2019

CENTRAL FLORIDA CARES
HEALTH SYSTEM

Behavioral Health Needs Assessment

707 Mendham Boulevard · Suite 201 · Orlando, Florida 32825

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May 30, 2019

To Our Valuable Stakeholders,

Central Florida Cares Health System, Inc. (CFCHS) is pleased to announce the completion of the 2019 Behavioral Health Needs Assessment. This needs assessment was successfully conducted with input from stakeholders and data from multiple state and private sectors. The 2019 Behavioral Health Needs Assessment analyzes the service capacity, identifies gaps and opportunities in our region. This needs assessment includes a complete analysis of CFCHS region to include input from the Consumer Strengths and Gap Survey and Provider Survey.

Central Florida Cares Health System, Inc., Managing Entities, is a not-for-profit organization contracted by the Department of Children and Families to oversee state-funded mental health and substance abuse treatment services in Circuits 9 and 18 (Brevard, Orange, Osceola, and Seminole counties). As a managing entity, CFCHS is a behavioral health administrative and management organization with a primary focus to promote a comprehensive, seamless system of recovery and resiliency to those individuals in the community who are in need of these services.

This needs assessment will serve as the foundation for developing a strategic plan to address the behavioral health needs in the CFCHS service area. Participation in the development and execution of a data-driven process has the potential to enhance program effectiveness, leverage limited financial resources, and strengthen the public health system. Collaboration among community partners can lead to improved health outcomes for all residents.

After reviewing the needs assessment, should you have any questions or areas that you would like CFCHS to address, please let us know.

Sincerely,

Maria Bledsoe
Chief Executive Officer

Acknowledgements

Thank-you to all the wonderful people who contributed to this report

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CFCHS Consumers
Health Leadership Council/ Community Vision of Osceola
Healthy Seminole
Primary Care Access Network
Seminole Prevention Coalition
Space Coast Health Foundation

Executive Summary

In 2017, there was an estimated 75,879 adults with serious mental illness in the four-county service area comprised of Brevard, Orange, Osceola, and Seminole Counties. This number has continually increased over the past three years. Additionally, there are 26,939 youth, ages 9-17 years, who are emotionally disturbed. This report, prepared for the Central Florida Cares Health System (CFCHS), is a compilation of primary and secondary data that identifies behavioral health needs and the community assets available to advance the healthcare delivery system to improve outcomes for all residents.

SERVICE AREA POPULATION

The population in the service area increased over the past five years to a total of 2,632,827 individuals. The greatest growth occurred in Osceola County where the population increased by 16.2 percent from 2013 to 2017. Racially, the service area is predominately White (71.1 percent), with the Black population accounting for 15.8 percent; Asian residents at 4.1 percent, and over seven percent of individuals who are of other races or belong to more than one racial group. Ethnicity varied among the counties where the Hispanic population ranged from 9.7 percent in Brevard County to over fifty percent in Osceola County. Participation in the labor force remained steady (2013-2107), unemployment decreased from 7.2 percent in 2013 to 3.8 percent in 2017. The percentage of individuals living below 200% of the Federal Poverty Level (FPL) decreased while those above at 400% FPL increased.

Overall, eighty percent of residents reported good to excellent health, the percentages of adults with good mental health decreased slightly in Brevard, Orange and Osceola counties but increased among those living in Seminole. Suicide rates decreased in Brevard and Seminole counties but increased in Orange and Osceola counties. In 2017, domestic violence and children experiencing child abuse decreased in all four counties from rates in the previous year. Increases in children experiencing sexual violence increased in Brevard and Osceola counties.

Although smoking decreased among adults in all four counties, alcohol consumption and binge drinking increased for this population group in the service area. The percentages of youth engaged in smoking tobacco and/or marijuana, as well as alcohol consumption and binge drinking, all decreased in the past three years.

Adults with any type of health insurance ranged from 77.1 percent in Osceola County to 87.2 percent in Seminole County. Rates of those insured increased among adults living in Brevard and Seminole Counties (2010 to 2016) while rates decreased in Orange County and remained stable in Osceola County during the same six-year period.

CFCHS CLIENT POPULATION

CFCHS funded organizations that served 31,227 clients in FY2017/18. Over forty percent of clients resided in Orange County, followed by Brevard County at 29.8 percent, Seminole County at 14.3 percent and Osceola County at 9.2 percent. Clients who reported their county as homeless accounted 1,477 clients although 3,825 clients reported their residential status as homeless.

Adults in CFCHS programs accounted for eighty percent of all clients with 43.5 percent enrolled in the Adult Mental Health (AMH) program and 36.7 percent in the Adult Substance Abuse program (ASA). The remaining twenty percent of clients were children/youth in the Child Mental Health (CMH) program at 7.0 percent and the Child Substance Abuse (CSA) program at 12.8 percent.

CFCHS clients were more racially diverse but similar ethnically when compared to the service area population. Clients in child/youth programs were more racially and ethnically diverse when compared to adult clients and the service area population, especially among those in the CSA program where nearly forty percent of youth were Black.

The vast majority of clients were living independently either with relatives, non-relatives or alone. CFCHS adult clients has lower educational attainment when compared to adults in the service area and most clients were unemployed.

NO WRONG DOOR

This assessment conducted among the CFCHS providers revealed that they strived to make all doors the right doors or eliminated doors completely using telehealth, and under took activities to ensure effective marketing and outreach to increase awareness. Providing patient-centered care (PCC) was ingrained into the organization culture. Providers effectively communication with their partners to improve coordination across the care continuum. Technology was embraced to improve the referral system, expand the use of health records, and alleviate some transportation barriers.

Lack of transportation and funding for peer support specialists (PSS) and telehealth technology were cited as critical elements needed to improve the provision of patient-centered care. The overall data collection and entry processes required by multiple systems to meet the various funding requirements is straining administrative budgets and threatening to impact the resources allocated for services for some providers. There are critical shortages of trained staff, ranging from counselors to psychiatrists, to serve those in need of behavioral health care.

The ability of peers to work as a bridge to services for clients, makes them an integral partner in the success of patient-centered care in the no wrong door model of care.

However, funding of the certification and training processes, along with recruitment (including background checks) and retention barriers present challenges prohibiting more extensive use of these vital individuals.

RECOVERY-ORIENTED SYSTEM OF CARE (ROSC)

A ROSC system that builds on the strengths of individuals using the full range of community support services required to achieve substance use abstinence, will improve the health, wellness and quality of life for those with or at risk of drug or alcohol problems. CFCHS providers completed the Self-Assessment Planning Tool (SAPT) for implementing recovery-oriented mental health services as a means of defining strengths and identifying weakness in the current behavioral health care system. Responses to fifty statements were scored where 1 or 2 indicated a weakness and 3 or 4 defined a strength. The averaged responses from all providers revealed a 3.4 score. Using encouraging language in the language spoken by the client, where the clients were supported in driving the process to identify their goals based on their hopes and preferences, were attributes that received nearly a perfect score. Weaknesses included the lack of a process for clients to develop the recovery-oriented outcome indicators and to assess client's satisfaction with the housing situation. Additionally, using a ROSC assessment as part of the overall quality improvement process was lacking in some organizations.

CONSUMER SURVEY

Awareness of where to find services when they were needed was still a challenge for almost thirty percent of consumers. Yet, most consumers did receive services when they needed them. Over sixty percent of consumers were aware of the 2-1-1 resource in their community. The majority of consumers reported that services were well coordinated, processes were understandable, and the services were patient centered. Brevard clients were less able to get the services they needed when compared to clients Orange, Osceola and Seminole counties. Most CFCHS clients needed multiple services of which housing assistance was hardest to get. Affordability ranked as the number one barrier preventing them from receiving the services they needed.

STAKEHOLDER SURVEY

Stakeholder respondents represented thirty community sectors ranging from advocacy to transportation. More than 75.0 percent of stakeholders were aware of the behavioral health resources available in their respective counties and well over eighty percent had knowledge of the 2-1-1 informational resource. However, they did not feel that the overall

community possessed the same level of awareness reporting that only fifteen percent felt that awareness was good to excellent. Like consumers, stakeholders felt that linkages to services were well coordinated, accessible, and patient centered but were less confident with the ease of the application and eligibility processes and the coordination across the continuum. Stakeholders cited the lack of a defined process on how a consumer was to locate services as the number one barrier to accessing services. Lack of transportation was number two and uninsured status as the third biggest barrier to care. Additional planning resources were needed to support the flow of consumers across the healthcare system. Respondents reported that there was a lack of beds of every type in every county in the service area. Provider shortages, identified as the third resource needed, was driving the lack of availability of providers to see patients when they needed to be seen.

POINT-IN TIME PILOT STUDY

The Mental Health Association of Central Florida (MHACF) participated in a proposed point-in-time study to identify services that were needed but not received and the reasons why. A total of 339 clients who contacted MHACF for services were screened and their responses were recorded for analysis. These were then grouped into six challenge/barrier categories that prevented the service from being accessed or delivered. The results gleaned from the point-in-time were similar to those from the consumer and stakeholder surveys. The lack of insurance to cover the cost of specialty care, lack of providers within the client's required mile range, affordability coupled with lack of insurance. Many clients needed multiple services and also had multiple challenges/barriers that prevented them from getting the care they needed.

MOVING FROM WHERE WE ARE TO WHERE WE WANT TO BE

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

Introduction

Central Florida Cares Health System, Inc. (CFCHS) is a not-for-profit corporation incorporated in the state of Florida. CFCHS is the managing entity for a network of publicly funded, licensed substance abuse and mental health providers who collectively operate a range of behavioral health services to form an integrated system of care. CFCHS's network of providers offer prevention, intervention, treatment and supportive services to clients residing throughout four Central Florida counties: Brevard, Orange, Osceola and Seminole. CFCHS is one of seven Managing Entities (MEs) in Florida which serve as regional systems of care. This structure enables the ME to tailor funding to meet the specific behavioral health needs in various regions throughout Florida.

As a managing entity, CFCHS receives funding from the State of Florida Department of Children and Families (DCF) and procures subcontracts with substance abuse and mental health providers, who, in turn, deliver services to eligible clients. CFCHS is responsible to DCF for monitoring and oversight of the Providers' activities. In addition, CFCHS utilizes other funding sources, promising practices, and/or pilot programs to support their providers in identifying and addressing the behavioral health needs in the community.

CFCHS is governed by a board comprised of consumers, stakeholders and community-based providers. The vision of Central Florida Cares is to achieve a comprehensive and seamless behavioral health system that promotes recovery and resiliency.

DEFINITION AND PURPOSE

The needs assessment is a process of assessing the physical, social and environmental health of a population to identify key health needs and assets within a community. Epidemiological, quantitative and qualitative research components define the data-driven process designed to improve health outcomes with the goal of ensuring that community resources are used efficiently and effectively. The assessment serves as the foundation for developing a strategic action plan to lead the community from 'where we are' to 'where we want to be'.

METHODOLOGY

The 2019 Behavioral Health Needs Assessment was prepared in accordance with the requirements of the SB12 (2016). Included in this report are the following components:

- A demographic profile was constructed for the four-county service community and for each individual county within the service area. The profile included a 5-year population growth trend, most recent year racial and ethnic composition, age range, educational attainment, employment, and federal poverty level (FPL) status. Indicators were reported as population percentages and selected to

compare with the demographics collected for the CFCHS client population. Data was gathered from the U.S. Census Bureau American Community Survey (2013-2017), and the U.S Bureau of Labor Statistics (2013-2017).

- A general health assessment was provided to present the overall health of the community and the unique health challenges within each county served by CFCHS providers. Data was gathered from FLHealthCHARTS.com (2013-2016), Behavioral Risk Factor Surveillance System (2010-2016) Florida Department of Law Enforcement (2015-2017), Florida Department of Children and Families (2015-2017), Florida Youth Substance Abuse Survey (2015-2017), Florida Youth Tobacco Survey (2015-2017), and Florida Department of Education (FLDOE), Educational Information and Accountability Services (EIAS).
- A CFCHS client demographic profile was constructed for the overall service area as well as for each county within the service area, and those who reported their residential status as homeless. CFCHS provided de-identified client data which was analyzed by Health Council staff. Data were provided by program and county. Client data were for FY 1718.
- An analysis of CFCHS costs by cost center (FY 1718) were provided by program and county.
- An assessment of the 'No Wrong Door' (NWD) model of care was accomplished through one-on-one interviews conducted with each CFCHS contracted provider. Providers shared information on referral and community awareness, person-centered counseling, eligibility for public programs, person-centered transition support, partnership and stakeholder involvement, and quality assurance and continuous improvement. Providers were measured on their use of the 17 elements of the Recovery-Oriented System of Care (ROSC) as defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) through an online survey portal. The results were scored and recommendations for improvement were provided. Additionally, providers supplied a list of the Evidenced-Based Practices (EBP) currently administered at their facilities.
- Resources for recovery support services were identified by county for populations suffering with Severe and Persistent Mental Illness (SPMI) and Serious Emotional Disturbance (SED).
- Two surveys were developed to identify the services that are needed but not available, barriers to accessing available services, and the level of awareness of community services. Surveys were completed by community stakeholders and CFCHS consumers (Client, parent, or client representative). Survey responses were gathered through an online portal and analyzed to identify the top five needs for CFCHS clients.
- A Point-in-Time study to assess the needs of wait-listed consumers was proposed but not approved by CFCHS providers due to the complexity of client flow through the facility and lack of additional staff. However, the Mental Health Association of Central Florida offered to conduct the study using interns to gather the required information. The results were included as a pilot-project for possible future reconsideration.

DATA NOTES

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

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

All death rates in this report are Age-Adjusted Death Rates (AADR). Age-adjustment is a statistical process applied to rates of disease, death, injuries or other health outcomes which allows communities with different age structures to be compared.

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

Attempts were made to collect homeless data from CFCHS providers. Most providers submitted data on homeless clients directly to CFCHS. For those providers who were able to provide data on the number of homeless clients, there was no method of accurately accounting for clients without access to personal identifiers which were not available. For this reason, homeless client data was gleaned from the CFCHS data set for those clients who reported their residential status as homeless.

Survey fatigue is a community problem which can prevent the gathering of information for future planning and policy making. Providers and stakeholders are surveyed throughout the year by funders, community partners, program management, public health agencies, schools, local government, and faith-based organizations, just to name a few. The focus of many surveys is redundant and the questions duplicative. Respondents are very weary of this process that requires valuable time with very little direct benefit. Every effort was made to streamline the survey design for this project while maintaining relevancy to the assessment requirements as directed by CFCHS.

DEFINITIONS

AFC - Awaiting Foster Care placement (this category was dropped from the Federal definition of homelessness on 12/15/2016)

AMH – Adult Mental Health

ASA – Adult Substance Abuse

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

CMH – Child Mental Health

Continuum of Care (CoC) – A local geographic area designated by HUD and served by a local planning body, which is responsible for organizing and delivering housing and services to meet the needs of people who are homeless as they move to stable housing and maximum self-sufficiency. The terms "CoC Governing Body" or "CoC Board" have the same meanings. In some contexts, the term "continuum of care" is also sometimes used to refer to the system of programs addressing homelessness.

CSA – Child Substance Abuse

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

Motels - Living in hotels or motels

Sheltered - Living in emergency or transitional shelters

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

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

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

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

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

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

Behavioral Health on a National and State Level

Mental Health America, supported by the Substance Abuse and Mental Health Administration (SAMHSA), the Centers for Disease Control and Prevention, and the Department of Education produced *The State of Mental Health in American 2018.* The goal of the report was to provide a snapshot of mental health status among youth and adults for policy and planning analysis and evaluation; track changes in prevalence of mental health issues and access to mental health care; understand how changes in national data reflect the impact of legislation and policies; and to increase dialogue to improve outcomes for individuals and families with mental health needs. Using fifteen measures of mental health, the report provided an understating of the prevalence of mental health concerns, including access to insurance and treatment issues. Data was used from SAMHSA's *National Survey on Drug Use and Health* (NSDUH) and the CDC's Behavioral Risk Factor Surveillance System (BRFSS). These national survey data sets included large sample sizes and utilized statistical modeling to provide weighted estimates. These data are more representative of the general population with the exclusion of the homeless population, active duty military or those who are institutionalized.

KEY FINDINGS AT THE NATIONAL LEVEL

- 18% of adults have a mental health condition (43 million Americans)
- Nearly half have a co-occurring substance use disorder
- 9.6 million experience suicidal ideation
- 56% of adults with a mental health illness DID NOT receive treatment
- 1 in 5 reported an unmet need
- 7.7% of youth had NO ACCESS to mental health services through their private provider
- Over 1.7 million youth with major depressive episodes DID NOT receive treatment

All fifty states and the District of Columbia were ranked using fifteen measures of mental health as noted below:

1. Adults with Any Mental Illness (AMI)
2. Adults with alcohol dependence and illicit drug use
3. Adults with serious thoughts of suicide
4. Youth with at least one Major Depressive Episode (MDE) in the past year
5. Youth with alcohol dependence and illicit drug use
6. Youth with severe MDE
7. Adults with AMI who did not receive treatment
8. Adults with AMI reporting an unmet need
9. Adults with AMI who are uninsured

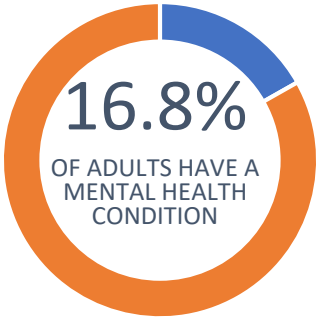
10. Adults with disability who could not see a doctor due to costs
11. Youth with MDE who did not receive mental health services
12. Youth with severe MDE who received some consistent treatment
13. Children with private insurance that did not cover mental or emotion problems
14. Students identified with emotional disturbance for an individualized education program
15. Mental health workforce availability

States with higher rankings (1 being the highest and 51 being the lowest) had a lower prevalence of mental illness and higher rates of access to care. Lower rankings indicated that there was a higher prevalence of mental illness and lower rates of access to care. Selected rankings for Florida are noted in the table below.

Ranking Indicator	Florida	Highest Ranked State (1)	Lowest Ranked State (51)
Overall	33	Massachusetts	Nevada
Adults Overall	24	Massachusetts	Utah
Youth Overall	37	South Dakota	Nevada
Prevalence of Mental Illness	10	South Dakota	Oregon
Access to Care	44	Vermont	Mississippi
Adult Alcohol Dependence	9	Maine	New Mexico
Adult Illicit Marijuana Use	24	Mississippi	DC
Adult Illicit Heroin Use	16	Texas	Alaska
Adult Illicit Cocaine Use	37	Utah	DC

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

SNAPSHOT OF FLORIDA MENTAL HEALTH AND SUBSTANCE ABUSE



THAT'S OVER **2.5 MILLION** FLORIDIANS

MOST FLORIDIANS LACK ACCESS TO CARE

61.7%

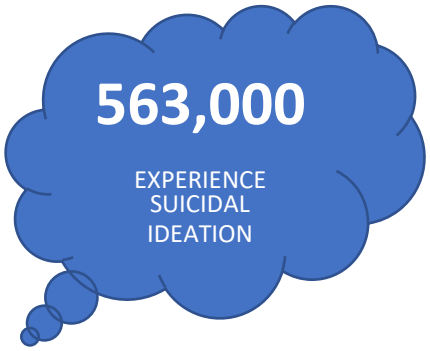
OF ADULTS WITH A MENTAL ILLNESS **DID NOT** RECEIVE TREATMENT

ONE IN 5.5

REPORT AN UNMET NEED

NEARLY 1/3

HAVE A CO-OCCURING SUBSTANCE USE DISORDER



10.1%

OF YOUTH HAD **NO ACCESS** TO MENTAL HEALTH SERVICES THROUGH THEIR PRIVATE INSURANCE

13.5%

PREVALENCE OF YOUTH MARIJUANA USE

106,000 THOUSAND

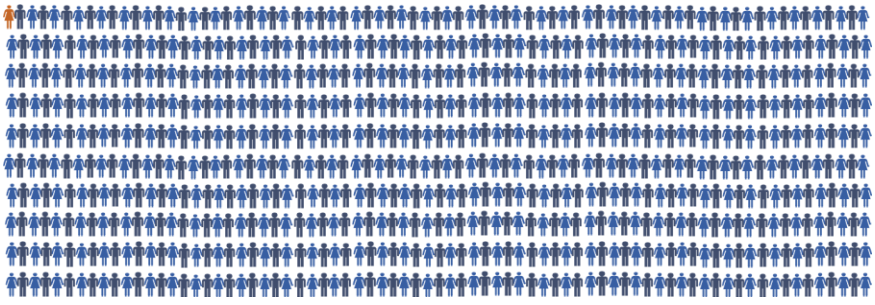
YOUTH WITH MAJOR DEPRESSIVE EPISODES

DID NOT

RECEIVE TREATMENT

THERE IS A SHORTAGE OF PROVIDERS

IN FLORIDA, THERE'S ONLY ONE MENTAL HEALTH PROFESSIONAL PER 750 PEOPLE



SOURCE: THE STATE OF MENTAL HEALTH IN AMERICAN 2018 (MENTAL HEALTH AMERICA)

CFCHS Service Area Demographic Profile

POPULATION DEMOGRAPHICS

Population in the four-county service area increased an average of two percent each year from 2013 to 2017. The total population growth for the five-year period at 8.4 percent, added 204,723 residents.

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

The racial composition in the service area and state was predominately White at 71.1 percent and 76.3 percent, respectively. The Black population accounted for 15.8 percent of the service area population and 16.0 percent of the population in Florida. American Indian and Native Hawaiian's represented less than one percent of residents in both population groups. The percentage of Asian residents, at 4.1 percent was higher in the service area when compared to the state at 2.5 percent. The service area was slightly more diverse when compared to the state with 4.8 percent having a race of Other and 3.3 percent of residents belonging to more than one racial group.

Ethnically, the service area had a slightly higher percentage of Hispanic residents, at 26.7 percent, when compared to the state at 22.9 percent.

The CFCHS service area population was younger when compared to the age distribution at the state level. Residents, 65 years of age or older, accounted for 14.4 percent of the population while in the state of Florida, 17.8 percent of residents were at least 65 years old.

EDUCATION AND EMPLOYMENT

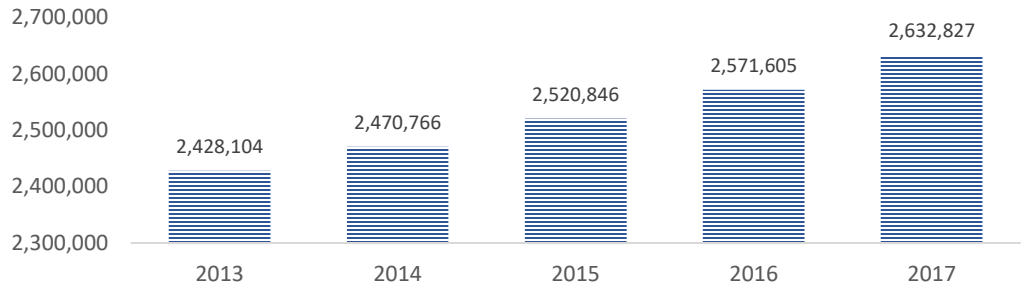
Data revealed the service area and state populations were very similar regarding education attainment. While slightly more residents in the state completed their education at the high school level (29.0 percent), residents in the service area had higher percentages of individuals who attended or graduated from college. Graduate or professional degrees were held by slightly more than ten percent of the population.

On average, 63.0 percent of the service area population participated in the labor force over the past five years. This was higher when compared to those employed in Florida at 58.4 percent. The unemployment rate for the service area decreased 45.8 percent from 2013 to 2017. In Florida, unemployment decreased 43.3 percent over the past five years.

POVERTY STATUS

During 2013 to 2017, the percent of residents living at < 200.0 percent of the FPL decreased in the service area and the state while those living at or above 400.0 percent of the FPL, increased.

FIGURE 1: CFCHS SERVICE AREA POPULATION ESTIMATES (2013-2017)

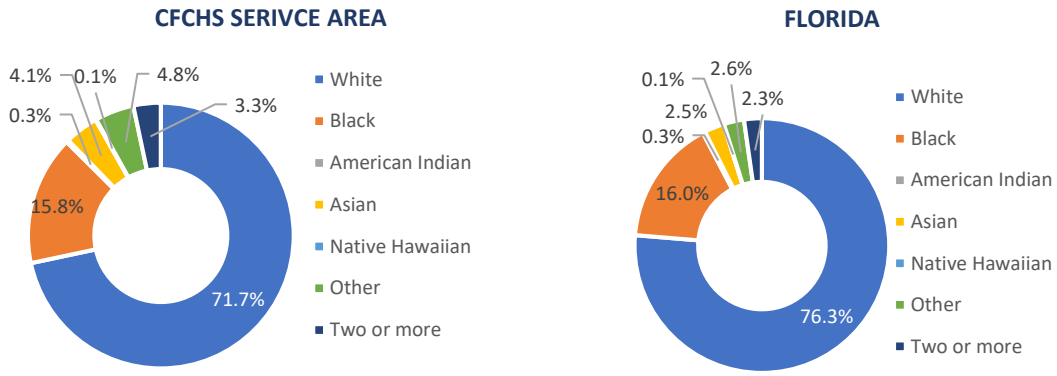


SOURCE: U.S. Census Bureau, American Community Survey

FIGURE 2: POPULATION BY GENDER (2013-2017)

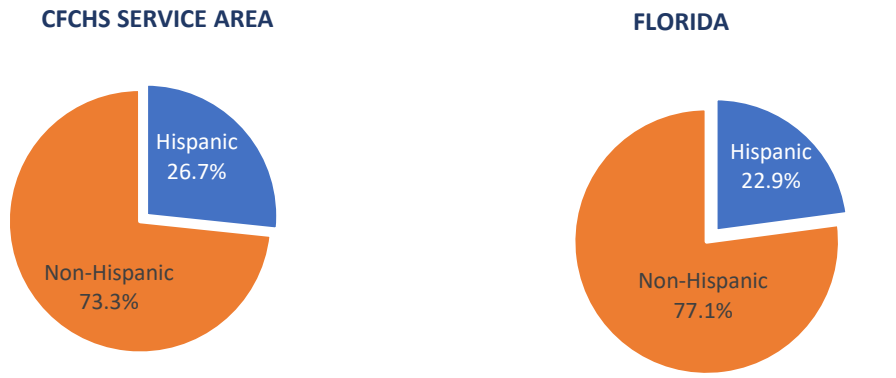
SOURCE: U.S. Census Bureau, American Community Survey

FIGURE 3: POPULATION BY RACE (2013-2017)



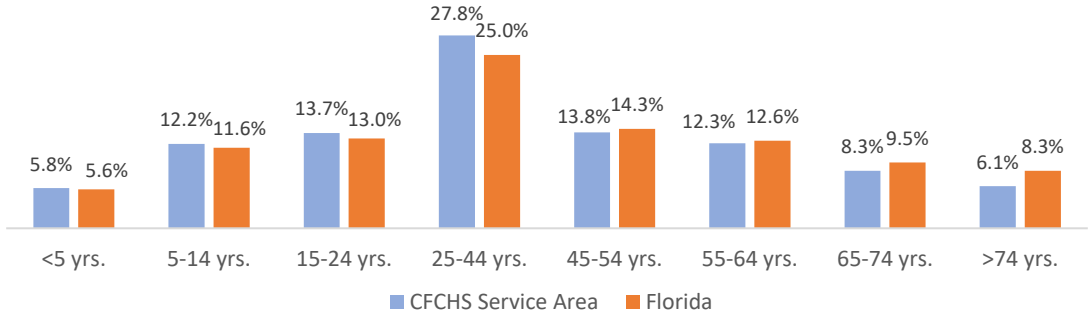
SOURCE: U.S. Census Bureau, American Community Survey

FIGURE 4: POPULATION BY ETHNICITY (2013-2017)



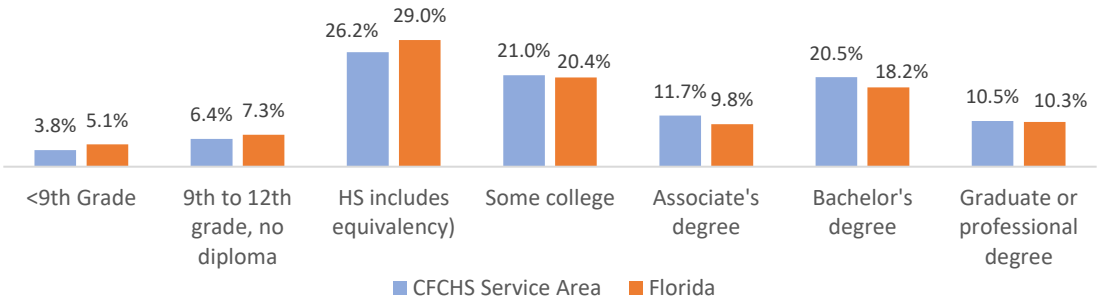
SOURCE: U.S. Census Bureau, American Community Survey

FIGURE 5: POPULATION BY AGE RANGE (2013-2017)



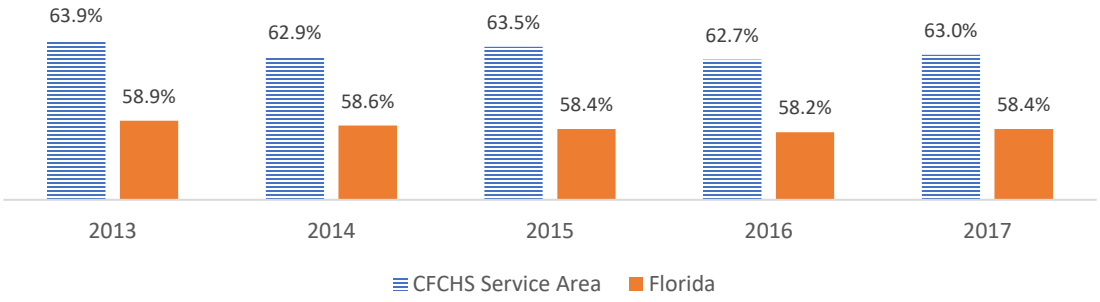
SOURCE: U.S. Census Bureau, American Community Survey

FIGURE 6: POPULATION BY EDUCATIONAL ATTAINMENT (2013-2017)



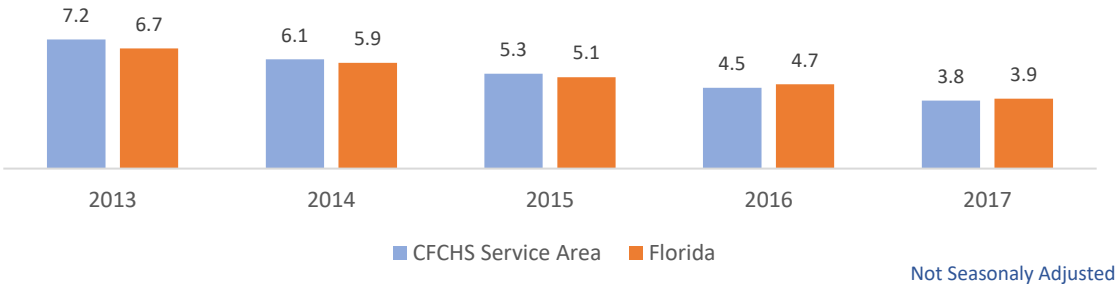
SOURCE: U.S. Census Bureau, American Community Survey

FIGURE 7: PARTICIPATION IN THE LABOR FORCE, (2013-2017)



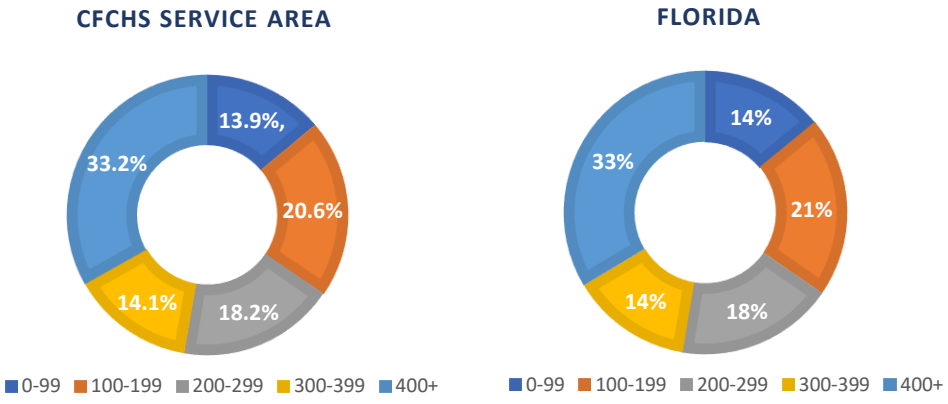
SOURCE: U.S. Bureau of Labor Statistics

FIGURE 8: UNEMPLOYMENT RATES (2013-2017)



SOURCE: U.S. Bureau of Labor Statistics (Not seasonally adjusted)

FIGURE 9: RATIO OF INCOME TO POVERTY LEVEL (2017)



SOURCE: U.S. Census Bureau, American Community Survey

CFCHS Service Area Health Status Profile

OVERALL HEALTH STATUS

BRFSS data (2016) estimates revealed an average of 80.0 percent of the adult population living in the service area said their overall health was "good" to "excellent". Higher percentages of men in Orange, Osceola and Seminole counties as well as Florida, reported good overall health when compared to women. Black residents living in Brevard and Osceola had the highest percentages of those with good to excellent overall health at 93.0 percent and 87.3 percent, respectively. Hispanics living in Seminole County had the lowest percentage of adults with good overall health, at 70.5 percent.

MENTAL HEALTH

Over ninety percent of adults in Seminole County said they had good mental health. Slight decreases were seen in the percentages of adults with good mental health in Brevard, Orange, and Osceola counties when comparing survey data from 2013 to 2016. In all counties and the state, more males reported having good mental health than females. The highest percentages of adults with good mental health in all counties were among the Black population. Good mental health ranged from a low of 80.4 percent for Hispanics in Osceola County to a high of 98.0 percent for Black residents living in Seminole County.

Among adults in the service area, the number of unhealthy mental health days was highest in Osceola County (4.8 days in the past 30 days) and lowest in Seminole County (2.8 days in the past 30 days). Hispanic women in Brevard and Osceola Counties had the highest average number of unhealthy mental health days in 2016 at 4.9 and 5.4 days, respectively. Across all counties, adults in the Black population had a lower average number of unhealthy days when compared to their White and Hispanic counterparts.

SUICIDE

The 2017 AADR for suicide was highest in Brevard County at 21.2 per 100,000 population. This was much higher than the rates in other counties which ranged from 10.8 per 100,000 in Orange County to 12.6 per 100,000 in Osceola County. The rate for Florida was 14.1 suicides per 100,000 population. Males were more than three times more likely to commit suicide than their female counterparts. Suicide rates among the White population were substantially higher than those among the Black and Hispanic populations in all counties in the service area and Florida. These rates should be interpreted with caution as the actual numbers can be small. An additional single death could cause a large increase in rate.

VIOLENCE AND ABUSE

Total domestic violence offences decreased slightly from 2016 to 2017 in all four counties and the state. The highest rate in 2017 was among the population in Brevard County, at

726.6 per 100,000 population, followed by Orange County at 634.4 per 100,000; Osceola County at 571.8 per 100,000; and 547.2 per 100,000 in Seminole County. The rate in Florida was 520.4 per 100,000 population.

Significant decreases occurred in the rates of child abuse during the past three years. Seminole County had the largest rate reduction in children experiencing child abuse (ages 5-11 years) during the 2015-2017 time period. The rate decreased from 905.5 per 100,000 population to 670.7 per 100,000 population. Child abuse was highest in Brevard County at 1046.6 per 100,000 population.

Children experiencing sexual violence (ages 5-11 years) was highest among those living in Osceola County at 89.8 offences per 100,000 population, followed by residents of Brevard County at 80.1 per 100,000 population. The rate for Orange County, at 53.4 per 100,000 population was lower than the Florida rate at 59.6 per 100,000 population. Seminole had the lowest rate of sexual violence among children at 31.9 per 100,000 population.

MENTAL ILLNESS

The estimated number of seriously mentally ill (SMI) adults increased in each of the four counties in the service area during 2015 to 2017. Osceola County experienced the highest increase of those with SMI, at 9.6 percent, during the three-year period. There was a five percent increase in the estimated number seriously mentally ill residents in Orange County; 3.4 percent increase in Seminole County and 2.7 percent increase among those living in Brevard County.

Estimates revealed the number of emotionally disturbed youth (ages 9-17 years) in the service area has remained almost constant over the past three years. Higher increases were observed in Orange and Osceola counties, at 2.8 percent and 5.9 percent, respectively. The number of emotionally disturbed youth increased less than one percent in Brevard and Seminole counties during 2015 to 2017.

The Florida Department of Education (FLDOE) reported less than one percent of children in kindergarten through 12 grades had an emotional/behavioral disability. The county percentages have remained constant over the past three years.

ADULT TOBACCO AND ALCOHOL USE

The percentage of adults who are current smokers decreased in all four counties of the service area as well as the state during the past six years. Current smokers in Brevard County accounted for 18.3 percent of the adult population while only 12.4 percent of adults were current smokers in Orange County. Males were more likely to smoke when compared to their female counterparts. Brevard County was the exception where 20.3 percent of adult women reported smoking compared to 16.3 percent of men. There were higher percentages of current smokers among the White population in Brevard, Orange

and Osceola counties. In Seminole County, the highest percentage of smokers were among Hispanics at 21.8 percent.

Binge drinking is defined as five consecutive drinks for men and four consecutive drinks for women. This form of alcohol consumption increased in all four counties in the service area and the state during 2010 to 2016. Binge drinking was highest in Seminole County at 20.1 percent. Men were more likely to binge drink than women and White adults were more likely to drink heavily when compared to adults of another race/ethnicity.

HIGH SCHOOL TOBACCO, ALCOHOL AND SUBSTANCE USE

During the past four years, the percentage of high school students who reported smoking cigarettes in the past 30 days decreased substantially in the four-county area and the state. The highest rate of smoking among students was in Brevard at 5.5 percent while the lowest rate, at 3.1 percent, was among high school students in Seminole County.

Rates of students who have used alcohol in the past 30 days also decreased according to the data from the Florida Youth Substance Abuse Survey (2012 to 2016). The percentage of students drinking decreased from 36.4 percent in 2012 to 22.2 percent in 2016 in Brevard County; from 32.3 percent to 23.3 percent in Orange County; from 23.8 percent to 18.2 percent in Osceola County, and in Seminole County, from 31.7 percent to 27.1 percent. In Florida, 25.5% of high schoolers reported having used alcohol in the past 30 days.

Binge drinking among high school students has steadily declined in all service area counties and the state. Seminole County had the highest percentage of binge drinkers, at 12.5 percent.

Marijuana use among those in high school decreased by smaller margins when compared to tobacco and alcohol usage. Seminole County had the highest percentage of those having used marijuana in the past 30 days, at 17.8 percent.

MIDDLE SCHOOL TOBACCO, ALCOHOL AND SUBSTANCE USE

Percentages of middle school students who had smoked or drank alcohol in the past 30 days were much lower when compared to those attending high school. Cigarette smoking in 2016 accounted for less than one percent of middle school students in Orange County and topped out at 1.2 percent in Brevard, Osceola and Seminole counties. The rate among Florida middle school students was 1.7 percent.

Alcohol consumption declined among the middle school population in all four counties and the state from 2012 to 2016. The percentages of those having used alcohol ranged from 7.4 percent in Brevard County to 5.8 percent in Seminole County. The rate for Florida was 8.3 percent.

Binge drinking also decreased over the past four years. In Osceola County, 3.2 percent of middle school students reported this behavior in 2016 which was lower than the percentage in 2012 at 4.3 percent. Similar patterns were observed in the other three counties in the service area and Florida.

Marijuana use among middle schoolers in 2016, ranged from 2.3 percent in Orange County to 1.7 percent in Osceola County. All counties and the state experienced decreases in the percentages of students using marijuana when comparing data from 2012 to 2016.

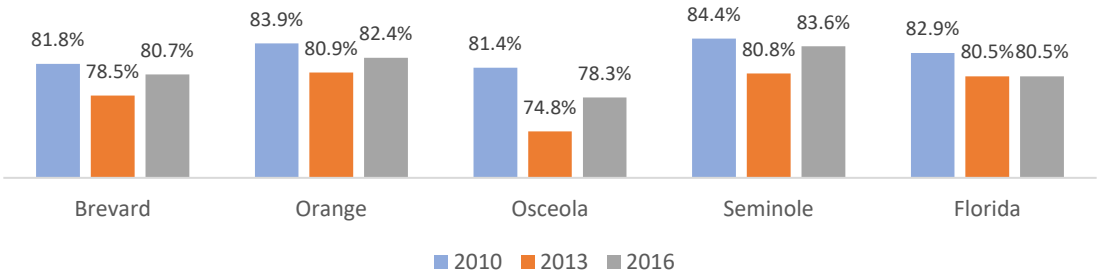
DISABILITY

Overall, the percentage of the population with a disability ranged from 15.3 percent in Brevard County to 10.1 percent in Seminole County. As expected, the percentage of those afflicted with a disability increased with age. In all counties, at least thirty percent of those ages 65 years and older had a disability (hearing, vision, cognitive, ambulatory, self-care or independent living).

HEALTH INSURANCE COVERAGE

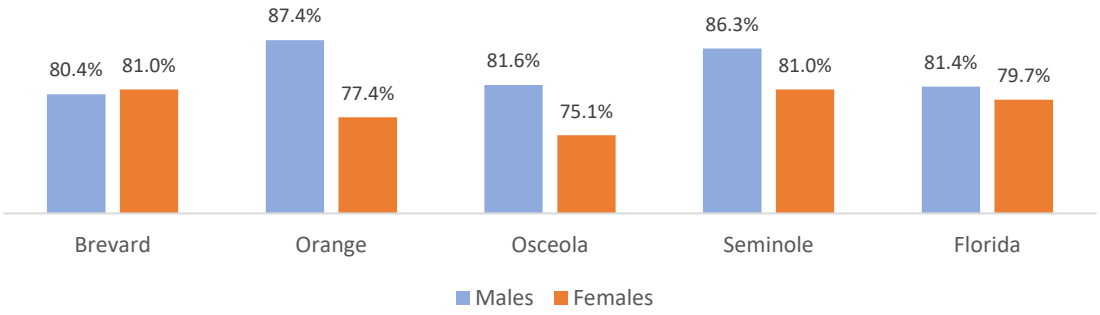
Insured rates differed by county as 87.2 percent of adults in Seminole County were covered by some type of insurance product, while 77.1 percent were covered in Osceola County. Rates in Brevard and Orange counties were 86.2 percent and 79.7 percent, respectively. By gender, higher percentages of women were insured when compared to men. In all four counties and the state, White adults were more likely to have health insurance when compared to those of another race and/or ethnicity.

FIGURE 10: ADULTS WHO SAID THEIR OVERALL HEALTH IS "GOOD" TO "EXCELLENT" (2010-2016)



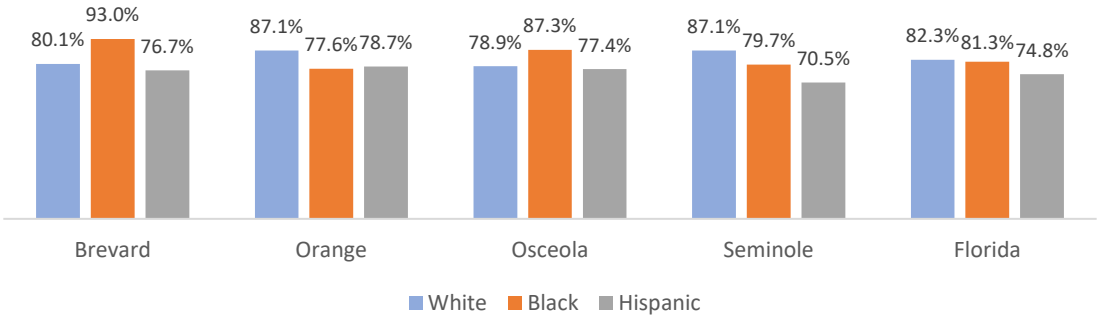
SOURCE: Behavioral Risk Factor Surveillance System

FIGURE 11: ADULTS WHO SAID THEIR OVERALL HEALTH IS "GOOD" TO "EXCELLENT" BY GENDER (2016)



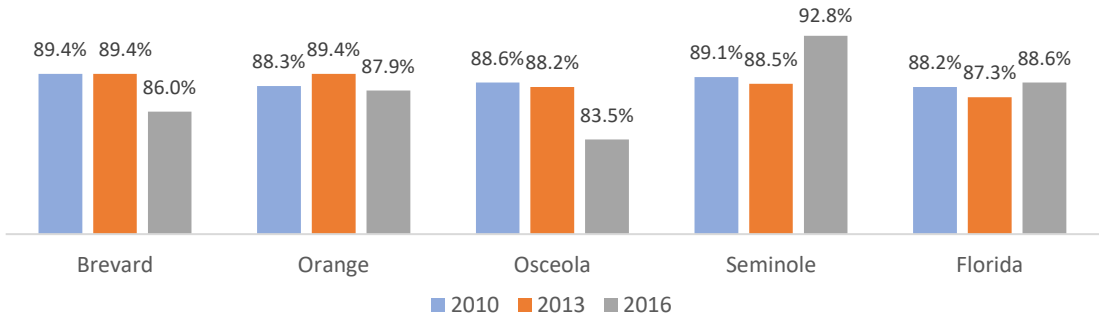
SOURCE: Behavioral Risk Factor Surveillance System

FIGURE 12: ADULTS WHO SAID THEIR OVERALL HEALTH IS "GOOD" TO "EXCELLENT" BY RACE AND ETHNICITY (2016)



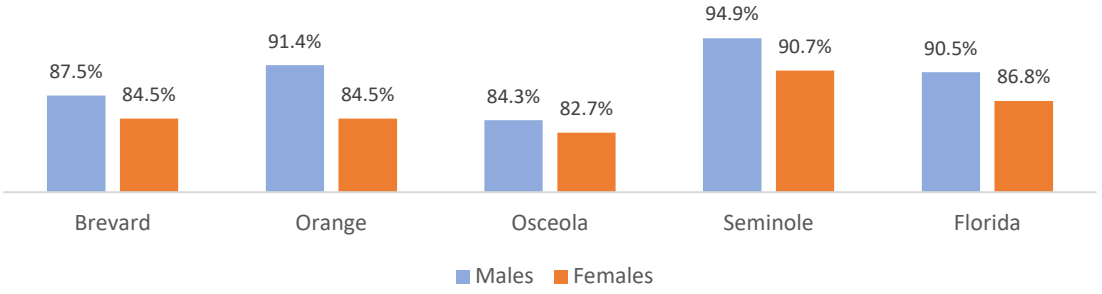
SOURCE: Behavioral Risk Factor Surveillance System

FIGURE 13: ADULTS WITH GOOD MENTAL HEALTH (2010-2016)



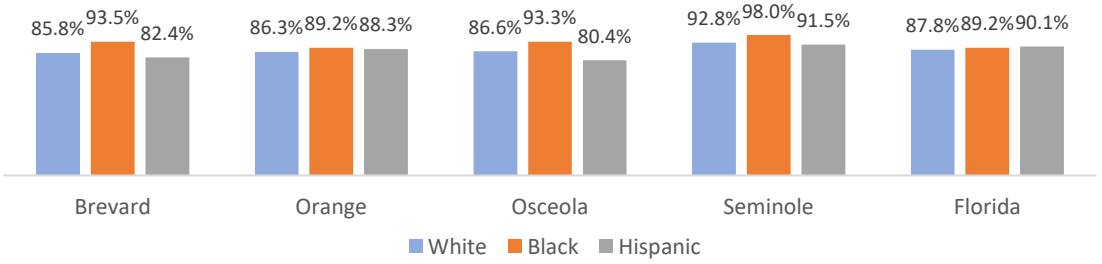
SOURCE: Behavioral Risk Factor Surveillance System

FIGURE 14: ADULTS WITH GOOD MENTAL HEALTH BY GENDER (2016)



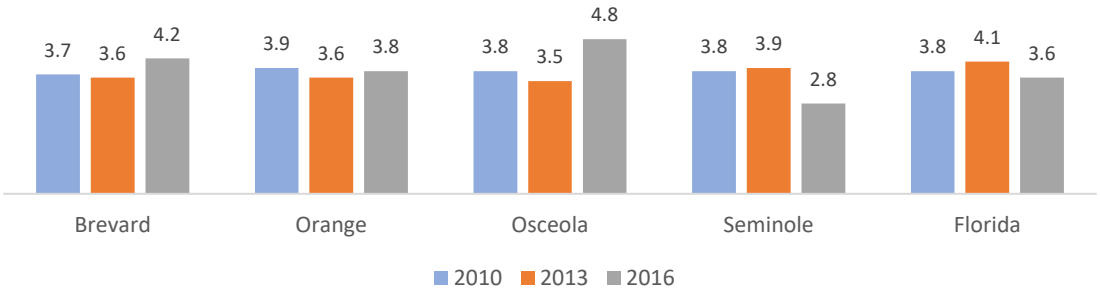
SOURCE: Behavioral Risk Factor Surveillance System

FIGURE 15: ADULTS WITH GOOD MENTAL HEALTH BY RACE AND ETHNICITY (2016)



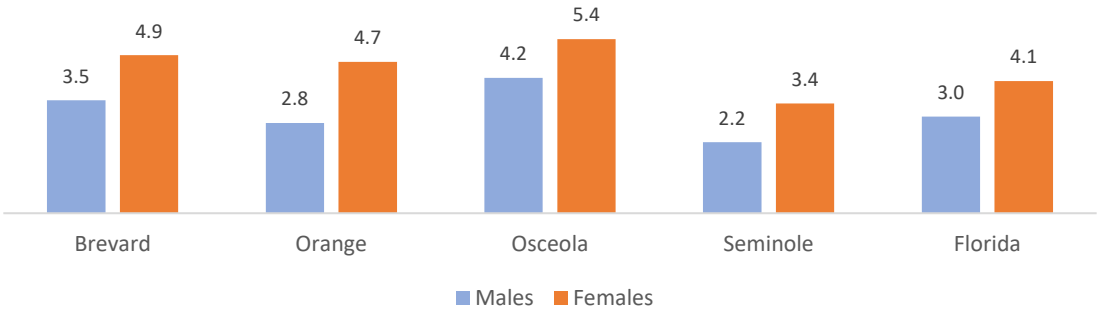
SOURCE: Behavioral Risk Factor Surveillance System

FIGURE 16: AVERAGE NUMBER OF ADULT MENTAL HEALTH DAYS (2010-2016)



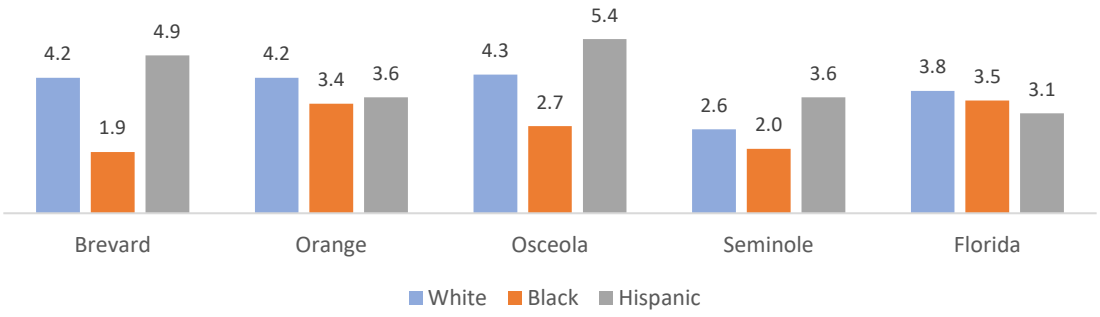
SOURCE: Behavioral Risk Factor Surveillance System (Unhealthy days in the past 30 days)

FIGURE 17: AVERAGE NUMBER OF ADULT MENTAL HEALTH DAYS BY GENDER (2016)



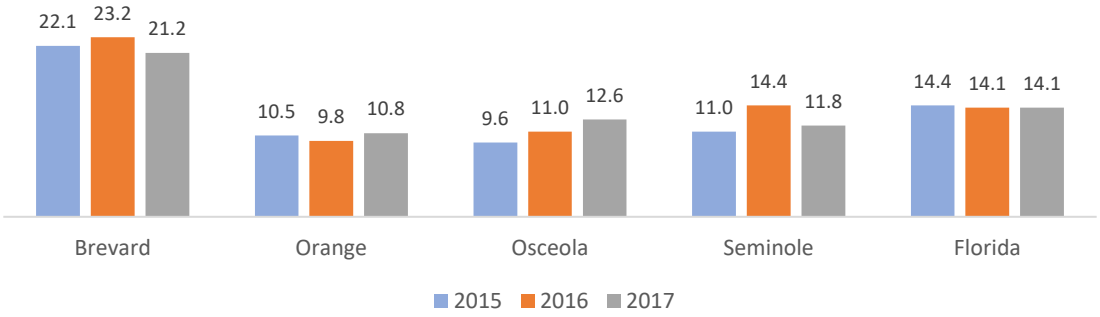
SOURCE: Behavioral Risk Factor Surveillance System (Unhealthy days in the past 30 days)

FIGURE 18: AVERAGE NUMBER OF ADULT MENTAL HEALTH DAYS BY RACE AND ETHNICITY (2016)



