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 Report and after submission to SAMHSA.

Florida

UNIFORM APPLICATION
FY 2022/2023 Combined MHBG ApplicationBehavioral Health Assessment and Plan

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 04/11/2022 11.23.37 AM)

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

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 Report and after submission to SAMHSA.

State Information

State Information

Plan Year

Start Year 2022

End Year 2023

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 2415 North Monroe St, Suite 400

City Tallahassee, Florida

Zip Code 32303-4190

II. Contact Person for the SAPT Grantee of the Block Grant

First Name Erica

Last Name Floyd-Thomas

Agency Name Florida Department of Children and Families

Mailing Address 2415 North Monroe St, Suite 400

City Tallahassee

Zip Code 32303-4190

Telephone

Fax

Email Address Erica.FloydThomas@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 2415 North Monroe St, Suite 400

City Tallahassee

Zip Code 32303-4190

II. Contact Person for the CMHS Grantee of the Block Grant

First Name Erica

Last Name Floyd-Thomas

Agency Name Florida Department of Children and Families

Mailing Address 2415 North Monroe St, Suite 400

City Tallahassee

Zip Code 32303-4190

Telephone

Fax

Email Address Erica.FloydThomas@myflfamilies.com

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

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 8/31/2021 5:41:10 PM

Revision Date 12/15/2021 8:29:30 AM

VI. Contact Person Responsible for Application Submission

First Name Nikki

Last Name Wotherspoon

Telephone (850) 717-4323

Fax (850) 487-2239

Email Address Nikki.Wotherspoon@myflfamilies.com

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

Footnotes:

Additional Contact Responsible for Application Submission:

Jeff Cece
(850) 717-4405
jeffrey.cece@myflfamilies.com

State of Florida
Department of Children and Families

Ron DeSantis
Governor

Shevaun L. Harris
Secretary

August 26, 2021

Wendy Pang, Grants Management Officer
Division of Grants Management, OPS
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, Rm 17E21C
Rockville, MD 20857

Dear Ms. Pang:

The Florida Department of Children and Families (Department) is designated as the agency responsible for the Substance Abuse and Mental Health Block Grants for the state of Florida. I hereby authorize the Department to apply for the Substance Abuse and Mental Health Block Grants for federal fiscal year 2022, and I certify the following:

(a) The block grant funds will be used to continue the transformation of Florida's substance abuse and mental health services and supports in a comprehensive community-based system of care for adults and children.

(b) The services and supports provided will continue to focus on the needs of the persons served and their families.

If you have any questions in relation to Florida's application, please contact Ms. Erica Floyd-Thomas, Assistant Secretary of Substance Abuse and Mental Health, Florida Department of Children and Families, at (850) 717-4416.

Sincerely,

Shevaun L. Harris
Secretary

2415 North Monroe Street, Suite 400, Tallahassee, Florida 32303-4190

Mission: Work in Partnership with Local Communities to Protect the Vulnerable, Promote Strong and Economically Self-Sufficient Families, and Advance Personal and Family Recovery and Resiliency

State Information

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

Fiscal Year 2022

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

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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 19 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, as applicable, with 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.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
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

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean 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).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
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 Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
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)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

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 other Certifications summarized above.

State: ____________________

Name of Chief Executive Officer (CEO) or Designee: Shevaun L. Harris

Signature of CEO or Designee[1]: ____________________

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:

RON DESANTIS
GOVERNOR

March 18, 2021

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 Shevaun L. Harris, 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.

Ms. Harris' mailing address is:
Secretary Shevaun Harris
Florida Department of Children and Families
2415 North Monroe Street
Suite 400, Room A100
Tallahassee, FL 32303

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

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

Fiscal Year 2022

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
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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.
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to State (Clear Air) Implementation Plans under Section 176(c) of the Clean 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).

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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)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

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 other Certifications summarized above.

State: ______________________

Name of Chief Executive Officer (CEO) or Designee: Shevaun L. Harris

Signature of CEO or Designee[1]:

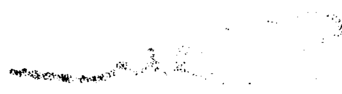
Title: Secretary, FL Department of Children & Families   Date Signed: 08/31/2021

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:



State Information

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

Fiscal Year 2022

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
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Section 1920	Early Serious Mental Illness	42 USC § 300x-9
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65

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 19 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).
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17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
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.

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b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
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    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--
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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)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

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.
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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: Shevaun L. Harris

Signature of CEO or Designee[1]: ______________________

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.

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

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

Footnotes:

RON DESANTIS
GOVERNOR

March 18, 2021

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 Shevaun L. Harris, 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.

Ms. Harris' mailing address is:
Secretary Shevaun Harris
Florida Department of Children and Families
2415 North Monroe Street
Suite 400, Room A100
Tallahassee, FL 32303

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

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

Fiscal Year 2022

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
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

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.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
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).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
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 182by:

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.
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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: Shevaun L. Harris

Signature of CEO or Designee[1]:

Title: Secretary, FL Department of Children & Families   Date Signed: 8/31/2021

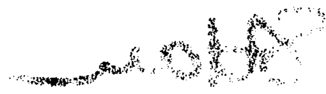
mm/dd/yyyy

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

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

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

Footnotes:



State Information

Disclosure of Lobbying Activities

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

Name

Shevaun L. Harris

Title

Secretary

Organization

Florida Department of Children and Families

Signature: Date:

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

Footnotes:

No one within the Florida Department of Children & Families, Office of Substance Abuse and Mental Health is currently registered as a lobbyist.

State Information

Disclosure of Lobbying Activities

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

Name

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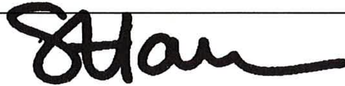
Title

Secretary

Organization

Florida Department of Children and Families

Signature:  Date: 8/31/2021

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

Footnotes:

No one within the Florida Department of Children & Families, 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 of care, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system of care 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 of care address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

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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 2022 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 Deputy Assistant Secretary, 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, and the Director of SAMH Data Quality Assurance.

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 Interagency Action Plan* by providing oversight, building capacity, creating policy, and mobilizing communities. The Office of Suicide Prevention is overseen by a Suicide Prevention Coordinator. The Suicide Prevention Coordinator serves as the chair of the Coordinating Council, supports and implements suicide prevention grants, including a 9-8-8 Planning Grant, and helps plan and coordinate the annual Suicide Prevention Day at the Capitol and other awareness activities. Additionally, The Statewide Office for Suicide Prevention and the Suicide Prevention Coordinating Council were established in 2007 pursuant to ch. 14.2019, F.S. The Council meets quarterly to focus on suicide prevention initiatives such as creating and implementing the Suicide Prevention Interagency Action Plan in Florida as well as increasing public awareness. The Suicide Prevention Coordinating Council consists of 27 members whose mission is to develop effective strategies for suicide prevention. This year, the Suicide Prevention Coordinating Council formed the following committees to focus on different tasks relating to suicide prevention:

1. The Planning and Evaluation Committee
2. The Special Populations Committee
3. The Governor's Challenge Committee

The First Responders Suicide Deterrence Task Force was established in 2020 by SB 7012. The purpose of the task force is to "make recommendations on how to reduce the incidence of suicide and attempted suicide among employed or retired first responders in the state." The task force is composed of six voting members, including nominated representatives from the Florida Professional Firefighters Association, the Florida Police Benevolent Association, the Florida State Lodge of the Fraternal Order of Police, the Florida Sheriffs Association, the Florida Police Chiefs Association, and the Florida Fire Chiefs Association. The six voting members and nine non-voting members represent various aspects of fire, emergency medical services, law enforcement, support personnel, academia, training, and behavioral health

services. The task force is directed to identify or make recommendations on developing training programs and materials that would better enable first responders to cope with personal life stressors and stress related to their profession and to foster an organizational culture that meets specific requirements. Findings and recommendations for training programs and materials to deter suicide among active and retired first responders will be reported to the Governor, the President of the Senate, and the Speaker of the House of Representatives by each July 1, beginning in 2021 and through 2023.

Structurally and operationally, the Department is decentralized into six regions, with each region representing multiple counties. Each region is somewhat autonomous, yet integrated within the broader organization, 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. Department contracts are managed by certified contract managers that serve as single points of contact. Regional staff is responsible for the implementation of the Department's substance abuse and mental health funding and statutory duties.

Behavioral Health Managing Entities

The Office of SAMH used to contract directly with behavioral health providers to implement the Community Mental Health Services (CMHS) 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.[1] As a result, the Office of SAMH contracts with seven Managing Entities for the administration and management of regional behavioral health systems of care throughout the state. The Managing Entities are private, non-profit organizations responsible for planning, implementation, administration, monitoring, data collection, reporting, and analysis for behavioral health care in their regions. Managing Entities contract with local service providers for the provision of prevention, treatment, and recovery support services.

Procurement of the Managing Entity 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 Managing Entities provides for a fixed payment contract, with the equivalent of a two-month advance payment, and equal monthly payments thereafter.[2] The Managing Entity is also permitted to carry up to 8% of state general revenue from fiscal year to fiscal year, for the life of the contract.[3]

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 Managing Entity meets statewide goals and is responsive to the unique conditions in each community. Table 1 below depicts each Managing Entity, the DCF regions within their catchment areas, and the number of rural and non-rural counties within their catchment areas.

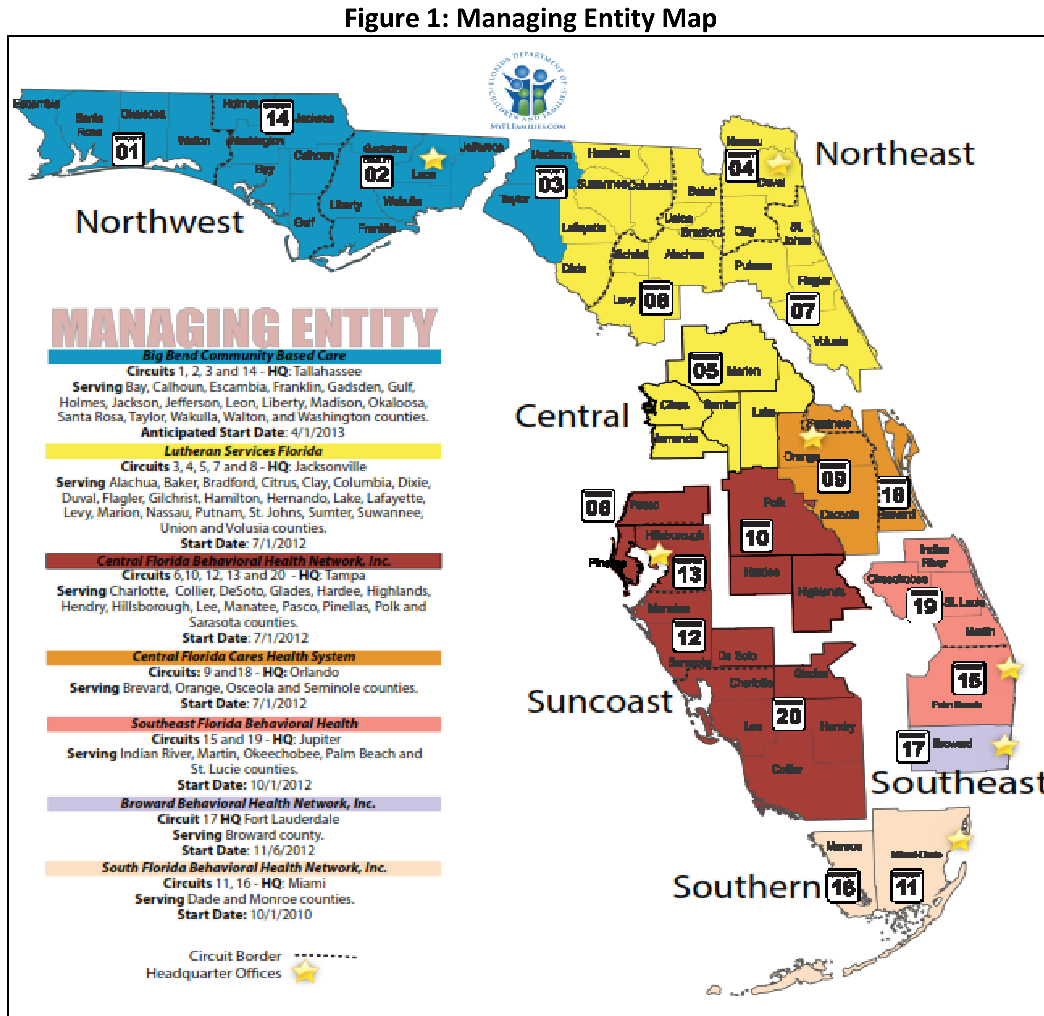
Table 1. Number of Florida Counties by Managing Entity Region and DCF Region

Managing Entity	DCF Region(s)	Rural Counties	Non-Rural Counties	Total Counties
Broward Behavioral Health Coalition (BBHC)	Southeast Region	0	1	1
Central Florida Cares Health System (CFCHS)	Central Region	0	4	4
Central Florida Behavioral Health Network (CFBHN)	Suncoast & Central Regions	5	9	14
Lutheran Services Florida Health Systems (LSFHS)	Northwest & Central Regions	10	13	23

Northwest Florida Health Network (NWFHN) / Big Bend Community Based Care (BBCBC)	Northeast & Northwest Regions	13	5	18
South Florida Behavioral Health Network (SFBHN)	Southern Region	1	1	2
Southeast Florida Behavioral Health Network (SEFBHN)	Southeast Region	1	4	5
Entire State of Florida		**30**	**37**	**67**

Figure 1 below is a color-coded map that depicts each Managing Entity's catchment area, start date, and DCF regions and circuits. It also lists each county within each Managing Entity's geographic catchment area.

Figure 1: Managing Entity Map



Behavioral Health Services

In Florida, as with many states, the CMHS 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.[4] 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.

The Florida KidCare program is the umbrella term for Florida's Children's Health Insurance Program (CHIP). Florida KidCare provides a continuum of health insurance coverage to children in families with incomes up to 200 percent of the

federal poverty level. The Florida KidCare program is comprised of four programmatic partners. The Florida Healthy Kids Corporation administers the Florida Healthy Kids program for children ages 5 through the end of age 18. The Florida Agency for Health Care Administration (AHCA) administers Medicaid services and the MediKids program for children ages 1 through 4. The Department of Health administers the Children's Medical Services Managed Care Plan. The Department of Children and Families determines eligibility for Medicaid and administers the Behavioral Health Network (BNET) for children ages 5 through the end of age 18 with serious emotional disturbances.[5]

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.[6] 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

Agency	Services
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 • 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 use 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 use disorder and emotional disturbance or serious emotional disturbance.

- For substance abuse treatment services:
    - Adults who have substance use disorders and a history of intravenous drug use;
    - Persons diagnosed as having co-occurring substance use and mental health disorders;
    - Parents who put children at risk due to a substance use disorder;
    - Persons who have a substance use 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 use 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 CMHS and SAPT 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; and
    - 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; and
    - 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; and
    - 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 General Appropriations Act and federal block grant funds ;
2) Child welfare involved parents/caretakers through Family Intensive Treatment Teams; and
3) Individuals with opioid misuse and opioid use disorders through federal discretionary grants (i.e., the 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 treatment 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. The Department is also working with the Florida Certification Board to create a training course for ALF owners and staff to replace the currently approved (and statutorily required) training.

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 33 Florida Assertive Community Treatment (FACT) teams, 41 Community Action Treatment (CAT) teams, 5 Community Forensic Multidisciplinary teams, 39 Mobile Response Teams, and 23 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 the community. They provide in-home services and supports, with heavy emphasis on community integration and bolstering family support systems.

Access to Local Crisis Call Centers

Every year, millions of individuals throughout the U.S. dial 2-1-1 for help with a variety of basic needs like food and shelter, as well as mental health crisis services. Florida 2-1-1 is a free, confidential service that connects Floridians with local community-based organizations offering thousands of different programs and services. Individuals can call 2-1-1 or search the Turn to 2-1-1 website for information on more than 40,000 different programs and services throughout Florida. The Florida Alliance of Information and Referral Services (FLAIRS) is the collaborative 2-1-1 association "responsible for studying, designing, implementing, supporting, and coordinating the Florida 211 Network and for

receiving federal grants."[7] FLAIRS provides a map of Florida's 2-1-1 network which is comprised of 12 Contact Centers (see Appendix A below). Some centers offer multilingual services 24-hours a day, 365 days per year. Other providers operate more limited in-house schedules and route evening, weekend, and holiday calls to neighboring crisis providers. Some providers have enhanced capacity for web-based interactions and text, chat, or email supports. Local data dashboards, with details on call volume and the type of service requests received by Florida's network of 2-1-1 Centers, are accessible at www.211Counts.org. In FY 19-20, Florida's 2-1-1 Centers reported approximately 653,541 calls and 837,521 total requests.[8] The National Suicide Prevention Lifeline (NSPL) is comprised of a nationwide network of over 180 local crisis call centers. Nine of the 2-1-1 Centers in Florida are "blended" members of the NSPL network, providing both crisis services and information and referral services. They are nationally accredited by the American Association of Suicidology and they answer calls to the NSPL from their local communities. In 2019, NSPL member call Centers operating in Florida reported 128,659 calls, up about 64% since 2016. The Department also commits funding to support the Crisis Center of Tampa Bay's Florida Veterans Support Line (www.MyFLVet.com). The Florida Veterans Support Line was launched as a pilot program in 2014 and it has since expanded to every county in Florida. Veterans and their loved ones can call 1-844-MyFLVet and be connected to a peer military veteran who has been trained to provide immediate emotional support, as well as VA and non-VA resources located throughout the community. Over the past year, 20,365 calls were received from veterans or their family members and 54,838 referrals were provided. Additionally, 4,523 veterans were linked to care coordination services.

