Assessment of Behavioral Health Services in Florida

FISCAL YEAR 2019-20

Department of Children and Families
Office of Substance Abuse and Mental Health

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I. INTRODUCTION

In 2016, the Florida Legislature passed Senate Bill 12, which significantly amended Florida Statute 394 (Florida Mental Health Act, commonly referred to as the Baker Act), and Florida Statute 397 (commonly referred to as the Marchman Act). The legislation addressed access to and the essential elements of a coordinated system of care for individuals with behavioral health conditions. The Department of Children and Families (Department) has embraced the concepts outlined in SB 12 and is working to shift from an acute care model of service delivery to a recovery model, offering an array of services and supports to meet an individual's and family's pathway to recovery and wellness. To that end, the Department's overarching goal is to transform behavioral healthcare in Florida into a Recovery-Oriented System of Care (ROSC).

This report addresses activities related to this transformation at the community level and satisfies the requirement in s. 394.4573, F.S., for the Department to submit an assessment of behavioral health services in Florida. This assessment considers the extent to which designated receiving systems function as No Wrong Door (NWD) models, the availability of treatment and recovery services that use recovery-oriented and peer-involved approaches, the availability of less-restrictive services, and the use of evidence-informed practices.

Community-based behavioral health services are provided through contract with seven non-profit Managing Entities. The purpose of the behavioral health Managing Entities is to plan, coordinate, and subcontract for the delivery of community mental health and substance use services, to improve access to care, to promote service continuity, to purchase services, and to support efficient and effective delivery of services. Services are provided by a network of local behavioral health providers. Information in this report is gathered directly from the Managing Entities, especially their community needs assessments.

This report also addresses s. 394.9082, F.S., which requires each Managing Entity to develop an annual Enhancement Plan. The Enhancement Plans are submitted by the Managing Entities by September 1st of each year and are available online at www.myflfamilies.com/service-programs/samh/publications/. These plans include a description of strategies for enhancing services and the identification of priority needs within the service areas overseen by each of the seven Managing Entities. The planning process must minimally include individuals served and their families, community-based care lead agencies, local governments, law enforcement agencies, service providers, community partners, and other stakeholders.

II. PRIORITY NEEDS

Priority needs were identified by the Managing Entities in a variety of ways, including but not limited to, analyses of waitlist records, surveys, and focus groups with consumers, providers, and other community stakeholders. The priority needs identified by each of the Managing Entities within their Enhancement Plans for 2019 are presented in Table 1 below.

Table 1: Managing Entity Priority Needs and Cost		
Managing Entity	**Priority Needs**	**Associated Budget**
Big Bend Community Based Care (BBCBC)	1. Expand detoxification services.	$884,213
	2. Increase forensic services.	$3,900,000
	3. Expand outpatient services, including FACT Teams.	$3,855,000
	4. Increase Managing Entity operational funding.	$565,500
	BBCBC TOTAL:	$9,204,713
Broward Behavioral Health Coalition (BBHC)	1. Develop and implement a plan for a Zero Suicide Initiative.	$500,000
	2. Housing and care coordination teams and family/peer support navigators.	$2,100,000
	3. Increase Managing Entity operational funding.	$856,459
	4. Multidisciplinary Treatment Teams (FIT, CAT, and FACT).	$2,600,000
	5. Fund the Broward Forensic Alternative Center.	$2,645,593
	BBHC TOTAL:	$ 8,702,052
Central Florida Behavioral Health Network (CFBHN)	1. Mental health and substance abuse services, including FACT and CAT teams.	$21,549,923
	2. Increase the number of school-based prevention programs.	$966,641
	3. Increase housing and supported housing options.	$916,661
	4. Increase Managing Entity operational funding.	$1,525,969
	CFBHN TOTAL:	$24,959,194
Central Florida Cares Health System (CFCHS)	1. Peer support services.	$470,734
	2. Care coordination.	$422,880
	3. Housing specialist (provider level).	$240,000
	4. Supportive group housing.	$918,418
	5. Adult mental health case management.	$351,550
	CFCHS TOTAL:	$2,403,582
Lutheran Services Florida Health Systems (LSFHS)	1. Increase Short Term Residential and Assisted Outpatient Treatment capacity.	$2,970,280
	2. Addictions Receiving Facility and substance abuse treatment.	$8,099,580
	3. Housing and care coordination.	$3,401,100
	4. Behavioral health/law enforcement co-responder teams.	$1,425,008
	5. Fund Central Receiving System implementation.	$5,000,000
	LFSHS TOTAL:	$20,895,968
Southeast Florida Behavioral Health Network (SEFBHN)	1. FACT Teams.	$2,049,503
	2. Forensic services.	$2,842,111
	3. Increase Managing Entity operational funding.	$3,341,659
	4. Increase the availability of psychiatric services.	$1,352,000
	5. Supportive housing.	$546,000
	6. Planning for primary/behavioral health integrated site pilot.	$50,000
	SEFBHN TOTAL:	$10,181,273
South Florida Behavioral Health Network (SFBHN)	1. Implementation of an additional NAVIGATE program.	$722,894
	2. Additional funding for care coordination and housing.	$874,745
	3. Increase Managing Entity operational funding.	$456,059
	4. Increase substance abuse residential capacity.	$26,897,449
	5. Implementation of additional FACT Teams.	$4,900,000
	6. Implementation of Centralized Receiving System.	$4,200,000
	SFBHN TOTAL:	$38,051,147
	TOTAL	**$114,397,929**

Overall, the total cost associated with the enhancements is $114,397,929. A variety of service needs were prioritized by the Managing Entities. The most frequently identified need was for intensive, community-based, multidisciplinary, team-based services, like those provided through Florida Assertive Community Treatment (FACT) Teams, Community Action Treatment (CAT) Teams, Family Intensive Treatment (FIT) Teams, and Coordinated Specialty Care teams for early serious mental illness (including First Episodes of Psychosis). Housing was the second most commonly identified need and additional care coordination capacity was third. Five of the seven Managing Entities included increases in their operational funding as a priority, which represented 6% ($6,745,646) of the enhancement costs. The Department will utilize these enhancement plans when developing future legislative budget requests.

III. BEHAVIORAL HEALTH RECEIVING SYSTEM PLANS - NO WRONG DOOR

Section 394.4573(1)(d), F.S., defines the No Wrong Door (NWD) model as "a model for the delivery of acute care services to persons who have mental health or substance use disorders, or both, which optimizes access to care, regardless of the entry point to the behavioral health care system." In accordance with the changes promulgated by Senate Bill 12, the Managing Entities collaborated with each Florida county to complete a Behavioral Health Receiving System plan. Implementation of the plan ensures coordinated provision of emergency services for people in need of crisis stabilization due to behavioral health disorders and supports a coordinated behavioral system of care. The plans describe how the community ensures the provision of the NWD model, which includes response to individual needs and integrates services among various providers. In addition to development of these plans, the Managing Entities were asked to identify and describe the characteristics of the NWD model currently demonstrated within the services provided by their networks. Summaries of the responses from each of the Managing Entities are presented below.

A. Big Bend Community Based Care (BBCBC):

Circuit 1 uses a Multiple Entry Points Model. Participating agencies include Baptist Hospital, Lakeview Center Acute Stabilization Unit (crisis stabilization and detoxification), and Fort Walton Beach Medical Center. Circuit 2 utilizes a Centralized Receiving Facility Model with Apalachee Center being the primary entry point for stabilization (crisis stabilization and detoxification). Other receiving facilities include Capital Regional Medical Center and Tallahassee Memorial Healthcare. Circuit 14 uses a Multiple Entry Points Mode.) Participating agencies include Life Management Center, Emerald Coast Behavioral Health, and CARE (detoxification).

BBCBC network providers and other community facilities participate in regular Circuit-level meetings to discuss general access to crisis services, Baker Act and Marchman Act issues, and coordination between facilities. These meetings include the behavioral health agencies, law enforcement, community stakeholders such as NAMI representatives, and the Managing Entity. Case managers from each of the community mental health programs visit individuals at the

receiving facilities to encourage continued care. These collaborative efforts ensure a continuum of services are provided to meet needs, prevent acute care stays when possible, assist when individuals are discharged back into the community, and provide the appropriate level of care to maintain stability. Services include support for competitive employment, educational attainment, independent living skills development, family support and education, wellness management and self-care, and assistance in obtaining housing that meets the individual's needs.

Analysis from DCF Northwest Region Substance Abuse & Mental Health Director:

It is unclear if the NWD policy is being constantly reviewed within the provider agencies. It is unclear if BBCBC has provided any follow-up training to current and new staff at agencies regarding this policy. This has not yet been mentioned on the monthly provider calls. The region will need to follow-up to ensure BBCBC is providing this training and support to their providers as required in statute.

B. Central Florida Behavioral Health Network (CFBHN):

CFBHN acute care providers adopted the NWD philosophy to ensure that a person is assessed utilizing co-occurring capable processes. The goal is to link the person to the appropriate needed services, in the right frequency, and at the appropriate level of care. This includes treatment and social support services. The NWD philosophy provides easy and convenient access to treatment. The acute care providers and local receiving facilities, transportation companies and law enforcement have agreements in place to ensure the most efficient and least impactful process to the individual.

The commitment to the NWD concept was fully implemented during the contract negotiations with the Central Receiving Systems (CRS) in Hillsborough and Manatee Counties. Although the concept is throughout the region, and ongoing training and contract requirements are in place, these services offered at the current CRS facilities represent a more advanced model that reaches across professions, providers, and service providers, including medical services.

Analysis from DCF SunCoast Region Substance Abuse & Mental Health Director:

The NWD philosophy has been integrated throughout the SunCoast Region to make sure that an individual entering a CSU or integrated CSU with a mental health diagnosis, a substance use diagnosis, or co-occurring diagnosis has a single point of entry that allows the system of care to respond to the needs of the individual. The SunCoast Region has two contracted Central Receiving Systems operating under the Department's Centralized Receiving Systems Grant. One is Centerstone in Manatee County, and the other is Gracepoint in Hillsborough County.

As outlined in both Centerstone's and Gracepoint's Receiving Systems Plans, they have addressed all key points per Managing Entity Contract Guidance Document 27: Centralized

Receiving System Grant. Gracepoint's plan has more content, community partnerships outlined, as well as data. Centerstone's plan focuses more on how care coordination is utilized in the NWD philosophy. Both Gracepoint and Centerstone are large agencies that have a long history of serving the community with a multi-level service array, and community partnerships that are strengths. Both Gracepoint and Centerstone have agreements in place with transportation companies and law enforcement to streamline processes for individuals receiving services. Both Centerstone and Gracepoint also have working relationships with the medical community to be more integrated within the system of care.

Barriers reported by Gracepoint include substance using individuals do not like being mixed with mental health patients, as well as a lack of step-down facilities and housing resources. Some best practices used by Gracepoint include staffing processes that allow for utilization of mobile resources out of Central Receiving during their mobile triage processes, their EHR sends alerts to the mobile and administrative team for quick clinical decision making.

Centerstone reported a greater demand for uninsured beds for individuals than what is currently allotted as a barrier. Some best practices used by Centerstone include the use of motivational interviewing and the use of stages of change. Centerstone also provides Crisis Intervention Team training to law enforcement.

