NWF Health Network

2022

Florida Cultural Health Disparity & Behavioral Health Needs Assessment

Regional Report

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NWF Health Network

June 14, 2022

Dear Community Stakeholders

I am pleased to announce NWF Health Network has completed its 2022 Behavioral Health and Cultural Disparity Needs Assessment. The Needs Assessment will help determine the types of resources needed and how best to deploy them across our network of behavioral health providers in our 18-county Northwest Florida coverage area.

This is the fourth formal Needs Assessment NWF Health Network has distributed since we assumed responsibility for the substance use disorder and mental health system of care through a Managing Entity (ME) contract award from the Department of Children and Families (DCF) in April of 2013.

We used a series of surveys to gather feedback from providers, stakeholders, consumers and their families, as well as the peer specialist/recovery communities. The Needs Assessment will help us better understand the current behavioral health system of care and support our mission to provide the highest quality child protection and behavioral health services to children, adults, and their families within their communities through a managed network of accredited providers.

The completed surveys included: consumer, cultural health disparity, peer review, stakeholder, and the No Wrong Door access system surveys. These surveys targeted specific groups which will allow the Managing Entity to develop programming in our provider network to meet the needs of the community.

We appreciate the assistance we have received in completing this year's Behavioral Health and Cultural Disparity Needs Assessment. We look forward to continuing the work with our partners and community stakeholders to serve the families and children of northwest Florida.

Sincerely,

Mike Watkins, CEO
NWF Health Network

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ACKNOWLEDGEMENTS

We want to thank and acknowledge the ongoing contributions of our providers and express gratitude for your participation and support.

2-1-1 Northwest Florida
2-1-1 Big Bend
Ability 1st
Apalachee Center
Baptist Health Care
Bay County District Schools
Bay County Sheriff
Big Bend AHEC
Boys Town North Florida
Bridgeway Center
CARE
CDAC Behavioral Health Care
DISC Village
Fort Walton Beach Medical Center
Franklin County Sheriff
Lakeview Center/Chautauqua Healthcare Services
Leon County Courts/A Life
Leon County Sheriff
Life Management Center
Mental Health Association of Okaloosa and Walton Counties
Okaloosa County Board of County Commissioners
PanCare Health
Panhandle Behavioral Services
Tallahassee Public Defender
Turn About

Thank you to all those who participated in surveys, interviews, and focus groups. Your invaluable input continues to inspire our commitment to provide access to high quality, affordable behavioral health care services in Northwest Florida.

Special Thanks to Central Florida Cares
for their leadership in spearheading this needs assessment.
and
Northwest Florida and Big Bend Health Councils
for planning, data analysis, and technical assistance.

EXECUTIVE SUMMARY

In 2020, there were an estimated 47,465 adults with serious mental illness and 15,058 youth (ages 9-17) with a serious emotional disturbance in the 18-county service area comprised of Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Taylor, Santa Rosa, Wakulla, Walton, and Washington counties. Between 2018 and 2020 the rates increased among adults (by <1percent) and among youth (by 9.1percent).

This report, prepared for the Northwest Florida Health Network (NWFHN), is a compilation of primary and secondary data that describe behavioral health care needs of individuals and their families and the assets available to meet those needs.

SERVICE AREA POPULATION

From 2016 to 2020, population in the service area increased by 74,076 (3.8 percent) to a total of 1,541,100 residents. The fastest growth occurred in Walton and Santa Rosa counties which grew by 15.7 percent and 10.8 percent, respectively. Other counties grew more slowly, and some, for example Gulf and Jackson counties decreased by 11.2 percent and 7 percent, respectively.

Adults 65 years of age or older accounted for 16.6 percent of the service area population and females accounted for slightly less than 50 percent of the population.

The racial composition in the service area was predominately White at 72 percent, slightly less than the state rate of 71.6 percent. The Black population accounted for 18.8 percent of the service area population and 15.9 percent of Florida's population. American Indian and Native Hawaiians represented less than one percent of the service area and state population. The percentage of Asian residents, at 2.4 percent, was similar to the state rate at 2.8 percent. The service area was slightly less diverse when compared to the state, with 1.8 percent identifying with a race of Other, and 4.5 percent identifying with more than one racial group. In the state, 3.3 percent of the population identified as other, and 6 percent identified with more than one racial group.

From 2016 to 2020, a total of 59 percent of the service area population participated in the labor force, and the rate of unemployment was 3.1 percent. The population with incomes less than 100 percent of the poverty level accounted for 9.7 percent and 15.8 percent had incomes between 100 and 199 percent poverty.

According to the Behavioral Risk Factor Surveillance System (BRFSS) Survey conducted between 2017 and 2020, an estimated 80.6 percent of adults (ages 18-64) living in the service area said their overall health was "good" to "excellent". More than 86.1 percent reported good mental health.

The overall suicide rate increased slightly between 2018 and 2020. The rate among males was more than triple the rate among females, while the rate among Whites was five times the rate among Blacks.

Although the rate of total domestic violence offenses decreased in the service area between 2017 and 2019, by 2019 it was still significantly higher than the state rate.

The rate of children (ages 5-11) experiencing child abuse decreased in the service area between 2017 and 2019. However, by 2019 the rate was still more than 1.5 times the state rate. Child sexual abuse rates changed very little from 2017 to 2019, except for briefly decreasing in 2018; by 2019 the rate in the service area was 1.8 times the state rate.

From 2017 to 2019, the average rate of current smokers among adults living in the service area was 19.1 percent, and the average rate of adult binge drinkers was 18.3 percent.

According to the Florida Youth Substance Abuse Survey (FYSAS), by 2020, there were increased rates of middle and high school students who reported never having smoked cigarettes, marijuana, or having consumed alcohol.

From 2015 to 2019, an estimated 16 percent of the civilian noninstitutionalized population in the NWFHN service area, and 13.7 percent in the state had a disability (including disabilities related to hearing, vision, cognitive, ambulatory, self-care, and independent living).

Between 2017 and 2019, an average of 83.6 percent of adults (ages 18-64 years) reported having some type of health insurance coverage.

NWFHN CLIENT POPULATION

NWFHN-funded organizations that served 33,313 clients in Fiscal Year (FY) 2000-2021, including 792 clients from outside of the catchment area. The greatest percentage of clients resided in Escambia County 31 percent, followed by Bay County 14.8 percent, Okaloosa County 12.4 percent, Leon County 9.7 percent, and Santa Rosa County 9.5 percent. Nearly 5percent of clients reported their residential status as unhoused.

Adult Mental Health (AMH) programs served 20,863 clients, and the Adult Substance Use Disorder (ASUD) programs served 7,690. An additional 6,881 clients were in the Child Mental Health (CMH) programs and 1,397 were in the Child Substance Use Disorder (CSUD) programs.

While females represented 56.5 percent of all NWFHN clients, and 54.2 percent of AMH clients, males accounted for a majority of clients in ASUD (52.8 percent), CMA (52.9 percent), and CSUD (51.5 percent) programs.

Most NWFHN clients were White (70 percent). This represents a lower percentage than in the service area population at 72.9 percent. Black NWFHN clients accounted for 22.8

percent of the client population, but only 18.9 percent of the population in the 18-county service area.

The percentage of Hispanics residing in the service area (6.4 percent) was higher than the rate of Hispanics in NWFHN programs (3.9 percent). The percentages of Hispanic clients in AMH and ASUD programs were slightly less than 4 percent, while the percentages in CMH and CSUD programs were 4.6 percent and 5.7 percent, respectively.

Adults, 25-44 years of age, accounted for 40.9 percent of clients in AMH and ASUD programs. This was nearly twice the percentage of adults in that age range in the service area (22.7 percent). Teen and young adult clients, 15-24 years of age, accounted for 16.4 percent of NWFHN clients which was slightly less than the percentage of those living in the service area at 17.9 percent. Among those enrolled in child/youth programs, 72 percent of clients in the CMH program were 5-14 years of age, and 46.3 percent of clients in the CSUD program were 15-19 years old.

The majority of NWFHN adults (55.3 percent) resided in one of three types of independent living conditions: with relatives (28.9 percent), with non-relatives (9.8 percent), or alone at 16.6 percent. Among AMH clients, 5.8 percent reported their status as unhoused, as did 7.8 percent of those in the ASUD program. Children/Youth lived dependently with relatives with CMH clients accounting for 87.6 percent and CSUD clients at 95 percent.

Overall, NWFHN clients attained lower educational levels when compared to those in the service area population, contributing to higher levels of unemployment among NWFHN clients than others in the service area. More than 41 percent of AMH clients and nearly 46 percent of ASUD clients were not employed while the unemployment rate was less than 4 percent in the service area and state.

NO WRONG DOOR PROVIDER INTERVIEWS

Providers are committed to No Wrong Door (NWD) Access to ensure that services or linkages to services are provided to everyone who comes in for help. Person-centered, trauma-informed care is built into organizational cultures. Providers are sensitive to emerging trends regarding language and other cultural issues consistent with inclusive and welcoming environments. The NWD Access is facilitated and supported by extensive training, discussions among leadership and staff, strong case management teams, and close-knit staff. Having a variety of programs within an organization improves efficiency by streamlining protocols that connect clients with needed services, resulting in enhanced effectiveness by ensuring synergistic effects of coordinated care.

Circuit one utilizes a Multiple Entry Point Model. Participating agencies include Baptist Hospital and HCA Florida Fort Walton-Destin Hospital. Circuit two utilizes a Centralized Receiving Facility Model with Apalachee Center being the primary entry point for stabilization; Crisis Stabilization Unit (CSU) and Detox. Other receiving facilities include

HCA Florida Capital Hospital and Tallahassee Memorial Healthcare. Similar to Circuit one, Circuit 14 uses a Multiple Entry Point approach to NWD. Participating agencies include Life Management Center, Emerald Coast Behavioral Health, and detox provider, Chemical Addition Recovery Effort, Inc.

In some areas, disruptions in the aftermath of Hurricane Michael, (e.g., structural damages, high staff turnover) impeded prioritization and implementation of the NWD Access policies, trainings, and practices. In some areas, recovery is still in progress.

Although time is of the essence when someone expresses the need for help, providers are not always able to respond within a small window of opportunity. Barriers include waitlists, worsening staff shortages, bifurcation of funding, and inconsistent diagnostic standards for substance use and mental health. Because substance use and mental health diagnoses are frequently co-occurring disorders, additional funding is needed for specialty care (i.e., psychiatry). Ready access to additional specialty services should be available to all substance use and mental health clients/patients. A standardized intake and screening process, including a comprehensive referral and feedback form/process with all necessary information that is easy to transmit to other programs and providers, are needed to expedite access to services. The biggest unmet need is for legislative and gubernatorial action to change funding structures and rates.

CONSUMER SURVEY

Most respondents said they know where to go for behavioral health services, and they were aware of the 2-1-1 information and referral resources in their respective counties. Nearly two-thirds of respondents were able to get the services they needed when they needed them. From a comprehensive list of services, the most frequently mentioned services that were hard to get were crisis stabilization support, assessment, and short-term residential treatment. The most frequently identified obstacles were related to affordability, stigma, and access (i.e., long waitlists, no evening or weekend appointments, eligibility criteria, and lack of knowledge regarding where to go for services).

STAKEHOLDER SURVEY

Stakeholder respondents represented 20 behavioral health service sectors. The most frequently cited sectors were, schools, unhoused services, case management, children serving agencies, adult mental health care, and social services. Every county in the service area is provided with behavioral health services, and 82.5 percent of respondents were aware of the availability of mental health and substance use services in their area.

More than half (51.5 percent) indicated they were aware of NWFHN resources. Of the seventeen respondents who had accessed NWFHN resources in the previous six months,

sixteen said the services were helpful. When asked if they had ever directed an individual to access NWFHN by calling or online, 22.7 percent said they had.

While 59.8 percent of respondents indicated they were aware of the 2-1-1 information and referral service, 22 (22.7 percent) had accessed this service in the previous six months. Of those 22, 12 said it was helpful, and 38 (39.2 percent of all respondents) said they have directed individuals to 2-1-1 by calling or on-line.

Most respondents rated community awareness of behavioral health treatment services in their area as very good (13.4 percent), good (26.8 percent), or fair (40.2 percent).

Nearly two-thirds of respondents agreed or strongly agreed that linkages to needed services are coordinated and well established across the system of care. More than two-thirds agreed or strongly agreed that behavioral health care and peer services are accessible in the service area. Two-thirds agreed or strongly agreed that the processes for referrals are easily accessible.

The most frequently cited barrier to access was no or very limited transportation at 73.2 percent. Additionally, 57.7 percent said consumers did not know where to go for services, 57.6 percent said consumers could not afford the services, and 38.1 percent cited stigma (worried what people would think, fear, shame) and long waitlists. More than two-thirds, 69.1 percent, cited two or more barriers. Respondents described a wide range of resources and services needed to facilitate integration of behavioral health care, primary care, specialty care, dental health care, transportation, safe housing, and follow up (via navigation and wrap-around services), especially in minority, rural, and low-income communities. Specific unmet needs included Medication Assisted Treatment (MAT [especially in rural areas]), assistance with Social Security Disability Insurance (SSDI), Medicaid, Affordable care Act (ACA) applications, and other needed services (e.g., housing, transportation, food, employment, etc.). Adequate funding was also needed to recruit and retain quality providers, including diverse providers that "look like" consumers. The types of patient-centered care resources and services that have improved quality of life of individuals include school-based services, crisis response services, and community-based providers.

CULTURAL HEALTH DISPARITIES SURVEY

Individuals who have received behavioral care services described their personal experiences and preferences related to those services. Although most respondents, 71.4 percent, indicated they are usually comfortable seeking behavioral health care services, only 26.5 percent indicated they trusted or strongly trusted the behavioral health care system to treat them with respect. While many respondents are uncomfortable discussing behavioral health issues at all, most respondents indicated that they have been most comfortable in a private office with a doctor (55.1 percent), speaking with a nurse

practitioner (26.5 percent), or via telehealth (22.4 percent). The majority identified more than one setting in which they have been most comfortable.

A majority of respondents (59.2 percent) indicated they would be more comfortable going to a traditional physician office than to faith-based care. Nearly half, 48.9 percent, said they would be unlikely or very unlikely to be comfortable in group therapy, while 67.3 percent would be likely or very likely to be comfortable in individual therapy.

Nearly all, 95.9 percent of respondents, indicated that when they received behavioral health care services, those services were available in their primary language all the time or most of the time.

Demographically, most respondents described their gender as female but 71.4 percent did not disclose their gender identity at all, and 30.6 percent did not disclose their current sexual orientation.

Most respondents (85.7 percent) identified their race as White, 4.1 percent as Black, 6.1 percent as multi-racial, and 93.9 percent identified as non-Hispanic/Latino or did not disclose their ethnicity at all.

Those in the age range 35-44 accounted for 38.8 percent of survey respondents. The next largest groups were adults 55-64 years of age (18.4 percent), followed by those 45-54 years (12.2 percent) and 25-34 years (12.2 percent).

PEER RECOVERY COMMUNITY SURVEY

Members of the Recovery Community and Certified Peer Recovery Community Specialists utilize their lived experience and skills learned in training to help others achieve and maintain recovery and wellness from mental health and/or substance use conditions. Of the 30 peers who responded to this survey, 63.3 percent described their behavioral health experience as adults with lived mental health conditions, and 13.3 percent described their experience as adults with lived co-occurring mental health and substance use conditions. Others described themselves as veterans with lived co-occurring mental health and substance use conditions, family members, or friends with lived (behavioral health) conditions.

A majority, 53.3 percent, said they are Certified Recovery Peer Specialists (CRPS), and an additional 30 percent said they have applied for certification and are in process.

Most respondents, 60 percent, cited personal fulfillment as one of the reasons/factors for staying with their current company. Forty percent said flexibility with work schedule, 33.3 percent indicated commitment to recovery principles were important factors. Work hours (30 percent), administrative support (23.3 percent), and competitive salary (16.7 percent) were also identified as important factors. Nearly half, 46.6 percent, identified two or more reasons/factors.

The most frequently identified barriers/challenges experienced in the hiring process were salary (56.7 percent), volunteer hours (26.7 percent), limited employment opportunities (23.3 percent), and exemption/background screening process (10 percent). Six respondents identified two or more barriers/challenges.

Respondents were asked to identify what training they would recommend for a peer to have to help them provide peer support services. From a list of 14 types of training, 11 types were identified by more than 50 percent of respondents. The most frequently cited trainings were the 40-hour required Peer Recovery Specialist Training/Helping Others Heal (90 percent), Wellness Recovery Action Plan (WRAP [80 percent]), Compassionate Fatigue/Self-care (76.7 percent), and Mental Health First Aid (70 percent). All respondents cited two or more trainings they would recommend for a peer to have.

Nearly two-thirds of respondents said that partnerships exist with peer support recovery programs, recovery community organizations, and other support groups. Nearly three-fourths said their organization helps reduce stigma by promoting person-centered recovery language.

MOVING FROM WHERE WE ARE TO WHERE WE WANT TO BE

This assessment can serve as the foundation for strategically addressing key behavioral health care needs as defined by consumers and their providers. Next steps include developing a comprehensive behavioral health care plan to enhance access and quality while mitigating barriers and weaknesses. Articulating and implementing measurable objectives and realistic action steps can help ensure a system that promotes individual, family, and community wellbeing and resilience. We hope that this needs assessment will help make those efforts more fruitful and effective.

NWFHN SERVICE AREA DEMOGRAPHIC PROFILE

Population Demographics

NWFHN's 18-county service area includes Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton, and Washington Counties. Demographic data in this section are based on 5-year estimates from 2016-2020.

Total population of the service area increased by 3.8 percent between 2016 and 2020, from 1,484,226 to 1,541,100. This increase added 56,874 residents to the service area.

In the service area females accounted for slightly less than 50 percent of the population while they accounted for 51.1 percent of the statewide population.

The racial composition in the service area was predominately White at 72 percent, slightly less than the state rate of 71.6 percent. The Black population accounted for 18.8 percent of the service area population and 15.9 percent of Florida's population. American Indian and Native Hawaiians represented less than 1 percent of the service area and state population. The percentage of Asian residents, at 2.4 percent, was similar to the state rate at 2.8 percent. The service area was slightly less diverse when compared to the state, with 1.8 percent identifying with a race of Other, and 4.5 percent identifying with more than one racial group. In the state, 3.3 percent of the population identified as Other, and six percent identified with more than one racial group.

Ethnically, the service area's percentage of Hispanic residents was 6.5 percent, significantly lower than the state rate of 25.8 percent.

The age distribution of the service area population was somewhat younger than the state's population. Residents, 65 years of age or older, accounted for 16.6 percent of the service area's population, while in the state, 20.5 percent of residents were at least 65 years old.

Education and Employment

Service area and state populations over the age of 25 years were very similar regarding educational attainment. Nearly 90 percent of residents in the service area and the state over 25 years of completed high school. The service area rate of 89.7 percent was slightly higher than the state rate of 88.5 percent.

In the service area, 17.7 percent of those over the age of 25 received a bachelor's degree, lower than the state rate of 19.3 percent. Graduate or professional degrees were held by 11 percent of those over the age of 25 in the service area compared to 11.3 percent statewide.

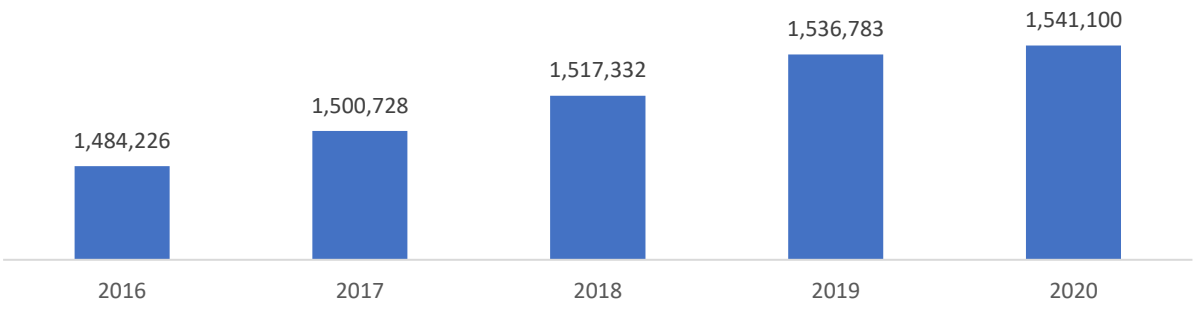
On average, 59 percent of the service area population participated in the labor force between 2015 and 2019, slightly higher than the statewide rate at 58.9 percent. During the same period, the average rate of unemployment in the service area was 3.1 percent, lower than the state rate of 5.4 percent.

Poverty Status

The ratios of income to poverty of residents in the service area and the state were very similar. The population of the area and the state with incomes less than 100 percent of the poverty level, accounted for 9.7 percent and 9.4 percent, respectively. Those with incomes between 100-199 percent of poverty accounted for 15.8 percent of the area, and 16.9 percent of the state population.

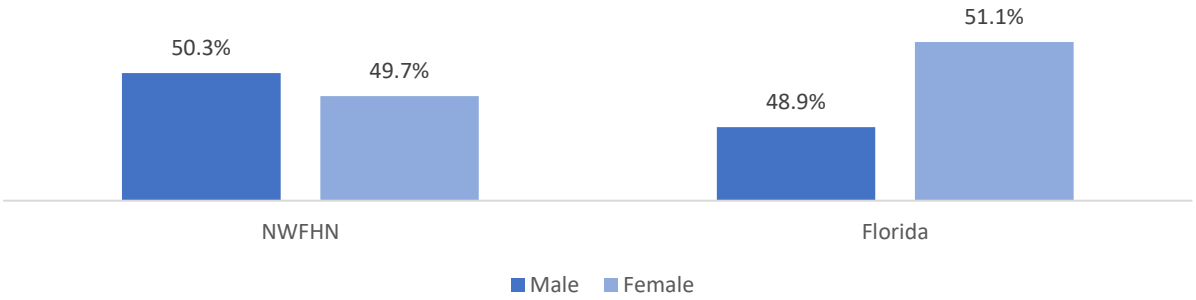
DEMOGRAPHIC CHARTS

Figure 1: NWFHN Substance Abuse Population Estimates (2016-2020)



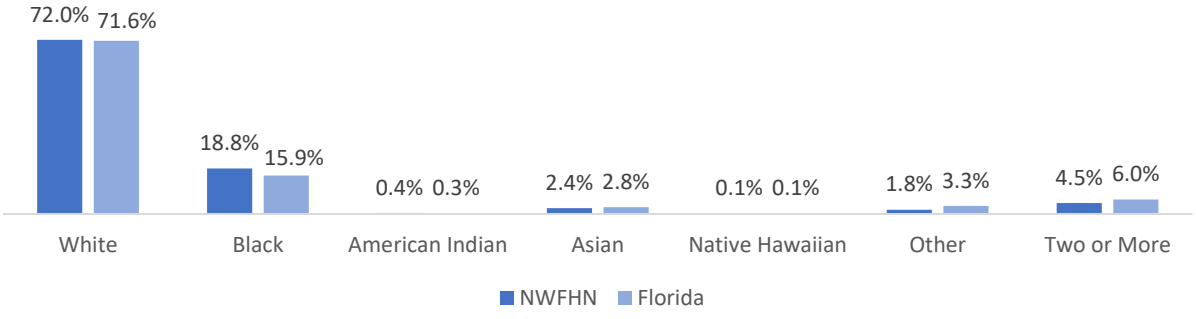
Source: Florida Legislature, Office of Economic and Demographic Research (EDR)

Figure 2: NWFHN Substance Abuse County Population by Gender (2016-2020)



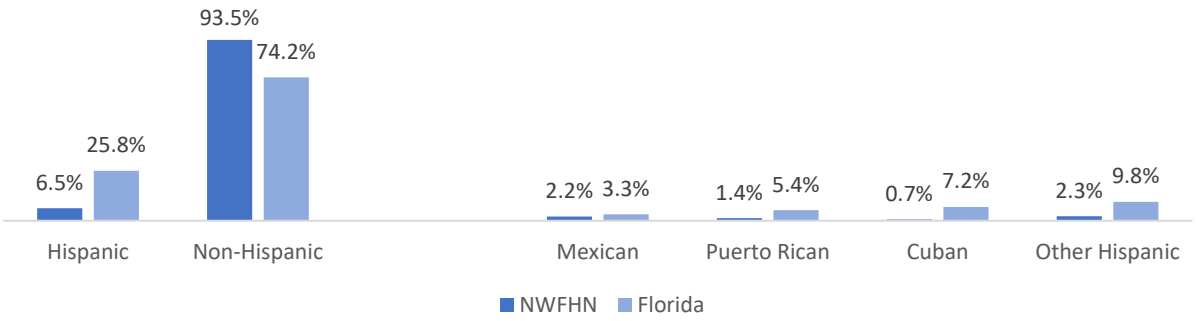
Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 3: NWFHN Substance Abuse County Population by Race, 2016-2020 (5-Year Estimate)



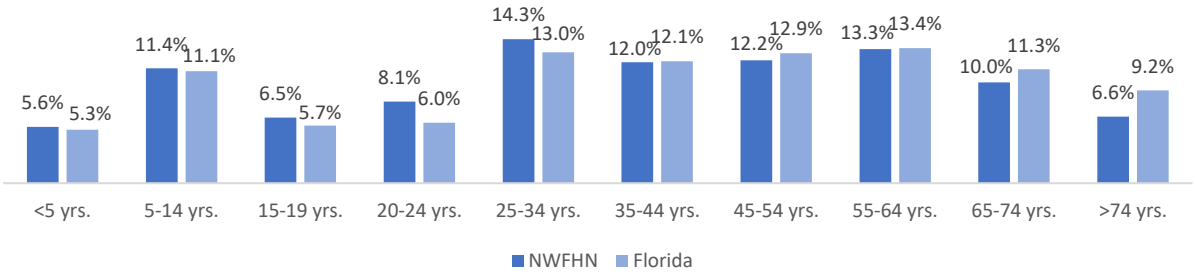
Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 4: NWFHN Substance Abuse Population by Ethnicity, 2016-2020 (5-Year Estimate)



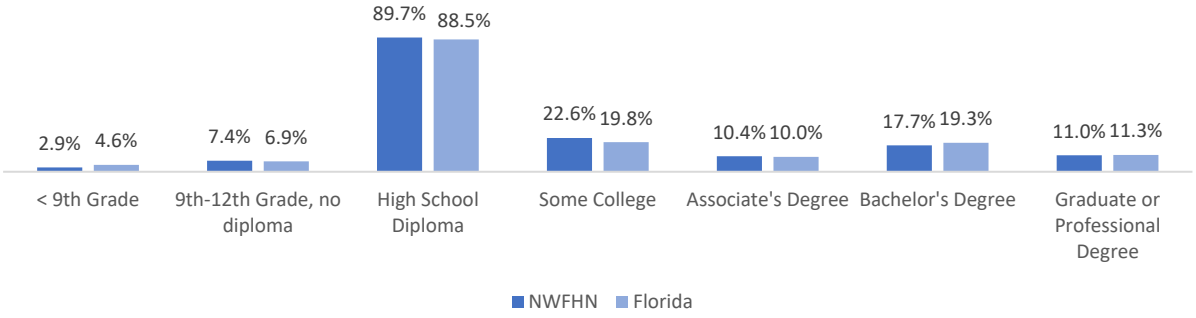
Source: U.S Census Bureau, American Community Survey, Table DP05

Figure 5: NWFHN Substance Abuse Population by Age Range, 2016-2020 (5-Year Estimate)



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

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

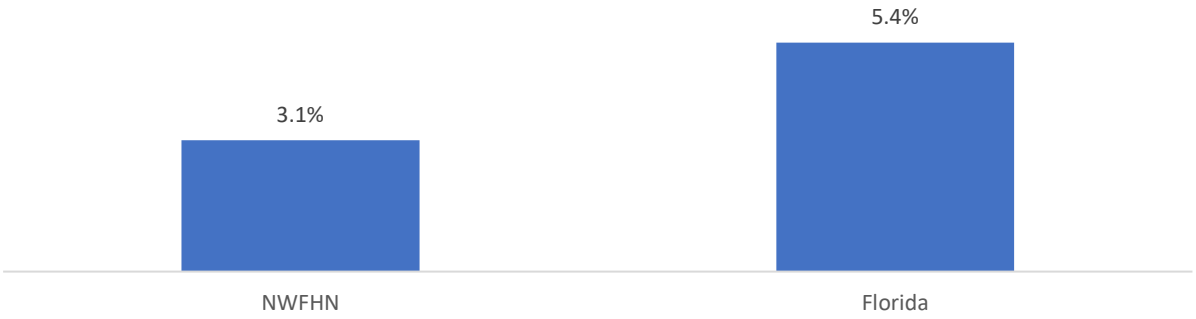


Source: U.S Census Bureau, American Community Survey, Table S1501

Figure 7: NWFHN Substance Abuse Population Participation in Labor Force, 2016-2020 (5-Year Estimate)

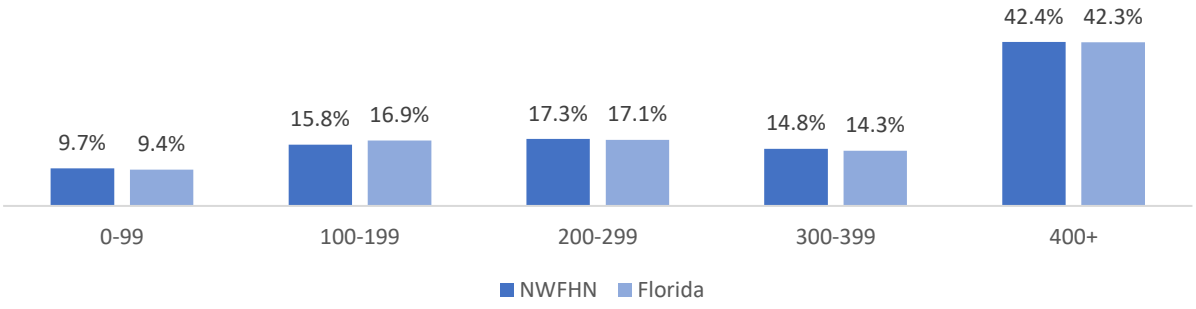
Source: U.S Census Bureau, American Community Survey, Table DP03

Figure 8: NWFHN Substance Abuse Population Unemployment Rates, 2016-2020 (5-Year Estimate)



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

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



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

NWFHN SERVICE AREA GENERAL HEALTH STATUS

Overall, Health Status

According to Behavioral Risk Factor Surveillance System (BRFSS) surveys conducted between 2017 and 2020, an estimated 80.6 percent of adults (ages 18-64) living in the service area said their overall health was “good” to “excellent”. For Florida, the rate was slightly lower at 80.3 percent.

Mental Health

The average percentage of adults, ages 18-64 years, in the service area who reported good mental health from 2017 to 2019, at 86.1 percent, was slightly lower than the state average of 86.2 percent. During the same time, adults in the NWFHN service area and the state reported 4.4 days of unhealthy mental days during the previous 30 days.

Suicide

The crude suicide death rate increased from 18.5/100,000 in 2018 to 19.2/100,000 population in 2020, representing an increase of 0.7/100,000 suicide deaths. At the state level, the suicide crude death rate decreased 2.5 deaths per 100,000 population during the same time and was lower throughout 2018 to 2020 when compared to the NWFHN service area population. Among males, the suicide death rates in the service area (29.4/100,000), and state (22.7/100,000), were more than triple the rates among females. The suicide death rate among White residents in the service area (23.7/100,000) was more than five times the rate for Black residents (4.7/100,000). This disparity was greater than at the state level where the rate of White suicide deaths was more than triple that of Blacks. It should be noted that the calculations required for the age-adjusted death rate for the NWFHN service areas was beyond the scope of this project.

Violence and Abuse

The rate of total domestic violence offenses decreased in the service area and the state between 2017 and 2019. During this time, the service area rate fell from 627.5/100,000 population to 608.1/100,000, but by 2019 was still significantly higher than the state rate of

496.5/100,000.

The rate of children (ages 5-11 years) experiencing child abuse, during 2017 to 2019, decreased in the NWFHN service area, falling from 1,117.7/100,000 in 2017 to 1,016.1/100,000 in 2019. During this same period, the state rate decreased from 857.9/100,000 to 662.7/100,000. By 2019, the service area rate was still more than 1.5 times the state rate.

Child sexual abuse rates changed very little from 2017 to 2019, except for briefly decreasing in 2018. In the NWFHN service area, the 2019 sexual abuse rate for children 5-11 years was 104.4/100,000. This was 1.8 times higher than the state rate of 57.8/100,000.

Mental Illness

The estimated number of adults with serious mental illness in the NWFHN service area increased by less than one percent, from 47,047 in 2018 to 47,465 in 2020. This was lower than the rate of increase at the state level of 3.5 percent.

Between 2018 and 2020, the estimated number of youth with an emotional disturbance (ages 9-17) in the NWFHN service area, increased by 9.1 percent, from 13,801 in 2018 to 15,058 in 2020. This was higher than the state increase of 3 percent.

The Florida Department of Education reported that 0.6 percent of K-12 grade children in the service area had an emotional/behavioral disability, slightly higher than the state rate of 0.5 percent. Service area rates and state rates were steady from 2018 to 2020.

Adult Tobacco and Alcohol Use

According to BRFSS survey data, between 2017 and 2019, 19.1 percent of adults living in the service area said they were current smokers, higher than the state rate of 14.8 percent.

The BRFSS survey defines binge drinking as five consecutive drinks for men and four consecutive drinks for women. From 2017 to 2019, the percentage of binge drinkers in the NWFHN service area was 18.3 percent, slightly higher than the state rate of 18 percent.

High School Tobacco, Alcohol and Substance Use

Numerous questions in the Florida Youth Substance Abuse Survey (FYSAS) relate to tobacco, alcohol, and substance use among middle and high school students. Data in this section are estimates from FYSAS 2016-2020.

The percentage of middle and high school students who reported never having smoked

cigarettes increased from 80.7 percent in 2016 to 87.4 percent in 2020. By 2020, 8.2 percent of students reported they had smoked once or twice, 2.5 percent reported that they smoked 'once in a while', and 0.6 percent said they smoked regularly. Overall, for middle and high school students in NWFHN service area and the state, the percentage of those who had never smoked increased.

In 2020, when students were asked about current smoking frequency, 97.2 percent of those living in the NWFHN service area did not smoke at all, while the state rate was slightly higher at 98.2 percent.

Questions relevant to vaping were included in the FYSAS for the first time in 2020. In the NWFHN service area, 26 percent of students reported vaping nicotine on at least one occasion in their lifetime, and 7.8 percent of students had vaped on 40 or more occasions. Rates at the state level were somewhat lower with 22.8 percent reporting vaping at least once and 5.9 percent vaping on 40 or more occasions. Rates of current nicotine vaping during the previous 30 days were much lower in the service area and the state when compared to lifetime rates. While 74 percent of students in the service area and 77.2 percent of the students in state had never vaped nicotine, 87 percent in the service area, and 88.6 percent in the state had not done so in the past 30 days.

The percentage of students in the service area who had not consumed alcoholic beverages on any occasions in their lifetimes increased from 60.7 percent in 2016 to 66.3 percent in 2020. The lifetime consumption of alcohol on one to two occasions, increased slightly from 13.8 percent in 2016 to 14.1 percent in 2020, while the rates of consuming alcohol on least 40 occasions decreased from 4 percent in 2016 to 2.8 percent in 2020. State rates and trends were very similar to those in the NWFHN service area. Overall, lifetime drinking decreased from 2016 to 2020 in the NWFHN service area and the state.

High school students were asked for the number of occasions in their lifetime when they had woken up after a night of drinking alcohol and were unable to remember the things they did or the places they went. The percentage of students in the service area who said this never happened increased from 81.6 percent in 2016 to 85.1percent in 2020, while the state rate increased from 84.1 percent to 86.2 percent. In 2020, 7.6percent of NWFHN service area students reported that this event happened on at least one to two occasions, nearly identical to the state rate of 7.4 percent.

The percentages of students living in the NWFHN service area not consuming alcohol during the previous 30 days increased from 81 percent in 2016 to 85.5 percent in 2020. This was very similar to the state rates and trend. The percentages of students who reported consuming alcohol on 1-2 occasions during the previous 30 days, decreased in the service area from 11.1 percent in 2016 to 9.1 percent in 2020, nearly identical to the state rates and trend.

The overall percentage of those binge drinking, defined as consuming 5 or more alcoholic drinks in a row in the past two weeks, decreased in the NWFHN service area from 8.9

percent in 2016 to 6.5 percent in 2020. In the state, there was a decrease from 7.8 percent in 2016 to 6.8 percent in 2020. These decreases in binge drinking were consistent with the overall increase in no binge drinking at all. Specifically, by 2020 93.5 percent in the NWFHN service area reported no binge drinking, which was almost identical to the state rate of 93.3 percent.

Between 2016 and 2020, the percentages of NWFHN service area students who had not used marijuana in their lifetimes increased slightly from 79 percent to 79.7 percent, almost identical to the state increase from 78.7 percent to 79.9 percent. For those who did use marijuana on one or more occasions, the overall percentages decreased slightly in the NWFHN service area from 21 percent in 2016 to 20.3 percent in 2020. At the state level, the decrease was similar when comparing 2016 at 21.3 percent to 2020 at 20.1 percent.

In 2020, the percentages of students not using marijuana in the previous 30 days (90.6 percent) was higher when compared with those who reported not using it at all in their lifetimes at 79.7 percent. These rates are almost identical to statewide rates.

In 2020, the percentage of students who reported vaping marijuana in their lifetimes on one or more occasions was lower in the NWFHN service area, at 14.6 percent, when compared to the state rate of 15.6 percent. This was also true when comparing the two groups of students who had vaped marijuana in the previous 30 days. In the NWFHN service area, 6.6 percent of students had vaped marijuana in the previous 30 days compared to 7.3 percent of students in the state.

Disability

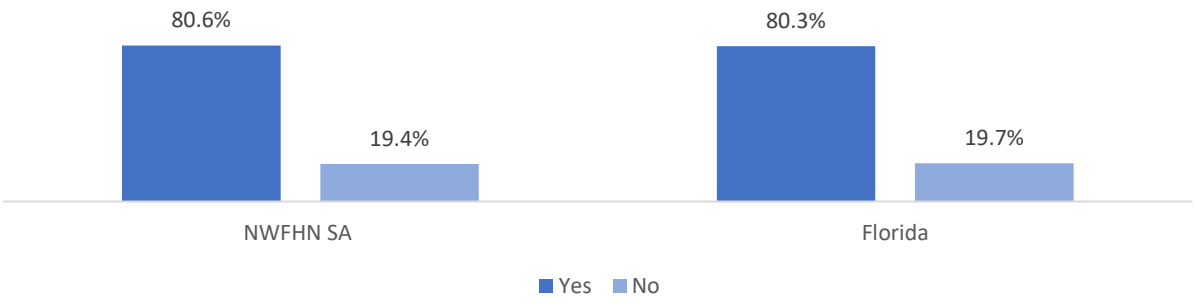
From 2016 to 2020, an estimated 16.1 percent of the civilian noninstitutionalized population in the NWFHN service area, and 13.6 percent in the state had a disability (including disabilities related to hearing, vision, cognitive, ambulatory, self-care, and independent living). The rates of disability among older adults, ages 65 years and older, at 39.9 percent were less when compared to the state at 48.9 percent.

Health Insurance Coverage

Between 2017 and 2019, most residents ages 18-64 years, living in the NWFHN service area and state, reported having some type of health insurance coverage. The state rate was slightly higher when compared to the NWFHN service area at 84.2 percent and 83.6 percent, respectively.

