Executive Summary

FLORIDA HOME VISITING STATEWIDE NEEDS ASSESSMENT UPDATE 2020

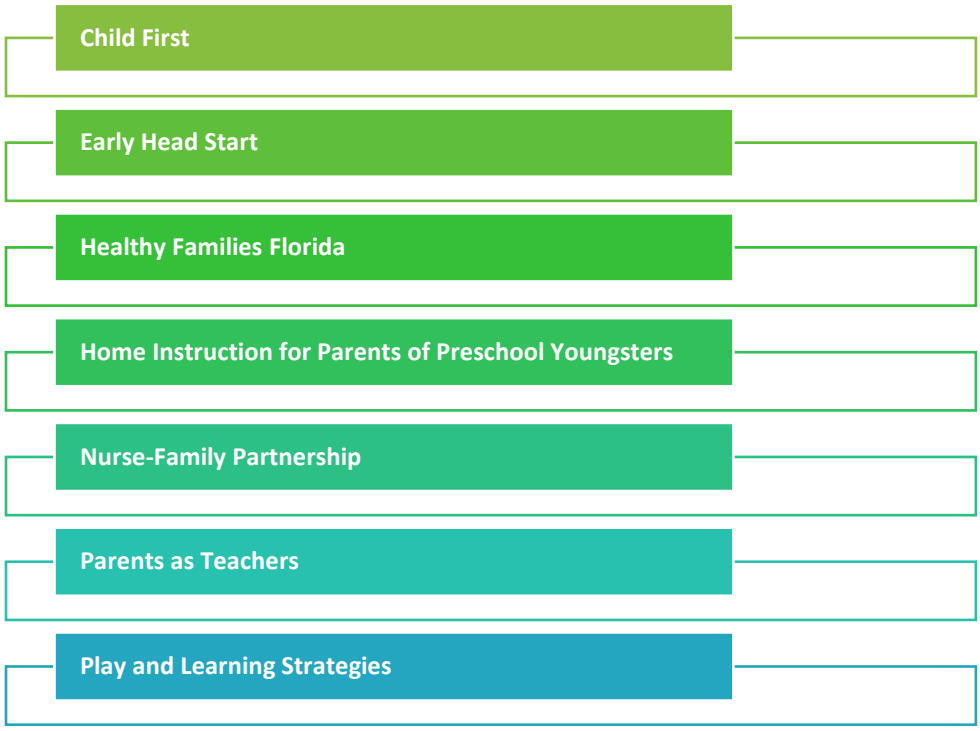
The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Initiative is authorized by Social Security Act, Title V, § 511(c) (42 U.S.C. § 711(c)) to support voluntary, evidence-based home visiting services for at-risk pregnant women and parents with young children up to kindergarten entry.[1]

Section 50601 of the Bipartisan Budget Act (BBA) of 2018 extended appropriated funding for the MIECHV Program through 2022, while section 50603 of the BBA required states to conduct a statewide needs assessment. The BBA further established that conducting a MIECHV statewide needs assessment update is a condition of receiving Title V Maternal and Child Health (MCH) Block Grant funding.

The purpose of this needs assessment update is to identify and understand the diverse needs of families living in high-risk communities and assessing the communities' own capacity for addressing the need. The results will help administrators strategically hone the existing continuum of home visiting and early intervention services, as well as thoughtfully plan for expansion of appropriate serves to fill the identified gaps, if additional funding becomes available.

The completion of the statewide home visiting needs assessment update was overseen by Florida MIECHV staff at the Florida Association of Healthy Start Coalitions (FAHSC). FAHSC contracted with the University of South Florida College of Public Health to spearhead the data analysis, with Dr. Jennifer Marshall as the team lead. A steering committee was formed to guide the completion of the project. The committee was comprised of 15 individuals from varying levels within home visiting (home visitors, supervisors, administrators, and state-level staff), state agencies/funders, model developers, university researchers, and parent representatives.

Florida invests state, federal, and local dollars in evidence-based home visiting programs aimed at improving family and child health, preventing child abuse and neglect, and promoting school readiness. There are currently seven evidence-based program models, according to the US Department of Health and Human Services, operating in Florida that are funded to serve nearly 17,000 families.



The primary funding for these services flows through three state agencies – Department of Children and Families (DCF), Department of Health (DOH), and the Office of Early Leaning (OEL) – and the Florida Association of Healthy Start Coalitions (FAHSC), which administers the Florida MIECHV Initiative.

Figure 1: Evidence-Based Home Visiting Programs in Florida with Hyperlinks

IDENTIFYING COMMUNITIES WITH CONCENTRATIONS OF NEED

The USF data analysis team collaborated with MIECHV leadership and the steering committee to select seven domains consisting of a total of 25 indicators that were inclusive of the eight constructs specified in section 511(b)(1)(A) of Title V. County and census tract level data were obtained to identify high-risk communities throughout Florida. Statewide counts and rates for each indicator were calculated, and a description of data sources, definitions, and derivations was provided.