C. Central Florida Cares Health System (CFCHS):

CFCHS' network includes Central Receiving Systems (CRS) that consist of designated Central Receiving Facilities (CRF) functioning as a NWD model. These designated receiving facilities serve as a single-entry point for persons with mental health or substance use disorders, or co-occurring disorders. In utilizing the NWD approach, these systems respond to individual needs by providing information, triage and assessments and crisis intervention on a 24-hour, 7 days a week basis. All individuals that present to a receiving facility are screened and triaged to determine immediate needs and plan for ongoing services or treatment and/or referrals. The CRS consist of partnerships among community stakeholders to identify new ways of meeting the needs of individuals with mental health and/or substance use disorders. They integrate services among various service providers, including ancillary services. These programs also provide or make referrals and/or arrangements for crisis support, assessment/triage services, crisis stabilization services, substance abuse detoxification, short-term residential treatment, residential treatment, case management, recovery support, medication assisted treatment, housing, primary care, domestic violence services, medical services, medication management, outpatient therapy, partial hospitalization, psychological services, psychiatric services, vocational rehabilitation, dietary services through the health department, and entitlement programs.

Analysis from DCF Central Region Substance Abuse & Mental Health Director:

Aspire Health Partners has operated the CRC in Orange County since 2003, serving over 500 individuals monthly since inception. One highlight of the CRC in Orange County is the 11-minute drop-off processing time by law enforcement officers. Over the last 16 years, this time has remained consistent and has been monitored and reported to the CRC Governing Board. This has been one of the most desirable features of the CRC to both the law enforcement agencies and the hospitals. The Orange County Transportation Plan is overseen by the CRF Governing Board, which is a strong collaboration of community partners, led by the Manager of the Mental Health and Homeless Division of Orange County government.

Contract Oversight Unit monitoring interviews with the providers illustrated that different perspectives exist across law enforcement agencies and departments within the service area. Challenges to coordinated planning and service delivery were also identified. Discharge planning for those that come through the Orange County CRS needs to be enhanced to help reduce readmissions.

There is also a need for more housing options as well as a housing specialist at Aspire. Although Aspire utilizes a person-centered process which helps to identify what services are immediately needed and begins framing what services might be needed in the future, there is a shortage of housing options for those in need of permanent supportive housing. There is a need for a more focused position regarding housing, as well as for development of more housing options in the community.

D. Lutheran Services Florida Health Systems (LSFHS):

Implementation of the NWD philosophy was assessed through focus groups in each of the five Circuits in the LSFHS catchment area. A summary of responses for each Circuit is presented below.

In Circuit 4, focus group participants report that the NWD model is effective at increasing collaboration and communication between providers and referrals to an appropriate agency for anyone who comes through their doors. NWD is used widely and daily within their organizations; one participant referred to it as part of their culture.

Participants emphasized their use of quality assurance/improvement (conducting monthly meetings to ensure standards are met and conducting focus groups to gain feedback from clients), person-centered counseling (peer specialists and care coordinators help establish client transition support services), and community awareness as key to the success of this model. A limitation mentioned by one organization's representative was due to the high volume of calls they receive, they have found it necessary to emphasize referring clients elsewhere.

In Circuit 7, organizations reported that the NWD model is a key part of their service philosophy – it is used widely and daily. Providers stressed that anyone who comes to them needing help will be connected to available services, whether in house or by appropriate referral. They spoke in great detail about their robust community referral system and how the Behavioral Health Consortium in St John's County has provided the opportunity to establish great relationships between all the provider agencies in their community, the school district and the sheriff's office.

Several agencies have open access centers that are designed to connect families with a variety of needed services. Some are open 24/7, others have a call center and clients can call to receive information about local services. One agency highlighted their mobile crisis team, which intervenes before a mental health issue reaches the level of a Baker Act, and works in collaboration with area schools, law enforcement, and mental health providers to respond to crisis calls and link families to needed services. Another agency trains their staff in High Fidelity Wraparound which parallels aspects of person-centered care management and person-centered transition support. Anyone experiencing homelessness is entered into the Homeless Management Information System or referred to an agency that can enter them in the system.

Participants emphasized use of person-centered counseling, participant engagement, person-centered transition support, engaging with the entire family, and hiring former clients as staff members as reasons for their successful use of this model. One agency spoke about how they provide aftercare, utilize peers, and work on transition plans from treatment.

In Circuits 3 and 8, focus group participants reported that the NWD model is effective in assisting their clients or referring those clients to an appropriate agency. For participants who provide direct care, they reported utilizing the NWD model daily and commonly viewed it as their access to care model. Several focus group participants were not direct service providers and emphasized their organization’s focus on community awareness, universal prevention strategies, and linking clients to services. For those participants who were not direct service providers, their use of the NWD model is in connecting anyone who contacts their organization to an appropriate agency who can best help them.

Participants emphasized their use of community awareness by engaging in numerous outreach activities, educational programs and events. Providers also highlighted person-centered treatment and person-centered counseling with an emphasis on the importance of peer support and consumer involvement in their treatment programs. The majority of participants reported they have ongoing mechanisms in place at their organizations to ensure quality assurance and quality improvement, such as conducting focus groups and satisfaction surveys with their consumers, stakeholders, and community partners.

In Circuit 5, focus group participants who were direct providers of care reported that their organizations provide services or assistance with referrals to an appropriate agency to anyone coming through their doors. For those participants whose organizations do not provide direct

services, they help in connecting clients to an appropriate agency that will best meet their needs. One participant reported utilizing peer support services to assist their clients. Another participant emphasized that while their organization's focus is on universal prevention strategies for substance abuse, they will refer anyone who contacts their agency to an appropriate resource to best help them. Overall, for those participants who provide direct care, they agreed that the NWD model is their organization's philosophy and is used daily. Others noted they could not adequately answer how widely or frequently this model is used without reviewing data at their organizations.

All participants emphasized their use of community awareness, regardless of whether they provide direct services or are more focused on prevention. Examples of community awareness discussed by several participants included a variety of outreach and education initiatives as well as advisory groups to help raise awareness. Participants also emphasized their use of consumer/stakeholder involvement, such as having consumers or peers serving as liaisons on their organization's boards and committees. They also discussed their organization's focus on person-centered counseling and person-centered transition support using case managers and peer specialists who work with their clients to make their transitions as smooth as possible. The majority of focus group participants emphasized their organization's use of quality assurance and quality improvement measures to ensure their standards of care are monitored on an ongoing basis (i.e. consumer feedback surveys and focus groups). One participant noted their organization utilizes a scorecard approach to track these indicators.

Analysis from DCF Northeast Region Substance Abuse & Mental Health Director:

LSFHS provided great insight in their report of provider stakeholder feedback received from focus group surveys. There was overall consensus that communities have made great strides to ensure the provision of the NWD model, responding to individual needs and integrating services among various providers when possible.

Overall providers report the NWD model is effective at increasing collaboration and communication between providers and referrals to an appropriate agency for anyone who comes through their doors and is widely used. Engagement with the entire family and the hiring of former clients as staff members are viewed as examples of the successful use of this model.

Best practices in the Region include open access centers (some open 24/7) and call centers, mobile response or crisis teams and the use of High-Fidelity Wraparound services. Anyone experiencing homelessness is entered into the Homeless Management Information System or referred to an agency that can enter them in the system. During focus groups most, providers report they have ongoing mechanisms in place at their organizations to ensure quality assurance and quality improvement, such as conducting focus groups and satisfaction surveys with their consumers, stakeholders, and community partners.

As far as collaborative programs working to change the trajectory of individuals in crisis, programs like the Co-Responder Program in Gainesville (where law enforcement and a therapist respond to crisis calls) and Project Save Lives in Duval (Gateway Community Services) where peers are in Emergency Departments to engage and follow up-with patients, who have made suicide attempts or overdoses, have proven highly effective. These programs use blended funding resources, such as LSFHS funding, county or city government funds, law enforcement resources, along with providers or grant funds.

In order to improve existing coordination and delivery, it may help to have a centralized information repository center of services, so providers know where to refer clients for specific services. Sharing of information between organizations is a barrier and focus group participants repeatedly brought up the efficacy of this model is limited due to capacity issues. Among the problems listed was a lack of a Baker Act facility in certain counties, the lack of detox and residential bed availability, and the shortage of licensed clinical professionals. Many reported having waiting lists and agency staff turnover due to burn out. All participants agreed they currently do not have the resources to meet the need and expanding capacity and funding sources would improve existing coordination and delivery of services. Focus group participants reported the biggest challenge to the effectiveness of the NWD model is the lack of adequate funding in the behavioral health care system in Florida.

E. Southeast Florida Behavioral Health Network (SEFBHN):

SEFBHN's NWD model continues to focus on our Mobile Response Teams (MRT) as entry points for referral to appropriate services based on an individual's unique needs. The MRTs are available to anyone and go to where the acute situation or crisis is. Services are free to the individual and the MRT addresses a wide variety of conditions, including suicidal and homicidal behaviors, individuals displaying hallucinations, family/peer conflicts and disruptive behavior. The MRT can be the first on the scene or they may be called in by Law Enforcement or other professionals (school personnel, adult and child protection staff, other medical personnel). Once they have responded they will spend as much time as needed to deescalate the situation and determine what additional services the individual may need. Further supporting the NWD model, the MRT will provide referrals to other services in the community to meet the ongoing needs of the individual and will follow-up to determine that the appropriate linkages have been made. When the situation warrants, they will assist with the individual being admitted to a Baker Act receiving facility or an inpatient detoxification facility depending on behaviors being displayed by the individual. The primary goal of MRTs is to lessen trauma and prevent unnecessary psychiatric hospitalizations. Enhanced funding has enabled the network MRT providers to hire additional staff to increase response time and increase access to psychiatrists even while out on a call.

As part of a NWD model, MRTs are very person-centered as they come to the individual, obtaining their input (and family members' input as appropriate) in determining how to proceed related to ongoing service needs. There is collaboration with community stakeholders

(i.e., school systems, law enforcement, child and adult protective investigations). Monthly conference calling and data collection inform continuous quality improvement and quality assurance of the services provided.

Analysis from DCF Southeast Region Substance Abuse & Mental Health Director:

While SEFBHN's focus for the NWD model is on their Mobile Response Teams as entry points into the system of care for those persons with acute and/or emergent needs, they omitted to include their web-based Care Coordination Module that facilitates ease of access and information sharing between their Network Service Providers. The Care Coordination Module brings Circuits 15 and 19 together in an electronic platform to look at consumer historical information, diagnosis, services, etc. regardless of the behavioral health disorder. This platform provides case managers and care coordinators the opportunity to look at what has worked well and what has not for mental health, substance use disorders, and co-occurring disorders, as well as service availability across the network while the consumer is still in an acute care setting. It paves the way for effective communication and information sharing across the two Circuits. Care coordination is funded at each acute care facility (Crisis Stabilization Unit, inpatient hospital, and detox facility).

All Managing Entity-contracted providers are capable of providing assessments and referrals to individuals in need of acute care services regardless of their entry point. Additionally, 2-1-1 is a resource that is readily available, highly utilized, and a strong community partner.

In Circuit 19, New Horizons of the Treasure Coast is a provider that demonstrates the NWD model in the system of care, as they provide services for mental health, substance use, and co-occurring disorders. They facilitate quarterly Baker Act Task Force Meetings that are inclusive of law enforcement, peers, school representatives, as well as other community stakeholders, providing a forum for discussion and dialogue about behavioral health issues.

