Florida

UNIFORM APPLICATION
FY 2020/2021 Block Grant Application

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and

COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 08/12/2019 1.29.55 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

Center for Mental Health Services
Division of State and Community Systems Development
State Information

Plan Year
   Start Year  2020
   End Year  2021

State SAPT DUNS Number
   Number  604604350
   Expiration Date

I. State Agency to be the SAPT Grantee for the Block Grant
   Agency Name  Department of Children and Families
   Organizational Unit  Office of Substance Abuse and Mental Health
   Mailing Address  1317 Winewood Blvd., Building 6, Room 274
                   Tallahassee, Florida
   Zip Code  32399-0700

II. Contact Person for the SAPT Grantee of the Block Grant
   First Name  Ute
   Last Name  Gazioch
   Agency Name  Florida Department of Children and Families, Substance Abuse and Mental Health Program Office
   Mailing Address  1317 Winewood Blvd., Building 6, Room 275
                   Tallahassee, Florida
   Zip Code  32399-0700
   Telephone  850-717-4322
   Fax  850-487-2239
   Email Address  Ute.Gazioch@myflfamilies.com

State CMHS DUNS Number
   Number  604604350
   Expiration Date

I. State Agency to be the CMHS Grantee for the Block Grant
   Agency Name  Department of Children and Families
   Organizational Unit  Office of Substance Abuse and Mental Health
   Mailing Address  1317 Winewood Blvd., Bldg 6, Room 229
                   Tallahassee
   Zip Code  32399-0700

II. Contact Person for the CMHS Grantee of the Block Grant
   First Name  Ute
   Last Name  Gazioch
   Agency Name  Department of Children and Families
III. Third Party Administrator of Mental Health Services

Do you have a third party administrator?  Yes ☐  No ☑

First Name  Natalie
Last Name  Kelly
Agency Name  Florida Association of Managing Entities

Mailing Address  122 South Calhoun Street
City  Tallahassee
Zip Code  32301
Telephone  850-570-5747
Fax
Email Address  natalie@flmanagingentities.com

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From
To

V. Date Submitted

Submission Date
Revision Date

VI. Contact Person Responsible for Application Submission

First Name  Jeffery
Last Name  Cece
Telephone  (850) 717-4501
Fax  (850) 487-2239
Email Address  Jeffery.Cece@myflfamilies.com

Footnotes:

Additional Contact Responsible for Submission:
Name: Nikki Wotherspoon
Telephone: (850) 717-4323
Fax: (850) 487-2239
Email: Nikki.Wotherspoon@myflfamilies.com
## Title XIX, Part B, Subpart II of the Public Health Service Act

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 1921</td>
<td>Formula Grants to States</td>
<td>42 USC § 300x-21</td>
</tr>
<tr>
<td>Section 1922</td>
<td>Certain Allocations</td>
<td>42 USC § 300x-22</td>
</tr>
<tr>
<td>Section 1923</td>
<td>Intravenous Substance Abuse</td>
<td>42 USC § 300x-23</td>
</tr>
<tr>
<td>Section 1924</td>
<td>Requirements Regarding Tuberculosis and Human Immunodeficiency Virus</td>
<td>42 USC § 300x-24</td>
</tr>
<tr>
<td>Section 1925</td>
<td>Group Homes for Recovering Substance Abusers</td>
<td>42 USC § 300x-25</td>
</tr>
<tr>
<td>Section 1926</td>
<td>State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18</td>
<td>42 USC § 300x-26</td>
</tr>
<tr>
<td>Section 1927</td>
<td>Treatment Services for Pregnant Women</td>
<td>42 USC § 300x-27</td>
</tr>
<tr>
<td>Section 1928</td>
<td>Additional Agreements</td>
<td>42 USC § 300x-28</td>
</tr>
<tr>
<td>Section 1929</td>
<td>Submission to Secretary of Statewide Assessment of Needs</td>
<td>42 USC § 300x-29</td>
</tr>
<tr>
<td>Section 1930</td>
<td>Maintenance of Effort Regarding State Expenditures</td>
<td>42 USC § 300x-30</td>
</tr>
<tr>
<td>Section 1931</td>
<td>Restrictions on Expenditure of Grant</td>
<td>42 USC § 300x-31</td>
</tr>
<tr>
<td>Section 1932</td>
<td>Application for Grant; Approval of State Plan</td>
<td>42 USC § 300x-32</td>
</tr>
<tr>
<td>Section 1935</td>
<td>Core Data Set</td>
<td>42 USC § 300x-35</td>
</tr>
</tbody>
</table>

## Title XIX, Part B, Subpart III of the Public Health Service Act

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 1941</td>
<td>Opportunity for Public Comment on State Plans</td>
<td>42 USC § 300x-51</td>
</tr>
<tr>
<td>Section 1942</td>
<td>Requirement of Reports and Audits by States</td>
<td>42 USC § 300x-52</td>
</tr>
<tr>
<td>Section</td>
<td>Title</td>
<td>Code</td>
</tr>
<tr>
<td>---------</td>
<td>---------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>1943</td>
<td>Additional Requirements</td>
<td>42 USC § 300x-53</td>
</tr>
<tr>
<td>1946</td>
<td>Prohibition Regarding Receipt of Funds</td>
<td>42 USC § 300x-56</td>
</tr>
<tr>
<td>1947</td>
<td>Nondiscrimination</td>
<td>42 USC § 300x-57</td>
</tr>
<tr>
<td>1953</td>
<td>Continuation of Certain Programs</td>
<td>42 USC § 300x-63</td>
</tr>
<tr>
<td>1955</td>
<td>Services Provided by Nongovernmental Organizations</td>
<td>42 USC § 300x-65</td>
</tr>
<tr>
<td>1956</td>
<td>Services for Individuals with Co-Occurring Disorders</td>
<td>42 USC § 300x-66</td>
</tr>
</tbody>
</table>
CERTIFICATION

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM’s Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.


10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions


14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.
1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a “covered transaction” and verify each lower tier participant of a “covered transaction” under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

b. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

c. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

d. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

e. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled “Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,”
generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801-3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children’s services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children’s services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children’s services and that all subrecipients shall certify accordingly.
The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

**HHS Assurances of Compliance (HHS 690)**


The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assigns for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

Printed: 8/12/2019 1:29 PM - Florida - OMB No. 0930-0168  Approved: 04/19/2019 Expires: 04/30/2022  Page 9 of 159
I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: ________________________________

Name of Chief Executive Officer (CEO) or Designee: Chad Poppell ________________________________

Signature of CEO or Designee¹: ________________________________

Title: Secretary, FL Department of Children & Families Date Signed: ________________________________

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.
July 3, 2019

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, 13N14-A
Rockville, Maryland 20857

To Whom It May Concern:

This letter is to inform you that Chad Poppell, Secretary of the Florida Department of Children and Families, is the authorized official designee to sign federal grant applications, assurances, certifications, and other grant-related documents on behalf of the State of Florida to the Substance Abuse and Mental Health Services Administration within the Department of Health and Human Services. This designation is effective for the remainder of my term as Governor.

Mr. Poppell’s mailing address is:
Secretary Chad Poppell
Florida Department of Children and Families
1317 Winewood Blvd.
Tallahassee, Florida 32399-0700

Thank you for supporting the State of Florida’s efforts to address substance use disorder and mental health services in our communities.

Sincerely,

Ron DeSantis
Governor
# State Information

**Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]**

**Fiscal Year 2020**

U.S. Department of Health and Human Services  
Substance Abuse and Mental Health Services Administrations  
Funding Agreements  
as required by  
Community Mental Health Services Block Grant Program  
as authorized by  
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act  
and  
Title 42, Chapter 6A, Subchapter XVII of the United States Code

## Title XIX, Part B, Subpart II of the Public Health Service Act

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 1911</td>
<td>Formula Grants to States</td>
<td>42 USC § 300x</td>
</tr>
<tr>
<td>Section 1912</td>
<td>State Plan for Comprehensive Community Mental Health Services for Certain Individuals</td>
<td>42 USC § 300x-1</td>
</tr>
<tr>
<td>Section 1913</td>
<td>Certain Agreements</td>
<td>42 USC § 300x-2</td>
</tr>
<tr>
<td>Section 1914</td>
<td>State Mental Health Planning Council</td>
<td>42 USC § 300x-3</td>
</tr>
<tr>
<td>Section 1915</td>
<td>Additional Provisions</td>
<td>42 USC § 300x-4</td>
</tr>
<tr>
<td>Section 1916</td>
<td>Restrictions on Use of Payments</td>
<td>42 USC § 300x-5</td>
</tr>
<tr>
<td>Section 1917</td>
<td>Application for Grant</td>
<td>42 USC § 300x-6</td>
</tr>
</tbody>
</table>

## Title XIX, Part B, Subpart III of the Public Health Service Act

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 1941</td>
<td>Opportunity for Public Comment on State Plans</td>
<td>42 USC § 300x-51</td>
</tr>
<tr>
<td>Section 1942</td>
<td>Requirement of Reports and Audits by States</td>
<td>42 USC § 300x-52</td>
</tr>
<tr>
<td>Section 1943</td>
<td>Additional Requirements</td>
<td>42 USC § 300x-53</td>
</tr>
<tr>
<td>Section 1946</td>
<td>Prohibition Regarding Receipt of Funds</td>
<td>42 USC § 300x-56</td>
</tr>
<tr>
<td>Section 1947</td>
<td>Nondiscrimination</td>
<td>42 USC § 300x-57</td>
</tr>
<tr>
<td>Section 1953</td>
<td>Continuation of Certain Programs</td>
<td>42 USC § 300x-63</td>
</tr>
<tr>
<td>Section 1955</td>
<td>Services Provided by Nongovernmental Organizations</td>
<td>42 USC § 300x-65</td>
</tr>
<tr>
<td>Section 1956</td>
<td>Services for Individuals with Co-Occurring Disorders</td>
<td>42 USC § 300x-66</td>
</tr>
</tbody>
</table>
ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM’s Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.


10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to
State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).


14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.
LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that
the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a
“covered transaction” and verify each lower tier participant of a “covered transaction” under the award is not presently debarred
or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a
drug-free work-place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a
controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for
violation of such prohibition;

b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement
   required by paragraph (a) above;

d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the
   employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no
      later than five calendar days after such conviction;

e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or
   otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title,
to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency
has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected
grant;

f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any
   employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the
      requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such
      purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

   g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d),
      (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code,
Section 1352, entitled “Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,”
generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801-3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.
The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

**HHS Assurances of Compliance (HHS 690)**


The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

**THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:**

1. **Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.**

2. **Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.**

3. **Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.**

4. **The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.**

5. **Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.**

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.
I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Chad Poppell

Signature of CEO or Designee: ________________________________

Title: Secretary, FL Department of Children & Families

Date Signed: mm/dd/yyyy

1 If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
July 3, 2019

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, 13N14-A
Rockville, Maryland 20857

To Whom It May Concern:

This letter is to inform you that Chad Poppell, Secretary of the Florida Department of Children and Families, is the authorized official designee to sign federal grant applications, assurances, certifications, and other grant-related documents on behalf of the State of Florida to the Substance Abuse and Mental Health Services Administration within the Department of Health and Human Services. This designation is effective for the remainder of my term as Governor.

Mr. Poppell’s mailing address is:
Secretary Chad Poppell
Florida Department of Children and Families
1317 Winewood Blvd.
Tallahassee, Florida 32399-0700

Thank you for supporting the State of Florida’s efforts to address substance use disorder and mental health services in our communities.

Sincerely,

Ron DeSantis
Governor

THE CAPITOL
TALLAHASSEE, FLORIDA 32399 • (850) 717-9249
State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

**Standard Form LLL (click here)**

<table>
<thead>
<tr>
<th>Name</th>
<th>Chad Poppell</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>Secretary</td>
</tr>
<tr>
<td>Organization</td>
<td>Florida Department of Children and Families</td>
</tr>
</tbody>
</table>

Signature:  
Date:  

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

**Footnotes:**

No one within the Office of Substance Abuse and Mental Health is currently registered as a lobbyist.
Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:
Provide an overview of the state’s M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state’s Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
Step 1: Assess the strengths and organizational capacity of the services system to address the specific populations.

Instructions: Provide an overview of the state’s M/SUD prevention, early identification, treatment, and recovery support systems, including the five criteria that must be addressed in state mental health plans. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states...This narrative must include a discussion of the current service system’s attention to the SABG priority populations: Pregnant Women, Injecting Drug Users, Women with Dependent Children, Persons at Risk for Tuberculosis, Individuals in Need of Primary Substance Abuse Prevention, and, for FY 2020 HIV-designated states or a state designated in any of the prior three FY and opted to use SABG funds for early intervention services for HIV.

Organizational Structure

The Office of Substance Abuse and Mental Health (SAMH) is a part of the Florida Department of Children and Families (hereafter referred to as the Department) and is the single state authority for substance abuse and mental health services. The Office of SAMH develops standards for the provision of prevention, treatment, and recovery services in partnership with other state agencies that also fund behavioral health services.

The Department operates under the direction of a Secretary who reports directly to the Governor. The Office of SAMH is led by an Assistant Secretary, who is supported by the Director of Substance Abuse and Mental Health, the Chief Hospital Administrator, the Director of State Mental Health Treatment Facilities Policies and Programs, the Director of the Sexually Violent Predator Program, the Director of SAMH Data Quality Assurance, and the Director of the Office of Homelessness.

The Office of SAMH is also home to the statewide Office of Suicide Prevention which, in coordination with the Florida Suicide Prevention Coordinating Council, develops and implements the Florida Suicide Prevention Strategy by providing oversight, building capacity, creating policy, and mobilizing communities. The Office of Suicide Prevention is overseen by a Suicide Prevention Specialist. The Suicide Prevention Specialist serves as the chair of the Coordinating Council, supports and implements suicide prevention grants, and helps plan and coordinate the annual Suicide Prevention Day at the Capitol and other awareness activities.

Structurally and operationally, the Department is decentralized into six regions, with each region representing multiple counties. Each region is somewhat autonomous and managed by a Regional Managing Director. The Regional Managing Director reports to the Department’s Assistant Secretary for Operations. Each region has a SAMH Director who reports to the Regional Managing Director and serves as the Department’s representative to the community for substance abuse and mental health issues. Pursuant to statute, Department contracts are managed by a single point of contact, a certified contract manager. Regional staff is responsible for the implementation of the Department’s substance abuse and mental health funding and statutory duties.

Behavioral Health Managing Entities (MEs)

The Office of SAMH used to contract directly with behavioral health providers to implement the Community Mental Health (CMH) and Substance Abuse Prevention and Treatment (SAPT) Block Grants. The Florida Legislature found that a managing structure that places responsibility for publicly-funded behavioral health services in local entities would promote access to care and continuity, be more efficient and effective, and streamline administrative processes to create cost efficiencies and provide flexibility to better match services to need. As a result, the Office of SAMH now contracts with seven Managing Entities (MEs) for the administration and management of regional behavioral health
systems of care throughout the state. The MEs are private, non-profit organizations responsible for planning, implementation, administration, monitoring, and data collection, reporting, and analysis for behavioral health care in their regions. MEs do not provide services, but contract with local service providers for the provision of prevention, treatment, and recovery support services. Prevention service providers are typically community-based organizations, like anti-drug coalitions, or behavioral health service providers that implement school- or family-based primary prevention programs.

Procurement of the ME contracts is governed by both ch. 287, F.S., which applies generally to all state contracts, and s. 402.7305, F.S., which applies specifically to Department contracts. In accordance with both Florida and federal law, the contracts were competitively procured. In addition to the procurement requirements, the statutory authority for the Department to contract with an ME provides for a fixed payment contract, with the equivalent of a two-month advance payment, and equal monthly payments thereafter. The ME is also permitted to carry up to 8% of state general revenue from fiscal year to fiscal year, for the life of the contract.

Consistent with the organizational structure of the Department, these contracts are executed, implemented, and managed by the Regional Managing Director and staff. In consultation with the Office of SAMH, the Regional SAMH Director ensures that each ME meets statewide goals and is responsive to the unique conditions in each community. Table 1 below depicts each ME, the DCF regions within their catchment areas, and the number of rural and non-rural counties within their catchment areas.

<table>
<thead>
<tr>
<th>Managing Entity</th>
<th>DCF Region(s)</th>
<th>Rural Counties</th>
<th>Non-Rural Counties</th>
<th>Total Counties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broward Behavioral Health Coalition (BBHC)</td>
<td>Southeast Region</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Central Florida Cares Health System (CFCHS)</td>
<td>Central Region</td>
<td>0</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Central Florida Behavioral Health Network (CFBHN)</td>
<td>Suncoast &amp; Central Regions</td>
<td>5</td>
<td>9</td>
<td>14</td>
</tr>
<tr>
<td>Lutheran Services Florida Health Systems (LSFHS)</td>
<td>Northwest &amp; Central Regions</td>
<td>10</td>
<td>13</td>
<td>23</td>
</tr>
<tr>
<td>Big Bend Community Based Care (BBBCC)</td>
<td>Northeast &amp; Northwest Regions</td>
<td>13</td>
<td>5</td>
<td>18</td>
</tr>
<tr>
<td>South Florida Behavioral Health Network (SFBHN)</td>
<td>Southern Region</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Southeast Florida Behavioral Health Network (SEFBNH)</td>
<td>Southeast Region</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Entire State of Florida</td>
<td></td>
<td>30</td>
<td>37</td>
<td>67</td>
</tr>
</tbody>
</table>

Figure 1 below is a color-coded map that depicts each ME’s catchment area, start date, and DCF regions and circuits. It also lists each county within each MEs geographic catchment area.
In Florida, as with many states, the CMH and SAPT Block Grants do not support the entirety of the publicly-funded behavioral health system. Medicaid comprises a significant portion of funding for behavioral health. The Florida Agency for Health Care Administration (AHCA) serves as Florida’s Medicaid authority. The Department, while the single state authority for substance abuse and mental health, shares administrative responsibility pursuant to Florida Statute with AHCA. It should be noted that the authority that delegates shared administrative responsibility does not provide for a shared information system between Block Grant funded providers and Medicaid providers.

In addition to State funding available through the Department and AHCA, Florida’s local governments have a statutory vehicle to support behavioral health services through a match requirement based on the state general revenue that a provider receives. This match may be satisfied through cash or in-kind contributions. The authorizing legislation has set this up as a community issue that is negotiated between local governments and providers. Furthermore, some local governments dedicate additional funding for behavioral health services, while others do not.

Based on the statutory authority of each state agency, there are a variety of behavioral health services that are offered to more specific segments of the population, as described in Table 2 below:
### Table 2. Behavioral Health Services at Other State Agencies

<table>
<thead>
<tr>
<th>Agency</th>
<th>Services</th>
</tr>
</thead>
</table>
| Florida Department of Health    | • Tobacco Cessation Program  
                               | • Positive Youth Development  
                               | • School Health Services (including Behavioral Health)  
                               | • Infant, Maternal, and Reproductive Health program  
                               | • Prescription Drug Monitoring Program  
                               | • Children’s Health Insurance Program  
                               | • Infectious Disease Surveillance and Control  |
| Florida Department of Education | • School based Behavioral Health Services  
                           | • Multiagency Network for Students with Emotional or Behavioral Disabilities (SEDNET)  |
| Florida Department of Juvenile Justice | • Behavioral Health Services |
| Florida Department of Elder Affairs | • Behavioral Health Services  |
| Florida Department of Corrections | • Institutional Behavioral Health Services  
                               | • Re-entry Behavioral Health Services |

Pursuant to s. 394.674, F.S., the following priority populations for funding are established for contracts implemented through the Department:

- **For adult mental health services:**
  - Adults who have severe and persistent mental illness. Included within this group are:
    - Older adults in crisis;
    - Older adults who are at risk of being placed in a more restrictive environment because of their mental illness;
  - Persons deemed incompetent to proceed or not guilty by reason of insanity under chapter 916;
  - Other persons involved in the criminal justice system;
  - Persons diagnosed as having co-occurring mental illness and substance abuse disorders; and
  - Persons who are experiencing an acute mental or emotional crisis.

- **For children’s mental health services:**
  - Children who are at risk of emotional disturbance;
  - Children who have an emotional disturbance;
  - Children who have a serious emotional disturbance; and
  - Children diagnosed as having a co-occurring substance abuse and emotional disturbance or serious emotional disturbance.

- **For substance abuse treatment services:**
  - Adults who have substance abuse disorders and a history of intravenous drug use;
  - Persons diagnosed as having co-occurring substance abuse and mental health disorders;
  - Parents who put children at risk due to a substance abuse disorder;
  - Persons who have a substance abuse disorder and have been ordered by the court to receive treatment.
  - Children at risk for initiating drug use;
  - Children under state supervision;
  - Children who have a substance abuse disorder but who are not under the supervision of a court or in the custody of a state agency; and
  - Persons identified as being part of a priority population as a condition for receiving services funded through the federal Block Grants.
Substance Abuse Services

Substance Abuse services in Florida are authorized by ch. 397, F.S., and regulated by ch. 65D-30, F.A.C. The Department is statutorily required to license certain substance abuse service components and approve credentialing entities for addiction professionals and recovery residences. Chapter 397, F.S., provides for a system of care that is community based, reflecting the principles of recovery and resiliency.

Section 397.305(3), F.S., requires a system of care that will “provide for a comprehensive continuum of accessible and quality substance abuse prevention, intervention, clinical treatment, and recovery support services in the least restrictive environment which promotes long-term recovery while protecting and respecting the rights of individuals, primarily through community-based private not-for-profit providers working with local governmental programs involving a wide range of agencies from both the public and private sectors.” The system of care is comprised of the following broad categories of substance abuse services:

- Primary prevention services that prevent or delay substance use and associated problems, which include:
  - Information dissemination
  - Education
  - Alternative drug-free activities
  - Problem identification and referral
  - Community-based processes
  - Environmental strategies

- Intervention services, which are structured services aimed at individuals at risk of substance abuse, focusing on outreach, early identification, short-term counseling and referral.

- Clinical treatment, which includes professionally directed services to reduce or eliminate misuse of alcohol and other drugs, such as:
  - Outpatient and intensive outpatient treatment
  - Day or night treatment
  - Medication-assisted treatment
  - Residential Treatment
  - Intensive inpatient treatment
  - Detoxification

- Recovery support services are designed to help individuals regain skills, develop natural support systems, and develop goals to help them thrive in the community and promote recovery, such as:
  - Aftercare
  - Supported housing
  - Supported employment
  - Recovery support

Within this service array, the Department is also implementing specialty programs aimed at the specific needs of certain populations, including:

1) Services for pregnant women and mothers through Specific Appropriation 370 of the FY2019-20 General Appropriations Act and federal block grant funds
2) Child welfare involved parents/caretakers through Family Intensive Treatment Teams
3) Individuals with opioid misuse and opioid use disorders through federal discretionary grants (i.e., State Targeted Response to the Opioid Crisis and State Opioid Response grants)
Mental Health Services

Florida Statute requires that there be a system of care for persons with serious mental illnesses and serious emotional disturbances. Section 394.453, F.S., states that, “It is the intent of the Legislature to authorize and direct the Department of Children and Family Services to evaluate, research, plan, and recommend to the Governor and the Legislature programs designed to reduce the occurrence, severity, duration, and disabling aspects of mental, emotional, and behavioral disorders.”

As noted earlier, mental health services for children and adults are provided by network service providers through contracts with managing entities, managed care organizations, other state departments, and local governments. Individuals who require the most restrictive clinical setting are served in state funded mental health treatment facilities. The Department also has administrative responsibility for the Juvenile Incompetent to Proceed Program and the Behavioral Health Network. The Juvenile Incompetent to Proceed Program offers competency restoration for children with criminal charges who are found incompetent by a court to proceed due to mental illness, developmental disability or autism. The Behavioral Health Network is an intensive behavioral health program for children enrolled in the State Children’s Health Insurance Program.

Part III of Chapter 394, F.S., outlines the guiding principles for child and adolescent mental health services funded by the Department. Based on SAMHSA’s System of Care principles, Florida has adopted a framework that requires services be individualized, culturally competent, integrated, and include the family in all decision-making. These services should ensure a smooth transition for children who will need to access the adult system for continued age-appropriate services and supports. Services must be provided in the least restrictive setting available and the Department funds an array of formal and informal support services in the home and community. For those children that require residential mental health treatment, the Department partners with AHCA to fund and oversee therapeutic group care and the Statewide Inpatient Psychiatric Program. The Statewide Inpatient Psychiatric Program provides residential mental health treatment in a secure setting with intensive treatment and serves children with severe emotional disturbances ages six through seventeen.

The system of care is comprised of the following broad categories of mental health services:

- Treatment services intended to reduce or ameliorate the symptoms of mental illness, which include psychiatric medication and supportive psychotherapies;
- Rehabilitative services, which are intended to reduce or eliminate the disability associated with mental illness and may include:
  - Assessment of personal goals and strengths;
  - Readiness preparation;
  - Specific skill training; and
  - Designing of environments that enable individuals to maximize functioning and community participation.
- Support services, which assist individuals in living successfully in environments of their choice. These include:
  - Income supports;
  - Recovery supports;
  - Housing supports; and
  - Vocational supports.
- Case management services, which are intended to assist individuals in obtaining the formal and informal resources that they need to successfully cope with the consequences of their illness. This includes:
  - Assessment of the person’s needs;
  - Intervention planning with the person, his or her family, and service providers;
  - Linking the person to needed services;
  - Monitoring service delivery;
Evaluating the effect of services and supports; and
   Advocating on behalf of the person served.

Assisted Living Facilities (ALFs) with Limited Mental Health Licenses (ALF-LMHL) are also a part of the housing continuum for adults living with mental illnesses. As a function of the Managing Entity contracts, each region submits a plan at least annually to ensure the delivery of services to those in an ALF with a mental health diagnosis. The plan addresses training for ALF-LMHL staff, placement, and follow-up procedures to support ongoing treatment for residents. The annual ALF-LMHL Regional Plans are kept on file at the Department.

Mental health services are also a covered service in the State Medicaid Plan. Mental Health services that are covered include modalities such as:

- Targeted case management;
- Behavioral health overlay services;
- Community behavioral health services (assessment, medical services, therapy, psychosocial rehabilitation, and in-home services up to age 20); and
- Inpatient services.

In addition to the Medicaid state plan services, managed care providers have an additional array of services they may choose to fund as long as they are utilized as "in lieu of" services for more restrictive and costly state plan services. Examples of these services include mobile crisis, recovery support, wraparound, and early intervention. Florida also has the first ever specialty managed care plan that specifically serves adults with serious mental illnesses and children with serious emotional disturbances.

The Department funds several team-based community interventions including thirty-three Florida Assertive Community Treatment (FACT) teams, forty-one Community Action Treatment (CAT) teams, five Community Forensic Multidisciplinary (CFM) teams, and twenty-three Family Intensive Treatment (FIT) teams. The focus of these teams is to divert individuals with significant behavioral health conditions from residential or institutionalized care and support them in their community. They provide in-home services and supports, with heavy emphasis on community integration and assisting the individual’s family and support system. Funding has also been appropriated to Child Welfare Community Based Care agencies to integrate child welfare and behavioral health services.

**Mental Health Treatment Facilities**

Florida has a network of Mental Health Treatment Facilities for individuals who meet the admission criteria pursuant to ch. 394, F.S., (relating to civil commitment) and ch. 916, F.S. (relating to forensic commitment). This is the most restrictive and intensive level of care for adults who have been committed to the Department. The state directly operates the following three treatment facilities:

- Florida State Hospital
  - Civil and Forensic Commitment Capacity
- Northeast Florida State Hospital
  - Civil Commitment Capacity
  - Forensic Step-down Services
- North Florida Evaluation and Treatment Center
  - Forensic Commitment Capacity.

Services include:

- Psychiatric assessment
- Treatment with psychotropic medication
• Health care services
• Individual and group therapy
• Individualized service planning
• Competency restoration assessment and training
• Vocational and educational services
• Addiction services
• Rehabilitation therapy and enrichment activities

The state contracts for services at four other sites:

• South Florida Evaluation Treatment Center
  o Forensic Commitment Services
• Treasure Coast Forensic Treatment Center
  o Forensic Commitment Services
• South Florida State Hospital
  o Civil Commitment Services
  o Forensic Step-down Services
• West Florida Community Care Center
  o Civil Commitment Services

Services are designed to help residents manage their symptoms and apply skills needed to successfully return to the community. For individuals who are incompetent to proceed, this includes achieving competency and returning to court in a timely manner.

Service Eligibility

In order to be considered eligible to receive substance abuse and mental health services funded by the Department, applicants must be a member of at least one of the priority or targeted populations, have an annual gross family income at or above 150% of the Federal poverty Income Guidelines (or a sliding fee scale is applied), have no other payer source, or qualify for a service that Medicaid or other third party payor does not pay. Service providers are required to make reasonable efforts to identify and collect benefits from third party payers when applicable.

Managing Entities, by both statute and contract, are required to develop and manage an integrated provider network that meets the behavioral health service needs of the community in which they are located. The services are to be accessible and responsive to individuals, families, and community stakeholders. This includes:

1. All priority populations as defined in statute;
2. Mental Health residents of assisted living facilities;
3. Persons ordered into involuntary outpatient placement;
4. Eligible children referred for residential placement;
5. Inmates approaching the end of their sentences;
6. Individuals that are currently in civil and forensic state Mental Health Treatment Facilities; and
7. Individuals who are at risk of being admitted into a civil or forensic state MH Treatment Facility (including diversionary community treatment and services prior to admission).

Addressing the Needs of Tribes and Diverse Racial, Ethnic, and Sexual Gender Minorities

The U.S. Census Bureau estimates Florida’s 2018 population was approximately 53.5% non-Hispanic white, 26.1% Hispanic or Latino, 16.9% Black or African American, 3.0% Asian, 0.5% American Indian and Alaska Native. There are two Federally Recognized Indian Tribes in Florida: the Miccosukee Tribe of Indians and the Seminole Tribe of Florida. The
Tribes decline to participate with the Department on SAMHSA grants for behavioral health services. Members of the Tribes are nonetheless able to obtain services through the Department’s publicly-funded network of providers.

