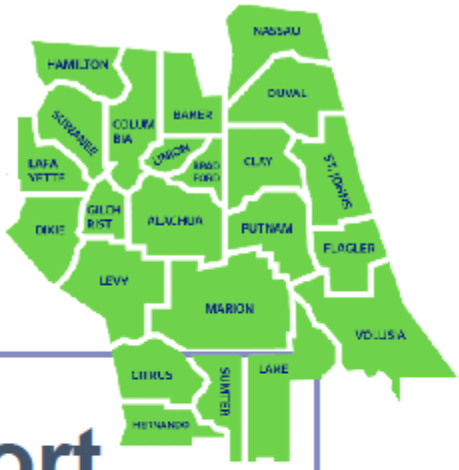
LUTHERAN SERVICES FLORIDA

2022

Florida Cultural Health Disparity & Behavioral Health Needs Assessment



Regional Report

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Greetings Community Members,

LSF Health Systems, your behavioral health Managing Entity for the Northeast and North Central region, proudly announces the completion of our 2022 Triennial Needs Assessment. As the second largest Managing Entity in the state, we serve 23 counties in Northeast and North Central Florida. This includes both urban and rural areas with diverse populations and unique needs. LSF Health Systems contracts with the Department of Children and Families to manage state-funded behavioral health services for those vulnerable citizens who are indigent, uninsured, or underinsured. This includes children, adults, and families who lack the financial resources to afford behavioral health care. Our goal is to provide the right service at the right time in the right setting. This supports our vision to create a world of safe children, strong families, and vibrant communities where every child, adult, and family have access to behavioral health services they need to live well and be well.

We would like to acknowledge Senator Darryl Rouson who embodies our vision and values. His legislative advocacy resulted in the inclusion of the health disparities focus on our assessment. Health disparities are often interpreted to mean racial or ethnic disparities; however, many dimensions of disparity exist in the United States, particularly in health. When health differences are seen to a greater or lesser extent between populations, there is disparity. Race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location all contribute to an individual's ability to achieve good health. LSF Health Systems appreciates Senator Rouson's recognition of the impact that social determinants have on health outcomes of specific populations.

The purpose of conducting a needs assessment every three years is to determine needs, gaps, barriers, and strengths in the behavioral health system of care. LSF Health Systems will use this report as a call to action, engaging providers, consumers, stakeholders, and community members in creating effective programs, policies, and community collaborations to bring positive change to our communities. The long-term goal of a community health needs assessment is to identify health priorities and develop impact strategies with all health-related stakeholders in the community. This report will serve to inform the development of the LSF Health Systems' Strategic Plan for 2022-2025 as well as the annual enhancement plans submitted to the Department of Children and Families to address unmet needs. Town Hall meetings with providers and stakeholders will be scheduled in each of the circuits served by LSF Health Systems to discuss the results of the Triennial Needs Assessment. We thank our communities for engaging in the needs assessment and assisting LSF Health Systems with implementing strategies to enhance the behavioral health system of care in our region.

Sincerely,

Dr. Christine Cauffield
Chief Executive Officer
Executive Vice President - SAMH
LSF Health Systems, Inc.

9428 Baymeadows Rd., • Bldg. III, Ste. 320 • Jacksonville, FL 32256 • Phone: 904-900-1075 • Fax: 904-900-1628

ACKNOWLEDGEMENTS

A special thank you to all those who participated in the needs assessment process including:

LSF Health Systems network service providers and community partners who promoted the Individual's Served Survey, Cultural Health Disparity Survey, Recovery Community Peer Specialist Survey, Stakeholder Survey, and No Wrong Door Survey.

LSF Health Systems network services providers who participated in the No Wrong Door Survey and Focus Groups.

Community members who completed the Individual's Served Survey, Cultural Health Disparity Survey, Recovery Community Peer Specialist Survey, and Stakeholder Survey.

Community members who participated in focus groups.

A special thank you to the professional staff at LSF Health Systems who served as the Steering Committee and leadership team for the behavioral health needs assessment:

Dr. Christine Cauffield, Chief Executive Officer, LSF Health Systems

Dr. David Clapp, Chief Operating Officer, LSF Health Systems

David Dolyak, Community Engagement Specialist, LSF Health Systems

Lesley Hersey, Community Engagement Specialist, LSF Health Systems

Julie Jennejahn, UNF Student Intern, LSF Health Systems

Dr. Matt Munyon, Director of Data Analytics, LSF Health Systems

Bryan Mingle, ROSC Specialist, LSF Health Systems

Dusty Pye, Chief Integration Officer, LSF Health Systems

EXECUTIVE SUMMARY

SERVICE AREA POPULATION

LSF Health Systems (LSFHS) serves 23-county region in Northeast and Central Florida which includes the counties of Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Hernando, Lake, Lafayette, Levy, Marion, Nassau, Putnam, St. Johns, Sumter, Suwannee, Union, and Volusia. In 2020, the estimated number of adults with serious mental health conditions was 127,850 in the 23-county service area. This number has increased 4.5 percent over the past three years. This report, prepared for LSFHS, is a compilation of primary and secondary data that identifies behavioral health needs and the community assets available to advance the health care delivery system to improve outcomes for all residents.

DEMOGRAPHIC PROFILE

The population in the service area increased (7.5 percent) over the past five years to a total of 4,067.330 individuals. Racially, the service area is predominately White (75.2 percent), with the Black population accounting for 15.4 percent, Asian residents at 2.7 percent, American Indians and Native Hawaiians represented less than one percent, and 2.2 percent of individuals who are of other races. Hispanic individuals make up 11 percent of the area's population, which is less than the percentage of Hispanic individuals in Florida (25.8 percent). This varies by county/circuit and some show higher rates.

LSFHS service area population is slightly younger when compared to the age distribution of Florida. In the service area 54.6 percent of the population participated in the labor force over the past five years. The ratio of income and poverty levels in the service area mirrors that of Florida. The percentage of individuals in the service area living below the Federal Poverty Level (FPL), according to five-year estimates from 2016 to 2020, was 9.1 percent (9.4 percent in Florida) with 16.7 percent living between 100 and 199 percent of FPL (17.1 percent in Florida), and 41.3 percent living at 400 percent or more of poverty (42.3 percent in Florida).

GENERAL HEALTH STATUS

Behavioral Risk Factor Surveillance System (BRFSS) data (2017 to 2019) estimates revealed 78.6 percent of adults, ages 18-64 years of age, living in the service area said their overall health was "good" to "excellent," compared to 80.3 percent in Florida overall. The average percentage of adults reporting good mental health over the past three years was 84.9 percent in the service area compared to 86.2 percent in Florida overall. Most residents (85.4 percent), ages 18-64 years, living in the ME service area reported having

some type of health insurance coverage which is slightly higher than Florida overall (84.2 pecent).

The crude suicide death rate decreased from 21.2/100,000 in 2018 to 18.7/100,000 in 2020; however, it should be noted that the suicide death rate for males in the Managing Entity (ME) service area was more than three times the rate among females. Additionally, the suicide death rate among the White population was three times the rate for Black residents in the ME service area.

The rates of domestic violence and child abuse have decreased over the last three years in the service area and across the state. The percentage of adults who are smokers and who binge drink are lower in the service area than the state. High school tobacco, alcohol, and substance use in the service area closely mirror the state.

In the ME service area, 15.7 percent of the noninstitutionalized population is estimated to have a disability, which includes hearing, vision, cognitive, ambulatory, self-care, and independent living, compared to 13.6 percent in the state.

CLIENT DEMOGRAPHIC PROFILE

LSFHS-funded organizations served 49,928 individuals in Fiscal Year (FY) 2020-2021. Slightly more than 22 percent of those served resided in Volusia County (11,185 individuals), followed by Duval County at 19.5 percent (9,756 individuals), Marion County at 8.6 percent (4,290 individuals), and Clay County at 6.9 percent (3,445 individuals). Adults in LSFHS programs accounted for 86.5 percent of all persons served with 53.2 percent enrolled in the Adult Mental Health (AMH) program and 33.3 percent in the Adult Substance Abuse program (ASA). The remaining individuals were in the Child Mental Health (CMH) program at 9.4 percent and the Child Substance Abuse (CSA) program at 4.1 percent.

Adults, ages 25-44 years of age, accounted for 48.6 percent of all LSFHS persons served by LSFHS providers while representing 23.7 percent of the population in the service area. Adults, ages 65 years and older, accounted for only three percent of the individuals served by LSFHS providers while representing 22.5 percent of the service area population.

HOMELESSNESS

The effects of homelessness on individuals are numerous, complicated, and very costly. In addition to poor physical health, homeless community members are at an increased risk for mental health conditions, drug dependency, behavioral health issues, assault, and even premature death. In 2021, the Florida Council on Homelessness reported there were 4,232 individuals who experienced homelessness in District 3, which includes counties in the 23-county LSFHS service area. Sheltered individuals represented 58.5 percent of those experiencing homelessness population, while 41.5 percent of the individual's

experiencing homelessness were unsheltered. Among veterans, 484 experienced homelessness in the LSFHS service area. The Florida Department of Education reported 14,992 students in the LSFHS service area experienced homelessness in the 2019-2020 academic year.

HOMELESSNESS PROFILE

A total of 2,728 individuals served by LSFHS providers experienced homelessness, representing 5.5 percent of all those served by LSFHS. Of the 2,728 individuals who experienced homelessness, 67.6 percent were enrolled in the AMH program, 31.8 percent in the ASA program, 0.4 percent were enrolled in the CMH program, and 0.1 percent were enrolled in the CSA program.

Almost 70 percent of individuals experiencing homelessness served by LSFHS providers were White, 20.2 percent were Black, 3.1 percent were Multi-Racial, and 6.2 percent identified as “Other” race.

Adults, ages 25-44 years, accounted for 59.7 percent of individuals experiencing homelessness served by LSFHS providers and only 48.6 percent of the overall number of individuals served by LSFHS providers.

NO WRONG DOOR ASSESSMENT PROVIDER INTERVIEWS

Three provider interview focus groups were conducted virtually to assess No Wrong Door (NWD) access. Providers were invited to participate in the focus groups after completing a brief NWD survey (80 responses). The interviews were used to gain qualitative understanding of the survey findings. Approximately 15 individuals participated.

Over 80 percent of survey respondents said that their agency has a role to play in NWD access, with 65 percent stating that it works well within their agency. The interviews showed that providers have worked internally and externally to improve NWD access. As expected with Florida ranked #49 in the nation for behavioral health spending per capita, providers noted funding limitations as a concern.

Interview respondents indicated that having relationships with individuals from various agencies in the area helped NWD access work well in their organization. A shortage in the workforce and not enough capacity was also a common theme across all three focus group provider interviews.

CULTURAL HEALTH DISPARITY SURVEY

For the 2022 needs assessment, a new survey was deployed to better understand the role of health disparities in behavioral health outcomes. A total of 300 participants completed a survey detailing their experiences and attitudes with respect to behavioral health. The survey assessed several focus areas including Comfort Seeking Care, Trust

in the Behavioral Health System, Feelings Regarding Behavioral Health Issues, Behavioral Health Treatment Settings, and Language Needs.

INDIVIDUAL'S SERVED SURVEY

An individual's served survey was conducted during early 2022 with 388 responses collected during the survey period. Data revealed the respondents were aware of where to go for mental health and substance use treatment when they needed them (90 percent), that most respondents learned about services from a family member/friend (31.6 percent), another individual in treatment or recovery (21.9 percent), law enforcement (15.3 percent), or by word of mouth (14.9 percent).

Most respondents indicated that they were able to receive the services they needed when they needed them (81 percent). Those who were unable to get the services they needed were asked a follow-up question to list the services they needed but did not receive. The service needed and not received most was "housing assistance" (10.7 percent) followed by "other" (9.8 percent), and "medication assistance program" (6.8 percent).

When asked, "What were the obstacles you experienced getting the care you needed" respondents said, "no or very limited transportation" (10.5 percent), "long waitlists" (9.8 percent), followed by "could not afford the service" (8.9 percent), "did not know where to go for services" (7.3 percent), and nearly 29 percent (28.9 percent) did not have any barriers.

STAKEHOLDER SURVEY

A survey of behavioral health stakeholders across the 23-county LSFHS service area yielded 387 responses. All 23 counties were represented in the survey. Nearly 88 percent of respondents strongly agreed or agreed that they were aware of the availability of mental health and substance use services in their area. While only 56 percent of respondents were aware of LSFHS, it is possible respondents were aware of LSFHS service providers, but not aware of the ME network in Florida and LSFHS' role as a ME. Although nearly 76 percent of respondents were familiar with 2-1-1, only 15.3 percent of respondents had used the 2-1-1 service in the past six months.

Respondents were not in agreement regarding the availability and accessibility of behavioral health care and peer services. Respondents were also not in agreement regarding the referral process with 46 percent indicating the process for referrals is not easily accessible.

Barriers for accessing services included not being aware of where to go for services (53.4 percent), affordability (17.9 percent), and transportation barriers (14.7 percent). Respondents were asked to "List the resources and services needed that are not available to improve patient-centered care and planning that are not available." Write in

responses included: providers, professionals, clinicians, therapists, transportation, housing, waitlist reduction, crisis stabilization services, residential services, case management services and case management coordination, Baker Act receiving facilities, school-based support services, Medicaid payment acceptance and expansion of Medicaid services, behavioral health support services, therapies, and childcare.

RECOVERY COMMUNITY PEER SUPPORT SURVEY

Peer Support Specialists' (PSS) bridge gaps in services in the NWD care model to improve patient-centered care. PSS were surveyed to evaluate their engagement, barriers, and improvements they would like to see in the health system. In total, 95 responses from peers were collected, representing 15 of the 23 counties in the service area. PSS participates in various recovery support roles throughout the health care system and in the community. Hospital emergency rooms, drop-in centers, corrections facilities, child welfare, and Medication Assisted Treatment (MAT) were some of the programs supported or run by PSS.

The participation and integration of PSS is evidence-based practice. In the LSFHS service area, peers overwhelmingly (81.1 percent) reported their agencies use person-centered language that helps reduce stigma. Nearly three-quarters of respondents indicated that peers are included in developing, promoting, evaluating, and improving programs. Nearly 60 percent of respondents said that people in recovery participate in management and board meetings.

LSFHS SERVICE AREA DEMOGRAPHIC PROFILE

Population Demographics

From 2016 to 2020, the estimated population in the 23-county service has increased from 3,784,476 to 4,067,330 (7.5 percent).

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

The racial composition in the service area varies slightly from the state. White residents account for 75.2 percent in the service area and 71.6 percent in Florida. The Black population accounted for 15.4 percent of the service area population and 15.9 percent of the population in Florida. American Indian and Native Hawaiians represented less than one percent of residents in both population groups. The percentage of Asian residents in the service area and the state was 2.7 percent and 2.8 percent, respectively. Those with a race of Other accounted for 2.2 percent of the service area population and 3.3 percent in the state.

Ethnically, the service area had a much lower percentage of Hispanic residents, at 11 percent when compared to the state at 25.8 percent.

The LSFHS service area population was slightly younger when compared to the age distribution at the state level. Residents, 65 years of age or older, accounted for 22.5 percent of the population while in the state of Florida, 20.5 percent of residents were at least 65 years old.

Education and Employment

Data revealed the service area and state populations were very similar regarding education attainment. In the LSFHS service area and in Florida, approximately 10 percent of the population have associate's degrees. In the service area 17.1 percent have bachelor's degrees compared to 19.3 percent in Florida. Graduate or professional degrees were held by 9.8 percent of the LSFHS service area and by 11.3 percent of Florida residents.

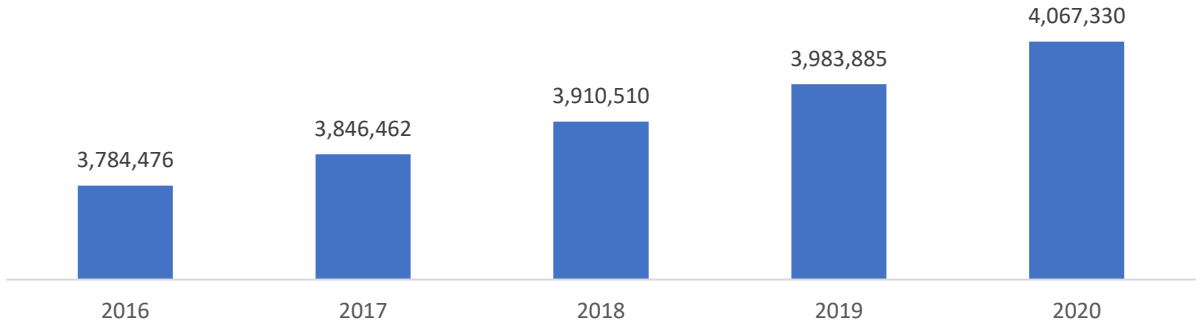
On average, 54.6 percent of the service area population participated in the labor force over the past five years. This was lower when compared to those employed in Florida at 58.9 percent. The unemployment rate for the service area during that same period was three percent compared to 5.4 percent in Florida.

Poverty Status

During 2016 to 2020, the ratio of income to poverty in LSFHS service area closely mirrored that of the state of Florida. The percent of residents living at < 200 percent of the Federal Poverty Level (FPL) was 25.8 percent in the LSFHS service area compared to 26.3 percent in Florida and those living at 400 percent the Federal Poverty Level in the LSFHS service area was 41.3 percent compared to 42.3 percent in Florida.

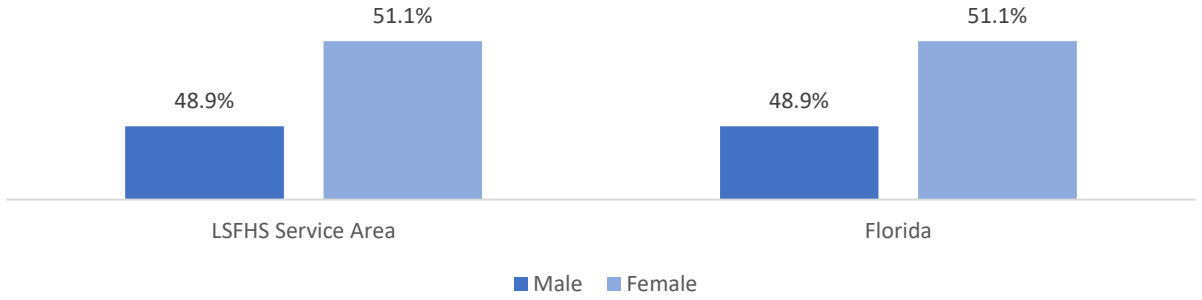
DEMOGRAPHIC CHARTS

Figure 1: LSFHS Service Area Population Estimates (2016-2021)



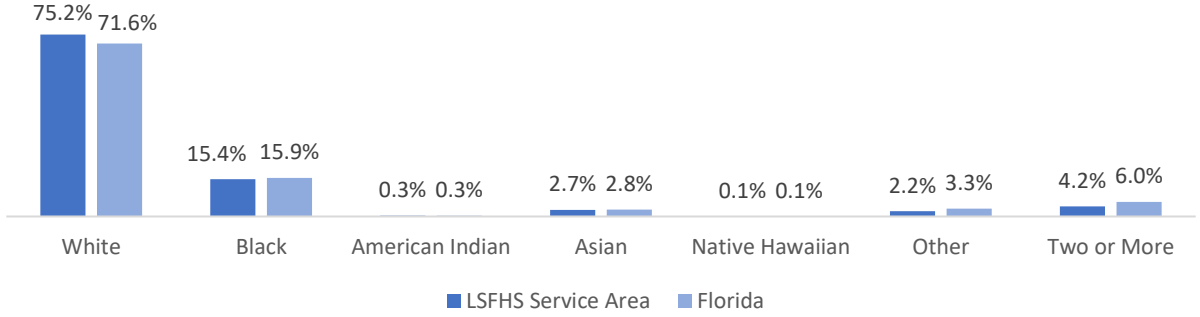
Source: Florida Legislature's Office of Economic and Demographic Research (EDR)

Figure 2: LSFHS Service Area County Population by Gender (2016-2020)



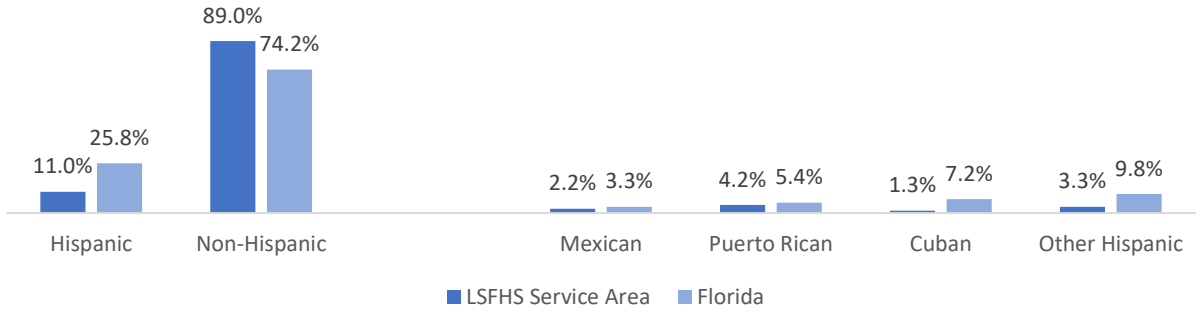
Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 3: LSFHS Service Area County Population by Race, 2016-2020 (5-Year Estimate)



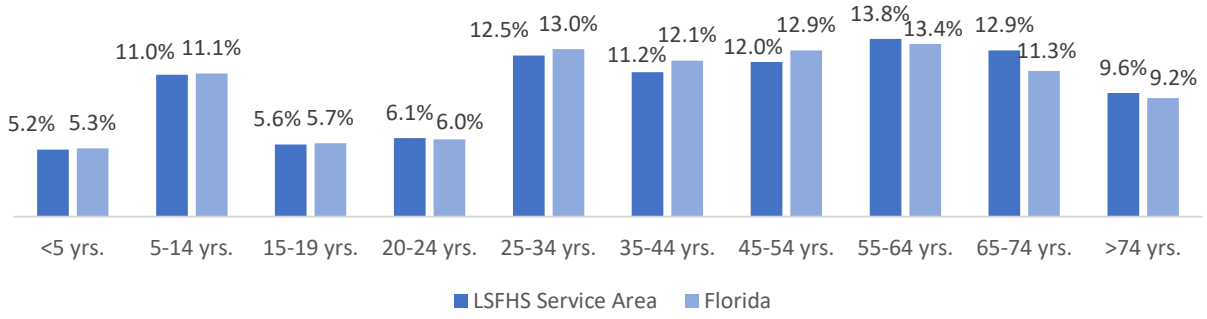
Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 4: LSFHS Service Area Population by Ethnicity, 2016-2020 (5-Year Estimate)



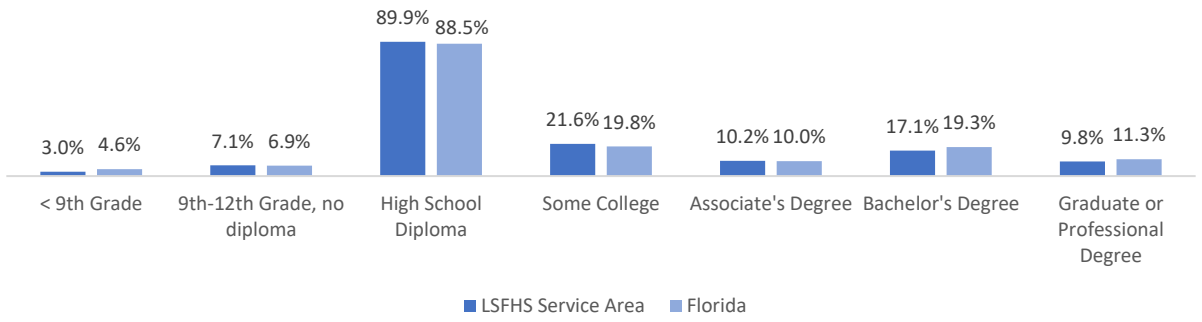
Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 5: LSFHS Service Area Population by Age Range, 2016-2020 (5-Year Estimate)



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

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



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

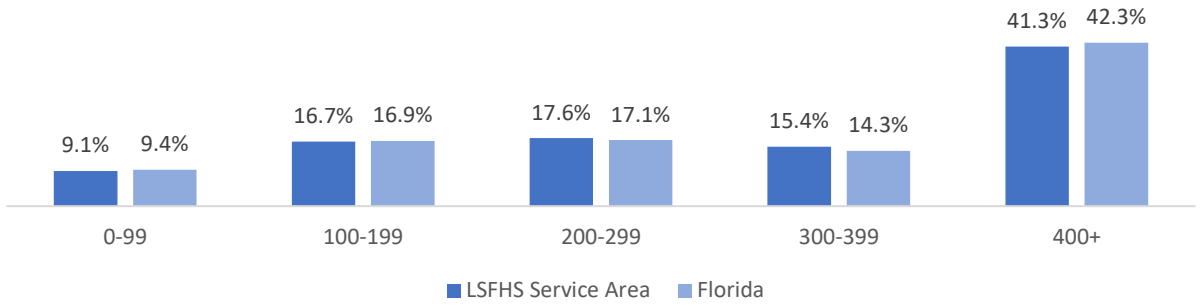
Figure 7: LSFHS Service Area Population Participation in Labor Force, 2016-2020 (5-Year Estimate)

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

Figure 8: LSFHS Service Area Population Unemployment Rates, 2016-2020 (5-Year Estimate)

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

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



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

LSFHS SERVICE AREA GENERAL HEALTH STATUS

Overall, Health Status

Behavioral Risk Factor Surveillance System (BRFSS) data (2017 to 2019) estimates revealed 78 percent 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 percent. 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 three years at 84.9 percent was below the rate for the state at 86.2 percent. The number of unhealthy mental days for the service area population, at 4.6 days in the past 30 days, was just above the rate among all adult residents, ages 18-64 years, in Florida at 4.4 days in the past 30 days.

The estimated number of adults with a seriously mental health condition in the LSFHS service area was 127,850 in 2020 compared to 122,517 in 2018. This represents an increase of 4.5 percent over the past three years. The estimated number of adults with a serious mental health condition in the state also increased by 3.5 percent from 2018 to 2020.

Among youth in the LSFHS service area, ages nine to 17 years, the estimated number of those who experienced an emotionally disturbance increased nearly three percent from 2018 to 2020, (35,046 in 2018 and 36,067 in 2020). This was slightly lower than the state percentage increase.

The Florida Department of Education (FLDOE) reported 0.7 percent of children in K-12 grades had an emotional/behavioral disability in the LSFHS service area. In the state, students with an emotional/behavioral disability accounted for 0.5 percent. These rates have been steady over the past three years.

Suicide

The crude suicide death rate decreased from 21.2/100,000 in 2018 to 18.7/100,000 population in 2020. This represents a decrease of 2.5/100,000 suicide deaths. At the state level, the suicide crude death rate decreased 2.5 deaths per 100,000 population during the same period but was lower when compared to the LSFHS service population (16.9/100,000 in 2018 and 14.4/100,000 in 2020 in Florida). Among males, the suicide death rate for the ME service area and state were more than three times the rate among females (29.6/100,000 compared to 8.2/100,000, respectively). The suicide death rate

among the White population was three times the rate for Black residents in the ME service area (21.8/100,000 compared to 7.0/100,000, respectively). The same held true at the state level where White to Black suicide deaths revealed a 3.2:1.0 ratio. It should be noted that the calculations required for the age-adjusted death rate for the ME service areas was beyond the scope of this project.

Violence and Abuse

The rate of total domestic violence offences decreased in the ME service area and the state from 2017 to 2020. In the ME service area, the rate fell from 643.7/100,000 to 594.8/100,000 over the past three years. This was still higher than the state rate of 496.5/100,000 in 2020.

The rate of children experiencing child abuse over the past three years (2017-2019) has continuously decreased in the ME Service area and state. Among children ages five to 11 years, the rate of child abuse fell from 873.4/100,000 in 2017 to 684.9/100,000 in 2019. This trend was observed in the state rates which decreased from 857.9/100,000 to 662.7/100,000 during the same period.

Child sexual abuse rates for children ages five to 11 decreased slightly from 2017 to 2019 in the LSFHS service area from 62.8/100,000 in 2017 to 60.8/100,000 in 2019. The Florida child sexual abuse rates for children ages five to 11 decreased from 59.6/100,00 in 2017 to 57.8/100,00 in 2019.

Adult Tobacco and Alcohol Use

BRFSS results revealed the percentage of adults living in the ME service area who are current smokers at 12.8 percent (2017-2019) was lower when compared to the state at 14.8 percent.

Binge drinking is defined as five consecutive drinks for men and four consecutive drinks for women. For 2017-2019, the percentage of binge drinkers in the ME service area was 17 percent. The percentage of binge drinkers in the state was slightly higher at 18 percent.

High School Tobacco, Alcohol and Substance Use

Data from the Florida Youth Substance Abuse Survey (FYSAS) indicated that the percentage of middle and high school students in the LSFHS service area who reported never having smoked cigarettes increased from 84.3 percent in 2016 to 91 percent in 2020. In 2020, 6.3 percent of students smoked once or twice and 2.2 percent reported that they had smoked once in a while. For middle and high school students in the state, the percentage of those having never smoked also increased over the past four years. The state has slightly higher rates when compared to the LSFHS service area.

When students were asked about smoking frequency, 97.5 percent of those living in the ME service area did not smoke at all compared to 98.2 percent in the state of Florida.

Vaping questions were included in the 2020 FYSAS for the first time. In the LSFHS service area, 25.2 percent of students reported vaping nicotine on at least one occasion in their lifetime. Slightly more than seven percent of students had vaped on 40 or more occasions. Rates at the state level were similar for frequency occasions of vaping nicotine in their lifetime. The percentage of students vaping nicotine during the past 30 days was lower in the service area and the state (12.6 percent compared to 11.4 percent, respectively). However, in the LSFHS service area, 3.1 percent of students reported vaping on 40 or more occasions during the past 30 days as compared to 2.4 percent in the state.

The percentage of students who did not consume alcoholic beverages on any occasions in their lifetime ranged from 60.5 percent in 2016 to 63.5 percent in 2020, which is slightly lower than the state percentage of 64.7 percent. For those who did consume alcoholic beverages on one to two occasions, the percentage ranged from a low of 14.4 percent to a high of 15 percent from 2016 to 2020. In the LSFHS service area, the percentages of students in 2020 consuming alcohol on more than two occasions ranged from 7.8 percent for three to five occasions to 2.7 percent for those consuming alcohol on at least 40 occasions. The LSFHS service area consumption percentages closely mirrored those of the state.

High school students were asked for the number of occasions in their lifetime when they had woken up after a night of drinking alcohol and were unable to remember the things they did or the places they went. The percentage of students reporting this event happening on at least one to two occasions in their lifetime (2020) in the ME service area and the state was 7.9 percent and 7.4 percent, respectively. When looking at previous reported data, this was a decrease from the percentages reported in 2016 for the ME service area and the state. In 2020, 84.5 percent of students in the service area reported never having had this experience, compared to the state at 86.2 percent.

The percentages of students living in the ME service area not consuming alcohol during the past 30 days increased from 80.7 percent in 2016 to 84.2 percent in 2020. The increase at the state level was higher when comparing percentages from 2016 (81.7 percent) to 2020, at 85.2 percent. The percentages of students who reported consuming alcohol on one to two occasions during the past 30 days decreased in the ME Service area and state from 2016-2020.

The overall percentage of those binge drinking, defined as consuming five or more alcoholic drinks in a row in the past two weeks, varied from eight percent in 2016 to 7.1 percent in 2018, and 7.7 percent in 2020. Florida experienced a decrease in the percentage of students who participated in binge drinking from 7.7 percent to 6.7 percent in 2020.

The percentages of students who have not used marijuana in their lifetimes has varied over the past four years in the LSFHS service area (77.7 percent in 2016, 78.7 percent in 2019 and 77.2 percent in 2020) while the state percentage has increased from 78.7 percent in 2016 to 79.9 percent in 2020. For those who did use marijuana on one to more than 40 occasions in their lifetime, the overall percentages decreased in the LSFHS service area from 6.7 percent in 2016 to 6.6 percent in 2020. At the state level, the rate decreased from 2016 (6.2 percent) to 2020 (5.5 percent). The percentages of students not using marijuana in the past 30 days was higher when compared to those who reported not using it in their lifetime. The percentages of students in the LSFHS service area and state who reported using marijuana in the past 30 days on one or more occasions, was 12.3 percent and 10.7 percent in 2020, respectively. The percentages of students who reported vaping marijuana in their lifetimes on one or more occasions was higher in the ME service area at 16.6 percent when compared to the state at 15.6 percent. This was also true when comparing the two groups of students who had vaped marijuana in the past 30 days. In the ME service area, eight percent of students had vaped marijuana in the past 30 days compared to 7.3 percent of students in the state.

Disability

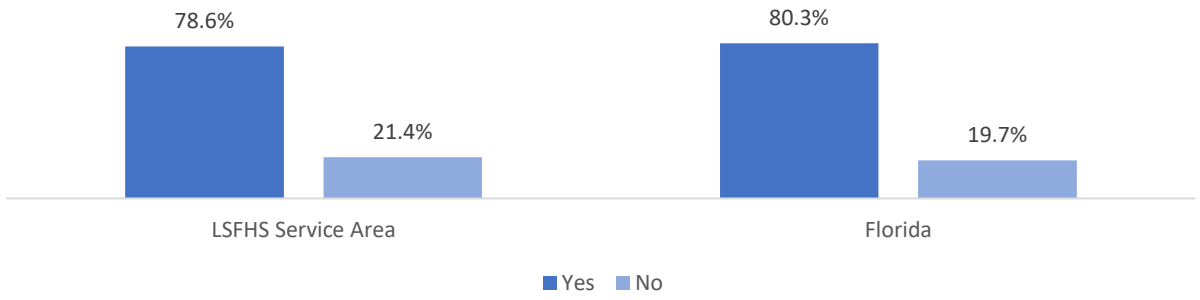
In the ME service area, 15.7 percent of the noninstitutionalized population is estimated to have a disability, which includes hearing, vision, cognitive, ambulatory, self-care, and independent living. At the state level, 13.6 percent of residents had a disability. The percentages of those with a disability were much higher among older adults, ages 65 years and older, at 48.3 percent for the LSFHS service area and the state.

Health Insurance Coverage

Most residents, ages 18-64 years, living in the LSFHS service area and state reported having some type of health insurance coverage. The percentage of those with insurance in the LSFHS service area was slightly higher when compared to the state at 85.4 percent and 84.2 percent, respectively.

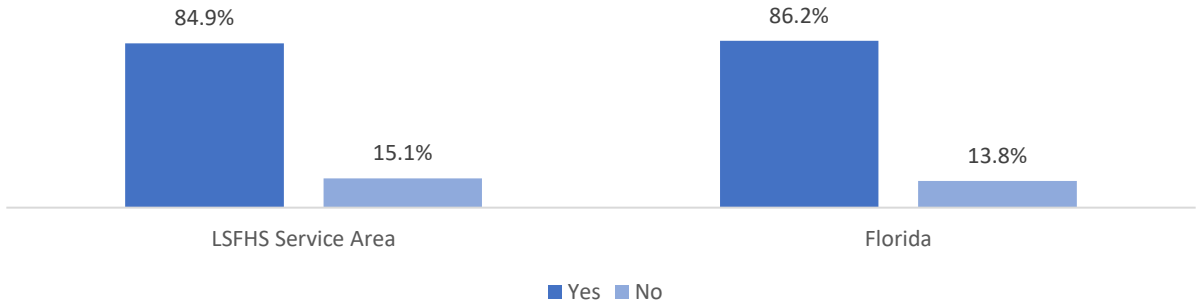
GENERAL HEALTH STATUS CHARTS

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



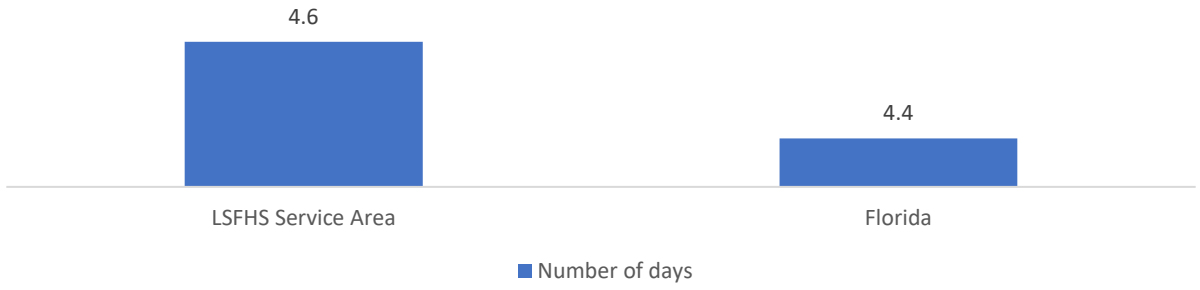
Source: Behavioral Risk Factor Surveillance System

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



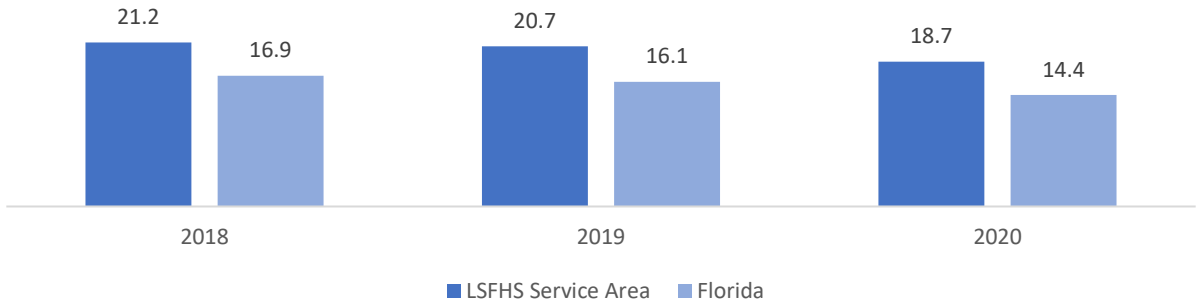
Source: Behavioral Risk Factor Surveillance System

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



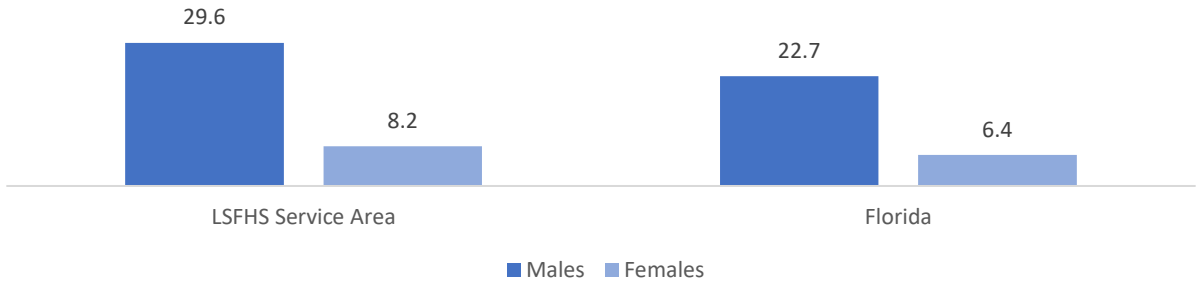
Source: Behavioral Risk Factor Surveillance System

Figure 13: LSFHS Service Area Crude Suicide Death Rates (2018-2020)



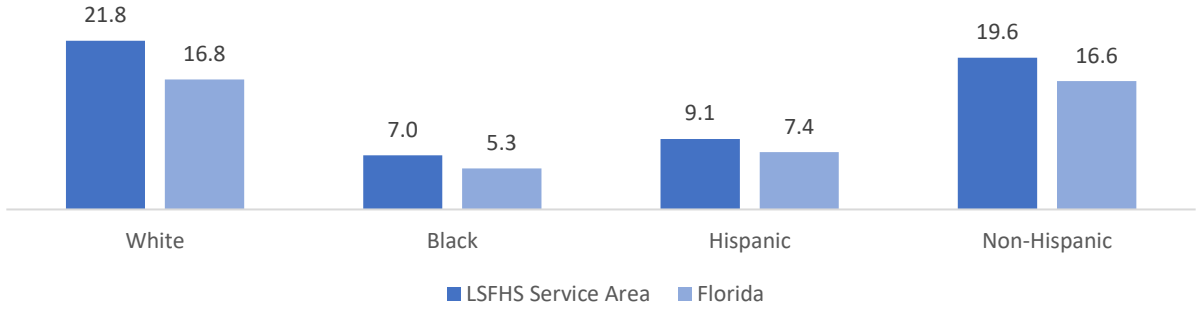
Source: Florida Department of Health, Bureau of Vital Statistics, Rate per 100,000

Figure 14: LSFHS Service Area Crude Suicide Death Rates by Gender (2020)



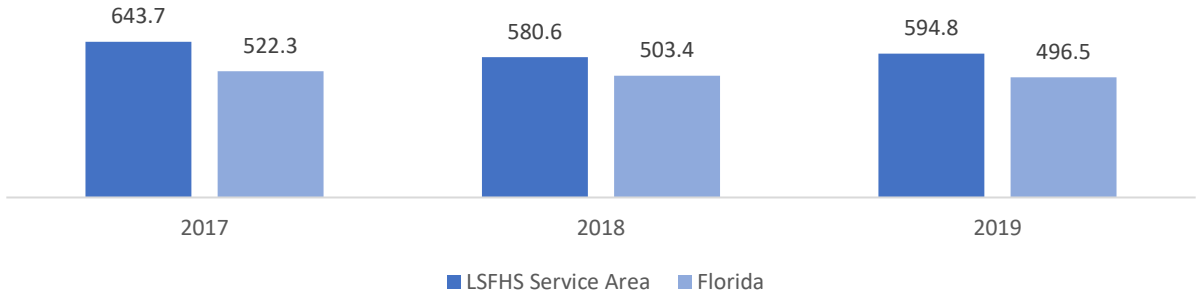
Source: Florida Department of Health, Bureau of Vital Statistics, Rate per 100,000

Figure 15: LSFHS Service Area Crude Suicide Death Rates by Race and Ethnicity (2020)



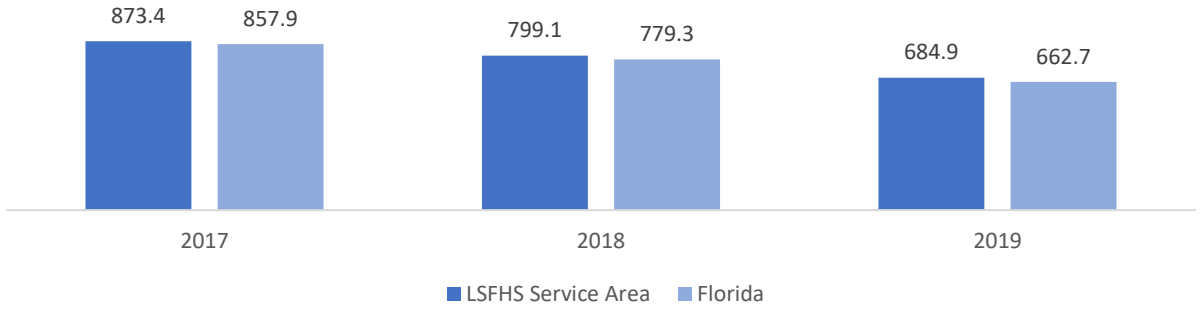
Source: Florida Department of Health, Bureau of Vital Statistics, Rate per 100,000

Figure 16: LSFHS Service Area Total Domestic Violence Offenses (2017-2019)



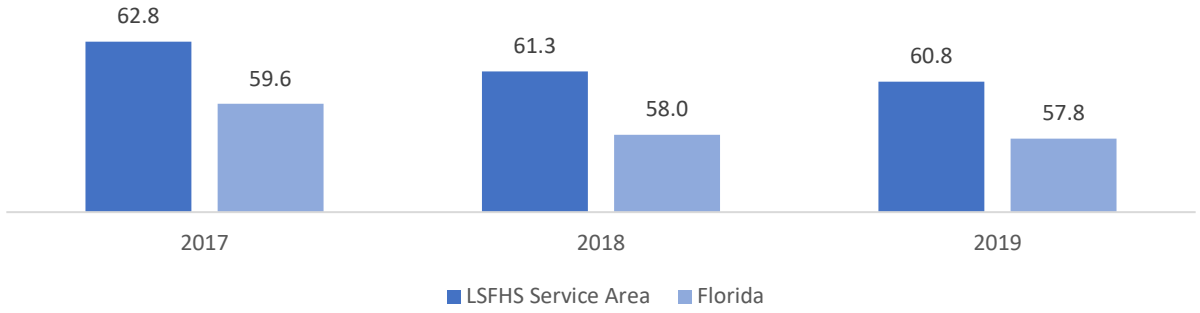
Source: Florida Department of Law Enforcement, Crime in Florida, Uniform Crime Report 2019, Rate per 100,000

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



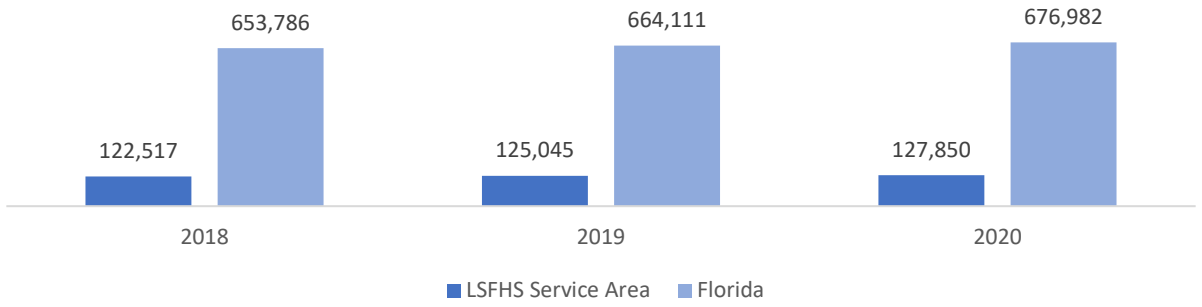
Source: Department of Children and Families, Florida Safe Families Network Data Mart, Rate per 100,000

