Thriving Mind South Florida
2025 Needs Assessment

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October 1, 2025

To Our Community,

Thriving Mind South Florida (Thriving Mind) is pleased to announce the release of the 2025 Triennial Behavioral Health Needs Assessment. This Needs Assessment was conducted with robust input from individuals served, community stakeholders, peers, families, and Network Service Providers (NSPs). It also included data from multiple state and local sources. The Needs Assessment process used surveys, interviews and focus groups to gain insights from all sources. The assessment analyzed service capacity, identified gaps and opportunities, and provides a resource that can be used to inform our strategic plans and other priorities.

Thriving Mind is the nonprofit Managing Entity (ME) that funds and oversees a safety net of mental health and substance use disorder treatment and prevention services for uninsured and underinsured adults and children in Miami-Dade County (Circuit 11) and Monroe County (Circuit 16), supported by the Florida Department of Children and Families (the Department) and other public and private sources. Thriving Mind provides administrative support, payer-of-last-resort service, quality improvement and payer-level care coordination, as well as collection and analysis of systemwide data for a network of approximately 44 treatment and prevention healthcare provider organizations. Thriving Mind is a cost-effective, evidence-based payer that operates with administrative overhead of approximately 4.04 percent, to maintain safety net services for a catchment area of more than 2.8 million residents. Our mission is to ensure that families and individuals affected by mental health and substance use disorders can readily access innovative, effective, and compassionate services that lead to health and recovery.

As part of Thriving Mind's contractual commitments to the Department, a comprehensive Triennial Behavioral Health Needs Assessment is completed, supplemented by annual Enhancement Plans that report year-by-year evolution of community needs. This current comprehensive Needs Assessment serves as a blueprint to guide planning for services offered through the regional coordinated system of behavioral health care supported by the Department through a contract to Thriving Mind. To assist in the development of the current Needs Assessment, Thriving Mind engaged Behavioral Science Research Institute (BSRI), a highly respected, competitively funded research and evaluation team. This Needs Assessment will serve as a foundation for modifications to our strategic plan to best support behavioral health needs in our community. Please let us know if you have questions or comments.

Sincerely,

John W. Newcomer, M.D.
President and CEO

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2025 Triennial Needs Assessment
Executive Summary

Thriving Mind South Florida (Thriving Mind) is pleased to announce the release of the 2025 Triennial Behavioral Health Needs Assessment. The Needs Assessment included robust survey engagement, followed by highly-attended in-person community engagement via focus groups and in-person meetings. This process included individuals served, community stakeholders, peers, families, and Network Service Providers (NSPs).

Thriving Mind provides services to Florida under a competitive contract from the Department of Children and Families (the Department). Under our contract with the Department, Thriving Mind delivers broad community engagement to measure effectiveness and track unmet needs, including this 2025 Triennial Behavioral Health Needs Assessment.

Thriving Mind is a high-performance non-profit (less than 5% overhead), working closely with the Department and the Florida Office of Attorney General to support uninsured individuals and families with behavioral health and substance use, as well as victims of violent crime. In addition, as required by contract with the Department, we successfully build sustainability for many years with external local, federal and philanthropic funding.

The 2025 Triennial Needs Assessment for Thriving Mind South Florida, the Managing Entity (ME) serving Miami-Dade and Monroe Counties, usefully informs on community needs regarding service capacity, gaps and opportunities. Under our contract with the Department, we use this resource in collaboration with the Department to inform plans and priorities.

This important assessment was conducted over nine months and integrates all of the above plus multiple external data sources, including socio-economic and health indicators. For example, Thriving Mind Individuals Served data (Fiscal Years 2020–2024) included three major surveys, 13 focus groups, and three community town hall sessions (made available virtually and in-person). This multi-method approach ensured that findings reflected both quantitative trends and lived experiences of service providers, persons served, and stakeholders.

Regional Context

The Southern Region is home to nearly 2.8 million residents, with a diverse population facing significant disparities in housing affordability, income distribution, and access to care. While educational attainment and income levels have risen since 2019, the cost of living — particularly housing — has outpaced wage growth. Rent burdens affect more than half of all households, and unhoused individuals, though reduced statewide over the past two decades, remain a pressing challenge in South Florida due to escalating housing costs.

The behavioral health landscape reflects both strengths and areas of concern. Miami-Dade County generally reports more favorable adult mental health outcomes than state averages, while Monroe County shows disproportionately high hospitalization and suicide rates among adults, especially older adults. Youth indicators have improved in both counties, with notable reductions in reported depression and suicidal ideation; however, early substance use, vaping, and risky behaviors remain areas of concern.

Service System and Individuals Served Demographics

Between Fiscal Years 2020-2024, Thriving Mind-funded organizations served more than 106,000 individuals served for treatment services, the majority residing in Miami-Dade. Adults represented nearly 80 percent of individuals served, with higher engagement in Adult Mental Health and Adult Substance Use programs. The individuals served population is racially and ethnically diverse, with over half identifying as Hispanic, though this proportion remains below the service area's overall Hispanic representation. Individuals served experience disproportionately high unemployment and lower educational attainment compared to the general population; 6 percent reported being unhoused at the time of service.

Key Findings

Awareness and Stigma: Surveys and focus groups revealed low public awareness of available behavioral health services, particularly outside crisis situations. Stigma, cultural barriers, language access limitations, and mistrust of institutions hinder help-seeking.

Access and Referrals: Strengths include strong perceptions of Thriving Mind as a resource hub and effective referral coordination within the ME network. Barriers include transportation, housing instability, insurance complexity, long waitlists for certain services (especially youth), and limited multilingual capacity.

Care Coordination: Providers reported high agreement on having strong coordination processes, but gaps remain due to underfunding for evidenced-based Care Coordination, siloed operations, inconsistent communication, and high staff turnover, especially in high-cost areas such as Monroe County.

Children's Services: Schools serve as key access points, and embedded services are valued. Barriers include lengthy enrollment processes, limited services for neurodivergent youth, and shortages of specialized staff.

Suicide Prevention: While multiple prevention resources exist, gaps in adult public awareness and peer-specific outreach persist. Significant underfunding exists for suicide prevention.

Peer Support: Highly valued for engagement and continuity of care, but peers face role confusion, underutilization, and stigma within organizations.

Behavioral Health and Housing: Housing instability is seen as both a barrier to and determinant of behavioral health outcomes. Providers describe systemic eligibility challenges, high costs, and limited supportive housing options.

Community Engagement Themes

Town hall participants affirmed housing as central to behavioral health, expressed concern over long waitlists (especially for adolescents), highlighted the undervaluation of peer specialists, and called for stronger interagency collaboration. Some perceived data as underestimating housing issues and overstating youth services capacity. Recommendations emphasized housing expansion, navigation support, family engagement, peer role elevation, and system-wide care coordination.

Priority Recommendations

Suicide Prevention -- While multiple prevention resources exist, gaps in adult public awareness and peer-specific outreach persist. Significant underfunding exists for suicide prevention.

Housing – Expand affordable and supportive housing options, improve Independent Living Facility (ILF[1])/Assisted Living Facility (ALF) oversight, and integrate behavioral health needs into housing eligibility. While Thriving Mind prioritizes housing concerns, our role as a Managing Entity is limited by funding and statute. For context, the term "ILF" is often used to refer to shared-housing living arrangements, which are not regulated by any entity, and are common in Miami-Dade County. Shared-housing living arrangements are not required to provide any kind of oversight or supervision. Individuals living in these types of living arrangements are expected to have the skills to live independently. NSPs often place individuals, upon discharge, in shared housing due to lack of affordable housing options.

Navigation and Awareness – Develop accessible resource guides, expand outreach via social media and community events, and leverage ride-share partnerships to address transportation barriers.

Family and School-Based Engagement – Increase parent education, enhance school partnerships, and implement teacher training in mental health identification.

Peer Support – Standardize training, supervision, and role definitions; address stigma and ensure equitable compensation.

Care Coordination – Strengthen cross-agency communication, reduce administrative barriers, and develop shared protocols for warm handoffs.

The data and community input presented in this assessment highlight both the complexity and the opportunity within the Southern Region's behavioral health system. Sustained investment in housing, workforce capacity, coordination, and culturally responsive services will be essential to meeting current needs and preparing for future challenges.

[1] ILF is a term that is recognized and widely used in the senior housing and long-term care industry. However, it is not official terminology for all age groups in the behavioral health system of care. Some experts use it to describe shared-housing arrangements where individuals are expected to have the skills to live independently. NSPs may place people in such housing due to limited affordable options. Despite their prevalence in Miami-Dade County, ILFs are unregulated and provide no required oversight or supervision.
Focus group participants used the term ILF on their own when discussing housing challenges and their impact on behavioral healthcare. They described it as distinct from an ALF. While we cannot be sure whether they meant ILF as a broader label for shared housing, their usage – as if it were a defined category – highlights the lack of clarity surrounding these terms.

Introduction

Within the Florida Department of Children and Families (the Department) is the Office of Substance Abuse and Mental Health (SAMH). SAMH is the state's sole legislatively designated authority on mental health and substance use.

In accordance with section 394.4573, Florida Statutes (F.S.), the Department must submit an annual assessment to the Governor, President of the Senate, and Speaker of the House of Representatives that provides an Assessment of Behavioral Health Services in the state. The Managing Entities Triennial Needs Assessment, augmented by annual enhancement plans, inform the Department regarding regional needs.

The statute emphasizes the need for continuity of care, especially for those transitioning between different levels of care or service providers. It also highlights the importance of a multidisciplinary approach and cooperation between various state agencies, community-based organizations, and service providers to ensure that individuals receive the necessary support and resources to aid their recovery and improve their overall well-being.

To enhance access to behavioral health services and improve care coordination across providers and service levels, the Florida Legislature mandated that the Department contract with nonprofit, community-based organizations known as the Managing Entities (MEs). These organizations work with local providers to ensure individuals receive timely care and prevent gaps in services.

The Needs Assessments submitted to SAMH by the MEs identify the most significant behavioral health priorities for each region, proposed strategies to implement, and resources required. As required by section 394.4573, F.S., all documentation submitted by MEs to the Department are included in the Appendix.

Florida Managing Entities

Under section 394.9082, F.S., SAMH is responsible for overseeing the performance of seven Managing Entities (MEs). The MEs are not-for-profit organizations that manage the delivery of behavioral health services within each of the Department's seven regions. The behavioral health services managed by the MEs include assessments, outpatient therapy for mental health and substance use, case management, residential services, peer support, crisis stabilization services, and other social supports such as supported housing, supported employment, peer-run organizations, and vouchers for essentials like transportation, clothing, or education. Individuals struggling with serious mental health disorders and/or substance use disorders are among the state's most vulnerable populations.

Furthermore, the MEs are tasked with the following statutory responsibilities:

- Establish a comprehensive network of qualified behavioral health providers sufficient to meet the needs of the region's population.
- Implement a coordinated system that facilitates prompt information sharing among providers, referral agreements, and shared protocols to ensure improved health outcomes.
- Collaborate with public receiving facilities and housing providers to support individuals and prevent inpatient readmissions.

- Develop strategies to divert youth and adults with mental health disorders and/or substance use disorders from the criminal and juvenile justice systems, while integrating behavioral health services with the Department's child welfare system.
- Promote care coordination across the network and monitor provider performance to ensure compliance with state, federal, and grant requirements.
- Build and maintain relationships with local stakeholders, such as government entities (e.g., county or city commissions), community organizations, and the families of those served.
- Manage funds and explore additional funding sources, such as grants and local matching funds.

The 2025 Triennial Needs Assessment for Thriving Mind South Florida, (The Southern Region) was completed over nine months and included data collection and stakeholder analysis using surveys, focus groups, and town hall-style feedback sessions. The following report covers an overview of the Southern Region and data from the specific Thriving Mind Individuals Served-base over four Fiscal Years (2020-2024), Network Provider Survey, Persons Served Survey, Stakeholder Survey, 13 focus groups, and three town hall presentations.

Thriving Mind South Florida Service Area Profile

This section of the report provides an overview of key socioeconomic trends within the Southern Region (Thriving Mind) target population, including residents of both Monroe and Miami-Dade counties. The data encompasses various factors such as population growth, educational attainment, income levels, housing stability, unemployment, and being unhoused. All information has been collected from reputable sources, including the U.S. Census Bureau, United for ALICE, the Bureau of Labor Statistics and Florida's Council on Homelessness, to ensure accuracy and reliability in understanding the region's evolving social and economic landscape.

Population Trends

The population served by Thriving Mind (Miami-Dade and Monroe counties) has remained relatively stable from 2019 to 2023. During this period, the population experienced a slight decrease of approximately 0.85 percent. In 2019, the population was nearly 2.8 million, but it gradually declined until 2021. The population then increased in 2022 and 2023, indicating a potential growth trend for upcoming years. *Source: U.S. Census Bureau. (Years 2019-2023). American Community Survey 1-Year Estimates, Table DP05: ACS Demographic and Housing Estimates.*

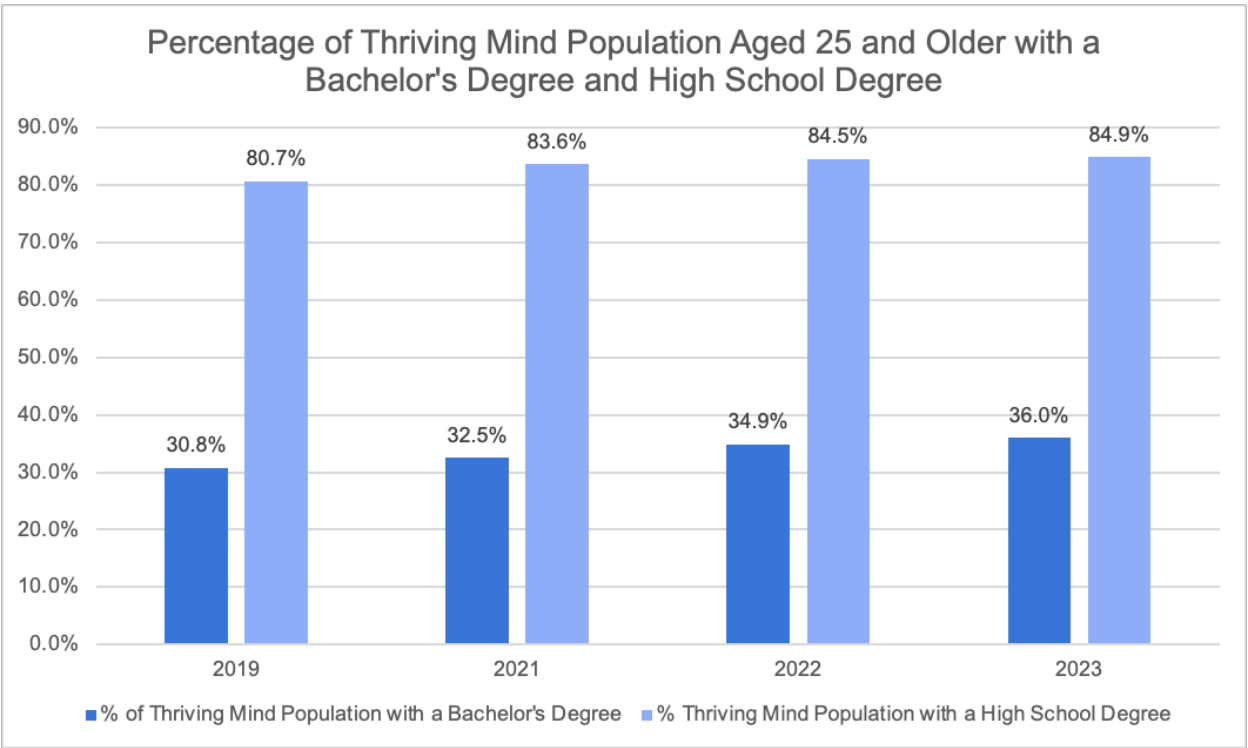
Educational Attainment

Between 2019 and 2023, the combined data for the Southern Region's population, reveals a positive trend in educational attainment among individuals aged 25 and older. The percentage of residents with a bachelor's degree increased from 30.8 percent to 36.0 percent from 2019 to 2023, indicating a growing emphasis on higher education across the region. High school graduation rates also reflected improvement, with the combined percentage rising from 80.7 percent to 84.9 percent from 2019 to 2023.

While Monroe County shows a higher percentage of high school graduates at approximately 93 percent in 2023, Miami-Dade County's increasing rates in bachelor's degree and high school

degree attainment highlight the ongoing efforts to enhance educational opportunities in a diverse population.

Graphic 1. Percentage of Thriving Mind Population with bachelor's degree and high school degree

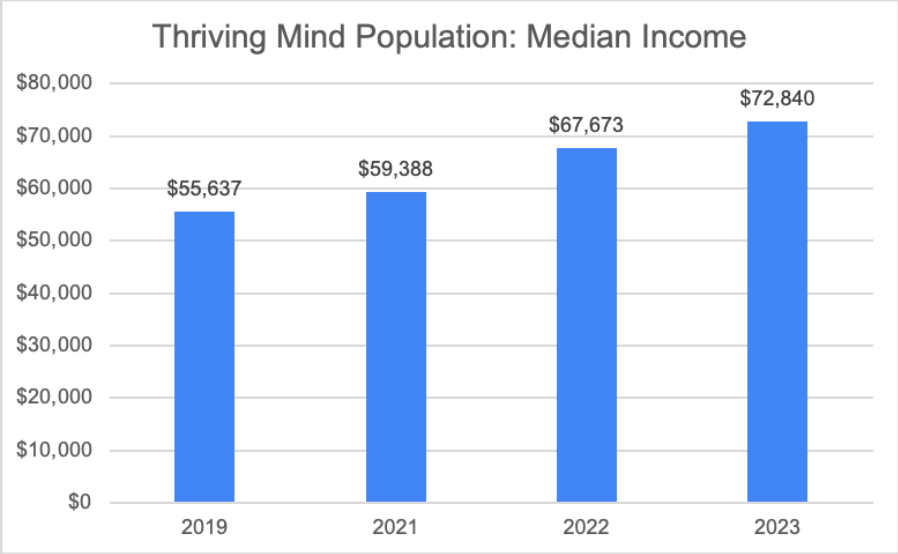


Data for the year 2020 was not available due to the pandemic.
Source: U.S. Census Bureau. (Years 2019-2023). American Community Survey 1-Year Estimates, Table DP02: Selected Social Characteristics in the United States.

Median Income

When examining the growth in income for both Miami-Dade and Monroe counties, there has been an upward trend from 2019 to 2023. The mean income increased from $55,637 to $72,840, resulting in a percentage increase of approximately 30.9 percent

Graphic 2. Thriving Mind Population Median Income



Data for the year 2020 was not available due to the pandemic.
Source: U.S. Census Bureau. (Years 2019-2023). American Community Survey 1-Year Estimates, Table DP03: Selected Economic Characteristics.

Housing Instability and the Unhoused

Between 2019 and 2023, 51.6 percent to 55.4 percent of households in the region were rent-burdened, spending more than 35 percent of their income on housing. Both Miami-Dade and Monroe counties face housing shortages and rising costs. The primary factor driving the recent rise in being unhoused is Florida's escalating housing costs. Between 2020 and 2023, median rents in the state increased by 30 percent, from $1,187 to $1,545, far outpacing wage growth and placing an increasing burden on low- and moderate-income households (Florida Council on Homelessness, 2024).

As of March 2024, Miami had the highest average rent among Florida's major cities, exceeding $2,500, roughly 18 percent higher than the statewide average of $2,115 (Florida Council on Homelessness, 2024).

Unhoused Individuals

Over the past two decades, Florida has led the nation in reducing individuals being unhoused, demonstrating the potential of coordinated strategies and targeted investments. From 2007 to 2023, the state achieved a 36 percent reduction in being unhoused despite significant population growth — a figure that translates to a 47 percent decline when adjusted for population increases (Florida Council on Homelessness, 2024). However, this progress has recently slowed primarily due to Florida's escalating housing costs. Between 2020 and 2023, median rents in the state increased by 30 percent, from $1,187 to $1,545, far outpacing wage growth and placing an increasing burden on low- and moderate-income households (Florida Council on Homelessness, 2024). This trend is especially pronounced in South Florida. As of March 2024, Miami had the highest average rent among Florida's major cities, exceeding $2,500, roughly 18 percent higher than the statewide average of $2,115 (Florida Council on

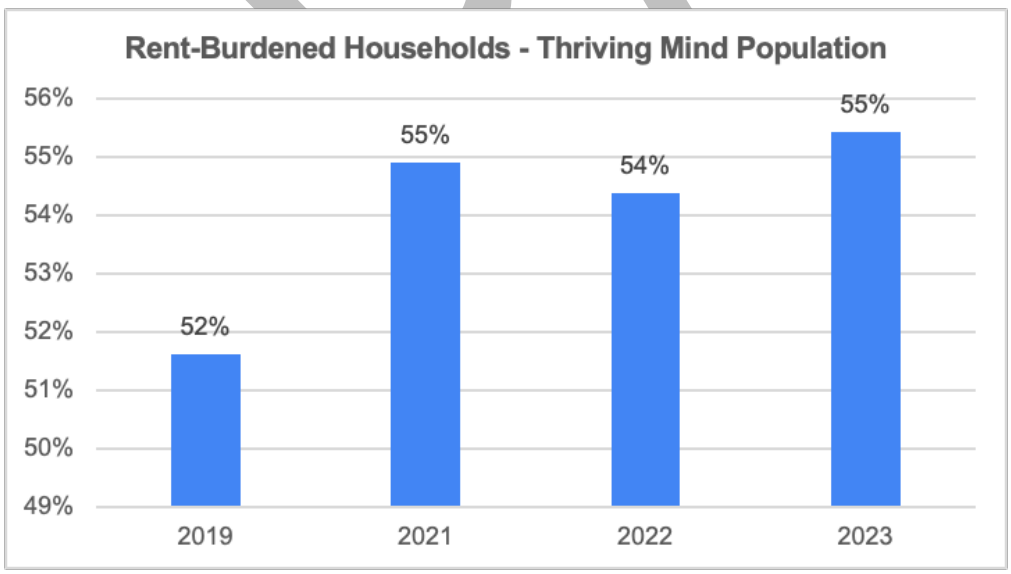
Homelessness, 2024). Although rental prices have recently begun to stabilize, housing remains unaffordable for many, particularly those earning less than 30 percent of the area median income (AMI), referred to as extremely low-income (ELI) households.

Graphic 3. Continuum of Care Funding from Federal and State Sources, Miami-Dade and Monroe (Fiscal Year 2023-2024)

Source	Miami-Dade & Monroe
Total Funding Award	$49,633,517.82
HUD Continuum of Care Fiscal Year 2023-2024	$46,996,387.00
State Total	$2,636,130.82
State Challenge	$1,683,011.12
State Staffing	$371,789.70
Emergency Solutions Grant	$503,498.00
State Temporary Assistance for Needy Families (TANF)	$78,832.00

Source: 2024 Florida's Council on Homelessness Annual Report

Graphic 4. Rent-burdened households

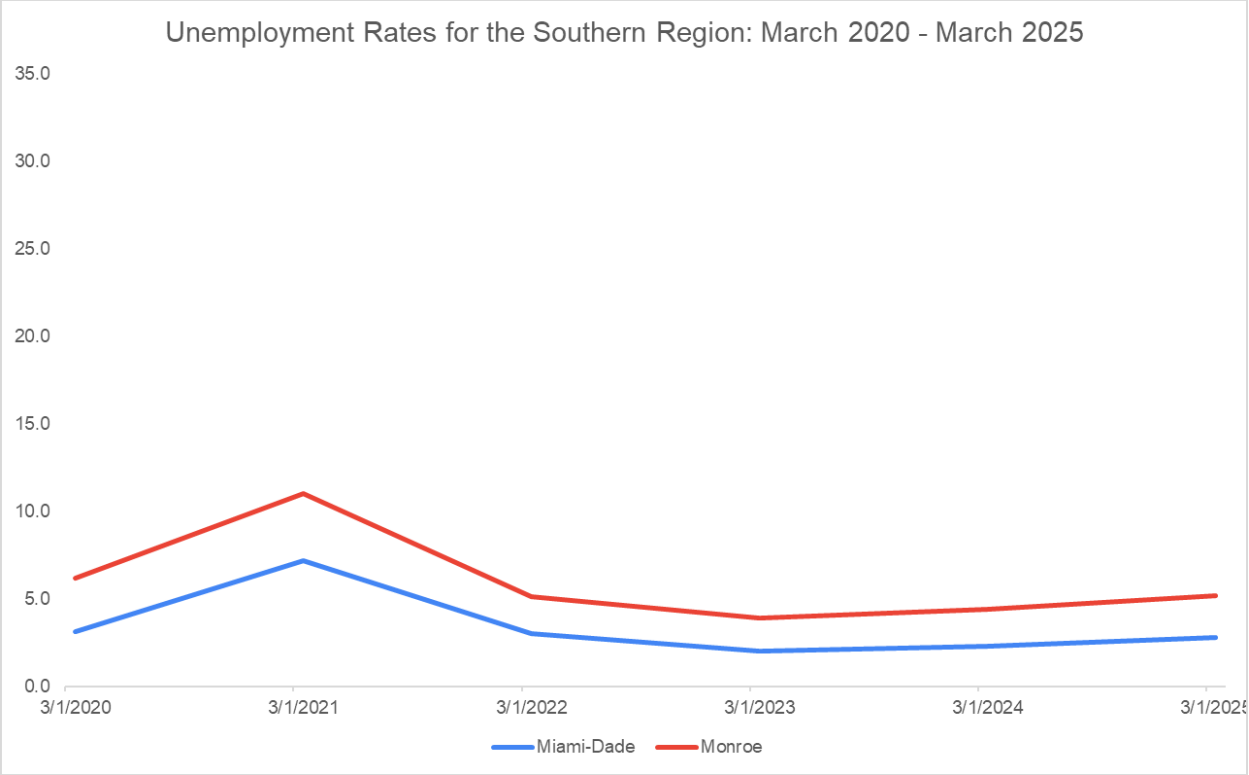


Data for the year 2020 was not available due to the pandemic.
Source: U.S. Census Bureau. (Years 2019-2023). American Community Survey 1-Year Estimates, Table DP04: Selected Housing Characteristics.

Unemployment

The unemployment trends in the Thriving Mind population display a clear V-shaped recovery, with both regions experiencing a sharp increase in unemployment rates during spring 2020 due to the COVID-19 pandemic, followed by a steady decline throughout 2021 and 2022. Over time, the rates in both counties have converged, gradually aligning around 1.8 percent to 2.5 percent by late 2024 and early 2025, reflecting a synchronized recovery in the local labor markets. This rapid decline from over 20 percent in the initial months of the pandemic to below 3 percent demonstrates strong economic resilience and effective recovery efforts, indicating a swift bounce-back and stabilization in employment levels across the region.

Graphic 5. Unemployment Rates for the Southern Region



Source:
FRED, Federal Reserve Bank of St. Louis. (Years 2020-2025). Unemployment rate for Miami-Dade, FL and Monroe County, FL. Retrieved May 14, 2025, from https://fred.stlouisfed.org/series/FLMIAM6URN

General behavioral health landscape

Mental Health

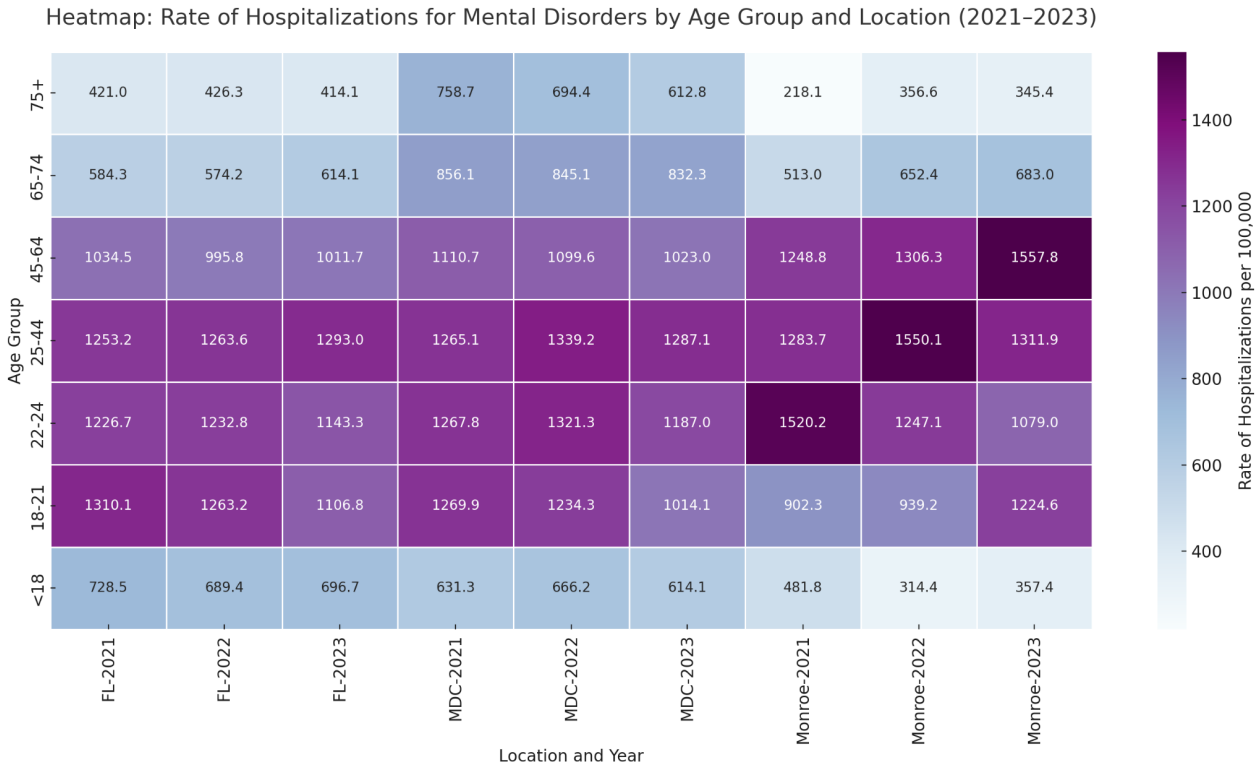
Compared to national data, Florida performs slightly better in adult mental health indicators. In 2021, Florida's depression rate was 17.8 percent versus 21.7 percent nationally, and the rate of frequent mental distress was 15.0 percent compared to 15.9 percent nationally, placing the state in the 1st and 2nd quartiles, respectively. However, disparities within Florida are notable.