The Department is committed to ensuring that the behavioral health workforce is prepared to meet the needs of Florida’s diverse population. As an example, to become a Certified Addiction Professional in Florida, individuals must demonstrate that they can select and use evidence-based and culturally-responsive counseling strategies that are specific and effective in meeting individual needs. They must be able to recognize individual differences between the counselor and person served by gaining knowledge about personality, culture, lifestyles, gender, sexual orientation, special needs, and other factors influencing behavior to provide services that are tailored and culturally competent. Licensed mental health counselors in Florida are required to have specific graduate-level course work that includes cultural foundations to improve cultural competence.

Florida’s Cultural and Linguistic Competence (CLC) Strategic Plan for 2018-2020 aims to provide effective, equitable, understandable, and respectful quality care that is responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. The 2018-2020 Strategic Plan has the following objectives:

- Provide trainings to organizations recommended by the CLC workgroup and the University of South Florida Evaluation Team.
- Assist regions with trainings to local partners and community members based on the National Standards for Culturally and Linguistically Appropriate Services (the National CLAS Standards).
- Identify local CLC champions in each region.
- Collaborate with CLC workgroup and youth/family organizations to create and promote a social marketing campaign to generate statewide awareness of cultural and linguistic competence, including the National CLAS Standards.
- Provide training to key stakeholders regarding the National CLAS Standard requirements for language and communication assistance.
- Collaborate with University of South Florida Evaluation Team and CLC workgroup to conduct CLC assessments.
- Provide technical assistance and support to all regions with CLC needs.
- Provide technical assistance around recommendations from the CLC assessment results.

Coordinated Specialty Care (CSC) Programs for Early Serious Mental Illness (ESMI)

States are required to spend at least 10% of the Community Mental Health Services Block Grant on Coordinated Specialty Care (CSC) programs for Early Serious Mental Illness (ESMI), including first episodes of psychosis, regardless of the age of the individual at onset. A prolonged duration of untreated mental illness predicts negative outcomes (like serious impairment, unemployment, homelessness, etc.) across different mental illnesses. Earlier treatment and interventions are therefore critical to reducing acute symptoms and improving long-term outcomes. CSC programs for ESMI are evidence-based and provide comprehensive, coordinated, individualized, and integrated services, including but not limited to intensive case management, individual and group therapy, supported employment, family education and supports, and appropriate psychotropic medication. The Department is currently funding the following seven CSC for ESMI teams:

- Henderson Behavioral Health serving Broward County since 2014
- Life Management Center serving Bay County since 2014
- South County Mental Health Center serving Palm Beach County since 2016
- Citrus Health Center serving Miami-Dade County since 2016
- Clay Behavioral Health Center serving Clay and Putnam counties since 2016
- Aspire Health Partners serving Orange County since 2019
- Success 4 Kids serving Hillsborough County since 2019
Success 4 Kids uses the OnTrackNY treatment model, all the other providers use the NAVIGATE treatment model.

**Services for Pregnant Women and Women with Dependent Children (PWWDC)**

Block Grant regulations stipulate that Florida must expend at least $9.3 million in federal and state funds on services for pregnant women and women with dependent children (PWWDC). In FY 17-18, Florida expended $15.1 million on services for PWWDC and served 1,977 pregnant women. The most commonly provided services were residential treatment, methadone maintenance, day care, and outpatient groups. Among those discharged from services, about 67% successfully completed services.

The Department employs a Women’s Services Coordinator who is responsible for reviewing data submitted by the Managing Entities, addressing any discrepancies, completing quarterly reports, and sharing resources related to PWWDC. The Department also participates on weekly calls held by the Florida Hospital Association and Florida Department of Health to discuss strategies for educating hospitals and medical professionals on ways to reduce the incidence and severity of neonatal abstinence syndrome. In partnership with the Florida Association of Alcohol and Drug Abuse and the Florida Certification Board, the Department also provides online trainings and resources on evidence-based practices and treatment for PWWDC.

**Services for Intravenous Drug Users and Other Persons at Risk for HIV and Tuberculosis**

Florida is required to expend 5% of the Substance Abuse Prevention and Treatment Block Grant on HIV Early Intervention Services. HIV Early Intervention Services (EIS) funded under the Block Grant may only be provided to individuals receiving treatment for substance use disorders and must be made available at the sites at which individuals are undergoing treatment for substance use disorders. The primary purpose of these set-aside funds is to provide onsite HIV testing services.

Allowable HIV Early Intervention Services may include one or any combination of the following activities:

- Pretest counseling;
- Posttest counseling;
- Tests to confirm the presence of HIV;
- Tests to diagnose the extent of the deficiency in the immune system;
- When provided to individuals with HIV, tests to provide information on appropriate therapeutic measures for preventing and treating the deterioration of the immune system and conditions arising from HIV, including tests for hepatitis C; and
- Therapeutic measures for preventing and treating the deterioration of the immune system and conditions arising from HIV.

HIV Early Intervention Services must be undertaken voluntarily by, and with the informed consent of, the individual. Receiving HIV Early Intervention Services may not be required as a condition of receiving treatment services for substance use disorders or any other services. HIV-testing and counseling services are provided in confidential, non-group settings, pursuant to the Department of Health’s protocol. Florida’s HIV EIS are delivered onsite through 42 drug treatment programs that collectively tested 31,202 individuals in FY 17-18. A total of 120 tests were positive for HIV.

The Department’s Block Grant coordinator regularly consults with officials from the Department of Health on proposed revisions to rules related to infectious disease control, best practices related to HIV EIS, the development of new needs-based allocation methodologies, standards for programmatic audits, and improvements to each Department’s respective data collection and surveillance systems.

All licensed substance abuse treatment programs in Florida are required to provide tuberculosis testing to high-risk individuals either directly or through referral, pursuant to Chapter 65D-30 of the Florida Administrative Code. County Health Departments in Florida offer free TB testing.
Primary Prevention of Substance Use

Florida, like all states, is required to spend at least 20% of the Substance Abuse Prevention and Treatment Block Grant award on primary prevention activities that are directed at individuals who do not require treatment for substance use disorders. All six strategies described by the Center for Substance Abuse Prevention are funded by the primary prevention set-aside. These strategies include information dissemination, education, alternative recreational activities, problem identification and referral, community-based processes, and environmental strategies. Primary prevention set-aside funds are allocated to all seven regional Managing Entities. The Managing Entities contract with prevention service providers, which are typically community-based organizations, like anti-drug coalitions, and behavioral health service providers that implement school- or family-based prevention programs. The networks of contracted prevention providers that the Managing Entities oversee are designed to be responsive to local needs and conditions. Data on prevention services is entered in the Performance Based Prevention System. In partnership with Collaborative Planning Group Systems Inc. (CPGSI), the Department helps identify and rectify data input errors through training and technical assistance provided to the MEs and prevention services providers. CPGSI provides written recommendations for improvement on an account-by-account basis to each ME. The Performance Based Prevention System now includes a web training tab to house trainings on various topics, including strategic planning.

State Epidemiological Outcomes Workgroup (SEOW)

Florida’s State Epidemiological Outcomes Workgroup (SEOW) plays several roles in state, regional, and community drug-related morbidity and mortality surveillance. Membership (n = 18) consists of epidemiologists and individuals who are knowledgeable about substance use issues including prevention, intervention, and treatment. Participating entities include the Department of Children and Families, Florida Department of Law Enforcement’s Medical Examiners Commission, Department of Health, the Agency for Health Care Administration, and the Department of Education. In addition, the SEOW’s composition includes a representative from each of the Drug Epidemiology Networks (DENs) that operate across the State of Florida. Both the SEOW and individual DENs produce annual reports that are reviewed by the Department and incorporated into strategic initiatives as appropriate.

1 S. 394.9082(1), Florida Statutes (F.S.).
2 Ch. 2013-47, L.O.F., and s. 394.9082(9), F.S.
3 Ibid.
4 S. 394.457, F.S.
5 S. 394.76, F.S.
6 S. 394.674(1), F.S.
Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:
This step should identify the unmet service needs and critical gaps in the state's current M/SUD system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

A data-driven process must support the state's priorities and goals. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data sets including, but not limited to, the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), the National Facilities Surveys on Drug Abuse and Mental Health Services, and the Uniform Reporting System (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorder prevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the Healthy People Initiative HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.


OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
Step 2: Identify the unmet service needs and critical gaps within the current system.

Instructions: This step should identify the unmet service needs and critical gaps in the state’s current behavioral health system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state’s behavioral health system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps. The state’s priorities and goals must be supported by a data-driven process. This could include data that is available through a number of different sources such as SAMHSA’s NSDUH, TEDS, NSSATS, the Behavioral Health Barometer, and state data. This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the SABG priority populations: Pregnant Women, Injecting Drug Users, Women with Dependent Children, Persons at Risk for Tuberculosis, Individuals in Need of Primary Substance Abuse Prevention, and, for HIV-designated states, Persons at Risk for HIV. In addition, this narrative must include a description of the composition of the State Epidemiological Outcomes Workgroup and its contribution to the state planning process. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

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, substance use disorders, 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 noninstitutional 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 institutions, and long-term hospitals. State- and sub-state level estimates are usually based on 2-year or 3-year averages to enhance precision. There is usually at least a 2-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 2016-2017 NSDUH, approximately 4.5% of children ages 12-17 and 7.1% of adults ages 18 and older experienced a substance use disorder in the past year.1 The majority of individuals with substance use disorders do not receive treatment, including approximately 92% of individuals with alcohol use disorders and 87% of individuals with an illicit drug use disorder.2 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% felt they needed treatment and made an effort to get it.3

The NSDUH estimates that 17.5% of adults in Florida experienced any mental illness in the past year.4 Looking more specifically at young adults ages 18-25, there was a statistically significant increase in the prevalence of any mental illness from 16.6% to 22.7% between 2008-2009 and 2016-2017.5 Only about 37% of Floridians with any mental illness receive mental health treatment or counseling.6

It is also estimated that 3.8% of adults in Florida experienced a serious mental illness (SMI) in the past year.7 Nationwide, about 67% of adults with SMI received mental health services in the past year.8 An estimate of the percent of these individuals that receive treatment is not publicly available for Florida. Looking more specifically at young adults ages 18-25, there was a statistically significant increase in the prevalence of SMI from 3.3% to 6.4% between 2008-2009 and 2016-2017.9 There was also a statistically significant increase in the prevalence of serious thoughts of suicide among young adults in Florida, from 6.1% up to 9.3% during this period.10
Among children ages 12-17 in Florida, approximately 13.0% experienced a major depressive episode in the past year.\textsuperscript{11} This reflects a statistically significant increase over the 2008-2009 estimate of 8.5%.\textsuperscript{12} Only about 33% of children experiencing a major depressive episode in the past year receive treatment for it.\textsuperscript{13}

The prevalence of serious emotional disturbances (SED) among children was last estimated by the Substance Abuse and Mental Health Services Administration (SAMHSA) in the Federal Register in 1997. The prevalence in Florida was estimated to be between 7% and 13%.\textsuperscript{14} These estimates, which are now over 20 years old, and which were not based on studies of children in Florida, are no longer useful for strategic planning purposes. A search for more current estimates identified a 2018 systematic review and meta-analysis of 12 peer-reviewed studies that estimated the prevalence of SED in the United States.\textsuperscript{15} Most of these studies spanned 1989 to 2015 and assessed children ages 8 to 17. Four studies incorporated U.S. national samples and eight included regional samples from Chicago; Boston; Pittsburg; Houston; upstate New York; Oregon; North Carolina; and, Connecticut, Georgia, New York, and Puerto Rico (combined). The pooled prevalence of SED with domain-specific impairment was 10.0%. Domain-specific impairment indicates substantial disruption in role functioning secondary to a psychiatric disorder in at least one functional domain of family, peers, educational settings, or the community. This definition meets the minimum criteria for SED established by SAMSHA. The pooled prevalence of SED with global impairment was 6.3%. Global impairment is more severe and indicates substantial impairment of role functioning in multiple domains.

States like Florida, which were not included as part of the regional samples in any of the studies incorporated into the meta-analysis of SED estimates, are in need of current state- and sub-state level estimates. Updates on the next steps related to SED estimation described in the workshop summary from the National Academies’ \textit{Standing Committee on Integrating New Behavioral Health Measures into SAMHSA’s Data Collection Programs} could inform state-level research plans and proposals to address this knowledge gap.\textsuperscript{16}

The National Survey on Children’s Health (NSCH) is one mechanism explored by the Committee with potential for collecting information on SED among children, though no current items on the survey match SAMHSA’s definition of SED. The NSCH is weighted to represent the population of noninstitutionalized children ages 0-17 living in households in Florida and provides data on their physical and emotional health.\textsuperscript{17} All information about children’s behavioral health from the NSCH is based on parent recollection and is not independently verified.

According to the most recently published (2016-2017) NSCH estimates, approximately 10.4% of children in Florida ages 0-17 have any kind of emotional, developmental, or behavioral problem, lasting a year or longer, for which they need treatment or counseling.\textsuperscript{18} This estimate varies according to the number of Adverse Childhood Experiences (ACEs) one is exposed to. The prevalence of emotional, developmental, or behavioral problems requiring treatment is 5.3% among children in Florida with no ACEs, 8.2% among children with one ACE, and 20.5% among children with two or more ACEs.\textsuperscript{19}

According to a similar measure from the NSCH, approximately 9.0% of children ages 3-17 in Florida received treatment or counseling from a mental health professional in the past year, and an additional 3.0% needed to see a mental health professional but did not.\textsuperscript{20} Among children who received or needed mental health treatment, approximately 35% did not have a problem getting it, 41% had a small problem getting it, and 24% had a big problem getting it.\textsuperscript{21} Among children in Florida who are currently insured and who used behavioral health care, 44% have insurance that always offers benefits or covers services that meet their behavioral health needs, 28% have insurance that usually offers benefits or coverage that meets those needs, and 28% have insurance that sometimes/never offers benefits or coverage that meets those needs.\textsuperscript{22}

\textbf{Florida with No Health Insurance and Living in Poverty}

The primary purpose of the Block Grants is to fund services for individuals without insurance or who cycle in and out of health insurance coverage, and to fund treatment and support services not covered by Medicaid, Medicare, or private insurance.\textsuperscript{23} According to 5-year (2013-2017) estimates from the American Community Survey, there are approximately
2,982,945 adult Floridians with no health insurance coverage (representing 14.9% of all adults in Florida). There are 369,896 children (under the age of 18) with no health insurance (representing about 8.5% of all children in Florida). The American Community Survey also indicates that 22.3% of children and 13.7% of adults live below the poverty level.24

The Prevalence of Behavioral Health Conditions among the Uninsured

SAMHSA’s Center for Behavioral Health Statistics and Quality recently provided the Department with state-level and Managing-Entity-level estimates of the prevalence of past-year serious mental illness (SMI) and substance use disorders (SUDs) by insurance status. Three years of NSDUH data (2015-2017) needed to be aggregated to produce the estimates in the table below, some of which are still suppressed due to low precision. Overall, the prevalence of SMI is higher among uninsured adults (5.0%) than it is among insured adults (3.4%). The prevalence of SUD is also higher among uninsured adults (11.9%) than it is among insured adults (6.7%). The statewide estimate of the prevalence of SUD among uninsured children (2.6%) may be particularly imprecise and should be interpreted with caution, based on the fact that all the substate estimates for this measure were suppressed. The prevalence of SUD among insured children is 5.0%, which is comparable to a previous estimate of 5.7% for all children, both insured and uninsured, using 2014-2016 NSDUH data.25

### Prevalence of Past-Year Behavioral Health Disorders Among Adults (Ages 18+) and Children (Ages 12-17) by Insurance Status and Managing Entity Catchment Area: Annual Average Based on 2015-2017 NSDUHs

<table>
<thead>
<tr>
<th>Managing Entity</th>
<th>Serious Mental Illness among Uninsured Adults</th>
<th>Serious Mental Illness among Insured Adults</th>
<th>Substance Use Disorder among Uninsured Adults</th>
<th>Substance Use Disorder among Insured Adults</th>
<th>Substance Use Disorder among Uninsured Children</th>
<th>Substance Use Disorder among Insured Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>BBHC</td>
<td>3.6%</td>
<td>2.1%</td>
<td>*</td>
<td>5.5%</td>
<td>*</td>
<td>2.4%</td>
</tr>
<tr>
<td>CFCHS</td>
<td>5.9%</td>
<td>3.2%</td>
<td>10.1%</td>
<td>5.8%</td>
<td>*</td>
<td>7.4%</td>
</tr>
<tr>
<td>CFBHN</td>
<td>4.8%</td>
<td>3.4%</td>
<td>10.7%</td>
<td>6.5%</td>
<td>*</td>
<td>3.5%</td>
</tr>
<tr>
<td>LSFHS</td>
<td>8.5%</td>
<td>3.8%</td>
<td>15.0%</td>
<td>7.2%</td>
<td>*</td>
<td>6.3%</td>
</tr>
<tr>
<td>BBCBC</td>
<td>6.7%</td>
<td>5.2%</td>
<td>*</td>
<td>8.6%</td>
<td>*</td>
<td>9.1%</td>
</tr>
<tr>
<td>SFBHN</td>
<td>0.8%</td>
<td>2.6%</td>
<td>10.8%</td>
<td>7.2%</td>
<td>*</td>
<td>2.1%</td>
</tr>
<tr>
<td>SEFBHN</td>
<td>5.6%</td>
<td>3.3%</td>
<td>10.6%</td>
<td>7.2%</td>
<td>*</td>
<td>4.8%</td>
</tr>
<tr>
<td>Statewide</td>
<td>5.0%</td>
<td>3.4%</td>
<td>11.9%</td>
<td>6.7%</td>
<td>2.6%</td>
<td>5.0%</td>
</tr>
</tbody>
</table>

* = Low Precision, Estimate Suppressed

The remainder of the 2014-2016 ME-level NSDUH estimates for SMI and SUD among the general household population in Florida, regardless of insurance status, are produced in the table below.26

### Prevalence of Past-Year Behavioral Health Disorders Among Adults (Ages 18+) and Children (Ages 12-17): Annual Average Based on 2014-2016 NSDUHs

<table>
<thead>
<tr>
<th>Managing Entity</th>
<th>Serious Mental Illness among Adults</th>
<th>Substance Use Disorder among Adults</th>
<th>Substance Use Disorder among Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>BBHC</td>
<td>3.0%</td>
<td>7.5%</td>
<td>5.8%</td>
</tr>
<tr>
<td>CFCHS</td>
<td>3.5%</td>
<td>8.0%</td>
<td>5.4%</td>
</tr>
<tr>
<td>CFBHN</td>
<td>3.6%</td>
<td>8.2%</td>
<td>5.9%</td>
</tr>
<tr>
<td>LSFHS</td>
<td>3.8%</td>
<td>8.3%</td>
<td>5.9%</td>
</tr>
<tr>
<td>BBCBC</td>
<td>4.2%</td>
<td>9.4%</td>
<td>5.9%</td>
</tr>
<tr>
<td>SFBHN</td>
<td>3.1%</td>
<td>6.2%</td>
<td>5.3%</td>
</tr>
<tr>
<td>SEFBHN</td>
<td>3.2%</td>
<td>7.2%</td>
<td>5.8%</td>
</tr>
<tr>
<td>Statewide</td>
<td>3.5%</td>
<td>7.9%</td>
<td>5.7%</td>
</tr>
</tbody>
</table>
Waitlist Records and 2-1-1 Call Center Requests for Behavioral Health Services

During FY 18-19, an average of approximately 1,343 individuals per month were placed on waiting lists for behavioral health services, as reported by the seven MEs. Statewide, on average, only a dozen pregnant women per month are placed on a waiting list, and they don’t stay on it long because they are granted priority admission status by the Department’s network of publicly-funded providers. About 118 individuals who are homeless and 220 individuals who inject drugs are placed on a waiting list per month.

During FY 18-19, there were also over 176,190 requests for behavioral health services reported by the sixteen 211 Call Centers through Florida. The table below depicts counts of requests received by service request category. Dividing some of the annualized figures for certain categories by 12 can give a sense of monthly call volume. For example, the FY 18-19 figures below reflect about 7,357 requests for mental health services per month and 4,380 requests for substance abuse services per month.

<table>
<thead>
<tr>
<th>211 Service Request Category*</th>
<th>Number of Requests (FY 18-19)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Services</td>
<td>88,284</td>
</tr>
<tr>
<td>Substance Abuse and Addictions</td>
<td>52,566</td>
</tr>
<tr>
<td>Crisis Intervention and Suicide</td>
<td>27,638</td>
</tr>
<tr>
<td>Mental Health Facilities</td>
<td>6,506</td>
</tr>
<tr>
<td>Marriage and Family</td>
<td>1,088</td>
</tr>
<tr>
<td>Other Mental Health and Addictions</td>
<td>108</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>176,190</strong></td>
</tr>
</tbody>
</table>

*Request category definitions are as follows: **Mental Health Services**: Assessment, screening, testing, counseling, and other therapies for a wide range of mental health issues; **Substance Abuse and Addictions**: Services, referrals, and information for substance abuse, prevention, education, detoxification, treatment, counseling, and addiction support groups; **Crisis Intervention or Suicide**: Direct help or finding programs and hotlines, providing emergency support, assistance, referrals, and information; **Mental Health Facilities**: Inpatient, outpatient, and residential facilities including hospitals, psychiatric units, and drop-in clinics; **Marriage and Family**: Counseling and referrals for marital, family, and other relationship issues.

Mental Health Care Professional Shortage Areas (HPSAs) in Florida

In Florida there are 152 areas experiencing a shortage of mental health professionals. Federal regulations stipulate that to be considered as having a shortage of providers, an area must have a population-to-provider ratio at least 30,000 to 1 (or 20,000 to 1 if there are unusually high needs in the community). In Florida, the percent of need met is 15%, compared to 27% for the entire United States. The percent of need met is computed by dividing the number of psychiatrists available by the number of psychiatrists that would be necessary to eliminate the mental health shortage, based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated). Florida is one of the worst states with regard to percent of the need met by the current workforce of psychiatrists, ranked 41 out of 50 states on this measure. Statewide, the number of additional psychiatrists needed to remove the shortage designation is 381. The expanded use of telepsychiatry – which entails videoconferencing for patient evaluation, medication management, and therapy – could help rural areas address the shortage by tapping into broader, out-of-state networks.

Unmet Service Needs and Critical Gaps as Reported by the Managing Entities

Managing Entities identify the top unmet behavioral health needs in their communities in a variety of different ways, including, but not limited to, analyses of waitlist records, surveys, and focus groups with consumers, providers, and other community stakeholders. This information relates to s. 394.9082(8), F.S., which requires each Managing Entity to develop a description of strategies for enhancing services and addressing three to five priority needs. The top service-related (i.e., non-administrative) needs identified by the Managing Entities for Fiscal Year 18-19 are presented below.
Big Bend Community Based Care (BBCBC):

1. Community Action Team (CAT) services
2. Forensic Assertive Community Treatment (FACT) services
3. Transition vouchers and supported housing options
4. Inpatient detoxification services
5. Outpatient mental health and substance abuse services (including peer-based care coordination and tele-therapy)

Central Florida Behavioral Health Network (CFBHN):

1. Short-term residential treatment beds
2. FACT and CAT team services
3. 24/7 Mobile Crisis Teams
4. In-home and on-site therapy services for high utilizers
5. Crisis stabilization beds
6. School-based prevention services focusing on opioid use
7. Housing vouchers and supported housing options

Central Florida Cares Health System (CFCHS):

1. Adult mental health residential treatment beds
2. Recovery support services
3. Children respite care
4. Adult case management services
5. Adult mental health outpatient treatment

Lutheran Services Florida Health Systems (LSFHS):

1. Care coordination and housing coordination for high utilizers
2. Central receiving system expansion to rural areas
3. Short-term residential treatment beds and assisted outpatient treatment
4. Adult substance abuse assessment services and residential beds

Southeast Florida Behavioral Health Network (SEFBHN):

1. FACT team services
2. Psychiatric services (including tele-medicine)
3. Supportive housing
4. Forensic services for diversion from State Mental Health Treatment Facilities
5. Planning for primary/behavioral health integrated site pilot

South Florida Behavioral Health Network (SFBHN):

1. Coordinated Specialty Care for Early Serious Mental Illness (implementation of the NAVIGATE Model)
2. Care coordination
3. Housing
4. Services for individuals with opioid use disorders (including detoxification, residential, and outpatient medication-assisted treatment services)
5. System of Care specialists and Quality Assurance/Improvement specialists
Broward Behavioral Health Coalition (BBHC):

1. Mental health services and residential beds
2. Residential substance abuse beds and sober housing
3. Short term residential treatment (extended acute care beds)
4. Medication-assisted treatment for opioid use disorders
5. Housing and care coordination team treatment teams, vouchers, and Family/Peer Navigators
6. Multidisciplinary treatment teams (CAT, FIT, and FACT teams)
7. Broward Forensic Alternative Center services for diversion from State Mental Health Treatment Facilities

The Department’s principal way of tackling these needs is by advocating for new state funding through Legislative Budget Requests that describe these unmet needs in more detail and make a compelling case for the beneficial outcomes obtained by addressing them. A performance indicator related to these efforts is included to track progress over the next two years. It calls for the Department to draft and submit budget requests to fund the unmet needs prioritized by Department leadership, namely CAT team services, short-term residential beds, community forensic beds, and outpatient telehealth services. Additional details regarding unmet needs related to supportive housing, medication-assisted treatment, care coordination, and intensive team-based services, and associated performance indicators, are provided later.

<table>
<thead>
<tr>
<th>#1. Priority Area: Priorities Identified by Managing Entities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal:</strong> Address the unmet needs identified by the seven Managing Entities.</td>
</tr>
<tr>
<td><strong>Objectives:</strong></td>
</tr>
<tr>
<td>(1) Draft and submit a legislative budget request to fund additional CAT team services.</td>
</tr>
<tr>
<td>(2) Draft and submit a legislative budget request to fund additional short-term residential beds.</td>
</tr>
<tr>
<td>(3) Draft and submit a legislative budget request to fund additional community forensic beds.</td>
</tr>
<tr>
<td>(4) Draft and submit a legislative budget request to fund additional outpatient telehealth services.</td>
</tr>
<tr>
<td><strong>Indicator:</strong> The number of objectives achieved.</td>
</tr>
<tr>
<td><strong>Baseline (FY 18-19):</strong> Zero objectives achieved.</td>
</tr>
<tr>
<td><strong>First Year (FY 19-20) Target:</strong> Achieve 2 out of 4 objectives.</td>
</tr>
<tr>
<td><strong>Second-Year (FY 20-21) Target:</strong> Achieve 4 out of 4 objectives.</td>
</tr>
</tbody>
</table>

**Care Coordination and Intensive Team-based Services**

The Managing Entities, community stakeholders, and the Department’s leadership have identified a need for more care coordination to reduce readmissions to acute levels of care (like crisis stabilization units, inpatient units, detox facilities, state mental health treatment facilities). Ongoing care coordination initiatives are helping ensure that systems of care are recovery-oriented and function as no-wrong-door models. Care coordination serves to assist individuals who are not effectively connected with the services and supports they need to transition successfully from higher levels of care to effective community-based care. This includes services and supports that affect a person’s overall well-being, such as primary physical health care, housing, and social connectedness. Care coordination connects systems including
behavioral health, primary care, peer and natural supports, housing, education, vocation and the justice systems. It is time-limited, with a heavy concentration on educating and empowering the person served and provides a single point of contact until a person is adequately connected to the care that meets their needs. The Department formed a Care Coordination Project Team to make recommendations to the Assistant Secretary on the implementation of statewide care coordination activities. Pursuant to s. 394.9082(3)(c), Florida Statutes, the Department has defined several priority populations. Managing Entities and provider agencies are expected to minimally serve the following two populations:

1. Adults with a serious mental illness (SMI) or co-occurring disorders who demonstrate high utilization of acute care services, including crisis stabilization, inpatient, and inpatient detoxification services. High utilization is defined as having three or more acute care admissions within 180 days or having acute care admissions that last 16 days or longer.

2. Adults with a SMI awaiting placement in a state mental health treatment facility (SMHTF) or awaiting discharge from a SMHTF back to the community.

Populations identified to potentially benefit from care coordination that may be served in addition to the two required groups above include:

1. Persons with a SMI or co-occurring disorders who have a history of multiple arrests, involuntary placements, or violations of parole leading to institutionalization or incarceration.

2. Caretakers and parents with a SMI or co-occurring disorders involved with child welfare.

3. Individuals identified by the Department, Managing Entities, or Network Service Providers as potentially high risk due to concerns that warrant Care Coordination, as approved by the Department.

<table>
<thead>
<tr>
<th>#2. Priority Area: Intensive Team-Based Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal:</strong> Provide intensive, team-based services to children with serious emotional disturbances (SED).</td>
</tr>
<tr>
<td><strong>Objective:</strong> Increase the number children served by Community Action Teams.</td>
</tr>
<tr>
<td><strong>Indicator:</strong> The number of children with SED served by Community Action Teams.</td>
</tr>
<tr>
<td><strong>Baseline (FY 18-19):</strong> In FY 18-19, the unduplicated count of children served was 3,081</td>
</tr>
<tr>
<td><strong>First Year (FY 19-20) Target:</strong> Increase the number served by 50 (for a total of 3,131 children served).</td>
</tr>
<tr>
<td><strong>Second-Year (FY 20-21) Target:</strong> Increase the number served by 50 (for a total of 3,181 children served).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#3. Priority Area: Florida Assertive Community Treatment (FACT)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal:</strong> Standardize and improve FACT team fidelity monitoring activities.</td>
</tr>
<tr>
<td><strong>Objectives:</strong></td>
</tr>
<tr>
<td>(1) Form a workgroup to review and improve FACT Guidance Document, including participants from the Managing Entities, FACT providers, FACT advisory council members, Block Grant Planning Council members, and other stakeholders as appropriate.</td>
</tr>
</tbody>
</table>
(2) Provide a standardized set of instructions to the Managing Entities on how to monitor the fidelity of the FACT teams to the ACT model.

(3) All 7 Managing Entities will provide a written status report to the Department documenting how recommendations from FACT advisory councils are being implemented.

**Indicator:** The number of objectives achieved.

**Baseline (FY 18-19):** Zero objectives achieved.

**First Year (FY 19-20) Target:** Achieve 1 out of the 3 objectives.

**Second-Year (FY 20-21) Target:** Achieve 3 out of the 3 objectives.

---

**Supported Housing to Reduce Homelessness**

According to 2019 Point-In-Time counts of individuals who are homeless, 4,947 individuals surveyed reported experiencing serious mental illness (SMI), while 3,948 reported a substance use disorder. The prevalence of SMI among individuals who are homeless was 16.2% in 2018 and 17.3% in 2019. The prevalence of SUD among individuals who are homeless was 14.1% in 2018 and 13.8% in 2019. A stable living environment is important to recovery and housing is the most consistently identified unmet need across Managing Entities and from year-to-year. An associated performance indicator calls for increasing access to permanent supportive housing.