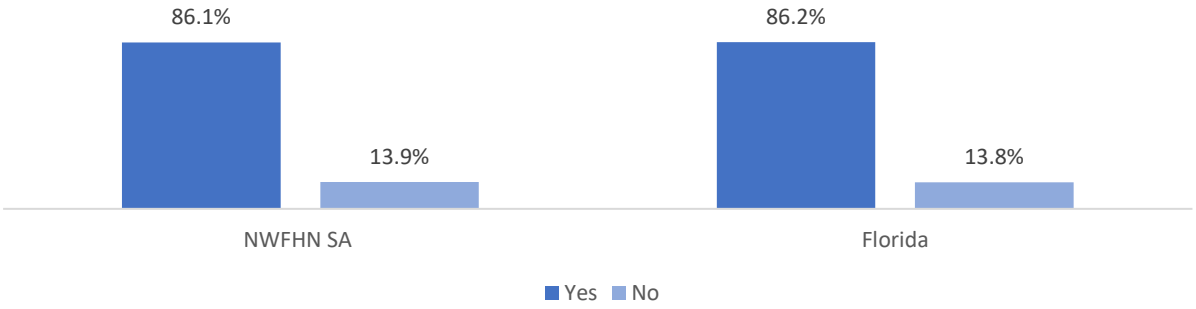
GENERAL HEALTH STATUS CHARTS

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



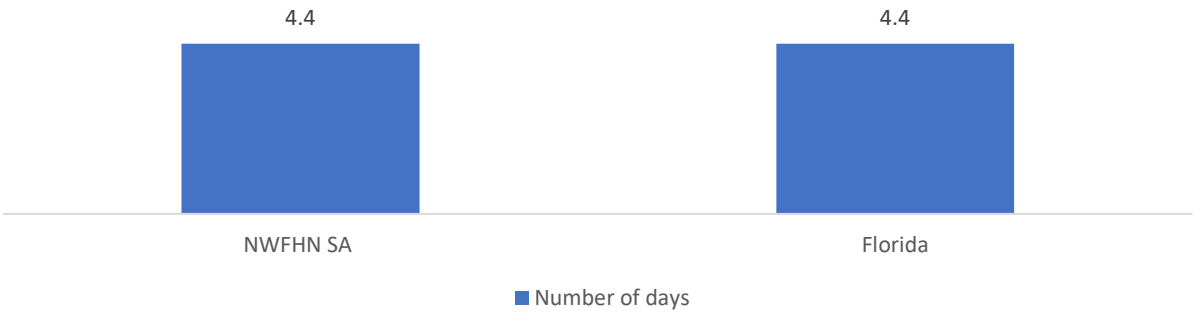
Source: Behavioral Risk Factor Surveillance System

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



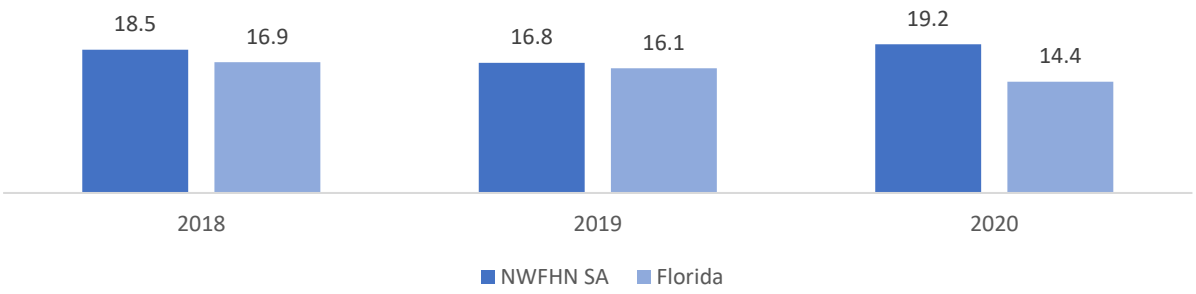
Source: Behavioral Risk Factor Surveillance System

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



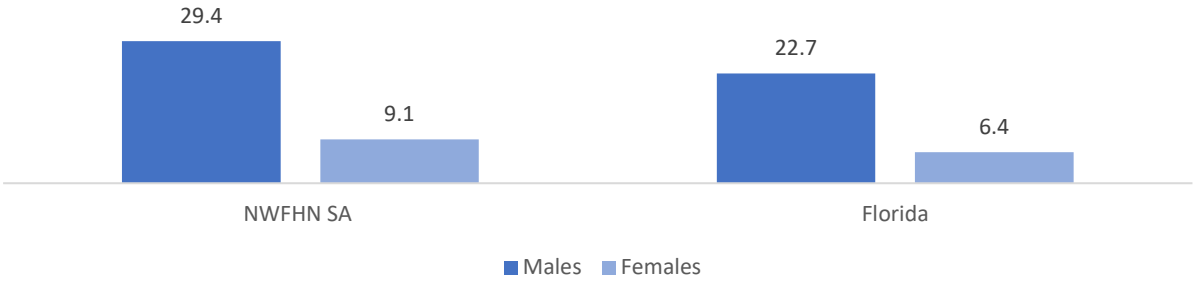
Source: Behavioral Risk Factor Surveillance System

Figure 13: NWFHN Substance Abuse Crude Suicide Death Rates (2018-2020)



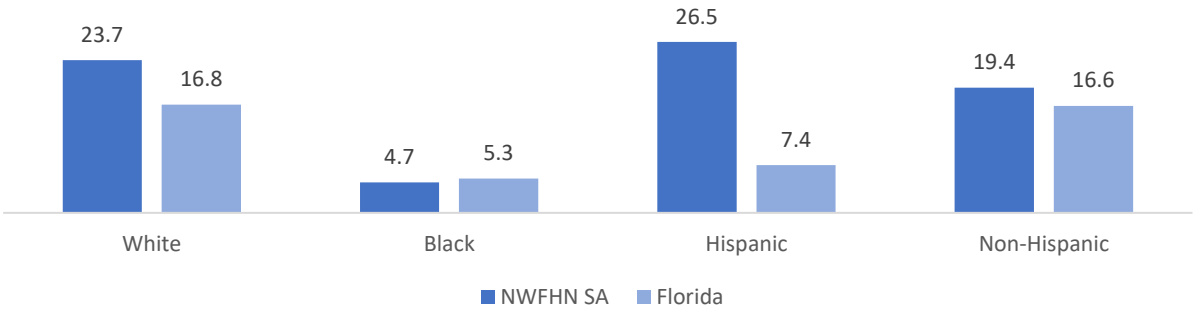
Source: Florida Department of Health, Bureau of Vital Statistics, Rate per 100,000

Figure 14: NWFHN Substance Abuse Crude Suicide Death Rates by Gender (2020)



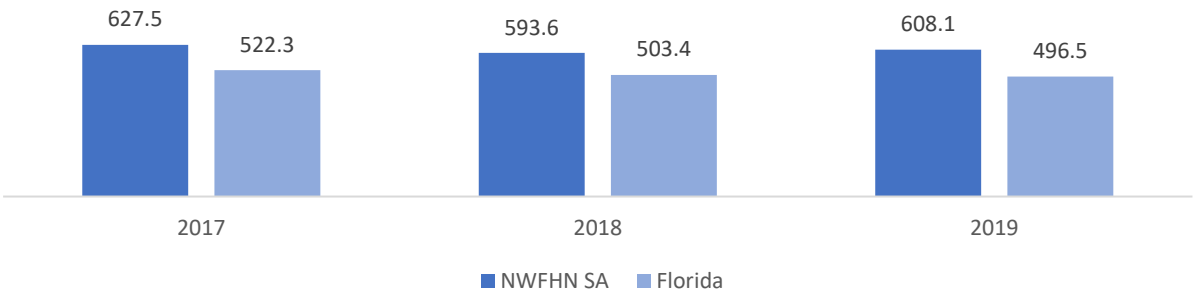
Source: Florida Department of Health, Bureau of Vital Statistics, Rate per 100,000

Figure 15: NWFHN Substance Abuse Crude Suicide Death Rates by Race and Ethnicity (2020)



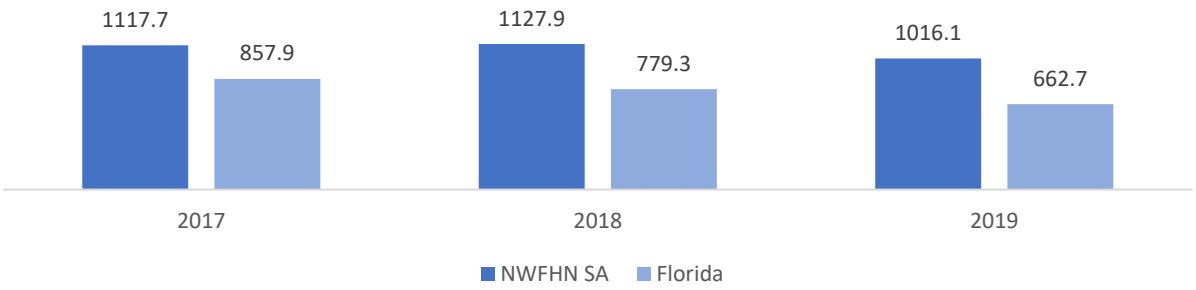
Source: Florida Department of Health, Bureau of Vital Statistics, Rate per 100,000

Figure 16: NWFHN Substance Abuse Total Domestic Violence Offenses (2017-2019)



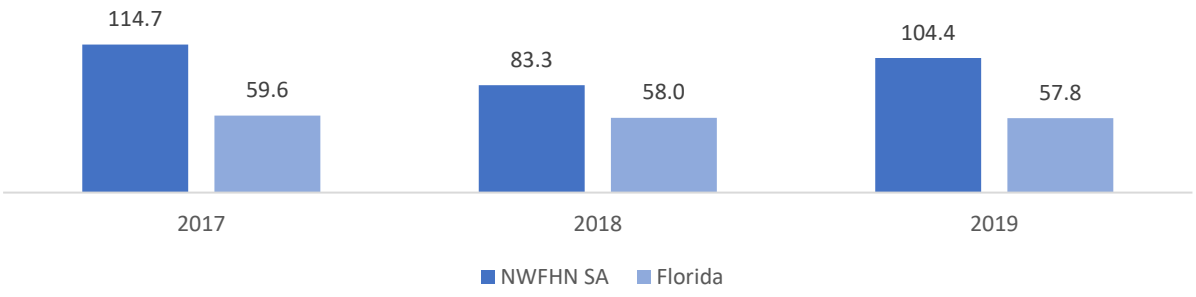
Source: Florida Department of Law Enforcement, Crime in Florida, Uniform Crime Report 2019, Rate per 100,000

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



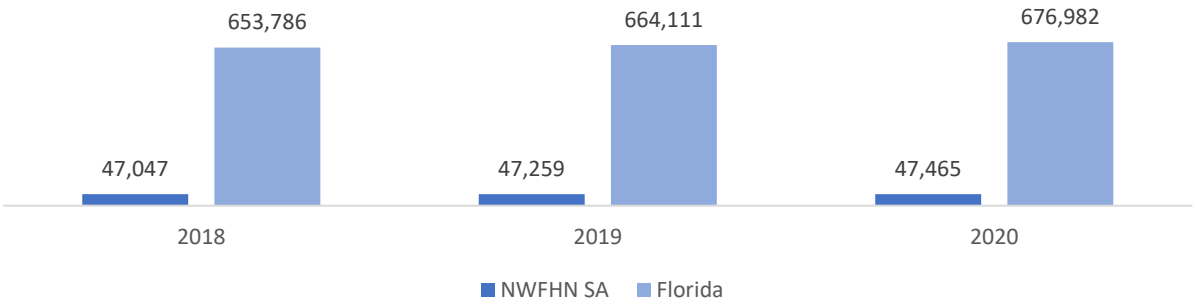
Source: Department of Children and Families, Florida Safe Families Network Data Mart, Rate per 100,000

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



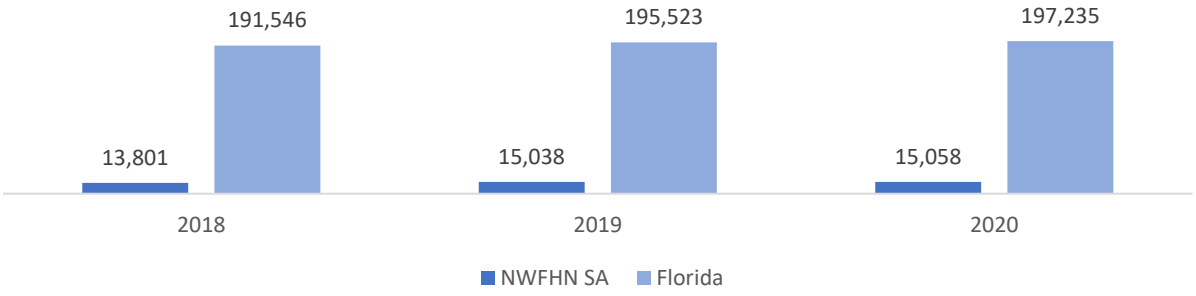
Source: Department of Children and Families, Florida Safe Families Network Data Mart, Rate per 100,000

Figure 19: NWFHN Substance Abuse Estimated Number of Seriously Mentally Ill Adults (2018-2020)



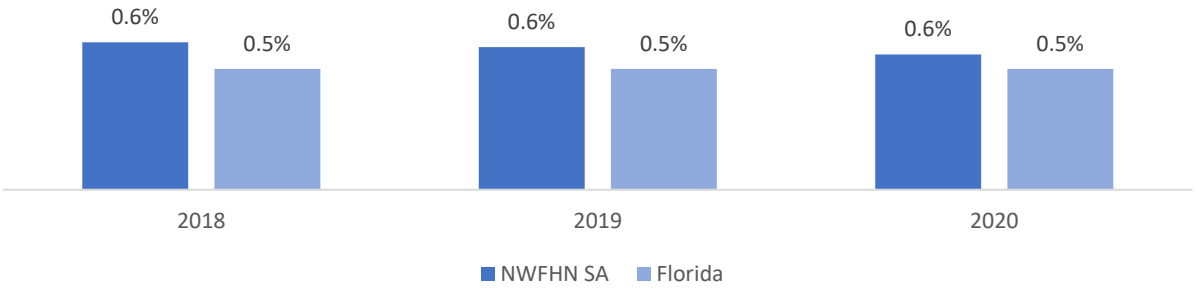
Source: Estimates based on Department of Health and Human Resource Report Mental Health U.S. 1995

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



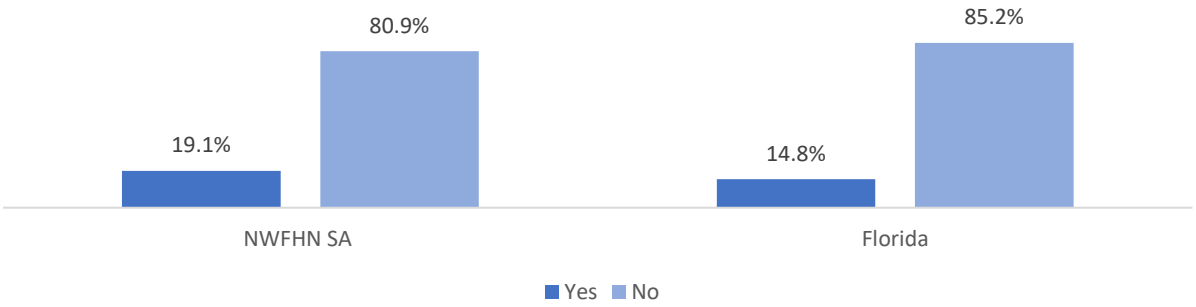
Source: Estimates based on Department of Health and Human Resource Report Mental Health U.S. 1995

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



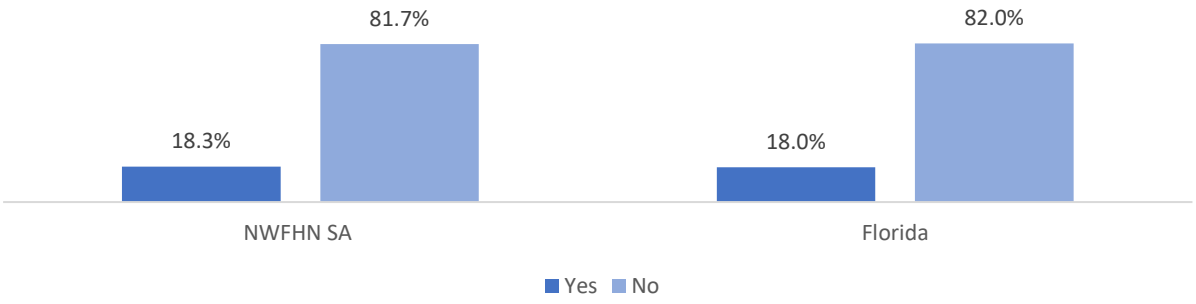
Source: Florida Department of Education, Education Information and Accountability Services (EIAS)

Figure 22: NWFHN Substance Abuse Percentage of Adults Who Are Current Smokers (2017-2019)



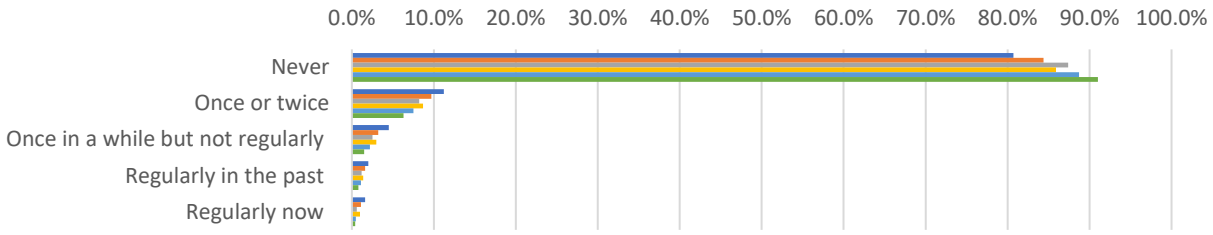
Source: Behavioral Risk Factor Surveillance System

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



Source: Behavioral Risk Factor Surveillance System

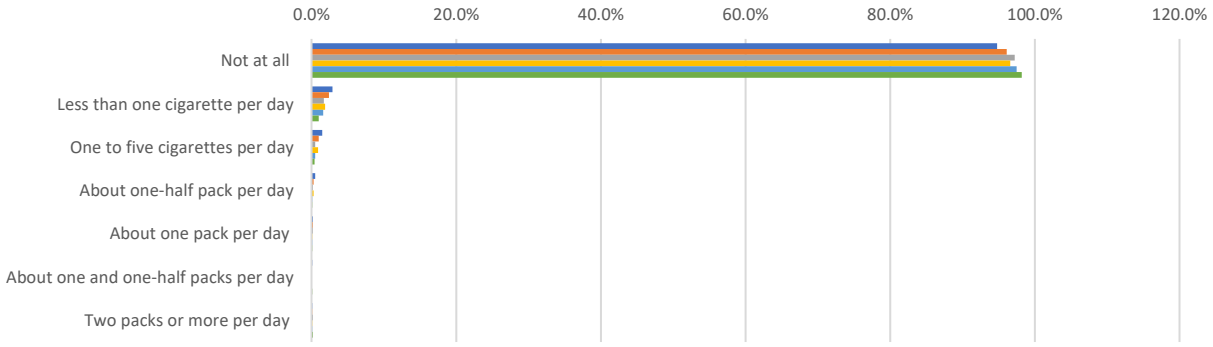
Figure 24: NWFHN Substance Abuse Having Ever Smoked Cigarettes (MS and HS 2016-2020)



	Regularly now	Regularly in the past	Once in a while but not regularly	Once or twice	Never
NWFHN SA 2016	1.6%	2.0%	4.5%	11.2%	80.7%
NWFHN SA 2018	1.1%	1.6%	3.2%	9.7%	84.4%
NWFHN SA 2020	0.6%	1.2%	2.5%	8.2%	87.4%
Florida 2016	1.0%	1.4%	3.0%	8.7%	85.9%
Florida 2018	0.5%	1.1%	2.2%	7.5%	88.7%
Florida 2020	0.4%	0.8%	1.5%	6.3%	91.0%

Source: Florida Youth Substance Abuse Survey

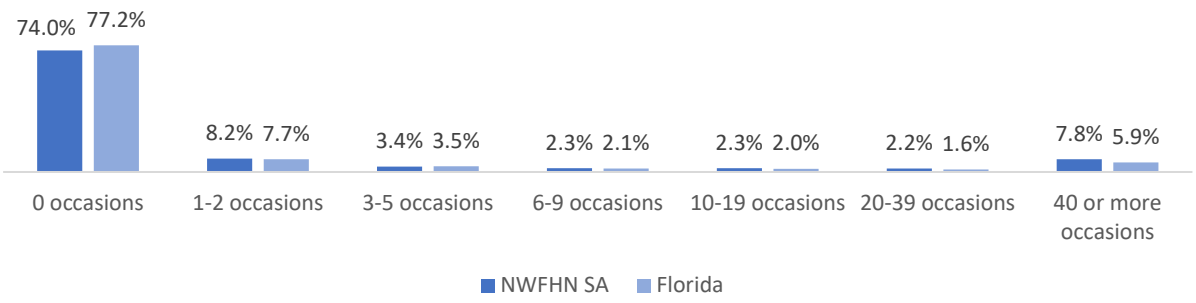
Figure 25: NWFHN Substance Abuse – How Frequently Have You Smoked Cigarettes in the Past 30 Days? (MS and HS 2016-2020)



	Two packs or more per day	About one and one-half packs per day	About one pack per day	About one-half pack per day	One to five cigarettes per day	Less than one cigarette per day	Not at all
NWFHN SA 2016	0.1%	0.1%	0.2%	0.5%	1.5%	2.9%	94.8%
NWFHN SA 2018	0.1%	0.0%	0.2%	0.3%	1.0%	2.4%	96.1%
NWFHN SA 2020	0.2%	0.0%	0.2%	0.2%	0.5%	1.7%	97.2%
Florida 2016	0.1%	0.0%	0.1%	0.3%	0.9%	1.9%	96.6%
Florida 2018	0.1%	0.0%	0.1%	0.1%	0.5%	1.6%	97.5%
Florida 2020	0.2%	0.1%	0.1%	0.1%	0.4%	1.0%	98.2%

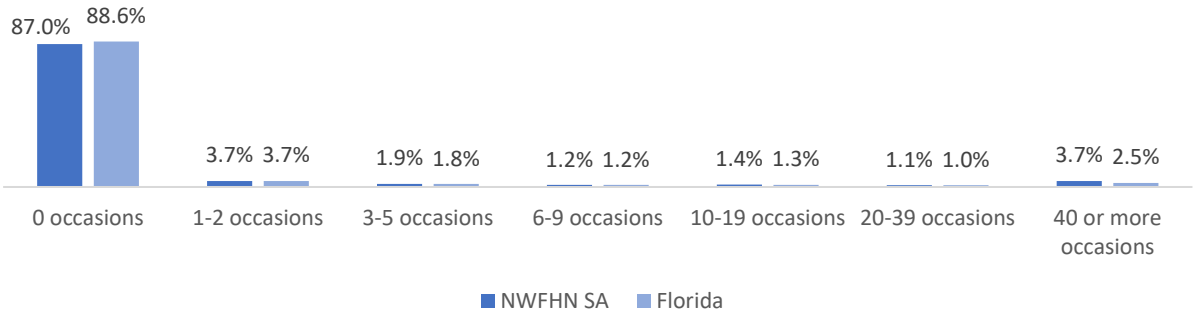
Source: Florida Youth Substance Abuse Survey

Figure 26: NWFHN Substance Abuse – On How Many Occasions Have You Vaped Nicotine in Your Lifetime? (MS and HS 2020)



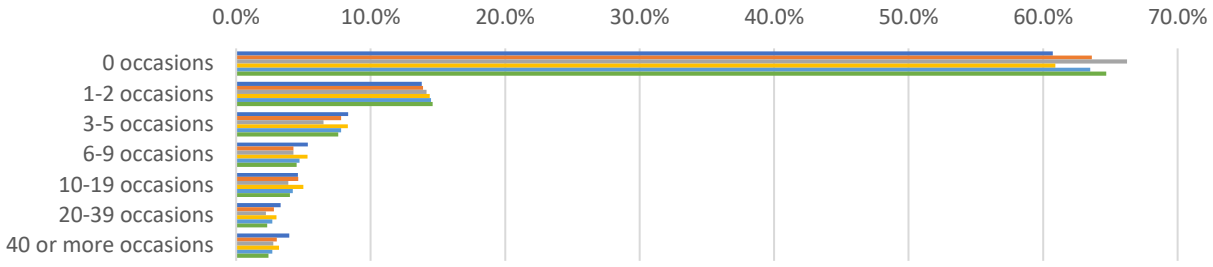
Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

Figure 27: NWFHN Substance Abuse – On How Many Occasions Have You Vaped Nicotine During the Past 30 Days? (MS and HS 2020)



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

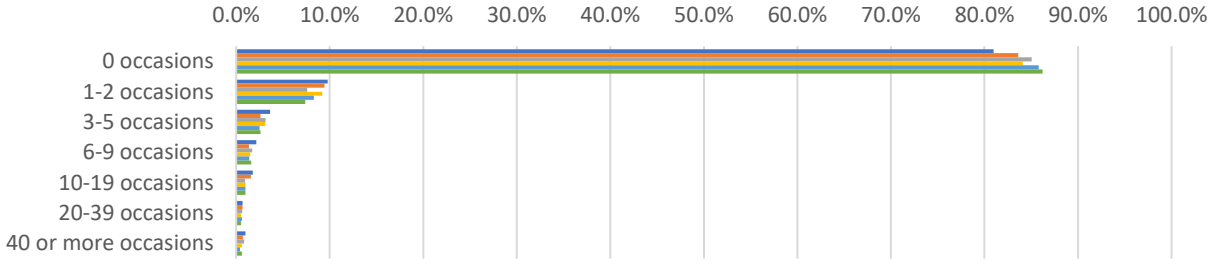
Figure 28: NWFHN Substance Abuse – On How Many Occasions Have You Had Alcoholic Beverages to Drink in Your Lifetime? (MS and HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
NWFHN SA 2016	4.0%	3.3%	4.6%	5.3%	8.3%	13.8%	60.7%
NWFHN SA 2018	3.0%	2.8%	4.6%	4.3%	7.8%	13.9%	63.6%
NWFHN SA 2020	2.8%	2.2%	3.9%	4.3%	6.5%	14.1%	66.3%
Florida 2016	3.2%	3.0%	5.0%	5.3%	8.3%	14.4%	60.9%
Florida 2018	2.7%	2.7%	4.2%	4.7%	7.8%	14.5%	63.5%
Florida 2020	2.4%	2.3%	4.0%	4.5%	7.6%	14.6%	64.7%

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

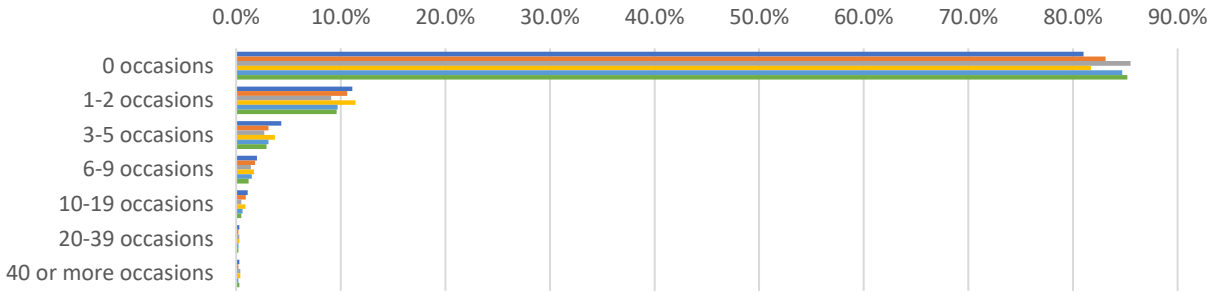
Figure 29: NWFHN Substance Abuse – On How Many Occasions in Your Lifetime Have You Woken Up After a Night of Drinking Alcoholic Beverages and Not Been Able to Remember Things You Did or the Places You Went? (HS Only 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
NWFHN SA 2016	1.0%	0.7%	1.8%	2.2%	3.6%	9.8%	81.0%
NWFHN SA 2018	0.7%	0.7%	1.6%	1.4%	2.6%	9.4%	83.6%
NWFHN SA 2020	0.9%	0.7%	0.9%	1.7%	3.2%	7.6%	85.1%
Florida 2016	0.6%	0.5%	1.0%	1.5%	3.1%	9.2%	84.1%
Florida 2018	0.4%	0.6%	1.0%	1.4%	2.5%	8.3%	85.8%
Florida 2020	0.6%	0.5%	1.0%	1.6%	2.6%	7.4%	86.2%

Source: Florida Youth Substance Abuse Survey

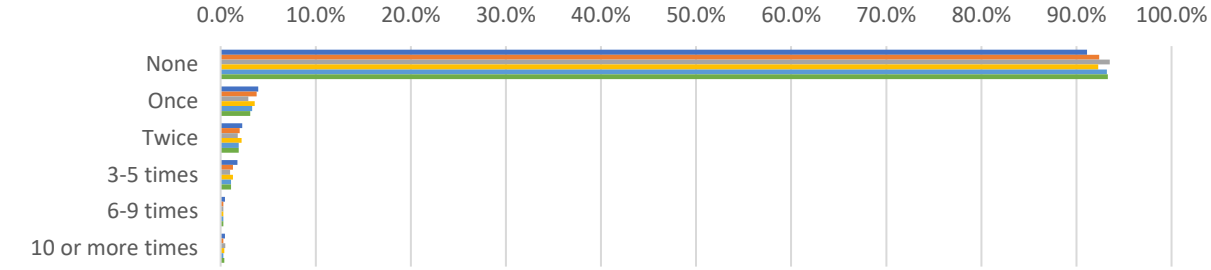
Figure 30: NWFHN Substance Abuse – On How Many Occasions Have You Had Beer, Wine, or Hard Liquor in the Past 30 Days? (MS and HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
NWFHN SA 2016	0.3%	0.3%	1.1%	2.0%	4.3%	11.1%	81.0%
NWFHN SA 2018	0.2%	0.2%	0.9%	1.8%	3.1%	10.6%	83.1%
NWFHN SA 2020	0.4%	0.3%	0.5%	1.4%	2.7%	9.1%	85.5%
Florida 2016	0.4%	0.3%	0.9%	1.7%	3.7%	11.4%	81.7%
Florida 2018	0.2%	0.2%	0.6%	1.5%	3.1%	9.7%	84.7%
Florida 2020	0.3%	0.2%	0.5%	1.2%	2.9%	9.6%	85.2%

Source: Florida Youth Substance Abuse Survey

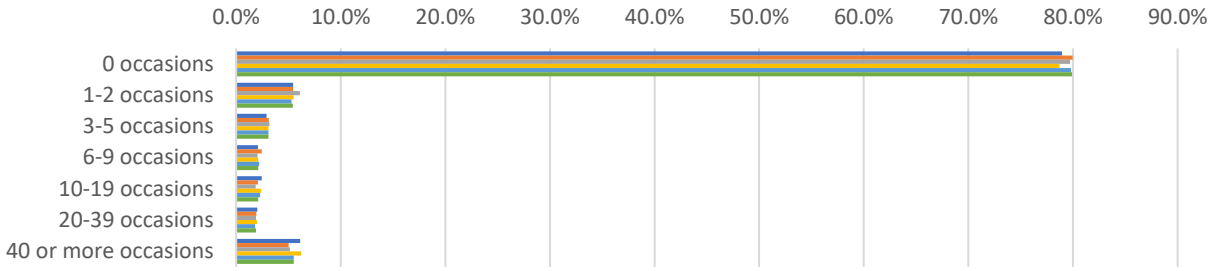
Figure 31: NWFHN Substance Abuse – Think Back Over the Past 2 Weeks...How Many Times Have You Had Five or More Alcoholic Drinks in a Row? (MS and HS 2016-2020)



	10 or more times	6-9 times	3-5 times	Twice	Once	None
NWFHN SA 2016	0.4%	0.4%	1.8%	2.3%	3.9%	91.1%
NWFHN SA 2018	0.3%	0.3%	1.3%	2.0%	3.8%	92.4%
NWFHN SA 2020	0.5%	0.3%	1.0%	1.8%	2.9%	93.5%
Florida 2016	0.4%	0.3%	1.3%	2.2%	3.6%	92.3%
Florida 2018	0.3%	0.3%	1.1%	1.9%	3.3%	93.2%
Florida 2020	0.4%	0.3%	1.1%	1.9%	3.1%	93.3%

Source: Florida Youth Substance Abuse Survey

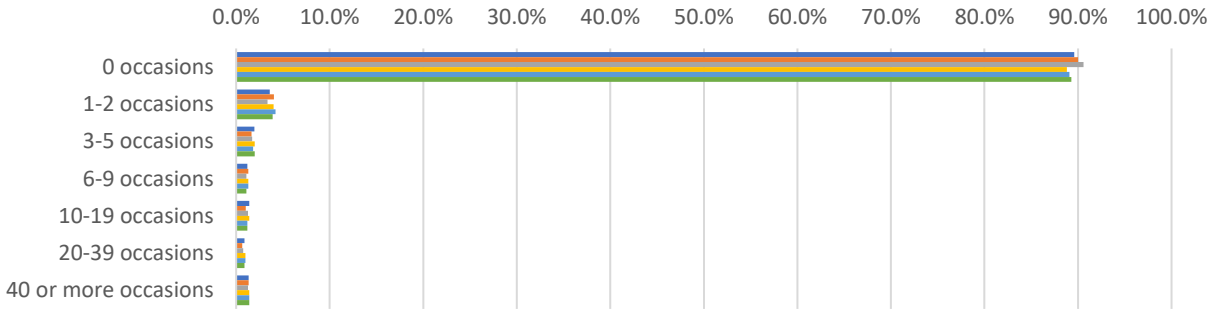
Figure 32: NWFHN Substance Abuse – On How Many Occasions Have You Used Marijuana or Hashish in Your Lifetime? (MS and HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
NWFHN SA 2016	6.1%	2.0%	2.4%	2.1%	2.9%	5.4%	79.0%
NWFHN SA 2018	5.0%	1.9%	2.1%	2.5%	3.1%	5.4%	80.0%
NWFHN SA 2020	5.2%	1.9%	1.9%	2.1%	3.2%	6.1%	79.7%
Florida 2016	6.2%	2.0%	2.4%	2.1%	3.1%	5.5%	78.7%
Florida 2018	5.5%	1.8%	2.3%	2.2%	3.1%	5.3%	79.8%
Florida 2020	5.5%	1.9%	2.1%	2.1%	3.1%	5.4%	79.9%

Source: Florida Youth Substance Abuse Survey

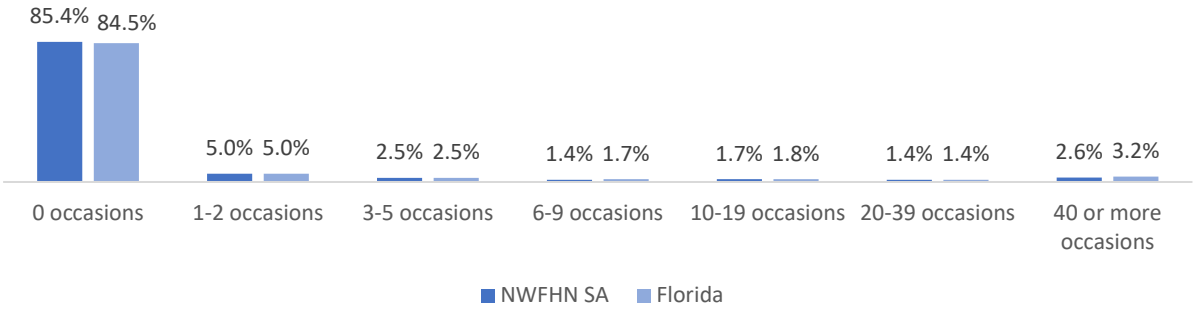
Figure 33: NWFHN Substance Abuse – On How Many Occasions Have You Used Marijuana or Hashish during the Past 30 Days? (MS and HS 2016-2020)



	40 or more occasions	20-39 occasions	10-19 occasions	6-9 occasions	3-5 occasions	1-2 occasions	0 occasions
NWFHN SA 2016	1.3%	0.9%	1.4%	1.2%	2.0%	3.6%	89.6%
NWFHN SA 2018	1.3%	0.6%	1.0%	1.3%	1.6%	4.0%	90.0%
NWFHN SA 2020	1.3%	0.8%	1.3%	1.1%	1.7%	3.4%	90.6%
Florida 2016	1.4%	1.0%	1.4%	1.3%	2.0%	4.0%	88.8%
Florida 2018	1.4%	1.0%	1.2%	1.3%	1.8%	4.2%	89.1%
Florida 2020	1.4%	0.9%	1.2%	1.1%	2.0%	3.9%	89.3%

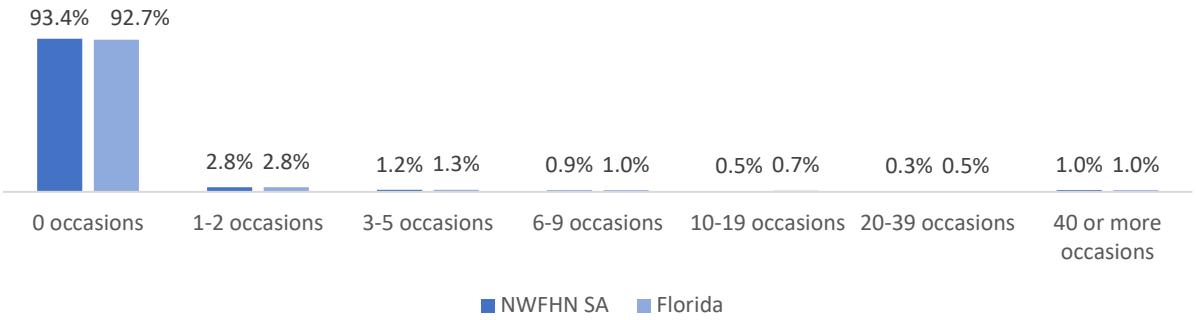
Source: Florida Youth Substance Abuse Survey

Figure 34: NWFHN Substance Abuse – On How Many Occasions Have You Vaped Marijuana in Your Lifetime? (MS and HS 2016-2020)



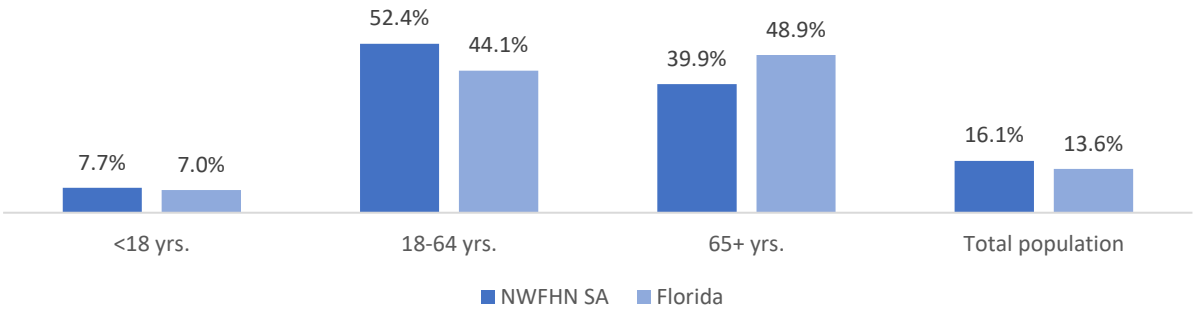
Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

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



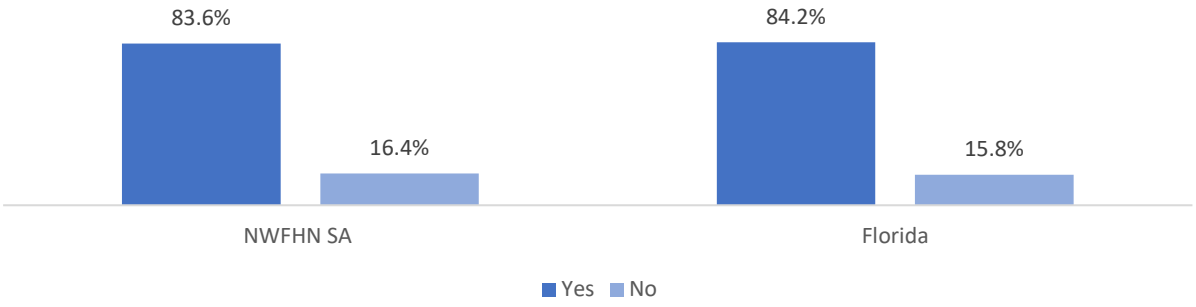
Source: Florida Youth Substance Abuse Survey (Includes e-cigarette, vape pens, JUUL)

Figure 36: NWFHN Substance Abuse Civilian Noninstitutionalized Population with a Disability (2016-2020)



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

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



Source: Behavioral Risk Factor Surveillance System

NWFHN SERVICE AREA CLIENT DEMOGRAPHIC PROFILE

Client Population

NWFHN-funded organizations served 33,313 clients in FY 2020-2021. This included 792 clients (2.4 percent) from out of the catchment area as well as residents from all 18 counties in the service area. The highest percentage of clients were from Escambia County (31 percent, 10,331 clients), followed by Bay County at 14.8 percent (4,928 clients), Okaloosa County at 12.4 percent (4,120 clients), Leon County at 9.7 percent (3,232 clients), and Santa Rosa County at 9.5 percent (3,152 clients). Nearly 5 percent of clients (1,526) reported their residential status as unhoused.

The Adult Mental Health (AMH) program served 56.6 percent (20,863 clients) and the Adult Substance Use Disorder (ASUD) program served 20.9 percent (7,690 clients). An additional 22.2 percent of clients were in children's programs with 18.7 percent (6,881 clients) in the Child Mental Health (CMH) program, and 3.8 percent (1,397 clients) in the Child Substance Use Disorder (CSUD) program.

Gender

Females represented 56.5percent of all NWFHN clients and 54.2 percent of AMH clients. Males accounted for the majority of clients in ASUD (52.8 percent), CMH (52.9 percent), and CSUD (51.5 percent) programs.

Race

Most NWFHN clients were White (70 percent), a slightly lower percentage of the population of than service area population at 72.9 percent. Black NWFHN clients accounted for 22.8 percent of the client population, while representing only 18.8 percent of the population in the 18-county service area. Overall, 7.2 percent of all clients identified their race as other than White or Black, including 3.3 percent multi-racial and 2.5 percent other.

Ethnicity

The percentage of Hispanics residing in the 18-county service area, at 6.5 percent, was higher than the rates of Hispanics in NWFHN programs (3.9 percent). The percentages of Hispanic clients in AMH and ASUD programs were slightly lower, while the rates in CMH and CSUD programs were slightly higher.

Age Range

Adults, 25-44 years of age, accounted for 40.9 percent of clients in AMH and ASUD programs. This was nearly twice the percentage of adults in that age range in the 18-county area (26.3 percent). Teen and young adult clients, 15-24 years of age, accounted for 16.4 percent of NWFHN clients, which was slightly lower than the percentage of those living in the service area at 14.6 percent. Among those enrolled in child/youth programs, 72 percent of clients in the CMH program were 5-14 years of age, and 53.5 percent of clients in the CSUD program were 5-14 years old.

Residential Status

The majority of NWFHN adults (55.3 percent) resided in one of three types of independent living conditions: with relatives (28.9 percent), with non-relatives (9.8 percent), or alone at 16.6 percent. Among AMH clients, 5 percent reported their status as unhoused, as did 7.8 percent of those in the ASUD program. Children/Youth living dependently with relatives accounting for 87.6 percent of CMH clients and 95 percent of CSUD clients.

Educational Attainment

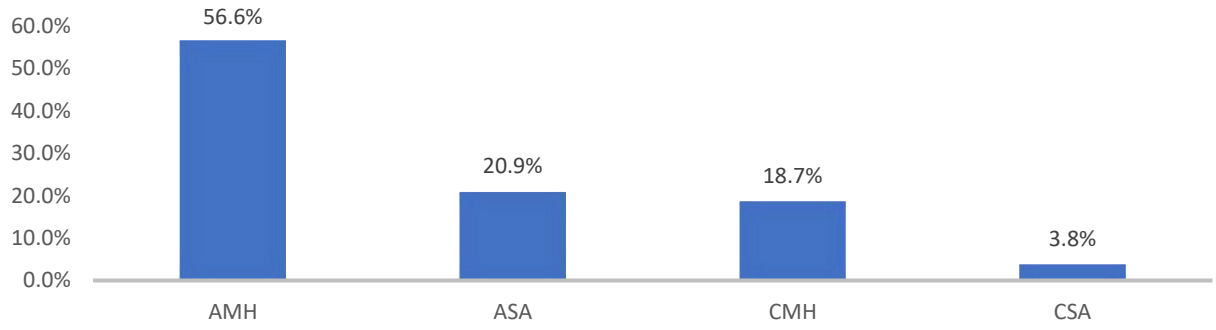
NWFHN clients attained lower educational levels when compared to those in the service area as a whole. Among NWFHN clients, educational attainment at the high school level was 58.4 percent of AMH clients and 61.2 percent for ASUD clients. This was significantly lower than 89.7 percent of residents who graduated high school in the 18-county service area. The percentage of adult NWFHN clients who earned a college degree (2.5 percent) was well below the overall rate for residents living in the service area (39.1 percent).

Employment Status

Lower educational attainment was one of several factors contributing to much higher levels of unemployment among NWFHN clients when compared to the overall rate of the service area population. Unemployment ranged from 41.7 percent among AMH clients, to 45.9 percent among ASUD clients, while the unemployment rate in the service area and state was 3.1 percent.