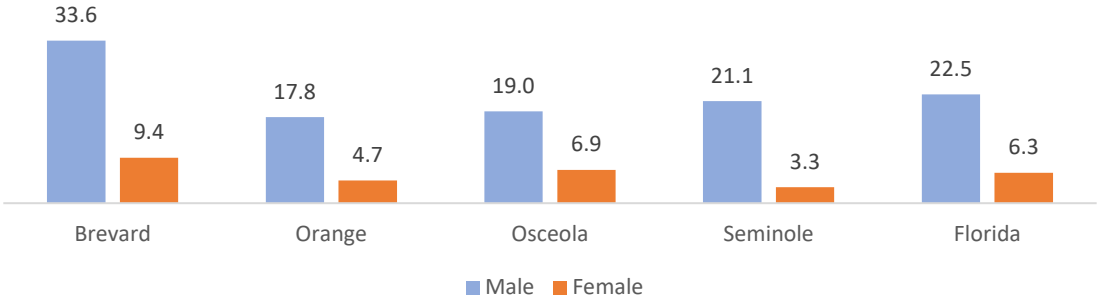
SOURCE: Behavioral Risk Factor Surveillance System (Unhealthy days in the past 30 days)

FIGURE 19: SUICIDE AGE-ADJUSTED DEATH RATE (2015-2017)



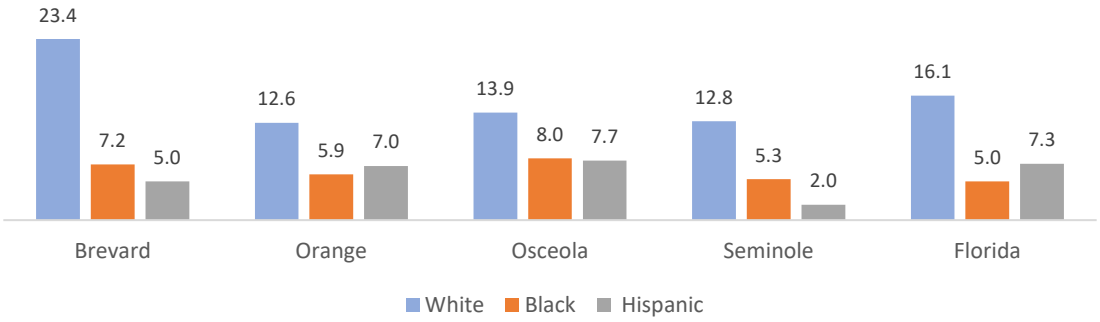
SOURCE: Florida Department of Health, Bureau of Vital Statistics (per 100,000 population)

FIGURE 20: SUICIDE AGE-ADJUSTED DEATH RATE BY GENDER (2017)



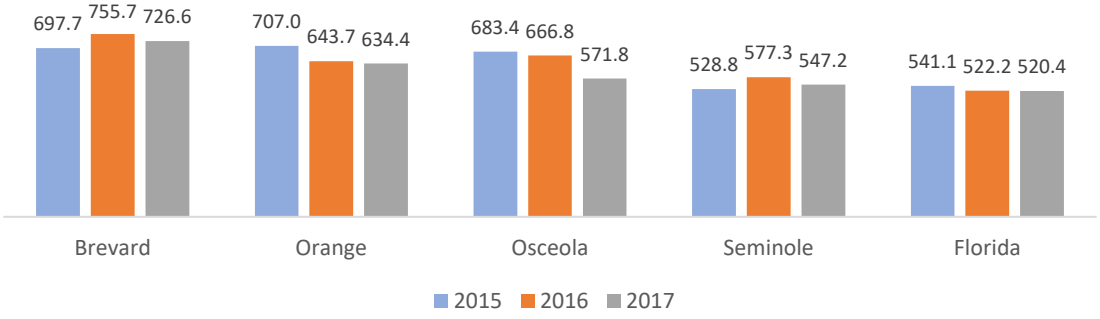
SOURCE: Florida Department of Health, Bureau of Vital Statistics (per 100,000 population)

FIGURE 21: SUICIDE AGE-ADJUSTED DEATH RATE BY RACE AND ETHNICITY (2017)



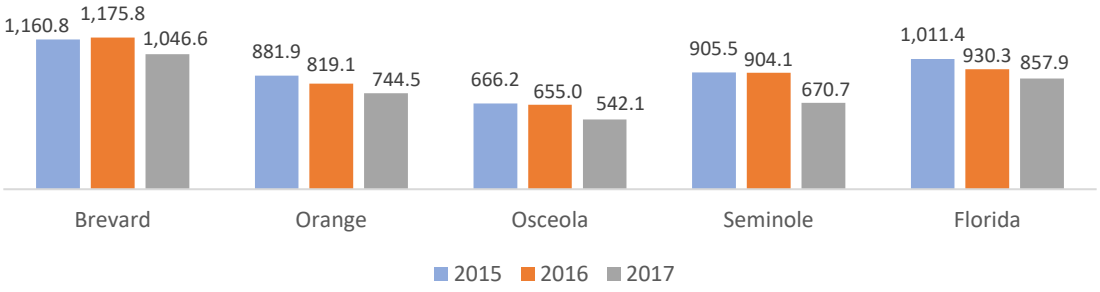
SOURCE: Florida Department of Health, Bureau of Vital Statistics (per 100,000 population)

FIGURE 22: TOTAL DOMESTIC VIOLENCE OFFENCES (2015-2017)



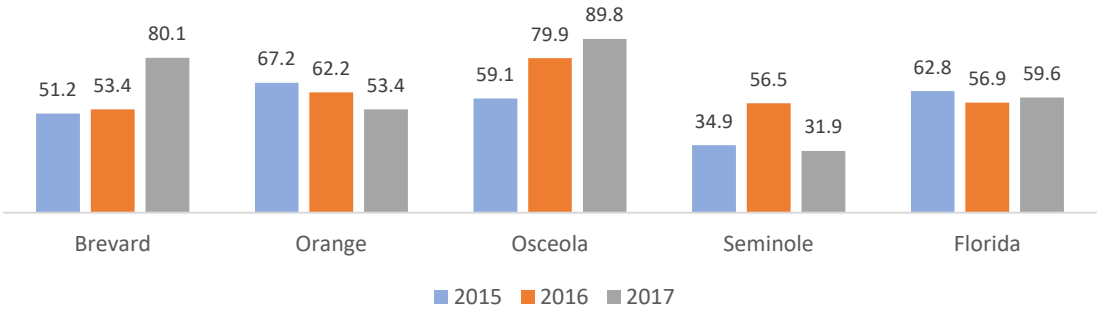
SOURCE: Florida Department of law Enforcement (per 100,000 population)

FIGURE 23: RATE OF CHILDREN EXPERIENCING CHILD ABUSE AGES 5-11 YEARS (2015-2017)



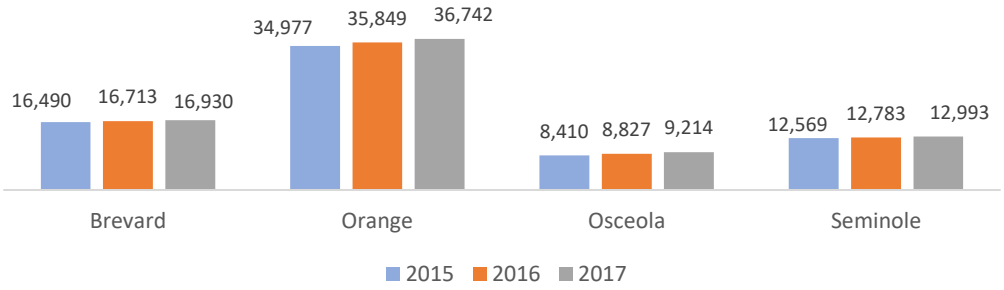
SOURCE: Florida Department of Children and Families, Florida Safe Families Network Data Mart (per 100,000 population)

FIGURE 24: RATE OF CHILDREN EXPERIENCING SEXUAL VIOLENCE AGES 5-11 YEARS (2015-2017)



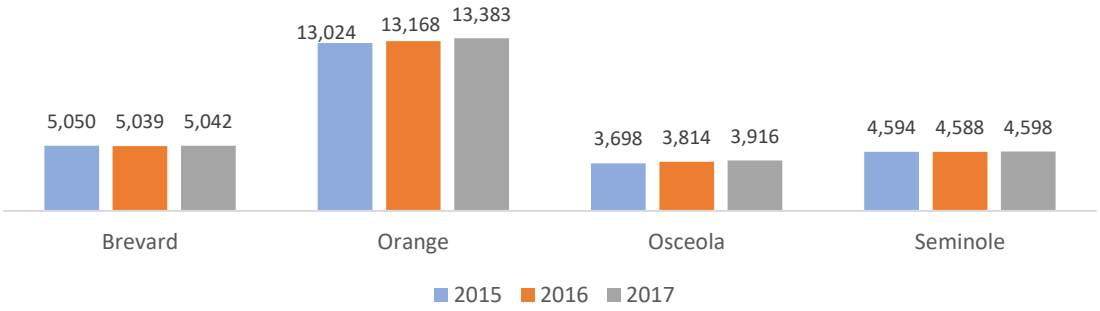
SOURCE: Florida Department of Children and Families, Florida Safe Families Network Data Mart (per 100,000 population)

FIGURE 25: ESTIMATED NUMBER OF SERIOUSLY MENTALLY ILL ADULTS (2015-2017)



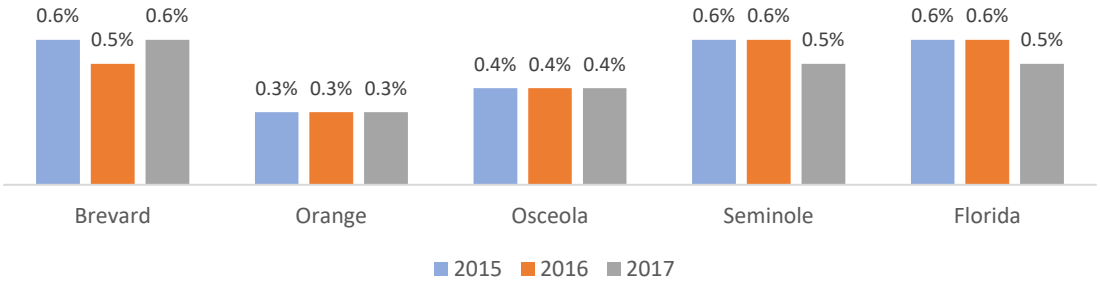
SOURCE: Estimates based on Department of Health and Human Services report Mental Health

FIGURE 26: ESTIMATED NUMBER OF EMOTIONALLY DISTURBED YOUTH AGES 9-17 YEARS (2015-2017)



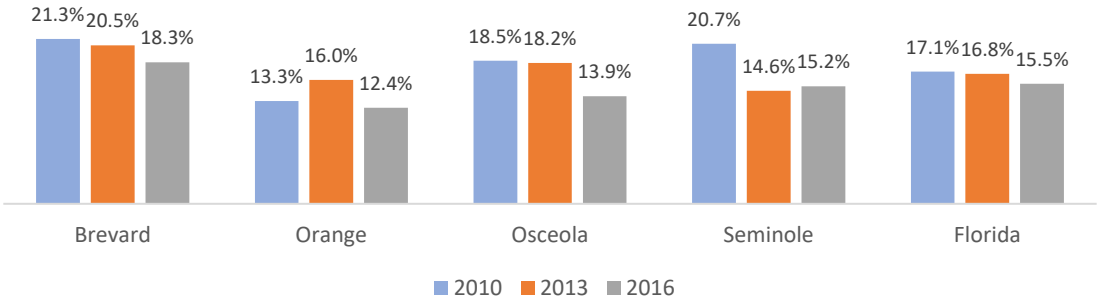
SOURCE: Estimates based on Department of Health and Human Services report Mental Health

FIGURE 27: CHILDREN WITH EMOTIONAL/BEHAVIORAL DISABILITY GRADES K-12 (2015-2017)



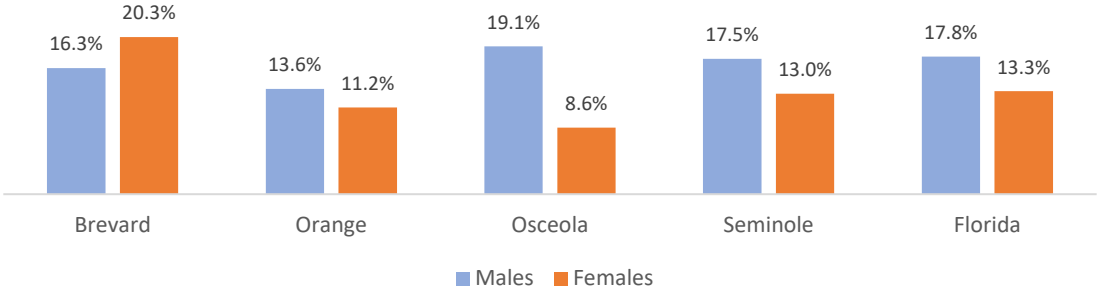
SOURCE: Florida Department of Education, Education Information and Accountability Services (EIAS)

FIGURE 28: ADULTS WHO ARE CURRENT SMOKERS (2010-2016)



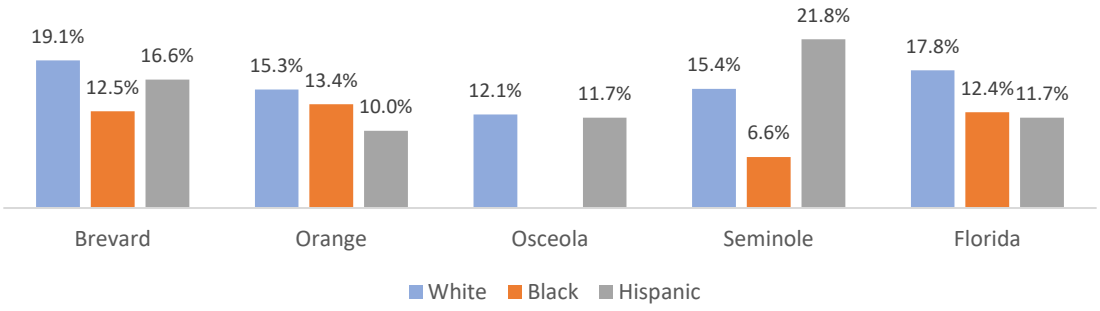
SOURCE: Behavioral Risk Factor Surveillance System

FIGURE 29: ADULTS WHO ARE CURRENT SMOKERS BY GENDER (2016)



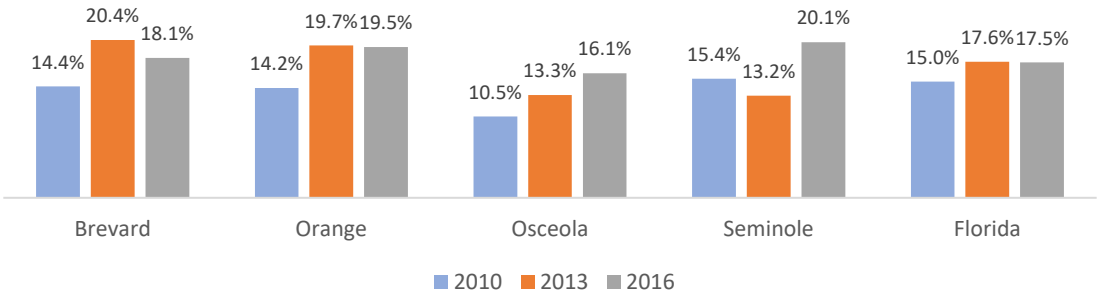
SOURCE: Behavioral Risk Factor Surveillance System

FIGURE 30: ADULTS WHO ARE CURRENT SMOKERS BY RACE AND ETHNICITY (2016)



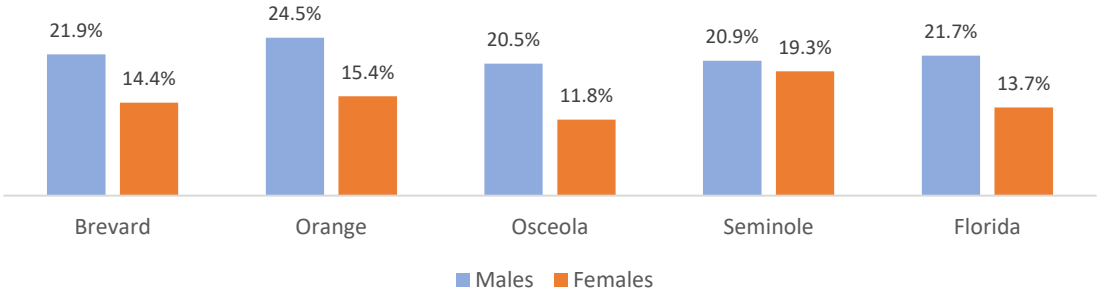
SOURCE: Behavioral Risk Factor Surveillance System (missing data indicate sample size is statistically unreliable)

FIGURE 31: ADULTS WHO ENGAGE IN HEAVY OR BINGE DRINKING (2010-2016)



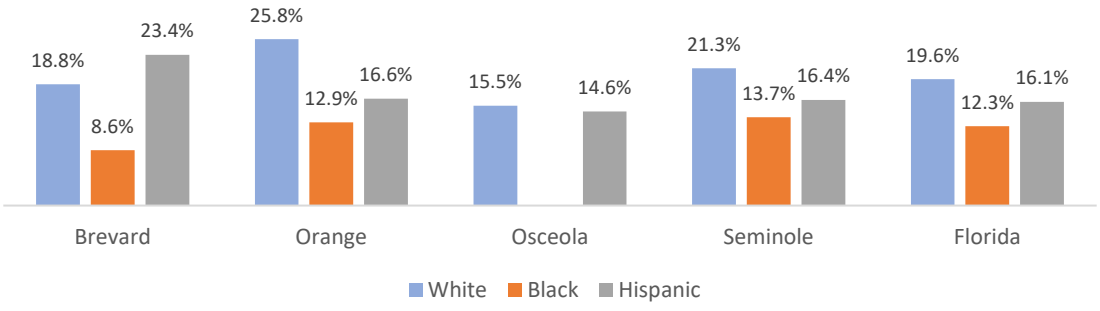
SOURCE: Behavioral Risk Factor Surveillance System

FIGURE 32: ADULTS WHO ENGAGE IN HEAVY OR BINGE DRINKING BY GENDER (2016)



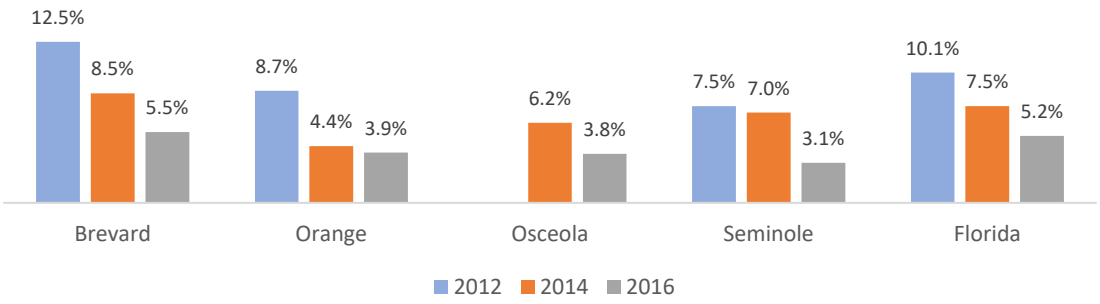
SOURCE: Behavioral Risk Factor Surveillance System

FIGURE 33: ADULTS WHO ENGAGE IN HEAVY OR BINGE DRINKING BY RACE AND ETHNICITY (2016)



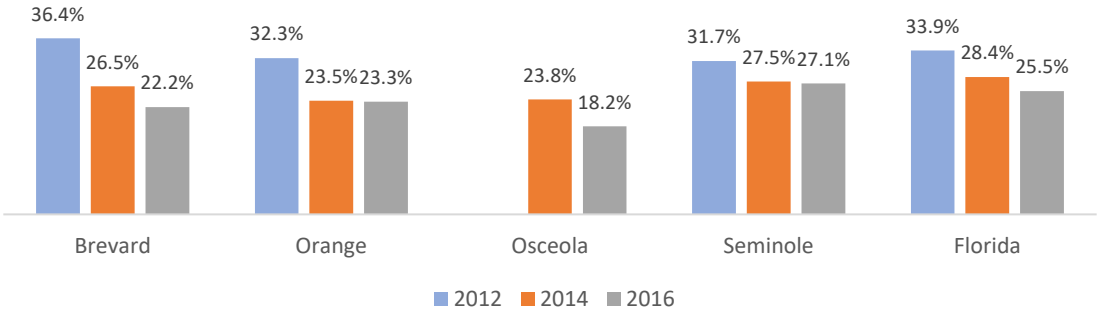
SOURCE: Behavioral Risk Factor Surveillance System (Missing data indicate sample size is statistically unreliable)

FIGURE 34: HIGH SCHOOL STUDENTS SMOKING CIGARETTES IN PAST 30 DAYS (2012-2016)



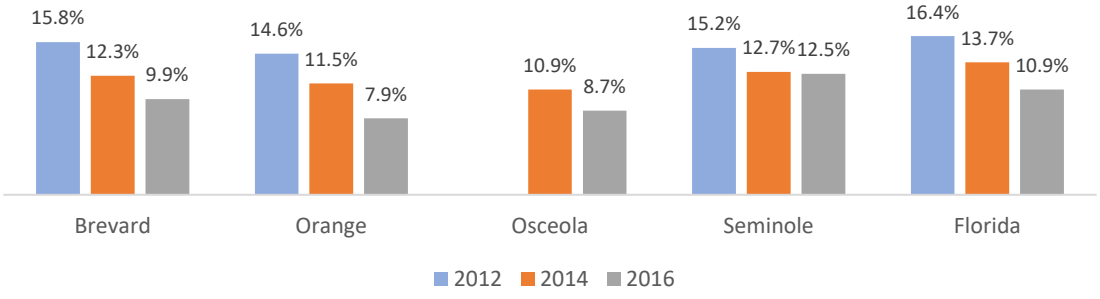
SOURCE: Florida Department of Children and Families, Florida Youth Tobacco Survey (Missing data indicate sample size is statistically unreliable)

FIGURE 35: HIGH SCHOOL STUDENTS WHO HAVE USED ALCOHOL IN PAST 30 DAYS (2012-2016)



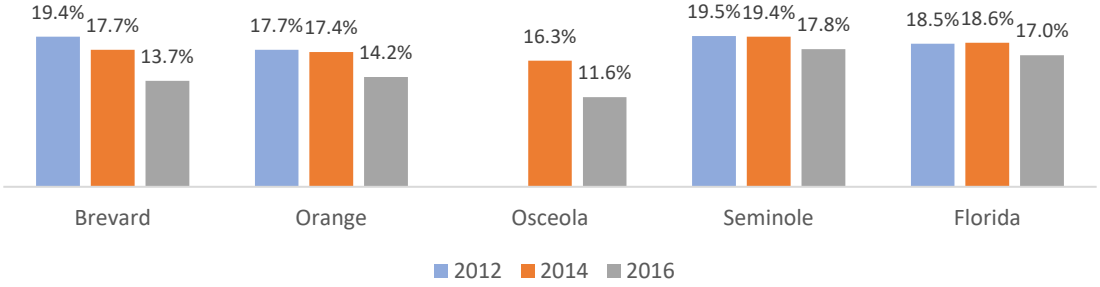
SOURCE: Florida Department of Children and Families, Florida Youth Substance Abuse Survey (Missing data indicate sample size is statistically unreliable)

FIGURE 36: HIGH SCHOOL STUDENTS REPORTING BINGE DRINKING (2012-2016)



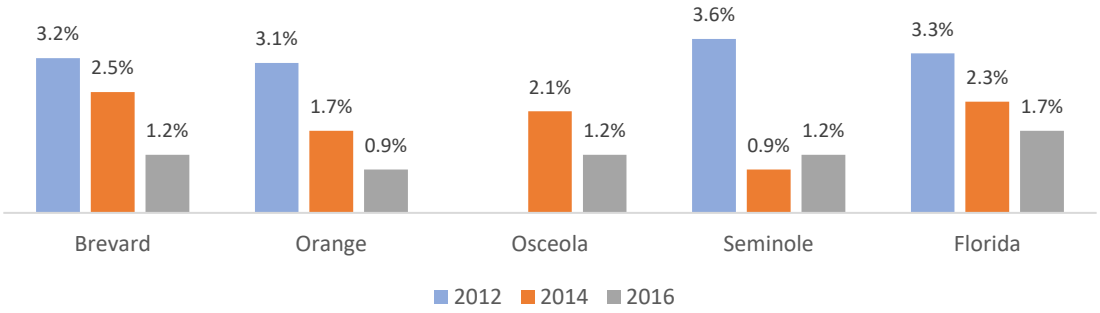
SOURCE: Florida Department of Children and Families, Florida Youth Substance Abuse Survey (Missing data indicate sample size is statistically unreliable)

FIGURE 37: HIGH SCHOOL STUDENTS USING MARIJUANA IN PAST 30 DAYS (2012-2016)



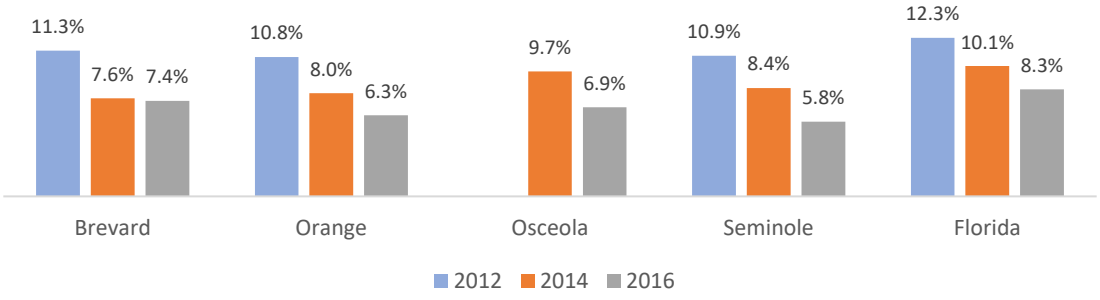
SOURCE: Florida Department of Children and Families, Florida Youth Substance Abuse Survey (Missing data indicate sample size is statistically unreliable)

FIGURE 38: MIDDLE SCHOOL STUDENTS SMOKING CIGARETTES IN PAST 30 DAYS (2012-2016)



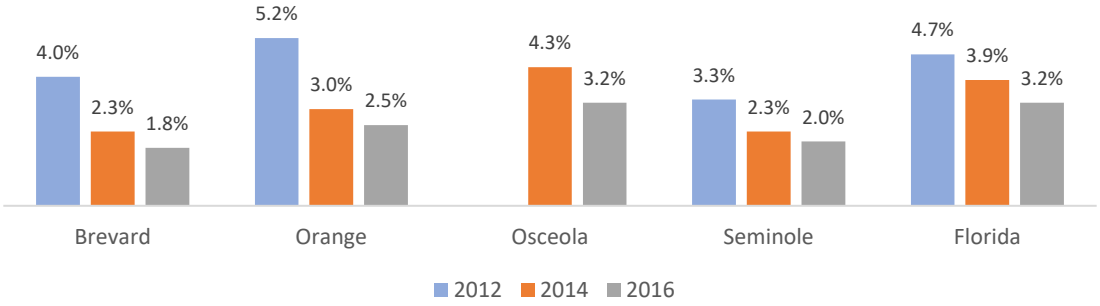
SOURCE: Florida Department of Children and Families, Florida Youth Tobacco Survey (Missing data indicate sample size is statistically unreliable)

FIGURE 39: MIDDLE SCHOOL STUDENTS WHO HAVE USED ALCOHOL IN PAST 30 DAYS (2012-2016)



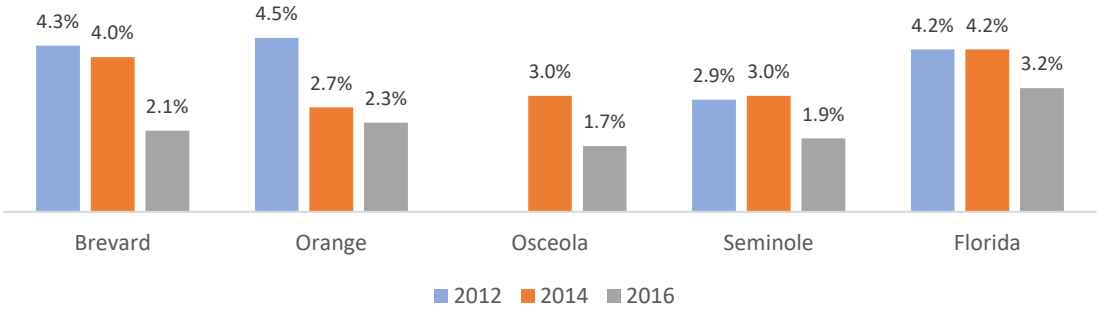
SOURCE: Florida Department of Children and Families, Florida Youth Substance Abuse Survey (Missing data indicate sample size is statistically unreliable)

FIGURE 40: MIDDLE SCHOOL STUDENTS REPORTING BINGE DRINKING (2012-2016)



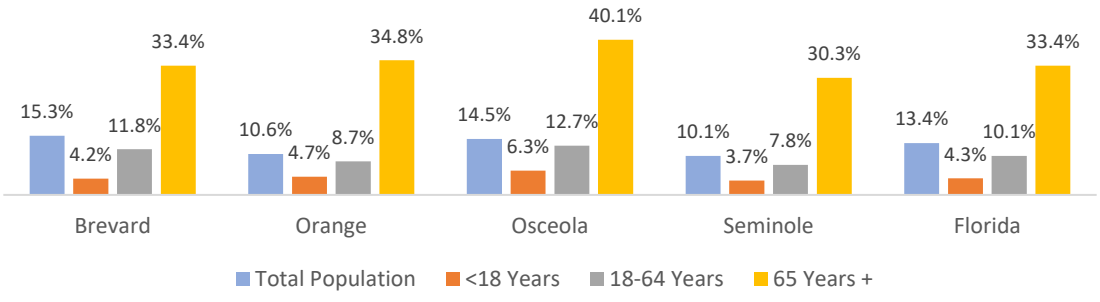
SOURCE: Florida Department of Children and Families, Florida Youth Substance Abuse Survey (Missing data indicate sample size is statistically unreliable)

FIGURE 41: MIDDLE SCHOOL STUDENTS USING MARIJUANA IN PAST 30 DAYS (2012-2016)



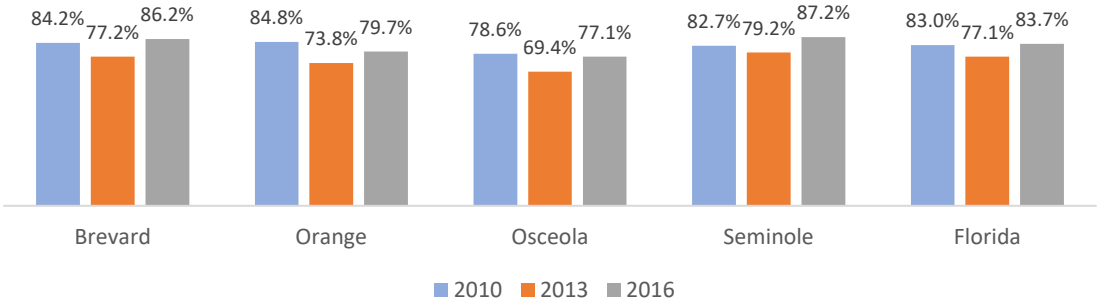
SOURCE: Florida Department of Children and Families, Florida Youth Substance Abuse Survey (Missing data indicate sample size is statistically unreliable)

FIGURE 42: CIVILIAN NONINSTITUTIONALIZED POPULATION WITH A DISABILITY (2013-2017)



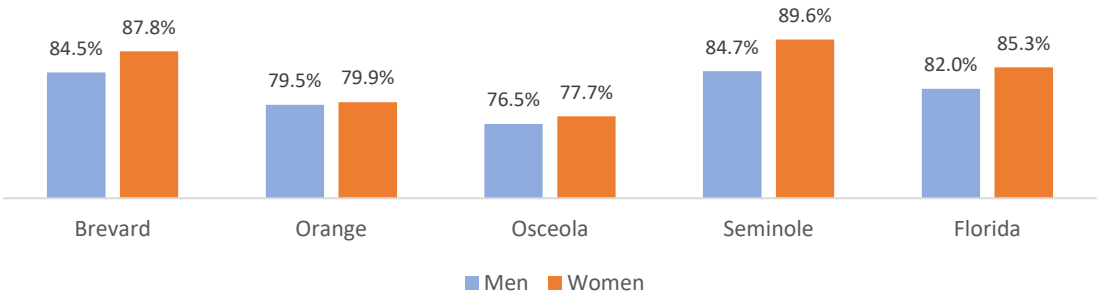
SOURCE: U.S Census Bureau, American Community Survey (2013-2017) Disability includes: Hearing, vision, cognitive, ambulatory, self-care, and independent living.

FIGURE 43: ADULTS WITH ANY TYPE OF HEALTH INSURANCE COVERAGE (2010-2016)



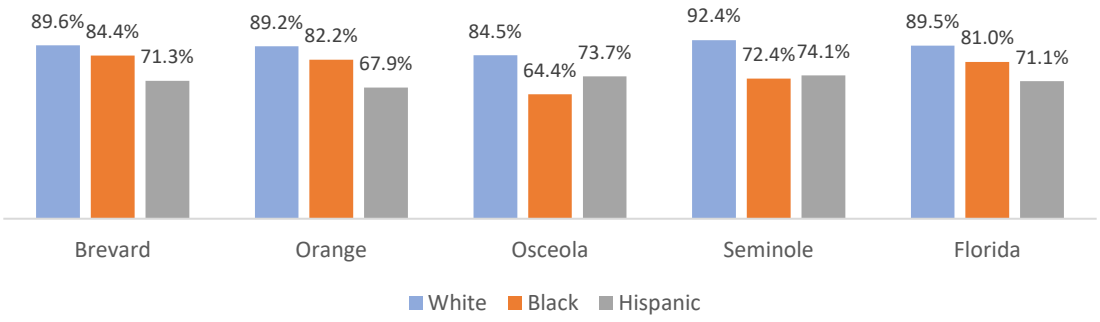
SOURCE: Behavioral Risk Factor Surveillance System

FIGURE 44: ADULTS WITH ANY TYPE OF HEALTH INSURANCE COVERAGE BY GENDER (2016)



SOURCE: Behavioral Risk Factor Surveillance System

FIGURE 45: ADULTS WITH ANY TYPE OF HEALTH INSURANCE COVERAGE BY RACE AND ETHNICITY (2016)



SOURCE: Behavioral Risk Factor Surveillance System

CFCHS Clients - Demographic Profile

CLIENT POPULATION

CFCHS funded organizations that served 31,227 clients in FY2017/18. This number included a small amount of duplication (<1.0 percent) in that some clients moved from one county to another, were enrolled in more than one program or changed residential status during the one-year time period. Over forty percent of clients resided in Orange County (13,092 clients), followed by Brevard County at 29.8 percent (9,321 clients), Seminole County at 14.3 percent (4,476 clients) and Osceola County at 9.2 percent (2,861 clients). Clients who reported their county as homeless accounted for 4.7 percent or 1,477 clients. It should be noted that 3,825 clients reported their residential status as homeless.

Adults in CFCHS programs accounted for eighty percent of all clients with 43.5 percent enrolled in the Adult Mental Health (AMH) program and 36.7 percent in the Adult Substance Abuse program (ASA). The remaining twenty percent of clients were children/youth in the Child Mental Health (CMH) program at 7.0 percent and the Child Substance Abuse (CSA) program at 12.8 percent.

GENDER

Males represented more than fifty percent of all clients in all programs ranging from 63.8 percent in the CSA program to 54.9 percent in the AMH program. Females accounted 45.5 percent of clients in AMH program yet only 36.2 percent of those in the CSA program.

RACE

The majority of CFCHS clients were White (59.8 percent) which was much lower than the percentage in the service area at 71.7 percent. Conversely, Black CFCHS clients accounted for 24.1 percent of the client population while representing only 15.8 percent of clients in four-county service area. This same pattern was evident in all programs when analyzing clients by race. Child/Youth programs were more racially diverse when compared to adult programs as 17.3 percent of clients in the CMH were multi-racial (<10.0 percent in AMH and ASA programs) and 39.8 percent of clients in the CSA program reported their race as Black. This was more than double the percentage of Blacks in the service area population, indicating an area of need for that population group.

ETHNICITY

The percentage of Hispanics in the CFCHS client population was reflective of the ethnic distribution of residents in the service area. Ethnic composition of clients in the AMH, ASA and CSA programs and the service area community were similar. However, clients in the CMH program were more ethnically diverse as Hispanics accounted for 32.7 percent of clients while representing 22.1 percent of residents living in the four-county area.

AGE RANGE

As expected, the age range distribution among CFCHS clients did not mimic that of the service area population. Adults, ages 25-44 years of age, accounted for 42.4 percent of those in the AMH and ASA programs while representing only 27.8 percent of the population in the four-county area. Teen and young adult clients, ages 15-24 years of age, represented 24.3 percent of clients while accounting for only 13.7 percent of those living in the service area population. Among those enrolled in child/youth programs, 66.3 percent of clients in the CMH program were 5-14 years of age and 66.9 percent of clients in the CSA program were 15-17 years old.

RESIDENTIAL STATUS

The majority of CFCHS adults resided in one of three types of independent living conditions: with relatives (41.9 percent); with non-relatives (15.2 percent); or alone at 60.0 percent. Among AMH clients, 12.3 percent reported their status as homeless, as did 17.3 percent of those in the ASA program. Children/Youth lived dependently with relatives.

EDUCATIONAL ATTAINMENT

CFCHS clients attained lower educational levels when compared to those in the service area population. Among CFCHS adults, educational attainment was limited to high school for 44.8 percent of AMH clients and 45.4 percent of ASA clients. This compares to 26.2 percent of residents in the four-county area who did not have more than a high school education. Consequently, the percentages of adult CFCHS clients who earned college degrees were well below those for residents living in the service area.

EMPLOYMENT STATUS

Lower educational attainment was one of several factors that contributed to much higher levels of unemployment among CFCHS clients when compared to those in the service area. Over eighty percent of AMH clients and 74.3 percent of ASA clients were not employed. In the service area and Florida, less than four percent of residents were unemployed.

NOTE: SOURCE FOR ALL CHARTS IN THIS SECTION: CFCHS FY2017/18

FIGURE 46: CFCHS CLIENTS BY COUNTY

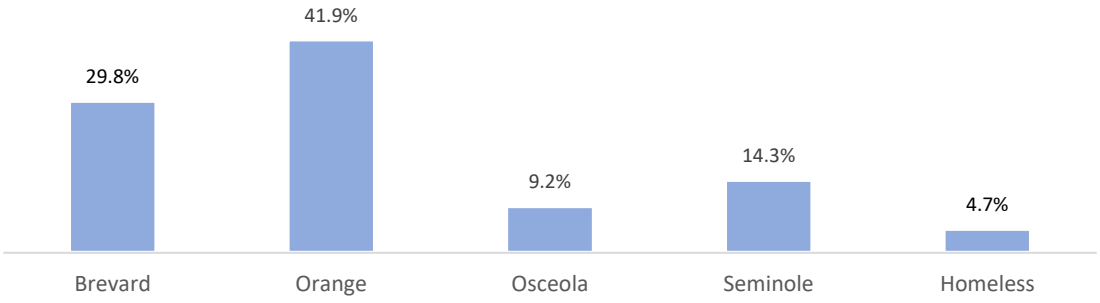
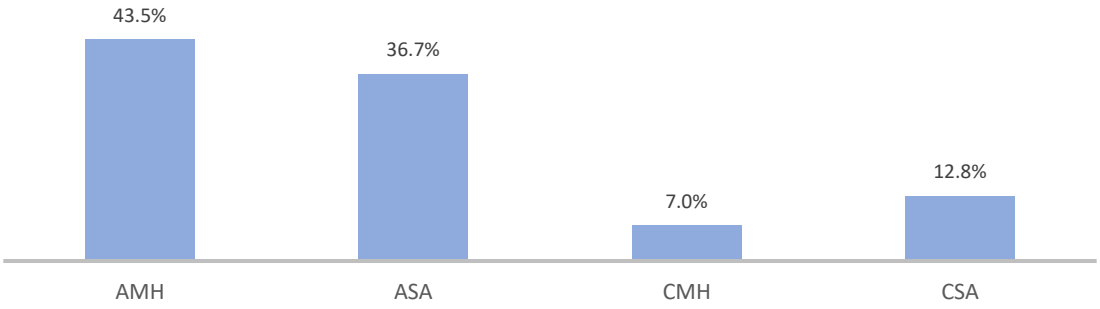


FIGURE 47: CFCHS CLIENTS BY PROGRAM



AMH (Adult Mental Health), ASA (Adults Substance Abuse), CMH (Child Mental Health) and CSA (Child Substance Abuse).

