Statewide Drug Policy Advisory Council
2020 Annual Report

To the Governor,

the President of the Senate,

and the Speaker of the
House of Representatives

December 1, 2020

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Acronyms Used in this Report

ACE	Adverse Childhood Experience
ACGME	Accreditation Council for Graduate Medical Education
AHCA	Agency for Health Care Administration
AMA	American Medical Association
API	Application Programming Interface
ASTHO	Association of State and Territorial Health Officials
BCOR	Building Communities of Recovery
CAT	Community Action Team
CDC	Centers for Disease Control and Prevention
CDP	Community Driven Product
CEO	Chief Executive Officer
CHD	County Health Department
CHIP	Community Health Improvement Plan
CMO	Chief Medical Officer
CMS	Case Management System
CNPPA	Child Nicotine Poisoning Prevention Act
COPS	Community Oriented Policy Services
DATA 2000	Drug Addiction Treatment Act of 2000
DCF	Florida Department of Children and Families
DEA	Drug Enforcement Administration
DEN	Drug Epidemiology Network
DOE	Florida Department of Education
DOH	Florida Department of Health
ED	Emergency Department
EDR	Electronic Death Registration
EIS	Epidemic Intelligence Service
EMS	Emergency Medical Services
EMSTARS	EMS Tracking and Reporting System

FAC	Florida Administrative Code
FADAA	Florida Alcohol and Drug Abuse Association
FDA	Food and Drug Administration
FD&C Act	Federal Food, Drug, and Cosmetic Act
FDC	Florida Department of Corrections
FDLE	Florida Department of Law Enforcement
FHA	Florida Hospital Association
FIT	Family Intensive Treatment
FL-DOSE	Florida's Drug Overdose Surveillance and Epidemiology
FLHealthCHARTS	Florida Health Community Health Assessment Resource Tool Set
FPQC	Florida Perinatal Quality Collaborative
FQHC	Federally Qualified Health Center
FYSAS	Florida Youth Substance Abuse Survey
HEROS	Helping Emergency Responders Obtain Support
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
IDEA	Infectious Disease Elimination Act
LTC	Long-Term Care
MAT	Medication Assisted Therapy
ME	Medical Examiner
MHPAEA	Mental Health Parity and Addiction Equity Act
MMA	Managed Medical Assistance
MORE	Maternal Opioid Recovery Effort
MTF	Monitoring the Future
NAS	Neonatal Abstinence Syndrome
NASTAD	National Alliance of State and Territorial AIDS Directors
NCHS	National Center for Health Statistics
NSDUH	National Survey on Drug Use and Health
OD2A	Overdose Data to Action Grant
ODMAP	Overdose Detection Mapping Application Program

OMNI	Opioid, Maternal Health, and Neonatal Abstinence Syndrome Initiative
ONDCP	Office of National Drug Control Policy
OUD	Opioid Use Disorder
PDMP	Prescription Drug Monitoring Program
PPO	Preferred Provider Organization
POSC	Plans of Safe Care
RCO	Recovery Community Organization
ROSC	Recovery Oriented System of Care
RDSTF	Regional Domestic Security Task Force
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPT	Substance Abuse Prevention and Treatment
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SEOW	State Epidemiological Outcomes Workgroup
SEP	Syringe-Exchange Program
SMMC	Statewide Medicaid Managed Care
SOR	State Opioid Response
STD	Sexually Transmitted Disease
STR	State Targeted Response
SUD	Substance Use Disorder
USPSTF	U.S. Preventive Services Task Force

Message from the State Surgeon General Scott A. Rivkees, MD

The 2020 Annual Report of the Statewide Drug Policy Advisory Council (Council) has been made available for policymakers and statewide leadership. This report is provided during a year in which Florida has faced the additional challenges of the coronavirus disease 2019 (COVID-19) pandemic. While our resources addressed the pandemic, we continued to focus on the opioid epidemic and other substance abuse issues in Florida. Section 397.333, Florida Statutes, directs the Florida Department of Health (DOH) to serve as the coordinating entity for the Council, and the content of this report reflects the updates and information from the Council members.

Early in 2020, the work of the Statewide Task Force on Opioid Abuse was completed. Led by Attorney General Ashley Moody, this Task Force comprised expertise in law enforcement, mental health, policy, addiction and education. The Task Force produced a report which outlined several positive steps the state may take to move toward eliminating the opioid epidemic. The Council members have reviewed the Task Force report, and they have included helpful supporting items in this 2020 Annual Report. The Task Force report can be accessed at this location: https://doseofrealityfl.com/pdfs/opioid-task-force-findings-recommendations-opioid-abuse.pdf

Throughout Florida's response efforts to COVID-19, we have seen indications of increased substance abuse. The Overdose Detection Mapping Application Program (ODMAP) indicates that nationally, compared to last year, drug overdoses increased 18 percent in March 2020, 29 percent in April 2020, and 42 percent in May 2020.[1]

Despite these troubling trends, DOH continues to partner with local and state agencies and strategic organizations to increase prevention initiatives and help save the lives of those who struggle with substance abuse. In September 2019, DOH's state health office and the Broward, Duval and Palm Beach county health departments (CHDs) were awarded funding through the Overdose Data to Action (OD2A) grant from the Centers for Disease Control and Prevention (CDC). This three-year funding provides $58.8 million for surveillance strategies that will improve the collection and timely dissemination of actionable overdose data. The funding will also be used for prevention strategies implemented at the local level.

During the first year of the OD2A grant, the state health office allocated $2.2 million in mini-grants to fourteen counties to assist local communities experiencing high impacts from the overdose epidemic. All fourteen counties received funding toward accomplishing core surveillance and prevention activities of the OD2A objectives. Five counties also received additional funding to implement evidence-based curriculums in public schools, and two counties received additional funding to pilot community paramedicine projects focused on improving patient follow-up among individuals most at risk of overdosing. The state also allocated funding to support five Florida Epidemic Intelligence Service (EIS) opioid fellows assigned to CHDs.

DOH continues to operate the Helping Emergency Responders Obtain Support (HEROS) program through funding provided by the Governor and the Legislature. Between July 1, 2018 and June 30, 2020, DOH provided approximately 305,095 doses of naloxone to approximately 291 agencies that employ licensed emergency responders in 58 of Florida's 67 counties. In order to accelerate the process of shipping naloxone to emergency responder agencies, the HEROS program established a monthly rounds system. The program will review applications

during each round, determine successful applicants and place orders for naloxone to help keep our communities safe.

DOH's Opioid Use Dashboard was recently updated with 2019 data for opioid-related non-fatal overdose emergency department visits and hospitalizations, as well as all drug-related non-fatal overdose emergency department visits and hospitalizations. DOH also released 2018 data in the Opioid Use Dashboard for Neonatal Abstinence Syndrome Birth Defect. The information can be accessed at this location: http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.OpioidUseDashboard.

The Council has proposed several significant recommendations for our policy makers and state agencies to consider. Information regarding prevention steps will continue to guide agencies in addressing core messages to help youth avoid drug use and promote treatment options. There is important information about the need to expand the use of naloxone in our communities. The 2020 Annual Report also addresses the need to ensure an adequate workforce composed of physicians with a specialty in addiction medicine, individuals with lived experience and peers attempting to enter the workforce to assist those with substance abuse issues. There are also critical recommendations to enhance and expand the use of data.

I would like to emphasize how grateful we are for the members of the Council. These experts are giving their professional time to serve the people of Florida in addressing drug policy. DOH remains committed to supporting this critical Council and the important work that is being done.

Scott A. Rivkees, MD
State Surgeon General

Summary of 2020 Meetings
Statewide Drug Policy Advisory Council

As required by section 397.333(4)(b), Florida Statutes, Florida's Statewide Drug Policy Advisory Council's (Council) 2020 Annual Report analyzes the problem of substance abuse in the state and provides updates on recommendations to the Governor and Legislature for consideration.

On January 28, 2020 the Council heard a presentation regarding the Overdose Data to Action (OD2A) grant. In September 2019, the Florida Department of Health (DOH) state health office and the Broward, Duval, and Palm Beach County Health Departments (CHDs) were awarded funding through the OD2A grant from the Centers for Disease Control and Prevention (CDC). This three-year grant provides $58.8 million for surveillance strategies to improve the collection and timely dissemination of actionable overdose data, and prevention strategies implemented at the local level that are informed by more timely data streams. The state also allocated funding to support five Florida Epidemic Intelligence Service (EIS) opioid fellows assigned to CHDs. There was also a presentation from Duval CHD, one of the three counties that received OD2A funding. Duval County had more than 550 opioid deaths in 2017. The Council also received a legislative update on relevant bills. Some of the bills discussed included Senate Bill (SB) 298 Prior Authorization for Opioid Alternatives, House Bill (HB) 743 Nonopioid Alternatives, and HB 339 Drug Trafficking Offenses. Council members provided individual updates.

On April 21, 2020 the Council was scheduled to meet. However, due to coronavirus disease 2019 (COVID-19), this meeting was postponed.

On July 21, 2020 the Council heard a presentation on "Community Partnerships to Reduce Neonatal Abstinence Syndrome & Improve Maternal Recovery from Opioid Use Disorder." This focused on the work of the Maternal Opioid Recovery Efforts (MORE) initiative and the "Urgent Maternal Mortality Message." This work is important because drug-related deaths are now the leading cause of death to mothers during pregnancy or within one year afterwards in Florida. Twenty-three hospitals participate in the MORE initiative, which represents 35 percent of births in the state. The goal is to link these hospitals with community partners, as they all touch substance-affected mothers, infants, and families. There was a presentation on "Addressing Behavioral Health through Community Health Improvement Planning" which focused on the community health improvement plan (CHIP) process, reviewing behavioral health activities addressed in CHIPs, and recognizing the impact of COVID-19 on community health improvement planning. As of March 2020, 88 percent of Florida counties address behavioral health within their CHIPs. Common behavioral health themes in CHIPs include: education/awareness (substance use, opioid prescribing practices, trauma), trainings (mental health first aid, Naloxone administration), access to behavioral health services (transportation, telehealth), and screening/care coordination. There was also a presentation on "Florida Medicaid Coverage of Telemedicine & Telehealth" was presented as well. Florida Medicaid serves approximately 4 million of Florida's most vulnerable citizens, including children, pregnant women, older adults, and persons with disabilities. The Statewide Medicaid Managed Care (SMMC) program was implemented in Fiscal Year 2013-2014 and updated in Fiscal Year 2019-2020. The three components of the SMMC program are: Managed Medical Assistance (MMA) – acute care like doctor visits, etc., Long-Term Care (LTC) – care given in a nursing home or assisted living facility, and Dental. With Medicaid covering telemedicine, there are many benefits of telemedicine for patients. These include expanded access and after-hours care, remote monitoring, and management for chronic conditions, reduced hospital readmissions, reduced waiting times to see a practitioner, reduced travel time and cost, and better access to specialists. Additional benefits for those with behavioral health disorders, including substance use disorder (SUD) includes more expedient access to specialists or other

providers not otherwise available, for example crisis intervention, evaluation to determine diagnosis or treatment recommendation, and medication management. There was also a presentation on the OD2A grant. The grant supports awareness and education provided through media campaigns and community and school-based collaborations for prevention. In addition, the grant includes Florida's Drug Overdose Surveillance and Epidemiology (FL-DOSE) and it supports increased Medication Assisted Treatment (MAT) and community paramedicine for patient follow-up. The Council members shared individual updates and discussed the status of the 2020 Annual Report.

Council members requested a meeting to focus fully on the 2020 Annual Report. On September 8, 2020, the Council met and reviewed the recommendations from the 2019 DPAC Annual Report. Members discussed which recommendations needed to be revised or deleted. There was also a discussion about new recommendations that may be added to the report. Several Council members were asked to make revisions and provide that information to DOH. The draft 2020 DPAC Annual Report will be edited and a revised version will be provided to the Council members before the next meeting.

On October 20, 2020 the Council held the fourth meeting of the year. There were four presentations. Mary Mayhew, Chief Executive Officer (CEO) of the Florida Hospital Association, spoke about preventing overdose deaths in hospitals and opportunities to further partner with the Council. Dr. Yuri Maricich, Chief Medical Officer (CMO) of Pear Therapeutics, gave a presentation about prescription digital therapies which are intended to increase the retention of patients with opioid use disorder (OUD) in outpatient treatment by providing cognitive behavioral therapy. Annie White, Assistant Special Agent in Charge with the Florida Department of Law Enforcement's Office of Statewide Intelligence did a presentation on the Overdose Mapping and Application Program (ODMAP). In addition, Dr. Jared Jashinsky, Epidemiologist & Project Manager with DOH presented "Recent Trends in Fatal and Non-fatal Overdoses." This presentation focused on preliminary data regarding drug overdoses in early 2020. The Council also reviewed the recommendations for the 2020 Annual Report and voted to approve the report.

2020 Recommendations
Statewide Drug Policy Advisory Council

1. Establish the Florida Office of Drug Control.

2. State agencies and commercial health plans provided service delivery flexibilities to respond to the challenges related to the delivery of mental health and substance use disorder care during the COVID-19 pandemic. It is recommended that the state agencies, commercial health plans, and other private payors permanently adopt these flexibilities, specifically:
   - Waiving prior authorization requirements and services limits (frequency, duration, and scope) for all behavioral health services (including targeted case management).
   - Maintaining payment parity for telehealth services by reimbursing services provided via telemedicine at the same rate as face-to-face encounters.
   - Expanding coverage of telehealth services to include telephone communications, only when rendered by licensed psychiatrists and other physicians, physician extenders, and licensed behavioral health practitioners.
   - Requiring managed care plans to waive limits on medically necessary services when additional services will maintain the health and safety of an enrollee diagnosed with COVID-19 or when it is necessary to maintain an enrollee safely in their home.
   - Using audio-only services when video capability is not available, and services can only be provided telephonically, which should be thoroughly documented.