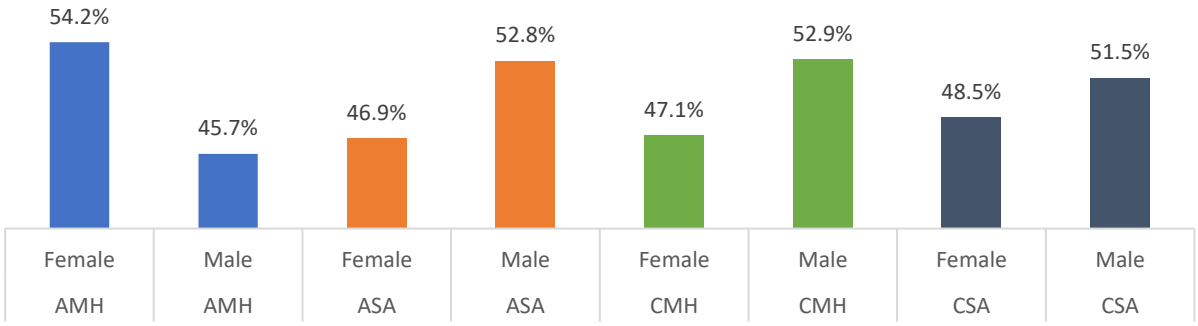
CLIENT DEMOGRAPHIC CHARTS

Figure 38: NWFHN Clients by Program



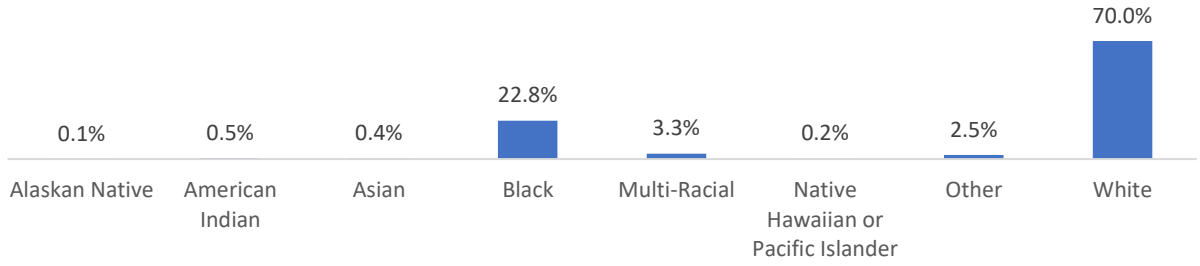
Source: NWFHN Client Data

Figure 39: NWFHN Clients by Program and Gender



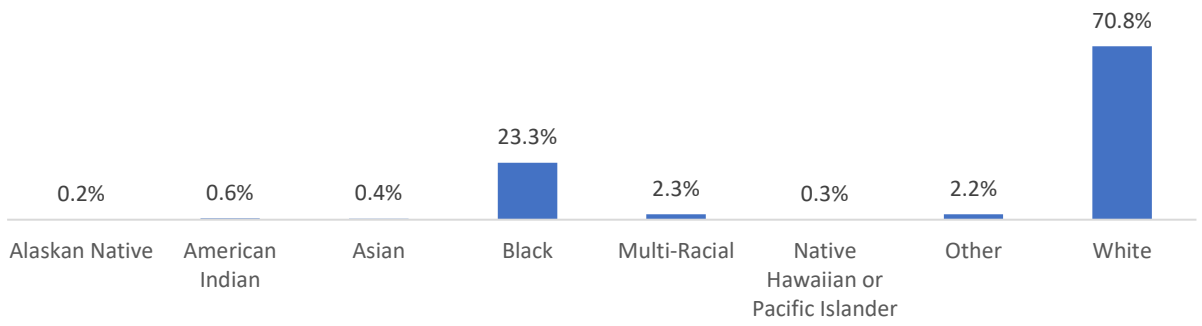
Source: NWFHN Client Data

Figure 40: NWFHN Clients by Race



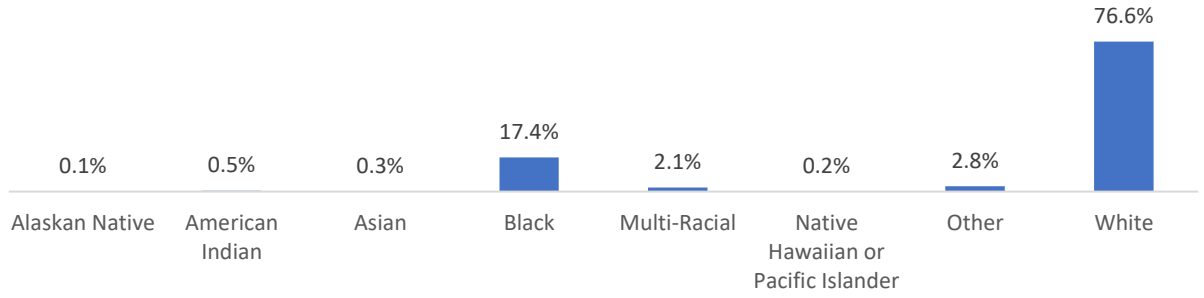
Source: NWFHN Client Data

Figure 41: NWFHN AMH Clients by Race



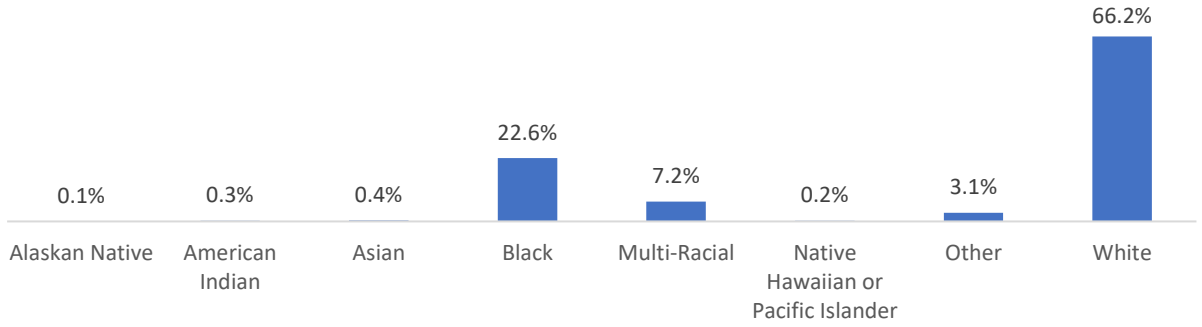
Source: NWFHN Client Data

Figure 42: NWFHN ASUD Clients by Race



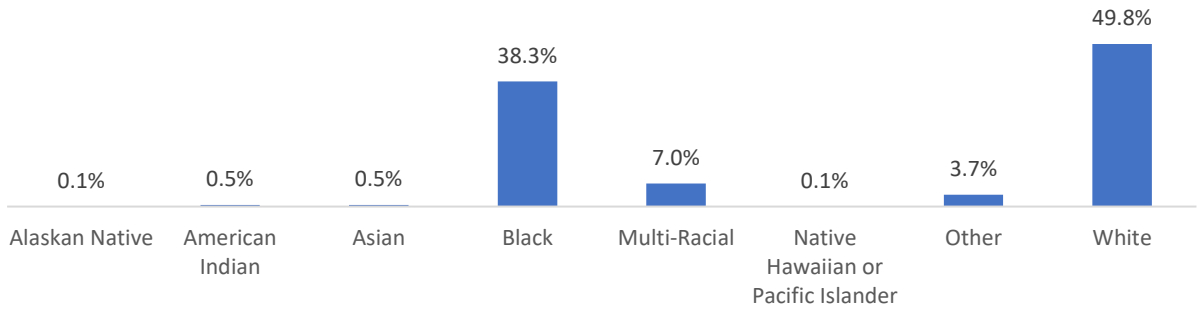
Source: NWFHN Client Data

Figure 43: NWFHN CMH Clients by Race



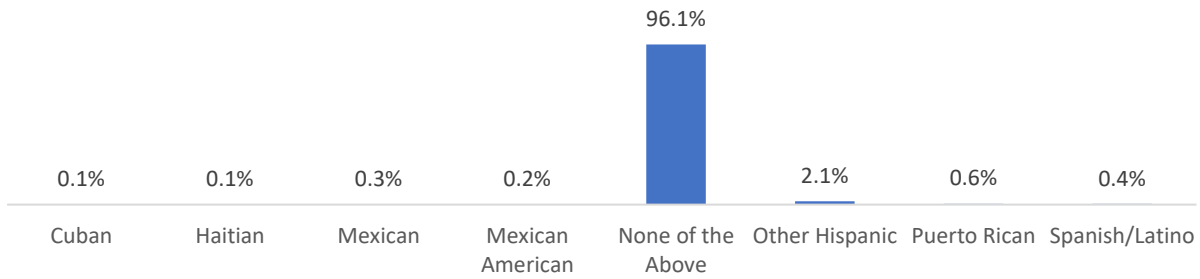
Source: NWFHN Client Data

Figure 44: NWFHN CSUD Clients by Race



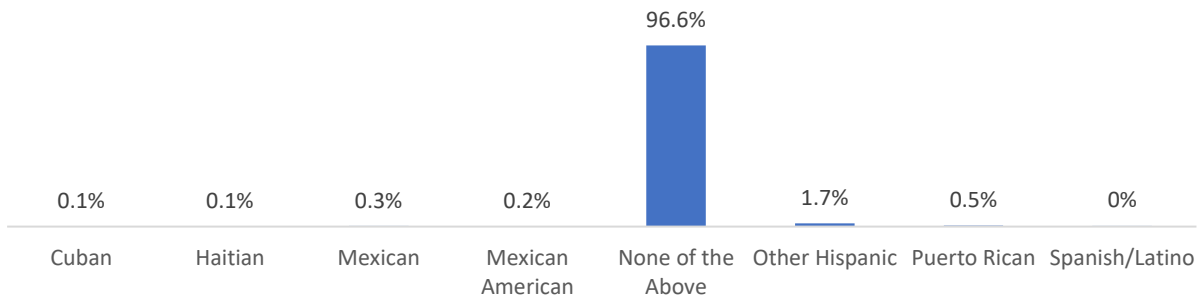
Source: NWFHN Client Data

Figure 45: NWFHN Clients by Ethnicity



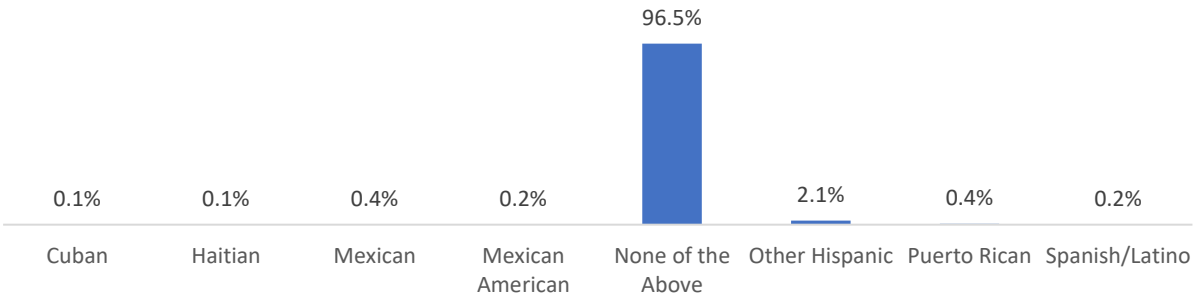
Source: NWFHN Client Data

Figure 46: NWFHN AMH Clients by Ethnicity



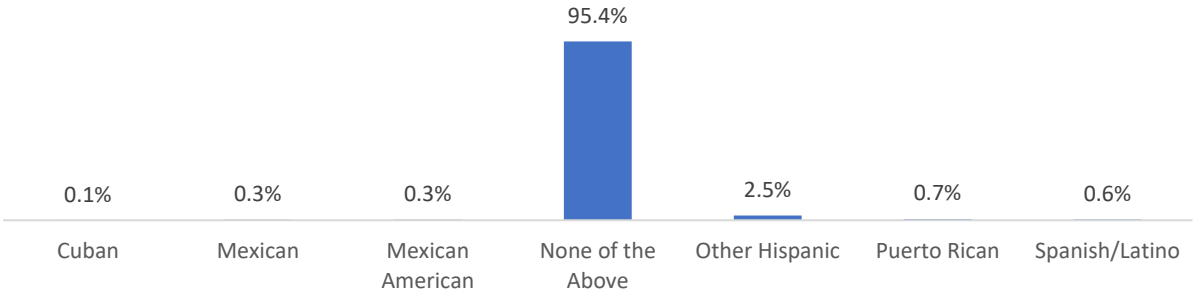
Source: NWFHN Client Data

Figure 47: NWFHN ASUD Clients by Ethnicity



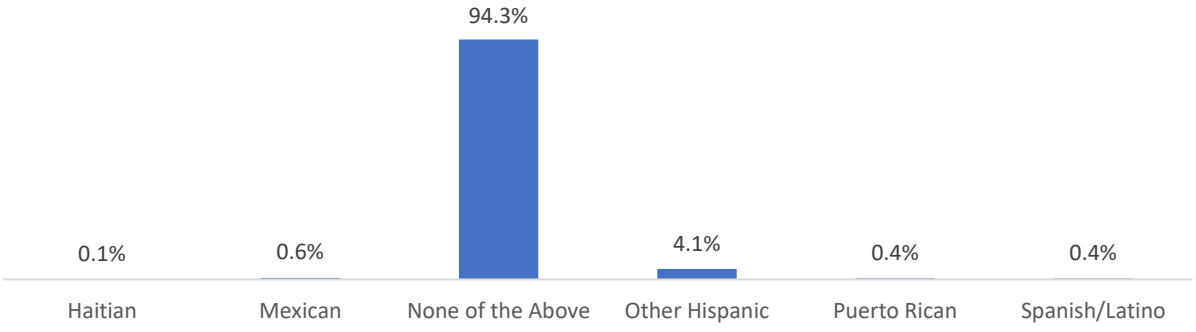
Source: NWFHN Client Data

Figure 48: NWFHN CMH Clients by Ethnicity



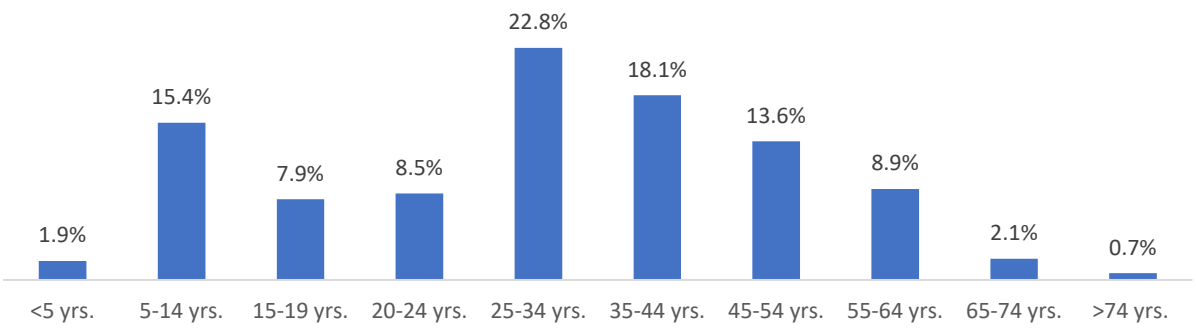
Source: NWFHN Client Data

Figure 49: NWFHN CSUD Clients by Ethnicity



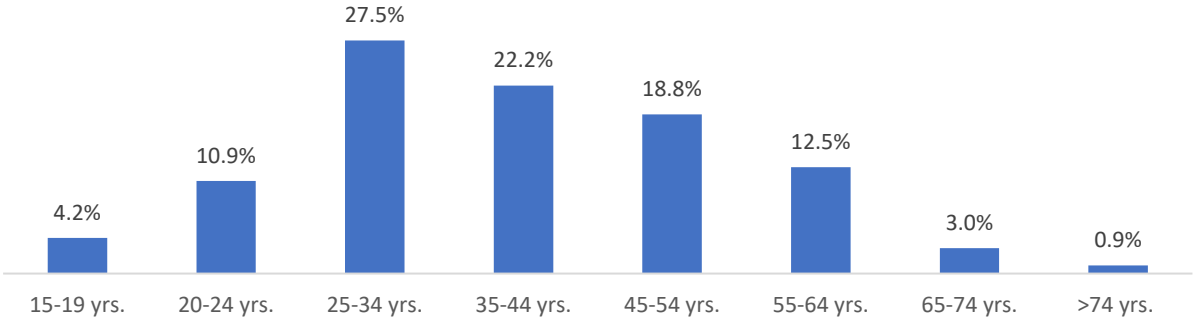
Source: NWFHN Client Data

Figure 50: NWFHN Clients by Age Range



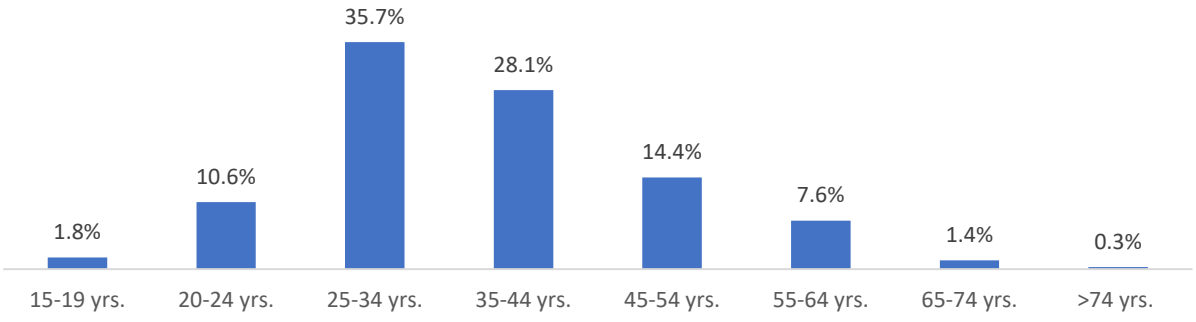
Source: NWFHN Client Data

Figure 51: NWFHN AMH Clients by Age Range



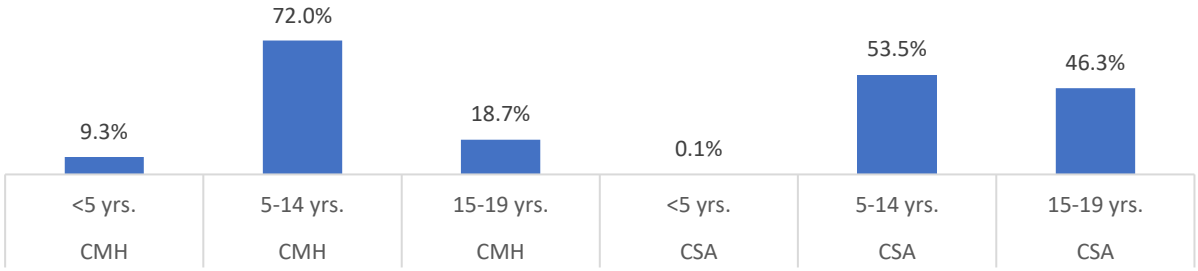
Source: NWFHN Client Data

Figure 52: NWFHN Substance Use Disorder Clients by Age Range



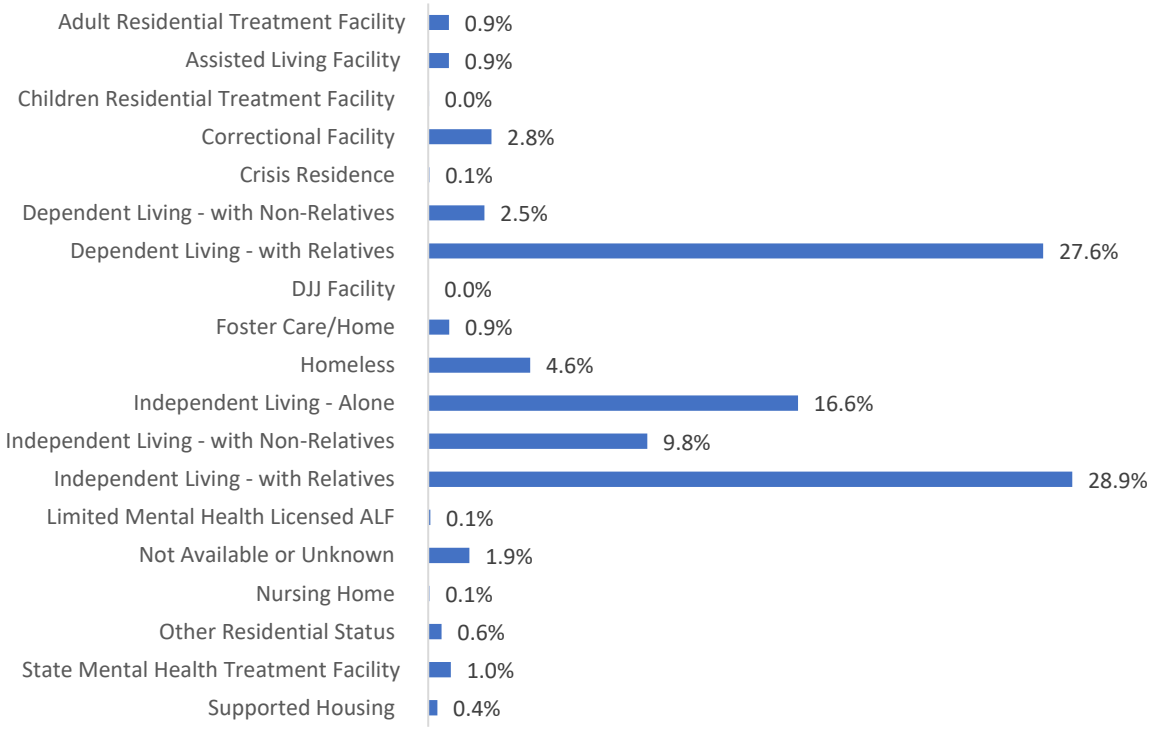
Source: NWFHN Client Data

Figure 53: NWFHN CMH and CSUD Clients by Age Range



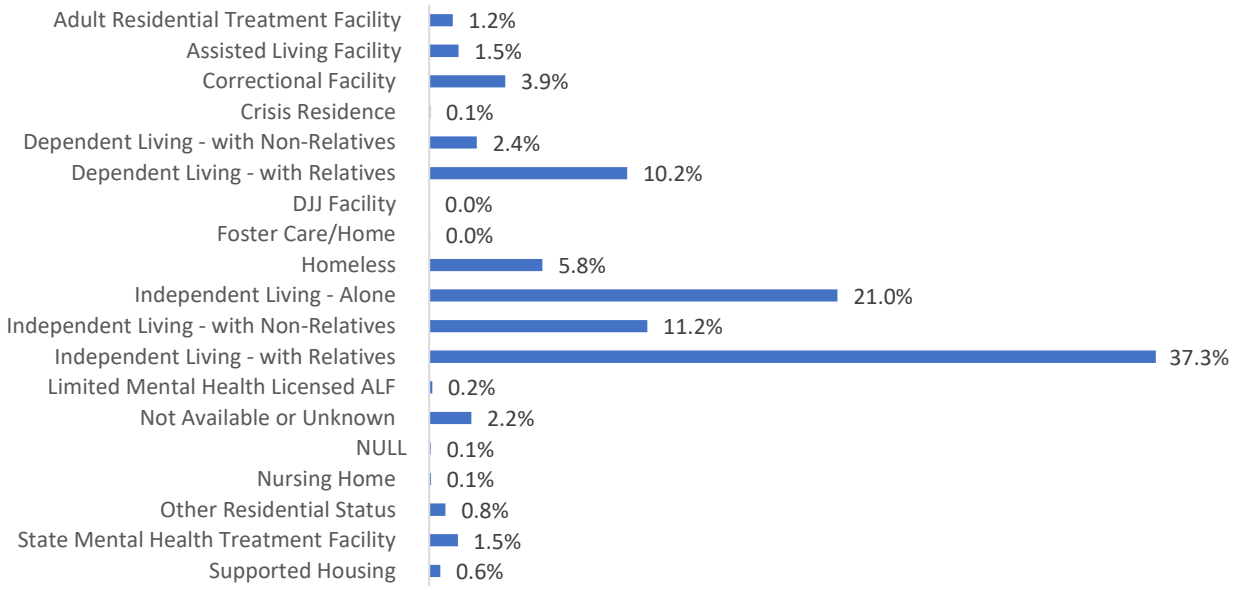
Source: NWFHN Client Data

Figure 54: NWFHN Clients by Residential Status



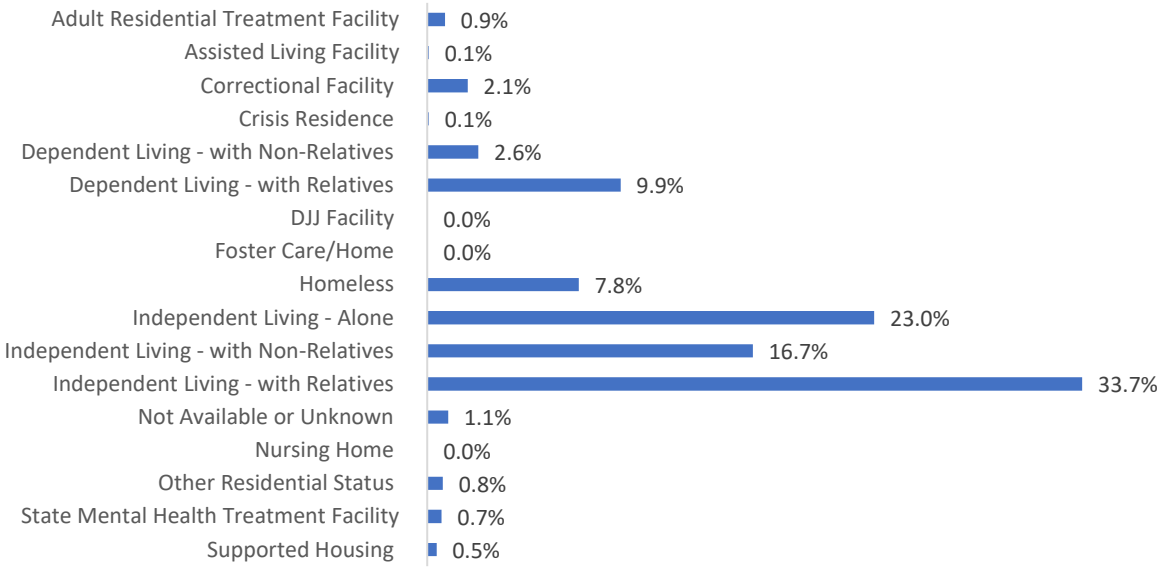
Source: NWFHN Client Data

Figure 55: NWFHN AMH Clients by Residential Status



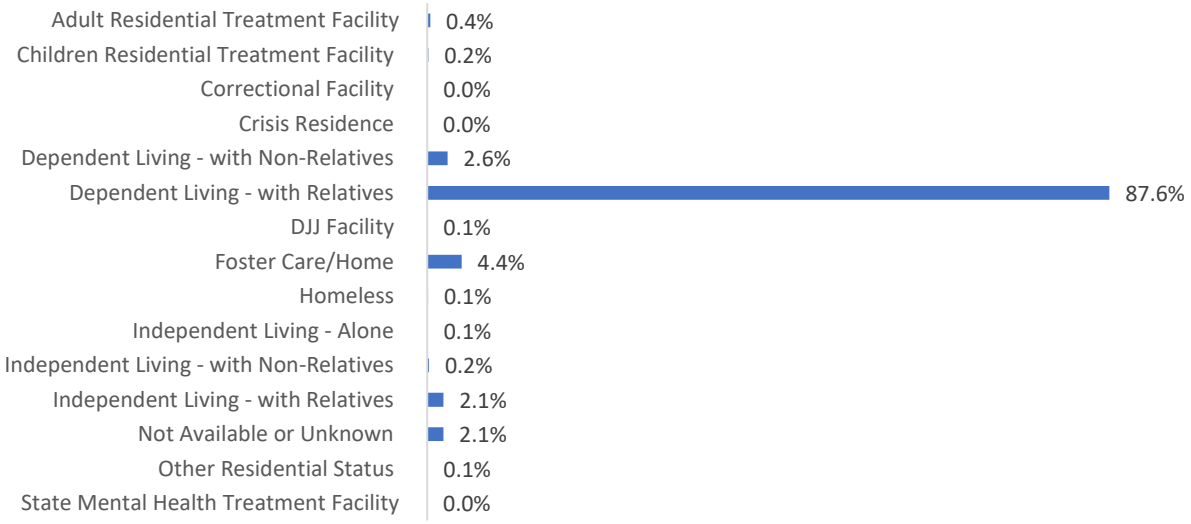
Source: NWFHN Client Data

Figure 56: NWFHN ASUD Clients by Residential Status



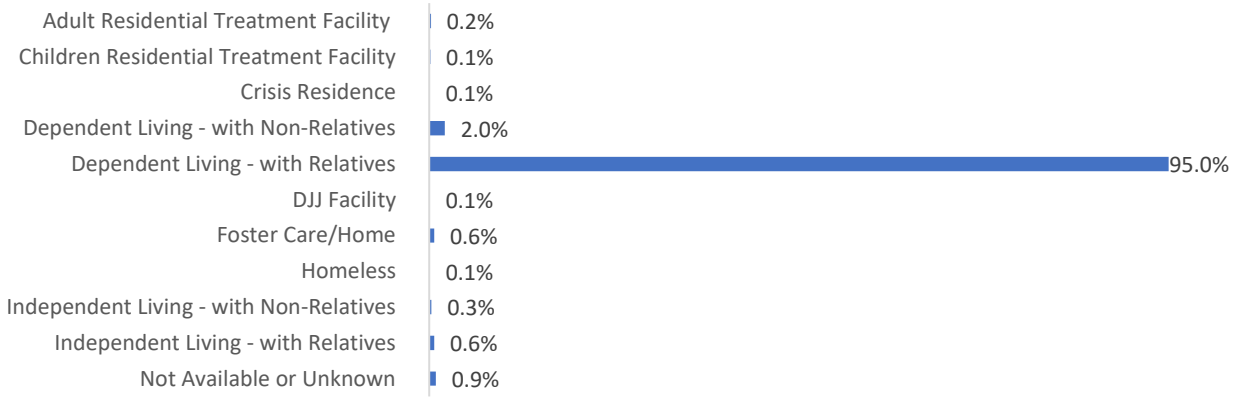
Source: NWFHN Client Data

Figure 57: NWFHN CMH Clients by Residential Status



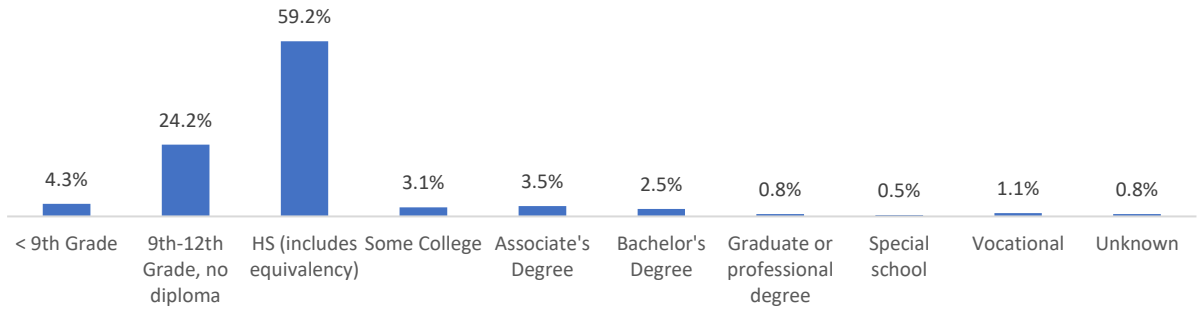
Source: NWFHN Client Data

Figure 58: NWFHN CSUD Clients by Residential Status



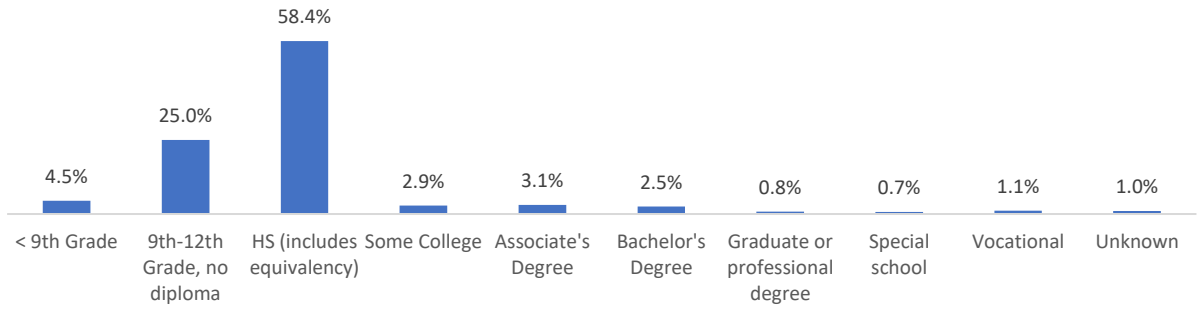
Source: NWFHN Client Data

Figure 59: NWFHN Clients by Educational Attainment



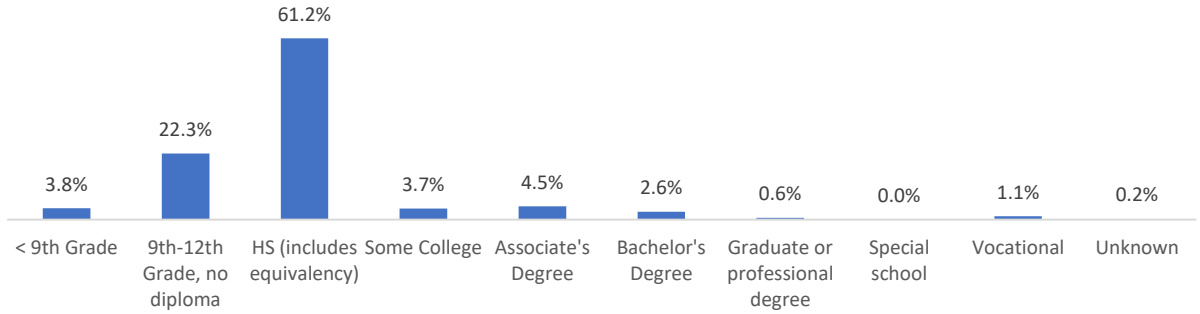
Source: NWFHN Client Data

Figure 60: NWFHN AMH Clients by Educational Attainment



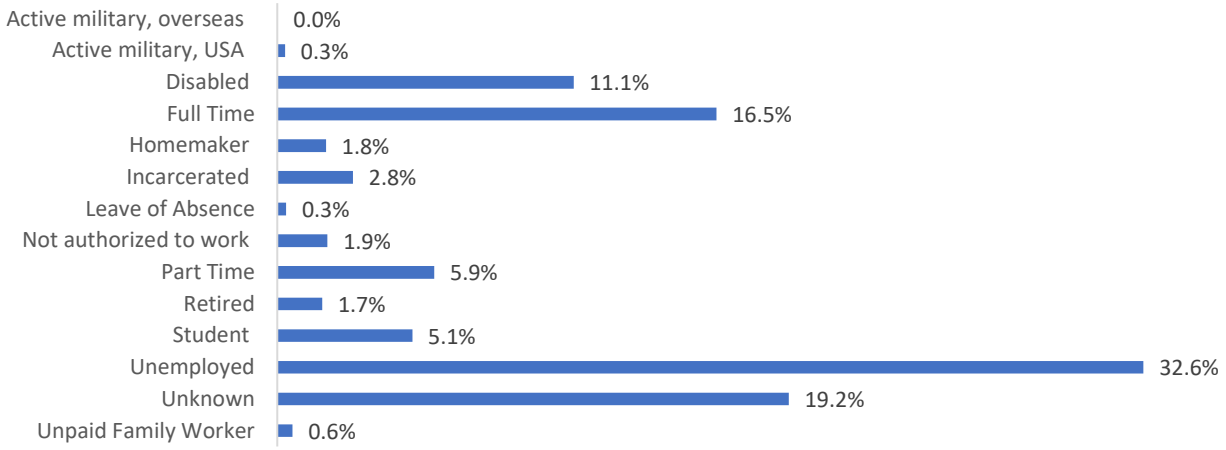
Source: NWFHN Client Data

Figure 61: NWFHN ASUD Clients by Educational Attainment



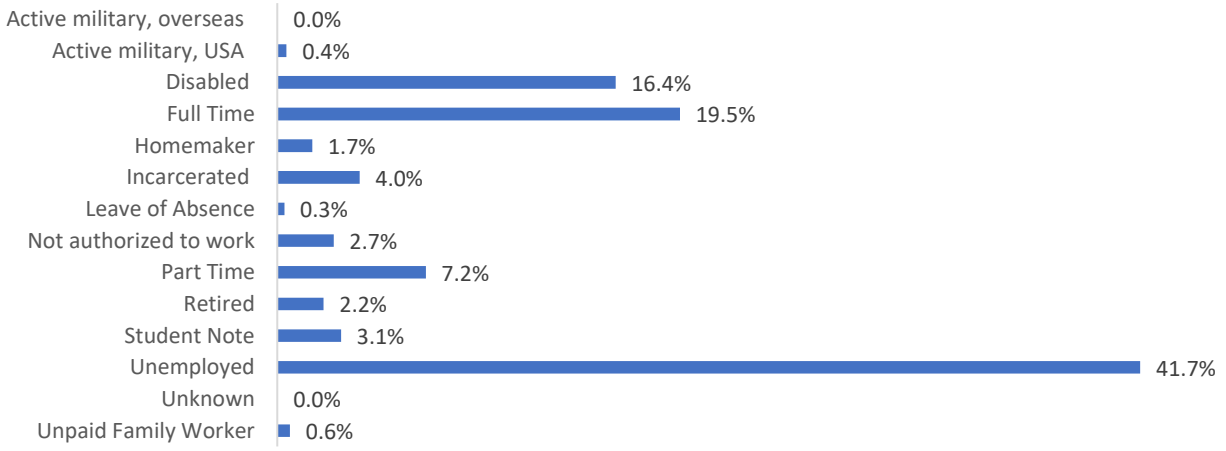
Source: NWFHN Client Data

Figure 62: NWFHN Clients by Employment Status



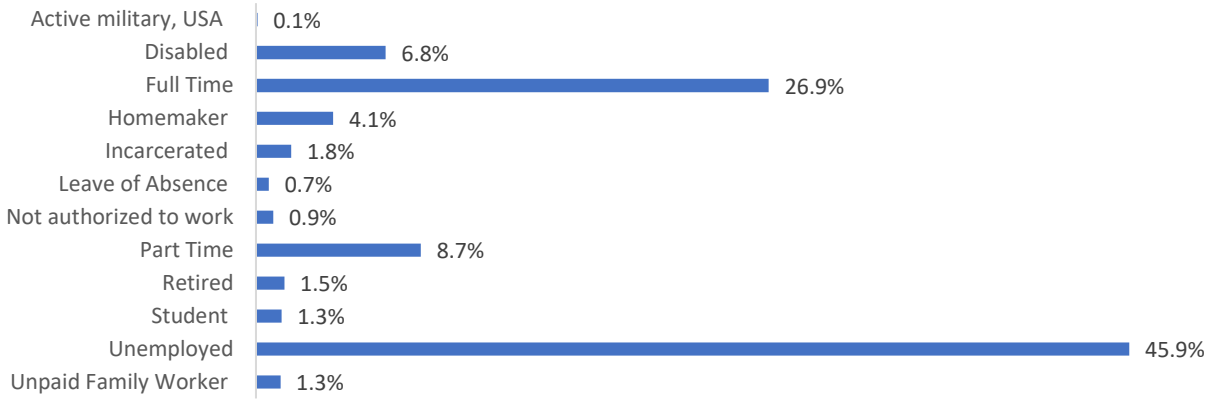
Source: NWFHN Client Data

Figure 63: NWFHN AMH Clients by Employment Status



Source: NWFHN Client Data

Figure 64: NWFHN ASUD Clients by Employment Status



Source: NWFHN Client Data

NWFHN SERVICE AREA UNHOUSED POPULATION

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

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

In 2021, the Florida Council on Homelessness reported there were 1,589 unhoused individuals in Northwest Florida (Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton, and Washington counties). Nearly 57.6 percent (1,514) were sheltered and 42.2 percent (857) were unsheltered. Chronically unhoused, defined as continually unhoused for over a year, increased from 374 individuals in 2017 to 602 people in 2020. Unhoused veterans decreased during the same time from 288 in 2017 to 203 in 2020. Families with children experiencing homelessness decreased by 36.5 percent from 606 in 2017 to 385 in 2020.

The number of unhoused students in public schools increased 94.1 percent from 8,357 in 2015-2016 to 16,219 in the 2018-2019 school year. Of the 16,219 students who were unhoused in 2018-2019, more than 71.1 percent were in a shared housing arrangement

and 7.2 percent were living in motels.

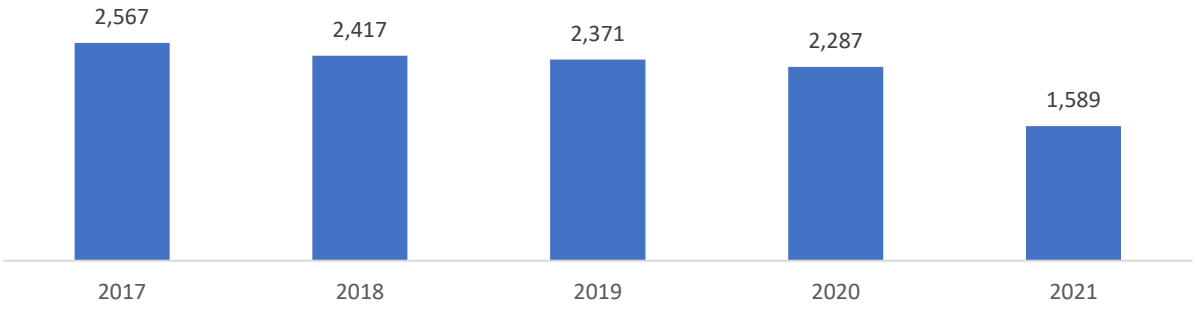
Due to the COVID-19 pandemic, this year saw an unprecedented infusion of federal funding to address homelessness and housing instability. With these funds appropriated by Congress, the State, local governments, CoCs, and partner agencies have invested in solutions to homelessness, including rent and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

Figure 65: CoC Funding from Federal and State Sources, NWFHN Service Area (SFY20-21)

Source	NWF Service Area
Total Funding Award	$18,025,694.40
HUD CoC FFY20	$3,371,435.00
State Total	$14,654,259.40
State Challenge	$439,500.00
Emergency Solutions Grant	$890,000.00
ESG-CV	$12,755,688.00
State Staffing	$428,571.40
State TANF-HP	$140,500.00

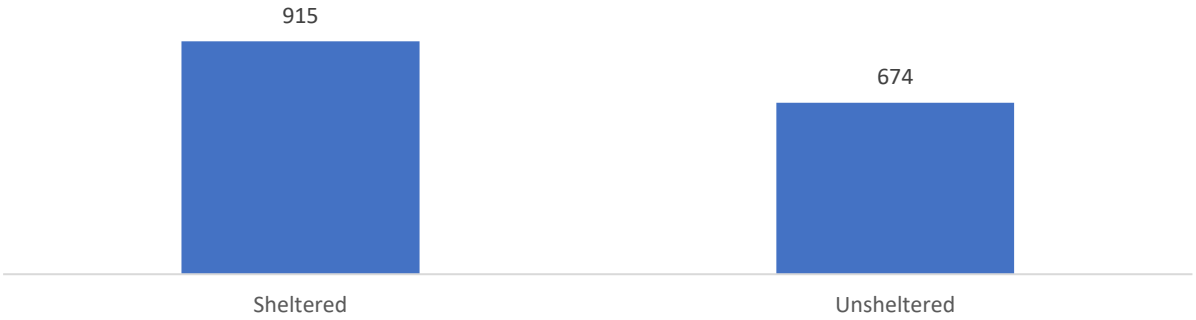
Source: 2021 Florida's Council on Homelessness Annual Report

Figure 66: Total Unhoused Population, NWFHN Service Area (2017-2021)



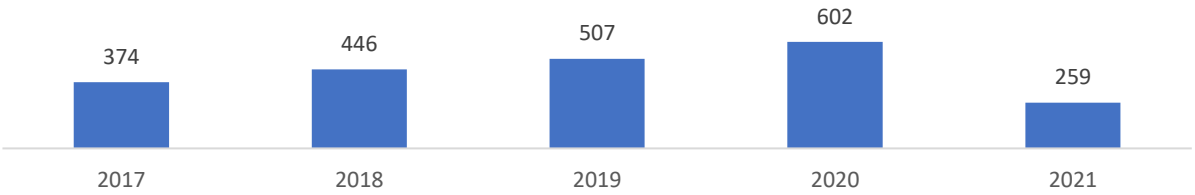
Source: 2021 Florida's Council on Homelessness Annual Report

Figure 67: Total Unhoused Population Sheltered and Unsheltered, NWFHN Service Area (2021)



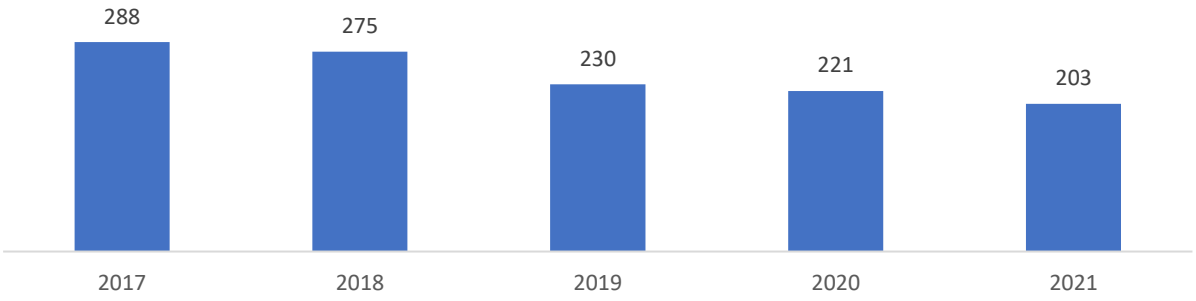
Source: 2021 Florida's Council on Homelessness Annual Report. FL-515 did not conduct an unsheltered PIT Count. FL-504 and FL-511 conducted a modified PIT Count. FL-506 conducted a full PIT Count.

Figure 68: Chronic Unhoused, NWFHN Service Area (2017-2021)



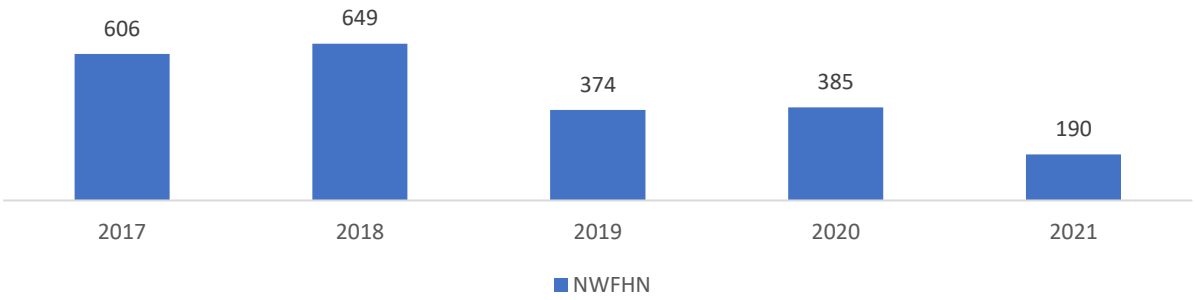
Source: 2021 Florida's Council on Homelessness Annual Report

Figure 69: Unhoused Veterans, NWFHN Service Area (2017-2021)



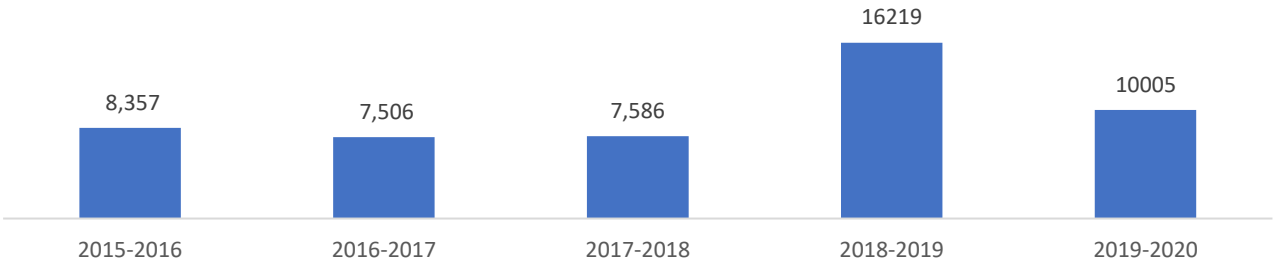
Source: 2021 Florida's Council on Homelessness Annual Report

Figure 70: Unhoused Families – Total Persons in Families with Children, NWFHN Service Area (2017-2021)



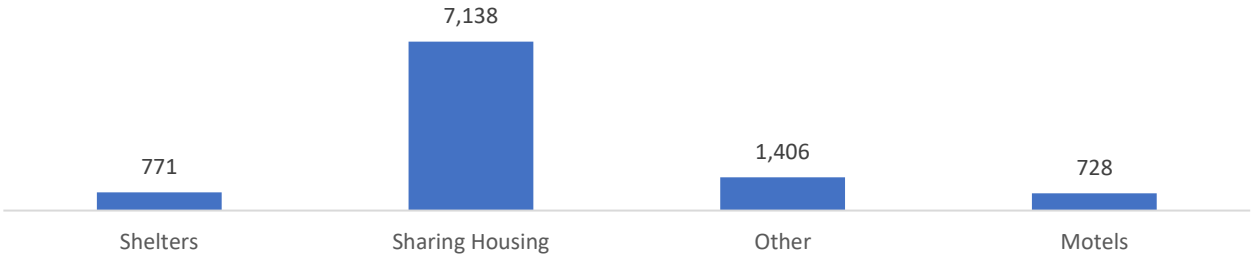
Source: 2021 Florida's Council on Homelessness Annual Report

Figure 71: Florida DOE – Reported Unhoused Students in Public Schools, NWFHN Service Area (2015-2020)



Source: 2021 Florida's Council on Homelessness Annual Report

Figure 72: Reported Unhoused Students in Public Schools by Living Situation, NWFHN Service Area (2019-2020)



Source: 2021 Florida's Council on Homelessness Annual Report

NWFHN UNHOUSED CLIENT PROFILE

Of the 33,313 clients served during FY2020-2021, 4.6 percent (1,526) were unhoused. While NWFHN served unhoused clients in every county, the highest numbers of unhoused clients resided in Escambia (541 clients), Leon (411 clients), Bay (191 clients), and Okaloosa (142 clients), accounting for 1,289 clients, 84.5 percent of all unhoused clients in the NWF service area.

Nearly two-thirds (63.2 percent) of all unhoused clients were male, 65.9 percent of unhoused males were in the AMH program and 61.4 percent were in the ASUD program. Three-fourths (75 percent) of unhoused male children were in CMH and 100 percent were in CSUD.