Mobile Response Teams (MRTs)

Mobile Response Teams (MRTs) provide readily available crisis care in the community and increase opportunities to stabilize individuals in the least restrictive setting to avoid the need for hospital or emergency department utilization. The Managing Entities contract with providers for MRTs, with statewide access to this service across all 67 counties. There are currently 39 MRTs. A map depicting the MRTs is available on the Department's website. In 2020, House Bill 945 amended s. 394.495, F.S., to include MRT in the child and adolescent array of services, outline programmatic requirements, and expand MRT eligibility to include children that are served by the child welfare system and are experiencing or at risk of experiencing placement instability. The Department published a Guidance Document that identifies eligibility, roles and responsibilities, service components, and output measures. MRT program requirements include:

- Reasonable access to MRT services among all the counties in the Managing Entity service region
- Establish response protocols with local law enforcement agencies, local community-based care lead agencies, child protective investigators, and the Department of Juvenile Justice
- Provide information about MRT services to foster parents
- Services must be available 24 hours per day, 7 days a week
- Access to a board-certified or board-eligible psychiatrist or psychiatric nurse practitioner
- MRTs may triage requests to determine the level of severity and provide an in-person response within 60 minutes when clinical criteria for an immediate response is met. The in-person response may be face-to-face at the location of the crisis or via telehealth
- Provide an array of crisis response services responsive to individuals and their family including
    - Evaluation and assessment,
    - Stabilization services,
    - Safety and crisis planning, and
    - Brief care coordination with a warm handoff to another service provider as clinically indicated.

The Department began collecting data in July 2019 about the MRT services. For State Fiscal Year 20-21, the MRTs received 22,160 calls and responded either face to face or through telehealth to 16,651 of those calls. Of the 16,651 calls responded to, 3,145 calls resulted in an involuntary examination and 13,506 (or about 81%) were potentially diverted from an involuntary examination.

Availability of Short-term Crisis Receiving and Stabilization Centers

Crisis stabilization is an acute care service, offered 24-7, that provides brief, intensive residential treatment services that meet the needs of individuals experiencing mental health crises who would otherwise require hospitalization.[9] Crisis Stabilization Units (CSUs) and Children's Crisis Stabilization Units (CCSUs) are residential facilities, serving as an alternative to inpatient hospitalization, that conduct voluntary examinations and involuntary examinations under Florida's Baker Act. In Florida, individuals that are involuntarily admitted for examination go to a network of "designated" facilities, approved by the Department, that provide emergency screening, evaluation, and short-term stabilization.

There are 126 designated Baker Act Receiving Facilities in Florida, including 64 public facilities that have a contract with a Managing Entity and 62 private facilities. Designated Baker Act receiving facilities are facilities where involuntary examinations occur. These include hospitals licensed under Chapter 395 F.S., and CSUs licensed under Chapter 394 F.S. The Department designates all Baker Act receiving facilities regardless of type. There are also 4 Short Term Residential Treatment (SRT) facilities in Florida, which only admit adults and provide a step-down for individuals in CSUs needing a more extended, but less intensive level of treatment. These programs were created to function as a stepdown from CSUs and to divert individuals from higher levels of care like State Mental Health Treatment Facilities. Addictions Receiving Facilities (ARFs) and Juvenile Addictions Receiving Facilities (JARFs) are secure, acute care facilities providing 24-7 emergency screening, evaluation, detoxification, and stabilization services. ARFs are designated by the Department to serve individuals with substance impairment who meet placement criteria. Joint CSU/ARFs and joint CCSU/JARFs provide integrated services addressing both substance impairment and mental health crises. The number of designated facilities and beds are presented in the table below. Note that the total number of beds is 5,927 and this reflects the combined total of public beds (2,195) and private beds (3,732). Adding any other category of beds will result in duplication because some beds are classified in more than one way since they are used for either children, adults, mental health, or substance impairment, depending on the need.

Designated Baker Act Facilities and Beds in Florida (July 2021)									
	CSU	Hospital	CCSU/JARF	CSU/ARF	SRT	Public	Private	Children	Adult
Total Facilities	36	74	9	3	4	64	62	41	117*
Total Beds	963	4,627	152	90	95	2,195	3,732	806	5,121

* This figure includes facilities with all population beds.

Section 394.4573, Florida Statutes, calls for the implementation of local no-wrong-door models for the delivery of acute care services for individuals with behavioral disorders, regardless of their entry point into the behavioral health system. A designated, centralized receiving system – responsible for assessment, evaluation, and triage of individuals with mental health or substance use disorders – is considered an essential element of a coordinated system of care.

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 and Forensic Step-down Services)
- North Florida Evaluation and Treatment Center (Forensic Commitment Capacity)

The state contracts for services at four other sites:

- South Florida Evaluation Treatment Center (Forensic Commitment Services)
- Treasure Coast Forensic Treatment Center (Forensic Commitment Services)
- South Florida State Hospital (Civil Commitment Services and Forensic Step-down Services)
- West Florida Community Care Center (Civil Commitment Services)

Services are designed to help individuals manage their symptoms and apply skills needed to successfully return to the community. Services include psychiatric assessments, treatment with psychotropic medication, health care services, individual and group therapy, individualized service planning, vocational and educational services, addiction treatment services, rehabilitation therapy and enrichment activities. 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,[10] 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 distribution of races/ethnicities among the general Florida population is approximately 53.0% White, 15.0% Black, 26.6% Hispanic, 2.7% Asian, 0.2% American Indian/Alaska Native, 0.1% Native Hawaiian/Other Pacific Islander, and 2.4% multiple races.[11] There are two Federally Recognized Indian Tribes in Florida: the Miccosukee Tribe of Indians and the Seminole Tribe of Florida. Members of the Tribes are able to obtain services through the Department's publicly-funded network of providers. The Seminole Tribe is also participating in the Department's 9-8-8 Planning Grant coalition. With respect to sexual identity, according to estimates from the 2018-2019 National Survey on Drug Use and Health, approximately 84.7% of Floridians identify as heterosexual, 2.0% identify as lesbian or gay, 3.3% identify as bisexual, and 0.4% don't know.[12]

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 individually 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. Emotional and behavioral assessments are also required

to assess and address an individual's social, ethnic, and cultural factors.[13] Furthermore, individuals receiving drug treatment services have a guaranteed right to nondiscriminatory services, whereby service providers may not deny an individual access to services solely on the basis of race, gender, ethnicity, age, sexual preference, HIV status, prior service departures against medical advice, disability, or number of relapses.[14] The Department also has agency-wide policies, plans and procedures that facilitate access to interpretation and translation services to thousands of non-English speakers throughout Florida.

Additionally, the Florida Children and Youth Cabinet, chaired by First Lady DeSantis, is examining the stigma around mental illness specifically among minority communities through a newly formed workgroup. According to the most recent update, peer support is the principal theme emerging from workgroup meetings and discussions about stigma and resiliency.[15] Peer specialists in Florida (described in more detail in following sections) are required to complete two hours of cultural and linguistic competence training.

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. One CSC-ESMI team (Success 4 Kids) uses the OnTrackNY treatment model, all the other providers use the NAVIGATE treatment model.

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

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 19-20, Florida expended $12.5 million on services for PWWDC and served 1,703 pregnant women. The most commonly provided services were residential treatment, medication-assisted treatment, and case management. The Women's Services Coordinator is responsible for reviewing data submitted by the Managing Entities, addressing discrepancies, completing quarterly reports, and sharing resources related to PWWDC. The Department also participates on recurring 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. Recently, the Department hired a Statewide Substance Exposed Newborn Care Coordinator. This position is responsible for overseeing a statewide coordinated response across programs for families at risk of or with infants born substance exposed and for providing guidance to six regional Substance Exposed Newborn Care Coordinators. The Department also continues to contract with the Florida Association of Alcohol and Drug Abuse and the Florida Certification Board to provide online trainings and resources on evidence-based practices and treatment specific to PWWDC to enhance workforce development.

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 41 drug treatment programs that collectively tested 14,443 individuals in FY 19-20. A total of 154 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, and improvements to 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 activities, problem identification and referral, community-based processes, and environmental strategies. The Department licenses providers of prevention services; identifies data-driven, statewide, strategic priorities; develops competitive applications for prevention grant funding opportunities; provides trainings on innovative prevention practices; leads data quality improvement initiatives; and collaborates with other state agencies on surveillance and resource coordination. The Department also manages the competitive review process for the Block Grant-funded, school-based, Prevention Partnership Grant (PPG) proposals, in partnership with the Department of Education and the Department of Juvenile Justice.[16] The Department's Statewide Prevention Coordinator also recently collaborated with nurses, counselors, educators, and Department of Education representatives on the development of standards in the Florida Administrative Code for mental and emotional health education and substance use health education for grades K-12. The Department also manages prevention specific appropriations from the Legislature, most recently in partnership with the Florida Alliance of Boys and Girls Clubs on a youth opioid prevention project.

Networks of prevention service providers, which include community-based organizations, like anti-drug coalitions, and behavioral health service providers, implement various evidence-based school- and family-based prevention programs throughout the state. The Department also funds a variety of campaigns throughout the state designed to prevent youth substance use. These include different variations of Social Norms Campaigns, as well as Use Only as Directed, Know the Law, Talk: They Hear You, Friday Night Done Right, No One's House/Not in My House, We ID, Parents Who Host Lose the Most, Lock Your Meds, Be the Wall, and Safe Homes/Safe Parties. As many of these campaign names imply, they involve activities that address a variety of substances and behaviors, and include messages targeting parents and other adults that encourage responsible social hosting and supervision, restricting youth retail and social access to alcohol and medications, conveying disapproval of youth substance use, and modeling substance-free recreational activities.

The prevention system in Florida has a clear directive to be responsive to the needs of diverse racial, ethnic, and gender minorities, as well as American Indian/Alaska Native populations residing in the state. The Department's prevention partners are empowered with the flexibility to respond to local needs and conditions. The Department's Prevention Services Guidance Document requires data analysis to identify populations to be targeted through culturally appropriate, evidence-based prevention programs.[17] Providers of prevention services are also required to use the planning process known as the Strategic Prevention Framework, which includes cultural competence as a cross-cutting principle that should be integrated into each step (assessment, capacity building, planning, implementation, and evaluation).[18] The Managing Entities monitor and address the needs of the diverse communities they serve in a variety of ways, including inclusive needs assessments that use demographic data throughout the process of writing, reviewing, and negotiating prevention contracts. Efforts are made to ensure that the prevention programs and strategies which are selected will be effective within diverse communities and providers are asked to demonstrate their effectiveness at reaching various demographics.

Data on prevention services is entered in the Department's Performance Based Prevention System, which is operated through a contract with Collaborative Planning Group Systems, Inc (CPGSI). In partnership with CPGSI, the Department helps identify and rectify data input errors through training and technical assistance provided to the Managing Entities and prevention services providers. CPGSI provides written recommendations for improvement on an account-by-account basis to each Managing Entity. The Performance Based Prevention System now includes a web training tab to house trainings on various topics, including strategic planning. Population-level data includes age of first use, future intentions to use, alcohol-related vehicle crashes, DWI rates, arrests, perceived availability, perceived harm, perceived parental disapproval, retailer citations, pills collected through drug take-back events, substance-related school suspensions, and lifetime and past 30-day prevalence rates for a variety of substances. Provider-level profiles and service records contain a variety of data elements and variables, including but not limited to, funding source, substance problem type, strategy type, activity codes, IOM targets, program/campaign names, counties of service, activity counts and descriptions, service recipient demographics (age, race/ethnicity, etc.) outputs types (i.e., media generated, services provided, training provided, community action/change, etc.).

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[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] Florida Agency for Health Care Administration. (2021). *Florida KidCare – Title XXI – Children's Health Insurance Program (CHIP)*. Retrieved from https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/program_policy/FLKidCare/index.shtml; Florida KidCare. (2021). *Florida KidCare Partners*. Retrieved from https://www.floridakidcare.org/.
[6] S. 394.76, F.S.
[7] S. 408.918(3), F.S.
[8] 211 Counts. (2021). *Top Service Requests by All Florida Call Centers – Custom Date: July 1, 2019 through June 30, 2020*. Retrieved on March 3, 2021 from www.211counts.org.
[9] Section 65E-14.021(4)(e), Florida Administrative Code.
[10] S. 394.674(1), F.S.

[11] Kaiser Family Foundation. (2021). *Population Distribution by Race/Ethnicity* (Timeframe: 2019). Based on 2008-2019 American Community Survey 1-Year Estimates. Retrieved from https://www.kff.org/statedata/.
[12] Substance Abuse and Mental Health Services Administration. (2021). *National Survey on Drug Use and Health: 2-Year RDAS* (2018-to 2019). Restricted Online Data Analysis System (RDAS). Row Variable = SEXIDENT; Column Variable = STNAME (Florida).
[13] S. 65E-12.107(2)(d), Florida Administrative Code.
[14] S. 397.501(2), F.S.
[15] Governor Ron DeSantis News Release. (2021). *First Lady Casey DeSantis Chairs Children and Youth Cabinet Meeting – Cabinet Receives Updates on the Social Stigma of Mental Health and Building Resiliency in Florida's Students*. Retrieved from https://www.flgov.com/2021/07/27/first-lady-casey-desantis-chairs-children-and-youth-cabinet-meeting-2/.
[16] S. 397.77, F.S. (School Substance Abuse Prevention Partnership Grants).
[17] Florida Department of Children and Families. (2019). *Guidance 10 – Prevention Services*. Retrieved from www.myflfamilies.com/service-programs/samh/managing-entities/2019/IncDocs/Guidance%2010%20Prevention.pdf.
[18] Substance Abuse and Mental Health Services Administration. (2019). *A Guide to SAMHSA's Strategic Prevention Framework*. Retrieved from www.samhsa.gov/sites/default/files/20190620-samhsa-strategic-prevention-framework-guide.pdf.

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 of care 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 of care.
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, SUD prevention, and SUD treatment goals at the state level.

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 2018-2019 NSDUH, approximately 3.8% of children ages 12-17 and 5.9% of adults ages 18 and older experienced a substance use disorder in the past year.[1] With respect to the prevalence of needing *but not receiving* treatment, in 2018-2019 approximately 3.8% of children ages 12-17 in Florida, and 5.6% of adults ages 18 and older, needed treatment for substance use but did not receive it. Looking at Floridians ages 18-25, the treatment gap is even higher, with 11.4% of young adults in Florida needing but not receiving treatment for substance use.[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]

Furthermore, according to the most recent Assessment of Behavioral Health Services, in FY 19-20 there were approximately 787 individuals placed on a waitlist for outpatient drug treatment services. During this same period, 162 individuals who inject drugs and 145 individuals who were homeless were also placed on a waitlist for outpatient drug treatment services.[4] Adults in some areas of the state wait 19 days, on average, between their assessment and their first outpatient drug treatment service. With respect to residential drug treatment, 388 individuals were placed on the waitlist in FY 19-20.

The NSDUH estimates that 17.2% of adults in Florida experienced any mental illness in the past year.[5] 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 25.2% between 2008-2009 and 2018-2019. 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 10.8% during this period.[6]

Adults with serious mental illness (SMI) are persons with a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual (DSM) that results in functional impairment. Approximately 4.3% of adults in Florida experienced SMI in 2018-2019.[7] Rates of SMI are higher among Whites in Florida (5.3%), relative to Blacks (2.2%), Hispanics (2.9%), and other or multiple races (2.5%).[8] Looking more specifically at young adults ages 18-25, there was a statistically significant increase in the prevalence of SMI from 3.3% to 7.3% between 2008-2009 and 2018-2019.

Managing Entity-level NSDUH estimates for SUD and SMI among the general household population in Florida are produced in the table below.[9]

Prevalence of Past-Year Behavioral Health Disorders Among Adults (Ages 18+) and Children (Ages 12-17): Annual Average Based on 2016-2018 NSDUHs			
Managing Entity	**Serious Mental Illness among Adults**	**Substance Use Disorder among Adults**	**Substance Use Disorder among Children**
BBHC	3.1%	6.3%	3.4%
CFCHS	3.8%	6.4%	4.0%
CFBHN	4.0%	6.7%	4.5%
LSFHS	4.2%	7.3%	4.7%
BBCBC	4.7%	8.5%	5.0%
SFBHN	3.1%	6.0%	3.4%
SEFBHN	3.4%	6.5%	4.0%
Statewide	**3.8%**	**6.8%**	**4.2%**

Children with serious emotional disturbances (SED) have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM that results in functional impairment. The most recent systematic review and meta-analysis of 12 peer-reviewed studies estimates the prevalence of SED (with domain-specific impairment) at 10.0%.[10] Furthermore, among children ages 12-17 in Florida, approximately 13.2% experienced a major depressive episode in 2018-2019, which reflects a statistically significant increase over the 2008-2009 estimate of 8.5%.[11] According to the most recently published 5-year average, only about 38% of children ages 12-17 with a major depressive episode in Florida receive depression care.[12]

The prevalence of 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%.[13] These estimates are now over 20 years old and were not based on studies of children in Florida. 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.[14] Most of these studies spanned 1989 to 2015 and assessed children ages 8 to 17. The pooled prevalence of SED with domain-specific impairment is 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 is 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, need 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' *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.[15] 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.[16] 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 (2018-2019) 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.[17] 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 4.4% among children in Florida with no ACEs, 9.8% among children with one ACE, and 19.9% among children with two or more ACEs.[18] According to a similar measure from the NSCH, approximately 10.3% of children ages 3-17 in Florida received treatment or counseling from a mental health professional in the past year, and an additional 2.6% needed to see a mental health professional but did not.[19] Among children who received or needed mental health treatment, approximately 56.4% did not have difficulty getting it, 26.8% found it was somewhat difficult to get it, and 16.1% found it was very difficult to get it.[20] Among children in Florida who are currently insured and who used behavioral health care, 44.3% have insurance that always offers benefits or covers services that meet their behavioral health needs, 19.9% have insurance that usually offers benefits or coverage that meets those needs, and 35.8% have insurance that sometimes/never offers benefits or coverage that meets those needs.[21]

According to the most recent Assessment of Behavioral Health Services, in FY 19-20 there were approximately 2,283 individuals placed on a waitlist for outpatient mental health services.[22] Unmet needs related to mental health and substance use are also captured through calls to Florida's 2-1-1 Centers. In FY 20-21, Florida's 2-1-1 Centers reported approximately over 136,000 requests related to mental health needs, as depicted in the table below.[23]

211 Service Request Category	Number of Requests (FY 20-21)
Mental Health Services	92,443
Crisis Intervention and Suicide	35,230
Mental Health Facilities	7,383
Marriage and Family	946
Other Mental Health and Addictions	487
Total:	**136,489**

The Health Resources and Services Administration reports that there are 209 areas experiencing a shortage of mental health professionals in Florida. In Florida, the percent of need met is 17%, compared to 27% for the entire United States.[24] Statewide, the number of additional practitioners needed to remove the shortage designation is 389. For mental health geographic designations based on the ratio of population to psychiatrist , the designation must have a ratio of 30,000 to 1, while for population designations or geographic designations in areas with unusually high needs, the threshold is 20,000 to 1.