3. Develop and implement a substance-use prevention strategy designed to reduce drug use among youth (ages 12-17). The strategy should focus on (1) the deployment of a unified anti-drug messaging campaign, (2) increase/maintain substance use prevention efforts by securing/sustaining front-end prevention funding, and (3) by expanding state partnerships with anti-drug coalitions, educational institutions, law enforcement, and other members of the 12 Community Sectors. Collectively, these efforts will enhance substance use prevention efforts, allow for the unified employment of limited resources towards a common goal, and reduce the impact of substance use among youth by 10 percent and marijuana use among youth by 3 percent.

4. Deploy an evidence-based substance use prevention program designed to reduce drug use among youth (ages 12-17). The curriculum should focus on evidence-based and/or evidence-informed prevention strategies proven to reduce substance use, while also increasing youth resiliency, coping strategies, positive mental health, and responsible decision-making. The Florida Department of Children and Families (DCF) should lead, in collaboration with DOH and the Florida Department of Education (DOE), a statewide initiative designed to increase and coordinate prevention efforts across Florida through a partnership with coalitions, community SUD providers, school districts, faith-based groups, and business entities. The end goal is to better link existing prevention education programs with Florida's educators, and reduce substance use and abuse among Florida's youth.

5. Develop and implement a comprehensive e-cigarette/e-liquid prevention strategy designed to reduce vaping among youth (ages 11-17) and limit the negative health effects associated with e-cigarettes, e-liquids, and/or other vaping materials.

6. Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with SUDs, as well as those at-risk of developing those disorders.[2] To evaluate what evidence-based practices are presently in use in Florida to identify problematic alcohol or drug behavior in the primary care setting and to promote the implementation of SBIRT in our state, the following is recommended:
    - DOH should lead an initiative to review the extent SBIRT and/or other evidence-based practices are utilized in primary care settings across Florida to identify and intervene with patients showing symptoms of problematic alcohol and/or drug use.
    - Agency for Health Care Administration (AHCA) should report to the Legislature on the availability of Medicaid coverage for SBIRT, and if not available, what changes to the state's Medicaid plan, billing, and coding practices would need to be made to implement SBIRT.
7. When filling prescriptions for controlled substances, strongly encourage pharmacies to educate consumers on safe medication storage and disposal procedures. Establish a media campaign to educate consumers on reason for safe use, safe storage, and safe disposal and the location of safe disposal boxes in each community.
8. Expanding naloxone availability among people who use drugs and their peers through hospital emergency departments (ED) and floor units (with little to no paperwork, and no separate trip to the pharmacy), Emergency Medical Services (EMS)/fire rescue naloxone leave-behind programs, CHDs, and Federally Qualified Health Centers (FQHCs).
9. Encourage county commissions to establish Syringe Exchange Programs (SEP).
10. Encourage the continued establishment of warm handoff programs from hospital EDs to community OUD treatment providers to address opioid overdoses; issue naloxone to overdose patients before they leave the ED; and have AHCA report on the extent warm handoff protocols have been implemented in EDs across the state.
11. Expand additional fellowship and residency programs for physicians to obtain a specialty in addiction medicine with a goal of increasing physicians with an addiction medicine specialty.
12. Pass model legislation that will align Florida law with the federal Mental Health Parity and Addiction Equity Act (MHPAEA) and require all state health agencies, health plans, and commercial insurance to report annually on the implementation of the parity act in Florida. These reports should be transparent and available to inform the public.
13. State health agencies, health plans, and commercial insurers should remove prior authorization requirements for evidence-based MAT to allow for use of medications such as buprenorphine, naltrexone, naloxone, and methadone.
14. Promote legislation that adds the Secretary of AHCA and the Commissioner of the Office of Insurance Regulation as members to the Statewide Drug Policy Advisory Council.
15. Continue the statewide Recovery Oriented System of Care (ROSC) initiative designed to promote and enhance recovery efforts in Florida and support the continued development of recovery community organizations (RCOs) and a statewide RCO that helps link community initiatives.
16. Develop and implement a stigma reduction campaign designed to reduce the shame associated with SUD and other mental illness/injuries. Messaging should increase the awareness of MAT options, reduce the stigma associated with addiction, and inform the public of the many benefits that come with obtaining psychological and/or counseling services from a licensed professional.

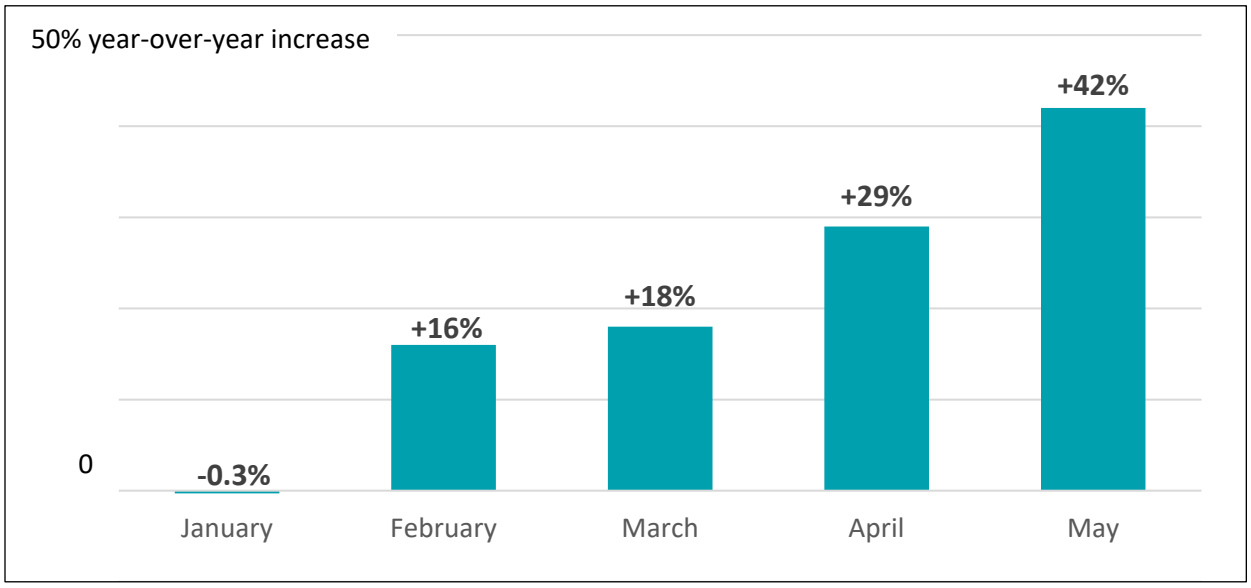
17. Evaluate the impact of SB 1120 (2020): Substance Abuse Services on agency background screening requirements related to the eligibility of individuals with lived experience/peers attempting to enter the workforce; continue efforts to reduce the administrative burden of the background screening and exemption process; promote consistency among state agencies related to the background screening exemption process; ensure an individual with lived experience is part of the exemption review panel; and have AHCA, DCF, and the Florida Department of Corrections (FDC) provide an annual report on the number of individuals that applied for an exemption, actual timeframes for the process, and number approved/disapproved with reasons why.
18. Create a statewide dashboard of substance abuse data measures that are readily available to policy makers and the public and can be used to monitor trends and identify emerging threats.
19. Encourage all counties and municipalities to implement the ODMAP system in locations and agencies that do not participate in real-time overdose tracking. Through wider utilization, law enforcement and non-EMSTARS (EMS Tracking and Reporting System) fire departments can track suspected overdose activity throughout all 67 counties. Agencies can utilize information obtained through ODMAP to identify high risk areas, equip personnel for increased overdose activity, and to warn neighboring agencies of sudden overdose activity within their counties and/or suspected transit routes.
20. The Council recommends the modernization, improvement, and appropriate funding for the Baker and Marchman Acts to increase effectiveness of the Baker and Marchman Acts to serve the people of Florida.

Executive Summary

Introduction

Florida and the entire nation face ongoing drug-related threats like the opioid epidemic while dealing with the new challenge of COVID-19 infections. Initial data is indicating that our communities are experiencing an increase in drug abuse during this time of COVID-19. Data from the ODMAP indicated that nationally, compared to last year, drug overdoses increased 18 percent in March 2020, 29 percent in April 2020, and 42 percent in May 2020.[3]

Figure A. Percent increase in overdoses per month in 2020, compared to same months in 2019



Note: Percent growth reference the 1,201 agencies reporting to ODMAP by January 2019.[4]

Preliminary data from DOH indicate that there was a spike in fatal and non-fatal drug overdoses in Florida starting in March 2020. Monthly fatal overdoses were 571 in March 2020, 606 in April 2020, and 707 in May 2020, compared with a monthly average of 501 cases from previous months. The preliminary data also indicate that monthly fatal overdoses for women of child bearing was 103 in March 2020, 107 in April 2020, and 126 in May 2020, compared with a monthly average of 75 overdoses from previous months. The data also indicate that the non-fatal drug overdose rate increased in all seven of Florida's Regional Domestic Security Task Force (RDSTF) regions between March 2020 and May 2020.[5]

Regarding the percentage of surveyed Florida youth who vaped nicotine (e-cigarettes, vape pens, JUUL), in their lifetime and past 30 days, there has been a decrease among high school students among lifetime use from 17.4% (2019) to 15.6% (2020).[6] These continuing risks provide the need for ongoing collaboration at the local, state, and national level.

Need for Services and Receipt of Services among the General Population

The National Survey on Drug Use and Health (NSDUH) provides important estimates of substance use, SUDs, and other mental illnesses at the national, state, and sub-state levels. The NSDUH is an annual survey of the civilian, noninstitutionalized population ages 12 and older, using face-to-face, computer-assisted interviews. The NSDUH collects information from

residents of households, persons in noninstitutionalized group quarters (e.g., shelters, rooming/boarding houses, college dormitories, migratory worker camps, and halfway houses), and civilians living on military bases. Persons excluded from the survey include persons with no fixed household address (e.g., homeless and/or transient persons not in shelters), active-duty military personnel, and residents of institutional group quarters, such as correctional facilities, nursing homes, mental health institutions, and long-term hospitals. State- and sub-state level estimates are usually based on two-year or three-year averages to enhance precision. There is usually at least a two-year lag between the date when the data are collected, and the state-level estimates are published.

According to the most recently published, Florida-specific estimates from the 2017-2018 NSDUH, approximately 4.3 percent of children ages 12-17 and 6.6 percent of adults ages 18 and older experienced a SUD in the past year.[7] The majority of individuals with substance use disorders do not receive treatment, including approximately 92 percent of individuals with alcohol use disorders and 87 percent of individuals with an illicit drug use disorder.[8] It is important to note, the vast majority (96%) of individuals classified by the NSDUH as needing, but not receiving, substance use treatment also report that they did not feel they needed it. Only about 1 percent felt they needed treatment and made an effort to get it.[9]

The State Epidemiological Outcomes Workgroup (SEOW)

Florida's SEOW plays several roles in state, regional, and community drug-related morbidity and mortality surveillance. Membership (n = 18) consists of epidemiologists and individuals who are knowledgeable about substance use issues including prevention, intervention, and treatment. Participating entities include DCF, FDLE–Medical Examiners (ME) Commission, DOH, AHCA, and the DOE. In addition, the SEOW's composition includes a representative from each of the Drug Epidemiology Networks (DENs) that operate across the state of Florida. Through the Partnerships for Success grant, eight counties were selected for DEN development and implementation including Broward, Duval, Hillsborough, Manatee, Palm Beach, Taylor, Walton and Washington. Both the SEOW and individual DENs produce annual reports that are reviewed by DCF and incorporated into appropriate strategic initiatives. These reports indicate that fentanyl and fentanyl-analogs continue to drive overdoses, including deaths involving cocaine. Polydrug toxicity is still the most common pattern observed among deaths caused by drugs. Rural counties reported an increase in heroin use and the emergence of fentanyl. An updated SEOW Report will be available at the end of November 2020 at the following location: https://www.myflfamilies.com/service-programs/samh/publications/.

Primary Prevention of Substance Use: Trends from the Florida Youth Substance Abuse Survey (FYSAS)

Substance use among youth in Florida continues to trend downward. Among middle and high school students in Florida, between 2008 and 2020, the prevalence of lifetime alcohol use decreased from 53 percent to 35 percent and the past 30-day prevalence of alcohol use decreased from 30 percent to 15 percent. Regarding binge drinking by students (in the past two weeks), the prevalence decreased from 15 percent to 7 percent. High school students are asked if they ever woke up after a night of drinking and did not remember the things they did or the places they went. Between 2014 and 2020, the lifetime prevalence of "blacking out" among high school students decreased from 19 percent to 14 percent.

Regarding marijuana use, the prevalence of lifetime and past 30-day marijuana use among middle and high school students between 2008 and 2020 is essentially flat. Lifetime prevalence decreased from 21 percent to 20 percent, and past 30-day prevalence was approximately 11 percent in both 2008 and 2020. Looking more specifically at vaping marijuana, approximately 16 percent of middle and high school students reported vaping marijuana at least once in their

lifetime in 2020, and approximately 7 percent done so in the past 30-days. Regarding the use of any illicit drug other than marijuana, the lifetime prevalence decreased from 21 percent to 14 percent between 2008 and 2020. The prevalence of the current (past 30-day) use of any illicit drugs other than marijuana decreased from 9 percent to 6 percent.[10]

In the area of prevention, the Florida National Guard Counterdrug Program provided the "Night Vision Anti-Drug" presentation to 17,339 elementary, middle, and high school students during the 2020 calendar year.