Most unhoused clients were White (1,026, 67.2 percent), 409 (26.8 percent) were Black, and 91 (9.4 percent) were other races. This was similar to the rates for all NWFHN clients; 70percent were White, 22.8 percent were Black, and 7.2 percent were other races.

Of the 1,526 unhoused clients, 42 (2.8 percent) were Hispanic, compared to 3.9 percent of all clients, and 6.5 percent of the service area population as a whole.

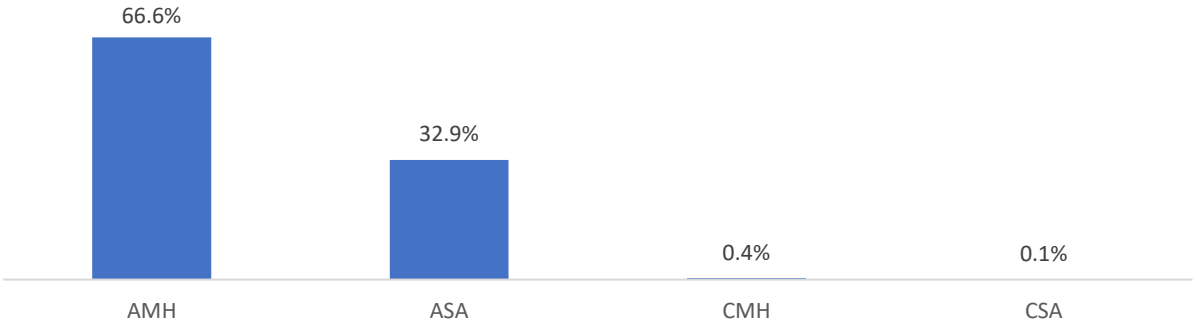
Overall, 75.1 percent of adult unhoused clients were 25-54 years of age. Among all NWFHN clients, 54.5 percent were in this age range. Additionally, 13.5 percent unhoused clients were 55-64 years, 7.6 percent were 20-24 years, and 3.2 percent were in other age ranges. These ranges were fairly consistent in adult and children's programs.

Most adult unhoused clients completed high school (59.7 percent), while 27.4 percent completed 9th-12th grade with no diploma. More than 3 percent completed some college, and nearly 2 percent completed an associate degree. These rates were similar for clients in AMH and ASUD programs, for those who were unhoused and for all clients.

Overall, 62.9 percent of adult unhoused clients were unemployed, 10.4 percent were employed full time, and 2.5 percent were employed part time.

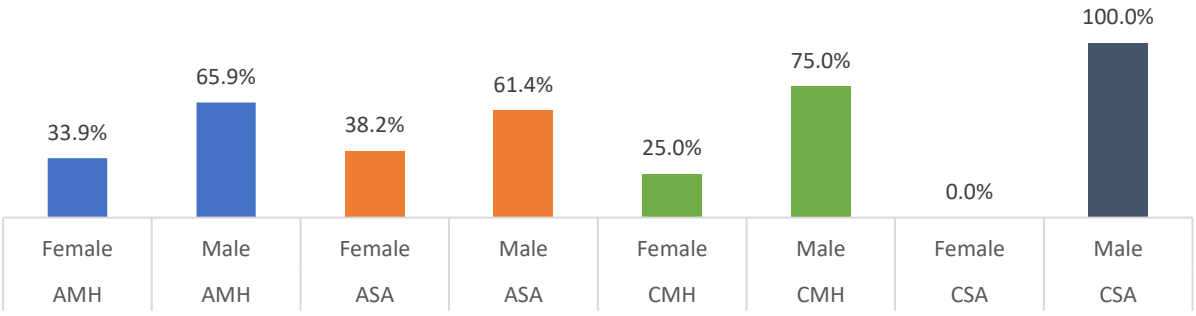
NWFHN UNHOUSED CLIENT CHARTS

Figure 73: NWFHN Unhoused Clients by Program



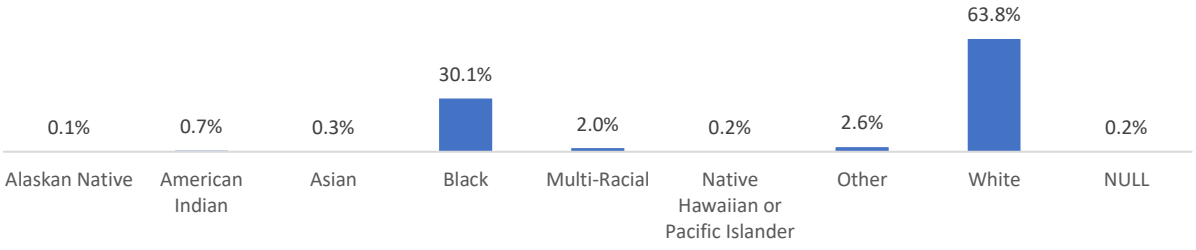
Source: NWFHN Client Data

Figure 74: NWFHN Unhoused Clients by Gender



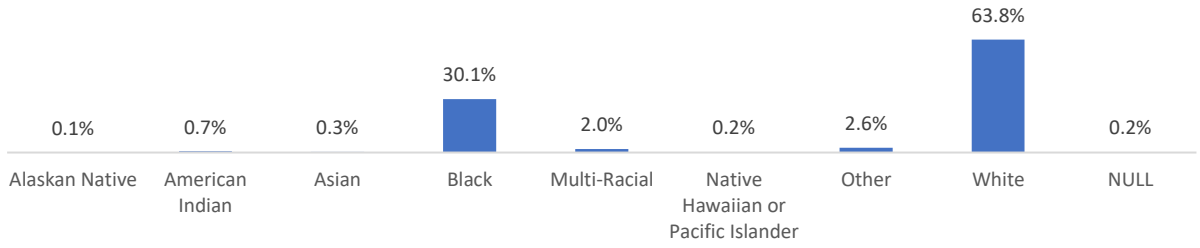
Source: NWFHN Client Data

Figure 75: NWFHN Unhoused Clients by Race



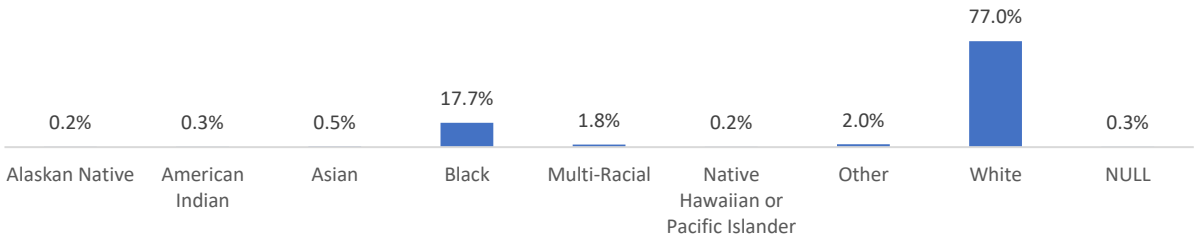
Source: NWFHN Client Data

Figure 76: NWFHN Unhoused AMH Clients by Race



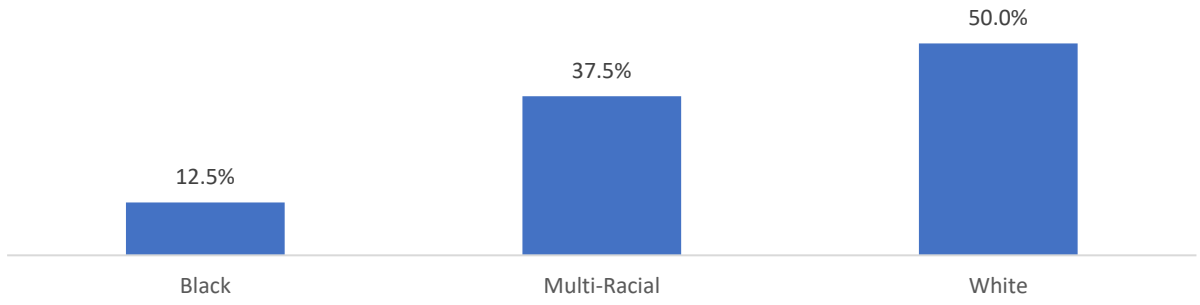
Source: NWFHN Client Data

Figure 77: NWFHN Unhoused ASUD Client by Race



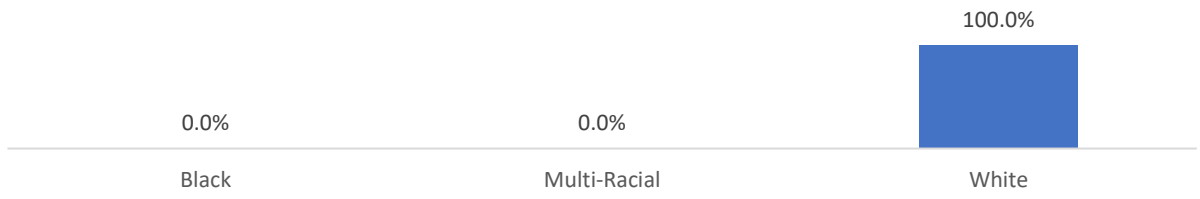
Source: NWFHN Client Data

Figure 78: NWFHN Unhoused CMH Clients by Race



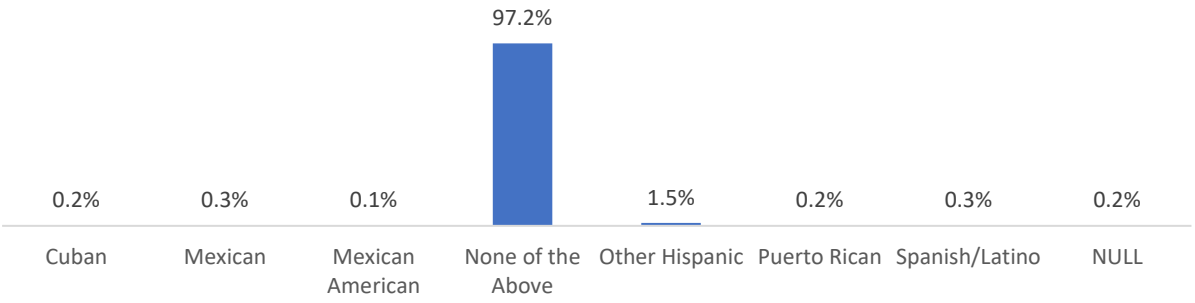
Source: NWFHN Client Data

Figure 79: NWFHN Unhoused CSUD Clients by Race



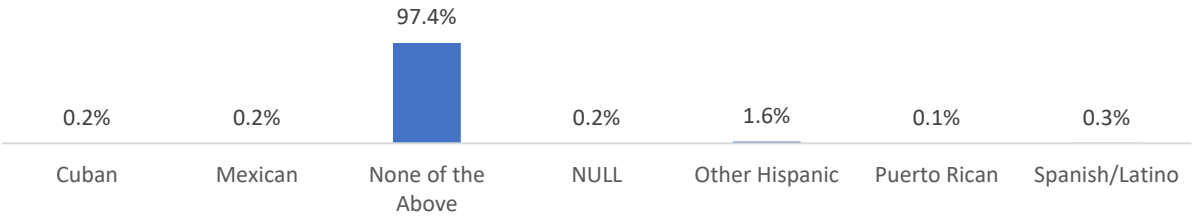
Source: NWFHN Client Data

Figure 80: NWFHN Unhoused Clients by Ethnicity



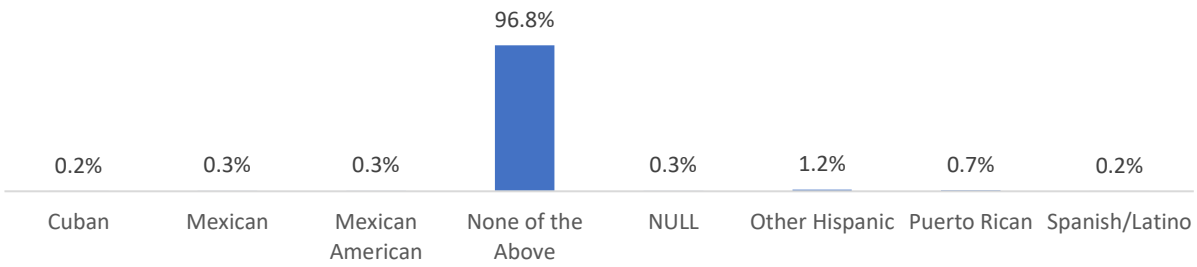
Source: NWFHN Client Data

Figure 81: NWFHN Unhoused AMH Clients by Ethnicity



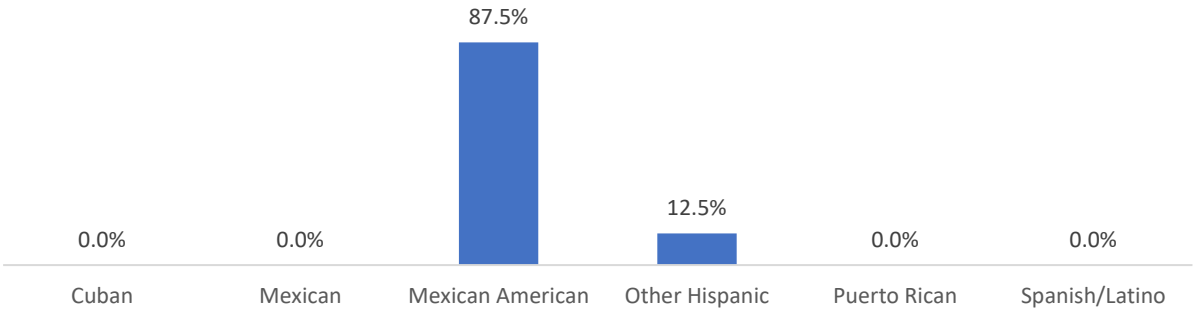
Source: NWFHN Client Data

Figure 82: NWFHN Unhoused ASUD Clients by Ethnicity



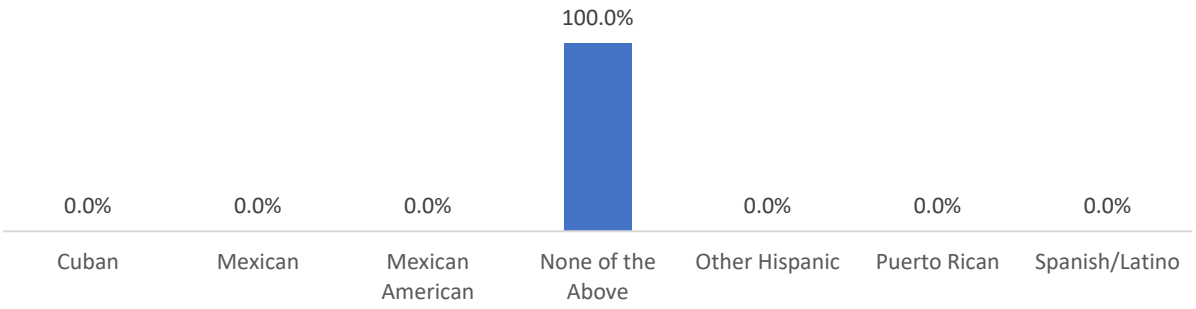
Source: NWFHN Client Data

Figure 83: NWFHN Unhoused CMH Clients by Ethnicity



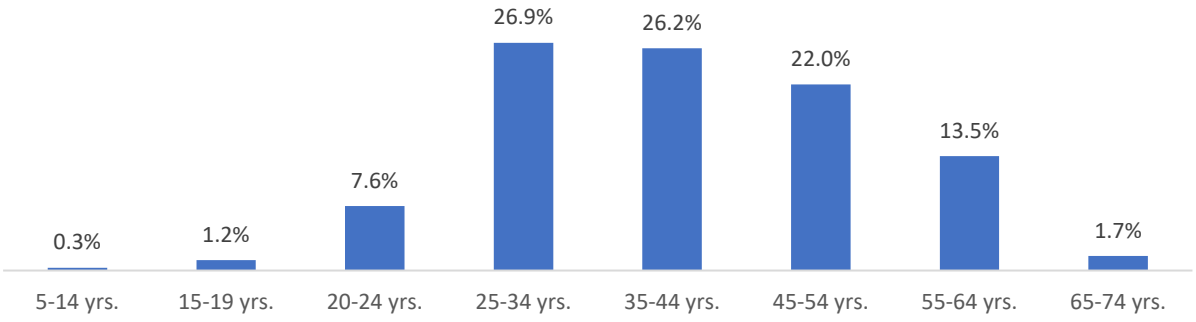
Source: NWFHN Client Data

Figure 84: NWFHN Unhoused CSUD Clients by Ethnicity



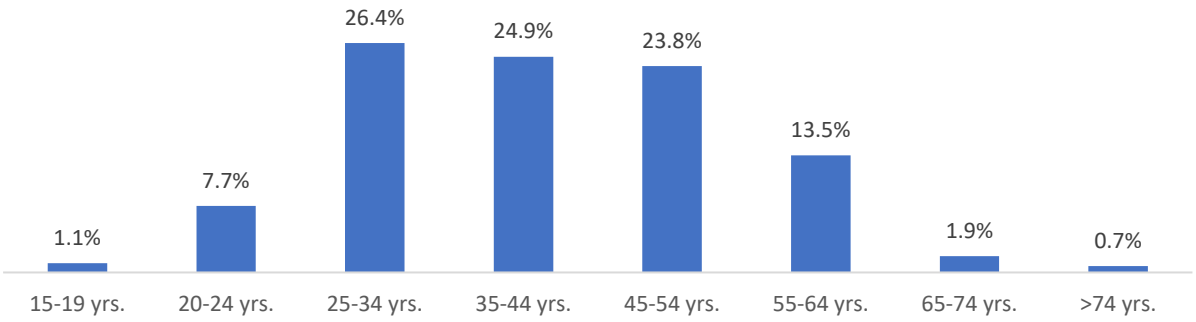
Source: NWFHN Client Data

Figure 85: NWFHN Unhoused Clients by Age Range



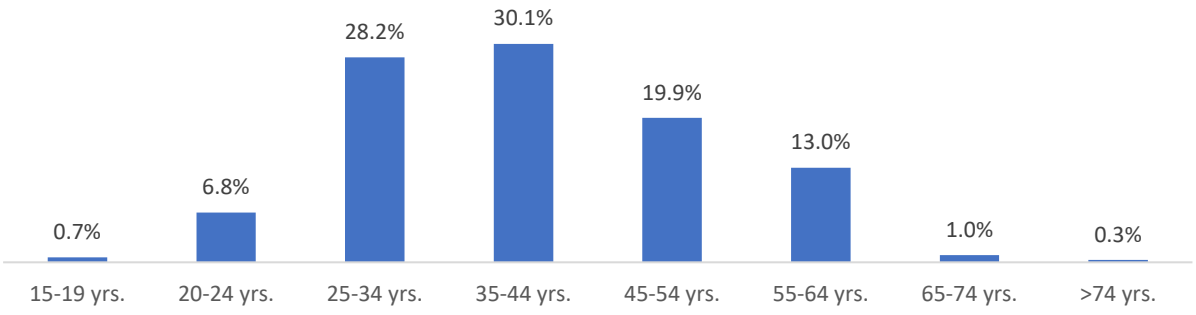
Source: NWFHN Client Data

Figure 86: NWFHN Unhoused AMH Clients by Age Range



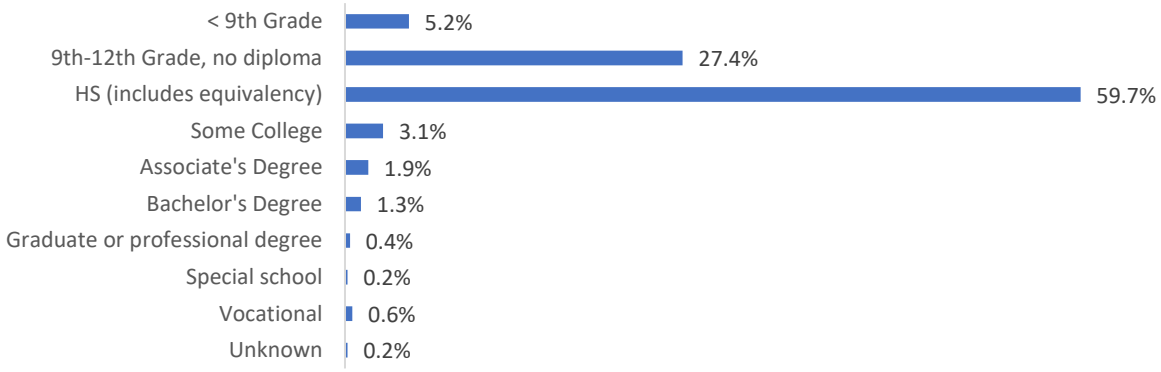
Source: NWFHN Client Data

Figure 87: NWFHN Unhoused ASUD Clients by Age Range



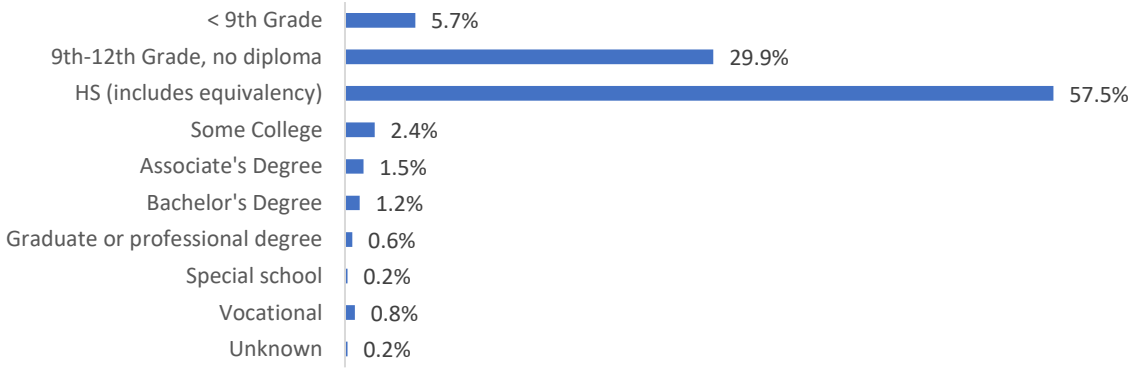
Source: NWFHN Client Data

Figure 88: NWFHN Unhoused Clients by Educational Attainment



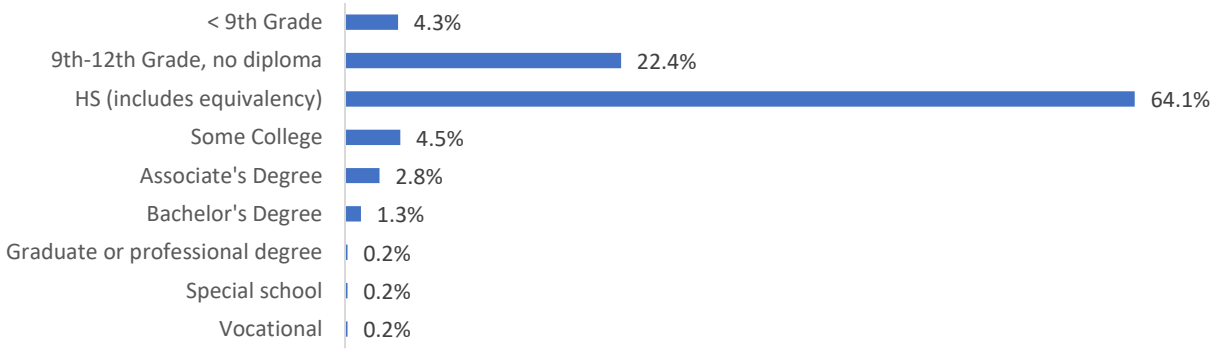
Source: NWFHN Client Data

Figure 89: NWFHN Unhoused AMH Clients by Educational Attainment



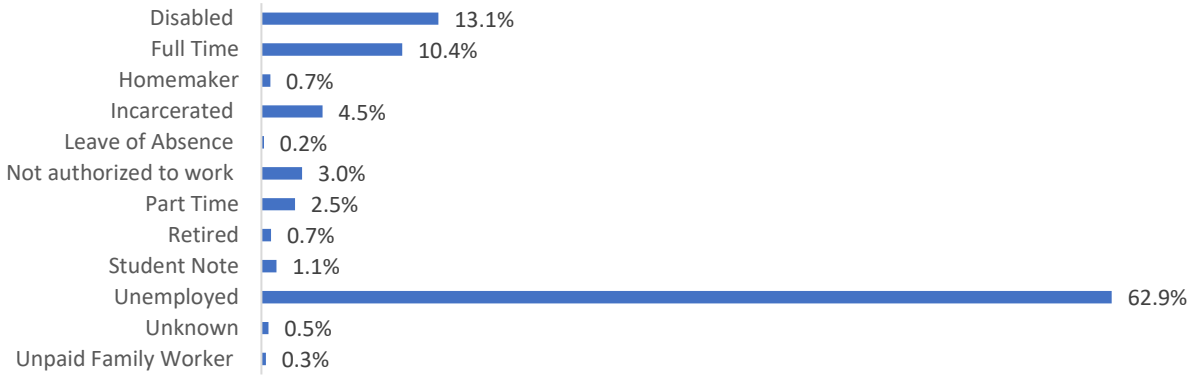
Source: NWFHN Client Data

Figure 90: NWFHN Unhoused ASUD Clients by Educational Attainment



Source: NWFHN Client Data

Figure 91: NWFHN Unhoused Clients by Employment Status



Source: NWFHN Client Data

COST CENTER DESCRIPTION, EXPENDITURES, AND OVER/UNDER PRODUCTION (FY2020-2021)

MENTAL HEALTH PROGRAM

Cost Center Description	Expenditures	Over/Under Production
Assessment	$12,643.84	$0.00
Case Management	$2,154,476.27	$119,681.36
Day Treatment	$25,726.00	$403,540.07
Drop-In/Self Health Centers	$69,402.96	$0.00
In-Home and Onsite	$151,377.85	$0.01
Intervention (Individual)	$191,815.95	$64,381.87
Medical Services	$3,372,931.06	$212,516.92
Outpatient-Individual	$1,558,583.52	$1,404,272.43
Outreach	$170,839.69	$42,502.68
Residential II	$152,934.00	$0.00
Residential III	$346,500.00	$966,854.61
Residential IV	$156,312.00	$0.00
Supported Employment	$0.00	$0.00
Supportive Housing/Living	$319,226.75	$2,070.29
Supported Employment	$238,332.75	$10,768.00
Information and Referral	$152,195.25	$42,460.12
Outpatient (Group)	$477,956.58	$0.00
RandB with Sup. II	$448,357.82	$0.00
Intervention Group	$8,184.06	$4,546.65
TOTAL	**$10,007,796.34**	**$3,273,595.01**

Source: NWFHN Program Data

SUBSTANCE USE PROGRAM

Cost Center Description	Expenditures	Over/Under Production
Assessment	$51,087.21	$0.00
Case Management	$1,258,513.72	$76,956.19
Crisis Support/Emergency	$28.89	$0.00
Day Treatment	$232,603.27	($0.00)
In-Home and Onsite	$71.37	$0.00
Intervention (Individual)	$438,918.81	$31,807.73
Medical Services	$1,079,513.21	$63,964.21
Medication-Assisted Tx	$12,045.00	$0.00
Outpatient-Individual	$1,708,783.56	$87,116.45
Outreach	$636,798.41	$57,831.40
Residential II	$3,509,125.89	$241,200.33
Residential III	$445,000.00	$11,855.27
Residential IV	$67,159.88	$0.00
Supportive Housing/Living	$324.85	$0.00
TASC	$127,790.59	$9,212.91
Supported Employment	$921,064.68	$65,464.87
Supportive Housing/Living	$158,411.73	$0.00
Information and Referral	$69,139.00	$86,650.16
Outpatient (Group)	$360,857.73	$33,128.63
RandB with Sup. II	$168,723.39	$0.00
Intervention Group	$32,519.70	$14,191.05
Recovery Support (Individual)	$42,725.75	$0.00
Recovery Support (Group)	$37,709.81	$2,026.38
TOTAL	**$11,358,916.43**	**$781,405.59**

Source: NWFHN Program Data

NWFHN All Cost Centers	Expenditures	Over/Under Production
Grand Total	$21,366,712.77	$4,055,000.60

CULTURAL HEALTH DISPARITY SURVEY SUMMARY

INTRODUCTION

To help improve the behavioral health system of care, NWFHN developed and distributed a survey to elicit feedback from consumers focusing on awareness and experience concerning behavioral health care services in the service area, specifically consumers' levels of trust and comfort regarding service settings and providers. The 14-question survey was structured as yes/no, single- and multi- select multiple choice, and Likert Scale items.

Ordinarily, this type of survey would be conducted in person throughout the community. However, due to concerns and limitations attributable to COVID-19, NWFHN decided that online data collection from a convenience sample would be more appropriate at this time. A link to the online survey was e-mailed to providers, who in turn, distributed it broadly to their consumers. A total of 49 consumers responded to this survey.

Survey data were downloaded into an Excel spreadsheet and analyzed by the planning team. Descriptive frequencies were calculated by dividing the number of responses by the total number of respondents. Numerous tables and graphs were developed to illustrate the data. Findings were presented to and discussed with NWFHN and integrated into the assessment.

SUMMARY OF FINDINGS

Although most respondents, 71.4 percent, indicated they are usually comfortable seeking behavioral health care services, only 26.5 percent indicated they trusted or strongly trusted the behavioral health care system to treat them with respect.

Respondents were asked to rank the statements that most closely describe their feelings regarding their behavioral health issues. Less than half, 42.8 percent, indicated they mostly or somewhat felt it was a private issue they keep to themselves; 40.8 percent indicated they mostly or somewhat felt this is a private issue that stays in the family; 42.9 percent said they mostly or somewhat felt comfortable sharing their challenges with others (professionals, family members, friends, clergy, etc.), and 26.5 percent said they mostly or somewhat were more comfortable with people like themselves. For each statement, the most frequently mentioned descriptions of their feelings regarding their behavioral health issues were "neutral" and "no response".

Most respondents indicated that they have been most comfortable discussing behavioral health concerns in a private office with a doctor (55.1 percent), speaking with a nurse practitioner (26.5 percent), or hybrid of telehealth (22.4 percent). All of the above was mentioned by 16.3 percent of respondents and 8.2 percent indicated, "none". The majority (55.1 percent) identified more than one setting in which they have been most

comfortable.

Most respondents, 59.2 percent, indicated they would be more comfortable going to the traditional physician office, and 38.8 percent would prefer faith-based behavioral health care services.

Nearly half, 48.9 percent, said they would be unlikely or very unlikely to be comfortable in group therapy, while 67.3 percent would be likely or very likely to be comfortable in individual therapy.

Nearly all, 95.9 percent of respondents, indicated that when they received behavioral health care services, those services were available in their primary language all of the time or most of the time.

Most respondents (81.6 percent) described their gender as female, 12.2 percent as male, and 6.1 percent preferred not to answer this question.

When asked to describe their gender identity, most respondents (71.4 percent) preferred not to answer, or did not respond to this question at all. More than 16 percent described themselves as cisgender and 12.2 percent as gender fluid.

When asked to describe their current sexual orientation, 61.2 percent responded heterosexual/straight, 8.2 percent responded asexual, and 30.6 percent preferred not to answer, or did not respond at all.

Most respondents (85.7 percent) described themselves as White, 4.1percent as Black, and 6.1percent as Multi-Racial.

Four percent described their ethnicity as Mexican American, two percent as Spanish/Latino, and 93.9 percent said none of the above, or did not respond at all.

Nineteen respondents, 38.8 percent, were ages 35-44 years. The second largest age group consisted of those 55-64 years of age (18.4 percent), followed by those 45-54 years (12.2 percent), and 25-34 years (12.2 percent).

CULTURAL HEALTH DISPARITY SURVEY CHARTS

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

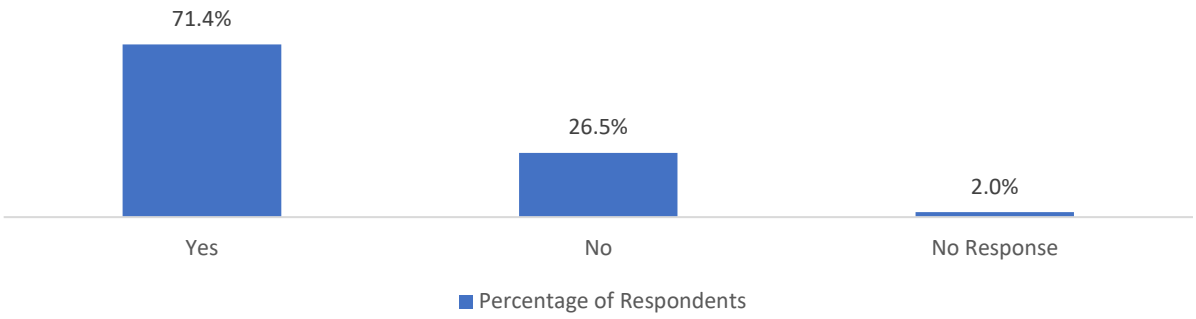


Figure 93: On a scale of 1 to 5, with 5 being 'strongly agree', how would you rate your trust in the behavioral health care system to treat you with respect?

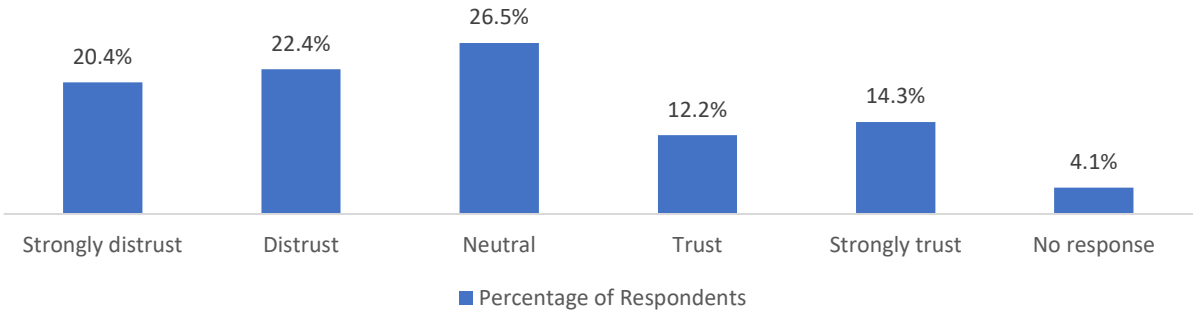


Figure 94: Please rank the statement below that most closely describe your feelings regarding your behavioral health issue, with (1) being the most and (5) being the least. “This is a private issue I keep to myself.”

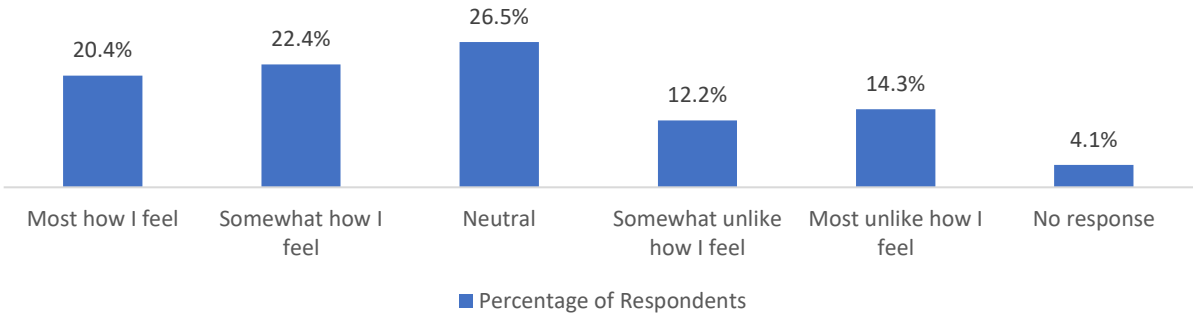


Figure 95: Please rank the statement below that most closely describe your feelings regarding your behavioral health issue, with (1) being the most and (5) being the least. "This is a private issue that stays in the family."

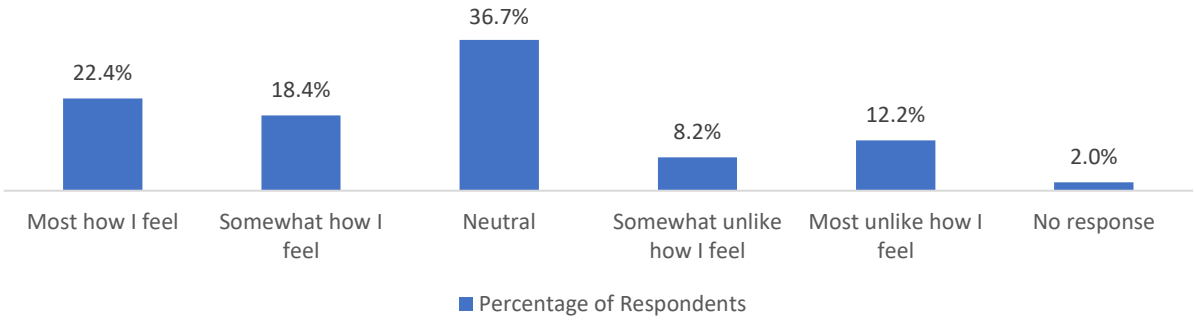


Figure 96: Please rank the statement below that most closely describe your feelings regarding your behavioral health issue, with (1) being the most and (5) being the least. "I am comfortable sharing my challenges with others."

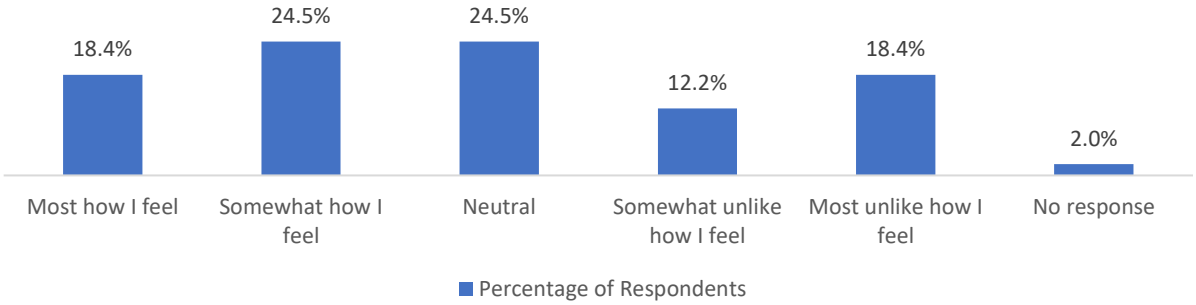


Figure 97: Please rank the statement below that most closely describe your feelings regarding your behavioral health issue, with (1) being the most and (5) being the least. "I am more comfortable with people like me."

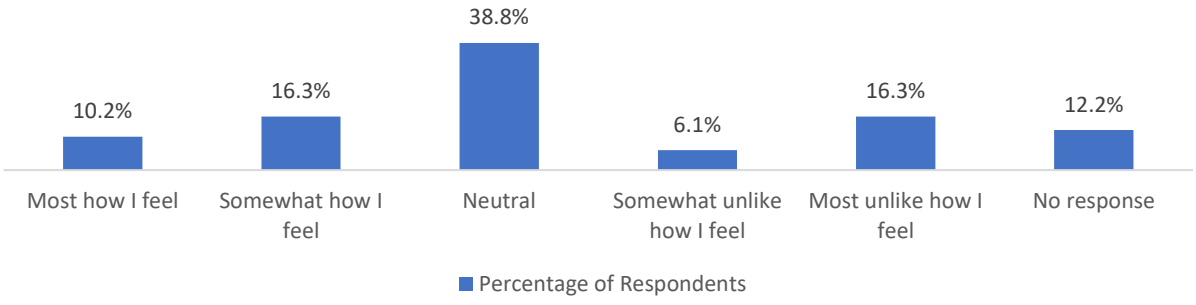


Figure 98: In which setting(s) have you been most comfortable discussing your behavioral health concerns? (Check all that apply)

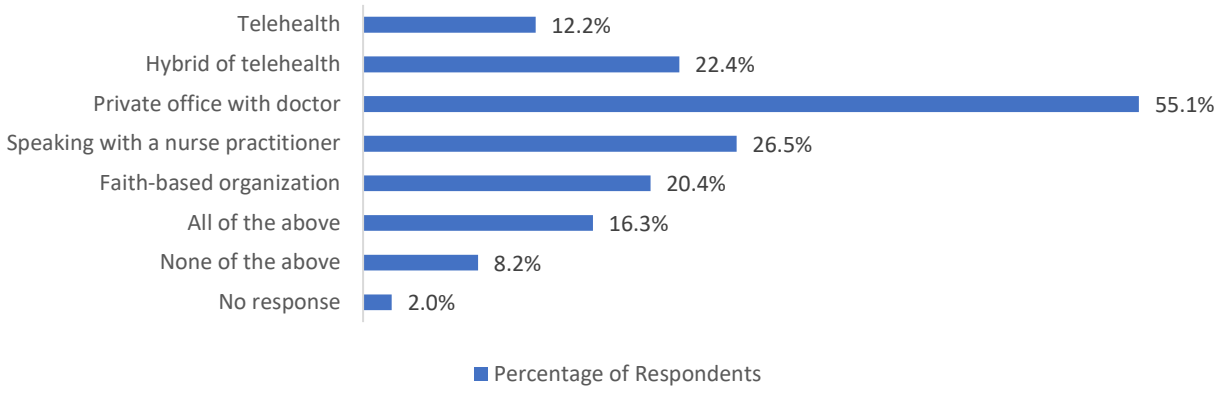


Figure 99: If given a choice for receiving behavioral health care services, would you be more comfortable going to a faith-based organization OR prefer the traditional physician office?

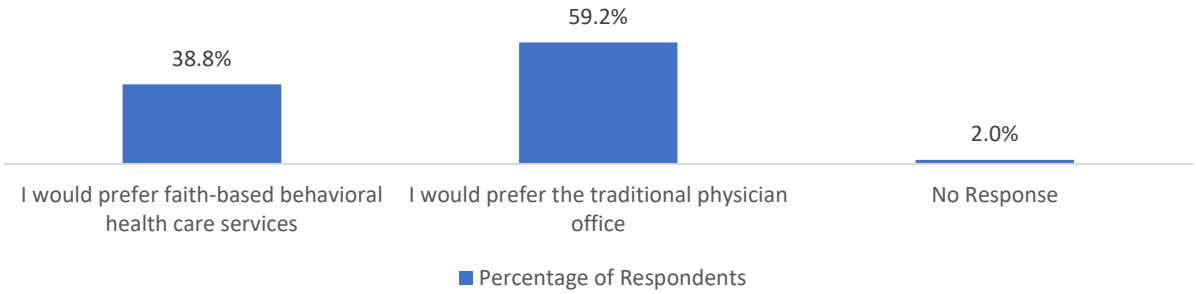


Figure 100: Now thinking about treatment options, on a scale of 1 to 5, with 5 being 'very likely', how comfortable would you be in group therapy?

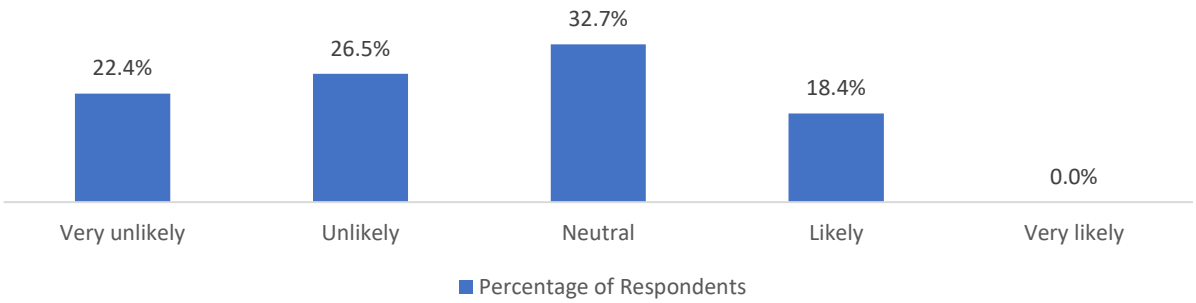


Figure 101: On a scale of 1 to 5, with 5 being 'very likely', how comfortable would you be in individual therapy?

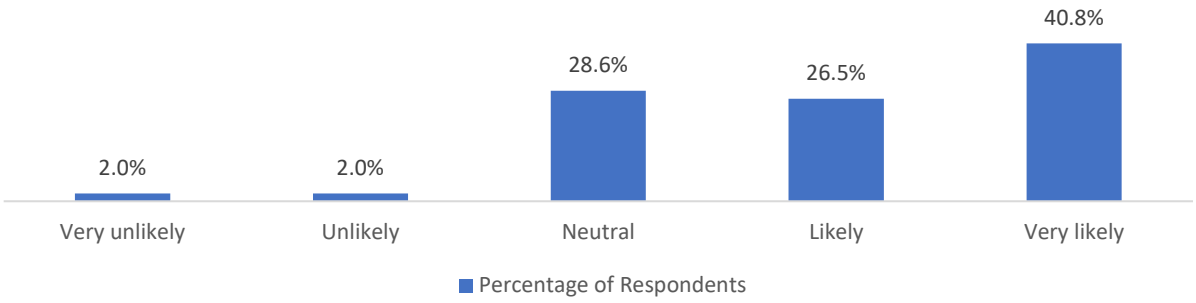


Figure 102: When you have received behavioral health care services in the past, were they mostly available in your primary language?