FIGURE 48: CFCHS CLIENTS BY PROGRAM AND GENDER

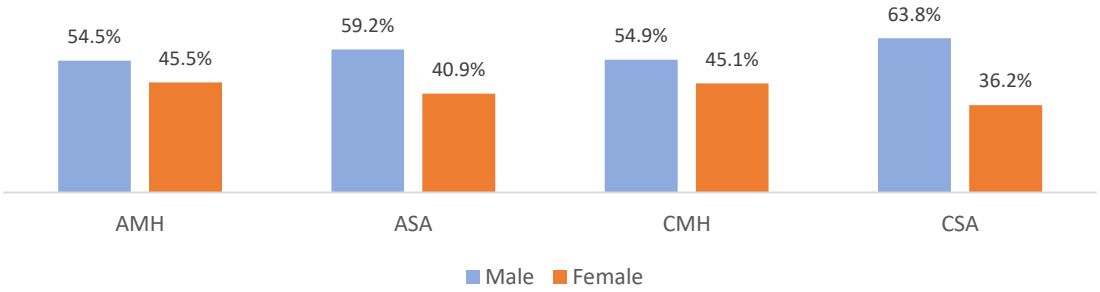


FIGURE 49: CFCHS CLIENTS BY RACE

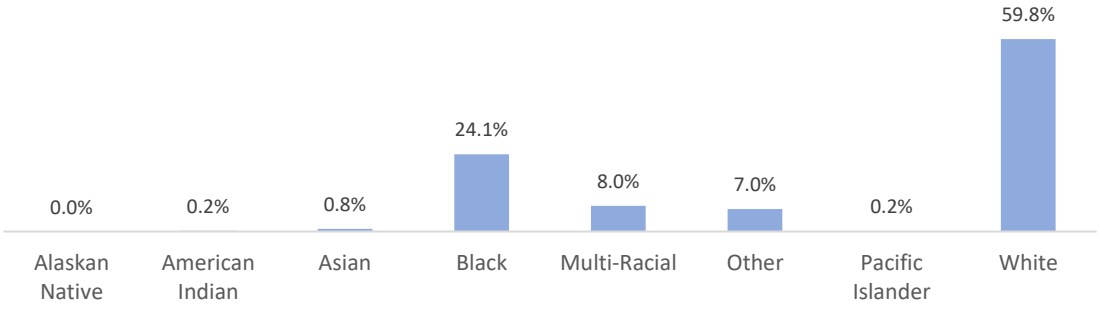


FIGURE 50: CFCHS CLIENTS BY PROGRAM AND RACE

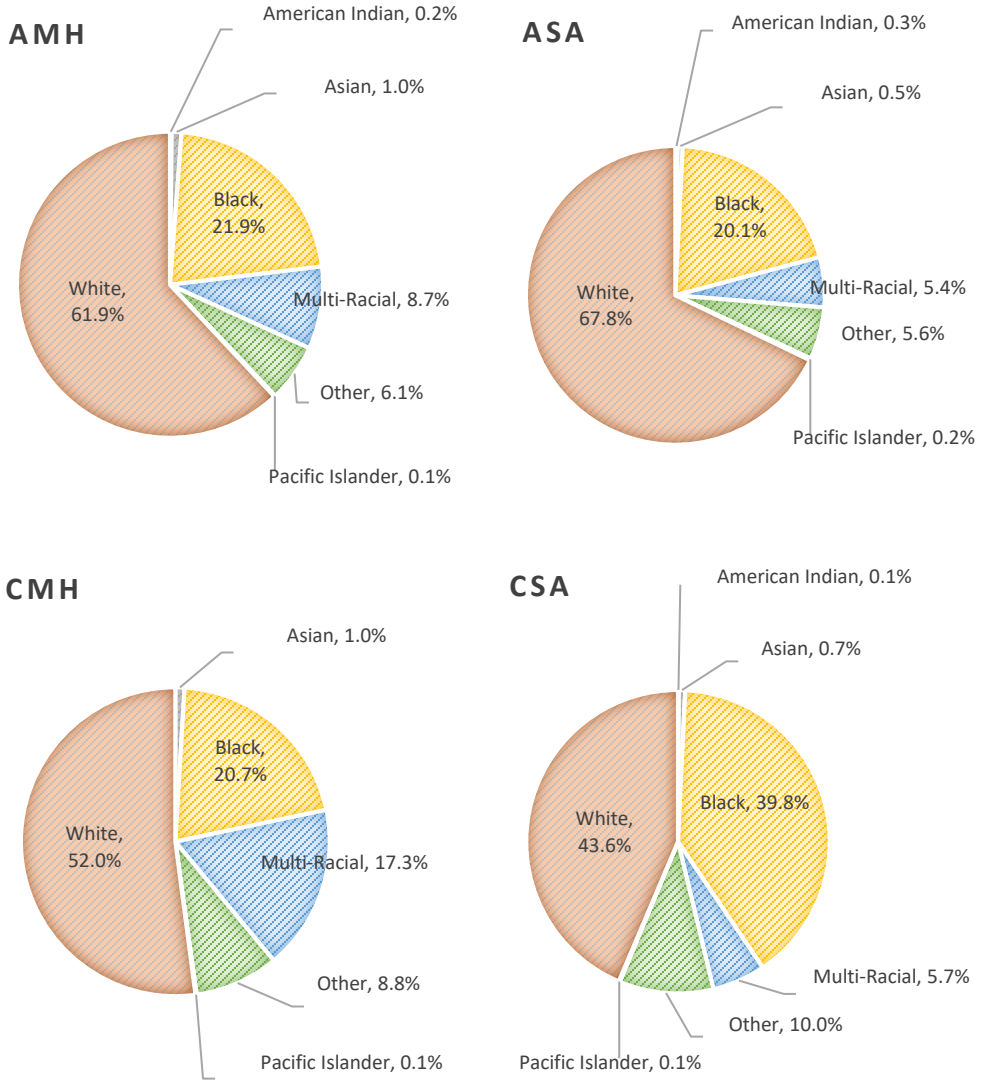


FIGURE 51: CFCHS CLIENTS BY ETHNICITY

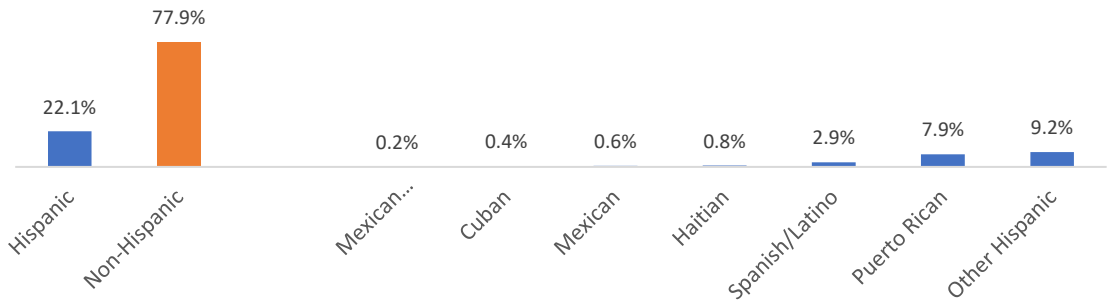


FIGURE 52: CFCHS ADULT CLIENTS BY PROGRAM AND ETHNICITY

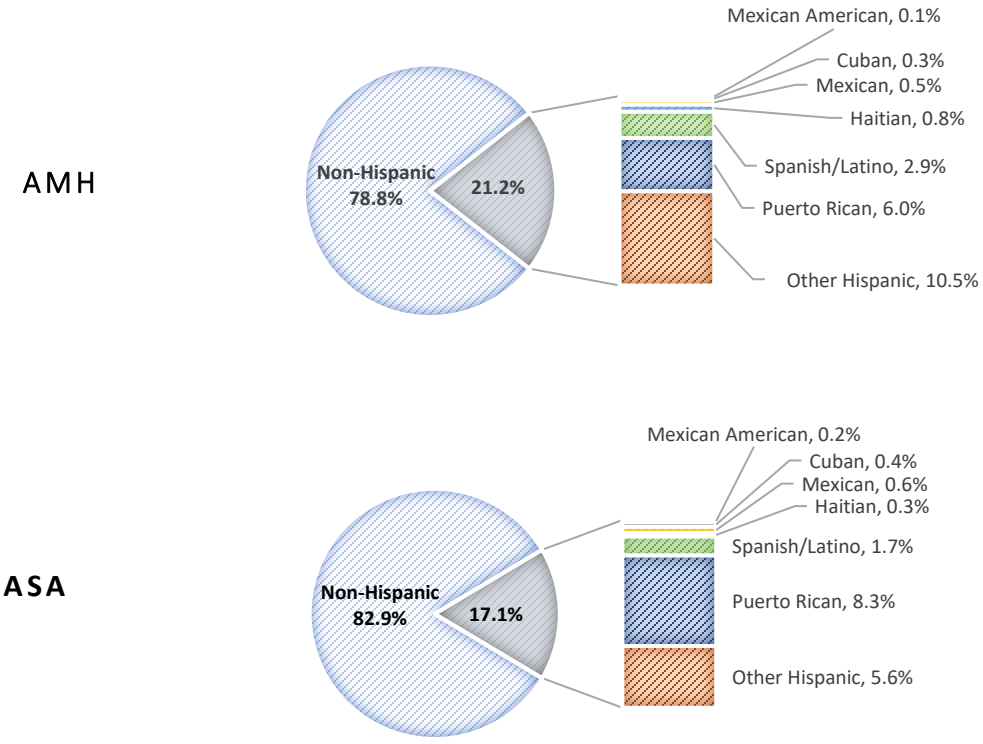


FIGURE 53: CFCHS CHILD CLIENTS BY PROGRAM AND ETHNICITY

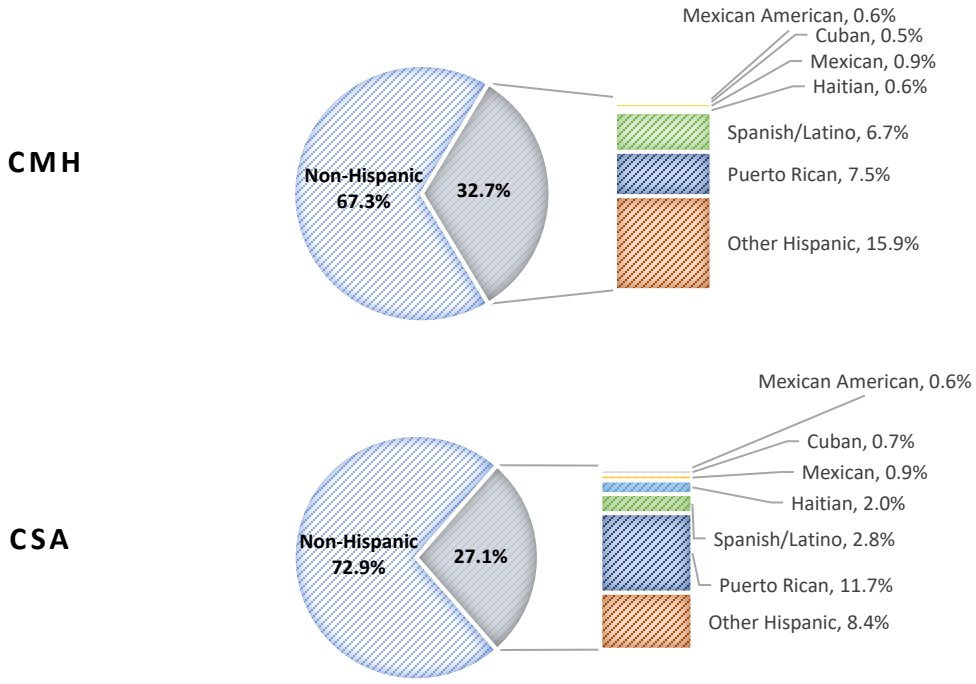


FIGURE 54: CFCHS CLIENTS BY AGE RANGE

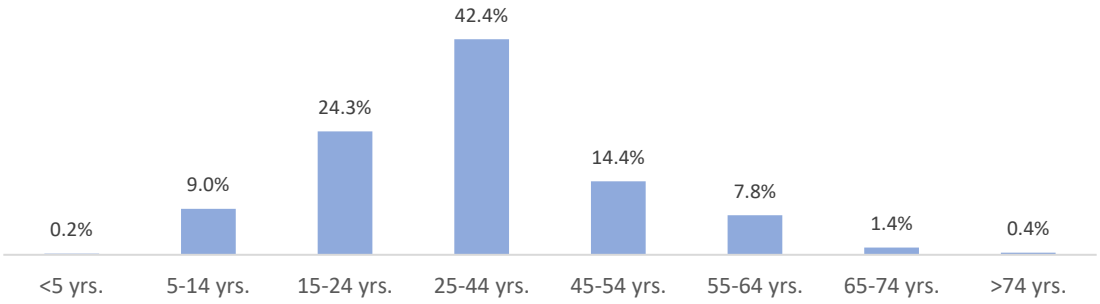


FIGURE 55: CFCHS ADULT CLIENTS BY PROGRAM AND AGE RANGE

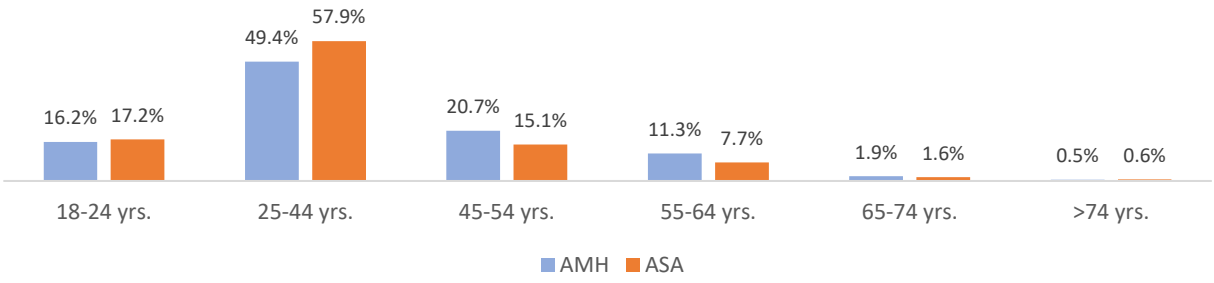


FIGURE 56: CFCHS CHILD CLIENTS BY PROGRAM AND AGE RANGE

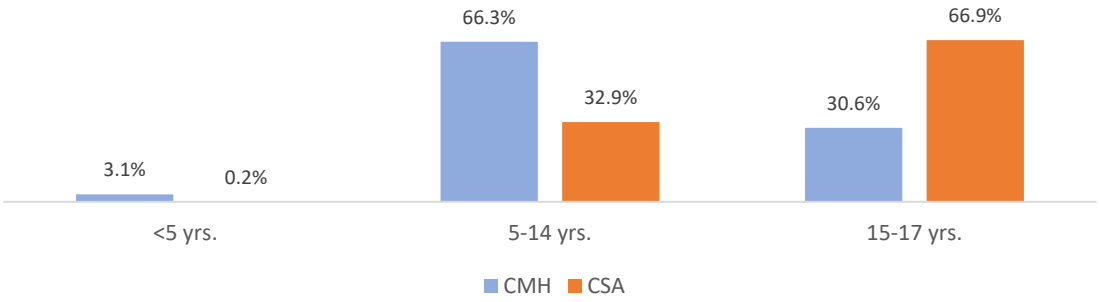


FIGURE 57: CFCHS CLIENTS BY RESIDENTIAL STATUS

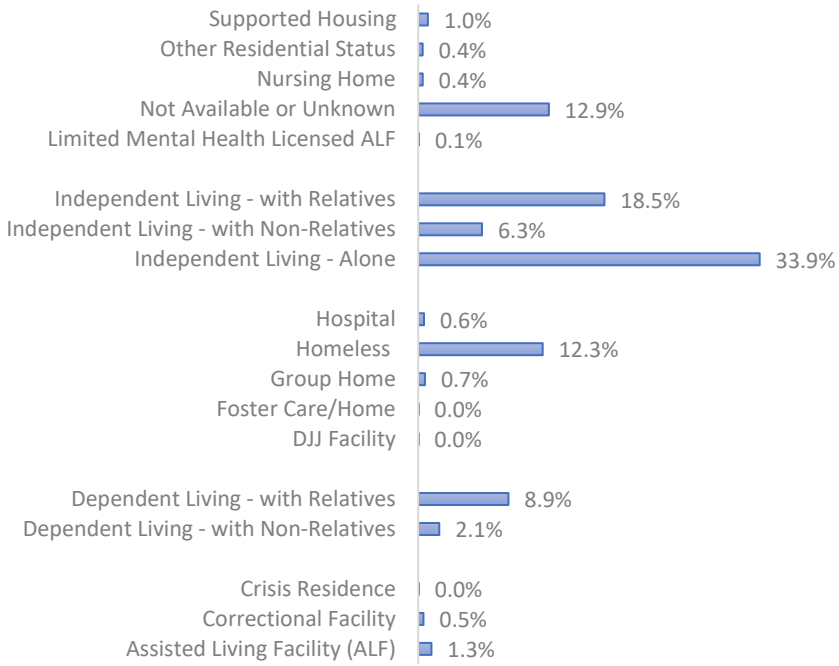


FIGURE 58: CFCHS AMH CLIENTS BY RESIDENTIAL STATUS

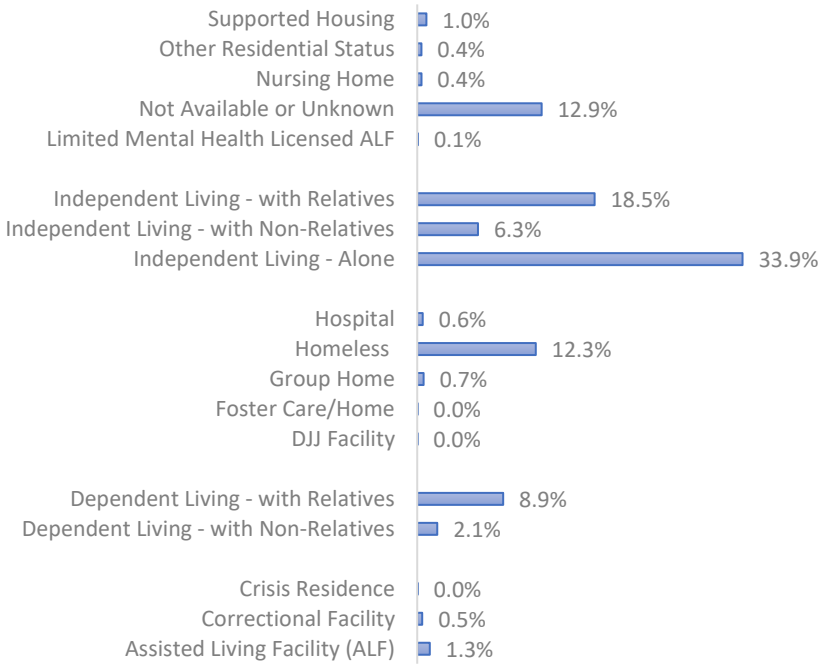


FIGURE 59: CFCHS ASA CLIENTS BY RESIDENTIAL STATUS

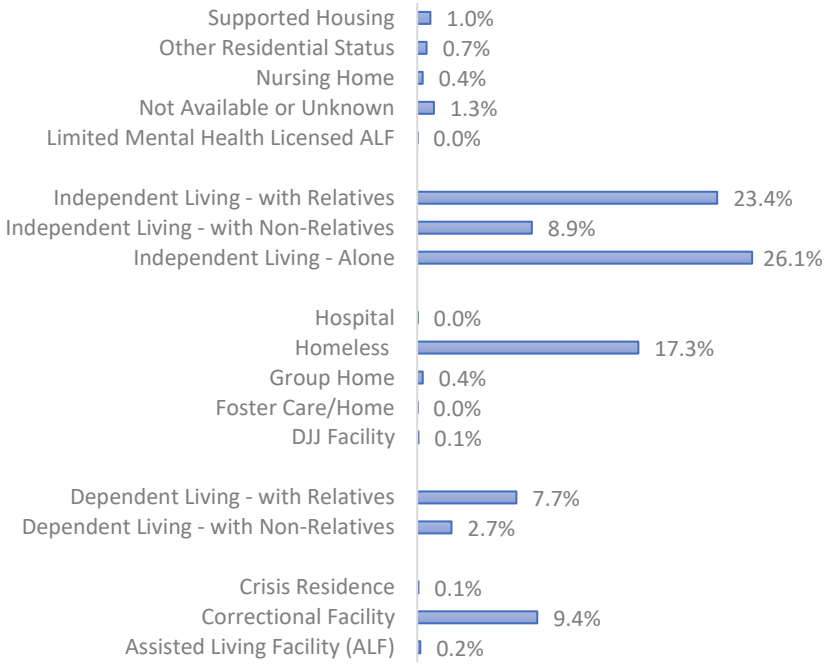


FIGURE 60: CFCHS CMH CLIENTS BY RESIDENTIAL STATUS

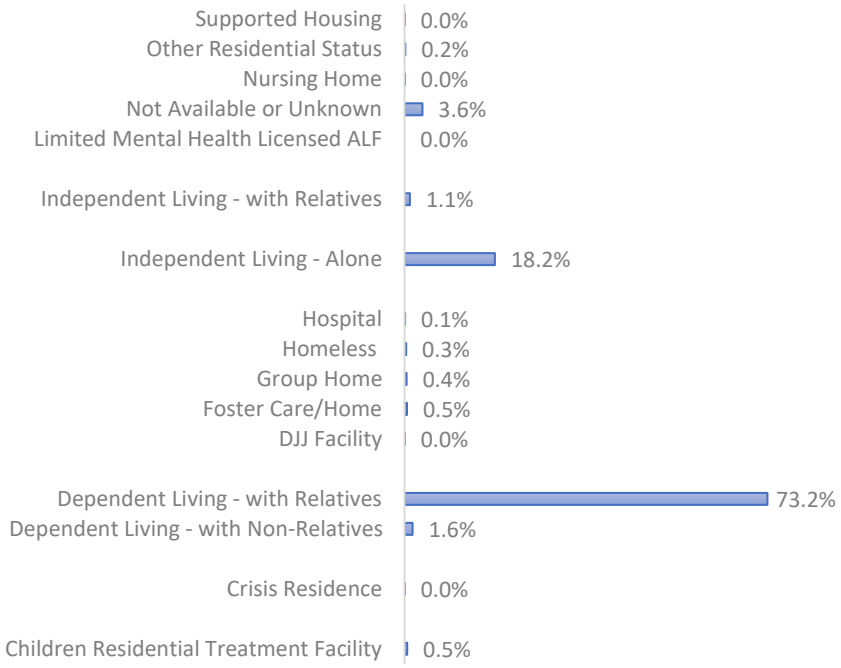


FIGURE 61: CFCHS CSA CLIENTS BY RESIDENTIAL STATUS

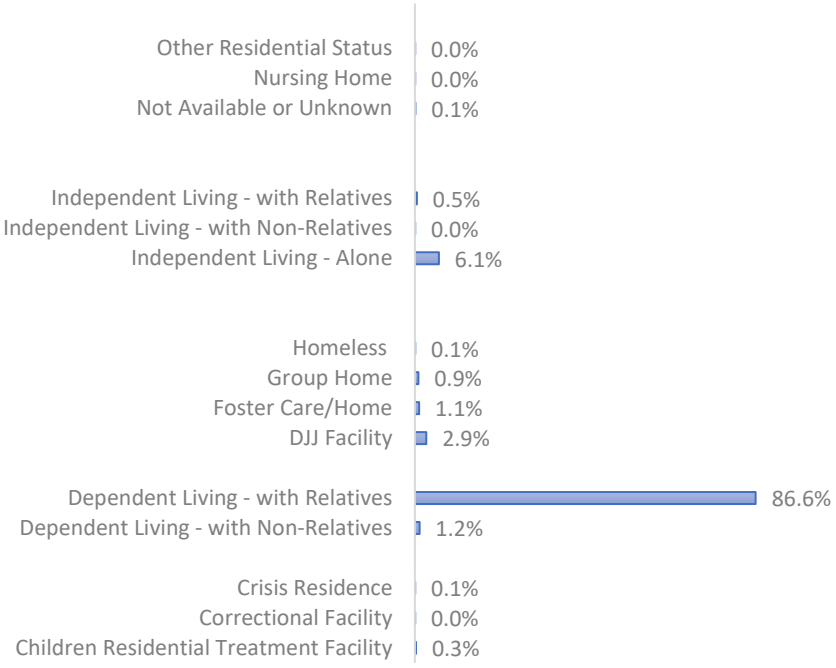


FIGURE 62: CFCHS AMH CLIENTS BY EDUCATIONAL ATTAINMENT

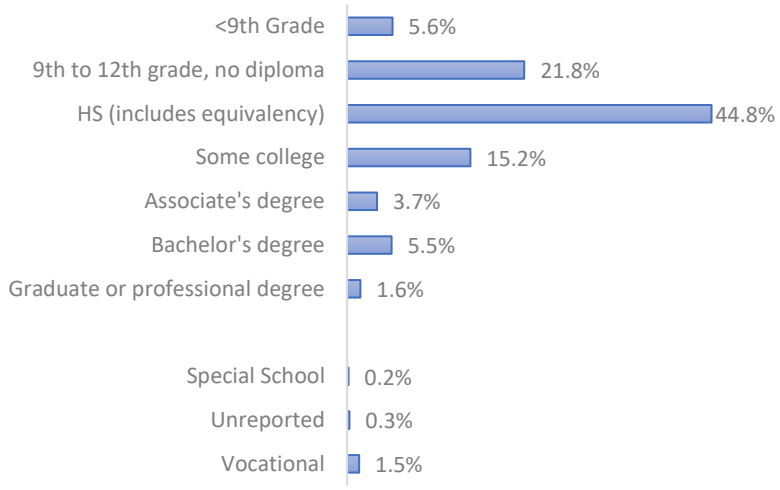


FIGURE 63: CFCHS ASA CLIENTS BY EDUCATIONAL ATTAINMENT

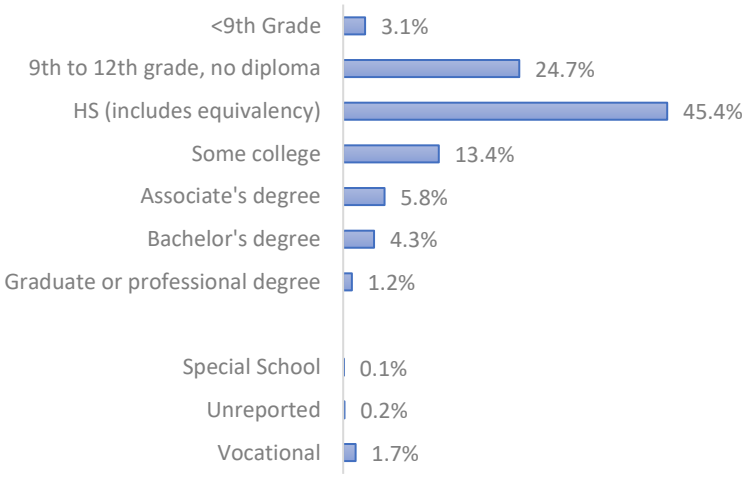


FIGURE 64: CFCHS CLIENTS BY EMPLOYMENT STATUS

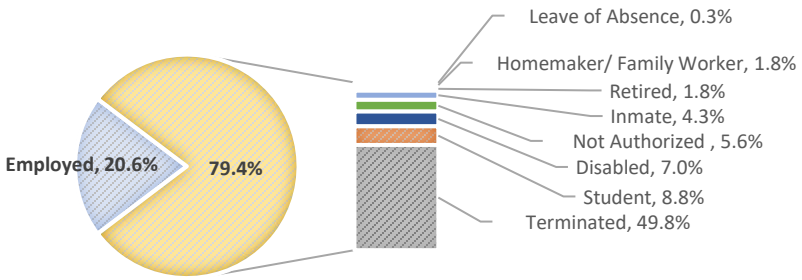


FIGURE 65: CFCHS AMH CLIENTS BY EMPLOYMENT STATUS

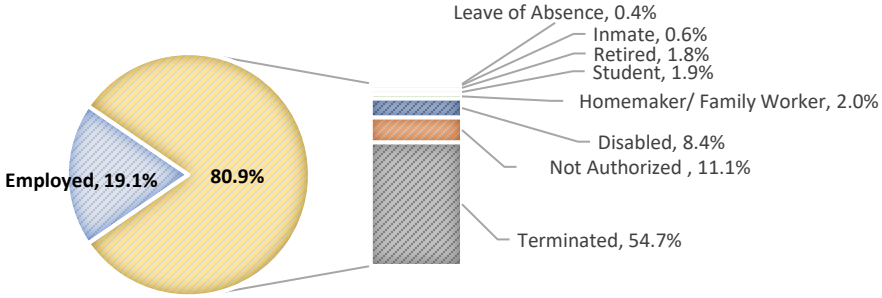
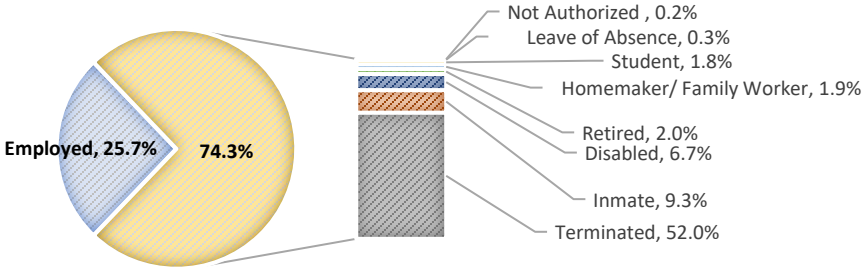


FIGURE 66: CFCHS ASA CLIENTS BY EMPLOYMENT STATUS



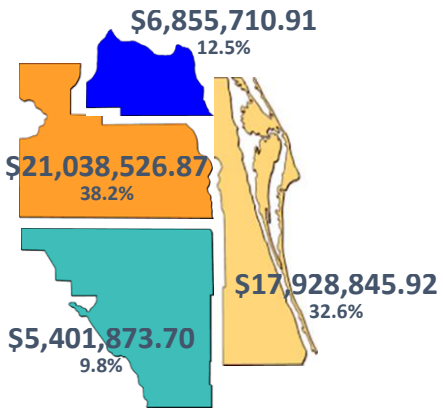
CFCHS Costs

CFCHS FY1718

$55,020,533.01

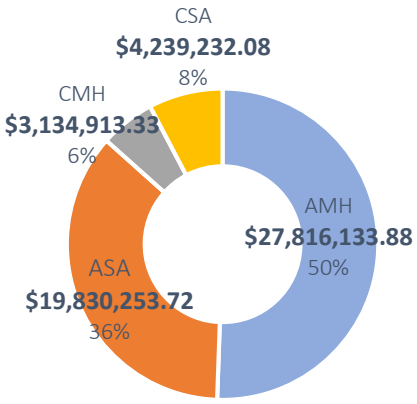
FOR SERVICE COSTS

BY COUNTY



Homeless clients - $664,670.73 (1.2%)
Out-of-State clients - $3,130,9.4.88 (5.7%)

BY PROGRAM



BY COST CENTER

ASSESSMENT	$151,668.98
CASE MANAGEMENT	$3,852,821.72
CRISIS STABILIZATION	$12,365,234.77
CRISIS SUPPORT	$25,524.06
DAY TREATMENT	$166,564.32
INCIDENTAL EXPENSES	$1,688,913.00
IN-HOME/ON-SITE	$417,655.71
INPATIENT	$1,834,240.55
INTENSIVE CASE MANAGEMENT	$210,025.97
INTERVENTION	$1,489,544.86
INTERVENTION – GROUP	$231,837.13
MEDICAL SERVICES	$2,890,110.62
METHADONE MAINTENANCE	$362,518.20
OUTPATIENT - GROUP	$961,808.30
OUTPATIENT - INDIVIDUAL	$1,996,897.62
RECOVERY SUPPORT - GROUP	$3,477.04
RECOVERY SUPPORT - INDIVIDUAL	$141,301.09
RESIDENTIAL LEVEL 1	$1,587,236.80
RESIDENTIAL LEVEL 2	$10,283,205.38
RESIDENTIAL LEVEL 3	$1,361,471.75
RESIDENTIAL LEVEL 4	$363,625.58
ROOM & BOARD LEVEL 2	$2,774,874.90
ROOM & BOARD LEVEL 3	$1,545,913.74
SHORT-TERM RESIDENTIAL TX	$2,227,431.99
SUBSTANCE USE DETOXIFICATION	$4,382,722.24
SUPPORTED HOUSING	$339,584.82
TASC	$1,364,321.87

FIGURE 67: CFCHS SERVICE AREA COSTS BY COST CENTER AND PROGRAM

COST CENTER	AMH	ASA	CMH	CSA	GRAND TOTAL
Assessment	$85,806.52	$23,455.36	$42,407.10		$151,668.98
Case Management	$1,856,271.80	$888,392.51	$1,108,157.41		$3,852,821.72
Crisis Stabilization	$11,522,560.72		$842,674.05		$12,365,234.77
Crisis Support/Emergency	$22,462.81		$3,061.25		$25,524.06
Day Treatment (Day/Night)		$166,564.32			$166,564.32
Incidental Expenses	$889,690.00	$678,711.00	$120,512.00		$1,688,913.00
In-Home and On-Site Services	$159,741.64		$257,914.07		$417,655.71
Inpatient	$1,737,645.00		$96,595.55		$1,834,240.55
Intensive Case Management	$210,025.97				$210,025.97
Intervention	$11,518.22	$752,237.70	$246,509.69	$479,279.25	$1,489,544.86
Intervention - Group		$71,445.33		$160,391.80	$231,837.13
Medical Services	$2,365,890.45	$479,477.62	$30,752.62	$13,989.93	$2,890,110.62
Methadone Maintenance		$362,518.20			$362,518.20
Outpatient - Group	$512,236.15	$440,769.22	$3,485.29	$5,317.64	$961,808.30
Outpatient - Individual	$590,991.49	$1,141,541.27	$239,022.48	$25,342.38	$1,996,897.62
Recovery Support - Group	$2,416.81	$1,060.23			$3,477.04
Recovery Support - Individual	$38,697.52	$102,603.57			$141,301.09
Residential Level 1		$1,507,078.50	$80,158.30		$1,587,236.80
Residential Level 2	$739,077.80	$7,216,880.94		$2,327,246.64	$10,283,205.38
Residential Level 3	$50,240.13	$1,311,231.62			$1,361,471.75
Residential Level 4	$196,718.92	$166,906.66			$363,625.58
Room & Board Level 2	$2,711,211.38		$63,663.52		$2,774,874.90
Room & Board Level 3	$1,545,913.74				$1,545,913.74
Short-term Residential TX	$2,227,431.99				$2,227,431.99
Substance Abuse Detoxification		$4,207,597.22		$175,125.02	$4,382,722.24
Supported Housing/Living	$339,584.82				$339,584.82
TASC		$311,782.45		$1,052,539.42	$1,364,321.87
GRAND TOTAL	**$27,816,133.88**	**$19,830,253.72**	**$3,134,913.33**	**$4,239,232.08**	**$55,020,533.01**

FIGURE 68: BREVARD COUNTY COSTS BY COST CENTER AND PROGRAM

COST CENTER	AMH	ASA	CMH	CSA	GRAND TOTAL
Assessment	$12,955.82	$9,021.85	$14,432.20		$36,409.87
Case Management	$412,843.98	$572,683.91	$197,370.95		$1,182,898.84
Crisis Stabilization	$4,107,823.40		$445,627.08		$4,553,450.48
Crisis Support/Emergency	$57.03		$11.55		$68.58
Day Treatment (Day/Night)		$123,990.12			$123,990.12
Incidental Expenses	$325,112.00	$496,414.00	$36,886.00		$858,412.00
In-Home and On-Site Services	$4,526.64		$130,803.41		$135,330.05
Inpatient	$1,725,920.00		$67,536.00		$1,793,456.00
Intervention	$11,518.22	$244,701.84	$230,070.11	$866.30	$487,156.47
Intervention - Group		$18,464.03		$182.70	$18,646.73
Medical Services	$835,433.89	$60,979.35	$2,834.63	$1,774.20	$901,022.07
Methadone Maintenance		$5,858.88			$5,858.88
Outpatient - Group	$148.38	$94,328.12	$19.61		$94,496.11
Outpatient - Individual	$51,703.92	$253,922.67	$61,346.69	$219.27	$367,192.55
Recovery Support - Individual	$0.00	$2,996.32			$2,996.32
Residential Level 1		$815,061.80	$55,042.68		$870,104.48
Residential Level 2	$90,590.82	$1,498,454.52		$219,728.83	$1,808,774.17
Residential Level 3	$1,410.63	$584,807.73			$586,218.36
Residential Level 4	$30,805.00	$43,554.60			$74,359.60
Room & Board Level 2	$1,423,455.00		$10,801.60		$1,434,256.60
Room & Board Level 3	$827,979.00				$827,979.00
Substance Abuse Detoxification		$1,298,896.94		$82,935.96	$1,381,832.90
Supported Housing/Living	$0.00				$0.00
TASC		$222,972.94		$160,962.80	$383,935.74
GRAND TOTAL	**$9,862,283.73**	**$6,347,109.62**	**$1,252,782.51**	**$466,670.06**	**$17,928,845.92**

FIGURE 69: ORANGE COUNTY COSTS BY COST CENTER AND PROGRAM

COST CENTER	AMH	ASA	CMH	CSA	GRAND TOTAL
Assessment	$42,906.12	$3,306.47	$20,036.18		$66,248.77
Case Management	$685,371.53	$217,129.22	$473,931.99		$1,376,432.74
Crisis Stabilization	$4,503,458.54		$182,726.84		$4,686,185.38
Crisis Support/Emergency	$19,941.58		$2,343.59		$22,285.17
Day Treatment (Day/Night)		$42,393.96			$42,393.96
Incidental Expenses	$279,965.00	$103,569.00	$71,348.00		$454,882.00
In-Home and On-Site Services	$91,567.12		$97,491.70		$189,058.82
Inpatient			$1,876.00		$1,876.00
Intensive Case Management	$190,324.19				$190,324.19
Intervention		$345,087.06	$10,687.63	$135,502.57	$491,277.26
Intervention - Group		$41,075.18		$42,565.57	$83,640.75
Medical Services	$1,022,453.86	$323,930.54	$23,096.47	$3,664.71	$1,373,145.58
Methadone Maintenance		$292,484.48			$292,484.48
Outpatient - Group	$83,067.39	$192,465.61	$2,996.93	$74.20	$278,604.13
Outpatient - Individual	$202,277.85	$578,154.66	$103,572.31	$8,201.42	$892,206.24
Recovery Support - Group	$2,275.26	$96.60			$2,371.86
Recovery Support - Individual	$33,460.80	$39,051.92			$72,512.72
Residential Level 1		$109,734.70	$9,270.00		$119,004.70
Residential Level 2	$320,267.26	$3,503,922.31		$412,170.88	$4,236,360.45
Residential Level 3	$20,399.88	$331,236.94			$351,636.82
Residential Level 4	$115,582.08	$35,453.00			$151,035.08
Room & Board Level 2	$340,224.78		$10,114.65		$350,339.43
Room & Board Level 3	$674,116.05				$674,116.05
Short-term Residential TX	$1,848,683.90				$1,848,683.90
Substance Abuse Detoxification		$1,897,699.74		$28,957.28	$1,926,657.02
Supported Housing/Living	$339,584.82				$339,584.82
TASC		$25,464.64		$499,713.91	$525,178.55
GRAND TOTAL	**$10,815,928.01**	**$8,082,256.03**	**$1,009,492.29**	**$1,130,850.54**	**$21,038,526.87**

FIGURE 70: OSCEOLA COUNTY COSTS BY COST CENTER AND PROGRAM

COST CENTER	AMH	ASA	CMH	CSA	GRAND TOTAL
Assessment	$11,409.03	$9,292.84	$6,024.77		$26,726.64
Case Management	$296,200.08	$29,535.56	$383,307.82		$709,043.46
Crisis Stabilization	$1,143,248.34		$36,343.38		$1,179,591.72
Crisis Support/Emergency	$584.83		$72.92		$657.75
Incidental Expenses	$214,036.00	$53,875.00	$8,985.00		$276,896.00
In-Home and On-Site Services	$19,822.65		$21,997.54		$41,820.19
Intensive Case Management	$7,559.28				$7,559.28
Intervention		$95,996.48	$5,239.40	$8,535.10	$109,770.98
Intervention - Group		$1,212.98		$685.90	$1,898.88
Medical Services	$132,978.39	$31,446.75	$2,402.51	$1,308.83	$168,136.48
Methadone Maintenance		$4,896.76			$4,896.76
Outpatient - Group	$2,236.43	$82,823.55	$468.75	$5,243.44	$90,772.17
Outpatient - Individual	$86,788.60	$183,497.34	$37,506.29	$12,526.57	$320,318.80
Recovery Support - Group		$782.29			$782.29
Recovery Support - Individual		$9,751.03			$9,751.03
Residential Level 1		$509,501.70			$509,501.70
Residential Level 2	$4,701.32	$297,535.16		$275,408.13	$577,644.61
Residential Level 3		$102,982.30			$102,982.30
Residential Level 4		$84,193.00			$84,193.00
Room & Board Level 2	$567,621.48				$567,621.48
Room & Board Level 3	$12,860.67				$12,860.67
Short-term Residential TX	$41,233.57				$41,233.57
Substance Abuse Detoxification		$438,023.22		$3,619.66	$441,642.88
TASC		$343.53		$115,227.53	$115,571.06
GRAND TOTAL	**$2,541,280.67**	**$1,935,689.49**	**$502,348.38**	**$422,555.16**	**$5,401,873.70**

FIGURE 71: SEMINOLE COUNTY COSTS BY COST CENTER AND PROGRAM

COST CENTER	AMH	ASA	CMH	CSA	GRAND TOTAL
Assessment	$17,523.79	$448.04	$1,858.57		$19,830.40
Case Management	$317,299.09	$56,802.91	$48,279.90		$422,381.90
Crisis Stabilization	$862,703.68		$26,067.45		$888,771.13
Crisis Support/Emergency	$1,051.95		$283.02		$1,334.97
Day Treatment (Day/Night)		$180.24			$180.24
Incidental Expenses	$46,165.00	$21,010.00	$3,293.00		$70,468.00
In-Home and On-Site Services	$43,825.23		$7,621.42		$51,446.65
Inpatient	$1,407.00		$6,097.00		$7,504.00
Intensive Case Management	$1,324.45				$1,324.45
Intervention		$50,077.47	$512.55	$332,129.12	$382,719.14
Intervention - Group		$8,410.05		$111,536.65	$119,946.70
Medical Services	$328,752.45	$48,531.77	$2,331.75	$1,919.61	$381,535.58
Methadone Maintenance		$41,112.68			$41,112.68
Outpatient - Group	$379,435.74	$62,712.75			$442,148.49
Outpatient - Individual	$234,572.88	$103,978.15	$32,568.32	$4,395.12	$375,514.47
Recovery Support - Group	$141.55				$141.55
Recovery Support - Individual	$4,482.04	$47,154.77			$51,636.81
Residential Level 1		$23,878.70			$23,878.70
Residential Level 2	$247,180.94	$1,270,178.90		$409,599.86	$1,926,959.70
Residential Level 3	$28,429.62	$246,328.95			$274,758.57
Residential Level 4	$50,331.84				$50,331.84
Room & Board Level 2	$237,136.20		$42,747.27		$279,883.47
Room & Board Level 3	$21,331.77				$21,331.77
Short-term Residential TX	$267,062.46				$267,062.46
Substance Abuse Detoxification		$390,624.02		$37,565.10	$428,189.12
TASC		$60,099.84		$265,218.28	$325,318.12
GRAND TOTAL	**$3,090,157.68**	**$2,431,529.24**	**$171,660.25**	**$1,162,363.74**	**$6,855,710.91**

FIGURE 72: HOMELESS COSTS BY COST CENTER AND PROGRAM

COST CENTER	AMH	ASA	GRAND TOTAL
Assessment	$127.91	$597.38	$725.29
Case Management	$12,277.47	$5,193.50	$17,470.97
Crisis Stabilization	$261,452.46		$261,452.46
Crisis Support/Emergency	$41.88		$41.88
Incidental Expenses	$1,346.00	$92.00	$1,438.00
Inpatient	$2,814.00		$2,814.00
Intervention		$1,970.30	$1,970.30
Intervention - Group		$1,054.80	$1,054.80
Medical Services	$7,907.72	$6,474.43	$14,382.15
Methadone Maintenance		$3,302.80	$3,302.80
Outpatient - Group	$14,625.29	$556.47	$15,181.76
Outpatient - Individual	$1,190.34	$3,068.68	$4,259.02
Recovery Support - Individual		$1,938.61	$1,938.61
Residential Level 2	$13,561.50	$147,457.22	$161,018.72
Residential Level 3		$7,053.15	$7,053.15
Residential Level 4		$650.00	$650.00
Room & Board Level 2	$99,175.30		$99,175.30
Short-term Residential TX	$15,838.06		$15,838.06
Substance Abuse Detoxification		$54,903.46	$54,903.46
GRAND TOTAL	**$430,357.93**	**$234,312.80**	**$664,670.73**

FIGURE 73: OUT OF SERVICE AREA COSTS BY COST CENTER AND PROGRAM

COST CENTER	AMH	ASA	CMH	CSA	GRAND TOTAL
Assessment	$883.85	$788.78	$55.38		$1,728.01
Case Management	$132,279.65	$7,047.41	$5,266.75		$144,593.81
Crisis Stabilization	$643,874.30		$151,909.30		$795,783.60
Crisis Support/Emergency	$785.54		$350.17		$1,135.71
Incidental Expenses	$23,066.00	$3,751.00			$26,817.00
Inpatient	$7,504.00		$21,086.55		$28,590.55
Intensive Case Management	$10,818.05				$10,818.05
Intervention		$14,404.55		$2,246.16	$16,650.71
Intervention - Group		$1,228.29		$5,420.98	$6,649.27
Medical Services	$38,364.14	$8,114.78	$87.26	$5,322.58	$51,888.76
Methadone Maintenance		$14,862.60			$14,862.60
Outpatient - Group	$32,722.92	$7,882.72			$40,605.64
Outpatient - Individual	$14,457.90	$18,919.77	$4,028.87		$37,406.54
Recovery Support - Group		$181.34			$181.34
Recovery Support - Individual	$754.68	$1,710.92			$2,465.60
Residential Level 1		$48,901.60	$15,845.62		$64,747.22
Residential Level 2	$62,775.96	$499,332.83		$1,010,338.94	$1,572,447.73
Residential Level 3		$38,822.55			$38,822.55
Residential Level 4		$3,056.06			$3,056.06
Room & Board Level 2	$43,598.62				$43,598.62
Room & Board Level 3	$9,626.25				$9,626.25
Short-term Residential TX	$54,614.00				$54,614.00
Substance Abuse Detoxification		$127,449.84		$22,047.02	$149,496.86
TASC		$2,901.50		$11,416.90	$14,318.40
GRAND TOTAL	**$1,076,125.86**	**$799,356.54**	**$198,629.90**	**$1,056,792.58**	**$3,130,904.88**

Brevard County - Demographic Profile

POPULATION DEMOGRAPHICS

The population in Brevard County increased an average of one percent each year from 2013 to 2017. The total population growth for the five-year period, at 4.1 percent, added 22,516 residents.

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

The racial composition in Brevard County, the service area and state were predominately White at 82.9 percent, 71.7 percent, and 76.3 percent, respectively. The Black population accounted for 10.2 percent of Brevard's population and 16.0 percent of the population in Florida. American Indian and Native Hawaiian's represented less than one percent of residents in Brevard County. The percentage of Asian residents, at 2.4 percent was lower in Brevard County when compared to the service area at 4.1 percent but similar to the state rate at 2.5 percent. Brevard County was slightly less diverse when compared to the state with 1.3 percent having a race of Other and 2.8 percent of residents belonging to more than one racial group.

Ethnically, Brevard County had a much lower percentage of Hispanic residents, at 9.7 percent, when compared to the service area at 26.7 percent and the state at 22.9 percent.

Brevard County's population was older when compared to the age distribution in the service area and the state. Residents, 65 years of age or older, accounted for 22.7 percent of the population when compared to 14.4 percent in the service area and 17.8 percent in Florida.

EDUCATION AND EMPLOYMENT

Data revealed the service area and state populations were very similar regarding education attainment. Slightly more residents in Brevard County completed their education at the high school level, (27.7 percent compared to 26.2 percent in the service area), and attained an associate degree (12.8 percent compared to 11.7 in the service area). Graduate or professional degrees were held by 11.6 percent of the population in the county when compared to 10.5 percent in the service area and 10.3 in the state.

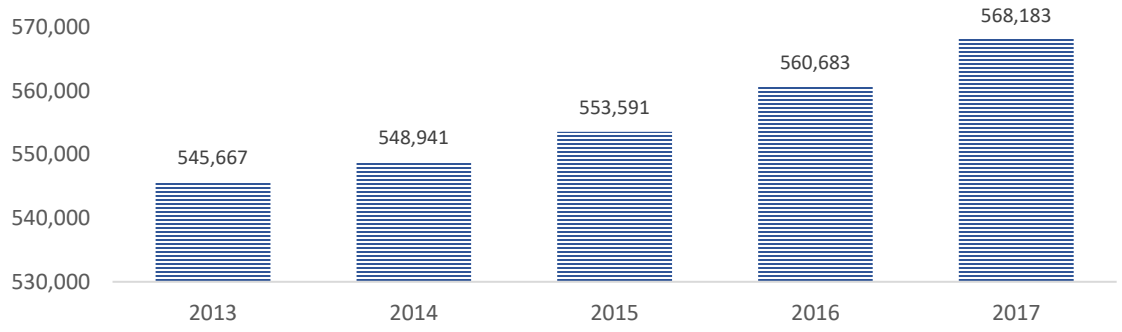
Participation in the labor force for Brevard County residents decreased each year between 2013 and 2016 but remained fairly stable when comparing 2016 to 2017 data. This could be attributed to larger percentage of the population being at or older than retirement age. In Brevard, 53.8 percent of the population participated in the labor force. This was lower when compared to the service area, at 63.0 percent but the same as the state rate. The unemployment rate for the service area decreased 46.4 percent from 2013 to 2017. This

was similar to decreases in the unemployment rate in the service area, at 45.8 percent, and Florida, at 43.3 percent, during the same time period.

POVERTY STATUS

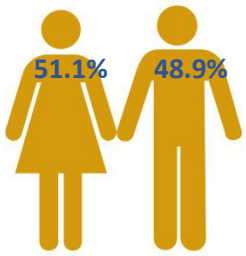
Over the past five years, the percent of Brevard County residents living at <200% FPL decreased from 36.3 percent in 2013 to 29.9 percent in 2017 while those living at greater than 200% FPL increased. Those at 400% FPL increased from 32.3 percent in 2013 to 36.0 percent in 2017.

FIGURE 74: BREVARD COUNTY POPULATION ESTIMATES (2013-2017)



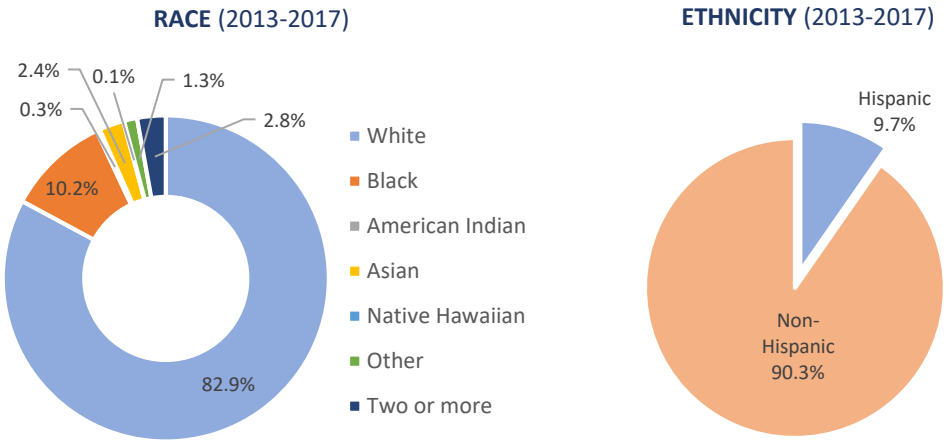
SOURCE: U.S. Census Bureau, American Community Survey

FIGURE 75: BREVARD COUNTY POPULATION BY GENDER (2013-2017)



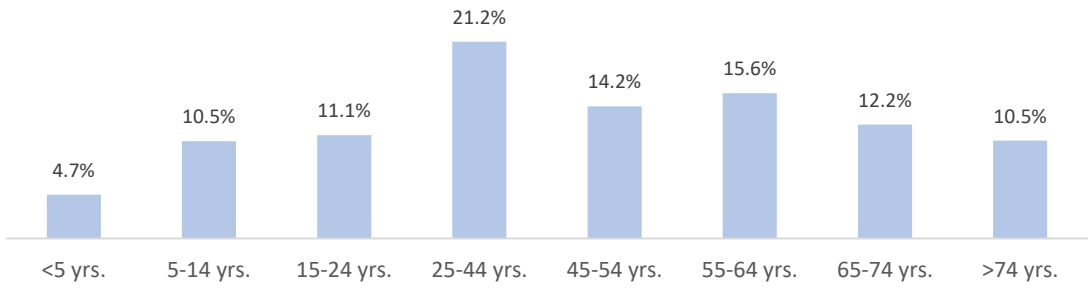
SOURCE: U.S. Census Bureau, American Community Survey

FIGURE 76: BREVARD COUNTY POPULATION BY RACE AND ETHNICITY (2013-2017)



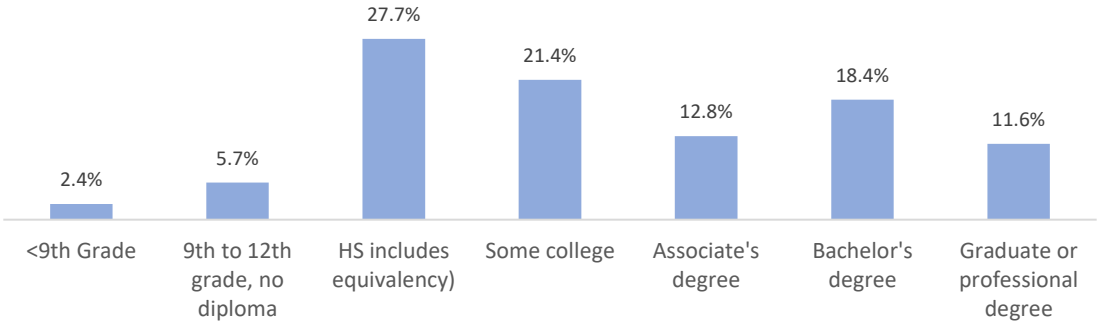
SOURCE: U.S. Census Bureau, American Community Survey

FIGURE 77: BREVARD COUNTY POPULATION BY AGE RANGE (2013-2017)



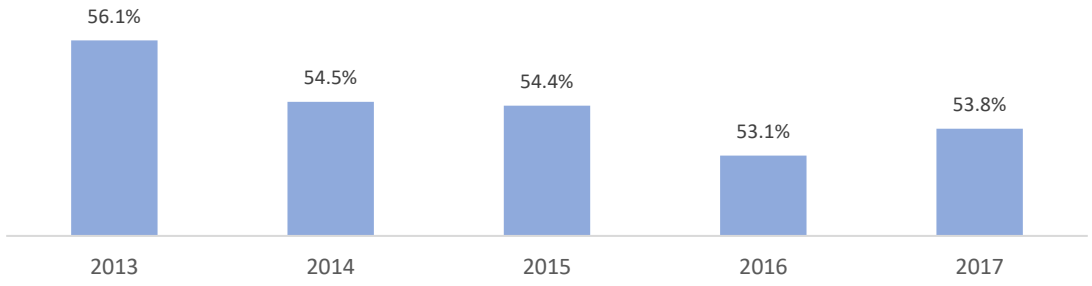
SOURCE: U.S. Census Bureau, American Community Survey

FIGURE 78: BREVARD COUNTY POPULATION BY EDUCATIONAL ATTAINMENT (2013-2017)



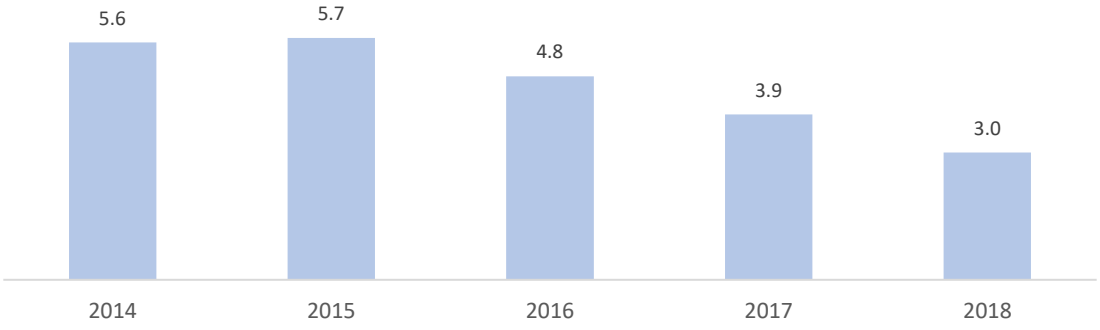
SOURCE: U.S. Census Bureau, American Community Survey

FIGURE 79: BREVARD COUNTY PARCIPATION IN THE LABOR FORCE (2013-2017)



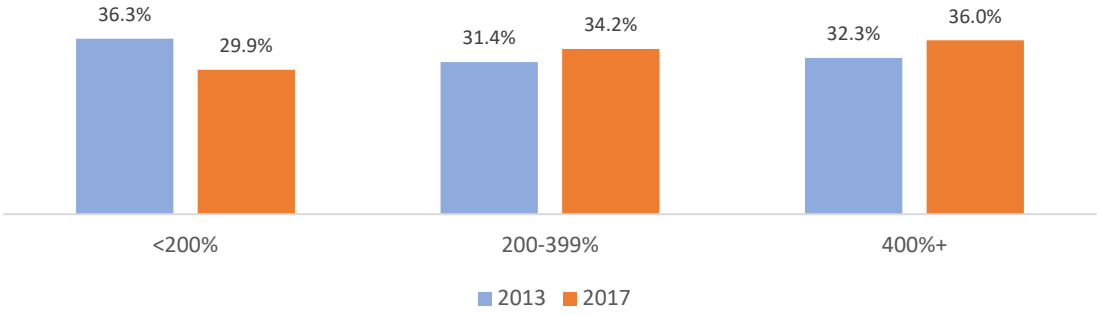
SOURCE: U.S. Bureau of Labor Statistics

FIGURE 80: BREVARD COUNTY POPULATION UNEMPLOYMENT RATE (2014-2018)



SOURCE: U.S. Bureau of Labor Statistics (Not seasonally adjusted)

FIGURE 81: BREVARD COUNTY RATIO OF INCOME TO POVERTY LEVEL (2013 & 2017)



SOURCE: U.S. Census Bureau, American Community Survey

Brevard County CFCHS Clients - Demographic Profile

CLIENT DEMOGRAPHICS

Almost ninety percent of all clients were enrolled in adult programs with 43.3 percent in the AMA program and 46.3 percent in the ASA program. When comparing all counties in the service area, Brevard County had the lowest percentage of clients enrolled in the CSA program at 3.6 percent. Children in the CMH program accounted for 6.7 percent of all Brevard clients.

Males accounted for larger percentages of clients in all programs at 52.1 percent of AMH Clients, 55.1 percent of ASA clients and 56.0 percent of clients in the CMH program. Greater gender disparity was noted among those in the CSA program where males accounted for 72.9 percent of clients.

Clients in Brevard County were predominately White. The percentage of Black clients ranged from 13.1 percent to 15.0 percent in AMH, ASA, and CMH programs but accounted for 30.6 percent of clients in the CSA program.

Hispanic clients represented 7.0 percent of all Brevard County clients. Slightly higher percentages of Hispanic clients were in enrolled in the CMH and CSA programs at 9.7 percent and 9.8 percent, respectively.

Adults, ages 25-44 years accounted for 47.8 percent of AMH clients and 56.5 percent of ASA clients. Thirty percent of clients in adult programs were between the ages of 18 and 24 years. Among child/youth programs, 64.5 percent of those in the CMH program were 5-14 years of age while 68.6 percent of clients in the CSA program were older at 15-17 years of age.

RESIDENTIAL STATUS

Close to fifty percent of clients in the AMH program resided in one of three types of independent living situations. (Living alone, with non-relatives, or with relatives). This was much lower when compared to clients in the ASA program where 73.4 percent of clients were living independently. Children/Youth lived dependently with relatives.

EDUCATIONAL ATTAINMENT

Almost eighty percent of AMH clients and seventy percent of ASA clients did not have more than a high school education. Of these, 12.3 percent of AMH clients and 24.2 percent of ASA clients did not have a diploma.

EMPLOYMENT STATUS

The majority of clients in the AMH and ASA programs were unemployed at 81.4 percent and 70.6 percent, respectively. Among AMH unemployed clients, 33.5 percent had been terminated while over fifty percent of ASA clients were let go from their jobs.