**#4. Priority Area:** Housing

**Goal:** Increase access to stable, community-based housing.

**Objective:** Increase access to stable, permanent supportive housing.

**Indicator:** The number of individuals served accessing permanent supportive housing.

**Baseline (FY 18-19):** FY 18-19 baseline is pending.

**First Year (FY 19-20) Target:** Increase the number by 3% over the FY 18-19.

**Second-Year (FY 20-21) Target:** Increase the number by 3% over the FY 19-20 performance.

---

**Pregnant Women and Women with Dependent Children**

Nearly 6 out of 10 (58%) deliveries in 2017 were to women who were enrolled in Medicaid. In 2017, approximately 10,175 deliveries were to women who were diagnosed with opioid abuse, opioid overdose, or who used prescribed opioids during pregnancy. This reflects a decrease from 2015, when there were 11,543 such deliveries. The Agency for Health Care Administration recently analyzed all mothers enrolled in Medicaid who gave birth to a baby with a neonatal abstinence syndrome diagnosis and found that 13% were diagnosed with opioid abuse, dependence, or overdose during the 1st Trimester, compared to 34% diagnosed in the 2nd Trimester, and 53% diagnosed in the 3rd Trimester. These figures reflect an opportunity for earlier engagement.

The Department of Children and Families faces similar opportunities to improve outreach and early engagement, since only about 25% if women served through the Department’s special appropriation are pregnant while engaged in
services. According to preliminary FY 18-19 figures, the Department served 2,113 pregnant women. The most commonly provided services are residential, methadone maintenance, day care, and outpatient groups. Among those discharged from services, about 67% successfully completed services. There were 161 live births reported, 95 of which were born drug free. The vast majority (88%) of women served delivered an infant with a birth weight of 5.5 pounds or higher.\textsuperscript{36}

Recently published findings from a review of 2,434 pregnancy-associated deaths in Florida from 2005 to 2016 indicate that substance misuse is a significant contributing factor for all pregnancy-associated deaths in Florida (regardless of the actual cause or manner of death). A pregnancy-associated death is a death of a woman from any cause, while she is pregnant or within one year of termination of pregnancy, regardless of the duration and site of the pregnancy. About 12% of the deaths reviewed from 2005-2016 were the direct result of substance use overdoses, mostly from accidents or suicides. In 2016, there were 41 deaths from substance use. Pregnancy-associated deaths with substance use as the primary cause of death increased 645% from 2005 to 2016, while pregnancy-associated deaths with substance use as an associated cause of death increased 144%.\textsuperscript{37}

<table>
<thead>
<tr>
<th>#5. Priority Area: Services for Pregnant Women and Women with Dependent Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority Type: Substance Abuse Treatment (SAT)</td>
</tr>
<tr>
<td>Populations: PWWDC</td>
</tr>
<tr>
<td>Goal: Serve women earlier in their pregnancies.</td>
</tr>
<tr>
<td>Objectives: Increase the percent of women served through the Department’s special funding allocation that are pregnant when they are engaged in services.</td>
</tr>
<tr>
<td>Indicator: The percent of women served through the Department’s special funding allocation that are pregnant when they are engaged in services.</td>
</tr>
<tr>
<td>Baseline (FY 18-19): FY 18-19 baseline is pending.</td>
</tr>
<tr>
<td>First Year (FY 19-20) Target: Increase the indicator by 3% over the FY 18-19 baseline.</td>
</tr>
<tr>
<td>Second-Year (FY 20-21) Target: Increase the indicator by 3% over the FY 19-20 performance.</td>
</tr>
</tbody>
</table>

Coordinated Specialty Care (CSC) Early Serious Mental Illness (ESMI) including First Episodes of Psychosis (FEP)

States are required to spend at least 10% of the Community Mental Health Services Block Grant on Coordinated Specialty Care (CSC) programs for Early Serious Mental Illness (ESMI), including first episodes of psychosis, regardless of the age of the individual at onset. Evidence indicates that a prolonged duration of untreated mental illness predicts negative outcomes (like serious impairment, unemployment, homelessness, etc.) across different mental illnesses. Earlier treatment and interventions are therefore critical to both reducing acute symptoms and improving long-term outcomes. CSC programs for ESMI are evidence-based and provide comprehensive, coordinated, individualized, and integrated services, including but not limited to intensive case management, individual and group therapy, supported employment, family education and supports, and appropriate psychotropic medication as indicated.

The Department is currently funding the following seven CSC for ESMI teams:

- Henderson Behavioral Health serving Broward County since 2014
- Life Management Center serving Bay County since 2014
- South County Mental Health Center serving Palm Beach County since 2016
Citrus Health Center serving Miami-Dade County since 2016
Clay Behavioral Health Center serving Clay and Putnam counties since 2016
Aspire Health Partners serving Orange County since 2019
Success 4 Kids serving Hillsborough County since 2019

All these providers use the NAVIGATE treatment model, except for Success 4 Kids, which uses the OnTrackNY model.

#6. Priority Area: Coordinated Specialty Care (CSC) for Early Serious Mental Illness (ESMI)

Goal: Improve functioning among individuals served by CSC for ESMI programs.

Objective: Increase the percent of individuals served that experience improvements in functioning.

Indicator: The percent of individuals served that experience improvements in functioning.

Baseline (FY 18-19): FY 18-19 baseline is pending.

First Year (FY 19-20) Target: Increase the indicator by 3% over the FY 18-19 baseline.

Second-Year (FY 20-21) Target: Increase the number by 3% over the FY 19-20 performance.

Individuals At-Risk for HIV and HIV Early Intervention Services (EIS)

In 2018, Florida identified 4,906 new cases of HIV. The HIV case rate decreased from 24.1 per 100,000 in 2017 to 23.4 per 100,000 in 2018. Miami has the highest rate of new HIV diagnoses in the entire county, followed by Orlando with the second highest rate. The highest proportion of adults who received an HIV diagnosis in 2017 had male to male sexual contact as their mode of exposure (61%), followed by female heterosexual contact (19%), male heterosexual contact (13%), male injection drug use (2%), female injection drug use (2%), and both injection drug use and male to male sexual contact (2%). Approximately 11% of individuals living with an HIV diagnosis in Florida inject drugs. The Department’s implementation of the Block Grant HIV Early Intervention Services set-aside supports the Department of Health’s plan to eliminate HIV transmission and reduce HIV-related deaths. A key component is the implementation of routine HIV screening in health care settings, like substance use disorder treatment facilities. People with HIV who are aware of their status can get HIV treatment, which lowers the level of HIV in the blood, reduces HIV-related illness, and lowers the risk of transmitting HIV to others. For persons at increased risk for HIV, a pill (Truvada®) taken once daily can reduce the risk of acquiring HIV through sexual contact by over 90% and through injection drug use by 70%.

Routine and efficient HIV testing through the Department’s network of treatment providers helps many at-risk individuals know their status and links individuals who are HIV positive to HIV care. Additionally, as explained in more detail below, the Department’s network of behavioral health treatment providers play an important role in helping retain individuals in HIV care and suppressing their viral loads by addressing any unmet needs they might have for addiction treatment, housing, and ancillary support services.

The chart below depicts the HIV Continuum of Care for people living with HIV and, more specifically, for people who inject drugs living with HIV in Florida. The HIV Continuum of Care reflects the series of steps a person living with HIV takes from initial diagnosis, to being retained in HIV care, and achieving a very low level of HIV in the body (i.e., viral suppression), which makes transmitting the virus to others less likely. Among HIV positive individuals who inject drugs in Florida, approximately 71% are in HIV care, 65% are retained in care (with care documented on two or more occasion at least three months apart), and 55% are virally suppressed (HIV-1 RNA load less than 200 copies/mL). HIV positive individuals who inject drugs are less likely to be in care and virally suppressed, compared to the general population of individuals living with HIV, as depicted below.
Between 2014 and 2016, researchers interviewed 619 individuals living with HIV/AIDS throughout Florida. Approximately 32% reported suboptimal adherence to their antiretroviral therapy. About 16% were homeless, 31% had symptoms of depression, and 29% had symptoms of anxiety. Approximately 58% reported illicit drug use, 37% reported non-binge (low-level) drinking, 25% reported binge drinking, and 9% reported heavy drinking. The proportion of individuals with optimal antiretroviral therapy adherence was significantly lower with each increasing category of alcohol consumption, compared to those who abstained from alcohol. Specifically, optimal adherence was reported by 80% of non-drinkers, 68% of low-level drinkers, 58% of binge drinkers, and 51% of heavy drinkers. Heavy alcohol consumption was also associated with twice the odds of having suboptimal HIV viral suppression compared to non-drinkers, even when controlling for other potential confounding variables. According to the authors, these findings “help reinforce the potential benefits of screening and brief intervention for alcohol problems in HIV care settings, especially when persons are having difficulties maintaining consistent HIV viral suppression.”

The Department of Health analyzed 4,151 responses to an anonymous survey designed to collect information on the met and unmet needs of people living with HIV/AIDS. It should be noted that the survey did not collect protected health information and respondents were not confirmed to have an HIV/AIDS diagnosis. As depicted in the table below, most respondents living with HIV/AIDS that needed mental health or substance abuse treatment services were able to obtain them, but 6.6% of people were unable to get mental health services and 3.1% were unable to get substance abuse treatment services:

<table>
<thead>
<tr>
<th>Access and Utilization of Mental Health and Substance Abuse Services Among People Living with HIV/AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did Not Need Service</td>
</tr>
<tr>
<td>----------------------</td>
</tr>
<tr>
<td>Mental Health Service</td>
</tr>
<tr>
<td>Substance Abuse Treatment Service</td>
</tr>
</tbody>
</table>

Among individuals living with HIV/AIDS who reported barriers to receiving services, the most commonly reported barriers were not knowing where to get services (13.8%), inability to pay (8.4%), and inability to get transportation (6.3%). The number of respondents reporting that they did not know where to get services doubled since the last needs assessment in 2013. To address this barrier, the authors suggest developing comprehensive lists of services by county, including contact information for service providers, and making them easily accessible through County Health Departments and case managers. This recommendation is being incorporated into an associated performance indicator.
In FY 17-18, the Department introduced new guidance to the Managing Entities regarding the implementation of the HIV Early Intervention Services set-aside. This updated guidance aligns with DOH testing protocols and is designed to help drug treatment providers develop more efficient and routine onsite HIV testing procedures. The goal is to increase the number HIV tests conducted through the Department’s network of drug treatment providers. Plans to gauge the impact of the new guidance are incorporated into a new Block Grant performance indicator.

States with an AIDS case rate of 10 or more per 100,000 become “designated” states that are required to spend 5% of the SAPT Block Grant award on HIV Early Intervention Services (EIS). Florida has been a “designated” state since the inception of the set-aside. The official AIDS case rate measure that determines whether a state is “designated” for the set-aside requirement is published in the CDC’s HIV Surveillance Reports. Florida’s AIDS case rate was 26 per 100,000 in 2008. The most recently published estimates reflect an AIDS case rate of 12.1 per 100,000 in 2017. If the current downward trend continues, it may be only a few more years before Florida is granted the option of continuing to obligate 5% of the SAPT Block Grant award for HIV EIS or discontinuing that practice. SAMHSA allows states that were designated in any of the three years prior to the year for which they are applying for funds to continue to obligate and expend funds for HIV EIS if they so choose. The analyses proposed in the associated performance indicator will help position Florida to make an informed decision about sustaining and integrating the set-aside-funded HIV EIS when the time comes.

### #7. Priority Area (based on an unmet need or gap): Infectious Disease Control

**Goal:** Improve the implementation of Florida’s HIV Early Intervention Services set-aside

**Objectives:**

1. Conduct an analysis of the specific HIV tests and testing processes used by HIV EIS providers, share the analysis with the Department of Health, and consult with them regarding ways to improve value or reduce costs.

2. Conduct an analysis of the impact of the new HIV EIS Guidance Document on the number of individuals tested and number of tests conducted using FY 16-17 as a baseline, FY 17-18 as a transition period, and FY 18-19 as a new target year to expect an overall increase.

3. Analyze the HIV testing policies, procedures, and processes used by the providers that spend less than $100 per individual tested or per test conducted, identify best practices that contribute to their efficiency, and share them with the other providers.

4. Analyze the variation in positivity rates between HIV EIS providers and locations and attempt to identify relationships between positivity rates and methods of targeting individuals for testing.

**Indicator:** The number of objectives achieved.

**Baseline (FY 18-19):** Zero objectives achieved.

**First Year (FY 19-20) Target:** Achieve 2 out of the 4 objectives.

**Second-Year (FY 20-21) Target:** Achieve 3 out of the 4 objectives.
Individuals At-Risk for Tuberculosis and Tuberculosis Services

In 2017, 549 tuberculosis (TB) cases were reported in Florida. This represents a 14% decrease in cases from 2016 and is the lowest number of cases reported in the past two decades. The 2017 TB incidence rate was 2.7 per 100,000. The following risk factors were identified among the 2017 cases:

- Excess alcohol use in the past year (13%)
- HIV co-infection (11%)
- Illicit drug use within the past year (8%)
- Homelessness (6%)òn

TB cases where the use of alcohol and other drugs are identified as risk factors have been declining over the past two decades. Looking more specifically at injection drug use as a risk factor, the Department of Health estimates that only about 1% to 2% of TB cases are associated with injection drug use. The number of adult AIDS diagnoses with co-occurring TB decreased from 84 cases in 2013, down to 58 cases in 2017.

It is important that people who have TB take medications exactly as prescribed and finish the course of treatment. If they stop taking the medication too soon, they can become sick and may spread the infection to other people. Furthermore, if they do not take the medicine correctly or receive incomplete treatment, the TB bacteria may develop resistance to those drugs and become harder and more expensive to treat. Fortunately, it is estimated that 99% of individuals with TB in Florida successfully complete treatment.

One study investigated factors that contributed to a 2008-2009 outbreak of TB at an assisted living facility for adults with mental illness in Florida. Eighteen individuals were diagnosed with TB during this outbreak and treatment nonadherence was found to be a contributing factor that was documented among half of these patients. Illicit drug use, alcohol use, and tobacco use were all prevalent among this population (39%, 50%, and 94%, respectively), though these behaviors were not explored as variables associated with nonadherence as part of this study. Researchers cited “poor insight, aversion to side effects, and poor alliance with treating clinicians” as potential obstacles to adherence common among individuals with mental illness. They speculate that “assessing all patients with mental illness for the potential of treatment nonadherence at the time of diagnosis could help TB programs anticipate and prepare for some of these problems.”

According to a 2018 survey of methadone clinics throughout Florida, they are currently serving approximately 3 individuals with TB. No individuals with TB were discharged due to inability to pay in 2016 or 2017. Methadone clinics were asked to identify any barriers to enrolling and retaining individuals with TB, HIV/AIDS, or a history of intravenous drug use into care. A lack of affordable housing and inability to pay were the most commonly cited barriers, followed by transportation. The Department’s Block Grant Coordinator met with representatives from the Department of Health to review the findings described above and discuss potential recommendations. A new Block Grant performance indicator is established to guide implementation of those recommendations.

#8. Priority Area (based on an unmet need or gap): Infectious Disease Control

Goal: Improve access to behavioral health services among individuals with HIV or TB

Objectives:

(1) Disseminate “access to care” phone lines (which regional Managing Entities established to help indigent and uninsured individuals access behavioral health services through their networks of
publicly-funded providers) to County Health Departments, Medical Directors, Nursing Directors, Regional Nurses, Program Managers, and Social Service Managers.

(2) Incorporate “access to care” lines into DOH’s website, 211 Big Bend materials, and resource appendices in the DOH manuals for TB, Hepatitis C, Case Management, HIV Counselors, and STD Field Services, as appropriate.

(3) Conduct a training for DOH staff regarding available behavioral health treatment resources, particularly Medication-Assisted Treatment for opioid use disorders, which involves the use of methadone, buprenorphine, and naltrexone medications.

**Indicator:** The number of objectives completed.

**Baseline (FY 18-19):** Zero recommendations implemented.

**First Year (FY 19-20) Target:** Achieve 1 out of 3 objectives.

**Second-Year (FY 20-21) Target:** Achieve 3 out of 3 objectives.

---

**Hope for Healing**

Florida’s First Lady Casey DeSantis is promoting the [www.HopeForHealingFL.com](http://www.HopeForHealingFL.com) initiative and conducting mental health listening sessions throughout the state, which involves the collaboration of the Department of Children and Families, Department of Health, Department of Juvenile Justice, Department of Education, and the Agency for Health Care Administration. This initiative is intended to help people access a variety of public and private sector prevention and intervention resources before they experience a mental health crisis. Comprehensive Mental Health and Substance Abuse Resource Guides are being developed to provide help in a timely fashion, and local search tools are being developed to help families find behavioral health services where they live. School-based mental health training and education is also being expanded. Reducing suicides and the stigma of mental illness are priorities. According to First Lady DeSantis, “Many Floridians are struggling with mental illnesses that are not visible to an outside observer. We must work to reduce the stigma so often associated with mental illness and focus efforts on getting those the help they need, before it is too late.”

As part of this initiative, telehealth portals are being installed in 63 public schools throughout six mostly rural counties in Northwest Florida that are still recovering from the devastation of Hurricane Michael. Each school will have one portal in a centralized location determined by the school. After receiving a referral from a guidance counselor, and written consent from a parent or legal guardian, each student will have the opportunity to speak one-on-one in private with a mental health service provider who will assess and if necessary, begin to treat the student. Parents will have the ability to call into the session via a mobile app or receive a summary from the provider following the session if they are unable to participate. “While this is an innovative, 21st century approach and a promising start to tackling the mental health crisis, we understand that this is just one piece of the puzzle. We want to make sure that people realize that hope is on the horizon and at the end of the day this community will be made whole,” said First Lady DeSantis.

**Suicide Prevention**

In 2018, there were 3,552 deaths by suicide in Florida, up from 3,187 in 2017. Suicide is the eighth leading cause of death in Florida. The prevalence of serious thoughts of suicide in the past year among adults ages 18-25 in Florida increased from 6.1% to 9.3% between 2008 and 2017. The Statewide Office for Suicide Prevention (SOSP) and the Suicide Prevention Coordinating Council are analyzing the number of individuals exposed to suicide prevention trainings.
and activities. The SOSP received completed Suicide Prevention Activities forms from 39 entities and estimated that 29,208 individuals were exposed to suicide prevention activities in Calendar Year 2018.

#9. Priority Area: Suicide Prevention

**Goal:** Decrease the number of deaths by suicide.

**Objective:** Increase the number of individuals exposed to suicide prevention resources.

**Indicator:** The number of individuals exposed to suicide prevention resources.

**Baseline (FY 18-19):** FY 18-19 figures are pending.

**First Year (FY 19-20) Target:** Increase the number of individuals exposed to suicide prevention resources by 1,000 more than the FY 18-19 baseline.

**Second-Year (FY 20-21) Target:** Increase the number of individuals exposed to suicide prevention resources by 1,000 more than the FY 19-20 figure.

### Primary Prevention of Substance Use

Substance use among youth in Florida continues to trend downward. Among middle and high school students in Florida, between 2008 and 2019, the prevalence of lifetime alcohol use decreased from 53% down to 37% and the past-30-day prevalence of alcohol use decreased from 30% down to 15%. Regarding binge drinking (in the past 2 weeks), the prevalence decreased from 15% down to 7%. 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 19% down to 13%.

Regarding marijuana use, the prevalence of lifetime and past 30-day marijuana use among middle and high school students is essentially flat between 2008 and 2019. Lifetime prevalence decreased from 21% down to 20%, and past 30-day prevalence decreased from 11% down to 10%. Looking more specifically at vaping marijuana, approximately 15% of middle and high school students reported vaping marijuana at least once in their lifetimes in 2019, and approximately 8% did so in the past 30-days. Regarding the use of any illicit drug other than marijuana, the lifetime prevalence decreased from 21% down to 15% between 2008 and 2019. The prevalence of the current (past 30-day) use of any illicit drugs other than marijuana decreased from 9% down to 6%.

The Department partnered with the Collaborative Planning Group to conduct the Statewide Substance Abuse Prevention Needs Assessment, which was completed in June 2017. Focus groups (with participants from Managing Entities, providers, and coalitions) conveyed an interest in sharing best practices, evidence of effectiveness, and challenges. Since then, the Department has collected input from Managing Entities, prevention providers, and community-based organizations, regarding content for a new Statewide Substance Abuse Prevention Plan. The following key domains that have emerged from this process will be addressed in the forthcoming Prevention Plan: (1) Targeting prevention resources to communities identified at the highest risk for substance misuse and substance-related harmful consequences; (2) Increasing the number of strategic, interagency partnerships; (3) Attracting, training, and retaining a qualified prevention workforce; (4) Formalizing opportunities for face-to-face, collaborative planning meetings with various partners; and, (5) Evaluating prevention programs that have never been tested. In order to adequately inform the draft of the Prevention Plan, the Department’s Prevention EBP Workgroup will need to complete several steps outlined in the associated performance indicator, like classifying prevention programs with inconclusive, mixed, or limited findings as either evidence-based or not, describing and classifying currently funded environmental strategies, and developing a list of untested prevention programs that should be prioritized for evaluations using experimental or
quasi-experimental designs. The EBP Workgroup will consider consulting the Title IV-E Prevention Services Clearinghouse to identify all the evidence-based drug prevention programs that have also have experimental evidence of effectiveness at preventing other mental, emotional, and behavioral problems (i.e., depression, anxiety, conduct disorders, suicidality, academic failure, school suspensions, family conflict). When it comes to classifying environmental strategies, the EBP Workgroup will consult standards established by the Society of Prevention Research.66

#10. Priority Area: Primary Prevention

Goal: Comprehensively describe of the evidence-base for primary prevention services provided in Florida.

Objectives:

(1) Classify 3 out of 6 prevention programs with inconclusive, mixed, or limited findings as either evidence-based or not.

(2) Classify 6 out of 6 prevention programs with inconclusive, mixed, or limited findings as either evidence-based or not.

(3) Publish a detailed descriptive report on all the Block Grant funded environmental prevention strategies currently being implemented.

(4) Classify at least half of all the environmental strategies currently being implemented as either evidence-based or not.

(5) Identify all the evidence-based drug prevention programs that have experimental evidence of effectiveness at preventing other mental, emotional, and behavioral problems (i.e., depression, anxiety, conduct disorders, suicidality, academic failure, school suspensions, family conflict).

(6) Develop a list of untested prevention programs that need to be evaluated with an experimental design and prioritize them according to the volume of individuals they serve and funds they expend.

Indicator: The number of objectives achieved.


First Year (FY 19-20) Target: Achieve 2 out of 6 objectives.

Second-Year (FY 20-21) Target: Achieve 4 out of 6 objectives.

#11. Priority Area: Primary Prevention

Goal: Improve the prevention workforce.

Objective: Increase the knowledge, skills, and abilities of the prevention workforce in Florida.

Indicator: The number of prevention-related trainings conducted.

Baseline (FY 18-19): In FY 18-19, FADAA conducted 4 prevention webinars.
The State Epidemiological Outcomes Workgroup (SEOW)

Florida’s State Epidemiological Outcomes Workgroup (SEOW) plays several roles in state, regional, and community drug-related morbidity and mortality surveillance. Membership (n = 18) consists of epidemiologists and individuals who are knowledgeable about substance use issues including prevention, intervention, and treatment. Participating entities include the Department of Children and Families, Florida Department of Law Enforcement – Medical Examiners Commission, Department of Health, the Agency for Health Care Administration, and the Department of Education. In addition, the SEOW’s composition includes a representative from each of the Drug Epidemiology Networks (DENs) that operate across the State of Florida. Through the Partnerships for Success grant, eight counties were selected for DEN development and implementation including Broward, Duval, Franklin, Hillsborough, Manatee, Palm Beach, Walton, and Washington. Both the SEOW and individual DENs produce annual reports that are reviewed by the Department and incorporated into strategic initiatives as appropriate. A review of the findings from the most recent SEOW and DEN reports reveals cautious optimism that the decrease in deaths caused by opioids observed during the first half of 2018 will still be maintained in the full 2018 Medical Examiners report that will be released later. Additionally, fentanyl and fentanyl-analogs continue to drive overdoses, including deaths involving cocaine. Polydrug toxicity is still the most common pattern observed among deaths caused by drugs. Rural counties report an increase in heroin use and the emergence of fentanyl. A copy of the 2018 SEOW Report is available at the following location: www.myflfamilies.com/service-programs/samh/publications/docs/Florida%20SEOW%20Annual%20Report%202018.pdf.

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

On February 1, 2019, Governor Ron DeSantis signed an Executive Order (No. 19-36) declaring a state of emergency due to the epidemic of opioid-related deaths. In 2017, there were 4,279 deaths in Florida where at least one opioid was identified as a cause of death. The Department of Children and Families has taken the lead regarding the deployment of evidence-based resources to prevent opioid-related deaths. State and federal funds, including SAMHSA’s State Targeted Response (STR) Grant, State Opioid Response (SOR), and Substance Abuse Prevention and Treatment (SAPT) Block Grant, are directed at the most effective interventions. According to a model published in the American Journal of Public Health in 2018, the interventions that will reduce the greatest number of opioid overdose deaths over 5 to 10 years in the U.S. are identified in the table below.

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Estimated Number of Opioid Deaths Prevented Over 5 Years</th>
<th>Estimated Number of Opioid Deaths Prevented Over 10 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expansion of Naloxone Availability</td>
<td>10,200</td>
<td>21,200</td>
</tr>
<tr>
<td>Expanded Access to Medication-Assisted Treatment</td>
<td>4,900</td>
<td>12,500</td>
</tr>
<tr>
<td>Expansion of Needle Exchange Programs</td>
<td>2,700</td>
<td>5,900</td>
</tr>
<tr>
<td>Reduced Prescribing for Acute Pain</td>
<td>1,900</td>
<td>8,000</td>
</tr>
<tr>
<td>Expansion of Prescription Drug Disposal Programs</td>
<td>300</td>
<td>2,400</td>
</tr>
</tbody>
</table>

Expansion of Naloxone Availability: Research indicates that naloxone distribution can reduce community-level overdose mortality by as much as 37% to 90%. It is conservatively estimated that one heroin overdose death is prevented for every 164 naloxone kits distributed. Additionally, studies suggest that increasing health awareness through training programs that accompany naloxone distribution reduces the use of opioids and increases users’ desire to seek addiction treatment. The Department initiated an Overdose Prevention Program in August of 2016. The program has been...
funded through a variety of sources, including General Revenue, the SAPT Block Grant, the STR grant, and the SOR grant. Organizations enrolled in the program distribute free, take-home naloxone kits directly to people who use drugs or are otherwise at risk of experiencing an overdose and to their loved ones that may witness an overdose. There are currently 105 organizations participating in the program, including substance use and mental health treatment facilities, hospital emergency departments, harm reduction programs, peer recovery organizations, homeless service providers, federally qualified health centers, and other community-based organizations. Since the start of the program, over 76,000 naloxone kits have been distributed among participating providers and 3,010 overdose reversals have been reported. An associated performance indicator calls for increasing the number of Emergency Department sites participating in the Department’s naloxone distribution program (currently there are 10) and the number of EMS/Fire naloxone leave behind programs in operation (currently there are only 5).

**Expanded Access to Medication-Assisted Treatment (MAT):** Methadone and buprenorphine maintenance are the most effective ways to decrease the illicit use of opioids and reduce the risk of overdose. Research shows that 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. Most of the nearly 13,000 individuals that received STR funded services were maintained on methadone. Additionally, before STR there were only 65 authorized buprenorphine prescribers in the Department’s network of publicly-funded treatment providers. Now there are 163 prescribers, representing a 150% increase in capacity. For clients who have already completed opioid detoxification, long-acting injectable naltrexone (Vivitrol) is another FDA-approved medication that may help prevent relapse. The number of Vivitrol prescribers in the Department’s network quadrupled over the course of STR, increasing from only 11 prescribers up to 46.

**Expansion of Needle Exchange Programs:** Syringe exchange programs are front line public health interventions that effectively reduce the spread of HIV and hepatitis C by reducing the sharing, reuse, and circulation of syringes and injecting equipment. Research shows that every dollar spent on syringe exchange programs saves at least three dollars in treatment costs averted. Syringe exchange programs provide a range of comprehensive healthcare services including testing and counseling for various infectious diseases, overdose prevention, and vaccinations. Syringe exchange programs also facilitate recovery from substance use disorders by linking people who use drugs to treatment services. Florida’s first legal syringe exchange program – called the IDEA Exchange – opened in Miami-Dade County on December 1, 2016. The program provides compassionate and nonjudgmental services and empowers people who use drugs to make healthier and safer choices regardless of whether they are ready to stop using drugs. Since the start of the IDEA Exchange in Miami, 1,147 have enrolled in the program. A total of 1,059 HIV rapid tests have been performed among participants, with an HIV positivity rate of 12.5% (self-reported or newly diagnosed). A total of 877 hepatitis C rapid tests have been performed, with a 46.7% positivity rate. Additionally, 340 participants have been referred to substance use treatment services. Compared to the fixed exchange site in Miami, the mobile van is more likely to attract people who inject drugs from higher risk and harder to reach groups (i.e., more women, more African Americans, higher self-reported hepatitis C virus seropositivity, lower socioeconomic status, more homelessness). Miami’s program also reduced the number of syringes improperly disposed of in public places by nearly 50%.

The recently released 2018 Interim Report on *Drugs Identified in Deceased Persons by Florida Medical Examiners* observes that between the last 6 months of 2017 and the first 6 months of 2018, Florida experienced a 7% reduction in opioid-caused deaths. The Department supports widespread naloxone distribution to people who use drugs through both the Miami IDEA syringe exchange and a partner peer-outreach program in Palm Beach County – called Rebel Recovery – which may have contributed to steeper reductions in opioid-caused deaths in South Florida. Miami-Dade had a 39% reduction, Palm Beach had a 36% reduction, and Broward had a 29% reduction in opioid-caused deaths. It should be noted that about 10% of the IDEA Exchange participants using the mobile van unit and 20% of those using fixed site in Miami are residents of Broward County. In partnership with the Department, the IDEA Exchange has distributed 2,432 boxes of Narcan and documented 1,347 reported reversals. In Palm Beach County, Rebel Recovery distributed 5,481 boxes of Narcan and documented 478 reported reversals.
Effective on July 1, 2019, new legislation in Florida (Senate Bill 366) permits county commissions to authorize the establishment of additional syringe exchange programs through county ordinances. County Health Departments will be enlisted to provide ongoing advice and recommendations regarding program operation. The Department of Children and Families will assist the Department of Health and County Health Departments in this capacity and will ensure that new programs are equipped with overdose reversal kits and establishing the processes and relationships needed to effectively link individuals to addiction treatment services.