As this assessment was being submitted, SEFBHN was in the midst of contracting with Drug Abuse Foundation in Circuit 15 for a co-occurring unit, ensuring that the entry point into a traditionally, substance use disorder treatment facility also serves as part of the NWD model.

Circuit 15 and 19 are fortunate to have peers working at providers, Mental Health Association of America, and Rebel Recovery (operating only in Circuit 15), a peer-run nonprofit organization that is also a new Recovery Community Center. The utilization of peer services, regardless of the behavioral health disorder, has been strong and growing in these Circuits to conduct outreach and engagement into services, as well as meeting the social determinant factors that anchor consumers to the community and prevent or reduce admission/readmission into acute care services, where clinically appropriate.

Further, SEFBHN has been working with the Healthcare District in Palm Beach and Palm Beach County to implement integrated physical and behavioral health services, as part of their NWD

model. SEFBHN is innovative in building a system of care that ensures consistent access across its network to meet the needs of its consumers. The Mobile Response Team, 2-1-1, and the Care Coordination Module facilitate the NWD model and system. SEFBHN has a very well developed CQI process with multiple network partner participation and involvement, working together to form a NWD System of Care.

SEFBHN's acute care providers and community-based providers, in both Circuits, can optimize the continued building of a NWD model by having something like an MOU, formalizing their NWD model and system. Circuit 19 could benefit from growing their peer support network workforce and equipping it with peer supervision.

F. South Florida Behavioral Health Network (SFBHN):

As requested in all SFBHN's network provider contracts, the network provider shall implement a NWD model by developing a process for assessing, referring and/or treating clients with co-occurring disorders, to increase access of persons identified as co-occurring, to provide services for both disorders regardless of the entry point to the behavioral health system. As used in conjunction with the Comprehensive, Continuous, Integrated System of Care model, NWD requires that systems develop policies and procedures that mandate a welcoming approach to individuals with co-occurring psychiatric and substance disorders in all system programs, eliminate arbitrary barriers to initial evaluation and engagement, and specify mechanisms for helping each client (regardless of presentation and motivation) to get connected to a suitable program as quickly as possible.

A copy of the network provider's NWD policy is maintained in the network provider contract file. Should any updates to the to the NWD policy and procedure occur during the term of this contract, the network provider must submit the amended procedures to the contract manager within 30 calendar days of the adoption.

Analysis from DCF Southern Region Substance Abuse & Mental Health Director:

As a response to Senate Bill 12, SFBHN collaborated with Miami-Dade County to create the Miami-Dade County Designated Receiving System Plan, which was approved by the Board of County Commissioners in 2017. SFBHN did not get state funding to implement the Centralized Receiving System (CRF) in 2017. Subsequently, SFBHN got $1 million from Miami-Dade County to implement the CRF. With community and stakeholder feedback, SFBHN decided to maintain the same process they had for Baker Acts for law enforcement, so law enforcement continued to transport to an appropriate or the nearest receiving facility.

SFBHN identified the need for at least three Centralized Receiving Facilities and determined that the county should be broken down into north, central, and south regions. Due to funding limitations, SFBHN has only been able to implement a CRF in the central region (Banyan Health Systems). The following services are available at the CRF: crisis stabilization services, substance

abuse inpatient detoxification, assessment, crisis support/ emergency, and referral. SFBHN is still having issues with providers denying admission to clients without sound clinical justification. The most relevant example is Here's Help, Inc., with these types of issues so prevalent for years, that SFBHN is holding a contract negotiation to address it.

Through the work of the Opioid Behavioral Health Consultants (BHCs), the SAMH regional office has been able to see firsthand that the attempted referrals to link child welfare-involved caregivers to treatment services proves challenging. These appear to be arbitrary barriers. For example, the provider may not be as welcoming or willing to serve an individual with a co-occurring disorder, despite the contract language for an inclusive approach.

Additionally, the following opportunities for improvement were identified:

- According to the 11th Judicial Circuit General Magistrate, there are individuals who are waiting 30-60 days for their first outpatient substance abuse appointment.
- Providers are not keeping waitlists, nor have they been instructed that if they are unable to accommodate a person within a certain timeframe to refer out. Individual providers seem to have internal NWD policies, however they are not seeking services outside of their agency to ensure timely linkage.
- Additionally, when linking individuals with care coordination, providers are requiring that individuals still be processed by their traditional Intake Staff in order to be enrolled in care coordination. This process seems to contradict a model that is meant to be supportive of individuals who have not been able to conform to traditional methods and not in-line with NWD philosophy.
- Furthermore, there is no mention of a CRS in SFBHN's response. Monroe seems to have a more robust system than Miami. Though Miami has the one aforementioned designated CRF, the belief is that this only serves a limited area delineated by zip codes. The Miami CRF has not been advertised to its full extent and may be underutilized.
- Although network service provider contracts have the NWD language, as mentioned with the specific example of the provider Here's Help, individuals are being denied admission without sound clinical justification
- Providers not having a willingness to accept individuals with co-occurring disorders.

G. Broward Behavioral Health Coalition (BBHC):

To gauge how the BBHC system of care functions as a NWD model of care, 32 network providers completed online surveys to gather first -hand knowledge and insight on their perceptions of how well this model of care has been implemented across Broward County. The survey instrument assessed various agency actions that support the six key elements of the NWD. Excerpts of the providers' responses are reproduced below.

All providers were in general agreement on the use of the NWD model and how it is currently defined. A warm handoff, a welcoming environment and engagement at every contact point

were viewed as an integral component to the NWD model as it increases the success of the overall policy of connecting clients to needed services. Providers believe that procedures to redirect clients to the appropriate door when they needed services was important regardless of the initial entry point. One hundred percent of providers operate trusted facilities where information can be accessed by all people.

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 indicated that the printed Connections guidebook and its online version were useful in identifying options and linkages for consumers needing services that the provider did not offer. 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.

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, law enforcement, Department of Corrections, Department of Juvenile Justice, Veterans Services offices, Assisted Living Facilities, hospitals, the Children's Trust, and schools/school boards. Additionally, 84% of providers reported targeted outreach to specific populations as required to fulfill their mission and meet the needs of the clients they served, including forensic populations, mothers and children, foster care youth, the LGBTQ community, adults 55 years of age and older, homeless youth and adults, and cultural, racial and ethnic minorities. Providers looked to every opportunity to work with any partner who could improve the flow of clients through the system.

There was a broad range of activities that providers used to access the effectiveness of their outreach and marketing efforts. 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 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.

Providers identified that there has been an increased level of communication between partners and with consumers to increase awareness of the behavioral health services available in

Broward County. Community engagement had replaced word of mouth which helped increase awareness. Targeting specific populations and the use of mobile crisis units had proven very effective.

Broward 2-1-1 has received additional funding in order to reduce call wait times and numerous providers identified that they have transitioned to include an in-house intake Department and streamlined the referral processes and improved communication and coordination with key referral sources and stakeholders. The community implemented a "Power of Peers" program to address the limitations of case managers with large caseloads in order to assist individuals who have been discharged from the State Hospital with support and linkages. Increased community engagement fostered stronger partnership and stakeholder relationships. The 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.

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 ensured the application of the most modern treatment available. Numerous providers identified the implementation of Peer Specialist Services within their programs as being a critical way to provide person-centered care. Additionally, providing recovery-oriented services facilitates providing person-centered care.

Some barriers still exist. The services that are currently offered may not be the optimal solution for a client. The provider on occasion has only the second or third best option available because the optimal option has a very long wait list or at times there is not a live voice on the phone when someone calls. 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 results in limited options for transportation and housing or other supportive services. The lack of psychiatrists and peer specialists, prevalence of insurance denials, and stigma regarding behavioral health issues all played a role in reducing the overall effectiveness of patient-centered care.

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. To ensure successful follow-up some providers took on the responsibility of transportation or accompanied the client to their first appointment. Some providers were dedicated to outreach and educational to prevent a crisis or minimize the effects of an emergency. Providing a client with the knowledge of where and

when to seek services or how to establish a support system were stabilizing forces for the client, thus reducing the severity of consequences should they have an unintended set back.

Transportation was cited by providers as the number one barrier to person-centered care, especially for indigent clients. Providers also reported spending 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.

Staffing needs were three-fold. There is a shortage of staff (ranging 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.

Single points of entry with knowledgeable, welcoming staff that spend time with the client screening their needs and ensuring they are guided to the appropriate service or agency to assist with their needs was a common identified asset to providing consumers with access to services. Lack of health insurance or underinsured clients, transportation, and housing 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. Staffing is extremely fluid moving from agency to agency, often untrained to adequately fill the new position and providers report not having funding available to train and retrain staff. Level funding has not kept pace with client growth nor the overall increase in the severity of those needing behavioral healthcare. Housing options are in short supply amid heavy demand.

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.
- Strong working relationships were the crux of the system.

What does not work well:

- Referrals not making appointments 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.

- The necessity to repeat assessments and evaluations, thereby duplicating efforts.
- 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.
- HIPAA and Florida Statutes governing confidentiality can interfere with opportunities to share information across providers.

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.
- Having a universal consent form across the network of providers.
- Providers should be encouraged to use the 2-1-1 information line, and organizations should be diligent with updating their information on programming on 2-1-1.
- Universal access to client information to allow sharing of information.
- System of Care Meetings divided by population of focus such as Children system of Care versus Adult System of Care.
- A database that is linked to the other systems.

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.

Providers are bound to the standards established by their accreditation agencies in addition to the requirements they must meet when working with the Department of Corrections, Department of Children and Families, 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.

Analysis from DCF Southeast Region Substance Abuse & Mental Health Director:

While BBHC addressed NWD access to community-based services for their consumers and across systems which they have been working on fortifying as part of their NWD System of Care, they did not address the CRS operated by Henderson Behavioral Health, a collaborative effort by public and private acute care facilities. The CRS is comprised of 5 facilities that

entered a Memorandum of Understanding for acute care services, community services, and community support services for persons with mental health, substance use disorders, or co-occurring disorders.

The Henderson CRC provides adults experiencing a crisis a convenient point of entry for immediate assessment, as well as subsequent referral and linkage to appropriate and available providers and services. The CRC offers crisis support/emergency services, psychiatric services, case management, care coordination, peer recovery support, referral and linkages 24/7. Additionally, the CRC staff provides training on how the CRC can assist with helping Emergency Departments with diversion alternatives and community resources. Data is provided monthly at the BBHC ROSC CQI Meeting regarding persons served at the CRC.

The CRS also works with South Florida Wellness Network, a peer run Recovery Community Organization, as well as Fellowship Foundation Recovery Community Organization. Fellowship Living Facilities, Inc. has respite services for individuals with a substance use disorder awaiting admission to residential treatment, in between levels of care, or transitioning into the community and into a stable living environment. The CRC plays a huge role across many systems, including but not limited to, the specialty courts. The CRS works with an array of community partners to help individuals attain much needed resources. Of note, the CRC has played a pivotal role in Broward's newest specialized Community Court that opened in January 2019. The CRS provides staff support on a weekly basis conducting, assessments, evaluations and makes recommendations to the court for those individuals who are homeless, have committed low-level criminal offences and have concurrent behavioral health needs.