Miami-Dade County typically reports better adult mental health outcomes than the state, with consistently lower hospitalization rates (e.g., a total rate of 407.9 in 2021 declining to 381.0 in 2023) and fewer adults reporting poor mental health. In contrast, Monroe County has seen sharp increases, especially in hospitalization rates for adults aged 18–24 (from 552.8 in 2021 to 719.4 in 2023) and adults aged 25–44 (from 561.8 in 2021 to 813.1 in 2023). Among youth, Miami-Dade showed higher distress in earlier years (e.g., 50.1 percent reported feeling depressed or sad in 2021) but has since improved (to 38.5 percent in 2023). Meanwhile, Monroe youth have shown substantial gains, with only 32.2 percent reporting frequent sadness in 2024 (down from 41.4 percent in 2021), and significant drops in feelings of failure (from 27.6 percent in 2021 to 19.9 percent in 2024).

Serious Mental and Emotional Illnesses

Long-term trends in serious mental and emotional disorders across Florida show a consistent and high burden, particularly for adults, with increasing disparities at the county level. According to the Florida Department of Health, statewide emergency department visits and hospitalizations related to mental health disorders remain elevated, with rates of 925.7 per 100,000 for both in 2023. Adults aged 18-64 consistently display the highest hospitalization rates, with individuals aged 25-44 in Florida reaching 1,293 per 100,000 in 2023. Youth rates are lower overall but still significant, especially in emergency visits. Notably, Monroe County's adults aged 25-44 experience some of the highest rates statewide, with hospitalizations reaching 1550.1 in 2022 and 1311.9 in 2023 — both exceeding those of Miami-Dade and the state average. Miami-Dade reported hospitalization rates comparable to those at the state level.

Graphic 6. Rate of hospitalizations for mental health disorders by age group



Source: FLHealthCHARTS

Additional data on specific psychiatric disorders underscores the urgency of targeted interventions in South Florida. Compared to data from Florida and Monroe County, Miami-Dade shows particularly high hospitalization rates for schizophrenia. In contrast, Monroe County exhibits very high hospitalization rates related to drug and alcohol-induced mental disorders, particularly among adults aged 45-64.

Suicide

Over the past three years, suicide trends in Florida have shown a modest increase at the state level, with the age-adjusted suicide death rate rising from 13.77 per 100,000 in 2021 to 14.08 in 2023. This figure remains slightly below the U.S. national rate of 14.5 in 2021. However, Monroe County's age-adjusted suicide rate stands out, nearly doubling from 16.31 in 2021 to 31.55 in 2023 — more than double the state average and over four times higher than the rate in Miami-Dade, which remained low and stable (7.29 to 7.72 per 100,000). Age-specific data reveal that in Florida, adults over the age of 45 account for the highest suicide rates, with those 75 and older reaching 24.0 per 100,000 in 2023. Similarly, Monroe County shows extremely high rates among older adults, including 80.6 per 100,000 for those 75+ in 2023, further highlighting the vulnerability of aging populations in that region.

Youth trends reveal widespread distress and a persistent risk of suicidal ideation and behavior, though with some variation over time and across counties. According to the Florida Youth Substance Abuse Survey (FYSAS), the percentage of students in Florida who reported attempting suicide decreased from 8.1 percent in 2021 to 7.3 percent in 2023. Additionally, the percentage of students who reported thinking that life is not worth it declined from 33.2 percent in 2021 to 26.9 percent in 2024. Miami-Dade County followed a similar pattern, with students who had seriously considered suicide decreasing from 14.4 percent in 2021 to 10.6 percent in 2024, and suicide attempts also declined. Similarly, Monroe youth reported decreased suicidal ideation (29.7 percent in 2021 to 19.6 percent in 2024) and attempts (5.5 percent in 2024). Despite improvements in reported youth mental health indicators, Monroe County remains a critical area for intervention due to alarming adult suicide rates and ongoing vulnerability among specific youth subgroups.

Adult Alcohol and Substance Use

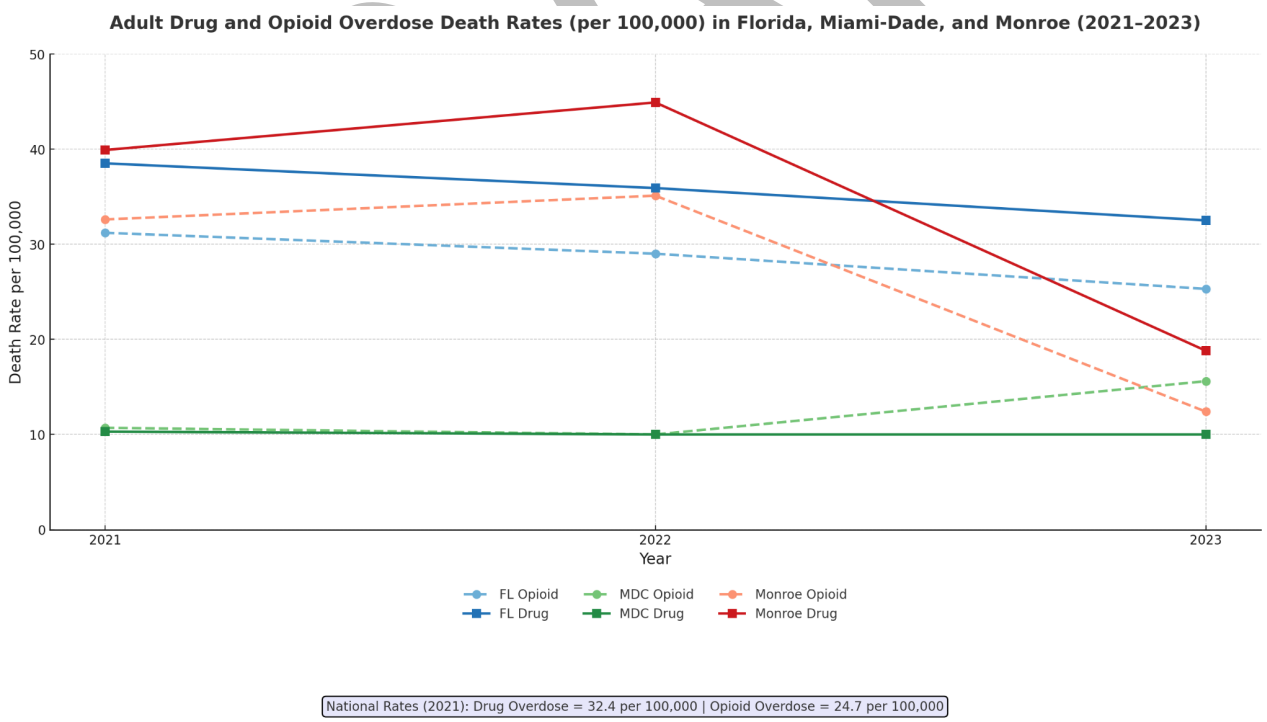
Florida's adult tobacco use rates, particularly for smoking and e-cigarette (vaping) use, show favorable trends compared to national figures. According to the Behavioral Risk Factor Surveillance System (BRFSS), Florida ranks in the top quartile nationally for both smoking (11.3 percent in 2022, decreasing to 10.5 percent in 2023) and e-cigarette use (6.1 percent in 2022, rising slightly to 7.6 percent in 2023), remaining below U.S. averages (smoking: 14 percent and e-cigarette use: 7.7 percent). Notably, in 2023, over 55 percent of current smokers in Florida attempted to quit at least once in the past year, indicating a strong interest in cessation and an increase since 2021, when only 53.9 percent attempted to quit.

In 2021, the percentage of adults in Florida who engaged in heavy, or binge drinking dropped from 18.2 percent in 2021 to 16.7 percent in 2023. Although this figure was lower than the national average (18.4 percent), the state still ranks in the 4th quartile for this indicator, placing 39th out of all states nationwide. Adult alcohol use in Florida remains a significant public health concern, especially regarding excessive drinking and alcohol-related injuries. Particularly, Miami-Dade County saw 18 alcohol-related motor vehicle fatalities in 2023 and 151 alcohol-related injuries, highlighting persistent risks in urban settings. Monroe County, while small in

population, reported 2 alcohol-related fatalities and 8 injuries in 2023, reflecting a disproportionately high burden per capita. Additionally, Monroe's alcohol-related crash count dropped from 46 in 2022 to 28 in 2023, but the fatality rate rose, suggesting possible severity of incidents or limited emergency response capacity.

Long-term trends indicate that adult substance use in Florida remains a significant public health challenge, with various indicators placing the state below national benchmarks. In 2022, 16.7 percent of Florida adults reported non-medical drug use, which is higher than the national average of 15.9 percent, positioning the state in the fourth quartile and ranking it 39th nationwide. Florida's opioid overdose death rate dropped from 31.2 per 100,000 in 2021 to 25.3 in 2023, while the overall drug overdose death rate fell from 38.5 to 32.5 per 100,000 during the same period. In 2023, Miami-Dade County reported lower annual age-adjusted death rates for drug and opioid overdoses compared to the state average. The overall drug overdose death rate in Miami-Dade County increased from 14.6 per 100,000 in 2021 to 15.6, while Florida's rate was 32.5. The opioid death rate was 10.3 per 100,000, compared to Florida's 25.3. However, the number of non-fatal overdose emergency visits continues to rise, climbing from 2,171 in 2021 to 2,439 in 2023, representing a 12.3 percent increase. Miami-Dade County also led South Florida in stimulant-involved overdoses (130) and opioid-involved visits (494) in 2023. In contrast, Monroe County, despite its smaller population, showed a disproportionately high impact, with a drug overdose death rate of 39.9 per 100,000 in 2021, 44.9 in 2022, and a significant drop to 18.8 in 2023. Monroe County's opioid death rate was 35.1 per 100,000 in 2022 — more than triple Miami-Dade County's rate — and 18.8 in 2023.

Graphic 7. Adult drug and opioid overdose death rates



Source: FLHealthCHARTS

Youth Substance Use

Between 2021 and 2024, Florida saw steady declines in youth alcohol, tobacco, and other substance use, though early initiation and certain high-risk behaviors remain concerns. High school binge drinking fell from 6.7 percent to 4.4 percent, and lifetime alcohol use dropped from 33.6 percent to 26.9 percent, with Miami-Dade generally reporting slightly lower rates than the state and Monroe showing more variability and occasional spikes, especially in risky behaviors like drinking and driving. Tobacco and nicotine use, particularly vaping, also declined significantly statewide, with both Miami-Dade and Monroe showing similar downward trends, though early vaping initiation continues to warrant attention. Marijuana use decreased notably, with Miami-Dade reflecting stronger declines than Monroe, which maintains higher prevalence of vaping marijuana, Delta-8/10 THC use, and other substances like inhalants.

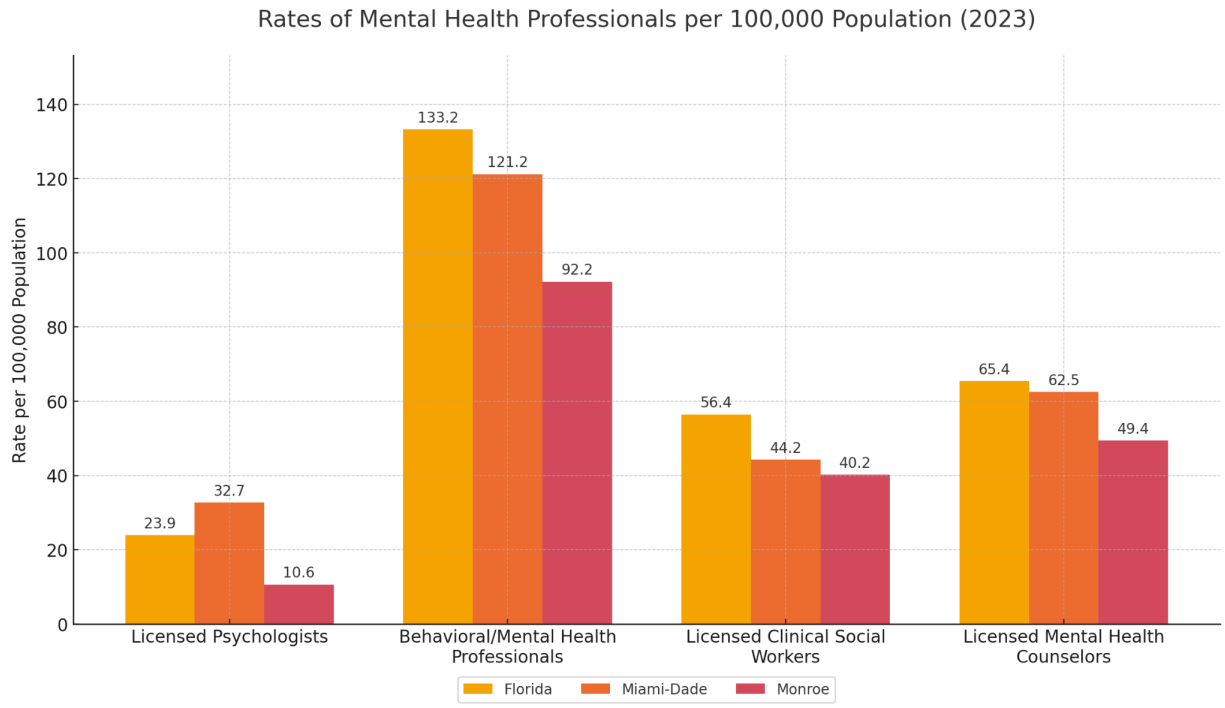
Despite these declines, several indicators suggest persistent challenges. Household exposure to substance use affects roughly one in five students statewide and more than a quarter in Monroe. Juvenile drug arrests rose statewide by more than 30 percent from 2021 to 2023, even as Miami-Dade saw decreases and Monroe's numbers remained stable. Treatment enrollments increased sharply at the state level, with Monroe showing extreme year-to-year fluctuations. Risk behaviors like riding with someone under the influence of marijuana remain common, underscoring the need for targeted, community-specific prevention strategies that address early initiation, household exposure, and access to emerging substances.

Access to Health Care and Infrastructure

In 2021, 13.3 percent of Florida adults avoided care due to cost, significantly higher than the national average of 10.1 percent, which placed the state in the 4th quartile and ranked it 43rd in the nation. Similarly, Florida's uninsured rate was 11.2 percent, compared to the U.S. average of 8.0 percent, ranking the state 46th out of 50. Although the percentage of adults with any healthcare coverage in Florida improved from 87.7 percent in 2021 to 89.1 percent in 2023, indicators of affordability and consistent care remain concerning. In 2023, 12.9 percent of adults reported being unable to see a doctor due to cost, and only 80 percent had a personal doctor. Nationally, 85.4 percent of adults report having a personal doctor, suggesting that Florida lags behind in primary care continuity.

The state also lags behind the nation in the availability of mental health providers. In 2022, the state reported 214.6 mental health providers per 100,000 population, which is significantly lower than the national rate of 324.9. This positions Florida in the fourth quartile and ranks it 42nd. Miami-Dade County, although better resourced than Monroe County, mirrors this statewide shortage. In 2023, Miami-Dade County had 121.2 behavioral health professionals per 100,000 and 32.7 licensed psychologists — more than the state rate of 23.9, but still far below the national benchmark of 45.4 psychologists per 100,000. Monroe County experiences even greater access issues, with just 92.2 behavioral/mental health professionals and 10.6 psychologists per 100,000 population (Source: FLHealthCHARTS).

Graphic 8. Rates of Mental Health Professionals by Population



Source: FLHealthCHARTS

Resource disparities are most pronounced in specialized care infrastructure. In 2023, Monroe County had no rehabilitation beds, no intensive residential treatment beds, and no child or adolescent psychiatric beds. In contrast, the same year, Miami-Dade County had 424 rehabilitation beds and a moderate supply of 644 psychiatric beds for adults (23.1 per 100,000), although this is still below the national average of 26.4 beds per 100,000 for adults. Overall, Florida had just 18.3 adult psychiatric beds per 100,000 people in 2023, compared to the U.S. average of 34.1. These gaps — especially in rural areas like Monroe — highlight unmet needs in mental health care delivery and emphasize the urgency of strengthening the mental health infrastructure across South Florida.

Thriving Mind Individuals Served Demographics

Population Served

Thriving Mind-funded organizations served more than 106,049 individuals over four fiscal years covered in this report: 2020-2021, 2021-2022, 2022-2023, and 2023-2024, serving between 24,000 and 29,000 unique individuals each year. The vast majority, over 90 percent, resided in Miami-Dade County (97,554 individuals), followed by Monroe County, which accounted for 8.0 percent of the total (8,495 individuals).

Adults made up 79.3 percent of the overall population served. Of these, 54.6 percent were enrolled in the Adult Mental Health program, 21.6 percent in the Adult Substance Use program, and 3.1 percent in the Co-Occurring Adult program. Among individuals served, 12.2 percent

participated in the Child Mental Health program, 7.9 percent in the Child Substance Use program, and 0.6 percent in the Co-Occurring Child program.

For the 2023-2024 Fiscal Year, program-specific, unique program area counts included:

Graphic 9. Individuals served by program area (Fiscal Year 2023-2024)

Program Area	# Served
Adult Mental Health	16,040
Adult Substance Use	7,250
Child Mental Health	3,210
Child Substance Use	2,444
Co-Occurring Adult	1,303
Co-Occurring Child	165

Gender

Men/boys represented the majority of population served in the Adult Substance Use, Children's Substance Use, Co-Occurring Adult, and Co-Occurring Child programs. They comprised 71.0 percent of Adult Substance Use individuals, 66.3 percent of Children's Substance Use individuals, 69.5 percent of Co-Occurring Adult individuals served, and 51.5 percent of Co-Occurring Child individuals. Women/girls accounted for more than 50 percent of individuals in the Adult Mental Health and Children's Mental Health programs, making up 50.7 percent and 53.4 percent of the population served, respectively.

Race

The majority of Thriving Mind individuals served were White, representing 64.5 percent of clientele, which was lower than the percentage in the service area population of 73.9 percent. Black individuals served accounted for 26.8 percent of the population served, despite representing only 17.6 percent of the population in the two-county service area.

Children's Mental Health individuals served more closely matched the racial distribution of the general population when compared to individuals served in other programs, with 72.5 percent of the clientele being White and 20.1 percent being Black. The percentage of multi-racial individuals served in all programs was higher when compared to the population in the service area.

Ethnicity

Hispanic individuals accounted for 54.0 percent of Thriving Mind individuals served, which is notably lower than their proportion in the service area population (68.8 percent). Similarly, Hispanic participation was consistently lower across all adult, child, mental health, and substance use programs, with rates ranging from 40.7 percent among Adult Substance Use individuals served to 57.4 percent among Children's Mental Health individuals served.

Age Range

Adults between 25 and 44 years old comprised the largest age group, making up 39.1 percent of Adult Mental Health individuals served, and 45.2 percent of Adult Substance Use individuals served, compared to just 27.5 percent in the general service area. Conversely, adults aged 65 and older represented only 7.4 percent of individuals served, despite comprising 16.8 percent of the general population.

Among children, those under age 5 made up less than 2 percent of Children's Mental Health and Children's Substance Use individuals served. Older teens (ages 15 to 19) were more prevalent in the Children's Substance Use program compared to Children's Mental Health.

Residential Status

A higher proportion of Adult Mental Health individuals served reported living independently, either alone or with others, compared to Adult Substance Use individuals served. Specifically, 37.0 percent of Adult Mental Health individuals served reported living independently, while only 18.5 percent of Adult Substance Use individuals served did so. When focusing on those living independently alone, 11.0 percent of Adult Mental Health individuals served fell into this category compared to 5.7 percent of Adult Substance Use individuals served.

Across all programs, 6.0 percent of individuals served reported being unhoused, with figures ranging from 7.9 percent in Adult Mental Health to 0.02 percent in Children's Substance Use. A notable portion of residential status data was reported as "Unknown," comprising 31.5 percent of Adult Mental Health individuals served, 47.0 percent of Adult Substance Use individuals served, 68.3 percent of Children's Mental Health individuals served, and 74.0 percent of Children's Substance Use individuals served.

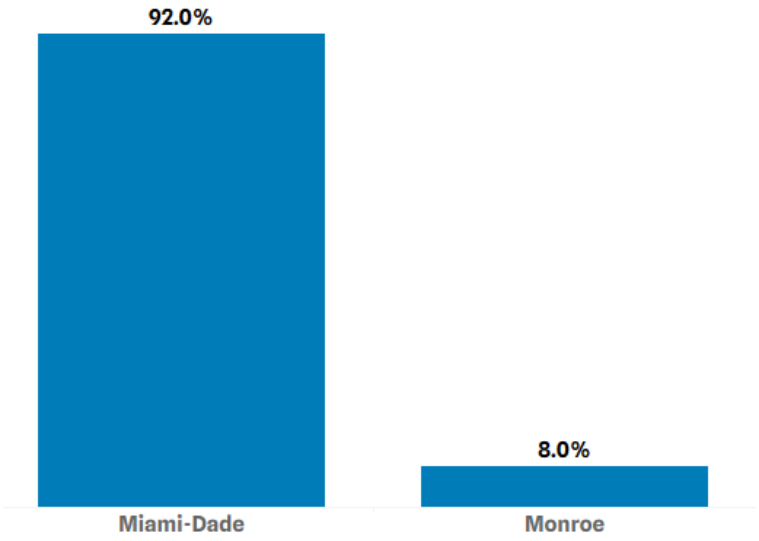
Educational Attainment

Thriving Mind individuals served generally had lower educational attainment compared to the service area population. Among adult individuals served, 35.3 percent of Adult Mental Health and 34.6 percent of Adult Substance Use individuals served had no education beyond a high school diploma. Across all adult individuals served, 35.1 percent had not completed education beyond a high school diploma, a rate significantly lower than that of the general population. Only 14.2 percent of adult individuals served reported pursuing higher education.

Employment Status

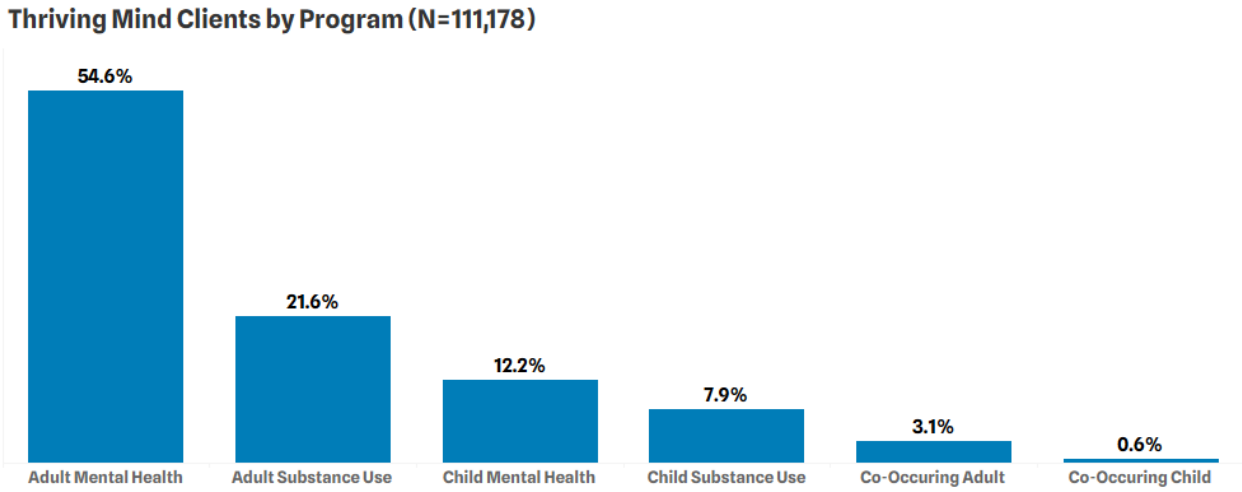
Unemployment rates among Thriving Mind individuals served were substantially higher than in the general service area. Overall, 25.4 percent of individuals served reported being unemployed, with rates reaching 38.3 percent among Adult Mental Health individuals served and 39.5 percent among Adult Substance Use individuals served. In contrast, the five-year estimated unemployment rate for the service area stood at just 2.8 percent (2019–2023).

