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Lee County
Human Services Gap Analysis

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February 5, 2020

Mr. Glen Salyer
Assistant County Manager
Lee County, Florida

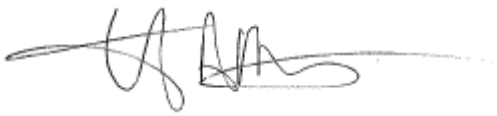
Dear Glen:

Enclosed are the findings of the Gap Analysis of Human Services in Lee County. Per your direction, this report is intended to be of value to the community focusing on a range of services, not solely on the responsibilities of the Lee Board of County Commissioners (BoCC).

Consistent with that direction, these findings incorporate the perspectives of many human service providers in the County. There has been a high level of participation through various means by people too numerous to thank personally. They have demonstrated in this study what I believe to be one of the strengths of the County's human services community a high level of cooperation focused on their clients' and the community's best interests.

This study was only possible in this timeframe with the extensive support provided by County staff. Please contact me if you have questions or comments. It was a pleasure to work with you on this project.

Cordially,



Herbert A. Marlowe, Jr., Ph.D.
Principal

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Table of Contents

Index of Data Tables

Index of Figures

EXECUTIVE SUMMARY

Introduction

The Lee Board of County Commissioners directed staff to identify gaps in the public and private systems of delivering vital human services in Lee County. The results of this Gap Analysis are reported here.

This comprehensive assessment addresses multiple services, including those that may not be under the purview of County Commissioners. This report, which identifies gaps but does not recommend specific solutions, is intended by design to be of value to the entire community rather than to be used specifically as an internal County document.

The Gap Analysis utilizes a system model that incorporates traditional needs assessment – a focus on the gap between an identified need and the capacity of existing services to meet that need – as only one of a set of analytical methods. The full set of analyses are summarized below.

Gap Analysis: The Analytical Methodology

Gaps in this assessment are examined from multiple perspectives. These include:

Need/Capacity. This is the most common understanding of "gap," in that the number of people needing a service is greater than the level of services that can be provided.

Behavioral Outcomes. The ultimate test of the value and validity of any human service program is its impact on behavior and/or life condition. To assess this gap perspective, databases reporting various population-correlated statistics on behaviors such as drug use per capita rates or homeless persons who were housed in permanent housing were used to compare Lee County with other counties in the state.

Evidence-Based Practices. Known as evidence-based practices, these programs have been evaluated by academic researchers and found to be effective. All human service programs are well intentioned. However, intentions do not always result in positive or long-term change. Evidence-based programs, or "best practices," have been found to effectively turn intention into positive impacts.

Policy/Process. In some cases, regulations or organizational processes inadvertently result in service gaps. For example, this may result from eligibility restrictions or communication gaps.

Access/Geography. This examines whether a gap exists between where people who need services reside and the location where those services are provided.

Equity Funding. There are varieties of funding streams involved in the human services field. Various formulas exist that underlie those funding streams. The question here is whether Lee County is funded equitably when compared with other counties in the state.

Scope of the Analysis

The assessment examined the various dimensions of the human services system. This included:

Systems of Care. These systems range in formality from highly linked to a loose network of providers. They focus on a set of issues or behaviors that are problematic from some perspective. The following systems were analyzed:

- Behavioral health;
- Behavioral health and criminal justice interface;
- Child abuse and neglect;
- Domestic violence;
- Elder abuse, neglect and exploitation;
- Sexual violence and stalking;
- Trauma and effects of violence exposure;
- Suicide and self-harm;
- Juvenile delinquency; and,
- Homelessness.

Special Populations. These are persons who are grouped by either age, disability, or life status and who also share a common set of issues. While they are likely served in multiple systems of care, they bring their own issues, which are best identified in separate discussions. The issues of the following special populations were examined:

- Intellectual and developmental disabilities;
- Congenital hearing and visual disabilities;

- Persons with other physical disabilities;
- Senior citizens; and,
- Veterans.

Development. The systems of care and special populations are characterized by some difficulty, or risk, that require an extra level of attention and intervention. Development is concerned with normal development patterns and tasks and how they can be fostered for everyone. The perspective examined child and youth development.

Infrastructure. This dimension encompasses the basic human needs of housing, transportation, food and employment. It also encompasses the organizational infrastructure needed to deliver services such as staff, facilities, organizational structure and technology.

Findings

When compared to either national, state or local data or to accepted best practices, there are gaps of varying degrees of significance in each system-of-care as well as in the services provided to various special populations, child and youth development and infrastructure. The three most critical of these are:

Behavioral Health. Consistently, the data-collection tools used for this analysis point to behavioral health services as having the most serious gaps in the County. These data-collection tools included various surveys that have been conducted in Lee County, the perspectives of professionals, comparative financial data showing that Florida ranks anywhere from 48th to 50th in terms of per-capita funding for mental health services, and the fact that behavioral health problems are found to be factors in almost all the systems of care assessed in this analysis.

Housing. With the same consistency across the methods used, housing for special-needs clients (supportive housing) and housing for workers (affordable housing using HUD definitions) were identified as one of the three most significant gaps from a countywide perspective. From a clinical perspective, the effectiveness of any treatment intervention is weakened if the person is in an unstable, unsafe or otherwise poor housing situation. If people are homeless, in highly transitory housing or in housing that is stressful because of crime, violence or poor quality, the resultant stressors can become overwhelming. These stressors can lead to relapse into more problematic

behavior or regression. From a system-of-care perspective, housing is a critical component to overall success.

Transit. Just as housing was consistently identified as a dominant gap, so was transit. While not as critical to positive outcomes as housing, transit remains a key component for the success of systems of care. Being able to access care and support, employment or basic-life necessities are all elements needed by system-of-care plans. This gap is critical for residents dependent upon public transportation to access support services and/or the employment and educational opportunities required to address their needs.

Other common issues. Varieties of services were examined in this analysis. Several gaps, in addition to the above three, were found to exist across the various services. These are detailed in the "Conclusions" chapter.

- Staffing. There is a significant shortage of professionals in the various fields such as nursing, psychiatry, psychology and social work. Low-compensation issues make retention of technicians, first-line or direct care workers, whose salaries are most often in the $10-$12 an hour range, difficult.

- The increasing complexity of the work. Increased knowledge of the human brain, the growing body of evidence-based practices that require specialized training, and the diversity of clients, make the work of delivering outcome-based human services increasingly complex. For example, child-care workers would ideally have at least an Associate's degree in child development. Early childhood educators are discussing Bachelor degrees as the minimum standard.

- The need for more integrated service delivery systems. Clients overlap various systems of care, particularly physical and mental health, which are strongly linked. A more integrated approach is needed. There has been an emphasis on greater integration of physical and mental health services among professionals, but for a variety of factors that has not yet been achieved.

- Evidence-based practices. Many providers in the area use a variety of evidence-based practices. Continuing to emphasize the use of such practices should be encouraged by all funders. An example of evidence-based practice is various forms of Cognitive Behavioral Therapy, which has been studied with control groups and found to be effective. Providing the training required to use these practices is challenging due to costs and limited staffing.

- More coordinated and flexible funding streams. Local decision-making would be strengthened if there were a greater opportunity to target external funds in ways more consistent with local needs. For example, the eligibility requirements for Healthy Start funding leaves parents who would benefit ineligible because their income is slightly above eligibility limits while being insufficient to pay for these services.

- Prevention and early intervention. Widely recognized as the most effective long-term strategies, finding the means to dedicate funds to these interventions would bring long-term benefit to the community.

- The Silver Wave. The proportion of Lee County residents who are elderly will continue to increase. Preparing to address the human service issues that will arise is a key future task. Various programs define the age that constitutes an elderly status as 55, 60, 62 or 65. For data analysis purposes, the age that was used was whatever age criterion the program being examined used.

- Public understanding and education. Some people are not aware of services for which they are eligible. There can be prejudice or bias toward certain groups of people for whom human services is a necessity.

- Data gaps. The need for greater information collection and sharing, especially across systems, will grow. For example, real-time data about the psychiatric status of jail inmates would be beneficial to those agencies responsible for mental health planning. Many of these systems of care have high-demand users who often cycle through their services. Between systems, interagency information sharing on high-demand users could be helpful to provide actions that are more effective.

- Affordability. As communities become more economically dynamic and diverse, they become more expensive. Housing, transportation and food comprise a larger proportion of their living costs than considered reasonable. For example, housing affordability is worse in the larger and more economically diverse counties of Florida, affordability challenges also exist in Lee. As noted in the report, it is estimated that 22% of children in the county live in poverty and 37% of households are cost-burdened for housing.[1]

[1] This data will be found in chapter 3.

For approximately 44% of the households, only 16% of the rental housing stock is affordable.[2] Transportation costs are considered affordable if they are 15% or less of household income. This would be $7,281 per year for the average Lehigh Acres household. The estimated driving costs for Lehigh Acres are $12,822 per year.[3] According to a USDA survey, 18.1% of Lee County adults report a time in the past year ("often" or "sometimes") when the food they bought just did not last, and they did not have money to get more.[4] For 8% of the senior population (65 or older), or slightly more than 19,000 persons, their household income falls below the federal poverty guideline.[5]

- In-home services. For reasons of transportation and clinical benefit, greater delivery of services in-home is needed. These in-home services have been found to be highly beneficial because they allow the clinician to observe the family in a natural setting and remove some of the barriers to accepting interventions.

- Trauma. People who are exposed to violence, natural or manmade disaster, feel at risk of harm or seeing others harmed can be traumatized by the event. If this exposure is repeated or occurs with regularity, the likelihood some of one being traumatized increases. The experience of trauma has both physical, physiological and psychological effects. Both victims and those working with victims can experience trauma. Post-traumatic stress disorder in the military is one example of the impacts of experiencing or observing traumatic events. There is a need for a broader understanding of trauma by behavioral health professionals as well as other professionals who deliver human services.

- Education for non-behavioral health disciplines. There is a need for other professionals who interact with the various systems of care to have a better understanding of various behaviors associated with differing conditions. There has been a recent emphasis on more training on mental health issues or developmental disability issues for law enforcement personnel as one example. These same recommendations can be made for other elements of the criminal justice system.

[2] This data will be found in chapter 5.
[3] www.esri.com/software/american-community-survey
[4] Lee County Health Needs Assessment, Lee Health
[5] This data will be found in chapter 27.

- Assessment. An improved ability to assess individuals and families would be of value across the various systems of care. For example, a greater ability to more fully assess the mental status of people who are homeless or entering jail could lead to better decisions about interventions. Being able to better assess potential elder abuse is another example of improvement potential.

- Employment. For the adult-oriented human service systems of care, employment is a consistent concern. The benefits of employment are obvious. Barriers include transportation, employer bias, the need for some special accommodations and training. People with developmental disabilities, histories of drug abuse or mental illness, or people with jail or prison records face employment challenges of differing types.

- Language and cultural diversity. As the County becomes more culturally and linguistically diverse, demands are being placed upon the human service field to respond with bi- or multi-lingual staff and more culturally sensitive interventions or services.

- Growing service demand in Lehigh Acres. The demographics are becoming more diverse and households are cost-burdened from a combination of housing and transportation costs. Services are currently limited as the chapter on spatial matching demonstrates.

- Technology. As with the rest of society, technology is changing how work is done. There are potential benefits for service provision. Telepresence, in which services could be delivered remotely through the internet, is one example of how technology could improve access to services.

Chapter 34 addresses those services for which the BoCC has certain responsibilities and/or which are of the most significant financial impact. This chapter addresses topics such as:

> Behavioral health and criminal justice. The County funds the jail and other criminal justice components. A significant proportion of jail inmates have mental health or substance- abuse issues that are a cost-burden to the County. Examining alternative or additional approaches could have a financial impact.

Performance-For-Results Funding. The County funds various nonprofits. Examining these programs from a system-of-care approach and evidence-based practices perspectives could enhance their value.

Homelessness. The County serves as the lead agency for the Continuum of Care. There has been an increased emphasis on diversion and prevention. Additional resources on those points could be cost-effective.

Housing. While the County is not a housing developer, it has several tools that could assist the development community to respond to the need for supportive and affordable housing.

CHAPTER 1
Introduction

Purpose of the Study

This report addresses potential gaps in the human services system in Lee County, Florida. It is a comprehensive assessment covering not only those services provided by the Lee Board of County Commissioners, but also services provided through federal and state governments, as well as those provided through private means. It is intended to be of use to the community in determining priorities and investments.

The Definition of Human Services in this Assessment

Human services are defined in this study as:

Development services. These are efforts intended to strengthen, enrich or improve the quality of life for members of the community through developing resiliency, social skills and development of the whole person. Excluded from the definition for the scope of this study are arts and culture activities (except those designed for therapeutic purposes), general education and the activities of civic and faith communities. Included in this definition are recreation programs for persons of any age and quality child-care programs.

Prevention services. Certain behaviors can be harmful to self or others, regardless of any demographic or socio-economic category. Communities wish to prevent those behaviors from developing in the first place. Programs and efforts to prevent the development of problematic behavior, such as anti-smoking campaigns, are examples of programs that would be covered in this assessment. These services are targeted to the community at-large.

Early Intervention services. These are services that are targeted to more specific groups that are deemed to be at a higher level of risk. This risk may have been determined by research studies that have found a certain category of people to be more likely to develop a problematic behavior or that face a challenging situation requiring additional support. The risk may also be determined by an early set of behaviors that have been shown to be related to the development of more serious problems. For example,

children who enter school without a certain level of reading skill are challenged and may have greater difficulties in school.

Intervention and Treatment. These are services designed to intervene to:

- Modify problematic behavior;
- Address a complex social condition that results from a combination of personal behavior, social and economic forces and/or geographic factors;
- Address issues that arise from physical or personal disaster, victimhood, loss of support systems or relationships;
- Provide basic needs such as housing, food, and transportation.

What is excluded from this study are any comprehensive assessments of the following systems:

- The public education system, at any level, except where there are direct linkages to social services such as addressing the needs of homeless children;
- Private elementary, middle, high school, vocational or higher education services. Child-care and pre-K programs are examined;
- The public and private physical health care systems of the community, except for physical disabilities that have significant social service implications such as people whose disability requires personal care;
- The arts and culture entities.

Gap Analysis: A Multi-dimensional Perspective

Gaps in this assessment are examined from multiple perspectives. These include:

The gap between need and capacity. This is the most common understanding of "gap" in that the number of people needing a service is greater than the level of services that can be provided. This gap is referred to as the Needs / Capacity Gap.

Behavioral outcomes. The ultimate test of the value and validity of any human service program is its impact on behavior (such as no use of drugs) or life status or conditions (such as being in permanent housing). To assess this gap perspective, several data-

bases reporting various population-level statistics on behaviors were used to compare Lee County with other counties in the State.

Best practices. Known as evidence-based practices, these are programs that have been evaluated and found to be effective. All human service programs are well intentioned. However, intentions do not always result in positive or long-term change. Evidence-based programs, or best practices, have been found to effectively turn intention into positive impacts.

Policy/Process. In some cases, regulations or organizational processes inadvertently result in service gaps. This may be due to eligibility restrictions, communication gaps or other sources.

Access and Geography. This gap examines whether a gap exists between where the people needing services reside and the location in which those services are provided.

Equity Funding. There are a variety of funding streams involved in the human services field. Various formulas exist that underlie those funding streams. The question here is whether Lee County is funded equitably when compared with other counties in the State.

Methodology

This assessment used a variety of data sources to identify gaps. When multiple sources identified a gap, the conclusion was determined to be more reliable and valid than if the gap was only identified by one source. The data sources for the assessment included:

Population Data. This data came from both public and private databases that reported prevalence of certain behaviors or conditions. Data gathered included a variety of metrics, such as per-capita ratios or percentages. Wherever possible, data specific to Lee County was used and compared with the State of Florida averages, ratios, percentages, etc. It is considered population data because it is measuring a condition in a population, such as seniors in Lee County, rather than an individual's status.

Research Studies and Expert Opinion. The topics addressed in this study do not solely exist in Lee County. These are issues every community in the nation faces to some

degree. For most of these issues, there is a long history of efforts and interventions intended to address the issue or problem. For many of these topics, there is a research base that seeks to determine scope, causality, effectiveness of various solutions and implications. In addition to research and evaluation studies, professional associations have developed a process in which knowledge is shared and skills and solutions are promoted. This results in a body of expert opinion of people who have worked in the field for years and understand its strengths and weaknesses. This information was gathered by the means listed below:

- Surveys
- Focus groups
- Interviews
- Literature reviews

Program Data. Each service program maintains some level of data about their services. These vary in comprehensiveness, detail, length of data collection, reliability and validity. Whatever the varying quality, this is still a source of information. Some of the data types examined here include:

- Outputs
- Financials
- Staffing

Report Format

The report is organized in eight sections as described below:

Section One: Descriptive and Quantitative data. This section uses various quantitative data sources to examine potential gaps in human services. It consists of three chapters as listed below:

- Lee County Demographics
- Behavioral Outcomes
- Comparison of Surveys

Section Two: Infrastructure. This section addresses basic needs such as housing, transportation, employment and food, as well as the organizational infrastructure needed to provide services such as staffing, facilities, organizational capacity and technology.

- Housing
- Transportation
- Food
- Employment
- Staffing
- Facilities
- Organizational Capacity
- Information and Technology

Section Three: Development. This chapter addresses the first element of a service system – development. It consists of one chapter on child and youth development.

Section Four: Systems of Care. These are systems designed to address a specific issue, such as homelessness or domestic violence. There are 10 chapters in this section and they are organized in the chapter format presented below. They may cover prevention, early intervention or treatment services from both a Needs / Capacity perspective and/or a Best Practice perspective. Each concludes with a listing of gaps.

Section Five: Special Populations. This section addresses four populations for which there are distinctive issues as well as distinctive funding sources. These populations are persons with intellectual and developmental disabilities, persons with congenital deaf and blind issues, persons with disabilities and veterans.

Section Six: Geography. This section consists of one chapter that examines spatial mismatch.

Section Seven: Financial. This section examines which entities are responsible for funding the various services, funding equity issues and a determination of the Lee Board of County Commissioners' current human services related expenditures.

Section Eight: Conclusions. This section examines the core drivers underlying the human services issues such as behavioral health, trauma and cost-burdened households. It concludes with an examination of the Lee County strategy.

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Section One: Quantitative Data

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CHAPTER 2
Lee County Description and Demographics

County Description

Assessment of demographic characteristics can indicate the need for access to a variety of services in a community. Factors such as population growth, age trends and economy help to shape regional needs and also play a role in identifying potential gaps in available services and resources.

Lee County is the eighth most populated county in the State of Florida. Located on the Gulf Coast of Florida, Lee County encompasses approximately 813 square miles of land including several small islands in the Gulf of Mexico. The County is bordered by Charlotte County to the north, Hendry County to the east and Collier County to the south. Lee County comprises the Cape Coral – Fort Myers, FL Metropolitan Statistical Area (MSA). The City of Cape Coral is the largest City within the MSA. Other units of local government within the MSA are the City of Bonita Springs, the City of Fort Myers, the Town of Fort Myers Beach, the Village of Estero, and the City of Sanibel. Unincorporated areas of the County are mostly divided into named communities. These include: Bayshore, Boca Grande, Buckingham, Caloosahatchee Shores, Olga, Captiva, Greater Pine Island, Matlacha, Lehigh Acres, Northeast Lee County, Alva, North Olga, North Fort Myers, Page Park, San Carlos Island, Southeast Lee County, Tice and others.

Figure 1. Lee County, Florida Location

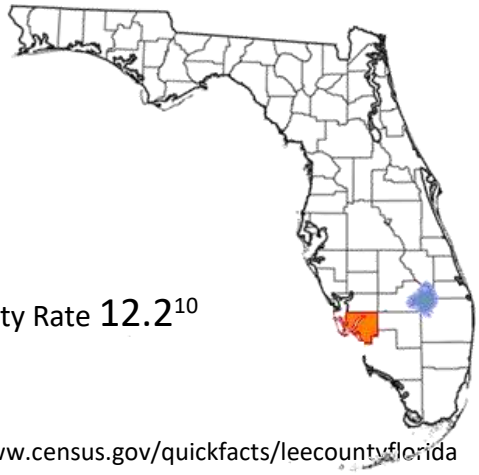
Lee County, Florida

Population 754,610[6]

Number of Households 281,222[7]

Median Age is 48.8[8]

Median Household Income $56,129[9] Poverty Rate 12.2[10]

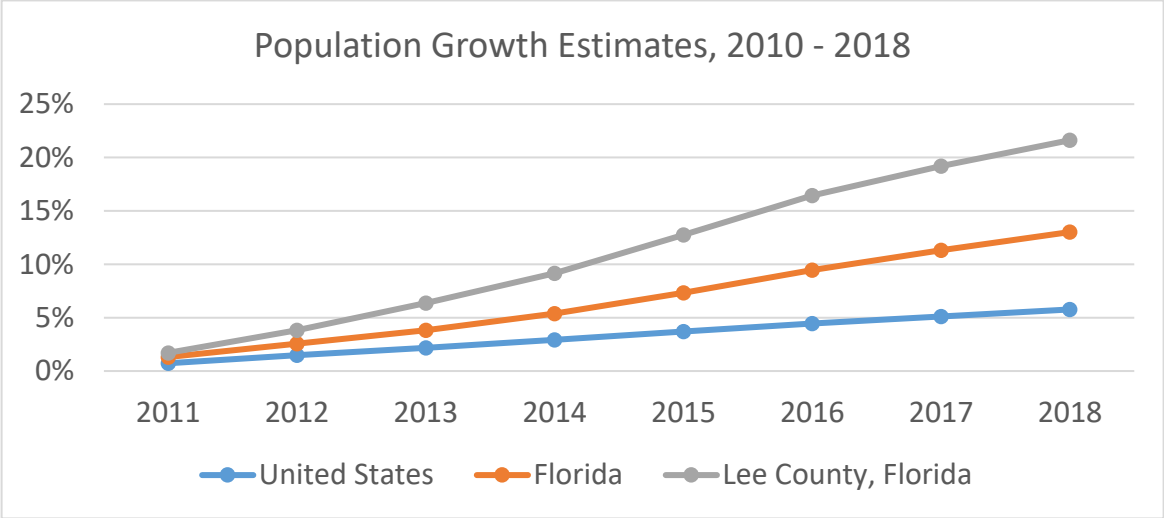


[6] American Community Survey, Quick Facts, https://www.census.gov/quickfacts/leecountyflorida
[7] American Community Survey, DP03, 2018 1-Year Estimates
[8] American Community Survey, S0101: 2018 ACS 1-Year Estimates
[9] American Community Survey, DP03, 2018 1-Year Estimates
[10] American Community Survey, S1701, 2018 1-Year Estimates

Population Growth

The 2018 American Community Survey One-Year Population Estimate indicates a total population of 754,610 in Lee County, a 22% increase over the 2010 census of 620,454. Figure 2 displays a comparison of Lee County to the population growth in Florida and the United States.

Figure 2. Population Growth Estimates[11]



In addition to the growth of the permanent residents, Lee County has a cyclical, seasonal population increase of 18% in standard dwelling units.[12]

Data from the Bureau of Economic and Business Research at the University of Florida indicates a projected population growth for 2030. Projections anticipate that unincorporated Lee County will experience the greatest growth at 140,000 or 38%. The City of Cape Coral will see an influx of population, growing 34.5% by 2030. The entire Lee County population is anticipated to grow by more than 240,000, or 32.8% by 2030; 18% over the anticipated State population growth rate.

[11] American Community Survey, B01003: 2018 ACS 1-Year Estimates
[12] Lee County Community Development

Table 1. Population Change Countywide [13]

University of Florida, Bureau of Economic and Business Research (BEBR)

Jurisdiction	Total Population 2010	Estimated Population 2019	Total Population 2030 (Projection)[14]	Percent Change 2010 - 2019	Projected Percent Change 2019 - 2030
Urban County					
Bonita Springs	43,857	54,437	62,645	24.1%	15.1%
Fort Myers Beach	6,277	6,520	5,818	3.9%	-10.8%
Sanibel	6,469	6,756	6,920	4.4%	2.4%
Estero*	0	32,412	48,125[15]	N/A	48.5%
Unincorporated	345,548	361,315	501,646	4.6%	38.8%
*Unincorporated (Plus Estero)**	*345,548*	*393,727*	*549,771*	*13.9%*	
Total Urban County	402,151	461,440	625,154	14.7%	35.5%
Entitlement Jurisdictions					
Cape Coral	154,305	185,837	249,942	20.4%	34.5%
Fort Myers	62,298	87,871	101,525	41.0%	15.5%
Total Lee County	**618,754**	**735,148**	**976,621**	**18.8%**	**32.8%**
State of Florida					
State of Florida	18,801,332	21,208,589	24,340,500	12.8%	14.8%

*Estero Incorporated in December 2014.

[13] Bureau of Economic and Business Research (BEBR), University of Florida 201
[14] 2030 City projections from Bureau of Economic and Business Research (BEBR), University of Florida 2017
[15] Metro Forecasting Models projections, The Village of Estero Comprehensive Plan

Limited English Proficiency

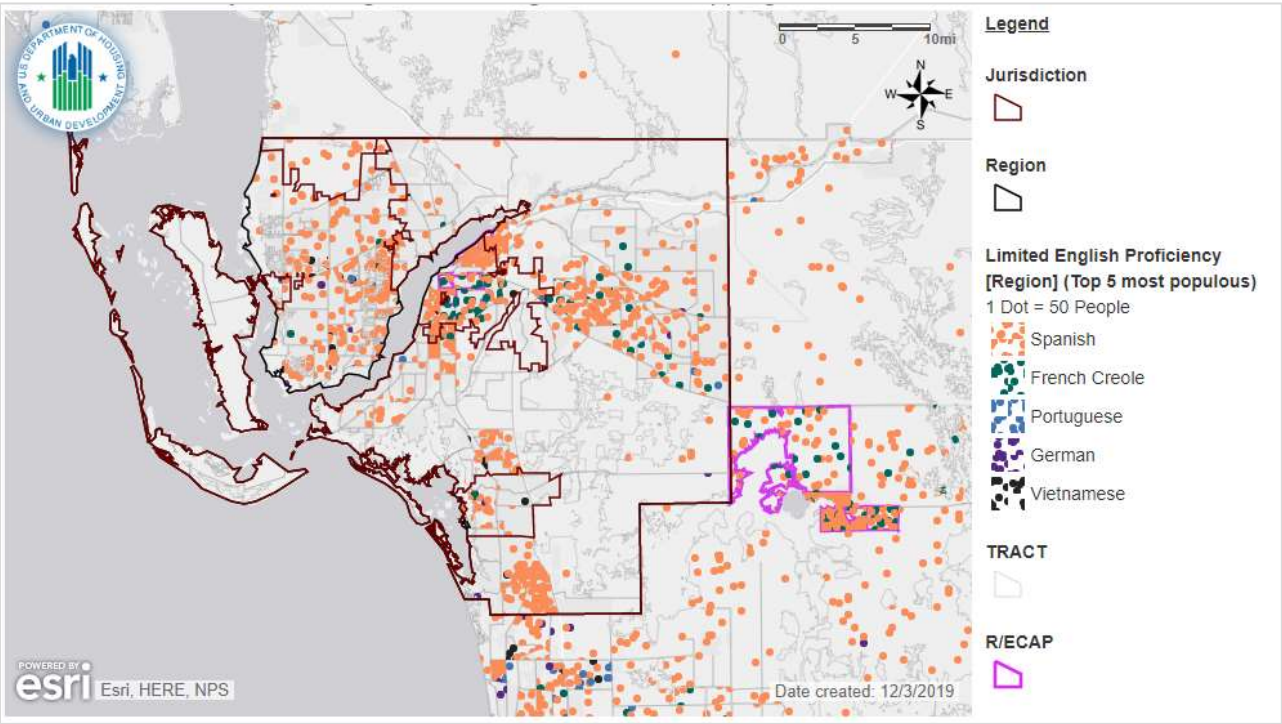
People with Limited English Proficiency (LEP) are defined by the federal government as those with a limited ability to read, write, speak or understand English. American Community Survey data reports on households in which English is not spoken at home. In 2017, the Census Bureau reported that 147,361 people across Lee County (21.1 percent of the population) spoke at least one language other than English. Of these, 62,713 (9.4 percent of the population) spoke English less than "very well." Translation of vital documents is required for HUD entitlement communities if the number of LEP persons in a single language group constitutes 5% or 1,000, whichever is less. The language group to qualify according to this threshold is Spanish.

Table 2. Limited English Proficiency Language Group, 2017 [16]

Language Group	Number of LEP Speakers	Percent of Total Population
Spanish	47,083	7.83%
French Creole	4,633	0.77%
Portuguese	1,130	0.19%
German	1,049	0.17%

[16] HUD AFFH Data (AFFHT0004) Released November 17, 2017.

Figure 3. Map of Limited English Proficiency Language Group, 2017



Race, Ethnicity and National Origin

Overall, Lee County has become more diverse since 2010. This is due to two factors: an increase in racial and ethnic minority population and a decrease in the percentage of white population. After white residents, the largest racial/ethnic group in Lee County is Hispanic. Hispanic or Latino is an ethnic classification by the U.S. Census Bureau. However, Hispanic individuals can be of any race.

The 2018 Census estimates indicated a major shift in population composition from 2010, which showed a 70.8% white (not Hispanic or Latino) and Hispanic or Latino (any race) population, comprising 18.4% of the County's total population. In 2018, 66.3% of the population identified as white (not Hispanic or Latino) and Hispanic or Latino (any race) populations, comprised 21.9% of the County's total population.

The County's population that is Hispanic or Latino increased from 114,098 to 165,233 people from 2010 and 2018, an increase of 45%.

Table 3. Lee County Race/Origin[17]

US Census American Community Survey, 2018.

Race/Origin	2018		2010	
	#	%	#	%
Not Hispanic or Latino	589,377	78.1%	506,053	81.6%
White alone	*500,358*	*66.3%*	*438,950*	*70.8%*
Black or African American alone	*64,553*	*8.6%*	*48,326*	*7.8%*
American Indian and Alaska Native alone	*487*	*0.1%*	*680*	*0.1%*
Asian alone	*12,098*	*1.6%*	*8,631*	*1.4%*
Native Hawaiian and Other Pacific Islander alone	*272*	*0.0%*	*0*	*0.0%*
Some other race alone	*3,730*	*0.5%*	*1,970*	*0.3%*
Two or more races:	*7,879*	*1.0%*	*7,496*	*1.2%*
Hispanic or Latino - All Races	165,233	21.9%	114,098	18.4%
TOTAL	**754,610**			**620,151**

Age

The age characteristics of a community give insight into current and future demand for resources. The age composition of a community affects housing and service demands since different age groups have very different needs. Seniors may seek healthcare services, community activities and financial assistance to manage budgeting on a fixed income.

Lee County's overall median age of 48.8 years old is six years greater than the State's median age of 42.2 years old. [18]

The proportion of residents over 65 years of age has increased 5% since 2010.

[17] American Community Survey, B03002: 2018 ACS 1-Year Estimates
[18] American Community Survey, S0101: 2018 ACS 1-Year Estimates

The population projection by BEBR indicates that between 2020 through 2030, Lee County's population of 65 and older residents will increase by 44%; and between 2020 through 2045 that population is projected to increase by more than 54%.[19]

Poverty, Employment, and Economy

Household income, employability and economy are potentially the most important factors in determining the resources needed in a community. Economic factors play an important role in a household's health, housing stability, educational opportunities, transportation options and the ability to engage in community activities.

Area Median Income and Poverty Level

In 2012, the median household income (MHI) in Lee County was $46,278 (in 2012 inflation adjusted dollars). In 2018, the estimated median family income was $56,129, an increase of $9,851 from 2012.

More than 30% of the County households earned less than $35,000 in 2018, and 36.4% earned more than $75,000 in 2018. Those with household income of $35,000 to $74,999 represented 33.5% of all income groups.

[19] https://www.bebr.ufl.edu/population

Table 4. Income and Benefits (In 2018 Inflation Adjusted Dollars)[20]

	#	%
Total Households	281,222	100%
Less than $10,000	17,520	6.20%
$10,000 to $14,999	12,359	4.40%
$15,000 to $24,999	28,058	10.00%
$25,000 to $34,999	26,702	9.50%
$35,000 to $49,999	40,002	14.20%
$50,000 to $74,999	54,356	19.30%
$75,000 to $99,999	32,815	11.70%
$100,000 to $149,999	38,900	13.80%
$150,000 to $199,999	14,006	5.00%
$200,000 or more	16,504	5.90%

Median Household Income	$56,129.00
Mean Household Income	$80,438.00

Based on five-year estimates, approximately 10.2% of all families and 14.9% of all individuals in Lee County had an income below the poverty level. Overall, Lee County's poverty rates are lower than the statewide rate. However, disparities exist for female-headed households, especially those with children under the age of 18.

[20] American Community Survey, DP03: 2018 ACS 1-Year Estimates

Table 5. Percentage Below Poverty Level in the Last 12 Months

(ACS 5-year Estimates 2013-2017) [21]

	Florida	Lee County
All families	11.10%	10.20%
With related children of the householder under 18 years	18.20%	19.80%
With related children of the householder under 5 years only	17.00%	17.30%
Married couple families	6.30%	5.90%
With related children of the householder under 18 years	8.90%	9.90%
With related children of the householder under 5 years only	7.00%	7.20%
Families with female householder, no husband present	26.80%	28.90%
With related children of the householder under 18 years	36.50%	39.20%
With related children of the householder under 5 years only	39.10%	40.40%
All people	15.50%	14.90%
Under 18 years	22.30%	24.90%
Related children of the householder under 18 years	22.00%	24.60%
Related children of the householder under 5 years	24.60%	27.00%
Related children of the householder 5 to 17 years	21.00%	23.70%
18 years and over	13.70%	12.60%
18 to 64 years	14.80%	15.00%
65 years and over	10.30%	7.80%
People in families	12.60%	12.40%
Unrelated individuals 15 years and over	26.60%	24.90%

[21] American Community Survey, S1702 and S1701: 2013-2017 ACS 5-Year Estimates

Employment and Other Sources of Income

Employment is the primary source of income for most Lee County residents. More than 265,000 residents in Lee County are employed. A key factor in determining the needs of Lee County residents is determining if they have enough income to maintain a normal standard of living.

According to data from the Florida Department of Economic Opportunity, the occupations with the most employment are as follows:[22]

[22] Florida Department of Economic Opportunity, Wage Estimates, http://www.floridajobs.org/workforce-statistics/data-center/statistical-programs/occupational-employment-statistics-and-wages

Table 6. Florida Occupational Employment and Wages; Cape Coral-Fort Myers MSA

(Released.)

	2018	Hourly Wage (2018 wage estimates in dollars)			
Title	**Employment**	**Mean**	**Median**	**Entry****	**Exp*****
Total all occupations	**265,780**	**20.67**	**15.83**	**10.36**	**25.83**
Retail Salespersons	14,150	12.50	10.64	8.97	14.27
Waiters and Waitresses	8,290	11.21	9.33	8.85	12.40
Cashiers	7,880	11.00	10.39	9.04	11.99
Combined Food Preparation and Serving Workers, Including Fast Food	6,780	10.36	9.88	8.87	11.11
Customer Service Representatives	6,650	14.88	13.61	10.77	16.94
Landscaping and Grounds-keeping Workers	5,940	13.07	12.29	10.60	14.31
Office Clerks, General	5,900	15.52	14.59	10.41	18.07
Registered Nurses	5,660	32.26	31.66	25.76	35.51
Construction Laborers	4,480	15.63	15.12	11.16	17.87
Secretaries and Administrative Assistants, Except Legal, Medical,	4,330	17.13	16.36	12.37	19.51
Stock Clerks and Order Fillers	4,290	12.91	12.00	10.08	14.32
Cooks, Restaurant	4,100	13.74	13.57	10.65	15.28
General and Operations Managers	3,680	49.58	38.47	22.47	63.13
Carpenters	3,360	18.98	18.57	13.96	21.49
Nursing Assistants	3,350	14.13	13.90	11.46	15.47
Receptionists and Information Clerks	3,000	14.32	14.16	11.58	15.69
First-Line Supervisors of Retail Sales Workers	2,990	22.75	21.07	13.93	27.17
First-Line Supervisors of Office and Administrative Support Worker	2,960	26.77	24.76	16.77	31.78
Janitors and Cleaners, Except Maids and Housekeeping Cleaners	2,900	12.61	11.75	10.13	13.86
Maids and Housekeeping Cleaners	2,870	11.52	11.21	9.57	12.49
Bookkeeping, Accounting, and Auditing Clerks	2,650	18.62	18.31	12.92	21.48

	2018	Hourly Wage (2018 wage estimates in dollars)			
Title	**Employment**	**Mean**	**Median**	**Entry****	**Exp*****
Sales Representatives, Wholesale and Manufacturing, Except Technical and Scientific Products	2,640	32.35	28.31	15.99	40.53
Laborers and Freight, Stock, and Material Movers, Hand	2,630	14.34	13.85	10.88	16.07
Maintenance and Repair Workers, General	2,630	17.57	16.93	12.45	20.14
First-Line Supervisors of Construction Trades and Extraction Work	2,530	28.17	27.22	19.70	32.40
First-Line Supervisors of Food Preparation and Serving Workers	2,510	21.29	15.07	11.13	26.37
Food Preparation Workers	2,500	11.78	11.12	9.24	13.04
Elementary School Teachers, Except Special Education	2,370	63,684 *	64,661*	49,469 *	70,791 *
Heavy and Tractor-Trailer Truck Drivers	2,260	18.91	17.82	13.51	21.61
Security Guards	2,200	13.10	12.68	10.14	14.58
Medical Assistants	2,120	15.96	15.47	13.05	17.41
Light Truck or Delivery Services Drivers	2,040	15.75	13.89	9.93	18.66

* Annual Wage.
** Entry Wage - This is the wage an entry-level worker might expect to make. It is defined as the average (mean) wage earned by the lowest third of all workers in a given occupation.
*** Experienced Wage - This wage represents what an experienced worker might expect to make. It is defined as the average (mean) wage earned by the upper two-thirds of all workers in a given occupation.
Wages based on 2nd qtr. 2018 survey.

In addition to income from employment, there are other sources from which households can gain income. Social Security and retirement income are the largest non-employment income sources in Lee County. The percent of the population that receives public assistance and / or Food Stamps / SNAP is lower in Lee County (11.6%) than statewide (15%). [23]

[23] American Community Survey, B19058: 2017 5-Year Estimates

Labor Force

Labor is defined as members of the population who are available and willing to work, and who are currently employed or have recently looked or a job. Lee County's labor force participation rate is 52.9%, indicating that approximately 337,314 individuals over the age of 16 are currently employed or are seeking employment. Lee County's unemployment rate is 4.4%. [24]

[24] American Community Survey, 2018 1-Year Estimates

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CHAPTER 3
Behavioral Outcomes

Introduction

Behaviors, or outcomes, are the "bottom-line" gap in that the goal of human services programming of almost any type is to affect some degree of behavioral change. That change may be positive in the sense of exhibiting more pro-social or constructive behavior. It may be negative from the perspective of diminishing anti-social, destructive, or harmful behavior. This is the ultimate test of the value of any intervention – does it make some difference in a person's life as well as provide an overall benefit to society at large?

This chapter examines both behavioral outcomes as directly measured, as well as conditions that can influence behavioral outcomes. For example, binge drinking is a direct behavioral outcome; difficulty in accessing a physician can influence and shape a behavioral outcome.

This chapter also includes a case study examining the impact of additional funding on population outcomes. Children's outcomes in Lee County are compared to those of Florida counties who have a Children's Services Council as either an independent taxing district or a dependent one.

Methodology

Comparison of Public Databases. This analysis is based on a variety of public databases that compare a behavior in Lee County with the same behavior in other Florida counties. In a few cases, a national comparison is used if there are no state comparative data.

Why compare Lee to other Florida counties and not national data points? While there are local differences in Florida counties, they all operate within the same state policy framework and, for the most part, all have the same tools to work with to address the needs and concerns of the county they serve. Counties or parishes in other states have

different tools and must work within different state policy frameworks. While comparisons among differing Florida counties are rarely "apple to apple" comparisons, they are at least "apple to fruit". Trying to compare a Florida county to a county in any other state may become an "apple to vegetable" exercise.

The Limitations of Public Databases. Public databases have several limitations:

1) They usually have a time lag of one to three years. Data is always collected retrospectively and sometimes not annually.
2) There may be challenges of not using consistent practices in collection and coding, so that the data from one jurisdiction may not be fully comparable to that of another.
3) There may be some anomalous event that creates an outlier situation that can skew those databases where averages are reported.
4) The data may not allow the level of detailed analysis one would desire. Some databases only compare state level data. Some have data at a county level and not at a census tract level.

Given these limitations, caution should always be exercised in the interpretation of comparisons. That stated, these are the tools that exist to compare behavioral outcomes.

Findings

Data gathered from the various public databases compares Lee County data to data for the State of Florida. The comparisons are color coded as follows:

- Green: The Lee County data point is better than the State data point by 10% or more
- Yellow: The Lee County data point is within a 10% range, above or below, the State data point
- Red: The Lee County data point is worse than the State data point by 10% or more.

Appendix K explains the methodological reasoning behind these determinations. The findings are organized in the following categories:

Aggregated Data. These are databases that combine various data sources to create summary or index scores. Their value is that they help make overall patterns clear and provide a bigger picture. In addition, because it is aggregated data, it is likely to be somewhat more stable. However, there can be significant year-to-year variance on specific behaviors simply due to survey response variation, data collection variances, coding error or differing interpretation of questions.

Behaviors of Concern and Significance. These databases examine various behaviors that can be understood as positive and desirable, or problematic and concerning. It is these behaviors that often raise public concern and that6 are often the focus of various interventions. This section reports data for behavioral health outcomes, violence and crime outcomes, and various health outcomes.

Service Capacity and Infrastructure Data. These tables present data on behaviors themselves or service and access data that shape behavior. Specific tables address various indicators of access to services, treatment capacity and housing.

The tables present the comparative data from various databases. The source database is identified in each table.

Aggregated Data

Comparison of Aggregated Data. Some of the databases aggregate various specific behaviors to generate a score ranking Lee County within the State. As Table 7 shows, Lee County on six of the eight aggregates is ranked in the Top 25% or higher of Florida counties on those six indexes. Of the remaining two indexes, Lee is average on one and below average on the other. From an overall perspective, behavioral outcomes in Lee County are superior to the average county in the State and, for the most part, Lee County is in the Top 25% of the State as to preferred or desired direction for behavioral outcomes.

Table 7. Comparison of Aggregated Data[25]

Source	Data Title	Year	Lee County	State Avg	Comparison to State
County Health Rankings	Health Outcomes (overall) of 67 Counties	2019	11	34	Higher than average
County Health Rankings	Length of Life of 67 Counties	2019	18	34	Higher than average
County Health Rankings	Quality of Life of 67 Counties	2019	12	34	Higher than average
County Health Rankings	Health Factors (overall) of 67 Counties	2019	18	34	Higher than average
County Health Rankings	Health Behaviors of 67 Counties	2019	9	34	Higher than average
County Health Rankings	Clinic Care of 67 Counties	2019	14	34	Higher than average
County Health Rankings	Social Economic Issues of 67 Counties	2019	32	34	Within 10% average
County Health Rankings	Physical Environment of 67 Counties	2019	46	34	Below average

Behaviors of Concern and Significance

Behavioral Health. Table 8 reports various indices related to behavioral health, including mental health and substance abuse data points. As shown in the table, the data is mixed for Lee County. The preponderance of "worse" comparisons are related to either adult or youth alcohol-related behaviors. The other "worse" cluster is depression at any age and suicide for persons 19-21. Lee County has fewer hospitalizations for mental disorders than other counties. This could be related to the higher alcohol indicators. However, there are a variety of factors that can determine this number (such as a lower

[25] https://www.countyhealthrankings.org/app/florida/2019/rankings/lee/county/outcomes/overall/snapshot

capacity of beds), so one should be cautious in concluding that mental illness is less problematic in Lee. The two clearly positive indicators are that Lee County residents have fewer unhealthy mental days than the average State resident and that the County is ranked ninth in the State on overall health behaviors.

Table 8. Behavioral Health Outcomes

Source	Data Point	Year	Lee	State	Comparison
Lee Drug Free Coalition Need Assessment 2019[26]	Past 30 day use of alcohol by students - middle school	2018	6.50%	7.30%	Better
Lee Drug Free Coalition Need Assessment 2019	Past 30 day use of alcohol by students - high school	2018	26.30 %	21.20 %	Worse
Lee Drug Free Coalition Need Assessment 2019	Percent of students who used alcohol before or during school in the past 12 months - middle school	2018	3.10%	3.70%	Better
Lee Drug Free Coalition Need Assessment 2019	Percent of students who used alcohol before or during school in the past 12 months - high school	2018	7%	6.70%	Within 10% average
Lee Drug Free Coalition Need Assessment 2019	Percent of students reporting that in the last 12 months they had attacked someone with the intent to harm - middle school	2018	6.30%	6.70%	Within 10% average

[26] Lee Drug Free Coalition

Source	Data Point	Year	Lee	State	Comparison
Lee Drug Free Coalition Need Assessment 2019	Percent of students reporting that in the last 12 months they had attacked someone with the intent to harm - high school	2018	6%	7%	Better
Lee Drug Free Coalition Need Assessment 2019	Past 30 day use of alcohol by students - ages 10-14	2018	8.50%	8.10%	Within 10% average
Lee Drug Free Coalition Need Assessment 2019	Past 30 day use of alcohol by students - ages 15-17	2018	24%	20.90 %	Worse
Lee Drug Free Coalition Need Assessment 2019	Past 30 day use of alcohol by female students	2018	18.40 %	16.80 %	Worse
Lee Drug Free Coalition Need Assessment 2019	Past 30 day use of alcohol by male students	2018	17.20 %	13.80 %	Worse
Lee Drug Free Coalition Need Assessment 2019	Percent of students binge drinking in past 30 days - age 10-14	2018	4.90%	3.20%	Worse
Lee Drug Free Coalition Need Assessment 2019	Percent of students binge drinking in past 30 days - Age 15-17	2018	10.40 %	9.40%	Worse
Lee Drug Free Coalition Need Assessment 2019	Percent of female students binge drinking in past 30 days	2018	7.70%	6.70%	Worse
Lee Drug Free Coalition Need Assessment 2019	Percent of male students binge drinking in past 30 days	2018	8.70%	6.90%	Worse
Lee Drug Free Coalition Need Assessment 2019	Past 30 day use of marijuana by	2018	3.5%	3.70%	Within 10% average

Source	Data Point	Year	Lee	State	Comparison
	students - middle school				
Lee Drug Free Coalition Need Assessment 2019	Past 30 day use of marijuana by students - high school	2018	14.80 %	16.30 %	Within 10% average
Lee Drug Free Coalition Need Assessment 2019	Lifetime use of depressants by students - middle school	2018	2.60%	2.30%	Within 10% average
Lee Drug Free Coalition Need Assessment 2019	Lifetime use of depressants by students - high school	2018	4.10%	5.90%	Better
Lee Drug Free Coalition Need Assessment 2019	Lifetime use of prescription pain relievers - middle school	2018	2.40%	2.60%	Within 10% average
Lee Drug Free Coalition Need Assessment 2019	Lifetime use of prescription pain relievers - high school	2018	4.70%	5%	Within 10% average
Lee Drug Free Coalition Need Assessment 2019	Lifetime use of amphetamines - middle school	2018	1.80%	1.20%	Worse
Lee Drug Free Coalition Need Assessment 2019	Lifetime use of amphetamines - high school	2018	3.80%	3.60%	Within 10% average
Lee Drug Free Coalition Need Assessment 2019	Past 30 day use of depressants - middle school	2018	0.50%	0.90%	Better
Lee Drug Free Coalition Need Assessment 2019	Past 30 day use of depressants - high school	2018	2.20%	1.60%	Worse

Source	Data Point	Year	Lee	State	Comparison
Lee Drug Free Coalition Need Assessment 2019	Age adjusted Death Rate Per 100,000 Suicide all means	2012 - 2014	16.60 %	14%	Worse
Health Equity Profile [27]	Hospitalizations for mental disorders, Per 100,000 population	2017	625.1	975.4	Better
		2018	598.5	978.2	Better
Healthiest Weight Profile [28]	Average number of unhealthy mental days in the past 30 days	2016	2.8	3.6	Better
Healthiest Weight Profile	Adults whose poor physical or mental health kept them from doing usual activities on 14 or more of the past 30 days **(Among adults who have had at least one day of poor mental or physical health)**	2016	20.8%	18.6%	Worse
Social and Mental Health [29]	Hospitalizations for mental disorders 3-Yr Rate Per 100,000	2014 -16	592.4	983.5	Better
		2016 -18	595.2	958.4	Better
Social and Mental Health	Hospitalizations for mental disorders, except drug and alcohol-induced mental disorders 3-Yr Rate Per 100,000	2014 -16	417.1	821.5	Better
		2016 -18	393.3	792.9	Better

[27] Florida Health Charts; Health Equity Profile: http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.HealthEquityProfile
[28] Florida Health Charts; Healthiest Weight Profile: http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.HealthiestWeightCountyProfile Data source: Behavioral Risk Factor Surveillance System (BRFSS)
[29] Florida Health Charts; County Health Profile: http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.CountyHealthProfile

Source	Data Point	Year	Lee	State	Comparison
Social and Mental Health	Hospitalizations for mental disorders age 18-21	2016-18	733.5	1197.5	Better
Social and Mental Health	Hospitalizations for mental disorders age 22-24	2016-18	829.4	1227.0	Better
Social and Mental Health	Hospitalizations for mental disorders age 25-44	2016-18	880.8	1313.6	Better
Social and Mental Health	Hospitalizations for mental disorders age 45-64	2016-18	922.2	1226.0	Better
Social and Mental Health	Hospitalizations for mental disorders age 65-74	2016-18	476.3	586.7	Better
Social and Mental Health	Hospitalizations for mental disorders age 75 or older	2016-18	229.5	347.8	Better
Social and Mental Health	Hospitalizations for mood and depressive disorders	2016-18	258.5	480.2	Better
Social and Mental Health	Hospitalizations for schizophrenic disorders	2016-18	98.4	251.3	Better
Social and Mental Health	Alcohol-suspected Motor Vehicle Crashes 3-Yr Rate Per 100,000	2015-17	65.3	52.8	Worse
Social and Mental Health	Alcohol-suspected Motor Vehicle Crashes	2016-18	62.4	49.5	Worse
Social and Mental Health	Alcohol-suspected Motor Vehicle Crash Deaths 3-Yr Rate Per 100,000	2016-18	2.5	2.8	Within 10% average

Source	Data Point	Year	Lee	State	Comparison
Social and Mental Health	Alcohol-suspected Motor Vehicle Crash Injuries 3-Yr Rate Per 100,000	2015-17	42.2	34.9	Worse
		2016-18	31.7	24.0	Worse
Social and Mental Health	Suicide (Age-Adjusted Death rate)	2016-18	15.5	14.5	Worse
County Death Data Comparison [30]	Suicide Age Adjusted Death Rate Per 100,000 Total Population	2017	14.3	14.1	Within 10% average
		2018	15.3	17.0	Within 10% average
Community Health Needs Assessment [31]	% Diagnosed Depression	2017	22.1	16.5	Worse
Community Health Needs Assessment	Suicide (age adjusted death rate)	2017	16.9	14	Worse
Aging in FL Profile [32]	Engage in heavy or binge drinking 65+	2016	14.8	8.7	Worse
Child Health Status [33]	Suicide death rate, ages 19-21 Per 100,000 population	2015-17	16.1	12.6	Worse
		2016-18	15.9	12.7	Worse
Child Health Status	Suicide death rate, ages 12-18 Per 100,000 population	2015-17	5.3	5.3	Within 10% average
		2016-18	5.2	5.8	Within 10% average

[30] Florida Health Charts; County Death Data Comparison: http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.CountyDeathDataComparison
[31] 2017 Community Health Needs Assessment Report; Lee Health and FL Dept. of Health in Lee County
[32] Florida Health Charts; Aging in Florida Profile: http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.AgingInFloridaProfile
[33] Florida Health Charts: Child Health Status Profile: http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.ChildHealthStatusProfile

Violence Related Behavior. Table 9 reports outcome data of violence-related behaviors. As with behavioral health, the outcomes are mixed.

Lee County's outcomes are better than the State on various specific crime indices such as domestic violence, rape or assault. The county is average on various child abuse indicators. Where the numbers are worse than the State of Florida are with youth. Youth in Lee County experience higher rates of homicide, suicide (as noted in Table 8), sexual violence and arrests.

Table 9.Comparison of Violence related Behaviors

Sources	Data Title	Year	Lee County	State	Comparison to State
Community Health Needs Assessment	Violent Crime per 100,000	2017	359.2	514.6	Better
Child Health Status Profile	Violent Crime per 100,000	2017	327.8	416.2	Better
Health Equity Profile	Incarceration rate	2017	2.3	2.6	Better
		2018	2.7	2.7	Within 10% average
Social and Mental Health	Index Crimes 3-Yr Rate Per 100,000	2015-17	2085	3156.9	Better
		2016-18	1931.9	2948.5	Better
Social and Mental Health	Larceny 3-Yr Rate Per 100,000	2015-17	1229.3	2016.8	Better
		2016-18	1154.4	1906.0	Better
Social and Mental Health	Burglary 3-Yr Rate Per 100,000	2015-17	369.8	490.9	Better
		2016-18	311.2	422.2	Better
Social and Mental Health	Aggravated Assault 3-Yr Rate Per 100,000	2015-17	242.1	298.9	Better
		2016-18	220.5	280.4	Better

Sources	Data Title	Year	Lee County	State	Comparison to State
Social and Mental Health	Motor Vehicle Theft 3-Yr Rate Per 100,000	2015-17	128.3	208.5	Better
		2016-18	134.7	205.8	Better
Social and Mental Health	Robbery 3-Yr Rate Per 100,000	2015-17	75.5	98.6	Better
		2016-18	68.4	90	Better
Social and Mental Health	Rape 3-Yr Rate Per 100,000	2015-17	34.3	38.0	Better
		2016-18	36.7	38.8	Within 10% average
Social and Mental Health	Murder 3-Yr Rate Per 100,000	2015-17	5.7	5.3	Within 10% average
		2016-18	6.0	5.3	Worse
Social and Mental Health	Forcible Sex Offenses 3-Yr Rate Per 100,000	2015-17	53.4	53.4	Within 10% average
		2016-18	55.7	54.4	Within 10% average
Social and Mental Health	Domestic Violence Offenses 3-Yr Rate Per 100,000	2015-17	414.8	527.8	Better
		2016-18	424.1	514.3	Better
County Death Data Comparison	Homicide Age Adjusted Death Rate Per 100,000 Total Population	2107	6.6	6.5	Within 10%
		2018	6.7	6.6	Within 10% average
Kids Count (Florida Child Well-being Index) [34]	Delinquency Cases Received (Percent reduction from 2007/08 counts	2008-17	(46%)	(55%)	Worse

[34] Florida Kids Count (Annie E. Casey Foundation): http://www.floridakidscount.org/

Sources	Data Title	Year	Lee County	State	Comparison to State
	through 2016/17 counts)				
MyFLFamilies.com [35]	Chart - Abuse during In-Home Services (% of Children Not Abused)	2007-19	93.58%	95.07 %	Within 10% average
MyFLFamilies.com	Chart - Young Adults Aging out who did not Perpetrate Abuse by their 25th birthday.	2014-19	84.21%	86.85 %	Within 10% average
MyFLFamilies.com	Chart - Removal Rate per 100	2009-19	4.70%	4.80%	Within 10% average
Child Health Status	Homicide deaths 5-11 Per 100,000 population	2015-17	0	.7	Within 10% average
			0	.7	Within 10% average
Child Health Status	Homicide deaths 12-18 Per 100,000 population	2015-17	9.3	5.4	Worse
			7.2	5.3	Worse
Child Health Status	Homicide deaths 19-21 Per 100,000 population	2015-17	19.3	13.7	Worse
			19.1	14.9	Worse
Child Health Status	Children experiencing child abuse ages 5-11	2015-17	850.4	932.8	Within 10% average
Child Health Status	Children experiencing sexual violence ages 5-11	2015-17	73.5	59.8	Worse

[35] Florida Department of Children and Families; Planning and Performance Measures https://myflfamilies.com/programs/childwelfare/dashboard/abuse-during-in-home-services.shtml

Sources	Data Title	Year	Lee County	State	Comparison to State	
	Per 100,000 population					
Child Health Status	Arrests, All Offenses by County, Youth Ages 10-17 Per 100,000 population	2014-16	4473.1	4028.3		Worse
Child Health Status	Referrals to Department of Juvenile Justice Per 100,000 population	2017	3888.3	3479.3		Worse
		2018	3784.3	3121.7		Worse
Child Health Status	School Environmental Safety Incidents (Violent acts K-12)	2017	2802.9	2408.0		Worse
Child Health Status	Out of School Suspensions K-12	2017	4390.4	5044.4		Better

Health Related Behavior – Nutrition. Table 10 reports comparative nutritional outcomes, in which physical characteristics may impact the human services system. As the table shows, Lee County is basically the same as the rest of the State. There is mixed data on obesity. However, underweight individuals occur at rates greater than the State average.

Table 10. Comparison of Nutritional Related Outcomes

Source	Data Title	Year	Lee County	State	Comparison to State
Healthiest Weight Profile	Adults who consume at least 5 servings of fruits and vegetables a day	2013	17.9%	18.3%	Within 10% average
Healthiest Weight Profile	Adults who are overweight	2016	37.7%	35.8%	Within 10% average
Healthiest Weight Profile	Adults who are obese	2016	27.5%	27.4%	Within 10% average
Healthiest Weight Profile	Adults who are at a healthy weight	2016	31.5%	34.5%	Within 10% average
Healthiest Weight Profile	Adults who are underweight	2016	3.3%	2.3%	Worse
Community Health Needs Assessment	%Obese (BMI 30+)	2017	31.2%	26.8%	Worse
flhealthcharts.com[36]	Obesity (Births to Obese Mothers at time Pregnancy Occurred)	2018	29.2%	26.2%	Worse
flhealthcharts.com	Obesity (WIC children >=2 who are overweight or obese)	2018	29%	27.1%	Within 10% average

[36] Florida Health Charts (Interactive): http://www.flhealthcharts.com/Charts/DataViewer/BirthViewer/BirthViewer.aspx?cid=0606

Source	Data Title	Year	Lee County	State	Comparison to State
Child Health Status	High School students who are underweight	2016	4.7%	3.6%	Worse
		2018	5.2%	4.2%	Worse
Child Health Status	Middle School students who are underweight	2016	5%	5.2%	Within 10% average
		2018	3.6%	4.7%	Worse
Healthiest Weight Profile	Middle and high school students who are at a healthy weight	2016	66.7%	66.4%	Within 10% average
Healthiest Weight Profile	Middle and high school students who are underweight	2016	4.8%	4.2%	Worse
Healthiest Weight Profile	Middle and high school students who are overweight or obese	2016	28.5%	29.4%	Within 10% average
Healthiest Weight Profile	Middle and high school students who are obese	2016	13.2%	13.0%	Within 10% average
Healthiest Weight Profile	Middle and high school students who are overweight	2016	15.3%	16.3%	Within 10% average

Health Related Behavior – Alzheimer's / HIV. Table 11 reports data for two physical health conditions that often create the need for social service supports – Alzheimer's and HIV/Aids. As the chart shows, Lee County data is better than the average county in the State.

Table 11. Comparison of Alzheimer's and HIV Outcomes

Source	Data Title	Year	Lee County	State	Comparison to State
Community Health Needs Assessment	Alzheimer's Disease (age adjusted death rate) per 100,000	2017	12.1	19.2	Better
Aging in Florida Profile	Probable Alzheimer's Cases 65+	2017	12.7%	13.3%	Within 10% average
Aging in Florida Profile	Alzheimer's Age-Adjusted Death Rate	2018	17%	20%	Better
Community Health Needs Assessment	HIV Aids (age adjusted death rate) per 100,000	2017	3.1	5.9	Better
Community Health Needs Assessment	HIV Prevalence per 100,000	2017	294.3	606.1	Better
County Death Data Comparison	HIV/AIDS Age Adjusted Death Rate Per 100,000 Total Population	2017	1.2	3.2	Better
		2018	2.0	2.9	Better
County Health Data Comparison [37]	AIDS Cases per 100,000	2017	6	9.9	Better
		2018	5.3	9.2	Better
County Health Profile	HIV/AIDS - 3-year age adjusted death rates per 100,000	2015-17	1.4	3.7	Better
		2016-18	1.7	3.3	Better
County Health Profile	AIDS Cases (3-Yr Rate Per 100,000)	2016-18	6.2	9.8	Better

[37] Florida Health Charts; County Health Status Comparison: http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.CountyHealthStatusComparison

Health Related Behaviors – Health Practices. Table 12 reports data on the health practices of Lee County residents. Poor health practices can lead not only to physical difficulties, but also to stress upon the human services of a community. With several positive exceptions, the residents of Lee County are like the other residents of Florida.

Table 12. Comparison of Health Practices

Source	Data Title	Year	Lee County	State	Comparison to State
Community Health Needs Assessment	% Meeting Physical Activity Guidelines	2017	26.8%	21.8%	Better
Aging in FL Profile	Reported good, very good or excellent health status 65+	2016	78.5%	75.7%	Within 10% average
Aging in FL Profile	Physically unhealthy days in the past month 65+	2016	4.7%	4.9%	Within 10% average
Aging in FL Profile	Reported fair or poor health status 65+	2016	21.5%	24.3%	Better
Aging in FL Profile	Meet aerobic activity recommendations 65+	2016	50.4%	45.7%	Better
Aging in FL Profile	Meet muscle strengthening recommendations 65+	2016	36.1%	31.0%	Better
Healthiest Weight Profile	Adults who are sedentary	2016	27.8%	29.8%	Within 10% average
Healthiest Weight Profile	Adults who meet aerobic recommendations	2016	48.5%	44.8%	Within 10% average

Source	Data Title	Year	Lee County	State	Comparison to State
Healthiest Weight Profile	Adults who meet muscle strengthening recommendations	2016	35.6%	38.2%	Within 10% average
Healthiest Weight Profile	Adults who are inactive or insufficiently active	2016	52.5%	56.7%	Within 10% average

Service Capacity and Infrastructure Data

Access to Services. Table 13 presents comparative access data. Access is defined in several ways, including:

1) geographic accessibility of a service or benefit
2) a financial definition, as indicated by insurance coverage
3) language barriers
4) availability of service providers
5) transportation

In this table, some state comparative data was not available so national level data were used. The data are color coded orange.

As with the other tables, data for Lee County are mixed, with the County being better on some data points, average on others and worse on others. Most the "worse" data points occur when compared to national data. It is possible that all Florida counties would be worse on these comparisons so they should not be viewed as overly significant. One other "worse" data point is of questionable value. It covers private recreational facilities. Since public recreational facilities are more important, this data point should be ignored. Two other data points, related to distance from healthy food sources or recreational parks, are due to the suburban nature of the county in that the population is highly distributed in a low-density pattern.

Two indicators that are more significant are the higher percentage of children 0-17 without health insurance and the lower rates of pre-natal care in the first trimester.

Each of these can have significant health implications.

Table 13. Access to Services

Source	Data Title	Year	Lee County	State	Comparison
Healthiest Weight Profile	Population that live within a 1/2 mile of healthy food source	2016	21.8%	30.9%	Worse
Healthiest Weight Profile	Population that live within a 1/2 mile of a fast food restaurant	2016	31.9%	33.9%	Within 10% average
Healthiest Weight Profile	Population that live within a ten-minute walk (1/2 mile) of an off-street trail system	2016	39.5%	18.2%	Better
Health Equity Profile	Population living within ½ mile of a park	2016	22.6%	43.2%	Worse
Healthiest Weight Profile	Workers who used taxicab, motorcycle, bicycle, or other means to work	2016 5-yr Est	3.1%	2.2%	Better
Healthiest Weight Profile	Workers who used car, truck, or van - drove alone Workers who walk to work	2016 5-yr Est	79.8%	79.5%	Within 10% average
Healthiest Weight Profile	Workers who walk to work	2016 5-yr Est	1.0%	1.5%	Worse
Community Health Needs Assessment	Private Recreation/Facilities per 100,000	2017	7.4	9.8	Worse

Source	Data Title	Year	Lee County	State	Comparison
Community Health Needs Assessment	Linguistically Isolated Population	2017	5.6%	6.5%	Within 10% average
Healthiest Weight Profile	Population 5+ that speak English less than very well	2016 5-yr Est	9.3%	11.7%	Better
Community Health Needs Assessment	Population with Low Food Access	2017	38.2%	25.7%	Worse
Community Health Needs Assessment	No Prenatal Care First Trimester	2017	36.6%	28.3%	Worse
County Birth Data Comparison	Births with Adequate Prenatal Care (Kotelchuck index)	2015-17	73.8%	70.5%	Within 10% average
School Age Child Adolescent Profile [38]	Children ages 0-17 without health insurance	2012-16	10.9%	8.9%	Worse
US Census [39]	Uninsured children	2018	9.3%	7.2%	Worse
Community Health Needs Assessment	% (18-64) Lack Health Insurance	2017	14.7%	20.9%	Better

[38] Florida Health Charts; School-aged Child and Adolescent Profile: http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.School-agedChildandAdolProfile
[39] US Census; Uninsured children: https://www.census.gov/programs-surveys/sahie.html

Source	Data Title	Year	Lee County	State	Comparison
Community Health Needs Assessment	% have Dental Insurance	2017	50.6%	66.5%	Worse
Community Health Needs Assessment	% have Dental Insurance	2017	50.6%	66.5%	Worse
Community Health Needs Assessment	% Difficulty accessing healthcare past year	2017	43.5%	35%	Worse
Community Health Needs Assessment	% Difficulty Getting Appointment past year	2017	20.4%	15.4%	Worse
Community Health Needs Assessment	% Difficulty Finding Physician past year	2017	14%	8.7%	Worse
Community Health Needs Assessment	% Transportation Hindered Doctors Visit past year	2017	9.3%	5%	Worse

Facilities. Table 14 reports data on comparative facility capacity. As shown in the table, Lee County falls below the state average on a variety of treatment or care beds. This can be attributed in part to the high growth rate of Lee County. In fast growing counties, it is difficult for the service infrastructure to keep up as it takes longer to build the facilities than it does to grow the population. The impact of this data on behavioral outcomes is that it may be difficult to access services.

Table 14. Facilities

Source	Data Title	Year	Lee County	State	Comparison
Health Resources Availability	Total Hospital Beds Rate Per 100,000	2017	259.55	312.3	Worse
		2108	260.6	308.2	Worse
Health Resources Availability	Total Acute Care Beds Rate Per 100,000	2017	207.61	253.5	Worse
		2018	201.8	248.9	Worse
Health Resources Availability	Total Specialty Beds Rate Per 100,000	2017	51.94	58.8	Worse
		2018	58.8	59.2	Within 10% average
Health Resources Availability	Total Nursing Home Beds Rate Per 100,000	2017	318.19	407.6	Worse
		2018	393.2	399.8	Within 10% average

Housing. Table 15 compares housing in Lee County with the State. As the table indicates, the County faces the same housing challenges as the rest of the State. This data can impact behavior due to the stresses that occur from being cost-burdened or living in sub-standard, or crowded, housing.

Table 15. Comparative Housing Data

Source	Data Title	Year	Lee County	State	Comparison
Health Equity Profile	Renter-occupied households with gross rent costing 30% or more of household income	2013-17	52%	57%	Within 10% average
Health Equity Profile	Severe housing problems	2015	18.5%	20.8%	Within 10% average
US Census – Quick Facts [40]	Owner-occupied housing unit rate	2013-17	69.8%	64.8%	Within 10% average
US Census – Quick Facts	Median gross rent	2013-17	$1035	$1077	Within 10% average

[40] US Census – Quick Facts: https://www.census.gov/quickfacts/leecountyflorida

Children and Youth

This section addresses a variety of outcomes related to children and youth. It follows the same color-coding as prior tables.

Table 16 presents data about a variety of birth factors. As with other tables, Lee County has a mix of better and worse indicators when compared to State of Florida averages.

Table 17 presents data on various health outcomes. Health outcomes are like the State.

Table 18 presents data regarding violence outcomes. In these cases, outcomes for youth in Lee County are consistently worse than the State average.

Table 19 presents data on the status of foster care in the County. Lee County youth are in foster care at rates higher than the State average.

Table 20 presents data on the percentage of children in single-parent homes. Lee County has a similar percentage as the State of Florida.

Table 16. Birth Data

Sources	Data Title	Year	Lee County	State	Comparison to State
Community Health Needs Assessment	Births to Teenagers under 20	2017	6.8%	5.9%	Worse
Kids Count	Births to Mothers under age of 20 (27th in State in 2017)	2017	5.51%	4.83%	Worse
County Death Data Comparison	Infant Mortality Rate Per 1,000 live Births Per 100,000 Total Population	2107	5.2	6.1	Lower
Kids Count	Low-birthweight babies	2017	8.0%	8.8%	Within 10% average

Sources	Data Title	Year	Lee County	State	Comparison to State
Community Health Needs Assessment	No Prenatal Care First Trimester	2017	36.6%	28.3%	Worse
County Birth Data Comparison	Births with Adequate Prenatal Care (Kotelchuck index)	2015-17	73.8%	70.5%	Within 10% average
Florida Health[41]	Resident Infant Deaths (Rate per 1000)	2017	5.2	6.1	Better
		2018	5.9	6	Within 10% average
Florida Health	Resident Fetal Deaths (Rate per 1000)	2017	7.9	6.9	Worse
		2018	7.2	6.7	Within 10% average

Table 17. Health Indicators for Children and Youth

Sources	Data Title	Year	Lee County	State	Comparison to State
Kids Count	Immunization Levels in Kindergarten	2006-18	94.10%	93.70%	Within 10% average
WIC Children [42]	Obesity (WIC children >=2 who are overweight or obese)	2018	28.95%	27.10%	Within 10% average

[41] FL Health Charts, Infant Deaths and Fetal Deaths, http://www.flhealthcharts.com/charts/SearchResult.aspx
[42] FL Health Chats, WIC Children, http://www.flhealthcharts.com/charts/OtherIndicators/NonVitalIndRateOnlyDataViewer.aspx?cid=0679

Sources	Data Title	Year	Lee County	State	Comparison to State	
Child Health Status	Percent of middle school students without sufficient vigorous physical activity	2016	78.5%	78.3%		Within 10% average
Kids Count	Overweight & obese 1st, 3rd and 6th grade students	2016/17	33.6%	34.3%		Within 10% average
Healthiest Weight Profile	Middle and high school students who are overweight	2016	15.3%	16.3%		Within 10% average
Child Health Status	High School students who are underweight	2016	4.7%	3.6%		Worse
Child Health Status	Percent of high school students without sufficient vigorous physical activity	2016	79.3%	80.6%		Within 10% average
Child Health Status	Percent of high school students without sufficient vigorous physical activity	2016	79.3%	80.6%		Within 10% average
School Age Child Adolescent Profile	Children ages 0-17 without health insurance	2012-16	10.9%	8.9%		Worse

Table 18. Violence Outcomes regarding Children and Youth

Sources	Data Title	Year	Lee County	State	Comparison to State
Child Health Status	Children experiencing sexual violence ages 5-11 Per 100,000 population	2015-17	73.5	59.8	Worse
Child Health Status	Arrests, All Offenses by County, Youth Ages 10-17 Per 100,000 population	2014-16	4473.1	4028.3	Worse
Child Health Status	Referrals to Department of Juvenile Justice Per 100,000 population	2017	3888.3	3479.3	Worse
Kids Count	Youth contacts with the juvenile justice system	2017/18	16.8%	16.4%	Within 10% average
Child Health Status	Homicide deaths 12-18 Per 100,000 population	2015-17	9.3	5.4	Worse
Child Health Status	Homicide deaths 19-21 Per 100,000 population	2015-17	19.3	13.7	Worse

Table 19. Foster Care Outcomes

Sources	Data Title	Year	Lee County	State	Comparison to State
School Age Child Adolescent Profile	Children in foster care ages 5-11 Per 100,000	2017	563.4	413.7	Worse
Child Health Status	Children under 18 in Foster Care Per 100,000 population	2017	708.3	537.7	Worse
Census - American Community Survey	Independent Living Difficulty Perc - 18 to 24	2013-2017	2.80%	2.30%	Worse
MyFLFamilies.com	Chart - Young Adults Aging out with Educational Achievement (also see link)	2007-19	90.91%	88.55%	Within 10% average

Table 20. Home Status of Children and Youth

Sources	Data Title	Year	Lee County	State	Comparison to State
Child Health Status	Children under 18 in single-parent households	2013-17	39.4%	38.1%	Within 10% average

Conclusion

From the broader perspective of aggregated data, Lee County behavioral outcomes are in the top quartile of the State. As would be true for any other County, whether in the top quartile or not, there is variation within the specific outcome level. Every County in the top quartile will have a mix of "better, same or worse" indicators. There is always room for improvement, even for those behaviors where the rates are "better".

Within this context, there are specific indicators that warrant further investigation and attention. Investigation is needed because even though none of these indicators should be viewed as the final word, they should be considered as signals for concern. For Lee County, the signals that warrant further examination include:

- Alcohol-related Behaviors. Among both adults and youth there are higher rates of problematic alcohol-related behavior reported for the County. The Drug Free Coalition 2019 Needs Assessment discusses this topic in some detail and offers several explanatory factors as well as strategies. It should form the basis for further community conversation and action.

- Suicide, particularly Youth Suicide. Existing data indicates higher rates in Lee County. This data should be more thoroughly investigated to ensure these are not reporting anomalies and do indeed represent an issue of concern for the community. If accurate, community strategy and action is warranted.

- Youth Violence. Rates of homicide and sexual violence among youth are higher in Lee County. As with Youth Suicide, this data should be more thoroughly investigated to ensure these are not reporting anomalies and do indeed represent an issue of concern for the community. If accurate, community strategy and action is warranted.

Impacting Population Outcomes: A case study

Introduction

The goal of any intervention is change toward more constructive, productive and healthier behaviors and attitudes. It is a common assumption that increased funding will increase the likelihood of moving a selected outcome in a desired direction. In Florida, data exists that allows this assumption to be tested.

Eight Florida counties have independent taxing districts that provide funds for services for children 18 and younger. These funds are not to replace K-12 education funds, but rather to provide for services not available through public education sources. These counties have used these resources to provide a variety of services including early childhood education, parenting education, youth intervention programs for a variety of risk-behaviors, children's mental health and other programs that would benefit children and youth. Without doubt, numerous children have benefited personally from these programs and services. Two counties (Duval and Manatee) have dependent districts, meaning that these fall under the Board of County Commissioners.

The question here, however, is not whether children have benefitted, but rather if these investments have been sufficiently powerful that population-level behaviors have changed. More specifically, how do outcomes and key indicators in these counties compare to Lee? The hypothesis that this analysis will test is presented below.

The Hypothesis

Population level child wellbeing and certain behavioral outcomes in Florida counties with Children Service Councils (CSC) will be consistently better than in Lee County (which does not have a special taxing district for children's programs).

Methodology

The Florida Child Well-Being Index was used as the data source for this analysis. Appendix H describes the components and sources for the index that can be found at http://floridakidscount.org/.

The Data

Tables 21 to 24 provide the data that will be used to test this hypothesis. The database for this analysis was Kids Count data -- the largest and most widely used database for population statistics about children. Data are reported annually as a Child Well-Being Index. It includes relevant socio-economic indicators that impact the wellbeing of children as well as behavioral outcomes.

Ranked Comparisons

Table 21 identifies the top ten counties in Florida using the overall Kids Count ranking averaged across the most recent three years. One of these, Martin, has an independent Children's Services Council (CSC). The remaining counties do not have a CSC.

Table 21. Overall Child Wellbeing Rankings: Top 10 Counties 3-Year Average[43]

County	2019	2018	2017	Rank of 67 Counties 3-Year Average
Saint Johns	1	1	3	**1.7**
Okaloosa	3	2	4	**3.0**
Sarasota	5	4	1	**3.3**
Nassau	6	3	2	**3.7**
Santa Rosa	2	6	8	**5.3**
Martin	8	8	5	**7.0**
Clay	12	5	6	**7.7**
Brevard	14	9	12	**11.7**
Wakulla	7	16	19	**14.0**
Leon	16	10	18	**14.7**

[43] http://floridakidscount.org/docs/2019Index/2019-cwbi.pdf

Table 22 reports the overall CSC county rankings from one being best to 67 being worst compared to Lee County. Consistent with normal data analysis, the best and worst outliers were removed but are shown at the bottom of the table. Four clusters were then determined based on the criterion of being five points or less from each other. Lee County ranks in cluster three along with Hillsborough and Pinellas. As the table shows, after removing outliers, four CSC counties have a higher ranking on overall child-wellbeing than Lee.

Table 22. Comparison of Overall CSC Counties and Lee County Ranks on Child Wellbeing

County	2019	2018	2017	Rank of 67 Counties 3-Year Average
Cluster One				
Palm Beach	10	13	27	**16.7**
Broward	18	19	23	**20.0**
Cluster Two				
Manatee*	27	28	20	**25.0**
St Lucie	37	40	10	**29.0**
Cluster Three				
Hillsborough	28	35	40	**34.3**
Pinellas	29	45	32	**35.3**
Lee**	42	36	37	**38.3**
Cluster Four				
Duval*	48	43	51	**47.3**
Miami-Dade	44	46	56	**48.7**
Outliers				
Martin	8	8	5	**7.0**
Okeechobee	59	59	65	**61.0**

*Dependent CSCs

** No CSC

Table 23 provides a more detailed view of the rankings on specific metrics.

Table 23. County Rankings on Specific Child Wellbeing Variables

	BROWARD	DUVAL	HILLSBOROUGH	LEE	MANATEE	MARTIN	MIAMI-DADE	OKEECHOBEE	PALM BEACH	PINELLAS	ST. LUCIE
Economic Variables											
Children in poverty	5	10	8	7	3	1	9	11	2	4	6
Unemployment rate	2	6	3	3	3	4	2	7	5	1	8
High housing cost-burden (>30% income spent)	10	5	6	4	3	2	11	1	9	7	8
Interventions											
Teens not in school and not working	4	10	5	8	9	1	6	11	3	7	2
3 & 4-year-old children not enrolled in school	2	6	7	10	9	4	1	11	3	5	8
4th grade students not proficient in English Language Arts	2	7	4	6	3	5	1	9	2	5	8
8th grade students not proficient in math	3	8	8	2	6	1	5	4	1	9	7
High school students not graduating on time	8	7	5	9	6	2	6	10	3	4	1
Low-birthweight babies	9	10	8	3	2	1	4	8	5	7	6
Uninsured children	6	2	4	8	5	10	3	9	7	2	1
Overweight and obese 1st, 3rd & 6th grade students	3	4	1	7	2	6	10	9	8	5	11

	BROWARD	DUVAL	HILLSBOROUGH	LEE	MANATEE	MARTIN	MIAMI-DADE	OKEECHOBEE	PALM BEACH	PINELLAS	ST. LUCIE
High school teens who used alcohol/drugs (past 30 days)	1	2	3	8	7	11	5	9	6	4	10
Children in single parent families	6	11	8	9	4	1	10	2	3	7	5
Children living in high poverty areas	3	8	7	6	8	1	9	10	5	2	4
Children with verified maltreatment (per 1,000)	7	8	5	3	9	6	1	11	2	10	4
Youth contacts with the juvenile justice system (per 1,000)	2	3	7	6	10	5	1	11	4	8	9
AVERAGES	**4.3**	**6.6**	**5.5**	**6.5**	**6.2**	**4.2**	**4.8**	**8.8**	**4.0**	**5.8**	**5.8**
	BROWARD	**DUVAL**	**HILLSBOROUGH**	**LEE**	**MANATEE**	**MARTIN**	**MIAMI-DADE**	**OKEECHOBEE**	**PALM BEACH**	**PINELLAS**	**ST. LUCIE**

Note: If the same value was reported, then the comparisons repeat ranking number (a tie).

Green = Highest ranking of the group

Blue = Lowest ranking of the group

Table 24 breaks out the specific Lee County rankings solely for ease of reference.

Table 24. Ranked Comparison Results for Lee County on Specific Kids Count Metrics

Metric	Lee County Rank: 1=highest, 11=lowest
Economic Variables	
Children in Poverty	7
Unemployment	3
Housing Cost Burden	4
Interventions	
Teens not in school and not working	8
3 & 4-year-old children not in school	10
4th grade students not proficient in English Arts	6
8th grade students not proficient in math	2
High school students not graduating on time	9
Low birthweight babies	3
Uninsured children	8
Overweight & Obese, 1st, 3rd and 6th grades	7
High school teens who used alcohol/drugs last 30 days	8
Children in single-parent families	9
Children living in high poverty areas	6
Children with verified maltreatment (per 1000)	3
Youth contacts with Juvenile Justice system (per 1,000)	6
Average Rank	**6.5**

Table 24 is divided into two sections. The first section reports comparative economic variables. Because these are outside of the mission of a CSC, they are not used for comparative purposes but are legitimate potential explanatory variables. The second section is titled interventions because each of these metrics could be addressed through a program or service. Investments in these programmatic areas would be expected to yield some impact.

Among the 11 counties being compared, Lee's average rank is 6.5. There are two low rankings that skew the ranking. Lee is 10th among the comparison counties on 3-and 4-year-old children not being school. The other variable that clearly impacts this is the fact that Lee County is ranked ninth in terms of high school students not graduating on time.

As the data in Tables 21 to 24 indicate, the CSC counties are not consistently superior to Lee County in outcomes and key indicators of child wellbeing. In fact on the overall Kids Count score, Lee is exceeded substantively only by five of the 10 counties with CSCs. On certain outcomes, some exceed Lee, while on those same outcomes Lee exceeds others.

Comparison of Averages

A problem with ranked comparison is that a small difference, for example a tenth of a point, results in one county being ranked higher or lower than another. Given the vagaries of data collection, the two counties are more likely equal. Therefore, a ranking can be misleading.

An alternative is to consider average scores. An average score can also mislead if there are substantive outliers. For example, calculating average salary is misleading if 99 of 100 people make $50,000 or less but one person makes $2 million. Because the Kids Count data does not have such significant outliers, an average score would result in an accurate comparison.

Table 25 reports three average scores on the Kids Count variables. The State, Lee County and the average score of the CSC counties as equal units. Scores were not calculated based on population, as the unit of measure here is the county itself.

To increase the reliability of the data, the averages are based on the number of years of reported data in the Kids Count reports, which range from three years to six years. These varying years (by metric) were averaged to smooth the data. The one anomaly from this approach is that the average unemployment rate covered the years 2010 to 2019. As such, it is much higher than today's rate. However, it is still a legitimate comparison across the three comparison units.

Using the same methodology as with prior tables, scores within a 10% range of the State or CSC average are considered equivalent to account for data collection error. Applying this standard to Table 25, Lee County is equal to either the CSC counties and State averages in all cases except for three which are coded "Green" for better than average or "Red" for worse than average.

As reported in Table 25, there is a higher percentage of 3-and 4-year-old children not in school in Lee County compared to averages. An interesting observation is that by the fourth grade County students are equivalent to the rest on the state on proficiency in English Arts and by the eighth grade in proficiency in math. This data can be interpreted to mean that the quality of elementary education is sufficient to help these students catch up to their peers or the impact of early schooling does not provide any lasting advantage.

Other significant data in Table 25 is percentage of children living in high poverty areas and the percentage being maltreated are lower (more than 10%) than the CSC or state averages. These data support a theory, discussed later in this chapter, that neighborhoods or where one lives significantly impacts a child's wellbeing and future development.

Table 25. Comparison of Average County Scores

(Child Well-being Indexes from 2017, 2018, and 2019)

Metric	CSC	Lee	State
Economic Variables			
Percentage of Children in Poverty	23.33	22.52	22.54
Percentage of Households (Owners or Renters) with Housing Cost Burden	39.97	37.08	39.58
Unemployment Rate	7.12	7.28	6.98
Interventions			
Percentage of Teens not in school and not working	8.96	8.67	8.47
Percentage of 3 & 4-year-old children not in school	50.25	57.53	49.30
Percentage of 4th grade students not proficient in English Arts	73.85	74.00	72.00
Percentage of 8th grade students not proficient in math	80.78	78.50	79.50
Percentage of High school students not graduating on time	20.19	22.82	19.70
Percentage of births that are Low birthweight babies	8.55	7.96	8.70
Percentage of Uninsured children	11.81	13.52	8.82
Percentage of Overweight & Obese, 1st, 3rd and 6th grades	35.44	32.97	28.97
Percentage of High school teens who used alcohol/drugs last 30 days	37.17	36.64	36.54
Percentage of Children in single-parent families	35.35	36.50	34.98
Percentage of Children living in high poverty areas	13.76	10.58	12.93
Number of Children with verified maltreatment (per 1000)	9.87	7.68	8.63
Number of Youth contacts with Juvenile Justice system (per 1,000)	25.78	25.78	25.52

CSC Funding

The hypothesis being tested is that child wellbeing in Lee County will be worse when compared to that of the CSC counties who have a dedicated funding source for children's services. Table 26 summarizes the funding of the independent and dependent CSCs. The table reports the total funding for the past five years, the number of children in each county under 18 and an annualized average per capita (child under 18) investment.