To continue to address the NWD model, Henderson Behavioral Health, having the CRF and as a member of the CRS, requested for and received Designation as an Addictions Receiving Facility in 2019. Furthermore, telehealth and telemedicine has been added to the BBHC system of care for individuals and families to access services at any point in the system.

The NWD model works well in Broward with warm hand offs from the state hospital and acute care services to the community, ensuring that individuals are linked to services the same day. Many network facilities and providers deliver co-occurring services. BBHC's description of what comprises the list of needs and gaps in this NWD model for community-based services is on point.

In terms of strengths, BBHC, through its survey has identified how the NWD is operationalized by their network service providers who deliver community-based services. The network providers clearly elaborate how the system of care operates as a NWD, addressing the key elements of what it means to have a NWD system of care. BBHC has a CRS coordinated by the CRC. Broward County has a Transportation Plan for its CRC. Regarding opportunities for improvement, while BBHC surveyed its consumers, the consumer survey did not specifically address the NWD model of care per se. However, the questions asked in the survey do address access to acute care, community care, and barriers to care.

H. Consumer Satisfaction Survey Results

Managing Entities are required to collect and report consumer satisfaction survey data from subcontracted service providers (though short-term programs, like detoxification and CSUs, are exempt from this requirement). There are four items from the consumer satisfaction survey that are related to NWD access. The values for these four items are identified in Table 2 below, by Managing Entity, broken-out by adults and children, for FY 14-15 through FY 18-19.

Across different Managing Entities and different years, satisfaction across survey items related to NWD is generally high, with most values above 90%. Comparing FY 14-15 with FY 18-19, notable increases were observed on all measures among adults served under CFBHN and children served under SFBHN. In contrast, decreases were observed on all measures among both adults and children served under LSFHS.

Table 2: Consumer Satisfaction Survey Items Related to No Wrong Door Access

Big Bend Community Based Care (BBCBC)					
Adults	**FY 14-15**	**FY 15-16**	**FY 16-17**	**FY 17-18**	**FY 18-19**
I received services when I needed them.	98%	99%	99%	99%	99%
It was easy for me to get to the office.	97%	97%	97%	98%	98%
I received services that were very helpful.	99%	98%	98%	99%	99%
The staff helped me find other services that I needed.	91%	91%	92%	91%	92%
Children	**FY 14-15**	**FY 15-16**	**FY 16-17**	**FY 17-18**	**FY 18-19**
I received services when I needed them.	98%	98%	98%	97%	97%
It was easy for me to get to the office.	96%	94%	97%	98%	96%
I received services that were very helpful.	98%	99%	99%	98%	98%
The staff helped me find other services that I needed.	85%	89%	88%	89%	90%
Broward Behavioral Health Coalition (BBHC)					
Adults	**FY 14-15**	**FY 15-16**	**FY 16-17**	**FY 17-18**	**FY 18-19**
I received services when I needed them.	99%	98%	98%	97%	98%
It was easy for me to get to the office.	95%	94%	93%	94%	96%
I received services that were very helpful.	99%	99%	98%	97%	98%
The staff helped me find other services that I needed.	97%	97%	96%	96%	97%
Children	**FY 14-15**	**FY 15-16**	**FY 16-17**	**FY 17-18**	**FY 18-19**
I received services when I needed them.	97%	99%	99%	97%	97%
It was easy for me to get to the office.	76%	87%	87%	86%	80%
I received services that were very helpful.	98%	99%	98%	97%	98%
The staff helped me find other services that I needed.	91%	94%	94%	91%	91%
Central Florida Behavioral Health Network (CFBHN)					
Adults	**FY 14-15**	**FY 15-16**	**FY 16-17**	**FY 17-18**	**FY 18-19**
I received services when I needed them.	76%	96%	99%	99%	99%

It was easy for me to get to the office.	74%	94%	97%	96%	97%
I received services that were very helpful.	75%	96%	99%	99%	99%
The staff helped me find other services that I needed.	71%	92%	95%	94%	94%
Children	**FY 14-15**	**FY 15-16**	**FY 16-17**	**FY 17-18**	**FY 18-19**
I received services when I needed them.	99%	98%	99%	99%	98%
It was easy for me to get to the office.	96%	93%	94%	95%	95%
I received services that were very helpful.	99%	96%	99%	98%	98%
The staff helped me find other services that I needed.	91%	89%	91%	91%	92%
Central Florida Cares Health System (CFCHS)					
Adults	**FY 14-15**	**FY 15-16**	**FY 16-17**	**FY 17-18**	**FY 18-19**
I received services when I needed them.	99%	99%	100%	99%	99%
It was easy for me to get to the office.	97%	97%	97%	98%	97%
I received services that were very helpful.	99%	99%	99%	99%	99%
The staff helped me find other services that I needed.	95%	95%	95%	97%	96%
Children	**FY 14-15**	**FY 15-16**	**FY 16-17**	**FY 17-18**	**FY 18-19**
I received services when I needed them.	99%	98%	98%	99%	98%
It was easy for me to get to the office.	87%	87%	85%	92%	83%
I received services that were very helpful.	98%	98%	98%	99%	98%
The staff helped me find other services that I needed.	95%	95%	93%	96%	91%
Lutheran Services of Florida Health Systems (LSFHS)					
Adults	**FY 14-15**	**FY 15-16**	**FY 16-17**	**FY 17-18**	**FY 18-19**
I received services when I needed them.	99%	97%	99%	99%	84%
It was easy for me to get to the office.	95%	94%	95%	94%	81%
I received services that were very helpful.	98%	97%	99%	99%	84%
The staff helped me find other services that I needed.	93%	91%	94%	93%	80%
Children	**FY 14-15**	**FY 15-16**	**FY 16-17**	**FY 17-18**	**FY 18-19**
I received services when I needed them.	98%	98%	98%	98%	75%
It was easy for me to get to the office.	94%	93%	93%	95%	73%
I received services that were very helpful.	99%	98%	98%	99%	75%
The staff helped me find other services that I needed.	90%	84%	87%	89%	68%
Southeast Florida Behavioral Health Network (SEFBHN)					
Adults	**FY 14-15**	**FY 15-16**	**FY 16-17**	**FY 17-18**	**FY 18-19**
I received services when I needed them.	99%	99%	99%	98%	99%
It was easy for me to get to the office.	90%	95%	91%	92%	93%
I received services that were very helpful.	98%	99%	99%	99%	99%
The staff helped me find other services that I needed.	95%	97%	96%	96%	96%
Children	**FY 14-15**	**FY 15-16**	**FY 16-17**	**FY 17-18**	**FY 18-19**
I received services when I needed them.	99%	99%	98%	91%	98%
It was easy for me to get to the office.	90%	94%	88%	78%	82%
I received services that were very helpful.	97%	99%	99%	92%	99%
The staff helped me find other services that I needed.	89%	94%	93%	84%	89%

South Florida Behavioral Health Network (SFBHN)					
Adults	**FY 14-15**	**FY 15-16**	**FY 16-17**	**FY 17-18**	**FY 18-19**
I received services when I needed them.	98%	98%	89%	97%	83%
It was easy for me to get to the office.	97%	96%	88%	94%	98%
I received services that were very helpful.	99%	98%	89%	97%	99%
The staff helped me find other services that I needed.	96%	97%	88%	96%	97%
Children	**FY 14-15**	**FY 15-16**	**FY 16-17**	**FY 17-18**	**FY 18-19**
I received services when I needed them.	41%	91%	59%	90%	65%
It was easy for me to get to the office.	38%	79%	51%	79%	82%
I received services that were very helpful.	41%	82%	60%	91%	97%
The staff helped me find other services that I needed.	39%	77%	55%	87%	89%

I. Secret Shopper Calls to Central Receiving Facilities

A team of Department staff recently placed a series of "secret shopper" calls to the nine providers operating Central Receiving Facilities in an effort to describe the extent to which they reflect NWD access. The team identified publicly-listed phone numbers by searching the internet for provider names and navigating their websites. They dialed numbers labeled, "About Services," "Access/Assessment Center," "Inpatient Care & Crisis Line," "Adult Crisis," "Confidential Help Now," "Crisis," "Adult Mobile Crisis & Walk-in," "24/7 Hotline," and "Mainline." They stated that they were calling on behalf of a brother, who was described as 26 years of age, homeless, uninsured, previously diagnosed with bipolar disorder, and possibly misusing opioids. Provider staff that answered the phone were asked to describe the services they offer directly and the services they don't offer (but might provide referrals or linkages to), using housing, transportation, and methadone maintenance services as examples.

The team observed several strengths. Some providers were patient, helpful, and knowledgeable about their services and external resources; they sought to find answers to questions they could not answer themselves. Some providers appropriately encouraged an assessment to help determine needs and placement options. Some provider staff, and phone menus, mentioned Mobile Response Teams as a resource.

The team also observed the following areas in need of improvement:

- The team was unable to reach live individuals at a couple providers using publicly listed phone numbers. One prominently listed helpline was inaccurate due to a transposed digit.
- Some phone menus contain many potentially confusing options.
- Some providers spoke too quickly to clearly understand, lacked information, used stigmatizing terminology (e.g. "clean" and "addict"), and offered unsolicited opinions (e.g., "people may be on MAT for a year or two, hopefully not longer," "he has to want to get off drugs," the advantage of the inpatient setting is "they can't get drugs"). An

opportunity for improvement exists regarding the use of recovery-oriented, person-first language.
- No providers offered direct transportation assistance. A couple providers recommended calling law enforcement for transportation.
- Detox is usually the first (and sometimes the only) substance abuse service mentioned. One provider stigmatized the use of medications: "We don't do methadone. We don't do anything addictive. We detox them."
- One provider stated that if you relapse, you will be thrown out of their residential program.

Overall, the team received the impression that it is challenging to navigate various contact lists, programs, and access points, particularly for individuals with complex behavioral health needs that lack access to transportation and information about evidence-based interventions.

IV. RECOVERY-ORIENTED AND PEER-INVOLVED APPROACHES

Section 394.4573, F.S., calls for an assessment of "the availability of treatment and recovery services that use recovery-oriented and peer-involved approaches." A system that adopts recovery-oriented and peer-involved approaches offers a flexible and comprehensive menu of services that meet each individual's needs. The system offers services that are consumer- and family-driven. Family members, caregivers, friends, and other allies are incorporated in recovery planning and recovery support. Peer-to-peer recovery support services are made available. Florida's vision is to establish an integrated, values-based Recovery-Oriented System of Care (ROSC) where recovery is expected and achieved through meaningful partnerships and share decision making with individuals, communities and systems. During statewide ROSC summit activities, five key priorities were identified to lead and ensure system-wide transformation, including promoting collaborative service relationships, training and technical assistance, promoting community integration, increasing peer-based recovery support services, and developing a strong recovery-oriented workforce. Regional ROSC groups have developed strategic action plans to address these priorities. Below, the Managing Entities have identified and described the characteristics of recovery-oriented and peer-oriented approaches demonstrated within their systems of care.

A. Big Bend Community Based Care (BBCBC):

BBCBC focuses policies, procedures, and monitoring process to ensure ROSC principles intertwine with service delivery. In addition, BBCBC is partnering with the Department to roll out new initiatives and pilot programs. As an example, BBCBC participated in the Statewide Provider Self-Assessment Planning Tool (SAPT) pilot program. Seven providers and one partnering agency participated: Lakeview Center, Apalachee Center, CDAC, Florida Therapy Services, Bridgeway, DISC, Okaloosa Board of County Commissioners, and Chautauqua. Each of these agencies identified programs selected by senior leadership. Surveys were completed by

people served, leadership, and direct care staff. Once the data was collected, results were shared with the agencies and strategic action plans initiated. A direct outcome of the SAPT pilot was the creation of ROSC action teams to implement ROSC principals within the agencies.

