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Human Services Needs Assessment - Qualitative Data: Public Forums, Mail Surveys, Focus Groups, and Interviews

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A REPORT TO PINELLAS COUNTY HUMAN SERVICES

Julienne Giard, M.S.W.

January 2005
The University of South Florida

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Louis de la Parte Florida Mental Health Institute

The Louis de la Parte Florida Mental Health Institute at the University of South Florida has a mission to strengthen mental health services throughout the state. The Institute provides research, training, education, technical assistance, and support services to mental health professionals and agencies as well as consumers, consumer organizations, and behavioral health advocates statewide. At the state level, the Institute works closely with the Departments of Children and Families (DCF), Corrections (DOC), Elder Affairs (DOEA), Education (DOE), and the Agency for Health Care Administration (AHCA), as well as with members and staff of the State Legislature and providers of mental health services throughout Florida.

Comprised of three primary research departments, Mental Health Law & Policy, Child & Family Studies, and Aging & Mental Health, and a number of specialized centers, the Institute conducts research and program evaluations, provides training and consultations, and offers a number of academic courses at the masters and doctoral levels.

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Human Services in Pinellas County
Qualitative Data: Public Forums, Mail Surveys, Focus Groups, and Interviews

Final Report To Pinellas County Human Services Department

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This report details the methods and findings from data collected at public forums, focus groups, key informant interviews, and through open-ended questions on the mail surveys to providers and citizens/consumers. Each of these efforts yielded perceptions of how the human services system in Pinellas County currently operates with respect to the four designated areas (homeless services, health care, mental health and substance abuse services, and basic needs, such as food or emergency financial assistance). Unmet needs and barriers were found to be met with frustration, exasperation, and even a sense of grief and loss. Motivated by the belief that changes should and can be made, people shared personal stories, the perspectives of others, and their thoughts on what they considered the most important issues.

The “working poor” or people who are above, but near, eligibility requirement thresholds were constantly referred to as being in need of services. The area of the county, the day-to-day changes within an agency, or even the knowledge or span of networked resources of the person who answers the phone can yield an individual experience with the human services system that is completely different. The geographic, personal, or systemic barriers are similarly variable, and necessitate a system that is both structured and flexible in order to be dependable, accountable, and reflective of the episodic and chronic needs within Pinellas County.

From the consumer standpoint, personal determination, existing resources, and coping affect their success or failure to achieve or maintain self reliance. The frustration of the service providers and the people in need of or receiving services is captured here and deserves pointed reflection and consideration.

Recurrent top concerns that cut across all four areas of human services included: lack of affordable housing, transportation difficulties, lack of health care for the un/underinsured, including lack of prescription assistance, funding restrictions, lack of common eligibility criteria, and a lack of communication and coordination. Interestingly, there is a sense that while many services are available in Pinellas County, knowledge of these services that are constantly changing in terms of capacity, funding, and requirements is greatly lacking not only from the public’s perspective, but between and among the providers.

In terms of topic frequency serving as a proxy for focus at the public forums, transportation problems stood as the most mentioned. Following were homeless issues, a lack of affordable housing, the system being uncoordinated, and a lack of health care.

Among the citizen mail survey, the topic of homeless issues was most frequently discussed, followed by mental health/substance abuse, positive remarks concerning successful programs, a lack of health care and affordable housing, the system being
uncoordinated, and a lack of information about existing services. Alternately, providers focused their attention on barriers and recommendations involving the system being uncoordinated, increasing human services in general, the lack of information about existing services, transportation, and changing the view of the social services system.

The five provider-attended focus groups on each of the four topical areas (in addition to system-wide issues) ranked the top unmet needs and barriers to a coordinated system of care for children, adults, the elderly, and all age groups. Within homeless services, the top unmet need for all age groups was the lack of permanent, affordable, and supportive housing. Inadequate, scattered, and fragmented funding was cited as the top barrier. Indigent services for the un/underinsured was cited as the top unmet need in health care, while a lack of community priority and vision was seen as being the top barrier. The need for a client-focused system and pathways of care, in addition to a lack of adult housing and decent, affordable, and accessible transition housing for felons were ranked as the top unmet needs within mental health/substance abuse. Top barriers within this category included too many separate funding streams (starting from the top) and public transportation problems for clients that does not have oversight. Interestingly, lack of medical services and insurance, in conjunction with a lack of emergency assistance with rent/mortgage, utilities (e.g., deposits), and living expenses were said to be the top unmet basic needs. A lack of central communication/coordination and independent case management was seen as the top barrier. Overall, transportation was cited as the top system-wide unmet need for adults and the elderly, while the top barriers included turf-guarding and funding restrictions.

The key informant interviews for each of the four areas centered on perceptions, service adequacy, barriers, and the steps needed to actuate change. Specific accounts, scenarios, and examples were given to illustrate the bimodal directionality of how the systems are influenced by the county, state, and federal government from the top-down and by consumers and the public from the bottom-up.
Researchers at the Florida Mental Health Institute, University of South Florida, under contract to the Pinellas County Human Services Department, collected data over several months in 2004 from people in Pinellas County for a human services needs assessment. Human Services was defined in collaboration with the county as including four areas: homeless services, health care, mental health and substance abuse services, and basic needs. This report details the methods and findings from data collected at public forums, focus groups, key informant interviews, and through open-ended questions on the mail surveys to providers and citizens/consumers.
Methodology

Approximately 585 people participated in the activities listed in Table 1. There is some duplication because some people participated in multiple data collection activities. In addition, the three rows of provider participants in the table below are duplicative; only the maximum number of provider responses (250) was used to calculate the total number of participants across methods (585). Mail survey participants were paid for their time, but the participants in the other activities were not. All participation was, of course, voluntary and participants in the focus groups and interviews were assured their comments would be kept confidential and only aggregately reported.

Table 1. Data Collection Methods

<table>
<thead>
<tr>
<th>Method</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public forums</td>
<td>105</td>
</tr>
<tr>
<td>Comment pages from public forum participants</td>
<td>15</td>
</tr>
<tr>
<td>Provider surveys – question about barriers</td>
<td>250</td>
</tr>
<tr>
<td>Provider surveys – question about recommendations</td>
<td>191</td>
</tr>
<tr>
<td>Provider surveys – “other” comments</td>
<td>35</td>
</tr>
<tr>
<td>Citizen/Consumer surveys – “other” comments</td>
<td>166</td>
</tr>
<tr>
<td>Focus groups with providers</td>
<td>37</td>
</tr>
<tr>
<td>Key informant interviews</td>
<td>12</td>
</tr>
</tbody>
</table>

Four public forums were held throughout October at four locations in north-, mid- and south-county (i.e., Tarpon Springs, Clearwater, Dunedin, and St. Petersburg). Flyers advertising the public forums were left in prominent public areas nearly a month prior to the meetings. Many service providers were also sent flyers to display, newspaper and circular advertisements were secured, and the Pinellas County Human Services Department website posted the meeting information at http://www.pinellascounty.org/humanservicessurvey/info.htm. The press release was picked up by both the St. Petersburg Times and Tampa Tribune newspapers (Times Publishing Co., 2004a; Isbitts, 2004).

Scheduling parameters included two hours for each session, with three of the four taking place during the late afternoon or evening: the Tarpon Springs meeting was held on October 7, 2004 from 6 – 8 p.m. at the CAP Center (19 people attended); the Clearwater meeting was held on October 12 from 10 – 12 p.m. at the YMCA High Point (17 people); the Dunedin meeting was held on October 19 from 6 – 8 p.m. at the Dunedin Public Library (21 people); and the St. Petersburg
meeting was held on October 20 from 4 – 6 p.m. at the Sunshine Center (48 people). Public forum attendees were given the options of speaking and having their comments audio taped, submitting their written comments on “comment pages,” filling out a hard copy of the community survey, and/or visiting the survey website at http://www.pinellascounty.org/SocialServices/default.htm.

Providers, consumers, and other citizens of Pinellas County completed mail surveys through a structured sampling process, and other people not formally sampled could complete the survey online as well [See Roger Boothroyd’s report for a complete description of the mail survey methodology]. The surveys included open-ended questions that asked participants for additional “other” comments; service providers were also asked open-ended questions about barriers to service and their recommendations. Answers were then analyzed with other qualitative data from the public forums, focus groups, and interviews presented in this report.

Five focus groups were held in September – November, 2004. Four of the groups took place at Worknet Pinellas (4525 140th Avenue North, Clearwater), which is considered “mid-county.” A list of service provider invitees representing the four topical areas (homelessness, health care, mental health/substance abuse, and basic needs) was provided by the Pinellas County Human Services Department. The 98 invitations requested attendance at one of four sessions. A fifth focus group took place at the Pinellas County Human Services Department Clearwater office.

The health care and basic needs focus groups were both held first on September 29, 2004 at 9:00 – 11:00 a.m. and 2:00 – 4:00 p.m., respectively. The health care session consisted of 10 participants, while the basic needs group contained 11. The homeless and mental health/substance abuse focus groups were rescheduled because of one of the hurricanes and took place nearly a month later on October 27 and 28, respectively. The homeless session occurred from 2:00 – 4:00 p.m. and contained three participants, while the mental health/substance abuse session was held from 10:00 – 12:00 p.m. with seven attendees. The system-wide focus group was held on November 16 from 2:00 – 4:00 p.m. and had seven participants.

There are several types of focus group methods. We chose to use the nominal group technique because we wanted to generate a lot of ideas, to assure that all members participated freely without influence from other participants, and we wanted to identify priorities for further examination. We hired a professional focus group facilitator who had been trained by Dr. Richard Krueger who has written several books on focus groups. Prior to conducting the focus groups, a pilot test of the focus group protocol was administered at the University of South Florida with students and professionals. Please see Appendix A for the detailed focus group facilitator guide that was created for this project.

A detailed description of all discussed topics at the focus groups, including how they were ranked, is provided in Appendix B. Each focus group attendee was asked to list unmet needs and barriers to a coordinated system of care within
Pinellas County (two separate exercises in the group). Because of the capacious nature of homelessness, health care, mental health/substance abuse, and basic needs, participants were asked to stratify their list of unmet needs into elderly, adult, and child populations where possible. However, many of the unmet needs were said to apply to all age groups. After the compiled list of unmet needs and barriers to a coordinated system of care were compiled by the group, participants were asked to vote for their top two concerns in each of these areas. The topic with the most votes was discussed in depth (e.g., suggestions for resolving the unmet need or barrier, who is responsible for the changes). All focus groups were audio taped and transcribed for analysis.

**Interviews** were conducted with 12 of 14 key informants identified by the Pinellas County Human Services Department. Please see Appendix C for a copy of the protocols. These informants included both service providers and administrators representing the four topical areas (homelessness, health care, mental health/substance abuse, and basic needs). The one-hour, face-to-face, scheduled key informant interviews took place during November and December, 2004.

The two interviewers (the authors of this work) developed a detailed interview protocol and attended the first interview together to ensure that their data collection would be similar.

The interviews were audio-taped and transcribed, and the interviewers also took notes to aid in analyzing interview findings. All interviewees were informed that their comments would remain confidential, including person, place of employment, or any other identifiable references.

**Analyses**

The public forum transcripts, comment pages, provider mail survey open-ended comments, and citizen/consumer mail survey open-ended comments were analyzed using Atlas.ti™ software.

Atlas.ti is a qualitative software program owned and supported by Scientific Software Development™, and is described as a “workbench for the qualitative analysis of large bodies of textual, graphical, audio, and video data” (http://www.atlasti.com).

Verbatim transcripts of the public forums and the other text data documents were imported into Atlas.ti to produce the output described in the sections below. The text in the documents was coded using a standard code list in Atlas.ti as a way to summarize the data. The code list was made specifically for this project by reviewing the text documents.

In the tables in this report, the frequencies within the themes (across data collection methods, i.e., public forums, comment pages) are roughly equivalent to the number of people that mentioned them. Participants sometimes made two distinct comments related to a theme, which may have been counted twice. Participants often made comments related to more than one topic or theme, so the total frequency is more than the number of participants in these activities.
The interview and focus group data were not analyzed using Atlas.ti. The type of focus group conducted yielded rankings and brief discussion that could be summarized with the aid of computer software. The interview data was already “coded” according to the sections of the protocol (e.g., perceptions, suggestions) and could be summarized across participants in this way.

Strategies for increasing the rigor of these qualitative methods were employed. For example, detailed guides/protocols were developed; the design of the data collection methods permitted completion of the work within a time frame brief enough to assure accuracy of the information; a multidisciplinary group of interviewers was employed (allowing for the confrontation of biases); in-depth interviews were targeted to the most knowledgeable respondents; external review by organizations and agencies being studied was sought. The multiple sources of data help to compensate for limitations or biases associated with any one source or method of data collection (Silverman & Ricci, 1990).
Public Forums

The four public forums captured a wide variety of perspectives, from elected representatives to service provider administrators, volunteers, and those receiving or needing services. All of these participants created a picture of different individual experiences, each corresponding to unforeseen temporary or chronic problems. The topics mentioned do not always fit neatly into the four categorical areas of homelessness, health care, mental health/substance abuse, and basic needs. Participants often discussed systemic factors that are either contextual or indirect to these four areas of the human services system, such as the wage rate, the education system, public awareness, complacency and avoidance, zoning restrictions, horizontal and vertical connectedness between and within service providers (e.g., agency-to-agency relationships or with planning/funding groups and community leaders), job training, and flexibility of the system.

Within the descriptions that follow, a concerted effort has been made to capture the concerns and sentiments expressed with as much depth as possible; every scenario unfortunately cannot be addressed, however. The overriding theme found in all of the forums was that people connected to the human services system within Pinellas County are frustrated by problems that they see as capable of being improved. Cautious optimism for positive change is immediately apparent from this process, tempered by the belief that “poverty is not going to go away.”

Table 2 shown below details the top 5 response frequencies by topic for the public forums and comment pages collected at the forums. A summative table that includes responses from the provider and citizen mail surveys, in addition to the public forums and comment pages, can be found in Appendix D. The two tables do not differ significantly, although the order shuffles slightly. The top 5 issues are the same, with the exception of mental health/substance abuse having been replaced by lack of health care in the public forum only table.

<table>
<thead>
<tr>
<th>Code</th>
<th>Tarpon</th>
<th>Clearwater</th>
<th>Dunedin</th>
<th>St. Pete</th>
<th>Comment Pages</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation problems</td>
<td>4</td>
<td>7</td>
<td>11</td>
<td>6</td>
<td>4</td>
<td>32</td>
</tr>
<tr>
<td>Homeless Issues</td>
<td>11</td>
<td>3</td>
<td>3</td>
<td>7</td>
<td>6</td>
<td>30</td>
</tr>
<tr>
<td>Lack of affordable Housing</td>
<td>1</td>
<td>6</td>
<td>6</td>
<td>10</td>
<td>6</td>
<td>29</td>
</tr>
<tr>
<td>System not coordinated</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>6</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>Lack of health care</td>
<td>0</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>17</td>
</tr>
</tbody>
</table>
Homeless Services

The Tarpon Springs public forum spent a great deal of time on homelessness. It was said that the service provision level is “disconnected” from the rest of the county and the city’s municipal authorities (i.e., elected representatives), where close relationships and coordination were said to be greatly needed. Without a shelter between Clearwater and Hudson, with the exception of the Methodist Church cold night shelter, it was said that Tarpon Springs needs a facility; a Day Shelter run by and paid for by some of the churches that could serve the estimated 100-150 homeless within the city was suggested.