Opioid Epidemic

The Drugs Identified in Deceased Persons by Florida Medical Examiners 2019 Annual Report indicated that there were 6,128 opioid-related deaths reported (which averages more than 16 deaths per day). This is 552 more than the previous year, which represents slightly under a 10 percent increase. Overall, 7,142 individuals died with one or more prescription drugs in their system, which is a 7 percent increase. The drugs were identified as either the cause of death or merely present in the decedent. These drugs may have also been mixed with illicit drugs and/or alcohol. The drugs that caused the most deaths were fentanyl (3,244), cocaine (1,843), benzodiazepines (1,074, including 614 alprazolam deaths), morphine (984), fentanyl analogs (922), ethyl alcohol (989) and heroin (809).[11]

Evidence-Based Responses to the State of Emergency Due to the Epidemic of Opioid-Related Deaths

DCF has taken the lead regarding the deployment of evidence-based resources to prevent opioid-related deaths. State and federal funds, including the Substance Abuse and Mental Health Services Administration's (SAMHSA) State Targeted Response (STR) grant, State Opioid Response (SOR), and Substance Abuse Prevention and Treatment (SAPT) block grant, are directed at the most effective interventions. According to a model published in the *American Journal of Public Health* in 2018, the interventions that will reduce the greatest number of opioid overdose deaths over 5 to 10 years in the U.S. are identified in the table below.[12] All of these interventions were recommended by the Council in previous Annual Reports. An update on each of them follows.

Figure B. Evidence-Based Interventions to Reduce Opioid Deaths Nationwide Over 5 to 10 Years[13]

Intervention	Estimated Number of Opioid Deaths Prevented Over 5 Years	Estimated Number of Opioid Deaths Prevented Over 10 Years
Expansion of Naloxone Availability	10,200	21,200
Expanded Access to MAT	4,900	12,500
Expansion of Syringe Exchange Programs	2,700	5,900
Reduced Prescribing for Acute Pain	1,900	8,000
Expansion of Prescription Drug Disposal Programs	300	2,400

Expansion of Naloxone Availability

Research indicates that naloxone distribution can reduce opioid overdose rates by as much as 11 percent to 46 percent.[14] It is conservatively estimated that one heroin-related overdose death is prevented for every 164 naloxone kits distributed.[15] In addition, studies suggest that increasing health awareness through training programs that accompany naloxone distribution may reduce the use of opioids and increases users' desire to seek addiction treatment.[16] DCF initiated an Overdose Prevention Program in August 2016. The program has been funded through a variety of sources, including State General Revenue, the SAPT block grant, the STR grant, and the SOR grant. Organizations enrolled in the program distribute free, take-home naloxone kits directly to people who use drugs or are otherwise at risk of experiencing an overdose and to their loved ones who may witness an overdose. There are currently 149 organizations participating in the program, including substance use and mental health treatment facilities, hospital EDs, harm reduction programs, peer recovery organizations, homeless service providers, FQHCs, and other community-based organizations. Since the start of the program, over 104,000 naloxone kits have been distributed from participating providers and over 5,000 overdose reversals have been reported. In order to take the fight against opioid deaths to the next level, DCF and the Council endeavor to increase the number of hospital ED sites participating in the naloxone distribution program and the number of EMS/fire rescue naloxone leave-behind programs in operation. In Fiscal Year 2018-2019, there were 10 ED sites participating in the program. In Fiscal Year 2019-2020, 15 additional EDs were enrolled, bringing the current total to 25 EDs. In Fiscal Year 2018-2019, there were only five EMS/Fire naloxone leave-behind programs in operation. In FY 2019-2020, an additional five programs were enrolled, bringing the current total up to 10 leave-behind programs.

In response to the nationwide opioid epidemic, funding has been made available through DOH for emergency opioid antagonists. DOH has established the Helping Emergency Responders Obtain Support (HEROS) program for the purpose of acquiring emergency opioid antagonists for agencies that employ emergency responders. Between July 1, 2018 and June 30, 2020 HEROS provided approximately 305,095 doses of naloxone to approximately 291 agencies that employ licensed emergency responders. DOH has spent $9.7 million or 97 percent of the $10 million ($5 million allocation each Fiscal Year) allocation. In addition, DOH has provided naloxone to agencies that employ licensed emergency responders in 58 of Florida's 67 counties. Since July 1, 2020, DOH has accelerated the process to ship naloxone to emergency responder agencies by establishing monthly rounds. The goal is to review applications during each round, determine successful applicants, and place orders for naloxone based on available funding and applicants meeting HEROS program requirements the first week of the next month. The HEROS program will complete six application rounds between July 1, 2020 to December 31, 2020.

Expanded Access to Medication-Assisted Treatment (MAT)

Methadone and buprenorphine maintenance are effective ways to decrease the illicit use of opioids and reduce the risk of overdose. Research shows the risk of fatal overdoses is at least cut in half when individuals are enrolled in agonist (methadone or buprenorphine) maintenance treatment for opioid dependence.[17] Expansion of access to MAT continues through DCF's SOR grant, funded by SAMHSA through 2022 as described in the table below:

Figure C. DCF – SOR grant

Grant	Project Period	Annual Award Amounts
State Opioid Response (SOR) 1	9/30/2018 through 9/29/2020 No Cost Extension Approved	$76,186,527 (Year 1) $50,056,851 (Year 2)
State Opioid Response (SOR) 2	9/30/2020 through 9/29/2022	$100,170,437 (Year 1) $100,170,437 (Year 2)

Additionally, in 2017 there were only 65 authorized buprenorphine prescribers in DCF's network of publicly-funded treatment providers. There are now 108 prescribers. For clients who have already completed opioid detoxification, long-acting injectable naltrexone (Vivitrol) is another U.S. Food and Drug Administration (FDA)-approved medication that helps prevent relapse. The number of Vivitrol prescribers in DCF's network quadrupled, increasing from only 11 prescribers in early 2017 up to 45 prescribers in 2020. Under SOR 1, nearly 12,000 individuals received MAT (including 3,722 served with methadone, 5,523 served with buprenorphine, and 770 served with Vivitrol).

Expansion of Syringe Exchange Programs (SEPs)

SEPs are front line public health interventions that effectively reduce the spread of HIV and hepatitis C by reducing the sharing, reuse, and circulation of syringes and injecting equipment.[18] Research shows that every dollar spent on SEPs saves at least three dollars in averted treatment costs.[19] SEPs provide a range of comprehensive healthcare services including testing and counseling for various infectious diseases, overdose prevention, and vaccinations. SEPs also facilitate recovery by linking people with SUDs to treatment services.[20] Florida's first legal SEP –called the Infectious Disease Elimination Act (IDEA) Exchange–opened in Miami-Dade County on December 1, 2016. The program provides compassionate and nonjudgmental services and empowers people who use drugs to make healthier and safer choices regardless of whether they are ready to stop using drugs. From July 1, 2019 to June 30, 2020, 710 participants were served. During this time, 302 participants were tested for HIV and 264 participants were tested for hepatitis C. In addition, 71 participants entered drug counseling or treatment.[21]

Senate Bill 366, the Infectious Disease Elimination Programs, passed in 2019, permits county commissions to authorize the establishment of additional SEPs through county ordinances.[22] The law requires county commissioners to take several steps including enlisting the help of CHDs to provide ongoing advice and recommendations regarding program operation. Additional information can be found at this location: http://www.floridahealth.gov/programs-and-services/idea/exchange.html.

Overdose Data to Action (OD2A) Grant

In September 2019, the DOH state health office and the Broward, Duval, and Palm Beach CHDs were awarded grant funding through the OD2A grant from the CDC. This three-year grant provides $58.8 million for (A) surveillance strategies to improve the collection and timely dissemination of actionable overdose data, and (B) prevention strategies implemented at the local level that are informed by more timely data streams. During year 1 of the grant, the state health office allocated $2.2 million in mini-grants to 14 counties to assist local communities experiencing high impacts from the overdose epidemic. All 14 counties received funding to accomplish core surveillance and prevention activities of OD2A, including support for awareness campaigns to highlight the risks of OUD and enhancements to surveillance systems

and data collection efforts to assist with monitoring overdose trends, understanding which populations are most at risk to prioritize resources, and evaluating ways to distribute resources. Five counties also received additional funding to implement evidence-based curriculums in public schools (Brevard, Manatee, Nassau, Pasco, and Sarasota) and two counties received additional funding to pilot community paramedicine projects to improve patient follow-up among individuals most at risk of overdosing (Clay and Marion). The state also allocated funding to support five Florida EIS opioid fellows assigned to CHDs.

Opioid, Maternal Health, and Neonatal Abstinence Syndrome Initiative (OMNI)

Florida was one of five states to be selected by the CDC and Association of State and Territorial Health Officers (ASTHO) for a site placement of a Maternal & Neonatal Opioid Prevention Coordinator to support the OMNI. The coordinator's role was specifically designed to support the MORE project by identifying and drawing together stakeholders in communities with high rates of Neonatal Abstinence Syndrome (NAS) to help connect resources, identify system barriers, and share insights, gaps, and lessons learned with the broader Florida NAS stakeholder group.

In response to the growing opioid crisis and the resulting increase in NAS, the DOH partnered with the Florida Perinatal Quality Collaborative (FPQC) at the University of South Florida, to implement the MORE Initiative. The purpose of the initiative is to increase the number of pregnant women with OUD who receive treatment during pregnancy and maintain treatment after delivery. Florida's Pregnancy Associated Mortality Review committee released an Urgent Maternal Mortality Message this year, emphasizing that drug-related deaths were the leading cause of death to mothers during pregnancy or within one year afterwards in 2017, accounting for one in four of these deaths in Florida.

Hospitals face significant challenges addressing issues contributing to these high rates of maternal death, and there are several opportunities for improving interventions, including reducing the risk of overdose, reducing the impact/severity of NAS by getting women into treatment as early as possible, and addressing other system barriers, such as the availability of universal SBIRT at each point of interaction with women with OUD. To be successful in each of these areas, it is essential to help hospitals connect with the system of care in their community to develop a cohesive approach to identification, referral, and treatment.

A shortage of MAT providers still presents barriers to care for women in communities throughout Florida. In community visits, the shortage of MAT, behavioral health, and inpatient bed services for pregnant and postpartum women was the single biggest challenge reported, with 15 out of 18 communities citing this as a barrier. Most counties also identified fragmented care, poor systems for referral, and outdated data systems as a barrier to care.

Although AHCA successfully removed the pre-authorization requirement for MAT, some communities are still facing barriers with this as the policy change is not fully understood by payers or pharmacists. DOH will work with AHCA to continue to educate pharmacists and payers about changes regarding MAT prescribing.

Finally, the majority of counties had concerns about the acceptability of treatment. Even when women were identified as needing treatment for OUD, they often refused treatment due to fear of repercussions, stigmas, and the overarching fear of losing custody of their infant. The initiative worked with women in recovery to develop a short video that can be used to encourage women to seek needed care. DOH is working with the DCF and Healthy Start to develop a framework and messaging for Plans of Safe Care (POSC) that will help improve POSCs across the state, improve reporting, and train providers on how to use motivational interviewing to engage women and encourage them to start the treatment and recovery process.[23]

Florida Prescription Drug Monitoring Program (PDMP)

The PDMP provides data related to controlled substance prescriptions in the state. From July 1, 2019 to June 30, 2020, there were 30,355,360 controlled substance prescriptions dispensed to Florida patients, a 2.6 percent decline from the previous year. In addition, 4.9 million people in Florida were prescribed one or more controlled substances, a decrease of 8.4 percent. Alprazolam, oxycodone SA, and hydrocodone SA were ranked the top three most commonly dispensed controlled substances for the fifth year in a row, together representing 35.6 percent of the total controlled substances dispensed from July 1, 2019 to June 30, 2020. Drugs with the largest year-to-year decreases in dispensing were hydrocodone SA (-7.9%), temazepam (-6.1%), and tramadol SA (-3.8%). [24]

Behavioral Health Workforce

Florida is experiencing a shortage of health care professionals to meet the growing needs of our state. For behavioral health professionals, the shortage is reaching near critical levels. Supply and demand for behavioral health practitioners are affected by factors including: population growth, aging of Florida's population, expansion of insurance coverage, changes in health care reimbursement, retirement, attrition, reduction in stigma to seek care, the opioid epidemic, low reimbursement rates, and geographic location of the health care workforce. While need grows, the workforce remains static at best. Meanwhile, Florida's aging population (age 65 and older) is expected to exceed any other age group by 2030 causing a dynamic shift in future behavioral health care needs. A recent addition to the behavioral health workforce has been the utilization of peers with lived experience, however, many of these individuals are unable to work due to background screening requirements and the bureaucratic burden of seeking an exemption. In addition, the size of the medical workforce with a specialty in addiction medicine is inadequate to meet the state's growing needs.[25]

Florida Statewide Task Force on Opioid Abuse

The Council wishes to thank the Florida Statewide Task Force on Opioid Abuse for the recommendations contained in their 2020 report. The Task Force report was extensive and multifaceted, and it identified a variety of promising interventions. The Task Force also highlighted a set of priority recommendations, and the Council would like to echo and amplify the Task Force's call to increase access to MAT and associated psychosocial support services, including peer-based recovery support services and naloxone distribution. Research reviewed and summarized by this Council shows that this approach is the most effective way to reduce opioid-related deaths. The Task Force is also commended for highlighting the importance of screening and brief interventions, warm handoffs, mobile medication teams, telehealth, inmate reentry planning, improved data sharing, and school-based prevention programs and many other worthy suggestions which complement the conclusions of this Council. Additional information is available at this location: https://DoseofRealityFL.com.

Law Enforcement Perspective

Florida law enforcement remains engaged in the current effort to reduce the availability of heroin, fentanyl, fentanyl analogs, and other substances contributing to opioid involved overdose and overdose deaths. Efforts to reduce deaths involving specific opioids (heroin and fentanyl analogs) appear to be trending slowly in a positive direction, based on indicators used to gauge illicit drug activities and the drug abuse environment.

According to the Drugs Identified in Deceased Persons by Florida Medical Examiners (2019 Interim Report), opioid involved deaths increased by 2 percent over the same period (January through June) in 2018; opioid-caused deaths also increased (6%). Deaths involving heroin, fentanyl, and fentanyl analogs also increased. The most significant increase were deaths

involving fentanyl which increased 26 percent; and deaths caused by fentanyl increased 28 percent. Decreases were seen within the prescription opioid category; deaths caused by hydrocodone decreased 1 percent and deaths caused by oxycodone decreased by 16 percent.