**Reduce Prescribing for Acute Pain:** The Department of Children and Families, the Department of Health, and a variety of community-based partners, including anti-drug coalitions throughout the state, have worked for many years on educational campaigns and initiatives designed to encourage safe prescribing practices and reduce the volume of unused opioids available for theft, diversion, and abuse. These efforts recently culminated with the enactment of new legislation (House Bill 21), which went into effect in Florida on July 1, 2018, that limits prescriptions for acute pain to a 3-day supply (with the potential for an extension up to a maximum of 7 days with additional documentation). Preliminary research shows that the law substantially reduced opioid prescriptions. Six months after implementation of the law, the proportion of patients receiving opioid prescriptions for common outpatient surgical procedures decreased by 21%, and the average total opioid dose prescribed decreased by 64 Morphine Milligram Equivalents. The proportion of patients receiving opioid prescriptions for longer than a 3-day supply decreased by 68%. The authors of this study concluded that, “The legislation should significantly decrease the amount of unused opioid pills potentially available for diversion and abuse.” Updates from the Department of Health also reflect decreases in the number of days' supply of controlled substances dispensed to patients and the Morphine Milligram Equivalents per prescription.

**Expansion of Prescription Drug Disposal Programs:** Historically, the most commonly implemented opioid misuse prevention activities in Florida have been designed to reduce the supply of prescription drugs available for theft, diversion, and misuse. These activities include safe storage and disposal campaigns, participation in drug “Take-Back” events, the establishment of prescription drug drop boxes, and the provision of lock boxes and drug deactivation systems. Community education and awareness campaigns incorporating safe use, safe storage, and safe disposal messages have been supported by the Block Grant’s primary prevention set-aside and the Drug Free Communities grant for at least a decade. SAMHSA’s Center for Application of Prevention Technologies (CAPT) recently summarized evaluation findings from a selection of media campaigns designed to prevent prescription drug misuse. According to SAMHSA’s summary, during the implementation of the *Use Only as Directed: Utah Prescription Pain Medication Program*, the number of unintentional prescription drug-related overdose deaths decreased, along with willingness to share prescriptions and to use someone else’s prescription drugs. In addition to Block Grant primary prevention set-aside funds, the Department also authorizes the use of State Opioid Response grant prevention funds for media campaigns based on the *Use Only as Directed* initiative, and to date thousands of Floridians are estimated to have been reached by campaign messages.

### #12. Priority Area (based on an unmet need or gap): Reducing Opioid-Related Deaths

**Goal:** Increase access to naloxone to prevent opioid overdose deaths.

**Objectives:**

1. Increase number of Emergency Departments distributing naloxone kits upon discharge to patients at risk of experiencing an overdose.
2. Increase the number of Fire/EMS naloxone leave-behind programs.
3. Supply naloxone kits to all new Syringe Exchange Programs.

**Indicator:** The number of objectives achieved.
Landmark Consensus Report from the National Academies: *Medications for Opioid Use Disorder Save Lives*

On March 20, 2019, the National Academies of Sciences, Engineering, and Medicine issued a landmark Consensus Study Report titled, *Medications for Opioid Use Disorder Save Lives*. The committee introduces a new term – “medication-based treatment” for opioid use disorders instead of “medication-assisted treatment” – because this emphasizes the committee’s conceptual framework of opioid use disorder “as a chronic disorder for which medications are first-line treatments that are often an integral part of a person’s long-term treatment plan, rather than complementary or temporary aids on the path to recovery.” They observed that, “Behavioral interventions, in addition to medical management, do not appear to be necessary as treatment in all cases.” The committee concluded that, “A lack of availability or utilization of behavioral interventions is not a sufficient justification to withhold medications to treat opioid use disorder.” In other words, an individual’s refusal to participate in counseling does not justify involuntarily discharging them out of medication-based treatment. This mirrors the position of SAMHSA’s experts within Treatment Improvement Protocol 63, which states, "Counseling and ancillary services should target patients’ needs and shouldn’t be arbitrarily required as a condition for receiving opioid use disorder medication.

These findings and conclusions have important implications for the Department’s efforts to improve retention. The Department is aware that some treatment providers discharge individuals for failing to attend counseling sessions. It is also possible that failed admissions are related to counseling requirements that are perceived as onerous. To the extent that counseling requirements constitute a barrier to admission and retention in medication-based treatment, these policies and practices will need to be systematically identified and addressed through guidance documents, contract provisions, and training.

Another barrier to systematically improving retention in medication-assisted treatment (MAT) is the practice of involuntarily discharging individuals (i.e., “kicking them out” of treatment) for positive drug tests. According to SAMHSA’s Treatment Improvement Protocol 63, “If a patient does not discontinue all illicit drugs for extended periods, it doesn’t mean treatment has failed and should not result in automatic discharge. It means the treatment plan may require modification to meet the patient’s needs.” SAMHSA’s expert panel issued the following directive: “Do not require discontinuation of pharmacotherapy because of incomplete treatment response. Doing so is not a rational therapeutic response to the predicted course of a chronic condition.” Since relapses and rule violations are part of the disease of addiction, these behaviors should not result in immediate discharges from medication-based treatment services. Current involuntary discharge policies and practices will be examined and addressed through guidance documents, contract provisions, and training.

Collaborative site visits with MAT providers throughout the state, designed to provide quality assurance and transformation assistance, were recently conducted. Site visit teams consisted of representatives from the regional DCF offices, Managing Entities, and the Statewide Peer Network. Policies, procedures, and treatment charts were reviewed for features reflecting self-determination, person-centered care, and individualized services that support recovery. Interviews were conducted with individuals receiving services. A preliminary review of site-specific reports, with a particular focus on MAT-related obstacles, revealed the following findings and recommendations. Several programs rely heavily on the 12-step model and only offer NA/AA support groups. An overarching recommendation is that providers incorporate other support groups that are more supportive of medication-based treatment and recovery. One individual receiving services reported that the doctor demanded titration, despite the objections and intensified cravings reported by this individual. To further explore provider-level titration policies and expectations, the Department is reviewing MAT-related consent forms, policies, and program descriptions.

### Baseline (FY 18-19)

Zero objectives achieved.

### First Year (FY 19-20) Target

Achieve 1 out of 3 objectives.

### Second-Year (FY 20-21) Target

Achieve 2 out of 3 objectives.

---

**Printed: 8/12/2019 1:29 PM - Florida - OMB No. 0930-0168  Approved: 04/19/2019 Expires: 04/30/2022**
medication-based treatment, including arbitrary titration, will be addressed in the future through revised guidance documents, contract provisions, and training initiatives.

#13. Priority Area: Medication-Assisted Treatment

Goal: Improve access to medication-assisted treatment.

Objectives:

(1) Draft new contract provisions designed to ensure that Department-funded treatment providers are not imposing arbitrary counseling requirements on individuals with opioid use disorders in need of medication-based treatment services.

(2) Draft new contract provisions designed to ensure that Department-funded treatment providers are not inappropriately discharging individuals who continue to test positive for substance use.

(3) Draft new contract provisions designed to ensure that Department-funded treatment providers are not imposing arbitrary restrictions on the length of medication-based maintenance treatment services.

(4) Double the number of Emergency Departments that do onsite buprenorphine induction prior to discharge from 3 to 6.

Indicator: The number of objectives achieved.


First Year (FY 19-20) Target: Achieve 2 out of 3 objectives.

Second-Year (FY 20-21) Target: Achieve 3 out of 3 objectives.


Page 24 of 26
Planning Steps

Quality and Data Collection Readiness

Narrative Question:
Health surveillance is critical to SAMHSA’s ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA’s NBHQF. The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at [http://www.samhsa.gov/data/quality-metrics/block-grant-measures](http://www.samhsa.gov/data/quality-metrics/block-grant-measures). These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA’s success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA’s centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA’s state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities’ movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state’s data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

2. Is the state’s current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare,
3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

4. If not, what changes will the state need to make to be able to collect and report on these measures?
   Please indicate areas of technical assistance needed related to this section.

Footnotes:
Planning Step: Quality and Data Collection Readiness

Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

The Department’s data system, called the Financial and Services Accountability Management System (FASAMS), collects data submitted through monthly batch upload from the Managing Entities (MEs), each with their own local data systems. Data from hundreds of behavioral health provider sites are submitted through a variety of means to the MEs. The MEs, in turn, compile and format all the data for their catchment area and submit monthly files to FASAMS. The monthly file uploads include client demographics (e.g., name, age, race), treatment episode data (e.g., diagnoses, level of care needs, substances used, residential status), services provided (e.g., service type, date, unit of measure) as well as provider specific records such as location of service delivery sites and contracted services provided. The data dictionary for the specific data elements included in each of these files is available at the following location: www.myflfamilies.com/service-programs/samh/155-2/pamphlet-155-2-v13.shtml. FASAMS data is reportable at the client, program, provider, ME, and state levels.

Prevention service records are maintained in a separate system called the Performance Based Prevention System (PBPS).

Is the state’s current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

FASAMS is limited to Department-funded mental health and substance abuse services rendered by a Department-funded provider. FASAMS has the capability to receive Medicaid data from Florida’s Medicaid Authority but that process is presently on-hold while the Department works to deploy a Master Data Management process that can help identify persons that also receive services from the Department’s Office of Economic Self-Sufficiency (ESS), and Office of Child Welfare (OCW). In time, the FASAMS data will be integrated into a confederated environment that contains SAMH, ESS and OCW data.

Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

Yes, the Department does collect and report measures at the individual client level. De-identified client level data is shared as part of the annual submission of Uniform Report System (URS) data, Basic Client Information (BCI) data, and State Hospital Readmission (SHR) data. The Department intends to deploy a consolidated SA-MH Treatment Episode Data Set submission which will replace the URS, BCI, and SHR submissions.
## Planning Tables

### Table 1 Priority Areas and Annual Performance Indicators

<table>
<thead>
<tr>
<th>Priority #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Priority Area:</strong></td>
<td>Priorities Identified by Managing Entities</td>
</tr>
<tr>
<td><strong>Priority Type:</strong></td>
<td>SAT, MHS</td>
</tr>
<tr>
<td><strong>Population(s):</strong></td>
<td>SMI, SED, PWDC, ESMI, PWID, EIS/HIV, Other (Rural, Homeless)</td>
</tr>
<tr>
<td><strong>Goal of the priority area:</strong></td>
<td>Address the unmet needs identified by the seven Managing Entities.</td>
</tr>
<tr>
<td><strong>Objective:</strong></td>
<td>(1) Draft and submit a legislative budget request to fund additional CAT team services. (2) Draft and submit a legislative budget request to fund additional short-term residential beds. (3) Draft and submit a legislative budget request to fund additional community forensic beds. (4) Draft and submit a legislative budget request to fund additional outpatient telehealth services.</td>
</tr>
<tr>
<td><strong>Strategies to attain the objective:</strong></td>
<td>Ensure that legislative budget requests are data-driven, compelling, and based on a collaborative approach.</td>
</tr>
</tbody>
</table>

### Annual Performance Indicators to measure goal success

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator:</strong></td>
<td>The number of objectives achieved.</td>
</tr>
<tr>
<td><strong>Baseline Measurement:</strong></td>
<td>Zero objectives achieved.</td>
</tr>
<tr>
<td><strong>First-year target/outcome measurement:</strong></td>
<td>Achieve 2 out of 4 objectives</td>
</tr>
<tr>
<td><strong>Second-year target/outcome measurement:</strong></td>
<td>Achieve 4 out of 4 objectives</td>
</tr>
<tr>
<td><strong>Data Source:</strong></td>
<td>Legislative Budget Requests (LBRs)</td>
</tr>
<tr>
<td><strong>Description of Data:</strong></td>
<td>Written documents.</td>
</tr>
<tr>
<td><strong>Data issues/caveats that affect outcome measures:</strong></td>
<td>None.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Priority #</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Priority Area:</strong></td>
<td>Intensive Team-Based Services</td>
</tr>
<tr>
<td><strong>Priority Type:</strong></td>
<td>MHS</td>
</tr>
<tr>
<td><strong>Population(s):</strong></td>
<td>SED</td>
</tr>
<tr>
<td><strong>Goal of the priority area:</strong></td>
<td>Provide intensive, team-based services to children with Serious Emotional Disturbance (SED).</td>
</tr>
<tr>
<td><strong>Objective:</strong></td>
<td>Planning Tables</td>
</tr>
</tbody>
</table>
Increase the number children served by Community Action Teams.

**Strategies to attain the objective:**

Educating community partners on the eligibility, goals, approach to treatment, and location of current Community Action Teams to help generate more referrals.

**Annual Performance Indicators to measure goal success**

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>The number of children with SED served by Community Action Teams.</td>
</tr>
<tr>
<td>Baseline Measurement</td>
<td>In FY 18-19, the unduplicated count of children served was 3,081.</td>
</tr>
<tr>
<td>First-year target/outcome measurement</td>
<td>Increase the number served by 50 (for a total of 3,131 children served).</td>
</tr>
<tr>
<td>Second-year target/outcome measurement</td>
<td>Increase the number served by 50 (for a total of 3,181 children served).</td>
</tr>
<tr>
<td>Data Source</td>
<td>Numbers served as reported by providers in CAT monthly supplemental data reports.</td>
</tr>
<tr>
<td>Description of Data</td>
<td>This is the total number (unduplicated across all 41 CAT teams) of young people served.</td>
</tr>
<tr>
<td>Data issues/caveats that affect outcome measures</td>
<td>None.</td>
</tr>
</tbody>
</table>

**Priority #:** 3

**Priority Area:** Florida Assertive Community Treatment (FACT)

**Priority Type:** MHS

**Population(s):** SMI

**Goal of the priority area:**
Standardize and improve FACT team fidelity monitoring activities.

**Objective:**

1. Form a workgroup to review and improve FACT Guidance Document, including participants from the Managing Entities, FACT providers, FACT advisory council members, Block Grant Planning Council members, and other stakeholders as appropriate.

2. Provide a standardized set of instructions to the Managing Entities on how to monitor the fidelity of the FACT teams to the ACT model.

3. All 7 Managing Entities will provide a written status report to the Department documenting how recommendations from FACT advisory councils are being implemented.

**Strategies to attain the objective:**

Representatives from the Department’s Program Information Unit and Managing Entities will develop a plan to achieve the objectives within the specified timeframes.

**Annual Performance Indicators to measure goal success**

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>The number of objectives achieved.</td>
</tr>
<tr>
<td>Baseline Measurement</td>
<td>Zero objectives achieved.</td>
</tr>
<tr>
<td>First-year target/outcome measurement</td>
<td>Achieve 1 out of the 3 objectives.</td>
</tr>
<tr>
<td>Second-year target/outcome measurement</td>
<td>Achieve 3 out of the 3 objectives.</td>
</tr>
</tbody>
</table>
Priority #: 4
Priority Area: Housing
Priority Type: SAT, MHS
Population(s): Other (Homeless)

Goal of the priority area:
Increase access to stable, community-based housing.

Objective:
Increase access to stable, permanent supportive housing.

Strategies to attain the objective:
Provide annual trainings on permanent supportive housing and Housing First, and require relevant network service providers (case managers and care coordinators) to attend these. Update the guidance and standards under which network service providers prioritize housing-related services to individuals who are homeless or at imminent risk of homelessness.

Annual Performance Indicators to measure goal success

Indicator #:
1

Indicator: The number of individuals served accessing permanent supportive housing.

Baseline Measurement: FY 18-19 baselines is pending.

First-year target/outcome measurement: Increase the number by 3% over the FY 18-19.

Second-year target/outcome measurement: Increase the number by 3% over the FY 19-20 performance.

Data Source:
FASAMS

Description of Data:
Unduplicated counts of individuals based on housing status.

Data issues/caveats that affect outcome measures:
None.

Priority #: 5
Priority Area: Services for Pregnant Women and Women with Dependent Children
Priority Type: SAT
Population(s): PWWDC

Goal of the priority area:
Serve women earlier in their pregnancies.
Objective:
Increase the percent of women served through the Department’s special funding allocation that are pregnant when they are engaged in services.

Strategies to attain the objective:

---

**Annual Performance Indicators to measure goal success**

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator:</td>
<td>The percent of women served through the Department’s special funding allocation that are pregnant when they are engaged in services.</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
<td>FY 18-19 baseline is pending.</td>
</tr>
<tr>
<td>First-year target/outcome measurement:</td>
<td>Increase the indicator by 3% over the FY 18-19 baseline.</td>
</tr>
<tr>
<td>Second-year target/outcome measurement:</td>
<td>Increase the indicator by 3% over the FY 19-20 performance.</td>
</tr>
<tr>
<td>Data Source:</td>
<td>The reporting instrument that monitors the Department’s special appropriation for PWWDC.</td>
</tr>
<tr>
<td>Description of Data:</td>
<td>Numerator is the number of women served who are pregnant. The denominator is the number of all women served.</td>
</tr>
<tr>
<td>Data issues/caveats that affect outcome measures:</td>
<td>None.</td>
</tr>
</tbody>
</table>

---

Priority #: 6
Priority Area: Coordinated Specialty Care (CSC) for Early Serious Mental Illness (ESMI)
Priority Type: MHS
Population(s): SMI, ESMI

Goal of the priority area:
Improve functioning among individuals served by CSC for ESMI programs.

Objective:
Increase the percent of individuals served that experience improvements in functioning.

Strategies to attain the objective:
Provide training and technical assistance on the specific elements of these team-based services that research shows are most likely to improve functioning.

---

**Annual Performance Indicators to measure goal success**

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator:</td>
<td>The percent of individuals served that experience improvements in functioning.</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
<td>FY 18-19 baseline is pending.</td>
</tr>
<tr>
<td>First-year target/outcome measurement:</td>
<td>Increase the indicator by 3% over the FY 18-19 baseline.</td>
</tr>
<tr>
<td>Second-year target/outcome measurement:</td>
<td>Increase the number by 3% over the FY 19-20 performance.</td>
</tr>
<tr>
<td>Data Source:</td>
<td>FARS records in FASAMS</td>
</tr>
<tr>
<td>Description of Data:</td>
<td>The Functional Assessment Rating Scale documents and standardizes impressions from clinical evaluations or mental status exams that...</td>
</tr>
</tbody>
</table>
assess cognitive, social and role functioning.

Data issues/caveats that affect outcome measures:
None.

Priority #: 7
Priority Area: Infectious Disease Control
Priority Type: SAT
Population(s): EIS/HIV

Goal of the priority area:
Improve the implementation of Florida's HIV Early Intervention Services set-aside

Objective:
(1) Conduct an analysis of the specific HIV tests and testing processes used by HIV EIS providers, share the analysis with the Department of Health, and consult with them regarding ways to improve value or reduce costs.

(2) Conduct an analysis of the impact of the new HIV EIS Guidance Document on the number of individuals tested and number of tests conducted using FY 16-17 as a baseline, FY 17-18 as a transition period, and FY 18-19 as a new target year to expect an overall increase.

(3) Analyze the HIV testing policies, procedures, and processes used by the providers that spend less than $100 per individual tested or per test conducted, identify best practices that contribute to their efficiency, and share them with the other providers.

(4) Analyze the variation in positivity rates between HIV EIS providers and locations and attempt to identify relationships between positivity rates and methods of targeting individuals for testing.

Strategies to attain the objective:
The Department’s Block Grant Coordinator will work with leadership on a plan to achieve the objectives in the specified timeframes.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: The number of objectives achieved.
Baseline Measurement: Zero objectives achieved.
First-year target/outcome measurement: Achieve 2 out of 4 objectives.
Second-year target/outcome measurement: Achieve 3 out of 4 objectives.

Data Source:
Written reports from the Department’s Block Grant Coordinator.

Description of Data:
Written reports.

Data issues/caveats that affect outcome measures:
None.

Priority #: 8
Priority Area: Infectious Disease Control
Priority Type: SAT
Population(s): PWID, EIS/HIV, TB

Goal of the priority area:
Achieve 3 out of 4 objectives.

Printed: 8/12/2019 12:33 PM - Florida
Printed: 8/12/2019 1:29 PM - Florida - OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022
Improve access to behavioral health services among individuals with HIV or TB.

Objective:

(1) Disseminate “access to care” phone lines (which regional Managing Entities established to help indigent and uninsured individuals access behavioral health services through their networks of publicly-funded providers) to County Health Departments, Medical Directors, Nursing Directors, Regional Nurses, Program Managers, and Social Service Managers.

(2) Incorporate “access to care” lines into DOH’s website, 211 Big Bend materials, and resource appendices in the DOH manuals for TB, Hepatitis C, Case Management, HIV Counselors, and STD Field Services, as appropriate.

(3) Conduct a training for DOH staff regarding available behavioral health treatment resources, particularly Medication-Assisted Treatment for opioid use disorders, which involves the use of methadone, buprenorphine, and naltrexone medications.

Strategies to attain the objective:

The Department’s Block Grant Coordinator will incorporate the objectives and timeframes into workplans.

---

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:
The number of objectives achieved.

Baseline Measurement:

Zero objectives achieved.

First-year target/outcome measurement:

Achieve 1 out of 3 objectives.

Second-year target/outcome measurement:

Achieve 3 out of 3 objectives.

Data Source:

Emails and written documents.

Description of Data:

Written documents.

Data issues/caveats that affect outcome measures:

None.

---

Priority #:

9

Priority Area:

Suicide Prevention

Priority Type:

SAP, SAT, MHS

Population(s):

Other (Individuals at-risk of suicide)

Goal of the priority area:

Decrease the number of deaths by suicide.

Objective:

Increase the number of individuals exposed to suicide prevention resources.

Strategies to attain the objective:

The Department’s Suicide Prevention Coordinator will work with the regions, Managing Entities, network service providers, and other community partners.

---

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:
The number of individuals exposed to suicide prevention resources.
Baseline Measurement: FY 18-19 baseline is pending.

First-year target/outcome measurement: Increase the number of individuals exposed to suicide prevention resources by 1,000 more than the FY 18-19 baseline.

Second-year target/outcome measurement: Increase the number of individuals exposed to suicide prevention resources by 1,000 more than the FY 19-20 performance.

Data Source:
Responses to the Suicide Prevention Activities form.

Description of Data:
See the Suicide Prevention Activities form.

Data issues/caveats that affect outcome measures:
None.

Priority #: 10
Priority Area: Primary Prevention
Priority Type: SAP
Population(s): PP

Goal of the priority area:
Comprehensively describe of the evidence-base for primary prevention services provided in Florida.

Objective:

(1) Classify 3 out of 6 prevention programs with inconclusive, mixed, or limited findings as either evidence-based or not.

(2) Classify 6 out of 6 prevention programs with inconclusive, mixed, or limited findings as either evidence-based or not.

(3) Publish a detailed descriptive report on all the Block Grant funded environmental prevention strategies currently being implemented.

(4) Classify at least half of all the environmental strategies currently being implemented as either evidence-based or not.

(5) Identify all the evidence-based drug prevention programs that have experimental evidence of effectiveness at preventing other mental, emotional, and behavioral problems (i.e., depression, anxiety, conduct disorders, suicidality, academic failure, school suspensions, family conflict).

(6) Develop a list of untested prevention programs that need to be evaluated with an experimental design and prioritize them according to the volume of individuals they serve and funds they expend.

Strategies to attain the objective:
The Department’s Prevention Coordinator and Block Grant Coordinator will work with the EBP Workgroup on a plan to achieve the objectives in the specified timeframes. Also, since NREPP has been dismantled, the Department will consider consulting the Title IV-E Prevention Services Clearinghouse for objective 5, to identify relevant subdomains with favorable outcomes. Regarding classifying environmental strategies, the Department may consult standards established by the Society of Prevention Research in 2015 (Standards of Evidence for Efficacy, Effectiveness, and Scale-up Research in Prevention Science: Next Generation).

Annual Performance Indicators to measure goal success

Priority #: 11
Priority Area: Primary Prevention
Priority Type: SAP
Population(s): PP

Goal of the priority area:
Improve the prevention workforce.

Objective:
Increase the knowledge, skills, and abilities of the prevention workforce in Florida.

Strategies to attain the objective:
The Department’s prevention coordinator will work with the point of contact for workforce development contracts to ensure that appropriate prevention topics are identified and that trainings are scheduled in a timely manner.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: The number of prevention-related trainings conducted.
Baseline Measurement: In FY 18-19, FADAA conducted 4 prevention webinars.
First-year target/outcome measurement: Increase the number of prevention trainings by 3 (from 4 to 7).
Second-year target/outcome measurement: Increase the number of prevention trainings by 3 (from 7 to 10).

Data Source:
The Department’s programmatic lead on training contracts and Prevention Coordinator.

Description of Data:
Prevention trainings are identified by topic title and date.

Data issues/caveats that affect outcome measures:
None.

Priority #: 12
Priority Area: Reducing Opioid-Related Deaths
Priority Type: SAP, SAT
Population(s): PWWDC, PWID, Other (Rural, Homeless, Individuals who use drugs and their loved ones)

Goal of the priority area:
Increase access to naloxone to prevent opioid overdose deaths.

Objective:
(1) Increase number of Emergency Departments distributing naloxone kits upon discharge to patients at risk of experiencing an overdose.
(2) Increase the number of Fire/EMS naloxone leave-behind programs.

(3) Supply naloxone kits to all new Syringe Exchange Programs.

Strategies to attain the objective:

The Department’s Overdose Prevention Coordinator will incorporate the objectives into strategic plans.

---

**Annual Performance Indicators to measure goal success**

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator:</td>
<td>The number of objectives achieved.</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
<td>Zero objectives achieved.</td>
</tr>
<tr>
<td>First-year target/outcome measurement:</td>
<td>Achieve 1 out of 3 objectives.</td>
</tr>
<tr>
<td>Second-year target/outcome measurement:</td>
<td>Achieve 2 out of 3 objectives.</td>
</tr>
</tbody>
</table>

**Data Source:**

According to the Department's Overdose Prevention Coordinator, in FY 18-19, there were 10 Emergency Department sites participating in the Department’s naloxone distribution program and there were 5 EMS/Fire naloxone leave behind programs in operation.

**Description of Data:**

The number of participating Emergency Departments, EMS/Fire leave behind programs, and Syringe Exchange Programs are manually tracked by the Department’s Overdose Prevention Coordinator.

**Data issues/caveats that affect outcome measures:**

None.

---

**Priority #:** 13

**Priority Area:** Medication-Assisted Treatment

**Priority Type:** SAT

**Population(s):** PWWDC, PWID, Other (Individuals with Opioid Use Disorders (OUDs))

**Goal of the priority area:**

Improve access to medication-assisted treatment.

**Objective:**

(1) Draft new contract provisions designed to ensure that Department-funded treatment providers are not imposing arbitrary counseling requirements on individuals with opioid use disorders in need of medication-based treatment services.

(2) Draft new contract provisions designed to ensure that Department-funded treatment providers are not inappropriately discharging individuals who continue to test positive for substance use.

(3) Draft new contract provisions designed to ensure that Department-funded treatment providers are not imposing arbitrary restrictions on the length of medication-based maintenance treatment services.

(4) Double the number of Emergency Departments that do onsite buprenorphine induction prior to discharge from 3 to 6.

**Strategies to attain the objective:**

The Department’s Block Grant Coordinator and MAT Coordinator will incorporate the objectives into workplans.

---

**Annual Performance Indicators to measure goal success**

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator:</td>
<td>The number of objectives achieved.</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
<td>Zero objectives achieved.</td>
</tr>
</tbody>
</table>
First-year target/outcome measurement: Achieve 2 out of 3 objectives.

Second-year target/outcome measurement: Achieve 3 out of 3 objectives.

Data Source:
Draft contract provisions and surveys of Emergency Department practices through the Managing Entities.

Description of Data:
Written documents, including survey results.