Attendees at both the Dunedin and St. Petersburg public forums expressed concern regarding affordable housing, where development and redevelopment is lessening its availability. Older housing, especially manufactured and mobile home parks, were said to be targeted for condominiums and luxury apartments. At the Clearwater public forum, it was said that a recent document from the county comprehensive planning process set “the elimination of all mobile home parks” as one of its goal.

It was said in St. Petersburg that “if you’re homeless and stay around too long you’ll find yourself [subject to] Florida Statute [Chapter] 810 (Florida Statutes, 2004) at Pinellas County Jail for trespass.” This was said to lead to a “records situation,” where background checks on employment applications leads to unemployment.

Barriers: Policies

Without a shelter, it was said during the Tarpon Springs forum that referrals are made to CHIP [the Clearwater Homeless Intervention Project] or Everybody’s Tabernacle, but these places were said to be “backed up.” Being required to have a full-time job in 7 days at CHIP was said to be prohibitive for those with disabilities; these people “can’t always stay” at Everybody’s Tabernacle, since they are not “on disability yet.” A $30 payment per week, a felony within the prior 5 years, or a drinking problem were cited as additional barriers, in addition to the requirement to have an address or phone number to put on an employment application. Battered men and pregnant women were also said to face the additional problem of rarely being able to bring their children to shelters for those special populations.

The Clearwater public forum discussion pointed out that information sharing takes place between the shelters, where an altercation or an issue with a child acting out can cause displacement at multiple shelters. In Dunedin, a retirement home was said to be charging an annual 5% increase each fall, leading to income compression for retirees on a fixed income. It was also said that HUD establishes fair market rents, where a two-bedroom apartment Section 8 certificate amounts to $628 per month, which is below cost.

It was said in St. Petersburg that many of the landlords have been “let go and allowed to have substandard housing” (e.g., windows and refrigerators not working and leaking roofs). Complaints are said to be met with the pressure of being kicked out. The city was said to have no one overseeing the housing problem, and it was
suggested that the county collaborate with HUD by not limiting to Section 8 only, since other sections could be utilized to design a housing program for transition to independence.

**Barriers: Transportation**

Public transportation was cited as being “very modest” (Tarpon Springs), not having a reliable infrastructure (Dunedin) “very difficult” (Clearwater), “horrible” and “really very bad,” (St. Petersburg) within Pinellas County. It was also said to be magnified in difficulty for those with physical disabilities and within Tarpon Springs (e.g., two hour ride to Clearwater where services are located). As an implied issue that is prevalent across each of the four topical areas, transportation will remain as being implied for receiving all services and will not be revisited as a specific issue beyond this section.

In Tarpon Springs, it was said that people that have to decide between their car and apartment will give up the apartment first due to the greater need to have a car for work and other needs. It was explained that the people that have the most needs are the ones that do not have the transportation, and in Tarpon Springs the closest job training center PTEC [the Pinellas Technical Education Centers] and “many other services” (e.g., Department of Children and Families, Directions for medication appointments) are located in Clearwater.

In Dunedin, it was said that seniors face the decision of whether or not they can continue to drive their cars or not, leading to the question of “what happens next?” In Clearwater, it was reported that the focus on transportation is on adding more lanes to U.S. 19. rather than how to get the working poor to where they need to go. A person in St. Petersburg said that she is dependent on wheelchair transport involving the DART system, which has long waiting periods (30, 60, 90 days), and the DART system recently stopped using Yellow Cab, which has created capacity problems.

One advocate in St. Petersburg suggested having an Express Service between St. Petersburg, Clearwater, Tampa, and Tarpon Springs. For those living in St. Petersburg and having service jobs in Clearwater, riding a bicycle or “starting out at 4 o’clock in the morning” or “late at night” leads to not being able to gain or maintain employment.

**Barriers: Communication**

Communication, like transportation, crosses all four topical areas. The Dunedin, Clearwater, and St. Petersburg forums paid specific attention to this problem, which was said to be “overlooked in surveys of this type.” The deaf and hard of hearing population was said to experience significant barriers with respect to affordable housing and homeless shelters. It was stated that “there is a need for flashing symbols, lights, or other signaling devices to be placed in the home.” Deaf people were described as being afraid to go to shelters because they either do not know what is happening, fear that their things will be taken from them, or experience an attitude from people who may “look down on [them] or think that they are mentally retarded.” It was also said that they face significant barriers
regarding employment, owing to discrimination or “tremendous waiting periods for vocational rehabilitation services.”

Within this area were other issues concerning a lack of available translators for different languages and dialects within languages (e.g., Spanish-speakers from South America and Puerto Rico). Overall, funding and attention to communication were reported as being very low.

**Personal perspectives**

The perspectives of both the homeless as a group and as individuals were described several times by the forum participants and deserve mention. This section further illustrates some of the personal perspectives of trying to navigate and live within Pinellas County.

In Tarpon Springs, one homeless man was described as having been beaten to where he needed to be hospitalized; a woman in her 60s was raped and beaten; and four 19-20 year olds were said to have asked what they can do because the shelters are constantly full. The homeless were described as people who have been “stripped of their dignity and respect,” who are “afraid to sleep at night” and have “few possessions” that “have not been stolen.” Those with children are said to be “scared to death” and avoid being counted because they are afraid they are going to lose them. Also said to have added to the difficulty of the homeless census were those living out of their cars or who were afraid of being deported. It was said that the homeless “want to work. . .want to feel dignified. . .” and want to get in touch with their families.

The factors leading to homelessness include paychecks running out before the end of the month and not having adequate food and money to pay bills, an illness, loss of job, divorce, or other complex problems such as mental illness (said by one participant to be estimated at 80% of the homeless in Pinellas County) and the associated coping methods involving drugs and alcohol. In Dunedin, “they’re staying over at the parking lot at Wal-Mart or Publix. Sleeping there with their families with their vans or their trucks, [using] bathrooms in the stores and microwave ovens in the gas stations.” In Tarpon Springs, it was said, “I’ve worked with hundreds of persons who are considered homeless and. . .they are some of the neatest folks that I have ever dealt with in my entire life. . .they’ll say ’I don’t know what to do. I’m lost. I don’t know what to do.’”

**Health Care Services**

The lower income, “working poor” who do not have health insurance was a constant source of discussion in each of the public forums. They were said to “have to fall completely to the bottom before somebody else will pick them up, which is not very motivating or. . .fair for those that are trying to make a living for themselves.” One-time emergencies are especially problematic, where “their comments are ‘what am I supposed to do? Should I quit my job and then come back?’”
At the Clearwater forum, it was mentioned that a mobile medical van primarily aimed at the homeless population is planned to be expanded to include the working poor that have no health coverage. It was also said that there are over 30,000 refugees and immigrants in Tampa Bay, a huge wave of which came approximately six-and-a-half years ago and have since “reached the end of their time line” to where they can receive benefits in the area. Many of these people are elderly, have unique cultural needs, and are said to be becoming a “forgotten group of people.” A new wave of Somali Bantu is anticipated in the near future, which is expected to further increase this need.

Additionally, in Dunedin it was said, “We have a policeman in every elementary school but we do not have a nurse, [which] speaks volumes. . . .”

**Barriers: Policies**

At the Clearwater forum, it was said that Florida Kid Care requires certain documentation, and immigrants do not have a social security card. In Dunedin, it was said that refugees or visitors staying longer than they had planned are not seen in the Clearwater Free Clinic because they are not citizens. Children who are required to sign that they will take care of their parents who are immigrating are sometimes unable to afford, for example, diabetic medication. Those who are not entitled to Medicaid often seek emergency room treatment when they need medical care because they have no other place to go. Large medical bills from emergency treatment were then said to sometimes lead to bankruptcy issues.

One patient seen at the Free Clinic was a 65 year old diabetic with a blood glucose level of 500 [normal is 64 to 110 mg/dL (Ignatavicius & Workman, 2002)] who was working, yet unable to afford Medicare Part B. Surgical procedures such as a hernia repair were said to be denied, because “there’s no address. . .to release them when they finish the procedure.”

**Personal perspectives**

In Tarpon Springs, it was said that dental service is something that isn’t thought about, “because you can live with your teeth rottin’ out” and those things that are the most critical are the first things done. Vision was also mentioned, where children might never get their vision problems corrected. A man in St. Petersburg related that having a disability means being forced to live with others who have serious mental and physical problems—that they are all thrown together.

**Mental Health/Substance Abuse Services**

Mental health and substance abuse is in many ways a silent problem that is the most personal issue of the four being discussed within this report. It was previously stated that a number of homeless are also included within this category, which has important treatment implications. The ability to function within a structured service system in a way that is logical, coherent, and adaptable is dependent on both the complexity and operability of the system and individual. Be it a bus schedule, appointment time, or adherence to a drug regimen, people with mental health/substance abuse problems are particularly vulnerable to episodic or continual barriers.
In Tarpon Springs, it was said that “it’s not merely a meal or even a bed that’s needed. . . their problems are very complex.” A service provider reported a disconnect from those that believe people who are depressed can “just snap out of it. . .and the more people tell them that . . .the worse they feel and the harder it is to dig them out of that hole.”

In St. Petersburg, the amount of waiting to access mental health services was said to be “just criminal in this community,” where those working in the field were said to be doing a good job. However, “there’s not enough [staff or time].”

In Dunedin, mental health was said to be “an issue in our society that is often overlooked and too often under funded.” It was said to oftentimes be “difficult to find support for those whose behavior many of us do not understand and some of us do not want to understand,” yet “many of our. . .social problems could very well be prevented.” Another participant described the mental health system in Pinellas County as being “overburdened,” and said that the local police do not respond to calls in Greenwood [regarding drug trafficking].

**Barriers: Policies**

As mentioned previously, better transportation to Clearwater is needed to receive services for someone living in Tarpon Springs. It was said that a missed appointment due to a late bus results in the slot being taken by someone else.

A mother of a 13-year-old with mental health needs related that there are a lot of children that have emotional problems in the Juvenile Justice System who do not belong there. The Family Service Center that runs an at-risk shelter for youth has taken her son for a couple nights on an emergency basis, but since his IQ is too low according to their policy, she said that she has had to Baker Act him to Morton Plant Hospital when he has had problems.

At the Clearwater forum, it was said that “if you have a teenager and you’re having a great deal of difficulty in making things work. . .there's nothing available [short of criminal activity or hitting bottom]; if your teenager goes to school and punches out a teacher you've got all the help you need.”

In St. Petersburg, a woman said that rape victims need special services and to not be “bundled . . .together with the mentally ill.” She said, “We’re thrown into these mental institutions where we find people who are batterers making our condition even worse so that we can’t hold down a job.”

**Basic Needs Services**

The discussion of basic needs within the public forums was more-so a miscellaneous category that captures comments made within or between the discussions of the other three topical areas. Topics such as the lack of affordable housing, a livable wage, child care and day care needs, or the situational issues related to communication and being too ill to cook are certainly basic needs that are within these other areas. For example, it was said that deaf people who are Baker
Acted may remain in the hospital for several weeks without an interpreter. A woman said that she met someone in the hospital who did not know she needed to order her own food and went a whole day without eating. She also said that home care should be set up for those who cannot cook for themselves.

In Dunedin, child care was said to be $720/month for an infant, with many places “understaffed and overpopulated with children, resulting in neglected and insufficient care.” The need for child care specifically for sick children was mentioned in St. Petersburg, because it was explained that parents can sometimes lose their jobs if they don’t have access to this. Two teenage parents were cited as having also lost time as students in school because they did not have a support system.

Although related to transportation, wheelchair access on the buses for the disabled is definitely a basic need. St. Petersburg forum participants spent time on this issue, where it was said there is “very little consideration to where [the bus company PSTA—the Pinellas Suncoast Transit Authority] pours concrete. . .you have to go through the weeds and marsh to get to a piece of concrete” and the “angulation is too steep.” Handicapped-accessible apartments and buildings (specifically ramps) were said to be in the “best interest of physically challenged people, elderly people, and people on fixed incomes.”

Mail Surveys

The qualitative comments from providers and citizens on the mail surveys were analyzed. Table 3 presents a summary of the top five themes from the consumer surveys and the provider ratings for these same topics are also displayed. Consumer/citizens were most concerned, in these open-ended mail survey questions, about homeless issues and mental health/substance abuse issues; they also reported on successful programs in the community.

<table>
<thead>
<tr>
<th>Code</th>
<th>Citizen “Other”</th>
<th>Provider “Barriers”</th>
<th>Provider “Recomm.”</th>
<th>Provider “Other”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeless Issues</td>
<td>39</td>
<td>3</td>
<td>3</td>
<td>2</td>
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<tr>
<td>Successful programs</td>
<td>26</td>
<td>0</td>
<td>2</td>
<td>0</td>
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<tr>
<td>Mental Health / Substance Abuse</td>
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<td>5</td>
<td>2</td>
</tr>
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</tr>
<tr>
<td>Lack of affordable Housing</td>
<td>20</td>
<td>5</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
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<td>44</td>
<td>56</td>
<td>9</td>
</tr>
<tr>
<td>Lack of info about existing services</td>
<td>20</td>
<td>14</td>
<td>15</td>
<td>1</td>
</tr>
</tbody>
</table>

In contrast, lack of coordination and information about existing services were at the top of the list of provider responses. Providers also highly rated the need to increase funding and availability of human services in Pinellas County.
Focus Groups

One focus group for each of the four areas included in our definition of human services was held (homeless services, health care, mental health and substance abuse services, and basic needs), followed by a fifth focus group that concentrated on system-wide issues across all four areas. The findings from these groups are presented in this order, with the “top five” selected within each category (only one category did not have up to five). Flip charts were utilized during these meetings, and a detailed listing of all topics within subcategories (children, adults, elderly, and all age groups) can be found in Appendix B. Verbatim transcripts were also read to provide a qualitative discussion of the rankings and themes identified here. Demographics for participants in all five groups are found in Appendix E.

Homeless Services

Data gathered from the provider-attended homeless focus group is set against a context that includes both negative and positive local publicity. Negative publicity includes public complaints (Wilson, 2004), “no trespassing” signs, the prohibition of “aggressive panhandling” in St. Petersburg (Moore, 2004; Moore & Wilson, 2004), city and provider policies in Clearwater (Steinle, 2000), and even published opinions on the appropriateness of tax-directed charity (Haynes, 2004) and homelessness development (Jannelli, 2004). Positive publicity alternately applies to efforts to help the homeless in Tarpon Springs (Times Publishing Co., 2004b), Clearwater (Tisch, 2004; Tan, 2004), and St. Petersburg (Wilson, 2004).

The topic of homelessness, then, is a source of considerable debate. With 4,081 homeless people within Pinellas County in 2004 (Tan, 2004), service providers discussed a system for addressing and managing the needs and barriers to a coordinated system of care for this diverse population.

The top unmet needs and barriers to a coordinated system of homeless services identified by the participants in this focus group are presented here. While these were the most emphasized, the major drawback of listing these items to the exclusion of others is the loss of depth gained from reviewing supportive factors that contribute to or influence these top concerns. Attentive readers should be especially circumspect of the closely ranked topics. The listings provided in Appendix B will not be duplicated here, though the reader is encouraged to review all of the unmet needs and barriers participants spent time to discuss.