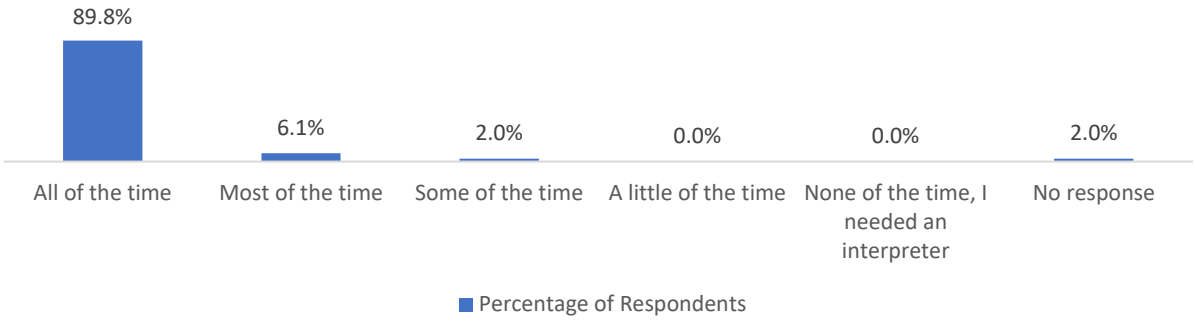


Figure 103: Which best describes your gender?

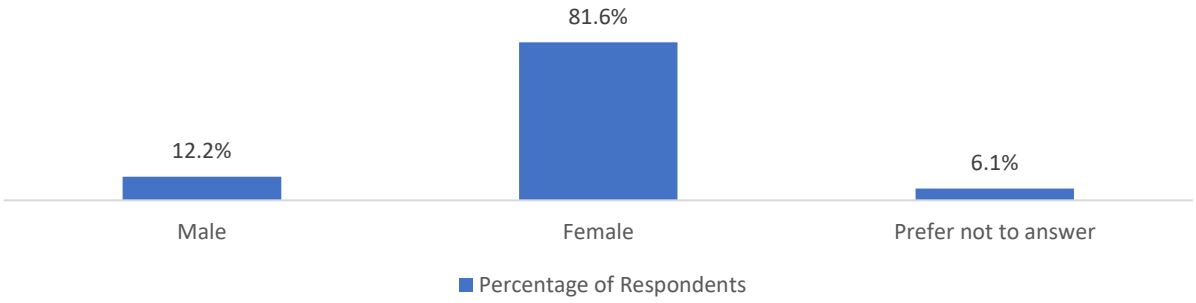


Figure 104: Which best describes your gender identity?

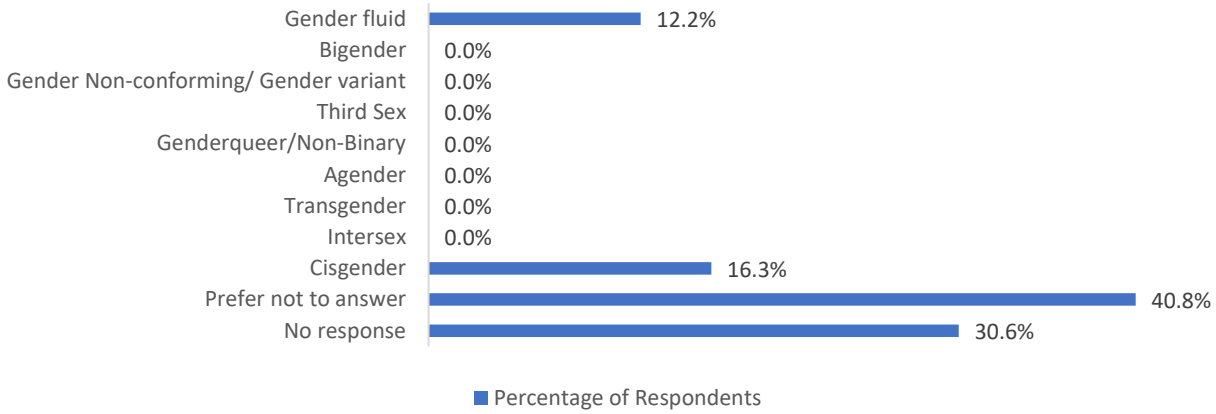


Figure 105: Which best describes your current sexual orientation? (Check all that apply)

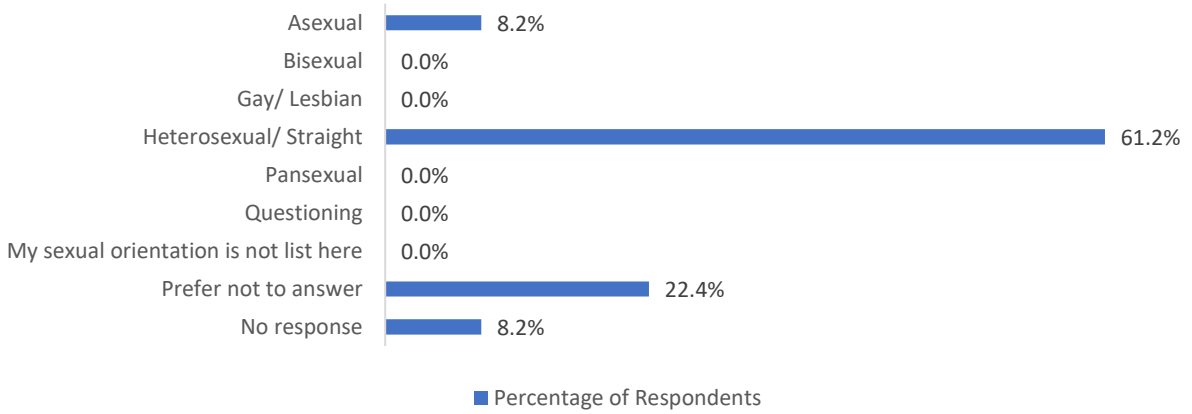


Figure 106: Which best describes your race?

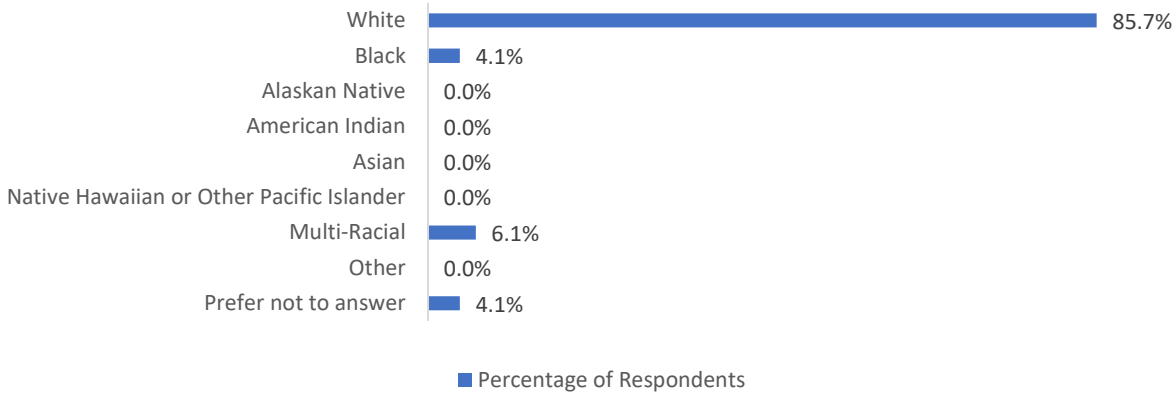


Figure 107: Which best describes your ethnicity?

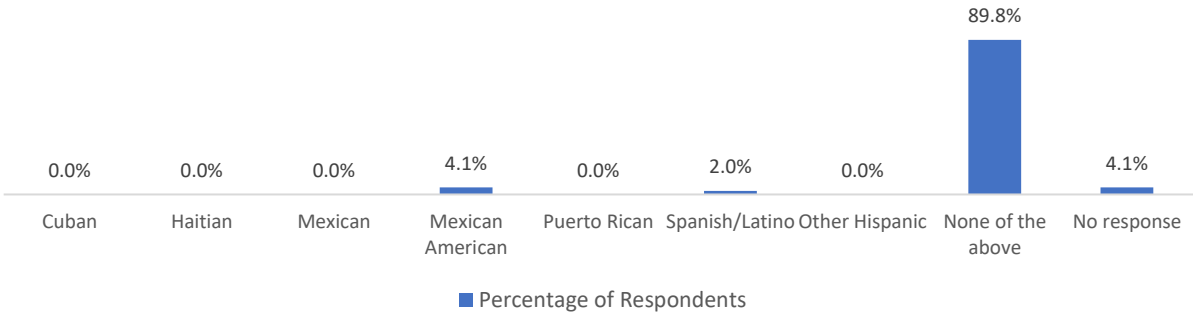
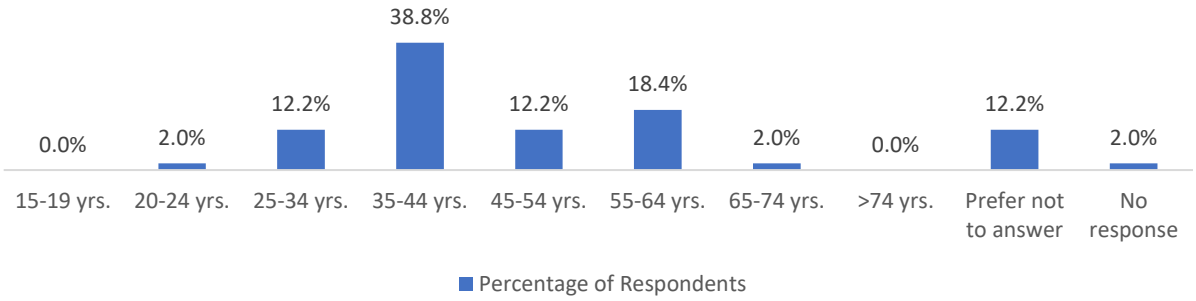


Figure 108: Please select your age range from the list below.



CULTURAL HEALTH DISPARITY SURVEY BY RACE AND ETHNICITY

The cultural health disparity survey was analyzed by race and ethnicity to further measure experience, awareness, and coordination of behavioral health services. This will help to facilitate focused strategic development and intervention implementation over the next three years. It should be noted that there were less than five respondents for the Black and Hispanic population groups.

Respondents were asked if they were comfortable seeking behavioral health care services. Most respondents were comfortable as 100 percent of Black, 66.7 percent of Hispanic, and 72.5 percent of White respondents selected yes to this question. Among Hispanic and White respondents, the percentages of those not comfortable seeking care were lower at 33.3 percent and 27.5 percent, respectively.

When asked if they trust the health care system to treat them with respect, 50 percent of Black respondents were neutral, and 50 percent trust to be treated with respect. Among Hispanic respondents, 33.3 percent were neutral, 33.3 percent trust, and 33.3 percent strongly trust to be treated with respect. More than half (56.1 percent) of White respondents, trust (41.5 percent) or strongly trust (14.6 percent), that the health care system would treat them with respect. White respondents who were neutral accounted for 31.7 percent.

Respondents were asked to describe their feelings regarding their behavioral health issues. When asked, if this is a private issue I keep to myself, 50 percent of Black respondents were neutral, and 50 percent indicated this is somewhat unlike how I feel. Among Hispanic respondents, 33.3 percent indicated this is somewhat how I feel, and 66.6 percent said this is somewhat or most unlike how I feel. White respondents were split on behavioral health issues being a private matter I keep to myself as 47.5 percent indicated this was most or somewhat how I feel, 30 percent were neutral, and 22.5 percent said this is somewhat or most unlike how I feel.

Regarding their behavioral health issues as a private matter that stays in the family, 50 percent of Black respondents indicated this is somewhat how they feel, and 50 percent were neutral. Hispanic respondents were split as 33.3 percent indicated this was somewhat how I feel, 33.3 percent were neutral, and 33.3 percent said this is most unlike how I feel. White respondents were also split on responses to this question as 43.9 percent indicated this was most or somewhat how I feel, 36.6 percent were neutral, and 19.5 percent indicated this is somewhat or most unlike how I feel.

Regarding comfort sharing their challenges with others, 100 percent of Black respondents indicated this is most or somewhat how I feel. Among Hispanic respondents, 33.3 percent indicated this is somewhat how I feel, 33.3 percent were neutral, and 33.3 percent said this was most unlike how I feel. Among White respondents, 42.5 percent indicated this is most or somewhat how I feel, 27.5 percent were neutral, and 30 percent said this is somewhat or most unlike how I feel.

When asked if they were more comfortable with people like them, Black respondents were split as 50 percent indicated this is somewhat how I feel, and 50 percent said this is somewhat unlike how I feel. Fifty percent of Hispanic respondents were neutral and 50 percent indicated this is most unlike how I feel. Among White respondents, 47.4 percent were neutral, 31.6 percent indicated this is most or somewhat how I feel, and 21.1 percent said this is somewhat or most unlike how I feel.

The most comfortable setting for discussing their behavioral health issues for Black respondents was a hybrid of telehealth (40 percent). Telehealth, private office with a doctor, and speaking with a nurse practitioner accounted for 20 percent each of Black respondents. Among Hispanic respondents, 60 percent preferred a private office with a doctor, and the remaining 40 percent were split evenly between telehealth and a hybrid of telehealth. White respondents preferred a private office with a doctor at 34.3percent. A hybrid of telehealth (12.9 percent) was preferred over telehealth. Speaking with a nurse practitioner accounted for 15.7 percent, 11.4 percent preferred faith-based, and 11.4 percent indicated all of the above.

When asked to choose between faith-based or the traditional physician office, 100 percent of Black and Hispanic respondents indicated the traditional physician office. Among White respondents, 42.5 percent indicated they would be more comfortable with faith-based care, and 57.5 percent preferred the traditional physician office.

Among Black respondents, 50 percent were very unlikely to be comfortable in group therapy, and 50 percent were neutral. For Hispanic respondents, 66.7 percent were likely to be comfortable in group therapy, and 33.3 percent were neutral. Over half of White respondents (53.7 percent) were very unlikely or unlikely to be comfortable in group therapy, 29.3 percent were neutral, and 17.1 percent were likely to be comfortable in group therapy. When asked about their comfort in individual therapy, 50 percent of Black, 66.7 percent of Hispanic, and 73.2 percent White respondents were likely or very likely to be comfortable in this setting.

When asked if the behavioral health services they received in the past were mostly available in their primary language, 100 percent of Black, 100 percent of Hispanic, and 90.2 percent of White respondents received services in their primary language all of the time. No respondents needed an interpreter.

CULTURAL HEALTH DISPARITY SURVEY BY RACE AND ETHNICITY CHARTS

Figure 109: Are you usually comfortable seeking behavioral health care services?

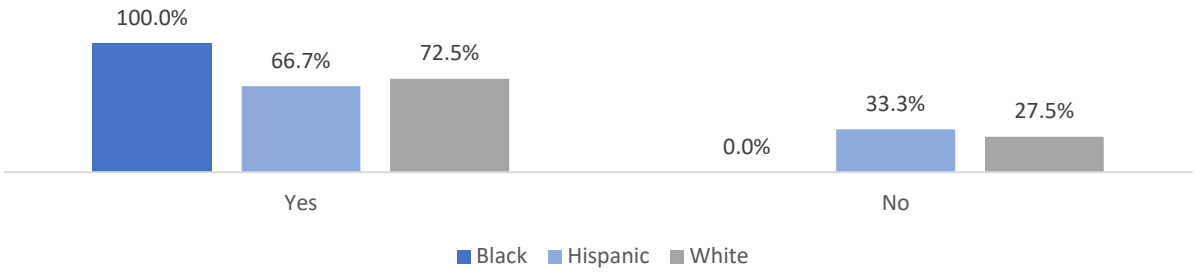


Figure 110: On a scale of 1 to 5, with 5 being 'strongly agree', how would you rate your trust in the behavioral health care system to treat you with respect?

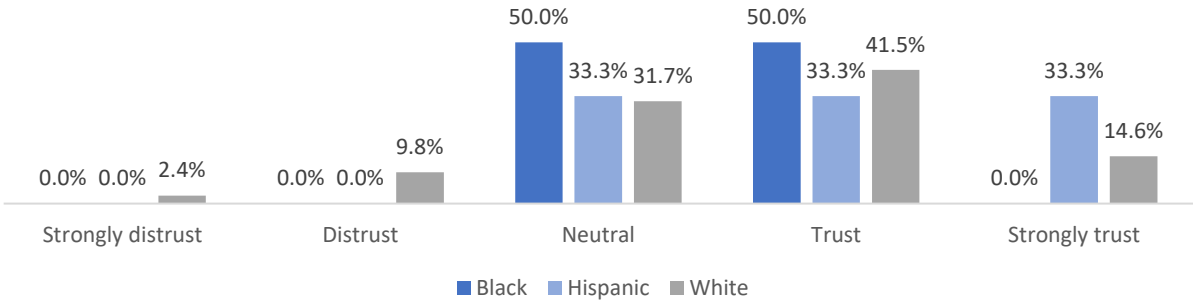


Figure 111: Please rank the statement below that most closely describes your feelings regarding your behavioral health issue, with (1) being the best and (5) being the least. This is a private issue I keep to myself.

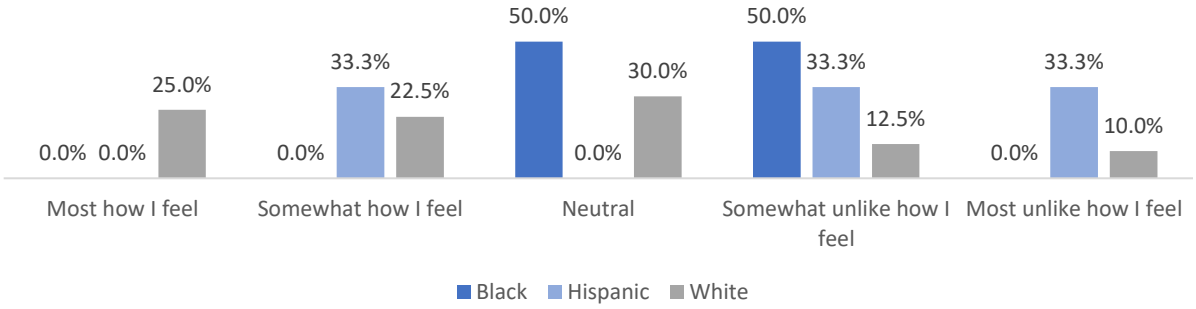


Figure 112: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the most and (5) being the least. This is a private issue that stays in the family.

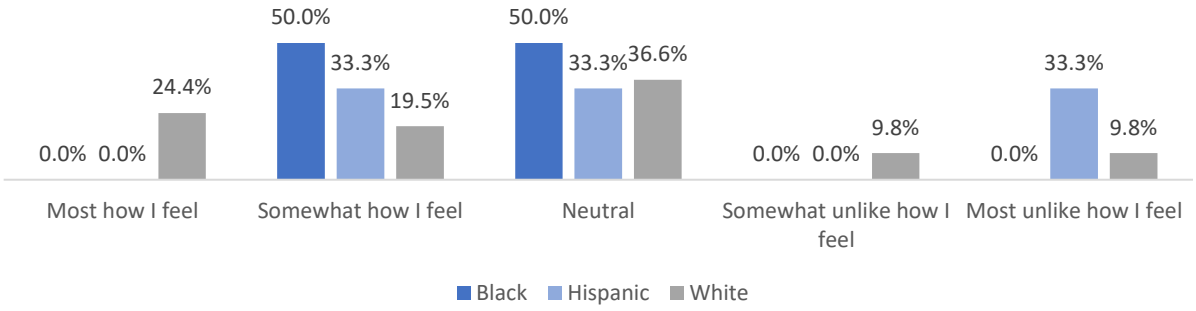


Figure 113: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. I am comfortable sharing my challenges with others.

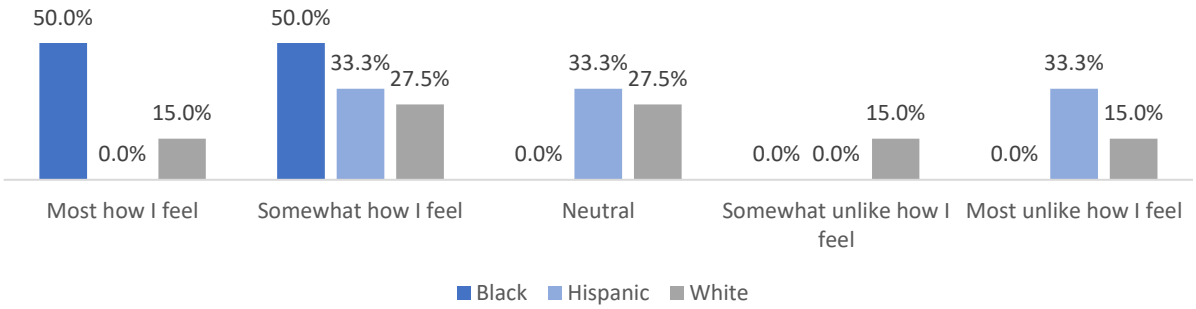


Figure 114: Please rank the statement below that most closely describes your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least. I am more comfortable with people like me.

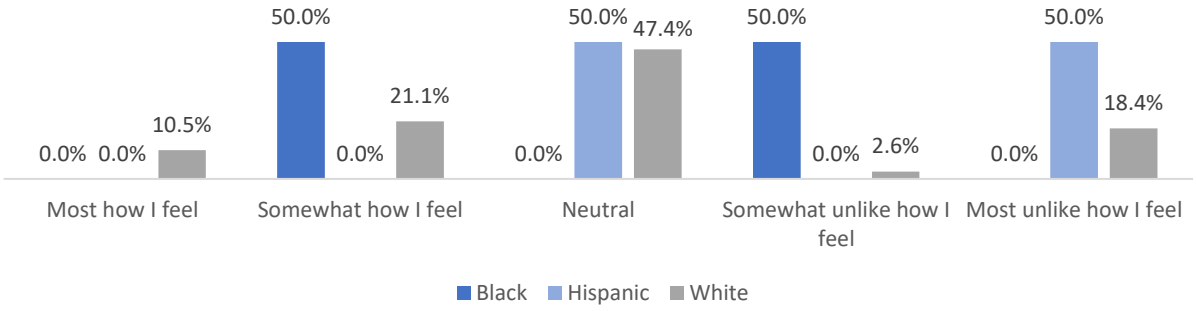


Figure 115: In which setting(s) have you been the most comfortable discussing your behavioral health concerns? (Check all that apply)

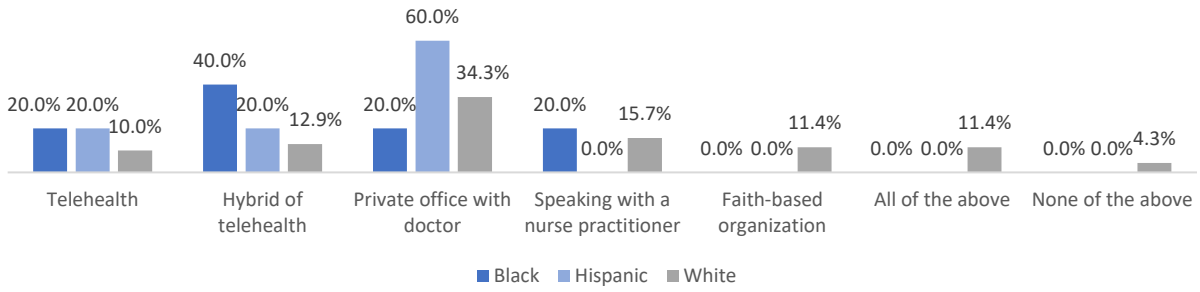


Figure 116: If given a choice for receiving behavioral health care services, would you be more comfortable going to a faith-based organization OR the traditional physician office?

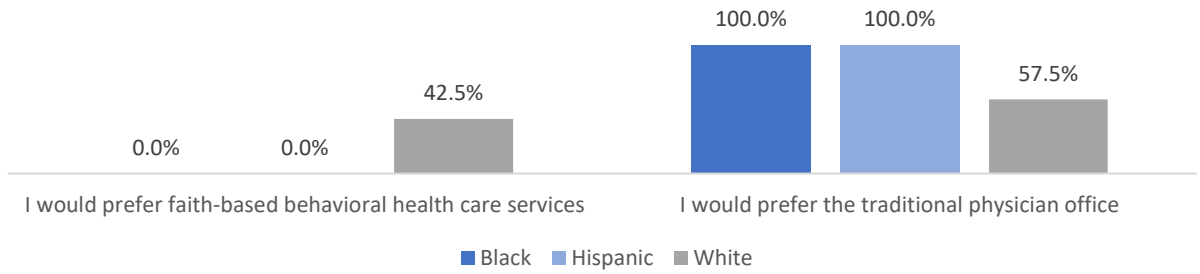


Figure 117: Now thinking about treatment options, on a scale of 1 to 5, with 5 being very likely, how comfortable would you be in group therapy?

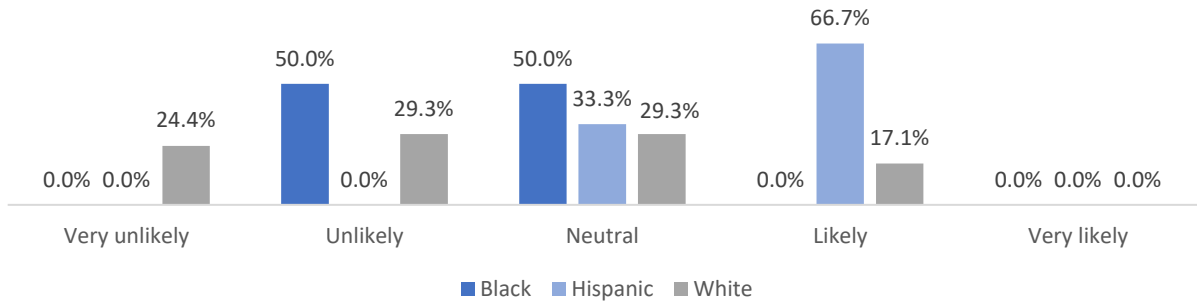


Figure 118: On a scale of 1 to 5, with 5 being very likely, how comfortable would you be in individual therapy?

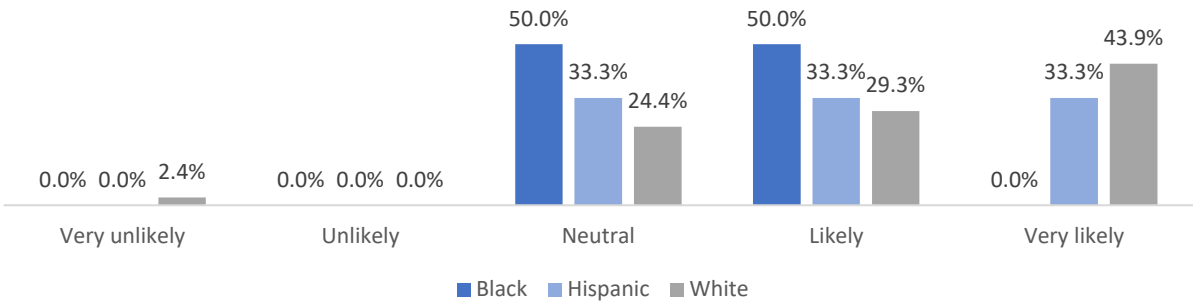
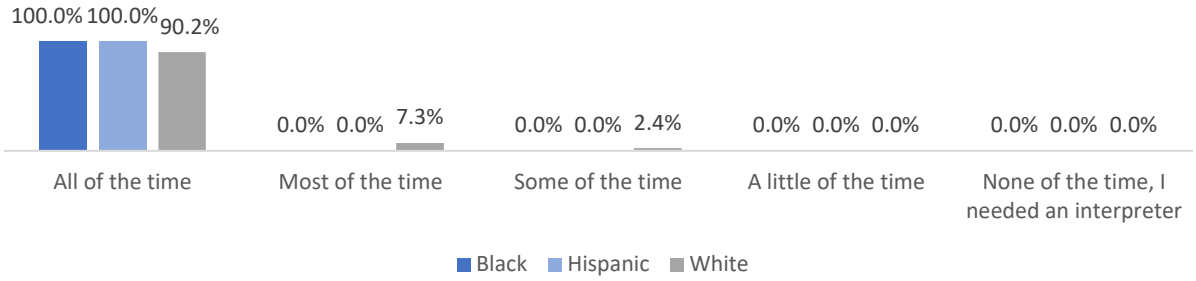


Figure 119: When you have received behavioral health care services in the past, were they available in your primary language?



CULTURAL HEALTH DISPARITY FOCUS GROUP SUMMARY

After analyzing the Cultural Health Disparities Survey responses, two focus groups were convened to elicit more detailed input from individuals who have had direct experience with the behavioral health system in NWFHN's service area. Focus group participants shared their behavioral health care experiences from one or more of the following perspectives:

- Those who needed and received services for themselves
- Those whose family members or close friends needed and received services
- Foster parents whose foster children needed and received services
- Those who provided services as a peer support specialist

The scope of focus group discussions included questions from the Cultural Health Disparities Survey as well as follow-up questions to the survey questions. Discussions included topics related to access, affordability, continuity of care, trust and respect, therapeutic settings and modalities, providers, and language barriers.

Focus group discussions were recorded and electronically transcribed. In this section, key findings are summarized. Sometimes, key findings and participants' comments were addressed during more than one question but are listed as part of only one section. These findings are intended to express the complexities of personal perspectives and experiences.

Survey Question 1. Are you usually comfortable seeking behavioral health care services?

Key Findings:

Discussions regarding this question focused on challenges with access, affordability, and continuity of care. Participants expressed the need for a broader range of options. Barriers included affordability, restrictive third-party payors such as, private insurance, Medicaid, and funding for children in foster care, as well as, complexity of the system, and the lack of qualified providers; especially for children.

Accessing services within the complex behavioral health system is exacerbated by a general lack of knowledge regarding available resources.

Learning how to advocate for self and family requires tenacity and persistence to navigate

the system and access needed care. This is extremely difficult for individuals and families amid a behavioral health crisis or during prolonged chronic behavioral health situations.

Complexities and delays in the system along with a lack of providers impede access to care for traumatized children in foster care, undermining the stability of placements. Extensive waiting periods for services and inconsistency with providers lead to interruptions in care, exacerbation of symptoms, and disrupted placements.

Survey Question 2: On a scale of 1 to 5, with 5 being “strongly agree”, how would you rate your trust in the behavioral health care system to treat you with respect?

Key Findings:

Mutual trust and respect can help resolve conflicts between families (who need to be informed and involved), providers (who must prioritize therapeutic needs of patients), and patients (whose privacy rights must be honored).

There is widespread lack of awareness of and access to early intervention, aftercare, peer support, and communication with consumers and their identified support networks. Providers and consumers need education regarding the role of peer support specialists.

Survey Question 3: Please rank the statements below that most closely describe your feelings regarding your behavioral health issues, with (1) being the best and (5) being the least.

____This is a private issue I keep to myself

____This is a private issue that stays in the family

____I am comfortable sharing my challenges with others (professionals, family members, friends, clergy, etc.)

____I am more comfortable with people like me

_ Other

Please explain_____

Key Findings:

Implicit trust and comfort with peers, (i.e., people with shared experiences), encourages meaningful discussions regarding behavioral health issues without fear of judgement or stigma.

Survey Question 4: In which settings have you been the most comfortable discussing your behavioral health concerns? (Choose all that apply)

____Telehealth (Talking to a health care provider over your phone or computer. This may include using a video)

____Hybrid of Telehealth (includes some face to face and some telehealth)

____Private office with doctor

____Speaking with a nurse practitioner

____Faith-based organization

____All of the above

____None of the above

_ Other

Please explain: _____

Key Findings:

Confidentiality as well as a private and safe physical environment influence the preference for in-person individual therapy. Although there is a value in telehealth, there is a higher value in in-person interaction.

Participants prioritized providers who are experienced working with people who have experienced trauma, have shared values, and welcome individuals who identify with marginalized groups.

For a supporter of a loved one receiving services, it's important that the provider is receptive to the supporter and the loved one and cultivates a therapeutic rapport with the client/patient. It's important that providers engage in a manner that builds trust, so that the loved one can experience the dignity of self-determination and select a provider that they are comfortable with. This in turn helps to dispel fear and provide comfort for the supporter.

Survey Question 5: If given a choice for receiving behavioral health care services, would you be more comfortable going to a faith-based organization OR prefer the traditional physician office?

Key Findings:

Some clients need services that are faith-based, but for some, faith-based services are unacceptable and are not viewed as safe or supportive. Some clients would prefer hybrid services that are open to both perspectives.

Survey Question 6: On a scale of 1 to 5, with 5 being very likely, how comfortable would you be in group therapy? (For the purpose of this discussion, “group therapy” refers to any services provided in a group setting, including fellowship, support groups, and any services outside of individual/couples/family sessions.)

Survey Question 7: On a scale of 1 to 5, with 5 being very likely, how comfortable would you be in individual therapy?

1. Very unlikely
2. Unlikely
3. Neutral
4. Likely
5. Very Likely

Key Findings:

Participants expressed a wide range of views regarding preferences for group therapy, individual therapy, or both. Most were open to both modalities under certain circumstances. Many who had experience with both saw value in both. Critical issues of concern regarding group therapy included privacy, confidentiality, and the suitability of group therapy for specific issues. Critical issues for *both* modalities included competence of the therapist and a safe and comfortable environment. Foster parents explained why group therapy had not been appropriate for the children in foster care in their homes.

Survey Question 8: When you have received behavioral health care services in the past, were they mostly available in your primary language?

Key Findings:

More accessible translation services are needed. Translators should be trained to translate regarding all health care issues, including behavioral health care issues.

Spanish is the most frequently cited language in need of translation. Spanish-speaking providers would be more effective than translators in communicating with patients/clients, their families, and their support networks.

It's very difficult to access translation services and Spanish-speaking services for children in foster care for all needed services, especially for behavioral health services.

NO WRONG DOOR SURVEY SUMMARY

INTRODUCTION

To help improve the behavioral health system of care, Northwest Florida Health Network developed and distributed a survey to elicit feedback from providers focusing on No Wrong Door (NWD) Access in the service area. Survey questions focused on how intake and referral for health services are streamlined across multiple agencies and departments so that no matter where people enter the system, they can easily gain access to behavioral health care services.

The 16-question survey was structured as yes/no and single- and multi-select multiple choice items. Ordinarily, this type of survey would be conducted in person throughout the community. However, due to concerns and limitations attributable to COVID-19, NWFHN decided that online data collection would be more appropriate at this time. A link to the online survey was e-mailed to all NWFHN providers. A total of five providers responded to this survey.

Survey data were downloaded into an Excel spreadsheet and analyzed by the planning team. Descriptive frequencies were calculated, and numerous tables and graphs were developed to illustrate the data. Findings were presented to and discussed with NWFHN and integrated into the assessment.

KEY FINDINGS

Survey respondents indicated they worked in one or more of the following:

- Adult Crisis Unit
- Adult Detoxification Unit
- Adult Mobile Response
- Adult Outpatient Program
- Children's Crisis Unit
- Children's Mobile Response
- Children's Outpatient Program
- Children's Residential Facility

The most frequently mentioned program was Adult Crisis Unit (26.7 percent) followed by Adult Mobile Response (20 percent). All but one respondent worked in more than one type of program.

When asked if No Wrong Door Access works well within their organization, 60 percent

said, “yes” and 40 percent said they weren’t sure.

Most respondents (60 percent) agreed that from their perspective their organization has a role to play in No Wrong Door Access. Forty percent weren’t sure.

Respondents were asked if they agreed that their organization has a strong care coordination process that includes warm handoffs to services and seamless care coordination. Fifty percent agreed and 50 percent strongly agreed.

All respondents either agreed (60 percent), or strongly agreed (40 percent), that their organization has taken action to improve the referral and care coordination process for individuals served.

Most respondents, (80 percent), strongly agreed that linkages to crisis intervention and support (i.e., the Mobile Response Teams, medication management, CRF, CIT Officer, BA, CSU, etc.) are occurring; 20 percent disagreed.

All respondents either agreed (60 percent), or strongly agreed (40 percent), that their organization promotes its services and resources very well, promotes awareness of available options, and linkages to needed services.

When asked if their organization provides person-centered care for all individuals served, 40 percent agreed, and 60 percent strongly agreed.

All respondents agreed or strongly agreed, that their agency hires employees who are culturally sensitive, and culturally competent for the population served.

All who responded to this question agreed that it’s easy for individuals to access the services they need quickly and efficiently.

When asked if they think a standard intake and screening process for state agencies and community partners would help individuals get into services more quickly, one respondent (20 percent) said, “yes”, one (20 percent) said, “no”, and three (60 percent) were not sure?

When asked if, in their opinion, their organization encourages (promotes) working with other community partners to ensure care coordination, 60 percent strongly agreed and 40 percent agreed.

Providers were asked if individuals in need of services have equal access to care. Of those who responded, 50 percent agreed and 50 percent strongly agreed.

When providers were asked if stakeholders help to address and advocate for equal access to care in system entry points, 60 percent strongly agreed, and 40 percent were not sure.

All respondents either agreed, (40 percent), or strongly agreed, (60 percent), that their organization ensures that services are of high quality and meet the needs of individuals served. All either agreed (60 percent) or strongly agreed (40 percent) that tracking individuals served, services, performance, and costs were undertaken to continually evaluate and improve outcomes.

NO WRONG DOOR SURVEY CHARTS

Figure 120: I work in a/an...

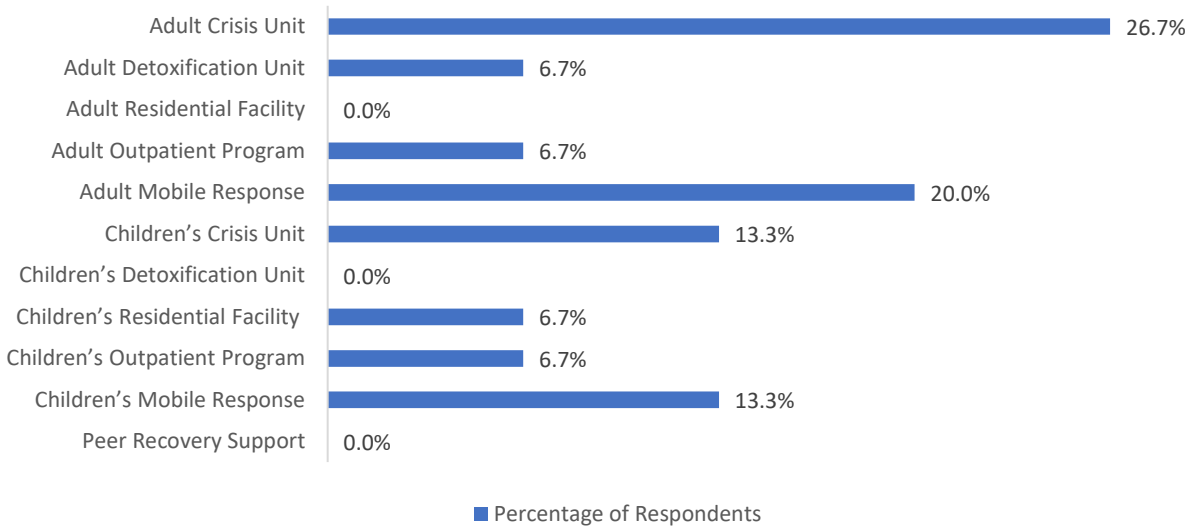


Figure 121: Do you think the "No Wrong Door" access works well within your organization?

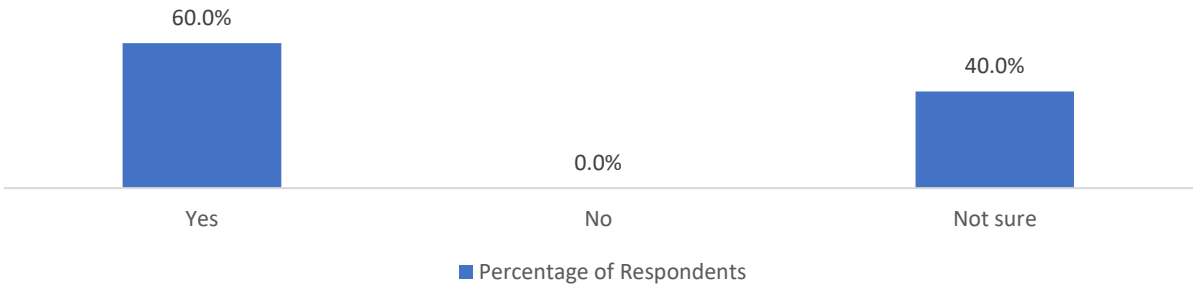


Figure 122: From your perspective your organization has a role to play in the "No Wrong Door" access.

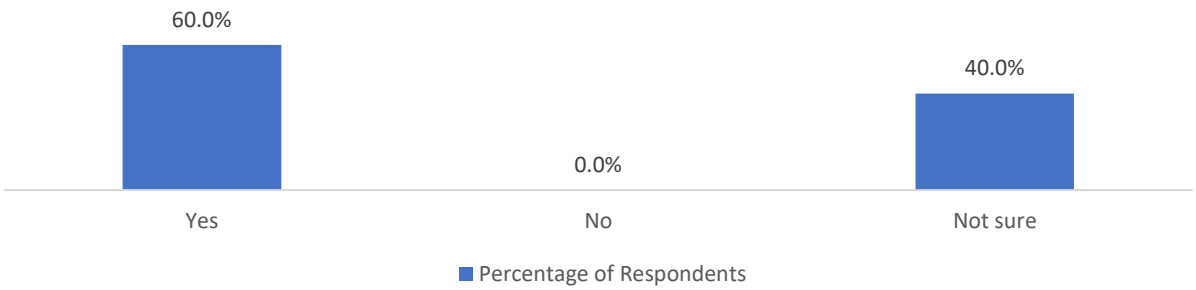


Figure 123: In your opinion, your organization has a strong care coordination process that includes warm handoffs to services and seamless care coordination.

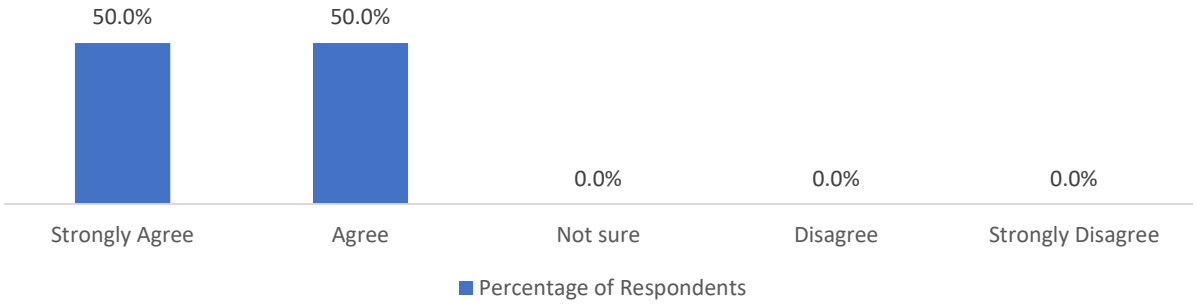


Figure 124: In your opinion, your organization has taken action to improve the referral and care coordination process for individuals served.

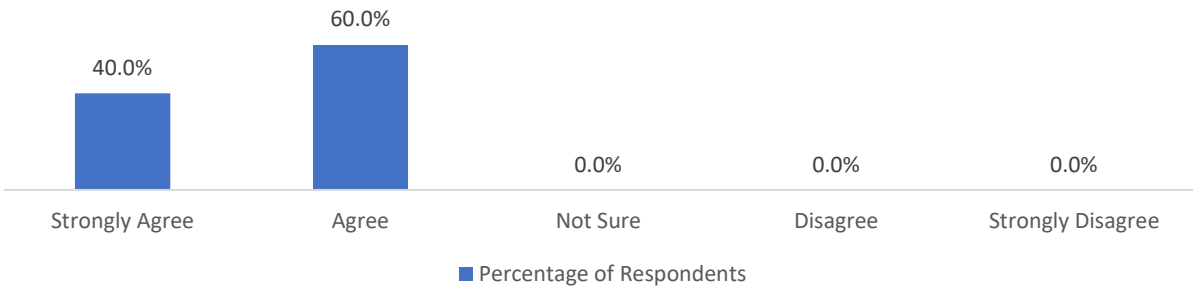


Figure 125: In your opinion, linkages to crisis intervention and support (like the Mobile Response Team, medication management, CRF, CIT Officer, BA, CSU, etc.) are occurring.

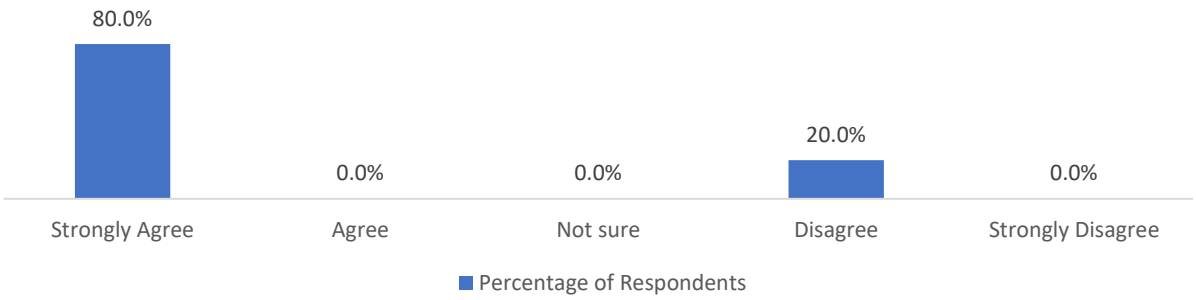


Figure 126: In your opinion, your organization promotes its services and resources very well.