Data issues/caveats that affect outcome measures:
None.
Planning Tables

Table 2 State Agency Planned Expenditures [SA]
States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2020/2021. ONLY include funds expended by the executive branch agency administering the SABG

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

<table>
<thead>
<tr>
<th>Activity (See instructions for using Row 1.)</th>
<th>A. Substance Abuse Block Grant</th>
<th>B. Mental Health Block Grant</th>
<th>C. Medicaid (Federal, State, and Local)</th>
<th>D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)</th>
<th>E. State Funds</th>
<th>F. Local Funds (excluding local Medicaid)</th>
<th>G. Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention* and Treatment</td>
<td>$164,324,825</td>
<td>$0</td>
<td>$11,700,008</td>
<td>$251,151,458</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>a. Pregnant Women and Women with Dependent Children*</td>
<td>$10,000,000</td>
<td>$0</td>
<td>$0</td>
<td>$20,000,000</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>b. All Other</td>
<td>$154,324,825</td>
<td>$0</td>
<td>$11,700,008</td>
<td>$231,151,458</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>2. Primary Prevention</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>a. Substance Abuse Primary Prevention</td>
<td>$45,575,067</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>b. Mental Health Primary Prevention</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)</td>
<td>$11,242,808</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>4. Tuberculosis Services</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>5. Early Intervention Services for HIV</td>
<td>$11,242,808</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>6. State Hospital</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>7. Other 24 Hour Care</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>8. Ambulatory/Community Non-24 Hour Care</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>9. Administration (Excluding Program and Provider Level)</td>
<td>$3,713,455</td>
<td>$0</td>
<td>$0</td>
<td>$10,740,142</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>10. Total</td>
<td>$224,856,155</td>
<td>$0</td>
<td>$0</td>
<td>$11,700,008</td>
<td>$261,891,600</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

* Prevention other than primary prevention
** The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.
### Substance Abuse Prevention & Treatment Table 2
(2-year planning period) 07/01/2019 - 06/30/2021

<table>
<thead>
<tr>
<th>Activity</th>
<th>SAPT Block Grant</th>
<th>Medicaid (Federal, State &amp; Local)</th>
<th>Other Federal Funds</th>
<th>State Funds</th>
<th>Local Funds</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Abuse Prevention &amp; Treatment</td>
<td>$164,324,825</td>
<td>$11,700,008</td>
<td>$251,151,458</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
</tr>
<tr>
<td>Pregnant Women &amp; Women with Dependent Children</td>
<td>$10,000,000</td>
<td>$-</td>
<td>$20,000,000</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
</tr>
<tr>
<td>All Other</td>
<td>$154,324,825</td>
<td>$11,700,008</td>
<td>$231,151,458</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
</tr>
<tr>
<td>Primary Prevention</td>
<td>$45,575,067</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
</tr>
<tr>
<td>Tuberculosis Services</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
</tr>
<tr>
<td>Early Intervention Services for HIV</td>
<td>$11,242,808</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
</tr>
<tr>
<td>Administration</td>
<td>$3,713,455</td>
<td>$-</td>
<td>$10,740,142</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
</tr>
<tr>
<td>SABG Total</td>
<td>$224,856,155</td>
<td>$11,700,008</td>
<td>$261,891,600</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
</tr>
</tbody>
</table>

### State Fiscal Year Planning Period 2019-20

<table>
<thead>
<tr>
<th>Activity</th>
<th>SAPT Block Grant</th>
<th>Medicaid (Federal, State &amp; Local)</th>
<th>Other Federal Funds</th>
<th>State Funds</th>
<th>Local Funds</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Abuse Prevention &amp; Treatment</td>
<td>$84,868,693</td>
<td>$5,850,004</td>
<td>$125,575,729</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
</tr>
<tr>
<td>Pregnant Women &amp; Women with Dependent Children</td>
<td>$5,000,000</td>
<td>$5,850,004</td>
<td>$115,575,729</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
</tr>
<tr>
<td>All Other</td>
<td>$79,868,693</td>
<td>$5,850,004</td>
<td>$110,575,729</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
</tr>
<tr>
<td>Primary Prevention</td>
<td>$22,821,888</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
</tr>
<tr>
<td>Tuberculosis Services</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
</tr>
<tr>
<td>Early Intervention Services for HIV</td>
<td>$5,674,513</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
</tr>
<tr>
<td>Administration</td>
<td>$125,159</td>
<td>$-</td>
<td>$5,370,071</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
</tr>
<tr>
<td>SABG Total</td>
<td>$113,490,253</td>
<td>$5,850,004</td>
<td>$130,945,800</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
</tr>
</tbody>
</table>

### State Fiscal Year Planning Period 2020-21 *

<table>
<thead>
<tr>
<th>Activity</th>
<th>SAPT Block Grant</th>
<th>Medicaid (Federal, State &amp; Local)</th>
<th>Other Federal Funds</th>
<th>State Funds</th>
<th>Local Funds</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Abuse Prevention &amp; Treatment</td>
<td>$79,456,132</td>
<td>$5,850,004</td>
<td>$125,575,729</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
</tr>
<tr>
<td>Pregnant Women &amp; Women with Dependent Children</td>
<td>$5,000,000</td>
<td>$5,850,004</td>
<td>$115,575,729</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
</tr>
<tr>
<td>All Other</td>
<td>$74,456,132</td>
<td>$5,850,004</td>
<td>$115,575,729</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
</tr>
<tr>
<td>Primary Prevention</td>
<td>$22,753,179</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
</tr>
<tr>
<td>Tuberculosis Services</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
</tr>
<tr>
<td>Early Intervention Services for HIV</td>
<td>$5,568,295</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
</tr>
<tr>
<td>Administration</td>
<td>$3,588,296</td>
<td>$-</td>
<td>$5,370,071</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
</tr>
<tr>
<td>SABG Total</td>
<td>$111,365,902</td>
<td>$5,850,004</td>
<td>$130,945,800</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
</tr>
</tbody>
</table>

* A finalized Allocation of Budget for SFY 2020/21 will not be available until June of 2020. Amounts for SFY 2020/21 are estimates.
### Table 2 State Agency Planned Expenditures [MH]

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2020/2021.

Planning Period Start Date: 7/1/2019   Planning Period End Date: 6/30/2021

<table>
<thead>
<tr>
<th>Activity</th>
<th>A. Substance Abuse Block Grant</th>
<th>B. Mental Health Block Grant</th>
<th>C. Medicaid (Federal, State, and Local)</th>
<th>D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)</th>
<th>E. State Funds</th>
<th>F. Local Funds (excluding local Medicaid)</th>
<th>G. Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention and Treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Pregnant Women and Women with Dependent Children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. All Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Primary Prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Substance Abuse Primary Prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Mental Health Primary Prevention</td>
<td></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)**</td>
<td>$9,477,135</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>4. Tuberculosis Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Early Intervention Services for HIV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. State Hospital</td>
<td></td>
<td>$0</td>
<td>$154,409,678</td>
<td>$580,874,502</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>7. Other 24 Hour Care</td>
<td>$9,591,439</td>
<td>$0</td>
<td>$416,918</td>
<td>$45,243,090</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>8. Ambulatory/Community Non-24 Hour Care</td>
<td>$64,188,862</td>
<td>$0</td>
<td>$13,480,320</td>
<td>$180,972,358</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>9. Administration (Excluding Program and Provider Level)***</td>
<td>$2,388,727</td>
<td>$0</td>
<td>$0</td>
<td>$15,473,868</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>10. Total</td>
<td>$0</td>
<td>$85,646,163</td>
<td>$0</td>
<td>$168,306,916</td>
<td>$822,563,818</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED

** Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside

*** Per statute, Administrative expenditures cannot exceed 5% of the fiscal year award.
### Community Mental Health Table 2

**(2 year planning period) 7/1/2019 - 06/30/2021**

<table>
<thead>
<tr>
<th>Activity</th>
<th>MH Block Grant</th>
<th>Medicaid (Federal, State &amp; Local)</th>
<th>Other Federal Funds</th>
<th>State Funds</th>
<th>Local Funds</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Hospitals</td>
<td>$0</td>
<td>$0</td>
<td>$154,409,678</td>
<td>$580,874,502</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Other 24 Hour Care</td>
<td>$9,591,439</td>
<td>$0</td>
<td>$416,918</td>
<td>$45,243,090</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Ambulatory/Community Non-24 Hour Care</td>
<td>$64,188,862</td>
<td>$0</td>
<td>$13,480,320</td>
<td>$180,972,358</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Mental Health Primary Prevention</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Evidence-Based Practices for Early Serious Mental Illness</td>
<td>$9,477,135</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Administration</td>
<td>$2,388,727</td>
<td>$0</td>
<td>$0</td>
<td>$15,473,868</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>MHBG Total</strong></td>
<td><strong>$85,646,163</strong></td>
<td>$0</td>
<td><strong>$168,306,916</strong></td>
<td><strong>$822,563,818</strong></td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

### State Fiscal Year Planning Period 2019-20 (07/01/2019 - 06/30/2020)

<table>
<thead>
<tr>
<th>Activity</th>
<th>MH Block Grant</th>
<th>Medicaid (Federal, State &amp; Local)</th>
<th>Other Federal Funds</th>
<th>State Funds</th>
<th>Local Funds</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Hospitals</td>
<td></td>
<td>$77,204,839</td>
<td>$290,437,251</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other 24 Hour Care</td>
<td></td>
<td>$4,588,954</td>
<td>$208,459</td>
<td>$22,621,545</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulatory/Community Non-24 Hour Care</td>
<td></td>
<td>$30,710,695</td>
<td>$6,740,160</td>
<td>$90,486,179</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Primary Prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence-Based Practices for Early Serious Mental Illness</td>
<td>$4,950,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration</td>
<td></td>
<td>$125,159</td>
<td></td>
<td>$7,736,934</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MHBG Total</strong></td>
<td><strong>$40,374,808</strong></td>
<td>$0</td>
<td><strong>$84,153,458</strong></td>
<td><strong>$411,281,909</strong></td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

### State Fiscal Year Planning Period 2020-21 (07/01/2020 - 06/30/2021)

<table>
<thead>
<tr>
<th>Activity</th>
<th>MH Block Grant</th>
<th>Medicaid (Federal, State &amp; Local)</th>
<th>Other Federal Funds</th>
<th>State Funds</th>
<th>Local Funds</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Hospitals</td>
<td></td>
<td>$77,204,839</td>
<td>$290,437,251</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other 24 Hour Care</td>
<td></td>
<td>$5,002,485</td>
<td>$208,459</td>
<td>$22,621,545</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulatory/Community Non-24 Hour Care</td>
<td></td>
<td>$33,478,167</td>
<td>$6,740,160</td>
<td>$90,486,179</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Primary Prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence-Based Practices for Early Serious Mental Illness</td>
<td>$4,527,135</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration</td>
<td></td>
<td>$2,263,568</td>
<td></td>
<td>$7,736,934</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MHBG Total</strong></td>
<td><strong>$45,271,355</strong></td>
<td>$0</td>
<td><strong>$84,153,458</strong></td>
<td><strong>$411,281,909</strong></td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

* A finalized Allocation of Budget for SFY 2020/21 will not be available until June of 2020. Amounts for SFY 2020/21 are estimates.
**Planning Tables**

**Table 3 SABG Persons in need/receipt of SUD treatment**

<table>
<thead>
<tr>
<th></th>
<th>Aggregate Number Estimated In Need</th>
<th>Aggregate Number In Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pregnant Women</td>
<td>0</td>
<td>1797</td>
</tr>
<tr>
<td>2. Women with Dependent Children</td>
<td>0</td>
<td>1920</td>
</tr>
<tr>
<td>3. Individuals with a co-occurring M/SUD</td>
<td>0</td>
<td>22418</td>
</tr>
<tr>
<td>4. Persons who inject drugs</td>
<td>0</td>
<td>15549</td>
</tr>
<tr>
<td>5. Persons experiencing homelessness</td>
<td>3948</td>
<td>10803</td>
</tr>
</tbody>
</table>

*Please provide an explanation for any data cells for which the state does not have a data source.*

The numbers in the "Aggregate Number in Treatment" column are FY 17-18 figures from records in the Department’s Substance Abuse and Mental Health Information System (SAMHIS). The estimated number of individuals who are homeless in need of treatment comes from 2019 Point In Time counts published in Florida’s Council on Homeless' Annual Report. With regard to the estimated number in need from the other populations, the National Survey on Drug Use and Health (NSDUH) is capable of providing state-level estimates of the number of people needing SUD treatment, but SAMHSA does not publish state-level estimates specifically for the populations listed in the table above. The Department is currently developing a proposal to send a statistician to a secure Research Data Center in Atlanta to access restricted microdata and determine how many years of data would need to be aggregated to produce Florida-specific, unsuppressed estimates for these populations (PW, WWDC, COD, and PWID).

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

**Footnotes:**
# Planning Tables

## Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2019      Planning Period End Date: 9/30/2021

<table>
<thead>
<tr>
<th>Expenditure Category</th>
<th>FFY 2020 SA Block Grant Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 . Substance Abuse Prevention and Treatment*</td>
<td>$79,456,132</td>
</tr>
<tr>
<td>2 . Primary Substance Abuse Prevention</td>
<td>$22,753,179</td>
</tr>
<tr>
<td>3 . Early Intervention Services for HIV**</td>
<td>$5,568,295</td>
</tr>
<tr>
<td>4 . Tuberculosis Services</td>
<td>$0</td>
</tr>
<tr>
<td>5 . Administration (SSA Level Only)</td>
<td>$3,588,296</td>
</tr>
<tr>
<td>6 . Total</td>
<td>$111,365,902</td>
</tr>
</tbody>
</table>

* Prevention other than Primary Prevention

** For the purpose of determining the states and jurisdictions that are considered ?designated states? as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be are required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a ?designated state? in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state a state?s AIDS case...
rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

Footnotes:

Tuberculosis Services in the State of Florida are administered through the Florida Department of Health. Also, $1,500,000 of Substance Abuse Prevention and Treatment and $480,000 of Primary Substance Abuse Prevention dollars listed above are planned expenditures for Table 6 Non-Direct Services/System Development [SA] based on prior year expenditures reported by the Managing Entities.
## Table 5a SABG Primary Prevention Planned Expenditures

**Planning Period Start Date:** 10/1/2019  
**Planning Period End Date:** 9/30/2021

<table>
<thead>
<tr>
<th>Strategy</th>
<th>IOM Target</th>
<th>FFY 2020 SA Block Grant Award</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Universal</td>
<td>$534,557</td>
</tr>
<tr>
<td></td>
<td>Selective</td>
<td>$267,278</td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td>$89,092</td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$890,927</strong></td>
</tr>
</tbody>
</table>

1. **Information Dissemination**

|                                 | Universal  | $4,410,090                     |
|                                 | Selective  | $2,205,045                     |
|                                 | Indicated  | $735,015                       |
|                                 | Unspecified| $0                             |
| **Total**                       |            | **$7,350,150**                 |

2. **Education**

|                                 | Universal  | $534,557                       |
|                                 | Selective  | $267,278                       |
|                                 | Indicated  | $89,092                        |
|                                 | Unspecified| $0                             |
| **Total**                       |            | **$890,927**                   |

3. **Alternatives**

|                                 | Universal  | $534,557                       |
|                                 | Selective  | $267,278                       |
|                                 | Indicated  | $89,092                        |
|                                 | Unspecified| $0                             |
| **Total**                       |            | **$890,927**                   |

4. **Problem Identification and Referral**

|                                 | Universal  | $2,138,226                     |
|                                 | Selective  | $1,069,112                     |
|                                 | Indicated  | $356,371                       |
|                                 | Unspecified| $0                             |
| **Total**                       |            | **$3,563,709**                 |

<p>|                                 | Universal  | $5,479,203                     |</p>
<table>
<thead>
<tr>
<th></th>
<th>Selective</th>
<th>$2,739,601</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Community-Based Process</td>
<td>Indicated</td>
<td>$913,199</td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>$9,132,003</strong></td>
</tr>
<tr>
<td></td>
<td>Universal</td>
<td>$267,278</td>
</tr>
<tr>
<td>6. Environmental</td>
<td>Selective</td>
<td>$133,639</td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td>$44,546</td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>$445,463</strong></td>
</tr>
<tr>
<td></td>
<td>Universal</td>
<td>$0</td>
</tr>
<tr>
<td>7. Section 1926 Tobacco</td>
<td>Selective</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>$0</strong></td>
</tr>
<tr>
<td></td>
<td>Universal</td>
<td>$0</td>
</tr>
<tr>
<td>8. Other</td>
<td>Selective</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>$0</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Total Prevention Expenditures</strong></td>
<td><strong>$22,273,179</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Total SABG Award</strong></td>
<td><strong>$111,365,902</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Planned Primary Prevention Percentage</strong></td>
<td><strong>20.00 %</strong></td>
</tr>
</tbody>
</table>

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

**Footnotes:**
The total for Table 5a of $22,273,179 plus the total amount for the Prevention column on Table 6 of $480,000 should equal the total for Row 2, Primary Prevention on Table 4 of $22,753,179. NW
# Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

<table>
<thead>
<tr>
<th>Activity</th>
<th>FFY 2020 SA Block Grant Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal Direct</td>
<td>$7,082,873</td>
</tr>
<tr>
<td>Universal Indirect</td>
<td>$6,281,037</td>
</tr>
<tr>
<td>Selective</td>
<td>$6,681,953</td>
</tr>
<tr>
<td>Indicated</td>
<td>$2,227,316</td>
</tr>
<tr>
<td><strong>Column Total</strong></td>
<td><strong>$22,273,179</strong></td>
</tr>
<tr>
<td><strong>Total SABG Award</strong></td>
<td><strong>$111,365,902</strong></td>
</tr>
<tr>
<td>Planned Primary Prevention Percentage</td>
<td><strong>20.00 %</strong></td>
</tr>
</tbody>
</table>

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

0930-0168 Approved: 06/07/2017 Expires: 06/30/2020

**Footnotes:**
The total for Table 5b of $22,273,179 plus the total amount for the Prevention column on Table 6 of $480,000 should equal the total for Row 2, Primary Prevention on Table 4 of $22,753,179. NW.
### Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2020 and FFY 2021 SABG awards.

**Planning Period Start Date:** 10/1/2019  
**Planning Period End Date:** 9/30/2021

<table>
<thead>
<tr>
<th>Targeted Substances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
</tr>
<tr>
<td>Tobacco</td>
</tr>
<tr>
<td>Marijuana</td>
</tr>
<tr>
<td>Prescription Drugs</td>
</tr>
<tr>
<td>Cocaine</td>
</tr>
<tr>
<td>Heroin</td>
</tr>
<tr>
<td>Inhalants</td>
</tr>
<tr>
<td>Methamphetamine</td>
</tr>
<tr>
<td>Synthetic Drugs (i.e. Bath salts, Spice, K2)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Targeted Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students in College</td>
</tr>
<tr>
<td>Military Families</td>
</tr>
<tr>
<td>LGBTQ</td>
</tr>
<tr>
<td>American Indians/Alaska Natives</td>
</tr>
<tr>
<td>African American</td>
</tr>
<tr>
<td>Hispanic</td>
</tr>
<tr>
<td>Homeless</td>
</tr>
<tr>
<td>Native Hawaiian/Other Pacific Islanders</td>
</tr>
<tr>
<td>Asian</td>
</tr>
<tr>
<td>Rural</td>
</tr>
<tr>
<td>Underserved Racial and Ethnic Minorities</td>
</tr>
</tbody>
</table>
# Planning Tables

## Table 6 Non-Direct Services/System Development [SA]

<table>
<thead>
<tr>
<th>Planning Period Start Date: 10/1/2019</th>
<th>Planning Period End Date: 9/30/2021</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Activity</th>
<th>A. SABG Treatment</th>
<th>B. SABG Prevention</th>
<th>C. SABG Combined*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information Systems</td>
<td>$507,930</td>
<td>$88,560</td>
<td></td>
</tr>
<tr>
<td>2. Infrastructure Support</td>
<td>$193,131</td>
<td>$84,787</td>
<td></td>
</tr>
<tr>
<td>3. Partnerships, community outreach, and needs assessment</td>
<td>$324,554</td>
<td>$161,237</td>
<td></td>
</tr>
<tr>
<td>4. Planning Council Activities (MHBG required, SABG optional)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Quality Assurance and Improvement</td>
<td>$275,737</td>
<td>$56,791</td>
<td></td>
</tr>
<tr>
<td>6. Research and Evaluation</td>
<td>$89,618</td>
<td>$60,749</td>
<td></td>
</tr>
<tr>
<td>7. Training and Education</td>
<td>$109,030</td>
<td>$27,876</td>
<td></td>
</tr>
<tr>
<td><strong>8. Total</strong></td>
<td><strong>$1,500,000</strong></td>
<td><strong>$480,000</strong></td>
<td><strong>$0</strong></td>
</tr>
</tbody>
</table>

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

0930-0168 Approved: 06/07/2017 Expires: 06/30/2020
Footnotes:
Based on Managing Entity reporting for previous cycle.

Amount of SABG Primary Prevention funds to be used for SABG Prevention Non-Direct-Services/Systems Development activities (from Table 4, Row 2) = $480,000.

*Managing Entity Administrative costs are funded entirely through a Legislative appropriation of state general revenue. Therefore, some of these activities receive additional funding through this appropriation. Totals listed above reflect block grant funds only.
Planning Tables

Table 6 Non-Direct-Services/System Development [MH]

MHBG Planning Period Start Date: 07/01/2019  MHBG Planning Period End Date: 06/30/2021

<table>
<thead>
<tr>
<th>Activity</th>
<th>FFY 2020 Block Grant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information Systems</td>
<td>$0</td>
</tr>
<tr>
<td>2. Infrastructure Support</td>
<td>$500,000</td>
</tr>
<tr>
<td>3. Partnerships, community outreach, and needs assessment</td>
<td>$0</td>
</tr>
<tr>
<td>4. Planning Council Activities (MHBG required, SABG optional)</td>
<td>$104,000</td>
</tr>
<tr>
<td>5. Quality Assurance and Improvement</td>
<td>$0</td>
</tr>
<tr>
<td>6. Research and Evaluation</td>
<td>$503,018</td>
</tr>
<tr>
<td>7. Training and Education</td>
<td>$0</td>
</tr>
<tr>
<td>8. Total</td>
<td>$1,107,018</td>
</tr>
</tbody>
</table>

0930-0168 Approved: 06/07/2017 Expires: 06/30/2020

Footnotes:
MHBG - Amounts are budgeted and contracted by state fiscal year. Amounts above reflect a two year period.

*Managing Entity Administrative costs are funded entirely through a Legislative appropriation of state general revenue.
Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.22 Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but “[h]ealth system factors” such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.23 It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.24

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.25 SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.26 For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.27

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.28

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.29 The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.30 Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes31 and ACOs32 may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.33 Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.34

One key population of concern is persons who are dually eligible for Medicare and Medicaid.35 Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.36 SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.37 Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.38 SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with...
partners to mitigate regional and local variations in services that detrimentally affect access to care and integration. SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment. Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states’ Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues. Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA’s National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.

SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs. However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

---

23 http://www.who.int/bulletin/volumes/91/2/12-108282.pdf.
29 http://www.samhsa.gov/health-disparities/strategic-initiatives
Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community-based mental and substance use disorders settings.

   The Department contracts with managing entities to oversee networks of behavioral health service providers. Each managing entity was asked to describe how their networks integrate behavioral health services and primary health care. Their responses are provided below.

   BBCBC: Big Bend Community Based Care continues to move providers in the direction of integration of mental health and primary health care. Some providers have contracted with local health providers to have a behavioral health professional in their setting and others had health providers in the mental health agencies.

   SEFBHN: Integrating mental health and primary health care continues to be an important aspect of treating individuals who have mental health needs. Individuals with serious mental illness have a shortened life expectancy compared to the general population which is impacted by access to physical health care. Life style choices for individuals with serious mental illness can also affect how they go about seeking health care – often times not knowing where such resources exist in the community. For our network providers, the ability to have either on-site primary care or Memorandums of Understanding (MOU) with Federally Qualified Health Centers (FQHC) can help to ameliorate the access to health care. In turn the FQHC’s also can refer individuals who come to them and present with behavioral health concerns can refer them to the mental health treatment centers.

   One of our Community Mental Health Centers utilizes a mobile medical van sponsored by the Palm Beach County Health Care District that comes to their location twice a week. New Horizons of the Treasure Coast (NHTC) has an MOU with Florida Community Health Centers in their rural areas. An additional resource utilized by NHTC is the Hands Clinic of St. Lucie County which is a free primary care clinic for indigent individuals who do not qualify for other forms of assistance (ie Medicaid). It is also noted the providers complete health assessments as part of the bio-psychosocial assessment. This assessment alerts the behavioral health provider of the individual’s primary health care needs which can then be incorporated into treatment plan and thus ensure the appropriate referrals for health care are made.

   Additional physical health conditions are monitored for individuals receiving Medication Management services. Their vitals, BMI, height and weight are monitored and based on findings they will be referred to primary health care clinic – whether it is on or off-site.

   Providers will also assist individuals including the parents of minors, in applying for benefits – (Medicaid and Medicare) and in
finding a medical home when it is determined they have limited access to primary health care. SEFBHN continues to employ a SOAR specialist who provides training and technical assistance to our providers on the use of SOAR. As a result of the emphasis placed on the implementation of SOAR there are now 15 SOAR dedicated specialists employed by our network providers which is an increase of 13 over the past 2 years.

SFBHN: SFBHN stresses to its providers the importance of primary care integration for the consumers of services. Contract language with the providers requires integration practices that are monitored by the SFBHN CQI team. SFBHN providers range along a continuum from separate systems and practices to enhanced coordination and collaboration among providers, usually involving care or case managers, to co-located care with providers sharing the same office or clinic, and for a few SFBHN providers, to fully integrated care where all providers function as a team to provide joint treatment planning. All providers are striving toward the optimum integrated care goals and provide responses to the MeHaf Self-Assessment scoring tool, which compares current and previous fiscal year responses regarding integration. Results are compiled by SFBHN’s data analytics team, and given to the providers annually.

BBHC: BBHC continues the implementation process for its integration project that enable all network providers to complete basic screenings at intake and with follow ups, as appropriate. This project is supported by the Primary Behavioral Health Care Integration (PBHCI) Committee and made up of BBHC Providers, Medical Providers, FQHCs, & MMA representatives. At this time, we have created sub-committees which are tasked with designing & implementing this project. The initial Blood Pressure Protocol is ready for a final review and approval from the committee. The Proposal for the Health Foundation will also be reviewed and approved by the PBHCI. The Resource Committee is in the process of identifying potential partners and will be developing a guide that all provider can use and/or can give to clients, as needed. Training began to be delineated at the committee meeting, on June 4, 2019. The expected project start date is October 1, 2019.

CFBH: CFBHN’s comprehensive approach strives to maximize the utility of funding through wraparound services to treat both the mental health and substance abuse issues for persons with co-occurring diagnoses. The ME encourages providers to co-locate and intimately collaborate with primary care and/or the Federally Qualified Health Care Centers. The Department of Health has representatives attending various community meetings, which are attended by the Behavioral Health Providers.

LSFHS: Many network service providers deliver an array of services that include both substance abuse and mental health services, enabling them to address the treatment needs of individuals with co-occurring disorders. Two of our largest providers, (Meridian Behavioral Healthcare and Lifestream Behavioral Healthcare) have on-site primary care clinics in one or more locations to integrate behavioral and primary health care. In Marion County the local Hospital Board Foundation is coordinating and funding a health campus that will deliver primary care, vision care, dental care and behavioral health services. The collaboration includes the Freed.O.M. Clinic and several service providers both inside and outside the LSFHS system. Block grant funds through the Managing Entity will help support substance abuse and mental health services provided by our participating network service providers. Other providers have agreements with the local Federally Qualified Health Clinics to coordinate the provision of primary and behavioral health care. The ME provides a Template for MOU with FQHC (Attachment 1) to aid the network service providers in securing these MOUs.

CFCHS: In some of the network provider’s acute care settings, they provide family practice physicians and ARNP’s to evaluate and treat medical conditions and refer to aftercare for follow-up. In substance abuse and mental health residential settings, some providers have both nursing and physician services to monitor medications and identify medical issues. This includes children’s residential facilities, where a physician and a psychiatrist is assigned to every child while they are in the program. The physicians work together to ensure all the needs of the client are covered. When a child is in need of services that are outside of what the doctors can provide, the client is referred out to a specialist. Doctors work with the Director of Nursing to obtain updates on all services the clients are receiving FACT teams coordinate and ensure appropriate medical, dental and vision services for each person served by the FACT program. This includes individuals with co-occurring mental health and substance use disorders. FACT has developed extensive resources and relationships with healthcare providers in both Brevard and Osceola Counties. This includes: local primary care physicians, Brevard Health Alliance, and the Florida Department of Health in Osceola County. FACT works with the current healthcare providers of each person served or helps the individual find a primary care provider of his/her choice. The FACT team obtains releases of information from the person served to enable the staff to communicate directly with the designated healthcare providers. This collaboration is essential because many of those served by the FACT team have complicated medical problems, often due to years of neglect, substance abuse, or non-compliance with medical treatments in the past. Medical treatments and appointments for each person served is recorded on the person’s schedule and when necessary a FACT staff is assigned to accompany the person to scheduled medical appointments. Any medical conditions requiring ongoing monitoring and treatment are also included on the person’s recovery plan. In cases where funding is an issue, FACT incidental funds may be utilized to ensure healthcare and medication needs are met.

Case managers assist in maximizing insurance benefits, setting appointments, transporting and accompanying clients to appointments, following-up on future appointments, and assisting with medication / filling prescriptions. Over the past several years, providers have been attempting to increase communication with clients’ primary care physicians. Providers have MOUs with local Health Care Centers, Orange Blossom Family Health, Winnie Palmer Hospital, etc. Some providers even have primary care clinics embedded in their behavioral health outpatient clinics. Those primary care clinics also serve as intake centers for persons
with suspected behavioral health concerns. One network provider reported that their agency promotes the “co-located” model of care whenever possible for mental health, physical health and substance abuse services. For example, they have a relationship with their local FQHC to provide on-site services for residential patients, and other consumers suffering from severe mental illness. Regarding co-occurring disorders, their plan over the last several years has also been to integrate services when possible. As an example, 70% of their CSU patients have a co-occurring disorder. That is addressed by providing efficient access to detox protocols as well as therapeutic co-occurring groups for these patients.

Another network provider is part of the Children’s Advocacy Center, which provides a coordinated response to concerns for child abuse that includes medical providers who complete medical evaluations and medical records reviews to ensure not only assessment of child abuse but coordinated care to ensure medical and mental health issues are addressed. Child Advocates connect families to any needed providers to ensure physical and mental health needs are met. That includes connecting families to The Healing Tree to address the impact of child abuse. A complete biopsychosocial evaluation of all participating family members seen at the agency assesses for physical, mental health and substance abuse related needs. They refer to local FQHCs for unmet physical health needs, as well as referring families to their primary care doctors when appropriate. This particular agency provides evidence-based treatment using a family systems model that addresses the symptoms of the abuse, provides psychoeducation and aids families in supporting their children for a stronger future and reduced long-term consequences of child abuse. If substance abuse issues require further evaluation or specific treatment, we refer families to organizations in the community who specialize in such treatment and then work in a coordinated fashion with those organizations if treatment is occurring in tandem with the work we do with the family at the agency.

Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

Each managing entity was asked to describe how they provide services and supports toward integrated systems of care for individuals and families with co-occurring disorders. Their responses are provided below.

SEFBHN: SEFBHN recognizes that treating addiction and a mental health disorder at the same time helps rehab clients address their unique relapse triggers, such as depression, mood swings or panic attacks. Legislation was passed that requires acute care behavioral health providers to use a No Wrong Door Practice Model in which they will need to minimally triage and stabilize any individuals brought to their facilities regardless of their area of specialization. SEFBHN is implementing the use of the Level of Care Utilization System (LOCUS) and the Child and Adolescent Level of Care Utilization System (CALOCUS) that will provide consistency with the network in how individuals are assessed and in determining their level of care needs. LOCUS is an evidence-based tool that can be used for assessing level of care for an individual who is experiencing both mental health and substance abuse concerns which support efforts to care for those with co-occurring disorders. Additional Level of Care tools also include the ASAM Continuum. While the ASAM (American Society of Addiction Medicine) Continuum is geared for individuals with substance use disorders it be used for assessing level of care for an individual who is experiencing both mental health and substance abuse concerns which support efforts to care for those with co-occurring disorders. Additional Level of Care tools also include the ASAM Continuum. While the ASAM (American Society of Addiction Medicine) Continuum is geared for individuals with substance use disorders it generates a report with validated clinical recommendations that can be incorporated into patient medical records. The report will thus enhance the clinician’s professional judgement in ruling co-occurring disorder in or out.