Graphic 10. Thriving Mind Individuals Served by County



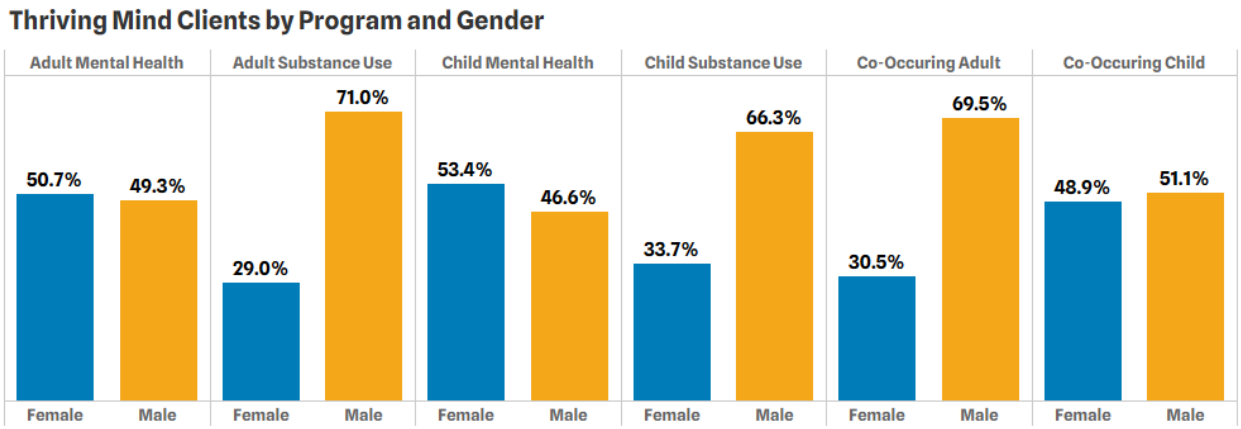
Source: Thriving Mind individuals served Data

Graphic 11. Thriving Mind Individuals Served by Program



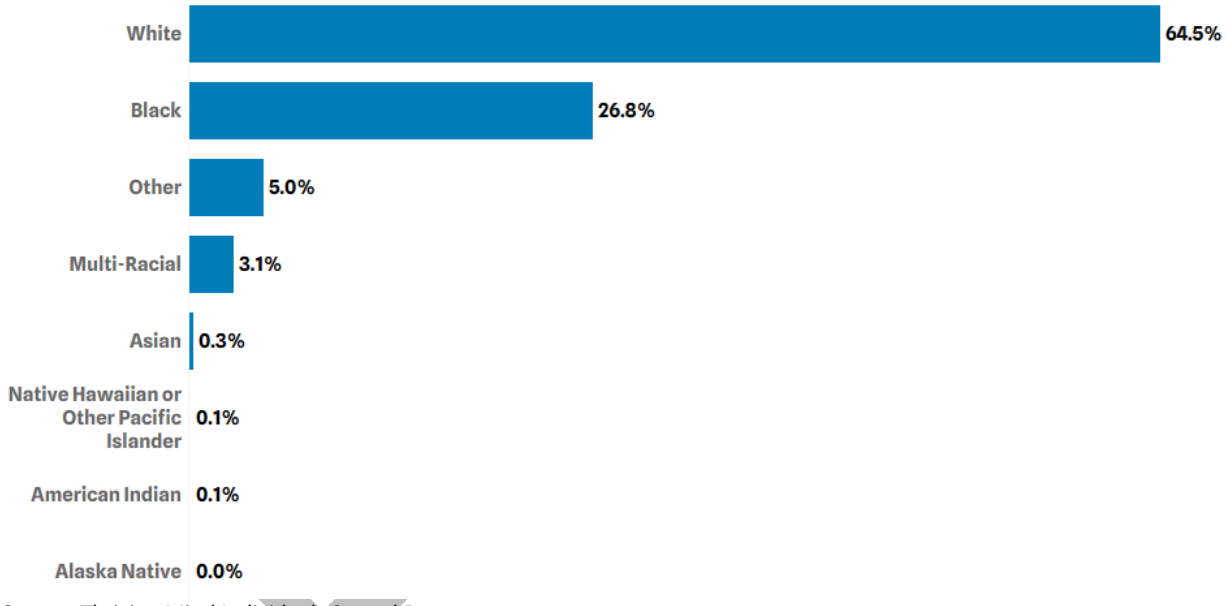
Source: Thriving Mind Individuals Served Data

Graphic 12. Thriving Mind Individuals Served by Program and Gender



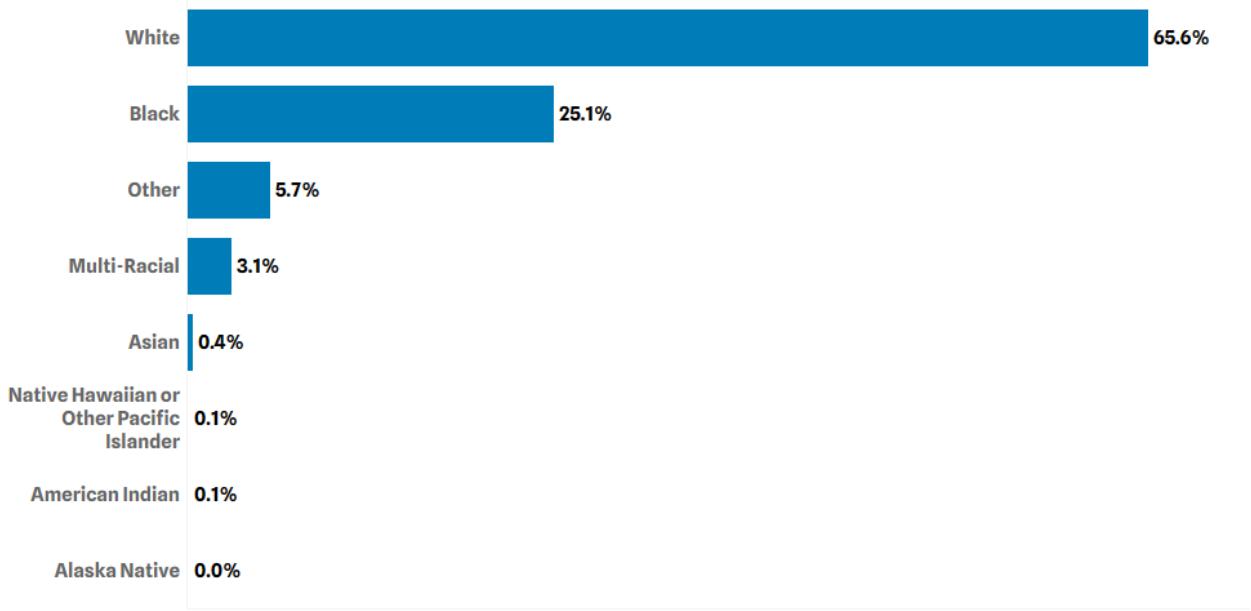
Source: Thriving Mind Individuals Served Data

Graphic 13. Thriving Mind Individuals Served by Race



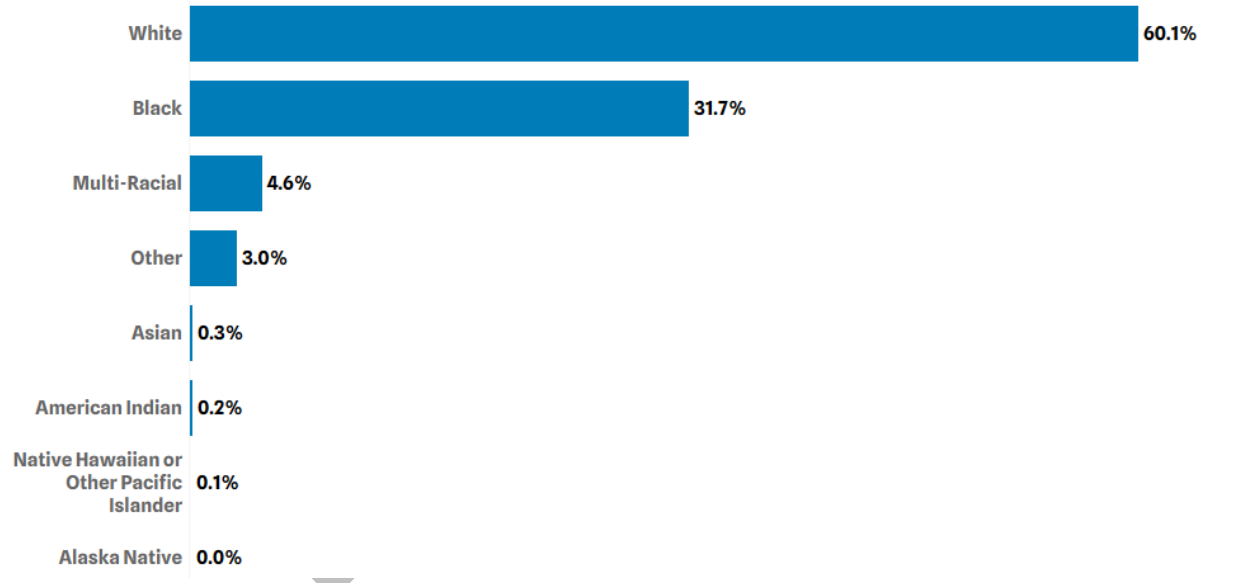
Source: Thriving Mind Individuals Served Data

Graphic 14. Thriving Mind Adult Mental Health Individuals Served by Race



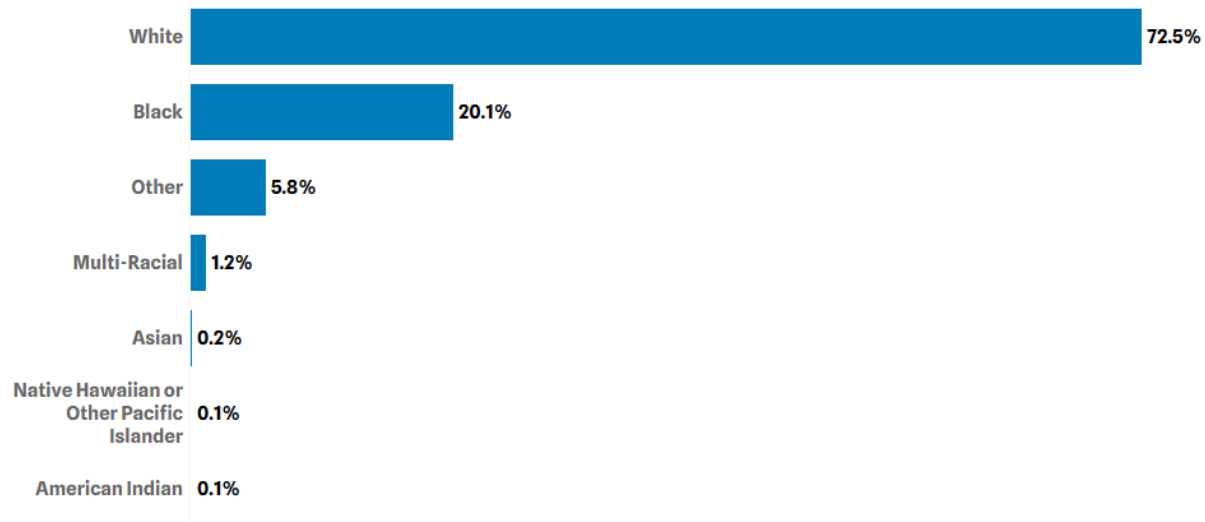
Source: Thriving Mind Individuals Served Data

Graphic 15. Thriving Mind Adult Substance Use Individuals Served by Race



Source: Thriving Mind Individuals Served Data

Graphic 16. Thriving Mind Children's Mental Health Individuals Served by Race

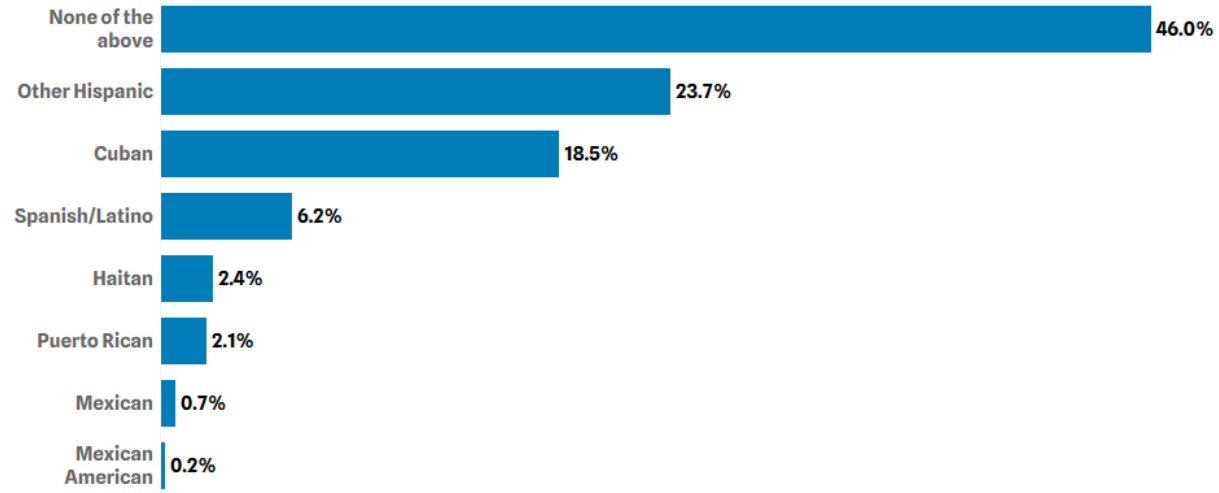


Source: Thriving Mind Individuals Served Data

Graphic 17. Thriving Mind Children's Substance Use Individuals Served by Race

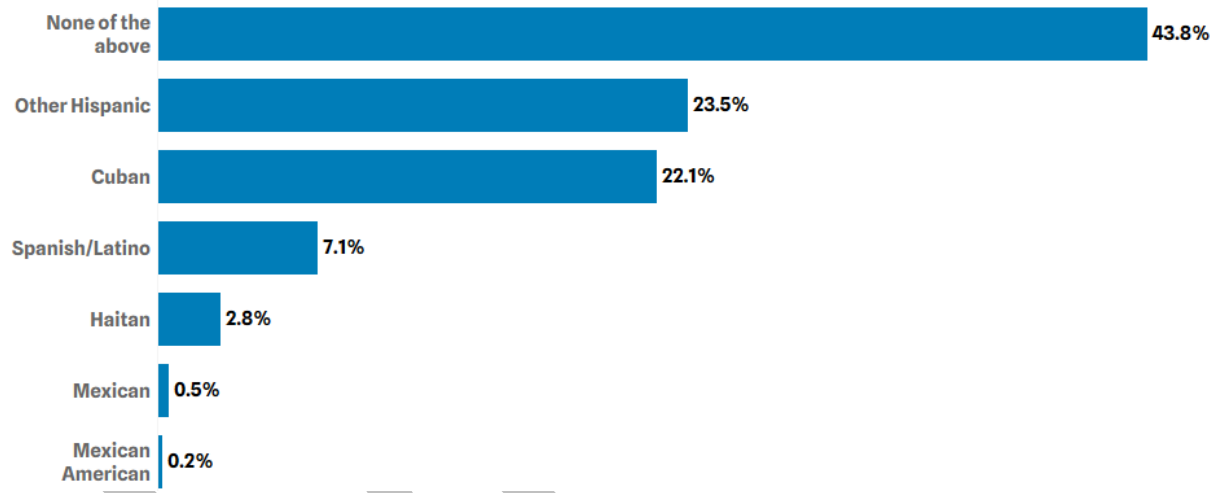
Source: Thriving Mind Individuals Served Data

Graphic 18. Thriving Mind Individuals Served by Ethnicity



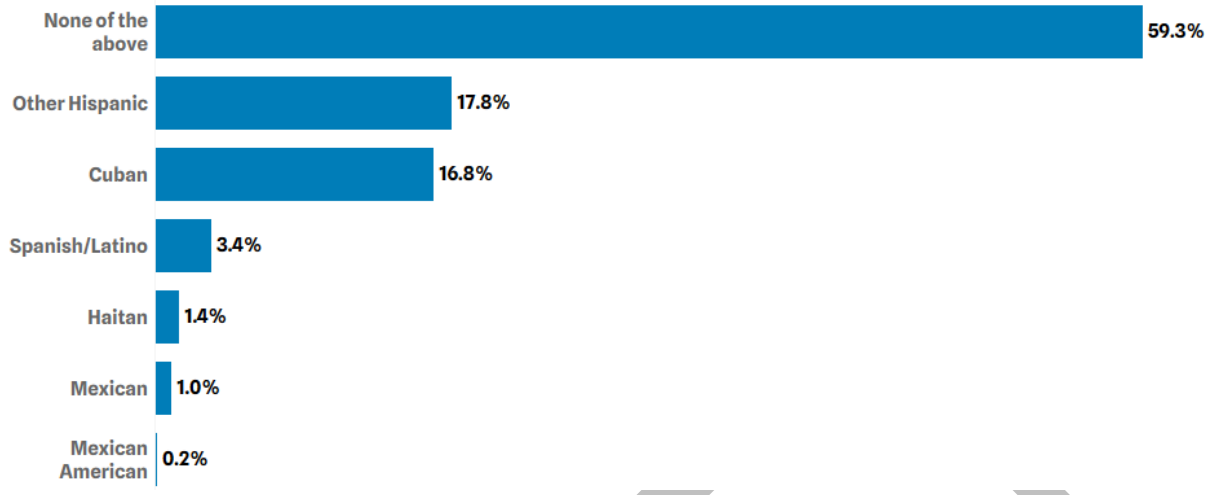
Source: Thriving Mind Individuals Served Data

Graphic 19. Thriving Mind Adult Mental Health Individuals Served by Ethnicity



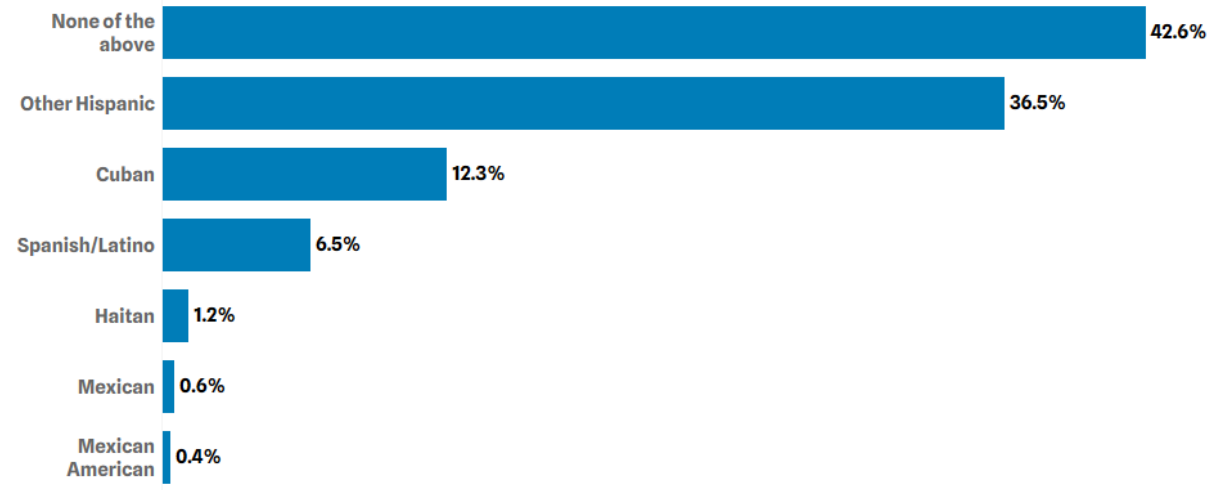
Source: Thriving Mind Individuals Served Data

Graphic 20. Thriving Mind Adult Substance Use Individuals Served by Ethnicity



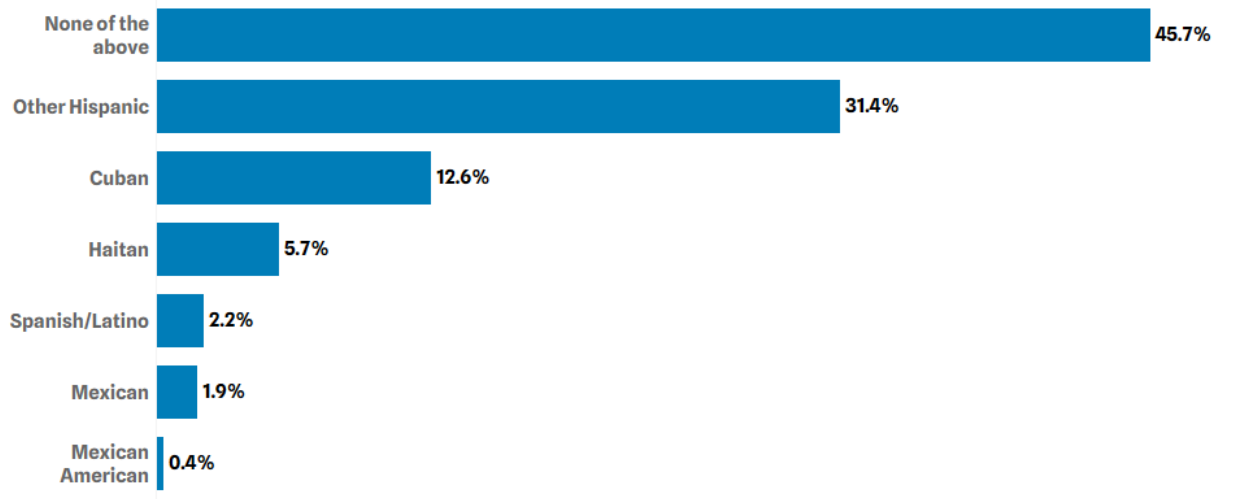
Source: Thriving Mind Individuals Served Data

Graphic 21. Thriving Mind Children's Mental Health Individuals Served by Ethnicity



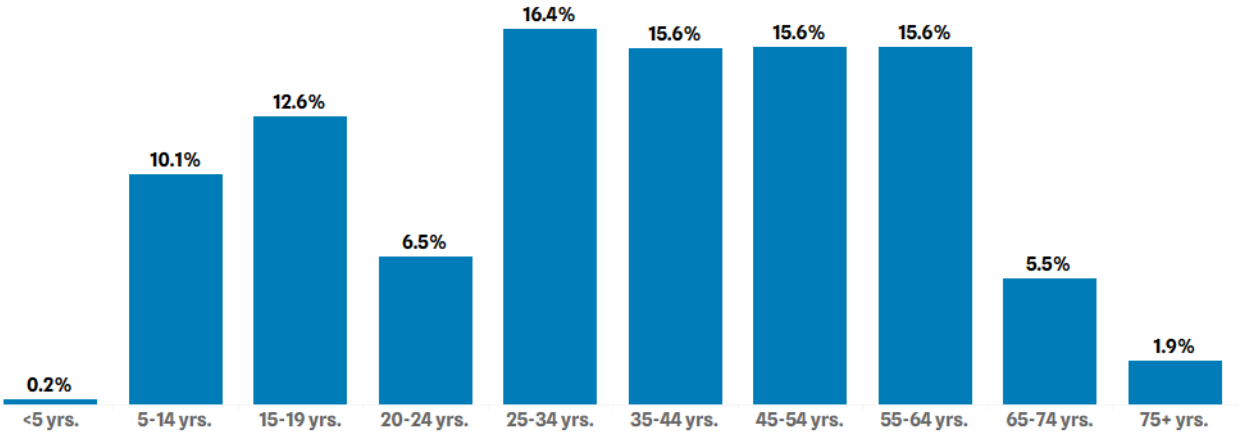
Source: Thriving Mind Individuals Served Data

Graphic 22. Thriving Mind Children's Substance Use Individuals Served by Ethnicity



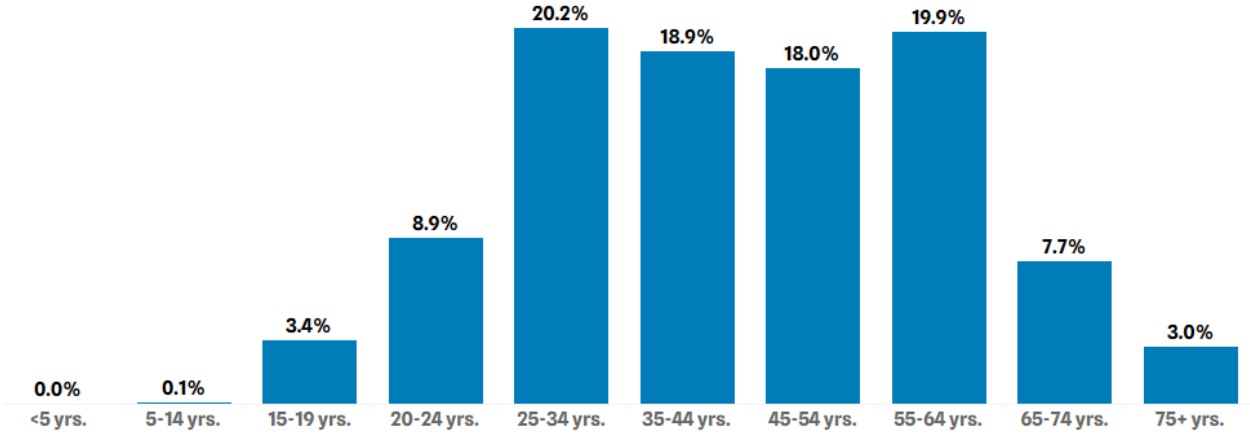
Source: Thriving Mind Individuals Served Data

Graphic 23. Thriving Mind Individuals Served by Age Range



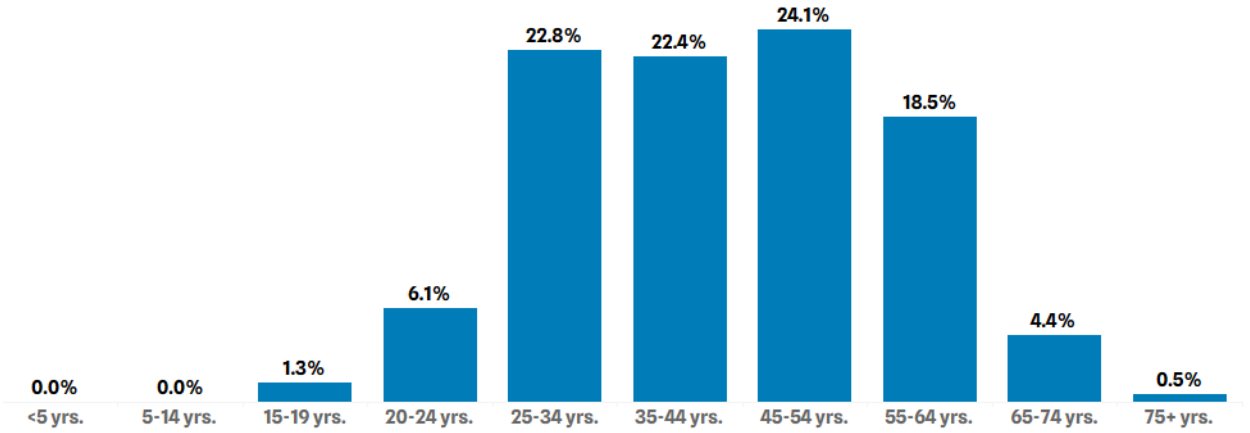
Source: Thriving Mind Individuals Served Data

Graphic 24. Thriving Mind Adult Mental Health Individuals Served by Age Range



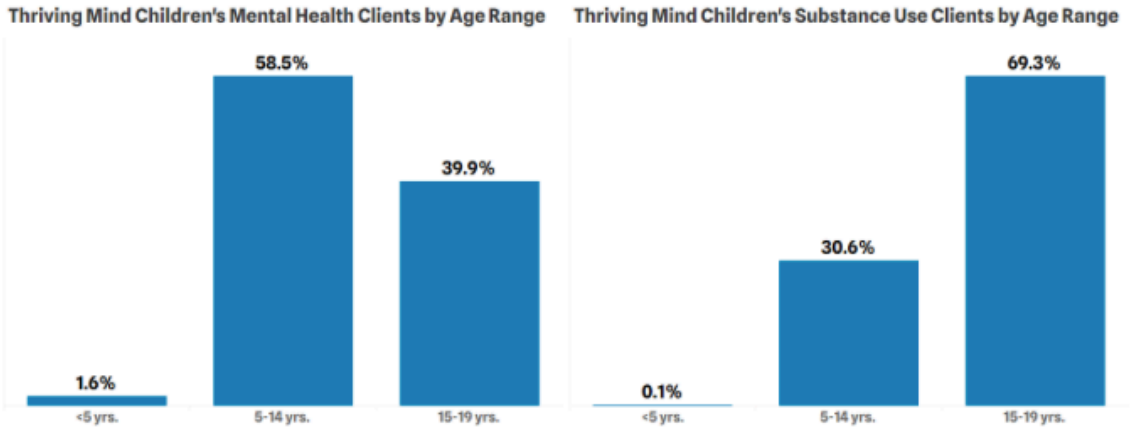
Source: Thriving Mind Individuals Served Data

Graphic 25. Thriving Mind Adult Substance Use Individuals Served by Age Range



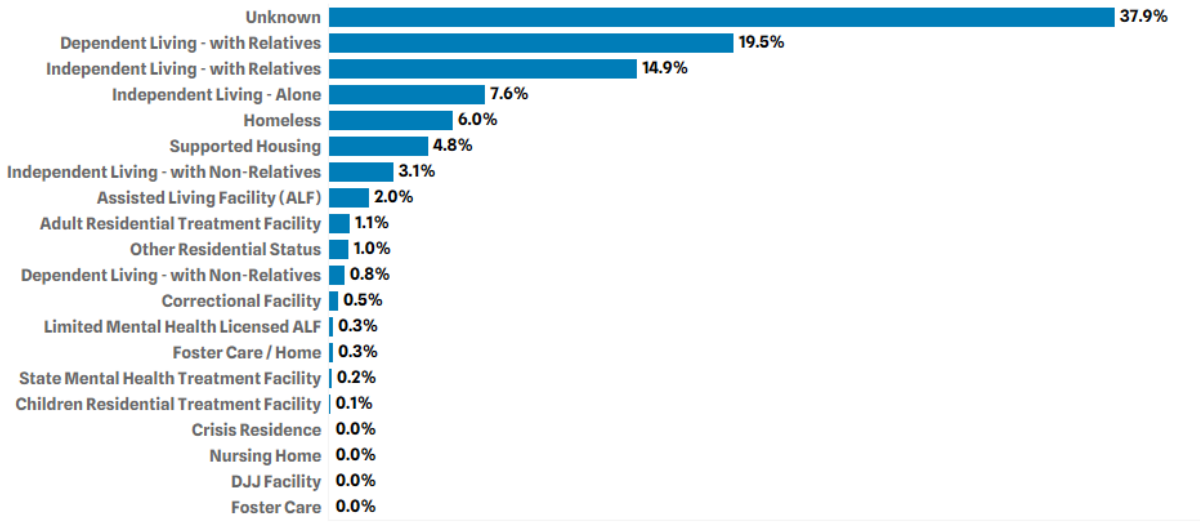
Source: Thriving Mind Individuals Served Data

Graphic 26. Thriving Mind Children's Mental Health and Substance Use Individuals Served by Age Range



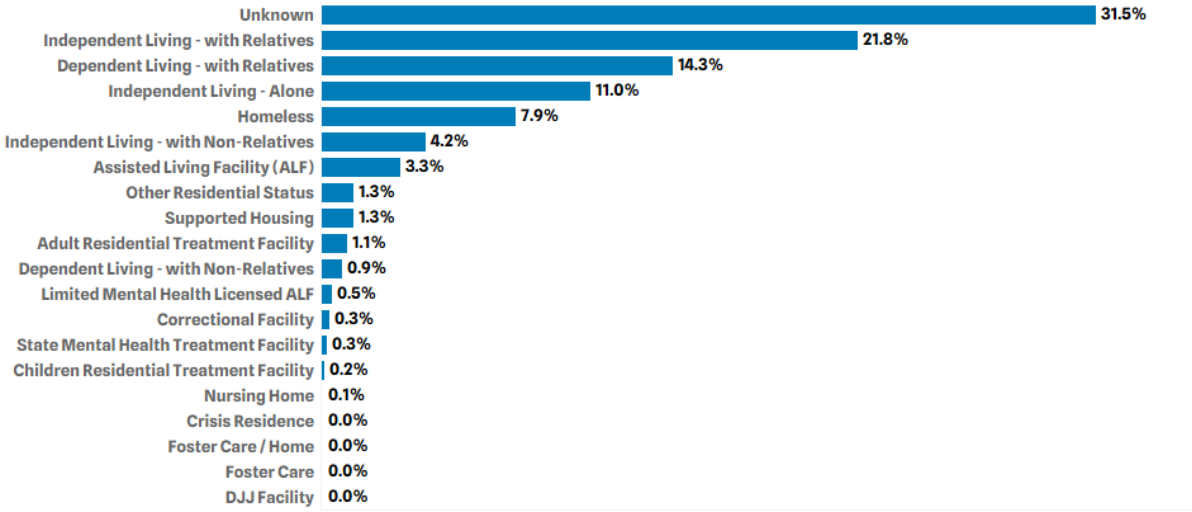
Source: Thriving Mind Individuals Served Data

