

Please provide any comments and input to DCF's Block Grant Coordinator at stephan.cooley@myFLfamilies.com. Any person can provide input both during the development of this report and after submission to SAMSHA.

Florida

UNIFORM APPLICATION

FY 2023 Mental Health Block Grant Report

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 03/31/2022 - Expires 03/31/2025
(generated on 11/15/2022 11.29.04 AM)

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 stephan.cooley@myFLfamilies.com. Any person can provide input both during the development of this report and after submission to SAMSHA.

A. State Information

State Information

State DUNS Number

Number 604604350

Expiration Date

I. State Agency to be the 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 Grantee of the Block Grant

First Name Maggie
Last Name Cveticanin
Agency Name Florida Department of Children and Families
Mailing Address 2415 North Monroe Street Suite 400
City Tallahassee
Zip Code 32303-4190
Telephone (904) 515-8064
Fax
Email Address Maggie.Cveticanin@myflfamilies.com

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

From 7/1/2021
To 6/30/2022

IV. Date Submitted

NOTE: This field will be automatically populated when the application is submitted.

Submission Date

Revision Date

V. Contact Person Responsible for Report Submission

First Name Jeffrey
Last Name Cece
Telephone 850-717-4405
Fax
Email Address Jeffrey.Cece@myflfamilies.com

0930-0168 Approved: 03/31/2022 Expires: 03/31/2025

Footnotes:

B. Implementation Report

MHBG Table 1 Priority Area and Annual Performance Indicators - Progress Report

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.

Objective:

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

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.

Edit Strategies to attain the objective here:
(if needed)

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.

New Second-year target/outcome measurement(if needed):

Data Source:

MRT Cumulative Data tracking spreadsheet.

New Data Source(if needed):

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.

New Description of Data(if needed)

Data issues/caveats that affect outcome measures:

None.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target:



Achieved



Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

In FY 21-22, 82.6% of calls requiring an acute response were diverted from involuntary examination, which achieves the first year target of at least 82%.

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).

Objective:

Increase the number of children served by Community Action Teams (CAT).

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.

Edit Strategies to attain the objective here:
(if needed)

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)

New Second-year target/outcome measurement(if needed):

Data Source:

The data source is the CAT monthly supplemental data reports.

New Data Source(if needed):

Description of Data:

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

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

None.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target:

☐

Achieved

☒

Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

The number individuals served by Community Action Teams (CAT) in FY 21-22 was 3,418, failing to reach the first year target to increase the numbers served by CATs by 50 (to 3,473).

In addition to CATs in Florida, the Department funds a service to assist individuals who are not effectively connected with the services and supports they need to transition successfully from higher levels of care to community-based care. Beginning in January 2021, the Department expanded the role of Care Coordination to include children/adolescents considered acute care high utilizers (defined as three or more admissions to a crisis stabilization unit or inpatient psychiatric hospital within 180 days). This expansion created an overlap in eligibility requirements and led to the Department urging Managing Entities to use Care Coordination as a way to help children on waiting lists for CAT services. This diverted individuals who may have been served by a CAT. In FY 21-22, 560 children and adolescents identified as acute care high utilizers received Care Coordination services.

The Florida legislature recently appropriated additional funding to expand team-based services, including CATs, which might increase the service capacity of existing teams and/or add new teams throughout the state.

How first year target was achieved (optional):

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.

Objective:

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

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).

**Edit Strategies to attain the objective here:
(if needed)**

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.

New Second-year target/outcome measurement(if needed):

Data Source:

Quarterly Contract reports.

New Data Source(if needed):**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.

New Description of Data:(if needed)**Data issues/caveats that affect outcome measures:**

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target:

☐

Achieved

☒

Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

For FY 21-22, 76% of Florida Assertive Community Treatment (FACT) clients maintained or improved their level of functioning, which is below the first year target of at least 77%. Although the Department failed to meet the first year target, there was still an increase from the baseline level.