SEFBHN also contracts with a provider (The Jerome Golden Center) for an evidence-based, licensed Level II Residential Treatment Facility specifically for adults with concurrent psychiatric and substance abuse diagnoses. The program is a short-term (30- to 90-day) structured living environment and provides residential integrated services where both disorders are primary and treated by one team simultaneously. They serve approximately 30-33 individuals a month. Funding is provided through a special legislative appropriation and is reimbursed on a daily rate, providing an evidence-based curriculum for Integrated Combined Therapies (ICT), which includes aspects of Motivational Enhancement Therapy (MET), Cognitive Behavioral Therapy (CBT), and Twelve Step Facilitation (TSF). The program also assists individuals in applying for benefits if they don’t have any at time of admission which helps to support successful discharge. They have met or exceeded performance measures related to individuals who are successfully discharged not relapsing or needing a hospital readmission.

The Jerome Golden Center also operates a team-based outpatient program call Synergy. This program is based on the tenants of the Assertive Community Treatment (ACT) model designed to provide integrated treatment and recovery services for individuals diagnosed with a severe and persistent mental illness and a co-occurring substance use disorder. The program utilizes a multidisciplinary service approach, delivered by a qualified team of clinicians and behavioral health professionals: psychiatrist, nurse, licensed mental health professional, and case managers, to respond to the various treatment and care coordination needs of persons at risks of psychiatric hospitalization or in need of community reintegration services. Recovery support, psychosocial rehabilitation, and partial hospitalization services are provided via referral to the Jerome Golden Center, Discovery Day Treatment program, and crisis support services are available at all times as an intensive case manager is on-call during non-office hours. Synergy has the capacity to serve 75 individuals at a time.

LSFH: Funding is flexible for providers to deliver services consistent with co-occurring treatment based on client treatment needs rather than funding category. Some providers have co-located CSU and detox beds to provide services based on client needs.
Technical assistance is provided by LSFSH staff to assist providers in drawing down funds and delivering services based on client treatment needs. LSFSH has advocated for dual license to streamline the process and reduce administrative burden on providers who deliver both substance abuse and mental health services.

CFBHN: CFBHN does not directly provide services. CFBHN does provide technical assistance and support for the direct service providers. There is ongoing collaboration and training with providers to enhance treatment for co-occurring mental health and substance abuse issues. Program staff facilitate technical assistance for providers to improve access to quality co-occurring treatments they provide. Staff also frequently discuss the most effective means of utilizing funds when it comes to organizations that are balancing limited resources with the needs of persons with cooccurring disorders.

BBHC: Through the BBHC CQI Committee, one of their areas of focus is serving those with co-occurring disorders to insure they are following the “no wrong door” model.

CFCHS: CFCHS posed this question to their provider network and shared the following responses:

-Devereux Foundation - Our staff of physicians and nurses communicate with the families and funders any concerns to ensure the client is getting their needs met. If our facility cannot provide the service we involved their case workers and Managed care plan to assist in getting the needs of the child met. If referrals are necessary we help support those.

-Children’s Home Society - We treat co-occurring disorders as a primary mental health issue when the co-occurring disorders are major mental health disorders co-occurring with a substance abuse disorder. In other cases where we do not specialize in the treatment of a co-occurring disorder, we refer out and follow up with the referral organization as required. We may also refer to case management if the initial service is not case management. If the original service is case management, we follow intervention according to our service plan, including intervention for all co-occurring disorders.

-Kinder Konsulting and Parents Too - If we feel the parent(s)/caretakers are having issues in these areas we do make the appropriate referrals. We do currently work in Orange County’s Baby Court Program where many of the parents are struggling with substance abuse issues. Due to the nature of this program, we work closely with the judge, attorney, case managers, and other therapists involved in the treatment of these parents.

-Wayne Densch Center (WDC) - The WDC provides referrals to both the mental health and physical health needs of its residents, case managers assist in maximizing insurance benefits, setting appointments, transporting and accompanying client to appointments, follows up on future appointments and medication needs. WDC also facilitates client participation in community educations, about health, wellness and nutrition.

-Eckerd Kids - Substance abuse history is an admission requirement for Eckerd’s rehousing program. Eckerd is an active member of the Brevard Homeless Coalition’s Coordinated Housing Assessment Team which ensures at referral to Eckerd that pertinent/allowable mental health and substance abuse info is passed on to ensure the appropriate case management service plan is created. If mental health services are needed or seen as a critical part of the client’s success plan, payment for these services are first explored with funder (CFCHS) to determine if it is an approved incidental expense or if an in-network provider can be utilized from alternative ME funds. Options for mental health and substance abuse services are also explored with local providers, several of which are member agencies of the local CoC. For Prevention education programs at the school, integrated SAMH services are inherent to the program structure, however appropriate open communication is maintained with the host schools to ensure co-occurring substance abuse and mental health concerns are adequately addressed, whether they are presented at referral from the school or arise during prevention education/counseling sessions provided by the Eckerd program.

-STEPs - Our agency maintains several Memorandum of Agreement with referral sources that have various funding streams including specific funded programs, sliding scale, self-pay and insurance.

-House of Freedom - We integrate these services as part of the treatment modality. Funding sources are either through self-pay or government grants.

-The Healing Tree - completes a full biopsychosocial assessment on each individual in the family who is seen for treatment. That assessment includes gathering information to assess for mental health and substance abuse concerns. Several staff at The Healing Tree are Certified Addictions Professionals or have prior experience providing substance abuse treatment. Additionally, in-service and external trainings are provided to staff to ensure their awareness and continued growth in the assessment and treatment of substance abuse concerns, as well as mental health disorders. The Healing Tree turns no family away for their inability to pay, so even if they are receiving services with another treatment provider to address substance abuse concerns or mental health issues that go above and beyond the scope of services at The Healing Tree, there is no deterrent in receipt of treatment related to payment. The Healing Tree also ensures releases are signed for any treatment provider with whom the family is working or to whom they are referred to ensure the ability to provide coordinated care.

-Gulf Coast Jewish Family and Community Services - Our agency utilizes stipends to assist caregivers with caring for SPMI individuals including forensic clients. Caregivers partner with providers to ensure all the needs of the individuals are met.

-Circles of Care - In outpatient departments, we have several CAP/MCAP therapists that provide co-occurring based therapies centered on the unique needs of the patient. At one of our mental health clinics which has a greater incidence of co-occurring disorders, on-site prevention and substance abuse services are offered as a primary or adjunct modality to an individual’s treatment plan. With regard to prevention services, one unique program staffs a social worker on-site at our local Health Department clinics. At these locations, a patient can be assessed for a substance abuse issues and receive care-coordination. If they also have mental health concerns and are eligible, TANF funds in mental health can be utilized for a seamless treatment episode.
8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services?

7. Is the SSA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care?

6. Do the M/SUD providers screen and refer for:
   a) Prevention and wellness education
   b) Health risks such as
      ii) heart disease
      iii) hypertension
      iv) high cholesterol
      v) diabetes
   c) Recovery supports

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state?

4. Who is responsible for monitoring access to M/SUD services by the QHP?

   In the Florida, the Agency for Health Care Administration (AHCA) ensures access to care for Medicaid recipients through contracts with insurance plans. For private health insurance, the Office of Insurance Regulation (OIR) has the regulatory authority in Florida and will conduct market examinations for compliance with the ACA.

3. a) Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs?
   b) and Medicaid?

- Community Counseling Center of Central Florida - We work with those that we have releases of info to coordinate benefits to make sure all parties are able to bill for appropriate services delivered and prioritized according to safety, need, court order etc.
- Community Treatment Center - Our counselors use a mix of Cognitive Behavior Therapy with a Motivationally Enhanced Treatment approach along with evidence-based practices. Our comprehensive, continuous, integrated system of care is recovery orientated, and trauma informed to help identify where the client is and assists to create interventions for motivation and positive behavioral changes. We use cognitive behavior therapy techniques to implement how their thoughts and feelings play a fundamental role in their behavior. Clients often experience thoughts or feelings that reinforce or compound their faulty beliefs. To combat these destructive thoughts and behaviors, we begin by helping the client to identify the problematic beliefs. It is important for the clients to learn how thoughts, feelings and situations can contribute to maladaptive behaviors. We then look at the actual behaviors that are contributing to the problem.
- Mental Health Resource Center - By design, MHRC FACT teams are co-occurring capable. MHRC coordinates and ensures appropriate medical, dental, and vision services for each person served by the FACT program. This includes individuals with co-occurring mental health and substance use disorders. MHRC has developed extensive resources and relationships with healthcare providers in both Brevard and Osceola Counties. This includes: local primary care physicians, Brevard Health Alliance, and the Florida Department of Health in Osceola County. MHRC works with the current healthcare providers of each person served or helps the individual find a primary care provider of his/her choice. The FACT team obtains releases of information from the person served to enable the staff to communicate directly with the designated healthcare providers. This collaboration is essential because many of those served by the FACT team have complicated medical problems, often due to years of neglect, substance abuse, or non-compliance with medical treatments in the past. Medical treatments and appointments for each person served is recorded on the person’s schedule and when necessary a FACT staff is assigned to accompany the person to scheduled medical appointments. Any medical conditions requiring ongoing monitoring and treatment are also included on the person’s recovery plan. In cases where funding is an issue, FACT incidental funds may be utilized to ensure healthcare and medication needs are met.
- Aspire Health Partners - Aspire has a full continuum of substance use disorder and mental health treatment. All services are capable of identifying the individual needs of the client through our assessment process. All clinical staff are trained in the identification and treatment of mental illness and underlying substance use disorders as well as substance use manifested due to a mental illness. We employ both psychiatrists and addictionologists physicians who are highly skilled in the practice of treating co-occurring disorders. Aspire’s training department provides ongoing training for both clinicians and other staff in the identification and treatment of co-occurring disorders.
- LifeStream Behavioral Center - LSBC serves as the health home for its consumers offering both medical and MHSA services in a holistic integrated setting using a common EHR and team approach. Referrals are made from both primary and behavioral health services. An interdisciplinary care coordination team meets weekly to review cases and discuss coordinated treatment plans and outcomes.
9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

The Department is not in a position to identify problems facing the implementation and enforcement of parity provisions.

10. Does the state have any activities related to this section that you would like to highlight?

Not at this time.

Please indicate areas of technical assistance needed related to this section

None.

Footnotes:
The Department respectfully declines to answer question 6 for the following reasons.

First, the question asks about "behavioral health providers." We can only speak to drug treatment providers, because we license those. Mental health treatment providers are licensed under a different agency (the Agency for Health Care Administration).

Second, our licensure standards for drug treatment providers call for physical health assessments, with specific references to pregnancy tests, STD tests, and "special medical problems or needs." A relevant excerpt is included below. However, it does not make specific references to heart disease, hypertension, cholesterol, diabetes, or wellness education, so we would not be 100% comfortable answering those in the affirmative. Furthermore, while the required psychosocial assessment, also excerpted below, does address the clients' perceived "strengths and abilities related to the potential for recovery," it does not explicitly require referrals for "recovery supports." Bear in mind that question 6 is a double-barreled question that asks if providers screen and refer for the listed conditions. We could answer "yes" with regard to the screening component since this is a licensure requirement, but not with regard to the referral component.
Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS).

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary’s top priority in the Action Plan is to “assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits.”

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA’s and HHS’s attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.


44 https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf

45 http://www.ThinkCulturalHealth.hhs.gov

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?
   a) Race
   b) Ethnicity
   c) Gender
   d) Sexual orientation
   e) Gender identity
   f) Age

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population?

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers?

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations?

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards?

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care?

7. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.
Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, (V = Q ÷ C)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states’ use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA’s Evidence Based Practices Resource Center assesses the research evaluating an intervention’s impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA’s Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,49 The New Freedom Commission on Mental Health,50 the IOM,51 NQF, and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).52 The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in “Psychiatry Online.”53 SAMHSA and other federal partners, the HHS’ Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA’s Treatment Improvement Protocol Series (TIPS)54 are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA’s Evidence-Based Practice Knowledge Informing Transformation (KIT)55 was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.
SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers’ decisions regarding M/SUD services.

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions?  
   - Yes  
   - No

2. Which value based purchasing strategies do you use in your state (check all that apply):
   - a) Leadership support, including investment of human and financial resources.
   - b) Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
   - c) Use of financial and non-financial incentives for providers or consumers.
   - d) Provider involvement in planning value-based purchasing.
   - e) Use of accurate and reliable measures of quality in payment arrangements.
   - f) Quality measures focus on consumer outcomes rather than care processes.
   - g) Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
   - h) The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed related to this section.

Footnotes:


50 The President’s New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.


53 http://psychiatryonline.org/

54 http://store.samhsa.gov

55 http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf
Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode (RAISE) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)?
   - Yes ☐ No ☐

2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI?
   - Yes ☐ No ☐

   If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

   The Department is currently funding the following seven CSC for ESMI teams:

   1. Henderson Behavioral Health serving Broward County since 2014
   2. Life Management Center serving Bay County since 2014
   3. South County Mental Health Center serving Palm Beach County since 2016
   4. Citrus Health Center serving Miami-Dade County since 2016
   5. Clay Behavioral Health Center serving Clay and Putnam counties since 2016
6. Aspire Health Partners serving Orange County since 2019

7. Success 4 Kids serving Hillsborough County since 2019

Success 4 Kids uses the OnTrackNY treatment model, all the other providers use the NAVIGATE treatment model. These two evidence-based programs for ESMI are described in more detail below.

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?
   The Block Grant Coordinator shares training and technical assistance events and resources with Florida’s network of ESMI set-aside funded providers.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI?

5. Does the state collect data specifically related to ESMI?

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI?

7. Please provide an updated description of the state’s chosen EBPs for the 10 percent set-aside for ESMI.
   Six out of the seven CSC for ESMI teams use the NAVIGATE model. The model is named “NAVIGATE” to convey the mission of helping individuals with ESMI and their families successfully find their way to psychological and functional well-being. When individuals are enrolled in the program, they and their families first meet with the Program Director, who explains the program and answers any of their questions. The program director then introduces them to the other team members, and first appointments are set up with each of them. The individual then begins to work with the prescriber to evaluate the role of medication, with the Individual Resiliency Trainer to promote individual resiliency by enhancing illness management and building strengths, with the Family Education clinician to learn how to work together as a family to support the individual’s recovery, and with the Supported Employment and Education specialist to pursue employment and educational goals. On average, individuals and families usually work closely with one of more members of the team for 6 to 12 months, followed by less frequent services.

   The seventh CSC for ESMI team in Florida (Success 4 Kids) uses the OnTrackNY model. The OnTrackNY team consists of an outreach and recruitment coordinator, a primary clinician who offers counseling and support to help individuals learn new skills to cope with what they are experiencing, a psychiatrist who collaborates through shared decision-making related to medication and medical concerns, a peer specialist who shares lived experiences to better navigate recovery, a supported education/employment specialist who helps with work/school, and a nurse to support overall health and wellness. Individuals and their loved ones are the most important members of the team. They work closely with the primary clinician and other staff to identify goals that are important to them and services that can help them accomplish their goals.

8. Please describe the planned activities for FFY 2020 and FFY 2021 for your state’s ESMI programs including psychosis?
   The Department will continue to explore various ways of documenting changes in functional improvement and other client-level outcomes that could be used to help demonstrate program impact, without burdening participating providers with additional reporting requirements.

9. Please explain the state’s provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.
   The Department solicits the limited information requested by SAMHSA (in Block Grant Applications/Reports and URS Table 16A) from the participating providers and MEs. With regard to the new URS table, data elements include number of admissions, number currently receiving services, fidelity monitoring measures used, and frequency of fidelity monitoring. Block Grant Applications and Reports typically ask about goals/objectives, indicators/outcomes, and challenges/barriers.

10. Please list the diagnostic categories identified for your state’s ESMI programs.
    Diagnostic criteria for mental illnesses are identified in the DSM-V. Some providers exclude individuals whose symptoms are substance-induced or due to general medical conditions.

    Please indicate areas of technical assistance needed related to this section.

    None at this time.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person’s strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person’s goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person’s needs and desires.

1. Does your state have policies related to person centered planning?

   Yes No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

   N/A

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

   The Department, through our regional MEs, utilizes several modalities to engage consumers and caregivers. These modalities allow for enhanced communication and assistance in making health care decisions.

   Family Intensive Treatment (FIT) Teams, Community Action Treatment, (CAT) Florida Assertive Community Treatment (FACT) Teams all employ a team-based approach which allows multiple avenues to engage the consumer. In addition, many other modalities are being utilized throughout the state. The following is an example of the types of additional consumer and caregiver engagement one of our managing entities employs in their service area.

   The Department also utilizes customer satisfaction surveys and feedback from community agencies and individuals. The Department partners with local National Alliance on Mental Illness (NAMI) affiliates to support awareness, education advocacy efforts and groups such as Family to Family that can be held within the CSU setting in order to further enhance engagement with the consumers and their family members. Further, the use of psychiatric advance directives is encouraged to provide an individual with the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly.

   The Department also continues to actively incorporate the Recovery Oriented Systems of Care (ROSC) framework throughout the state.

   SEFBHN is also recognized as a statewide leader in the implementation of the practice of High Fidelity Wraparound. The outcomes for High Fidelity Wraparound are most profound for individuals with complex needs and being served by cross-systems (i.e., Child Welfare, Juvenile Justice and Special Education). High Fidelity Wraparound Wraparound is a process that involves developing plans that are designed to be culturally competent, strengths based, and organized around family members’ own perceptions of needs and goals. The family is supported by service providers and natural supports who offer their expertise and support. Together they help the family develop a plan to achieve their vision. SEFBHN began the Wraparound Initiative in late 2014 with funding from Palm Beach County Human Services Department. SEFBHN has been very successful in expanding Wraparound throughout the network and in addition to sponsoring training for both SEFBHN and Non-SEFBHN network providers. To further support our providers in utilizing this practice, SEFBHN hired a Wraparound Coaching Specialist in FY17/18 and developed a tool box of resources available to our providers on our website. There are now 15 agencies that employ the use of the Wraparound inclusive of 21 certified coaches and 85 certified facilitators. The increased emphasis on SOAR has enabled more consumers to become more financially stable which has increased their ability to make decisions for themselves.

   SEFBHN continues to support the use of WRAP (Wellness Recovery Action Plan) and WHAM (Whole Health Action Management) which are evidence-based practices that support the consumer in determining what treatments and supports will work best for them. SEFBHN employs a staff member who is certified to train other professionals in the use of WRAP and WHAM. There are currently six providers within the network that offer WRAP and WHAM. The use of Peers is a very critical aspect of the engagement process for all of the above-named practices. They are often able to relate to clients due to their lived experience and encourage them to engage in treatment. In the last 2 years 109 individuals have completed the Helping Others Heal Peer Certification Training which is the first step in becoming a certified peer.
SEFBHN is currently implementing “My Strength” which is an evidence based, web-based platform that provides digital resources designed to compliment other forms of care, such as medication and direct contact with a behavioral health professional. My Strength is also available to agency staff to assist with their own well-being. SEFBHN is sponsoring the initial cost to implement the use of My Strength throughout the network but each agency will pay a one time fee (which is based on the size of the agency and number of clients served) to have access to My Strength and thus allow their clients to use it at no charge. My Strength can also be used as part of the interim services that are provided for individuals who are placed on waitlists for both substance use disorders and mental health disorders. My Strength will be rolled out over time within the network. Two agencies – the Drug Abuse Foundation and Community Partners have been selected as the first agencies to begin using it and training has been scheduled. It is anticipated that all agencies within the network will be trained and utilizing this effective resource by January 2020.

4. Describe the person-centered planning process in your state.

The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. Provider networks utilize a variety of person-centered planning processes, as well as, recovery services and supports including: drop-in centers, peer delivered motivational interviewing, peer specialists, supportive housing, Wellness Recovery Action Plan (WRAP), family navigators, peer wellness coaching, telephone recovery check-ups, whole health action management, mutual aid groups for individuals with mental health and substance abuse disorders, self-care and wellness approaches and person-centered planning.

In 2015, the Department of Children & Families (DCF) began building a foundation to transform the state’s behavioral health system of care, from an acute model to one that focuses on wellness and recovery; to become a Recovery-Oriented System of Care (ROSC). From 2016 to present, DCF has been actively promoting this transformation, by establishing meaningful partnerships with key stakeholders across the state. As a result, DCF, Managing Entities and state leaders have been mobilizing statewide and local recovery-oriented efforts to educate community behavioral health providers, community partners, and other key stakeholders. Please indicate areas of technical assistance needed related to this section.

None at this time.

Footnotes:
Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question
SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?  
   - Yes  
   - No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?  
   - Yes  
   - No

3. Does the state have any activities related to this section that you would like to highlight?
   - No.

   Please indicate areas of technical assistance needed related to this section

   None at this time.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
Environmental Factors and Plan

7. Tribes - Requested

Narrative Question
The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

56 https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?
   
   The Department has requested consultations with the leaders of the two federally-recognized tribes in Florida. Both the Seminole Tribe and the Miccosukee Tribe have declined to participate with the Department on SAMHSA grants for behavioral health services.

2. What specific concerns were raised during the consultation session(s) noted above?
   
   As stated above, both federally-recognized tribes in Florida have declined any consultation requests.

3. Does the state have any activities related to this section that you would like to highlight?
   
   No.
   
   Please indicate areas of technical assistance needed related to this section.
   
   None at this time.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022
Environmental Factors and Plan

8. Primary Prevention - Required SABG

Narrative Question
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. Information Dissemination providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. Education aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. Alternative programs that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. Problem Identification and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. Community-based Process that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. Environmental Strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)?
   - Yes
   - No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply)
   - Data on consequences of substance-using behaviors
   - Substance-using behaviors
   - Intervening variables (including risk and protective factors)
   - Other (please list)

   Other types of information collected as part of the most recently published statewide needs assessment include the following:

   - Perceived system strengths/assets and gaps/barriers from focus groups.
   - Current prevention initiatives, strategies, and resources.
   - General community-level demographic information (beyond identified risk and protective factors)

3. Does your state collect needs assessment data that include analysis of primary prevention needs for the following population groups? (check all that apply)
   - Children (under age 12)
   - Youth (ages 12-17)
   - Young adults/college age (ages 18-26)
   - Adults (ages 27-54)
   - Older adults (age 55 and above)
4. Does your state use data from the following sources in its Primary prevention needs assessment? (check all that apply)

- [x] Cultural/ethnic minorities
- [x] Sexual/gender minorities
- [x] Rural communities
- [ ] Others (please list)

5. Does your state use needs assessment data to make decisions about the allocation SABG primary prevention funds?

- [ ] Yes
- [x] No

If yes, (please explain)

Needs assessment data helps the state determine what training and technical assistance activities will be funded. Some Managing Entities also use needs assessment data when making decisions about which services to fund.

If no, (please explain) how SABG funds are allocated:
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals, families, and communities;

2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;

3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;

4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;

5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and

6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco, and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

### Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce?  
   - Yes  
   - No

   If yes, please describe

   There are two types of prevention certifications available for the prevention workforce in Florida. The Certified Prevention Specialist (CPS) credential is an entry-level credential for individuals who provide prevention-related services in the area of addiction only. The CPS requires a minimum of a high school diploma or general equivalency degree. The Certified Prevention Professional (CCP) credential is a professional credential for individuals who provide prevention-related services across the spectrum of targeted behaviors, including but not limited to addictions, delinquency, teen-pregnancy, suicide and drop-out prevention. The CCP requires a minimum of a bachelor’s degree.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce?  
   - Yes  
   - No

   If yes, please describe mechanism used

   The Department provides training and technical assistance to the prevention workforce through a contract with the Florida Alcohol and Drug Abuse Association and through the Block Grant Coordinator upon request.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies?  
   - Yes  
   - No

   If yes, please describe mechanism used
Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;

2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;

3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;

4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;

5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and

6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

**Planning**

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years?  
   - Yes  
   - No

   If yes, please attach the plan in BGAS by going to the Attachments Page and upload the plan

   The last time a statewide strategic prevention plan was published was 2013. That plan is obsolete. Here is an update on the Department’s process for developing a new statewide prevention plan:

   The Department partnered with the Collaborative Planning Group to conduct a Statewide Substance Abuse Prevention Needs Assessment, which was completed in June 2017. Focus groups (with participants from Managing Entities, providers, and coalitions) conveyed an interest in sharing best practices, evidence of effectiveness, and challenges. Since then, the Department has collected input from Managing Entities, prevention providers, and community-based organizations, regarding content for a new Statewide Substance Abuse Prevention Plan.

   Several key domains emerged from this process. These domains will be addressed in the forthcoming plan:

   (1) Targeting prevention resources to communities identified at the highest risk for substance misuse and substance-related harmful consequences;

   (2) Increasing the number of strategic, interagency partnerships;

   (3) Attracting, training, and retaining a qualified prevention workforce;

   (4) Formalizing opportunities for face-to-face, collaborative planning meetings with various partners;

   (5) Evaluating prevention programs that have never been tested.

   In order to adequately inform the draft, the Prevention EBP Workgroup will attempt to complete several steps outlined in an associated performance indicator during this planning cycle (i.e., classifying prevention programs with inconclusive, describing and classifying currently funded environmental strategies, and developing a list of untested prevention programs that need to be evaluated with an experimental design).

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan)  
   - Yes  
   - No  
   - N/A

3. Does your state’s prevention strategic plan include the following components? (check all that apply):

   a) Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
b) Roles and responsibilities

c) Process indicators

d) Outcome indicators

e) Cultural competence component

f) Sustainability component

g) Other (please list):

i) Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds?  
   Yes ☐ No ☒

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds?  
   Yes ☐ No ☒

If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based.

The EBP Workgroup regards primary substance use prevention EBPs as "programs that have been evaluated, through a peer-reviewed publication, with an experimental or quasi-experimental research design and found to produce statistically significant reductions in substance use outcomes, without any adverse effects."

As a second option, the Department’s program guidance for Managing Entity contracts (Guidance 1 - Evidence-based Guidelines) considers a program an EBP if it "is reported in peer-reviewed journals or has documented effectiveness which is supported by other sources of information and the consensus judgment of informed experts." Providers claiming EBP designation under this option must be able to provide a description of the theory of change, a logic model, a description of how the content and structure is similar to programs or strategies that appear in approved registries or in the peer-reviewed literature, and documentation that it was effectively implemented in the past, with results that show a consistent pattern of credible and positive effects. They must also include documentation of a review by, and consent of, a Panel of Informed Experts indicating that the implementation of this proposed program or strategy is appropriate for the community and likely to have a positive effect on the identified outcome and what evidence their decision was based upon. Following the selection of an option, the Network Service Provider must maintain sufficient documentation to support the decision.
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;

2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;

3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;

4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;

5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and

6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

### Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:
   a) SSA staff directly implements primary prevention programs and strategies.
   b) The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
   c) The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
   d) The SSA funds regional entities that provide training and technical assistance.
   e) The SSA funds regional entities to provide prevention services.
   f) The SSA funds county, city, or tribal governments to provide prevention services.
   g) The SSA funds community coalitions to provide prevention services.
   h) The SSA funds individual programs that are not part of a larger community effort.
   i) The SSA directly funds other state agency prevention programs.
   j) Other (please describe).

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:
   a) **Information Dissemination:**
      - Natural High
      - No One’s House
      - Parents Who Host Lose the Most
      - Safe Rx
      - Social Norms Campaign
      - Talk. They Hear You
      - Theater Troupe Peer Education Project
      - Watch Your BAC
      - WE ID Campaign
      - Toolkits/Resource Guides
      - Town Hall meetings,
      - Miscellaneous media campaigns.
   b) **Education:**
      - Active Parenting
      - Active Parenting of Teens
Alcohol Literacy Challenge
Brief Strengths Based Case Management
Creating Lasting Family Connections
Drug Free Youth (D-Fy)
Family Education Program
Family Life Intervention Program (FLIP)
Guiding Good Choices
Hidden in Plain Sight
I Can Problem Solve
Interactive Journaling
Know the Law
Life Skills Training (Botvin)
Lifeline Program
Living Skills (Adult)
Marijuana Download the Facts
Naloxone Trainings
New Horizons
Nurturing Families
Nurturing Fathers
Nurturing Parenting Program
Other
Parenting Wisely
Peaceful Alternatives to Tough Situations (PATTS)
Positive Action
Project ALERT
Project SUCCESS
Safe Use, Safe Storage, Safe Disposal
Second Step
Social Norms Campaign
SPORT Prevention Plus Wellness
Strengthening Families
Teen Intervene
Theater Troupe Peer Education Project
Too Good for Drugs
Too Good for Violence
Trauma Informed Care Education Series
Triple P Positive Parenting Program
Wellness Initiative for Senior Education (WISE)
Wise Owl
c) Alternatives:
   Friday Night Done Right
   Theater Troupe Peer Education Project
d) Problem Identification and Referral:
   Brief Strengths Based Case Management
   Family Life Intervention Program (FLIP)
   Interactive Journaling
e) Community-Based Processes:
   Coalition support, development, and capacity building
   Communities Mobilizing for Change on Alcohol
   Drug Free Youth
   Student Assistance Programs
f) Environmental:
   Compliance checks
   Drug deactivation packets
   Environmental scans
   I Steer Clear Alcohol and Drug Use Driving Prevention
   Know the Law
   Alcohol retailer education
   No One's House
   Project E-FORCSE
   Social Norms Campaign
   Talk. They Hear You
We ID Campaign

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means?

If yes, please describe

To ensure that SABG funds are used only to fund primary substance abuse prevention services which are not funded through other means, different methods are used based on the financial leadership of each Managing Entity. Providers may be instructed to report which budget code they are using to bill for their prevention units. This allows for the MEs to specifically track which units are being billed under SABG dollars. The MEs may also incorporate a written clause into their standard contract for services which will allow for the identification and removal of any sources which are not eligible for payment under the contract. Documentation of financial eligibility may also be reviewed for validation during on-site monitoring.
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

### Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years?  
   - Yes  
   - No  
   If yes, please attach the plan in BGAS by going to the Attachments Page and upload the plan. The Department does not have an evaluation plan for primary substance use prevention, however evaluation activities will be addressed in the forthcoming statewide prevention plan.