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



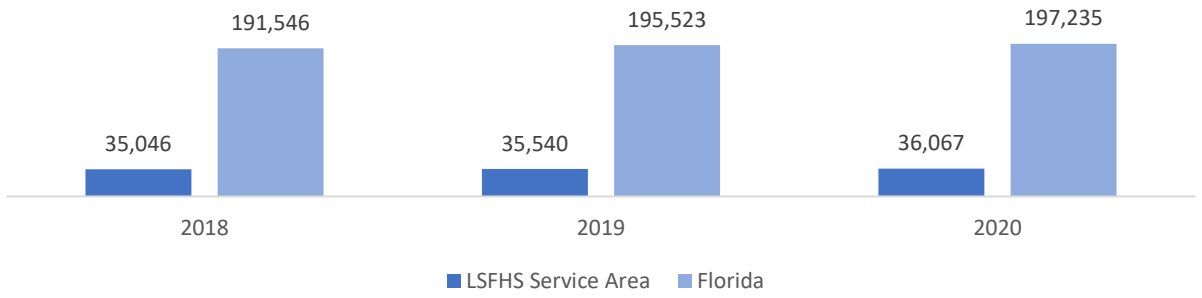
Source: Department of Children and Families, Florida Safe Families Network Data Mart, Rate per 100,000

Figure 19: LSFHS Service Area Estimated Number of Seriously Mentally Ill Adults (2018-2020)



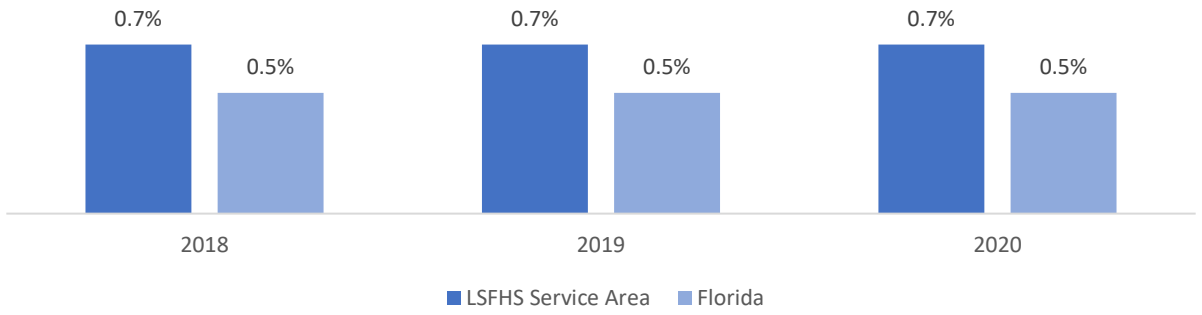
Source: Estimates based on Department of Health and Human Resource Report Mental Health U.S. 1995

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



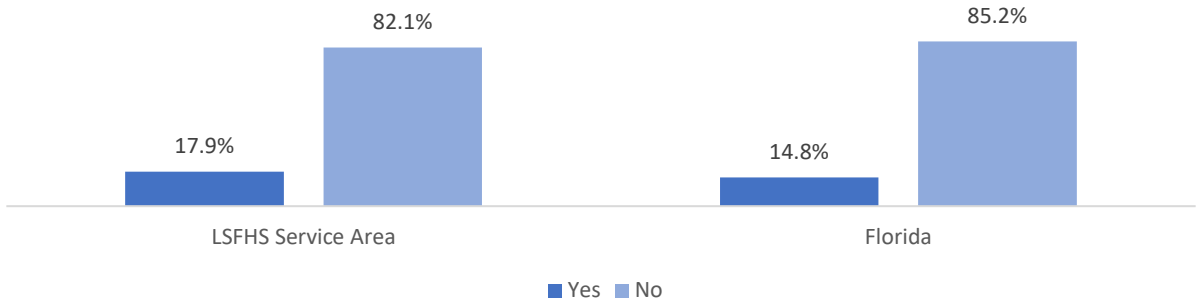
Source: Estimates based on Department of Health and Human Resource Report Mental Health U.S. 1995

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



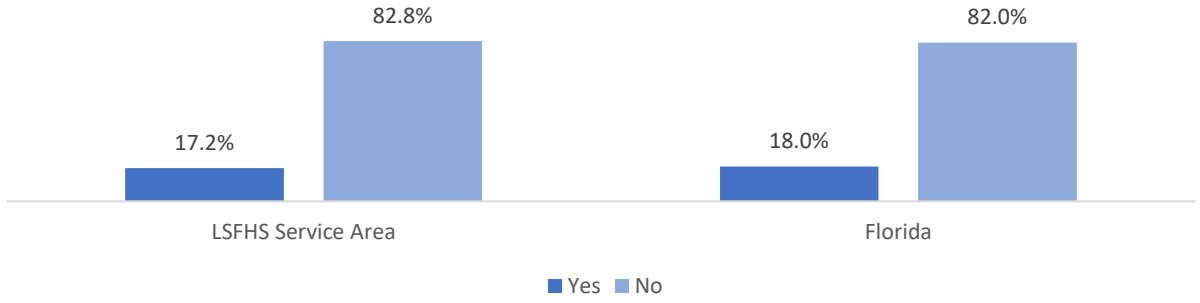
Source: Florida Department of Education, Education Information and Accountability Services (EIAS)

Figure 22: LSFHS Service Area Percentage of Adults Who Are Current Smokers (2017-2019)



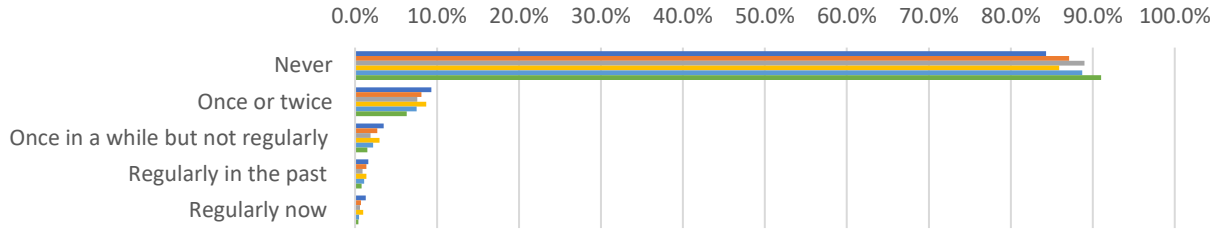
Source: Behavioral Risk Factor Surveillance System

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



Source: Behavioral Risk Factor Surveillance System

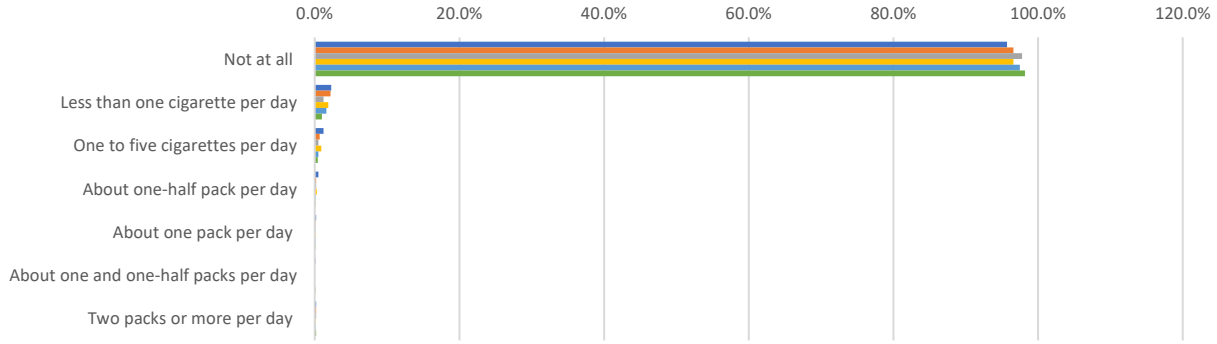
Figure 24: LSFHS Service Area Having Ever Smoked Cigarettes (MS&HS 2016-2020)



	Regularly now	Regularly in the past	Once in a while but not regularly	Once or twice	Never
LSFHS Service Area 2016	1.3%	1.6%	3.5%	9.3%	84.3%
LSFHS Service Area 2018	0.7%	1.4%	2.7%	8.1%	87.1%
LSFHS Service Area 2020	0.6%	0.9%	1.9%	7.6%	89.0%
Florida 2016	1.0%	1.4%	3.0%	8.7%	85.9%
Florida 2018	0.5%	1.1%	2.2%	7.5%	88.7%
Florida 2020	0.4%	0.8%	1.5%	6.3%	91.0%

Source: Florida Youth Substance Abuse Survey

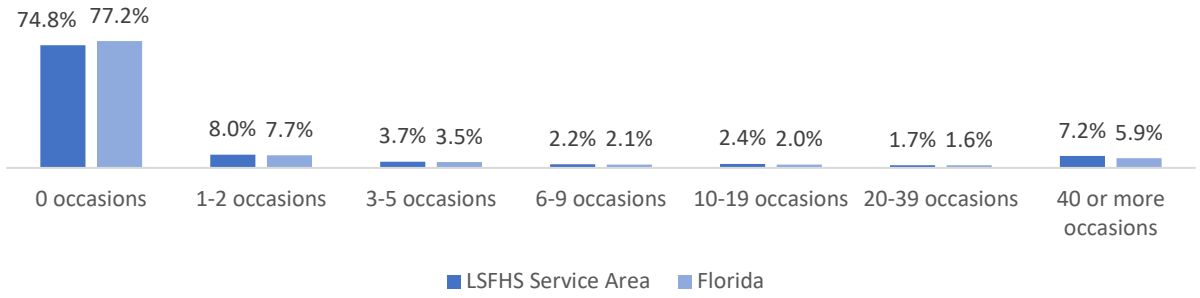
Figure 25: LSFHS Service Area – How Frequently Have You Smoked Cigarettes in the Past 30 Days? (MS&HS 2016-2020)



	Two packs or more per day	About one and one-half packs per day	About one pack per day	About one-half pack per day	One to five cigarettes per day	Less than one cigarette per day	Not at all
LSFHS Service Area 2016	0.2%	0.1%	0.2%	0.5%	1.2%	2.3%	95.7%
LSFHS Service Area 2018	0.2%	0.0%	0.1%	0.2%	0.7%	2.2%	96.6%
LSFHS Service Area 2020	0.2%	0.0%	0.1%	0.2%	0.5%	1.2%	97.8%
Florida 2016	0.1%	0.0%	0.1%	0.3%	0.9%	1.9%	96.6%
Florida 2018	0.1%	0.0%	0.1%	0.1%	0.5%	1.6%	97.5%
Florida 2020	0.2%	0.1%	0.1%	0.1%	0.4%	1.0%	98.2%

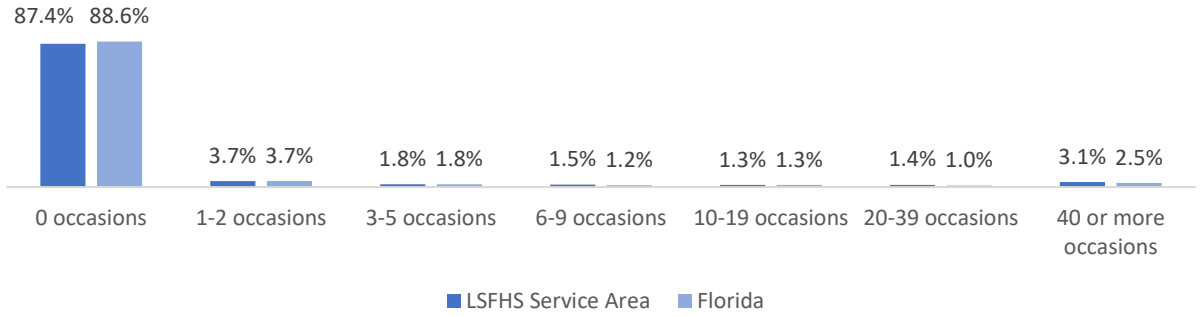
Source: Florida Youth Substance Abuse Survey

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



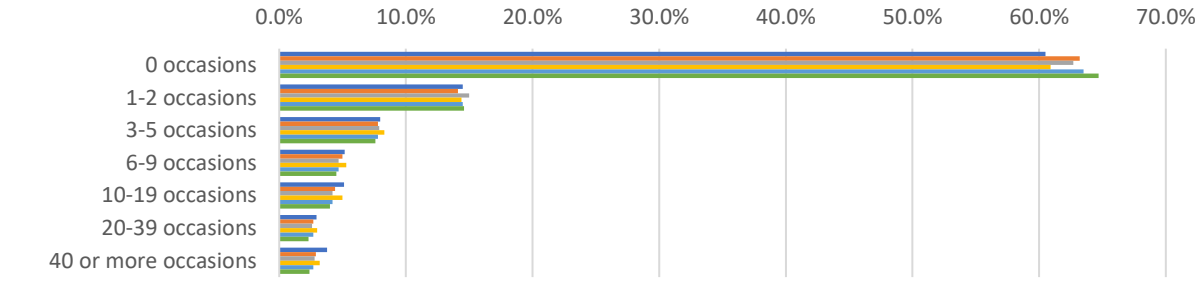
Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

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



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

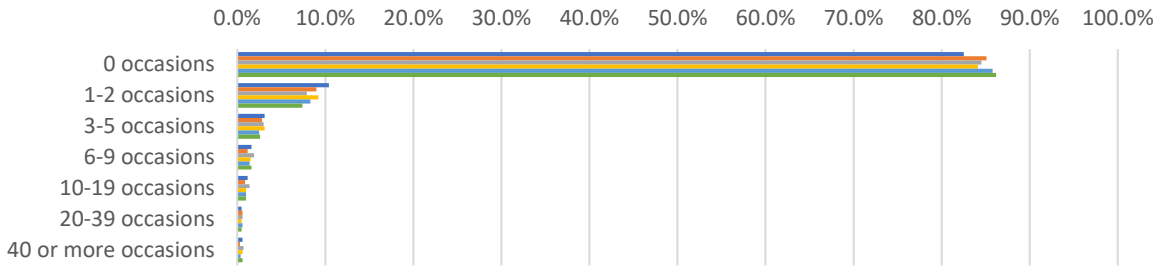
Figure 28: LSFHS Service Area – On How Many Occasions Have You Had Alcoholic Beverages to Drink in Your Lifetime? (MS&HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
LSFHS Service Area 2016	3.8%	2.9%	5.1%	5.2%	8.0%	14.5%	60.5%
LSFHS Service Area 2018	2.9%	2.7%	4.4%	5.0%	7.8%	14.1%	63.2%
LSFHS Service Area 2020	2.8%	2.6%	4.2%	4.7%	7.9%	15.0%	62.7%
Florida 2016	3.2%	3.0%	5.0%	5.3%	8.3%	14.4%	60.9%
Florida 2018	2.7%	2.7%	4.2%	4.7%	7.8%	14.5%	63.5%
Florida 2020	2.4%	2.3%	4.0%	4.5%	7.6%	14.6%	64.7%

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

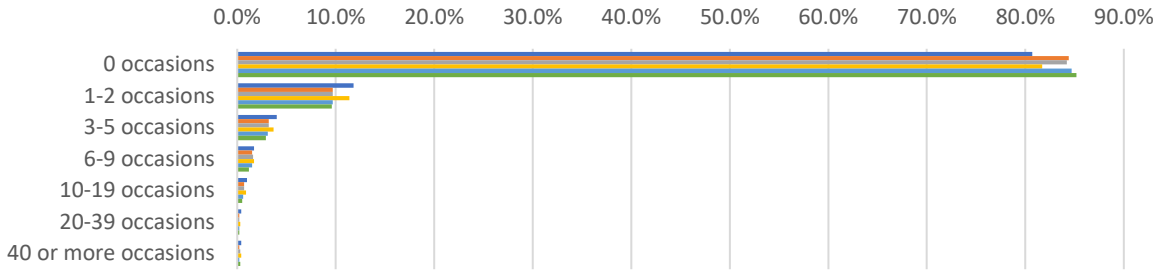
Figure 29: LSFHS Service Area – On How Many Occasions in Your Lifetime Have You Woken Up After a Night of Drinking Alcoholic Beverages and Not Been Able to Remember Things You Did or the Places You Went? (HS Only 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
LSFHS Service Area 2016	0.6%	0.5%	1.2%	1.6%	3.1%	10.4%	82.5%
LSFHS Service Area 2018	0.3%	0.6%	0.9%	1.2%	2.8%	9.0%	85.1%
LSFHS Service Area 2020	0.7%	0.6%	1.4%	1.9%	3.0%	7.9%	84.5%
Florida 2016	0.6%	0.5%	1.0%	1.5%	3.1%	9.2%	84.1%
Florida 2018	0.4%	0.6%	1.0%	1.4%	2.5%	8.3%	85.8%
Florida 2020	0.6%	0.5%	1.0%	1.6%	2.6%	7.4%	86.2%

Source: Florida Youth Substance Abuse Survey

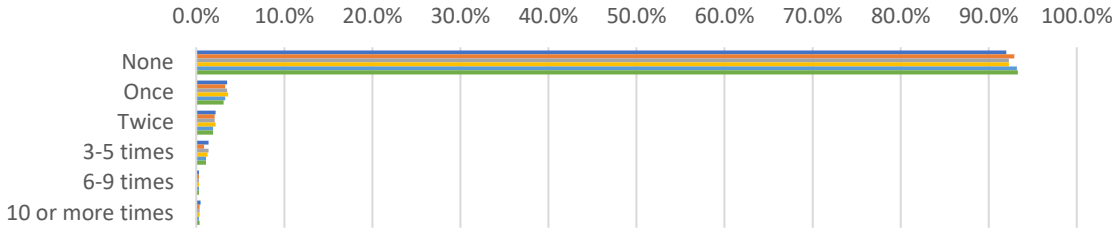
Figure 30: LSFHS Service Area – On How Many Occasions Have You Had Beer, Wine, or Hard Liquor in the Past 30 Days? (MS&HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
LSFHS Service Area 2016	0.4%	0.4%	1.0%	1.7%	4.0%	11.8%	80.7%
LSFHS Service Area 2018	0.2%	0.2%	0.7%	1.5%	3.2%	9.7%	84.4%
LSFHS Service Area 2020	0.3%	0.2%	0.7%	1.6%	3.2%	9.7%	84.2%
Florida 2016	0.4%	0.3%	0.9%	1.7%	3.7%	11.4%	81.7%
Florida 2018	0.2%	0.2%	0.6%	1.5%	3.1%	9.7%	84.7%
Florida 2020	0.3%	0.2%	0.5%	1.2%	2.9%	9.6%	85.2%

Source: Florida Youth Substance Abuse Survey

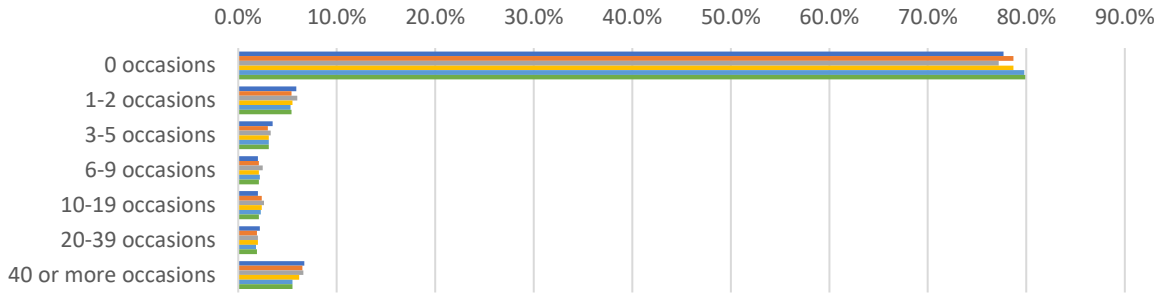
Figure 31: LSFHS Service Area – Think Back Over the Past 2 Weeks...How Many Times Have You Had Five or More Alcoholic Drinks in a Row? (MS&HS 2016-2020)



	10 or more times	6-9 times	3-5 times	Twice	Once	None
LSFHS Service Area 2016	0.5%	0.3%	1.4%	2.2%	3.5%	92.0%
LSFHS Service Area 2018	0.4%	0.3%	0.9%	2.1%	3.3%	92.9%
LSFHS Service Area 2020	0.4%	0.3%	1.4%	2.1%	3.5%	92.3%
Florida 2016	0.4%	0.3%	1.3%	2.2%	3.6%	92.3%
Florida 2018	0.3%	0.3%	1.1%	1.9%	3.3%	93.2%
Florida 2020	0.4%	0.3%	1.1%	1.9%	3.1%	93.3%

Source: Florida Youth Substance Abuse Survey

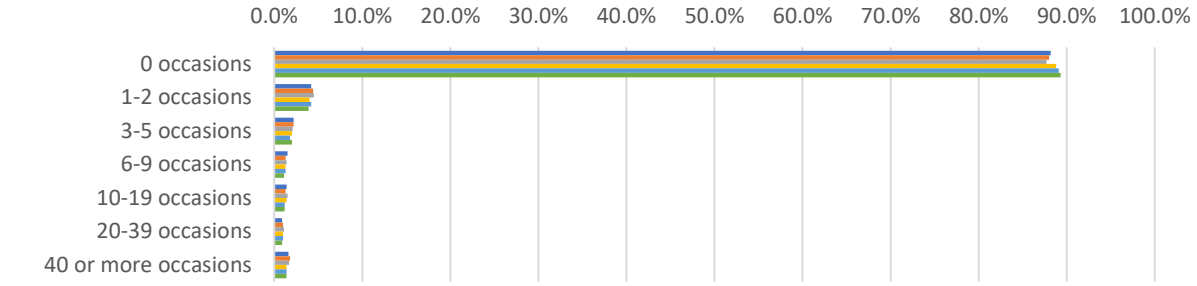
Figure 32: LSFHS Service Area – On How Many Occasions Have You Used Marijuana or Hashish in Your Lifetime? (MS&HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
LSFHS Service Area 2016	6.7%	2.2%	2.0%	2.0%	3.5%	5.9%	77.7%
LSFHS Service Area 2018	6.5%	1.9%	2.4%	2.1%	3.0%	5.4%	78.7%
LSFHS Service Area 2020	6.6%	2.0%	2.6%	2.5%	3.3%	6.0%	77.2%
Florida 2016	6.2%	2.0%	2.4%	2.1%	3.1%	5.5%	78.7%
Florida 2018	5.5%	1.8%	2.3%	2.2%	3.1%	5.3%	79.8%
Florida 2020	5.5%	1.9%	2.1%	2.1%	3.1%	5.4%	79.9%

Source: Florida Youth Substance Abuse Survey

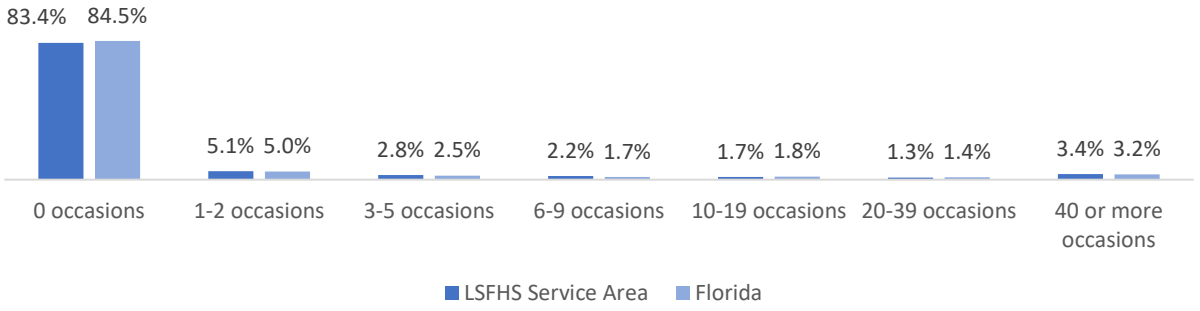
Figure 33: LSFHS Service Area – On How Many Occasions Have You Used Marijuana or Hashish During the Past 30 Days? (MS&HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
LSFHS Service Area 2016	1.6%	0.9%	1.4%	1.5%	2.2%	4.2%	88.2%
LSFHS Service Area 2018	1.8%	1.0%	1.3%	1.3%	2.2%	4.4%	88.0%
LSFHS Service Area 2020	1.7%	1.1%	1.5%	1.4%	2.1%	4.5%	87.7%
Florida 2016	1.4%	1.0%	1.4%	1.3%	2.0%	4.0%	88.8%
Florida 2018	1.4%	1.0%	1.2%	1.3%	1.8%	4.2%	89.1%
Florida 2020	1.4%	0.9%	1.2%	1.1%	2.0%	3.9%	89.3%

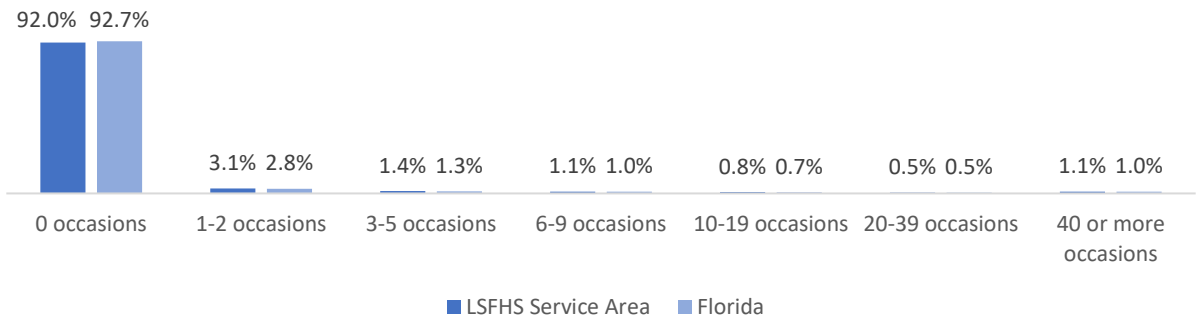
Source: Florida Youth Substance Abuse Survey

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



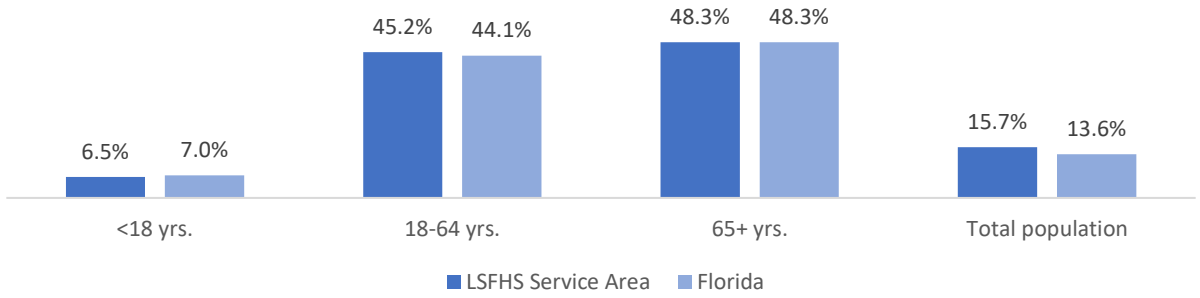
Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

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



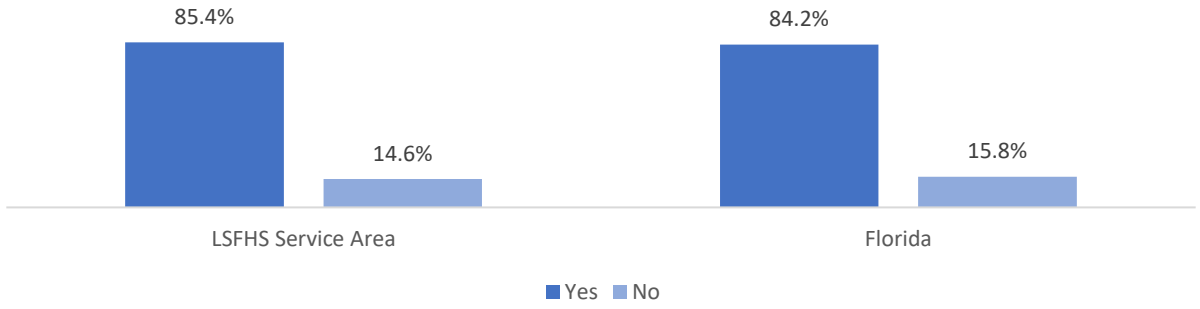
Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

Figure 36: LSFHS Service Area Civilian Noninstitutionalized Population with a Disability (2016-2020)



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

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



Source: Behavioral Risk Factor Surveillance System

LSFHS SERVICE AREA: DEMOGRAPHIC PROFILE OF INDIVIDUALS SERVED

Individuals Receiving Services Population Statistics

LSFHS-funded organizations served 49,928 individuals in FY 2020-2021. This number may include a small amount of duplication in that some people moved from one county to another, were enrolled in more than one program or changed residential status during the one-year time frame. Over 22 percent of people served resided in Volusia County (11,185 individuals), followed by Duval County at 19.5 percent (9,756 individuals), Marion County at 8.6 percent (4,290 individuals), and Clay County at 6.9 percent (3,445 individuals). People who reported living in another county accounted for 2.7 percent of all persons served.

Adults in LSFHS programs accounted for 86.5 percent of all persons served with 53.2 percent enrolled in the Adult Mental Health (AMH) program and 33.3 percent in the Adult Substance Abuse program (ASA). The remaining individuals were in the Child Mental Health (CMH) program at 9.4 percent and the Child Substance Abuse (CSA) program at 4.1 percent.

Gender

Males represented 50.1 percent of people served in the AMH program, 51.7 percent in the ASA program, 50.4 percent in the CMA program, and 68.3 percent in the CSA program. Females accounted for 49.9 percent persons served in AMH program and 49.6 percent of those in the CMH program. Females accounted for 48.3 percent in the ASA program and 31.7 percent in the CSA program.

Race

The majority of persons served were White (71.8 percent), which was a little lower than the percentage in the service area population at 75.2 percent. Conversely, Black LSFHS individuals accounted for 16.8 percent of the those served while representing 15.9 percent of the population in the 23-county service area. The percentage of Multi-Racial individuals in adult programs (ranged from 3.1 percent to 3.8 percent) were lower when compared to the service area (4.2 percent). Among child programs, the percentages of multi-racial individuals were higher (ranged from 4.4 percent to 6.6 percent) when compared to the service area.

Ethnicity

The percentage of Hispanics in the LSFHS population at eight percent, was less when compared to the percentage of the Hispanic population in the service area at 11 percent. The percentage of Hispanic individuals in all LSFHS programs ranged from 7.4 percent to 9.8 percent. Individuals identifying as “Other Hispanic” and “Puerto Rican” received more services than those identifying as Cuban, Haitian, Mexican, Mexican American, and Spanish/Latino.

Age Range

As expected, the age range distribution among individuals served by LSFHS providers did not mimic that of the service area population. Adults, ages 25-44 years of age, accounted for 48.6 percent of all individuals served. Those younger than 20 years of age represented 15.7 percent of those served. Adults, ages 25-44 years of age, accounted for 49.7 percent of those who participated in AMH programs and 66.4 percent of those who participated ASA programs. In comparison, adults in this age range represented 23.7 percent of the population in the 23-county area. Conversely, adults ages 65 years and older accounted for a far less percentage of persons served (three percent) when compared to those in the service area population at 22.5 percent. Children under five accounted for 1.1 percent and 0.4 percent of participants in the CMH and CSA programs, respectively. There was a higher percentage of older teens, ages 15-19 years of age, in the CSA program (62.6 percent) when compared to those in the CMH program (32.4 percent).

Residential Status

The percentage of individuals living independently-alone was higher for those in AMH programs (40.2 percent) as compared to those participating in ASA program (34.9 percent). Individuals living independently-with relatives was similar for AMH and ASA programs. People participating in AMH programs were more likely to experience homelessness than those participating in ASA programs (6.9 percent compared to 5.1 percent, respectively), however, residential status was missing for 17.4 percent of individuals in AMH programs and 20.4 percent of those in ASA programs. Residential status for children was missing for 79.2 percent of those in CMH programs and 79.8 percent of those in CSA programs.

Educational Attainment

Individuals served by LSFHS providers attained lower educational levels when compared to the general population in the service area. Among adults served, 77.7 percent did not

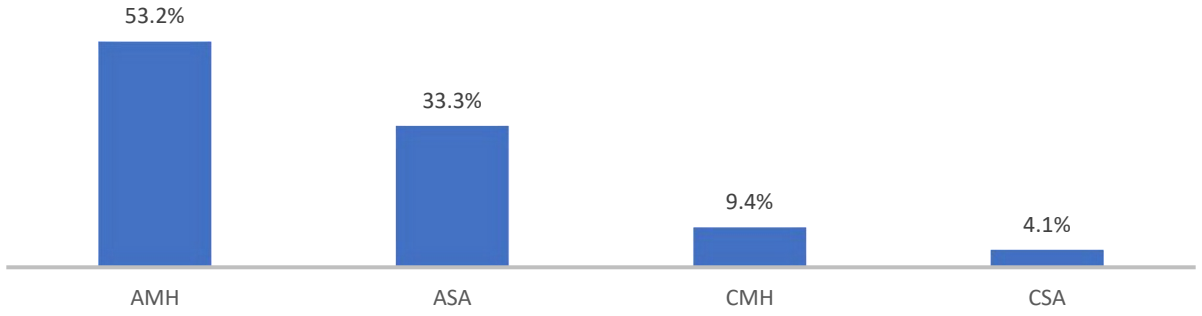
attain more than a high school education, and 23.9 percent of those attained a 9th-12th grade education without receiving a diploma. Only 18.9 percent of the population served by LSFHS providers went on for further education beyond high school. Among the general population in the LSFHS service area, 17.1 percent of adults ages 25 and older have a bachelor's degree compared to 2.9 percent of individuals receiving services from LSFHS providers.

Employment Status

Lower educational attainment was one of several factors that contributed to much higher levels of unemployment among adults served by LSFHS providers when compared to those in the service area. Unemployment ranged from 54.6 percent of those participating in AMH programs to 55.1 percent among those in ASA programs. The five-year estimate for unemployment in the service area was 3.0 percent (2016 to 2020).