Graphic 27. Thriving Mind Individuals Served by Residential Status



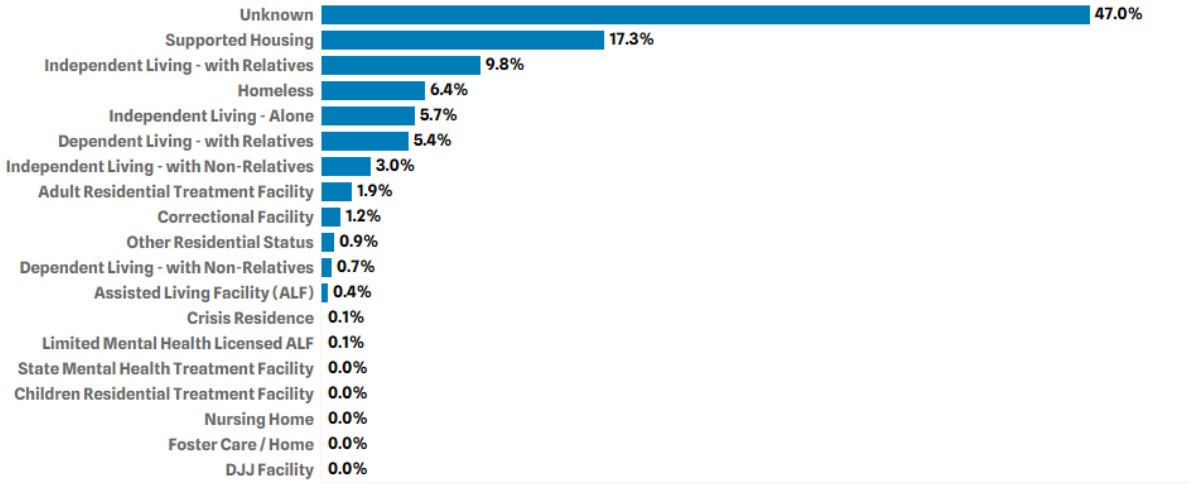
Source: Thriving Mind Individuals Served Data

Graphic 28. Thriving Mind Adult Mental Health Individuals Served by Residential Status



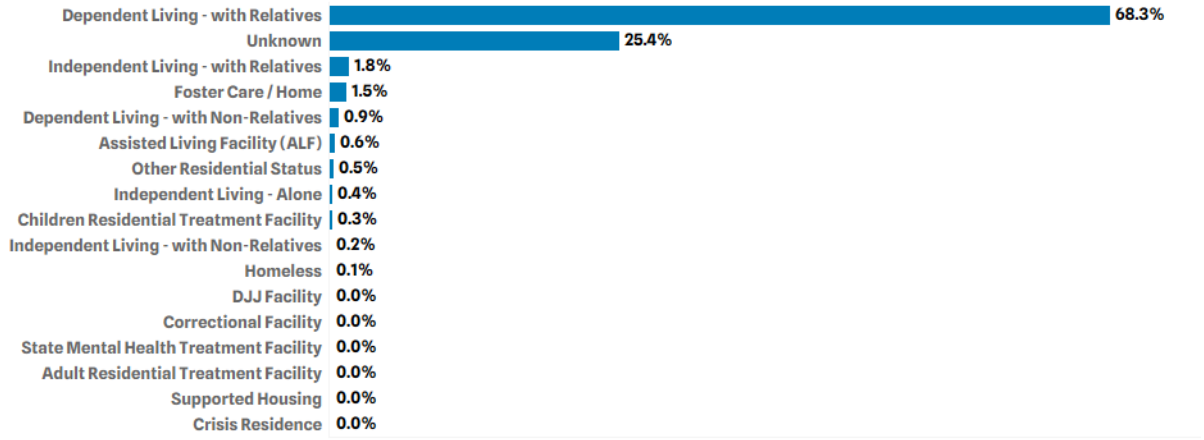
Source: Thriving Mind Individuals Served Data

Graphic 29. Thriving Mind Adult Substance Use Individuals Served by Residential Status



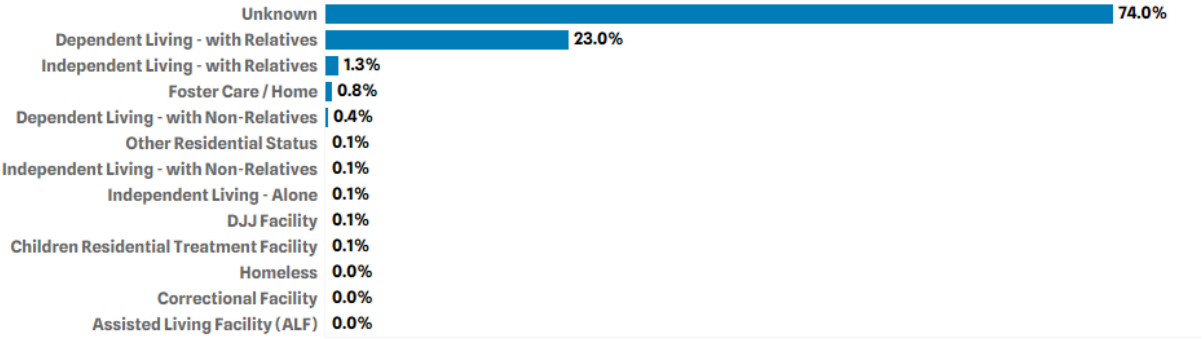
Source: Thriving Mind Individuals Served Data

Graphic 30. Thriving Mind Children's Mental Health Individuals Served by Residential Status



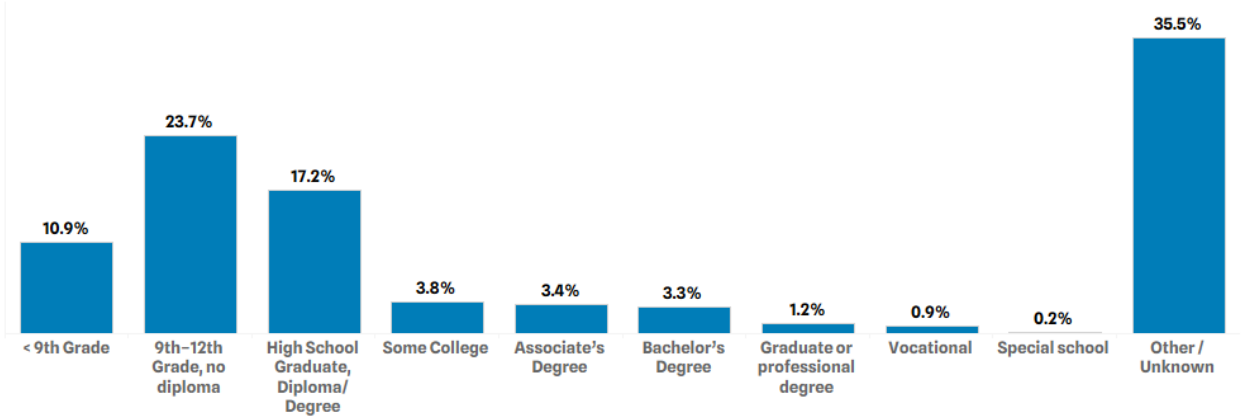
Source: Thriving Mind Individuals Served Data

Graphic 31. Thriving Mind Children's Substance Use Individuals Served by Residential Status



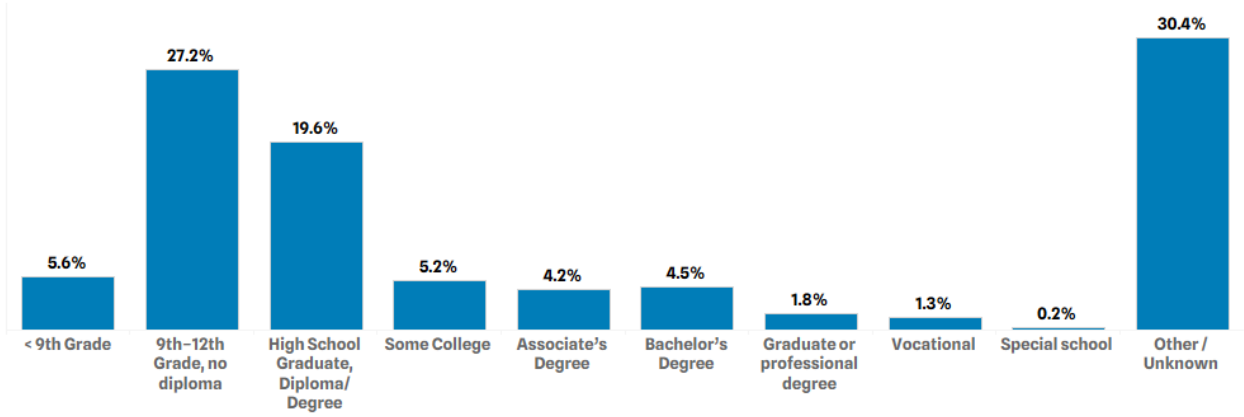
Source: Thriving Mind Individuals Served Data

Graphic 32. Thriving Mind Individuals Served by Educational Attainment



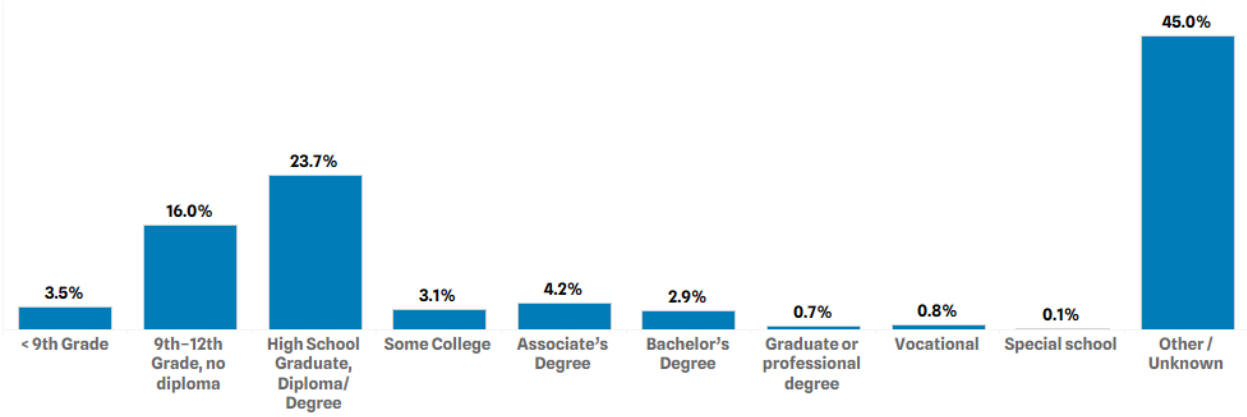
Source: Thriving Mind Individuals Served Data

Graphic 33. Thriving Mind Adult Mental Health Individuals Served by Educational Attainment



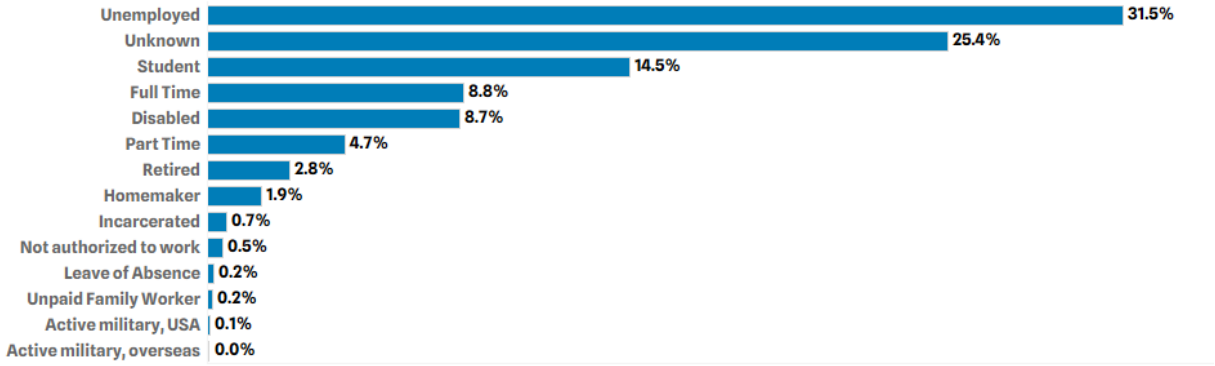
Source: Thriving Mind Individuals Served Data

Graphic 34. Thriving Mind Adult Substance Use Individuals Served by Educational Attainment



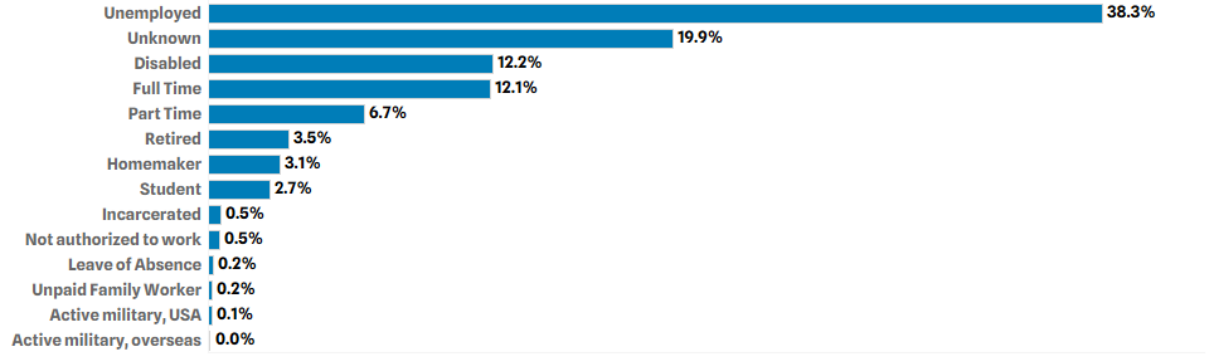
Source: Thriving Mind Individuals Served Data

Graphic 35. Thriving Mind Individuals Served by Employment Status



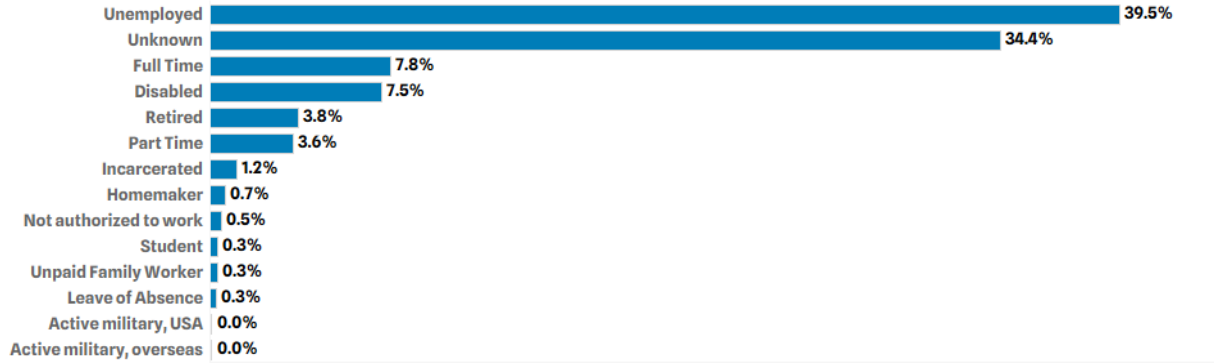
Source: Thriving Mind Individuals Served Data

Graphic 36. Thriving Mind Adult Mental Health Individuals Served by Employment Status



Source: Thriving Mind Individuals Served Data

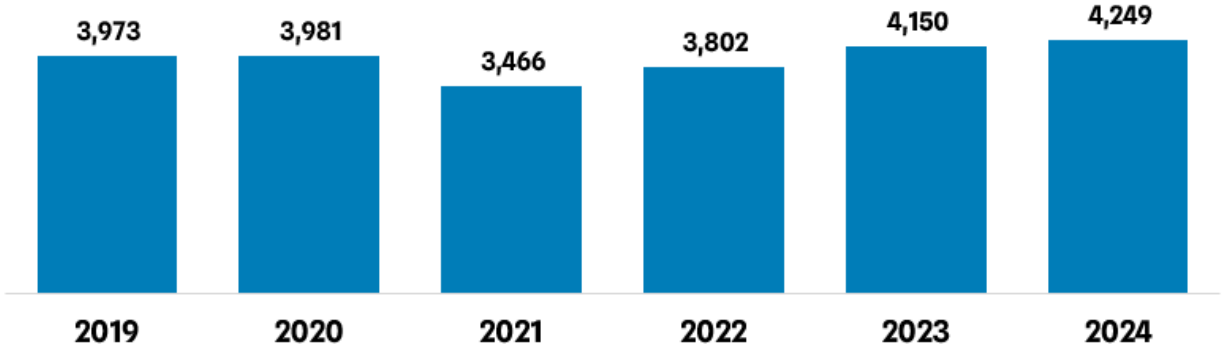
Graphic 37. Thriving Mind Adult Substance Use Individuals Served by Employment Status



Source: Thriving Mind Individuals Served Data

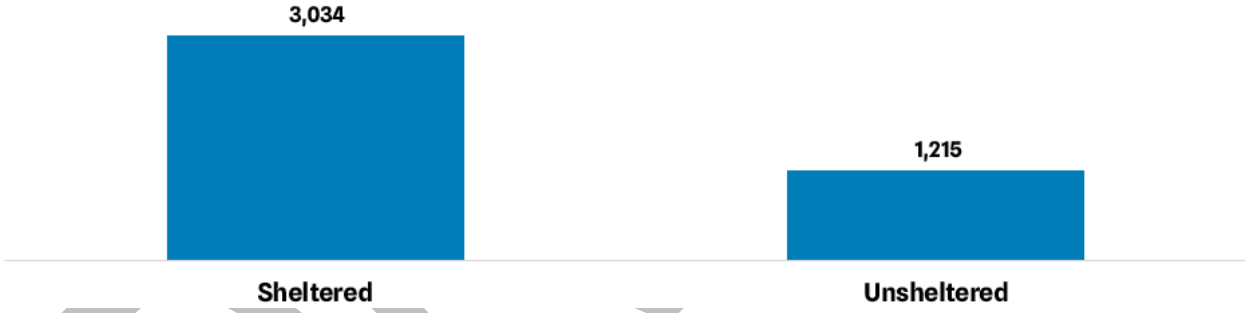
Thriving Mind Unhoused Individuals Served Demographics

Graphic 38. Total Unhoused Population, Miami-Dade and Monroe (2019-2024)



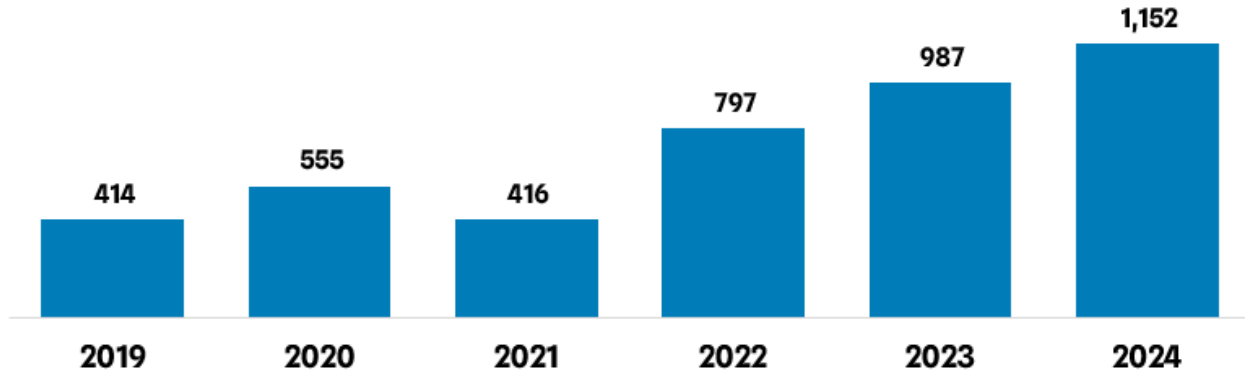
Source: 2024 Florida's Council on Homelessness Annual Report

Graphic 39. Total Unhoused Population Sheltered and Unsheltered, Miami-Dade and Monroe (2024)



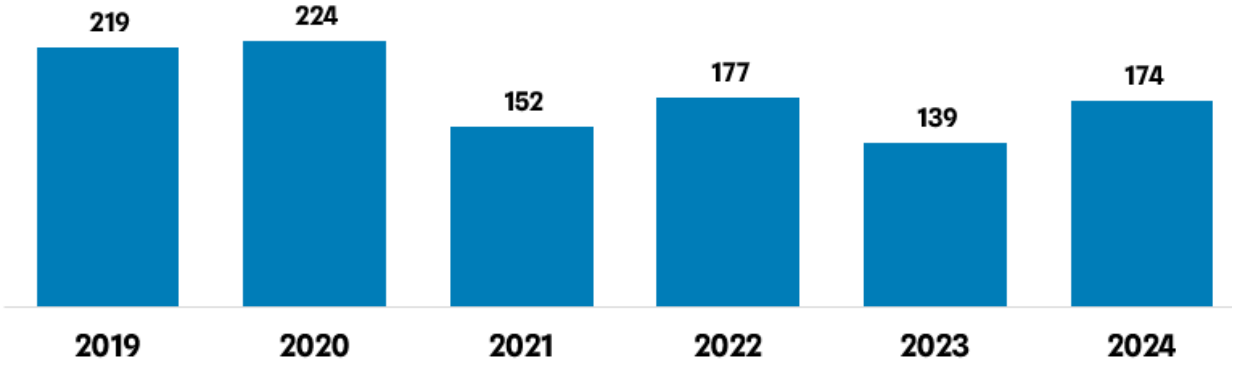
Source: 2024 Florida's Council on Homelessness Annual Report

Graphic 40. Chronically Unhoused, Miami-Dade and Monroe (2019-2024)



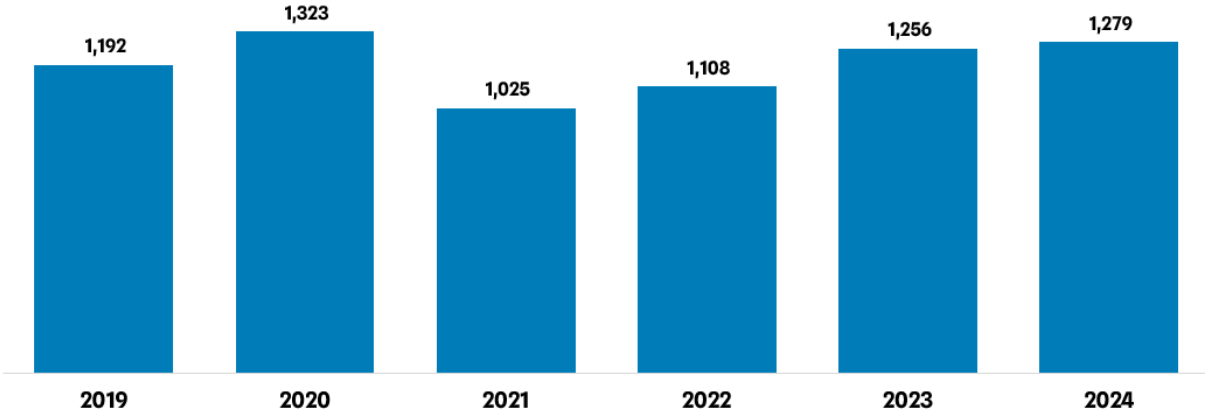
Source: 2024 Florida's Council on Homelessness Annual Report

Graphic 41. Unhoused Veterans, Miami-Dade and Monroe (2019-2024)



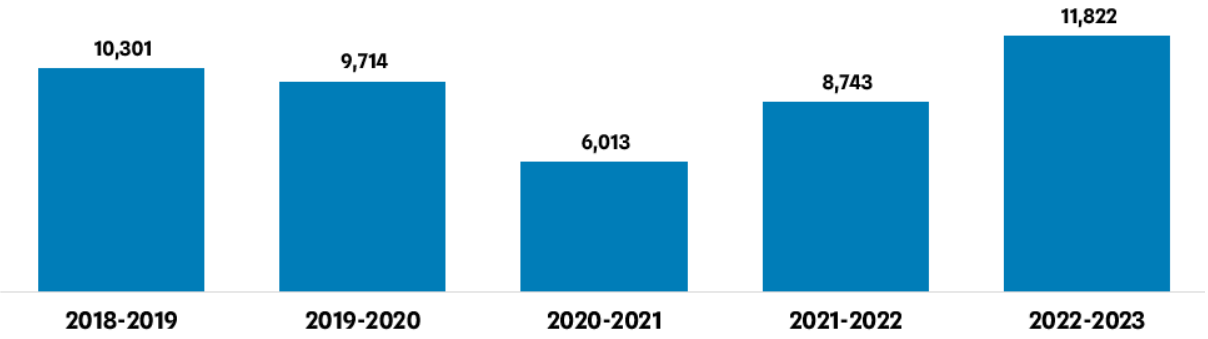
Source: 2024 Florida's Council on Homelessness Annual Report

Graphic 42. Families Who Are Unhoused, Miami-Dade and Monroe (2019-2024)



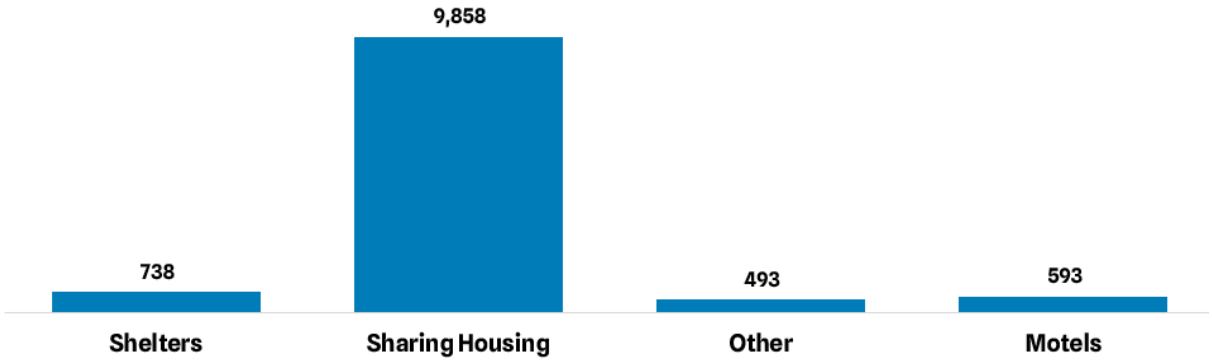
Source: 2024 Florida's Council on Homelessness Annual Report

Graphic 43. Reported Unhoused Students in Public Schools, Miami-Dade and Monroe (2018-2023)



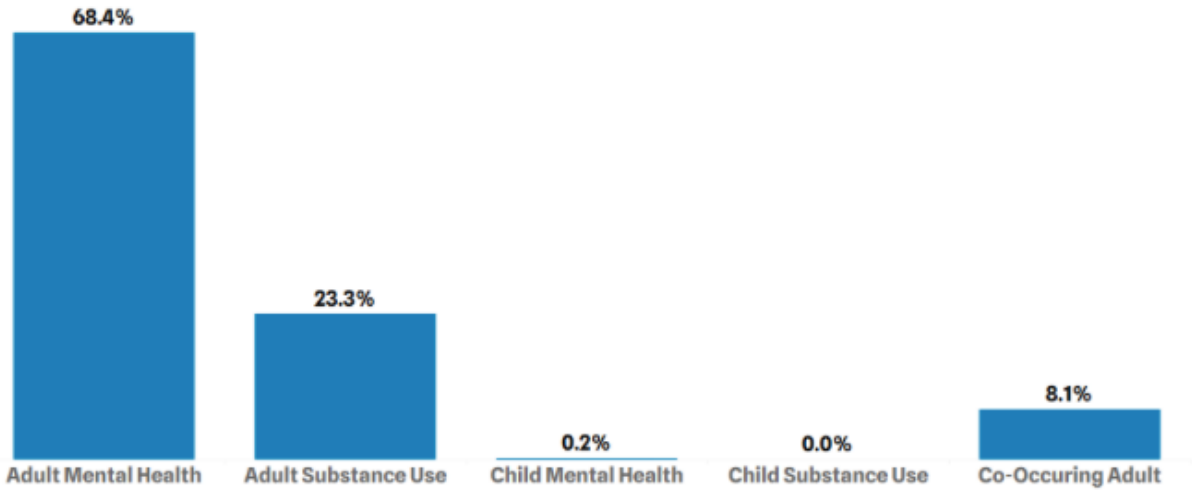
Source: 2024 Florida's Council on Homelessness Annual Report

Graphic 43. Reported Unhoused Students in Public Schools by Living Situation, Miami-Dade and Monroe (2022-2023)