Table 26. CSC Funding and Per Capita (Youth)

County	Total CSC Funding Last Five Years*	Number of Children 18 and Younger[44]	Annualized Per capita ((Five Year Funding/5)/total number)
Broward	$415,003,533	412,226	$201
Duval (Jacksonville)	$143,399,420	214,790	$134
Hillsborough	$194,812,891	323,828	$120
Manatee	$54,587,889	72,457	$151
Martin	$36,182,349	26,502	$273
Miami-Dade	$615,231,848	558,719	$220
Okeechobee	$3,419,162	8,872	$77
Palm Beach	$565,392,516	283,443	$399
Pinellas	$330,882,227	157,685	$420
St. Lucie	$44,225,976	63,151	$140
TOTALS	**$2,403,137,811**	**2,121,673**	**$227**

[44] American Community Survey, B09001. 2018 1-Year Estimates

Conclusion regarding the Hypothesis

The hypothesis is rejected. Child wellbeing and certain behavioral outcomes in the CSC counties are not comprehensively or consistently better than those in Lee County. There are exceptions for both better and worse specific outcomes as reported above.

Understanding the Conclusion

Why does Lee County have comparable ratings? As Table 26 shows, these counties as a group during the past five years have invested roughly $2.4 billion in children services. This is around $480 million annually. These are significant investments from anyone's perspective. On a per capita basis, the annual investment averages $227 per child as shown in Table 26.

Potential Explanations

Discussed below are several alternative explanations for the fact that child wellbeing and behavioral outcomes in Lee County are comparable to the CSC counties despite the lack of an independent taxing district.

Lee has invested just as much, just through programs under the Board of County Commissioners.

> This explanation would contend that Lee County has made a similar level of investment, just through its own departments. It is true that the County provides several such services that benefit children and youth. However, just as the Lee Board of County Commissioners make investments in recreation, libraries and human services, so do the County Commissions where these CSC's are located. We cannot then conclude that Lee County is just funding children services via a different funding stream and that would explain why the outcomes in Lee are like those of other counties.

Children and Youth in Lee County do not face the same challenges as the youth in these more urbanized counties.

First, neither St. Lucie, Martin or Manatee counties are more urbanized than Lee County. Second, as various tables presented earlier show, children and youth in Lee County have both better and worse behavioral outcomes compared to state averages. While one would hope the explanation to be true, it is implausible.

Poverty is less of an issue in Lee County compared to these other counties.

Table 27 shows the poverty rates for the CSC counties and the percentage of renters who are cost-burdened. This latter data is important because cost-burdened households are under more stress and can be less stable. If poverty levels were lower in Lee County, one conclusion could be that it would be more effective in Lee County to focus on continued efforts to reduce poverty. These poverty reduction efforts might be more effective than service programs. However, as the table indicates, child poverty in Lee County is better than some of the CSC counties and worse than others. Poverty is not an explanatory variable.

Table 27. Poverty[45]

County	Overall Poverty Rate	Child Poverty Rate	% of Owner or Renter Cost-Burdened[46]
Lee	**11.8%**	**20.4%**	**33.0%**
Broward	13.1%	18.0%	43.5%
Duval	15.1%	23.0%	34.9%
Hillsborough	15.5%	21.4%	35.1%
Manatee	10.8%	17.0%	31.9%
Martin	10.9%	16.7%	31.8%
Miami-Dade	16.7%	22.0%	48.5%
Okeechobee	21.8%	31.1%	25.3%
Palm Beach	11.8%	16.8%	39.1%
Pinellas	12.2%	17.2%	35.3%
St. Lucie	12.8%	19.1%	36.2%

Programmatic interventions by themselves have minimal long-term impact.

In this analysis, as well as many other data sources, professionals in the field have emphasized the need for housing, employment, transportation and in-home services. Any intervention that does not have these types of supports (often called wrap-around care) has one key flaw. Without these services, the individual is highly likely to return to his or her home community. In doing so they return to their peer networks, their physical environment and their network of drug suppliers, alcohol sources and overall opportunities for some illegal action. In effect, they are placed back into the same environment that allowed, encouraged or did not stop problem behavior. Any place you are in 24/7 for the long term has much greater impact than any program of several hours a week or for several weeks of intervention.

[45] https://www.census.gov/programs-surveys/saipe.html 2017.
[46] U.S. Census Bureau, American Community Survey 2013-2017 5 year estimates, table B25106

These comparison counties have the same challenges as Lee County in terms of housing, transportation, distressed neighborhoods, and alcohol and drug abuse. While any stand-alone programs or services they supported could have short-term benefit, there would not be any impact at the level of population statistics.

Given these dynamics, this explanation has some explanatory power. It can account for at least some of the fact that Lee County is comparable in child outcomes to these case comparison counties.

Disperse Allocation of Funds

CSCs are using public funds. As such, they must respond to a variety of public needs. This is entirely understandable and every investment they make is responding to some legitimate need.

The difficulty is that the more diluted the funding, the lesser the likelihood of long-term impact. To address the factors underlying any complex and challenging outcome requires the following:

- There must be concentrated effort. Enough funding must be provided to meet the quality, scope and intensity of service needed to impact a population-level outcome;
- There must be sustained effort. For many of the most challenging situations facing children, a multi-year effort is required. Programs offering several months of service are unlikely to make any long-term impact;
- One or more evidence-based practices must be used. Proven quality matters; and
- Specific interventions must be nested in a system-of-care approach. As discussed in the explanation that stand-alone programming has minimal impact, a system-of-care is required to affect behavior change long term. Operationally, however, this means that there are the added costs of wrap-around services. When all these costs are totaled, it will be a substantive investment. Any entity is limited in the number of such investments it can make.

Neighborhood Matters

On Table 27 it is reported that Lee County has a substantively lower proportion of children living in high poverty areas than the average CSC county or the State. There is growing scientific evidence that neighborhood has a significant impact on outcomes for young children. Hendren found that every year a child spends in a better neighborhood improves their adult outcomes such as earnings, college attendance, attending more selective colleges and the likelihood of marriage increased while decreasing the incidence of teenage births.[47] Chetty, et.al., found that moving to a lower-poverty neighborhood before the age of 13 increased college attendance and earning and reduced single parenthood rates.[48]

This is not to minimize the importance of families in childhood development. Other studies have found that the correlations between neighborhood and academic achievement is small once family background is controlled[49]. These contrasting studies demonstrate that multiple factors affect outcomes. Neighborhood is just one of these. However, the fact that in Lee County there is a lower proportion of children living in high-poverty areas certainly appears to have some impact on outcomes.

The fact that fewer children in Lee County live in high-poverty neighborhoods offers a defensible, if partial, explanation for Lee County's comparatively good rankings on Child Well-Being measures. It also offers a defensible, again if partial, explanation for lower rates of child mal-treatment.

Conclusion

It is important to remember that this is a discussion about population level behavioral outcomes. Certainly, individual children have benefited from CSC programming. But just as in school classes, some children benefit more than others. A class in school can be life changing for one person and very forgettable for another. The same phenomena apply to human service interventions of any type. The same intervention can change

[47] Hendren, N. 2016. Effects of moving to opportunity: Both statistically and social significant. NYU Furman Center. www.nyufurman.edu
[48] Chetty, R., et.al. 2016. The effects of exposure to better neighborhoods on children. The American Economic Review. 106(4): 855-902.
[49] Duncan, G. et.al. 2001. Sibling, peer, neighbor and schoolmate correlations as indicators of the importance of context for adolescent development. Demography. 38(3): 437-447.

one person's life and have no impact on the next person. Just as CSCs have positive impacts on individuals, so do recreation programs, libraries or efforts to make a neighborhood safer and more user-friendly.

Because CSCs are public entities and must broadly disburse funds to a variety of legitimate public needs, it is very difficult for them to concentrate and sustain funding at a sufficient level to move a behavioral outcome very far in a desired direction. Many other factors influence these outcomes that are outside of the control of the CSC (family, neighborhood, peer groups, economic conditions, public safety, etc.) It may even be unfair or unrealistic to expect the CSC to play a role in these factors.

Neighborhoods appear to be particularly powerful if joined with other more targeted interventions. It is reasonable that they would be so. A child is exposed to their neighborhood seven days a week and for hours at a time. The time devoted to any human service intervention is much less and interventions are artificial no matter the quality. Neighborhoods are natural and a child can observe a range of behavior and make decisions from all that information. As good as evidence-based programs are, they pale in both time of exposure and amount of information exposure.

Long-term impact on outcomes results from multiple sources. For example, a longitudinal study of in-home services found long-term positive outcomes such as lower rates of substance abuse among the children, lower rates of running away and fewer arrests[50]. It can be argued it is the location of the service, as well as its quality, that makes a difference. In-home services reduce the artificiality aspect and address the family in their natural setting. Neighborhoods and in-home services are two factors. Quality of the school system is a third factor[51]. Family and individual attributes are also significant factors.

That said, and individual benefit acknowledged, there is still a public fiduciary question to be considered. How legitimate is it to use public funds to address an issue when the likelihood of having a long-term impact on behavior is minimal? If funds were

[50] Olds, D. et.al. 1998. Long-term effects of nurse home visitation on children's criminal and anti-social behavior. JAMA. 250(14): 1238-1244.
[51] Slavin. Robert E., Nancy L. Karweit. and Barbara A- Wasik. 1993. "Preventing Early School Failure: What Works?" Educational Leadership 50(4): 10-18.

unlimited, this question would not need to be asked. However, funds are limited and so the question is whether there is some other use of these funds that would yield greater public benefit? These are questions of public policy and worthy of broad discussion and analysis.

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CHAPTER 4
Comparison of Recent Community Surveys

Introduction

This chapter compares the results of five community surveys and the Consolidated Plan HUD:

- 2019 Human Services Gap Analysis Survey. This survey was developed for this project. The survey is provided in Appendix A.

- 2017 Community Health Needs Assessment Report by Professional Research Consultants, Inc. (PRC). This was a community health survey conducted for Lee Health. It is provided in Appendix B.

- 2019 Needs Assessment for Community Services Block Grant (CSBG) Work Plan. This survey was conducted as part of developing the CSBG work plan. It is provided in Appendix C.

- 2019-2023 Consolidated Plan HUD. This is a required submission to HUD. The Community Development Block Grant (CDBG), HOME Investment Partnership Program (HOME), and the Emergency Solutions Grant (ESG) programs are continued through this process. It is provided in Appendix D.

- 2019-2028 Continuum of Care Plan for Homeless Services. This survey was conducted as part of the development of the strategic plan for homeless services. It is provided in Appendix E.

- 2019-2023 Analysis of Impediments to Fair Housing Choice. This survey was conducted as an element of meeting HUD requirements. It is included in Appendix F.

Results

Mental Health Services

Table 28 shows a consistent rating that Mental Health Services are not meeting community needs across the various surveys (excluding the Impediments survey, which did not ask any Mental Health Services questions).

Table 28. Mental Health Services

Gap Information Source	Service Description / Feedback
2019 Human Services Gap Analysis Survey	Rated Most Inadequate Services: - Available Residential Mental Health Services - Available Mental Health Services for Crisis - Available Mental Health Services for Children and Adolescents - Available Out-patient Mental Health Services Group with Poorly Met Needs Ranking: - Mentally Ill Needs Most Inadequate - Pick 3: - Available Mental Health Services for Children and Adolescents
2017 PRC Community Health Needs Assessment Report - Lee County, FL	- "Fair/Poor" Mental Health - Diagnosed Depression - Symptoms of Chronic Depression - Suicide Deaths - Mental Health ranked as a top concern in the Online Key Informant Survey
2019 Needs Assessment for CSBG Work Plan	- Increase mental health and substance abuse treatment programs (Homelessness) - Increase mental health and substance abuse (Public Services - Adults) - Increase mental health and substance abuse treatment programs (Public Services Youth)
2019-2023 Consolidated Plan HUD	N/A

2019-2028 Continuum of Care	- Action Step 1.2b: Create and support initiatives to increase the availability of, and successful linkages to, necessary mainstream benefits, physical health care, behavioral health care, education, employment, childcare, and legal assistance programs to promote housing stability. - Action Step 1.2c: Implement a collaborative to compare data from across systems and identify solutions for persons who have high service needs and frequently access multiple service systems.
2019-2023 Analysis of Impediments to Fair Housing Choice	N/A

Housing

Table 29 shows that Housing is widely identified as a community gap.

Table 29. Housing

Gap Information Source	Service Description / Feedback
2019 Human Services Gap Analysis Survey	Rated Most Inadequate Services: - Affordable Workforce Housing - Emergency / Temporary Shelters - Supportive Housing for Persons Needing Additional Support - Temporary Housing Assistance - Rapid Re-housing - Transitional Housing Most Inadequate - Pick 3 - Affordable Workforce Housing
2017 PRC Community Health Needs Assessment Report - Lee County, FL	N/A
2019 Needs Assessment for CSBG Work Plan	- Increase number of affordable rental units - Repair rental housing units - Increase the number of affordable, owner occupied units (Housing) - Increase opportunities in areas with high lower-income and minority populations (Fair Housing) - Provide education about fair housing laws for landlord/mortgage lenders/ realtors, etc. (Fair Housing) - Provide education about fair housing laws for renters and homebuyers (Fair Housing) - Increase the number of affordable housing units in high opportunity areas. - Increase programs to assist with repairs on aging housing units, both renter and owner occupied.

Gap Information Source	Service Description / Feedback
2019-2023 Consolidated Plan HUD	- Affordable Housing - Housing Rehabilitation and Reconstruction - Down Payment Assistance - Housing for Persons who are Homeless
2019-2028 Continuum of Care	- Action Step 1.2a: Advocate for community-wide policies and practices that support the development of safe and affordable housing.
2019-2023 Analysis of Impediments to Fair Housing Choice	- Reduce incidence of discrimination in the sale or rental of housing. - Increase racial and ethnic minority's access to home financing. - Affirmatively further fair housing programs in the County. - Improve housing accessibility for persons with disabilities. - Improve LEP persons' access to fair housing information. - Ensure that the members of protected classes are represented on local planning/zoning boards.

Transportation

Table 30 shows that Transportation is commonly mentioned as a community gap.

Table 30. Transportation

Gap Information Source	Service Description / Feedback
2019 Human Services Gap Analysis Survey	Rated Most Inadequate Services: - Public Transportation Most Inadequate - Pick 3: - Affordable Workforce Housing
2017 PRC Community Health Needs Assessment Report - Lee County, FL	Barriers to Access: - Lack of Transportation
2019 Needs Assessment for CSBG Work Plan	- Increase bus routes to areas where jobs are located - Increase bus routes in areas with high low-income and minority populations - Increase transportation options for persons who are elderly and/or disabled (Transportation)
2019-2023 Consolidated Plan HUD	N/A
2019-2028 Continuum of Care	N/A
2019-2023 Analysis of Impediments to Fair Housing Choice	- Improve regional transportation.

Child-care

Table 31 shows that Child-care was rated as one of the most serious gaps in two surveys.

Table 31. Child-care

Gap Information Source	Service Description / Feedback
2019 Human Services Gap Analysis Survey	Rated Most Inadequate Services: - Affordable Child-care
2017 PRC Community Health Needs Assessment Report - Lee County, FL	N/A
2019 Needs Assessment for CSBG Work Plan	- Increase low cost child-care programs (Public Services Youth) - Increase mental health and substance abuse treatment programs (Public Services Youth) - Increase afterschool programs (Public Services Youth)
2019-2023 Consolidated Plan HUD	N/A
2019-2028 Continuum of Care	N/A
2019-2023 Analysis of Impediments to Fair Housing Choice	N/A

Homelessness

Table 32 shows that Homelessness was rated as a community need in three surveys. However, it should be noted that some of these comments are duplicative of Table 28 – Mental Health Services and Table 29 – Housing.

Table 32. Homelessness

Service Description / Feedback	Service Description / Feedback
2019 Human Services Gap Analysis Survey	N/A
2017 PRC Community Health Needs Assessment Report - Lee County, FL	N/A
2019 Needs Assessment for CSBG Work Plan	- Increase mental health and substance abuse treatment programs - Increase rental assistance programs - Increase emergency shelter beds (Homelessness)
2019-2023 Consolidated Plan HUD	- Housing for Persons who are Homeless
2019-2028 Continuum of Care	- Goal 2.4: Assist people to move from homelessness to permanent housing, within 30 days, through appropriate and person-centered services.
2019-2023 Analysis of Impediments to Fair Housing Choice	N/A

Special Populations

Table 33 addresses gaps in services provided to Special Populations. The major concern is housing, which mirrors Table 29 – Housing.

Table 33. Special Populations

Gap Information Source	Service Description / Feedback
2019 Human Services Gap Analysis Survey	N/A
2017 PRC Community Health Needs Assessment Report - Lee County, FL	N/A
2019 Needs Assessment for CSBG Work Plan	- Provide accessible housing - Provider services to support independent living - Increase the capacity of adult daycare or other assisted living facilities - Increase assisted living beds and permanent housing units for low-income seniors. - Increase the number of housing units accessible to persons with disabilities and those on a fixed income.
2019-2023 Consolidated Plan HUD	N/A
2019-2028 Continuum of Care	- Action Step 2.2d: Advocate for the development of low-barrier temporary and permanent housing facilities, with co-located services, for sub-populations with high service needs such as, youth and survivors of domestic violence, dating violence, sexual assault, and human trafficking.
2019-2023 Analysis of Impediments to Fair Housing Choice	N/A

Conclusion

The three common concerns across all current surveys are Mental Health, Housing and Transportation. Affordable Child-care was noted in two of the surveys.

Section Two: Infrastructure

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CHAPTER 5
Housing

Introduction

This analysis will examine the potential of housing gaps from several perspectives:

1) A comparison of housing issues in Lee County with other counties in the State. The question here is whether Lee County is an outlier in the field of housing.
2) A cost-burdened examination. This analysis seeks to determine if the cost of housing in Lee County creates a significant financial burden such that residents are, at times, challenged to meet all their expenses. There are two parts to this analysis. One looks at the cost of housing by itself. The second part examines other costs, such as transportation, that may add to the cost-burden so that although the rental or mortgage costs may be manageable, high transportation costs result in a cost-burden.
3) An analysis of the housing location with regard to the location of everyday life needs. If housing is far from various services, it represents a different kind of cost-burden in terms of time as well as transportation costs. This perspective is labeled "access."
4) An examination of the community's response to the housing gap, if it indeed exists. This perspective examines status of the infrastructure needed to develop attainable, affordable, workforce or supportive housing, the planning process to develop such housing, the need for public education and engagement, and the regulatory environment.
5) An analysis of housing issues for select demographic groups.
6) An analysis of the impact of housing costs on the economic development of the community.

Note on Definitions of Housing Cost Burden. A housing cost-burden is defined by having to pay more than 30% of one's income for housing (rent/mortgage plus utilities). Severe housing cost-burden is defined as 50% of one's income. There are several critiques of these definitions, most of which center on it being too generic, non-applicable to those with higher incomes, or ignoring costs that may be associated with housing (such as transportation costs if one must commute significant distances to work to afford housing). Granted these difficulties, the measure still provides a useful indicator of the housing challenge.

Lee County Compared to the State of Florida

Table 34 reports comparable housing data for Lee County against the State. Lee County is essentially on par with the State regarding housing challenges.

Table 34. Comparative Housing Data

Source	Data Title	Year	Lee County	State	Comparison	
Health Equity Profile[52]	Owner-occupied households with gross rent costing 30% or more of household income	2013-17	26.5%	27%		Within 10% average
Health Equity Profile	Renter-occupied households with gross rent costing 30% or more of household income	2013-17	52%	57%		Within 10% average
Health Equity Profile	Severe housing problems	2015	18.5%	20.8%		Better

Is there an Affordability Gap? – Cost Burdened Housing

Cost-burdened housing is primarily defined as having to pay more than 30% of one's income for housing. Another approach to defining cost-burdened is to add in energy and/or transportation costs to reflect that, while the housing itself may be affordable, the costs associated with its energy efficiency (or lack thereof) or its location (that requires high transportation costs) may lead to a cost-burden. Tables 35 and 36 report local data that show the extent of the housing challenge in Lee County. Table 35 shows the rent that residents in various income categories can afford without being housing cost-burdened. Table 36 shows the percentage of rental units available in various cost ranges.

[52] Florida Health Charts, Health Equity Profile, http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.HealthEquityProfile

Table 35. Lee County Renter Household Income[53]

Income Group	Monthly Rent at 30% Housing Cost	% of Households in this income range
Under $10,000	Under $250	7.8
$10,000-24,999	$251-625	21.1
$25,000-34,999	$626-875	15
$35,000-49,999	$876-1,250	20.4
$50,000-74,999	$1,251-1,875	19
$75,000-99,999	$1,876-2,500	8.9
$100,000-149,000	$2,501-3,750	6.4

Table 36. Lee County Distribution of Paid Rent Ranges[54]

Rent Range	Percentage of Rental Units in this Range
<$300	1%
$300-399	0.8%
$400-499	1.1%
$500-599	1.8%
$600-699	3.1%
$700-799	4.5%
$800-999	11%
$1,000-1,249	40.7%
$1,250-1,499	17.9%
$1,500+	18.2%

However, Table 36 groups the rent data in ranges that differ from the income ranges in Table 35. Therefore, this analysis made three presumptions to allow for a more seamless comparison of the data:

1. It was presumed that the small percentage of rental units costing between $250-$300 per month (less than 1% of all units) was not significant enough to require an interpolation of this rental range category.
2. It was presumed that the percentage of rental units costing in the $600-$699 and $800-$999 rental ranges is evenly distributed throughout the ranges; and

[53] Need for Multi-Family Rental Apartments, City of Cape Coral, Reinhold P. Wolff Economic Research, Inc. L. Keith White, President June 2019
[54] Need for Multi-Family Rental Apartments, City of Cape Coral, Reinhold P. Wolff Economic Research, Inc. L. Keith White, President June 2019

3. Data were interpolated in those two ranges to split the ranges into four: $600-$625, $626-$699, $800-$875, $876-$999.

These presumptions and interpolations allow for the percentage of rental units in the rental ranges ending in $625 and $875 to correspond more accurately to the income groups presented in Table 35. The presumption of equal distribution within the range assigned 25% of the percentage of units in the $600-$699 rental range to the $600-$625 range, with the remaining 75% being assigned to the $626-$699 range. Similarly, 37.5% of the percentage of rental units in the $800-$999 range were assigned to the $800-$875 range, with the remaining 62.5% being assigned to the $876-$999 range. Table 37 presents the data in the interpolated rent range and percentage of rental unit categories.

Table 37. Annotated Distribution of Paid Rent Ranges

Rent Range	Original Percentage of Rental Units in this Range (Table 36)	Annotated Percentage of Rental Units in this Range
<$300	1%	1%
$300-499	0.8%	0.8%
$400-499	1.1%	1.1%
$500-599	1.8%	1.8%
$600-625	3.1%	0.78%
$626-699		2.33%
$700-799	4.5%	4.5%
$800-875	11%	4.13%
$876-999		6.88
$1,000-1,249	40.7%	40.7%
$1,250-1,499	17.9%	17.9%
$1,500+	18.2%	18.2%

Table 38 summarizes the data from Table 36 and Table 37.

Table 38. Affordable Rent Income (@30%) vs Available Units at that Income

Income Group	Monthly Rent at 30% Housing Cost	% of Households in this income range	Percentage of Rental Units in this Range
Under $10,000	Under $250	7.8%	1%
$10,000-24,999	$251-625	21.1%	4.48%
$25,000-34,999*	$626-875	15%	10.96%
	TOTAL	43.9%	16.44%

An examination of Table 38 shows the housing challenge in Lee County: The 28.9% of residents who earn less than $25,000, to avoid being housing cost-burdened (spending more than 30% of income on rent), must find rent at $625 a month or less. However, only 5.48% of rental units are available at this amount or less. Because this rental cost may not include utilities, the actual percentage of residents that are housing cost-burdened could be higher. For those in the $25,000-$34,999 income category, the rent range would be $626 to $875 per month; and only 10.96% of rental units are available at those amounts.

Under these presumptions, as Table 38 shows, approximately 43.9% of households are competing for 16.44% of the housing in the Lee County market that is affordable to them. At these ratios, it is likely that 27.46% (43.9 minus 16.44) of households earning less than $35,000 are cost-burdened by rent. This data should be considered as conservative estimates as other data sources report higher percentages such as shown in Tables 39 and 40. These differences are due to the use of varying categories for income, various databases and differing years of data. The significant point is that a substantive portion of county residents are cost-burdened.

Table 39. Low Income Housing in Lee County[55]

Total Low Income Apartments	4,545
Total Housing Units with Rental Assistance	1,785
Percentage of Renters Cost-Burdened	52.25%

Section 8 vouchers are intended to assist low-income persons with housing costs. The Fort Myers Housing Authority issues 1,768 vouchers of various categories[56] and the Lee County Authority issues 260.[57]

The above presumptions can, and should, be challenged in several ways, which include:

- While most of the above tables address rental cost-burden, Table 34 includes owned homes. A proportion of these households are longer-term residents and own or inherited their homes from a period when housing costs were much lower. On a pure income basis, they would be cost-burdened. However, they may not be.

[55] www.affordablehousingonline.org/LeeCounty
[56] Fort Myers Housing Authority
[57] Lee County Housing Authority

- Some people moving into the county bring equity from home sales and can reduce their monthly housing costs with that equity. From a current income perspective, they would appear to be cost-burdened. However, they may not be.
- Various other forms of financial assistance may be provided, and they are not showing up in the income categories.

The final piece of data indicating the Lee County housing challenge is the fact that vacancy rates in tax-credit housing is less than 1.5%.[58]

Transportation Cost Burden

Housing in Lehigh Acres is comparatively affordable and has become a major housing focus for many service workers. While the housing is comparatively affordable, what occurs due to commute distances is that households are now cost-burdened with transportation costs. Transportation costs are considered affordable if they are 15% or less of household income. This would be $7,281 per year for the average Lehigh Acres household. The estimated driving costs for Lehigh Acres are $12,822 per year.[59] The average household in Lehigh Acres commits 50% of its income to housing and transportation (24% housing, 26% transportation).[60]

Table 40 presents more detailed rental housing cost-burden data for Lee County.[61] This data is from a real estate data firm that tracks larger scale apartments. Mom and Pop rental units are not included in this data.

[58] Lee County Economic Development Office
[59] www.esri.com/software/american-community-survey
[60] Center for Neighborhood Technology, H+T Fact Sheet
[61] Salviati, C. 2019. 2018 Cost Burden Report. www.apartamentlist.com

Table 40. Rental Cost-burden in Lee County
(Larger apartment complexes)[62]

Category 2018 Data	Data
Total Number of Rental households	71,442
Overall percentage that are cost-burdened	55.4%
Percentage moderately cost-burdened	27.0%
Percentage severely cost-burdened (50%)	28.4%
Total Number of Cost burdened	39,614
Total Number of moderately cost-burdened households	19,325
Total number of severely cost-burdened households	20,289

Access and Housing

Table 41 examines various "access" indicators. "Access" in this table is measured in terms of distance from various services. This data is only reported and is not used for comparative analysis. As a review of the color codes indicate the data are mixed. Otherwise, there is little to distinguish Lee County from the State's norms.

[62] Salviati, C. 2019. 2018 Cost Burden Report. www.apartamentlist.com

Table 41. Comparison of Various Access Indicators

Source	Data Title	Year	Lee County	State	Comparison
Healthiest Weight Profile[63]	Population that live within a 1/2 mile of healthy food source	2016	21.8%	30.9%	Worse
Healthiest Weight Profile	Population that live within a 1/2 mile of a fast food restaurant	2016	24.8%	33.9%	Worse
Healthiest Weight Profile	Population that live within a ten-minute walk (1/2 mile) of an off-street trail system	2016	39.5%	18.2%	Better
Health Equity Profile[64]	Population living within ½ mile of a park	2016	22.6%	43.2%	Worse
Healthiest Weight Profile	Workers who used taxicab, motorcycle, bicycle, or other means to work	2016 5-yr Est	3.1%	2.2%	Better
Community Health Needs Assessment[65]	Population with Low Food Access	2017	38.2%	25.7%	Worse

Community Infrastructure and Culture

This perspective addresses a variety of topics, all of which relate to the community capacity and readiness to address its housing challenges. In no priority order, these issues are:

- Silos of Effort. There are a variety of efforts to address the housing issues of Lee County. These include faith-based efforts, nonprofit housing developers, local governments, private individuals and public housing authorities. The issue is that these efforts all too often operate in silos, missing the opportunity to leverage each other's knowledge, skills and resources.

[63] Florida Health Charts, Healthiest Weight Profile, http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.HealthiestWeightCountyProfile
[64] Florida Health Charts, Health Equity Profile, http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.HealthEquityProfile
[65] 2017 Community Health Needs Assessment.

- Public Attitude. A negative public perception exists for terms such as "attainable, affordable, workforce and supportive" housing. This often leads to the phenomenon of NIMBYism (Not In My Backyard) and pressure upon elected officials to deny various housing projects. This perception is often based on erroneous understandings of various housing projects and emanates from a concern that property values will be negatively affected. Projects of this type require a more proactive community engagement approach that helps identify community needs and concerns and incorporates them into final designs.

- Landlord Attitudes. With respect to persons with various special needs, or who have problematic backgrounds, landlords can be reluctant to rent. Outreach programs and support programs that assist landlords to enter this sub-market are an important feature.

- Organizational Structures. There are organizations, such as Community Development Corporations (CDCs), that provide tools to organize various housing efforts.

- The Complexity of Financing and Developing Market Alternative Housing. There are several tools that can be used to make "market alternative" housing feasible. However, these require specialized knowledge and skill sets that are unfamiliar to most developers. Examples of some financing tools include low-income housing tax credits, bonding through a Housing Finance Agency, a multi-family mortgage revenue bond, the community contribution tax credit, and project-based rental assistance (Section 202 and 811).

- Land Assembly. To develop projects of an impactful size, assembly of contiguous parcels can be required. The time to assemble a property of feasible and impactful size, however, often exceeds a developer's capacity or timeframe.

- The Expiration of Current Affordable Housing Units. Affordable housing units have been built with timeframes in which the affordability requirements terminate and the units can be rented at market rates. The low-income rent requirements for 585 housing units in Lee County will have expired by the end of 2019. An additional 53 will expire by the end of 2020, and another 158 by the end of 2023[66]. Depending

[66] HUD REAC, HUD MF contracts.

upon location and maintenance, some of these may be sold to re-enter as market rate housing. For others, there is the option to raise rents to a more market comparable rate. At the moment, more subsidized housing is being lost than is currently being developed. A strategy to replace these units is missing.

- The Regulatory Framework. The regulations on development may bring another set of challenges to "alternative to market" housing. For example, parking requirements may be different when a housing unit is composed of residents whose ability to afford automobiles is limited. Setbacks and other requirements may need to be modified in the case of duplexes or garage apartments in which owners could rent out these additional units.

- Credit Repair and First Time Home Buyer Assistance. This service is self-explanatory, but it is a key feature in helping families purchase their own homes.

Housing and Selected Demographic Groups

- Seniors. Lee County is a retirement destination and therefore has a substantive proportion of seniors. An emerging housing issue is the higher needs associated with the growth of the age 85 or older portion of the population. As one spouse dies and family income decreases, and as homes are not designed for aging-in-place; the housing needs of seniors likely will grow in significance.

- Individuals with Developmental Disabilities (IDDs). As federal and state policy is to move these persons away from institutions and into the community, there is limited housing that is both affordable and responsive to some of their specific needs. What will make this issue more challenging in the future is that a high proportion of these persons currently reside with their parents. As these parents either die or become unable to continue to live in their current residences, the issue arises as to where persons with developmental disabilities will live. Some of the special housing issues facing persons with IDDs include:

    - In Florida, 33% of individuals living with a family have a caregiver age 60 or older, which is approximately 75% higher than the national rate. This means that Florida, the third-most populous state, has more than 75,000 individuals with IDDs that have caregivers age 60 or older.

- Connected Housing Post-Family-Care. When assessing these figures, it becomes apparent that many individuals may need to transition from ad-hoc family based housing and transportation systems to other available systems, when their aging caregiver dies or becomes incapacitated. Given the numbers of individuals involved – both nationally and in Florida – it is expected that demand for housing in areas readily connected to services, supports the services, and then effective transportation can increase by a significant degree.

- Stereotypes and Prejudices. Landlords are sometimes reluctant to rent to persons with an IDD due to various stereotypes and prejudices.

- Affordability and Residential Choice. The issue of housing costs and affordability is particularly important when placed side-by-side with data from the National Core Indicators (NCI) Florida results. NCI Florida results show that 50% of respondents did not choose where they live. Forty percent did not choose who they live with.[67] Affordability, by its nature impacts residential choice, which in turn limits residential options. Similarly, location and physical environment impact residential choices and options.

- Cost-Burden. For households in Florida with at least one person with a disability (including but not limited to IDD households), the following table (Table 42) illustrates the cost-burden for these households. For example, in extremely low-income households (<=30% AMI) with a disabled individual, 66% (171,083 households) have a housing cost-burden greater than 50% of their income.[68] (AMI is "Average Monthly Income" for all households).

[67] "What We Learned from the National Core Indicators (NCI) Adult Consumer Survey: Results from People Across Florida That Used NCI in 2011-12." Alexandria, VA: National Association of State Directors of Developmental Disabilities Services and Human Services Research Institute, 2012: pp. 14-15.
[68] State of Florida Consolidated Plan, FFY 2011-2015. Tallahassee: Department of Community Affairs, p. 15.

Table 42. Cost Burden for Households in Florida Including at Least One Person with a Disability (Age 5+)[69]

Cost Burden				
Household Income	**Less Than 30%**	**30.01% to 50%**	**Greater Than 50%**	**Total Households**
30% of AMI or Less	56,629	30,900	**171,083**	258,612
30.01% to 50% AMI	76,256	72,058	124,361	272,675
50.01% to 80% AMI	163,797	108,360	74,221	346,378
80.01% to 120% AMI	220,205	79,180	29,280	328,665
Grand Total	**516,887**	**290,498**	**398,945**	**1,206,330**

- Persons with Behavioral Health Issues. Persons with serious mental illness issues, serious substance abuse issues or both face more than just housing challenges. They also face the challenge of obtaining wrap-around services that assist them to remain in a housing situation. Housing challenges are one of affordability, access to services and public perception and attitude.

- Persons with Criminal Records. Persons re-entering society from jail, or prison, face difficulties securing jobs and affordable housing. In addition to the affordability issue, there is the resistance of landlords and the broader community to having such persons nearby.

- The Homeless. A proportion of homeless persons have serious behavioral health issues. However, for many, it is a true affordability issue. The challenge is intervening to prevent the onset of homelessness. In the absence of that intervention, the challenge becomes how to secure housing once homeless.

[69] State of Florida Consolidated Plan, FFY 2011-2015, p. 15. Original data sources for chart: Shimberg Center for Housing Studies, 2009 American Community Survey.

Housing and Economic Development

The discussion so far has focused on housing as a human need – and this is certainly the proper approach. However, there is another reason to be concerned about housing affordability. As housing costs in regions become more and more expensive, the ability to retain or attract those businesses for whom housing costs can be a significant employee issue becomes more difficult. There are numerous stories about businesses relocating from Silicon Valley, or other very high cost areas, to communities where homes are more affordable.

While the significance of this issue is only one factor in relocation decisions, it is one that local communities should address because it is one they can influence. Major employers have noted the difficulty of filling lower-level positions due to housing costs.

Conclusion

From an overall poverty perspective, Lee County does not have the proportion of severe poverty that other counties do. What it does have is a somewhat higher proportion of residents who are on the margins of financial difficulty and must make a variety of financial tradeoffs, particularly with respect to housing. It is this marginality which puts residents at various risks including housing or transportation. This is particularly significant in the case of housing, in which at least 28% of the population is housing cost-burdened, thereby lacking the resources to address other needs as they emerge. For instance, when housing and transportation costs are combined, another significant percentage of residents become cost-burdened.

Special Note

There are methodological critiques of how both household income and federal poverty levels areas measured. These critiques will be found in Appendix J.

Gaps and Opportunities

Several strategies can be deployed to address housing needs. Some will require a community-level response, while others will require involvement from Lee County Government. Potential measures include:

- Convening all interested and affected parties to develop multi-partner efforts;
- Appointment of a lead person, office or contractor to coordinate internal County Housing efforts among departments and to identify funding tools;
- Development of a strategic or master plan for specific areas;
- Development of a planning process that addresses the financing and development dimensions distinctively associated with non-market rate housing;
- Active monitoring and strategy development for subsidized units which are nearing the end of their time requirements for providing below-market rents;
- Development and deployment of public education and engagement strategies to proactively address community concerns;
- Development of knowledge in the real estate, developer and banking sector of financing options and tools;
- Establishment of a community land trust;
- Securing of grants and philanthropic contributions;
- Additional provision of emergency financial assistance to assist people to stay in their homes; and,
- Credit repair programs.

CHAPTER 6
Transportation

Introduction

Whatever the data source (survey, interview, focus group), public transportation is consistently identified as a need. The same is true when the analysis is across-services or across-populations – one of the consistent barriers is inadequate public transportation.

In recognition of this need, the Board of County Commissioners has an annual transit operational budget of $25 million. Approximately $7 million of that budget is obtained through state and federal grants. Nearly $5 million is generated directly from Lee County Transit (LeeTran) via fare box and advertising. The remaining $13 million a year is allocated from general fund tax dollars.

Yet a gap remains. The question is why? Essentially, it boils down to a combination of demographics, design and convenience.

Population and Transit Market. The transit market in this case refers to the size of the population that could be users of the system. Sheer numbers affect the feasibility of public transportation**.** What also affects transit is age, race, gender, disability and related factors that shape the need and/or desire to use transit. As the population of the county grows both older and more disabled (which are indicated trends), a growing need for transit services will exist. While it is subsidized and not fully dependent upon fares, the fare box still matters. It matters not simply because of the income it generates but the eligibility it creates for other funds. While population matters, what matters even more is the density of the population, which leads to the next factor – design.

Land Use and Transportation Policy. For public transportation to be viable (frequent, reliable and accessible), the design of the community is critical. Public transportation systems function well (or at least adequately) in dense, urban environments with a high number of residents clustered together per square mile. Land use and zoning regulations determine density limits. The market ultimately determines density levels within allowable parameters. Effective public transportation is difficult in suburban

communities with low density and dispersed clustering of residences. Lee County is a suburban community.

Another design feature is the physical infrastructure. Transportation infrastructure is driven by transportation policy. Roadways designed to allow, if not encourage, suburban development result in low-density housing. In addition, they may not be designed to facilitate bus use by not providing pull-offs or ease-of-use features. Auto-centric communities are designed for individual automotive use, not mass transit of any type. Another dimension to roadway design is that for buses to attract riders, timeliness matters. Dedicated lanes that allow buses to move rapidly, especially during rush hours, can help gain ridership. However, unless these are designed in roadways from the start, they may be impractical from either a space perspective or a financial perspective. Parking requirements are another example of how policy can impact the use of transit. Where parking is expensive or limited, there is a push to use transit.

Convenience. One of the criticisms of public transit is that it is not convenient. It takes too long to get where you are going, or the hours of service are not convenient. This is where a vicious cycle begins. There are not enough riders to add more lines or frequency, so people do not ride. Fewer people ride, so it is hard to justify existing routes, much less new ones.

Context and Background: LeeTran and other Public Transport Providers

LeeTran is a department of Lee County government, responsible for operating the public transit system that serves the County. It operates 26 bus routes, a paratransit service for the disabled (called Passport – in compliance with the Americans with Disabilities Act) and an employer van pool program.

LeeTran employs approximately 287 people and has a fleet of 51 full-size buses, 12 trolleys, five trams and 51 paratransit vans. Half of its full-size fleet is hybrid, greatly reducing carbon emissions and increasing fuel efficiency.

Medicaid Clients. Medicaid clients may receive their Medicaid transportation through Good Wheels or a local Florida Managed Medical Assistance Provider (MMA), depending on Medicaid program criteria. Good Wheels is a Medicaid Provider as well as the designated Community Transportation Coordinator (CTC) for Lee County (under

Florida Statute F.S. 427). In addition to Medicaid clients, other individuals who are unable to provide for their own transportation due to age, disability, or income may be eligible for Transportation Disadvantaged service.

Conclusion

LeeTran provides critical services both to the workforce and to many people who rely on it to get to various services. LeeTran itself is exploring ways to expand ridership and meet community needs. Examples include van pools for employers, updating the core transit network, and smaller vehicles that can serve as a mobility-on-demand option in low-density areas. Some will prove to be effective; others will not. This is all to be encouraged and supported. However, any expectation that Lee County will have a public transportation system comparable to those of major urban areas is unrealistic for the near-term.

The end goal is not necessarily to have a system comparable to major urban areas (they have issues too), but to have an effective and usable system adapted for the needs and goals of Lee County. The alternatives discussed below can be worked in conjunction with transit to reach this objective in a realistic timeframe.

The question then becomes, what options are there in addition to the continued development of transit services? Those are discussed in the next section. The purpose of an alternatives discussion is to encourage service providers, who identify transportation as a significant barrier for their clients, to consider options that have the potential of lowering the demand placed upon clients to transport themselves and to provide services in different ways.

Complementary Strategies for Further Enhancement Public Transportation

Options exist for service providers and employers with low-wage employees who rely on public transportation. None of these represents a full or total solution to eliminate the transportation challenge. However, each could have some impact by making it easier for their clients to obtain services.

Telepresence. Because of advances in technology, the provision of services through some form of telepresence is becoming more feasible. While there are certainly cases

or treatments that require the physical presence of the person, services exist that can be delivered remotely, alleviating the need for transportation. There is currently an emphasis on the expanded delivery of clinical services through telemedicine or the broader management of health issues through telehealth[70]. Therapy and counseling services are now delivered through online chat, video or phone by private providers[71]. These services are being used in the areas such as domestic and family violence[72], substance abuse[73], elder abuse[74] and vision impairment[75]. Psychiatric medication adjustments are being provided remotely[76]. The ability for physical engagement is another option as telehealth now encompasses physical therapy treatments[77], child abuse[78], evaluations of domestic violence[79] and sexual assault[80].

Given the gap in mental health services in the County, the potential for service delivery via telepresence technologies should be considered. This is particularly true for special populations for whom the delivery of mental health services is challenging. One example is the deaf population; scholars in deaf studies have long called for mental health services to be delivered remotely.[81]

With the spread of 5G capacity and an increasing knowledge base about the effective use of telepresence tools, clients' transportation needs could diminish.

Location of Services along Major Bus Routes. Service agencies locate for financial or space availability reasons. While these cannot be ignored, another decision factor should be locations along existing public transportation corridors. While it is obviously not feasible to move entire agencies, it is more feasible to examine whether specific services could be provided at these locations while the administrative functions are

[70] www.healhtit.gov/topic/health-it-initiatives/telemedicine-and-tele-health. 2017
[71] www.mdive.com/counseling
[72] https://www.thehotline.orgr
[73] https://mhealthintelligence.com
[74] https://eldermistreatment.usc.edu
[75] www.ncbi.nim.nih.gov
[76] https://chironhealth.com
[77] https://www.apta.org/practice&patientcare
[78] https://pediatrics.asppublications.org/pediatrics/223.full.pdf
[79] https://www.ncbi.nim.nih.gov/pubmed
[80] https://safetcenter.psu.edu/new-technology-for-sexual-assault
[81] Wilson, J. & Wells, M. 2009. Telehealth and the deaf: A comparison study. The Journal of Deaf Studies and Education, 14(3): 386.402. https://doi.org/10.1093/deafed/enp008

housed elsewhere. To the degree that locations of these services could be coordinated to minimize locational changes for the client, this also would serve to mitigate the transportation barrier.

Encouragement of Workforce Housing near Employment. The above two concepts apply to the provision of human or health services. The other primary users of public transport are low-wage employees who rely upon it for transport to work. There are examples of employers who design housing into their development concept[82]. Land use regulations and zoning codes that allow or encourage such developments will reduce the need for public transportation.

Development of New Business Centers. The area along Interstate 75 and Southwest Florida International Airport will be the location of future commercial development. There is the potential for 50,000 jobs in this area during the long-term. As this develops, it will change the commuting patterns in the County. It will also offer the opportunity to provide workforce transportation, broadening the customer base of LeeTran. Planning a multi-modal transportation network for the coming economic core of the County will be an important element of future transportation planning.

Location of services, workforce housing location and new business centers are policy decisions in which transportation impacts and options should be a significant factor. These policy decisions impact population density and community design.

Gaps

The Needs / Capacity Gap. Due to factors of population design, community design and consumer convenience, a gap exists between the current level of service and the level of service that is desired by sectors of the community. This is the needs/capacity gap that transportation professionals continually seek to narrow.

The Transportation Policy Gap. The other gap is one of policy. Planning and regulations that shape the future design of the community do not adequately incorporate public transportation planning into those plans and policies. Over time, this policy gap can impact the Needs / Capacity Gap.

[82] https://www.winknew.com/2018/12/14/develperplanningaffordalblehousing

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CHAPTER 7
Food Security and Nutrition

Introduction

Common perceptions about food insecurity – episodic worries about the amount of food in the refrigerator or uncertainty about what the next meal will be – sometimes lead to incorrect conclusions about hunger and predictions that high percentages of people are going to bed hungry. While some certainly do, it is important to interpret the data correctly. This chapter addresses the link between food security and nutrition, and it concludes with an explanation of how food security is measured in the United States. The USDA itself states that "households can be classified as having very low food security based on a single, severe episode during the year. Readers should be mindful of this when interpreting food-insecurity statistics**.**"[83]

Various programs will be reviewed that are intended to reduce food insecurity. These programs aid families in relieving their food insecurity. They were never meant to be the full source of food for a family. Therefore, if the programs are readily available and all eligible people are participating, the question is whether there is a gap large enough to direct more local resources to this problem.

This chapter analyzes data about food insecurity surveys, examines statistics about nutrition-related outcomes and identifies sources and distribution systems for food and expenditures for assistance. There are data issues that make this analysis challenging; they also are discussed in the chapter.

The chapter concludes that food and nutrition services in Lee County were not identified as having as significant a gap as other service areas. However, food is a daily need and the conclusion does not mean there is no need to address food insecurity continually. It is to acknowledge, that the scope of the community's efforts make this area a less serious one from the perspective of comparative gaps.

[83] Household Food Security in the United States in 2018. U.S. Department of Agriculture

Context and Background

Both government and private programs address food security in the United States. The dominant federal programs are the Supplemental Nutrition Assistance Program (SNAP - commonly thought of as "food stamps"), Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and the National School Lunch Program (NSLP), along with other minor federal programs. The private sector addresses food security and nutrition primarily through a variety of nonprofit food banks and pantries run by nonprofits and religious institutions.

In 2018, 88.9% of U.S. households always had access to enough food for an active, healthy life for all household members. A study by the U.S. Department of Agriculture categorized the remaining 11.1% of households, down from 11.8% in 2017, as food-insecure for at least some period during the year. Of those, 4.3% had very low food security, not significantly different from 4.5% in 2017. These were households in which the food intake of one or more members was reduced and their eating patterns disrupted at times because the household lacked money and other resources for obtaining food. In 2018, prevalence of food insecurity declined to pre-recession (2007) levels. Among children as a separate statistical group, changes from 2017 in food insecurity and very low food security were not statistically significant. Very low food security among children was 0.6%. About 7.1% of U.S. households with both children and adults were categorize as food insecure in 2018. In 2018, the typical food-secure household spent 21% more on food than the typical food-insecure household of the same size and household composition. About 56% of food-insecure households participated in one or more of the three largest federal food and nutrition assistance programs – SNAP, WIC or a school lunch program – during the month prior to the 2018 survey.[84]

Lee County Data

During 2018 in the County, $10,165,356 in SNAP assistance (food stamps) was provided to 43,590 households including 87,892 people. The average benefit per person was approximately $116, and the average household benefit was $233 as of August 2019.[85]

[84] Household Food Security in the United States, 2018. U.S. Department of Agriculture, Economic Research Service.
[85] https://www.fns.usda.gov/pd/snap-program

In Florida during 2017, 468,867 women and children participated in the WIC program.[86]

WIC funding in Lee County in 2018 provided food and associated services at a monthly cost of $732,958, or an annualized estimate of $8,795,495.[87] The average WIC food cost per person per month was approximately $49[88]. That year, 15,066 people received WIC assistance and 22,874 were eligible; the Lee County participation rate was 65.9%. The state of Florida participation rate was 67.8%.[89] Various explanations have been offered as to why one-third of eligible participants does not take advantage of the WIC program. These explanations include a lack of knowledge about eligibility, mis-understanding of the program, avoiding the perceived shame of welfare, transportation barriers and income variations that could preclude eligibility at some points.

During 2018, 21.8% of Lee County adults "often" or "sometimes" worried about whether their food would run out before they had money to buy more, based on USDA survey data. This same study reports that an additional 18.1% "often" or "sometimes" in the past year experienced a lack of food with no money to buy more.[90]

Table 43 presents 15 nutrition-related outcomes for Lee County. On 10 indicators that address consumption of healthy food and weight issues, Lee County was within 10% of the Florida averages. (Please refer to appendix K for an explanation of this methodology). In four categories, Lee County had outcomes that differed from the state averages by more than 10%. These outliers include:

- The percentage of underweight adults – at 3.3% in Lee County, that's one person-per-hundred more than the state average. While the percentage difference is large, the numerical difference is not;
- Obese persons – at 31.2% in Lee, that's four people-per-hundred more than the state average;
- Births to obese mothers at the time of pregnancy – at 29.24%, that's three more pregnant women per-100 than the state average; and
- Overweight high school students – at 5.2%, Lee County has one more overweight high schooler per-hundred than the state average.

[86] National WIC Association. 2019-fl-wic-fact-sheet.pdf. www.nwlca.org
[87] https://www.fns.usda.gov/pd/wic-program
[88] ibid
[89] www.flhealthcarts.com/charts/otherindicators/nonvital
[90] Lee County Health Needs Assessment, Lee Health

While higher rates of being over- or under-weight can be related to food intake, they also are influenced by other variables and may not relate directly to food insecurity.

Table 43. Comparison of Nutritional Related Outcomes

Sources	Data Title	Year	Lee County	State	Comparison to State
Healthiest Weight Profile[91]	Adults who consume at least 5 servings of fruits and vegetables a day	2013	17.9%	18.3%	Within 10% average
Healthiest Weight Profile	Adults who are sedentary	2016	27.8%	29.8%	Within 10% average
Healthiest Weight Profile	Adults who are at a healthy weight	2016	31.5%	34.5%	Within 10% average
Healthiest Weight Profile	Adults who are underweight	2016	3.3%	2.3%	Worse
Healthiest Weight Profile	Adults who are overweight	2016	37.7%	35.8%	Within 10% average
Healthiest Weight Profile	Adults who are obese	2016	27.5%	27.4%	Within 10% average
Community Health Needs Assessment[92]	%Obese (BMI 30+)	2017	31.2%	26.8%	Worse
Maternal and Child Health[93]	Obesity (Births to Obese Mothers at time Pregnancy Occurred)	2018	29.24%	26.20%	Worse

[91]Florida Health Charts, http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.HealthiestWeightCountyProfile
[92] 2017 Community Health Needs Assessment Report; Lee Health and FL Dept of Health in Lee County
[93] http://www.flhealthcharts.com/charts/DataViewer/BirthViewer/BirthViewer.aspx?cid=0606

Sources	Data Title	Year	Lee County	State	Comparison to State
WIC Children[94]	Obesity (WIC children >=2 who are overweight or obese)	2018	28.95%	27.10%	Within 10% average
Healthiest Weight Profile	Middle and high school students who are at a healthy weight	2016	66.7%	66.4%	Within 10% average
Healthiest Weight Profile	Middle and high school students who are overweight	2016	15.3%	16.3%	Within 10% average
Healthiest Weight Profile	Middle and high school students who are obese	2016	13.2%	13.0%	Within 10% average
Healthiest Weight Profile	Middle and high school students who are underweight	2016	4.8%	4.2%	Within 10% average
Child Health Status[95]	High School students who are underweight	2016	4.7%	3.6%	Worse
		2018	5.2%	4.2%	Worse
Child Health Status[96]	Middle School students who are underweight	2016	5%	5.2%	Within 10% average
		2018	3.6%	4.7%	Better

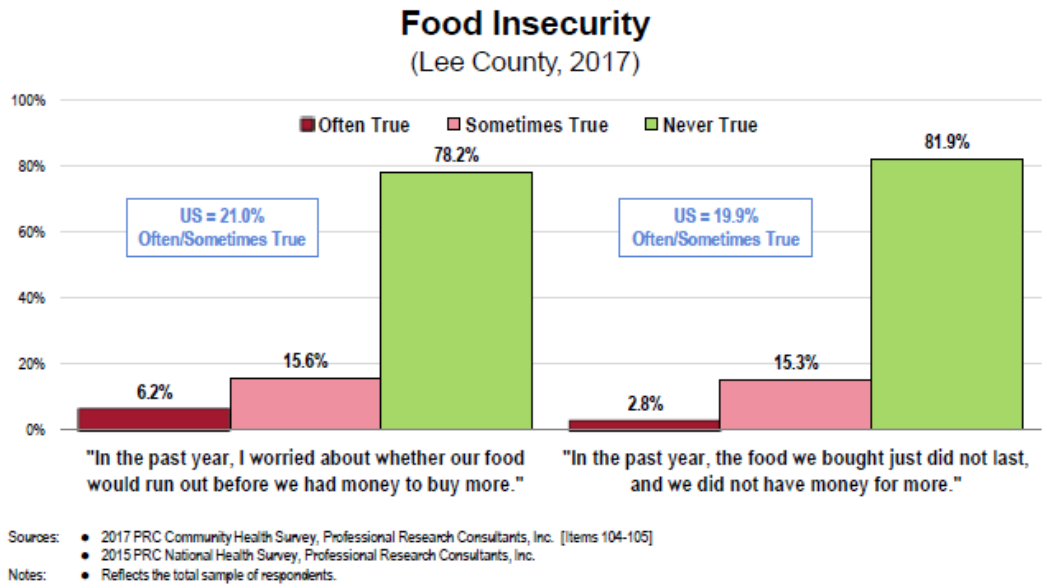
[94]http://www.flhealthcharts.com/charts/OtherIndicators/NonVitalIndRateOnlyDataViewer.aspx?cid=0679
[95] Florida Health Charts, Child Health Status http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.ChildHealthStatusProfile
[96] Florida Health Charts, Child Health Status http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.ChildHealthStatusProfile

Table 44 and Figure 4 show the levels of food insecurity in the County. As Figure 4 shows, data for Lee County are similar to national data on the question of worry regarding food availability but has a lower percentage of residents whose food did not last until more food could be purchased. Extrapolations from Table 44 suggests 12% to 15% of the total population and 4% of children provided responses that indicate they are food insecure. At the national level, about 20-21% of households provide responses that indicate food insecurity.

Table 44. Food Insecurity in Lee County[97]

Population	700,165
Overall Food-Insecure Population	86,050
Food-Insecure Children	26,400

Figure 4. Food Insecurity



Florida ranks 48th out of 50 states for highest percentage of households receiving food stamps at 2.3%. Only Alabama and Delaware, at 2.9%, had a higher percentage of their population receiving food stamps. The study is based on 7,510,882 Florida households that reported whether food stamps were received. 1,587,429 households in Florida

[97] Harry Chapin Food Bank

received food stamps in 2018, of which 43,590 were in Lee County.[98] There are stated concerns that the receipt of food stamps is no guarantee of food security since the per meal amount is limited. Again, these programs were never designed to be other than supplementary.

The System of Food Security in Lee County

Governmental Assistance: SNAP, WIC, School Lunch

The Florida Department of Children and Families and the Department of Elder Affairs administer the SNAP "food stamp" program here. The Florida Department of Health administers WIC, the program for woman, infants and children. The National School Lunch Program is administered by the USDA via local school systems. Some households may participate in multiple programs.

The Florida Department of Elder Affairs

Elder Affairs provides technical assistance to help Older Americans Act nutrition providers and USDA program providers to deliver quality services. In addition to the state's Congregate and Home Delivered Meals program, the unit administers the following federally funded programs:

- Adult Care Food Program
  This program assists eligible Adult Care Centers and Mental Health Day Centers in providing meals to elders. Eligibility extends beyond seniors (60 or older) to people age 18 or older with a functional disability.

- Senior Farmers' Market Nutrition Program
  This program improves the nutritional health of low-income elders by providing coupons that can be redeemed for locally grown fresh fruits and vegetables at approved farmers' markets.

[98] www.fns.usda.gov/pd/supplemental-nutrition-assistance-program-snap

- Nutrition Services Incentive Program (NSIP)
  The NSIP reimburses Area Agencies on Aging and service providers for the costs of congregate and home-delivered meals through a supplement of approximately $0.72 per meal as of 2015. Younger adults with disabilities also can be included.

- Supplemental Nutrition Assistance Program (SNAP)
  Formerly known as the food stamp program, this is for seniors (60 or older) and is administered through Elder Affairs.

Charitable Assistance

The Harry Chapin Food Bank collects and distributes food through more than 120 partner providers. Food pantries are open daily in Lee County. Every week about 28,000 people are fed through partner agencies and mobile pantries. The system works through several corporate contributors and extensive volunteer participation.

Harry Chapin provides in-school pantry programs and food kits at places where pantries are not present. The kits provide an average of 15 meals for a family. It also offers mobile pantries to make access easier.

In addition to Harry Chapin, other organizations in the community offer food pantries that distribute food from Harry Chapin as well as donations from their own members.

In addition to food pantries, several entities provide meals to needy people including the homeless. A board network of organizations offering food options exist.

Nutritional Education

In addition to the provision of food, there are efforts to educate the community about nutrition, wellness and financial management to assist in ensuring food security. The leader in this effort is the Institute for Food and Agricultural Sciences (IFAS) local extension office.

Gaps in Food Security

Food Quality

A key term in the USDA food security framework is "balanced meals." This includes protein, carbohydrates, vegetables and fruit. At times with respect to food banks, fruit and vegetables are limited, with the preponderance of donated food being highly processed food that can be easily stored. At other times, fresh produce is provided when seasonably available. Harry Chapin at times has 24% of its food in fresh produce form. However, food kits routinely include non-fresh items, such as canned vegetables and canned meat, cereal, spaghetti, macaroni and cheese, soups and stews, peanut butter, jelly, pasta, rice and beans. Fresh food is rarely supplied.

Fresh food can be purchased with food stamps. Emphasizing this is encouraged by educational programs. It is emphasized in the Florida Fresh efforts of the Florida Department of Agriculture, which promotes the use of fresh Florida food.

The data do not exist to determine what proportion of food assistance in the County could be considered as providing balanced meals. It is not unreasonable to assume that the proportion is less than preferred, primarily due to challenges in storing fresh food for later distribution.

Recommended diets and food models are provided through USDA and IFAS.

Food Quantity

As Table 44 indicates, more than 86,000 people are food insecure. More than 26,000 of them are children. It is estimated that 15% of these are seniors.[99] The purpose of a gap analysis is to understand what these numbers mean on a practical basis. If they mean, for example, that 26,000 children in Lee County go to bed hungry daily, then there is a community crisis. However, this figure does not indicate that at all.

The challenge in understanding the actual human implications of these numbers lies in the USDA's methodology as presented below in the definitions section. Take the

[99] www.harrychapin.org

questions about children, for example. Several of the questions ask if a food-shortage condition ever existed in the last 12 months. For some questions, the response choices are yes/no. For others, it is often/sometimes/never. There are two problems in trying to interpret these data. For the yes/no questions, there is a vast difference between someone who experiences a shortage condition once or twice a year compared with someone who experiences that condition monthly or weekly. For the often/sometimes/never, what may be "often" to one person could be "sometimes" for another.

This critique is not to deny the existence of food shortages, nor is it to imply that our societal goal of food shortages not occurring is invalid. However, it is to point out that determining the actual scope of the shortage is difficult based on this data. If one were trying to determine the actual size of the gap and the appropriate level of response, data that are more granular would be useful.

Estimating Scope of Food Insecurity in Lee County – A Hypothesis

To estimate actual scope, the following hypothesis will be tested:

> People receiving SNAP or WIC are not food-insecure, therefore no food insecurity exists in Lee County.

Some key facts for use in testing this hypothesis include:

- USDA reports that in 2018, 88.9% of U.S. households had access at all times to enough food for an active, healthy life for all household members. This is a valid percentage because these people never responded affirmatively to any of the USDA survey questions.

- Lee County's population will be estimated at 739,506 for purpose of this experiment.

- This means that 654,753 people in Lee County were food secure and 84,753 are estimated to be food insecure at some level. This is consistent with the 86,000-person estimate reported in Table 44.

- 87,892 people received food stamps, and another 15,066 received WIC benefits. There may be overlaps in this number but that cannot be determined from the available data sources. For this analysis, the numbers will be calculated as non-duplicative. This means 102,958 people received food assistance. In addition, there were school meals.

- When SNAP and WIC funds are combined, a total of nearly $19 million was provided to purchase food.

- Breakfast and lunch are free of charge at all 79 traditional Lee County public schools for the 2019-2020 school year. This will be the second school year both meals are being provided to all students through the Food and Nutrition Services Department Community Eligibility Program (CEP).[100]

- The School District of Lee County Food Service Budget is $72 million. The food service program of the School District of Lee County is supported by federal and state funds and through meal charges to adults and students. Federal and State funding programs include National School Lunch Program, School Breakfast Program and the Summer Lunch Program. [101]

Rejection of the Hypothesis

- The hypothesis is that people receiving SNAP or WIC are not food-insecure, therefore there is no food insecurity in Lee County. This most likely is a fallacious hypothesis given the regular use of food banks.

- Explanations for why the hypothesis was rejected.
    - How can the fact that the total of 654,753 self-reported food secure plus the 112,958 SNAP/WIC people equal 767,711 people, exceeding the County population? Here are some possible explanations:

    - SNAP/WIC do not equate to food security.

[100] School District of Lee County, https://www.leeschools.net/news/2019-2020/august_2019/breakfast_and_lunch_to_be_free_at_all_schools
[101] LCSD Final Budget 2019-2020 https://www.leeschools.net/common/pages/DisplayFile.aspx?itemId=24269200

- The average per-person per-month benefit was $48.95 in 2018. The average SNAP benefit in 2018 was $115.55. The average household benefit for SNAP was $233.20.
- WIC only reports per-person data. If a three-person household is presumed, the benefit would be $146.85.
- The USDA thrifty food plan, which is designed for people on benefits, recommends differing budgets for different ages with monthly ranges for individual adults from $159 per month to $186. For two-person families, the range is $367 to $386; for four-person families it is $564 to $647.[102]
- Clearly SNAP/WIC programs aid, but do not equate to food security on their own. It should be noted, however, these programs were never intended to be more than assistance.

- The proportion of income that lower-income families spend on food is higher than higher-income families.
  - Table 45 presents a national data estimation. The purpose of this table is not to present verified data specific to Lee County. Rather it is simply to demonstrate that it is logical that poorer people would spend a higher proportion of their income on food because one can only consume so much food. Higher income people may consume more expensive food or dine out more often and at more expensive restaurants, but there is still a limitation;
  - The lowest income quintile likely is also the cost-burdened for housing. Combining the 35% of income spent on food with 30% to 40% for housing, cost-burdened families are devoting 65% to 75% of their income to food and housing alone. Even at the next quintile level, budgeting 19% for food and 30% for housing leaves half of income for all other expenses.

[102] www.usda.gov

Table 45. Percentage of Income Spent on Food by Quintiles[103]

Income Quintile	Average Annual Income	Groceries	Dining Out	Total Food	Percent of income spent on food
Lowest 20%	$11,394	$2,582	$1,488	$4,070	35.72%
Next 20%	$29,821	$3,622	$2.049	$5,671	19.02%
Third 20%	$52,431	$4,038	$3,023	$7,061	13.47%
Fourth 20%	$86,363	$4893	$3,863	$8,756	10.14%
Top 20%	$188,103	$6,677	$6,402	$13,079	6.95%

Gaps

Based on this analysis, it is reasonable to conclude that approximately at least 20% of Lee County households are challenged each month to meet their basic needs for shelter, utilities, food and transportation. Table 46 presents the basis for this conclusion. Each family prioritizes the needs that will be met each month and one can presume that a need other than food is sometimes prioritized. While all families prioritize, not all families have to choose between having the money to buy food or having enough money to pay the rent. For 20% of Lee County households, this choice could occur occasionally.

Given the vagueness of how food insecurity is measured combined with the significant amount of public funds committed to providing food, it is difficult to accurately state the size or significance of a gap in food security in the County. The fact that 20% of households are cost-burdened to meet all their costs for housing, transportation and food would lend credence to the position that there is a food security gap. The number of individuals fed via the Harry Chapin food bank also lends credence to the possibility that some people need food assistance. In Southwest Florida (including Charlotte, Collier, Glades, Hendry and Lee counties), Harry Chapin feeds about 28,000 persons per week and estimate about 151,000 people struggle to provide food for themselves.

[103] www.thestreet.com

Presuming population proportions among counties, Lee County residents would be a substantive proportion of these people. Harry Chapin reports that most of its clients are working families.[104]

While acknowledging the good work of Harry Chapin and its many community partners, one can argue that the combination of private actors and public food funds either eliminate or reduce to a low level actual food insecurity in the county. Since food is needed daily, the need for private contributions and continued public funding does not go away. But what it does mean is that Lee County has successfully established a system of food supply so that food insecurity in the County is not a major gap.

Table 46. Estimation of Severe Financial Constraint*

Income Group	Monthly Rent at 30% housing cost	% of Households in this income range	% of Rental Units in this Range	Low Estimated % of Households Severe cost-burdened (50%) for housing	Estimated % of Income Spent on Food	Total % for Housing & Food
Under $10,000	Under $250	7.8	1	5	35%	85%
$10,000-$24,999	$251-625	21.1	3.7	15	25%**	75%

*This table is constructed from Table 38 of chapter 5 on housing and Table 45 of this chapter.

** The combination of these two incomes groups crosses the lowest and next-lowest income quintiles in which food percent ranges from 19% to 35%. 25% was selected as a deliberately conservative estimate, although more than half of the 10,000 to 25,000 income group would fall into the lowest quintile in which 35% of income is spent on food.

[104] www.harrychapin.org

Conclusion

After analyzing data about food insecurity surveys, examining statistics about nutrition-related outcomes, identifying sources and distribution systems for food and expenditures for assistance, it can be stated that food and nutrition services in Lee County were not identified as having as significant of a gap as other service areas. However, food is a daily need and the conclusion does not mean there is no need to address food insecurity continually. Rather it is to acknowledge the scope of the community's efforts make this area a less serious one from the perspective of a gap.

Definitions and Measurement

Food Security discussions often are based on the Department of Agriculture's Food Security Survey. For these discussions to be productive, they must be based on an understanding of the method of the study and how food insecurity is defined. The following are direct quotes from the USDA study.[105]

"How Was the Study Conducted?

Data for the ERS food security reports come from an annual survey conducted by the U.S. Census Bureau as the December supplement to the monthly Current Population Survey. ERS sponsors the annual Food Security Supplement survey, compiles and analyzes the responses. The 2018 survey covered 37,300 households, comprising a representative sample of about 130 million U.S. households. The survey asked one adult respondent per household questions about experiences and behaviors that indicate food insecurity during the calendar year, such as being unable to afford balanced meals, cutting the size of meals, or being hungry because of too little money for food. The food security status of the household was assigned based on the number of food-insecure conditions reported.

[105] Household Food Security in the United States in 2018. U.S. Department of Agriculture.

How was Food Security determined?

Responses to the 18 food security questions are reported in tables S-5 to S-6 of the Statistical Supplement (Coleman-Jensen et al., 2019). The food security status of each interviewed household is determined by the number of food-insecure conditions and behaviors the household reports. Households are classified as food secure if they report no food-insecure conditions or only one or two food-insecure conditions. Food-insecure conditions are indicated by responses of "often" or "sometimes" to questions 1-3 and 11-13; "almost every month" or "some months but not every month" to questions 5, 10 and 17; and "yes" to the other questions. They are classified as food insecure if they report three or more food-insecure conditions, based on questions 1-10 for households without children and questions 1-18 for households with children. Households are classified as having food-insecure children if they report two or more food-insecure conditions among the children in response to questions 11-18.

Food-insecure households are further classified as having either low food security or very low food security. The very low food security category identifies households in which the food intake of one or more members was reduced and eating patterns disrupted because of insufficient money and other resources for food. Households without children are classified as having very low food security if they report six or more food-insecure conditions (based on questions 1-10). Households with children age 0-17 are classified as having very low food security if they report eight or more food-insecure conditions among adults and/or children (based on questions 1-18). They are further classified as having very low food security among children if they report five or more food-insecure conditions among the children (that is, if they respond affirmatively to five or more of questions 11-18)."

The Food Security Questions in the CPS Food Security Supplement

The questions of the survey are listed below.

1. We worried whether our food would run out before we got money to buy more." Was that often, sometimes, or never true for you in the last 12 months?
2. "The food that we bought just didn't last and we didn't have money to get more." Was that often, sometimes, or never true for you in the last 12 months?

3. “We couldn’t afford to eat balanced meals.” Was that often, sometimes, or never true for you in the last 12 months?
4. In the last 12 months, did you or other adults in the household ever cut the size of your meals or skip meals because there wasn’t enough money for food? (Yes/No)
5. (If yes to question 4) How often did this happen—almost every month, some months but not every month, or in only 1 or 2 months?
6. In the last 12 months, did you ever eat less than you felt you should because there wasn’t enough money for food? (Yes/No)
7. In the last 12 months, were you ever hungry, but didn’t eat, because there wasn’t enough money for food? (Yes/No)
8. In the last 12 months, did you lose weight because there wasn’t enough money for food? (Yes/No)
9. In the last 12 months, did you or other adults in your household ever not eat for a whole day because there wasn’t enough money for food? (Yes/No)
10. (If yes to question 9) How often did this happen—almost every month, some months but not every month, or in only 1 or 2 months?

(Questions 11-18 were asked only if the household included children age 0-17)

11. “We relied on only a few kinds of low-cost food to feed our children because we were running out of money to buy food.” Was that often, sometimes, or never true for you in the last 12 months?
12. “We couldn’t feed our children a balanced meal, because we couldn’t afford that.” Was that often, sometimes, or never true for you in the last 12 months?
13. “The children were not eating enough because we just couldn’t afford enough food.” Was that often, sometimes, or never true for you in the last 12 months?
14. In the last 12 months, did you ever cut the size of any of the children’s meals because there wasn’t enough money for food? (Yes/No)
15. In the last 12 months, were the children ever hungry but you just couldn’t afford more food? (Yes/No)
16. In the last 12 months, did any of the children ever skip a meal because there wasn’t enough money for food? (Yes/No)
17. (If yes to question 16) How often did this happen—almost every month, some months but not every month, or in only 1 or 2 months?

18. In the last 12 months did any of the children ever not eat for a whole day because there wasn't enough money for food? (Yes/No)

Coding of Responses

Questions 1-3 and 11-13 are coded as affirmative (i.e., possibly indicating food insecurity) if the response is "often" or "sometimes." Questions 5, 10, and 17 are coded as affirmative if the response is "almost every month" or "some months but not every month." The remaining questions are coded as affirmative if the response is "yes."

Assessing Food Security Status in Households without Children

Households without children are classified as food insecure if they report three or more indications of food insecurity in response to the first 10 questions; they are classified as having very low food security if they report six or more food-insecure conditions out of the first 10 questions.

Assessing Food Security Status in Households with Children Age 0-17

Households with children are classified as food insecure if they report three or more indications of food insecurity in response to the entire set of 18 questions; they are classified as having very low food security if they report eight or more food-insecure conditions in response to the entire set of 18 questions.

The food security status of children in the household is assessed by responses to the child-referenced questions (questions 11-18). Households reporting two or more of these conditions are classified as having food insecurity among children. Households reporting five or more are classified as having very low food security among children."

What Is "Very Low Food Security"?

"Very low food security can be characterized in terms of the conditions that households in this category reported in the food security survey. Households without children classified as having very low food security reported six or more food-insecure conditions, and households with children reported eight or more food-insecure conditions, including conditions among both adults and children. Thus, the conditions reported by respondents reflect the definition of "very low food security": at times during the year, the food intake of household members was reduced and their normal eating patterns were disrupted because the household lacked money and other resources for food. In the 2018 survey, households classified as having very low food security (representing an estimated 5.6 million households nationwide) reported the following specific conditions:"

- 98% reported having worried that their food would run out before they got money to buy more.
- 97% reported that the food they bought just did not last and they did not have money to get more.
- 96% reported that they could not afford to eat balanced meals.
- 97% reported that an adult had cut the size of meals or skipped meals because there was not enough money for food; 90% reported that this had occurred in three or more months.
- 94% reported that they had eaten less than they felt they should because there was not enough money for food.
- 69% reported that they had been hungry but did not eat because they could not afford enough food.
- 47% reported having lost weight because they did not have enough money for food.
- 32% reported that an adult did not eat for a whole day because there was not enough money for food; 25% reported that this had occurred in three or more months.[106]

As noted above, all households without children classified as having very low food security reported at least six of these conditions. Most households with very low food security, 70%, reported seven or more food-insecure conditions. (Conditions reported by households with children were like those without children, but the reported food-insecure conditions of both adults and children were considered.)

Episodic vs Constant Food Insecurity.

"The survey found that the resulting instances of reduced food intake and disrupted eating patterns are usually occasional or episodic, but not usually constant. The food security measurement methods used in this report are designed to register these occasional or episodic occurrences. The questions used to assess households' food security status ask whether a condition, experience, or behavior occurred at any time in the past 12 months and households can be classified as having very low food security

[106] Source: USDA, Economic Research Service using data from U.S. Department of Commerce, U.S. Census Bureau,

based on a single, severe episode during the year. Readers should be mindful of this when interpreting food-insecurity statistics. Analyses of additional information collected in the food security survey on how frequently various food-insecure conditions occurred during the year, whether they occurred during the 30 days prior to the survey, and, if so, in how many days provide insight into the frequency and duration of food insecurity in U.S. households.

CHAPTER 8
Employment

Introduction

The value and importance of employment are self-evident. However, one or more barriers to employment may exist. These include:

- Transportation. As discussed previously, transportation difficulties in getting to work can affect an employee's reliability. For some people, getting to work may be challenging because of the lack of viable transportation options.
- Child-care. The hours of child-care available, or the reliance upon private individuals to provide child-care, may make it difficult to work certain hours during the workday. This can lead to being labeled as unreliable.
- Lack of a High School Diploma. The issue of dropping out of school has been discussed in other chapters. The lack of a high school diploma creates gaps in opportunities.
- Substance Abuse History. As with a lack of a high school diploma, a history of substance abuse creates opportunity gaps and bias issues.
- Mental Health History. As with substance abuse, a history of mental illness can result in a spotty work history, questions of reliability and a prejudice against employing such individuals.
- Physical Disabilities. These disabilities can make some jobs unfeasible. In other cases, employers may question the ability of a physically disabled person to do the job.
- Intellectual and Developmental Disabilities. These disabilities limit employment options for obvious reasons. However, other factors such as employer bias, parental concerns and potential gaps in appropriate employment settings also limit employment opportunities.
- Criminal Record. This precludes certain jobs and therefore creates opportunity gaps. Employer bias can also be a factor.
- Homelessness. The lack of a physical address or other types of documentation can be an employment barrier. Services provided by the Homeless Continuum of Care attempt to address this issue.

The barriers listed above may affect an employee's reliability or an employer's perception of their reliability.

The System-of-Care

A variety of State and local agencies exist with a mission that includes addressing employment opportunities. These agencies include:

- Florida Division of Vocational Rehabilitation (FDVR). The FDVR is a federal-state program that helps people with physical or mental disabilities get, or keep, a job. The School District of Lee County can refer to FDVR.
- Florida Division of Blind Services. This agency provides a variety of services to blind and visually impaired persons including employment services in conjunction with FDVR.
- Florida Agency for Persons with Disabilities. This state agency supports persons with developmental disabilities with a variety of services, including employment.
- Southwest Florida Workforce Development Board, Inc. (DBA CareerSource Southwest Florida) serves a five-county region including Lee County. It administers federal and state funds designated for employment and training services for individuals and for new or expanding businesses. It assists in employment searches, skills training in some cases and employability skills workshops.
- GED. The School District of Lee County Adult Education Program provides GED classes throughout the county.
- Career and Technical Education. The Adult and Career Education of the School District of Lee County provide programs in 18 clusters, all of which are employment clusters in the County.
- Technical Colleges. There are several technical colleges that provide career training such as Fort Myers Technical College and Southern Technical College.
- Public Academic institutions. Florida Gulf Coast University and Florida SouthWestern State College offer a broad range of academic offerings.

Gaps

No substantive gap exists in programmatic alternatives for individuals. There are skills gaps between the skills of the workforce and the needs of employers, as well as gaps in number of people available to fill needed jobs.

For individuals, barriers exist such as transportation, child-care and a person's history. However, these are not service gaps. For any person desiring a job and a career, there are both opportunities and support services available.

From a provider perspective, there may be logistical gaps in that an academic class may not be offered at a desired time or location. There are occasional scheduling difficulties. As with other service providers, staffing may be a challenge.

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CHAPTER 9
Staffing

Introduction

A consistent provider theme through various focus groups and interviews, has been the challenge of staffing to provide services. There are four elements involved. They are:

- The difficulty of attracting and retaining professional staff with the needed credentials. There is a national shortage.
- Staff stability and turnover at the lower-level positions due to low wages and difficult work.
- The ongoing demand for more technical expertise, even at lower-level positions.
- The high rate of population growth.

Each of these will be discussed in detail.

The Difficulty of Attracting and Retaining Professional Staff with the Needed Credentials: A National Shortage of Health Professionals

It is difficult to recruit or retain highly qualified professionals such as physicians, psychologists, social workers, etc. In some cases, it is a compensation issue, but other dimensions to the challenge exist.

There is a genuine national shortage in some fields. One such field is child psychiatry.[107] In Florida during 2018, there were 412 child and adolescent psychiatrists to serve 4,131,400 children. That is a ratio of 10 child-and-adolescent psychiatrists per 100,000 children under 18. In Lee County during 2018, there were 126,740 youth under 18 and only 10 child-and-adolescent psychiatrists. It is worth noting that the average age of a child / adolescent psychiatrist in Florida is 52. The only county in the state with a sufficient supply of child / adolescent psychiatrists is Alachua. This statistic of sufficiency is biased by the presence of the University of Florida's Department of Psychiatry in the Medical School.

[107] Workforce issues, 2019. America Academy of Child & Adolescent Psychiatry. www.aacap.org

With respect to psychologists, the Health Resources and Services Administration (HRSA)[108] expects the psychology workforce to grow by 1% between now and 2025 while the needed growth nationally is estimated at 6%. Using different assumptions about retirement (one-third of psychologists are 55 or older), this could mean a shortage of between 8,000 and 52,000 by 2025.[109]

The same is true for Licensed Clinical Social Workers[110][111] and Registered Nurses.[112] The Bureau of Labor Statistics projects the need for 203,700 new RNs each year through 2026; while actual workforce growth is expected to be 50,000 per year.[113] The Bureau of Labor Statistics projects the need for social workers to grow 11% from 2018 to 2028, much faster than the average for all occupations.[114]

There are a variety of reasons for the existing and growing shortage. These include:

- The current and upcoming retirement of these professionals without a re-supply in the pipeline.[115]
- Geographic disparities between large urban areas that have an adequate supply and rural or suburban areas that do not.[116]
- The need for increased specialty care, such as opioid addition, for which many professionals are not trained.[117]
- An aging society that requires more behavioral health care.[118]
- High turnover rates due to compensation and burn-out issues.[119]
- The sheer number of people needing behavioral health services exceeds the current capacity.[120]

[108] Health workforce projections: Clinical, Counseling and School Psychologists. HRSA Health Workforce. www.bhw.hrsa.gov
[109][109] Lange, S. 2018. Is there a shortage of clinical psychologists in the U.S. www.quora.com.
[110] Jackson, K. The behavioral health care workforce shortage. Social Work Today 19(3), 16.
[111] Burrows, H. 2019. The shortage of Licensed Social Workers in Central Florida. Dissertation. Walden University.
[112] Nursing Shortage, 2019. American Association of Colleges of Nursing
[113] Employment projections, 2016-2026. Bureau of Labor Statistics
[114] Occupational Outlook Handbook, 2018. www.bls.gov
[115] Jackson, op.cit.
[116] ibid
[117] ibid
[118] ibid
[119] ibid
[120] ibid

- A shortage of nursing school faculty is restricting nursing school enrollments.[121]

These factors are all present and are impacting Lee County service providers.

Another issue, more specific to Lee County, is that professional recruitment is locally challenging. Some of the potential reasons are:

- The trailing spouse issue. While the economy of the region is certainly diversifying, it is still not always easy for the spouse to find employment in his or her field. Larger, urban areas have an advantage.
- The dominance of retirement and tourism as economic drivers. While Lee County is highly attractive to retirees and tourists, new professionals do not fit these categories. In terms of professional interaction opportunities and lifestyle choices, the region must compete against other regions that may offer a broader range of options.

Table 47 provides various indicators regarding health care. Some staffing shortages are indicated by looking purely at staff ratios, while others are indirectly indicated by looking at the difficulty of getting appointments or the lack of available beds. The issues with appointments and the lack of beds certainly have other variables associated with them, but they do indicate staffing challenges as well.

[121] Nursing shortage, ibid.

Table 47. Health Care Staffing Comparison Data

Source	Data Title	Year	Lee County	State Avg	Comparison to State
Health Resources Availability [122]	Total Licensed Physicians per 100,000	2017	319.2	310.6	Within 10% average
Health Resources Availability [123]	Total Licensed Family Practice Physicians per 100,000	2017	17.0	19.2	Worse
Health Resources Availability [124]	Total Licensed Internists per 100,000	2017	56.9	47.8	Better
Health Resources Availability [125]	Total Licensed Pediatricians per 100,000	2017	19.0	22.3	Worse
Health Resources Availability [126]	Total Licensed Mental Health Counselors per 100,000	2017	33.7	52.7	Worse
Health Resources Availability [127]	Total Licensed Psychologists per 100,000	2017	13.8	22.5	Worse
Health Resources Availability [128]	Total Hospital Beds Rate Per 100,000	2018	260.6	308.2	Worse

Florida Health Charts:,
[122]Licensed Physicians,
http://www.flhealthcharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0327
[123] License Family Practice,
http://www.flhealthcharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0328
[124] Licensed Internists,
http://www.flhealthcharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0329
[125] Licensed Pediatricians,
http://www.flhealthcharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0331
[126] Licensed Mental Health Counselors,
http://www.flhealthcharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=9737
[127] Licensed Psychologists,
http://www.flhealthcharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=9738
[128] Hospital Beds, http://www.flhealthcharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0313

Source	Data Title	Year	Lee County	State Avg	Comparison to State
Health Resources Availability[129]	Total Acute Care Beds Rate Per 100,000	2018	201.8	248.9	Worse
Health Resources Availability[130]	Total Specialty Beds Rate Per 100,000	2018	58.8	59.2	Within 10% average
Community Health Needs Assessment[131]	Primary Doctors per 1000	2017	64.3	79.8	Worse
Community Health Needs Assessment	Live in a health professional shortage area	2017	26.5	54.7	Better
Community Health Needs Assessment	% Difficulty Getting Appointment past year	2017	20.4%	US Avg 15.4%	Worse
Community Health Needs Assessment	% Difficulty Finding Physician past year	2017	14%	US Avg 8.7%	Worse
Community Health Needs Assessment	% Difficulty accessing healthcare past year	2017	43.5%	US Avg 35 %	Worse
Community Health Needs Assessment	% Difficulty Getting Childs Healthcare past year	2017	12.5%	US Avg 3.9%	Worse

[129] Total Acute Care Beds, http://www.flhealthcharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0314
[130] Specialty Beds, http://www.flhealthcharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0315
[131] 2017 Community Health Needs Assessment Report; Lee Health and FL Dept. of Health in Lee County

Staff Stability and Turnover at the Lower-Level Positions Due to Low Wages and Difficult Work

Most direct-service staff at provider agencies are paid between $10 and $12 an hour. At this rate of pay, even when small hourly increases are implemented, staff turnover occurs as employees leave for other positions.

Another factor causing turnover is that the work is difficult and at times dangerous. Whether it is a bus driver being verbally abused, a mental health technician being physically attacked, or an employee observing the pain of others, none of this work is easy. For these reasons, front line employees burn out regularly and find different employment.

The growth rate of the County offsets this turnover to some degree. New residents who need work are always arriving. While this may be a numerical offset, there are both management and quality challenges. Program consistency is an important component of many service programs. However, it is challenging to achieve with staff turnover.

The Ongoing Demand for More Technical Expertise, even at Lower-Level Positions

There is an ongoing trend for direct-service work to be more technical in nature. In the 1970s, for example, aides in state mental hospitals were retrained to become psycho-social technicians. This is due in part to the fact that as the knowledge base in all these fields grows and becomes more specialized, the limitations of unskilled positions become apparent and the need for better skills becomes more obvious. To illustrate this phenomenon, take the case of child-care.

Child-care originally was just child-watching. It involved making sure no children were injured; they were fed, they took naps, etc. An employee only needed to be responsible to qualify for such a job.

As knowledge about the importance of brain development between the ages of 0 and 3 increased and the various forms of interaction that were helpful or harmful to children were better understood, simple child-watching became inadequate. Instead, the employee needed some knowledge of child development intellectually, emotionally and physically. Today there are minimum training standards coupled with a preference for

Child Development Associates credentials, in addition to the ideal of pursuing a Bachelor of Arts in Child Development.

This same pattern is true for almost any human service field, be it behavioral health, child abuse and neglect, trauma, intellectual and developmental disabilities, etc. The knowledge base has grown significantly and the importance of appropriate skills has increased with that knowledge base.

The High Rate of Population Growth

Lee County is in one of the nation's fastest growing regions. Growth is certainly preferable to population decline. However, it brings its own challenges. One of these is that the development of infrastructure needed to serve the growth in population is always slower than the growth itself. This is certainly true for physical infrastructure such as roads, water lines, etc. It is also true of human infrastructure.

In effect, people are coming to Lee County at a faster pace than the professionals needed to address the new residents' needs. Over time, this human infrastructure will catch up, just as physical infrastructure can catch up.