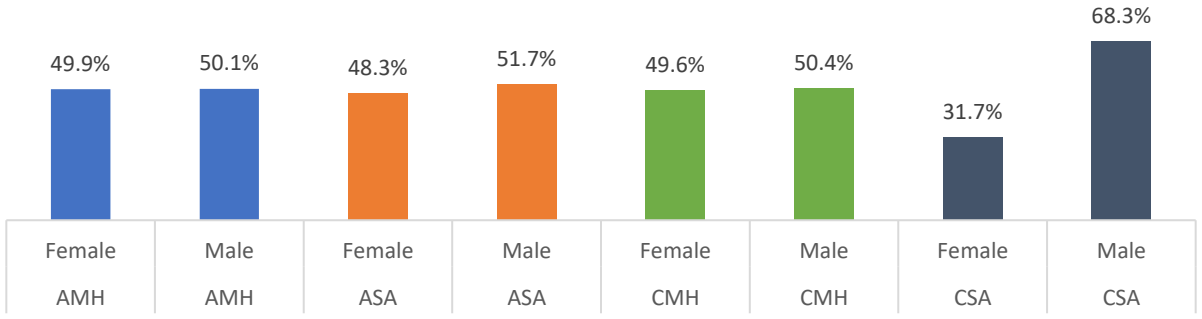
INDIVIDUALS SERVED DEMOGRAPHIC CHARTS

Figure 38: LSFHS Individuals Served by Program



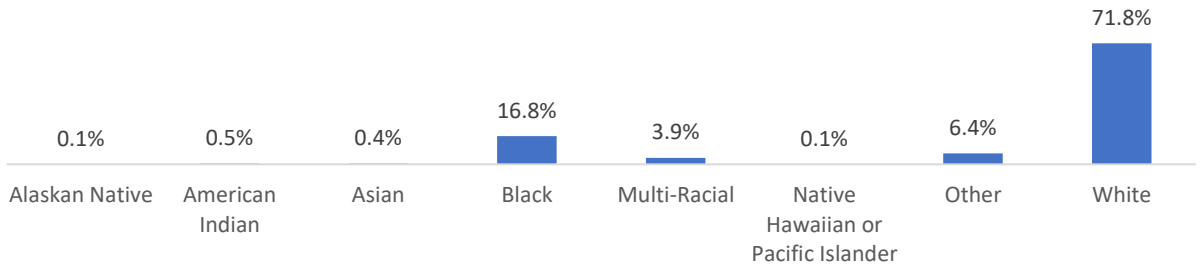
Source: LSFHS Individuals Served Data

Figure 39: LSFHS Individuals Served by Program and Gender



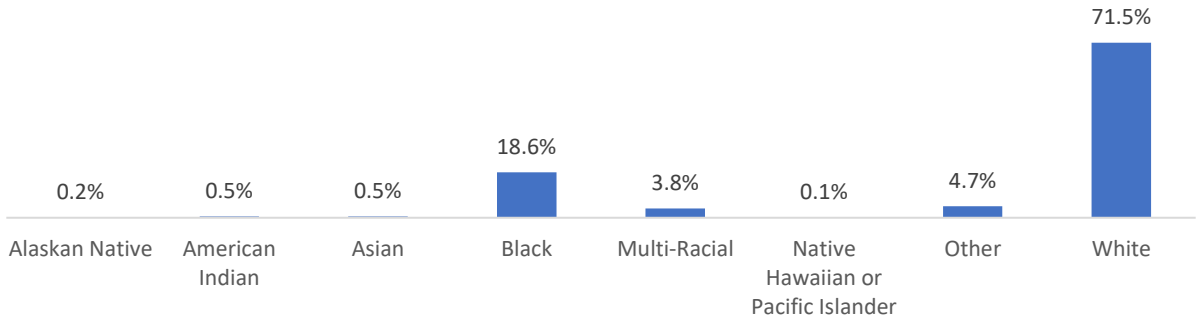
Source: LSFHS Individuals Served Data

Figure 40: LSFHS Individuals Served by Race



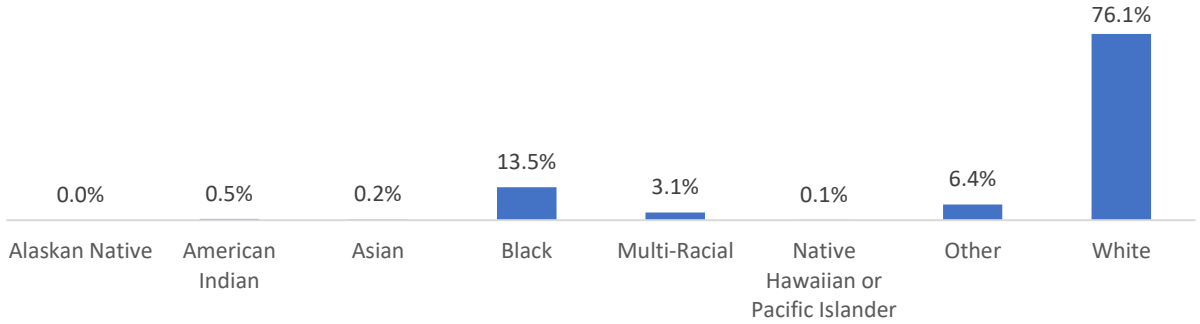
Source: LSFHS Individuals Served Data

Figure 41: LSFHS AMH Individuals Served by Race



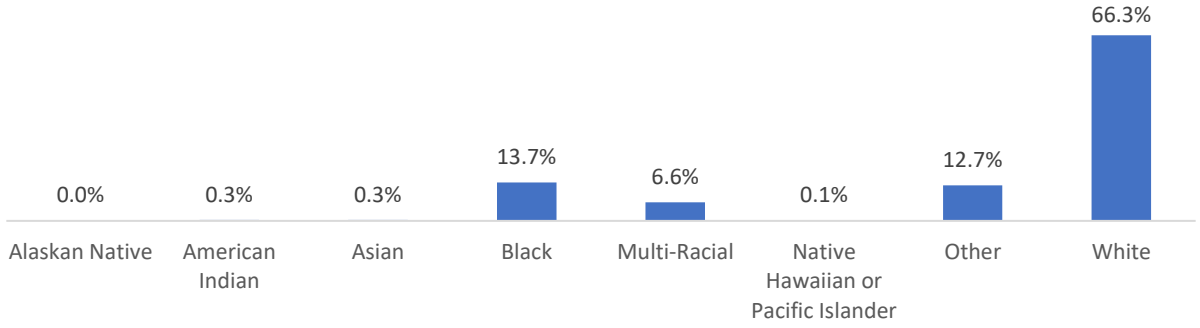
Source: LSFHS Individuals Served Data

Figure 42: LSFHS ASA Individuals Served by Race



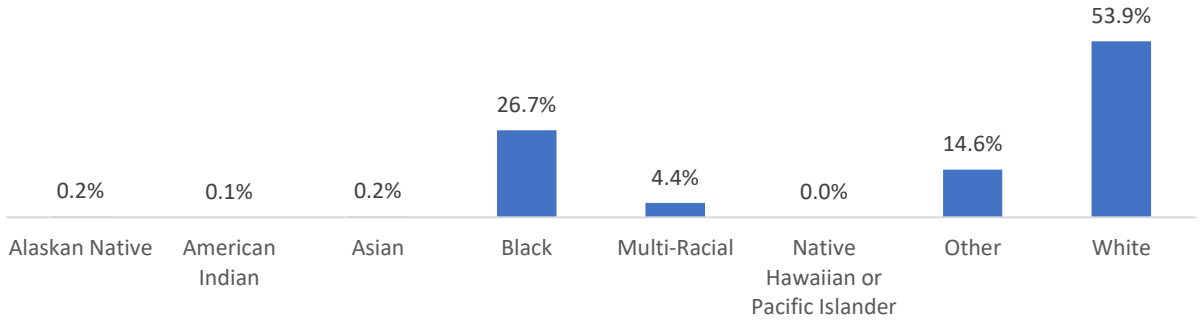
Source: LSFHS Individuals Served Data

Figure 43: LSFHS CMH Individuals Served by Race



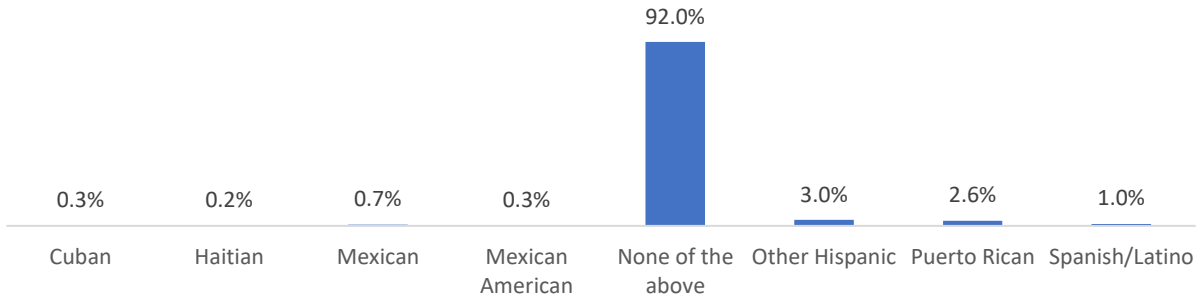
Source: LSFHS Individuals Served Data

Figure 44: LSFHS CSA Individuals Served by Race



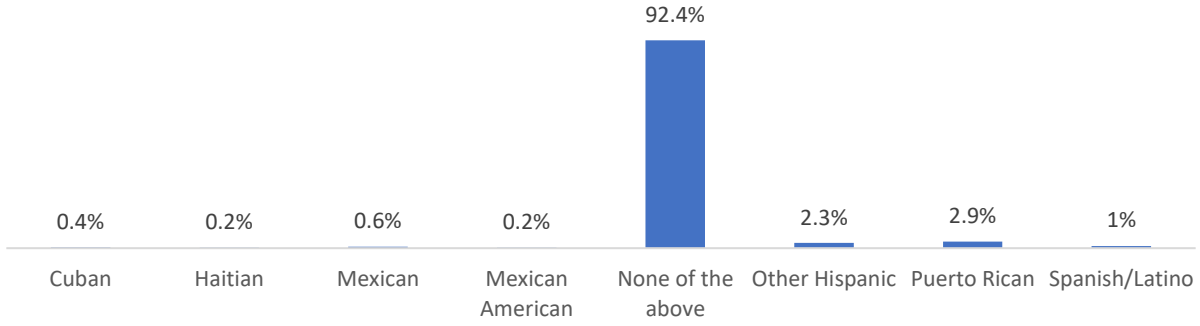
Source: LSFHS Individuals Served Data

Figure 45: LSFHS Individuals Served by Ethnicity



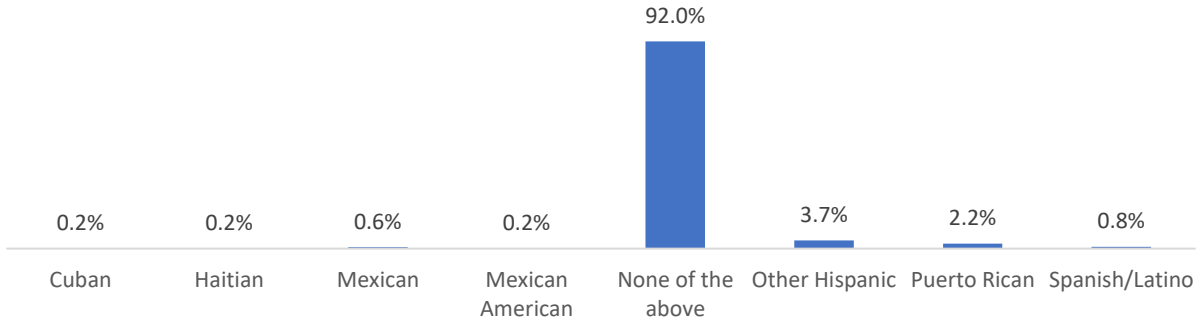
Source: LSFHS Individuals Served Data

Figure 46: LSFHS AMH Individuals Served by Ethnicity



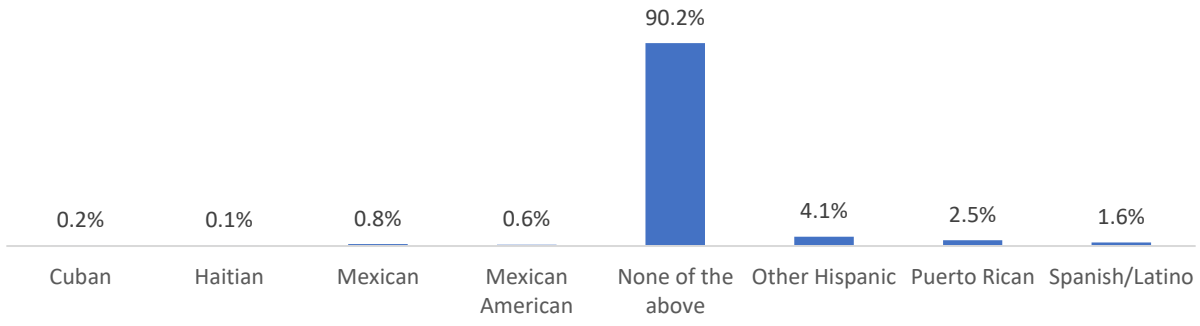
Source: LSFHS Individuals Served Data

Figure 47: LSFHS ASA Individuals Served by Ethnicity



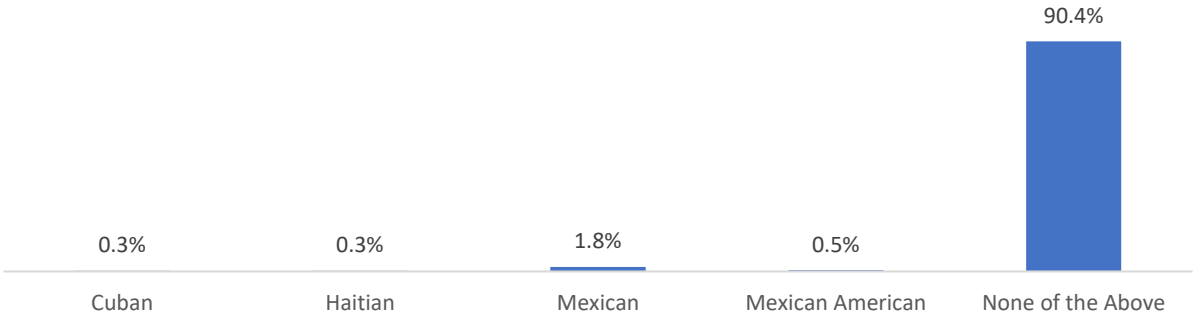
Source: LSFHS Individuals Served Data

Figure 48: LSFHS CMH Individuals Served by Ethnicity



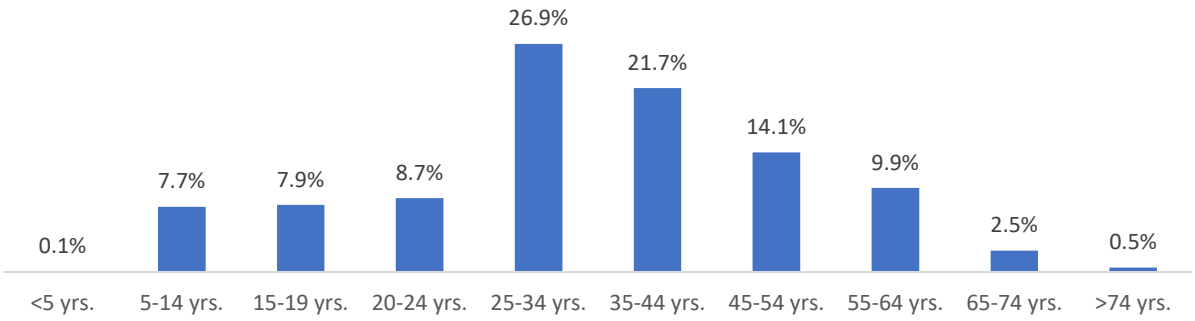
Source: LSFHS Individuals Served Data

Figure 49: LSFHS CSA Individuals Served by Ethnicity



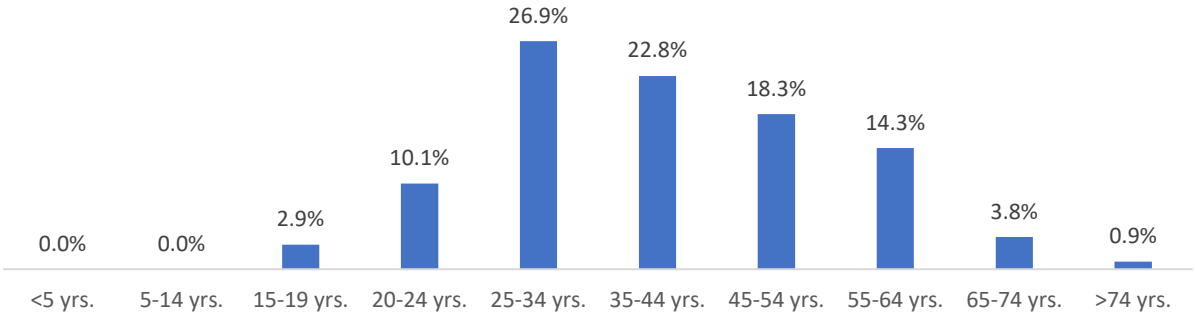
Source: LSFHS Individuals Served Data

Figure 50: LSFHS Individuals Served by Age Range



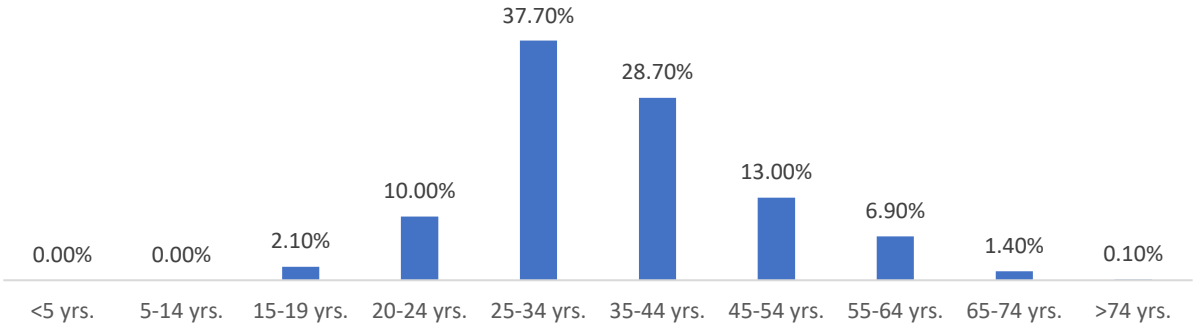
Source: LSFHS Individuals Served Data

Figure 51: LSFHS AMH Individuals Served by Age Range



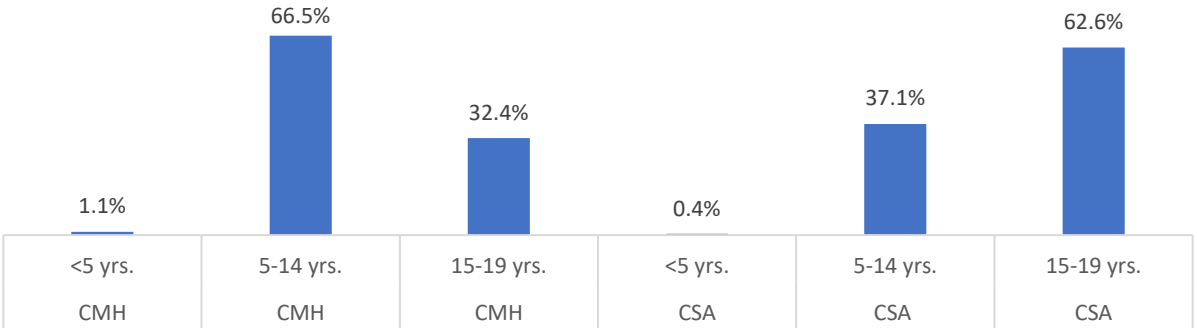
Source: LSFHS Individuals Served Data

Figure 52: LSFHS ASA Individuals Served by Age Range



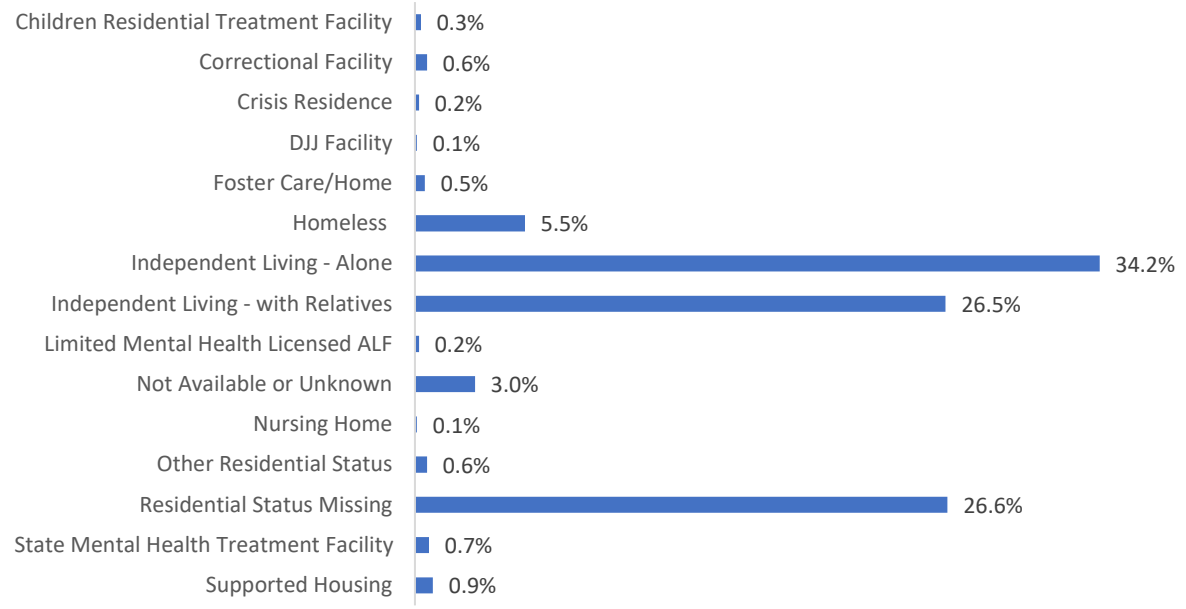
Source: LSFHS Individuals Served Data

Figure 53: LSFHS CMH and CSA Individuals Served by Age Range



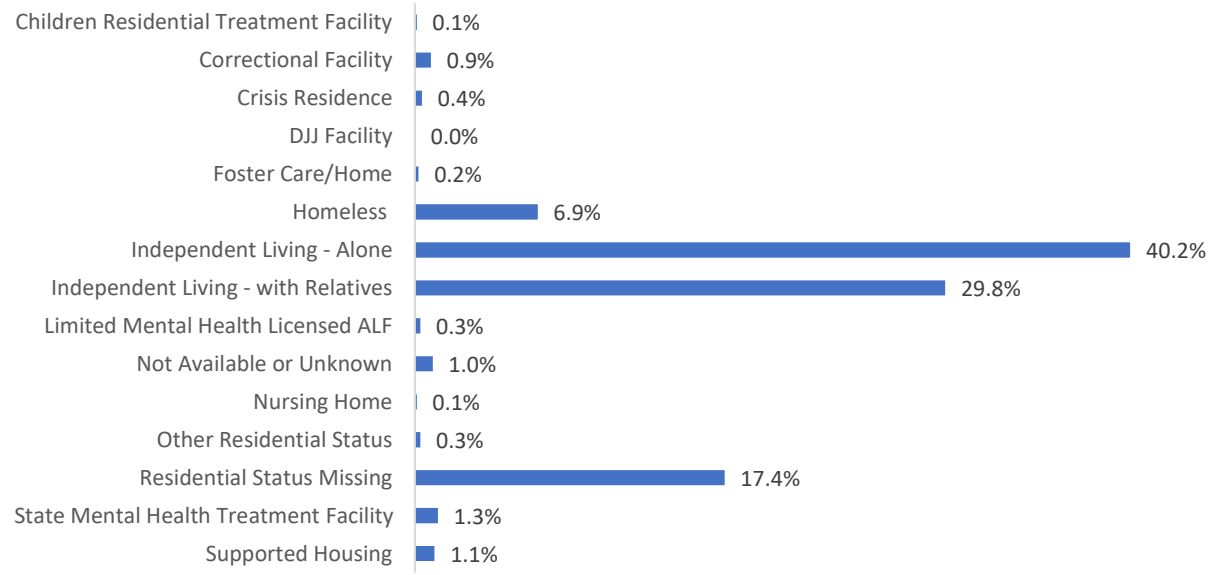
Source: LSFHS Individuals Served Data

Figure 54: LSFHS Individuals Served by Residential Status



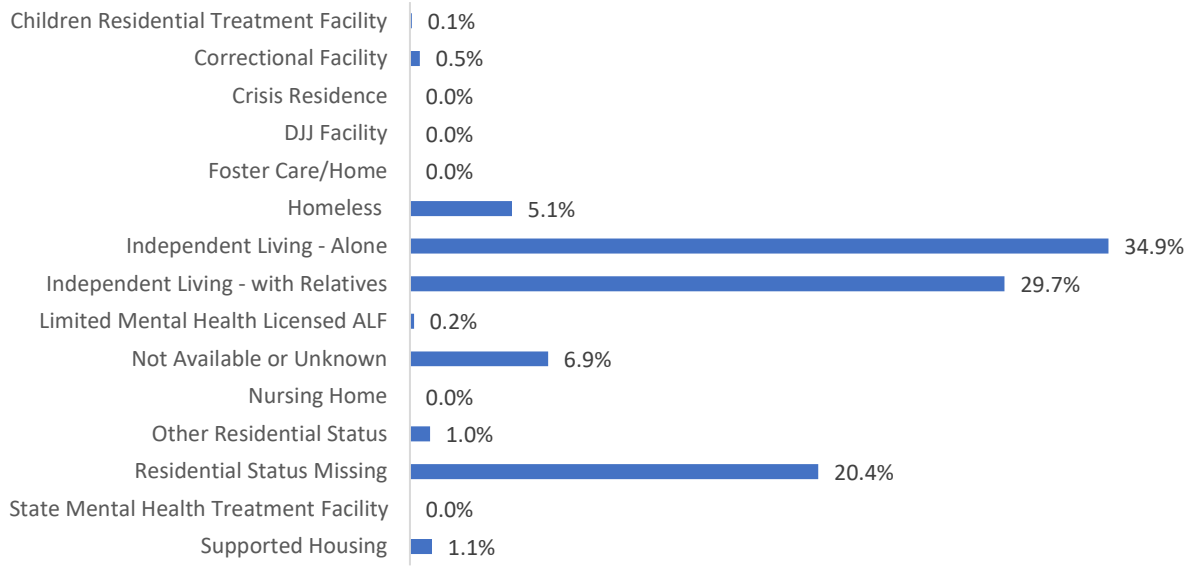
Source: LSFHS Individuals Served Data

Figure 55: LSFHS AMH Individuals Served by Residential Status



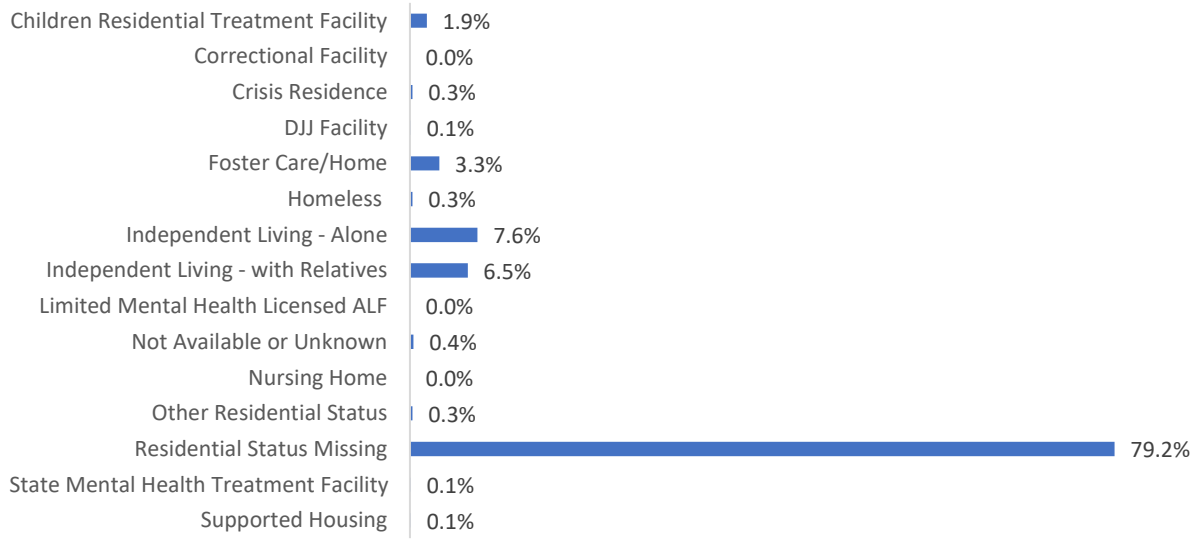
Source: LSFHS Individuals Served Data

Figure 56: LSFHS ASA Individuals Served by Residential Status



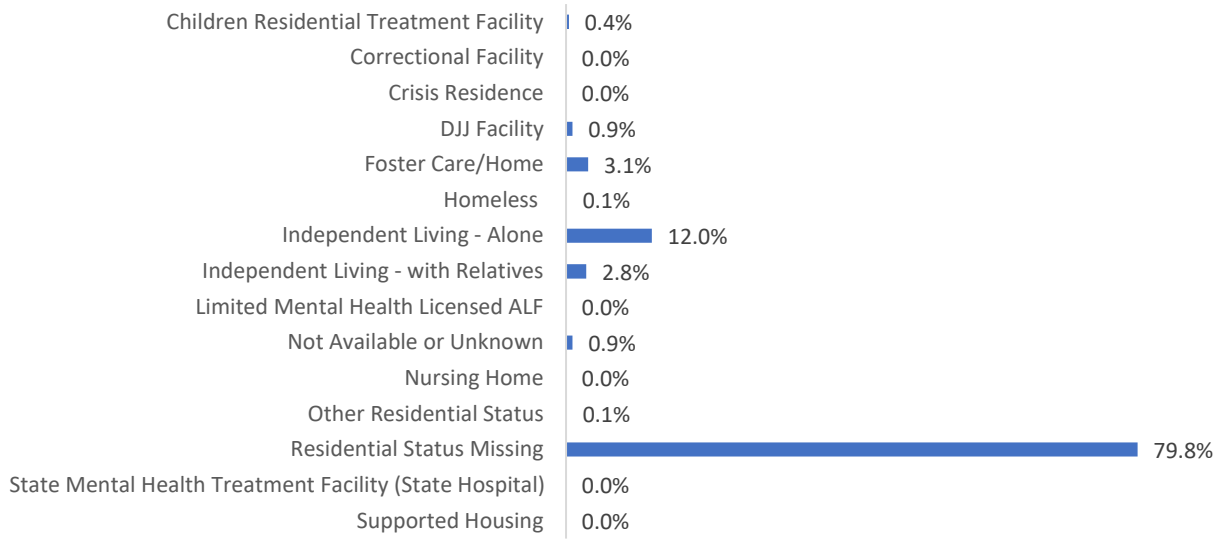
Source: LSFHS Individuals Served Data

Figure 57: LSFHS CMH Individuals Served by Residential Status



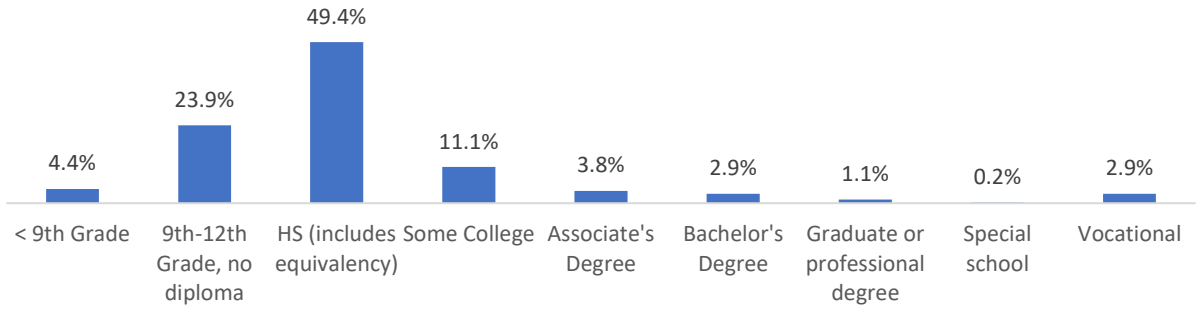
Source: LSFHS Individuals Served Data

Figure 58: LSFHS CSA Individuals Served by Residential Status



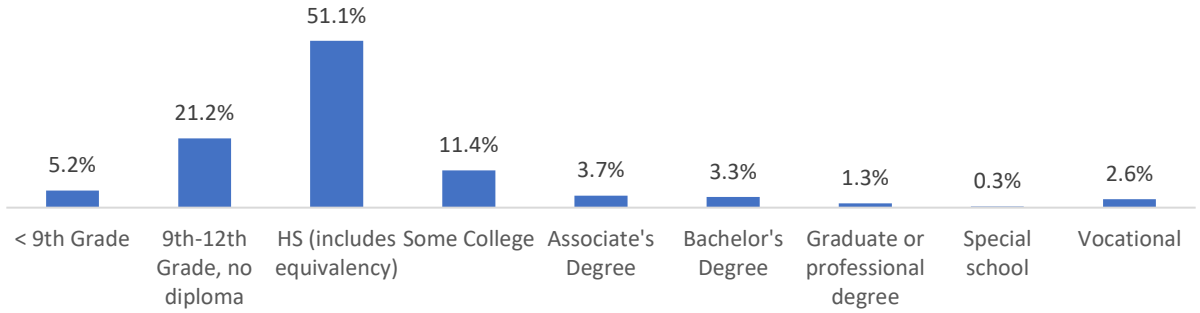
Source: LSFHS Individuals Served Data

Figure 59: LSFHS Individuals Served by Educational Attainment



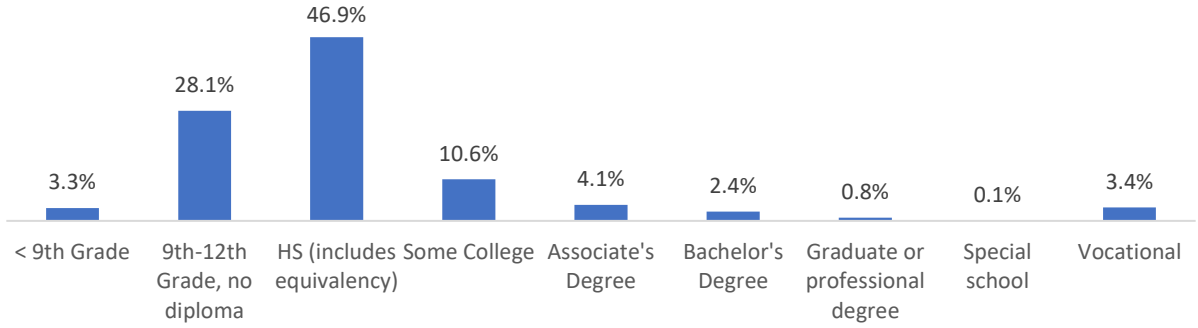
Source: LSFHS Individuals Served Data

Figure 60: LSFHS AMH Individuals Served by Educational Attainment



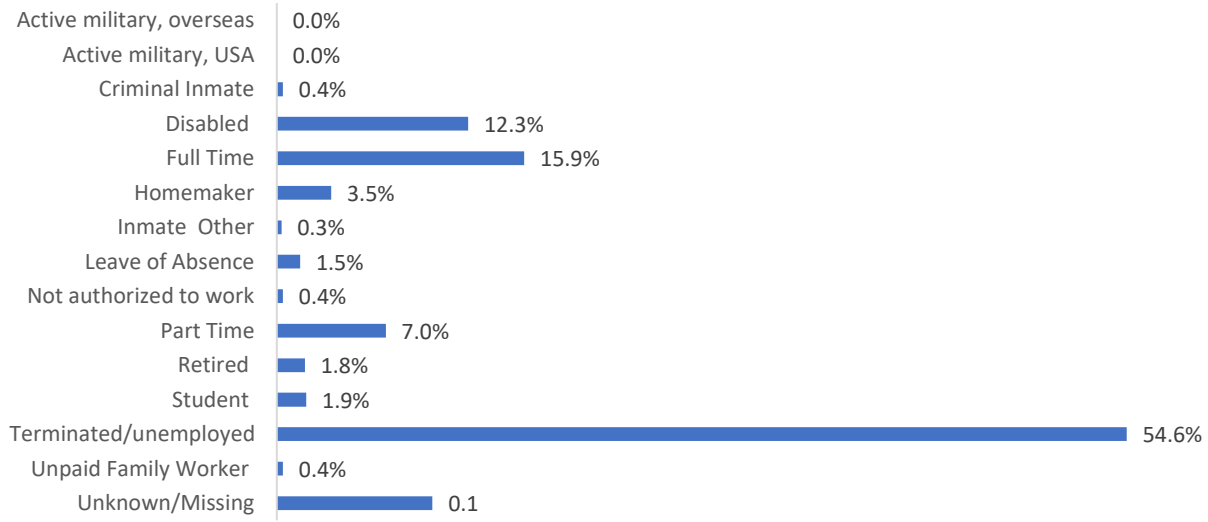
Source: LSFHS Individuals Served Data

Figure 61: LSFHS ASA Individuals Served by Educational Attainment



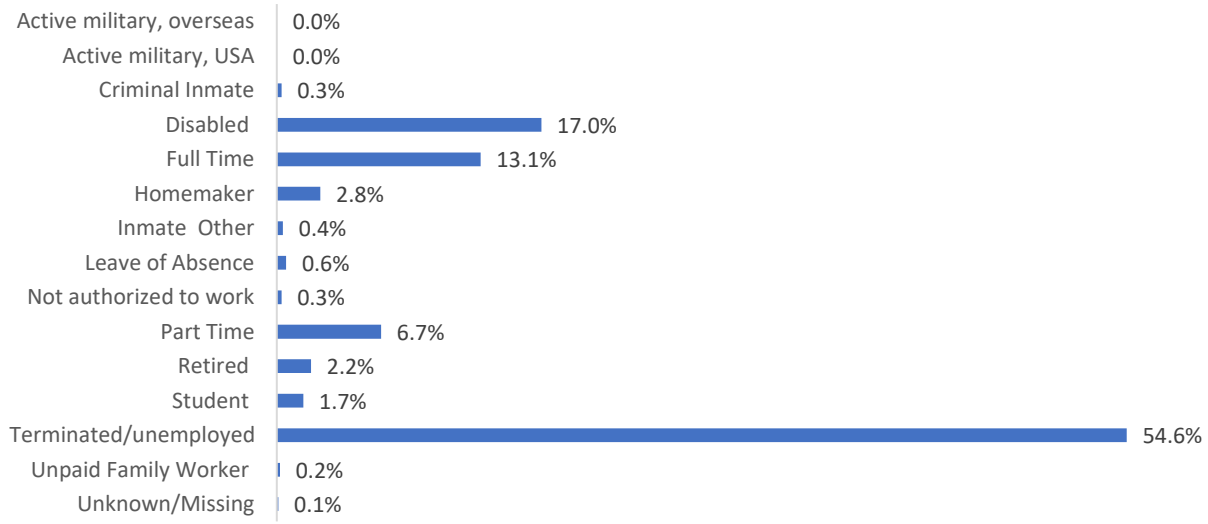
Source: LSFHS Individuals Served Data

Figure 62: LSFHS Individuals Served by Employment Status



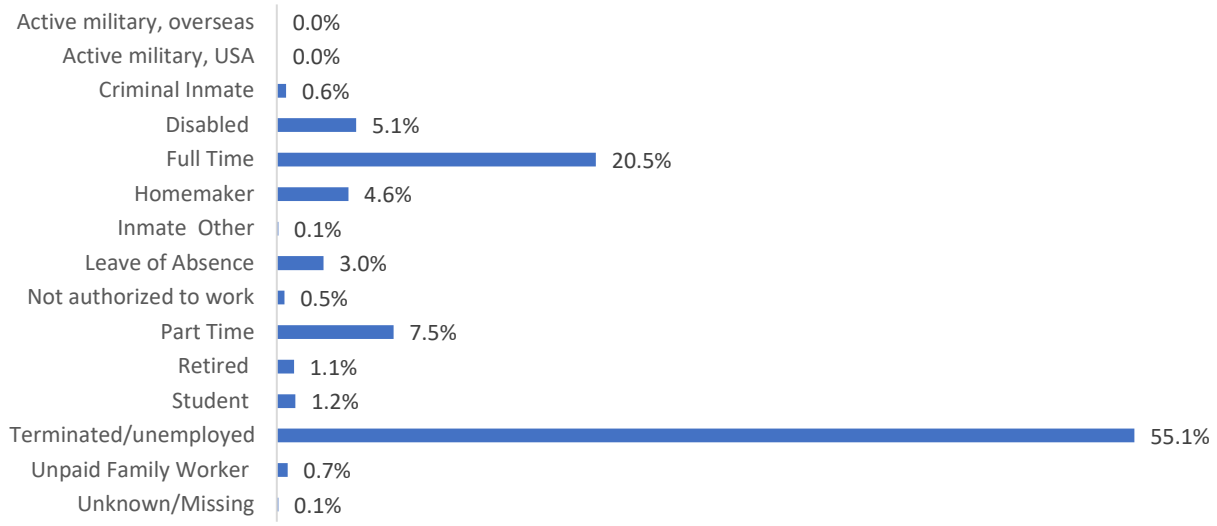
Source: LSFHS Individuals Served Data

Figure 63: LSFHS AMH Individuals Served by Employment Status



Source: LSFHS Individuals Served Data

Figure 64: LSFHS ASA Individuals Served by Employment Status



Source: LSFHS Individuals Served Data

LSFHS SERVICE AREA: INCIDENCE OF HOMELESSNESS

The 2021 Council on Homelessness Report states that the Point in Time Count (PIT) data provides a snapshot of homelessness. **Due to the pandemic, the 2021 PIT Count is not directly comparable to prior years' counts.** Typically, Continuums of Care (CoCs- A local geographic area designated by HUD and served by a local planning body, which is responsible for organizing and delivering housing and services to meet the needs of people who are homeless as they move to stable housing and maximum self-sufficiency) conduct a PIT Count of both sheltered and unsheltered households. This year, due to COVID-19 related safety concerns, only six of the 27 CoCs conducted such a count; 10 CoCs did not conduct an unsheltered count; and others conducted a modified form of the unsheltered count. All CoCs conducted a sheltered PIT count. For those that did not conduct an unsheltered count, the CoCs reported zero unsheltered persons, resulting in an undercount of total homelessness. According to the report:

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

In 2021, the Florida Council on Homelessness reported there were 4,232 individuals who had experienced homelessness in Districts 3 and 4, which includes counties in the 23-county LSFHS service area, *however, please note, this count does not include data for Baker, Dixie, or Union counties.* Sheltered homeless individuals represented 58.5 percent of the homeless population, while 41.5 percent of the homeless population were unsheltered. Individuals experiencing chronic homelessness, defined as continually homeless for over a year, decreased from 908 individuals in 2017 to 668 people in 20202. The number of those experiencing chronic homelessness in 2021 was 477 individuals. Homelessness among veterans increased during the same period from 515 in 2017 to 538 in 2020 with 484 veterans experiencing homelessness in 2021. Families experiencing homelessness in 2021 accounted for 993 individuals.

The number of homeless students, 16,335 in 2015-2016, decreased 8.2 percent to 14,992 in the 2019-2020 academic year. *Please note, data was not available for Gilchrist County.* Of those students who were homeless in 2019-2020, over 80 percent were in a sharing housing arrangement and 9.1 percent were living in motels. *Please note, totals for "Shelters" were not available for Baker County, Hamilton County, Lafayette County, Sumter County, and Union County. Totals for "Sharing Housing" data was also not available for Gilchrist County. The same applies to "Other" totals were unavailable for Baker County, Bradford County, Dixie County, Gilchrist County, Hamilton County, Levy County, Sumter County, Suwannee County, and Union County. "Motels" totals were not available for Baker County, Dixie County, Gilchrist County, and Levy County.*

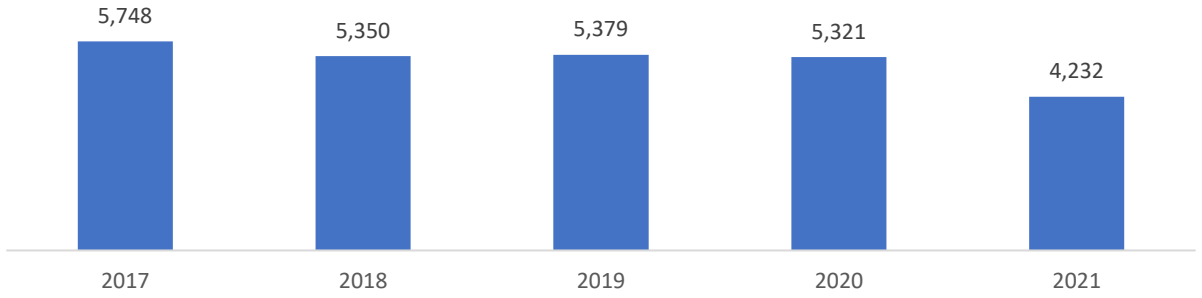
Due to the COVID-19 pandemic, this year saw an unprecedented infusion of federal funding to address homelessness and housing instability. With these funds appropriated by Congress, the State, local governments, CoCs, and partner agencies have invested in solutions to homelessness, including rent and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

Figure 65: CoC Funding from Federal and State Sources, District 3 and 4 (State FY 2020-2021)

Source	Districts 3 and 4
Total Funding Award	$27,720,389.31
HUD CoC FFY20	$9,943,554.00
State Total	$23,646,835.31
State Challenge	$793,000.00
State ESG-CV	$20,291,170.86
State Staffing	$749,999.95
State TANF-HP	$271,664.50
Emergency Solutions Grant	$1,541,000.00

Source: 2021 Florida's Council on Homelessness Annual Report

Figure 66: Total Homeless Population, District 3 and 4 (2017-2021)

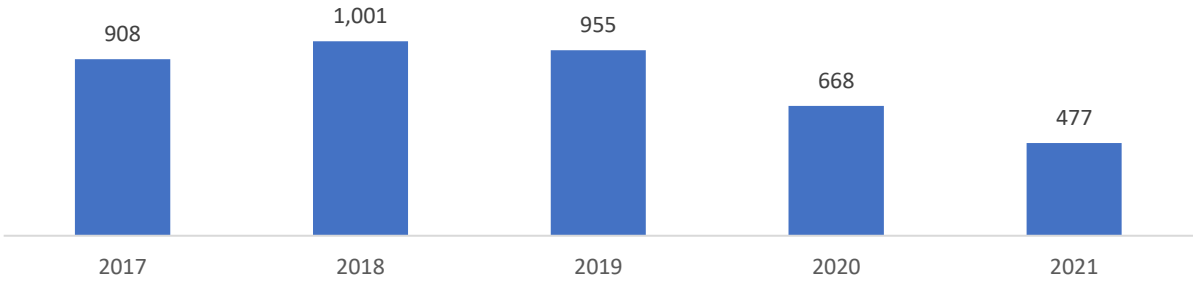


Source: 2021 Florida's Council on Homelessness Annual Report

Figure 67: Total Homeless Population Sheltered and Unsheltered, District 3 and 4 (2021)

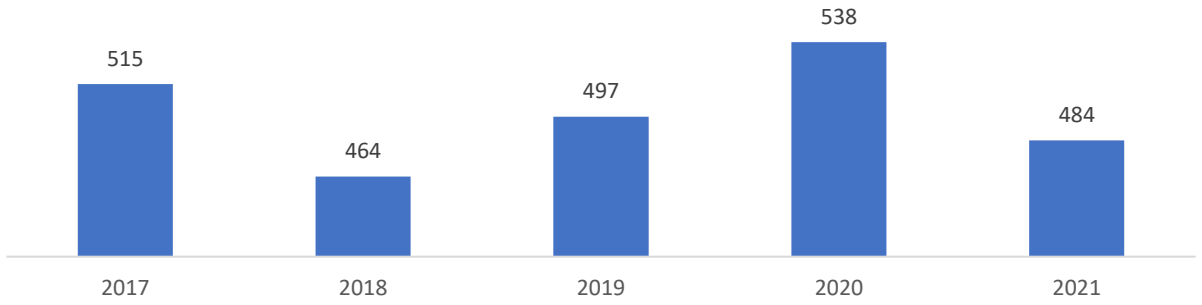
Source: 2021 Florida's Council on Homelessness Annual Report. FL-518 did not conduct an unsheltered PIT count. FL-504, FL-510, FL-512, and FL-514 conducted a modified unsheltered count. FL-508 and FL-520 conducted a full unsheltered count.

Figure 68: Chronic Homelessness, District 3 and 4 (2017-2021)



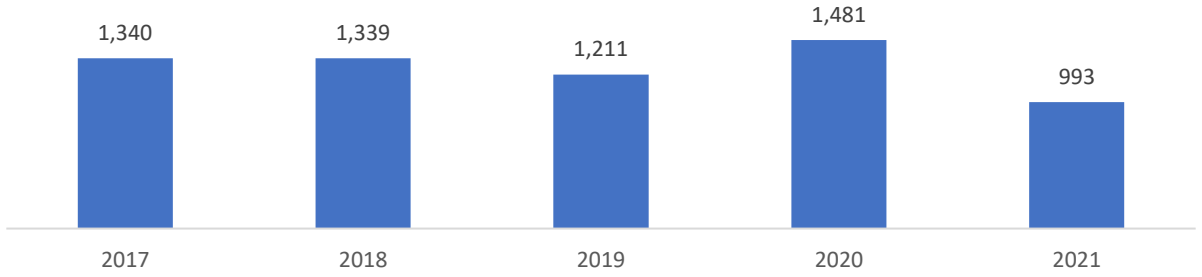
Source: 2021 Florida's Council on Homelessness Annual Report

Figure 69: Homelessness Among Veterans, District 3 and 4 (2017-2021)



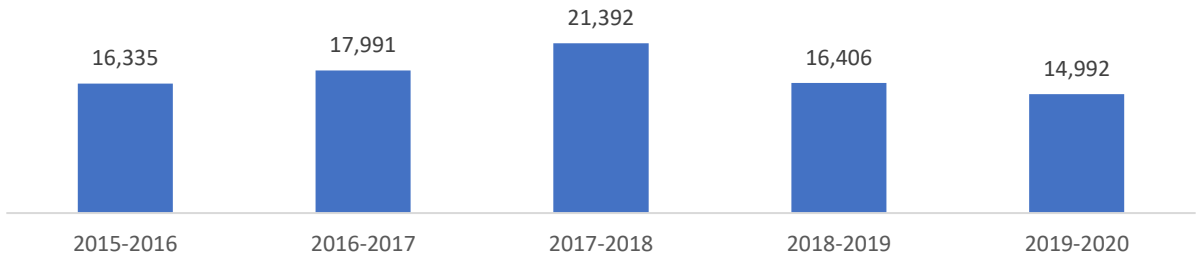
Source: 2021 Florida's Council on Homelessness Annual Report

Figure 70: Family Homelessness – Total Persons in Families with Children, District 3 and 4 (2017-2021)



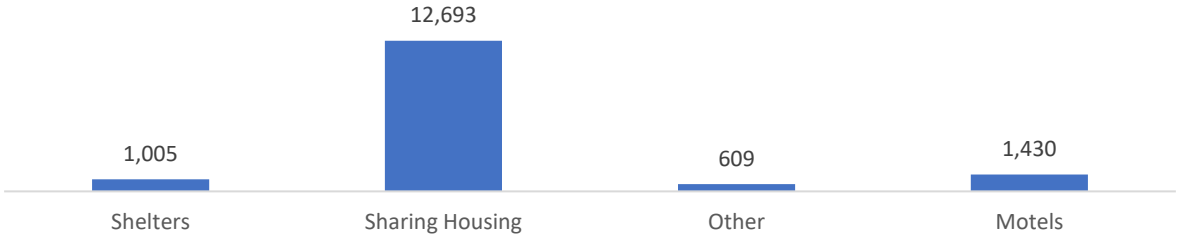
Source: 2021 Florida's Council on Homelessness Annual Report

Figure 71: Florida DOE – Reported Homeless Students in Public Schools (2015-2020)



Source: 2021 Florida's Council on Homelessness Annual Report. School Districts: 01, 02, 04, 09, 10, 12, 15, 16, 18, 21, 24, 27, 34, 35, 38, 42, 45, 54, 55, 60, 61, 63, & 64

Figure 72: Reported Homeless Students in Public Schools by Living Situation (2019-2020)



Source: 2021 Florida's Council on Homelessness Annual Report. School Districts: 01, 02, 04, 09, 10, 12, 15, 16, 18, 21, 24, 27, 34, 35, 38, 42, 45, 54, 55, 60, 61, 63, & 64

LSFHS HOMELESSNESS DATA

Homelessness Population Statistics

A total of 2,728 individuals served by LSFHS providers experienced homelessness, representing 5.5 percent of all those served. Of the 2,728 individuals who experienced homelessness, 67.6 percent were enrolled in AMH programs, 31.8 percent in ASA programs, 0.4 percent in CMH programs, and 0.1 percent in CSA programs.

Males accounted for 65.6 percent of LSFHS individuals experiencing homelessness compared to 34.4 percent females. Almost 70 percent of LSFHS individuals experiencing homelessness were White, 20.2 percent were Black, 3.1 percent were Multi-Racial, and 6.2 percent identified as “Other” race. In the general LSFHS client population, 71.8 percent of LSFHS individuals served were White, 16.8 percent were Black, Multi-Racial was 3.9 percent, and Other was 6.4 percent. Disparities exist for Black and Multi-Racial individuals when comparing the general LSFHS individuals served to LSFHS individuals experiencing homelessness. The percentages of Black and Other Race LSFHS individuals experiencing homelessness were higher when compared to White and Other LSFHS individuals experiencing homelessness.

White LSFHS individuals served represented 71.5 percent of AMH participants and 56.6 percent of LSFHS individuals experiencing homelessness. Black LSFHS individuals served represented 18.6 percent AMH participants and 24.4 percent of LSFHA individuals experiencing homelessness. White LSFHS individuals served represented 76.1 percent of all ASA participants and 78.8 percent of LSFHS individuals experiencing homelessness. Black LSFHS individuals served represented 13.5 percent of ASA participants and 12.1 percent LSFHS individuals experiencing homeless. Hispanic LSFHS individuals served represented eight percent of participating in LSFHS programs and 3.4 percent of LSFHS individuals experiencing homelessness.

Adults, ages 25-44 years, accounted for 59.7 percent of LSFHS individuals experiencing homelessness, and 48.6 percent of the LSFHS individuals served. Adults, ages 25-44 years, accounted for 56.5 percent of AMH individuals experiencing homelessness and 66.8 percent of ASA individuals experiencing homelessness.

Residential Status

All individuals experiencing homelessness reported their residential status as homeless.

Educational Attainment

Among individuals experiencing homelessness, 82.7 percent of those in the AMH program and 83.3 percent of those in the ASA program did not have more than a high

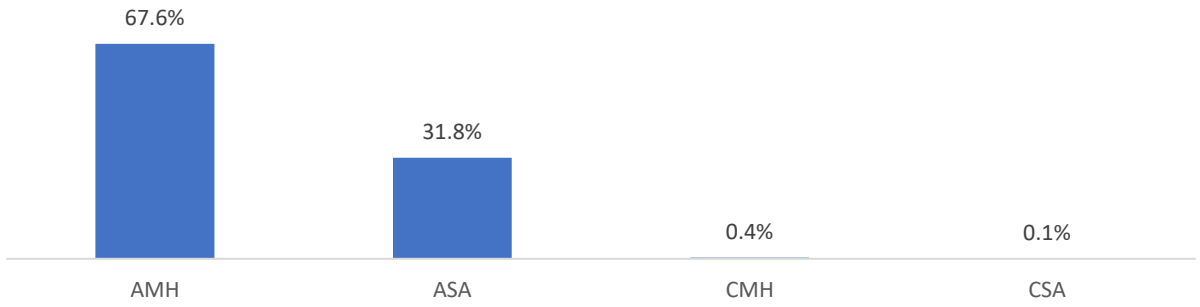
school education. Of these, 25.9 percent of AMH individuals experiencing homelessness and 27.9 percent of ASA individuals experiencing homelessness did not have a diploma. Among individuals experiencing homelessness, 2.3 percent in the AMH program and 2.7 percent in the ASA program attained a bachelor's degree.

