# Statewide Drug Policy Advisory Council
# 2021 Annual Report

---

To the Governor,

the President of the Senate,

and the Speaker of the
House of Representatives

December 1, 2021

# Table of Contents

# Statewide Drug Policy Advisory Council
# Members and Designees

### Department of Health
- Joseph A. Ladapo, MD, PhD
  *State Surgeon General*

### Florida Attorney General
- The Honorable Ashley Moody
- Rachel Kamoutsas
  *Deputy General Counsel*

### Office of Policy and Budget
- Chris Spencer
  *Policy Director*

### Florida Department of Law Enforcement
- Rick Swearingen
  *Commissioner*
- John McClellan
  *Special Agent Supervisor*
  *Office of Statewide Intelligence*

### Department of Children and Families
- Shevaun Harris
  *Secretary*
- Jeffrey Cece, MS, CPM
  *Office of Substance Abuse and Mental Health*

### Department of Corrections
- Mark Inch
  *Secretary*
- Maggie Agerton
  *Bureau Chief*
  *Substance Use Treatment Services*

### Department of Education
- Richard Corcoran
  *Commissioner*
- Tim Hay
  *Executive Director, Office of Safe Schools*

### Florida Highway Safety and Motor Vehicles
- Terry Rhodes
  *Executive Director*
- Colonel Gene Spaulding
  *Director*

### Department of Juvenile Justice
- Josefina M. Tamayo
  *Acting Secretary*
- Tracy Shelby, PhD
  *Director Mental Health and Substance Abuse Services*

### Department of Military Affairs
- Adjutant General James O. Eifert
- COL John L. Steele
  *Director of Military Support*
  *Florida National Guard*

### Florida Senate
- The Honorable Darryl Rouson

### Florida House of Representatives
- The Honorable Spencer Roach

### Supreme Court Appointee
- Judge Steve Leifman
  *Judiciary Member*
- Aaron Gerson
  *Office of the State Courts Administrator*

### Gubernatorial Appointees
- Mark P. Fontaine
  *Executive Advisor*
  *Florida Behavioral Health Association*
- Dotti Groover-Skipper
  *Founder, President and CEO*
  *HeartDance Foundation, Inc.*
- Doug Leonardo, LCSW
  *Sr. VP Operations and Development*
  *Central and North*
  *Chrysalis Health*
- Peggy Sapp
  *President, CEO*
  *Informed Families/The Florida Family Partnership*
- Kimberly K. Spence
  *CEO Keaton Corrections*
- Roaya Tyson
  *COO Gracepoint*
- John VanDelinder, PhD
  *Executive Director*
  *Sunshine State Association of Christian Schools*

### Staff Liaison
- Nathan Dunn, MSA
- Lori Reeves, MPH

# Acronyms Used in this Report

| | |
|---|---|
| ACE | Adverse Childhood Experience |
| AHCA | Agency for Health Care Administration |
| AMA | American Medical Association |
| CDC | Centers for Disease Control and Prevention |
| CCBHC | Certified Community Behavioral Health Clinics |
| CEO | Chief Executive Officer |
| CHD | County Health Department |
| CHIP | Community Health Improvement Plan |
| CME | Continuing Medical Education |
| COVID-19 | Coronavirus Disease 2019 |
| DATA 2000 | Drug Addiction Treatment Act of 2000 |
| DCF | Florida Department of Children and Families |
| DEA | Drug Enforcement Administration |
| DEN | Drug Epidemiology Networks |
| DJJ | Florida Department of Juvenile Justice |
| DOE | Florida Department of Education |
| ED | Emergency Department |
| EMS | Emergency Medical Services |
| EMSTARS | Emergency Medical Services Tracking and Reporting System |
| FAC | Florida Administrative Code |
| FADAA | Florida Alcohol and Drug Abuse Association |
| FANA | Florida Association of Nurse Anesthetists |
| FBHA | Florida Behavioral Health Association |
| FDA | Food and Drug Administration |
| FDC | Florida Department of Corrections |
| FDLE | Florida Department of Law Enforcement |
| FDOH | Florida Department of Health |
| FLHealthCHARTS | Florida 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 |
| IDEA | Infectious Disease Elimination Act |
| MAT | Medication-Assisted Treatment |
| ME | Medical Examiners |
| MHPAEA | Mental Health Parity and Addiction Equity Act |
| MORE | Maternal Opioid Recovery Effort |
| NAS | Neonatal Abstinence Syndrome |
| NSDUH | National Survey on Drug Use and Health |
| OD2A | Overdose Data to Action |
| ODMAP | Overdose Detection Mapping Application Program |
| OFR | Overdose Fatality Review |
| OMNI | Opioid Use Disorder, Maternal Outcomes, and Neonatal Abstinence Syndrome Initiative |
| ONDCP | Office of National Drug Control Policy |
| OUD | Opioid Use Disorder |
| PDMP | Prescription Drug Monitoring Program |
| RCO | Recovery Community Organization |
| ROSC | Recovery Oriented System of Care |
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| SBIRT | Screening, Brief Intervention, and Referral to Treatment |
| SEOW | State Epidemiological Outcomes Workgroup |
| SEP | Syringe Exchange Program |
| SOR | State Opioid Response |
| STR | State Targeted Response |
| SUD | Substance Use Disorder |
| U.S. | United States |

## Message from the State Surgeon General Joseph A. Ladapo, MD, PhD

Florida faces a mounting threat from overdose issues, and I look forward to working with the Statewide Drug Policy Advisory Council (Council) members to address these challenges. As we have worked to address the impacts of the coronavirus disease 2019 (COVID-19) pandemic, fatal and non-fatal drug overdoses have continued to rise. Nationally, in the 12-month period ending in February 2021, more than 95,000 people died of a drug overdose, which is a 30 percent increase in deaths from the previous year. During this time, similar trends were noted in Florida with a 33 percent increase in fatal drug overdoses.

The Florida Department of Health (FDOH) continues to partner with state and local agencies both on the Council and statewide to increase the focus on prevention, increase the number of people with substance use disorder (SUD) who are identified through screening, and to expand efforts to reduce overdose deaths through targeted harm reduction programs.

To make data on SUD and related issues more accessible to the public and to policymakers, FDOH enhanced the current dashboard to be a comprehensive Substance Use Dashboard during 2021. The information can be accessed on the Florida Substance Use Dashboard at flhealthcharts.com.

FDOH 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 July 14, 2021, FDOH provided approximately 417,663 doses of naloxone to approximately 326 agencies that employ licensed emergency responders in 62 of Florida's 67 counties.

The Council is reporting substantial progress on the 2020 recommendations for policy makers and state agencies and has proposed several significant recommendations for our policy makers and state agencies to consider for the coming year. The 2021 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 SUD issues.

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. FDOH remains committed to supporting this critical Council and the important work that is being done. Section 397.333, Florida Statutes, directs FDOH to serve as the coordinating entity for the Council, and the content of this report reflects the updates and information from the Council members.

Joseph A. Ladapo, MD, PhD
State Surgeon General

# Summary of 2021 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) 2021 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 26, 2021, the Council heard a presentation regarding electronic cigarette use from the Florida Department of Health's (FDOH) Bureau of Tobacco Free Florida. The focus of this presentation was on four primary goals that include: preventing youth initiation of tobacco, eliminating secondhand exposure, promoting quitting among all users, and strengthening statewide infrastructure (outreach). The 2020 Florida Youth Tobacco Survey showed an increase in e-cigarette use or vaping from 2014–2020. In September 2018, the Food and Drug Administration (FDA) declared vaping an epidemic due to the rising levels in 2017. The HeartDance Foundation's presentation acknowledged that drug addiction is used as a coercion tactic for human trafficking, the business of exploitation of vulnerabilities, and the illegal trade of human beings. These victims are often sold for purposes of sex, illegal adoptions, and labor. There are over 1.5 million trafficking victims in the United States (U.S.). Florida is third in the nation for instances of human trafficking, following California and Texas. The presentation covered ways to recognize sex trafficking and resources that may be used if someone were to come in contact with anyone in this industry. The Council also heard from the Agency for Health Care Administration (AHCA) on recommendations and other elements of the Council's 2020 Annual Report to highlight some aspects of the Medicaid program and better inform people about how limitations and programs operate. AHCA enacted a number of flexibilities during COVID-19 to maintain and ensure access to medical and behavioral services. AHCA reported significant progress on 2020 objectives. Next, the Council heard from the Broward County Health Department's (CHD) Overdose Data to Action (OD2A) program, with progress on integrating state and local prevention and response programs and improving linkages to care. Council members provided individual agency updates.

On April 20, 2021, the Council heard a presentation from FDOH on progress of work toward completing recommendation 18 from the 2020 Annual Report. FDOH worked with the Florida Community Health Assessment Resource Tool Set (FLHealthCHARTS) team and the existing opioid use data dashboard. FDOH conducted outreach to other agencies, including the Florida Department of Children and Families (DCF), AHCA, and other sources to collect significant data points to expand the data dashboard for surveillance of substance use statewide. The Council reviewed the current Opioid Use Dashboard and examined examples from other states. FDOH is projecting to have the updated Substance Used Dashboard completed during 2021. After a review of current 2021 bills in session from FDOH's Office of Legislative Planning, the Council heard from FDOH's Bureau of Emergency Medical Oversight on changes to the data system for the Overdose Detection Mapping Application Program (ODMAP); and it viewed the new combined drug overdose dashboard which integrates data from two sources – fatal drug overdose incident data, which comes from Florida's Vital Statistics death tables, and non-fatal drug overdose incident data from the Emergency Medical Services Tracking and Reporting System (EMSTARS). The dashboard will serve to standardize available information which is a priority from the Council's 2020 recommendations. Council members provided individual agency updates.

On July 20, 2021, Dr. Scott Rivkees provided an update on overdose deaths in Florida compared to national trends as part of his opening remarks. Dr. Avalon Adams-Thames with FDOH's OD2A program provided a presentation including the recent data released from the Centers for Disease Control and Prevention (CDC) on nationwide provisional drug overdose death counts and the current provisional data for Florida. Provisional data reflect a 37 percent increase in drug overdose deaths in Florida from 2019–2020. Dr. Brett Kirkland presented on behalf of the Florida Medical Examiners (ME) Commission on specific drugs contributing to overdose deaths in the first half of 2020. A representative from the Florida Association of Nurse Anesthetists (FANA) provided a presentation on non-opioid alternatives and supplemental FANA initiatives including legislative advocacy, task force, pain fellowships, and the Society for Opioid Free Anesthesia. The Florida Behavioral Health Association (FBHA) provided an overview of the Certified Community Behavioral Health Clinics (CCBHC) as a model to expand and improve behavioral health care. The presentation noted the impact the CCBHCs have had nationally and the impact to date in Florida. The remainder of the meeting was delegated to discussion of the Council's progress to date on the 2020 recommendations and collecting input from the Council to be added to the 2021 Annual Report. The content of the report is a compilation of information from the members of the Council.

On October 19, 2021, FDOH presented a tour of the updated Substance Use Dashboard, which incorporates significant design changes that make the data and information more accessible to the public and to policymakers. Dr. Joshua Barnett presented an overview of the Overdose Fatality Review (OFR) process, which is funded from the Comprehensive Opioid, Stimulant, and Substance Use Planning Grant. Participating counties include Broward, Putnam, Seminole, Collier, Duval, Orange, Palm Beach, and Pinellas. The goals of an OFR include developing quick response teams, increasing access to naloxone, and implementing the OFR process over a 3-year period. The program uses a person-centered approach to identify system gaps and policy issues that can be addressed to help prevent overdose deaths. Next, the Council reviewed the 2021 Annual Report recommendations and voted to approve the slate of 20 recommendations.

# 2021 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 challenges related to the delivery of mental health and SUD 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. To effectively address the opioid crisis, the impact of the pandemic, and the anticipated growth in mental health and SUD service needs, it is critical that a vibrant, stable, and well-trained workforce be available to provide prevention, treatment, and recovery services. To address the workforce crisis, the Council recommends adopting changes in payment methods, background screening, exemptions for peer specialist applications, and greater flexibility with telehealth, reimbursing providers the same amount for telehealth and in person visits.
4. Develop and implement a substance-use prevention strategy designed to reduce drug use among youth 12–17 years of age. The strategy should focus on: (1) deployment of a unified anti-drug messaging campaign; (2) increasing/maintaining substance use prevention efforts by securing/sustaining front-end prevention funding; and (3) expanding state partnerships with anti-drug coalitions, educational institutions, law enforcement, and other members of the 12 community sectors.
5. Deploy an evidence-based substance use prevention program designed to reduce drug use among youth 12–17 years of age. 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. DCF should lead, in collaboration with FDOH 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 to reduce substance use and abuse among Florida's youth.
6. Develop and implement a stigma reduction campaign designed to reduce the negative feelings associated with SUD and other mental illness/injuries. Messaging should increase

the awareness of medically assisted treatment options, reduce the stigma associated with addiction, and inform the public of the many benefits that come with obtaining psychiatric, psychological and/or therapeutic services from a licensed professional.

7. Encourage pharmacies to educate consumers on safe medication storage and disposal procedures when filling prescriptions for controlled substances. Establish a media campaign to educate consumers on reason for safe use, safe storage, and safe disposal as well as the location of safe disposal boxes in each community.
8. Establish medical marijuana advertisement standards that restrict the advertising methods of medical marijuana/cannabis evaluation clinics, conveyance shops, and other services or businesses not currently governed by Amendment 2 (section 381.986, Florida Statutes.)
9. Establish legislation to regulate (1) preparation, distribution, and sale of kratom-based products (Mytragyna Speciosa) that contain the alkaloids mytragynine and/or 7-hydroxymitragynine; (2) prohibit the preparation, distribution, and sale of adulterated or contaminated kratom products; (3) assign authorities and responsibilities to ensure compliance standards are met and/or maintained; and (4) establish corrective actions/penalties for actors/agencies that would violate such legislation.
10. 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) and fire rescue naloxone leave-behind programs, county health departments (CHDs), and any Federally Qualified Health Center (FQHC). Eliminate barriers that prevent direct dispensing of naloxone kits to all hospital patients at risk of overdose.
11. Expand efforts to encourage county commissions to establish syringe exchange programs (SEPs).
12. Encourage the continued establishment of warm handoff programs through hospital EDs to community opioid use disorder (OUD) treatment providers to address opioid overdoses. In addition, 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.
13. 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.
14. 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.
15. Require state health agencies, health plans, and commercial insurers to remove prior authorization requirements for evidence-based medication-assisted treatment (MAT) to allow for use of medications such as buprenorphine, naltrexone, naloxone, and methadone.
16. Promote legislation that adds the Secretary of AHCA and the Commissioner of the Office of Insurance Regulation as members to the Council.
17. 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 the Recovery Community Organization (RCO) and a statewide RCO that helps link community initiatives.

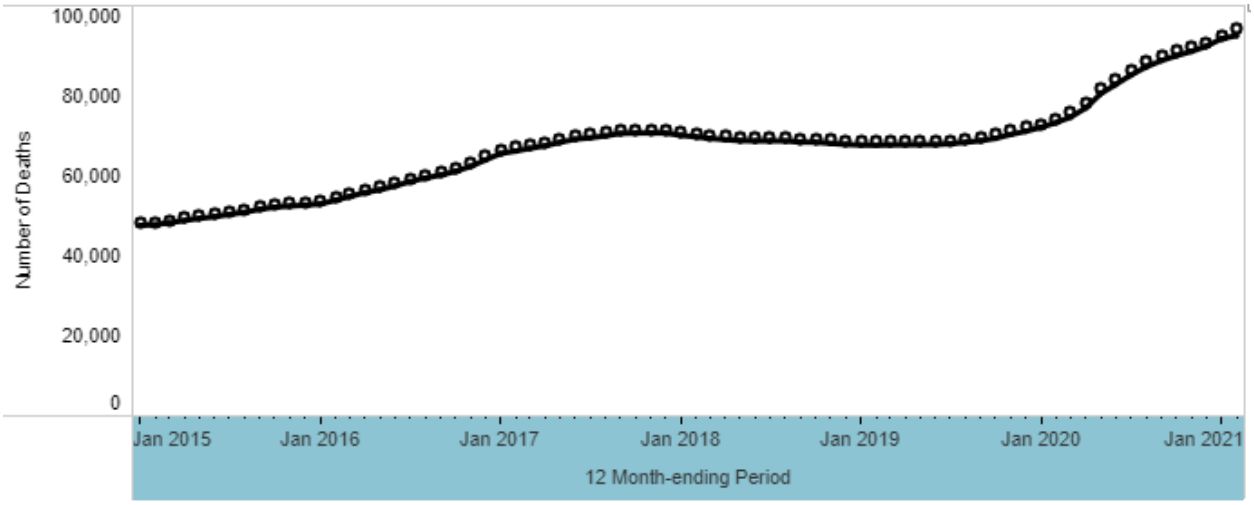
18. Evaluate the impact of Senate Bill 1120 (2020): Substance Abuse Services on agency background screening requirements related to the eligibility of individuals with lived experience/peers attempting to enter the workforce; continue efforts to reduce the administrative burden of the background screening 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 who applied for an exemption, actual time frames for the process, and the number approved/disapproved with reasons for the decisions.
19. 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.
20. Encourage Florida legislators to draft legislation/policy to support implementation of the 988 National Suicide Prevention Lifeline to begin July 16, 2022.