The group identified the following issues as the top five unmet needs (in rank order):

Lack of
• Housing (permanent, affordable, and supportive)
• Transportation
• Long-term (multi-year) funding
• Regional service centers
• Homeless prevention programming
The top unmet needs specific to children included a lack of: childcare (including after school care), medical detoxification, mental health treatment for 0-5 year olds, and scholarships for college/higher education. The elderly and adults were said to lack respite care, while adults were said to also lack medical detoxification and mental health services.

The top three **barriers to a coordinated system of care** (in rank order):

- Inadequate funding and fragmented / scattered funding
- Lack of business, academic and urban planners in planning for the county
- Political and civic construction of the county (20+ municipalities)

The discussion of homelessness included the issues of capacity (the term “overloaded” was used), regional service differences between north, mid, and south Pinellas, and the philosophical, policy, and funding emphasis on the “back end of the continuum” (affordable housing) versus prevention. It was said that while the federal government is “asking...to embrace a 10-year plan to end chronic homelessness as opposed to homelessness in general...they’re only willing to fund service initiatives one to two years at a time.” This 10-year plan was likened to “throwing 90% of the resources upon 10% of the [homeless] population,” where focusing on the visible homeless (vagrants) will lead to “minimum wage families losing their apartments...behind the scenes...unseen by the majority of society.”

The responsibility for making changes regarding this issue was said to be the Funder’s Collaborative, City Council, County Commission, and federal government departments (Education, Health and Human Services) and “anyone that is part of the planning process for the counties and municipalities along with anyone that funds social services, and the service providers...the coalitions and collaborations.”

Dedicated funding streams were also said to limit the ability to customize services to meet changes in client needs. Additionally, the lack of “cohesion to the funding sources or to the issues for which they can be used” was said to make it so that “you end up spending all of your time like a drowning man grabbing each little pot that floats by and not really being able to tie it all together to make an effective stand.”

The different municipalities (23) were said to also be in flux, containing “different laws, different guidelines, [and] different funding.” Within Pinellas County, it was said that there are “some municipalities where it’s illegal to panhandle...[and others] where there are designated panhandling areas...almost drawing circles on the sidewalk at certain corners and saying it’s alright to panhandle.” This was said to create a “wide extreme from one end of the county to the other.” A suggested resolution to this issue included having a coordinated system consisting of all of the municipalities (especially HUD-funded) to standardize everything from adjudication to structural design and funding.

Concerning affordable housing, it was said that there is affordable housing in Pasco, Hernando, and Citrus. However, “when you start getting up that far it’s too far now for them to get back down and work” and “employment there is limited.”
Regarding transportation, the bus system was described as being “expensive,” and traveling to “roads that are basically empty.” It was proposed that there be “more of a homeless transportation system that could get people to [their needed] services.” Other cities and jurisdictions that have developed such a system were said to work “quite well,” but would not work in the system that currently exists in Pinellas County.

The Pinellas Village was discussed as being a model for permanent supportive housing, yet it was reported that there is a long wait list to enter. Additionally, the suggestion was made to have one case manager headquartered in a regional service center to assist with system navigation from entry to exit (i.e., streets to permanent housing), in concert with “one body” to coordinate Pinellas County’s “planning, service provision, and funding.”

Health Care Services

The discussion of health care mainly included systemic, structural issues related to the provision of health services. These included: available hours for free clinics, a disease versus prevention-oriented system, and the affordability of home health.

The top five unmet needs (in rank order):

Lack of
- Health care services for the uninsured and underinsured
- Emergency prescription assistance
- Access to specialists
- Coordination / common eligibility / single point of entry
- Access to acute care outside the hospital for children

The top unmet needs specific to children included the need for residential placement for special needs or those with emotional problems and nutritional programs involving the hypertensive and diabetic. The elderly were said to be facing rising costs for prescriptions and long-term care and need adult day and respite care. Adults were said to need an efficient system for the working poor, involving insurance and income assistance.

The top five barriers to a coordinated system of care (in rank order):

Lack of
- Community priority / vision
- Funding
- Knowledge of all services among providers
- Community partnership
- Common eligibility / single point of entry
Cyclical effects, such as the indigent utilizing the hospital emergency rooms for their needs, emergency room physician referrals to specialists, and the subsequent denial of services based on their inability to pay, were said to be related to people's conditions worsening until they again need treatment at the hospitals. Similarly, the elderly who are “just above the poverty level” were said to not qualify for in-home care and become isolated and depressed, which leads to being “put on drugs and [needing social services].” This focus group was one of two to emphasize the issue of providing services to those above and near the federal poverty level (i.e., the working poor) with respect to Medicaid qualification.

Even with the same eligibility (e.g., 100, 150, or 200% of the Federal Poverty Level), it was said that there is no single point of entry for assistance. While there were said to be “many different programs [with] various funding and grants. . . groups that are funded and don’t have the population. . . can’t share their funds with others because they’re not in the same area.”

There was also mention of there being a need for services for illegal immigrants and those having received political asylum. Due to their immigration status, they are said to be afraid of deportation. A related issue is the stated lack of cultural awareness of providers, cultural sensitivity or competency.

It was said that several different models are being investigated to provide adult health care, such as Health Flex [AHCA, 2005] or a taxing model such as Penny for Pinellas (modeled after Hillsborough and Miami-Dade Counties) to fund a county indigent health care program. The group said key players to making changes include voters, elected officials, and the business and academic communities.

**Mental Health/Substance Abuse Services**

The discussion of mental health/substance abuse services also mainly included structural issues such as a lack of capacity resulting in waiting lists. This also takes the form of having a need for specific programs for Alzheimer’s disease and dementia for the elderly. Also included were discussions on fragmentation (i.e., multiple systems, providers, and billing method for separate disorders) and the resulting effect of short-term hospitalizations versus programs that keep people stabilized.

The top five **unmet needs** (in rank order):

Lack of

- Client-focused system / pathways of care
- Decent, affordable and accessible housing, including for felons
- Integrated care and funding for those with co-occurring mental health and substance abuse disorders
- Knowledge about what works and for whom
- System cohesion for client (multiple providers, agencies, services)

The top unmet needs specific to children included the need for mental health prevention programming. The elderly were said to be lacking: case management services, special programming for those with Alzheimer’s and dementia, housing related to Assisted Living Facilities with staff trained on mental health needs,
and affordable day care. For adults, there was said to be an overemphasis on 12-step recovery programs. Additionally, there was said to be a lack of: step-down (housing rehabilitation) options, services for the non-SPMI population (severe and persistently mentally ill), focus on employment, and 90-day residential programs. A coordinated group with the power to plan affordable housing was also said to be needed.

The top five barriers to a coordinated system of care (in rank order):

- Too many separate funding streams, starting from the federal government
- Public transportation problems
- Multi-governmental structure of Pinellas County
- Divergent laws and rules at every level of government
- Different data systems

Housing was said to be a major consideration within this area, whereas it was reported that someone moving from a shelter to transitional housing faces the requirement to work even if they are a parent of a child with a disability or a person with a disability him/herself. Additionally, people with co-occurring mental health and substance abuse disorders may have felonies, thereby making them unable to access Housing and Urban Development (HUD) funding. While supportive services and discharge planning were said to be available, restrictions such as these inhibit mental health/substance abuse improvement. Lack of coordination of care and service inconsistency was related as having a major impact on mental health/substance abuse issues over time.

Limitations for out-patient services following crisis unit or hospital-based care was said to lead to “more short-term hospitalizations rather than . . .keeping the person stable.” Client-specific services customized from a broad array with flexible funding were said to be necessary to reduce such recidivism.

The relationship between funding stream restrictions, coordination, and best-practice service provision were discussed at length, with the divergence originating at the federal level. It was said that there are “too many [different] programs. . .and funders. . .nobody really works to coordinate” the system. There was also said to be “fragmentation within your own structure,” with each funding source requiring different outcomes based on different logic models and tracked with different data systems.

At the same time, however, the combination of funding streams was said to already be happening, “and it’s going to be up to us to figure out how we’re going to fit into that system.” For example, it was said that “SAMHSA [the federal Substance Abuse and Mental Health Services Administration] is starting to integrate a little bit more,” and “there’s even talk now in Tallahassee. . .of bringing DCF funding and Medicaid funding under one umbrella. The key players identified as being able to make changes include state and county legislators.
Basic Needs Services

The examination of basic needs included an expanded discussion that touched on each of the other focus groups (homelessness, health care, and mental health/substance abuse). Examples included dental care, prescription assistance, emergency mental health services, affordable housing, rental assistance, shelter space, and childcare. Areas that can be characterized as basic needs included ongoing electrical assistance (beyond deposits), interpreters, and transportation. Of particular note is the inclusion of services for those above and near the federal poverty level (i.e., the working poor).

The top five **unmet needs** (in rank order):
Lack of
- Medical services / insurance
- Assistance with rent and utility deposits, electric assistance, rent / mortgage, emergency living expenses
- Prescription assistance
- Transportation; and no gas vouchers
- Mental health services

The top unmet needs specific to children included a lack of pre-Kindergarten services in “north county” for non-English speaking children and a lack of infant child care providers. The elderly were said to be lacking: knowledge about available services and assisted living options for people who are unable to afford private pay and are not poor enough for assistance. For adults, there was said to be a lack of: emergency mental health services, shelters for women and children (non-abusive), and financial assistance for child care (subsidization).

The top five **barriers to a coordinated system of care** (in rank order):
- Lack of central communication; coordination (independent case management)
- Funding requirements; lack of coordination at the funder level
- Rigid eligibility; delayed help until very poor
- Number and diversity of providers and players
- Fear of losing resources, but still having responsibility to provide services

With respect to adults who are working (i.e., the working poor), an income that is near but above the federal poverty level was said to yield a very limited amount of available services. If a person has a car, it was said that “no programs provide gasoline for them [in emergencies] and they’re not eligible for bus passes.” A parent who is working creates the need for childcare, and some shelters were said to not take families with children over 12 or who have not come out of an abusive relationship.

An elderly person was said to face a lack of assisted living options with a fixed income and needs assistance for situational issues when unexpected expenses arise (e.g., their water heater breaking leading to higher water and electric bills).
It was explained that the concept of the safety net is complicated by eligibility concerns, where a barrier is created by assistance that is delayed until people become very poor. These “people at the margin” necessitate crisis prevention. With different funding streams each mandating different requirements, it was said that too much is asked of those in need of services.

For the decision makers within Pinellas County, it was said that they “need to spend time on the other end at the local level at the phone lines [of service providers, 211] . . .they need to take the calls and see what the needs are from a realistic point of view.” The key players identified as being able to make changes include agencies and churches.

**System-Wide Issues**

The discussion of system-wide needs was undertaken by a fifth focus group, which identified the following top five unmet needs (in rank order):

Lack of

• Transportation
• Affordable health care (for the working and unemployed)
• Affordable housing options
• Emergency financial assistance to prevent homelessness
• Mental health funding (community mental health services, emergency beds)

The top unmet needs specific to children included a lack of: affordable out of school care, eye care (and glasses), and prevention services. The elderly were said to be lacking services to help them remain home and prescription coverage. For adults, there was said to be a lack of: substance abuse beds, mental health services for the non-SMI population, eye care, assistance for rent and utilities, prevention services, dental services for the low income, and training opportunities for un/ under-employed. Additionally, it was said that there is no receiving facility in “north county,” and consumers are faced with a choice between mental health counseling or prescriptions by a nurse practitioner.

The top five barriers to a coordinated system of care as identified by cumulative ranking included:

• Turf-guarding; agencies unwilling to give up their piece of the pie
• Funders’ restrictions; need for flexibility
• Lack of coordination by funders
• Reluctance to share information between agencies
• Lack of centralized data system

It was reported that there are a lack of community treatment options for those with mental health and substance abuse disorders (e.g., emergency beds, services for people who do not have severe problems, and no receiving facility in “north county”), affordable housing options (e.g., homeless shelters and services for the elderly to help them remain in their homes, including assistance for rent and
utilities), prevention services, eye and dental care for children and adults, medical care for the homeless, prescriptions for the elderly, training opportunities for the un- or under-employed, and general services for aliens.

With respect to health care, it was said that there is not “enough education on disease management or healthy lifestyles.” The system was described as “crisis oriented,” and dental care services were specifically said to “only cover relief of pain.” With a prevention-oriented system, it was said that more advanced care would not be necessitated as much.

Prevention was also related to homelessness, where it was said that “it’s a lot more cost-effective. . .than to let someone get evicted. . .[pay for] a bed in a shelter. . .job training [and assistance finding a job]” and then “a place to live after they’re ready to leave the shelter.” The final cost, with first and last month’s rent and utility deposits, amounts to “thousands and thousands of dollars, whereas. . .up front” the higher, eventual costs could have been prevented.

Transportation was discussed at length, which branched in relation to the discussion of a lack of coordination among funders and providers. Because of the “distance in the county from one end to the other,” discrimination toward low-income people, and supply versus demand capacity, bus routes and schedules were said to negatively impact social services and employment. A coordinated effort with information about “ridership” and a proposal that “would benefit both sides” (PSTA and those connected to the human services system) were said to be needed.

Funding mandates to partner with other agencies was said to be at odds with funding restrictions, the competitive market for the limited funding that is made available among the large amount of providers, and the organizational mission changes that morph in order to “[chase] the dollars.” Results include a lack of coordination and a reluctance to share information or create a centralized data system. Adaptation and flexibility, balanced with the expectations of the funding organizations, were said to be necessary to “accommodate the situation enough to [stay within the organization’s mission].

The key players identified as being able to make changes include PSTA, elected officials, County Commissioners, the Metropolitan Planning Commission, the business community, and those that represent the elderly.
Key Informant Interviews

Interviewees were composed of both service providers and administrators representing the four topical areas. Questions centered on perceptions, service adequacy (available services, funding, and coordination), barriers, and the next steps needed to actuate change (including priorities, follow-through, and the perceived capacity for change). Some responses were probed for examples or further explanation, especially regarding how improvements could be made to the system. The detailed interview protocols are located in Appendix C. The reader is asked to keep in mind that some of this information may be critical or even factually incorrect, as many different opinions were expressed. For example, if a respondent indicated that there are no services provided for a certain demographic, then it would be reported here as such without verification. Another example is the stated number of municipalities (24 versus 23 cited elsewhere).

Homeless Services

Across the findings reported below associated with perceptions, adequacy of homeless services, barriers, and suggested changes, the following points were made:

• Perceptions of the service providers and the homeless are similar
• The public has some misperceptions about people who are homeless
• People who are homeless often have to go to multiple agencies to get their needs met
• Homelessness often exacerbates other problems
• There are no shelters in north County (Tarpon Springs)
• The public transportation system (PSTA) is inadequate
• Stigma sometimes makes it difficult to locate services in the best location for consumers
• There is a lack of communication about what services are available
• There is a lack of affordable housing making the transition out of homelessness very difficult
• The County’s residency requirement is a problem
• There is poor communication between hospitals and shelters; although it may be improving
• There is more need for the mobile medical unit
• Elected officials, housing developers, and social services representatives were said to be responsible for the needed changes

Perceptions

While the needs of the homeless were said to be predominantly aligned among service providers and homeless people, vast differences in perception were said to exist between the homeless and the general public. It was said that people generally think of a homeless person as someone between 30-45 years old and an alcoholic drifter. However, a large percentage consists of families with children, which was said to be “increasing dramatically, [and] over 55% have been in Pinellas County for over a year, indicating that they are not passing through due to cold weather.”
The differences in perception between homeless people and the homeless service providers were said to be very little, because they were said to see the same things and understand the “collaborative nature” they need to have with one another. However, one respondent said that there are basic differences, in that the homeless within [the region mentioned] have a “low level of political consciousness (i.e., being organized).