FACT teams utilize a transdisciplinary approach to deliver comprehensive care and promote independent, integrated living for individuals with serious mental illness. The teams are required to maintain minimum staffing standards to ensure ACT is implemented with fidelity; however, throughout FY21-22 numerous FACT teams experienced staffing shortages, particularly in nursing and the peer specialist roles. The target, to increase the level of functioning of individuals served by FACT teams, may not have been achieved due to these staffing shortages. Implementing FACT with fully staffed team maximizes overall functional improvements and stability for individuals with serious mental illness.

The Florida legislature recently appropriated additional funding to expand team-based services, including FACT teams. The Department has directed Managing Entities to increase FACT team staffing with the goals to address staffing shortages and attract qualified professionals.

How first year target was achieved (optional):

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.

Objective:

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

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.

Edit Strategies to attain the objective here:
(if needed)

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.

New Second-year target/outcome measurement(if needed):

Data Source:

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

New Data Source(if needed):

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.

New Description of Data(if needed)

Data issues/caveats that affect outcome measures:

None.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☐ Achieved ☒ Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

In FY 21-22, 36% of discharges among pregnant women were successful, failing to meet the first year target of 63.3%. The Department is exploring both nationwide contextual factors and provider-level variables that might be associated with successful completion during this period (July 1, 2021 through June 30, 2022). Several findings are worth considering. First, pandemic-related stress, fear, and restrictions all may have played a contributing role. Surveys of pregnant women show that "ratings of stress, depression, and substance use remained consistently poor over time during the pandemic and mental/emotional health got progressively worse." Researchers found a relationship between elevated perceived stress and depression and subsequent reports of using substances to cope with social distancing, isolation, or stress related to the pandemic. COVID-19 was a significant source of stress for pregnant women. According to a survey of 4,451 pregnant women, nearly half (46%) lost income due to the pandemic. Furthermore, 27% reported high levels of Preparedness Stress and 29% reported Perinatal Infection Stress, with about 18% reporting high levels of both. Infections fears may have deterred continued participation in face-to-face group counseling or group residential treatment. The Centers for Disease Control and Prevention did not declare COVID-19 vaccines as safe for pregnant women until August 11, 2021, and vaccine hesitancy remains an ongoing challenge to this day. Additionally, ongoing post-pandemic behavioral health workforce shortages and turnover, particularly among case managers and care coordinators, may have impacted treatment quality and, by extension, program completion rates. In summation, fear of infection through group living arrangements in residential treatment programs, the need to establish or maintain employment, and increased substance use as a response to stress, and staff vacancies and turnover, may have all contributed to reduced rates of successful treatment completion among pregnant women. With respect to changes needed to meet the target in

the future, the Department is working with providers and Managing Entities to review the queries used to extract the discharge records, evaluate the continued inclusion of "Moved Out of State" as an unsuccessful discharge code, and identify factors associated with successful completion and dropout. Providers showing high rates of successful completion are being asked to describe what is working in the interest of advising and assisting providers with lower rates. Exploratory conversations conducted to date suggest that stable income through employment contributes to successful completion by facilitating access to post-discharge housing, with one program observing that women save about 75% of their income to ensure housing when they are discharged. Other variables that might contribute to successful completion include time spent in individual therapy sessions and access to specialty services that bolster skills related to coping with trauma, managing finances, parenting, etc. The Department is also examining exactly which program rules and policies are often violated and resulting in involuntary discharges, to explore whether formal changes to policy or practice are needed.

References: Lederhos Smith, C., et al. (2021). Substance Use and Mental Health in Pregnant Women During the COVID-19 Pandemic. Journal of Reproductive and Infant Psychology; Preis, H., et al. (2020). Vulnerability and Resilience to Pandemic-related Stress among U.S. Women Pregnant at the Start of the COVID-19 Pandemic. Social Science & Medicine, 266, 113348; Centers for Disease Control and Prevention. (2021). New CDC Data: COVID-19 Vaccination Safe for Pregnant People. Retrieved from <https://www.cdc.gov/media/releases/2021/s0811-vaccine-safe-pregnant.html>.

