Guidance 10
Prevention Services

Contract Reference: *Sections A-1.1 and C-1.2.3*

Authorities: *42 U.S.C. s. 300x-2*

45 C.F.R., pt. 96, sub. L.

S. 397.311(26)(c), F. S.

Ch. 65D-30, F.A.C.

Frequency: *Ongoing*

Due Date: *Not Applicable*

A. MANAGING ENTITY RESPONSIBILITIES

The Managing Entity shall ensure the administration and provision of evidence-based programs to the targeted populations indicated in the prevention planning documents.

The Managing Entity shall:

1. Collect and analyze data on substance use consumption and consequences to identify the substances and populations that should be targeted with prevention set-aside funds;
2. Purchase prevention activities and services with Substance Abuse Block Grant funds that are both consistent with the needs assessment data and are not being funded through other public or private sources.
3. Develop capacity throughout the state and Regions to implement a comprehensive approach to substance use issues;
4. Collect and analyze outcome data to ensure the most cost-efficient use of substance use primary prevention funds;
5. Review community prevention planning documents developed by community coalitions;
6. Purchase substance use prevention services, in compliance with *45 C.F.R. pt. 96, sub. L;*
7. Contract with and provide oversight to Prevention Partnership Grant (PPG) grantees;
8. Verify delivery of services;
9. Provide technical assistance to subcontracted prevention providers regarding implementation of evidence-based prevention practices; and
10. Provide oversight of prevention services consistent with Block Grant requirements.

B. NETWORK SERVICE PROVIDER RESPONSIBILITIES

The Managing Entity shall ensure that subcontracted prevention providers and coalitions:

1. Provide culturally appropriate evidence-based programs to the targeted populations.
2. Deliver prevention programs at the locations specified and in accordance with the Program Description of the strategy;
3. Partner with community coalitions, where available, to obtain their prevention planning documents and confirm that current programs are aligned with community substance misuse problems;
4. Collaborate with partners within the communities and state to focus on substance misuse prevention;

5. Follow the Center for Substance Abuse Prevention (CSAP) Six CSAP Strategies:
    a. Information Dissemination;
    b. Education;
    c. Alternatives;
    d. Problem Identification and Referral;
    e. Community Based Processes; and
    f. Environmental Strategies.
6. Report prevention services and activities that do not fit under one of the CSAP Strategies under the "Other" category in the ME Block Grant reporting template with a description.
7. Collect and analyze data on substance use consumption and consequences to identify the substances and populations that should be targeted with prevention set-aside funds;
8. Comply with state reporting requirements;
9. Comply with the requirement to enter all prevention data monthly into the Department's Performance Based Prevention System (PBPS);
10. Submit the Prevention Program Description using the PBPS format. The Managing Entity shall approve or reject the Program Description before any data submission can be done by the Network Service Provider;
11. Submit prevention data for all program participants, programs and strategies which occurred. Data submitted is consistent with the data maintained in the provider's program documentation, invoicing and sign-in sheets; and
12. Accurately report the following performance measures:
    a. A minimum of ninety percent (90%) of data shall be submitted no later than the 15th of every month for the month prior.
    b. A minimum of ninety percent (90%) of department-identified errors in data submitted shall be corrected within thirty (30) days of notification.

C. Defining Prevention

Prevention refers to the proactive approach to preclude, forestall, or impede substance misuse or mental health related problems. Strategies focus on increasing public awareness and education, community-based processes, and incorporating evidence-based practices. Programs designed to prevent the development of mental, emotional, and behavioral disorders are commonly categorized in the following manner:

1. Universal Indirect Prevention

Universal Indirect prevention services are provided to the general public or a whole population group that has not been identified on the basis of individual risk and is desirable for everyone in that group. Universal indirect services support population-based programs and can include meetings and events related to the design and implementation of components of the strategic prevention framework, including needs assessments, logic models, and comprehensive community action plans.

2. Universal Direct Prevention

Universal Direct prevention services directly serve an identifiable group of participants who have not been identified on the basis of individual risk. This includes interventions involving interpersonal and ongoing or repeated contact such as curricula, programs, and classes, including but not limited to school-based and family-based programs (e.g., parenting programs).

3. **Selective Prevention**

   Preventive interventions are targeted to individuals or to a subgroup of the population whose risk of developing mental, emotional, or behavioral disorders is significantly higher than average. Risk groups may be identified on the basis of biological, psychological, social, or environmental risk factors that are known to be associated with the onset of a disorder. Examples include programs offered to children exposed to risk factors, also known as Adverse Childhood Experience (ACES), such as parental divorce, parental mental illness, death of a close relative, or abuse, to reduce risk for adverse mental, emotional, and behavioral outcomes. These programs should lean heavily into the Protective and Compensatory Experiences, also known as PACES.

4. **Indicated Prevention**

   Indicated prevention services are targeted to high-risk individuals who are identified as having minimal but detectable signs or symptoms that foreshadow mental, emotional, or behavioral disorders, as well as biological markers that indicate a predisposition in a person for such a disorder but who does not meet diagnostic criteria at the time of the intervention. More specifically, indicated populations include individuals without substance use disorders, who may have already initiated substance use, perhaps in risky ways. In other words, indicated prevention services are designed to prevent progression to disorders and associated harmful consequences.