Persons who are homeless are said to view the system as very disjointed, to where “they have to travel to multiple agencies to receive assistance.” This was said to lead to the view that it is “a whole lot of work for them to just get their basic needs met.” From the funding perspective, one respondent asked, “Is it better to give a total of $50,000 in increments of $1,000 to 50 agencies, or 10 agencies $5,000?” Currently, someone who is homeless will go to agency A and receive $50 out of $400. Then this person has to visit Agencies B and C, and so forth to “bare his/her soul all over again, after already being ashamed. . .people tend to forget that even when you’re homeless you deserve the right to some amount of respect, integrity, and self-worth.”

An account was made of a man who called to complain because he and his neighbors were upset that “their children are going to be walking on the same streets that these homeless people are walking on and they’re afraid for their children.” It was said that there is a public perception of the homeless as sexual predators, that they want to be on the streets, and that they do not have any motivation.

Goals and objectives were said to be looked at from the funding-level perspective, where “we’ve worked with Jane Doe for a year and we’ve been able to get her back into some basic education. She is due to get her GED next month, and her children are in school and were absent a full month last year and only two days this year. . .the problem is that this is a homeless survey, but it could be a survey on the needs of the elderly next week and after that the needs of the mentally ill.”

“Homelessness,” it was said, “exacerbates numerous problems. . .drug use. . .job loss. . .loss of child care. . .[criminal involvement of children from the kids not being supervised]. . .it’s like a spider web.”

**Adequacy**

The perceived adequacy in addressing homelessness with respect to shelters, domestic violence services, emergency food services/soup kitchens, job training, transportation, mental health/substance abuse services, and health care for this population were each said to have their own specific problems. For example, people having difficulty were said to have the same issues, such as electric, rent, food, etc., yet there could be among ten completely different reasons from one person to another.

This was said to lead to someone needing to contact multiple service providers that can each offer a restricted amount of issue-specific assistance. This sentiment was echoed by several interviewees, one of which described the social services system as becoming “tunnel visioned, becoming almost as bad as the medical profession.” Differences in the level of assistance were reported to occur even within the same agency due to volume and screening (i.e., not asking the right questions or not probing to find the root issue).
Because of the funding to serve the severely mentally ill (e.g., Safe Haven containing 25 beds with a one-to-one staff ratio, low turnover, and costing nearly $1 million per year to operate) being compared to “other shelter programs that are serving 2,500 people a year,” it was said that an average person “sitting on a funding panel or an elected official...doesn’t understand.” This statement reflects the differences in perspective related to not considering service intensity compared with acuity.

There was said to be no 24-hour emergency shelter in southern Pinellas and no shelters at all in the northern part of the county; “unless you’re drunk and then you can go to Turning Point.” There was said to also be a need for transitional housing for single women with substance abuse problems in particular. Referring to the recent homeless survey, one respondent reported that there are different types of homeless people migrating to different areas instead of large groups uniformly migrating to south-, mid-, or north-Pinellas. “More single men with mental illness and substance abuse problems moved to St. Petersburg, more families with children moved to Clearwater, and in north county there are no shelters.” It was believed that this migration was due to the availability of shelters and services.

Domestic violence services were said to be adequate, “because there are separate funds specifically designated [for it]...and [it] receives more attention.” It was also said that there is a need for more street outreach for runaways, teens, and 18-21 year olds who are “preyed upon in a shelter.”

While emergency food services/soup kitchens were said to be adequately meeting needs, it was suggested that the ministries partner more with existing food centers.

Transportation for the homeless was described as “horrible.” WorkNet was said to provide bus passes once someone has been hired, but will not give a pass to look for a job. Since the buses stop running at 10:00, a lot of people were said to be offered “jobs that they can’t accept because they can’t get transportation when the shift ends at 11:00.”

Concerning health care for the homeless, it was explained that there is a problem with the Pinellas County residency requirement. It was said that the requirement simply consists of someone stating that they are moving to Pinellas County and plan to make it his/her home. However, “if a homeless man or woman comes from within the county and enters an emergency shelter, they are not considered a Pinellas County resident [and therefore are not able to access services through the Pinellas County Human Services Department].” Even while transitional housing does legally become their residence (an eviction must be processed to remove them, their mail is delivered there, they are registered to vote there, and their driver’s license is assigned to that address), Pinellas County will not recognize it as their legal residence “until they move out of transitional housing or somewhere else.”

Other issues with health care were said to involve “poor communication between the hospitals and the shelters.” Emergency room doctors were said to have formerly written prescriptions that service providers could not fill, leading to [the agency mentioned] sending them back to the emergency room; however, “they
It was also said that if the “mobile medical unit was operating more frequently, it would save a lot of ER trips.” This was said to be due to the shelter receiving visits from the unit two times a week (e.g., Tuesdays and Thursdays). If the front line person says, “the mobile medical unit is coming tomorrow,” the homeless man or woman would say that they could wait. The same response was said to not be the case if it was said that the unit would be coming in two or three days.

In terms of the best model for providing homeless services, it was said that the physical layout of long- and short-term housing providers makes a big difference. To prevent neighborhood complaints, an outdoor waiting area screened with bushes and fences prevents people from seeing the homeless entering, exiting, and waiting. It was also said that a model would consist of “management who understands that they are part of a community (e.g., attends association meetings, becomes a part of the neighborhood business district, partners with other social service providers for planning, etc.). However, some of the smaller shelters were cited as not having these resources.

Transitional housing for single women (Mid-Pinellas Homeless Outreach) and for men/women with substance abuse (in Clearwater) were said to have been provided once, but these services have been closed. Current providers are said to be “going way above their capacity to meet needs (e.g., a case load of 1 to 50 as opposed to 1 to 24). This “hectic” environment was said to be concurrent with higher acuity.

The prioritization and division of funding by the providers (e.g., nearly $3 million per year from HUD, funding from the State of Florida, Social Action Funding from the city and county, all going through the Homeless Coalition) was said to be a much better process than giving these responsibilities to an oversight funding body. However, larger organizations were said to be able to manipulate this process more than a one-person shelter “that can’t get to the table.”

Contact with the programs providing homeless services was said to largely come from word-of-mouth, in addition to referrals from other service providers, law enforcement, and an unknown amount from 2-1-1 (Tampa Bay Cares, Inc., 2004). One respondent described the coordination between mental health/substance abuse, homeless, and basic needs providers as “pretty solid,” since they “tend to be in the same networks” and “communicate pretty regularly.” The exception was said to be health care.

Concerning duplication of services, it was said that “because Pinellas County is so long and narrow with no transportation in between,” there is a mirror-image without duplication. Also, some services may sound like they are the same thing, but are in fact different. For example, Mustard Seed’s transitional housing “serves homeless men/women with a substance abuse problem, who might also have a mental illness, [while] Boley’s transitional housing “serves homeless men and women
with a mental health illness who might also have a substance abuse problem.” It was said that while the “average ear doesn’t hear the difference. . .the providers serving those people know there’s a huge difference.”

Another example given was the existence of five day care centers. While “they may be providing even identical services, if the demand is there then you need multiple sources.” It was said that fewer agencies with more scale (e.g., beds, clients, etc.) are not necessarily better. “In most instances you’re having to spend a concentrated amount of time to really work with an individual through whatever problems are facing them because they’re not coming in with singular problems anymore, they’re coming in with multiple problems.”

**Barriers**

Barriers include a lack of communication about the services that are available, a lack of case management (called “agency service management” by one respondent) for non-connected people, and priority shifting and deviating from the core missions of agencies when a new social issue receives attention (homelessness 15 years ago, then HIV/AIDS, and now hepatitis C). This was echoed by another interviewee, who spoke specifically about “specialty funding for veterans, HIV, substance abuse, mental health, domestic violence, women, and children.” It was said that “trying to find emergency shelter for plain old homeless people. . .forget it.”

Also mentioned was a requirement for deaf interpreter volunteers needing to be certified, which was said to be overly burdensome. Other “hoop jumping” included requiring homeless people to have an identification, get bus passes, and travel to many places. This was said to be especially difficult for the disabled. The services for the homeless were described as not being transactional, meaning that “spending time onward adds up, and some people that are the least able to follow through on advice require more intensive assistance.”

Very importantly, there was said to be a great lack of affordable housing in the county, making the transition out of homelessness very difficult. Language barriers (Spanish to English or vice versa) were also cited, in addition to “not having service providers help [the homeless] know what’s out there.” It was reported that the 2-1-1 line is met with a 30 minute wait to have the phone answered for some people.

People who are said to be “in a rut” were described as “going further in the hole.” A scenario was given of someone “working day labor paying more for housing than [the average person]” because he/she is unable to finance “first and last months’ rent for an apartment and instead pays $30 per day for a motel.“

Finally, stigma [NIMBYism, i.e., Not In My Back Yard] and its relationship with being able to locate services where they are needed was also mentioned as a barrier.

**Suggested changes**

Suggested changes included working with developers for set-asides to include affordable housing units and cutting administrative costs for small organizations by grouping them under a central council that could act as an administrative agency.
Agency-level suggestions included making sure that front-line staff receive the best training, constantly reminding staff of their goals/mission, and advocating that maintenance be included in funding.

The use of homeless system “navigators” was also mentioned, which was said to have been in the county-wide plan for years. A homeless person at any single point would be paired with a navigator (i.e., “buddy system”), who would then guide them through. In the current system, it was said that a case manager is assigned at nearly every agency. When asked about how such a system would be evaluated, it was explained that it would involve “pure follow-through.”

Suggested training for service providers included how to search for and access available housing, more management skills, cultural diversity training, and more training in general for small service providers through partnerships with larger providers.

A reduction in meetings or their alignment on the same day was also suggested. More conference calls and emails were said to be able to contribute to this reduction. In order to accommodate providers who are not able to leave their desks or community business partners, it was said that there should be more meetings before and after business hours.

Policy-level suggestions included changing the Pinellas County residency requirement, (described as currently “devastating” to a small number of people), creating a tax to fund homeless services, and pooling resources and the decision-making process at the funding level. Having agencies evaluate their missions and see where it is appropriate to partner and merge with existing agencies was also suggested to avoid unnecessary administrative overhead (e.g., desks, computers, liability and health insurance).

Priorities suggested for Pinellas County homeless services included prevention funding, an inebriate care center in north county, more affordable housing for the lowest income population, with priority access for homeless people, the removal of barriers for people with criminal histories, and street outreach tied to the ability to move people into housing.

Coordination at the city/county level is said to be an ongoing process, yet in order to have a unified approach, “leaders need to commit to funding.” The relationships between the “24 municipalities” were said to need improvement, while at the agency level it was stressed that there is a need to be more flexible to accommodate situational differences. The county and [a city in southern Pinellas] were described as trying to coordinate as funders and create a user-friendly system (a unified application, glossary, and budget). Monitoring visits for all funded agencies were said to focus on “programmatic issues and issues they may have in coordination or partnering with others in the community.”

All elected officials were said to be the key people that need to be involved in making the above changes happen, especially the “four key municipalities” (Pinellas County and the cities of Clearwater, St. Petersburg, and Largo), in concordance with housing developers. It was said that there is a “long way to go” in making
changes, yet the impetus is already occurring from the federal (e.g., HUD) and state governments. “The area of social services,” it was said, “should set an example that it can be done.”

Health Care Services

Across the findings reported below associated with perceptions, adequacy of health care services, barriers, and suggested changes, the following points were made:

• Health care providers focus heavily on short-term, acute care
• There are disconnects among provider roles as they relate to the community
• Prevention, primary medical care, prescriptions, dental and vision services are not being adequately addressed as priorities
• A big barrier is a lack of knowledge about what services are available
• Fragmentation stands as a barrier to receiving health care services
• Transportation and a lack of interpreters are also barriers
• Electronic medical records and common eligibility criteria across agencies would help
• Everyone in the county is responsible for ensuring changes

Perceptions

Cited as a major problem for the health care system is a short-term focus on acute care. It was said that although it is widely known what the leading indicators are for morbidity and mortality [Author’s Note: cf. Centers for Disease Control and Prevention, 2001], there is an overemphasis on specific indicators instead of “common sense” (e.g., eating habits, exercise). There is also insensitivity to differences in language and any kind of poverty, where cultures are disconnected from and mistrustful of the health care system.

It was said that differences in perspective for the actual provision and context of services between clients and providers (e.g., wait time for an appointment, privacy and confidentiality, and having a clean facility) can be attributed to a lack of communication between the two. A survey was said to be a mediating tool to make providers aware of client viewpoints.

One respondent said that there is a “misunderstanding of what the provider’s roles are” within the community. Hospitals, for example, were said to not fully understand the capacity and value of the Community Health Centers, the result being that “there’s not a real integration of services between the two.” Due to role misunderstanding and provider segmentation, “we don’t really see beyond that to see where we can have certain partnerships and cooperative agreements between providers.”

Part of the “disconnect” was said to include emergency rooms’ recent evolution “to not only provide trauma care, true ER care, but to be a kind of triage, almost medical home, and they [have even gone] so far as to kind of advertise and promote bigger, better, and faster.” These actions were said to “try to get the insured clients
who will help pay for the uninsured care,” but “it has done a real disservice to the whole idea of accessing primary preventive care in a responsible manner which can be done through the Community Health Centers, medical homes, and free clinics.”

A district health systems plan (conducted every couple of years) was cited as illustrating the belief of “key informants” (examples given included case managers, hospital administrators, and Health Department directors) that the “biggest barrier to care was not knowing what services are out there.”

Differences in priority were also cited, where the HIV/AIDS Care Council planning process was given as an example. The consideration of core services was said to include access to primary care and medications, yet “if they don’t have food in their stomach then medication doesn’t metabolize well and so what good is that?” While funding is said to be allocated to services that are certainly needed, funding is not “allocated for services that the clients are desperate for, like housing and food.”

**Adequacy**

While inpatient care, services for infectious diseases (e.g., HIV/AIDS, Hepatitis), and emergency care were said to be adequate within Pinellas County, primary/preventive medical care, dental, prescription, and vision services were said to be leaving gaps in the community.

Prevention was said to be a definite need, where there are inadequacies for the uninsured or under-insured. The health care system within Pinellas County was described by several respondents as “resource rich,” but “fragmented,” with “multiple entry points and multiple eligibilities.” It was said that time and resources are wasted on determining eligibility for federal, state, and county-funded programs, and there should be a common eligibility form to reduce waste and a sliding fee scale or premium based on income.

Described by one respondent as the “one that is the least adequate,” there are “very limited dental services, especially for adults.” Dental services were said to be generally inappropriate and often only for ROP (relief of pain). For pediatrics, there was said to still not be enough Medicaid providers or those who would accept a sliding fee scale.