Table 48 shows the Florida Department of Economic Opportunity's projections for job growth in various industries between 2018 and 2026.[132] Table 49 shows new job growth by industry category. Table 50 shows the fastest-growing occupations and Table 51 shows growth of new jobs in the various occupations. Many of these are positions in the human services field.

Conclusion

The challenge of staffing will remain into the near future. A factor to consider in decisions regarding new or expanded programs is the feasibility of securing adequately skilled staff to perform the required work.

[132] Florida Department of Economic Opportunity, http://www.floridajobs.org/workforce-statistics/data-center/statistical-programs/employment-projections

Table 48. Lee County Fastest Growing Industries by NAICS Title (PROJECTIONS

		Employment			
Rank	**NAICS Title**	**2018**	**2026**	**Growth**	**Percent Growth**
1	Educational Services	3,485	4,351	866	24.9%
2	Ambulatory Health Care Services	15,931	19,821	3,890	24.4%
3	Nursing and Residential Care Facilities	6,885	8,543	1,658	24.1%
4	Furniture and Related Product Manufacturing	714	880	166	23.3%
5	Social Assistance	3,887	4,658	771	19.8%
6	Support Activities for Transportation	825	976	151	18.3%
7	Health and Personal Care Stores	2,563	3,024	461	18.0%
8	Nonmetallic Mineral Product Manufacturing	788	929	141	17.9%
9	Transit and Ground Passenger Transportation	265	311	46	17.4%
10	Insurance Carriers and Related Activities	3,160	3,694	534	16.9%
11	Sporting Goods, Hobby, Book, and Music Stores	1,872	2,171	299	16.0%
12	Construction of Buildings	5,634	6,497	863	15.3%
13	Miscellaneous Manufacturing	546	629	83	15.2%
14	Professional, Scientific, and Technical Services	14,820	17,039	2,219	15.0%
15	Specialty Trade Contractors	21,757	24,948	3,191	14.7%
16	Local Government	36,780	42,167	5,387	14.7%
17	Administrative and Support Services	18,128	20,724	2,596	14.3%
18	State Government	4,816	5,487	671	13.9%

		Employment			
Rank	NAICS Title	2018	2026	Growth	Percent Growth
19	Air Transportation	676	768	92	13.6%
20	Couriers and Messengers	981	1,111	130	13.3%

Table 49. Lee County Industries Gaining the Most New Jobs (PROJECTIONS)

		Employment			
Rank	NAICS Title	2018	2026	Growth	Percent Growth
1	Local Government	36,780	42,167	5,387	14.7%
2	Ambulatory Health Care Services	15,931	19,821	3,890	24.4%
3	Specialty Trade Contractors	21,757	24,948	3,191	14.7%
4	Food Services and Drinking Places	30,438	33,417	2,979	9.8%
5	Administrative and Support Services	18,128	20,724	2,596	14.3%
6	Professional, Scientific, and Technical Services	14,820	17,039	2,219	15.0%
7	Nursing and Residential Care Facilities	6,885	8,543	1,658	24.1%
8	Educational Services	3,485	4,351	866	24.9%
9	Construction of Buildings	5,634	6,497	863	15.3%
10	Food and Beverage Stores	8,553	9,383	830	9.7%
11	Social Assistance	3,887	4,658	771	19.8%
12	Motor Vehicle and Parts Dealers	5,672	6,386	714	12.6%
13	State Government	4,816	5,487	671	13.9%
14	Amusement, Gambling, and Recreation Industries	6,333	6,955	622	9.8%

15	Insurance Carriers and Related Activities	3,160	3,694	534	16.9%
16	Health and Personal Care Stores	2,563	3,024	461	18.0%
17	Building Material and Garden Equipment and Supplies Dealers	4,082	4,525	443	10.9%
18	Repair and Maintenance	3,372	3,763	391	11.6%
19	Personal and Laundry Services	3,201	3,585	384	12.0%
20	Real Estate	4,457	4,836	379	8.5%

Table 50. Lee County Fastest-Growing Occupations (PROJECTIONS)

		Employment				Education	
Rank	**SOC Title**	**2018**	**2026**	**Percent Growth**	**2017 Median Hourly Wage ($)***	**FL†**	**BLS†**
1	Physician Assistants	245	341	39.20%	44.81	B	M
2	Nurse Practitioners	185	256	38.40%	46.15	M+	M
3	Personal Care Aides	1,127	1,506	33.60%	10.64	PS	HS
4	Business Teachers, Postsecondary	153	204	33.30%	-	B	D
5	Respiratory Therapists	539	713	32.30%	27.99	A	A
6	Health Specialties Teachers, Postsecondary	149	196	31.50%	-	M+	D
7	Physical Therapist Assistants	272	353	29.80%	29.3	A	A
8	Medical Assistants	2,137	2,771	29.70%	15.09	PS	PS
9	Logisticians	200	257	28.50%	26.31	B	B

		Employment				Education	
Rank	**SOC Title**	**2018**	**2026**	**Percent Growth**	**2017 Median Hourly Wage ($)***	**FL†**	**BLS†**
10	Diagnostic Medical Sonographers	229	294	28.40%	35.51	PS	A
11	Physical Therapists	441	560	27.00%	41.68	M+	D
12	Market Research Analysts and Marketing Specialists	443	561	26.60%	26.52	B	B
13	Physical Therapist Aides	140	177	26.40%	11.84	PS	HS
14	Food Servers, Nonrestaurant	377	476	26.30%	9.25	NR	NR
15	Financial Managers	492	620	26.00%	49.84	B	B
16	Software Developers, Applications	679	854	25.80%	33.7	A	B
17	Massage Therapists	376	470	25.00%	20.81	PS	PS
18	Occupational Therapists	191	236	23.60%	43.29	M+	M
19	Medical and Health Services Managers	260	321	23.50%	49.22	B	B
20	Self-Enrichment Education Teachers	390	481	23.30%	24.24	PS	HS
21	Insurance Claims and Policy Processing Clerks	254	313	23.20%	15.8	HS	HS
22	Healthcare Social Workers	186	229	23.10%	23.78	M+	M

		Employment				Education	
Rank	**SOC Title**	**2018**	**2026**	**Percent Growth**	**2017 Median Hourly Wage ($)***	**FL†**	**BLS†**
23	Cabinetmakers and Bench Carpenters	403	496	23.10%	16.45	PS	HS
24	Social and Community Service Managers	169	208	23.10%	30.72	A	B
25	Medical Scientists, Except Epidemiologists	129	158	22.50%	32.93	M+	D
26	Registered Nurses	6,110	7,473	22.30%	31.03	A	B
27	Ophthalmic Medical Technicians	239	292	22.20%	18.4	PS	PS
28	Medical Secretaries	473	577	22.00%	14.28	PS	HS
29	Cooks, Institution and Cafeteria	474	577	21.70%	13.37	HS	NR
30	Educational, Guidance, School, and Vocational Counselors	267	325	21.70%	28.1	M+	M
31	Phlebotomists	226	275	21.70%	14.65	PS	PS
32	Dental Assistants	632	767	21.40%	18.57	PS	PS
33	Dental Hygienists	328	398	21.30%	37.21	A	A
34	Surgical Technologists	452	548	21.20%	22	PS	PS
35	Management Analysts	1,028	1,243	20.90%	40.24	B	B
36	Nursing Assistants	3,918	4,726	20.60%	13.47	PS	PS

		Employment				Education	
Rank	**SOC Title**	**2018**	**2026**	**Percent Growth**	**2017 Median Hourly Wage ($)***	**FL†**	**BLS†**
37	Licensed Practical and Licensed Vocational Nurses	1,575	1,892	20.10%	20.8	PS	PS
38	Pharmacy Technicians	1,013	1,214	19.80%	14.7	PS	HS
39	Radiologic Technologists	515	617	19.80%	28.29	PS	A
40	Helpers--Roofers	147	176	19.70%	-	NR	NR
41	Structural Iron and Steel Workers	351	420	19.70%	20.57	PS	HS
42	Child, Family, and School Social Workers	492	588	19.50%	17.72	M+	B
43	Speech-Language Pathologists	206	246	19.40%	40.03	M+	M
44	Insurance Sales Agents	1,237	1,475	19.20%	22.11	PS	HS
45	Molders, Shapers, and Casters, Except Metal and Plastic	177	211	19.20%	14.3	HS	HS
46	Cardiovascular Technologists and Technicians	347	413	19.00%	17.8	PS	A
47	Family and General Practitioners	295	351	19.00%	-	M+	D
48	Dietetic Technicians	194	230	18.60%	13.54	PS	A
49	Compliance Officers	346	410	18.50%	23.48	PS	B

		Employment				Education	
Rank	**SOC Title**	**2018**	**2026**	**Percent Growth**	**2017 Median Hourly Wage ($)***	**FL†**	**BLS†**
50	Administrative Services Managers	185	219	18.40%	35.19	A	B

Table 51. Lee County Occupations Gaining the Most New Jobs (PROJECTIONS)

		Employment				Education	
Rank	**SOC Title**	**2018**	**2026**	**Total Job Openings**	**2017 Median Hourly Wage ($)***	**FL†**	**BLS†**
1	Registered Nurses	6,110	7,473	4,100	31.03	A	B
2	Retail Salespersons	13,262	14,495	17,073	10.66	HS	NR
3	Landscaping and Grounds keeping Workers	7,392	8,571	8,722	11.48	NR	NR
4	Combined Food Preparation and Serving Workers, Including Fast Food	6,947	8,064	11,995	9.75	NR	NR
5	Construction Laborers	6,186	7,157	6,351	14.23	NR	NR
6	Customer Service Representatives	6,383	7,235	7,723	13.26	PS	HS
7	Waiters and Waitresses	9,775	10,614	16,125	9.48	NR	NR
8	Nursing Assistants	3,918	4,726	4,655	13.47	PS	PS
9	Carpenters	4,728	5,437	4,367	19.09	PS	HS
10	Medical Assistants	2,137	2,771	2,702	15.09	PS	PS
11	Stock Clerks and Order Fillers	4,717	5,262	5,568	11.67	HS	HS
12	First-Line Supervisors of Retail Sales Workers	4,563	5,073	4,527	20.54	PS	HS

		Employment				Education	
Rank	SOC Title	2018	2026	Total Job Openings	2017 Median Hourly Wage ($)*	FL†	BLS†
13	Janitors and Cleaners, Except Maids and Housekeeping Cleaners	3,365	3,860	4,194	11.58	NR	NR
14	Cooks, Restaurant	3,880	4,361	5,049	12.99	PS	NR
15	First-Line Supervisors of Construction Trades and Extraction Workers	2,811	3,257	2,754	26.79	A	HS
16	Childcare Workers	2,495	2,914	3,525	10.8	PS	HS
17	Receptionists and Information Clerks	3,061	3,473	3,772	13.68	HS	HS
18	Food Preparation Workers	3,140	3,524	4,825	10.74	NR	NR
19	Maids and Housekeeping Cleaners	2,782	3,164	3,473	11.04	NR	NR
20	Personal Care Aides	1,127	1,506	1,853	10.64	PS	HS
21	Cashiers	9,231	9,610	14,361	9.49	HS	NR
22	Office Clerks, General	5,865	6,244	5,991	13.88	HS	HS
23	Laborers and Freight, Stock, and Material Movers, Hand	3,125	3,503	3,958	12.8	NR	NR
24	Sales Representatives, Wholesale and Manufacturing, Except Technical and Scientific Products	3,149	3,505	3,017	26.21	PS	HS
25	General and Operations Managers	2,481	2,835	2,063	42.51	A	B
26	Elementary School Teachers, Except Special Education	2,400	2,750	1,793	-	B	B

		Employment				Education	
Rank	SOC Title	2018	2026	Total Job Openings	2017 Median Hourly Wage ($)*	FL†	BLS†
27	Hairdressers, Hairstylists, and Cosmetologists	2,273	2,610	2,615	12.46	PS	PS
28	Maintenance and Repair Workers, General	2,838	3,174	2,653	16.97	PS	HS
29	Licensed Practical and Licensed Vocational Nurses	1,575	1,892	1,288	20.8	PS	PS
30	First-Line Supervisors of Food Preparation and Serving Workers	2,746	3,059	3,568	14.98	PS	HS
31	Heating, Air Conditioning, and Refrigeration Mechanics and Installers	2,056	2,336	1,943	20.84	PS	PS
32	Painters, Construction and Maintenance	2,019	2,294	1,724	14.92	PS	NR
33	Light Truck or Delivery Services Drivers	2,212	2,487	2,253	13.18	PS	HS
34	Security Guards	2,150	2,417	2,639	12.89	PS	HS
35	Accountants and Auditors	1,948	2,206	1,705	27.49	B	B
36	First-Line Supervisors of Office and Administrative Support Workers	2,873	3,121	2,562	24.33	A	HS
37	Teacher Assistants	1,629	1,873	1,652	-	PS	SC
38	Heavy and Tractor-Trailer Truck Drivers	2,173	2,412	2,169	17.86	PS	PS
39	Insurance Sales Agents	1,237	1,475	1,263	22.11	PS	HS
40	Roofers	1,349	1,587	1,372	16.07	PS	NR
41	Cleaners of Vehicles and Equipment	1,558	1,787	2,080	10.39	NR	NR

		Employment				Education	
Rank	SOC Title	2018	2026	Total Job Openings	2017 Median Hourly Wage ($)*	FL†	BLS†
42	Construction Managers	1,495	1,719	1,090	34.56	A	B
43	Management Analysts	1,028	1,243	976	40.24	B	B
44	Real Estate Sales Agents	1,717	1,930	1,529	31.34	PS	HS
45	Billing and Posting Clerks	1,240	1,452	1,266	16.74	HS	HS
46	Pharmacy Technicians	1,013	1,214	885	14.7	PS	HS
47	Counter and Rental Clerks	1,649	1,840	1,948	13.25	HS	NR
48	Police and Sheriff's Patrol Officers	1,240	1,428	862	23.01	PS	HS
49	Automotive Service Technicians and Mechanics	1,893	2,077	1,644	17.61	PS	PS
50	Secondary School Teachers, Except Special and Career/Technical Education	1,260	1,444	919	-	B	B

* Hourly wages for teaching occupations were calculated using a 40-hour work week for 9½ months per year.
† Education levels are abbreviated as follow.
Florida
A: associate degree
B: bachelor's degree
HS: high school diploma or GED
M+: master's, doctoral or professional degree
NR: no formal educational credential required
PS: postsecondary non-degree award
U.S. Department of Labor, BLS (Bureau of Labor Statistics)
A: associate degree
B: bachelor's degree
D: doctoral or professional degree
HS: high school diploma or GED
M: master's degree
NR: no formal educational credential required
PS: postsecondary non-degree award
SC: some college, no degree

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CHAPTER 10
County Facilities

Introduction

This chapter discusses recreational facilities in the County with an emphasis on facilities that the County provides. These facilities provide a variety of human service-related functions such as after-school programs, youth recreation and adult recreation. The libraries provide children's programs, spaces for adolescents and meeting spaces for community organizations. These services contribute to the physical health of the community for all age groups, positive youth development and alleviation of social isolation for seniors.

Findings

Figure 5 shows the Parks and Recreational Facilities, Public Libraries and Conservation 20/20 Lands across the County. These are widely distributed and are located near population centers.

Figure 5. Map of Lee County Parks, Conservation Lands and Libraries

Based on its comprehensive plan and needs analysis, the County plans to develop additional parks and libraries at sites across the County. Appendix G summarizes the County's Parks and Recreation Capital Improvement Projects (CIPs). Appendix H summarizes the County's Library System's CIPs.

Nonprofits are responsible for developing their own facilities. Other public agencies have similar responsibilities.

Conclusion

While some facilities are more intensely used than others – and during season there is high demand on facilities – there are no significant gaps in recreational facilities in the County.

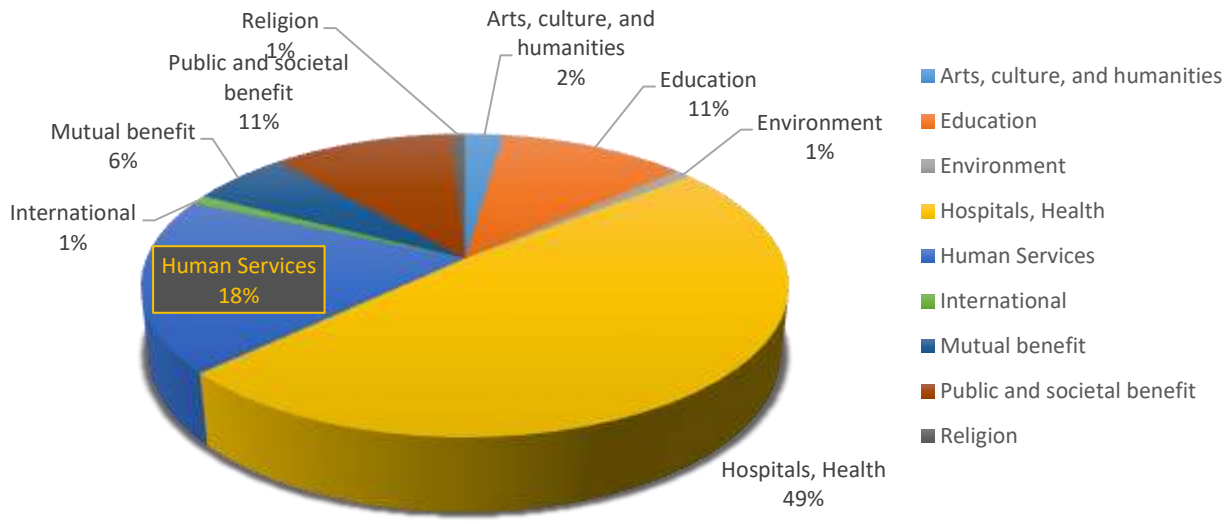
CHAPTER 11
Organizational Capacity

Introduction

According to the Internal Revenue Service (IRS), there are 247 nonprofit organizations in the County that are coded as human serving, with 198 of these reporting positive revenue. Human serving nonprofits differ from the arts and culture nonprofits in that their mission is addressing some human need, often of a deficit nature. Arts and culture nonprofits offer great value to the community and address higher-level human needs, but not basic needs such as food, physical health, illness of some sort, disabilities, or victimhood.

In Lee County, the proportion of revenue collected by the various nonprofits is shown in the following chart. Nonprofit organizations coded as "Human Services" collect 18% of the total revenue.

Figure 6. Revenue Collected by Tax Exempt Organizations in Lee County, Florida[133]



[133] IRS Exempt Organizations Business Master File Extracts: https://www.irs.gov/charities-non-profits/exempt-organizations-business-master-file-extract-eo-bmf

Thirty-eight of the local nonprofits form the core of the "Systems-of-Care" in the County. These 38 local nonprofits reported revenues from $49,696 up to $42,736,759. There are several core providers that are not based in Lee County; they are not included in these figures.

Key Trends in Human Serving Non-Profits

This chapter focuses on the human serving nonprofit sector. Three trends of significance exist:

- The growing knowledge base and specialization of services.
- Economy of scale pressures.
- The increasing significance of performance management capacity, if receiving public funds.

The Growing Knowledge Base and Specialization of Services

In recent years, there have been significant developments in our understanding of the human brain, of genetics and of epigenesis. Our understanding of what shapes and influences human behavior has vastly advanced. Of course, much is yet to be learned.

In addition to advances in brain research and related fields, therapeutic modalities are becoming more and more specialized as we learn what treatments are effective with certain conditions. More specialized training is demanded of staff as the number of specialties increases within the human services field.

Additionally as stated in a prior chapter, there is an ongoing trend for direct service work to be more technical in nature. In the 1970s for example, aides in the state mental hospitals were re-trained to become psycho-social technicians. This is due in part to the fact that as the knowledge base in all these fields grows and becomes more specialized, the limitations of unskilled positions become apparent and the need for better skills becomes more obvious. To illustrate this phenomenon, take the case of child-care.

Child-care originally was just child watching. It involved making sure no children were injured, they were fed, they took naps, etc. A person only needed to be responsible to qualify for such a job.

As knowledge about the importance of brain development between the ages of 0 and 3 increased, and the various forms of interaction that were helpful or harmful to children were better understood, and simple child-watching became inadequate. Instead, the employee needed some knowledge of child development intellectually, emotionally and physically. Today there are minimum training standards coupled with a preference for Child Development Associates credentials, in addition to the ideal of pursuing a Bachelor of Arts in Child Development.

This same pattern is true for almost any human service field, be it behavioral health, child abuse and neglect, trauma, intellectual and developmental disabilities, etc. The knowledge base has grown significantly and the importance of appropriate skills has grown with that knowledge base.

A natural outgrowth of specialization is the need for inter-disciplinary teams. One example of this is in the criminal justice field in which a variety of disciplines operate the various specialty courts. Treatment teams are standard practice in the behavioral health field.

Economy of Scale Pressures

The nonprofit sector is much like the for-profit sector from the perspective that economy of scale matters. There is the point at which organizations become too large to manage effectively. Few organizations in the nonprofit sector approach that problem. Most are so small that they are inefficient. They are inefficient because:

- There are so few staff that they all have to become generalists. While every organization needs a generalist or two, organizational efficiency occurs when most staff can specialize and complete their tasks in a timely and accurate manner because they have mastered those tasks. In a very small organization, one person must complete many tasks, which means they master none or a few at most.

- It is difficult to invest in training, professional development or knowledge of key trends. Small organizations tend to have very limited resources and the ability to invest in human capital is limited. As a result, staff skills are not advancing and may indeed be falling behind the field.

- It is difficult to complete non-repetitive work effectively. Small organizations must focus on their core work and in doing so have little time for other key tasks. For example, preparing a grant application can require extensive work as well as knowledge of what must go into the application for it to be competitive. When a staff member rarely fills out a grant application and is doing so during evenings or weekends, it will not be as competitive of an application as one completed by a grant specialist.

- Limited options for career advancement. Small organizations have very limited career paths, if any at all. While they certainly can attract new employees, it is difficult to keep employees who have career goals. These employees want to advance and broaden themselves professionally. Once they master the skills of their current job, they naturally will look for other opportunities. Small organizations are limited in their ability to provide these opportunities and will experience higher rates of turnover. Long-term staff are limited, which means that opportunities for more efficient work are limited.

The Increasing Significance of Performance Management Capacity, if Receiving Public Funds

It is a general fact that the reporting and documentation required by public funders usually exceeds that of private funders. Data collection, analysis and reporting are time-consuming activities, which can challenge even large organizations. For small organizations, it can be overwhelming. This means the reporting may not be of acceptable quality, may be inaccurate or may be missing.

The movement to assess performance in the use of public funds will not lessen. Indeed, the expectation of being able to demonstrate impact and outcomes will only increase. A larger organization can engage with an evaluation and assessment professional to assist with those tasks. For smaller organizations, it is just another task at the end of a long day.

Conclusion

The nonprofit sector forms key partnerships with public entities to provide services as well as generate private funding for those services. Given the broad range of needs and challenges, as well as the increasing complexity of the work, the emphasis should be on developing organizations that have the capacity and skills to fully address their mission. Concentrating the community's resources on the core "System-of-Care" providers is the most effective use of those resources.

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CHAPTER 12
Information and Technology

Introduction

Human service organizations have high information needs, just like any other business. Organizations with governmental contracts have extensive reporting requirements and required financial reporting. This results in administrative investments to meet reporting requirements as well as to fulfill operational and strategic decision-making needs.

Advances in technology will have a substantive impact on human services organizations. While there is no need to be on the cutting edge, agencies cannot fall too far behind the state-of-the-art if they are to remain viable.

The purpose of this chapter is to not only address current gaps, but also address emerging technologies that should be considered if future gaps are to be avoided. It will focus on trends that should be considered in future planning and development.

Trends

There are several trends that should be considered from an overall human services system framework. These include:

New HUD Regulations. Regulations continue to place a greater emphasis on the use of technology and data to inform the provision of human services.

Legislation. Several proposed legislative acts, including the HEARTH Act HMIS Final Rule (FR 5475), will require increased use of data systems over the next several years.

Other Initiatives. Incentives such as the monitoring of benchmark achievements for the U.S. Interagency Council on Homelessness for ending homelessness for various sub-populations are anticipated to require increased reporting capabilities.

Performance Data and Funding. In many cases, including the annual HUD Continuum of

Care funding process, performance data is used to make funding determinations. If data are inaccurate or performance is substandard, funding levels could be reduced.

The need for increased data sharing among mega-systems. Within the human services field there are at least four mega-systems: the human serving agencies who serve a range of individuals, the law enforcement agencies that deal with some of these same people, the education system that serves some of these same people or families, and the physical health system. Some persons cycle through these mega-systems. Families may be involved in one or more of them. While acknowledging various privacy concerns, there remains an on-going and potentially increasing need for information sharing among these mega-systems.

The increasing viability of tele-presence as an interaction and therapeutic tool. Telepresence is becoming more widely used in therapeutic settings. As 5G becomes more widespread, people become comfortable with the technology, and pressures for increased efficiency continue, there will be wider uses of telepresence technologies. Various legal and regulatory issues need to be resolved as well as technology investment requirements. Despite these challenges, it is a technology that cannot be ignored.

Robotics. Japan is currently facing the need to serve an elderly population with a limited workforce. In response to this challenge, it has invested in developing robots that can provide certain supports[134]. Among the types of robotics being developed are:

- Social-emotional or companion robots that provide various forms of interaction.[135]
- Specialized systems such as the Roomba – a robotic vacuum cleaner, floor-mopping robots, lawn-mowing robots and pill-dispensing robots.[136]
- Self-driving cars that will enhance senior and disabled mobility.[137]
- Robots that assist with nutrition by giving advice or reminders.[138]

[134] Japan's Robots: Robots used in care for the elderly. TRT World. YouTube. 3/28/18
[135] The future is elder care robots. www.waypointrobotics.com
[136] Matuszek, C. 2017. How robots could help the elderly age in their homes. www.Smithosonian.com. August 29th.
[137] Op.cit.
[138] Luukasik, S. et.al. 2017. Could robots help older people with age-related nutritional problems? International Journal of Environmental Research and Public Health. Doi: 10.3390/ijerph 15112535

Specialized Artificial Intelligence (AI)

A variety of specialized AI functions are being developed that could be of value to the human services field. These include:

- Voice. This form of AI will allow clients to interact with voice-response systems for certain needs.
- Cyber-security. Data security will continue to be an important topic.
- Emotion Recognition. As this AI develops, it could have important uses in the field.
- Personalized Health Advice. This AI can provide guidance for clients and employees.
- Object and movement detection for safety or logistics. Both have potential value.

Augmented work with AI

While some popular literature warns of AI and robots replacing humans, the near-future reality is that human and AI systems will work together. Some of the potential areas of people working with, and being augmented by, an AI system include:

- Clinical and Big Data Analysis. Clinicians could have AI systems that help bring the most recent science or assist in the interpretation of various diagnostics.
- Communication. This is about being able to communicate more effectively with team members, clients and the public.
- Translation. Using natural language tools, the challenges of serving clients with various languages could be reduced.
- Virtual Assistants. These are assistants who help staff with a variety of functions.
- Augmented Reality. There may be clinical value in being able to explore differing realities.

Conclusion

In the very near future, the delivery of human services could change significantly. New technology, new analytics and clearer performance standards all could develop. These

changes could make services more available, reduce or change costs, provide more data to determine effectiveness and efficiency, and become a factor in funding decisions.

Section Three: Development – The Foundation

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Chapter 13
Children and Youth Development

Introduction

This chapter addresses the systems and efforts that promote healthy child and youth development. The major system is the school system, which is not a focus of this study. The major challenges facing public education will be noted, but an analysis of the gaps in the School District of Lee County are not addressed. What is addressed are those efforts prior to public-school entry.

The hope is that every child has a safe, healthy and productive path to adulthood. Unfortunately, not all children do. The gaps in addressing their needs are addressed in separate chapters as noted below:

- Some children and youth develop mental health and/or substance abuse issues. These are addressed in the chapter "Behavioral Health."

- Other children are neglected, abused, exposed to violence or need to be placed out of their family home. The services to address their needs are addressed in the chapter "Child Abuse and Neglect, Foster Care, Adoptions."

- Some children engage in problematic behaviors that make them a risk to themselves or others and as a result engage in some way with the justice system. The services to address their needs are addressed in the chapter "Child Abuse and Neglect, Foster Care, Adoptions."

- Some children are victims of non-family violence, including sexual violence. The services to address their needs are addressed in the chapter "Child Abuse and Neglect, Foster Care, Adoptions."

- Some children are born with or develop various intellectual and developmental disabilities. They are addressed in the chapter "Persons with Intellectual and Developmental Disabilities (IDD)."

- Other children are born with or develop visual or hearing impairments. They are addressed in the chapter **"**Deafness and Blindness: Birth or Early Childhood Development."

- Some children experience homelessness. The chapter "Homelessness" addresses this topic.

- Many children live in families that are cost-burdened for housing and may rely on public transportation to some degree. These topics are covered in the infrastructure chapters on housing and transportation.

The above chapters discuss the community's response to children for whom the desired development track has failed. This chapter focuses on that track and how it might be more effective.

The services described in this chapter are beneficial and important to the development of any child. There has been a recognition, however, that some children are at greater risk of failing to meet developmental milestones, live in higher-risk conditions or, for some other reason, need additional support. The services described herein are both "developmental" in that they support an expected and desired developmental path and "preventative" in that they address issues that could result in deviation from that path. Because poverty is one indicator of at-risk status, a separate section on childhood poverty is included in this chapter. Chapter 2 provides a summary of poverty in the County. Federal Poverty Guidelines vary by household size. As shown in Table 58 of this chapter the Federal Poverty Level (FPL) for a four-person household is $24,250. There are various formulas for defining poverty for program purposes that may define poverty by a percentage of the FPL, such as 200%. Poverty statistics are developed both by the U.S Census Bureau and the U.S. Department of Housing and Development.

The format of this chapter begins with a context and background section. Then the system-of-care is described, followed by a gaps analysis. A section on childhood poverty closes the chapter.

Context and Background

Nearly 18% of County residents (approximately 132,000 people or 17.6%) are younger than 18. Of those, 4.6% are under 5 years of age (approximately 34,000 children).[139]

The 0-to-Age-8 Emphasis in Child Development: Advances in Brain Research

Research in child development has stressed the significance of early brain development. The first eight years of life, including natal development, build the foundation for future learning, health and life success.[140] In reality, the development of a healthy brain begins before pregnancy and continues during pregnancy.[141]

Long-term negative consequences for the child's brain can come from exposure to stress and trauma.[142] Poverty, unstable home environments, violence and a lack of access to quality early education can negatively affect a child's development and long-term health and wellbeing.[143] Therefore, it is important to track the developmental milestones of at-risk children to detect problems early and to use evidence-based interventions.[144] In Lee County these milestones are tracked to various degrees by child-care providers through the Early Learning Coalition and the school system. The Kids Count database reports some of these milestones and is commonly used to compare counties.

Brain research is described in detail below so that the rationale for the 0-to-age-8 emphasis can be clearer.

- A baby is born with roughly 100 billion neurons,[145] which is almost all the neurons the brain will ever have. [146]

[139] U.S. Census
[140] www.cdc.org/childdevelopment/earlybraindevelopment
[141] ibid.
[142] ibid
[143] www.astho.org/maternalandchildhealth/earlybraindevelopment
[144] ibid
[145] Aoki C, Siekevitz P. Plasticity in brain development. *Sci Am*. 1988; 259(6):56-64. https://www.ncbi.nlm.nih.gov/pubmed/2849807.
[146] Graham J. Children and Brain Development: What We Know About How Children Learn. Cooperative Extension Publications. https://extension.umaine.edu/publications/4356e/.

- Although a newborn has about the same number of neurons as an adult, it has only 25% of its adult brain volume. This is because an infant's neurons are connected by about 50 trillion connections, called synapses, whereas a grownup has about 500 trillion synapses.[147] The human brain is fully developed by around age 25, although it continues to develop throughout life at a slower pace.

- The network of synapses grows rapidly during the first year and continues to do so during toddlerhood. This network ultimately determines how a child thinks and acts. However, not all synapses remain as the child grows. Some neurons will be activated by life experiences and create new connections or strengthen existing ones. Unused connections will be eliminated, which is called synaptic pruning.

- The human brain in the early years has high neuroplasticity; it is easily able to change and adapt due to experience. This is a great strength, but it also means that the experiences a child has during the early years can have a significant impact.

- An example of synaptic pruning is quoted here:[148] "Let's say a parent consistently shows a toddler love and care, then the 'love-and-care connections' will develop or strengthen over time. But if the parent constantly punishes or is harsh to the child, then the 'punitive-and-harsh connections' will be stronger instead. And because the love-and-care experience is missing, those corresponding brain cells will wither and eventually be removed from the child's brain network. As a result, the child grows up lacking the love-and-care understanding that is essential to create healthy, meaningful relationships in his future life".

There are two other key concepts in childhood brain development. They are Critical/Sensitive Periods and the twin effects of Nature and Nurture (Environment) on Child Development.

- Critical / Sensitive Periods. A critical /sensitive period is a time when synaptic connections in certain brain regions are higher neuroplasticity.

[147] Gauvain M, Cole M. *Readings on the Development of Children*. 5th ed. Worth Publishers; 2008
[148] Brain Development – Why a Child's Early Years' Matter. Parenting for Brain. 2019

Connections are formed or strengthened given the appropriate experiences. After the critical period has passed, the synapses become stabilized with less plasticity. For example, it is easier for a young child to learn a new language and attain proficiency before puberty. The sensitive period for language mastery is from birth to before puberty.

- Nature vs Nurture in Child Development. As noted above, early life experiences significantly influence how the network of brain cells is formed. However, early life experience may have another significant impact on a child's life.

  Scientific evidence indicates that life experiences can affect how information in a gene is used (epigenetics). In some cases, genes can be slowed or shut off, and in other cases a gene's output can be increased.[149] Even more important, these epigenetic changes can be permanent and passed down from generation to generation. This latter finding has significance for at-risk children.

  While there has been a lengthy debate about the comparative significance of nature vs. environment, the field of epigenetics offers a different way for this discussion and analyses to develop. Both genes and environment are important factors.

The System-of-Care: The Major Public Investment Strategies

In Florida, the development of children and youth occurs through three major areas of public investment. Each are discussed below.

Healthy Start/Maternal Child Health/Newborns

The Florida Department of Health offers Healthy Start as "a free home visiting program that provides education and care coordination to pregnant women and families of

[149] Stiles J, Jernigan TL. The Basics of Brain Development. *Neuropsychol Rev*. November 2010:327-348. doi:10.1007/s11065-010-9148-4

children younger than 3. The goal of the program is to lower risk factors associated with preterm birth, low birth weight, infant mortality and poor developmental outcomes.

Healthy Start offers:

- Home visiting;
- Prenatal and parenting education;
- Interconception education including reproductive life planning;
- Stress management education; and
- Care coordination to help families learn about resources available in the community and assistance in accessing those services.[150]

Florida's Healthy Start initiative was signed into law on June 4, 1991. Healthy Start legislation provides for universal risk screening of all Florida's pregnant women and newborn infants to identify those at risk of poor birth, health and developmental outcomes. Healthy Start is funded from a mix of State and federal funds. Every physician is required to offer the Healthy Start Prenatal Risk Screen. Women are then referred to the Healthy Start program if the risk screen so indicates. A second survey is conducted at birth. Services available if needed include:

- Help to have a healthy pregnancy weight;
- Phone calls or visits with a Care Coordinator, who is a trained nurse or social service worker;
- Information about local resources;
- Free classes in baby care, breastfeeding and childbirth education;
- Help to stop smoking;
- Help with high stress, difficult problems or postpartum depression;
- Help with breastfeeding, including in-home postpartum support;
- Check-ups on the baby's health and development;
- Free parenting classes;
- Grief counseling; and
- Help with necessary baby supplies.

Healthy Start Southwest Florida covers Collier, Hendry, Glades and Lee counties. In 2018, more than 15,000 pregnant women and infants were served. In addition to the standard

[150] www.floridahealth.gov/programs&services/infant_child&adolescent/healthystart

services, the Help Me Grow program seeks to address early identification of developmental or behavioral concerns. Another offered program is the Nurse-Family Partnership for first-time, low-income mothers in which R.N. visits are provided for the first two years. There are also classes for pregnant teens and young mothers.

Table 52 presents data relevant to Healthy Start in Lee County as well as the other counties the program serves.

Table 52. Community Demographics

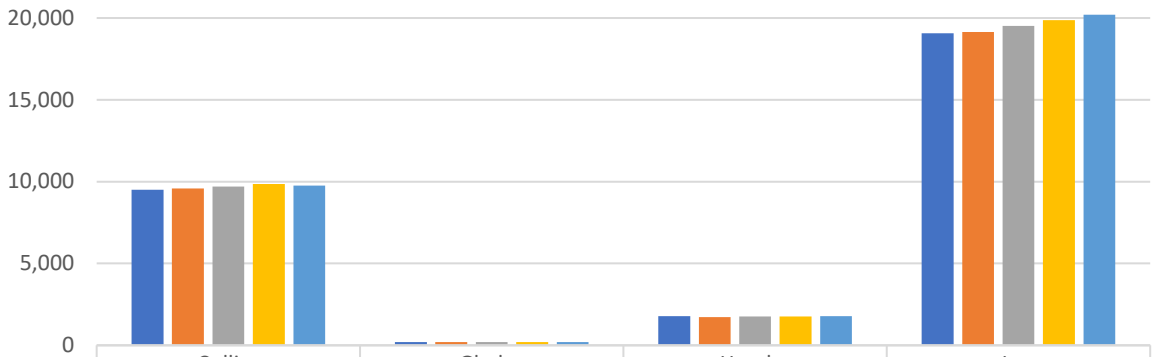
	Collier	Glades	Hendry	Lee
Total Population	356,774	13,197	39,064	700,165
Number of women of childbearing age	51,385	1,613	7,324	110,253
Number of children under five	16,669	477	2,855	33,694
Percentage of population that is White	89.2%	80.8%	80.2%	86.3%
Percentage of population that is Black	7.5%	14.0%	13.7%	9.4%
Percentage of population that is some other race or two or more races	3.3%	5.2%	6.1%	4.3%
Percentage of population that is Hispanic[151]	27.2%	20.8%	51.9%	20.2%
Percentage of population with at least a high school diploma	86.5%	73.7%	65.1%	87.3%
Median family income	$72,804	$43,206	$44,603	$61,847
Percentage of people with children under five below the federal poverty level	25.1%	34.8%	31.8%	27.0%
Percentage of population that speaks a language other than English at home	32.5%	22.5%	47.2%	22.1%
Percentage of population that has moved in the last year	16.8%	11.4%	16.1%	15.8%

Source: American Community Survey, 2013-2017 estimate

The mission of Healthy Start is to increase healthy births and reduce infant deaths. Figure 7 provides context for assessing mission success by reporting the total number of births. Figures 8 and 9 summarize two important indicators of the mission: low birth weight and infant mortality. As figure 8 indicates, the percentage of low-birth weights in Lee County has declined slightly during the five reporting periods. As figure 9 indicates, infant death rates per 1,000 births has a slight decline during the five reporting periods. In both cases the rates in Lee County are better than State averages.

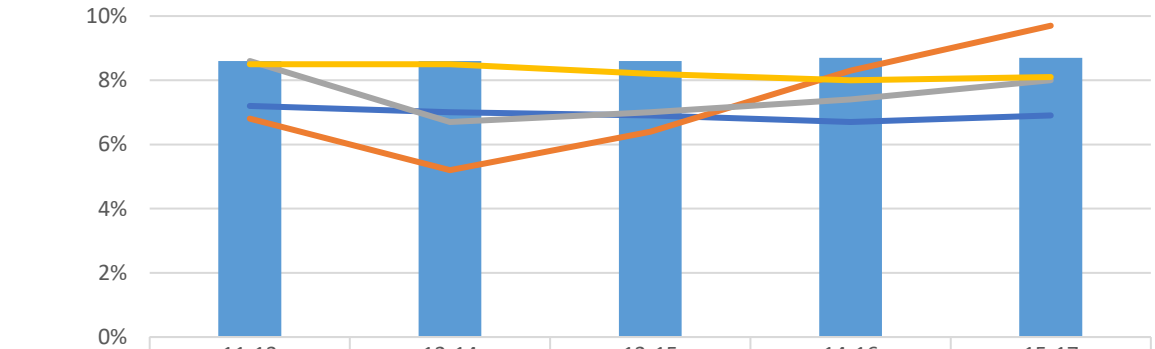
[151] The terms "Hispanic" and "Latino" are used interchangeably by the U.S. Census Bureau to refer to persons of Cuban, Mexican, Puerto Rican, Central and South American, Dominican, Spanish, and other Hispanic descent. Hispanics/Latinos may be of any race.

Figure 7. Number of Births in each County, Rolling Three-year Average



	Collier	Glades	Hendry	Lee
11-13	9,499	207	1,775	19,070
12-14	9,590	194	1,729	19,152
13-15	9,698	204	1,769	19,527
14-16	9,867	205	1,770	19,879
15-17	9,761	206	1,779	20,206

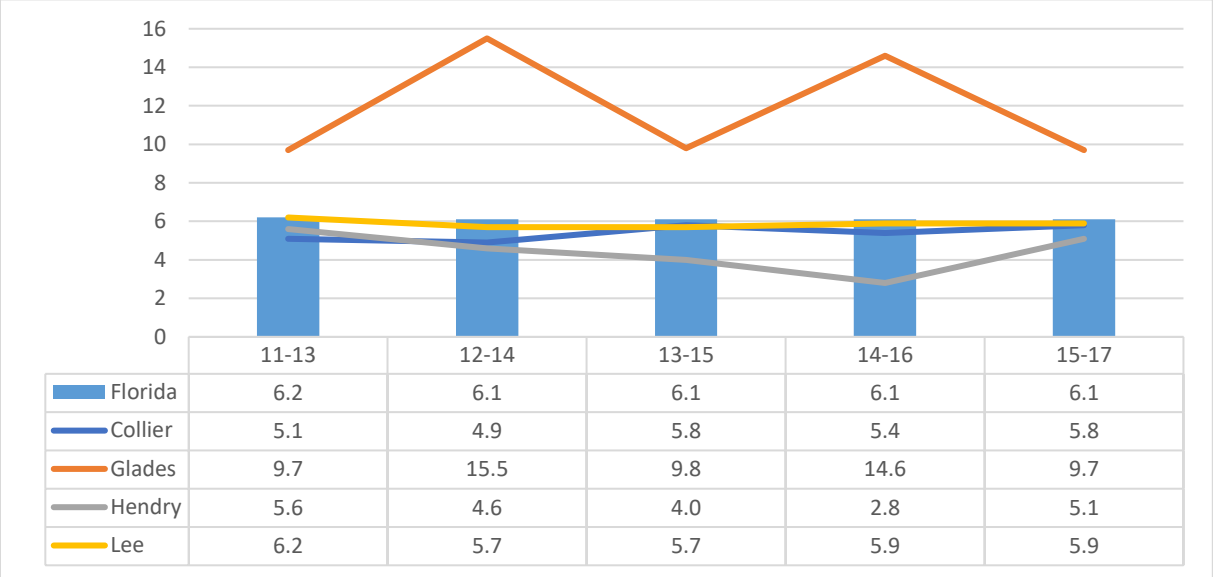
Figure 8. Percentage of Live Births under 2,500 grams, Rolling Three-year Average



	11-13	12-14	13-15	14-16	15-17
Florida	8.6%	8.6%	8.6%	8.7%	8.7%
Collier	7.2%	7.0%	6.9%	6.7%	6.9%
Glades	6.8%	5.2%	6.4%	8.3%	9.7%
Hendry	8.6%	6.7%	7.0%	7.4%	8.0%
Lee	8.5%	8.5%	8.2%	8.0%	8.1%

Source: Florida Department of Health, CHARTS

Figure 9. Infant Death Rate per 1,000 Live Births, Rolling Three-year Average



	11-13	12-14	13-15	14-16	15-17
Florida	6.2	6.1	6.1	6.1	6.1
Collier	5.1	4.9	5.8	5.4	5.8
Glades	9.7	15.5	9.8	14.6	9.7
Hendry	5.6	4.6	4.0	2.8	5.1
Lee	6.2	5.7	5.7	5.9	5.9

Source: Florida Department of Health, CHARTS

Other related programs include:

Nurse-Family Partnership (NFP)

NFP is a free, voluntary program for first-time mothers. Each mother that NFP serves is partnered with a registered nurse early in her pregnancy and receives ongoing home visits that continue through her child's second birthday. NFP is an evidence-based community health program with three decades of research proving that it works.

Healthy Families Florida (HFF)

HFF is funded by the Ounce of Prevention Fund of Florida (a private nonprofit) and is supported by the Florida Department of Children and Families. It is a nationally accredited home visiting program for expectant parents and parents of newborns experiencing stressful life situations. The program seeks to improve childhood outcomes and increase family self-sufficiency through parent education and community support. It is a voluntary program.[152]

[152] www.healthyfamiliesfla.org

Help Me Grow.

The Help Me Grow program of Healthy Start promotes early identification of developmental, behavioral or educational concerns. It provides:

- Development and behavioral screenings;
- Information and resources;
- Referrals;
- Enrollment assistance; and
- Networking opportunities for families and other stakeholders.

Connect

This is a new service being provided in Lee County. It is intended to eliminate duplication of services with respect to in-home parenting programs. This does not take the place of the screens that are conducted at the Obstetrician's office or hospital.

Clients (self-referrals or agency referrals) can refer directly to the number provided in the Connect flier. When clients call the number, a Connect Intake Advisor will review their information and circumstances and will decide which of the several in-home parenting programs (Healthy Start, Nurse Family Partnership or Healthy Families) will best fit their needs.

Drug Exposed Newborn Task Force

Because of the high number of babies exposed to drugs, a Drug Exposed Newborn Task Force in Lee County has been established. Its focus is to seek solutions and identify strategies to address this vulnerable population.

School Readiness and Preschool Programs

Significant emphasis and public investment have been placed on preschool programs. There is a range of research that indicates the investment in early childhood development programs results in long-term economic and social benefits for the children themselves as well as society at large.[153] A 2005 Rand study found a return on investment ranging from $1.80 to $17.07 for every dollar invested in an early childhood

[153] Marlowe, H. & Arrington, L. 2009. The economic impact of investments in programs for children and youth. Report to Collier County.

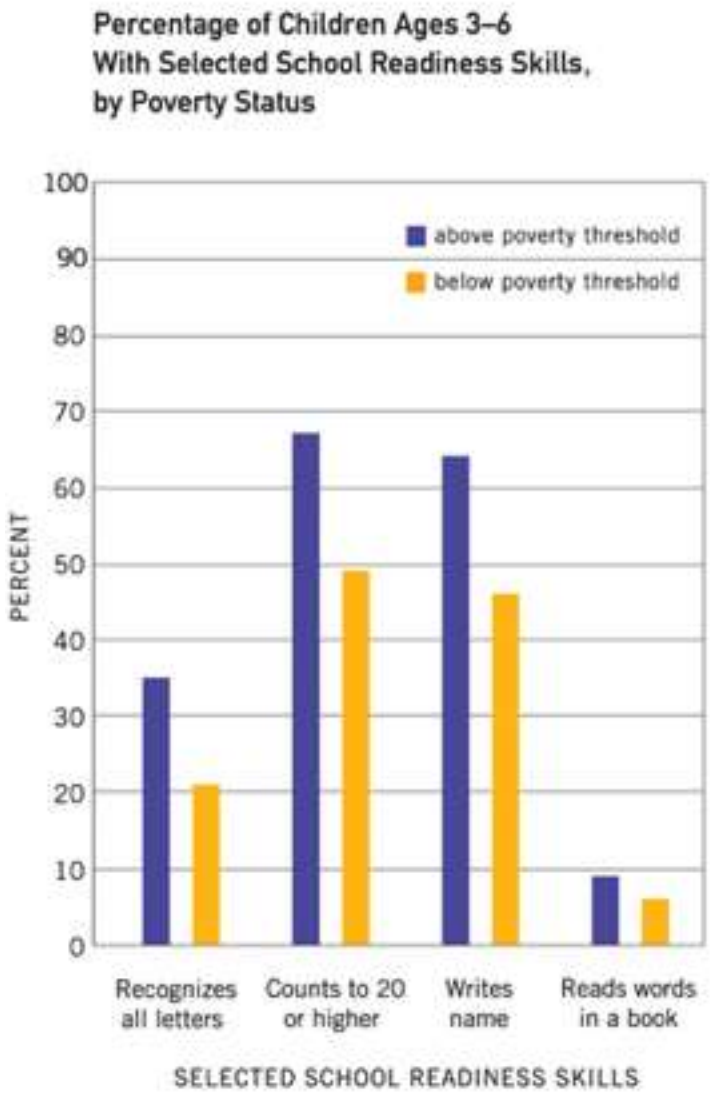
intervention.[154] The $1.80 pole consists of basic childhood education programs that would be found in any quality program. The $17.07 pole consists of highly enriched programs that offer a range of activities and options provided consistently through a long period of time.

As with all research however, there are mixed findings and substantive questions of research design and data interpretation regarding the impact of preschool. Major longitudinal (long-term, multiple-observation) studies of the Perry Preschool Project and the Abecedarian Project criticized those highly regarded and heavily studied preschool programs as unrealistically costly as well as dated.[155] A comprehensive meta-analysis of preschool studies found that participants gained about a 1/3 of a year of school.[156] Another study found a gain of a half-year to a full-year.[157] Other studies have raised concerns about the return on investment. The U.S. Department of Health and Human Services found that third-graders who participated in Head Start as 3- and 4-year-olds showed no clear benefits in cognitive or social-emotional development when compared with students who didn't attend Head Start.[158] In contrast to this conclusion, other researchers have found longer-term benefits of Head Start that include more years of schooling, higher earnings and better health.[159]

Recognizing the possible limitations of the preschool programming, there has been an emphasis on the ages of 0 to 8, along with a schooling emphasis on ages 3 to 8. This is due, in part, to a recognition that there is a school-readiness gap separating disadvantaged children from their more affluent peers. With the first 18 months, low-income children begin to fall behind in vocabulary development and other skills critical to school success.[160] Figure 10 provides examples of this pattern.

[154] www.rand.org/publishedresearch/researchbriefs/provenbenefitsofearlychildhoodinterventions.
[155] Weir, K. 2014. The preschool puzzle. Monitor on Psychology, 45(5) 41
[156] Duncan, G, 2013. Investing in preschool programs. Journal of Economic Perspectives, 27(2): 109-132.
[157] Yoshikawa, H. 2013. Investing in our future: The evidence based on preschool education. Society for Research in Child Development.
[158] Weir, op.cit.
[159] Yoshikawa, op.cit.
[160] www.gradelevelreading.net/3rdgradereadingsuccessmatters

Figure 10. Percentage of Children Ages 3-6 with Selected School Readiness Skills by Poverty Status



Source: O'Donnell, Kevin. Parents' Reports of the School Readiness of Young Children from the National Household Education Surveys Program of 2007, Table 2. National Center for Education Statistics. August 2008. www.childtrendsdatabank.org/?q=node/291

Other data points that illustrate this gap are:[161]

- 61% of low-income children have no children's books at home.
- By age 2, poor children are already behind their peers in listening, counting and other skills essential to literacy.
- A child's vocabulary as early as age 3 can predict third-grade reading achievement.
- By age 5, a typical middle-class child recognizes 22 letters of the alphabet, compared to 9 for a child from a low-income family.

Why Success by Age 8 Matters

The reason age 8 is so significant is that it has been determined that children who are not proficient in reading when finishing the third-grade are more likely to enter the "drop-out of school" track.[162] Students' reading skill level by third-grade (e.g., proficient, basic, or below basic) affects their likelihood of graduating from high school. Twenty-three percent of students with below-basic reading skill levels dropped out or failed to finish high school on time, compared with 9% of students with basic skill levels and 4% of students with proficient reading skills.[163] The impacts of dropping out of school are discussed under the public-school system section.

Why the Quality of Early Childhood Education is Critical for Future Success.

Early Childhood Education is defined as covering the ages of 0 to 8. While preschool is encompassed, numerous studies have indicated the importance of a continued emphasis through age 8, particularly for at-risk children.

Neuroplasticity and epigenesis are two major cornerstones in understanding child brain development. Parents play a significant role in brain development, and some parenting styles have been found to be better than others.[164]

[161] ibid
[162] Early Warning: Why Reading at 3rd grade matters. Annie E. Casey Foundation
[163] Hernandez DJ. Double jeopardy: how third-grade reading skills and poverty influence high school graduation. New York: The Annie E. Casey Foundation; 2011
[164] Impact of Parenting Practices on Adolescent Achievement: Authoritative Parenting, School Involvement, and Encouragement to Succeed. By Laurence Steinberg, Susie D. Lamborn, Sanford M. Dornbusch, Nancy Darling, 1992

In addition to programs that provide parental education, early childhood education is also important to a child's cognitive growth. Quality preschools have been shown to benefit children's' development in the long term.[165] Early childhood education increases a child's cognitive development, reduces grade retention and improves behavior during elementary years.[166] Studies have found that when these students grow up, they tend to be involved less in delinquency and are more likely to have a skilled job.[167]

As an example of studies that examine the longer-term impacts of quality early childhood education, the following is quoted:

> "Researchers led by Arthur Reynolds, Ph.D., at the University of Minnesota, Minneapolis, followed the 30-year progress of 989 children who attended the Child-Parent Centers (CPC) program in inner-city Chicago as preschoolers.
>
> "This study suggests that a high-quality, early childhood intervention program, especially one that extends through third grade, can have benefits well into adult life," said James A. Griffin, Ph.D., deputy chief of the Child Development Branch at the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD).
>
> The CPC program provides intensive instruction in reading and math, combined with frequent educational field trips, from pre-kindergarten through third grade. The program also provides parents with job and parenting skills training, educational classes and social services. In addition, the program encouraged parents to volunteer in classrooms, assist with field trips and participate in parenting support groups.
>
> Researchers compared the educational outcomes of graduates from 20 CPC schools to those of 550 children from low-income families who attended five other early randomly selected schools in the Chicago area with childhood intervention programs. The researchers collected information on the children

[165] Early Child Care and Children's Development Prior to School Entry: Results from the NICHD Study of Early Child Care. *American Educational Research Journal*. March 2002:133-164. doi:10.3102/00028312039001133
[166] Barnett WS. Long-Term Effects of Early Childhood Programs on Cognitive and School Outcomes. *The Future of Children*. 1995:25. doi:10.2307/1602366
[167] Barnett WS. Preschool education and its lasting effects: Research and policy implications. *Boulder and Tempe: Education and the Public Interest Center & Education Policy Research Unit*. 2008

from administrative records, schools and families, from birth through 35 years of age.

On average, graduates of the CPC program—whether they took part in preschool only or attended until second or third grade—completed more years of education than those who participated in other early intervention programs.

Among those receiving an intervention in preschool, children in the CPC group were more likely as adults to achieve an associate's degree or higher (15.7% vs. 10.7%), including a bachelor's degree (11% vs. 7.8%) and master's degree (4.2% vs. 1.5%).

CPC graduates who attended the program through second or third grade had even higher educational gains than their counterparts: associate's degree or higher (18.5% vs. 12.5%), including a bachelor's degree (14.3% vs. 8.2%) and master's degree (5.9% vs. 2.3%).

The authors wrote that, to their knowledge, their study is the first to follow participants past age 25, a time in life when many people attain advanced degrees. Their previous research has shown that CPC graduates have gone on to have higher incomes, lower rates of serious crime and incarceration and lower rates of depression, compared to those who participated in other early interventions.

The authors added that successful early childhood programs can also improve adult health. They noted that adults with less education are more likely to adopt unhealthy habits like smoking and to experience high blood pressure, obesity and mental health problems[168].

What is Quality Early Childhood Education?

Quality always has an "eye of the beholder" dimension to it. However, for public investments to be made, the term must be defined beyond consumer perception.

[168] Reynolds, A.J., et al. A multicomponent, preschool to third grade preventive intervention and educational attainment at 35 years of age. *JAMA Pediatrics*. Doi:110.1001/jamapediatrics.2017.4673

The following are elements of high-quality, early childhood education programs as indicated by research and professional standards.[169] These include:

- Early learning standards and curricula that address the whole child, are developmentally appropriate, and are effectively implemented;
- Assessments that consider the children's academic, social-emotional, and physical progress and contribute to instructional and program planning;
- Well-prepared teachers who provide engaging interactions and classroom environments that support learning;
- Ongoing support for teachers, including coaching and mentoring;
- Support for English learners and students with special needs;
- Meaningful family engagement;
- Sufficient learning time;
- Small class sizes with low student-teacher ratios;
- Program assessments that measure structural quality and classroom interactions; and
- A well-implemented state quality rating and improvement system.

[169] Wechsler, M. et.al. 2016 The building blocks of high-quality early childhood education programs. www.learningpolicyinstitute.org

The Public-School System

While not an element of this gap analysis, the presence of the public-school system should be acknowledged. In addition to the educational elements, public schools are a major source of food security and nutrition, child and youth socialization and recreation and health education and services. Success in school is highly correlated with future life success, and failure to complete high school has several negative features as described below.

There are many factors involved in the decision to drop out of school. These include:

- Students whose parents are not involved are more likely to drop out of school.[170]
- Drop-out rates are higher in schools with safety and violence issues.[171]
- Sixth-graders who exhibit high aggression scores and low-study skills have a 50% drop-out rate compared with sixth-graders with low-aggression scores and high study skills who have a drop-out rate of less than 2%. [172]

Dropping out of school has a negative impact for both the student who drops out and for society. The key points are:

- Half of Americans on public assistance are dropouts. A Northeastern University study found that each high school dropout costs taxpayers $292,000 through the course of his or her life.[173]

- Lifetime earnings of high school dropouts are $260,000 less than peers who earn a diploma.[174] Table 53 shows the unemployment rates and weekly income differences for people age 25 or older who are working full time.

[170] Jaynes, WH. The relationship between parental involvement and urban secondary school student academic achievement. Urban Educ. 2007; 42(1):82–110.
[171] Bekhuis, T. Unsafe public schools and the risk of dropping out: a longitudinal study of adolescents. Paper presented at the annual meeting of the Eastern Psychological Association; 1995; Boston (MA).
[172] Orpinas, P. 2018. Longitudinal examination of aggression and study skills from middle to high school. Journal of School Health. 83(30 246
[173] graduationalliance.com
[174] graduationalliance.com

Table 53. 2018 Unemployment and Income by Education Level[175]

Education Status	Unemployment Rate	Weekly Median Income
Bachelor's Degree	2.8	$1,198
High School Diploma	4.1	$730
Less than High School Diploma	5.6	$553

- In some areas and at some times he unemployment rate for dropouts has been 4% higher than the national average.[176]
- Each year's class of dropouts will cost the country more than $200 billion during their lifetimes in lost earnings and unrealized tax revenue.[177]
- The estimated tax revenue loss from every male between the ages of 25 and 34 who did not complete high school would be approximately $944 billion, with cost increases due to public welfare and crime at $24 billion.[178]
- Students from low-income families have a dropout rate of 10%; middle-income families have a dropout rate of 5.2%; and the high-income family dropout rate is 1.6%.
- High school dropouts are more likely to have higher rates of heart disease, diabetes, asthma and high blood pressures than high school graduates.[179] They are more likely to die prematurely.[180]
- Dropouts have a higher rate of poverty (27%) when compared with high school graduates (14%) and college graduates (5%).[181]

[175] U.S. Bureau of Labor Statistics
[176] graduationalliance.com
[177] Catterall, J. S. (1985). *On the social costs of dropping out of schools.* (Report No. 86-SEPT-3). Stanford, CA: Stanford University, Center for Educational Research.
[178] Thorstensen, B. I. *If you build it, they will come: Investing in public education* (PowerPoint Presentation). Retrieved January 12, 2004. Available:http://abec.unm.edu/resources/gallery/present/invest_in_ed.pdf
[179] Vaughn, M, et.al. 2014. Dropping out of school and chronic disease in the United States. Z Gesundh Wiss 22(3): 265-27
[180] DeBaum, B. et.al. 2013. Well and Well-Off: Decreasing Medicaid and Health-Care costs by increasing educational attainment. http://alt4ed.org.
[181] 2012-2016 American Community Survey 5 Year Estimates. U.S. Census Bureau

- High school graduates are less likely to engage in criminal behavior or require social services.[182]
- The good news is that the national graduation rate for 2016 was 84.1%, an all-time high.[183]

Other Elements of the System of Services and Programs Addressing Early Childhood Care and Education

There are several components that address the years of early childhood in which educational opportunities could occur. With overlap among these, they include:

- Unlicensed Care – informal. These services are provided in a home for children from a single family.
- Unlicensed Care – family. These serve a group of non-related children.
- Unlicensed Care – religious, summer camps, nonprofit membership organizations and hotel-care organizations are exempt from licensing requirements.
- Registered Family Daycare. Registered settings must meet minimal standards including annual health and safety checks, personnel background checks and staff training in literacy and language development. There are staffing ratio requirements.
- Licensed family daycare. These facilities must meet the registered standards plus CPR/First Aid Training and provision of accommodations for special needs children. There are also staffing ratio requirements.
- Licensed Child-care Centers. These are facilities licensed by the Florida Department of Child and Family Services to ensure a healthy and safe environment along with proper staffing. They are not required to be staffed by credentialed teachers or

[182] Sum, A. et al. (2009). The Consequences of Dropping Out of High School: Joblessness and Jailing for High School Dropouts and the High Costs for Taxpayer. Boston, MA: Center for Labor Market Studies
[183] U.S. Department of Education, National Center for Education Statistics (NCES) through Public high school 4–year adjusted cohort graduation rate (ACGR), by race/ethnicity and selected demographics for the United States, the 50 states, and the District of Columbia: School year 2014–15. Retrieved from: https://nces.ed.gov/ccd/tables/ACGR_RE_and_characteristics_2014-15.asp.

assistants but are required to have staff with 40 hours of child-care training. The age of children in a care center can range from weeks to 12 years.

Some daycares primarily provide a child-watching service while others seek to add support for healthy development as a basis for school readiness.

- Preschools. Preschools serve children ages 2 to 4. The curriculum in preschools can range from no curriculum at all (the children play and socialize the whole time) to teaching young children how to read. Most preschools are a mixture of play and learning.

- Early Head Start. This is a program for infants, toddlers and pregnant women. Early Head start occurs in three settings:
  - Center based;
  - Early child-care partnership, licensed family daycare home; and
  - Great Kids, Great Start, weekly home visits and twice monthly groups.

- Head Start. Head Start is funded by the federal government and is available free of charge to low-income families who have 3- to 5-year-old children. It follows a federally mandated curriculum with the goal of preparing at-risk children to succeed in kindergarten.

- School Readiness Program. This provides financial assistance for income-eligible families for early education and care. It is funded primarily by a federal Child-care and Development Fund Block Grant. The State of Florida Office of Early Learning administer the grant. Eligible children are form 0 to 8 years of age and qualifying family incomes are 200% or less than the federal poverty level.

- Voluntary Pre-Kindergarten (VPK). VPK is a state-funded program for 4-year-olds.

- Early Learning Coalitions. These are nonprofit organizations that manage local child-care and development programs under the oversight of the Florida Office of Early Learning.

- School Readiness. This is a funding source. Using federal funds, the State assists with childcare expenses for eligible families.

Gaps in in the Child and Youth Development System

Healthy Start and other Maternal Health Programs

As noted by the Florida Department of Health, the need for services statewide has continued to outstrip resources.[184] Therefore, some of the State's efforts have been limited. The State has prioritized specific target groups or ZIP codes, and it has identified that across Florida additional program funding is required to cover additional recipients.

A Lee County-focused needs assessment, which was conducted by the local Healthy Start agency, identified access to prenatal care as the priority local gap. [185] Other gaps this need assessment identified were (1) a racial disparity in birth outcomes, (2) increased programming to address the needs of mothers older than 18 without a high school education and (3) births to mothers who were overweight or obese. Additionally, in Lee County there was a need to address infant deaths, births to smoking mothers, births with an inter-pregnancy interval of less than 18 months and births to mothers age 15 to 19.

Consistent with the conclusions of the Florida Department of Health program analyses, the major gap in Lee County as well as the State, is that there are more people eligible for the program than the programs have the capacity to serve.[186]

[184] www.floridahealth.gov
[185] www.healthystartbaby.org . Healthy Start Southwest Florida Needs Assessment. October 2019.
[186] www.floridahealth.gov

Child and Youth Development

There are three gaps in the child and youth development area. One is that the demand for subsidized child-care exceeds funding capacity by as much as 1,025 children as of the most recent count. A second is that the incentives to meet quality childcare standards are inadequate. The third is that the desired level of quality childhood efforts is not being achieved. Each are discussed below.

Subsidized Child-care

The system serving child and youth development has a similar gap between the demand for subsidized childcare in Lee County and the available service. As of November 2019, there is a waitlist for of 1,025 individuals.[187] This is a single waitlist managed by the Early Learning Coalition for licensed child-care. Again, note that any gaps in the public-school system are not addressed.

Potential contributors to this gap include:

- Since 2011, the reimbursement rates for VPK have not been adjusted.[188]
- For this coming year, state funding will be limited to ages 0 to 5. After-school programs will no longer receive state support.[189]

Quality incentives

A second gap in the child and youth development system is that incentives to meet quality standards are inadequate for the effort required.[190] The costs associated with meeting the various programmatic and staffing requirements are not commensurate with the incentives.

Desired quality

The desired quality level of early childhood efforts is not being achieved. The following data supports this conclusion. Table 54 shows that VPK students in Lee

[187] communication, Early Learning Coalition
[188] ibid.
[189] ibid.
[190] ibid.

County fall below the state average on a readiness for kindergarten measure. Table 55 reports data on educational variables. Fifty-eight percent of children age 3 or 4 in the county are not enrolled in a preschool program. If the thesis that quality early childhood education leads to later success exists, then three of the other variables in Table 55 are indicative of low-quality levels. Seventy-three percent of fourth-grade students are not proficient (the top-level rating; others are basic and below basic) in English language arts. Sixty-six percent of eighth-grade students are not proficient in math. Seventeen percent of the students do not graduate on time.

Another indicator of the effectiveness of quality early childhood education is a lesser probability of involvement with the justice system. Table 56 shows Lee County variables on this behavior. As the table shows, youth in Lee County have higher-than-average rates. One must not draw evidence of direct causality from this data, but it does raise the question as to whether higher quality early childhood education efforts could have impacted these numbers.

Table 54. Kindergarten Readiness Scores[191]

District Number	District Name	Number of Test Takers	Number "Ready for Kindergarten" (Scoring 500+ on Star Early Literacy Assessment) *	Percentage "Ready for Kindergarten" (Scoring 500+ on Star Early Literacy Assessment) *
00	FLORIDA	185,252	97,652	53%
36	LEE	6,408	2,539	40%

[191] Fall 2018 FLKRS results by school district. Florida Kindergarten Readiness Screener. http://www.fldoe.org/accountability/assessments/k-12-student-assessment/flkrs/

Table 55. Education

Sources	Data Title	Year	Lee County	State	Comparison to State
Kids Count[192]	3&4-year-old children not enrolled in school	2012-2016	58.6%	49.5%	Worse
		2013-2017	57.8%	49.5%	Worse
Kids Count	4th grade students not proficient in English Language Arts	2019 (Spring)	73%	70%	Within 10%
Kids Count	8th grade students not proficient in math	2019 (Spring)	66%	79%	Better
Kids Count	High school students not graduating on time	2019	17.20%	13.9%	Worse

[192] http://www.floridakidscount.org/

Table 56. Violence Outcomes Regarding Children and Youth

Sources	Data Title	Year	Lee County	State	Comparison to State
Child Health Status[193]	Arrests, All Offenses by County, Youth Ages 10-17 Per 100,000 population	2014-16	4,473	4,028	Worse
Child Health Status	Referrals to Department of Juvenile Justice Per 100,000 population	2018	3,784	3,121	Worse
Kids Count[194]	Youth contacts with the juvenile justice system	2017-18	18.2%	16.4%	Worse
Child Health Status	Homicide deaths 5-11 Per 100,000 population	2016-18	0	.7	N/A
Child Health Status	Homicide deaths 12-18 Per 100,000 population	2016-18	7.2	5.3	Worse
Child Health Status	Homicide deaths 19-21 Per 100,000 population	2016-18	19.1	14.9	Worse

Interview and focus groups conducted for this analysis indicated a factor contributing to the quality outcome gap is that prevailing local wage levels make it difficult to attract or retain persons with certificates in Child Development (Child Development Associates), a non-BA credential.

[193] FL Health Charts. Child Health Status Profile, http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.ChildHealthStatusProfile
[194] http://www.floridakidscount.org/

Table 57 shows State-level data on the mean wages of various occupations comparable in education and work experience to child-care workers. Two categories of jobs are compared. One group is classified as "relationship jobs" in which the relationship between the job and the customer is highly personal. The other category is transactional in which the relationship is primarily impersonal and time limited.

As the table indicates, child-care workers have a lower median hourly wage than other jobs which are also primarily relationship in nature. There are several implications of this fact.

One is turnover. The interviews/focus groups raised this as an issue. If the child-care worker and caretaker jobs are compared, there is a 50-cents-an-hour difference that translates to a 5% raise if one goes from child-care worker to caretaker. At this level of wage, a 5% raise is significant. The interviews/focus groups reported that people would leave existing positions for relatively small hourly increases.

The second is quality. Stability is an important variable in almost all jobs, but it is particularly important in relationship-based jobs, even more so for jobs involving children. A different person behind the rental counter is not a significant event. A change in a person with whom you interact daily and have learned to trust is more significant.

Table 57. Median and Mean Hourly Wages for Selected Jobs in Florida[195]

Code	Title	Median Hourly Wage	Average Hourly Wage
Relationship Jobs			
39-9011	Child-Care Worker	10.51	11.34
39-9021	Personal Care Assistant	10.68	11.24
39-2021	Caretaker	11.05	11.91
31-1011	Home Health Aide	11.11	11.67
39-9032	Recreation Worker	11.69	13.23
31-1013	Psychiatric Aide	11.89	12.45
Transactional Jobs			
33-9091	Crossing Guard	11.46	12.13
31.1015	Orderly	11.83	12.76
41-2021	Counter and Rental Clerk	12.54	14.14
43-5021	Courier	13.80	14.58

[195] www.bls.gov. May 2018 Occupational and Wage Estimates, Florida

Poverty as a Risk-Factor for Children and Youth

Researchers agree that there is a clear and established relationship between poverty, socio-economic status and health outcomes—including increased risk for disease and premature death.[196] Residents of impoverished neighborhoods or communities are at increased risk for mental illness,[197] chronic disease,[198] higher mortality and lower life expectancy.[199] They are also at risk for negative academic outcomes and violence[200]

Poverty can negatively affect how the body and mind of the child develop.[201] Children in poverty fall behind their more economically secure peers starting in infancy and widening in toddlerhood.[202] Children in poverty are likely to have poor physical[203] and behavioral health.[204] Children from families that receive welfare assistance are three times more likely to use welfare benefits when they become adults than children from families who do not receive welfare.[205]

[196] Singh GK, Siahpush M. Widening socioeconomic inequalities in US life expectancy, 1980–2000. International Journal of Epidemiology. 2006;35(4):969-979
[197] Caughy MO, O'Campo PJ, Muntaner C. When being alone might be better: Neighborhood poverty, social capital, and child mental health. Social Science & Medicine. 2003; 57(2):227-237.
[198] Braveman PA, Cubbin C, Egerter S, Williams DR, Pamuk E. Socioeconomic disparities in health in the United States: What the patterns tell us. Am J Public Health. 2010; 100(S1): S188-S196.
[199] Mode NA, Evans MK, Zonderman AB. Race, neighborhood economic status, income inequality and mortality. PLoS ONE. 2016; 12; 11(5):1-14. doi: 10.1371/journal.pone.0154535
[200] Sharkey, P. et.al. 2012. The effect of local violence on children's attention and impulse control. Am J Public Health. 2012 Dec; 102(12):2287-93. doi: 10.2105/AJPH.2012.300789. Epub 2012 Oct 18
[201] Early experiences can alter gene expression and affect long-term development. 2010. The National Scientific Council on the Developing Child. Working paper #10. Retrieved from www.developingthechild.harvard.edu.
[202] Halle, T. et.al. 2009. Disparities in early learning and development: Lessons from the Early Childhood Longitudinal Study. Child Trends. www.childtrends.org
[203] MLaughlin, K. et.al. 2012. Food insecurity and mental disorders in a national sample of U.S. Adolescents. J Am Acad Child Adolesc Psychiatry. 2012 Dec; 51(12):1293-303. doi: 10.1016/j.jaac.2012.09.009. Epub 2012 Nov 6.
[204] Jordan, R. et.al. 2013. HOST Youth: The challenges of growing up on low-income housing. Urban Institute. www.urban.org
[205] Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Title I, 104th Cong., 2nd Sess. (1997). Available from: https://www.gpo.gov/fdsys/pkg/BILLS-104hr3734enr/pdf/BILLS-104hr3734enr.pdf

Definition of Poverty

The official measure of poverty was established by the Office of Management and Budget (OMB) in Statistical Policy Directive 14 and is designed to be used by federal agencies in their statistical work.

Official poverty data comes from the Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC), formerly called the Annual Demographic Supplement or simply the "March Supplement."

Government-aid programs are not required to use the official poverty measure as eligibility criteria. Each aid program may define eligibility differently. Many government-aid programs use either a different poverty measure, the Department of Health and Human Services (HHS) poverty guidelines, or variants thereof.

How the Census Bureau Measures Poverty

Following the Office of Management and Budget's (OMB) Statistical Policy Directive 14, the Census Bureau uses a set of money income thresholds that vary by family size and composition to determine who is in poverty. If a family's total income is less than the family's threshold, then that family and every individual in it is considered in poverty. The official poverty thresholds do not vary geographically, but they are updated for inflation using the Consumer Price Index (CPI-U). The official poverty definition uses money income before taxes and does not include capital gains or noncash benefits including public housing, Medicaid and food stamps.

U.S. Department of Health and Human Services poverty guidelines

The poverty guidelines are the other version of the federal poverty measure. They are issued each year in the Federal *Register* by the Department of Health and Human Services (HHS). The guidelines are a simplification of the poverty thresholds for use for administrative purposes — for instance, to determine financial eligibility for certain federal programs. The *Federal Register* notice of the 2015 poverty guidelines is available.

The poverty guidelines are sometimes loosely referred to as the “federal poverty level” (FPL), however, that phrase is ambiguous and should be avoided, especially in situations

(e.g., legislative or administrative) in which precision is important. Table 58 shows the guidelines.

Table 58. 2015 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

PERSONS IN FAMILY/HOUSEHOLD	POVERTY GUIDELINE
For families/households with more than 8 persons, add $4,160 for each additional person.	
1	$11,770
2	$15,930
3	$20,090
4	$24,250
5	$28,410
6	$32,570
7	$36,730
8	$40,890

Children in Poverty is Created Using Statistical Modeling

Data comes from the Small Area Income and Poverty Estimates program, which uses data from the American Community Survey. Estimates are produced using complex statistical modeling. Model usage allows for the generation of more stable estimates for places with small populations or survey counts.

Child Poverty in Lee County

Table 59 reports on child poverty in Lee County. The most recent data, 2017, indicates that child poverty (defined as 200% of FPL) is slightly worse than the State average once the 10% range is calculated.

Table 59. Child Poverty in Lee County

Sources	Data Title	Year	Lee County	State	Comparison to State
Community Health Needs Assessment[206]	Children Below 200% FPL	2017	55.9	49.5	Worse
FL Health Charts[207]	Individuals Under 18 Below Poverty Level	2011	21.6	20.9	Within 10% average
		2013	25.4	23.6	Within 10% average
		2015	26.9	24.1	Within 10% average
		2017	24.9	22.3	Within 10% average
FL Health Charts[208]	Families under 100% of poverty with children under age 18	2013-17	19.8	18.2	Within 10% average
Kids Count[209]	Children in Poverty (Census Small Area Income and Poverty Estimates	2017	20.4	20.6	Within 10% average
		2016	22.0	21.3	Within 10% average
		2014	26.1	24.2	Within 10% average

[206] 2017 Community Health Needs Assessment Report; Lee Health and FL Dept. of Health in Lee County
[207] FL Health Charts. Individuals Under 18 Below Poverty Level, http://www.flhealthcharts.com/charts/OtherIndicators/NonVitalIndRateOnlyDataViewer.aspx?cid=0295
[208] FL Health Charts. School-aged Child and Adolescent Profile – 2018 http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.School-agedChildandAdolProfile
[209] https://www.census.gov/programs-surveys/saipe.html

Section Four: Systems of Care

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CHAPTER 14
Behavioral Health

Introduction

Interviews and focus groups, frequently and consistently, identified the general area of behavioral health (mental health/substance abuse/co-occurring disorders) as a service need for both adults and children/youth. This chapter seeks to better define the nature of this gap and the specific gaps that exist within the general field of behavioral health.

The analysis begins with an examination of the behavioral health status of residents of the State. It then turns to a more specific examination of behavioral health status of residents of Lee County. From those analyses, an examination of funding is developed because many service gaps can be traced to funding gaps. This information is then used to identify specific service gaps.

Context and Background

National Trends

This analysis is focused on behavioral health in Lee County. There are national trends, however, which should be noted as they may appear in Lee County. In fact, focus groups have identified some of these trends as present in the County. These national trends include:

Youth mental health is worsening:

- "From 2012 to 2017, the prevalence of past-year Major Depressive Episode (MDE) increased from 8.66% to 13.01% of youth ages 12-17".[210]
- Between 2008 and 2017, the proportion of adolescents who experienced serious psychological distress in the last 30 days increased by 71% and the proportion that seriously considered attempting suicide increased by 47%.[211]

[210] The state of mental health in America, 2020. Pg. 8. Mental Health America
[211] Twenge, J. et.al. 2019. Age, period, and cohort trends in mood disorder indicators and suicide-related outcomes in a nationally representative dataset, 2005-2017. Journal of Abnormal Psychology, 128(3): 185-199.

Suicidal ideation is increasing in young adults:

- There was a statistically significant increase in suicide ideation from 3.77% in 2012 to 4.19% in 2017 for all adults. The highest increase in rates was found in young adults 18-25.[212]

The prevalence of substance abuse, in general, is decreasing:

- Except for marijuana and alcohol use, abuse of other substances has declined or remained flat from 2012 to 2017.[213]

There is an extensive unmet need for treatment:

- 70% of youth with severe MDE (Major Depressive Episode) do not receive treatment.[214]
- 57% of adults with AMI (Any Mental Illness) did not receive any mental health treatment in 2016-17.[215]
- The most commonly reported reason for not receiving treatment was the cost of care.[216]

Accessing care can be difficult because of staffing and insurance issues:

- There is a shortage of behavioral health professionals. The behavioral health workforce shortage is expected to continue with significant shortages of psychiatrists, psychologists, family and marriage counselors, and social workers by 2025.[217]

[212] Piscopo, K. et.al. 2016. Suicidal thoughts and behavior among adults: Results from the 2015 National Survey on Drug Use and Health. NSDUH Data Review.
[213] National Institute on Drug Abuse. 2018. Monitoring the Future Survey: High School and youth trends. DrugFacts.
[214] The state of mental health in America, 2020. Pg. 11, Mental Health America
[215] op. cit. pg. 8
[216] Collins, S. et.al. 2019. Health insurance coverage eight years after the ACA. The Commonwealth Fund.
[217] Health Resources and Services Administration. 2015. National projections of supply and demand for behavioral health practitioners, 2013-2025.

- Two-thirds of primary care physicians cannot obtain mental health services for patients who need them.[218]
- In an experimental test, it was found that only 17% of child psychiatrists would accept a new patient and the wait time was 42.9 days.[219]
- Private insurance companies reimburse at lower rates for behavioral health services.[220]
- Psychiatrists receive lower insurance reimbursements when compared to non-psychiatrist medical doctors providing the same service. For this reason, many will not take insurance, requiring cash payments instead.[221]
- Commercial and Medicare Advantage plans pay mental health providers, in their networks significantly lower rates than what traditional Medicare pays.[222]
- Prior authorization requirements act as a barrier to services by creating an administrative hassle.[223]

Florida Residents: A Behavioral Health Perspective

Whether it is attributed to the generally moderate climate, the ability to be active year-round or some other variable, Florida ranks 12th in the nation on lower prevalence rates of mental health and substance abuse (1 = lowest prevalence rates, 51 = highest prevalence rates).[224] The six indicators comprising this ranking were:

- Adults with Any Mental Illness (AMI)
- Adults with Substance Use Disorder in the Past Year
- Adults with Serious Thoughts of Suicide
- Youth with At Least One Major Depressive Episode (MDE) in the Past Year
- Youth with Substance Abuse Disorder in the Past Year
- Youth with Severe MDE

[218] Cunningham, P. Beyond parity: primary care physicians' perspective on access to mental health care. Health Aff (Millwood) 2009. 28(3), 490-501.
[219] Cama, S. et.al. 2017. Availability of outpatient mental health care by pediatricians and child psychiatrists in five U.S. cities. International Journal of Health Services. 47(4): 621-635.
[220] Millman, 2017
[221] Mark, T., et.al. 2017. Differential reimbursement of psychiatric services by psychiatrists and other medical providers. Psychiatric Services. http://doi.org/10.1176/appi.ps.201700271.
[222] Mayer. H. 2019. Commercial plans' lower rates for mental healthcare may reduce patient access. Modern Healthcare. February 5th, 2019.
[223] Funkenstein, A. et.al. 2013. Insurance prior authorization approval does not substantially lengthen the emergency department length of stay for patients with psychiatric conditions. 61(5): 596-597
[224] The state of mental health in America, 2020. Mental Health America.

These analyses used the US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration's (SAMSHA) National Survey of Drug Use and Health (NSDUH) and the CDC's Behavioral Risk Factor Surveillance System (BRFSS). As with any survey, limitations exist. These are noted in the Mental Health America report from which this data is selected.

From other perspectives, Florida resembles the nation. For example:

- 61.7% of adults with AMI (Any Mental Illness) did not receive treatment.[225]
- 65.8% of adolescents ages 12 to 17 with a Major Depressive Episode (MDE) did not receive treatment.[226]
- Major Depressive Episodes (MDE) among 12- to 17-year-olds increased from 8.1% in 2011 to 11.9% in 2014.[227]
- According to 2016 data on deaths, suicide counts are higher than homicides in 62 of Florida's 67 counties.[228] In Lee County, there were 113 suicides and 46 homicides.

Lee County Residents: A Behavioral Health Perspective.

For the most part, as Table 60 shows, the rates of various behavioral health indicators for Lee County mirror Florida. However, there are some exceptions worth noting.

- On an overall health behaviors index, Lee County is ranked ninth in the State (one being best).[229]
- Alcohol use by minors is above the State average on several indicators.[230]
- The number of unhealthy mental health days within the past 30 days is below the State average.[231]
- Suicide among the 19- to 21-age group is higher than the State average.[232]

[225] Facts about Mental Health in Florida. 2018. Florida Behavioral Health Association.
[226] Behavioral Health Barometer, Florida, V4. SAMSHA
[227] ibid.
[228] Facts, Op cit.
[229] County Health Rankings
[230] Lee County Drug Free Coalition Needs Assessment, 2019
[231] Healthiest weight profile
[232] Child Health Status

Table 60. Behavioral Health Indicators - Lee County

Total Number of indicators	41	Percentage
Number in which Lee County is above average by 10% or more	10	31.25%
Number in which Lee County is within a 10% average range	9	28.125%
Number in which Lee County is below average by 10% or more	13	40.625%
Number of below average indicators involving alcohol	9	28.125%

In summary, the residents of Lee County face the same behavioral health issues as their fellow Floridians. While there is local variation among counties, the overall issues they face are the same. The residents of Lee County do not differ in any significant way with respect to mental illness or substance abuse than Floridians overall.

There are two implications of this data. One is that national and state issues in behavioral health are very likely to be relevant to Lee County in some manner. The second is that federal and State funding policy and practice can significantly impact Lee County as it faces many of the same issues that other counties in the state and nation face.

Medicaid

Through SAMSHA and the National Institute on Drug Abuse (NIDA), federal funds are provided for a variety of services, often experimental programs. These are best considered supplemental funding and only marginally affect operational behavioral health delivery.

What is of more significance at the treatment delivery level is Medicaid. Medicaid is the single largest payer for mental health services in the United States. It has been estimated that 48% of Medicaid spending is now spent on behavioral health issues.[233]

Medicaid is a partnership between the federal and state governments in which there is shared responsibility for program design, operations and costs. Each state administers its own Medicaid program according to federal guidelines. The federal government matches state funds, usually ranging from 50% to 76%, with specific exceptions. The public mental health system of Florida is highly dependent upon State and Medicaid funds for it operations. State funding is discussed in the following section.