# Executive Summary

## Introduction

Florida and the entire nation face ongoing drug-related threats like the opioid epidemic while dealing with the continuing challenge of COVID-19 infections. Data indicate that our communities are experiencing an increase in drug abuse and overdose during this time of COVID-19, including a dramatic increase in drugs adulterated with fentanyl. Data from the National Center for Health Statistics indicated that nationally, compared to previous years, drug overdose deaths increased more than 30 percent in September of 2020 through February 2021.[1]

**Figure A: Monthly-Ending Provisional Counts of Fatal Drug Overdoses in the United States.**




Reported provisional counts are the number of deaths received and processed for the 12-month period ending in the month indicated. Provisional counts are subject to change as more drug overdoses are accounted for after adjusting for incomplete reporting.

Data from FDOH indicate there is an increase in substance use in Florida as evidenced by the 24 percent increase in drug-involved ED visits and EMS responses in 2020 compared to 2019. In 2020, the number of fatal overdoses increased 37 percent to more than 7,500 people, the largest number of annual drug overdose deaths recorded in Florida, compared to the estimated 5,500 in 2019, and 4,900 in 2018.

Preliminary data from January through September of 2021 show a 13 percent increase in drug-involved ED visits and an 18 percent increase in EMS responses when comparing to the same period in 2020.

This report compiles efforts from a multitude of Florida agencies to identify problem areas and propose recommendations to improve outcomes. Several recommendations from the 2020 Annual Report have been accomplished.

## 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, SUD, 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 SUD in the past year.[2] The majority of individuals with SUD 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.[3] 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 attempted to get it.[4]

### The State Epidemiological Outcomes Workgroup (SEOW)

Florida's SEOW assists with state, regional, and community drug-related morbidity and mortality surveillance. Membership (n = 27) consists of epidemiologists and individuals who are knowledgeable about substance use issues including prevention, intervention, and treatment. Participating entities include DCF, the Florida Department of Law Enforcement (FDLE) – ME Commission, FDOH, AHCA, and 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 (2016-2021), 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 strategic initiatives as appropriate. A copy of the Florida SEOW Annual Report 2019 is available on DCF's publication website here: https://www.myflfamilies.com/service-programs/samh/publications/docs/Florida%20SEOW%20Annual%20Report%202019.pdf.

### Drug Related Deaths

The *Drugs Identified in Deceased Persons* by the Florida ME 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).[5]

Opioid related deaths increased again in 2020, according to the *Drugs Identified in Deceased Persons* by the Florida ME (2020 Interim Report). Opioid related deaths increased by 13 percent over the same period (January through June) in 2019; opioid-caused deaths also

increased by 51 percent. Deaths involving heroin, fentanyl, and fentanyl analogs also increased. The most significant increases were deaths involving fentanyl which increased 70 percent; and deaths caused by fentanyl increased 81 percent. Changes were also seen within the prescription opioid category; deaths caused by hydrocodone decreased 7 percent and deaths caused by oxycodone increased by 10 percent.[6]

A comparison of FDLE laboratory submissions between 2019 and 2020 revealed increases in heroin, fentanyl, morphine, and buprenorphine. Prescription opioids, hydrocodone, hydromorphone, and oxycodone decreased. Increased laboratory submissions of methamphetamine were consistent with the trend noted in last year's data. 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 ME.

Although the majority of overdose deaths are related to opioids, stimulants are responsible for a number of deaths. According to the *Drugs Identified in Deceased Persons* by the Florida ME (2020 Interim Report), deaths from cocaine increased 44 percent over the same period in 2019. Methamphetamine deaths increased by 56 percent. Deaths from amphetamines also increased by 54 percent. However, many of the amphetamine deaths likely represent methamphetamines that have been metabolized to amphetamine, rather than prescription amphetamine drugs.

### 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 (SAMHSA) State Targeted Response (STR) grant, State Opioid Response (SOR), and Substance Abuse Prevention and Treatment 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.[7] 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.**[8]

| 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 Medication-Assisted Treatment | 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 |

Additionally, AHCA added Medicaid COVID-19 state of emergency flexibilities that allowed for many behavioral health treatment services to be delivered via telemedicine. These treatment services included medication management services such as Medication-Assisted Therapy

(MAT), and extended Methadone take-home medications to two weeks for stable clinically appropriate recipients.

AHCA covers behavioral health evaluation, diagnostic, and treatment recommendation services through telemedicine. AHCA reimburses the behavioral health assessment and medication management screening services through telemedicine, at the same rate detailed on the community behavioral health fee schedule. Providers must perform all service components designated for the procedure code billed.

Due to Florida's COVID-19 state of emergency, AHCA implemented many flexibilities to ensure continuity of care for recipients including the following:

- Waiving prior authorization requirements and services limits (frequency, duration, and scope) for all behavioral health services including targeted case management.
- Lifting service limits for behavioral health services.
- Allowing for behavioral health treatment services to be delivered via telemedicine.
- Allowing for behavioral health services to be delivered via audio-only telemedicine when video capability is not available, and services can only be provided telephonically.
- All flexibilities AHCA has allowed are outlined at http://portal.flmmis.com/FLPublic/Provider_COVID19/tabId/160/Default.aspx. AHCA will continue to assess the need for continued flexibilities in these areas.

**Expansion of Naloxone Availability**

DCF has made considerable progress deploying the medications that are proven to reduce opioid-related overdoses and mortality, namely the opioid overdose antidote called naloxone and the two FDA-approved agonist maintenance medications for OUD: methadone and buprenorphine. Expanding naloxone availability is the intervention that will reduce the greatest number of opioid overdose deaths.[9] Compelling research, including an interrupted time series analysis and cost-benefit analyses, demonstrates that opioid overdose mortality is reduced by distributing naloxone to individuals at risk of an overdose and to their peers and family who may witness an overdose, particularly through syringe access programs, treatment programs, re-entry programs, mobile outreach programs, homeless service providers, and other community-based organizations that provide continuous, low-barrier access to naloxone.[10] People who use drugs deploy naloxone to save a life at a rate nearly 10 times that of laypeople who do not use drugs, which substantiates DCF's prioritization of naloxone distribution efforts among people who are not yet engaged in treatment.[11]

Evaluation research confirms that bystander naloxone administration is a safe and effective method for preventing overdose deaths and that the associated education effectively improves overdose recognition and response.[12] Since the inception of DCF's Overdose Prevention Program, over 168,000 naloxone kits have been distributed. Nearly 3,000 individuals were trained on overdose prevention, recognition, and response and 10,267 overdose reversals have been reported. The reporting of reversals is encouraged but not required, which means that the actual number of overdose reversals is considerably higher. Every breath enabled by naloxone represents a new opportunity for hope and recovery. DCF plans to sustain the naloxone distribution program that is currently funded under the SOR grant using American Rescue Plan Act funds after the conclusion of the SOR project period at the end of September 2022.

The risk of fatal overdoses is cut in half when individuals are enrolled in agonist-based maintenance treatment, according to every systematic review, meta-analysis, and large cohort study published over the past decade.[13] A retrospective analysis of 40,885 individuals with OUD

published last year analyzed the comparative effectiveness of different treatment pathways, including no treatment (comparison group), inpatient detox or residential, intensive outpatient or partial hospitalization, non-intensive outpatient, naltrexone (Vivitrol), and buprenorphine or methadone. Only buprenorphine/methadone effectively saved lives and was associated with a 76 percent reduction in overdose at 3 months and a 59 percent reduction at 12 months.[14] DCF is making considerable progress expanding Florida's capacity for methadone maintenance treatment. There are currently 48 methadone clinics operating in Florida and 39 new clinics have been awarded the opportunity to receive a license. Beyond reducing mortality, these agonist medications also improve retention in care. Meta-analyses of randomized controlled trials demonstrate that maintenance with methadone or buprenorphine is more effective at retaining individuals in care and suppressing opioid misuse (as measured by self-reports and urine/hair analysis) than any other approach, including detoxification and counseling.[15]

Florida has made considerable progress increasing access to these evidence-based medications over the past several years, with support from SAMHSA. Under the STR grant (May 2017 through April 2019), nearly 13,000 individuals received MAT services. Buprenorphine (55%) was the most prevalent, followed by methadone (34%) and long-acting naltrexone (11%). Under the SOR 1 Grant (September 2018 through September 2021), approximately 12,500 individuals have received MAT to date. Again, buprenorphine (56%) was the most common treatment, followed by methadone (40%) and to a lesser extent, long-acting naltrexone (7%). DCF will work with the Managing Entities on expanding access to 24-7 assessment and induction sites. DCF will continue to promote and support policies and practices that improve engagement and retention in care, particularly the Medication First model, as articulated by experts convened by SAMHSA, the American Society of Addiction Medicine, and the National Academies of Sciences, Engineering, and Medicine, and others.[16] Medication First practices logically expand access (particularly to buprenorphine products and methadone) and improve engagement and retention by dismantling identified barriers (e.g., requirements for assessments or treatment planning sessions prior to prescribing, arbitrary counseling or Alcoholics Anonymous/Narcotics Anonymous participation requirements, arbitrary tapering or time limits, and automatic discharges for relapses).

### Youth & Young Adult Substance Use

Substance use among students in Florida continues to decline. Among middle and high school students in Florida, between 2010 and 2020, the prevalence of lifetime alcohol use decreased from approximately 52 percent to 35 percent and the past-30-day prevalence of alcohol use decreased from 29 percent to 15 percent. Regarding binge drinking (in the past 2 weeks), the prevalence decreased from about 14 percent to 7 percent. High schoolers 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. The lifetime prevalence of "blacking out" among high schoolers decreased from approximately 19 percent to 14 percent from 2014 (the first year this item appeared on the Florida Youth Substance Abuse Survey (FYSAS) to 2020. Regarding marijuana use, the prevalence of lifetime and past 30-day marijuana use among middle and high school students also decreased between 2010 and 2020. Lifetime prevalence decreased from approximately 24 percent to 20 percent, and past 30-day prevalence decreased from 13 percent to 11 percent.[17]

Trends in early initiation are also encouraging. The percentage of high school youth who started using alcohol (more than a sip) at age 13 or younger decreased from 27 percent to about 16 percent. The percentage who started using marijuana at age 13 or younger decreased from 11 percent to 8 percent. Access to alcohol and marijuana among middle and high school students

in Florida continues to decline. Between 2010 and 2020, the percentage of students who said alcohol was “sort of easy” or “very easy” to get decreased from about 46 percent to 31 percent. The percentage of students who said marijuana was “sort of easy” or “very easy” to get also decreased from about 44 percent to 32 percent. These reductions in access may be contributing to the continued decline in alcohol and marijuana use among students in Florida.

With respect to particularly high-risk and antisocial substance-related behaviors, long-term progress in Florida is less dramatic but still encouraging. For example, in 2013 (the first year these questions appeared on the survey in their current form), 6.4 percent of middle and high school students reported using alcohol before or during school (in the past 12 months). Additionally, 9.8 percent smoked marijuana and 3.4 percent used another drug before or during school.[18] Estimates for 2020 reflect minimal progress with respect to these behaviors, with approximately 5.2 percent of students consuming alcohol, 9.5 percent smoking marijuana, and 3.5 percent using other drugs before or during school. Additionally, between 2012 and 2020, the percentage of Florida high school students who reported driving a vehicle after drinking alcohol decreased from 8 percent to 4 percent. The percentage who reported riding in a vehicle driven by someone who had been drinking alcohol decreased from 21 percent to about 15 percent. The percentage who reported driving a vehicle after using marijuana decreased less dramatically, from 11 percent to 9 percent. The percentage who reported riding in a vehicle driven by someone who had been using marijuana decreased from 25 percent to 22 percent.

Florida’s substance use prevention system infrastructure needs to be responsive to childhood trauma as a prominent risk factor for substance use and other problems. In 2020, DCF started collecting data on the prevalence of adverse childhood experiences (ACEs) among high schoolers, through the FYSAS. Data analysis is based on 14 items measuring 10 different ACEs. Nearly one out of three (32%) Florida high school students reported no ACEs. Conversely, about 22 percent of Florida high school students reported four or more ACEs, considered a high level of trauma. Examples of ACEs include parental separation/divorce, living with someone who went to jail/prison, and physical and emotional abuse and neglect. Students with four or more ACEs report substance use rates two times higher than students with fewer than four ACEs. For example, students with fewer than four ACEs report a past-month alcohol use rate of 17 percent, compared to 31 percent for those with four or more ACEs. Marijuana use shows a similar pattern, with past-month rates of about 12 percent among low-trauma students and 29 percent among high-trauma students. White students, female students, and students from low socioeconomic status families are more likely to report high levels of ACEs.[19] In order to prevent ACEs, the CDC recommends strengthening economic supports to families, ensuring a strong start for children (early childhood home visitation, high-quality child care, and preschool enrichment with family engagement), and teaching skills like social-emotional learning and parenting skills.[20]

According to the most recently published Florida-specific estimates from the 2018–2019 NSDUH, approximately 3.8 percent of children ages 12-17 and 5.9 percent of adults ages 18 and older experienced SUD in the past year.[21] With respect to the prevalence of needing but not receiving treatment in 2018–2019, approximately 3.8 percent of children ages 12-17 and 5.6 percent of adults ages 18 and older in Florida needed treatment for substance use but did not receive it. Looking at Floridians ages 18-25, the treatment gap is even higher, with 11.4 percent of young adults needing but not receiving treatment for substance use.[22] Importantly, the vast majority (95%) of individuals classified by the NSDUH as needing but not receiving drug treatment also report that they did not feel they needed it. Only about 2 percent felt they needed treatment and attempted to get it.[23] The most recently published prevalence rates for various

substances and SUD among young adults (ages 18-25) and adults in Florida are presented in the table below:

**Figure C. Prevalence of Substance Use and Substance Use Disorders in the Past Year, in Florida, by Adult Age Group (2018-2019)**

| | 18 and Older | 18-25 | 26 and Older |
|---|---|---|---|
| **Pain Reliever Misuse** | 3.8% | 5.0% | 3.6% |
| **Heroin Use** | 0.2% | 0.4% | 0.2% |
| **Cocaine Use** | 1.8% | 5.0% | 1.4% |
| **Methamphetamine Use** | 0.4% | 0.5% | 0.4% |
| **Pain Reliever Use Disorder** | 0.7% | 0.7% | 0.7% |
| **Illicit Drug Use Disorder** | 2.4% | 6.8% | 1.8% |
| **Alcohol Use Disorder** | 4.1% | 7.1% | 3.7% |

Due to changes in the wording of the questions in the NSDUH, continuous trends are only available for a few select measures. Trends in the past-year prevalence of cocaine use, marijuana use, and alcohol use disorders among adults ages 18 and older are presented in the table below.[24] Between 2008-2009 and 2018-2019, the prevalence of cocaine use among adults in Florida is essentially flat. The prevalence of marijuana use increased from 9.9 percent up to 15.0 percent, while the prevalence of alcohol use disorders decreased from 7.2 percent down to 4.2 percent.

**Figure D. Prevalence of Cocaine Use, Marijuana Use, and Alcohol Use Disorders in the Past Year Among Adults Ages 18 and Older in Florida (2008-2019)**

| | 2008-2009 | 2010-2011 | 2012-2013 | 2014-2015 | 2016-2017 | 2018-2019 |
|---|---|---|---|---|---|---|
| **Cocaine Use** | 1.9% | 1.7% | 1.9% | 2.0% | 2.1% | 1.8% |
| **Marijuana Use** | 9.9% | 10.7% | 11.2% | 12.5% | 13.7% | 15.0% |
| **Alcohol Use Disorder** | 7.2% | 6.1% | 6.4% | 6.2% | 5.6% | 4.2% |

According to the most recent Assessment of Behavioral Health Services, in fiscal year (FY) 2019–2020 there were approximately 787 individuals placed on a waitlist for outpatient drug treatment services. During this same period, 162 individuals who inject drugs and 145 individuals who were homeless were also placed on a waitlist for outpatient drug treatment services.[25] Adults in some areas of the state wait 19 days, on average, between their assessment and their first outpatient drug treatment service. With respect to residential drug treatment, 388 individuals were placed on the waitlist in FY 2019–2020.

### 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.[26] Florida Medicaid covers MAT under the Community Behavioral Health Fee Schedule and buprenorphine under the pharmacy benefit. Expansion of

access to MAT continues through DCF's SOR grant, funded by SAMHSA through 2022 as described in the table below:

**Figure E. DCF – SOR grant 2018 through 2022**

| Grant | Project Period | Annual Award Amounts |
|---|---|---|
| State Opioid Response (SOR) 1 | 9/30/2018 through 9/29/2020<br>No Cost Extension Approved | $76,186,527 (Year 1)<br>$50,056,851 (Year 2) |
| State Opioid Response (SOR) 2 | 9/30/2020 through 9/29/2022 | $100,170,437 (Year 1)<br>$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 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). Florida Medicaid covers Vivitrol through an automated prior authorization process that will look for a diagnosis of OUD or alcohol use disorder in the medical history and if found, it will pay immediately at the pharmacy.

### Expansion of Syringe Exchange Programs (SEPs)

SEPs are front line public health interventions that effectively reduce the spread of Human Immunodeficiency Virus (HIV) and hepatitis C by reducing the sharing, reuse, and circulation of syringes and injecting equipment.[27] Research shows that every dollar spent on SEPs saves at least three dollars in averted treatment costs.[28] 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 SUD to treatment services.[29] 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 it 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.[30]

Senate Bill 366, the Infectious Disease Elimination Programs, passed in 2019, permits county commissions to authorize the establishment of additional SEPs through county ordinances.[31] 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. As of July 2021, nine counties have passed ordinances authorizing SEPs, including Alachua, Broward, Miami-Dade, Hillsborough, Leon, Manatee, Orange, Palm Beach, and Pinellas.