Prescription assistance and vision services were also described as lacking, and “compassionate care programs,” with the assistance of a case manager, can be “extremely tedious and. . .really poor.” There are prescriptions through the Health Department for family planning (birth control), communicable diseases (especially sexually transmitted diseases), and for those with HIV/AIDS through Ryan White funding, but “it’s a piece here. . .a piece here. . .a piece here.” Primary care in general was described as being “inflexible, where it’s tied to specific things that have to be done.”

The funding allocation to job training to “get people back into working, perhaps insured,” so that they can be taken “off the roles of federal and general revenue dollars and spread the cost of care throughout the private sector as well,” was said to
be an omission. “We’re real good at thinking about how to treat and care, but we’re not real good at looking at other opportunities to empower people to treat and care for themselves.”

There was believed to have been more access to adult dental care in the past, due to university funding that had come and gone. Changes to the Health Department’s services were said to have taken place in the early 90s after Governor Chiles was elected, which led to a heavy focus on prenatal care to the neglect of some other issues.

Having a collaborative health care practitioner team consisting of diverse levels of education and experience (e.g., physicians, nurse practitioners, registered nurses, licensed practical nurses, social workers) was cited as a potential model for providing health care services. Having such a structure, which “depends upon the community that you’re in [and] what works best for your community,” was explained as being necessitated by “precipitating factors. . .that make one at-risk for the illness (domestic violence, ongoing stress, and poor nutrition).”

Coordination between health care service providers was described as increasing informally (through health fairs, community expos, and human service coalition projects), yet formal mechanisms such as case manager training are not funded. It was said that the service providers “understand that they need to collaborate [and] build a referral network,” but formal methods have to be “funded really well in order to get it to work really well.”

Duplication was described as being present, but that there is “opportunity in duplication.” Examples included prescription drugs for the uninsured, planning contracts, and non-profits that overlap with a statutory mission (e.g., the Healthy Start Coalition). For the prescription drug programs, there are “opportunities for integration,” and while a “small segment overlaps, those are very diverse populations.” For planning contracts and non-profit overlap, “just because you’re created by statute to do something doesn’t mean you’re the best entity to do it. . .you really have to look for what’s going to serve the community.”

The 2-1-1 service was said to be “very helpful” for referring people to the Health Department, and the mobile medical van (partly funded by the federal Bureau of Primary Health Care and Pinellas County government) was said to be a great help for people who are homeless.

**Barriers**

People’s psychosocial issues were reported as being a barrier to the receipt of adequate health care, and mental health was said to often get separated and shorted in funding decisions; “it’s almost virtually impossible to be physically healthy if you are not mentally healthy,” one respondent stated.

It was said that “we all have different funders, different rules, different eligibility, etc. . .so some poor person has to go and get an eligibility for WIC, an eligibility here, an eligibility there, and they’re still by any means going to be a zero percent pay.”
Fragmentation was mentioned many times as a response to this question, and it was said that “you almost have to have somebody be a medical navigator for you.” Transportation and a lack of interpreters were also cited as barriers, where there is a “current Mexican population coming into Clearwater. . .we have the Southeast Asians we’ve had for a good 30 years in St. Petersburg. . .in the 80s we had Eastern European Balkans come in, and now we’ve had Somali Bantu refugees. It still is a county that’s about 88% Caucasian, but the minority population is growing.”

Other barriers included the absence of a funding mechanism, the increasing rate of uninsured, cultural disconnects (e.g., awkwardness caused from having children interpreting for parents or where the rank and status of women in certain populations makes it so that they are unable to access care without them present), and people not understanding 1) how to access care and 2) how to keep from getting into a “loop in the first place.” An example of the Ryan White Care Council was given, where people were not able to attend a community forum because they “did not have cars, bus money, tokens,” and it was not within walking distance. The perspectives gained from the meeting, then, were those of “primary care providers, representatives from the pharmaceutical industry, and case managers. . .depending on who you have sitting around the table, you’re going to get a real hodgepodge.”

It was also said that “if they can’t walk at night to a provider that’s open, they can’t go because they’ve got to work during the day or they’ve got to take care of their kids. . .and then if [they] don’t have money to pay for drugs,” or don’t have food to prevent sickness caused by the drugs, then “they don’t take them.”

**Suggested changes**

Common eligibility criteria across programs and providers, electronic medical records and an increase in pro bono work from physicians were suggested changes. More emphasis on prevention and chronic disease management were also suggested improvements, especially in the interest of reducing uncompensated care to decrease the number of ER visits; “If you have a place for someone to go, they’ll learn about their diabetes before they end up showing at the hospital.”

The allocation of funding was described as “disproportionate” and “backwards,” where “most of the money we’ve spent on most of us in our lifetimes. . .is done in the last 30 days of life.” It was said that priorities should be shifted to where, “if you can get them at the age of 13 and they’re not overweight, not smoking, and have good nutritional habits, then you have probably bought yourself 30 or 40 years.” The capacity for this to change was doubted, however, since “children don’t vote.”

The suggestion was made to have block funding that would be prioritized at the local level. Oregon was cited as a model example of having a near universal health care system. While it was said that Americans are generally afraid of having such a system because it “sounds socialist,. . .people have to understand that [health care] is not direct, it’s more indirect, and there’s a systemic return.”

It was said that the Community Health Centers, the county government, and the Health Department have been attempting to form a triad to say, “We have a building. You don’t. We don’t have staff. You do.”
A better system to identify, define, and prioritize the needs of the community was described by one respondent as being modeled after the Ryan White Care Council model. The organizations that have “either been created by statute or have demonstrated through their missions that they plan [and] have worked with the community about strategies. . .should be the recognized leader.” Their planning functions could then “flow up to a Human Services Planning Council, which should sit to review those planning documents, prioritize service needs, and then recommend funding to the Juvenile Welfare Board, United Way, Pinellas County government, City of St. Pete, etc.”

It was said that there should be an administrative or process audit of “what happens when somebody comes into the system; how they move through the system.” It would then be asked, “Where are too many hands touching that person where they really don’t need to?” Bringing in the “consumers who are actually consuming the service” would also be sought.

Additional training needs were said to be needed in the areas of cultural competency and “understanding that medicine is one thing, health is something else, and health is what we do . . .you don’t measure [social issues such as domestic violence] with a blood pressure cuff or glucose meter, [yet] the reality is that they’re not reimbursed by the insurance companies.”

Health care providers were said to be highly trained in disease intervention as opposed to health. Highly educated physicians were said to not be needed in many cases, especially for prevention. The example of obstetricians predominantly being used for deliveries when 80% of births are normal was given. In Europe, the midwives are used in conjunction with physicians that act as consultants for complications, yielding a savings of half the cost.

Having an organized training effort for front line service workers (i.e., case managers) to understand the services in the community (e.g., eligibility requirements, forms) was also cited.

Suggestions were made to have an electronic passport card, electronic medical records, and common eligibility. To prevent malpractice rates from increasing, it was said that “physicians, the practitioners, and every provider either take X amount of pro-bono work or become volunteers [to gain] sovereign immunity.” The use of volunteers was also mentioned regarding the creation of satellite sites (e.g., located at the St. Pete Free Clinic, Community Centers, and ER) to train people to apply for and receive free prescription drugs from available pharmaceutical industry programs.

Described as needing to become the main priority for health care services in Pinellas County was prevention. The examples of early screening and chronic disease management (including pharmaceuticals) were given, in addition to school-based prevention for children. It was said that “if we don’t manage diabetes and hypertension. . .we’re going to get them in the ER.”

While it was said that “changes have to be occurring in small groups,” it was also mentioned that “every person in the county (e.g., parents, extended family, preschool, neighborhood) needs to be involved in making the above changes happen,
[since] we all have our own individual and collective responsibilities, [and] when there are people who are not well, it truly does drag down all of us since we’re all impacted.” This sentiment was echoed by several respondents.

**Mental Health/Substance Abuse Services**

Across the findings reported below associated with perceptions, adequacy of mental health/substance abuse services, barriers, and suggested changes, the following points were made:

- The abilities and limitations of agencies are not understood by the public
- There is a lack of funding in several categories (e.g., outpatient services, care for people with severe mentally ill and the non-SMI population, and mandates)
- The system is not allowing people to become self-sufficient
- Common outcomes and their associated data requirements are needed
- Case management is ineffective and duplicated
- There is no coordination of receiving facility capacity on a real-time basis
- Residential care for people with substance abuse problems is needed
- There is a need for more transitional housing
- The public transportation system is a problem
- There are multiple oversight bodies, all with different performance outcome measures and data requirements
- There is a great need for more vocation training
- County representatives need to advocate changes at the federal, state, and local levels

**Perceptions**

Differences were said to exist between what the public perceives agencies should do and what agencies can or are obligated to do. This lack of understanding was said to be due to the complications of the mental health/substance abuse service system concerning regulations, funding, and terminology. In order to address this problem, it was suggested that there be an opportunity to pool resources and collaborate for an awareness campaign.

Agencies were cited as also needing to be dedicated to consumer awareness (i.e., providing information and referrals), staffing a type of “consumer liaison.” While it was said that the disconnect could never be completely alleviated due to constant changes in rules and regulations, “you could certainly do steps to strengthen the messages.”

Concerning housing specifically, it was said that mental health and substance abuse are not being viewed as a chronic persistently relapsing medical condition. If a person has a relapse, then they are “kicked out. . .now those that were housed are all of a sudden homeless.”
Adequacy

There is a reported complete lack of funding for outpatient services, and while “after care” (changed to “continuing care”) is desired for programs such as sobriety maintenance, it is an “unfunded mandate.” The research and evaluation for the models of treatment were also said to be underfunded, yet they are also mandated.

There is also a need for more transitional housing and for restoring civil rights (e.g., from a felony conviction). Case management is said to be “ineffective” and a misunderstood term, since it is categorical as opposed to holistic; a person can potentially have more than 12 case managers. There is also frustration that counseling/treatment is relegated to directly-matched funding streams, even when lead-to factors are closely related. There are virtually no services for the working poor, and the public transportation problems contribute to non-compliance.

The level of care required for people with severe mental illness (e.g., Schizophrenia) is said to be cost prohibitive and underfunded. It was said that there is “never enough money for medications.” Residential treatment for drug and alcohol abuse was cited as being non-existent, since insurance providers no longer pay for it.

Many of the shelters were said to not have mental health professionals. Most shelters were said to have the requirement to be working on a plan of care to move the individual toward self-sufficiency. This was explained to mean meeting with a mental health counselor and being put on medication. Someone who does not want to be put on medication was said to possibly become disruptive. Because of the level of care that they require, it was said that sometimes those persons are not appropriate there.

Pinellas County was said to have some funding for special projects. After advertising an RFP (Request For Proposals), all of the mental health/substance abuse providers were said to have joined to form a new 501c3 agency (PG3) and submitted one application. However, the county subsequently did not award any funding that year because of funding shortfalls.

The funding in Pinellas County for mental health/substance abuse services was described as being per-capita and for those that have no money to meet the highest needs. However, it was said that this system “leaves no opportunity for any prevention funding for those families that might be at greatest risk (e.g., within the middle class working poor).”

There are two groups of mental health/substance abuse stakeholders that meet on a somewhat regular basis in Pinellas County: The Mental Health Coalition and the Mental Health Leadership Group.

While it was said that there are a lot of services that could be “more coordinated,” duplication was said to be a “mismomer.” It was asked, “Are you duplicating a service if a family member went in and out [or] moved? . . .people say everybody’s doing case management, but they’re doing pieces of case management. . . is any one person doing case management for the holistic person or the family? No, because they’re not funded to.”
Barriers

There was said to be no coordination of receiving facility capacity on a real-time basis, and that there is a wait list for all mental health services. It was also said that since the system is set up for the extreme poor, it prevents people from being able to gradually build self-sufficiency.

There were said to be no services for the deaf and very little availability of translators. Citing recent Census data for Pinellas County, one respondent said that the Hispanic-speaking population quadrupled, yet the capacity to serve that population is not being built.

Transportation was cited as being “a tremendous barrier.” It was asked if anyone had ever investigated the bus routes, to where it was overlaid with all the service provider appointments to answer the question, “Does [being on a bus six hours a day] have anything to do with their lack of compliance?”

Different database systems for mental health/substance abuse are also consuming administrative time to enter the same information many times. Each funding source or oversight agency requires different outcomes to be analyzed, to where it seems that “nobody wants to know about the whole picture. . .there's too many barriers for clients to jump through due to each person having a piece of the puzzle. . .where they might have 20 case managers, they could very well have 20 to 30 performance goals.” Database examples include:

- SAMIS - Juvenile Welfare Board of Pinellas County database
- JCAHO accreditation standards – compliance issues surrounding care environment, patient safety and consumer satisfaction.
- DCF/Department of Children and Families - reporting entered based on client self-report at intake via the State Integrated Substance Abuse Report to the DCF data warehouse.
- Central Florida Behavioral Healthcare Network (CFBHN) - data is also extracted and reported to this entity. Additionally, there are mandatory reportable outcome measures.
- Department of Corrections - outcome measures are not consistent with DCF outcome measures
- Department of Juvenile Justice also has different outcome measures
- HUD - mandates that providers participate in a Homeless Management Information System (HMIS) - the contracted provider that is handling this in Pinellas County is 211 Tampa Bay Cares via the Tampa Bay Information Network

Suggested changes

More overlay services and discharge planning processes were said to be needed between providers, where resources can be pooled “to find out ways to better serve the consumer as opposed to having to go agency to agency.” More HIPAA (Health Insurance Portability and
Accountability Act) consent forms was suggested as allowing providers to “truly build a seamless container of care for our client populations without violating 42 CFR.”

There is a need to have innovation that is funded, such as going where the clients are as opposed to vice versa. Examples include granting a travel allowance and incentives for going into homes to provide services using evidence-based models. There are also opportunities to save administrative costs. For example, there are over a thousand non-profits in Pinellas, and there are common requirements for each of them to have CPR/First aid. Resources can be pulled together to save on these types of costs.

Common outcome measures was cited as being needed to eliminate administrative duplication. Additionally, how these outcomes are evaluated should be changed. For example, it was said substance abuse outcomes are abstinence-based instead of being evaluated as a chronic condition with relapses. It was explained that other medical conditions contain indicators that consider the conditions as chronic versus acute.

Overall, funding for mental health/substance abuse services was said to have been much more flexible in the past. It was said that “it’s not just that the funding’s not there. . .the funding’s there. . .it’s just that you have so many more restrictions on what you’re allowed to use the funding for.” Specifically, it was said that there is a need to provide funding for job training and education to enable people to become self-sufficient. An innovative example was given of women being trained as plumbers in the early 1990s to gain a level of income security for themselves and their children. The concern for “whether [a] job will allow for eventual financial stability, based on the number of mouths to feed, pay rate, etc.” was said to be needed beyond merely job placement that would “set the clients up for failure.”

Another respondent said that vocational training should be “approached in an integrated fashion,” where “every model says that the best practice is to develop individual recovery plans. . .and those have to address all of the different domains of their lives and be focused on self-sufficiency.” Without addressing the vocational piece, which has “really been gutted in the last 10 years,” you’re basically making it impossible for them to become self-reliant.”

The capacity for change was described as requiring advocacy on all levels, where Pinellas County needs to “push the platform on a federal, state-wide, and local level. . .you can’t be hurriedly trying to solve one problem and create 12 others.”