The problem with Medicaid Funding is that many providers consider the reimbursement rates, often expressed as a percentage of the Medicare rate, inadequate. For example, in Florida the rate for physicians for behavioral health care is 58% of the Medicare rate for that same care.[234] Only three states in the nation provide a lower rate than Florida.[235] Recent analyses show that primary care providers and psychiatrists are among the least likely professionals to accept Medicaid. Only 35% of psychiatrists will accept new patients with Medicaid.[236]

The State of Florida

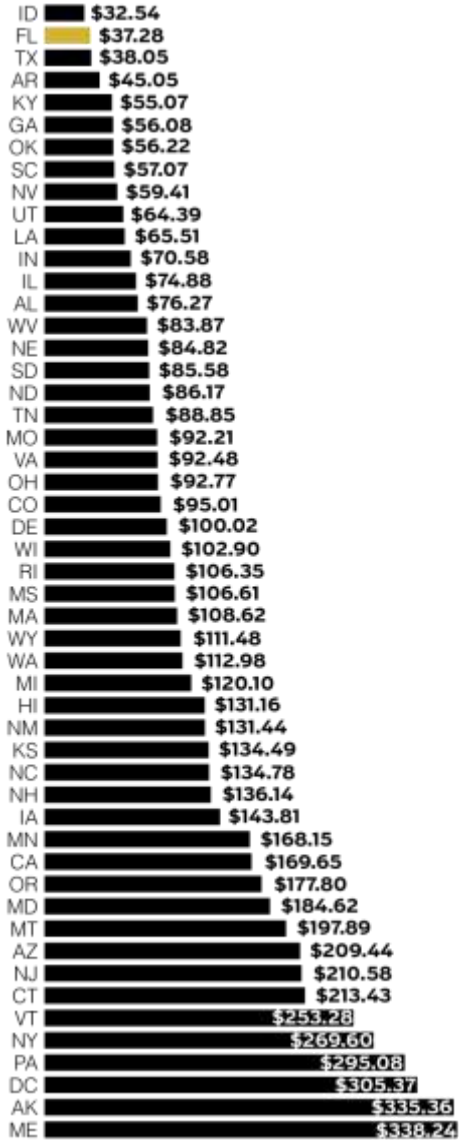
Given the funding formulas for funding behavioral health services in Florida, the status of behavioral health services in Lee County is determined in large part by the State. For this reason, the status of behavioral health services in the State will be examined from four perspectives: per capita funding, absolute funding, behavioral health funding as a percentage of state expenditures, and a prevalence/access formula.

[233] Mandros, A. 2017. Medicaid behavioral carve-outs. www.open-minds.com/market-briefings
[234] Medicaid-to-Medicare fee index. The Henry J. Kaiser Family Foundation. State Health Facts. www.kff.org.
[235] Ibid.
[236] www.macpac.gov/publication/physician-acceptance-of-new-medicaid-patients-new-findings/

The Per Capita Perspective

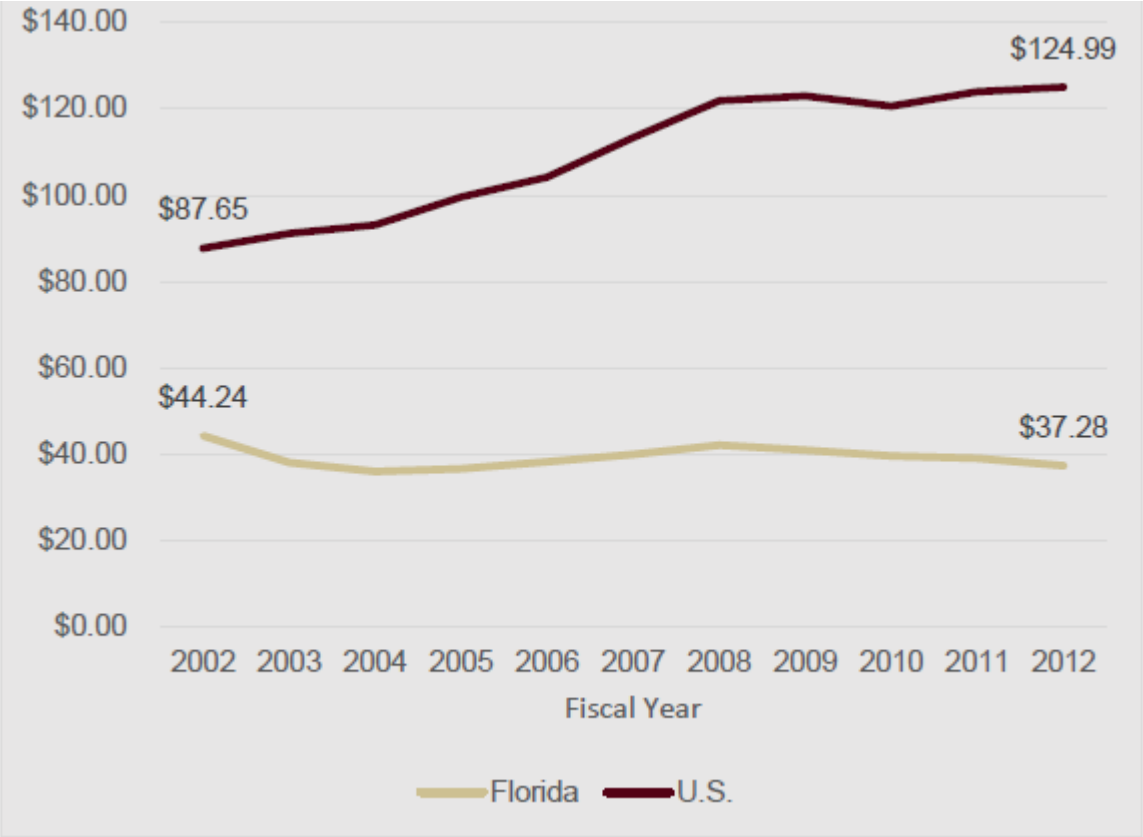
Using per capita expenditures as the metric, depending upon the source, Florida is often ranked somewhere between 48th and 50th in per-capita funding for mental health services.[237] Figure 11 is an example of one calculation reaching this conclusion.[238] Figure 12 shows the trend in per capita funding in Florida.[239]

Figure 11. Florida Per Capita Funding for Mental Health Services Compared to Other States



[237] National Association of State Mental Health Program Directors. www.nasmhpd.org
[238] ibid.
[239] Heeken, K. 2016. Mental health trends in Florida. FSU: Claude Pepper Center.

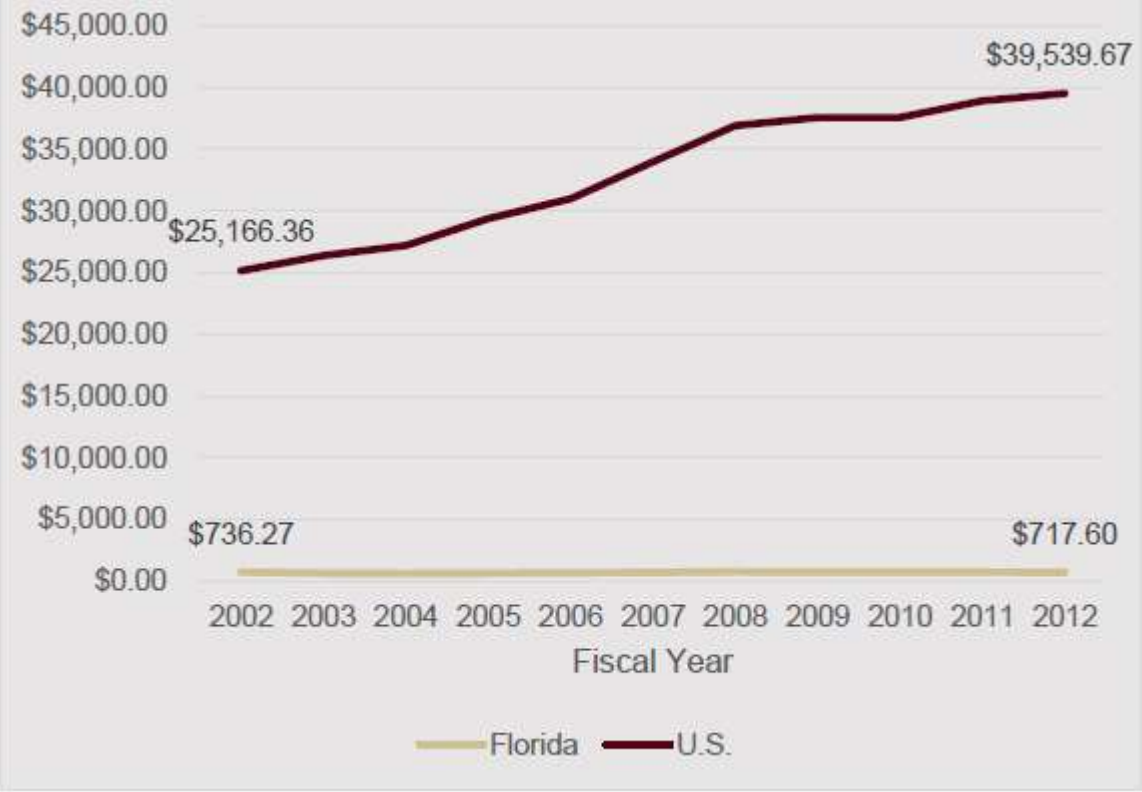
Figure 12. State Mental Health Agencies per Capital Expenditure



Absolute Annual Funding

Another perspective on State funding is to view trends over time. Figure 13 shows funding trends in the State compared to national trends.[240] As the figure shows, Florida's funding is basically static compared to an increase in funding nationally. This table shows an ongoing trend of reductions in State funding for behavioral health services in the context of a rapidly growing population.

Figure 13. Comparison of State of Florida Funding Trends for Behavioral Health Compared to National Trends



State Mental Health Agencies Total Expenditure (in millions)

[240] Keeken, ibid.

Proportion of State Total Funds Expended upon Behavioral Health Services

Another way to compare state expenditures for mental health services is to determine the percentage of the State's budget spent on mental health programs. Using this metric, Florida ranks 41st out of 50 states.[241] Table 61 below shows these rankings.

Table 61. State Rankings: Mental Health Expenditures as a Percentage of Total State Expenditures, Average of FY 2012 and 2013

1	Main 5.6	18	North Carolina 2.4	35	Alabama 1.5
2	Pennsylvania 5.6	19	Iowa 2.3	36	Illinois 1.5
3	Arizona 4.8	20	Washington 2.3	37	Rhode Island 1.4
4	New York 3.9	21	Alaska 2.1	38	South Carolina 1.3
5	New Jersey 3.8	22	New Mexico * 1.9	39	Massachusetts 1.2
6	New Hampshire 3.7	23	Ohio 1.9	40	Texas 1.2
7	Montana 3.5	24	South Dakota 1.9	41	Florida * 1.1
8	Vermont 3.4	25	Tennessee 1.9	42	Wyoming 1.1
9	California 3.2	26	Georgia 1.9	43	North Dakota 1.1
10	Maryland 3.1	27	Indiana 1.8	44	Delaware 1.0
11	Minnesota 3.0	28	Colorado 1.8	45	Louisiana 1.0
12	Connecticut 2.8	29	Virginia 1.7	46	Oklahoma 1.0
13	Nevada 2.7	30	Mississippi 1.7	47	Kentucky 0.9
14	Oregon 2.7	31	Nebraska 1.7	48	Idaho 0.8
15	Kansas 2.6	32	Utah 1.7	49	West Virginia 0.8
16	Michigan 2.6	33	Hawaii 1.6	50	Arkansas 0.7
17	Missouri 2.5	34	Wisconsin 1.5		

*Data available for only one year.

[241] Jaffe, D. & Torrey E. 2017. Funds for treating individuals with mental illness. www.mentalillnesspolicy.org

A Prevalence/Access Formula

Using a more complex ranking tool that combines prevalence and access, Mental Health America (a nonprofit advocacy group) found that Florida is 32nd overall in the nation when prevalence and access factors are combined. Florida is ranked 24th in the nation for adults and 36th for youth in this ranking system.[242] While these are certainly better numbers than the per capita funding rates, Florida still ranks in the lower half of the nation.

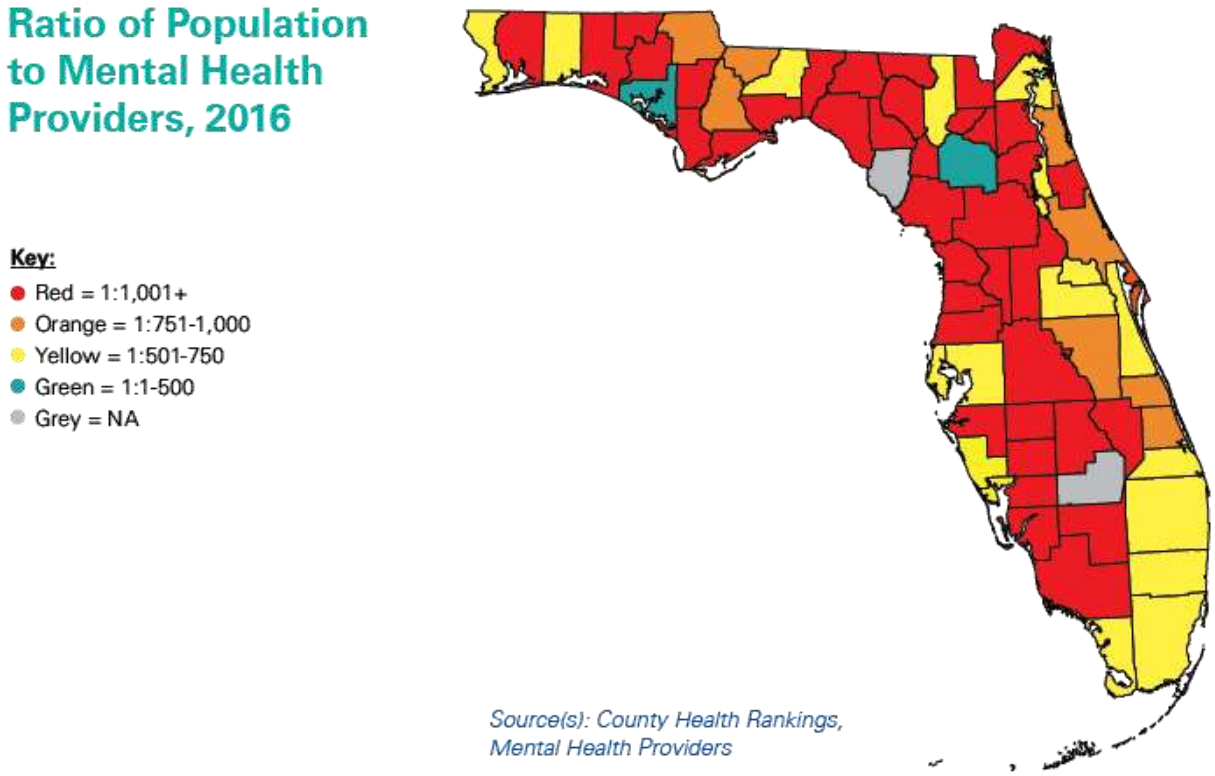
Lee County

These numbers set the context for behavioral health services in Lee County and help explain why it is so widely viewed as a serious gap between need and capacity. In seeking to better understand this gap at the level of Lee County, the following points are relevant:

- Lee County has fewer behavioral health providers than many other areas of the State. There is obviously a relationship between available providers (or the lack thereof) and available services (or the lack thereof). Figure 14 illustrates this gap.[243] This is in a context of a national shortage of mental health professionals. One analysis concluded that in 2017 the United States fulfilled an estimated 33% of its needs for mental health professionals[244]. The behavioral health workforce shortage is expected to continue with significant shortages of psychiatrists, psychologists, family and marriage counselors and social workers by 2025.[245]

[242] The State of Mental Health in America 2020. Mental Health America. www.mhanational.org
[243] County Health Rankings – Mental Health Providers.
[244] Kaiser Family Foundation. 2017. State health data –mental health care health professional shortage areas.
[245] Health Resources and Services Administration. 2015. National projections of supply and demand for behavioral health practitioners, 2013-2025.

Figure 14. Ratio of Population to Mental Health Providers, 2016



- There is high staff turnover at the direct-service work level. This high level of turnover is due to low compensation, challenging work environments and the cost of housing and commuting in Lee County. High staff turnover creates challenges in service delivery and could limit access at times.

- There are inequities in State funding to the detriment of Lee County. These inequities are widely and publically acknowledged.[246] As new or additional State funds are committed to the mental health system, there is an ongoing effort to address these inequities. This effort, however, will take years. Table 62 documents this inequity by judicial circuit. Lee County is the largest county by population in Circuit 20.

[246] Zeitlen, J and Gluck, F. Unequal treatment: Children's mental health dollars vary across state. New-Press, July 24, 2019.

Table 62. Funding Equity

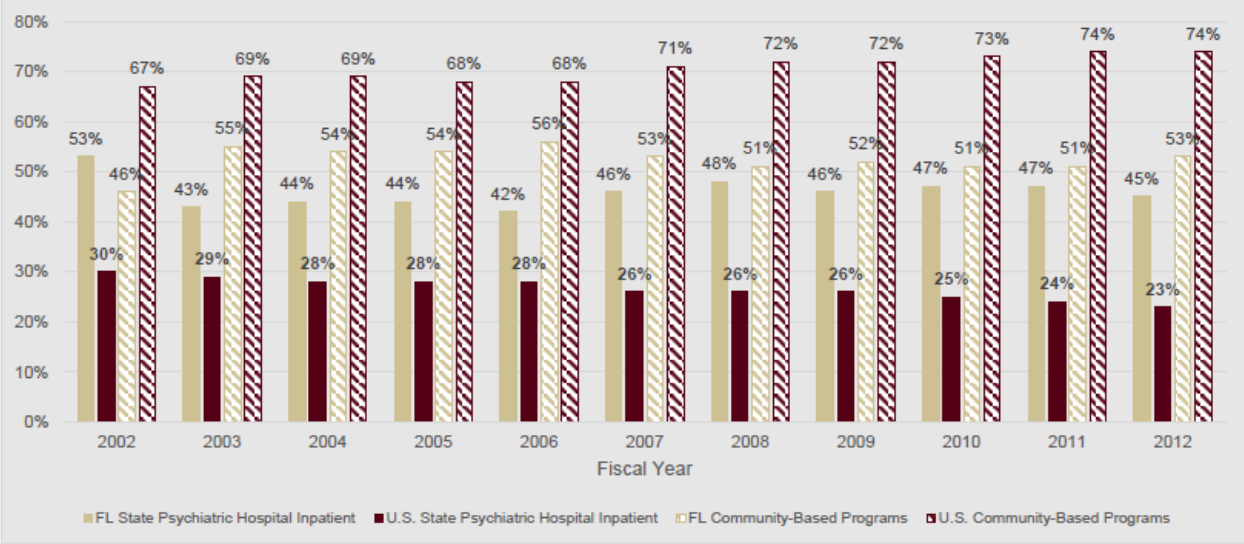
Non-Acute Care	Per person funding
Circuit 6 (Pasco)	$87.45
Circuit 6 (Pinellas)	$93.59
Circuit 10 (Hardee, Highlands and Polk)	$95.35
Circuit 12 (DeSoto, Manatee and Sarasota)	$80.50
Circuit 13 (Hillsborough)	$93.70
Circuit 20 (Charlotte, Collier, Glades, Hendry and Lee)	$65.11

- There is significant seasonality in Lee County's population. Trying to staff for this variation in demand can be operationally challenging. Depending upon the base number selected for use in any per-capita analysis, it can skew the data and mis-represent the resources and needs of the County.

- Compared to other states, Florida spends a greater proportion of its mental health funds on state hospitals and less on community-based care. The implication for Lee County, as it also is for most other counties, is inadequate State funding for community-based services. Figures 15 illustrates this.[247]

[247] Heekin, op.cit.

Figure 15. State Mental Health Agency Expenditures by Type of Program as a Percent of Total Expenditures



- This gap creates two specific costs for communities and their local governments. One is the cost of chronic homelessness in which a substantive proportion of the chronically homeless have behavioral health issues. The second is the cost of local jail services where there are many inmates with behavioral health issues. One recent internal analysis found that 905 of the approximately 1,800 inmates were receiving psychotropic medications. This does not include those who refuse medication.[248]

System-of-Care

The behavioral health system of consists of public and private (for and nonprofit) entities. Private behavioral health services are paid through various forms of insurance or private payments. Public services are funded primarily by the State of Florida with county governments paying a proportionate share of costs and Medicaid also reimbursing eligible expenses.

The system consists of the following components:

[248] Communication from k. Brown, Public Defender, 2019

- The state mental hospitals. These provide clinical services to those individuals for whom community treatment is inappropriate and provide competency restoration services.

- The Central Florida Behavioral Health Network. This is a private entity that manages state mental health funding for a region of the state that includes Lee County. It primarily manages contracts with private entities for various services.

- Community mental health centers. These centers provide in-patient, out-patient and consultative/educational services, including services for indigent people.

- Florida Assertive Community Treatment (FACT) and Community Action (CAT) teams. These outreach teams carry a caseload of individuals who otherwise have a high likelihood of being in residential treatment or jail.

- The Lee County Jail and jail re-entry. Conservatively, 25% of jail inmates are mentally ill to some degree. Another significant percentage of them abuse substances. The jail provides medications and limited interventions.

- Mobile Mental Health Services. These services are intended to assist law enforcement officers when they are dealing with a mentally ill person.

- Various other in-patient or out-patient providers. These private and nonprofit groups provide a variety of services.

Gaps

Given the above points, one would expect various gaps in the provision of behavioral health services. There are a variety of behavioral health interventions that all show some gap between need and capacity. The question, therefore, is one of priority.

Priority Gaps based on the Central Florida Behavioral Health Network Data

In 2019, the managing entity for Lee County, The Central Florida Behavioral Health Network, developed an Enhancement Plan for Fiscal Year 2019/2020 that identifies the priorities for developing additional capacity. These priorities were:

- Short-term Residential Beds

- Expansion of the number of FACT Teams (Florida Assertive Community Treatment)
- Expansion of the funds available to each FACT Team
- Expansion of CAT Teams (Community Action Teams)
- Forensic residential and jail re-entry
- In-home / on-site services and case management services for high need / high utilizing persons
- School-based prevention
- Supportive housing

Priority Gaps – Lee County Drug-Free Coalition Needs Assessment Survey

- Mental health funding
- Additional beds for detox and recovery
- Expansion of evidence-based programs

Gaps Based on Survey

Based on survey feedback conducted specifically for this project, and consistent with the Central Florida Behavioral Network priorities, prevention is another priority.

The Relationship of Housing and Transportation Gaps to Behavioral Health

The cost of housing in the county presents challenges to many people with behavioral health issues. A number are unemployed, while others have sporadic employment. In addition to the challenge of affording housing, the stigma of mental illness, or drug abuse, could bias landlords. Housing can create stress for people that are already challenged. From this perspective, the housing situation may contribute to problematic behavior.

The limitations of the public transportation system mean that it may be difficult to keep appointments, get to work (when employed) in a timely manner, or access other services that are needed. Missed appointments may result in medication gaps and problematic behavior.

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CHAPTER 15
Criminal Justice and Behavioral Health: Sequential Intercepts and System-of-Care Approaches to Analysis

Introduction

Given the significant impact of behavioral health issues on the criminal justice system and the subsequent impact of criminal justice on behavioral health, an analysis of gaps in this system is an important component of a broader Human Services Gap Analysis.

The sequential intercept model was used to conduct this gap analysis. An expert panel[249] was convened to comment on each intercept, identifying true gaps (non-existent programs or services) as well as needs / capacity gaps (the needs exceed capacity).

The Intercepts are:

Intercept 0: Community Services. These are services intended to address the individual in the community before arrest.

Intercept 1: Diversion. This intercept is designed to take arrested individuals to an appropriate facility rather than booking them into jail.

Intercept 2: Screening and Mental Health Classification and Pre-trial Diversion / Intervention. This intercept seeks to ensure an appropriate designation is made and to offer an alternative to further engagement with the criminal justice system.

Intercept 3: Specialty Courts. These are a variety of courts designed to address specific types of problematic behaviors in a non-criminal framework.

Intercept 4: Treatment. These addresses treatment services provided by the jail.

[249] This panel consisted of representatives of Court Administration, Public Defender, Sheriff and State Attorney

Intercept 5: Release, Re-entry, Reintegration, Community Corrections. These are the services designed to help the inmate successfully re-enter the community and avoid recidivism.

After this sequential intercept examination, a system-of-care model will be used to identify any gaps.

The following document is designed to inform the panel as to the scope of the issue, the various practices that are associated with each intercept point, and the elements of a system-of-care approach. Where available, data are provided on the effectiveness of these practices.

Context and Background

Studies estimate that between 7% and 10% of police-citizen encounters involve a mentally ill individuals.[250] Mentally ill individuals not receiving treatment are more likely to have police contact.[251] Officers have been found to be 1.4 to 4.5 times more likely to use force with people with mental health issues than with those without such issues.[252] "Suicide by Cop" is now a recognized term in common use. One study found it accounted for 11% of police shootings.[253] Additionally, there is higher risk of injury to all parties involved.

Nationally, there are more mentally ill people in jails than in hospitals. This is also an accurate statement for Florida as the odds of a mentally ill person being in jail or prison compared to a hospital is 4.9 to 1.[254] In five other states, the odds are higher. Stated another way, Florida has the sixth highest rank nationally when looking at the proportion of mentally ill people being in jail or prison when compared to a mental hospital.

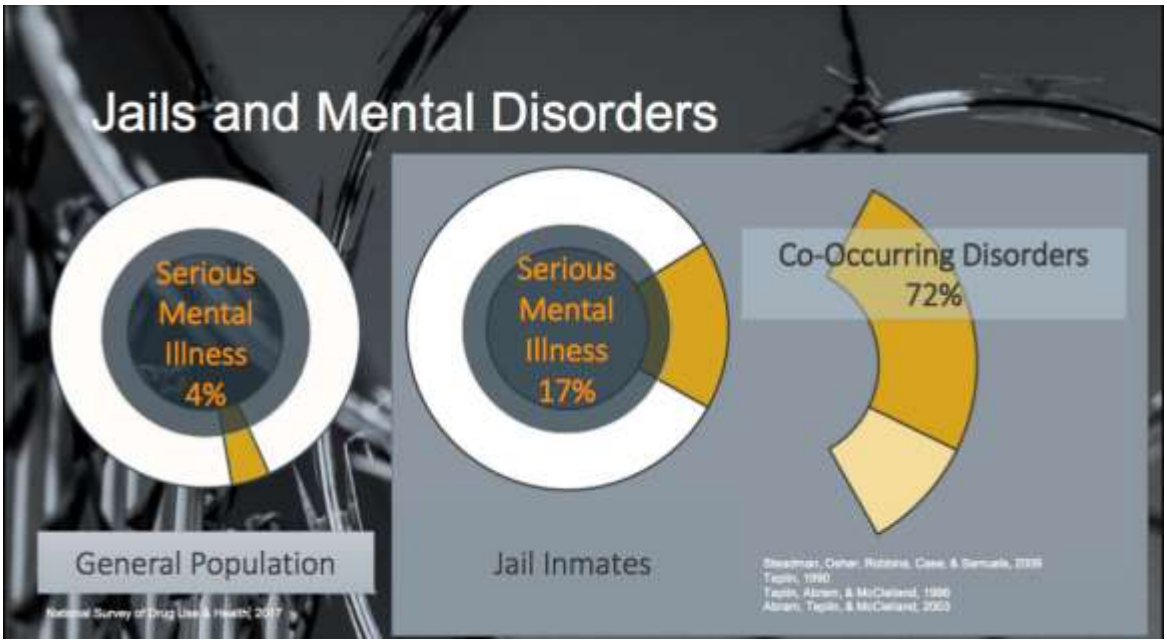
[250] Franz, D. et.al. 2011. Crisis intervention teams may prevent arrests of people with mental illness. Police practice and research. 12(3), 265-272. Deane, M. et.al. 1999. Emerging partnerships between mental health and law enforcement. Psychiatric Services, 50(1), 99-101
[251] Munetz, M. et.al. 2006. Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness. Psychiatric Services, 57(4), 544-549.
[252] Engel, R. et.al. 2001. Policing mentally disordered suspects. Criminology, 39(2), 225-252.
[253] Huston, H., et.al. 1998. Suicide by cop. Annals of Emergency Medicine, 32(6).
[254] More mentally ill persons are in jails and prisons than hospitals. Treatment Advocacy Center Report. http://mentalillnesspolicy.org/ngri/jails-vs-hospitals.html

While dramatic, the above data are from the early 2000s. At that time, Florida was ranked 45th in the nation for mental health spending per capita. Currently, it is ranked between 48th and 50th. Statistically, a strong correlation has been established between the percentages of mentally ill people in jails or prisons and the amount of mental health funding. The lower the funding, the higher the rate of mentally ill people in jail or prison. The probability that jails and prisons in Florida are populated with mental ill people remains high.

Estimates of inmates with serious mental health problems range from 15% for men and 30% for women[255] to 50%[256] to 64%[257], respectively. Counts tend to be based on either use of psychotropic medications or assessment of severe mental illness. These differing approaches to counting lead to wide variations in estimates. Individuals with serious mental illness also are likely to have substance abuse issues. One study found that 72% of seriously mentally ill inmates had a drug or substance abuse problem.[258] Inmates are more likely to have co-occurring mental health and substance abuse issues due to a variety of factors: exposure to violence, various stressors, genetic predispositions and the presence of criminogenic risk factors.[259] Figure 16 provides a graphical display of this data.

[255] Jailing people with mental illness. National Alliance on Mental Health. https://www.nami.org/learn-more/pullic-policy/jailing-people-with-mental-illness.
[256] Most prisoners are mentally ill. The Atlantic, April 7, 2015
[257] Mental health problems of prison and jail inmates. 2006. BJS Special Report. https://www.bjs.gov/content/pub/pdf/mhppji.pdf
[258] Adults with behavioral health needs under correctional supervision. National Institute of Corrections. https://www.bja.gov/Publications/CSG-Behavioral Framework. pdf
[259] Montoya, E., 2018. Accurately identify people in your jail with behavioral health treatment needs. NACO Conference.

Figure 16. Jails and Mental Disorders



The follow-up question is: "What proportion of inmates with a behavioral health issue receive treatment?" Estimates vary from 15% [260] to 17.5% .[261]

- One study concluded that the consequence of these factors is that "county jails have become the de facto mental health care system."[262] In 2014, there were 744,600 inmates in county and city jails. If 20% of them had a serious mental illness, jail inmates with severe psychiatric disease in U.S. jails numbered approximately 149,000 that year. The number has grown since then. [263] As Kaeble notes, "*If the estimated populations of jail and state prison inmates with serious mental illness are combined, there is an estimated population of 383,200 inmates with mental illness. Since there are only approximately 38,000 individuals with serious mental illness remaining in state mental hospitals, this means 10 times more individuals with serious mental illness are in jails*

[260] Fries, B. 2010. Independent study of mental health and substance abuse. Lansing, MI: State of Michigan Department of Corrections. https://www.michigan.gov/documents/corrections/2010
[261] James. D. & Glaze, L. 2006. Mental health problems of prison and jail inmates. Special Report. Bureau of Justice Statistics. https://www.bjs.gov/content/pub/pdf/mhppji.pdf.
[262] As the nation's mental health care system has splintered, county jails are facing unprecedented challenges. Managing Mental Illness in Jails. Police Executive Research Forum. 2018.
[263] Torrey, E.F., Zdanowicz, M.T., Kennard, A.D., Lamb, H.R., Eslinger, D.F., Biasotti, M.I., Fuller, D.A. (2014). The treatment of persons with mental illness in prisons and jails: A state survey. Arlington, VA: Treatment Advocacy Center.

and state prisons than in the remaining state mental hospitals." [264]

- Another factor that contributes to the complexity of this issue is that research studies indicate an association between being exposed to trauma and the perpetration of crime, especially chronic victimization.[265] It has been found that rates of childhood and adult trauma are high among jail inmates and prisoners.[266] Adverse childhood experiences have been found related to child abuse, domestic violence, sexual offenders and stalkers. [267] The rate of posttraumatic stress disorder is higher among the incarcerated population than people living in everyday communities.[268]

Managing Behavioral Health Issues in Jail: The challenges

There are several problems with jails having to manage a high proportion of mentally ill, substance abusers or individuals with co-occurring disorders. These include:[269]

- Jails were not designed as hospitals. Adaptations such as the behavioral-health wing in the Lee County Jail have been made. However, at a purpose level, a jail cannot be a hospital nor can a hospital be a jail.

- It costs more to manage mentally ill people. They are a greater management problem and the risk of violence is increased.[270] They also receive more disciplinary infractions.[271]

[264] Kaeble, D., Glaze, L., Tsoutis, A., Minton, T. (2016). Correctional populations in the United States, 2014. *Bureau of Justice Statistics.*
[265] Jaggi, L. et.al. 2016. The relationship between trauma, arrest and incarceration history among Black Americans. Soc Mental Health 6(3): 187-206
[266] Wolff, N. & Shi, J. 2012. Childhood and adult trauma experiences of incarcerated persons and their relationship to adult behavioral health problems and treatment. Int J Environ Res Public Health. 9(5): 1908-1926.
[267] Reavis, J. et.al. 2013. Adverse childhood experiences and adult criminality. Perm J. 17(2): 44-48.
[268] Campbell, C. A., Albert, I., Jarrett, M., Byrne, M., Roberts, A., Phillip, P., … Valmaggia, L. (2016). Treating multiple incident post-traumatic stress disorder (PTSD) in an inner-city London prison: The need for an evidence base. *Behavioral and Cognitive Psychotherapy, 44,112*-117. doi:/10.1017/S135246581500003X.
[269] More mentally ill, op.cit.
[270] As the nation's, op.cit.
[271] Gibbons, j. et.al. 2006. Confronting confinement. New York: Versa Institute of Justice. https://www.vera.org/publications/confronting-confinement.

- Mentally ill inmates stay longer and are less likely to be released on parole or other forms of discretionary release.[272] A study of the Orange County (Florida) Jail found the average stay for all inmates was 26 days; for mentally ill inmates, it was 51 days.[273] The main reason mentally ill inmates are incarcerated longer than other prisoners is that many find it difficult to understand and follow jail and prison rules. In one study, jail inmates were twice as likely (19% versus 9%) to be charged with facility rule violations. [274] In another study, in Washington State prisons, mentally ill inmates accounted for 41% of infractions even though they constituted only 19% of the prison population.[275]

- The cost of health care is increased.[276] One analysis found that the cost of an inmate with mental health issues was nearly four times the cost of an inmate without mental health needs.[277] A 2007 study of Broward County[278] found that it costs $80 a day to house a regular inmate but $130 a day for an inmate with mental illness. While overall costs have risen since 2007, the ratio remains, due primarily to the costs of psychotropic medications or lawsuits.[279]

- Mentally ill inmates are more likely to commit suicide. It is estimated that as many as half of all suicides are committed by the estimated 15% to 20% of inmates with serious mental illness.[280] This creates demands on staff for suicide watch.

- The re-offending rate for individuals with serious mental illness is higher than the rate among all individuals with criminal histories.[281]

[272] Porporinao, F. et.al. 1992. The prison careers of offenders with mental disorders. Ottawa: Correctional Service of Canada.
[273] Council of State Governments (2002). *Criminal Justice/Mental Health Consensus Project*.
[274] Butterfield, F. (2003, October 22). Study finds hundreds of thousands of inmates mentally ill. *New York Times*.
[275] Fuller, D.A., Sinclair, E., Geller, J., Quanbeck, C., Snook, J. (2016). Going, going, gone: Trends and consequences of eliminating state psychiatric beds, 2016. Arlington, VA: Treatment Advocacy Center.
[276] As the nation's op.cit.
[277] Sheriffs addressing the mental health crisis. 2019. Community Oriented Policing Services, U.S. Department of Justice.
[278] Miller, C.M., Fantz, A. (2007, November 15). Special "psych" jails planned, *Miami Herald*.
[279] Bender, E. (2003). Community treatment more humane, reduces criminal-justice costs, *Psychiatric News, 38*, 28.
[280] Goss, J.R., Peterson, K., Smith, L.W., Kalb, K., Brodey, B.B. (2002). Characteristics of suicide attempts in a large urban jail system with an established suicide prevention program. *Psychiatric Services, 53*, 574–579.
[281] Treat or Repeat: A state survey of serious mental illness. Treatment Advocacy Center. 2017.

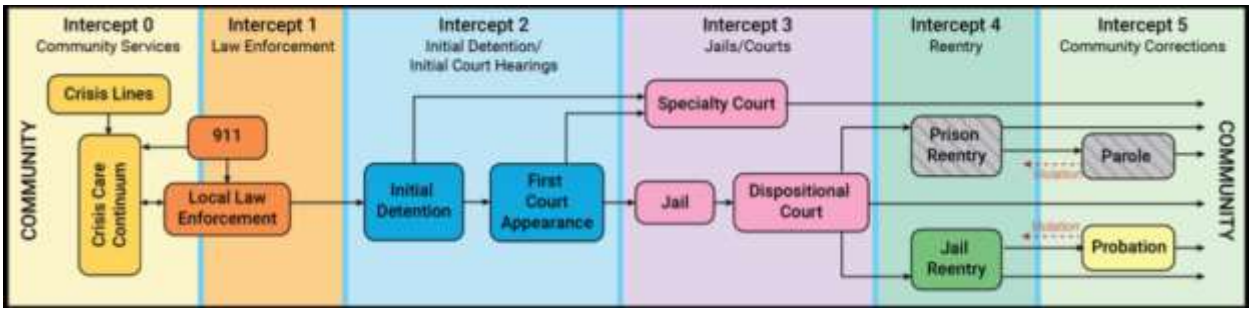
Best Practices – Sequential Intercept Model

Given the individual costs of managing mentally ill people in jail, the inability of a county government to control state funding levels, and the fiscal costs to counties, what is an alternative? The sequential intercept model, described below, offers a framework of best practices. These best practices represent the optimal approaches a local government has available to manage a challenging situation it did not create.

The Sequential Intercept Model

The sequential intercept model consists of six intervention (or intercept) points. Each of them seeks to either divert a mentally ill person from an inappropriate jail admission to some other setting better designed to address their issues, place them in a more appropriate restricted setting, or support them post-release to avoid recidivism. It is shown in Figure 17 below.

Figure 17. The Sequential Intercept Model



Intercept 0: Community Services

These are services intended to address the person in the community prior to arrest. This may take several forms or components. They include:

- Crisis Intervention Teams (CIT). This involves training of police officers in various mental health issues so that they are better prepared to handle situations involving the mentally ill and are better able to distinguish criminal behavior from mental illness. Jurisdictions adopting this approach have seen significant drops in use of

force incidences with people with mental illness.[282] CIT is not considered a proven best practice due to a lack of rigorous evaluation studies.[283] It has been shown to improve officer understanding[284] and competencies and attitudes[285] regarding dealing with mentally ill people. Data shows that CIT training results in reduced arrests in the ranges of 15%[286] to 19%.[287]

- Mental Evaluation Teams (MET), Mental Health Evaluation Teams (MHET) or Psychiatric Emergency Response Teams (PERT). These teams take a variety of forms. Some are teams in which a mental health professional is episodically paired with a deputy for calls when a mentally ill person may be involved. In other cases, the mental health professional rides on patrol. In larger jurisdictions, these may be stand-alone teams that are called in by deputies. The Los Angeles County Sheriff's Department documented several benefits to such teams.[288] These were:
  - On average, 2.7 deputies were relieved at the site, freeing them up to respond to other calls.
  - On average, one patrol sergeant was relieved.
  - There was a significant reduction in use of force. This was estimated to save the county $4.8 million.
  - In addition to this cost savings, there are likely undocumented savings in avoided staff injuries, patient injuries, added hospital costs and civic claims and lawsuits.
  - Nine "Suicide by Cop" situations were avoided.
  - The need to call in off-duty Crisis Negotiation Team personnel was reduced from 100 incidents in 2016 to 27 incidents in 2018, eliminating considerable overtime expenditures.
  - The County's MET team also helped address issues with inmates who had barricaded themselves in cells.

[282] Sherriff's addressing, op.cit
[283] Gatens, A. 2018. Responding to individuals experiencing mental health crisis. www.icjia.state.fl.us
[284] Ellis, H. 2014. Effects of a Crisis Intervention Team (CIT) training program upon police officers before and after CIT training. Archives of Psychiatric Nursing, 28, 10-16.
[285] Compton, M. et.al. 2014. The police-based crisis intervention team (CIT) model: Effect on officers' knowledge, attitudes and skills. Psychiatric Services, 65(4), 517.522.
[286] Vickers, B. 2000. Memphis Tennessee police department's crisis intervention team. Rockville, MD. Bureau of Justice Assistance.
[287] Franz, S. et.al. 2011. Crisis intervention teams may prevent arrests of people with mental illness. Police Practice and Research, 12(3), 265-272.
[288] Los Angeles County Sheriff Department, Annual Report, Mental Evaluation Teams, 2019.

- Developmentally Disabled for Patrol Class. Persons with developmental disabilities, including Autism, also require some specialized knowledge. The Los Angeles County Sheriff's Department developed a special training program as a component of its mental health training to address this need.[289]

- Broad, specialized mental health training (CIT, Mental Health First Aide) for police officers, Fire/EMS first responders, dispatchers, state attorneys, public defenders and others.

Intercept 1: Diversion

This intercept is designed to take arrested individuals to an appropriate facility rather than booking them into jail.

- Drop-off Centers, Mobile Crisis Units, Walk-in Centers. These are voluntary units in which mental health staff can assess and assist people whom law enforcement personnel do not determine to be risks to themselves or others. A major advantage of these centers for law enforcement personnel is that they can quickly return to their duties as the time involved is minimal.[290]
- Crisis Stabilization Units (CSUs). These are restricted units for people who are a risk to self or others.
- Forensic Alternative Center. Section 916.185, F.S. established the Forensic Hospital Diversion Pilot, modeled after the Miami-Dade Forensic Alternative Center (MDFAC). The MDFAC provides competency restoration services and a continuum of care during commitment and after re-entry. The MDFAC has led to the following results:[291]
    - Individuals are ready for discharge from forensic commitment an average of 64 days (43%) sooner than individuals who complete competency restoration services in forensic treatment facilities and spend an average of 32 fewer days (19%) under forensic commitment.
    - Some individuals can receive competency restoration services in the community.

[289] Los Angeles, op.cit.
[290] Sheriff's addressing, op.cit.
[291] wwwfloridasupremecourt.org/pub_info/documents/11-14-2007_Mental_Health_Report.pdf

- The clear majority who remain linked to services through MDFAC demonstrate no additional involvement in the criminal justice system. People who remain linked to MDFAC spent a total of 85 days in jail during a follow-up period. In that same period, people who did not remain linked spent 1,435 days in jail.

Intercept 2: Screening and Mental Health Classification and Pre-trial Diversion / Intervention

Screening. This intercept tool is designed to identify individuals with mental health issues upon their entry into jail. The National Commission on Correctional Health Care (NCCHC) Standards for Health Services in Jail require all people being booked get a screening of their mental health history and needs.[292] The challenge has been the quality of the screenings in terms of accuracy. Early screening efforts were found to miss up to 63% of inmates who had acute mental symptoms.[293] Another problem has been many false positives (i.e. identify persons as having mental health issues who don't).[294] In response to these problems, standardized screening instruments were developed.[295] There are now validated mental health and substance abuse screening tools.[296] However, given the prevalence of co-occurring mental health substance abuse disorders, a mental health screen is complicated. Currently there is no validated "co-occurring screening tool.[297]

Pre-trial Diversion / Intervention. Pre-trial diversion is run by the State Attorney's Office and allows for the dropping of charges in exchange for an agreed upon set of actions by the person facing charges. For this tool to be effectively used with mentally ill people, some factors to consider include:

[292] Sheriff's addressing, op.cit.
[293] Teplin, l. 1990. Detecting disorder: the treatment of mental illness among jail detainees. Journal of Consulting and Clinical Psychology. 58(2), 233-236.
[294] Brooker, C. 2009. Review of service delivery and organizational research focused on prisoners with mental disorders. Journal of Forensic Psychiatry and Psychology. 20, 102-123.
[295] Ford, 2005. Evidence-based enhancement of detection, prevention, and treatment of mental illness in the correctional systems. www.ncjrs.org/pdffiles1/nij/grants/210829.pdf
[296] Montoya, 2018. Op. cit.
[297] Montoya, 2018. Op.cit.

- The use of data-driven risk assessments. Studies have found that less than 10% of jurisdictions use these tools.[298]
- The use of social workers in Public Defender Offices to assist with screening.[299]
- A quick connection to behavioral health services and case management.[300]
- The presence of legal aid attorneys and others to assist with housing, financial assistance, etc.[301]
- Systems in place so that the behavioral health providers can communicate with pre-trial release staff.[302]
- The status of the jail as a "covered entity" under HIPAA or a "federally assisted" program under 42 CFR Part 2.[303]

Intercept 3: Specialty Courts

These are a variety of courts designed to address specific types of problematic behaviors in a non-criminal framework. Among these are drug courts, mental health courts, veteran's courts, dual diagnosis courts and behavioral health courts. They may serve adults, juveniles or both. In some cases, these are called problem-solving courts or therapeutic courts, as they seek to find solutions beyond incarceration.

Adult Mental Health Courts

From four in 1997, the number of mental health courts has grown to more than 300. These courts combine court supervision with community-based treatment in lieu of a jail sentence.

Research studies on Mental Health Courts have various findings. An Urban Institute study found they are modestly effective at reducing recidivism, but it was unclear on whether they had a positive effect on participants' mental health.[304] Others have

[298] Laura and John Arnold Foundation, 2013. Developing a national model for pre-trial risk assessment. www.arnoldfoundation.org/wp-content/uploads,2014/02/LJAF-research-summary_PSA_Court_4_1.pdf
[299] Fader-Towe, H. 2015. Improving responses to people with mental illness at the pretrial stage. The Council of State Governments: Justice Center
[300] ibid.
[301] ibid.
[302] ibid.
[303] ibid.
[304] Kim, K. et.al. 2015. The processing and treatment of mentally ill persons in the criminal justice system. Urban Institute: Research Report

reported larger impacts on recidivism.[305] [306] It has been found that Mental Health Courts are more effective than the traditional court system and jails at connecting participants with treatment.[307] There are potential cost savings due to reduced recidivism and avoided jail and court costs.[308] One conclusion is that Mental Health Courts need to target those with serious mental illness and those who are at the highest risk of further crime.[309] An alternative conclusion is the need to produce more performance data.[310]

Dual Diagnosis Court

Dual diagnosis is a significant issue, as approximately 75% of mentally ill people involved in the criminal justice system also have substance abuse issues.[311] The limited research on the topic of dual diagnosis in drug court found that dual diagnosis significantly increased the odds of serious program failure.[312] A study focusing on the impact of a court diversion effort for dually diagnosed individuals found it to be effective in both reducing recidivism and reducing the number of days incarcerated.[313] Orange County (California) established a dual diagnosis court to address people with both drug addiction and some form of serious mental illness.[314]

[305] Andrews, M. 2015. Mental health courts are popular, but are they effective. NPR, December 16, 2015.
[306] Rossman, S. et.al. 2012. Criminal justice interventions for offenders with mental illness. Urban Institute Research Report.
[307] Almquist, L. et.al. 2009. Mental health courts: A guide to research-informed policy and practice. New York: Council of State Governments Justice Center.
[308] Almquist, op.cit.
[309] Andrews, op.cit.
[310] Waters, N. 2011. Responding to the need for accountability in Mental Health Courts. Future Trends in State Courts. National Center for State Courts.
[311] Peters, R. et.al. 2004. Co-occurring disorders and specialty courts. National Gains Center. www.csgjusticecenter.org
[312] Zettler, H. 2018. The impact of dual diagnosis on Drug Court Failure. International Journal of Offender Therapy and Comparative Criminology. 63 (3), 357-382
[313] Frisman, l. et.al. 2008. Outcomes of court-based jail diversion for people with co-occurring disorders. Journal of Dual Diagnosis, 2(2).
[314] Levitzky, C. 2004. The County's new dual diagnosis court program to celebrate its first graduation. Superior Court of California, County of Orange.

Drug Courts

Drug courts focus on individuals with substance abuse issues, offering them the opportunity to enter drug treatment under court supervision rather than jail. There are more than 4,000 drug courts operating nationwide, including 91 in Florida.[315] Fifty-four of these are adult, 20 are juvenile, 13 are family dependency and four are DUI courts.[316]

Studies of drug courts have found that recidivism can be reduced by 35% to 40%.[317] A Florida analysis found drug court participants were 80% less likely to go to prison.[318] The National Institute of Justice found an average savings of $6,744 per participant.[319]

Juvenile Mental Health Court

These are similar in purpose and design to adult mental health courts with an emphasis on the distinguishing issues of the juvenile population.[320]

Veterans Courts

Veterans courts are designed to assist justice-involved defendants with the complex treatment needs associated with substance abuse, mental health and other issues unique to the traumatic experience of war, including post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI). The first veterans' court was established in Buffalo, NY, in 2008.[321] As of March 2019, there were 31 veterans' courts in Florida[322] and more than 400 nationally.[323]

[315] National Drug Court Database & Map. 2019. National Drug Court Resource Center. www.ndcrc.org.
[316] Drug Courts, 2019. Florida Courts. www.flcourts.org
[317] What are drug courts. 2019. National Drug Court Resource Center. www.ndcrc.org
[318] Drug Courts, 2019. Op.cit.
[319] op.cit.
[320] Cocozza, J. 2006. Juvenile Mental Health Courts: An emerging strategy. National Center for Mental Health and Juvenile Justice.
[321] Veterans Courts. 2018. National Center for State Courts. www.themarshallproject.org.
[322] Veterans Courts, 2019. Florida Courts. www.flcourts.org
[323] Tsai, j. 2018. A national study of veterans' treatment court participants. Administrative policy and Mental Health. 45(2), 236-244.

Studies of veterans' courts have found mixed results. One study found participants who completed the program had lower recidivism rates.[324] Another found improvements in mental health, overall functioning and social connectedness.[325] However, another study found higher rates of new incarcerations, which might have been due to stricter monitoring.[326]

Out-patient Competency Restoration

Research studies have found that out-patient competency restoration produces similar outcomes to inpatient programs at a fraction of the cost and without compromising public safety.[327]

Intercept 4: Treatment

The estimated scope of mental illness in jails ranges greatly. On the low end, about 20% of inmates in jails are estimated to have serious mental illness.[328] Estimates project 14.5% of men and 31% of women in jail have a serious mental illness.[329] On the higher end, it is estimated that 64% of people booked into local jails are diagnosed with, or have a diagnosable mental illness.[330] Seventy-two percent of people in jail with a serious mental illness also have a substance-use disorder.[331] The percentage of jail inmates who are seriously mentally ill are five times higher than the proportion of the general population.[332]

There are seven recommended services in jails. They include:[333]

[324] Hartley, R. et.al. 2016. Waging war on recidivism among justice-involved veterans. Criminal Justice Policy Review. Doi: 10.1177/08874034144562602.
[325] Knudsen, K. 2016. A specialized treatment court for veterans with trauma exposure. Community Mental Health Journal, 52(2), 127-135.
[326] Tsai, J et.al. 2016. Diversion of veterans with criminal justice involvement to treatment courts. Psychiatric Services 68(4), 375-383.
[327] Gowensmith, W. et.al. 2016. Outpatient competency restoration as a promising approach to modern challenges. Psychology, Public Policy and Law, 22 (3)
[328] Serious mental illness prevalence in jails and prisons. 2016. Treatment Advocacy Center
[329] Vera institute of justice. 2016. The burden of mental illness behind bars. www.vera.org.
[330] Jail mental health initiatives. 2019. Harris County Sheriff's Office. www.harriscountycit.org.
[331] Vera op.cit.
[332] Bronson, J. 2017. Indicators of mental health problems reported by prisoners and jail inmates, 2011-12. Bureau of Justice Statistics: Special Report. NCJ250612.
[333] NCCHC Standards for Mental Health Services in Correctional Facilities. 2015

- Intake services – suicide risk, mental health screening, mental health assessment and evaluation
- Treatment – medication, crisis intervention, counseling and psychosocial education
- Discharge planning

The most common form of treatment is prescription medication.[334]

While jails are now the de facto mental hospitals, they are not equipped to provide the services of mental hospitals. A 2011 survey found that half of the surveyed jails had provided little training, and less than half offered treatment.[335] A detailed audit of mental health services in Kansas found that its jails were providing from two to six of the nationally recommended services listed above.[336] Virginia, in a study of its jails, found that 13% of inmates refused psychotropic medications.[337]

The jail systems of the nation are creating responses to this situation. Some of these are listed below as examples of emerging practices.

Community Forensic Residential Facilities

In response to a 2006 forensic bed crisis, the Supreme Court of Florida convened a set of stakeholders to address the issue. The group's report, *Transforming Florida's Mental Health System*,[338] issued several recommendations. One recommendation was to provide community-based residential treatment alternatives to serve individuals that have less serious offenses, do not pose significant safety risks and otherwise would be admitted to State treatment facilities.

[334] Bronson, J. 2017. Indicators of mental health problems reported by prisoners and jail inmates, 2011-12. Bureau of Justice Statistics: Special Report. NCJ250612.
[335] Best practices in Mental Health at corrections facilities. 2011. Partnership for the Common Good.
[336] Community mental health: Evaluating mental health services in local jails. 2018. Performance Audit Report, Legislative Division of Post Audit, State of Kansas. www.kslpa.org.
[337] Mental illness in jails report. 2018. Virginia Compensation Board. www.rga.lis.virginia.gov.
[338] Available at htpp://www.floridasupremecourt.org/pub_info/documents/11-14-2007_Mental_Health_Report.pdf

In response to this recommendation, the Florida Department of Children and Families and the 11th Judicial Circuit implemented a pilot program of this type, operated by a community-based treatment provider.[339] The treatment regime begins in a crisis stabilization unit, followed by residential treatment and competency restoration. Once completed, community placement can be authorized. The program encompasses both competency restoration and community re-entry.

An analysis of the program found:

- Individuals participating in the program are ready for discharge from forensic commitment an average of 64 days sooner than those assigned to State forensic facilities.
- When structured at the optimal 20 beds, the program costs about one-third less than the State forensic facilities.
- In terms of program impact, individuals who remain linked to the program had 68% fewer jail bookings and 94% fewer jail days.

Suicide Prevention

Since mentally ill inmates are at higher risk of suicide, a variety of strategies to address this issue are developing. In Jefferson, CO, one strategy being evaluated is for those at risk of suicide to be placed in a more open setting to enable better observation and monitoring.[340] Los Angeles is placing two per cell after having found that inmates will bring attention to their cell if a suicide attempt is made.[341] Palm Beach County found that sexual deviants and inmates with longer sentences were at higher suicidal risk.[342] These inmates are immediately referred to the County's mental health unit for evaluation.

[339] Miami-Dade Forensic Alternative Center Pilot Program Status Report
[340] Managing mental illness in jails. 2018. Police Executive Research Forum
[341] Managing mental illness, op.cit.
[342] Managing mental illness, op.cit.

Co-occurring Disorders Treatments

As noted already, a high proportion of mentally ill inmates also have substance abuse issues. In response to this situation, Essex County, MA, established a 28-day inpatient detox program and a 42-bed addiction treatment facility.

Medical Psychologist

Lafayette Parish, LA, hired a medical psychologist; this gave the parish more accurate and prompt diagnoses of mental illnesses and more comprehensive treatment. The results included less disruptive behavior, fewer assaults and a 67% reduction in pharmaceutical costs due to more accurate diagnoses and more comprehensive treatment plans.[343]

Tele-Psychiatry

Tele-psychiatry is a tool that enables a police officer, a corrections officer or other staff, to interact with a mental health professional remotely. It can also be used for direct patient interaction. Harris County, TX, can connect via iPads to mental health professionals when dealing with a person with mental health, substance abuse or developmental disabilities. Los Angeles County is testing a telepresence program in its jail.

Cognitive-Behavior Therapies

These programs seek to address anti-social thinking and behavior patterns combined with mental health care, with the intent of preventing re-incarceration.[344]

[343] Managing mental illness, op.cit.
[344] Stringer, H. 2019. Improving mental health for inmates. Monitor on psychology, 50(30, 46.

Trauma-Informed Care

These are staff training programs to help staff understand the nature of trauma and how to interact with people who likely have experienced some form of trauma.[345]

Therapeutic Communities

A program that can be offered during incarceration that has proven to reduce future incarcerations is the Amity in-prison therapeutic community.[346] While this research occurred on prisoners, the key design element was a dedicated housing unit. In this research, substance abuse was the focus.

Specialized Facilities and Programs

It is commonly accepted that jails now house more mentally ill individuals than mental hospitals.[347] In response to this fact, a variety of specialized facilities are being developed by sheriff and / or jail administrators. Some examples include:

- Pinellas County has developed a homeless shelter at one of the Sheriff's facilities.[348]
- Harris County, TX, has developed a Mental Health and Medical Security Unit.[349] In addition, it has a 108-bed unit for the most serious mentally ill. It also has a Crisis Intervention Response Team for incidents in the jail.

Intercept 5: Release, Re-entry, Reintegration, Community Corrections

To lower the rates of recidivism, there have been several efforts to develop programs that help released inmates successfully return to their communities. The value of this is self-evident from a cost-of-inmate factor along with the various human and community benefits. There are studies of best practice re-entry programs that have shown

[345] Stringer, op.cit.
[346] Amity in-prison therapeutic community. 2011. Crimesolutions.gov
[347] Jail mental health initiatives. 2019. Harris County, TX Sheriff's Office. www.harriscountycit.org.
[348] Managing mental illness in jail. 2018. Police Executive Research Forum
[349] Jail mental health initiatives, 2019. Op cit.

significant reductions in recidivism.[350] The Minnesota Comprehensive Offender Re-Entry Plan showed reduced recidivism[351] as did the High-Risk Revocation Reduction Program.[352]

Other studies show mixed results at best.[353] Employment focused re-entry programs have had little success in reducing recidivism.[354] A job by itself is no guarantee. Federal Second Chance Act re-entry programs that offer case management, employment assistance and cognitive-behavioral therapy showed no impact on arrests, convictions, or incarcerations at the 30-month follow-up.[355]

There are two key components of re-entry from a mental health perspective. One is linking the person to a mental health provider. The second is addressing all the other life issues and barriers that persons with criminal records face.

Some examples of re-entry programs include:[356]

- Critical time intervention (CTI). This is a time-limited, evidence-backed program that provides support for times of transition.[357]
- The Helping HANDS (Health, Access, Navigation, Deliver, Services) program of Palm Beach County. This program involves the mental health provider prior to release.
- Sheriff's Integrated Access Team. This Hennepin County, MN, team conducts interviews both at entry to the jail and prior to release to determine the needs of the individual.
- Arapahoe County, CO, has a partnership with a mental health provider. This puts staff in the jail to help with addiction education and re-entry planning.
- Sarasota County SHIFTS (Sheriff's Housing Facilitating Initiative Transient Services). This focuses on transients who must be relocated and 24/7 housing is provided with intake, triage and assessment services.[358]

[350] Corrections and Reentry. Crimesolutions.gov
[351] Minnesota Comprehensive Offender Reentry Program. 2016. Crimesolutions.gov
[352] High-Risk Revocation Reduction Program, 2018. Crimesolutions.gov
[353] Muhlausen, D. 2018. Research on returning offenders programs and promising practices. National Institute of Justice.
[354] Muhlausen, op.cit.
[355] Muhlausen, op.cit.
[356] Managing mental illness in jail. Op.cit.
[357] www.criticaltime.org
[358] www.caslinc.org

Some best practices are:

- Start early and create a plan for release on the first day of incarceration.[359] This is a two-phased approach in which there is work prior to release and then a year-long follow up is conducted. This has proved to be effective.[360]
- Address underlying attitudes about crime and work.[361]
- Adopt a framework such as Risk-Needs-Responsivity.[362] Responsivity means intervening in a manner that is appropriate and matches the abilities of the person.
- Utilize evidence-based interventions such as Family Functional Therapy for dysfunctional youth[363], Enhanced Thinking Skills[364] or others.
- Use cognitive-behavioral approaches.[365]
- Target criminogenic needs.[366]
- Address housing, employment, transportation and other basic needs.[367]
- Ensure continuity of medications so that the released inmate has an adequate supply of medications as well as access to pharmacies.
- Provide a linkage with a mental health provider prior to release.
- Proactively re-instate public benefits.
- Address opioid issues through naloxone programs.

System-of-Care Model

The value of the sequential intercept model is that it identifies how potential inmates can be diverted to a more appropriate setting and can be better served if jail is the most appropriate placement. It also addressed how recidivism can be prevented.

Another way to examine the Criminal Justice / Behavioral Health interface is to take the viewpoint of a system-of-care. Of relevance to this discussion is the Recovery-Oriented system-of-care model developed for addressing substance abuse issues as well as mental health issues. Beacuse a high proportion of inmates and mentally ill have even

[359] Johnson, S. Four elements of successful reentry programs. Social solutions.
[360] Allegany County PA jail-based reentry specialist program. Crimesolutions.gov
[361] Johnson, Op.cit.
[362] op.cit
[363] Functional Family Therapy, 2011. Crimesolutions.gov
[364] Enhanced Thinking Skills. Crimesolutions.gov
[365] Listwan, S. et.al. 2006. How to prevent prisoner reentry programs from failing. Federal Probation, 70(3), 19-25
[366] Listwan op.cit
[367] Listwan, op.cit.

higher rates of substance abuse issues, the Recovery-Oriented system-of-care is the most appropriate model for this analysis.

A recovery-oriented system-of-care model has the following elements:

- Person-centered and choices.[368]
- Inclusive of family and other allies.[369]
- Individualized, integrated and comprehensive services adapted across the lifespan.[370]
- Systems anchored in community with a system-wide framework.[371]
- Continuity and continuum of care, ongoing monitoring and outreach, and chronic care strategies.[372]
- Strength-based.[373]
- Culturally responsive.[374]
- Commitment to peer recovery supports.[375]
- Flexible financing and pooled funding.[376]

From a system-of-care perspective, each of the interventions described in the discussion on sequential intercepts are more likely to be effective if organized, delivered and managed using the above elements. Such an approach avoids intervention "silos" and provides consistent support for each intervention.

[368] Laughame, R. et.al. 2006. Trust, choice and power in mental health. Social Psychiatry and Psychiatric Epidemiology, 41(11), 843-852.
[369] Noel, N. et.al. 1987. Predictors of attrition from an outpatient alcoholism treatment program for couples. Journal of Studies on Alcohol, 48(3), 229-235.
[370] Babor, T. et.al. 2008. Alcohol and drug treatment systems in public health perspective. International journal of Methods in Psychiatric Research, 17(51), 550-559.
[371] Broome, K. et.al. 2002. The role of social support following short-term inpatient treatment. American Journal of Addictions, 11, 57-65.
[372] Haggerty, J. et.al. 2003. Continuity of care: A multi-disciplinary review. British Medical Journal. 327, 1219-1221.
[373] Rapp, R. et.al. 1998. Predicting post primary treatment services and drug use outcome: A multivariate analysis. American Journal of Drug and Alcohol Abuse, 24, 603-615.
[374] Longshore, Dr. et.al. 1999. Effects of a culturally congruent intervention on cognitive factors related to drug-use recovery. Substance Use and Misuse, 34(9), 1223-1241.
[375] Galanter, M. et.al. 1998. Homelessness and mental illness in a professional and peer-led cocaine treatment clinic. Psychiatric Services, 49(4), 533-535.
[376] Reynolds, K. et.al. 2005. Innovative ways to finance mental health services in a primary care setting. Washtenaw, MI: Washtenaw Community Health Association.

As noted in the sequential intercept analysis, several of the specific services resulted in mixed outcomes. Operated and evaluated in isolation, this would be expected. What has not occurred is an evaluation of a comprehensive system-of-care in which all the specific services operate under a common framework and are functionally linked.

Gaps & Priorities: Criminal Justice and Behavioral Health Priority Components

Intercepts 0 & 1: Community Response and Diversion.

Establishment of a Mental Health Evaluation Team (i.e. interceptor). This team would be immediately available to Law Enforcement Officers to determine an appropriate response based on an assessment of the individual. This assessment could be done remotely by phone, by video link or in-person.

Additional Training of Law Enforcement Personnel with respect to available resources, contact procedures and additional CIT or advanced CIT (where needed).

Increase in the Number of FACT Teams. FACT teams provide an assertive community treatment response that actively monitors serious mentally ill individuals and keeps them in the community through medications intervention and other mechanisms.

Increase in the Resources available to FACT teams, particularly housing funds.

Multi-capability Facility to support diversion. Discussed in Intercepts 2, 3 and 4 below.

Intercepts 2, 3 & 4: Screening / Pre-trial Diversion, Specialty Courts, Treatment.

Establishment of a Multi-Capability Forensic Alternative Facility (in part modeled after Section 916.185, F.S.). This facility would be designed to provide several key services with appropriate levels of control:

- Immediate drop-off site for law enforcement for people who need to be removed from the community temporarily, but who are not a threat to themselves or others. This could include detox capacity.

- Baker Act CSU for people who are a threat to themselves or others.

- Residential facilities for pre-trial release under conditions.

- Residential facilities for jail inmates with Serious Mental Illness diagnoses (modeled after the jail's current behavioral unit).

- Step-down capacity to enable more coordinated re-entry efforts, involuntary outpatient services, movement from more restricted to less restricted units and community competency restoration.

Establishment of a Rapid Response Team

The rapid response team targets clients in jail who are quickly identified as having a severe mental illness. There is no structure, signed releases or consent to trigger the team's involvement. For example, the jail would contact the defense attorney and say this person appears to be in crisis. The defense attorney would call a meeting with the team to decide the best approach in assisting the client's crisis issue. The rapid response team is not a court, but more of an identification process to divert individuals out of the jail to more appropriate settings – Baker Act, mental health court, outpatient services etc. This rapid response team may not have any bearing on the overall litigation of the criminal case.

If there were a team consisting of a judge, an assistant state attorney, an assistant public defender, LCSO officer or correction staff, and a community provider such as FACT, or a behavioral health service provider then clients could be identified in crisis at first appearance (the day after their arrest) and appropriate action can be taken to help move them into a more appropriate setting within 24 to 48 hours of arrest. The idea would be that the judge in this team would follow their case. Currently, clients often sit in jail 30 to 60 days and sometimes in isolation before they are released. They may be released with no conditions or support. The idea would be to get the client psychiatrically stabilized as quickly as possible, so that they can be in the right frame of mind to agree to programs such as mental health court, etc.

Establishment of Additional Specialty Courts

916 Court. This court would focus on competency restoration. A multi-disciplinary team approach typical of other specialty courts would be established. Processes and procedures would need to be developed with all involved parties prior to establishment.

Intercept 5: Re-entry.

Establishment of Additional Correctional Full-time Equivalents (FTEs)
Additional FTEs would enable the Sheriff to establish case-load management systems so that planning for re-entry can begin upon admittance to the jail or forensic facility. This would include coordination with various post-release wrap-around services, Intercept 0 and 1 points and specialty courts.

System-of-Care

Overall coordination. There is a need for an overall perspective on the system. All approaches should be considered, whether it is the Public Safety Coordinating Council, an office dedicated to this, or a multi-agency / disciplinary team.

CHAPTER 16
Child Abuse and Neglect, Foster Care, Adoptions

Introduction

This chapter addresses the topic of children who suffer from abuse and neglect. Some of these children are placed in the foster care system either temporarily or until the time their parents can resume parental duties.

This chapter has four sections. They are:

- Section One: Context and Background. This section provides national, state and local Lee County data about the scope and status of sexual abuse.
- Section Two: The System-of-Care. This section describes the various services and responsible entities whose mission it is to address this issue.
- Section Three: System Gaps. These are gaps in services, current unmet needs and any potential emerging issues.
- Section Four: Definitions. This section provides formal and legal definitions of the various terms used in the system. It is provided in case the reader desires clarification on any of these terms, or it may assist in data interpretation.

Context and Background

- 9% of all Medicaid expenses are related to child maltreatment. This equates to $5.9B;[377]
- Seven children per 1,000 are victims of neglect. 1.7 per 1,000 are victims of physical abuse, 0.8 per 1,000 are victims of sexual abuse and 0.5 are victims of emotional abuse;[378]
- Approximately 3 million cases of child abuse, involving 5.5 million children, are reported each year;[379]
- Approximately one in 20 children have been physically abused in their lifetime;[380]

[377] Economic impact of child abuse. www.fncac.org.
[378] U.S. Department of Health and Human Services: Administration for Children and Families and Office of Child Abuse and Neglect
[379] Child abuse and neglect. www.healthychildren.org
[380] ibid.

- Almost one in four girls and one in eight boys will be sexually abused before they are 18 years old;[381]
- For women, after the ages of 18 to 24, the next most common age for sexual violence in a home or family setting is 11- to 17-years-old;[382]
- Most child abuse occurs within the family. The leading factor in Florida is parental substance abuse. Other risk factors include parental depression or other mental health issues, a parental history of childhood abuse and domestic violence;[383]
- Child neglect and other forms of maltreatment are more common in families living in poverty or among parents who are teenagers or who abuse drugs or alcohol;[384]
- More children are abused by a caregiver or someone they know than by strangers;[385]
- Physical abuse in children can lead to brain dysfunction;[386]
- Physically abused children showed central nervous system damage,[387] physical defects,[388] mental retardation[389] and serious speech problems;[390]
- Severe childhood maltreatment is later related to self-destructive behavior,[391] suicide,[392] depression[393] and substance abuse.[394]

[381] ibid
[382] *National Intimate Partner and Sexual Violence Survey, 2010 Summary Report. National Center for Injury Prevention and Control, Division of Violence Prevention, Atlanta, GA, and Control of the Centers for Disease Control and Prevention.*
[383] Child abuse and neglect, www.healthychildren.org
[384] ibid
[385] ibid.
[386] Dykes, L. 1986. The whiplash shaken infant syndrome: what has been learned. Child Abuse and Neglect, 10:211-221.
[387] Elmer, E. & Gregg, G. 1967. Developmental characteristics of abused children. Pediatrics, 40(4): 596-602
[388] Green, A. 1978. Psychopathology of abused children. Journal of the American Academy of Child Psychiatry. 17:92-103.
[389] Martin, H. et.al. 1974. The development of abused children. Advances in Pediatrics, 21:25-73.
[390] Morse, C. et.al. 1970. A 3-year follow-up study of abused and neglected children. American Journal of Diseases of Children. 120:439-446.
[391] Gutierres, S. & Reaich, J. 1981. A developmental perspective on runaway behavior: Its relationship to child abuse. Child Welfare 60-89-94
[392] DeWilde, E. et.al. 1992. The relationship between adolescent suicidal behavior and life events in childhood and adolescence. American Journal of Psychiatry, 149(1): 45-51
[393] Stein, J. et.al. 1988. Long-term psychological sequelae of child sexual abuse. In G. Wyatt and G. Powell (eds) Lasting effects of child sexual abuse. Newbury Park, CA: Sage
[394] Ludwig, G & Anderson, M. 1989. Substance abuse in women: Relationship between chemical dependency of women and past reports of physical and/or sexual abuse. International Journal of Addictions 248): 739-754.

Lee County Data

Table 63 presents various data points relevant to child abuse and neglect in Lee County. Lee County mirrors the State average in most cases. However, there are a comparatively higher portion of children in foster care than the State average. Given the variety of factors that lead to foster care, this is not a pure indicator of child abuse or neglect.

Table 63. Child Abuse and Neglect Indicators in Lee County

Sources	Data Title	Year	Lee County	State	Comparison to State
MyFLFamilies.com[395]	Children Entering Care Who Achieve Permanency within 12 Months	2018	43.2%	41.4%	Within 10% average
		2019	44.7%	40.2%	Better
MyFLFamilies.com	Chart - Abuse during In-Home Services (% of Children Not Abused) (Average State Fiscal Year)	2018	94.4%	94%	Within 10% average
		2019	94.2%	94.7%	Within 10% average
MyFLFamilies.com	Chart - Children with No Recurrence of Verified Maltreatment w/in 12 Months (Average State Fiscal Year)	2018	91.3%	91.9%	Within 10% average
		2019	92.9%	92.4%	Within 10% average
MyFLFamilies.com	Chart - Young Adults Aging out who did not Perpetrate Abuse by their 25th Birthday	2019 Q1	84.21%	87.35%	Within 10% average
		2018 Q1	82.35%	88.34%	Within 10% average
MyFLFamilies.com	Chart - Removal Rate per 100 Alleged Victims	2018	5.2	5.2	Same

[395] Florida Department of Children and Families, Child Welfare Statistics Dashboard https://myflfamilies.com/programs/childwelfare/dashboard/

Sources	Data Title	Year	Lee County	State	Comparison to State
School Age Child Adolescent Profile[396]	Children Experiencing Child Abuse Ages 5-11 per 100,000	2015-17	850.4	932.8	Better
		2016-18	863.2	855.3	Within 10% average
School Age Child Adolescent Profile	Children in foster care ages 5-11 Per 100,000	2017	563.4	413.7	Worse
		2018	571.3	455.7	Worse
School Age Child Adolescent Profile	Children in foster care ages 12-17 Per 100,000	2017	481.8	410.6	Worse
		2018	511.8	362.4	Worse
Child Health Status[397]	Children under 18 in Foster Care Per 100,000 population	2017	708.3	537.7	Worse
Child Health Status[398]	Children Experiencing Sexual Violence Ages 5-11 per 100,000 population	2015-17	73.5	59.8	Worse
MyFLFamilies.com	Removal Rate per 100 Alleged Victims for Investigation Closed By Quarter (*County group is a region that includes – Lee, Collier, Charlotte, Hendry and Glades counties*)	Oct – Dec 2018 (Quarter)	5.6	4.8	Worse
		Jan – Mar 2019	5.03	5.17	Within 10% average
		April – June 2019	5.23	4.8	Within 10% average
		July – Sept 2019	7.27	5.78	Worse

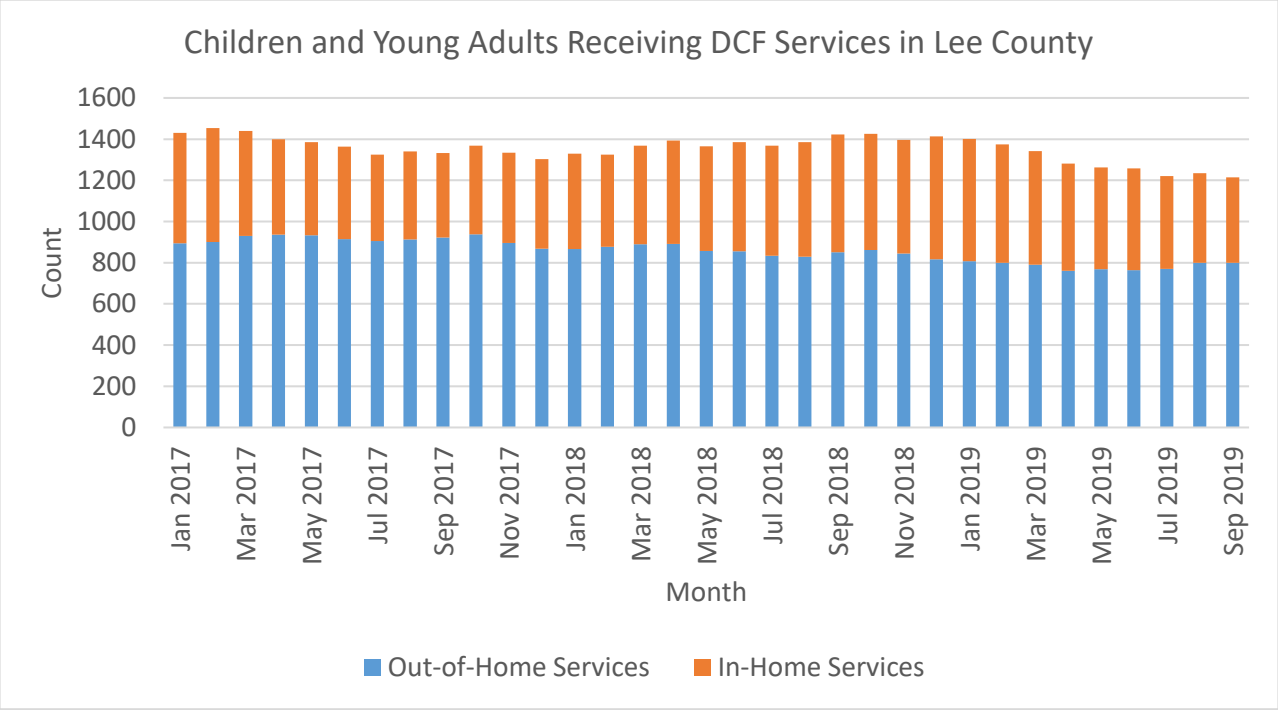
With respect to exiting foster care in 2018, 30 18- to 21-year-olds were in extended foster care and 39 18- to 22-year-olds were enrolled in post-secondary education

[396] Florida Health Charts,
School-aged Child and Adolescent Profile
http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.School-agedChildandAdolProfile
[397] Child Health Status
http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.ChildHealthStatusProfile
[398] Florida Health Charts, Children Experiencing Sexual Violence ages 5-11
http://www.flhealthcharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0561

services and support services. Fifty-six youths aged out and 17 were terminated for non-compliance.

Figure 18 shows out-of-home services in Lee County on a downward trend. In 2017, the average was 913 per month, while in 2019 the average was 784 per month. In-home services have increased since 2017, when the average monthly count was 460 children and young adults. In 2018, the average was 525, and in 2019 the average was at 503 as of September.

Figure 18. Children and Young Adults Receiving DCF Services in Lee County[399]



[399] https://www.myflfamilies.com/programs/childwelfare/dashboard/cya-inhome.shtml
https://www.myflfamilies.com/programs/childwelfare/dashboard/c-in-ooh.shtml

System-of-Care

The system-of-care consists of the following major entities (as shown in Figures 19 and 20):

- The Florida Department of Child and Family Services (DCF). DCF is the state agency with funding, administrative and regulatory authority;
- Children's Network of Southwest Florida. This agency is contracted by DCF to provide local services. It manages sub-contracts with specific service providers;
- Child Advocacy Center (CAC). This local nonprofit provides assessment and intervention services;
- Adoption Agencies. These are agencies that provide adoption services that may include foster care children;
- Foster Care Agencies. These local nonprofits manage foster care services either by providing a home setting themselves or by working with foster parents;
- The Legal System will be involved as specific actions are needed.

Figure 19. Children's Network of SWFL System-of-Care Overview

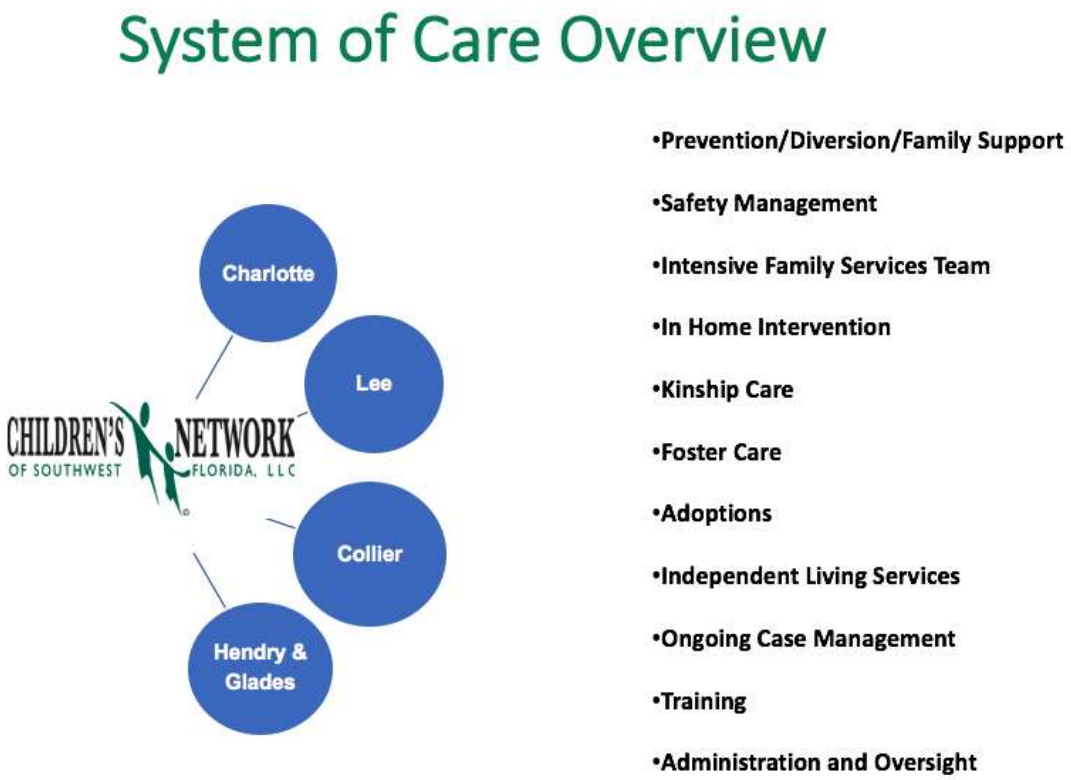
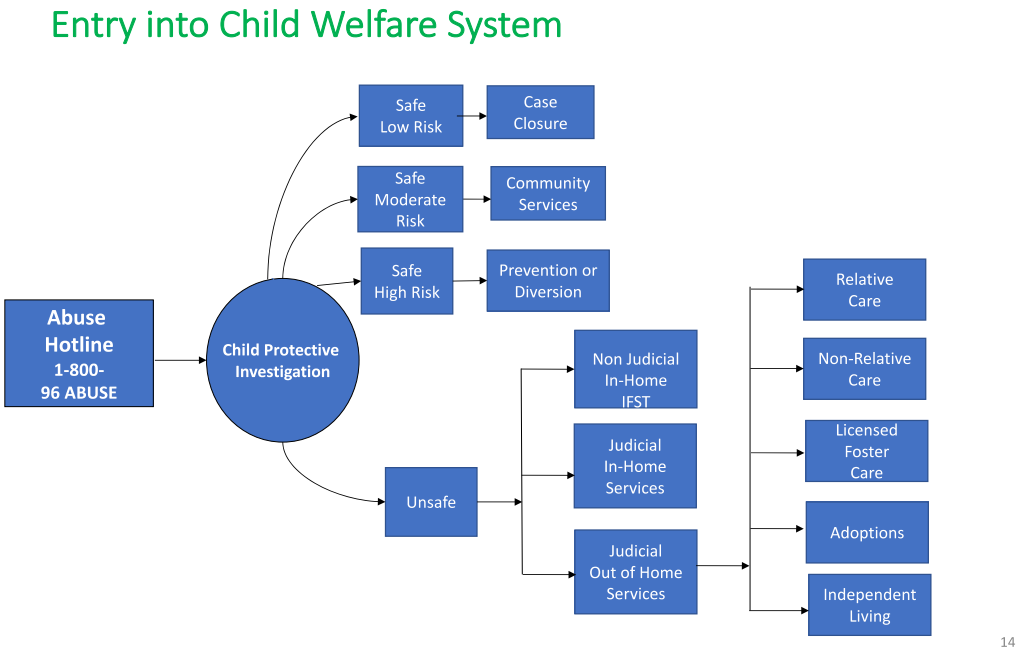


Figure 20. Illustrates the Process Stages of the System-of-Care



Child Sexual Abuse

Child sexual abuse cases are generally handled by the Department of Health's Child Protection Teams (CPTs), whose role is to supplement the assessment and protective supervision activities of DCF. Services provided by CPTs include diagnostic medical evaluations, medical consultations, family psychosocial interviews and forensic interviews.

In Florida, CPTs work closely with Children's Advocacy Centers (CACs), most of which are unaffiliated with FCASV's certified sexual assault programs. A CAC is a community-based, child-focused facility where children who are victims of abuse or neglect are interviewed and receive medical exams. If necessary, therapy and other critical services are provided in a non-threatening and child friendly environment. A CAC brings together an array of professionals to work together on the investigation, treatment and prosecution of child abuse cases. The primary goal of a CAC is to minimize the level of trauma experienced by child victims, improve prosecutions and provide efficient and thorough provision of necessary services to the child victim and the child's family.

CACs provide services such as:

- Forensic interviews conducted by specially trained professionals in a non-threatening, child-friendly environment.
- Crisis intervention and emotional support for victims and non-offending family members.
- Counseling for victims and non-offending family members so that they may begin to heal from emotional wounds associated with child abuse.
- Specialized forensic medical evaluations.
- Multidisciplinary review of cases by a team of professionals, such as law enforcement officials, child protection teams, prosecutors, medical professionals, mental health professionals, victim assistance staff and child advocates.
- Evidence-based prevention and intervention programs to reduce the likelihood of child maltreatment and to provide safe and caring homes for children. Two examples are:
  - Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).[400] TF-CBT is an evidence-based treatment for children and adolescents impacted by trauma and their parents or caregivers. Research shows that TF-CBT successfully resolves an array of emotional and behavioral difficulties associated with single, multiple and complex trauma experiences.
  - EMDR (Eye Movement Desensitization and Reprocessing).[401]
- Professional training and community education to effectively respond to child abuse.

Gaps in Child Abuse and Neglect & Foster Care

The following gaps are noted:

- The major gaps for children aging out of foster care are affordable housing and transportation;
- The primary reasons for removal of a child from a home are parental figure substance abuse, domestic violence and inadequate supervision. The gaps noted in the behavioral health and domestic violence chapters apply here;

[400] www.TF-CBT.org
[401] SAMHSA's National Registry of Evidence-based Programs and Practices (2011). http://legacy.nreppadmin.net/ViewIntervention.aspx?id=199.

- Transportation for parents to access services, attend court and visit with their child if in out-of-home care;
- There is a greater need for substance abuse services for dependency youth than there are resources;
- A longer term of treatment for serious substance abuse is needed;
- Child-care resources are very limited for children with behavioral issues;
- More foster parents are needed than are available. This gap is even higher when the child has special medical or behavioral needs;
- Every effort is made to keep siblings together in foster care. If the family is very large this is very difficult to achieve;
- There is a lack of preventive services to intervene for parents who are having difficulty with children who are exhibiting behavioral issues. This may result in the child entering the foster care system;
- For children involved in the Juvenile Justice System, it can take a long time to reach adjudication. These children are hard to maintain in a traditional foster care setting;
- There is an unmet need for immediate access to child-care services for families with a Safety Plan. As noted in the staffing chapter, many child-care jobs are minimum wage or slightly above. This results in high rates of turnover. While no business wants high turnover rates, it is problematic in child-care because children benefit from the stability of the adults in their lives, including child-care providers;
- Three evidence-based programs (Safe at Home, Parent-Child Psychotherapy and Cognitive-Behavioral Therapy) need to be more widely available;
- More crisis management and same-day counseling services are needed;
- A variety of in-home services are needed, such as crisis intervention and behavior management;
- Greater capacity to provide a variety of assessments is needed – substance abuse, domestic violence, child sexual abuse, mental health.