Several sources were considered in development of a full conceptual framework of domains/indicators. These constructs represent factors that serve as risk or protective factors, maternal or child health outcomes, or special populations or health issues that home visiting programs are specifically designed to address.

A comprehensive list of all considered indicators was presented to the steering committee. The committee members completed a survey to rank order indicators within each domain and suggest any additional indicators.

The USF team then reduced the list of indicators to those with accurate, up-to-date, and population-wide data available at the county level (and if possible, at the sub-county level). Indicators that did not meet the three criteria were removed. The final list includes seven domains and 25 indicators.

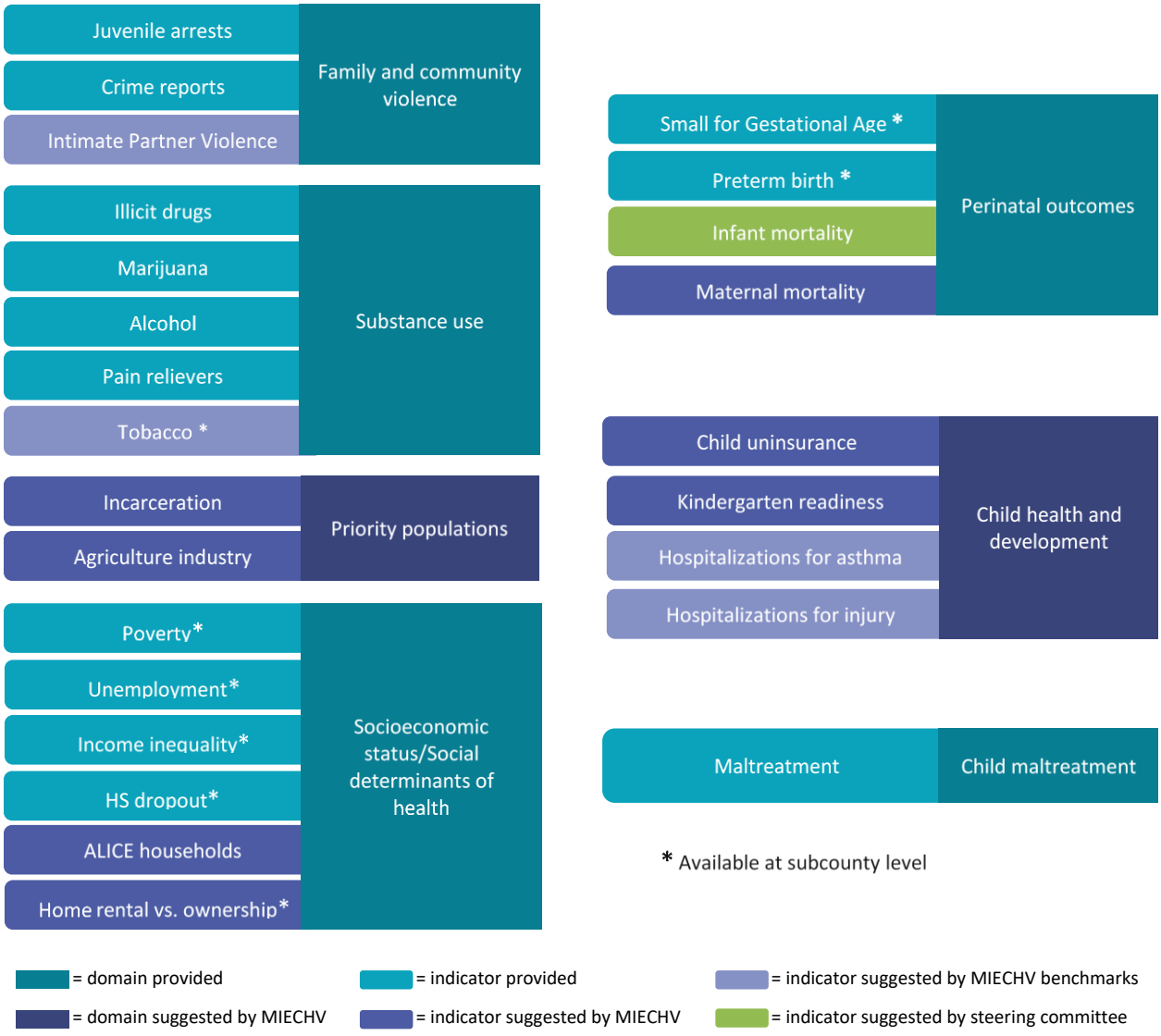


Figure 2: Final Indicator Framework

The “simplified method”, an option which utilizes data provided by HRSA, was adapted to account for the seven domains that were selected for the analysis and census tract level analysis for indicators for which data were available. The means of counties and standard deviation, state mean, and other descriptive statistics (number of missing, range, etc.) were calculated for each indicator. Z-scores (standardized indicator value) were calculated for each county level indicator value. For each county, the proportion of indicators with a z-score greater than one within each domain was calculated. Counties were considered high-risk for a given domain if at least half of the indicators within a domain had z-scores greater than or equal to one. Counties with two or more high-risk domains were identified as high-risk. For data extracted from the American Community Survey, 5-year estimates were used.