**Basic Needs Services**

Across the findings reported below associated with perceptions, adequacy of basic needs services, barriers, and suggested changes, the following points were made:

- There are differences in perception between providers and consumers regarding accessibility, solutions, and situational considerations
- Rent/mortgage and utility assistance stand as major needs
- Lack of an adequate public transportation is a problem
Variations in service provision occur from both personal and situational differences

Basic needs should be ensured before addressing other areas

Enlightened leadership from the political and residential spheres are needed to make changes

Perceptions

It is suggested that the reader re-review the homeless services section on perceptions, since the perceptions of those connected with basic needs services (i.e., consumers, providers, neighborhood residents) are either very similar or exactly the same. This is due to the mixed inclusion of the homeless in the respondents’ answers. Extracted comments that were definitively related to basic needs will be provided here.

It was said that there is a need for the public to understand that “we’re not living in the times of their mothers or fathers or grandparents. . .people don’t live off the land anymore and there are single parent working households where people are struggling to pay their bills and feed their families. . .single mothers who have had men walk away from their families or die are using the system because of a circumstance that happened to them. . .people forget that they have not always been where they are today, where they seem to think ‘I struggled to get where I am’ but don’t realize that the people they’re talking about are doing the same thing that they were doing then.”

Between providers and consumers, it was said that there is a definite difference in the perception of accessibility. Hours of operation were cited as an example, where “somebody’s electric is being turned off today and the agencies providing utility assistance require [him/her] to make an appointment.”

Interestingly, one respondent said that aside from possible discrepancies in understanding or a difference of opinion about basic needs, there is more of a “lack of recognition on both parts. . .about how to solve it.” From the client’s perspective, it was said that there is not an understanding that resources are limited and that agencies make decisions based on the availability of these resources. However, crisis situations such as someone about to “lose the roof over their head or the utility is about to be shut off,” leads to a misunderstanding of “why somebody can’t just write a check.”

Also cited was the viewpoint of having all problems be the same, where “10 people can walk in the door for a specific type of assistance, either electric or rent or food and the reason they’re here are 10 totally different reasons. . .how we respond has to be based on those situations.” An example was given of a girl and her roommate who had been staying at a motel, working, and would be paid the Friday of that week. They had asked for assistance to pay for the remainder of the week’s hotel costs. The agency in question “normally doesn’t [pay for a] motel, since it’s more expensive, yet the consideration that they would be only need short term
assistance and would be using their resources to get into a longer term solution was made. If they had said that they were unemployed, out of money, and staying at the hotel, “I probably would have tried to get ‘em into a shelter.”

### Adequacy

Rent/mortgage assistance was said to be grossly misaligned with the needs, due to the housing market value. It was said that, “someone will walk in the door with a $300 voucher and can’t find a place to use it, so instead of having anybody off the street, we’ve got no one off the street.”

Utility assistance was also said to be a critical need area, especially regarding deposits. It was said that since some programs providing basic needs services have begun requiring appointments, “there’s so many people in need the appointments are a week or two away.”

It was also explained that chronically low income or impoverished areas have bad insulation, older, faulty appliances that consume energy, and problems with leaking roofs. Those who have written a bad check become cash-only payers, to where even an agency check will not be accepted.

Food donations are cyclical, where summer donations are down and children are home from school (and not taking advantage of the free school lunch program). If someone has a medical condition, providing a special diet was said to create another set of issues.

Clothing was said to not be a critical need, since there are enough donations and these can be recycled. Women’s clothing is especially abundant, yet different types of men’s clothing (seasonally related) is said to sometimes be needed. Volunteers were said to always be needed to assist in collecting and distributing items such as food and clothing.

It was said that most agencies do not assist with vehicle insurance, meaning that people will simply not have it to get to and from work. The topic of car repairs was also mentioned as being an issue.

Cited as services that are no longer provided included dental visits (Medicaid providers have diminished, and the county was said to have had a geriatric dental program) and a reduction in overall existing services (e.g., time limitations, more stringent eligibility).

The suggested model for providing basic needs services was said to be an “informal one based on trust.” It was explained that networking and relationships are needed to “be able to cut through everything to get people the services they need.” Specifically, it was said that there is an opportunity to have a work-study program to where education is prioritized over training. For example, parents with dependent children would be able to finish a GED or St. Petersburg College and also work at the agency to be able to “pull themselves together and move forward.”
It was said that there is a current focus on homelessness because it is “the most picturesque,” although “hunger has been an issue and continues to be an issue in this country but you can’t see it. . .we don't have little bloated bodies walkin’ around.” It was said that in this person’s experience when the new “buzz word” comes around (for a while it was drugs and then HIV/AIDS) everything else goes by the wayside.” It was said that there is a need to take a “holistic look at the needs and not put all of our concentration in one area, one group of people, one segment of society, one age group, one race, one neighborhood, because as soon as you do that then it has to give somewhere else. . .I'm not saying it’s not needed, just to don't take it from somewhere else.”

**Barriers**

The discussion of barriers for basic needs focused on accessibility, such as highly inconvenient hours of operation, appointment requirements, and problems with the transportation system. It was said that city and council planning, beyond coalition meetings, does not include the people who are providing services so that they have a voice in the plan.

From the client’s perspective, it was said that there are privacy concerns for the elderly, some cultures have a fear of authority, and there are misunderstandings in communication (i.e., language interpretation).

Significant numbers of people with basic needs were said to be illiterate (e.g., are unable to fill out an application, can barely read street signs). These people were said to have “learned how to survive and fake it, but they’re faking it only and so the result is that they can’t take advantage of the services, they don’t know what’s available, they don't know how to get it, and they don't know how to connect it efficiently.” Additionally, many people were said to need budgeting skills, which was said to be secondary to food, since “budgeting follows through everything that you do.”

At the agency level, an example was given that barriers can be raised by the volume of people at any given time and the unwillingness of certain provider personnel to deal with clients who “aren’t very pleasant, or aren’t pleasant in [their] eyes.” Differences in how clients are treated were also described, where some may receive priority over others. Someone was said to be lucky to reach someone who will “will say, ‘let me guide you through this maze and let me get you to the right doors, or let me make a phone call for you so they’ll let you in the door when you get there.’”

**Suggested changes**

Changes were said to need to be accomplished without placing too much emphasis on any one issue so that there can be a complete picture. Areas of need were said to need to be “worked on simultaneously. It’s like raising a kid, you can’t make their dinner and not care if they’re wearing clothes outside to play or who’s going to keep the roof over their head.” Both the formal and informal systems within the county were said to need to integrate.
Another respondent said that there is a need to form a strategic team that would make a connection with the state and county (and industry), followed by a coordination and centralization of all activities that would be as efficient as possible.

A focus on education beyond training was cited as being needed to “provide a level of consciousness. People need political education, social education. They need education about who they are and what they’re doing, what their aspirations are and how these things work. Otherwise just training people from one task to another, how to make a bed or how to be a fry cook, doesn’t get them anywhere.”

It was said that the public should be encouraged to volunteer more in order to dispel myths about people who are poor and have basic needs. This volunteerism would allow people to “have that face-to-face contact and hear the stories themselves. . .hear the plight of what is going on with the people that we’re serving.” It was mentioned that many of the schools in Pinellas County require community service, and that it is especially important for “kids that come from those affluent homes involved in programs like this, they walk away with something and they talk about it to their parents, and it may put things in a little more perspective for their parents too.”

The use of technology was suggested as a way to better coordinate the provider system and save case managers a lot of time. However, it was recognized that there are confidentiality issues such as HIPAA that would need to be worked around.

Basic needs were said to need to be the main priority for Pinellas County, since “if you’re meeting basic needs then people can worry about other things like getting better jobs, taking care of the children. . .substance abuse. . .a health issue. . .or mental health issue. . .until you can rest assured that you have an apartment or a home to go to and a loaf of bread in the cupboard” it is difficult to concentrate on other things.

In terms of change and the capacity for that change, it was said that there is a need to have enlightened leadership, political will, the interest of residents, changes that are made strategically, and a feeling of trust that has to be built first to be able to talk honestly about the problems and their solutions. Additionally, it was said that there has to be an “honest belief that the government, or whoever, wants solutions and not the problem to throw money at.”
Summary

Data from the focus groups, public forums, key informant interviews and mail surveys yielded perceptions of how the human services system currently operates with respect to the four topical areas (homelessness, health care, mental health/substance abuse, and basic needs). Unmet needs and barriers, interwoven as affecting or effecting the other, are met with frustration, exasperation, and even a sense of grief and loss. Motivated by the belief that changes should and can be made, advocates shared personal stories, the perspectives of others, and their thoughts on what they considered the most important issues. The next step, prioritization, will involve weighing the disparate priorities among the general public, service providers, city/county officials and administrators, and consumers.

Comparing the findings of the 1992 needs assessment, duplication of services is reported as far less of an issue. Instead, similar services are said to be supplemental with respect to the needs that exist. Fragmentation and uncoordinated services remain as constants, and the responsibility for changing them is reported as belonging to the funding sources, in large part.

Recurrent top concerns identified included lack of affordable housing, transportation difficulties, lack of health care for the un/underinsured, including lack of prescription assistance, funding restrictions, and a lack of communication and coordination. Interestingly, there is a sense that while many services are available in Pinellas County, knowledge of these services that are constantly changing in terms of capacity, funding, and requirements is greatly lacking not only from the public’s perspective, but between and among the providers.

The people that were constantly referred to were the “working poor” who are above but near eligibility requirement thresholds. The area of the county, the day-to-day changes within an agency, or even the knowledge or span of networked resources of the person who answers the phone can yield an individual experience with the human services system that is completely different. From the consumer standpoint, personal determination, existing resources, and coping affect their success or failure to achieve or maintain self reliance. The frustration of the service providers and the people in need of or receiving services is captured here and deserves pointed reflection and consideration.
The geographic, personal, or systemic barriers are similarly variable, and necessitate a system that is both structured and flexible in order to be dependable, accountable, and reflective of the episodic and chronic needs within Pinellas County. Consideration must also be made to address the “hierarchy of needs” and their interrelationships. Abraham Maslow purported a model to convey that physiological needs take precedence over safety, love and belonging, esteem and recognition, and self-actualization (Maslow, 1968). The categories investigated here (homelessness, health care, mental health/substance abuse, and basic needs) can be viewed as major components that are necessary to achieve at least a minimum standard of self-integrity.

The consequences of gaps and inadequacies within these areas encompass significantly more than the direct service provision costs alone. Economic, social, and psychological losses are incurred to consumers, family members, and the community. Absenteeism, productivity, peace of mind, and quality of life are examples of the intangible effects that elude quantification, but contribute to its impact and implications. As maintained by Dale Hyland in his critique of the 1992 needs assessment, “each of us are potential customers of the vast service delivery network and have the need to ensure that cost-efficiency and accountability for results are maintained” (Hyland, 1993).
References


Pinellas County Needs Assessment

Introduction (2 minutes)

Good morning/afternoon and welcome to our session. Thank you for taking the time to join our discussion today on the human service needs of Pinellas County.

My name is Seraphine Pitt Barnes and I represent the University of South Florida. Assisting me is Julienne Giard, also from the University of South Florida. Our role today is to guide the discussion, not participate. You are the experts and we are here to learn from you.

As part of a human service needs assessment on behalf of Pinellas County, we are attempting to identify the unmet needs in the [homeless, health care, mental health/substance abuse, basic needs] system, identify the barriers to a coordinated system, and explore the possibilities for change. You were all invited because you are providers of these services in Pinellas County.

Before we begin, let me remind you of some ground rules. Please speak up and only one person should speak at a time. We’re tape recording the session because we don’t want to miss any of your comments. If several people are talking at the same time the tape will get jumbled and we’ll miss your comments. There may be times throughout the discussion that I may interrupt you, please don’t let me cut you off. However, we may need to move forward as we have a lot to cover.

There are no right or wrong answers, but rather differing points of view. Please feel free to share your point of view even if it differs from what others have said. In this session, it is important that everyone fully participates. Everyone is an important resource.

We will be on a first name basis today. The information will be summarized for the final report, and no names will be attached to their comments. We assure you complete confidentiality.

Our session will last about two hours, and we will not be taking a formal break. In the event you may need to use the restroom at any time, they are located…. We have placed name cards on the table in front of you to help us remember each other’s names.

Ice Breaker (2 minutes)

Let’s find out some more about each other by going around the room one at a time. Tell us your name and the organization you represent.

APPENDIX A

Focus Group Facilitator Guide
**Activity 1 (40 minutes)**

At this time I would like each of you to brainstorm, for about 5 minutes. The question is, "What are the unmet needs in the [homeless, health care, mental health/substance abuse, basic needs] system." Please categorize by age group (i.e. children, adults, elderly). Keep in mind all racial/ethnic groups.

*Participants will be instructed to write ideas on a sheet paper provided for them.*

**Co-moderator:** Write question on the flip chart for all to view, “What are the unmet needs in the [homeless, health care, mental health/substance abuse, basic needs] system?”

*Participants will be instructed to share their ideas, round robin approach.*

**Co-moderator:** Records and numbers ideas on flip chart.

Would you give me one idea from your list?

Are there any questions or comments group members would like to make about the first item?

**Co-moderator:** If unmet needs list takes up more than one page of the flip chart, we will need to tape the sheets of paper to the wall, so all needs can be in plain view of participants.

*Participants will be instructed to rank their unmet needs on index cards.*

**Moderator & Co-moderator:** Will collect index cards and tabulate.

The most highly rated unmet needs (2-3) for this group are:

Let’s talk about the first need.

- **Tell me more about...**
- **How can the need for … in Pinellas County be resolved?**
- **Who are the key players in resolving this need in Pinellas County?**

**Activity 2 (40 minutes)**

Now we are going to go through the same process, but with a new topic.

This time brainstorm, for about five minutes. The question is, "What are the barriers to a coordinated system of care in the [homeless, health care, mental health/substance abuse, basic needs] sector?"

**Co-moderator:** Write question on the flip chart for all to view, “What are the barriers to a coordinated system of care in the [homeless, health care, mental health/substance abuse, basic needs] sector?”

*Participants will be instructed to share their ideas, round robin approach.*

**Co-moderator:** Records and numbers ideas on flip chart.

Would you give me one idea from your list?

Are there any questions or comments group members would like to make about the first item?
Co-moderator: If barriers list takes up more than one page of the flip chart, we will need to tape the sheets of paper to the wall, so all barriers can be in plain view of participants.

[Participants will be instructed to rank their barriers on index cards.]

Moderator & Co-moderator: Will collect index cards and tabulate.

The most highly rated barriers to a coordinated system of care (2-3) for this group are:

- Let’s talk about the first barrier.
- Tell me more about the…
- How can the barrier of … in Pinellas County be addressed?
- Who are the key players in addressing this barrier in Pinellas County?

Now let’s talk about the possibilities for change. (30 minutes)

- What are some of the successful changes that have been made to the [homeless, health care, mental health/substance abuse, basic needs] system in Pinellas County?
- What are some of the unsuccessful changes that have been made to the [homeless, health care, mental health/substance abuse, basic needs] system in Pinellas County?
- What are some of the changes that need to be made in the Pinellas County [homeless, health care, mental health/substance abuse, basic needs] system?
- Tell me about the willingness of people and organizations in Pinellas County to make these changes.

Summary – Brief (2 minutes)

This is what we talked about-----Did I leave anything out or would anyone like to add anything?