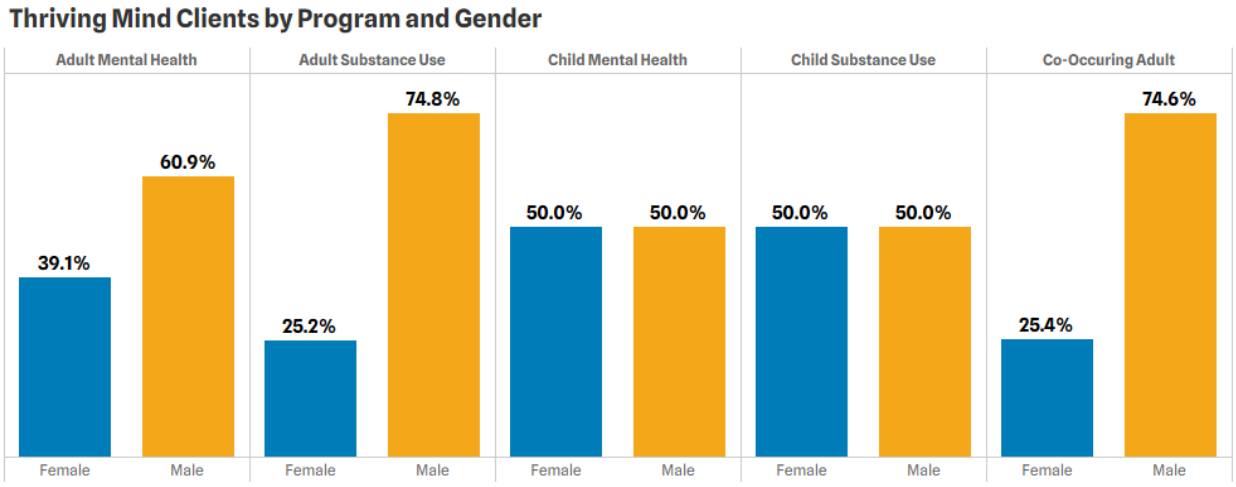
Source: Thriving Mind Individuals Served Data

Graphic 44. Thriving Mind Unhoused Individuals Served by Program



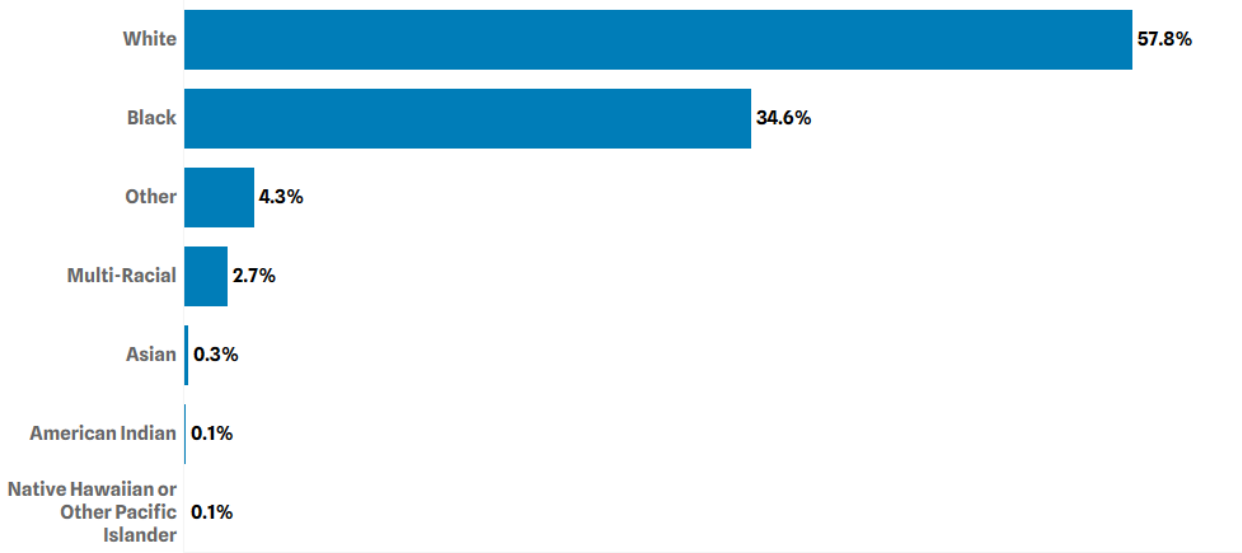
Source: Thriving Mind Individuals Served Data

Graphic 45. Thriving Mind Unhoused Individuals Served by Program and Gender



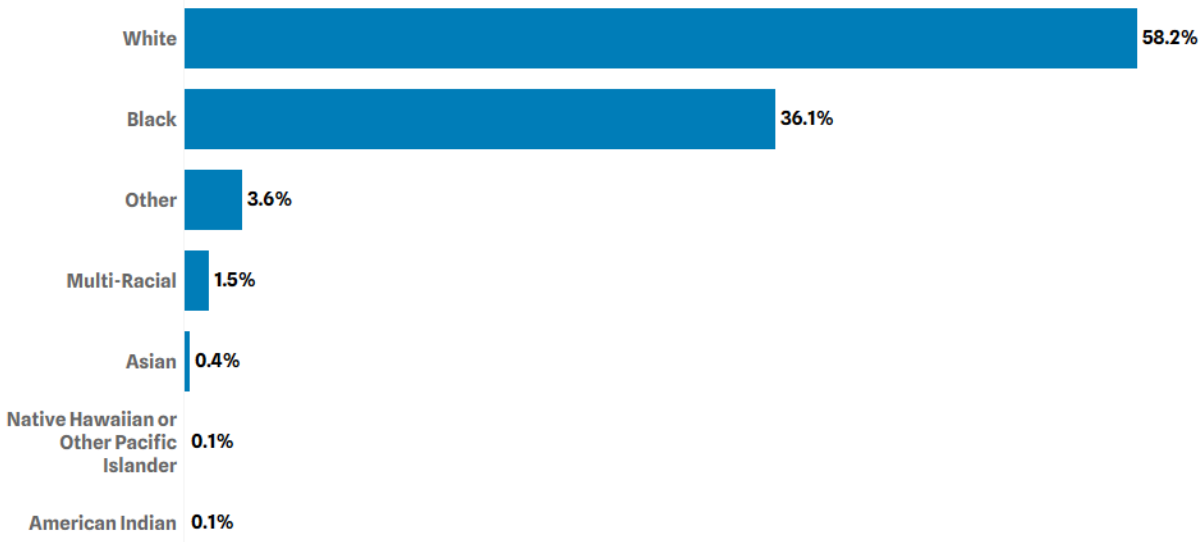
Source: Thriving Mind Individuals Served Data

Graphic 46. Thriving Mind Unhoused Individuals Served by Race



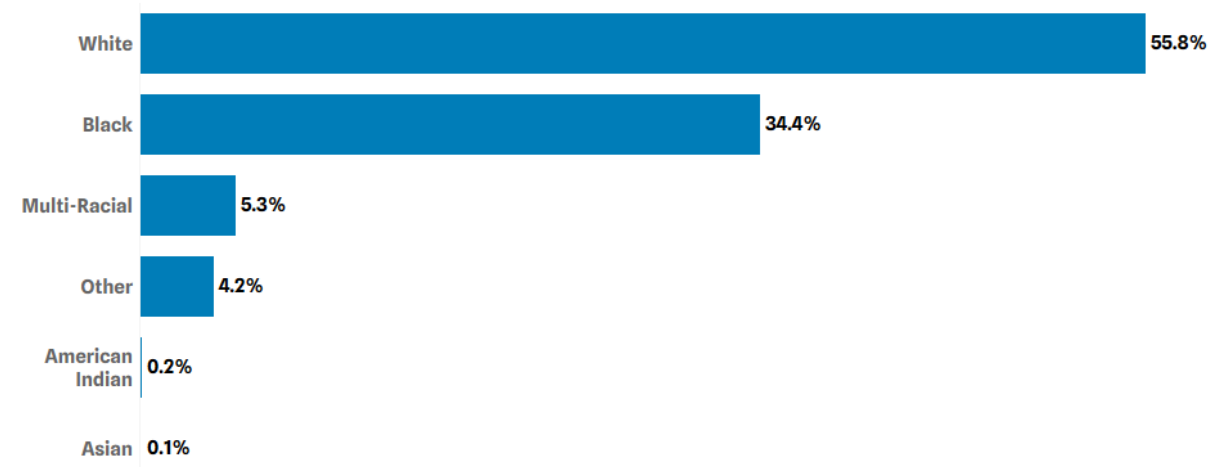
Source: Thriving Mind Individuals Served Data

Graphic 47. Thriving Mind Unhoused Adult Mental Health Individuals Served by Race



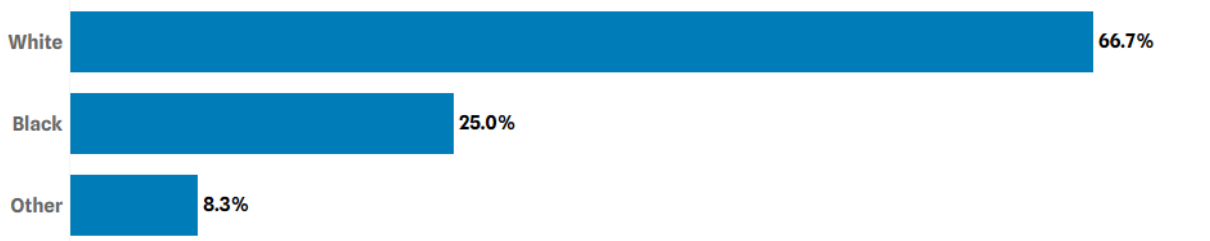
Source: Thriving Mind Individuals Served Data

Graphic 48. Thriving Mind Unhoused Adult Substance Use Individuals Served by Race



Source: Thriving Mind Individuals Served Data

Graphic 49. Thriving Mind Unhoused Children's Mental Health Individuals Served by Race

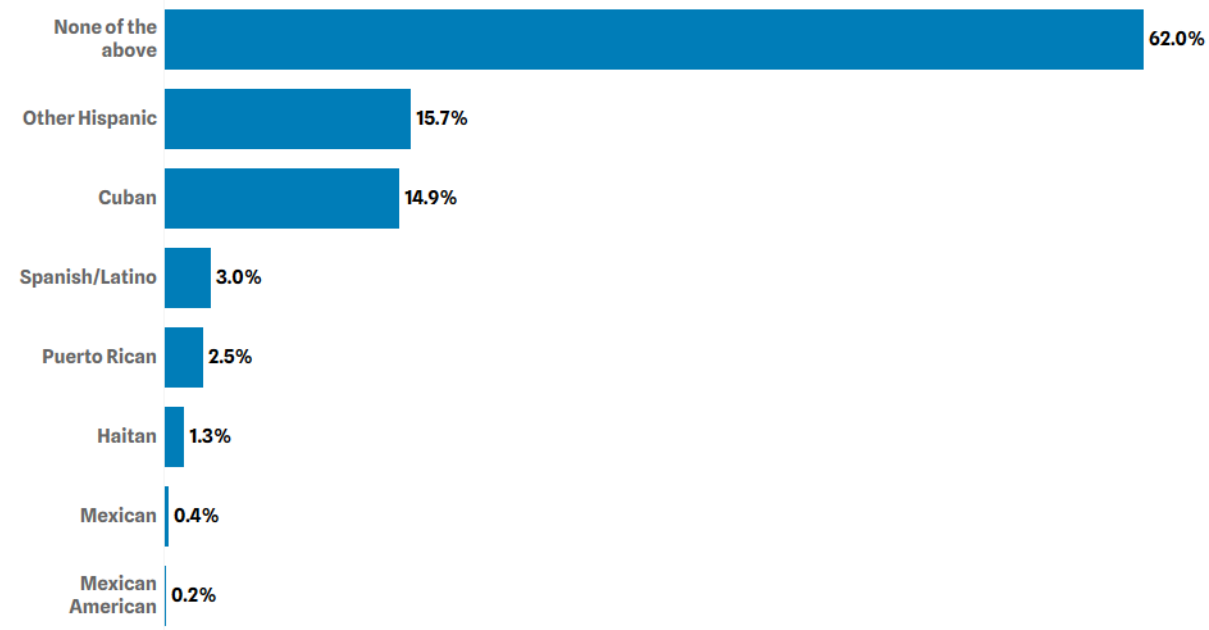


Source: Thriving Mind Individuals Served Data

Graphic 50. Thriving Mind Unhoused Children's Substance Use Individuals Served by Race

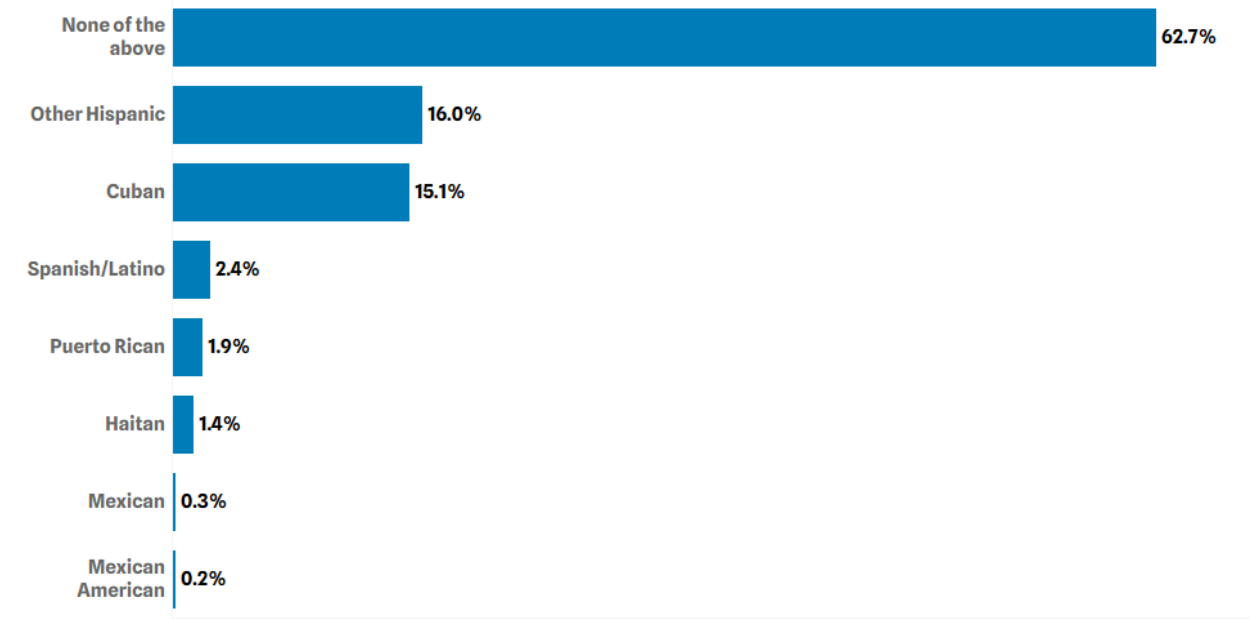
Source: Thriving Mind Individuals Served Data

Graphic 51. Thriving Mind Unhoused Individuals Served by Ethnicity



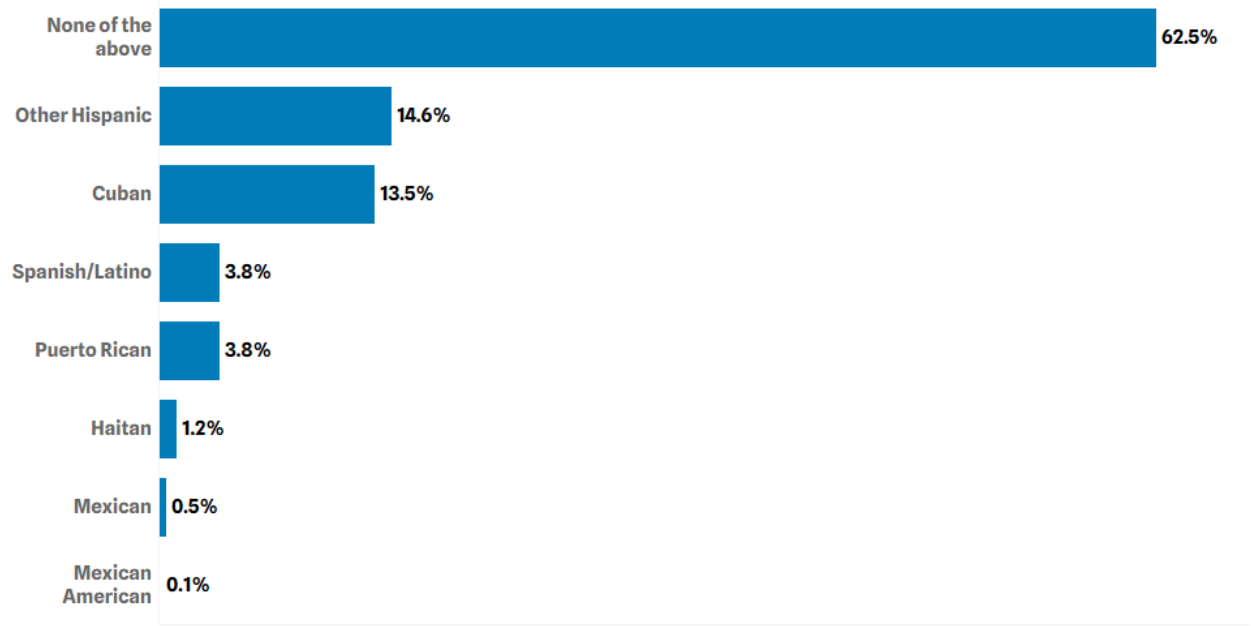
Source: Thriving Mind Individuals Served Data

Graphic 52. Thriving Mind Unhoused Adult Mental Health Individuals Served by Ethnicity



Source: Thriving Mind Individuals Served Data

Graphic 53. Thriving Mind Unhoused Adult Substance Use Individuals Served by Ethnicity

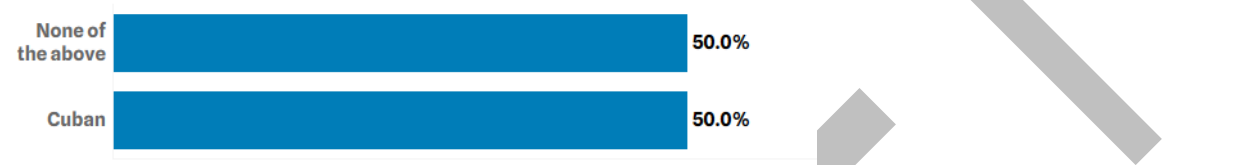


Source: Thriving Mind Individuals Served Data

Graphic 54. Thriving Mind Unhoused Children's Mental Health Individuals Served by Ethnicity

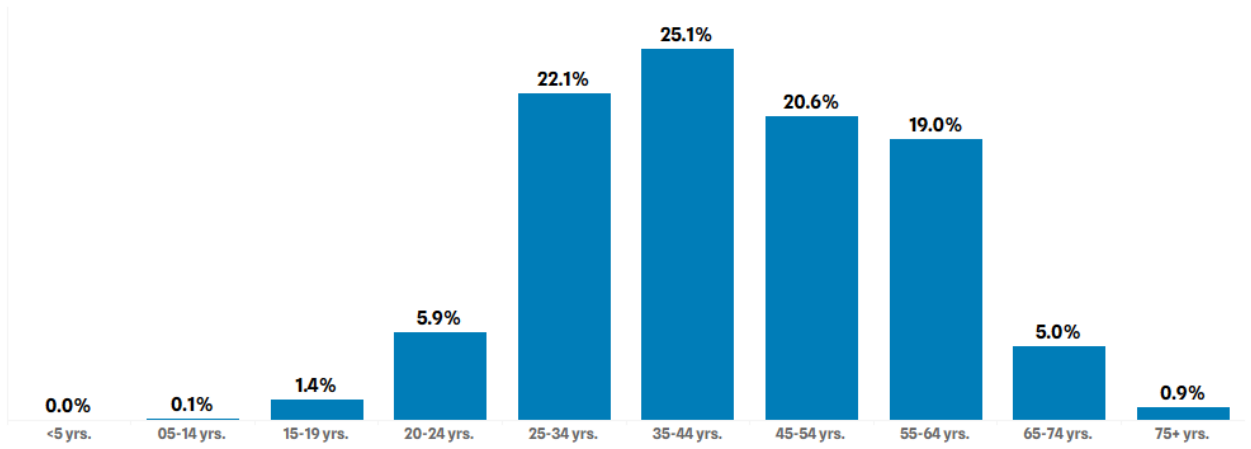
Source: Thriving Mind Individuals Served Data

Graphic 55. Thriving Mind Unhoused Children's Substance Use Individuals Served by Ethnicity



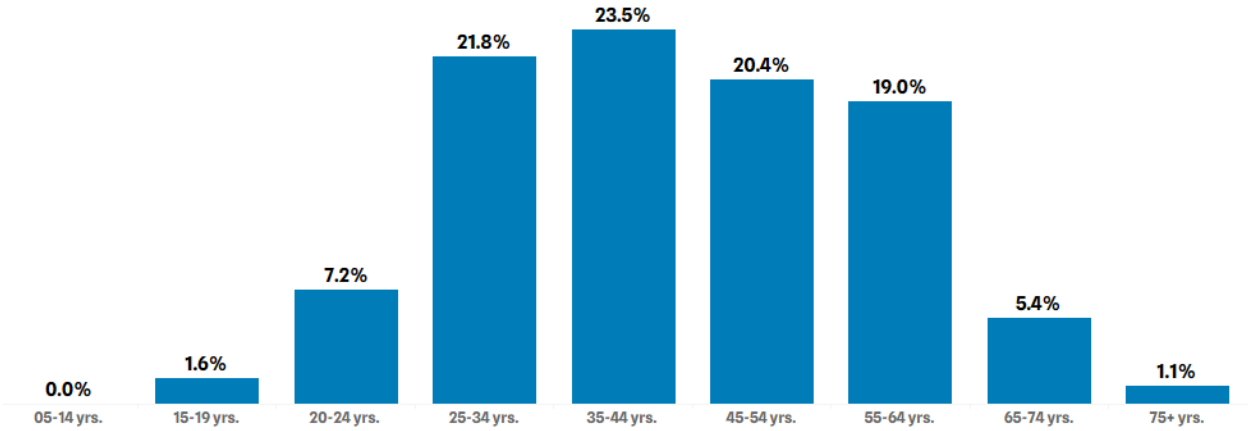
Source: Thriving Mind Individuals Served Data

Graphic 56. Thriving Mind Unhoused Individuals Served by Age Range



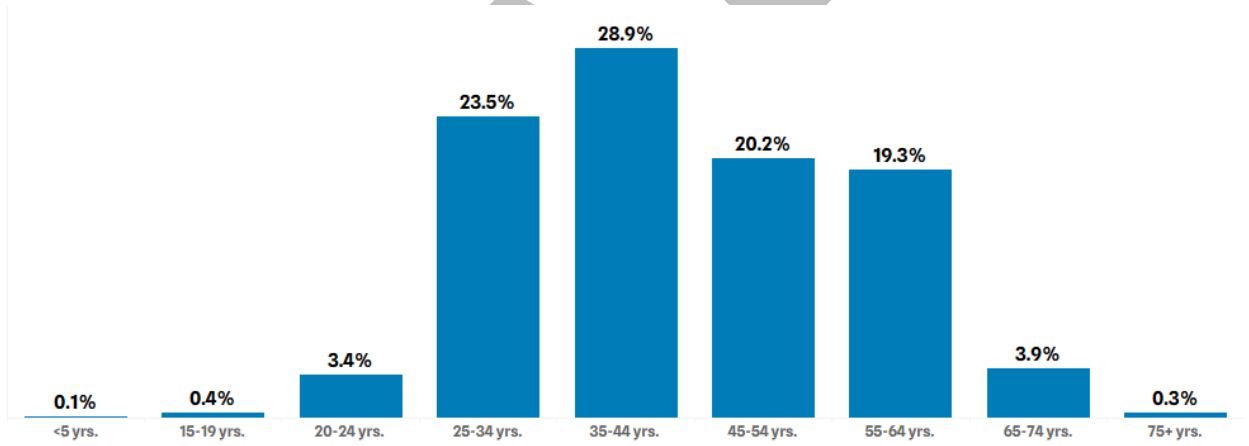
Source: Thriving Mind Individuals Served Data

Graphic 57. Thriving Mind Unhoused Adult Mental Health Individuals Served by Age Range



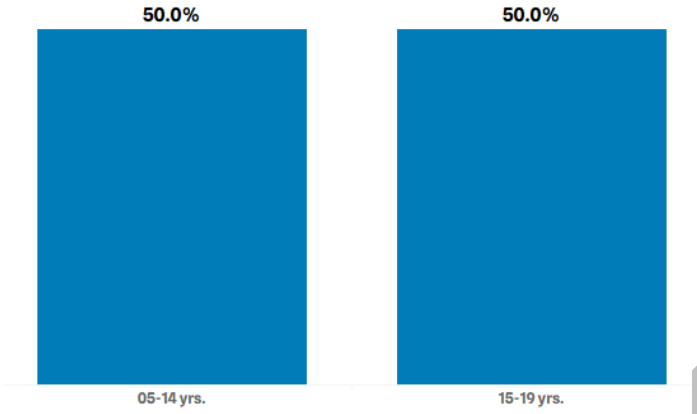
Source: Thriving Mind Individuals Served Data

Graphic 58. Thriving Mind Unhoused Adult Substance Use Individuals Served by Age Range



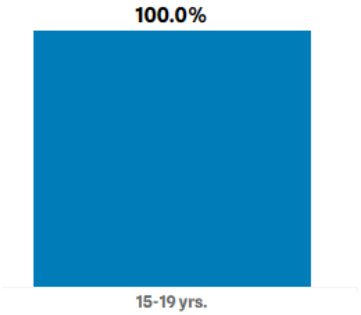
Source: Thriving Mind Individuals Served Data

Graphic 59. Thriving Mind Unhoused Children's Mental Health Individuals Served by Age Range



Source: Thriving Mind Individuals Served Data

Graphic 60. Thriving Mind Unhoused Children's Substance Individuals Served by Age Range



Source: Thriving Mind Individuals Served Data

Survey and Focus Group Findings

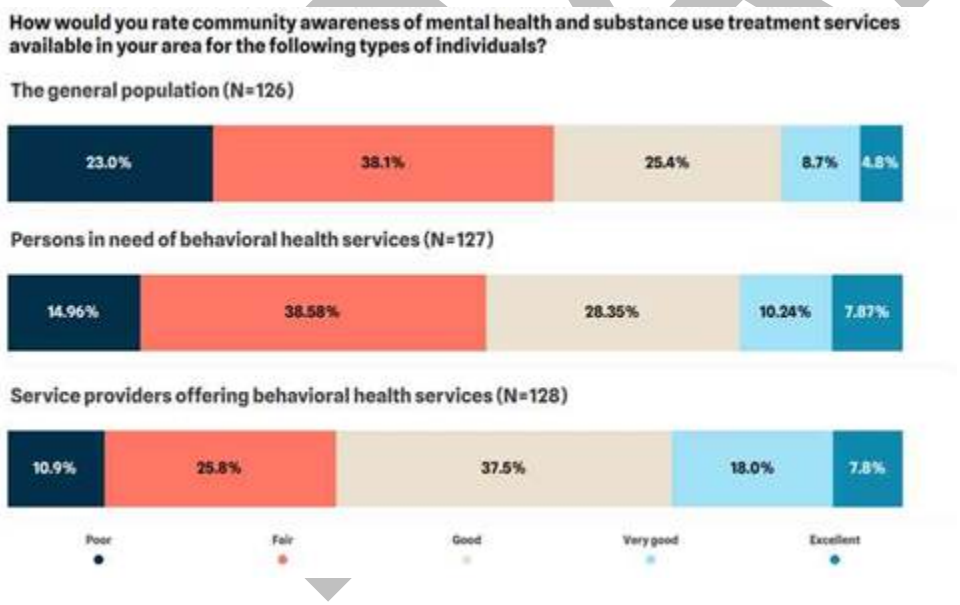
The following section covers a summary of findings from the Network Provider Survey (n = 226), Persons Served Survey (n = 99), Stakeholder Survey (n = 203), and 13 focus groups (n = 65) held with Thriving Mind Network Service Provider staff. Surveys were released between March-June 2025 by Thriving Mind contract managers and were hosted in Qualtrics. Focus groups were hosted virtually by Behavioral Science Research Institute (BSRI) and were grouped by staff role/type (e.g., CEO, clinician, quality improvement, case manager).

Feedback from these data sources was analyzed and summarized to form the feedback for town hall presentations, hosted in July 2025. Data was analyzed according to themes including resource/service awareness, access and referrals, care coordination, children's services, suicide awareness, peer support, and housing. Appendix A (Stakeholder Survey), Appendix B (Persons Served Survey) and Appendix C (Provider Survey) include lists of all survey items and responses.

<u>General Awareness</u>

Data from the Stakeholder Survey indicated perceptions that the general population has relatively low levels of awareness about behavioral health services (61.1 percent said it was poor or fair). Perceptions of awareness increased slightly for persons who need to access services but were still low. Not surprisingly, providers working in behavioral health had the highest community awareness.

Graphic 61. Community awareness of mental health and substance use treatment services available



Data from focus groups helped to highlight potential reasons for these gaps in awareness. Individuals across groups mentioned that stigma and cultural barriers can make it hard for some communities to engage with mental and behavioral health concepts. Additionally, language barriers and lack of trust in institutions make access even harder. Providers reported consistent challenges in communicating across these divides. Furthering the stigma, participants noted that media coverage often focused on mental health disorders in the context of violence, substance use, or crime, portrayals which create fear and further reinforce harmful stereotypes.