BBCBC partnered with the Department and The Peer Coalition of Florida (PSCFL) to conduct a Quality Assurance Site Visit review of Lakeview's Medication Assisted Treatment (MAT) services. BBCBC participated in workshops that addressed the scope of the site visits, which agencies would be responsible for the various components, and development of the tool to be used. PSCFL offered technical assistance and workshops leading up to and during the site visits. The team reviewed policy and procedures relating to MAT, patient files, conducted staff and peer interviews and toured the facility. A summary of the site visit was provided on the agency's strengths, opportunities, and recommendations for transformation. Lakeview developed a strategic plan based on the results of the summary and provided that to BBCBC, who in turn provided to the Department and PSCFL. Follow-up meetings have occurred between Lakeview, BBCBC, and the Department to assist Lakeview.

BBCBC has partnered with Florida State Hospital (FSH) to assist with the roll out of ROSC initiatives on a State Mental Health Treatment Facilities level. BBCBC provided an introduction of ROSC principles to leadership, which developed into quarterly ROSC events. Stakeholder and FSH discuss the implementation of ROSC on a hospital level. This partnership continues to flourish, and new initiatives are being developed.

BBCBC arranged a meeting between FSH staff and staff from the Bay County Jail learn more about and tour each other's facility. Continued planning meetings will occur to work on ROSC processes and procedures between the two agencies and will include jails around the Region.

BBCBC, in partnership with the Regional SAMH office, developed a Region ROSC action plan. ROSC committees and efforts continue to develop and grow across the Region and BBCBC continues to look for new relationships that can advance ROSC efforts.

Analysis from DCF Northwest Region SAMH:

BBCBC has not had much follow-up with the peer site reviews. BBCBC needs to revisit their Regional ROSC Action Plan to revise and update it. BBCBC has done a lot with ROSC in the region. However, now that they are past the initial phases of ROSC implementation, there needs to be more focus on working with providers to incorporate ROSC language into policies, procedures, and HR processes.

B. Central Florida Behavioral Health Network (CFBHN):

CFBHN, utilizing the Department's ROSC framework, is working to transform Florida's substance use and mental health system into a ROSC. Of the Department's five key indicators for ROSC, CFBHN has chosen to prioritize the following three indicators:

Promoting Collaborative Service Relationships:

- Increased ROSC collaborative service relationships, which have expanded from eleven to over forty-nine.
- Developed a SunCoast ROSC transformation planning committee that meets monthly to promote and integrate ROSC throughout the region.
- Provided a ROSC Transformation Workshop in April 2019 for the SunCoast Region to engage, educate and encourage implementation for change and provide an atmosphere for collaboration among the Network.
- Provided technical assistance in partnership with the Florida Alcohol and Drug Abuse Association to develop Recovery Community Organizations in Circuits 6, 10, 12, 13, and 20.
- Collaborated with NAMI Florida's NAMI Advocacy Group and coordinated a train the trainer NAMI's Smarts signature program for Circuit 13 and Circuit 6 NAMI affiliates to educate their members on effective advocacy practices.

Training and Technical Assistance:

CFBHN worked with eight providers in the SunCoast Region in completing the Self-Assessment Planning Tool (SAPT) Pilot Project, Person – Recovery Self-Assessment and the Provider – Recovery Self-Assessment online surveys. The Department collected the data and provided the cumulative and raw scores to CFBHN. CFBHN distributed the scores to each agency for further analysis and requested the completion of a plan to address challenges and or barriers.

Eight providers completed the 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 3.0 score.

Each agency utilized the data collected to create an action plan to document strengths and identify weaknesses within their system of care. CFBHN is providing technical assistance to each agency based on their individual plans to address the areas of weakness individually and through monthly ROSC calls. Technical assistance includes training in cultural competence sponsored by CFBHN and working with agency staff to examine their quality improvement processes to include recovery-oriented surveys as a part of their process. In an effort to provide agencies the ability to develop advanced directives, CFBHN will continue to provide Wellness Recovery Action Plan training (WRAP) to providers within the region. This is so that providers can provide WRAP training to their clients and have trained WRAP Facilitators within their agencies to build capacity and to ensure ongoing WRAP Training within their facilities.

Other examples of technical assistance include the following:

- Continued to provide monthly SunCoast Region ROSC Transformation Workgroup to promote recovery principles in the delivery of services, provide additional support to

subcontractor staff on how to integrate peer services, identify and highlight subcontractors as centers of excellence to share their promising practices and provide TA by guiding discussions on changing agency policies and procedures to align with recovery principles.

- Collaborated with other Managing Entity staff members, the Department's SRT HQ Program Director, Statewide Coordinator of Integration, and Recovery Services, SunCoast Region's Recovery Quality Assurance Specialist and the Peer Support Coalition of Florida staff and developed a plan to train subcontractor staff on implementing the Recovery Oriented Improvement Monitoring Tool.
- Collaborated with the Department's SunCoast SAMH staff to provide technical support to network service providers who volunteered to complete the SAPT Pilot Project.
- Provided educational presentations on recovery principles, concepts and practices to reduce stigma and increase long term recovery to consumer and grassroots organizations, faith-based organizations, behavioral health stakeholders, FIT Teams, and network providers.
- Collaborated with the Florida Certification Board and the Department's SunCoast SAMH office to provide a workshop to the community on "Service Engagement and Brief Interventions in Healthcare Settings for Peer Specialists."

Increase Peer-based Support Services:
CFBHN continues to work to increase the capacity of Certified Recovery Peer Specialists that its provider agencies can hire to provide peer services. Activities include the following:

- Provided Recovery Peer Specialist training, such as "Helping Others Heal" (40-hour State approved curriculum) and the evidence-based program "Wellness Recovery Action Plan" to build capacity in the Recovery Peer Specialist workforce development.
- Partnered with NAMI Pinellas and Personal Enrichment through Mental Health Services to provide peers with an opportunity to obtain their provisional certification and volunteer hours by providing peer supports at the CSU and receiving supervision and technical assistance in completing their certification from NAMI Pinellas.
- Participated on the Pinellas County Children's Mental Health Initiative (sponsored by the Juvenile Welfare Board) to build a scalable mental health system of care that will improve the quality, scope and scale of children's services in Pinellas County.

Analysis from DCF SunCoast Region SAMH:

CFBHN has focused on 3 of the 5 key factors of the ROSC framework to develop a strong certified peer workforce in our system of care. With CFBHN, as well as with the Recovery Oriented Quality Improvement Specialist, through the State Opioid Response grant there has been training and technical assistance. Currently there are 165 Certified Recovery Peer Specialists in our region, and many more are in the process of applying for certification and are either being paid or volunteering and hold many different job titles such as recovery peer specialist, recovery support specialist, recovery navigator, etc.

ROSC practices within CFBHN, as well as network providers, are being implemented and appear to be growing within our system of care. Some barriers to this growth can be the level II background checks that cause delays in hiring peers, and low reimbursement rates. Some best practices in the region are trainings, such as Helping Others Heal and Wellness Recovery Action Plan, and workshops on service engagement and brief interventions in healthcare settings for peer specialists. Another best practice is the development of community partnerships with county partners, and agencies not subcontracted through CFBHN.

C. Central Florida Cares Health System (CFCHS):

In support of the Department's efforts toward focusing the behavioral health system to a ROSC, CFCHS has promoted person centered approaches within its network of providers through oversight of service delivery, technical assistance and clinical reviews. CFCHS Board of Directors includes persons with lived experience with mental illness/substance use disorder as a consumer or family member who provide feedback and assist in decisions to improve CFCSH's system of care. CFCHS administration includes a ROSC Specialist position who is an individual in recovery with lived experience to serve as a key person in ROSC related activities. These activities include but are not limited to: on-going quality assurance and improvement activities; training and technical assistance; the implementation and enhancement of recovery approaches and services within the local system of care; and promotion of effective engagement and care coordination strategies. The ROSC Specialist conducts trainings in Wellness Recovery Action Plan, Mental Health First Aid, Peer Recovery Specialist certification, and overview of the ROSC philosophy from CFCHS Board of Directors, staff to network and community stakeholders.

CFCHS' provider network includes peer recovery support services. CFCHS network defines the Peer Support Specialist as a person who has progressed in their own recovery from alcohol or other drug abuse or mental disorder and is willing to self-identify as a peer. The Peer Support Specialists work towards engaging individuals in behavioral health services. They work with the individual on meeting recovery goals, teach and mentor individuals in problem-solving skills in order to overcome fears, learn coping strategies, and engage in self- care and relapse prevention. Peer Recovery Supports encourage socialization with family and friends and participation in community based pro-social activities. Peer support includes community networking such as social, recreational, spiritual, educational, or vocational linkages. Unlike other clinical staff, peers can share their personal recovery experiences and role model healthy behavior, connect through social media, telephone, and email. They are able to aid individuals in keeping appointments and can assist them as they navigate the system of care on a more personal level. Services may be provided on a group or individual basis.

CFCHS' network providers also collaborate with the National Alliance on Mental Illness (NAMI) as another form of peer support to engage family members in the recovery process. NAMI provides support, education and encouragement for families, along with advocacy, and respite. CFCHS network providers provide NAMI with meeting space and encourage families to

participate in NAMI groups as a support for them in coping with family members who have a mental health disorder. NAMI will become a member of CFCHS board in October.

In order to increase the number of Certified Recovery Peer Specialists in our network, CFCHS contracts with the Mental Health Association of Central Florida to provide a 40-hour training to prepare peers in becoming a Florida Certified Recovery Peer Specialists. Through the training, peers can gain knowledge of the major content areas: Advocacy Mentoring, Professional Responsibility and Recovery Support. In addition, Mental Health Association also provides training in Wellness Recovery Action Plan (WRAP). Individuals are given the opportunity to learn tools to meet recovery goals, maintain wellness, and develop a plan for potential crises.

Analysis from DCF Central Region SAMH:

CFCHS subcontracts with the RASE Project, a Recovery Community Organization. RASE began serving Osceola County in 2017 and has since expanded services to Brevard County and the Seminole County jail. This provider is a unique addition to the service array as a recovery support service program that is peer run. RASE provides recovery support to individuals with substance use disorders and has incidental funds to pay for provision of Medication Assisted Treatment services through a private doctor based on a set rate identified in a Memorandum of Understanding. The goal of CFCHS is to expand the RASE Project to serve all four counties in the service area.

During the 2019 Contract Oversight Unit monitoring, it was identified that some providers did not seem to have an awareness of ROSC principles, while others stated that the Managing Entity has provided training on ROSC and had reviewed treatment plans for ROSC principles. Peer services were reported to be used more in residential substance abuse treatment than in mental health. Having a peer on staff as a ROSC specialist is a major strength for CFCHS regarding recovery-oriented and peer-involved approaches. The ROSC specialist is very engaged with the providers and is a very strong advocate working to enhance the adoption of ROSC principles throughout the system of care. Through her lived experience, the ROSC specialist is extremely knowledgeable and able to provide high quality technical assistance to the providers.