D. Substance Abuse Prevention and Treatment Block Grant

Federal regulations for the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) require the state to spend, or set-aside, at least twenty percent (20%) of the award on services for individuals who do not require treatment for substance use. This entails the implementation of a comprehensive primary prevention system which includes a broad array of prevention strategies directed at individuals not identified to be in need of treatment.

SAPTBG set-aside funds cannot be used to fund Screening, Brief Intervention, Referral and Treatment (SBIRT) programs. Other examples of strategies that will not be approved for SAPTBG Prevention funding include:

1. Relapse prevention programs;
2. Domestic violence programs;
3. Case management for parenting teens;
4. Mental Health First Aid; or
5. Any services provided within prison or jails.

Primary prevention programs can include activities and services provided in a variety of settings for both the general population and targeted sub-groups who are at high risk for substance abuse and the underlying factors driving a problem. At-risk populations include:

1. Children of parents who use substances;
2. Pregnant women and teens;
3. Adolescents who drop out of school;
4. Individuals exhibiting violent and delinquent behavior;
5. Individuals with mental health challenges;
6. Individuals who are socio-economically disadvantaged;
7. Individuals who are physically disabled;
8. Individuals who have experienced abuse
9. Individuals who already use substances;
10. Youth who do not have a home or who have ran away from home; and

11. Parents who use substances.

E. Data-Based Decision Making

The Managing Entity shall continue to implement prevention strategies that are research-based and informed by community needs assessments through the subcontracted provider network, in connection with child and youth serving systems (i.e., child welfare providers, school systems, juvenile justice).

The strategic planning process is a conceptual framework that can be used in a variety of different contexts. The Center for Substance Abuse Prevention calls this process the Strategic Prevention Framework (SPF). SPF contains five basic elements[1] and two overarching principles[2] that overlap and interact throughout the process, relying on research and data to determine strategies. Subcontracted prevention providers must engage in this strategic planning process which guides local development of needs assessments, logic models, community action plans, and evaluation plans. Please refer to the document via the link below.

a. https://www.samhsa.gov/resource/ebp/strategic-prevention-framework

F. Environmental Strategies and Community Coalitions

Environmental prevention strategies are activities that are intended to reduce or restrict social and retail access to, and economic availability of, alcohol and other drugs by modifying features of the physical environment. Examples include compliance checks, social host laws, restricting alcohol availability at events, increasing prices, and keg registration. The availability of substances is at the center of the definition of environmental strategies, and it positions anti-drug coalitions at the helm, since the most recent evaluation of the Drug Free Communities program indicates that the "availability of substances that can be abused" is a risk factor that 86% of anti-drug coalitions throughout the U.S. select for change. Regarding standards of evidence for environmental strategies, several important resources can be consulted, including standards established by the Centers for Disease Control and Prevention and the Society of Prevention Research.

Community Coalitions are local partnerships among multiple sectors of the community that respond to community conditions by developing, implementing, and evaluating comprehensive plans that lead to measurable, population level reductions in drug use and related problems. Scientific studies indicate that the community coalition approach is an effective strategy for addressing alcohol, tobacco and other substance use and misuse-related problems. Coalitions connect multiple sectors of the community to collaborate and develop plans, policies and strategies to achieve reductions in the rates of consumption at the community level, promoting positive well-being. Community coalitions reside at the heart of a proven comprehensive public health approach to support prevention efforts via a structured planning process that promotes civic engagement and the building of social capital.[3]

G. The Prevention Partnership Grants

Prevention Partnership Grants (PPG), established under s. 397.99, F.S., are awarded once every three years. Guidance on Managing Entity administration of the PPG is provided in **Guidance 14**.

Suicide Prevention Through and With Substance Use Prevention

Federal law stipulates that the SAPT primary drug prevention set-aside funds must be used for activities that prevent or reduce the risk of substance use (including alcohol and other drugs) among individuals who do not require treatment for substance use disorders. Therefore, it would be impermissible, for example, to use primary prevention

[1] Assessment, planning, implementation, evaluation, and capacity.
[2] Cultural competence and sustainability.
[3] https://www.cadca.org/why-community-coalitions

set-aside funds on a universal campaign that merely encouraged people experiencing suicidal thoughts to reach out for professional help. In order to be eligible for primary drug prevention set-aside funding, such a campaign would arguably also need to include content designed to prevent or reduce substance use. Also, in order to be eligible for primary drug prevention set-aside funding, such a campaign could target indicated populations (i.e., individuals who have started using substances but not yet escalated to a substance use disorder diagnosis), but it could not target individuals diagnosed with substance use disorders.