A comparison of FDLE laboratory submissions between 2018 and 2019 revealed increases in heroin, fentanyl, morphine, and buprenorphine. Prescription opioids, hydrocodone, hydromorphone, and oxycodone decreased. Consistent with the trend noted in last year's data, were increased laboratory submissions of methamphetamine. Increases, in both the occurrence of methamphetamine in the deceased, and in the cause of death in the deceased were also noted in the interim report of the Florida MEs.

In September 2019, Florida was one of eight states named among the recipients of grant funding from the U.S. Bureau of Justice Assistance. The grant proposal outlined an initiative to expand the use of naloxone (Narcan) by law enforcement responders who are first on the scene of a suspected opioid overdose. The proposal also outlined a plan to share overdose data from law enforcement and EMS in Florida with community health and mental health services in an effort to mitigate opioid overdose deaths in Florida through overdose follow-up activities. As a result of the collaborative project, suspected overdose surveillance data is available in near real-time, supporting public safety and public health efforts to mobilize an immediate response to a sudden increase, or spike in overdose events. In July 2020, FDLE was awarded approximately $2.2 million in federal grant funds through the Community Oriented Policing Services (COPS) program to augment investigations related to the distribution of illicit opioids including heroin, fentanyl, Carfentanil, and other fentanyl derivatives; as well as the illegal distribution of diverted prescription opioids. Both of these grant funded opportunities will assist law enforcement in creating inroads for collaboration with the public health sector (prevention/treatment) as well as curbing the availability of opioids (supply reduction).

While the opioid crisis continues, the availability of other illicit drugs also impacts Florida to varying degrees across regions. In particular, methamphetamine is gaining a foothold in many areas of the state. This is not the home-brew methamphetamine that has long been an issue in certain regions. The availability of a manufactured methamphetamine from super labs south of the U.S./Mexico border has increased substantially over the past few years. This availability has become more widespread across the state and is not merely a regional problem. The geographical size and diverse population of Florida has resulted in diverse drug problems across the state.

There are two important national issues in 2019 and 2020 relative to the impact that the supply and demand has on the price of some illicit drugs. First, are the conditions at the border. With increased security and scrutiny, the volume of drugs successfully making it across the border may be reduced, at least until cartels make adaptations to counter actions by border security agents. A reduced supply can often result in higher drug prices for the consumer. Second, the COVID-19 lockdown may also impact the ability to move contraband (drugs/drug proceeds) in either direction across the border. Both issues may provide opportunities for enhanced interdiction. While progress continues in combatting illegal drug activities throughout Florida, and tackling the opioid crisis continues to be a priority, impacts of widespread use of many other dangerous drugs will require vigilance from the law enforcement community, in partnership with other stakeholder groups.

Statewide Drug Policy Advisory Council
Completed Recommendations from Previous Annual Reports

1. Modernize medical examiner data systems to reduce the wait time to obtain and produce invaluable drug-related death information.

The DOH Bureau of Vital Statistics is seeking to improve the timeliness and the quality of drug overdose information regarding death records and the transfer of this information between systems. Florida will develop a pilot between two ME districts for the collection and the transfer of relevant drug information from the toxicology lab (University of Florida), to the MEs Case Management Systems (CMS) and then transfer data to DOH Bureau of Vital Statistics Electronic Death Registration (EDR) system. Data will then go to the ME Commission and the National Center for Health Statistics (NCHS). The goal of this effort is to concentrate on improving the time it takes for the data to get back to the CMS and have the data uploaded electronically through an Application Programming Interface (API), thereby saving considerable time from using paper/fax/pdf reports and the ME's re-keying data into the CMS.

2020 Recommendations

1. Establish the Florida Office of Drug Control.

The Council supports Governor Ron DeSantis' decision to re-establish the Florida Office of Drug Control. The legislature should reestablish the office in statute and provide the required resources to employ a director and support staff to implement the work of the Florida Office of Drug Control.

Due to the fact that addiction tears at the fabric of communities across the state, it is imperative that various levels of government at the federal, state, county, and local level work together with non-governmental entities and stakeholders to address this problem. A multidisciplinary approach is necessary to address this priority and to ensure the correct balance between awareness, prevention, treatment, law enforcement, legislative priorities, and policy.

Creation of a statewide Office of Drug Control is a proven strategy that results in a coordinated effort across all state entities to promote drug control strategies, support interdiction efforts, and provide leadership in ensuring prevention, treatment, and recovery efforts are appropriately coordinated and funded. The Director and staff serve at the pleasure of the Governor and are responsible for all matters related to the research, coordination, and execution of programs related to alcohol and drug control. Typical duties of such an office include:

- Development and implementation of a statewide strategic plan to reduce the prevalence of alcohol and substance use and abuse in Florida.
- Annually submit to the Governor, President of the Senate, and Speaker of the House of Representatives a report on the effectiveness of state policies and coordinated state efforts to address alcohol and substance abuse and addiction; the effectiveness of illegal drug interdiction efforts; the promotion of healthy, drug free communities; and the progress of executive agencies in implementing initiatives outlined in the strategic plan.
- Review existing research on effective intervention, prevention, treatment, and recovery strategies and use this information to promote substantive policy.
- Monitor data trends related to use, abuse, supply, drug crimes, overdoses, prevention, treatment, and recovery.
- Manage a statewide dashboard of alcohol and substance use data that is readily available to policy makers and the public and can be used to forecast trends and threats.
- Issue policy recommendations to executive branch agencies that will result in greater coordination and collaboration related to resource utilization and service linkage.
- Coordinate media and other public information campaigns to: inform on the dangers of alcohol and substance abuse; promote healthy, drug free living; respond to emergencies such as the opioid/overdose epidemic; promote prevention; and highlight the benefits of treatment and recovery support services

The U.S. Office of National Drug Control Policy (ONDCP) is a model for this type of initiative. By congressional authorization, the office will annually set forth a comprehensive plan for the year to reduce illicit drug use and the consequences of such use by promoting prevention, early intervention, treatment, and recovery support for individuals with SUDs.

The 1999 Florida Drug Control Strategy stated "it is the express intent of the law establishing the Office of Drug Control to establish and institutionalize a rational process for long-range planning, information gathering, strategic decision making, and funding for the purpose of

limiting substance abuse in Florida." [26] The Florida Drug Control Strategy 1999-2005 produced by the former Florida Office of Drug Control documented how agencies were working together on an initiative to revise administrative rules governing substance abuse programs. These agencies included the DCF, the FDC, the Department of Juvenile Justice, and other partners. The Florida Drug Control Strategy 1999-2005 indicates opportunities for better coordination among agencies and law enforcement to reduce substance abuse. [27]

2. State agencies and commercial health plans provided service delivery flexibilities to respond to the challenges related to the delivery of mental health and substance use disorder care during the COVID-19 pandemic. It is recommended that the state agencies, commercial health plans, and other private payors permanently adopt these flexibilities, specifically:

- **Waiving prior authorization requirements and services limits (frequency, duration, and scope) for all behavioral health services (including targeted case management).**
- **Maintaining payment parity for telehealth services by reimbursing services provided via telemedicine at the same rate as face-to-face encounters.**
- **Expanding coverage of telehealth services to include telephone communications, only when rendered by licensed psychiatrists and other physicians, physician extenders, and licensed behavioral health practitioners.**
- **Requiring managed care plans to waive limits on medically necessary services when additional services will maintain the health and safety of an enrollee diagnosed with COVID-19 or when it is necessary to maintain an enrollee safely in their home.**
- **Using audio-only services when video capability is not available, and services can only be provided telephonically, which should be thoroughly documented.**

These flexibilities resulted in continued care, addressed transportation concerns, and allowed access to care that was not previously available. The pandemic has been traumatic and has impacted our collective sense of well-being.[28] This trauma will be long lasting for children, adults, and families and medical providers are also experiencing a significant increase in individuals seeking care and a higher acuity in patients presenting for treatment that will continue well beyond the emergency period. These individuals require their managed care plans to waive limits on medically necessary services when these treatments/services will be needed to maintain the health and safety of an enrollee diagnosed with COVID-19, or when it will be necessary to maintain an enrollee safely in their home.

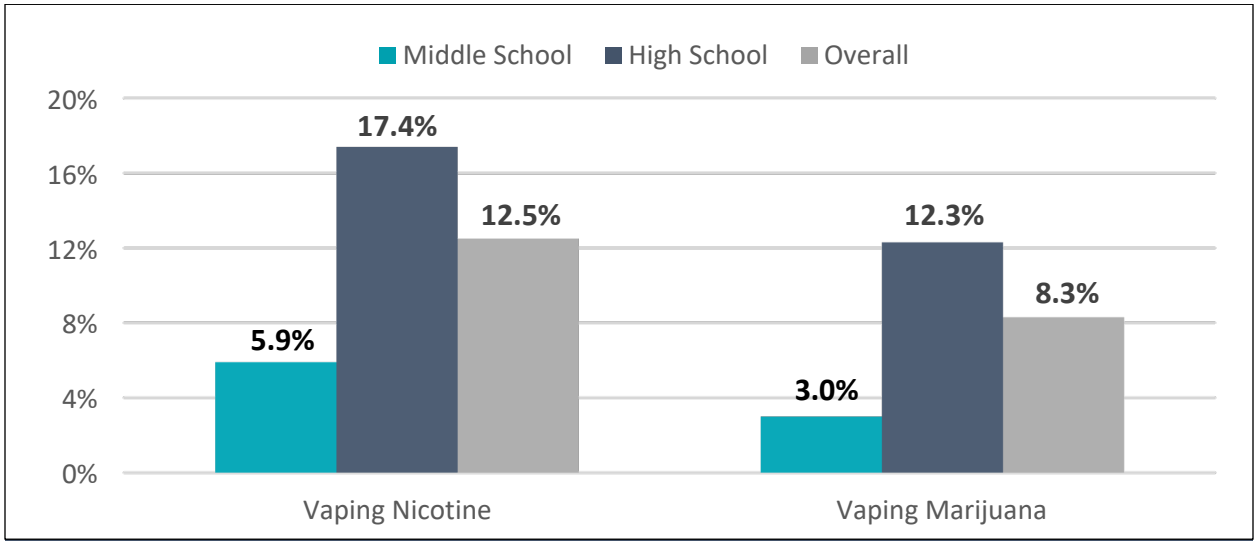
The COVID-19 pandemic has had a significant impact on the delivery of mental health and SUD prevention, as well as treatment and recovery services across Florida and the country, challenging traditional delivery systems. Assisting this effort was the innovation and waiver of rules authorized by federal and state agencies and commercial health plans to allow flexibilities related to telehealth and audio-only telephonic services. Without these flexibilities, access to services would have been significantly diminished due to social distancing restraints, availability of transportation, stay in place orders, and quarantine requirements. Community mental health and SUD service providers report that the flexibilities allowed providers to continue serving clients during a period of increased anxiety, depression, psychosis, and substance abuse directly related to the isolation and economic uncertainty of the COVID-19 pandemic.

Prevention

3. Develop and implement a substance-use prevention strategy designed to reduce drug use among youth (ages 12-17). The strategy should focus on (1) the deployment of a unified anti-drug messaging campaign, (2) increase/maintain substance use prevention efforts by securing/sustaining front-end prevention funding, and (3) by expanding state partnerships with anti-drug coalitions, educational institutions, law enforcement, and other members of the 12 Community Sectors. Collectively, these efforts will enhance substance use prevention efforts, allow for the unified employment of limited resources towards a common goal, and reduce the impact of substance use among youth by 10 percent and marijuana use among youth by 3 percent.

In many ways, Florida has made significant gains in preventing substance use among youth. According to the 2019 FYSAS high school students reported a 22.2 percent reduction in their past 30-day alcohol use, 12.9 percent reduction in tobacco use, and 1 percent reduction in marijuana use as compared to 2004.[29] Despite these gains, new trends demonstrate the need for concern. According to the 2019 Monitoring the Future (MTF) survey, 25.4 percent of 12th graders have used some form of e-cigarette to consume liquid nicotine within the past 30 days. The MTF survey further outlined a 4.2 percent increase in the vaping of marijuana and a 5.6 percent increase in the vaping of nicotine.[30] The 2019 FYSAS also noted that 17.4 percent of Florida's high school students vape nicotine and another 12.3 percent vape marijuana.[31]

Figure D
Past 30-Day E-Cigarette/E-Liquid Use (2019 FYSAS)



Recognizing vaping as an enduring and significant problem, the Food and Drug Administration (FDA) expanded their anti-vaping/e-cigarette prevention campaign. The campaign, entitled "The Real Cost," is part of the FDA's ongoing effort to protect youth from the dangers associated with e-cigarettes. The FDA uses a science-based approach to educate young people on the dangers of e-cigarettes and it hopes to reach 10 million students nationally. To deploy their message, the FDA employs television ads, online videos, websites, social media, and printed materials distributed throughout the U.S. at no cost to the end user.[32] With the use of a multifaceted drug

prevention campaign, Florida can reduce and/or delay the use of alcohol, e-cigarettes, tobacco, and/or other recreational drugs by youth ages 12-17. To maximize impact, community partners such as the DCF, DOE, Florida National Guard Counterdrug Program, and other anti-drug organizations should be engaged in the process.

Preventing drug use before it starts is a fundamental tenet of a comprehensive approach to drug control. The science of prevention has evolved and significantly improved. Decades of research shows that prevention is most effective when carried out over the long-term with repeated evidence-based interventions.[33] Additional prevention strategies which have proved successful include the deployment of anti-drug awareness campaigns, expansion of drug take-back events, and the strengthening of anti-drug coalitions across Florida. To succeed in prevention efforts, Florida should continue to support its anti-drug coalitions by maintaining or expanding grant opportunities similar to DCF's Prevention Partnership grants, SAMHSA grants, and the ONDCP grants.[34, 35, 36] Funds obtained through these sources are used to implement evidence-based prevention programs, fund local prevention messaging campaigns, and expand prescription drug take-back events.