Employment Status

Of individuals experiencing homelessness, 5.7 percent were employed full time, 3.7 percent employed part time, and over 78 percent had been terminated/unemployed with 9.4 percent being disabled and unable to work.

LSFHS HOMELESSNESS CHARTS

Figure 73: LSFHS Homelessness by Program

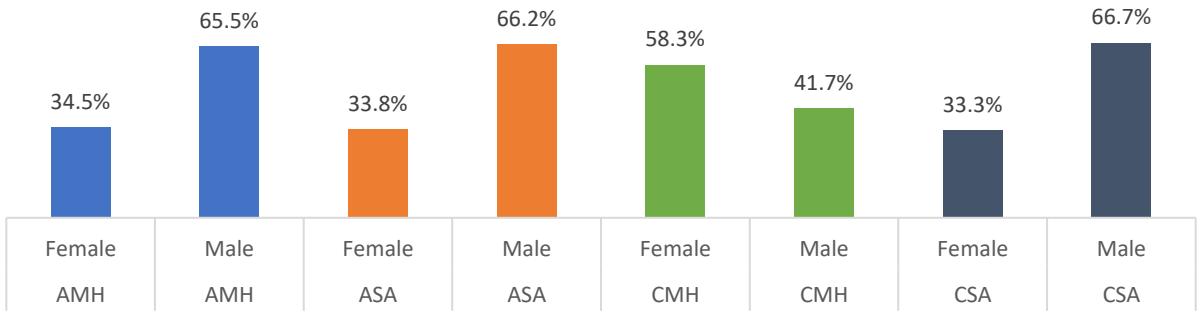


Source: LSFHS Individuals Served Data

Figure 74: LSFHS Homelessness Gender

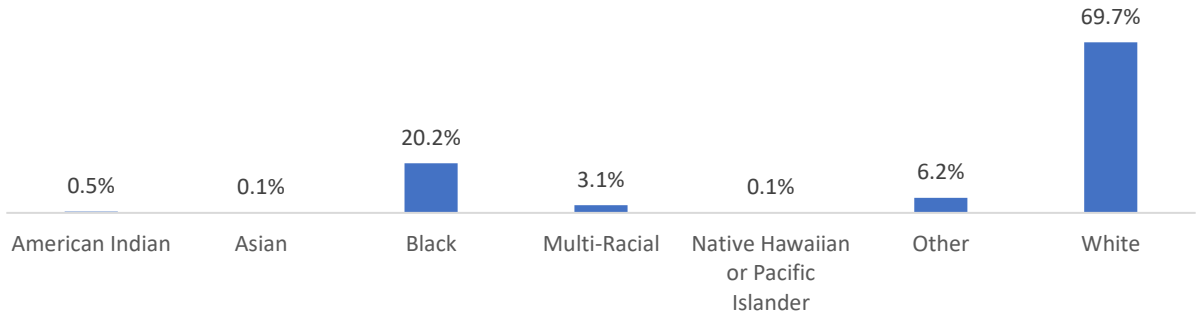
Source: LSFHS Individuals Served Data

Figure 75: LSFHS Homelessness by Program and Gender



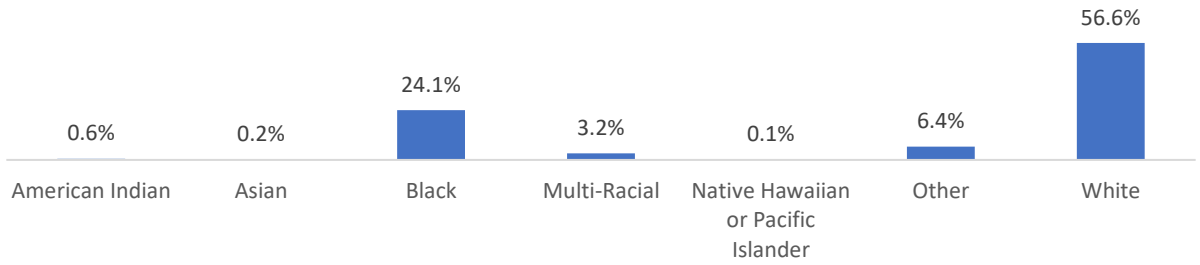
Source: LSFHS Individuals Served Data

Figure 76: LSFHS Homelessness by Race



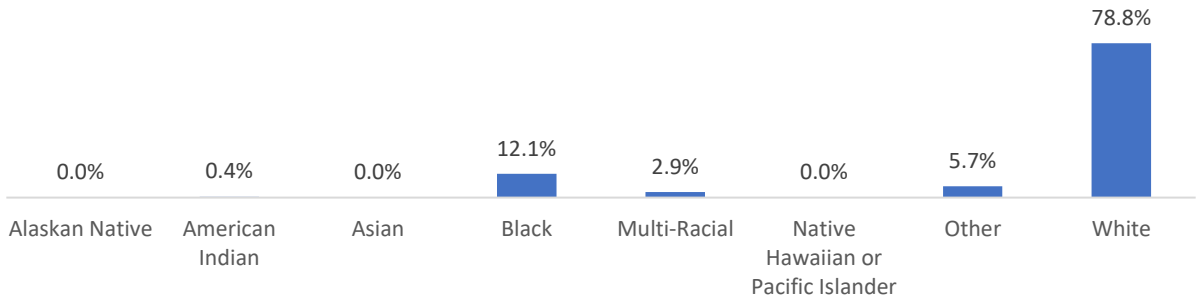
Source: LSFHS Individuals Served Data

Figure 77: LSFHS Homelessness AMH by Race



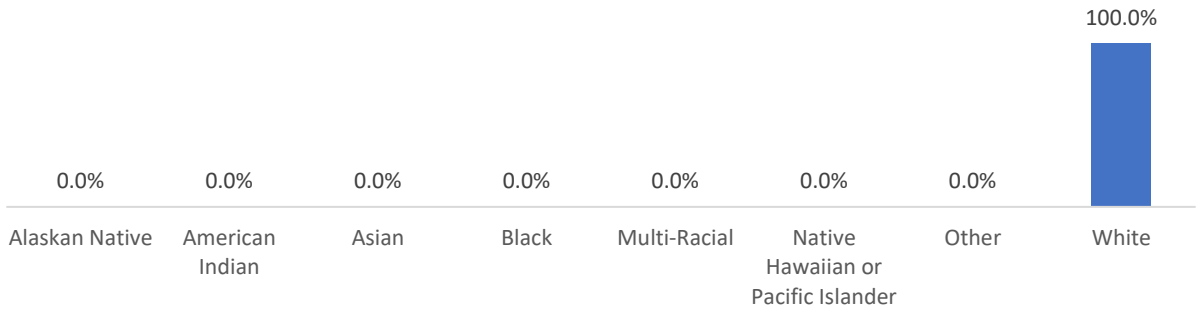
Source: LSFHS Individuals Served Data

Figure 78: LSFHS Homelessness ASA by Race



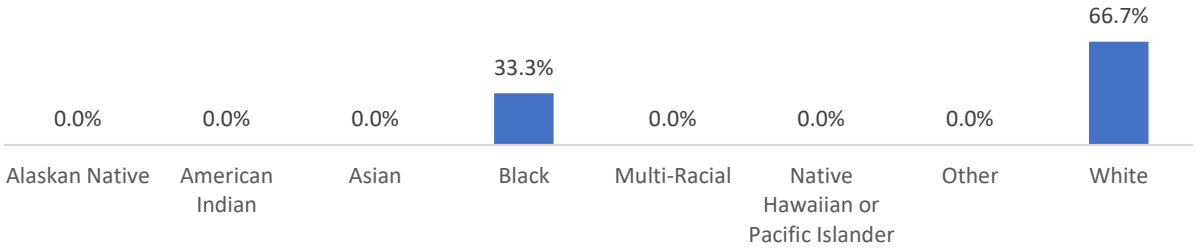
Source: LSFHS Individuals Served Data

Figure 79: LSFHS Homelessness CMH by Race



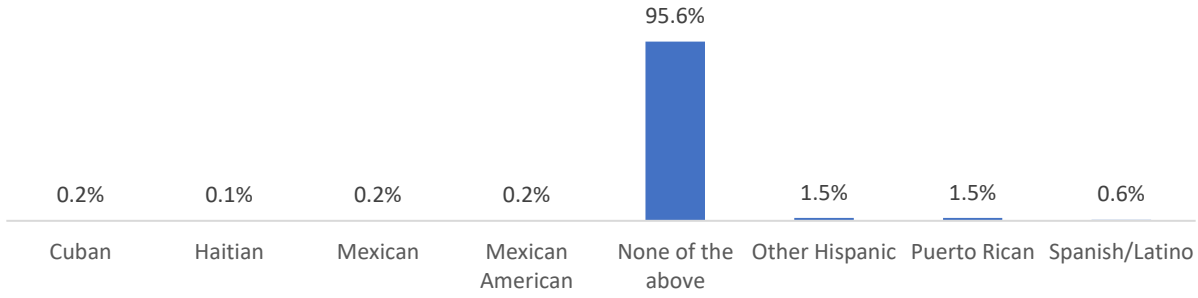
Source: LSFHS Individuals Served Data

Figure 80: LSFHS Homelessness CSA by Race



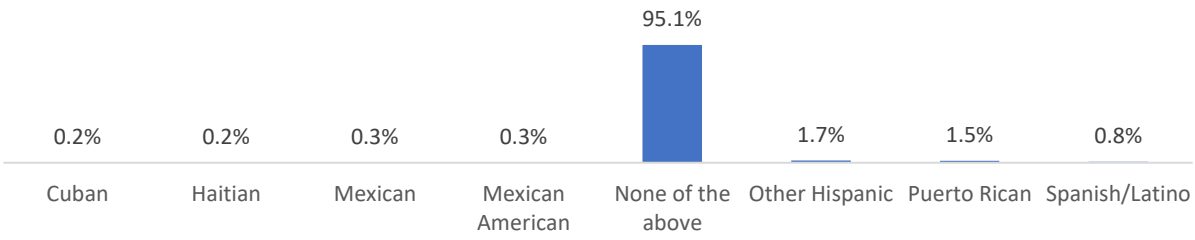
Source: LSFHS Individuals Served Data

Figure 81: LSFHS Homelessness by Ethnicity



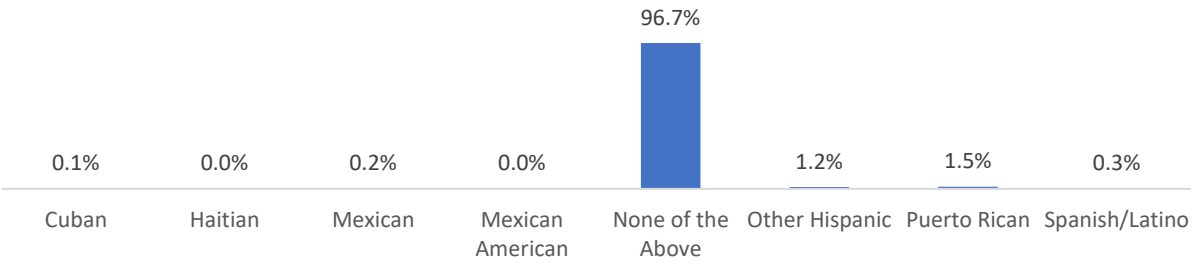
Source: LSFHS Individuals Served Data

Figure 82: LSFHS Homelessness AMH by Ethnicity



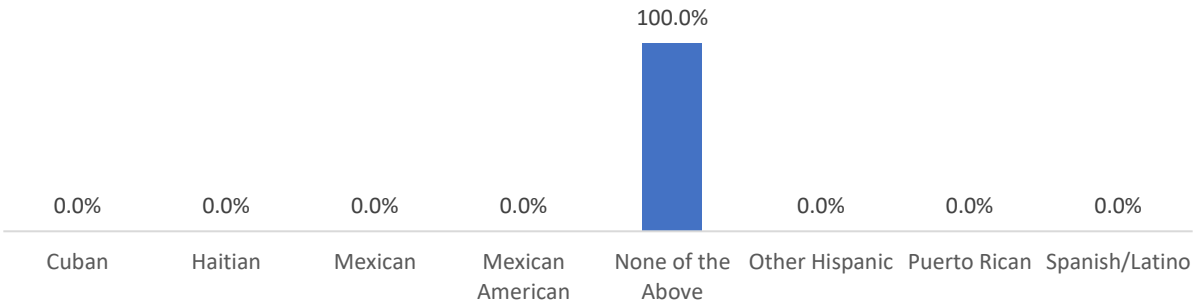
Source: LSFHS Individuals Served Data

Figure 83: LSFHS Homelessness ASA by Ethnicity



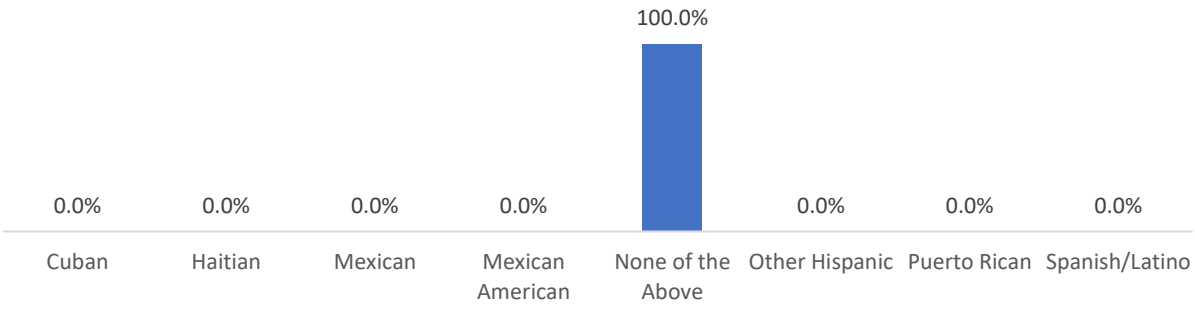
Source: LSFHS Individuals Served Data

Figure 84: LSFHS Homelessness CMH by Ethnicity



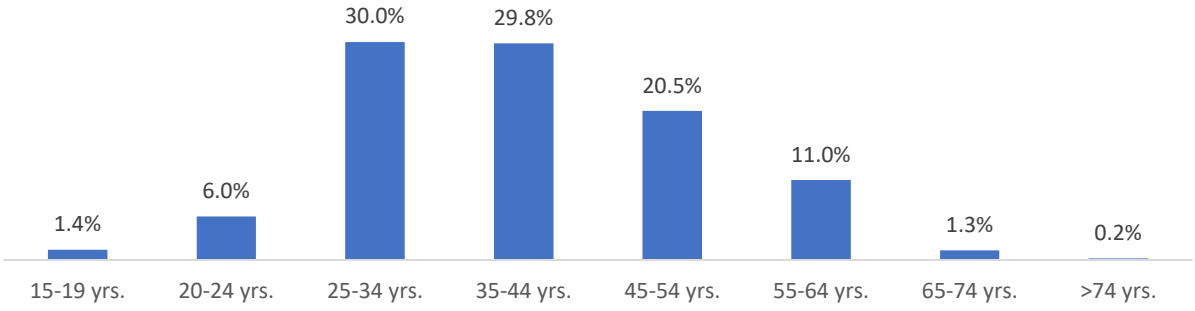
Source: LSFHS Individuals Served Data

Figure 85: LSFHS Homelessness CSA by Ethnicity



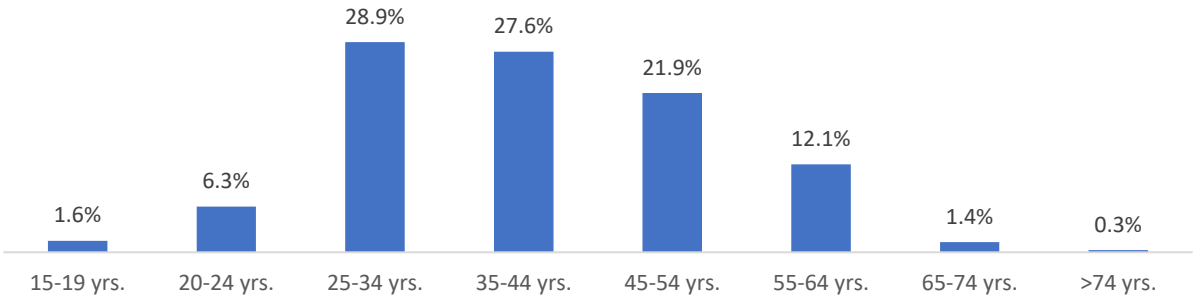
Source: LSFHS Individuals Served Data

Figure 86: LSFHS Homelessness by Age Range



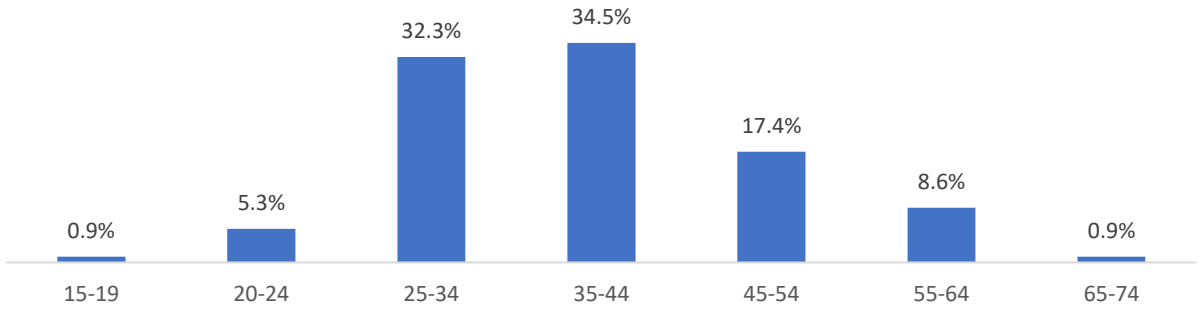
Source: LSFHS Individuals Served Data

Figure 87: LSFHS Homelessness AMH by Age Range



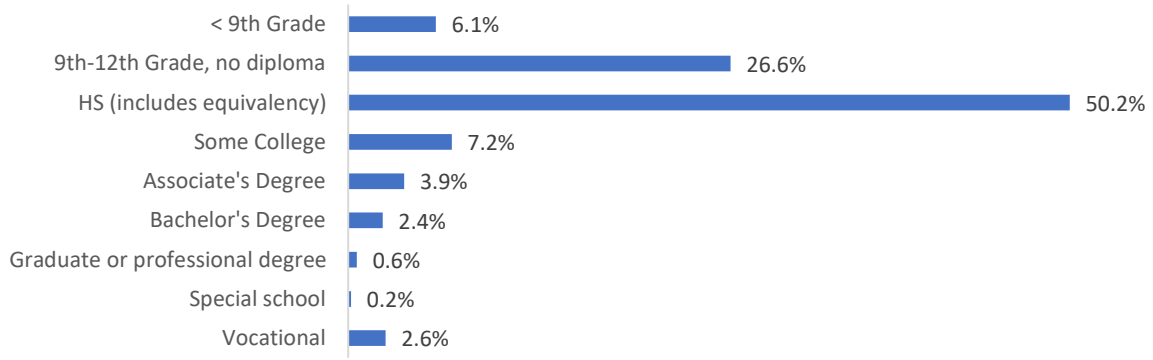
Source: LSFHS Individuals Served Data

Figure 88: LSFHS Homelessness ASA by Age Range



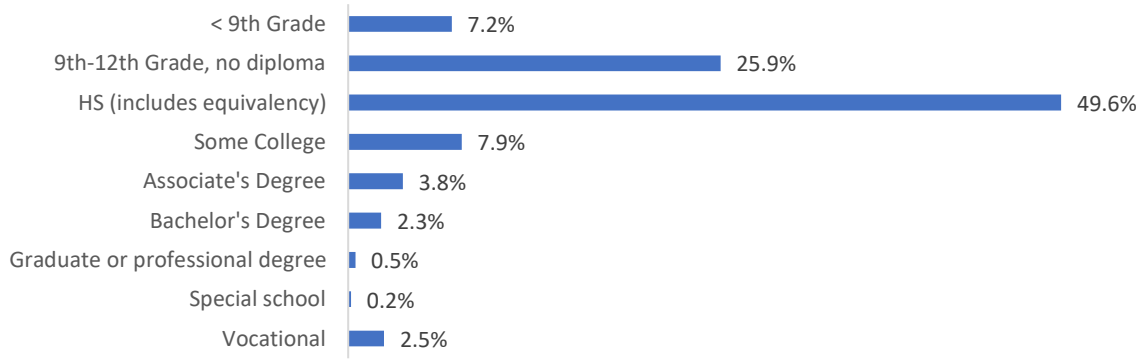
Source: LSFHS Individuals Served Data

Figure 89: LSFHS Homelessness by Educational Attainment



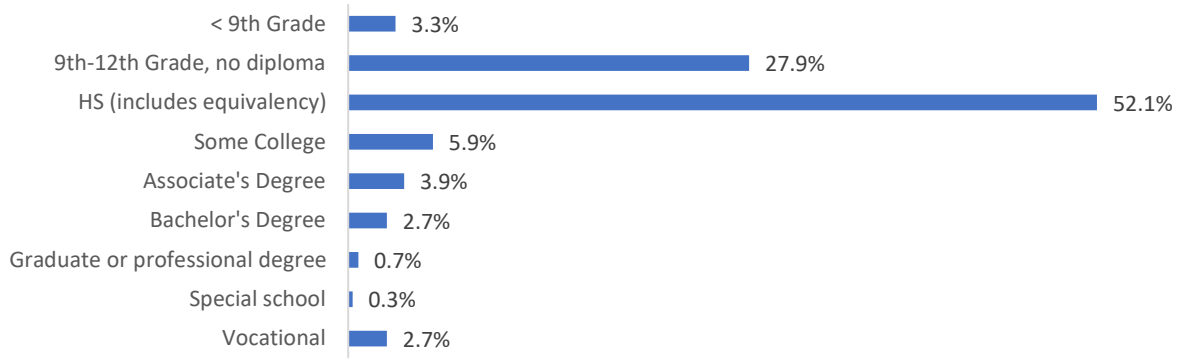
Source: LSFHS Individuals Served Data

Figure 90: LSFHS Homelessness AMH by Educational Attainment



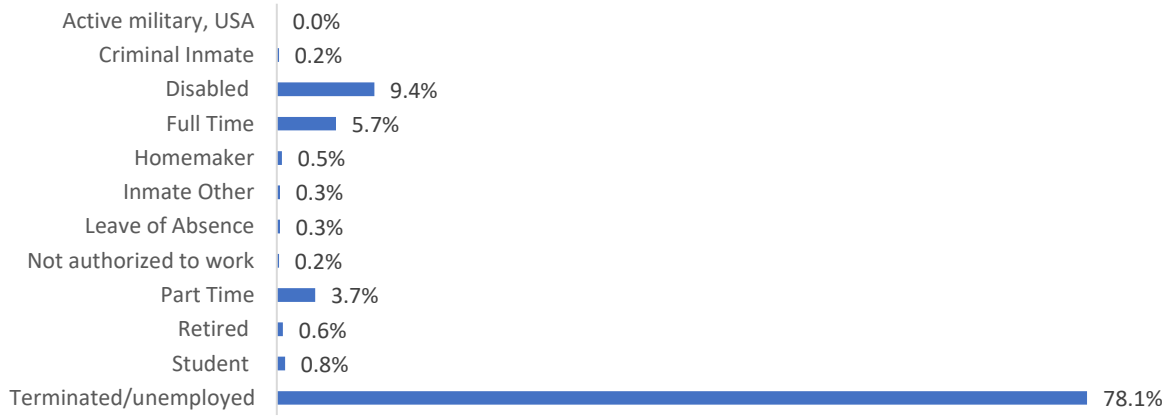
Source: LSFHS Individuals Served Data

Figure 91: LSFHS Homelessness ASA by Educational Attainment



Source: LSFHS Individuals Served Data

Figure 92: LSFHS Homelessness by Employment Status



Source: LSFHS Individuals Served Data

COST CENTER DESCRIPTION, EXPENDITURES, AND OVER/UNDER PRODUCTION (FY 2020-2021)

ADULT MENTAL HEALTH PROGRAM

Cost Center Description	Expenditures	Over/Under Production
Assessment	$176,218.72	$17,597.39
Case Management	$2,299,553.87	$175,992.12
Crisis Stabilization Units	$16,052,987.11	$1,467,429.93
Crisis Support/Emergency	$4,523,168.22	$2,771,697.04
Day Care	$5,477.30	$14.58
Day Treatment	$114,818.43	$70,921.63
Detoxification Services - SA Detox Beds	$112,398.10	$0.00
Drop-in/Self-Help Centers	$547,962.08	$156,892.88
Information and Referral	$105,265.76	$172,894.48
In-Home and On-site Services	$150,040.93	$5,101.07
Inpatient	$691,957.98	$514,254.65
Intensive Case Management	$60,394.92	$23,619.05
Intervention - Group	$864.27	$0.00
Intervention - Individual	$132,053.53	$5,076.81
Medical Services	$2,050,514.66	$639,795.47
Mental Health Clubhouse Services	$892,007.32	$68,869.58
Outpatient - Group	$131,246.58	$7,714.80
Outpatient - Individual	$1,059,425.60	$158,702.25
Outreach	$1,008,227.26	$167,298.12
Recovery Support - Group	$11,949.34	$3,240.26
Recovery Support - Individual	$81,103.65	$42,567.04
Residential Level II	$796,952.42	$15,642.91
Residential Level II - (Enhanced Rate)	$62,368.64	$0.00
Residential Level II (Enhanced Rate)	$217,920.00	$0.00
Residential Level III	$31,082.68	$3,655.80
Residential Level IV	$431,336.55	$25,841.55
Respite Services	$330,142.18	$53,048.82
Room and Board Level II	$1,126,050.59	$238,595.56
Room and Board Level III	$734,893.79	$24,381.21
Room and Board Level III (Enhanced Rate)	$46,784.00	$0.00
Supported Employment	$397,482.52	$50,064.56
Supported Housing/Living	$200,920.40	$16,291.23
Supportive Housing/Living - Monthly	$115,310.50	$79,793.50
TOTAL	**$34,698,879.90**	**$6,976,994.28**

Source: LSFHS Program Data

ADULT SUBSTANCE ABUSE PROGRAM

Cost Center Description	Expenditures	Over/Under Production
Aftercare - Group	$38,327.28	$3,604.49
Aftercare - Individual	$78,373.81	-$760.04
Assessment	$282,852.95	$12,774.92
Case Management	$588,819.62	$33,069.20
Crisis Support/Emergency	$1,798,311.86	$173,515.25
Day Care	$30,469.90	$11.44
Detoxification Services - SA Detox Beds	$5,950,850.38	$390,747.76
Information and Referral	$154,047.62	$4,381.11
Intervention - Group	$3,476.74	$361.17
Intervention - Individual	$179,993.02	$944.44
Medical Services	$1,597,276.33	$36,564.12
Medication Assisted Treatment – Enhanced	$1,313,035.78	$62,285.06
Medication-Assisted Treatment	$2,693,439.38	$48,618.98
Outpatient - Group	$295,096.10	$11,941.24
Outpatient - Individual	$952,589.59	$50,600.63
Outreach	$481,789.91	$61,997.09
Prevention - Indicated	$24,447.04	$4,553.16
Prevention - Selective	$1,920.34	-$516.77
Prevention - Universal Direct	$245,362.65	$19,092.35
Prevention - Universal Indirect	$737,385.60	$80,090.40
Recovery Support - Group	$14,583.66	$2,281.96
Recovery Support - Individual	$68,424.23	$5,552.03
Residential Level II	$3,530,014.31	$485,385.50
Residential Level II - (Enhanced Rate)	$860,792.35	$62.69
Respite Services	$95.92	$0.00
Room and Board Level II	$101,423.67	$2.33
TOTAL	**$22,023,200.04**	**$1,487,160.50**

Source: LSFHS Program Data

CHILD MENTAL HEALTH PROGRAM

Cost Center Description	Expenditures	Over/Under Production
Assessment	$19,290.81	-$152.17
Case Management	$109,896.33	$37,827.77
Crisis Stabilization Units	$1,614,786.80	$2,599,801.71
Crisis Support/Emergency	$2,839,302.43	$567,170.48
Day Treatment	$372,504.74	$11,082.11
FSPT - Information and Referral	$129,852.63	$67,114.34
FSPT - Intervention - Individual	$192,998.16	$96,960.29
Information and Referral	$160,520.27	$629.57
In-Home and On-site Services	$7,875.13	$3,458.21
Intensive Case Management	$88,281.05	$3,512.30
Intervention - Individual	$44.93	$0.00
Medical Services	$35,220.31	$3,336.14
Outpatient - Group	$105.11	$35.12
Outpatient - Individual	$76,206.23	$15,671.01
Outreach	$198,739.56	$12,931.25
Room and Board Level II	$4,093.32	$0.00
Room and Board Level II STGC - B	$49,354.30	$0.00
Room and Board Level II STGC - N	$16,740.00	$0.00
Room and Board Level I	$108,255.00	$0.00
TOTAL	**$6,024,067.11**	**$3,419,378.13**

Source: LSFHS Program Data

CHILD SUBSTANCE ABUSE PROGRAM

Cost Center Description	Expenditures	Over/Under Production
Alachua - Prevention - Universal Direct	$150,000.00	$650.00
Case Management	$938.67	$802.79
Clay Baker Bradford - Prevention - Universal Direct	$150,000.00	$537.50
Crisis Support/Emergency	$442,924.81	$81,531.52
Dixie Gilchrist Levy - Prevention - Universal Direct	$150,000.00	$162.50
Information and Referral	$157,263.77	$0.00
Intervention - Group	$31,938.37	$9,030.63
Intervention - Individual	$123,727.67	$33,757.65
Outpatient - Group	$228.80	$0.00
Outpatient - Individual	$1,204.16	$822.31
Outreach	$215,877.72	$15,726.79
Prevention - Indicated	$334,668.80	$2,282.90
Prevention - Selective	$159,411.91	$6,797.95
Prevention - Universal Direct	$2,458,215.17	$171,308.33
Prevention - Universal Indirect	$1,157,810.37	$117,537.63
Putnam - Prevention - Universal Direct	$150,000.00	$437.50
Residential Level II	$1,001,923.80	$198,839.55
Residential Level II - (Enhanced Rate)	$53,647.56	$2,288.44
TOTAL	**$6,739,781.58**	**$642,513.98**

Source: LSFHS Program Data

LSF All Cost Centers	Expenditures	Over/Under Production
Grand Total	$69,485,928.63	$12,526,046.89

CULTURAL HEALTH DISPARITY SURVEY SUMMARY

BACKGROUND

The Behavioral Health Needs Assessment Cultural Health Disparity survey was available in January through February 2022. It was distributed by LSFHS and their providers to peer specialists throughout the 23-county service region with the intent of reaching individuals served in ZIP Codes with high CDC social vulnerability index scores (SVI). This was used to identify LSFHS individuals who served at a high risk for experiencing cultural health disparity.

SURVEY RESPONSES

In total, 300 responses were collected during the survey period from residents in 90 ZIP Codes. Slightly more than 62 percent of respondents were female, and 35 percent were male, eight percent preferred not to answer. Most respondents were heterosexual/straight (54.8 percent), preferred not to answer (16.2 percent), asexual (9.6 percent), bisexual (4.6 percent), with 8.6 percent of respondents selecting “my sexual orientation is not listed here.” Nearly 57 percent of respondents were White, 29 percent Black, 4.7 percent Multi-Racial and 5.7 percent preferred not to answer. The majority of respondents were not Hispanic (87.3 percent); however, six percent were Puerto Rican, 2.7 percent Spanish/Latino, and one percent Haitian. Age of respondents varied from 15-19 years (14.7 percent), 20-24 years (five percent), 25-34 years (13 percent), 35-44 years (16.3 percent), 45-54 years (19.3 percent), 55-64 years (14.7 percent), 65-74 years (5.7 percent), and older than 74 years at three percent. Adults with lived substance use conditions accounted for 22 percent of respondents, 15 percent were adults with lived mental health conditions, and 15 percent were family members or friends with someone with lived experience. Respondents represented 15 of the 23 counties in the service area including: Alachua, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Hernando, Lake, Levy, Marion, Nassau, Putnam, St. Johns, and Volusia counties. Duval County respondents represented 41.1 percent of all respondents with Hernando and St. Johns counties each having 7.4 percent of respondents.

Most respondents (83 percent) reported usually being comfortable seeking behavioral health care services and 16 percent reporting not being comfortable seeking behavioral health care services. Respondents were asked to rate their trust in the behavioral health care system to treat them with respect on a one to five scale with five being “strongly trust” and one being “strongly distrust.” Of all respondents, 66.8 percent of respondents “strongly trust” or “trust” the behavioral health care system to treat them with respect while 16.4 percent “strongly distrust” or “distrust” the system.

Respondents were asked a series of questions about their feelings regarding their behavioral health issues. More than 20 percent of respondents feel their behavioral health

issues are private issues they keep to themselves; 35 percent of respondents feel it is a private issue that stays in the family, 34.7 percent feel comfortable sharing challenges with others, and eight percent were comfortable sharing with people like themselves.

Respondents were asked, “In which settings have you been the most comfortable discussing your behavioral health concerns?” Respondents were most comfortable with a hybrid of telehealth (29.4 percent), private office with doctor (27.1 percent), all the options (18.3 percent), and telehealth (14 percent). If given a choice for receiving behavioral health care services at faith-based organization or a traditional physician office, 58.3 percent preferred the traditional setting compared to 39.7 percent who preferred a faith-based setting. Only 45.7 percent of respondents would be comfortable in group therapy (selected “likely” or “very likely”) and 36 percent would not be comfortable (selected “unlikely” or “very unlikely”). Comfort in individual therapy was higher with 82.7 percent of respondents being “likely” or “very likely” comfortable in individual therapy. Most respondents (92 percent) said services were available in their primary language all of the time and 3.7 percent said most of the time.

CULTURAL HEALTH DISPARITY SURVEY CHARTS

Figure 93: Are you usually comfortable seeking behavioral health services?

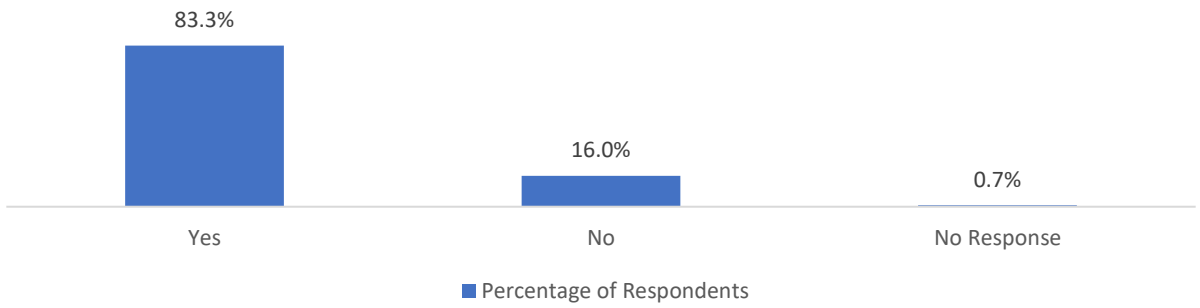


Figure 94: On a scale of 1 to 5, with 5 being 'strongly agree', how would you rate your trust in the behavioral health care system to treat you with respect?

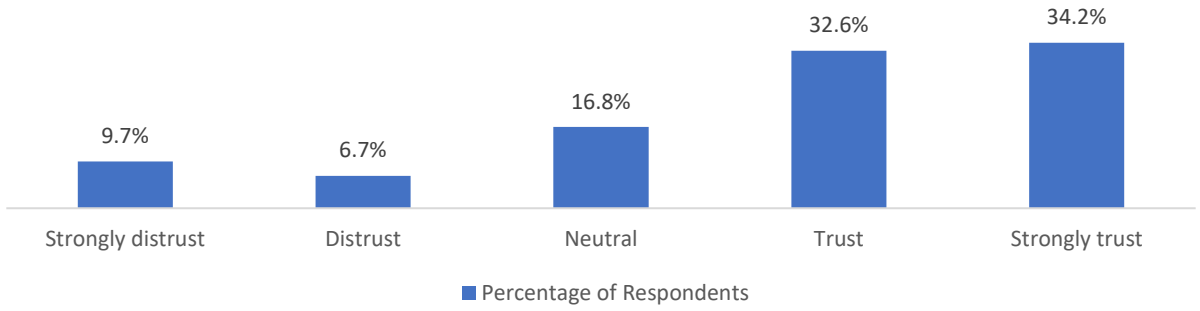


Figure 95: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. "This is a private issue I keep to myself."

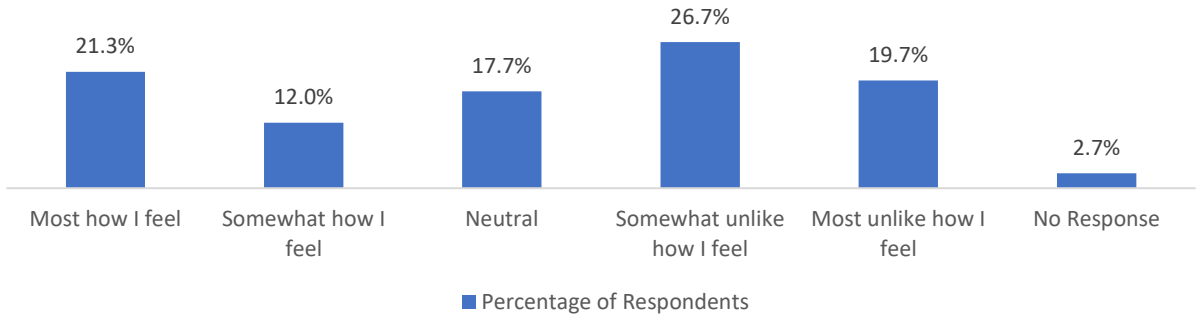


Figure 96: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. "This is a private issue that stays in the family."

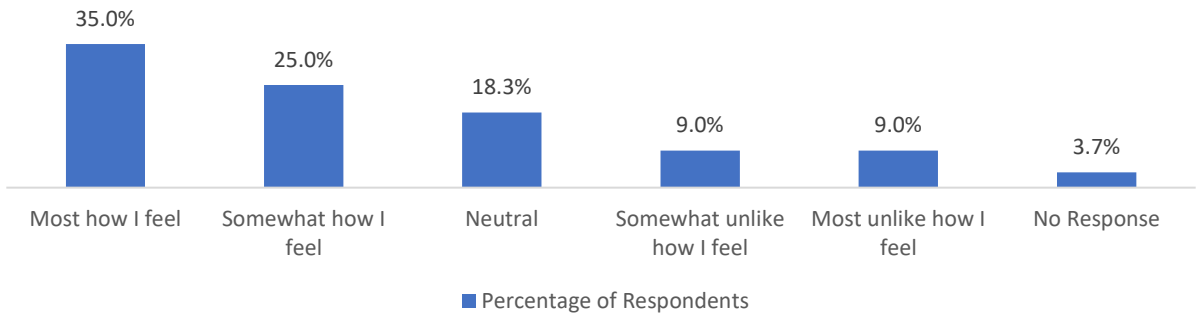


Figure 97: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. "I am comfortable sharing my challenges with others."

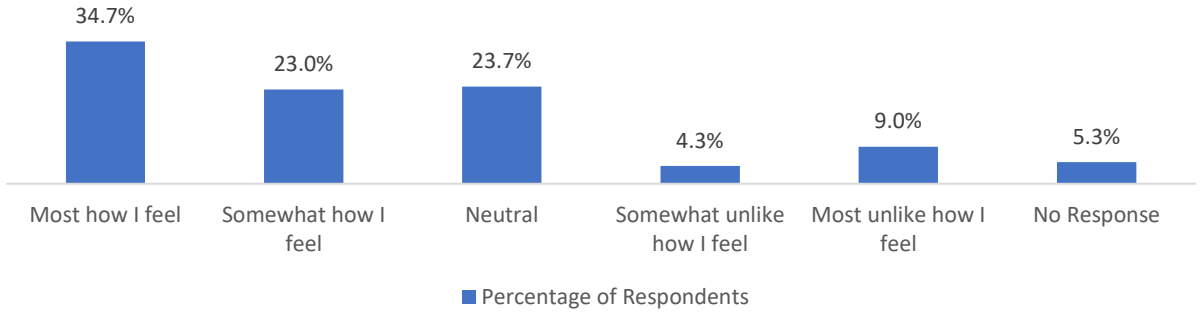


Figure 98: Please rank the statement below that most closely describes your feelings regarding your behavioral health issue, with (1) being the best and (5) being the least. "I am more comfortable with people like me."

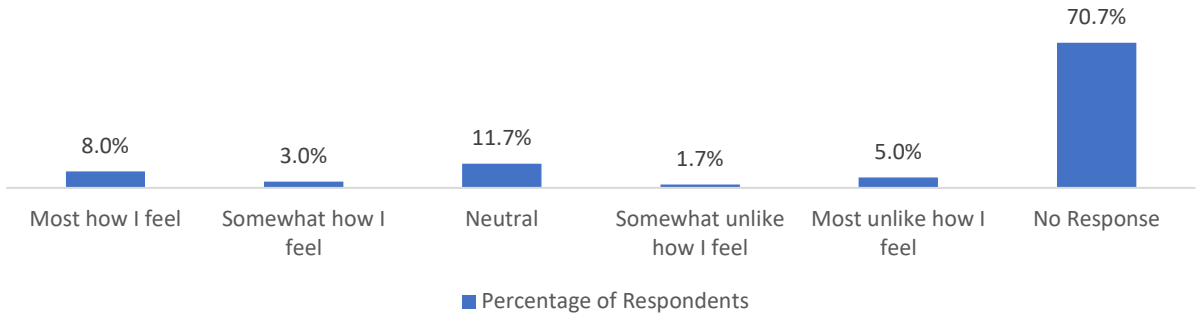


Figure 99: In which settings have you been the most comfortable discussing your behavioral health concerns? (Check all that apply)

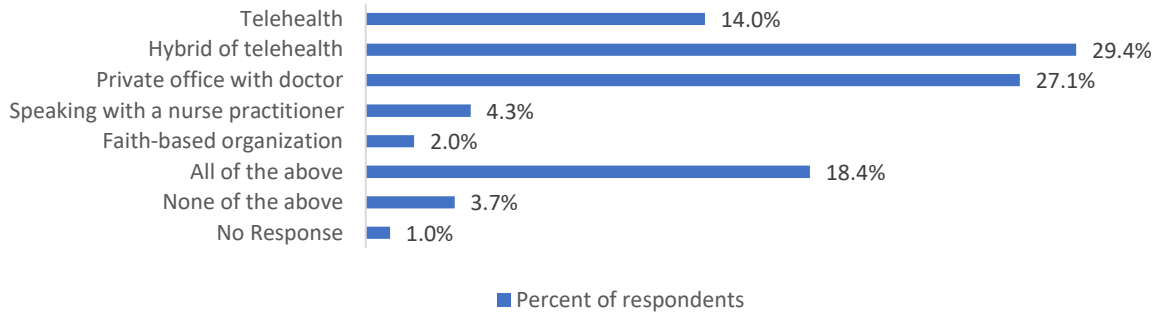


Figure 100: If given a choice for receiving behavioral health care services, would you be more comfortable going to a faith-based organization OR prefer the traditional physician office?

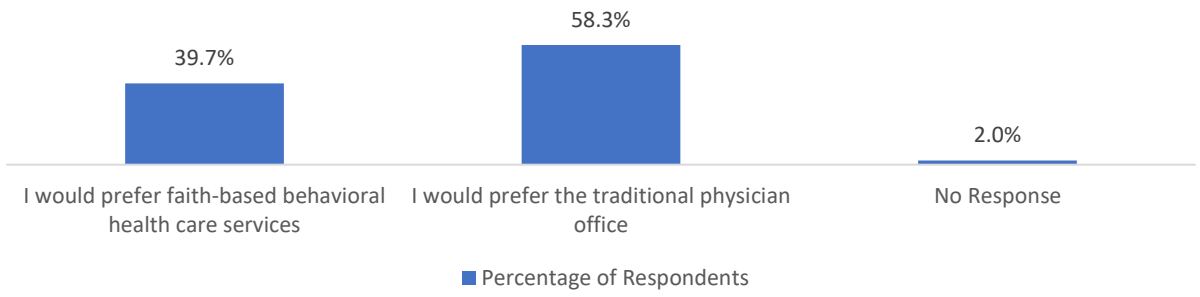


Figure 101: Now thinking about treatment options, on a scale of 1 to 5, with 5 being 'very likely', how comfortable would you be in group therapy?

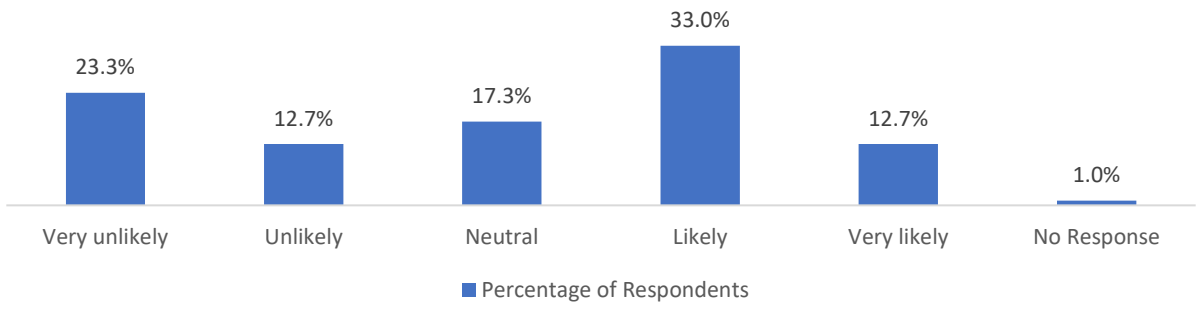


Figure 102: On a scale of 1 to 5, with 5 being 'very likely', how comfortable would you be in individual therapy?

