is limited availability and access to services through private insurance plans. Continuing to bring awareness of behavioral health services and mental illness through education for community members, behavioral health staff, and community groups would help decrease stigma and make more people comfortable with behavioral health.

NO WRONG DOOR SURVEY AND FOCUS GROUP SUMMARY

CFBHN PROVIDER INTERVIEWS

Provider interviews were held with various behavioral health providers across the region to gather additional feedback regarding the No Wrong Door process and entry into care. Six focus group provider interviews were held virtually from February through March 2022 resulting in approximately 50 participants. Prior to the provider interviews participants were asked to complete the No Wrong Door survey. For the survey and throughout the interviews No Wrong Door was defined as "a model for the delivery of acute care services to persons who have mental health or substance use disorders, or both, which optimizes access to care, regardless of the entry point to the behavioral health care system". The results of the No Wrong Door survey were used to guide each of the six group provider interviews. Depending on the survey results not all questions from the interview guide may have been used during that specific group interview.

NO WRONG DOOR SURVEY SUMMARY

When asked where they work, the respondents gave the following top three responses: adult outpatient program (28%), children's outpatient program (16%), and adult residential facility (14%). Over 90% of respondents said that their agency has a role to play in the No Wrong Door access with a little over 60% stating that it works well within their agency. Eighty-three percent of the survey takers either strongly agreed or agreed that their organization has taken action to improve the referral and care coordination for individuals served. Of those that either strongly agreed or agreed (87%) believed that linkages to crisis intervention and support are occurring. When asked if they believed that their organization promotes awareness of available options and linkages to needed services, 90% strongly agreed or agreed. A little over 40% of respondents either disagreed or strongly disagreed that it's easy for individuals to access the services they need quickly and efficiently. Over 90% strongly agreed or agreed that their organization ensures that services are of high quality and meet the needs of individuals served.

WHAT DOES THE TERM "NO WRONG DOOR ACCESS" MEAN TO YOU?

Providers had multiple definitions to what No Wrong Door Access means. One definition was that wherever a family or client enters, there would be a warm handoff to whatever services they are seeking. Another definition provided was that for a patient or individual that is wanting or seeking assistance, there is no wrong place to receive and seek services regardless of the access point (emergency room, central intake, or detox services). This should also be done regionally, regardless of the person's county of residence. For providers, this coordinated entry is the goal for any person that is looking to access services. Not all systems talk to each other so some people

seeking services do fall through the cracks. In "behavioral health there are so many different access points and even then, an individual in the community may not be aware of all the resources available."

DO YOU THINK THE "NO WRONG DOOR" ACCESS WORKS WELL WITHIN YOUR ORGANIZATION?

How well the No Wrong Door access works varies. There is successful access when the resources in the community are available such as the availability of nurses and beds. Also, it varies by facility type and how the person enters the system. When a person is seeking services there tends to be a long wait time. After an individual is assessed their "stories" do not necessarily follow them when being transferred to different agencies. Some providers do not utilize a health information exchange while some others do.

WHAT ARE SOME THINGS THAT YOU THINK WORK WELL?

The formation of relationships with individuals from various agencies in the area are beneficial. These relationships are useful when connecting clients to services that may not be available at the initial facility the person entered. Having a point person at an agency that is familiar with various available programs also helps. The crisis mobilization teams work well when inpatient is at capacity.

WHAT ARE SOME OPPORTUNITIES FOR IMPROVEMENT?

A shortage in workforce and thus not enough capacity was a common theme across all six focus group provider interviews. Creating a community information system for all agencies to access is an opportunity for improvement. For example, this system could include where this person has received services and what services they have received. When having to refer outside of an agency there is an issue with care coordination and people falling through the cracks when referrals are made. Operationalizing technology to expediate moving people through the system and getting them where they need to be. There is a need for an increase in services to get patients to services in a timely manner.

IN WHAT SPECIFIC WAYS CAN YOUR AGENCY IMPROVE ON THE REFERRAL AND CARE COORDINATION PROCESS FOR INDIVIDUALS SERVED?

Creating a unified platform or using one that is already in existence and having all agencies/facilities updating it. Having more agencies getting onboard to using a unified platform will increase the succession of care coordination. The addition of more Florida Assertive Community Treatment (FACT) teams would be an improvement. One of the largest barriers to care

coordination is the funding source, so having an unrestricted funding source can help to reduce this barrier. Current restrictive funding can only pay for certain services limiting access. Increase in community outreach so community members and other agencies in the area can learn about what an agency offers would be an improvement. An increase in staff and funding for staff are needed to improve on the referral and care coordination process for individuals served.

HAVE YOU OR YOUR AGENCY IDENTIFIED ANY BARRIERS OR OBSTACLES TO BECOMING A PART OF THE NO WRONG DOOR SYSTEM?

Currently, there is a lack of fiscal and staff resources. Not being able to pay a competitive salary to attract the right people is a large barrier. More people are asking for help then ever before, but there are less staff available. Staff shortages affects the safety of workers and clients at various times of the day, especially at night.

IN YOUR OPINION, YOUR ORGANIZATION PROMOTES ITS SERVICES AND RESOURCES VERY WELL. CAN YOU GIVE EXAMPLES OF THIS?

A YouTube channel was created to offer a way for people to participate in a certain program if they could not physically come to the center. Conducting fundraisers and outreach events for promotion. The COVID-19 pandemic paused a lot of outreach activities to the community.

HOW DOES YOUR AGENCY PROMOTE AWARENESS OF AVAILABLE OPTIONS AND POSSIBLE LINKAGES TO NEEDED SERVICES?

Advisory committee meetings are helpful to promote awareness of available options. Use billboards with co-branding of services to promote linkages to care.

WHAT ELSE COULD BE DONE TO INCREASE THE LEVEL OF AWARENESS OF BEHAVIORAL HEALTH SERVICES IN THE COMMUNITY?

Some suggestions to increase awareness of behavioral health services in the community include social-media campaigns, tabling events, stuff intake envelopes with different providers information, have a walk (like a 3K/5K), and physically handing out pamphlets at local provider offices. People who work in the behavioral health field know about the resources, but that knowledge doesn't transfer to community members. There is an issue with funding as a large portion of funds that an agency receives cannot be use for marketing. Ensuring that all marketing materials can be translated and are culturally appropriate since there are a variety of different cultures and languages being spoken in the region. A consistent message that was shared among

the six focus group provider interviews was the worry of promoting services when agencies would not be able to fulfill the needs of everyone due to staff shortages.

IN YOUR OPINION, YOUR ORGANIZATION PROVIDES PERSON-CENTERED CARE FOR ALL INDIVIDUALS SERVED.

DESCRIBE HOW YOUR AGENCY IMPLEMENTS PERSON-CENTERED CARE.

Entities strive to provide person-centered care, but this can be hindered due to funding issues (using multiple streams of funding for one client). Care is not dictated; choices are offered to patients. Agencies must meet the individuals where they are at in their journey. There are very few restrictions for telehealth as to who can or cannot receive telehealth services, which helps with person-centered care.

WHAT RESOURCES OR SUPPORTS WOULD YOUR AGENCY NEED TO IMPROVE PERSON-CENTERED CARE?

A change in the Baker Act criteria can be helpful to remove barriers created by the act. Continue to provide education to staff and community members to help with removing stigma. Investing in trauma informed care would be beneficial.

IN YOUR OPINION YOUR AGENCY HIRES EMPLOYEES WHO ARE CULTURALLY SENSITIVE AND CULTURALLY COMPETENT FOR THE POPULATION SERVED.

IF NOT, ARE YOU AWARE OF YOUR AGENCY DOING ANYTHING TO IMPROVE IN THIS AREA?

There are employees who are culturally sensitive but there remains a need to address cultural competency. Some agencies have open discussions about cultural competency and how to aid patients from different backgrounds, which is vital to providing person-centered care. Over the past couple of years some agencies were working to hire a diverse staff, but this has become difficult due to shortages, and lack of salary funding. A few agencies have implemented diversity, equity, and inclusion (DEI) training. Another agency has made cultural competency training mandatory for senior management. There are several agencies that have these trainings but it's not a requirement for staff to participate.

IS THERE ANYTHING YOUR AGENCY COULD DO TO IMPROVE?

Having better access to translators and/or translation services could improve outcomes for patients served. There is a need for more cultural sensitivity training. This type of training should be implemented as a part of the new hiring process. Usually, once people begin their work, they

are too busy to take time off to attend training, or they are not paid for their time to attend training outside of normal work hours/days.

IN YOUR OPINION, IT'S EASY FOR INDIVIDUALS TO ACCESS THE SERVICES THEY NEED QUICKLY AND EFFICIENTLY.

IF YES, WHAT WORKS WELL ABOUT THE CURRENT PROCESS WITH INDIVIDUALS FOR ACCESSING SERVICES?

Many agencies have created walk-in access which gives individuals an easy access point to start receiving services. The addition of telehealth services is another great option for patients to access services. Telehealth has made it easier for those with individuals that don't have reliable transportation to continue accessing services.

IF NO, WHAT ARE THE MAJOR BARRIERS THAT KEEP INDIVIDUALS FROM ACCESSING THE SERVICES THAT THEY NEED?

Stigma is still a huge barrier for patients to access services they need. Even if someone has insurance, they are still experiencing some issues accessing services, including certain places not taking the insurance, and the overall cost. Staffing challenges and paying for staff was a barrier that was consistently brought up through all the focus group interviews. Without sufficient staff there are long waitlists for individuals to gain access to services. Cultural and language barriers are also a consistent issue. There is a need for more bilingual staff/providers. Also, people want access to a provider that looks like them and knows their culture. Transportation to services continues to be a large barrier for individuals to access services, especially if they are in a rural area. Some services are only offered during normal business hours as people who work during the day cannot access most services due to work schedules. Parents and clients do not always know where to go, how to pay for services, and which services they have access to.

DO YOU THINK A STANDARD INTAKE AND SCREENING PROCESS FOR STATE AGENCIES AND COMMUNITY PARTNERS WOULD HELP INDIVIDUALS GET INTO SERVICES MORE QUICKLY?

Among all focus group provider interviews the consensus was that a standard system could help but there are some reservations. It is understood that a system would take a lot of manpower to keep it updated and that sufficient training would be required. A central hub so the different systems could "talk to each other". Having a standard intake and screening process could benefit clients in multiple ways. For example, a client wouldn't have to tell their story over and over during the process, and they could reach out and make new connections.

WHAT DO YOU THINK WOULD NEED TO BE ACCOMPLISHED TO IMPLEMENT A STANDARD INTAKE AND SCREENING PROCESS FOR THE REGION/STATE/SYSTEM?

There is a lack of knowledge of HIPAA. It can be interpreted differently by various departments, agencies, and facilities. There would need to be an agreement on which tools would be used across all systems. A barrier to having a standard intake and screening process is the various funding sources agencies have as the data reporting requirements can vary greatly.

IN YOUR OPINION, YOUR ORGANIZATION ENCOURAGES (PROMOTES) WORKING WITH OTHER COMMUNITY PARTNERS TO ENSURE CARE COORDINATION.

WHICH PARTNERS DO YOU WORK WITH MOST? WHAT WORKS WELL IN THESE PARTNERSHIPS?

There are partnerships between agencies but having personal relationships with staff at other agencies works best. The community is about using social capital to get clients where they need to be, but this is not sustainable. Virtual meetings are primarily used to share information but could be used to help problem solve issues that agencies are facing.

IN YOUR OPINION, INDIVIDUALS IN NEED OF SERVICES HAVE EQUAL ACCESS TO CARE.

WHY? WHY NOT? WHAT WORKS WELL?

There are a lot of socioeconomic issues that prevent someone from having equal access to care. Some examples include not having access to reliable transportation, being uninsured, having insurance (public or private) that doesn't cover everything, and not having a provider speak your primary language. "Just because you have access to private insurance does not mean you can afford copays, or the costs associated with receiving care." Not having the adequate funding to aid clients and relying on certain funding streams that have limited criteria, means many people are left out of the system.

IN YOUR OPINION, YOUR ORGANIZATION TRACKS INDIVIDUALS SERVED, SERVICES, PERFORMANCE, AND COST TO CONTINUALLY EVALUATE AND IMPROVE OUTCOMES?

IF NOT, HOW CAN THIS BE IMPROVED?

This information is tracked more particularly for care coordination, Crisis Stabilization Unit (CSU), and outpatient services. Some funding requires this information for deliverables. Agencies utilize the data in the best ways possible and are required to monitor multiple measures.

NO WRONG DOOR SURVEY CHARTS

Figure 109: I work in a...

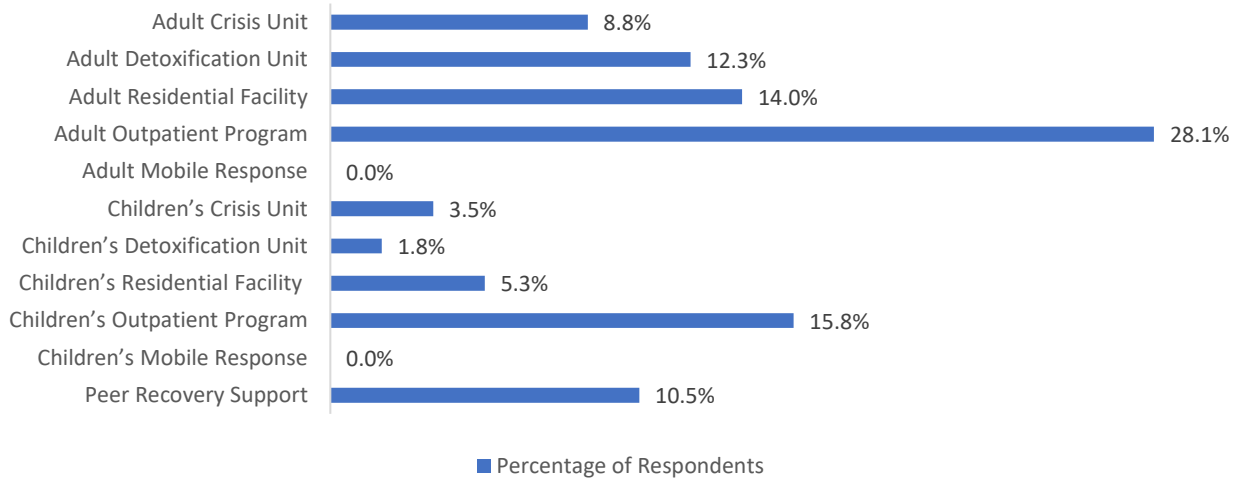


Figure 110: Do you think the "No Wrong Door" access works well within your organization?

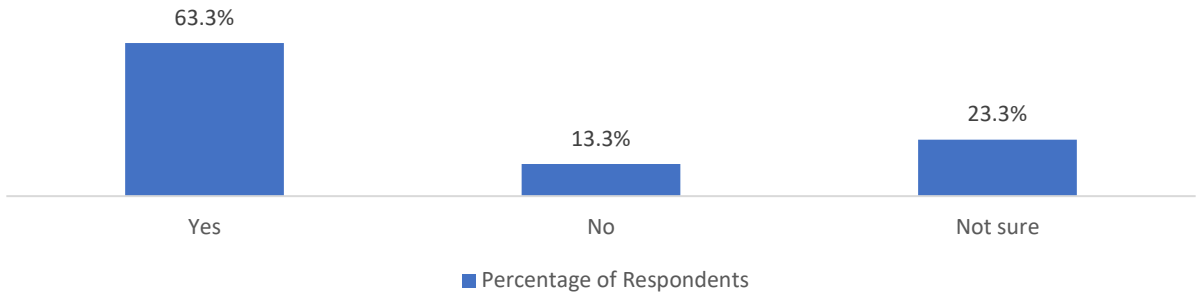


Figure 111: From your perspective your organization has a role to play in the "No Wrong Door" access.