### Overdose Data to Action (OD2A) Grant

In September 2019, the FDOH state health office and the Broward, Duval, and Palm Beach CHDs were awarded grant funding through the OD2A grant from the CDC. This now four-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. During year two of the grant, the state health office-maintained allocations of $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. These activities include support for awareness campaigns to highlight the risks of OUD and additional year 4 expansion to include SUD 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 continuous funding to implement evidence-based curriculums in public schools (Brevard, Manatee, Nassau, Pasco, and Sarasota) and two counties received continuous funding to support community paramedicine projects to improve patient follow-up among individuals most at risk of overdosing (Clay and Marion). FDOH continues to fund the support of five Florida Epidemic Intelligence Service opioid fellows assigned to CHDs.

**Opioid Use Disorder, Maternal Outcomes, and Neonatal Abstinence Syndrome Initiative (OMNI)**

Florida was one of five states to be selected by the CDC and the Association of State and Territorial Health Officials for a site placement of a Maternal & Neonatal Opioid Prevention Coordinator to support OMNI. The coordinator's role was specifically designed to support the Maternal Opioid Recovery Effort (MORE) initiative 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, FDOH 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 Screening, Brief Intervention and Referral to Treatment (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 a series of community meetings in counties with high rates of NAS, the shortage of MAT, behavioral health, and inpatient bed services for pregnant and postpartum women was the single biggest challenge reported by community members. Fifteen out of 18 communities cited this as a barrier. Most counties also identified fragmented care, poor systems for referral, and outdated data systems as barriers to care.

Although AHCA successfully removed the pre-authorization requirement for MAT, some communities are still facing barriers because this policy change is not fully understood by payers or pharmacists. FDOH will work with AHCA to continue to educate pharmacists and payers about changes regarding MAT prescribing. AHCA also added nationally recognized SBIRT codes to the Medicaid Practitioner's fee schedule to be retroactively effective January 1, 2021. This evidence-based approach can help to identify risky behavior and provide appropriate interventions to promote timely treatment for OUD. AHCA is supporting a free continuing medical education (CME) eligible course on SBIRT for obstetrics and gynecology providers in October 2021.

Another area of concern for communities is related to 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. FDOH is working with DCF and Florida's Healthy Start to develop a framework and messaging for Plans of Safe Care that will help improve plans across the state. Efforts will focus on improving reporting as well as training providers on how to use motivational interviewing to engage women and encourage them to start the treatment and recovery process.[32]

In the final year of OMNI, FDOH worked with the FPQC to bring together partners to identify specific barriers to screening and treating pregnant women with OUD. The MAT Workgroup made the following recommendations: (1) Increase the number of qualified medical professionals who can screen and treat pregnant and postpartum women with OUD; (2) Ensure seamless transfer of care for postpartum women with OUD to comprehensive services; (3) Foster coordinated and integrated care delivery for clinical treatment, behavioral and mental health services, and wrap-around services; (4) Increase identification and referral of pregnant women with OUD and increase access to naloxone for both pregnant and postpartum women; and (5) Leverage the use of existing Medicaid flexibility (via state plan amendments or waivers) to provide sustainable and comprehensive care for pregnant and postpartum women with OUD.

### Florida's Prescription Drug Monitoring Program (PDMP)

Florida's PDMP, the Electronic-Florida Online Reporting of Controlled Substance Evaluation Program (E-FORCSE), provides data related to controlled substance prescriptions in the state. From July 1, 2020 to June 30, 2021, there were 30,617,442 controlled substance prescriptions dispensed to Florida patients, a 0.9 percent increase from the previous year. In addition, five million people in Florida were prescribed one or more controlled substances, an increase of 2.6 percent. Oxycodone SA, alprazolam, and hydrocodone SA were ranked the top three most commonly dispensed controlled substances for the sixth year in a row, together representing 35.6 percent of the total controlled substances dispensed from July 1, 2020 to June 30, 2021. Drugs with the largest year-to-year decreases in dispensing were temazepam (-3.9%), lorazepam (-1.3%) and tramadol SA (-1.1%).[33]

### 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,

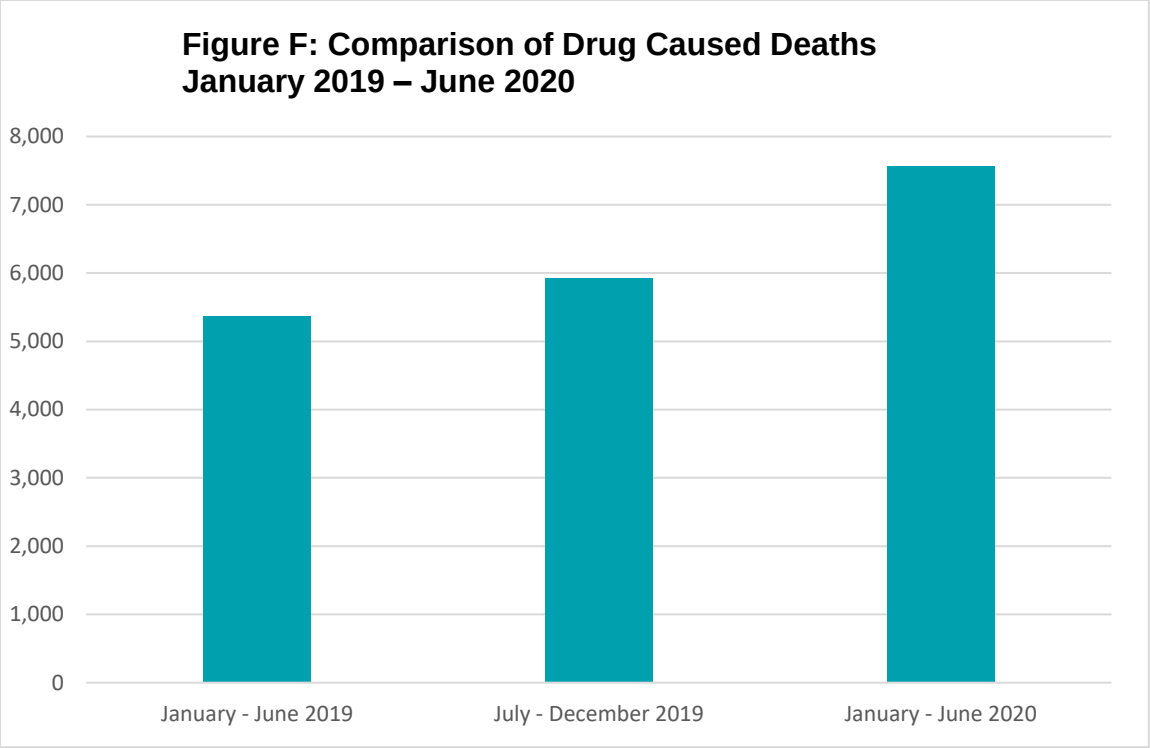
the workforce remains static at best. Meanwhile, Florida's aging population (age 65 and older) is expected to exceed any other age group by 2030, causing a dynamic shift in future behavioral health care needs. A recent addition to the behavioral health workforce has been the utilization of peers with 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.[34]

### Law Enforcement Perspective

Florida law enforcement remains engaged in their current effort to reduce the availability of heroin, fentanyl, fentanyl analogs, and other substances contributing to opioid involved overdose and overdose deaths. The threats posed by fentanyl have increased in recent years as Mexico-based drug trafficking organizations have been mass-producing illicit fentanyl and fentanyl-laced counterfeit pills. In September 2021, the Drug Enforcement Administration (DEA) warned that there has been a sharp increase in the number of fake prescription pills containing illicit fentanyl.[35]

According to the Drugs Identified in Deceased Persons by the Florida ME (2020 Interim Report), opioid involved deaths increased by 30.5 percent over the same period (January through June) in 2019; opioid-caused deaths also increased (51%). The most significant increase were deaths involving fentanyl which increased 70 percent; and deaths caused by fentanyl increased 81 percent.

For the first time since 2013, ethanol was not the most prevalent drug reported. The most frequently occurring drugs found in decedents were fentanyl (2,838), ethyl alcohol (2,814), benzodiazepines (2,182, including 833 alprazolam occurrences), cocaine (1,851), cannabinoids (1,647), methamphetamine (962), amphetamine (942), fentanyl analogs (905) and morphine (870). Since heroin is rapidly metabolized to morphine, this may lead to a substantial over-reporting of morphine-related deaths as well as significant under-reporting of heroin-related deaths.




Note: Not all drugs are included in the above chart. Source material obtained through Drugs Identified in Deceased Persons by Florida Medical Examiners 2020 Interim Report.

In July 2020, FDLE was awarded approximately $2.2 million in federal grant funds through the Community Oriented Policing Services 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 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, (including stimulants) also impacts Florida to varying degrees across regions. Methamphetamine is gaining a particularly strong 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. and Mexico border has increased substantially over the past few years. Its 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.

The situation at the U.S. southwest border has become an important national issue in 2020 and 2021 relative to the impact that supply and demand has on the price and availability of some illicit drugs. Reported seizures of illicit fentanyl along the border have surpassed those of heroin and have been increasing since at least 2018.[36] The COVID-19 lockdown may have had some impact on the flow of illicit drugs across the border but reported seizures of illicit fentanyl and methamphetamine for 2021 have surpassed reports for 2019 and 2020.[37] 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.

## 2021 Completed Recommendations from Previous Annual Reports

1. 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.

   The Florida Youth Survey vendor is currently in the process of finalizing the 2021 Florida Youth Tobacco Survey data that were collected during the 2021 survey administration, and FDOH will complete the analysis this year. It is estimated that final reports will be ready before the end of 2021. This recommendation is essentially complete with ongoing support.

2. SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with SUD, as well as those at-risk of developing those disorders.[38] 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:

   - FDOH 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.
   - AHCA should report to the Legislature on the availability of Medicaid coverage for SBIRT; and if it is not available, what changes need to be made to the state's Medicaid plan, billing, and coding practices to promote implementation of SBIRT in Florida.
   - H0049 (screening) and H0050 (brief intervention), nationally recognized SBIRT codes, have been added to the practitioner fee schedule and will be retroactively effective January 1, 2021. AHCA is working with plans and partners, including FDOH and the FPQC to implement a CME course for physicians. It will measure progress with increased SBIRT by monitoring the frequency of billing for SBIRT. This recommendation is essentially complete, with ongoing support planned.

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

   - FDOH completed this activity during 2021 and the new dashboard was presented to the Council at the October 2021 meeting. https://flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=SubstanceUseDashboard. The link will be active to the public before the end of 2021.

4. Encourage all counties and municipalities to implement the ODMAP in locations and agencies that do not participate in real-time overdose tracking. Through wider utilization, law enforcement and non-EMSTARS fire departments can track suspected overdose activity throughout all 67 counties. Agencies can utilize information obtained through the 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 $750,000 to five sub-awardees, and it is executed over a 24-month period for further expansion of the 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 the ODMAP training and implementation within new agencies. There is still a large percentage of Florida counties/municipalities that do not participate in the ODMAP.

FDOH uses an additional platform that has the capability to track overdoses, Biospatial, a national application that provides near real-time overdose mapping and detection. The Biospatial platform uses EMS data that FDOH already collects and produces analytics to track overdoses. Although many counties are not utilizing the ODMAP, nearly 97 percent of EMS agencies in Florida are submitting data through EMSTARS. The data are shared through the Biospatial platform. Florida adopted the use of this platform to assist in improving the situational awareness and response capabilities of overdose and other public health events. This recommendation will be tabled until the integration issues associated with the ODMAP and EMSTARS have been resolved.

# 2021 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.

Because 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:

- Develop and implement 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 following: 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 that 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 do the following: 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 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 SUD.

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."[39] 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 FDC, the Florida Department of Juvenile Justice (DJJ), and other partners. The Florida Drug Control Strategy 1999-2005 indicates opportunities for better coordination among agencies and law enforcement to reduce substance abuse.[40]

**2. State agencies and commercial health plans provided service delivery flexibilities to respond to the challenges related to the delivery of mental health and SUD care during COVID-19. 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 but 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 enrollees diagnosed with COVID-19 or when it is necessary to maintain enrollees safely in their homes.**
- **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.[41] This trauma will be long lasting for children, adults, and families. Medical providers are also experiencing a significant increase in individuals seeking care as well as 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 enrollees diagnosed with COVID-19 or when it will be necessary to maintain enrollees safely in their homes.

COVID-19 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 COVID-19.

Prior authorization and service limit flexibilities enacted for behavioral health services in response to Florida's COVID-19 state of emergency ended July 1, 2021. State of emergency telemedicine flexibilities remain in effect at time of publication, but the future of specific options is not yet certain. AHCA continues to monitor and evaluate the use and benefits of telemedicine. Future changes to AHCA's telemedicine have not been determined.

**3. To effectively address the opioid crisis, the impact of the pandemic, and the anticipated growth in mental health and SUD service need, it is critical that a vibrant, stable, and well-trained workforce be available to provide prevention, treatment, and recovery services. To address the workforce crisis, the Council recommends adopting changes in payment methods, background screening, exemptions for peer specialist applications, and greater flexibility with telehealth, reimbursing providers the same amount for telehealth and in person visits.**

The Council recommends:

- Support prospective payment as a critical component of Florida's CCBHC initiative. Authorize the managing entities to utilize a prospective payment model.
- Encourage the Legislature to consider modifying background screening legislation related to peer specialists to allow easier access into the workforce. For example, allowing an individual to work prior to full payment of fines and fees if the individual is honoring a payment plan
- Encourage DCF to streamline the exemption process related to peer specialist applicants working with adolescents and adults with mental health or SUD.
- Allow greater flexibility to telehealth services, especially in rural areas of the state. Continue the current flexibilities with telehealth as a mode of service provision and provide payment parity and coverage parity for services provided via telehealth, meaning the behavioral health service is reimbursed for the same amount whether provided via telehealth or in person.

Florida, along with the rest of the country, is experiencing a shortage of health care professionals to meet the growing need. For behavioral health professionals, the shortage in Florida is reaching near critical levels. The shortage has a direct impact on the ability to provide critical treatment and recovery services. The inability to staff critical SUD and mental health services has resulted in a reduction of service availability at the same time the need for services is increasing. The impact of COVID-19 has also added an additional stressor to workforce concerns. While it is anticipated the need for behavioral health services in Florida will increase due to the impact of the pandemic and the continuing opioid crisis, the providers of mental health and SUD services across the state are already struggling to fill existing vacant positions.

SAMHSA recently published the *Behavioral Health Workforce Report.*[42] The report explores the number of providers needed for mental health and SUD models of care, and it displays the supply and demand for each behavioral health occupation. The report shows the stark contrast between medical and treatment providers that are currently available versus what is needed to address the mental health and SUD issues faced by millions of Americans. The report utilized five different sources to estimate the number of behavioral health providers across the country needed to treat individuals diagnosed with moderate to severe mental illness and SUD. Figure G displays the report's findings:

**Figure G. Provider Availability vs. Need, 2020**

| Occupation | Number in Workforce | Workforce Needed | Additional Need |
|---|---|---|---|
| Addiction Medicine Physicians | 3,171 | 44,484 | 41,313 |
| Addiction Psychiatrists | 1,164 | 44,484 | 43,320 |
| Counselors | 283,540 | 1,719,768 | 1,436,228 |
| Nurses | 110,275 | 658,757 | 548,482 |
| Peer Support Specialists | 23,507 | 1,126,845 | 1,103,338 |
| Social Workers | 117,770 | 214,384 | 96,614 |

One specific example of workforce need in Florida is behavioral healthcare technicians. At present a significant number of vacancies for behavioral health technicians exist across the state. In August of 2020, the web-based job recruitment platform Indeed[43] listed over 1,300 vacancies and ZipRecruiter[44] listed over 3,000 vacancies in Florida. The U.S. Bureau of Labor Statistics projects an expected job growth rate of 12 percent for this occupation from 2019 to 2029.[45]

Another indication of trouble in the workforce is the turnover rate of existing employees. The Florida Behavioral Health Association conducted a survey of its members in May 2021.[46] The survey indicated the following annual turnover rates on a variety of positions:

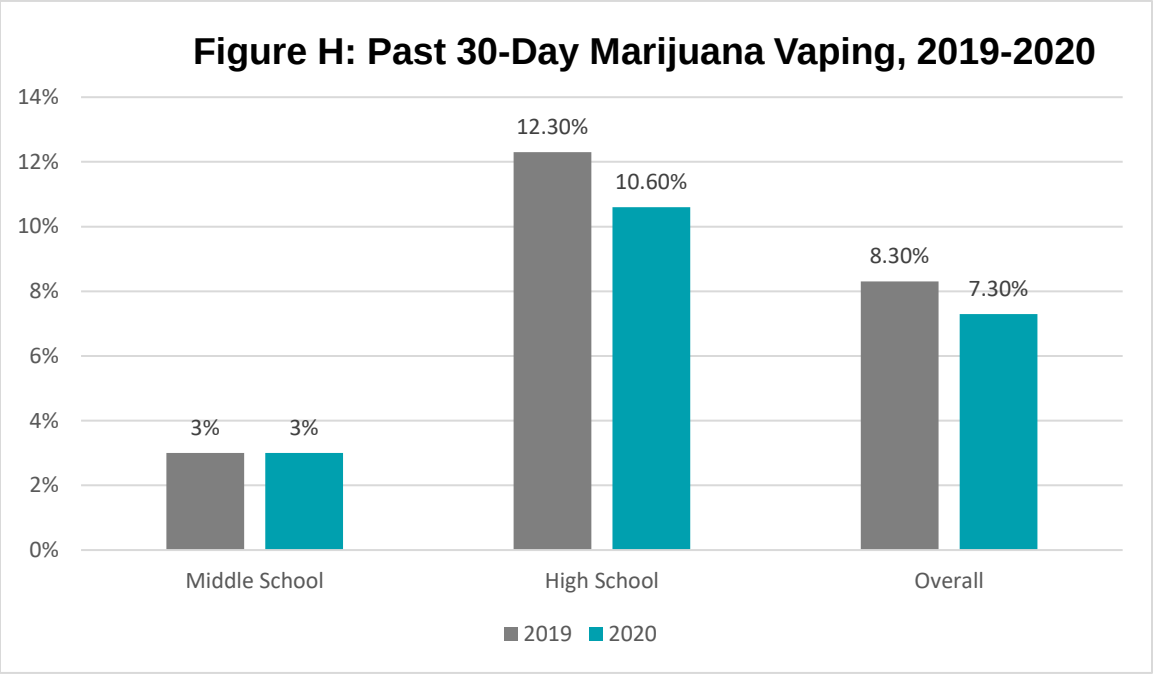
| | |
|---|---|
| Behavioral Health Tech: Certified | -16% |
| Clinician: Bachelors, unlicensed | -34% |
| Clinician: Masters and unlicensed | -57% |
| Licensed Clinical Social Worker | -15% |
| Licensed Marriage Family Therapist | -17% |
| Licensed Mental Health Counselors | -26% |
| Licensed Practical Nurses | -35% |
| Peer Specialist | -26% |
| Physician: Medical | -19% |
| Registered Nurses | -32% |
| Senior Clinical Manager: Licensed | -15% |