SOURCE FOR ALL CHARTS IN THIS SECTION: CFCHS FY2017/18

FIGURE 82: BREVARD COUNTY CLIENTS BY PROGRAM

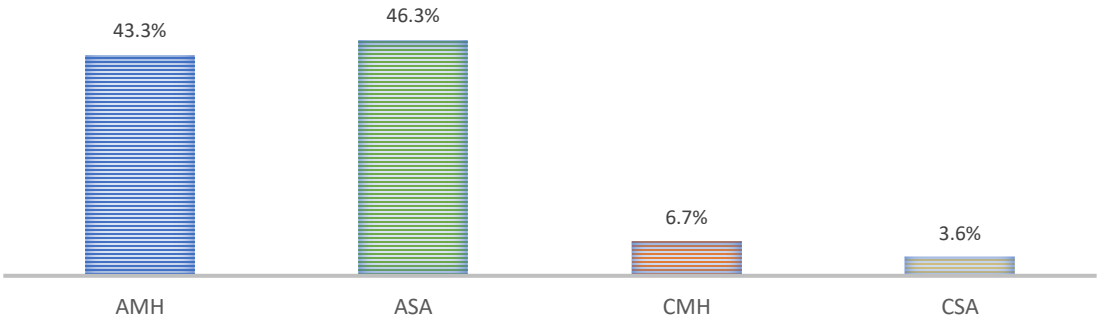


FIGURE 83: BREVARD COUNTY CLIENTS BY PROGRAM AND GENDER

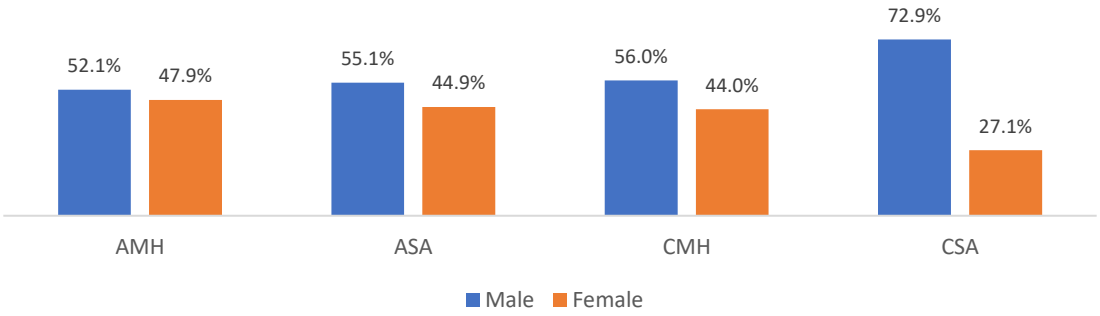


FIGURE 84: BREVARD COUNTY CLIENTS BY RACE

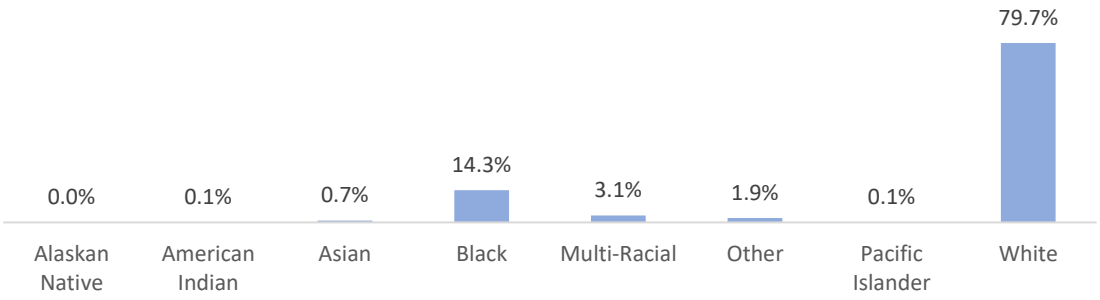


FIGURE 85: BREVARD COUNTY CLIENTS BY PROGRAM AND RACE

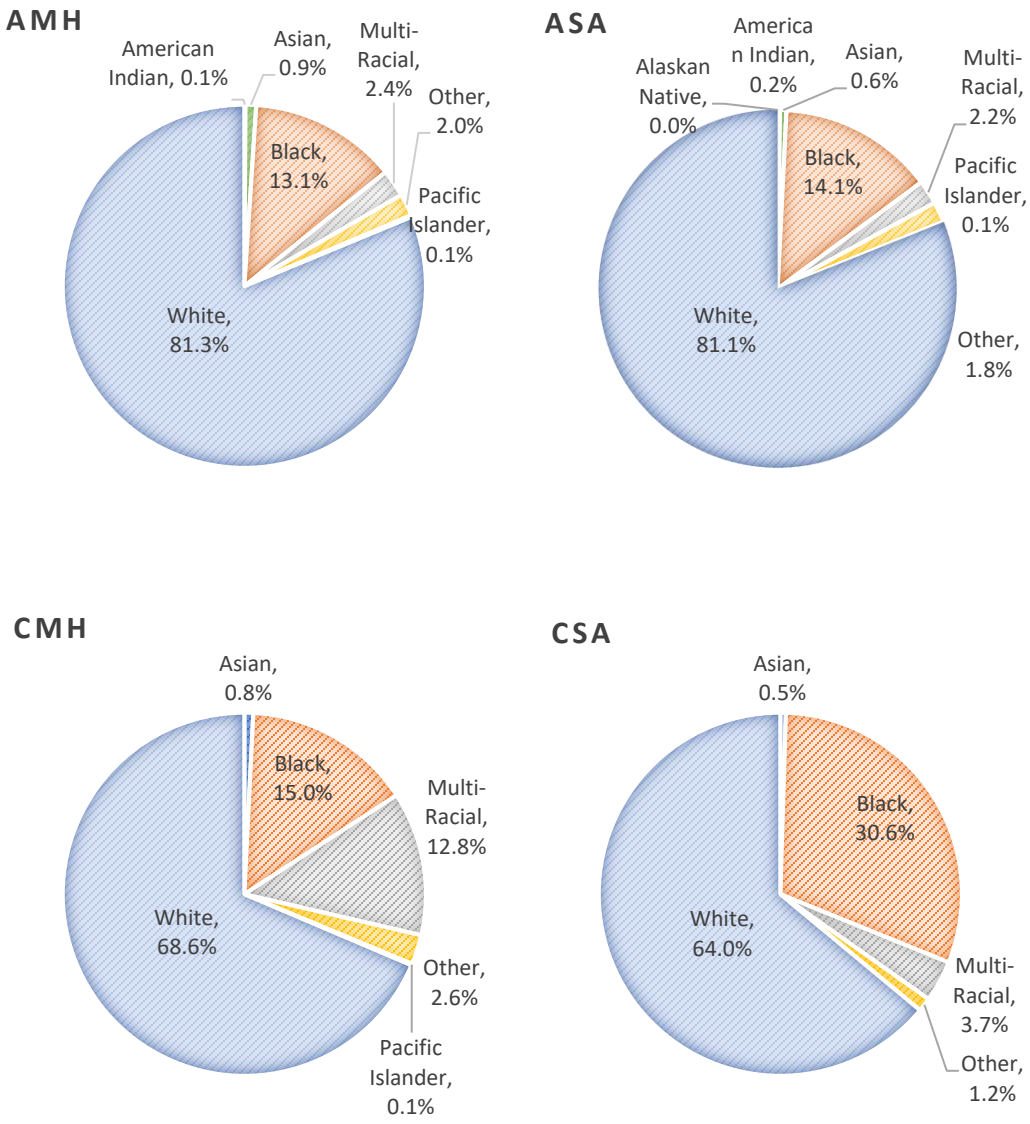


FIGURE 86: BREVARD COUNTY CLIENTS BY PROGRAM AND ETHNICITY

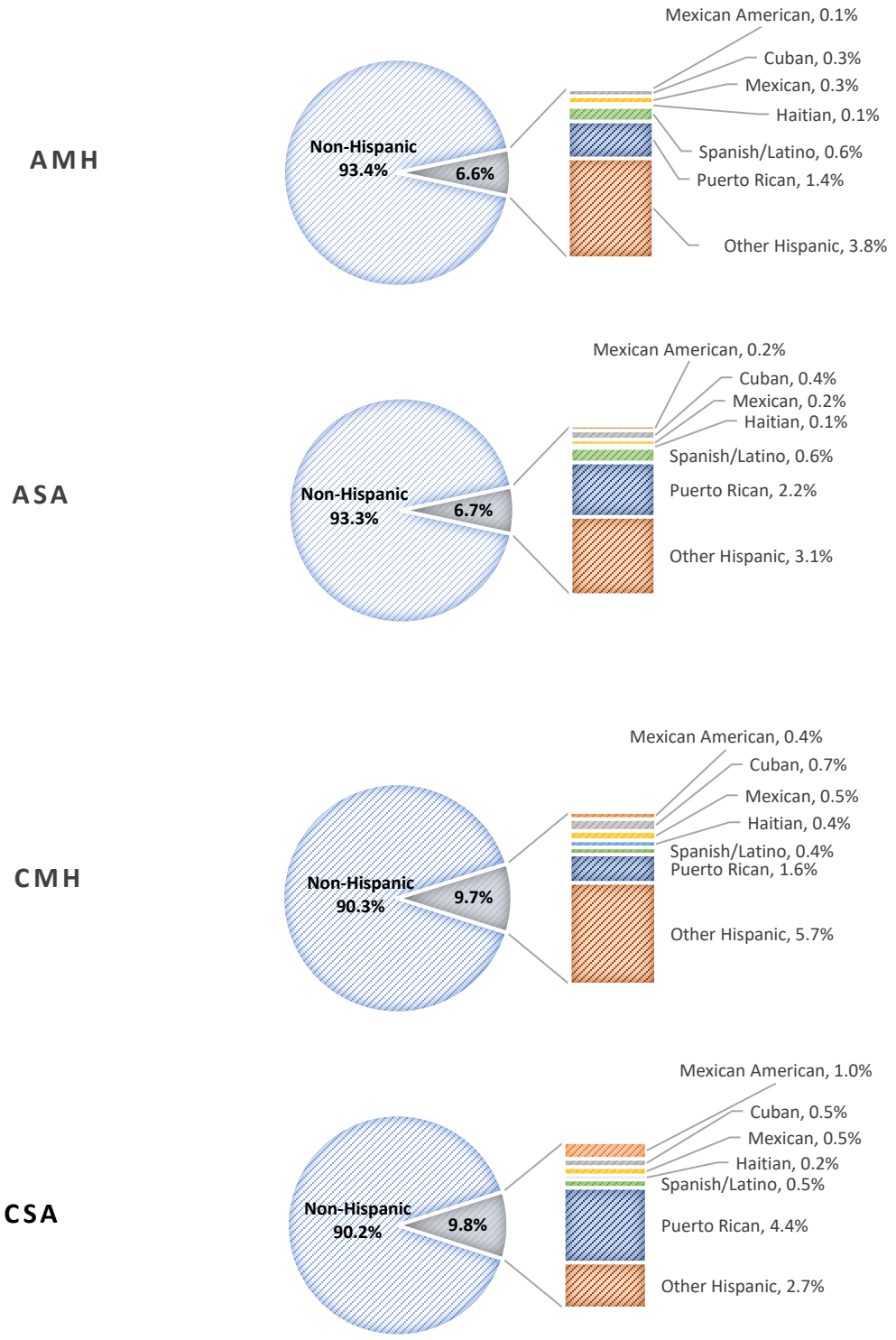


FIGURE 87: BREVARD COUNTY CLIENTS BY AGE RANGE

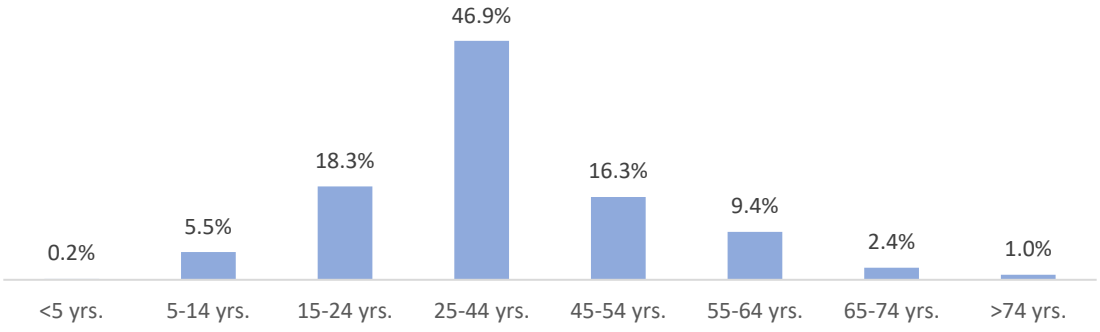


FIGURE 88: BREVARD COUNTY ADULTS CLIENTS BY PROGRAM AND AGE RANGE

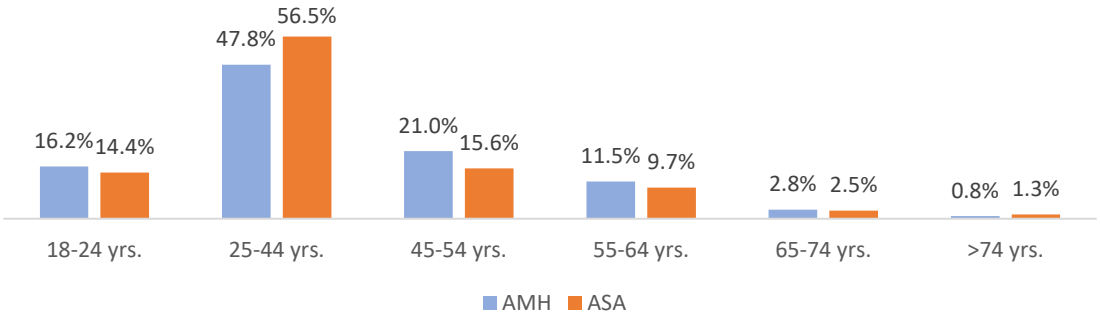


FIGURE 89: BREVARD COUNTY CHILD CLIENTS BY PROGRAM AND AGE RANGE

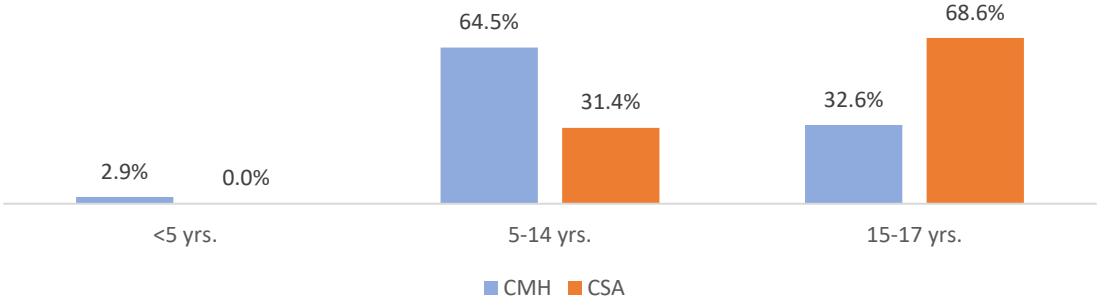


FIGURE 90: BREVARD COUNTY AMH CLIENTS BY RESIDENTIAL STATUS

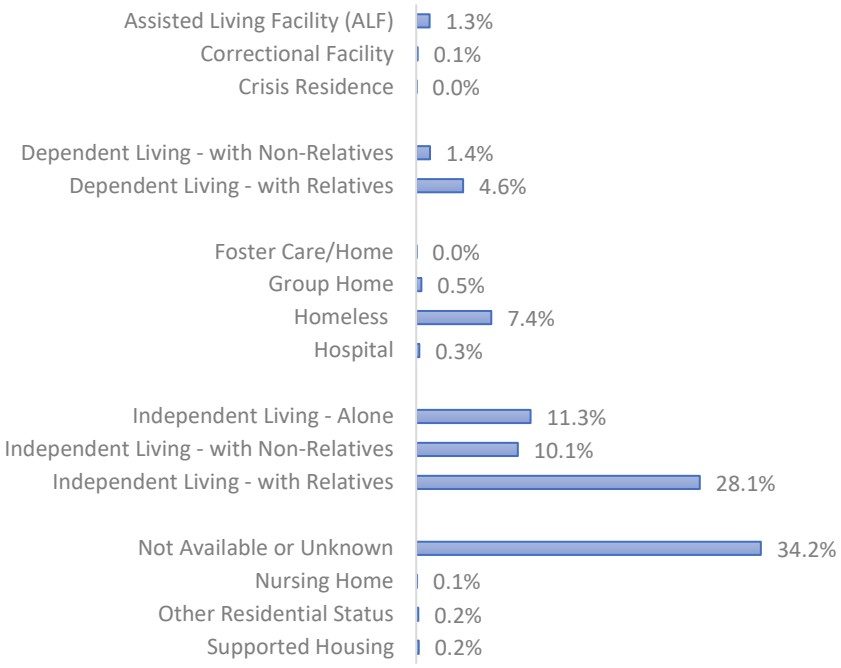


FIGURE 91: BREVARD COUNTY ASA CLIENTS BY RESIDENTIAL STATUS

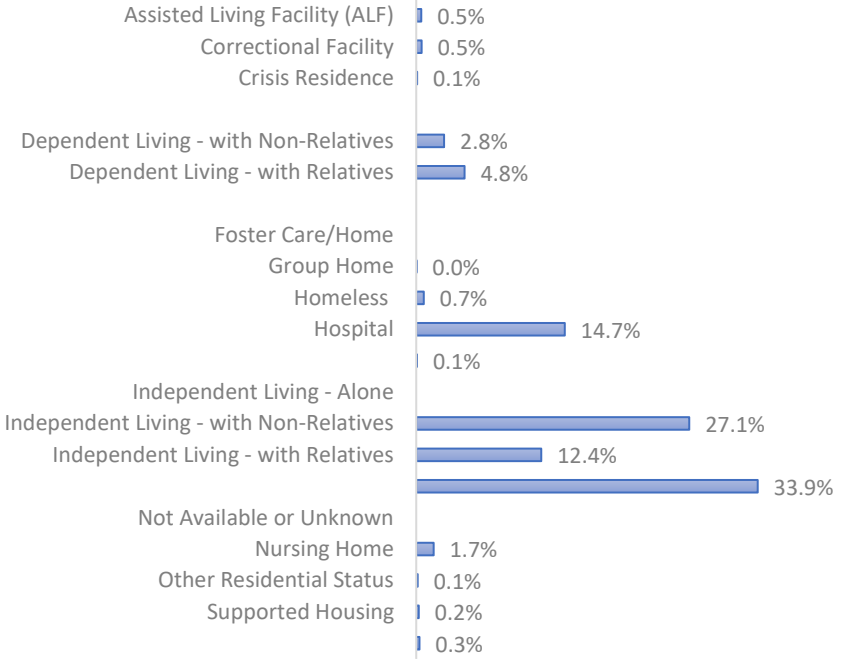


FIGURE 92: BREVARD COUNTY CMH CLIENTS BY RESIDENTIAL STATUS

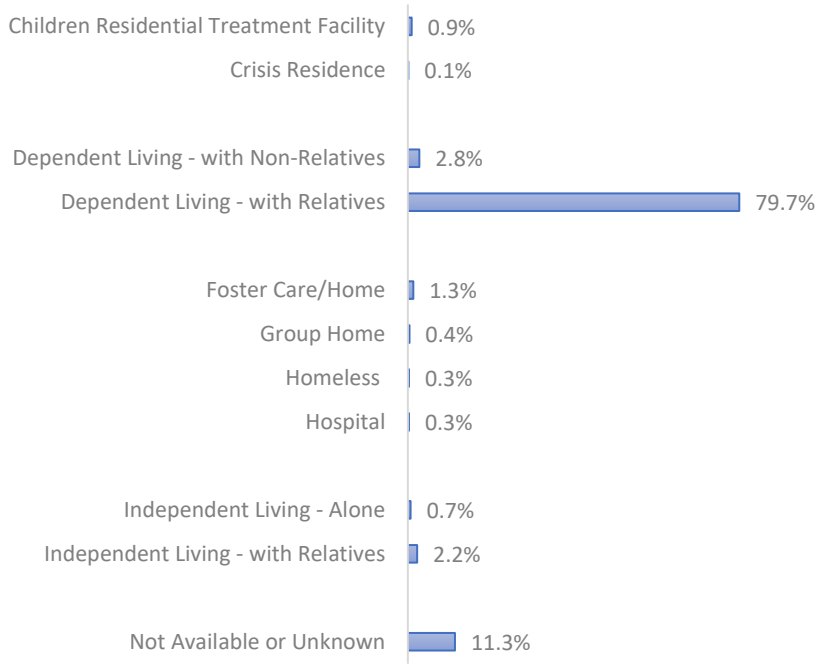


FIGURE 93: BREVARD COUNTY CSA CLIENTS BY RESIDENTIAL STATUS

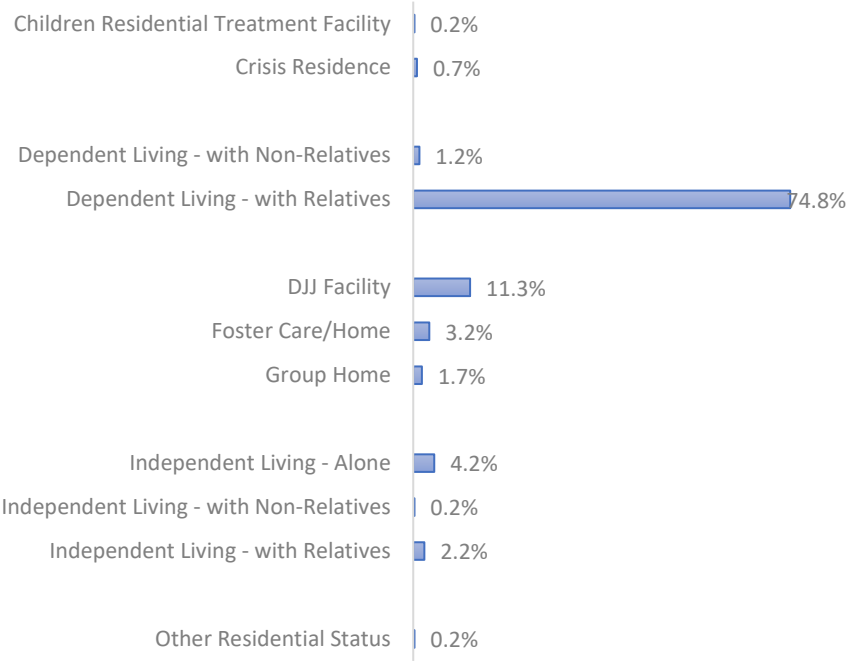


FIGURE 94: BREVARD COUNTY AMH CLIENTS BY EDUCATIONAL ATTAINMENT

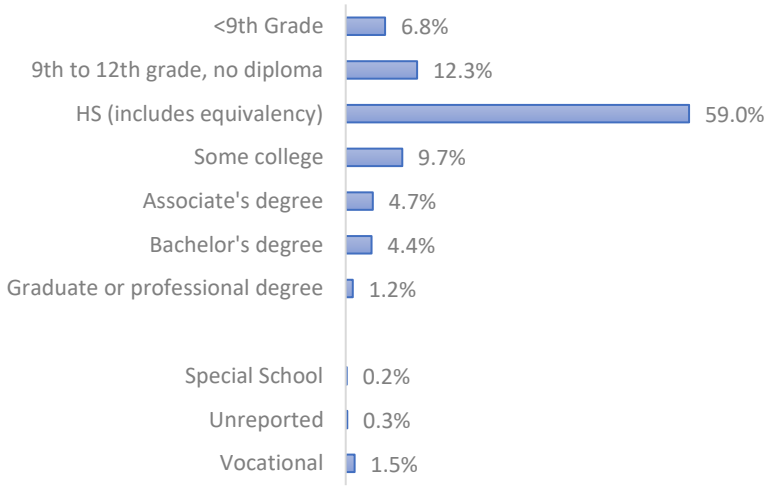


FIGURE 95: BREVARD COUNTY ASA CLIENTS BY EDUCATIONAL ATTAINMENT

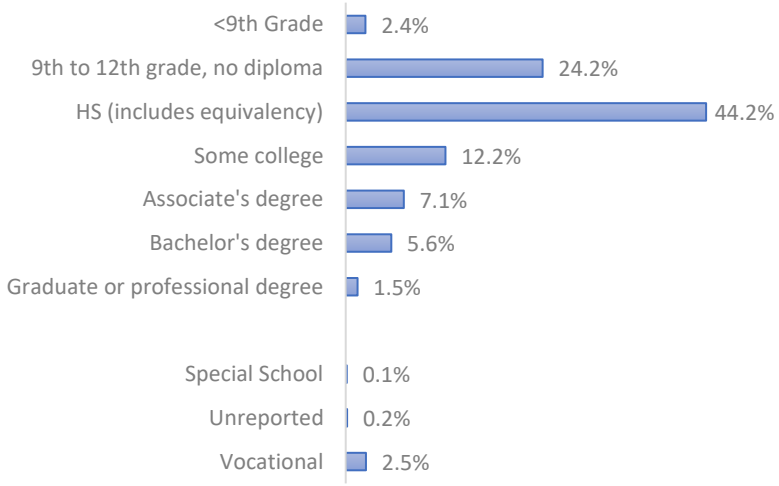


FIGURE 96: BREVARD COUNTY AMH CLIENTS BY EMPLOYMENT STATUS

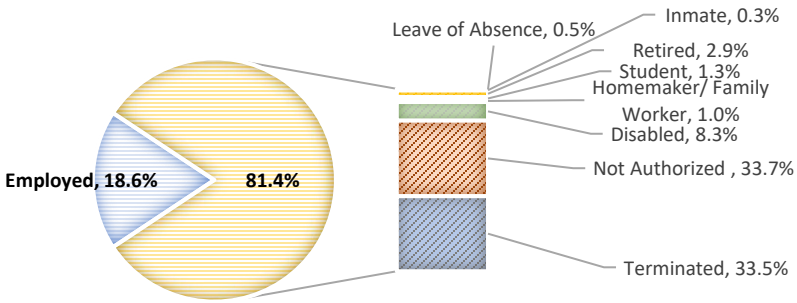
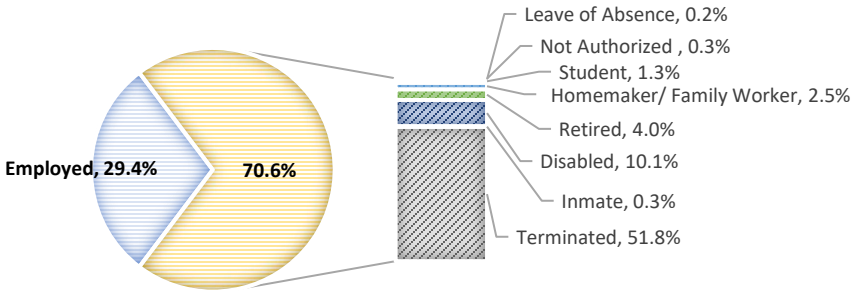


FIGURE 97: BREVARD COUNTY ASA CLIENTS BY EMPLOYMENT STATUS



Orange County - Demographic Profile

POPULATION DEMOGRAPHICS

Population in Orange County increased an average of 2.4 percent each year from 2013 to 2017. The total population growth for the five-year period at 9.4 percent, added 114,800 residents.

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

The racial composition in Orange County was more diverse than the service area and the state with a lower percentage of White residents and a higher percentage of Black residents. In Orange County, 63.7 percent of the population was White when compared to the service area and state rates at 71.7 percent, and 76.3 percent, respectively. The Black population accounted for 20.9 percent of Orange's population but 15.8 percent of the service area population and 16.0 percent of the residents in Florida. American Indian and Native Hawaiian's represented less than one percent of residents in the county. The percentage of Asian residents, at 5.2 percent was higher in Orange County when compared to the service area at 4.1 percent and the state at 2.5 percent. Orange County also had a greater percentage of residents who were of an Other race (6.5 percent compared to 4.8 percent in the service area) but similar percentages of residents who had more than one race (3.4 percent in Orange County and 3.3 percent in the service area).

Ethnically, Orange County had a higher percentage of Hispanic residents, at 30.2 percent, when compared to the service area at 26.7 percent and the state at 22.9 percent.

Orange County's population was slightly younger when compared to the age distribution in the service area and the state. Residents, 65 years of age or older, accounted for 11.2 percent of the population when compared to 14.4 percent in the service area and 17.8 percent in Florida.

EDUCATION AND EMPLOYMENT

Data revealed Orange County, the service area and state populations were very similar regarding education attainment. Just over twenty-five percent of residents completed their educational attainment by high school graduation. Slightly more residents in Orange County attained a bachelor's degree, at 21.9 percent when compared to 20.5 percent in the service area and 18.2 percent in Florida.

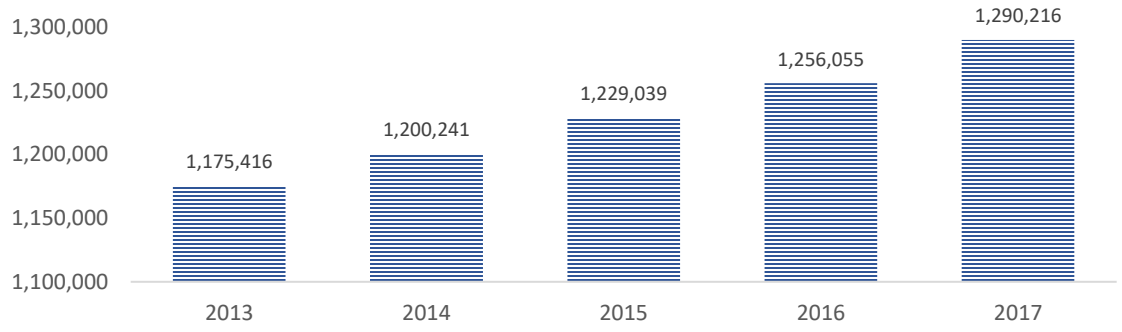
Overall, participation in the labor force for Orange County residents remained stable at 67.0 percent between 2013 and 2017. This was slightly higher when compared to the service area, at 63.0 percent and 58.4 percent for the state. The unemployment rate for

the service area decreased 47.2 percent from 2013 (6.8 percent) to 2017 (3.6 percent). This was slightly higher than decreases in the unemployment rate in the service area, at 45.8 percent, and Florida, at 43.3 percent, during the same time period.

POVERTY STATUS

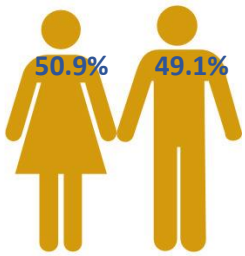
Over the past five years, the percent of Orange County residents living at < 200% of the FPL decreased from 41.0 percent in 2013 to 37.1 percent in 2017 while those living at greater than 200% FPL, but less than 400% FPL, remained stable. The percentage of residents living at 400% FPL and higher increased from 27.3 percent in 2013 to 31.5 percent in 2017.

FIGURE 98: ORANGE COUNTY POPULATION ESTIMATES (2013-2017)



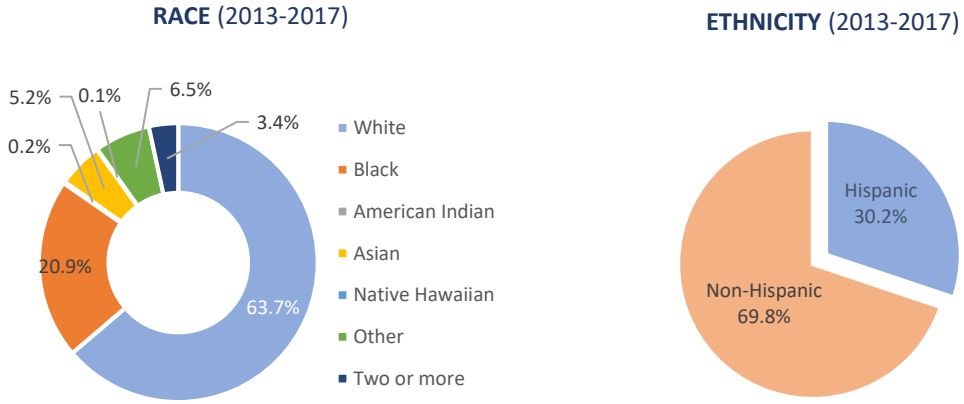
SOURCE: U.S. Census Bureau, American Community Survey

FIGURE 99: ORANGE COUNTY POPULATION BY GENDER (2013-2017)



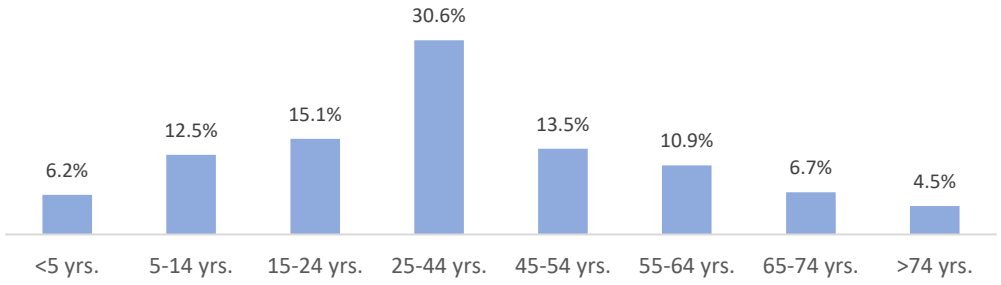
SOURCE: U.S. Census Bureau, American Community Survey

FIGURE 100: ORANGE COUNTY POPULATION BY RACE AND ETHNICITY (2013-2017)



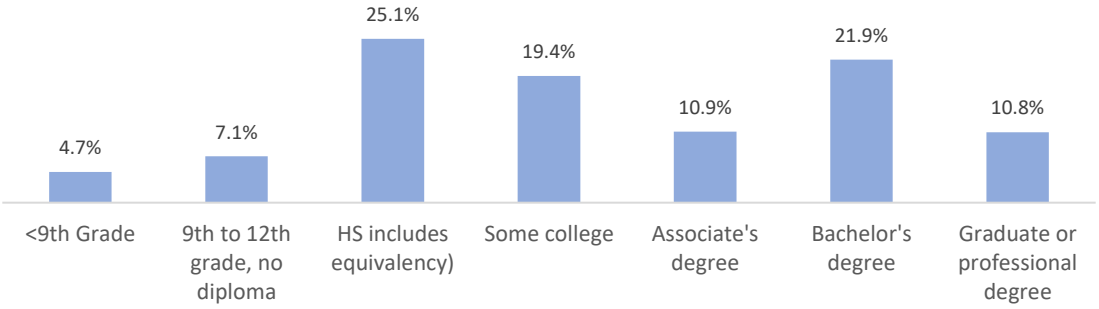
SOURCE: U.S. Census Bureau, American Community Survey

FIGURE 101: ORANGE COUNTY POPULATION BY AGE RANGE (2013-2017)



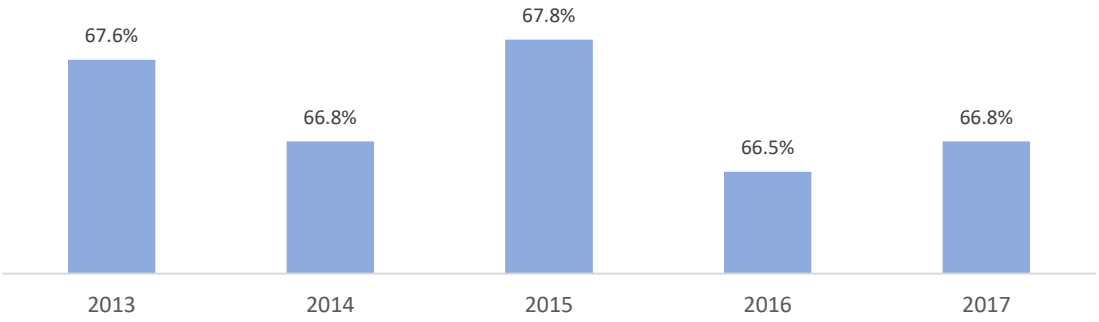
SOURCE: U.S. Census Bureau, American Community Survey

FIGURE 102: ORANGE COUNTY POPULATION BY EDUCATIONAL ATTAINMENT (2013-2017)



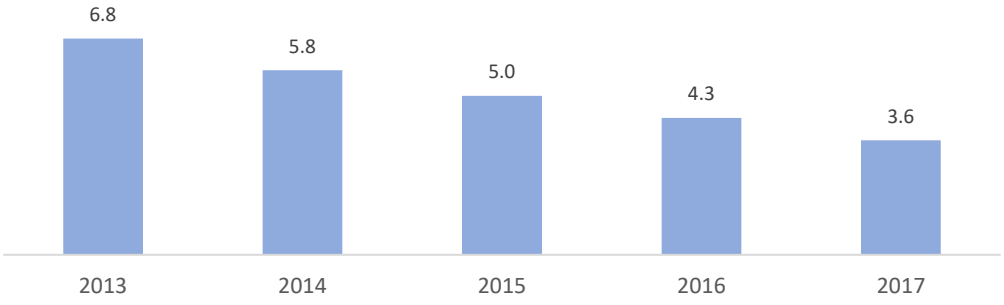
SOURCE: U.S. Census Bureau, American Community Survey

FIGURE 103: ORANGE COUNTY PARTICIPATION IN THE LABOR FORCE (2013-2017)



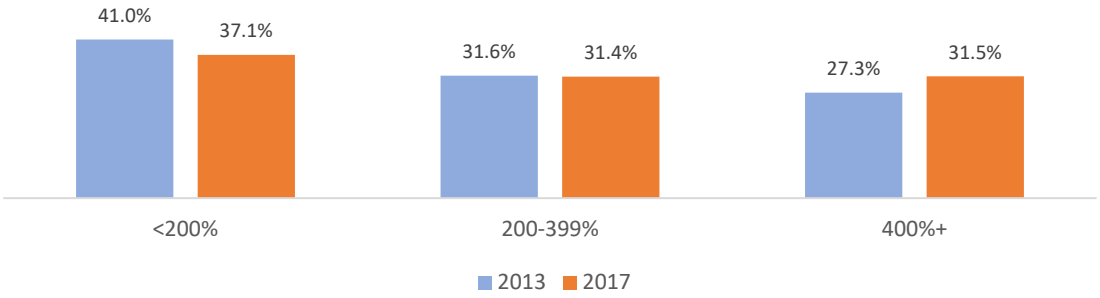
SOURCE: U.S. Bureau of Labor Statistics (Population 16 years and older)

FIGURE 104: ORANGE COUNTY UNEMPLOYMENT RATE (2013-2017)



SOURCE: U.S. Bureau of Labor Statistics (Not seasonally adjusted)

FIGURE 105: ORANGE COUNTY RATIO OF INCOME TO POVERTY LEVEL (2017)



SOURCE: U.S. Census Bureau, American Community Survey

Orange County CFCHS Clients - Demographic Profile

CLIENT DEMOGRAPHICS

Slightly less than eighty percent of clients were enrolled in adult programs with 41.6 percent in the AMH program and 36.2 percent in the ASA program. Children in the CMH program accounted for 7.9 percent of all Orange County clients while 14.3 percent were enrolled in the CSA program.

Males accounted for larger percentages of clients in all programs at 56.7 percent of AMH Clients, 62.1 percent of ASA clients and 55.5 percent of clients in the CMH program. Greater gender disparity was noted among those in the CSA program where males accounted for 66.1 percent of clients.

Among the four behavioral health programs, client demographics were more diverse when compared to the racial composition in the county. White clients in Orange County accounted for 48.2 percent compared to 63.7 percent in the general county population. Black clients represented 33.0 percent of clients when representing just over twenty percent of the population in the county. Orange County's client diversity included 8.9 percent of clients who were multiracial and 8.8 percent who reported a race of Other. This was higher than the multiracial and Other percentages in the county at 3.4 and 6.5, respectively. In the CSA program, Blacks represented 50.7 percent of clients. Hispanic clients represented 26.6 percent of all Orange County clients with 11.7 percent identifying as other Hispanic and 7.6 percent were Puerto Rican. Among the AMH program, 27.0 percent of clients were Hispanic as were 40.9 percent of clients in the CMH program. This compares with 30.2 percent in Orange County.

Adults, ages 25-44 years, accounted for 51.0 percent of AMH clients and 58.8 percent of ASA clients. Over thirty percent (35.5) of clients in adult programs were between the ages of 18 and 24 years and 35.6 percent were 45-55 years of age. Among child/youth programs, 67.0 percent of those in the CMH program were 5-14 years of age while 66.7 percent of clients in the CSA program were older at 15-17 years of age.

RESIDENTIAL STATUS

Close to seventy percent of clients in the AMH program resided in one of three types of independent living situations. (Living alone, with non-relatives, or with relatives). This was much higher when compared to clients in the ASA program where 43.2 percent of clients were living independently. Children/Youth lived dependently with relatives.

EDUCATIONAL ATTAINMENT

Over seventy percent of adult clients did not have more than a high school education. Of these, 27.3 percent of AMH clients and 24.0 percent of ASA clients did not have a diploma.

EMPLOYMENT STATUS

The majority of clients in the AMH and ASA programs were unemployed at 83.1 percent and 80.2 percent, respectively. Among AMH unemployed clients, 71.6 percent had been terminated while fifty percent of ASA clients were let go from their jobs.