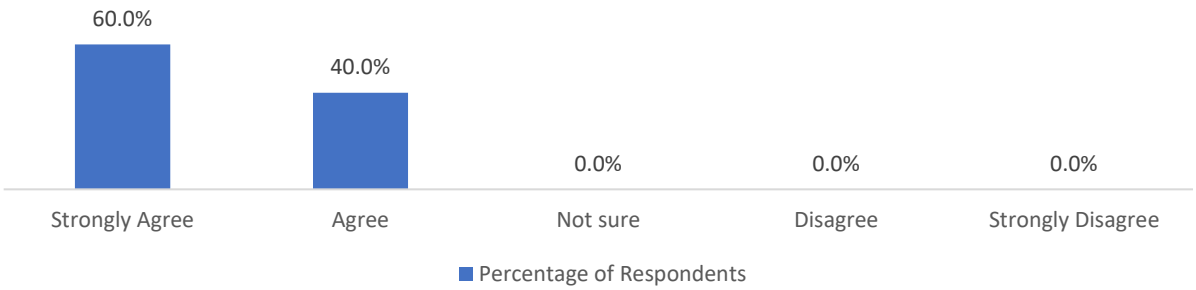


Figure 127: In your opinion, your organization promotes awareness of available options and linkages to need services.

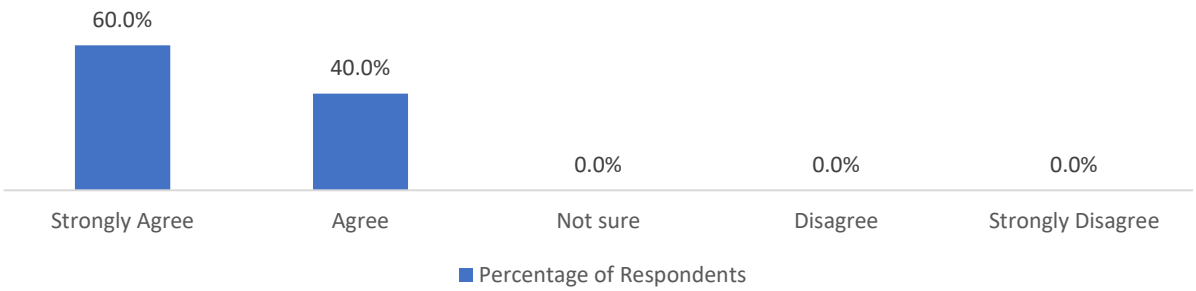


Figure 128: In your opinion, your organization provides person-centered care for all individuals served.

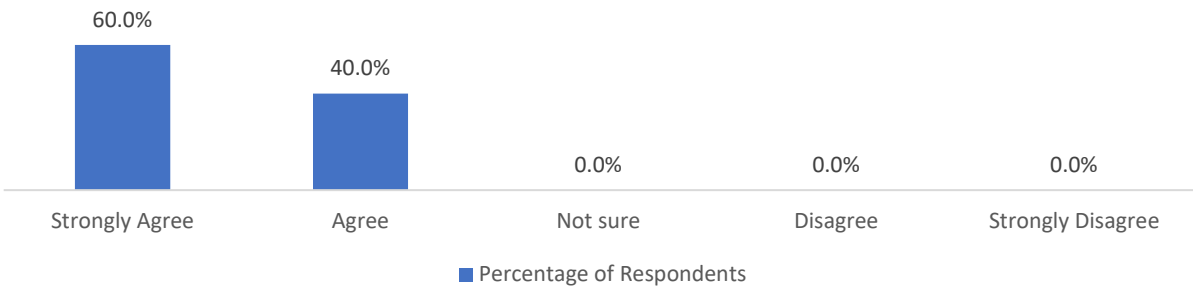


Figure 129: In your opinion, your agency hires employees who are culturally sensitive and culturally competent for the population served.

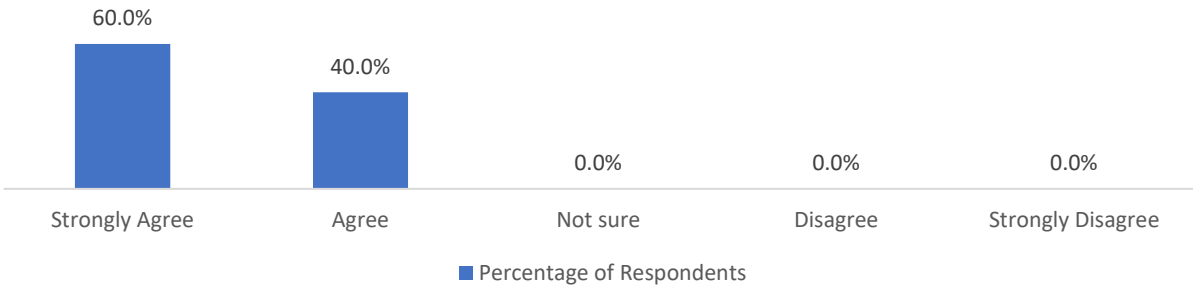


Figure 130: In your opinion, it's easy for individuals to access the services they need quickly and efficiently.

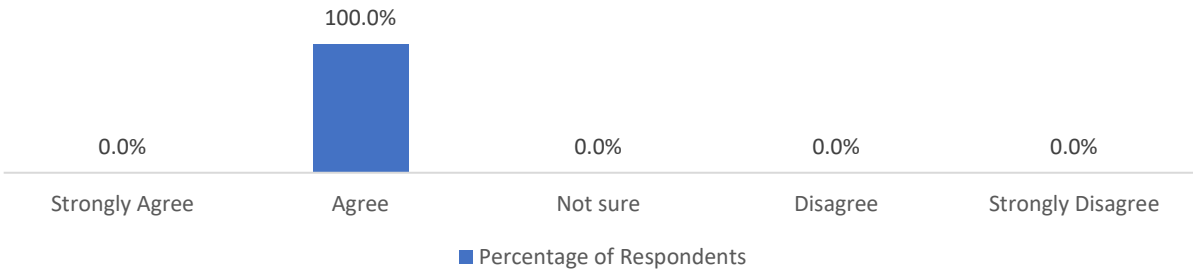


Figure 131: Do you think a standard intake and screening process for state agencies and community partners would help individuals get into services more quickly?

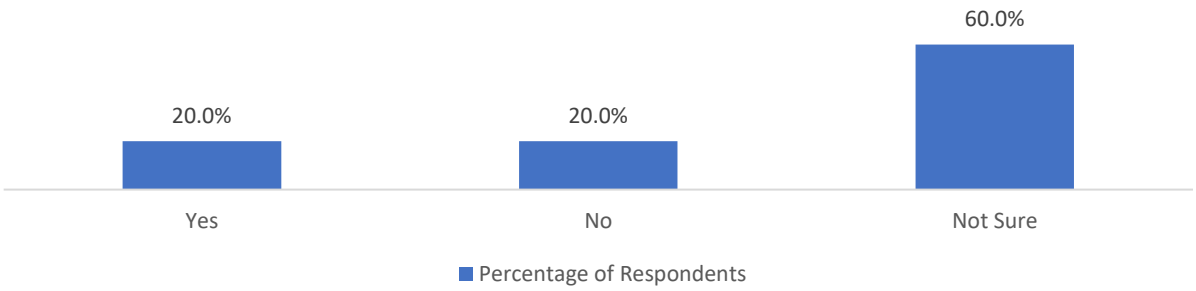


Figure 132: In your opinion, your organization encourages (promotes) working with other community partners to ensure care coordination.

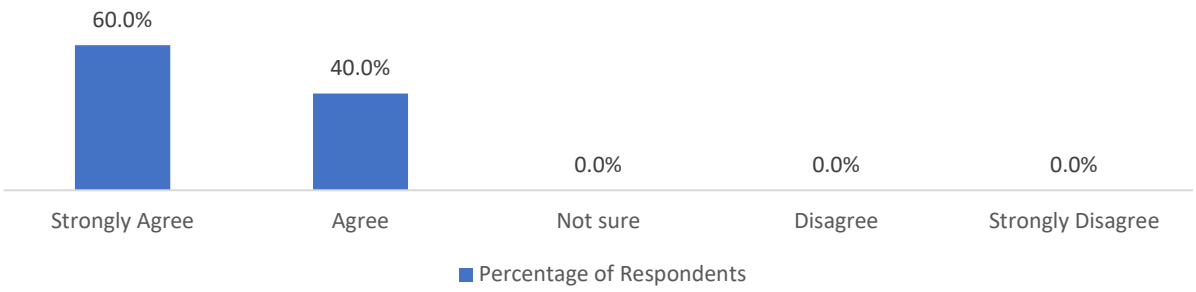


Figure 133: In your opinion, individuals in need of services have equal access to care.

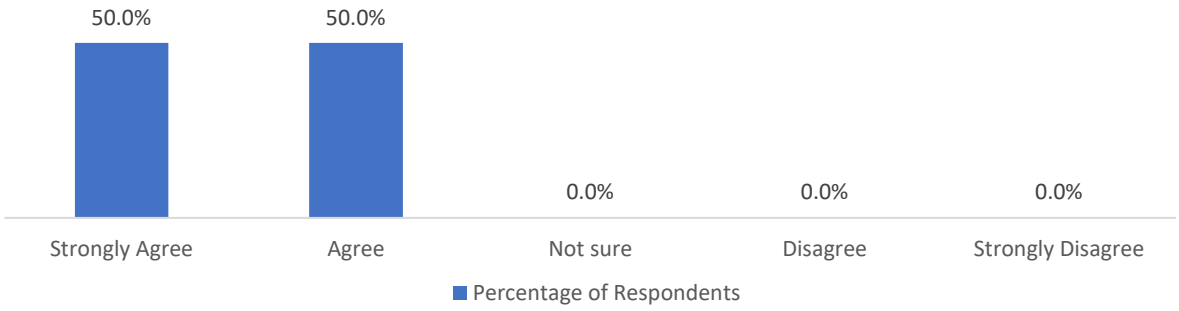


Figure 134: In your opinion, stakeholders help to address and advocate for equal access to care in system entry points.

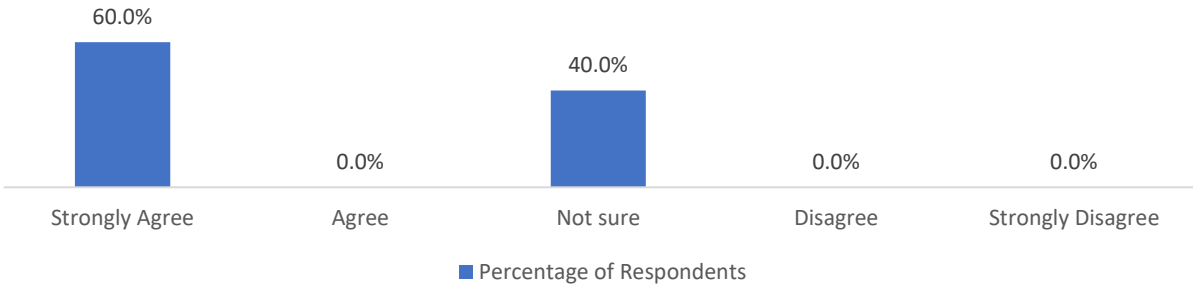


Figure 135: In your opinion, your organization ensures that services are of high quality and meet the needs of individuals served.

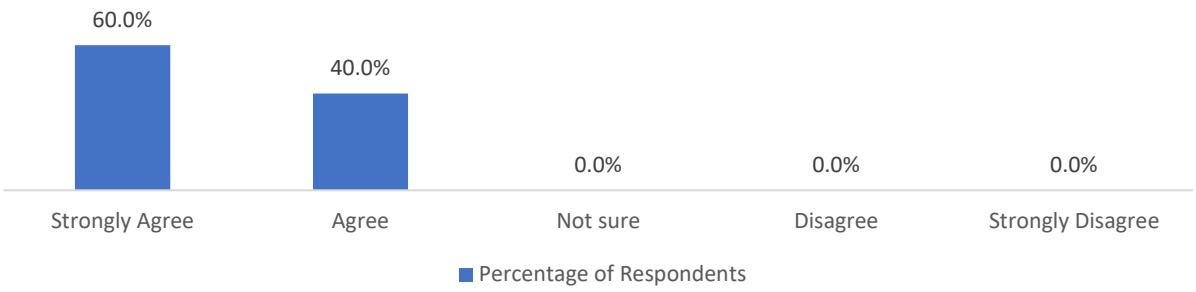
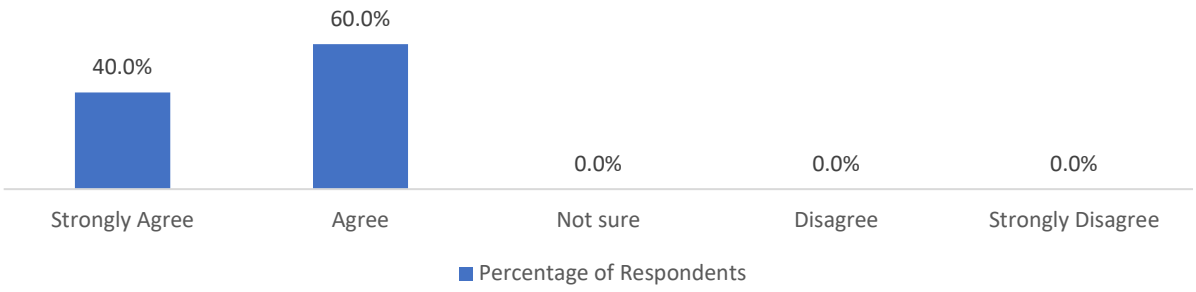


Figure 136: In your opinion, your organization tracks individuals served, services, performance, and cost to continually evaluate and improve outcomes.



NO WRONG DOOR NWFHN PROVIDER FOCUS GROUP SUMMARY

After analyzing the No Wrong Door (NWD) Access Survey responses, interviews were scheduled to elicit more detailed input from providers who have had direct experience with the behavioral health system in NWFHN's service area.

The scope of interviews included questions from the NWD Access Survey as well as follow-up questions. Discussions included topics related to the following:

- NWD Access
- Information, Referral, and Community Awareness
- Person-Centered Care and Transitional Support
- Streamlined Access and Eligibility
- Partnerships and Coordination of Efforts
- Quality Assurance and Continuous Improvement

In this section, selected survey questions, follow-up questions, and key findings are summarized. Sometimes, key findings were addressed during more than one question but are articulated in only one section. All names of individuals and providers were omitted to encourage candor and protect privacy.

Opening Question. What does No Wrong Door Access mean to you?

Survey Question 1. Do you think "No Wrong Door Access" works well within your organization? **Follow-up Interview Questions:**

Tell us about your experience with No Wrong Door Access within your organization. Do you think your organization's current approach to No Wrong Door Access works well? What are some things that you think work well? What are some opportunities for improvement?

Key Findings:

Providers' understanding of NWD Access includes making sure they provide services or a linkage to services to everyone who comes in for help. It's important to make sure people who are seeking help get the help they need. This helps to ensure people in need are not sent back out feeling helpless or hopeless.

NWD Access is a part of the organization's culture. When someone walks on campus seeking services, it is a best practice to walk people to warm handoffs, and ensure folks are in the right space.

NWD Access is facilitated and supported by extensive training and discussions among leadership and staff.

Disruptions in the aftermath of Hurricane Michael, (e.g., structural damages, high staff turnover, etc.) impeded prioritization and implementation of NWD Access policies, trainings, and practices. While collaboration and integration are effective and necessary, some immediate issues may need to be addressed in other ways. Recovery from the distractions caused by Hurricane Michael is still in progress.

Bifurcation of funding and inconsistent diagnostic standards for substance use and mental health create barriers to NWD Access.

Having a variety of programs within an organization improves efficiency by streamlining protocols to connect clients with needed services. This results in enhanced effectiveness by ensuring and supporting the synergistic effects of coordinated care.

Opportunities for Improvement:

NWD Access" can be facilitated by streamlining processes for appointments, intake, screening, aftercare, etc.

Telehealth has improved access as providers and consumers have adapted well to the new normal of telehealth, Zoom availability, etc.

NWD Access can be facilitated by training across all behavioral health services and providers to coordinate, plan, and implement assessment, treatment, and aftercare to meet accreditation standards such as the Commission on Accreditation of Rehabilitation Facilities (CARF).

Survey Question 2. From your perspective, your organization has a role to play in "No Wrong Door Access".

Follow-up Interview Question:

What are the ways that your agency plays a role in No Wrong Door Access?

Key Finding:

A strong case management team and a close-knit staff facilitate NWD Access.

Survey Question 4. In your opinion, what action has your agency taken to improve the referral and care coordination process for individuals served?

Follow-up Interview Question:

In what specific ways can your agency improve the referral and care coordination process for individuals served?

Key Findings:

Providers should continue to develop coordinated services with Crisis Stabilization Units (CSU) to facilitate intensive care coordination for high utilizers.
Providers should continue to develop processes to expedite referrals from outpatient to specialty teams, including referrals from Community Action Teams to adult services.

Funding and staff shortages result in some substance use providers running deficits due to large numbers of referrals.

Some providers receive funding for Medication Assisted Treatment (MAT) but are unable to provide needed services due to lack of capacity (i.e., shortage of providers).

Survey Question 5. In your opinion, are linkages to crisis intervention and support (e.g., Mobile Response Teams, medication management, Crisis Intervention Teams, Baker Act, Crisis Stabilization Units., etc.) occurring?

Follow-up Interview Question:

Have you or your agency identified any barriers or obstacles to becoming a part of the No Wrong Door Access system?

Key Finding:

Because substance use and mental health diagnoses are frequently identified as co-occurring disorders, additional funding is needed for specialty care (i.e., psychiatry). Ready access to additional specialty services should be available to all substance use and mental health clients/patients.

INFORMATION, REFERRAL, AND COMMUNITY AWARENESS

Survey Question 6. In your opinion, does your organization promote its services and resources very well.

and

Survey Question 7. In your opinion, does your organization promote awareness of available options and linkages to needed services?

Follow-up questions:

Can you give examples? How does your agency promote awareness of available options and possible linkages to needed services (e.g., brochures, social media, billboards, website, handouts,

etc.)? What else could be done to increase the level of awareness of behavioral health services in the community?

Key Findings:

Providers, community partners, and NWFHN collaborate to conduct community-based activities promoting prevention services and resources.

Providers participate in community-based meetings to identify and analyze strengths and weaknesses in the current system of care and develop strategies to manage strategic issues.

Providers' public relations specialists promote behavioral health wellness and treatment services through marketing efforts such as community outreach via print, broadcast, and electronic media. Messages are often tailored to address issues relevant to holiday seasons, specific community needs, and specialty programs.

All the above-mentioned activities could be expanded and increased via social media.

Expand awareness of resources to address critical issues such as Medication Assisted Treatment (MAT) for opioid use disorder.

PERSON-CENTERED CARE AND TRANSITIONAL SUPPORT

Survey Question 8. In your opinion, does your organization provide person-centered care for all individuals served?

Follow-up Interview Question:

Describe how your agency implements a person-centered system of care.

Key Findings:

Providers implement person-centered Recovery Oriented System of Care (ROSC) training and policies.

Person-centered, trauma-informed care is built into organizational cultures. Providers are sensitive to emerging trends regarding language and other cultural issues to ensure inclusive and welcoming environments.

Providers' emphasis on person-centered care and trauma-informed care as best practices have been internalized and is promoted throughout leadership and treatment teams.

Providers routinely ask consumers where and when they want services to prioritize patients' convenience. Providers' values include client safety, flexibility to meet client needs, autonomy, and choice regarding clients' therapeutic goals.

Providers elicit and are responsive to client feedback.

Follow-up Interview Question:

What resources or supports would your agency need to improve person-centered care?

Key Findings:

Develop protocols (e.g., staff peer mentoring/review) to ensure that each client is treated as an individual, rather than generically with “one size fits all” assessments, treatment plans, etc.

Fund ongoing trainings and mentoring to ensure leadership and staff, including new staff, understand values and practices associated with person-centered care. This is especially important due to high staff turnover.

Fund frequent trainings regarding Mental Health First Aid (MHFA).

Partner with other providers or Managing Entities to develop cost effective lending libraries of training materials.

Survey Question 9. In your opinion, does your agency hire employees who are culturally sensitive and culturally competent for the population served?

Follow-up Interview Questions:

If not, are you aware of your agency doing anything to improve in this area? Is there anything your agency could do to improve?

Key Findings:

Provide training to new employees and current employees.

Facilitate trainings with other providers to promote the beneficial exchange of information.

Allocate funds for training including guest speakers and cost-effective virtual training.

Recent Cultural Competency Audit included anonymous survey and identified the need for additional training, especially regarding cultural competency. Identified issues of concern are addressed in quarterly trainings and include topics such as:

- Recognition of the professional and organizational strength developed by a commitment to serving families/clients of different cultures.
- Recognition of the strength developed by a commitment to developing a diverse staff.
- Developing and distributing printed materials to reflect the importance of diversity and cultural sensitivity and competence.
- The need for leadership development and advancement to cultivate diversity.
- Recognition of the importance of training to promote cultural sensitivity and competence specific to LGBTQ+ clients.
- The need for additional training to increase awareness of clients’ cultures and beliefs, and how to appropriately translate awareness into best practices.

STREAMLINED ACCESS AND ELIGIBILITY

Survey Question 10. In your opinion, it's easy for individuals to access the services they need quickly and efficiently.

Follow-up Interview Questions:

If yes, what works well about the current process with individuals for accessing services? If no, what are the major barriers that keep individuals from accessing the services that they need?

Key Finding:

Time is of the essence when someone expresses the need for help, but providers are not always able to respond within the small window of opportunity. Barriers include waitlists and staffing shortages.

Survey Question 11. Do you think a standard intake and screening process for state agencies and community partners would help individuals get into services more quickly?

Follow-up Interview Questions:

Why or why not? What do you think would need to be accomplished to implement a standard intake and screening process for the region/state/system?

Key Findings:

A standard intake and screening process, including a comprehensive referral and feedback form/process, with all necessary information that is easy to transmit to other programs and providers, is needed.

Judicial Circuit 14 has developed an effective form for services related to child welfare.

Because of billing protocols and standardized processes, Federally Qualified Healthcare Centers (FQHC) may be able to provide services more efficiently and effectively.

PARTNERSHIPS AND COORDINATION OF EFFORTS

Survey Question 12. In your opinion, your organization encourages (promotes) working with other community partners to ensure care coordination.

Follow-up Questions:

Which partners do you work with most? What works well in these partnerships?

Key Findings:

Working well across the region requires effective communication and an overall respect for the importance of NWD Access.

Leadership and staff training promotes professional standards and practices.

Training to elicit a shift in perspective helps providers empathize with clients seeking services.

Working closely with schools (e.g., through weekly staffing meetings with school leadership and providers) to ensure wraparound services and individualized solutions for youth in crisis, are available.

Having long term collaborative relationships with NWFHN and providers is necessary to develop mutual respect and understanding. This will help to foster respect for the multiple perspectives and roles necessary to achieve beneficial outcomes.

Reengage communities to resume communication after Hurricane Michael and COVID-19 eliminated many meetings. There is a need to restart some meetings to increase direct communication among similar providers.

Survey Question 13. In your opinion, individuals in need of services have equal access to care.

Follow-up Interview Questions: Why? Why not? What works well?

Key Findings:

All clients can receive services because access to services is not based on the ability to pay. Providers welcome all people in need.

Providers are committed to universal equal access.

The current funding system favors service provision to some in a more expedited way than for others. Shifting to universal equal access will require additional funding and staffing.

Survey Question 14. In your opinion, stakeholders help to address and advocate for equal access to care in system entry points.

Follow-up Interview Question

If not, how can this be improved?

Key Findings

Stakeholders advocate for individuals who are seeking services by sharing information directly with providers, helping people transcend seemingly insurmountable barriers in the system.

QUALITY ASSURANCE AND CONTINUOUS IMPROVEMENT?

Survey Question 16. In your opinion, your organization tracks individuals served, services, performance, and cost to continually evaluate and improve outcomes.

Follow-up Interview Question:

If not, how can this be improved?

Key Findings:

There are already a multitude of monitoring systems and standards, regarding services, finances, facilities, staffing, etc.

Biggest need is legislative and gubernatorial action to change funding structure and rates.

INDIVIDUALS SERVED SURVEY SUMMARY

INTRODUCTION

To help improve the behavioral health system of care, NWFHN developed and distributed a survey to elicit feedback from consumers. The focus of this survey is consumer awareness and experience concerning behavioral health care services in the service area.

The survey instrument was comprised of 17 questions regarding county of residence, awareness of, access to, and utilization of available services, quality of care, and service gaps. Responses were structured as yes/no, multiple choice, and Likert Scale options.

Ordinarily, this type of survey would be conducted in person throughout the community. However, due to concerns and limitations attributable to COVID-19, NWFHN decided that online data collection from a convenience sample would be more appropriate at this time. A link to the online survey was e-mailed to providers, who in turn distributed it broadly to their consumers. A total of 46 consumers responded.

Survey data were downloaded into an Excel spreadsheet and analyzed by the planning team. Descriptive frequencies were calculated by dividing the number of responses by the total number of respondents. Tables and graphs were developed to illustrate the data. Findings were presented to and discussed with NWFHN and integrated into the assessment.

SUMMARY OF FINDINGS

Nineteen (41.3 percent) respondents identified as adults receiving services, 12 (26.1 percent) as caregivers representing a person receiving services, and 9 (19.6 percent) as parents of a child receiving services.

Adult Mental Health Services were received by 52.2 percent of respondents (or the person they are representing) and 32.6 percent received Child Mental Health Services. Adult Substance Use Services were received by 23.9 percent of respondents. Twelve (26.1 percent) received two or more types of services.

While the majority of respondents were residents of Leon or Bay Counties (39.1 percent and 28.3 percent, respectively), 61.1 percent of the service area's 18 counties had at least one respondent.

When asked if they know where to go for behavioral health services, 67.4 percent said yes, 13 percent said no, and 19.6 percent said sometimes.

While nearly two-thirds of respondents said they are aware of the 2-1-1 information and referral resource in their county, only 17.4 percent had ever called for assistance. Among those who called, when asked if 2-1-1 was helpful in getting them to the services they needed, 75 percent said yes, and 25 percent said sometimes.

Nearly two-thirds, 63 percent, said they were able to get the services they needed when they

needed them.

From a comprehensive list of services, 13 respondents identified 22 specific services they needed but were unable to get. The most frequently mentioned services were crisis stabilization support (38.5 percent), assessment (30.8 percent), and short-term residential treatment (30.8 percent). Ten respondents identified two or more specific services they were unable to get.

When asked how many times they were unable to get the services they needed during the previous 12 months, 2 said one to two times, 3 said three to four times and 2 said five or more times. Altogether, 84.8 percent did not indicate they had been unable to get services they needed during the previous twelve months.

Most respondents, 63 percent, indicated that the services they needed were available, 17.4 percent said there was a waitlist for needed services, and 10.9 percent said the services they needed were not available.

More than two-thirds, 69.6 percent, agreed or strongly agreed that the services and planning they received were focused on their treatment needs.

Fewer than half (43.5 percent) had to wait 1 to 2 weeks to receive services, 21.7 percent had to wait 3 to 4 weeks, 17.4 percent had to wait more than a month, and 8.7 percent had to wait more than two months.

While most respondents traveled less than 30 minutes to access services (34.8 percent, up to 15 minutes; 37 percent, 16 to 30 minutes), 8.7 percent traveled 31 minutes to 1 hour, and 15.2 percent traveled more than an hour.

Driving myself or relative/friend drives me were the most frequently identified means of transportation to getting the care they needed, 65.2 percent and 32.6 percent, respectively.

From a comprehensive list of obstacles, 28 respondents identified a total of 13 barriers that they experienced while trying to get the care they needed. Sixteen respondents identified more than one. The most frequently identified obstacles were related to affordability (i.e., could not afford the services, 23.9 percent), stigma (i.e., worried what people would think, fear, shame, 19.6 percent), and access (i.e., long waitlists, 13 percent; no evening or weekend appointments, 13 percent; did not meet eligibility criteria, 13 percent; did not know where to go for services, 13 percent). In addition to the obstacles listed in the survey, each of six respondents specified an additional obstacle they encountered: amount of time before I could get an appointment; had to pay out of pocket because insurance didn't cover the service. Providers that took insurance had no availability; no legitimate evaluations; good providers not covered by insurance; handicap inaccessible; lack of attention to critical need.

INDIVIDUALS SERVED SURVEY CHARTS

Figure 137: Which best describes you?

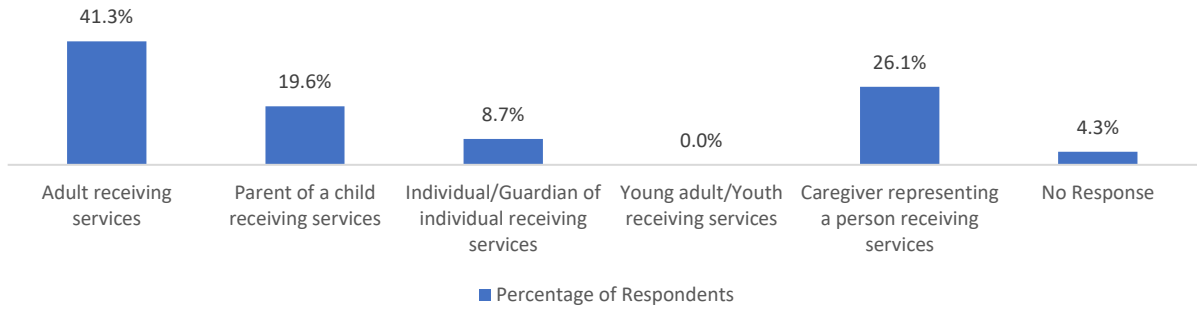


Figure 138: What type of service did you or the person you are representing receive?

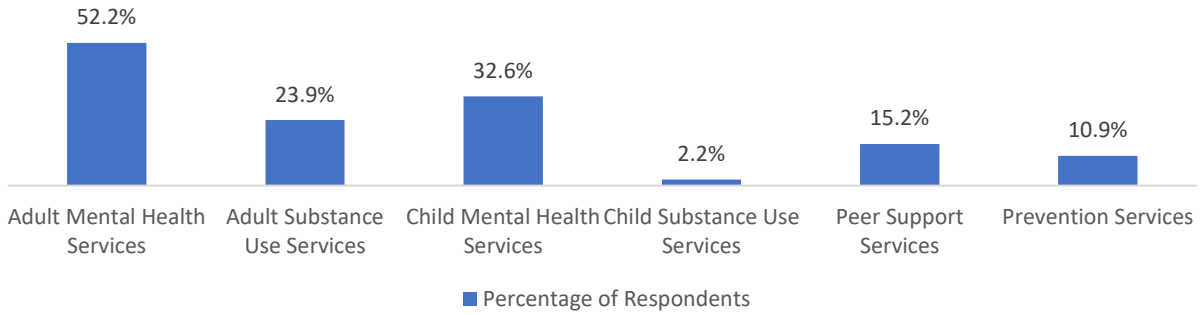


Figure 139: Which county do you live in?

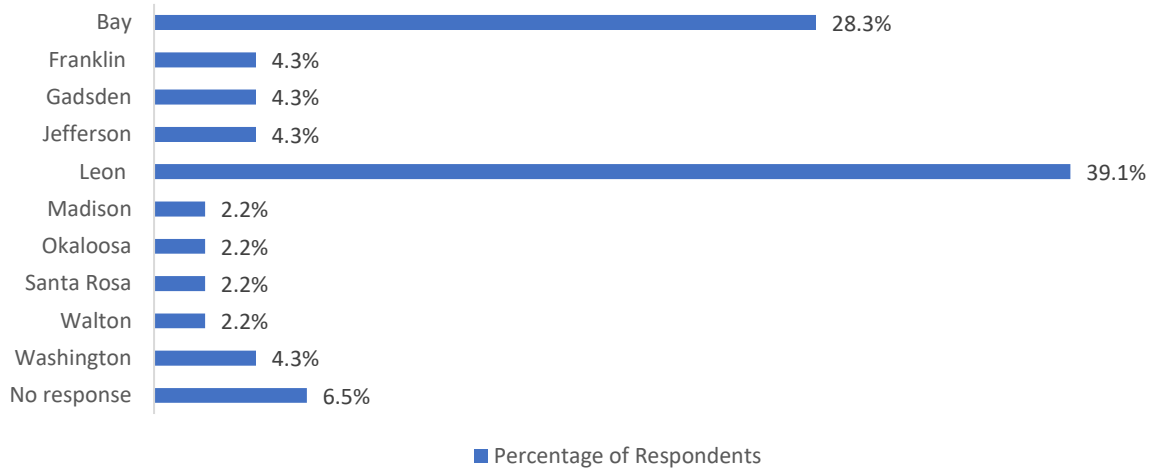


Figure 140: Did you know where to go for mental health and substance use treatment services when you needed them?

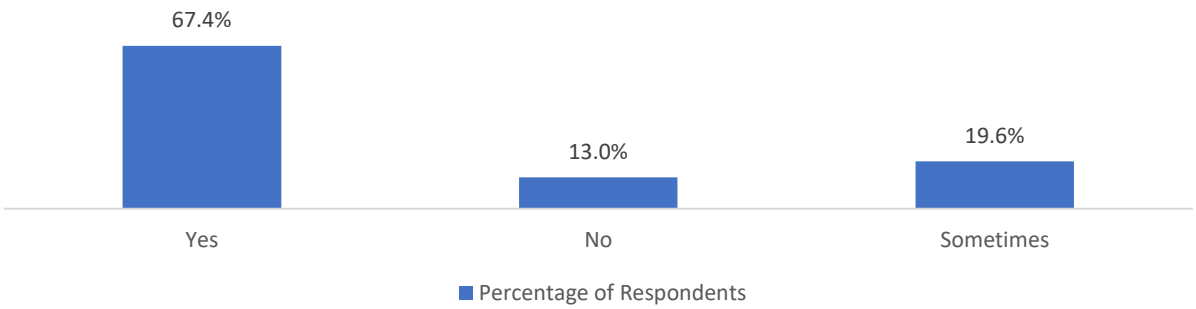


Figure 141: How did you learn about mental health and substance use treatment services when you needed them?

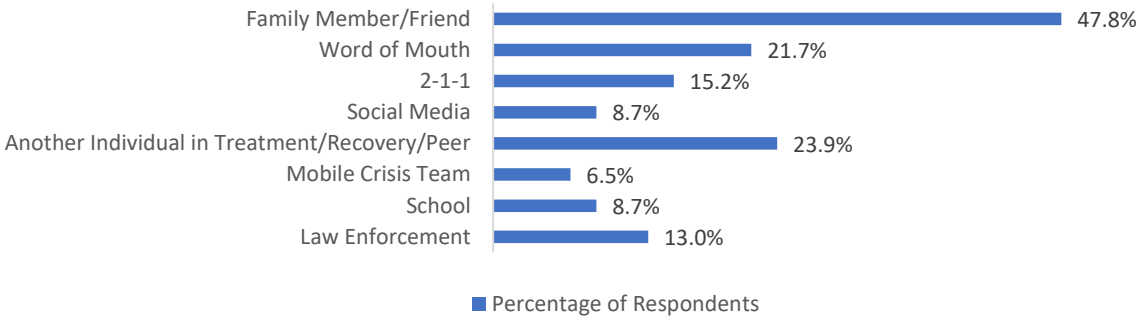


Figure 142: Are you aware of the 2-1-1 Information and Referral Resource in your community?

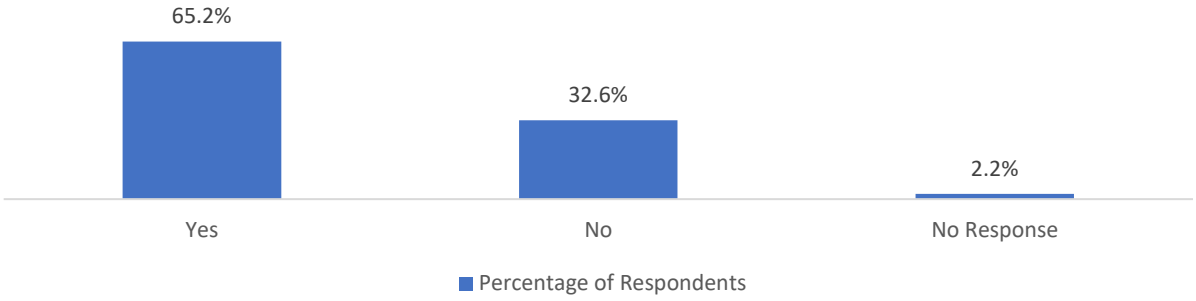


Figure 143: Have you ever called 2-1-1 Information and Referral Resource for assistance?

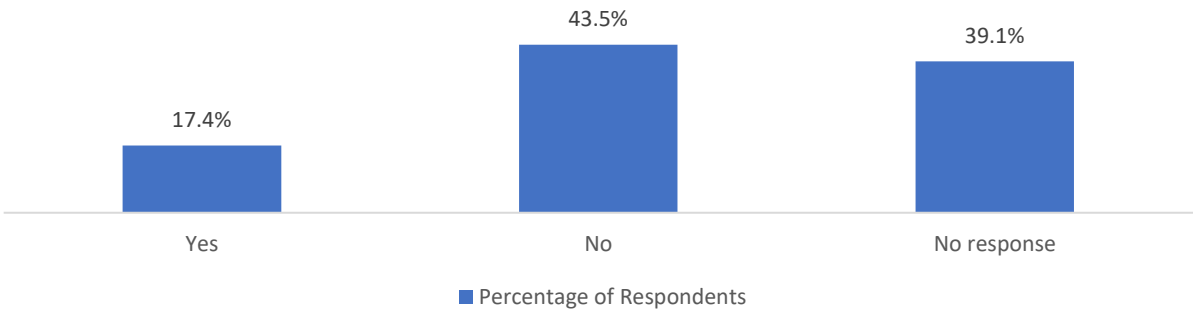


Figure 144: When you called the 2-1-1 Information and Referral Resource, were they helpful in getting you the services needed?

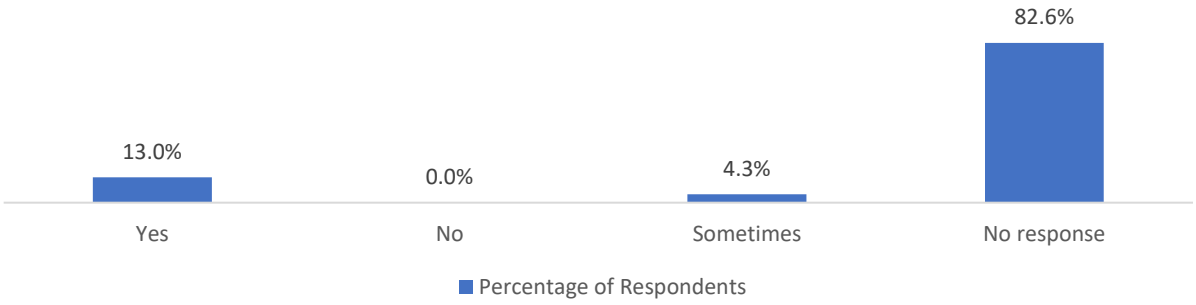


Figure 145: Were you able to get all the services you needed when you needed them?

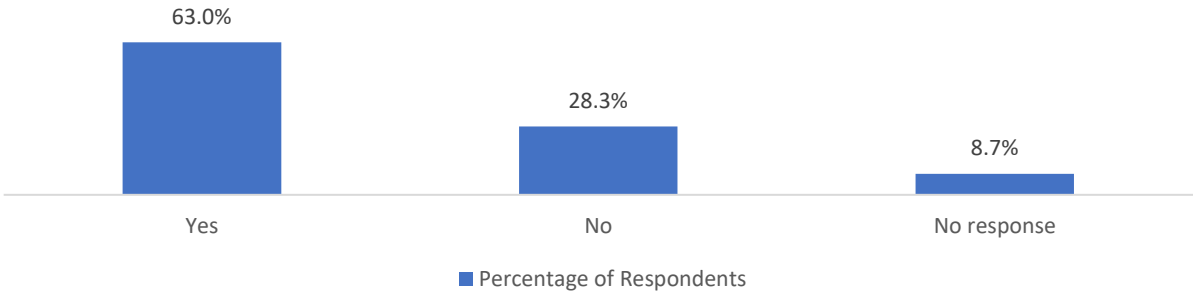


Figure 146: If no, please choose from the list below, the services you needed but were not able to get.

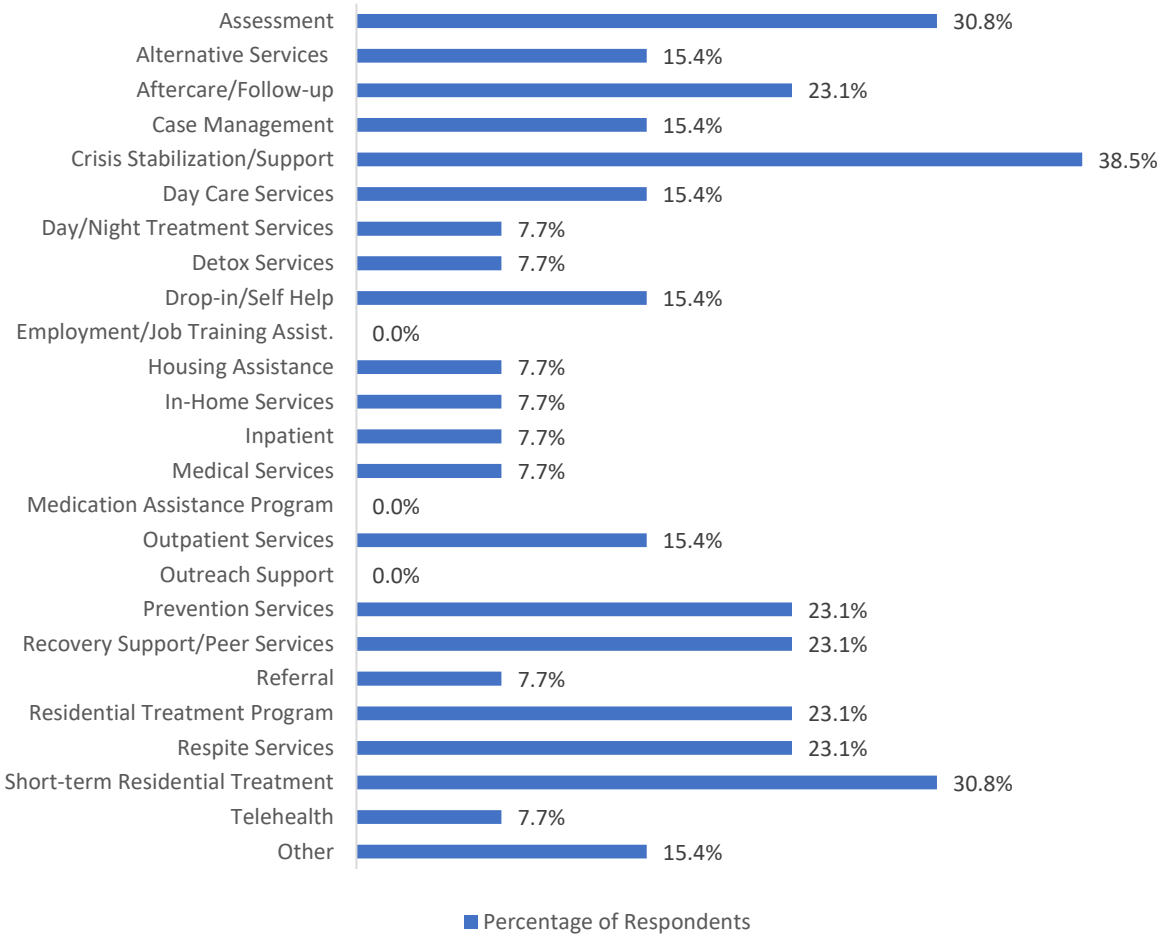


Figure 147: How many times during the last 12 months were you not able to get the services you needed?

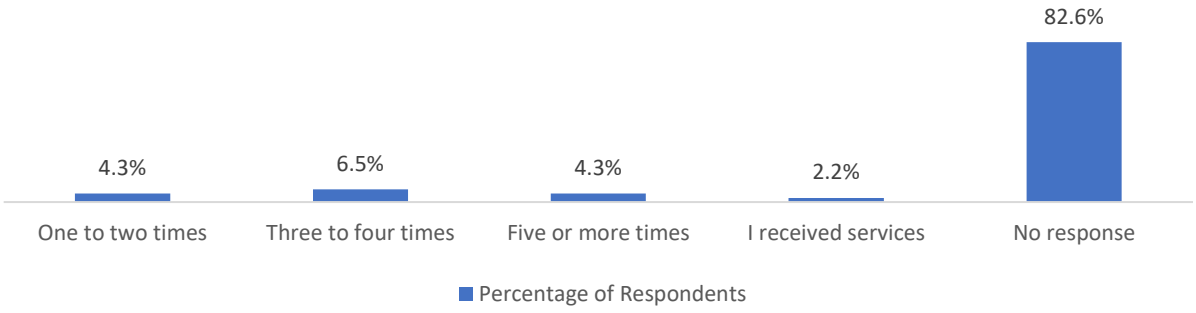


Figure 148: The services I needed were:

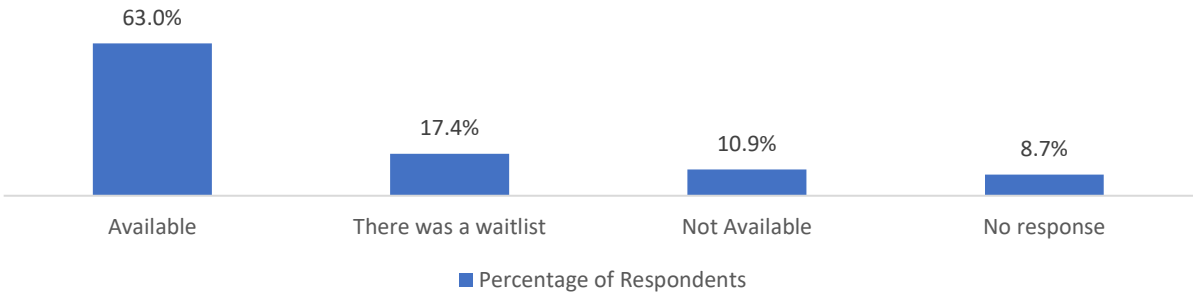


Figure 149: The services and planning I received were focused on my treatment needs (patient centered).