These intervention initiatives conducted in conjunction with a large-scale, multi-agency prevention campaign would potentially have a significant impact to the community. Partner organizations and community stakeholders would utilize their already existing social media platforms, websites, and other media outlets to dispatch substance use prevention messages. As a result, these messages would be more widely available throughout the state and at minimal cost to the taxpayer. Statistical analysis continues to demonstrate that combining multiple evidence-based approaches in a comprehensive prevention program is more effective than a single activity alone. Moreover, these early investments yield large dividends in substantially reduced treatment and criminal justice costs, saving taxpayer dollars while reducing the number of young people whose lives are tragically affected by early substance abuse.[37] By ensuring prevention funding is continually available, local communities will consistently provide substance use prevention efforts throughout Florida. These funds will allow for the better integration of the 12 Community Sectors, which in turn, will improve a greater understanding of addiction, reduce the impact of stigma, and allow for the unified deployment of limited resources towards a healthier community.

4. Deploy an evidence-based substance use prevention program designed to reduce drug use among youth (ages 12-17). The curriculum should focus on evidence-based and/or evidence-informed prevention strategies proven to reduce substance use, while also increasing youth resiliency, coping strategies, positive mental health, and responsible decision-making. The Florida Department of Children and Families (DCF) should lead, in collaboration with DOH and the Florida Department of Education (DOE), a statewide initiative designed to increase and coordinate prevention efforts across Florida through a partnership with coalitions, community SUD providers, school districts, faith-based groups, and business entities. The end goal is to better link existing prevention education programs with Florida's educators, and reduce substance use and abuse among Florida's youth.

In Florida, over 660,000 adults and 181,000 children live with a serious mental illness.[38] The initial onset of many mental health and/or SUDs typically occurs during childhood or adolescence. This information provides state and local leadership with an opportunity to address these issues prior to an individual reaching a crisis state. Communities can do this by implementing evidence-based practices designed to treat mental health issues early and prevent substance use among youth.

Florida's communities are geographically and culturally unique. Therefore, all evidence-based practices must be flexible and adaptable to the needs of specific populations. These practices must contain a core prevention foundation that remains uniform across the state and provides guidance to administrators on acceptable changes or adaptations in methods of delivery. This process would ensure fidelity and provide measurable, repeatable, and effective outcomes. Collaboration between evidence-based administrators, researchers, and developers would be mandatory. To facilitate this process, SAMHSA has established an evidence-based practice online resource center. The SAMHSA resource center contains a collection of evidence-based resources for a broad range of audiences. These resources include substance use prevention plans, treatment improvement protocols, toolkits, resource guides, clinical practice guidelines, and science-based resources.[39]

Governor DeSantis identified quality mental and emotional health and substance use and abuse education as high priorities for Florida's Legislature. For decades, Comprehensive Health Education has included mental and emotional health and substance use and abuse as part of required instruction through section 1003.42(2)(n), Florida Statutes, but it did not include an instructional time requirement or the assurance mechanisms to support and verify instruction.

In an effort to ensure Florida students receive this critical education requirement, the DOE established Florida Administrative Code (FAC) 6A-1.094121 (Mental and Emotional Health Education) and FAC 6A-1.094122 (Substance Use and Abuse Health Education).[40, 41] FAC 6A-1.094121 was approved by the State Board of Education on July 17, 2019 and requires that all students (grades 6-12) receive a minimum of five hours of mental and emotional health education. The State Board of Education also approved FAC 6A-1.094122 on August 21, 2019, requiring all Florida school districts to provide annual substance use and abuse education to students (grades K-12). The selected course content must advance with each grade level through developmentally appropriate instruction and skill building. Decisions about which course(s) to use are determined at the school district level. These rules are in effect for the 2020-2021 school year.

With the deployment of an evidence-based and/or evidence-informed prevention strategy, Florida has the opportunity to reduce substance use among youth. Prevention programs such as these have been proven to reduce drug use, while also increasing youth resiliency, enhancing their mental health, and providing students with sound protective factors that will aid them in making critical decisions.

Many adult issues, including chronic diseases, substance dependency, depression, and other mental health conditions, are now understood to be negative outcomes to experiencing trauma and toxic stress in childhood. The Adverse Childhood Experiences (ACE) study discovered a direct relationship between these "adverse childhood experiences" and lifelong physical and mental health conditions.[42] The ACEs considered for the study included:

- Emotional, physical, or sexual abuse
- Emotional and physical neglect
- Parental separation or divorce
- Incarceration of a family member or a mother who is treated violently
- Household member with substance dependency or mental illness

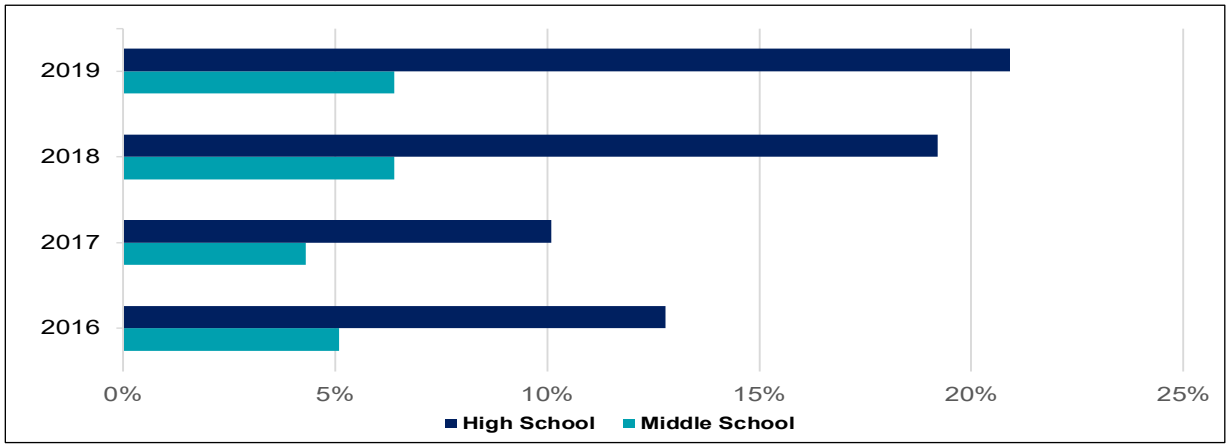
The study linked the number of ACEs with health records and found that the cumulative effect of four or more adversities were predictive of a cascade of health and psychosocial complications in adulthood including substance use.[43] SUDs are more common in persons with ACEs, especially with cumulative adverse experiences as detailed below:

- Compared with persons with no scores on the ACE screening instrument, the risk of heavy drinking, self-reported alcoholism, and marrying an alcoholic were two to four times higher for the persons with multiple ACE scores even when the person's parent did not have alcoholism.[44]
- Research shows a 500 percent increase of risk of alcoholism with four or more ACEs and attribute ACEs to account for one half to two third of serious problems with drug use.[45, 46]
- Higher ACE scores had a strong relationship to initiation of drug use as well as to having drug use problems, drug addiction, and intravenous drug use. When compared with people with no ACEs, people with five or more ACEs were 7 to 10 times more likely to report illicit drug use and addiction.[47]
- At the extremes of ACE scores, the figures for injected drug use are even more powerful. For instance, a male child with an ACE score of six, when compared to a male child with an ACE score of zero, has a 46-fold (4,600%) increase in the likelihood of becoming an injection drug user sometime later in life.[48]

5. Develop and implement a comprehensive e-cigarette/e-liquid prevention strategy designed to reduce vaping among youth (ages 11-17) and limit the negative health effects associated with e-cigarettes, e-liquids, and/or other vaping materials.

There has been a 52.3 percent increase in the use of e-cigarettes/e-liquids by Florida's youth (ages 11-17) since 2015.[49] According to the CDC, this health emergency is a national epidemic. The CDC's research confirms that in 2019 more than one in four (27.5%) high school students and 1 in 10 (10.5%) middle school students reported they had used e-cigarettes/e-liquids within the past 30 days.[50] The continued rise in e-cigarette use is likely due to unregulated advertising methods, a wide range of flavored vaping products, and extremely high nicotine content. Many of these devises come in shapes designed to mimic the look of markers, highlighters, USB flash drives, etc., making them very easy to conceal.

Figure E. FYSAS Past 30 Day Vaping Trend



Source: https://www.myflfamilies.com/service-programs/samh/prevention/fysas/2019/docs/FYSAS%202019%20(Final).pdf

Additionally, 8,269 children (ages 6 and under) were accidentally poisoned by consuming e-liquids during the period of 2012-2017.[51] Most, 92.5 percent of these children were exposed by ingesting e-liquids.[52] The FDA believes these children consumed liquid nicotine because of the child-friendly packaging, cartoon placement, and diverse flavoring options.[53] The Child Nicotine Poisoning Prevention Act (CNPPA) of 2015 requires that all e-liquids sold, manufactured, and/or distributed to be packaged in child resistant containers.[54] The CNPPA has helped reduce e-liquid exposures; however, the poisoning rate remains high as compared to 2012. In fact, new trends suggest that some youth populations are now deliberately drinking e-liquids and/or eating/chewing e-liquid pods/cartridges to gain access to the nicotine.[55]

In 2016, the FDA published a rule that extends its regulatory authority to all tobacco products. This regulation includes e-cigarettes, e-liquids, hookahs, cigars, and pipe tobacco. Prior to this regulation, these products were sold without any review of their ingredients, manufacturing processes, or their potential dangers.[56] Additionally, the ruling ensures e-cigarettes/e-liquids are not sold to minors and not available for purchase in vending machines that are accessible by youth. Since 2016, the FDA has sent 735 warning letters and issued 159 fines to Florida businesses for violating FDA's 2016 e-cigarette/e-liquid regulation.[57] Given FDA's limited time and resources, it should be assumed that additional violations would have been identified if other agencies were given the authority to conduct compliancy inspections. On December 20, 2019, the President signed legislation amending the Federal Food, Drug, and Cosmetic Act (FD&C Act), and raising the federal minimum age for sale of tobacco products from age 18 to age 21. This legislation (known as "Tobacco 21" or "T21") took effect immediately, and it is now illegal for a retailer to sell any tobacco product—including cigarettes, cigars, and e-cigarettes—to anyone under age 21. The new federal minimum age of sale applies to all retail establishments and persons with no exceptions. The Federal FD&C Act does not require that states pass laws to raise their sales age to 21, but it does require states to demonstrate that their retailers are complying with the law. If not, the state eventually risks losing some portion of their federal substance abuse grant funding. [58, 59] Florida has not established e-cigarette/e-liquid advertising laws that prohibit youth targeting or ban the sale of flavored vaping products popular among Florida's youth. Tobacco companies, prior to the 1998 *Master Settlement Agreement*, commonly used marketing practices designed to target youth, encouraging them to experiment with cigarettes, chewing tobacco, and other items containing nicotine. These practices included the use of cartoon advertisements, brand name endorsements, outdoor signage, billboards, public transit ads, and free tobacco company merchandise/samples. Many of these same advertising methods have been retooled by vaping companies and are now being employed to target youth.[60] Electronic cigarette retailers in the state of Florida are not required to obtain a Tobacco Retail License to sell or manufacture e-cigarettes and/or e-liquids.[61] This precludes Florida's ability to inspect and/or regulate e-cigarette/e-liquid manufacturing processes and retail establishments where these products are sold. On January 2, 2020, the President of the U.S. announced a nationwide ban of flavored pod-based vape cartridges, excluding tobacco and menthol flavors. Since the President's announcement, the FDA expanded the restriction to include disposable flavored e-cigarettes like Puff Bar and Mojo. The FDA clearly states they will prioritize enforcement efforts against businesses that violate the guidance outlined within the policy.[62] The FDA expects this policy to reduce the use of e-cigarettes/e-liquids by youth, limit accidental poisoning, and/or prevent its use entirely. The policy does not include flavored e-liquid used in open vape systems or menthol-flavored pod products, allowing more than 15,000 flavors to still be on the market. Additionally, the restrictions exempt sleek, open pod systems like Suorin and Smok, popular brands youth use to refill with flavored e-liquid. With the development and deployment of a comprehensive e-cigarette/e-liquid

prevention strategy, Florida can better protect its youth and limit the negative health effects associated with vaping. This strategy may include:

- Comprehensive flavor ban without product, flavor or retailer exemptions reduces youth initiation and promote cessation among adults.
- Strong youth access laws accompanied with enforcement programs, including retailer education, that focus on retailer compliance instead of youth possession penalties.
- State and local licensure requirements for businesses that manufacture and/or sale any tobacco product, including e-cigarettes, that is consistently implemented across all product types. [63]

6. Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with SUDs, as well as those at-risk of developing those disorders.[64] To evaluate what evidence-based practices are presently in use in Florida to identify problematic alcohol or drug behavior in the primary care setting and to promote the implementation of SBIRT in our state, the following is recommended:

- **DOH should lead an initiative to review the extent SBIRT and/or other evidence-based practices are utilized in primary care settings across Florida to identify and intervene with patients showing symptoms of problematic alcohol and/or drug use.**
- **Agency for Health Care Administration (AHCA) should report to the Legislature on the availability of Medicaid coverage for SBIRT, and if not available, what changes to the state's Medicaid plan, billing, and coding practices would need to be made to implement SBIRT.**

Early identification and early intervention are the keys to addressing unhealthy alcohol and drug use and the likelihood of an individual developing a SUD. SBIRT is an evidence-based practice used to identify, reduce, and prevent risky use that can have short and long-term health impacts and social, legal, and financial consequences [65].

The U.S. Preventive Services Task Force (USPSTF) recommends screening for unhealthy alcohol use in primary care settings in adults 18 years and older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.[66] Additionally, an analysis of USPSTF recommendations included providing screening and brief intervention for alcohol misuse in adults as one of the highest priority prevention services in terms of cost-effectiveness and clinically preventable burden of disease.[67]

The USPSTF also recommends screening for unhealthy drug use in adults 18 years and older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred.[68]

Typically, this practice is conducted in medical settings including community health centers, and has proved to be successful in hospitals, specialty medical practices such as HIV/STD clinics, EDs, and workforce wellness programs. SBIRT can be effectively streamlined in primary care workflows and enables health care teams to systematically screen and assist people who may not be seeking help for their substance use, but whose drinking or drug use may cause or complicate their ability to handle health, work, and family issues. SBIRT aims to prevent

unhealthy consequences of alcohol and drug use among those whose use may not have reached the diagnostic level of a SUD.[69]

Research validates that the SBIRT model reduces health care costs,[70] decreases the severity of both drug and alcohol use, and reduces the risk of physical trauma and the percentage of patients who go without specialized substance abuse treatment.[71]

SBIRT's use across health care settings is dependent on the state's coding and billing policies. States are working to "activate" Medicaid codes for SBIRT in their respective Medicaid plans.