SOURCE FOR ALL CHARTS IN THIS SECTION: CFCHS FY2017/18

FIGURE 106: ORANGE COUNTY CLIENTS BY PROGRAM

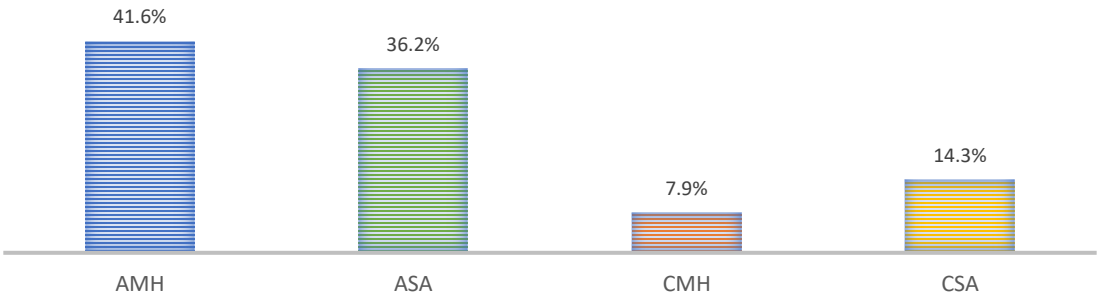


FIGURE 107: ORANGE COUNTY CLIENTS BY PROGRAM AND GENDER

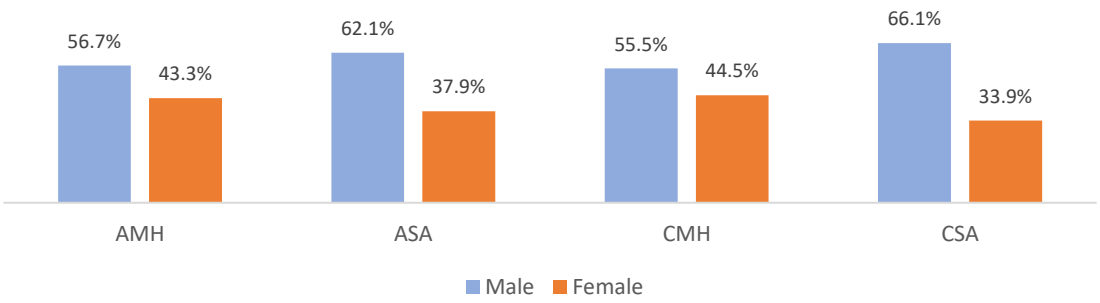


FIGURE 108: ORANGE COUNTY CLIENTS BY RACE

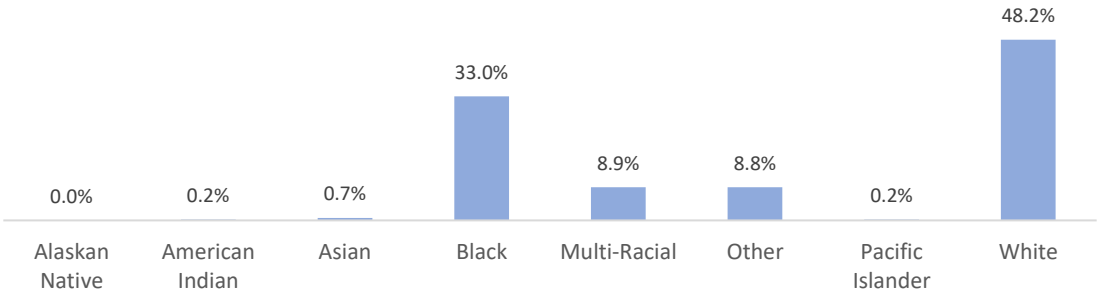


FIGURE 109: ORANGE COUNTY CLIENTS BY PROGRAM AND RACE

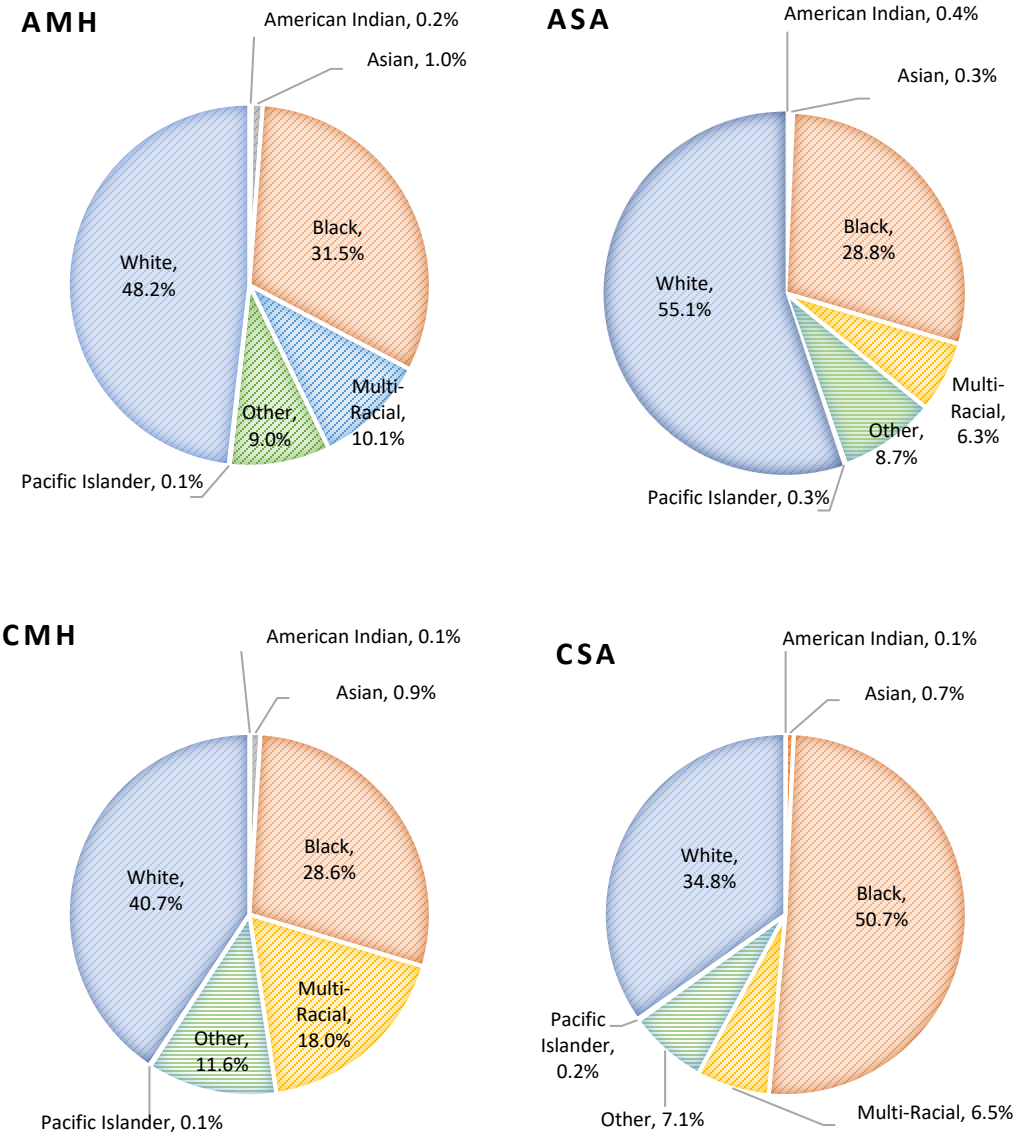


FIGURE 110: ORANGE COUNTY CLIENTS BY PROGRAM AND ETHNICITY

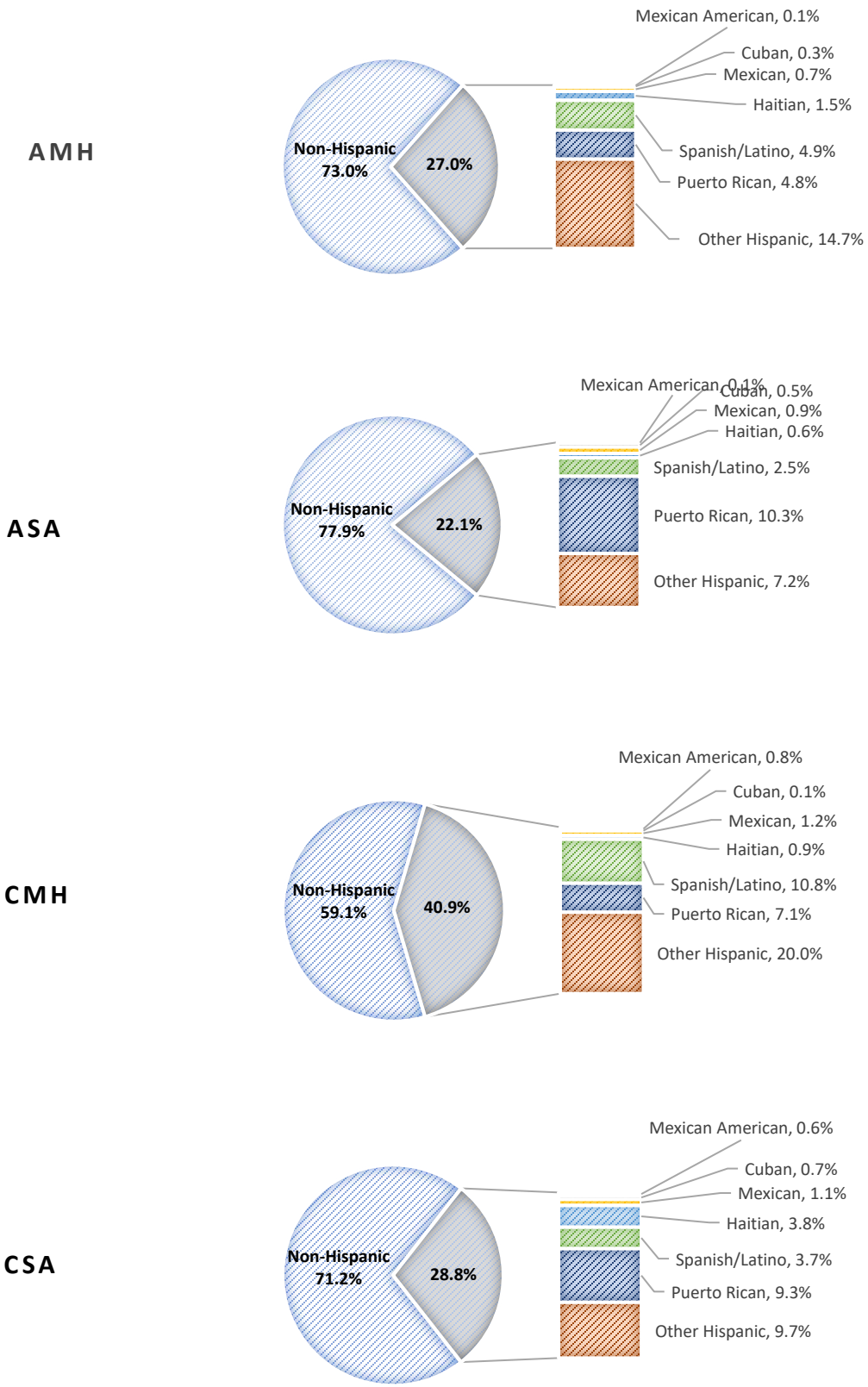


FIGURE 111: ORANGE COUNTY CLIENTS BY AGE RANGE

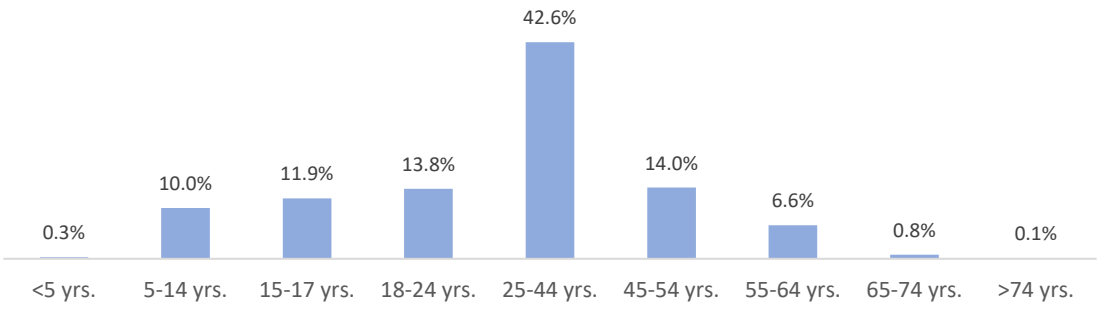


FIGURE 112: ORANGE COUNTY ADULT CLIENTS BY PROGRAM AND AGE RANGE

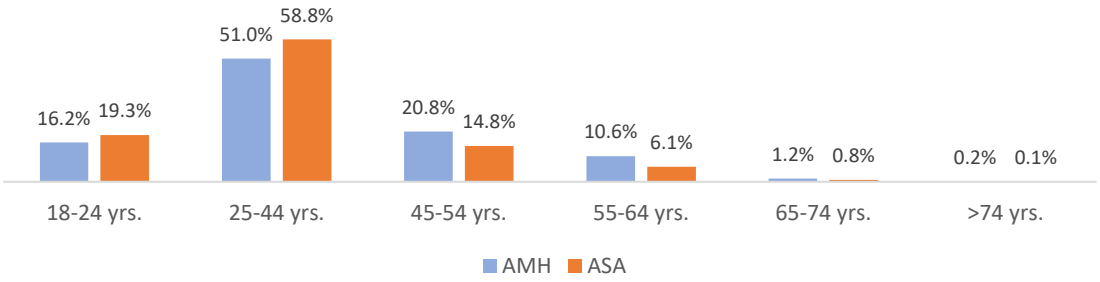


FIGURE 113: ORANGE COUNTY CHILD CLIENTS BY PROGRAM AND AGE RANGE

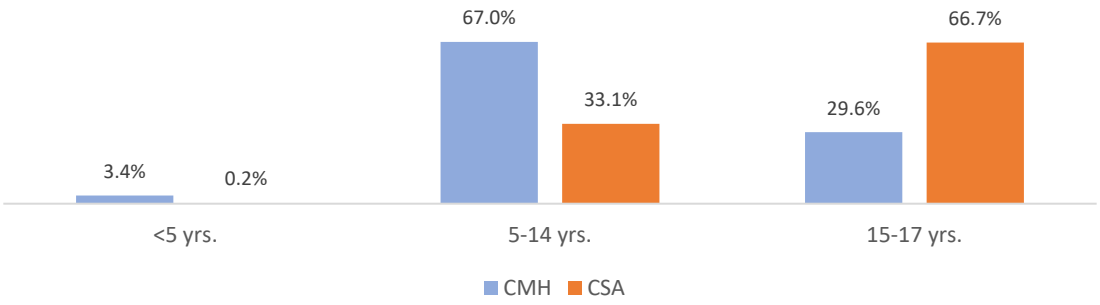


FIGURE 114: ORANGE COUNTY AMH CLIENTS BY RESIDENTIAL STATUS

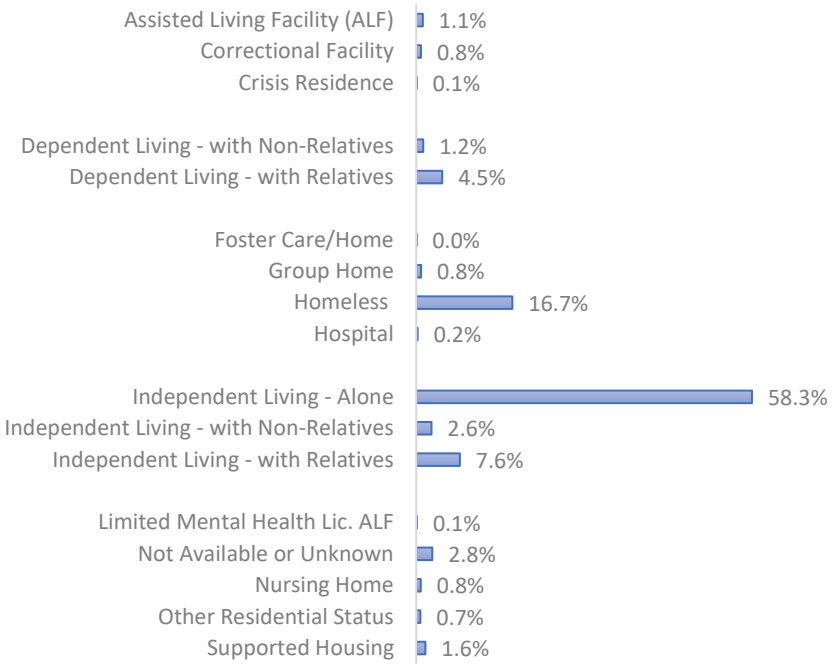


FIGURE 115: ORANGE COUNTY ASA CLIENTS BY RESIDENTIAL STATUS

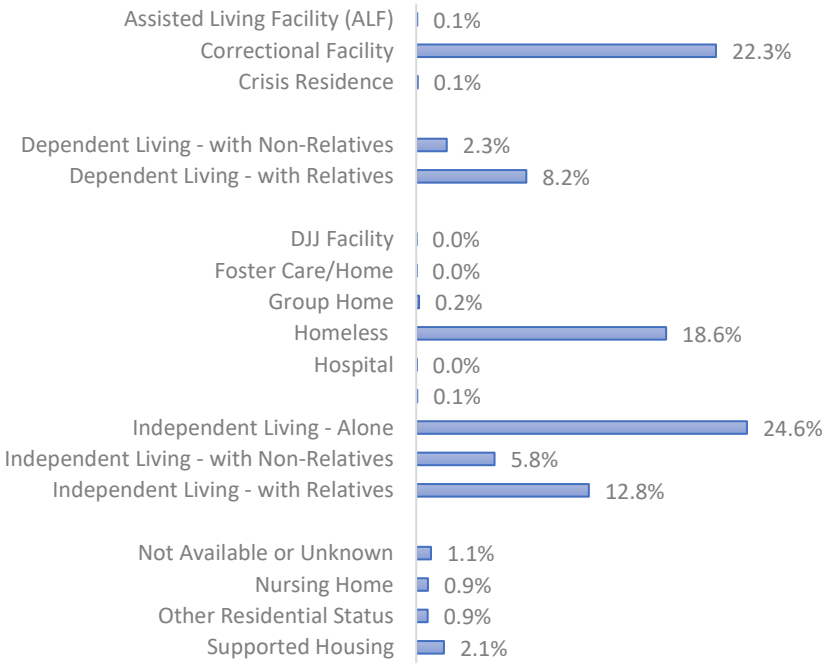


FIGURE 116: ORANGE COUNTY CMH CLIENTS BY RESIDENTIAL STATUS

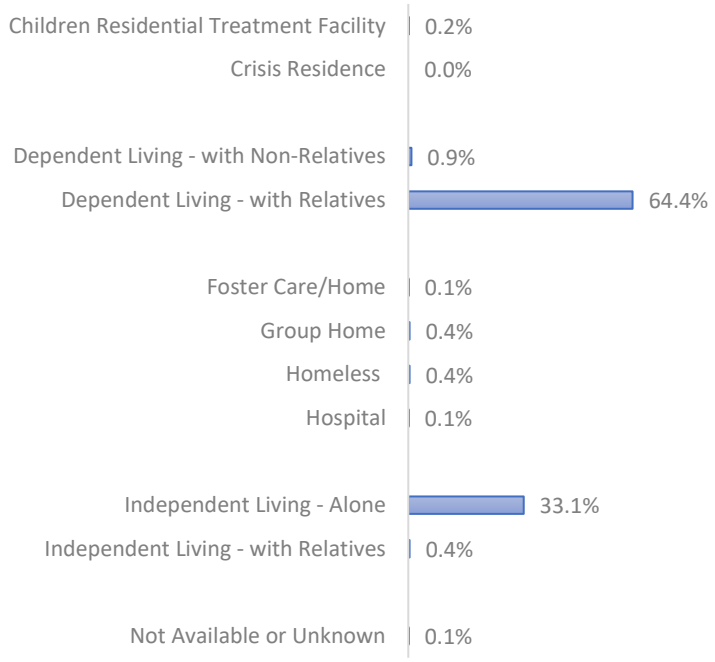


FIGURE 117: ORANGE COUNTY CSA CLIENTS BY RESIDENTIAL STATUS

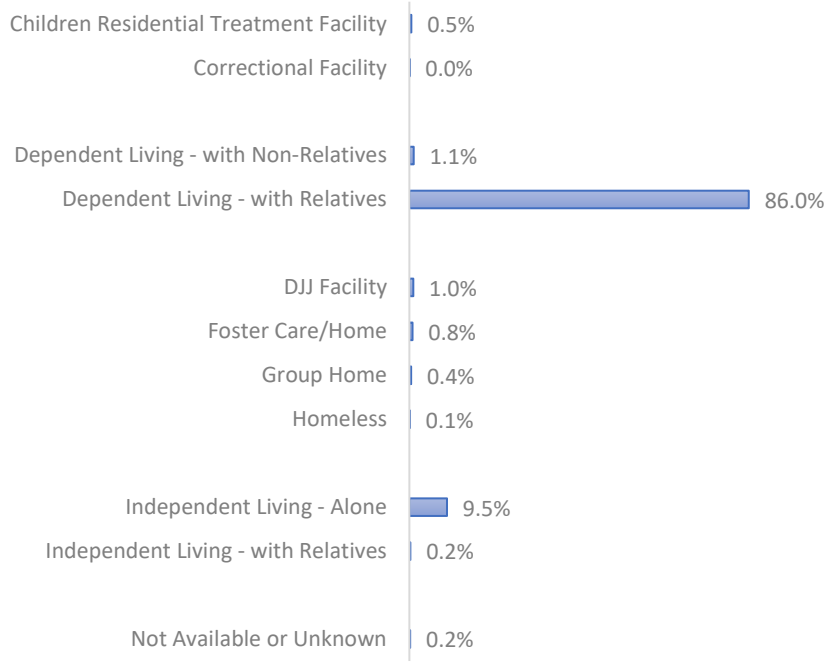


FIGURE 118: ORANGE COUNTY AMH CLIENTS BY EDUCATIONAL ATTAINMENT

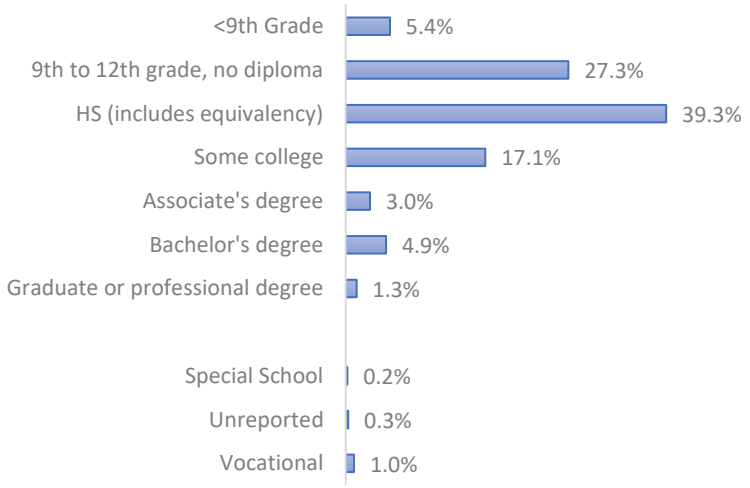


FIGURE 119: ORANGE COUNTY ASA CLIENTS BY EDUCATIONAL ATTAINMENT

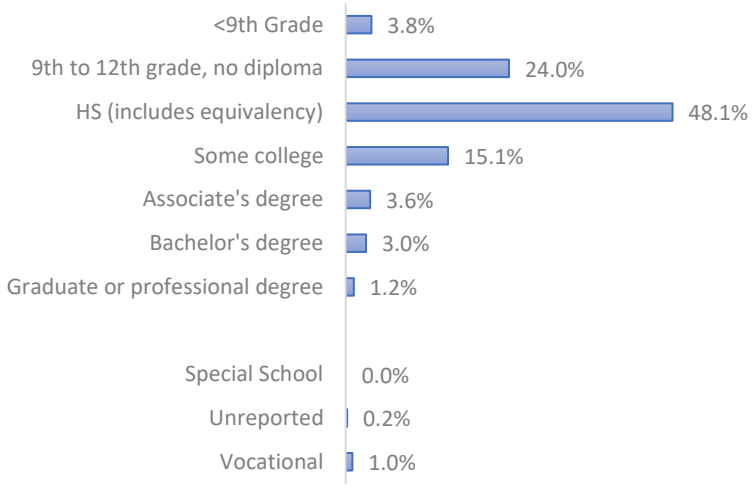


FIGURE 120: ORANGE COUNTY AMH CLIENTS BY EMPLOYMENT STATUS

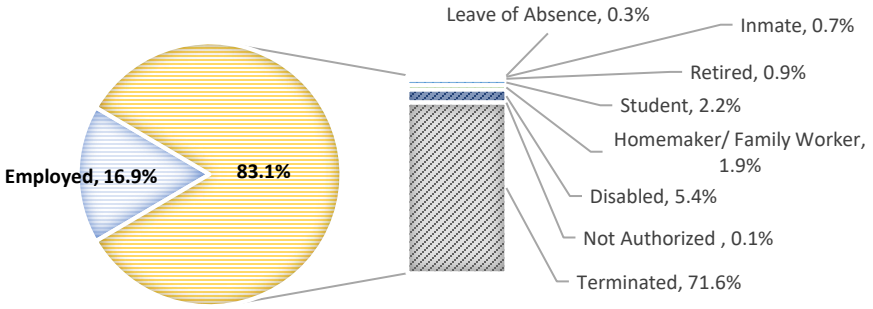
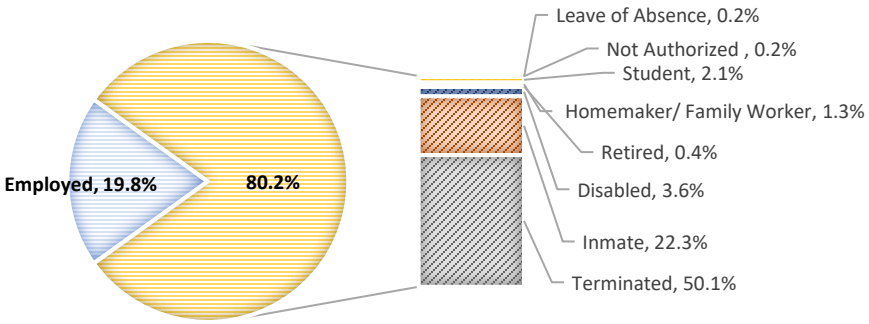


FIGURE 121: ORANGE COUNTY ASA CLIENTS BY EDUCATIONAL ATTAINMENT



Osceola County - Demographic Profile

POPULATION DEMOGRAPHICS

The population in Osceola County increased an average of 4.8 percent each year from 2013 to 2017. The total population growth for the five-year period, at 16.2 percent, added 45,331 residents.

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

Racially, 74.4 percent of the population in Osceola County was White when compared to the service area and state rates at 71.7 percent, and 76.3 percent, respectively. The Black population accounted for 11.2 percent of Osceola's population, slightly below the 15.8 percent in the service area population and 16.0 percent of the residents in Florida. American Indian and Native Hawaiian's represented less than one percent of residents in the county. The percentage of Asian residents, at 2.5 percent was lower in Osceola County when compared to the service area at 4.1 percent but the same as the state rate. Osceola County had a greater percentage of residents who were of an Other race (7.3 percent compared to 4.8 percent in the service area) and percentages of residents who had more than one race (4.0 percent in Osceola County and 3.3 percent in the service area).

Ethnically, Osceola County had a highest percentage of Hispanic residents than other counties in the service area, at 51.6 percent. This was more than double the state rate at 22.9 percent.

Osceola County's population was younger when compared to the age distribution in the service area and the state with higher percentages of young residents and lower percentages of those who were older. Residents, 65 years of age or older, accounted for 12.5 percent of the population when compared to 14.4 percent in the service area and 17.8 percent in Florida.

EDUCATION AND EMPLOYMENT

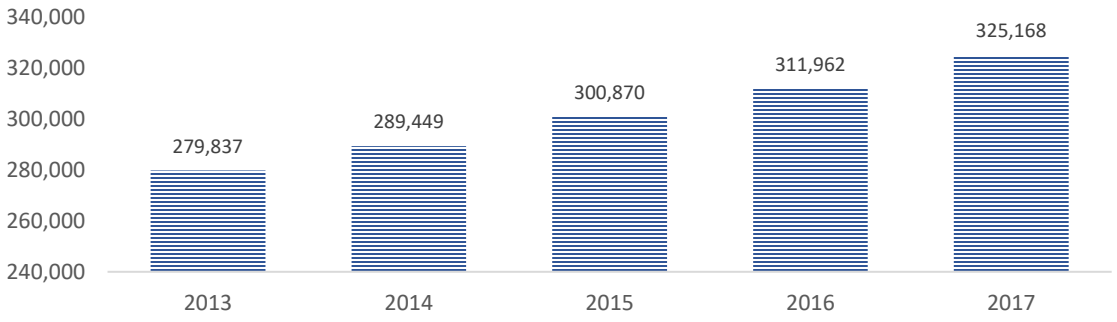
Data revealed higher percentages of Osceola County residents who did not earn a high school diploma or had only graduated high school when compared to the service area and state populations. The percentage of residents completing the 12th grade without receiving a diploma or equivalency was 8.5 percent in Osceola and 6.4 percent in the service area. Those not attaining education beyond high school, at 32.2 percent in Osceola County, was higher when compared to the service area at 26.2 percent and the state at 29.0 percent. Osceola residents subsequently had lower percentages of residents who earned a degree than those in the four-county area and Florida.

Participation in the labor force for Osceola County residents continually increased from 59.5 percent in 2013 to 63.5 percent in 2017. This was similar when compared to the service area rate, at 63.0 percent (2017) and higher than the rate of 58.4 percent for the state. The unemployment rate for the service area decreased 46.8 percent from 2013 (7.9 percent) to 2017 (4.2 percent). This was slightly higher than decreases in the unemployment rate in the service area, at 45.8 percent, and Florida, at 43.3 percent, during the same time period.

POVERTY STATUS

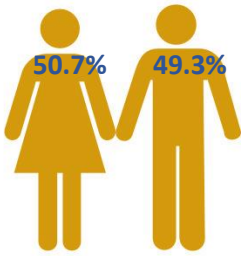
Over the past five years, the percent of Osceola County residents living at <200% FPL decreased from 49.3 percent in 2013 to 42.0 percent in 2017 while those living at greater than 200% FPL increased. The percentage of residents living at 400% FPL increased from 17.7 percent in 2013 to 21.9 percent in 2017.

FIGURE 122: OSCEOLA COUNTY POPULATION ESTIMATES (2013-2017)



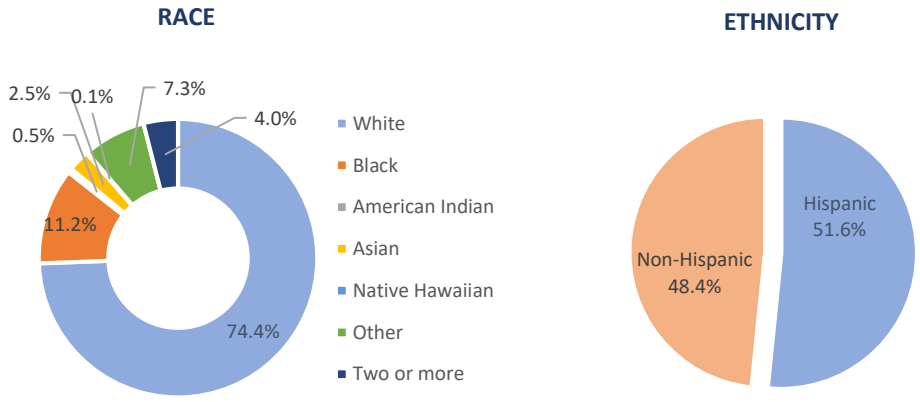
SOURCE: U.S. Census Bureau, American Community Survey

FIGURE 123: OSCEOLA COUNTY POPULATION BY GENDER (2013-2017)



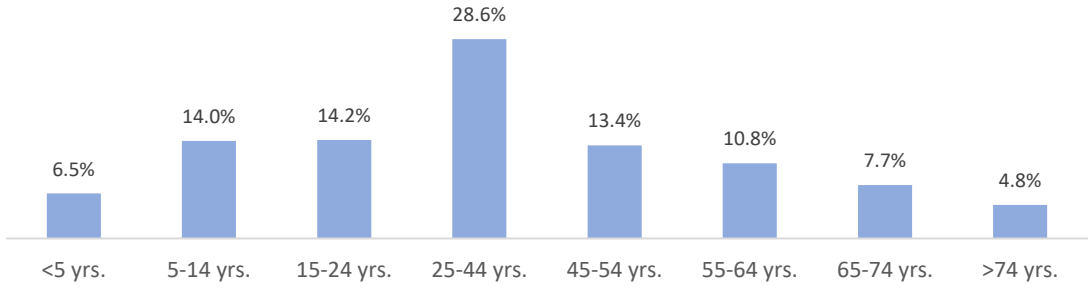
SOURCE: U.S. Census Bureau, American Community Survey

FIGURE 124: OSCEOLA COUNTY POPULATION BY RACE AND ETHNICITY (2013-2017)



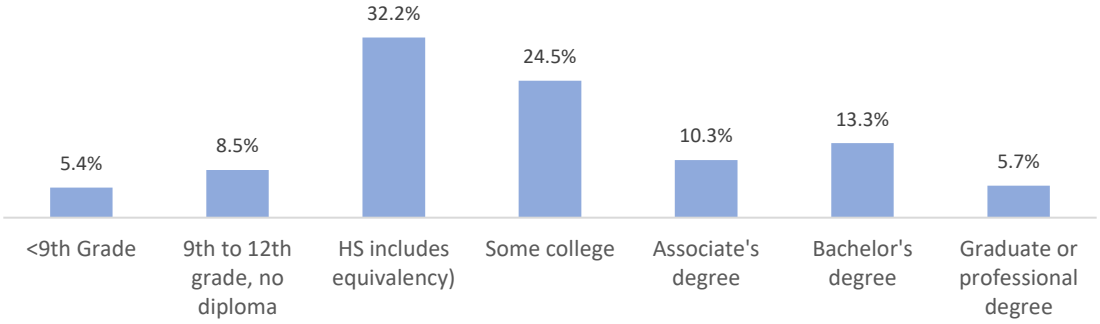
SOURCE: U.S. Census Bureau, American Community Survey

FIGURE 125: OSCEOLA COUNTY POPULATION BY AGE RANGE (2013-2017)



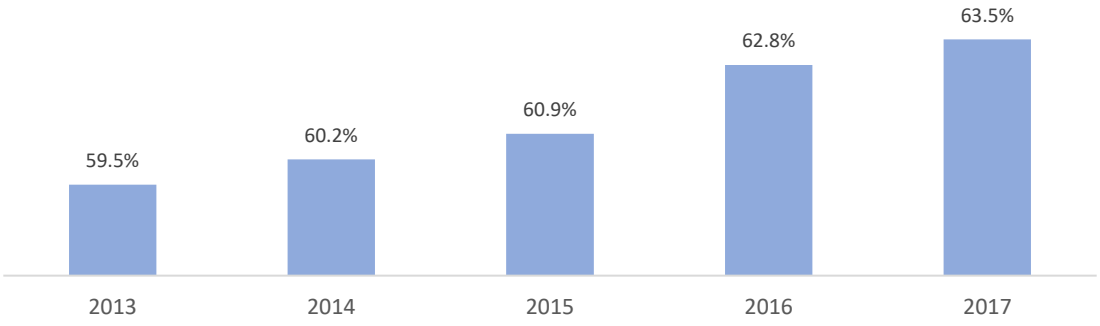
SOURCE: U.S. Census Bureau, American Community Survey

FIGURE 126: OSCEOLA COUNTY POPULATION BY EDUCATIONAL ATTAINMENT (2013-2017)



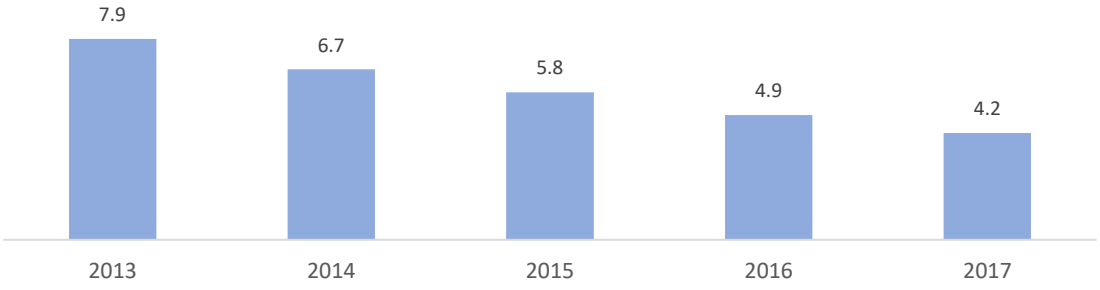
SOURCE: U.S. Census Bureau, American Community Survey

FIGURE 127: OSCEOLA COUNTY PARCIPATION IN THE LABOR FORCE (2013-2017)



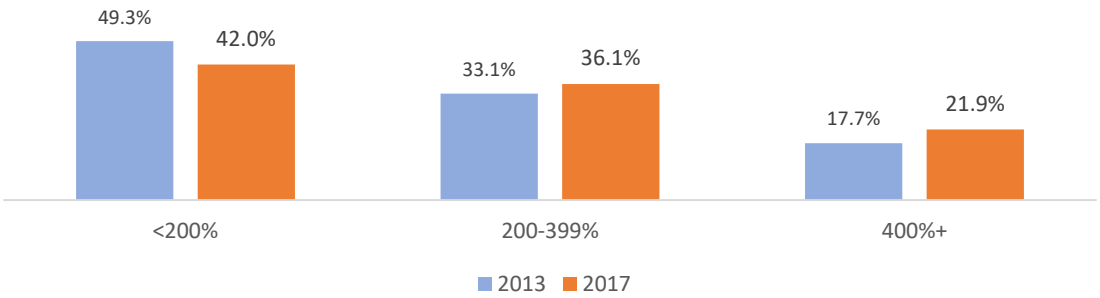
SOURCE: U.S. Bureau of Labor Statistics (Population 16 years and older)

FIGURE 128: OSCEOLA COUNTY UNEMPLOYMENT RATE (2013-2017)



SOURCE: U.S. Bureau of Labor Statistics (Not seasonally adjusted)

FIGURE 129: OSCEOLA COUNTY RATIO OF INCOME TO POVERTY LEVEL (2017)



SOURCE: U.S. Census Bureau, American Community Survey

Osceola County CFCHS Clients - Demographic Profile

CLIENT DEMOGRAPHICS

Just over seventy-five percent of all clients were enrolled in adult programs with 41.8 percent in the AMH program and 34.1 percent in the ASA program. Children in the CMH program accounted for 9.6 percent of all Osceola County clients while 14.6 percent were enrolled in the CSA program.

Males accounted for larger percentages of clients in all programs at 57.4 percent of AMH Clients, 65.3 percent of ASA clients, 54.5 percent of clients in the CMH program, and 71.5 percent of those in the CSA program.

Osceola County clients were more racially diverse when compared to the general population. The White population in Osceola County, at 74.4 percent, was higher when compared to the client population where Whites ranged from 60.8 percent of AMH clients to 31.7 percent of CSA clients. The Black population was disproportionately represented in the CMH program accounting for 25.7 percent of clients when only 11.2 percent of county residents identified as Black. Multi-racial individuals also accounted for much larger percentages of clients when compared to the general county population. Hispanic clients were slightly underrepresented in the adult programs but accounted for higher percentages of clients in child programs when compared to ethnic composition of the general population.

Adults, ages 25-44 years, accounted for 47.9 percent of AMH clients and 59.9 percent of ASA clients. Over thirty percent (38.3) of clients in adult programs were between the ages of 18 and 24 years and 34.8 percent were 45-55 years of age. Among child/youth programs, 64.6 percent of those in the CMH program were 5-14 years of age while 72.2 percent of clients in the CSA program were older at 15-17 years of age.

RESIDENTIAL STATUS

Among clients in the AMH program, 63.8 percent resided in one of three types of independent living situations. (Living alone, with non-relatives, or with relatives). This was slightly higher when compared to clients in the ASA program where 57.0 percent of clients were living independently. Children/Youth lived dependently with relatives.

EDUCATIONAL ATTAINMENT

Over seventy percent of adult clients did not have more than a high school education. Of these, 33.5 percent of AMH clients and 34.9 percent of ASA clients did not have a diploma.

EMPLOYMENT STATUS

The majority of clients in the AMH and ASA programs were unemployed at 79.8 percent and 67.6 percent, respectively. More than fifty percent of adult clients were unemployed due to termination.

SOURCE FOR ALL CHARTS IN THIS SECTION: CFCHS FY2017/18

FIGURE 130: OSCEOLA COUNTY CLIENTS BY PROGRAM

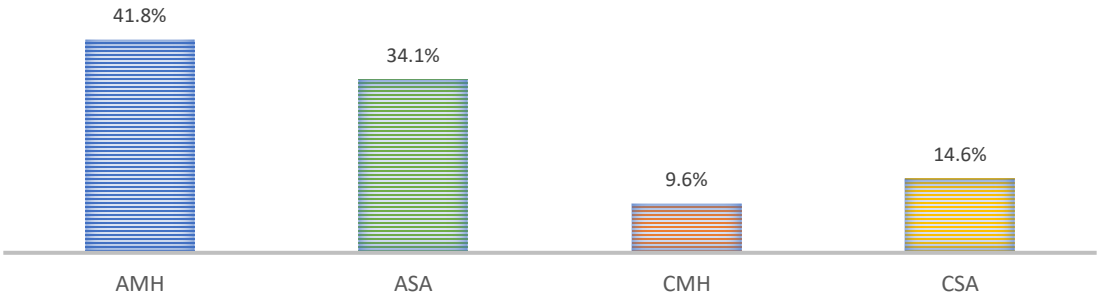


FIGURE 131: OSCEOLA COUNTY CLIENTS BY PROGRAM AND GENDER

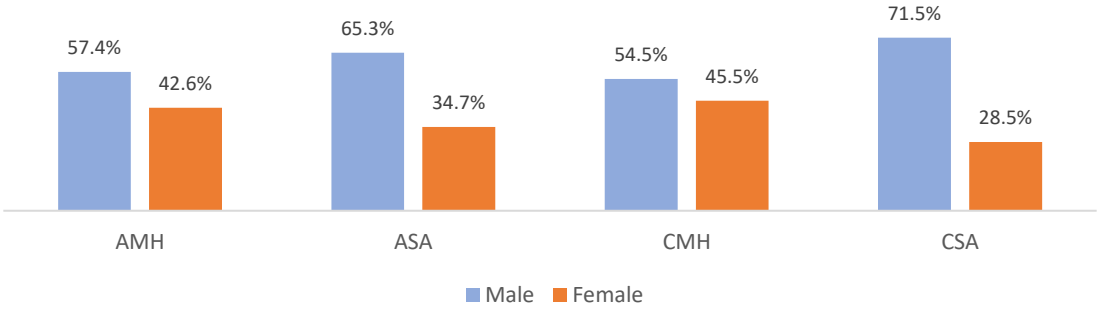


FIGURE 132: OSCEOLA COUNTY CLIENTS BY RACE

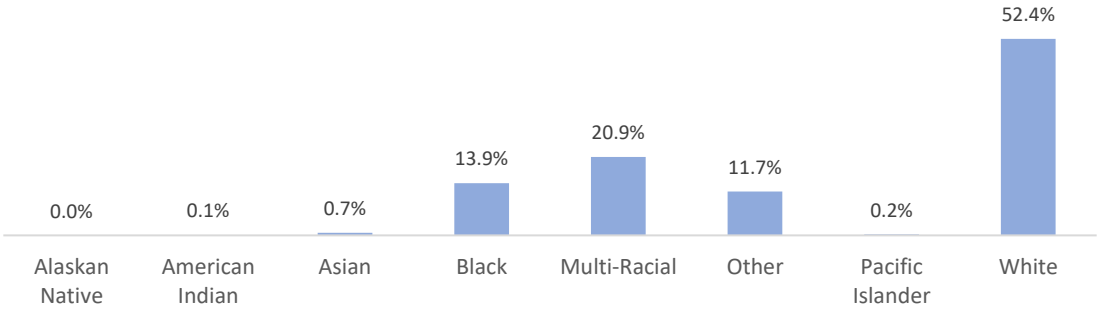


FIGURE 133: OSCEOLA COUNTY CLIENTS BY PROGRAM AND RACE

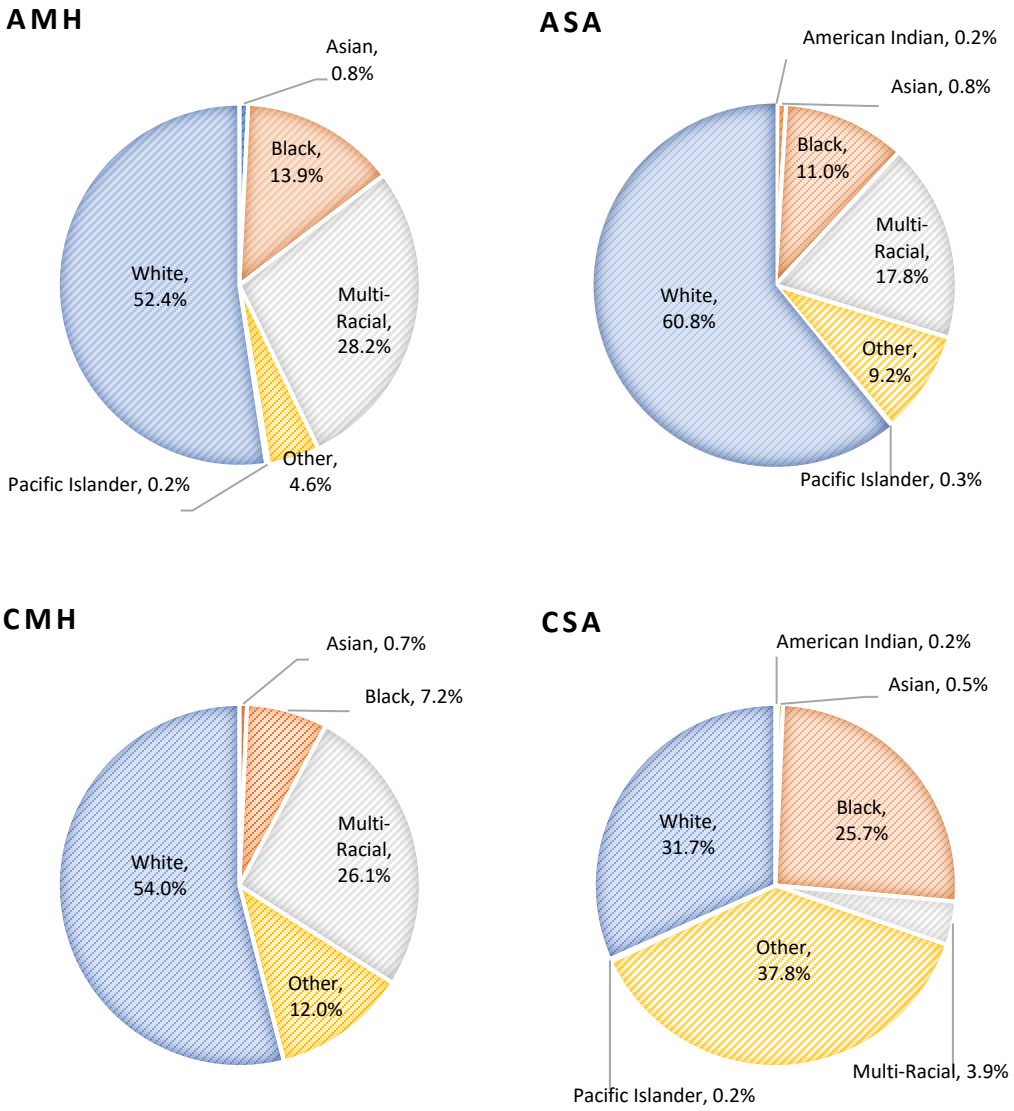


FIGURE 134: OSCEOLA COUNTY CLIENTS BY PROGRAM AND ETHNICITY

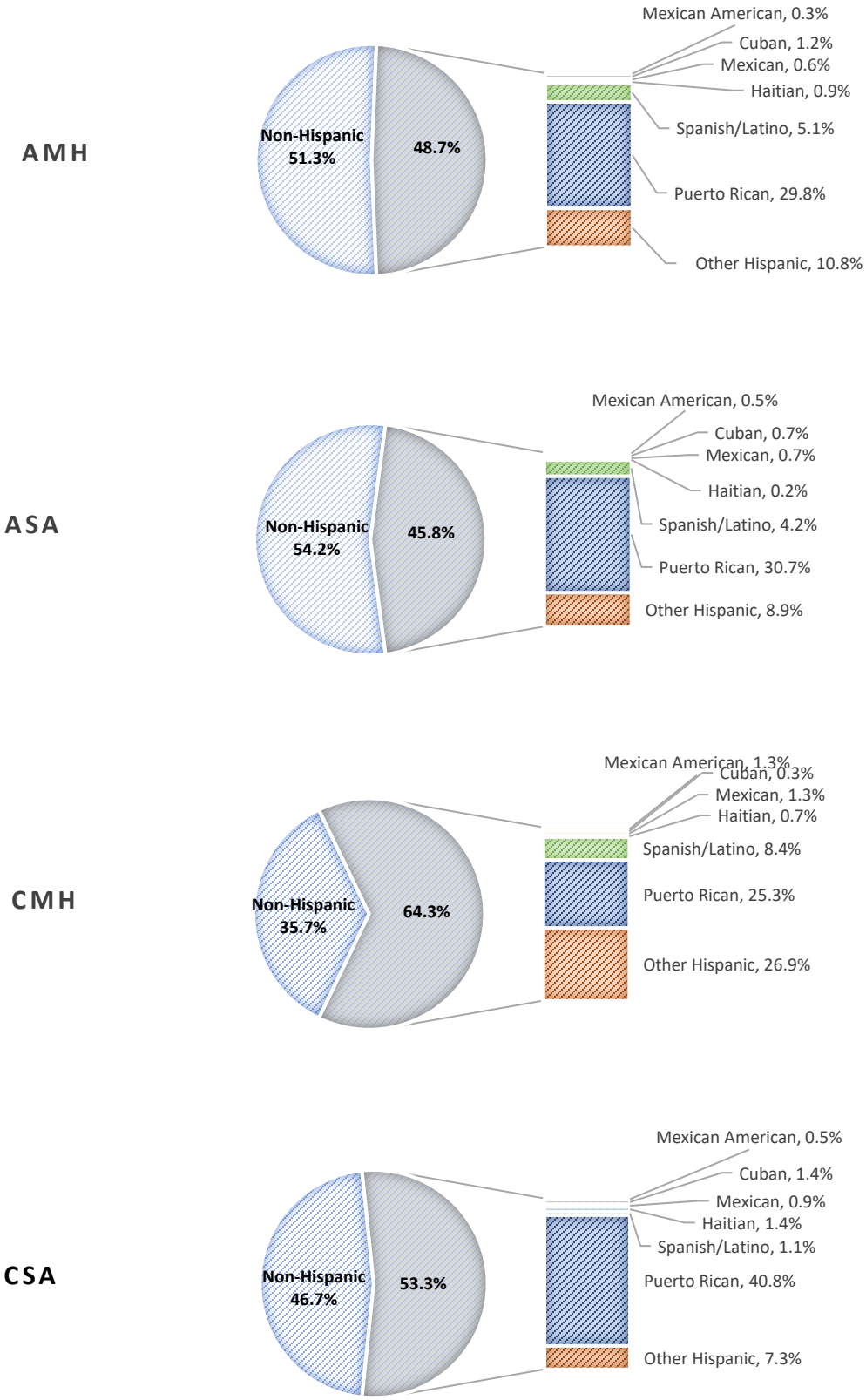


FIGURE 135: OSCEOLA COUNTY CLIENTS BY AGE RANGE

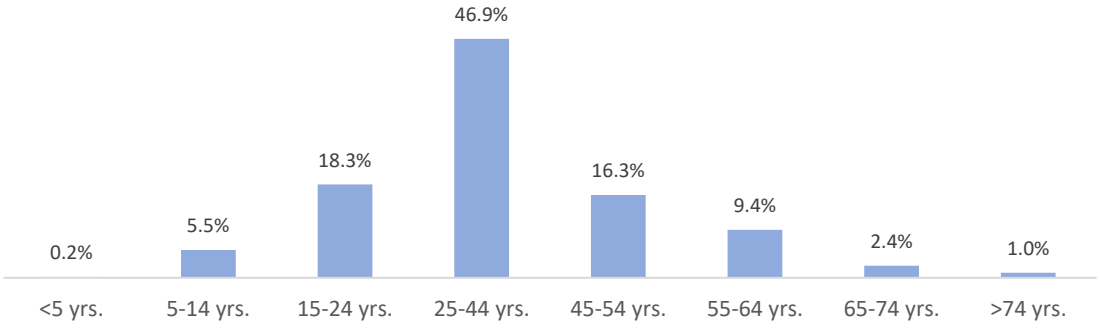


FIGURE 136: OSCEOLA COUNTY ADULT CLIENTS BY PROGRAM AND AGE RANGE

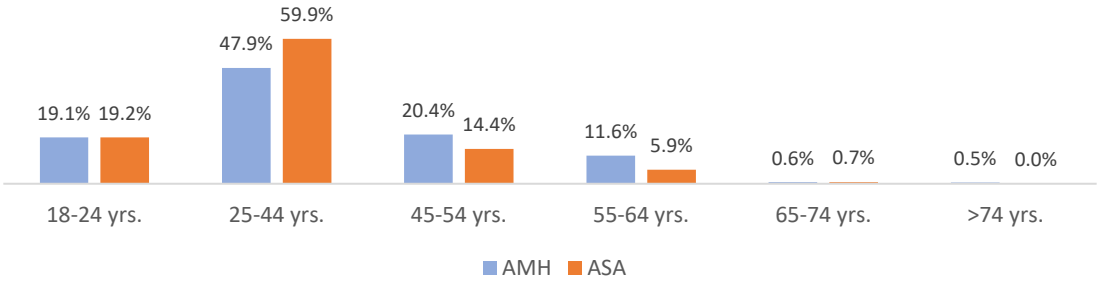


FIGURE 137: OSCEOLA COUNTY CHILD CLIENTS BY PROGRAM AND AGE RANGE

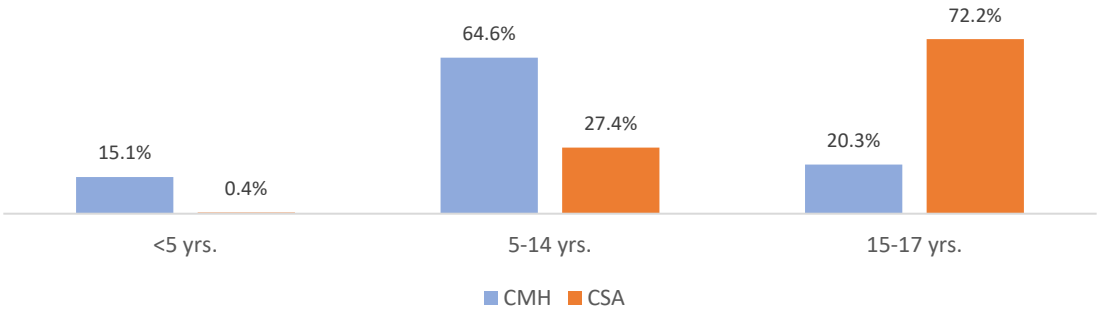


FIGURE 138: OSCEOLA COUNTY AMH CLIENTS BY RESIDENTIAL STATUS

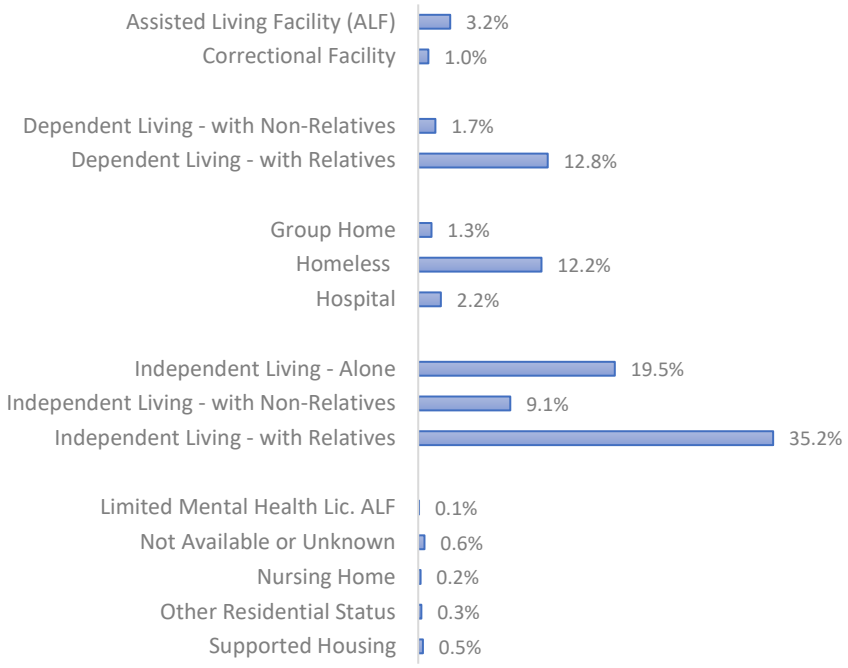


FIGURE 139: OSCEOLA COUNTY ASA CLIENTS BY RESIDENTIAL STATUS

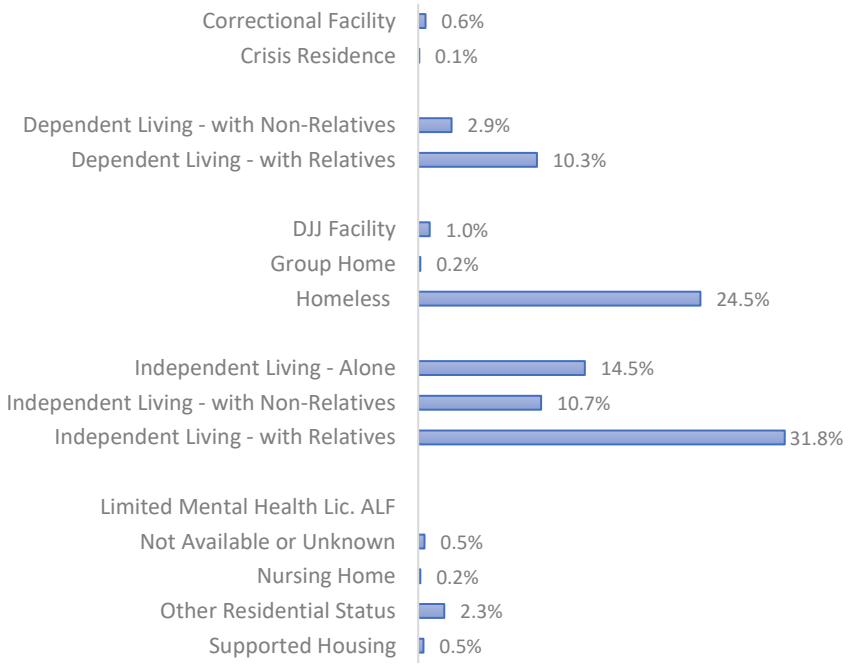


FIGURE 140: OSCEOLA COUNTY CMH CLIENTS BY RESIDENTIAL STATUS

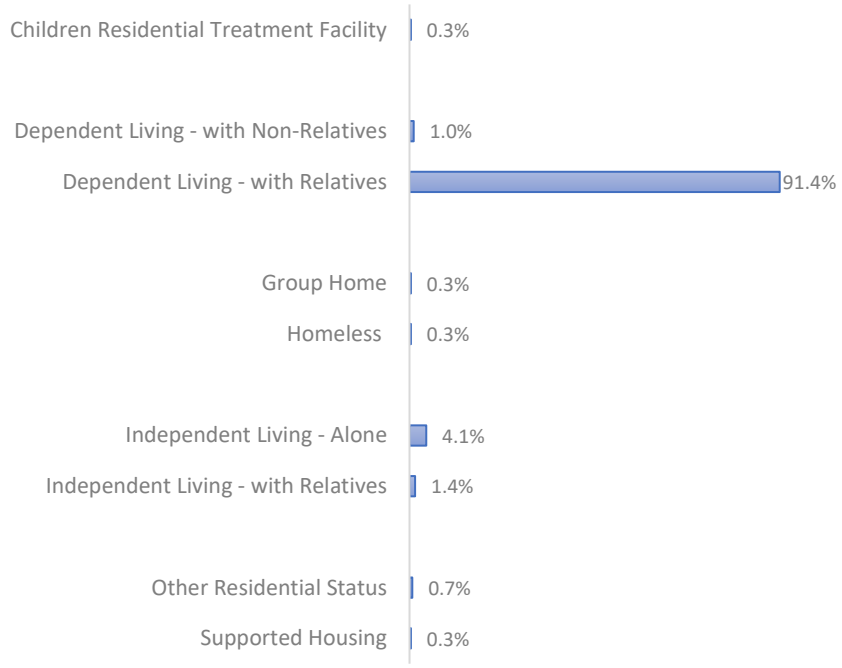


FIGURE 141: OSCEOLA COUNTY CSA CLIENTS BY RESIDENTIAL STATUS

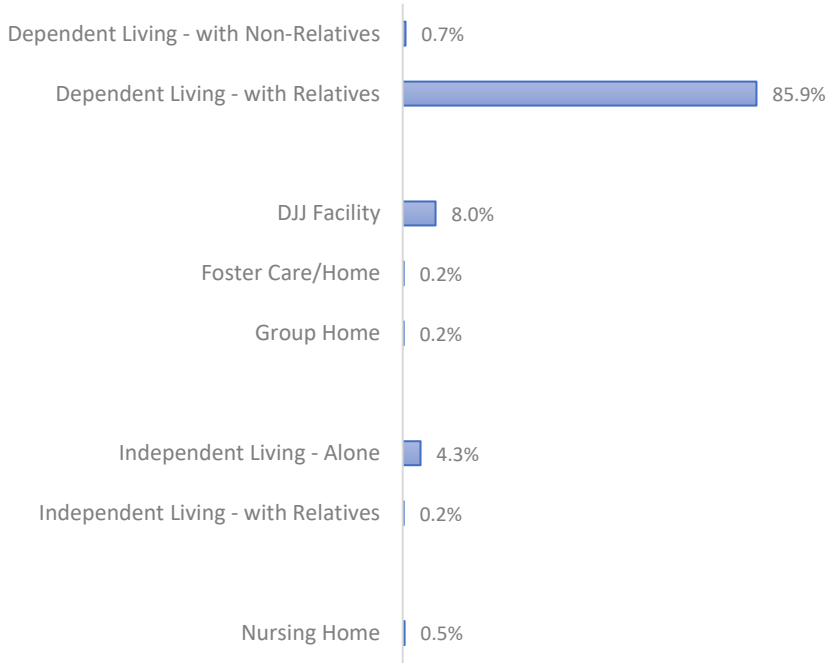


FIGURE 142: OSCEOLA COUNTY AMH CLIENTS BY EDUCATIONAL ATTAINMENT

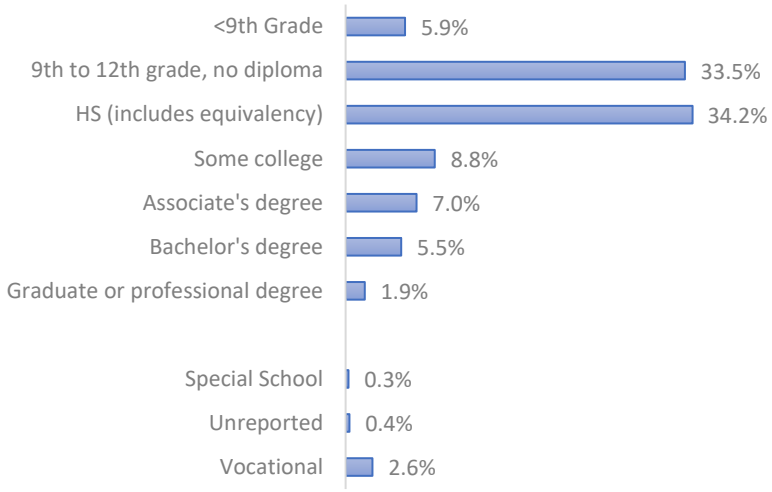


FIGURE 143: OSCEOLA COUNTY ASA CLIENTS BY EDUCATIONAL ATTAINMENT

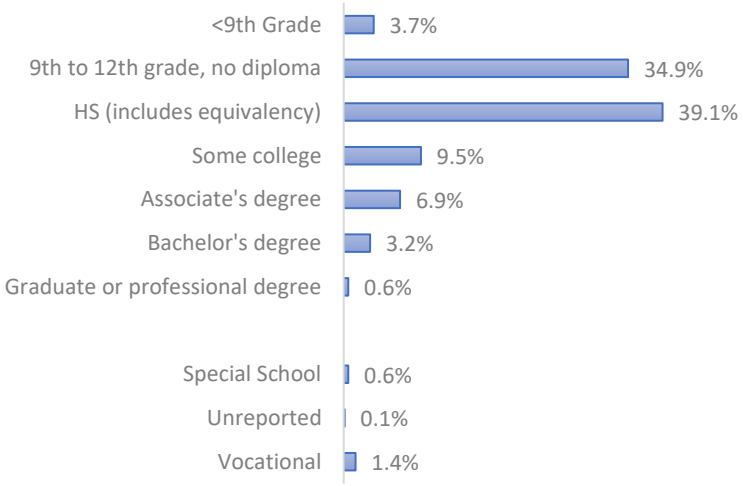


FIGURE 144: OSCEOLA COUNTY AMH CLIENTS BY EMPLOYMENT STATUS

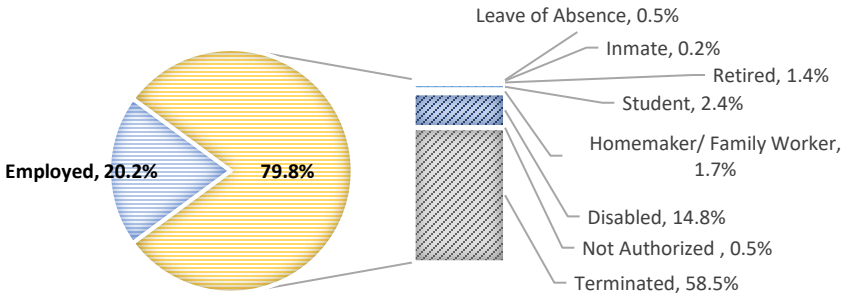
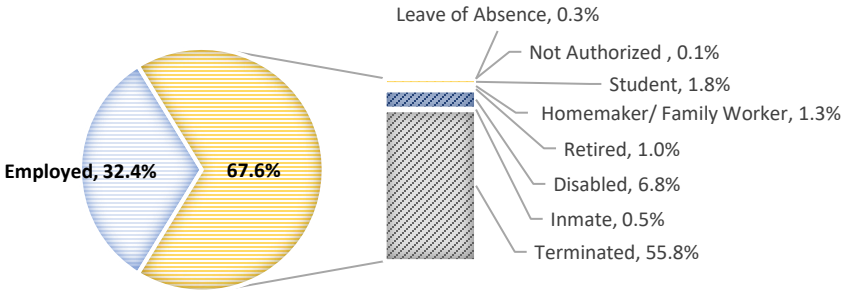


FIGURE 145: OSCEOLA COUNTY ASA CLIENTS BY EMPLOYMENT STATUS



Seminole County - Demographic Profile

POPULATION DEMOGRAPHICS

The population in Seminole County increased just over one percent each year from 2013 to 2017. The total population growth for the four-year period at 5.2 percent, added 22,076 residents.

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

Racially, 78.3 percent of the population in Seminole County was White when compared to the service area and state rates at 71.7 percent, and 76.3 percent, respectively. The Black population accounted for 11.5 percent of Seminole's population, slightly below the 15.8 percent in the service area population and 16.0 percent of the residents in Florida. American Indian and Native Hawaiian's represented less than one percent of residents in the county. The percentage of Asian residents, at 4.3 percent was slightly higher in Seminole County when compared to the service area at 4.1 percent and the state at 2.5 percent. Seminole County had a lower percentage of residents who were of an Other race (2.3 percent compared to 4.8 percent in the service area) but the same percentage of residents who had more than one race, at 3.3 percent.

Ethnically, Seminole County had a lower percentage of Hispanic residents, at 20.1 percent when compared to the service area and the state at 26.7 percent and 22.9 percent, respectively.

Seminole County's population was very similar to the service area age distribution across all age ranges. Residents 65 years of age or older, accounted for 14.4 percent of the population. Seminole County was slightly younger when compared to the state where 17.8 percent of the population in Florida was at least 65 years of age.

EDUCATION AND EMPLOYMENT

Seminole County residents attained higher educational levels when compared to other counties in the service area and the state. Data revealed higher percentages of Seminole County residents who earned degrees and lower percentages of residents who limited education to less than or no more than a high school diploma. In Seminole County, 14.2 percent held an associate degree, 25.4 percent had earned a bachelor's degree and 12.1 percent had either a graduate or professional degree. This compares to percentages in the service area at 11.7 percent, 20.5 percent and 10.5 percent, respectively.

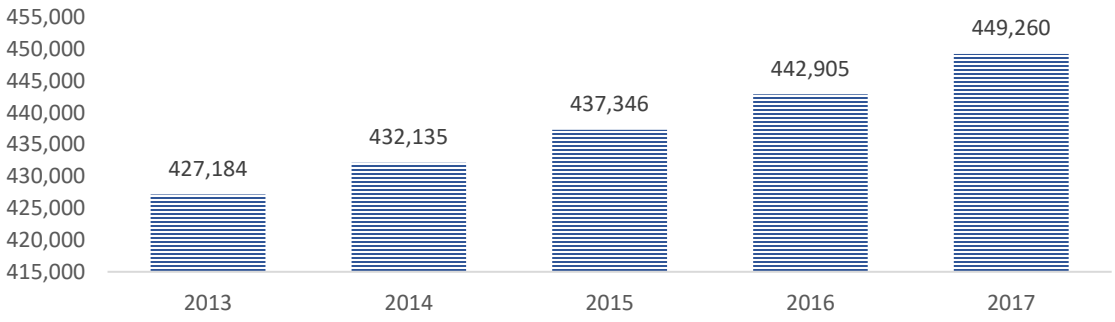
Participation in the labor force for Seminole County residents continually decreased from 66.9 percent in 2013 to 63.7 percent in 2017. However, the unemployment rate for the

county also decreased by 46.2 percent during the same time period. This was a similar decrease to those observed in the service area, at 45.8 percent, and Florida, at 43.3 percent. A possible explanation for this occurrence is the decision of older residents to remain in the county after retirement.