Definitions

- Physical abuse is an injury to a child's body due to hitting, kicking, shaking, burning or other show of force.
- Sexual abuse is any sexual activity that a child cannot understand or consent to.
- Child neglect can include physical neglect (food, shelter, etc.), emotional neglect (failing to provide comfort, love), or medical neglect. Verbal abuse is a form of emotional neglect.

- The Federal Child Abuse Prevention and Treatment Act (CAPTA), (42 U.S.C.A. §5106g), as amended by P.L. 111-320, the CAPTA Reauthorization Act of 2010 defines child abuse and neglect as, at minimum:
  "Any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm."

The State of Florida definitions are more detailed. They include:

Physical Abuse
Citation: Ann. Stat. § 39.01

"Abuse" means any willful act or threatened act that results in any physical, mental, or sexual abuse, injury, or harm that causes or is likely to cause a child's physical, mental, or emotional health to be significantly impaired. Abuse of a child includes the birth of a new child into a family during an open dependency case when the parent or caregiver has been determined to lack the protective capacity to safely care for the children in the home and has not substantially complied with the case plan toward successful reunification or met the conditions for return of the children into the home. Abuse of a child includes acts or omissions.

"Harm" to a child's health or welfare can occur when a person inflicts or allows to be inflicted upon the child physical, mental, or emotional injury. Such injury includes, but is not limited to, any of the following:

- Willful acts that produce specific serious injuries
- Purposely gives a child poison, alcohol, drugs, or other substances that substantially affect the child's behavior, motor coordination, or judgment or that result in sickness or internal injury
- Leaves a child without adult supervision or arrangement appropriate for the child's age or mental or physical condition
- Uses inappropriate or excessively harsh discipline that is likely to result in physical injury, mental injury as defined in this section, or emotional injury
- Commits, or allows to be committed, sexual battery against the child
- Allows, encourages, or forces the sexual exploitation of a child
- Abandons the child
- Exploits a child or allows a child to be exploited
- Neglects the child
- Exposes a child to a controlled substance or alcohol

- Uses mechanical devices, unreasonable restraints, or extended periods of isolation to control a child
- Engages in violent behavior that demonstrates a wanton disregard for the presence of a child and could reasonably result in serious injury to the child
- Negligently fails to protect a child in his or her care from inflicted physical, mental, or sexual injury caused by the acts of another
- Has allowed a child's sibling to die because of abuse, abandonment, or neglect
- Makes the child unavailable for impeding or avoiding a protective investigation unless the court determines that the parent, legal custodian, or caregiver was fleeing from a situation involving domestic violence

Neglect
Citation: Ann. Stat. § 39.01

"Neglect" occurs when a child is deprived of, or can be deprived of, necessary food, clothing, shelter, or medical treatment or a child is permitted to live in an environment when such deprivation or environment causes the child's physical, mental, or emotional health to be significantly impaired or to be in danger of being significantly impaired. Neglect of a child includes acts or omissions.

Within the context of the definition of 'harm,' the term 'neglects the child' means that the parent or other person responsible for the child's welfare fails to supply the child with adequate food, clothing, shelter, or health care, although financially able to do so or although offered financial or other means to do so.

"Medical neglect" means the failure to provide or allow needed care as recommended by a health-care practitioner for a physical injury, illness, medical condition, or impairment or the failure to seek timely and appropriate medical care for a serious health problem that a reasonable person would have recognized as requiring professional medical attention. Medical neglect does not occur if the parent or legal guardian of the child has made reasonable attempts to obtain necessary health-care services or the immediate health condition giving rise to the allegation of neglect is a known and expected complication of the child's diagnosis or treatment and either of the following is true:

- The recommended care offers limited net benefit to the child, and the morbidity or other side effects of the treatment may be greater than the anticipated benefit.

- The parent or legal guardian received conflicting medical recommendations for treatment from multiple practitioners and did not follow all recommendations.

Sexual Abuse/Exploitation
Citation: Ann. Stat. § 39.01

"Sexual abuse of a child" means one or more of the following acts:

- Any penetration, however slight, of the vagina or anal opening of one person by the penis of another person, whether there is the emission of semen.
- Any sexual contact between the genitals or anal opening of one person and the mouth or tongue of another person.
- Any intrusion by one person into the genitals or anal opening of another person, including the use of any object for this purpose, not including any act intended for a valid medical purpose.
- The intentional touching of the genitals or intimate parts, including the breasts, genital area, groin, inner thighs and buttocks, or the clothing covering them, of either the child or the perpetrator, not including the following:
    - An act that may reasonably be construed to be a normal caregiver responsibility or any interaction with or affection for a child
    - An act intended for a valid medical purpose
- The intentional masturbation of the perpetrator's genitals in the presence of a child.
- The intentional exposure of the perpetrator's genitals in the presence of a child, or any other sexual act intentionally perpetrated in the presence of a child, if such exposure or sexual act is for sexual arousal or gratification, aggression, degradation, or other similar purpose.
- The sexual exploitation of a child, including the following:
    - A child offering to engage in or engaging in prostitution
    - Allowing, encouraging, or forcing a child to solicit for or engage in prostitution, engage in a sexual performance, or participate in the trade of human trafficking, as provided in § 787.06(3)(g)

"Harm" to a child can occur when any person:

- Commits or allows to be committed sexual battery or lewd or lascivious acts against the child.
- Allows, encourages, or forces the sexual exploitation of a child, including engaging in prostitution or a sexual performance.

Emotional Abuse
Citation: Ann. Stat. § 39.01

"Mental injury" means an injury to the intellectual or psychological capacity of a child as evidenced by a discernible and substantial impairment in the ability to function within the normal range of performance and behavior.

Abandonment
Citation: Ann. Stat. § 39.01

"Abandoned" or "abandonment" occurs when the parent or legal custodian of a child or, in the absence of a parent or legal custodian, the caregiver, while being able, has made no significant contribution to the child's care and maintenance or has failed to establish or maintain a substantial and positive relationship with the child.

For purposes of this subsection, 'establish or maintain a substantial and positive relationship' includes, but is not limited to, frequent and regular contact with the child through frequent and regular visitation or frequent and regular communication to or with the child and the exercise of parental rights and responsibilities. Marginal efforts and incidental or token visits or communications are not sufficient to establish or maintain a substantial and positive relationship with a child. A man's acknowledgement of paternity of the child does not limit the period considered in determining whether the child was abandoned.

The term does not include a surrendered newborn infant, as described in § 383.50; a "child in need of services"; or a "family in need of services," as defined in chapter 984. The incarceration of a parent, legal custodian, or caregiver responsible for a child's welfare may support a finding of abandonment.

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CHAPTER 17
Domestic Violence/Intimate Partner Violence

Introduction

Violence in the form of physical, emotional or psychological abuse can occur between spouses, domestic partners and people in intimate relationships. In the case of a family unit, children can be exposed to violence between the parental figures and may also be abused themselves.

This chapter's format, like other system-of-care chapters, includes background information, Lee County data, a summary of the system-of-care, gaps and definitions.

Context and Background

The following facts reflect the magnitude of the problem from a national perspective:

- The most common age in which intimate partner violence first occurs is 18- to 24-years-old for both women and men;
- More than one in three women (35.6%) and more than one in four men (28.5%) in the United States have experienced rape, physical violence and/or stalking by an intimate partner in their lifetime[402];
- An estimated 1.3 million women are victims of physical assault by an intimate partner each year[403];
- 16% of homeless people are victims of domestic violence[404];
- Approximately 50% of all women who are homeless report that domestic violence was the immediate cause of their homelessness[405];
- 85% of domestic violence victims are women[406];

[402] *National Intimate Partner and Sexual Violence Survey, 2010 Summary Report. National Center for Injury Prevention and Control, Division of Violence Prevention, Atlanta, GA, and Control of the Centers for Disease Control and Prevention.*
[403] *Costs of Intimate Partner Violence Against Women in the United States. 2003. Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control, Atlanta, GA*
[404] The U.S. Conference of Mayors 2013 Status Report on Hunger & Homelessness, A 25-City Survey (2013).
[405] "Pressing Issues Facing Families Who Are Homeless." The National Center on Family Homelessness. (2013).
[406] *Bureau of Justice Statistics Crime Data Brief, Intimate Partner Violence, 1993-2001, February 2003.*

- Historically, females have been victimized most often by someone they knew[407];
- Among mothers (with children) who are homelessness, more than 80% had previously experienced domestic violence[408];
- 63% of homeless women have been victims of intimate partner violence as adults[409];
- 33% of homeless women have been victims of severe assault by their current or most recent intimate partner [410].

Experts in the field of domestic violence or intimate partner violence argue that actual rates of abuse are more prevalent than most people realize. There are many factors contributing to this reality. Some of these factors are related to the embarrassment victims feel, fear of retribution or additional abuser violence resulting from disclosure, lack of resources and societal beliefs.

Lee County Data

As shown in Tables 64 and 65, domestic violence rates in Lee County are significantly lower than the State average. This does not infer that it is not a concern; it is simply to state a fact.

There are 97 domestic violence shelter beds in Lee County. Between Oct. 1, 2017 and Sept. 30 , 2018, 3,111 domestic violence survivors were served by bed provision, counseling or crisis response. 2,793 of these were adults and 318 were minors. The shelter itself served 541 people, of which 274 were adults and 267 were minors.

[407] *U.S. Department of Justice, Bureau of Justice Statistics, "Criminal Victimization, 2005," September 2006.*
[408] Aratani, Y. (2009). "Homeless Children and Youth, Causes and Consequences. National Center for Children in Poverty."
[409] Browne, A. 1998. "Responding to the Needs of Low Income and Homeless Women Who are Survivors of Family Violence." Journal of American Medical Women's Association. 53(2): 57-64.
[410] Browne, A. 1998. "Responding to the Needs of Low Income and Homeless Women Who are Survivors of Family Violence." Journal of American Medical Women's Association. 53(2): 57-64

Table 64. Domestic Violence in Lee County

Sources	Data Title	Year	Lee County	State	Comparison to State
Social and Mental Health	Domestic Violence Offenses 3-Yr Rate Per 100,000	2015-17	414.8	527.8	Better

Table 65. Rates of Domestic Violence – Lee County, FDLE Data

			Lee County	State
Indicators	Data Year	Number of Cases	3-Yr Rate Per 100,000	3-Yr Rate Per 100,000
Crime and Domestic Violence				
Domestic Violence Offenses	2016-18	8932	424.1	514.3
Domestic Violence Offenses	2013-15	7884	400	548.7

The System-of-Care

The system consists of three service points – a crisis line, counseling services and shelters. All are provided by Abuse Counseling and Treatment (ACT). More in-depth services can be provided via behavioral health providers if needed, including homeless services and child-care.

Gaps

Some of the gaps include:

- Public and professional awareness of the signs of domestic violence;
- Public understanding about the nature of domestic violence;
- Services for children exposed to violence;
- Housing, mental health and financial assistance services for women and children who are homeless due to domestic violence;
- Enhanced protection for women at work or in the community.

Definitions

The State of Florida's definition of domestic violence is:

> Citation: Ann. Stat. § 741.28
>
> "Domestic violence" means any assault, aggravated assault, battery, aggravated battery, sexual assault, sexual battery, stalking, aggravated stalking, kidnapping, false imprisonment, or any criminal offense resulting in physical injury or death of one family or household member by another family or household member.

CHAPTER 18
Elder Abuse, Neglect and Exploitation

Introduction

This chapter addresses a topic that is likely to grow in significance as the proportion of the population that is elderly continues to grow nationally and in Lee County. Elder abuse, neglect or exploitation is a growing issue because of physical or mental decline, social isolation and an increasing diversity of means to defraud. This chapter follows the format of other chapters with a context section that provides background, available data specific to Lee County, a description of the available services and a list of existing gaps.

Context and Background

This section provides national, state and local information and data to help define the nature and scope of the issue.

- Approximately one in 10 Americans age 60 or older have experienced some form of elder abuse[411]. It is estimated that only one in 14 cases of abuse are reported[412];
- Elders who have been abused have a 300% higher risk of death[413];
- Nearly 90% of substantiated abuse cases occur at home[414];
- One-third of elder abusers are children of the victim[415];
- Most abusers are either addicted or mentally ill[416];
- Nearly 18,570 seniors in Lee County participated in SNAP (food stamps). 27,375 were eligible for a participation rate of 68% [417];

[411] www.ncoa.org
[412] Bonnie. R. et.al. (Eds). 2003. Abuse, Neglect and Exploitation in an Aging America. Washington, DC: National Academies Press.
[413] Dong, X. et.al. 2009. Elder self-neglect and abuse and mortality risk in a community-dwelling population. Journal of the American Medical Association, 302(5): 517-526.
[414] University of Kentucky survey. 2004. National Center on Elder Abuse
[415] ibid.
[416] Markarian, A. 2014. Brooklyn District Attorney
[417] 2018 Profile of Older Floridians, FL Department of Elder Affairs

- The median income for all county residents was $52,052. For those age 65 and older, it was $47,128[418];
- 12% of seniors (27,375) in Lee County were at or below the 125% of Federal Poverty Level[419];
- 3.7% of Lee County residents are age 85 or older[420].

Lee County Data

Table 66 shows the changing dependency ratio in Lee County over time[421]. The higher the ratio, the greater the proportion of seniors compared to the working age population.

Table 66. Dependency Ratio Over Time

Year	2018	2020	2030	2040
Ratio	.43	.44	.52	.53
65+ population	182,275	193,556	258,500	292,890
15-64 population	420,257	437,873	495,615	553,155

[418] 2018 profile, op.cit.
[419] 2018 profile, op.cit.
[420] 2018 profile, op.cit.
[421] 2018 profile, op.cit.

Table 67 shows Elder Abuse Cases per 1,000 in Florida as reported through Adult Protective Services, DCF.

Table 67. Elderly Abuse Cases in Florida per 1,000 Persons

Month	Abuse Rate Among Elderly Persons, per 1,000
Jan 2018	0.10
Feb 2018	0.11
Mar 2018	0.11
Apr 2018	0.12
May 2018	0.13
Jun 2018	0.14
Jul 2018	0.12
Aug 2018	0.14
Sept 2018	0.13
Oct 2018	0.13
Nov 2018	0.11
Dec 2018	0.12

Table 68 reports the number of adult protection reports for the 20th Circuit.

Table 68. Adult Protection Scorecard[422]

Department of Children and Families Suncoast Region: 20th Circuit (Lee, Collier, Charlotte, Hendry, Glades)

Month	Adult Protection Reports Received
Jan 2018	246
Feb 2018	217
Mar 2018	255
Apr 2018	221
May 2018	244
Jun 2018	211
Jul 2018	200
Aug 2018	231
Sept 2018	195
Oct 2018	201
Nov 2018	189
Dec 2018	202
2018 TOTAL	2,612

[422] https://www.myflfamilies.com/general-information/planning-performance-measures/aps-scorecard.shtml

According to the October 2019 Program Scorecard from the Adult Protective Services Program Office, the Suncoast Region, which includes Lee County, had 7.5 active cases per investigator. This was the lowest rate of the six regions. The percent of total workforce capacity for the Suncoast region was reported at 84.93%. Table 69 reports this data.

Table 69. Adult Protective Investigators Workload[423]

Region Indicators	NW	NE	Central	SC	SE	Southern
Average Active Investigations per API	10.7	13.7	13.8	7.5	14.2	15.5
Percent Total Workforce Capacity	89.66%	88.37%	100%	84.93%	77.55%	85.19%

Table 70 notes the suicide rate for adults over 60.

Table 70. Suicide Rates Adults 60+[424]

Sources	Data Title	Year	Lee County	State	Comparison to State	
Suicide Deaths 60+	Suicides in Adults over 60, per 100,000	2018	19.3	23.7		Lower
		2017	19.8	20.9		Within 10% average
		2016	17.5	20.8		Lower

[423] https://www.myflfamilies.com/general-information/planning-performance-measures/aps/APS%20-%20October%202019%20Performance.pdf
[424]http://www.flhealthcharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0116

The System-of-Care in Addressing Elder Abuse, Neglect and Exploitation in Lee County

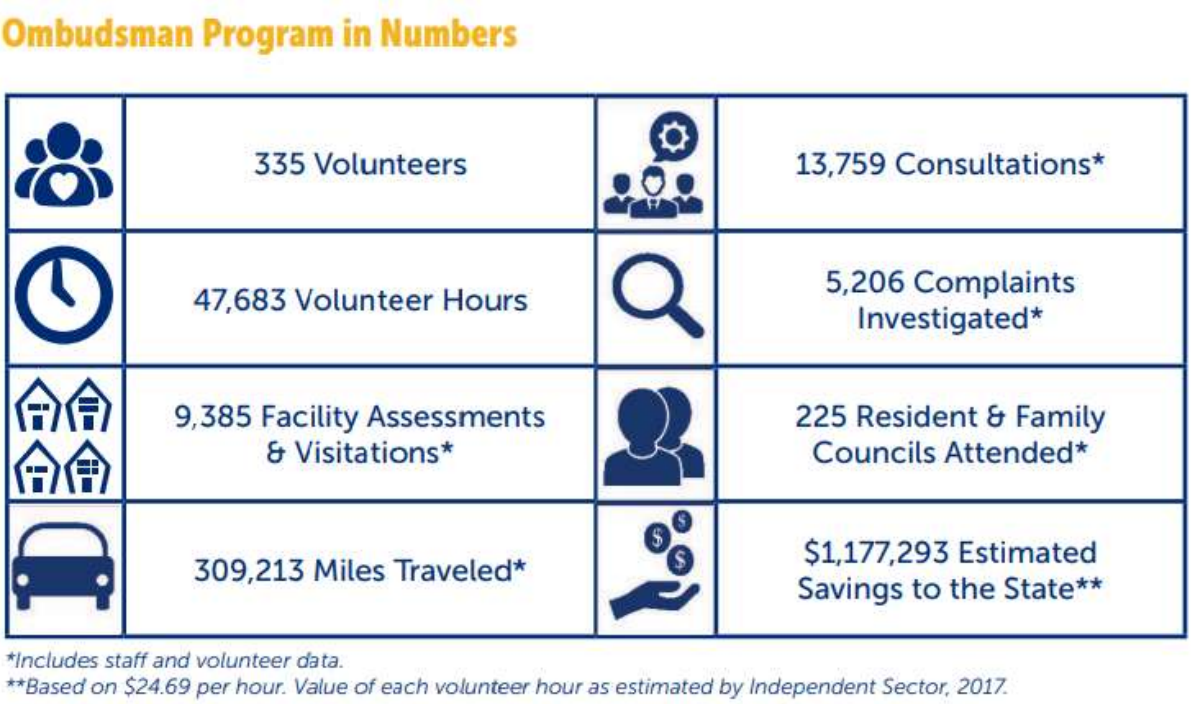
The Florida Department of Elder Affairs is purposed to address the needs and issues of Florida's elderly population (60 or older). The Department works in conjunction with the Department of Children and Families (DCF) Adult Protective Services and the Aging Network to protect disabled adults or elderly people from further occurrences of abuse, neglect or exploitation. Services provided may include protective supervision, placement and in-home and community-based services. There is an abuse hotline (800-96-ABUSE) for reporting any type of abuse.

In Southwest Florida, the Area Agency on Aging has an Elder Abuse Prevention Program that is intended to increase the awareness of elder abuse, neglect and exploitation. They provide training classes to seniors and caregivers. The AAASWFL is also the state's designated Aging and Disability Resource Center for Southwest Florida providing information and resources for seniors (60 or older) and adults with disabilities. As such, it also operates the Elder Helpline (866-41-ELDER) and serves as the State's entry point for long-term care programs. It also serves as the managing entity for government funded elder and disability programs. The Lee County lead agency is Friendship Centers. They provide an adult day program, operate 10 dining sites, provide case management, health and wellness and in-home care among other services.

The Long-Term Care Ombudsman Program (LTCOP)[425] is a statewide, volunteer-based system of local units that act as advocates for residents of long-term care facilities. Through 13 district offices that together cover the entire state, volunteers work with staff to identify, investigate, and resolve complaints made by, or on behalf of, residents of nursing homes, assisted living facilities, adult family-care homes, and continuing care retirement communities. The Southwest Office serves Sarasota, DeSoto, Charlotte, Glades, Lee, Hendry and Collier Counties. Figure 21 shows activity data.

[425] http://elderaffairs.state.fl.us/doea/ombudsman_program.php

Figure 21. State of Florida Ombudsman 2017-2018 Annual Report[426]



In addition to the governmental agencies, there is an active attorney presence in lawsuits against nursing homes for neglect or abuse.

Gaps

Experts in the field of elder abuse note that it is about 20 years behind child abuse and domestic violence in knowledge and research[427]. For example, data detailing the factors leading to elder suicide is not as fully available as would be preferred.

Financial exploitation is a growing issue with the increase in the number of internet or phone scams targeted at elderly persons. Cognitive impairment often makes those seniors more vulnerable.

In addition to the internet or phone scams, some seniors also are exploited by family or

[426] http://ombudsman.myflorida.com/publications/ar/LTCOP_2017_2018_Annual_Report.pdf
[427] Deane, ibid.

caregivers. This in some cases is called financial abuse.

There are significant research and data gaps on how to best prevent or intervene in cases of elder abuse.[428]

Definitions

Elder abuse may take several forms, which include:

- Physical abuse, neglect or mistreatment (i.e. bruises, abrasions, burns);
- Emotional/Psychological abuse, frequent arguments between the caregiver and older adult, unexplained withdrawal from activities. This includes verbal abuse, belittling and threats;
- Sexual abuse;
- Financial abuse/Exploitation, misuse of funds, thefts, scams;
- Neglect, bedsores, poor hygiene, unusual weight loss.

The Florida legal definition of elder abuse in found in F.S. 825.102 Abuse, aggravated abuse and neglect of an elderly person or disabled adult; penalties. —

(1) "Abuse of an elderly person or disabled adult" means:

(a) Intentional infliction of physical or psychological injury upon an elderly person or disabled adult;

(b) An intentional act that could reasonably be expected to result in physical or psychological injury to an elderly person or disabled adult; or

(c) Active encouragement of any person to commit an act that results or could reasonably be expected to result in physical or psychological injury to an elderly person or disabled adult.

[428] Deane, ibid

What is Adult Abuse?[429]

"Abuse" means any willful act or threatened act by a relative, caregiver, or household member which causes or is likely to cause significant impairment to a vulnerable adult's physical, mental or emotional health. Abuse includes acts and omissions.

Signs of Abuse of the Elderly or People with Disabilities

Abuse may cause various injuries such as scratches, cuts, bruises, burns, broken bones, or bedsores. It can also result in confinement, rape or sexual misconduct and verbal or psychological abuse.

Neglect may cause starvation, dehydration, over- or under-medication, unsanitary living conditions, lack of personal hygiene. Neglected adults may also not have heat, running water, electricity or medical care.

Exploitation may result in loss of property, money or income. Exploitation means misusing the resources of an elderly or disabled person for personal or monetary benefit. This includes taking Social Security or SSI (Supplemental Security Income) checks, misusing a joint checking account or taking property and other resources.

Sometimes the elderly or disabled become isolated or ill and do not have someone who is willing and able to help meet their basic needs.

What is Adult Neglect?

Neglect means the failure or omission on the part of the caregiver to provide the care, supervision and services necessary to maintain the physical and mental health of a

[429] https://www.myflfamilies.com/service-programs/adult-protective-services/what-is-adult-abuse.shtml

vulnerable adult, including but not limited to food, clothing, medicine, shelter, supervision and medical services, which a prudent person would consider essential for the wellbeing of a vulnerable adult. The term "neglect" also means the failure of a caregiver or adult to make a reasonable effort to protect a vulnerable adult from abuse, neglect or exploitation by others. "Neglect" is repeated conduct or a single incident of carelessness, which produces or could reasonably be expected to result in serious physical or psychological injury, or a substantial risk of death.

What is Adult Exploitation?

Adult exploitation means a person who stands in a position of trust and confidence with a vulnerable adult knowingly, by deception or intimidation, obtains or uses, or endeavors to obtain or use, a vulnerable adult's funds, assets or property with the intent to temporarily or permanently deprive a vulnerable adult of the use, benefit or possession of the funds, assets or property for the benefit of someone other than the vulnerable adult.

Or

That a person who knows or should know that the vulnerable adult lacks the capacity to consent, obtains or uses, or endeavors to obtain or use, the vulnerable adult's funds, assets or property with the intent to temporarily or permanently deprive the vulnerable adult of the use, benefit or possession of the funds, assets or property for the benefit of someone other than the vulnerable adult.

CHAPTER 19
Sexual Violence and Stalking (non-partner)

Introduction

This chapter addresses the topic of sexual violence. This can include physical assault and rape, stalking or other forms of intimidation or threat. This chapter covers non-partner violence. Intimate partner violence is addressed in the chapter on domestic violence.

This chapter has four sections. They are:

- Section One: Context and Background. This section provides national, state and local Lee County data about the scope and status of sexual abuse.
- Section Two: The System-of-Care. This section describes the various services and responsible entities whose mission it is to address this issue.
- Section Three: System Gaps. These are gaps in services, current unmet needs and any potential emerging issues.
- Section Four: Definitions. This section provides formal and legal definitions of the various terms used in the system. It is provided in case the reader desires clarification on any of these terms, or it may assist in data interpretation.

Context and Background

- Over 1 million (1,266,000) women in Florida have been raped at some point in their lives. That's 17% or one in six women in Florida[430];
- 41.8% of women, or 3,111,000, in Florida have been victimized by sexual violence other than rape[431];
- (79.6% of female victims who have experienced one or more completed rapes, experienced the first rape before the age of 25; 42.2% were under 18 at the time of the first completed rape[432];

[430] Black, M. et.al. 2011. The National Intimate Partner and Sexual Violence Survey: 2010 Summary Report. Atlanta, GA: Centers for Disease Control and Prevention.
[431] Ibid.
[432] ibid

- 20.4% of men, or 1,437,000, in Florida have been victimized by sexual violence other than rape[433];
- 27.8% of male victims who experienced at least one completed rape, experienced the first rape when they were 10 years of age or younger[434];
- 43% of college women report experiencing abusive dating behaviors including physical, sexual, via technology, verbal or controlling abuse. The most common abusive behavior experience is controlling behavior (32%), physical (22%) and sexual (22%)[435];
- Teens report an even higher occurrence of abusive dating behaviors including physical, sexual, via technology, verbal or controlling abuse; the most common abusive behavior experience is controlling behavior (47%), physical/sexual (29%) and via technology (24%)[436];
- 84% of homeless women have experienced severe physical or sexual abuse at some point in their lives[437].

Lee County Data

As Tables 71, 72 and 73 show, the rate of rape or forcible sexual offenses in Lee County is overall lower than the State average. This does not infer that it is not a concern; it is simply to state a fact.

[433] ibid.
[434] ibid
[435] Fifth & Pacific Companies, Inc. Conducted by Knowledge Networks, (December 2010), "College Dating Violence and Abuse Poll".
[436] Fifth & Pacific Companies, Inc. and Family Violence Prevention Fund. Conducted by Tru Insight, (June 2009), "Teen Dating Abuse Report".
[437] *Browne, A. 1998. "Responding to the Needs of Low Income and Homeless Women Who are Survivors of Family Violence." Journal of American Medical Women's Association. 53(2): 57-64.*

Table 71. Comparison Data

Sources	Data Title	Year	Lee County	State	Comparison to State
Social and Mental Health[438]	Rape 3-Yr Rate Per 100,000	2015-17	34.3	38.0	Better
Community Health Needs Assessment[439]	Violent Crime per 100,000	2017	359.2	514.6	Better

Table 72. Rates of Forcible Sexual Offences in Lee County Compared to the State of Florida Average, 2018[440]

County	Population	Rape by Force	Attempted Rape	Forcible Fondling	Total Forcible Sex Offenses	Offence to County Population Ratio	Percentage
Lee	713,903	267	9	137	413	1729	0.00057851
Florida	20,840,986	8,105	331	3,471	11,907	1750	0.000571326

Table 73. Rates of Rape and Forcible Sex Offences, FDLE data

			Lee County	State
Indicators	Data Year	Number of Cases	3-Yr Rate Per 100,000	3-Yr Rate Per 100,000
Crime and Domestic Violence				
Rape	2016-18	774	36.7	38.8
Rape	2013-15	524	26.6	36.4
Forcible Sex Offenses	2016-18	1173	55.7	54.4
Forcible Sex Offenses	2013-15	817	41.5	52.4

[438] Florida Health Charts, Domestic Violence Offenses http://www.flhealthcharts.com/Charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0312
[439] 2017 Community Health Needs Assessment Report; Lee Health and FL Dept of Health in Lee County
[440] Florida Department of Law Enforcement. www.fdlw.state.fl.us

The System-of-Care

In addition to Law Enforcement and Judicial System involvement, the System-of-Care in Lee County for addressing sexual violence consists of two primary service providers, the Abuse Counseling and Treatment (ACT) Center and the Child Advocacy Center (CAC) in conjunction with the Child Protection Team of the Florida Department of Health. Their roles are:

- ACT does forensic examinations for people over 18, sexual violence forensics for persons over 18 and domestic violence for under 18;
- CAC provides forensic examinations for under 18 and sexual assault assistance for under 18.

Abuse Counseling and Treatment (ACT).

When a victim reports a sexual assault to law enforcement, law enforcement will contact the ACT hotline for a forensic examination. The hotline will then call a Certified SANE (Sexual Assault Nurse Examiner) to respond to the rape crisis center. The Center will then contact an on-call crisis response counselor. The State of Florida requires Certified Rape Crisis Centers to respond and provide a forensic examination within 1.5 hours of the call.

Everyone will respond to the rape crisis center, which is owned and operated by ACT. The on-call counselor will first meet with the victim to validate feelings, discuss the examination, review the role of law enforcement and detail the services to be provided. The SANE will then collect medical history and assault information. This will determine what evidence needs to be collected. Pictures are taken of any bruising or wounds. The on-call counselor will accompany the victim throughout this process.

Once the exam is completed and all evidence is documented, a chain of custody is established and evidence collection is turned over to a law enforcement detective. All of this is done only with consent from the victim.

If a victim does not want to report or is uncertain whether he/she wants to report to law enforcement, the same processes are completed and the evidence is stored in a

locked refrigerator for up to one year, per to State Certification Guidelines. Clothing collected that may have DNA on it is stored in a locked cabinet.

If a victim presents at one of the area hospitals because they have injuries so bad they cannot come to the center, the hospital will contact the hotline and the on-call SANE and counselor will respond to the hospital to perform the forensic examination and to offer support.

Evidence is only handled by the SANE. What happens during the exam is always driven by permission from the victim and the information they have provided. When (if) evidence is turned over to law enforcement, there is a chain of custody that needs to be followed. The SANE collecting the evidence would be the one turning over the evidence and it is only turned over to a detective, not an officer.

Evidence can consist of the following:

- Blood draw
- Urine collection
- Swabs for collection of sperm and perpetrator DNA
- Swab for victim DNA
- Collection of clothing
- Photographs of any Injuries

Once the forensic collection is complete, the victim has the opportunity to shower and is given other clothing to wear if her/his clothing has been collected as evidence. The counselor will set up an appointment for the victim to come to counseling and they will also do a follow up phone call to check on her/him before the counseling.

The entire process, from the time the victim gets to the rape crisis center until the time everything is complete, takes about three hours per victim.

CAC- Child Sexual Abuse

Child sexual abuse cases are generally handled by the Department of Health's Child Protection Teams (CPTs), whose role is to supplement the assessment and protective supervision activities of the Department of Children and Families. Services provided by

CPTs include diagnostic medical evaluations, medical consultations, family psychosocial interviews and forensic interviews.

In Florida, CPTs work closely with Children's Advocacy Centers (CACs), most of which are unaffiliated with FCASV's certified sexual assault programs. A CAC is a community-based, child-focused facility in which children who are victims of abuse or neglect are interviewed and receive medical exams. If necessary, therapy and other critical services are provided in a non-threatening and child-friendly environment. A CAC brings together an array of professionals to work together on the investigation, treatment and prosecution of child abuse cases. The primary goal of a CAC is to minimize the level of trauma experienced by child victims, improve prosecutions and provide efficient and thorough provision of necessary services to the child victim and the child's family.

Children's Advocacy Centers provide services such as:

- Forensic interviews conducted in a non-threatening, child-friendly environment;
- Crisis intervention and emotional support for victims and non-offending family members;
- Counseling for victims and non-offending family members so that they may begin to heal from emotional wounds associated with child abuse;
- Medical evaluations and services;
- Multidisciplinary review of cases by a team of professionals, such as law enforcement officials, child protection teams, prosecutors, medical professionals, mental health professionals, victim assistance staff and child advocates;
- Evidence-based prevention and intervention programs to reduce the likelihood of child maltreatment and to provide safe and caring homes for children;
- Professional training and community education to effectively respond to child abuse;
- Sexual assault assistance for people under 18.

Gaps

For adults, there are no significant gaps in the service system.

For children, the following are the most significant gaps:

- Provision of evidence-based therapies. These therapeutic options are not available in the County.

- In-home and after-care services. There is a need for increased in-home services.

External to the systems themselves, the most significant gaps are:

- Public perception, personal shame and a lack of willingness to report;

- Public education pertaining to a lack of understanding of what constitutes sexual assault.

Definitions

The Florida Uniform Crime Reports program defines "Rape" as the penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person or object, without the consent of the victim. This definition includes either gender of victim or offender, and instances where the victim is incapable of giving consent because of temporary or permanent mental or physical incapacity (including due to the influence of drugs or alcohol) or because of age. Physical resistance is not required on the part of the victim to demonstrate lack of consent. Attempts to commit rape are also included.

The Florida Uniform Crime Reports program defines "Forcible Sex Offenses" as any sexual act directed against another person, forcibly and/or against that person's will, or not forcibly or against the person's will, where the victim is incapable of giving consent. The element of force or threat of force is necessary (unless the victim is unable or too young to give consent) before a sexual offense is reported in this category. Any sexual act or attempt involving force is classified as a forcible sex offense regardless of the age of the victim or the relationship of the victim to the offender. The "Forcible Sex Offense" category includes offenses classified as "Rape" and "Fondling".

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CHAPTER 20
Trauma and Effects of Violence Exposure

Introduction

In recent years, the effects of exposure to violence have become better understood. No matter the age of the person, violence exposure can lead to varying levels of trauma. Trauma can have both physiological and psychological impacts, both short- and long-term.

The more formal Systems of Care all face trauma in some way, whether it is domestic violence, child abuse, people with PTSD, elder abuse, sexual abuse, etc. There is no separate system addressing exposure to violence, and there shouldn't be, as the dynamics underlying violence exposure can be diverse. The purpose of this chapter is to emphasize the seriousness and scope of the issue so that it can be considered in the overall human services system.

In addition to people who are victims of violence, there is a better understanding of who are exposed to violence. In combat, this is called post-traumatic stress disorder. However, there are other people who are also exposed to violence. This includes first responders, the professionals and para-professionals who work with victims of child abuse, domestic violence, elder abuse, rape, etc.

This chapter follows the format of other Systems of Care chapters with a Context Section, Lee County Data Section, System-of-Care Description and Gap Analysis.

Context and Background

Victims

The following facts illustrate the scope and impacts of trauma:

- Children exposed to various forms of trauma have more attachment and behavior disorders[441] and are at greater risk for alcohol and substance abuse disorders;[442]
- Trauma exposure is related to anti-social behavior;[443]
- Post-Traumatic Stress Disorder is related to exposure to violence and maltreatment;[444]
- Depression is related to violence exposure;[445]
- Anxiety is related to violence exposure;[446]
- Suicidal ideation is higher for people exposed to various forms of violence or trauma;[447]
- Exposure to trauma and self-injurious behaviors are related;[448]
- One study found that 73.9% of females in jail or prison and 86.1% of males in jail or prison had experienced physical or sexual abuse.[449] Another study found 56% of male inmates had experienced childhood physical trauma and 25% had experienced emotional abuse, particularly abandonment.[450]

[441] Grayson, J. 2006. Maltreatment and its effects on early brain development. Virginia Child Protection Newsletter, 77:1-16

[442] Bellis, M. et.al. 2014. The biological effects of childhood trauma. Child Adolesc Psychiatr Clin N Am. 23(2): 185-222.

[443] Lansford, J. et.al. 2002. A 12-year prospective study of the long-term effects of early child physical maltreatment on psychological, behavioral, and academic problems in adolescence. Archives of Pediatrics & Adolescent Medicine., 156(8)), 824-830.

[444] Ibid.

[445] Trickett, P. et.al. 2011. The impact of sexual abuse on female development: Lessons from a multigenerational, longitudinal research study. Development and Psychopathology, 23(2) 453-476.

[446] Ibid.

[447] Duke, N. et.al. 2010. Adolescent violence perpetration: Association with multiple types of adverse childhood experiences. Pediatrics, 125(4), 778-786.

[448] Ibid.

[449] Pinas, D. The sequential intercept model as a framework. SAMSHA Center for Behavioral Health and Justice Transformation.

[450] Wolf, N. & Shi, J. 2012. Childhood and adult trauma experiences of incarcerated persons and their relationship to adult behavioral health problems and treatment. Int. J Environ Res Public Health. 9(5): 1908-1926.

Many researchers have concluded that some children who witness or are victims of domestic violence experience a profound and lasting impact on their lives and hopes for the future. "A child's developing brain can mistakenly encode the violence," says Children of Domestic Violence[451], adding that kids can grow up believing that violence is normal and that they are to blame for it. Studies that support this conclusion provide the following information:

- By age 12, 83% of homeless children have been exposed to at least one serious violent event and nearly 25% have witnessed acts of violence within their families;[452]
- 30% to 60% of perpetrators of intimate partner violence also abuse children in the household;[453]
- The single best predictor of children becoming either perpetrators or victims of domestic violence later in life is whether they grow up in a home where there is domestic violence. Studies from various countries support the findings that rates of abuse are higher among women whose husbands were abused as children or who saw their mothers being abused;[454]
- Boys who witness domestic violence are twice as likely to abuse their own partners and children when they become adults;[455]
- Teens that have witnessed violence within their own family are 50% more likely to be involved in an abusive relationship themselves;[456]
- Violent relationships in formative years can have serious ramifications by putting the victims at higher risk for substance abuse, eating disorders, risky sexual behaviors and further domestic violence;[457]
- Per person costs from the ages of 20 to 64 because of being exposed to domestic violence as a child is $50,000. These costs include healthcare spending ($11,000),

[451] https://www.domesticshelters.org/articles/statistics/children-and-domestic-violence
[452] *Bassuk, E.L., Weinreb, L.F., Buckner, J.C., Browne, A., Salomon, A., & Bassuk, S.S. (1996). "The characteristics and needs of sheltered homeless and low-income housed mothers." Journal of the American Medical Association, 276, 640-646.*
[453] *Edelson, J.L. (1999). "The Overlap Between Child Maltreatment and Woman Battering." Violence Against Women. 5:134-154*
[454] "*Behind Closed Doors: The Impact of Domestic Violence on Children." UNICEF, Child Protection Section and The Body Shop International (2006).*
[455] *Strauss, Gelles, and Smith, "Physical Violence in American Families: Risk Factors and Adaptations to Violence" in 8,145 Families*
[456] Fifth & Pacific Companies, Inc. and Family Violence Prevention Fund[456]. Conducted by Tru Insight, (June 2009), "Teen Dating Abuse Report".
[457] Decker M, Silverman J, Raj A, 2005. Dating Violence and Sexually Transmitted Disease/HIV Testing and Diagnosis Among Adolescent Females. Pediatrics. 116: 272-276.

criminal behavior ($14,000), and loss of labor market productivity ($26,000). Applied to the entire nation, the economic burden is more than $55 billion.[458]

Persons Working with Victims

The effects of exposure to violence or traumatic events not only affects those generally considered to be victims, it also affects others. First responders, police officers, or firefighters/EMS professionals may be regularly exposed to violence, physical harm, natural disasters, or other types of traumatic events. It is estimated that 30% of first responders develop behavioral health conditions as compared to 20% in the general population.[459] 69% of EMS professionals have never had enough time to recover between traumatic events.[460]

professionals or paraprofessionals who provide counseling or other clinical services to persons experiencing trauma can experience what is termed "secondary exposure" or "vicarious trauma."[461] These people may manifest symptoms such as those associated with Post-Traumatic Stress Disorder (PTSD). These experiences also lead to "burn-out."[462] It should be noted that the interaction does not have to be face-to-face. Telephone interactions can lead to vicarious trauma.[463] A study of 911 operators, for example, found a link to PTSD based on their indirect exposure to trauma.[464]

[458] *Holmes, M.R., Richter, F.G.C., Votruba, M.E. et al (2018). "Economic Burden of Child Exposure to Intimate Partner Violence in the U.S." Journal of Family Violence.*

[459] Abbot, C. et.al. 2015. What's killing our medics? Ambulance Service Manager Program, Conifer, CO: Reviving Responders. Retrieved from www.revivingresponders.com/orginalpaper.

[460] Bentley, M. A., Crawford, J. M., Wilkins, J. R., Fernandez, A. R., & Studnek, J. R. (2013). An assessment of depression, anxiety, and stress among nationally certified EMS professionals. *Prehospital Emergency Care, 17*(3), 330–338. https://doi.org/10.3109/10903127.2012.761307

[461] Diehm, R., et.al. 2015. The impact of secondary exposure to trauma on mental health professionals. InPscyh. 37(1). www.psychology.org.au.

[462] Craig, C., & Sprang, G. (2010). Compassion satisfaction, compassion fatigue, and burnout in a national sample of trauma treatment therapists. *Anxiety, Stress, and Coping, 23*(3), 319-339.

[463] Dunkley, J., & Whelan, T. (2006). Vicarious traumatisation in telephone counsellors: internal and external influences. *British Journal of Guidance and Counselling, 4,* 451- 469.

[464] Muller, R. 2017. Trauma exposure linked to PTSD in 911 Dispatchers. www.psychologytoday.com.

Lee County Data

Trauma is associated with various forms of violence and abusive behavior. As noted, childhood abuse and trauma are associated with various problems in adulthood. Table 74 summarizes available data on Child Abuse and Neglect Indicators in Lee County.

Table 74. Child Abuse and Neglect Indicators in Lee County

Sources	Data Title	Year	Lee County	State	Comparison to State
MyFLFamilies.com[465]	Children Entering Care Who Achieve Permanency within 12 Months	2018	43.2%	41.4%	Within 10% average
		2019	44.7%	40.2%	Better
MyFLFamilies.com	Chart - Abuse during In-Home Services (% of Children Not Abused) (Average State Fiscal Year)	2018	94.4%	94%	Within 10% average
		2019	94.2%	94.7%	Within 10% average
MyFLFamilies.com	Chart - Children with No Recurrence of Verified Maltreatment w/in 12 Months (Average State Fiscal Year)	2018	91.3%	91.9%	Within 10% average
		2019	92.9%	92.4%	Within 10% average
MyFLFamilies.com	Chart - Young Adults Aging out who did not Perpetrate Abuse by their 25th Birthday	2019 Q1	84.21%	87.35%	Within 10% average
		2018 Q1	82.35%	88.34%	Within 10% average
MyFLFamilies.com	Chart - Removal Rate per 100 Alleged Victims	2018	5.2	5.2	Same
School Age Child Adolescent Profile[466]	Children Experiencing Child Abuse Ages 5-11 per 100,000	2015-17	850.4	932.8	Better
		2016-18	863.2	855.3	Within 10% average
School Age Child Adolescent Profile	Children in foster care ages 5-11 Per 100,000	2017	563.4	413.7	Worse
		2018	571.3	455.7	Worse
		2017	481.8	410.6	Worse

[465] Florida Department of Children and Families, Child Welfare Statistics Dashboard https://myflfamilies.com/programs/childwelfare/dashboard/

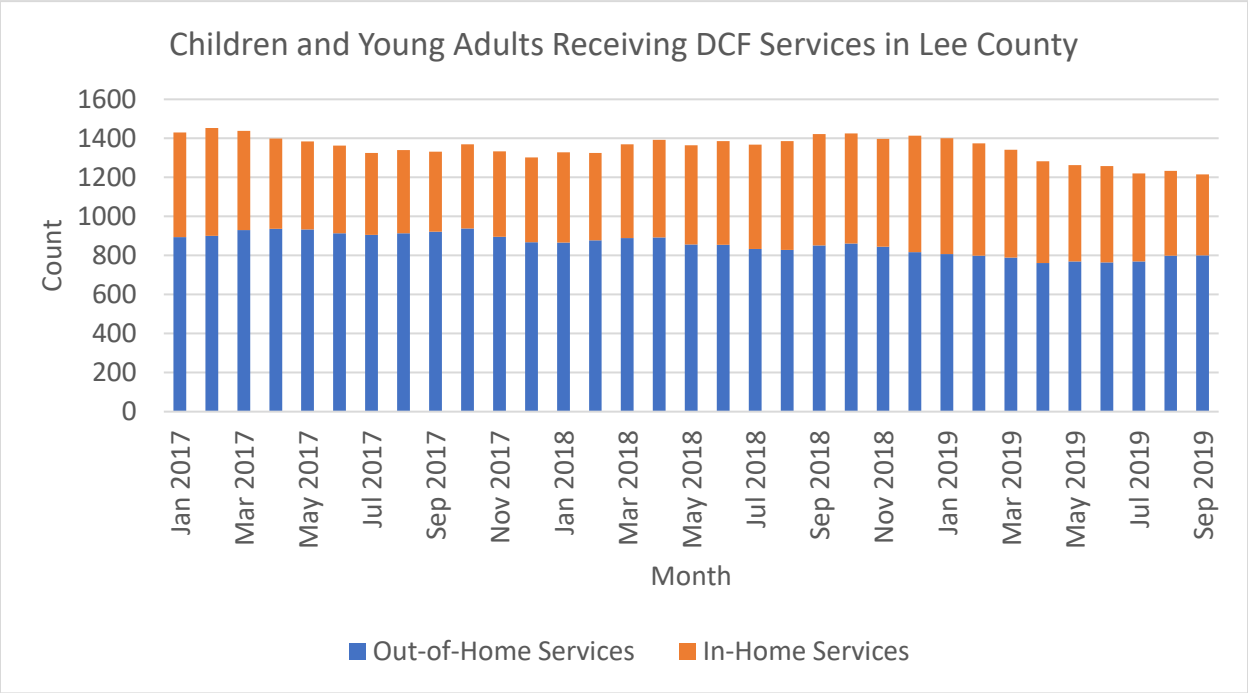
[466] Florida Health Charts, School-aged Child and Adolescent Profile http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.School-agedChildandAdolProfile

Sources	Data Title	Year	Lee County	State	Comparison to State	
School Age Child Adolescent Profile	Children in foster care ages 12-17 Per 100,000	2018	511.8	362.4		Worse
Child Health Status[467]	Children under 18 in Foster Care Per 100,000 population	2017	708.3	537.7		Worse
Child Health Status[468]	Children Experiencing Sexual Violence Ages 5-11 per 100,000 population	2015-17	73.5	59.8		Worse
MyFLFamilies.com	Removal Rate per 100 Alleged Victims for Investigation Closed by Quarter (*County group is a region that includes – Lee, Collier, Charlotte, Hendry and Glades counties*)	Oct – Dec 2018 (Quarter)	5.6	4.8		Worse
		Jan – Mar 2019	5.03	5.17		Within 10% average
		April – June 2019	5.23	4.8		Within 10% average
		July – Sept 2019	7.27	5.78		Worse

[467] Child Health Status
http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.ChildHealthStatusProfile
[468] Florida Health Charts, Children Experiencing Sexual Violence ages 5-11
http://www.flhealthcharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0561

Figure 22 shows the number of children receiving some form of DCF services in Lee County. While this does not mean each child has experienced severe trauma, there has been at least some disruption in their life.

Figure 22. Children and Young Adults Receiving DCF Services in Lee County[469]



469 [469] https://www.myflfamilies.com/programs/childwelfare/dashboard/cya-inhome.shtml https://www.myflfamilies.com/programs/childwelfare/dashboard/c-in-ooh.shtml

Tables 75 and 76 report on domestic violence in Lee County. The experience of domestic violence is a traumatic one for the victim and for children, if involved.

Table 75. Domestic Violence in Lee County

Sources	Data Title	Year	Lee County	State	Comparison to State
Social and Mental Health	Domestic Violence Offenses 3-Yr Rate Per 100,000	2015-17	414.8	527.8	Better

Table 76. Rates of Domestic Violence – Lee County, FDLE Data

			Lee County	State
Indicators	Data Year	Number of Cases	3-Yr Rate Per 100,000	3-Yr Rate Per 100,000
Crime and Domestic Violence				
Domestic Violence Offenses	2016-18	8932	424.1	514.3
Domestic Violence Offenses	2013-15	7884	400	548.7

Tables 77, 78 and 79 present data on other forms of trauma: Rape, Forcible Sexual Offences and Violent Crime.

Table 77. Rates of Forcible Sexual Offences in Lee County Compared to the State of Florida Average, 2018[470]

County	Population	Rape by Force	Attempted Rape	Forcible Fondling	Total Forcible Sex Offenses	Offence to County Population Ratio	Percentage
Lee	713,903	267	9	137	413	1729	0.00057851
Florida	20,840,986	8,105	331	3,471	11,907	1750	0.000571326

[470] Florida Department of Law Enforcement. www.fdlw.state.fl.us

Table 78. Rates of Rape and Forcible Sex Offences, FDLE Data

			Lee County	State
Indicators	Data Year	Number of Cases	3-Yr Rate Per 100,000	3-Yr Rate Per 100,000
Crime and Domestic Violence				
Rape	2016-18	774	36.7	38.8
Rape	2013-15	524	26.6	36.4
Forcible Sex Offenses	2016-18	1173	55.7	54.4
Forcible Sex Offenses	2013-15	817	41.5	52.4

Table 79. Comparative Data on Rape and Violent Crime

Sources	Data Title	Year	Lee County	State	Comparison to State
Social and Mental Health[471]	Rape 3-Yr Rate Per 100,000	2015-17	34.3	38.0	Better
Community Health Needs Assessment[472]	Violent Crime per 100,000	2017	359.2	514.6	Better

[471] Florida Health Charts, Domestic Violence Offenses http://www.flhealthcharts.com/Charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0312
[472] 2017 Community Health Needs Assessment Report; Lee Health and FL Dept. of Health in Lee County

As the context discussion indicated, abused children are at greater risk of becoming an adult abuser. Table 80 reports the one data source that indicates these behaviors are as likely to occur in Lee County as they are elsewhere in the State.

Table 80. Young Adults Aging Out of Out-of-Home Care who did not Perpetrate Abuse by their 25th Birthday by County

Sources	Data Title	Year	Lee County	State	Comparison to State	
MyFLFamilies.com[473]	Young Adults Aging out who did not Perpetrate Abuse by their 25th Birthday	2014-19	84.21%	86.85%		Within 10% average

As the context discussion indicated, people experiencing severe trauma are at greater risk of suicide. Table 81 presents data on suicide in Lee County.

Table 81. Suicide Rates in Lee County, FL

Sources	Data Title	Year	Lee County	State	Comparison to State	
Community Health Needs Assessment	Suicide (age adjusted death rate) per 100,000	2017	16.9	14		Worse
County Death Data Comparison	Suicide Age Adjusted Death Rate Per 100,000 Total Population	2107	14.3	14.1		Within 10% average
Child Health Status	Suicide death rate, ages 19-21 Per 100,000 population	2015-17	16.1	12.6		Worse

[473] https://myflfamilies.com/programs/childwelfare/dashboard/aging-out-abuse.shtml

System-of-Care

The following entities form the system-of-care for addressing exposure to violence in Lee County.

Children's Advocacy Center (CAC). A CAC is a community-based, child-focused facility in which children who are victims of abuse or neglect are interviewed and receive medical exams. If necessary, therapy and other critical services are provided in a non-threatening and child friendly environment. A CAC brings together an array of professionals to work together on the investigation, treatment and prosecution of child abuse cases. The primary goal of a CAC is to minimize the level of trauma experienced by child victims, improve prosecutions and provide efficient and thorough provision of necessary services to the child victim and the child's family.

The Behavioral Health Providers. Each behavioral health provider offers therapies that can address trauma issues.

Veterans Administration. The VA offers a variety of counseling and assistance services for Veterans with PTSD and other forms of trauma.

Abuse and Counseling Treatment (ACT). ACT offers counseling and therapeutic services for people experiencing domestic violence, intimate partner violence, or sexual or physical assault.

Best Practices. The following are considered best practices and are being used in Lee County:

- Child-Parent Psychotherapy (ages 0 to 5)[474]
- Parent-Child Interaction Therapy (2 to 7)[475]
- Eye Movement and Desensitization and Reprocessing (2 to 17)[476]
- Trauma-Focused Cognitive Behavioral Therapy (3 to 18)[477]
- Problematic Sexual Behavior – Cognitive Behavior Therapy (3 to 14)[478]

[474] www.childparentpsychotherapy.com
[475] www.pcit.org
[476] www.emdr.com
[477] www.tfcbt.org
[478] www.psbcbt_ouhsc.edu

- Alternative for Families: A Cognitive Behavioral Therapy (5 to 17)[479]
- Child and Family Trauma Stress Intervention (7 to 18)[480]

Gaps

The following are the most significant gaps.

- Gaps identified in the chapters on domestic violence, child abuse, elder abuse and sexual violence apply here but will not be repeated.

- In-home services need to be increased.

- A better understanding of trauma is needed by related professionals who periodically interact with people experiencing trauma. This includes an understanding of trauma, the indicators of trauma and the effective interventions to working with trauma victims.

- A better understanding of trauma experienced by professionals and technicians who work with victims, whose work exposes them to either violent acts, severe bodily injuries, non-natural deaths, natural disasters, or other forms of extreme negative events and behaviors is needed.

[479] www.afcbt.org
[480] www.medicineyale.edu/childstudy/communitypartnerships/cvtc/cftsi

CHAPTER 21
Suicide and Self-harm

Introduction

Rates of suicide have increased to a point at which there is increased policy attention. The Florida Association of Counties (FAC) is currently conducting a survey to determine what efforts are underway to prevent suicide. FAC is asking for information in three areas specifically:

- Funded mental health services that are aimed at preventing suicide;
- Local ordinances aimed at reducing access to lethal means, such as storage of medicines or firearms;
- Infrastructure improvements aimed at reducing the use of common suicide locations such as places with heights or railroad tracks. These improvements may limit access, erect barriers or add signage encouraging help.

Context and Background

Nationally, the suicide rate increased 25.4% from 1999 to 2016, with increases occurring in every state, save for Nevada. Between 2001 through 2017, the rate increased 31%. [481] In 2017, there were an estimated 1.4 million suicide attempts and more than 47,000 deaths by suicide, making it the 10th leading cause of death in the United States. Firearms were involved in half of all suicides, and there were more than twice as many deaths by suicide than by homicide.[482]

Between 2000 and 2007, the suicide rate among youth ages 10 to 24 hovered around 6.8 deaths per 100,000 people. Then, the rate curved upward, reaching a rate of 10.6 deaths per 100,000 by 2017 — a 56% increase in less than two decades.[483] Based on the 2017 Youth Risk Behaviors Survey, 7.4% of youth in grades 9 to 12 reported that they had made at least one suicide attempt in the past 12 months. Female students

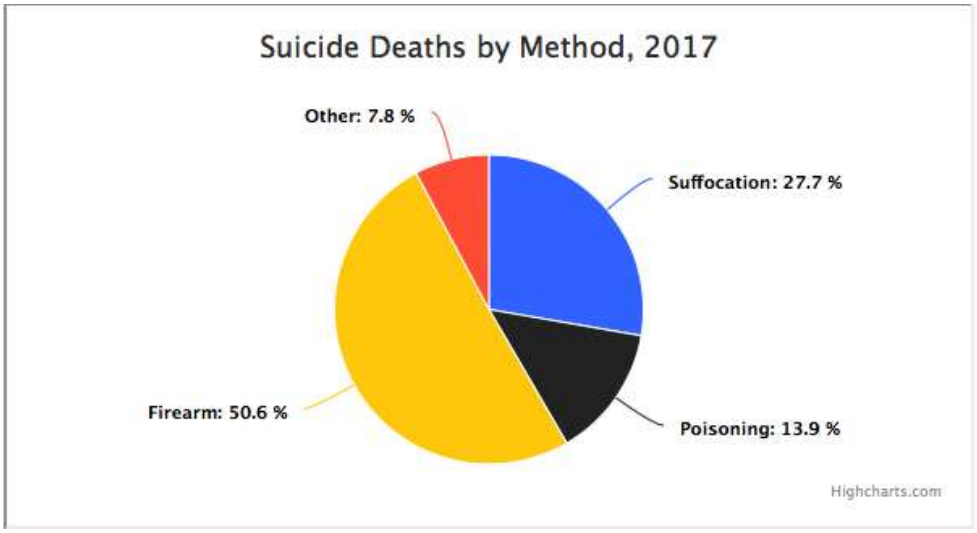
[481] Suicide rates. National Institute of Mental Health
[482] Suicide. 2019. Annual Report. www.americashealthrankings.org
[483] Santhanam, L. 2019. Youth suicide rates are on the rise in the U.S. October 18. www.pbr.org

attempted almost twice as often as male students (9.3% vs. 5.1%). Black students reported the highest rate of attempt at 9.8% with white students at 6.1%. Approximately 2.4% of all students reported making a suicide attempt that required treatment by a doctor or nurse.[484]
Societal costs associated with suicide were estimated at $70 billion. These costs include lifetime medical fees and lost work costs[485].

Populations with disproportionately high suicide rates include:[486]

- Males compared with females.
- American Indian/Alaska Native and white adults. Suicide rates among Hispanic, black and Asian/Pacific Islander adults are at least two times lower than rates among American Indian/Alaska Native and white adults among both genders.
- Older adults: By age and gender, the highest suicide rate is among males ages 65 and older, followed by males ages 45 to 54. Among females, those ages 45 to 54 had the highest rate, followed by those ages 55 to 64.
- Veterans: Suicide rates among veterans were 1.5 times greater than non-veterans, after adjusting for age and gender in 2016.
- Those living in rural areas compared with those living in urban areas.
- LGBTQ+ adults and youth compared with heterosexual adults and youth.

Figure 23. Suicide Deaths by Method[487]



[484] Suicide attempts. American Foundation for Suicide Prevention. www.afsp.org
[485] op.cit.
[486] op.cit.
[487] Suicide statistics. American Foundation for Suicide Prevention. www.afsp.orgh

Risk Factors. Mental health disorders and/or substance use disorders are the most significant risk factors for suicidal behaviors. In addition, environmental factors such as stressful life events and access to lethal means such as firearms or drugs may increase the risk of suicide. Previous suicide attempts and a family history of suicide are also risk factors.[488]

People most at risk tend to share specific characteristics. The main risk factors for suicide are:

- Depression, other mental disorders or substance abuse disorder
- Certain medical conditions
- Chronic pain
- A prior suicide attempt
- Family history of a mental disorder or substance abuse
- Family history of suicide
- Family violence, including physical or sexual abuse
- Having guns or other firearms in the home
- Having recently been released from prison or jail
- Being exposed to others' suicidal behavior, such as that of family members, peers or celebrities

Suicide and Other Problems

Suicide threats or self-harm can be related to other issues. For example, threats of suicide or self-harm is the leading reason why a college student who is an abused partner stays in the relationship (24%)[489]:

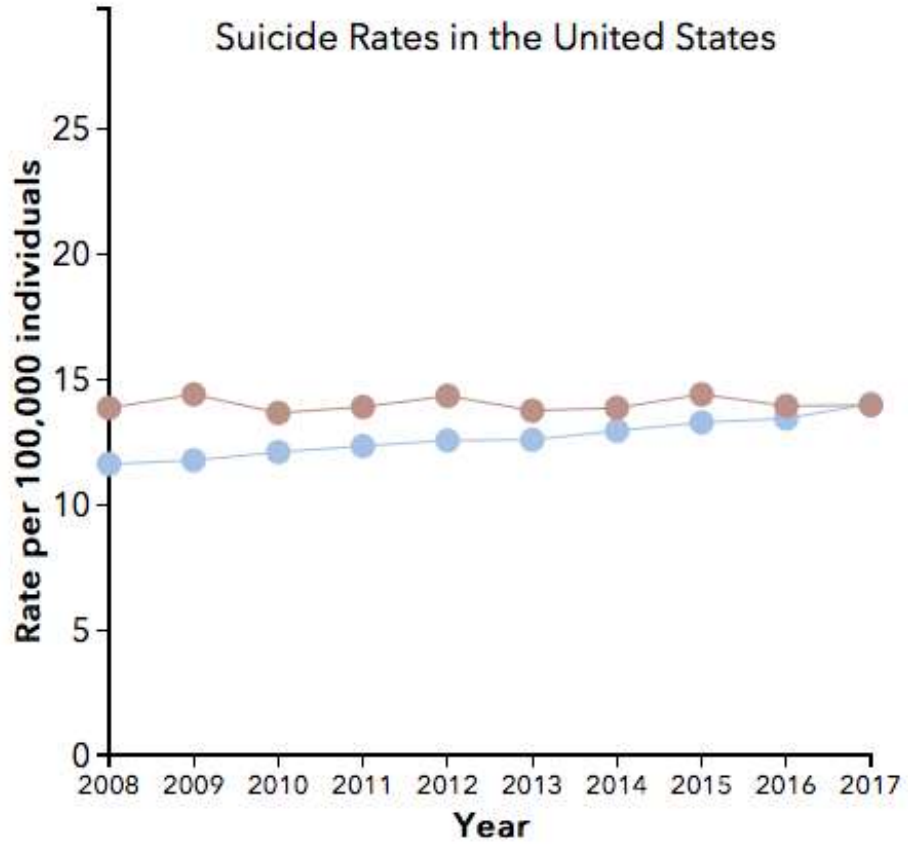
[488] op.cit.
[489] Fifth & Pacific Companies, Inc. Conducted by Knowledge Networks, (December 2010), "College Dating Violence and Abuse Poll".

Suicide in Florida

Florida has a suicide age-adjusted rate of 14 people per 100,000[490]. In 2017, there were 3,227 suicides in the State[491]. Suicide is the eight-leading cause of death in the State.[492] Compared to the rates of other states, Florida is ranked 37th[493] in one survey and 32nd in another.[494]

Figure 24 compares suicide rates in Florida to the United States.

Figure 24. Suicide Rates in the United States



[490] Stats of the State of Florida. 2017. National Center for Health Statistics. Centers for Disease Control and Prevention.
[491] Op.cit.
[492] op.cit
[493] op.cit
[494] Knowles, M. 2018. U.S. States ranked by suicide rate. www.beckershospitalreview.com

Lee County Data

Suicide rates for Lee County are shown in Table 82 below. As the table indicates, they are somewhat worse than State averages.

Table 82. Suicide rates in Lee County

Sources	Data Title	Year	Lee County	State	Comparison to State
Community Health Needs Assessment[495]	Suicide (age adjusted death rate) per 100,000	2017	16.9	14	Worse
County Death Data Comparison[496]	Suicide Age Adjusted Death Rate Per 100,000 Total Population	2107	14.3	14.1	Within 10% average
Child Health Status[497]	Suicide death rate, ages 19-21 Per 100,000 population	2015-17	16.1	12.6	Worse

Higher rates of suicide are reported nationally for LGBTQ+ persons. There is no local data available to determine the scope of the issue, if any, in Lee County.

The System-of-Care: Best Practices

Proven and promising practices include:

- Universal suicide screening at hospital emergency departments[498]
- Coordination of suicide-prevention efforts across health-care, social, education and employment services[499]

[495] 2017 Community Health Needs Assessment Report; Lee Health and FL Dept. of Health in Lee County
[496] Florida Health Charts; County Death Data Comparison: http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.CountyDeathDataComparison
[497] Florida Health Charts: Child Health Status Profile: http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.ChildHealthStatusProfile
[498] Weir, K. 2019. Worrying trends in U.S. Suicide rates. Monitor on Psychology. 50(3), 24. www.apa.org
[499] op.cit.

- Workplace suicide prevention programs[500]
- Monthly reporting of suicides by local jurisdictions[501]
- Development of safety plans for at-risk people[502]
- Reduction of access to lethal means[503]
- Training of General Practitioners to recognize and treat depression and suicidality[504]
- The prediction of suicide risk using electronic health records[505]
- The use of cognitive behavioral therapy and dialectical behavior therapy[506]
- Collaborative care. This is a team-based approach that adds behavioral health care management and a mental health specialist to primary care[507]

The System-of-Care in Lee County

There is no funding specifically dedicated to suicide prevention in Lee County. SalusCare is funded for mental health/substance abuse in the following programs that could address suicidal issues:

- Crisis stabilization units for both children and adults
- Children's therapeutic behavioral onsite services
- Children's crisis support/emergency services
- Access and counseling, case management, outpatient therapy

There is also a mobile crisis unit funded through the Central Florida Behavioral Health Network, which is administered by the Center for Progress and Excellence.

In addition, there are various hotlines that could be used. The National Suicide Prevention Lifeline is 800 273 TALK (8255).

[500] op.cit
[501] op.cit.
[502] op.cit
[503] op. cit.
[504] Feltz-Cornelis, C. et.al. 2011. Best practice elements of multilevel suicide prevention strategies. Crisis. 31:319-333.
[505] Suicide prevention. National Institute of Mental Health. www.nimh.nih.gov
[506] op.cit.
[507] op.cit

Gaps

The gaps that are present elsewhere in local jurisdictions exist in Lee County. These include:

- Data gaps as to the local scope and details
- Limited mental health services
- Limited training for all professions on suicide and suicide prevention
- Gaps in inter-disciplinary teams
- Lack of some of the best practices identified above
- Public perception and shame

Intentionally left blank.

CHAPTER 22
Juveniles

Introduction

The system for addressing problematic issues by juveniles in Florida is called the Juvenile Justice System. Its purpose is to intervene as early as possible to prevent further problematic behavior, while at the same time giving equal consideration to public safety.

Context and Background

The development of delinquent behavior is a result of a complex interaction of individual, social and community conditions.[508] For individuals, there are both genetic and environmental factors that start at fetal development and continue throughout life. Table 83[509] shows the risk and protective factors associated with the development of juvenile delinquency.

Table 83. Risk and Protective Factors by Domain

Risk Factor			
Domain	**Early Onset (ages 6-11)**	**Late Onset (ages 12-14)**	**Protective Factor***
Individual	General offenses Substance use Being male Aggression ** Hyperactivity Problem (antisocial) behavior Exposure to television violence Medical, physical problems Low IQ Antisocial attitudes, beliefs Dishonesty**	General offenses Restlessness Difficulty concentrating** Risk taking Aggression** Being male Physical violence Antisocial attitudes, beliefs Crimes against persons Problem (antisocial) behavior Low IQ Substance use	Intolerant attitude toward deviance High IQ Being female Positive social orientation Perceived sanctions for transgressions

[508] The development of delinquency. The National Academies of Sciences, Engineering Medicine. www.nap.edu
[509] Office of the Surgeon General, 2001

Risk Factor			
Domain	**Early Onset (ages 6-11)**	**Late Onset (ages 12-14)**	**Protective Factor***
Family	Low socioeconomic status/poverty Antisocial parents Poor parents-child relationship Harsh, lax, or inconsistent discipline Broken home Separation from parents Other conditions Abusive parents Neglect	Poor parents-child relationship Harsh, lax, or inconsistent discipline Poor monitoring, supervision Low parental involvement Antisocial parents Broken home Low socioeconomic status/poverty Abusive parents Family conflict**	Warm, supportive relationships with parents or other adults Parents' positive evaluation of peers Parental monitoring
School	Poor attitude, performance	Poor attitude, performance Academic failure	Commitment to school Recognition for involvement in conventional activities
Peer group	Weak social ties Antisocial peers	Weak social ties Antisocial, delinquent peers Gang membership	Friends who engage in conventional behavior
Community		Neighborhood crime, drugs Neighborhood disorganization	

The following figures and tables describe the status of juveniles engaged with the Justice System in Lee County. All data in the figures and tables comes from the Department of Juvenile Justice website so individual citations will not be made. A review of these tables will confirm that many of the risk factors identified in Table 83 are operational for Lee County juveniles involved in the justice system.

Figure 25. Declining Rate of Arrests for Juvenile Offenses

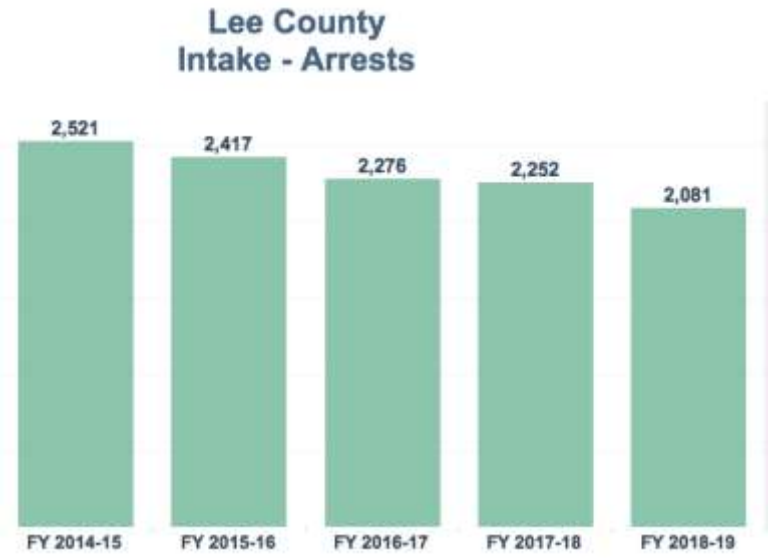


Figure 26. Decline in the Number of Juveniles on Probation

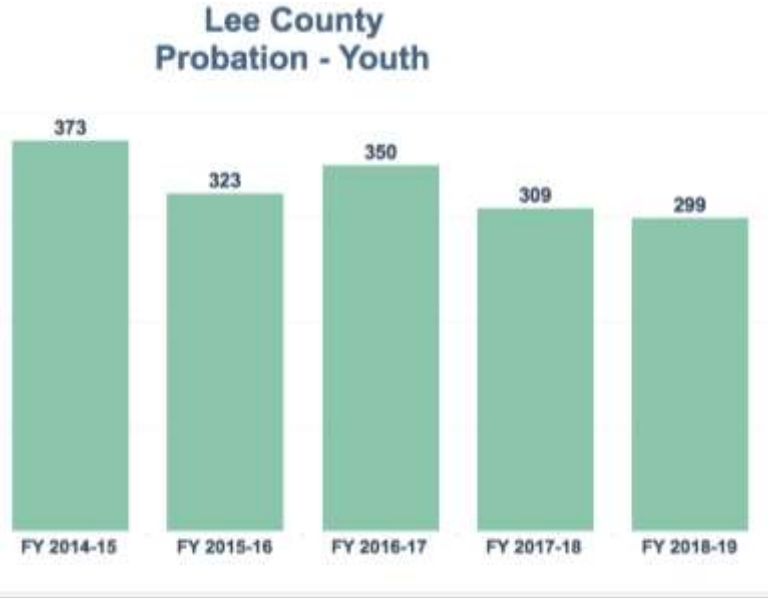
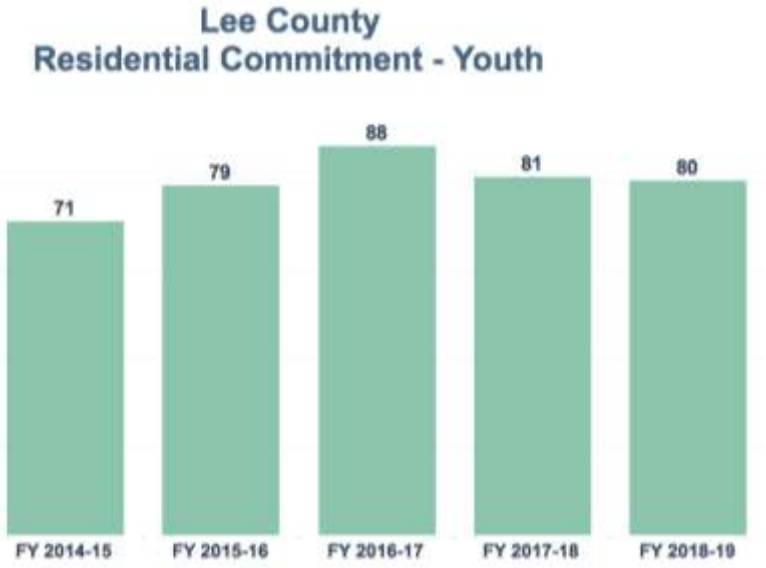


Figure 27. The Number of Lee County Children in Some Form of Residential Restriction



The following tables provide informative data as to the characteristics of juveniles involved in the justice system. Table 84 indicates that nearly 85% are still engaged in school, while nearly 10% have dropped out of school. Table 85 shows that 44% have a family member who has spent time in jail or prison. Table 86 describes the nature of their peer associations; Table 87 describes mental health history; Table 88 shows alcohol use; and Table 89 shows drug use. Tables 90 and 91 report data on physical and sexual abuse.

Some of the significant data points include:

- 44% of juveniles have had a family member in jail or prison
- 45% of juveniles engage in the use of illegal or prescription drugs
- 22% either lack friendships or have friendships with anti-social individuals

Family history, drug abuse and friendship patterns are the highest correlates of problematic juvenile behavior.

Table 84. School Data

School Data	Number	Percentage
Drop-out	103	9.91%
Full-time	883	84.99%
Graduated	25	2.41%
Other	28	2.69%
	1039	1

Table 85. Family History with Criminal Justice System

Family History with Criminal Justice System	Number	Percentage
Family with a history of jail/prison	465	44.33%
Family with no history of jail/prison	584	55.67%
	1049	

Table 86. Peer Associations

Peer Associations	Number	Percentage
All anti-social friends	77	7.48%
All pro-social friends	470	45.68%
Gang member	6	0.58%
No consistent friends	149	14.48%
Pro and anti-social friends	327	31.78%
	1029	

Table 87. Mental Health History

Mental Health History	Number	Percentage
History of mental health issues	177	16.87%
No history of mental health issues	872	83.13%
	1049	

Table 88. Alcohol Usage

Alcohol Usage	Number	Percentage
Current usage	198	18.88%
Current usage with life problems	34	3.24%
No current usage	817	77.88%
	1049	

Table 89. Drug Usage

Drug Use	Number	Percentage
Current drug use	343	32.70%
current use with life problems	138	13.16%
No current drug use	568	54.15%
	1049	

Table 90. History of Physical Abuse

History of Physical Abuse	Number	Percentage
History	134	12.77%
No history	915	87.23%
	1049	

Table 91. History of Sexual Abuse

History of Sexual Abuse	Number	Percentage
History	79	7.53%
No history	970	92.47%
	1049	

The System-of-Care: The Juvenile Justice System

The Juvenile Justice System is operated primarily as a state function (Department of Juvenile Justice or DJJ) in coordination with the judicial system of the State and law enforcement.

The system consists of the following components:

Civil Citation

A law enforcement officer has the discretion to issue a civil citation to a youth involved in some illegal criminal misdemeanor action. This requires parental engagement and requires an appearance the same as any other "ticket" does. If parents refuse involvement, the youth is arrested and taken to the Juvenile Assessment Center (JAC).

Truancy Intervention Program (TIP)

This board seeks to address very early indicators of habitual truancy so that the child is not deemed truant. Elementary and middle school students are identified by their school social worker as being chronically truant with more than 19 unexcused absences in a school year. Students are in violation of Florida Statute 984.12.

Truancy, Ungovernable, Run-Away (TURN Board)

This board seeks to address truant, ungovernable, run-away behaviors by a youth to avoid further involvement with the Juvenile Justice System. Students are in violation of Florida Statute 984.12. Students are referred by their school social worker or a parent.

Children in Need of Services/Families in Need of Services (CINS/FINS)

The DJJ contracts with a nonprofit to address run-away, habitually truant, ungovernable or homeless children through the CINS/FINS services. These youths and their families can be provided with non-residential counseling or can be housed up to 30 days in a CINS/FINS shelter while family counseling occurs and arrangements are made to either return home or go to a state placement. Lutheran Services operates the CINS/FINS program in Lee County. Formal action would be referred to as a CINS Petition. At that

point, a judge would have jurisdiction over the child. The relevant Florida Statute is 984.15.

Juvenile Assessment Center (JAC)

If a juvenile is arrested, he/she will go to the Juvenile Assessment Center (JAC). This is an intake and booking facility for defendants under the age of 18.

Several agencies work at the JAC to facilitate collaboration between the State Attorney's Office (SAO), Department of Juvenile Justice (DJJ), the school system and social services focused on Delinquency Diversion and Family Support Services. The agencies work together to recommend and provide services and sanctions for the juveniles. In Lee County, the JAC is operated by the Lee County Sheriff's Office (LCSO).

JACs provide law enforcement with a central receiving facility at which youth can be screened and booked without further involvement of law enforcement.

The DJJ determines which of the following initial intake status actions is most appropriate:

- Direct release to parents or other home setting
- Intensive home detention
- Intensive home detention with an electronic monitoring device
- A diversion program and referral on-site, if the juvenile has a drug, alcohol or mental health problem
- Secure detention

Other than diversion, these alternatives are time-limited for 21 days. If the youth is re-arrested, the 21-day clock begins again. Otherwise, he/she remains in intake status until a disposition of the case is made, usually within 60 to 120 days.

Diversion and Probation

For youth who are first-time offenders, alternative programs are available. Diversion programs in Lee County are Neighborhood Accountability Boards, Juvenile Arbitration and the Juvenile Diversion Alternative Program. Each youth is assigned a Juvenile Probation Officer. At the completion of the diversion program, the DJJ will close the

case and the State Attorney will nolle pros it.

Juvenile Detention Center

If the juvenile remains in custody, he or she will be transferred to a juvenile detention facility. These centers hold youth that are awaiting court dates or placement in a residential facility. The Southwest Florida Juvenile Detention Center serves Lee, Hendry, Glades and Charlotte counties.

Detention is the custody status for youth who are held pursuant to a court order or after being taken into custody for a violation of the law. In Florida, a youth may be detained only when specific statutory criteria, outlined in section 985.215 Florida Statute, are met. Criteria for detention include current offenses, prior history, legal status and any aggravating or mitigating factors.

Youth under age 18 taken into custody by law enforcement are screened by the Florida Department of Juvenile Justice to determine if they should be detained in a secure detention facility. Detention screening is performed by juvenile probation staff using a standardized Detention Risk Assessment Instrument (DRAI).

The Florida Department of Juvenile Justice operates 21 secure detention centers in 21 counties with a total of 1,243 beds. Pre-disposition detention costs are shared by State and County government. Post-disposition costs are primarily funded by State general revenue dollars. All detention centers receive additional federal funding in the form of the National School Lunch and Breakfast funds. County governments have a funding responsibility for Detention Centers based on State formulas.

Youth placed in secure detention have been assessed as risks to public safety, per the DRAI, and must remain in a physically secure detention center while awaiting court proceedings. Youth in custody for minor crimes that are not considered a risk to public safety may be released into the custody of their parents or guardian.

Courts

Youth will be given a Notice to Appear within 30 days of the day they were arrested. The hearing process is as follows:

- Arraignment. At arraignment, the youth will enter a plea;

- Docket Sounding. At docket sounding, the youth will either continue with the plea originally entered or they will change it;
- Adjudicatory. Adjudicatory is the trial phase;
- Disposition. Disposition is the sentencing phase.

Residential

Residential facilities are for youth who are required by a judge to stay in the care of the department for an extended time. There are varying levels of security. Commitments are for indeterminate periods of time and may include conditional release.

Gaps

The major gap in the system occurs between the expiration of the initial JAC assignment after 21 days and the disposition by DJJ and the court. During this period, there is no support for the youth or family.

The DJJ faces many of the same challenges encountered by other organizations in the State and County. Challenges include:

- Staffing, recruitment and turnover;
- Having to deal with more complex behaviors at earlier ages;
- Managing probation with dysfunctional families for whom services may be limited;
- Family instability due to income, risk of homelessness, domestic violence, child abuse, transportation challenges or other factors;
- Securing mental health or substance abuse services in a timely manner.

Chapter 23
Homelessness

Introduction

This chapter will consist of the following sections:

- Context and Background
- Current Thinking on Addressing Homelessness
- The Homeless Service System in Lee County
- Gaps
- Definitions

Homelessness is a complex issue that has multiple dimensions, including:

- Lack of available and appropriate housing
- Limited access to transportation
- Mental health and substance abuse issues
- Poverty
- Low income that leads to temporary financial instability
- Lifestyle choices
- Physical health issues
- Frequent interactions with law enforcement
- Food security / insecurity and malnutrition
- Threats to physical safety

Several of these issues are addressed in other chapters and will not be repeated here. These include:

- Housing. The basic issue for homelessness. However, it underlies so many other service needs that it is addressed in the Infrastructure Chapter.

- Transportation. This is a core issue for homeless people. As with housing, it is an issue that cuts across populations and services. As such, it is addressed in the Infrastructure Chapter.

- Mental Health and Substance Abuse and Law Enforcement Interaction. Behavioral health issues and subsequent involvement with law enforcement, affect a part of the homeless population. This is also true for other human

service areas. For this reason, two separate chapters, Behavioral Health and Criminal Justice, were developed. The needs of the homeless are addressed in these chapters.

- Food Security and Nutrition. This topic is certainly a concern for homeless people, but it is also a concern for many others. Therefore, there is a separate chapter on Food Security and Nutrition.

Information about gaps for homeless people will be found in those chapters. This chapter will address the remaining issues.

Context and Background

Homelessness is a national issue[510] and neither Florida nor Lee County are exempt. It is estimated that on any given night 0.2% of Americans, or 17 people per 10,000, are homeless.[511] In Florida, it is estimated there are 31,000 homeless individuals, or 15 per 10,000 people.[512] However, data related to homelessness should be used with caution. In Lee County, the National Alliance to End Homelessness estimates that 728 people are homeless for a 9.8 per 10,000 per-capita rate.[513] As noted by the National Law Center on Homelessness and Poverty:[514]

- There are differing definitions of homelessness with HUD using a narrow definition and the US Department of Education using a broader definition.
- The "point-in-time" counting method used by HUD has limitations.

Nationally, homelessness is driven by four factors:[515]

- A lack of affordable housing
- Unemployment or extremely low income[516]
- Poverty
- Behavioral health needs and gaps in services

[510] The State of Homelessness in America. www.whitehouse.gov/wp-content/uploads/2019/09.
[511] Ibid.
[512] National Alliance to End Homelessness. www.endhomelessness.org
[513] ibid.
[514] Homelessness in America. 2018. National Law Center on Homelessness. https://inchp.org/uploads/2018/10
[515] Homelessness in America. 2018. National Law Center on Homelessness. https://inchp.org/uploads/2018/10
[516] National Low Income Housing Coalition, HOUSING SPOTLIGHT: THE AFFORDABLE RENTAL HOUSING GAP PERSIST 2 (Aug. 2014), http://nlihc.org/sites/default/files/HS_4-1.pdf

Another factor, for women specifically, is domestic violence.[517]

It is important to note that there are different types of homeless. One categorization schema identifies three types:

- The Chronic / Long-term Homeless. This is the common, public image of the homeless often seen on the streets, under bridge, or in parks. These people are homeless for long periods of time and often have behavioral health issues. Their appearance is often bedraggled and they are often of concern to the public.

- The Episodic or Cyclical Homeless. These are people who fall in and out of homelessness, often associated with their mental illness.

- Situational or Transitional Homeless. These are people forced into homelessness because of a life event (loss of a job, disaster, domestic violence, loss of a breadwinner). This is often short-term. Many of these are the hidden homeless who sleep in their car or at a friend's house.

- Some prefer to break out the hidden homeless as a fourth type. These people often do not access homeless services and are less likely to be counted.

- Veterans have also been identified as a special group that may fall into any of the above categories.

Data about the homeless also can be organized into the following categories:[518]

- Sheltered individuals
- Unsheltered individuals
- Sheltered people in families
- Unsheltered people in families
- Chronically homeless
- Veterans

[517] Tischler, et al., Mothers experiencing homelessness: mental health, support and social care needs, 15 Health Soc. Care Cmty. 3, 246-253 (May 2007); see also Ellen Shelton, et al., Homeless Study Fact Sheet: Long-Term Homelessness, Wilder Res. Ctr. (Apr. 2013) (finding that at least 32% of homeless Minnesota women reported becoming homeless due to domestic violence).
[518] National Alliance, op.cit.

- Unaccompanied children and youth

Addressing Homelessness: The Current State of Thinking and Best Practices

As with all attempts to address complex social issues, the thinking about effective intervention evolves. The current state of thinking regarding homeless prevention and services includes:

The Continuum of Care (CoC) Concept. The concept of a continuum of care is that individuals are best served in an integrated system-of-care that tracks them over time through a comprehensive array of services spanning all levels of intensity of services.[519]

The Continuum of Care (CoC) Structure. This is a regional or local planning body that coordinates housing-services funding for homeless families and individuals.

Housing First.[520] The concept of Housing First is simple. Provide housing first, then combine that housing with supportive services. This approach is a shift from the traditional approach of getting someone ready for housing. It has proved to be effective with the chronic homeless.[521] This approach has the following elements:

- There is a focus on helping individuals and families access and sustain rental housing as quickly as possible and the housing is not time-limited;
- A variety of services are delivered primarily following a housing placement to promote housing stability and individual wellbeing;
- Such services are time-limited or long-term depending upon individual need; and
- Housing is not contingent on compliance with services – instead, participants must comply with a standard lease agreement and are provided with the services and supports that are necessary to help them do so successfully. [522]

Rapid Rehousing.[523] Rapid rehousing is just that. The goal is to help individuals and families quickly exit homelessness and return to permanent housing. Housing First is a key part of this approach with its emphasis on housing without pre-conditions. Rapid re-housing consists of the following services:

[519] www.ncbi.nim.nih.gov
[520] National Alliance, op.cit.
[521] U.S. Interagency Council on Homelessness
[522] Tampa Hillsborough Homeless Initiative. www.thhi.org
[523] National Allliance, op.cit.