How first year target was achieved (optional):

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.

Objective:

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

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.

**Edit Strategies to attain the objective here:
(if needed)**

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.

New Second-year target/outcome measurement(if needed):

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.

New Data Source(if needed):

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.

New Description of Data:(if needed)**Data issues/caveats that affect outcome measures:**

None.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☐ Achieved ☒ Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

In FY 21-22, 78.7% of individuals served by CSC for ESMI programs experienced improvements in functioning or symptom severity, which is below the first year target of at least 80%.

All except for three teams reported success rates of 80% or higher. Unfortunately, their rates were low enough to pull the overall percentage down, causing us to fail to achieve the first year target.

Coordinating discussion with high- and low-achieving providers will provide insight into what works and areas for meaningful improvement. [HOLD for potential re-write focusing on an exploratory survey analysis of the providers re: factors perceived to be associated with functional improvement vs. decompensation]

Below is the list of teams ranked by percentage of individuals served by CSC for ESMI teams who experienced improvements in function or symptom severity. Percentages are based on data reported by the Managing Entities via the Block Grant Reporting Template. Note that Clay Behavioral Health Center, Inc. and Citrus Health Network, Inc. have multiple teams and are listed multiple times below.

Life Management Center (54%)
Early Treatment Program - South Brevard (56%)
Early Treatment Program - Central Brevard (63%)
Success 4 Kids and Families (82%)
Clay Behavioral Health Center, Inc. (88%)
Citrus Health Network, Inc. (94%)
Aspire Health Partners (98%)
Citrus Health Network, Inc. (100%)
Clay Behavioral Health Center, Inc. (100%)
Peace River Center (100%)
South County Medical Health Center - NAVIGATE Program (100%)

How first year target was achieved (optional):

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.

Objective:

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

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.

Edit Strategies to attain the objective here:
(if needed)

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%

New Second-year target/outcome measurement(if needed):

Data Source:

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

New Data Source(if needed):

Description of Data:

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

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

None

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☒ Achieved ☐ Not Achieved (if not achieved,explain why)

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

In FY 21-22 among providers reporting at least one positive HIV test, the percent of tests that were positive exceeded the first year target of 0.10%. Providers reported 162 positive HIV tests out of 10,989 total tests conducted, resulting in a positivity rate of 1.47% and achieving the first year target.

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.

Objective:

Maintain a low tuberculosis case rate.

Strategies to attain the goal:

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

Edit Strategies to attain the objective here:

(if needed)

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.

New Second-year target/outcome measurement(if needed):

Data Source:

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

New Data Source(if needed):

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.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

None.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☒ Achieved ☐ Not Achieved *(if not achieved, explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

The tuberculosis case rate for FY 21-22 was 2.3 per 100,000.

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.

Objective:

(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.

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.

Edit Strategies to attain the objective here: (if needed)

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.

New Second-year target/outcome measurement(if needed):

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.

New Data Source(if needed):

Description of Data:

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

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

None.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☒ Achieved ☐ Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:**How first year target was achieved (optional):**

Three of seven objectives were completed, achieving the first year target for this performance indicator. The three objectives listed below are accomplished.

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

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.

To achieve Objective 1, the Department conducted literature reviews for 13 out of 20 environmental strategies being implemented in Florida. The resulting report is attached.

To achieve Objectives 6 and 7, a prevention workforce survey was developed and administered by the Florida Alcohol and Drug Abuse Association (FADAA). The report detailing the findings and recommendations is attached. Recommendations 1 and 2 were implemented, see below.

RECOMMENDATION 1: Advertise and promote the Florida Behavioral Health Conference Prevention Training Track.