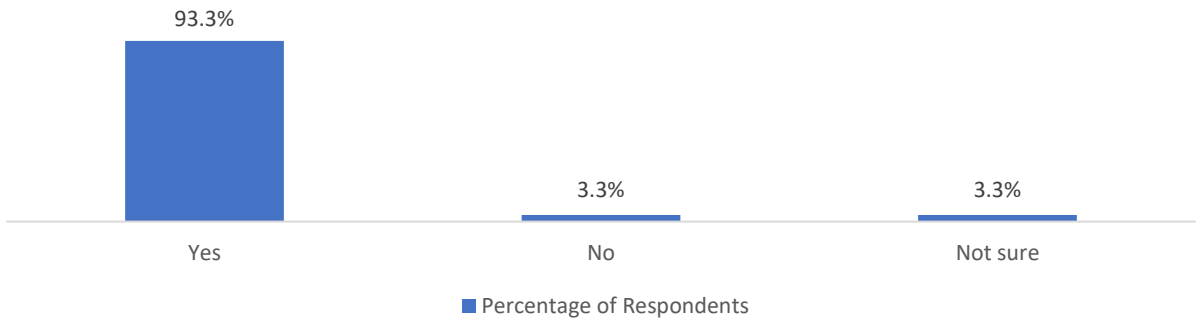


Figure 112: In your opinion, your organization has a strong care coordination process that includes warm handoffs to services and seamless care coordination.

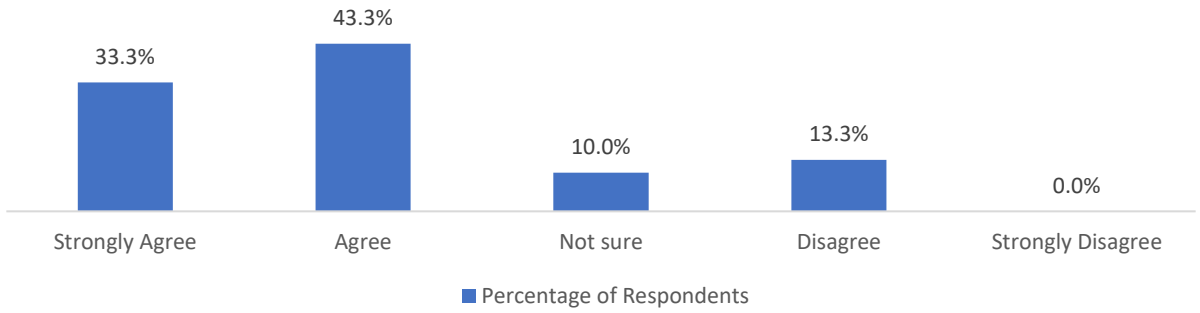


Figure 113: In your opinion, your organization has taken action to improve the referral and care coordination process for individuals served.

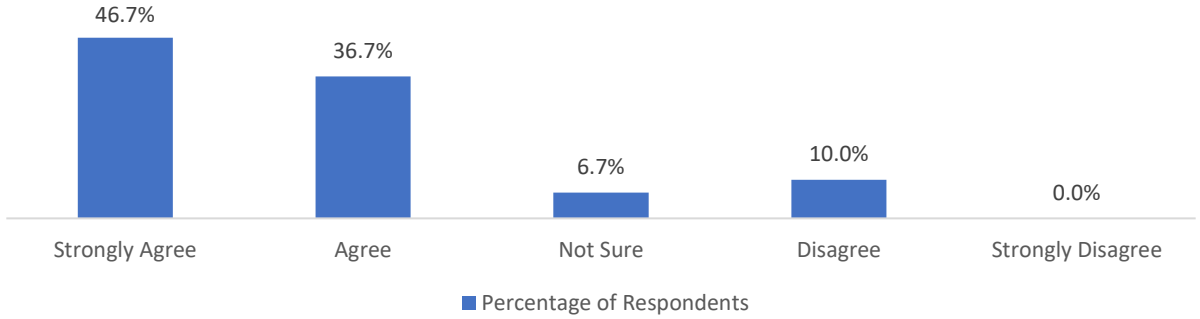


Figure 114: In your opinion, linkages to crisis intervention and support (like the Mobile response Team, medication management, CRF, CIT Officer, BA, CSU, etc.) occurring.

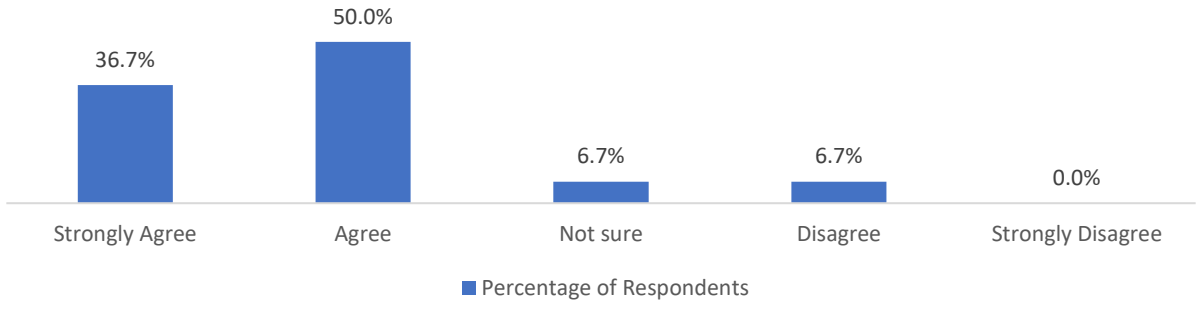


Figure 115: In your opinion, your organization promotes its services and resources very well.

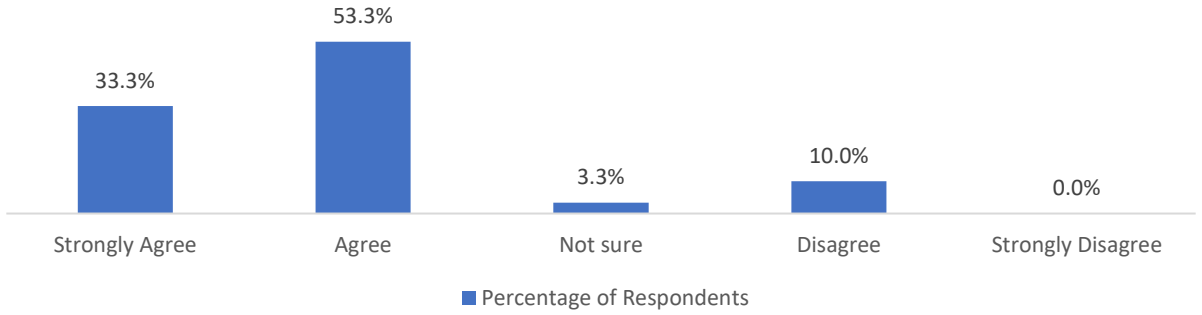


Figure 116: In your opinion, your organization promotes awareness of available options and linkages to need services.

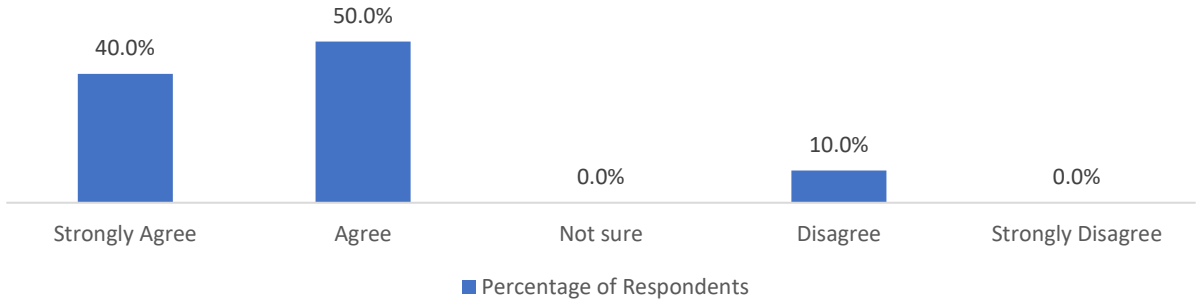


Figure 117: In your opinion, your organization provides person-centered care for all individuals served.

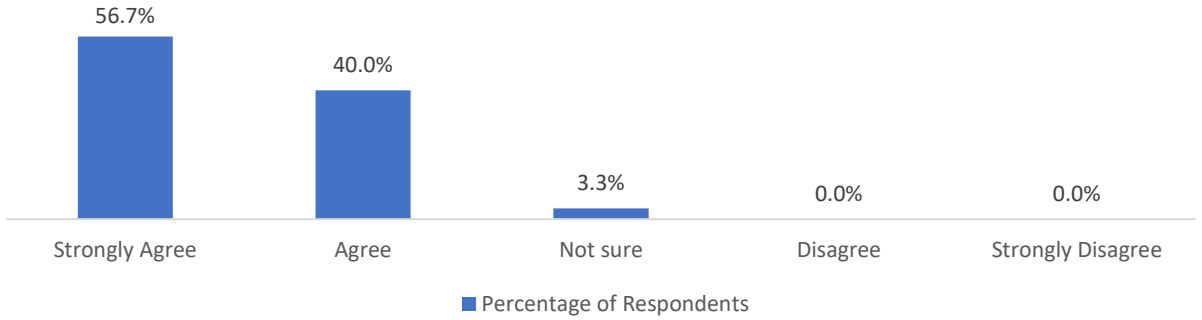


Figure 118: In your opinion, your agency hires employees who are culturally sensitive and culturally competent for the population served.

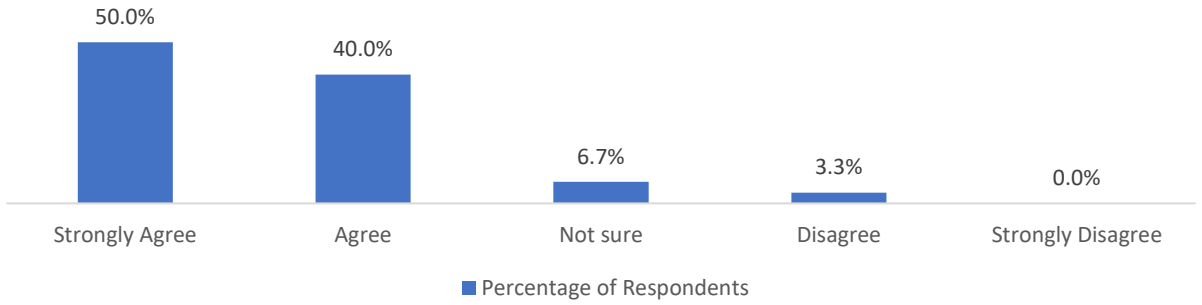


Figure 119: In your opinion, it's easy for individuals to access the services they need quickly and efficiently.

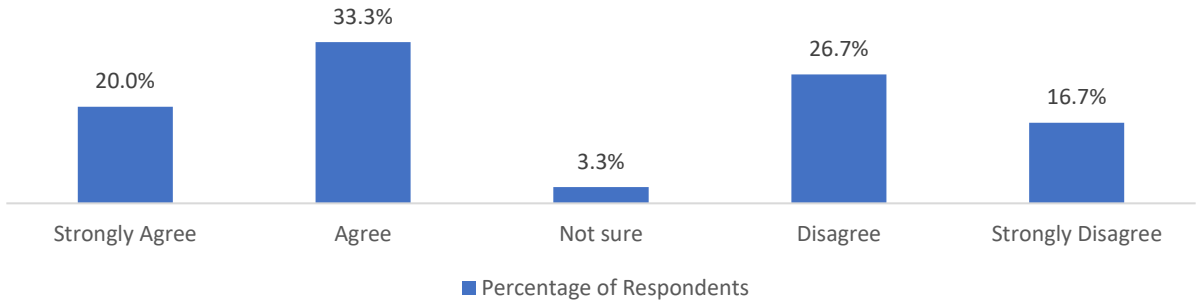


Figure 120: Do you think a standard intake and screening process for state agencies and community partners would help individuals get into services more quickly?

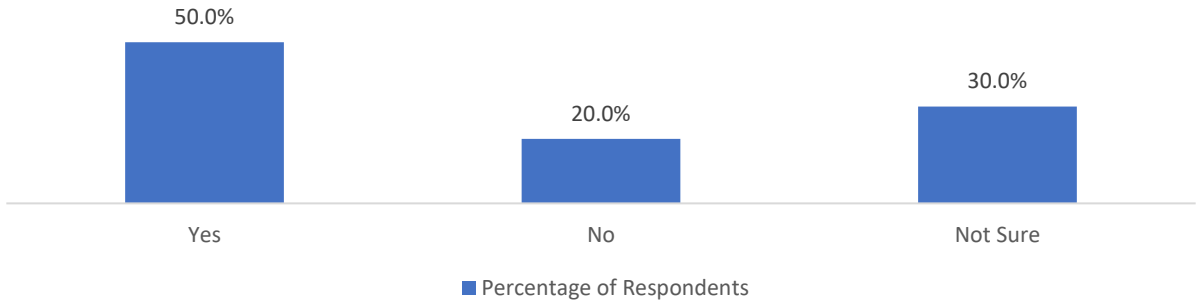


Figure 121: In your opinion, your organization encourages (promotes) working with other community partners to ensure care coordination.

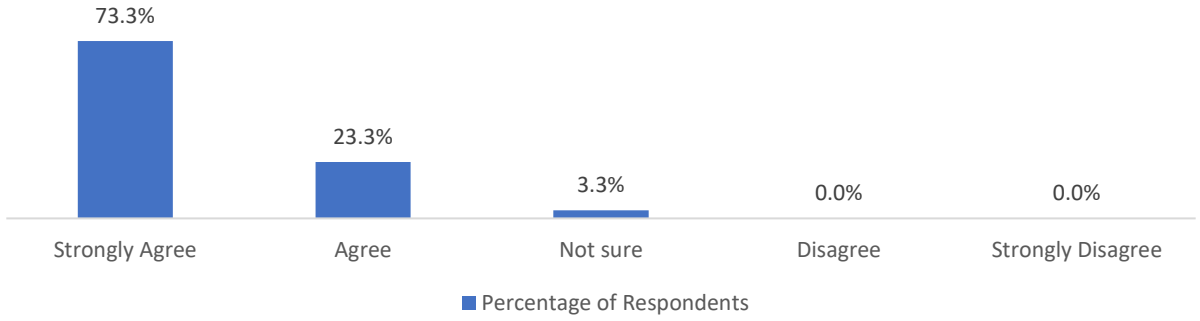


Figure 122: In your opinion, individuals in need of services have equal access to care.

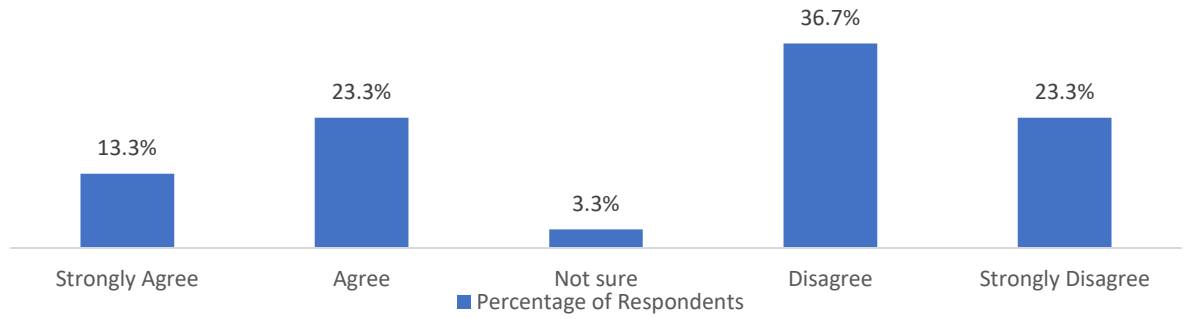


Figure 123: In your opinion, stakeholders help to address and advocate for equal access to care in system entry points.