7. When filling prescriptions for controlled substances, strongly encourage pharmacies to educate consumers on safe medication storage and disposal procedures. Establish a media campaign to educate consumers on reason for safe use, safe storage, and safe disposal and the location of safe disposal boxes in each community.

Several resources are available to help people in Florida understand the proper steps to dispose of unused medication:

- The Florida Office of Attorney General's drug abuse prevention site, https://doseofrealityfl.com/drug-take-back.html, offers a link to an interactive map to locate drug take back locations.
- The Florida Department of Environmental Protection (DEP) offers information online regarding pharmaceutical waste management for homeowners. In addition to addressing frequently asked questions, DEP's web page includes information about drug drop off locations and steps to take at home to properly dispose of old unused medication. DEP's web page is located here: https://floridadep.gov/waste/permitting-compliance-assistance/content/pharmaceutical-waste-management.
- The CVS Health locations with drop boxes may be found here: https://www.cvs.com/content/safer-communities-locate.
- The Walgreens locations with drop boxes may be found here: https://www.walgreens.com/topic/pharmacy/safe-medication-disposal.jsp.
- The U.S. Drug Enforcement Administration (DEA) Diversion Control Unit hosts National Take Back Days (https://takebackday.dea.gov/). There were 1,040 pounds collected in Florida during 2020.
- Publix Pharmacy continues to partner with Informed Families/The Florida Family Partnership to feature the Lock Your Meds campaign. In-store signage was distributed to and displayed in 694 Publix stores at the pharmacy counter. Additionally, Publix "Carepoints" documents, featuring the Lock Your Meds message and an appeal to take the pledge to prevent prescription drug abuse, were printed and distributed with all prescription purchases. The month-long campaign reaches more than 1 million Floridians, or about 50 customers per store, per day. Those who took the pledge also received a home medicine inventory card download. These customers also had the opportunity to opt in to receive additional prevention education information throughout the year. Through their partnership with Publix, Informed Families also developed a web page focusing on safe disposal locations in Florida, which is consistently updated: https://www.informedfamilies.org/lym/safedisposal.
- Through the SOR grant, DCF is funding a safe use, safe storage, and safe disposal campaign based on the Use Only as Directed initiative from Utah. Over 1 million people have seen or heard a campaign message to date.

Treatment and Recovery

8. Expanding naloxone availability among people who use drugs and their peers through hospital emergency departments (ED) and floor units (with little to no paperwork, and no separate trip to the pharmacy), Emergency Medical Services (EMS)/fire rescue naloxone leave-behind programs, CHDs, and Federally Qualified Health Centers (FQHCs).

Research shows that overdose mortality can be reduced by distributing naloxone to individuals at risk of experiencing an overdose and to their peers and family who may witness an overdose, through SEPs, drug treatment programs, community meetings, support groups for family members of people who use opioids, re-entry programs, mobile outreach programs, homeless service providers, and other community-based distribution programs that provide continuous, low-barrier access to naloxone.[72] It is conservatively estimated that one heroin overdose death is prevented for every 164 naloxone kits distributed.[73]

According to a recent statement from the FDA supporting the expansion of naloxone access, "naloxone is a critical tool for individuals, families, first responders, and communities to help reduce opioid overdose deaths, but access to naloxone continues to be limited in some communities." The FDA reiterated that "all three forms of naloxone are FDA-approved and may be considered as options for community distribution and use by individuals with or without medical training to stop or reverse the effects of an opioid overdose." The FDA is also continuing the agency's efforts to make naloxone available over-the-counter.[74]

Bystanders are present in approximately 40 percent of opioid overdose deaths and approximately 65 percent of nonfatal overdoses.[75] Tragically however, when someone overdoses in the U.S. a 911 call is made less than 50 percent of the time.[76] Fear of police involvement is the most commonly cited reason for delaying or deterring a call for help for an overdose victim.[77]

Fortunately, people who use opioids and their friends and family members can reverse opioid overdoses and revive individuals using naloxone. Naloxone is remarkably safe and has no potential for abuse. When given to individuals who are not under the influence of opioids, it produces no harmful effects. It is relatively quick and easy to train people who use opioids and their loved ones on the use of naloxone. Research confirms that bystander/layperson naloxone administration is a safe and effective community-based method for preventing overdose deaths and that the associated education effectively improves overdose recognition and response.[78] Thus, it is critical that naloxone is provided to people who use drugs and their peers, as they are commonly the first responders at the scene of an overdose and are able to immediately administer naloxone to someone who is not breathing and save their life.

DCF initiated an Overdose Prevention Program in August 2016. The program has been funded through a variety of sources, including State General Revenue, the SAPT block grant, the STR grant, and the SOR grant. Organizations enrolled in the program distribute free, take-home naloxone kits directly to people who use drugs, people with a history of drug use, and to their peers and loved ones who may witness an overdose. There are currently 110 organizations participating in the program, including substance use and mental health treatment facilities, hospital EDs, harm reduction programs, peer recovery organizations, homeless service providers, FQHCs, and other community-based organizations. Since the start of the program, over 79,000 naloxone kits have been distributed among participating providers and 3,184

overdose reversals have been reported. In Palm Beach County, Rebel Recovery distributed 5,481 naloxone kits and documented 478 reported reversals.[79] Unsurprisingly, and much like the experience in other states, the most effective naloxone distribution programs enrolled in DCF's program are operated by organizations that serve people who use drugs with a peer-oriented, harm-reduction framework.

Between 2006 and 2009, Massachusetts provided overdose education and naloxone kits to thousands of people who use opioids and their families, friends and social service providers. An interrupted time series analysis compared communities that did not implement the program to low implementation communities (enrolling ≤ 100 participants per 100,000 population) and high implementation communities (enrolling > 100 participants per 100,000 population). Low implementation communities experienced a 27 percent decrease in opioid overdose death rates, and high implementation communities experienced a 46 percent decrease in opioid overdose death rates.[80]

In 2013, North Carolina began prioritizing naloxone distribution to populations at high risk for overdose, namely people who inject drugs, individuals receiving medication-assisted treatment, people with a history of opioid use who were formerly incarcerated, and individuals engaged in sex work. A recently published evaluation of this program found that high distribution counties experienced a 14% decrease in opioid overdose death rates, and low distribution counties experienced an 11% decrease in opioid overdose death rates, relative to counties with no naloxone distribution.[81] Several other studies conducted in the U.S. have also documented reductions in opioid overdose mortality associated with naloxone distribution programs, all of which were evaluations of naloxone distribution programs that *prioritized people who use drugs and those around them*, most commonly through Syringe Exchange Programs and drug treatment programs, but also through mobile vans, HIV education drop-in centers, pain management clinics, and single room occupancy hotels, for example.[82]

Researchers recently simulated the impact of 13 different naloxone distribution models on overdose deaths and found that expanding naloxone distribution through a single SEP can reduce a community's overdose deaths by 65%. Results showed that, "optimal [naloxone] distribution methods may include secondary distribution so that the person who picks up naloxone kits can enable others in the community to administer naloxone, as well as targeting naloxone distribution to sites where individuals at high risk for opioid overdose death are likely to visit, such as syringe exchange programs." [83]

Additional research demonstrates that distributing naloxone to laypeople, particularly those likely to experience or witness an overdose, is the most cost-effective way to prevent overdose deaths. Researchers analyzed the cost-effectiveness of eight different naloxone distribution strategies among three target groups (laypeople, police and fire personnel, and EMS personnel). The top four most cost-effective strategies all involved high naloxone distribution to laypersons. Strategies that did not distribute a significant amount of naloxone kits to laypeople always ranked last. Thus, when facing resource constraints, naloxone distribution to laypeople should be prioritized.[84] Other research shows that people who use drugs deploy take-home naloxone to save a life at a rate nearly 10 times that of laypeople who do not use drugs, emphasizing the need to prioritize naloxone distribution efforts and resources among people who are actively using drugs.[85]

There is no evidence indicating that access to naloxone encourages or increases the use of heroin or other opioids. Rather, studies suggest that increasing health awareness through naloxone training and distribution actually reduces the use of opioids.[86] DCF's Overdose Prevention Coordinator and Harm Reduction Coordinator is available to help with training and technical assistance to organizations interested in establishing targeted naloxone distribution programs.

People who have experienced an overdose are treated in Florida EDs every day, making these important settings for expanding naloxone distribution. Nonfatal opioid overdose remains the most significant risk factor for subsequent fatal overdose and provides an identifiable opportunity for overdose education and naloxone distribution. Research confirms that EDs are an effective way to provide take-home naloxone kits to high-risk individuals who have not previously received overdose education and naloxone.[87]

Hospital EDs and floor units should be offering take-home naloxone kits prior to/upon discharge to patients at risk of experiencing an opioid overdose. Hospitals should operate under non-patient specific naloxone standing orders in order to allow for broader distribution of naloxone, reduce the burden on prescribers and dispensers by removing the need to write individual prescriptions, reduce bureaucratic and system-wide barriers to receiving naloxone, and allow for ED and floor unit staff to hand naloxone directly to the patient (as opposed to sending the patient to a pharmacy where the medication may never be obtained due to cost, stigma, and other barriers). It is also important to allow for patients to receive more than one naloxone kit as they may know people at risk of overdose and they can provide additional kits to them directly as well as to friends and family that may witness an overdose.

Hospital EDs and floor units should offer naloxone kits upon discharge to:

- Patients who received treatment for an overdose.
- Patients being treated for other drug-related issues, such as endocarditis, cellulitis, abscesses, and vein/wound care related to injection-drug use.
- Patients identified as having an OUD.

The Florida Hospital Association issued the following guidelines to help increase access to naloxone in EDs:

“Emergency department providers and hospital-based pharmacies should operate under non-patient specific naloxone standing orders to ensure that take-home naloxone kits are offered and provided to anyone in the emergency department at risk of opioid overdose, and to the friends and family of those patients at risk of opioid overdose. Any patient in the emergency department due to opioid overdose should be provided with a take-home naloxone kit upon discharge. Friends and family members of the patient should also be provided with take-home naloxone kits upon the patient’s discharge. Hospitals are encouraged to coordinate a follow-up process for individuals who need additional naloxone kits.” [88]

Florida hospitals can have a role in helping to save lives by making sure opioid overdose survivors and those around them are easily and readily equipped with the antidote before they are discharged from EDs.

In 2018, the Legislature appropriated $5 million in recurring State General Revenue funds to the DOH “for the purchase of emergency opioid antagonists to be made available to emergency responders.” [89] The naloxone distribution program established with these funds is called the HEROS Program. DOH can help expand these life-saving efforts by encouraging EMS/fire rescue to establish naloxone leave-behind programs. Some EMS/fire rescue programs leave naloxone kits behind at the scene of an overdose, with overdose survivors, friends, family members, and bystanders who may be at high risk for witnessing or experiencing an overdose. The HEROS program has the resources available to do evidence-based, targeted distribution through leave-behind programs.

It should also be noted that entities receiving naloxone through DOH’s HEROS program are required to enter data into EMSTARS or ODMAPS. Both of these surveillance and overdose hotspot mapping initiatives should be used to help guide the targeted deployment of evidence-

based resources that prevent overdose deaths, such as distributing naloxone directly to individuals who use drugs or who are likely to witness an overdose.

Consider the following directive, which comes directly from the *Overdose Spike Response Framework* guide for ODMAP stakeholders: "Developing a plan for messaging and engaging families and friends of individuals at risk is one key component to reducing injury and death from overdose. Family and friends of individuals at risk for an overdose will approach and manage their loved one's risk, based on their own stage of readiness for change, as well as the stage of readiness of their loved one. Therefore, family and friends require information on a variety of topics including: where to get naloxone, how to administer naloxone, and/or how to encourage their loved one(s) to seek treatment." [90] Rather than having emergency responders advise individuals at the scene of an overdose on where to obtain naloxone, they should just distribute naloxone at the scene. Currently, there are only six EMS/fire rescue naloxone leave behind programs in operation in Florida. The DOH may need to review and revise (as needed) any track-and-trace rules, and any other rules, that may constitute barriers to establishing naloxone leave-behind programs.

CHDs and FQHCs can also help distribute naloxone kits to targeted at-risk populations. These entities can use EMSTARS to identify opioid overdose hotspots and develop outreach and distribution strategies to saturate at-risk individuals in those communities with naloxone. In response to public health emergencies, DOH is capable of mobilizing outreach teams through CHDs to engage individuals who use drugs in order to provide them with hepatitis A vaccines, for example.

9. Encourage county commissions to establish Syringe Exchange Programs (SEP).

In order to make a larger impact in reducing overdose deaths, Florida can improve naloxone distribution by targeting people most likely to experience an opioid overdose. While SEPs are the most effective organizations at saving lives by distributing naloxone directly to people who use drugs, there is currently only one SEP operating in Florida - the IDEA Exchange in Miami-Dade County. The IDEA Exchange has distributed 3,443 boxes of Narcan and documented 1,807 overdose reversals.[91] During the 2019 Legislative Session, the Legislature voted to expand SEPs statewide through the passage of SB 366 (2019) Infectious Disease Elimination Programs, which allows county commissions to pass ordinances to authorize local SEPs. County commissions are encouraged to pass ordinances establishing new SEPs throughout the state. The following county commissions have approved an SEP ordinance: Alachua, Broward, Hillsborough, Leon, Manatee, Miami-Dade, Orange, and Palm Beach. Two counties have executed the Letter of Agreement with the DOH: Manatee and Palm Beach. DOH is finalizing the data screens that will be used to capture the required SEP data elements. DOH is collaborating with the National Alliance of State and Territorial AIDS Directors (NASTAD) to deliver virtual capacity building trainings for community-based organizations around the state who are interested in becoming an SEP.