Regarding opportunities for improvement, while the RASE Project provides a unique addition to the service array, education of community partners is needed as to the value of peers, as demonstrated by the Osceola County jail denying this provider access to incarcerated individuals. Implementation of ROSC principles and awareness of the support available through the CFCHS team members varies across providers and the four counties CFCHS covers. It appears that larger providers demonstrated a higher level of involvement with the CFCHS and were more aware of the support and resources available but may not fully understand the ROSC principles. There is a need for more mental health peers to serve within the CSUs. CFCHS is looking to increase the capacity and has been proactive regarding working on this, but there has been a lack of those specific peers.

D. Lutheran Services Florida Health Systems (LSFHS):

Implementation of ROSC was assessed through focus groups in each of the five Circuits in the LSFHS catchment area. A summary of the response from each Circuit is presented below.

Circuit 4 focus group participants incorporate elements of ROSC into various policies and procedures across their agencies. Some examples mentioned were recruiting people to their Board of Directors who are in recovery or who have family members in recovery, incorporating a parent model with wrap around services, involving clients in their own treatment plans, and using peer specialists who can better relate to clients, thereby increasing the number of people who decide to enter treatment plans. Externally, participants report partnering with other agencies to give their clients access to a wider variety of services by either co-locating services or by strengthening existing partnerships. A few participants have worked to create a collaborative group of area providers that meet bi-monthly to improve care coordination and talk about best practices and how to resolve barriers and share resources.

All providers in this group agreed that this model is widely used, and that ROSC improves outcomes for individuals, families and communities. One participant stated that, "There is always more buy-in when clients are part of their recovery," and another that, "They are more invested when they are part of the solution."

In Circuit 7 the majority of focus group participants viewed the ROSC model as one that is widely used throughout their organizations and stated that they incorporate various elements of this model into many of their programs. Several participants noted their organizations rely heavily on their partnerships with other agencies to help meet their clients' needs. A shared goal for many participants was connecting their clients to support systems within their communities and working towards full independence. A few participants discussed how their organizations have worked on High Fidelity Wraparound Plans as examples of how they utilize a recovery-oriented system of care program with aspects of person-centered counseling and transition support. Another participant highlighted how their organization is continuing their efforts to develop a rich care coordination program that works with family members, caregivers and peer support to assist their clients in recovery. It was noted by another focus group participant that their organization's Mobile Response Team program was a good example of how they utilize ROSC principles.

Several focus group participants shared examples of how their organizations utilize specific elements of ROSC. One participant noted their origination recently expanded their program to be more culturally responsive, incorporating peers and ensuring their programs are evidence-based and providing research-based training. Another participant noted their organization is focused on patient-centered aspects and being strength-based and culturally responsive in all of their programs. Several participants discussed how their organizations use system-wide education and training for all their staff members. Another participant reported their organization tries to be culturally sensitive to best meet their clients' needs – such as providing

translators to assist with language barriers – but would like to become more culturally responsive to the needs of the LBGTQ population.

Many focus group participants reported that ROSC improves outcomes for many individuals, families and communities. One participant emphasized the challenges faced when working with the homeless population who often do not have strong support networks. Another participant emphasized the importance of the work their organization does in assisting clients who transition out of hospital settings and linking them with the appropriate services in their community, so they have the best system of support. It was noted that the ROSC model can be helpful in soliciting feedback from consumers and encouraging family and community involvement, so their clients have a higher chance of success in achieving their goals. One participant reported their organization utilizes peers because "people with lived experiences are extremely helpful in recovery." One participant also emphasized that all staff in their organization is trained in ROSC to help them work better as a team on a common mission.

Circuits 3 and 8 focus group participants agreed that recovery to the highest level is the shared goal for all their clients. They reported their organizations utilize the 17 elements of ROSC in a variety of ways depending on their agency's focus. Those organizations providing direct services highlighted how peer support plays an important role in their treatment programs, such as in criminal diversion programs. For those participants whose organizations do not provide direct services, they discussed different ways they utilize community awareness and prevention strategies.

All participants emphasized that the ability of their recovery-oriented programs to be successful is dependent on funding. The majority of participants mentioned that their biggest programmatic challenge is not being adequately and flexibly financed. A limitation mentioned by one representative was their organization's ongoing reliance on grants which do not provide long-term support once that funding source ends. Another participant mentioned their organization's loss of funding to continue to provide peer support specialists for their clients which is an important component of recovery. All participants agreed that the ROSC model is used as widely as the funding permits.

Participants agreed that the ROSC model improves outcomes for individuals, families and the community. However, its effectiveness relates directly back to having the adequate funding to fully support all elements of these programs. It was noted by one participant that rural communities face much bigger funding challenges because they do not have the revenue base to get locally matched dollars required for many grants. Another participant discussed the limitations of this model's effectiveness due to the fact that the current health care system is driven by medical symptoms and not the social determinants of health. It was noted that it can be especially challenging to have a measurable impact on these social determinants. Another limitation of recovery-oriented programs mentioned was the challenge of recruiting peer support specialists for their mental health and substance abuse programs.

It was also emphasized that the Mental Health Clubhouse is a perfect example of a recovery-oriented model and has a great success rate of returning people back into their communities as well as preventing hospitalizations and interactions with law enforcement. With only 11 mental health clubhouses available in the 67 counties of Florida, access is a huge barrier.

In Circuit 5, many of the focus group participants who were direct service providers reported that the ROSC model is widely used at their organizations and they operate under the elements of this model on an ongoing basis. One participant noted that ROSC is embedded into all of their organization's policies, procedures, and practices and emphasized that everything they do is consumer and family driven. Another participant discussed how all of their organization's policies and processes are tested by data and outcomes. It was reported by several participants that their organizations do some elements of the ROSC model better than others and they are addressing those areas that need improvement. One participant mentioned their organization is working towards adopting the ROSC model throughout their agency, but they encountered some challenges and are working with a consultant to assist them in being more consistent with this model across their entire organization. Another participant mentioned their organization is working on increasing the number of peer support individuals and partnering with other organizations who have certification in the ROSC model.

The majority of participants agreed that the biggest challenge to implementing all elements of the ROSC model at their organization is related to behavioral health not being adequately and flexibility financed. Many emphasized that they are doing the best they can to meet their clients' needs within the funding limitations in Florida. Another issue they reported was the difficulty in finding quality behavioral health employees and feel it is a systemic problem. One participant also noted that substance abuse prevention is funded at lower levels than mental health prevention and that they must stretch their resources in this area.

It was agreed by the majority of focus group participants that the ROSC model improves outcomes for individuals, clients, and families and encourages communities to work together. One participant noted that they see their clients become more committed to their treatment when they work with peers and then later want to become part of the peer support system to help others as well. It was also emphasized by one participant that this model only improves outcomes when that individual is motivated for treatment and embraces the recovery-oriented system of care; it is by no means "a magic bullet." One participant also emphasized that while ROSC may improve outcomes for families and communities, it does not always result in improved outcomes with the state and it is dependent on what specific outcomes are being measured. It was also mentioned by one participant that the peer support aspect of the ROSC model can be especially challenging when working with the homeless population who often do not have a strong family or other support system.

Analysis from DCF Northeast Region SAMH:

Communities have made great strides to ensure ROSC has been incorporated in policy, procedures and culture for flexible and comprehensive services to meet people's needs that are consumer/ family-driven for long term recovery. Across the region, providers expressed the valued importance of promoting collaborative service relationships, training and technical assistance, promoting community integration, increasing peer-based recovery support services, and developing a strong recovery-oriented workforce.

Providers report partnering with other agencies to give their clients access to a wider variety of services by either co-locating services or by strengthening existing partnerships. Across the Region, collaborative provider and community groups meet to improve care coordination, share best practices, work on barriers, and share resources. Use of High-Fidelity Wraparound Plans, Mobile Response Teams, evidence-based and research-based training are viewed as examples of good ROSC utilization. Direct service providers have increased their understanding as to the importance peer supports plays in their treatment programs.

The Gainesville Opportunity Center (Circuit 3/8) and Vincent House in Hernando (Circuit 5) have operational mental health Clubhouses. The Clubhouse Model provides a community of support and an opportunity for those with mental illness to work, build relationships, find housing, etc., and they link members to the outside services. There are only 11 of these statewide. Continuing to enhance the capacity of these types of programs greatly supports recovery.

Provider focus groups noted several challenges (which were also heard in other venues), including rural communities lacking the revenue base to get locally matched dollars required for many grants, the health care system being driven by medical symptoms and not the social determinants of health, and difficulties recruiting peer support specialists for their mental health and substance abuse programs. The biggest challenge to implementing all elements of the ROSC model is inadequate and inflexible financing. Another issue commonly reported was difficulty finding quality behavioral health employees. Limitations are often mentioned in Regional meetings include ongoing reliance on grants which do not provide long-term support once that funding source ends.

The June 2019, the Self-Assessment/Planning Tool (SAPT) roll-up report completed by the SAPT consultant and DCF epidemiologist provided feedback from LSFHS's catchment area. The purpose of the SAPT is to help behavioral health systems and programs move from more traditional and limiting views of what is possible for persons with behavioral health disorders to practices reflecting a recovery vision.

The Recovery Self-Assessment (RSA) for Provider Staff is designed to gauge the degree to which programs implement recovery-oriented practices from the perspective of agency provider staff who are providing service. The RSA Persons Receiving Services' section and survey are for individuals receiving services from a Community Behavioral Health Provider. This survey is

designed to gauge the degree to which programs implement recovery-oriented practices from the perspective of the individuals who are receiving services. Table 3 below shows the results of the RSA Provider and Persons Served surveys. As a region, on the Likert scale of 1 -5, providers rated their recovery orientation slightly higher in every category, but ratings scores were close. However, both areas averaged 4 or above and no individual scores were below 3.8. This is a good indicator the Region is moving in the right direction for ROSC.

Table 3: Northeast Region Recovery Self-Assessment (RSA) Scores		
	RSA Survey of Persons Served	**RSA Survey of Providers**
Life Goals	4.1	4.2
Involvement	4.2	4.4
Diversity of Treatment Options	4.1	4.2
Choice	3.9	4.0
Individually Tailored Services	3.8	4.0
Inviting Factor	3.9	4.1
Average:	**4.0**	**4.1**

E. Southeast Florida Behavioral Health Network (SEFBHN):

As the system of care in Circuits 15 and 19 is committed to a NWD philosophy as well as the principles of a Recovery-Oriented System of Care (ROSC) and as such meets individuals where they are rather than providing siloed services, SEFBHN is cognizant of the need to integrate services across substance use and mental health providers. This includes the need to provide training and technical assistance in trauma-informed care, co-occurring psychiatric and substance use conditions, and Wraparound services. SEFBHN has been a leader in the development and implementation of training and technical assistance in ROSC, Wraparound and Trauma-Informed Care and has worked with their system partners including child welfare, the school system, law enforcement, primary healthcare providers, and the criminal justice system to integrate across sectors. The implementation of the ROSC initiative remained an important topic throughout the FY 2018/19 and continues for FY 2019/20. Network providers are encouraged to identify what resources they would need or how they could redirect existing resources to ensure their respective agencies are ROSC competent.