POVERTY STATUS

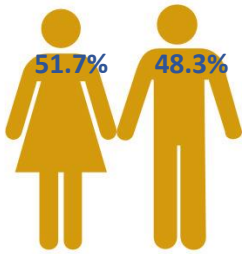
Over the past five years, the percentage of Seminole County residents living at <200% FPL decreased modestly from 29.5 percent in 2013 to 27.4 percent in 2017. Decreases were also noted among those living at 200% - 399% FPL. The percentage of residents living at 400% FPL increased from 38.0 percent in 2013 to 43.0 percent in 2017.

FIGURE 146: SEMINOLE COUNTY POPULATION ESTIMATES (2013-2017)



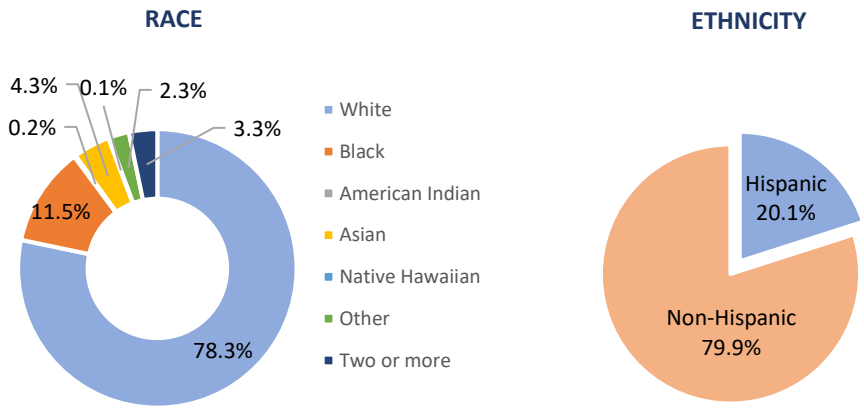
SOURCE: U.S. Census Bureau, American Community Survey

FIGURE 147: SEMINOLE COUNTY POPULATION BY GENDER (2013-2017)



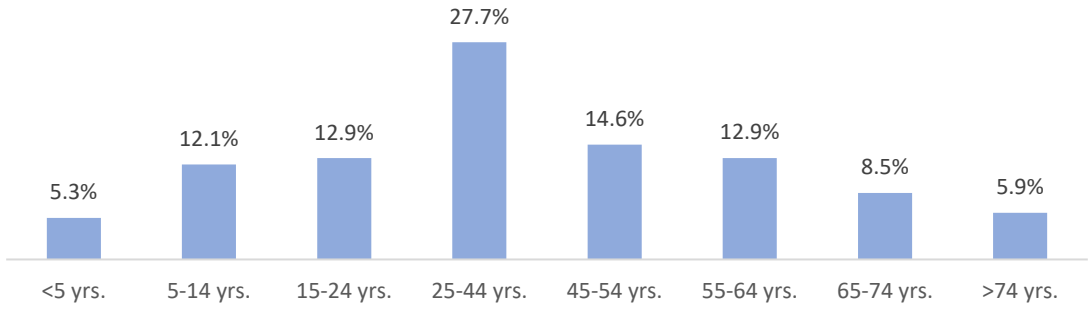
SOURCE: U.S. Census Bureau, American Community Survey

FIGURE 148: SEMINOLE COUNTY POPULATION BY RACE AND ETHNICITY (2013-2017)



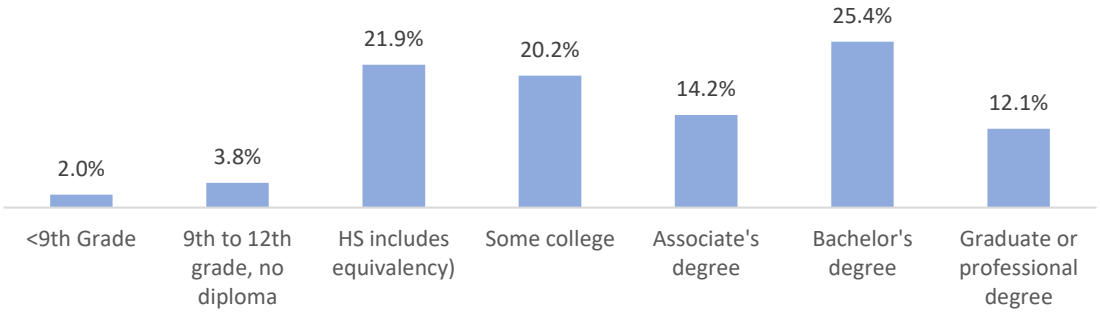
SOURCE: U.S. Census Bureau, American Community Survey

FIGURE 149: SEMINOLE COUNTY POPULATION BY AGE RANGE (2013-2017)



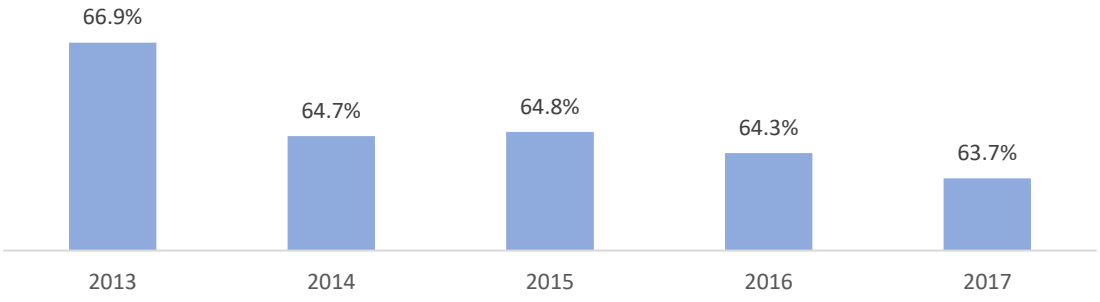
SOURCE: U.S. Census Bureau, American Community Survey

FIGURE 150: SEMINOLE COUNTY POPULATION BY EDUCATIONAL ATTAINMENT (2013-2017)



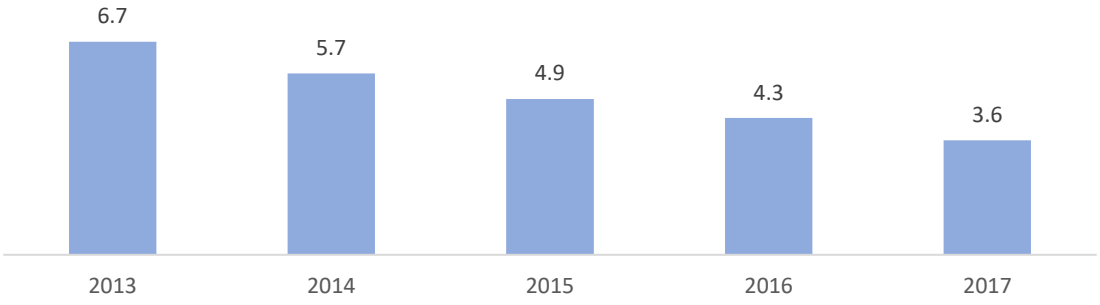
SOURCE: U.S. Census Bureau, American Community Survey

FIGURE 151: SEMINOLE COUNTY PARTICIPATION IN THE LABOR FORCE (2013-2017)



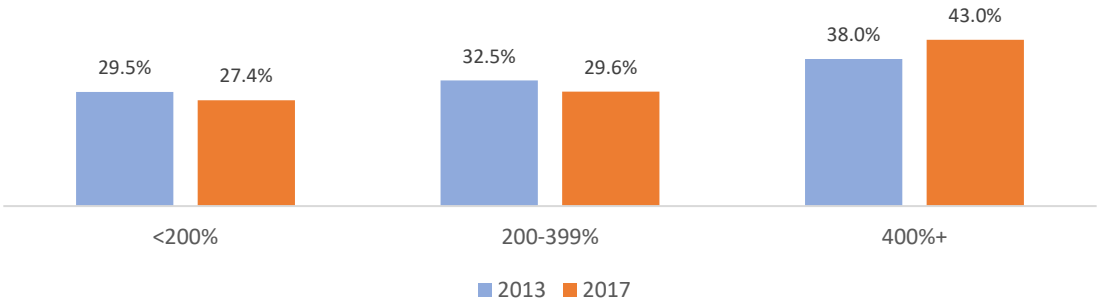
SOURCE: U.S. Bureau of Labor Statistics (Population 16 years and older)

FIGURE 152: SEMINOLE COUNTY UNEMPLOYMENT RATE (2013-2017)



SOURCE: U.S. Bureau of Labor Statistics (Not seasonally adjusted)

FIGURE 153: SEMINOLE COUNTY RATIO OF INCOME TO POVERTY LEVEL (2017)



SOURCE: U.S. Census Bureau, American Community Survey

Seminole County CFCHS Clients - Demographic Profile

CLIENT DEMOGRAPHICS

The majority of clients in Seminole County were enrolled in adult programs which accounted for 68.0 percent of all clients. Children in the CMH program accounted for 4.0 percent of clients while 27.9 percent were enrolled in the CSA program.

Males accounted for larger percentages of clients in in the ASA and CSA programs at 56.6 percent and 54.4 percent of CSA clients. More females were enrolled in the AMH program when compared to their male counterparts. Males and females were equally represented in the CMH program.

The racial composition of clients was representative of those in the general population in all programs except the CSA program. Black children accounted for 30.6 percent of the CSA client population while representing only 11.5 percent of the general county population. Multi-racial individuals also accounted for a larger percentage of clients in the CMH program, at 19.9 percent when compared to the general population at 3.3 percent. Generally, Hispanic clients were representative of the general population except for those in the ASA program where only 14.0 percent identified as Hispanics compared to 20.1 percent in the county population.

Adults, ages 25-44 years, accounted for 48.1 percent of AMH clients and 63.7 percent of ASA clients. Twenty-five percent of clients in adult programs were between the ages of 18 and 24 years and 35.7 percent were 45-55 years of age. Among child/youth programs, 56.8 percent of those in the CMH program were 5-14 years of age while 64.6 percent of clients in the CSA program were older at 15-17 years of age.

RESIDENTIAL STATUS

Among clients in the AMH program, 52.1 percent resided in one of three types of independent living situations (living alone, with non-relatives, or with relatives) and 35.2 percent lived dependently. For clients in the ASA program, 60.9 percent lived independently, and 21.3 percent lived dependently. Children/Youth lived dependently with relatives.

EDUCATIONAL ATTAINMENT

More than fifty percent of adult clients did not have more than a high school education. Of these, 21.3 percent of AMH clients and 22.9 percent of ASA clients did not have a diploma.

EMPLOYMENT STATUS

The majority of clients in the AMH and ASA programs were unemployed at 72.3 percent and 69.2 percent, respectively. More than fifty percent of adult clients were unemployed due to termination.

SOURCE FOR ALL CHARTS IN THIS SECTION: CFCHS FY2017/18

FIGURE 154: SEMINOLE COUNTY CLIENTS BY PROGRAM

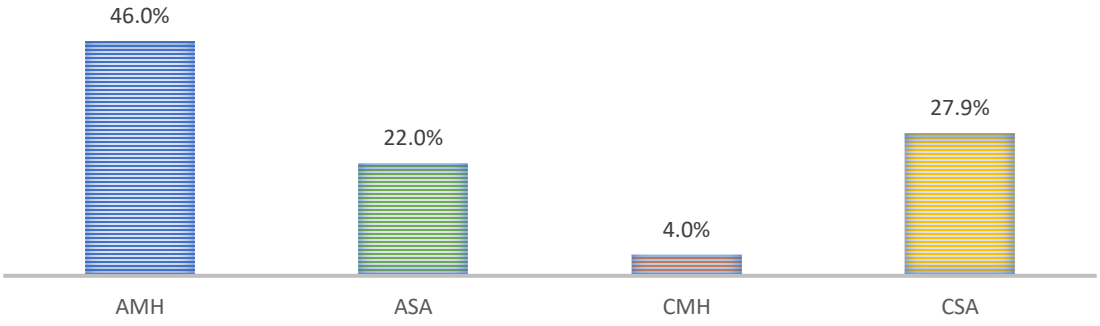


FIGURE 155: SEMINOLE COUNTY CLIENTS BY PROGRAM AND GENDER

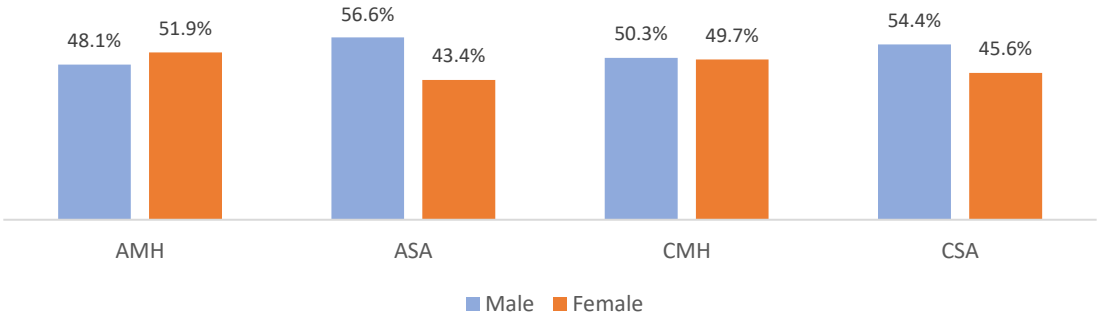


FIGURE 156: SEMINOLE COUNTY CLIENTS BY RACE

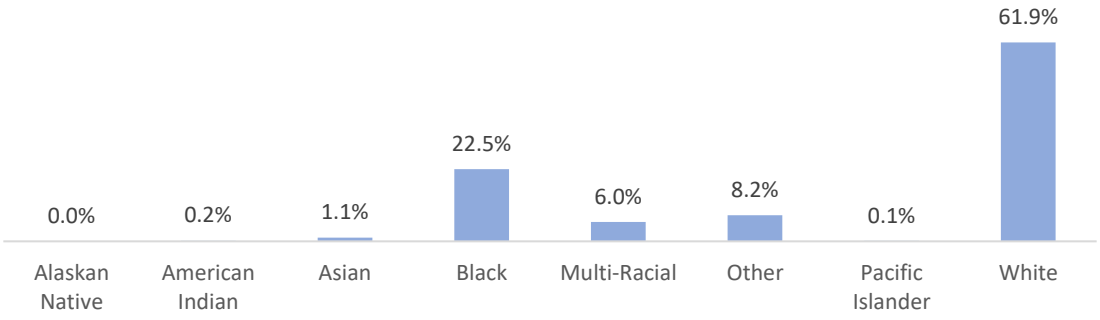


FIGURE 157: SEMINOLE COUNTY CLIENTS BY PROGRAM AND RACE

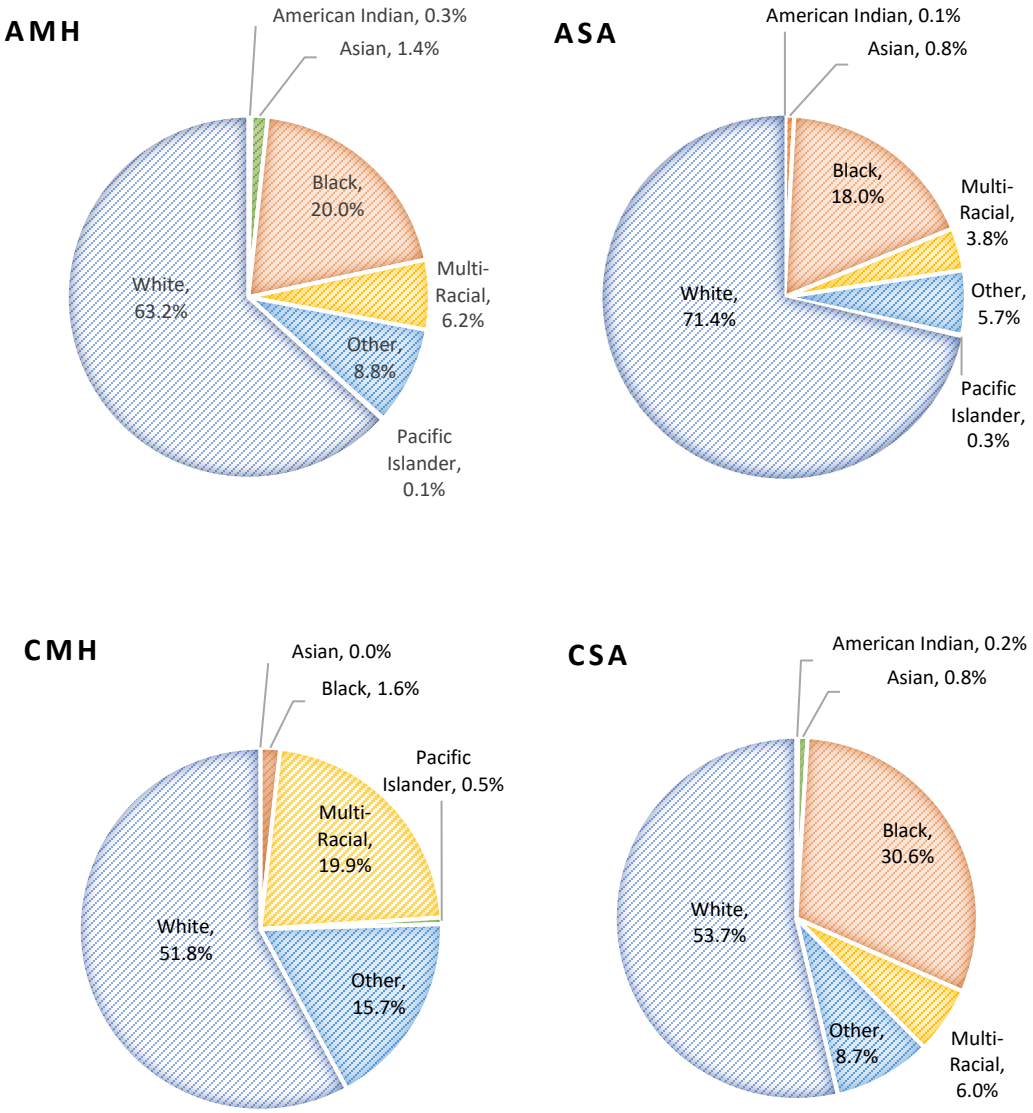


FIGURE 158: SEMINOLE COUNTY CLIENTS BY PROGRAM AND ETHNICITY

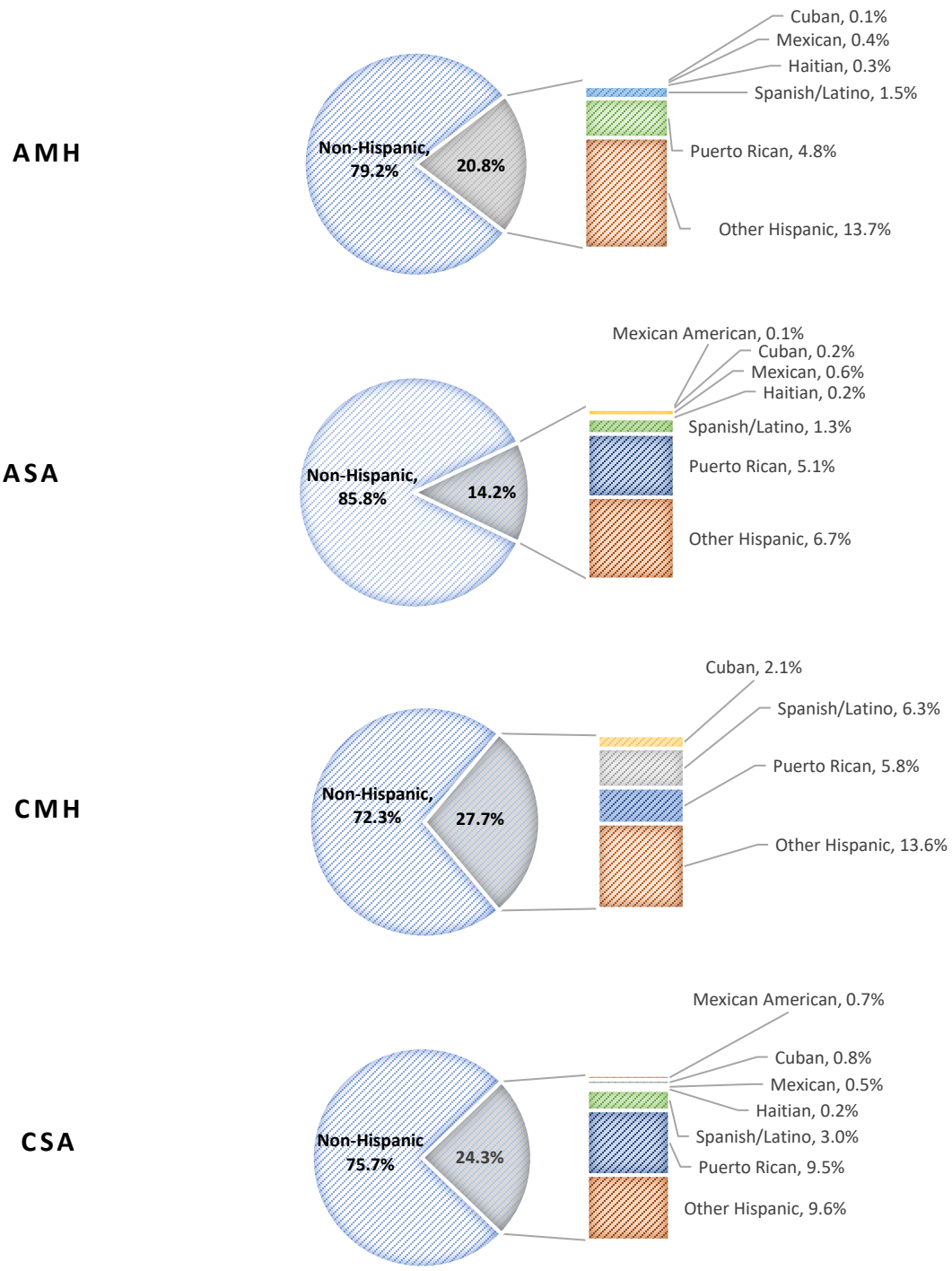


FIGURE 159: SEMINOLE COUNTY CLIENTS BY AGE RANGE

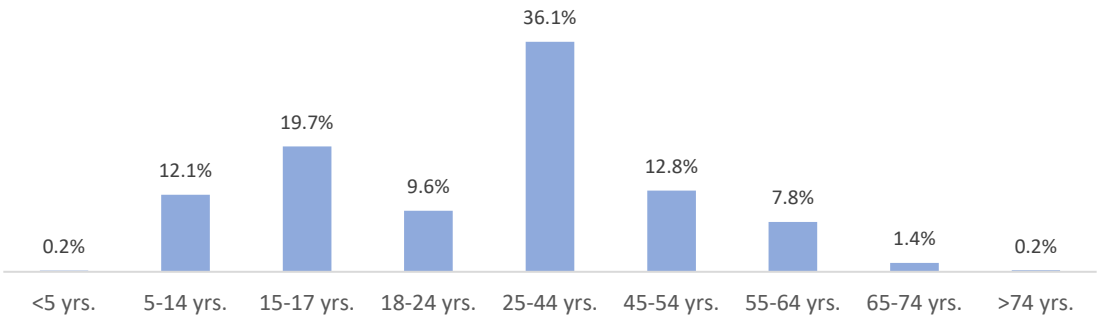


FIGURE 160: SEMINOLE COUNTY ADULT CLIENTS BY PROGRAM AND AGE RANGE

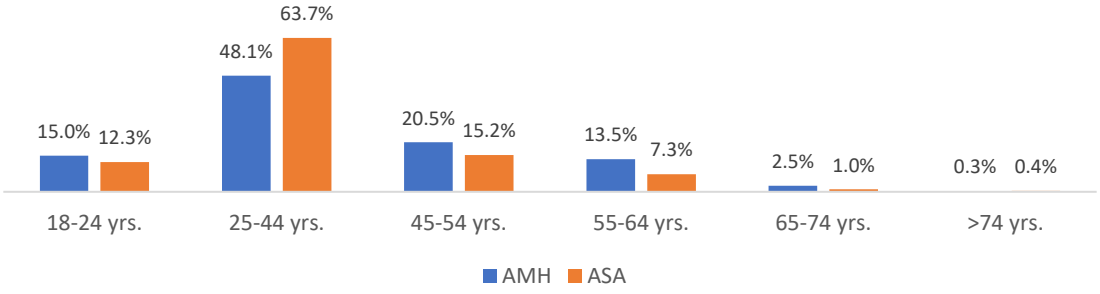


FIGURE 161: SEMINOLE COUNTY CHILD CLIENTS BY PROGRAM AND AGE RANGE

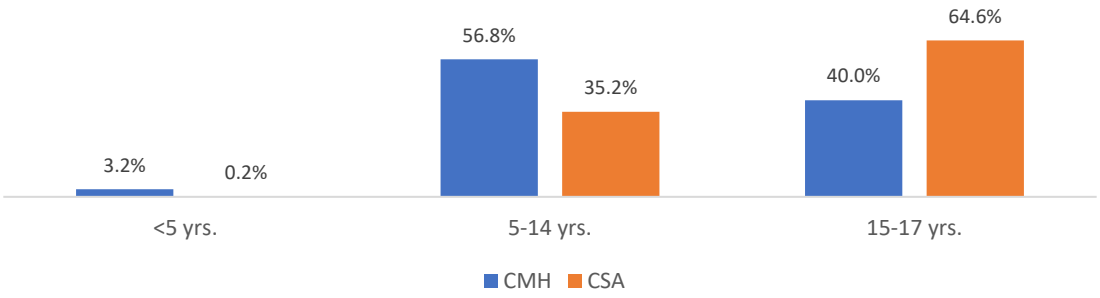


FIGURE 162: SEMINOLE COUNTY AMH CLIENTS BY RESIDENTIAL STATUS

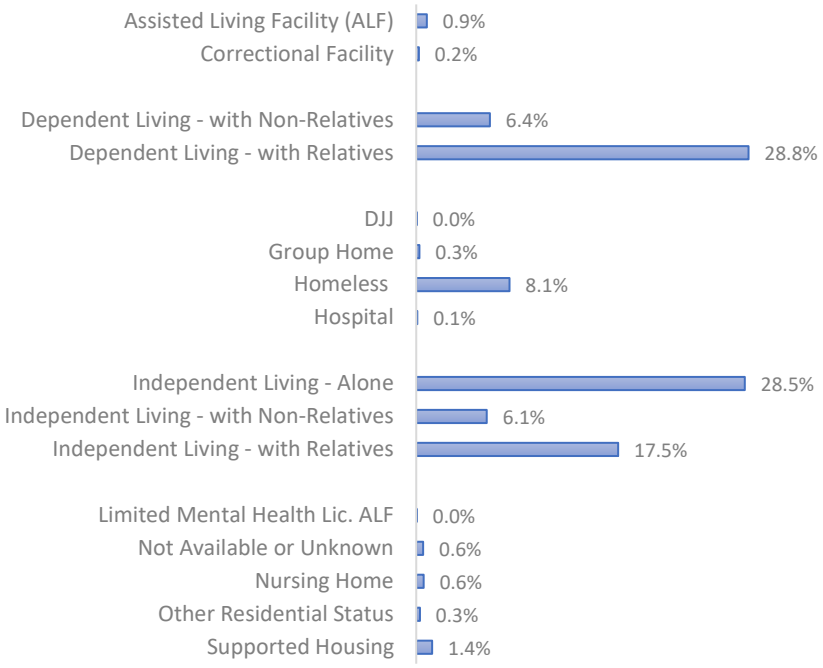


FIGURE 163: SEMINOLE COUNTY ASA CLIENTS BY RESIDENTIAL STATUS

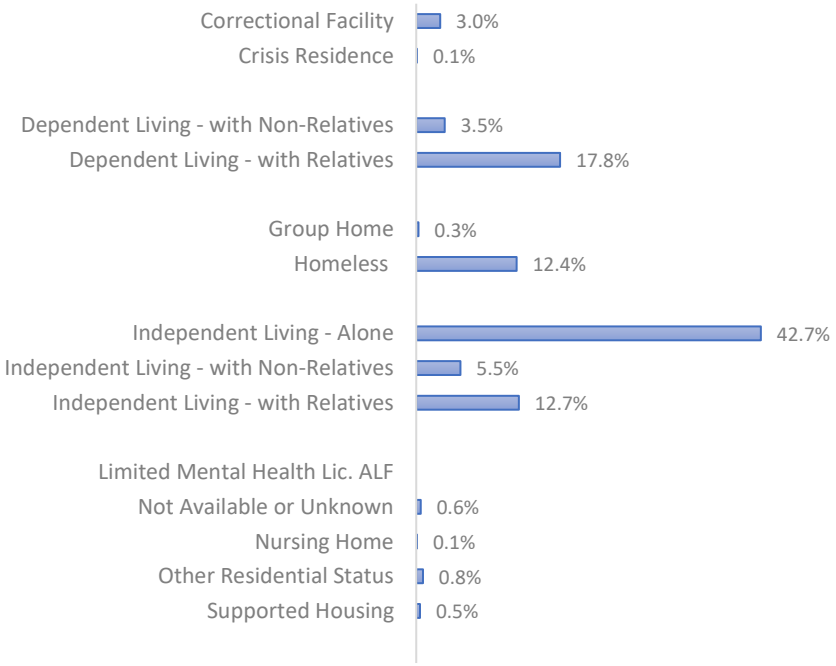


FIGURE 164: SEMINOLE COUNTY CMH CLIENTS BY RESIDENTIAL STATUS

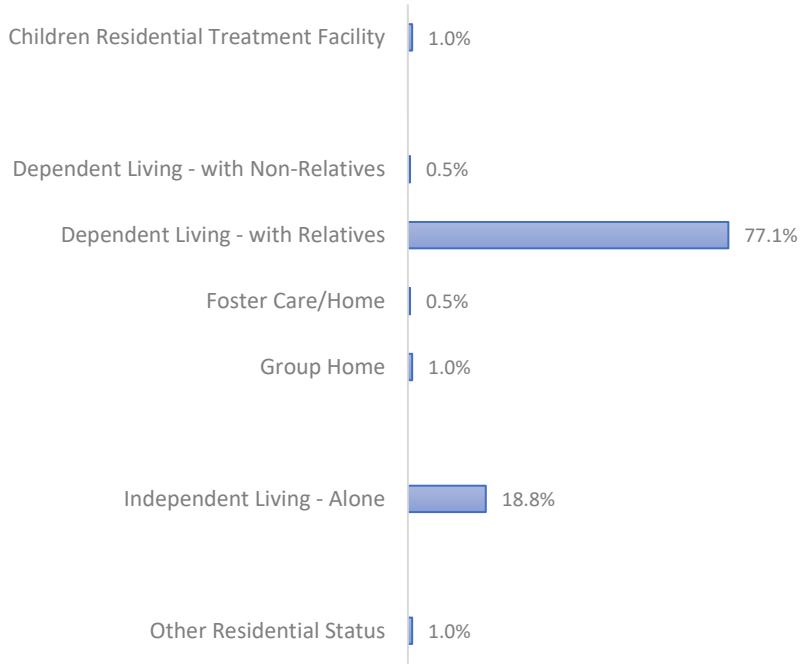


FIGURE 165: SEMINOLE COUNTY CSA CLIENTS BY RESIDENTIAL STATUS

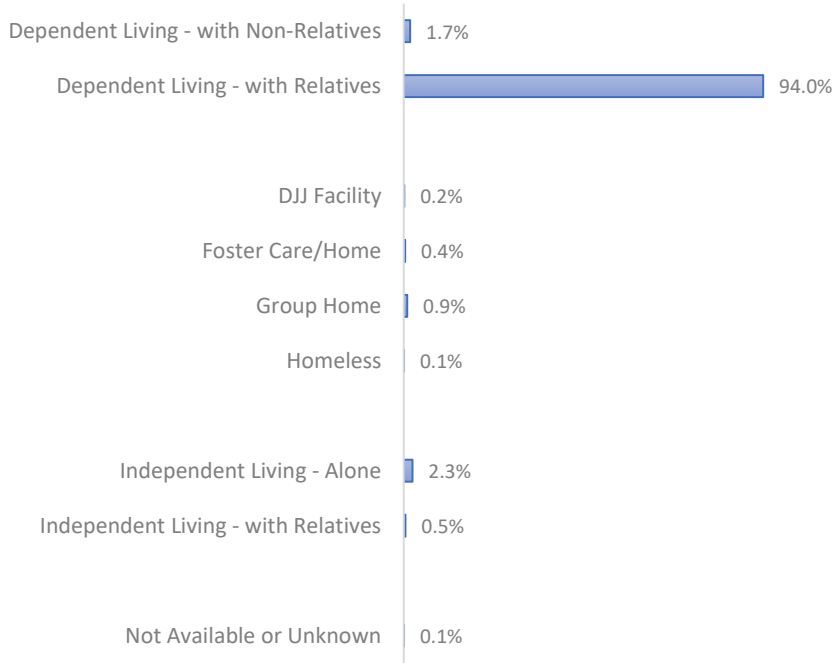


FIGURE 166: SEMINOLE COUNTY AMH CLIENTS BY EDUCATIONAL ATTAINMENT

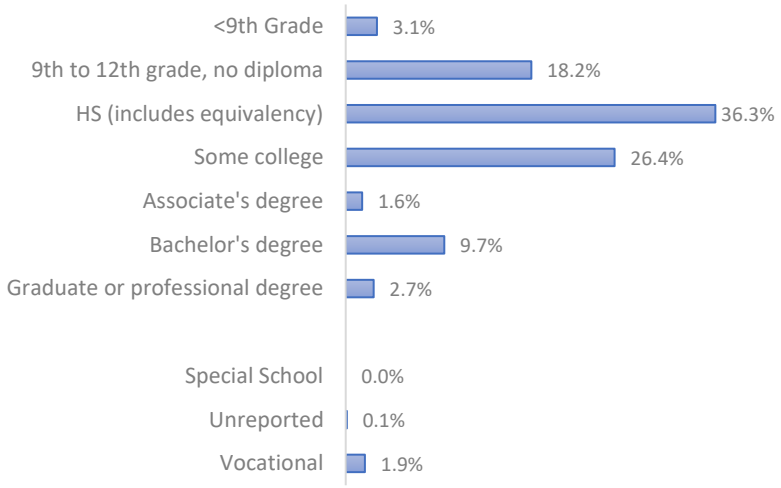


FIGURE 167: SEMINOLE COUNTY ASA CLIENTS BY EDUCATIONAL ATTAINMENT

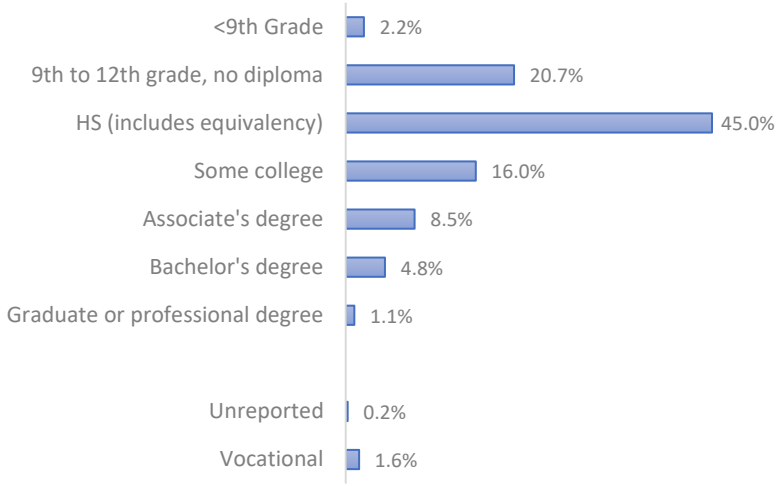


FIGURE 168: SEMINOLE COUNTY AMH CLIENTS BY EMPLOYMENT STATUS

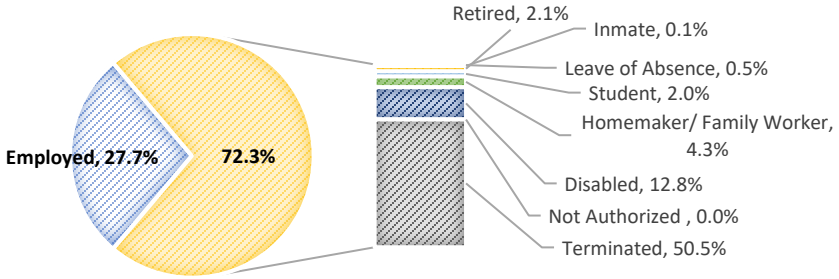
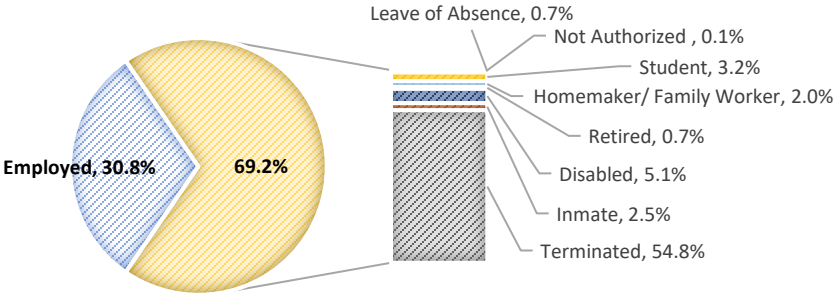


FIGURE 169: SEMINOLE COUNTY ASA CLIENTS BY EMPLOYMENT STATUS



Central Florida Homeless Population Profile

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

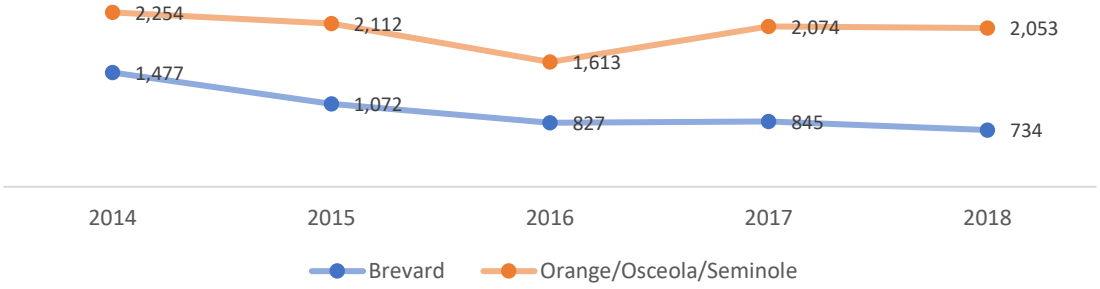
In 2018, the Florida Council on Homelessness reported there were 2,787 individuals who were homeless in Central Florida (Brevard, Orange, Osceola and Seminole counties). Close to thirty percent were unsheltered and 13.9 percent were chronically homeless. In Brevard County, there were 213 people in families with children who were homeless and 713 people in Orange, Osceola and Seminole in the same situation. Among veterans, 169 were homeless in Brevard County while 181 veterans were homeless throughout the other three counties. The Florida Department of Education reported 13,272 students in Central Florida were homeless in the 2016-2017 academic year. Almost seventy percent of homeless students resided in a shared housing environment, 24.2 percent lived in motels, 4.3 percent were sheltered, 2.2 percent were unsheltered, and 0.4 percent were awaiting foster care.

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

Source	Brevard	Orange/Osceola/Seminole
Total Funding Award	$1,150,159.85	$8,093,163.85
HUD CoC	$689,017.00	$7,550,681.00
State Total	$461,142.85	$542,482.85
State Challenge	$118,000.00	$205,500.00
State HUD-ESG	$200,000.00	$199,740.00
State Staffing	$107,142.85	$107,142.85
State TANF-HP	$36,000.00	$30,100.00

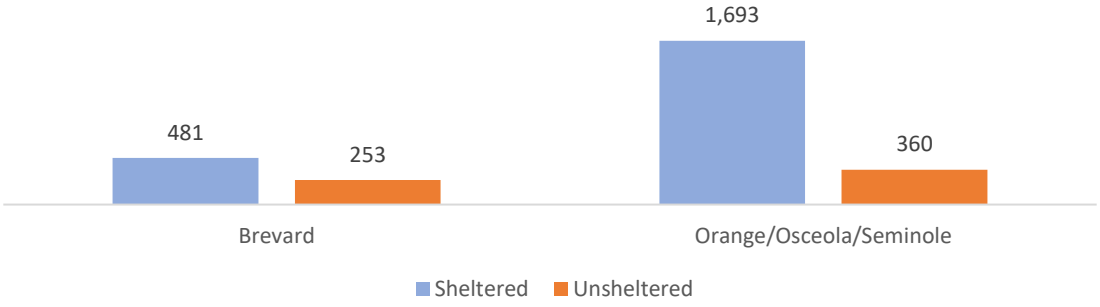
SOURCE: Council on Homelessness Annual Report (2018)

FIGURE 170: TOTAL HOMELESSNESS IN CENTRAL FLORIDA



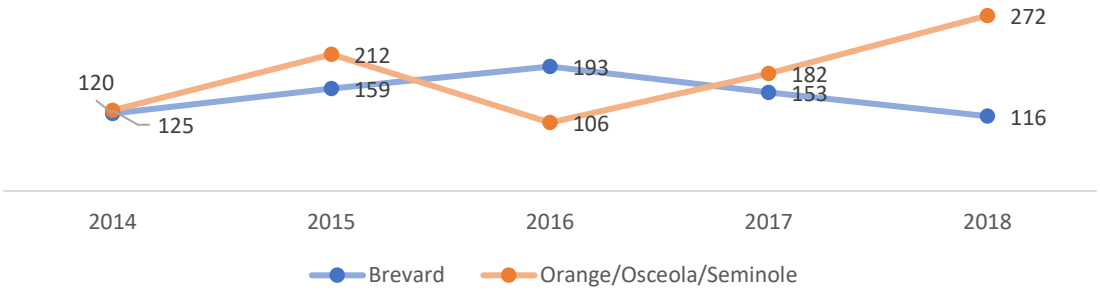
SOURCE: Council on Homelessness Annual Report (2018)

FIGURE 171: TOTAL HOMELESS SHELTERED AND UNSHELTERED



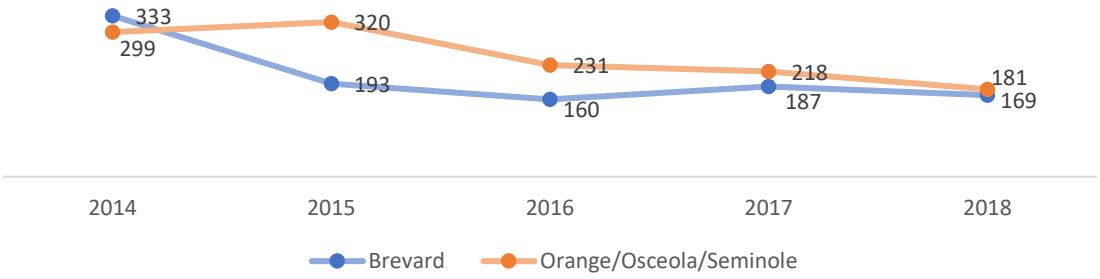
SOURCE: Council on Homelessness Annual Report (2018)

FIGURE 172: CHRONIC HOMELESSNESS



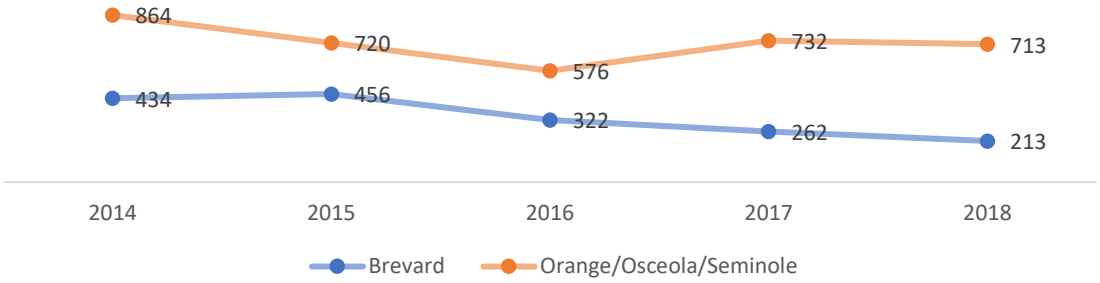
SOURCE: Council on Homelessness Annual Report (2018)

FIGURE 173: HOMELESSNESS AMONG VETERANS



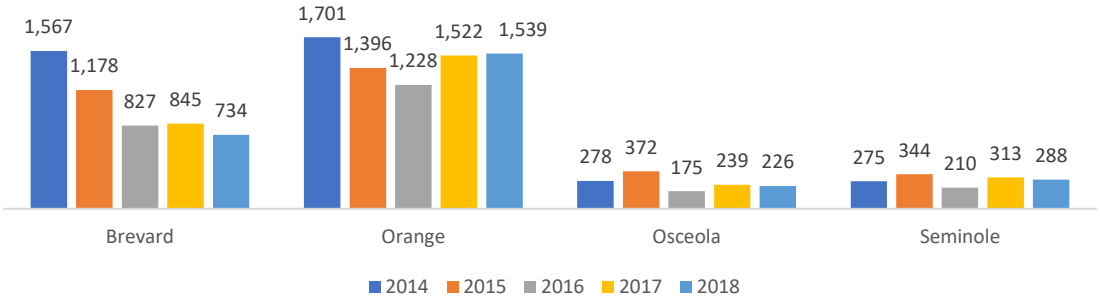
SOURCE: Council on Homelessness Annual Report (2018)

FIGURE 174: FAMILY HOMELESSNESS: TOTAL PERSONS IN FAMILIES WITH CHILDREN



SOURCE: Council on Homelessness Annual Report (2018)

FIGURE 175: POINT-IN-TIME COUNTS OF HOMELESS PERSONS



SOURCE: Council on Homelessness Annual Report (2018)

FIGURE 176: FLORIDA DOE - REPORTED HOMELESS STUDENTS

CoC Area	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017
Brevard	1,645	1,690	1,845	1,973	2,262
Orange	7,234	6,736	6,800	6,853	6,130
Osceola	3,156	4,941	4,675	3,562	3,341
Seminole	2,235	2,034	1,992	1,898	1,539

SOURCE: Council on Homelessness Annual Report (2018)

FIGURE 177: REPORTED HOMELESS STUDENTS 2016-2017

CoC Area	Shelters	Sharing Housing	Unsheltered	Motels	AFC
Brevard	140	1,764	111	228	19
Orange	300	3,947	60	1,792	31
Osceola	67	2,273	97	897	<11
Seminole	64	1,160	18	292	<11

SOURCE: Council on Homelessness Annual Report (2018)

Homeless CFCHS Clients – Demographic Profile

DEMOGRAPHICS

A total of 3,825 homeless clients were only enrolled in adult programs with 72.8 percent in the AMH program and 27.2 in the ASA program.

Males accounted for larger percentages of clients in the AMH and ASA programs at 74.7 percent and 69.2 percent, respectively.

Homeless clients in the AMH program were racially more diverse when compared to the general service population while those in the ASA program were representative of the four-county area. White homeless clients accounted for 60.3 percent of those in the AMH program and Black homeless clients represented 27.0 percent of clients in the same program. In the general population, Blacks accounted for 15.8 percent of the total population. Multi-racial individuals also accounted for a larger percentage of clients in the AMH (10.9 percent) and ASA (6.2 percent) programs when compared to the service area population at 3.3 percent. Hispanic clients in the AMH program, at 36.3 percent, were overrepresented while Hispanic clients in the ASA, at 10.8 percent, were unrepresented when compared to the general population where 26.7 percent were Hispanic.

Adults, ages 25-44 years, accounted for 57.1 percent of AMH clients and 41.5 percent of ASA clients. Older homeless clients in the ASA program were overrepresented, at 18.5 percent, when compared the general population at 12.3 percent.

RESIDENTIAL STATUS

All homeless clients reported their residential status as homeless.

EDUCATIONAL ATTAINMENT

Among the homeless, 83.8 percent of AMH clients and 79.0 percent of ASA clients did not have more than a high school education. Of these, 29.2 percent of AMH clients and 15.8 percent of ASA clients did not have a diploma.

EMPLOYMENT STATUS

Only 2.5 percent of homeless clients were employed and over ninety percent had been terminated.