- Housing search and landlord negotiation
- Short-term financial assistance
- Home-based stabilization services

Coordinated Intake and Assessment.[524] HUD describes coordinated intake and assessment as a "powerful tool designed to ensure that homeless persons / families are matched with the right intervention, among all of the interventions available in the community's continuum of care (CoC), as quickly as possible. It standardizes the access and assessment process for all clients and coordinates referrals across all providers in the CoC. When providers intake and assess clients using the same process, and when referrals are conducted with an understanding of all programs including their offered services and bed availability, participants can be served with the most appropriate intervention and not with a 'first come, first served' approach."

This approach is a step beyond "No Wrong Door" and is closer to "One Way In."

Prevention and Diversion.[525] Prevention is aimed at keeping people in their current housing situation. Diversion is a strategy that prevents homelessness for people seeking shelter by helping them identify immediate alternate housing arrangements and, if necessary, connecting them with services and financial assistance to help them return to permanent housing.[526]

Trauma Informed Care.[527] Trauma informed care is an evidence-based practice that helps providers address the triggers and vulnerabilities of people experiencing trauma. Since homelessness is a traumatic experience, it is an appropriate form of intervention.

Motivational Interview.[528] This is an approach utilizing interaction with people that focuses on strengthening the motivation to change. It uses an understanding of how hard it is to change learned behaviors.

[524] National Alliance, op.cit.
[525] National Alliance, op.cit.
[526] Source: http://endhomelessness.org/wp-content/uploads/2011/08/creating-a-successul-diversion-program.pdf
[527] SAMSHA best practices. www.samsha.gov
[528] trauma informed care. www.familyhomelessness.org

The Homeless Service System in Lee County

It should be noted that the Lee County homeless services system is engaged in the best practices identified above.

As the Lead Agency for the Continuum of Care, the Lee County Department of Human and Veteran Services (HVS) is responsible for making funding applications, contracting with sub-recipients and monitoring performance. In addition, HVS serves as the lead agency for the CoC's Homeless Management Information System (HMIS) and as the staff for the Continuum of Care Governing Board. In these roles, HVS staff compose and maintain required policies and procedures, coordinate strategic planning and reporting, facilitate Board meetings and membership and coordinate the implementation of the Coordinated Entry system.

The CoC Governing Board has been established to act on behalf of the CoC membership to oversee the responsibilities of the CoC, the operation of the Homeless Management Information System (HMIS), the implementation of the Coordinated Entry System and long-term strategic planning. In Lee County, the Continuum of Care is a broad group of individual stakeholders and organizations that are engaged to ensure that homelessness is rare, brief and one-time. Collaboration among CoC members occurs through regular meetings of the Governing Board, the Lee County Homeless Coalition and various subcommittees.

The CoC is responsible to:

- Hold at least semi-annual meetings
- Invite new members
- Adopt and update a governance charter
- Appoint committees / subcommittees / workgroups
- Establish performance targets
- Monitor project and system performance
- Make recommendations for resource allocation
- Develop system-wide policies and procedures
- Complete the annual application for HUD CoC funding
- Plan and conduct an annual Point in Time (PIT) and Housing Inventory Count (HIC)
- Establish and operate a CoC-wide HMIS

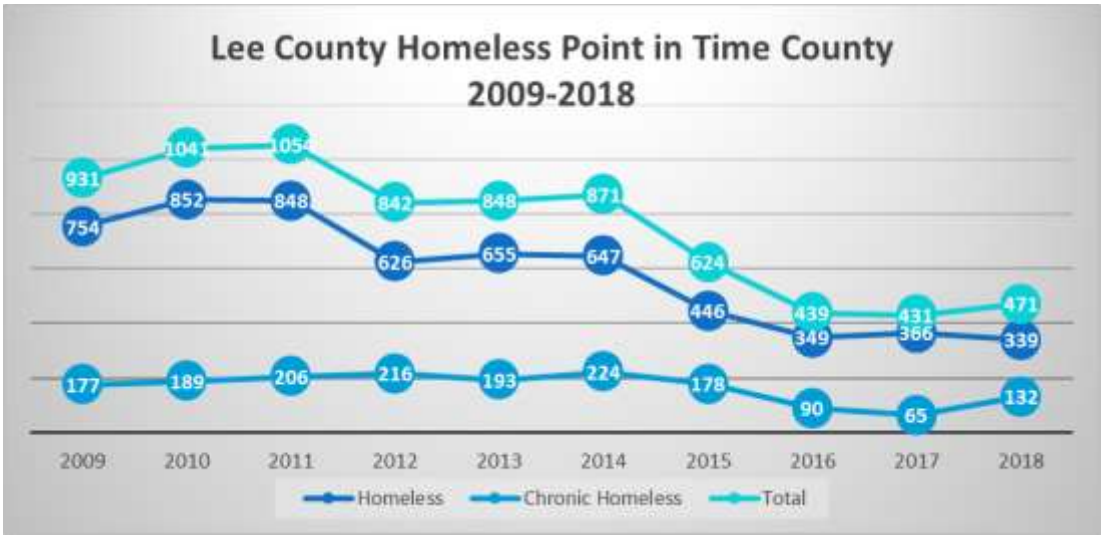
- Coordinate the implementation of a service system that meets the needs of homeless people. At a minimum, the system must include: outreach, engagement, assessment, shelter, housing, supportive services and prevention services.
- Conduct an annual gaps analysis of homeless needs and services
- Consult with Emergency Solutions Grants recipients and Consolidated Planning jurisdictions
- Apply for and administer State homeless funding
- Coordinate the delivery of services by establishing and operating a coordinated entry system

There are currently:

- 27 service providers participating in HMIS
- 52 service providers in the CoC (excluding victims' service providers);
- 13 providers with executed member agency MOUs

This system has been effective in reducing homelessness in Lee County by 58% since 2009.[529] Figure 28 shows this decrease using point in time data.

Figure 28. Lee County Homeless Point in Time 2009-2018



[529] 2019-2028 Strategic Plan, Lee County Continuum of Care

In fiscal year 2018, the CoC was awarded more than $10.4 million. Table 92 shows the breakdown of funding sources.

Table 92. Continuum of Care, Lee County 2018 Funding

Federal Grant Funds	
Grant funds from U.S. Housing and Urban Development and Veterans Affairs	
Total Federal Grant Awards	**$5,482,775**
State Grant Funds	
Grant funds from the Florida Department of Children and Families and the Florida Department of Economic Opportunity	
Total State Grant Awards	**$2,153,570**
Private Funds	
Includes various private foundation grants and donations provided to nonprofits	
Total Private Funds	**$1,496,758**
Local Government Funds	
Includes Community Development Block Grant (CDBG) from Cape Coral, local funds from City of Fort Myers, County Homeless, Partnering for Results (PFR) and 10 Year Plan funds	
Total Local Government Funds	**$1,273,638**
Total Homelessness Assistance Funds	**$10,406,741**

The current focus of the CoC is to provide:

- Quick identification of people experiencing homelessness and those at-risk
- Prevention of the loss of housing and diversion
- Rapid re-housing
- Quick connection to services

Total Number of clients served in the CoC during FY17-18 (July 1, 2017 – June 30, 2018): 7,954

Table 93 shows the ages of people receiving prevention services through Lee County Human and Veteran Services between 2013 and 2018. It is of note that more than 250 of these are 60 or older.

Table 93. Client Age Ranges Receiving Homelessness Prevention Services (2013 – 2018)

Age Range	Count of Household Members
Under 18	2485
18-24	399
25-29	391
30-39	786
40-49	664
50-59	583
60-69	197
70+	60
Total	**5565**

Table 94 provides a multi-year perspective on older clients served by HVS.

Table 94. Elderly Clients Served by HVS

HVS Programs (Programs provided at HVS)

FY17 (10/1/16 - 9/30/17)	**FY18 (10/1/17 - 9/30/18)**
All Clients	**All Clients**
Age 60-64 - **474**	Age 60-64 - **433**
Age 65+ - **1403**	Age 65+ - **1318**
Homeless	**Homeless**
Age 60-64 - **21**	Age 60-64 - **25**
Age 65+ - **37**	Age 65+ - **35**

All HMIS PROGRAMS (Programs at 27 Agencies participating in the HMIS)

FY17(10/1/16-9/30/17)	**FY18 (10/1/17-9/30/18)**
All Clients	**All Clients**
Age 60-64 - **902**	Age 60-64 - **785**
Age 65+ - **2222**	Age 65+ - **1895**
Homeless	**Homeless**
Age 60-64 - **132**	Age 60-64 - **144**
Age 65+ - **138**	Age 65+ - **125**

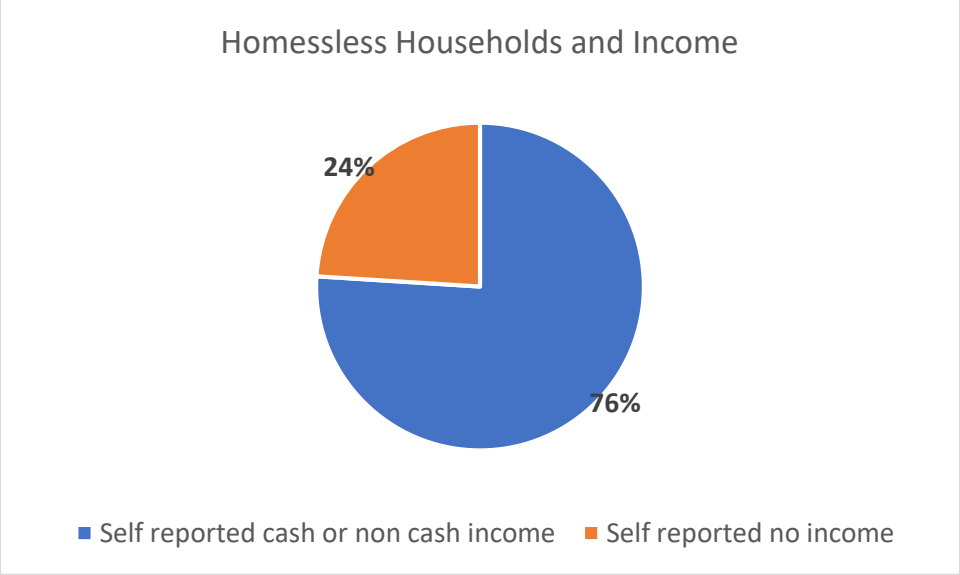
Table 95 shows the income level of individuals receiving homelessness prevention assistance.

Table 95. Income Level of Persons Receiving Homelessness Prevention Assistance

Federal Poverty Level Range	Count	%
0-24%	75	4.3%
25-49%	169	9.7%
50-74%	271	15.5%
75-99%	309	17.7%
100-124%	277	15.8%
125% +	649	37.1%
Total	**1750**	

As shown in Figure 29, based on coordinated entry tracking, 76% of households have some cash or non-cash income. The average for this group was $991 a month.

Figure 29. Coordinated Entry Homeless Households and Income Reporting[530]



[530] Provided by Lee County Human and Veteran Services

Recent data. The following Individuals or families have contacted the United Way 211 service between Sept. 30, 2019, and Nov. 22, 2019 indicating that they are homeless and have children in the household:

- Number of children who are homeless: 329
- Number of households with children who are homeless: 148

County staff reports that many of these households are first-time homeless and are able to get back on their feet with a small amount of rental assistance and connections to employment and childcare. These households often do not score high in prioritization for permanent housing resources and end up waiting longer than more vulnerable households. While this is not true in all cases, these households also tend to have some sort of local support network and may be able to be diverted from the homeless system with just a small amount of financial assistance or a homelessness prevention program.

System Gaps

In addition to the gaps noted in the introduction: supportive and affordable housing, transportation, behavioral health services, jail diversion or re-entry, and food (which are discussed again below), the following are other significant gaps:

Emergency Response Funding. This funding helps people to remain in their current housing situation. There is a system in place not only to provide financial assistance, but also to provide financial planning and other supports so that the need for repeated assistance is limited. Individuals are limited to three requests for assistance in a lifetime. As noted earlier in this chapter, there are substantive numbers of households that one-time assistance with rent or other expenses enables them to remain in their homes and avoid a homelessness situation.

Table 96 shows the number of people who have used this service.

Table 96. Emergency Response Funding by Households

Times in Intake*	Heads of Household
1	1925
2	146
3	9
4	1
Total	**2081**

*5 year period, 2013 – 2018.

Housing. Homelessness, for most of the homeless, is a housing-cost problem. Lee County has a challenge with housing affordability as the chapter on housing discusses in detail. Creating more affordable housing would certainly reduce the number of homeless. However, as fundamental as it is, it is not the sole solution.

Acknowledging that affordable and appropriate housing comprises the most significant gap, there are other gaps to be addressed if homelessness is to be reduced and alleviated. These include:

Public Perception. As noted earlier, the most common public perception of homelessness is that of the chronic homeless person. However, what is unrecognized are employed people who are homeless because they cannot afford housing, or people such as victims of domestic violence who are now homeless. Between Sept. 4, 2019, and Nov. 25, 2019, 76% of clients who contacted the CoC's Coordinated Entry System self-reported as having cash or non-cash income. The average monthly income reported by those clients was $991 per month. A broader and more accurate understanding will help shape public and private response to this issue.

Behavioral Health. Most chronic homeless are faced with mental illness issues, substance abuse issues or both. Given the limited behavioral health services in the county, these people often reside in jail or are on wait-lists for services.

Physical Health. The CoC has established a strong network to address physical health issues. It is an ongoing issue, however, and there is always the need for additional specialty services such as dentistry, optimality and chronic-disease management.

Staffing. There is a significant volunteer effort in the community as noted in Table 97.

Table 97. Volunteer Summary

End Date	Number of Volunteers				Total # of Volunteers
	Lee Health	United Way	Lee County	Habitat for Humanity	
12/31/2012	882	2,223	1,125	3,052	**7,282**
12/31/2013	759	2,350	1,564	5,319	**9,992**
12/31/2014	801	1,898	1,222	6,420	**10,341**
12/31/2015	999	2,543	1,298	7,096	**11,936**
12/31/2016	1,185	2,773	985	7,948	**12,891**
12/31/2017	1,161	2,874	1,001	5,554	**10,590**

Long Waiting Lists for Affordable Child-care. Once we acknowledge that a percentage of homeless people have jobs with inadequate compensation to cover all expenses, the child-care cost issue becomes clear. Only with rare exceptions can children be taken to a job. To keep the job, child-care must be paid for. This can mean something else isn't getting paid for and that is most likely housing. The waiting list for child-care services for low-income working families in Lee County was 961 as of Sept. 30, 2019.

Increased Coordination of all Community Service Providers. Many service providers do not participate in the Homeless Management Information System, resulting in either duplication of services, inefficient use of resources or a lack of knowledge about resources. While not a negative in and of itself, it does mean the resources of the community are not as fully coordinated and optimized as they could be. The participation rate of HMIS is 51.9%.

Literacy and English as a Second Language. Programs are limited in their availability.

Support or Wrap-around Services. In obtaining job training or employment, these support or wrap-around services are needed to help ensure people complete training programs or are dependable employees. Child-care is one example of such a service.

Collaboration between Private Employers and the Service Providers. For those service providers seeking to help the homeless find employment, a strong set of relationships with employers is needed. Unfortunately, it is not currently at that level.

Jail Diversion. There is a need for more extensive jail diversion options. This gap is addressed in the chapter on Behavioral Health and Criminal Justice.

Jail Re-entry. There is a need for programs and services to help released inmates successfully re-enter the community. This gap is addressed in the chapter on Behavioral Health and Criminal Justice.

Transportation. Some homeless people do not own vehicles. For those who do, this represents another cost that must be met to keep a job or to have a place to sleep at night. The gaps related to transportation are discussed in the chapter on Infrastructure.

Definitions

As with other human services programs, it is important to understand how the issue is defined. These definitions result in data and statistics that convey the scope of the issue. Homelessness is defined in various ways. Below are federal definitions and key terms that are used when talking about youth who have run away and / or are experiencing homelessness. These are direct quotes from federal websites.

U.S. Department of Education (ED)

Subtitle VII-B of the McKinney-Vento Homeless Assistance Act defines *homeless children and youths* as follows: The term "homeless children and youths"—

A. means individuals who lack a fixed, regular and adequate nighttime residence (within the meaning of section 11302(a)(1) of this title); and

B. includes—

i. children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement;
ii. children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping

accommodation for human beings (within the meaning of section 11302(a)(2)(C) of this title);

iii. children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and

iv. migratory children (as such term is defined in section 6399 of title 20) who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i) through (iii).

42 U.S.C. § 11434a(2)

Subtitle VII-B of the McKinney-Vento Homeless Assistance Act defines unaccompanied youth as follows:

The term "unaccompanied youth" includes a youth not in the physical custody of a parent or guardian.42 U.S.C. § 11434a(6)

U.S. Department of Housing and Urban Development (HUD)

HUD defines homelessness for their program into four categories. The categories are:

Category 1: Literally Homeless

Individual or family who lacks a fixed, regular and adequate nighttime residence, meaning:

1. (i) Has a primary nighttime residence that is a public or private place not meant for human habitation;
2. (ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing and hotels and motels paid for by charitable organizations or by federal, State and local government programs); or
3. (iii) Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution

Category 2: Imminent Risk of Homelessness

Individual or family who will imminently lose their primary nighttime residence, provided that:

1. (i) Residence will be lost within 14 days of the date of application for homeless assistance;
2. (ii) No subsequent residence has been identified; and (iii) the individual or family lacks the resources or support networks needed to obtain other permanent housing

Category 3: Homeless under other Federal statutes

Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:

1. (i) Are defined as homeless under the other listed federal statutes;
2. (ii) Have not had a lease, ownership interest, or occupancy agreement in permanent housing during the 60 days prior to the homeless assistance application;
3. (iii) Have experienced persistent instability as measured by two moves or more during in the preceding 60 days; and
4. (iv) Can be expected to continue in such status for an extended period of time due to special needs or barriers

Category 4: Fleeing/Attempting to Flee Domestic Violence

Any individual or family who:

1. (i) Is fleeing or attempting to flee their housing or the place they are staying because of domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions related to violence that has taken place in the house or has made them afraid to return to the house, including:

    • Trading sex for housing
    • Trafficking
    • Physical abuse

• Violence (or perceived threat of violence) because of the youth's sexual orientation;

2. (ii) Has no other residence; and
3. (iii) Lacks the resources or support networks to obtain other permanent housing.

U.S. Department of Health and Human Services (HHS) Definitions

The Runaway and Homeless Youth Act (RHYA)

RHYA (42 U.S.C. §5732a) defines HOMELESS YOUTH as individuals who are "less than 21 years of age...for whom it is not possible to live in a safe environment with a relative and who have no other safe alternative living arrangement." This definition includes only those youth who are unaccompanied by families or caregivers. This definition is used in connection with the Basic Center Program and the Transitional Living Program.

For the Basic Center Program, the homeless youth is an individual who is less than 18 years of age or is less than a higher maximum age if the state where the center is located has an applicable state or local law (including a regulation) that permits such higher maximum age in compliance with licensure requirements for child- and youth-serving facilities.

For the Transitional Living Program, the age is defined as 16- to 21-years-old, or 22 years of age if previously in care, under certain circumstances.

In addition, the Basic Center Program serves:

Runaway Youth —The term "runaway", used with respect to a youth, means an individual who is less than 18 years old and who absents himself or herself from home or a place of legal residence without the permission of a parent or legal guardian.

And

Youth at Risk of Separation from the Family —The term "youth at risk of separation from the family" means an individual— (A) who is less than 18 years of age; and (B) (i) who has a history of running away from the family of such individual; (ii) whose parent,

guardian, or custodian is not willing to provide for the basic needs of such individual; or (iii) who is at risk of entering the child welfare system or juvenile justice system as a result of the lack of services available to the family to meet such needs.

Finally, the Street Outreach Program (which attempts to outreach and refer youth to the above-mentioned transitional living and runaway youth programs) has this definition of youth who are the target of outreach:

Street Youth —The term "street youth" means an individual who— (A) is— (i) a runaway youth; or (ii) indefinitely or intermittently a homeless youth; and (B) spends a significant amount of time on the street or in other areas that increase the risk to such youth for sexual abuse, sexual exploitation, prostitution, or drug abuse.

Section Five: Special Populations

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CHAPTER 24
Persons with Intellectual and Developmental Disabilities (IDD)

Introduction

This chapter addresses the characteristics, needs and services for persons with intellectual and developmental disabilities. It consists of a background and context section that presents national, State and local information. It then describes the various services provided and with a summary of gaps. The chapter closes with a set of definitions of various terms in the field.

Background and Context

In Florida, the agency with prime responsibility for serving persons with developmental disabilities is the State of Florida Agency for Persons with Disabilities. Other State agencies have significant roles, such as the Agency for Health Care Administration (AHCA), which manages Medicaid, Vocational Rehabilitation (VR) and the Bureau of Exceptional Education and Student Services (BEESS). In addition, other agencies are involved as part of Employment First. The lead consumer advocate is the Florida Developmental Disabilities Council. Nonprofits primarily provide local services using a variety of titles, more frequently chapters of The Arc.

In 2017, there were an estimated 472,000 persons with intellectual and developmental disabilities (IDD) in the State, 56% of whom live with families. Thirty-one percent of these family caregivers are older than 60 (110,000)[531]. About 1.5% to 2.5% of Lee County residents have an IDD diagnosis. Using an estimated county population of 739,000 for 2019, this would mean approximately 11,000 to 18,000 persons in the County have an IDD. Approximately 56% of persons with IDD live with their families, 15% in their own home and 29% in a licensed residential facility.[532]

With respect to financial support for these persons, Florida ranks 49th out of the 50 states, and spends less than $2 per $1,000 of aggregate statewide personal income[533]

[531] State of the States report. 2019. Florida Developmental Disabilities Council
[532] 2019 IBudget Waiver Redesign. 2019. Tallahassee, FL: Agency for Persons with Disabilities.
[533] Lipinski, A. & Breen, V. 2019. Florida's fiscal effort ranks second to last in total IDD spending. Fact Sheet. Tallahassee: Florida Developmental Disabilities Council.

per person for IDD services. It ranks 46th in paying for group home care and 44th for supported living. Several of the gaps identified in this analysis relate directly to funding.

What are the qualifying factors to be considered as a person with an intellectual and/or developmental disability? Persons with an affirmative response to any of the following are considered to have an IDD:

- Deafness or serious difficulty in hearing (all ages)
- Blindness or serious difficulty in seeing (all ages)
- Serious difficulty in concentrating, remembering or making decisions because of a physical, mental or emotional condition (5 years or older)
- Serious difficulty walking or climbing stairs (5 years or older)
- Difficulty dressing or bathing (5 years or older)
- Difficulty doing errands alone (e.g., visiting a doctor's office or shopping) because of a physical, mental, or emotional condition (15 years or older)

Among people who report serious limitations, 46% report mobility disability, 39% report problem-solving or concentration limitations, 26% report hearing and 21% report vision, with 43% reporting more than one limitation.[534]

[534] Centers for Disease Control and Prevention. CDC grand rounds: public health practices to include persons with disabilities. MMWR Morb Mortal Wkly Rep. 2013;62(34):697---701.

The Challenges underlying the major gaps

The major challenges facing persons with IDDs in Florida and Lee County are listed below. These challenges provide the context for the specific gaps discussed in this chapter. These challenges include:

The Wait List

In FY 2017, approximately 6% (19,000) of the 350,000 family caregivers received services from the Agency for Persons with Disabilities (APD). The June 2019 waitlist was 21,661 persons.[535] In Lee County there are approximately more than 500 persons on the list.[536]

Aging Caregivers

Approximately 71% of individuals with IDDs live at home (with their family or on their own). Data from the State of the States in Developmental Disabilities report finds that in Florida 31% of individuals living with a family have a caregiver age 60 or older, approximately 75% higher than the national rate. That translates to more than 75,000 individuals with developmental disabilities with caregivers age 60 or older in Florida, the third-most populous state.[537]

Dual Diagnoses – Lack of a continuum of care

Nationally, it is estimated that 30% to 35% of all people with an IDD also have a mental health diagnosis. Families find difficulty navigating between different agencies for treatment and support services. Most of the available mental health services do not have adaptations required for those who have co-existing IDD diagnoses. Individuals and families need a continuum of care that specializes in the needs of those with IDDs and a co-existing mental health diagnosis.

There is no integrated system or continuum of care to meet the needs of dually diagnosed individuals.

[535] Lulinski, op.cit
[536] Wait List Data, June 2019. Tallahassee, FL: Agency for Persons with Disabilities.
[537] State of the States in Developmental Disabilities. Boulder, CO: University of Colorado, Administration on Intellectual and Developmental Disabilities, and National Institute on Disability and Rehabilitation Research, as cited in "Living in the Community: Options for Floridians with Disabilities." Report by ROOF/FDDC, p. 17.

Staffing

The purpose of the Medicaid iBudget Waiver is to provide home and community-based supports and services to eligible persons with developmental disabilities living at home or in a home-like setting, utilize an individual budgeting approach, and provide enhanced opportunities for self-determination.[538] In the IDD field, staff pay is tied to rates for services in the iBudget Waiver. In effect, this means most employees are paid in the $10-per-hour range. It is difficult to retain these persons as the job market is tight and there are jobs available with starting pay of $12 per hour. In addition to the normal challenges of providing quality care with regular turnover, some people with an iBudget Waiver are unable to obtain services due to staffing shortages. The State's practice of keeping rates lower exacerbates this staffing challenge.

Underserved Groups

There are six groups that could be considered as underserved. These include:

- Persons with IDDs who have co-occurring mental health issues. These persons are highly likely to be unemployed and represent a group that is hard to employ from an agency perspective.
- People who are a member of a minority group. People who are of minority status may face several challenges. Some have limited English proficiency and find it difficult to communicate their needs and concerns. Second, some are fearful of contact with public agencies for various reasons. Third, there may be the perception of bias toward them or they may not feel welcomed.
- Any person with limited English proficiency. Florida is a highly diverse state linguistically with more than 200 languages and dialects. People who are not conversant in English are less likely to be aware of services or feel comfortable attempting to contact those services.
- People with limited computer skills/people without internet access. There are a plethora of resources on the internet and more and more work is done via the web. Those who do not have ready access to the internet, or who are uncomfortable in that environment are likely to be less aware of services and

[538] https://ahca.myflorida.com/Medicaid/hcbs_waivers/ibudget.shtml

therefore are likely to be underserved.

- The deeply transportation challenged. As noted earlier as well as in the Transportation Report, many persons with developmental disabilities can access transportation services either through public programs or family and friends. A small percentage of people do not have these services available or don't have the support systems that help them obtain transportation. Given this gap, they are likely to be underserved.
- Families who are not in crisis. Due to iBudget funding limitations, the only practical way to access iBudget funding is for the person to be in crisis such as death or disability of the family that has been supporting them.

The Gaps

Employment

Context and Background

According to the 2013-2017 American Community Survey 5-Year Estimate, there are 2.5 million Floridians age 16 and older who have a disability of some type. Of those, only 18.8%, or 473,979, are employed.[539] The National Core Indicators (NCI) study, focused on persons with developmental disabilities, found that 10% of respondents from Florida had a paid job.[540] Yet research indicates that that almost half of individuals who are not working in the community want a job.[541]

Thinking about employment for persons with intellectual and developmental disabilities has evolved over time as Figure 30 illustrates. The current approach is labeled "Employment First." Employment First is the work expression of the philosophical and conceptual developments that emphasize both the ability and right of persons with IDDs to live, play and work in everyday communities. Employment First is self-determination, self-advocacy and community inclusion in that they are research-based ideas and findings that in turn shape policy and strategy, which leads to system and practice change.

[539] Success stories, Vocational Rehabilitation. http://www.rehabworks.org/docs/success_booklet.pdf
[540] NCI State Adult Consumer Survey State Outcomes, 2012-2013
[541] Ibid.

Figure 30. Employment First

The Gaps Related to Employment

Obtaining and maintaining employment is an on-going challenge for persons with IDDs. The most significant barrier – transportation – is examined separately below. In addition to transportation, other gaps and barriers include:

- The shift to web-based applications. Job searches and applications are increasingly web-based. This creates barriers for some.
- Employer perceptions and attitudes.[542] Employers underestimate the talent and skills of people with any disabilities (70.67%). Table 98 below lists those various perceptions.
- Workplace assistance. A study of barriers to the use of workplace assistance services found the following barriers:[543]
    - Lack of awareness or knowledge of the services
    - A fear of employer resistance
    - A concern about the appropriateness of such services in the workplace
    - Logistical challenges

[542] VR Need Assessment Survey, 2015
[543] Neri, M. no date. Barriers to the use of workplace assistance services. University of California.

- Assistive technology challenges. User feedback on assistive technology provided through the Florida Alliance for Assistive Services and Technology (FAAST) or other venues included the following concerns stated by users:[544]
    - Quality: Quality of wheelchairs poor;
    - Replacement schedule: Medicaid program is rigid on replacement Persons can only get wheelchair every five years; low reimbursement for replacement.;
    - Technical assistance and maintenance: Maintenance is not funded. i-Pads and similar electronic tools need technical assistance and support to fix when broken and there are low reimbursement for repairs.;
    - Wait times: Long waits for adaptive equipment.; and
    - Assistance: FAAST is trying to improve access/loan program, basic chair is covered, but not an adapted chair.

- Work Schedules. Persons with IDDs are frequently prevented from working nights and on weekends because of the lack of flexibility in the structure of their service delivery supports, living situation and limited transportation options.[545] Given that many service jobs require such hours, this limits their choices.

- Safety. Families often have concerns about the safety of their family member when in an employment setting – or any other community setting for that matter.

- Potential loss of benefits. The concern is that if the family member makes too much money he/she may lose Medicaid coverage or other supports that are based on income levels.

[544] Personal communication. FAAST.
[545] Ibid.

Table 98. Perceptions of Barriers to Hiring Persons with Disabilities (PWD)
Governor's Commission on Jobs for Floridians with Disabilities[546]

Potential Barrier	Mean Score*
Employees with Disabilities have physical and/or stamina restrictions on their assigned job duties	3.000
There are health and safety concerns with hiring PWDs in this organization	2.957
Cost increases attributable to extending health, life, and/or disability coverage are too high	2.936
Type of work in this organization is unsuitable for PWDs	2.894
Organization lacks access/facilities/equipment suitable for PWDs	2.823
Cost of accommodations for PWDs is too high	2.816
PWDs lack the specific job-related experience required of job applicants for this organization	2.766
Employees with disabilities require additional management and supervisory time	2.752
Cost of training PWDs is too high	2.738
Employees with disabilities lack the ability to travel for work	2.638
PWDs lack the requisite skills and training of job applicants for this organization	2.631
Employees with disabilities lack the ability to work under great time pressure and stress	2.624
Employees with disabilities create additional workload for the HR staff	2.596
Employees with disabilities tend to be less productive	2.454
Organization is concerned about potential negative reactions from clients and customers	2.390

[546] Source: Born, Patty and Dumm, Randy. "Key Factors that Assist Employers to Recruit, Interview, Hire and Retain People with Disabilities." Prepared for The Able Trust through Florida State University, June 2011. p.8

Potential Barrier	Mean Score*
Employees with disabilities tend to have poor attendance and punctuality records	2.348
Staff may feel uncomfortable if asked to work with a PWD	2.298
*Respondents were asked to indicate on a scale from 1 to 5 (where 1 indicates "strongly disagree" and 5 indicates "strongly agree") to rate their perception of each of these barriers. The results show an average score per barrier sorted from high to low.	

- Self-employment barriers. System type barriers identified in the assessment of Florida's self-employment pilot included:
  - Complicated Work Incentives for those seeking self-employment. Federal work-incentive policies are geared toward wage employment and are very complicated relative to funding self-employment for persons with developmental disabilities;[547]
  - Funding Challenges for those seeking self-employment. Policies and funding in Vocational Rehabilitation, Social Security and Medicaid are geared toward wage employment and pose barriers to self-employment;[548]
  - Agency and staff attitudes. Agencies and their staff are oriented to thinking in terms of wage employment and do not view self-employment as an option;[549]
  - Know-how. Some of the key players involved in service delivery do not possess either formal training or depth of knowledge in what it takes to start a small business and what kinds of support persons with disabilities would need to succeed as entrepreneurs;[550] and
  - Policies that Lead to Financial Disincentives for Self-Employment. People with disabilities are concerned about the risk of losing disability benefits because of earnings from a small business.[551]
- Attitudes and Culture about Employment of persons with IDD. Finally, there

[547] Self-employment, op.cit. pg. 35.
[548] Ibid. pg. 35.
[549] Ibid. pg. 34.
[550] Ibid. pg. 34.
[551] Ibid. pg. 35.

are the barriers of attitude and culture, comfort with existing practices and existing systems that reinforce those practices as discussed in the summary section. Some additional barriers not discussed in the summary section include:

- Prioritizing individual jobs over group supported employment. The data suggest that individual employment yields higher levels of income and an array of job choices than does group supported employment, even though people in group-supported employment work more hours on average. Individuals in group-supported employment were also more likely to report that they want to work elsewhere. The benefits and advantages of individual employment should be reflected in policy and operational practices that prioritize individual employment outcomes.[552]
- Consistency in service planning and supporting career goals. The Florida Employment First Findings Report found that "employment is not perceived as a priority within the service planning process."[553] Other data suggest that almost half of individuals who are not working in the community want a job, but one study found that only 26% of those who want a job have community employment as a goal in their service plan. Ensuring that employment is identified as a priority during everyone's plan and providing training to staff are priorities.[554]
- Gaps in know-how. As the job market changes and new expectations emerge for persons with IDDs, the question will arise as to whether professional staff have the training or depth of knowledge in what it takes to succeed as a job coach in newer fields of work. Staff training and cross-system collaboration and capacity building will be a significant challenge.
- Increased technical assistance. There is a need for the Agency for Persons with Disabilities (APD) to offer greater technical assistance or consultation resources to provider organizations to assist them in expanding or improving employment
- School focus. There is a need for a more consistent emphasis on

[552] Ibid.
[553] Ibid., pg. 8.
[554] Ibid.

employment in schools and during the transition process.[555] There is also the need to address the home-schooling area.

- Greater consistency in communications to families. The Florida Employment First Findings Report identified a need to improve the information flow to families, particularly addressing the gap between those on a waiver and those not on it.[556]
- Increased support to employers. The Florida Employment First Findings Report identified a need to provide increased employer support in the context of job changes that are reducing employer interest in persons with disabilities.[557]
- Inconsistent Performance Expectations of Involved Agencies. Gaining greater employment opportunities for individuals with developmental disabilities will require collaboration across multiple entities working at federal, State and local levels. Yet each entity has its own performance metrics, which may be inconsistent with the program goal.
- A Single Point of Contact is needed. [558] This gap has been identified and hopefully will be eliminated or ameliorated by a new web portal called Abilities Work.
- Not everyone prefers the Employment First Approach. For people who have 20 years or more in other employment models, Employment First is a poor fit from their perspective. They did not receive the public education supports that current graduates have had. They have been in more sheltered or structured employment settings that they are comfortable and satisfied with. There is the need for a dual approach fitted to the history and expectations of various sub-groups of persons with IDD.

[555] Ibid. pg. 16.
[556] Ibid., pg. 16.
[557] Ibid. pg. 18.
[558] Ibid, pg. 6.

Transportation

Context and Background

This is perhaps the primary barrier to employment**;** 76% of persons with developmental disabilities who are seeking a job need transportation (personal or public) (76.16%).[559] Transportation was also identified as the most significant barrier in the Governor's Commission 2014 report.[560] It is also a barrier in other life tasks.

The Gaps Related to Transportation

There are several dimensions to this barrier. These include:

- Many paratransit systems operate with limited hours and relatively long (45-minutes to an hour) client pick-up windows. These limitations imposed in many paratransit systems effectively limit employment opportunities.
- A significant obstacle to greater utilization of public transportation by individuals with IDDs is the amount of funding available to provide trips, particularly paratransit trips, which are more expensive than trips taken on a fixed-route system.
- An additional challenge results from the continued heavy reliance on informal means of transportation (caregivers, family members and friends). This poses a unique challenge to the transportation system as it relates to persons with IDDs because of the large number of caregivers older than 60. As caregivers age, their own issues can make it more difficult for them to be a reliable source of transportation for work.
- Demand nationally falls far below capacity; 75% of actual demand was not serviced in FY 2013-2014.[561]
- There is a variance in County capacity to meet demand. Actual demand met at the County level ranges from a low of 1.38% in rural Gilchrist County to a high of 289.94% in Miami-Dade County. In other words, Miami-Dade County

[559] VR Need Assessment Survey, 2015
[560] 2014 Governor's Commission on Jobs for Floridians with Disabilities Report, pg. 4.
[561] *Unmet and Latent Demand for Transportation Disadvantaged Services*, p. 39. Note: There was no significant reduction in the numbers of transportation disadvantaged individuals between FY 2012-2013 and FY 2013-2014.

transit providers achieved more overall actual trips than the number needed to serve the transportation disadvantaged population alone. Lee County had a 3.32%.[562]

Health

Context and Background

People with disabilities consistently report higher rates of obesity, lack of physical activity and smoking. Some also have higher rates of newly diagnosed cases of diabetes and their percentages of cardiovascular disease are three to four times higher.[563] Although they have higher rates of chronic diseases than the general population, adults with disabilities are significantly less likely to receive preventive care. As an illustration, people with cognitive limitations are up to five times more likely to have diabetes than the general population[564]

People with disabilities are a health disparity population. Health disparities refer to differences in health outcomes at the population level, differences that are linked to a history of social, economic or environmental disadvantages, and for which there is general agreement that these differences are avoidable.

Adults with intellectual or other developmental disabilities (IDD) face a cascade of health disparities. They often.[565]

- have complex or difficult-to-treat medical conditions
- have difficulty accessing health care
- may receive inadequate health care
- may have difficulties expressing their symptoms and pain
- receive little attention to wellness, preventive care and health promotion

[562] CUTR report provided by Robert Codie, Lee Tran
[563] Reichard A, Stolzle H, Fox MH. Health disparities among adults with physical disabilities or cognitive limitations compared to individuals with no disabilities in the United States. Disabil Health J. 2011;4 (2):59---67.
[564] Reichard A, Stolzle H. Diabetes among adults with cognitive limitations compared to individuals with no cognitive disabilities. Intellect Dev Disabil. 2011;49(3):141---154.
[565] http://vkc.mc.vanderbilt.edu/etoolkit/resources/

The Gaps Related to Health

There is a critical lack of primary care, dental and specialty medical personnel to treat the health care needs of individuals with disabilities.

Medicare and Medicaid reimbursement to providers is significantly below the reimbursement from other health insurance sources, discouraging practitioners from serving the populations such as individuals with IDDs who depend primarily on these government insurance programs.

There is fragmented Health Care Financing for Persons with IDDs.[566] The fragmentation of the health care financing resources for individuals with IDDs aggravates these disparities. Consumers are not the "customer" of Medicaid; the providers of services who are paid to provide care are the "customers." Although surveys are done with individuals with IDDs who are enrolled in the Medicaid support waiver, there is no organized quality improvement at the level of the individual related to their basic health and medical status provided under the Medicaid state plan. More than half of the individuals with IDDs who are enrolled in the basic state plan are on the waiting list for the support waiver, and have virtually no interaction with a case manager except to update their eligibility. The person working with clients on the support waivers is focused primarily on the services paid by the waiver, not health care received on a fee for service basis. When wheelchairs or other assistive technology is inadequate for the individual's need, those expenditures are driven by the federal Medicaid rules, and there is no authority by either the Agency for Health Care Administration (ACHA) or the Agency for People with Disabilities (APD) to challenge those rules.

Persons with IDDs have more complex medical needs than do the general population and require access to medical care from a network of providers that are knowledgeable in treating persons with their disabilities. Every major report addressing the poor health of people with IDDs has called for improvements in training of health care providers about adults with disabilities. Improved training of health care providers can support earlier identification and intervention for children with disabilities, improved services for youths with disabilities transitioning into the adult-care system and improved health care and health promotion for adults with disabilities including IDDs. During times of

[566] Ervin, D. 2014. Healthcare for Persons with Intellectual and Developmental Disabilities. Nim.ncbi.nih.gov/pmc/articles/PMC409823

emergency or in disaster situations, persons with disabilities an be especially vulnerable.[567]

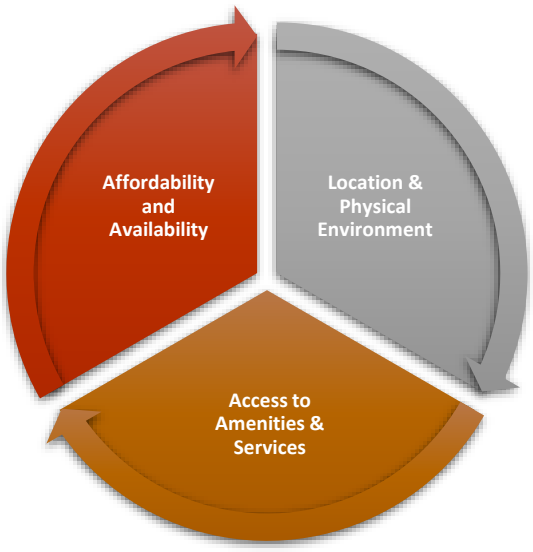
One gap related to the need for specialized health professionals is that the transition from pediatric to adult health care can be challenging for individuals with IDD.

Housing

Context and Background

For a multitude of reasons, housing is a critical element in the wellbeing of individuals with IDD. Housing not only provides physical shelter; it is also a significant factor in providing a stable and supportive environment for individuals with IDDs. Housing is not solely an important issue for multiple reasons, it also is a multi-faceted issue. Three key elements (affordability, location and physical environment and availability of amenities and services) serve as a framework through which to review housing gaps. Figure 31 illustrates these components.

Figure 31. Housing Components



[567] Rubin, L. et.al. 2016. Health care for persons with disabilities. New York: Springer

In Florida 31% of individuals living with a family have a caregiver age 60 or older, which is approximately 75% higher than the national rate. That translates to more than 75,000 individuals with IDDs with caregivers age 60 or older in Florida, the third most-populous state.

The Gaps Related to Housing

- Connected Housing Post-Family-Care. Assessing these figures, it becomes apparent that many individuals may need to transition from ad-hoc family-based housing and transportation systems to available systems when their aging caregiver dies or becomes incapacitated. Given the numbers of individuals involved – nationally and in Florida by extension – it is expected that demand for housing in areas readily connected to services, supports and effective transportation may increase to a significant degree.

- Stereotypes and prejudices. Landlords are sometimes reluctant to rent to people with IDD, due to various stereotypes and prejudices.

- Affordability and residential choice. The issue of housing costs and affordability is particularly important when placed side-by-side with data from the National Core Indicators (NCI) Florida results. NCI Florida results show that 50% of respondents did not choose where they live. Forty percent did not choose with whom they live.[568] Affordability by its nature impacts residential choice, which in turn limits residential options. Similarly, location and physical environment similarly impact residential choice and options.

- Cost-burden. With respect to the cost-burden for households in Florida with at least one person with a disability (including but not limited to IDD households), the following table (Table 99) illustrates the cost-burden for these households. For example, for extremely low-income households (30% AMI) with a disabled individual, 66% of these households (171,083 households) have a housing cost-burden greater than 50% of their income.[569] (AMI is average monthly income for all households).

[568] "What We Learned from the National Core Indicators (NCI) Adult Consumer Survey: Results from People Across Florida That Used NCI in 2011-12." Alexandria, VA: National Association of State Directors of Developmental Disabilities Services and Human Services Research Institute, 2012: pp. 14-15.
[569] State of Florida Consolidated Plan, FFY 2011-2015. Tallahassee: Department of Community Affairs, p. 15.

Table 99. Cost Burden for Households in Florida Including At Least One Person with a Disability (Age 5+)[570]

Cost Burden				
Household Income	**Less Than 30%**	30.01% to 50%	Greater Than 50%	Total Households
30% of AMI or Less	56,629	30,900	171,083	258,612
30.01% to 50% AMI	76,256	72,058	124,361	272,675
50.01% to 80% AMI	163,797	108,360	74,221	346,378
80.01% to 120% AMI	220,205	79,180	29,280	328,665
Grand Total	**516,887**	**290,498**	**398,945**	**1,206,330**

- Spatial mismatch. Spatial mismatch analysis, in the social sciences, has been traditionally employed to illustrate the disconnect between the location of low-income neighborhoods and available job opportunities. The absence or relative weakness of public transportation systems in many areas has traditionally exacerbated this spatial mismatch.[571] In general terms, spatial mismatch means that housing and other elements of daily life are spread far apart; it's hard to get from housing to these other activities (especially employment) on a regular basis.

- Voucher Programs. Voucher programs provide direct rental assistance to eligible families, including families with members that possess an IDD. There are two primary voucher programs that target individuals with disabilities: Non-Elderly People with Disabilities (NED) vouchers and Mainstream five-year vouchers. There also is an NED Category 2 voucher program. However, NED Category 2 pertains to a more limited universe of individuals transitioning from nursing homes to the community. Figure 32 details the location and availability of

[570] State of Florida Consolidated Plan, FFY 2011-2015, p. 15. Original data sources for chart: Shimberg Center for Housing Studies, 2009 American Community Survey.
[571] For a primer on the historic use of spatial mismatch theory, please see Kain, John F. "Housing Segregation, Employment, and Metropolitan Decentralization". Quarterly Journal of Economics 82 (2): 175–197 (1968).; and Kain, John F. "A pioneer's perspective on the spatial mismatch literature". Urban Studies 41 (1): 7–32 (2004).

NED/Mainstream Housing Vouchers for Individuals with Disabilities in Florida.[572] The Housing Authority of the City of Fort Myers (HACFM) has 40 Mainstream Vouchers.

- Public Housing Wait List. The waiting list for public housing had 2,784 applicants, 17 of which self-identified as disabled. The Public Housing Agency (PHA) reported that most applicants do not answer questions regarding accessibility needs. The most common needs are basic handrails in the bathroom, ramps for the door and basic items that HACFM can provide quickly.

Table 100. Other HACFM data: Characteristics of Residents

Program Type								
	Certificate	Mod-Rehab	Public Hearing	Vouchers				
				Total	Project-based	Tenants-based	Special Purpose Voucher	
							Veteran Affairs Supportive Housing	Family Unification Program
# Homeless at admission	0	0	9	0	0	0	0	0
# of Elderly Program Participants (>62)	0	0	331	578	22	471	85	0
# of Disabled Families	0	0	119	627	26	533	68	0
# of Families requesting accessibility features	0	0	786	2073	11	1970	70	22
# of HIV/AIDS program participants	0	0	0	0	0	0	0	0
# of DV victims	0	0	0	0	0	0	0	0

Characteristics of Public Housing Residents by Program Type

[572] Source for Figure 3: "Database of Vouchers for People with Disabilities." Technical Assistance Collaborative. URL: http://www.tacinc.org/knowledge-resources/vouchers-database/?state=FL&submit.x=8&submit.y=14

Alternate Data Source Name: 2019 HACFM PHA Data

- Accessibility. A portion of individuals with IDD have mobility issues. Finding homes that have a variety of accessibility features is challenging even setting cost aside.

Figure 32. NED/Mainstream Housing Vouchers for Individuals with Disabilities in Florida

State	PHA Name	City	NED	Mainstrm 5 Yr	NED Cat 2
FL	Alachua County Housing Authority	Gainesville	0	75	0
FL	Boley Centers for Behavioral Health Care	St. Petersburg	0	181	0
FL	Broward County Housing Authority	Lauderhill	75	50	0
FL	Carrfour Supportive Housing	Miami	0	50	0
FL	City of Pensacola Housing Authority	Pensacola	50	0	0
FL	Clearwater Housing Authority	Clearwater	0	75	0
FL	Collier County Housing Authority	Immokalee	0	0	25
FL	Crestview Housing Authority	Crestview	0	0	0
FL	Deland Housing Authority	Deland	0	0	0
FL	Fort Walton Beach Housing Authority	Fort Walton Beach	0	0	0
FL	Gainesville Housing Authority	Gainesville	0	0	0
FL	Hernando County Housing Authority	Brooksville	0	0	0
FL	Hialeah Housing Authority	Hialeah	298	0	0
FL	Hillsborough County-BOCC	Tampa	100	0	0
FL	Housing Authority of Boca Raton	Boca Raton	75	0	0
FL	Housing Authority of Brevard County	Merritt Island	200	0	0
FL	Housing Authority of Lee County	North Fort Myers	0	0	0
FL	Housing Authority of New Smyrna Beach	New Smyrna Beach	0	0	0
FL	Housing Authority of the City of Cocoa	Merritt Island	75	0	0
FL	Housing Authority of the City of Daytona Beach	Daytona Beach	0	0	0
FL	Housing Authority of the City of Deerfield Beach	Deerfield Beach	52	0	0

State	PHA Name	City	NED	Mainstrm 5 Yr	NED Cat 2
FL	Housing Authority of the City of Fort Lauderdale	Fort Lauderdale	0	0	0
FL	Housing Authority of the City of Fort Myers	Fort Myers	0	0	0
FL	Housing Authority of the City of Fort Pierce	Fort Pierce	100	0	0
FL	Housing Authority of the City of Lakeland	Lakeland	0	20	0
FL	Housing Authority of the City of Miami Beach	Miami Beach	0	0	0
FL	Housing Authority of the City of Sarasota	Sarasota	0	0	0
FL	Housing Authority of the City of St. Petersburg	St. Petersburg	0	0	0
FL	Housing Authority of the City of Stuart	Stuart	0	0	0
FL	Housing Authority of the County of Flagler	Bunnell	0	0	0
FL	Housing Partnership	West Palm Beach	0	75	0
FL	Indian River County Board of County Comm	Vero Beach	0	0	0
FL	Jacksonville Housing Authority	Jacksonville	0	0	0
FL	Miami-Dade Housing Authority	Miami	210	75	0
FL	NW Florida Regional Housing Authority	Graceville	0	0	0
FL	Ocala Housing Authority	Ocala	0	0	0
FL	Orange County Comm Orange County	Orlando	0	0	0
FL	Orlando Housing Authority	Orlando	400	0	0
FL	Ormond Beach Housing Authority	Ormond Beach	0	0	0
FL	Pahokee Housing Authority	Pahokee	0	0	0
FL	Panama City Housing Authority	Panama City	0	0	0
FL	Pasco County Housing Authority	Dade City	0	0	0
FL	Pinellas County Housing Authority	Clearwater	0	0	0
FL	Punta Gorda Housing Authority	Punta Gorda	25	0	0
FL	Seminole County Housing Authority	Oviedo	0	0	0
FL	Tallahassee Housing Authority	Tallahassee	0	75	0

State	PHA Name	City	NED	Mainstrm 5 Yr	NED Cat 2
FL	Tampa Housing Authority	Tampa	150	0	0
FL	Titusville Housing Authority	Titusville	125	0	0
FL	Walton County Board of County Comm	De Funiak Springs	0	0	0
FL	West Palm Beach Housing Authority	West Palm Beach	175	0	0

Education System

Context and Background

A range of programs designed to assist persons with IDDs from birth through post-secondary education exist.

The Gaps Related to Education

Some of the gaps within this program range include:

- There is a need for additional local outreach and early identification to overcome the barriers that often immobilize families when confronted with a child with developmental issues. Engaging families who are often overwhelmed by issues unrelated to the child requires effective and culturally sensitive outreach. Parents may have little understanding about the value of developmental screening and services to their children's long-term success;

- Assessment sites may not be readily accessible due to transportation barriers;

- Accurate identification of children with Intellectual Disabilities and Autism Spectrum Disorder. Accurate identification is challenging because it is a spectrum and the knowledge base is still developing;

- Family mobility, in some cases, makes follow-up difficult;

- The level of staff cultural competency needed is not always present.

Service Delivery Systems

Context and Background

Just as the mental health field engaged in the process of de-institutionalization in which the focus moved from institutional care to community-based care, so has the field of intellectual and developmental disabilities. However, there is one significant difference. While being in a mental hospital was not always voluntary, the provision of institutional care to individuals with IDD was established as a right. They could waive this right and obtain community-living support in concept.

The thinking behind this shift was that many individuals with IDD could live productive lives in a community setting and that their quality of life would be better. As a concept, this is preferable. The issue is that just as mental health community funds did not adequately flow into the community, neither have IDD funds.

In recent years, this community focused model has also emphasized employment and a fuller community life for individuals with IDD. No one would argue with this goal. However, there are generational tensions between the younger generation for whom the school system was redesigned to foster these capabilities and older people who did not have these school experiences. These conflicts play out not just in the individuals with IDD but with their families' differing expectations.

For service providers, these dual expectations create challenges. On the one hand, they are willingly attempting to comply with both State and federal policy as well as what are viewed as current best practices. One the other hand, they have clients and families with expectations of more traditional services and who believe that service model is best for their situation.

Gaps Related to Service Delivery

The gap here is primarily one of funding. While funding overall is inadequate, it is particularly challenging for legacy programs, which are viewed as adhering to past practices. Funding for these legacy services are now more reliant than ever on private contribution.

Greater consistency in communications to families is needed. The Florida Employment First Findings Report identified a need to improve the information flow to families, particularly addressing the gap between those on the waiver and those not on it.

Policy/Procedure issues

Context and Background

In a system as complex as the intellectual and developmental disabilities field involving both State and federal funding, there will be a variety of policy or procedure issues that may have effects that create or minimize gaps.

Gaps Related to Policy/Procedures

- Funding challenges. Neither the VR (Vocational Rehabilitation) or APD (Agency for Persons with Disabilities) systems are funded at an adequate level to respond in a timely manner to demand. There have been significant funding increases intended to address this issue, but the fact remains that both systems are inadequately funded in the context of the needs they are seeking to address.
- Billable activities.[573] Employment providers explained that often the activities that are considered "best practices" are not billable, creating a disincentive. Examples included developing employer connections, solo transportation time for the employment specialist to a job site, time spent completing documentation and required paperwork, and phone-based consultation with employers and other supports.
- Inconsistency of incentives. In the Florida Employment First Findings Report stakeholders reported that it is more profitable for an agency to provide Adult Day Training living services compared with individualized integrated employment.[574]
- iBudget issues. The Employment First Findings Report stated that "in some cases, implementation of iBudget includes a reduction in the total resources available to an individual in exchange for greater control over resources. Findings revealed concerns among many that after paying for essential services like

[573] Employment First, op. cit. pg. 10.
[574] Ibid., pg. 10.

supported living, there will not be funding available within individual budgets for services like employment."[575]

Formal Definitions

Below are two definitions of intellectual and developmental disabilities, one from the National Institute of Health and the second from Florida's state agency (Agency for Persons with Disabilities) which is charged with overseeing services to this population.

National Institute of Health Definition

What are Intellectual and Developmental Disabilities (IDDs)?[576]

Intellectual and developmental disabilities (IDDs) are disorders that are usually present at birth and that negatively affect the trajectory of the individual's physical, intellectual and/or emotional development. Many of these conditions affect multiple body parts or systems.

Intellectual disability starts any time before a child turns 18 and is characterized by problems with both:

- Intellectual functioning or intelligence, which include the ability to learn, reason, problem solve and other skills; and
- Adaptive behavior, which includes everyday social and life skills.

The term "developmental disabilities" is a broader category of often lifelong disability that can be intellectual, physical or both.

"IDD" is the term often used to describe situations in which intellectual disability and other disabilities are present.

State of Florida – Agency for Persons with Disabilities definitions

Intellectual Disability: A term used when a person has certain limitations in both mental functioning and in adaptive skills such as communicating, taking care of him or herself and social skills. These limitations will cause a person to learn and develop more slowly. People with intellectual disabilities may take longer to learn to speak, walk, and take

[575] Ibid. pg. 11.
[576] https://www.nichd.nih.gov/health/topics/idds/conditioninfo/default

care of their personal needs such as dressing or eating. They are likely to have trouble learning in school. They will learn, but it will take them longer. As defined in Chapter 393 F.S., an intellectual disability means significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior which manifests before the age of 18 and can reasonably be expected to continue indefinitely. Adaptive behavior means the effectiveness or degree with which an individual meets the standards of personal independence and social responsibility expected of his or her age, cultural group and community. Significantly sub-average general intellectual functioning means performance that is two or more standard deviations from the mean score on a standardized intelligence test specified in the rules of the agency.

DD (Developmental Disability): A disorder or syndrome defined in Florida statute as autism, cerebral palsy, intellectual disability, spina bifida, Down syndrome, Prader-Willi syndrome, and Phelan-McDermid syndrome that manifests before the age of 18 and constitutes a substantial handicap that can be expected to continue indefinitely.

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CHAPTER 25
Deafness and Blindness: Birth or Early Childhood Development

Introduction

Some children are born with, or develop at an early age, visual and hearing difficulties of sufficient severity to require various types of supports. This chapter focuses on those children and their services. As people age, visual and hearing issues increase. Those difficulties are addressed in the chapters on individuals with other disabilities and seniors.

The format for this chapter consists of a background section, a description of the system-of-care, the gaps and a definitions section.

Context and Background

Blindness and Vision Difficulty

According to the 2018 American Community Survey (ACS), there are approximately 559,943 children with vision difficulty in the U.S. The 2016 ACS reported 571,800 with a visual disability.[577]

According to the FY 2017 Annual Report from the American Printing House for the Blind (APH), based on data from January 2016, there are approximately 63,657 U.S. children, youth and adult students in educational settings who are legally blind.[578]

There are an estimated 2,500 blind/visually impaired children in Florida's public schools.[579] Of these, 153 are in the School District of Lee County.

Deafness and Hard of Hearing

About two to three out of every 1,000 children in the U.S. are born deaf or hard of hearing. Over 90% of these children are born to parents who can hear. Early

[577] American Community Survey, S1810. https://www.census.gov/programs-surveys/acs/
[578] 2017 Annual Report: American Printing House for the Blind, Inc. http://www.aph.org/annual-reports
[579] www.lighthouse.org

identification of children who are born deaf or hard of hearing is critical to ensure that their families have the resources they need to help their children acquire language, spoken and/or visual and achieve age-appropriate communicative, cognitive, academic, social and emotional development. According to American Community Survey 2018 estimates, 408,754 children under 18 in the U.S. had hearing difficulty. In 2016, that number was 431,255.[580]

The following statistics help define the issue:[581]

- 90% of all deaf children are born into hearing families.
- Of those families, only 10% ever learn to effectively communicate with their deaf child. The other 90% do not.
- American Sign Language is the third most commonly used language in the United States.
- Deafness is the No. 1 birth defect in the United States.
- 75% to 85% of deaf high school graduates only read at a third- to fourth-grade level.
- Deafness is the costliest single disability in terms of special education costs, averaging $25,000 per year per child, compared to $5,100 for a typical hearing child.
- The average lifetime cost to society of a child born deaf in terms of medical, educational and productivity losses is $1,020,000.

The Prevalence of Hearing Loss in Children

- More than 1 million children in the United States have a hearing loss.
- Six in every 1,000 infants born in the United States have some degree of hearing loss.
- About three out of every 1,000 infants born in the United States has a severe or profound hearing loss.
- 83 out of every 1,000 children in the United States have what is termed an educationally significant hearing loss.

[580] American Community Survey, S1810. https://www.census.gov/programs-surveys/acs/
[581] http://www.asha.org/public/hearing/disorders/children.htm (American Speech-Language-Hearing Association.

The System-of-Care

Federal Policy

The Early Hearing Detection and Intervention Act (EHDI) in 2000 and subsequent federal funding established state newborn hearing screening programs in hospitals. At the time of its passage, the average age of identification of deaf children was about 2½-years-old; children who were hard of hearing often were identified much later. The goals of the EHDI program include hearing screening of all newborns by age 1 month, confirmation of hearing status by 3 months and enrollment in an early intervention program for deaf and hard of hearing babies and their families by 6 months.

Today, about 95% of newborns have a hearing screening before they leave the hospital.

State Agencies: Florida Division of Vocational Rehabilitation and Division of Blind Services

Vocational Rehabilitation (VR) is a federal-state program that helps people who have physical or mental disabilities get or keep a job. VR is committed to helping people with disabilities find meaningful careers.

VR has counselors who are specially trained to understand the needs and abilities of people who are deaf, hard of hearing, or deaf-blind, including counselors who use American Sign Language.

VR provides services to address hearing loss issues in the workplace, as well as guidance and counseling on how to cope with hearing loss. In addition, VR can provide interpreting services for job interviews and may provide employers and co-workers training on how to communicate with those who are deaf.

VR and the Florida Division of Blind Services (DBS) have a cooperative agreement to help serve individuals with both hearing and vision loss. At the time of referral, counselors from the two agencies will meet with the client who is deaf-blind to determine necessary services and which agency should take the lead in providing services to the eligible customer. If required, the customer may receive services from both agencies as outlined in his/her Individualized Plan for Employment.

The Florida Division of Blind Services mission is to help blind and visually impaired Floridians achieve their goals and live productive and independent lives. Services cover

all ages from babies to senior citizens. The agency also offers Employer Services, the Braille and Talking Books Library and the Business Enterprise Program. Specific programs include:

- The Blind Babies Program provides community-based early-intervention education to children from birth through 5-year-olds who are blind or visually impaired, and to their parents and families, and through community-based provider organizations.

- The Children's Program serves children who are blind from age 5 through transition to the Vocational Rehabilitation Program. This program supplements services already offered by the school system to foster the child's learning and ability to function independently. The child's parents, guardian and family members should be an integral part of the program to foster independence.

- The goal of the Transition Program is to assist young people in meeting their future employment goals through transitioning from school to work or from school to a higher educational program. Students must have a visual impairment in both eyes and require vocational rehabilitation services to prepare for employment. Transition services are generally provided through the Vocational Rehabilitation Program. However, they also could be provided through the Children's Program. In either case, the student will have a Plan of Services. The types of services to be provided through Blind Services are normally incorporated into the student's Individual Education Plan as well. The final goal is to ensure that a child can be an independent adult.

- Independent Living Services are provided to enable individuals who are blind or severely visually impaired to live more independently in their homes and communities with a maximum degree of self-direction. Successful outcomes enable individuals to live more independently in their community and/or transition to the working world.

- Vocational Rehabilitation Services are provided to assist blind and visually impaired individuals seeking employment. Qualified individuals must have a bilateral visual impairment that constitutes or results in a substantial impediment to employment and needs services to prepare for, enter, engage in,

or retain gainful employment. Successful outcomes lead to achievement of employment goals.

- The Rehabilitation Center for the Blind and Visually Impaired is a place where people who are blind can reside temporarily while they learn to lead productive, self-sufficient lives. The Rehabilitation Center program incorporates instruction in a variety of independence skills, as well as case management, including home management, cooking, cleaning, personal care, labeling, orientation and mobility, Braille, access computer technology, adaptive equipment and devices, college prep, job readiness, home repairs, adaptation to blindness and many other skills that contribute to independence and the confidence to seek the highest level of employment possible.

Florida Department of Education. Children or youth who are determined to be deaf or hard of hearing can be determined to be Exceptional Student Education (ESE) eligible. As such there are special programs and supports.

The Florida School for the Deaf and Blind[582], St. Augustine. FSDB is a fully accredited, tuition-free state public school for eligible Pre-K and K-12 students who are deaf/hard of hearing, blind/visually impaired, or deafblind. Transportation for day and boarding students is provided free of charge. FSDB serves 975 or more students each year through statewide parent-infant/family programs as well as a Montessori Pre-K early learning center and K-12 elementary, middle and high schools on its campus.

Local Agencies

Florida Agencies Serving the Blind: This is a group of 18 member agencies, most of which include "Lighthouse" as part of their names, who are the independent nonprofit providers of specialized Vision Rehabilitation and Education for people of all ages who are blind or visually impaired. Their local service areas (some agencies serve just one county and others have multiple counties), combine to provide full coverage for all 67 Florida counties, with more than 2 million severely visually impaired residents, including 2,000 children between birth and age 21. Lighthouse of SWFL is in Lee County.

[582] www.fsdbk12.org

School District of Lee County. The district provides educational services to 153 students identified as deaf or hard-of-hearing. The Deaf or Hard-of Hearing Program offers a full continuum of services to meet both academic and communication needs identified on a student's Individual Educational Plan (IEP). Eligibility for the program is based on both a documented hearing loss and educational need. Students ages 3 through 22 can receive itinerant services at their home school or attend a designated school site where classes are taught by a teacher certified in deaf education. Designated visual impairment intervention schools include Villas Elementary, Varsity Lakes Middle and Fort Myers High. The auditory-oral and total communication options are available at all levels. Sign language interpreting services provide students access to classroom curriculum and extracurricular activities. Additionally, a range of audiological services are provided for students through the district audiologist.

Gaps

The following gaps are noted:

Mental Health Services. The status of mental health services for deaf and hard of hearing people in the United States is less than adequate. Mental health service providers may mistake cultural, language and communication issues for intellectual delays, developmental delays or mental illness.

Communication challenges in the criminal justice and court systems. Deaf and hard of hearing individuals face greater legal challenges due to communication barriers that are typically not recognized by lawyers, courts or police. In encounters with the police, lack of communication may result in detention without the ability to call one's lawyer. The provision of effective communication can be provided in a variety of ways, such as qualified interpreters, real-time captioning (or CART) or other accommodations.

Newborn evaluations for deafness/hard of hearing. While the EDHI provided for in-hospital evaluations, not all newborns who are suspected of being deaf or hard of hearing receive the necessary follow-up evaluations they need to confirm their hearing status.

Early Screening for Vision Difficulties: Many children do not receive a vision screening until they are nearing school age (ages 4 or 5) and this can cause missed opportunities for intervention.

Employment. One study found that 29.5% of individuals with a visual disability were employed full-time in 2016[583]. Another found 32%. [584] 48% of deaf people are employed[585]. However, discrimination in employment is a documented phenomenon[586]. While there is employer bias there is also parental resistance. Some parents do not think their child capable of employment.[587]

Fear of Losing Benefits if employed. There is a fear of losing benefits if one becomes employed. The Florida Ticket to Work program is designed to resolve this concern. A gap is a lack of awareness of this program by some.

The lack of specialized services for deaf/blind persons. Deaf-blind individuals are a highly diverse group with various combinations of vision or hearing loss occurring at various times and sequences[588]. There is no coherent local, State or national funding for services for this population. Knowledge about this population is limited in the health care field. There is a lack of interpreters and training for respite care providers.

Guide Dogs. It is estimated that there are 10,000 guide dog teams currently working in the U.S. There are only about 2% of blind and visually impaired individuals with guide dogs[589]. This is because guide-dog schools require a strict set of pre-requisite specialized skills and training in orientation and mobility skills to qualify for a dog.

Computer Access. Learning to use the computer while blind requires specialized training and interventions to use enlargement software and screen readers.

[583] Erickson, W. et.al. 2017. Disability statistics from the American Community Survey. Ithaca, NY: Cornell University.
[584] Bell, E. et.al. 2018. Rehabilitation and employment outcomes for persons that are blind or visually impaired. Journal of Blindness Innovation and Research. 8(1)
[585] Garberoglio, C et.a. 2016. Deaf people and employment in the United States. National Deaf Center on Postsecondary Outcomes.
[586] https://www.npr.org/2019/01012/deafandunemploye
[587] https://www.npr.org/2019/01012/deafandunemployed
[588] www.aadb.org
[589] Guide Dogs for the Blind. www.guidingeyes.org

Staffing shortage. There is a critical staffing shortage of teachers and qualified professionals to provide appropriate interventions to the blind and visually impaired. What makes this gap even more challenging is there are few universities that offer programs leading to certification. Qualifications to teach the blind and visually impaired can be found at https://www.acvrep.org/ and https://aerbvi.org/

Definitions[590]

Vision difficulty. Children with vision difficulty are children who range in age from birth to 17-years-old. This definition includes those children who have serious difficulty seeing even when wearing glasses as well as those who are blind.

Legal blindness. Students who are legally blind can range in age from birth to 21-years-old. This definition only includes those students with vision loss who are legally blind. Legal blindness is a level of vision loss that has been defined by law to determine eligibility for benefits. It refers to explicitly to those who have a central visual acuity of 20/200 or less in the better eye with the best possible correction, or a visual field of 20 degrees or less.

Low Vision or Partially Sighted. This is having visual acuity and/or field of vision that is less than normal or having a visual limitation in only one eye. Vision that is limited to a narrow angle in the center of the field of vision is sometimes called Tunnel Vision.

[590] www.dbs.myflorida.com

CHAPTER 26
Persons with other Physical Disabilities

Introduction

In addition to people with intellectual and developmental disabilities or those born with hearing and visual disability, there are other forms of disability. While these first two are associated with birth or childhood, other disabilities may develop later in life. This chapter addresses three other disabilities – vision loss during adulthood, hearing loss during adulthood and physical disabilities.

There is a broad range of very specific disabilities, some of these disabilities are due to injury and others develop during the course of one's life. When combined with the physical impacts of aging, some of these disabilities are associated with the elderly. The area is often addressed under the rubric of independent living.

Context and Background

What is Independent Living?

Independent living can be considered a movement, a philosophy or specific programs. In the context of the Administration for Community Living (ACL), independent living programs are supported through funding authorized by the Rehabilitation Act of 1973, as amended (the Act). Title VII, Chapter 1 of the Act states the current purpose of the program is to "promote a philosophy of independent living including a philosophy of consumer control, peer support, self-help, self-determination, equal access, and individual and system advocacy, to maximize the leadership, empowerment, independence, and productivity of individuals with disabilities, and the integration and full inclusion of individuals with disabilities into the mainstream of American society."

Key provisions of the Act include responsibilities of the Designated State Entity (DSE), provisions for the Statewide Independent Living Councils (SILCs), requirements for the State Plan for Independent Living (SPIL) and Center for Independent Living standards and assurances. (See below for details on all these areas.)

To receive funding, states must jointly develop and submit a State Plan for Independent Living (SPIL), which is a three-year plan for providing independent living services in the state. The Designated State Entity (DSE) is the agency that, on behalf of the State, receives, accounts for and disburses funds received under Subpart B of the Act. The Statewide Independent Living Council (SILC) is an independent entity responsible to monitor, review and evaluate the implementation of the SPIL. Centers for Independent Living (CILs) are consumer-controlled, community-based, cross-disability, nonresidential private nonprofit agency that is designed and operated within a local community by individuals with disabilities and provides an array of independent living services.

Independent Living in Florida

The Florida Independent Living Council (FILC), formed in 1999, is a not-for-profit statewide planning organization. The council is made up of 14 voting members who are appointed by the Governor and the majority of the voting members must consist of individuals with disabilities who are not employed by a Center for Independent Living (CIL) or a state agency.

The role of the FILC is to provide leadership, research, planning and education required to support independent living services in Florida.

Vision Loss and Blindness

Florida leads the nation in blind population, and it is growing. Florida has 21 million residents (Census as of July 2016) of which 19.4% are 65 years old or older. Applying Florida's population to findings from a nine-year longitudinal study of Medicare recipients performed by Duke University[591], the number of severely visually impaired Florida seniors is currently in the range of 2 million older individuals. An annual census performed by the American Printing House for the Blind yields a total of 3,000 severely visually impaired children in public schools[592].

As diabetes becomes ever more common, adults are being affected with diabetic retinopathy, which causes blindness; other major causes of adult vision loss are

[591] (https://www.ncbi.nlm.nih.gov/pubmed/12963614
[592] www.beyondvisionloss.org

glaucoma, macular degeneration, retinitis pigmentosa and cataracts. At the other end of the generational spectrum, a steady 6% of premature babies have an associated vision impairment in addition to other handicaps[593].

It should be noted that despite the growth of the senior population there is a decrease in the prevalence of both vision loss and blindness. However, for seniors ages 85 and older, percentages significantly increase (22.3% with vision loss and 2.3% experiencing blindness in 2014)[594].

While there are not Florida specific data, data exist on vision loss for people 40 and older. The latest version of *Vision Problems in the U.S.*, (2012) provides a diagnoses-specific look at visual impairment for Americans age 40 and older. The study defines vision impairment as "having worse than 20/40 vision in the better eye, even with eye glasses," and the study defines blindness according to the United States' definition of legal blindness, or "visual acuity with best correction in the better eye worse than or equal to 20/200 or a visual field extent of less than 20 degrees in diameter."

The following are selected estimates for Americans ages 40 and up from the 2012 *[Vision Problems in the US:]*[595]

- 2,907,691 people have vision impairment not including blindness (2.0% of the 40 and older population, as estimated by the 2010 Census)
    - 337,752 age 40 to 64 (0.33% of the same-age population)
    - 2,569,959 age 65 and older (6.4% of the same age population)
- 1,288,275 people are legally blind (0.90% of the 40 and older population, as estimated by the 2010 Census)
    - 155,002 age 40 to 64 (0.15% of the same-age population)
    - 1,133,272 age 65 and older (2.8% of the same-age population)
- 2,069,403 people have age-related macular degeneration, often called "AMD."[596]

[593] Statistics about Seniors with Vision Loss. Originally Published as "Research Navigator: Age is just a Number" **February 25, 2016**
[594] ibid
[595] www.visionproblemsus.org
[596] www.visionproblemsus.org

- 24,409,978 people have cataracts. By age 80, more than half of all Americans have cataract(s)
- 7,685,237 people have diabetic retinopathy. Which also increases the risk of cataract and glaucoma.
- 2,719,379 people have glaucoma[597]

In terms of trends the following are estimated[598]:

- Cases of early age-related macular degeneration are expected to double by 2050, from 9.1 million to 17.8 million for those age 50 or older.
- Cases of diabetic retinopathy among people age 65 or older are expected to quadruple by 2050, from 2.5 million to 9.9 million.

Hearing Loss

- The U.S. Department of Health and Human Services estimates[599]

  - Number of adults with hearing trouble: 41.3 million
  - Percent of adults with hearing trouble: 16.5%
  - Of these, almost 6 million are profoundly deaf.
  - There are more than 800,000 deaf or hard-of-hearing individuals in Florida.

Physical Difficulties and Activities of Daily Living

Local statistics in this area are limited. National data reports the following data[600]:

- Number of adults unable (or very difficult) to walk a quarter-mile: 19.4 million
- Percent of adults unable (or very difficult) to walk a quarter-mile: 7.8%
- Number of adults with any physical functioning difficulty: 40.7 million
- Percent of adults with any physical functioning difficulty: 16.3 million

[597] Vision problems in the U.S. www.visionproblemsusa.org
[598] Center for Disease Control and Prevention, Behavioral Risk Factor Surveillance System
[599] http://www.nidcd.nih.gov/health/statistics/hearing.asp (National Institute on Deafness another Communications Disorders)
[600] : Summary Health Statistics Tables for U.S. Adults: National Health Interview Survey, 2018, Tables A-6b, A-6c pdf icon[PDF – 147 KB]

- Number of adults age 18 and older reporting a lot of difficulty or cannot do at all in at least one domain of functioning: 20.7 million (2017)
- Percent of adults age 18 and older reporting a lot of difficulty or cannot do at all in at least one domain of functioning: 8.7% (2017)
- Number of adults age 65 and older reporting a lot of difficulty or cannot do at all in at least one domain of functioning: 9.5 million (2017)
- Percent of adults age 65 and older reporting a lot of difficulty or cannot do at all in at least one domain of functioning: 19.5% (2017)

The disability of some individuals is sufficient that they need personal care assistance. Statistics include:[601]

- Percent of adults age 65 to 74 who need help with personal care from others: 3.9%
- Percent of adults age 75 and older who need help with personal care from others: 11.6%

Disabled Seniors

Duplicating data from the chapter on seniors, the following Table 101 shows the disability status of seniors in Lee County.

Table 101. Disability Status of Seniors[602]

Disability status of seniors	Number
One type of disability	33,211
Two or more disabilities	29,403
Specific disability (could have more than one)	
Hearing	28,380
Vision	9,422
Cognitive	14,721
Ambulatory	37,095
Self-care	11,935
Independent Living	22,114
No Disabilities	173,329
Probable Alzheimer's	22,756

Disabled Veterans

[601] Source: Health, United States, 2018, table 15 pdf icon [PDF – 9.8 MB]

[602] Profile of older Floridians, op.cit

A variety of services are provided to disabled veterans. These are described in the chapter on veterans.

Poverty and Disability

One of the consequences of disabilities can be lowered income or poverty. Some statistics are presented below. Disability is both a cause and consequence of poverty. It is a cause because it can lead to job loss, reduced earning, barriers to skill development and significant additional expenses. It is a consequence because poverty can limit access to health care, appropriate housing and accessible transportation.

The poverty rate for working-age people with disabilities is nearly two-and-a-half times higher than that for people without disabilities[603]. The Census Bureau estimated the poverty rate for individuals with disabilities to be 28.4% in 2013, compared to 12.4% for those without disabilities[604]. For example, the annual earnings and poverty status of non-institutionalized individuals age 21 to 64 with a visual disability in the United States in 2016[605].

- Median Annual Earnings: $38,500
- Median Annual Household Income: $41,300
- Number living below the poverty line: 1,048,600 (27.7%)

System-of-Care

There are a range of agencies addressing disability in the State. They are described below. Each operates as its own system.

[603] Vallas, R. et.ao. 2014. Disability is a cause and consequence of poverty. www.talkpoverty.org
[604] Denavas-Walt, C. et.al. 2014. Income in poverty in the United States. 2013. U.S. Census
[605] Summary Health Statistics Tables for the U.S. Population: National Health Interview Survey, 2018, Table P-3c pdf icon [PDF – 104 KB]

Home Health Services – ACHA

Home Health Services provide skilled nursing and home health aide services for Medicaid recipients from birth to end of life. Private-duty nursing and personal-care services can be provided for Medicaid recipients under 21 years of age. Personal-care services provide assistance with activities of daily living (ADL) and age-appropriate instrumental activities of daily living (IADL) to help the person complete tasks he/she would normally be able to if not for a medical condition or disability.[606] Examples of ADL activities including eating, bathing, dressing, toileting and transferring. IADL includes light housework, meal preparation, grocery shopping, etc. These services are Medicaid funded and managed in the State by the Agency for Health Care Administration.

Community and Support Services – Florida Department of Elder Affairs

These are non-Medicaid Services for people 60 or older. The Older Americans Act funds adult day care, caregiver training and support, chore, congregate dining, home-delivered meals, homemaker services, information and referral assistance, medical transportation, nutrition education, personal care and shopping assistance. The Community Care for the Elderly (CCE) program uses State funds to provide case management and other services to frail elders age 60 and older. Other services include adult day health care, home health aide, counseling, home repair, medical therapeutic care, home nursing, emergency alert response and information. CCE services assist elders to perform certain daily tasks such as meal preparation, bathing or grooming. The Home Care for the Elderly (HCE) uses State funds to provide a subsidy to caregivers to help maintain low-income elders in their own homes or in the homes of caregivers. Payment is made for support and health maintenance and to assist with food, housing, clothing and medical care. A special subsidy is available to help with specialized health care needs. The Respite for Elders Living in Everyday Families (RELIEF) offers in-home respite that is an expansion of respite currently available through other programs, including evening and weekend respite. The purpose of this service is to increase the ability of a family unit to continue to care for a homebound-elderly individual by providing in-home respite beyond the basic provisions of current public programs. It is volunteer based.

[606] acha.myflorida.com

OAA funds are allocated by formula to Area Agencies on Aging which in turn contract with local providers.

The Florida Department of Elder Affairs administers the CCE program through the Area Agencies on Aging, which in turn subcontract with lead agencies that provide services through a network of providers. To be eligible, someone must be 60 or older and functionally impaired. Priority is given to those who have been determined by Adult Protective Services to be victims of abuse, neglect or exploitation and who need immediate services.

The Home Care for the Elderly provides care for those 60 and older in family-type living arrangement within private homes as an alternative to institutional or nursing home care. A basic subsidy of $106 per month is provided. Special subsidies are provided in certain conditions. The Area Agency on Aging is responsible for local administration and determination of eligibility.

A variety of food assistance programs also are offered. These include:

- Adult Care Food Program:
  This program assists eligible Adult Care Centers and Mental Health Day Centers in providing meals to elders. In addition to seniors, those 18 or older with a functional disability are eligible.
- Senior Farmers Market Nutrition Program:
  This program improves the nutritional health of low-income elders by providing coupons that can be redeemed for locally grown fresh fruits and vegetables at approved farmers markets.
- Nutrition Services Incentive Program (NSIP):
  The NSIP reimburses Area Agencies on Aging and service providers for the costs of congregate and home-delivered meals through a supplement of approximately $0.72 per meal as of 2015. Younger adults with disabilities can also be included.

Florida Coordinating Council for the Deaf and Hard of Hearing, Florida Department of Health

The Council's website describes its role as follows:[607]

[607] www.floridahealth.gov/home/providersand partner resources/FCCDHHhome

Florida Coordinating Council for the Deaf and Hard of Hearing, hereafter referred to as the "Coordinating Council" is mandated by Section 413.271 Florida Statutes to serve as an advisory and coordinating body which recommends policies that address the needs of Florida's deaf, hard of hearing, late-deafened and deaf-blind (hereafter referred to collectively as "hearing loss") community.

The Coordinating Council is a resource for deaf and hard of hearing Floridians who need assistance with everyday needs including employment, education and access to services. The Coordinating Council is dedicated to assisting the nearly 3 million Floridians affected by hearing loss through providing technical assistance and resources to individuals, governmental agencies, private and public organizations.

The Coordinating Council's technical assistance allows both public and private entities to better and more efficiently serve persons with hearing loss and their families.

Assistance to Veterans[608]

What follows are edited quotes from the reference site:

The Aid and Attendance Pension benefit is another program available in Florida that can be used to pay family members to provide care. This program is only relevant for war-time veterans or their surviving spouses who require assistance with their activities of daily living. Spouses cannot be paid as caregivers, but adult children and other relatives can be compensated.

The Aid and Attendance Pension benefit is a cash benefit and the amount of financial assistance varies depending on the beneficiary's current income. Annually, the VA sets a maximum amount of income a beneficiary can have and then the VA supplements the veteran's income up to the point of the maximum benefit. For example, in 2018, the Maximum Annual Pension Rate (MAPR) for a couple is approximately $25,000. If the couple has $15,000 in income, the VA will give them an additional $10,000.

The VA does allow families to deduct certain expenses from their income, so in practice they can still be eligible even if their income is considerably higher than $25,000 per year. One expense they can deduct from their countable income is their cost of care. Therefore, an elderly veteran can hire their adult child (or another relative or friend) to provide them with personal care and the amount they pay their caregiver can be

[608] www.payingforseniorcare.com

deducted from their income. The VA will compensate the veteran an amount equal to what they pay to their caregiver over and above their existing pension benefit. The spouse cannot be the caregiver.

Another option veterans can use to pay their caregivers is a program called Veterans Directed Home and Community Based Services (VD-HCBS). For veterans who require the level of care on par with what is provided in a nursing home, this program gives them the option to receive that care at home and to pay family members or friends for providing care. In brief, how this program works is that the veteran is provided with a budget for care instead of being provided with care by the VA. The responsibility for finding the care providers, then falls onto the veteran and / or their family. With control of the budget, the veteran can hire family members, friends and even their spouses to provide them with the hands-on assistance with the activities of daily living they would otherwise receive in a nursing home.

Any veteran that participates in the VA Medical Center Care system and requires "nursing home level care" is eligible for this program. Notably, veterans with Alzheimer's usually meet these criteria. Veterans can only be referred to AAASWFL by Bay Pines VA Healthcare System. The Veterans Administration refers clients who are at risk of institutional placement. AAASWFL then assists the veterans with budget management and finding programs that suit their needs.

Gaps

The primary gap is that the need for services exceeds the available financial resources. This is demonstrated by the size of the waitlists for services. In Florida, as of 2017 the following waitlists existed[609]:

- Individuals with IDD: 21,017
- Aged/Disabled: 49,798
- Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI): 201

[609] Waiting List Enrollment for Medicaid Section 1915© Home and Community-Based Services Waivers. www.kff.org/statehealthfacts/medicaid&CHIP/homeandcommunitybasedservices/waitinglist

Of note, the waiting list in Florida differs from national patterns. Nationally, 67% of the waiting list is composed of those with IDD, while seniors and adults comprise 28%. Florida is the opposite.[610]

Key Future Trends. The increase in the number of people receiving Medicaid HCBS and the number of people in need of those services over the years is attributable to a number of factors. Those include the aging of the population; the fact that medical and technological advances that prolong the lifespan provide previously unavailable treatments for certain conditions and offer new options to support independent community living; changing individual and societal preferences for HCBS in lieu of institutional care; and state efforts to meet their community integration obligations under the Americans with Disabilities Act (ADA) and the *Olmstead* decision.[611]

[610] ibid
[611] https://www.kff.org/medicaid/issue-brief/key-questions-about-medicaid-home-and-community-based-services-waiver-waiting-lists/view/footnotes/#footnote-399062-20

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Chapter 27
Seniors

Introduction

This chapter begins with this quote about the future of Florida. It is an accurate description of Lee County's future.

The Silver Wave[612]

"Seniors will constitute the majority of Florida's predicted population growth between now and 2030, and this boom means Florida will encounter elder issues in a way the state – already a longtime haven for retirees – has never seen before.

Persons age 65 and older currently make up about 20% of Florida's population. By 2030, more than one in four Floridians will be part of this age group. Florida adds a quarter-million additional residents each year through 2030, and the majority of these new residents – 57% of them – will be age 60 and older.

Between 2015 and 2050, the age 85 and older population is projected to more than triple, which has significant implications. This age group is the most likely to need long-term services and support to help with everyday tasks such as bathing, dressing, eating, transferring and toileting. Members of this age group not only have higher rates of disability than younger people, but they are also more likely to live alone, without a spouse or other family member to provide them with assistance.