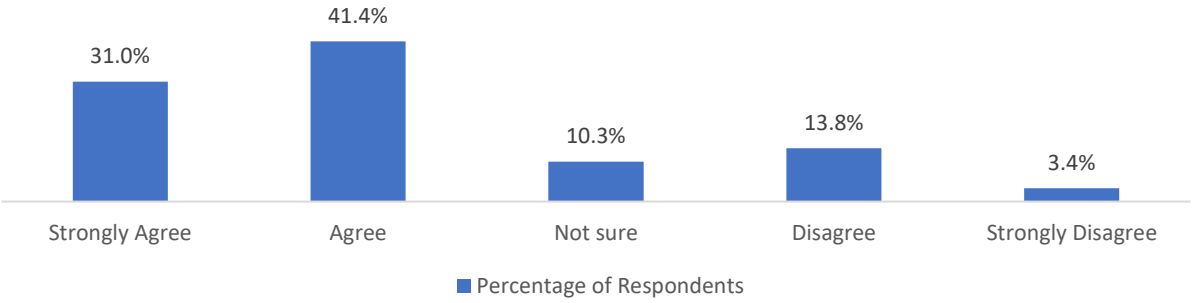


Figure 124: In your opinion, your organization ensures that services are of high quality and meet the needs of individuals served.

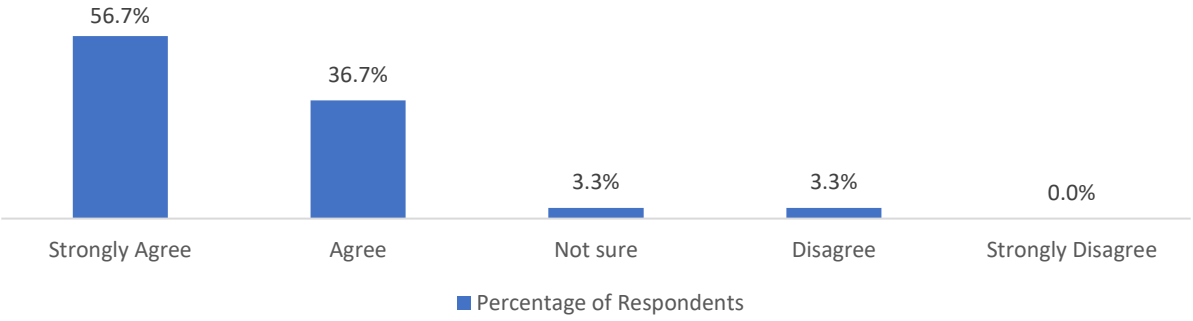
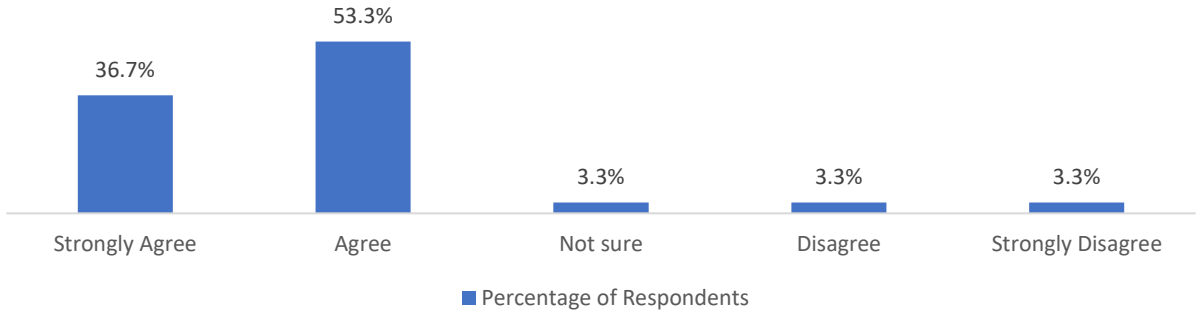


Figure 125: In your opinion, your organization tracks individuals served, services, performance, and cost to continually evaluate and improve outcomes.



INDIVIDUALS SERVED SURVEY SUMMARY

BACKGROUND

The Behavioral Health Needs Assessment Consumer/Client survey was available from January 7-February 14, 2022. It was distributed by Central Florida Behavioral Health Network and their community partners via email along with flyers the contained the survey information and a QR code. The survey was available in English, Spanish, and Haitian Creole.

Sixty-eight (68) responses were collected during the survey period. Most respondents (70.6%) were adults who were receiving services, followed by 11.8% who were the parent of a child receiving services, and caregivers representing a person receiving services (7.4%).

Survey respondents indicated they were receiving adult mental health services (72.1%), adult substance use services (32.4%), peer support services (23.5%), child mental health services (18.4%), prevention services (11.8%), or child substance use services (1.5%).

Ten out of 14 counties in the service area were represented in the responses. The largest percentage of respondents were from Pasco County (41.2%), followed by Lee County (22.1%), Collier County (10.3%), and Hillsborough County (5.9%). The following counties did not have any respondents: Glades, Hardee, Hendry, and Polk.

AWARENESS OF LOCAL RESOURCES

Data revealed the respondents were aware of where to go for mental health and substance use treatment when they needed them (82.1%) and that most respondents learned about services from a family member/friend (33.8%), another individual in treatment or recovery (33.8%), or by word of mouth (30.9%).

Client respondents indicated that they were aware of the 2-1-1 information and referral resources in their county (70.6%), while 29.4% had called, and 47.8% found the 2-1-1 service helpful.

SERVICE NEEDS & BARRIERS

The majority of respondents indicated that they were able to receive the services they needed when they needed them (63.1%). Of those who were not able to get the services they needed, the most common responses were housing assistance (52.2%), case management (34.8%), crisis stabilization/support (30.4%), alternative services (30.4%), and employment/job training assistance (30.4%).

Most respondents noted that the services they needed were available (56.1%). However, over 40.4% indicated that there was a waitlist for the services they needed.

The wait time from requesting an appointment for services to the time the client received the services varied with respondents indicating it took 1-2 weeks (26.8%) or over 2 months (26.8%), while 12.5% indicated that they never received an appointment.

Clients were asked about the obstacles/barriers they encountered getting the care they needed, and 33.8% indicated there were long waitlists, they could not afford the services (19.1%), they did not know where to go for services (17.7%), that they had very limited or no transportation (17.7%) or that they did not meet the eligibility criteria (16.2%). Stigma, lack of evening/weekend appointments, and services not available in the county were also frequently mentioned as barriers. Additionally, 30.9% of respondents indicated they did not have any barriers.

INDIVIDUALS SERVED SURVEY CHARTS

Figure 126: Which best describes you?

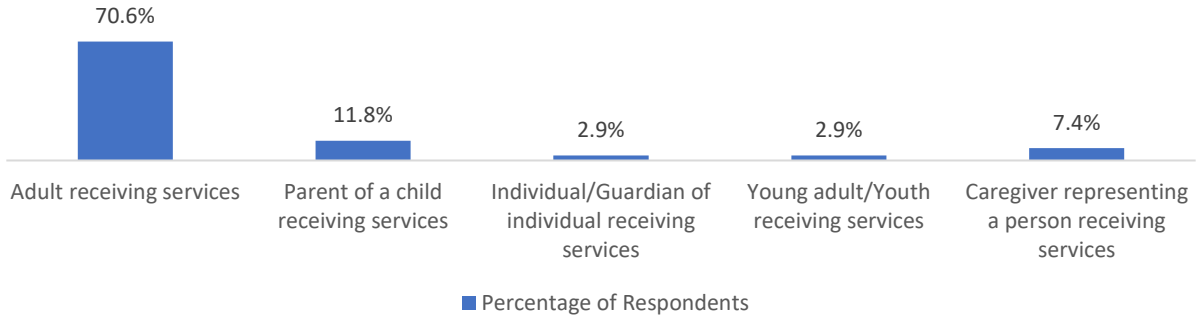


Figure 127: What type of service did you or the person you are representing receive?

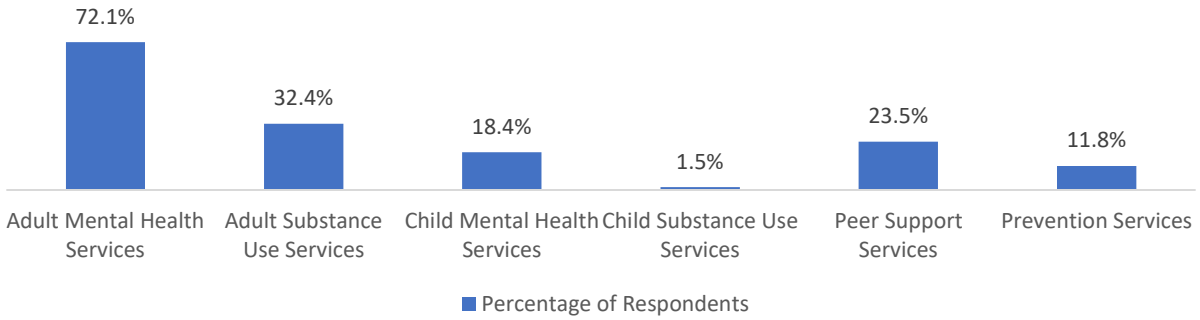


Figure 128: Which county do you live in?

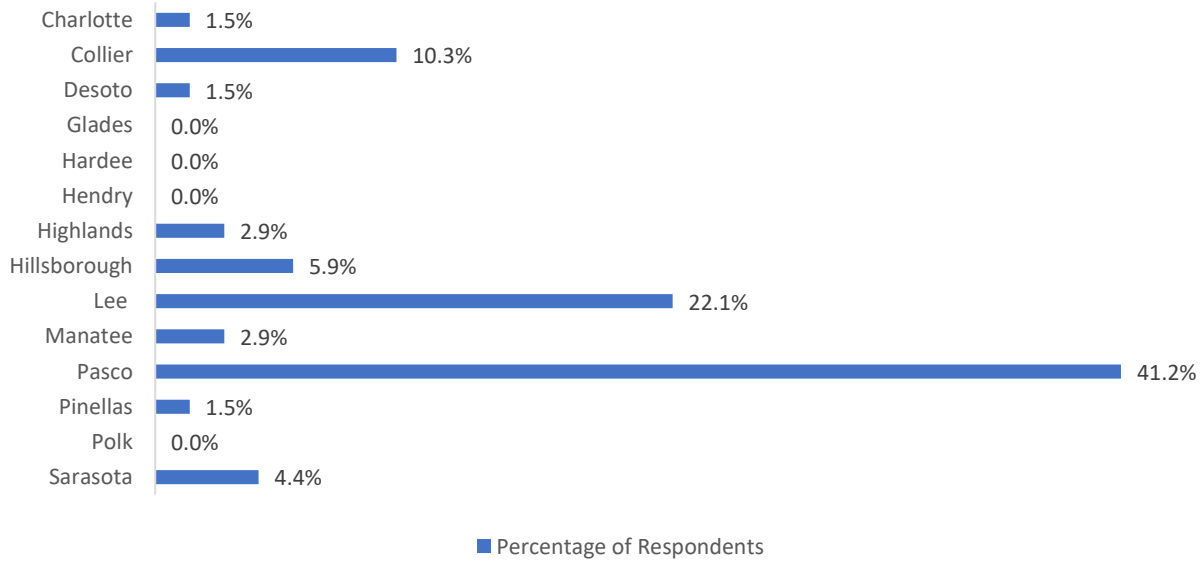


Figure 129: Did you know where to go for mental health and substance use treatment services when you needed them?

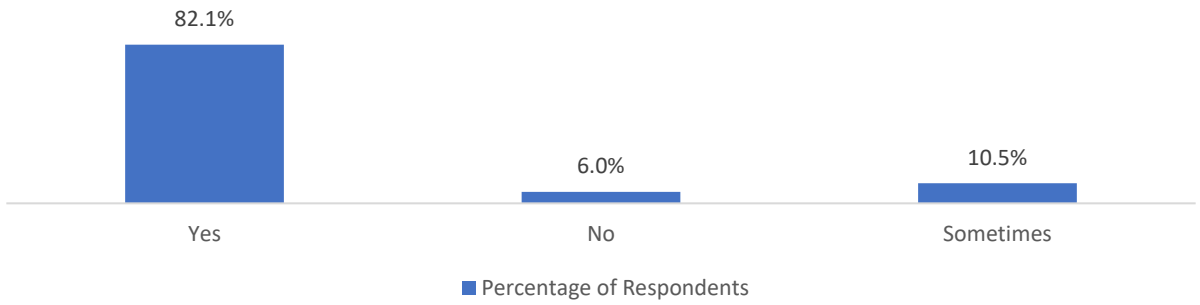


Figure 130: How did you learn about mental health and substance use treatment services when you needed them?

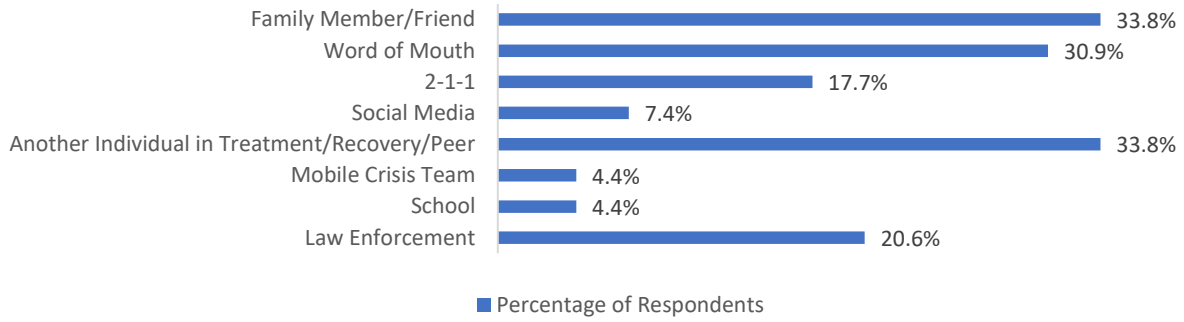


Figure 131: Are you aware of the 2-1-1 Information and Referral Resource in your community?

Figure 132: Have you ever called 2-1-1 Information and Referral Resource for assistance?

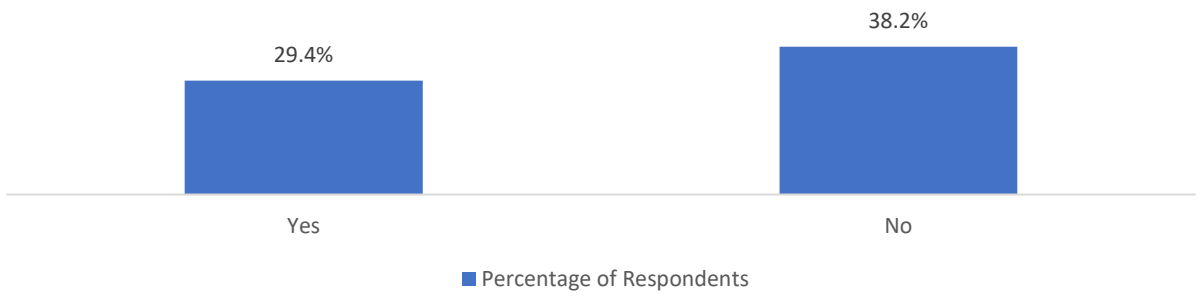


Figure 133: When you called the 2-1-1 Information and Referral Resource, were they helpful in getting you the services needed?

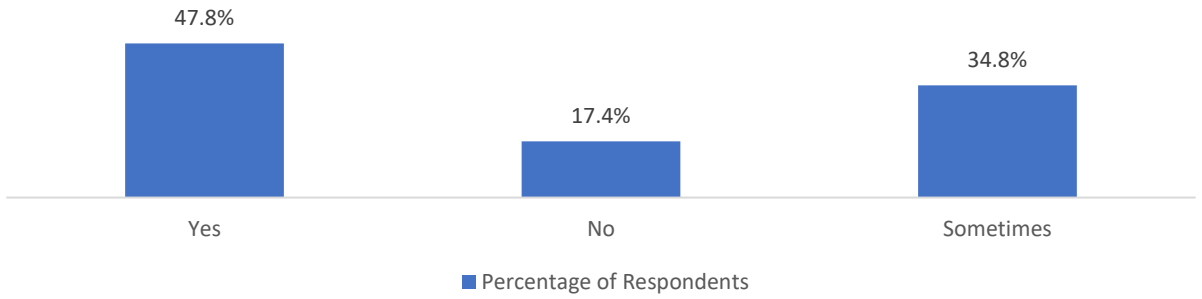


Figure 134: Were you able to get all the services you needed when you needed them?