One of the greatest needs identified relates to serving individuals in community settings instead of State Mental Health Treatment Facilities (SMHTF), which are expensive and highly restrictive. Currently, capacity in the community for services intensive enough to treat and maintain individuals with serious mental illnesses and complex needs (i.e., co-occurring substance use disorders, co-morbid medical conditions, criminal justice involvement, frequent hospitalizations, etc.) in the community. These individuals are often ordered into SMHTFs, with challenges discharging them back into the community because of insufficient capacity for necessary services. According to the SMHTF's April 2021 Seeking Placement Report, 104 individuals were awaiting discharge from a civil facility (66 of which were waiting more than 30 days) and 52 individuals were awaiting discharge from a forensic facility.

Lack of Health Insurance, Poverty, and Behavioral Health Conditions

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.[25] According to estimates from the National Survey on Drug Use and Health, approximately 17% of Floridians with substance use disorders are uninsured, and 20% of Floridians needing but not receiving treatment for substance use are uninsured.[26] With respect to adults in Florida who inject drugs, it is estimated that about 33% are uninsured.[27] Additionally, 19% of adults in Florida with serious mental illness lack health insurance.[28]

According to estimates from the American Community Survey for 2019, uninsured rates vary by race/ethnicity in Florida. The uninsured rate among all nonelderly individuals in Florida is 16.3% (compared to 10.9% nationwide). Looking exclusively at children ages 0-18, about 7.5% are uninsured in Florida, compared to 5.6% nationwide.[29] Looking specifically at rates by race/ethnicity, uninsured rates are lower among Whites (13.3%), compared to Blacks (17.3%), Hispanics (21.2%), and American Indians/Alaska Natives (20.6%).[30] The poverty rate among all Floridians was about 12.7% in 2019 (compared to 12.3% nationwide). Poverty rates also vary by race/ethnicity in Florida. Breaking it out by race/ethnicity, the poverty rate is 9.2% among Whites, 19.8% among Blacks, 15.7% among Hispanics, 10.2% for Asian/Native Hawaiian and Pacific Islanders, 13.9% among American Indian/Alaska Natives, and 14.7% among individuals of multiple races.[31]

The distribution of uninsured individuals in Florida by race/ethnicity is 38.9% White, 38.2% Hispanic, 17.7% Black, 2.5% Asian/Native Hawaiian and Pacific Islander, 2.5% multiple races, and 0.3% American Indian/Alaska Native.[32] For comparison, the distribution of races/ethnicities among the general Florida population is approximately 53.0% White, 15.0% Black, 26.6% Hispanic, 2.7% Asian, 0.2% American Indian/Alaska Native, 0.1% Native Hawaiian/Other Pacific Islander, and 2.4% multiple races.[33] For additional comparative purposes, the distribution of race/ethnicity among Floridians *with substance use disorders* is approximately 66% White, 7% Black, 25% Hispanic, and 1% other or multiple races, according to 2018-2019 estimates from NSDUH.[34] Alternatively, the distribution of race/ethnicity among Floridians *needing but not receiving treatment for substance use* is approximately 67% White, 10% Black, 19% Hispanic, and 4% other or multiple races.[35] The distribution of race/ethnicity among adults in Florida with serious mental illness is approximately 72% White, 8% Black, 18% Hispanic, and 3% other or multiple races.[36] According to an earlier analysis of Florida-specific NSDUH estimates, the prevalence of SMI is only about 1.5% higher among uninsured adults than it is among insured adults, whereas the prevalence of substance use disorders among uninsured adults is nearly twice as high as the prevalence among insured adults.[37]

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

Assessments of Behavioral Health Services, conducted in partnership with the Managing Entities pursuant to s. 394.4573, Florida Statutes, describe the extent to which designated receiving systems function as no-wrong-door models, the availability of services that use recovery-oriented and peer-involved approaches, and the availability of less-restrictive services. Managing Entities identify top unmet system needs in a variety of different ways, including analyses of waitlist records, surveys, and focus groups with consumers, providers, and other community stakeholders. Assessments and associated enhancement plans were recently updated reflect conditions that changed during the pandemic. A summary of the unmet needs related to treatment and recovery support services for individuals with substance use disorders is provided below. Each Managing Entity rank-ordered the services and projects according to priority.

Big Bend Community Based Care / North West Florida Health Network (BBCBC/NWFHN):

1. Outpatient services like outreach, intervention, assessment, case management, and supported housing
2. Recovery support specialists and supervisors

3. Detoxification services
4. Buprenorphine-based treatment for opioid use disorders
5. Long-acting injectable naltrexone (Vivitrol) for alcohol use disorders
6. Expanded medication-assisted treatment and counseling services
7. Implementation of a virtual training platform for training and maintaining licensure/certifications

Broward Behavioral Health Coalition (BBHC):

1. Residential treatment services
2. Residential detoxification services (Addiction Receiving Facility)
3. Transitional housing/recovery housing
4. Peer support services (including at emergency departments and detoxification units)
5. Outpatient treatment services
6. Medication-assisted treatment services for alcohol use disorders
7. Telehealth Virtual Platform
8. Managing Entity Systems Level Care Coordination (Housing and Employment)
9. Specialized Care Coordination/Housing teams (within network providers) supported by intensive case management and transition vouchers
10. Family Intensive Treatment (FIT) team services

Central Florida Behavioral Health Network (CFBHN):

1. Housing vouchers and services
2. Supportive employment and housing services
3. Medication-assisted treatment and harm reduction services for a Tampa General pilot project serving participants at the Syringe Services Program
4. Care Coordination services
5. Community-based co-occurring treatment services and temporary housing for individuals released from jail
6. Marchman Act services (10 beds)
7. Community-based services including telehealth/telephonic services for substance use disorders

Central Florida Cares Health System (CFCHS):

1. An additional Behavioral Health Consultant
2. Medication-assisted treatment services for opioid use disorders and associated counseling and case management (including psychiatric services for co-occurring disorders).
3. Supportive group housing with mental health overlay services for adults with co-occurring substance use disorders and serious mental illnesses (prioritizing FACT step-down and SMHTF discharges)
4. 4 Housing Specialists at network providers
5. A Housing Specialist at the Managing Entity
6. 6 Care Coordinators at network providers
7. An Adult/Child Care Coordinator at the Managing Entity

Luther Services of Florida Health Systems (LSFHS):

1. Care Coordination and Housing Coordination

2. Adult treatment capacity for substance use disorders, including assessment, medication-assisted treatment, medical services, outpatient, recovery support, and residential.
3. Behavioral health/law enforcement co-responder teams
4. Expanded treatment access to residential, outpatient, and peer recovery support for individuals screened in Emergency Departments
5. Neonatal Abstinence Syndrome/Substance Exposed Newborn (NAS/SEN) Care Coordination

Southeast Florida Behavioral Health Network (SEFBHN):

1. Medication-assisted treatment for alcohol use disorders and tobacco use disorders
2. Reduce turnover and attract critically needed staff with improved compensation (for medical, therapeutic, support, and case management staff)
3. Enhance Recovery Support Services (outreach, engagement through all levels of treatment, supported housing and supported employment)
4. Bring all unfunded residential treatment capacity back online and add co-occurring beds
5. Expand Spanish-speaking and Creole speaking trainings and opportunities to become certified peers
6. Training on Seeking Safety (especially for peers doing outreach), WHAM, Motivational Interviewing, High Fidelity Wraparound certification, and Recovery-Oriented Cognitive Therapy
7. Computers and educational supplies and equipment to help providers delivery recovery support services, such as linkages to health care, employment, updating resumes, housing, and local Recovery Community Organization services
8. Supportive housing in certified Recovery Residences for individuals with substance use disorders or co-occurring disorders who are initiating medication-assisted treatment
9. Project Lift (mentoring, training, therapeutic sessions and counseling)

South Florida Behavioral Health Network (SFBHN):

1. Residential treatment capacity
2. Housing and Care Coordination
3. Expand the CCSU/Juvenile Addictions Receiving Facility (JARF)
4. Recovery Community Organization expansion
5. Peer certification training
6. Medication-assisted treatment (MAT) outreach team to educate the recovery community
7. Medication-assisted treatment (MAT) Community Crisis Team within the Centralized Receiving Facility
8. In-house COVID testing and Personal Protective Equipment (PPE)
9. Peer support groups (Double Trouble)
10. ASAM certification training support

With respect to mental health system gaps for treatment and recovery support services for individuals with SMI and SED, broadly speaking, the most frequently identified needs are usually related to housing, care coordination, and intensive, multidisciplinary, team-based services. Examples of team-based services include Florida Assertive Community Treatment (FACT) teams, Community Action Treatment (CAT) teams, Family Intensive Treatment (FIT) teams, Mobile Response Teams (MRTs), and Coordinated Specialty Care teams for Early Serious Mental Illness (CSC-ESMI). Intensive services through Mobile Response Teams, FACT teams, CAT teams, and CSC-ESMI teams are addressed and prioritized through associated performance indicators and objectives, described in more detail later. FACT teams and CSC-ESMI teams are excellent examples of intensive services that can be applied upstream, before the need for deeper-end, costly care in Crisis Stabilization Units, State Mental Health Treatment Facilities, or jails. For example, according to FY 19-20

FACT team data, 100% of individuals served are maintained in the community (not admitted to a State Mental Health Treatment Facility), 47% are living independently, and 23% are either employed, going to school, or volunteering. An abbreviated list of unmet needs related to treatment and recovery support services for SMI and SED is provided below, ranked-ordered according priority by the Managing Entities:

North West Florida Health Network / Big Bend Community Based Care (NWFHN/BBCBC):

1. Expand outpatient services, including case management, medical services (medication management), drop-in centers, outreach, supported housing, intervention, recovery support, and telehealth.
2. Forensic ACT team services with a focus on housing
3. Club Houses
4. Recovery Support Specialists
5. Expand services for children at-risk of child welfare involvement (including CAT team type services and respite)
6. Expand Mobile Response Team services
7. Technology enhancements to improve telehealth delivery among contracted service providers (upgrade switches, phone systems, routers, and networks)
8. Expand the use of travel nurses in crisis programs
9. Various training needs

Broward Behavioral Health Coalition (BBHC):

1. Short Residential Treatment beds
2. New FACT Team
3. ME Systems Level Care Coordination (ME Housing Coordinators and ME Care Coordinators)
4. Care Coordination Teams
5. Expansion of existing CAT Team
6. Jail Diversion Team (Stepping-Up Initiative)
7. Residential beds
8. Expand Suicide Hotline with warm handoffs and continue to implement Zero Suicide Initiative
9. Expand Mobile Response Team services to adults 26 and older and to include warm handoffs
10. Broward Forensic Alternative Center services, including crisis stabilization, Short-term Residential Treatment, competency restoration, and living skills

Central Florida Behavioral Health Network (CFBHN):

1. Recovery through Work Program (supported housing, supported employment, clubhouse services).
2. Mobile Response Team enhancements
3. Supportive employment and housing services
4. Continuation of Housing positions at the Managing Entity
5. FACT team services
6. CAT team services
7. Short-term residential treatment
8. Equipment to support remote working for network service providers
9. Treatment and temporary housing for individuals with SMI released from jail
10. Children's Care Coordinator and Adult Care Coordinator
11. Technology system improvements for the Managing Entity and network service providers

12. The Healthy Transitions program to help youth and young adults navigate and connect to mental health services like case management and care coordination

Central Florida Cares Health System (CFCHS):

1. Peer Recovery Mental Health Respite Care with a Certified Recovery Peer Specialist
2. Suicide Prevention Program
3. Mobile Response Team expansion
4. Crisis Intervention Team Coordinator at the Managing Entity
5. Supportive group housing with mental health overlay services for adults with co-occurring disorders
6. Expanding forensic transitional beds
7. Care Coordinators at the providers
8. Adult Care Coordinator and Adult Care Coordinator positions at the Managing Entity
9. Housing Specialists at the providers
10. Housing Specialist at the Managing Entity

Lutheran Services of Florida Health Systems (LSFHS):

1. Behavioral health/law enforcement co-responder teams
2. Care Coordinators and Housing Coordinators at the Managing Entity
3. Expand FACT team services
4. Expand CAT team services
5. Permanent Supportive Housing Care Coordinators
6. You're Not Alone Suicide Prevention Campaign
7. Various training needs
8. Expand Mobile Response Team services

Southeast Florida Behavioral Health Network (SEFBHN):

1. Short-Term Residential Treatment
2. Forensic Multidisciplinary Teams
3. Increase access to psychiatric services and telemedicine
4. Mobile Response Team enhancements
5. Enhanced screening and assessment for suicide risk through staff training and education
6. FACT Team services
7. CAT Team services
8. Enhance outreach services to individuals who are homeless
9. Children's Care Coordination services
10. Respite services
11. Community Support Navigation through the NAMI Family to Family education program
12. Multisystemic Therapy with providers who collaborate with child welfare partners
13. Community Crisis Respite ("The Livingroom Model")
14. Supportive housing
15. Various training and telehealth enhancements

South Florida Behavioral Health Network (SFBHN):

1. Peer Respite Care Program

2. Expand Coordinated Specialty Care for Early Serious Mental Illness (CSC-ESMI) using the NAVIGATE model
3. Enhance Children's Crisis Response Teams (CCRT)
4. Expand FACT Team services
5. Expand supportive housing, recovery support, and other services for individuals exiting higher levels of care, at-risk of homelessness, or experiencing homelessness
6. Care Coordination Teams using Critical Time Intervention model
7. Managing Entity-level and provider-level care coordination and housing coordination
8. SOAR Specialist to assist with SSI/SSDI
9. Psychiatric residential treatment for youth
10. Expand Mobile Response Team services
11. Centralized Receiving Facilities

The following three performance indicators are associated with some of the key team-based services that address many of these needs, namely Mobile Response Teams, CAT teams, and FACT teams.

#1 Priority Area: Mobile Crisis Response Team Diversions

Priority Type: Crisis Services (CS)

Required Population: Crisis Services

Goal: Ensure Mobile Response Teams maintain high diversion rates.

Objective: Increase the percentage of MRT calls requiring an acute response that are diverted from an involuntary examination.

Indicator: The number of objectives achieved.

Baseline (FY 20-21): In FY 20-21, 81.1% of MRT calls requiring an acute response were diverted from an involuntary examination.

First Year (FY 21-22) Target: At least 82% of MRT calls requiring an acute response are diverted from an involuntary examination.

Second-Year (FY 22-23) Target: At least 83% of MRT calls requiring an acute response are diverted from an involuntary examination.

#2 Priority Area: Intensive Team-based Services (CAT Teams for Children with SED)

Priority Type: Mental Health Services (MHS)

Required Population: SED

Goal: Expand intensive, team-based services to children with serious emotional disturbances (SED).

Objective: Increase the number of children served by Community Action Teams.

Indicator: The number of children with SED served by Community Action Teams.

Baseline (FY 20-21): The baseline figure from SFY 20-21 is 3,423 children served by Community Action Teams.

First Year (FY 21-22) Target: By June 30, 2022, increase the number of children served by 50 (for a total of 3,473 children served).

Second-Year (FY 22-23) Target: By June 30, 2023, increase the number of children served by 50 (for a total of 3,523 children served).

#3 Priority Area: Intensive Team-Based Services (Florida Assertive Community Treatment)

Priority Type: Mental Health Services (MHS)

Required Population: SMI

Goal: Increase functioning among individuals served by FACT teams.

Objectives: Increase the percentage of individuals served by FACT teams through the Department maintain or improve their level of functioning.

Indicator: The percent of FACT clients served by the Department that either maintain or improve their level of functioning.

Baseline: In FY 20-21, 75% of FACT clients served by the Department maintained or improved their level of functioning.

First Year (FY 21-22) Target: At least 77% of FACT clients served by the Department will either maintain or improve their level of functioning.

Second-Year (FY 22-23) Target: At least 78% of FACT clients served by the Department will either maintain or improve their level of functioning.

Housing and Homelessness

A stable living environment is fundamental to recovery from mental disorders and substance use disorders. Unfortunately, housing is the most consistently identified unmet need across Managing Entities and from year-to-year. According to 2021 Point-In-Time counts of individuals who are homeless, 2,705 individuals surveyed (or about 13%) reported experiencing serious mental illness, while 3,047 individuals (or about 14%) reported experiencing a substance use disorder. The prevalence of SMI among individuals who are homeless was about 17% in 2020. The prevalence of substance use disorders among individuals who are homeless was approximately 12% in 2020.[38]

According to the 2021 Annual Report from Florida's Council on Homelessness, the number of people experiencing homelessness over the last 10 years decreased by more than 50%. This is due, in part, to increased effort, collaboration, and investment among all systems of care to expand permanent housing solutions; Homeless Continuums of Care (CoCs) that have embraced, promoted, and utilized a Housing First approach; and, service providers using best practices. These

evidence-based strategies include implementation of Housing First programs, employment and training opportunities for persons at-risk or experiencing homelessness, Permanent Supportive Housing and Rapid Re-housing interventions, diversion from homelessness, homelessness prevention services, and development of the Coordinated Entry System making homelessness rare, brief, and one-time.[39]

People experiencing homelessness often overlap between multiple systems, which is why the Department supports collaborative efforts between Managing Entities, Continuums of Care, Public Housing Authorities, Florida Housing Finance Corporation, and other local community-based care providers to enhance the ability to strategically target these multi-system consumers and coordinate housing and services aimed at housing stabilization and retention. In Florida, Continuums of Care (CoC) refer to a group of stakeholders in a geographic area that are working together to address homelessness. The CoCs are comprised of homeless-serving nonprofits, entities from the philanthropic sector, businesses, local governments, housing developers, realtors, health care systems, and more. These partnerships help create a strong system that incorporates housing and supportive services funded by a variety of sources, helping to quickly identify, assess, shelter, and permanently house individuals and families experiencing homelessness. Understanding the correlation between recovery and housing, the Office of Substance Abuse and Mental Health spearheaded a Managing Entity Housing Coordination initiative in 2016, establishing partnerships between housing providers, service providers, behavioral health agencies, CoCs, and other systems serving consumers who overlap between these resource-limited systems. This initiative is focused on ensuring individuals with behavioral health disorders live in the most independent, least restrictive housing possible in their local community and receive services in community-based settings that support wellness, recovery, and resiliency.