While turnover cannot be correlated solely to available funding for salaries, the lack of competitive salaries plays a significant role in the ability to staff safety net providers. Competition for employees from larger health systems, managed care organizations, school districts, and federal agencies such as the U.S. Department of Veterans Affairs is significant. While these systems have more flexibility to set competitive salaries, community providers are often limited by the resources allocated for services. The CCBHC model being implemented nationally and in Florida has allowed providers to leverage their grant funding and/or Medicaid payment structure to train, recruit, and retain highly qualified staff.[47]

# Prevention

**4. Develop and implement a substance-use prevention strategy designed to prevent drug use among youth (ages 12-17). The strategy should focus on (1) the deployment of a unified anti-drug messaging campaign, (2) increasing/maintaining substance use prevention efforts by securing/sustaining front-end prevention funding, and (3) expanding state partnerships with anti-drug coalitions, educational institutions, law enforcement, and other members of the 12 community sectors.**

Efforts like these will enhance substance use prevention efforts, allow for the unified employment of limited resources toward 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 2020 FYSAS, high school students reported a 22.1 percent reduction in their past 30-day alcohol use and a 12.6 percent reduction in cigarette use as compared to 2004.[48] Despite these gains, new trends demonstrate the need for concern. According to the 2020 Monitoring the Future (MTF) survey, 24.7 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 that 12.2 percent vaped marijuana, 1.8 percent vaped hallucinogens, and another 1.7 percent vaped amphetamines.[49] The 2020 FYSAS also noted that 15.6 percent of Florida's high school students vaped nicotine and another 10.6 percent vaped marijuana.




Graph highlights "past-30-day marijuana vaping (2019-2020)" trends identified in the 2020 Florida Youth Substance Abuse Survey.

Recognizing vaping as an enduring and significant problem, the 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, smoking, and chewing tobacco. 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.[50,51] 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 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 show that prevention is most effective when carried out over the long-term with repeated evidence-based interventions.[52] 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.[53,54,55] Evidence-based prevention programs, local prevention messaging campaigns, and prescription drug take-back events cannot happen without them.

These intervention initiatives conducted in conjunction with a large-scale, multi-agency prevention campaign would potentially have a significant impact to the communities served. 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. These early investments can reduce treatment and criminal justice costs, and more importantly, prevent tragedy among youth. By ensuring prevention funding is continually available, local communities can 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 toward a healthier community.

In addition, DCF is implementing a variety of campaigns throughout the state designed to prevent youth substance use. These include different variations of Social Norms Campaigns, as well as Use Only as Directed, Know the Law, Talk: They Hear You, Natural High, Friday Night Done Right, No One's House/ Not in My House, We ID, Hidden in Plain Sight, Safe Rx, Parents Who Host Lose the Most, Lock Your Meds, Be Smart Rx, Be the Wall, Safe Homes / Safe Parties, and Project Sticker Shock. As many of these campaign names imply, they involve activities that address a variety of substances and behaviors, and include messages targeting parents and other adults that encourage responsible social hosting and supervision, restricting youth retail and social access to alcohol and medications, conveying disapproval of youth substance use, and modeling substance-free recreational activities.

DCF continues to secure set-aside funds from the Substance Abuse Prevention and Treatment Block Grant to implement a variety of primary substance use prevention programs throughout the state. In addition to this recurring block grant funding, DCF secures primary prevention funds through other SAMHSA grants, namely the Partnerships for Success grant and the SOR grant. Funding from these sources is used to implement a variety of evidence-based primary

prevention campaigns and programs, many of which are implemented in conjunction with schools, anti-drug coalitions, law enforcement partners, and faith-based organizations. Block Grant prevention funding also supports various community-based processes, encompassing activities like community organizing, planning, networking, and coalition building. Anti-drug coalitions throughout Florida have considerable experience obtaining active participation from all 12 community sectors, including schools, faith-based organizations, and law enforcement. This expectation has been embedded in training content used by the Community Anti-Drug Coalitions of America and SAMHSA's Center for Substance Abuse Prevention for many years. Additionally, entities funded through the Drug Free Communities Support Program are required to have representatives from all 12 sectors. According to 2020 DFC Progress Report data, almost all (93%) of Drug Free Community coalitions throughout the country report having at least one current member from each sector. Entities that routinely convene members from these sectors in Florida now include 38 anti-drug coalitions, the Statewide Drug Policy Advisory Council, and the Children and Youth Cabinet, among others.

**5. Deploy an evidence-based substance use reduction program designed to decrease drug use among youth (ages 12-17). The curriculum will 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. DCF should lead, in collaboration with FDOH and 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.**

DCF's Statewide Prevention Coordinators collaborated with nurses, counselors, educators, and DOE representatives to develop standards in the Florida Administrative Code for Florida's substance use prevention for grades K-12. On July 14, 2021, the State Board of Education adopted Substance Use and Abuse standards for grades 6-12. These standards will provide support and guidance for the teaching of substance use and abuse education in Florida's schools, and will be fully implemented beginning with the 2022-2023 school year. This will allow opportunities for students to develop an awareness of the dangers associated with the use and abuse of harmful substances.

DCF and Managing Entities use several funding sources to implement a variety of youth substance use prevention programs throughout the state. Some of the evidence-based substance use prevention programs target multiple risk and protective factors related to substance use which overlap with risk and protective factors related to other mental, emotional, and behavioral problems. Meta-analyses show that a broad set of interventions designed to promote healthy development, including school-based social and emotional learning programs, mentoring, early childhood programs, and programs targeting family disruptions have significant effects on substance use, mental health, and anti-social behavior. Significant effects on these problem outcomes are found in meta-analyses of promotion programs as well as meta-analyses of programs that target these specific problem outcomes. Several of the various evidence-based substance use prevention programs that are being implemented throughout Florida aim to build coping and decision-making skills or address parenting behaviors and family relationships/interactions, and may help produce favorable outcomes in domains beyond

substance use, including academic achievement, delinquency, conduct problems, and symptoms of depression and anxiety, though a comprehensive review of the evaluation literature across all of these programs and across all of these outcomes is beyond the scope of this report.

It should also be observed that DCF supports a statewide prevention system that provides many opportunities for coordination and collaboration with partner agencies, including the FDOH and DOE. At the state-level, representatives from all these agencies, and many others, routinely address interagency coordination and collaboration through the Statewide Drug Policy Advisory Council and the Children and Youth Cabinet. DCF also hosts a monthly Children's Behavioral Health Call with representatives from FDOH and other state agencies. Managing Entities and the anti-drug coalitions in their contracted networks also engage in community needs assessments that collect input and data from a variety of local partners from multiple different community sectors, including healthcare professionals, educational professionals, and faith-based groups. Furthermore, section 397.99, Florida Statutes, directs DCF to administer evidence-based youth prevention programs in cooperation with DOE and DJJ.

Every three years, community-based organizations and schools submit proposals for funding and DCF coordinates the review of applications in partnership with DOE and DJJ. Additionally, FDOH oversees the State Health Improvement Planning process, which entails collaboration with DCF on behavioral health goals and objectives. Local CHDs also develop Community Health Improvement Plans (CHIPs) through a collaborative process that entails various community partners assessing the status of local communities and resources/assets for promoting behavioral health. Currently, 88 percent of county CHIPs address behavioral health, including domains like suicide prevention, mental health first aid, ACEs, and integration with primary care, among others. Initiatives like these represent important ongoing opportunities for continuing to develop and improve interagency partnerships and coordination.

Prior to COVID-19, more than 660 thousand adults and 181 thousand adolescents lived with a serious mental illness within Florida.[56] Since April, 2020, Florida's diagnosis rate has increased by 12.7 percent.[57] Extended periods of isolation, excessive worry, and emotional distress without healthy coping skills or proper psychological support may have prompted the onset of additional mental health disorders. 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 should 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.[58]

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, DOE established Florida Administrative Code rule 6A-1.094124.[59] This new rule was developed by the State Board of Education in November 2020 and requires students in grades 6-12 to receive a minimum of five hours of mental and emotional health education and students in grades K–12 to receive an annual substance use/abuse prevention class. 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. This rule is in effect for the 2021-2022 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 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 of experiencing trauma and toxic stress in childhood. The CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) study discovered a direct relationship between these "adverse childhood experiences" and lifelong physical and mental health conditions.[60] 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.[61] SUD is more common in persons with ACEs, especially with cumulative adverse experiences as detailed below:

- Compared with persons with no scores on the ACEs 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 ACEs scores even when the person's parent did not have alcoholism.[62]
- 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-thirds of serious problems with drug use.[63,64]
- Higher ACEs 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 seven to ten times more likely to report illicit drug use and addiction.[65]

- At the extremes of ACEs scores, the figures for injected drug use are even more powerful. For instance, a male child with an ACEs score of six, when compared to a male child with an ACEs score of zero, has a 46-fold (4,600%) increase in the likelihood of becoming an injection drug user sometime later in life.[66]

**6. Develop and implement a stigma reduction campaign designed to reduce the negative feelings associated with SUD and other mental illness/injuries. Messaging should increase the awareness of medically assisted treatment options, reduce the stigma associated with addiction, and inform the public of the many benefits that come with obtaining psychiatric, psychological and/or therapeutic 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.[67] Societal norms and attitudes drive the first two types, while the third occurs when individuals internalize these negative opinions. 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.[68]

Through a stigma reduction campaign, Florida can (1) educate citizens on the benefits of recovery and (2) guide them in obtaining treatment. Parallel to this effort, Florida should continue to bring awareness to DCF's naloxone initiative. Naloxone is the medication used to reverse opioid overdose. DCF provides information on where individuals can access this medication within Florida. Targeted audiences for this campaign should include high-risk populations, their friends, and family. Campaign mediums include radio ads, interviews with key stakeholders, printed materials, and a website that allows individuals to search for the nearest naloxone distribution site within their area: https://isavefl.com/.

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

**7. Encourage pharmacies to educate consumers on safe medication storage and disposal procedures when filling prescriptions for controlled substances. Establish a media campaign to educate consumers on reason for safe use, safe storage, and safe disposal as well as 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 offers information online regarding pharmaceutical waste management for homeowners. In addition to addressing frequently asked questions, the website includes information about drug drop off locations and steps to take at home to properly dispose of old unused medication. The website can be accessed 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 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.

AHCA surveyed the health plans regarding the storage and disposal of controlled drugs. The response from the plans was that they do not have formal pharmacy outreach, but they focus on encouraging pharmacies to promote education on these topics.

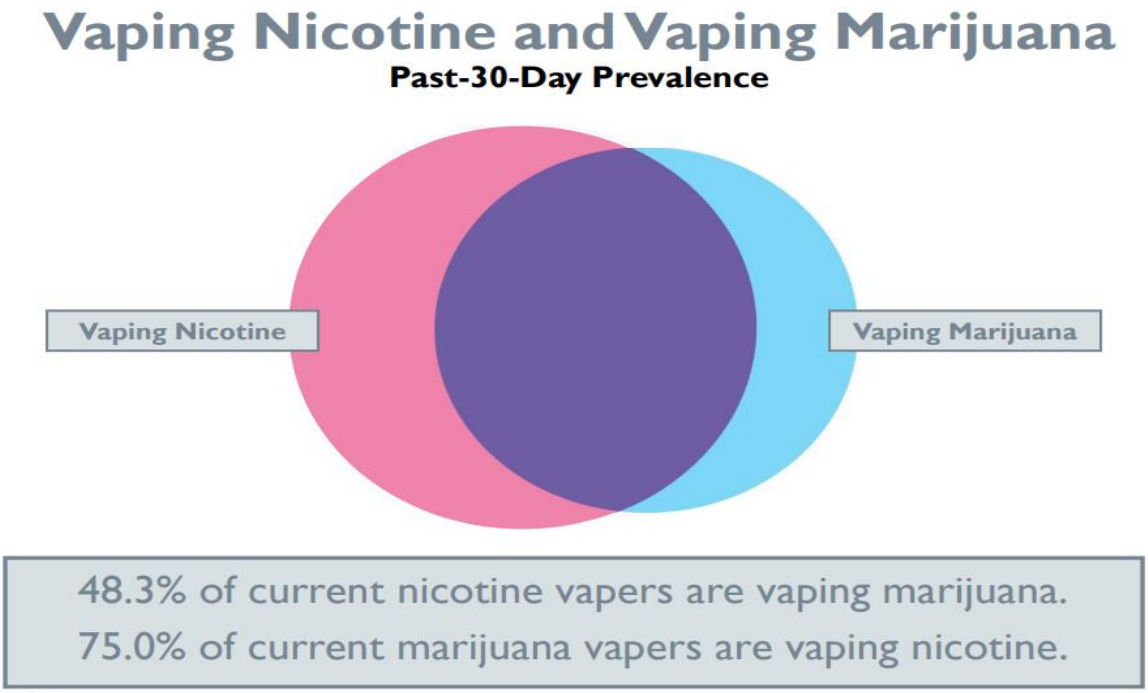
**8. Establish medical marijuana advertisement standards that restrict the advertising methods of medical marijuana/cannabis evaluation clinics, conveyance shops, and other services or businesses not currently governed by Amendment 2 (section 381.986, Florida Statutes.)**

Since the passing of Amendment 2, the Florida medical marijuana initiative in 2016, 371 medical marijuana treatment centers have opened throughout the state. Florida's treatment centers are regulated by laws established under section 381.986, Florida Statutes, and indirectly supported by 2,717 physicians.[69] The physicians have completed the state mandated two hour "Florida Physician Medical Marijuana Course," which then qualifies them to register their patients into the "Medical Marijuana Use Registry." The registry is an online database that medical marijuana treatment centers use to validate the patient's qualifying condition, dosage, and authorized forms of medical marijuana. Prior to adding the patient to the registry, a physician must diagnose the individual's condition(s) and then determine if the benefit of medical marijuana outweighs the potential health risks associated with use.[70] To accomplish this task, several physicians have opened medical marijuana/cannabis evaluation clinics.

While section 381.986, Florida Statutes, clearly defines the advertising laws that govern treatment centers, no legislation exists to regulate methods used by evaluation clinics. Several communities throughout Florida have seen evaluation clinics utilize cartoons, billboards and other forms of advertisement that do not meet the standards outlined in the statute. Evaluation clinics such as these have established marketing campaigns to sell their products and services to the public without consideration for the long-term negative impacts to Florida's youth. These

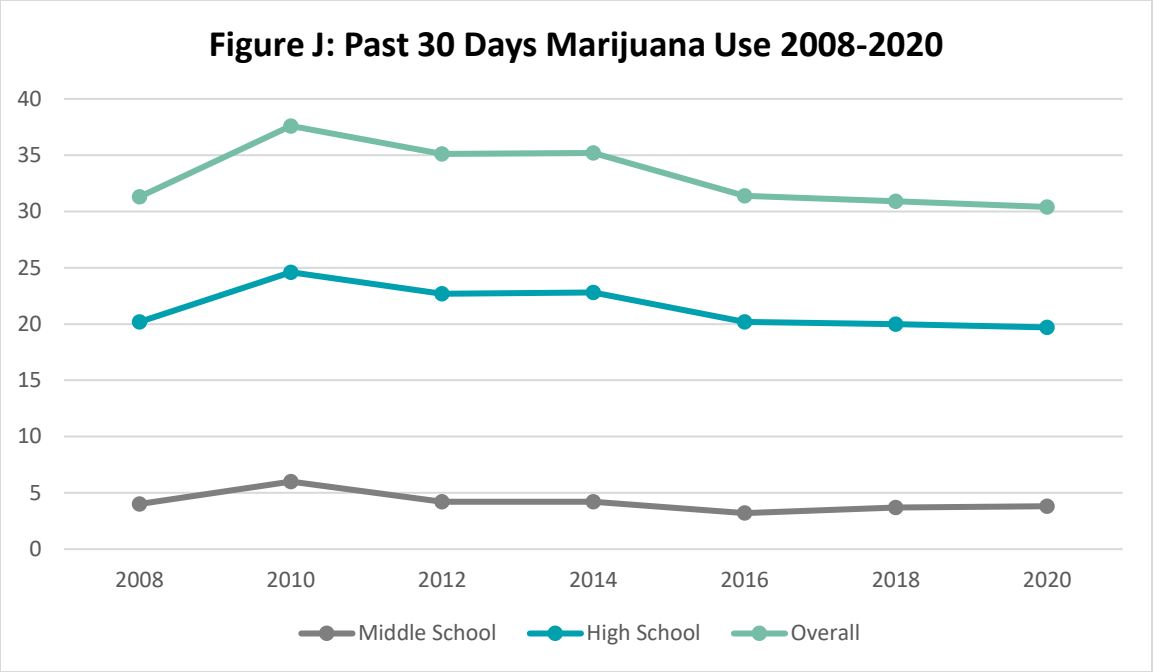
advertising methods are reminiscent of techniques used by tobacco companies prior to the November 1998 Master Settlement Agreement that ended the practice of "youth targeting."[71] After this pivotal ruling, tobacco companies retired the use of cartoon advertisements, outdoor billboards, transit vehicles, as well as limited their use of sports marketing, event sponsorship, and promotional product distribution.[72] Although the advent of vaping delivery systems have directly impacted youth tobacco use trends, campaigns such as "The Real Cost" have yielded positive results in impacting education initiatives.[73] These results are reinforced by rational, practical regulation such as the Master Settlement Agreement outlined above, as well as section 381.986, Florida Statutes. Furthermore, the statute implements a statewide cannabis and marijuana education and illicit use prevention campaign to publicize "the short-term and long-term effects of cannabis and marijuana use, particularly on minors and young adults."[74] Campaigns like these were not designed to directly compete with unrestricted industry marketing practice.