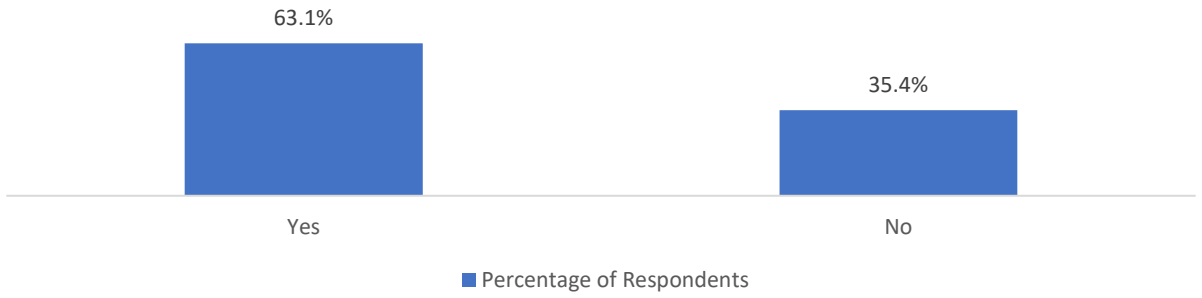


Figure 135: If no, please choose from the list below, the services you needed but were not able to get.

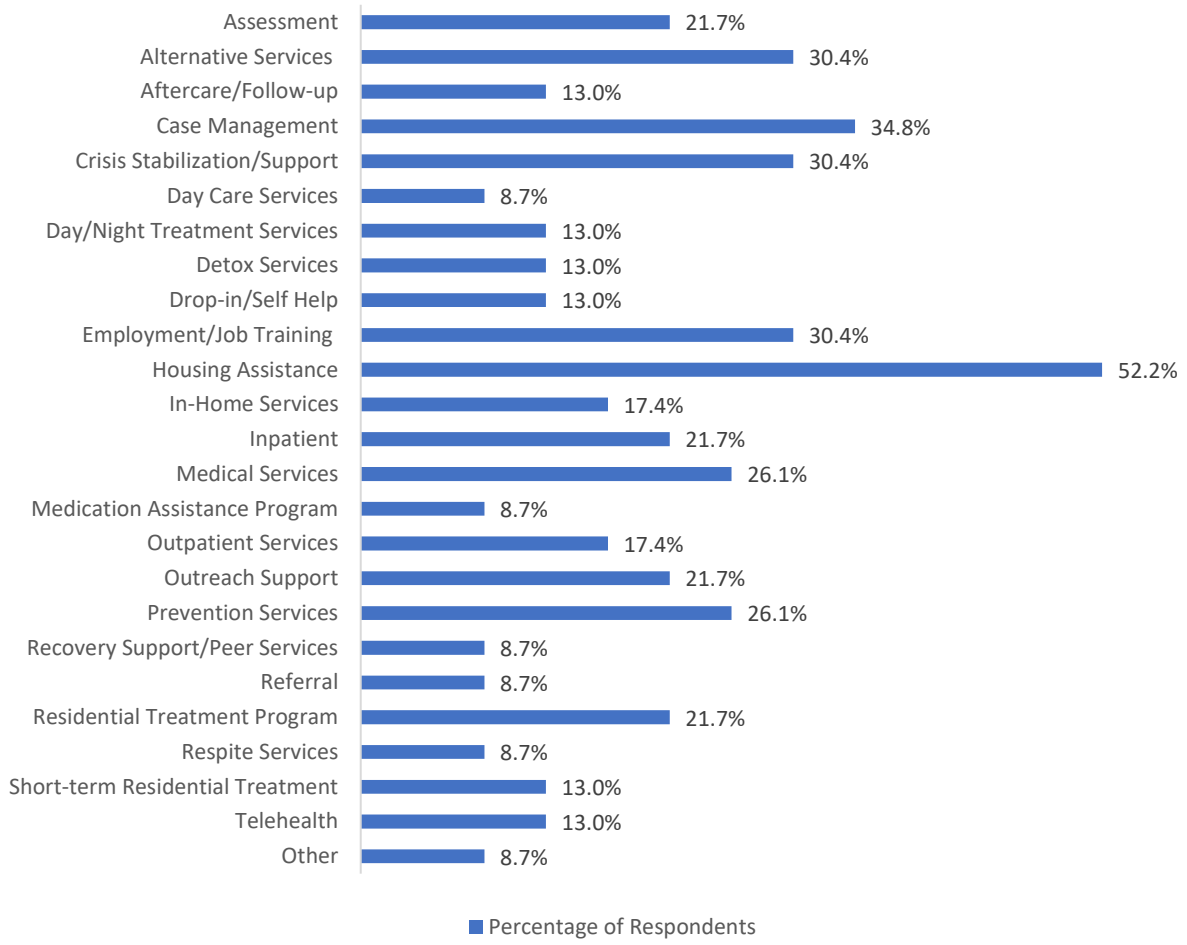


Figure 136: How many times during the last 12 months were you Not able to get the services you needed?

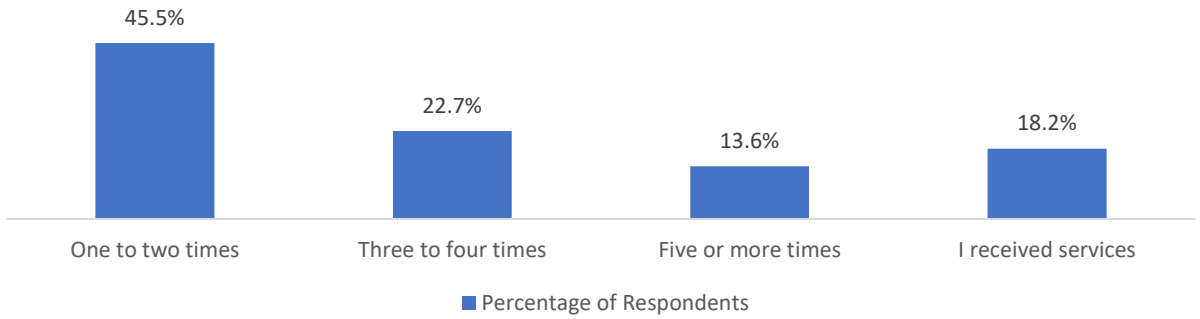


Figure 137: The services I needed were:

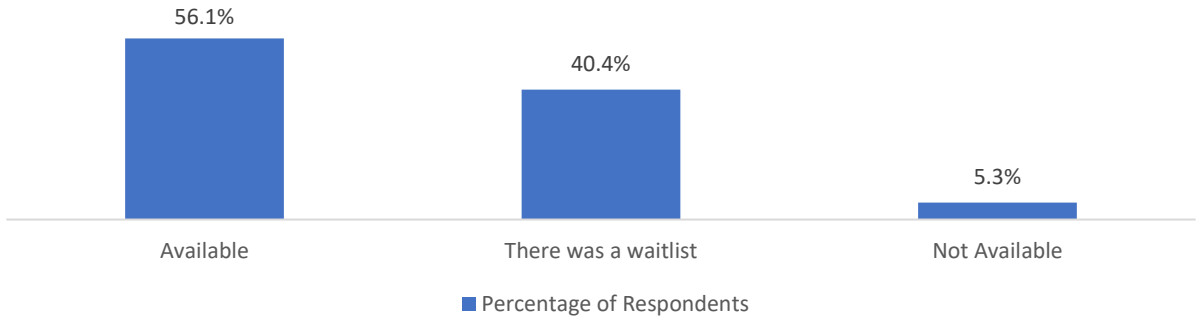


Figure 138: The services and planning I received were focused on my treatment needs (patient-centered).

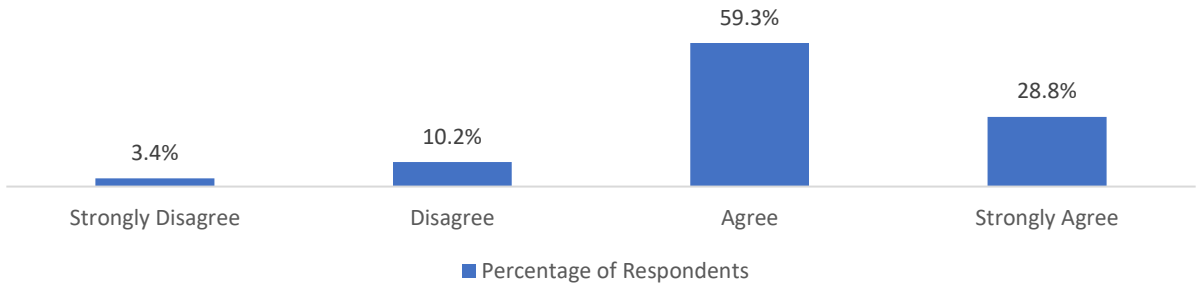


Figure 139: How long did it take from the time you requested an appointment for services to the time you received the services?

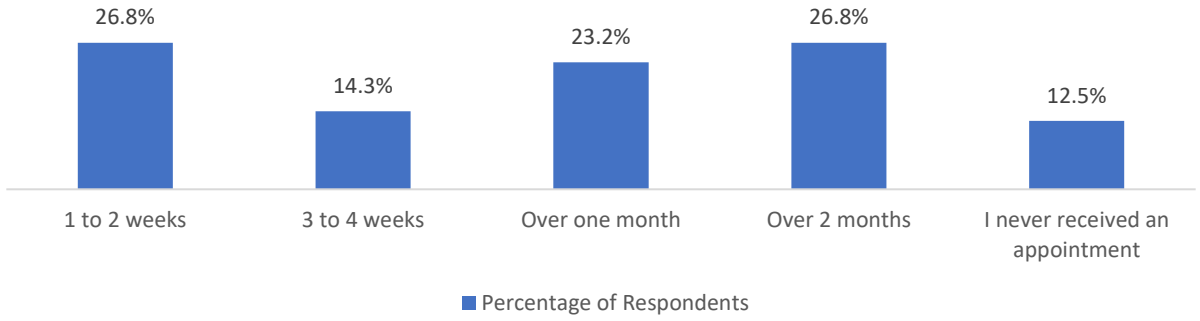


Figure 140: How long did it take to travel to the service?

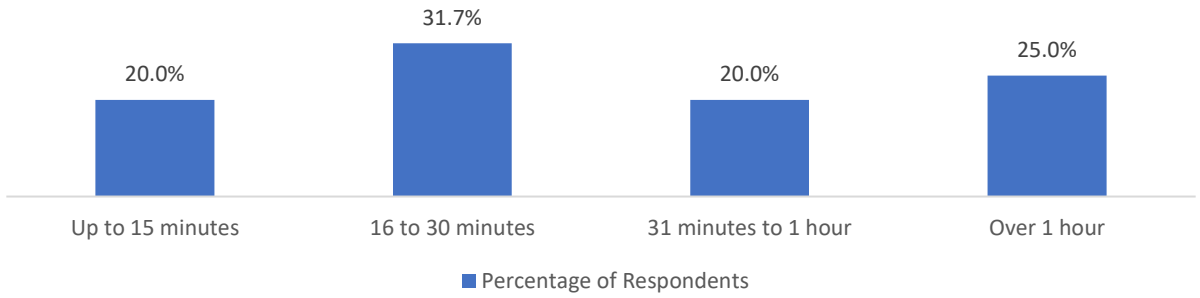
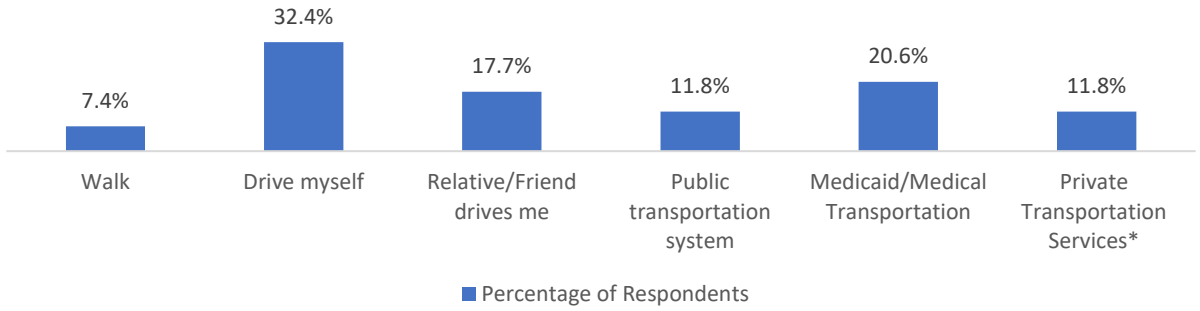
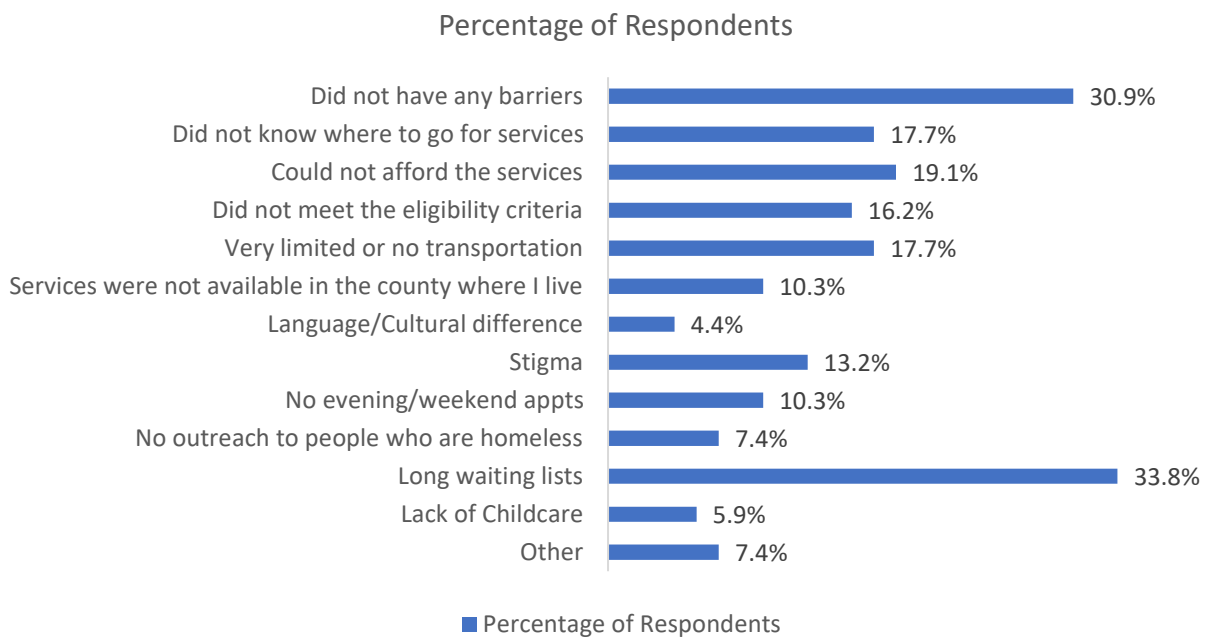


Figure 141: How do you travel to get services?



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

Figure 142: What were the obstacles you experienced getting the care you needed?



STAKEHOLDER SURVEY SUMMARY

BACKGROUND

The Behavioral Health Needs Assessment Stakeholder Survey was available from January 7-February 14, 2022. It was distributed by Central Florida Behavioral Health Network and their community partners via email along with flyers that contained the survey information and a QR code. The survey was available in English, Spanish, and Haitian Creole.