Survey findings were used to develop the Prevention Training Track for the 2022 Florida Behavioral Health Conference. Communications about the conference and Prevention Training Track were shared with Department staff, Managing Entities, providers, advocates, and other stakeholders around the state.

RECOMMENDATION 2: Develop and deliver webinars and workshops through the FY 22-23 FADAA training and technical assistance contract.

Trainings and webinars developed to target gaps identified in the survey and are set to be delivered through the FY 22-23 FADAA training and technical assistance contract. The first two webinars "Prevention Ethics" and "Substance Use Prevention Messaging for Emerging Adults and College Students" were delivered in September 2022 and November 2022, respectively. Upcoming webinars include "Integrating Substance Use Prevention with Wellness" in November 2022 and "Role and Impact of Social Media on Behavioral Health Prevention" in December 2022.

RECOMMENDATION 3: Facilitate prevention skills training and technical assistance.

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.

Objective:

(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 (CAPRSS) 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.

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.

**Edit Strategies to attain the objective here:
(if needed)**

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 1 out of the 9 objectives.

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

New Second-year target/outcome measurement(if needed):

Data Source:

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

New Data Source(if needed):

Description of Data:

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

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

None.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☒ Achieved ☐ Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

The first year target (achieve 1 out of 9 objectives) is achieved. Two objectives, listed below, were accomplished.

Objectives:

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

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. (Achieved)

In FY 21-22, two new recovery community organizations (RCO) were on-boarded and transitioned from early development into the existing stage, bringing the total number of existing RCOs in Florida to 15 and achieving objective 4. Recovery Point Palatka transitioned to the existing stage in March 2022. Rise up for Recovery transitioned to the existing stage in April 2022.

Additionally, two RCOs applied for accreditation in FY 21-22, achieving objective 5. The Miami Project applied in May 2022, and Recovery Epicenter applied in June 2022.

0930-0168 Approved: 03/31/2022 Expires: 03/31/2025

Footnotes:

NOT FINAL

PRIMARY PREVENTION TRAINING REPORT 2022

INTRODUCTION

Training System

The Florida Department of Children and Families Office of Substance Abuse and Mental Health (SAMH) develops and delivers training and technical assistance for primary prevention professionals in partnership with The Florida Alcohol and Drug Abuse Association (FADAA) and the Florida Certification Board (FCB).

FADAA is a non-profit membership association whose mission is to advance substance use disorder and co-occurring treatment, prevention, and research through communications, professional development, and public policy leadership. FADAA recently merged with the Florida Behavioral Health Association whose purpose is to unite individuals and business entities engaged directly or indirectly in behavioral health and behavioral medicine.

Through a contract with SAMH, FADAA provides webinars and workshops to support the use of evidence-based practices by behavioral health and primary prevention professionals in Florida. Training is delivered at no charge to participants via live workshops and webinars for continuing education credit.

Certification

The Florida Certification Board (FCB) designs, develops, and manages credentialing programs for over 30 health and human services professions and certifies more than 20,000 professionals statewide, including prevention professionals.

The FCB currently offers two primary prevention credentials: Certified Prevention Professional (CPP) and the Certified Prevention Specialist (CPS). The CPP designation is a professional credential for people who work with individuals, families, and communities to create environments and conditions that support wellness. The CPP designates competency in the domains of Planning and Evaluation; Prevention Education and Service Delivery; Communication; Community Organization; Public Policy and Environmental Change; and Professional Responsibility. The CPS is an entry-level credential which qualifies individuals to only work in the field of substance use prevention under appropriate supervision. The CPS designates competency in the same domains as the CPP but with fewer education and training requirements.

According to FCB data, the number of certified prevention professionals rose from 169 in FY19-20 to 204 in FY20-21. However, the field has articulated a need for training to meet the domain requirements for certification and to maintain the credential.