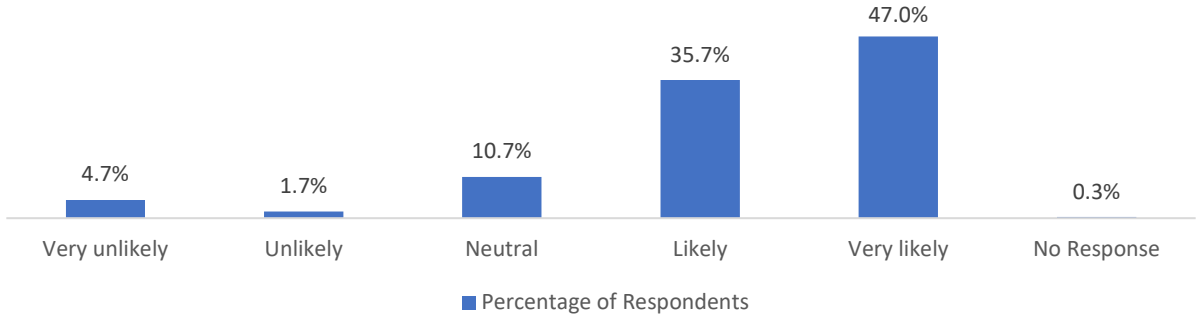


Figure 103: When you have received behavioral health care services in the past, were they mostly available in your primary language?

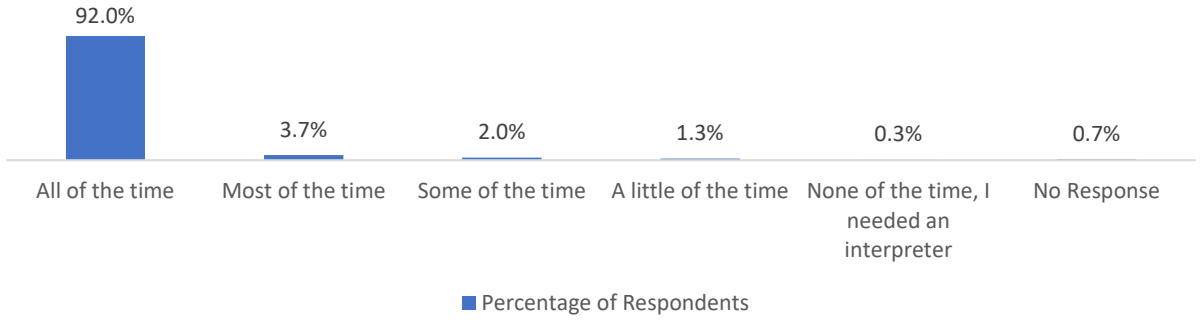


Figure 104: Which best describes your gender?

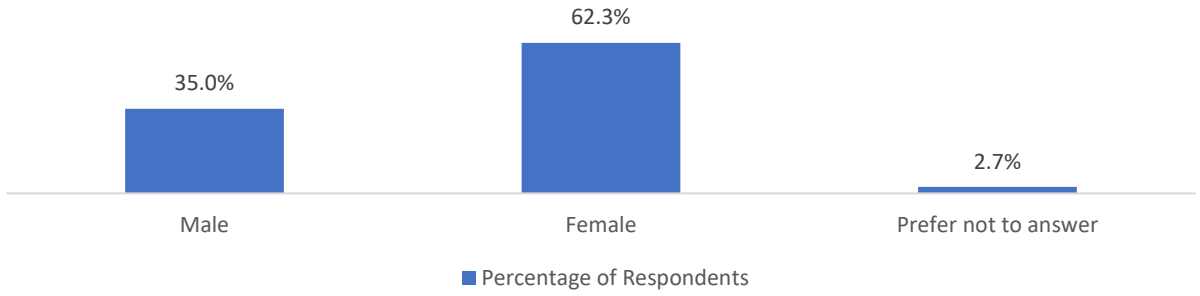


Figure 105: Which best describes your gender identity?

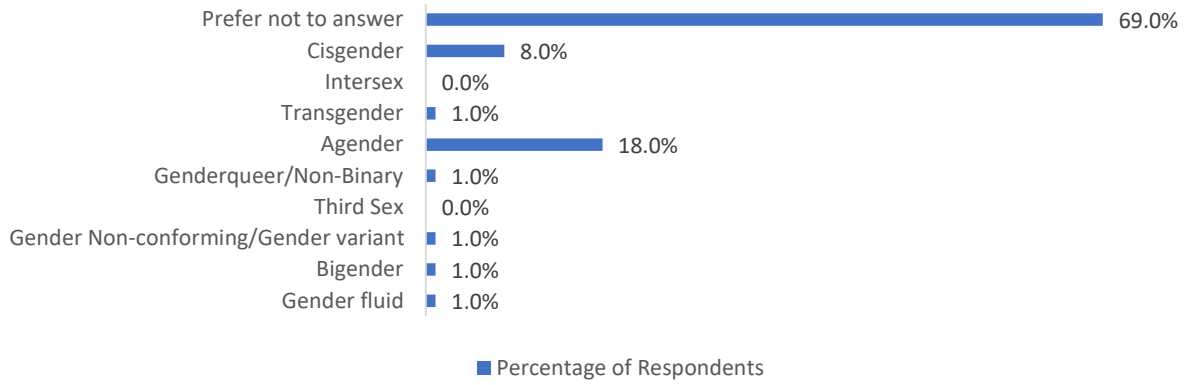


Figure 106: Which best describes your current sexual orientation? (Check all that apply)

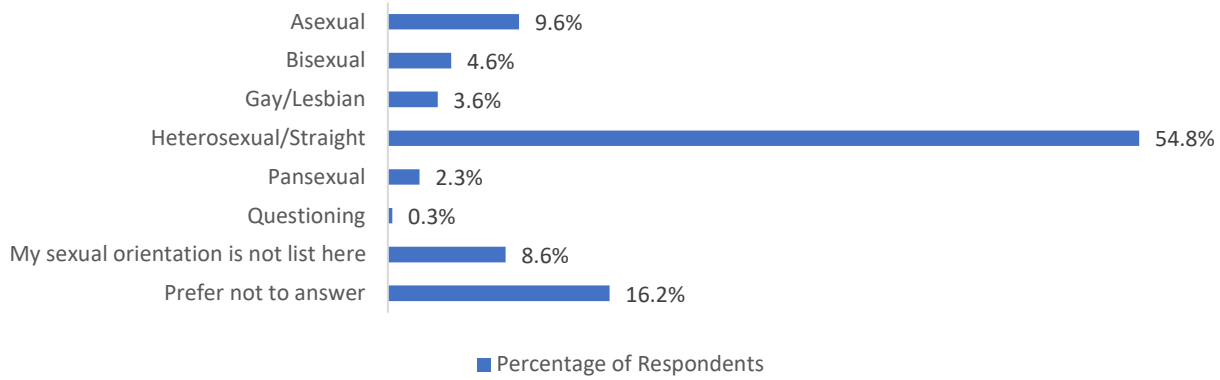


Figure 107: Which best describes your race?

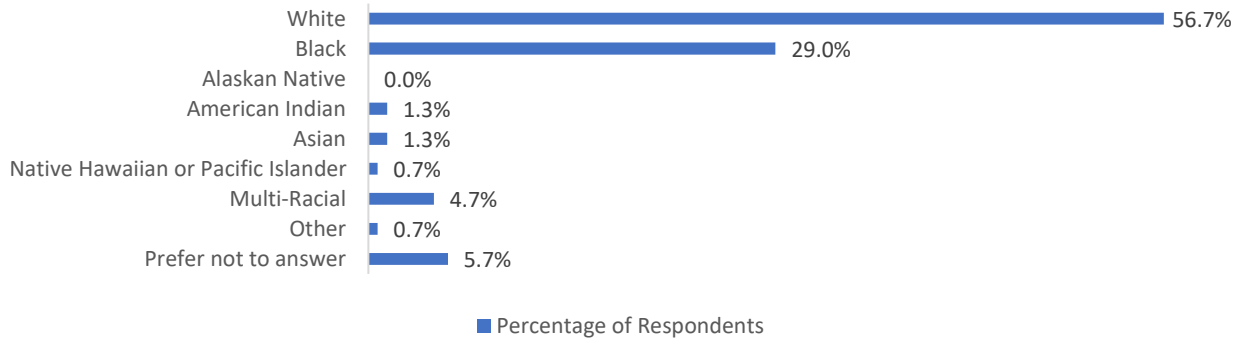


Figure 108: Which best describes your ethnicity?

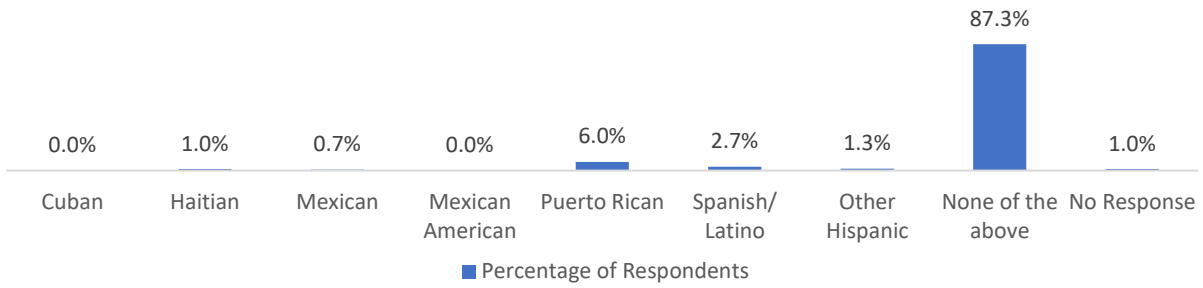
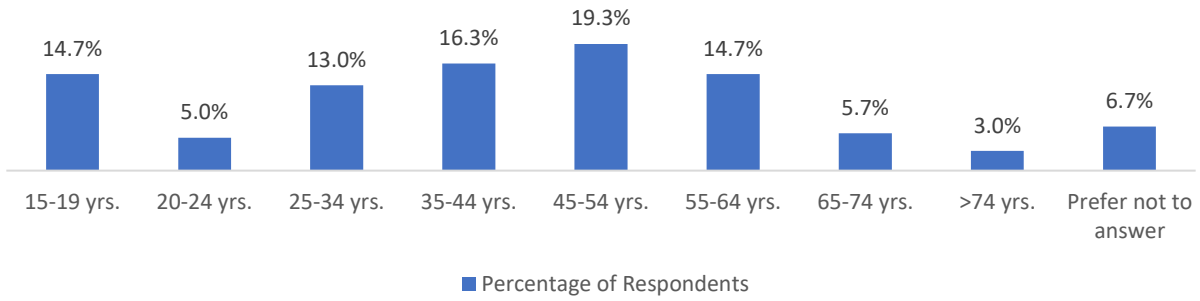


Figure 109: Please select your age range from the list below.



CULTURAL HEALTH DISPARITY SURVEY BY RACE AND ETHNICITY

The cultural health disparity survey was analyzed by race and ethnicity to further measure experience, awareness, and coordination of behavioral health services. This will help tailor outreach and treatment options based on the unique needs and preferences of individuals over the next three years.

Most respondents were comfortable seeking behavioral health care services. Black respondents (96.6 percent) were more likely to be comfortable seeking care when compared to Hispanic (82.9 percent) and White respondents (78.6 percent).

When asked if they trust the health care system to treat them with respect, 88.5 percent of Black participants responded positively. Specifically, 40.2 percent trusted and 48.3 percent strongly trusted they would be treated with respect. These percentages were higher when compared to other demographic groups. Among Hispanic respondents, 42.9 percent trusted and 31.4 percent strongly trusted they would be treated with respect. Slightly more than half (55.4 percent) of White respondents trusted (25.6 percent) or strongly trusted (29.8 percent) that the health care system would treat them with respect.

Respondents were asked to describe their feelings regarding their behavioral health issues. When asked if this was “a private issue I keep to myself,” Black respondents (26.7 percent) indicated that this was most how I feel (18.6 percent) or somewhat how I feel (8.1 percent). Among Hispanic respondents (44.1 percent), indicated this was most (20.6 percent) or somewhat how they feel (14.7 percent). White respondents (39.8 percent) were more likely to feel this was a private issue kept to themselves as 14.9 percent indicated this was somewhat or most how they feel (24.8 percent).

Regarding their behavioral health issues as a private matter that stays in the family, a greater percentage of Black and Hispanic respondents indicated this was unlike how they feel while a greater percentage of White respondents indicated this was most how they feel. Among Black respondents73.3 percent indicated this was somewhat unlike or most unlike how I feel. Only 34.4 percent of White respondents indicated this was somewhat or most unlike how they feel while 41.7 percent indicated this was most or somewhat how they feel.

Most respondents were comfortable sharing their challenges with others. Among Black respondents, 37.2 percent indicated this was most how they feel or somewhat how they feel (38.4 percent). Hispanic respondents who most feel this way accounted for 31.4 percent while 17.1 percent indicated this was somewhat how they feel. Among White respondents, 37.7 percent indicated this was most how they feel or somewhat how they feel (19.8 percent).

Black respondents (82.4 percent) were likely to be more comfortable with people like them when compared to Hispanic (65.7 percent) and White respondents (51.3 percent). Among

Black respondents, 50.6 percent indicated this was most how they feel or somewhat how they feel (31.8 percent). For Hispanic respondents, 40 percent indicated that this most how they feel or somewhat how they feel (25.7 percent). Among White respondents, 29.7 percent indicated this was most how they feel, and 21.5 percent indicated this was somewhat how they feel.

The most comfortable setting for discussing their behavioral health issues for Black respondents was a hybrid of telehealth at 64 percent. In a private office with a doctor accounted for 14 percent of Black respondents and 14 percent indicated all of the above were comfortable settings. Hispanic respondents preferred to be in a private office with a doctor (38.2 percent) or a hybrid of telehealth at 32.4 percent. Over 20 percent indicated all of the above were also comfortable settings. White respondents also preferred a private office with a doctor at 33.3 percent. Among White respondents, 19 percent were comfortable with telehealth and 19.6 percent were comfortable with all settings. No Black or Hispanic respondents chose faith-based organizations as a comfortable setting and only three percent of White respondents selected this option.

When asked to choose between faith-based or the traditional physician office, results were opposite of the results in the preceding question. Most Black respondents (73.8 percent) indicated they would be more comfortable going to a faith-based organization. Among Hispanic respondents, 45.5 percent were comfortable in a faith-based setting and 54.5 percent were comfortable in a traditional physician office. Only 22.8 percent of White respondents indicated they were comfortable in a faith-based organization while 77.2 percent preferred the traditional physician office. Network Service Providers (NSP) may be able to offer insight on this contradiction.

Among Black respondents, 80.2 percent were likely or very likely to be comfortable in group therapy. This was much higher when compared to Hispanic and White respondents at 41.2 percent and 31.5 percent, respectively. When asked about their comfort in individual therapy, more than 75 percent of respondents from all three population groups were comfortable in this setting. Among respondent groups, 96.6 percent of Black respondents indicated they would be comfortable in individual therapy, along with 82.9 percent of Hispanic respondents, and 76.9 percent of White respondents.

When asked if the behavioral health services they received in the past were mostly available in their primary language, 90.8 percent of Black respondents, 82.4 percent of Hispanic respondents, and 95.2 percent of White respondents received services in their primary language all of the time. Those needing an interpreter accounted for 2.9 percent of Hispanic respondents, and 1.1 percent of Black respondents.

CULTURAL HEALTH DISPARITY SURVEY BY RACE AND ETHNICITY CHARTS

Figure 110: Are you usually comfortable seeking behavioral health care services?

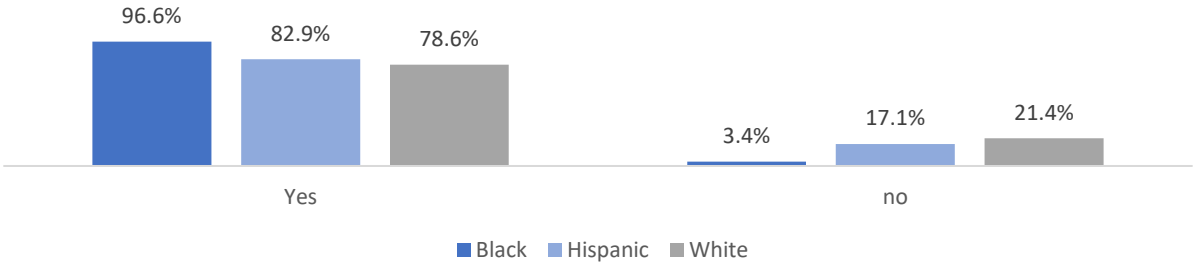


Figure 111: On a scale of 1 to 5, with 5 being 'strongly agree', how would you rate your trust in the behavioral health care system to treat you with respect?

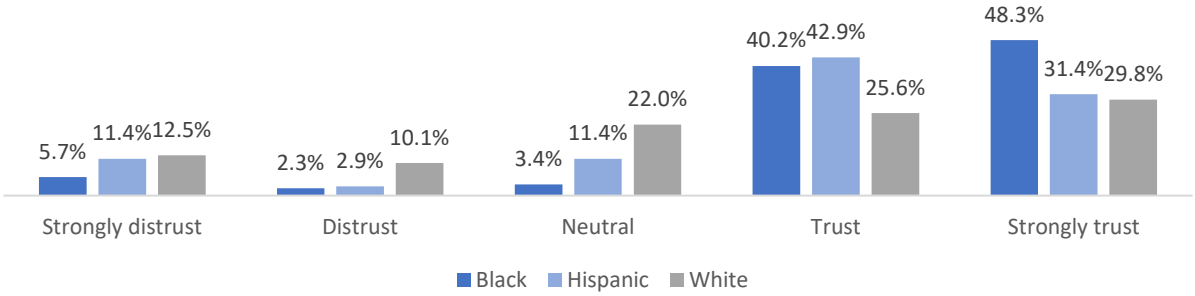


Figure 112: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. This is a private issue I keep to myself.

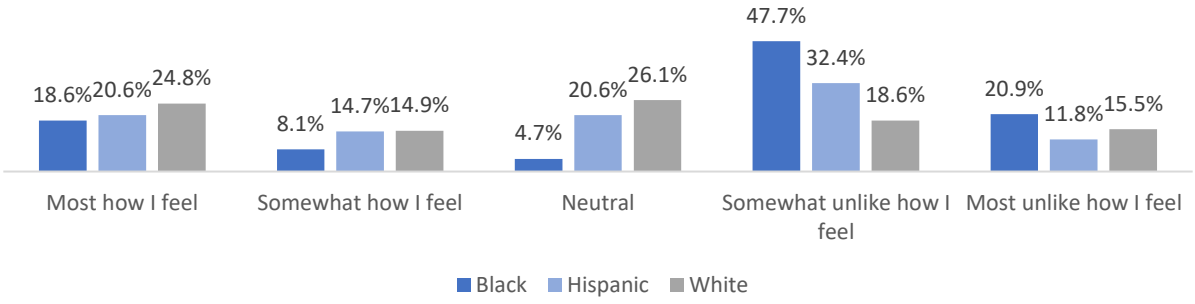


Figure 113: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. This is a private issue that stays in the family.

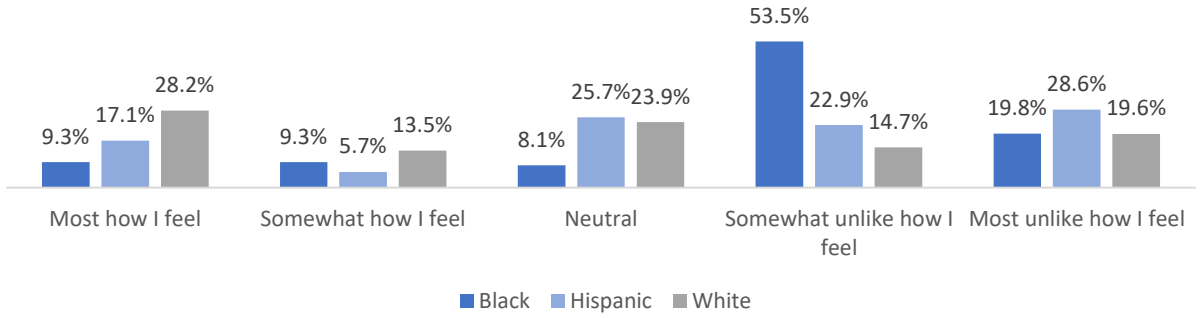


Figure 114: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. I am comfortable sharing my challenges with others.

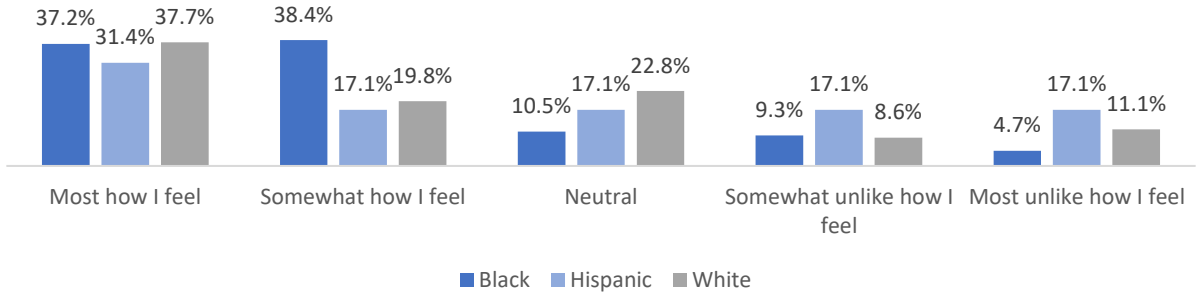


Figure 115: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. I am more comfortable with people like me.

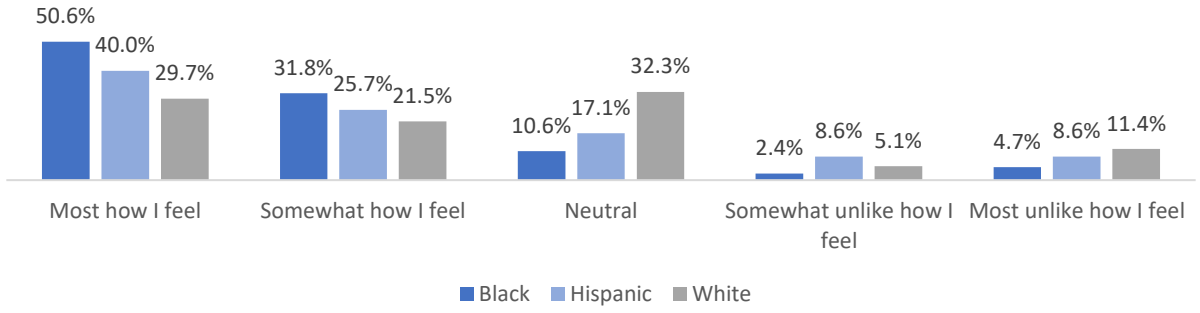


Figure 116: In which setting(s) have you been the most comfortable discussing your behavioral health concerns? (Check all that apply)

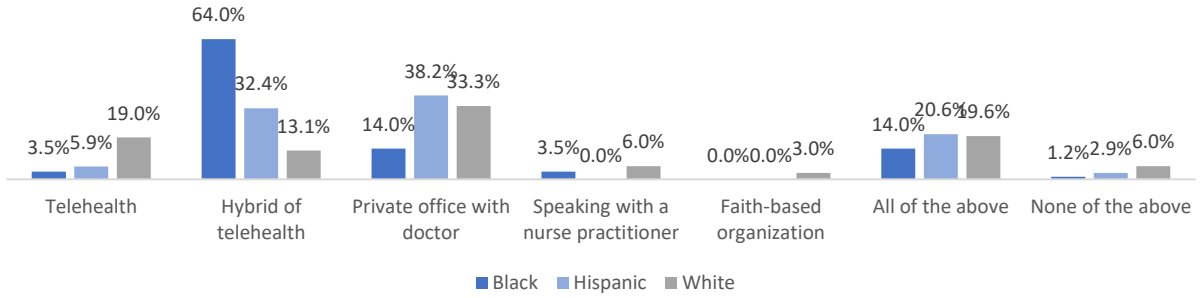


Figure 117: If given a choice for receiving behavioral health care services, would you be more comfortable in a faith-based organization OR prefer the traditional physician office?

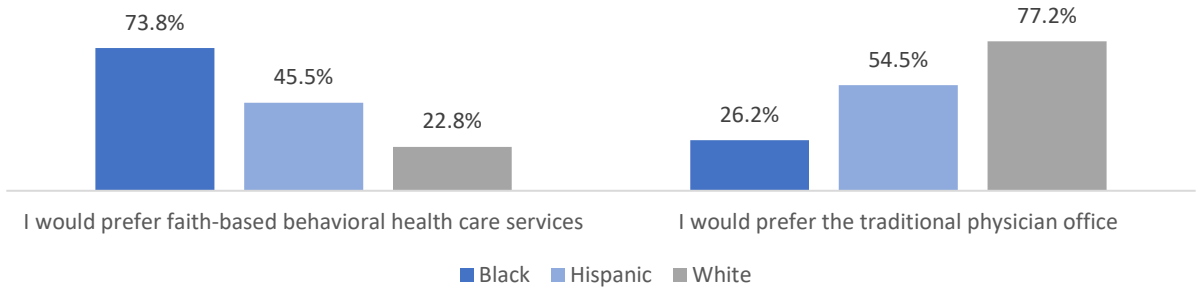


Figure 118: Now thinking about treatment options, on a scale of 1 to 5, with 5 being very likely, how comfortable would you be in group therapy?

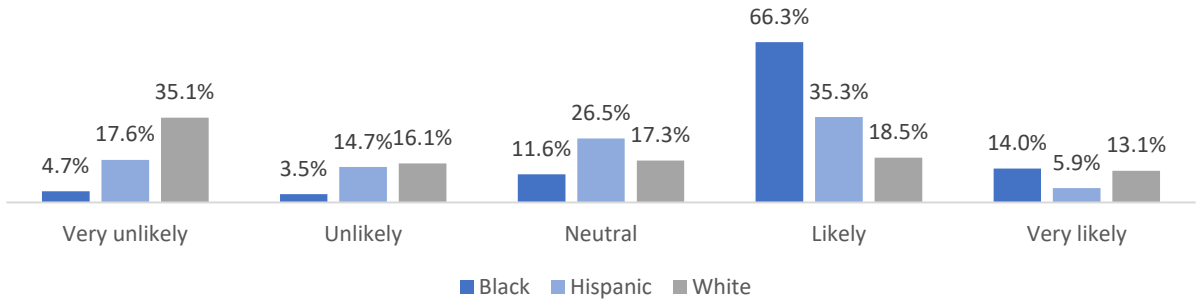


Figure 119: On a scale of 1 to 5, with 5 being very likely, how comfortable would you be in individual therapy?

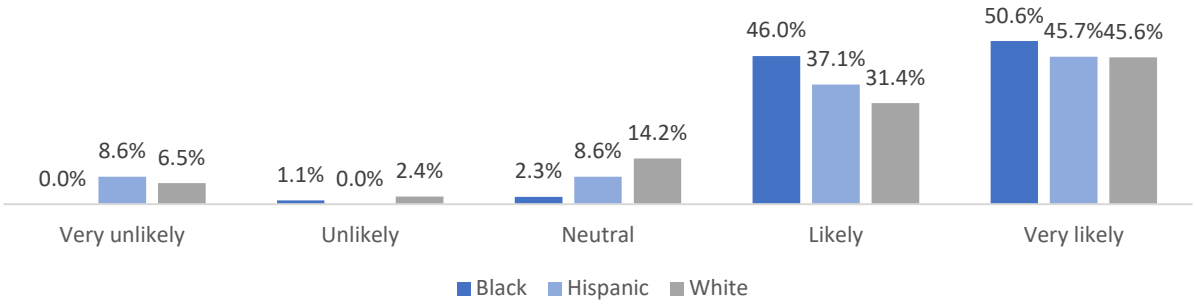
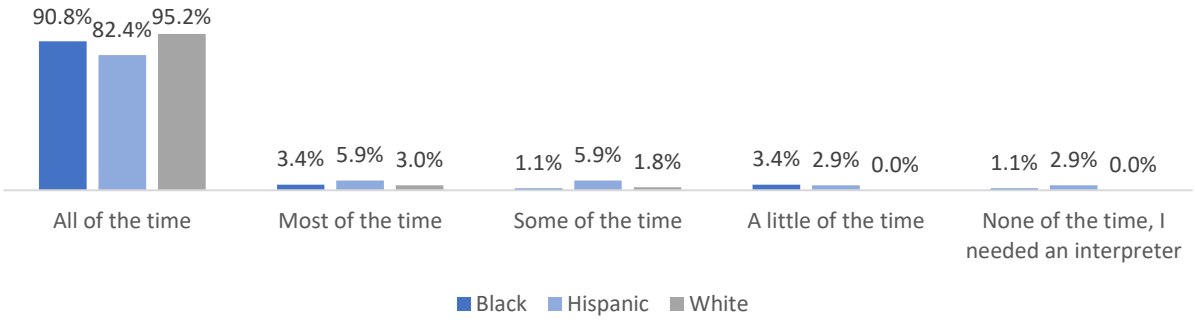


Figure 120: When you have received behavioral health care services in the past, were they mostly available in your primary language?



CULTURAL HEALTH DISPARITY FOCUS GROUP SUMMARY

FOCUS GROUP METHODOLOGY

LSF Health Systems is one of seven behavioral health Managing Entities (ME) contracted by the Florida Department of Children and Families (DCF) to manage the state-funded system of behavioral health care for people who face poverty and are without insurance. LSF Health Systems serves a 23-couty region in Northeast and Central Florida which includes the counties of Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Hernando, Lake, Lafayette, Levy, Marion, Nassau, Putnam, St. Johns, Sumter, Suwannee, Union, and Volusia.

Lutheran Services of Florida recruited and provided access to a total 36 number of behavioral health clients and stakeholders to participate in four separate behavioral health services focus groups. The eligibility criteria for participating in the focus groups was that participants were 18 years or older and lived in the LSF Health Systems service area. Focus group sessions were held for two hours each and were facilitated by WellFlorida staff via the Zoom platform. The script of ten questions (see below) about behavioral health services in the ME service area was used to obtain the feedback from the participants. A summary of the respondents' input is provided below.

SCHEDULE OF FOCUS GROUP SESSIONS

Date (2022)	Time	Number of Participants
March 14	10 a.m. - 11:30 a.m.	11
March 14	2:30 p.m. - 4 p.m.	8
March 18	10a.m. - 11:30 a.m.	8
March 22	10a.m. -11:30 a.m.	9

FOCUS GROUP SUMMARY

Each of the four focus groups followed the same focus group script. The following pages present summaries of the focus group participants' responses to each question. A summary of the responses across the four groups for each of the ten questions is provided.

Question 1: Tell us about your most recent experience seeking behavioral health services? (Prompts: how did you learn about the provider, were you referred by someone?) Tell us about how you choose or selected your current (or most recent) behavioral health services provider?

Summary of Responses: Various experiences prompted focus group participants to access behavioral health services. Across the four focus groups no clients expressed an inability to find services. However, a common comment from focus group participants was that services were not so much personally sought but accessed as a result of being court ordered, placement in a detoxification unit, or having been released from jail. Other participants expressed that they sought out specific providers such as a pediatric provider, one who accepted their insurance, or provided telehealth services to meet their schedule demand or transportation barriers.

List of Responses (paraphrased focus group participant responses):

- Had to find a service without a long wait list
- Found provider on insurance website
- Court ordered
- Veteran's Administration referral
- Detox admission and discharges
- Jail discharge
- Needed pediatric specialist
- Telehealth services available

Question 2: Did you experience barriers or obstacles when seeking behavioral health services? If so, what were the barriers and how did you overcome them? Were there barriers you could not overcome? If so, what were the barriers and what would have helped you overcome them?

Summary of Responses: Answers depended on the focus group participant's life situation. For example, for single parents, persons with limited incomes, and those on Medicaid, there were housing, childcare, Medicaid acceptance, and transportation barriers. COVID-19 also presented barriers as participants expressed that the pandemic seemed to create a shortage of providers. Some participants did not want to go to one-on-one therapy during the pandemic. Those who relied on telehealth services expressed frustrations with technology issues, including internet access or specific computer issues that forced them to use their cell phones for telehealth services.

List of Responses (paraphrased focus group participant responses):

- Wait time
- Medicaid has a limited set of providers
- Technology issues
- Transportation including price of gas
- Staff turnover impact ability to establish client provider relations
- Finding one to fit my schedule
- Financial barriers
- Chose by what insurance offers
- Needed to get housing, childcare, and employment first
- Difficult for single parents to get childcare to attend appointments
- During pandemic there was a shortage of providers

- During pandemic did not want to go in person so had to find a provider that offered
  telehealth services

Question 3: What makes you feel comfortable getting behavioral healthcare services? (Prompts: person understands you, values of your culture, is a part of your community, know your privacy is maintained, etc.)

Summary of Responses: A common experience among focus group participants was that building trust and not being judged are essential to feeling comfortable with a provider. Other key items discussed that contribute to participants feeling comfortable were having a provider who understood their behavioral health traumas and or individual histories and backgrounds. Participants expressed that providers who are interested in client progress and not just checking on medication status made them comfortable, made them feel the provider cared about their progress and understood them. Having consistency with a provider as well as the recognition that behavioral health is an integral to overall health and well-being was important to participants.

List of Responses (paraphrased focus group participant responses):

- Feeling comfortable with the provider
- Trusting the provider
- Ability of provider to understand participant's type of trauma/behavior health issue
- Non-judgmental providers
- Ability to establish rapport with provider
- Provider who helps maintain progress
- Provider interested in your progress and not just your medications
- Maintaining consistency with provider because building trust and progress takes time
- Understanding that behavioral health is part of overall health and wellness in general

Question 4: What helps build a good provider-client relationship?

Summary of Responses: Provider competency was a common topic of discussion. Competency could include the ability to develop a trusting client-provider relationship. Within the client-provider relationship, the ability of the provider to mirror the client's situation, hold the client accountable for their responsibilities to achieve progress in identifying the specific behavioral health issue(s), and for there to be a bit of humor in therapy as humor were cited as helpful. A few respondents expressed they prefer a provider of a specific gender.

List of Responses (paraphrased focus group participant responses):

- Provider competency
- Time to develop relationships
- Trust

- Humor
- Building a partnership with the provider
- Providers who hold a client accountable
- Gender of provider in some cases
- Ability to mirror client, to put themselves in the same role as client (peer)
- Ability to get to the real problem
- Maintenance of confidentiality

Question 5: What services have you been satisfied with and why? Any services that you've been dissatisfied with or that need improvement and if yes, why? (Prompt or example of family involvement as part of satisfaction).

Summary of Responses: Participants expressed that good case management which includes coordination of care from primary care physicians to empathetic trusting providers, proper medication management, availability of providers, and a good patient to provider ratio are service characteristics they have been satisfied with. Other services participants were satisfied with included being able to reach providers by telephone and providers who hold the client accountable.
Services participants were dissatisfied with were predominantly centered around crisis care including hospital and inpatient admissions and Baker Act admissions. Crisis management discussions highlighted the damage caused by Baker Act admissions for children, emergency services that inappropriately medicate clients, and the lack of training among law enforcement officers to properly aid clients and families in crisis. A suggestion was made that emergency room health workers could benefit from training about behavioral health and crisis management. Other services participants expressed dissatisfaction with was the ability to receive primary and dental care and unreliability of transportation at times.

List of Responses (paraphrased focus group participant responses):
Satisfied

- Good case management
- Proper medication management
- Therapist who holds client accountable
- Good patient provider ration
- Provider who takes the patient seriously

Dissatisfied

- Crisis management, particularly for children
- Care coordination after incarceration
- Law enforcement interactions when officers not trained in crisis intervention
- Coordination of discharge from jail
- Too much process and time to move from detox centers to residential can sometimes cause relapse to detox.
- Baker Act admissions of children can cause permanent harm
- Mismedication

- Dental and primary care is needed and is expensive
- Transportation not on schedule
- Difficult to get intervention for a client who is deteriorating, not wait for a crisis leading to hospitalization
- Emergency crisis care

Question 6. How many of you have received behavioral health services through telehealth? How was that experience? Would you like to continue it? For those who haven't tried telehealth, would you like to try it? If not, why?

Summary of Responses: A few participants in the focus group sessions had used telehealth services. Overall, they found it convenient, especially for medicine assessments. Telehealth users found telehealth convenient, saved on transportation costs, and found it a mechanism to receive care consistently and continuously. Participants thought telehealth services can be a good way to receive behavioral health services if there are no technology issues. Telehealth services also were found to be a way to overcome wait times for appointments and expedite service. On-telehealth servicer users in the groups said they would give telehealth a try but expressed they would prefer to initially meet the provider in person.

List of Responses (paraphrased focus group participant responses):
Responses from Those Who had Used Telehealth Services: about 15 total for all groups

- For medication checkup it was fine but not for therapy
- Love telehealth. It is convenient
- Other people in room or area can listen to conversations (lack of privacy, security, and confidentiality
- Some technology issues at times
- Awkward to do
- Good if you have a busy life and with a full-time job can't take time off work
- Easy and convenient to schedule
- Saves on driving or depending on transportation

Responses from Those Who had Not Used Telehealth Services:

- Would absolutely try
- Would like to meet the provider prior to using

Question 7: What is appealing or unappealing about group therapy? Why would or wouldn't you go to group therapy?

Summary of Responses: A small number of participants participated in group therapy and overall found it helpful. Hearing and learning from others and making friends was cited as beneficial. Participants who choose not to or have never used group therapy or find it unappealing had concerns about confidentiality. Participants expressed that if a

client has difficult, complex issues to overcome, one-on-one therapy would be better than group therapy. Private people or those with difficulty talking also find group therapy unappealing.

List of Responses (paraphrased focus group participant responses):

Appealing Aspect of Group Therapy:

- Would it be ok if you are with people with shared experiences
- Voluntary clients are more invested, but some court-ordered participants just show up because they must
- If in a group, you're not going to be judged
- It's a way to make friends
- Hearing other's stories makes you feel you are not alone
- Group trust is necessary

Non-appealing Aspects of Group Therapy:

- Concerns about confidentiality if people talk outside of the group
- I have trouble just talking one-on-one with the therapist, never mind talking in a group
- Private people don't want to share their issues with strangers
- I have a lot to work through that I am not comfortable exposing to others
- Can be invasive

Question 8: What services do you think are most important for people living with behavioral health needs? What services are needed but not available?

Summary of Responses: There were a variety of responses to this question. Many of the needs expressed were conveyed throughout the entire focus group sessions in response to other questions posed. The focus group participants clearly expressed the need for medication management, case coordination, improved crisis services and transportation. Participants also voiced needs for supportive services such as housing, parenting classes, trauma-informed care, services specific for domestic violence victims, services for persons upon discharge from residential treatment facilities, specific services for children, peer services in schools, food at day treatment facilities, and primary, vision and dental care. Participants summarized that services need to be available for everyone and not just limited to the specific needs or behavioral issues of certain individuals.

List of Responses (paraphrased focus group participant responses):

Most important service needs:

- Medication management
- Medication and talk therapy in tandem, individually they don't work
- Case coordination
- Crisis services
- Psychiatric urgent care

- Community supervision
- Housing, residential facility
- Expansion of FACT team services
- Transportation to services

Services not available:

- Supportive housing, residential
- Separate facilities for children
- School therapists only serve females – need the same service for males
- Peer services, particularly in schools
- Wrap-around services – FACT team, MAT team; more services in the community to help those who come out of residential treatment
- Parenting class for those whose children go to residential, to stop the cycle, help the whole family
- Trauma-informed care for adopted children and parents of adopted children
- Service for everyone, not just limited to certain individuals
- Vision services
- Primary and dental care
- Group for women who are victims of domestic violence. (Some centers have counseling but can go to regular providers through Meridian)
- No food services at social rehab (day treatment that lasts all day), have to bring in own food, snacks in morning

Question 9: Are there groups of people who have a difficult time getting the behavioral health services they need? If so, who are those people and why is it more difficult for them to access the services.

Summary of Responses: The responses to this question about groups of people who have a difficult time getting behavioral health services are reflective of many of the barrier issues discussed by the focus group participants throughout the sessions. Participants expressed that there many groups and individuals who face disparities caused by their environment and various social determinants of health including lack of health insurance, race, poverty, education, housing deficiencies, income, and language barriers.

List of Responses (paraphrased focus group participant responses):

- People who don't have transportation
- Low-income persons can't get gas, or don't have a car
- People who have social anxiety to get treatment
- Hard to get into a van full of people if you have social anxiety
- People with language barriers
- People with different types of abilities (physical, behavioral, intellectual, developmental)
- People without resources
- People out of jail or state hospitals

- Groups that have difficult time include children. Services not available, especially if you don't have health insurance
- Homeless people, people who don't know how or where, might be scared or intimidated
- Hard to get help until you get in trouble and incarcerated
- Those that must go to detox first to get help
- Detox is more for alcoholics, not for cocaine, other drugs
- Insurance, drug of choice, stable housing are issues, getting arrested or negative act gets you to services
- Those in poverty and people of color, it's (services) not as open to them, not as offered to them as often as it is to others.
- Persons who suffer addiction remain in poverty if they are unable to maintain steady employment
- People not educated about mental health, parents are addicted, I had to wait till I was older to make my own decisions, environment makes it difficult to access services
- The homeless population needs services, but they can't access it, community services are needed

Question 10: If there was anything you could change about behavioral health services, what would it be?
Summary of Responses: While many of the responses to this question reflect needs for improvements in the delivery and availability of behavioral health services for many groups and individuals, participants expressed that many people need services. Focus group participants expressed that mainstreaming behavioral/mental health care by removing stigmas and elevating acceptance, compassion, and competencies of medical providers to treat and coordinate care will provide opportunities for everyone to have a chance to succeed and achieve mental and physical well-being.

List of Responses (paraphrased focus group participant responses):

- Remove barriers so everyone has a chance to receive services barriers
- Increase supply of services. There is such a demand and low supply
- Improved coordination between the providers
- Information sharing between facilities and providers
- Continuum of care increasing staff, weekend appointments, wrap around services, including housing and weekend hours
- Improve the criminal justice system role in behavioral health care
- Competence of providers
- Integrated care, therapist like a primary care doctor, medicines
- Training for medical personnel such as primary care physicians
- Compassion and understanding from providers
- Safe transportation
- Remove stigma, need ER staff nurses and doctors to take mental health seriously

- Get help with the different types of little problems and get the proper help, proper medications
- Services are segmented
- Better diagnosis
- Improved services for children and adolescents to prevent Baker Act admissions and related crisis
- Insurance

NO WRONG DOOR SURVEY SUMMARY

BACKGROUND

The Behavioral Health Needs Assessment No Wrong Door (NWD) survey was available in March 2022 for several weeks. It was distributed by LSFHS to staff at funded providers via email.

The NWD Survey included 17 questions. The purpose of the survey was to access the extent to which providers have implemented six criteria adopted from the Administration for Community Living as the integrated system with key consideration of: information, referral, and community awareness, person-centered counseling, eligibility determination, person-centered transition support, partnerships and stakeholder involvement, and quality assurance and continuous improvement.

A total of 80 responses were collected during the survey period. Providers who responded worked in a variety of settings (providers could select all that applied) including:

- Adult Crisis Unit (8.9 percent)
- Adult Detoxification Unit (2.4 percent)
- Adult Residential Facility (4.9 percent)
- Adult Residential Facility (4.9 percent)
- Adult Outpatient Program (46.3 percent)
- Adult Mobile Response (4.9 percent)
- Children's Crisis Unit (3.3 percent)
- Children's Detoxification Unit (zero percent)
- Children's Residential Facility (2.4 percent)
- Children's Outpatient Program (18.7 percent)
- Children's Mobile Response (4.1 percent)
- Peer Recovery Support (2.4 percent)

Most respondents worked in organizations that provide Adult Outpatient Programs or Children's Outpatient Programs.

SURVEY RESPONSES

The following narrative summarizes responses to each survey question. The survey question is provided in Italics and is followed with the responses according to percentage.

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

- Yes (65 percent)
- No (6.3 percent)

- Not Sure (28.8 percent)

Question: *From your perspective, your organization has a role to play in the "No Wrong Door" access.*

- Yes (81.3 percent)
- No (1.3 percent)
- Not Sure (17.5 percent)

Most respondents agreed their organization has a role to play in NWD access.

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

- Strongly Agree (37.5 percent)
- Agree (45 percent)
- Not Sure (6.3 percent)
- Disagree (7.5 percent)
- Strongly Disagree (1.3 percent)
- No Response (2.5 percent)

More than 82 percent of providers "strongly agreed" or "agreed" their organization has a strong care coordination process that provides warm handoffs to services, yet 8.8 percent disagreed or strongly disagreed.

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

- Strongly Agree (47.5 percent)
- Agree (36.3 percent)
- Not Sure (12.5 percent)
- Disagree (1.3 percent)
- Strongly Disagree (1.3 percent)
- No Response (1.3 percent)

According to respondents, 83.8 percent of organizations have improved the referral and care coordination process for individuals served while 2.6 percent of respondents did not believe their organization had improved the referral and care coordination process. Given these responses, there may be room for continued improvement, however, organizations have already made strides in improvement efforts.