To supplement identification of counties deemed high-risk due to their comparatively worse scores on indicators comprising more than one domain, when available, census tract level data were used to identify larger concentrations of risk within counties. That is, a purely county-level analyses may mask high-risk communities, particularly in counties with large populations. We operationalized the “sub-county” or “community” concept with data collected at the census tract level. Although census tract level data were not available for most of the indicators in this needs assessment, we were able to obtain reliable data for eight of the 25 county-level indicators. The hybrid county- and tract-level analysis approach was taken due to lack of recent, quality data at the sub-county level for all 25 indicators and because selecting county alone as the unit of analysis may not identify high-risk communities in higher population counties. Counties identified by our method reflect the level of risk in Florida by highlighting communities that met the threshold for high-risk domains or indicators based on county- and tract-level analyses.

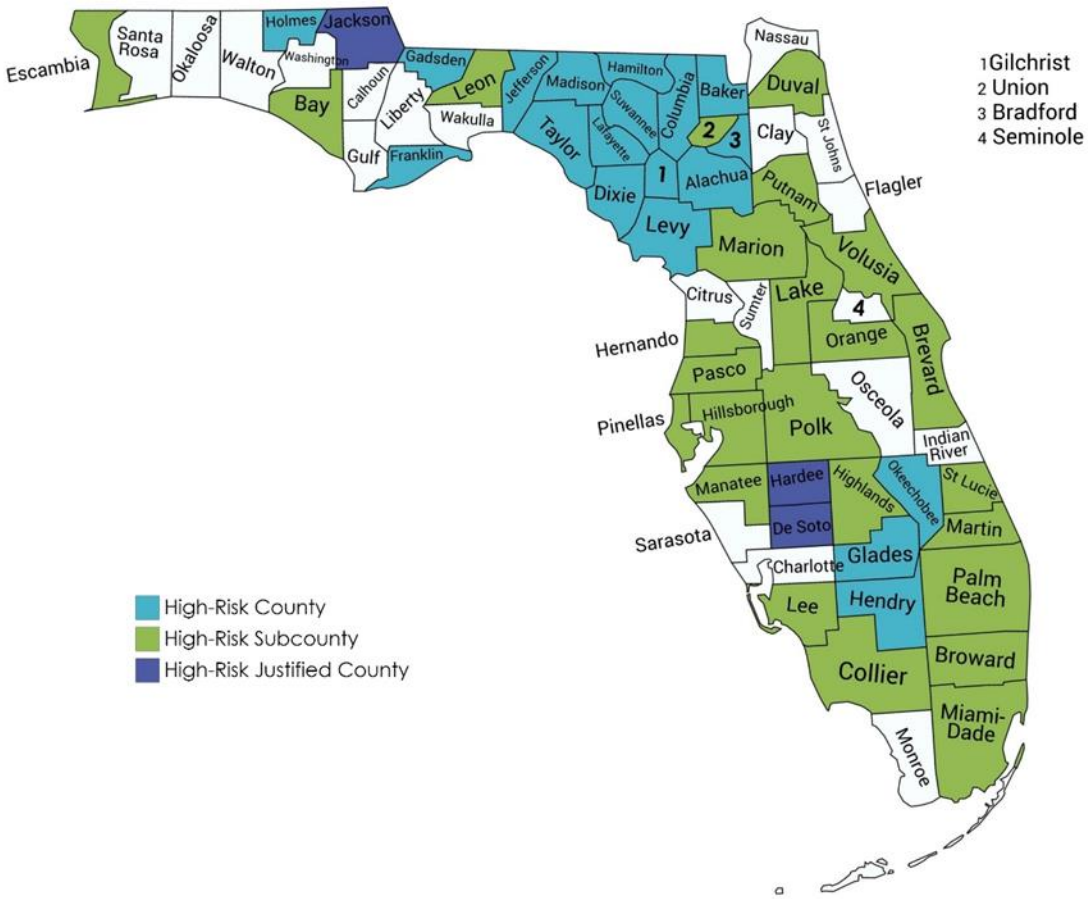
A total of 47 counties were identified as high-risk; 19 identified with county-level data, 25 counties identified with tract-level analyses, and an additional three counties with justification, as illustrated below.

The decision to justify three additional counties was made for varying reasons. More than 30% of births in Jackson County are in high-risk census tracts. Hardee County has the highest percent of farmworkers (23% of population) living in its communities. And Desoto County has the highest percentage of children (72%) who scored less than a 500 on the Star Early Literacy assessment, which means only 28% of the children in DeSoto County are considered “ready for kindergarten.” Given that all three of these counties are currently implementing MIECHV-funded programs and additional risks are known, both with quantitative and qualitative data, the decision was made to classify them as high-risk and continue services to these counties.

There are two additional counties that are currently served by MIECHV – Clay and Sarasota – that did not show as high-risk during the county- and tract-level analysis. Due to the small amount of data supporting a high-risk

classification and a recent reduction in funding, the decision was made in conjunction with the providers to discontinue MIECHV-funded services in these counties by FY21-22. The few families being served in these counties are completing the program or are being transferred to other services.