2. Does your state’s prevention evaluation plan include the following components? (check all that apply):
   - Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
   - Includes evaluation information from sub-recipients
   - Includes SAMHSA National Outcome Measurement (NOMs) requirements
   - Establishes a process for providing timely evaluation information to stakeholders
   - Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
   - Other (please list):

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:
   - Numbers served
   - Implementation fidelity
   - Participant satisfaction
   - Number of evidence based programs/practices/policies implemented
   - Attendance
   - Demographic information
   - Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:
   - 30-day use of alcohol, tobacco, prescription drugs, etc
   - Heavy use
   - Binge use
Perception of harm

Disapproval of use

Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

Other (please describe):
Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Maximizing independence for persons with behavioral health disorders, including those with co-occurring mental health and substance abuse disorders, is a foundational goal within Florida’s system of care. Utilizing the framework of a Recovery Oriented System of Care (ROSC), Florida places an emphasis on person-centered planning, family and certified peer involvement, shared decision-making, cultural competency and multi-faceted pathways to recovery within the community.

Programs such as the Florida Assertive Community Treatment Teams (FACT Teams) are a critical component in providing services that are specifically designed to maintain individuals with serious and persistent mental health disorders in the community. FACT Teams can be utilized to prevent an individual from going into a more intensive residential program or can serve as a step-down service for individuals coming out of the state mental health treatment facilities. The individuals served by the FACT Team are provided with regular weekly contact from various FACT Team members depending upon their individual needs. Flexible funding also allows for immediate access to tangible items an individual may need that will also assist with keeping them in the community and minimize the risks of future institutionalization.

Clubhouses provide non-clinical services which include a work-ordered day and peer-to-peer recovery support, services and assistance. Clubhouses promote recovery from mental illness and provide structured, community-based services designed to strengthen and/or regain the consumer’s interpersonal skills, meaningful work, employment, education and help them do well in the community.

Mobile Crisis is an outreach service that provides mobile crisis intervention and assessment for adults and children. This service is available 24 hours a day/7 days a week and is available to the community should a consumer need additional support or intervention.

Drop-In Centers are intended to provide a range of opportunities for individuals with severe and persistent mental illness to independently develop, operate, and participate in social, recreational and networking activities.

Federally Qualified Health Centers (FQHC) are community-based organizations that provide comprehensive primary and preventative medical care, including health, oral, and mental health/substance abuse services to persons of all ages, regardless of their ability to pay or health insurance status.

Mental Health Court (MHC) is a voluntary diversion program with the goal of increasing access to and engagement in treatment for persons with serious mental illness. A Case Manager makes the necessary referrals and follows up on the individual’s progress. They will also appear in court on a regular basis which allows the judge to closely monitor the individual’s compliance. Mental Health Courts are a collaborative effort between judges, the public defender, the state’s attorney, police and probation officers, case managers and the individuals being served.

Care Coordination serves to assist individuals who are not effectively connected with the services and supports they need to transition successfully from higher levels of care to effective community-based care. This includes services and supports that affect a person’s overall well-being. The Department created the transitional voucher project to assist eligible individuals obtain and maintain accessible, affordable housing with supportive recovery services. Individuals experiencing homelessness, receiving care coordination services or ready to transition from FACT Programs to a lower level of community care.

Additional services and supports provided to assist in helping individuals with behavioral health disorders to function within the community are, Vocational Rehabilitation, Supported Employment Programs, Re-entry Services, Case Management, Medication...
Management.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

   a) Physical Health
   - [ ] Yes
   - [ ] No

   b) Mental Health
   - [ ] Yes
   - [ ] No

   c) Rehabilitation services
   - [ ] Yes
   - [ ] No

   d) Employment services
   - [ ] Yes
   - [ ] No

   e) Housing services
   - [ ] Yes
   - [ ] No

   f) Educational Services
   - [ ] Yes
   - [ ] No

   g) Substance misuse prevention and SUD treatment services
   - [ ] Yes
   - [ ] No

   h) Medical and dental services
   - [ ] Yes
   - [ ] No

   i) Support services
   - [ ] Yes
   - [ ] No

   j) Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)
   - [ ] Yes
   - [ ] No

   k) Services for persons with co-occurring M/SUDs
   - [ ] Yes
   - [ ] No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)
N/A

3. Describe your state’s case management services

Pursuant to Chapter 65E-14, Florida Administrative Code, case management services “consist of activities that identify the recipient’s needs, plan services, link the service system with the person, coordinate the various system components, monitor service delivery, and evaluate the effect of the services received.” This covered service includes clinical supervision provided to a service provider’s personnel by a professional qualified by degree, licensure, certification, or specialized training in the implementation of this service.

There is an additional covered service delivered through community mental health providers called intensive case management. Chapter 65E-14. F.A.C., describes intensive case management as “activities aimed at assessing recipient needs, planning services, linking the service system to a recipient, coordinating the various system components, monitoring service delivery, and evaluating the effect of services received. These services are typically offered to persons who are being discharged from a hospital or crisis stabilization unit who are in need of more professional care and who will have contingency needs to remain in a less restrictive setting.”

4. Describe activities intended to reduce hospitalizations and hospital stays.

In an effort to reduce hospitalizations, Central Receiving Facilities have been opened throughout the state and include Comprehensive Services Centers or Access Centers with walk in services that are available to assist individuals in crisis, provide initial assessment, and help identify and refer the individual to services that are the most appropriate level of care for their needs.

Managing Entities work with providers and care coordinators to improve transitions from acute and restrictive to less restrictive community-based levels of care; decrease avoidable hospitalizations, inpatient care, incarcerations, and homelessness; with a focus on an individual’s wellness and community integration. Managing Entities and providers statewide work to facilitate the recovery-oriented system of care (ROSC) by coordinating a network of community-based services that are person-centered.
In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state’s M/SUD system.

**Target Population (A) Statewide prevalence (B) Statewide incidence (C)**

<table>
<thead>
<tr>
<th>Target Population (A)</th>
<th>Statewide prevalence (B)</th>
<th>Statewide incidence (C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Adults with SMI</td>
<td>3.8%</td>
<td>625,000</td>
</tr>
<tr>
<td>2. Children with SED</td>
<td>7.0%</td>
<td>150,497</td>
</tr>
</tbody>
</table>

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

The most recent state-level estimate of the prevalence of SMI among the non-institutionalized adult household population is based on 2016-2017 NSDUHs. This estimate is published by SAMHSA and retrieved from the following location:


The prevalence of serious emotional disturbances (SED) among children was last estimated by the Substance Abuse and Mental Health Services Administration (SAMHSA) in the Federal Register in 1997. The prevalence in Florida was estimated to be between 7% and 13%. These estimates, which are now over 20 years old, and which were not based on studies of children in Florida, are no longer useful for strategic planning purposes. Updates on the next steps related to SED estimation described in the workshop summary from the National Academies’ Standing Committee on Integrating New Behavioral Health Measures into SAMHSA’s Data Collection Programs could inform state-level research plans and proposals to address this knowledge gap.

The figures reported in the table above rely on the lower limit of the range published in the Federal Register (7.0%). The 2017 SED figures in the table above are estimate prepared by NRI for SAMHSA in 2018. These figures were retrieved from the following location:

Narrative Question:
Criterion 3: Children's Services
Provides for a system of integrated services in order for children to receive care for their multiple needs.

**Criterion 3**

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

- **a)** Social Services
  - Yes [ ]  No [ ]

- **b)** Educational services, including services provided under IDE
  - Yes [ ]  No [ ]

- **c)** Juvenile justice services
  - Yes [ ]  No [ ]

- **d)** Substance misuse prevention and SUD treatment services
  - Yes [ ]  No [ ]

- **e)** Health and mental health services
  - Yes [ ]  No [ ]

- **f)** Establishes defined geographic area for the provision of services of such system
  - Yes [ ]  No [ ]
a. Describe your state’s targeted services to rural population.

Rural Populations:

The state of Florida is made up of 67 counties. Of those 67 counties, 30 are considered “rural.” A wide variety of outreach methods are employed to target the rural population. Statewide, providers offer telehealth services, satellite offices within rural communities and staff who provide in-home services such as care coordination. In addition, several MEs participate along with service providers to ensure they are involved in rural county community meetings on a regular basis, updating rural communities on any change in services and providing information regarding mental health and/or co-occurring disorders. This is meant to facilitate open dialogue and feedback regarding the types and quality of services offered in each community. Community engagement specialists and trainers work within rural communities to provide training on available resources and how to access those resources, as well as deliver other pertinent training to communities such as Mental Health First Aid and Youth Mental Health First Aid to assist citizens in understanding mental illness and how to respond. In addition, assistance in the form of bus passes, gas cards and transportation services are initiated to aid families who may not otherwise be able to travel to receive services and supports in an outpatient setting.

b. Describe your state’s targeted services to the homeless population.

Homeless Populations:

ME staff work to engage local Homeless Coalitions and Homelessness Continuum of Care (CoC) and have dedicated seats or otherwise actively participate in the work of each CoC. Partnerships between the ME and CoCs is critical in reaching individuals experiencing homelessness. These collaborations are aimed at linking individuals in need of mental health assistance and pairing them with needed housing interventions offered through CoC funding. The ME has providers in each judicial circuit that utilize Transition Voucher funding to cover service and housing costs to those individuals experiencing homeless or at imminent risk of homelessness and qualify for “care coordination” efforts. To date, the ability to use this unique funding stream has allowed clients to be quickly housed and connected to needed services. The clients who have benefited from this unique strategy have been able to bypass extended waitlists for housing and services, thus avoiding decompensation. These funds are effectively used to help stabilize individuals who have histories of recurring admissions to Crisis Stabilization Units and/or SMHTFs and connect these individuals to benefits through the SOAR process.

There are ME contracted agencies that offer Supportive Housing/Living services which assist individuals with mental illness and substance abuse in selecting permanent housing in addition to providing services and supports that will enable the individual to maintain their housing so they can continue to live successfully in the community. The ME has a SOAR specialist who trains and provides technical assistance to ensure that providers are assisting individuals with applying for social security benefits and that they are entering data in the Online Application Tracking (OAT) system.

Many of our MEs also participate in the Projects for Assistance in Transition from Homelessness (PATH) programs, which offers an array of services including outreach, substance abuse treatment, mental health treatment, educational assistance, job training and housing.

c. Describe your state’s targeted services to the older adult population.

Elderly Populations:

ME staff work with adult protection teams, which look at some of the most vulnerable individuals in each community (many of whom are older adults). The work of Housing & Resource Specialists is often targeted to those that are aging and in need of ALF or Nursing Home care with a primary mental health diagnosis. In addition, these specialists work with the ALFs and Nursing Homes in their areas to build relationships and rapport while educating facilities on the perceived versus actual risks associated with taking on a resident with a primary mental health diagnosis. MEs also participate in coalitions such as Aging and Senior Coalitions and provide information and education on the proper use of a Baker Act, as well as provider services their members may benefit from to avoid unnecessary Baker Acts and better manage care for those with mental health symptoms and diagnosis.
Criterion 5

Describe your state’s management systems.

State Financial Resources for Mental Health Service Providers:

In State Fiscal Year 2018, Florida spent $100,481,286 in state dollars on community mental health services for children and adults. This pays for a variety of services, include CAT teams, FACT teams, transitional beds, medications, and competency restoration services.

State Staffing for Mental Health Services Providers:

Community mental health providers are supported by the Department’s Office of Substance Abuse and Mental Health, which has approximately 43 full-time staff members. These staff members collect and report data, manage finances, develop policies, and administer programs through a Data Team, a Policy Team, a Clinical Team, a Children's Behavioral Health Team, and Block Grant Coordinators, among others.

State Training for Mental Health Services Providers:

The Department requests training for mental health service providers through SAMHSA’s TA Tracker System or otherwise provides for these services through contracts. The Department works with the Florida Certification Board on webinars, online courses, workshops, and learning collaboratives dealing with topics like the Baker Act, Assessing Suicide Risks, National Cultural Competency Standards, Integration of Peer Services, among others. The Department also works with the Florida Alcohol and Drug Abuse Association on webinars and workshops dealing with topics like Level of Care LOCUS CALOCUS Patient Placement, Treating the LQBT Community, Multidimensional Family Therapy, Trauma Informed Care for Women, DSM-V, Recovery Oriented Systems of Care, and First Episode Psychosis.

Training of Providers of Emergency Services for Individuals with SMI and SED:

The Department requests training for providers of emergency mental health services through SAMHSA’s TA Tracker System or otherwise provides for these services through contracts. The Department works with the Florida Certification Board to provide a webinar on Baker Act Procedures for Law Enforcement and online courses on Law Enforcement and the Baker Act and Emergency Medical Treatment: Florida’s Baker Act and Marchman Act.
Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SABG

Narrative Question
Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:
   a) A full continuum of services
      i) Screening
      ii) Education
      iii) Brief Intervention
      iv) Assessment
      v) Detox (inpatient/social)
      vi) Outpatient
      vii) Intensive Outpatient
      viii) Inpatient/Residential
      ix) Aftercare; Recovery support
   b) Services for special populations:
      Targeted services for veterans?
      Adolescents?
      Other Adults?
      Medication-Assisted Treatment (MAT)?
Criterion 2: Improving Access and Addressing Primary Prevention - See Narrative 8. Primary Prevention - Required SABG.
Criterion 3: Pregnant Women and Women with Dependent Children (PWDDC)

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability?  
   - Yes [ ]  No [ ]

2. Does your state make prenatal care available to PWDDC receiving services, either directly or through an arrangement with public or private nonprofit entities?  
   - Yes [ ]  No [ ]

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care?  
   - Yes [ ]  No [ ]

4. Does your state have an arrangement for ensuring the provision of required supportive services?  
   - Yes [ ]  No [ ]

5. Has your state identified a need for any of the following:
   - a) Open assessment and intake scheduling  
     - Yes [ ]  No [ ]
   - b) Establishment of an electronic system to identify available treatment slots  
     - Yes [ ]  No [ ]
   - c) Expanded community network for supportive services and healthcare  
     - Yes [ ]  No [ ]
   - d) Inclusion of recovery support services  
     - Yes [ ]  No [ ]
   - e) Health navigators to assist clients with community linkages  
     - Yes [ ]  No [ ]
   - f) Expanded capability for family services, relationship restoration, and custody issues?  
     - Yes [ ]  No [ ]
   - g) Providing employment assistance  
     - Yes [ ]  No [ ]
   - h) Providing transportation to and from services  
     - Yes [ ]  No [ ]
   - i) Educational assistance  
     - Yes [ ]  No [ ]

6. States are required to monitor program compliance related to activities and services for PWDDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Florida contracts with seven regional MEs to oversee network service provider compliance with Block Grant rules regarding pregnant women and women with dependent children, which address preference in admissions, the provision of interim services, and the provision of comprehensive services (medical care, prenatal care, pediatric care, gender-specific therapeutic interventions, case management, etc.). MEs conduct onsite monitoring and desk reviews using Block Grant compliance monitoring tools. Any issues that are found are addressed through Corrective Action Plans (CAPs). Consequences for noncompliance range from remedial (like required training, technical assistance, and policy revisions) to severe (like contract termination). Additional details from each of the Managing Entities are provided below.

BBCBC - BBCBC’s monitoring procedures include clinical review of the most intensive levels of care such as detox and residential as well as specific review of requirements for pregnant women and women with dependent children. BBCBC’s subcontracted substance abuse providers assure priority admission for pregnant women by assessing individuals who present for treatment and determining the services needed. If the identified level of care is not immediately available, all providers ensure interim services are provided while awaiting more intense level of treatment. Providers are contractually required to maintain any waitlist information within BBCBC’s Behavix data system. The electronic waitlist allows providers to note whether or not the individual on the waitlist is one of the priority populations including pregnant women. The waitlist also has a feature that allows the notation of whether or not interim services are being provided. The Behavix data system sends email notification of priority populations added to the waitlist to the Prevention Specialist and Network Coordinators for follow up. Furthermore, during site visits, the BBCBC monitoring team reviews files to determine if pregnant women are placed in a program or have interim arrangements made within 48 hours.

CFCHS - In the event that high priority clients, such as pregnant women, are unable to receive the recommended service upon entering the facility and has to wait longer than the required timeframe stipulated in the block grant, the network providers must add these clients to the electronic waitlist system managed by the managing entity within the same day the services was recommended. The UM Specialist monitors the population served and waitlist requirements by completing a desk review at least once a week. The UM specialist monitors the wait list to ensure that all network service providers follow all guidelines and to ensure that the individual receives the service fairly quickly. The UM Specialist reviews the wait list at least once a week. She will communicate to the subcontractor by phone, in person or by email to ensure that clients do not wait too long for services. As a result, the wait list does not normally go past 30 days. By the 10th of each month, the network service provider will attest if they do or do not have a wait list. The UM Specialist ensures that the wait list is completed by the network service provider by reviewing waitlist attestation submissions monthly, and reviewing the length of time, interim services offered, and the type of...
CFBHN - Providers are instructed in the Block Grant trainings and annual review that pregnant women needing substance abuse treatment must be admitted to the level of care necessary within 48 hours. If the admission cannot occur within 48 hours, they are instructed to call CFBHN for assistance by the UM Department. From there, CFBHN staff coordinate with other providers to get the pregnant person into treatment as soon as possible. CFBHN conducts quarterly “Secret Shopper Calls” to providers that receive funds to serve pregnant women and women with dependent children to monitor for compliance with Women’s Block Grant requirements. CFBHN prepares scorecards to discuss call outcomes with each provider. Strategies for improving performance are determined (or corrective actions are issued) and followed up on as necessary. The provider network is kept apprised of progress with this process in adult system of care webinars every other month. Further, CFBHN performs monthly monitoring of MSA81 data (which is also sent to DCF) and PPW expansion participant data to ensure that required data are entered and that expected targets are reached. If a program is not submitting data or if performance targets are missed, the program manager addresses technical assistance deficits or barriers with the provider staff. CFBHN’s utilization management staff in their care coordination of persons served with priority ensure admission of pregnant women occurs within 48 hours. If admission is not available within that timeframe interim services are offered.

SEFBHN - SEFBHN continues to emphasize to our providers that pregnant women and women with dependent children are to be prioritized for services. SEFBHN Coordination of Care staff make it their priority to ensure that pregnant consumers never have to go on the network Electronic Waitlist and are admitted to the appropriate level of treatment care within 48 hours of request for help. The only exception to this may be if the individual herself refuses treatment in a given facility as she has expressed wanting to wait for a bed in a different facility. While this is a rare situation, interim services will be provided until the bed in the specific facility becomes available.

SEFBHN Care Coordination staff work closely with provider to identifying services and will assist with linkage to other providers to ensure the pregnant consumer is receiving the services they need including pre-natal care. Our peer support agency, Rebel Recovery who also works across treatment providers to assist the consumer in navigating what can be a complex system. They advocate for the mother and her children within the child welfare system and family court. Consumer complaints or other external complaints are also immediately addressed with the providers if there is concern that a pregnant woman is not being prioritized for services.

The topic of priority populations including pregnant women is also addressed periodically at our Continuous Quality Improvement (CQI) Committee meetings. These meeting also allow for networking between providers which enhances their ability to coordinate care for consumers. SEFBHN also conducts on-site validation reviews of our providers who treat pregnant women. Consumer charts are reviewed as are their policies regarding pregnant women. Providers will be required to develop a Performance Improvement Plan (PIP) to address any noted deficiencies. When a provider is struggling to improve the quality of services even after implementing a PIP, SEFBHN will arrange for additional technical assistance and consultation so that agency can function more successfully. We will also include DCF licensing when assisting a provider to raise their standards of care. Review of incident reports and data surveillance provide additional avenues for monitoring the care offered by our providers. When a provider is not able to adequately address our concerns, we will do additional on-site visits and chart reviews and SEFBHN leadership will meet with the provider’s leadership to determine what barriers are preventing the provider from improving their quality of care. SEFBHN has also notified an agency’s Board of Directors of the deficiencies and requested approval from our own Board of Directors to impose financial penalties. In the past we have terminated our contractual relationship with providers who have lacked the capacity to improve. During this current reporting period it has not been necessary to do so. It is always our goal to find a mutual solution that will result in the continuation of services.

SEFBHN - Pregnant women are a top priority population within SEFBHN’s System of Care and receive priority placement to their recommended level of care. If the recommended level of care is residential treatment, SEFBHN SOC staff makes all efforts to place Pregnant Women in programs that specialize in the treatment for women. Efforts are made to refer the mother to programs where she can remain in residential treatment with her child. Women are prioritized on the waitlists and are placed in the first available opening at the recommended level of care. If the recommended level of care is residential treatment and a bed is available, the individual is referred to treatment immediately in those services. If a residential program bed is not immediately available, the individual is placed on the centralized wait list and offered interim services. SEFBHN SOC Staff works with its provider network to identify treatment beds within the expected seven days of a woman being placed on the waitlist. The availability of treatment beds for these women are monitored daily.

In addition, SEFBHN has a rigorous monitoring process. Provider receiving Block Grant funding are reviewed annually where Block Grant requirements is the within the scope of the review. SEFBHN has dedicated Block Grant monitoring tools and checklists to review the eligibility, accuracy and completeness of program services and data. Service records for a sample of consumers are randomly selected for detailed review. Any noted deficiencies are addressed with the service provider through a corrective action plan.

BBHC - BBHC identifies compliance issues using a Block Grant Monitoring Tool. Several corrective actions are required in the event of noncompliance. Providers may be required to submit any outstanding documentation verifying that the issue has been resolved. Quality Improvement Plans may be required to address clinical deficiencies identified for the first time that do not impact the client safety and that require an extensive period of time to demonstrate the resolution. Providers may need to implement trainings and initiative ongoing monitoring to ensure that compliance issues are resolved. Finally, CAPs may be required when the deficiencies identified are severe and prevalent throughout the organization. These findings require a formal response and require a follow up process that is outlined in BBHC’s Corrective Action Plan Policy.
LSFHS - LSFHS ensures compliance through the routine and non-routine onsite and desk reviews conducted by the Network Management, Clinical, and Compliance Departments. A monitoring tool specifically designed for Block Grant regulations applicable to pregnant women and women with dependent children is used. Any compliance issues that are identified are addressed through CAPs. Providers have 14 days to complete and submit CAPs. CAPs may result in revisions to policies and procedures, documentation of training, additional onsite or desk reviews, technical assistance, etc. Consequences for noncompliance with a CAP escalate from the provider being ineligible for available lapse funding all the way up to termination of the contract.
**Criterion 4, 5 and 6: Persons Who inject Drugs (PWID), Tuberculosis (TB), Human Immunodeficiency Virus (HIV), Hypodermic Needle Prohibition, and Syringe Services Program**

### 3. Persons Who Inject Drugs (PWID)

#### Criterion 4, 5 and 6: Persons Who inject Drugs (PWID)

1. Does your state fulfill the:
   - a) 90 percent capacity reporting requirement
   - b) 14-120 day performance requirement with provision of interim services
   - c) Outreach activities
   - d) Syringe services programs
   - e) Monitoring requirements as outlined in the authorizing statute and implementing regulation

2. Has your state identified a need for any of the following:
   - a) Electronic system with alert when 90 percent capacity is reached
   - b) Automatic reminder system associated with 14-120 day performance requirement
   - c) Use of peer recovery supports to maintain contact and support
   - d) Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)?

3. States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Florida contracts with seven regional MEs to oversee network service provider compliance with Block Grant rules regarding people who inject drugs, which address preference in admissions, the provision of interim services, the maximum amount of time they can wait before admission, and 90% capacity reporting. MEs conduct onsite monitoring and desk reviews using Block Grant compliance monitoring tools. Any issues that are found are addressed through Corrective Action Plans (CAPs). Consequences for noncompliance range from remedial (like required training, technical assistance, and policy revisions) to severe (like contract termination). Additional details from each of the Managing Entities are provided below.

BBHC identifies compliance issues using a Block Grant Monitoring Tool. Several corrective actions are required in the event of noncompliance. Providers may be required to submit any outstanding documentation verifying that the issue has been resolved. Quality Improvement Plans may be required to address clinical deficiencies identified for the first time that do not impact the client safety and that require an extensive period of time to demonstrate the resolution. Providers may need to implement trainings and initiative ongoing monitoring to ensure that compliance issues are resolved. Finally, CAPs may be required when the deficiencies identified are severe and prevalent throughout the organization. These findings require a formal response and require a follow up process that is outlined in BBHC’s Corrective Action Plan Policy.

According to CFCHS, in the event that a person who injects drugs is unable to receive the recommended service, the provider must add them to the electronic wait list system managed by CFCHS within the same day the service was recommended. CFCHS’ Utilization Management (UM) Specialist monitors the wait list and completes a desk review at least once a week. The UM Specialist monitors the wait list to ensure that all network service providers follow all guidelines and to ensure that the individual receives the service as quickly as possible. The UM Specialist communicates with the subcontracted provider by phone, in person, or by email to ensure that clients do not wait longer than needed for services. The UM Specialist ensures that the wait list is completed by the network service provider by reviewing waitlist attestation submissions monthly, and reviewing the length of time, interim services offered, and the type of services clients are waiting to receive.

SFBHN has a rigorous monitoring process where providers receiving Block Grant funding are reviewed on an annual basis with services funded under the Block Grant being in scope. SFBHN has dedicated Block Grant monitoring tools and checklists to review the eligibility, accuracy and completeness of program services and data. Service records for a sample of consumers are randomly selected for detailed review. Any noted deficiencies are addressed with the service provider through a CAP.

SFBHN employs the use of an electronic waitlist to help ensure that providers comply with Block Grant rules regarding persons who inject drugs. The waitlist ensures that individuals who inject drugs are given priority admission status for services. The use of the waitlist allows providers to proactively manage admissions, refer to other providers when capacity is not available, transition clients to lower levels of care as appropriate, and ensure that individuals receive interim services while they are waiting for admission. The SFBHN care coordination team monitors the waitlist and assists providers in troubleshooting complex cases.

| a) 90 percent capacity reporting requirement | Yes | No |
| b) 14-120 day performance requirement with provision of interim services | Yes | No |
| c) Outreach activities | Yes | No |
| d) Syringe services programs | Yes | No |
| e) Monitoring requirements as outlined in the authorizing statute and implementing regulation | Yes | No |
| a) Electronic system with alert when 90 percent capacity is reached | Yes | No |
| b) Automatic reminder system associated with 14-120 day performance requirement | Yes | No |
| c) Use of peer recovery supports to maintain contact and support | Yes | No |
| d) Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)? | Yes | No |
where it is difficult to locate the appropriate level of care. SEFBH N conducts on-site validation reviews of providers who treat individuals who inject drugs, which includes chart reviews and consumer interviews. If deficiencies are noted the provider will be put on a CAP. The CAP is monitored by the SEFBH N Provider Relations Specialist and Quality Assurance staff to ensure that the steps outlined in the CAP address the issues noted during the on-site review. Follow-up reviews will be conducted depending on the issues identified during the monitoring process. If providers are not bringing their services into compliance, then SEFBH N will terminate their contract.

LSFH S ensures compliance through the routine and non-routine onsite and desk reviews conducted by the Network Management, Clinical, and Compliance Departments. A monitoring tool specifically designed for Block Grant regulations applicable to people who inject drugs is used. Any compliance issues that are identified are addressed through CAPS. Providers have 14 days to complete and submit CAPS. CAPS may result in revisions to policies and procedures, documentation of training, additional onsite or desk reviews, technical assistance, etc. Consequences for noncompliance with a CAP escalate from the provider being ineligible for available lapse funding all the way up to termination of the contract.

According to BBCBC, programs that receive Block Grant funding and that treat individuals for intravenous substance abuse must notify the ME upon reaching 90% of their capacity to admit individuals into the program. Notification of this fact must occur within seven days. The BBCBC Behavix system has enhanced automated functionality to allow the tracking of residential bed capacity as well as provider wait list and 90% capacity reports. Furthermore, during site visits, the BBCBC monitoring team reviews files to determine if IV drug users are placed into treatment in a timely manner or provided with interim services if an opening is temporarily unavailable.

CFBHN delivers annual Block Grant services training for providers that receive Block Grant funds to serve people with substance abuse to reinforce awareness of program requirements and to promote compliance. CFBHN also conducts quarterly “Secret Shopper Calls” to providers that receive funds to serve people who inject drugs to monitor for compliance with Block Grant requirements. The ME prepares scorecards to discuss outcomes with each provider. Strategies for improving performance (or corrective actions are issued if warranted) are determined. The provider network is kept apprised of progress with this process through monthly webinars. CFBHN Utilization Management staff coordinates care for to ensure that people who inject drugs are admitted within 14 days of request and that interim services are provided.

### Tuberculosis (TB)

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your state identified a need for any of the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Business agreement/MOU with primary healthcare providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Cooperative agreement/MOU with public health entity for testing and treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Established co-located SUD professionals within FQHCs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

All licensed treatment programs in Florida are required to provide TB testing to high-risk clients either directly or through referral, pursuant to Chapter 65D-30 of the Florida Administrative Code. County Health Departments in Florida offer free TB testing.

### Early Intervention Services for HIV (for "Designated States" Only)

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your state identified a need for any of the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Establishment of EIS-HIV service hubs in rural areas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Establishment or expansion of tele-health and social media support services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Syringe Service Programs

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.C§ 300x-31(a)(1)(F))?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3. Do any of the programs use SABG funds to support elements of a Syringe Services Program?  

   Yes  ☐  No  ☐  

   If yes, please provide a brief description of the elements and the arrangement.
**Criterion 8,9&10**

**Service System Needs**

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement

2. Has your state identified a need for any of the following:
   - a) Workforce development efforts to expand service access
   - b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services
   - c) Establish a peer recovery support network to assist in filling the gaps
   - d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities)
   - e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations
   - f) Explore expansion of services for:
     - i) MAT
     - ii) Tele-Health
     - iii) Social Media Outreach

**Service Coordination**

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care?

2. Has your state identified a need for any of the following:
   - a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services
   - b) Establish a program to provide trauma-informed care
   - c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education

**Charitable Choice**

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 ($54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)?

2. Does your state provide any of the following:
   - a) Notice to Program Beneficiaries
   - b) An organized referral system to identify alternative providers?
   - c) A system to maintain a list of referrals made by religious organizations?

**Referrals**

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs?