The vision for ROSC is to establish an integrated, values-based recovery-oriented system of care where recovery is expected and achieved through meaningful partnerships and shared decision making with individuals, communities and systems. To this end, SEFBHN has five key priorities including Promoting Collaborative Service Relationships, Training and Technical Assistance, Promote Community Integration, Increased Peer-based Recovery Support Services; and Developing a Strong Recovery-Oriented Workforce. At the provider level, being truly recovery-oriented is an organizational culture and philosophy that is understood by every member of an organization and experienced by the person receiving services at every level. It is not simply a strategy or policy. Characteristics include effectively meeting basic needs and offering comprehensive services that are strength-based, customization by client choice, self-determination, community integration and recovery focus (hope is instilled, and recovery is the expectation).

A System of Care (SOC) philosophy is that our community has a spectrum of effective, community-based services and supports for children and youth with or at-risk of mental health or other challenges and their families. This is organized into a coordinated network, which builds meaningful partnerships with the families and youth, and in addition addresses cultural and linguistic needs, in order to increase functioning at home, school and in the community. The core values to SOC approaches include being community-based, family-driven/youth-driven and culturally and linguistically competent.

Wraparound guiding principles are in alignment with ROSC and SOC principles, and therefore appear to be a well-chosen vessel to help deliver these principles to the SEFBHN provider network and community-at-large. Natural and informal supports are integral for peer-to-peer recovery support services across the SEFBHN network including in peer-run organizations, CAT, FIT, wraparound programs, care coordination, Mobile Response Teams, residential and outpatient programs.

Analysis from DCF Southeast Region SAMH:

SEFBHN is the leader among Managing Entities in having a strong workforce that is trained in Wraparound care management and delivering this service with fidelity. Similarly, SEFBHN has provided training and technical assistance in both Circuits for Trauma Informed Care. SEFBHN built a toolkit for use throughout the state and by other Managing Entities and providers for Wraparound care management that implements ROSC principles and the NWD model. SEFBHN has conducted assessments of their provider network's ROSC competency and provided technical assistance and trainings. Furthermore, SEFBHN trained its board members on ROSC to make it a priority beginning in FY 17-18 and continues to make it a priority.

Additionally, SEFBHN has been working to increase the peer specialist workforce throughout Circuits 15 and 19, encouraging providers to hire trained peers and facilitate their certification process and attaching peers to recovery support services. Through their many partnerships with community stakeholders, SEFBHN has been able to positively influence them to also work towards transforming their value-driven system from acute care to one that is a ROSC. For example, Palm Beach County has funded a second Recovery Community Organization and sees the value of emphasizing and gaining competency in a ROSC. Rebel Recovery, funded by SEFBHN and a peer run organization, has grown significantly whereby they now have peers for substance use disorders, mental health disorders, and co-occurring disorders that work in the forensic (courts and jails), child welfare system, facilities, hospitals, and in other settings.

SEFBHN has taken the lead to implement services, training, technical assistance, and toolkits that are ROSC competent. SEFBHN has used various meetings as platforms to transform and pave the way for ROSC principles and values to be implemented in provider organizations. SEFBHN encourages, supports, and enables the growth of the peer recovery support specialist workforce in both Circuits to the extent that it funds a peer run organization, Rebel Recovery,

which is also a Recovery Community Organization. SEFBHN has influenced this transformation to include stakeholders such as Palm Beach County to begin their own transformation to a ROSC.

One opportunity for improvement applies to long-standing providers that are structured around clinical services. Their peer specialists need appropriate non-clinical supervision. Peer-run organizations are more successful in employing peers than providers for this reason. The greatest opportunity that exists is a state-driven or legislative opportunity around the exemption process for individuals wanting to become Certified Recovery Peer Specialists. The exemption process is long and requires extensive documentation. When background screening looks at the total history of an individual, some documents pre-date electronic record keeping and are lost or destroyed, preventing the exemption process from moving forward.

F. South Florida Behavioral Health Network (SFBHN):

A recovery-oriented system of care is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve improved health, wellness and quality of life for those with or at risk. Recovery-oriented systems support person-centered and self-directed approaches to care that build on the strengths and resilience of individuals, families and communities to take responsibility for their sustained health, wellness and recovery from mental health and substance use conditions.

SFBHN supports ROSC throughout our system of care and is working with the Department and its network providers for adoption of these principals throughout our system. Our providers are employing peers across the network to spread the message of recovery. Based on informal discussions with consumers, many of our network providers are engaging consumers in developing a treatment plan and empowering consumers to play a role in their recovery. Our providers have been also reaching out to the family and support for a consumer to involve as many stakeholders to the conversation as possible. Our Peers on the Move project follows recently discharged consumers from the State Hospital and facilitates through he transition into the community. The peers that work for Peers on the Move meet regularly with consumers in the community and serve as a model of recovery.

Analysis from DCF Southern Region SAMH:

The SAPT and RSA Tools are designed to gauge strengths and weaknesses in our community. However, SFBHN has not used the tools despite much discussion. Peers on The Move (POTM) is a strength in our community and has been very helpful in conjunction with Care Coordinators in assisting individuals being discharged from State Mental Health Treatment Facilities. SFBHN's observation that, "Our providers are employing peers across the network to spread the message of recovery," is of concern because it implies reliance on hiring peers for spreading the

principles of ROSC. Furthermore, “informal discussions with consumers” can be misleading as a way of gauging the pulse of ROSC.

The system lacks in providing peers access when it involves child welfare related families. Perhaps, because the situations are more complex, the system is not able to provide the same level of peer support, with the exception maybe of programs that use a model that includes a “mentor” or a “peer” (i.e., FACES, CAT, FIT, the RPG grant via the Community Based Care lead agency). There are models of peer recovery support implemented in other parts of the country for parents involved with the child welfare system that are rarely (if at all) available and implemented in this region. SFBHN does not seem to have equal amounts of energy assigned to expanding the peer-support to that child welfare population, despite the fact that it is, and has been, a priority population of interest for the Department.

G. Broward Behavioral Health Coalition (BBHC):

The purpose of BBHC’s administration of the Self-Assessment/Planning Tool for Implementing Recovery-Oriented Services (SAPT) is to help behavioral health systems and programs move from more traditional and limiting views of what is possible for persons with behavioral health disorders to practices that reflect a recovery vision. The SAPT survey includes 50 items organized under the domains of Administration (12 items), Treatment (21 items), and Community Integration (17 items). The instrument uses a four-point rating scale to rate the degree of agreement or disagreement with each item. The SAPT survey items describe key recovery-oriented service activities for each of the 3 domains to help agency staff determine, on a four-point scale, the degree to which agency performance is reflected by each statement. An average organizational score of 1 or 2 is an area of weakness needing improvement, and an average organizational score of 3 or 4 is an area of strength. The overall average for the BBHC provider network is 3.2 with 72% of network providers scoring as “strong” in the ROSC framework. This overall score describes the BBHC Provider Network as a strength in understanding and implementing the principles of ROSC. The network goal after reviewing the SAPT results is to help translate the vision of recovery into effective policies and practice and to support continuous quality improvement (CQI) processes at provider agencies. BBHC’s CQI committee is tasked with providing oversight to the implementation of ROSC by providing training, technical assistance and guidance in implementing next steps.

Experience in implementing peer support services throughout the community has closed many of the gaps in services to support engagement and community integration for consumers. Through various initiatives such as the Power of Peers program, the One Community Partnership 2 grant, and the Family-CPR child welfare grant, BBHC has been able to hire peer specialists to work with adults, youth and families for ongoing supports. Additionally, BBHC supports Youth M.O.V.E. and Federation of Families chapters who engage youth and families with lived experience to develop leadership and advocacy across the system of care. BBHC also sponsors training for initial and continuing education for peer specialists, their supervisors, and case managers on WRAP, WHAM, Mental Health First Aid and other evidence-based practices.

The ability of peers to work as a bridge to services for behavioral health clients, makes an integral partner in the success of patient-centered care in the NWD model of care. Providers were surveyed on their utilization of peer support specialists (PSS). In the BBHC network, 50% of providers reported utilizing PSS. There are 152 employed PSS, of which 40 (26%) were certified and 112 (74%) were non-certified. Nearly 78% of PSS work a full time 40-hour work week.

BBHC providers report that one of the most significant strengths gained by using peers is the trusting bond that is formed between the consumer and the PSS. Using their own experience, peers know how to advocate for and support their clients and possess a wealth of information to assist clients in navigating the system of care. Peers are reported to play a crucial role in engaging consumers into services and retaining consumers throughout treatment and serve to act as role models for consumers early in recovery.

Despite the many strengths PSS bring to the continuum of care, providers identified barriers to recruiting and employing PSS. The unique characteristic of peers also creates challenges when working within a provider agency. Providers reported the need for specialized peer supervision that recognizes the unique circumstances of peers is integral to the success of any peer program. Peers are more prone to stress and can be more deeply impacted by negative outcomes with clients. Additionally, peers may be receiving disability subsides which limit the number of hours they are able to work and subsequently diminish their employment opportunities.

Funding for training and certification was the number one source of assistance needed by providers to implement their use of PSS. Training in peer supervision was also identified by providers as a need that would assist implementation of PSS and in the retention of PSS. Specific training topics that providers identified that would be useful in implementing PSS included Cultural Competence, Establishing Boundaries and Ethics, Motivational Interviewing, Suicide Prevention, and Trauma Informed Care.

Providers were asked to identify recommendations to improve the implementation of PSS in Broward County. 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 job. As a result, the pool of applicants is very small. Providers identified that a revision of the background check limitations, specifically regarding criminal offenses, was needed to expand the hiring pool of these support specialists. Providers recommended having an expedited process or waiver for the background screening for peers that may have ineligible items in their criminal record. Providers also identified the need for training for supervision of PSS and additional funding for PSS as critical for increased implementation of PSS throughout the system of care.

Analysis from DCF Southeast Region SAMH:

BBHC has funded peer support services in all levels of care and created programs that are specifically operated by peers, yielding high success rates in outreach and engagement. Furthermore, BBHC funds South Florida Wellness Network, a peer run Recovery Community Organization, that delivers services across many systems to include forensic (court and jails), schools, youth, hospitals, the child welfare system, and more. ROSC has been an ongoing transformation that was slow to start and has picked up speed across all providers.

Regarding strengths, BBHC's board transformed one of its committee meetings from "The System of Care" to "The Recovery Oriented System of Care." This meeting is literally standing room only. Stakeholders across various systems (i.e., the public defender's office, school district, private hospitals, private providers, and more) attend this meeting, including providers in the BBHC network. BBHC's programs involve peers at the epicenter of services. Providers continue to transform the system of care to and adopt the values and principles of a ROSC, infusing this transformation in all aspects of their business.

One opportunity for improvement applies to long-standing providers that are structured around clinical services. Their peer specialists need appropriate non-clinical supervision. Peer-run organizations are more successful in employing peers than providers for this reason. The greatest opportunity that exists is a state-driven or legislative opportunity around the exemption process for individuals wanting to become state Certified Recovery Peer Specialists. The exemption process is long and requires extensive documentation. When background screening looks at the total history of an individual, some documents pre-date electronic record keeping and are lost or destroyed, preventing the exemption process from moving forward.