Florida's identified high-risk counties are depicted in the map below.



IDENTIFYING THE QUALITY AND CAPACITY OF EXISTING PROGRAMS

In order to determine the quality and capacity of existing programs, data were collected from evidence-based models that are eligible for MIECHV funding and surveys were completed by home visiting programs, community stakeholders, and parents in the identified high-risk counties.

The type of data needed to assess the quality and capacity of existing home visiting programs in Florida were unavailable in a format that was comparable across programs. Therefore, the steering committee came up with a list of information that was important, and the needs assessment team developed an Excel spreadsheet to capture the requested information. To assess the quality and capacity, the following information was requested:

- Number of funded family slots
- Number of families served in the most recently completed program year
- Funding sources
- Age criteria for enrollment
- 12-month retention of families served
- Demographic characteristics (race, ethnicity, and language) of participants and home visitors

This information was collected for each program at the county level – some adjustments were necessary for multi-county programs. It was ultimately decided by the team not to include the retention rates in the report because programs had varying levels of ability to accurately track the information, programs calculate retention differently, and two of the programs (Child First and PALS) can be completed in less than a year.

As part of their work on the needs assessment, HRSA estimated the number of families who are likely to be eligible for MIECHV services in each state. That number was based on the following criteria:

- Number of families with children under the age of six living below 100% of the poverty line plus the number of families in poverty with a child under the age of one and no other children under the age of six (a proxy for families with a pregnant woman that would also be eligible for MIECHV services)

AND

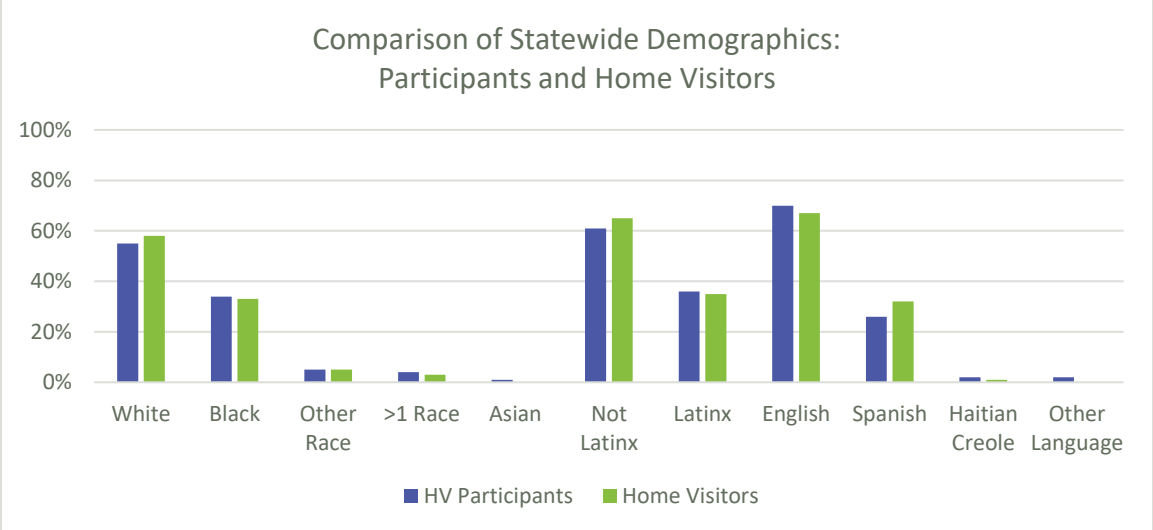
- Belongs to one or more of the following at-risk sub-populations:
  - Mothers with low education (high school diploma or less)
  - Young mothers under the age of 21
  - Families with an infant (child under the age of 1)

Based on this methodology, Florida has an estimated 111,366 families who are eligible for MIECHV services. According to the spreadsheets collected from the evidence-based programs operating in Florida, there is funding to serve 16,639 families. We currently have the capacity to serve only 15% of the estimated families in need of services. Only 12 (18%) counties have enough funded slots to serve 50% or more of their families. Almost 27% (18) of all of Florida's counties can only serve 10% or less of their families in need.

It is important to note that the estimate of need is solely based on the priorities of HRSA, the funder of MIECHV – other funding sources may prioritize different factors and, therefore, have a different estimate of need.

Identifying Gaps in Staffing

At the time of collection, roughly 93% of home visiting positions statewide were filled. A minimal number of vacancies ensures that programs can maximize funding and serve the full capacity of families. Demographic information was collected for the currently employed home visitors and compared to the demographic information of families served to ensure that the cultural and linguistic needs of families are met and that programs are provided in a relevant and appropriate way.



The data depict a diverse population of families receiving services and an equally diverse core of professional home visitors who serve them. It appears that the cultural and language needs of families are met in a relevant and appropriate manner as the largest difference is that there are six percent more Spanish speaking staff than Spanish speaking families. All other characteristics match very closely across the state. It should be noted that larger variances can be seen in specific counties.