FIGURE 178: HOMELESS CLIENTS BY PROGRAM

FIGURE 179: HOMELESS CLIENTS BY PROGRAM AND GENDER

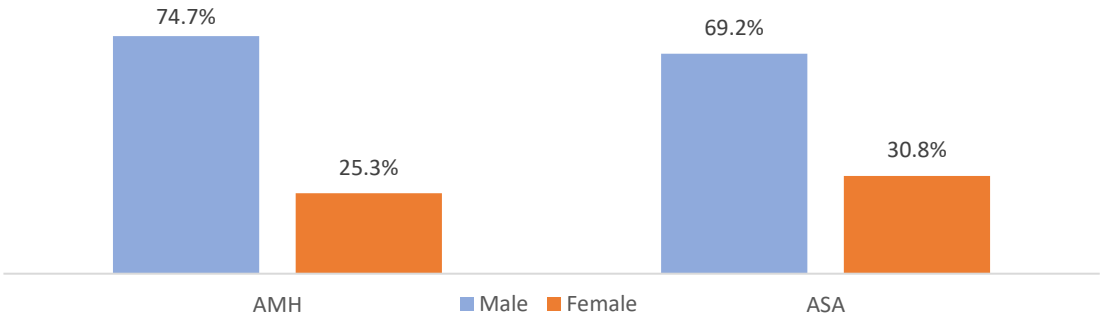


FIGURE 180: HOMELESS CLIENTS BY PROGRAM AND RACE

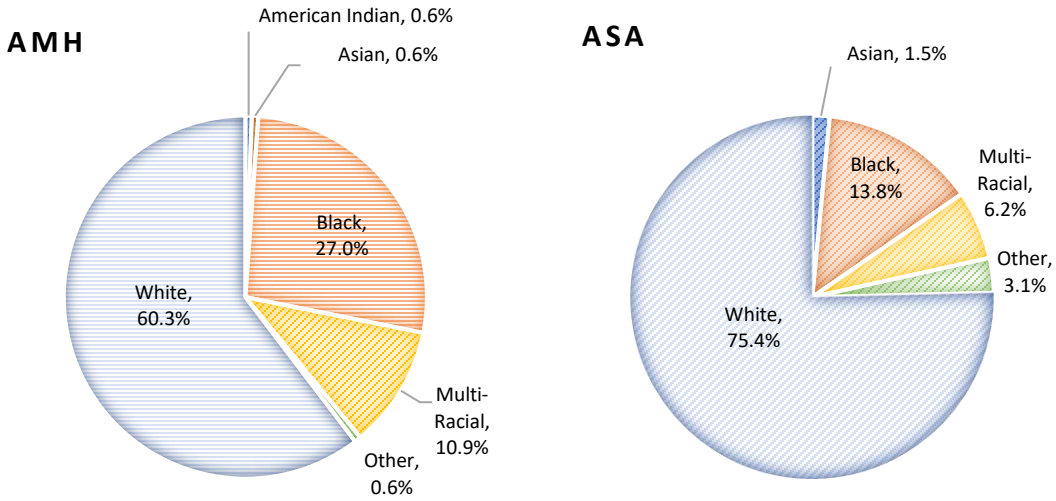


FIGURE 181: HOMELESS CLIENTS BY PROGRAM AND ETHNICITY

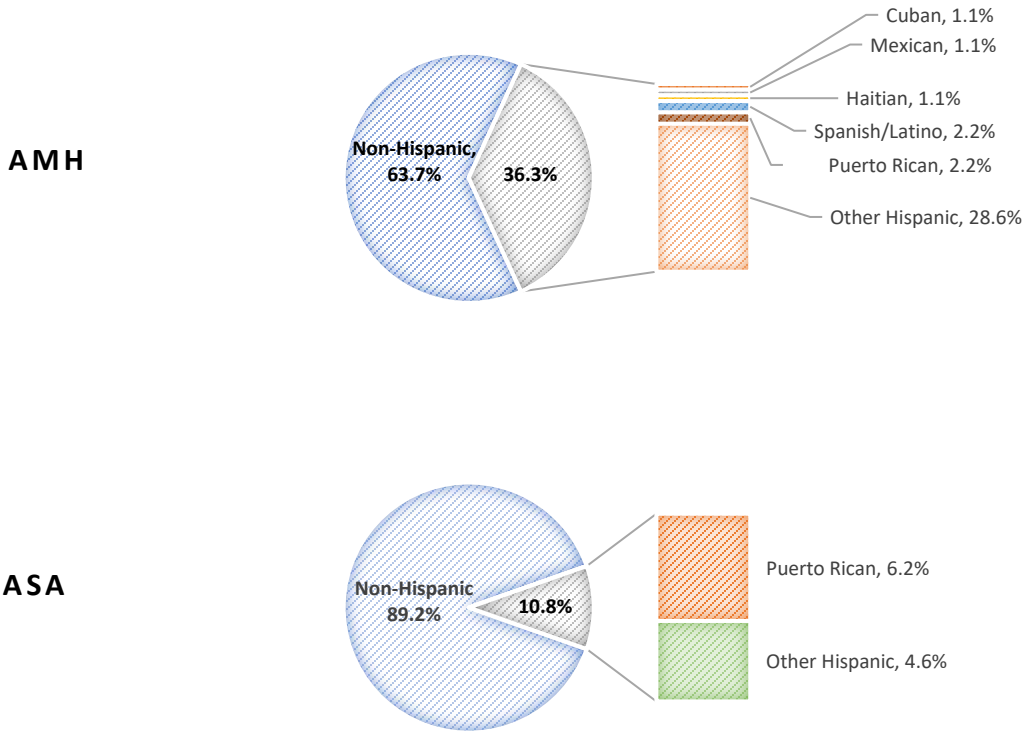


FIGURE 182: HOMELESS CLIENTS BY PROGRAM AND AGE RANGE

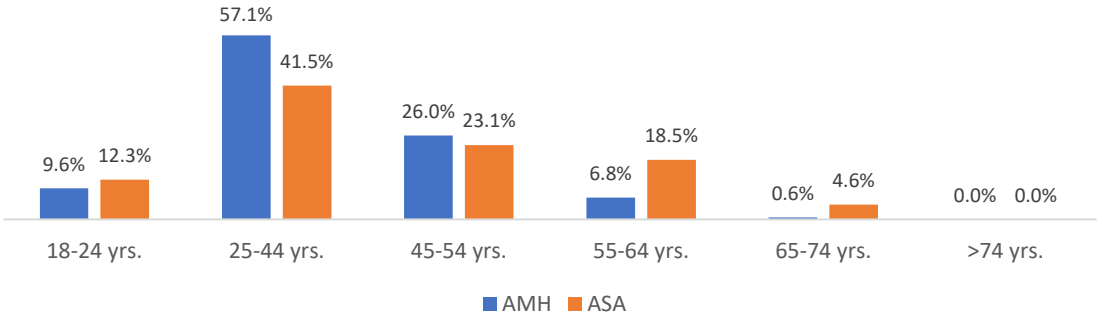


FIGURE 183: HOMELESS AMH CLIENTS BY EDUCATIONAL ATTAINMENT

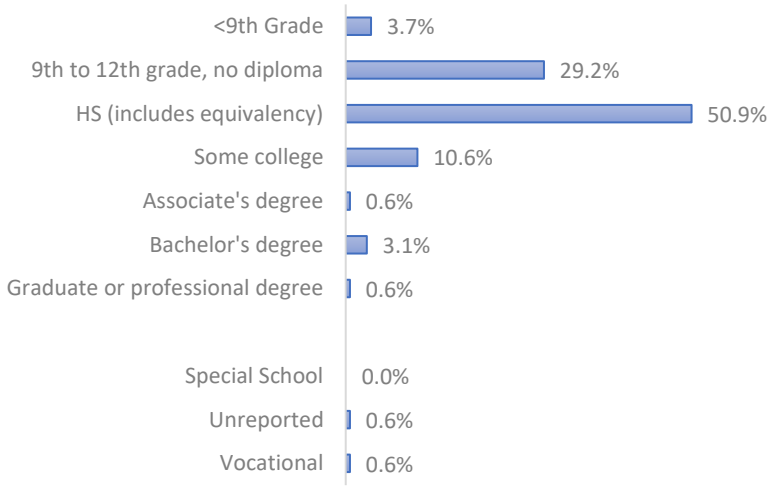


FIGURE 184: HOMELESS ASA CLIENTS BY EDUCATIONAL ATTAINMENT

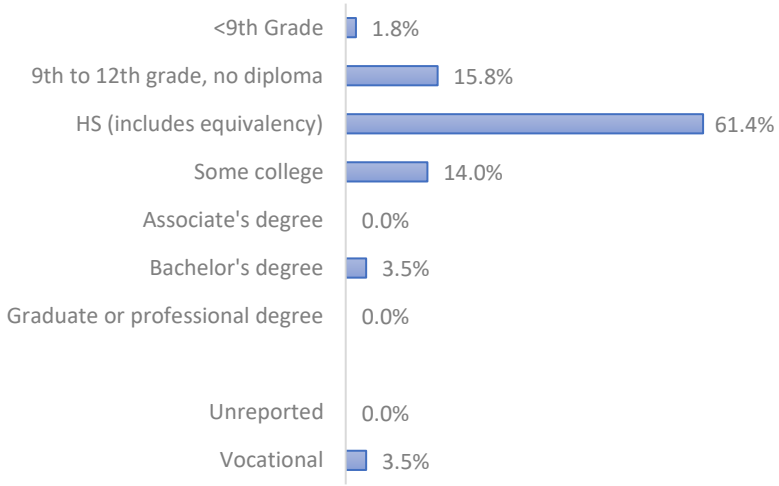
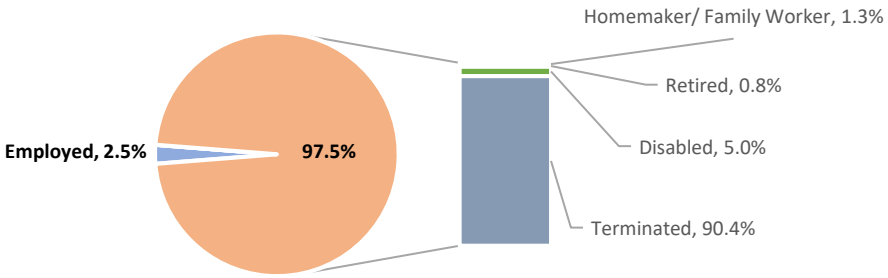


FIGURE 185: HOMELESS CLIENTS BY EMPLOYMENT STATUS

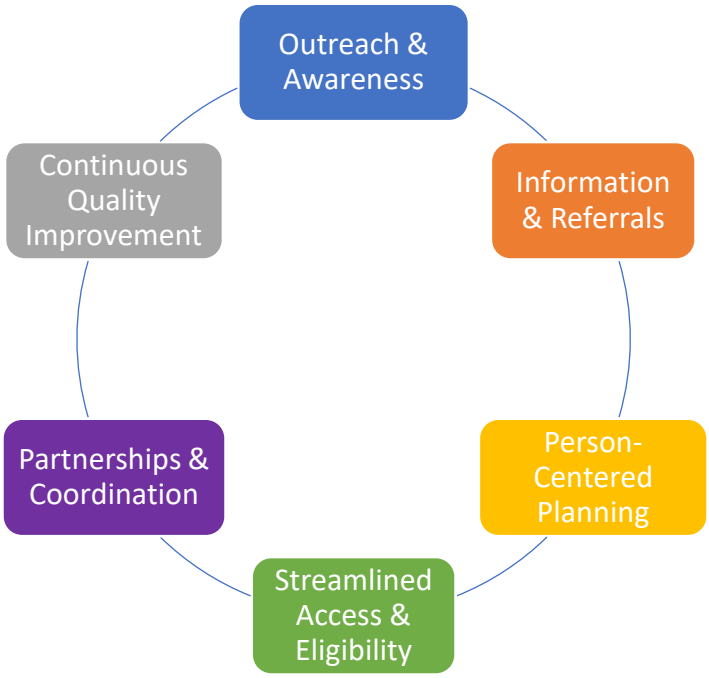


No Wrong Door (NWD) Assessment

The No Wrong Door framework is an approach that supports streamlined access to services and supports for substance use and mental health recovery. It is defined as:

> *A model of integrated and coordinated service delivery based on the premise that every door in the service system should be the right door. It represents a philosophy whereby service providers (including agencies and schools) are committed to actively engaging clients to ensure they receive appropriate and adequate support for their needs regardless of their initial entry point. (nowrongdoor.com)*

FIGURE 186: KEY ELEMENTS OF THE NO WRONG DOOR FRAMEWORK



Source: Adapted from Administration for Community Living Centers for Medicare & Medicaid Services

Outreach and Awareness

- Must proactively engage in education to promote public awareness of the resources that are available in the system.

Information and Referral

- Develop formal linkages with key referral sources to ensure the staff in these entities know about the functions of the NWR system.
- Staff have current information and tools to identify and refer clients to and within the system.

Person – Centered Planning

- A process that is directed by the individual. It may also include a representative whom the person has chosen freely or is authorized to make health decisions for the person.
- Focuses on the individuals' strengths, abilities, preferences, personal goals, needs and desired outcomes.

Streamlined Access and Eligibility

- Individuals are assessed once using a common or standard data collection method.
- Eligibility determination is streamlined and as timely as possible.
- The process considers the individuals' goals and preferences.

Partnership and Coordination

- Ensure key partners and stakeholders have meaningful input into the ongoing and implementation of the NWD system.
- Develop communications strategy and processes that facilitate on-going communications among the various agencies and organizations in the system.
- Identify existing resources currently being used to support access functions across multiple state administered programs.
- Determine how these resources can best be coordinated and integrated to align the operation and performance with the NWD system.

Continuous Quality Improvement

- Feedback is continually collected and used to improve the performance of the systems functions and procedures.
- Collection, analysis, and reporting information across the system to inform decision-making about the NWD system.
- Data analysis should support on-going program management, planning, budgeting, and continuous quality improvement to support program and policy development.

To gage how the CFCHS system of care functions as a NWD model of care, providers participated in one-on-one interviews to gather first -hand knowledge and insight on their perceptions of how well this model of care has been implemented across the four-county service area. The survey instrument assessed various agencies actions that support the six key elements of the NWD. The providers responses are summarized below.

HOW WOULD YOU DEFINE A NO WRONG DOOR SYSTEM?

All providers were in general agreement on the use of the NWD model and how it is currently defined. A warm hand-off was viewed as an integral component to be added as it increases the success of the overall policy of connecting clients to needed services. Providers had developed procedures to redirect clients to the appropriate door when the needed services fell beyond the scope of the initial entry point. Collaboration among providers fostered their ability to open any door to any needed services, noting that sometimes there are only windows, pathways and hallways available to get the client to the next point of care.

Some providers are taking the NWD model to the next level as they embraced technological advances that virtually eliminate tangible brick and mortar doors. It begs the questions: how many doors are too many doors; what to do with the old doors that offer no options for innovation; and are doors still relevant? Integrating these new doors with the old doors will be a challenge as the behavioral health care system in Central Florida continues to evolve.

Outreach and Awareness

IS THIS A TRUSTED PLACE WHERE ALL PEOPLE CAN ACCESS INFORMATION?

One hundred percent of providers operate trusted facilities where information can be accessed by all people.

WHAT KINDS OF OUTREACH IS YOUR AGENCY ENGAGED IN TO PROMOTE AWARENESS OF AVAILABLE OPTIONS AND LINKAGES TO NEEDED SERVICES? ARE SPECIFIC POPULATIONS TARGETED?

Providers engaged in many forms of outreach to promote services, enhance the flow of referrals, disseminate options for care and recovery, and build linkages to needed services. Across the board, providers attended community meetings and promotional events to connect with other providers, supportive stakeholders, and potential clients. These events served as major educational platforms for all community partners, especially those providing support services. They actively participated with cabinets, coalitions, task forces and sat on boards of other organizations which served as a way of staying informed and

connected to community partners in the behavioral health environment. Providers used website development to transition manual systems to online systems which resulted in increased access and treatment adherence while reducing stigma barriers. Most providers partnered in some way with their local 2-1-1 information and support resource. This served to broaden provider reach and strengthen connectivity to the community.

Facilities with large well development marketing departments were more likely to use social media outlets for promotion and outreach. They also had broad marketing plans or were in the process of developing a plan.

Providers had long standing service relationships with many community organizations that played a role in the delivery of their care services such as the Department of Children and Families (DCF), law enforcement, Department of Corrections, Department of Juvenile Justice, schools/school boards. Additionally, they targeted outreach to specific populations as required to fulfill their mission and meet the needs of the clients they served. Some included but were not limited to landlord networks, grandparent's groups, Rotary, Kiwanis and Little League. Providers looked to every opportunity to work with any partner who could improve the flow of clients through the system.

WHAT KINDS OF ACTIVITIES, IF ANY, ARE USED TO ASSESS THE EFFECTIVENESS OF OUTREACH AND MARKETING ACTIVITIES?

There was a broad range of activities that providers used to access the effectiveness of their outreach and marketing efforts. Much of the data collected was contractually required. Smaller grassroots organizations who relied on walk-ins employed modest methods such as monitoring the number of clients per day, week, and month. Larger organizations developed more sophisticated and comprehensive data systems that tracked and trended resource allocation versus expenditures, origins of client referrals, assessed current and future access and capacity, and collected detailed client metrics for financial and operational planning. Most providers were required to prepare monthly reports, monitor website and social media activity, and conduct client and stakeholder surveys. Close working relationships with their partners helped ensure seamless referrals to ensure clients received the services they needed when they needed them.

FROM YOUR PERSPECTIVE, DOES THIS OUTREACH RESULT IN AWARENESS? WHY OR WHY NOT?

Although many efforts are underway to improve awareness, it is still a work in progress. On the plus side, many providers noted that there had been an increased level of communication between partners to 'get done what needed to get done'. They were keenly aware of what other providers are doing and who they are serving. Community engagement had replaced word of mouth which helped increase awareness. County transportation plans, more effective law enforcement engagement, and maintaining

community relationships improved awareness across the board. Targeting specific populations and the use of mobile crisis units had proven very effective.

Providers cited lack of trust and education coupled with stigma and fear as factors that prevented clients from accessing the services they needed. Health care and health insurance systems are both complicated and difficult to navigate. The process is further stressed when a client is in crisis.

WHAT ARE THE KEY REFERRAL SOURCES TO YOUR AGENCY?

Key referral sources named by providers included:

Advent Health
Behavior Net
Brevard 2-1-1
Brevard Cares
Brevard County Jail
Brevard County Probation
Brevard Drug Court Team
Brevard Family Partnership
Central Florida Cares Health System
Child Abuse Task Force
Child Advocacy Groups
Children's Medical Services
Children's Home Society
Circles of Care
Community Based Care of Central Florida
Department of Children and Families
Department of Children and Families
Department of Corrections
Devereux
District School Systems
Family Intervention Services (FIS) Program
Florida Safety Council
Google
Guardian Ad Litem Program
Health Care Center for the Homeless
Health Clinics
Healthcare Providers
Healthy Start Coalition
Heart of Florida United Way 2-1-1
Homeless Services Network
Housing and Urban Development
Housing Coalitions
Landlords and realtors
Law Enforcement
National Safety Council
One Heart
Orange Blossom Family Health
Orange County Coalition for a Free Community
Orange County Government
Orange County Health Department
Orange County Jail
Orange County Probation
Orlando Health
Osceola County Government
Osceola County Health Department
Osceola County Jail
Partner Organizations
Pharmacies
Physicians who can prescribe Suboxone
Primary Care Physicians
Probation and Parole Services
Receiving Centers
Seminole Behavioral Health
Seminole County Government
Seminole County Health Department
Seminole County Jail
Seminole Prevention Coalition
Social Service Providers
State of Florida Department of Corrections
State of Florida of Juvenile Justice
Veterans Administration

Information and Referral

WHAT HAS BEEN ACCOMPLISHED OVER THE PAST TWO YEARS TO IMPROVE THE SYSTEM OF REFERRALS FOR SERVICES?

Heart of Florida United Way (HFUW) 2-1-1 and Brevard 2-1-1 have improved the processes for updating their resources while expanding texting and chatting capabilities. Increased community engagement fostered stronger partnership and stakeholder relationships. More sophisticated websites with online referral systems, use of electronic health record, increased staff, and expanded hours of operation enabled providers to be more creative, effective and adaptable in responding to the needs of their clients. IT technology such as telehealth allowed organizations to 'meet the clients where they are' thus reducing travel times, transportation issues and missed appointments. It also permits the provider to be anywhere due to the elimination of restrictive geographical boundaries. The placement of PSS in the hospital ER helped navigate clients through the system to the correct resources.

Person-Centered Care (PCC)

IN YOUR ESTIMATION, IS YOUR AGENCY PROVIDING PERSON-CENTERED CARE? IF YES: WHAT WORKS WELL (OR IS MISSING)? IF NO: WHAT PREVENTED YOU OR HAS BEEN A BARRIER TO IMPLEMENTATION?

All providers delivered patient-centered care as it is ingrained into the organizational culture and a requirement of their accreditation and governing bodies. Person-centered care was more effective when it was individually focused on clients' strengths and abilities, clients were a team player in their care, participated in goal setting, and family members were directly involved in the treatment plan. Breaking down individual goals into smaller, more manageable milestones that could be incorporated in the daily life, yielded better outcomes. The use of Evidence-Based Practices (EBPs) ensured the application of the most modern treatment available.

Some barriers still existed. The services that are currently offered may not be the optimal solution for a client. In a system with limited options and availability, the provider on occasion has only the second or third best option available because the optimal option has a very long wait list or is being used by a client inappropriately (not a good fit but one that will work for now because there are no other options). The establishment of unrealistic goals from the onset, especially if the client was low functioning was viewed as less than ideal. Funding never keeps pace with the level of need for care. This resulted in continuous knocking on the door for services, reduced use of PSS, limited options for transportation or other supportive services which marginalized the effectiveness of PCC. As funding is not braided for both mental health and substance use services, the diagnosis is manipulated, in some cases, to meet the funding requirements. Some organizations are more flexible than others but it's always a struggle to stretch precious dollars. The lack of psychiatrists,

prevalence of insurance denials, the client's own behavior, and stigma regarding addiction all played a role in reducing the overall effectiveness of patient-centered care.

HOW WELL DOES YOUR ORGANIZATION IMPLEMENT PERSON-CENTERED PLANNING ACROSS THE CONTINUUM? HOW WELL DO YOU IMPLEMENT A FOLLOW-UP COMPONENT TO THE PROCESS?

All providers were committed to doing whatever it took to get clients the care they needed. Most programs were designed to assist the client in maintaining their physical health which included engagement of providers across the continuum of care.

The structure and type of the various programs dictated the level of follow-up required. Most program services included a follow-up component that ranged from 30 days to up to two years for those still on medication for detox. Engaged clients exhibited more permanent stability requiring less follow-up when compared to those whose basic needs were not met. Services for children involved more frequent monitoring, sometimes on a weekly basis to stabilize a client in crisis. Follow-up periods for students ranged from 9 to 12 months.

To ensure successful follow-up some providers took on the responsibility of transportation, accompanied the client to their first appointment, or delivered their medications. Some providers were dedicated to outreach and educational to prevent a crisis or minimize the effects of an emergency. Arming a client with the knowledge of where and when to seek services or how to establish a financial support system were stabilizing forces for the client, thus reducing the severity of consequences should they have an unintended set back.

WHAT RESOURCES/SUPPORTS WOULD BE NECESSARY TO IMPROVE THE RESULTS OR IMPLEMENT IF YOU ARE NOT CURRENTLY DOING PERSON-CENTERED PLANNING?

Funding for PSS and telehealth technology were cited as two of the top improvements needed to enhance PCC. Transportation was cited by some providers as the number one barrier to person-centered care, especially for indigent clients who do not qualify for Medicare/Medicaid transportation.

Providers spent a great deal of time entering duplicate data in multiple systems for various funding sources to satisfy all data requirements. Administration time is costly in terms of time and dollars. Streamlining the data collection processes would free up resources that would be effectively allocated for services.

Timing is a critical component when implementing services to produce a desired behavioral health outcome. Research has shown early intervention yields a more successful result, especially for children. Conducting behavioral health assessments even earlier than the standard protocols currently used, would help improve the effectiveness of the PCC model.

Staffing needs were three-fold. There is a shortage of staff (ranged from counselors to psychiatrists) available for hire, and providers need additional funding to hire them once they find

them. Retaining staff is the next challenge. Providers do not have the funding to match salaries offered by insurance companies who easily lure them away with increased compensation.

Overall, funding has not keep paced with reimbursement sources and/or the general cost of doing business. This ranged from rent increases to continuous investment in software to stay relevant and connected.

Streamlined Access and Eligibility

WHAT WORKS AND WHAT DOESN'T WHEN CONSUMERS ARE SEEKING SERVICES? WHAT ARE THE MAJOR BARRIERS FOR CONSUMERS IN ACCESSING SERVICES?

Telehealth worked to reduce complications and crisis. Issues related to traditional appointments such as transportation and inconvenient times are greatly reduced. It also eliminated the system as the barrier so providers can be truly integrated.

Lack of health insurance or underinsured clients, and transportation were the major barriers for clients accessing services. Insurance providers, whether public or private, have complicated rules, at times impossible criteria to be met, and too many hoops and check boxes that placed burdensome constraints on already complicated situations.

The system itself is in a state of constant fluctuation and can be the barrier. Meeting HEDIS requirements may streamline the referral process. Providers had few ways to keep track of partners who are leaving the system as new ones arrive. Staffing is extremely fluid moving from agency to agency, often untrained to adequately fill the new position. Level funding has not kept pace with client growth nor the overall increase in the severity of those needing behavioral healthcare. Beds and housing options are in short supply amid heavy demand.

WHAT WOULD BE NECESSARY TO UTILIZE INTAKE AND SCREENING INSTRUMENTS ACROSS STATE AGENCIES AND THROUGH COMMUNITY PARTNERS?

This was viewed as one of the greatest frustrations of all providers. It was stated as an impossibility as every accreditation body, funder, program, monitoring tool, management system and electronic health record had unique requirements and utilized different platforms and systems that did not communicate. Funding budgets did not allow for the inordinate amount of time required to enter the same data in multiple formats for the same clients. Some efforts were made to streamline the intake and screening instruments. But after many labor-intensive hours there was no measurable improvement.

They only solution offered was to have a single funding source with a single accreditation set of regulatory requirements and standards, which providers felt was impossible.

Partnerships and Coordination Efforts

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

List of Partners: 2-1-1, Aspire, Federation of Families, Wrap Around Orange, Orange County government, Department of Children and Families, Department of Corrections, Probation, Court system, Peace Club, Pharmacies, Community stakeholders, Brevard Family Partnership, Florida Safety Council, Brevard Health Alliance, Dream Center, Turning Point, Faith Families, LifeStream Behavioral Center, Central Florida Behavioral Hospital, Park Place Behavioral Healthcare, Osceola Regional Hospital, Space Coast Health Foundation, Behavioral Health Task Force, Schools, Department of Juvenile Justice, Law Enforcement, Zebra Coalition, and Coalition for the Homeless.

Having organizations with flexible dollars made it easier to serve clients effectively. Communication and establishing good working relationships with partners were essential for eliminating silos and finding solutions. Thinking out of the box was required when there were less resources available.

HOW WELL ARE PROGRAMS AND SERVICES COORDINATED ACROSS THE SYSTEM?

Providers had differing opinions on the level of coordination across the system. Overall, some elements were coordinated but services across the continuum were not well coordinated.

What works well:

- Internal referrals were well coordinated.
- Programs and services are coordinated but moving the clients through the various systems presented challenges.
- Strong working relationships were the backbone of the system.

What does not work well:

- Referrals out due to lack of follow-up procedures.
- High staff turnover results in new staff not being properly trained or educated which leads to a breakdown of coordination.
- There is an unrealistic expectation that the community at large should have awareness regarding the availability of services when the providers cannot keep pace with the everchanging partner landscape.
- When dealing with DCF, there are many layers of bureaucracy. Finding the right person to make the right connections is extremely time consuming.
- It is very difficult to get the funding for the proper level of care or if changes need to be made to the current level of care.
- The lack of discharge notifications at the state level greatly hindered discharge planning at the local level.

- Many partner organizations are non-profits all vying for the same dollars to serve the same clients in the same geographical area. Territorial silos are created out of fear for survival.

Some suggestions:

- ME to take a bigger role in pushing out provider updates
- Provide funding for medications and PPS
- Increase options for consumers who do not want to go to certain facilities
- Consider holding quarterly meetings to improve communication

WHAT COULD IMPROVE COMMUNICATION?

- Warm handoffs work well when navigating the clients across the continuum. This should be done by all community providers and partners.
- Knowledge transfer is lacking. All new staff need to be thoroughly trained and educated to avoid clients falling through the cracks, which is costly on many levels.
- Bring partners together, have the tough conversations to learn the rules and roles of those you work with.
- Educate ER staff on the Baker Act (BA) and mental health to reduce unnecessary BA's. Need to find a better way of dealing with these situations.
- No funding available for psychiatrist to attend meetings so they are left out of the loop.
- Child welfare case managers need to be more responsive and engaged if success is to be attained.
- Single funder
- Need a method for clients to retain diagnosis information as documentation of diagnosis is required for receiving services.

Continuous Quality Improvement

WHAT ROLE DO CONSUMERS AND STAKEHOLDERS PLAY IN DESIGNING AND REFINING ENTRY POINT SYSTEMS TO ENSURE EQUAL ACCESS FOR PERSONS REGARDLESS OF AGE OR INCOME?

For most providers, consumers or family members participated as board members or served on leadership or advisory councils. Client input helped define the need so providers can adjust their services accordingly. Their insight is invaluable in defining what is working, what doesn't work and what needs to work.

Client and stakeholder surveys are used extensively throughout the system. Providers used these to guide development and implementation of services and engage new partners. It was suggested that the community needs to step up and share in the overall responsibility in caring for those with mental health issues.

HOW DOES YOUR AGENCY ENSURE THAT SERVICES ARE OF HIGH QUALITY AND MEET THE NEEDS OF THE CONSUMER?

Providers are bound to the standards established by their accreditation agencies in addition to the requirements they must meet when working with the VA, DOC, DCF, etc. They tracked outcomes, conducted quality and peer reviews, collected client and employment statistics, performed file reviews, showed up unannounced for site visits, established grievance processes, implemented quality management plans, assessed internal quality controls, directed risk management and high-risk studies, administered client satisfaction surveys, and used data analytics to ensure high quality is attained in meeting the needs of the client at all levels.

HOW DO YOU TRACK CONSUMERS, SERVICES, PERFORMANCE AND COST TO CONTINUALLY EVALUATE AND IMPROVE OUTCOMES?

Providers tracked clients through internal data collection systems and/or electronic health records. For providers not providing treatment, no outcomes data was reported but budget reviews were conducted. The use of precious resources required that every penny was accounted for in every program. Detailed financial and operational data was also collected, analyzed and reported out on at least a quarterly basis to ensure outcomes were met in the most efficient and effective ways. Continuous performance improvement identified outliers and trends to meet emerging service demands.

ANECDOTAL STORIES

Providers shared some anecdotal stories to illustrate the complexity of delivering care services in a system that at times works against their very best efforts. They have been included to provide additional insight to the reader and food for thought when considering policy changes.

Rules are sometimes impossible to follow

An indigent mother with a child needs a court order for child support. The father of the child is in jail and the mother of the child has a restraining order. The mom needs a letter from the father that states he is in jail. The mom cannot go to the jail because she would violate the court order of protection. The provider cannot go on the client's behalf as that would also be in violation of the court order. There needs to be another was to show he is in jail and unable to provide the child support without requiring a letter that is impossible to obtain.

No STEPS in Brevard County

In Orange and Seminole counties, STEPS staff go directly to the jail to the client's cell to arrange for services BEFORE the client is released. This goes a long way to ensuring s better outcome than if someone is released at 3:30 AM with nowhere to go and no way to get there. This is not available in Brevard County.

Sometimes it's the little things that make a big difference

One provider program offers fieldtrips for children. During the bus ride to the planned event the children exhibited a lot of behavioral issues making it challenging for staff to keep everyone under control for the ride. When it was discovered that the children were hungry, the provider offered snacks on the trip. This completely changed their unruly behavior and bus trips became an enjoyable experience for everyone. Unfortunately, there is no money in any budget to pay for these snacks. The cost burden is absorbed by the staff's personal resources. This is also the case when lunch is not sent in with the child for the trip. Food at world famous Orlando venues can be quite costly.

In-between a rock and a hard place

Managing eligibility to receive services is a very time-consuming process as the criteria constantly change. Eligibility status is recorded monthly and a person must be recertified if they find employment. If they report that they have a job, the recertification will cause them to lose services as they no longer meet the eligibility criteria. The leaves the client with two options…one is to lie about having the job, the other is to turn down the employment opportunity. It becomes a vicious cycle.

R-E-S-P-E-C-T

At a low- income housing program, staff is aware that one client is walking the parking lot at night unable to sleep. Based on experience, this is a sign that the client's medication may need to be adjusted. As provider services are only available during the hours of 9:00 AM to 5:00 PM, the client must choose between going to work or going to their appointment. After waiting weeks for an appointment, they arrive only to find out that the appointment was cancelled. There was never any notification from the service provider to the client, who has a cell phone, that this change occurred. Respect for the client, the clients time and their transportation efforts to keep the appointment are needed. Increased communication on the CM level would also go a long way in keeping the client on the path to full recovery.

How long is too long?

A peer support specialist applied for a position only to be turned down due to an unpaid court fee. The peer was totally unaware of the $100 fee that was related to an event 25 years prior. After paying the fee, the peer waited 12 months for an exemption that enabled employment.

Peer Support Specialists (PSS) Assessment

According to Mental Health America:

> *Peer support is the "process of giving and receiving encouragement and assistance to achieve long-term recovery." Peer supporters "offer emotional support, share knowledge, teach skills, provide practical assistance, and connect people with resources, opportunities, communities of support, and other people". In behavioral health, peers offer their unique lived experience with mental health conditions to provide support focused on advocacy, education, mentoring, and motivation.*
>
> *Peer providers can play many roles in support for people living with psychiatric disorders and/or in addiction recovery. They are capable of facilitating education and support groups and working as a bridge linking people to services as they transition from hospitals or jails into the community. Peers also work one-on-one as role models, mentors, coaches and advocates.*
>
> *Peers go by many names and can work in many different settings. Many peers have additional training and certification that demonstrate their skills and knowledge. Combined with their lived experience and ability to engage and connect with consumers, peer supporters are a dynamic and growing group that continue to transform lives and systems.*

PEER SUPPORT SPECIALISTS IN THE CENTRAL FLORIDA CARES HEALTH SYSTEM

The ability of peers to work as a bridge to services for behavioral health clients, makes them an integral partner in the success of patient-centered care in the no wrong door model of care. Providers were surveyed on their utilization of peer support specialists. In the CFCHS there were thirty-three PSS, of which 27.2 percent were certified and 72.7 percent were non-certified. Four additional individuals were volunteer PSS. Over ninety percent of PSS worked a full time 40-hour work week.

WHAT TYPES OF PROGRAMS DO PSS SUPPORT?

PSS were used in various recovery support roles throughout the healthcare system. Peers ran support groups for bisexuals and transgenders, provided self-care, suicide prevention, dealing with schizophrenia, introduction into Wellness Recovery Action Plans (WRAP), addiction and assistance

for mental health crisis, Projects to Assist in Transition from Homelessness (PATH), Florida Assertive Community Treatment (FACT) team, Outpatient residential treatment programs, substance abuse outpatient, and suboxone-State Targeted Response (STR) programs.

STRENGHTS EXPEREINCED BY PROVIDED PSS

One of the most significant strengths gained by using peers was the trusting bond that formed between the client and the peer specialist. Peers became like family and even went into the homes of clients. Peers knew how to advocate for and support their clients, had 'street credibility' because they had walked the walk, possessed a wealth of information having navigated the system firsthand, and were experienced with all levels of engagement. Due to the close relationship between a peer and client, peers were often able to diminish the consequences associated with a relapse by reading the telltale signs that signaled slipping into old habits.

BARRIERS TO RECRUITING/EMPLOYING PSS

There were several challenges cited by providers on recruiting and employing peer support specialists. The certification and training costs associated with PSS were high and limited funding options were available to offset these expenses. The same criteria a peer needed to possess for hire were the same principles that barred them from being hired, such as past drug use, mental health issues or even a previous criminal conviction. Passing a background check was exceeding difficult for peers who would then need to hurdle the recruitment stigma. Consequently, there were a limited number of PSS available for hire. Additionally, funding also limited the ability of agencies to pay for the PSS position. If agencies were able to find and hire a PSS, it was very hard to hold on to them.

The turnover rate, in most cases was very high as support specialists usually moved on to other employment opportunities within a year. As salary ranges were not standardized, other agencies were able to hire away a PSS for pennies on the dollar.

The unique characteristics of peers created challenges in being accepted as an equal team member (associated stigma) by other agency employees. PSS were often not respected by those with earned degrees. They were more prone to stress and were deeply affected by a death of a client. Some PSS with mental health issues did not possess the stability required for the job, amid their overwhelming desire to help. Additionally, many peers were receiving disability subsides which limited the number of hours they were able to work and subsequently diminished their employment opportunities.

TRAINING NEEDS THAT MAY ASSIST IMPLEMENTING PSS SERVICES

Funding for training and certification was the number one source of assistance needed by providers to implement their use of PSS. Some providers indicated that the training and certification program was too rigorous, leading to the exclusion of potential candidates. Other requests included in-house training as well as Relais platform training for staff. This was needed to help dispel the PSS stigma and reduce the overall internal tension among agency employees.

RECOMMENDATIONS TO IMPROVE THE IMPLEMENTATION OF PSS

The background check that all potential PSS must pass is very demanding and does not make allowances for the kind of experiences peers bring to the table. A serious review and revision of the background check limitations, specifically regarding criminal offenses, was needed to expand the hiring pool of these vital support specialists. Also needed was improved communication and collaboration among peer groups and organizations. Incentives was suggested as a way to increase collaboration.

Recovery-Oriented System of Care (ROSC) Assessment

SAMHSA defines ROSC as:

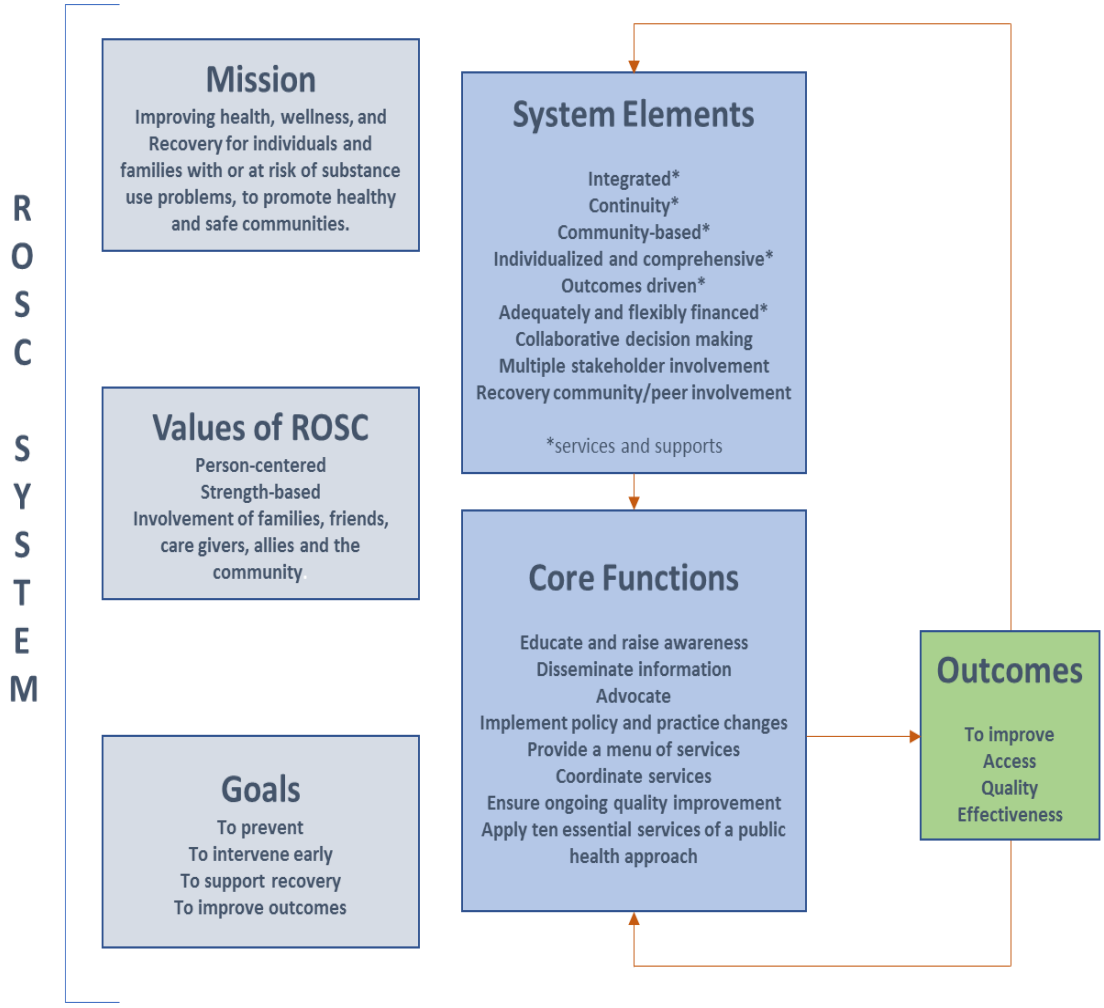
> *"A coordinated network of community-based services and supports that are person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems."*

SAMHSA explains that the central focus of ROSC is to create an infrastructure or "system of care" with the resources to effectively address the full range of substance use problems within communities. Optimally, a ROSC system will provide more options for individuals and families which will enable informed decision-making throughout the care and recovery process. Services are designed to be accessible, welcoming, and easy to navigate. As substance use and mental health conditions usually require long-term involvement with the health care system, ROSC services and supports should include the provision for continuing care following treatment, such as education, self-care, regular health care visits and linkages to community resources that provide the stability required to keep an individual in recovery.

In a ROSC, organizations are guided by a set of values, goals, elements, core functions, and outcomes to achieve the ROSC's mission. To promote the health of individuals, families and communities, a public health approach is adopted. Substance use disorders are influenced by various social determinants of health (social and physical environment, income, education, and life skills). Only by understanding these determinants and applying strategies to influence them can the disease be impacted. A public health approach focuses on prevention of substance use problems in the general population, and addresses symptoms when they first emerge, rather than when they become acute or chronic. A public health approach also uses data to monitor health problems to evaluate the effectiveness of services. Increasingly, technology is being used in a ROSC to improve access to services, assist with information sharing, increase quality and efficiency through use of electronic health records, and support recovery through social networks. Proficiency with technology will become more critical as health care reform is implemented and integration with a primary care focus. A multi-disciplinary workforce is also viewed as critical to delivering quality care in a ROSC. (SAMHSA ROSC Resource Guide, September 2010).

The diagram pictured below illustrates a ROSC framework that includes the mission, values, goals, system elements, core functions and outcomes of the system. The principals of a ROSC and health care are closely aligned. A major component of a ROSC is implementing the provisions of health care reform to provide high-quality substance use services. To achieve reform, integration of substance use services will need to occur within the primary care settings. Primary care providers will likely require additional education and training on how to screen and intervene with at-risk populations, and on how to refer individuals with more severe conditions to specialty settings.

Additionally, specialty providers may be required to establish new partnerships, enhance technology, establish quality improvement systems, expand capacity, recruit and train staff, and work with health insurance plans.



SOURCE: SAMHSA ROSC Resource Guide 2010

To assess the ROSC strengths and weakness within the CFCHS, providers were asked to complete the Self-Assessment Planning Tool for Implementing Recovery-Oriented Mental Health Services (SAPT): Version 2.0. This instrument was originally developed at the University of South Florida (USF) Louis dl la Parte Florida Mental Health Institute (FMHI) under contract to Florida's Medicaid authority, the Agency for Health Care Administration (AHCA). This adaptation came after the tool was published in 2011 and has been revised to support the Recovery Oriented System of Care (ROSC) Process in the State of Florida. ROSC is a system transformation initiative being led by Florida's Department of Children and Families (DCF) to establish an integrated, value-based recovery-oriented system of care where recovery is expected and achieved through meaningful partnerships and shared decision making with individuals, communities and systems.

The ROSC framework has been supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) to assist with the transformation of behavioral health service systems to a recovery orientation throughout the United States (SAMHSA, 2010). ROSC is designed for organizing and coordinating multiple services, supports and systems, and supports person centered, self-directed approaches to services.

The SAPT survey includes 3 domains and covered 14 sub-categories that described key recovery-oriented service activities.

DOMAINS and SUB-CATEGORIES:

ADMINISTRATION

- Philosophy
- Continuous Quality Improvement (CQI)
- Outcome Assessment
- Staff Support
- Peer and Family Support

TREATMENT

- Validation of the Person
- Person-Centered Decision Making
- Self-Care – Wellness
- Advance Directives
- Alternatives to Coercive Treatment

COMMUNITY INTEGRATION

- Access
- Basic Life Resources
- Meaningful Activities and Roles
- Peer Leadership

The goal of the SAPT is to help agencies establish policies and practices that result in positive, recovery-oriented service outcomes.

PROFILE OF CFCHS PROVIDERS WHO COMPLETED THE ROSC SURVEY

63.2%
OF PROVIDERS SERVE
ADULTS & CHILDREN

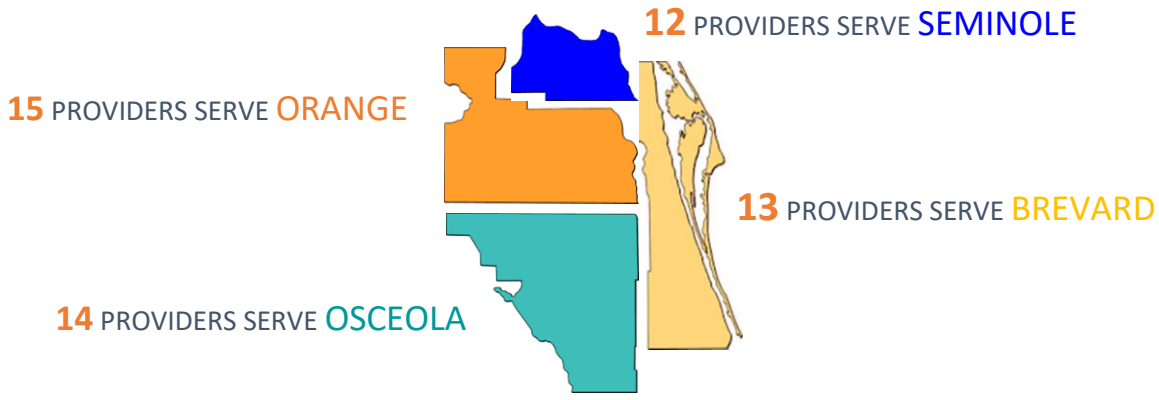
31.5%
OF PROVIDERS SERVE
ADULTS ONLY

5.3%
OF PROVIDERS SERVE
CHILDREN ONLY

52.6%
OF PROVIDERS CARED FOR THOSE WITH
MENTAL HEALTH & SUBSTANCE USE DISORDERS

31.5%
OF PROVIDERS CARED FOR THOSE WITH
MENTAL HEALTH CONDITIONS

15.8%
OF PROVIDERS CARED FOR THOSE WITH
SUBSTANCE USE DISORDERS



The survey instrument used a rating scale to assess the degree to which the services were implemented within the agency. All of the items were scored using a four-point Likert scale: 1 = Strongly Disagree; 2=Mostly Disagree; 3= Mostly Agree; and 4=Strongly Agree. Higher scores (3.0 to 4.0) indicated ROSC strengths while scores between 1.0 to 2.9, identified weakness with the system of care. Scores from all CFCHS providers were averaged to provide a total score for each activity. Scores from all activities were averaged to provide overall domain scores.

The activities and scores for each domain can be found in the tables below. Recommendations to improve low scores, those below 3.0 are provided for each domain.

FIGURE 187: ROSC SURVEY RESPONSES FOR ADMINISTRATION

ADMINISTRATION	Score
The agency strategic planning process incorporates diverse viewpoints from peers.	3.5
The agency has a process in place to ensure that peers are included in quality improvement activities as equal partners with professionals.	3.2
The agency administers the ROSI or other recovery-oriented surveys as part of the quality improvement process.	2.9
The agency uses outcome indicators that track quality of life.	3.4
The agency uses standardized, quantifiable scales for assessing recovery outcomes.	3.3
The agency has a process for peers to participate in developing recovery-oriented outcome indicators (e.g., ROSI).	2.8
The agency uses outcome measurement processes to improve recovery-oriented services.	3.4
The agency has a comprehensive program to promote recovery-oriented knowledge, attitudes, and skills in its workforce.	3.3
Clinical supervision focuses on the capable delivery of recovery-oriented services.	3.3
Clinical staff evaluations assess the capable delivery of recovery-oriented services.	3.0
The agency hiring criteria include competencies in delivering recovery-oriented services.	3.1
The agency provides training in self-advocacy for peers and family.	3.0
DOMAIN TOTAL	3.2

The total domain score of 3.2 for Administration indicated that providers mostly or strongly agreed with the activity statements above. Exceptions for this was the administering of the ROSI survey as part of the continuous quality improvement process and the process for peers to participate in developing recovery-oriented outcome indicators. There could be legitimate barriers for incorporating these activities into the CQI process such as difficulty locating peers with the skills, time and interest to participate as equal members of the CQI team or having the necessary financial resources to support peer involvement at this level. Remedies to overcome these barriers could include:

- Advertise openings for peers interested in CQI activities as widely as possible.
- Help peers participate in CQI activities by providing training and identifying resource (money for time and expenses) to facilitate their involvement.

FIGURE 188: ROSC SURVEY RESPONSES FOR TREATMENT

TREATMENT	Score
Agency staff use person-first language in all verbal and written communication.	3.6
Agency staff use language that is encouraging and hopeful in conversations with persons who are receiving services.	3.9
Agency services are provided in the person's spoken language as often as possible.	3.9
Agency assessment tools are culturally sensitive.	3.8
Agency staff implement culturally sensitive service plans that consider the impact of culture on the person's experience of mental illness.	3.8
Agency staff have assessed and are aware of their own cultural competence/biases.	3.5
Agency staff are sensitive to the person and family's experience, history of immigration, and country of origin.	3.8
The persons receiving services are encouraged and assisted in identifying their own goal(s).	3.9
The persons receiving services direct the therapeutic alliance/partnership.	3.6
The persons receiving services drive the process of goal setting based on their hopes and preferences. **	3.9
Assessment and intervention activities are integrated as part of a holistic treatment approach. **	3.6
Treatment is provided in the context of a trusting and hopeful relationship.	3.9
Agency staff work from a strengths/asset-based model. **	3.8
Agency staff and peers collaborate to develop an individual service plan that identifies needed resources and supports. **	3.9
The person receiving services defines his/her family's level of involvement in the service plan. **	3.8
The agency provides wellness education and support to peers (e.g., Wellness Recovery Action Plan – WRAP).	3.4
The agency provides education and support to family members and significant others to help support the person's process of recovery.	3.4
Agency staff encourage peers to build self-care plans based on their strengths and abilities.	3.8
Services are available when peers feel they are needed.	3.4
The agency has a process in place for the review of advance directives when peers experience relapse/incapacitation. *	3.1
Agency clinical staff are trained to assess the person's possible history of abuse/trauma.	3.5
DOMAIN TOTAL	3.7

* Adapted from The American Association of Community Psychiatrist Guidelines for Recovery Oriented Services (Sowers, 2005).
** Adapted from Treatment Planning for Person-Centered Care: The Road to Mental Health and Addiction Recovery (Adams & Grieder, 2005).

Providers averaged score of 3.7 indicated that TREATMENT was based on the patient-centered care model where the focus was on the individual's strengths and abilities rather than their illness or disability. Overall, providers presented a hopeful orientation, communicated to peers in

an empathetic manner and staff possessed the cultural awareness and sensitivity required to serve a diverse population.

FIGURE 189: ROSC SURVEY RESPONSES FOR COMMUNITY INTEGRATION

COMMUNITY INTEGRATION	Score
Agency staff return communications from peers/families at the first opportunity.	3.6
The agency provides peers and families with comprehensive information about community resources, including detailed information about eligibility criteria and processes for making applications.	3.6
The agency facilitates opportunities for peers to participate in community activities of their choice.	3.3
The agency provides community education designed to decrease stigma and increase early identification of mental illnesses and the recovery process.	3.4
The agency has a process in place to determine peers' satisfaction with their housing.	2.9
The agency ensures that peers are provided access to all available independent and supported housing options.	3.1
Agency staff use person-centered planning that includes strategies to assist peers in securing and maintaining employment.	3.3
The agency ensures that peers are provided access to all available employment and training opportunities.	3.3
Agency staff ensure that peers experience support and assistance for their employment choices.	3.4
Agency staff utilize person-centered planning that includes strategies to assist peers in pursuing educational goals.	3.5
The agency ensures that peers have access to all available educational opportunities.	3.4
Agency staff ensure that peers experience support and assistance for their educational choices.	3.3
Agency staff assist peers to develop the interpersonal skills needed to initiate and maintain positive relationships with others.	3.6
The agency ensures that peers have opportunities to initiate and maintain positive interpersonal relationships in the community.	3.6
Agency staff utilize person-centered planning that takes into account a person's spiritual needs and interests.	3.7
Agency staff view spirituality as an integral part of the person and not merely as an expression of pathology.	3.6
The agency provides peers with information regarding peer run services (e.g., support groups, drop-in centers, respite services and mentoring programs).	3.4
DOMAIN TOTAL	3.4

Providers scored 3.4 on COMMUNITY INTEGRATION indicating they created an environment that was welcoming, respectful, and responsive to peer's needs. They provided peers and families with information regarding resources, eligibility requirements and guided the application process when needed. Staff assisted peers with developing interpersonal skills needed to maintain positive supportive personal and community relationships. The patient-centered care planning included the peer's spirituality needs and interests and recognized this as an essential need for the peer's happiness. One weakness that did surface was the providers' ability to determine the peer's satisfaction with and access to housing. Options within the service area are limited. Remedies to consider:

- Assess the peer's challenges to access housing. Include them in the discussions about strategies to address challenges that are under their control.
- Establish partnership with community organizations who can advocate for changes in policies and procedures that will open more doors for housing options.
- Explore additional funding revenues.

RECOVERY SUPPORT SERVICES BY COUNTY

A component of this assessment included the identification of recovery support services by county. The list below was created from online research just as a community member in need of services would undertake. It is not intended to be a directory of all services available nor is it intended to promote one service over another. The community of providers and their availability for behavioral health services can be very fluid based on a myriad of social and economic factors. It was beyond the scope of this project to provide details regarding contact information, services provided, hours of operation or eligibility criteria for the providers listed below.

FIGURE 190: LIST OF ROSC RESOURCES BY COUNTY

BREVARD COUNTY	ORANGE COUNTY	OSCEOLA COUNTY	SEMINOLE COUNTY
Aspire Health Partners	2-Strive	AGAPE Therapy Institute	2-Strive
B.O.A.T.	ADAPT Behavioral Services	Aspire Health Partners	Alcoholics Anonymous
Behavior Basics	AGAPE Therapy Institute	Caribbean Community Connection	Ascension Lutheran Church – Manna Project
Brevard Achievement Center	Alcoholics Anonymous	Catholic Charities	Aspire Health Partners
Brevard Rescue Mission	Aspire Health Partners	Celestial Church of Christ	Caribbean Community Connection
Caribbean Community Connection	Boys Town Central Florida	Center for Independent Living	Catholic Charities
Center for Drug Free Living	Caribbean Community Connection	Central Florida Counseling & Recovery Centers	Celestial Church of Christ
Central Florida Counseling & Recovery Centers	Catholic Charities	Central Florida Haven of Hope Ministries	Center for Independent Living
Children's Home Society	Celestial Church of Christ	Chrysalis Health	Central Florida Counseling & Recovery Centers
Circles of Care	Center for Independent Living	Circle of Friends Services	Central Florida Haven of Hope Ministries
Clinical Services	Central Florida Counseling & Recovery Centers	Coalition for the Homeless of Central Florida	Chrysalis Health
Community of Hope	Central Florida Haven of Hope Ministries	Community Counseling Center of Central Florida	Circle of Friends Services
Community Psychological Services	Chrysalis Health	Depression and Bipolar Support Alliance – Central Florida	Coalition for the Homeless of Central Florida
Creative Care Center – Adult Day Care	Circle of Friends Services	Devereux	Community Counseling Center of Central Florida

BREVARD COUNTY	ORANGE COUNTY	OSCEOLA COUNTY	SEMINOLE COUNTY
Crosswinds Transitional Living Program	Coalition for the Homeless of Central Florida	Everyone's Counseling Center	Depression and Bipolar Support Alliance – Central Florida
Devereux	Community Counseling Center of Central Florida	Heart of Florida United Way	Devereux
Drug Court	Depression and Bipolar Support Alliance – Central Florida	Hispanic Family Counseling	Forgotten One's Resource Center
Eckerd Connects	Devereux	Holy Redeemer Catholic Church	Gulf Coast Jewish Family and Community Services
Eckerd Connects	Everyone's Counseling Center	House of Freedom	HD Counseling
Florida Safety Council	Forgotten One's Resource Center	Iglesia Cristiana Renuevo	Heart of Florida United Way
Florida Tech Behavioral Services of Psychology	Friends of Children & Family	IMPOWER	Hispanic Family Counseling
Health Care For Homeless Veterans	Gulf Cost Jewish Family and Community Services	Joy Metropolitan Community Church	Hope Helps
Hispanic Family Counseling	H.O.P.E's Corner Counseling	Kinder Konsulting & Parents Too, Inc.	House of Freedom
Housing and Community Development, City of Melbourne	HD Counseling	LYNX	IMPOWER
Housing for Homeless	Heart of Florida United Way	Meals on Wheels	Joy Metropolitan Community Church
IMPOWER	Hispanic Family Counseling	Mental Health Association of Central Florida	Kinder Konsulting & Parents Too, Inc.
IMPOWER	House of Freedom	Narcotics Anonymous	Let's Talk
KidsPeace	IMPOWER	National Alliance on Mental Illness – Greater Orlando	LYNX
Kinder Konsulting & Parents Too, Inc.	Joy Metropolitan Community Church	New Beginnings of Central Florida	Meals on Wheels

BREVARD COUNTY	ORANGE COUNTY	OSCEOLA COUNTY	SEMINOLE COUNTY
Lifetime Counseling Center	Kinder Konsulting & Parents Too, Inc.	Orange Blossom Family Health	Mental Health Association of Central Florida
Mental Health Association of Central Florida	Let's Talk	Orlando Union Rescue Mission	Mental Health Association of Central Florida
Mental Health Resource Center – Brevard FACT Team	LifeStream Behavioral Center	Osceola Christian Ministry Center	Milestone Counseling Center
Mentor Network	Lynx	Park Place Behavioral Health Care	Narcotics Anonymous
National Alliance on Mental Illness – Brevard	Meals on Wheels	Positive Behavioral Solutions	National Alliance on Mental Illness – Greater Orlando
North Brevard Charities Sharing Center	Mental Health Association of Central Florida	RASE Project	Orange Blossom Family Health
Patriot House	Milestone Counseling Center	Recovery House of Central Florida	Orlando Union Rescue Mission
Pre-independent Living Group Home	Narcotics Anonymous	Solid Rock Church of God	Positive Behavioral Solutions
Project Maybe	National Alliance on Mental Illness – Greater Orlando	Specialized Treatment, Education and Prevention Services	Recovery House of Central Florida
RASE Project	Orange Blossom Family Health	Spirit of Joy Ministries	REGA Mental Health Center
Recovery House of Central Florida	Orlando Union Rescue Mission	The Healing Tree/Orlando Health	Seminole Prevention Coalition
Seaside Counseling Center	Positive Behavioral Solutions	The Transition House, Inc.	Specialized Treatment, Education and Prevention Services
Space Coast Recovery Center	Recovery House of Central Florida	Therapy International	Spirit of Joy Ministries
Specialized Treatment, Education and Prevention Services	REGA Mental Health Center	Total Health Guidance	STEPS
STEPS	Rescue Outreach Mission of Central Florida	Transition House	The Sharing Center

BREVARD COUNTY	ORANGE COUNTY	OSCEOLA COUNTY	SEMINOLE COUNTY
Supporting our ASD Kids, Inc.	Salvation Army	Turning Point of Central Florida	The Transition House, Inc.
The Family Learning Program	Specialized Treatment, Education and Prevention Services	University Behavioral Center	Therapy International
The Scott Center for Autism	Spirit of Joy Ministries		Total Health Guidance
Total Health Guidance	STEPS		Transition House
Treatment Alternative for Safer Communities	The Healing Tree/Orlando Health		Turning Point of Central Florida
University Behavioral Center	The Transition House, Inc.		University Behavioral Center
Vocational Rehabilitation, Central, South and North	Therapy International		
	Total Health Guidance		
	Turning Point of Central Florida		
	University Behavioral Center		
	Wayne Densch Center		

Evidenced-Based Practices

According to the National Alliance on Mental Illness, evidence-based practices (EBPs), are treatments that have been researched academically or scientifically, been proven effective, and replicated by more than one investigation or study. The EBP model integrates medically researched evidence with individual patient values and the clinical experience of the provider. Evidence-based treatment practices are meant to make treatment more effective for more people by using scientifically proven methods and research.