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

- Strongly Agree (30 percent)
- Agree (45 percent)
- Not Sure (20 percent)
- Disagree (five percent)
- Strongly Disagree (zero percent)

Given that nearly 20 percent of respondents were "Not Sure," providers may need more information regarding linkages to crisis intervention and support services in their service area.

Question: *In your opinion, your organization promotes its services and resources very well.*

- Strongly Agree (33.8 percent)
- Agree (41.3 percent)
- Not Sure (11.3 percent)
- Disagree (8.8 percent)
- Strongly Disagree (3.8 percent)
- No Response (1.3 percent)

More than three-quarters of respondents "agreed" or "strongly agreed" that their organization promotes its services and resources well. Twelve percent "disagreed" or "strongly disagreed" which indicates an opportunity for improving the promotion of services and resources.

Question: *In your opinion, your organization promotes awareness of available options and linkages to needed services?*

- Strongly Agree (38.8 percent)
- Agree (38.8 percent)
- Not Sure (13.8 percent)
- Disagree (6.3 percent)
- Strongly Disagree (2.5 percent)

More than three-quarters of survey respondents "agreed" or "strongly agreed" that awareness of available options and linkages to needed services were promoted by their

organizations. However, more than 20 percent were “not sure” or “disagreed” to some extent, indicating that more can be done for such promotion and linkages.

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

- Strongly Agree (50 percent)
- Agree (40 percent)
- Not Sure (7.5 percent)
- Disagree (2.5 percent)
- Strongly Disagree (zero percent)

Ninety percent of respondents “agreed” or “strongly disagreed” that their organization provides person-centered care for all individuals served with 2.5 percent who “disagreed” indicating a high confidence in the provision of person-centered care.

Question: *In your opinion your agency hires employees who are culturally sensitive and culturally competent for the population served?*

- Strongly Agree (42.5 percent)
- Agree (43.8 percent)
- Not Sure (12.5 percent)
- Disagree (1.3 percent)
- Strongly Disagree (zero percent)

Overall, respondents believed their organization hires culturally sensitive and culturally competent staff.

Question: *In your opinion, it is easy for individuals to access the services they need quickly and efficiently.*

- Strongly Agree (23.8 percent)
- Agree (36.3 percent)
- Not Sure (12.5 percent)
- Disagree (20 percent)
- Strongly Disagree (7.5 percent)

Sixty percent of respondents believed it is easy for individuals to access the services they need quickly and efficiently while 27 percent of respondents “disagree” or “strongly disagree.” The result points to the need for further assessment of how individuals access services.

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

- Yes (55 percent)
- No (12.5 percent)
- Not Sure (32.5 percent)

Respondents' opinions regarding a standard intake process were mixed. While some respondents believed a standard intake process would help (50 percent), many were unsure (32.5 percent) or did not think it would help (12.5 percent).

Question: *In your opinion, your organization encourages working with other community partners to ensure care coordination.*

- Strongly Agree (43.8 percent)
- Agree (41.3 percent)
- Not Sure (8.8 percent)
- Disagree (five percent)
- Strongly Disagree (zero percent)
- No Response (1.3 percent)

Most respondents "strongly agreed" or "agreed" their organization works well with community partners ensuring care coordination.

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

- Strongly Agree (38.8 percent)
- Agree (23.8 percent)
- Not Sure (15 percent)
- Disagree (18.8 percent)
- Strongly Disagree (3.8 percent)

Many respondents (22.5 percent) "disagreed" or "strongly disagreed" that individuals in need of services have equal access while 15 percent of respondents were "not sure."

Question: *In your opinion, Stakeholders help to address and advocate for equal access to care in system entry points.*

- Strongly Agree (13.8 percent)
- Agree (38.8 percent)
- Not Sure (35 percent)
- Disagree (10 percent)
- Strongly Disagree (2.5 percent)

Slightly more than half of the respondents "strongly agreed" or "agreed" that stakeholders help to address and advocate for equal access to care in system entry points while (35 percent) of respondents were "not sure."

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

- Strongly Agree (42.5 percent)
- Agree (47.5 percent)
- Not Sure (6.3 percent)
- Disagree (3.8 percent)
- Strongly Disagree (zero percent)

Survey respondents were in strong agreement (90 percent) that their organizations ensure high quality services are delivered and that they meet the needs of individuals.

Question: *In your opinion, your organization tracks individuals served, services, performance, and costs to continually evaluate and improve outcomes?*

- Strongly Agree (31.3 percent)
- Agree (52.5 percent)
- Not Sure (15 percent)
- Disagree (1.3 percent)
- Strongly Disagree (zero percent)

More than 80 percent of respondents “strongly agreed” or “agreed” their organization tracks individuals served, services, performance, and costs to continually evaluate and improve outcomes indicating continuous improvement is a strong component of provider organizations’ processes.

NO WRONG DOOR SURVEY CHARTS

Figure 121: I work in a/an...

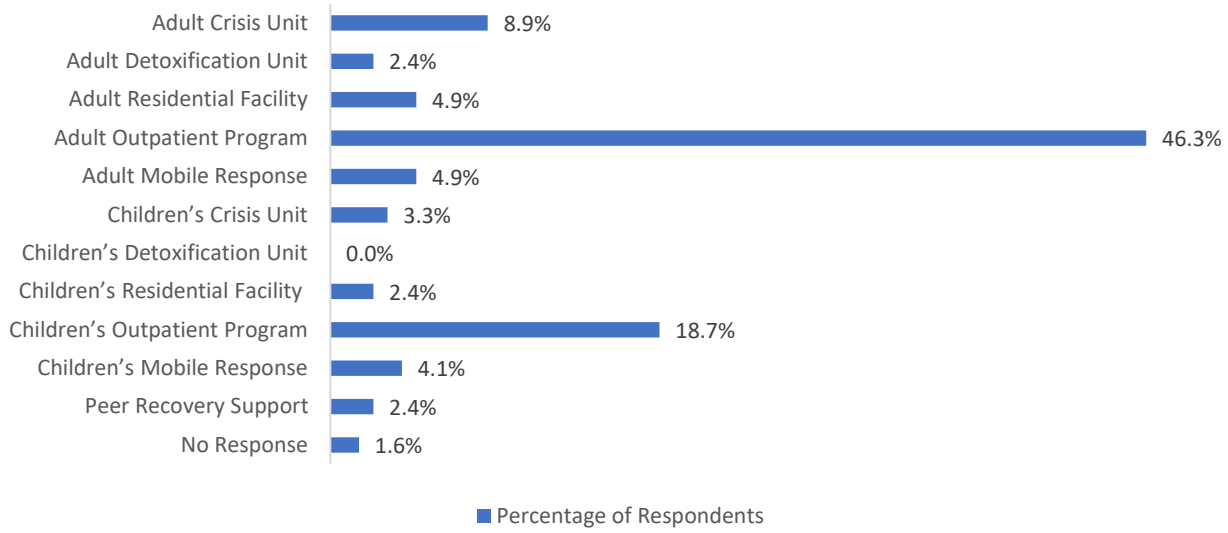


Figure 122: Do you think the "No Wrong Door" access works well within your organization?

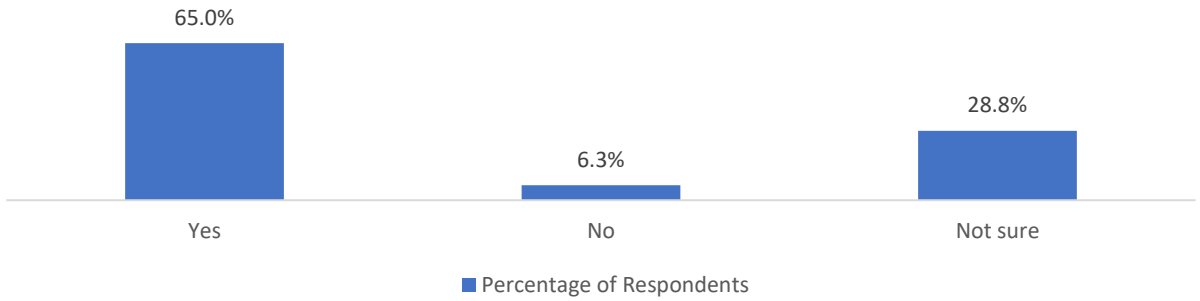


Figure 123: From your perspective your organization has a role to play in the "No Wrong Door" access.

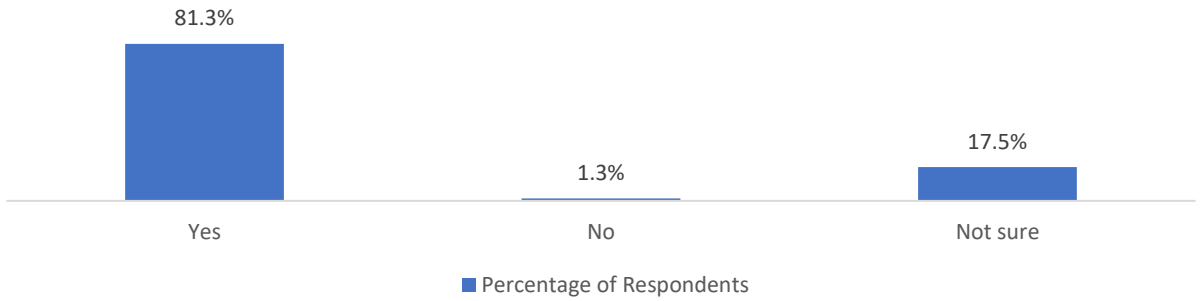


Figure 124: In your opinion, your organization has a strong care coordination process that includes warm handoffs to service and seamless care coordination.

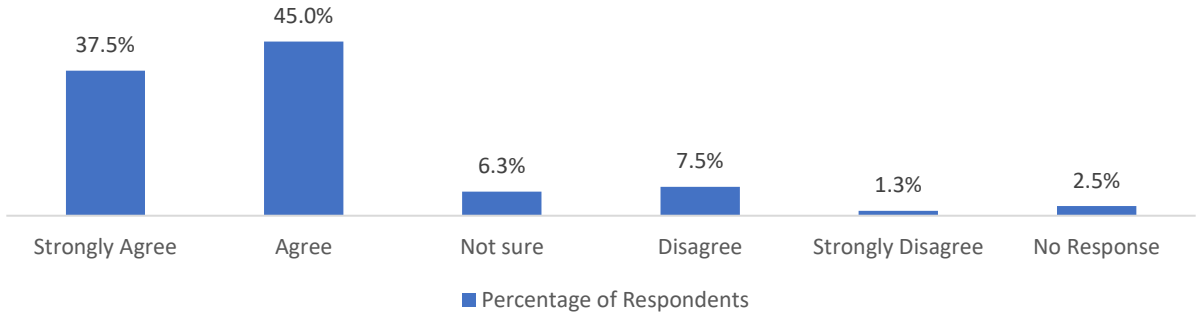


Figure 125: In your opinion, your organization has taken action to improve the referral and care coordination process for individuals served.

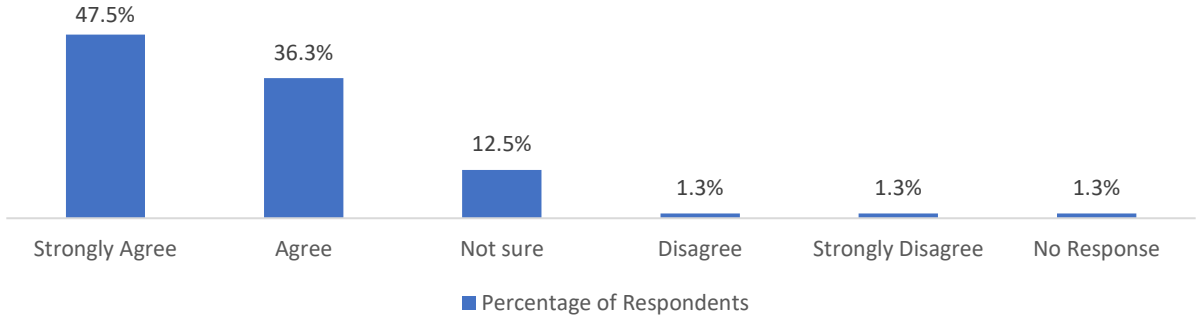


Figure 126: In your opinion, linkages to crisis intervention and support (like the Mobile Response Team, medication management, CRF, CIT Officer, BA, CSU, etc.) are occurring.

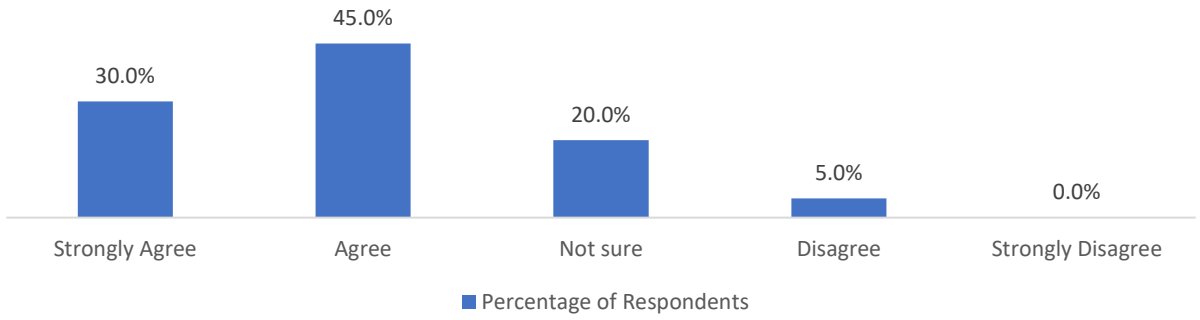


Figure 127: In your opinion, your organization promotes its services and resources very well.

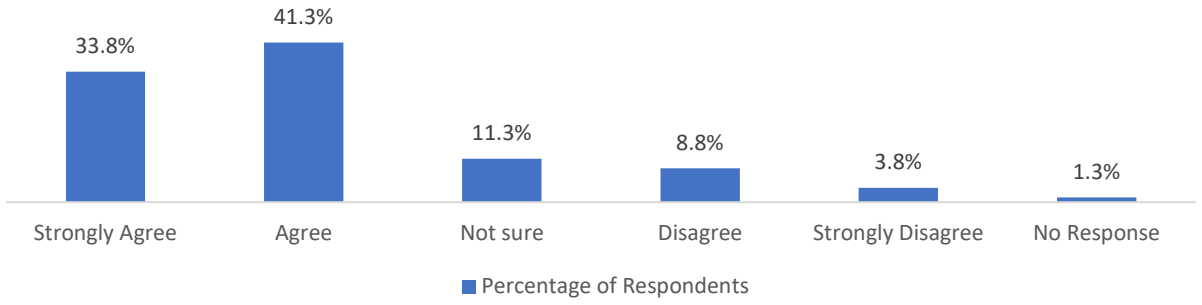


Figure 128: In your opinion, your organization promotes awareness of available options and linkages to needed services.

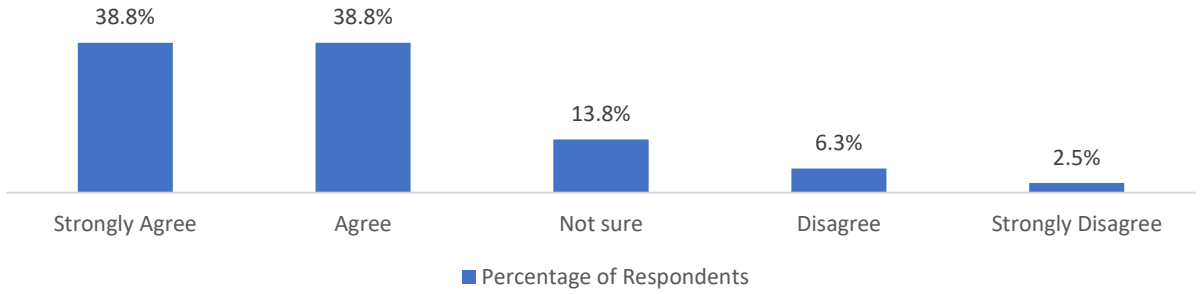


Figure 129: In your opinion, your organization provides person-centered care for all individuals served.

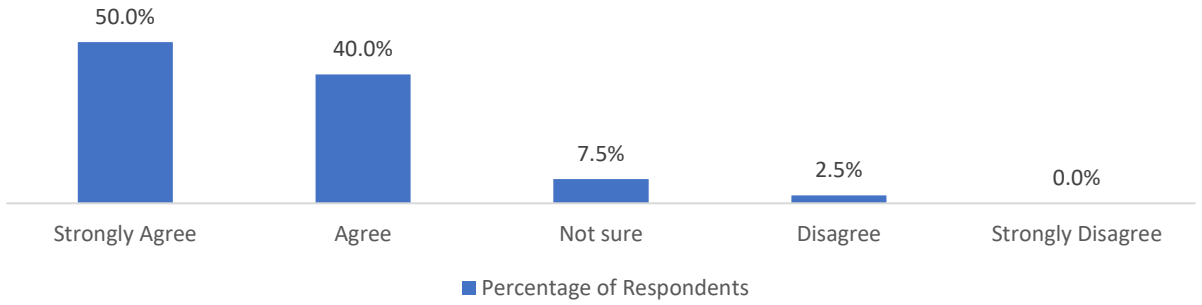


Figure 130: In your opinion, your agency hires employees who are culturally sensitive and culturally competent for the population served.

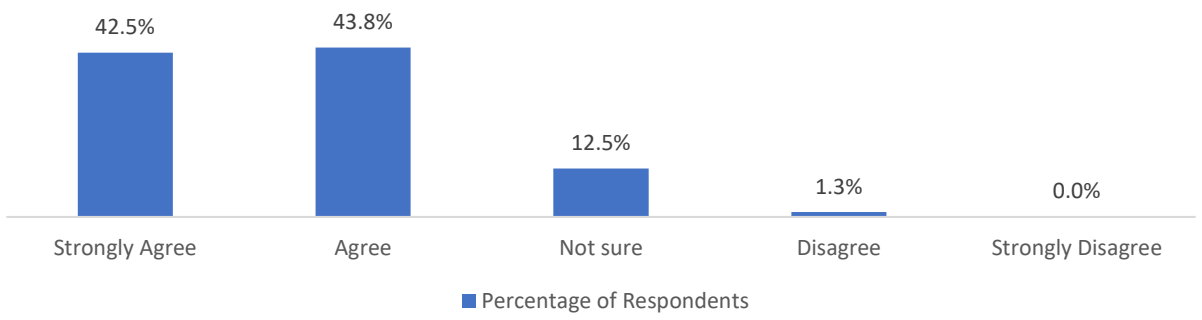


Figure 131: In your opinion, it's easy for individuals to access the services they need quickly and efficiently.

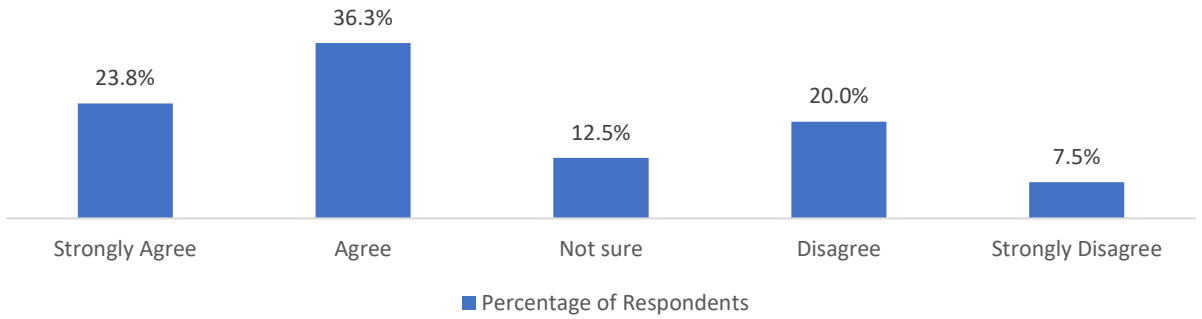


Figure 132: Do you think a standard intake and screening process for the state agencies and community partners would help individuals get into services more quickly?

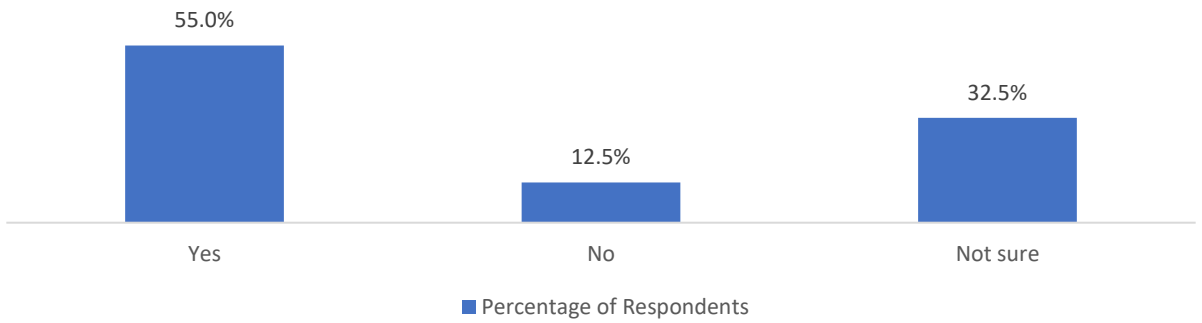


Figure 133: In your opinion, your organization encourages (promotes) working with other community partners to ensure care coordination.

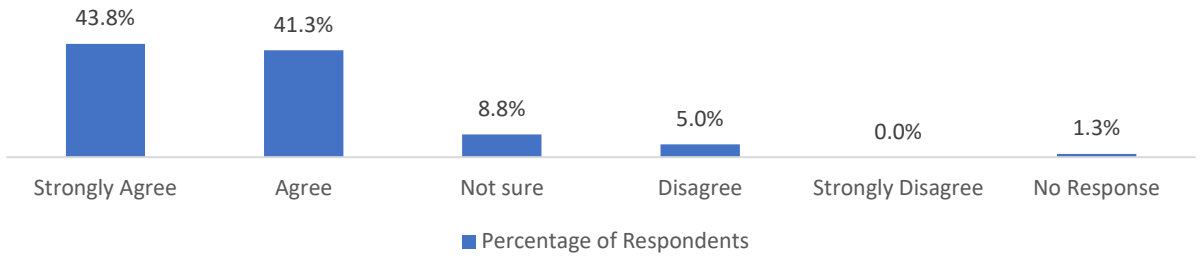


Figure 134: In your opinion, individuals in need of services have equal access to care.

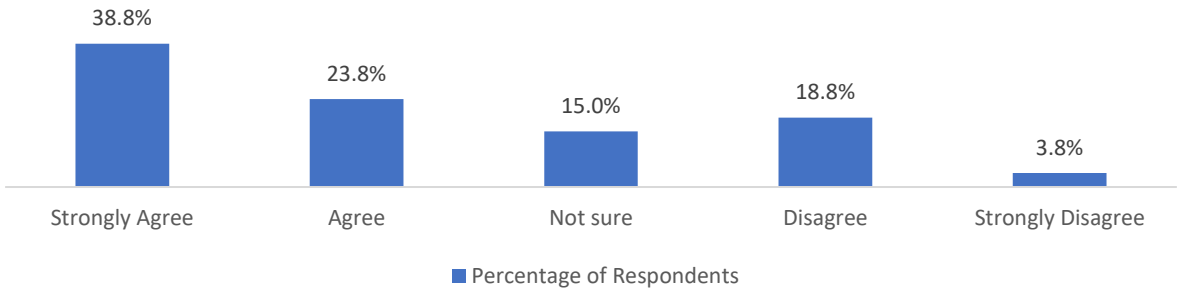


Figure 135: in your opinion, stakeholders help to address and advocate for equal access to care in system entry points.

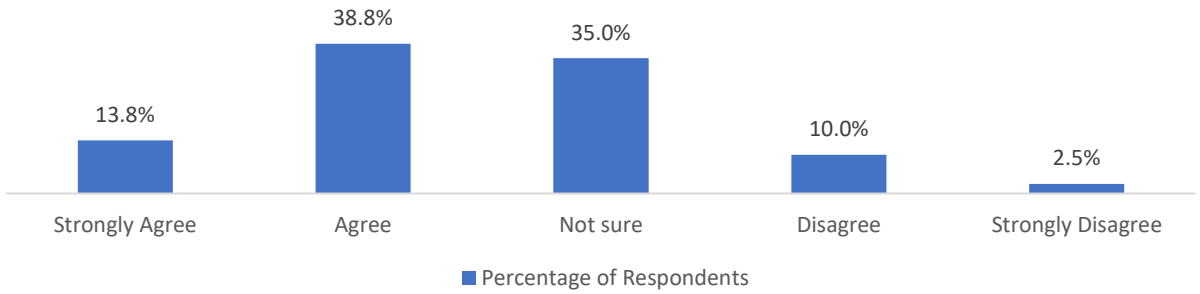


Figure 136: In your opinion, your organization ensures that services are of high quality and meet the needs of individuals served.

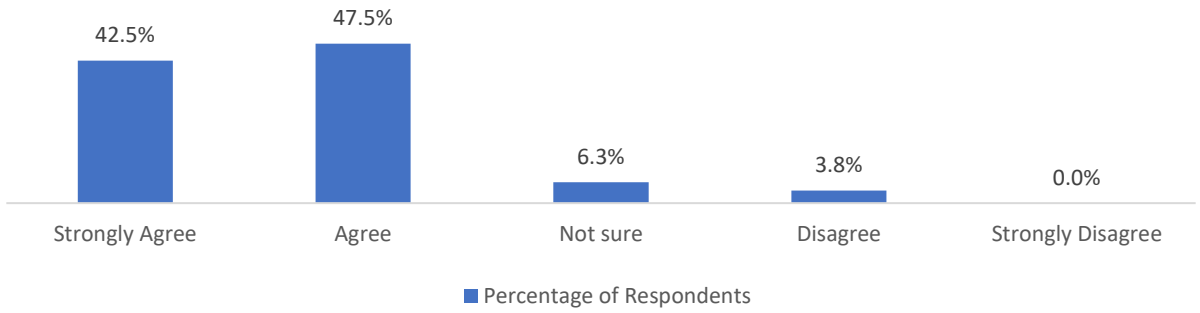
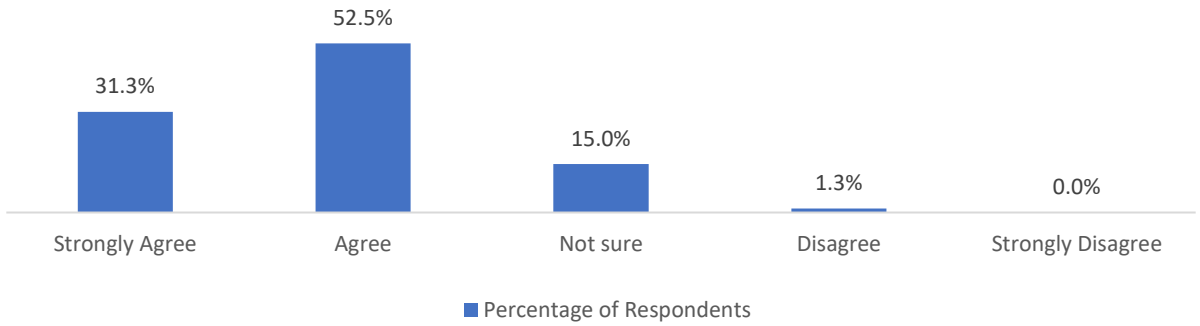


Figure 137: In your opinion, your organization tracks individuals served, services, performances, and costs to continually evaluate and improve outcomes.



NO WRONG DOOR LSFHS PROVIDER FOCUS GROUP SUMMARY

FOCUS GROUP METHODOLOGY

LSFHS is one of seven behavioral health Managing Entities (ME) contracted by DCF to manage the state-funded system of behavioral health care for people who face poverty and are without insurance. LSFHS serves a 23-county region in Northeast and North Central Florida which includes the counties of Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Hernando, Lake, Lafayette, Levy, Marion, Nassau, Putnam, St. Johns, Sumter, Suwannee, Union, and Volusia.

LSFHS promoted the NWD Provider focus groups to contracted provider leaders. Three focus groups were facilitated by WellFlorida Council via the Zoom Platform and each focus group was one hour in length. The script of six questions (see below) about behavioral health services in the ME service area was used to obtain feedback from the participants. A summary of the respondents' input is provided below.

SCHEDULE OF FOCUS GROUP SESSIONS

Date (2022)	Time	Estimated Number of Participants
April 22	1pm - 2pm	5
April 25	12pm - 1 pm	8
April 26	9am - 10am	5

FOCUS GROUP SUMMARY

Each of the three focus groups followed the same focus group script. The following pages present summaries of the focus group participants' responses to each question. A summary of the responses across the three groups for each of the six questions is provided. The summaries are followed by themes that were identified.

Question 1: In what ways has your organization improved referral and care coordination? What are suggestions for continued improvement?

Summary of Responses: Referrals are now accessible online for convenience and providers work with many partners to promote services and remove barriers to services. To remove direct access barriers, providers meet individuals where they are, such as in the home, school, community locations, etc. The online referral form allows anyone to

refer individuals served from anywhere. Some providers have incorporated monthly meetings with care coordination teams. These meetings provide a regular opportunity to examine referral sources, 30-day readmission rates, and other metrics to improve services and processes. Provision of services in additional locations has improved referral and care coordination. One provider shared his experience working with LSF for technical assistance related to improving referrals and care coordination. In his opinion, improvements based on the technical assistance received made a noticeable difference in referrals and care coordination. A provider expressed that many changes in the intake process occurred including assigning an assistant to manage phone calls and communications for referrals and care coordination. This organization now completes the formalized intake process in person. This required hiring additional staff and finding grants to fund those new staff positions geared at improving the referral process and care coordination.

List of Responses (Paraphrased focus group participant responses):

- Online referral forms
- Meeting individuals served in person in locations that are convenient to them such as in schools, their home, community organizations, etc.
- Improved referral processes with partnering community organizations
- Monthly meetings to review referrals and success and challenges
- Difficult to engage the parents and without their engagement children are often not referred to or treated
- Paperwork takes four times the amount of time than the time to work with people
- LSF helped our organization improve and streamline our services. Noticeable improvements have been made in a short time.
- Hired additional staff to assist with referrals and care coordination
- Applied to grants and received additional funding to support additional referral and care coordination staff
- Formalized intake as an in-person process
- Staff offer in-home services to maintain contact with individuals served
- Continual improvements occurring

Question 2: How does your agency promote awareness of available options and possible linkages to needed services? What else can be done to increase awareness of behavioral health services?

Summary of Responses: Agencies expressed a variety of promotional activities including community outreach to the public and organizations, internet-based promotion, speaking engagements, resource guides, and social media, however, most respondents agreed that their expertise is not in marketing and that efforts could most likely be improved. Restricted funding creates challenges for the availability of services especially

for persons in need of services who are commercially insured as many of the programs are not reimbursed by commercial insurances. For example: If a person does not have insurance, they have access to programs, but it is difficult to provide care coordination for individuals served with commercial insurance when their insurance does not cover the services provided. MOUs with partners has improved care coordination.

List of Responses (Paraphrased focus group participant responses):

How does your agency promote awareness of available options and possible linkages to needed services?

- Social Media
- Community Outreach
- Speaking engagements
- Paid advertising
- Resource Guides (being listed in)
- Communication team assigned to promote awareness of services
- Care coordinators will soon be located at juvenile care centers in Volusia
- Partnerships with other organizations
- Provide trainings to school guidance counselors

What else can be done to increase awareness of behavioral health services?

- Continued outreach
- Improved overall marketing (efforts guided by someone with marketing expertise)
- Ability to serve all individuals with the services that are the best fit for their needs regardless of insurance status and ability to pay

Question 3: What resources or supports does your agency need to improve person-centered care?

Summary of Responses: Common themes among focus group participants for needed resources or supports were additional funding for existing funded/allowable services, funding for services that are not currently allowable under Medicaid, the ability to recruit, hire and maintain staff, ability to seek and receive reimbursement for all best practices, and an increase in Medicaid reimbursement rates.

List of Responses (Paraphrased focus group participant responses):

- Additional funding
- Funding to cover the cost of services for persons with private insurance
- Difficult to recruit and hire new staff, difficult to retain staff

- Lack of individuals who want to work in publicly funded behavioral health due to lower salaries than those in private practice
- Young professionals want to earn more money than they can earn in behavioral health, so they are not entering the behavioral health field.
- Need access to free training on evidence-based practices
- Need increased Medicaid reimbursement rates to ensure we can provide adequate services
- Funding for non-funded services that are best practices

Question 4: What does your organization do or provide that helps people access services quickly and easily? What barriers prevent easy and quick access to services?

Summary of Responses: Providers responded that telehealth, mobile buses, walk-in availability, peers, working closely with law enforcement, 24/7 response teams, and low cost or no cost services (for those who qualify) help people access services quickly and easily. Providers responded that limited internet access, transportation, paperwork, lack of staff, fear, stigma, language barriers, and awareness of available services were barriers to quick and easy access to services.

List of Responses (Paraphrased focus group participant responses):

What does your organization do or provide that helps people access services quickly and easily?

- Telehealth allows us to leverage staff from one area to serve individuals in a different area. Expansion of that service is expected because it helps reduce the waiting time for individuals served.
- Purchased a mobile bus
- Open access – people come in/walk in and are immediately able to see a clinician and have an assessment and treatment plan.
- Telehealth
- Walk-ins are able to see a clinician and have an assessment, receive a treatment plan, and go to a group session that day if the client wants. People can have their first treatment session in four days.
- Peers in the emergency room allows individuals served to immediately receive treatment and the peers see anyone, regardless of opioid use disorder.
- Work closely with the police department on crisis cases and get through the crisis before burdening individuals served with paperwork. Paperwork can be time intensive, so we worked with insurance companies to determine what part of the paperwork is absolutely necessary.
- 24/7 response team and emergency screening
- 24/7 access center to accept referrals and coordinate intake
- Peers

- Low cost or no cost services for persons who qualify

What barriers prevent easy and quick access to services?

- Telehealth can be a barrier when internet service is limited or not strong
- Transportation
- Paperwork
- Lack of staffing
- Fear
- Stigma
- Language barriers
- Barriers for persons with limited hearing
- Provider capacity
- People in the community not knowing about the services available and the affordability of those services (some people qualify for free or reduced cost services)
- Limited funding

Question 5: What would a standard intake and screening process for state agencies and community partners look like?

Summary of Responses: Providers expressed concerns related to a standard intake and screening process. Concerns centered on the volume of paperwork needed by various agencies and the inability to limit the standard intake and screening process in a way that will reduce paperwork burdens on individuals served and providers. Redundancy in collecting information from individuals served is frustrating for providers and individuals, but not all providers require the same information from persons served. Providers found value in a more streamlined process for individuals served and providers, especially given the high volume of paperwork required. Providers also expressed a desire to share information more quickly with other providers, especially those who use behavioral health services frequently throughout the state. Paperwork required by providers is often determined by accrediting bodies and funding sources and these vary at each provider causing significant challenges in creating a standard intake and screening process. Providers stressed the need to negotiate with funders about required forms and to limit what is collected to only the items that providers can justify. Forms are complicated and hard to understand making it difficult for individuals to fill out forms accurately and quickly.

List of Responses (Paraphrased focus group participant responses):

- Standard process would be ideal but highly unlikely
- Release of information forms allows us to see records, but it often takes a long time to receive the records. Having access to the records would be helpful and a standard process may help with that accessibility
- A standard intake and screening that could be shared between providers would require all providers to use the same electronic record system

- Standard screening tools may be possible, but standard intake and processes overall will be provider specific
- FASAMS (Financial and Services Accountability Management System) could be part of the solution, however, it isn't fully working yet.
- Accrediting bodies all have different standards and providers must comply with those standards
- We need a process that isn't 20 pages long, forms that can be filled out and understood by someone with a 5th grade reading level so our services can start as quickly as possible
- Medicaid requires some information and LSF requires something else
- Is any other state using a standard intake and screening process?
- We need to ask funders: "Why do you need to know this information?" If they cannot justify the request, we should not be required to provide it.

Question 6. Are there individuals in need of services who do not have equal access to care? If so, who are those individuals and what makes it harder for them to have access to care?

Summary of Responses: Providers responded that there are people in services without equal access to care including those with limited transportation, limited internet access, those who have a severe and persistent mentally health condition, those who are involved with the criminal justice system, those with limited health literacy, those living below the poverty line, those with insufficient insurance and high copays, those with disabilities, people of color, LGBTQ+, and other groups who frequently experience health disparities.

List of Responses (Paraphrased focus group participant responses):

- Those involved in the criminal justice system
- People who have a severe and persistent mental health condition
- Lower economic status
- Those in poverty and living below the poverty line
- People who do not trust the system
- People who do not have access to a provider who looks like them
- People of color
- LGBTQ+
- Children with parents lacking resources or unwilling to seek assistance
- Transportation disadvantaged
- People who do not meet the eligibility criteria for funded services
- People with private insurance with high copays
- Rural residents
- Lack of childcare
- Deaf and hard of hearing

- Persons with disabilities
- Persons with limited English proficiency

Additional comments of note:

- It is important for legislatures to know how the system works, that we are seeing the tip of the iceberg for mental health, suicide, overdoses, opioids. This is not going to get better without doing more to provide services and support the peers and providers. These issues impact everything else: child welfare, education, family well-being, everything. When we talk about the staff shortage, how do we get more people in this field and licensed? What will the state do to encourage or incentivize people to go into this field in Florida? How do we identify people in our treatment programs who can become providers?
- Florida is near the bottom of the country in per capita funding for mental health and substance misuse services. The state has been pouring more money into MHSA and it is helping, but it must continue if we are to be in the middle of the nation for resources. We have been woefully underfunded for so long that it takes a while to catch up. How do we sustain the profession of MHSA? Why do I need to be in abject poverty to do this work? Stigma continues to be a barrier for this profession. We have to message our profession differently and people need to value it and we need comparable salaries to recruit new professionals. People feel valued by what they get paid. If you are educated with a master's degree and a license, but you are not making a livable salary, why go into that profession?
- Reduce complexity in billing and paperwork
- Politics has become more important than people and that should change
- Stop persecuting innocent people and start valuing human life
- We need better coordination between the child welfare system and behavioral health system

INDIVIDUALS SERVED SURVEY SUMMARY

BACKGROUND

The Behavioral Health Needs Assessment Individuals Served survey was available in January thru February 2022. It was distributed by LSFHS and their providers to individuals served through various distribution methods including flyers, emails, and word of mouth. To be eligible to complete the survey, respondents must have received a service through a LSFHS funded provider and be at least 18 years of age at the time of the survey. Parents of children individuals served were eligible to respond on behalf of services received by their children.

The survey received 388 responses during the survey period with 16 of the 23 counties in the LSFHS service area represented. Volusia (35.8 percent) and Marion (20.4 percent) counties had the most representation.

Respondents received one of the following service types: adult mental health services, adult substance use services, child mental health services, child substance use services, peer support services, and/or prevention services. The largest percent of responses were from adults who received or receive adult substance use serves (49.9 percent) followed by adult mental health services at 25.7 percent of respondents. Responses for child mental health services (7.7 percent) and child substance use services (2.6 percent) were limited. Peer support services represented 6.9 percent of responses and prevention services represented 6.4 percent of responses.

SURVEY RESPONSES

Ninety percent of respondents know where to go for mental health and substance use treatment services, 4.6 percent were not aware of where to go for those services, and 3.6 percent said they know where to go “sometimes.” Respondents were asked, “How did you learn about mental health and substance use treatment services when you needed them?” The majority of respondents learned through a family member or friend (31.6 percent), another individual in treatment/recovery/peer (21.9 percent), law enforcement (15.3 percent), and word of mouth (14.9 percent). Of the remaining respondents, 2.3 percent learned of services through 2-1-1, social media (5.3 percent), school, and the mobile crisis team (3.6 percent each). Less than half (47.9 percent) of respondents were familiar with 2-1-1 referral line and 59 respondents (15.2 percent) had ever called 2-1-1. Of those who called the 2-1-1 referral line, 36 respondents found it helpful, seven respondents did not find it helpful, and 16 respondents said it was helpful “sometimes.”

Respondents were asked, “Were you able to get all the services you needed when you needed them?” and nearly 81 percent responded “Yes” and 19 percent responded “No.” Those who were unable to get the services they needed were asked a follow-up question

to list the services they needed but did not receive. The service needed and not received most was “housing assistance” (10.7 percent) followed by “other” (9.8 percent) and “medication assistance program” (6.8 percent). Respondents were also asked, “How many times during the last 12 months were you not able to get the services you needed?” Respondents who did not receive services one to two times accounted for 36.7 percent, 15.2 percent of respondents did not receive services three to four times, and 11.5 percent of respondents did not receive services five or more times in the last 12 months.

Respondents were asked about the availability of needed services. Sixty-one percent of respondents said the service needed was available, 12 percent said there was a waitlist, and slightly more than two percent of respondents said the service needed was not available. Most (78 percent) respondents said the services received were focused on their individual needs, while close to 20 percent of respondents did not believe the services received were focused on their individual needs.

Survey respondents were asked, “How long did it take from the time you requested an appointment for services to the time you received the services?” The majority of respondents waited one to two weeks for an appointment (55.9 percent), 15 percent waited three to four weeks, 8.5 percent reporting never receiving an appointment, and 17 percent waited over one to two months for an appointment. Most respondents (69.3 percent) traveled 30 minutes or less to their appointments with 21.1 percent traveling 31-60 minutes to their appointments. Respondents drove themselves to the appointment accounted for 31.1 percent. Those driven by a relative or friend represented 23 percent of respondents, nine percent of respondents walked to their appointment, and 14.2 percent used the public bus system.

When asked, “What were the obstacles you experienced getting the care you needed?”, respondents said no or very limited transportation (10.5 percent), long waitlists (9.8 percent), could not afford the service (8.9 percent), and 7.3 percent did not know where to go for services. Those with no barriers accounted for 28.9 percent of respondents.

INDIVIDUALS SERVED SURVEY CHARTS

Figure 138: Which best describes you?

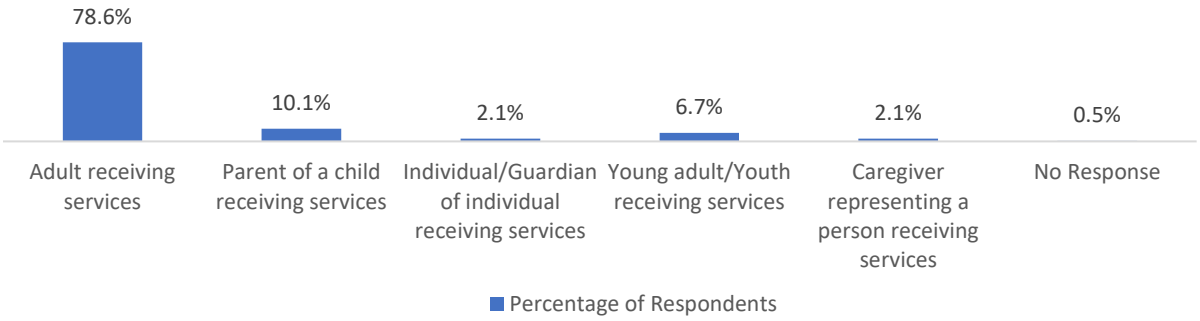


Figure 139: What type of service did you or the person you are representing receive? (Check all that apply)

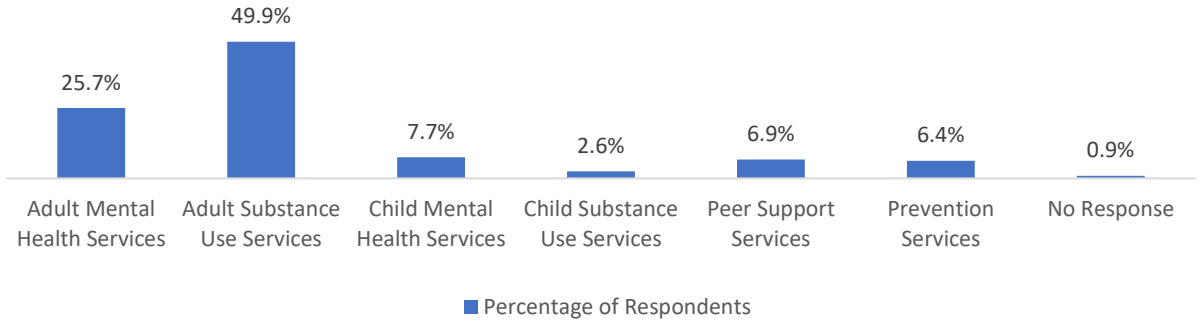


Figure 140: Which county do you live in?

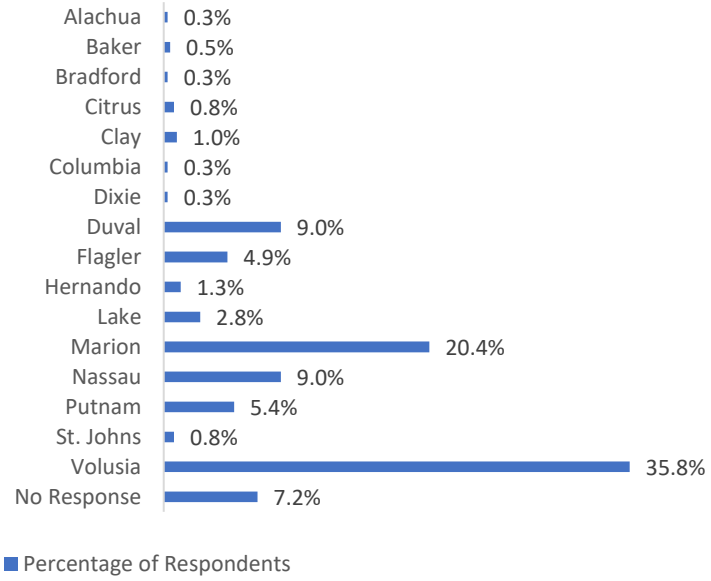


Figure 141: Did you know where to go for mental health and substance use treatment services when you needed them?