Assessing the Results of the Stakeholder Surveys from the High-Risk Communities

To obtain more detailed information about the counties identified as high-risk, surveys were distributed to home visiting programs, community partners, and parents in those communities. The surveys for home visiting programs and community partners were designed to assess the quality and capacity of the home visiting programs; the availability of community resources, including substance abuse and mental health services; and community readiness and capacity to expand home visiting services. They were piloted in Jefferson, Madison, and Taylor Counties. The surveys were completed by 100 home visiting staff from 37 counties and 202 community stakeholders from 26 counties. The parent survey was designed to capture their opinions of home visiting programs and other needs and services within the community. The parent survey was available in English, Spanish, and Haitian Creole. This survey was completed by 455 parents from at least 33 counties.

Identified Gaps in Community Resources

Overall, an equal number of the community partner survey participants responded that there are (43, 38%) or are not (42, 37%) sufficient providers to serve clients with early childhood services in their communities. An additional 29 (25%) were not sure. Across the board, the home visiting program respondents perceive early childhood services to be less available than the community partners. Survey respondents were also asked to indicate if specific early childhood services are available, not available, or inaccessible to meet the needs of families in their communities.

Community partner survey respondents perceived that Head Start/Early Head Start, quality childcare, speech/language therapy, and early intervention services were available in their communities. Most home visiting program survey participants reported that Head Start, pediatric health care, and early intervention were available in their communities, although at a lower rate. However, quality childcare, speech/language therapy, and Child Find (Part B) services were perceived as available, but insufficient. Notably, mental health services for infants, toddlers, and preschoolers were reported more often as insufficient or unavailable by a large proportion of community partners and home visiting staff.

When asked in an open-ended question whether their community has the resources they need for their families, many parents answered that their community does not. While nearly half of respondents answered that their community does have family resources, the main barriers to access included inflated costs and a need for more resources, especially quality and affordable childcare, which respondents listed as difficult to find. Parents mentioned that there were a few parks, but they could use more recreational opportunities for younger children, and available options are too expensive. Many respondents noted that transportation is an issue, and reliable and trustworthy transportation is difficult to find. Health care was also reported to be too expensive, especially for children. Parents noted that resources are especially hard to find during the COVID-19 pandemic.

For non-English speakers, respondents noted that organizations could do more to provide information/education on the programs and services available to them, and the frequent use of acronyms without explanations is confusing. It was noted that foster children do not receive sufficient resources. Parents also indicated that there could be more educational support and that qualifications for resources are too specific, which severely limits access to resources for community members. Parents also mentioned that the waiting lists for services take too long.

Parents also have mixed opinions about whether resources in the community are easy to access. A third (34%) of parents strongly agreed or agreed, 22% were neutral, and 19% disagreed or strongly disagreed.

The most common barriers to accessing community resources were waiting lists, mentioned by 87 (19%) and not qualifying because of income, mentioned by 66 parents (15%). There were 93 parents (20%) who mentioned other barriers that were not listed. These other barriers included: COVID-19, lack of information/knowledge or advertising about programs, too many steps to maintain services, being new to the area, income caps are too low, services are not offered in another language, and resources are needed for families fostering their displaced relatives.

Regarding specific resources that would help their families, most parent respondents recommended more mental health services (14%), quality childcare providers (13%), and Early Head Start (11%). Other possible resources mentioned include: more help for families that step in to take care of a relative taken by the state, affordable recreational activities for kids, better transportation, a bigger or better community center, clothing assistance, diaper program, college, low cost insurance for all children with disabilities, affordable housing, night nurse, assistance for disabilities and bills, higher income cap for services, free swimming classes, more clinics, more education on available resources, assistance with homelessness, assistance with teenagers with behavioral problems, post adoption therapy, evening or after hours care, dental services, affordable childcare providers for non-migrant families, more resources for single working or married struggling parents, and food stamps.

Strengths and Weaknesses in Utilization of Home Visiting Services

According to the home visiting program survey responses, the primary strengths of their county's home visiting programs were that parents learn child development and positive parenting (89, 13%) and that they connect families to needed services (89, 13%), families get the services they need (84, 12%), children have better outcomes (82, 12%), and there is improved family engagement (75, 11%). Also noted was a reduction in child deaths and maltreatment (67, 10%), improved school readiness (62, 9%), and improved birth outcomes (62, 9%). Other outcomes mentioned in comments included more father involvement, social connection, increased child spacing/family planning, healthy pregnancies and postpartum, psychosocial counseling, and access to prenatal care. It was perceived by most that home visiting program staff reflect the community they serve in terms of race and ethnicity "a great deal" (73, 79%) and "somewhat" (17, 18%), with two (2%) reporting "not at all."

Weaknesses noted in communities' home visiting programs by home visiting survey respondents were the limited ability to provide families with needed money or supplies (55, 23%), the inability to serve all who are eligible (37, 16%), waiting lists (31, 13%), and eligibility restrictions/limitations (31, 13%). Challenges related to referral processes include that families are referred to a service, but there is little to no follow up (21, 9%), that it is a complicated process to connect to a program (15, 6%), or, within a model, there are too many visits required (14, 6%).