The Office of Substance Abuse and Mental Health will continue to advocate for and support affordable, supportive, and recovery housing, and recovery services to aid individuals with substance use, mental health or co-occurring disorders, those addicted to opiates, and those experiencing or at risk of homelessness. As housing has been clearly demonstrated to be a social determinant of health, Florida Housing Finance Corporation (FHFC) dedicated funding to support pilot projects aimed at serving persons experiencing chronic homelessness who are also high utilizers of public systems. FHFC-funded PSH projects operated by Ability Housing and Carrfour Supportive Housing projects are aimed at providing housing and supportive services to some of Florida's most vulnerable persons experiencing homelessness. Despite the 56 developments funded by FHFC that target homeless households and 26,701 CoC permanent housing beds, Florida has a deficit of 368,506 affordable rental homes that are affordable and available for renters whose income falls within zero to 30% area median income.[40]

Pregnant Women and Women with Dependent Children

In SFY 19-20, the Department served 1,703 pregnant women and expended $12.5 million on services for pregnant women and women with dependent children. The most commonly provided services were residential treatment, medication-assisted treatment, and case management. There were 187 live births reported, 116 of which were born drug free. Most women served (64%) delivered an infant with a birth weight of 5.5 pounds or higher. Funding services for this priority population helps Florida reduce disparities in maternal mortality rates. Researchers recently analyzed the association between Florida's maternal mortality rates and targeted, pregnancy-related public health expenditures on services like nurse home visits, depression screening, psychosocial counseling, and the Women, Infants, and Children (WIC) nutrition program. Using administrative data from all 67 Florida counties, they found that a 10% increase in expenditures led to a 3.9% decrease in overall maternal mortality rates, after controlling for demographic and socioeconomic factors, including income, unemployment, and access to care. More specifically, a 10% increase in spending was significantly associated with a 13.5% reduction in maternal mortality rates among Black mothers and a 20.0% reduction in Black-White disparities.[41]

While there is a strong correlation between the frequency of mothers and newborns with opioid-related diagnoses in hospitals, most hospitals tend to identify more infants than mothers. According to analysis of records from 105 hospitals in Florida, the average number of newborns with Neonatal Abstinence Syndrome or Opioid Exposure was 33.5, whereas the average number of mothers with Opioid Use Disorders was only 14.5. This discordance is statistically significant. According to the research team, the basis for the inadequate identification of the mothers "may be a lack of screening, lack of disclosure of opioid use, or lack of documentation by providers." More specifically, "Women may not feel safe disclosing prenatal opioid use because of legitimate distrust of the health care, social, and legal systems." Additionally, "Providers may be reluctant to document mothers' prenatal opioid use, given potential repercussions."[42] Department representatives are collaborating with partners at the Department of Health on an initiative to expand the use of evidence-based screenings, warm linkages to care, and care coordination among this population. The Department aims to promote higher levels of engagement by shifting from an investigation-focused approach led by Child Welfare to a recovery-oriented approach that provides seamless wraparound services and supports for pregnant mothers using substances.

In FY 19-20, the successful treatment completion rate among pregnant women served was 54.6%. In FY 20-21, the successful completion rate was 61.3% The Department intends to improve successful completion rates among pregnant women through an associated performance measure that calls for a 2 percentage point increase (above the FY 20-21 baseline) by June 30, 2022 and another 2 percentage point increase by June 30, 2023. For context, research indicates that pregnant women living in the Northeast U.S. have higher treatment completion rates (56.6%) than those living in the West (49.9%), Midwest (48.1%), and South (36.0%).[43] Improving treatment completion rates may entail focusing on things like stigma, the provision of childcare services, and cultural competence.

#4 Priority Area: Services for Pregnant Women and Women with Dependent Children

Priority Type: Substance Abuse Treatment (SAT)

Populations: PWWDC

Goal: Improve access to services for pregnant women.

Objectives: Increase the rate of successful treatment completion among pregnant women served by the Department.

Indicator: The percent of discharges among pregnant women that are successful.

Baseline (FY 20-21): In FY 20-21, 61.3% of discharges among pregnant women were successful.

First Year (FY 21-22) Target: By June 30, 2022, increase the percentage of pregnant women discharges that are successful by 2 percentage points (from 61.3% up to 63.3%).

Second-Year (FY 22-23) Target: By June 30, 2023, increase the percentage of pregnant women discharges that are successful by 2 percentage points above the FY 21-22 performance.

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), Life Management Center (serving Bay County), South County Mental Health Center (serving Palm Beach County), Citrus Health Center (serving Miami-Dade County), Clay Behavioral Health Center (serving Clay and Putnam counties), Aspire Health Partners (serving Orange County), and Success 4 Kids (serving Hillsborough County). All these providers use the NAVIGATE treatment model, except for Success 4 Kids, which uses the OnTrackNY model. Across all the teams, the percent of individuals served that experienced improvements in functioning or symptom severity in FY 20-21 was 80.1%. An associated performance indicator calls for the teams to maintain or exceed an 80% target with regard to the percent of individuals served that improve.

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

Priority Type: Mental Health Services (MHS)

Required Population: ESMI

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

Objective: Maintain a high percent of individuals served that experience improvements in functioning or symptom severity.

Indicator: The percent of individuals served by CSC-ESMI teams that experience improvements in functioning or symptom severity.

Baseline: 80% of individuals served by CSC for ESMI programs experienced improvements in functioning or symptom severity (FY 20-21).

First Year (FY 21-22) Target: At least 80% of individuals served by CSC for ESMI in FY 21-22 experience improvements in functioning or symptom severity.

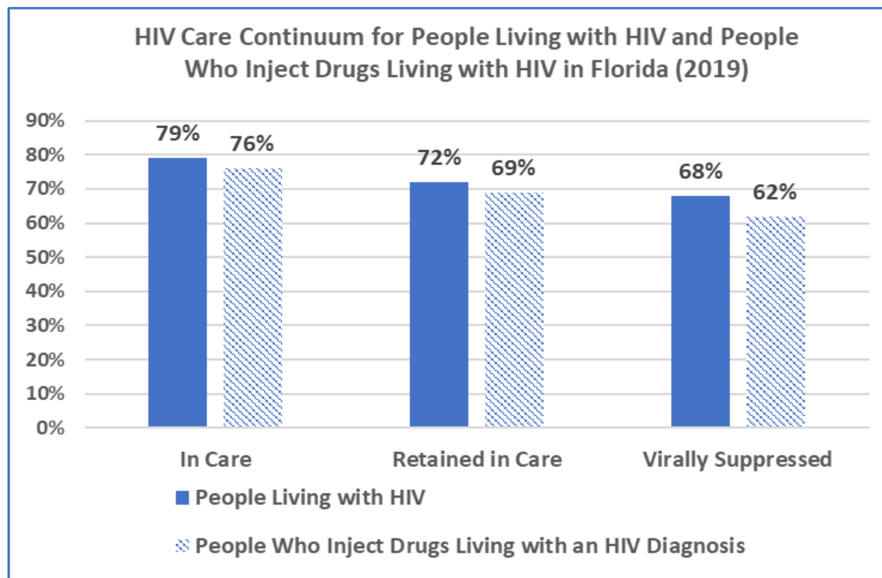
Second-Year (FY 22-23) Target: At least 80% of individuals served by CSC for ESMI in FY 22-23 experience improvements in functioning or symptom severity.

Persons Who Inject Drugs, are At-Risk for HIV, and in Need of HIV Early Intervention Services

In 2019, Florida identified 4,584 new cases of HIV. The HIV case rate decreased from 22.7 per 100,000 in 2018 to 21.6 per 100,000 in 2019.[44] Miami has the highest rate of new HIV diagnoses in the entire country, Orlando has the third highest rate, and Jacksonville has eighth highest rate.[45] The highest proportion of adults who received an HIV diagnosis in 2019 had male to male sexual contact as their mode of exposure (59%), followed by female heterosexual contact (19%), male heterosexual contact (14%), male injection drug use (3%), female injection drug use (2%), and both injection drug use and male to male sexual contact (2%).[46] Approximately 11% of individuals living with an HIV diagnosis in Florida inject drugs.[47] 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.[48] For persons at increased risk for HIV, a medication taken once daily can reduce the risk of acquiring HIV through sexual contact by over 90% and through injection drug use by 70%.[49] 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 76% are in HIV care, 69% are retained in care (with care documented on two or more occasion at least three months apart), and 62% are virally suppressed (HIV-1 RNA load less than 200 copies/mL).[50] 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.



According to an earlier analysis of suboptimal adherence to antiretroviral therapy among individuals living with HIV/AIDS throughout Florida, heavy alcohol consumption is associated with twice the odds of suboptimal HIV viral suppression compared to non-drinkers, even when controlling for other potential confounding variables.[51] Fortunately, most individuals with HIV/AIDS in Florida that need behavioral health services for alcohol and other drug use disorders report that they are able to access them. The Department of Health analyzed 3,476 responses to an anonymous survey, administered in 2019, designed to collect information on the met and unmet needs of people living with HIV/AIDS.[52] As depicted in the table below, only about 5% of respondents were unable to get professional mental health counseling and 2% were unable to get professional addiction treatment services:

Access and Utilization of Mental Health and Substance Abuse Services Among People Living with HIV/AIDS				
	Did Not Need Service	**Received Service**	**Needed Service but Could Not Receive**	**Needed Service but Did Not Know About Service**
Professional Mental Health Counseling/Therapy	53%	36%	5%	6%
Professional Addiction Counseling	79%	16%	2%	3%

Florida is required to spend exactly 5% of the SAPT Block Grant award on HIV Early Intervention Services, which includes HIV testing, pre- and post-test counseling, and diagnostic and therapeutic measures related HIV. Block Grant regulations stipulate that these HIV testing services can only be provided to individuals receiving treatment for substance use disorders, at the sites at which they are undergoing treatment. This federal requirement is triggered when a state's AIDS case rate exceeds 10 per 100,000, *according to the most recent calendar year for which such data are available*.[53] In 2009, Florida's AIDS case rate was 23.7 per 100,000.[54] According to the most recently published estimate, Florida's AIDS case rate in 2019 was 10.9 per 100,000.[55] With the AIDS case rate forecasted to continue trending downward, Florida will be prepared to repurpose the funds when Florida's AIDS case rate reaches 10 or fewer and the HIV EIS set-aside requirement is discontinued. When the 2020 AIDS case rate is published (around May/June 2022), SAMHSA will determine if the HIV set-aside requirement still applies to Florida. 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 repurposing those funds. 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. Analysis of the cost-effectiveness of Florida's HIV EIS programs will help the Department determine the path forward that will make the greatest impact on the health of vulnerable individuals with substance use disorders.

According to recent models, "the path to HIV elimination, given current funding, is one that focuses primarily on prompt diagnosis with sustained treatment of those infected." More specifically, "Given stable funding and the current effectiveness of intervention delivery, sizeable reductions in HIV incidence may be realized by focusing on screening persons at highest risk of HIV, linking the newly diagnosed to care, and supporting those in treatment to achieve and maintain viral suppression."[56] Earlier guidelines suggested that an HIV prevalence of 1% could be used as a general threshold for recommending routine (as compared with targeted) HIV screening in health care settings like drug treatment facilities, while noting that routine screening may be recommended at lower prevalence rates depending on available resources and circumstances. Research now indicates that routine screening is cost-effective if the prevalence of undiagnosed HIV infection is as low as 0.05%.[57] To ensure that HIV EIS set-aside funded providers are providing cost-effective testing services that adequately target high-risk individuals, an associated performance indicator applies a higher standard to the prevalence of HIV positive tests, calling on HIV EIS set-aside funded providers to maintain a 0.10% HIV test positivity rate (among providers reporting positive tests). This is twice the size of the cost-effectiveness standard applied to the prevalence of undiagnosed HIV infections in these settings and may entail more targeted deployment of testing capacity.

#6 Priority Area: Infectious Disease Control

Priority Type: Substance Abuse Treatment (SAT)

Required Population: PWID and HIV EIS

Goal: Ensure the implementation of Florida's HIV EIS set-aside is cost-effective.

Objectives: Ensure HIV EIS funds are cost-effective by targeting services to maintain an HIV test positivity rate of at least 0.10%.

Indicator: The percent of HIV tests that are positive (among providers reporting at least one positive test).

Baseline (FY 20-21): In FY 20-21, the percent of HIV tests that were positive (among providers reporting at least one positive test) was 1.01%.

First Year (FY 21-22) Target: In FY 21-22, the percent of HIV tests that are positive (among providers reporting at least one positive test) will be at or above 0.10%

Second-Year (FY 22-23) Target: In FY 22-23, the percent of HIV tests that are positive (among providers reporting at least one positive test) will be at or above 0.10%

Individuals At-Risk for Tuberculosis (TB)

All licensed substance abuse treatment programs in Florida are required to provide tuberculosis testing to high-risk individuals either directly or through referral. In 2020, 412 tuberculosis (TB) cases were reported in Florida.[58] This represents a 26% decrease in cases from 2019 and is the lowest number of cases reported in the past two decades. The 2020 TB incidence rate was 1.9 per 100,000.[59] The following risk factors were identified among the 2020 cases:

- Excess alcohol use in the past year (13%)
- HIV co-infection (7%)
- Illicit drug use within the past year (9%)
- Homelessness (6%)[60]

TB cases where the use of alcohol and other drugs are identified as risk factors have been declining over the past two decades.[61] 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.[62] The number of HIV diagnoses with TB in Florida decreased from 66 in 2016 down to 28 in 2020.[63]

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. 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, the vast majority of individuals with TB in Florida successfully complete treatment, and the expedient provision of behavioral health services and supports helps Florida maintain this rate.[64] Between 2008 and 2018, the percent of individuals with TB successfully completing treatment ranged from 95% to 99%.

#7 Priority Area: Infectious Disease Control

Priority Type: Substance Abuse Treatment (SAT) and Mental Health Services (MHS)

Required Population: Tuberculosis (TB)

Goal: Prevent the spread of tuberculosis (TB) through screening of at-risk individuals and behavioral health services that support TB medication adherence and TB treatment completion.

Objectives: Maintain a low tuberculosis case rate.

Indicator: The tuberculosis case rate (per 100,000).

Baseline: Florida's 2020 tuberculosis case rate was 1.9 per 100,000.

First Year (FY 21-22) Target: Maintain a 2021 tuberculosis case rate at or below 2.5 per 100,000.

Second-Year (FY 22-23) Target: Maintain a 2022 tuberculosis case rate at or below 2.0 per 100,000.

Primary Prevention of Substance Use and Substance Use Disorders

Substance use among students in Florida continues to decline. Among middle and high school students in Florida, between 2010 and 2021, the prevalence of lifetime alcohol use decreased from approximately 52% down to 34% and the past-30-day prevalence of alcohol use decreased from 29% down to 14%. Regarding binge drinking (in the past 2 weeks), the prevalence decreased from about 14% 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 approximately 19% down to 12% from 2014 (the first year this item appeared on the survey) to 2021. Regarding marijuana use, the prevalence of lifetime and past 30-day marijuana use among middle and high school students also decreased between 2010 and 2021. Lifetime prevalence decreased from approximately 24% down to 18%, and past 30-day prevalence decreased from 13% down to 9%. Finally, the lifetime prevalence of the use of any illicit drug *other than marijuana* also decreased from 21% down to 14%. Current (past 30-day) use of any illicit drug other than marijuana decreased from 9% down to about 5%.[65]

Trends in early initiation are also encouraging. The percent of high school youth that started using alcohol (more than a sip) at age 13 or younger decreased from 27% down to about 14%. The percent that started using marijuana at age 13 or younger decreased from 11% down to 7%. Additionally, between 2010 and 2021, the percent of students that said alcohol was "sort of easy" or "very easy" to get decreased from about 46% down to 30%. The percent of students that said marijuana was "sort of easy" or "very easy" to get also decreased from about 44% down to 29%. These reductions in access may be contributing to the continued decline in alcohol and marijuana use among students in Florida.[66]

With respect to particularly high-risk and antisocial substance-related behaviors, long-term progress in Florida is less dramatic but still encouraging. For example, in 2013 (the first year these questions appeared on the survey in their current form), 6.4% of middle and high school students reported using alcohol before or during school (in the past 12 months). Additionally, 9.8% smoked marijuana and 3.4% used another drug before or during school.[67] Estimates for 2021 reflect moderate progress with respect to these behaviors, with approximately 4.4% of students consuming alcohol, 7.3% smoking marijuana, and 2.6% using other drugs before or during school. Additionally, between 2012 and 2021, the percent of Florida high school students who reported driving a vehicle after drinking alcohol decreased from 8% down to 3%. The percent who reported riding in a vehicle driven by someone who had been drinking alcohol decreased from 21% down to about 14%. The percent who reported driving a vehicle after using marijuana decreased less substantially, from 11% down to 7%. The percent who reported riding in a vehicle driven by someone who had been using marijuana decreased from 25% down to 19%.