Block Grant Goals and Objectives

A priority area for substance abuse prevention in Florida is to promote evidence-based prevention services delivered by a professional prevention workforce. To that end, SAMH established two (2) objectives:

1. Develop and administer a prevention workforce survey to identify gaps in the prevention workforce and publish recommendations for addressing the identified gaps.
2. Implement at least two of the published recommendations based on the prevention workforce survey findings.

SURVEY

In partnership with FADAA, SAMH surveyed prevention providers and professionals statewide about their training needs. The survey was developed and administered by FADAA. In addition to soliciting demographic information and data about the current prevention workforce, the survey included three (3) open-ended related to primary prevention training needs:

1. What are three (3) topics you would like to see covered on the prevention track at the statewide Florida Behavioral Health Conference?
2. What specific trainings would benefit prevention staff?
3. What specific training would you benefit from to enhance your professional development?

Via email, FADAA distributed a Google survey using Microsoft Outlook forms in two phases. Initially, the survey was administered on March 22, 2022, to 57 FADAA Prevention Committee members, representing prevention providers and professionals as well as Managing Entities throughout Florida. Within a period of two weeks, FADAA received 25 responses. To increase the response rate, the FADAA Prevention Committee Members redistributed the survey to their prevention providers and staff on May 22, 2022. FADAA received another 34 additional responses for a total of 59 respondents. Responses were received from 42 prevention providers, 15 substance use coalitions, and 2 Managing Entities – primarily representing the Southern and Suncoast Regions with some representation from the Northeast and rural counties. Respondents represented the following professionals: prevention specialists, program managers, prevention coordinators, CEOs, and directors from all regions in Florida.

FINDINGS

Results ranged from requests for technical assistance with prevention planning, evaluation, and data collection to information about specific substances, engagement, and social media. The highest ranked training topics included the CPP and CPS certification process and certification domain topics such as prevention ethics and supervision.

Respondents identified the following training needs and topics to enhance professional development (ranked from highest to lowest):

TRAINING TOPIC	AFFILIATED CPP/CPS CERTIFICATION DOMAIN
1. CPP and CPS Certification process and domain topics for prevention	
2. Prevention-specific ethics	Prevention-Specific Ethics (6 hours)
3. Using or providing prevention supervision	Professional Growth and Responsibility (10 hours)
4. Evidence based practices for preventing use of specific substances (i.e., vaping and marijuana, Delta 8/9 and CBD)	Understanding Addiction (24 hours)
5. Impact of Substance Use on Families	
6. Increasing parental and community engagement	Community Organization (15 hours)
7. Use and impact of social media	Communication (10 hours)
8. Prevention issues or strategies for special populations	Prevention Education and Service Delivery (15 hours)
9. Intersection of Harm Reduction and Prevention	
10. Integrating Substance Use Prevention with wellness	
11. Selecting the Right Prevention Approach for your target population	Planning and Evaluation (30 hours)
12. Environmental prevention strategies	Public Policy and Environment Change (10 hours)

Survey respondents also requested training for the following specialized prevention skills:

- CPP and CPS Certification Process
- Substance Abuse Prevention Skills Training (SAPST)
- Selective, Indicative, Universal, Direct Strategic Framework
- CADCA Training
- Data collection, analysis, and billing
- Planning and Evaluation

RECOMMENDATIONS

During fiscal year 21-22, SAMH, in partnership with FADAA, delivered four (4) evidence-based, prevention-related webinars to meet the CPP/CPS certification domains and respond to training requests on participant webinar evaluations from previous training events.

1. Building Partnerships and Disseminating Evidence-Based Practice to Address Stigma in Rural Communities
2. Understanding Fentanyl
3. Risk and Protective Factor Theory: Understanding Root Causes of Substance Use Disorders
4. Prevention Strategies to Address Behavioral Health Disparities.

The following strategies are recommended for FY 22-23 to further meet SAMH's objective to promote evidence-based prevention services delivered by a professional prevention workforce.