Ultimately, feedback from provider staff found that many individuals only become aware of mental health services after a crisis — such as hospitalization, arrest, or loss. This approach was perceived as delaying help and reducing the chance for early intervention.

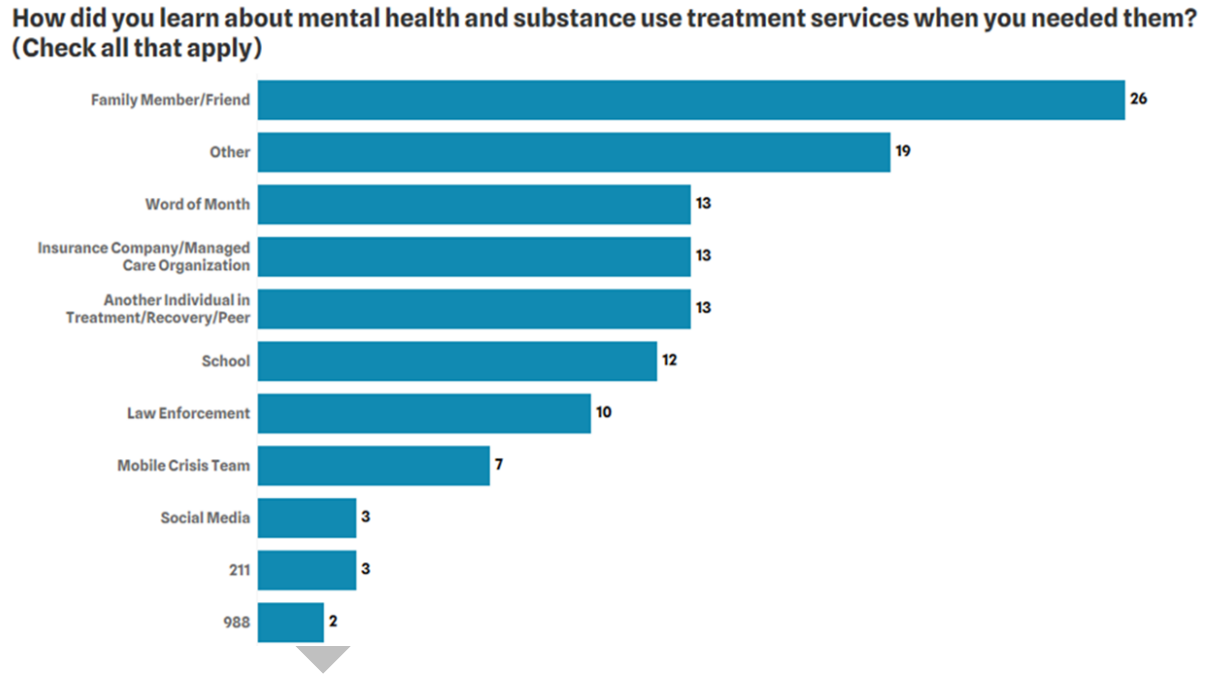
“No one looks at a person with mental health and says, ‘Oh this is a tragedy or no fault of their own.’ People want to be disconnected from mental health struggles.” *Peer Support specialist*

Access and Referral Pathways

Strengths

When asked how they learned about services when needed, data from the Persons Served Survey indicated hearing most often from family or friends, followed by word of mouth. The “other” category consisted of other community-based organizations. Additional resources such as targeted case management referrals and system supports such as 211 were also mentioned. Regional differences emerged with providers from Monroe County specifically recognizing the strength of community presence and outreach events as key to helping connect people to services.

Graphic 62. How did you learn about services when you needed them



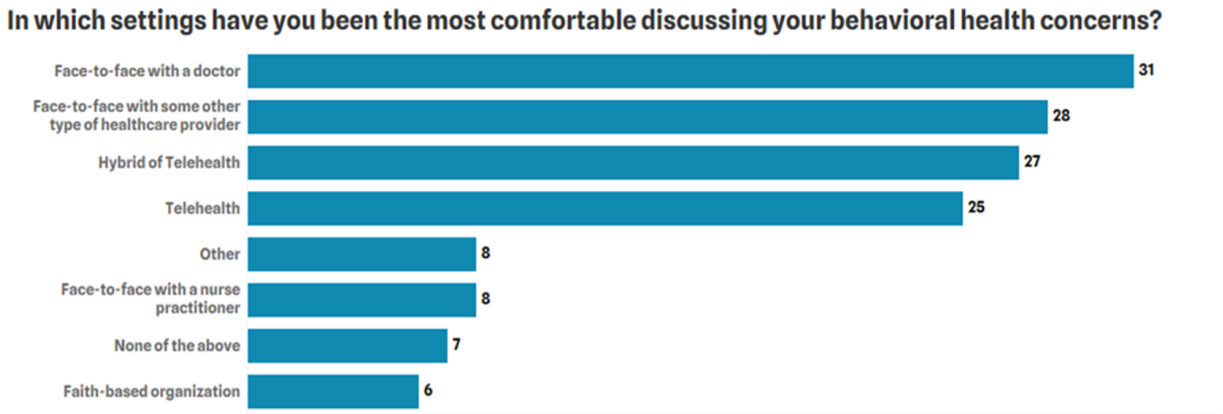
Still, many in focus groups recognized that individuals may also get connected to resources following a crisis, or as a mandate through a legal pathway. This was seen as a less ideal way to engagement, often reactionary rather than proactive decision-making.

Data from surveys and focus groups also found that providers have positive perceptions of Thriving Mind as a resource hub and also identified numerous staff as being resources for coordinating referrals and supporting linkages to providers and other information. Participants

described the Managing Entity (ME) as creating a “community of providers” and playing a key role in removing barriers, particularly in complex cases. Stakeholders and providers noted that the ME’s referral process was clear and reliable, often including consent forms and Individuals Served histories that streamlined transitions. Providers also highlighted its structured support, including regular check-ins and shared resources.

Finally, data from the Persons Served Survey found that individuals were nearly as comfortable discussing behavioral health concerns via telehealth or a hybrid of telehealth and in-persons services as solely in-person with healthcare providers or doctors. This marked a slow but continual shift since the COVID-19 pandemic in which more providers are able to offer telehealth services, and more individuals are receptive to this modality.

Graphic 63. In which settings have you been comfortable discussing behavioral health concerns



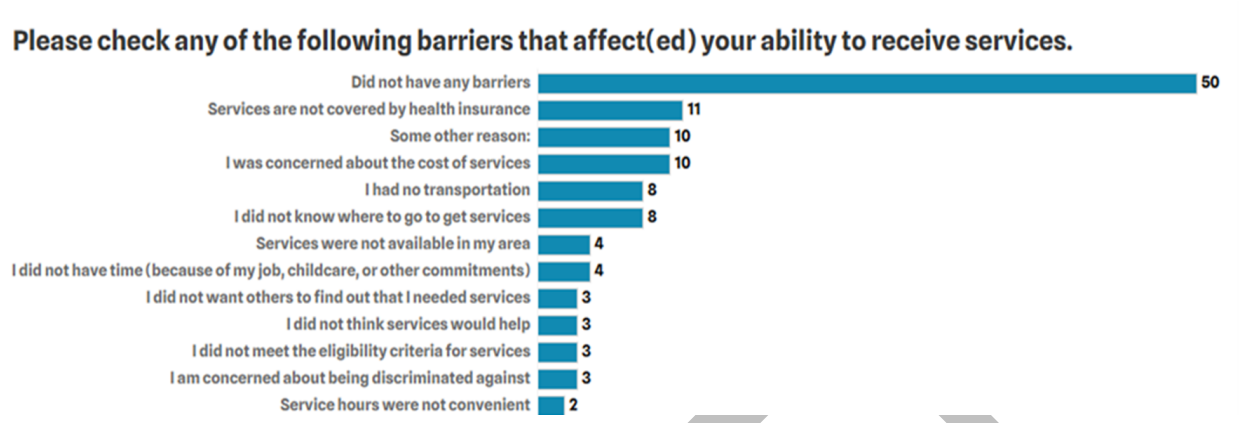
Barriers

Providers in focus groups and data from surveys also recognized some areas for improvement regarding access points. The most common barrier cited was financial with housing instability, unemployment, challenges securing benefits (insurance, disability), and transportation, particularly in rural and southern areas such as Homestead, Cutler Bay, and the Florida Keys, all being mentioned.

Furthermore, insurance complexities and conflicts were also mentioned by both persons served and providers. Changes to and definitions about covered services were discussed as key challenges to navigating someone’s care, particularly when developing plans for “stepping” down to a less restrictive care environment.

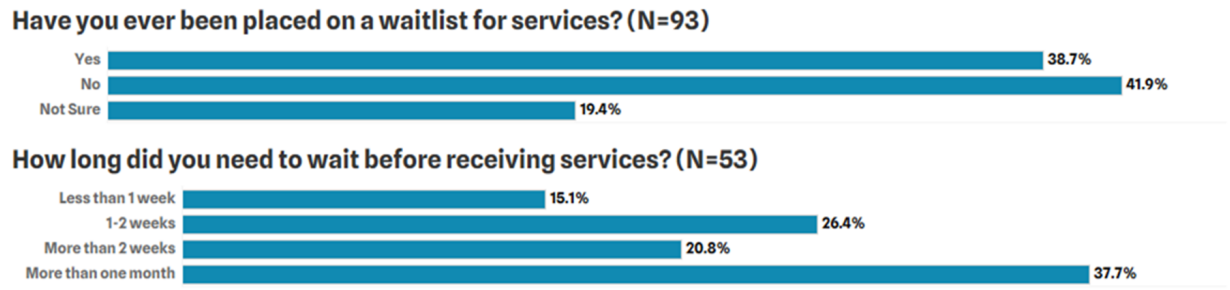
“We don’t have a lot to go on to get patients into step-down programs ... The cost is a lot and all we hear is ‘we don’t have enough money.’ Who’s going to pay that? The patient doesn’t have benefits to be able to afford those costs” (*Case Manager*).

Graphic 64. Barriers that affected ability to receive services



Providers also perceived administrative barriers such as required documentation processes, strict eligibility criteria, and authorization procedures as further delaying referrals or resulting in denials of care. Long waitlists and provider shortages for some services were discussed, as many noted that the rise in population has not been matched by an increase in beds, particularly in state and forensic hospitals, which has created severe bottlenecks in the system. Data from the Persons Served Survey indicated that nearly 42 percent of individuals were knowingly placed on a waitlist with an additional 19.4 percent being unsure. For those who waited for services, more than one-third (37.7 percent) were waiting more than one month.

Graphic 65. Waitlists for services



Although dynamic, the ME wait times provided to BSRI in May 2025 included the following:

- Adult Substance Use Residential Treatment: 2 weeks for males and no wait or a couple of days for females.
- Adult Mental Health Residential Treatment: 1-2 months for males and females
- Adolescent Substance Use Residential Treatment: No wait
- Adolescent Outpatient Wraparound: 1 month.

In focus groups, providers also commented that language access was limited outside of Spanish and Haitian Creole, and several noted needing services for other migrant groups, including Portuguese, Russian, or Eastern European speakers. Although interpreters might be available, provider staff believed that their persons served were less likely to share sensitive

concerns through a third party, and that differences in how mental health is understood and talked about furthered the cultural gaps in treatment planning and delivery. Finally, several providers mentioned challenges specific to immigrant communities and a fear of disclosing immigration status. Providers perceived legal fears — especially among undocumented families — were making it harder to engage individuals and families through clinics and home visits.

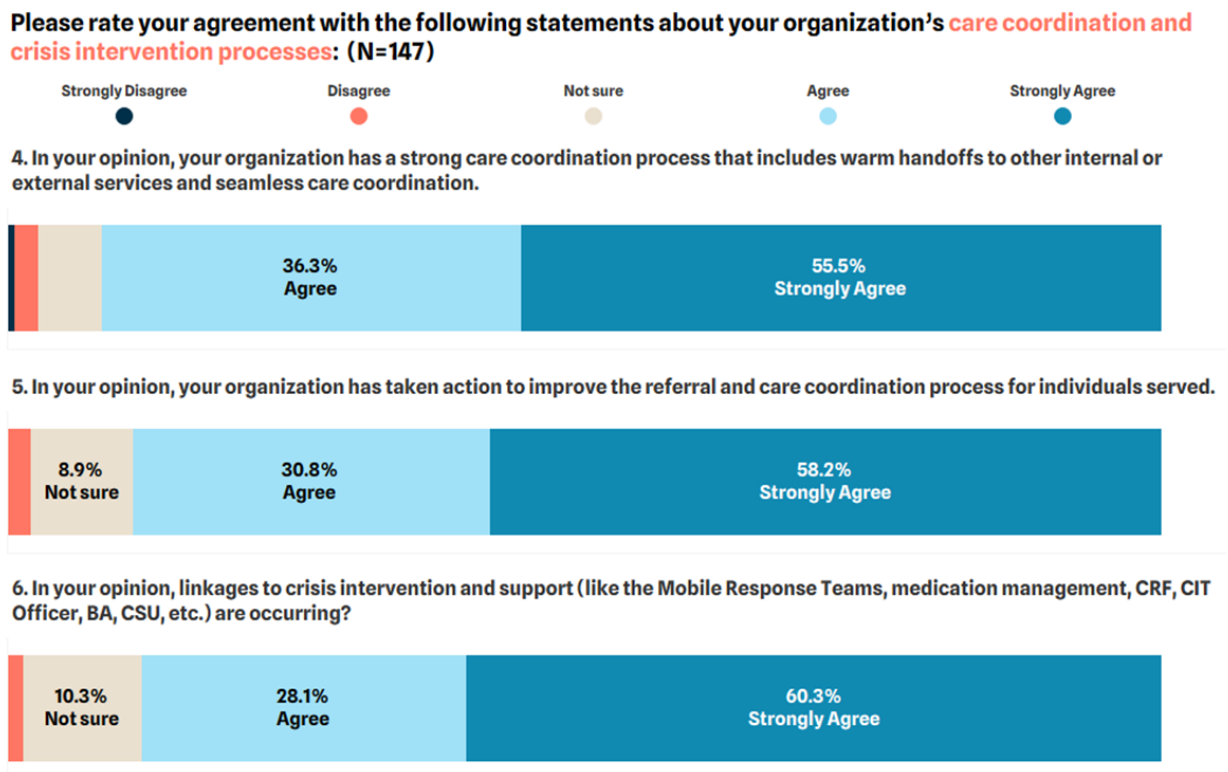
"[Much] has changed [for immigrants coming to us for services], and we're becoming more aware of that and reaching out to the kids and the parents. This has opened up a new arena for us to [focus on for] outreach." (*Clinician*)

Care Coordination

Strengths

Provider Survey data indicated extremely positive perceptions about care coordination with 91.8 percent agreeing or strongly agreeing that their organization has a strong process including warm hand-offs; 89 percent agreed or strongly agreed their organization has taken action to improve the referral and care coordination process, and 88.4 percent agreed or strongly agreed that linkages to crisis care are occurring.

Graphic 66. Care coordination and crisis intervention processes



Additionally, nearly all providers — 94.5 percent — agreed or strongly agreed that their organization promotes working with other community partners to ensure care coordination.

Graphic 67. Partnerships and coordination efforts

These sentiments were also mimicked in focus groups. Providers emphasized the importance of leadership fostering regular communication and mutual understanding across agencies, which created a strong foundation for supporting those in need.

Barriers

When asked about barriers to care coordination processes, focus group participants identified both organizational and structural challenges. They discussed some organizations working in silos or operating without regular communication which was believed to result in a duplication of services, a lack of clarity about what others offer, and situations where individuals served have to "start over" when transferring care. This sentiment seemed to emerge when multiple organizations were involved in someone's care. Some participants also described cases where organizations kept services in-house instead of referring to more specialized providers, in some cases, to avoid the aforementioned barriers.

Finally, focus group participants, especially those in leadership roles, emphasized that limited funding and funding cuts directly affected their coordination capacity and their ability to engage in marketing and outreach. Perceptions of inconsistent funding streams and differing paperwork requirements across funders created workflow inefficiencies, and high staff turnover continued to disrupt the continuity of care, especially in areas with high living costs and limited compensation. This was a particular challenge for service providers in Monroe County, but other Miami-Dade providers also commented that retaining staff (some of whom were living in Broward or Palm Beach for affordability) was a major issue.

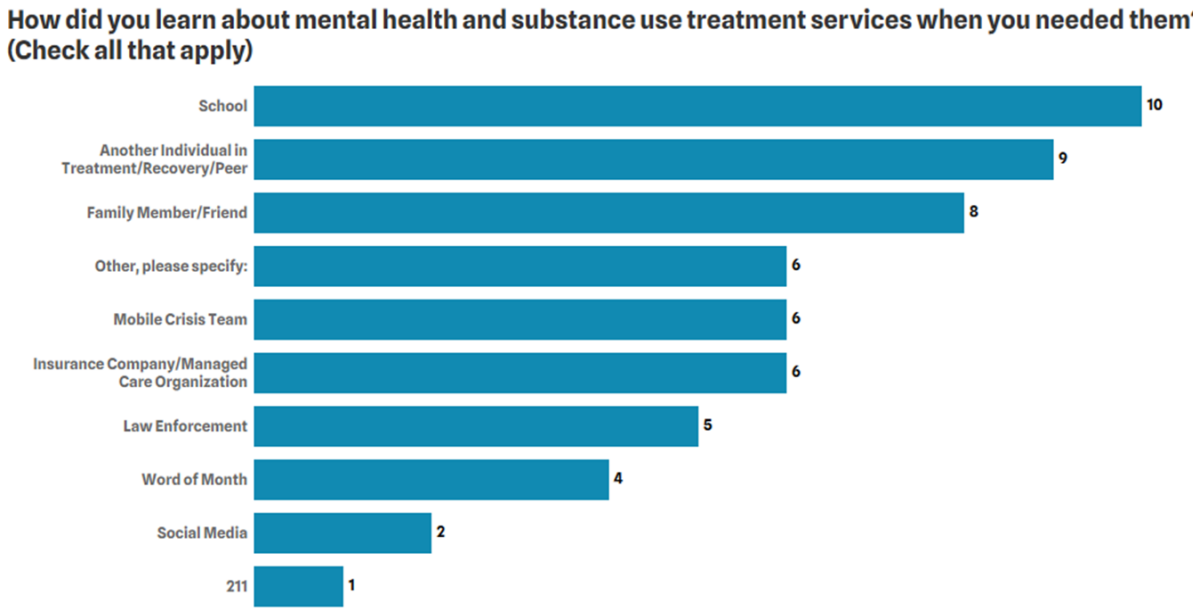
"You go back five to six years, and the issue was recruitment. And now, it's retention. Because you invest so much in your staff to be well-trained and well-versed in the services we provide and then it is so hard to retain them." (*CEO*)

Children's Services

Strengths

Children's services stood out as an area of relative strength across both the survey and focus groups. Of the 40 individuals who completed the Person Served Survey specific to Children's Mental Health or Children's Substance Use, schools were the dominant way families reported being connected to behavioral health services. Schools also emerged as a key resource for prevention and engaging families via focus groups, including several staff noting the benefits of having a presence/offices within schools and coordinating closely with trust counselors and other school personnel. Focus group participants working in the children's system of care also described their organization's strategies for engagement and high-quality services, like setting clear treatment goals, maintaining consistent communication with families, offering extended evening hours, and using telehealth for kids over 12 years.

Graphic 68. How did you learn about services when you needed them



Barriers

While there were clear strengths in children's services, providers also pointed to several persistent barriers that limit access, quality, and continuity of care. They mentioned some parents misinterpret early signs of mental health disorders as misbehavior, creating unrealistic expectations about the chronic nature of several behavioral health conditions. As mentioned with adult services, providers noted the lengthy enrollment and documentation process, and some wished for less restrictive and non-clinical options such as drop-in centers for youth and young adults. Of note was the challenge of finding specific services for youth with neurodivergence and more intensive behavioral health needs as some treatment facilities could

not accommodate this growing population of youth. Additionally, participants emphasized the difficulty of finding staff with the training and willingness to work with these challenging cases.

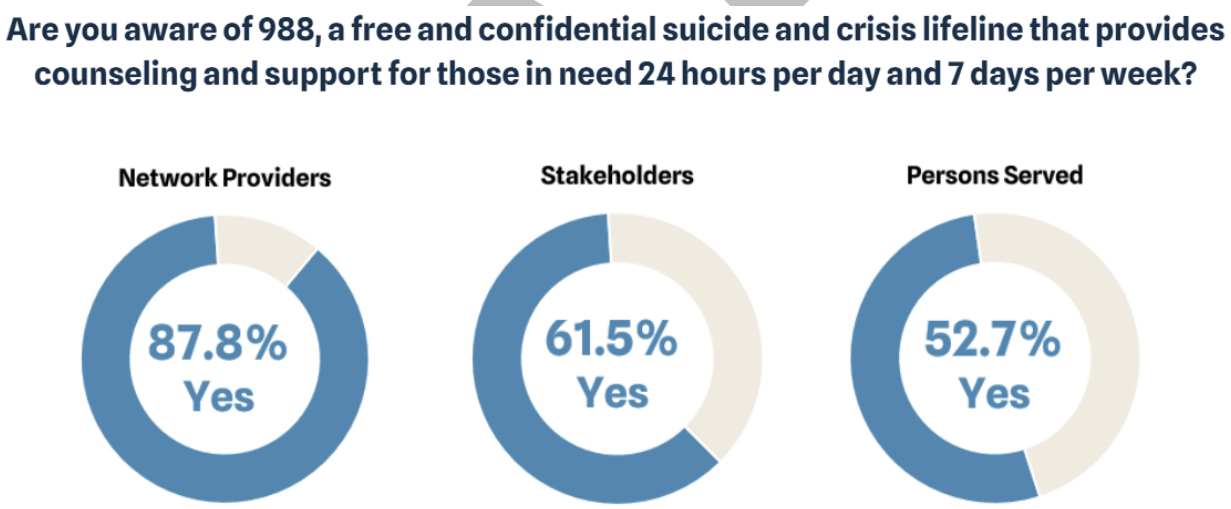
Suicide Awareness

Strengths

When it comes to suicide awareness and prevention, survey data and focus group participants highlighted a number of well-established supports and also named some ongoing gaps. On the strengths side, participants acknowledged a wide range of suicide prevention services already in place. These included the 988 Florida Lifeline, NAMI Miami-Dade programs, Mobile Response Teams, school-based campaigns, standardized risk assessments like the Columbia suicide severity rating scale, and ongoing education and outreach. Several focus group participants were excited to share that 988 was being widely promoted in schools via student ID cards and in bathroom stalls.

Barriers

Graphic 69. Awareness of 988 Florida Lifeline



Additional barriers such as limited funding for peer specific suicide outreach and wellness-based programs, and a lack of public awareness continued to be a concern. Despite increased awareness among students, public awareness still lags among adults and broader community members (see above).

“As clinicians, we know [about 988], but if you ask the general public, they don't know [about 988].”

Peer Services

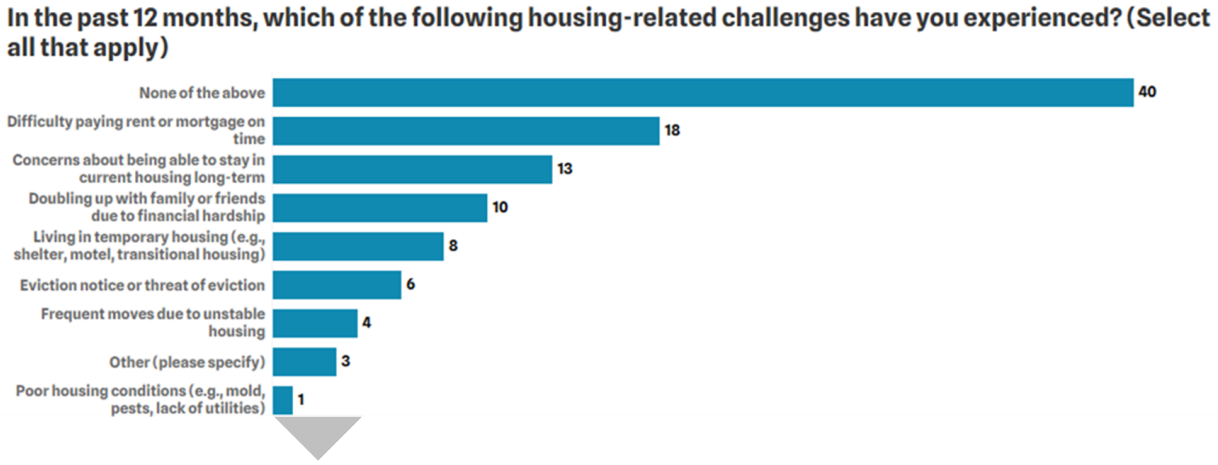
Peer support was perceived by focus group participants as a critical service, providing essential warm handoffs and fostering strong relationships, particularly for individuals and families navigating complex systems. Participants in all focus groups emphasized that peers often work flexibly and responsively, integrating frameworks like the Recovery-Oriented System of Care (ROSC) and Wellness Recovery Action Plans (WRAP). These roles were seen as complementary to clinical care. However, within the peer support focus groups, individuals shared concerns about being assigned tasks outside their scope — like medication monitoring or administering urinalyses. Others described stigma and discrimination within their own organizations that undervalued peer work or misunderstood its purpose.

"The value of the peer role needs to be expressed to all organizations because we are an enhancement. We are not there to take someone's job, and the discrimination and stigma doesn't always come from the outside; sometimes it can come from within [other provider organizations]." (*Peer Support Specialist*)

Behavioral Health and Housing

Housing barriers were asked on the Persons Served Survey, with approximately 60 percent of respondents citing at least one barrier. The most commonly selected challenge was difficulty paying the rent or mortgage on time.

Graphic 70. Housing-related challenges



Focus group participants across all groups repeatedly cited that obtaining both stable and appropriate housing for their persons served were major barriers to those individuals successfully engaging in treatment and recovery. Focus group participants described how individuals served face systemic disqualifiers like criminal records, evictions, poor credit, or income limits, and that options were more limited for certain groups like mothers with children, transgender individuals, or people with criminal offenses.

In several groups, provider staff described a cycle where people need a job to maintain housing but can't get or keep stable employment — especially with untreated mental health conditions. This cycle was perceived to push individuals into being unhoused, making it even harder to achieve independence or continue care. They also noted issues with discharge planning, and one case manager described it as, "like piecing together a puzzle."

Focus Group participants also consistently described the cost of housing as "astronomical", creating financial barriers for individuals seeking mental health services. They cited high costs for Assisted Living Facilities (ALFs) and Independent Living Facilities (ILFs) as being, in their opinions, inconsistent with the goal of placing someone in sustainable housing, especially for those with limited financial resources or relying on benefits.

"A lot of the families that we serve are low-income families, and the cost of living around here is astronomical and they can't afford it. And some of them are battling mental health issues that keep them from getting a job… so it kind of goes hand in hand. They are not able to acquire the income to get housing sometimes because of their mental health situations. And then they can't afford the mental health services either!" (*Peer Support Specialist*)

Finally, providers perceived the eligibility criteria across programs to be fragmented and too often not account for behavioral health needs at all. For example, several individuals commented that Assisted Living Facility (ALF) access was typically based on physical — not mental — health conditions, meaning people with serious mental health disorders may not qualify. In some cases, focus group participants reported that their individuals served had to discontinue medications like suboxone just to be eligible for housing, raising both clinical and ethical concerns.

"It feels like your mental health is competing with (being unhoused)." (*Case Manager*)

Several strengths also emerged from focus group feedback with regard to housing. Those strengths included providers discussing specific partnerships they already had with ALFs and ILFs, which they trusted. Having these personal connections (e.g., a specific person to go to) supported their ability to connect individuals to housing and create important access points for care continuity. Additionally, several providers across groups mentioned the excellent partnership they had with outreach teams via the Homeless Trust and other partners. They specifically noted the effectiveness of these teams to actively engage individuals who may not otherwise be connected to services. Finally, several organizations reported collaborating with housing-focused agencies such as Fellowship House, Mother Teresa, Lotus House, the Homeless Trust, and Camillus House to support individuals served with more stable placements.

Focus Group Recommendations

The following recommendations were specifically shared by focus group participants during groups and have been divided into several categories including general, children's services, peer services, and behavioral health housing.

General

Strengthen Collaboration Across Providers: Providers expressed a desire for regular opportunities to share information, such as monthly peer meetings and ongoing cross-organization outreach. Other suggestions included expanding provider directories and strengthening the convening role of Thriving Mind to help build relationships across agencies.

Increase Access and Eligibility: Recommendations for this included the development of online tools to match individuals served with services based on criteria such as location, level of care, and payment ability.

Promote Cross-Sector Partnerships: Improving partnerships with schools and other sectors was a key recommendation for promoting early intervention and mental health awareness.

Expand Funding for Outreach, Support Services, and Capacity Building: Participants highlighted the need for greater investment in outreach, marketing, transportation, and cross-training of staff to reduce access inequities.

Expand Access Through Community and Home-Based Services: Participants recommended the development of more home- and community-based behavioral health services, particularly for settings like schools, jails, and residential homes to reduce barriers such as transportation and stigma.