10. Encourage the continued establishment of warm handoff programs from hospital EDs to community OUD treatment providers to address opioid overdoses; issue naloxone to overdose patients before they leave the ED; and have AHCA report on the extent warm handoff protocols have been implemented in EDs across the state.

The CDC has cited EDs as important centers for OUD interventions and care transitions, including the induction of buprenorphine as part of the overdose protocol. This practice has been shown to be superior to motivational interviewing and referral alone. A 2015 study by researchers at the Yale School of Medicine tested three interventions for opioid-dependent patients who were treated in a hospital ED. The first group was given a handout with contact

information for addiction services. The second group received an interview on information about treatment options such as assistance in connecting with treatment. The third group received an interview, plus the first dose of buprenorphine, with take home doses and a scheduled appointment with a primary care provider within 72 hours. The study found that 78 percent of patients in the third group (buprenorphine) were still in treatment 30 days later, compared with 45 percent in the group that only got the interview and 37 percent who only got the handout. [https://www.npr.org/sections/health-shots/2017/08/22/545115225/hospitals-could-do-more-for-survivors-of-opioid-overdoses-study-suggests]

Direct linkage from the ED to a community OUD provider, known as "warm handoffs", are proving to be a better option to serve this population, however, these interventions are infrequently utilized. According to the Florida Hospital Association, there are 209 EDs in Florida. To date, only a limited number have been identified as having, or in the process of implementing, a warm handoff protocol.

As the opioid epidemic continues, EDs will play an integral part in mitigating the human toll on many levels through screening and identification of patients at risk for OUD, managing acute opioid withdrawal, initiating MAT, and coordinating linkage to outpatient treatment. However, much work remains to be done to create, validate, disseminate, and implement effective evidence-based strategies to accomplish these challenging tasks within the unique care environment of the ED.

DCF's Substance Abuse and Mental Health Program Office, when allocating federal SOR grant funds, has prioritized the development of ED warm handoff programs for individuals experiencing an opioid overdose. Utilizing the resources of the Aetna All in for Florida: An ER intervention Project grant program managed by the Florida Alcohol and Drug Abuse Association (FADAA), multiple issues related to the establishment of ED warm handoff programs have surfaced including providing health care with non-recurring funding, available funding for community providers to accept ED referrals, issues related to peers working in the ED, a waiver to prescribe buprenorphine under the Drug Addiction Treatment Act of 2000 (DATA 2000) training for physicians, training for peers and providers, hospital pharmacy rules, legal considerations, and hospital administration support.

11. Expand additional fellowship and residency programs for physicians to obtain a specialty in addiction medicine with a goal of increasing physicians with an addiction medicine specialty.

There is an opportunity to expand the subspecialty of addiction medicine to help ensure patients with a SUD are being properly treated by medical professionals. The Accreditation Council for Graduate Medical Education (ACGME) has accredited Florida institutions to sponsor addiction medicine and addiction psychiatry fellowships, which are one-year training programs. For addiction medicine fellowships, the University of Florida has been approved for six positions and six are filled, the University of South Florida is approved for 2 new positions and both are filled, and Larkin Community Hospital is approved for two new positions and both are filled. For addiction psychiatry fellowships, the University of South Florida has been approved for two positions and both are filled and Jackson Memorial has been approved for three positions and none are filled, due to funding issues.[92]

The opioid epidemic in Florida is changing the dynamic on the delivery of SUD treatment and care. The standard for care for an OUD is MAT combined with behavioral counseling. SUD treatment programs across the state have had to add and/or increase medical professionals on treatment teams in order to evaluate, prescribe, and medically monitor MAT medications. In

order to prescribe buprenorphine, medical personnel must complete a training course and pursue a waiver to prescribe buprenorphine under the DATA 2000. There is a growing need for physicians certified in addiction medicine.[93]

Figure F. Addiction Medicine Specialties among Florida Physicians [94]

Specialty	Count
Addiction Medicine – Anesthesiology	51
Addiction Medicine – Family Medicine	40
Addiction Medicine – Internal Medicine	10
Addiction Medicine – Neurology	2
Addiction Medicine – Psychiatry	32
Total	**135 (N = 52,684)**

12. Pass model legislation that will align Florida law with the federal Mental Health Parity and Addiction Equity Act (MHPAEA) and require all state health agencies, health plans, and commercial insurance to report annually on the implementation of the parity act in Florida. These reports should be transparent and available to inform the public.

In 2008, the U.S. Congress unanimously approved the Paul Wellstone and Pete Domenici MHPAEA known as the federal parity law. Many state legislatures have passed similar laws to ensure parity enforcement. The federal law seeks to eliminate discriminatory access to mental health and SUD benefits in health insurance coverage. The federal parity law prohibits plans from applying financial requirements or treatment limitations to mental health and SUD benefits that are more restrictive than those applied to medical/surgical benefits. Treatment limitations and financial requirements to be evaluated include co-pays, deductions, co-insurance, day or visit limits, pre-authorization policies, frequency of treatment limits, fail first policies, and non-qualitative treatment limitations.

Many states have passed model legislation to facilitate implementation and enforcement of the MHPAEA and to strengthen parity provisions within state law. Examples include: explicit oversight requirements for state regulators (RI); requirements for an annual report on claim denials, complaints and appeals (VA); requirement for plans to submit parity compliance information to the state insurance regulator and/or Medicaid agency (CA, MA, CT); requirement for state agency to develop performance quality indicators to evaluate plan compliance (VT); state laws requiring coverage for prescription drugs for SUDs (IL); length of stay protections (MD); and requirements for peer-reviewed clinical review criteria related to medical necessity determinations (NY).[95] During the 2019 Legislative Session, three bills (SB 700: Insurance Coverage for Mental and Nervous Disorders, SB 102: Recovery Residences, SB 360: Insurance Coverage Parity for Mental Health and Substance Use Disorders) were introduced that would have better aligned Florida law with the federal parity legislation. None of these bills passed.

The Parity Tracking Project highlights significant barriers to front-line state enforcement of the MHPAEA. The report concluded that regulators cannot conduct a complete assessment of parity compliance through a review of the form with even a comprehensive data-gathering template because the required information is often not available in these documents. To

address the barriers in parity compliance and consumer information, the report offered recommendations for consideration:

- Regulatory agencies should require carriers to submit their internal analyses for ensuring that plans are parity compliant.
- Regulatory agencies should use a parity compliance template.
- Regulatory agencies should develop model contracts that fully describe mental health and SUD benefits.
- Regulatory agencies should inform consumers of their rights under the law, including how to take action.
- Regulatory agencies should enhance the provider community's capacity to identify potential parity act violations.[96]

In Florida, the majority of Medicaid recipients receive their services through a managed care plan contracted with the AHCA under the SMMC program. The current SMMC contract contains a requirement that the health plan must comply with the MHPAEA:

- The managed care plan shall comply with all applicable federal and state laws, rules, and regulations.
- The managed care plan shall conduct an annual review of its administrative, clinical, and utilization management practices to assess its compliance with the MHPAEA under this contract.
- The managed care plan shall submit to AHCA an attestation of the managed care plan's compliance with the MHPAEA no later than November 1 of each year, in a manner and format to be specified by AHCA.[97]

The health plan must develop distinct policies and procedures for monitoring and demonstrating compliance with the MHPAEA, including procedures to monitor for and assure parity in the application of quantitative treatment limits and non-quantitative treatment limits for medical and behavioral health services.[98] Each plan is required to submit an annual attestation to AHCA detailing compliance with the MHPAEA.

AHCA has several other avenues for monitoring health plan compliance with parity. These include but are not limited to: review of health plan policies and procedures (including utilization management); monitoring of provider and recipient complaints; and monthly submission of complaint, grievance, and appeals reporting. Reports required by AHCA include quantitative treatment limits and non-quantitative treatment limits, in addition to the following:

Denial, Reduction, Termination, or Suspension of Service Report

- Medical necessity
- Service authorization
- Service amounts and frequency

Enrollee Complaints, Grievances, and Appeals Report

- Access to care
- Medical necessity
- Service authorization
- Enrollment/disenrollment
- Pharmacy benefits
- Excluded benefits

Additionally, AHCA conducted its own internal analysis of how the state plan benefits for mental health meet the MHPAEA requirements. The state plan benefit categories of services reviewed for both mental health/substance abuse benefits and medical/surgical benefits included:

- Inpatient
- Outpatient
- Emergency care
- Prescription drugs

AHCA determined from its analysis that the Florida Medicaid program makes available a package of services under the behavioral health benefits, which is not more restrictive than what it offers under medical/surgical benefits. Additionally, AHCA determined that the behavioral health service limits were more expansive for adults than what is provided through the medical/surgical benefit. It is recommended that the AHCA parity review be published to better inform the public. It is also recommended that AHCA and health plans inform consumers on what services are available to them and how they fulfill the requirements of the MHPAEA.

13. State health agencies, health plans, and commercial insurers should remove prior authorization requirements for evidence-based MAT to allow for use of medications such as buprenorphine, naltrexone, naloxone, and methadone.

Currently, Florida's Medicaid State Plan covers behavioral health medication management services as part of a continuum of care for individuals diagnosed with a SUD. MAT is covered in conjunction with psychiatric evaluations, counseling, and behavioral therapies to ensure comprehensive treatment. For example, covered treatment may include monitoring current medication dosage and side-effects as well as ensuring concerns or changes in health status are addressed properly. Behavioral health-related medical services such as screenings, verbal interactions, and specimen collection are also covered to assist in drug management and treatment of SUD. MAT services can also include methadone-based treatment. Florida Medicaid covers medication management services in addition to a bundled weekly reimbursement for MAT.

Additionally, several health plans provide expanded benefits for substance abuse such as additional behavioral health medical services, substance abuse treatment, and outpatient detoxification services. Expanded benefits are extra benefits above and beyond the minimum required benefits detailed in the State Plan. Health plans offer these benefits to their enrollees without a capitation payment from AHCA. A comprehensive listing of expanded benefits by health plan can be located on the website at: http://ahca.myflorida.com/medicaid/statewide_mc/outreach_presentations.shtml.

Florida Medicaid enforces prior authorization standards for medication management services with all health plans. Additionally, Florida Medicaid requires continuity of care when a recipient is receiving MAT and changes plans. The new plan is required to cover the existing course of authorized treatment.

Specific to MAT, AHCA covers buprenorphine, naltrexone, and methadone patients with SUD. AHCA allows Medicaid patients to receive up to a 30-day supply of buprenorphine, buprenorphine/naloxone tablets, Suboxone film, or Zubsolv tablets for initiation of therapy for OUD without the prior authorization through the pharmacy benefit. This allows the prescriber to immediately start the patient on MAT. The prescriber can then submit a prior authorization to Medicaid to continue treatment. Prior authorization requests are reviewed within 24 hours of

receipt. The buprenorphine prior authorization form and criteria can be found at: http://www.ahca.myflorida.com/medicaid/Prescribed_Drug/drug_criteria.shtml. The buprenorphine prior authorization allows up to a three-month authorization for a buprenorphine containing medication for an initial request and up to a six month authorization for continuation of therapy.

MAT with buprenorphine is also available through the automated prior authorization process for pregnant women. The pharmacy system will look for diagnosis of OUD and diagnosis of pregnancy. If both are found in the system, the claim will pay at the pharmacy immediately. Health plans are required to implement all these edits.

Medicaid patients can also receive the following medications for treatment. These medications are available with no co-pay.

- Naltrexone tablets which are covered without prior authorization through the pharmacy benefit.
- Vivitrol (naltrexone) injectable can be received at the pharmacy through an automated prior authorization. The pharmacy computer system verifies that the recipient is 18 years of age or older and has a diagnosis of alcohol and/or OUD on file. If both are confirmed, the claim will pay. This automation eliminates the need for prior authorization paperwork submission through the pharmacy benefit. Vivitrol is also available through the medical benefit under J2315 if administered in a medical office setting.
- Sublocade (buprenorphine) injectable can be received at the pharmacy through an automated prior authorization. When the claim information is entered, the pharmacy computer system verifies that the recipient has received a minimum of seven days of treatment with a buprenorphine-containing oral product. If confirmed, the claim will pay for Sublocade through the pharmacy. Sublocade is also available through the medical benefit under Q9992 if administered in a medical office setting.
- Methadone tablets are available through methadone clinics.
- Narcan (naloxone) nasal spray and naloxone vials are covered to treat overdose through the pharmacy benefit and under the medical setting under J2310. Medicaid allows a maximum of one Narcan kit (two nasal sprays) per year. Additional kits within the same year require prior authorization.

The Medicaid preferred drug list is located at: http://www.ahca.myflorida.com/medicaid/Prescribed_Drug/preferred_drug.shtml. MAT not listed on the preferred drug list do require prior authorizations, which are reviewed within 24 hours of receipt. Medications on the preferred drug list are reviewed at least annually by the Pharmaceutical and Therapeutics Committee which is composed of physicians and pharmacists.

Medicaid has a single preferred drug list that the Medicaid health plans follow. The Medicaid health plans cannot be more restrictive than fee-for-service Medicaid. Under the medical benefit, plans can use step therapy or prior authorized medications.