V. AVAILABILITY OF LESS RESTRICTIVE SERVICES

Section 394.4573, F.S., directs the Department to assess the availability of "less-restrictive services." Outpatient services are less restrictive than residential treatment and acute care services. In order to gauge the availability of these less restrictive outpatient services, the Department asked the Managing Entities to provide waitlist numbers and statistics regarding the number of days between assessment and receipt of first outpatient service for certain special populations. These populations are highlighted because they are designated as priority populations according to federal and state statutes or because they are a particularly vulnerable group. For the purposes of this analysis, outpatient services for substance abuse include the following covered services:

• Aftercare • Day treatment • Medical services • Substance abuse outpatient detoxification • Treatment Alternatives for Safer Communities	• Case management • Florida Assertive Community Treatment Team • Medication-assisted treatment • Supported employment	• Comprehensive Community Service Team • In-home and on-site • Outpatient • Supportive housing/living

The tables below depict the figures provided by the Managing Entities. Regarding the length of time between assessment and first service, averages were not calculated due to missing values. The range of values reported by the Managing Entities is presented instead of averages. Table 4 below shows that many individuals, including individuals who are members of special populations, are placed on waitlists for outpatient substance abuse services.

Table 4: Number of Individuals Placed on a Waitlist for Outpatient Substance Abuse Services

Population	FY 15-16	FY 16-17	FY 17-18	FY 18-19
Pregnant women who inject drugs	0	0	0	3
Pregnant women	2	3	0	8
Women with dependent children	54	0	0	0
Adults who inject drugs	22	44	33	62
Children who inject drugs	0	0	0	0
Adults involved in the child welfare system	68	66	25	0
Children involved in the child welfare system	5	1	0	0
Adults who are homeless	3	38	5	17
Children who are homeless	0	0	0	0
Children involved in the juvenile justice system	107	10	0	0
All other adults	208	133	324	486
All other children	5	0	1	0

Table 5 below shows that individuals may have to wait weeks for their first outpatient substance abuse service.

Table 5: Range of Average Days from Assessment to First Outpatient Substance Abuse Service

Population	FY 15-16	FY 16-17	FY 17-18	FY 18-19
Pregnant women who inject drugs	0-64 days	0-18 days	2-22 days	0-73 days
Pregnant women	0-25 days	0-13 days	2-11 days	0-64 days
Women with dependent children	0-17 days	0-12 days	2-11 days	0-25 days
Adults who inject drugs	2-22 days	0-18 days	3-18 days	0-63 days
Children who inject drugs	0-36 days	0-73 days	0-73 days	0-17 days
Adults involved in the child welfare system	0-18 days	1-11 days	2-8 days	0-19 days
Children involved in the child welfare system	0-11 days	0-12 days	1-9 days	0-50 days

Table 5: Range of Average Days from Assessment to First Outpatient Substance Abuse Service				
Population	**FY 15-16**	**FY 16-17**	**FY 17-18**	**FY 18-19**
Adults who are homeless	3-18 days	0-8 days	0-8 days	0-112 days
Children who are homeless	0-8 days	0-5 days	0-5 days	0-17 days
Children involved in the juvenile justice system	1-50 days	0-62 days	0-61 days	0-86 days
All other adults	0-18 days	0-9 days	3-5 days	0-74 days
All other children	0-33 days	0-43 days	0-42 days	0-41 days

Regarding outpatient mental health services, the following covered services are included:

• Aftercare • Day treatment • Intensive case management • Supported employment	• Case management • Florida Assertive Community Treatment Team • Medical services • Supportive housing/living	• Comprehensive Community Service Team • In-home and on-site • Outpatient

Table 6 below shows that many individuals, including individuals who are members of special populations, are placed on waitlists for outpatient mental health services according to data reported by the Managing Entities.

Table 6: Number of Individuals Placed on a Waitlist for Outpatient Mental Health Services				
Population	**FY 15-16**	**FY 16-17**	**FY 17-18**	**FY 18-19**
Individuals with forensic involvement discharged from State Mental Health Treatment Facilities	12	23	15	4
Individuals with civil involvement discharged from State Mental Health Treatment Facilities	32	111	2	4
Adults who are homeless	251	181	32	8
Children who are homeless	0	2	3	0
Pregnant women	0	0	4	0
Individuals involved in the child welfare system	0	0	0	3
Adults involved in the criminal justice system	7	106	21	8
Children involved in the juvenile justice system	0	0	0	0
All other adults	809	423	635	848
All other children	1,901	638	410	227

Table 7 below shows a wide range of average days between assessment and receipt of first outpatient mental health services.

Table 7: Range of Average Days from Assessment to First Outpatient Mental Health Service				
Population	**FY 15-16**	**FY 16-17**	**FY 17-18**	**FY 18-19**
Individuals with forensic involvement discharged from State Mental Health Treatment Facilities	0-18 days	0-4 days	0-5 days	0-42 days

Table 7: Range of Average Days from Assessment to First Outpatient Mental Health Service				
Population	**FY 15-16**	**FY 16-17**	**FY 17-18**	**FY 18-19**
Individuals with civil involvement discharged from State Mental Health Treatment Facilities	0-14 days	0-12 days	0-15 days	0-44 days
Adults who are homeless	0-16 days	1-32 days	0-29 days	0-35 days
Children who are homeless	0-7 days	0-22 days	4-21 days	0-19 days
Pregnant women	0-15 days	0-6 days	0-6 days	0-23 days
Individuals involved in the child welfare system	0-45 days	0-59 days	6-43 days	0-28 days
Adults involved in the criminal justice system	0-13 days	0-30 days	0-29 days	0-24 days
Children involved in the juvenile justice system	0-16 days	0-30 days	4-46 days	0-25 days
All other adults	2-98 days	2-68 days	6-82 days	0-67 days
All other children	0-33 days	1-29 days	6-21 days	0-21 days

The implementation of Mobile Response Teams and the expansion of telehealth services represent important advances in access to less restrictive services. Managing Entities are also using multidisciplinary teams and, in some instances, increasing in-home and onsite counseling services as alternatives to residential treatment.

VI. USE OF EVIDENCE-INFORMED PRACTICES

Section 394.4573, F.S., calls for a description of the extent to which providers use evidence-informed practices. A variety of different evidence-informed practices are used within the Managing Entities' provider networks. All Managing Entities provided extensive lists which are available online at www.myflfamilies.com/service-programs/samh/publications/. What is unknown is the extent to which these evidence-informed practices are available and at what level of fidelity.

Since Managing Entities cover large geographic areas and contract with multiple providers, it may be that only one provider offers the evidence-informed practice, or it may only be available in one county. Level of adherence to the model, also known as fidelity, is also not assessed. Provider staff may have been trained in an evidence-informed practice, but whether the model is implemented to fidelity is not known.

VII. REGIONAL EVALUATION OF ENHANCEMENT PLANS

Section 394.4573, F.S., directs the Department to include an evaluation of each Enhancement Plan submitted by the Managing Entities. The Department's Regional Offices reviewed the seven Managing Entity Enhancement Plans, and all generally agreed that they adequately describe strategies for enhancing services, target populations, counties to be served, service targets, and the specific services to be purchased. They also generally agreed that the proposed budgets address the unmet needs, that the expected outcomes address the problem, and that the action steps listed will lead to strategy implementation. The strengths and weakness identified are listed in Table 8 below.

Table 8: Regional Department Office Review of Managing Entity Enhancement Plans

Managing Entity	Enhancement Plan Strengths	Enhancement Plan Weaknesses
Big Bend Community Based Care (BBCBC)	• Provides the top priorities on the plan that are reported by community stakeholders, community providers, and statistical data that align with the unmet needs of the region. • The plan adequately describes the target population and counties to be served through the priorities. • The plan describes clearly the service targets within the plan. • The plan includes the action plans to address each priority within the plan. • The plan includes the budgets to address the priorities within the plan.	• The only weakness determined by the region in relation to the plan is the fact that the budgets for each priority does not list/describe the service capacity units; minimum required service level units; proposed rates; and covered services are not listed for each priority (within their budgets for each priority).
Broward Behavioral Health Coalition (BBHC)	• The plan addresses the needs assessment conducted in 2016 and what has been identified collectively by the Broward County stakeholders and community to date. The plan is in alignment with the statewide initiative to reduce families in crisis and prevent re-entry.	• While BBHC addresses housing in this plan, it is important to emphasize the need for affordable and permanent housing for individuals with a behavioral health disorder in Broward County.
Central Florida Behavioral Health Network (CFBHN)	• The enhancement plan addresses the needs from both the Needs Assessment and ongoing regional counsel input on local needs to date. The plan adequately describes the target population and counties to be served through the priorities, as well as services and action steps. The services such as CAT and FACT teams would help with the Department's goal to reduce those in crisis and the prevention services would help contribute to the Department's goal to increase pre-crisis contacts.	• The strategies in priority 3 (housing) could extend beyond additional vouchers and staffing needs at CFBHN.
Central Florida Cares Health System (CFCHS)	• It acknowledges and addresses gaps in the system of care that are absolutely needed.	• Compared to a couple other plans, this one is not as specific in regard to separating the services according to program area and it does not outline as many enhancements.
Lutheran Services Florida Health Systems (LSFHS)	• The plans all well aligned with feedback gleaned from the multiple Regional Barrier Breaker, Partnership, Consortium, Community and Stakeholder forums attended throughout Region, as well as assessments and surveys mentioned. The strategies and measures are critical to support the Secretary's Wildly	• The enhancement plan had to be completed before the triennial needs assessment was completed.

Managing Entity	Enhancement Plan Strengths	Enhancement Plan Weaknesses
	Important Goal and the NER SAMH WIG to reduce the number of crisis re-entries by 10% by June 2021.	
Southeast Florida Behavioral Health Network (SEFBHN)	• Reflective of areas of needs. • Concise strategy descriptions for each priority. • The plan is focused on many critical areas of need.	• Needs increased peer support services. • Needs affordable housing and permanent housing. • Needs increased substance use disorder treatment services for Okeechobee County.
South Florida Behavioral Health Network (SFBHN)	• The plan does address the current needs of the community in terms of addressing early intervention and housing/care coordination.	• SFBHN used the Plan as an opportunity to enhance the functional capacity at the Managing Entity by requesting additional administrative dollars for staff, though the intent of the Enhancement Plan is to address service delivery needs.

VIII. CONCLUSION:

A variety of priority needs were reported by the Managing Entities, though the most frequently identified need was for intensive, community-based, multidisciplinary, team-based services. Housing was the second most commonly identified need. The Department may use the priority needs and associated enhancement plans to develop Legislative Budget Requests in the future, in accordance with s. 394.9082(8), F.S. The Managing Entities continue to report progress toward the development of NWD models and recovery-oriented and peer-involved approaches to service delivery. Especially notable is their commitment to ROSC and increasing access to peer-involved approaches. That said, several opportunities for improvement are noted.

In terms of assessing the implementation of NWD models, it appears that most stakeholder feedback was ascertained from service providers. It is recommended that the Managing Entities emphasize community perspective, specifically that of individuals trying to access the system of care. Service providers can give important insight into how they incorporate the model into practice and how well they work together to refer individuals and conjointly serve them. However, they are not poised to report on the user experience. It is important to hear from referring entities, such as law enforcement, the courts, schools, child welfare, and consumer groups such as NAMI, to gain their perspective on access to behavioral health services.

In future, it may be beneficial to explore the availability of evidence-based practices in more detail. Adding the counties and capacity for number of individuals served will provide a more comprehensive picture of actual availability. Additionally, asking providers how they monitor adherence to the practice model as well as frequency of trainings would provide an indication of fidelity.