**Figure I. Vaping Nicotine and Vaping Marijuana, Florida Youth**




Graph outlines "vaping nicotine and vaping marijuana side-by-side comparison" identified in the 2020 Florida Youth Substance Abuse Survey. Graph provided by FDLE.

Florida businesses participating in the medical marijuana trade may already be recklessly impacting youth in recreational marijuana use. Results from the 2020 FYSAS observed no meaningful change for middle school students in general marijuana use, while national data suggests an increase in use. Moreover, the FYSAS suggests a significant overlap between vaping both nicotine and marijuana delivery systems, with a clear indication that nearly half of reporting Florida students use both.[75] This is alarming when considering the previous 5-year decline in adolescent use of marijuana.




Graph highlights “past-30-day marijuana use (2008-2020)” trends identified in the 2020 Florida Youth Substance Abuse Survey.

SAMHSA reports that, “Marijuana use among all adult age groups, both sexes, and pregnant women is going up. At the same time, the perception of how harmful marijuana use can be is declining.” One in 10 people who use marijuana will become addicted, and that rate increases to 1 in 6 when someone starts before turning 18 years of age.[76] Research suggests long-term use of marijuana inhibits brain development, causes lung damage, and potentially cannabis use disorder. When considered collectively, these factors are strikingly similar to those that led to the 1998 Master Settlement Agreement. The decline in perception of harm is a direct result of unrestricted industry advertisement practices disrupting public education campaigns. With the amendment of section 381.986, Florida Statutes, Florida may correctly apply the same regulations that currently govern the Medical Marijuana Treatment Centers to the Medical Marijuana & Cannabis Evaluation Clinics.

**9. Establish legislation to regulate preparation, distribution, and sale of kratom-based products (Mytragyna Speciosa) that contain the alkaloids mytragynine and/or 7-hydroxymitragynine; prohibit the preparation, distribution, and sale of adulterated or contaminated kratom products; assign authorities and responsibilities to ensure compliance standards are met and/or maintained; and establish corrective actions/penalties for actors/agencies that would violate such legislation.**

Kratom (Mytragyna Speciose) is a tropical tree native to Southeast Asia. Consuming kratom can produce both sedative and stimulant effects (dosage dependent) and lead to psychotic symptoms and psychological/physiological dependence.[77] Kratom is typically smoked, brewed into tea, chewed, or ingested through capsules. Kratom has been used in Southeast Asia for many years, but only recently seen in the U.S. Kratom’s effects on the body include nausea, itching, sweating, dry mouth, constipation, increased urination, tachycardia (rapid heartbeat), vomiting, drowsiness, and loss of appetite. In some cases, kratom users have experienced

anorexia, weight loss, insomnia, hepatotoxicity (chemical driven liver damage), seizures and hallucinations.

The Central Ohio Poison Control Center and the Nationwide Children's Hospital recently conducted a study of kratom through the use of the National Poison Data System. Data were collected and analyzed during the period of 2011–2017. During this time, U.S. poison centers received 1,800 calls due to kratom exposure. Most occurred in adults over the age of 20, but 137 were in teens, and 48 were in children under the age of 12, including 7 newborns, suggesting that kratom crosses the placenta during pregnancy.[78] National Poison Data System reported only 13 kratom related calls in 2011, while in 2017, they received 682 calls. The 5,146 percent increase of poison control calls from the year 2011 as compared to the year 2017 identifies an intensification of use and highlights the dangers associated with the drug. Overall, nearly one third (32%) of the calls resulted in admission to a healthcare facility and more than half (52%) resulted in serious medical outcomes, especially among teenagers and adults. Taking kratom with another substance increased the odds of admission to a health care facility and of having a serious medical outcome. The medical effects noted in this study ranged from tachycardia, agitation/irritability, and hypertension (high blood pressure) to seizures, coma (loss of consciousness), increased bilirubin, renal (kidney) failure, and death.[79] According to the CDC, kratom appears to be increasing in the U.S., and the reported medical outcomes and health effects suggest an emerging public health threat.

The FDA continues to warn consumers not to use kratom. Research conducted by the FDA, CDC, and various other independent laboratories consistently determines that kratom binds to the same opioid receptors as morphine, which can then lead to addiction, abuse, and dependence.[80] The FDA remains concerned that some kratom producers claim their product contains medical benefit. Many distributors market their products to individuals with SUD as a tool in achieving their sobriety from opioids and alcohol. Due largely to these concerns, the FDA has issued warning letters to multiple kratom vendors that have specifically marketed their products to people with SUD advising that their kratom will assist with opiate and alcohol withdrawals. The FDA believes these unsubstantiated claims will potentially delay an individual in need of treatment from entering legitimate recovery programs, thus, significantly increasing their chances of overdose and death. The FDA does not currently view kratom as a legitimate medication or substance that can assist individuals with SUD in achieving sobriety.[81]

The Florida ME did not specifically track mytragynine in the *Drugs Identified in Deceased Persons by Medical Examiners 2019 Annual Report*, yet 82 occurrences were reported throughout the state in 2019.[82] For this reason all the ME began reporting occurrences of mytragynine in the 2020 edition.[83] With Florida's development and implementation of legislation similar to New York State's Senate Bill S6104 (New York State Kratom Consumer Protection Act)[84] safety measures could be emplaced that would mitigate some risks associated with kratom, or kratom related products that have been identified by the FDA and CDC.

**Potential Actions by the Legislature could include:**

1. Kratom products prepared, distributed, sold, or exposed for sale in Florida:
   a) Shall not be adulterated with a dangerous non-kratom substance and/or any substance that affects the strength, quality, or can render the product dangerous to the consumer.
   b) Shall not contain a level of 7-hydroxymitragynine in the alkaloid fraction that is greater than 2 percent of the overall alkaloid composition of the product.
   c) Shall not contain residual solvent levels higher than is allowed in USP 467.

d) Shall not be contaminated with a dangerous non-kratom substance. A kratom product is contaminated with a dangerous non-kratom substance if the kratom product contains a poisonous or otherwise deleterious non-kratom ingredient, including, but not limited to, the substances listed in Florida's Schedule I controlled substance list.[85]
e) Shall not contain any synthetic alkaloids including synthetic mytragynine, synthetic 7-hydroxymitragynine, or any other synthetically derived compounds of the kratom plant.
f) Shall not claim to be of any medical benefit, or type of medically assisted treatment for opioids and/or alcohol addiction withdrawal symptoms.
g) Shall provide adequate labeling/directions necessary for safe and effective use by consumers, to include a recommended serving size.

2. No kratom producer, distributer, processor, or retailor shall distribute, sell, or expose for sale a kratom product to any individual under 21 years of age.

3. Violations:
   a) A processor that violates approved legislation is subject to an administrative fine of not more than $500 for the first offense and not more than $1,000 for the second or subsequent offense. Upon the request of a person to whom an administrative fine is issued, the director shall conduct a hearing in accordance with the (insert relevant code section).
   b) A retailer does not violate approved legislation if it is shown by a preponderance of the evidence that the retailer relied in good faith upon the representations of a manufacturer, processor, packer, or distributor of food represented to be a kratom product.

## Treatment and Recovery

**10. Expand naloxone availability among people who use drugs and their peers through hospital EDs and floor units (with little to no paperwork, and no separate trip to the pharmacy) for all hospital patients at risk of overdose, EMS/fire rescue naloxone leave-behind programs, CHDs, and 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.[86] It is conservatively estimated that one heroin overdose death is prevented for every 164 naloxone kits distributed.[87]

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.[88]

Bystanders are present in approximately 40 percent of opioid overdose deaths and approximately 65 percent of nonfatal overdoses.[89] Tragically however, when someone overdoses in the U.S. a 911 call is made less than 50 percent of the time.[90] Fear of police involvement is the most commonly cited reason for delaying or deterring a call for help for an overdose victim.[91]

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.[92] 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 Substance Abuse Prevention and Treatment 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. In 2021, DCF worked with the FPQC and FDOH to distribute naloxone kits postpartum to women immediately after delivery of their infant, along with provider education for

nurses and physicians. 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.[93] 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.[94]

In 2013, North Carolina began prioritizing naloxone distribution to populations at high risk for overdose, namely people who inject drugs, individuals receiving MAT, 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 percent decrease in opioid overdose death rates, and low distribution counties experienced an 11 percent decrease in opioid overdose death rates, relative to counties with no naloxone distribution.[95] 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 SEPs and drug treatment programs, but also through mobile vans, HIV education drop-in centers, pain management clinics, and single room occupancy hotels.[96]

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 percent. 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." [97]

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.[98] 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.[99]

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.[100] 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.[101]

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 who 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."[102]

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. Medicaid covers naloxone on the pharmacy and medical side without prior authorization.

In 2018, the Legislature appropriated $5 million in recurring State General Revenue funds to FDOH "for the purchase of emergency opioid antagonists to be made available to emergency responders."[103] The naloxone distribution program established with these funds is the HEROS

program. FDOH 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 FDOH's HEROS program are required to enter data into EMSTARS or ODMAP. Both 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."[104] 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 FDOH 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, FDOH is capable of mobilizing outreach teams through CHDs to engage individuals who use drugs in order to provide them with hepatitis A vaccines.

### 11. Encourage county commissions to establish Syringe Exchange Programs (SEPs).

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. SEPs are the most effective organizations at saving lives by distributing naloxone directly to people who use drugs. One of these SEPs, the IDEA Exchange in Miami-Dade County, has distributed 3,443 boxes of naloxone and documented 1,807 overdose reversals.[105] During the 2019 Legislative Session, the Legislature voted to expand SEPs statewide through the passage of Senate Bill 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 FDOH: Manatee and Palm Beach. FDOH is finalizing the data screens that will be used to capture the required SEP data elements. FDOH is collaborating with the National Alliance of State and Territorial AIDS

Directors to deliver virtual capacity building trainings for community-based organizations around the state who are interested in becoming an SEP.

**12. 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: Emergency Room Intervention Project grant program managed by the Florida Alcohol and Drug Abuse Association, multiple issues related to the establishment of ED warm handoff programs have surfaced. This includes 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.

AHCA’s Medicaid Quality Bureau is currently working with stakeholders on developing standardized discharge protocols. The bulk of this effort is concentrated on appropriate referrals, case management, and sharing of resources between hospitals and plans. Presently,

the initiative is not focused on individuals with OUD but high-risk individuals with potentially preventable hospital events.

Florida Medicaid health plans may be independently initiating or participating in collaborative arrangements with hospitals and emergency rooms to help facilitate efficient and effective warm handoffs from emergency room physicians to qualified health plan providers. In alignment with DCF efforts, and as an add on to current Medicaid Quality Bureau efforts, AHCA should consider encouraging the widespread adoption of such an approach across Medicaid health plans. This alignment would facilitate the implementation of strategic partnerships focused on identifying and removing barriers, integrating, and operationalizing processes and collaboratively implementing warm handoff programs to improve outcomes of the OUD population.

The Medicaid Quality Bureau has recently relaunched many of the quality initiatives with a new behavioral health lens. As part of AHCA's efforts around reducing NAS, recent policy changes now allow providers to be reimbursed for SBIRT. In 2021, AHCA partnered with local organizations to develop and promote a SBIRT CME training for providers. Additionally, plans are working to create internal processes that will have one direct contact for OUD/SUD information. This contact information will be shared with hospitals, doctor's offices, and MAT treatment centers.

**13. 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 SUD are being properly treated by medical professionals. The Accreditation Council for Graduate Medical Education 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 seven fellows training in the specialty, the University of South Florida has one fellow, and Larkin Community Hospital has three fellows. For addiction psychiatry fellowships, the University of South Florida has been approved for two positions and none are filled. The University of Miami/Jackson Health System has been approved for three positions and two are filled. [i]

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.[106] Out of the 52,684 physicians in Florida, only about 0.25 percent—one-quarter of one percent—are certified in addiction medicine.

**Figure K. Addiction Medicine Specialties among Florida Physicians.** [107]

| 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)** |

**14. Pass model legislation that will align Florida law with the federal 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 (Rhode Island); requirements for an annual report on claim denials, complaints and appeals (Virginia); requirement for plans to submit parity compliance information to the state insurance regulator and/or Medicaid agency (California, Massachusetts, Connecticut); requirement for the state agency to develop performance quality indicators to evaluate plan compliance (Vermont); state laws requiring coverage for prescription drugs for SUDs (Illinois); length of stay protections (Maryland); and requirements for peer-reviewed clinical review criteria related to medical necessity determinations (New York).[108] During the 2019 Legislative Session, three bills were introduced that would have better aligned Florida law with the federal parity legislation (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). 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.[109]

In Florida, the majority of Medicaid recipients receive their services through a managed care plan contracted with AHCA under the Statewide Medicaid Managed Care program. The current program 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.[110]

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.[111] 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 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.

**15. 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 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.

Federal changes in April 2021 enabled more providers to prescribe buprenorphine for up to 30 patients without meeting full waiver training requirements.[112]

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.

Specific to MAT, AHCA covers buprenorphine, naltrexone, and methadone to patients with SUD. AHCA has expanded access to MAT. AHCA has made buprenorphine tablets, Suboxone film, and Zubsolv tablets available through an automated process which looks for a diagnosis of OUD. If the diagnosis is found, the claim will pay at the pharmacy. If the diagnosis is not found, the pharmacy or physician can call the Florida Medicaid Pharmacy Benefit Manager help desk at 877-553-7481 and an override will be entered. The changes were implemented in July of 2021.

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 7 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.
- 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 naloxone 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 SUD. 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.[113, 114, 115]

Prior authorization limitations to MAT for SUD disproportionately affects pregnant and postpartum 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, 36 percent of Preferred Provider Organizations and more than half of Consumer Driven Products.[116]

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.[117]

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.[118, 119]

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. However, MAT is most certainly a centerpiece of managing opioid dependency in pregnancy, and it is best applied as part of a comprehensive treatment program that includes obstetric care, counseling, and wrap-around services.[120] There is still a significant treatment gap in pregnant women's receipt of substance abuse services overall. Barriers to care include lack of transportation, lack of childcare services, intensive time requirements, additional costs and co-pays, stigma, and regulatory roadblocks such as prior authorization.[121, 122]

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.[123]

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") would be 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 that MAT is affordable.[124] 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 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.[125] 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.[126]

**16. 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. It 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 4.9 million Medicaid recipients at a cost of over $26 billion annually for 2021 and has over 100,000 actively enrolled service providers. During State FY 2017–2018, AHCA spent over $3 billion dollars on prescribed drugs through the Florida Medicaid program. It shares similar goals with the Council and would be a valuable addition to its membership.

The 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 residents of Florida. The Office of Insurance Regulation also plays a significant role to ensure that Florida meets the requirements of the federal MHPAEA.

**17. Continue the statewide ROSC initiative designed to promote and enhance recovery efforts in Florida and support the continued development of the RCO 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 SUD 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.[127]

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 an RCO locator with information on each RCO can be found on the Floridians for Recovery website at: https://floridiansforrecovery.org/tst-locator/.[128]

**18. Evaluate the impact of Senate Bill 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 FDC provide an annual report on the number of individuals who applied for an exemption, actual time frames for the process, and number approved/disapproved with reasons for the decisions.**

The use of peers, or individuals with lived experience, has grown significantly in Florida over the past five years. Research has shown that recovery from SUD or mental illness is facilitated by the use of social support provided by peers.[129] 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.[130] 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 warm handoff programs encouraging, and at times transporting, individuals who have overdosed and received treatment in an ED 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 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.[131]

Recent legislation, Senate Bill 1120 (2020): Substance Abuse Services, addresses individuals who have been disqualified from employment with 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 may see additional use of peer specialists.

To be enrolled in Medicaid or to be employed by a managed care health plan an individual has to be screened under sections 408.809, 435.04(2) and 435.04(4), Florida Statutes. These have different disqualifying offenses than what is in the bill but are required for those employment or enrollment purposes. Therefore, even though the bill allows for individuals who work with an SUD treatment provider or recovery residence to be screened under different requirements to allow for individuals with convictions in their past to be able to obtain certification as peer specialists and find employment in prevention, treatment, and recovery programs, it does not change the screening requirements for employment with a managed care health plan or enrollment as a Medicaid provider.

# Data Collection and Surveillance

**19. 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.**

Passed in 1971 but effective in 1972, exactly fifty years ago, the Florida Legislature enacted a landmark piece of legislation—Chapter 394, Florida Statutes—that revolutionized how Florida cares for individuals struggling with mental illness. It also passed similar legislation in the 1970s—Chapter 397—to help individuals addicted to drugs and alcohol. More commonly known as Florida's Baker and Marchman Acts, these laws have been subject to numerous revisions since their enactments, but their fundamental structure has remained unchanged despite numerous case law and scientific developments. This proposal represents the first comprehensive reform of Florida's civil commitment system to reflect these developments and thus remove structural inefficiencies that are limiting access to treatment and causing state resources to be wasted.