Thank you for your time!
Homeless Services
(N = 3 people)

Location: Worknet Pinellas (4525 140th Avenue North, Clearwater)
Date: October 27, 2004
Time: 2:00 – 4:00 p.m.

Unmet needs

Participants were asked to brainstorm a list of unmet needs. They each contributed to a group list on a flip chart through a round-robin approach until their lists were completed. Participants were then asked to rank what they thought were the top two unmet needs from the group list. The unmet need with the most votes (see “ranking” column) was further discussed by the group (e.g., how can it be addressed, who is responsible for addressing this unmet).

<table>
<thead>
<tr>
<th>Topic</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>(All) Lack of housing (permanent affordable &amp; supportive)</td>
<td>2</td>
</tr>
<tr>
<td>(All) Lack of Transportation</td>
<td>1</td>
</tr>
<tr>
<td>(All) Lack of long-term (multi-year) funding</td>
<td>1</td>
</tr>
<tr>
<td>(All) Lack of regional service centers</td>
<td>1</td>
</tr>
<tr>
<td>(All) Lack of homeless prevention programming</td>
<td>1</td>
</tr>
</tbody>
</table>

Other unmet needs (this list was generated by participants in the initial round-robin exercise, but not voted as the top unmet needs):

<table>
<thead>
<tr>
<th>Children</th>
<th>Elderly</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Lack of childcare (including after school care)</td>
<td>• Lack of respite care</td>
</tr>
<tr>
<td>• Lack of medical detox</td>
<td></td>
</tr>
<tr>
<td>• Lack of MH treatment for 0-5 year olds</td>
<td></td>
</tr>
<tr>
<td>• Lack of scholarships for children for education (college/higher education)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adults</th>
<th>All Age Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Lack of respite care</td>
<td>• Lack of system navigators</td>
</tr>
<tr>
<td>• Lack of medical detox</td>
<td>• Lack of medical care (including dental, vision, prescription, non prescription medicine)</td>
</tr>
<tr>
<td>• Lack of MH services</td>
<td>• Lack of transitional services</td>
</tr>
<tr>
<td></td>
<td>• Lack of long-term follow-up care</td>
</tr>
<tr>
<td></td>
<td>• Lack of comprehensive discharge planning (hospitals, jails, providers)</td>
</tr>
</tbody>
</table>
Barriers to a coordinated system of care

Participants were asked to brainstorm a list of barriers to coordinated system of care for homeless services in Pinellas County. They each contributed to a group list on a flip chart through a round-robin approach until their lists were completed. Participants were then asked to rank what they thought were the top two barriers from the group list. The barrier with the most votes (see “ranking” column) was further discussed by the group (e.g., how can it be addressed, who is responsible for addressing this barrier).

<table>
<thead>
<tr>
<th>Topic</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate funding &amp; fragmented funding (scattered)</td>
<td>3</td>
</tr>
<tr>
<td>Lack of business, academic &amp; urban planners in planning</td>
<td>2</td>
</tr>
<tr>
<td>Political &amp; civic construction in county (20+ municipalities)</td>
<td>1</td>
</tr>
</tbody>
</table>

Other barriers (this list was generated by participants in the initial round-robin exercise, but not voted as the top barriers):
- Lack of coordination of federal agencies
- Fear of losing resources
- Inflexibility of funding & eligibility requirements
- Lack of standardization of funding, laws, etc.
- Fear of losing agency identity
- Shape & density of county (tome consuming to provide services)
- Lack of coordination/communication with other counties/coalitions
### Health Care Services

(N = 10 people)

Location: Worknet Pinellas (4525 140th Avenue North, Clearwater)

Date: September 29, 2004

Time: 9:00 – 11:00 a.m.

### Unmet Needs

<table>
<thead>
<tr>
<th>Topic</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>(All) Indigent services for uninsured &amp; underinsured</td>
<td>4</td>
</tr>
<tr>
<td>(All) Emergency prescription assistance</td>
<td>3</td>
</tr>
<tr>
<td>(All) Access to specialists (e.g., Geriatricians)</td>
<td>3</td>
</tr>
<tr>
<td>(All) Lack of coordination/common eligibility/ single point of entry</td>
<td>2</td>
</tr>
<tr>
<td>(Children) Access to acute care outside hospital</td>
<td>2</td>
</tr>
<tr>
<td>(Children) Lack of health insurance for all children under 19</td>
<td>2</td>
</tr>
<tr>
<td>(Adults) Access to health care outside hospital</td>
<td>2</td>
</tr>
<tr>
<td>(All) Unfunded mandates from Tallahassee → accountability</td>
<td>1</td>
</tr>
<tr>
<td>(All) Basic MH services for uninsured</td>
<td>1</td>
</tr>
<tr>
<td>(All) Home health aides &amp; nurses</td>
<td>1</td>
</tr>
<tr>
<td>(All) Lack of community partnership</td>
<td>1</td>
</tr>
<tr>
<td>(Elderly) Affordable home health care</td>
<td>1</td>
</tr>
</tbody>
</table>
Other unmet needs:

<table>
<thead>
<tr>
<th>Children</th>
<th>Elderly</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Residential placement – special needs/emotional problems</td>
<td>• Rising cost for long term care</td>
</tr>
<tr>
<td>• Nutritional programs (hypertension, diabetes problems)</td>
<td>• Rising cost of prescriptions</td>
</tr>
<tr>
<td></td>
<td>• Adult daycare/respite</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adults</th>
<th>All Age Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Efficient system for working poor (insurance &amp; income assistance)</td>
<td>• Emergency MH services</td>
</tr>
<tr>
<td></td>
<td>• Corporate &amp; citizen responsibility for healthy lifestyle</td>
</tr>
<tr>
<td></td>
<td>• Affordable comprehensive dental program</td>
</tr>
<tr>
<td></td>
<td>• No reimbursement for prevention services</td>
</tr>
<tr>
<td></td>
<td>• Affordable health insurance for working poor</td>
</tr>
<tr>
<td></td>
<td>• Cultural competency of providers</td>
</tr>
<tr>
<td></td>
<td>• Lack of user-friendly transportation</td>
</tr>
<tr>
<td></td>
<td>• Medicaid/Medicare does not reimburse for hearing aids, vision devices, etc.</td>
</tr>
<tr>
<td></td>
<td>• Providers not informed of all services</td>
</tr>
<tr>
<td></td>
<td>• Health services for illegal aliens &amp; political refugees</td>
</tr>
</tbody>
</table>

Barriers to a coordinated system of care

<table>
<thead>
<tr>
<th>Topic</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of community priority/vision</td>
<td>6</td>
</tr>
<tr>
<td>Lack of funding</td>
<td>4</td>
</tr>
<tr>
<td>Lack of knowledge of all services among providers</td>
<td>3</td>
</tr>
<tr>
<td>Lack of community partnership</td>
<td>2</td>
</tr>
<tr>
<td>Lack of common eligibility/single point of entry</td>
<td>2</td>
</tr>
<tr>
<td>The National health system</td>
<td>2</td>
</tr>
<tr>
<td>Funding source constraints/ categorical funding</td>
<td>1</td>
</tr>
<tr>
<td>Lack of system to educate community</td>
<td>1</td>
</tr>
</tbody>
</table>
Other barriers:
- Duplication of services (geographically & programmatically)
- Not wanting to give up control
- Lack of transportation/challenges
- Concentration of services in some areas of county
- Rising cost of liability insurance
- Lack of compatible information systems
- No way to share medical information electronically
- Limited eligibility scope
- Lack of buy-in to the concept

**Mental Health/Substance Abuse Services**
(N = 6 people)

Location: Worknet Pinellas (4525 140th Avenue North, Clearwater)
Date: October 28, 2004
Time: 10:00 – 12:00 p.m.

**Unmet needs (Ranking = number of votes as a top unmet need)**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>(All) Need client-focused system / pathways of care</td>
<td>4</td>
</tr>
<tr>
<td>(Adults) Lack of housing &amp; transitional housing (decent &amp; affordable, accessible) and for felons</td>
<td>4</td>
</tr>
<tr>
<td>(All) Lack of integrated (care and funding) for those with co-occurring MH &amp; SA disorders</td>
<td>3</td>
</tr>
<tr>
<td>(All) Need to identify “what works” &amp; “for whom”</td>
<td>2</td>
</tr>
<tr>
<td>(All) Fragmentation of system for client (multiple providers/agencies/services)</td>
<td>1</td>
</tr>
<tr>
<td>(Adults) Lack of detox beds</td>
<td>1</td>
</tr>
<tr>
<td>(Adults) Lack of coordination between outreach, housing &amp; treatment</td>
<td>1</td>
</tr>
<tr>
<td>(Elderly) Lack of one-on-one in-home counseling</td>
<td>1</td>
</tr>
</tbody>
</table>
### Barriers to a coordinated system of care

<table>
<thead>
<tr>
<th>Topic</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Too many separate funding streams, starting from top</td>
<td>5</td>
</tr>
<tr>
<td>Public transportation problems/no one over them – transportation of MH/SA clients</td>
<td>5</td>
</tr>
<tr>
<td>Multi-governmental structure of county</td>
<td>3</td>
</tr>
<tr>
<td>Divergent laws &amp; rules from Feds to local level</td>
<td>1</td>
</tr>
<tr>
<td>Different data systems</td>
<td>1</td>
</tr>
<tr>
<td>Outcome reporting – separate, but needs to be integrated</td>
<td>1</td>
</tr>
<tr>
<td>Lack of staff competent to treat MH &amp; SA disorders (co-occurring)</td>
<td>1</td>
</tr>
</tbody>
</table>

Other barriers:
- Need to shift from medical model to social model
- Territoriality/turfism
- Too many programs & funders
- Medical clearance of MH pt for acute care (waste of resources)
Basic Needs
(N = 10 people)

Location: Worknet Pinellas (4525 140th Avenue North, Clearwater)
Date: September 29, 2004
Time: 2:00 – 4:00pm

Unmet needs (Ranking = number of people who voted this as one of their top two unmet needs)

<table>
<thead>
<tr>
<th>Topic</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>(All) Lack of medical services/insurance</td>
<td>4</td>
</tr>
<tr>
<td>(All) Lack of assistance with rent &amp; utility deposits &amp; Lack of electric assistance, rent/mortgage, emergency living expenses</td>
<td>4</td>
</tr>
<tr>
<td>(All) Lack of prescription assistance</td>
<td>3</td>
</tr>
<tr>
<td>(All) Lack of transportation (local); no gas vouchers; outside of county</td>
<td>2</td>
</tr>
<tr>
<td>(All) Lack of mental health services</td>
<td>2</td>
</tr>
<tr>
<td>(Children) Lack of health care for children of non-working poor</td>
<td>2</td>
</tr>
<tr>
<td>(Adults) Lack of decent paying employment; livable wage</td>
<td>2</td>
</tr>
<tr>
<td>(All) Lack of referral/tracking of basic needs provided</td>
<td>1</td>
</tr>
<tr>
<td>(All) Disparity in services between North and South county; lack of standardization of services</td>
<td>1</td>
</tr>
<tr>
<td>(All) Lack of affordable housing</td>
<td>1</td>
</tr>
<tr>
<td>(Adults) Limited health insurance/services for the working poor</td>
<td>1</td>
</tr>
<tr>
<td>(Adults) Lack of dental care</td>
<td>1</td>
</tr>
<tr>
<td>(Elderly) Lack of dental care</td>
<td>1</td>
</tr>
</tbody>
</table>
### Other unmet needs:

<table>
<thead>
<tr>
<th>Children</th>
<th>Elderly</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Lack of pre-Kindergarten services in North county for non-English</td>
<td>• Lack of knowledge about available services</td>
</tr>
<tr>
<td>speaking children</td>
<td>• Lack of assisted living options for people who can’t afford private</td>
</tr>
<tr>
<td>• Lack of infant child care providers</td>
<td>pay &amp; are not poor enough for assistance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adults</th>
<th>All Age Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Lack of emergency mental health services</td>
<td>• Lack of special diet food vouchers</td>
</tr>
<tr>
<td>• Lack of shelters for women &amp; children (non-abusive)</td>
<td>• Lack of food vouchers</td>
</tr>
<tr>
<td>• Lack of financial assistance for child care (subsidized)</td>
<td>• Lack of toiletries</td>
</tr>
<tr>
<td></td>
<td>• Lack of preventative services for Hepatitis C screening and treatment</td>
</tr>
<tr>
<td></td>
<td>• Lack of shelter space – no openings (not DV); for boys 12-18</td>
</tr>
<tr>
<td></td>
<td>lacking</td>
</tr>
<tr>
<td></td>
<td>• Lack of bilingual/bicultural staff</td>
</tr>
<tr>
<td></td>
<td>• Lack of interpreters (Bosnian, Deaf, etc.)</td>
</tr>
</tbody>
</table>

### Barriers to a coordinated system of care

<table>
<thead>
<tr>
<th>Topic</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of central communication/ coordination (independent case management)</td>
<td>5</td>
</tr>
<tr>
<td>Funding requirements; lack of coordination at funder level</td>
<td>4</td>
</tr>
<tr>
<td>Rigid eligibility; delayed help until very poor</td>
<td>3</td>
</tr>
<tr>
<td>Number &amp; diversity of providers and players</td>
<td>2</td>
</tr>
<tr>
<td>Fear of losing resources but still having responsibility to provide services</td>
<td>2</td>
</tr>
<tr>
<td>Lack of data about unmet needs &amp; need for coordinated system</td>
<td>1</td>
</tr>
<tr>
<td>Lack of PR/marketing</td>
<td>1</td>
</tr>
<tr>
<td>Lack of education of providers of what’s available</td>
<td>1</td>
</tr>
<tr>
<td>Territoriality; geographically, programmatically</td>
<td>1</td>
</tr>
</tbody>
</table>
Other barriers:
- Too many conflicting requirements of clients (all at the same time)
- Need to shadow other staff/providers
- Lack of incentive
- Lack of common case management software
- People who chase money
- Confidentiality/HIPAA
- Lack of technology and staff
- Funders need to remove barriers to coordinated care
- Special interest groups
## System-Wide Needs

Location: Clearwater (1100 Cleveland Ave.)  
Date: November 16, 2004  
Time: 2:00 – 4:00 pm

### Unmet needs

<table>
<thead>
<tr>
<th>Topic</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Adults) Lack of transportation</td>
<td>5</td>
</tr>
<tr>
<td>(Elderly) Lack of transportation</td>
<td>5</td>
</tr>
<tr>
<td>(All) Lack of affordable health care (working &amp; unemployed)</td>
<td>3</td>
</tr>
<tr>
<td>(All) Lack of affordable housing options</td>
<td>2</td>
</tr>
<tr>
<td>(Adults) Lack of emergency financial assistance to prevent homelessness</td>
<td>2</td>
</tr>
<tr>
<td>(All) Lack of mental health funding (community mental health services, emergency beds)</td>
<td>1</td>
</tr>
<tr>
<td>(Children) Lack of affordable child care</td>
<td>1</td>
</tr>
</tbody>
</table>

### Other unmet needs:

<table>
<thead>
<tr>
<th>Children</th>
<th>Elderly</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Affordable out of school care</td>
<td>• Lack of services to help them remain home</td>
</tr>
<tr>
<td>• Lack of eye care (and glasses)</td>
<td>• Lack of prescription coverage</td>
</tr>
<tr>
<td>• Lack of prevention services</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adults</th>
<th>All Age Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>• No receiving facility in North County</td>
<td>• Lack of medical care for homeless</td>
</tr>
<tr>
<td>• Lack of substance abuse beds</td>
<td>• Lack of services for aliens</td>
</tr>
<tr>
<td>• Choice between mental health counseling or prescriptions (by nurse practitioner)</td>
<td>• Lack of homeless shelters (emergency &amp; transitional)</td>
</tr>
<tr>
<td>• Lack of mental health services for non-SMI population</td>
<td></td>
</tr>
<tr>
<td>• Lack of eye care</td>
<td></td>
</tr>
<tr>
<td>• Lack of assistance for rent &amp; utilities</td>
<td></td>
</tr>
<tr>
<td>• Lack of prevention services</td>
<td></td>
</tr>
<tr>
<td>• Lack of dental services for low income</td>
<td></td>
</tr>
<tr>
<td>• Lack of training opportunities for un/under-employed</td>
<td></td>
</tr>
</tbody>
</table>
### Barriers to a coordinated system of care

<table>
<thead>
<tr>
<th>Topic</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Turf-guarding – agencies unwilling to give up their piece of the pie</td>
<td>4</td>
</tr>
<tr>
<td>Funders’ restrictions/need for flexibility</td>
<td>4</td>
</tr>
<tr>
<td>Lack of coordination by funders</td>
<td>2</td>
</tr>
<tr>
<td>Reluctance to share information between agencies</td>
<td>1</td>
</tr>
<tr>
<td>Lack of centralized data system</td>
<td>1</td>
</tr>
<tr>
<td>Lack of identifying priorities</td>
<td>1</td>
</tr>
<tr>
<td>Lack of transportation</td>
<td>1</td>
</tr>
</tbody>
</table>

Other barriers:
- Competition for funding
- Homelessness
- Language barriers
- Large number of agencies
Homeless Services

Perceptions
1. How do the homeless perceive the homeless provider system?
2. What is the public perception of homeless people and/or homelessness services?
3. Are there any differences between the perceptions of homeless people and the homeless service providers?
   • If so, what is the effect of this difference?