Florida's substance use prevention system infrastructure needs to be responsive to childhood trauma as a prominent risk factor for substance use and other problems. In 2020, the Department started collecting data on the prevalence of adverse childhood experiences (ACEs) among high schoolers, through the Florida Youth Substance Abuse Survey (FYSAS). Data analysis is based on 14 items measuring 10 different ACEs. In 2021, fewer than one out of three (29%) of Florida high school students reported no ACEs. Conversely, about 22% of Florida high school students reported four or more ACEs, considered a high level of trauma. Examples of ACEs include parental separation/divorce, living with someone who went to jail/prison, and physical and emotional abuse and neglect. Students with four or more ACEs report substance use rates two times higher than students with fewer than four ACEs. For example, students with fewer than four ACEs report a past-month alcohol use rate of 15%, compared to 32% for those with four or more ACEs. Marijuana use shows a similar pattern, with past 30-day rates of about 10% among low-trauma students and 29% among high-trauma students. White students, female students, and students from low socioeconomic status families are more likely to report high levels of ACEs.[68] In order to prevent ACEs, the Centers for Disease Control and Prevention recommends strengthening economic supports to families, ensuring a strong start for children (with early childhood home visitation, high-quality

child care, and preschool enrichment with family engagement), and teaching life skills and parenting skills to bolster resiliency and help parents and children manage stress and emotions.[69]

Shifting focus to adult populations, the table below shows the most recently published NSDUH prevalence rates for various substances and substance use disorders, among three adult age groups in Florida (18 and older, 18-25, and 26 and older).[70]

Prevalence of Substance Use and Substance Use Disorders in the Past Year, in Florida, by Adult Age Group (2018-2019)			
	18 and Older	18-25	26 and Older
Pain Reliever Misuse	3.8%	5.0%	3.6%
Heroin Use	0.2%	0.4%	0.2%
Cocaine Use	1.8%	5.0%	1.4%
Methamphetamine Use	0.4%	0.5%	0.4%
Pain Reliever Use Disorder	0.7%	0.7%	0.7%
Illicit Drug Use Disorder	2.4%	6.8%	1.8%
Alcohol Use Disorder	4.1%	7.1%	3.7%

Due to changes in the wording of the questions in the NSDUH, continuous trends are only available for a few select measures. Trends in the past-year prevalence of cocaine use, marijuana use, and alcohol use disorders among adults ages 18 and older are presented in the table below.[71] Between 2008-2009 and 2018-2019, the prevalence of cocaine use among adults in Florida is essentially flat. The prevalence of marijuana use increased from 9.9% up to 15.0%, while the prevalence of alcohol use disorders decreased from 7.2% down to 4.2%.

Prevalence of Cocaine Use, Marijuana Use, and Alcohol Use Disorders in the Past Year Among Adults Ages 18 and Older in Florida (2008-2019)						
	2008-2009	2010-2011	2012-2013	2014-2015	2016-2017	2018-2019
Cocaine Use	1.9%	1.7%	1.9%	2.0%	2.1%	1.8%
Marijuana Use	9.9%	10.7%	11.2%	12.5%	13.7%	15.0%
Alcohol Use Disorder	7.2%	6.1%	6.4%	6.2%	5.6%	4.2%

Based on input from various partners, including Managing Entities, prevention providers, and community-based organizations, the following activities are of particular strategic importance to Florida's prevention system: (1) Targeting prevention resources to individuals and 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. Since then, the Department has conducted in-depth reviews of the evidence behind various prevention programs and developed a list of programs to be prioritized for future evaluations. A detailed descriptive report on environmental prevention strategies (that aim to reduce youth access to alcohol and other drugs) was developed to guide the field toward resources for evaluating the effectiveness of these efforts. The objectives within the associated primary prevention performance indicator build on this prior work and set the stage for future changes to the prevention system that direct resources toward rigorously tested programs that reduce the use of alcohol and other substances while also preventing interrelated problems, like symptoms of depression, suicide-related thoughts and behaviors, and Adverse Childhood Experiences.

#8 Priority Area: Primary Drug Prevention

Priority Type: Substance Abuse Prevention (SAP)

Required Population: Primary Prevention (PP)

Goal: Promote evidence-based prevention services delivered by a professional prevention workforce.

Objectives:

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

(2) Identify and increase access to evidence-based drug prevention programs that also have experimental evidence of effectiveness at preventing symptoms of depression.

(3) Identify and increase access to evidence-based drug prevention programs that also have experimental evidence of effectiveness at preventing suicide-related thoughts and behaviors.

(4) Identify and increase access to programs that address Adverse Childhood Experiences by helping parents and youth build skills to manage stress and emotions.

(5) Publish a proposal to reallocate set-aside funds from ineffective programs or untested programs to effective programs.

(6) Develop and administer a prevention workforce survey to identify gaps in the prevention workforce and publish recommendations for addressing the identified gaps.

(7) Implement at least two of the published recommendations based on the prevention workforce survey findings.

Indicator: The number of objectives achieved.

Baseline (FY 20-21): Zero objectives completed.

First Year (FY 21-22) Target: By June 30, 2022, achieve 3 out of the 7 objectives.

Second-Year (FY 22-23) Target: By June 30, 2023, achieve 5 out of the 7 objectives.

The State Epidemiological Outcomes Workgroup (SEOW)

Florida's State Epidemiological Outcomes Workgroup (SEOW) assists with state, regional, and community drug-related morbidity and mortality surveillance. Membership (n = 27) consists of epidemiologists and individuals who are knowledgeable about substance use issues including prevention, intervention, and treatment. Participating entities include 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. The participating DENs are in Broward, Duval, Hillsborough, Manatee, Palm Beach, Taylor, Walton, and Washington counties. Both the SEOW and individual DENs produce annual reports that are reviewed by the Department and incorporated into strategic initiatives as appropriate. Fentanyl and fentanyl-analogs continue to drive overdoses, including deaths involving stimulants like cocaine and methamphetamine. According to the 2020 *Interim Report of Drugs Identified in Deceased Persons by Florida Medical Examiners*, fentanyl has now displaced alcohol as the most frequently detected substance among decedents. 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 2019 SEOW Report is available on the Department's publication website. An updated SEOW Report is currently under development.

Suicide Prevention Through Substance Use Prevention

According to the Florida Department of Health, there were 3,427 deaths due to suicide in 2019, in addition to 12,514 hospitalizations for non-fatal self-inflicted injuries. Suicide is the second leading cause of death for Floridians ages 10 to 34 years old.[72] In 2018-2019, the prevalence of serious thoughts of suicide in the past year was 4.0% among adults 18 and older. Among Floridians ages 18-25, the prevalence of serious thoughts of suicide increased significantly from 6.1% in 2008-2009 up to 10.8% in 2018-2019.[73] A multivariate analysis of Florida high school students demonstrated that tobacco use, alcohol use, and depressive symptoms were all significantly associated with increased odds of suicide ideation. Tobacco use, alcohol use, marijuana use, and depressive symptoms were all significantly associated with increased odds of both suicide planning and suicide attempts. Adverse Childhood Experiences, namely measures of interpersonal violence, were also significantly associated with these measures of suicidality.[74]

According to a meta-analysis of 30 longitudinal studies, there is a positive and significant association between alcohol use and both fatal and nonfatal suicide attempts. Alcohol use increases the probability of suicidal attempts by 110% and the probability of suicide mortality by 65%. However, in this meta-analysis, the association between alcohol and suicide ideation is not significant.[75] According to a more recently published meta-analysis of 48 studies (spanning 1995 to 2020), among patients with substance use disorders, the pooled prevalence of past-year suicide ideations is 35% and the prevalence suicide attempts is 20%. These rates are higher than the rates observed among the general population. Smoking, a history of sexual abuse, depression, and alcohol and cannabis use disorders are significantly associated with suicide ideations. Being female, having a history of physical and sexual abuse, depression, substance use, and polysubstance use are significantly associated with suicide attempts.[76] Given the interrelationship between suicide risk and substance use, reducing the use of alcohol and other drugs is a way to reduce-related experiences. A recently published meta-analysis of individual-level psychological interventions designed to reduce alcohol use revealed a modest decrease in self-harm (encompassing non-suicidal self-injury and attempted suicide), but not suicidal ideation.[77] Another meta-analysis of studies conducted among individuals with substance use disorders found evidence of reduced self-harm following Cognitive Behavioral Therapy and Dialectical Behavioral Therapy interventions.[78] With respect to *population-level* interventions, typically involving restrictions on alcohol availability, a recent systematic literature review showed that most studies found an association with reduced suicides or self-harm, predominantly among males.[79]

According to SAMHSA, "Alcohol and drug misuse are second only to depression and other mood disorders as the most frequent risk factors for suicidal behavior…People at risk for suicide and substance misuse share a number of risk factors that include depression, impulsivity, and thrill-seeking/life threatening behaviors. Because risk and protective factors for the two can overlap, prevention professionals need to be aware of them and to implement prevention programming that reduces risk and enhances protective factors."[80] Substance use is more than a risk factor for suicide, it is a mechanism/means of dying by suicide. For example, according to 2020 interim data from Florida Medical Examiners, approximately 13-18% of deaths caused by sedatives (i.e., alprazolam, diazepam, and clonazepam) in Florida are suicides. With respect to opioids, approximately 15% of deaths caused by oxycodone and 24% of deaths caused by hydrocodone are suicides.[81] Prevention efforts targeting access to pharmaceutical sedatives and opioids are therefore part and parcel of reducing suicides by increasing safe storage practices and decreasing access to lethal means.

The Florida Governor's Challenge team is an interdisciplinary team of suicide prevention experts charged with the development and implementation of a state plan to prevent suicide among service members, veterans, and their families. The Governor's Challenge team plan advances the U.S. Department of Veterans Affairs' National Strategy for Preventing Veteran Suicide (2018-2028) and incorporates evidence-based strategies from the CDC's Preventing Suicide:

A Technical Package of Policy, Programs, and Practices.[82] Florida is home to 21 military bases and 1.5 million veterans. According to the most recently published report, 557 Florida veterans died by suicide in 2018. The Florida veteran suicide rate (36.8 per 100,000) is higher than the rate observed among southern states (32.3 per 100,000).[83] The Florida Governor's Challenge Team is prioritizing lethal means safety and safety planning, with a specific goal to increase naloxone (the opioid overdose antidote) distribution and reduce overdoses.[84]

Florida's 2020-2023 Florida Suicide Prevention Interagency Action Plan deploys the Social-Ecological Model for suicide prevention, and identifies four focus areas and eleven strategies to decrease suicide experiences among Floridians. This model targets risk factors for suicide such as easy access to lethal methods, the use of alcohol and other substances, depression, and a family history of child maltreatment. Strategies include promoting the use of evidence-based interventions that target suicide risk, facilitating interagency collaboration to improve access to mental health care, provision of caring follow-up and support to communities and individuals after a suicide event, and increasing the provision of life skills training programs that address critical thinking, stress management, and coping, to help Floridians safely address stressors and challenges.[85] Another strategy entails increasing awareness of existing behavioral health and suicide prevention resources. Florida's First Lady Casey DeSantis recently announced expansions to the Hope for Healing website: www.HopeForHealingFL.com. Since 2019, the Hope for Healing initiative has helped people access a variety of public and private sector prevention and intervention resources, while addressing the stigma that often deters individuals from seeking help.[86] In 2021, additional resources were added to the website, which now reflects resources from several state agencies, including the Department of Children and Families, Department of Education, Department of Elder Affairs, Department of Veterans' Affairs, Department of Health, and the Division of Emergency Management. First Lady Casey DeSantis' Hope Ambassadors program, which is a critical component of Hope for Healing, is creating settings where students can volunteer, mentor their peers, and develop leadership skills and resiliency. As part of this pilot program, 25 schools started Hope Ambassador clubs in 2020-2021, where they tackled topics like homelessness, confronting risks for substance use, and how to ask for help and navigate available resources. The clubs also utilized social media to encourage students to boost and promote healthier conversations.[87] Additionally, the Florida Children and Youth Cabinet, chaired by First Lady DeSantis, is examining the stigma around mental illness and suicide among minority communities. According to the most recent update, peer support is the principal theme emerging from workgroup meetings and discussions about stigma and resiliency.[88]

Recovery Support Services and Recovery-Oriented Systems of Care

The Department supports the provision of peer recovery support services and the development of Recovery Community Organizations (RCOs). In Florida, RCOs organize recovery-focused advocacy activities, carry out recovery-focused community education, outreach, and peer-based recovery support services. They work closely with community treatment providers and other stakeholders to provide harm reduction and recovery support services. RCOs use the Recovery Capital Scale as a component of the recovery planning process. Recovery capital is conceptually linked to natural recovery, solution-focused therapy, strengths-based case management, recovery management, resilience and protective factors, wellness, and sustained recovery. Currently there are 11 existing RCOs in Florida, as well as 13 RCOs in the early development phase, 7 in the emerging phase, and 2 in the early interest phase. RCO development is integral to advancing the vision of a recovery-oriented system of care, which entails a shift from a purely reactive, stabilization-based, acute care model of service delivery to a recovery model, which focuses attention on prevention, early intervention, harm reduction, and wellness. Associated objectives call for the Department to increase the number of RCOs in the early development phase from 13 up to 15 and to increase the number of RCOs that have transitioned from the early development phase to the existing/established stage from 11 up to 13. Additionally, an objective calls for increasing the number of RCOs that apply for accreditation through the Council on Accreditation of Peer Recovery Support Services from 3 up to 5.

The Department collaborates with Faces & Voices of Recovery (FAVOR) and the Florida Behavioral Health Association to build the capacity of RCOs through training and technical assistance, virtual RCO mentorship, RCO Bootcamp, and introductions to accreditation standards. FAVOR is a nationally recognized RCO that works to support individuals in long-term recovery from substance use disorders and their family members, friends, and allies in a variety of ways. Services include capacity building in support of the national recovery movement, fighting the stigma of addiction and creating recovery messaging trainings. FAVOR assists local communities of recovery, community partners, and Managing Entities with helping RCOs become accredited through the Council on Accreditation of Peer Recovery. Additionally, Floridians for Recovery, a statewide RCO network, hosted a Statewide Recovery Leadership Summit with over 150 recovery leaders in attendance. Additionally, the State Mental Health Treatment Facilities are using champions, workgroups, monthly calls, and summits to embed the recovery-oriented framework throughout operations and programs. The Department also deploys Recovery Oriented Quality Improvement Specialists (ROQIS) – individuals in recovery with lived experience in the behavioral health system of care – to engage in on-going quality assurance and improvement activities, support the implementation and enhancement of recovery approaches and services, and promote effective engagement and care coordination strategies. In addition, ROQIs provide technical assistance and consultation to promote the expansion of effective outreach and engagement, medicated assisted treatment, and care coordination services. An associated objective entails analyzing billing codes for various peer services, and publishing a list of recommendations to break-out and specify new codes, as needed, to improve the management and monitoring of these services.

In partnership with the Florida Certification Board, the Department developed a process and protocol for onsite recovery-oriented monitoring, which includes reviews of facilities and medical records, and interviews with employees and persons served. This innovative program uses evidence-based measures of recovery principles and applies these measures to service provider organizations. A recovery-oriented quality improvement component was added to the State's traditional quality improvement monitoring practices for contracted mental health and substance use provider organizations. A blueprint details the rationale, procedures, and tools used for this new component. Clinical record reviews review a source of potential evidence of recovery-oriented principles and practices that are recorded within persons served clinical charts to identify and measure evidence across 7 domains: Meeting Basic Needs, Medication-Assisted Treatment, Strengths-Based Approach, Customization and Choice, Opportunity to Engage in Self-Determination, Network Supports/Community Integration, and Recovery Focus. The Measuring Recovery-Oriented Principles and Practices Tool breaks down each domain and describes the kind of information that should be present to address that principle. Preliminary analysis of recovery practices documented in medical record reviews shows that providers are scoring highest in the domain of Strength-based Planning (average score of 3.2 on a 5-point scale) and lowest in the domain of Recovery Focus (average score of 2.1 on a 5-point scale). To bolster ROSC capacity and quality data monitoring and reporting, an associated objective calls for the Department to develop and pilot a statewide provider-level tracking system for recovery domain scores obtained during Recovery-Oriented Quality Improvement monitoring visits, in part to see if the subsequent training/TA is having an impact. Another objective calls for maintaining high scores within the four core domains of recovery (among providers with an established baseline score). Scores will also be used to help describe and evaluate the impact of Department's new contractual guidance on Recovery Management Practices (Guidance Document 35). The impact of the new Guidance Document may also be observed through responses to the Department's recently revised Consumer Satisfaction Survey. Associated objectives call for the Department to publish a report describing and evaluating the impact of recent changes and enhancements to the Consumer Satisfaction Survey, as well as the impact of the new Guidance Document.

The final objective calls for Neonatal Abstinence Syndrome/Substance Exposed Newborn (NAS/SEN) Care Coordinators to provide training on how to link pregnant women with substance use disorders to peer recovery support services through RCOs. This may include exploration of the continued role for telehealth in the provision of support services for pregnant and parenting women. Interviews with women who participated in integrated care for substance use disorders reveal that peer support, from a woman with lived experience with a substance use disorder during pregnancy, benefits them by sustaining engagement in treatment, bolstering accountability for participating in treatment, and improving

access to well-coordinated medical and social support and resources.[89] The ability to connect with other women who understand both addiction and motherhood was a crucial benefit identified by all participants. This initiative will also mutually support the separate performance indicator that aims to increase rates of successful program completion among pregnant women with substance use disorders.

#9 Priority Area: Recovery Support Services and Recovery Oriented Systems of Care

Priority Type: Substance Abuse Treatment (SAT) and Mental Health Services (MHS)

Required Population: PWWDC, PWID, and SMI

Goal: Establish an integrated, value-based Recovery Oriented System of Care where recovery is expected and achieved through meaningful partnerships and shared decision-making.

Objectives:

(1) Develop and pilot a statewide provider-level tracking system for recovery domain scores obtained during Recovery-Oriented Quality Improvement monitoring visits.

(2) Maintain a score of "4" or higher in each of the four core domains of recovery (among providers with an established baseline score).

(3) Increase the number of RCOs in the early development phase from 13 up to 15.

(4) Increase the number of RCOs that have transitioned from the early development phase to the existing/established stage from 11 up to 13.

(5) Increase the number of RCOs that apply for accreditation through the Council on Accreditation of Peer Recovery Support Services from 3 up to 5.

(6) Analyze variation in billing codes for peer services and publish a list of recommendations to break-out and specify new codes as needed.

(7) Publish a report describing and evaluating the impact of recent changes and enhancements to the Consumer Satisfaction Survey.

(8) Publish a report describing and evaluating the impact of the new Recovery Management Practices contract Guidance Document 35.

(9) Neonatal Abstinence Syndrome/Substance Exposed Newborn (NAS/SEN) Care Coordinators will provide training on how to link pregnant women with substance use disorders to peer recovery support services through RCOs.

Indicator: The number of objectives achieved.

Baseline (FY 20-21): Zero objectives achieved.

First Year (FY 21-22) Target: By June 30, 2022, achieve 1 out of the 9 objectives.

Second Year (FY 22-23) Target: By June 30, 2023, achieve 3 out of the 9 objectives.

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Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Mobile Crisis Response Team Diversions

Priority Type: MHS

Population(s): SMI, SED, Other (Adolescents w/SA and/or MH, Crisis)

Goal of the priority area:

Ensure Mobile Response Teams maintain high diversion rates.