While these Acts have remained relatively static since their passage, outside factors have changed dramatically. When the Baker Act was passed, it created a legal process to involuntarily hospitalize individuals primarily in state psychiatric hospitals. At the time, Florida had significantly more psychiatric hospital beds than it has today serving a state population of approximately 6.8 million people. According to DCF, there are a little over 2,600 state hospital beds of which two-thirds of admissions are forensic and 69 percent of bed capacity is occupied by individuals with forensic involvement serving a state population of approximately 21.3 million people.

In a study by three authors affiliated with the Department of Mental Health Law and Policy at the University of South Florida, they found that involuntary examinations under the Baker Act "are associated with increased risk of arrest." They concluded that "an involuntary examination is a significant signal that individuals with serious mental illness are at risk of arrest. In fact, each involuntary examination was associated with a 12 percent increase in the risk of arrest. An individual Baker Acted four times in a year has almost a 50 percent chance of being arrested in the near future."[132]

They further stated that "the results are striking for several reasons. Most important, involuntary civil commitment is designed to achieve both therapeutic and public safety outcomes. Our data, showing that use of the emergency examination provision of Florida's involuntary civil commitment statute is associated instead with an increased risk of arrest, suggest that the principal aims of civil commitment are not being met." In many cases, they conclude, "a Baker Act admission is just one more disjointed and uncoordinated intervention in the lives of people who because of various vulnerabilities are generally at risk for arrest." In many ways, Florida has an acute emergency crisis system for people with mental illnesses, but it lacks a treatment system to treat and manage these chronic illnesses.

Based on data from the Florida Mental Health Institute at the University of South Florida, there were nearly 211,000 involuntary examinations under the Baker Act in FY 2018–2019.[133] Involuntary Baker Act examinations more than doubled (115.31% increase) in the last 17 years. More than 50 percent (106,327) were initiated by law enforcement. More than half (55.8%) of all

involuntary examinations were based on evidence of “harm to self only.” One in five (21.52%) were based on “both harm to self and harm to others.” “Harm to others only” was the evidence for 5.6 percent of all involuntary examinations. In a one-year period, it is typical for 21 percent of people with an involuntary (Baker Act) examination to have two or more involuntary examinations.

While the people with two or more involuntary exams in a year account for 21 percent of the people with involuntary exams in that year, their involuntary exams account for 44 percent of the total involuntary exams for the year. While the people with five or more involuntary exams account for 2 percent of people with exams in that year, their exams account for 12 percent of the total involuntary exams.

Florida ranks 43rd nationally in access to mental health care, has the 4th highest rate of adults with mental illnesses who are uninsured, and at $39.55 per capita, spending for community-based treatment ranks 49th among all states and the District of Columbia. Ironically however, Florida is spending inordinate resources on acute mental health services.[134]

Costs to house people with mental illnesses in Florida’s jails, prisons, and forensic treatment facilities is minimally $2.2 million dollars per day or roughly $800 million dollars per year. The State of Florida currently spends 25 percent of its entire mental health services budget ($835,480,828)—approximately $212 million dollars annually—for 1,652 forensic beds in state mental health treatment facilities serving approximately 4,012 individuals; most of whom are receiving services to restore competency so that they can stand trial on criminal charges.[135,136]

Given the substantial overlap between mental illness and addiction, many of the changes recommended in the Baker Act reform legislation are also recommended for the Marchman Act.

Further, the recommendation is that similar data be collected by the Florida Mental Health Institute for the Marchman Act as is already collected for the Baker Act.

Improving access to treatment under this proposal will help Florida avoid unnecessary acute care spending and will afford those with serious mental illnesses an opportunity for hope and recovery.

### 20. Encourage Florida legislators to draft legislation/policy to support implementation of the 988 National Suicide Prevention Lifeline to begin July 16, 2022.

A new federal law requires states to have a 988 phone system in place by July 16, 2022. The new number is intended to provide an alternative to 911 or the current 10-digit national suicide hotline and should make it easier to find help during a mental health crisis. States are able to raise funds to support the 988 line, and those funds may be used for dedicated call centers, trained mobile response teams, and stabilization services for people in crisis. The new law requires that 988 calls be answered by certified suicide prevention call centers.[137]

The launch of 988 lines presents an opportunity to redirect crisis calls from the 911 system to a system specifically designed to streamline a connection for immediate help. For a fully operationalized 988 system, the state needs to connect robust 988 crisis hotline centers with other emergency systems, including emergency medical services, 911, Veteran’s Crisis Line, and other services. Additionally, the state should assess its capacity to effectively respond to this new system and should make plans to add additional treatment capacity where needed. The system should include data collection and report usage and services to help track progress

and make decisions based upon data. Mobile crisis teams can be an important part of such a system, and legislation could create a framework to support this by defining how the system will be funded, what components are required to be in place, what kind of professionals can serve on mobile crisis teams, and how treatment costs will be covered for those who may not have insurance.[138]

# References


[1] Ahmad FB, Rossen LM, Sutton P. Provisional drug overdose death counts. National Center for Health Statistics. 2021. Retrieved from https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

[2] U.S. Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2017 and 2018). *Table 30 – Selected Drug Use, Perceptions of Great Risk, Past Year Substance Use Disorder and Treatment, and Past Year Mental Health Measures in Florida, by Age Group: Percentages, Annual Averages Based on 2017-2018 NSDUHs*. Retrieved from https://www.samhsa.gov/data/report/2017-2018-nsduh-state-specific-tables.

[3] U.S. Substance Abuse and Mental Health Services Administration. (2015). *Behavioral Health Barometer: Florida, 2015*. Retrieved from www.samhsa.gov/data/sites/default/files/2015_Florida_BHBarometer.pdf

[4] U.S. Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2020). *Results from the 2019 National Survey on Drug Use and Health: Detailed Tables*. Table 7.66B Perceived Need for Substance Use Treatment and Whether Made an Effort to Get Treatment in Past Year among Persons Aged 12 or Older Classified as Needing But Not Receiving Substance Use Treatment, by Demographic Characteristics: Percentages, 2015-2019. Retrieved from https://www.samhsa.gov/data/report/2019-nsduh-detailed-tables

[5] Drugs Identified in Deceased Persons by Florida Medical Examiners 2019 Annual Report. Retrieved from https://www.fdle.state.fl.us/MEC/Publications-and-Forms/Documents/Drugs-in-Deceased-Persons/2019-Annual-Drug-Report.aspx

[6] Drugs Identified in Deceased Persons by Florida Medical Examiners 2020 Interim Report. Retrieved from https://www.fdle.state.fl.us/MEC/Publications-and-Forms/Documents/Drugs-in-Deceased-Persons/2020-Interim-Drug-Report-FINAL.aspx https://www.fdle.state.fl.us/MEC/Publications-and-Forms/Documents/Drugs-in-Deceased-Persons/2020-Interim-Drug-Report-FINAL.aspx

[7] Pitt, A. L., Humphreys, K., & Brandeau, M. L. (2018). Modeling Health Benefits and Harms of Public Policy Responses to the US Opioid Epidemic. *American Journal of Public Health, 108*(10), 1394-1400.

[8] Pitt, A. L., Humphreys, K., & Brandeau, M. L. (2018). Modeling Health Benefits and Harms of Public Policy Responses to the US Opioid Epidemic. *American Journal of Public Health, 108*(10), 1394-1400.

[9] Pitt, A. L., et al. (2018). Modeling Health Benefits and Harms of Public Policy Responses to the US Opioid Epidemic. *American Journal of Public Health, 108*(10), 1394-1400.

[10] Walley, A. Y., et al. (2013). Opioid Overdose Rates and Implementation of Overdose Education and Nasal Naloxone Distribution in Massachusetts: Interrupted Time Series Analysis. *BMJ, 346*, f174; Doe-Simkins, M., et al. (2009). Saved by the Nose: Bystander-administered Intranasal Naloxone Hydrochloride for Opioid Overdose. *American Journal of Public Health, 99*, 788-791; Enteen, L., et al. (2010). Overdose Prevention and Naloxone Prescription for Opioid Users in San Francisco. *Journal of Urban Health, 87*, 931-941; Maxwell, S., et al. (2006). Prescribing Naloxone to Actively Injecting Heroin Users: A Program to Reduce Heroin Overdose Deaths. *Journal of Addictive Diseases, 25*, 89-96; Naumann, R.B., et al. (2019). Impact of a Community-Based Naloxone Distribution Program on Opioid Overdose Death Rates. *Drug and Alcohol Dependence, 204*; Davidson, P. J., et al. (2015). Naloxone Distribution to Drug Users in California and Opioid-Related Overdose Deaths. *Drug and Alcohol Dependence, 156*, e2-e101; Coffin, P. O. & Sullivan, S. D. (2013). Cost-effectiveness of Distributing Naloxone to Heroin Users for Lay Overdose Reversal. *Annals of Internal Medicine, 158*, 1-9.

[11] Bennett, A. S., et al. (2018). From Peers to Lay Bystanders: Findings from a Decade of Naloxone Distribution in Pittsburgh, PA. *Journal of Psychoactive Drugs, 50*(3), 240-246.

[12] Giglio, R. E., et al. (2015). Effectiveness of Bystander Naloxone Administration and Overdose Education Programs: A Meta-Analysis. *Injury Epidemiology, 2*(1), 10; Clark, A. K., et al. (2014). A Systematic Review of Community Opioid Overdose Prevention and Naloxone Distribution Programs. *Journal of Addiction Medicine, 8*(3), 153-163; McDonald, R. & Strang, J. (2016). Are Take-home Naloxone Programmes Effective? Systematic Review Utilizing Application of the Bradford Hill Criteria. *Addiction, 111*, 1177-1187; Lewis, C. R., et al. (2017). Intranasal Naloxone and Related Strategies for Opioid Overdose Intervention by Nonmedical Personnel: A Review. *Substance Abuse and Rehabilitation, 8*, 79-95.

[13] Santo, T., Clark, B., Hickman, M. et al. (2021). Association of Opioid Agonist Treatment with All-Cause Mortality and Specific Causes of Death Among People with Opioid Dependence: A Systematic Review and Meta-analysis. *JAMA Psychiatry*; Degenhardt, L., et al. (2011). Mortality among Regular or Dependent Users of Heroin and Other Opioids: A Systematic Review and Meta-Analysis of Cohort Studies. *Addiction, 106*, 32-51; White, M., et al. (2015). Fatal Opioid Poisoning: A Counterfactual Model to Estimate the Preventive Effect of Treatment for Opioid Use Disorder in England. *Addiction, 110*(8), 1321-1329; Pierce, M., et al. (2016). Impact of Treatment for Opioid Dependence on Fatal Drug-Related Poisoning: A National Cohort Study in England. *Addiction, 111*(2), 298-308; Sordo, L., et al. (2017). Mortality Risk During and After Opioid Substitution Treatment: Systematic Review and Meta-Analysis of Cohort Studies. *BMJ, 357*, j1550.

[14] Wakeman, S. E., et al. (2020). Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder. *JAMA Network Open*, 3(2).

[15] Mattick, R. P., et al. (2009). Methadone Maintenance Therapy versus No Opioid Replacement Therapy for Opioid Dependence. *The Cochrane Library*, Issue 3; Mattick, R. P., et al. (2014). Buprenorphine Maintenance versus Placebo or Methadone Maintenance for Opioid Dependence. *Cochrane Library*, Issue 6; Nielsen, S., et al. (2016). Opioid Agonist Treatment for Pharmaceutical Opioid Dependent People. *Cochrane Library*, Issue 5; National Academies of Sciences, Engineering, and Medicine. (2019). *Medications for Opioid Use Disorder Save Lives*.

[16] Substance Abuse and Mental Health Services Administration. (2018). *Treatment Improvement Protocol 63: Medications for Opioid Use Disorder*. Publication No. SMA 18-5063; National Academies of Sciences, Engineering, and Medicine. (2019). *Medications for Opioid Use Disorder Save Lives*; American Society of Addiction Medicine. (2020). *The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder (2020 Focused Update)*; Winograd, R. P., et al. (2019). The Case for a Medication First Approach to the Treatment of Opioid Use Disorder. *American Journal of Drug and Alcohol Abuse, 45*(4), 333-340.

[17] Florida Department of Children and Families. (2020). *2020 Florida Youth Substance Abuse Survey State Report*. Retrieved from https://www.myflfamilies.com/service-programs/samh/prevention/fysas/2020/docs/2020%20Statewide%20FYSAS%20Report%20per%20Section%20C2-2.3.pdf.

[18] Florida Department of Children and Families. (2013). *2013 Florida Youth Substance Abuse Survey ATOD Prevalence Tables*. Retrieved from https://www.myflfamilies.com/service-programs/samh/prevention/fysas/2013/docs/2013FYSASStatewideTables.pdf.

[19] Florida Department of Children and Families. (2020). *2020 Florida Youth Substance Abuse Survey State Report*. Retrieved from https://www.myflfamilies.com/service-programs/samh/prevention/fysas/2020/docs/2020%20Statewide%20FYSAS%20Report%20per%20Section%20C2-2.3.pdf.

[20] Centers for Disease Control and Prevention. (2019). *Preventing Adverse Childhood Experiences (ACEs): Leveraging the Best Available Evidence*. Retrieved from https://www.cdc.gov/violenceprevention/pdf/preventingACES.pdf.

[21] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2020). *Table 29: Selected Drug Use, Perceptions of Great Risk, Past Year Substance Use Disorder and Treatment, and Past Year Mental Health Measures in Florida, by Age Group: Percentages, Annual Averages Based on 2018-2019 NSDUHs*. Retrieved from https://www.samhsa.gov/data/sites/default/files/reports/rpt32885/2019NSDUHsaeSpecStates/NSDUHsaeFlorida2019.pdf.

[22] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2020). Table 29: Selected Drug Use, Perceptions of Great Risk, Past Year Substance Use Disorder and Treatment, and Past Year Mental Health Measures in Florida, by Age Group: Percentages, Annual Averages Based on 2018-2019 NSDUHs. Retrieved from https://www.samhsa.gov/data/sites/default/files/reports/rpt32885/2019NSDUHsaeSpecStates/NSDUHsaeFlorida2019.pdf.

[23] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2020). *Results from the 2019 National Survey on Drug Use and Health: Detailed Tables*. Table 5.35B Perceived Need for Substance Use Treatment and Whether Made an Effort to Get

Treatment in Past Year among Persons Aged 12 or Older Classified as Needing But Not Receiving Substance Use Treatment, by Demographic Characteristics: Percentages, 2018 and 2019. Retrieved from https://www.samhsa.gov/data/report/2019-nsduh-detailed-tables.

[24] Substance Abuse and Mental Health Services Administration. (2021). *Substance Abuse & Mental Health Data Archive - Interactive NSDUH State Estimates*. Retrieved from https://pdas.samhsa.gov/saes/state.

[25] Florida Department of Children and Families. (2020). *Assessment of Behavioral Health Services in Florida – Fiscal Years 2020-21*. Retrieved from https://www.myflfamilies.com/service-programs/samh/publications/docs/2020-21%20Assessment%20of%20Behavioral%20Health%20Services%20in%20Florida.pdf.

[26] Degenhardt, L., Bucello, C., Mathers, B., Briegleb, C., Ali, H., Hickman, M., & McLaren, J. (2011). Mortality among Regular or Dependent Users of Heroin and Other Opioids: A Systematic Review and Meta-Analysis of Cohort Studies. *Addiction, 106*, 32-51; White, M., Burton, R., Darke, S., Eastwood, B., Knight, J., Millar, T., Musto, V., & Marsden, J. (2015). Fatal Opioid Poisoning: A Counterfactual Model to Estimate the Preventive Effect of Treatment for Opioid Use Disorder in England. *Addiction, 110*(8), 1321-1329; Pierce, M., Bird, S. M., Hickman, M., Marsden, J., Dunn, G., Jones, A., & Millar, T. (2016). Impact of Treatment for Opioid Dependence on Fatal Drug-Related Poisoning: A National Cohort Study in England. *Addiction, 111*(2), 298-308; Sordo, L., Barrio, G., Bravo, M. J., Indave, B. I., Degenhardt, L., Wiessing, L., Ferri, M., & Pastor-Barriuso, R. (2017). Mortality Risk During and After Opioid Substitution Treatment: Systematic Review and Meta-Analysis of Cohort Studies. *BMJ, 357*, j1550.

[27] Platt, L. et al. (2017). Needle and Syringe Programmes and Opioid Substitution Therapy for Preventing HCV Transmission Among People Who Inject Drugs: Findings from a Cochrane Review and Meta-Analysis. *Addiction, 113*, 545-563; Ksobiech, K. (2003). A Meta-Analysis of Needle Sharing, Lending, and Borrowing Behaviors of Needle Exchange Program Attenders. *AIDS Education and Prevention, 15*(3), 257-268; Wodak, A. & Cooney, A. (2006). Do Needle Syringe Programs Reduce HIV Infection Among Injecting Drug Users: A Comprehensive Review of the International Evidence. *Substance Use & Misuse, 41*, 777-813; Hagan, H., Jarlais, D. C., Friedman, S. R., Purchase, D., & Alter, M. J. (1995). Reduced Risk of Hepatitis B and Hepatitis C Among Injecting Drug Users Participating in the Tacoma Syringe-Exchange Program. *American Journal of Public Health, 85*, 1531–1537; Hagan, H., Pouget, E. R., Des Jarlais, D. C., & Lelutiu-Weinberger, C. (2008). Meta Regression of Hepatitis C Virus Infection in Relation to Time Since Onset of Illicit Drug Injection: The Influence of Time and Place. *American Journal of Epidemiology, 168*, 1099–1109; Turner, K. M., Hutchinson, S., Vickerman, P., Hope, V., Craine, N., Palmateer, N., May, M., Taylor, A., De Angelis, D., Cameron, S., Parry, J., Lyons, M., Goldberg, D., Allen, E., & Hickman, M. (2011). The Impact of Needle and Syringe Provision and Opiate Substitution Therapy on the Incidence of Hepatitis C Virus in Injecting Drug Users: Pooling of UK Evidence. *Addiction, 106*(11), 1978–1988; MacDonald, M. et al. (2003). Effectiveness of Needle and Syringe Programmes for Preventing HIV Transmission. *International Journal of Drug Policy, 14*(5-6), 353-357.