Available Services & Funding
1. Are the following services adequately addressing homelessness?
   • Emergency/transitional shelters?
   • Domestic violence services?
   • Runaway shelters for teens?
   • Emergency food services/soup kitchens?
   • Job training?
   • Transportation?
   • Mental health/substance abuse services?
   • Health Care?
2. Are some homeless providers better than others and why—what is the best “model?”
3. Are there any homeless services that used to be provided and are not any longer?
4. What services receive the most funding, and do you agree with these service allocations?
   • With the provider allocations?
   • With the geographic allocations?

Coordination
1. How are people coming into contact with the programs providing services (e.g., a referral system)?
2. What is the correlation between homelessness and mental health/substance abuse, health care, and basic needs—is there a coordinated referral system between these areas?
3. Is there coordination between service providers?
   - What form does this coordination take (e.g., coordinated planning, funding, referrals)?
   - Is there duplication in services?
   - Are their geographic areas that are under-funded or over-funded?
   - Are there types of services that are under-funded or over-funded?

4. What improvement could be made for services providers to better coordinate?

Barriers
1. What are the barriers for receiving services (beyond implied financial issues)?

<table>
<thead>
<tr>
<th>External/Access</th>
<th>Internal/Personal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility/program constraints</td>
<td>Cultural</td>
</tr>
<tr>
<td>(e.g., waiting lists/appointments)</td>
<td>Help seeking avoidance/dignity</td>
</tr>
<tr>
<td>Referral follow-up incomplete</td>
<td>Language/communication barriers</td>
</tr>
<tr>
<td>Transportation</td>
<td>Isolation</td>
</tr>
<tr>
<td>Physical/disability issues</td>
<td>Depression/other mental health issues</td>
</tr>
</tbody>
</table>

Next steps
1. If you were the top administrator in charge of a program for homeless people in [Northern/Mid/South] Pinellas, what changes would you make and why?
   - What homeless services would you like to see continued/discontinued?
   - What could homeless service providers do in addition to what they do now (e.g., better coordinate, have less paperwork, etc.)?
   - Are there any skills or training needs currently unavailable that could benefit homeless people?
   - Are there any skills or training needs currently unavailable that could benefit homeless service providers?

Prioritization
1. What should be the main priorities for Pinellas County homeless services (and how do these differ from what the priorities are now or appear to be now)?
   - First priority
   - Second priority
   - Third priority
2. What should be the main priorities for funding for Pinellas County homeless services (and how do these differ from the current priorities)?
   - First priority
   - Second priority
   - Third priority
**Follow-through via Strategic Planning**
1. Who would be responsible for these changes?
2. How long would it take to accomplish the changes?
3. How would the changes be measured (i.e., what would be the indicators)?

**Capacity for Change**
1. What is the capacity for change to take place?
   - Are you willing to make changes?

**Health Care Services**

**Perceptions**
1. Are there any differences between the perceptions of those that receive health care services and the service providers?
   - If so, what is the effect of this difference?

**Available Services & Funding**
1. Are the following services adequately addressing health care needs?
   - Primary/preventive medical care
   - Inpatient hospital care
   - Dental
   - Prescriptions
   - Vision (e.g., eye exams/corrective lenses)
   - Infectious disease care (e.g., HIV/AIDS, hepatitis)
   - Other (please specify)
2. Are some providers better than others and why—what is the best “model?”
3. Are there any services that used to be provided and are not any longer?
4. What services receive the most funding, and do you agree with these service allocations?
   - With the provider allocations?
   - With the geographic allocations?

**Coordination**
1. How are people coming into contact with the programs providing services (e.g., a referral system)?
2. What is the correlation between health care and mental health/substance abuse, homelessness, and basic needs—is there a coordinated referral system between these areas?
3. Is there coordination between service providers?
   - What form does this coordination take (e.g., coordinated planning, funding, referrals)?
   - Is there duplication in services?
   - Are their geographic areas that are under-funded or over-funded?
   - Are there types of services that are under-funded or over-funded?

4. What improvement could be made for services providers to better coordinate?

**Barriers**

1. What are the barriers for receiving services (beyond implied financial issues)?

   **External/Access**
   - Eligibility/program constraints (e.g., waiting lists/appointments)
   - Referral follow-up incomplete
   - Transportation
   - Physical/disability issues

   **Internal/Personal**
   - Cultural
   - Help seeking avoidance/dignity
   - Language/communication barriers
   - Isolation
   - Depression/other mental health issues

**Next Steps**

1. If you were the top administrator in charge of a program for people in need of health care services in [Northern/Mid/South] Pinellas, what changes would you make and why?
   - What services would you like to see continued/discontinued?
   - What could service providers do in addition to what they do now (e.g., better coordinate, have less paperwork, etc.)?
   - Are there any skills or training needs currently unavailable that could benefit people in need of health care?
   - Are there any skills or training needs currently unavailable that could benefit service providers?

**Prioritization**

1. What should be the main priorities for health care services in Pinellas County (and how do these differ from what the priorities are now or appear to be now)?
   - First priority
   - Second priority
   - Third priority
2. What should be the main priorities for funding for health care services in Pinellas County (and how do these differ from the current priorities)?

   - First priority
   - Second priority
   - Third priority

**Follow-through via Strategic Planning**

1. Who would be responsible for these changes?
2. How long would it take to accomplish the changes?
3. How would the changes be measured (i.e., what would be the indicators)?

**Capacity for Change**

1. What is the capacity for change to take place?
   - Are you willing to make changes?

**Mental Health/Substance Abuse**

**Perceptions**

1. Are there any differences between the perceptions of those receiving mental health/substance abuse services and the service providers?
   - If so, what is the effect of this difference?

**Available Services & Funding**

1. Are the following services adequately addressing mental health/substance abuse?
   - Out-patient mental health counseling
   - In-patient mental health treatment
   - Mental health crisis centers
   - Prescriptions for mental health
   - Substance abuse detoxification centers
   - Substance abuse day treatment centers
   - Sobriety maintenance programs
   - Housing for persons with mental illness and substance abuse clients
   - Substance abuse residential treatment centers
   - Case management services
   - Job/vocational training

2. Are some providers better than others and why—what is the best “model?”
3. Are there any services that used to be provided and are not any longer?
4. What services receive the most funding, and do you agree with these service allocations?
   - With the provider allocations?
   - With the geographic allocations?
Coordination

1. How are people coming into contact with the programs providing services (e.g., a referral system)?

2. What is the correlation between mental health/substance abuse and homelessness, health care, and basic needs—is there a coordinated referral system between these areas?

3. Is there coordination between service providers?
   - What form does this coordination take (e.g., coordinated planning, funding, referrals)?
   - Is there duplication in services?
   - Are their geographic areas that are under-funded or over-funded?
   - Are there types of services that are under-funded or over-funded?

4. What improvement could be made for services providers to better coordinate?

Barriers

1. What are the barriers for receiving services (beyond implied financial issues)?

<table>
<thead>
<tr>
<th>External/Access</th>
<th>Internal/Personal</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Eligibility/program constraints (e.g., waiting lists/appointments)</td>
<td>• Cultural</td>
</tr>
<tr>
<td>• Referral follow-up incomplete</td>
<td>• Help seeking avoidance/dignity</td>
</tr>
<tr>
<td>• Transportation</td>
<td>• Language/communication barriers</td>
</tr>
<tr>
<td>• Physical/disability issues</td>
<td>• Isolation</td>
</tr>
<tr>
<td></td>
<td>• Depression/other mental health issues</td>
</tr>
</tbody>
</table>

Next steps

1. If you were the top administrator in charge of a program for mental health/substance abuse services in [Northern/Mid/South] Pinellas, what changes would you make and why?
   - What services would you like to see continued/discontinued?
   - What could service providers do in addition to what they do now (e.g., better coordinate, have less paperwork, etc.)?
   - Are there any skills or training needs currently unavailable that could benefit mental health/substance abuse people?
   - Are there any skills or training needs currently unavailable that could benefit mental health/substance service providers?
Prioritization
1. What should be the main priorities for Pinellas County mental health/substance abuse services (and how do these differ from what the priorities are now or appear to be now)?
   - First priority
   - Second priority
   - Third priority
2. What should be the main priorities for funding for Pinellas County mental health/substance services (and how do these differ from the current priorities)?
   - First priority
   - Second priority
   - Third priority

Follow-through via Strategic Planning
1. Who would be responsible for these changes?
2. How long would it take to accomplish the changes?
3. How would the changes be measured (i.e., what would be the indicators)?

Capacity for Change
1. What is the capacity for change to take place?
   - Are you willing to make changes?

Basic Needs

Perceptions
1. Are there any differences between the perceptions of those that need basic needs and the service providers?
   - If so, what is the effect of this difference?

Available Services & Funding
1. Are the following services adequately addressing basic needs?
   - Help with rent/mortgage
   - Help with utilities
   - Help with food
   - Help with clothing
   - Help with transportation
   - Help with affordable housing
   - Job/vocational training
   - Travelers aid to return to home community
   - Other (please specify)
2. Are some providers better than others and why—what is the best “model?”

3. Are there any services that used to be provided and are not any longer?

4. What services receive the most funding, and do you agree with these service allocations?
   - With the provider allocations?
   - With the geographic allocations?

**Coordination**

1. How are people coming into contact with the programs providing services (e.g., a referral system)?

2. What is the correlation between basic needs and mental health/substance abuse, health care, and homelessness—is there a coordinated referral system between these areas?

3. Is there coordination between service providers?
   - What form does this coordination take (e.g., coordinated planning, funding, referrals)?
   - Is there duplication in services?
   - Are their geographic areas that are under-funded or over-funded?
   - Are there types of services that are under-funded or over-funded?

4. What improvement could be made for service providers to better coordinate?

**Barriers**

1. What are the barriers for receiving services (beyond implied financial issues)?

   **External/Access**
   - Eligibility/program constraints (e.g., waiting lists/appointments)
   - Referral follow-up incomplete
   - Transportation
   - Physical/disability issues

   **Internal/Personal**
   - Cultural
   - Help seeking avoidance/dignity
   - Language/communication barriers
   - Isolation
   - Depression/other mental health issues

**Next Steps**

1. If you were the top administrator in charge of basic needs in [Northern/Mid/South] Pinellas, what changes would you make and why?
   - What services would you like to see continued/discontinued?
   - What could service providers do in addition to what they do now (e.g., better coordinate, have less paperwork, etc.)?
   - Are there any skills or training needs currently unavailable that could benefit people with basic needs?
   - Are there any skills or training needs currently unavailable that could benefit service providers?
Prioritization
1. What should be the main priorities for basic needs in Pinellas County (and how do these differ from what the priorities are now or appear to be now)?
   - First priority
   - Second priority
   - Third priority
2. What should be the main priorities for funding for basic needs in Pinellas County (and how do these differ from the current priorities)?
   - First priority
   - Second priority
   - Third priority

Follow-through via Strategic Planning
1. Who would be responsible for these changes?
2. How long would it take to accomplish the changes?
3. How would the changes be measured (i.e., what would be the indicators)?

Capacity for Change
1. What is the capacity for change to take place?
   - Are you willing to make changes?
## APPENDIX D

### Atlas.ti Frequency Output for Public Forums, Comment Pages & Mail

<table>
<thead>
<tr>
<th>Code</th>
<th>Tarpon</th>
<th>Clearwater</th>
<th>Dunedin</th>
<th>St. Pete</th>
<th>Comment Pages</th>
<th>Providers &quot;Other&quot;</th>
<th>Citizens &quot;Other&quot;</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeless issues</td>
<td>11</td>
<td>3</td>
<td>3</td>
<td>7</td>
<td>6</td>
<td>2</td>
<td>39</td>
<td>71</td>
</tr>
<tr>
<td>Lack of affordable housing</td>
<td>1</td>
<td>6</td>
<td>6</td>
<td>10</td>
<td>6</td>
<td>1</td>
<td>20</td>
<td>50</td>
</tr>
<tr>
<td>Transportation problems</td>
<td>4</td>
<td>7</td>
<td>11</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>16</td>
<td>50</td>
</tr>
<tr>
<td>Mental health / Substance abuse</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>6</td>
<td>2</td>
<td>2</td>
<td>24</td>
<td>41</td>
</tr>
<tr>
<td>System not coordinated</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>6</td>
<td>6</td>
<td>9</td>
<td>12</td>
<td>41</td>
</tr>
<tr>
<td>Lack of health care</td>
<td>0</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>20</td>
<td>39</td>
</tr>
<tr>
<td>Successful programs</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>26</td>
<td>36</td>
</tr>
<tr>
<td>Lack of info about existing services</td>
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<td>3</td>
<td>0</td>
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<td>1</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>Differing views of human services</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>Lack of prescription assistance</td>
<td>0</td>
<td>1</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>10</td>
<td>19</td>
</tr>
<tr>
<td>Increase all human services</td>
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<td>0</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>Lack of food</td>
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<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>10</td>
<td>16</td>
</tr>
<tr>
<td>Emergency financial assistance</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Need more dental services</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Prevention</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>Communication barriers</td>
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<td>1</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Need continuing ed., job training</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>Child care</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Attitudes of caseworkers, etc.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Services for the hearing impaired</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Not familiar with these services</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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### Appendix E  Focus Group Demographics

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