Strategies to attain the goal:

The Department will monitor performance on an ongoing basis and offer training and technical assistance resources as needed to maintain performance standards.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The percent of MRT calls requiring an acute response that are diverted from an involuntary examination.

Baseline Measurement: In FY 20-21, 81.1% of MRT calls requiring an acute response were diverted from an involuntary examination.

First-year target/outcome measurement: At least 82% of MRT calls requiring an acute response are diverted from an involuntary examination.

Second-year target/outcome measurement: At least 83% of MRT calls requiring an acute response are diverted from an involuntary examination.

Data Source:

MRT Cumulative Data tracking spreadsheet.

Description of Data:

The numerator is the number of calls requiring an acute response that were diverted from an involuntary examination and the denominator is the number of calls requiring an acute response. For the 2020-2021 baseline, the numerator is 13,506 calls diverted, and the denominator is 16,651 calls requiring an acute response.

Data issues/caveats that affect outcome measures:

None.

Priority #: 2

Priority Area: Intensive Team-Based Services (CAT Teams for Children with SED)

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Expand intensive, team-based services to children with serious emotional disturbances (SED).

Strategies to attain the goal:

Department representatives will educate various community partners on the eligibility, goals, approach to treatment, and location of current CAT teams to help generate more referrals.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of children with Serious Emotional Disturbance (SED) served by Community Action Teams.

Baseline Measurement: In FY 20-21, 3,423 children were served by Community Action Teams.

First-year target/outcome measurement: By June 30, 2022, increase the number of children served by 50 (for a total of 3,473 children served)

Second-year target/outcome measurement: By June 30, 2023, increase the number of children served by 50 (for a total of 3,523 children served)

Data Source:

The data source is the CAT monthly supplemental data reports.

Description of Data:

This is the total number of young people served, unduplicated across all CAT teams.

Data issues/caveats that affect outcome measures:

None.

Priority #: 3

Priority Area: Intensive Team-Based Services (Florida Assertive Community Treatment)

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Increase functioning among individuals served by FACT teams.

Strategies to attain the goal:

The Department is exploring the use of a tool for measuring the fidelity of implementation of assertive community treatment services, and may pilot its implementation in the near future. Also, FACT teams are required to incorporate this indicator as a performance measure, pursuant to the contract Guidance Document 16 (FACT Handbook).

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The percent of FACT clients served by the Department that either maintain or improve their level of functioning.

Baseline Measurement: 75% of FACT clients served by the Department maintained or improved their level of functioning in FY 20-21.

First-year target/outcome measurement: At least 77% of FACT clients served by the Department will either maintain or improve their level of functioning.

Second-year target/outcome measurement: At least 78% of FACT clients served by the Department will either maintain or improve their level of functioning.

Data Source:

Quarterly Contract reports.

Description of Data:

The numerator is the number of FACT clients served by the Department that either maintained or improved their level of functioning. The denominator is the total number of FACT clients served by the Department. For these purposes, the Department will consider the performance of FACT teams that use the same assessment (FARS). Each individual served will be counted once using the most recently

available sequentially administered FARS scores.

Data issues/caveats that affect outcome measures:

None

Priority #: 4

Priority Area: Services for Pregnant Women and Women with Dependent Children

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Improve services for pregnant women.

Strategies to attain the goal:

The Department will monitor discharges on an ongoing basis in coordination with regional Department representatives, Managing Entities, and Neonatal Abstinence Syndrome/Substance Exposed Newborn (NAS/SEN) Care Coordinators, and headquarters subject matter experts. Obstacles to successful completion will be described and analyzed. The Department will also identify and promote relevant training materials designed to improve retention and completion rates. The Women's Services Coordinator is responsible for reviewing data submitted by the Managing Entities, addressing discrepancies, completing quarterly reports, and sharing resources. Additionally, the Statewide NAS/SEN Care Coordinator is responsible for overseeing a statewide coordinated response across programs for families at risk of or with infants born substance exposed and for providing guidance to six regional NAS/SEN Care Coordinators. The Department also continues to contract with the Florida Association of Alcohol and Drug Abuse and the Florida Certification Board to provide online trainings and resources on evidence-based practices and treatment specific to pregnant women.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The percent of discharges among pregnant women that are successful.

Baseline Measurement: In FY 20-21, 61.3% of discharges among pregnant women were successful.

First-year target/outcome measurement: By June 30, 2022, increase the percentage of pregnant women discharges that are successful by 2 percentage points (from 61.3% up to 63.3%).

Second-year target/outcome measurement: By June 30, 2023, increase the percentage of pregnant women discharges that are successful by 2 percentage points above the FY 21-22 performance.

Data Source:

The Department's Financial and Services Accountability Management System (FASAMS)

Description of Data:

The numerator is the number of pregnant women discharges reflecting successful completion, comprised of three discharge reason codes: (1) successfully completed treatment, (2) successfully completed transfer to another program/facility, and (3) successfully completed transfer to another program/facility that is not in the reporting system. The denominator is the number of all pregnant women discharges.

Data issues/caveats that affect outcome measures:

None.

Priority #: 5

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

Priority Type: MHS

Population(s): ESMI

Goal of the priority area:

Improve functioning or symptom severity among individuals served by Coordinated Specialty Care (CSC) for Early Serious Mental Illness (ESMI) programs.

Strategies to attain the goal:

The Department will monitor progress, periodically consult with the teams regarding obstacles, and secure any training/TA needed to address inadequate progress.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The percent of individuals served by CSC-ESMI teams that experience improvements in functioning or symptom severity.

Baseline Measurement: 80% of individuals served by CSC for ESMI programs experienced improvements in functioning or symptom severity (FY 20-21).

First-year target/outcome measurement: At least 80% of individuals served by CSC for ESMI in FY 21-22 experience improvements in functioning or symptom severity.

Second-year target/outcome measurement: At least 80% of individuals served by CSC for ESMI in FY 22-23 experience improvements in functioning or symptom severity.

Data Source:

Data is reported by the CSC-ESMI teams and based on various instruments measuring functional improvement, including the Brief Psychiatric Rating Scale and Basis-32.

Description of Data:

The numerator is the unduplicated number of initial/baseline assessments. The denominator is the unduplicated number of the most recent subsequent assessments showing improvements in functioning or symptom severity.

Data issues/caveats that affect outcome measures:

None.

Priority #: 6

Priority Area: Infectious Disease Control

Priority Type: SAT

Population(s): PWID, EIS/HIV

Goal of the priority area:

Ensure the implementation of Florida’s HIV EIS set-aside is cost-effective.

Strategies to attain the goal:

The Department analyze historical provider-level variation in test positivity rates to identify factors associated with both high and low performance, and share findings and recommendations with any underperforming providers.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The percent of HIV tests that are positive (among providers reporting at least one positive test).

Baseline Measurement: In FY 20-21, the percent of HIV tests that were positive (among providers reporting at least one positive test) was 1.01%.

First-year target/outcome measurement: In FY 21-22, the percent of HIV tests that are positive (among providers reporting at least one positive test) will be at or above 0.10%

Second-year target/outcome measurement: In FY 22-23, the percent of HIV tests that are positive (among providers reporting at least one positive test) will be at or above 0.10%

Data Source:

Data are self-reported by providers through contract Template 2 (SAMH Block Grant Reporting Template).

Description of Data:

The numerator is the number of positive HIV tests and the denominator is the total number of tests administered.

Data issues/caveats that affect outcome measures:

None

Priority #: 7

Priority Area: Infectious Disease Control

Priority Type: SAT

Population(s): TB

Goal of the priority area:

Prevent the spread of tuberculosis (TB) through screening of at-risk individuals and behavioral health services that support TB medication adherence and TB treatment completion.

Strategies to attain the goal:

Collaborate with the Department of Health regarding opportunities to convey behavioral health resources and training opportunities.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The tuberculosis case rate (per 100,000).

Baseline Measurement: Florida's 2020 tuberculosis case rate was 1.9 per 100,000.

First-year target/outcome measurement: Maintain a 2021 tuberculosis case rate at or below 2.5 per 100,000.

Second-year target/outcome measurement: Maintain a 2022 tuberculosis case rate at or below 2.0 per 100,000.

Data Source:

Tuberculosis cases per 100,000 come from the Florida Department of Health and are published at www.flhealthcharts.com.

Description of Data:

For the baseline (Calendar Year 2020), the numerator is 412 tuberculosis cases, and the denominator is 21,640,766 individuals, yielding a rate of 1.9 per 100,000.

Data issues/caveats that affect outcome measures:

None.

Priority #: 8

Priority Area: Primary Prevention

Priority Type: SAP

Population(s): PP, Other (Adolescents w/SA and/or MH, Children/Youth at Risk for BH Disorder)

Goal of the priority area:

Promote evidence-based prevention services delivered by a professional prevention workforce.

Strategies to attain the goal:

With respect to identifying programs with evidence of effectiveness at reducing substance use, symptoms of depression, and suicide-related thoughts and behaviors, the Title IV-E Prevention Services Clearinghouse will be consulted for reviews of the evidence on mental health, substance use, and

parent skill-based programs/services. Archived evidence reviews previously hosted on SAMHSA's NREPP will also be examined. With respect to the evidence for environmental prevention strategies, the Department may consult standards established by the Society of Prevention Research in Standards of Evidence for Efficacy, Effectiveness, and Scale-up Research in Prevention Science: Next Generation (2015) and the Centers for Disease Control and Prevention's Guide to Community Preventive Services. Progress toward the objectives will be monitored and discussed on recurring conference calls between the Department's Prevention Coordinator and each Managing Entity's Prevention Coordinator.

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: By June 30, 2022 achieve 3 out the 7 objectives.

Second-year target/outcome measurement: By June 30, 2023, achieve 5 out of the 7 objectives.

Data Source:

All information associated with the objectives that comprise the performance indicator (i.e., program lists, priorities, surveys, recommendations, process measures, proposals, etc.) will be reported by the Department's Prevention Coordinator.

Description of Data:

The data varies from objective to objective, but it includes published reports, program lists, priorities, surveys, recommendations, and proposals.

Data issues/caveats that affect outcome measures:

None.

Priority #: 9

Priority Area: Recovery Support Services and Recovery Oriented Systems of Care

Priority Type: SAT, MHS

Population(s): SMI, SED, PWWDC, ESMI, PWID, Other (Adolescents w/SA and/or MH, Criminal/Juvenile Justice, Homeless, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Establish an integrated, values-based Recovery Oriented System of Care where recovery is expected and achieved through meaningful partnerships and shared decision-making.

Strategies to attain the goal:

The Department's Statewide Coordinator of Integration and Recovery Services will collaborate with system partners on each of the objectives.

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: By June 30, 2022, achieve 1out of the 9 objectives.

Second-year target/outcome measurement: By June 30, 2023 achieve 3 out of the 9 objectives.

Data Source:

All information regarding the completion of each objective will be reported by the Department's Statewide Coordinator of Integration and Recovery Services.

Description of Data:

The data varies from objective to objective, but it includes published reports, published analyses, and RCO development phase reports.

Data issues/caveats that affect outcome measures:

None.

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

Footnotes:

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 2022/2023.
ONLY include funds expended by the executive branch agency administering the SABG.

Planning Period Start Date: 7/1/2021 Planning Period End Date: 6/30/2023

Activity (See instructions for using Row 1.)	Source of Funds									
	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SABG)[a]	J. ARP Funds (SABG)[b]
1. Substance Abuse Prevention[c] and Treatment	$155,945,846.00		$0.00	$36,418,892.00	$254,017,478.00	$0.00	$0.00		$73,648,729.00	$21,391,544.00
a. Pregnant Women and Women with Dependent Children[c]	$5,000,000.00				$20,000,000.00					
b. All Other	$150,945,846.00			$36,418,892.00	$234,017,478.00				$73,648,729.00	$21,391,544.00
2. Primary Prevention[d]	$44,555,956.00		$0.00	$0.00	$0.00	$0.00	$0.00		$20,879,345.00	$359,542.00
a. Substance Abuse Primary Prevention	$44,555,956.00								$20,879,345.00	$359,542.00
b. Mental Health Primary Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Tuberculosis Services										
5. Early Intervention Services for HIV	$11,138,989.00								$5,219,836.00	
6. State Hospital										
7. Other 24-Hour Care										
8. Ambulatory/Community Non-24 Hour Care										
9. Administration (excluding program/provider level) MHBG and SABG must be reported separately	$11,138,989.00			$8,045,618.00	$24,157,494.00				$4,648,809.00	$664,115.00
10. Crisis Services (5 percent set-aside)										
11. Total	**$222,779,780.00**	**$0.00**	**$0.00**	**$44,464,510.00**	**$278,174,972.00**	**$0.00**	**$0.00**	**$0.00**	**$104,396,719.00**	**$22,415,201.00**

[a] The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between July 1, 2021 – March 14, 2023 should be entered in Column I.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between September 1, 2021 and June 30, 2023 should be entered in Column J.

[c] Prevention other than primary prevention

[d] The 20 percent set aside funds in the SABG must be used for activities designed to prevent substance misuse.

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Footnotes:

*Represents 2-year budget estimates.
**Column A represent Federal Award Estimate

Planning Tables

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 2022/2023.
Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: 7/1/2021 Planning Period End Date: 6/30/2022

Activity (See instructions for using Row 1.)	Source of Funds									
	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SABG)	J. ARP Funds (MHBG)[b]
1. Substance Abuse Prevention and Treatment										
a. Pregnant Women and Women with Dependent Children										
b. All Other										
2. Primary Prevention										
a. Substance Abuse Primary Prevention										
b. Mental Health Primary Prevention[e]										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[d]		$9,900,000.00						$5,526,348.00		$9,480,736.00
4. Tuberculosis Services										
5. Early Intervention Services for HIV										
6. State Hospital				$172,579,632.00	$585,480,932.00					
7. Other 24-Hour Care		$9,864,446.00		$4,142,094.00	$23,958,328.00			$5,480,542.00		$9,859,965.00
8. Ambulatory/Community Non-24 Hour Care		$66,015,902.00	$9,735,942.00	$27,720,166.00	$160,336,506.00			$36,677,469.00		$65,985,919.00
9. Administration (excluding program/provider level)[f] MHBG and SABG must be reported separately		$4,776,058.00	$1,043,970.00	$1,508,158.00	$797,294.00			$2,401,371.00		$4,740,368.00
10. Crisis Services (5 percent set-aside)[g]		$4,964,748.00			$36,600,000.00			$4,802,740.00		$4,740,368.00
11. Total	**$0.00**	**$95,521,154.00**	**$10,779,912.00**	**$205,950,050.00**	**$807,173,060.00**	**$0.00**	**$0.00**	**$54,888,470.00**	**$0.00**	**$94,807,356.00**

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard SABG expenditures are for the state planned expenditure period of July 1, 2021 – June 30, 2023, for most states.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025,** which is different from expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A-G are for the state planned expenditure period of July 1, 2021 - June 30, 2022, for most states

[d] Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside.

[e] While a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

[f] Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

[g] Row 10 should include Crisis Services programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

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

Footnotes:

Florida plans to expend $36,414,005 in SFY 2021-22 and $18,474,465 in SFY 2022-23 of Covid-19 Relief Funding. $12,000,000 of ARP funds are planned for use in SFY 21-22 for a First Responder Crisis Hotline. Utilization of $35,701,840 of ARP funding is planned to begin in SFY 2022-23. - NW

*Period revised to reflect estimated two-year expenditure period per request from federal PO.
**Based on current state fiscal year AOB.
***Column A represents estimated federal award.

Column J revised at PO request to reflect total ARP award and set aside percentages. The state will be expending these funds over the course of multiple state fiscal years through September 2025. - NW

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	7,000	1,703
2. Women with Dependent Children	22,406	14,736
3. Individuals with a co-occurring M/SUD	544,912	15,616
4. Persons who inject drugs	20,001	12,133
5. Persons experiencing homelessness	3,047	8,216

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

No cells are blank.

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

Footnotes:

1a (Pregnant Women in Need): Estimates of the past-year of prevalence of illicit drug and/or alcohol dependence/abuse from SAMHSA's Restricted Use Data Analysis System (RDAS) using 2015-2018 NSDUH data indicate that 6% of pregnant women in Florida (weighted count = 7,000) experienced past-year illicit drug and/or alcohol dependence/abuse. [SOURCE: Substance Abuse and Mental Health Services Administration. (2021). National Survey on Drug Use and Health: 4-Year RDAS (2015 to 2018). Restricted Online Data Analysis System (RDAS). Row Variable = UDPYILAL; Column Variable = PREGNANT; Control Variable = STNAME (Florida)].

1b (Pregnant Women in Treatment): FY 19-20 records from the Department's Financial and Services Accountability Management System (FASAMS)

2a (Women with Dependent Children in Need): According to 2019 estimates from the American Community Survey (ACS), there are 400,109

female householders (no spouse/partner present) with children under age 18 in Florida. Additionally, according to 2018-2019 NSDUH estimates, approximately 5.6% of adults in Florida needed treatment for substance use but did not receive it. The aggregate number estimated in need was calculated by applying 5.6% to the number of women with dependent children. [SOURCES: United States Census Bureau. (2021). 2019: ACS 5-Year Estimates Data Profiles - Florida. TableID: DP02; Substance Abuse and Mental Health Services Administration. (2021). Table 30: Selected Measures in Florida, Annual Averages Based on 2018-2019 NSDUHs].

2b (Women with Dependent Children in Treatment): FY 19-20 records from the Department's Financial and Services Accountability Management System (FASAMS)

3a (Individuals with Co-Occurring Disorders in Need): According 2019 NSDUH estimates, approximately 3.2% of adults in the South U.S. experienced past-year co-occurring substance use disorder and any mental illness. This prevalence rate was applied to the number of adults in Florida (17,028,476) to produce the estimated number in need. [SOURCES: Substance Abuse and Mental Health Services Administration. 2019 NSDUH Detailed Tables. Table 8.10B. Retrieved from https://www.samhsa.gov/data/report/2019-nsduh-detailed-tables]; Florida Department of Health. (2020). FLHealthCHARTS Population Query System. 2019 Population by County by Year, Age = 18 and older].

3b (Individuals with Co-Occurring Disorders in Treatment): FY 19-20 records from the Department's Financial and Services Accountability Management System (FASAMS)

4a (Persons Who Inject Drugs in Need): According to an algorithm-based analysis of hospitalizations for injection-related infections in Florida from 2017, there are 20,001 individuals who inject drugs in Florida [SOURCE: Coye, A. E., et al. (2021). A Missed Opportunity: Underutilization of Inpatient Behavioral Health Services to Reduce Injection Drug Use Sequelae in Florida. Substance Abuse Treatment, Prevention, and Policy, 16(46)].