[28] Nguyen, T. Q., Weir, B. W., Pinkerton, S. D., Des Jarlais, D. C., & Holtgrave, D. (2012). *Increasing Investment in Syringe Exchange is Cost Saving HIV Prevention: Modeling Hypothetical Syringe Coverage Levels in the United States*. 19th International AIDS Conference, Washington D.C; Gold, M., Gafni, A., Nelligan, P., & Millson, P. (1997). Needle Exchange Programs: An Economic Evaluation of a Local Experience. *Canadian Medical Association Journal, 157*, 255-262.

[29] Hagan, H., McGough, J. P., Thiede, H., Hopkins, S., Duchin, J., & Alexander, E. R. (2000). Reduced Injection Frequency and Increased Entry and Retention in Drug Treatment Associated with Needle-Exchange Participation in Seattle Drug Injectors. *Journal of Substance Abuse Treatment, 19*, 247-252; Kuo, I., Brady, J., Butler, C., Schwartz, R., Brooner, R., Vlahov, D., & Strathdee, S. A. (2003). Feasibility of Referring Drug Users from a Needle Exchange Program into an Addiction Treatment Program: Experience with a Mobile Treatment Van and LAAM Maintenance. *Journal of Substance Abuse Treatment, 24*, 67-74; Kidorf, M., King, V. L., Neufeld, K., Peirce, J., Kolodner, K., & Brooner, R. K. (2009). Improving Substance Abuse Treatment Enrollment in Community Syringe Exchangers. *Addiction, 104*, 786-795; Brooner, R., Kidorf, M., King, V., Beilenson, P., Svikis, D., & Vlahov, D. (1998). Drug Abuse Treatment Success Among Needle Exchange Participants. *Public Health Reports,*

*113*(Supplement 1), 129-139; Heimer, R. (1998). Can Syringe Exchange Serve as a Conduit to Substance Abuse Treatment? *Journal of Substance Abuse Treatment, 15*, 183-191; Strathdee, S. A., Ricketts, E. P., Huettner, S., Cornelius, L., Bishai, D., Havens, J. R., Beilenson, P., Rapp, C., Lloyd, J. J., Latkin, C. A. (2006). Facilitating Entry into Drug Treatment Among Injection Drug Users Referred from a Needle Exchange Program: Results from a Community-Based Behavioral Intervention Trial. *Drug and Alcohol Dependence, 83*, 225-232; Shah, N. G., Celentano, D. D., Vlahov, D., Stambolis, V., Johnson, L., Nelson, K. E., Strathdee, S. A. (2000). Correlates of Enrollment in Methadone Maintenance Treatment Programs Differ by HIV-Serostatus. *AIDS, 14*, 2035-2043; Strathdee, S. A., Celentano, D. D., Shah, N., Lyles, C., Stambolis, V. A., Macalino, G., Nelson, K., & Vlahov, D. (1999). Needle-Exchange Attendance and Health Care Utilization Promote Entry into Detoxification. *Journal of Urban Health, 76*, 448-460.

[30] 2020 Annual Syringe Exchange Program Report, October 1, 2020

[31] Laws of Florida. (2019). *2019-143* (Committee Substitute for Committee Substitute for Senate Bill No. 366). Retrieved from http://laws.flrules.org/2019/143.

[32] Final Report; Association of State and Territorial Health Officials (ASTHO) Opioid, Maternal Health, and Neonatal Abstinence Syndrome Initiative (OMNI) Local Enhancement Project 2019-2020

[33] Electronic-Florida Online Reporting of Controlled Substances Evaluation (E-FORCSE), 2019-2020. Prescription Drug Monitoring Program Annual Report. December 1, 2020.

[34] Fontaine, M. (2019) Executive Advisor, Florida Behavioral Health Association

[35] United States Drug Enforcement Administration. September 30,2021 *Department of Justice and DEA Announce Seizures of Historic Amounts of Deadly Fentanyl-Laced Fake Pills in Public Safety Surge to Protect U.S. Communities.* Retrieved from https://www.dea.gov/press-releases/2021/09/30/department-justice-and-dea-announce-seizures-historic-amounts-deadly-2

[36] U.S. Customs and Border Protection. FY 2020. *Drug Seizure Statistics*, Retrieved from https://www.cbp.gov/newsroom/stats/drug-seizure-statistics

[37] U.S. Customs and Border Protection. FY 2020. *Drug Seizure Statistics*, Retrieved from https://www.cbp.gov/newsroom/stats/drug-seizure-statistics https://www.cbp.gov/newsroom/stats/drug-seizure-statistics

[38] About Screening Brief Intervention, and Referral to Treatment (SBIRT). (Last Updated 2020, April 16). *SAMHSA Substance Abuse and Mental Health Services Administration*. Retrieved from https://www.samhsa.gov/sbirt/about

[39] Florida Drug Control Strategy 1999; Office of Drug Control; Executive Office of the Governor; Page 1-6

[40] Florida Drug Control Strategy 1999-2005; Office of Drug Control; Executive Office of the Governor

[41] Nirmita Panchal, Rabah Kamal. *The Implications of COVID-19 for Mental Health and Substance Use - Issue Brief*. 21 Aug. 2020, Retrieved from www.kff.org/report-section/the-implications-of-covid-19-for-mental-health-and-substance-use-issue-brief/.

[42] Substance Abuse and Mental Health Services Administration (2020), Behavioral Health Workforce Report

[43] Behavioral Health Technician job posting, August 2021.Retrieved from Indeed, https://indeed.com/jobs?q=behavioral%20health%20technician&l=Florida&vjk=dcedead1a4888bf0, August 2021

[44] Behavioral Health Technician Job posting, October 2021. Retrieved from ZipRecruiter. https://www.ziprecruiter.com/candidate/search?radius=25&search=behavioral+health%3Dtechnician=technician&location=FL, August 2021

[45] Bureau of Labor Statistics, Occupational Employment and Wages, May 2020, 29-2053 Psychiatric Technicians. https://www.bls.gov/oes/current/oes292053.htm#(1)

[46] Florida Behavioral Health Association, 2021 FBHA Turnover Survey

[47] Leading a Bold Shift in Mental Health and Substance Use Care, CCBHC Impact Report, May 2021, National Council for Mental Wellbeing

[48] FYSAS - Florida Department of Children and Families (www.myflfamilies.com)

[49] Monitoring the Future Study: Trends in Prevalence of Various Drugs | National Institute on Drug Abuse (NIDA)

[50] "The Real Cost": A Cost-Effective Approach | FDA

[51] The Real Cost Campaign | FDA
[52] 2020 ONDCP National Drug Control Strategy (www.legislativeanalysis.org) Prevention Partnership Grants (PPG) - Florida Department of Children and Families (www.myflfamilies.com)
[53] 2020 ONDCP National Drug Control Strategy (www.legislativeanalysis.org) Prevention Partnership Grants (PPG) - Florida Department of Children and Families (www.myflfamilies.com)
[54] Grants | SAMHSA
[55] Office of National Drug Control Policy | The White House
[56] Florida's mental-health epidemic reaches crisis point - NAMI Greater Orlando, Inc. - NAMI Greater Orlando, Inc. (namigo.org)
[57] Beyond the Pandemic: Long-Term Changes and Challenges for Health in Florida (floridataxwatch.org)
[58] Evidence-Based Practices Resource Center | SAMHSA
[59] 24754999, 6A-1.094124 - Florida Administrative Rules, Law, Code, Register - FAC, FAR, eRulemaking (flrules.org)
[60] U.S. Centers for Disease Control and Prevention. (2013). Adverse childhood experiences (ACE) study: About the study. Retrieved from http://www.cdc.gov/ace/about.htm
[61] Shonkoff, J. P. & Garner, A. S. (2012) Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood, Adoption, and Dependent Care, Section on Developmental and Behavioral Pediatrics. The lifelong effects of early childhood adversity and toxic stress. Amer Academy of Pediatrics, 129(1), 232-264.
[62] Dube, S. R., Anda, R.F., Felitti, V. J., Edwards, V. J., & Croft, J. B. (2002). Adverse Childhood Experiences and persons alcohol abuse as an adult. Addictive Behaviors. 25(5), 713-25.
[63] Dube, S.R., Felitti, V.J., Dong, M., Chapman, D.P., Giles, W.H., and Anda, R.R. (2003). Childhood abuse, neglect and household dysfunction and the risk of illicit drug use: The Adverse Childhood Experiences Study. Pediatrics (111)3, 564-72. Retrieved https://pubmed.ncbi.nlm.nih.gov/12612237/
[64] Felitti, V. J. (2003). Origins of Addiction. Retrieved from: https://www.acesconnection.com/blog/dr-vincent-felitti-the-origins-of-addiction-evidence-fromthe-adverse-childhood-experiences-study
[65] Dube, S. R., Anda, R.F., Felitti, V. J., Edwards, V. J., & Croft, J. B. (2002). Adverse Childhood Experiences and persons alcohol abuse as an adult. Addictive Behaviors. 25(5), 713-25.
[66] Felitti, V. J. (2003). Origins of Addiction. Retrieved from: https://www.acesconnection.com/blog/dr-vincent-felitti-the-origins-of-addiction-evidence-fromthe-adverse-childhood-experiences-stud
[67] https://medschool.cuanschutz.edu/family-medicine/about/news/disrupting-the-status-quo-blog/disrupting-the-status-quo/stigma%27s-impact-on-health
[68] 2020-Interim-Drug-Report-FINAL.aspx (state.fl.us)
[69] Office of Medical Marijuana Use (OMMU). Weekly Update (July 30, 2021). Retrieved From https://knowthefactsmmj.com/about/weekly-updates
[70] Florida State Legislature. Chapter 381.986 - Medical use of marijuana. Retrieved From http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0300-0399/0381/Sections/0381.986.html
[71] Truth Initiative. Tobacco Industry Master Settlement Agreement. Retrieved From https://truthinitiative.org/who-we-are/our-history/master-settlement-agreement
[72] Public Health Law Center. The Master Settlement Agreement: An Overview. Retrieved From https://www.publichealthlawcenter.org/sites/default/files/resources/MSA-Overview-2018.pdf
[73] U.S. Food & Drug Administration. The Real Cost Campaign. Retrieved from The Real Cost Campaign | FDA
[74] Florida Department of Children and Families. 2020 Florida Youth Substance Abuse Survey State Report. Retrieved from FYSAS - Florida Department of Children and Families (myflfamilies.com)
[75] Substance Abuse and Mental Health Services Administration. Know the Risks of Marijuana. Retrieved From https://www.samhsa.gov/marijuana
[76] U.S. Department of Health & Human Services - Office of Population Affairs. Substance Use in Adolescence. Retrieved From https://www.hhs.gov/ash/oah/adolescent-development/substance-use/marijuana/risks/index.html

[77] Drug Enforcement Administration. 2017. *Drugs of Abuse*. Retrieved from https://www.dea.gov/sites/default/files/drug_of_abuse.pdf https://www.dea.gov/sites/default/files/drug_of_abuse.pdf

[78] CNN Health. February 21, 2019. *Poison control calls for kratom increased from one a month to two a day, study says*. Retrieved from https://www.cnn.com/2019/02/21/health/Kratom-exposures-poison-control-study/index.html https://www.cnn.com/2019/02/21/health/Kratom-exposures-poison-control-study/index.html

[79] Science Daily. February 21, 2019. *Study Finds Increase in calls to U.S. Poison Control Centers for Kratom exposure*. Retrieved from https://www.sciencedaily.com/releases/2019/02/190221083427.htm https://www.sciencedaily.com/releases/2019/02/190221083427.htm

[80] U.S. Food and Drug Administration. September 11, 2019. *FDA and Kratom*. Retrieved from https://www.fda.gov/news-events/public-health-focus/fda-and-Kratom https://www.fda.gov/news-events/public-health-focus/fda-and-Kratom

[81] U.S. Food and Drug Administration. September 11, 2018. *Statement from FDA Commissioner Scott Gottlieb, M.D., on new warning letters FDA is issuing to companies marketing kratom with unproven medical claims; and the agency's ongoing concerns about kratom*. Retrieved from https://www.fda.gov/news-events/press-announcements/statement-fda-commissioner-scott-gottlieb-md-new-warning-letters-fda-issuing-companies-marketing https://www.fda.gov/news-events/press-announcements/statement-fda-commissioner-scott-gottlieb-md-new-warning-letters-fda-issuing-companies-marketing

[82] Drugs Identified in Deceased Persons by Florida Medical Examiners 2019 Annual Report. Retrieved from https://www.fdle.state.fl.us/MEC/Publications-and-Forms/Documents/Drugs-in-Deceased-Persons/2019-Annual-Drug-Report.aspx https://www. fdle.state.fl.us/MEC/Publications-and-Forms/Documents/Drugs-in-Deceased-Persons/2019-Annual-Drug-Report.aspx

[83] Drugs Identified in Deceased Persons by Florida Medical Examiners 2020 Interim Report. Retrieved from https://www.fdle.state.fl.us/MEC/Publications-and-Forms/Documents/Drugs-in-Deceased-Persons/2020-Interim-Drug-Report-FINAL.aspx www.fdle.state.fl.us/MEC/Publications-and-Forms/Documents/Drugs-in-Deceased-Persons/2020-Interim-Drug-Report-FINAL.aspx

[84] New York State Senate. Senate Bill S6104 2019-2020 Legislative Session. Retrieved from https://www.nysenate.gov/legislation/bills/2019/s6104 https://www.nysenate.gov/legislation/bills/2019/s6104

[85] Florida Schedule 1 Controlled Substance List. Florida Statute 0893.03. Retrieved from http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&URL=0800-0899/0893/Sections/0893.03.html https://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&URL=0800-0899/0893/Sections/0893.03.html

[86] Walley, A. Y., Xuan, Z., Hackman, H. H., Quinn, E., Doe-Simkins, M., Sorensen-Alawad, A., et al. (2013). Opioid Overdose Rates and Implementation of Overdose Education and Nasal Naloxone Distribution in Massachusetts: Interrupted Time Series Analysis. *BMJ, 346*, f174; Doe-Simkins, M., Walley, A. Y., Epstein, A., & Moyer, P. (2009). Saved by the Nose: Bystander-administered Intransal Naloxone Hydrochloride for Opioid Overdose. *American Journal of Public Health, 99*, 788-791; Enteen, L., Bauer, J., McLean, R., Wheeler, E., Huriaux, E., Kral, A. H., et al. (2010). Overdose Prevention and Naloxone Prescription for Opioid Users in San Francisco. *Journal of Urban Health, 87*, 931-941; Maxwell, S., Bigg, D., Stanczykiewicz, K., & Carlberg-Racich, S. (2006). Prescribing Naloxone to Actively Injecting Heroin Users: A Program to Reduce Heroin Overdose Deaths. *Journal of Addictive Diseases, 25*, 89-96; Naumann, R.B., Durrance, C.P., Ranapurwala, S.I., Austin, A.E., Proescholdbell, S., Childs, R., Marshall, S.W., Kansagra, S., & Shanahan, M.E. (2019). Impact of a Community-Based Naloxone Distribution Program on Opioid Overdose Death Rates. *Drug and Alcohol Dependence, 204.*

[87] Coffin, P. O. & Sullivan, S. D. (2013). Cost-effectiveness of Distributing Naloxone to Heroin Users for Lay Overdose Reversal. *Annals of Internal Medicine, 158*, 1-9.

[88] U.S. Food and Drug Administration. (2019). "Statement on continued efforts to increase availability of all forms of naloxone to help reduce opioid overdose deaths." FDA Press Release. https://www.fda.gov/news-events/press-announcements/statement-continued-efforts-increase-availability-all-forms-naloxone-help-reduce-opioid-overdose

[89] Mattson, C. L., O'Donnell, J., Kariisas, M., Seth, P., Scholl, L., & Gladden, R. M. (2018). Opportunities to Prevent Overdose Deaths Involving Prescription and Illicit Opioids, 11, States, July 2016-June 2017. *MMWR, 67*(34), 945-957; Bohnert, A. S. B., Tracy, M., & Galea, S. (2012). Characteristics of Drug Users Who Witness Many Overdoses: Implications for Overdose Prevention. *Drug and Alcohol Dependence, 120*(1-3), 168-173.