Over 460 responses were collected during the survey period. The top five service sectors that had the highest percentage of respondents were: case management (10.2%), other (8.4%), children and family services (7.8%), social services (7.6%), and adult mental health care (7.1%).

All 14 counties in the service area were represented in the responses. The highest percentage of respondents were from Pinellas County (13.4%), followed by Hillsborough County (12.3%), Manatee County (9.1%), Pasco County (8.6%), and Lee County (8.5%).

SURVEY RESPONSES

About 90% of respondents strongly agreed or agreed that they were aware of the availability of mental health and substance use services in their area. While 51% where aware of Central Florida Behavioral Health Network (CFBHN), 49% of people had accessed CFBHN's resources in the past 6 months. Most survey takers (58%) found the offered CFBHN resources were helpful. When asked if they ever directed individuals to access CFBHN by calling or online, 59% of respondents said no.

The majority (92%) of respondents were aware of the 2-1-1 information and referral resource. Although most of survey takers were aware of the 2-1-1 resource, 62% had not accessed 2-1-1 in the past 6 months. For those who accessed the 2-1-1 information and referral resource, 60% of respondents found it helpful. Eighty-eight percent of respondents had directed individuals to access 2-1-1 by either calling or online. The top three crisis response models in the service area were the Mobile Crisis Response Team (37.3%), Behavioral Health Response Team (20.6%), and Tampa Crisis Intervention Response Team (11.9%).

Survey takers were asked to rate the community's awareness of mental health and substance use treatment services using a scale from excellent to poor. Forty percent of respondents rated the awareness as fair. Over 40% of respondents indicated that the linkages to need services were not being coordinated and established across the system of care. Over 50% of respondents either strongly agree or agree that behavioral health care and peer services were accessible in the area. Respondents were split with 42% who agreed and 43% who disagreed on if the processes for referrals were easily accessible. Most respondents (56%) either disagreed or strongly disagreed that programs and services are coordinated across the system of care.

When asked to identify barriers for consumers accessing services in their community, most respondents said no or very limited transportation (13.4%), followed by long waitlists (12.9%), did not know where to go for services (11.5%), could not afford the services (11.2%), and stigma (10.2%). Survey takers were asked to list resources and services to improve patient-centered care and planning that are not available. There were over 260 responses to this question. Some of the responses included: shortage of providers/staff including peer specialists, transportation, affordable housing, bilingual providers, access to services in a timely manner, care coordination, increased access to certain behavioral and substance use treatment on the weekend, and increased access for uninsured patients. There were 565 different patient-centered care resources and services that were provided by survey respondents. Responses included names of specific service agencies/organizations, care management, and access to services.

STAKEHOLDER SURVEY CHARTS

Figure 143: Percentage of respondents by organization service sector.

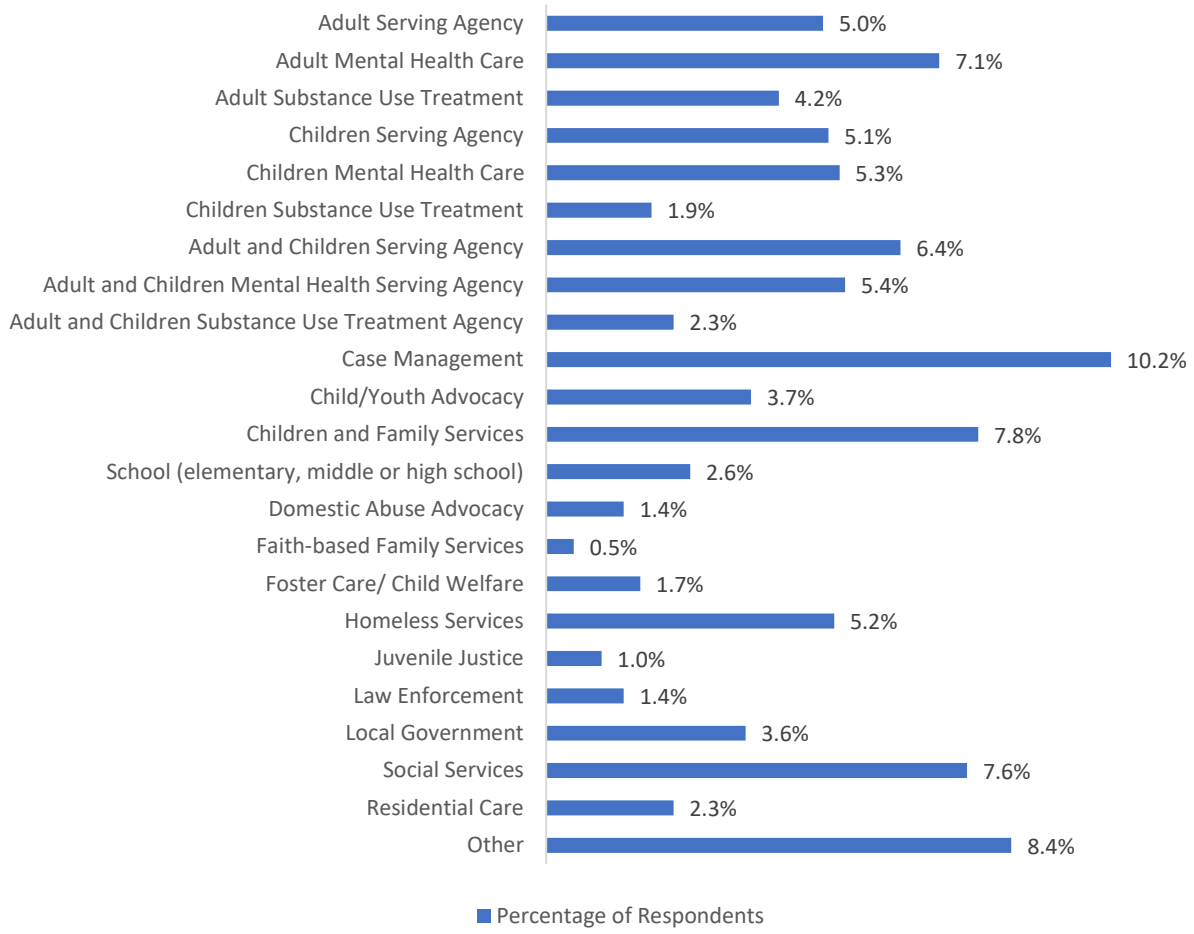


Figure 144: Percentage of stakeholder respondents by county.

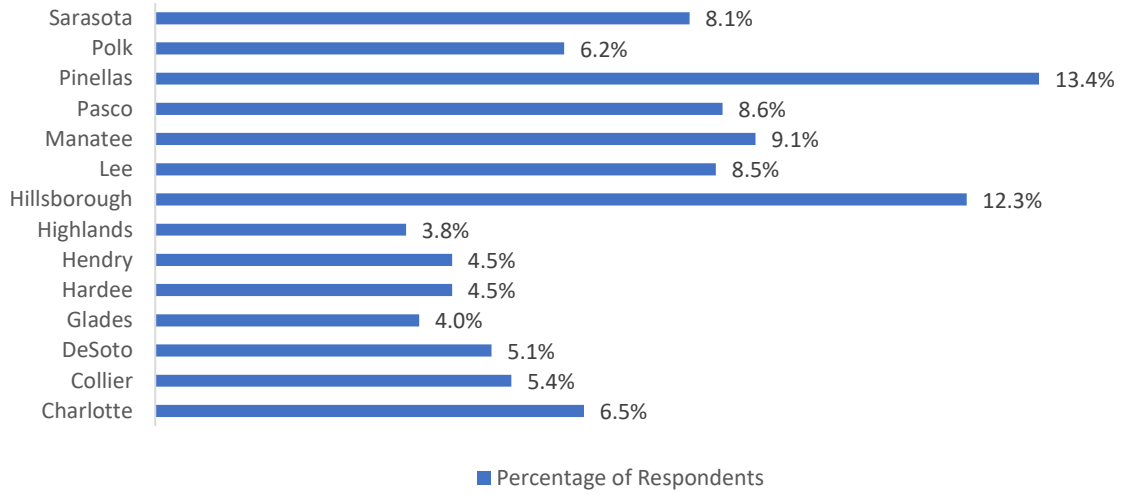


Figure 145: You are aware of the availability of mental health and substance use services in your area.

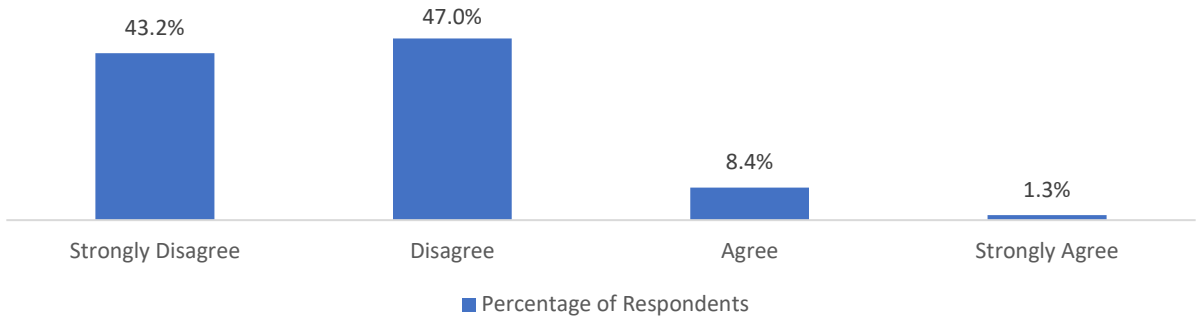


Figure 146: Are you aware of Central Florida Behavioral Health Network (Managing Entity) resources?

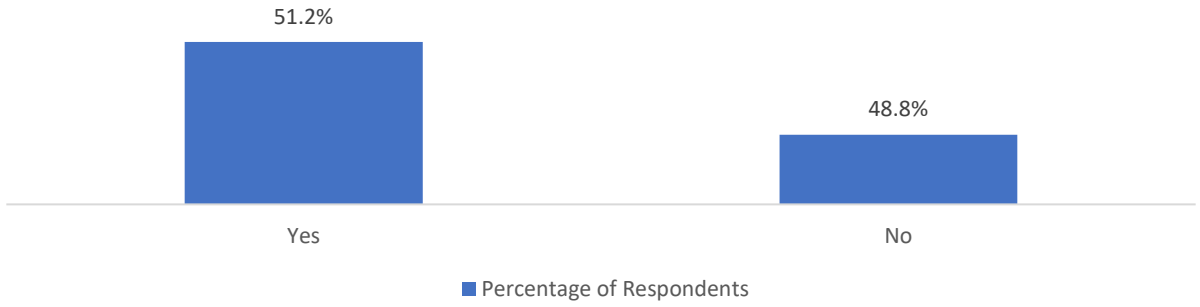


Figure 147: Have you accessed Central Florida Behavioral Health Network (Managing Entity) resources in the past 6 months?

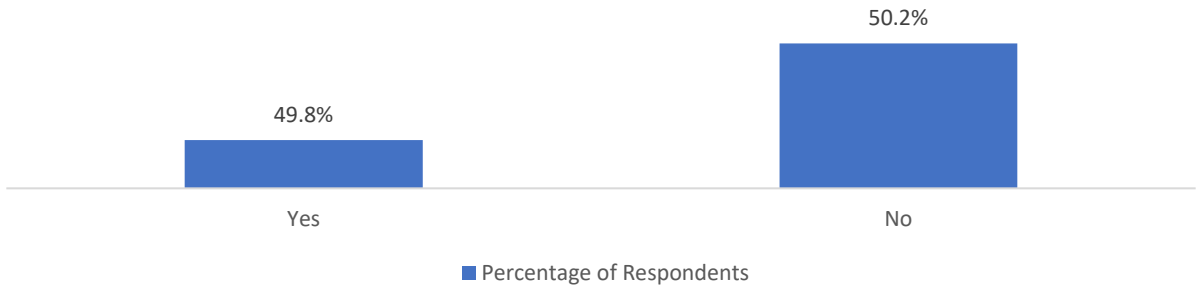


Figure 148: When you accessed Central Florida Behavioral Health Network (Managing Entity) resources, was it helpful?

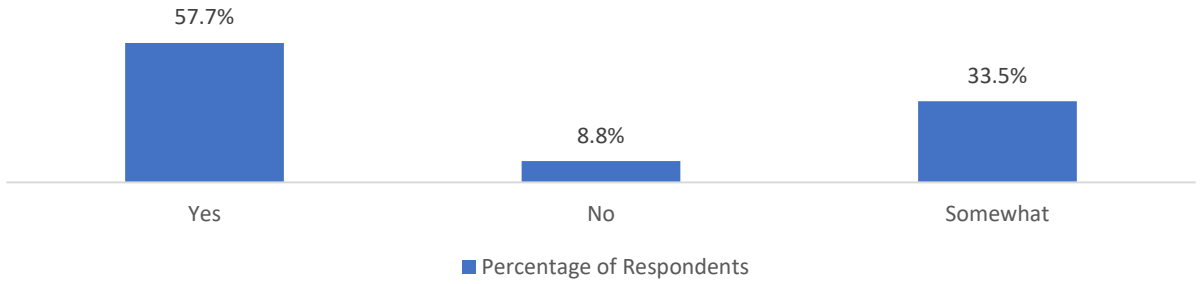


Figure 149: Have you ever directed individual to access Central Florida Behavioral Health Network (Managing Entity) by calling or online?

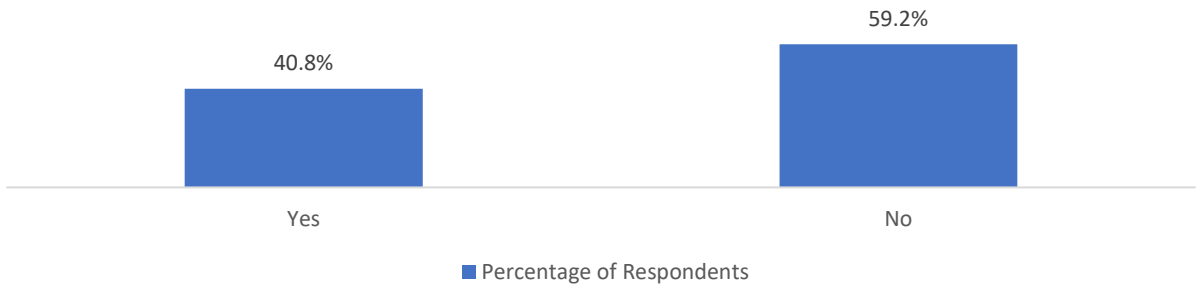


Figure 150: Are you aware of the 2-1-1 Information and Referral Resource?

Figure 151: Have you accessed the 2-1-1 Information and Referral Resource in the past 6 months?

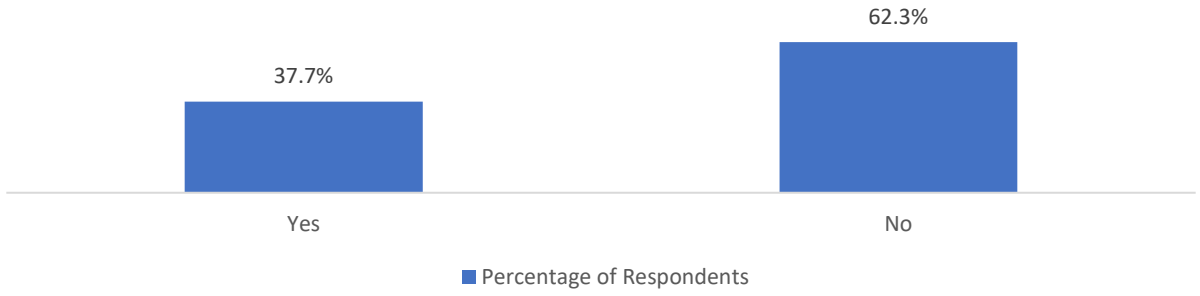


Figure 152: When you accessed the 2-1-1 Information and Referral Resource, was it helpful?