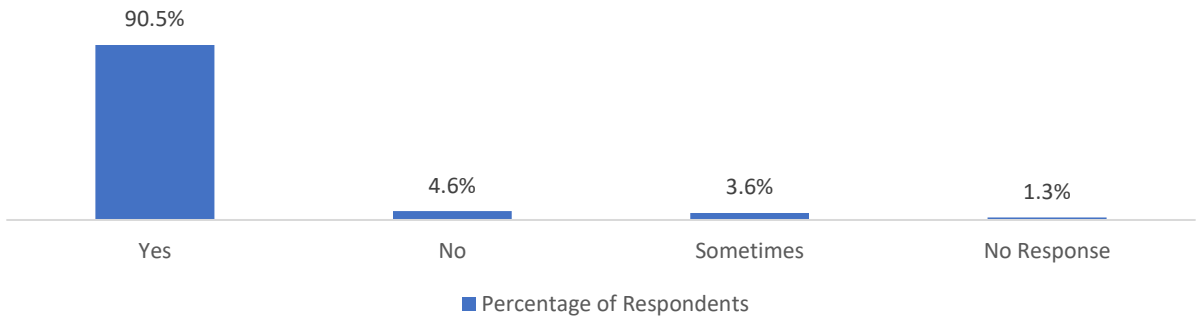


Figure 142: How did you learn about mental health and substance use treatment services when you needed them? (Check all that apply)

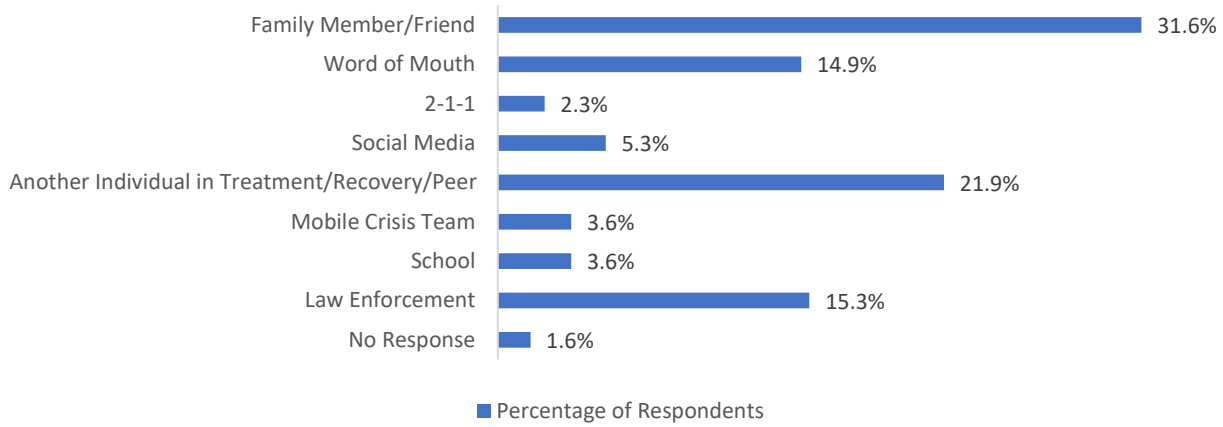


Figure 143: Are you aware of the 2-1-1 Information and Referral Resource in your community?

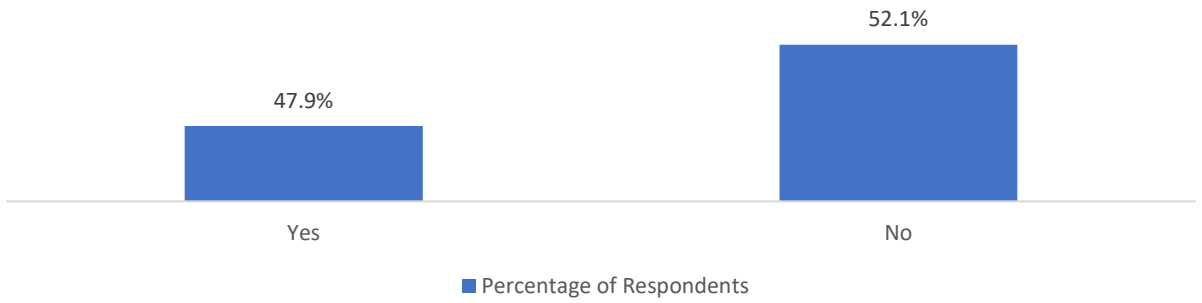


Figure 144: Have you ever called 2-1-1 Information and Referral Resource for assistance?

Figure 145: When you called the 2-1-1 Information and Referral Resource, were they helpful in getting you the services needed?

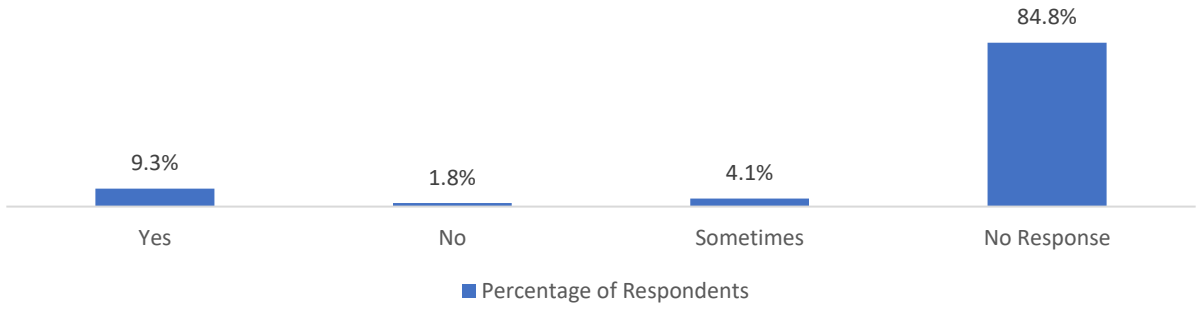


Figure 146: Were you able to get all the services you needed when you needed them?

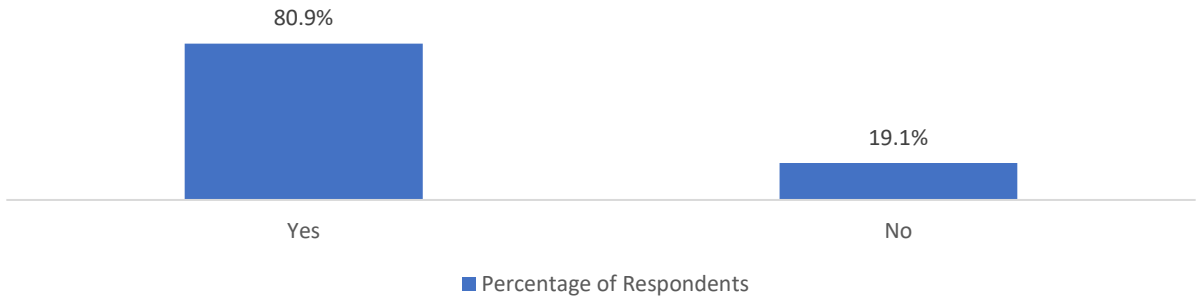


Figure 147: If no, please choose from the list below, the services you needed but were not able to get.

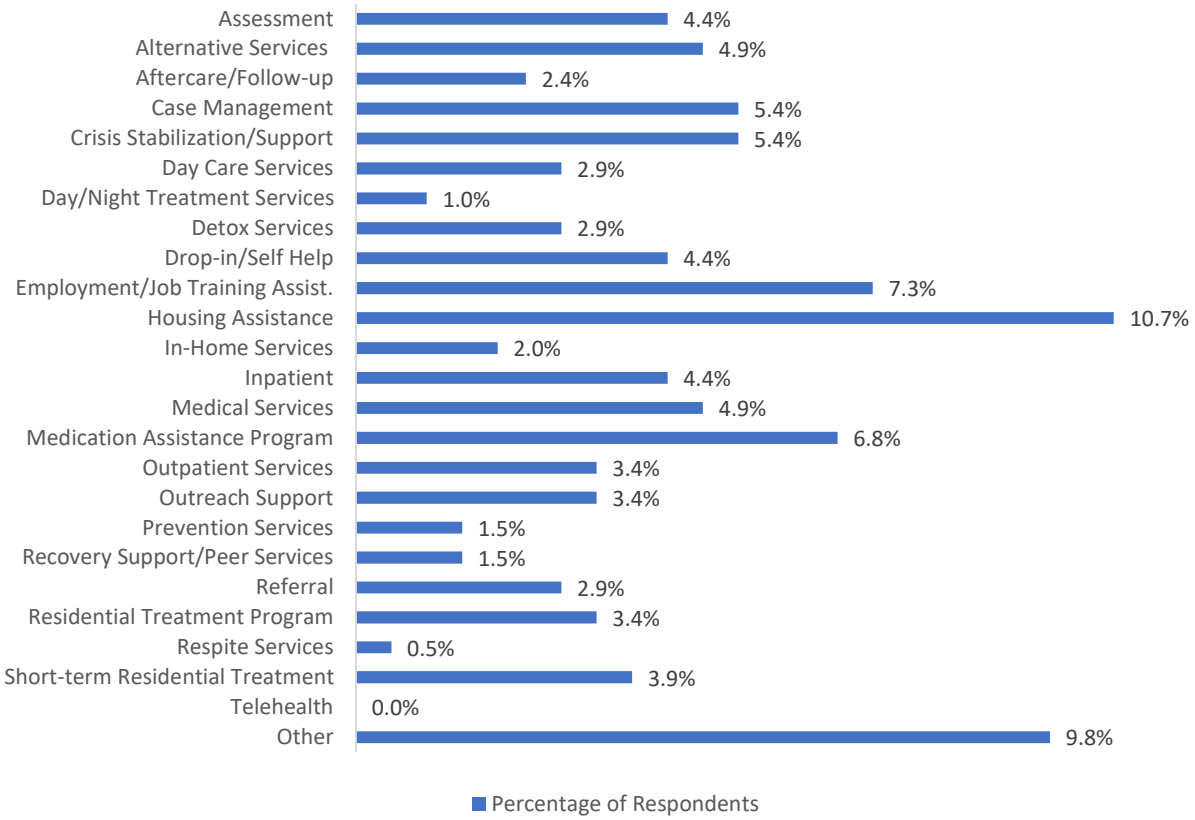


Figure 148: How many times during the <u>last 12 months</u> were you not able to get the services you needed?

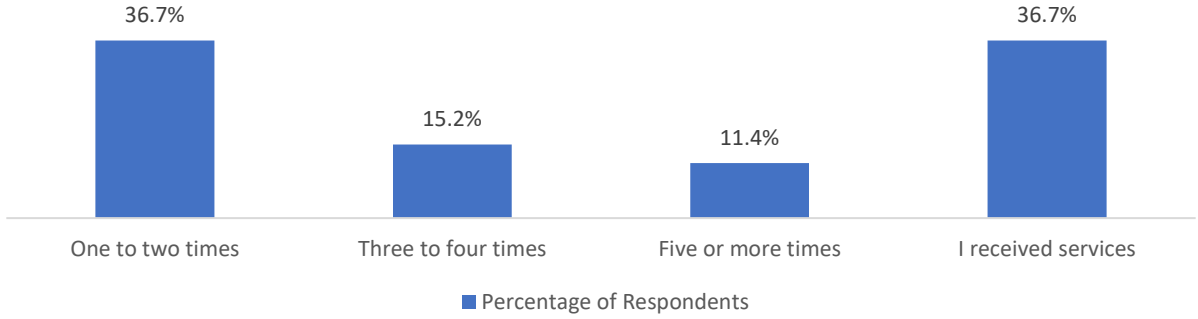


Figure 149: The services I needed were:

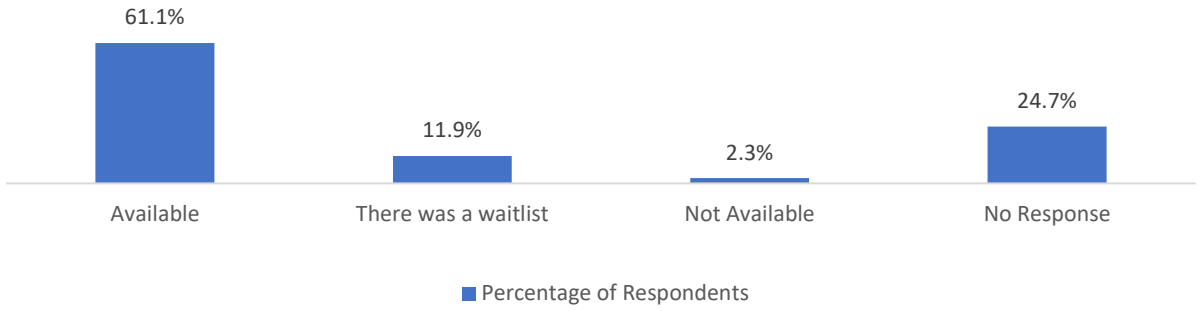


Figure 150: The services and planning I received were focused on my treatment needs (patient centered)

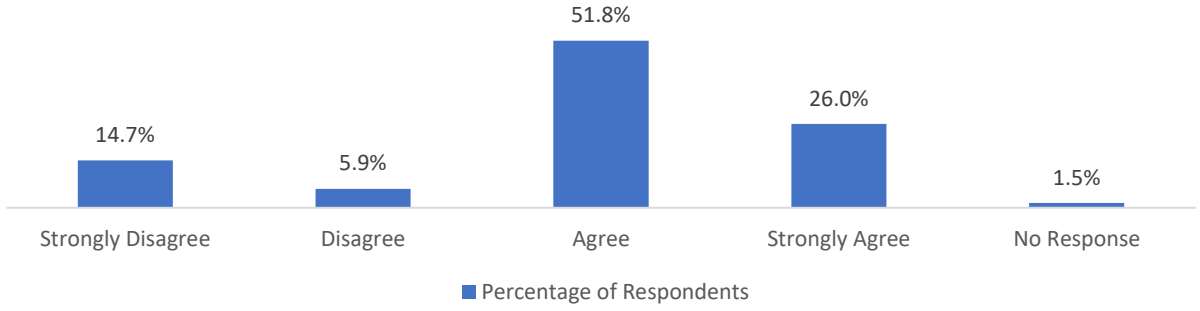


Figure 151: How long did it take from the time you requested an appointment for services to the time you received the services?

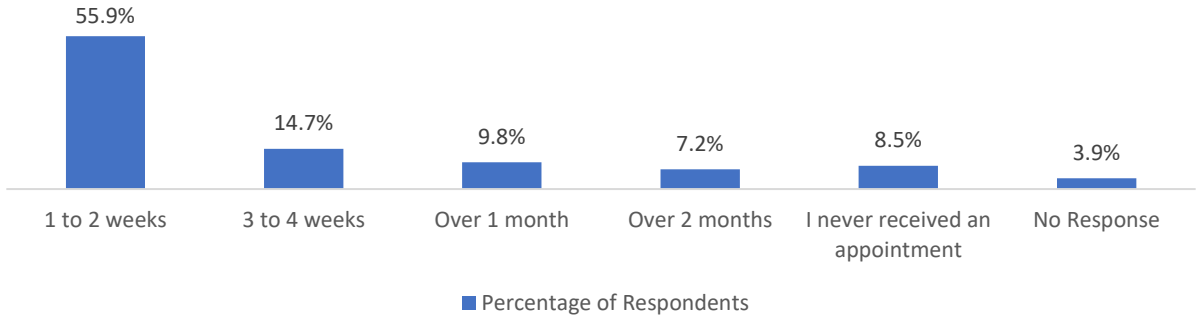


Figure 152: How long did it take you to travel to the service?

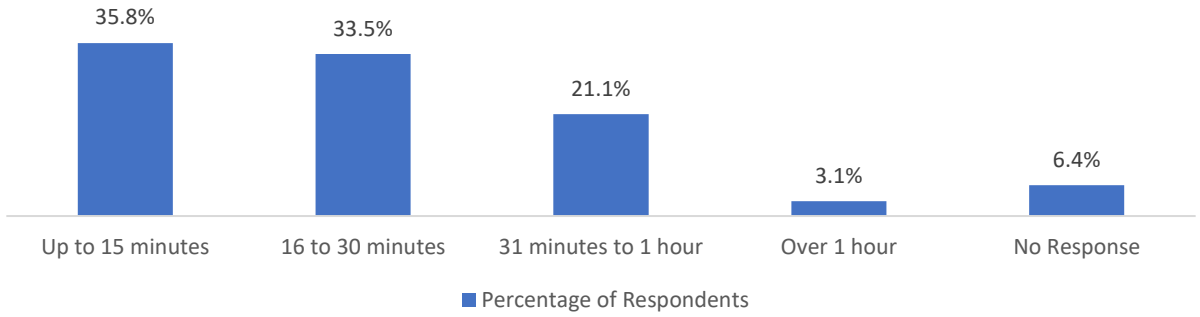
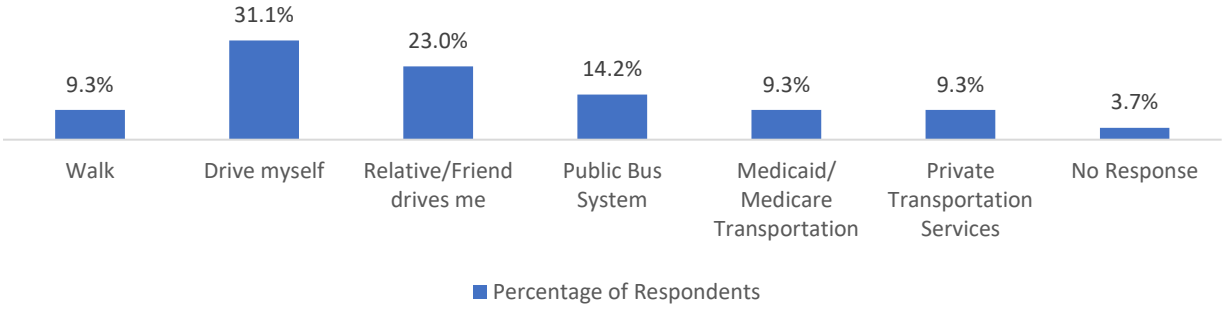
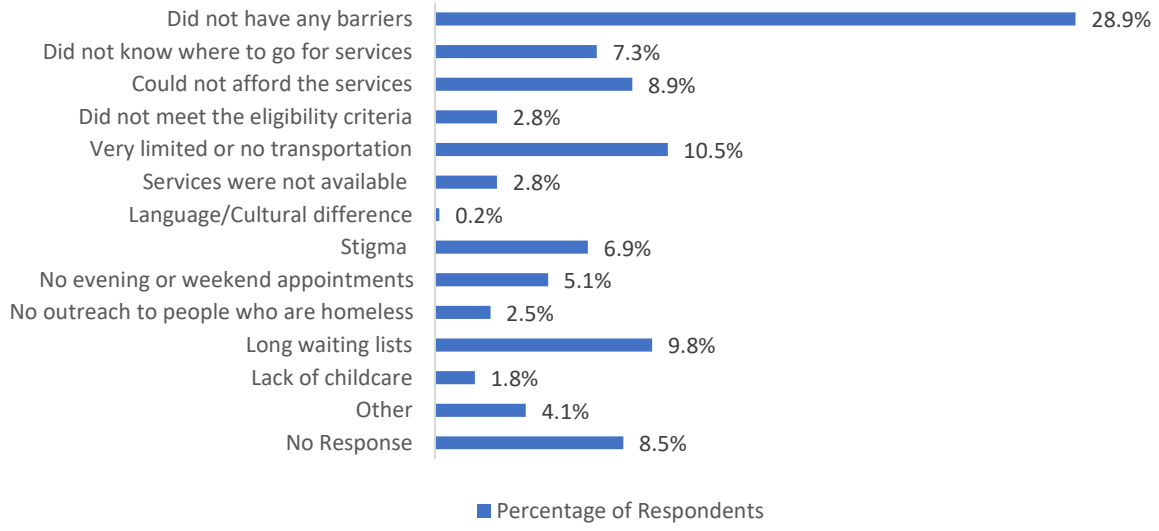


Figure 153: How do you travel to get to services? (Check all that apply)



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

Figure 154: What were the obstacles you experienced getting the care you needed? (Check all that apply)



Note-Services were not available in the county where I live

STAKEHOLDER SURVEY SUMMARY

BACKGROUND

The Behavioral Health Needs Assessment Stakeholder survey was available in January thru February 2022. It was distributed by LSFHS, their providers, and community partners through various distribution methods including flyers, emails, and word of mouth. The intent of the survey was to better understand the perspectives of community partners and organizations serving in the 23-county region.

SURVEY RESPONSES

In total, 387 responses were collected during the survey period. Respondents were asked to select the service sector which best described their organization. Respondents of children and family services organizations accounted for 11.5 percent case management organizations (9.3 percent), children mental health care organizations (7.7 percent), and adult mental health care organizations (6.4 percent). All 23 counties in the LSFHS service area were represented in the survey, with respondents providing services in St. Johns at 7.6 percent, Marion (7.5 percent), Citrus (six percent) and Hernando County at 6.1 percent. Respondents we asked to rate their level of agreement to the statement, “You are aware of the availability of mental health and substance use services in your area?” Most (88 percent) responded, “agree” or “strongly agree.” Those not aware of services accounted for 12 percent of respondents. When respondents were also asked if they were aware of LSFHS resources, 56 percent said “yes” and 44 percent said “no.” It is possible that respondents are aware of LSFHS service providers, but not aware of LSFHS and the ME network in Florida. Respondents who had accessed LSFHS services in the past six months accounted for 24.6 percent while 75.5 percent had not accessed services. Of those who accessed services in the past six months, the majority said the services were helpful (74 out of 95), 20 said “somewhat helpful” and one respondent said “no.” When respondents were asked if they have ever directed someone else to LSFHS services, 28.7 percent said “yes” and 70 percent responded “no.”

The 2-1-1 information and referral resource can be used to find resources by speaking with an operator. Nearly 76 percent of respondents were familiar with 2-1-1, and 15.3 percent of respondents (59 respondents) had used the 2-1-1 service in the past six months. Of the 59 respondents who used 2-1-1 in the past six months, 34 said the service was helpful, 20 said the service was somewhat helpful, and five said the service was not helpful. Although most respondents did not use 2-1-1 in the past six months, 58 percent had directed others to 2-1-1.

Survey respondents were asked to select the Crisis Response Model in their area. The most selected models were Mobile Crisis Response Team (23.3 percent), Mobile

Response Team (15.4 percent), and Behavioral Health Response Team (13.5 percent). The remaining 37 percent of respondents did not answer this question. The question did not include an “I don’t know” response option, so it is possible respondents who did not respond were unaware of what type of crisis response model is in their area.

When respondents were asked to rate the awareness of mental health and substance use treatment services in their area 11.6 percent rated it “excellent” or “very good,” 30 percent rated it “good,” and 58.4 percent rated it “fair” or “poor.” Linking people to needed services and coordinating care is an important component of success in service delivery systems. Respondents were asked if links to needed services are coordinated and well established across the system of care. Respondents were equally split as 49.1 percent “strongly agree” or “agree,” and 50.1 percent “strongly disagreed” or “disagreed.”

Respondents were asked if behavioral health care and peer services are accessible in your area. More respondents “strongly agree” or “agree” (55.1 percent) while 44.5 percent of respondents “strongly disagree” or “disagree.”

Respondents were also split on if the processes for referral are easily accessible as 52 percent “strongly agree” or “agree,” and 46.2 percent either “strongly disagreed” or disagreed.”

More than half of the respondents did not believe programs and services are coordinated across the system of care (51.7 percent).

Barriers for accessing services included not being aware of where to go for services (53.4 percent), affordability (17.9 percent), and transportation barriers (14.74 percent). Respondents were asked to list the resources and services needed that are not available to improve patient-centered care and planning. Write-in responses included: providers, professionals, clinicians, therapists, transportation, housing, waitlist reduction, crisis stabilization services, residential services, case management services and case management coordination, Baker Act receiving facilities, school-based support services, Medicaid payment acceptance, expansion of Medicaid services, behavioral health support services, therapies, and childcare.

Respondents were asked to list the top three patient-centered care resources and services that have improved quality of life of individuals. These were counseling services, crisis response teams, and access to medication and medication services.

STAKEHOLDER SURVEY CHARTS

Figure 155: Please select the service sector which best describes your organization? (Check all that apply)

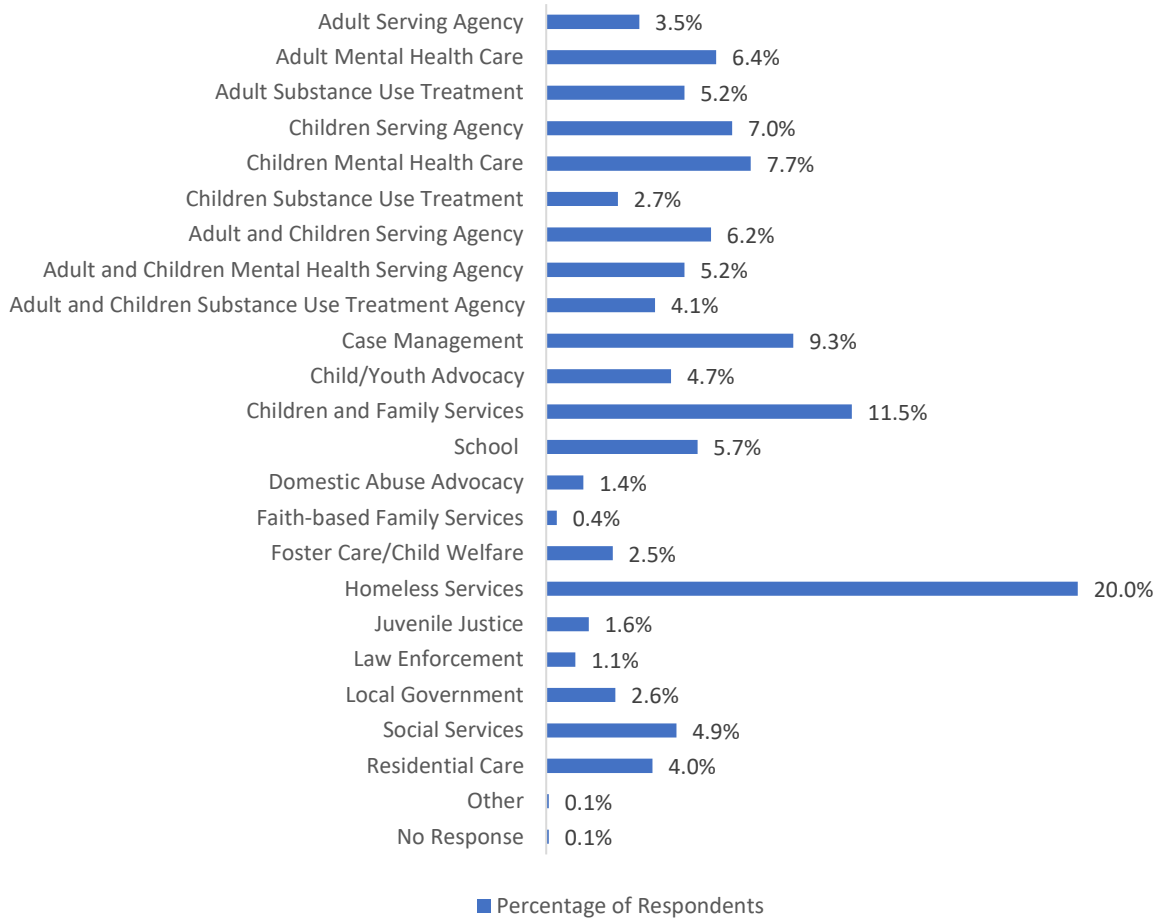


Figure 156: In which county do you provide services? (Check all that apply)

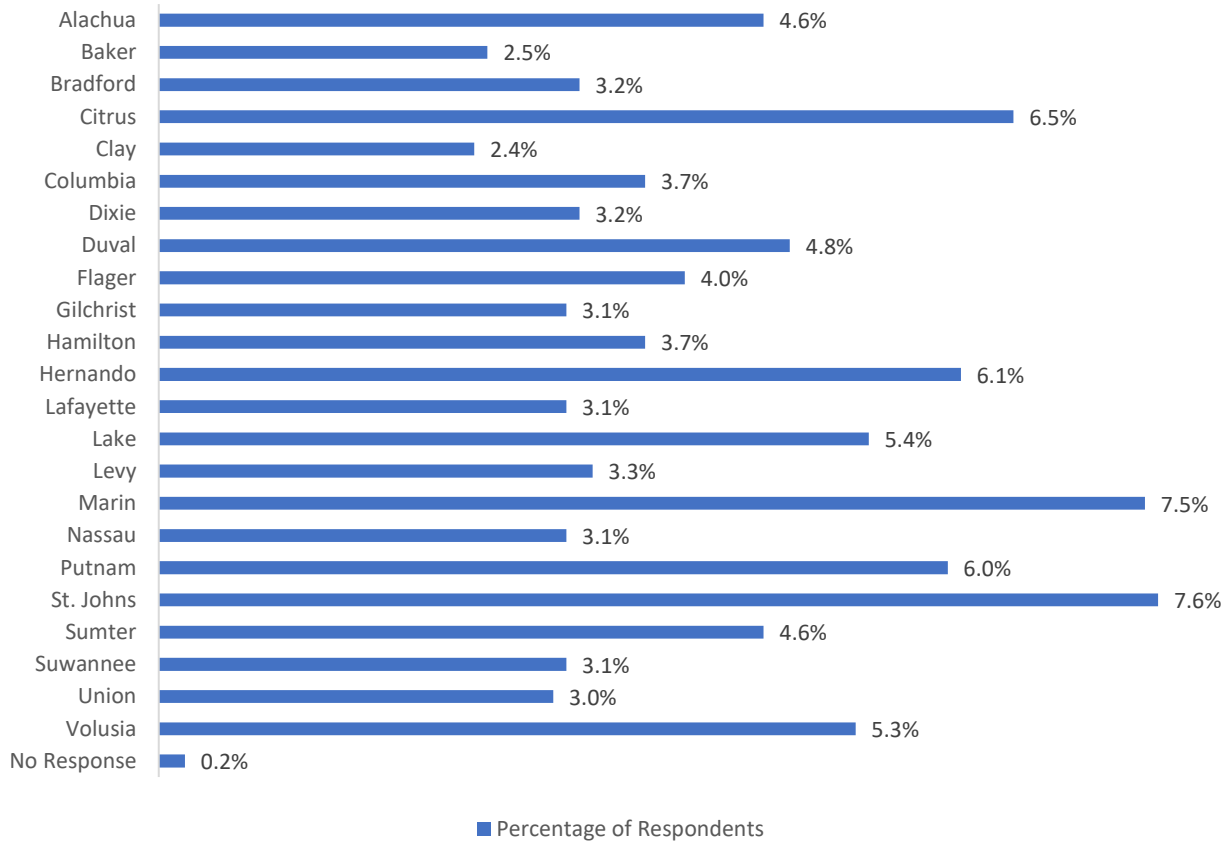


Figure 157: You are aware of the availability of mental health and substance use services in your area.

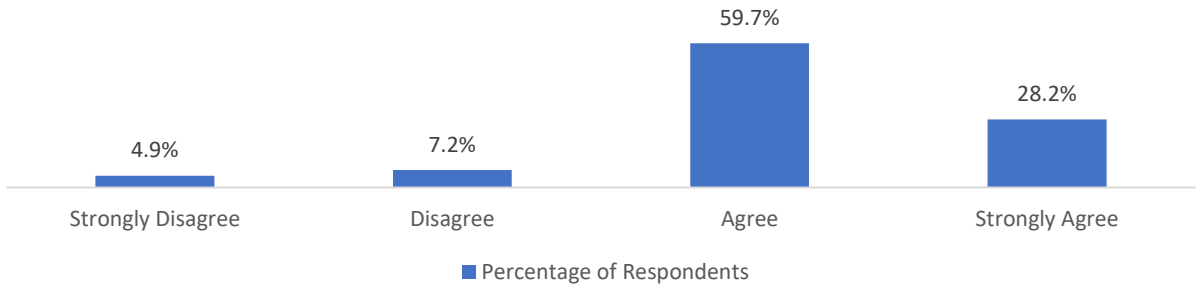


Figure 158: Are you aware of LSF Health Systems (Managing Entity) resources?

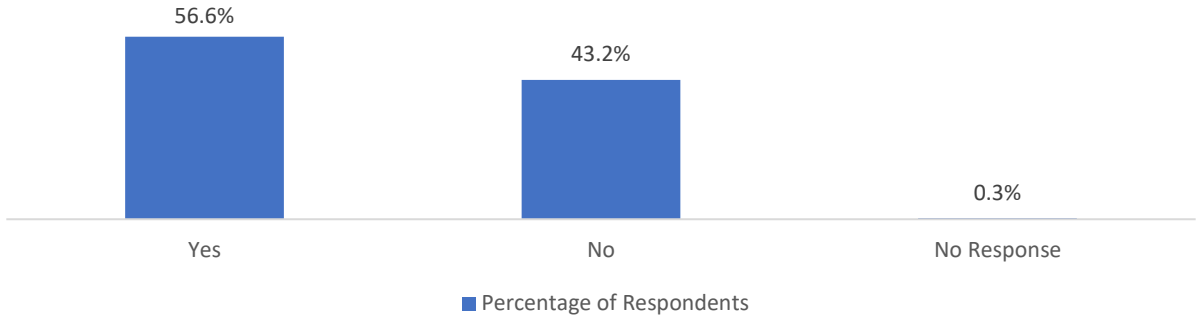


Figure 159: Have you accessed LSF Health Systems (Managing Entity) resources in the past 6 months?

Figure 160: When you accessed LSF Health Systems (Managing Entity) resources, was it helpful?

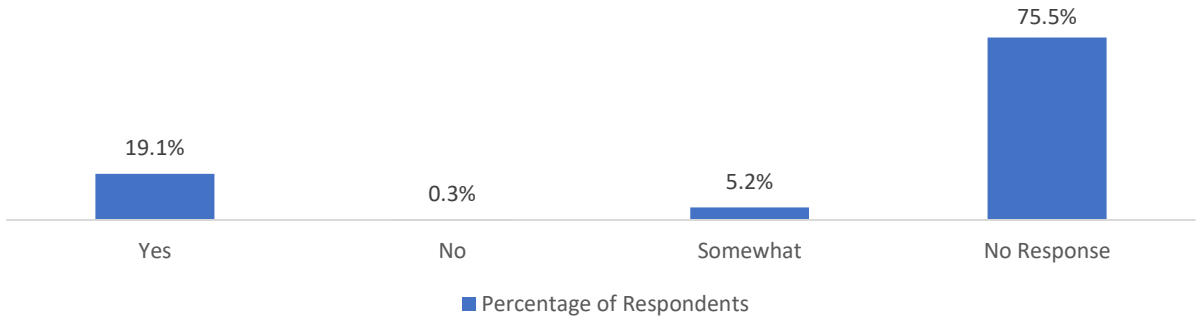


Figure 161: Have you ever directed individuals to access LSF Health Systems (Managing Entity) by calling or online?

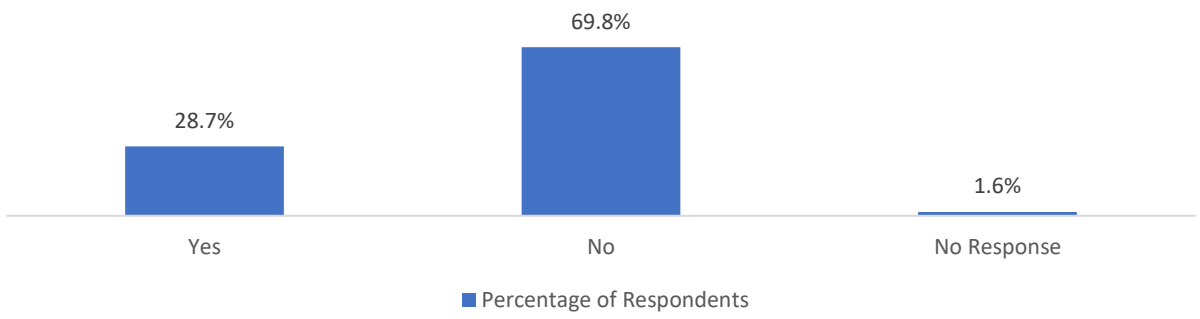


Figure 162: Are you aware of the 2-1-1 Information and Referral Resource?

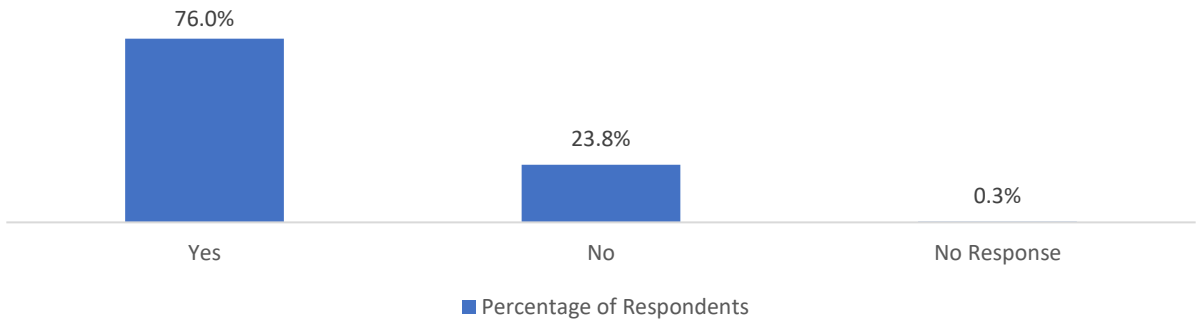


Figure 163: Have you accessed the 2-1-1 Information and Referral Resource in the past 6 months?

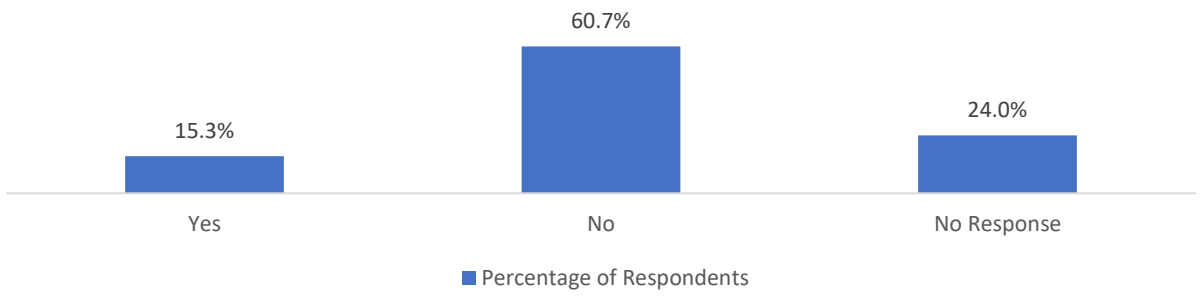


Figure 164: When you accessed the 2-1-1 Information and Referral Resource, was it helpful?

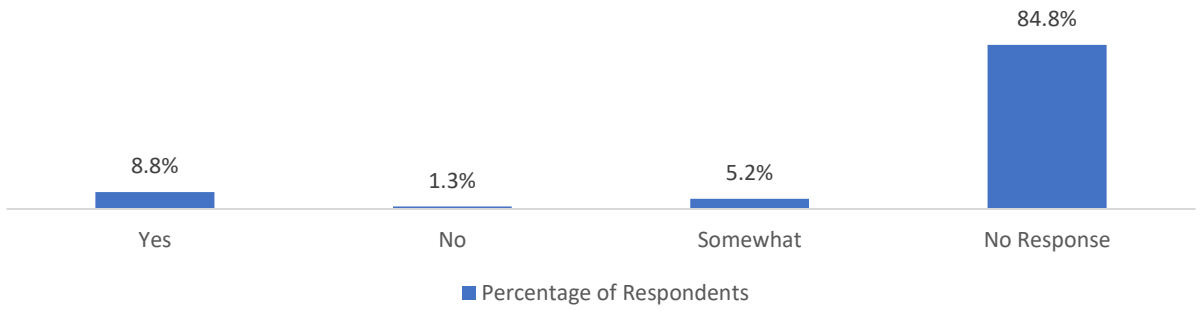


Figure 165: Have you ever directed individuals to access the 2-1-1 Information and Referral Resource by calling or online?

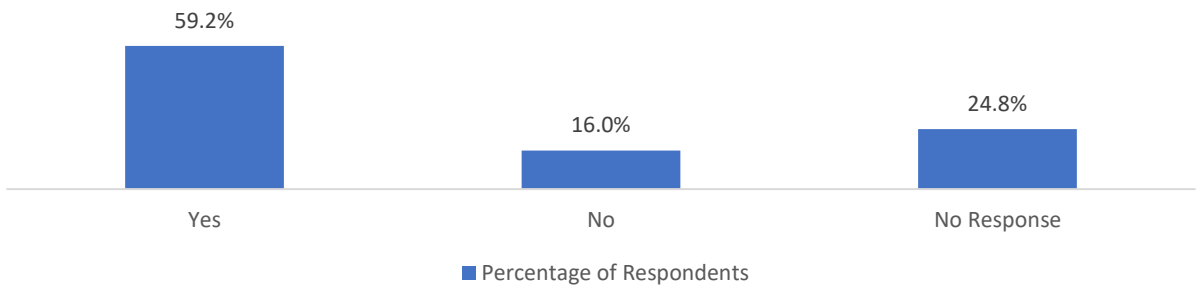


Figure 166: Select the crisis response model in your area. (Check all that apply)

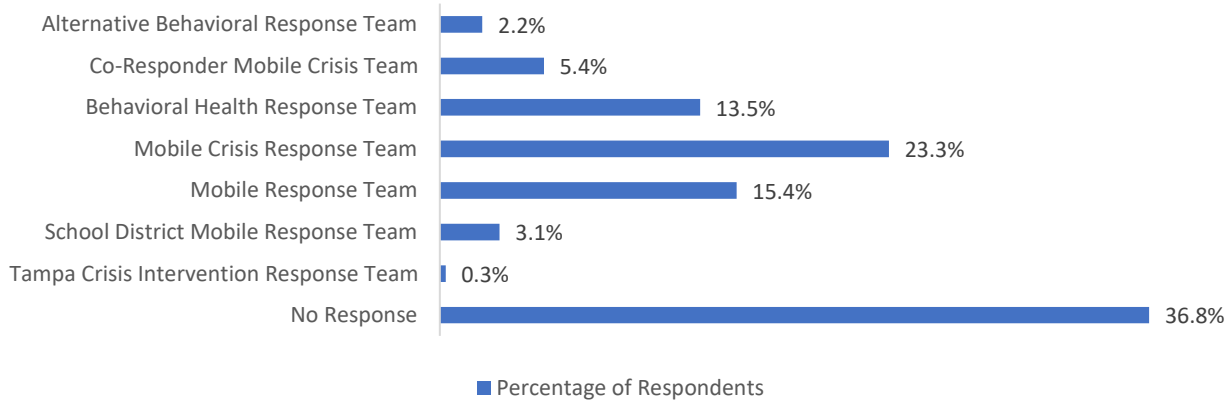


Figure 167:How would you rate community awareness of mental health and substance use treatment services in your area?

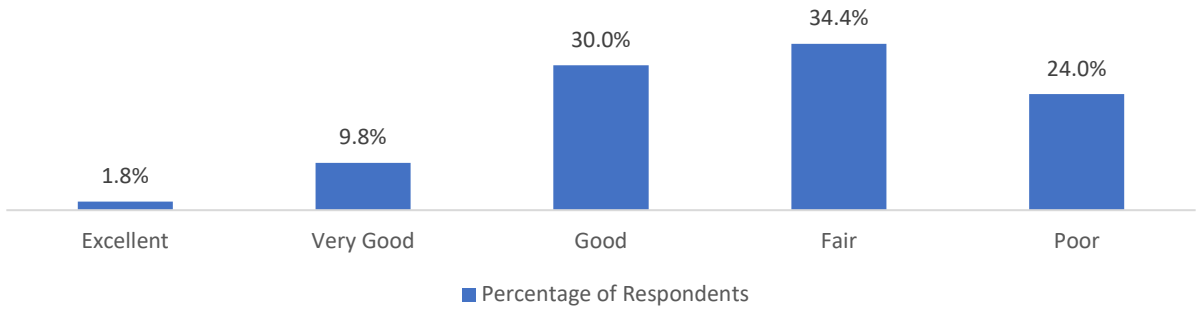


Figure 168: Linkages to needed services are coordinated and well established across the system.