A review of the scientific evidence and relevant SAMHSA publications indicates that substance use is an important risk factor for suicide-related thoughts and behaviors. A multivariate analysis of Florida high school students demonstrated that tobacco use, alcohol use, and depressive symptoms were all significantly associated with increased odds of suicidal ideation. Tobacco use, alcohol use, marijuana use, and depressive symptoms were all significantly associated with increased odds of both suicide planning and suicide attempts.[1] According to a meta-analysis of 30 longitudinal studies, there is a positive and significant association between alcohol use and both fatal and nonfatal suicide attempts. Alcohol use increases the probability of suicide attempts by 110% and the probability of suicide mortality by 65%.[2] According to a more recently published meta-analysis of 48 studies (spanning 1995 to 2020), smoking, depression, and alcohol and cannabis use disorders are significantly associated with suicide ideations. Depression, substance use, and polysubstance use are significantly associated with suicide attempts.[3]

Given the interrelationship between suicide risk and substance use, reducing the use of alcohol and other drugs is a way to reduce suicide-related experiences. A recently published meta-analysis of individual-level psychological interventions designed to reduce alcohol use revealed a modest decrease in self-harm (encompassing non-suicidal self-injury and attempted suicide), but not suicidal ideation.[4] With respect to *population-level* interventions, typically involving restrictions on alcohol availability, a recent systematic literature review showed that most studies found an association with reduced suicides or self-harm, predominantly among males.[5] According to SAMHSA, "Alcohol and drug misuse are second only to depression and other mood disorders as the most frequent risk factors for suicidal behavior…People at risk for suicide and substance misuse share a number of risk factors that include depression, impulsivity, and thrill-seeking/life threatening behaviors. Because risk and protective factors for the two can overlap, prevention professionals need to be aware of them and to implement prevention programming that reduces risk and enhances protective factors."[6]

A recently published meta-analysis of 25 studies of longitudinal associations between substance use disorders (SUDs) and suicidality found that SUDs significantly predict subsequent suicidality, and suicidality significantly predicts subsequent SUDs. According to the authors, "Because effects were significant in both directions, results suggest that the bidirectional hypothesis may be the best fit for understanding the association between SUDs and suicidality in youth. Indeed, SUDs and suicidality may be exacerbating each other consistently across development." They also argue that "A cross-influence of SUDs with suicidality could notably be prevented by targeting the mechanisms thought to explain their associations, for example by increasing coping and problem-solving skills. Some programs targeting these skills have already been shown to prevent both substance use and suicidality, and may also prevent co-morbidity when youth already experience one or the other..."[7]

SAMHSA's evidence-based guide to *Treatment for Suicidal Ideation, Self-Harm, and Suicide Attempts* also recommends a focus on programs with skill building components: "Skills training during treatment involves youth learning, practicing, and applying a variety of coping skills that help youth better navigate everyday challenges and stressors. Skills training sessions may focus on emotional regulation, distress tolerance, cognitive restructuring, communication skills, help seeking, problem-solving, and/or conflict resolution. This training should be calibrated with what put that youth at risk for suicide. For example, if an adolescent male client tends to experience suicidal thoughts after interpersonal conflicts with his friends, parents, and significant other, a clinician might prioritize different coping skills than for an adolescent female who suffers from perfectionism, anxiety, depression, and feelings of failure."[8]

Substance use is more than a risk factor for suicide, it is a *mechanism/means* of dying by suicide. For example, according to 2020 interim data from Florida Medical Examiners, approximately 17-21% of deaths caused by sedatives (i.e., alprazolam, diazepam, and clonazepam) in Florida are suicides. With respect to opioids, approximately 14% of deaths caused by oxycodone and 23% of deaths caused by hydrocodone are suicides.[9] Prevention efforts targeting access to pharmaceutical sedatives and opioids are therefore part and parcel of reducing suicides by increasing safe storage practices and decreasing access to lethal means.

H. Resources

Managing Entities FY23-24 Templates | Florida DCF (myflfamilies.com)

A Guide to SAMHSA's Strategic Prevention Framework
https://www.samhsa.gov/resource/ebp/strategic-prevention-framework

Substance Abuse and Mental Health Services Administration Prevention Resources
https://www.samhsa.gov/prevention-week/toolkit/prevention-resources

Prevention of Substance Use and Mental Disorders
Guidance documents to assist communities with prevention planning
https://www.samhsa.gov/find-help/prevention#resources-publications

Florida Administrative Code & Florida Administrative Register Standards for Prevention
https://www.flrules.org/gateway/ruleno.asp?id=65D-30.013&Section=0

National Research Council and Institute of Medicine. (2009).
Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. Washington, DC: The National Academies Press.
https://pubmed.ncbi.nlm.nih.gov/20662125/

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[3] Armoon, B. et al. (2021). Prevalence, Sociodemographic Variables, Mental Health Condition, and Type of Drug Use Associated with Suicide Behaviors Among People with Substance Use Disorders: A Systematic Review and Meta-Analysis. *Journal of Addictive Diseases* (online ahead of print).

[4] Witt, K. et al. (2021). Effect of Alcohol Interventions on Suicidal Ideation and Behavior: A Systematic Review and Meta-Analysis. *Drug and Alcohol Dependence, 226*(1).

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[8] Substance Abuse and Mental Health Services Administration. (2020). *Treatment for Suicidal Ideation, Self-Harm, and Suicide Attempts Among Youth*. SAMHSA Publication No. PEP20-06-01-002. Retrieved from https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-06-01-002.pdf.

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