Children's Services

Voluntary Services: Providers mentioned wanting more youth respite programs or drop-in centers.

Transportation: Because children’s services were less plentiful compared with adult services, providers noted more transportation barriers to connect families to children’s services.

Education: Focus group participants recommended the ME engage in more concerted psychoeducation to families about behavioral health conditions emerging in youth and about treatments and expectations for recovery.

Peer Services

Enhance Peer Support Training and Certification: Invest in robust training programs and certification processes to ensure peers are well-equipped to support individuals effectively.

Prioritize Individuals Served-Centered, Compassionate Engagement: Meet individuals where they are physically and emotionally, leading with compassion and actively seeking to understand their unique needs and perspectives.

Formalize Peer Supervision and Cross-Training: Implement peer supervision models to provide

specialized support to peer teams, and ensure all staff (peers or not) are cross-trained to enhance service delivery.

Advocate for the Role: Help agencies recognize that the role is not there to "take someone's job", and eliminate discrimination. Also, address funding disparities and ensure that peer specialists receive equitable compensation and recognition for their contributions.

Behavioral Health Housing

Strengthen Relationships: Build strong relationships with ILF/ALF administrators to facilitate access; including establishing and maintaining existing contracts with ILFs and ALFs.

Increase Funding: Providers mentioned the need to increase incidental funding to support housing initiatives, including engaging family members to support stable housing goals.

Town Hall Presentation Findings

Introduction and Methodology

Following the data analysis of surveys and focus groups, the findings were presented to the broader community. Specifically, Thriving Mind South Florida and BSRI hosted three regional town halls in July 2025 to gather feedback on preliminary findings. One town hall took place in person and two were conducted virtually. Participants included behavioral health providers, key collaborators across sectors, administrators, and frontline staff from Miami-Dade and Monroe counties, many of whom had contributed to earlier surveys or focus groups.

Each town hall featured a presentation of key findings, followed by small-group breakout discussions. Participants were prompted to share what stood out, what they agreed or disagreed with, and what recommendations they had for improving the system. To reduce repetition, overlapping content is discussed only once under the most relevant section. Themes presented below reflect areas of saturation across all three events.

Key Reflections: Takeaways and Agreements

Participants shared a mix of affirmations and memorable takeaways. The most frequently discussed themes included housing, waitlists, peer support roles, family resistance, and provider coordination.

Housing is central to behavioral health. Housing was the most frequently cited takeaway and point of agreement. Participants described housing scarcity, affordability issues, and regulatory confusion (particularly between ILFs and ALFs) as barriers to care. Many confirmed the link between housing instability and poor mental health outcomes.

Stigma and fear continue to shape access. Attendees described persistent stigma around mental health in many communities, especially immigrant and Latinx families. Fear of Immigration and Customs Enforcement (ICE), concerns about documentation, and general mistrust of institutions were noted as deterrents for families seeking care. These concerns often feed denial and reduce follow-through after intake.

Waitlists are long, especially for youth. Wait times were described as worsening, particularly for adolescent services. Some noted individuals served waiting over two months for care, often resulting in disengagement. This theme aligned with the Needs Assessment Draft, which reported long waitlists for older youth.

Peer specialists are undervalued. Participants consistently agreed that peer support is an essential yet misunderstood component of care. Several shared that peers are often mistaken for clerical support or drivers, and that role confusion undermines their effectiveness. Suggestions included expanding supervision opportunities and formal certification to clarify and elevate the peer role.

Coordination and collaboration are uneven. There was strong agreement that many providers work in silos. Staff retention, funding constraints, and lack of shared protocols hinder warm handoffs and continuity of care. While collaboration was cited as a system strength in some cases, most described it as inconsistent or limited to personal relationships.

Divergences and Disagreements

Participants were asked to share experiences that didn't align with the presentation or what they found surprising. While many comments reinforced known challenges, several specific disagreements emerged.

***Individuals being unhoused felt underrepresented*.** Multiple attendees challenged the idea that individuals being unhoused had declined. Clinicians reported seeing more older adults and families experiencing housing issues, and suggested current definitions may obscure actual need. Several cited the loss of housing-related funding as a driver of this increase.

***Collaboration remains more aspirational than real*.** While the presentation framed cross-agency collaboration as a goal, many participants expressed skepticism about its current state. They cited examples of people not answering their calls, duplicated efforts, and disconnected systems. Some noted that collaboration efforts, such as Thriving Mind convenings, have not yet translated into everyday practice.

***Youth services capacity is overstated*.** Several providers shared that the availability of youth placements and residential services was worse than suggested. They also described needing more specialized programs to handle severe behavioral issues and co-occurring conditions.

***Cultural stigma is shifting*.** Some were surprised at how prevalent stigma still appeared in the data, stating that in their experience, mental health is now discussed more openly on social media and among younger people. Others suggested this varies by neighborhood or family background.

Recommendations

Participants offered concrete ideas for improving the behavioral health system. These are grouped into five domains of saturated feedback.

1. Address Housing Instability

- Stop using ILFs as substitutes for ALFs unless appropriately licensed.
- Provide oversight and transparency around ILF/ALF licensing and payment practices.
- Create a housing-specific resource guide with availability, eligibility, and contact details.
- Increase housing options for individuals with behavioral health needs, including for older adults.

2. Improve Navigation and Public Awareness of Services

- Host in-person or virtual meet-and-greets for Thriving Mind providers to build relationships.
- Develop a public-facing guidebook (digital and print) and hold "job fair"-style events to promote services.
- Build a stronger social media and outreach presence to raise awareness of behavioral health resources.
- Partner with ride-share companies (e.g., Uber, Lyft) to help individuals and families reach appointments once they are connected to care.

3. Strengthen Family and School-Based Engagement

- Train teachers to identify behavioral health needs using tools like Mental Health First Aid.
- Engage parents directly in care (e.g., Community Action Treatment Teams (CAT) team model) and offer support for parents themselves.
- Partner with The Children's Trust and others to expand parent education and promote Thriving Mind services.

4. Elevate and Expand Peer Support Roles

- Provide training and supervisory opportunities for peer specialists.
- Educate providers about the scope of peer roles to reduce misconceptions.
- Address stigma and job security concerns around peer positions.

5. Enhance Care Coordination and System Design

- Improve communication and referral systems across agencies.
- Reduce paperwork and create electronic systems to streamline service access.
- Support data-sharing agreements that facilitate coordination and reduce duplication.

Conclusions

This needs assessment confirms that while Thriving Mind South Florida's network demonstrates significant strengths in coordination, provider commitment, and innovative partnerships, persistent systemic barriers limit equitable access to behavioral health care in Miami-Dade and Monroe counties. Housing affordability, workforce retention, service capacity for youth and specialized populations, and public awareness remain critical challenges.

Addressing these issues requires a multi-pronged approach that integrates housing solutions into behavioral health planning, fosters cross-sector partnerships, and invests in culturally competent, person-centered care models. By acting on the recommendations identified here — and continuing to engage stakeholders in collaborative problem-solving — Thriving Mind and its partners can strengthen the region's capacity to provide timely, high-quality services that promote recovery, resilience, and well-being for all residents.

Appendices

Appendix A. Collaborator Survey Item-by-item

1. Are you employed by a Thriving Mind South Florida provider?		
	Frequency	Percent
Yes	150	66.4 percent
No	76	33.6 percent
Total	226	100.0 percent

2. Please select the County you work in:		
	Frequency	Percent
Miami-Dade	112	77.2 percent
Monroe	33	22.8 percent
Total	145	100.0 percent

3. I work in a (check all the apply):		
	Responses	
	N	Percent of Participants
Adult Crisis Unit	21	14.3 percent
Adult Detoxification Unit	9	6.1 percent
Adult Residential Facility	16	10.9 percent
Adult Outpatient Program	65	44.2 percent
Adult Mobile Response	5	3.4 percent
Children's Crisis Unit	9	6.1 percent
Children's Detoxification Unit	1	0.7 percent
Children's Residential Facility	4	2.7 percent
Children's Outpatient Program	37	25.2 percent
Children's Mobile Response	6	4.1 percent
Peer Recovery Support	25	17.0 percent
Other, please specify:	35	23.8 percent
Total	233	158.5 percent

Please rate your agreement with the following statements about your organization's care coordination and crisis intervention processes:

4. In your opinion, your organization has a strong care coordination process that includes warm handoffs to other internal or external services and seamless care coordination.		
	Frequency	Percent
Strongly Agree	81	55.5 percent
Agree	53	36.3 percent
Not sure	8	5.5 percent
Disagree	3	2.1 percent

Strongly Disagree	1	0.7 percent
Total	146	100.0 percent

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

	Frequency	Percent
Strongly Agree	85	58.2 percent
Agree	45	30.8 percent
Not sure	13	8.9 percent
Disagree	3	2.1 percent
Total	146	100.0 percent

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

	Frequency	Percent
Strongly Agree	88	60.3 percent
Agree	41	28.1 percent
Not sure	15	10.3 percent
Disagree	2	1.4 percent
Total	146	100.0 percent

7. Your organization promotes its services and resources very well.

	Frequency	Percent
Strongly Agree	81	55.1 percent
Agree	54	36.7 percent
Not sure	6	4.1 percent
Disagree	6	4.1 percent
Total	147	100.0 percent

8. Your organization promotes awareness of available options and linkages to needed services.

	Frequency	Percent
Strongly Agree	78	53.4 percent
Agree	58	39.7 percent
Not sure	5	3.4 percent
Disagree	5	3.4 percent
Total	146	100.0 percent

9. It's easy for individuals to access the services they need quickly and efficiently.

	Frequency	Percent
Strongly Agree	71	48.6 percent
Agree	54	37.0 percent
Not sure	10	6.8 percent
Disagree	9	6.2 percent

Strongly Disagree	2	1.4 percent
Total	146	100.0 percent

10. Your organization encourages (promotes) working with other community partners to ensure care coordination.

	Frequency	Percent
Strongly Agree	96	66.2 percent
Agree	41	28.3 percent
Not sure	7	4.8 percent
Disagree	1	0.7 percent
Total	145	100.0 percent

Please rate your agreement with the following statements about your organization's partnerships and coordination efforts.

11. Individuals needing services have equal access to care.

	Frequency	Percent
Strongly Agree	97	66.9 percent
Agree	37	25.5 percent
Not sure	5	3.4 percent
Disagree	6	4.1 percent
Total	145	100.0 percent

12. Have you made any referrals to the new 988/Florida Lifeline?

	Frequency	Percent
Yes	51	34.7 percent
No	78	53.1 percent
I am not aware of the 988/Florida Lifeline	18	12.2 percent
Total	147	100.0 percent

13. Access to needed services is coordinated and linkages to care are well established across the Managing Entity system of care.

	Frequency	Percent
Strongly Agree	54	37.0 percent
Agree	56	38.4 percent
Not sure	27	18.5 percent
Disagree	8	5.5 percent
Strongly Disagree	1	0.7 percent
Total	146	100.0 percent

Please rate your agreement with the following statements about access to services and care coordination.

14. Access to needed services is coordinated and linkages to care are well established across the Medicaid system of care.

	Frequency	Percent
Strongly Agree	44	30.6 percent

Agree	48	33.3 percent
Not sure	39	27.1 percent
Disagree	13	9.0 percent
Total	144	100.0 percent

15. Access to needed services is coordinated and linkages to care are well established across the Commercial Insurance system of care.

	Frequency	Percent
Strongly Agree	35	24.0 percent
Agree	40	27.4 percent
Not sure	58	39.7 percent
Disagree	12	8.2 percent
Strongly Disagree	1	0.7 percent
Total	146	100.0 percent

16. Access to needed services is coordinated and linkages to care are well established across the Veterans Affairs (VA) system of care.

	Frequency	Percent
Strongly Agree	27	18.6 percent
Agree	35	24.1 percent
Not sure	76	52.4 percent
Disagree	7	4.8 percent
Total	145	100.0 percent

17. In general, behavioral health care and peer services are accessible in my area.

	Frequency	Percent
Strongly Agree	78	53.4 percent
Agree	52	35.6 percent
Not sure	6	4.1 percent
Disagree	8	5.5 percent
Strongly Disagree	2	1.4 percent
Total	146	100.0 percent

18. The referral process is easily accessible.

	Frequency	Percent
Strongly Agree	66	45.5 percent
Agree	52	35.9 percent
Not sure	16	11.0 percent
Disagree	10	6.9 percent
Strongly Disagree	1	0.7 percent
Total	145	100.0 percent

19. Please select the barriers for consumers accessing services in your community. (Check all that apply)

	Responses	
	N	Percent of Participants
Did not have any barriers	27	19.7 percent
I was concerned about the cost of services	50	36.5 percent
Services are not covered by health insurance	52	38.0 percent
I did not meet the eligibility criteria for services	35	25.5 percent
I did not know where to go to get services	34	24.8 percent
I did not think services would help	22	16.1 percent
I did not have time (because of my job, childcare, or other commitments)	44	32.1 percent
I did not want others to find out that I needed services	18	13.1 percent
I am concerned about being discriminated against	9	6.6 percent
I had no transportation	70	51.1 percent
Services were not available in my area	18	13.1 percent
Service hours were not convenient	29	21.2 percent
Some other reason:	10	7.3 percent
Total	418	305.1 percent

Appendix B. Persons Served Survey Item-by-item

1. Which of the following best describes you:

	Frequency	Valid Percent
Adult receiving services	46	49.5 percent
Parent of a child receiving services	24	25.8 percent
Caregiver/Guardian of individual receiving services	5	5.4 percent
Young adults/Youth receiving services	16	17.2 percent
I received services in the past but am not currently receiving them.	2	2.2 percent
Total	93	100.0 percent

2. What type(s) of service(s) did you or the person you represent receive? Please check all that apply.

	Responses	
	N	Percent of Cases
Adult Mental Health Services	42	46.2 percent
Adult Substance Use Services	16	17.6 percent
Children Mental Health Services	37	40.7 percent
Children Substance Use Services	15	16.5 percent
Peer support services	26	28.6 percent
Prevention services	8	8.8 percent
Crisis services	10	11.0 percent
Total	154	169.2 percent

3. Which county do you live in?

	Frequency	Valid Percent
Miami-Dade County	87	96.7 percent
Monroe County	3	3.3 percent
Total	90	100.0 percent

4. If you need to access mental health and/or substance use treatment services, do you know where to go or who to contact?

	Frequency	Valid Percent
Yes	76	82.6 percent
No	10	10.9 percent
Sometimes	6	6.5 percent
Total	92	100.0 percent

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

	Responses

	N	Percent of Cases
Family Member/Friend	26	28.0 percent
Word of Mouth	13	14.0 percent
211	3	3.2 percent
988	2	2.2 percent
Social Media	3	3.2 percent
Another Individual in Treatment/Recovery/Peer	13	14.0 percent
Mobile Crisis Team	7	7.5 percent
Insurance Company/Managed Care Organization	13	14.0 percent
School	12	12.9 percent
Law Enforcement	10	10.8 percent
Other	19	20.4 percent
Total	121	130.1 percent

7. Were you able to get the services you needed when you needed them?

	Frequency	Valid Percent
Yes, all of the services I needed	67	72.0 percent
Yes, some of the services I needed	17	18.3 percent
No	9	9.7 percent
Total	93	100.0 percent

8. Please choose from the list below the services you needed but could not get (check all that apply).

	Responses	
	N	Percent of Cases
Assessment	1	4.2 percent
Alternative Services (acupuncture, art therapy, meditation, etc.)	5	20.8 percent
Aftercare/Follow-up	2	8.3 percent
Case Management	11	45.8 percent
Day Care Services	2	8.3 percent
Employment/Job Training Assistance	1	4.2 percent
Housing Assistance	9	37.5 percent
In-Home Services	5	20.8 percent
Inpatient	1	4.2 percent
Medical Services	1	4.2 percent
Medication Assistance Program	1	4.2 percent
Outpatient Services	4	16.7 percent
Outreach Support	1	4.2 percent
Prevention Services	1	4.2 percent
Referral	2	8.3 percent

Residential Treatment Program	1	4.2 percent
Short-term Residential Treatment	1	4.2 percent
Telehealth	2	8.3 percent
Other	4	16.7 percent
Total	55	229.2 percent

9. How many times during the last 12 months were you NOT able to get the services you needed?

	Frequency	Valid Percent
One or two times	9	56.3 percent
Three or four times	6	37.5 percent
Five or more times	1	6.3 percent
Total	16	100.0 percent

10. Have you ever been placed on a waitlist for services?

	Frequency	Valid Percent
Yes	36	38.7 percent
No (Go to question 12)	39	41.9 percent
Not Sure	18	19.4 percent
Total	93	100.0 percent

11. How long did you need to wait before receiving services?

	Frequency	Valid Percent
Less than 1 week	8	15.1 percent
1-2 weeks	14	26.4 percent
More than 2 weeks	11	20.8 percent
More than one month	20	37.7 percent
Total	53	100.0 percent

12. Please check any of the following barriers that affect(ed) your ability to receive services.

	Responses	
	N	Percent of Cases
Did not have any barriers	50	53.8 percent
I was concerned about the cost of services	10	10.8 percent
Services are not covered by health insurance	11	11.8 percent
I did not meet the eligibility criteria for services	3	3.2 percent
I did not know where to go to get services	8	8.6 percent
I did not think services would help	3	3.2 percent
I did not have time (because of my job, childcare, or other commitments)	4	4.3 percent
I did not want others to find out that I needed services	3	3.2 percent
I am concerned about being discriminated against	3	3.2 percent

I had no transportation	8	8.6 percent
Services were not available in my area	4	4.3 percent
Service hours were not convenient	2	2.2 percent
Some other reason:	10	10.8 percent
Total	119	128.0 percent

13. The services and planning I received were focused on my personal treatment needs while respecting my background and experiences (patient-centered).

	Frequency	Valid Percent
Strongly Disagree	11	12.0 percent
Disagree	2	2.2 percent
Agree	24	26.1 percent
Strongly Agree	55	59.8 percent
Total	92	100.0 percent

14. In which settings have you been the most comfortable discussing your behavioral health concerns? (Choose all that apply)

	Responses	
	N	Percent of Cases
Telehealth (Talking to a health care provider over your phone or computer. This may include using a video)	25	28.7 percent
Hybrid of Telehealth (includes some face-to-face and some telehealth)	27	31.0 percent
Face-to-face with a doctor	31	35.6 percent
Face-to-face with a nurse practitioner	8	9.2 percent
Face-to-face with some other type of healthcare provider:	28	32.2 percent
Faith-based organization	6	6.9 percent
None of the above	7	8.0 percent
Other	8	9.2 percent
Total	140	160.9 percent

15. Please rate your agreement with the following statements:

I am aware of the availability of mental health and substance use services in my area.

	Frequency	Valid Percent
Strongly Disagree	10	11.2 percent
Disagree	5	5.6 percent
Agree	28	31.5 percent
Strongly Agree	46	51.7 percent
Total	89	100.0 percent

I am aware of Thriving Mind South Florida Health System (Managing Entity) resources.

	Frequency	Valid Percent
Strongly Disagree	11	12.4 percent
Disagree	13	14.6 percent
Agree	27	30.3 percent
Strongly Agree	38	42.7 percent
Total	89	100.0 percent

16. Have you accessed Thriving Mind South Florida (Managing Entity) resources in the past 6 months?

	Frequency	Valid Percent
Yes	22	24.7 percent
No	67	75.3 percent
Total	89	100.0 percent

17. Have you recommended Thriving Mind South Florida (Managing Entity) funded providers and/or resources to someone else?

	Frequency	Valid Percent
Yes	27	31.0 percent
No	60	69.0 percent
Total	87	100.0 percent

18. Are you aware of youth substance use prevention services (parent/school/community-based) available in your area?

	Frequency	Valid Percent
Yes, and I have participated	18	20.0 percent
Yes, I am aware, but I have never participated	41	45.6 percent
No, I was not aware of these services	31	34.4 percent
Total	90	100.0 percent

19. Are you aware of suicide awareness/prevention services offered in the community, including 988 or evidence-based services such as Question Persuade Refer (QPR) training?

	Frequency	Valid Percent
Yes, and I have participated	22	26.2 percent
Yes, I am aware, but I have never participated	44	52.4 percent
No, I was not aware of these services	18	21.4 percent

20. Are you aware of 988, a free and confidential suicide and crisis lifeline that provides counseling and support for those in need 24 hours per day and 7 days per week?

	Frequency	Valid Percent
Yes	48	52.7 percent
No	43	47.3 percent

Total	91	100.0 percent

21. What was your experience with the 988 suicide and crisis lifeline?

	Frequency	Valid Percent
I have never used the 988 lifeline	43	89.6 percent
I was satisfied with the 988 lifeline	4	8.3 percent
I was unsatisfied with the 988 lifeline	1	2.1 percent
Total	48	100.0 percent

22. Which best describes your gender identity?

	Frequency	Valid Percent
Male	30	32.6 percent
Female	55	59.8 percent
Some other way not listed	1	1.1 percent
Prefer not to answer	6	6.5 percent
Total	92	100.0 percent

23. Which best describes your current sexual orientation?

	Frequency	Valid Percent
Heterosexual/Straight	55	61.1 percent
Gay/Lesbian	4	4.4 percent
Bisexual	7	7.8 percent
Queer	1	1.1 percent
My sexual orientation is not listed here	3	3.3 percent
Prefer not to answer	20	22.2 percent
Total	90	100.0 percent

24. In the past 12 months, which of the following housing-related challenges have you experienced?

	Responses	
	N	Percent of Cases
Difficulty paying rent or mortgage on time	18	20.7 percent
Eviction notice or threat of eviction	6	6.9 percent
Frequent moves due to unstable housing	4	4.6 percent
Doubling up with family or friends due to financial hardship	10	11.5 percent
Living in temporary housing (e.g., shelter, motel, transitional housing)	8	9.2 percent
Concerns about being able to stay in current housing long-term	13	14.9 percent
Poor housing conditions (e.g., mold, pests, lack of utilities)	1	1.1 percent
Other	3	3.4 percent
None of the above	40	46.0 percent
Total	103	118.4 percent

25. Which best describes your race?		
	Frequency	Valid Percent
White	42	47.2 percent
Black	31	34.8 percent
Other	1	1.1 percent
More than one race	8	9.0 percent
Prefer not to answer	7	7.9 percent

26. Which best describes your ethnicity?		
	Frequency	Valid Percent
Hispanic or Latino	43	49.4 percent
Non-Hispanic or Latino	25	28.7 percent
Prefer not to answer	19	21.8 percent

27. What best describes your cultural identity?		
	Responses	
	N	Percent of Cases
Cuban	24	28.2 percent
Puerto Rican	7	8.2 percent
Dominican	6	7.1 percent
Haitian	4	4.7 percent
Other Caribbean	4	4.7 percent
Colombian	1	1.2 percent
Venezuelan	2	2.4 percent
Argentinean	1	1.2 percent
Other South American	3	3.5 percent
Other Hispanic:	9	10.6 percent
Other Non-Hispanic:	11	12.9 percent
Prefer not to answer	19	22.4 percent
Total	91	107.1 percent

Please select your age range from the list below.		
	Frequency	Valid Percent
15-19 yrs.	12	13.6 percent
20-24 yrs.	5	5.7 percent
25-34 yrs.	18	20.5 percent
35-44 yrs.	19	21.6 percent
45-54 yrs.	11	12.5 percent
55-64 yrs.	6	6.8 percent
65-74 yrs.	5	5.7 percent

>74 yrs.	2	2.3 percent
Prefer not to answer	10	11.4 percent
Total	88	100.0 percent

Appendix C. Stakeholder Survey Item-by-item

1. Please tell us about where you live and/or work (check all that apply).		
	Responses	
	N	Percent of Cases
I live in Miami-Dade.	88	73.9 percent
I work in Miami-Dade.	80	67.2 percent
I live in Monroe County.	6	5.0 percent
I work in Monroe County.	7	5.9 percent
None of the above	10	8.4 percent
Total	191	160.5 percent

2. Do you work in the mental health and/or substance use field?		
	Frequency	Valid Percent
Yes	80	73.4 percent
No	29	26.6 percent
Total	109	100.0 percent

3. Are you employed by a Thriving Mind South Florida funded healthcare provider organization?		
	Frequency	Valid Percent
Yes	48	44.0 percent
No	61	56.0 percent
Total	109	100.0 percent

4. Please select the service sector which best describes your organization? (Check all that apply)		
	Responses	
	N	Percent of Cases
Adult Serving Agency	19	17.4 percent
Adult Mental Health Care	41	37.6 percent
Adult Substance Use Treatment	25	22.9 percent
Children Serving Agency	16	14.7 percent
Children Mental Health Care	16	14.7 percent
Children Substance Use Treatment	10	9.2 percent
Adult and Children Serving Agency	15	13.8 percent
Adult and Children Mental Health Serving Agency	16	14.7 percent
Adult and Children Substance Use Treatment Agency	11	10.1 percent
Case Management	33	30.3 percent
Child/Youth Advocacy	13	11.9 percent
Children and Family Services	35	32.1 percent

School (elementary, middle or high school)	8	7.3 percent
Domestic Abuse Advocacy	7	6.4 percent
Faith-based Family Services	4	3.7 percent
Foster Care/ Child Welfare	10	9.2 percent
Homeless Services	11	10.1 percent
Juvenile Justice	5	4.6 percent
Law Enforcement	5	4.6 percent
Local Government	5	4.6 percent
Social Services	15	13.8 percent
Residential Care	13	11.9 percent
Other	12	11.0 percent
Total	345	316.5 percent

Please rate your agreement with the following:

5. I am aware of the availability of mental health and substance use services in my area.

	Frequency	Valid Percent
Strongly Disagree	6	5.7 percent
Disagree	6	5.7 percent
Agree	51	48.1 percent
Strongly Agree	43	40.6 percent
Total	106	100.0 percent

6. I am aware of Thriving Mind South Florida Health System (Managing Entity) resources.

	Frequency	Valid Percent
Strongly Disagree	4	3.7 percent
Disagree	10	9.3 percent
Agree	53	49.5 percent
Strongly Agree	40	37.4 percent
Total	107	100.0 percent

7. Have you accessed Thriving Mind South Florida (Managing Entity) resources in the past 6 months?

	Frequency	Valid Percent
Yes	38	40.4 percent
No	56	59.6 percent
Total	94	100.0 percent

8. When you accessed Thriving Mind South Florida (Managing Entity) resources, were they helpful?

	Frequency	Valid Percent
Yes	54	75.0 percent
No	7	9.7 percent
Somewhat	11	15.3 percent
Total	72	100.0 percent

9. Have you ever directed individuals to access Thriving Mind South Florida (Managing Entity) by calling or online?

	Frequency	Valid Percent
Yes	48	51.6 percent
No	45	48.4 percent
Total	93	100.0 percent

10. Have you recommended Thriving Mind South Florida (Managing Entity) funded-providers and/or resources to someone else?

	Frequency	Valid Percent
Yes	67	72.0 percent
No	26	28.0 percent
Total	93	100.0 percent

11. Are you aware of the 9-8-8 resource?

	Frequency	Valid Percent
Yes	68	63.6 percent
No	39	36.4 percent
Total	107	100.0 percent

12. Have you or anyone you know accessed the 9-8-8 resource in the past 6 months?

	Frequency	Valid Percent
Yes	17	15.9 percent
No	90	84.1 percent
Total	107	100.0 percent

13. When you or someone you know accessed 9-8-8, was it helpful?

	Frequency	Valid Percent
Yes	17	94.4 percent
Somewhat	1	5.6 percent
Total	18	100.0 percent

14. Have you ever directed individuals to access 9-8-8 by calling or online?

	Frequency	Valid Percent
Yes	18	100.0 percent

How would you rate community awareness of mental health and substance use treatment services available in your area for the following types of individuals?

15. The general population

	Frequency	Valid Percent
Poor	25	23.8 percent
Fair	40	38.1 percent
Good	27	25.7 percent
Very good	8	7.6 percent
Excellent	5	4.8 percent
Total	105	100.0 percent

16. Persons in need of behavioral health services

	Frequency	Valid Percent
Poor	15	14.2 percent
Fair	42	39.6 percent
Good	31	29.2 percent
Very good	9	8.5 percent
Excellent	9	8.5 percent
Total	106	100.0 percent

17. Service providers offering behavioral health services

	Frequency	Valid Percent
Poor	11	10.3 percent
Fair	27	25.2 percent
Good	42	39.3 percent
Very good	18	16.8 percent
Excellent	9	8.4 percent
Total	107	100.0 percent

Please rate your agreement with the following statements about access to services and care coordination.

18. Access to needed services is coordinated and linkages to care are well established across the Managing Entity system of care.

	Frequency	Valid Percent
Strongly Disagree	3	2.8 percent
Disagree	11	10.3 percent
Unsure	34	31.8 percent
Agree	49	45.8 percent
Strongly Agree	10	9.3 percent

Total	107	100.0 percent

19. Access to needed services is coordinated and linkages to care are well established across the Medicaid system of care.

	Frequency	Valid Percent
Strongly Disagree	5	4.7 percent
Disagree	16	15.0 percent
Unsure	45	42.1 percent
Agree	33	30.8 percent
Strongly Agree	8	7.5 percent
Total	107	100.0 percent

20. Access to needed services is coordinated and linkages to care are well established across the Commercial Insurance system of care.