Barriers Faced by Home Visiting Programs in High-Risk Counties

The primary barriers noted by the home visiting program survey respondents are lack of funding to pay home visitors a competitive salary and inconsistency or lack of funding in general. Additionally, limited availability or accessibility of health and social services and family supports, inactive or no parent groups were noted. Other barriers were geographic location, lack of quality referrals, availability or retention of qualified staff, and lack of community support or understanding of the program. Respondents also noted that turnover in other agency staff and disengagement of the board or advisory group can cause impediments.

The community partner respondents noted barriers that made it difficult for expectant or new parents to access services were: unaware of services (78, 19%), lack of transportation (76, 18%), wait list (70, 17%), limited number of providers (59, 14%), and services are unaffordable (54, 13%).

Presence of Local Early Childhood Systems Coordination

More than half (56, 56%) of the home visiting survey respondents reported that they knew of a coordinating council for early childhood systems, with the most often reported being Head Start/Early Head Start, Early Steps, or the local Children's Services Council. Other coordinating entities mentioned were a Child Abuse Prevention & Permanency Advisory Council (14 respondents noted), the school district, Part B/LEA, Healthy Start Coalitions, childcare providers, foundations, and the Early Childhood Comprehensive Systems Impact Project. Most home visiting survey respondents (55, 59%) do not know if their county has a system of care grant; 11 respondents (16%) reported that they are participating as a stakeholder with the system of care leadership. Similarly, the community stakeholder survey respondents were less sure about whether there was a system of care grant (66% don't know) but 24 (21% of those who responded) did participate in system of care leadership in their community.

Assessing Community Readiness

Utilizing the community survey mentioned earlier, questions were developed to assess the community resources available in the high-risk areas, as well as their readiness to implement a new home visiting program.

Nearly 83% (99) of community partner survey respondents think that there is a need for additional home visiting services in their communities. Interestingly, many commented that due to the pandemic, home visiting services are needed more, and that society may be more accepting of the services during this unprecedented time. Half (44, 50%) of the home visiting survey participants thought more home visiting services were needed (19/22% disagreed and 25/28% were unsure).

Related to expansion of home visiting services, the majority of community partner survey respondents (65, 42%) felt that their community is ready and has the capacity to expand; 36 (23%) felt that they did not, and a third (53, 34%) were unsure. More than half of the home visiting survey respondents noted the same.

Most home visiting respondents (88, 70%) and community partner respondents (120, 64%) felt that community members in their counties think providing services for expectant and new parents and their young children is a priority and would support new or expanded efforts to meet their needs (rated seven or higher on 1-10 scale). Additionally, 41% (48) of community partners felt that community members and leaders would provide support (financially, in-kind resources, training, etc.) for community resources. Few respondents (10, 8%) felt that they would not provide support, and half (51, 51%) did not know. Similarly, when asked "How would you assess the level of potential resources in the community to support home visiting services for expectant or new parents and their young children?" 39% of 120 community partners felt that support was evident in their counties (rated seven or higher on a 1-10 scale).

There were 206 parents (45%) who strongly agreed or agreed that their community cares about families with young children. Only 26 strongly disagreed or disagreed (6%), while 107 (24%) were neutral.

CAPACITY FOR PROVIDING SUBSTANCE USE DISORDER TREATMENT AND COUNSELING SERVICES

The Office of Substance Abuse and Mental Health (SAMH) is housed within the Florida Department of Children and Families (DCF) and serves as the single state agency for the provision of mental health and substance use disorder prevention, treatment, and recovery services. DCF is committed to preventing substance use disorders and promoting emotional health and wellness to improve the lives of families across Florida.

In Florida, DCF provides treatment for substance abuse through a community-based provider system that offers detoxification, treatment, and recovery support for adolescents and adults affected by substance misuse, abuse, or dependence.

Community-based behavioral health services are provided through contracts with seven nonprofit Managing Entities. The purpose of the Managing Entities is to plan, coordinate, and subcontract for the delivery of community mental health and substance abuse services, to improve access to care, to promote service continuity, to purchase services, and to support efficient and effective delivery of services. DCF's regional SAMH offices administer Managing Entity contracts with support from the Office of SAMH headquarters office.

The Office of SAMH's overarching goal is to transform behavioral healthcare in Florida into a Recovery-Oriented System of Care (ROSC). A ROSC is a network of clinical and nonclinical services and supports that sustain long-term, community-based recovery. As local entities, ROSCs implement the guiding principles of recovery orientation while reflecting the unique variations in each community's vision, institutions, resources, and priorities.

Except for the DCF-operated mental health treatment facilities in northern Florida, most behavioral health services are provided through contracts and subcontracts. These contracts are executed and administered by either the Office of SAMH or a regional SAMH office. In consultation with the Office of SAMH, the Regional SAMH Director ensures Managing Entities meet statewide goals and are responsive to the community needs.