Add to that the increasing rate in the number of people living with Alzheimer's disease and related dementias. In Florida alone, an estimated 480,000 older adults live with Alzheimer's today, and this figure is expected to increase to 720,000 in the next 11 years. Alzheimer's disease is the number one most costly condition to Medicare and Medicaid budgets, more costly to the nation than heart disease or cancer."

[612] The Silver Wave. Florida Health Care Association.

Context and Background

Current projections for the number of seniors in Lee County, age 65 and older, range from 182,764[613] to 188,866.[614] The Department of Elder Affairs estimates various age brackets within the senior category. Table 102 shows their estimates for 2018.

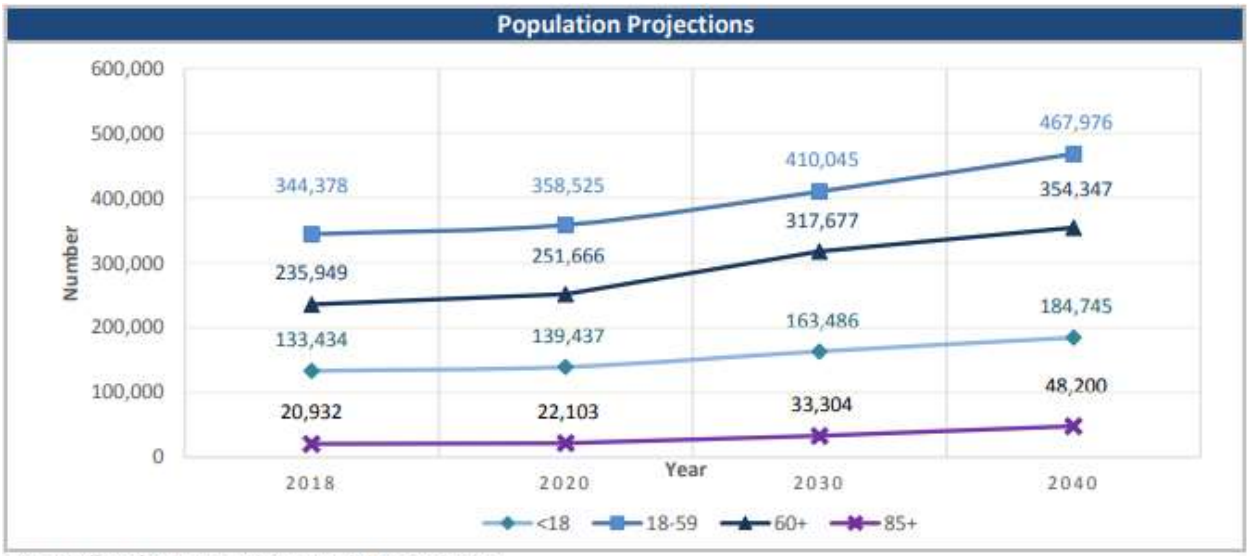
Table 102. Age Group Population Estimates for Lee County[615]

Age	Population	Percentage
60+	235,949	33.1%
65+	182,764	25.6%
70+	129,834	18.2%
75+	80,402	11.3%
80+	43,806	6.1%
85+	20,932	2.9%

The department of Elder Affairs projects the 85 and older age group population to be 48,200 by 2040, as shown below in Figure 33.

[613] Profile of Older Floridians, lee County, 2018. Website: elderaffairs.state.fl.us
[614] Website:worldpopulationview.com/leecountyfl
[615] Profile of older Floridians, op.cit

Figure 33. Lee County Population Projections[616]



Source: Office of Economic and Demographic Research, 2017

Table 103. Financial Status of Seniors[617]

Financial Status	Number	Percentage
Below poverty guideline	19,109	8.1%
Below 125% of FPL	28,288	12.0%
Minority below FPL	5,835	2.5%
Minority below 125% of FPL	7,596	32%

As Table 103 notes that about 8% of seniors have an income that is below the federal poverty line. Another source estimates that approximately 4% of seniors age 65 to 74 live below the poverty line and approximately 3% of seniors age 75 and older are classified as living in poverty.[618] This is approximately 13,000 seniors, which is close to the estimate in Table 105 of food-insecure seniors. Appendix I summarizes some of the methodological issues with the federal poverty line.

Table 104 presents a view of senior households from the perspective of housing cost-burden. While these are not individuals in poverty, the table does indicate that nearly 14% of the county's seniors are financially constrained.

[616] FL Dept of Elder Affairs. 2018 Projections, Lee County

[617] ibid.

[618] Website: datausa.io/leecountyfl

Table 104. Elder Households with Cost Burden[619]

Above 30% and Income Below 50% Area Median Income

Elder Households	101,499
Percent of all households	13.9%

One of the potential consequences of financial constraint is food insecurity. Tables 105 and 106 present data on this situation.

Table 105. Food Insecurity in Lee County[620]

Population	700,165
Overall Food-Insecure Population	86,050
Food-Insecure Seniors (Est)	12,900

With respect to SNAP or Food Stamps, Table 106 presents a more challenging view of food security for seniors than does Table 105.

Table 106. Seniors and SNAP 2017[621]

Participants	14,430
Potentially Eligible	28,288
Participation Rate	51%

Another consequence of financial constraint is the use of health care services. Table 107 presents data on this issue.

Table 107. Medically Underserved (65+)[622]

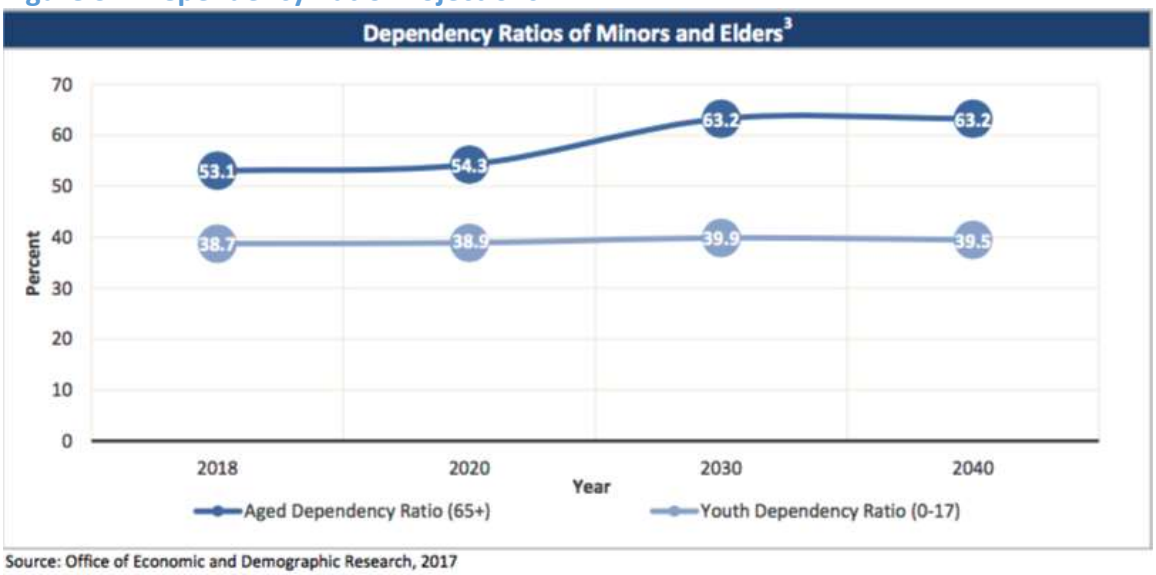
Total Medically Underserved	46,801
Living in Areas Defined as Medically Underserved	46,801

Dependency Ratio. This is the percentage of seniors compared to non-senior adults. The higher this percentage, the lower the workforce numbers available to support the needs of senior citizens. The projected dependency ratios are shown in Figure 34 below. By 2030, the dependency ratio in Lee County will be 63%. This means that there will be close to one senior (65 and older) for every working-age adult in the County. This

[619] The Shimberg Center for Housing Studies, 2017
[620] Harry Chapin Food Bank
[621] Profile of older Floridians, op.cit
[622] Profile of older Floridians, op.cit.

will represent a serious challenge to a workforce for which there is a high need for senior services. Table 108 presents data on the current disability status of seniors. These numbers will only increase in the future.

Figure 34. Dependency Ratio Projections



Source: Office of Economic and Demographic Research, 2017

Table 108. Disability Status of Seniors[623]

Disability Type / Description	Number
One Type of Disability	33,211
Two or more Disabilities	29,403
Specific Disability (could have more than one)	
Hearing	28,380
Vision	9,422
Cognitive	14,721
Ambulatory	37,095
Self-care	11,935
Independent Living	22,114
No Disabilities	173,329
Probable Alzheimer's	22,756

[623] Profile of older Floridians, op.cit

The System-of-Care

The State of Florida's Department of Elder Affairs has overall responsibility for addressing various senior issues. It contracts with the Area Agency on Aging (AAA) for Southwest Florida to provide programs and services that help older adults and adults with disabilities to live as independently as possible. Services include:

- The Elder Hotline
- Home and community-based care
- Medicare counseling
- Health and wellness workshops
- Elder abuse prevention and education
- Emergency home energy assistance
- Medicare savings for low-income beneficiaries
- Medicaid-managed long-term care
- Respite care
- Veteran-directed home and community-based services.

Most these programs are provided through Federal and State grants.[624]

Federal Grants

Older Americans Act (OAA):

Title III B: Provides supportive services to help elders live independently in their own homes and communities.

Title III C1: Provides congregate meals and nutrition education in strategically located centers.

Title III C2: Provides home-delivered meals and nutrition education to home-bound individuals.

Title III D: Provides disease prevention and health promotion services. These services are designed to help adults age 60 and older through education and activities that support and promote healthy lifestyles and behaviors.

Title III E: Provides services through the National Family Caregiver Support Program. These services help families caring for frail elders. Assistance is also available

[624] Website: aaaswfl.org

to grandparents or older relatives who are caregivers for children 18 and younger or for children with disabilities.

Title VII: Provides the Elder Abuse Prevention program. This program is designed to increase awareness of the problem of elder abuse, neglect and exploitation.

State of Florida Grants

Community Care for the Elderly (CCE): The CCE program provides community-based services to help frail elders live in the least restrictive, yet most cost-effective, environment suitable to their needs.

Alzheimer's Disease Initiative (ADI): The ADI program provides services to meet the changing needs of individuals with, and families affected by, Alzheimer's disease and similar memory disorders.

Home Care for the Elderly (HCE): The HCE program supports care for Floridians, age 60 and older, living in private homes as an alternative to institutional or nursing home care.

Local Activities

In addition to managing the above programs, the Area Agency on Aging Southwest Florida (AAASWFL) also seeks to inform seniors about emergency planning, disaster assistance, special medical needs, special needs shelters and registering for special needs shelters. AAASWFL offers a free, evidence-based caregiver support workshop, "Powerful Tools for Caregivers," and a free, evidence-based falls prevention / balance workshop. These workshops are provided in Lee County.

In addition to these social services targeted to seniors, there is also a range of facilities and health care services designed for seniors. Table 109 provides a summary.

Table 109. Health Care Facilities for Seniors

Facility / Service Type	Number or Beds or Agencies
Skilled Nursing Facilities	2,230 beds
Assisted Living Facilities	3,711 beds
Medicaid Certified Home Health Care Agencies	15
Medicare Certified Home Health Care Agencies	35
Homemaker and Companion Service Companies	58
Adult Day Care Capacity	548 persons
Adult Family Care Home Beds	98 beds

Needs More Specific to Seniors

While seniors share many of the same needs as other age groups, they do have some specific needs that a system-of-care should address. These include:

- Activities of Daily Living (ADL) (bathing, dressing, etc.) and Instrumental Activities of Daily Living (IADL) (heavy chores, shopping) Assistance. 19% needed ADL and 54% needed IADL.[625]

- Isolation[626] and Living Alone. Seniors who live alone are at greater risk. Those living with someone, particularly with their spouse, have a better mental health status, more income and are more likely to receive care.[627] 20% of Lee County residents age 65 and older live alone, putting them at risk of social isolation or a lack of regular contact with others. Social isolation relates to several health issues, including poor diet, dementia, lack of exercise, high blood pressure, arthritis and depression. There also is a correlation between isolation and elder abuse, exploitation and self-neglect.

- Medications. 50% of seniors in Florida have delayed filling prescription medications for a limited period. 27% have delayed for three months or more.[628]

- Dental / Eye Care. 27% have not been able to afford dental or eye care.[629]

[625] Assessing the needs of Elder Floridians, 2016. Department of Elder Affairs
[626] Data provided by AAASWFL
[627] Robards, J., et al (2012). Marital status, health and mortality. Maturitas, 73(4), 295–299.
[628] Assessing, op.cit.
[629] ibid.

- Information. Studies have shown that one of the key reasons elders do not participate in SNAP (or Food Stamps) is they mistakenly believe they will get only the minimum benefit ($16). In fact, in Federal Fiscal Year 2009, the average monthly benefit for each person older than 60 in the program nationally was $119 per month.

- Falling. Nationwide, falls are the leading cause of fatal and nonfatal injuries among seniors age 65 and older (Bergen, Stevens, & Burns, 2016). One out of four older adults fall each year, and 20% of those falls cause serious injuries such as broken bones or head injuries. DOH data indicate that the 2017 death rate from unintentional falls in Lee County was 86.9 per 100,000, far higher than the statewide average of 54.6 deaths per 100,000.

Gaps in the System-of-Care

Some of the following gaps have been addressed in other chapters and will simply be noted here:

- Housing. For a proportion of seniors, housing is a cost-burden.

- Food Security. A proportion of seniors, many of whom are housing cost-burdened, also face food insecurity. It is estimated that 30% of seniors are at-risk of malnutrition.[630] For those who live alone, the percentage is 37%. [631] Older people are significantly less likely to participate in SNAP (or Food Stamps).

- Elder Abuse. 18% of seniors reported being a victim of fraud or swindle.[632]

- Self-harm. Approximately 8% of statewide elders had to go without treatment for emotional or mental health issues.[633]

- Transportation. "About one-half of statewide respondents (47%) reported that they get around by driving themselves. The remaining one-fifth (18%) of elders reported using a variety of other modes of transportation, such as taxis, vans, special transit

[630] Assessing the needs of Elder Floridians, 2016. Department of Elder Affairs
[631] ibid
[632] Assessing the needs of Elder Floridians, 2016. Department of Elder Affairs
[633] ibid.

and senior ride services. Without access to affordable transportation, seniors may face poorer health, social isolation and a reduced quality of life. Research has shown that elders age 65 and older, who no longer drive, take 15% fewer trips to the doctor, 59% fewer trips to shop or eat out, and 65% fewer trips to visit friends and family, when compared to drivers of the same age."[634]

- Behavioral Health. A significant percentage of seniors do not access mental health care services. This is partially a cost issue and partially a negative perception of mental illness issue.

- Staffing. One in seven Florida nurses work in a skilled nursing or hospice facility. There is a 62.4% turnover rate. The turnover rate for nursing assistants ranges from 45% to 66%.[635] While the population of seniors will grow by 100%, the primary labor pool for long-term care, women age 25 to 64, will only grow by 1%. [636]. There will also be a need for more specialized staff. As the dependency ratio in Lee County continues to rise, there will be fewer and fewer people to provide professional caregiving.

Elder Specific Gaps

The following gaps are of significance to seniors. Some can be of benefit to other groups also.

- Information and Education. A portion of seniors do not understand the programs and services available to them. The comparatively lower percentage accessing Food Stamps is an example. Also, there is the attitude among some about not taking "welfare." This negative perception needs to be addressed.

- Caregiver Support. While a percentage of elders live in nursing homes or assisted living facilities, far more are cared for at home.[637] The waitlist for home and community services means there is a gap in caregiver support and respite care. Florida has 2.7 million residents who are part-time or full-time caregivers for an aging loved one. However, Florida ranks 46th in terms of offering support. In the

[634] ibid.
[635] The silver wave, op.cit.
[636] ibid.
[637] The silver wave, op.cit.

seven-county region that includes Lee County, recent needs assessments have determined that about one-third of older adults (age 60 or older) consider themselves an unpaid caregiver for someone else—and most (69%) receive no additional help with the caregiving. It's not uncommon for caregivers to neglect self-care in favor of caring for their loved one—but this altruism has a cost. Nationwide, 22% of caregivers believe their health has declined because of caregiving, 20% report high physical strain and 35% report high emotional stress.[638]

- There is a waitlist for home and community based services. As of February 2019, there were 71,650 Floridians on the list. The State spends 22% of its Medicaid funds on home and community-based services. The national average is 45%.[639] The State's waitlist prioritizes those with the highest level of need to ensure those who are at the highest risk of hospitalization or placement in a nursing facility are prioritized for services.

- In Lee County, lengthy waitlists exist for all the home and community-based programs funded through the state DOEA and Older Americans Act programming, including Community Care for the Elderly (CCE), Home Care for the Elderly (HCE), Alzheimer's Disease Initiative (ADI) and Older Americans Act Title IIIB (OAA3B). Consumers are prioritized based on the results of their assessments conducted by AAASWFL.

    - As of Dec. 1, 2019, the Lee County waitlist consisted of:
        - CCE: 107 Active, 1,335 waitlisted (CCE provides in-home services such as housekeeping, meals, personal care / hygiene, adult day care, transportation and case management).
        - HCE: 33 Active, 190 waitlisted (HCE provides a small stipend to an in-home family caregiver to assist in payment for the client's needs).
        - ADI: 36 Active, 406 waitlisted (ADI provides services that support / provide temporary relief from caregiving responsibilities for someone with Alzheimer's Disease or related disorders).
        - OAA3B: 63 Active, 1439 waitlisted.

[638] Data provided by AAASWFL
[639] Website: health.wusf.usf.edu

- Waitlist Explanation. Clients are waitlisted for all the programs for which they are eligible at the time of their assessment. This means the same person could be wait-listed for more than one of the above programs at the same time. Also, a waitlist does not mean that they have a high level of need. There are a small number of people who have had assessments performed just to make sure they're "in the system," despite not really having many challenges.

- Reimbursement rates for long-term care do not cover the costs. It is estimated that Medicaid underfunds nursing center care by more than $12 per patient per day, making the delivery of quality services very difficult.[640]

[640] ibid.

CHAPTER 28
Veterans

Introduction

At the national, State and local level there is a commitment to address the needs of those who served in the nation's military. The dominant service provider is the Veteran's Administration. Both the State and County governments also provide support.

Context and Background

There are 1,525,400 veterans in Florida. Of these, 789,717 are 65 years of age or older. Florida has the nation's third-largest veteran population – behind California and Texas.[641]

In Lee County, the veteran population is 59,238.

System-of-Care

The system-of-care for Veterans is a combination of federal, State and County services. The prime entities include:

- Veterans Administration (VA). Nationally, the VA provides a network of hospitals, clinics and nursing homes for veterans in addition to administering a variety of benefit programs and cemeteries.

- Florida Department of Veterans Affairs. Within the State, there are a variety of benefits for veterans:
    - Homestead tax exemptions or discounts
    - Educational benefits
    - Various employment benefits
    - Various exemptions from fees

[641] Fast Facts. Florida Department of Veterans Affairs. www.floridavets.org

- Lee County Veteran Services. Lee County Veteran Services is part of the Department of Human Services and provides counseling and education to veterans, their dependents and survivors on potential benefits available from the Department of Veterans Affairs and other government agencies. This office prepares all applications for benefits, which include:
    - Compensation and pension benefits
    - Aid and attendance benefits
    - Appeals modernization program
    - Survivor and burial benefits
    - Additional VA benefits

Local Resources for Veterans

In addition to the direct services provided by Lee County Veteran Services, there are other local services. These include:

A VA Healthcare Center in Cape Coral. The Cape Coral clinic offers the following services:

- Primary care
- Mental healthcare
    - Post-traumatic stress disorder
    - Substance abuse counseling, intensive outpatient program and a recovery program
    - General mental health counseling
    - Sexual trauma recovery
- Women's healthcare
- Ambulatory surgery
- Audiology
- Cardiology and EKGs / echocardiograms
- Compensation and pension examinations in cooperation with the Veterans Benefits Administration
- Coumadin clinic
- Dental

- Dermatology
- Eye care
  - Blind Rehabilitation Outpatient Services (BROS) for the visually impaired
  - Low vision clinic compensation
  - Optometry
  - Surgery including laser eye surgery
- Gastroenterology
- Home and community care (clinic-based home care, community homeless veteran services and outreach, nursing home, community hospice)
- Imaging
  - X-ray
  - Ultrasound
  - MRI
  - CT
  - Mammography
- Neurology/EEGs
- Nuclear imaging (standard and cardiovascular diagnostics)
- Nutrition counseling / weight management
- Orthopedics
- Pharmacist consultation and medication pick-up
- Phlebotomy (blood draws and specimen collection)
- Physical and occupational therapy
- Podiatry
- Prosthetics
- Tobacco cessation program
- Social work
- Spinal cord injury
- Urology
- Referrals to specialty care at the C.W. Bill Young VA Medical Center

Vet Centers. These centers offer community-based counseling for a range of social and psychological services, including professional readjustment counseling to veterans and families, military sexual trauma counseling and bereavement counseling for families that experience an active-duty death.

In addition, there are various volunteer and nonprofit organizations such as Hearts and Homes for Veterans. Finally, there is the local human services network that serves veterans.

Gaps

Nationally, gaps have been identified and efforts developed to ameliorate the gaps.

Among these are:

Transition from Active Service to Civilian Life. For those veterans needing services from the VA (such as traumatic brain injury, post-traumatic stress disorder – PTSD, substance abuse, mental health, etc.), there have been gaps in the transition.

Homelessness. In the 2000 to 2019 timeframe, homelessness among veterans was identified as a serious gap. 45% of homeless veterans were found to suffer from mental illness.[642]

Since that time, a variety of efforts have been enacted. Homelessness among veterans in Florida has been effectively cut in half since 2011. Significant reasons for Florida's substantial decrease in the rate of homelessness among veterans are the national initiatives implemented to end veteran homelessness. In Florida, millions of dollars have been invested through VA Supportive Services for Veteran Families grants, as well as HUD VA Supportive Housing (VASH) vouchers that provide long-term rental assistance to help homeless veterans with high needs obtain and sustain permanent housing. Florida's Point in Time (PIT) 2011 count reported 5,644 homeless veterans. The 2017 count reported 2,789 homeless veterans. (2017 Florida Council on Homelessness Annual Report.)[643]

Lee County has an active program to reduce veteran homelessness.

[642] www.apa.org/advocacy/military-veterans/mentalhealthneeds.
[643] ibid.

Scheduling and Capacity for VA Services. Delays in scheduling services for veterans became a topic of considerable concern.[644] The RAND Corporation conducted an independent assessment of veterans health care. They concluded that more resources and capabilities will be needed to meet the growing demands.[645]

Mental Health and Substance Abuse Services. 20% to 30% of veterans who served in Iraq or Afghanistan suffer from major depression or post-traumatic stress disorder.[646] [647] 25% of these veterans showed signs of a substance abuse disorder.[648] However, only 50% of veterans who need this service will receive it.[649] This topic was a concern in 2011,[650] and there has been improvement.[651] However, demand still exceeds capacity.

Suicide. There are high suicide rates among veterans. The rate of suicide among female veterans is 35 per 100,000, a rate much higher than among female civilians.[652] In 2014, among male veterans, it was 41.6 per 100,000. Professionals in the field attribute this to uneven access to appropriate mental health services provided by the VA or local mental health providers.[653]

[644] Butler, M. 2014. VA scheduling scandal. www.journal.ahima.org
[645] Hussey, P. et.al. 2015. Resources and capabilities of the Department of Veterans Affairs to provide timely and accessible care to veterans. Rand Corporation.
[646] ibid
[647] www.thenationalcouncil.org/topics/veterans
[648] National Institute of Drug Abuse
[649] SMVR TA centers. www.samsha.gov
[650] Senate Hearing 112-212. 2011. U.S. Government Publishing Office.
[651] DAV report. https://www.dav.org/wp-content/uploads/2018 Women-Veterans Report Sequel.pdf
[652] Ramchand, R. 2017. Congressional testimony before the Senate appropriations committee preventing veteran's suicides. April 27.
[653] Hester, R. 2017. Lack of access to mental health services contributing to the high suicide rates among veterans. Int. J. Ment Health Syst. 11:47 doi: 10.1186/s13033-017-0154-2

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Section Six: Geography

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CHAPTER 29
Spatial Match Analysis

Introduction

The purpose of this gap analysis is to determine the degree to which service providers are located with respect to where their clients reside. One of the major gaps that has been identified in Lee County is public transportation in that it is not easy for many to access service locations. The desired goal would be that services are provided close enough to residences that transportation is not a barrier. The purpose of a special match analysis is to determine the degree to which that goal is realized.

Figure 35 is a map showing the service locations of human service providing agencies in Lee County. An agency may have more than one location so the map does not equate to the number of service providers. As the map indicates, most service providers are clustered in the older areas of Fort Myers and along U.S. 41. Other service providers are scattered across the County.

Figure 35. Map United Way 211 Providers

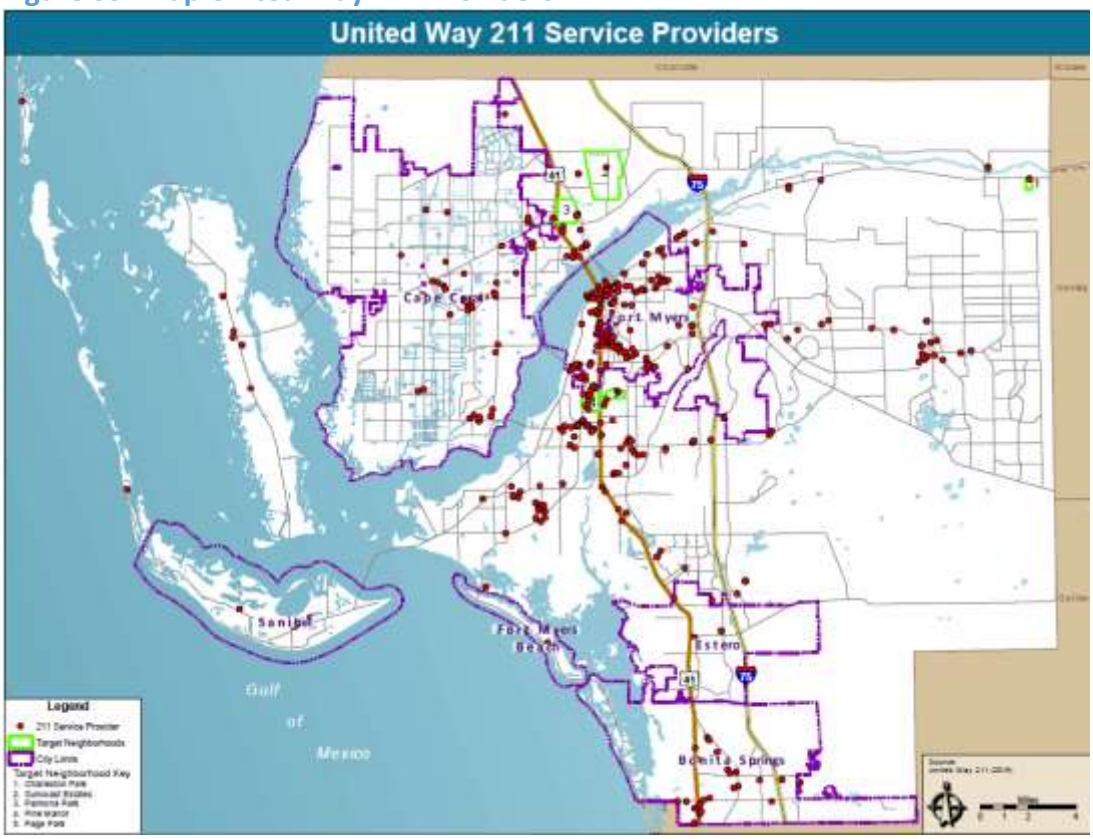


Figure 36. Overlays the service providers onto a map of low-to-moderate income areas. These areas vary in terms of population density. As the map indicates, the Lehigh Acres area is sparsely served.

Figure 36. Map HUD Low/Mod Income Areas with 211 Service Providers

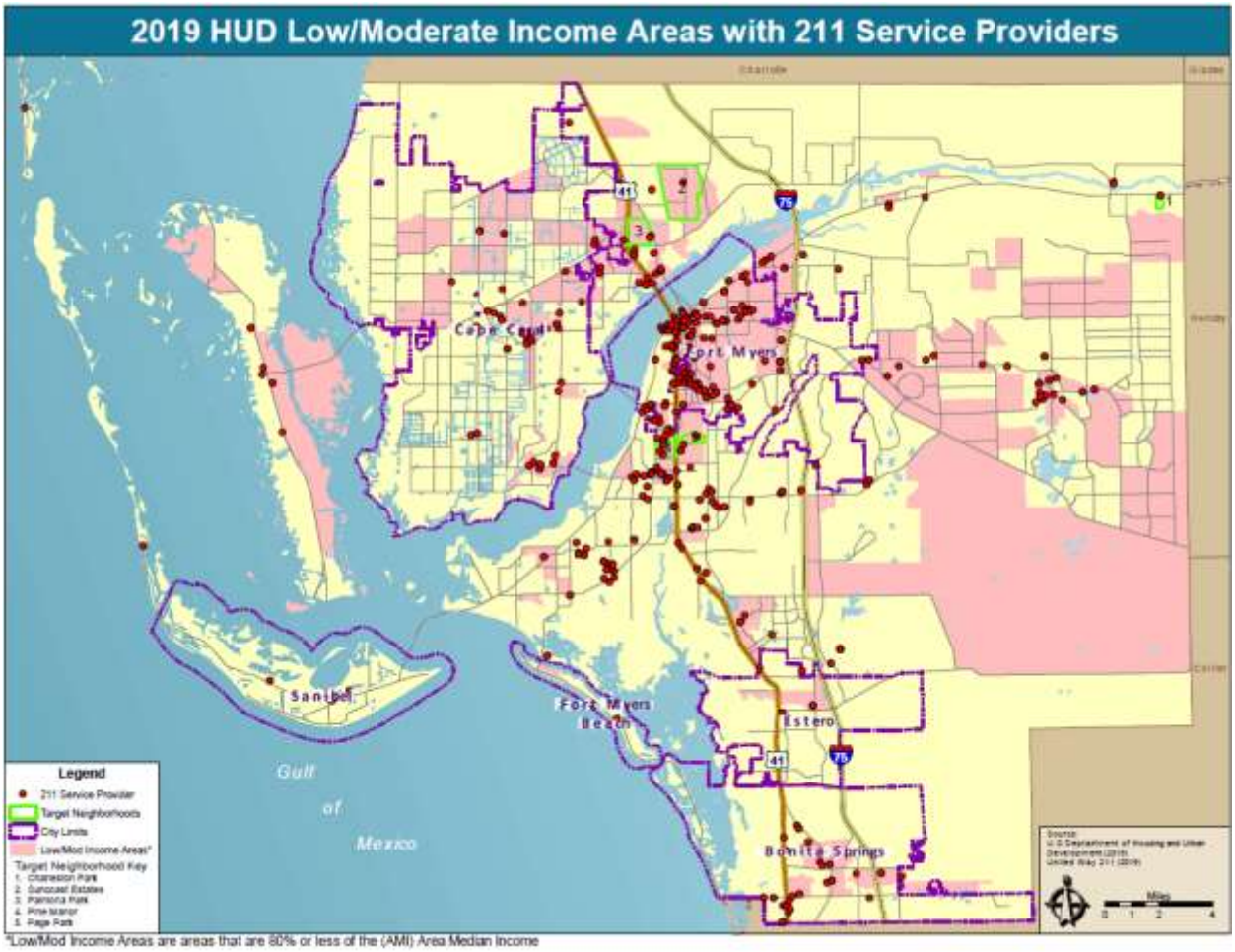


Figure 37. Distribution of parks, recreational facilities and libraries

As the figure indicates, these facilities are distributed across the county.

Figure 37. Map Parks, Preserves, Conservation Land and Public Libraries

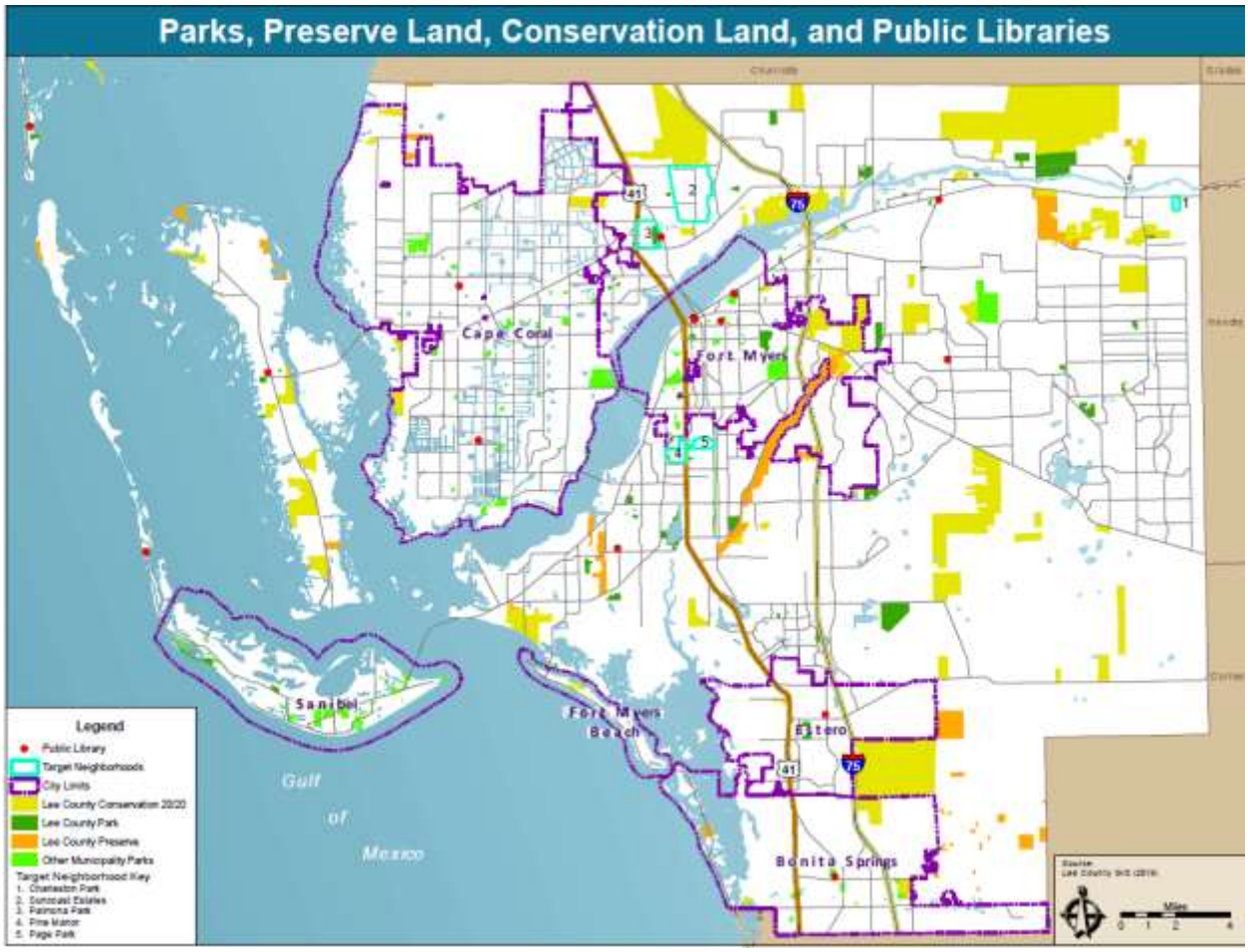
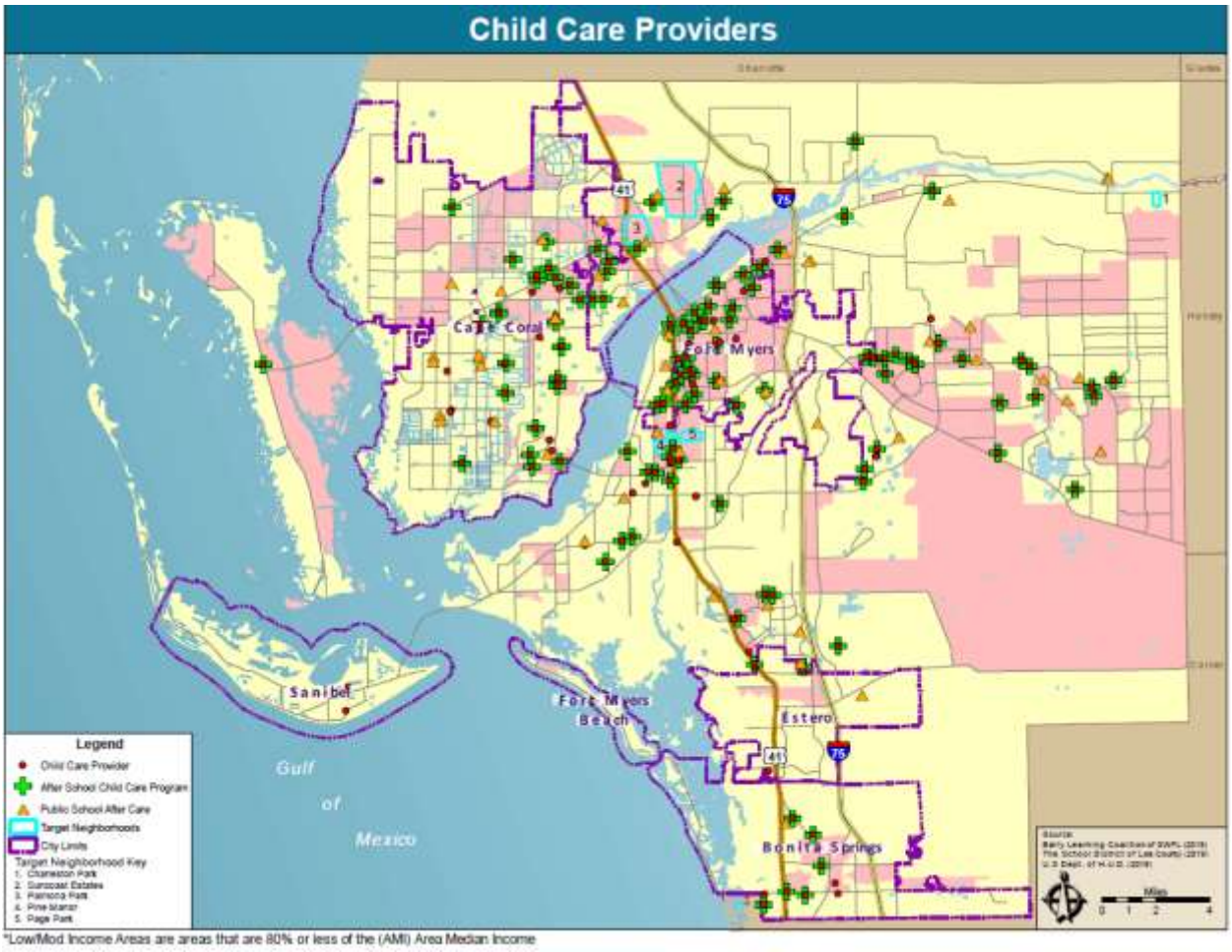


Figure 38. Distribution of childcare centers and after-school programs

As the figure indicates, there is a fair dispersal of providers, with Lehigh Acres again being less densely served.

Figure 38. Map Childcare Providers



GAPS

From a spatial perspective, most services providers are located in greater downtown Fort Myers. As the population of the county has grown and geographically dispersed, service locations have not matched that growth pattern. This concentration leads to transportation challenges.

Section Seven: Funding

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CHAPTER 30
Funding Responsibility and Other Roles

Introduction

This study has identified a variety of gaps in the broader human service delivery system. As the chapters have noted, this is a highly complex set of systems. The funding is equally complex with a variety of funding streams, formulas and requirements.

Findings

Table 110 does not attempt to summarize this complexity. Rather it seeks to categorize certain high-level information as described in the following paragraph.

The table has four categories. One category is a Federal/State funding source that can mean either direct federal funding, federal funding that is administered through the State, a federal-state partnership or State generated funds. A second category is required County funding, which can mean a required match of the County or a General Fund appropriation as a part of a County function. A third category is non-required County funding, which is a policy choice and or a description of the County's role. A fourth category is "other," which addresses other agencies that have a funding responsibility.

"X"s are placed in the boxes in the table to indicate the entities having some funding responsibility. "N/A" refers to non-applicable.

Table 110. Fiduciary Responsibilities and Other Roles

Topic	FED/ State	County - Required	County – Policy Choice	Other
Infrastructure Funding				
Supportive Housing	X		Policy Choice; Administration of Federal/State Funds	
Affordable Housing	X		Policy Choice; Administration of Federal/State Funds	
Transit	X		Policy Choice	
Food Security & Nutrition	X		IFAS Nutrition Education	
Facilities	X		Policy Choice: Comprehensive Plan	Municipalities
Employment	X		Policy Choice: Economic Development	School District, Workforce Dev.
Child & Youth Development Funding				
Child and Youth Development	X		Policy Choice: Recreation; after school. PFR $	
Systems of Care Funding				
Behavioral Health	X	Mental Health Match	OVERMATCH	
Behavioral Health and Criminal Justice	X	Mental Health Match, Jail	OVERMATCH: Specialty Courts, Diversion	
Child Abuse and Neglect; Foster Care	X		Policy Choice	SHERIFF – County General Fund
Domestic Violence	X		Policy Choice	SHERIFF – County General Fund
Elder Abuse, Neglect & Exploitation	X		Policy Choice	SHERIFF – County General Fund
Sexual violence and stalking				SHERIFF – County General Fund
Exposure to violence				
Suicide and self-harm				

Topic	FED/ State	County - Required	County – Policy Choice	Other
Juvenile delinquency	X	Detention portion		SHERIFF – County General Fund
Homelessness	X		Policy Choice	
Public Health Dept	X	X		
Special Populations Funding				
Intellectual and Developmental Disabilities	X	MEDICAID		
Hearing and Visual Disabilities - Children	X	MEDICAID		
Persons with other physical disabilities	X	MEDICAID		
Seniors	X		Policy Choice – Recreational facilities per Comp Plan	
Veterans	X		Policy Choice: Veterans Office	

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CHAPTER 31
Equity Funding

This chapter seeks to address the question of whether Lee County receives an equitable share of State or federal funding to address the needs of its residents. There is no such thing as perfect equity due to funding cycles, special projects, cost of living variations, accuracy of census counts or other factors that create variability.

The focus of this chapter is whether there is a significant variation in funding provided to Lee County. There appears to be only one, which is in mental health per-capita funding. Table 111 presents the data.

Table 111. Non-Acute Funding for Mental Health Services, Central Florida Behavioral Network [654]

Non-Acute Funding	Funding Per Person
Circuit 6 (Pasco)	$87.45
Circuit 6 (Pinellas)	$93.59
Circuit 10 (Hardee, Highlands and Polk)	$95.36
Circuit 12 (DeSoto, Manatee and Sarasota)	$80.50
Circuit 13 (Hillsborough)	$93.70
Circuit 20 (Charlotte, Collier, Glades, Hendry and Lee)	$65.11

Clearly, Circuit 20 is substantially underfunded on a per-person basis. The State of Florida is ranked between 48 and 50 as to the level of State funding for mental health services as discussed in the behavioral health chapter. There are significant gaps in mental health services in the State as a result. This makes the funding level for Lee County even more insufficient and is a major factor in why mental health services are considered a severe gap by community professionals.

[654] Central Florida Behavioral Health Network

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CHAPTER 32
County Funding

Introduction

Prior chapters have identified which entities are responsible for funding the various human services being provided in the county. "Human services" is defined broadly as those services that promote the physical and psychological wellbeing of Lee County residents. It encompasses the basic human needs for food, shelter, employment, transportation and recreation. It also includes those services most commonly thought of as human services that address the needs of people in deep poverty or those with various disabilities. It does not include public safety needs addressed by law enforcement, fire protection and emergency medical services nor does it include physical health services.

This chapter reports on the FY 18/19 funding that was provided by the Lee Board of County Commissioners (BoCC). Count-provided funding was of three types:

Mandated. This is County funding for human services that is required by law and regulation. In some cases, the specific amount of the funding is stated. In other cases, the requirement is that the County fund the program or service, but the specific funding level is not stated.

Policy Choice. These are programs or services that the BoCC chooses to fund or not. There is no requirement that these programs or services be funded. Rather it is a policy decision on the part of the Board, which means it can be modified at the direction of the Board.

Grants and Donations. These are funds the County secures for use in Lee County via submittal of proposals or some other mechanism. These are outside-the-County resources that are obtained for the benefits of Lee County residents.

The Definition of Human Services

The internal structure of county governments varies by a mix of policy direction and managerial choice. One county may group a range of services into one department and label that department human services. Another may choose to distribute that same group of services across several departments. Using those department budgets as an indicator of commitment to human services is erroneous.

Therefore, a review of department funding to determine a county's commitment to human services is likely to be misleading. The more accurate approach is to incorporate all programs and services that promote human health and wellbeing. Some of these services are focused on individuals with disabilities or "problems" or in deep poverty. Others are for the welfare of all residents whose wellbeing is supported or enhanced by the program.

The criteria for this analysis is general wellbeing. From that perspective recreation programs, library services or transit are equally a human service as is a program focused solely on serving a homeless person.

Mandated Funding

Table 112 presents the programs and services which County government is mandated to provide. As the table shows, the County commits slightly more than $29 million to various services.

Table 112. Mandated Services

Medicaid [1]	$8,965,047
State Mandated [3]	
Child Protective Team Exams	$245,700
Indigent Cremation	$57,241
Mental Health	$4,425,451
State Health (incl. operating expense) [3]	$2,285,329
Juvenile Justice Cost Share [1]	$1,915,460
Inmate Medical Expense [2]	$11,297,090
TOTAL	**$29,191,318**

1 Lee County BOCC Non-Departmental General Fund
2 Lee County Sheriff's Office General Fund
3 Lee County BOCC Human Services General Fund

Policy Choice Funding

This is funding that is at the discretion of the Board of County Commissioners. As the table shows, the County spends roughly $80 million by choice on the wellbeing of its residents.

Table 113. Policy Choice funding FY 18-19 Actuals

Partnering for Results Program [3]:			
Youth Services		$2,869,804	
Disabled		$821,463	
Seniors		$399,927	
Domestic Violence		$327,519	
HIV/AIDS		$121,720	
Behavioral Health		$85,155	
Homeless		$78,000	
United Way 211		$45,000	
Affordable Housing		$35,786	
Veterans		$25,000	
Sub-total		$4,809,374	$4,809,374
Human Service Dept. Operating [3]		$4,029,065	
Sub-total			$4,029,065
Comprehensive Human Services			
Transit [5]		$16,730,848	
Partnering for Transportation Results [6]		$444,254	
Lee County Parks and Recreation [7]		$22,220,215	
Lee County Library Services [8]		$32,035,769	
Sub-total			$71,431,086
TOTAL			**$80,269,525**

3 Lee County BOCC Human Services General Fund
5 Lee County BOCC Transit (Lee Tran) General Fund, Fares, Ads (excludes Beach Trolley)
6 Lee County BOCC Transit Grants (Non-Departmental)
7 Lee County BOCC Parks MSTU and General Fund (excludes: Professional and Amateur Sports: $7.4 million and Conservation 2020: $5.4 million)
8 Lee County BOCC Library Mileage

Table 114 shows where the Lee BoCC provides discretionary funding annually to the court system of $7.7 million for additional positions in the following areas: Pretrial Services, Drug Court, Veterans Court, Domestic Violence, Teen Court, Juvenile Arbitration, Mediation, Family Court, Public Guardians, Jail Reduction, Early Resolution Cases, Mental Health Court, Initial Defense Unit, Rapid Response Unit, Guardian Ad Litem and Legal Aid.

Table 114. Court System FY 18-19 Actuals

Entity	Additional Discretionary Funding for Positions
Court Administration	$5,523,938
State Attorney	$649,300
Public Defender	$771,265
Guardian Ad Litem	$80,160
Legal Aid(s)	$719,366
TOTAL	**$7,744,029**

Grants and Donations

Table 115 shows the amount of grants and donations that were obtained by the County for the benefits of residents. More than $15 million was secured for these purposes.

Table 115. Discretionary Grants/Donations

Community Development Block Grant [4]	$2,184,886
Criminal Justice, Mental Health, Substance Abuse [4]	$226,319
Community Service Block Grant [4]	$95,748
HOME Investment Partnerships Program [4]	$1,145,132
Emergency Grant Solutions [4]	$463,918
Low Income Home Energy Assistance Program [4]	$1,158,870
Neighborhood Stabilization Program (1&3) [4]	$494,227
Human Services Other [4]	$338,174
Homeless Coalition Staffing [4]	$26,786
Florida Challenge Grant [4]	$80,113
Unified Staffing Grant [4]	$80,357
HOPWA [4]	$94,169
TANF Homeless Prevention [4]	$36,774
FEMA Disaster Case Management [4]	$515,392
Supportive Housing Program (Human Services) [4]	$1,474,389
Transit Federal and State Funding [9]	$6,913,693
TOTAL	**$15,328,947**

4 Lee County BOCC Human Services Grants and Donations
9 Lee Tran Fed and State Funding

Total

As Table 116 shows, the total expenditure of funds for the wellbeing of County residents was more than $132 million.

Table 116. Total Human Services Expenditure

Mandated	$29,191,318
Policy Choice	$88,013,554
Grants	$15,328,947
GRANT TOTAL	**$132,533,819**

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Section Eight: Conclusions

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CHAPTER 33
Core Drivers

Introduction

This study has identified numerous gaps with varying degrees of impact and significance. The question this chapter seeks to answer is whether there is a set of underlying factors that contribute to many of these gaps in part if not in whole. The chapter will present the argument that there are four factors that are found in most gaps. This is not to imply that these are the only four factors or that other factors are not at work; nor is it to imply that for any specific individual that these four factors are always present singularly or in some combination. They are not, and there are certainly other factors to consider, some of which are specific to the topic under examination.

These four factors are termed the "core drivers" in that (1) they are common to many service needs and (2) they drive much of the activity needed to address the needs in a comprehensive way. What are these four factors or drivers?

The core argument of this chapter is presented in Section One: Core Drivers. Section Two presents an illustrative case study of how these core drivers relate to a selected human service problem, domestic violence. Section Three discusses why these core drivers are significant. Section Four contains five attachments, four of which provide more in-depth discussion of the core drivers. A fifth attachment relates to the case study.

Section One: The Core Drivers

The four core drivers are cost-burden & poverty, serious mental illness, substance abuse and trauma. Each is discussed below with its rationale for being considered a core driver.

Cost burden & poverty. The term cost-burden is used here with the term poverty because there are critiques of Federal Poverty Levels as being unrealistic as to actual cost of living.[655] The concept of cost-burden will be used to help address this criticism. Poverty is used in two senses: Its standard financial use and as the poverty of experience. This is a broader concept of poverty that encompasses the point that impoverished individuals or families, particularly children, do not have a variety of important developmental experiences. It should be noted that there are multiple critiques of both how household income is calculated as well as the federal poverty level. These are discussed in Appendix J. However, because proposed alternatives are not yet broadly used or available, the existing data will be used.

It is evident from the design of many human services that cost-burden is a factor. For some services, poverty level determines eligibility. For others, the only reason they are needed, such as food banks, it that the person or household is cost-burdened.

In addition, human services are public services in the sense they are designed to be provided to the public regardless of their economic resources. Individuals with a mental illness for example, may be able to pay for private mental health care through personal wealth or insurance. For those without such financial options, public mental health services are provided. By this very fact, cost-burden and poverty is a frequently found factor in many human services.

Serious mental illness. The term Serious Mental Illness (SMI) describes a mental, behavioral or emotional disorder that results in serious functional impairment and substantially interferes with or limits one or more major life activities. These include schizophrenia, severe bipolar illness and severe major depression. The

[655] www.nccp.org/topics/measuringpoverty.

term Any Mental Illness (AMI) covers all recognized mental illnesses, of which there are more than 300 diagnostic categories.[656]

Unless one has independent financial resources, there is a logical link between serious mental illness and cost-burden. Individuals with serious mental illness are frequently unable to secure employment or maintain employment stability, and as a result they are financially challenged.

Serious mental illness has been linked at times to issues involving other systems of care including.[657]

- Legal
- Homelessness
- Self-harm
- Domestic violence
- Various medical conditions
- Substance abuse
- Dropping out of school
- Unemployment

Substance abuse. Substance abuse can be considered a sub-category of mental health in that addictive disorders are classified as a mental illness. As noted just above, 19% of adults with mental illness also experienced a substance abuse disorder. These are called co-occurring disorders. Studies link depression, anxiety and substance abuse and find that alcohol and drugs are often used to self-medicate the symptoms of mental health problems.[658]

There are significant costs incurred by communities in terms of criminal justice costs, loss of local economic productivity and loss of community safety. Other social problems associated with substance abuse include:[659]

- Domestic violence
- Child abuse

[656] National Institute of Mental Health/home/mentalhealthinformation/statistics
[657] Mayo, ibid.
[658] https://www.helpguide.org/articles/addictions
[659] www.healthypeople.gov/2020topicsandobjectives/substanceabuse

- Crime
- Suicide
- Homicide
- Teenage pregnancy
- HIV/AIDS and sexually transmitted diseases
- Financial exploitation of family members or vulnerable persons
- Physical fights

Trauma. While trauma can be linked to mental health or illness or substance abuse from both causal and consequential perspectives, it is significant enough to be considered as a separate driver. Those who are mentally healthy and have no history of substance abuse can experience trauma that results in some level of maladaptive behavior or internal distress.

SAMHSA[660] defines trauma as:[661] "Individual trauma results from an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life-threatening with lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual wellbeing."

First, trauma impacts everyone differently. Many people exhibit resilient behaviors or brief symptoms. Short-term reactions are normal. Others have more destructive reactions, including:[662]

- Mental illness
- Anxieties
- Depression
- Avoidance
- Difficulty regulating anger, shame, sadness
- Addiction: self-medication to control emotions
- Compulsive behaviors such as gambling
- Poor physical health outcomes, including long-term fatigue, sleep disorders
- High-risk behaviors, such as eating disorders

[660] Substance Abuse and Mental Health Services Administration
[661] www.integration.samsha.gov/clinical practice/trauma
[662] ibid.

Section Two: How these core drivers underlie various human service issues: A case study of domestic violence

The Thesis

These thesis of this case study is simple. It is that if one examines cases of domestic violence in-depth, there is a reasonable probability that one or more of the core drivers will be present. This is not true in every case, as there are abusers who are not seriously mentally ill, do not abuse substances, who were not exposed to trauma and are affluent. But the probability is that in a good percentage there will be at least one core driver present.

A case study

To examine how these four drivers relate to the other human services issues, an in-depth analysis of one issue will be conducted. The issue of domestic violence will be used.

In domestic violence, one spouse or partner – this example uses the male in a heterosexual relationship – abuses the other physically, psychologically or emotionally. This abuse may occur without any evidence of mental illness, substance abuse, prior abuser, trauma or poverty. There have been a variety of explanations offered to understand the causes of domestic violence. These are provided in Attachment E.[663]

Explaining causality is not what this section is attempting to do. Instead, this is an attempt to determine correlation and/or association. Correlation is not causality. Furthermore, each of the causal models discussed in Attachment E attempted to be all-encompassing. No such argument is made here. Instead, this is an attempt to determine probabilities.

These four core drivers cannot explain all problematic behavior, however, they do indicate probability. If the household is under a cost-burden, and if a male (to use a common experience) is engaged in substance abuse, there is a higher probability that domestic violence may occur. Or if the male (again to draw on

[663] theories of violence. www.hdrlibrary.umn.edu

likelihood) was abused in some form as a child and carries that trauma, then the likelihood of domestic violence increases. The same goes for mental illness. When more of the four core drivers are present, the likelihood is greater. The hypothesis of this analysis is that the presence of one or more of these four drivers increases the likelihood of problematic behaviors or situations. It should be noted that there is no personality type associated with being a batterer.[664]

If this hypothesis has validity, it means that interventions in any of the four core drivers would affect a variety of human service issues. It should be noted that there is a concern in the domestic violence field that mental illness, alcoholism, childhood trauma or poverty can be used as excuses to justify or explain an act of domestic violence. These acts are inexcusable and are no reason for anyone – the person being abused, law enforcement or treatment professional – to ignore or minimize such acts. However, it is an empirical question as to whether abusers have higher rates of these factors than non-abusers. To test the hypotheses, the following statistics are examined:

Studies of men arrested for domestic violence have found:

- The prevalence of depression, aggression and mood disorder:
  - There are high rates of PTSD;[665]
  - There are high rates of depression;[666]
  - Men who are abusers report higher rates of anxiety than non-abusers;[667]
  - Rates of aggression were higher than with males not having a mental health issue.[668]
- Rates of alcohol and drug disorders are very high:[669]
  - There is a high correlation between alcohol and substance abuse and intimate partner violence. Incident studies have found that up to 92% of intimate partner violence (IPV) assailants used drugs

[664] ibid
[665] Shorey, R. et.al. 2012. The prevalence of mental health problems in men arrested for domestic violence. J. Fam Violence. 27(8): 741-748.
[666] Ibid.
[667] Hester, M. 2015. "Occurrence and impact of negative behavior, including domestic violence and abuse, in men attending UK primary care health clinics: a cross-sectional survey." BMJ Open 2015;5: e007141 DOI: 10.1136/bmjopen-2014-007141
[668] ibid
[669] ibid.

or alcohol on the day of the assault, and nearly half were described by families as daily substance abusers for the prior month;[670]

- Between 24% and 45% of domestic violence incidents involved alcohol/drug use;[671]
- The most consistent predictor of a call to police for a domestic assault was drunkenness.[672]

- There is a high prevalence of prior criminal records:
  - A study in Massachusetts found that 84.4% of men arrested for domestic violence has prior criminal records averaging 13 charges including alcohol/drug and offenses against persons;[673]
  - A similar study in Cook County, IL, found that 57% of men charged with domestic violence has prior records for drug offenses and other crimes. On the average, they had 13 arrests.[674]
- Childhood trauma may be present:
  - Boys who witness abuse in the home are seven times more likely to batter;[675]
  - Childhood trauma has been found to be related to violence against women as adults;[676]
  - Parental mental illness, addiction and domestic violence are strongly associated with childhood physical abuse.[677]
- Poverty is present:
  - Families who experience domestic violence are often impoverished. For example, 63% of welfare recipients in Michigan had experienced several physical abuses. Half of homeless women and children report being victims of domestic violence;[678]

[670] ibid.
[671] ibid
[672] ibid
[673] Klein A. 2015. Practical implications of current domestic violence research for probation officers and administrators. www.bwjp.org/assets/documents/pdfs
[674] ibid.
[675] Theories of violence. www.hrlibrary.umn.edu
[676] Fulu, E. et.al. 2017. Pathways between childhood trauma, intimate partner violence and harsh parenting. The Lancet. 5 (5) 512-522.
[677] Fuller-Thompson E., et.al. 2019. Parental mental illness, addiction, domestic violence tied to childhood abuse. J. Interpers Violence. Doi:10.1177/0886260519853407
[678] Satyanathan, D. et. Al. Domestic violence and poverty. Michigan Family Impact Seminars. www.purdue.edu

- Poor and minority women are disproportionally affect by domestic violence;[679]
- It is estimated that roughly 80% of homeless mothers with children have previously experienced domestic violence.[680]

Another set of data indicate that the individuals being abused, primarily women, themselves suffer from some forms of mental illness either prior to the abuse or because of abuse[681], [682]:

- 54% to 84% of battered women suffer from PTSD;
- 63% to 77% of battered women experience depression, and
- 38% to 75% percent experience anxiety;
- Abuse rates are higher among homeless women with serious mental illnesses. A study with 99 episodically homeless women with serious mental illness, found that significant numbers had been physically (70%) or sexually (30.4%) abused by a partner. Rates of physical or sexual abuse in adulthood by any perpetrator were 87% and 76%, respectively;
- Women who have experienced domestic abuse are three times the risk of developing a mental illness, including severe conditions such as schizophrenia and bipolar disorder, as those who have not;[683]
- Women who are abused as children are at increased risk of being victimized in adulthood.[684]

This data indicates that the core drivers of mental illness, substance abuse, trauma and poverty are correlated with domestic violence. The act of domestic violence itself is traumatic and children who observe it are experiencing trauma. Again, this is not an argument for causation that these core drivers cause domestic violence. Nor do they fully explain or account for domestic violence.

[679] Aizer, A. 2011. Poverty, violence and health. J. Hum Resour. 46(3): 518-538.
[680] The intimate relationship between domestic violence and homelessness. Institute for Children, Poverty and Homelessness. www.icphusa.org
[681] Briere, J. & Jordan, C. 2004. Violence against women: Outcome complexity and implications for assessment and treatment. J Interpers Violence, 19: 1252
[682] Trauma, mental health and domestic violence. www.fcadv.org
[683] Mahase, E. 2019. Women who experience domestic abuse are three times as likely to develop mental illness. BMJ 2019:365:14126
[684] Cold, J. et.al. 2001. Relation between childhood sexual and physical abuse and risk of victimization in women. The Lancet 358: 450-454

What they do offer, however, is practical guidance for interventions. In a limited-resource world, choices must be made as to which interventions to support. Clearly, interventions that seek to address mental health, substance abuse, trauma or poverty are likely to have positive impacts on the rates of domestic violence. Will they fully end it? No. Can there be an impact? Yes.

Domestic violence was examined as a case study. It is beyond the scope of this paper to examine other social issues such as stranger violence, child abuse and neglect, elder abuse and neglect, etc. to determine if these core drivers are factors in those situations. It is likely they are for the following reasons:

- The experience of being abused or victimized has some shared core components, which generate some similar psychological or emotional effects.
- There are documented impacts across various categories of human service needs. For example, the high percentage of homeless women and children who have experienced domestic violence.
- These problematic situations involve some level of trauma for someone.

Conclusion

The thesis that mental illness, substance abuse, trauma or poverty could be related to domestic violence is accepted.

Section Three: Why are these core drivers significant?

Three reasons:

1. Cost-burden, mental illness and substance abuse underlie the three major gaps of the human services system in Lee County. As reported elsewhere in this assessment, housing, transportation and mental health are consistently reported in various data collection methods as the three most significant needs. Cost-burden underlies the housing and transportation barriers. The lack of services to address serious mental illness and substance abuse speak for themselves.

2. As reported in the funding section, substantive funds are expended by federal, State and local government on various human service issues. The effectiveness of many of the Systems-of-Care, and the funds dedicated to them, is limited by the resources and tools available to address cost-burden, mental illness, substance abuse or trauma. The case study on domestic violence presented below will illustrate how these four factors impact other human service issues.

3. Stand-alone interventions, which address only a single issue while ignoring the other factors in a person's life, are minimally effective at best. This is the concept behind System-of-Care thinking, which emphasizes addressing the whole person. If an intervention does not address these four core drivers in addition to the specific presenting issue, it is of minimal value in most cases.

Section Four: Attachments

Four attachments are provided after this chapter that provide a more in-depth discussion of each of these four drivers. A fifth attachment is related to the case study. These attachments are:

Attachment A: Cost-burden and poverty. The housing chapter provides data on housing cost-burden in the county and other chapters, such as food and nutrition, provide data. This attachment however combines all that information so that the reader can gain an understanding of the scope of cost-burden and poverty in Lee County.

Attachment B: Serious Mental Illness. This attachment provides an overview of the topic. The behavioral health and behavioral health and criminal justice chapters provide in-depth perspectives. This attachment focuses on behaviors associated with mental illness.

Attachment C: Substance Abuse. As with Attachment B, this attachment provides an overview. The same two chapters listed above provide the in-depth. This attachment focuses on behaviors associated with substance abuse.

Attachment D. Trauma. This attachment provides an overview. The chapters on domestic violence, child abuse, elder abuse, sexual violence and exposure to violence all address specific settings in which trauma may occur. This attachment focuses on behaviors associated with trauma.

Attachment E: Explanations for domestic violence. This attachment provides supplementary information relevant to the case study presented below.

Attachment A: Cost-Burden and Poverty

Cost-burden and Poverty

The term cost-burden is used here with the term poverty because there are critiques of Federal Poverty Levels as being unrealistic as to actual cost of living.[685]The concept of cost-burden will be used to help address this criticism. Poverty will be used in two senses: Its standard financial use and as the poverty of experience. This is a broader concept of poverty that encompasses the point that impoverished individuals or families, particularly children, do not have a variety of important developmental experiences. This concept will be further discussed later in this chapter.

Cost-burden makes empirical assumptions about what proportion basic cost-of-living categories (food, housing, transportation and utilities) should comprise a household's budget. Household size shifts these proportions, but the concept applies across household sizes.

The following are some standard definitions:

- HUD defines cost-burdened families as those who pay more than 30% of their income for housing and may have difficulties paying for other necessities;[686]

- Severe cost-burden is defined as paying more than 50% of one's income for rent.[687]

However, there are several problems with this definition. Household size can significantly affect this percentage. Cost-of-living differences can also make it problematic. None of this is to deny that households can find it difficult to afford housing once other living costs are included.

HUD has established that low-income households (those earning less than 50% of the area median income and who pay more than half their income in rent) live in

[685] www.nccp.org/topics/measuringpoverty.
[686] www.huduser/gov/portal/pdredge/pdr_edge_fead_article_092214
[687] ibid

substandard housing conditions.[688] While there are legitimate differences on how to measure cost-burden, its reality is acknowledged.

Florida is among the highest cost-burdened states for rental housing at 56.4%.[689] However, among the major Florida counties and the counties on the west coast, in 2017 (as shown in Table 117), Lee County had the lowest cost-burden percentage. In 2018, it did not.

Table 117. Cost-burdened Data[690]

County	Percentage of Cost-burdened Renters 2017	Percentage of Cost-burdened Renters 2018[691]
Broward	61.4%	61.3%
Charlotte	51.7%	63.5%
Collier	56.9%	58.5%
Hillsborough	53.4%	53.0%
Lee	48.7%	55.4%
Manatee	57.3%	49.0%
Miami-Dade	64.8%	64.3%
Orange	56.0%	55.3%
Palm Beach	59.3%	60.7%
Pinellas	55.4%	53.6%
Sarasota	55.4%	52.3%

A variety of websites designed to assist with budgeting have the following recommended budget percentages for non-housing expenses. These include:

- 15% to 20% for transportation;
- 15% for food and household supplies;
- 5% to 10% for utilities; and
- 10% to 20% for healthcare and insurance.

These sites recommend that housing, food and transportation should not exceed 65% of household income.

[688] 2013. Worst case housing needs 2011: Report to Congress. HUD.
[689] Salviati, C. 2018. 2018 Cost Burden Report. www.apartmentlist.com
[690] op.cit.
[691] https://www.apartmentlist.com/rentonomics/cost-burden-2019/

To examine actual spending practices, the Bureau of Labor Statistics produces an annual report on consumer expenditures. These numbers show what various households spend. As Table 118 shows, the average household spends slightly more than 30% to 32% on housing including utilities. The next highest percentage is transportation in the 15% to 17% range and food in the 12% to 13% range. If the mid-point of these ranges is taken, then 59% to 60% of household income is spent on these three basics.

Using this data, a moderate cost-burdened household may be defined as those spending substantially more than 60% of their income on a combination of housing, transportation and food. Severe cost-burden is defined primarily in terms of housing costs with households spending 50% or more of their income on housing (rent, mortgage and utilities) considered as severely burdened. A severe cost-burdened household would spend 75% to 80% of its income on housing, transportation and food.

Table 118. Shares of average expenditures on selected major components by composition of consumer unit, 2018[692]

Item	All Consumer Units	Married Couple Only	Married Couple with Children
Housing	32.8%	30.2%	31.3%
Transportation	15.9%	15.6%	17.1%
Food	12.9%	12.4%	13.2%
Personal insurance and pensions	11.9%	11.7%	14.0%
Healthcare	8.1%	10.2%	7.0%
Apparel and services	3.0%	2.7%	3.2%

Transportation is the second largest housing expenditure category after housing.[693]

Cost-burden in Lee County

Having derived the above definitions of moderate and severe cost-burdened, is there an issue of cost-burden in Lee County? As the tables below will demonstrate, more than 20,000 households in Lee County live on a month-to-month existence in which any unusual expense may not be manageable.

[692] Consumer expenditures, 2018. Bureau of Labor Statistics. Economic News Release, September 10, 2018
[693] TET 2018 – Household spending on transportation. U.S. Bureau of Transportation Statistics. www.bts.gov

Table 119 presents more detailed rental housing cost-burden data for Lee County.

Table 119. Moderate and Severe Housing Cost-Burden[694]

Category 2018 Data	Data
Total Number of Rental households	71,442
Overall percentage that are cost-burdened	55.4%
Percentage moderately cost-burdened	27.0%
Percentage severely cost-burdened	28.4%
Total Number of Cost burdened	39,614
Total Number of moderately cost-burdened households	19,325
Total number of severely cost-burdened households	20,289

As the table indicates, more than 20,000 households in Lee County are severely cost-burdened with respect to spending 50% or more on housing. If average transportation and food costs are added in, the total cost-burden of these households for the three basics is 75% to 80%. As stated earlier, these households are in a marginal or month-to-month existence where any unusual expense may not be manageable.

The Impacts of Being Cost-burdened as Severe Poverty

For purposes of this analysis, severe cost-burden will be equated to poverty. What are the conditions associated with poverty and what are the consequences of poverty?

These associated conditions[695] are linked to poverty:

- Substandard housing
- Homelessness
- Inadequate nutrition
- Inadequate child-care
- Lack of access to health care
- Unsafe neighborhoods
- Under-resourced schools

[694] Salviati, op.cit.
[695] Effects of poverty, hunger and homelessness on children and youth. American Psychological Association, Public Interest directorate. Children, Youth and Families.

- Poor academic achievement
- School drop-out
- Abuse and neglect
- Behavioral and socioemotional problems
- Physical health problems
- Developmental delays

Researchers have determined the following effects:

- Poverty in general has negative effects on social life[696]
- It has negative effects on political participation[697]
- The risk of weakening social relations is increased[698]
- Poverty can be a major cause of social tensions[699]
- Children from poor backgrounds lag at all stages of education[700]
- People with lower incomes are at more risk of social isolation[701]
- There is a relationship between poverty and crime[702]
- Alcohol and substance abuse are associated with poverty[703]
- Poverty is related to anti-social behavior[704]

The Poverty of Experience

Child development research has identified that lack of school readiness separates disadvantaged children from their more affluent peers. As early as age 18 months, low-income children begin to fall behind in vocabulary development and other skills critical for school success.[705]

[696] Mood, C. & Jonsson, J. 2016. The social consequences of poverty: an empirical test on longitudinal data. Soc Indic Res: 127:633-652.
[697] Ibid
[698] ibid
[699] effects of poverty on society. www.borgenproject.org
[700] effects op.cit
[701] impact of poverty on relationships. www.jrf.org.uk/data/impact-poverty-relationships
[702] Poverty and crime. 2011. www.poverties.org
[703] Effects of poverty on society, health, children and violence. www. Poverties.org
[704] ibid
[705] www.gradelevelreading.net/3rdgradereadingsuccessmatters

Other data points that illustrate this gap are:[706]

- 61% of low-income children have no children's books at home;
- Poor children hear as many as 4 million fewer words than their more affluent peers;[707]
- By age 2, poor children are already behind their peers in listening, counting and other skills essential to literacy;
- A child's vocabulary as early as age 3 can predict third-grade reading achievement;
- By age 5, a typical middle-class child recognizes 22 letters of the alphabet, compared to nine for a child from a low-income family;
- It has been determined that children who are not proficient in reading when finishing the third-grade are more likely to enter the "drop-out of school" track[708]. Students' reading skill level by third-grade (e.g., proficient, basic, or below basic) affects their likelihood of graduating from high school. 23% of students with below-basic reading skill levels dropped out or failed to finish high school on time, compared to 9% of students with basic skill levels and 4% of students with proficient reading skills.[709]

Dropping out of school has a negative impact both for the student who drops out and for American society. The key points are:

- Increased demand for public assistance.
    - Half of Americans on public assistance are dropouts. A study out of Northeastern University found that each high school dropout costs taxpayers $292,000 through the course of their lives.[710].

[706] ibid

[707] Gilkerson, J. et.al. 2016. Mapping the language environment using all-day recordings and automated analysis. American Journal of Speech Language Pathology. Doi.org/10.1044/2016_AJSLP-15-0169.

[708] Early Warning: Why Reading at 3rd grade matters. Annie E. Casey Foundation

[709] Hernandez DJ. Double jeopardy: how third-grade reading skills and poverty influence high school graduation. New York: The Annie E. Casey Foundation; 2011

[710] graduationalliance.com

- Reduced opportunity for tax revenue.
    - Less income means less taxes paid.[711] Lifetime earnings of high school dropouts are $260,000 less than peers who earn a diploma. Dropouts on average bring in $20,241 annually ($10,000 less than high school grads and more than $36,000 less than those with a bachelor's degree).
    - The unemployment rate for dropouts is generally 4% higher than the national average.[712]
    - Each year's class of dropouts will cost the country more than $200 billion during their lifetimes in lost earnings and unrealized tax revenue.[713]
    - The estimated tax revenue loss from every male between the age of 25 and 34 who did not complete high school would be approximately $944 billion, with cost increases to public welfare and crime at $24 billion.[714]
- Demand for health care and inability to afford health care.
    - High school dropouts are more likely to have higher rates of heart disease, diabetes, asthma and high blood pressures than high school graduates.[715] They are more likely to die prematurely.[716]
    - Dropouts have a 27% higher rate of poverty compared to 14% for high school graduates and 5% for college graduates.[717]

[711] graduationalliance.com
[712] graduationalliance.com
[713] Catterall, J. S. (1985). *On the social costs of dropping out of schools.* (Report No. 86-SEPT-3). Stanford, CA: Stanford University, Center for Educational Research.
[714] Thorstensen, B. I. *If you build it, they will come: Investing in public education* (PowerPoint Presentation). Retrieved January 12, 2004. Available:http://abec.unm.edu/resources/gallery/present/invest_in_ed.pdf
[715] Vaughn, M, et.al. 2014. Dropping out of school and chronic disease in the United States. Z Gesundh Wiss 22(3): 265-27
[716] DeBaum, B. et.al. 2013. Well and Well-Off: Decreasing Medicaid and Health-Care costs by increasing educational attainment. http://alt4ed.org.
[717] 2012-2016 American Community Survey 5 Year Estimates. U.S. Census Bureau

- Demand for law enforcement, corrections and prisons.
    - High school graduates are less likely to engage in criminal behavior or require social services.[718]

Poor reading skills by age 8 are not the only reason for dropping out of school of course. Some other factors are:

- Students whose parents are not involved are more likely to drop out of school;[719]
- Drop-out rates are higher in schools with safety and violence issues;[720]
- Sixth-graders who exhibit high aggression scores and low study skills have a 50% drop-out rate compared to those with low aggression scores and high study skills who have a drop-out rate of less than 2%;[721]
- Drop-out rates are related to family income. Students from low-income families have a dropout rate of 10%; students from middle-income families have a dropout rate of 5.2%, and 1.6% of students from high-income families dropout.

The immediate consequences of being cost-burdened can be stress, housing instability, food insecurity and/or potential inability to be a reliable employee. The longer-term possible consequences of lower income can be health issues, reliance on welfare and/or engagement with the criminal justice system. These can separately or in some combination contribute to problematic behaviors requiring some form of social intervention.

[718] Sum, A. et al. (2009). The Consequences of Dropping Out of High School: Joblessness and Jailing for High School Dropouts and the High Costs for Taxpayer. Boston, MA: Center for Labor Market Studies
[719] Jaynes, WH. The relationship between parental involvement and urban secondary school student academic achievement. Urban Educ. 2007;42(1):82–110.
[720] Bekhuis, T. Unsafe public schools and the risk of dropping out: a longitudinal study of adolescents. Paper presented at the annual meeting of the Eastern Psychological Association; 1995; Boston (MA).
[721] Orpinas, P. 2018. Longitudinal examination of aggression and study skills from middle to high school. Journal of School Health. 83(30 246

Attachment B: Mental Health Discussion

Mental Health

The term mental health refers to a person's cognitive, behavioral and emotional wellbeing. It is a state of psychological wellbeing from which an individual can function effectively in society, cope with the stresses of normal life, work productively and contribute to their community. Sometimes the term is used to refer to an absence of a mental disorder. However, it is not simply the absence of mental disorder, but the presence of various strengths.

Life complications that may be linked at times to mental illness include:[722]

- Legal and financial problems;
- Poverty and homelessness;
- Self-harm or harm to others;
- Weakened immune system;
    - Heart disease and other medical conditions;
    - Problems with tobacco, alcohol or drugs;
    - Missing work or school;
    - Relationship difficulties;
- Dropping out of school: high school students with a significant symptom of depression are more than twice as likely to drop compared to their peers:[723]
- Unemployment: the rate of unemployment is higher among adults with mental illness;[724]
- Substance abuse: 19% of adults with mental illness also experienced a substance abuse disorder.[725]

Mental Illness Can Range in Severity and Type. There are various classification schemas. The DSM identifies 300 specific mental illnesses. One such schema identifies the following types:

[722] Mayo, ibid.
[723] Dupere, V. et.al. 2018. Revisiting the link between depression symptoms and high school drop-out. J. Adolesc Health 62(2):205-211.
[724] Lipari, op.cit.
[725] Lipari, op.cit.

- Anxiety disorder is severe fear or certain situations. There are a variety of sub-types such as panic disorders, phobias and obsessive-compulsive disorder;
- Mood disorders are significant changes in mood. Sub-types include major depression, bipolar disorder, seasonal affective disorder;
- Schizophrenia, the primary psychotic disorder, is a highly complex condition that may be a group of related illnesses. Schizophrenia may include delusions, thought disorders, hallucinations, withdrawal, lack of motivation, a flat mood;
- Eating disorders;
- Addictive and substance abuse disorders;
- Impulse control, personality and conduct disorders;
- Trauma-related disorders;
- Attention Deficit Hyperactivity Disorder.

Mental illness can be caused by a variety of factors including:[726]

- Inherited traits;
- Environmental exposure prior to birth to drugs, alcohol and other toxins;
- Brain chemistry;
- The interaction between nature and nurture, which can affect brain development.

The risk of mental illness can be associated with additional factors such as:[727]

- Stressful life situations;
- A chronic medical condition;
- Brain damage due to serious injury;
- Traumatic experiences;
- User of alcohol or drugs;
- A childhood history of abuse and neglect;
- Few healthy relationships.

The term Serious Mental Illness (SMI) describes a mental, behavioral or emotional disorder that results in serious functional impairment and substantially interferes with or limits one or more major life activities. These include schizophrenia, severe bipolar

[726] Mental illness. www.mayoclinic.org. Patient Care & Health Information//diseases and conditions
[727] Mayo ibid

illness and severe major depression. The term Any Mental Illness (AMI) covers all recognized mental illnesses.[728]

Scope of the Issue.

It is estimated that one in five Americans experience mental health problems each year.[729] A 2015 estimate has 9.8 million adults with serious mental illness.[730] In 2017, this number was estimated to be 11.2 million persons.[731] This was 4.8% to 5% of all American adults at the time. One in six youth age six to 17 experience a mental health disorder each year.[732] Lifetime prevalence of any mental disorder among adolescents age 13 to 18 however was 49.5%.[733]

Treatment Data

- 43% of U.S. adults with any mental illness received treatment in 2018.[734]
- 64% of U.S. adults with serious mental illness received treatment in 2018.[735]
- 50% of U.S. youth age 6 to 17 with a mental health disorder received treatment in 2016.[736]

Impact

Mental illness is the leading cause of disability. Nearly 25% of the nation's 8 million SSDI recipients have a mental impairment as their primary qualification for benefits.[737] Psychiatric disabilities comprise the largest diagnostic group on Social Security disability rolls.[738]

[728] National Institute of Mental Health/home/mentalhealthinformation/statistics
[729] What is mental health? Medical News Today. www.medicalnewstoday.com
[730] ibid.
[731] National institute
[732] Whitney, D & Peterson, M. 2019. US National and State-level prevalence of mental health disorders and disparities of Mental Health Care use in Children. JAMA Prediatr, 173(4): 389-391.
[733] National Institute
[734] Lipari. R. et.al. 2019. Key Substance Abuse and Mental Health Indicators in the United States. Results from the 2018 National Survey on Drug Use and Health. SAMSHA
[735] ibid.
[736] Whitney, op.cit.
[737] Goodman, N. et.al. 2005. Federal program expenditures for working-age people with disabilities. Ithaca, NY: Employment and Disability Institute. Cornell University.
[738] Bond, G. et.al. 2007. Can SSDI and SSI beneficiaries with mental illness benefit from evidence-based supported employment? Psychiatric Services. www.ps.psychiatryonline.org.

Attachment C: Substance Abuse

Substance Abuse

Substance abuse can be considered a sub-category of mental health in that addictive disorders are classified as a mental illness. As noted just above, 19% of adults with mental illness also experienced a substance abuse disorder. These are called co-occurring disorders. Studies link depression, anxiety and substance abuse and find that alcohol and drugs are often used to self-medicate the symptoms of mental health problems.[739]

Given the impact of substance abuse on individuals and society, it will be presented as a distinctive driver here while acknowledging there is overlap.

Impact

Impact on Individuals

A variety of negative impacts can occur for individuals abusing drugs. These include:

- Death, illness and disabilities: More are associated with drug abuse than any other preventable health condition;[740]
- Stroke, psychosis, overdose and death;[741]
- Mental illness, HIV/AIDS, cancer or other diseases;
- Impaired decision-making, stress, experience of normal pleasures, nutrition, sleep and increased impulsivity risk for trauma and violence.

Impact on Families

The impact on families of a substance-abusing member can vary greatly depending upon family structure and age. Children may act as surrogate parents, develop elaborate denial systems, engage in age-inappropriate

[739] https://www.helpguide.org/articles/addictions
[740] Effects of drug abuse and addiction. www.gatewayfouindation.org/home/FAQs
[741] Health consequences of drug misuse. www.drugabuse.gov/Home/relatedtopics

behavior. Older parents with substance-abusing children may be enablers. Spouses may become co-dependent.

Impact on Other Relationships

There can be financial, work problems or resentment in other relationships.

Impact on Communities

There are significant costs incurred by communities in terms of criminal justice costs, loss of local economic productivity and loss of community safety. Other social problems associated with substance abuse include:[742]

- Domestic violence
- Child abuse
- Crime
- Suicide
- Homicide
- Teenage pregnancy
- HIV/AIDS and sexually transmitted diseases
- Financial exploitation of family members or vulnerable persons
- Physical fights

Just as there are a variety of mental illnesses, so are there differing forms of substance abuse. Among these are:

Legal or Illegal Drugs[743]

- Opioids: narcotic pain-killing drugs produced from opium or made synthetically;
- Barbiturates, benzodiazepines and hypnotics: Central nervous system depressants;
- Alcohol: The main cause of death among people under 21 due to injury;
- Cannabis: Often the first drug tried and a gateway drug;
- Synthetic cannabinoids (K2 or Spice): Chemical compounds that are like marijuana in effects but more addictive and dangerous;[744]
- Meth, cocaine and other stimulants: Can be prescription or illegal, used to boost energy, lose weight or control appetite;

[742] www.healthypeople.gov/2020topicsandobjectives/substanceabuse
[743] Drug addiction. www.mayoclinic.org/patientcare&healthinformation/diseasesand conditions
[744] Drug addiction. www.mayoclinic.org/patientcare&healthinformation/diseasesand conditions

- Club drugs: Commonly used at night clubs, concerts and parties; may cause sedation, confusion, memory loss and may be associated with sexual assault;
- Hallucinogens: Cause hallucinations, impulsive behavior, reduced perception of reality;
- Inhalants: Fluids or gases, which can be inhaled and may cause brain damage or sudden death.

Scope of the Problem

The following facts demonstrate the scope of the issue.

- It was estimated in 2017 that 18 million people age 12 and older (6% of the age 12 and older population) had misused medications at least once in the prior year.[745]
- Almost 21 million Americans have at least one addiction, yet only 10% receive treatment.[746]
- Drug overdose deaths have more than tripled since 1990.[747]
- From 1999 to 2017, more than 700,000 Americans died from overdosing on a drug.[748]
- In 2017, 34.2 million Americans committed DUI, 21.4 million under the influence of alcohol and 12.8 million under the influence of drugs.[749]
- About 20% of Americans who have depression or an anxiety disorder also have a substance use disorder.[750]
- In 2015, 66.7 million people reported binge drinking in the past month with 27.1 million using illicit drugs or misusing prescription drugs.[751]
- Substance misuse and substance use disorders also have serious economic consequences, costing more than $400 billion annually in crime, health and lost productivity.[752]

[745] Misuse of prescription drugs. National Institute on Drug Abuse/publications/research reports
[746] Statistics on Addiction in America. www.recoveryworldwide
[747] ibid
[748] ibid
[749] ibid
[750] ibid
[751] Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs and Health. www.ncbi.nim.nih.gov
[752] Sacks JJ, Gonzales KR, Bouchery EE, Tomedi LE, Brewer RD. 2010 national and state costs of excessive alcohol consumption. American Journal of Preventive Medicine. 2015;49(5): e73–e79

The factors affecting the likelihood of addiction include:

- Family history of addiction
- Mental health disorder
- Peer pressure
- Lack of family involvement
- Early use.

Attachment D: Trauma

Trauma

While trauma can be linked to mental health or illness or substance abuse from both causal and consequential perspectives, it is significant enough to be considered as a separate driver. Persons who are mentally healthy and have no history of substance abuse can experience trauma that results in some level of maladaptive behavior or internal distress.

SAMHSA defines trauma as:[753]

"Individual trauma results from an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life-threatening with lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual wellbeing."