Seven steps for the provider in the evidence-based practice treatment process:

1. Assess the patient and discover their clinical needs; ask the right questions.
2. Acquire relevant research and look into all investigations or studies.
3. Appraise the applicability, validity and quality of the knowledge to the patient's case.
4. Discuss results of research with client and determine integration with their individual values, needs and goals.
5. Apply the knowledge by collaboratively developing a shared plan of action between the provider and patient.
6. Implement the plan.
7. Assess your own performance on a case-by-case basis.

EVIDENCE–BASED PRACTICES DELIVERED BY CFCHS PROVIDERS

ACCEPTANCE AND COMMITMENT THERAPY (ACT)

- Aspire Health Partners
- The Transition House

ALCOHOL LITERACY CHALLENGE

- Informed Families

ALTERNATIVES FOR FAMILIES COGNITIVE BEHAVIORAL THERAPY

- The Healing Tree/Orlando Health

APPLIED SUICIDE INTERVENTION SKILLS TRAINING PROGRAM (ASIST)

- 2-1-1 Brevard
- Heart of Florida United Way

ASSERTIVE COMMUNITY TREATMENT

- Aspire
- LifeStream Behavioral Center
- Mental Health Resource Center

BEHAVIOR THERAPY

- Aspire Health Partners
- Circles of Care
- Devereux
- Gulf Coast Jewish Family and Community Services
- IMPOWER
- Kinder Konsulting & Parents Too, Inc.
- LifeStream Behavioral Center
- The Transition House

BRIEF COGNITIVE BEHAVIORAL THERAPY

- Aspire Health Partners
- Children's Home Society of Florida
- Circles of Care
- Community Treatment Center
- Devereux
- Gulf Coast Jewish Family and Community Services
- IMPOWER
- Kinder Konsulting & Parents Too, Inc.
- LifeStream Behavioral Center
- Park Place Behavioral Healthcare
- STEPS
- The Transition House
- Wayne Densch Center

BRIEF STRATGEIC FAMILY THERAPY

- Aspire Health Partners
- Children's Home Society of Florida
- Circles of Care
- IMPOWER
- LifeStream Behavioral Center

CHILD-PARENT PSYCHOTHERAPY

- Children's Home Society of Florida
- Circles of Care
- IMPOWER
- Kinder Konsulting & Parents Too, Inc.
- The Transition House

CIRCLES OF SECURITY

- Kinder Konsulting and Parents Too, Inc.

COGNITIVE BEHAVIORAL THERAPY

- Aspire Health Partners
- Children's Home Society of Florida
- Circles of Care
- Community Treatment Center
- Devereux
- Gulf Coast Jewish Family and Community Services
- House of Freedom
- IMPOWER
- Kinder Konsulting & Parents Too, Inc.
- LifeStream Behavioral Center
- Mental Health Resource Center
- The Healing Tree/ Orlando Health
- Park Place Behavioral Healthcare
- STEPS
- The Transition House
- University Behavioral Center
- Wayne Densch Center

COPING CAT

- Children's Home Society of Florida
- Kinder Konsulting & Parents Too, Inc.
- STEPS

DIALECTICAL BEHAVIOR THERAPY (DBT)

- Aspire Health Partners
- Circles of Care
- Devereux
- Gulf Coast Jewish Family and Community Services
- LifeStream Behavioral Center
- Mental Health Resource Center
- The Healing Tree/Orlando Health
- The Transition House
- University Behavioral Center

EXPERIENTIAL THERAPY

- Aspire Health Partners
- Circles of Care
- Kinder Konsulting & Parents Too, Inc.
- STEPS
- The Transition House

EYE MOVEMENT DESENSITIZATION REPROCESSING (EMDR)

- Aspire Health Partners
- Circles of Care
- Kinder Konsulting & Parents Too, Inc.
- LifeStream Behavioral Center
- The Healing Tree/Orlando Health
- The Transition House

FLOOR TIME

- Kinder Konsulting & Parents Too, Inc.

GRIEF AND TRAUMA INTERVENTION FOR CHILDREN (GTI)

- Children's Home Society of Florida
- IMPOWER
- Kinder Konsulting & Parents Too, Inc.

INTEGRATED STAGE BASED TREATMENT FOR CO-OCCURRING DISORDERS

- Mental Health Resource Center

LIFE SKILLS TRAINING (LST)

- Aspire Health Partners
- Circles of Care
- RASE Project
- LifeStream Behavioral Center
- Park Place Behavioral Healthcare
- STEPS
- The Transition House
- Wayne Densch Center

LIVING IN BALANCE

- Aspire Health Partners
- Circles of Care
- RASE Project
- Community Treatment Center
- House of Freedom
- STEPS
- University Behavioral Center

MATRIX MODEL

- Aspire Health Partners
- House of Freedom
- Park Place Behavioral Healthcare
- STEPS
- The Transition House
- University Behavioral Center

MINDFULNESS BASED COGNITIVE THERAPY

- Aspire Health Partners
- Children's Home Society of Florida
- Circles of Care
- Gulf Coast Jewish Family and Community Services
- IMPOWER
- Kinder Konsulting & Parents Too, Inc.
- The Healing Tree/Orlando Health
- Park Place Behavioral Healthcare
- The Transition House
- Wayne Densch

MORAL RECONATION THERAPY

- Aspire Health Partners
- community Treatment Center
- STEPS

MOTIVATIONAL ENHANCEMENT THERAPY (MET)

- Aspire Health Partners
- Community Treatment Center
- House of Freedom
- LifeStream Behavioral Center
- Park Place Behavioral Healthcare
- STEPS
- The Transition House

MOTIVATIONAL INTERVIEWING

- Aspire Health Partners
- Children's Home Society of Florida
- Circles of Care
- RASE Project
- Devereux
- Eckerd Family Services
- Eckerd Connects
- Gulf Coast Jewish Family and Community Services
- House of Freedom
- IMPOWER
- LifeStream Behavioral Center
- The Healing Tree/Orlando Health
- Park Place Behavioral Healthcare
- STEPS
- The Transition House
- University Behavioral Center
- Wayne Densch Center

PLAY THERAPY

- Aspire Health Partners
- Children's Home Society of Florida
- Devereux
- IMPOWER
- Kinder Konsulting & Parents Too, Inc.
- LifeStream Behavioral Center
- The Healing Tree/Orlando Health
- The Transition House

PROJECT ALERT

- Informed Families

PROJECT SUCCESS

- Circles of Care

QPR GATEKEEPER TRAINING FOR SUICIDE PREVENTION

- 2-1-1 Brevard

RATIONAL EMOTIVE BEHAVIORAL THERAPY (REBT)

- Aspire Health Partners
- Circles of Care
- Eckerd Family Services
- Gulf Coast Jewish Family and Community Services
- The Transition House

SECOND STEP

- Eckerd Connects
- Gulf Coast Jewish Family and Community Services

SEEKING SAFETY

- Aspire Health Partners
- Community Treatment Center
- Gulf Coast Jewish Family and Community Services
- LifeStream Behavioral Center
- Park Place Behavioral Healthcare
- STEPS
- The Transition House
- University Behavioral Center

SITUATIONAL FAMILY THERAPY

- Children's Home Society of Florida
- Circles of Care
- IMPOWER
- Kinder Konsulting & Parents Too, Inc.
- STEPS

SOCIAL SKILLS GROUP INTERVENTION (S.S. GRIN)

- Aspire Health Partners
- Circles of Care
- Kinder Konsulting & Parents Too, Inc.

SOULTION FOCUSED THERAPY

- Aspire Health Partners
- Children's Home Society of Florida
- Circles of Care
- Gulf Coast Jewish Family and Community Services
- IMPOWER
- LifeStream Behavioral Center
- The Healing Tree/Orlando Health
- Park Place Behavioral Healthcare
- The Transition House
- Wayne Densch Center

SOLUTION FOCUSED TRAUMA RECOVERY THERAPY

- Aspire Health Partners
- Children's Home Society of Florida
- Circles of Care
- The Transition House

STRENGTHENING FAMILES

- Aspire Health Partners
- Circles of Care
- Gulf Coast Jewish Family and Community Services
- LifeStream Behavioral Center

STRUCTURAL FAMILY THERAPY

- Children's Home Society of Florida
- Circles of Care
- IMPOWER
- Kinder Konsulting & Parents Too, Inc.
- STEPS

SUPPORTIVE EXPRESSIVE THERAPY

- Aspire Health Partners
- Circles of Care
- Kinder Konsulting & Parents Too, Inc.

SYSTEMIC TRAINING FOR EFFECTIVE PARENTING (STEP)

- Community Treatment Center
- STEPS

TEAM SOLUTIONS AND SOLUTIONS FOR WELLNESS

- LifeStream Behavioral Center
- Park Place Behavioral Healthcare

THINKING FOR A CHANGE (T4C)

- Community Treatment Center
- Devereux
- STEPS
- The Transition House

TOO GOOD FOR DRUGS

- Aspire Health Partners
- Eckerd Connects

TOO GOOD FOR VIOLENCE

- Aspire Health Partners
- Eckerd Connects

TRAUMA-FOCUSED COGNITIVE BEHAVIOR THERAPY (TFCBT)

- Aspire Health Partners
- Children's Home Society of Florida
- Circles of Care
- Devereux
- Gulf Coast Jewish Family and Community Services
- IMPOWER
- Kinder Konsulting & Parents Too, Inc.
- LifeStream Behavioral Center
- The Healing Tree/Orlando Health
- The Transition House
- University Behavioral Center

TRIPLE P PARENTING

- Kinder Konsulting & Parents Too, Inc.

WELLNESS RECOVERY ACTION PLAN (WRAP)

- Aspire Health Partners
- Devereux
- Gulf Coast Jewish Family and Community Services
- IMPOWER
- LifeStream Behavioral Center
- Park Place Behavioral Healthcare
- The Transition House
- University Behavioral Center

Consumer Survey Results

The consumer survey was completed by 224 respondents in the four-county service area. Over fifty percent of consumers were adults and over sixty percent were receiving mental health services. One half of all consumers lived in Orange County while the remaining fifty percent resided in Brevard, Osceola and Seminole counties.

KNOWING WHERE TO GO FOR SERVICES

Knowing where to go for services is the first step in accessing healthcare. Among respondents, 65.7 percent indicated that they knew where to go for services if they needed them. Regarding 2-1-1 awareness, almost two-thirds of respondents knew of this resource and fifty percent of those had previously called for assistance. Almost sixty percent of those that did call 2-1-1 for support, found that it was only helpful sometimes or not at all.

ACCESS AND PERCEPTION OF THE HEALTHCARE PROCESS

Over seventy-five percent of respondents were able to get services when they needed them and agreed or strongly agreed that services were well coordinated, the eligibility process was understandable, the application process was easy, and services were patient centered.

SERVICES THAT WERE NEEDED BUT NOT RECEIVED

More consumers in Brevard County reported that they were unable to get the services they needed when compared to the other three counties in the service area. Overall, twenty-one percent of clients (49) were not able to get services when they needed them. Most clients needed multiple services. Twenty-three consumers were not able to get housing assistance making it the number one service that consumers said they needed but did not get. This was followed by crisis stabilization/support, outpatient services, long-term residential treatment and after-care follow-up. Over twenty-five percent of consumers indicated they were not able to get the services five or more times.

BARRIERS TO NEEDED SERVICES

Most consumers indicated they had more than one challenge when seeking services. Affordability ranked as the top barrier prevented consumers from receiving needed services. Long wait lists, lack of transportation, services not available in their county of residence and not knowing where to go for services were among the top five barriers for consumers.

FIGURE 191: WHICH BEST DESCRIBES YOU?

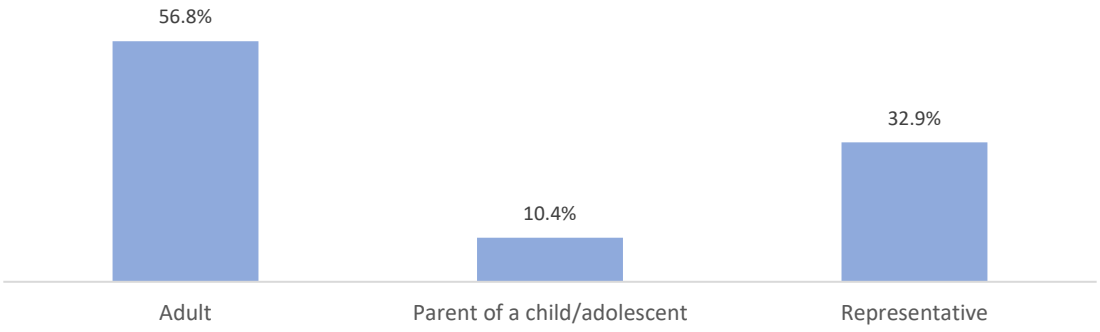


FIGURE 192: WHAT TYPE OF SERVICE DID YOU OR YOUR FAMILY MEMBER RECEIVE?

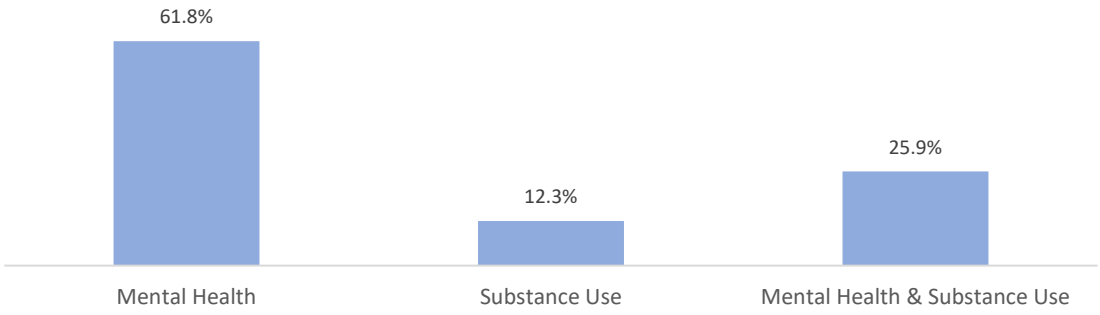


FIGURE 193: WHICH COUNTY DO YOU LIVE IN?

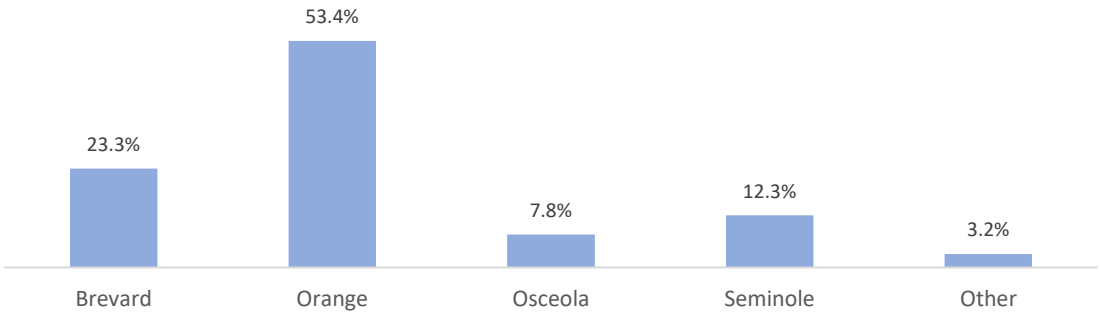


FIGURE 194: DID YOU KNOW WHERE TO GO FOR SERVICES WHEN YOU NEEDED THEM?

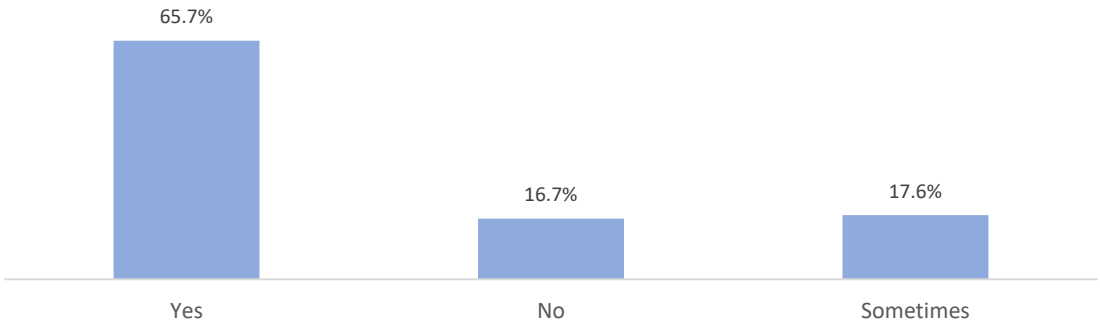


FIGURE 195: ARE YOU AWARE OF 2-1-1 AND HAVE YOU EVER CALLED?

FIGURE 196: WHEN YOU CALLED 2-1-1, WAS IT HELPFUL?

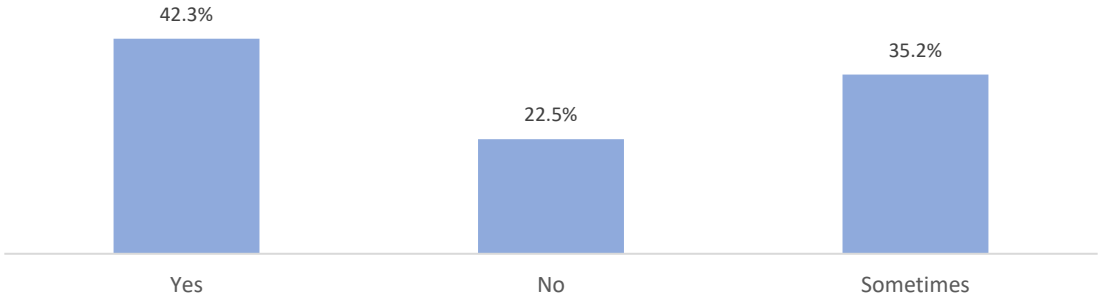


FIGURE 197: CONSUMER RESPONSES TO THE FOLLOWING STATEMENTS

HEALTH CARE SYSTEM STATEMENTS	STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE	SAMPLE SIZE
Services were well coordinated	7.5%	13.4%	44.6%	34.4%	186
The eligibility guidelines were easy to understand	4.8%	18.1%	43.1%	34.0%	188
The application process was easy for me	4.9%	16.8%	43.2%	35.1%	185
I felt the services and planning I received were patient-centered	7.9%	10.0%	45.8%	36.3%	190

FIGURE 198: SERVICES CONSUMERS NEEDED BUT WERE UNABLE TO GET

SERVICE NEEDED BUT NOT RECEIVED	RESPONDENTS		COUNTY			
	%	#	Brevard	Orange	Osceola	Seminole
Housing assistance	9.9%	23	14	6	2	1
Crisis Stabilization/Support	7.3%	17	9	4	1	3
Outpatient services	6.9%	16	10	3	1	2
Long-term Residential treatment program	6.0%	14	7	3	2	2
Aftercare/Follow-up	5.6%	13	7	3	2	1
Alternative Services (acupuncture, art therapy, mediation, etc.)	5.2%	12	6	2	2	2
Other	4.7%	11	5	4	1	1
Case management	4.3%	10	8	1	1	-
Recovery Support	4.3%	10	5	2	2	1
Respite services	4.3%	10	4	3	2	1
Day Care Services	3.9%	9	4	2	2	1
Employment/job training assistance	3.9%	9	4	3	1	1
Medical services	3.9%	9	7	-	-	2
Medication assistance program	3.9%	9	6	2	1	-
Short-term residential treatment	3.9%	9	5	2	-	2
Assessment	3.4%	8	6	1	-	1
Detox services	3.4%	8	4	2	2	-
In-home services	3.4%	8	5	3	-	-
Outreach support	3.4%	8	4	1	1	2
Drop-in/Self help	3.0%	7	3	2	1	1
Inpatient	2.2%	5	5	-	-	-
Day/night treatment services	1.7%	4	1	3	-	-
Referral	1.3%	3	3	-	-	-
TOTAL RESPONDENTS	**100%**	**232***	**132**	**52**	**24**	**24**

*Not an unduplicated number of consumers. Multiple consumers had more than one barrier.

FIGURE 199: HOW MANY TIMES DURING THE PAST YEAR WERE YOU UNBALE TO GET THE SERVICES YOU NEEDED?

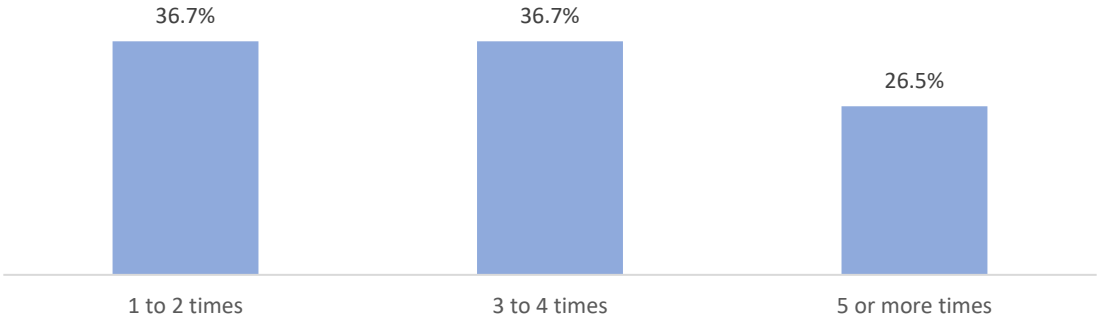


FIGURE 200: WHAT WERE THE BARRIERS TO GETTING THE CARE YOU NEEDED?

SERVICE BARRIERS	RESPONDENTS		COUNTY			
	%	#	Brevard	Orange	Osceola	Seminole
Could not afford the services	16.9%	25	15	6	2	2
Long wait lists	15.5%	23	17	5	1	-
None or very limited transportation	13.5%	20	12	5	3	-
Services were not available in the county where I live	12.2%	18	12	2	3	1
Did not know where to go for services	10.8%	16	8	4	1	3
Did not meet the eligibility criteria	8.1%	12	7	4	1	
No evening or weekend appointments	6.8%	10	7	1	1	1
No outreach to people who are homeless	6.1%	9	6	3	-	-
Lack of childcare	4.1%	6	3	1	2	-
Other	4.1%	7	2	3	-	2
Stigma	1.4%	2	1	-	-	1
TOTAL RESPONDENTS	100%	148*	90	34	14	10

*Not an unduplicated number of consumers. Multiple consumers had more than one barrier.

Stakeholder Survey Results

The stakeholder survey was administered in the four-county area to gather information on awareness, access to care, and barriers to behavioral health resources. Ninety respondents represented thirty community sectors. Over 56 percent of stakeholders were from Seminole County and 44.7 percent were from Brevard County. The remaining 76.6 percent of stakeholders were from Orange and Osceola counties at 38.3 percent, respectively.

AWARENESS

Over 75.0 percent of stakeholders were aware of the behavioral health resources available in their respective counties. Regarding the 2-1-1 resource, 86.6 percent of respondents had knowledge of this informational source. Twenty-five percent of those had accessed 2-1-1 in the past 12 months, of those slightly more than fifty percent found it to be useful, while more than thirty percent found it to be only somewhat useful. Over sixty percent of stakeholders had directed consumers to the 2-1-1 resource for behavioral health services. Overall, less than fifteen percent of respondents felt community awareness for behavioral health resources was excellent or very good.

ACCESS TO BEHAVIORAL HEALTH CARE SERVICES

Stakeholders were asked to rate their agreement on statements about the process of accessing behavioral health services. Most respondents agreed that linkages were coordinated and well established, that care and planning services were patient-centered across the continuum, and accessible. Stakeholders were less confident about the eligibility and application processes, standardization of intake and screening across the various partners, and coordination of services across the continuum.

BARRIERS

Lack of awareness of where services are located was identified as the number one barrier to accessing behavioral health care services. Stakeholders also indicated that there was no defined process on how a consumer was to navigate through the various doors and pathways to access the services they need. Transportation was acknowledged as the number two barrier to care. The third barrier was a consumer's insured/uninsured status. This also crossed over into general affordability of services with high deductibles, lack of funders to cover these costs for those without insurance coverage, and the overall high cost associated with this type of specialty care. Even with insurance, consumers struggled to find providers who would accept their insurance, especially those with Medicaid. When consumers do not have the "right" insurance, there are few options available to them and no guidance on how to find the care they need.

NEEDED RESOURCES/SUPPORTS THAT ARE NOT AVAILABLE

An analysis of stakeholder responses revealed that planning between organizations was the number one support needed to improve the overall system of care. Planning was needed to guide consumers from inpatient to outpatient, from assessment to referral, and from receiving center to referral providers. In addition, planning was needed on the coordination of consumer services based on payer source and the integration of mental health and medical services. Stakeholders noted that the all the above is further complicated by untrained staff. This issue of the lack of adequate training for staff was similarly highlighted by providers during their one-on-one interviews. The number two needed resource was simply more beds, for every service category in every county. The third resource was identified as the lack of provider availability to see patients when they needed services. This was driven by an overall shortage of providers to serve the population in need, especially psychiatrists for adults as well as children/youth and those who accept Medicaid.

The 90 stakeholder respondents represented the following community sectors:

- Residential Care
- Social Services
- Behavioral healthcare
- Local Government
- Law enforcement
- Juvenile Justice
- Homeless services
- Faith-based family services
- County schools
- Children and family services
- Child/Youth advocacy
- Case Management
- Community members
- Non-profit food pantry
- Courts
- Preventive child injuries
- State government
- Hospitals
- State health department
- Community Associations
- Health promotion and education
- Leadership training
- Health clinics
- Skilled nursing care
- Home health
- School board
- Outreach and advocacy
- Funders
- Transportation
- CBC

FIGURE 201: COUNTIES REPRESENTED BY STAKEHOLDERS

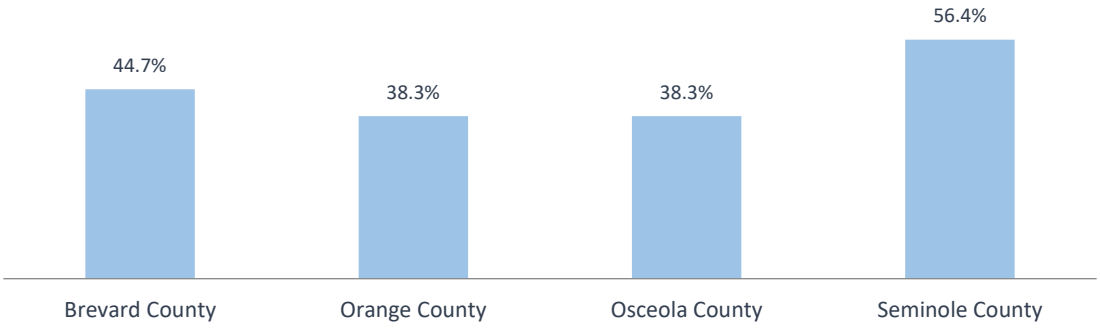


FIGURE 202: YOU ARE AWARE OF THE BEHAVIORAL HEALTH SERVICES IN YOUR COUNTY

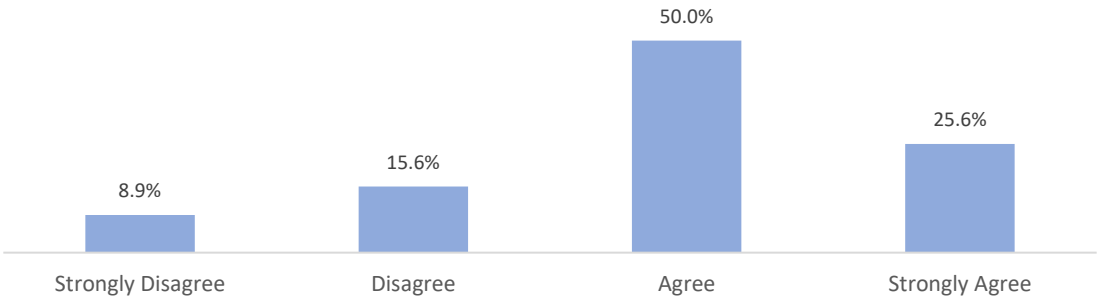


FIGURE 203: ARE YOU AWARE OF THE 2-1-1 RESOURCE?

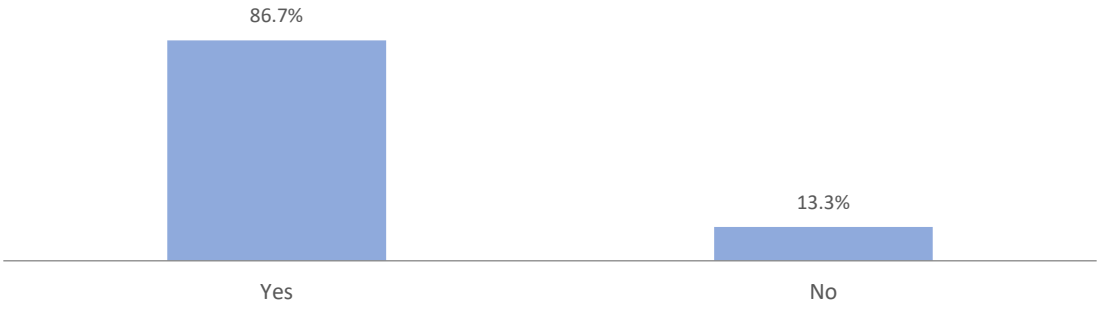


FIGURE 204: HAVE YOU ACCESSED 2-1-1 IN THE PAST 12 MONTHS?

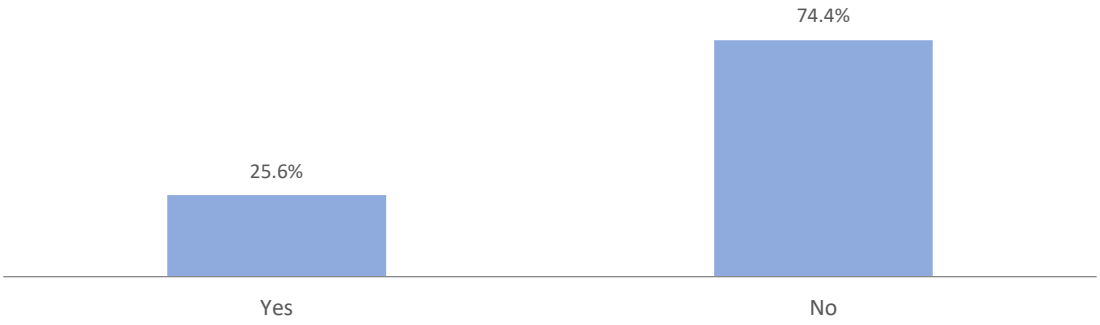


FIGURE 205: WHEN YOU ACCESSED 2-1-1, WAS IT HELPFUL?

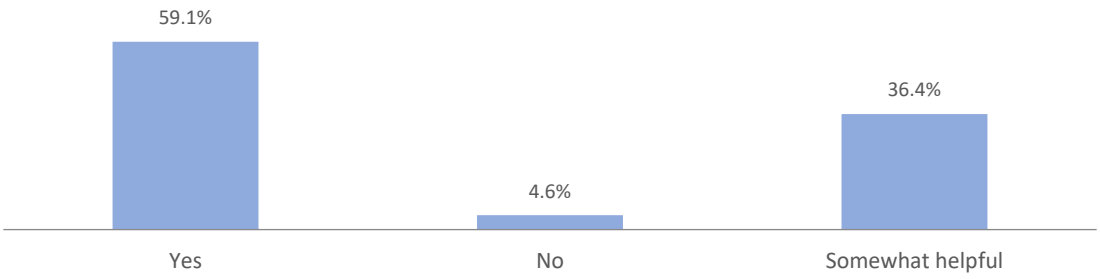


FIGURE 206: IN THE PAST 12 MONTHS, HAVE YOU DIRECTED CONSUMERS TO ACCESS THE 2-1-1 RESOURCE FOR BEHAVIORAL HEALTH CARE SERVICES?

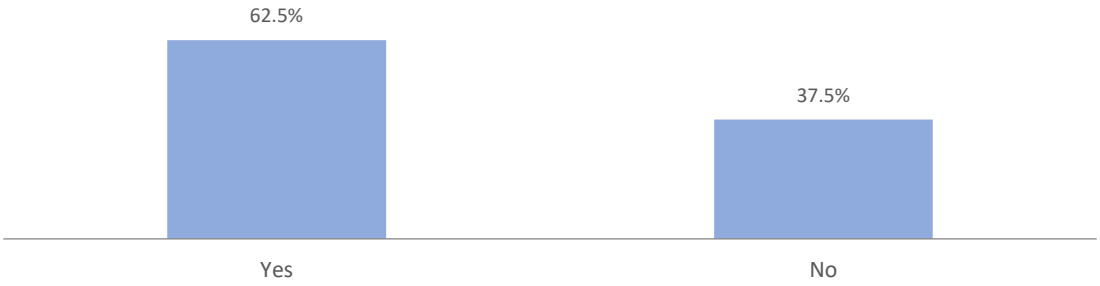


FIGURE 207: HOW WOULD YOU RATE COMMUNITY AWARENESS OF BEHAVIORAL HEALTH CARE SERVICES IN YOUR COUNTY?

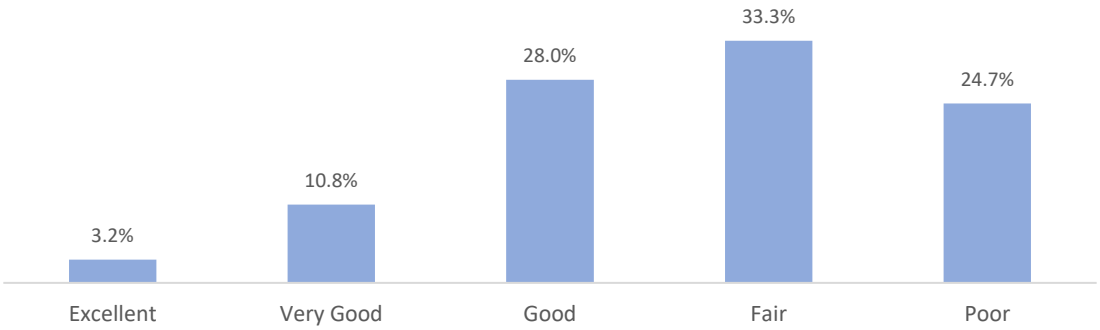


FIGURE 208: LINKAGES TO NEEDED SERVICE ARE COODINATED AND WELL ESTABLISHED ACROSS THE CONTINUUM OF CARE

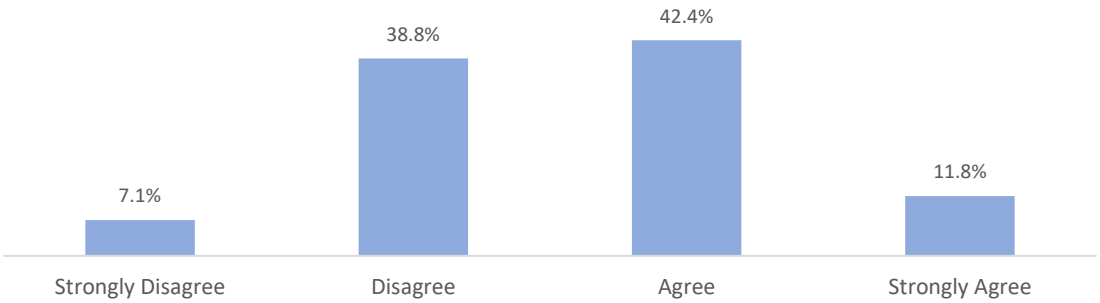


FIGURE 209: CARE AND PLANNING SERVICES ARE PATIENT-CENTERED ACROSS THE CONTINUUM OF CARE

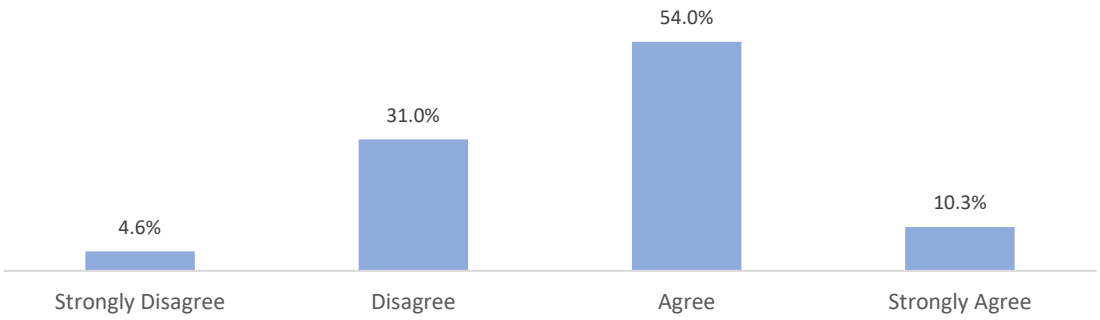


FIGURE 210: IN GENERAL, BEHAVIORAL HEALTH CARE AND SUPPORT SYSTEMS ARE ACCESSIBLE IN YOUR COUNTY

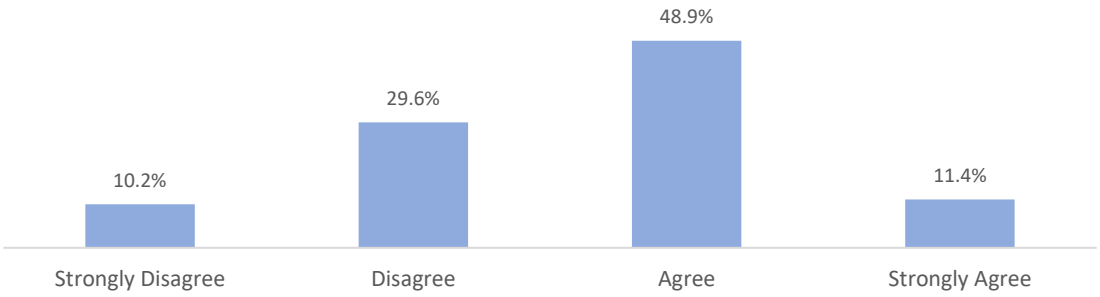


FIGURE 211: ELIGIBILITY CRITERIA AND PROCESSESS FOR MAKING APPLICATIONS ARE READILY AVAILABLE AND EASY TO ACCESS

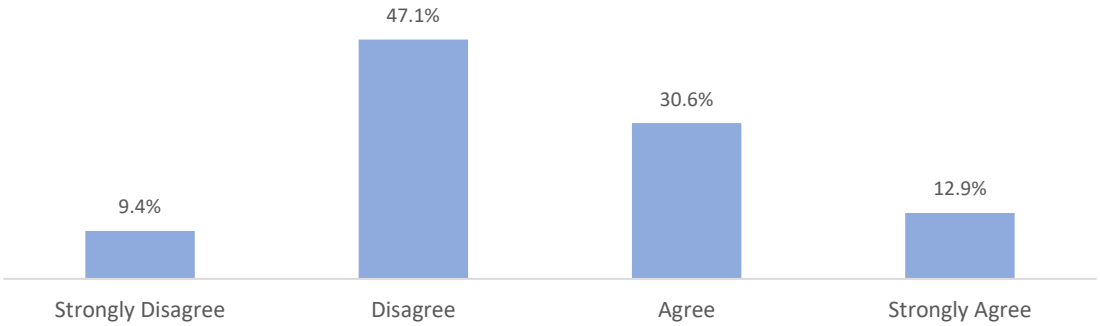


FIGURE 212: INTAKE AND SCREENING INSTRUMENTS ARE STANDARDIZED ACROSS COMMUNITY AND STATE PARTNERS

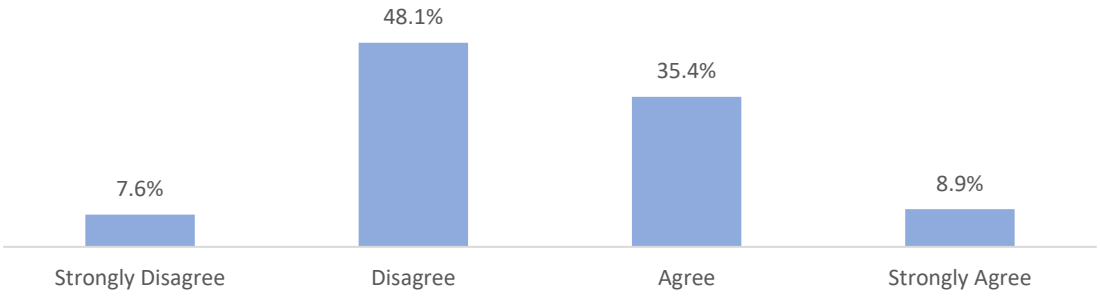


FIGURE 213: PROGRAMS AND SERVICES ARE COORDINATED ACROSS THE CARE SYSTEM

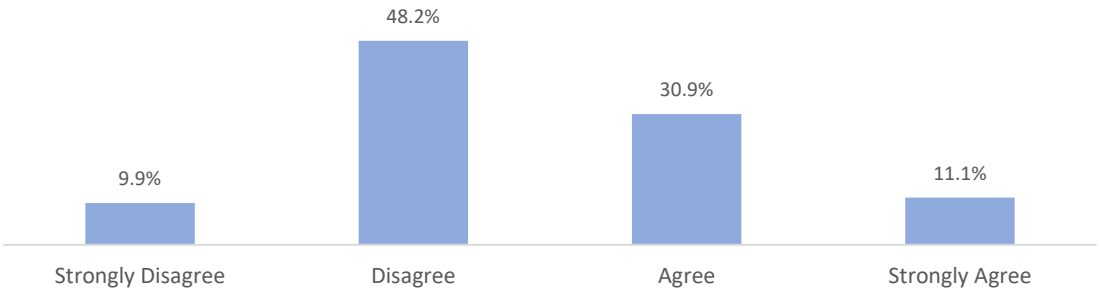


FIGURE 214: TOP THREE BARRIERS

1 LACK OF AWARENESS

- Where services are located
- No defined process to find services once they are needed

2 TRANSPORTATION

3 INSURED/UNINSURED STATUS

- High Deductibles
- Lack of funding to cover deductibles
- Lack of providers who accept Medicaid
- Insurance not accepted
- Even with insurance, cost of services are too high

FIGURE 215: RESOURCES/SUPPORTS NEEDED THAT ARE NOT AVAILABLE

#1 Planning between organizations	#2 Additional beds of every type	#3 Additional psychiatrists/providers
•Inpatient to outpatient •Assessment to referral •Receiving Center to referral providers •Integration of behavioral health services and medical care •Lack of trained staff	•Lack of beds in every county	•Lack of psychiatrists for adults, children and youth •Lack of psychiatirsts who accept Medicaid

Point-in-Time Pilot Study

To gain insight on the needs of consumers who were wait listed, a proposal was made to conduct a point in time study where providers would track the unmet service need requests that were received during a prescribed time period. After discussion with the CFCHS providers, it was determined that this type of observation was not feasible due to the many ways clients entered the facility or system of care. However, the Mental Health Association of Central Florida was interested in the data and offered to follow through on the proposed project. The study was administered during October 2018. Data was collected by agency interns from callers who reached out for needed services. The services that were needed and not received were grouped into coded categories for analysis. The challenges that prevented the receipt of services were grouped into the following six categories:

- Services needed did not exist
- Consumer could not afford to pay for the service
- Consumer did not have insurance to cover the cost of the service
- Consumer did not meet the eligibility requirements to receive the service
- Lack of providers who offered the service in the required mile range
- Provider did not have availability to accommodate the client (no appointments, no open beds, etc.)

A total of 339 clients were screened during the thirty-day period. Close to two-thirds of clients were females, almost fifty percent were between the ages of 25-44 years, and over eighty percent were adults inquiring about services for themselves.

Psychiatric evaluation, psychiatric services and individual counseling were the most needed and hardest to obtain services. Over thirty-five percent of callers lacked the insurance needed to receive the service. The lack of providers within the callers required mile range prevented 18.9 percent of consumers from obtaining needed services. Just over thirteen percent of callers had a combination of two challenges as they were unable to afford the service and did not have insurance to cover the cost. There were thirty-three unique combinations of the challenges listed above that prevented the remaining thirty percent of callers from receiving the services they were seeking.

FIGURE 216: POINT-IN-TIME CLIENTS BY GENDER

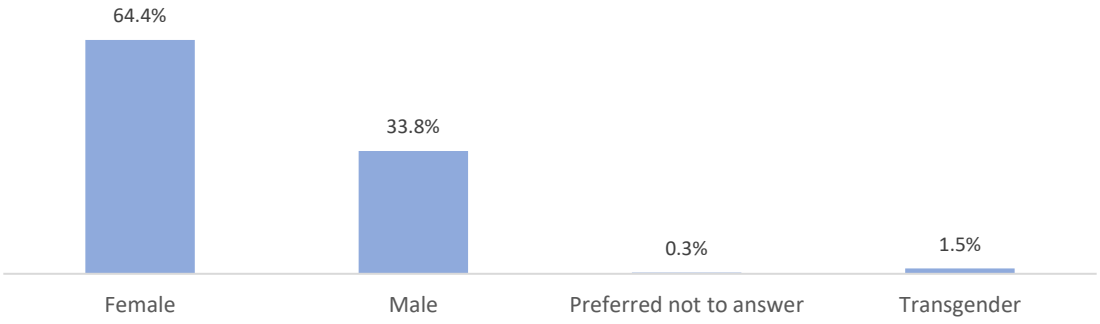


FIGURE 217: POINT-IN-TIME CLIENTS BY RELATIONSHIP

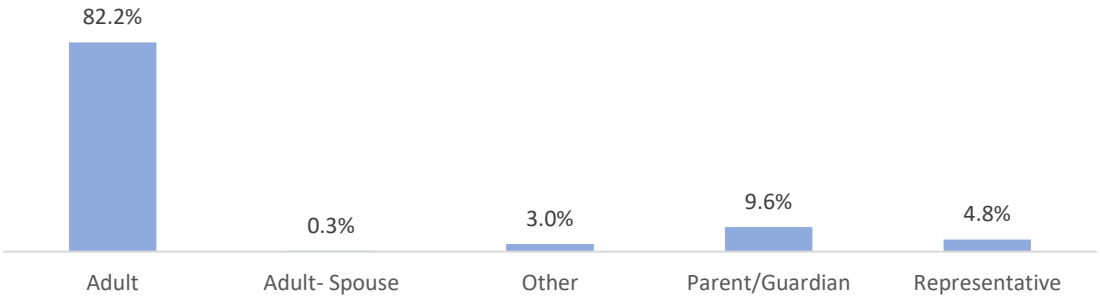
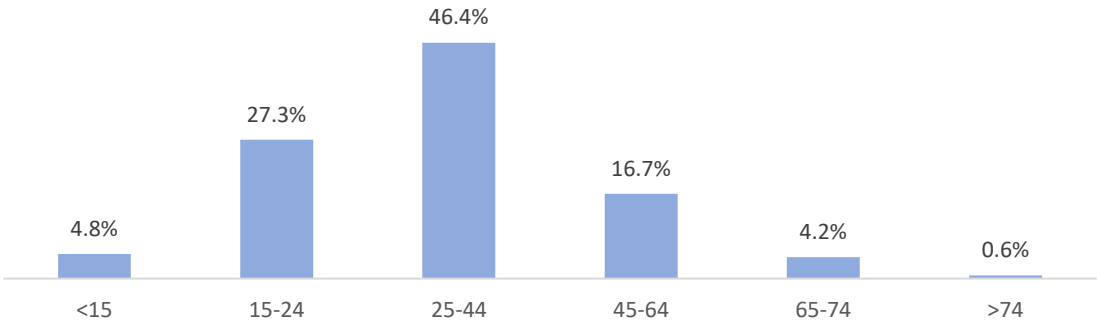


FIGURE 218: POINT-IN-TIME CLIENTS BY AGE RANGE



The services needed did not exist (or were very limited)

- Very limited options for long term residential, group homes and assisted living facilities
- Clinical Trials
- Support for neurology-bilateral nerve condition
- Group homes that offer support for narcissist abuse
- Emotional Support Animal (ESA) evaluations
- Grief counseling is hard to find in the area

Consumer could not afford to pay for the service

- Low cost psychiatric services
- Homeless services
- Employment assistance
- Advocacy reporting
- Financial services

Consumer did not have insurance to cover the cost of the service

- Psychiatric evaluation
- Psychiatric services
- Addictions counseling
- Baker Act facility
- Baker Act letter
- Case Management
- Counseling (couples, family and individual)
- Court ordered evaluation
- Detox
- Short-term residential
- Intensive outpatient
- Employment assistance
- Financial services
- Medication management
- Prescription assistance
- Primary care services
- Support Groups
- Transportation

Consumer did not meet eligibility requirements to receive the service

- Psychiatric services
- Individual and family counseling

Lack of providers within client's required mile range

- Psychiatric evaluation
- Psychiatric services
- Group home

- Long-term residential
- Counseling (in-home, group, family, and individual)
- Primary care services
- Baker Act facility
- Forensic psychologist
- Addictions counseling
- Intensive outpatient
- Detox
- Case management
- Crisis Stabilization
- Legal services
- Employment assistance

Provider had no availability to accommodate the client (no appointments, no open beds, etc.)

- Psychiatric Evaluation
- Psychiatric Services
- Individual Counseling
- Long-term residential
- Primary care services

Other barriers:

- Needed to enlarge mile range to find a provider
- Counseling needs were beyond the scope of in-home counselor
- Long wait list for psychiatric evaluation and services
- Client had insurance but it was not accepted by the provider
- Providers did not answer the phone
- Clinical researchers were difficult to locate
- Grief counselors who accepted Medicaid
- Client had out-of-state insurance
- Limited options for support groups that were currently running
- Availability of low-cost services to treat schizophrenia
- Housing providers who assisted individuals with mental health issues
- Appointment lead time was too short (Client needed appointment within days not weeks)
- Lack of providers who treated non-epileptic seizures
- Lack of domestic violence resources
- Lack of providers who accepted Medicaid
- Needed more Spanish speaking counselors

The Health Council of East Central Florida, Inc. was contracted by CFCHS to conduct the behavioral health needs assessment. The Health Council is a private, non-profit healthcare planning agency providing research, education and program support to improve healthcare delivery and outcomes. The East Central Florida District VII encompasses the four counties of Brevard, Orange, Osceola and Seminole.

Created in 1982 by the Florida legislature under Florida Statue Section 408.033, the Health Council of East Central Florida became one of eleven Local Health Councils to serve as a network of non-profit agencies that conduct regional health planning and implementation activities. Originally charged with overseeing the Certificate of Need (CON) process for local healthcare facilities, the activities undertaken by the health councils are designed to improve access to healthcare, reduce disparities in health status, assist state and local governments in the development of sound and rational healthcare policies, and advocate on behalf of the underserved. Currently, there are ten councils providing services to eleven districts across Florida.

The Health Council is governed by a 12-menber board who are appointed by the county commissioners within the district. Board members represent the three main stakeholders in the delivery of healthcare services: consumers, providers, and purchasers. Members serve for two years and are eligible for reappointment.

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