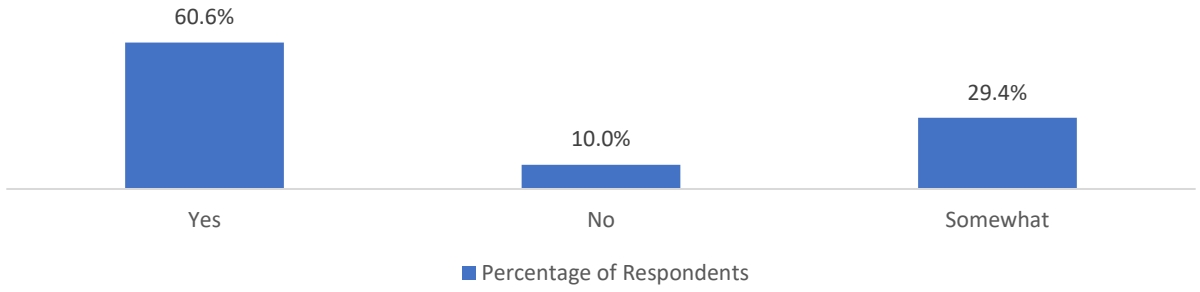


Figure 153: Have you ever directed individuals to access the 2-1-1 Information and Referral Resource by calling or online?

Figure 154: Select the crisis response model in your area. (Check all that apply)

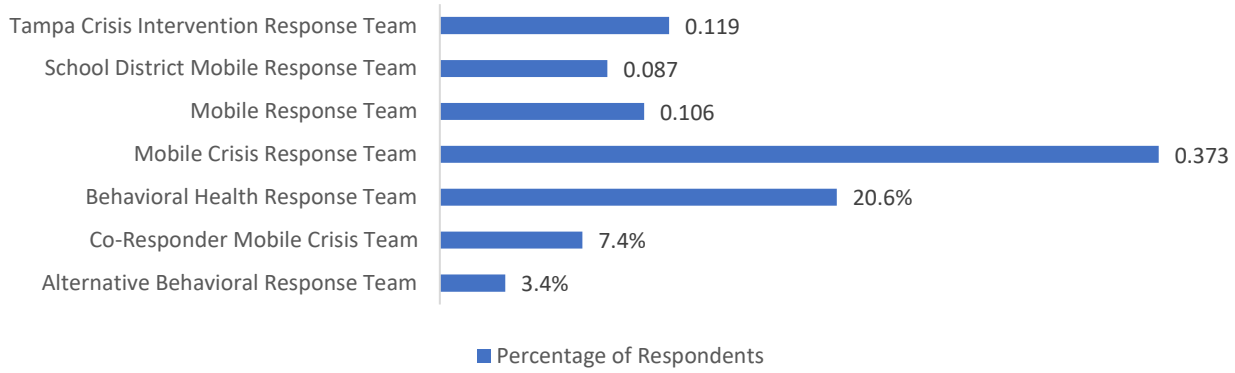


Figure 155: How would you rate community awareness of mental health and substance use treatment services in your area?

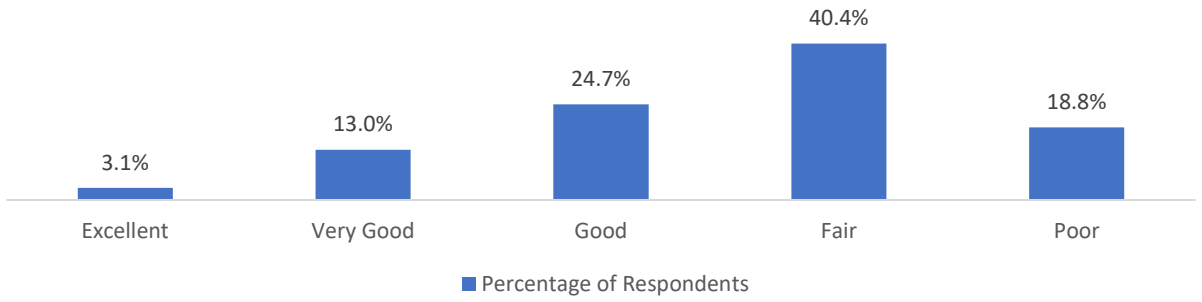


Figure 156: Linkages to needed services are coordinated and well established across the system.

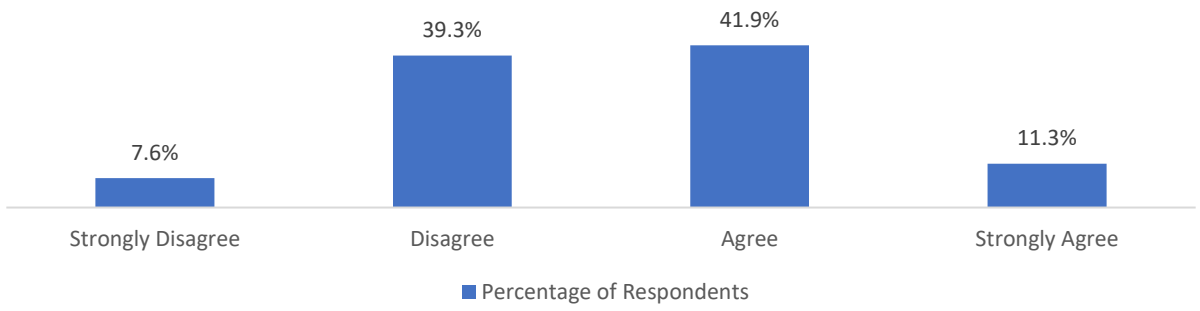


Figure 157: In general, behavioral health care and peer services are accessible in your area.

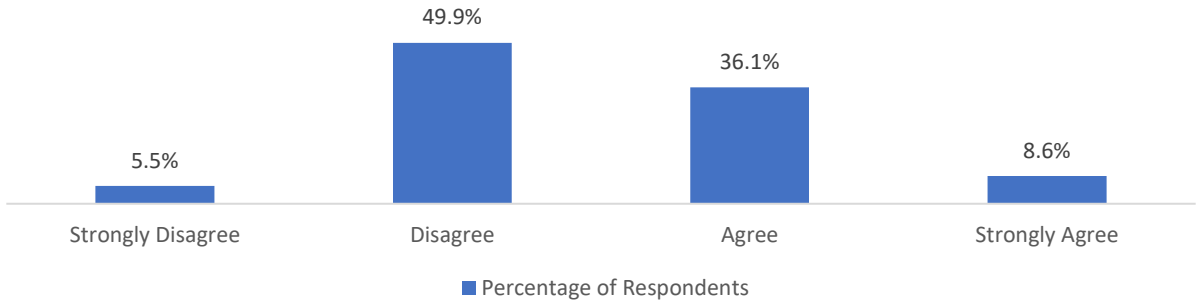


Figure 158: The process for referrals is easily accessible.

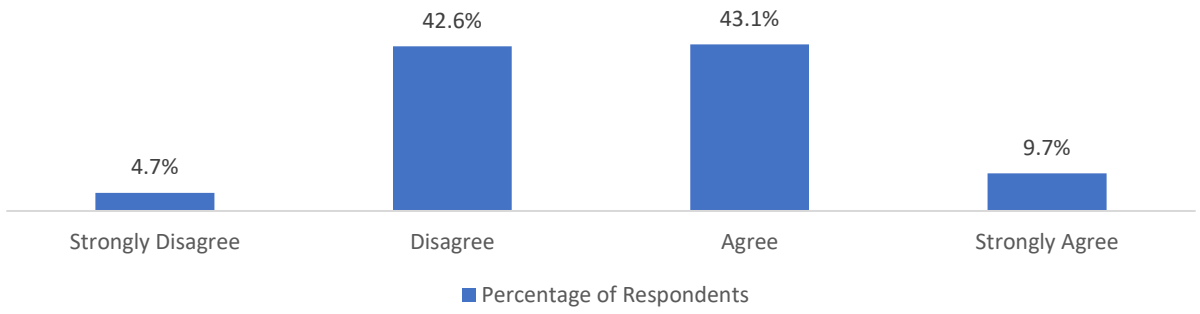


Figure 159: Programs and services are coordinated across the system of care.

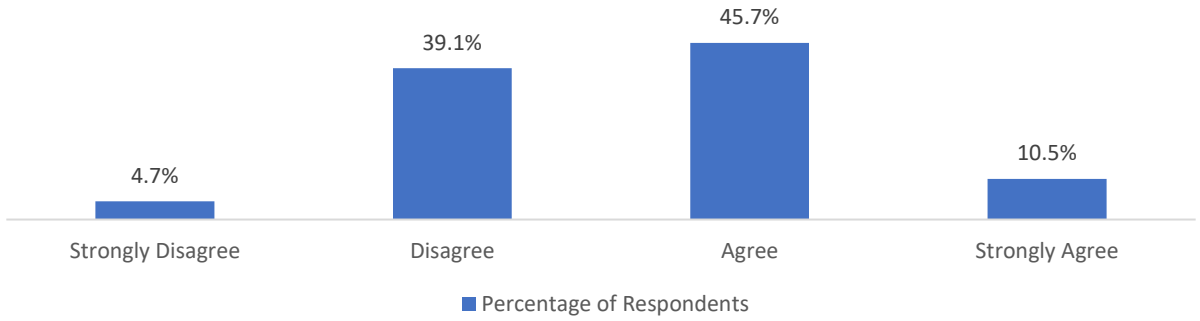


Figure 160: List the barriers for consumer accessing services in your community. (Check all that apply)

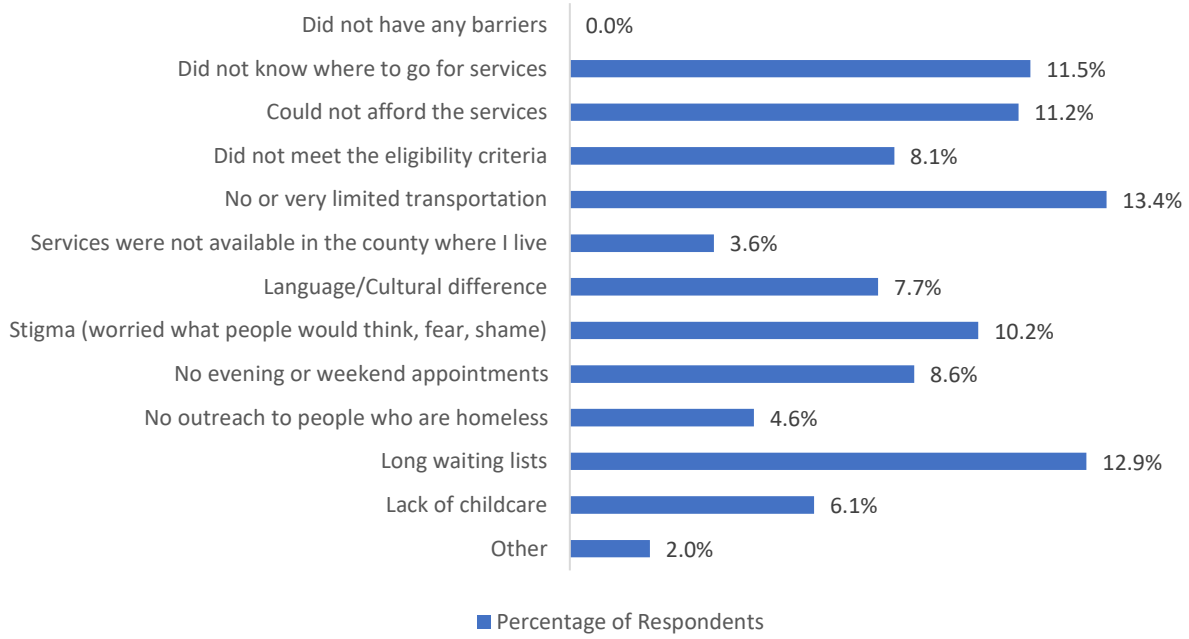


Figure 161: List the resources and services needed that are not available to improve patient-centered care and planning.

Needed Resources and Services
Shortage of providers and staff
More peer specialists
Aid in transportation
Affordable housing
Bilingual providers
Access to services in a timely manner
Weekend access to behavioral health services
Increased access for uninsured patients
Care coordination

Figure 162: List the top 3 patient-centered care resources that have improved quality of life for individuals.

TOP THREE PATIENT-CENTERED RESOURCES
Behavioral Health Service Agencies
Case Management
Access to Services

PEER RECOVERY COMMUNITY/SUPPORT SPECIALIST'S SURVEY SUMMARY

PEER SUPPORT SPECIALISTS IN THE CENTRAL FLORIDA CARES HEALTH SYSTEM

Peer Support Specialist (PSS) bridge gaps in services in the No Wrong Door care model to improve patient-centered care. PSS were surveyed to evaluate their engagement, barriers, and improvements they would like to see in the health system. Sixty-six PSS responded to the survey, 30.3% were adults with a lived substance use condition, and an additional 30.3% were adults with lived co-occurring mental health and substance use conditions. Of the 14 counties with CFBHN locations, Hillsborough County was the most represented at 25.8% with Pasco and Polk County tied as the second most at 12.1% each. Other counties represented were Lee County (10.6%), Pinellas and Collier County (9.1% respectively), Manatee and Sarasota County (7.6% respectively), and Charlotte County (6.1%). PSS are employed at a variety of agencies ranging from mental health and substance use for adults and children to community and family/peer organizations. They may be employed or volunteer for one or multiple agencies. Approximately 48.5% of PSS have been involved for more than 3 years and 63.6% of all respondents have a work schedule averaging 40 hours per week, 15.2% exceed the 40-hour schedule.

Peer Specialists were evaluated for the certifications they hold for peer specialist and recovery support specialist. Approximately 22.7% of respondents were not certified. Individuals who have applied for and are in the process of receiving certification made up 16.7% of respondents while 6.1% held a provisional certification as a recovery peer specialist. Exactly 50% of all respondents were Certified Recovery Peer Specialist (CRPS) and 4.6% were Certified Recovery Support Specialist (CRSS). Only 3% of respondents were Nationally Certified Peer Specialists (NCPS).

WHAT TYPES OF PROGRAMS DO PSS SUPPORT?

PSS were used in various recovery support roles throughout the health care system and in the community. Hospital emergency rooms, drop-in centers, corrections facilities, child welfare, and Medication Assisted Treatment (MAT) were some of the programs supported or run by PSS. Peer recovery support roles assisted families through grassroots organizations like National Alliance on Mental Illness (NAMI) and Family Intervention Treatment Team (FITT).

Partnerships with agencies outside of the health care system were heavily recognized by specialists. PSS can connect their patients with social services related to food pantries, halfway housing, Recovery Community Organizations (RCO), employment agencies, and child welfare services to aid in recovery.

STRENGTHS EXPEREINCED BY PSS

Approximately 95% of PSS reported that their organization utilizes person-centered recovery language to help reduce stigma. Over 75% responded that their organization included peers in developing, evaluating, and improving programs. Strength of peer support materials, programs, and best practices included inviting individuals in recovery to management and board meetings.

BARRIERS TO RECRUITING/EMPLOYING PSS

Multiple barriers were mentioned regarding the employment and recruiting of PSS. The length of hiring and screening processes were among the top barriers cited. PSS expressed experiences with significant delays for background checks and exemptions. Additionally, salary and pay were the most selected barriers with PSS indicating that the lack of raises does not compensate for the cost of living.

TRAINING NEEDS THAT MAY ASSIST IMPLEMENTING PSS SERVICES

PSS prioritized Peer Recovery Specialist training, Wellness Recovery Action Plan (WRAP), trauma informed training, and professional responsibility/ethics as areas of need. Mental health first aid was identified and aims to benefit those serving both adults and children. Peer Recovery Specialist Training should require at least 40 hours to maintain and improve the skills of specialists along with peer support training within organizations.

RECOMMENDATIONS TO IMPROVE THE IMPLEMENTATION OF PSS

Peer Support Specialists found it was important to include peers in recovery during all stages of the process for the development of effective programs. Documentation training would aid in improving the continuity of care to ensure patient notes and progress are updated for better communication among providers. PSSs suffer from compassion fatigue, limited employment opportunities, and extended work hours. Selfcare is vital to PSSs success in supporting patients. As an employee, flexible work schedules, support from administration, and work hours reaffirm their commitment to supporting their patients. PSS are dedicated to their work gaining personal fulfillment and committed to recovery principles when helping their community.