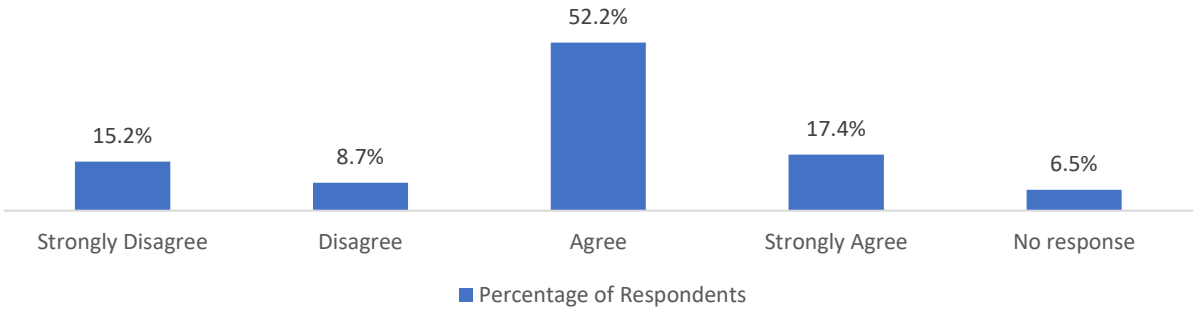


Figure 150: How long did it take from the time you requested an appointment for services to the time you received the services?

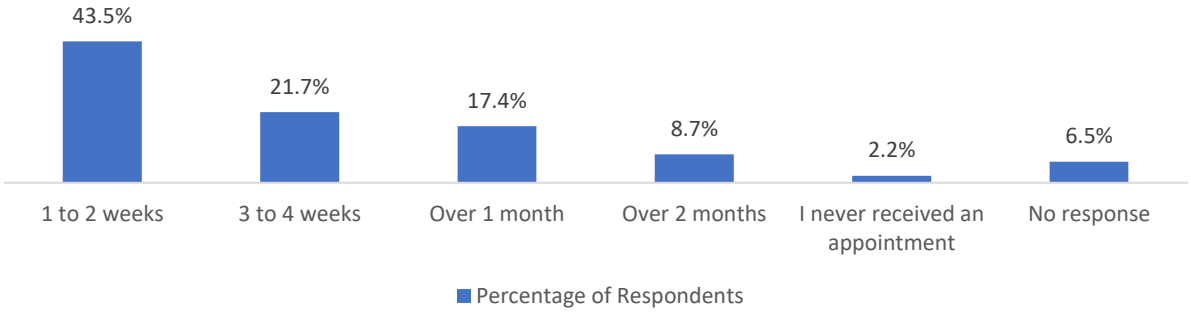


Figure 151: How long did it take to travel to the service?

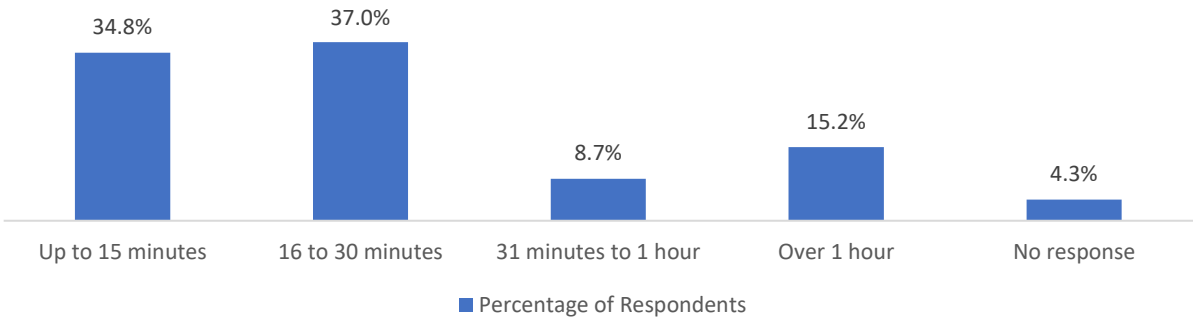


Figure 152: How do you travel to get services?

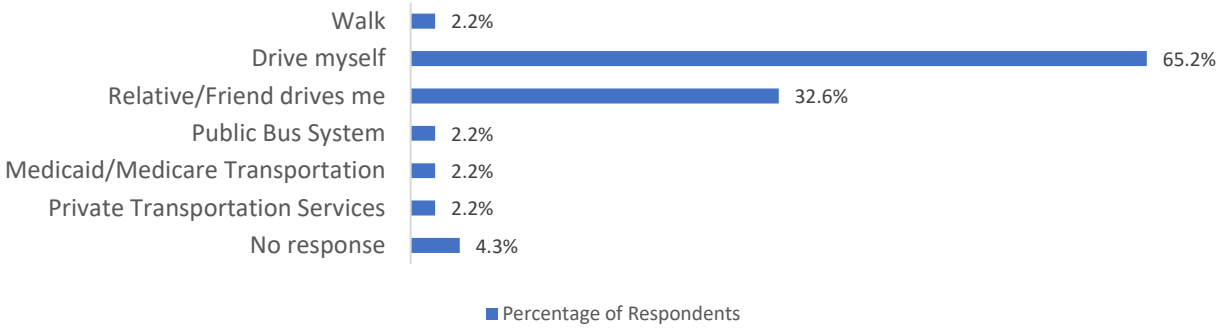
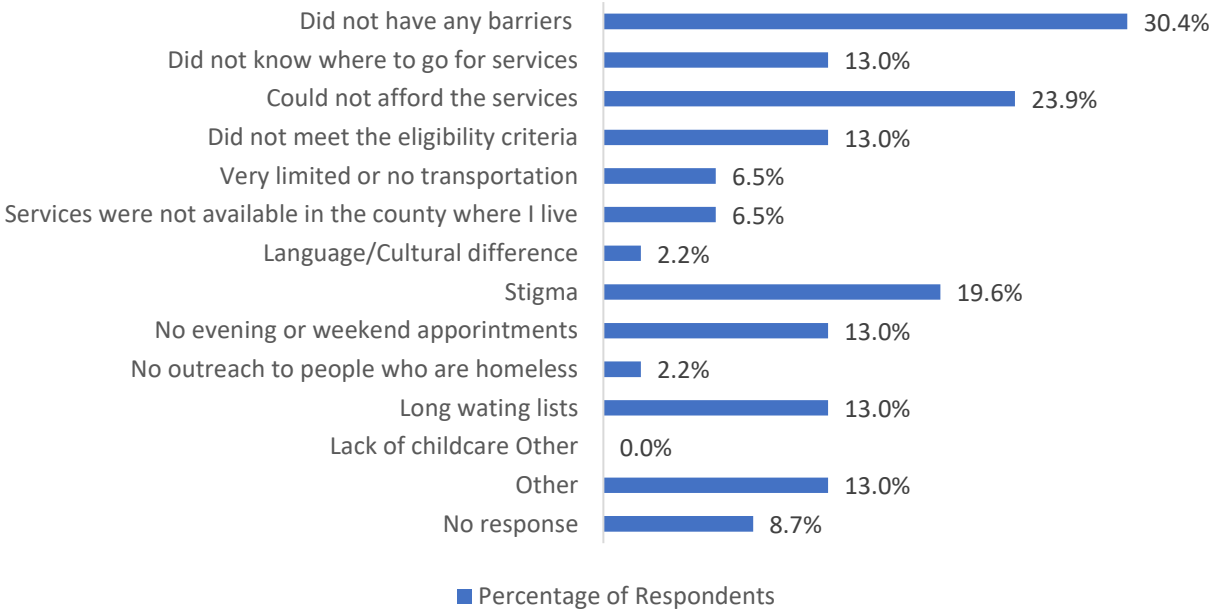


Figure 153: What were the obstacles you experienced getting the care you needed?



STAKEHOLDER SURVEY SUMMARY

INTRODUCTION

To help improve the behavioral health system of care, NWFHN developed and distributed a survey to elicit feedback from a wide range of stakeholders including health care providers as well as state, local, and community organizations and agencies. The focus of this survey was stakeholder awareness and experience concerning behavioral health care services in the service area.

The survey instrument was comprised of 20 questions regarding the scope of available services, awareness of, access to, and utilization of available services, quality of care, and service gaps. Responses were structured as yes/no, single- and multi- select multiple choice, and Likert Scale items.

Ordinarily, this type of survey would be conducted in person throughout the community. However, due to concerns and limitations attributable to COVID-19, NWFHN decided that online data collection from a convenience sample would be more appropriate at this time. A link to the online survey was e-mailed to a broad range of stakeholders and a total of 97 responded.

Survey data were downloaded into an Excel spreadsheet and analyzed by the planning team. Descriptive frequencies were calculated, numerous tables, and graphs were developed to illustrate the data. Findings were presented to and discussed with NWFHN and integrated into the assessment.

SUMMARY OF FINDINGS

When respondents were asked to select the service sector(s) which best describes their respective organizations, they identified 20 service sectors. The most frequently selected sectors were school (elementary, middle, or high school) at 13.9 percent, unhoused services (12.4 percent), case management (10.4 percent), and children serving agency (7.7 percent). Smaller percentages of respondents cited a wide range of sectors such as adult mental health care and social services. More than a quarter, 25.8 percent, selected (but did not specify) other sectors that were not included in the survey list. It should be noted that many stakeholders provided services to more than one sector. The denominator was the total number of responses not the total number of respondents.

Respondents indicated that every county in the service area is provided behavioral health services and stakeholders served more than just one county. There were more services available in Bay and Calhoun counties when compared to other counties in the service area. Among counties with the least services were Escambia, Gadsden, Jefferson, Leon, Santa Rosa, and Taylor.

Most respondents, 82.5 percent, agreed or strongly agreed that they are aware of the availability of mental health and substance use services in their area.

Slightly more than half of respondents, 51.5 percent, indicated they are aware of NWFHN resources, 17.7 percent had accessed NWFHN resources in the past 6 months, and 16.5 percent said the resources were helpful. Of the 17 who said they had accessed NWFHN resources in the previous six months, 16 said the services were helpful. When asked if they had ever directed an individual to access NWFHN by calling or online, 22.7 percent said they had.

Nearly 60 percent of respondents indicated they are aware of 2-1-1 information and referral service, 22 percent had accessed this service in the previous 6 months, and 17.6 percent said it was helpful. Of the 22 who said they had accessed 2-1-1 in the previous six months, 17 said the service was helpful. When asked if they had ever directed individuals to 2-1-1 by calling or online, 39.2 percent of all respondents (65.5 percent of those who were aware of 2-1-1) said they had done so.

The most frequently identified crisis response models in respondents' respective areas were mobile response teams (43.3 percent), behavioral health response teams (28.9 percent), mobile crisis response team (21.6 percent), and school district mobile response teams (16.5 percent). Sixteen respondents cited more than one response model and 25 did not respond to this question.

Most respondents, a total of 80.4 percent, rated community awareness of behavioral health treatment services in their area as very good (13.4 percent), good (26.8 percent), or fair (40.2 percent).

Nearly two-thirds of respondents, a total of 61.9 percent, agreed or strongly agreed that linkages to needed services are coordinated and well established across the system of care. More than two- thirds, a total of 68 percent, agreed or strongly agreed that behavioral health care and peer services are accessible in their area.

Two-thirds, 65.9 percent, agreed or strongly agreed that the processes for referrals are easily accessible, and nearly two-thirds, 62.9 percent, agreed or strongly agreed that programs and services are coordinated across the system of care.

From a list eleven barriers to access, the most frequently cited barriers included the following: no or very limited transportation at 73.2 percent; 57.7 percent said consumers did not know where to go for services; 52.6 percent said consumers could not afford the services; 38.1 percent cited stigma (worried what people would think, fear, shame), and long waitlists. Only 10 (10.3 percent) respondents identified only one barrier and 4 respondents said they did not have any barriers.

Respondents described a wide range of resources and services needed to facilitate integration of behavioral health care, primary care, specialty care, dental health care, transportation, safe housing, follow up via navigation, and wrap-around services, especially in minority, rural, and low- income communities. Specific services included Medication Assisted Treatment (especially in rural areas), assistance with SSDI, Medicaid, and ACA applications. Other needed services included housing, transportation, food, and employment. Also, adequate funding is needed to recruit and retain quality providers, including diverse providers that "look like" consumers.

The types of patient-centered care resources and services that have improved quality of life of individuals included, school-based services, mobile crisis response services, and community-based providers.

STAKEHOLDER SURVEY CHARTS

Figure 154: Percentage of respondents by organization service sector.

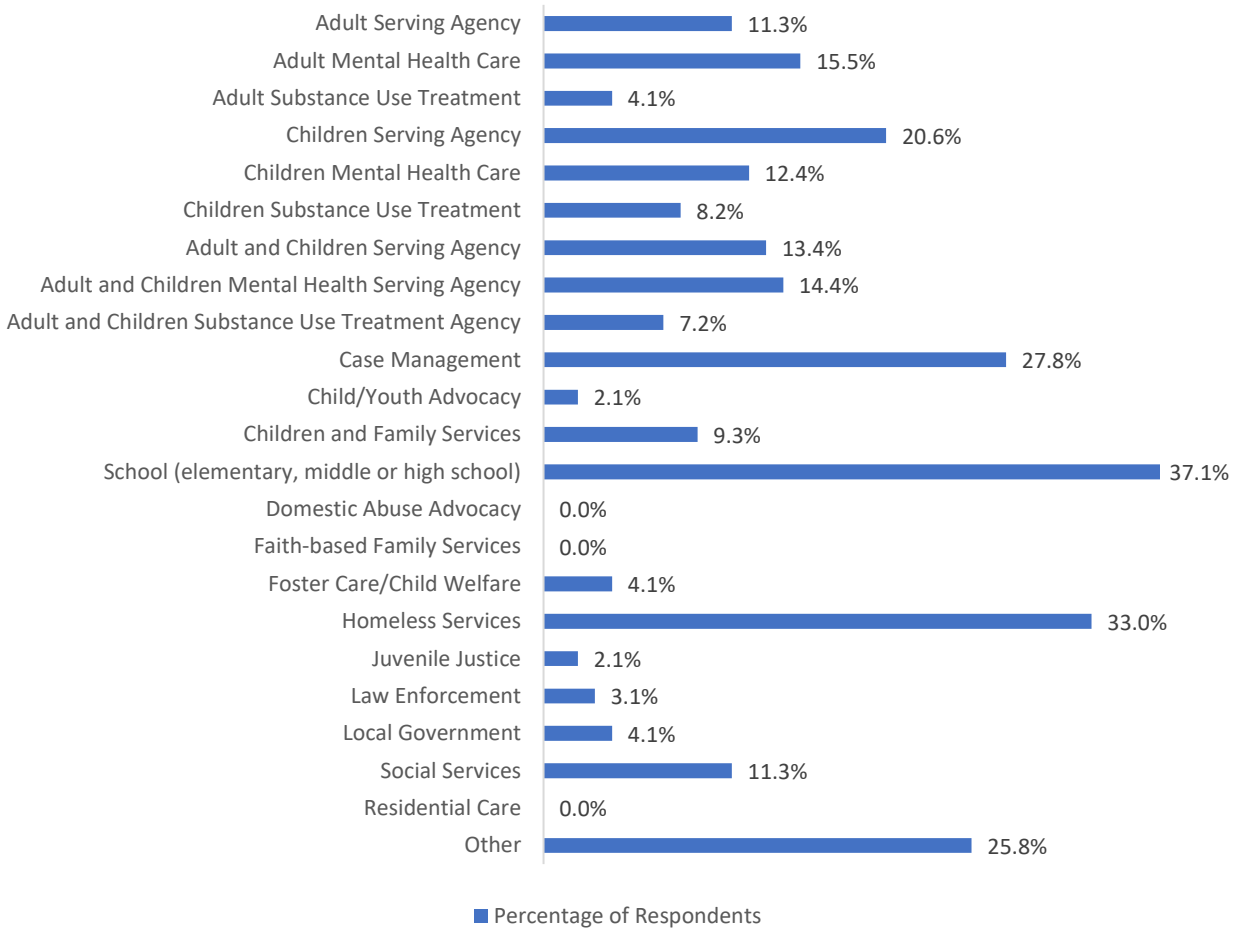


Figure 155: Percentage of stakeholder respondents by county.

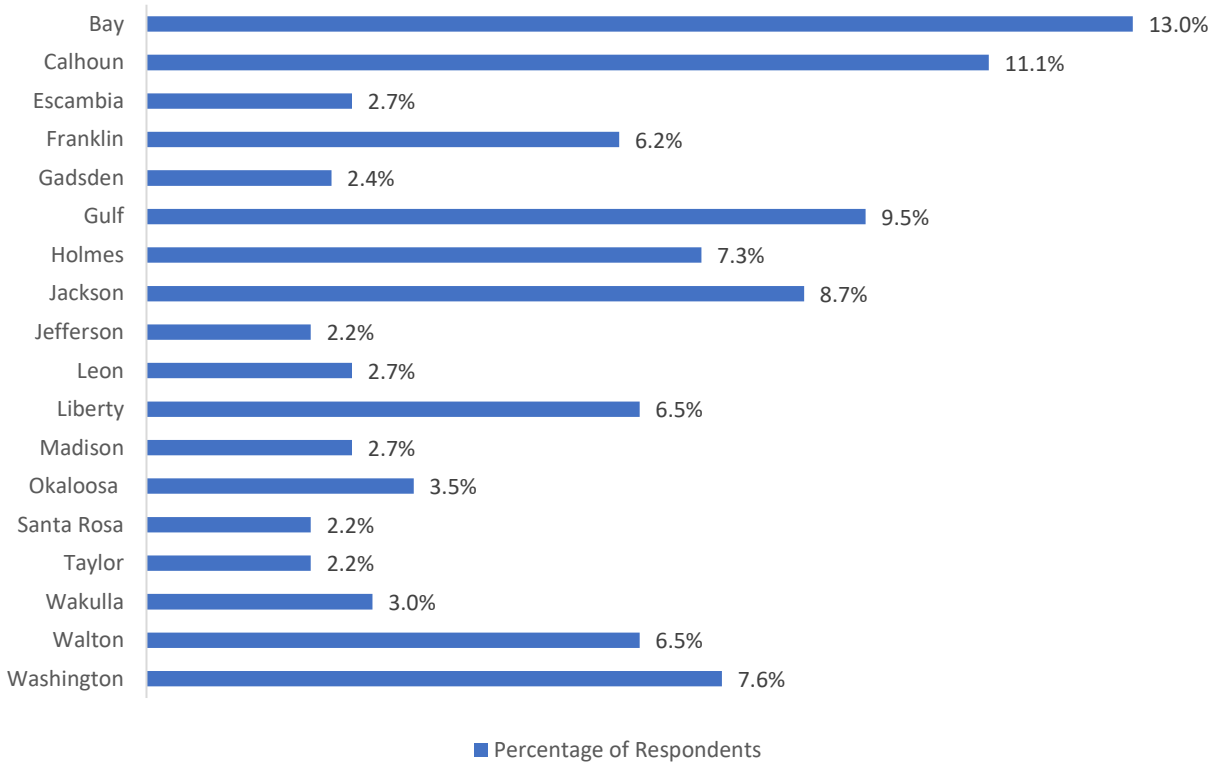


Figure 156: You are aware of the availability of mental health and substance use services in your area.

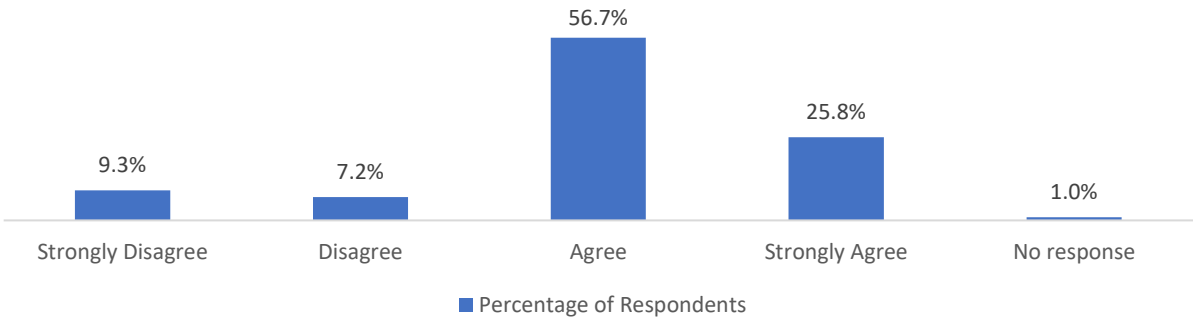


Figure 157: Are you aware of Northwest Florida Health Network (Managing Entity) resources?

Figure 158: Have you accessed Northwest Florida Health Network (Managing Entity) resources in the past 6 months?

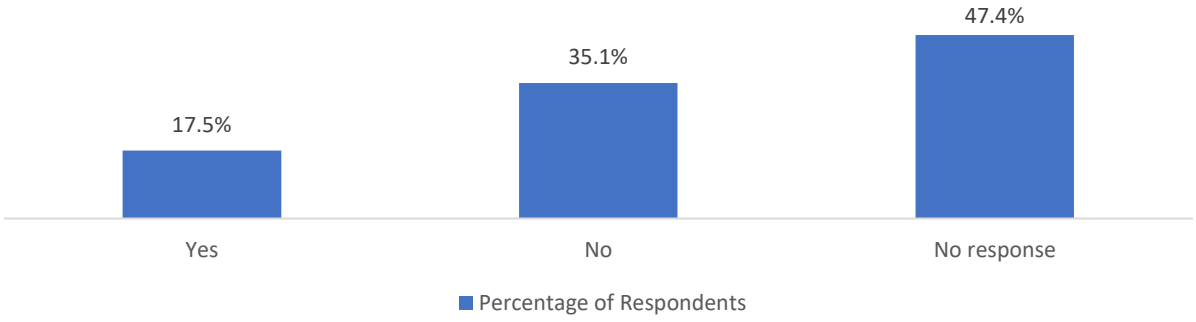


Figure 159: When you accessed Northwest Florida Health Network (Managing Entity) resources, was it helpful?

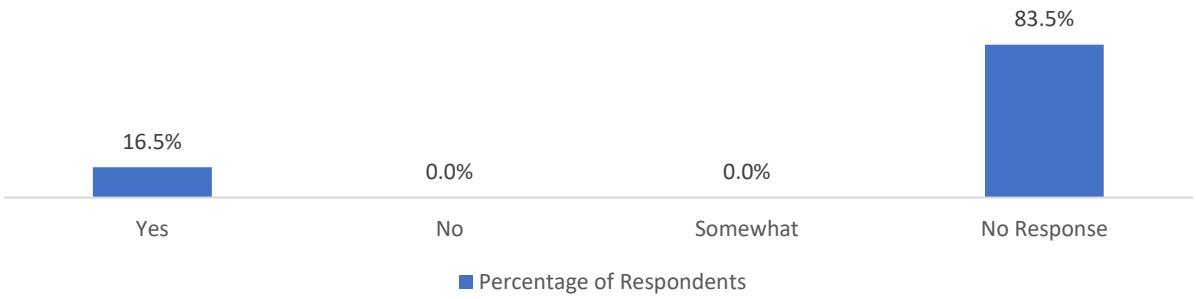


Figure 160: Have you ever directed individuals to access Northwest Florida Health Network (Managing Entity) by calling or online?

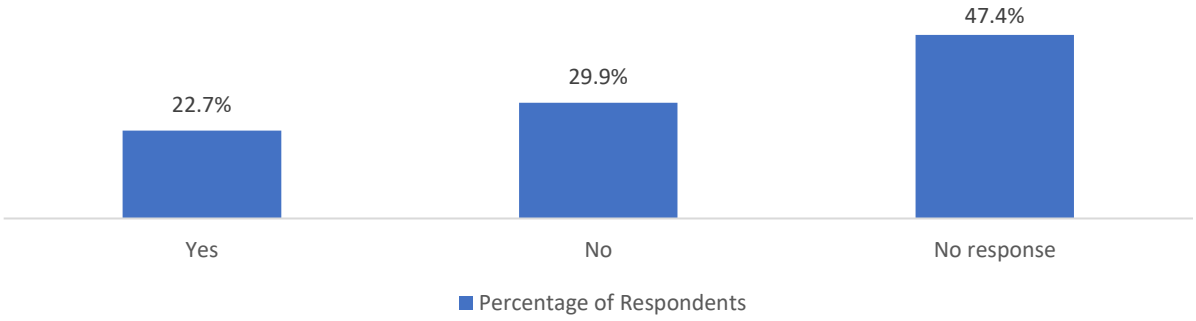


Figure 161: Are you aware of the 2-1-1 Information and Referral Resource?

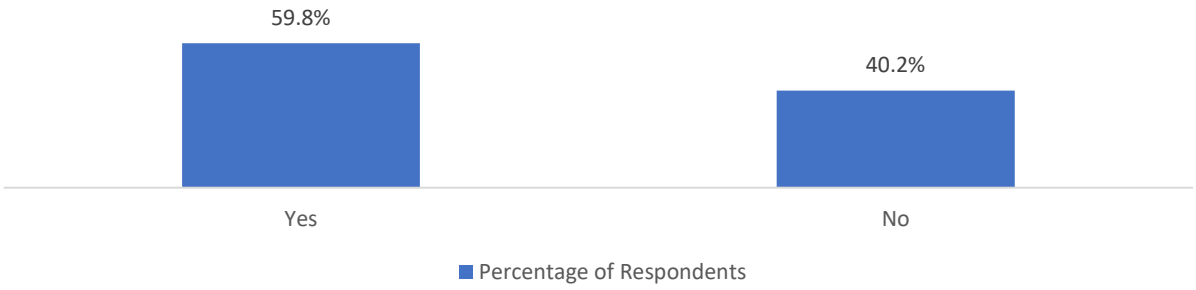


Figure 162: Have you accessed the 2-1-1 Information and Referral Resource in the past 6 months?

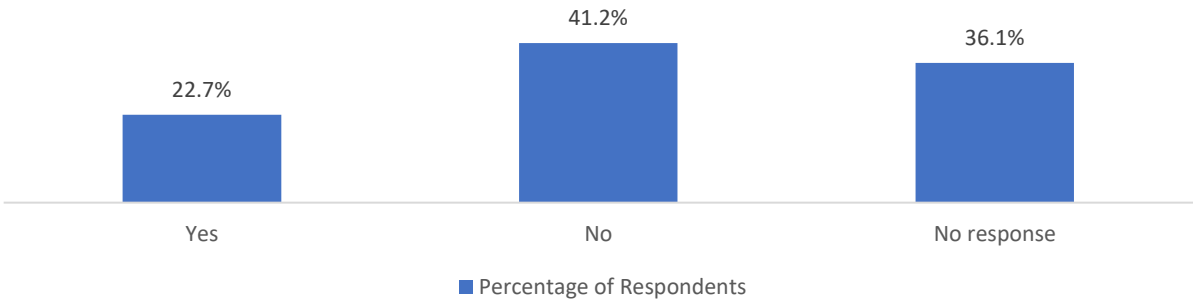


Figure 163: When you accessed the 2-1-1 Information and Referral Resource, was it helpful?

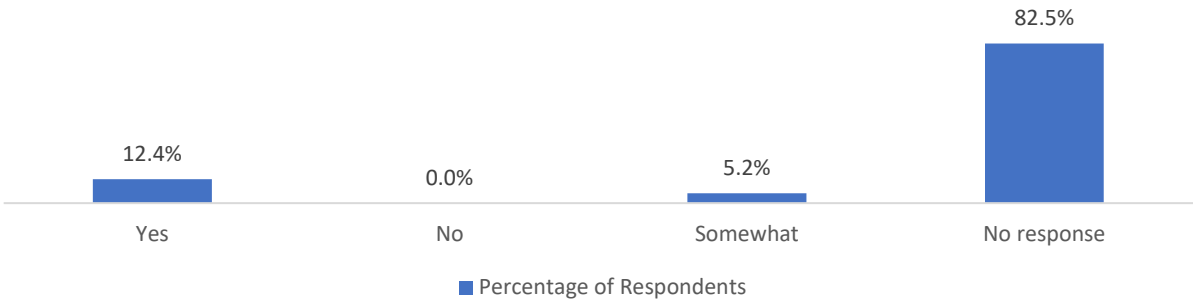


Figure 164: Have you ever directed individuals to access the 2-1-1 Information and Referral Resource by calling or online?

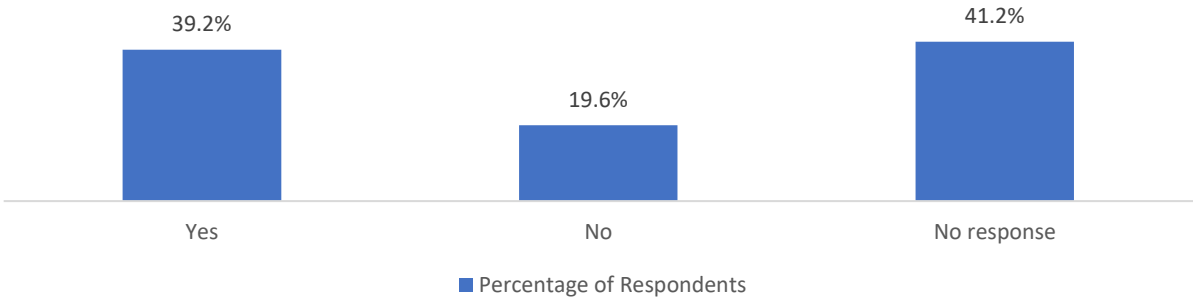


Figure 165: Select the crisis response model in your area. (Check all that apply)

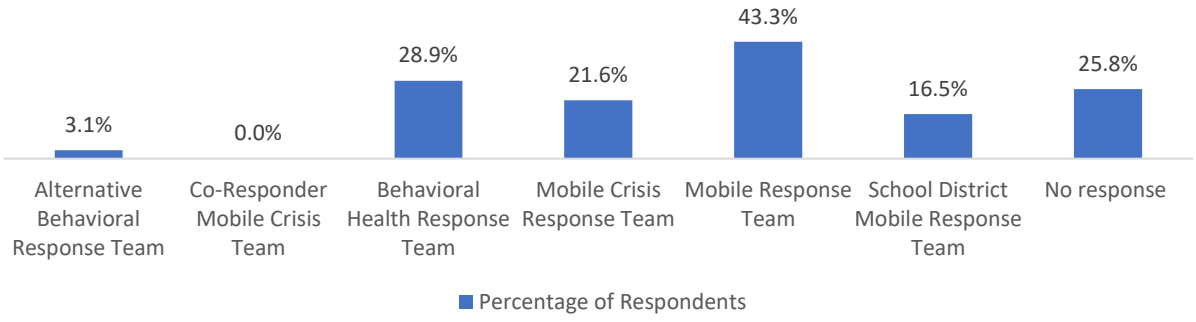


Figure 166: How would you rate community awareness of mental health and substance use treatment services in your area?

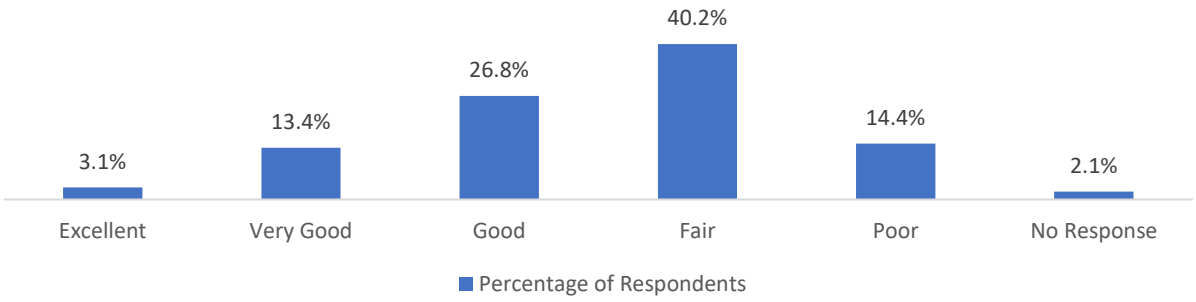


Figure 167: Linkages to needed services are coordinated and well established across the system.

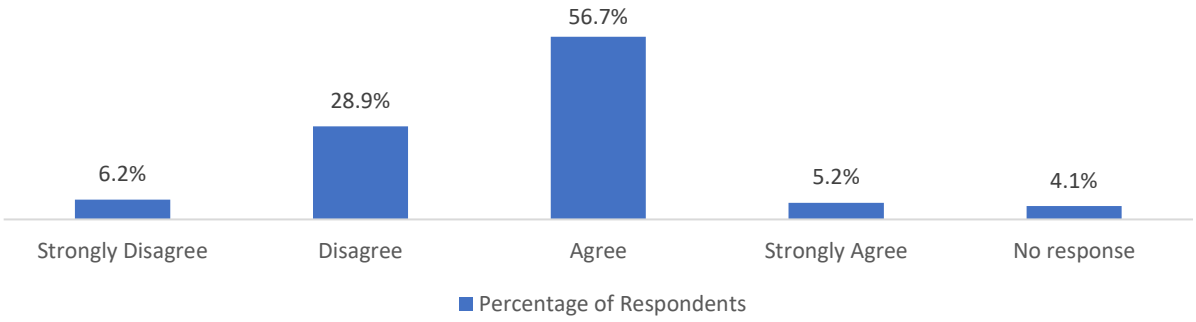


Figure 168: In general, behavioral health care and peer services are accessible in your area.

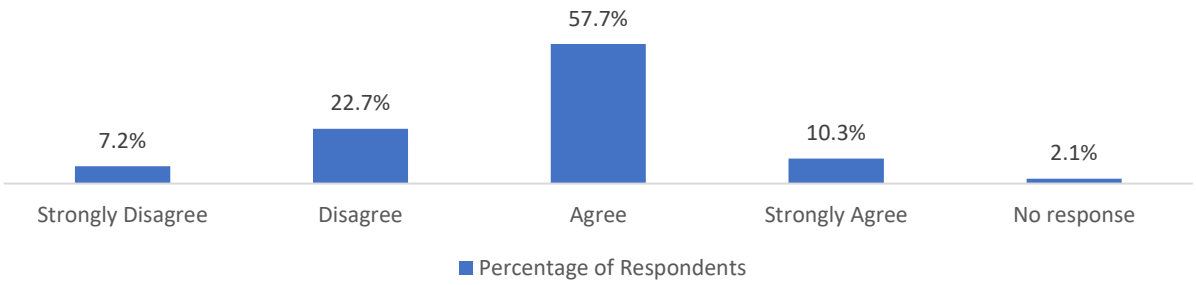


Figure 169: The process for referrals is easily accessible.

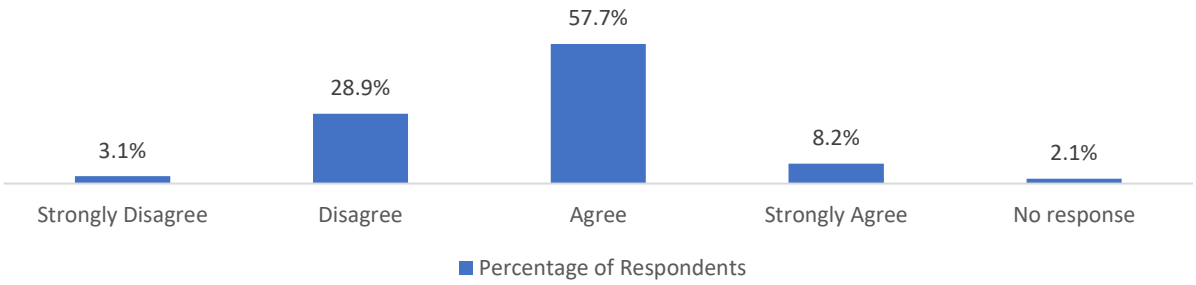


Figure 170: Programs and services are coordinated across the system of care.

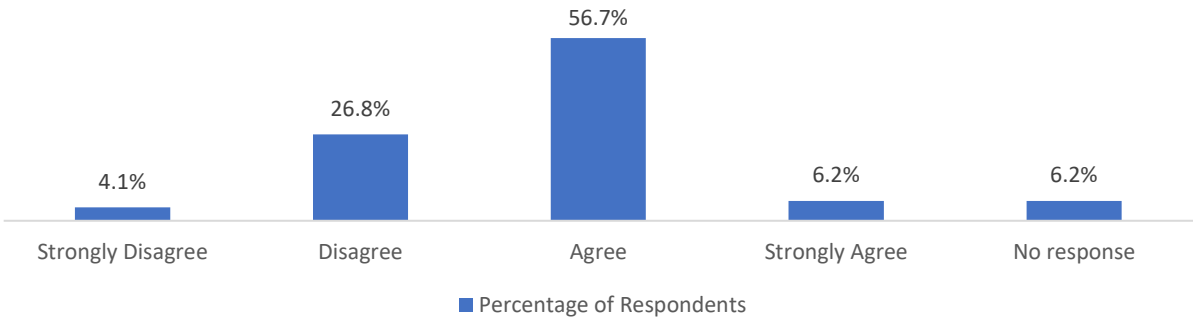


Figure 171: List the barriers for consumers accessing services in your community. (Check all that apply)

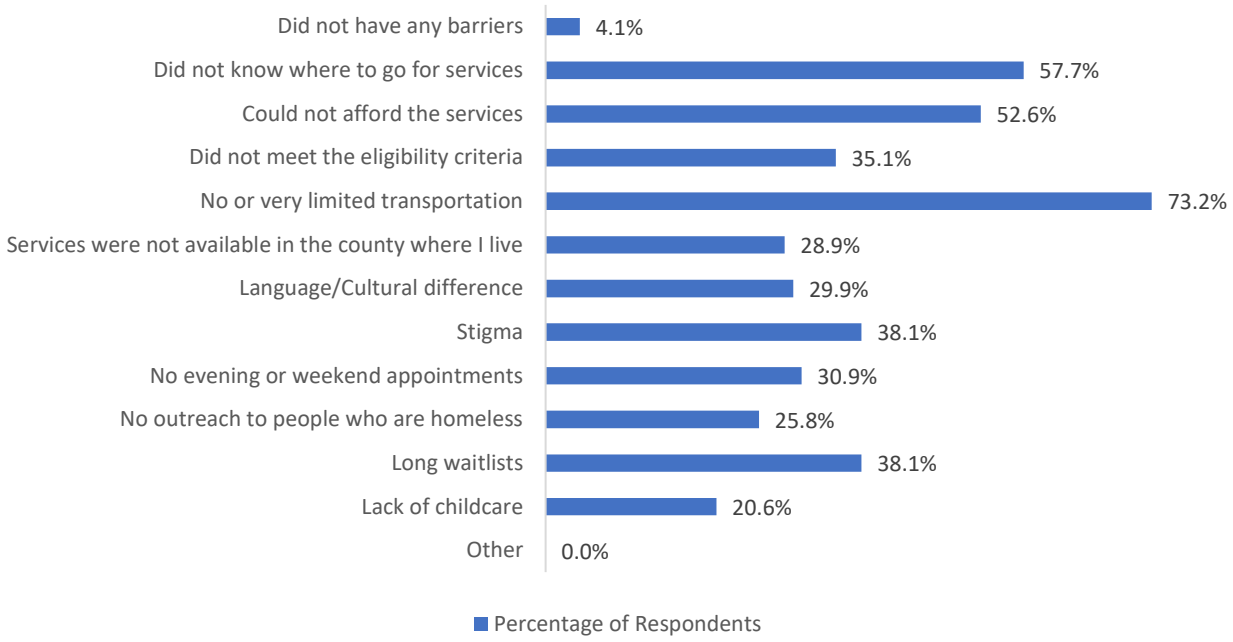


Figure 172: List the resources and services needed that are not available to improve patient-centered care and planning.

Needed Resources and Services
Medication Assisted Treatment (MAT)
Community-based services other than telehealth
Accessible up-to-date information regarding available services, especially in rural areas.
Adequate access to services in minority, rural, and low-income communities.
Safe, affordable housing
Assistance with SSDI, Medicaid, ACA applications and other needed services (e.g., housing, transportation, food, employment, etc.).
Services for families with children, e.g., behavioral analysis, intensive outpatient, residential treatment, inpatient substance use treatment for teens, Autism screening and treatment, human trafficking resources and support for teens, outreach via schools, respite for parents.

Medicaid and other funding for providers to integrate behavioral health care, primary care, specialty care, dental health care, and follow-up via navigation and wrap-around services.
Adequate funding to recruit and retain quality providers, including diverse providers that "look like" consumers.
Integration of behavioral health care, primary care, specialty care, dental health care, transportation, housing, and follow-up via navigation and wrap-around services, especially in minority, rural, and low-income communities.

Figure 173: List the top three patient-centered care resources that have improved quality of life for individuals.

TOP THREE PATIENT-CENTERED RESOURCES
School-based Services
Mobile Crisis Response Services
Community-based Providers

PEER RECOVERY COMMUNITY/SUPPORT SPECIALIST'S SURVEY SUMMARY

INTRODUCTION

NWFHN focuses policy, procedures, and monitoring process to ensure Recovery Oriented System of Care (ROSC) principles are integrated with service delivery.

To help improve the behavioral health system of care, NWFHN developed and distributed a survey to elicit feedback from peer recovery community/support specialists. Learning from their experiences and perspectives will help to improve the behavioral health system of care in Northwest Florida.

The 18-question survey was structured as yes/no, single- and multi- select multiple choice, and Likert Scale items. Ordinarily, this type of survey would be conducted in person. However, due to concerns and limitations attributable to COVID-19, NWFHN decided that online data collection would be more appropriate at this time. A link to the on-line survey was e-mailed to peer recovery community/peer support specialists. A total of 30 peer specialists responded to this survey.

Survey data were downloaded into an Excel spreadsheet and analyzed by the planning team. Descriptive frequencies were calculated by dividing the number of responses by the total number of respondents; numerous tables, and graphs were developed to illustrate the data. Findings were presented to and discussed with NWFHN and integrated into the assessment.

SUMMARY OF FINDINGS

Most survey respondents, 63.3 percent, described their behavioral health experience as adults with lived mental health condition, and 13.3 percent described their experience as adults with lived co-occurring mental health and substance use condition. Smaller percentages described their experience as veteran with lived co-occurring mental health and substance use condition, or family member or friend with lived (behavioral health) condition(s). Because this question asked for respondents to select the type of experience that best describes their experience, these data do not describe whether respondents have had more than one type of experience.

The largest percentages of respondents lived in Bay County (43.3 percent), Okaloosa County (13.3 percent), and Holmes and Liberty Counties (10 percent each). Smaller percentages lived in Calhoun, Escambia, Jackson, Leon, Santa Rosa, and Walton counties.

Respondents were asked to describe all the types of service agencies by which they are employed/ volunteered. Thirteen respondents identified more than one type of service agency. The most frequently mentioned types of agencies were adult mental health services (50 percent), followed by peer support services (43.3 percent), and adult substance use services (30 percent). Prevention services and recovery community organizations were each mentioned by 23.3 percent of respondents. Smaller percentages of respondents identified child mental health services, family/peer organizations, and other types of agencies.

Nearly half, 46.7 percent, of respondents indicated they have been employed/volunteered with their agency more than 3 years. An additional 30 percent indicated they have been employed or volunteered with their agency one to two years.

Two-thirds, 66.7 percent, of respondents' work schedules average 40 hours per week. An additional 20 percent worked more than 40 hours per week, 13.3 percent worked 20 hours per week or less, and 10 percent work up to 10 hours per week.

Most respondents, 83.3 percent, indicated that the agency where they are employed/volunteered, utilize recovery peer support services within the services they provide in the community. Another 10 percent were not sure if recovery peer support services were utilized. When asked if their agency adheres to recovery support best practices, 70 percent said yes, and 13.3 percent were not sure.

When asked to describe their qualification status, 53.3 percent said they were a Certified Recovery Peer Specialist (CRPS). An additional 30 percent said they applied for

certification and were in process.

When asked to select the facility/program setting that best describes where they deliver services, respondents identified 26 different settings, and eight respondents mentioned two or more settings. The most frequently cited settings were, Outpatient Recovery Community Organization (RCO) at 23.3 percent, followed by child serving organization at 16.7 percent, and family/peer grassroots organizations at 16.7 percent. Detoxification and medication assisted treatment settings were each mentioned by 13.3 percent of respondents. In addition to those listed in the survey question, "Other" facilities/programs mentioned were, Transitional Resource Center, CAT, CDAC, EPIC, in-home case management, 90 percent of the above, MHA, school and private, and state government.

Most respondents, 60 percent, cited personal fulfillment as one of the reasons/factors for staying with their current company. Forty percent said flexibility with work schedule and 33.3 percent indicated commitment to recovery principles. Work hours (30 percent), administrative support (23.3 percent), and competitive salary (16.7 percent), were also identified as important factors. Nearly half, 46.6 percent, identified two or more reasons/factors.

The most frequently identified barriers/challenges experienced in the hiring process were salary (56.7 percent), volunteer hours (26.7 percent), limited employment opportunities (23.3 percent), and exemption/background screening process (10 percent). Six respondents identified two or more barriers/challenges.