Other definitions include:
"A psychological, emotional response to an event or an experience that is deeply distressing or disturbing".[754]

"Trauma is the experience of severe psychological distress following any terrible or life-threatening event.[755]"

What is more significant than the scope, are the impacts, which are discussed next.

[753] www.integration.samsha.gov/clinical practice/trauma
[754] www.centerforanxieitydisorders.com/whatistrauma
[755] www.psychologytoday.com/basics/trauma

Impacts of Trauma

First, trauma impacts everyone differently. Many people exhibit resilient behaviors or brief symptoms. As the Center for Substance Abuse Treatment notes.[756] "The impact of trauma can be subtle, insidious, or outright destructive. How an event affects an individual depends on many factors, including characteristics of the individual, the type and characteristics of the event(s), developmental processes, the meaning of the trauma and sociocultural factors".

Short-term reactions are normal. Others have more destructive reactions, including:[757]

- Mental illness
- Anxieties
- Depression
- Avoidance
- Difficulty regulating anger, shame, sadness
- Addiction, such as self-medication to control emotions
- Compulsive behaviors such as gambling
- Poor physical health outcomes, including long-term fatigue, sleep disorders
- High-risk behaviors, such as eating disorders

In addition to the above effects, early trauma can affect brain development[758] and physiological development.[759]. In adults, severe emotional trauma can affect the region of the brain that regulates negative emotions.[760]

[756] Treatment Improvement Protocol Series No 57. Center for Substance Abuse Treatment. Rockville, MD: SAMSHA
[757] ibid.
[758] www.harleytherapy.co.uk.couselling/childhoodeffectsoftrauma
[759] DeBellis, M. et.al. 2014. The biological effects of childhood trauma. Child Adolesc Psychiatry Clin N Am. 23(2): 185-222
[760] www.brainblogger/2015/01/24

Types of Trauma

There are several types of trauma[761]. These include:

- Sexual assault
- Child maltreatment including bullying and early childhood trauma
- Domestic violence, physical, emotional or psychological
- War-related trauma
- Medical trauma
- Traumatic loss or grief
- Natural disaster
- Community violence[762]

In the above types, a person is experiencing a traumatic situation. It is important to note that simply witnessing an act of violence can be traumatic.[763]

Scope

The following data points illustrate the scope of trauma.

- One estimate is that 61% of men and 51% of women report exposure to at least one lifetime traumatic event.[764] Another is that 70% of adults have experienced some type of traumatic event at least once in their lives.[765]
- 90% of clients in public behavioral health care settings have experienced trauma.[766]
- Approximately 35 million children have experienced one or more types of childhood trauma.[767]

[761] www.teachtrauma.com
[762] wwwnctsn.org/whatischildtrauma
[763] https://www.psychguides.com/trauma
[764] integration op.cit
[765] www.thenationalcouncil.org/uploads/2013/05/trauma-infographic
[766] integration, op.cit
[767] The National Survey of Children's Health, 2018. Health Resources and Services Administration Maternal and Child Health Bureau

Attachment E: Suggested causes for domestic violence

Suggested Causes for Domestic Violence

The following causes have been examined by researchers. Each as a stand-alone cause was found to be problematic. These causes include:

- All men who are abusers are mentally ill;
- Battered women are mentally ill;
- Men battered because they had learned violence in their families as children, and women sought out abusive men because they saw their mothers being abused. This is the learned behavior theory;
- Violence is a loss of control. Alcohol use leads to a loss of control;
- The learned helplessness theory which argued that women stay in abusive relationships due to a personality disorder;
- The cycle of violence theory that men did not express their feelings regularly and then exploded;
- The family conflict model which argued that both the man and woman contributed to violence;
- Abuse is about maintaining control and power;
- Abuse reflects societal norms of dominance and inequality.

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CHAPTER 34
The Board of County Commissioners: Specific Issues

Introduction

This analysis has identified numerous gaps in the overall human services system in the County. As indicated in the funding responsibilities section, the BoCC has specific responsibilities for certain elements of that system. This chapter focuses on responsibilities that the County is legally mandated to address, has chosen to address by policy and/or has significant financial implications for County government.

Overall Analysis Findings

As noted in the Executive Summary and elsewhere, the three major gaps identified by the assessment were behavioral health, housing and transit. This chapter addresses certain aspects of those major gaps which are either the responsibility of the County or in which the County has made major investments. These aspects are discussed in the "Key Points and Conclusions" section immediately following this paragraph.

Key Points and Conclusions

Area One: Behavioral Health and Criminal Justice

Introduction

Two major systems interface as numerous people in the criminal justice system need behavioral health treatment and assistance. Addressing these issues is costly and complicated. Lee County is not unique in having this challenge as most communities are faced with these same issues.

Key Points

- As noted above, behavioral health services are one of the three most critical gaps in the County.

- At least 25% of jail inmates have mental health issues and would be better served in a more appropriate facility.[768] According to some local professionals, this percentage may be under-estimated in Lee County.
- Inmates with mental health issues stay about twice the time of the general population and cost between two and four times as much to manage.
- This represents up to $20 million that could be used more productively.
- Varieties of solutions are proposed in the chapter on behavioral health and criminal justice.

Conclusion

This is the county's largest investment area for which it has full responsibility. Given its significance, a more thorough analysis of the solutions proposed in the chapter on behavioral health and criminal justice is warranted. This will involve substantive analytical work on actual costs and potential cost-benefits as well as multi-stakeholder planning for any changes.

Area Two: PFR Funding

Introduction

The County provides funds to a variety of local nonprofits under its Partnering for Results (PFR) program. Ensuring these investments are both productive and efficient is an on-going endeavor.

Key Points

The County currently provides more than $5 million in funding for local agencies.

Conclusion

There are two areas to examine in greater depth with respect to PFR funding:

1. During proposal and selections, give greater weight to evidence-based programs.
2. Requiring requesters to address their system-of-care features.

[768] Conclusion of expert panel comprised of Court Administration, Public Defender, Sheriff and State Attorney after review of data presented by the Sheriff.

Area Three: Homelessness

Introduction

Homelessness is an ongoing concern driven by a variety of factors. The County has assumed a lead agency role in addressing homelessness in the County.

Key Points

The provision of emergency housing funds does not last the full year and has been generated from a variety of sources, some of which were one-time. There is a life-time limit of three assistance events with IFAS providing budgeting training. Revising these policies to keep people in existing housing may save significant staff effort in finding other housing.

Conclusion

A General Fund commitment to this service, along with other funds the Department of Human and Veteran Services may be able to generate, could be a cost-effective and cost-beneficial investment to prevent a repetitive homeless status and to lower public costs associated with it.

Area Four: Housing

Introduction

All of the data collection methods for this project identified supportive and affordable housing as a critical need. The value of any treatment program is lessened if the person does not have stable and safe housing.

Key Points

- This is one of the three most critical gaps.
- The County has a variety of tools to assist the private sector in developing non-market rate housing.
- Housing costs are beginning to be problematic from an economic development perspective.
- Responsibility for housing strategy is dispersed in County government.

Conclusion

The County is clearly not in the housing business as a developer. It does have a variety of tools to facilitate housing development. Given the critical nature of this issue from both supportive housing and affordable housing perspectives, a re-thinking of the County's strategy regarding housing is warranted.

Area Five: Transit

Introduction

As with housing, all of the data collection methods identified a lack of public transit as a major barrier to client success. The inability to get to treatment, to work, to everyday life tasks, affects the value of other interventions.

Key Points

Transit is considered one of the three most critical gaps in the human services field.

Conclusion

Public expectations about transit are not aligned with the fiscal realities of transit. Public education on this challenge is warranted. Given this challenge, continuing to incorporate the public transit perspective in transportation planning is warranted.

CHAPTER 35
Conclusions

Introduction

As reported in the prior chapters, there are numerous gaps in the various systems of care whether defined by an issue such as elder abuse, neglect and exploitation, or by a population or demographic group like individuals with intellectual and developmental disabilities. This chapter will not simply repeat those findings. It will address common gap themes and underlying patterns. Underlying patterns emerge from the needs identified among various service delivery systems or from trends that affect the delivery of human services in Lee County. There is no priority order to the presentation of the themes and patterns.

Patterns

Pattern One: Population Growth and Infrastructure

One underlying pattern is that the population growth of Lee County outruns its infrastructure. The provision of human services requires staffing, facilities and organizational systems. For the most part, human services are provided on a reactive basis. For instance, a need emerges of sufficient scale and significance that members of the community decide to respond. The organizational form needed to respond to this need takes time to develop. Rarely can one generate the funds, establish an organizational structure, find an appropriate facility and hire staff as quickly as the need develops and is recognized. This phenomenon is true even in slow-growth communities. It is even truer in the high-growth areas.

Pattern Two: The National Shortage of Professionals

Chapter 9 presented data about a national shortage of various behavioral health professionals. In high-growth Lee County, this shortage can be even more acute. Time and the development of technologies that enable these professionals to be more productive in their service delivery could lessen this problem. For the moment, however, this pattern presents an operational challenge to the expansion of services to fill gaps. Even if all of the other necessary elements were in place – the money, the

buildings and the organizational structure – staffing shortages could limit the ability to deliver services.

Pattern Three: Compensation Issues for Direct-service and First-line Workers

The wage compensation for most direct-services workers ranges from minimum wage to $12 to $14 per hour. Wages at this level can mean high staff turnover as a job with a 25-cents-per-hour raise can be significant. This compensation level, coupled with work that can be highly demanding and stressful, is not conducive to a stable work force in fields in which relationships with clients are important.

Pattern Four: The Increasing Complexity of the Work and the Further Professionalization of the Field

There is a tendency to believe that work in the human services field simply requires a high level of concern for people coupled with a willingness to serve others. While those are requirements, far more skill and knowledge is required to be effective. The field deals with the most complex of phenomenon – human behavior – in its full range of expression. There are on-going advances in brain research, genetics, the combined impacts of environment and biology and various forms of intervention. Even with the most basic services, such as childcare, there is a growing knowledge and skill base that is required of a childcare worker.

Pattern Five: The Need for More Integrated Delivery Systems

It has long been recognized that individuals have multiple needs and that addressing one need while ignoring others is a pathway to failure. The concepts of systems of care and "wrap-around" services have developed as a response. While much progress has been made, there is much to be done. Of significance is the physical health and mental health interface where conditions in either category can affect the other. The significance of integrated approaches to physical and mental health has been recognized. However, this recognition has yet to turn into operational reality.

Pattern Six: Evidence-based Practice

Without doubt, every human service program or effort is well intentioned, and most possess a logic that leads to the belief they will make a difference. The reality is otherwise. Some efforts have no impact; others have a short-term impact. A few could

have a negative impact. For these reasons, the field in general has emphasized high-quality evaluations of programs to determine if they are effective. Efforts that pass these evaluations are termed evidence-based. They represent the best investment of public or private resources.

Pattern Seven: The Need for More Coordinated and Flexible Funding Streams

With respect to federal funds, these are often the result of interest group lobbying and are therefore written for a specific group of people. Administrative regulations then develop the eligibility criteria. In effect, equally needy individuals who may fail to meet a specific criterion are ineligible to receive services. This can also result in less than effective use of public funds when State or local funds are required as match. The ability of local officials to most effectively respond to their community and its distinctive features is therefore limited.

Pattern Eight: The Need for Prevention and Early Intervention

The research data on the long-term social and financial costs to society of failing to address known at-risk issues in early childhood is very clear. The operational challenge is that those investment costs occur in the present while the savings are far in the future. Given current needs and the challenge of addressing those needs, it is difficult to invest in prevention and early intervention.

Pattern Nine: The Silver Wave

As noted in the chapter on seniors, the growth of the senior population in Lee County will be significant. As this population ages and the 85 and older age group increases proportionally, there will be increased demand for public services. As the dependency ratio discussed in that chapter changes, there will be proportionally fewer workers to provide the needed services. The open question is whether there will be sufficient advances in technology to offset the needed workers.

Pattern 10: Public Understanding and Education

This pattern involves a combination of ignorance and stigma. Some people are not aware of services for which they are eligible or that are available. At the same time, there still is a stigma attached to mental illness or shame associated with certain events such as sexual abuse or financial exploitation. As noted in various chapters, there is a reluctance to report various violations, and as a result the scope of some problems is severely under-estimated.

Pattern 11: The Data Gaps

There are several sub-fields in the arena of human services and the level of data collection varies greatly. Data collection is not cost-free and often it becomes a lower priority. Yet the lack of data, or data gaps, make planning and public investments challenging. Even more than basic data collection, data on impacts and effective intervention also is lacking. The current and growing need for services, coupled with significant financial investments made by governmental bodies and private philanthropy, strengthens the need for better data to help these investment decisions. More importantly, better data and better data sharing would help service providers be more effective and efficient.

Pattern 12: Dynamic and Diverse Economies and Affordability

One of the current realities is that the more dynamic and diverse a local economy becomes, the more challenging affordability becomes. This is obvious in areas such as San Francisco, the Silicon Valley or Boston. Some of this is due to local land-use policies that make housing development difficult. However, that is not the only reason. For a local analysis, compare rental housing affordability in Lee, Broward and Palm Beach counties as shown in Table 120. While Lee County is significantly increasing its diversity beyond retirement and tourism, both Broward and Palm Beach have long achieved a greater diversity so that tourism and retirement are less dominant economic drivers. One could assume that as these service economy drivers become less dominant, affordability would increase. As the table shows, that does not occur. Instead, both Broward and Palm Beach are more cost-burdened.

Table 120. Renter Cost-burden Comparison

County	Renter Cost-Burdened Percentage
Broward	61.3%
Lee	55.4%
Palm Beach	60.7%

Pattern 13: In-home Services

In addition to the need for more integrated physical and mental health care, there is a recognized need to provide more services in-home. This has several advantages. First, the transportation barrier is eliminated. Second, any stigma attached to going to a facility, particularly a mental health or substance abuse facility, is avoided. Third, a significant clinical advantage is that the family can be seen in its natural setting. This provides important data to the treatment provider.

Pattern 14: Trauma

Trauma is not a new concept, but the scientific and clinical understanding of its impact has increased in recent years. The experience of trauma is highly personal, but it is found in almost every specific system-of-care. Having professionals trained in recognizing and addressing trauma is a growing requirement for effective service delivery.

Pattern 15: Education for Non-Behavioral Health Disciplines

Just as there is a growing demand for increases in the knowledge and skill of human service professionals, there is the same need for other professionals who interact with the system to have a better understanding of various behaviors associated with differing conditions. There has been a great emphasis on including mental health professionals with law enforcement. The field of developmental disabilities shares a similar concern that law enforcement officials understand some of the behaviors associated with this disability.

Pattern 16: Assessment

An improved ability to assess individuals and families would be of value across the various sub-fields. Professionals in the field rely upon assessments to determine treatment plans, placements, classification and allocation of resources. The use of valid and reliable assessment tools by persons trained in the administration and interpretation of the assessment is a step toward greater effectiveness and efficiency.

Pattern 17: Employment

For the adult-oriented human service systems of care, employment is a consistent concern. The benefits of employment are obvious. A variety of challenging barriers exists including transportation, employer bias, the need for some special accommodations and training.

Pattern 18: Language and Cultural Diversity

As the County becomes more culturally and linguistically diverse, demands are being placed upon the human service field to respond with multi-lingual staff and more culturally sensitive interventions or services.

Pattern 19. The Growing Service Demand in Lehigh Acres

There are high transportation costs for these residents both financially and in terms of commute times. Service sites in Lehigh Acres are limited and there are proportionally fewer available services.

Pattern 20: Increased Use of Technology

There is a growing use of various telepresence tools to deliver services. This use will increase as technology improves and comfort level on the part of both clients and clinicians increases. Yet to be determined are the potential uses of specific Artificial Intelligence (AI) tools to address specific issues. AI has the potential to address staffing issues from an agency perspective. AI and robotics have the potential to provide client services to address the worker gap projected in the dependency ratios.

Common Gap Themes

Common Theme One: Mental Illness and Substance Abuse

Across all the systems of care examined in this study, significant gaps in mental health and substance abuse services were mentioned. As noted, the State of Florida is among the states spending the least on mental health funding. As noted in the Equity Funding chapter, Lee County is funded for mental health services at a lower rate than other counties. At the same time, the County expends significant financial resources on its jail and criminal justice system, which houses a significant proportion of mentally ill inmates. This is the most significant service gap in the County that affects almost all human services in one way or another.

Common Theme Two: Housing

Finding housing for individuals with disabilities or various human service issues is highly challenging, both for cost and perception factors. There is a significant gap in permanent supportive housing capacity. In addition, a sizable number of households are cost-burdened, which means they may place demands upon the human service system.

Common Theme Three: Transportation

Transportation gaps are the third commonly mentioned gap. The inability to get to services is a problem from a client perspective. The unreliability of clients in keeping appointments is a problem from the provider perspective. The cost of providing a more comprehensive public transit system is a problem from a funder perspective. There is no simple solution to this gap. Instead, there will be incremental steps including smaller vehicles, greater use of telepresence options and location of services along major transit routes.

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Appendices

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Appendix A.

Human Surveys Gap Survey Results

Rate the adequacy of services

For each service below, please rate the adequacy of services in Lee County on a scale of 1 to 5

Survey Group	Services	1 - Most Inadequate	2 - Inadequate	3	4	5 - Highly Adequate	6 - Don't know	"N" Total with (6- Don't Know Out)	Average	Low to High
HOUSING	Affordable Workforce Housing	18	6	3	2		3	29	1.62	1
BEHAVIORAL HEALTH	Available Residential Mental Health Services	13	15	2			2	30	1.63	2
HOUSING	Emergency / Temporary Shelters	12	14	5	1			32	1.84	3
HOUSING	Supportive Housing for Persons Needing Additional Support	11	13	4		1	3	29	1.86	4
HOUSING	Temporary Housing Assistance	9	14	4	1		4	28	1.89	5
HOUSING	Rapid Re-housing	10	9	7	1		5	27	1.96	6
HOUSING	Transitional Housing	9	9	9			5	27	2.00	7
BEHAVIORAL HEALTH	Available Mental Health Services for Crisis	11	11	7	2		1	31	2.00	8
JUSTICE INVOLVED SERVICES	Re-entry after Jail or Prison - Housing	8	11	2	2	1	8	24	2.04	9
MAINSTREAM SERVICES	Affordable Health Care / Insurance	11	9	9	2		1	31	2.06	10
BEHAVIORAL HEALTH	Available Mental Health Services for Children and Adolescents	7	14	5	2		4	28	2.07	11
CHILDREN/YOUTH	Affordable Child-care	9	9	8	2		4	28	2.11	12
JUSTICE INVOLVED SERVICES	Re-entry after Jail or Prison – Supportive Services	6	11	4	1	1	9	23	2.13	13
BEHAVIORAL HEALTH	Available Out-patient Mental Health Services	7	15	5	4		1	31	2.19	14
MAINSTREAM SERVICES	Public Transportation	8	12	7	5			32	2.28	15
CHILDREN/YOUTH	Child Abuse Prevention	6	7	9	3		7	25	2.36	16
JUSTICE INVOLVED SERVICES	Domestic Violence Prevention	5	9	8	3		7	25	2.36	17
SERVICES FOR PERSONS WITH DISABILITIES	Sheltered Employment for Persons with Developmental Disabilities	4	6	5	3		14	18	2.39	18
JUSTICE INVOLVED SERVICES	Victim Assistance – Rape/Sexual Violence	5	7	6	4		10	22	2.41	19
BEHAVIORAL HEALTH	Substance Abuse Residential Treatment Programs	5	11	6	2	2	6	26	2.42	20
SERVICES FOR PERSONS WITH DISABILITIES	Services for Persons with Developmental Disabilities	5	9	6	3	1	8	24	2.42	21
JUSTICE INVOLVED SERVICES	Victim Assistance – Domestic Violence	5	8	6	5		8	24	2.46	22
CHILDREN/YOUTH	Child Abuse Intervention	6	5	10	4		7	25	2.48	23
CHILDREN/YOUTH	Parenting Support	4	10	7	5		6	26	2.50	24
JUSTICE INVOLVED SERVICES	Victim Assistance – Other crimes	5	6	5	4	1	11	21	2.52	25
CHILDREN/YOUTH	Available Child-care for Working Parents	8	5	7	8		4	28	2.54	26
BEHAVIORAL HEALTH	Substance Abuse Prevention Programs	3	13	7	4	2	3	29	2.62	27
BEHAVIORAL HEALTH	Substance Abuse Outpatient Treatment Programs	4	8	9	4	1	6	26	2.62	28
SENIOR SERVICES	Supportive Services for the Elderly (transportation, meals, personal care)	7	3	5	7	1	9	23	2.65	29
JUSTICE INVOLVED SERVICES	Domestic Violence Services & Support Groups	4	5	11	5		7	25	2.68	30
SERVICES FOR PERSONS WITH DISABILITIES	Services for Hearing Impaired	3	5	7	4	1	12	20	2.75	31
SENIOR SERVICES	Senior Recreational Facilities/Programs	6	3	7	6	2	8	24	2.79	32
CHILDREN/YOUTH	Child-care that Meets a Quality Standard	3	6	9	7		7	25	2.80	33

Survey Group	Services	1 - Most Inadequate	2 - Inadequate	3	4	5 - Highly Adequate	6 - Don't know	"N" Total with (6- Don't Know Out)	Average	Low to High
SERVICES FOR PERSONS WITH DISABILITIES	Services for Visually Impaired	3	5	8	5	1	10	22	2.82	34
CHILDREN/YOUTH	Youth Recreational Facilities/Programs	3	5	10	9		5	27	2.93	35
CHILDREN/YOUTH	After-school Care	3	5	10	8	1	5	27	2.96	36
MAINSTREAM SERVICES	Education and Job Training Services	1	6	14	9		2	30	3.03	37
MAINSTREAM SERVICES	Employment Support (soft skills, job application skill; job links)	1	7	12	9	1	2	30	3.07	38
MAINSTREAM SERVICES	Food Availability / Nutritional Support	2	7	10	7	5	1	31	3.19	39

Most Inadequate (Pick 3)

Of the various services above, please select the three you believe are the most inadequate.

Affordable Workforce Housing	15	16%
Public Transportation	9	9%
Available Mental Health Services for Children and Adolescents	8	8%
Available Residential Mental Health Services	7	7%
Emergency / Temporary Shelters	7	7%
Rapid Re-housing	6	6%
Affordable Child-care	4	4%
Available Mental Health Services for Crisis	4	4%
Temporary Housing Assistance	4	4%
Transitional Housing	4	4%
Supportive Housing for Persons Needing Additional Support	3	3%
Affordable Health Care / Insurance	2	2%
Available Out-patient Mental Health Services	2	2%
Employment Support (soft skills, job application skill; job links)	2	2%
Parenting Support	2	2%
Re-entry after Jail or Prison - Housing	2	2%
Substance Abuse Prevention Programs	2	2%
Substance Abuse Residential Treatment Programs	2	2%
Victim Assistance – Rape/Sexual Violence	2	2%
Available Child-care for Working Parents	1	1%
Child Abuse Prevention	1	1%
Child-care that Meets a Quality Standard	1	1%
Domestic Violence Services & Support Groups	1	1%
Education and Job Training Services	1	1%
Food Availability / Nutritional Support	1	1%
Re-entry after Jail or Prison – Supportive Services	1	1%
Services for Persons with Developmental Disabilities	1	1%
Supportive Services for the Elderly (transportation, meals, personal care)	1	1%

Rate how well the group's needs are being met

For each need below, please rate how well the group's needs are being met in Lee County.

	1 - Poor	2 - Inadequate	3	4	5 - Excellent	6 - Don't know	Total with (6-Don't Know Out)	Average	Low to High
Homeless needs	11	10	5	2	1	3	29	2.03	4
Elderly needs	4	4	8	7	2	7	25	2.96	10
Migrants needs	6	7	8	2		9	23	2.26	5
Children needs	4	8	5	10	1	4	28	2.86	9
Disabled needs	3	9	10	6		4	28	2.68	7
Developmentally Impaired needs	4	10	8	5		5	27	2.52	6
Visually Impaired / Deaf / Hard of Hearing needs	2	5	11	2	1	11	21	2.76	8
Mentally Ill needs	11	12	3	3		3	29	1.93	3
Working Poor needs	10	12	5	1		4	28	1.89	1
Veterans needs	4	4	5	6	5	8	24	3.17	11
Re-entry needs (Persons released from jail or prison)	9	8	5	1		9	23	1.91	2

If question 5 did not address a group's needs that you are aware of please list that group below.

OTHER						
Affordable Housing for workforce		1				
Low Income		1				
Single women without dependent children	1					
Those needing emergency shelter (especially if they have been arrested in the past)			1			

Three needs that are the most unmet

For the group(s) that you have specific knowledge, please list up to three needs that are the most unmet.

Response	Please list up to three needs that are the most unmet:
Children	1. Parental Supportive Services 2. Increases wages for Early Learning Educators 3. Academic summer programs for children entering kindergarten.
Children	Healthy food Stable home environment Utilities shut off
Children	The school system will push out students with a 'certificate' that is not a diploma. This makes it impossible for young adults to get jobs that have a living wage. Affordable housing that is not third-world quality. Access to fresh food for persons who live in underserved neighborhoods
Children	protection from all forms of abuse, available food, safe transportation to and from school
Children	Preventive care and support , education, community support, affordable recreation activities , MENTORSHIP CONNECTIONS.
Children	No safe and affordable housing for families in poverty, no quality early childhood programs available at no cost, no foster homes. Children are sleeping in cots in the business office of Lutheran Services overnight with social workers having to sleep at their desks.
Children	Stable home lives, nutrition, mental health services
Developmentally Impaired	employment, housing, transportation
Developmentally Impaired	Adults who are developmentally impaired need more resources and assistance for caregivers
Elderly	Transportation Medical Transportation - Non-emergency
Elderly	No insurance covers home health for dementia and 80% of my caseload is Medicaid eligible but there are no memory care beds available in Lee County. Wait list up to two years. Absolutely no financial support for a disease that cost between $6-14,000 a month.
Elderly	Where are the resources - Elderly has no idea where to go - no PSAs advising them where resources are available
Elderly	Housing Transportation Easy accessibility of services
Elderly	affordable housing, transportation, affordable home care
Homeless	More Shelters, Affordable housing, More resources based on needs such as Health care, Clothing, transportation, obtain birth certificates
Homeless	Housing Assistance-deposit, 1st and last month's rent Deposit for water and electric Housing for felonies and evictions
Homeless	More options to transition out of homeless Support Funds
Homeless	Alternative shelters for mentally ill homeless Any shelter for homeless single women without dependent children Public transportation
Homeless	1-Housing for someone who does not have a substance abuse issue. 2- ID's 3- Mental Health care
Homeless	Shelter, Help finding a job
Homeless	Homeless or on the verge of becoming homeless, working poor benefits for them, mentally ill services for them
Homeless	Affordable housing Temporary re housing Transitional housing
Homeless	Affordable Housing, Access to Healthcare, Community of Support
Homeless	Transportation Shelter
Mentally Ill	Available Services for individuals in Crisis, Mental Health Education, Community Awareness and Support, Pre and Post Intervention Services
Mentally Ill	Access to services, transportation, community support education and prevention
Mentally Ill	Housing MH services including MM and CM services

Mentally Ill	Residential services, outpatient services, community integration services.
Mentally Ill	affordable treatment, quality of service, supportive housing (residential care)
Mentally Ill	1-Housing 2- Case Management
Mentally Ill	No quality services at no cost, access and wait lists makes it difficult to obtain services, caseloads are too high for mental health workers.
Mentally Ill	No insurance to afford to address their mental health needs Parents, children are families feeling that they are not worth the help and their needs are not important or immediate
Migrants	Income, language assistance
Migrants	Education Resources
Other	Inmates that are incarcerated, but identifying as victims of human trafficking 1. Do not have anybody to go to court with them to speak on behalf of them as a victim to help get them into a program. 2. Do not have a support group to process their trauma. 3. Housing that promotes rehabilitation from being a victim of human trafficking
Other	Kids that foster out of the system
Persons released from jail or prison	transitional housing is the biggest one, employment for felons
Persons released from jail or prison	Reentry is a huge problem that is unmet by the nation. Should be programs that begin in prison and assist in the transition to community living to include: housing, employment, treatment, education...etc.
Persons released from jail or prison	Access to Employment, Housing, Collaborative Community Support Services
Persons released from jail or prison	Transitional Housing Job services SA and MH counseling
Veterans	Veterans wait too long for medical care, their mental health issues are not adequately addressed in a timely manner, many of our homeless are veterans, and many have mental health/drug issues. We owe them much better care and consideration.
Visually Impaired / Deaf / Hard of Hearing	Transportation Housing Easy accessibility of services
Working Poor	Availability of child-care, and housing
Working Poor	
Working Poor	affordable housing, healthcare, childcare
Working Poor	medical care, affordable housing, affordable child-care
Working Poor	Affordable housing Job training MH services Dental
Working Poor	Affordable afterschool care Make less than what can afford in rent Not able to make ends meet even though working hard to maintain stable housing for their family.
Working Poor	Affordable housing Dental care
Working Poor	Resources
Working Poor	Affordable housing, transportation resources, education and community support programs
Working Poor	Living wage, transportation, child-care

Services Difficult to Obtain

Are there any other human services in addition to those listed above that are difficult to obtain in Lee County?

If Yes, what are they?
Assistance with first/last/deposit for housing and not eliminating homeless who were evicted in the past.
Burial Assistance for those who cannot afford to bury or cremate their loved one
Dental Affordable medical Affordable daycare Clothing
Evidenced base treatment programs for youth, prevention programs, homebased services available for all new parents, residential programs for youth with mental health issues
Help for the undocumented, and more programs for people with more severe mental health.
income does not match cost of living in this area; more accessible, timely, direct transportation (remote areas-parts of Cape Coral, Lehigh Acres, Bonita Springs, North Fort Myers)
Prescription Assistance Affordable Rent for Families (in line with wages)
Section 8
Transportation for undocumented immigrants or pregnant woman in need of prenatal appointments
Transportation- more bus stops that are closer to employees work. More shelters at the bus stops to prevent heat strokes. Less expensive tickets to ride the bus.

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Appendices B- F

Appendix B.

PRC Comprehensive Health Needs Assessment
http://www.leecounty.healthforecast.net/2017%20PRC%20CHNA%20Report%20-%20Lee%20County,%20FL.pdf

Appendix C.

Need Assessment for CSBG Work Plan
https://www.leegov.com/dhs/funding/csbg

Appendix D.

2019-2023 Consolidated Plan HUD
http://www.leegov.com/dhs/Documents/Planning/Final%20Draft%20for%20Public%20Comment.pdf

Appendix E.

Continuum of Care Plan
http://www.leegov.com/dhs/Documents/CoC/Lee%20County%20CoC%20Strategic%20Plan%202019.pdf

Appendix F.

Impediments to Fair Housing Choice
http://www.leegov.com/dhs/Documents/Fair%20Housing/Final%20PY%202019%20Analysis%20of%20Impediments%20to%20Fair%20Housing%20Choice.pdf#search=Impediments%20to%20Fair%20Housing%20Choice

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Appendix G.

Lee County Parks and Recreation CIP

Parks and Recreation CIP as of Oct. 30, 2019

Project name	Status	Summary	BoCC direction
JY Linear Park Trailhead	The design consultants STA has been approved by procurement.	With the first section of John Yarbrough Linear Park having opened to the public back in 2005, this County facility now stretches for 4.8 miles in between Six Mile Cypress Parkway and Colonial Boulevard, as well as along Ten Mile Canal. The development of a new segment in between Colonial Boulevard and Hanson Street, roughly 1.8 miles long, is also being planned by the City of Fort Myers. To better accommodate users, there is a need to develop a trailhead facility containing paved parking, restrooms and other amenities, as none currently exist, which is causing problems. Most notably, from a parking perspective, patrons arriving at this facility in vehicles are having to park on adjacent private properties, one of which recently posted "No Parking" signage. Additionally, people who have disabilities have difficulties accessing this park given that there is no ADA-compliant parking. To remedy these problems, the County purchased an abutting 7.3-acre property off Six Mile Cypress Parkway in 2018 with the specific intent of developing it with	This project is slated for the December 3rd Board meeting.

Project name	Status	Summary	BoCC direction
		paved parking, among other amenities.	
Telegraph Creek Kayak Launch	Possibly purchasing property	This primitive launch parcel is 0.9 acres off North River Rd. located on Telegraph Creek in Alva.	No further information.
Abel Canal Greenway	Waiting on a LAP Agreement from FDOT. The design phase, which is tentatively scheduled to begin in 2020, is expected to take between 30 and 38 months to complete.	This joint project between Lee County and the Florida Department of Transportation involves the design and construction of a 12'-wide paved shared-use pathway along the northern side of the Able Canal. Once constructed, this pathway will extend for roughly 6 miles and provide connections between significant existing public sites, including a 578-acre stormwater management area (i.e., Harns Marsh), Lehigh Acres Park/Barbara Farrell Park, Lehigh Elementary School and Lehigh Acres Trailhead Park. This pathway will also provide connections between various residential and commercial areas. Additionally, this project will involve the design and construction of new stormwater management areas, a 240'-long bicycle/pedestrian bridge spanning the Charlie Diversion Canal, high-emphasis crosswalks at roadway intersections, shade structures, site amenities (e.g., benches, kiosks and recycling/trash receptacles), signage and landscaping.	

Project name	Status	Summary	BoCC direction
Lehigh Community Park Expansion	Working with procurement and plan on going out to bid.	Purchased 41.8 acres within Lehigh Community Park, which will meet the demands of the Lehigh Community. Plans to design and construct multipurpose fields and other park amenities for the future.	
Alva Equestrian Park		Recently acquired 85 acres parcel, located off North River Road in Alva. Plans for this park will consist of hiking and equestrian trails. Future plans to add restrooms.	No further information.
Matanzas Pass Boardwalk Expansion	Construction to start November/December 2019.	Replacing portion of the existing boardwalk, bridges, benches, pavilion and kayak launch.	BoCC awarded contract at the 11/5/19 meeting.
Phillips Park Expansion	Closed on property 11/2019.	Adding pickleball courts and basketball court.	
Brooks Park Master Plan & Improvements	The design consultants STA has been approved by procurement.	Adding a paved parking lot, restrooms, and shade structure.	This project is slated for the December 3rd Board meeting.
Player Development Complex Fields		Adding 12 to 15 youth baseball fields on property located adjacent to the existing complex.	
Pine Island Commercial Marina	Bathymetric survey of canal complete by Coastal Engineering Consultants, Inc. Plans and specs expected by end of November 2019.	Dredging along 650 feet of the canal and boat slip, replacing 450 linear feet of seawall along the canal, installing concrete sidewalk, and installing one standard and one boat trailer Americans with Disabilities Act (ADA) parking spaces.	
Lynn Hall Park Boardwalk & Dune Improvement	Construction to start November 2019.	Construction of dune walkovers and ADA ramps.	BoCC awarded contract at the 11/5/19 meeting

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Appendix H.

Lee County Library System's CIP

Library CIP as of November 2019

Project name	Status	Summary
Bonita Springs Public Library	Project was substantially complete on 7/1/2019. Library was open to the public in August 2019. Final completion was issued on 11/27/2019. Punch list is largely complete with a few outstanding warranty items.	New (Replacement) Public Library for Bonita Springs **Budget: $14,195,196**
Administration East Bldg. – Library Administration Office Renovation	In process to hire an architect to start the design.	Library Administration Office to be located to Administration East Building **Budget: $80,000 (Design Only)**
East County Regional Library	Final walk thru completed 6/18/2019. Waiting on close out documents.	AMH addition and miscellaneous renovations **Budget: $550,000**
North Fort Myers Public Library	Project was substantially complete on 6/17/2019. Library was open to the public in August 2019. Final completion was issued on 11/07/2019. Punch list is complete. Working on close out.	New (Replacement) Public Library for North Fort Myers **Budget: $13,637,654**
South County Library Renovations	Not Started.	Building renovations **Budget: $4,000,000**
Riverdale Library Renovations	Not Started.	Building renovations **Budget: $1,500,000**

NW Regional Library Sewer Service	Construction should take place starting April / May 2020 pending public sewer availability.	Public utility connection **Budget: $1,500,000**
***Lakes Regional Library Renovations**	In design / GMP approval pending	Building renovations **Budget: $1,167,973**

*The lakes renovation is technically a budgeted major maintenance project. The funding is from a bequest left specifically to the Lakes Library.

Appendix I.

Child Well-Being Index Summary

Child Well-Being Technical Explanation

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FLORIDA CHILD WELL-BEING INDEX SUMMARY

Keeping a focus on where counties can make life better for our children & families			BROWARD (18th overall)		DUVAL (48th overall)		HILLSBOROUGH (28th overall)	
ECONOMIC WELL-BEING		YEAR	%	Number			%	Number
	Children in poverty	2009	16.6		22.6		22.2	
		2011	20.5		25.5		23.7	
		2014	20.1	79,836	26.7	54,020	23.3	70,010
		2016	18.3	73,826	20.6	42,564	20.0	62,184
		2017	18.0	73,178	23.0	48,079	21.4	67,670
	Unemployment rate	2010	10.2		11.4		10.7	
		2011	9.4		10.3		9.6	
		2015	5.0	49,980	5.7	26,386	5.0	34,139
		2016	4.6	46,241	5.0	23,601	4.5	31,675
		2019*	3.3	34,548	3.7	18,499	3.4	25,376
	High housing cost-burden (>30% income spent)	2010	48.3		40.1		40.8	
		2007-2011	50.8		39.7		42.4	
		2012-2016	44.4	298,721	36.3	124,260	36.3	180,089
		2013-2017	43.5	294,274	34.9	121,502	35.1	177,499
	Teens not in school and not working	2006-2010	8.5		11.2		9.9	
		2012-2016	6.8	6,043	9.4	4,031	7.2	4,987
		2013-2017	6.6	5,895	9.4	4,053	6.9	4,774
EDUCATION WELL-BEING		YEAR	%	Number			%	Number
	3 & 4 year old children not enrolled in school	2007-2011	39.2		46.2		52.4	
		2012-2016	42.1	18,978	51.2	12,670	50.8	17,638
		2013-2017	41.1	18,994	50.9	12,358	52.0	17,978
	4th grade students not proficient in English Language Arts	2014/15	73.0	14,237	77.0		73.0	11,056
		2015/16	75.0	15,395	77.0	7,745	74.0	11,762
		2017/18	69.0	14,162	76.0	7,785	72.0	12,214
		Spring 2019*	66.0	13,174	74.0	7,666	71.0	12,045
	8th grade students not proficient in math	2014/15	75.0		91.0		94.0	7,659
		2015/16	73.0	9,296	86.0	4,856	89.0	7,157
		2017/18	77.0	9,681	91.0	4,571	91.0	7,035
		Spring 2019*	78.0	9,557	90.0	4,379	90.0	7,203
	High school students not graduating on time	2011/12	23.6		32.3		27.4	
		2014/15	23.4		23.4	1,980	24.0	3,485
		2015/16	21.3	4,208	21.2	1,740	20.9	3,073
		2016/17*	19.0		19.2		17.1	
		2017/18*	15.7		14.9		14.2	

FLORIDA CHILD WELL-BEING INDEX SUMMARY

Keeping a focus on where counties can make life better for our children & families			BROWARD (18th overall)		DUVAL (48th overall)		HILLSBOROUGH (28th overall)	
HEALTH WELL-BEING		YEAR	%	Number			%	Number
	Low-birthweight babies	2010	9.1		9.3		9.1	
		2011	9.3		9.0		9.4	
		2015	9.3	2,074	10.0	1,306	9.0	1,586
		2016	9.7	2,194	10.0	1,330	8.9	1,541
		2017	9.7	2,164	10.0	1,315	9.3	1,613
	Uninsured children	2009	26.7		19.7		21.6	
		2010	14.6		9.9		10.6	
		2014	10.5	43,850	7.1	15,033	7.9	25,006
		2015	7.3	31,110	6.1	12,897	6.4	20,483
		2016	7.0	29,524	5.3	11,332	5.5	18,020
		2017*	8.3	35,698	6.5	14,005	7.1	23,765
	Overweight and obese 1st, 3rd & 6th grade students	2008/09	36.7		24.2		29.3	
		2010/11	17.6		29.7		33.8	
		2013/14	41.0	18,616	32.5	7,630	33.8	15,668
		2015/16	34.8	19,732	32.9	8,773	34.1	16,917
		2016/17*	31.7	16,606	32.9	8,912	33.9	16,647
		2017/18	31.3	18,210	33.6	9,046	25.7	13,711
	High school teens who used alcohol/drugs (past 30 days)	2010	39.9		43.0		47.1	
		2012	38.9		37.3		36.6	
		2014	32.3	356	38.3	402	37.7	341
		2016	34.2	192	33.4	302	32.1	236
		2018	27.2	154	29.2	166	30.4	
FAMILY & COMMUNITY		YEAR	%	Number			%	Number
	Children in single parent families	2006-2010	33.5		36.6		35.5	
		2011-2015	35.7	126,385	40.8	72,455	36.9	97,309
		2012-2016	35.9	126,999	40.3	72,256	37.0	99,104
		2013-2017	36.6	129,581	39.2	71,171	37.2	101,309
	Children living in high poverty areas	2006-2010	7.6		11.7		11.5	
		2011-2015	9.3	37,321	15.4	31,588	14.9	45,172
		2012-2016	7.5	30,066	14.0	28,885	15.2	46,576
		2013-2017	8.8	35,865	14.1	29,232	12.6	39,265
	Children with verified maltreatment (per 1,000)	2011/12	9.7		9.3		7.8	
		2015/16	11.7	4608	10.7	2244	9.5	3029
		2016/17	10.3	4,117	9.6	2058	8.7	2,782
		2017/18	8.9	3,569	9.1	1973	7.5	2,468
	Youth contacts with the juvenile justice system (per 1,000)	2009/10	37.7		42.9		43.7	
		2011/12	29.3		29.7		31.3	
		2014/15	15.4	2,785	24.0	2,137	24.4	3,354
		2016/17	12.1	2,170	17.9	1,636	18.5	2,625
		2017/18	11.2	2,007	12.5	1,150	17.2	2,486
Data from: http://floridakidscount.org/ 2017, 2018, 2019 INDEX								
*Updates made using the same sources more recent data or additional categories rows were not included in the FL Child Well-Being Index								

FLORIDA CHILD WELL-BEING INDEX SUMMARY

Keeping a focus on where counties can make life better for our children & families		LEE (42nd overall)		MANATEE (27th overall)		MARTIN (8th overall)	
ECONOMIC WELL-BEING		%	Number	%	Number	%	Number
	Children in poverty	18.2		23.1		22.1	
		25.9		26.7		21.9	
		26.1	32,594	22.5	14,980	20.7	5,264
		22.0	28,354	20.5	14,321	17.9	4,634
		20.4	26,584	17.0	11,868	16.7	4,356
	Unemployment rate	12.5		11.4		10.8	
		10.9		10.0		9.9	
		5.0	16,084	5.0	8,162	5.2	3,670
		4.6	15,077	4.6	7,693	4.9	3,465
		3.4	11,799	3.4	6,124	3.5	2,618
	High housing cost-burden (>30% income spent)	38.8		38.5		37.4	
		42.5		41.1		37.9	
		34.0	87,744	33.1	44,958	33.7	21,199
		33.0	87,320	31.9	44,793	31.8	20,173
	Teens not in school and not working	9.4		10.3		8.7	
		8.4	2,345	8.8	1,318	7.3	468
		8.2	2,359	9.1	1,374	5.6	360
EDUCATION WELL-BEING		%	Number	%	Number	%	Number
	3 & 4 year old children not enrolled in school	56.2		56.4		46.8	
		58.6	7,849	58.0	4,390	39.5	987
		57.8	7,673	56.9	4,189	41.7	1,158
	4th grade students not proficient in English Language Arts	75.0	4,804	73.0	2,508	71.0	
		74.0	4,948	76.0	2,923	75.0	1,018
		74.0	5,248	72.0	2,824	72.0	950
		73.0	5,031	70.0	2,665	72.0	929
	8th grade students not proficient in math	86.0	2,949	78.0	2,508	59.0	
		81.0	3,140	75.0	2,048	68.0	751
		81.0	3,599	84.0	1,773	62.0	655
		66.0	3,863	86.0	1,721	59.0	632
	High school students not graduating on time	28.1		23.8		15.1	
		25.3	1,630	22.1	643	11.1	171
		22.2	1,367	16.5	459	11.3	172
		21.3		18.9		16.1	
		17.2		14.6		12.1	

FLORIDA CHILD WELL-BEING INDEX SUMMARY

Keeping a focus on where counties can make life better for our children & families		LEE (42nd overall)		MANATEE (27th overall)		MARTIN (8th overall)	
HEALTH WELL-BEING		%	Number	%	Number	%	Number
	Low-birthweight babies	7.8		7.9		7.0	
		7.9		8.3		7.9	
		7.5	510	6.8	237	5.3	67
		8.6	581	7.6	262	7.5	96
		8.0	536	7.8	271	7.2	91
	Uninsured children	25.8		24.3		22.4	
		15.7		13.0		15.2	
		13.0	17,096	9.9	7,036	9.6	2,639
		9.3	12,382	7.9	5,655	12.3	3,323
		8.0	10,918	7.0	5,168	9.0	2,483
		9.3	12,655	7.5	5,569	10.5	2,907
	Overweight and obese 1st, 3rd & 6th grade students	28.0		44.5		32.2	
		34.0		52.7		32.9	
		32.1	6,204	29.7	2,592	32.3	1,296
		33.9	6,407	3.7	3,764	33.6	1,313
		33.6	6799	29.7	3,258	35.4	1,386
		36.2	8101	31.1	3,477	36.0	1,464
	High school teens who used alcohol/drugs (past 30 days)	42.8		43.8		45.2	
		42.5		34.6		42.4	
		35.2	180	33.4	147	36.5	144
		30.5	224	30.5	275	38.9	200
		32.2		31.7		37.4	
FAMILY & COMMUNITY		%	Number	%	Number	%	Number
	Children in single parent families	30.7		34.3		28.3	
		38.9	43,622	34.5	20,167	27.6	6,531
		39.0	44,302	35.2	20,851	27.7	6,450
		37.4	42,431	35	21,003	29.1	6,897
	Children living in high poverty areas	8.3		17.5		11.1	
		10.5	13,231	21.2	14,348	2.8	724
		11.7	14,781	15.9	10,922	13	3,382
		11.8	15,178	14.1	9,807	3.7	975
	Children with verified maltreatment (per 1,000)	7.2		11.2		5.5	
		8.1	1,044	17.4	1208	7.2	176
		8.9	1,151	14.4	1,032	9.6	233
		6.5	870	11.6	851	7.6	188
	Youth contacts with the juvenile justice system (per 1,000)	41.0		54.3		41.9	
		30.7		41		31.1	
		22.1	1,228	32.4	980	20.1	242
		18.3	1,069	21.3	681	18.6	220
		16.8	1,011	21.7	703	14.9	178
Data from: http://floridakidscount.org/ 2017, 2018, 2019 INDEX							

FLORIDA CHILD WELL-BEING INDEX SUMMARY

Keeping a focus on where counties can make life better for our children & families		MIAMI-DADE (44th overall)		OKEECHOBEE (59th overall)		PALM BEACH (10th overall)	
ECONOMIC WELL-BEING		%	Number	%	Number	%	Number
	Children in poverty	24.0		31.7		21.5	
		28.9		36.2		24.1	
		27.7	149,722	35.3	2,986	21.9	
		24.8	135,018	29.4	2,527	19.0	52,473
		22.0	121,165	31.3	2,635	16.8	47,117
	Unemployment rate	11.1		12.6		11.0	
		9.4		11.9		10.0	
		6.1	81,983	6.2	1,068	5.0	34,867
		5.4	72,494	5.4	956	4.8	34,228
		3.3	47,135	4.1	719	3.6	26,706
	High housing cost-burden (>30% income spent)	52.9		34.7		44.7	
		54.6		39.6		46.1	
		49.3	421,253	28.3	3,633	39.9	214,719
		48.5	416,055	25.3	3,372	39.1	212,377
	Teens not in school and not working	10.4		19.8		8.8	
		8.4	10,587	13.3	304	6.2	3,895
		7.8	9,892	15.0	353	6.1	3,875
EDUCATION WELL-BEING		%	Number	%	Number	%	Number
	3 & 4 year old children not enrolled in school	42.8		73.6		44.3	
		40.0	25,565	72.3	804	42.9	12,904
		40.0	25,620	72.2	754	41.2	12,518
	4th grade students not proficient in English Language Arts	73.0	18,165	84.0		73.0	9,822
		71.0	19,015	81.0	382	71.0	10,132
		67.0	17,695	84.0	389	69.0	10,147
		64.0	16,640	81.0	361	66.0	9,472
	8th grade students not proficient in math	87.0	13,642	91.0		76.0	6,439
		84.0	13,907	82.0	251	61.0	7,690
		85.0	12,920	77.0	280	57.0	7,409
		85.0	12,051	83.0	269	59.0	8,284
	High school students not graduating on time	24.0		41.1		23.0	
		21.9	5,818	34.1	165	20.6	2,967
		19.6	5,209	29.5	124	17.7	2,446
		19.3		28.3		15.0	
		14.6		23.1		12.8	

FLORIDA CHILD WELL-BEING INDEX SUMMARY

Keeping a focus on where counties can make life better for our children & families		MIAMI-DADE (44th overall)		OKEECHOBEE (59th overall)		PALM BEACH (10th overall)	
HEALTH WELL-BEING		%	Number	%	Number	%	Number
	Low-birthweight babies	9.1		10.0		8.9	
		8.7		7.9		9.1	
		8.4	2733	7.3	38	8.5	1,259
		8.6	2,809	7.2	35	8.3	1,236
		8.4	2,657	9.3	50	8.5	1,281
	Uninsured children	34.0		31.2		25.7	
		17.2		14.1		15.8	
		9.8	55,839	13.2	1,177	11.3	31,912
		7.8	44,501	11.1	980	8.8	25,332
		6.8	38,760	8.1	718	7.7	22,525
		6.7	38,773	9.7	839	8.4	24,691
	Overweight and obese 1st, 3rd & 6th grade students	42.9		34.8		39.3	
		43.9		31.5		38.8	
		37.7	25,371	39.6	622	37.6	12,998
		40.3	17,525	37.9	552	37.5	14,654
		40.6	17,386	40.8	612	36.8	14,823
		41.6	26,650	41.4	578	36.7	10,711
	High school teens who used alcohol/drugs (past 30 days)	41.8		51.8		46.0	
		43.4		45.0		43.7	
		37.2	321	41.1	218	40.7	398
		31.1	203	30.5	138	33.3	306
		31.1		32.5		31.4	
FAMILY & COMMUNITY		%	Number	%	Number	%	Number
	Children in single parent families	35.3		32.4		33.9	
		36.8	172,002	40.9	2,814	35.0	84,523
		37.5	174,609	37.8	2,481	34.8	84,561
		37.6	175,723	32.4	2,188	33.8	82,868
	Children living in high poverty areas	13.8		7.6		8.0	
		22.7	124,875	49.6	4,474	14.8	40,375
		20.5	112,390	30.1	2,701	12.4	34,186
		18.7	103,273	24.7	2,194	11.3	31,440
	Children with verified maltreatment (per 1,000)	5.1		24.1		7.3	
		4.4	2499	15.5	146	5.0	1,364
		3.9	2,200	16.5	156	4.3	1,168
		2.9	1,648	17.2	162	4.2	1,186
	Youth contacts with the juvenile justice system (per 1,000)	27.5		47.7		31.1	
		16.2		35.4		25.4	
		11.1	2,788	19.9	85	17.4	2,152
		8.2	2,084	21.1	93	14.6	1,808
		7.5	1,925	30.2	134	14.6	1,840
Data from: http://floridakidscount.org/ 2017, 2018, 2019 INDEX							

FLORIDA CHILD WELL-BEING INDEX SUMMARY

Keeping a focus on where counties can make life better for our children & families		PINELLAS (29th overall)		ST. LUCIE (37th overall)		State of Florida	
ECONOMIC WELL-BEING		%	Number	%	Number		
	Children in poverty	18.7		25.4		21.5	
		23.6		31.7		25.1	
		22.2	34,874	36.6	15850.0	24.2	962,857
		19.6	30,877	26.3	16,032	21.3	869,892
		17.2	27,024	19.1	11,873	20.6	850,924
	Unemployment rate	10.8		13.8		11.1	
		9.7		12.6		10.0	
		4.9	23,111	6.2	8,191	5.4	522,065
		4.4	21,081	5.7	7,601	4.9	480,368
		3.1	15,865	4.3	6,327	3.5	363,000
	High housing cost-burden (>30% income spent)	38.9		44.0		41.8	
		42.1		47.4		43.1	
		36.2	146,807	37.6	40,907	37.3	2,754,755
		35.3	143,678	36.2	39,878	36.1	2,712,928
	Teens not in school and not working	9.0		10.1		9.7	
		8.7	3,154	5.9	802	8.0	75,614
		8.0	2,896	5.7	792	7.7	73,002
EDUCATION WELL-BEING		%	Number	%	Number		
	3 & 4 year old children not enrolled in school	53.2		52.4		48.9	
		49.9	8,537	55.6	3,827	49.5	223,266
		49.2	8,493	52.8	3,647	49.5	223,989
	4th grade students not proficient in English Language Arts	75.0	5,402	81.0	2,382	73.0	
		74.0	5,521	82.0	2,442	74.0	154,853
		75.0	5,743	77.0	2,365	71.0	153,187
		72.0	5,288	76.0	2,231	70.0	147,939
	8th grade students not proficient in math	93.0	3,230	82.0	1,805	81.0	
		90.0	3,536	83.0	1,741	78.0	105,044
		91.0	3,552	90.0	1,644	80.0	104,397
		91.0	3,046	88.0	1,475	79.0	103,199
	High school students not graduating on time	28.0		29.4		25.5	
		21.7	1,696	24.5	728	22.1	44,254
		19.9	1,527	13.2	382	19.3	38,214
		17.1		9.9		17.7	
		14.0		8.2		13.9	29,124

FLORIDA CHILD WELL-BEING INDEX SUMMARY

Keeping a focus on where counties can make life better for our children & families		PINELLAS (29th overall)		ST. LUCIE (37th overall)		State of Florida	
HEALTH WELL-BEING		%	Number	%	Number		
	Low-birthweight babies	9.1		8.9		8.7	
		8.8		8.1		8.7	
		7.6	663	7.8	243	8.6	19,367
		8.5	719	8.7	262	8.7	19,661
		8.8	725	8.6	259	8.8	19,699
	Uninsured children	22.4		25.6		8.7	
		11.0		15.0		13.4	
		8.4	13,983	10.0	6283	9.7	406,126
		6.0	10,010	7.1	4,464	7.3	312,070
		7.0	11,650			6.6	282,464
		6.5	10,815	5.5	3,102	7.2	314,181
	Overweight and obese 1st, 3rd & 6th grade students	32.4		40.7		34.5	
		34.9		38.7		34.4	
		40.5	9,292	40.4	3,548	35.5	194,508
		41.9	11,366	39.8	3,255	35.0	199,422
		35.9	8,234	39.9	3,573	34.3	193,809
		35.1	7,565	43.5	3,744	34.5	205,359
	High school teens who used alcohol/drugs (past 30 days)	44.6		44.5		43.6	
		37.1		38.4		40.4	
		37.1	491	35.9	167	36.3	11,157
		36.8	257	27.7	123	32.9	12,425
		30.5		33.4		29.5	9,187
FAMILY & COMMUNITY		%	Number	%	Number		
	Children in single parent families	35.7		34.2		33.2	
		38.3	53,185	34.8	18,930	35.7	1,253,515
		37.7	52,221	35.9	19,378	35.7	1,258,425
		37.0	51,500	35.2	19,048	35.3	1,258,424
	Children living in high poverty areas	5.8		9.2		8.5	
		7.0	11,241	13.0	7,947	13.5	547,478
		9.5	15,251	12.7	7,740	12.3	500,585
		7.0	11,234	10.2	6,249	11.2	458,646
	Children with verified maltreatment (per 1,000)	14.8		9.5		9.3	
		14.6	2,357	8.5	527	9.4	38843
		12.8	2,078	7.4	4,563	8.3	34,481
		11.9	1,944	7.4	472	7.5	31,585
	Youth contacts with the juvenile justice system (per 1,000)	41.9		46.7		40.4	
		31.8		33.8		30.0	
		30.8	2,262	26.9	745	23.0	42,211
		21.3	1,551	21.4	602	17.8	33,389
		20.7	1,507	20.8	591	16.4	31,206
Data from: http://floridakidscount.org/ 2017, 2018, 2019 INDEX							
*Updates made using the same sources more recent data or additional cate							

2019 Florida Child Well-being Index - Terminology and Sources

All rates are per 100 (percentages) unless otherwise noted.
An asterisk (*) represents data that are suppressed due to confidentiality. This is when there are less than 10 when reporting a number or when the denominator is less than 100 when reporting a percentage.
An increase or decrease of at least 1% constitutes change.

Index Rank
Rankings are based on a scale containing 16 indicators of child well-being. Indicators in each category are:

Economic- children in poverty, unemployment rate, high housing cost burden, teens not in school and not working
Education- 3 and 4 year old children not enrolled in school, fourth-grade students not proficient in English Language Arts, eighth-grade students not proficient in math, high school students not graduating on time
Health- low-birthweight babies, uninsured children, overweight and obese 1st, 3rd, and 6th-grade students, high school teens who used alcohol/drugs in the past 30 days.
Family and Community- children in single parent families, children living in high poverty areas, children with verified maltreatment, and youth contacts with the Juvenile Justice System.

Given the nature of our data, we were able to convert all data to ratios by county. Working with ratios by county gave us the advantage to compare all counties fairly, regardless of the county's population size. All of our indicators were selected to follow the same direction, in our case, lower numbers are best. That way when we summed all ratios, high values in one indicator did not mask low values in another or vice versa. Scores for each indicator were summed to produce a score for each of the four categories by county. Then, the scores for the four categories were summed to produce an overall county score. The counties were ranked from 1 (best) to 67 (worst) for each category and as an overall rank for the state.

Economic
Children in poverty – Children under age 18 who are living below the federal poverty level as determined by the U.S. Census Bureau's Small Area Income and Poverty Estimates (SAIPE) program.

In 2017, the poverty threshold for two adults and two children under age 18 was $24,858.

The U.S. Census Bureau's Small Area Income and Poverty Estimates (SAIPE) program provides annual estimates of income and poverty statistics for all school districts, counties, and states. The main objective of this program is to provide estimates of income and poverty for the administration of federal programs and the allocation of federal funds to local jurisdictions. In addition to these federal programs, state and local programs use the income and poverty estimates for distributing funds and managing programs. The estimates are not direct counts from enumerations or administrative records, nor direct estimates from sample surveys. Instead, for counties and states, they model income and poverty estimates by combining survey data with population estimates and administrative records. For school districts, they use the model- based county estimates and inputs from federal tax information and multi-year survey data to produce estimates of poverty. Detailed information about SAIPE methodology and data input can be found at https://www.census.gov/programs-surveys/saipe.html

U.S. Census Bureau, Small Area Income and Poverty Estimates, Washington, DC

Unemployment rate – The unemployment rate represents the number unemployed as a percent of the labor force.

Unemployed - All persons who had no employment during the reference week (identified in the survey), were available for work, except for temporary illness, and had made specific efforts to find employment sometime during the 4-week period ending with the reference week. Persons who were waiting to be recalled to a job from which they had been laid off need not have been looking for work to be classified as unemployed.

Employed - All persons who, during the reference week, (a) did any work at all (at least 1 hour) as paid employees, worked in their own business, profession, or on their own farm, or worked 15 hours or more as unpaid workers in an enterprise operated by a member of the family, and (b) all those who were not working but who had jobs or businesses from which they were temporarily absent because of vacation, illness, bad weather, childcare problems, maternity or paternity leave, labor-management dispute, job training, or other family or personal reasons, whether or not they were paid for the time off or were seeking other jobs

Labor force - comprises all persons age 16 and older classified as employed or unemployed.

The Local Area Unemployment Statistics (LAUS) program is a federal-state cooperative effort in which monthly estimates of total employment and unemployment are prepared for approximately 7,500 areas. These estimates are key indicators of local economic conditions. The Bureau of Labor Statistics (BLS) of the U.S. Department of Labor is responsible for the concepts, definitions, technical procedures, validation, and publication of the estimates that state workforce agencies prepare under agreement with BLS. The concepts and definitions underlying LAUS data come from the Current Population Survey (CPS), the household survey that is the source of the national unemployment rate. State monthly model- based estimates are controlled in "real time" to sum to national monthly employment and unemployment estimates from the CPS. These models combine current and historical data from the CPS, the Current Employment Statistics (CES) survey, and state unemployment insurance (UI) systems. Estimates for counties are produced through a building-block approach known as the "Handbook method." This procedure also uses data from several sources, including the CPS, the CES program, state UI systems, and the Census Bureau's American Community Survey (ACS), to create estimates that are adjusted to the statewide measures of employment and unemployment. Detailed information about unemployment statistics can be found at https://www.bls.gov/lau/

U.S. Department of Labor, Bureau of Labor Statistics, Washington, DC

High housing cost burden – Occupied households (both owner and renter occupied) that spent more than 30 percent of their monthly income for housing costs (rent, mortgage payments, taxes, insurance, and/or related expenses).

U.S. Census Bureau, American Community Survey 2013-2017 5 year estimates, table B25106

Teens not in school and not working – Teens age 16-19 who were not enrolled in school, were unemployed, and were not in the labor force.

Not enrolled in school – All teens age 16-19 not enrolled in school either part-time or full-time. Unemployed – All civilians age 16-19 are classified as unemployed if they (1) were neither “at work” nor “with a job but not at work” during the reference week, and (2) were actively looking for work during the last 4 weeks, and (3) were available to start a job. Also included as unemployed are civilians who did not work at all during the reference week, were waiting to be called back to a job from which they had been laid off, and were available for work except for temporary illness.

Not in the labor force - All people age 16-19 who are not classified as members of the labor force. this category consists mainly of students, homemakers, retired workers, and seasonal

workers interviewed in an off season that were not looking for work, institutionalized people, and people doing only incidental unpaid family work (less than 15 hours during the reference week).

U.S. Census Bureau, American Community Survey 2013-2017 5 year estimates, table B14005

Education

3 & 4 year old children not enrolled in school –3 and 4 year old children who were not enrolled in either public or private school at any time during the 3 months prior to the time of the interview.

U.S. Census Bureau, American Community Survey 2013-2017 5 year estimates, table B14003

The Florida Standards Assessment (FSA) has replaced the Florida Comprehensive Assessment Test 2.0 (FCAT 2.0). Beginning with the 2014-15 school year the student assessment results reported are based on the new standards. Students FSA responses are scored into 5 categories:
Level 1- Inadequate – Highly likely to need substantial support for the next grade/course. Level 2 - Below satisfactory – Likely to need substantial support for the next grade/course. Level 3 - Satisfactory – May need additional support for the next grade/course.
Level 4 - Proficient – Likely to excel in the next grade/course.
Level 5 - Mastery – Highly likely to excel in the next grade/course.

Fourth grade students not proficient in English Language Arts –4th grade students scoring inadequate, below satisfactory, and satisfactory on the English Language Arts FSA.

Eighth grade students not proficient in math - 8th grade students scoring inadequate, below satisfactory, and satisfactory on the Math FSA.

Note: Due to no students having been reported as tested in Franklin County for the 8th grade mathematics portion of the Florida Standard Assessment for school year 2017/2018, 2016/17 data were used for the current year.

Bureau of K-12 Student Assessment, Florida Department of Education, Tallahassee, Florida

High school students not graduating on time - High school students not graduating on time as defined by the Federal Graduation Rate.

Federal Graduation Rate - Federal regulations require each state to calculate a four-year adjusted cohort graduation rate, which includes standard diplomas but excludes GEDs, both regular and adult, and special diplomas. The US Department of Education (USED) adopted this calculation method in an effort to develop uniform, accurate and comparable graduation rates across all states. The USED required states to begin calculating the new graduation rate in 2010-11.

Florida's graduation rate is a cohort graduation rate. A cohort is defined as a group of students on the same schedule to graduate. The graduation rate measures the percentage of students who graduate within four years of their first enrollment in ninth grade. Subsequent to their enrollment in ninth grade, students who transfer out and deceased students are removed from the calculation. Entering transfer students are included in the graduation rate for the class with which they are scheduled to graduate, based on their date of enrollment. In the calculation, stringent guidelines are prescribed for not only the definition of a graduate, but also for the

definition of a transfer.
Students who transfer to adult education programs or Department of Juvenile Justice (DJJ) facilities remain with their regular high schools' cohorts.

Bureau of Accountability and Reporting, Florida Department of Education, Tallahassee, Florida

Health

Low birthweight babies – Infants born to resident mothers who weighed less than 2,500 grams (5 lbs. 8.2 oz.) at birth.

Division of Public Health Statistics and Performance Management, Florida Department of Health, Tallahassee, Florida

Uninsured children – Children under age 19 with no health insurance coverage.

The U.S. Census Bureau's Small Area Health Insurance Estimates (SAHIE) program produces timely, single-year estimates for all counties and states by detailed demographic and income groups.
SAHIE are model-based enhancements of the American Community Survey (ACS) estimates created by integrating additional information from administrative records, postcensal population estimates, and decennial census data. SAHIE methodology employs statistical modeling techniques to combine this supplemental information with survey data to produce estimates that are more reliable. SAHIE are broadly consistent with the direct ACS survey estimates, but with the help from other data sources, SAHIE estimates are more precise than the ACS 1-year and 5-year survey estimates for most counties. Detailed information about SAIPE methodology and data input can be found at https://www.census.gov/programs-surveys/sahie.html

U.S. Census Bureau, Small Area Health Insurance Estimates, Washington, DC

Overweight and obese 1st, 3rd, and 6th grade students –1st, 3rd, and 6th grade students with a body mass index greater than or equal to the 85th percentile.

Florida schools are required to do Body Mass Index (BMI) screenings for students in 1st, 3rd, and 6th grade to identify children who are at risk for obesity which may lead to other health problems. The screening uses the child's age, height, and weight to determine body density. It does not take into account muscle mass or bone structure. BMI is a number calculated from a person's weight and height. BMI provides a reliable indicator of body fatness for most people and is used to screen for weight categories that may lead to health problems.

Healthy weight – 5th through the 84th percentile Underweight – less than the 5th percentile Overweight – 85th through the 94th percentile Obese – greater than or equal to 95th percentile

Division of Community Health Promotion, Florida Department of Health, Tallahassee, Florida

High school teens who used alcohol/drugs (past 30 days) – Surveyed high school youth who indicated use of alcohol or any illicit drug in the past 30 days.

The Florida Youth Substance Abuse Survey (FYSAS) is a collaborative effort between the Florida departments of Health, Education, Children and Families, Juvenile Justice, and the Governor's Office

of Drug Control. It is based on the "Communities That Care" survey, assessing risk and protective factors for substance abuse, in addition to substance abuse prevalence.
Each year there are minor adjustments made to the FYSAS instrument (i.e. in 2011 two items measuring the use of synthetic marijuana were added), therefore caution should be used when comparing measures from one year to another. Detailed information about the survey and methodology can be found at https://www.myflfamilies.com/service-programs/samh/prevention/fysas/Note: 2012 data were used for the baseline year for Hardee County due to no students being reported as participating in the Florida Youth Substance Abuse Survey in 2014.

Note: 2016 data were used for the current year for Hardee and Taylor counties due to no students being reported as participating in the Florida Youth Substance Abuse Survey in 2018.

2018 Florida Youth Substance Abuse Survey
Substance Abuse and Mental Health Program Office, Florida Department of Children and Families, Tallahassee, Florida

Family and Community
Children in single parent families – Children under age 18 living in families with only one parent present. Parent is either a male householder or a female householder with no spouse present.

U.S. Census Bureau, American Community Survey 2013-2017 5 year estimates, table B09002

Children living in high poverty areas – Children under age 18 living in census tracts where the poverty rates of the total population are 30% or more.

In 2017, the poverty threshold for two adults and two children under age 18 was $24,858.

Population Reference Bureau analysis of data from the U.S. Census Bureau, 2000 Decennial Census Summary File 1 and Summary File 3 and the 2006-2010 to 2013–2017 American Community Survey 5- year data.
Population Reference Bureau, Washington, DC

Children with verified maltreatment – Children (unduplicated) with at least one finding of verified maltreatment (child abuse and / or neglect). The number of children with verified maltreatment and the total child population (ages 0-17) in each county was used to calculate a maltreatment rate per 1,000 children. Data are reported for the period July 1, 2017 to June 30, 2018.

> Investigation- Once a call to the Florida Abuse Hotline is accepted, it is referred to either the Department of Children and Families or the Sheriff's office for a Child Protective investigation.

The term verified maltreatment is used when a preponderance of credible evidence exists and results in a determination that the specific harm or threat of harm was the result of abuse, abandonment or neglect.

FSFN Data Repository; Run Date 9/13/2018
Florida Department of Children and Families, Tallahassee, Florida

January 1, 2013 and 2017 Population Estimates
Office of Economic and Demographic Research, Florida Legislature

Youth contacts with the Florida Juvenile Justice System – Youth (unduplicated) taken into custody by

a law enforcement officer based on probable cause and charged with a law violation. Youth are not arrested but rather screened and assessed through the Florida Department of Juvenile Justice (FLDJJ) intake process. The number of children screened through the intake process and the total child population (ages 10-17) in each county was used to calculate a rate per 1,000 youth.

Bureau of Research & Data Integrity, Florida Department of Juvenile Justice, Tallahassee,

Florida January 1, 2018 Population Estimates
Office of Economic and Demographic Research, Florida Legislature

Appendix J.

Calculating Household Income

Appendix J: Household Income and Federal Poverty Level: Critiques of the methodologies:

Household Income

Critique #1: How the Census measures household income in incomplete

Basically only cash income (wages, interest or dividends, social security, etc.) is measured. Items not measured include taxes paid, earned income tax credit benefits received, and all kinds of noncash benefits. If you get something from the government that's not cash — Medicare or Medicaid or SNAP, for example — that's not income. And if you get something from your job that's not cash, health insurance for example, that's not income either[769].

Critique #2 The census's inflation measure is too pessimistic

The Census Bureau adjusts for inflation using the consumer price index rather than either of the two main "chained" price indexes that economists generally regard as more accurate, and which tend to grow less year to year

Critique #3 Demographic effects make comparisons of median incomes tricky

Compared with 1999, the current American population contains a greater share of retired people and a greater share of people in their early 20s because the millennial and baby boom generations contain more people than the Silent Generation and Generation X cohorts.

The flip side is that in 1999, experienced middle-aged workers made up a larger share of our population. Both retired people and inexperienced workers earn less than veteran workers.

Consequently, the demographic shift from millennials being small children to millennials being young workers pushes median household income down. The demographic shift

[769] Yglesisas, M. 2016. 5 ways the census income report misleads us about the real state of the U.S. Economy. www.vox.com. 9/15/2016

from older boomers being experienced workers to being retirees also pushes median household income down.

Critique #4: Household size is shrinking

Generally, the fewer people in a household, the lower the household income. Depending on the details of your life (child support, housing arrangements, tax status, etc.), your actual disposable income may go up or down. But the census doesn't care about disposable income; it's very simplistically looking at household money income.

Critique #5: The survey data is problematic

The census report is survey data — basically a big poll. Polls are great when you don't have better information.

Quoting Yeglesisas, "*using a survey to assess Americans' income in 2015 is a little like running a poll to figure out who won the 2012 election when you could count the votes instead. The problem here is federal privacy laws generally prohibit government statistical agencies from relying on administrative data to produce national economic statistics.*

The same applies, of course, to government social programs. Instead of running a poll on how many people get federal housing assistance, we could look at housing agencies' records. When ***Bruce Meyer and Nikolas Mittag got access to New York state administrative data****, they found massive undercounting in the surveys of the number of people who were getting useful stuff from the government. They found that more than a third of people getting housing assistance, 40 percent of people getting food stamps, and 60 percent of people getting TANF or state-based general assistance didn't say so when surveyed. And even people who said they got assistance underestimated how much they were getting.*

In total, the administrative data showed that the poverty rate was about 2.5 percentage points lower than the surveys showed."[770]

[770] ibid.

Federal Poverty Guidelines[771]

Background

A poverty measure typically has two components: the thresholds used to determine whether an individual or family's income is below the poverty line, and the resource-counting rules used in making that determination.

Critique #1: The thresholds are out of date

Current poverty thresholds were established in the 1960s. At that time, research indicated that the typical family spent about one-third of its income on food, so poverty thresholds were derived by multiplying a low-cost food budget by three. Since then the thresholds have only been adjusted for inflation. A family is considered poor if its pre-tax cash income falls below the applicable poverty threshold. Living costs and standards have changed in many ways since the 1960s. Food now comprises only about one-seventh of an average family's expenditures. The poverty line represented nearly 50% of median income for a family of four in the early 1960s, but now represents only about 28% of median income. So, the level at which a family is considered poor has fallen further and further outside the mainstream.

Critique #2: The thresholds are essentially arbitrary

This is because they simply represent a number calculated more than 40 years ago and then adjusted for inflation, and they no longer represent anything in relation to family incomes or costs.

Critique #3: The resource-counting rules both understate and overstate resources.

They fail to reflect the effects of policies such as refundable tax credits, near-cash benefits such as Supplemental Nutrition Assistance Program (formerly food stamps) or subsidized housing assistance. At the same time, they also do not consider the impact for family budgets of tax liabilities, work expenses, or health care costs.

Critique #4: The rules make no adjustment for geographical variation.

There are large variations in costs across areas and regions of the country.

[771] Poverty vs Federal Poverty Level. www.publichealthonline.gwu.edu/blog/poverty-vs-federalpovertylevel

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Appendix K.

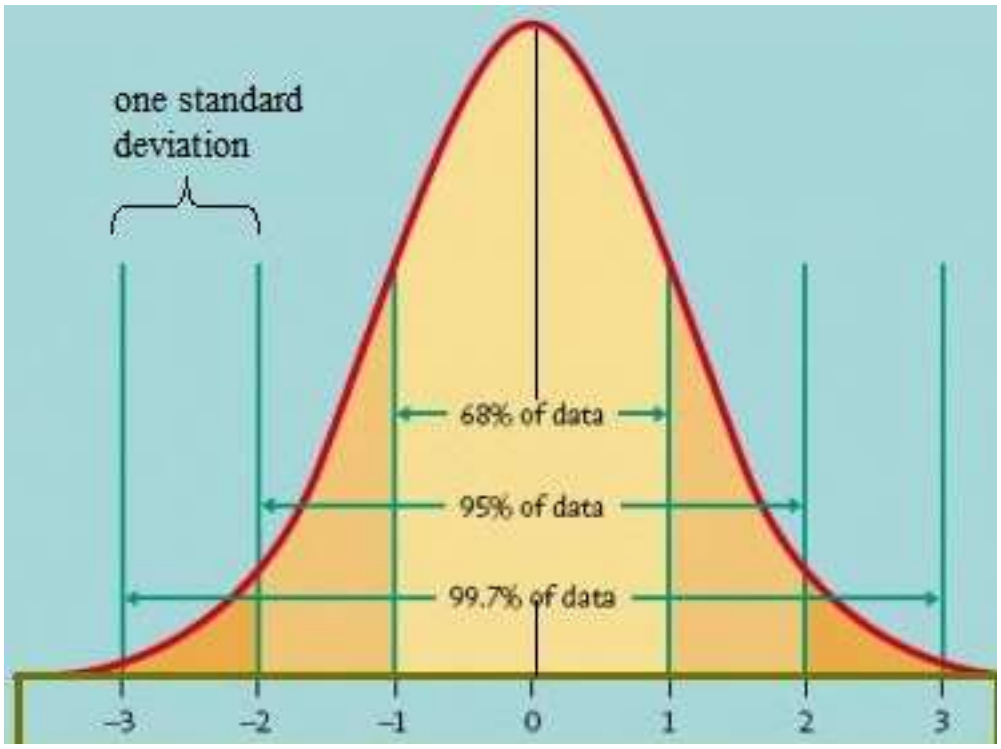
The Bell Curve and Smoothing Data

Appendix J: The Bell Curve and Smoothing Data

The Bell Curve

The Bell Curve is a statistical model presenting the assumed frequency of a normal distribution of data. It is shown in figure 39. The "0" represents the mean score of the distribution. 68.2% of the scale will fall within one standard deviation of the mean.

Figure 39. The Bell Curve and Its Standard Deviations



The Data Issue

This report draws its data from a variety of sources, some private but primarily official governmental sources. Most of this data involves one or more of the following methods:

- National, state or local surveys which sample the overall population
- Local public records which have been aggregated;
- State level data collected from state agencies which are organized into various geographical sub-regions
- Aggregations of various data bases

While each of these sources provides helpful data, each has its own limitations. These include:

- Differences in data collection practices which can range from consistency and quality of data collection to differing interpretation of variables;
- Differences in data reporting from year to year;
- Data may be collected at a general level without the detailed data that enables a more granular analysis. This can create the need for data interpolation or other forms of estimation;
- Vagueness in survey questions;
- Survey responses may be inaccurate due to memory, mis-understanding of the question, survey fatigue or a hesitation to provide full information for some reason.

Table 121 is an illustration of the data interpretation challenge. The data in the table is aggregated data used to create an overall child wellbeing index for Florida counties. As the table shows, there can be significant variation in annual rankings. Averaging is one way of smoothing this data so that a more reliable and valid ranking can be developed. It also serves as a cautionary tale in any comparative rankings or ratings that hard precision is illusionary. It is an over-simplification that a small average difference is in any way meaningful.

Table 121. Overall Child Well Being Rankings: Top Ten Counties 3 Year Average[772]

County	2019	2018	2017	Rank of 67 Counties 3-Year Average
Saint Johns	1	1	3	**1.7**
Okaloosa	3	2	4	**3.0**
Sarasota	5	4	1	**3.3**
Nassau	6	3	2	**3.7**
Santa Rosa	2	6	8	**5.3**
Martin	8	8	5	**7.0**
Clay	12	5	6	**7.7**
Brevard	14	9	12	**11.7**
Wakulla	7	16	19	**14.0**
Leon	16	10	18	**14.7**

These factors require caution in data interpretation. Cautionary steps include:

- Use of multiple data sources where available;
- Use of multi-year data where available;
- The smoothing of data through various statistical techniques such as moving averages or exponential smoothing;[773]
- Use of error rates in probability sampling;
- Reference to meta-analysis studies if available;
- Formulation of alternative hypotheses;
- Examination of alternative explanations via literature review.

[772] http://floridakidscount.org/docs/2019Index/2019-cwbi.pdf
[773] What are moving average or smoothing techniques? www.itl.nist.gov

Comparative Analysis

One of the analytical tools used in this analysis is the comparison of Lee County data to State of Florida or other Florida counties where such data is available. In some cases, this is per-capita data, in other cases averages. The challenge is how to reasonably compare such data and avoid false conclusions about the validity of any differences.

For example, assume the State of Florida average is 15.2 (with a higher number being better) and Lee County's average is 14.9. In terms of this score Lee County is below average. But is it really? If one were working with probability statistics this question could be tested empirically through standard error data to determine if the difference was statistically significant or not. Yet even statistical significance may be of little to no practical significance. Practical significance is determined by a variety of factors such as:

- How many people are impacted by the difference?
- What is the cost and time required to impact the number of people impacted?
- How significant an issue is this for the persons involved?
- How does this difference compare to other differences that may exist?
- How well do we understand causal factors and effective strategies?
- If we were to attempt to reach or exceed average (assuming we are below it), what would it cost, how likely is success and to what degree would the quality of life in the community improve in a meaningful way?

To avoid drawing non-valid conclusions in this study when comparative data is being examined, the following criterion was used:

If the Lee County average was within 10% of the comparable average, above or below, then Lee County was considered as average. This conclusion is reported in the various tables as "within 10% average". Why 10%?

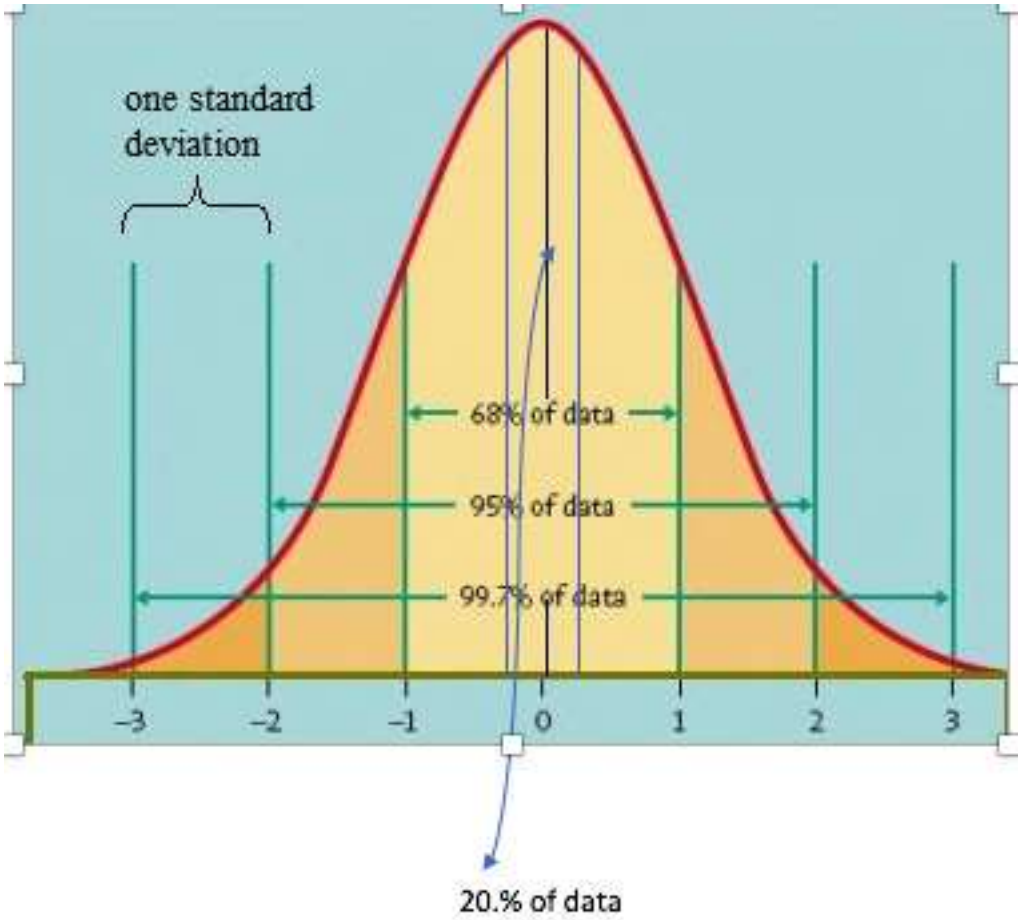
The Bell Curve in figure 39 shows that 68% of a normal distribution responses fall within one standard deviation. Approximately 30% of this one standard deviation is equal 10% of one side of the mean. Given the deviations that would be expected from multiple samplings or due to collection error, this is an estimation that numbers falling within one-third of the standard deviation may be considered functionally or practically equivalent. This is not an argument that they are statistically equivalent but rather that they are functionally equivalent.

Figure 40 illustrates the proportion of the Bell Curve that it is assumed equals functional equivalence.

Why compare Lee to other Florida counties and not national data points?

While there are local differences in Florida counties, they all operate within the same state policy framework and, for the most part, all have the same tools to work with to address the needs and concerns of the county they serve. Counties or parishes in other states have different tools and must work in different state policy frameworks. While comparisons among differing Florida counties are rarely "apple to apple" comparisons, they are at least "apple to fruit." Trying to compare a Florida county to a county in any other state may become an "apple to vegetable" exercise.

Figure 40. Functional Equivalence Bell Curve Assumption



Limitations of this Approach

There are several limitations of this approach. These include:

- Non-normal bell curves. Not all data fits a normal bell curve distribution. In these cases, a ten percent (10%) variation could be more or less significant than it would be in a normal distribution.

- Lack of standard deviation and range data. This data is often not provided in the data bases available for this analysis.

- Highly precise data. This approach assumes that, for the reasons explained above, the data available for this analysis has a sufficient degree of variability that assuming an average is very precise is erroneous. If the data is highly precise with very little variability, a slightly below or above average score could be meaningful.

Mis-interpretations of this approach

This approach is vulnerable to the following mis-interpretations:

- There is no need for improvement. Data falling within the 10% range of the average score means there is no need for community action. It does not mean this at all. A community may decide that being "average" on any measure is not their goal or desire. This data simply states where a community is, not where it wants to be.

- Average means there is no gap. This is a variation of the prior mis-interpretation. These comparisons are made within the State of Florida. The State itself may have a gap compared to the nation. In this case, it simply means that the gap in Lee County is the same as the gap in the other counties. Or there may be a national gap and Lee County is like the rest of the nation.

- The focus should be on those areas where Lee County is below average. Not necessarily. Any additional investments should be based on the best available understanding of causal factors. It is possible that making greater investments in an

area where the County is even above average may be the most effective strategy to raise a below average behavior.

Accurate Interpretations of this Approach

This data is best interpreted using the following guidelines:

- Focus for further analysis. This approach does not seek to be the final word on any outcome. Rather it seeks to sort this data to facilitate further analysis and discussion. Differences may be false and due simply to collection procedures or substantive due to actual community conditions. The presentation of comparative data made in this analysis is intended to help focus that discussion and determine which outcomes may need greater community attention.

- Functional significance. This approach is not intended to calculate statistical significance or could it with the existing data limitations. Rather it is intended to help focus on the practical implications of differences.

- Causal modeling. In a resource-constrained world, the question always is how to use those limited resources for optimum impact. Discussion and analysis of how the various behaviors are related to one another and which could have the most impact can begin with these data.