PEER RECOVERY COMMUNITY/SUPPORT SPECIALIST'S SURVEY CHARTS

Figure 163: Which best describes your experience?

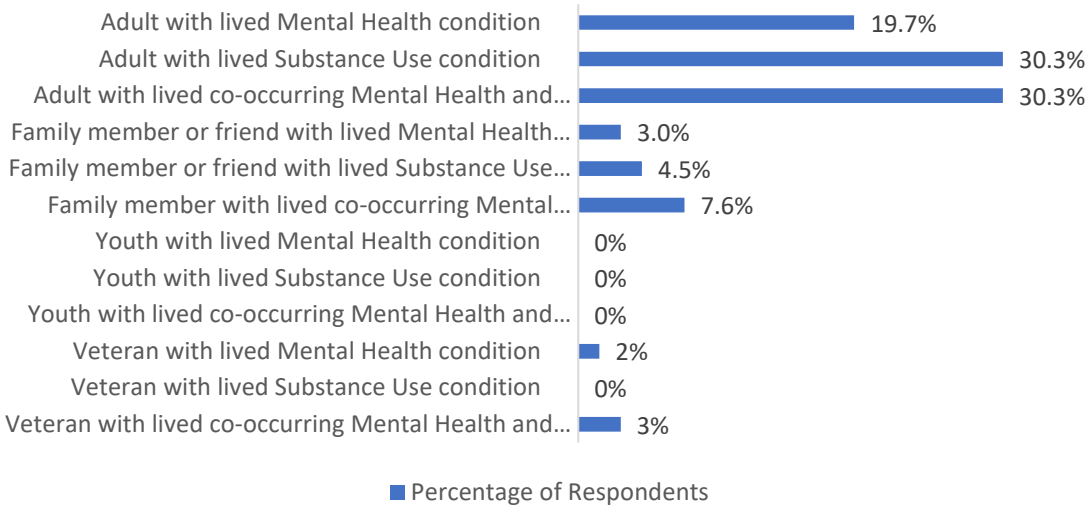


Figure 164: Which county do you live in?

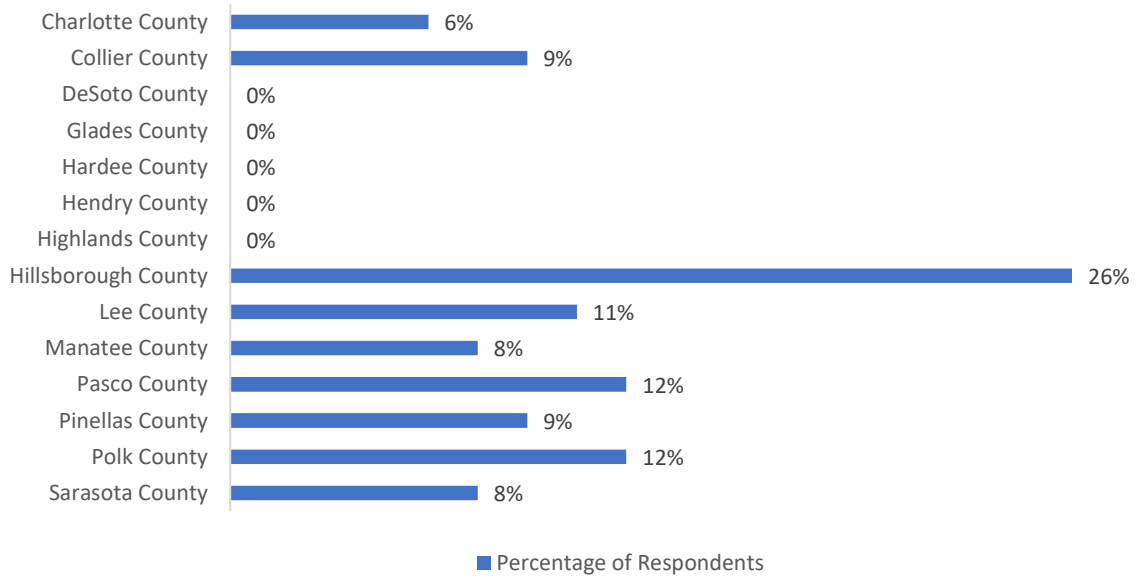


Figure 165: What type of service are you employed or volunteer with? (Check all that apply)

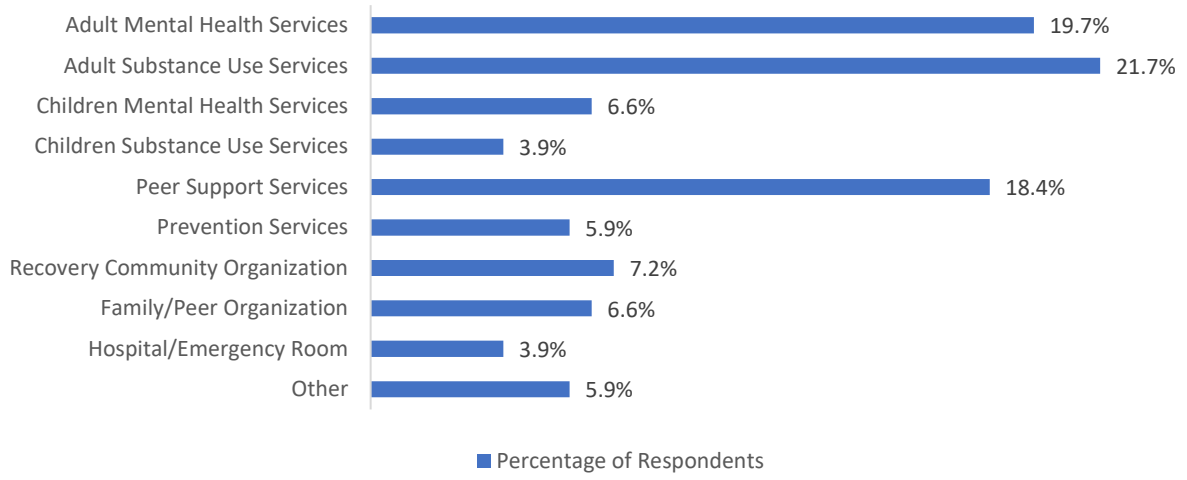


Figure 166: How long have you been employed/volunteered with the agency?

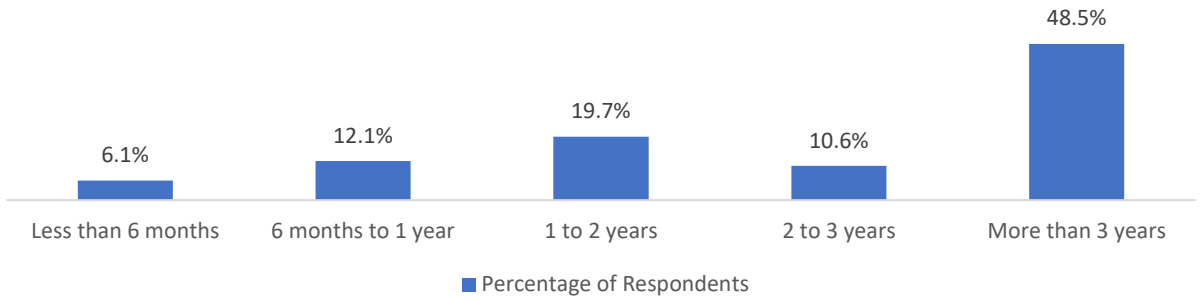


Figure 167: My work schedule averages...

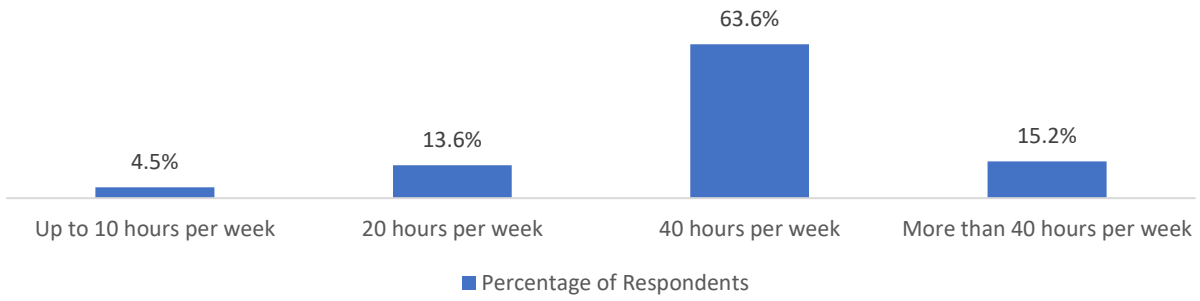


Figure 168: Does the agency where you are employed, or volunteer, utilize recovery peer support services within the services they provide in the community?

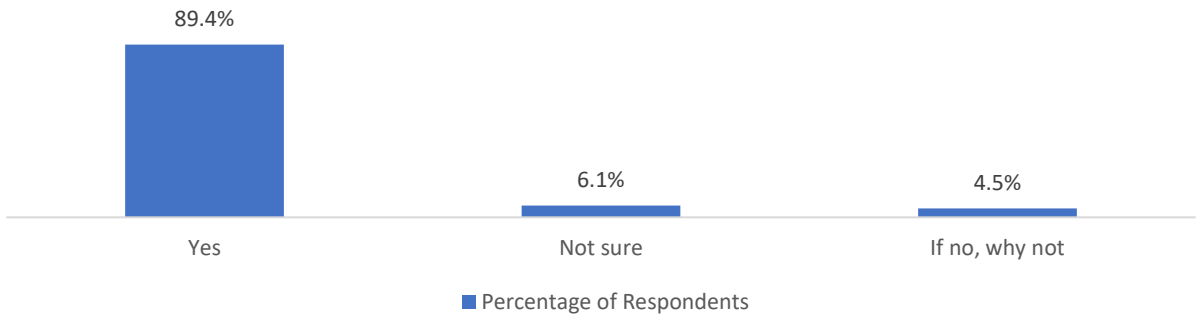


Figure 169: Does the agency where you are employed, or volunteer, adhere to recovery support best practices?

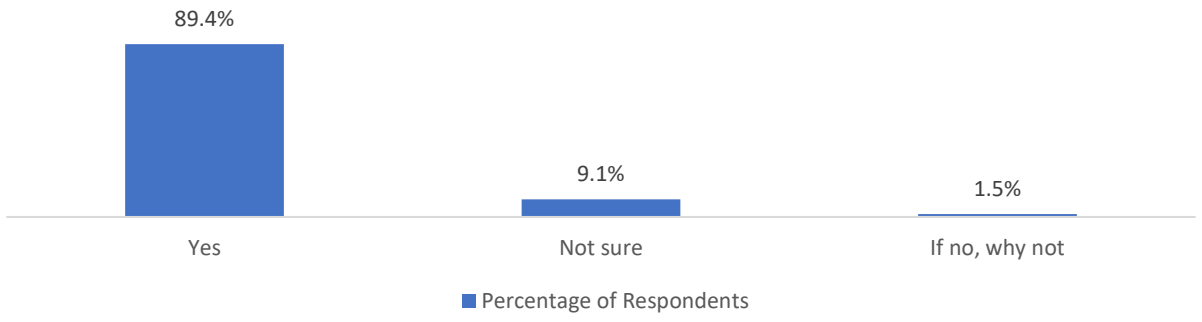


Figure 170: Please indicate the qualifications that best describe your status. (Check all that apply)

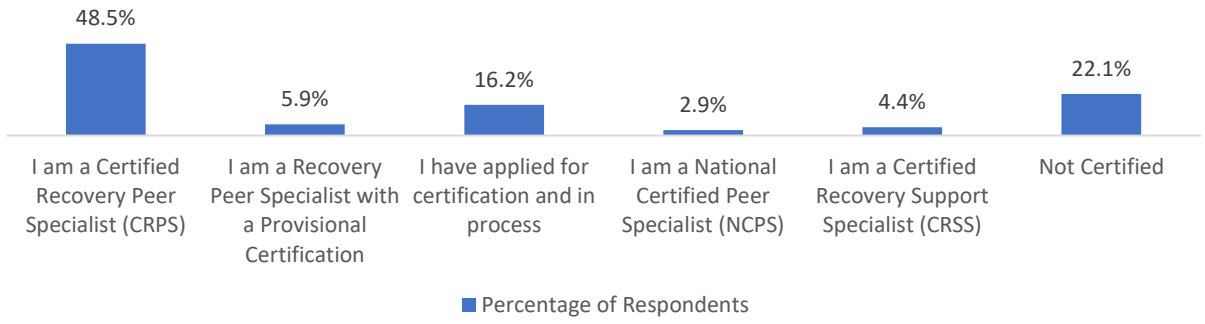


Figure 171: Please indicate the facility/program setting(s) that best describes where you deliver peer recovery support services. (Check all that apply)

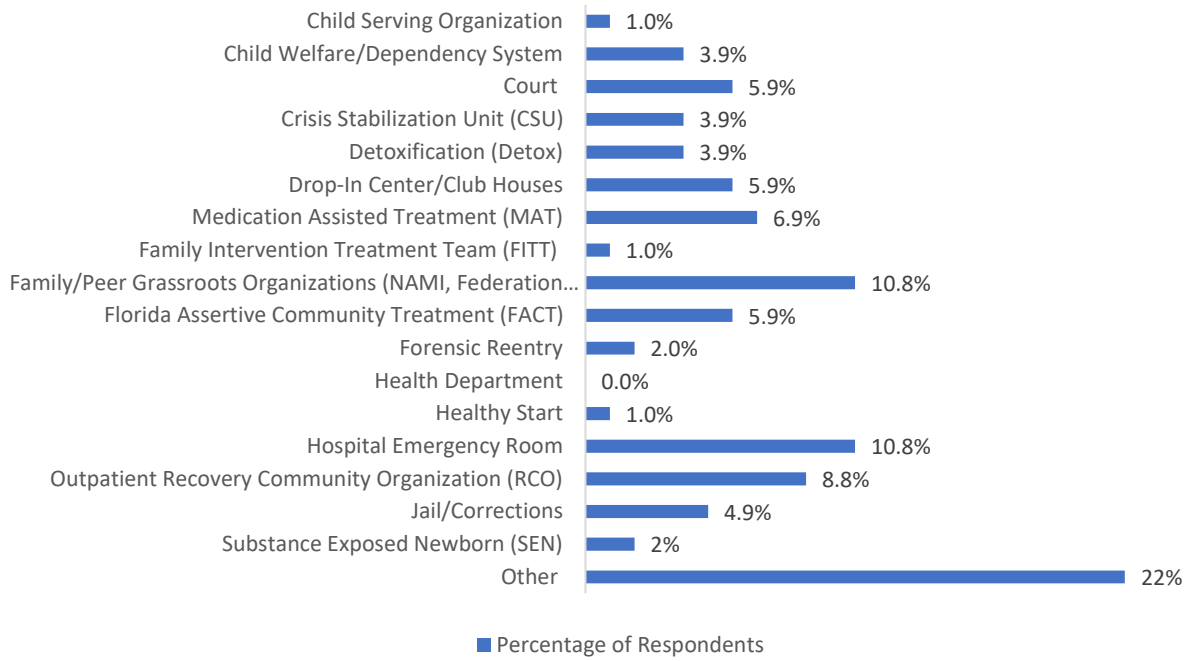


Figure 172: What are the reasons/factors for staying with the company? (Check all that apply)