Nearly $774 million is expended to carry out the provision of community substance abuse and mental health services. Just over $700 million ($422 million for mental health and $255 million for substance abuse services) is allocated to the managing entities to provide community substance abuse and mental health services. During FY18-19, 339,093 individuals were served. Just over 197,000 adults received mental health care and nearly 98,000 received substance abuse services. For children/adolescents, 26,518 were treated for substance abuse issues and 7,100 received mental health treatment.

In addition to funding appropriated by the Florida Legislature, DCF also oversees and implements several federal grants, including Florida's State Opioid Targeted Response Grant, Florida's State Opioid Response Grant, the Florida Healthy Transitions Grant, Florida's System of Care Expansion and Sustainability Project, and Partnership for Success.

Services for Pregnant Women and Women with Dependent Children

Integration of child welfare and behavioral health is essential to successful outcomes for children and families served by DCF. Parental substance use and or mental health conditions are evident in over 60% of the cases of child maltreatment. Access to quality treatment and recovery support is critical as children and youth in these families are more vulnerable to maltreatment as parental capacities are diminished. Additionally, children exposed to these issues in their caregiving adults are at high risk for behavioral disorders themselves.

Block Grant regulations stipulate that Florida must expend at least $9.3 million in federal and state funds on services for pregnant women and women with dependent children. In FY17-18, Florida expended $15.1 million on services for this population and served 1,977 pregnant women. The most commonly provided services were residential treatment, methadone maintenance, day treatment, and outpatient groups. Among those discharged from services, about 67% successfully completed services.

DCF is currently working to provide additional information on residential programs that offer services for women and their children, but it was not available at the time of this report. Based on information from other sources, it is estimated that roughly half (49%) of Florida's counties have treatment facilities that offer programs for pregnant and postpartum women.[2] However, only 18% of Florida's counties are known to have a family residential treatment facility[3], meaning the child(ren) can live in the facility with their mother. Of the 15 counties that were identified as high-risk in the substance use disorder domain, only one has a family residential treatment facility. It is unknown at this time as to which of these facilities receive funding from DCF.

Child Welfare

To support families involved in the child welfare system in accessing treatment and support services, Behavioral Health Consultants (BHCs) are co-located with Child Protective Investigators (CPIs). Through Florida's State Opioid Response (SOR) funding, 12 BHCs have been hired, with two staffing each of the six regions. The BHCs are licensed or certified behavioral health professionals who provide technical assistance and consultation to CPIs and child welfare case managers on the identification of behavioral health conditions, their effects on parenting capacity, and engagement techniques. Consultants also assist investigative staff and dependency case managers in understanding the signs and symptoms of opioid use disorders and the best practices to engage and treat, including the use of medication-assisted treatment; provide clinical expertise and assist with the identification of parents with opioid disorders in the child welfare system. To help ensure coordination of services, their role is also to develop contacts, facilitate referrals, and assist investigative staff with engaging clients in recommended services and improving timely access to treatment.[4] In addition to expanding the cohort of BHCs, DCF has allocated $8 million of SOR supplemental funds to each region to address the treatment needs of families who are involved in the child welfare system.

Family Intensive Treatment (FIT) teams have been piloted throughout the state to provide specialized treatment for parents with primary substance use disorders who come in contact with the child welfare system and who have young children ages birth to eight. FIT is family focused and integrated across the child welfare, behavioral health, and judicial systems. Treatment involves joint planning and case management by a team of professionals which include child welfare workers, alcohol and drug treatment professionals, court representatives, and medical professionals. Families are provided wraparound and comprehensive community services to address the multiple needs of parents and children, including parenting skills to increase protective capacity, mental health, health, childcare, housing, and other services.

Florida Department of Health

The Department of Health (DOH) partners with the Florida Department of Children and Families to ensure a concerted effort to focus on behavioral health disorders and to prevent and reduce substance abuse and its negative effects on health. Goals include decreasing the number of infants born with neonatal abstinence syndrome and to reduce the number of opioid overdose deaths. Strategies include increasing the number of pregnant women in treatment for opioid disorders and increasing access to naloxone kits for first responders. Increasing the number of child welfare-involved families (both parents and children) with access to behavioral health services is a priority. Decreasing the number of newborns experiencing neonatal abstinence syndrome and the number of opioid overdose deaths are also goals for this priority area.

Survey Respondents' Identified Gaps in the Current Level of Substance Abuse and Mental Health Treatment and Counseling Services

The needs assessment revealed that 16 (24%) rural counties in the north central area of the state have at least 26% of the indicators at risk for substance abuse. This is problematic in that rural areas lack adequate medical care, community resources, and providers and facilities that specialize in treating substance use disorders.

The majority of home visiting program survey respondents (55, 61%) answered that there are not sufficient substance use prevention, treatment, recovery, and relapse prevention support services in their counties, while 21% (19) did not know and 18% (16) reported yes. Services reported as available in respondents' counties included: mental health counseling (66, 18%), case management services (59, 16%), crisis intervention (50, 13%), HIV testing or counseling (47, 12%), medical care (46, 12%), and fewer than 10% reported availability of support services such as childcare, housing assistance, legal assistance, and financial assistance for treatment.