[90] McLean, K. (2018). Good Samaritans vs. Predatory Peddlers: Problematizing the War on Overdose in the United States. *Journal of Crime and Justice, 41*(1), 1-13; Doe-Simkins, M., Quinn, E., Xuan, Z., Sorensen-Alawad, A., Hackman, H., Ozonoff, A., & Walley, A. Y. (2014). Overdose Rescues by Trained and Untrained Participants and Change in Opioid Use Among Substance-Using Participants in Overdose Education and Naloxone Distribution Programs: A Retrospective Cohort Study. *BMC Public Health, 14*(1); Sherman, S. G., Gann, D. S., Scott, G., et al. (2008). A Qualitative Study of Overdose Responses Among Chicago IDUs. *Harm Reduction Journal, 5*(1), 2; Baca, C. T. & Grant, K. J. (2007). What Heroin Users Tell Us About Overdose. *Journal of Addictive Diseases, 26*(4), 63-68; Tracy, M., Piper, T. M., Ompad, D., et al. (2005). Circumstances of Witnessed Drug Overdose in New York City: Implications for Intervention. *Drug and Alcohol Dependence, 79*, 181-190; Tobin, K. E., Davey, M. A., & Latkin, C. A. (2005). Calling Emergency Medical Services During Drug Overdose: An Examination of Individual, Social, and Setting Correlates. *Addiction, 100*(3), 397-404.

[91] Koester, S., Mueller, S. R., Raville, L., Langeggar, S., & Binswanger, I. A. (2017). Why Are Some People Who Have Received Overdose Education and Naloxone Reticent to Call Emergency Medical Services in the Event of Overdose? *International Journal of Drug Policy, 48*, 115-124; McLean, K. (2018). Good Samaritans vs. Predatory Peddlers: Problematizing the War on Overdose in the United States. *Journal of Crime and Justice, 41*(1), 1-13; Zadoretzky, C., McKnight, C., Bramson, H., Des Jarlais, D., Phillips, M., Hammer, M., & Cala, M. E. (2017). The New York 911 Good Samaritan Law and Opioid Overdose Prevention Among People Who Inject Drugs. *World Medical & Health Policy, 9*(3), 318-340; Follett, K. M., Council, W. R. C. P., Piscitelli, A., Parkinson, M., & Munger, F. (2014). Barriers to Calling 9-1-1 During Overdose Emergencies in a Canadian Context. *Critical Social Work, 15*(1), 18–28; Bennett, A. S., Bell, A., Tomedi, L., Hulsey, E. G., & Kral, A. H. (2011). Characteristics of an Overdose Prevention, Response, and Naloxone Distribution Program in Pittsburgh and Allegheny County, Pennsylvania. *Journal of Urban Health, 88*(6), 1020–1030; Sherman, S. G., Gann, D. S., Scott, G., et al. (2008). A Qualitative Study of Overdose Responses among Chicago IDUs. *Harm Reduction Journal, 5*(1), 2; Pollini, R. A., McCall, L., Mehta, S. H., Celentano, D. D., Vlahov, D., & Strathdee, S. A. (2006). Response to Overdose Among Injection Drug Users. *American Journal of Preventive Medicine, 31*(3), 261-264; Seal, K. H., Downing, M., Kral, A. H., et al. (2003). Attitudes about Prescribing Take-home Naloxone to Injection Drug Users for the Management of Heroin Overdose: A Survey of Street-recruited Injectors in the San Francisco Bay Area. *Journal of Urban Health, 80*(2), 291-301; Tracy, M., Piper, T. M., Ompad, D., et al. (2005). Circumstances of Witnessed Drug Overdose in New York City: Implications for Intervention. *Drug and Alcohol Dependence, 79*, 181-190; Baca, C. T., & Grant, K. J. (2007). What Heroin Users Tell Us About Overdose. *Journal of Addictive Diseases, 26*(4), 63-68; Wagner, K. D., Harding, R. W., Kelley, R., Labus, B., Verdugo, S. R., Copulsky, E., Bowles, J. M., Mittal, M. L., & Davidson, P. J. (2019). Post-overdose Interventions Triggered by Calling 911: Centering the Perspectives of People Who Use Drugs. PLOS ONE, 14(10), e0223823. Retrieved from https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0223823.

[92] Giglio, R. E., Li, G., & DiMaggio, C. J. (2015). Effectiveness of Bystander Naloxone Administration and Overdose Education Programs: A Meta-Analysis. *Injury Epidemiology, 2*(1), 10; Clark, A. K., Wilder, C. M., & Winstanley, E. L. (2014). A Systematic Review of Community Opioid Overdose Prevention and Naloxone Distribution Programs. *Journal of Addiction Medicine, 8*(3), 153-163; McDonald, R. & Strang, J. (2016). Are Take-home Naloxone Programmes Effective? Systematic Review Utilizing Application of the Bradford Hill Criteria. *Addiction, 111*, 1177-1187; Lewis, C. R., Vo, H. T., & Fishman, M. (2017). Intranasal Naloxone and Related Strategies for Opioid Overdose Intervention by Nonmedical Personnel: A Review. *Substance Abuse and Rehabilitation, 8*, 79-95; Green, T. C., Heimer, R., & Grau, L. E. (2008). Distinguishing Signs of Opioid Overdose and Indication for Naloxone: An Evaluation of Six Overdose Training and Naloxone Distribution Programs in the United States. *Addiction, 103*, 979-989; Jones, J. D., Roux, P., Stancliff, S., Matthews, W., & Comer, S. D. (2014). Brief Overdose Education

Can Significantly Increase Accurate Recognition of Opioid Overdose Among Heroin Users. *International Journal of Drug Policy, 25*, 166-170.

[93] University of Miami, Miller School of Medicine. (2019). IDEA Exchange FDOH Quarterly Report (July 12, 2019).

[94] Walley, A. Y., Xuan, Z., Hackman, H. H., Quinn, E., Doe-Simkins, M., Sorensen-Alawad, A., et al. (2013). Opioid Overdose Rates and Implementation of Overdose Education and Nasal Naloxone Distribution in Massachusetts: Interrupted Time Series Analysis. *BMJ, 346*, f174.

[95] Naumann, R. B., Durrance, C. P., Ranapurwala, S. I., Austin, A. E., Proescholdbell, S., Childs, R., Marshall, S. W., Kansagra, S., & Shanahan, M. E. (2019). Impact of a Community-Based Naloxone Distribution Program on Opioid Overdose Death Rates. *Drug and Alcohol Dependence, 204.*

[96] Doe-Simkins, M., Walley, A. Y., Epstein, A., & Moyer, P. (2009). Saved by the Nose: Bystander-administered Intransal Naloxone Hydrochloride for Opioid Overdose. *American Journal of Public Health, 99*, 788-791; Enteen, L., Bauer, J., McLean, R., Wheeler, E., Huriaux, E., Kral, A. H., et al. (2010). Overdose Prevention and Naloxone Prescription for Opioid Users in San Francisco. *Journal of Urban Health, 87*, 931-941; Maxwell, S., Bigg, D., Stanczykiewicz, K., & Carlberg-Racich, S. (2006). Prescribing Naloxone to Actively Injecting Heroin Users: A Program to Reduce Heroin Overdose Deaths. *Journal of Addictive Diseases, 25*, 89-96; Davidson, P. J., Wheeler, E., Proudfoot, J., Xu, R., & Wagner, K. D. (2015). Naloxone Distribution to Drug Users in California and Opioid-Related Overdose Deaths. *Drug and Alcohol Dependence, 156*, e2-e101.

[97] Keane, C., Egan, J. E., & Hawk, M. (2018). Effects of Naloxone Distribution to Likely Bystanders: Results of an Agent-Based Model. *International Journal of Drug Policy, 55*, 61-69.

[98] Townsend, T., Blostein, F., Doan, T., Madson-Olson, S., Galecki, P., & Hutton, D. W. (2019). Cost-Effectiveness Analysis of Alternative Naloxone Distribution Strategies: First Responder and Lay Distribution in the United States. *International Journal of Drug Policy* (in press).

[99] Bennett, A. S., Bell, A., Doe-Simkins, M., Elliott, L., Pouget, E., & Davis, C. (2018). From Peers to Lay Bystanders: Findings from a Decade of Naloxone Distribution in Pittsburgh, PA. *Journal of Psychoactive Drugs, 50*(3), 240-246.

[100] Seal, K. H., Thawley, R., Gee, L., Bamberger, J., Kral, A. H., Ciccarone, D., Downing, M., & Edlin, B. R. (2005). Naloxone Distribution and Cardiopulmonary Resuscitation Training for injection Drug Users to Prevent Heroin Overdose Death: A Pilot Intervention Study. *Journal of Urban Health, 82*(2), 303-311; Maxwell, S., Bigg, D., Stanczykiewicz, K., & Carlberg-Racich, S. (2006). Prescribing Naloxone to Actively Injecting Heroin Users: A Program to Reduce Heroin Overdose Deaths. *Journal of Addictive Diseases, 25*(3), 89-96; Wagner, K. D., Valente, T. W., Casanova, M., Partovi, S. M., Mendenhall, B. M., Hundley, J. H., Gonzalez, M., & Unger, J. B. (2010). Evaluation of an Overdose Prevention and Response Programme for Injection Drug Users in the Skid Row Area of Los Angeles, CA. *International Journal of Drug Policy, 21*, 186-193; Doe-Simkins, M., Quinn, E., Xuan, Z., Sorensen-Alawad, A., Hackman, H., Ozonoff, A., & Walley, A. (2014). Overdose Rescues by Trained and Untrained Participants and Change in Opioid Use Among Substance-Using Participants in Overdose Education and Naloxone Distribution Programs: A Retrospective Cohort Study. *BMC Public Health, 14*(297); Jones, J. D., Campbell, A., Metz, V. E., & Comer, S. D. (2017). No Evidence of Compensatory Drug Use Risk Behavior Among Heroin Users After Receiving Take-home Naloxone. *Addictive Behaviors, 71*, 104-106; Marco, C. A., Trautman, W., Cook, A., Mann, D., Rasp, J., Perkins, O., & Ballester, M. (2018). Naloxone Use Among Emergency Department Patients with Opioid Overdose. *Journal of Emergency Medicine, 55*(1), 64-70.

[101] Jakubowski, A., Pappas, A., Isaacsohn, L., Castillo, F., Masyukova, M., Silvera, R., Holaday, L., Raush, E., Farooq, S., Veltri, K. T., Cunningham, C. O., & Bachhuber, M. A. (2019). Development and Evaluation of a Pilot Overdose Education and Naloxone Distribution Program for Hospitalized General Medical Patients. *Substance Abuse, 40*(1).

[102] Florida Hospital Association. (2017). Florida Hospital Association Guidance on Implementing House Bill 249 – Opioid Use and Prescribing in Emergency Departments.

[103] Laws of Florida. (2018). *Chapter 2018-13 – Committee Substitute for Committee Substitute for House Bill No. 21*. Retrieved from http://laws.flrules.org/2018/13.

[104] Washington/Baltimore High Intensity Drug Trafficking Area. (2018). *Overdose Spike Response Framework: A Companion Guide for ODMAP Stakeholders*. Retrieved from www.odmap.org/Content/docs/ODMap-Overdose-Response-Framework-2018-3.29.18.pdf.

[105] 2020 Annual Syringe Exchange Program Report; October 1, 2020

[106] Mark Fontaine, Executive Advisor, Florida Behavioral Health Association

[107] Florida Department of Health; Primary Care Office; Physician Workforce Development; http://www.floridahealth.gov/provider-and-partner-resources/community-health-workers/physician-workforce-development-and-recruitment/index.html

[108] Examining State Legislative Strategies to Enhance MH/SUD Parity Enforcement, Gabrielle de la Gueronniere, Legal Action Center

[109] Parity Tracking Project: Making Parity a Reality, Executive Summary, Ellen Weber, Legal Action Center, National Center on Addiction and Substance Abuse, Treatment Research Institute

[110] ATTACHMENT II EXHIBIT II-A – Effective Date: February 1, 2019 MANAGED MEDICAL ASSISTANCE (MMA) PROGRAM. Retrieved from http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/Contracts/2019-02-01/Exhibit_II_A-MMA_2019-02-01.pdf

[111] 2018–2023 Model Health Plan Contract. *Agency for Health Care Administration*. Retrieved from http://ahca.myflorida.com/Medicaid/statewide_mc/model_health_FY18-23.shtml

[112] https://www.federalregister.gov/documents/2021/04/28/2021-08961/practice-guidelines-for-the-administration-of-buprenorphine-for-treating-opioid-use-disorder

[113] Bazazi A. R., Yokell M., Fu J. J., Rich J. D., Zaller N. D. Illicit use of buprenorphine/naloxone among injecting and noninjecting opioid users. J Addict Med. 2011;5(3):175-180. doi:10.1097/ADM.0b013e3182034e31

[114] Richert, T., Johnson, B. (2015) Long-term self-treatment with methadone or buprenorphine as a response to barriers to opioid substitution treatment: the case of Sweden. Harm Reduct J.;12:1. doi:10.1186/s12954- 015-0037-2

[115] Carroll J. J., Rich J. D., Green T. C. (2018). The More Things Change: Buprenorphine/naloxone Diversion Continues While Treatment Remains Inaccessible. J Addict Med.doi:10.1097/ADM.0000000000000436

[116] Reif, S., Creedon, T. B., Horgan, C. M., Stewart, M. T., Garnick, D. W. (2017). Commercial Health Plan Coverage of Selected Treatments for Opioid Use Disorders from 2003 to 2014. J Psychoactive Drugs.;49(2):102-110. doi:10.1080/02791072.2017.1300360

[117] Evidence-Based Strategies for Preventing Opioid Overdose: What's Working in the United States An introduction for public heath, law enforcement, local organizations, and others striving to serve their community Authors: Jennifer J. Carroll, PhD, MPH; Traci C. Green, PhD, MSc; and Rita K. Noonan, PhD https://www.cdc.gov/drugoverdose/pdf/pubs/2018-evidence-based-strategies.pdf

[118] Association of State and Territorial Health Officials http://www.astho.org/prevention/nas-neonatal-abstinence-report/

[119] Johnston A, Mandell T, Meyer M. "Treatment of opioid dependence during pregnancy: Vermont guidelines." Available at http://www.uvm.edu/medicine/vchip/documents/ICONFULLTREATMENTGUIDELINESFINAL.pdf.

[120] Guttmacher Institute. "State policies in brief: Substance abuse during pregnancy." Available at http://www.guttmacher.org/statecenter/spibs/spib_SADP.pdf.

[121] Association of State and Territorial Health Officials. 2014. *Neonatal Abstinence Syndrome: How States Can Advance the Knowledge Base for Primary Prevention and Best Practices of Care*. Retrieved from http://www.astho.org/prevention/nas-neonatal-abstinence-report/

[122] Young N, Gardner S, Otero C, et al. "Substance-exposed infants: State responses to the problem." Rockville, MD: Substance Abuse and Mental Health Services Administration. Available at http://www.ncsacw.samhsa.gov/files/Substance-Exposed-Infants.pdf.

[123] ACOG Committee on Health Care for Underserved Women and American Society of Addiction Medicine. "Committee opinion number 524: Opioid abuse, dependence, and addiction in pregnancy." Obstet Gynecol. 2012. 119(5):1070-6.

[124] American Medical Association. (2019). *National Roadmap on State-Level Efforts to End the Opioid Epidemic: Leading Edge Practices and Next Steps*. Retrieved from www.end-opioid-epidemic.org/wp-content/uploads/2019/09/AMA-Manatt-National-Roadmap-September-2019-FINAL.pdf.

[125] American Medical Association. (2019). *American Medical Association Prior Authorization (PA) Physician Survey*. Retrieved from www.ama-assn.org/system/files/2020-06/prior-authorization-survey-2019.pdf.

[126] Kermack, A., Flannery, M., Tofighi, B., McNeely, J., & Lee, J. D. (2016). Buprenorphine Prescribing Practice Trends and Attitudes among New York Providers. *Journal of Substance Abuse Treatment, 74*.

[127] Recovery Community Organization Toolkit, Faces and Voices of Recovery

[128] Recovery Community Organizations in Florida (map); All in Florida: A Recovery Project, Florida Alcohol and Drug Abuse Association, November 2019

[129] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. What are peer recovery support services?

[130] Recovery Peer Specialists – An Overview (power-point); Department of Children and Families; July 23, 2019

[131] Senate Bill 900 Bill Analysis and Fiscal Impact Statement, The Florida Senate; Committee on Children, Families, and Elder Affairs; March 8, 2019.

[132] Robst, J. M., Constantine, R., & Petrila, J. (2011). Association of involuntary psychiatric examination with probability of arrest of people with serious mental illness. *Psychiatric Services*, *62*(9), 1060-1065

[133] https://www.usf.edu/cbcs/baker-act/documents/ba_usf_annual_report_2018_2019.pdf

[134] The State of Mental Health in America 2021, Mental Health America https://www.mhanational.org/research-reports/2021-state-mental-health-america; Based on report of per capita expenditures for community-based programs, by state for 2012: http://www.nri-incdata.org/RevExp2012/T12.pdf

[135] Estimate based on average jail inmate per diem cost of $67.37 calculated from FDOC 2016 Annual Jail Capacity Survey and multiplied by average daily population of 9,500 detainees. http://www.dc.state.fl.us/pub/jails/2016/2016AnnualJailCapacitySurvey.pdf

[136] Estimate based on an average per diem cost of $336 multiplied by 1,615 forensic and forensic step-down beds.http://floridafiscalportal.state.fl.us/Document.aspx?ID=18129&DocType=PDF (p. 338) https://www.nasmhpd.org/sites/default/files/forensic%20nasmhpd%20presentation_ITB%20Panel.pdf (p. 5)

[137] Federal Communications Commission. 2019. Retrieved from *988 Fact Sheet*, retrieved from https://www.fcc.gov/sites/default/files/988-fact-sheet.pdf

[138] National Alliance on Mental Illness, NAMI Urges Swift Action to Reimagine Crisis Response Ahead of 988 Launch Next Year, July 2021. Retrieved from https://www.nami.org/Press-Media/Press-Releases/2021/NAMI-Urges-Swift-Action-to-Reimagine-Crisis-Response-Ahead-of-988-Launch-Next-Year