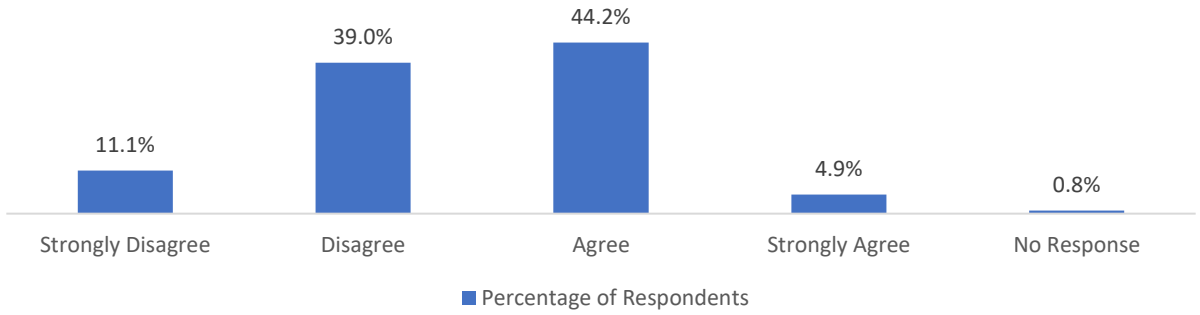


Figure 169: In general, behavioral health care and peer services are accessible in your area?

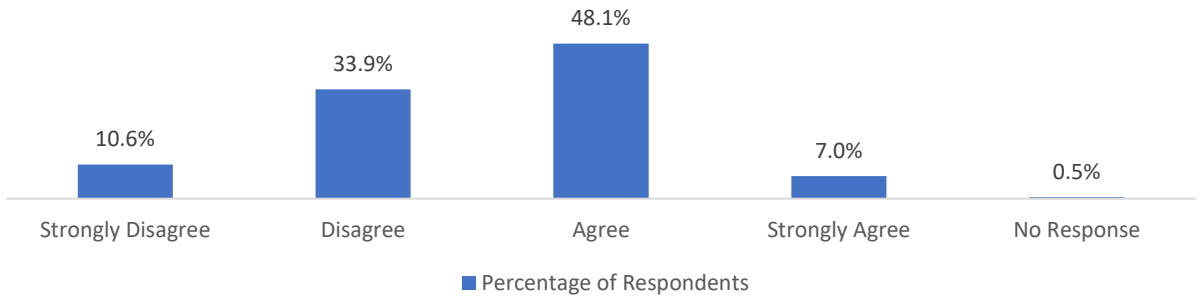


Figure 170: The process for referrals is easily accessible.

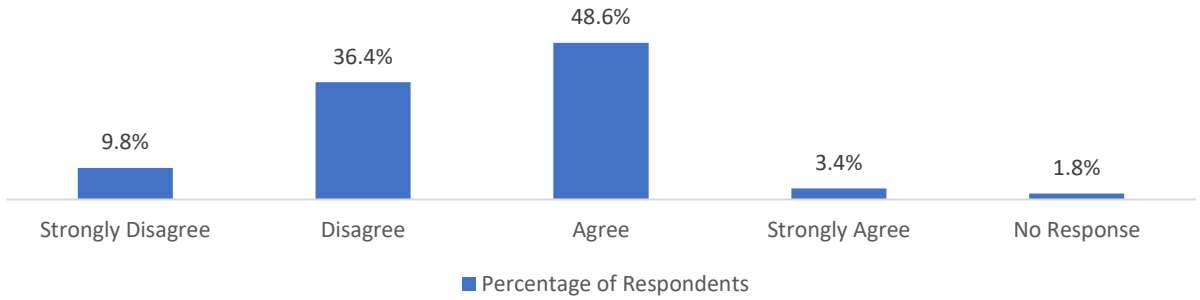


Figure 171: Programs and services are coordinated across the system of care.

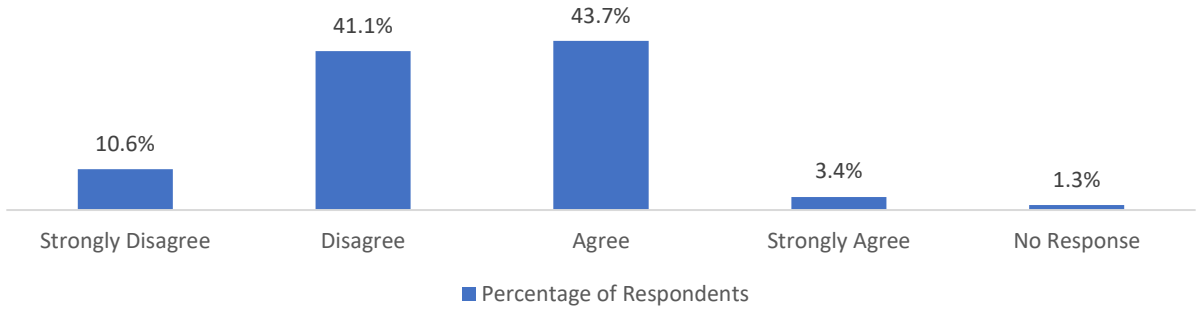


Figure 172: List the barriers for consumers accessing services in your community. (Check all that apply)

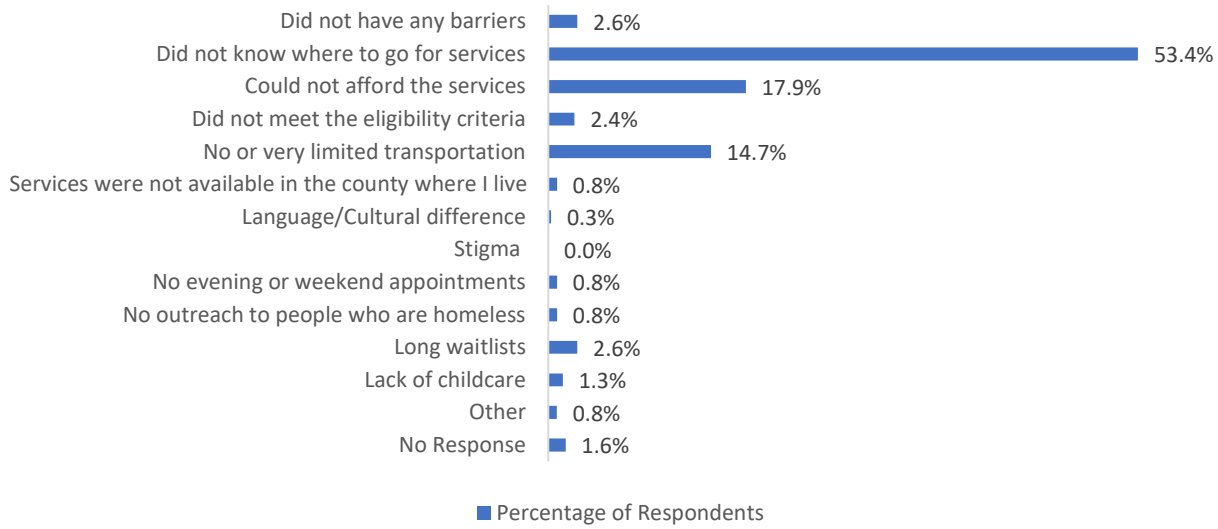


Figure 173: List the resources and services needed that are not available to improve patient-centered care and planning.

Needed Resources and Services
Providers, Professionals, Clinicians, Therapists
Transportation
Housing
Wait List Reduction
Crisis Stabilization Services
Residential Services
Case Management Services and Case Management Coordination
Baker Act Receiving Facilities
School-Based Support Services
Medicaid Payment Acceptance and Expansion of Medicaid Services
Behavioral Health Support Services
Therapies
Childcare

Figure 174: List the top three patient-centered care resources that have improved quality of life for individuals.

TOP THREE PATIENT-CENTERED RESOURCES
Counseling Services
Crisis Response Teams
Access to Medication and Medication Services

PEER RECOVERY COMMUNITY/SUPPORT SPECIALIST'S SURVEY SUMMARY

BACKGROUND

The Behavioral Health Needs Assessment Recovery Community Peer Specialist survey was available in January thru February 2022. It was distributed by LSFHS and their providers to peer specialists throughout the 23-county service region. The intent of the survey was to better understand the perspectives of peer specialists who serve in the 23-county region.

SURVEY RESPONSES

In total, 95 responses were collected during the survey period. Of the respondents, 43.2 percent were adults with lived co-occurring mental health and substance use conditions, 22.1 percent were adults with lived substance use conditions, 14.7 percent were adults with lived mental health conditions, and 14.8 percent were family members or friends with someone with lived experience. Respondents represented 15 of the 23 counties in the service area which included, Alachua, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Hernando, Lake, Levy, Marion, Nassau, Putnam, St. Johns, and Volusia counties. Duval County respondents represented 41.1 percent of all respondents with Hernando and St. Johns counties each accounting for 7.4 percent of respondents.

Respondents were employed by a variety of service agency types including: adult mental health service agencies (12.7 percent), adult substance use service agency (18.6 percent), peer support service agency (22.3 percent), recovery community organization (13.2 percent), children mental health service agency (6.4 percent), children substance use service agency (five percent), hospital/emergency room (4.1 percent), prevention services (7.7 percent), family/peer organizations (five percent), and other (1.4 percent) which included DCF, Family Dependency Drug court, state government, not employed. Of the respondents, 31.6 percent have been employed by the agency for more than three years, 25.3 percent were with the agency for less than six months, and 17.9 percent were at the agency for one to two years. Nearly half of respondents (46.3 percent) work 40 or more hours per week while 23.2 percent work more than 40 hours per week, and 28.7 percent work 20 hours or less per week. Nearly 95 percent of respondents reported their agency uses peer support services with 8.4 percent of respondents unsure if peer support services are provided by their agency. Respondents overwhelmingly believe their agency adheres to recovery support best practices (87.4 percent), while 9.5 percent were unsure.

Qualifications varied as Certified Recovery Peer Specialists accounted for 32.4 percent of respondents, Certified Recovery Support Specialists (9.8 percent), applied for certification and in process (27.5 percent), Recovery Peer Specialist with Provisional

Certification (3.9 percent), National Certified Peer Specialist (2.9 percent), and not certified (21.6 percent). Respondents provide peer specialist services in a variety of settings with the most frequent settings being outpatient recovery community organization (12.5 percent), court (10.9 percent), medication assisted treatment (10.3 percent), and jail/corrections (8.7 percent).

Peer specialist respondents were asked why they stayed with the company. Responses varied as personal fulfillment accounted for 24.6 percent of respondents, commitment to recovery principles (20.4 percent), flexibility with work schedule (20 percent), and work hours (13.1 percent). Barriers to hiring presented challenges for peer specialists. The most common barriers included: Exemption/background screening process (21.8 percent), salary (32.3 percent), limited employment opportunities (18 percent), and work/schedule hours (nine percent). Write-in responses included court costs, lack of disability awareness, and long hiring process.

Peers recommended a variety of trainings to assist in implementing peer support services including compassion fatigue/self-care, 40 hour required peer recovery specialist training, boundaries/ethics/professional responsibility, mental health first aid, trauma informed training, and others.

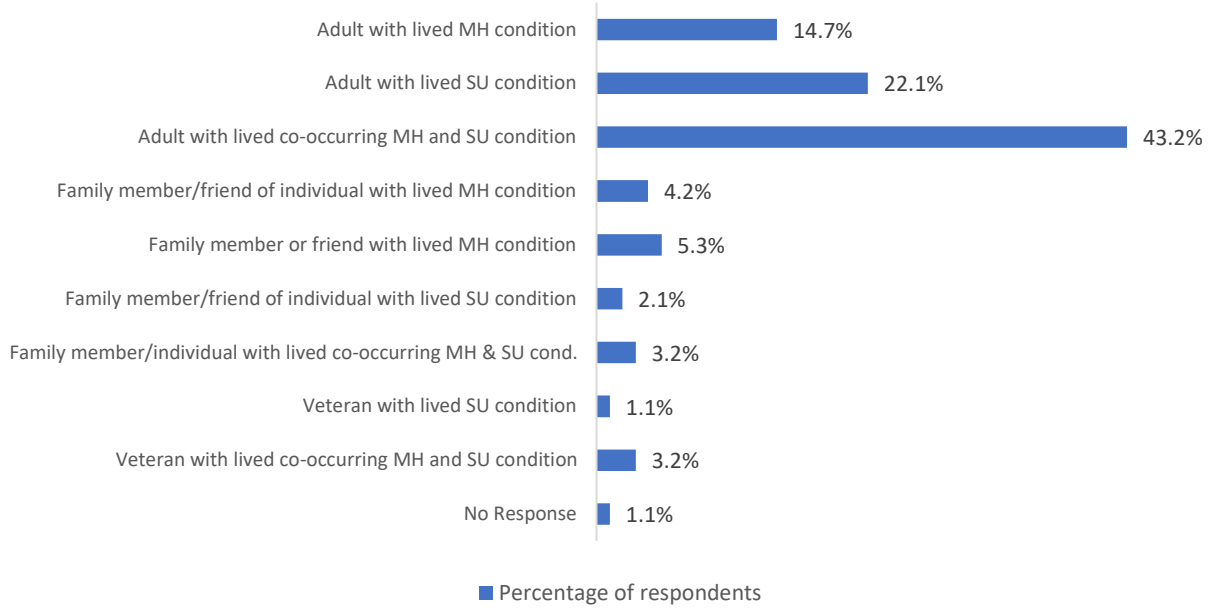
Partnerships existed between peer support recovery programs, recovery community organizations and other organizations as reported by 67.4 percent of respondents. Partnerships with organizations that provide other types of services were reported and included Career Source, daycare, child welfare, faith-based, drop-in centers, food panties, housing, Florida Department of Health, jail/corrections, probation, and transportation agencies.

Peers (81.1 percent) reported their agencies use person-centered language that helps reduce stigma with only 5.3 percent reporting their agencies do not use person-centered language. One write-in response indicated that clinical language is used more than person-centered language. Another write-in response indicated that the agency uses person-centered language, but some “staff struggle to put it into practice.”

Nearly three-quarters of respondents indicated that peers are included in developing, promoting, evaluating, and improving programs. Nearly 60 percent of respondents said that persons in recovery participate in management and board meetings. Of those who reported that persons in recovery do not participate in management and board meetings, write-in responses for “why not” included: hierarchy that only includes clinicians/medical professionals, peers without a bachelor’s degree, higher education is not considered important except when they are “required to be employed to qualify for certain grants,” and traditional hierarchy.

PEER RECOVERY COMMUNITY/SUPPORT SPECIALIST'S SURVEY CHARTS

Figure 175: Which best describes your experience?



Note-Mental Health (MH) and Substance Use (SU)

Figure 176: Which county do you live in?

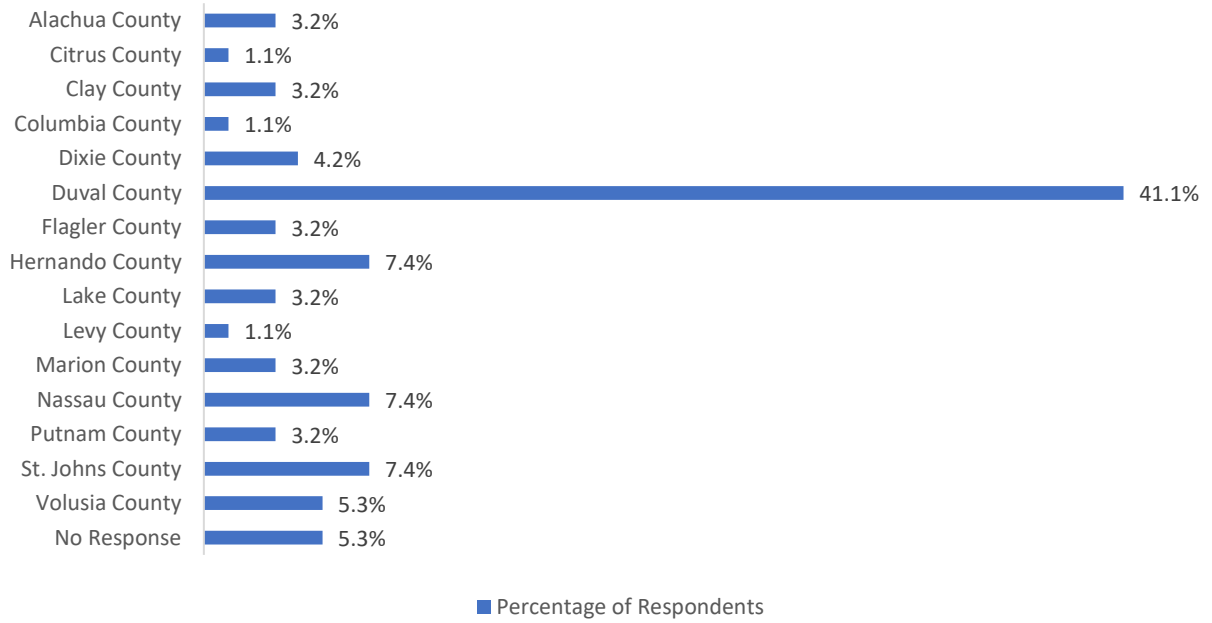


Figure 177: What type of service are you employed or volunteer with? (Check all that apply)

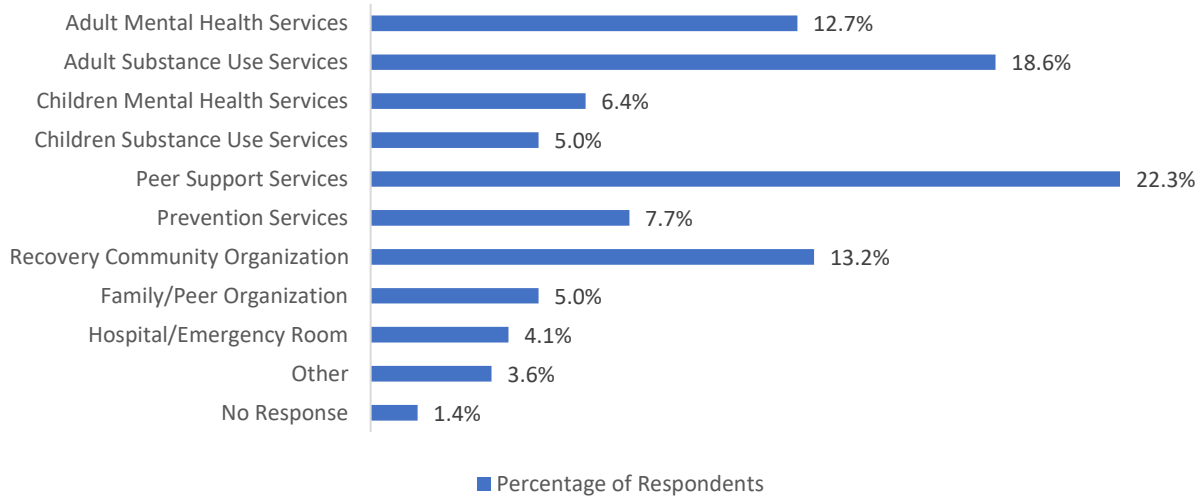


Figure 178: How long have you been employed/volunteered with the agency?

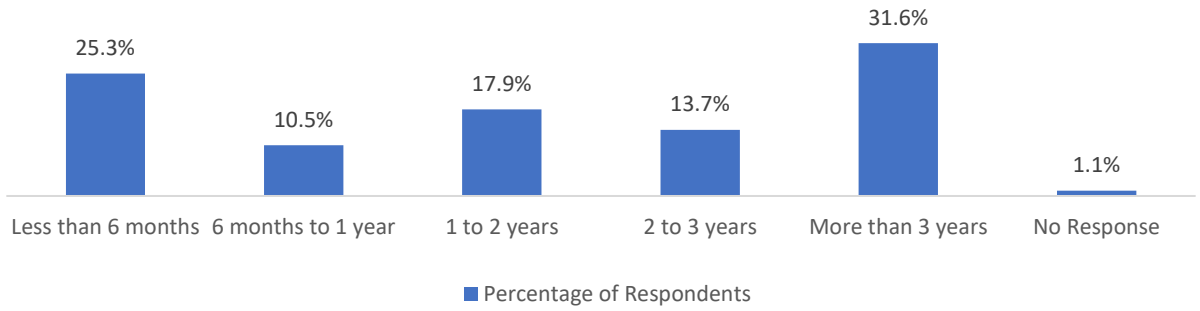


Figure 179: My work schedule averages...

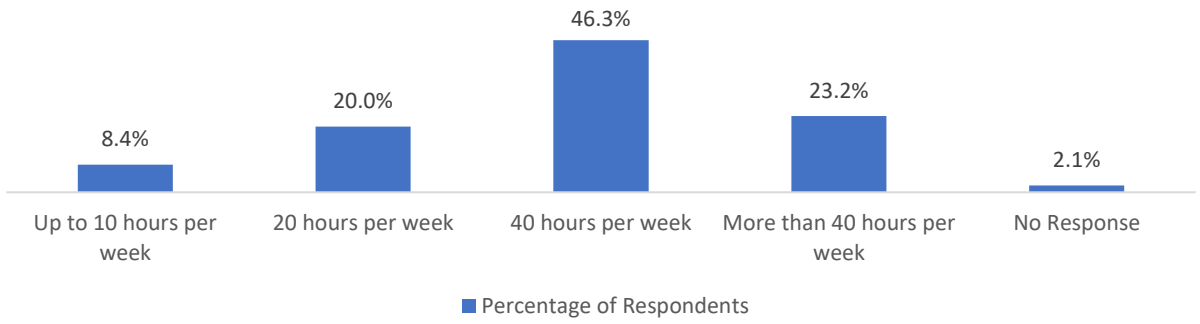


Figure 180: Does the agency where you are employed, or volunteer, use recovery peer support services within the services they provide in the community?

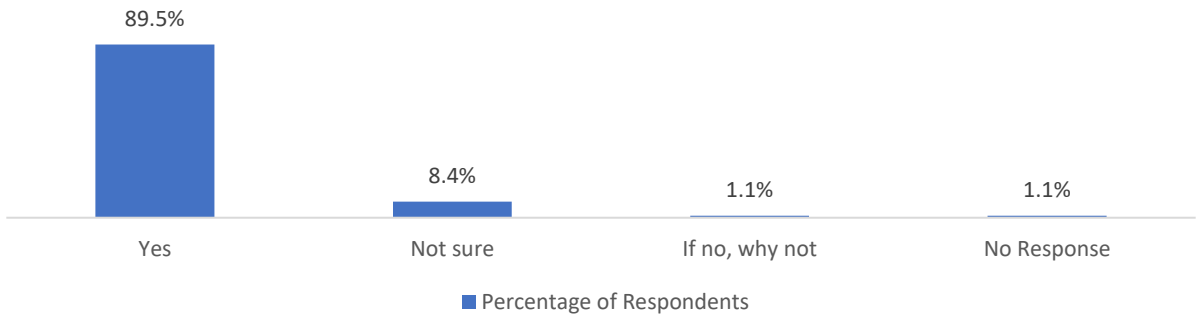


Figure 181: Does the agency where you are employed, volunteer, adhere to recovery support best practices?

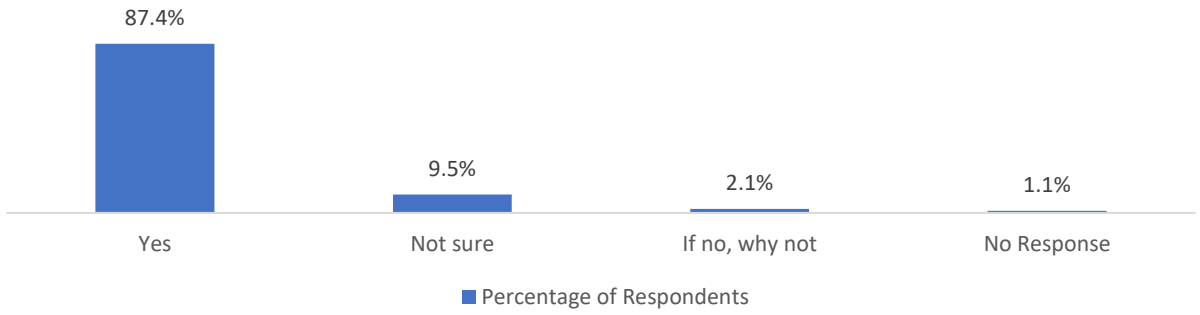


Figure 182: Please indicate the qualifications that best describe your status. (Check all that apply)

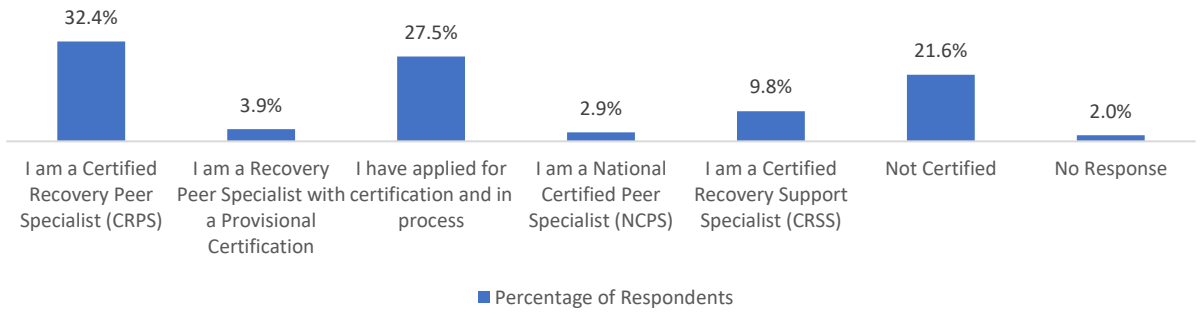


Figure 183: Please indicate the facility/program setting(s) that best describes where you deliver peer recovery support services. (Check all that apply)

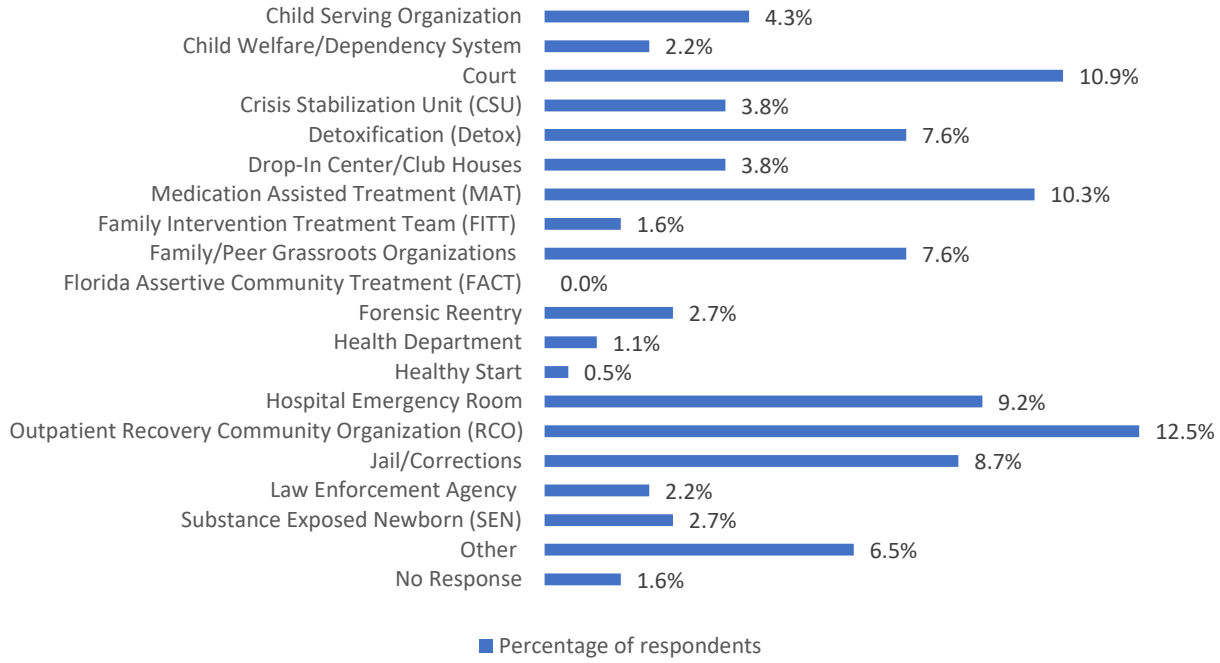


Figure 184: What are the reasons/factors for staying with the company? (Check all that apply)

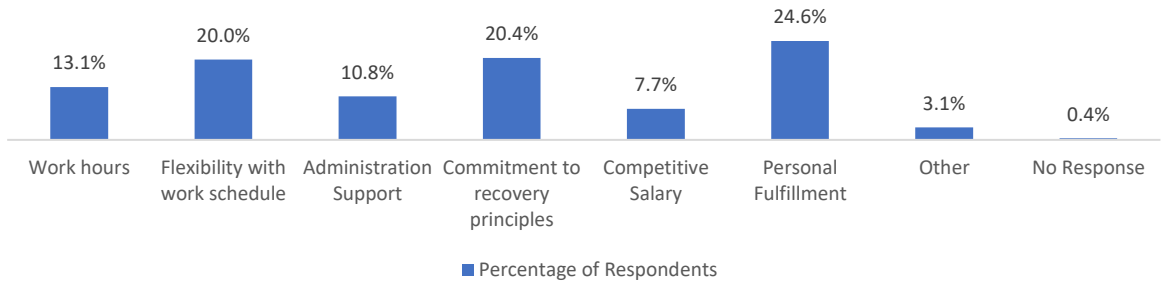


Figure 185: What barriers/challenges have you experienced in the hiring process? (Check all that apply)

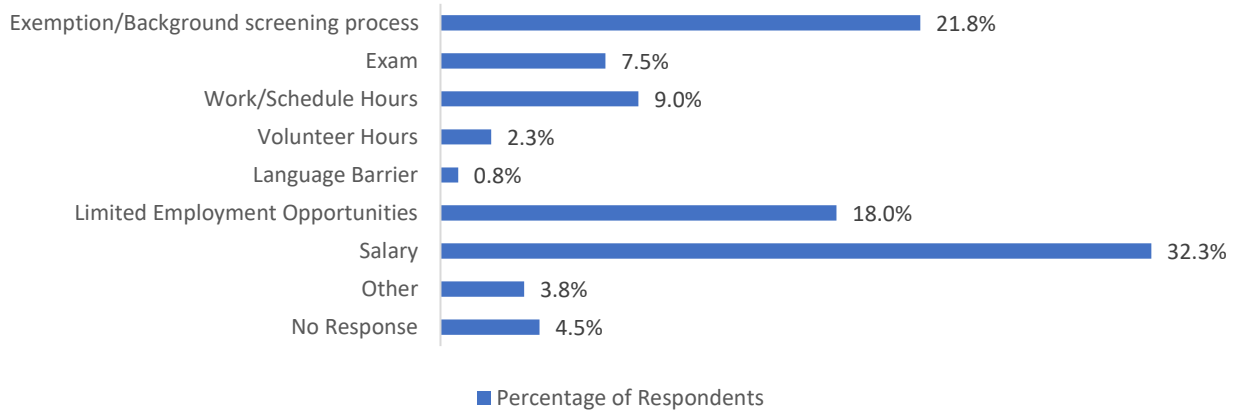


Figure 186: What training would you recommend for peers to have to help them provide Peer Support Services? (Check all that apply)

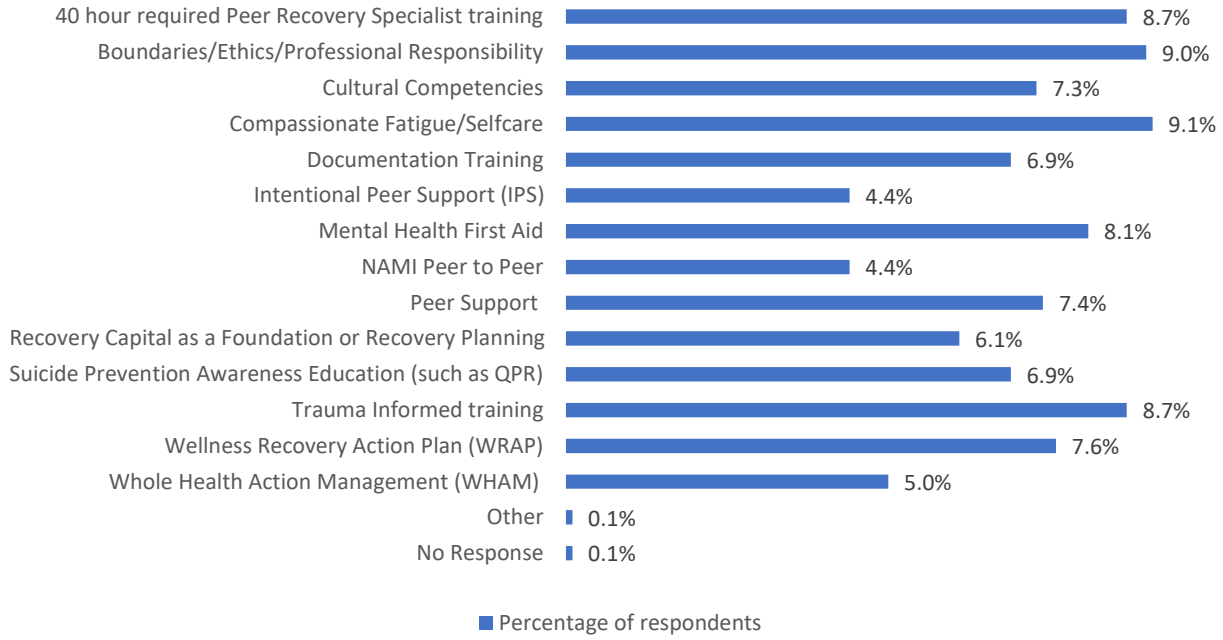


Figure 187: Are there partnership that exist with peer support recovery programs, recovery community organizations, and other support groups?

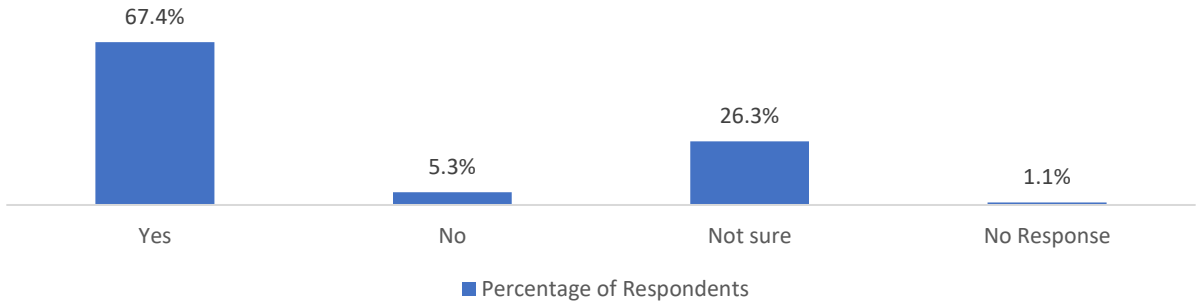


Figure 188: Are you aware of partnerships with other organizations that provide other resources such as: (Check all that apply)

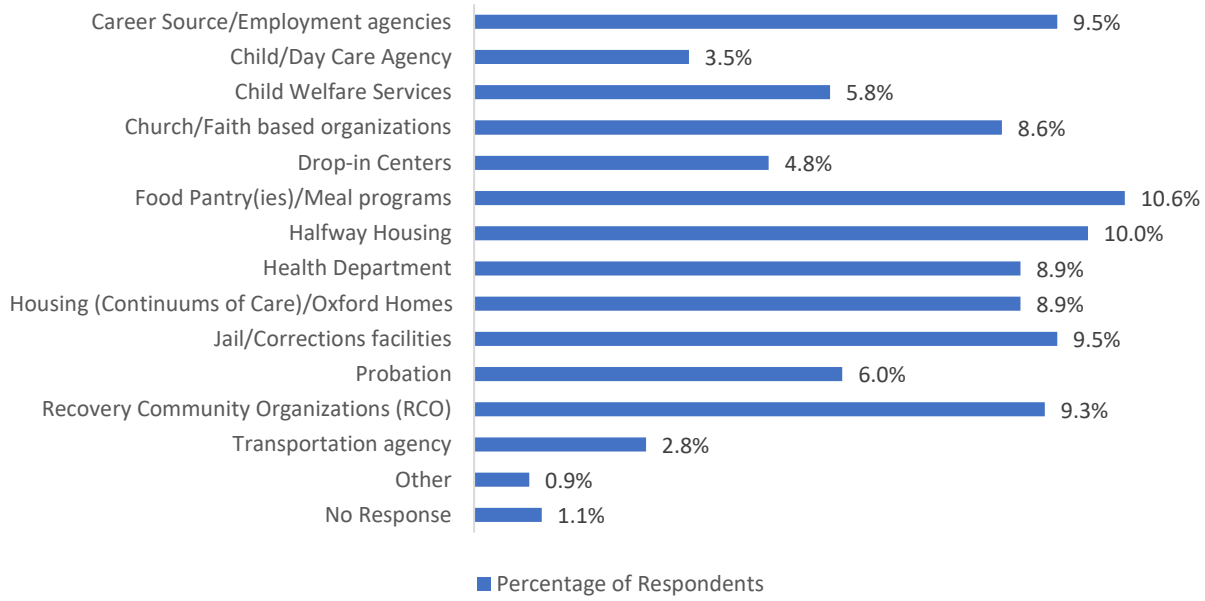


Figure 189: Do you have the ability to offer choices to the individuals where you serve at the agency you are employed/volunteer?

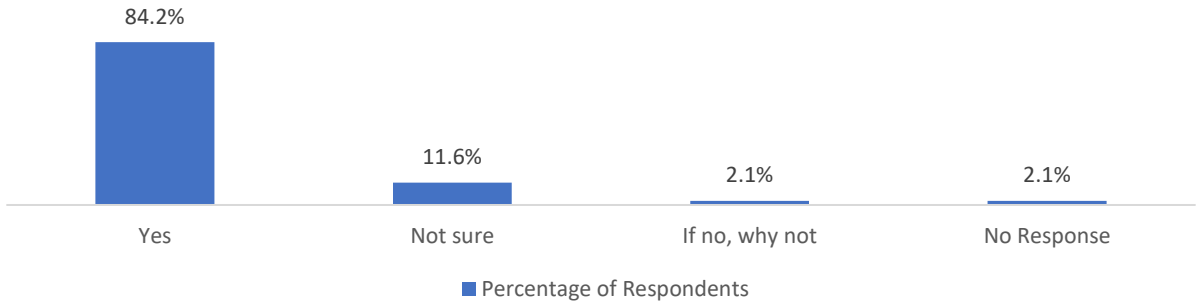


Figure 190: Does the organization where you are employed/volunteer with help to reduce stigma by promoting recovery language that is patient centered?

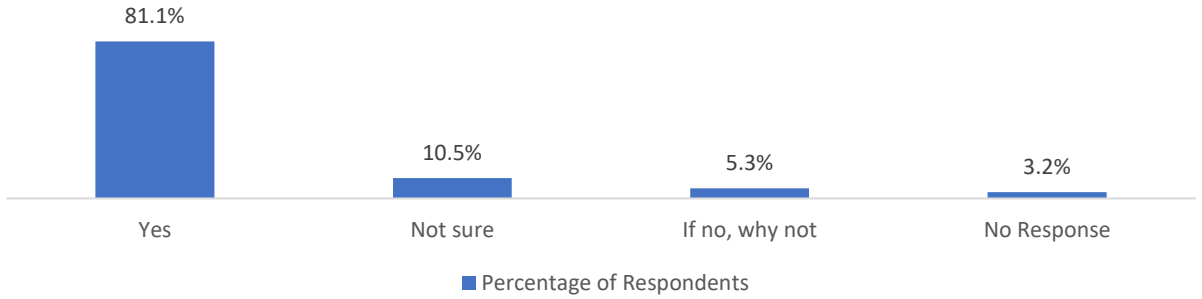


Figure 191: Does the agency where you are employed/volunteer include peers in developing and promoting effective program development, evaluation, and improvement?

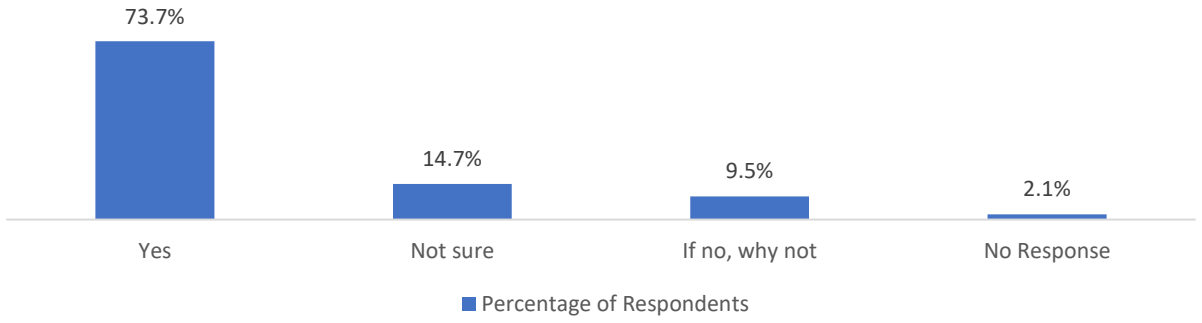
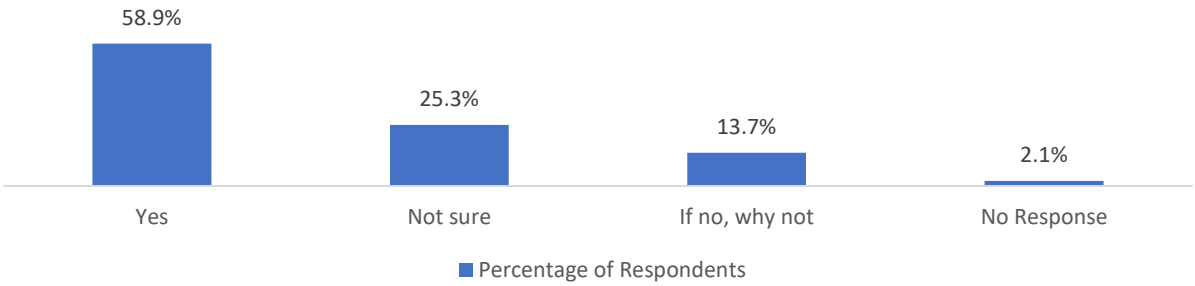


Figure 192: Does the agency where you are employed/volunteer with include persons in recovery in management and board meetings?



RECOVERY ORIENTED SYSTEM OF CARE RESOURCES

LSFHS

Addiction Recovery Lakeside	**Awakening-Nassau**
Addiction Recovery Live Oak	Beaches Recovery
Addiction Recovery of Brooksville	Breakthroughs Counseling and Recovery
Addiction Recovery of Citrus Hills	DeLand Addiction Recovery
Addiction Recovery of Citrus Springs	Drug and Alcohol Rehab Experts
Addiction Recovery of Inverness	Drug and Alcohol Rehab Advisers
Addiction Recovery of Lake City	Drug and Alcohol Rehab Advisers Lake City
Addiction Recovery of Macclenny	Drug and Alcohol Rehab Experts
Addiction Recovery of Orange City	Drug Rehab and Alcohol Detox Recovery Center Starke, Fl
Addiction Recovery of St. Augustine South	Drug Rehab and Suboxone Clinic Recovery Center Jacksonville, Fl
Addiction Recovery Starke	Drug Rehab Spring Hill
Alachua Addiction Recovery	Drug Treatment
Atlantic Recovery Center	Drug Rehab and Alcohol Detox Jacksonville, Fl Inpatient Recovery Center
Augustine Recovery	Epic Recovery Center
Fernandina Beach Addiction Recovery	Jasper Drug and Alcohol Rehab List
Flagler Beach Addiction Recovery	Journey to Independence Recovery
Fleming Island Addiction Recovery	Lifestream Behavioral Center

RECOVERY SYSTEM OF CARE RESOURCES

Florida Recovery Center	**Live Oak Opioid Addiction Treatment Centers**
Gateway Steps to Recovery	Mayo Drug and Alcohol Rehab List
Harmony Hills	Meridian - Suwannee County Counseling Center
Haven Recovery Center	Meridian - Union County Clinic, Lake Butler
Inpatient Cocaine, Drug, and Alcohol Rehab Helpline Cross City	Meridian Behavioral Healthcare Levy County
Inpatient Cocaine, Drug, and Alcohol Rehab Helpline Starke	New Hope Opioid Addiction Treatment Centers
Inpatient Cocaine, Drug, and Alcohol Rehab Helpline White Springs	New Paths Recovery Center
Inpatient Drug Alcohol Rehab Advisers	Ocala Addiction Recovery
Inpatient Drug and Alcohol Center	Palatka Addiction Recovery
Inpatient Drug Detox Centers	Pathways to Recover
Inpatient Drug, Alcohol, Cocaine Rehab Advisers Chiefland	Quantum's Oceanside Recovery
Inpatient Drug, Alcohol, Cocaine Rehab Advisers Tavares	Recovery Counseling and More, Inc.
Inpatient Drug Alcohol Rehab Advisers	Recovery Solutions
Jasper Addiction Recovery	Recovery Keys
Ridge Manor Addiction Recovery	Tavares Inpatient Drug Alcohol Rehab Advisers
Road Center	TDC Substance Abuse Treatment
Serenity Springs Recovery Center	TDC Substance Abuse Treatment
Smart Recovery Gainesville	TDC Substance Abuse Treatment
Spencer Recovery Center	The Centers
Spring Hill Addiction Recovery	The Drug Detox Center Ocala

Springs Gardens Detox and Recovery	The Recovery Village Drug and Alcohol Rehab
Starting Point Behavioral Healthcare	Vince Carter Sanctuary
Substance Abuse of East Palatka	Volusia County Comprehensive Treatment Center
Substance Abuse of Fleming Island	Yulee Addiction Recovery
Substance Abuse of Gainesville	Substance Abuse of San Mateo
Substance Abuse of Jennings	Tavares Addiction Recovery
Substance Abuse of Live Oak	
Substance Abuse of Macclenny	
Substance Abuse of Otter Creek	

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