According to 91 community partners, only 25% (23) think there are sufficient substance use providers for providing intervention, treatment, and recovery services to meet the needs of pregnant women and families

with young children who may be eligible for home visiting services. Forty-five percent (41) responded that there were insufficient providers and almost 30% (27) did not know.

When asked to specify the types of service providers that are available in their communities to treat this population, the majority of both the community partners and the home visiting programs indicate that most services are insufficient to meet the need. Most notably was the lack of clinics or services for substance exposed newborns. Outpatient counseling, residential treatment, and care coordination were noted as the most available.

Both the home visiting program respondents and community partners reported that there are clearly not enough providers to serve the mental health needs of respondents' clients. Specific services available were outpatient or in-home counseling, residential treatment, or psycho-educational classes. However, 32% of home visiting program respondents noted that residential treatment was not available in their county and 72% noted that residential treatment *that allows children to stay with parent* is not available in their county. Half (48%) of the same respondents noted a lack of psychoeducational classes for mental health, and others reported that in-home counseling (29%) and residential treatment (25%) was unavailable in their county. Far fewer community stakeholders reported that these services are available.

Almost 69% (66) of community partners noted that there are not enough providers to serve clients who have mental health challenges; 18 (19%) said yes and 12 (13%) were unsure. Seventy-five (83%) home visiting program staff reported inadequate number of providers, while 15 (17%) said there were enough providers.

Barriers to Receiving Treatment and Counseling Services for Substance Use Disorders

Responses from both the home visiting program survey and the community partner survey are similar when describing the barriers to receiving substance use disorder treatment and counseling services. The home visiting programs noted that some communities have efforts in place to address gaps and barriers to services, focusing on pregnant women and families with young children. Often there is a partnership with local hospitals, courts, child welfare agencies and providers. About 40% of home visiting program survey respondents reported that they participate in these community efforts, through activities such as community meetings, outreach, courts, task forces/coalitions, or direct care. Only half of the community partner survey participants stated that they participate in any community efforts to collaborate with state or local partners, i.e., hospitals, court system, child welfare agencies, substance use treatment providers, to address the gaps and barriers to care for pregnant women and families with young children impacted by substance use issues.

As noted earlier, the respondents provided a wealth of information regarding substance abuse treatment in the survey and, given the space limitation for this report, FAHSC will continue to examine and analyze the qualitative data provided and compile an ancillary report to share with stakeholders, such and the Office of SAMH at the Department of Children and Families and the Department of Health.

CONCLUSION

As one of the largest and most diverse states in the US, the need for home visiting services in Florida is great. There are currently seven evidence-based models operating in Florida that were funded to serve 16,639 in FY19-20. This comes nowhere close to meeting the estimated need of 111,366 families and the gap will continue to grow. In FY20-21, Florida MIECHV will see a reduction in funded family slots with larger cuts looming for FY21-22 unless there is an increase in funding. We also anticipate additional need as a result of the pandemic, and home visiting could benefit those families – especially the newly poor who are not familiar with resources they have never needed to access. Additionally, parents are facing increased stressors that compete with their ability to effectively meet the health and developmental needs of their children.

Following an extensive data analysis, 47 counties in Florida were determined to have concentrations of risk – 19 counties were identified through the initial county-level risk assessment, 25 counties were identified following

the subcounty analysis, and an additional three counties were included due to special circumstances. Each of the 47 counties has a unique set of risk factors and varying levels of available home visiting services.

A set of three surveys were utilized to gain the input of over 700 stakeholders living and working in high-risk counties, including home visiting staff, community partners, and parents with young children. Community partners overwhelmingly recognize the need for additional home visiting services in their community, while home visiting staff are split down the middle. The primary concern shared by home visiting staff were over saturating counties with smaller populations and low birth rates. Concerns were also raised about the lack of available programs that enroll older children (2-3 years old). In order to take these concerns into account and assist with future planning, the estimated need for MIECHV-eligible families, as well as the total number of current slots for evidence-based home visiting, are included for all high-risk counties in the county profiles that accompany the full report. The surveys also indicate a need for better coordination within the continuum of early childhood services.

Although Florida is already investing a substantial amount of resources into providing substance use disorder treatment and counseling services for pregnant women and families, the surveys indicate that it is not nearly enough. Surveys also show that even where services are available, there are still substantial barriers for accessing services.

The good news is that state agencies and non-profits that serve pregnant women and families with young children are working together more than they ever have in the past to collaborate on efforts to better coordinate services, and to meet the needs of families. Numerous organizations are working together on efforts to promote equity and reduce implicit bias so that we can improve outcomes for the diverse families in Florida.

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[1] Social Security Act, Title V, § 511(c)

[2] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. National Directory of Drug and Alcohol Abuse Treatment Facilities (2018). Retrieved September 28, 2020. **https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/nssats_directory_2018.pdf**

[3] Volunteers of America. Directory of Residential Substance Use Disorder Treatment Programs for Parents with Children. Retrieved September 29, 2020. **https://www.voa.org/pdf_files/family-based-residential-treatment-directory**

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