Respondents were asked to identify what training they would recommend for a peer to have to help them provide peer support services. From a list of fourteen types of training, all types were identified by at least 30 percent of respondents and eleven types were identified by more than 50 percent of all respondents. The most frequently cited trainings were 40-hour required Peer Recovery Specialist training/Helping Others Heal (90 percent), Wellness Recovery Action Plan (WRAP) 80 percent), Compassionate Fatigue/Self-care (76.7 percent), and Mental Health First Aid (70 percent). All respondents cited two or more trainings.

When asked if there are partnerships that exist with peer support recovery programs, recovery community organizations and other support groups, 63.3 percent said yes, 6.7 percent said no, and 30 percent said they weren't sure.

Respondents were asked about partnerships with other organizations that provide resources. Most respondents were aware of two or more of the thirteen types of resources listed in the survey question. The most frequently identified resources were food pantry/meal programs and church/faith-based organizations identified by 56.7 percent of respondents, Career source/employment agencies by 50 percent, child welfare services by 46.7 percent, health department and Recovery Community Organizations (RCOs) by 43.3 percent, and housing (halfway housing, 30 percent and Oxford Homes 36.7 percent).

Nearly two-thirds, 63.3 percent, of respondents said they have the ability to offer choices to the individuals they serve at the agency at which they are employed/volunteer, 23.3

percent said they cannot, and 13.3 percent said they aren't sure.

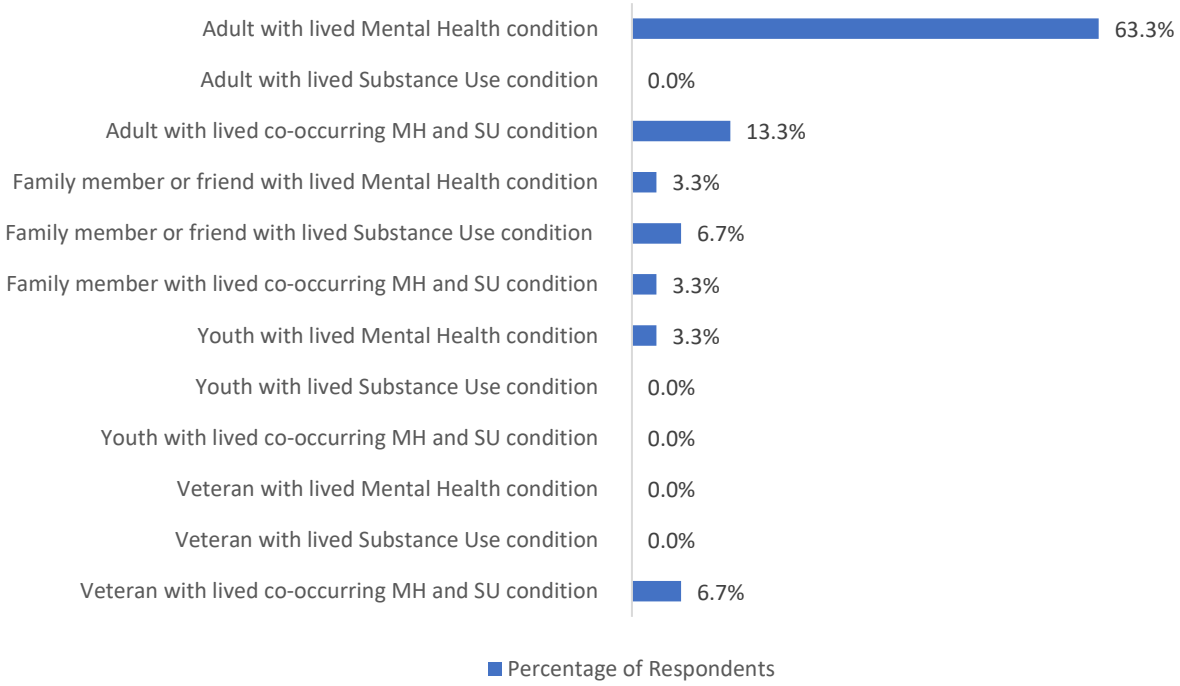
When asked if the organization where they are employed/volunteer helps reduce stigma by promoting recovery language that is patient centered, 73.3 percent said yes, 6.7 percent said no, and 20 percent said they are not sure.

Most respondents, 60 percent, said that the agency where they are employed/volunteer includes peers in developing and promoting affective program development, evaluation, and improvement; 20 percent said no, and 20 percent said they are not sure.

When asked if the agency where they are employed/volunteer includes persons in recovery in management and board meetings, less than half, 43.3 percent, said yes, 26.7 percent said no, and 30 percent said they are not sure.

PEER RECOVERY COMMUNITY/SUPPORT SPECIALISTS SURVEY CHARTS

Figure 174: Which best describes your experience?



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

Figure 175: Which county do you live in?

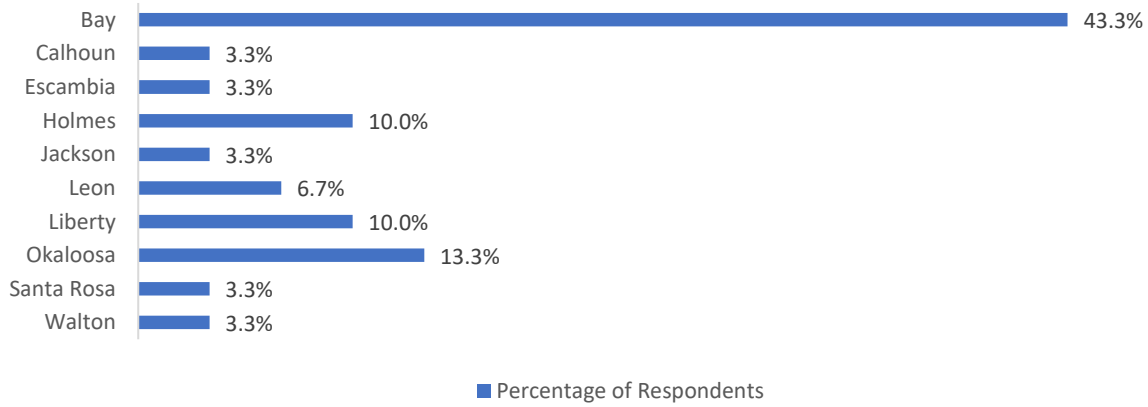


Figure 176: What type of service are you employed or volunteer with? (Check all that apply)

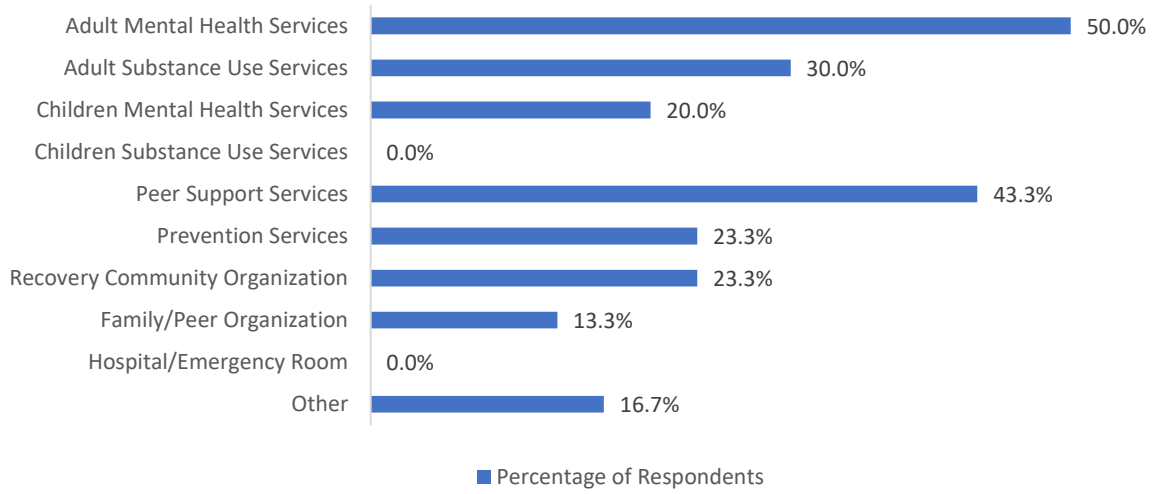


Figure 177: How long have you been employed/volunteered with the agency?

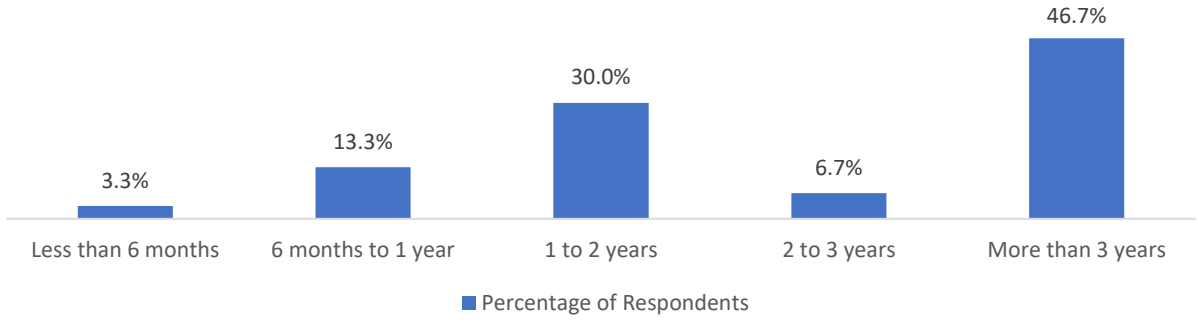


Figure 178: My work schedule averages...

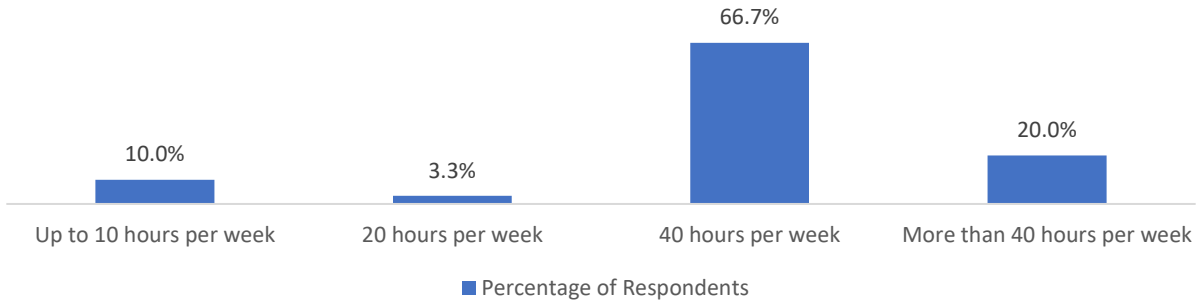


Figure 179: Does the agency where you are employed, or volunteer, utilize recovery peer support services within the services they provide in the community?

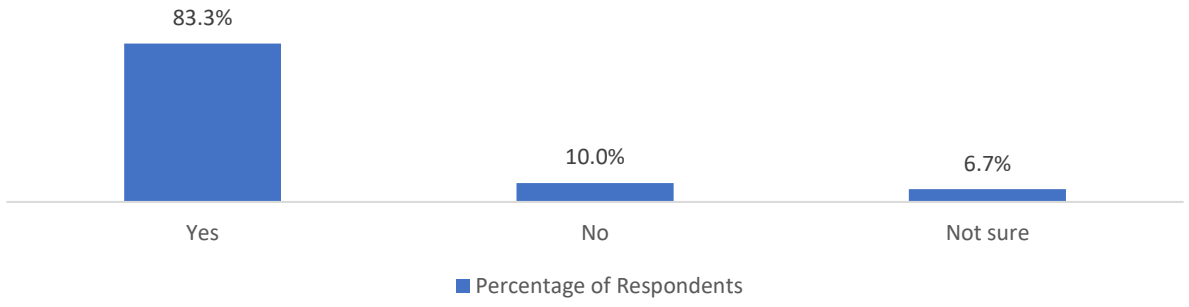


Figure 180: Does the agency where you are employed, or volunteer, adhere to recovery support best practices?

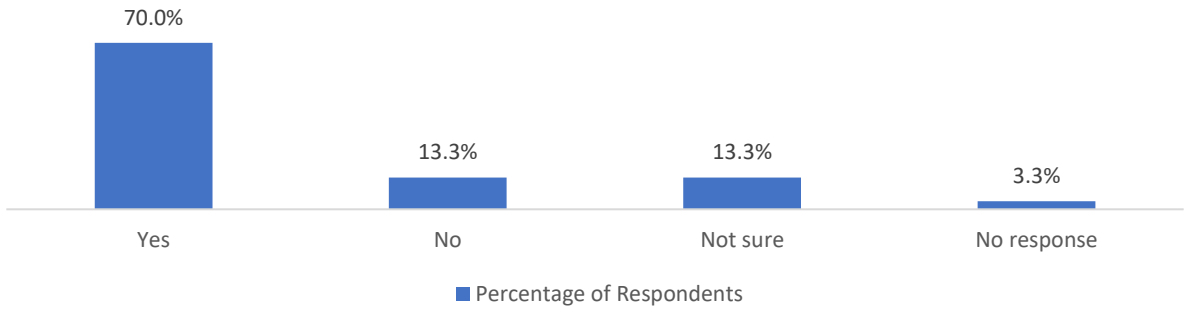


Figure 181: Please indicate the qualifications that best describe your status. (Check all that apply)

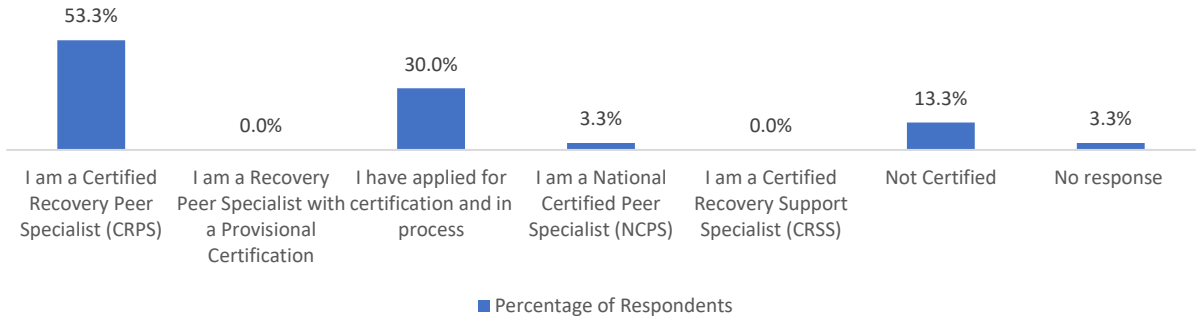


Figure 182: Please indicate the facility/program setting(s) that best describes where you deliver peer recovery support services. (Check all that apply)

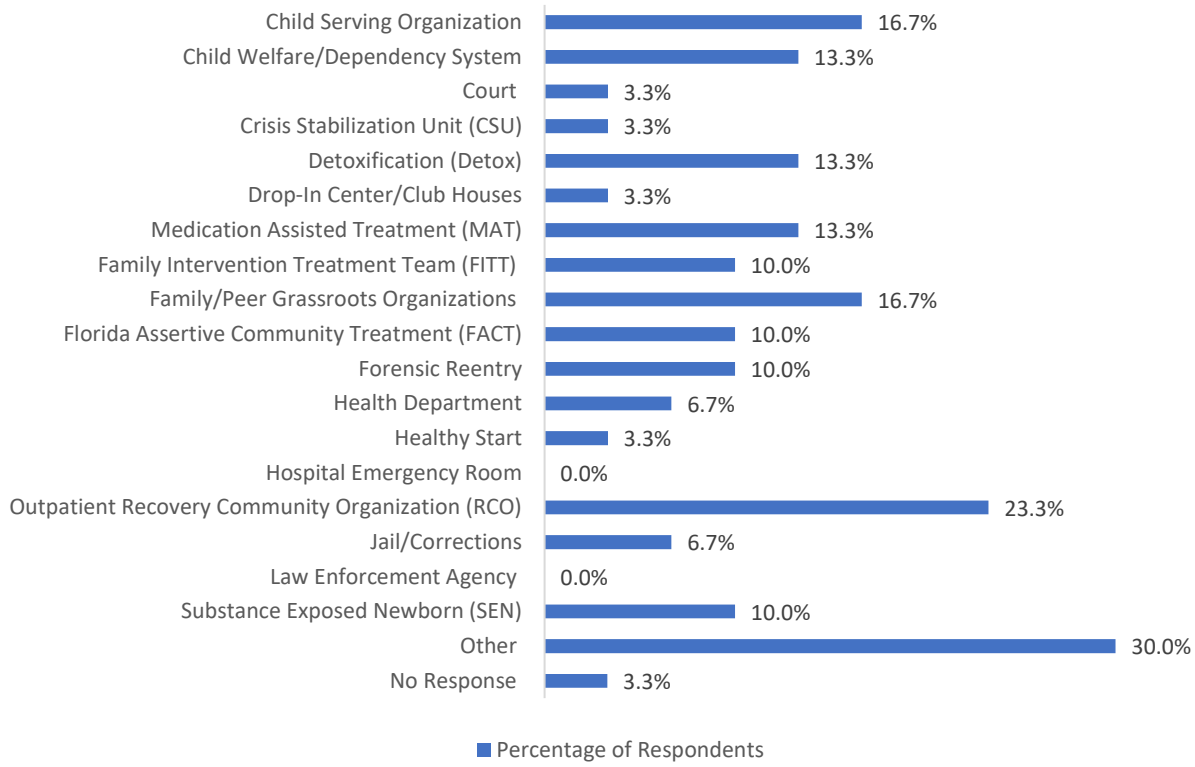


Figure 183: What are the reasons/factors for staying with the company? (Check all that apply)

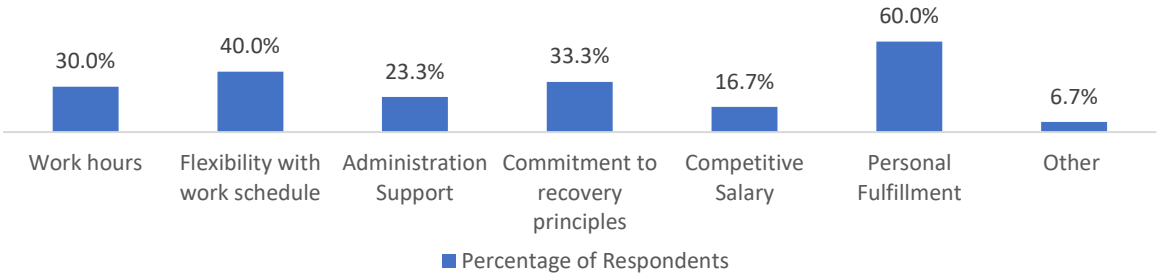


Figure 184: What barriers/challenges have you experienced in the hiring process? (Check all that apply)

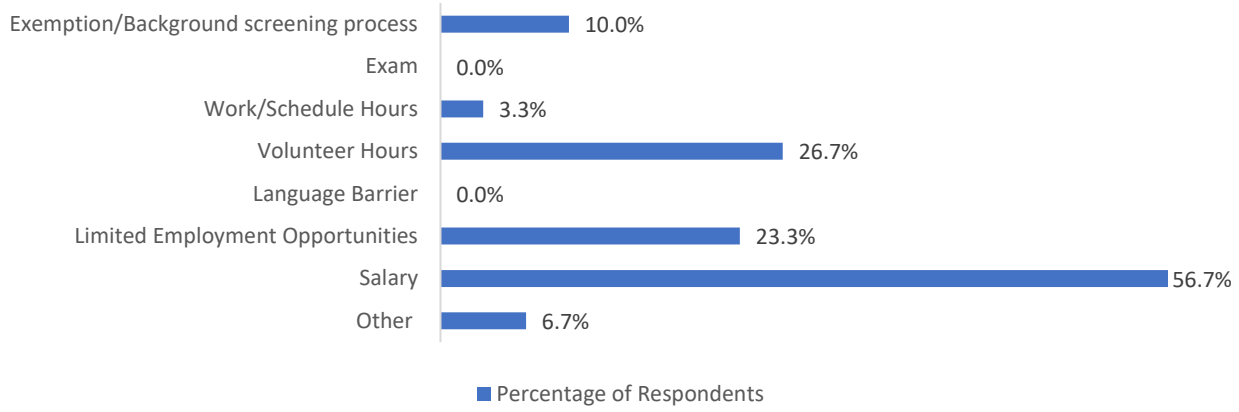
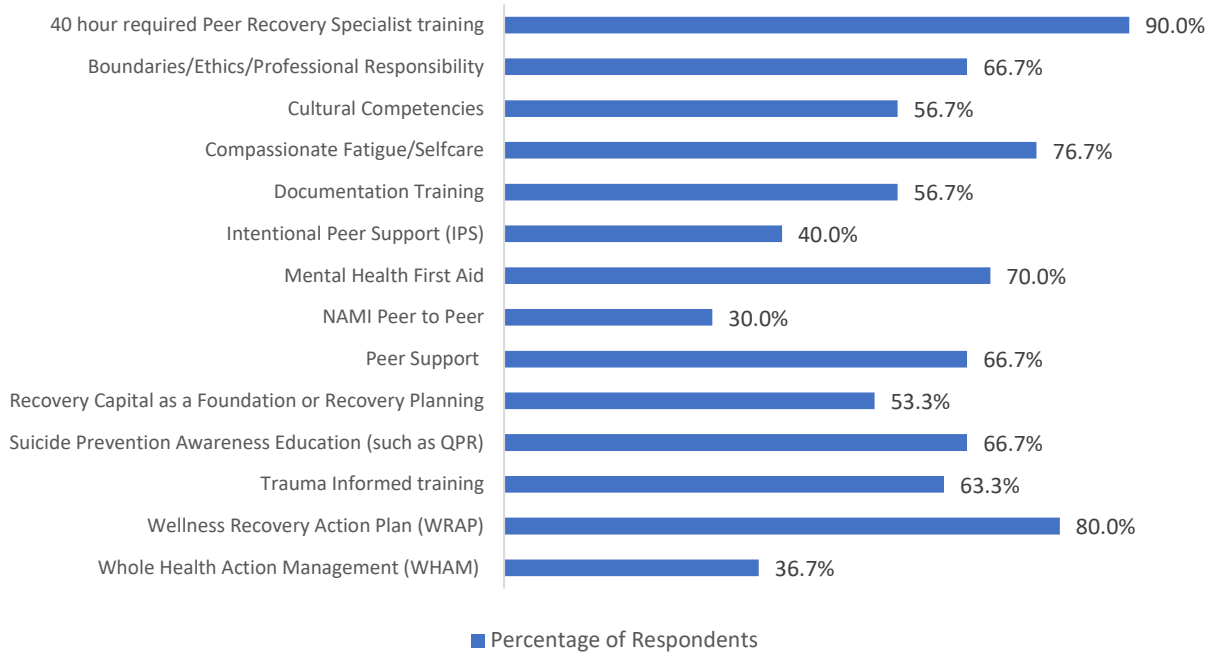


Figure 185: What training would you recommend for peers to have to help them provide peer support services? (Check all that apply)



Note: 40 hour required Peer Recovery Specialist Training/Helping Others Heal

Figure 186: Are there partnerships that exist with peer support recovery programs, recovery community organizations, and other support groups?

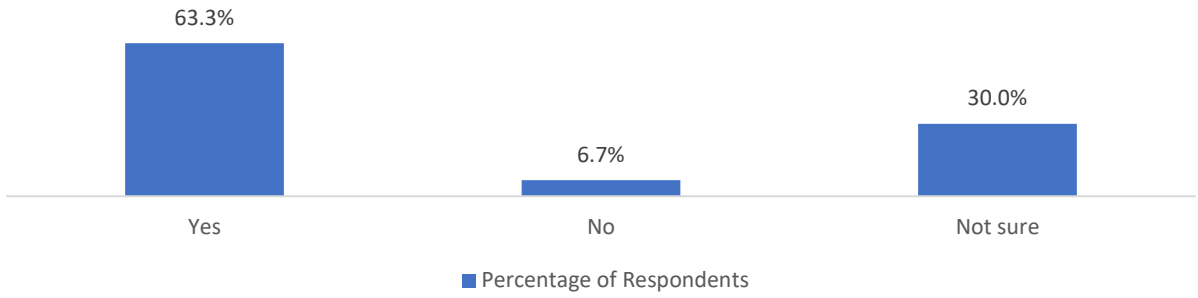


Figure 187: Are you aware of partnerships with other organizations that provide other resources such as: (Check all that apply)

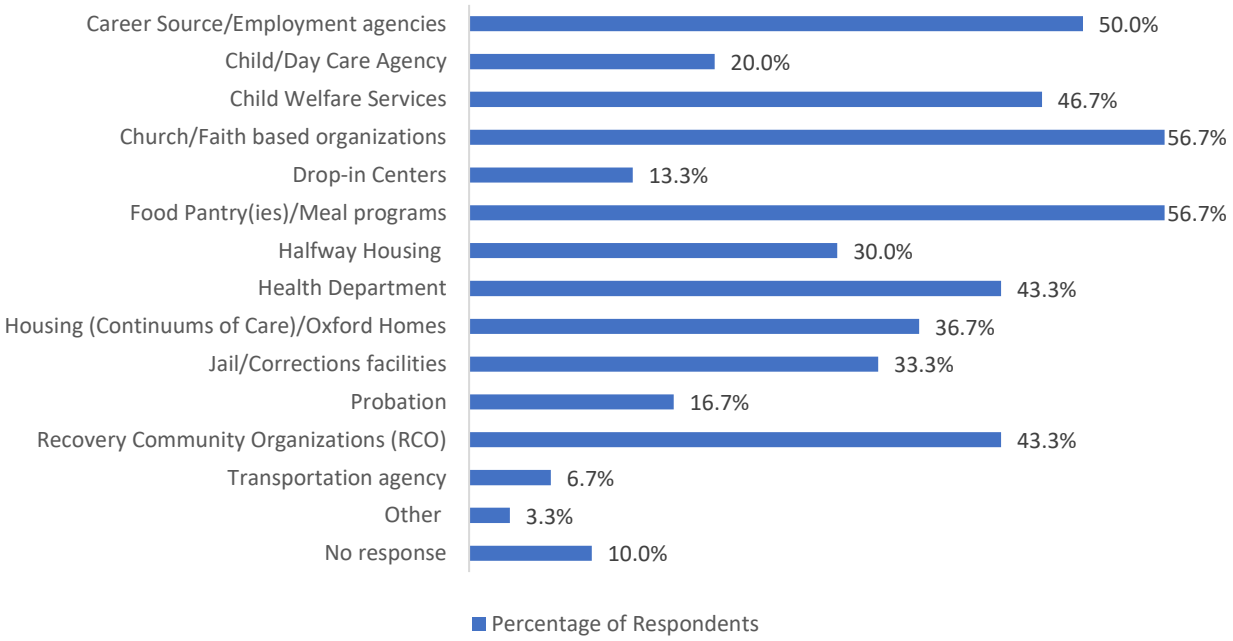


Figure 188: Do you have the ability to offer choices to the individuals where you serve at the agency you are employed/volunteer?

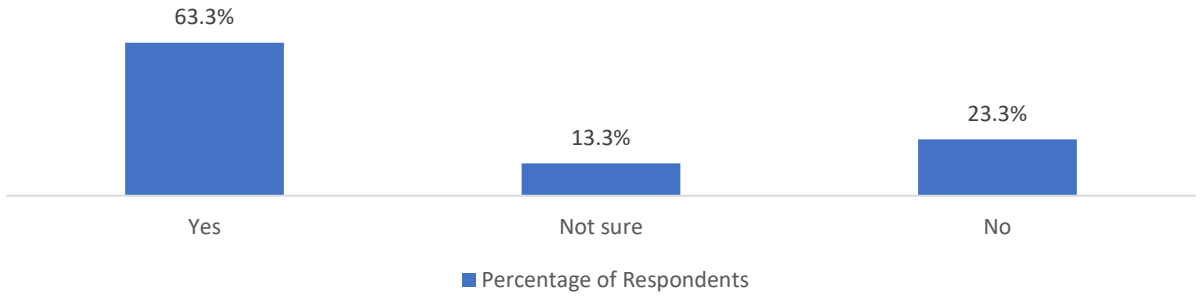


Figure 189: Does the organization where you are employed/volunteer with help to reduce stigma by promoting recovery language that is patient centered?

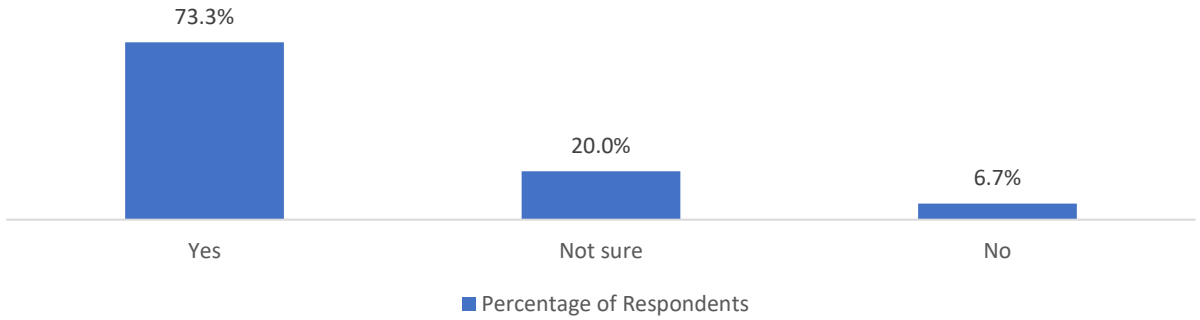


Figure 190: Does the agency where you are employed/volunteer include peers in developing and promoting effective program development, evaluation, and improvement?

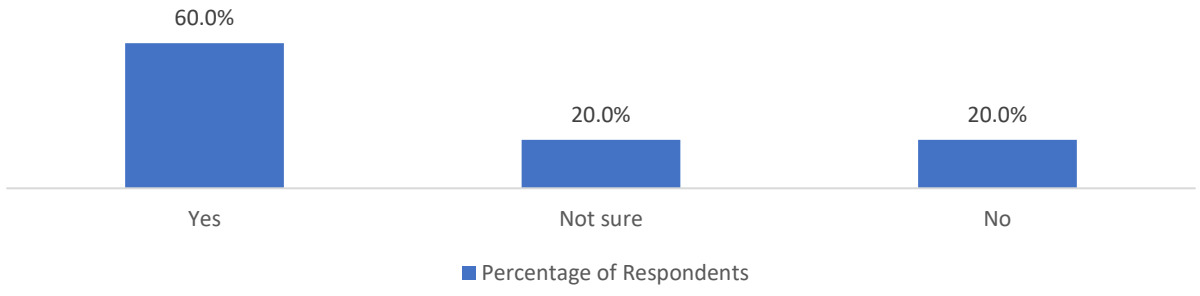
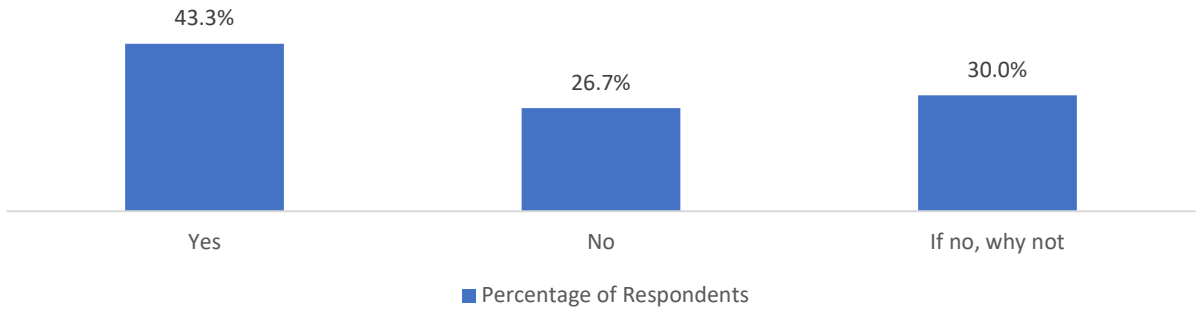


Figure 191: Does the agency where you are employed/volunteer with include persons in recovery management and board meetings?



RECOVERY RESOURCES

RECOVERY RESOURCES IN THE NORTHWEST REGION

Apalachee Center Inc.	Florida Therapy Services
Avalon Center of Lakeview	Journey Pure
Baptist Hospital	Lakeview Center Inc.
Bayshore Retreat LLC	Life Management Center
Blue Spring Outpatient Center	New Season Treatment Center
Bridgeway Center Inc.	New Season Pensacola
Century Clinic	Okaloosa Outpatient Center
Chemical Addictions Recovery Effort	Panhandle Comprehensive Treatment Center
Children's Home Society of Florida	Senior Enrichment
DISC Village Inc.	Treatment Center of Panama City
Gulf Breeze Recovery	Turn About Inc. of Tallahassee
Gulf Coast Addiction Medicine LLC	Twelve Oaks Recovery
Emerald Coast Behavioral Hospital	

If you are looking for more specific resources in your area, please contact 2-1-1.

REFERENCES

2022 State of Mental Health in America. (2022). Mental Health America.
2022 State of Mental Health in America.pdf (mhanational.org)

Dictionary.Com, LLC. (2022). Gender and Sexuality.
bigender Meaning | Gender and Sexuality | Dictionary.com

Behavioral Risk Factor Surveillance System. (2017-2019). Florida Department of Health.
Behavioral Risk Factor Surveillance System (BRFSS) | Florida Department of Health

Florida Youth Substance Abuse Survey. (2018-2020). Florida Department of Health.
Florida Youth Substance Abuse Survey | Florida Department of Health (floridahealth.gov)

Children Experiencing Child Abuse Ages 5-11. (2017-2019) Florida Department of Health.
Children Experiencing Child Abuse Ages 5-11 - Florida Health CHARTS - Florida Department of Health (flhealthcharts.gov)

Children Experiencing Sexual Violence Ages 5-11. (2017-2019). Florida Department of Health.
Children Experiencing Sexual Violence (Aged 5-11 Years) - Florida Health CHARTS - Florida Department of Health (flhealthcharts.gov)

Estimated Seriously Emotionally Disturbed Youth 9-17. (2018-2020). Florida Department of Health.
Estimated Seriously Emotionally Disturbed Youth 9-17 - Florida Health CHARTS - Florida Department of Health (flhealthcharts.gov)

Estimated Seriously Mentally Ill Adults. (2018-2020). Florida Department of Health.
Estimated Seriously Mentally Ill Adults - Florida Health CHARTS - Florida Department of Health (flhealthcharts.gov)

Florida's Council on Homelessness Annual Report 2021. (2021). Florida Department of Children and Families. 2021CouncilReport.pdf (myflfamilies.com)

Glossary of Terms. (2022). Human Rights Campaign.
Human Rights Campaign (hrc.org)

Students with Emotional/Behavioral Disability (K-Grade 12). (2018-2020). Florida Department of Health.
Students with Emotional/Behavioral Disability (Kindergarten - 12th Grade) - Florida Health CHARTS - Florida Department of Health (flhealthcharts.gov)

Suicide Deaths. (2018-2020). Florida Department of Health.
Suicide Deaths - Florida Health CHARTS - Florida Department of Health (flhealthcharts.gov)

Uniform Crime Report. (1992-2020). Florida Department of Law Enforcement.
UCR Domestic Violence (state.fl.us)

U.S. Census Bureau, American Community Survey. (2016-2020). Demographic and Housing Estimates. United States Government.
ACS Table DP05. Census - Table Results

U.S. Census Bureau, American Community Survey. (2016-2020). Disability Characteristics. United States Government.
ACS Table S1810. Census - Table Results

U.S. Census Bureau, American Community Survey. (2016-2020). Educational Attainment. United States Government.
ACS Table S1501. United States Government. Census - Table Results

U.S. Census Bureau, American Community Survey. (2016-2020). Ratio of Income to Poverty Level of Families in the Past 12 Months. United States Government.
ACS Table B17026. United States Government. Census - Table Results

What does it Mean to be Agender? (2022). Healthline, Healthline Media.
What Does It Mean to Be Agender? 18 Things to Consider (healthline.com)

TRIENNIAL NEEDS ASSESSMENT ADDENDUM

Top Five Unmet Needs

1) Outpatient Services – Case Management, Outpatient Services, Medication Management (Substance Abuse and Mental Health, in all service areas)
2) Residential/Inpatient and Detox Services (Substance Abuse and Mental Health, in all service areas)
3) Housing options and Supported Housing (Substance Abuse and Mental Health, in all service areas)
4) Psychiatric Services (Substance Abuse and Mental Health, in all service areas)
5) Transportation (access to services, particularly in rural counties)

NO WRONG DOOR

See pages 16, 86-101 of Florida Cultural Health Disparity and Behavioral Health Needs Assessment.

RECOVERY ORIENTED SERVICES AND PEER SUPPORT

Northwest Florida Health Network (NWFHN) continues to foster partnerships with network providers, The Peer Support Coalition of Florida, and NAMI to increase Peer Networks across the Region.

See pages 17, 120-132 of Florida Cultural Health Disparity and Behavioral Health Needs Assessment.

Figure 1: List of Network Service Providers with peer positions.

Agency Circuit 1
Mental Health Ass. Of Okaloosa/Walton (MHAOW)
Lakeview Center, Inc. (LCI)
Bridgeway Center, Inc. (BCI)
Chautauqua Healthcare Services (CHS)
CDAC Behavioral Healthcare, Inc. (CDAC)

Agency Circuit 2
DISC Village
Apalachee

Agency Circuit 14
Life Management Center
CARE

LESS-RESTRICTIVE SERVICES

Diverting persons served from deeper levels of service is an ongoing priority for Northwest Florida Health Network (NWFHN). Contractual agreements, partnerships and collaborations are utilize to implement programs designed to prevent the need for crisis stabilization, detox, state hospital admission, intensive residential programs, and incarceration. Programs focused in intervention also woven into NWFHN's array of less-restrictive services.

While NWFHN's network has a robust array of services, there is still a need for additional services to prevent person served from needing intensive community services.

Figure 2: List of implemented programs to prevent the need for deeper levels of service.

Implemented Services	
Program	**Population Served**
Community Action Teams (CAT)	Youth
Florida Assertive Community Team (FACT)	Adults
Care Coordination	Youth and Adults
Short-term Residential (SRT)	Adults
Medicated-Assisted Treatment(MAT)	Adults
Family Intensive Treatment (FIT)	Adults
Forensic Diversion	Adults
MRT	Youth and Adults
Sheriff Outreach Programs	Youth and Adults
Early Psychosis Program	Adults

Needed Services	
Programs	**Population Served**
Additional Case management	Youth and Adult

Additional Early Psychosis	Adults
Substance use programs	Youth and Adults

EVIDENCE-BASED PRACTICES

NWFHN's network service providers were asked to provide a comprehensive list of evidence-based practices (EBP) as part of the required Needs Assessment and as required by FS 394.4573. Additionally, NWFHN requested providers outline how they are ensuring fidelity to the model, for each EBP identified.

See attachment 1.

YOUTH GAPS AND SERVICES

NWFHN has worked collaboratively with stakeholders to develop a plan promoting a more coordinated mental health system of care for children, adolescents, and transitional age youth. NWFHN has continued to engage providers, system partners and other stakeholders to further our children's continuum of care by developing a shared vision and shared values towards this end. Following community discussions, a survey was sent to community stakeholders to obtain additional feedback on priorities. The top three areas identified in the NW region are:

1. Need for increased services for youth with significant behaviors including sexual or physically aggressive behaviors.
2. Capacity gaps for youth who need residential programs / SIPP placement or therapeutic foster care.
3. Lack of specialized service capacity for youth with dual diagnosis of developmental disabilities and mental health disorders.

A list, with descriptions, of gaps and recommendations to address listed gaps are as follows:

Gaps

- Early Intervention services and coordination to assist those 0-5 obtain services and / or be linked to the larger system of care.
    - Limited Infant Mental Health Services including Child Parent Psychotherapy.
    - Lack of established process for 0-5 who are expelled from daycare to be linked to services.
    - Limited Parent-Child therapeutic services

- Early Intervention: Although services are available for prevention and early intervention, families often do not access services until a period of crisis.
- Family inclusion and engagement. Some services focus only on the youth without viewing the family as a system. Engagement, voice, and choice, and client led services should be strong components of service provision.
- Processes to assure individuals are receiving services at the needed "dosage" (frequency).
- Limited services for behavioral issues:
    - For youth with significant sexual or aggressive behavior.
        - Limited Intensive behavioral health homes and must be on med waiver to access.
            - If a youth is deemed eligible, there is no appropriate place while awaiting the intensive behavioral home.
        - May be denied by SIPP due to inability to safely manage.
        - One residential program in the state that is able to manage those who need more of a behavioral than cognitive approach and it maintains a long wait list.
        - Very limited service providers to asses and treat inappropriate sexual behaviors.
    - ABA services are limited due to a limited number of providers.
    - Limited services available for those on the med wavier (who meet APD eligibility).
    - An increasing number of parents of biological and adoptive youth who are relinquishing their rights, resulting in foster care. The foster care system is also not equipped to manage these challenging youth.
- CAT Team wait lists / need for additional teams.
- Utilization of natural and community supports to prevent families from deeper end services and to assist in transitions when treatment goals have been achieved. Families are often understandably anxious when services are complete.
- No residential substance use options in the region.
- A pediatric acute care system that is unable to handle peak times during the year (spring and fall), which leads to youth being sent long distances and youth waiting in emergency rooms and receiving facilities for a treatment bed.
    - Capacity is impacted when individual's needs require a private room.
- Youth who age out of the system are placed at a higher risk of poverty, sexual exploitation, financial issues and homelessness

- The current crisis (pandemic) presents additional problems and increases the disparities that already exist.
- Creation of new mental health programs but no qualified employee to fill positions.
- Finding appropriate providers to meet the needs of the children in crisis, who are 5 and under, especially when they are uninsured.
- Economic disparities, poverty.
- Lack of training and education for the community, schools, and stakeholders.
- Barriers to treatment due to stigmas- including individuals with lived experiences.
- Parents not understanding mental health and praying that their kids are okay.
- "SAY it Out Loud' can be offered in a school-based program.
- Community not knowing about NAMI being available in the community.
- Extensive waitlist for assessment with a community provider and evaluators.
- Transportation, especially in the rural counties.
- Lack of transitional services for children leaving school.

Recommendations

Comprehensive Coordinated System of Care

1. To facilitate parents and caregivers obtaining services and supports through increased education regarding early signs and symptoms, ease and awareness of processes, increased skills for family engagement to assure linking to services.
2. Increase collaborations across systems with similar expectations for practice in Recovery Oriented System of Care principles. NWFHN has been providing education around the ROSC initiative to further enhance adoption across systems, however acceptance across systems would be an opportunity to increase a paradigm shift.
3. Increase use of Mobile Response Teams (No Wrong Door entry to services and supports) to provide an immediate response to a behavioral health crisis and support for service entry.
4. Utilize Care Coordination to improve youth's ability to live at home with their families.
5. Increase availability of LGBQT+ competent services
6. Increasing the availability of advanced practiced registered nurse (APRN) or physician assistants specialized in child psychiatry to help reduce waitlists for child psychiatry. Consideration of a consortium of psychiatrists willing to support this effort while working with local medical society, pediatricians, and American Psychiatric Association as well as other local stakeholders.
7. Increased funding for respite is often needed to further support youth and families.

8. Investigate opportunities for continued and expanded funding for increased children's care coordination across our system would help ensure youth and families are bridged from one service to another without drop-offs and service disconnects.
9. Leverage funders' ability to support a well-qualified workforce whether through trainings, incentives or fee increases.
10. APD applications take several months on average for approval even when crisis applications are being requested. Often when a youth is approved, they are then placed on a waitlist for services with APD, which can complicate a situation where a youth is in dire need of placement in a group home facility. Working with APD to improve this process seems critical to help meet the needs of these youth who have intellectual disabilities and not a primary behavioral health need.
11. Further system-level support through stakeholder policies recommending, requiring and/or referring for the use of High-Fidelity Wraparound for those youth with complex needs (cross systems) would be beneficial to our enhanced coordinated system of care.

<u>Integrated Service Delivery and Supports</u>

1. Support a well-qualified and well-trained workforce across all systems including increasing the availability of recovery supports.
2. Additional training for clinicians depending on identified needs in coverage areas. EMDR, Trauma focused Cognitive Behavioral Therapy, behavioral modification therapies, Dialectical Behavior Therapy, and LGBTQ+ training are some that have been identified as needing further training.
3. Increase collaboration between schools, mobile response, emergency rooms and community behavioral health providers to assure family engagement in times of crisis, including those times when a Baker Act is not necessary.
4. Address pediatric acute stabilization capacity and related process to improve ability to manage peak period of youth Baker Acts
5. To increase transparency, AHCA should consider requiring MMA plans to share policies with MEs.
6. Increased awareness of Family Team/Challenge Staffings and Local Review Teams for those agencies that are not part of NWFHN network. Often, youth need this level of staffing when they are in crisis and are identified in a crisis. If the family Team / Challenge Staffing is used earlier in the process, crisis situations could potentially be avoided.
7. Consistent workforce training across Providers for both basic suicide prevention and intervention, both at on boarding and again at regular intervals.

Data Systems and Evaluation

1. Find solutions to sharing individual and aggregate data across systems re: persons served, access to care and recurrence data specific to population/area served.
2. Improve the availability of Medicaid data for youth who are high utilizers of behavioral health services for the purpose of Family Care Coordination and improving the children's system of care.
3. Be part of a continuous quality improvement cross system project to address quality improvement for shared programs.