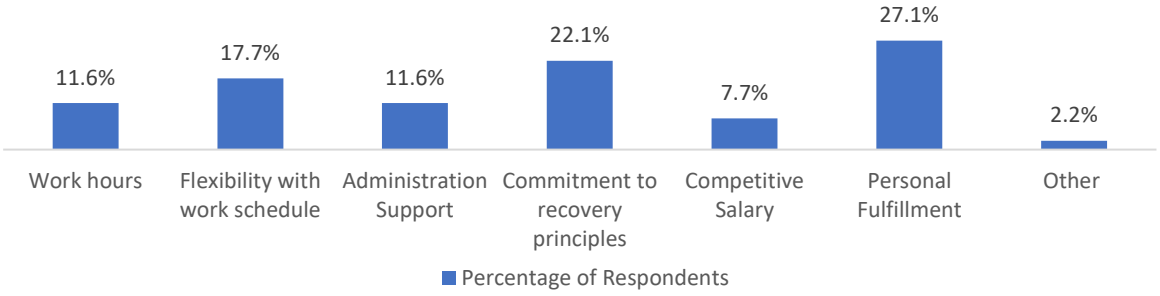


Figure 173: What barriers/challenges have you experienced in the hiring process? (Check all that apply)

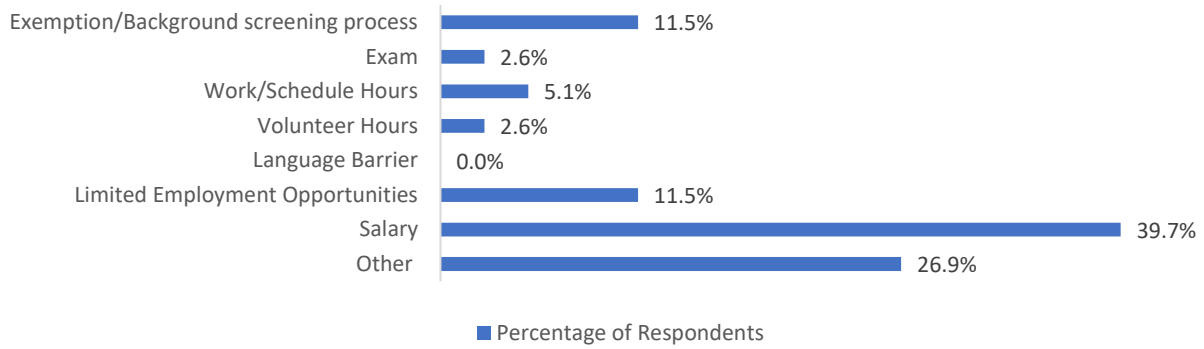


Figure 174: What training would you recommend for peers to have to help them provide peer support services? (Check all that apply)

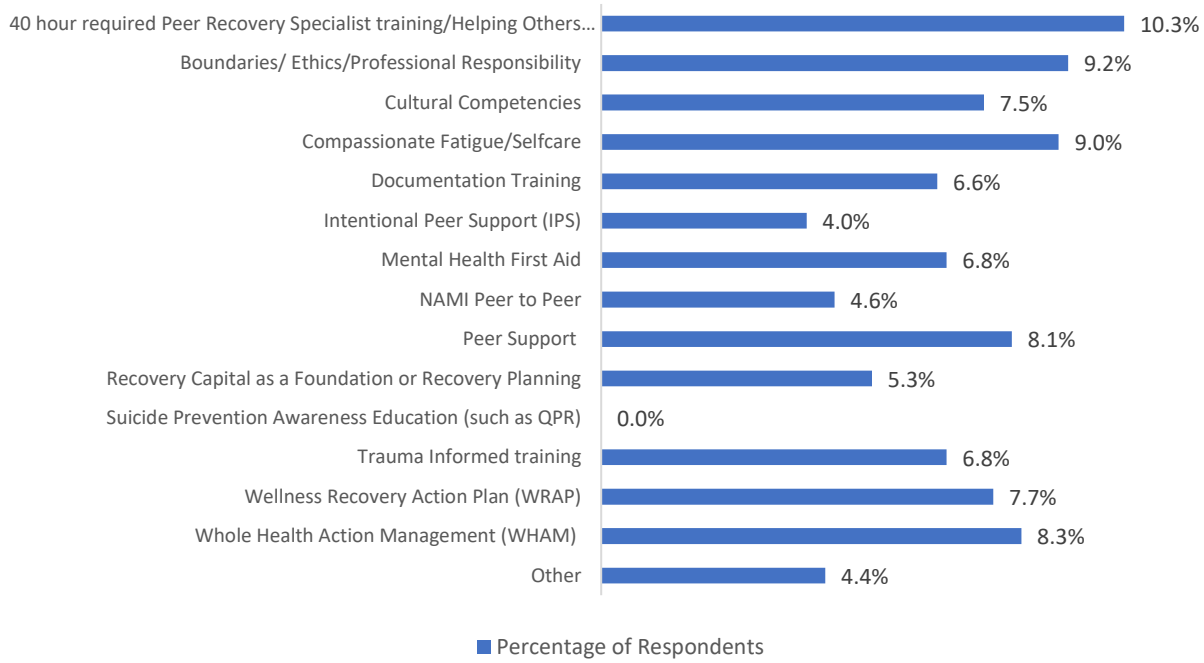


Figure 175: Are there partnerships that exist with peer support recovery programs, recovery community organizations, and other support groups?

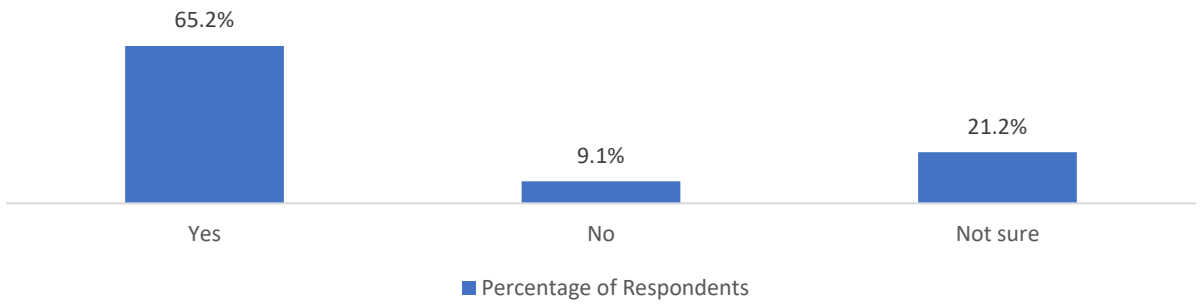


Figure 176: Are you aware of partnerships with other organizations that provide other resources such as: (Check all that apply)

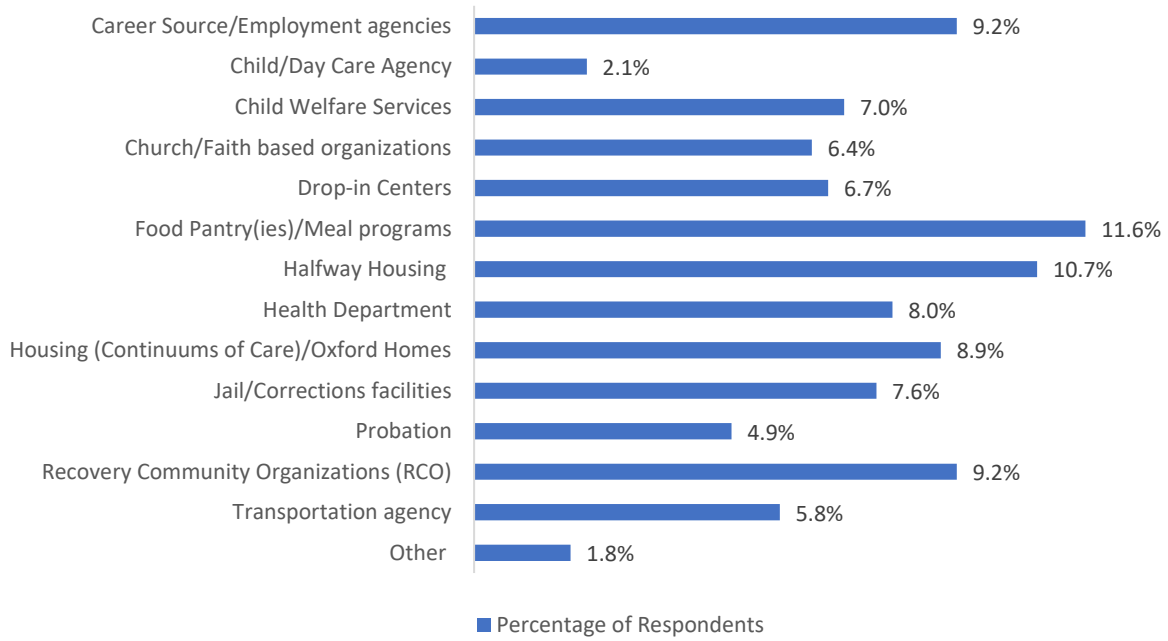


Figure 177: Do you have the ability to offer choices to the individuals where you serve at the agency you are employed/volunteer?

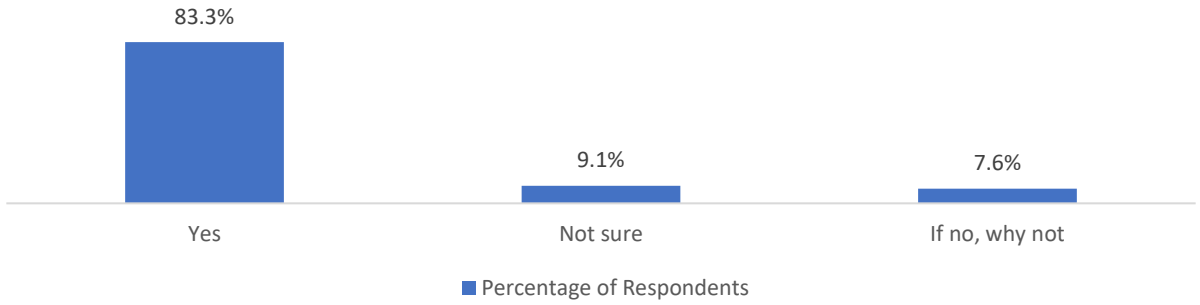


Figure 178: Does the organization where you are employed/volunteer with help to reduce stigma by promoting recovery language that is patient-centered?

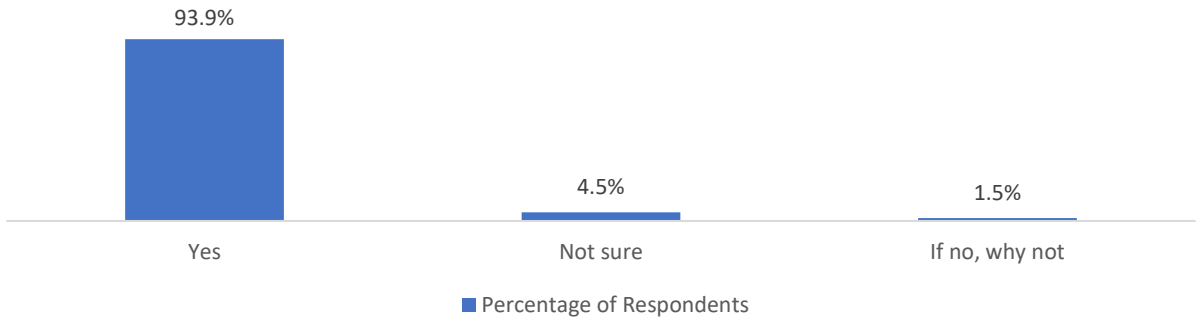


Figure 179: Does the agency where you are employed/volunteer include peers in developing and promoting effective program development, evaluation, and improvement?

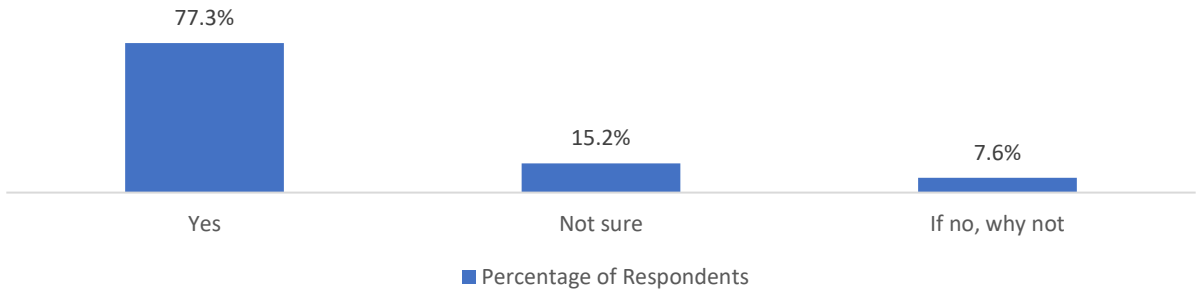
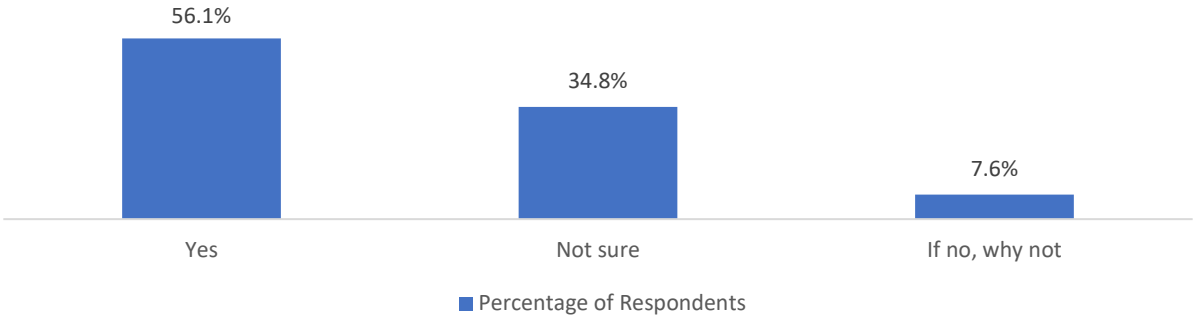


Figure 180: Does the agency where you are employed/volunteer with include persons in recovery management and board meetings?



RECOVERY ORIENTED SYSTEM OF CARE RESOURCES

CFBHN
RECOVERY ORIENTED SYSTEM OF CARE RESOURCES

ACTS Adult Addiction Receiving Facility	Florida Treatment for Change
ACTS Juvenile Addiction Receiving Facility	Footprints Beachside Recovery
ACTS Thonotosassa Youth Residential	Frankies Place Counseling & Prevention Services
Agency for Community Treatment Services (ACTS)	Gracepoint Adult Outpatient & Assessment Center
Alternatives in Behavioral Health	Hazelden Betty Ford Foundation
Calusa Recovery	Lakeland Centers
Centerstone of Florida Sawyer Road	Lifeworks Substance Abuse Services
Coalition Recovery	Multiple Innovations to Recovery 7 Summit Pathways
Cove Behavioral Health Medication Assisted Treatment Program	Naples Metro Treatment Center of Florida
Cove Behavioral Health Outpatient & Opiate Addiction Treatment Services	Nextep
Crossing Bridges of the Palm Beaches	North Tampa Behavioral Health
Detox of South Florida	Operation PAR Highpoint
Dignity Healing	Operation PAR Therapeutic Community

Fairwinds Treatment Center Residential	Park Royal Hospital
River Oaks Treatment Center	Tri-County Human Services Agape Halfway House
SalusCare Transitional Living Center	Tri-County Human Services/5-Bed Project FL Center
Sarasota County DUI & Drug Court	Tri-County Human Services/RASUW Center for Women
Solutions	White Sands Alcohol & Drug Rehab
Spencer Recovery Centers Florida	White Sands Alcohol & Drug Rehab Fort Myers
Tampa Crossroads Non-Residential Counseling Services	White Sands Treatment Center
Tampa Crossroads Rose Manor Women's Residential Program	White Sands Treatment Center Clearwater Alcohol & Drug Rehab
Terrace Landing Finest Medical Center	White Sands Treatment Center Sarasota Alcohol & Drug Rehab
Tranquil Shores	White Sands Treatment Center Alcohol & Drug Rehab
Tri County Human Services Detox Unit	The Willough at Naples

Source: SAMHSA