4b (Persons Who Inject Drugs in Treatment): FY 19-20 records from the Department's Financial and Services Accountability Management System (FASAMS)

5a (Persons Experiencing Homelessness in Need): According to 2021 Point-In-Time counts of individuals who are homeless, 3,047 individuals (or about 14%) reported experiencing a substance use disorder.[SOURCE: Florida’s Council on Homelessness. (2021). Florida’s Council on Homelessness 2021 Annual Report. Retrieved from https://www.myflfamilies.com/service-programs/homelessness/docs/2021CouncilReport.pdf.]

5b (Persons Experiencing Homelessness in Treatment): FY 19-20 records from the Department's Financial and Services Accountability Management System (FASAMS)

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Expenditure Category	FFY 2022 SA Block Grant Award	COVID-19 Award[1]	ARP Award[2]
1 . Substance Use Disorder Prevention and Treatment[3]	$77,972,923.00	$73,648,729.00	$21,391,544.00
2 . Primary Substance Use Disorder Prevention	$22,277,978.00	$20,879,345.00	$359,542.00
3 . Early Intervention Services for HIV[4]	$5,569,495.00	$5,219,836.00	$0.00
4 . Tuberculosis Services	$0.00	$0.00	$0.00
5 . Administration (SSA Level Only)	$5,569,494.00	$4,648,809.00	$664,115.00
6. Total	**$111,389,890.00**	**$104,396,719.00**	**$22,415,201.00**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in this column.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in this column.

[3]Prevention other than Primary Prevention

[4]For the purpose of determining which states and jurisdictions 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 (SABG); 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 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 required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services 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'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.

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

Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

A		B		
Strategy	IOM Target	FFY 2022		
		SA Block Grant Award	COVID-19[1]	ARP[2]
1. Information Dissemination	Universal	$534,671	$501,105	$8,629
	Selective	$267,336	$250,552	$4,315
	Indicated	$89,112	$83,517	$1,438
	Unspecified	$0	$0	$0
	Total	**$891,119**	**$835,174**	**$14,382**
2. Education	Universal	$4,411,040	$4,134,110	$71,189
	Selective	$2,205,520	$2,067,055	$35,595
	Indicated	$735,173	$689,018	$11,865
	Unspecified	$0	$0	$0
	Total	**$7,351,733**	**$6,890,183**	**$118,649**
3. Alternatives	Universal	$534,670	$501,105	$8,628
	Selective	$267,336	$250,552	$4,315
	Indicated	$89,112	$83,517	$1,438
	Unspecified	$0	$0	$0
	Total	**$891,118**	**$835,174**	**$14,381**
4. Problem Identification and Referral	Universal	$2,138,686	$2,004,417	$34,516
	Selective	$1,069,343	$1,002,209	$17,258
	Indicated	$356,448	$334,070	$5,753
	Unspecified	$0	$0	$0
	Total	**$3,564,477**	**$3,340,696**	**$57,527**
	Universal	$5,480,383	$5,136,319	$88,447

5. Community-Based Process	Selective	$2,740,191	$2,568,159	$44,224
	Indicated	$913,397	$856,053	$14,741
	Unspecified	$0	$0	$0
	Total	**$9,133,971**	**$8,560,531**	**$147,412**
6. Environmental	Universal	$267,336	$250,552	$4,315
	Selective	$133,668	$125,276	$2,157
	Indicated	$44,556	$41,759	$719
	Unspecified	$0	$0	$0
	Total	**$445,560**	**$417,587**	**$7,191**
7. Section 1926 Tobacco	Universal	$0	$0	$0
	Selective	$0	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$0**	**$0**	**$0**
8. Other	Universal	$0	$0	$0
	Selective	$0	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$0**	**$0**	**$0**
Total Prevention Expenditures		**$22,277,978**	**$20,879,345**	**$359,542**
Total SABG Award[3]		**$111,389,890**	**$104,396,719**	**$22,415,201**
Planned Primary Prevention Percentage		**20.00 %**	**20.00 %**	**1.60 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023.

[3]Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Florida is using our full Covid-19 Relief funding before beginning the APR funding, so the majority of the 20% planned Primary Prevention for the ARP funding falls outside of the planning period above. - NW

Auto-calculation for primary prevention percentages planned is incorrect. Will contact BGAS Helpdesk to let them know there is a glitch in this form.

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Activity	FFY 2022 SA Block Grant Award	COVID-19 Award[1]	ARP Award[2]
Universal Direct	$7,084,397	$6,639,632	$114,334
Universal Indirect	$6,282,390	$5,887,975	$101,391
Selective	$6,683,393	$6,263,803	$107,863
Indicated	$2,227,798	$2,087,935	$35,954
Column Total	**$22,277,978**	**$20,879,345**	**$359,542**
Total SABG Award[3]	**$111,389,890**	**$104,396,719**	**$22,415,201**
Planned Primary Prevention Percentage	**20.00 %**	**20.00 %**	**1.60 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023.

[3]Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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

Footnotes:

Florida is using our full Covid-19 Relief funding before beginning the APR funding, so the majority of the 20% planned Primary Prevention for the ARP funding falls outside of the planning period above. - NW

Planning Tables

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 2022 and FFY 2023 SABG awards.

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

	SABG Award	COVID-19 Award[1]	ARP Award[2]
Targeted Substances			
Alcohol	☑	☑	☑
Tobacco	☐	☐	☐
Marijuana	☑	☑	☑
Prescription Drugs	☑	☑	☑
Cocaine	☐	☐	☐
Heroin	☑	☑	☑
Inhalants	☐	☐	☐
Methamphetamine	☑	☑	☑
Bath salts, Spice, K2)	☐	☐	☐
Targeted Populations			
Students in College	☐	☐	☐
Military Families	☐	☐	☐
LGBTQ	☐	☐	☐
American Indians/Alaska Natives	☐	☐	☐
African American	☐	☐	☐
Hispanic	☐	☐	☐
Homeless	☐	☐	☐
Native Hawaiian/Other Pacific Islanders	☐	☐	☐
Asian	☐	☐	☐
Rural	☐	☐	☐

Underserved Racial and Ethnic Minorities			

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023.

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

Footnotes:

Planning Tables

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

Planning Period Start Date: 10/1/2021   Planning Period End Date: 9/30/2023

Activity	FFY 2022				
	A. SABG Treatment	B. SABG Prevention	C. SABG Integrated[1]	D. COVID-19[2]	E. ARP[3]
1. Information Systems	$507,930.00	$88,560.00		$175,000.00	$175,000.00
2. Infrastructure Support	$193,131.00	$84,787.00			
3. Partnerships, community outreach, and needs assessment	$324,554.00	$161,237.00			
4. Planning Council Activities (MHBG required, SABG optional)					
5. Quality Assurance and Improvement	$275,737.00	$56,791.00			
6. Research and Evaluation	$89,618.00	$60,749.00			
7. Training and Education	$109,030.00	$27,876.00		$437,500.00	$312,500.00
8. Total	**$1,500,000.00**	**$480,000.00**	**$0.00**	**$612,500.00**	**$487,500.00**

[1]Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

[2]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in Column D.

[3]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in Column E.

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

Footnotes:

Planning Tables

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

MHBG Planning Period Start Date: 07/01/2021 MHBG Planning Period End Date: 06/30/2022

Activity	FFY 2022 Block Grant	FFY 2022[1] COVID Funds	FFY 2022[2] ARP Funds	FFY 2023 Block Grant	FFY 2023[1] COVID Funds	FFY 2023[2] ARP Funds
1. Information Systems	$0.00	$175,000.00				
2. Infrastructure Support	$250,000.00	$52,500.00				
3. Partnerships, community outreach, and needs assessment	$0.00					
4. Planning Council Activities (MHBG required, SABG optional)	$52,000.00					
5. Quality Assurance and Improvement						
6. Research and Evaluation	$251,509.00					
7. Training and Education		$560,000.00				
8. Total	**$553,509.00**	**$787,500.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

[1] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15,2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

[2] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

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

Footnotes:

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 homes[31] and ACOs[32] 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.[39] 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.[40]
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.[41] 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.

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[27] **http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/**

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[29] Health Care Integration, **http://samhsa.gov/health-reform/health-care-integration**; SAMHSA-HRSA Center for Integrated Health Solutions, (**http://www.integration.samhsa.gov/**)

[30] Health Information Technology (HIT), http://www.integration.samhsa.gov/operations-administration/hit; Characteristics of State Mental Health Agency Data Systems, Telebehavioral Health and Technical Assistance Series, **https://www.integration.samhsa.gov/operations-administration/telebehavioral-health**; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, **http://www.americantelemed.org/home**; National Telehealth Policy Resource Center, **https://www.cchpca.org/topic/overview/**;

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[33] Waivers, **http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html**; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, **http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf**

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[35] Medicare-Medicaid Enrollee State Profiles, **http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html**; About the Compact of Free Association, **http://uscompact.org/about/cofa.php**

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[40] About the National Quality Strategy, **http://www.ahrq.gov/workingforquality/about.htm**;

[41] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, **http://www.cms.gov/cciio/resources/letters/index.html**; Affordable Care Act, Indian Health Service, **http://www.ihs.gov/ACA/**

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.

Multidisciplinary teams (e.g., CAT, FACT, CSC-ESMI) and Care Coordination services are important mechanisms for integrating primary care and specialty care for co-occurring behavioral disorders in community-based settings. Network service providers offer primary care directly onsite or through referral arrangements with local clinics and FQHCs. Network service providers also offer integrated services for co-occurring disorders, and entire networks are required to operate as No Wrong Door models of access and report on the extent to which systems reflect this model. The Department and Managing Entities also provide training and technical assistance on service integration.

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

The Department does not have any funding or payment strategies particularly designed to foster co-occurring capabilities, aside from the standing capability to bill for co-occurring disorders and efforts to avoid allocating funds through restrictive silos, where possible.

3. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through Qualified Health Plans? — ○ Yes ◉ No

b) and Medicaid? — ○ Yes ◉ No

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

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

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? — ◉ Yes ○ No

6. Do the M/SUD providers screen and refer for:

a) Prevention and wellness education — ◉ Yes ○ No

b) Health risks such as

ii) heart disease — ◉ Yes ○ No

iii) hypertension ◉ Yes ○ No

iv) high cholesterol ◉ Yes ○ No

v) diabetes ◉ Yes ○ No

c) Recovery supports ◉ Yes ○ No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? ○ Yes ◉ No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? ○ Yes ◉ No

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. These responsibilities fall under the purview of the Office of Insurance Regulations.

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.

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

Footnotes:

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." However, it does not make specific references to heart disease, hypertension, cholesterol, diabetes, or wellness education, though these are common elements of primary care visits. Furthermore, while the required psychosocial assessments address the clients' perceived "strengths and abilities related to the potential for recovery," it does not explicitly require referrals for "recovery supports."

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[42], **Healthy People, 2020**[43], **National Stakeholder Strategy for Achieving Health Equity**[44], 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)[45].

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."[46]

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[47]. 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[48]. 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.

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[42] **http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**

[43] **http://www.healthypeople.gov/2020/default.aspx**

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

[45] **http://www.ThinkCulturalHealth.hhs.gov**

[46] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[47] https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

[48] https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf

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	◉ Yes ○ No
b) Ethnicity	◉ Yes ○ No
c) Gender	◉ Yes ○ No
d) Sexual orientation	○ Yes ◉ No
e) Gender identity	○ Yes ◉ No
f) Age	◉ Yes ○ No

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? ○ Yes ◉ No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? ◉ Yes ○ No

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? ○ Yes ◉ No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) Standards? ○ Yes ○ No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? ○ Yes ◉ No

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

The Florida Children and Youth Cabinet, chaired by First Lady DeSantis, is examining the stigma around mental illness specifically among minority communities through a newly formed workgroup.

Emotional and behavioral assessments are also required to assess and address an individual's social, ethnic, and cultural factors.

Furthermore, individuals receiving drug treatment services have a guaranteed right to nondiscriminatory services, whereby service providers may not deny an individual access to services solely on the basis of race, gender, ethnicity, age, sexual preference, HIV status, prior service departures against medical advice, disability, or number of relapses. The Department also has agency-wide policies, plans and procedures that facilitate access to interpretation and translation services to thousands of non-English speakers throughout Florida.

Please indicate areas of technical assistance needed related to this section

None.

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

Footnotes:

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.

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[49] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[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.

[51] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[52] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[53] **http://psychiatryonline.org/**

[54] **http://store.samhsa.gov**

[55] **https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-how-to-use-the-ebp-kit-10112019_0.pdf**

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 focused on consumer outcomes rather than care processes.
- **g)** ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, accountable care organization, 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?

Not at this time.

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

Not at this time.

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

Footnotes:

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 currently funds seven CSC for ESMI/FEP teams:
• Life Management Center of NW FL – Bay County
• Clay Behavioral Health Center – Clay and Putnam Counties
• Success for Kids and Families – Hillsborough County
• Aspire Health Partners – Orange County
• South County Mental Health Center – Palm Beach County
• Henderson Behavioral Health Center – Broward County
• Citrus Behavioral Health Center – Miami-Dade County

Six of the teams utilize the NAVIGATE model and one team utilizes the OnTrackNY model.

In SFY 21-22, 22-23 and 23-24, the Department will be temporarily expanding CSC services through the use of the Covid

Relief and American Rescue Plan Supplemental funds received in 2021.

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? ○ Yes ◉ No

5. Does the state collect data specifically related to ESMI? ◉ Yes ○ No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? ◉ Yes ○ No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

Six out of seven CSC – 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 or more members of the team for 6 to 12 months, followed by less frequent services.

The seventh CSC – 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 2022 and FFY 2023 for your state's ESMI programs including psychosis?

CSC-ESMI teams are expected to maintain minimum enrollment numbers and ensure that at least 80% of individuals served experience improvements in functioning or symptom severity, monitored through an associated performance indicator for this Block Grant planning cycle. Department representatives are also planning to conduct site visits with each of the CSC-ESMI teams during this period.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

Data on service provision and outcomes are reported from the CSC-ESMI through reporting templates. The impact is demonstrated through the associated performance indicator, which calls for at least 80% of individuals served to improve.

10. Please list the diagnostic categories identified for your state's ESMI programs.

The current diagnoses recognized by providers of Coordinated Specialty Care for ESMI programs includes schizophrenia, schizoaffective disorder, schizophreniform disorder, delusional disorder or psychosis not otherwise specified. At this time, none of the ESMI programs in Florida serve individuals who are experiencing substance-induced psychosis.

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

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.

Not applicable.

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

The Department deploys 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.

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.

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

Not at this time.

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

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?

None at this time.

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**[56] 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?

With respect to crisis services, the Department conducted a few consultation sessions with the Seminole Tribe, resulting in their confirmed participation in the 9-8-8 planning coalition, and a burgeoning interest in establishing a tribal Lifeline call center. To date, no consultations have been conducted with the Miccosukee Tribe, but outreach efforts are ongoing. With respect to prevention services, Department representatives working on the State Opioid Response grant recently communicated with the Tribes regarding prevention resources, including naloxone kits for overdose prevention.

2. What specific concerns were raised during the consultation session(s) noted above?

The Seminole Tribe expressed concerns regarding crisis response times for geographically isolated tribal members.

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

None at this time.

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

None at this time.

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Footnotes:

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) ◉ Yes ○ No

- **a)** ☑ Data on consequences of substance-using behaviors
- **b)** ☑ Substance-using behaviors
- **c)** ☑ Intervening variables (including risk and protective factors)
- **d)** ☑ 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 assesment 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)

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

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

- [ ] Archival indicators (Please list)
- [x] National survey on Drug Use and Health (NSDUH)
- [x] Behavioral Risk Factor Surveillance System (BRFSS)
- [x] Youth Risk Behavioral Surveillance System (YRBS)
- [x] Monitoring the Future
- [x] Communities that Care
- [x] State - developed survey instrument
- [ ] Others (please list)

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds? (●) Yes ( ) No

If yes, (please explain)

All Managing Entities use needs assessment data when making decisions about which services to fund.

Needs assessment data helps the state determine what training and technical assistance activities will be funded.

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:

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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. Additionally, Florida requires the prevention workforce to have the Substance Abuse Prevention Skill Training (SAPST) as a foundational course of study in substance abuse prevention,

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.

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

If yes, please describe mechanism used

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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 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. Based on more recent input from various partners, including Managing Entities, prevention providers, and community-based organizations, the following activities are of particular strategic importance to Florida's prevention system:

(1) Targeting prevention resources to individuals and 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.

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)** ☐ Timelines
- **c)** ☐ Roles and responsibilities
- **d)** ☐ Process indicators
- **e)** ☐ Outcome indicators
- **f)** ☐ Cultural competence component
- **g)** ☐ Sustainability component
- **h)** ☐ 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:

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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
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

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 ◉ Yes ○ No

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 for 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

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

a) ☐ Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
b) ☐ Includes evaluation information from sub-recipients
c) ☐ Includes SAMHSA National Outcome Measurement (NOMs) requirements
d) ☐ Establishes a process for providing timely evaluation information to stakeholders
e) ☐ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
f) ☐ Other (please list:)
g) ☑ Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

a) ☑ Numbers served
b) ☐ Implementation fidelity
c) ☐ Participant satisfaction
d) ☑ Number of evidence based programs/practices/policies implemented
e) ☑ Attendance
f) ☑ Demographic information
g) ☐ Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

a) ☑ 30-day use of alcohol, tobacco, prescription drugs, etc
b) ☑ Heavy use
☑ Binge use
☑ Perception of harm
c) ☑ Disapproval of use

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

e) ☐ Other (please describe):

Footnotes:

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-occuring 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-occuring M/SUDs	◉ Yes ○ No

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

Not applicable.

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.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

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.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	4.3%	733,000
2.Children with SED	7.0%	151,196

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 (4.3%) is based on 2018-2019 National Surveys on Drug Use and Health (NSDUH). This estimate is published by SAMHSA and retrieved from Table 30 at the following location:

https://www.samhsa.gov/data/sites/default/files/reports/rpt32885/2019NSDUHsaeSpecStates/NSDUHsaeFlorida2019.pdf

The statewide incidence of adults with SMI (732,000) is published in Table 29 at the following location:

https://www.samhsa.gov/data/sites/default/files/reports/rpt32885/2019NSDUHsaeSpecStates/NSDUHsaeFlorida2019.pdff

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%. The figures reported in the table above rely on the lower limit of the range published in the Federal Register (7.0%).