	Frequency	Valid Percent
Strongly Disagree	9	8.4 percent
Disagree	14	13.1 percent
Unsure	52	48.6 percent
Agree	26	24.3 percent
Strongly Agree	6	5.6 percent
Total	107	100.0 percent

Please rate your agreement with the following statements about access to services and care coordination. -

21. The referral process is easily accessible.

	Frequency	Valid Percent
Strongly Disagree	6	5.7 percent
Disagree	16	15.1 percent
Unsure	31	29.2 percent
Agree	39	36.8 percent
Strongly Agree	14	13.2 percent
Total	106	100.0 percent

22. Access to needed services is coordinated and linkages to care are well established across the Veterans Affairs (VA) system of care.

	Frequency	Valid Percent
Strongly Disagree	7	6.5 percent
Disagree	12	11.2 percent
Unsure	55	51.4 percent

Agree	29	27.1 percent
Strongly Agree	4	3.7 percent
Total	107	100.0 percent

23. In general, behavioral health care and peer services are accessible in my area.

	Frequency	Valid Percent
Strongly Disagree	4	3.7 percent
Disagree	13	12.1 percent
Unsure	16	15.0 percent
Agree	59	55.1 percent
Strongly Agree	15	14.0 percent
Total	107	100.0 percent

24. Please select the barriers for consumers accessing services in your community.

	Responses	
	N	Percent of Cases
Did not have any barriers	15	15.8 percent
I was concerned about the cost of services	41	43.2 percent
Services are not covered by health insurance	46	48.4 percent
I did not meet the eligibility criteria for services	30	31.6 percent
I did not know where to go to get services	35	36.8 percent
I did not think services would help	23	24.2 percent
I did not have time (because of my job, childcare, or other commitments)	28	29.5 percent
I did not want others to find out that I needed services	15	15.8 percent
I am concerned about being discriminated against	13	13.7 percent
I had no transportation	38	40.0 percent
Services were not available in my area	20	21.1 percent
Service hours were not convenient	26	27.4 percent
Some other reason	12	12.6 percent
Total	342	360.0 percent

Appendix D. South Florida Behavioral Health Network (SFBHN) DBA/Thriving Mind South Florida Fiscal Year 2024/2025 Enhancement Plan[2]

Local Funding Request

Process of determining unmet need

Thriving Mind South Florida (South Florida Behavioral Health Network, Inc.; Thriving Mind), completed its 2022-2023 Triannual Needs Assessment on Oct. 1, 2022. Thriving Mind participated in a statewide needs assessment exercise and engaged the Health Council of South Florida (HCSF), a private, non-profit 501(c)3 organization serving as the state-designated local health planning agency for Miami-Dade and Monroe Counties, to conduct its portion of the comprehensive behavioral needs assessment and cultural health disparity report. Consequently, HCSF collected qualitative and quantitative data to conduct analysis and recommendations for prioritization of services. The results were driven by collected information obtained through data analysis, feedback from community forums, surveys and interviews.

The process to complete the behavioral health community needs assessment included partnership with a combination of various key Thriving Mind groups, including board and advisory members, leadership, staff, and/or volunteers, as well as engagement with service providers, individuals served, family members, and caregivers. The resulting report was based on the latest data, focus group results, assessment outcomes, community forums, surveys (individual, peer recovery support, no wrong door, and stakeholder), and the integration of the Managing Entity (ME)-specific data sets. Also, integral to determining unmet needs is the ongoing engagement between the ME, Network Service Providers (NSPs), individuals served, and other community stakeholders.

Additionally, for Fiscal 2022-2023, Gov. Ron DeSantis approved a $126 million per year increase for critical unmet needs. The allocation to our region addressed many previously reported enhancement needs. In addition to significant expansion of residential capacity and other new initiatives in the Southern Region, Thriving Mind used these funds to transform the region's crisis response system (who to call, who responds, where to go).

In addition to support for 988 and increased children's crisis beds, Thriving Mind now offers a robust mobile response team (MRT) network that manages many of the calls previously leading to law enforcement response and Baker Act. Most of these individuals, including children engaged by MRTs because of calls from the schools, are now diverted into treatment within the Department of Children and Families (Department)-funded system of care.

The unexpected ending of non-recurring funds in the current Fiscal Year budget for the safety net organization for Miami-Dade and Monroe, Thriving Mind, is $17 million before our one-year mitigation efforts largely using as-yet-unapproved carry forward. Detailed below, these reductions will:

- reduce services in mental health treatment, FACT interventions, substance exposed newborn program

[2] The 2024-25 Enhancement Plan was submitted to the state under previous contract, in which our organization was contracted as South Florida Behavioral Health Network, Inc. (DBA Thriving Mind South Florida.)

- eliminate programs in substance use treatment for adults and children
- eliminate housing coordinator at critical housing program
- eliminate prevention programs

Thriving Mind mitigated the impact of the unexpected ending of non-recurring funds by using one-time, non-recurring carry-forward and supplemental residual balances to the total amount of **$9.4 million**. The region will still face significant challenges this year and in future years. In absence of additional applied carry forward (which is usually applied to "uncompensated service units"), there will be even larger budget reductions for services, and unmet needs will not be addressed.

Unmet need #1: Additional funding for housing

The problem or unmet need that this funding will address:

A great need exists for affordable housing in the Southern Region, which is comprised of Miami-Dade and Monroe Counties. For Fiscal Year 2023-2024, a total of 1,942 individuals served were unhoused at the time of admission into our services. Thriving Mind has continually advocated that housing measures are difficult to meet due to our region's higher cost of living in comparison to other parts of the state.

As of July 2024, the median sold price of a home in Miami-Dade County, Florida, was $541,100, which is a 10.7 percent increase from July 2023. In June 2024, the median price of a home in Monroe County, Florida was $925,000, which is a 4.6 percent decrease from the previous year.

The increased cost in housing is reflected in increased costs that roll down to our providers and individuals served. For Fiscal 2023-2024, a total of $315,318 was spent on Assisted Living Facility payments (152 payments for 19 individuals). This is up from $192,445 in Fiscal 2022-2023 (113 payments for 22 individuals).

Additionally, each of our counties has unique needs: Monroe is rural, and Miami-Dade is urban. Thriving Mind continues to advocate for lowering the target in the housing measure. Despite our success in implementing the use of transitional vouchers to assist with housing needs, the lack of affordable housing units continues to be a huge barrier in both counties. Therefore, more funding is needed to sustain and increase the number of individuals Thriving Mind serves through use of transitional vouchers.

The proposed strategy and specific services to be provided

Thriving Mind will continue to implement its Housing Collaborative to address the housing needs in our community. Thriving Mind will continue to:

- Provide agencies with technical assistance in coding and meeting the state targets.
- Track agency progress toward meeting state housing targets.

· Partner with Homeless Trust of Miami-Dade County on innovative and new ways to offer housing to individuals served who are in both the behavioral health and housing systems.

· Outreach to other system partners such as Veterans Affairs and housing developers.

· Strengthen relationships with local housing providers such as Carrfour Supportive Housing, Inc.

· Follow-up on housing recommendations based on Thriving Mind's Needs Assessment.

· Engage with Florida Housing and Finance for updates, funding availability, and resources.

· Continue to partner with Homeless Trust to assess the unduplicated count of unhoused persons served across the network continuum, prioritizing services for persons identified as High Need/High Utilization (HNHU) program participants.

· Research best practices to support increased utilization of non-traditional services, increased involvement from community providers, increased feedback from affected individuals served and their families, decreased housing insecurity, and increased treatment compliance.

· Collaborate with the professional trade organizations as well as other organizations that are addressing Housing and Homelessness issues including, but not limited, to: Florida Behavioral Health Association, the National Housing Council, the Florida Housing Council, the Florida Coalition for the Homeless, the Florida Supportive Housing Coalition, the Florida Council on Homelessness, and the Florida Assisted Living Association.

· Consult with our provider network to cross train clinical staff to complete Service Prioritization Decision Assistance Prescreen Tool (SPDAT) assessments for housing resource access.

Target population to be served

· Adult Mental Health adults who need housing or are at-risk of becoming unhoused.

· Adult Substance Use Disorder adults who need housing or are at-risk of becoming unhoused.

Counties to be served:

· Miami-Dade

· Monroe

Number of individuals to be served

· 150 adults in mental health treatment

- 60 adults in substance use disorder treatment

Please describe in detail the action steps to implement the strategy

- See attached excel workbook - Housing action plan tab

Identify the total amount of State funds requested to address the unmet need and provide a brief budget narrative. Please identify any other sources of state and county funding that will contribute to the proposal.

- $1.4 million - See attached excel workbook - Housing budget tab

Identify expected beneficial results and outcomes associated with addressing this unmet need.

Thriving Mind's goal is to develop nontraditional partnerships with community housing providers, organizations and agencies to facilitate access to supportive housing resources for individuals who are challenged with a mental health diagnosis and/or substance use diagnosis. This Housing Collaborative identifies and develops supportive housing services that complement/facilitate access to those individuals currently in our residential system of care and/or those who have the skills to benefit from supportive housing.

What specific measures will be used to document performance data for the project

a. Thriving Mind will measure success by improvements in state housing targets by the network.

b. Decrease the number of individuals who are unhoused in the system.

Unmet need #2: System level care-coordination

The problem or unmet need that this funding will address:

Care Coordination is the systematic management of the system of care to ensure that individuals with the highest level of need are linked to community-based care and provided the appropriate support to address their treatment needs. Care Coordination requires enhanced access to data about an individual's social determinants of health in addition to their clinical status to achieve safer and more effective care. As such, System-Level Care Coordinators review, analyze, trend and report utilization data of individuals receiving behavioral health service to identify, recommend and assist in implementing programmatic and system changes designed to further develop and improve the system by creating an enduring coordinated system.

Poorly managed care transitions for high-risk, high-need individuals from acute services to lower levels of care negatively affect a person's health and well-being, potentially causing additional utilization of acute, crisis services, avoidable re-hospitalization, or re-arrest. System-level care

coordination links individuals to provider-level care coordination and oversees coordinated care transitions to ensure warm handoff between levels of care. It also ensures that a person's needs and preferences are known and communicated at the right time to the right people, and that this information is used to guide the delivery of safe, appropriate, and effective care.

Thriving Mind is committed to sustaining the value added to the system, and lives of many of those who require our services by the system-level Care Coordination team. System-level Care Coordinators have proven effective in ensuring that the system of care is accessible, effective, efficient, and appropriate for individuals and families seeking services.

The proposed strategy and specific services to be provided

Thriving Mind will continue to implement Care Coordination throughout our system of care. Since its inception, the care coordination process has changed to meet the needs of those identified to meet criteria and in congruence with Guidance Document 4. Based on the needs of the Southern Region, Thriving Mind adjusts its target populations, adding new ones to best serve the needs of our community. Thriving Mind rolled out the implementation of Critical Time Intervention (CTI), an intensive nine-month care coordination model designed to assist adults aged 18 years and older with mental health disorders who are going through critical transitions, and who have functional impairments that preclude them from managing their transitional need adequately. CTI promotes a focus on recovery, psychiatric rehabilitation, and bridges the gap between institutional living and community services.

The Managing Entity is responsible for the following activities:

1. Identify, through data surveillance, individuals eligible for Care Coordination based on the priority populations identified.

2. Subcontract with Network Service Providers (NSPs) for the provision of Care Coordination using the allowable services. NSPs must demonstrate a successful history of:

    a. Collaboration and referral mechanisms with other NSPs and community resources, including, but not limited to, behavioral health, primary care, housing, and social supports.

    b. Benefits acquisition.

    c. Individual and family involvement; and

    d. Availability of 24/7 intervention and support.

3. Track individuals served through Care Coordination to ensure linkage to services and to monitor outcome metrics.

4. Manage Care Coordination funds and purchase services based on identified needs.

5. Track service needs and gaps and redirect resources as needed, within available resources.

6. Assess and address quality of care issues.

7. Ensure provider network adequacy and effectively manage resources.

8. Develop diversion strategies to prevent individuals who can be effectively treated in the community from entering State Mental Health Treatment Facilities (SMHTFs) or a Statewide Inpatient Psychiatric Program (SIPP).

9. Develop partnerships and agreements with community partners (i.e., managed care organizations, criminal and juvenile justice systems, community-based care organizations, housing providers, federally qualified health centers, etc.) to leverage resources and share data.

10. Provide technical assistance to NSPs and assist in eliminating system barriers.

11. Work collaboratively with the Department to refine practice and to develop meaningful outcome measures.

12. Implement a quality improvement process to establish a root cause analysis when care coordination fails.

Target population to be served

The Managing Entity will be focusing on the following target populations:

1. Adults with a serious mental health disorders, substance use disorder, or co-occurring disorders who demonstrate high utilization of acute care services, including crisis stabilization, inpatient, and inpatient detoxification services.

   a. For the purposes of this document, high utilization is defined as:

      i. a. Adults with three (3) or more acute care admissions within 180 days.

      ii. Adults with acute care admissions that last 16 days or longer.

      iii. Adults with three (3) or more evaluations at an acute care facility within 180 days, regardless of admission.

2. Adults with serious mental health disorders awaiting placement in a SMHTF or awaiting discharge from a SMHTF back to the community.

3. Adults involved with Jail Diversion Program and law enforcement.

4. Children and parents or caretakers in the child welfare system with behavioral health needs, including adolescents, as defined in s. 394.492, F.S. who require assistance in transitioning to services provided in 4 the adult system of care.

5. Children with a serious emotional disturbance (SED), substance use disorder (SUD), or co-occurring disorders who demonstrate high utilization of acute care services, including crisis stabilization, inpatient, and inpatient detoxification services.

   a. For the purposes of this document, high utilization is defined as:

i. Children/adolescents with three (3) or more acute care admissions or assessments within 180 days.

ii. Children with acute care admissions that last 16 days or longer.

iii. Children with three (3) or more evaluations at an acute care facility within 180 days, regardless of admission.

6. Children being discharged from Baker Act Receiving Facilities, Emergency Departments, jails, or juvenile justice facilities at least one time, who are at risk of re-entry into these institutions or of high utilization for crisis stabilization.

7. Children waiting admission or to be discharged from a Statewide Inpatient Psychiatric Program (SIPP).

8. Children and adolescents who have recently resided in, or are currently awaiting admission to or discharge from, a treatment facility for children and adolescents as defined in s. 394.455, which includes facilities (hospital, community facility, public or private facility, or receiving or treatment facility) and residential facilities for mental health, or co-occurring disorders.

9. Children involved with Law Enforcement. Families with infants experiencing or at risk for Neonatal Abstinence Syndrome or Substance Exposed Newborn.

10. Individuals referred and enrolled in the Jail Diversion Program (JDP).

11. Individuals (youth and adults) referred by, or to, a Law Enforcement Agencies and followed by that Law Enforcement agency.

12. Populations identified to potentially benefit from Care Coordination that may be served in addition to the two required groups include:

a. Persons with a serious mental health disorder, substance use disorder, or co-occurring disorders who have a history of multiple arrests, involuntary placements, or violations of parole leading to institutionalization or incarceration.

b. Caretakers and parents with a serious mental health disorder, substance use disorder, or co-occurring disorders involved with child welfare.

c. Individuals identified by the Department, managing entities, or network providers as potentially high risk due to concerns that warrant Care Coordination, as approved by the Department.

Counties to be served

- Miami-Dade
- Monroe

Number of individuals to be served

- 210 adults and

- 40 children

Please describe in detail the action steps to implement the strategy

- See attached excel workbook - System-Level Care Coordination action plan tab

Identify the total amount of state funds requested to address the unmet need and provide a brief budget narrative. Please identify any other sources of state and county funding that will contribute to the proposal.

- $750,000 - See System-Level Care Coordination budget tab

Identify expected beneficial results and outcomes associated with addressing this unmet need.

The long-term goal of care coordination in the Southern Region, when fully implemented, is to be able to utilize the data collected through this process to develop behavioral health treatment protocols like those that are currently used in the medical field. The development of these protocols will enable the system to better identify crisis indicators and improve early intervention services. Thriving Mind also seeks to provide care coordination to all target populations.

What specific measures will be used to document performance data for the project.

- Re-admission rates for individuals served in acute care settings.
- Length of time between acute care admissions.
- Length of time an individual waits for admission into a SMHTF or SIPP.
- Length of time an individual waits for discharge from a SMHTF; and
- Length of time from acute care setting and SMHTF discharge to linkage to services in the community.

Unmet need #3: Funding for Children's Respite Program

The problem or unmet need that this funding will address:

The responsibilities of caregiving can increase a family's risk for developing physical, mental, and financial problems. Requesting respite care for youth can help families maintain the caregivers' well-being and the family intact. It is not selfish or neglectful to take a break. Respite care offers the caregiver(s), and families, time to self-care, bring a sense of normalcy back into the home. It also offers the child an opportunity to learn new skills and participate in planned activities which increases socialization and independence. Families have identified respite as a major service delivery gap in our community. Unfortunately, there are no respite programs that adequately serve this population.

The proposed strategy and specific services to be provided:

Thriving Mind would like to fund a respite program for youth. A respite program is a voluntary, short-term, overnight program. Respite provides community-based, non-clinical crisis support to help youth and families, by providing temporary relief, improve family stability and reduce the risk of abuse and neglect.

Although respite can be offered 24 hours per day in a homelike environment for support during time of crisis, Thriving Mind proposes to start a program that offers planned respite, Friday evening through Sunday afternoon/evening. Thriving Mind would like to staff and operate the respite program with caregivers with lived experience caring for, or recovering from, mental health disorders and/or substance use disorder.

Target population to be served:

- Youth (14 to 17 years old) with a mental health disorder who are at risk of out of home placement who are receiving services from wraparound programs such as Community Action Treatment (CAT) teams, or Children's Crisis Response Team (CCRT), or have been staffed during Local Review Team meetings.

County to be served:

- Miami-Dade

Number of individuals to be served:

- 50 per Fiscal Year

Please describe in detail the action steps to implement the strategy:

- See attached excel workbook - Children's Respite action plan

Identify the total amount of State funds requested to address the unmet need and provide a brief budget narrative. Please identify any other sources of state and county funding that will contribute to the proposal.

- $582,400 - See attached excel workbook - Children's Respite budget tab

Identify expected beneficial results and outcomes associated with addressing this unmet need.

A study of Vermont's 10-year-old respite care program for families with children or adolescents with serious emotional disturbance found that participating families experience fewer out-of-home placements than non-users and were more optimistic about their future capabilities to take care of their children (Bruns, Eric, November 15, 1999). A more recent study on Return on Investment in Systems of Care for Children with Behavioral Health Challenges found that communities in which a broad array of home and community-based evidence-informed services are available decreases inpatient psychiatric hospitalizations and out of home placements. (Stroul, B., Pires, S., Boyce, S., Krivelyova, A., and Walrath, C. 2014). Piloting an evidence-informed respite care program, which includes data on performance measures and return on investment, will reduce overall cost to the system of care by preventing out of home placements.

What specific measures will be used to document performance data for the project

- Decrease out of home placement
- Decrease child welfare involvement
- Improve productivity of the home
- Improve school attendance

Unmet need #4 Children's Crisis Unit in South Miami-Dade and Monroe County

The problem or unmet need that this funding will address:

More than 600,000 residents of the Southern Region are children/youth, and there is only one Crisis Stabilization Unit (CSU) in the region. The shortage of children's CSU beds affects mostly Monroe County and the southern end of Miami-Dade. Children from these areas needing stabilization at the CSU could travel as far as 159 miles, over a three-hour trip, to access the nearest children's Baker Act facility. For a child or adolescent who is undergoing a mental health crisis, having to travel (sometimes three hours) this long distance is an added layer of distress to their current situation. In addition, children are often transported to the nearest adult receiving facility. Dropping off children at adult crisis units places a security and financial burden on the adult unit that needs to assign one-one staff and coordinate/pay transport to an available children Baker Act-designated facility. Note that, at times, this transfer had to be made to Broward County, one county north of Miami-Dade. Potentially, a family from Monroe County will have to travel through their county and Miami-Dade County to support/visit their child at a crisis unit in Broward County. However, and most importantly, not having access to a nearby children's crisis unit delays access to appropriate treatment for the child.

Miami-Dade's southernmost adult CSU has tracked the number of children dropped off at their receiving site over the years. Below is a chart of the numbers they have kept track off. The documented decrease in the number of children dropped off at this adult CSU is the result of training and educating law enforcement agencies on the revised 2023 Transportation Plan. The 2023 transportation plan directs LEO to take to the most appropriate facility designated to serve minors.

Despite the positive response we experienced with our law enforcement partners, it is noted that traveling farther away from their district removes their presence for longer periods of time. Consequently, these law enforcement partners are unable to respond to other emergencies within their districts. It is also important to note that one of our contracted providers, Community Health of South Florida, will be inaugurating a 20 bed CSU at their south Dade location. This building offers the system of care the opportunity to fund children's crisis services to meet the identified needs of the community.

This data in the chart below was tracked and provided by Community Health of South Florida (CHI).

Children from the Southern Region brought to CHI Adult Baker Act Facility	
Year	Number of Children
2017	336
2018	441
2019	599
2020	446
2021	363
2022	240
2023	185
2024	61 (Through August)

The proposed strategy and specific services to be provided:

Funding Network Service Provider (NSP) to provide crisis services.

Target population to be served:

- Children and Adolescents under the age of 18.

Counties to be served:

- Miami-Dade
- Monroe

Number of individuals to be served:

A 16-bed Children Crisis Stabilization Unit can potentially serve up to 1,900 children annually with an average length of stay of three days.

Please describe in detail the action steps to implement the strategy:

- See excel spreadsheet - Children's CSU action tab.

Identify the total amount of State funds requested to address the unmet need and provide a brief budget narrative. Please identify any other sources of state and county funding that will contribute to the proposal.

- $2,920,000 for 16 beds**.** See excel spreadsheet - Children's CSU budget plan tab.

At the time of this report, an existing Network Service Provider is building a facility at the southern end of county, close to the Monroe County line. The funds requested here could fund a 16 beds children crisis until, with no additional capital expenditure, that would meet the needs of both counties.

Identify expected beneficial results and outcomes associated with addressing this unmet need.

- Reducing the amount of time from onset of crisis and initiation of treatment at the CSU will prevent further psychological distress in the individual.

- Increased parental involvement, and family treatment due to proximity of facility.

- Improved discharge planning

What specific measures will be used to document performance data for the project

- Decreased admissions at Baker Act facilities outside of Miami-Dade County.

- Serving children/youth closer to home and family support

- Improved discharge planning, better grasp on resources for after-care

Unmet need #5: Additional funding for Suicide Prevention Services

The problem or unmet need that this funding will address:

Suicide is one of the top 10 leading causes of death in the United States, with one death every 11 minutes. Suicide attempts also result in an even larger number of non-fatal, intentional self-harm injuries. Suicide risk persists from youth to older age. In the U.S., it is the second-leading cause of death for people 10 to 34 years of age, the fourth-leading cause among people 35 to 54 years of age, and the eighth-leading cause among people 55 to 64 years of age. In 2022, the age-adjusted rate per 100,000 population of Deaths From Suicide (All) in Miami-Dade County was 8.1 compared to Florida at 14.1 and to Monroe County at 17.0.[1]

Thriving Mind data for 988 services for Fiscal Year 2023-2024 reported that 22,317 calls were received in the Region through the 988 Suicide and Crisis Lifeline. Of these, 71 were referred to the Mobile Response Team and 8,514 were referred to mental health services; 66 resulted in Voluntary Emergency Rescue; 89 in Involuntary Emergency Rescue, and 2,640 reported suicidal ideations.

Recognizing funding insecurity, Thriving Mind needs to establish a robust, sustainable, comprehensive suicide prevention strategy that addresses the needs of the community,

provides effective services, and promotes long-term mental health and well-being using data and evidence-based programming. Proposed funding will support service enhancement:

- through effective data collection strategies to support programming and funding decisions.

- through continued expansion of successful suicide prevention programming with validated outcomes.

The proposed strategy and specific services to be provided

Thriving Mind proposes to expand youth and adult education programs, focusing on evidence-based services, and research-based community awareness activities. These strategies are developmentally appropriate and culturally/linguistically competent prevention programs that fit within a comprehensive approach to suicide prevention. These include classroom curriculum, peer prevention programs, collaborations with local partners, participating in community events and fairs, campaigns in social media and the community, and engaging parents and families in prevention efforts.

Suicide prevention program services in the Region data show numbers served, below. Increase in numbers from one year to the next indicate need for additional services.

- More than 4,200 services were offered in Fiscal Year 2022-2023 and Fiscal Year 2023-2024 in Ending the Silence; Question, Persuade, Refer; Suicide Awareness, and other community events

- More than 8,500 individuals received services in Fiscal Year 2022-2023 and in Fiscal Year 2023-2024, through social media campaigns, mental health curricula, small group interventions, suicide prevention presentations and community outreach activities.

- More than 4,300 high risk youth and their families were identified as needing referral services in referral services for high-risk Youth and Families.

Based on identified need for suicide prevention services, Thriving Mind proposes specific services:

1. Expansion of Question Persuade Refer (QPR)

2. Expansion of End the Silence (ETS)

3. Expansion of Youth Prevention services in schools and community sites.

4. Participating in additional community events with collaborative partners for community education (Department of Health, schools, local service providers, businesses, etc.)

5. Our provider, Behavioral Science Research Institute (BSRI), will create a robust evaluation of services and data collection to support a comprehensive approach to suicide prevention in the Region, including Continuing to develop data sources for analytics.

Target population to be served

- Youth and adults

Counties to be Served

- Miami-Dade
- Monroe

Number of individuals to be served

- 345,318, total individuals served in EBPs (number does not include media campaigns).

It's well known/proven that early identification of risk factors will alleviate down-stream disease as well as cost. Programs are effective at identifying children/youth at high risk. Expansion of QPR will expand program to 5,000 a year; expansion of Ending the Silence will go to 3,000 a year, expansion of Youth Prevention services will increase high-risk youth to 50 a year; small group participants will go up to 50 a year; suicide prevention presentations will go up to 200 a year; referral services will go up to 6300 a year. Additionally, we will create a robust evaluation of services and data collection to support a comprehensive approach to suicide prevention in the Region.

Please describe in detail the action steps to implement the strategy

See tab Suicide Prevention tab in attached on spreadsheet.

Identify the total amount of state funds requested to address the unmet need and provide a brief budget narrative. Please identify any other sources of state and county funding that will contribute to the proposal.

- $610,000 - See Suicide Prevention budget tab in attached spreadsheet.

Identify expected beneficial results and outcomes associated with addressing this unmet need.

Millions of Americans, and data show youth between 10-34 years of age, seriously think about suicide, plan, or attempt suicide. Thriving Mind will use the enhance funding to collect and analyze data to drive funding and programming decisions in the Region. Program services will improve well-being and resiliency based on the best available evidence and research. Community education and awareness strategies, through a coordinated comprehensive prevention strategy, will bring attention to the risks and options for help those in crisis or thinking about suicide get the support and services they need. Stigma reduction programming will also assist individuals in starting positive conversations and getting the services they need.

What specific measures will be used to document performance data for the project.

The comprehensive evaluation of the system will produce process and outcome evaluation and performance measures. Those will include numbers served, reach through media, one Prevention Needs Assessment document with recommendations, outcome measures for QPR and ETS from matched pre-/post-tests, outcome measures for youth programming, types of

services requested and referred to through problem identification and referral, increased awareness of suicide and services available, and other as determined throughout the evaluation process.

Return on Investment

The return on investment (ROI) for substance use prevention and suicide prevention programs is a critical aspect of public health economics. These programs can save money in the long term by reducing the need for more intensive and costly treatments, improving productivity, and lowering healthcare costs

Various studies suggest that substance use prevention programs can yield significant returns. The National Institute on Drug Abuse (NIDA) reports that for every $1 spent on prevention, communities can save up to $10 in treatment costs and other associated costs such as lost productivity, healthcare, and criminal justice expenses.

For example, school-based programs can return $15 to $18 for every $1 spent. LifeSkills Training has shown an ROI of $25 for every $1 spent, largely due to reductions in substance use and related criminal activity. Community-based programs can also be cost-effective. Coalitions and media outreach, including collaboration with community partners at events, which target multiple risk factors for substance use, has shown a return of $5 to $11 per dollar invested.

Suicide prevention programs also demonstrate positive ROIs, though the data is more variable due to the complexity of measuring the economic impact of preventing a suicide. However, the costs of suicide — including lost productivity, medical costs, and the emotional toll on families and communities — are substantial. The economic cost of suicide and nonfatal self-harm averaged $510 billion (2020 U.S. dollars) annually, the majority from life years lost to suicide. Working-aged adults (aged 25–64 years) comprised nearly 75 percent of the average annual economic cost of suicide ($356 billion of $484 billion) and children and younger adults (aged 10-44 years) comprised nearly 75 percent of the average annual economic cost of nonfatal self-harm injuries ($19 billion of $26 billion).[1]

The ROI for both substance use prevention and suicide prevention programs is generally positive, with returns ranging from $2 to $25 for every dollar spent, depending on the specific program and its implementation. These investments are not only economically beneficial but also save lives and improve quality of life, making them valuable public health strategies.

[1] https://www.sciencedirect.com/science/article/pii/S0749379724000813