2. Has your state identified a need for any of the following:
   - a) Review and update of screening and assessment instruments
   - b) Review of current levels of care to determine changes or additions
c) Identify workforce needs to expand service capabilities

   Yes ☐ No ☐

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background

   Yes ☐ No ☐

Patient Records

1. Does your state have an agreement to ensure the protection of client records?

   Yes ☐ No ☐

2. Has your state identified a need for any of the following:

   a) Training staff and community partners on confidentiality requirements

      Yes ☐ No ☐

   b) Training on responding to requests asking for acknowledgement of the presence of clients

      Yes ☐ No ☐

   c) Updating written procedures which regulate and control access to records

      Yes ☐ No ☐

   d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure

      Yes ☐ No ☐

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers?

   Yes ☐ No ☐

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

   Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

   9 Block Grant subrecipients per year are selected to undergo an independent review.

3. Has your state identified a need for any of the following:

   a) Development of a quality improvement plan

      Yes ☐ No ☐

   b) Establishment of policies and procedures related to independent peer review

      Yes ☐ No ☐

   c) Development of long-term planning for service revision and expansion to meet the needs of specific populations

      Yes ☐ No ☐

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds?

   If Yes, please identify the accreditation organization(s)

   i) ☐ Commission on the Accreditation of Rehabilitation Facilities

   ii) ☐ The Joint Commission

   iii) ☐ Other (please specify)

      N/A
Criterion 7 & 11: Group Homes for Persons in Recovery and Professional Development

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program?  
   - [ ] Yes  [ ] No

2. Has your state identified a need for any of the following:
   a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service  
      - [ ] Yes  [ ] No
   b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing  
      - [ ] Yes  [ ] No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state’s substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:
   a) Recent trends in substance use disorders in the state  
      - [ ] Yes  [ ] No
   b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services  
      - [ ] Yes  [ ] No
   c) Performance-based accountability  
      - [ ] Yes  [ ] No
   d) Data collection and reporting requirements  
      - [ ] Yes  [ ] No

2. Has your state identified a need for any of the following:
   a) A comprehensive review of the current training schedule and identification of additional training needs  
      - [ ] Yes  [ ] No
   b) Addition of training sessions designed to increase employee understanding of recovery support services  
      - [ ] Yes  [ ] No
   c) Collaborative training sessions for employees and community agencies’ staff to coordinate and increase integrated services  
      - [ ] Yes  [ ] No
   d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort  
      - [ ] Yes  [ ] No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?
   a) Prevention TTC?  
      - [ ] Yes  [ ] No
   b) Mental Health TTC?  
      - [ ] Yes  [ ] No
   c) Addiction TTC?  
      - [ ] Yes  [ ] No
   d) State Targeted Response TTC?  
      - [ ] Yes  [ ] No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924, and 1928 (42 U.S.C. 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:
   a) Allocations regarding women  
      - [ ] Yes  [ ] No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:
   a) Tuberculosis  
      - [ ] Yes  [ ] No
   b) Early Intervention Services Regarding HIV  
      - [ ] Yes  [ ] No

3. Additional Agreements
   a) Improvement of Process for Appropriate Referrals for Treatment  
      - [ ] Yes  [ ] No
b) Professional Development

No

c) Coordination of Various Activities and Services

No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.


Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question
In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state’s CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2018-FFY 2019?
   - ○ Yes  ○ No

   Please indicate areas of technical assistance needed related to this section.
Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma 57 is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing “business as usual”? These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma58 paper.

57 Definition of Trauma: Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.
58 Ibid

Please consider the following items as a guide when preparing the description of the state’s system:

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues?  Yes  No
2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?  Yes  No
3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?  Yes  No
4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?  Yes  No
5. Does the state have any activities related to this section that you would like to highlight.

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.59

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.60 A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

Footnotes:


60 http://csgjusticecenter.org/mental-health/

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services? Yes No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? Yes No

3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system? Yes No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? Yes No

5. Does the state have any activities related to this section that you would like to highlight? Please indicate areas of technical assistance needed related to this section.
Environmental Factors and Plan

14. Medication Assisted Treatment - Requested (SABG only)

Narrative Question
There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders?  Yes No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women?  Yes No

3. Does the state purchase any of the following medication with block grant funds?  Yes No
   
   a) Methadone
   b) Buprenorphine, Buprenorphine/naloxone
   c) Disulfiram
   d) Acamprosate
   e) Naltrexone (oral, IM)
   f) Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*?  Yes No

5. Does the state have any activities related to this section that you would like to highlight?

Recent plans to raise awareness about MAT have been funded out of the STR and SOR grants, not the SAPT Block Grant.

*Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.

Footnotes:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022
Environmental Factors and Plan

15. Crisis Services - Requested

Narrative Question
In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.\(^{61}\) SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA’s publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises\(^ {62}\).

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

\(^{61}\) [SAMHSA](http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848)


Please check those that are used in your state:

1. **Crisis Prevention and Early Intervention**
   - a) Wellness Recovery Action Plan (WRAP) Crisis Planning
   - b) Psychiatric Advance Directives
   - c) Family Engagement
   - d) Safety Planning
   - e) Peer-Operated Warm Lines
   - f) Peer-Run Crisis Respite Programs
   - g) Suicide Prevention

2. **Crisis Intervention/Stabilization**
   - a) Assessment/Triage (Living Room Model)
   - b) Open Dialogue
   - c) Crisis Residential/Respite
   - d) Crisis Intervention Team/Law Enforcement
   - e) Mobile Crisis Outreach
   - f) Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. **Post Crisis Intervention/Support**
   - a) Peer Support/Peer Bridgers
   - b) Follow-up Outreach and Support
   - c) Family-to-Family Engagement
   - d) Connection to care coordination and follow-up clinical care for individuals in crisis
   - e) Follow-up crisis engagement with families and involved community members
f) Recovery community coaches/peer recovery coaches

4. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Footnotes:
Environmental Factors and Plan

16. Recovery - Required

Narrative Question
The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports); purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](https://www.samhsa.gov/). States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:
5. Does the state measure the impact of your consumer and recovery community outreach activity?  

   a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?  
   b) Required peer accreditation or certification?  
   c) Block grant funding of recovery support services.  
   d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state’s M/SUD system?  

2. Does the state measure the impact of your consumer and recovery community outreach activity?  

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.  

   According to Chapter 65E-14, Florida Administrative Code, “recovery support services are designed to support and coach an adult or child and family to regain or develop skills to live, work and learn successfully in the community. Services include substance abuse or mental health education, assistance with coordination of services as needed, skills training, and coaching. This Covered Service shall include clinical supervision provided to a service provider’s personnel by a professional qualified by degree, licensure, certification, or specialized training in the implementation of this service. For Adult Mental Health and Children’s Mental Health Programs, these services are provided by a Certified Family, Veteran, or Recovery Peer Specialist.”  

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.  

   According to Chapter 65E-14, Florida Administrative Code, “recovery support services are designed to support and coach an adult or child and family to regain or develop skills to live, work and learn successfully in the community. Services include substance abuse or mental health education, assistance with coordination of services as needed, skills training, and coaching. This Covered Service shall include clinical supervision provided to a service provider’s personnel by a professional qualified by degree, licensure, certification, or specialized training in the implementation of this service. For Adult and Children’s Substance Abuse programs, these services may be provided by a certified Peer Recovery Specialist or trained paraprofessional staff subject to supervision by a Qualified Professional as defined in Rule 65D-30.002, F.A.C. These services exclude twelve-step programs such as Alcoholics Anonymous and Narcotics Anonymous.”  

5. Does the state have any activities that it would like to highlight?  

   The Department funds a peer certification scholarship program designed to assist individuals with application and testing fees. The Department and the Florida Certification Board also developed the Youth Peer Endorsement for the Certified Recovery Peer Specialist Credential which requires additional training in WRAP, WHAM or Peer Whole Health and Resiliency, Vicarious Trauma/Self-care, Motivational interviewing and cultural and linguistic competence. Applicant attest to lived experience as an individual currently between the ages of 18 and 29 who experienced significant life challenges during the ages of 14 – 25 and that they are living a wellness- or recovery-oriented lifestyle for at least two years.  

   The Department’s Statewide Coordinator of Integration and Recovery Services also collaborates with NAMI on training and planning activities to support recovery-oriented systems of care and develop the peer specialist workforce in both the substance abuse and mental health fields. The focus of these trainings remains on training for Peer Specialists, training for agencies to successfully implement peer services, and training for systems to transition to recovery-oriented care. The goal is to develop and sustain a peer specialist workforce resulting in a statewide shift that focuses on peers, family, parent and caregivers. The Wellness Recovery Action Plan (WRAP) facilitator training is a certificate course, co-facilitated by Certified Advanced Level WRAP Facilitators using the Copeland Center’s standard five-day agenda. Participants in this certificate course learn how to use a manual to facilitate WRAP workshops using techniques that support a core set of values and ethics. This workshop is for anyone who has completed a Seminar I WRAP workshop. The Certified Recovery Peer Specialist (CRPS) facilitator training uses a train-the-trainer model to deliver the Helping Others Health course material in an effective manner. This course builds a pool of skilled facilitators who can teach the material to appropriate individuals who will receive the required 40-hour Peer Specialist training, as indicated by the required education domains set forth by the Florida Certification Board. This training helps to increase the capacity of Peer Specialists statewide. Finally, during the Trauma Informed Care and Peer Supporters Training, participants learn about organizational structure and treatment frameworks that involve understanding, recognizing, and responding to the effects of different types of trauma. This training includes approaches for peers to engage individuals with histories of trauma and develop strategies to assist that emphasize the physical, psychological, and emotional safety of consumers and that help survivors rebuild a sense of control and empowerment.  

   Please indicate areas of technical assistance needed related to this section.  

   None at this time.

Footnotes:

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question
The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court’s decision in *Olmstead v. L.C., 527 U.S. 581 (1999)*, provide legal requirements that are consistent with SAMHSA’s mission to reduce the impact of M/SUD on America’s communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court’s Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

Please respond to the following items

1. Does the state's Olmstead plan include:
   - Housing services provided. ☐ Yes ☐ No
   - Home and community based services. ☐ Yes ☐ No
   - Peer support services. ☐ Yes ☐ No
   - Employment services. ☐ Yes ☐ No

2. Does the state have a plan to transition individuals from hospital to community settings? ☐ Yes ☐ No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?
   Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
Environmental Factors and Plan

18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children’s needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children’s Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.

According to data from the 2015 Report to Congress on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and
residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

---


65The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.


---

Please respond to the following items:

1. Does the state utilize a system of care approach to support:
   a) The recovery and resilience of children and youth with SED? [Yes] [No]
   b) The recovery and resilience of children and youth with SUD? [Yes] [No]

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:
   a) Child welfare? [Yes] [No]
   b) Juvenile justice? [Yes] [No]
   c) Education? [Yes] [No]

3. Does the state monitor its progress and effectiveness, around:
   a) Service utilization? [Yes] [No]
   b) Costs? [Yes] [No]
   c) Outcomes for children and youth services? [Yes] [No]

4. Does the state provide training in evidence-based:
   a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? [Yes] [No]
   b) Mental health treatment and recovery services for children/adolescents and their families? [Yes] [No]

5. Does the state have plans for transitioning children and youth receiving services:
   a) to the adult M/SUD system? [Yes] [No]
   b) for youth in foster care? [Yes] [No]

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

The Department is committed to a consistent system of care approach and partnering with all child serving systems to ensure a youth-guided, family driven, culturally and linguistically responsive, community-based care across the state. Previously, the Department spearheaded the development and continuation of the children’s Interagency Agreement. This agreement between all key child serving agencies established a collaborative process for addressing the needs of children and youth served by multiple agencies. In addition, the agreement established local and state level multiagency teams that identify and address gaps in the system of care. The Interagency agreement requires the system of care values and principles to be practiced throughout all state and local levels.

The Department is also dedicated to person centered planning and has established guidelines to ensure implementation at all levels across the state. Contracted providers are obligated to participate and implement system of care values and principles in their respective regions and ensure sub-provider contracts include these as well, including provision of EBPs and accountability mechanisms.

Assessments focus on evaluating the strengths, needs, vision and culture of the child and their family. The wraparound process is an effective care coordination model to improve the lives of children and their families. Wraparound is an intensive, individualized...
care planning and management process for children with complex needs due to a serious emotional disturbance. Through structured and creative team meetings, care plans are designed to meet the unique needs of the child, caregivers, and siblings across a range of life domains. This process aims to result in plans that are more effective and more relevant to the recipient and family. In addition, there is an emphasis on integrating the child into the community and building the family's social support network.

The ten principles of wraparound parallel the values of the SOC in that all services must reflect:
• Family voice and choice;
• Natural supports;
• Team based planning;
• Collaboration;
• Community based care;
• Cultural competence;
• Individualized care;
• Strength based approaches;
• Persistence; and
• Outcome accountability.

Florida Law includes a requirement for a community-based system that is child-centered and family driven. This system provides for screening and assessment to promote early identification and treatment. It also provides for individualized, culturally competent, integrated and coordinated care, and a smooth transition to the adult system for continued age-appropriate services and supports. In addition, most provider agencies in the Florida have made advancements over the last few years that enable them to meet the needs of persons with co-occurring disorders.

The Department works collaboratively with all child-serving systems to prevent mental health issues through screening and early intervention to ensure children are equipped with the skills they need to achieve healthy growth and build a foundation to thrive in school and beyond. The Department is home to the Office of Family Safety. This provides an opportunity to harmonize child welfare and behavioral health principles which is especially important because of the traumatizing nature of the child welfare involvement for both children and families. The Department collaborates with the Department of Health’s Children's Medical Services division on the development of ways to strengthen the integration of primary care and behavioral health services.

The state of Florida’s Interagency Agreement between numerous agencies is designed to address the needs of specific children and families and the gaps in the system of care at the local and state levels through local and state level teams. The community and residential services provided include:
• Medicaid services through AHCA;
• Services to reduce recidivism through the Department of Juvenile Justice(DJJ);
• Educational services through the Department of Education (DOE);
• Residential care in group homes and residential habilitation centers through the Agency for Persons with Disabilities (APD); and
• Advocacy for the rights and best interests of a child involved in a court proceeding through the Guardian ad Litem (GAL) Program.

Effectively addressing the needs of children, adolescents, and their families in the mental health system requires innovative approaches to deliver coordinated, individually tailored, family-focused, and developmentally appropriate services and supports in the community to reduce the need for more restrictive levels of care. Florida has implemented Community Action Teams (CAT) statewide, which utilize a team approach to provide such comprehensive services to children ages 11 to 21 with a mental health diagnosis or co-occurring substance abuse diagnosis who have accompanying characteristics including being at-risk for out-of-home placement, history of hospitalizations, repeated failures in less intensive programs, criminal behaviors, or poor academic performance. Children younger than age 11 may be served if they meet more than one of these characteristics.

The CAT teams provide intensive, wraparound services to children and youths aged 11-21 who have a mental health diagnosis, a substance-use diagnosis or both. They include a psychiatrist or advanced registered nurse practitioner, a nurse, a mental health therapist, a case manager and a mentor. Additionally, someone on the team is available to the family around the clock. The aim of CAT is to stabilize a child’s mental illness or substance abuse and divert him or her from the state juvenile justice or child welfare systems.

The primary goals of the CAT program include:
• Improved school attendance, grades and graduation rates
• Decreased out-of-home placements and psychiatric hospitalizations
• Decreased substance use and abuse
• Improved functioning for the child and family

Family Intensive Treatment (FIT) teams have been piloted throughout the state to provide specialized treatment for parents with primary substance use disorders who come in contact with the child welfare system and who have young children ages birth to eight. FIT is family focused and integrated across the child welfare, behavioral health and judicial systems. Treatment involves joint
planning and case management by a team of professionals which include child welfare workers, alcohol and drug treatment professionals, court representatives, and medical professionals. There is cross training and collocation of services. They act as one treatment team with flexible spending, sharing data and accountability. Families are provided wraparound and comprehensive community services to address the multiple needs of parents and children, including parenting skills to increase protective capacity, mental health, health, child care, housing and other services.

The Florida Healthy Transitions Program strives to achieve policy and funding changes at the state and local level to improve cross-system collaboration, service capacity and workforce expertise; create, implement and expand research-supported services and supports that are culturally competent and youth-guided; and provide for continuity of care between child and adult behavioral health systems, while involving family and community members in the process.

The managing entities and providers who serve older adolescents are expected to provide them with the necessary supports and skills in preparation for coping with life as a young adult and facilitate a smooth transition to the adult mental health system for continuing age-appropriate treatment services, provided they meet the target population for the publicly-funded adult mental health system. Behavioral health services and supports are tailored to address the developmental needs of adolescents and may include supportive housing, supported employment, peer mentoring and education about their behavioral health needs to support wellness management.

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. These services are typically provided within the children’s mental health system and include diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a).

Community-based care organizations are responsible for transition planning with youth served by child welfare, in accordance with the requirements of the Road to Independence. During the 2013 legislative session, the extended foster care bill was passed that allows youth aging out of foster care at age 18 to choose to remain in extended foster care until they turn 21, giving them the option to continue receiving support through this challenging time. The majority of youth served by child welfare receive behavioral health and primary health services through a Medicaid managed care child welfare specialty plan, through the age of 20. However, youth who age out of foster care are eligible for Medicaid until the age of 26, per the guidelines of the Affordable Care Act.

7. Does the state have any activities related to this section that you would like to highlight?

   N/A

   Please indicate areas of technical assistance needed related to this section.

   None at this time.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question
Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state’s suicide prevention plan in the last 2 years?  
   - Yes  
   - No

2. Describe activities intended to reduce incidents of suicide in your state.
   Link to Florida’s Suicide Prevention Plan:

3. Have you incorporated any strategies supportive of Zero Suicide?  
   - Yes  
   - No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments?  
   - Yes  
   - No

5. Have you begun any targeted or statewide initiatives since the FFY 2018-FFY 2019 plan was submitted?  
   If so, please describe the population targeted.
   - Yes  
   - No

Please indicate areas of technical assistance needed related to this section.

Footnotes:
Florida updates the Suicide Prevention Plan every four years. The current plan covers the period of 2016 - 2020.
Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period?
   - Yes
   - No

2. Has your state identified the need to develop new partnerships that you did not have in place?
   - Yes
   - No
   If yes, with whom?
   N/A

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

Florida’s First Lady, Casey DeSantis is promoting the www.HopeForHealingFL.com initiative and conducting mental health listening sessions throughout the state, which involves the collaboration of the Department of Children and Families, Department of Health, Department of Juvenile Justice, Department of Education, and the Agency for Health Care Administration. This initiative is intended to help people access a variety of public and private sector prevention and intervention resources before they experience a mental health crisis. Comprehensive Mental Health and Substance Abuse Resource Guides are being developed to provide help in a timely fashion, and local search tools are being developed to help families find behavioral health services where they live.

The Department has an interagency agreement with the Agency for Health Care Administration for Pre-Admission Screening and Resident Review to help ensure that individuals are not inappropriately placed in nursing homes for long term care and another agreement to establish jointly-funded Florida Assertive Community Treatment (FACT) teams, which provide comprehensive, multidisciplinary care to help prevent recurrent hospitalization and incarceration among individuals with chronic, serious mental illness. The Department also has an interagency agreement with the Department of Education, Department of Health, and the Agency for Persons with Disabilities to provide transition services, support services, and employment services to students with
disabilities. The Department has an interagency agreement with the Department of Juvenile Justice to collaborate on meeting the behavioral needs of children involved in the juvenile justice system. The Department also has an interagency agreement with the Agency for Health Care Administration, Agency for Persons with Disabilities, Department of Juvenile Justice, Department of Education, Department of Health, the Guardian Ad Litem Program, and the Office of Early Learning to coordinate services and supports for children and collaborate on developing the resources necessary for children served by multiple agencies. There is also an agreement with the Department of Corrections to facilitate collaboration to ensure that incarcerated individuals with serious mental illness have access to mental health services upon their release.

The Department also has an agreement with Disability Rights Florida for a pilot project designed to more fully utilize existing FACT resources and create additional opportunities for community integration of individuals being discharged from state mental health treatment facilities (SMHTFs). This component is intended to transition FACT participants to less intensive community-based services and supports, allowing persons referred from SMHTFs to fill the vacated slots. This project provides care coordination and vouchers to purchase treatment and support services for adults transitioning from Florida Assertive Community Treatment (FACT) teams, acute crisis services, and institutional settings to independent community living. In addition to the FACT pilot project, the Department provides transitional vouchers to all managing entities for care coordination. The transitional voucher component is a flexible, consumer-directed voucher system designed to bridge the gap for persons with behavioral health disorders as they transition from acute or more restrictive levels of care to lower levels of care. The intent is to enable individuals to live independently in the community with treatment and support services based on need and choice and build a support system to sustain their independence, recovery, and overall well-being. The project aims to:

- Prevent recurrent hospitalization and incarceration;
- Provide safe, affordable, and stable housing opportunities;
- Maximize use of FACT resources and community supports;
- Increase participant choice and self-determination in their treatment and support service selection; and
- Improve community involvement and overall quality of life for program participants.

Please indicate areas of technical assistance needed related to this section.

None at this time.
Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council’s comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration. 69

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.


Please consider the following items as a guide when preparing the description of the state’s system:

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

   a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

   Florida’s Substance Abuse and Mental Health Planning Council is an integrated advisory body that helps the Department plan and implement both mental health services and substance abuse prevention, treatments and recovery support services.

   b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?

   Yes ☐ No ☐

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?

   Yes ☐ No ☐

3. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

   The Planning Council reviews the Department’s Block Grant applications, plans and reports, and makes recommendations on modifications. The Planning Council also monitors, reviews and evaluates, the allocation and adequacy of mental health services within Florida. The Council advocates for individuals and families through local and statewide efforts. Council members act as a liaison between state and managing entities in promoting a recovery oriented system of care. The Council advises the Department on allocation of services and creating a plan that supports the treatments and supports for recovery and a life in the community.

   Please indicate areas of technical assistance needed related to this section.

   None at this time.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms. 70

70 There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
Environmental Factors and Plan

Advisory Council Members
For the Mental Health Block Grant, there are specific agency representation requirements for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency

Start Year: 2020  End Year: 2021

<table>
<thead>
<tr>
<th>Name</th>
<th>Type of Membership*</th>
<th>Agency or Organization Represented</th>
<th>Address, Phone, and Fax</th>
<th>Email (if available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Melanie Brown-Woofter</td>
<td>Providers</td>
<td>Florida Council for Community Mental Health</td>
<td>PH: 850-224-6048</td>
<td><a href="mailto:melanie@fccmh.org">melanie@fccmh.org</a></td>
</tr>
<tr>
<td>Paul Cassidy</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td></td>
<td>PH: 850-723-7703</td>
<td><a href="mailto:paul@cassidymsw.com">paul@cassidymsw.com</a></td>
</tr>
<tr>
<td>Jeff Cece</td>
<td>State Employees</td>
<td>Florida Department of Children and Families</td>
<td>PH: 850-717-4405</td>
<td><a href="mailto:Jeffrey.Cece@myflfamilies.com">Jeffrey.Cece@myflfamilies.com</a></td>
</tr>
<tr>
<td>Tony DePalma</td>
<td>Others (Advocates who are not State employees or providers)</td>
<td>Disability Rights Florida</td>
<td>PH: 850-488-9071</td>
<td><a href="mailto:tonyd@disabilityrightsflorida.org">tonyd@disabilityrightsflorida.org</a></td>
</tr>
<tr>
<td>Wesley Evans</td>
<td>State Employees</td>
<td>Florida Department of Children and Families</td>
<td>PH: 850-509-8697</td>
<td><a href="mailto:Wesley.Evans@myflfamilies.com">Wesley.Evans@myflfamilies.com</a></td>
</tr>
<tr>
<td>Dana FogleSong</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>Florida Department of Education</td>
<td>PH: 850-245-3360</td>
<td><a href="mailto:kirk.hall@vr.fldoe.org">kirk.hall@vr.fldoe.org</a></td>
</tr>
<tr>
<td>Kirk Hall</td>
<td>State Employees</td>
<td>Florida Department of Juvenile Justice</td>
<td><a href="mailto:Andrew.Harrell@djj.state.fl.us">Andrew.Harrell@djj.state.fl.us</a></td>
<td></td>
</tr>
<tr>
<td>Mary Hodges</td>
<td>State Employees</td>
<td>Department of Elder Affairs</td>
<td>PH: 850-414-2184</td>
<td><a href="mailto:Hodgesm@elderaffairs.org">Hodgesm@elderaffairs.org</a></td>
</tr>
<tr>
<td>Christine Hurst</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td>Big Bend Community Based Care</td>
<td>PH: 850-774-4741</td>
<td><a href="mailto:cyh089@gmail.com">cyh089@gmail.com</a></td>
</tr>
<tr>
<td>Curtis Jenkins</td>
<td>State Employees</td>
<td>Florida Department of Education</td>
<td>PH: 850-245-7844</td>
<td><a href="mailto:Curtis.Jenkins@fldoe.org">Curtis.Jenkins@fldoe.org</a></td>
</tr>
<tr>
<td>Nelson Kull</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>Central Florida Cares Health System</td>
<td>PH: 407-617-3311</td>
<td><a href="mailto:jkull@cfl.rr.com">jkull@cfl.rr.com</a></td>
</tr>
<tr>
<td>Crystal Lilly</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td></td>
<td>PH: 407-615-0338</td>
<td><a href="mailto:clilly.ffcl@gmail.com">clilly.ffcl@gmail.com</a></td>
</tr>
<tr>
<td>Patrick Mahoney</td>
<td>State Employees</td>
<td>Florida Department of Corrections</td>
<td>PH: 850-228-9366</td>
<td><a href="mailto:Patrick.Mahoney@fdc.myfl.com">Patrick.Mahoney@fdc.myfl.com</a></td>
</tr>
<tr>
<td>Cheryl Molyneaux</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td></td>
<td>PH: 443-804-7151</td>
<td>info@db sacfl.org</td>
</tr>
<tr>
<td>Name</td>
<td>Membership Type</td>
<td>Agency/organization</td>
<td>Phone Number</td>
<td>Email Address</td>
</tr>
<tr>
<td>----------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------</td>
<td>-----------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Regina Rice</td>
<td>State Employees</td>
<td>Florida Department of Education</td>
<td>850-245-3471</td>
<td><a href="mailto:regina.rice@vr.fldoe.org">regina.rice@vr.fldoe.org</a></td>
</tr>
<tr>
<td>Elaine Roberts</td>
<td>State Employees</td>
<td>Florida Housing Finance Corporation</td>
<td>850-488-4197</td>
<td><a href="mailto:Elaine.Roberts@floridahousing.org">Elaine.Roberts@floridahousing.org</a></td>
</tr>
<tr>
<td>Peggy Scheuermann</td>
<td>State Employees</td>
<td>Florida Department of Health</td>
<td>850-245-4220</td>
<td><a href="mailto:Peggy.Scheuermann@flhealth.gov">Peggy.Scheuermann@flhealth.gov</a></td>
</tr>
<tr>
<td>Patrick Sheehan</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td></td>
<td>863-464-0527</td>
<td><a href="mailto:patrick@sfwn.org">patrick@sfwn.org</a></td>
</tr>
<tr>
<td>Maite Soria</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>Care Resource Community Health Centers, Inc.</td>
<td>954-567-7141</td>
<td><a href="mailto:msoria@careresource.org">msoria@careresource.org</a></td>
</tr>
<tr>
<td>Judge Mark Speiser</td>
<td>Others (Advocates who are not State employees or providers)</td>
<td>Florida Partners in Crisis</td>
<td></td>
<td><a href="mailto:mspeiser@17th.flcourts.org">mspeiser@17th.flcourts.org</a></td>
</tr>
<tr>
<td>James W. Taliaferro, Sr.</td>
<td>Others (Advocates who are not State employees or providers)</td>
<td>Mental Health America</td>
<td>850-769-5441</td>
<td><a href="mailto:mymha@comcast.net">mymha@comcast.net</a></td>
</tr>
<tr>
<td>Rick Wagner</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td>Lutheran Services of Florida</td>
<td>813-695-5490</td>
<td><a href="mailto:richardbwagner@earthlink.net">richardbwagner@earthlink.net</a></td>
</tr>
<tr>
<td>Cameron Wood</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td></td>
<td>407-988-5780</td>
<td><a href="mailto:cameron@peersupportfl.org">cameron@peersupportfl.org</a></td>
</tr>
</tbody>
</table>

*Council members should be listed only once by type of membership and Agency/organization represented.

**Footnotes:**

Wesley Evans is the Statewide Coordinator of Integration and Recovery Services for the State of Florida and represents Social Services on the Council.
### Environmental Factors and Plan

#### Advisory Council Composition by Member Type

<table>
<thead>
<tr>
<th>Type of Membership</th>
<th>Number</th>
<th>Percentage of Total Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Membership</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individuals in Recovery* (to include adults with SMI who are receiving, or</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>have received, mental health services)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Members of Individuals in Recovery* (to include family members of</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>adults with SMI)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents of children with SED/SUD*</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Vacancies (Individuals and Family Members)</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Others (Advocates who are not State employees or providers)</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Persons in recovery from or providing treatment for or advocating for SUD services</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Representatives from Federally Recognized Tribes</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Total Individuals in Recovery, Family Members &amp; Others</strong></td>
<td>20</td>
<td>57.14%</td>
</tr>
<tr>
<td>State Employees</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Providers</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Vacancies</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td><strong>Total State Employees &amp; Providers</strong></td>
<td>15</td>
<td>42.86%</td>
</tr>
<tr>
<td>Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Providers from Diverse Racial, Ethnic, and LGBTQ Populations</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations</strong></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Youth/adolescent representative (or member from an organization serving young people)</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

---

**Footnotes:**

In 2018, the Block Grant Coordinator briefed the Council on the request for race/ethnicity and LGBTQ status data for block grant reporting. The Council declined to authorize the Department to solicit this demographic information. Therefore, the Department is unable to report this information in the section titled: Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations.
Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?
   a) Public meetings or hearings?
   b) Posting of the plan on the web for public comment?
      If yes, provide URL: https://www.myFLfamilies.com/service-programs/samh/publications/
   c) Other (e.g. public service announcements, print media)

   OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Please provide any comments and input to DCF's Block Grant Coordinator at Jeffrey.Cece@myFLfamilies.com. Any person can provide input both during the development of this Application and after submission to SAMHSA.