The 2018 SED incidence figure in the table above (151,196) comes from the most recently available NRI report for SAMHSA prepared in 2019, using the lower limit estimate for Florida, retrieved from the following location:

https://wwwdasis.samhsa.gov/dasis2/urs/adult_smi_child_sed_prev_2018.pdf

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 preventiion 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

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's targeted services to rural population.

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 Managing Entities 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. 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 travel to receive services and supports in an outpatient setting.

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

Managing Entity 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 Managing Entity 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 Managing Entity 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 services. 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 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 Managing Entity 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 Managing Entities 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.

Managing Entity 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: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

State Financial Resources for Mental Health Service Providers:

In State Fiscal Year 2019-20, Florida spent $342,253,143 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, whose staff members collect and report data, manage finances, develop policies, and administer programs through a Data Team, a Policy Team, a Clinical 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 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 various topics related to mental health services.

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 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.

Footnotes:

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	◉ Yes ○ No
ii)	Education	◉ Yes ○ No
iii)	Brief Intervention	◉ Yes ○ No
iv)	Assessment	◉ Yes ○ No
v)	Detox (inpatient/social)	◉ Yes ○ No
vi)	Outpatient	◉ Yes ○ No
vii)	Intensive Outpatient	◉ Yes ○ No
viii)	Inpatient/Residential	◉ Yes ○ No
ix)	Aftercare; Recovery support	◉ Yes ○ No

b) Services for special populations:

Targeted services for veterans?	◉ Yes ○ No
Adolescents?	◉ Yes ○ No
Other Adults?	◉ Yes ○ No
Medication-Assisted Treatment (MAT)?	◉ Yes ○ No

Criterion 2

Criterion 3

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 PWWDC 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 PWWDC. 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 Managing Entities 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.). Managing Entities 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).

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

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, if applicable	◉ Yes ○ No
e)	Monitoring requirements as outlined in the authorizing statute and implementing regulation	◉ Yes ○ No

2. Has your state identified a need for any of the following:

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

3. States are required to monitor program compliance related to activites 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 Managing Entities to oversee network service provider compliance with Block Grant rules regarding people who inject drugs (PWID), which address preference in admissions, the provision of interim services, the maximum amount of time they can wait before admission, and 90% capacity reporting. Managing Entities 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).

Tuberculosis (TB)

1.	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?	○ Yes ◉ No

2. Has your state identified a need for any of the following:

a)	Business agreement/MOU with primary healthcare providers	○ Yes ◉ No
b)	Cooperative agreement/MOU with public health entity for testing and treatment	○ Yes ◉ No
c)	Established co-located SUD professionals within FQHCs	○ Yes ◉ No

3. 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.

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)

1.	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?	◉ Yes ○ No

2. Has your state identified a need for any of the following:

a)	Establishment of EIS-HIV service hubs in rural areas	○ Yes ◉ No
b)	Establishment or expansion of tele-health and social media support services	○ Yes ◉ No
c)	Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS	○ Yes ◉ No

Syringe Service Programs

1. 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.CÂ§ 300x-31(a)(1)F)? — ◉ Yes ○ No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? — ◉ Yes ○ No

3. Do any of the programs use SABG funds to support elements of a Syringe Services Program? — ○ Yes ◉ No

   If yes, plese 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 — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Workforce development efforts to expand service access — (●) Yes ( ) No
- **b)** Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — ( ) Yes (●) No
- **c)** Establish a peer recovery support network to assist in filling the gaps — (●) Yes ( ) No
- **d)** Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — (●) Yes ( ) No
- **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 — (●) Yes ( ) No
- **f)** Explore expansion of services for:
  - **i)** MAT — (●) Yes ( ) No
  - **ii)** Tele-Health — (●) Yes ( ) No
  - **iii)** Social Media Outreach — ( ) Yes (●) No

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? — (●) Yes ( ) No

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 — (●) Yes ( ) No
- **b)** Establish a program to provide trauma-informed care — (●) Yes ( ) No
- **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 — (●) Yes ( ) No

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)? — (●) Yes ( ) No

2. Does your state provide any of the following:

- **a)** Notice to Program Beneficiaries — ( ) Yes (●) No
- **b)** An organized referral system to identify alternative providers? — ( ) Yes (●) No
- **c)** A system to maintain a list of referrals made by religious organizations? — ( ) Yes (●) No

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? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Review and update of screening and assessment instruments — (●) Yes ( ) No
- **b)** Review of current levels of care to determine changes or additions — (●) Yes ( ) No
- **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 including 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.

   Nine 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? — ( ) Yes (•) No

   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

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 ○ Yes ◉ No

c) Coordination of Various Activities and Services ◯ Yes ◉ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

https://www.flrules.org/gateway/readFile.asp?sid=0&tid=0&cno=65E-14&caid=1048490&type=4&file=65E-14.doc

https://www.flrules.org/gateway/readFile.asp?sid=0&tid=0&cno=65D-30&caid=639150&type=4&file=65D-30.doc

Footnotes:

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 2020-FFY 2021? ○ Yes ◉ No

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

None.

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

Footnotes:

Technically the answer is "not applicable." Florida does not currently have a CQI plan.

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 Trauma[58] 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.

   None at this time.

   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

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.

[59] Journal of Research in Crime and Delinquency: *: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.*Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Ren?e L. Binder. **OJJDP Model Programs Guide**
[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?

   None at this time.

   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

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], 49 [4], and 63[5].

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.

TIP 40 - https://www.ncbi.nlm.nih.gov/books/NBK64245/ [ncbi.nlm.nih.gov]

TIP 43 - https://www.ncbi.nlm.nih.gov/books/NBK64164/ [ncbi.nlm.nih.gov]

TIP 45 - https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4131.pdf [store.samhsa.gov]

TIP 49 - https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4380.pdf [store.samhsa.gov]

TIP 63 - https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-006_508.pdf [store.samhsa.gov]

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)** [x] Methadone
- **b)** [x] Buprenophine, Buprenorphine/naloxone
- **c)** [x] Disulfiram
- **d)** [x] Acamprosate
- **e)** [x] Naltrexone (oral, IM)
- **f)** [x] 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 efforts to raise awareness about MAT have been funded out of the STR and SOR grants, not the SAPT Block Grant, and are described in period reports to SAMHSA Project Officers.

**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:

Environmental Factors and Plan

15. Crisis Services - Required for MHBG

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.

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[61] **http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

[62] Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. **http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427**

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention

- **a)** [x] Wellness Recovery Action Plan (WRAP) Crisis Planning
- **b)** [x] Psychiatric Advance Directives
- **c)** [x] Family Engagement
- **d)** [x] Safety Planning
- **e)** [x] Peer-Operated Warm Lines
- **f)** [x] Peer-Run Crisis Respite Programs
- **g)** [x] Suicide Prevention

2. Crisis Intervention/Stabilization

- **a)** [x] Assessment/Triage (Living Room Model)
- **b)** [ ] Open Dialogue
- **c)** [x] Crisis Residential/Respite
- **d)** [x] Crisis Intervention Team/Law Enforcement
- **e)** [x] Mobile Crisis Outreach
- **f)** [x] Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- **a)** [x] Peer Support/Peer Bridgers
- **b)** [x] Follow-up Outreach and Support
- **c)** [x] Family-to-Family Engagement
- **d)** [x] Connection to care coordination and follow-up clinical care for individuals in crisis
- **e)** [x] Follow-up crisis engagement with families and involved community members

f) ☑ Recovery community coaches/peer recovery coaches

g) ☑ Recovery community organization

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

None at this time.

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

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.**

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:

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? ◉ Yes ○ No

b) Required peer accreditation or certification? ◉ Yes ○ No

c) Block grant funding of recovery support services. ◉ Yes ○ No

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system? ◉ Yes ○ No

2. Does the state measure the impact of your consumer and recovery community outreach activity? ◉ Yes ○ No

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 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 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.

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

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

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

None

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

Footnotes:

Florida does not have a current Olmstead Plan, so the "no" responses above are actually "not applicable."

Additionally, State Mental Health Treatment Facility staff technically begin discharge planning upon admission and continue discharge planning throughout the stay. The provision of community-based housing, supports, and employment services is integral to improving readiness for discharge.

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.[63]. 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.[64]. 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.[65].

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.[66]. 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.[67].

According to data from the 2015 Report to Congress[68] 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).

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[63]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[64]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[65]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[66]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[67]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[68] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

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?

Not at this time.

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.

Florida transitioned to the 2020 – 2023 Florida Suicide Prevention Interagency Action Plan in August 2020. The plan identifies four focus areas (awareness, prevention, intervention, and caring follow-up and support) and 11 strategies to help guide prevention efforts across Florida. State agencies committed to expand suicide prevention efforts through specific action items to implement the goals and strategies from the Action Plan. The plan identifies both national and Florida-specific special populations, deemed to be at increased risk for suicide prevention. The plan document also includes examples of programs, trainings, and other activities that can be implemented at the local level. Example of action steps include:
• In Harm's Way a training for first responder/law enforcement/fire fighter agencies.
• Question Persuade Refer (QPR) training that teaches individuals how to recognize the warning signs of suicide and how to question, persuade, and refer someone to help. This is also known as a gatekeeper training.
• Mental Health First Aid training that focuses on youth and adults.
• Suicide Prevention Day at the Florida Capitol
• Implement Zero Suicide, a framework to promote organization-wide transformation toward safer suicide care in health and behavioral health care systems.
A copy of the 2020 – 2023 Florida Suicide Prevention Interagency Action Plan and a list of completed activities that relate to the Plan can be found on the homepage of the department's suicide prevention website at this link: www.myflfamilies.com/suicide-prevention.

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 2020-FFY 2021 plan was submitted? (●) Yes ( ) No

If so, please describe the population targeted.

The targeted populations are at-risk adults, military, veterans and their families, first responders, older Americans, members of the LGBTQ+ community, and youth/adolescents.

The Statewide Office for Suicide Prevention continues to serve as a member of Florida's Governor's Challenge Team. The Florida Governor's Challenge Team is an interdisciplinary team of suicide prevention experts. The Team has created a robust strategic plan to reduce suicide among service members, veterans, and their families and has entered the implementation phase. The First Responders Suicide Deterrence Task Force is charged with making recommendations on how to reduce the incidence of suicide and attempted suicide among employed or retired Florida first responders. The Task Force convened in December 2020 and produced their first of three annual reports in July 2021. The Statewide Office for Suicide Prevention helps lead the Task Force efforts.

In addition, Florida was awarded the Florida Implementation of the National Strategy for Suicide Prevention (FINS) Project that is a partnership with the Statewide Office for Suicide Prevention, the University of Central Florida, the University of South Florida, and Florida Hospital. The project ensures that health and behavioral health settings as well as adult-serving systems are prepared to identify, engage, and treat at-risk adults by using culturally competent evidence based/best-practice suicide prevention, treatment, safety planning, and care coordination services.

The Special Populations Committee of the Suicide Prevention Coordinating Council produces and disseminates targeted messaging materials for Florida and national special populations on a monthly basis. These populations include resources

focused on suicide loss survivors, older Americans, members of the LGBTQ+ community, and service members and veterans. A Suicide Prevention Ad campaign was launched during September 2020, Suicide Prevention Month. This campaign was a collaboration between Florida Department of Health and the Florida Department of Children and Families and included a joint effort with the Trevor Project to bring awareness to the mental health needs and suicide prevention of teens in the LGBTQ+ community.

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:

Florida updates the Suicide Prevention Plan every three years. The current plan covers the period 2020 -2023.

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?

Not applicable.

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

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.

[69] **https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf**

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 Advisory Council Members and 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:

August 2, 2021

Steven M. Fry
Substance Abuse and Mental Health Services Administration
Public Health Analyst
Center for Mental Health Services

Re: Planning Council's Involvement in Development and Review of 2022-2023 Block Grant Application

Dear Mr. Fry:

As the Chair of Florida's Behavioral Health Block Grant Planning Council, it is my pleasure to write in support of Florida's combined 2022-2023 Block Grant Application and Plan. A draft of 2022-2023 Block Grant Application was conveyed to the Council on August 3, 2021, along with a request for any comments, questions, and proposed revisions.

The Council proposed the following revisions and consideration:

- There is little mention of peer support services and how they are being utilized. There are a number of places peer support could have been included in the plan i.e. item #4 on page 111 as an example. There is a lot of focus on SUD services and "recovery supports" through RCOs, but this doesn't really include mental health.

- Are we using any block grant funds for trauma informed care - especially in reference to people served who are involved in the criminal justice system.

- Increased services and funding need to be used for diversion and supports for NGRI's being released from State Mental Health Facilities/Treatment Centers.

Should you have any questions, please contact me at clilly@ffcflinc.org.

Sincerely,

Crystal Lilly

Crystal Lilly
Chair, Florida's Block Grant Planning and Advisory Council

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: 2022 End Year: 2023

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Lucia Berry	Family Members of Individuals in Recovery (to include family members of adults with SMI)		PH: 772-678-5802	Safelifetoday@gmail.com
Melanie Brown-Woofter	Providers	Florida Council for Community Mental Health	PH: 850-224-6048	melanie@fccmh.org
Paul Cassidy	Family Members of Individuals in Recovery (to include family members of adults with SMI)		PH: 850-723-7703	paul@cassidymsw.com
Jeff Cece	State Employees	Florida Department of Children and Families	PH: 850-717-4405	Jeffrey.Cece@myflfamilies.com
Beth Dees	Family Members of Individuals in Recovery (to include family members of adults with SMI)		FL,	
Tony DePalma	Others (Advocates who are not State employees or providers)	Disability Rights Florida	PH: 850-488-9071	tonyd@disabilityrightsflorida.org
Carmen Dupont	State Employees	Department of Education - Division of Voc Rehab	PH: 850-245-3471	carmen.dupont@vr.fldoe.org
Veronica Ebuen	State Employees	Department of Education - Division of Voc Rehab	PH: 850-245-3360	veronica.ebuen@vr.fldoe.org
Wesley Evans	State Employees	Florida Department of Children and Families	PH: 850-509-8697	Wesley.Evans@myflfamilies.com
Cindy Foster	Others (Advocates who are not State employees or providers)	NAMI Florida		
Andrew Harrell	State Employees	Florida Department of Juvenile Justice		Andrew.Harrell@djj.state.fl.us
Mary Hodges	State Employees	Department of Elder Affairs	PH: 850-414-2184	Hodgesm@elderaffairs.org
Curtis Jenkins	State Employees	Florida Department of Education	PH: 850-245-7844	Curtis.Jenkins@fldoe.org
Latressa Johnson	Family Members of Individuals in Recovery (to include family members of adults with SMI)		PH: 407-470-2058	Johnsontressa33@gmail.com
Nelson Kull	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental	Central Florida Cares Health System	PH: 407-617-3311	jkull@cfl.rr.com

	health services)			
Crystal Lilly	Others (Advocates who are not State employees or providers)	Federation of Families - Central Florida	PH: 407-615-0338	clilly@ffcflinc.org
William Mollentze	Others (Advocates who are not State employees or providers)		FL,	
Cheryl Molyneaux	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		PH: 443-804-7151	info@dbsacfl.org
Kim Riley	State Employees	Florida Department of Corrections	PH: 850-519-6947	kim.riley@fdc.myfl.com
Elaine Roberts	State Employees	Florida Housing Finance Corporation	PH: 850-488-4197	Elaine.Roberts@floridahousing.org
Peggy Scheuermann	State Employees	Florida Department of Health	PH: 850-245-4220	Peggy.Scheuermann@flhealth.gov
Sarah Sheppard	State Employees	Department of Children & Families - SAMH		sarah.sheppard@myflfamilies.com
James W. Taliaferro, Sr.	Others (Advocates who are not State employees or providers)	Mental Health America	PH: 850-769-5441	mymha@comcast.net
Rick Wagner	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Lutheran Services of Florida	PH: 813-695-5490	richardbwagner@earthlink.net
Rosemary Weaver	Family Members of Individuals in Recovery (to include family members of adults with SMI)		FL,	
Cameron Wood	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		PH: 407-988-5780	cameron@peersupportfl.org

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

Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2022 End Year: 2023

Type of Membership	Number	Percentage
Total Membership	**35**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	3	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	6	
Parents of children with SED/SUD*	0	
Vacancies (Individuals and Family Members)	7	
Others (Advocates who are not State employees or providers)	5	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Total Individuals in Recovery, Family Members & Others	**21**	**60.00%**
State Employees	11	
Providers	1	
Vacancies	2	
Total State Employees & Providers	**14**	**40.00%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**0**	
Youth/adolescent representative (or member from an organization serving young people)	0	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

*The Planning Council reserves the right to keep their demographic data private at the request of their members.

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

Footnotes:

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?

		Yes	No
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:

23. Syringe Services (SSP)

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the **Consolidated Appropriations Act**, 2018 (P.L. 115-141) signed by President Trump on March 23, 2018[3].

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers[4]. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs[5]: These documents can be found on the Hiv.gov website: **https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs**,

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.hiv.gov/sites/default/files/hhs-ssp-guidance.pdf** ,
2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf**,
3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs** **http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf** ,

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
    - Include proposed protocols, timeline for implementation, and overall budget
    - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

End Notes

[1] Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[2] Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.§ 300x-31(a)(1)(F)) and 45 CFR § 96.135(a)(6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

[3] Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

[4] Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

[5]***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a **description of the elements of an SSP** that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

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Footnotes:

The Department does not provide SAPT Block Grant funds to Syringe Services Programs for syringe services.

Environmental Factors and Plan

Syringe Services (SSP) Program Information-Table A

If the state is planning to expend funds from the COVID-19 award, please enter the total planned amount in the footnote section.

Syringe Services Program SSP Agency Name	Main Address of SSP	Planned Dollar Amount of SABG Funds Expended for SSP	SUD Treatment Provider (Yes or No)	# Of Locations (include mobile if any)	Narcan Provider (Yes or No)
No Data Available					

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Footnotes:

The Department does not provide SAPT Block Grant funds to Syringe Services Programs for syringe services.

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 Report and after submission to SAMHSA.