When prior authorizations are required for treatment services, this may take up to several days to process with insurance providers. This processing time creates an immediate barrier to a patient's initiation onto MAT for SUDs. This delay forces patients to leave their provider's office without receiving potentially life-saving medication and requires them to return to receive it days later. During that time, treatment can be derailed. A patient may lose interest, lose access to their doctor, lose transportation, suffer an injury, or even die from an overdose. Self-treatment

with diverted (i.e. misused) opioid medications is common among individuals with OUD who have recently experienced barriers to or delays in starting buprenorphine-based MAT.[99, 100, 101]

Prior authorization limitations to MAT for SUD disproportionately affects pregnant and post-partum women and their children due to their vulnerability especially for low-income populations who have severely limited alternative resources. In 2014, prior authorization for prescription buprenorphine was still required for 35 percent of Health Maintenance Organizations (HMOs), 36 percent of Preferred Provider Organizations (PPOs), and more than half of Consumer Driven Products (CDPs).[102]

During pregnancy, universal screening efforts and enhanced substance abuse services—including accessible MAT for all women who need it—are important goals. At birth, the systematic approach to screening infants, monitoring for withdrawal signs using a scoring tool, and managing care for the mother and infant offer numerous opportunities for improving outcomes including the measured use of MAT.[103]

MAT is considered the standard of care for opioid-dependent pregnant women. Service delivery and treatment capacity should be streamlined to ensure women have access to needed services in a timely manner, whether they are staying in their community or in a medical home whenever possible. Compared to medication-assisted withdrawal, MAT is associated with better relapse prevention, decreased exposure to illicit drugs, and other high-risk behaviors, improved adherence to prenatal care, and improved neonatal outcomes. The goal of MAT is to prevent withdrawal during pregnancy and minimize fetal exposure to illicit substances.[104, 105]

MAT is not the only solution, it is also important to consider the implications of identifying prenatal substance abuse in efforts to increase access to care and improve clinical outcomes, but it is a centerpiece of managing opioid dependency in pregnancy, and is best applied as part of a comprehensive treatment program that includes obstetric care, counseling, and wrap-around services.[106] However, there is a treatment gap in pregnant women's receipt of substance abuse services overall. Barriers to care included lack of transportation, lack of child care services, intensive time requirements, additional costs and co-pays, stigma, and regulatory roadblocks such as prior authorization.[107, 108]

The removal of prior authorization requirements allows a patient to be initiated into treatment the same day they see their doctor. This immediate initiation reduces the patient's risk of overdose in the subsequent days and increases the likelihood that they will successfully engage in and remain connected to treatment. Due to regulations governing the provision of methadone, buprenorphine, and naltrexone are the only FDA-approved medications for OUD potentially subject to prior authorization requirements. There is a lower risk of overdose with buprenorphine because there is a ceiling effect on respiratory suppression.[109]

If prior authorization requirements were removed, health insurance providers would then cover the full cost of MAT as a standard benefit and all requirements that a physician contact the insurance provider for approval prior to writing the prescription (a process called "prior authorization") are removed. Without these prior authorization requirements, prescriptions for MAT medications to treat OUD can be written and filled as soon as a physician deems this treatment necessary, free from artificial delays. Policy makers and health care providers should work collaboratively with health insurance companies and state Medicaid programs to design and implement this policy.

Reducing and eliminating barriers to prescribing buprenorphine to treat OUD is critical to ensure greater access to care and reduce opioid overdose deaths. As noted earlier, prior authorization requirements for buprenorphine represent a common barrier cited by prescribers that can delay or interrupt patient care. In a September 2019 report titled *National Spotlight on State-Level Efforts to End the Opioid Epidemic*, the American Medical Association (AMA) Opioid Task Force

recommended removing prior authorization and other barriers to MAT for OUD – and ensure MAT is affordable.[110] A 2019 survey of physicians conducted by the AMA found that 64 percent of physicians reported waiting at least one business day for a prior authorization decision from health plans, and 29 percent reported waiting at least three business days. For those patients whose treatment requires a prior authorization, the physicians reported that the process results in delays in access to care 91 percent of the time. Additionally, 24 percent of physicians reported that prior authorizations have led to a serious adverse event for a patient in their care, and 16 percent reported that a prior authorization has led to a patient's hospitalization. When asked how often issues related to the prior authorization process lead to patients abandoning their recommended course of treatment, 74 percent of physicians reported that a prior authorization can lead to treatment abandonment. While only 2 percent of physicians reported that the prior authorization process has a somewhat or significant positive impact on patient clinical outcomes, 90 percent reported the process to result in a somewhat or significant negative impact on patient care and health outcomes.[111] A study conducted in 2016 among a sample of New York City public sector buprenorphine prescribers found that medication prior authorization requirements were the highest rated barriers to practice.[112]

14. Promote legislation that adds the Secretary of AHCA and the Commissioner of the Office of Insurance Regulation as members to the Statewide Drug Policy Advisory Council.

AHCA is a health policy and planning entity for the state of Florida. AHCA serves as the single state agency responsible for the administration of the Florida Medicaid program, authorized under Title XIX of the Social Security Act. The Florida Medicaid program serves approximately 3.9 million Medicaid recipients at a cost of over $28 billion annually and has over 100,000 actively enrolled service providers. During State Fiscal Year 2017-2018, AHCA spent over $3 billion dollars on prescribed drugs through the Florida Medicaid program. AHCA shares similar goals with the Council and would be a valuable addition to its membership.

Office of Insurance Regulation is responsible for all activities concerning insurers and other risk bearing entities, including licensing, rates, policy forms, market conduct, claims, issuance of certificates of authority, solvency, viatical settlements, premium financing, and administrative supervision, as provided under the insurance code or Chapter 636, Florida Statutes. For more information, visit https://www.floir.com/Office/AgencyOrganizationOperation.aspx. The Commissioner of Insurance Regulation who heads the Office of Insurance Regulation would be a valuable member of the Council since health insurance companies decide upon coverage and formularies affecting all of the residents of Florida. The Office of Insurance Regulation also plays a significant role to ensure that Florida meets the requirements of the federal MHPAEA.

15. Continue the statewide Recovery Oriented System of Care (ROSC) initiative designed to promote and enhance recovery efforts in Florida and support the continued development of recovery community organizations (RCOs) and a statewide RCO that helps link community initiatives.

Over the past several years, DCF has led an initiative to transform Florida's substance use and mental health system into a ROSC which serves as a framework for coordinating multiple systems, services, and supports that are person-centered, self-directed, and designed to readily adjust to meet the needs of persons served as well as their chosen pathway to recovery.

A ROSC is a network of clinical and nonclinical services and supports that sustain long-term, community-based recovery. As local organic entities, ROSCs reflect variations in each community's vision, institutions, resources, and priorities. Behavioral health systems and communities form ROSCs to:

- Promote good quality of life, community health, and wellness for all.
- Prevent the development of behavioral health conditions.
- Intervene earlier in the progression of illnesses.
- Reduce the harm caused by SUDs and mental health conditions on individuals, families, and communities.
- Provide resources to assist people with behavioral health conditions to achieve and sustain their wellness and to build meaningful lives for themselves in their communities.

Across the country, independent, nonprofit organizations that are peer-led and governed by persons in recovery, family members, and recovery allies mobilize resources within the community to make it possible for the over 23 million Americans still struggling with SUD to find long-term recovery. Each organization has a mission that reflects the issues and concerns within their community. These community groups, known as RCOs, share three core principles – recovery vision; authenticity of voice; and accountability to the recovery community.

RCOs use three primary strategies to achieve their mission:

- Public education and awareness – putting a face and a voice on recovery to reduce stigma and educate the public, policy makers, service providers, and media that recovery from SUD is possible.
- Policy advocacy – building recovery-oriented supportive communities, address public policy that eliminates discrimination against people in or seeking recovery and reduce barriers that keep persons seeking recovery from sustaining long-term recovery.
- Peer-based and other recovery support services and activities – innovating and delivering a variety of peer recovery support services and places to deliver those services while building a lasting physical presence in communities.[113]

There has been a focus on the development of RCOs in Florida over the past several years. As a result of an Aetna Foundation grant to FADAA, RCO development activities have taken place in 10 communities across Florida. Six of these organizations have completed the RCO development process and four are continuing to move through the development steps. Two additional communities have expressed a desire to begin the RCO development process. In addition, Floridians for Recovery, the statewide RCO, is working with key stakeholders in Putnam County to develop an RCO. These new and developing RCOs across Florida join the seven already existing RCOs bringing the total number of RCOs in Florida fully developed or under development to 20. In addition, Floridians for Recovery continues to build its capacity as the statewide RCO for Florida. Over the past year Floridians for Recovery received a Building Communities of Recovery grant from SAMHSA and Floridians for Recovery has established a Recovery Leadership Council engaging the leaders from all the RCOs in the state. A map displaying all the RCOs across Florida and a RCO locator with information on each RCO can be found on the Floridians for Recovery website at: https://floridiansforrecovery.org/tst-locator/.[114]

16. Develop and implement a stigma reduction campaign designed to reduce the shame associated with SUD and other mental illness/injuries. Messaging should increase the awareness of MAT options, reduce the stigma associated with addiction, and inform the public of the many benefits that come with obtaining psychological and/or counseling services from a licensed professional.

Individuals with a substance use or mental health disorder often experience three forms of stigma. These include structural, public, and self-stigma. Societal norms and attitudes drive the first two types, while the third occurs when individuals internalize these negative opinions.[4, 5] Self-stigma causes lowered self-esteem, decreased self-efficacy, and amplified feelings of embarrassment and shame. As a result, stigma can impede an individual's willingness to pursue treatment, thus placing them at a higher risk for crisis and/or fatal overdose.

Through this process, Florida can (1) reduce the negative perceptions of addiction within the community and (2) increase the likelihood of an individual to seek out and engage in needed treatment.

With the development and deployment of a stigma reduction campaign, individuals suffering from a SUD and the communities around them will gain a better understanding of addiction and the benefits of treatment.

17. Evaluate the impact of SB 1120 (2020): Substance Abuse Services on agency background screening requirements related to the eligibility of individuals with lived experience/peers attempting to enter the workforce; continue efforts to reduce the administrative burden of the background screening and exemption process; promote consistency among state agencies related to the background screening exemption process; ensure an individual with lived experience is part of the exemption review panel; and have AHCA, DCF, and the Florida Department of Corrections (FDC) provide an annual report on the number of individuals that applied for an exemption, actual timeframes for the process, and number approved/disapproved with reasons why.

The use of peers, individuals with lived experience, has grown significantly in Florida over the past five years. Research has shown that recovery from a SUD or mental illness is facilitated by the use of social support provided by peers.[115] These individuals serve multiple roles which include recovery support navigator by assisting in transition from institutional setting (jail/prison) to the community; crisis support; peer wellness coach; employment support coach; housing support specialist; and recovery coach.[116] Peers are essential team members of Community Action Teams, Family Intensive Treatment Teams, and Forensic Assertive Community Treatment teams. In addressing the opioid epidemic, peers serve a key role in emergency warm handoff programs encouraging, and at times transporting, individuals who have overdosed to pursue a treatment intervention. In 2019, the Legislature recognized the role of peers by codifying the definition of peer specialist in section 397.311, Florida Statutes.

Currently, there is a shortage of peers working in behavioral health services. One barrier to the use of peer services is the fact that peer specialist candidates often cannot pass background screening requirements in sections 435.04 and 408.809, Florida Statutes. Persons who have recovered from a SUD or mental illness often have a criminal history. Common offenses would include using and selling illegal substances, prostitution, and financial fraud. Section 435.04, Florida Statutes, allows persons with certain disqualifying offenses identified through background screening to apply to the respective state agency head (DCF, FDC, and AHCA

Secretary) for an exemption if it has been three or more years since their conviction. The applicant must provide all court records regarding their convictions (irrespective of how much time has passed since the offense occurred), letters of recommendation, evidence of their rehabilitation, education documents, evidence of employment, and a completed questionnaire. The requirements of this exemption often deter persons from becoming peer specialists.[117]

Recent legislation, SB 1120 (2020): Substance Abuse Services, addresses individuals who have been disqualified from employment with a SUD treatment provider or recovery residence due to a disqualifying offense. The legislation requires DCF to exempt individuals disqualified during background screening for having committed certain offenses. As a result, more individuals with convictions in their past may be able to obtain certification as peer specialists and find employment in prevention, treatment, and recovery programs. Also, private insurers and Medicaid managed care plans may see additional use of peer specialists.

Data Collection and Surveillance

18. Create a statewide dashboard of substance abuse data measures that are readily available to policy makers and the public and can be used to monitor trends and identify emerging threats.

A statewide dashboard of substance abuse data should be created in Florida Health Community Health Assessment Resource Tool Set (CHARTS) similar to the Opioid Use Dashboard: http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.OpioidUseDashboard. Agencies should continue efforts to develop a more systematic and sustainable approach to linking data and developing indicators from existing datasets. This process will shift to the Behavioral Health Priority Area Workgroup established under Florida's State Health Improvement Plan. This cross-agency workgroup covers mental illness and substance abuse issues and includes members from DOH, DCF, and community organizations.

19. Encourage all counties and municipalities to implement the ODMAP system in locations and agencies that do not participate in real-time overdose tracking. Through wider utilization, law enforcement and non-EMSTARS (EMS Tracking and Reporting System) fire departments can track suspected overdose activity throughout all 67 counties. Agencies can utilize information obtained through ODMAP to identify high risk areas, equip personnel for increased overdose activity, and to warn neighboring agencies of sudden overdose activity within their counties and/or suspected transit routes.

The ODMAP has expanded to approximately 293 agencies located within 95 percent of Florida's counties. This is a significant increase as compared to early 2019, before the Seminole County Sheriff's Office received the ODMAP Statewide Expansion and Response Grant on behalf of Florida. The grant provides $750 thousand to five sub-awardees, and it is executed over a 24-month period for further expansion of ODMAP. The five sub-awardees are Bay County Sheriff's Office, Pasco County Sheriff's Office, Charlotte County Sheriff's Office, City of Jupiter Police Department, and the Orange County government. The Seminole County Sheriff's Office will ensure the remaining funds are used to enroll new agencies into the ODMAP system. The Seminole County Sheriff's Office has hired a grant coordinator to assist in facilitating ODMAP training and implementation within new agencies. There is still a large percent of Florida counties/municipalities that do not participate, nor benefit from the information obtained through ODMAP. Therefore, many overdoses go unnoticed and the true expanse of Florida's opioid epidemic remains undetected.

20. The Council recommends the modernization, improvement, and appropriate funding for the Baker and Marchman Acts to increase effectiveness of the Baker and Marchman Acts to serve the people of Florida.

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