RECOMMENDATION 1

Advertise and Promote Florida Behavioral Health Conference Prevention Track Training

Survey findings were used by the FADAA Prevention Committee to develop the Prevention Training Track at the August 2022 Florida Behavioral Health Conference. The proposed training agenda includes:

- Suicide Prevention 101
- Collaborating with Key Stakeholders in your Community
- Prevention in the Changing Marijuana Landscape
- Prevention Certification Professional (CPP) and Certified Prevention Specialist (CPS) Overview
- PBPS Data Collection
- Role of Adverse Childhood Experiences (ACES) and SUD
- Inhalant Abuse

RECOMMENDATION 2

Develop and Deliver Webinars and Workshops through the FY 22-23 FADAA Training and Technical Assistance Contract

Based on the survey findings, SAMH recommends that the following prevention trainings be offered as webinars and workshops through the FADAA FY 22-23 training contract:

1. Prevention-Specific Ethics
2. Prevention Strategies for Vaping and Marijuana
3. Prevention Approaches for Families Impacted by Substance Use Workshops
4. Partnering with a Purpose: Increasing Parental and Community Engagement
5. Role and Impact of Social Media on Substance Use Prevention
6. The Intersection of Harm Reduction and Prevention
7. Integrating Substance Use Prevention with Wellness
8. Selecting the Right Prevention Approach for your Target Population

RECOMMENDATION 3

Facilitate Prevention Skills Training and Technical Assistance

To address training needs and gaps for specialized prevention skills, it is recommended that SAMH staff coordinate and facilitate zoom training meetings or workshops with its provider and coalition partners by June 30, 2023, for:

1. Developing a Quality Prevention Workforce: CPP and CPS Certification Process and Domains
2. Substance Abuse Prevention Skills Training (SAPST)
3. Coalition Training Topics
4. Data Collection, Analysis and Billing

These trainings meet the CPP/CPS Certification Domains of Planning and Evaluation, Prevention Education and Service Delivery, Community Organization, and Public Policy and Environment Change.

NOT FINAL

Identification of Evidence-Based Environmental Strategies

(Objective 1 from Performance Indicator #8)

As part of the 2022-2023 Block Grant planning cycle, performance indicator #8 has a First Year target (ending June 30, 2022) which calls for the achievement of three out of seven objectives. This report addresses and accomplishes Objective 1, which calls for the Department to classify at least half of all the environmental strategies currently being implemented as either evidence-based or not.

A detailed descriptive report on environmental prevention strategies (that aimed to reduce youth access to alcohol and other drugs) was developed in May 2020 to guide the field toward resources for evaluating the effectiveness of these efforts. The next step was to classify at least half of all the currently implemented environmental strategies as either evidence-based or not and add them, as a needed, to a list of untested prevention strategies to prioritize for rigorous evaluations in the future.

Before attempting to describe the evidence, if any, in support of the environmental prevention strategies used in Florida, a clear definition is needed. Although multiple exist, the preferred definition of environmental strategies focuses on the aim or purpose of modifying the physical environment in ways that restrict access or availability (i.e., supply reduction) and is clearly distinguished from motivational (i.e., demand reduction) strategies that aim to reduce the desire to use substances by modifying knowledge, attitudes, beliefs, normative perceptions, etc.

Methodology

Department staff searched the literature to explore the evidence base of 13 of the 20 environmental prevention strategies identified in the May 2020 report (Table 1). Searches were completed using Google Scholar and PubMed. Search terms consisted of a combination of the strategy name; substance(s) targeted, if applicable, such as alcohol, tobacco, and prescription drugs; and “prevention,” “substance use,” or “substance abuse.”

Several important resources were consulted, including the Wyoming Survey & Analysis Center’s (WYSAC) *Environmental Strategies Tool*—a resource that examines the evidence related to various environmental prevention strategies.¹ The tool touches on various topics, such as community norms, retail availability, and social availability. Findings and recommendations from the Centers for Disease Control and Prevention’s Community Preventive Services Task Force (CPSTF) were also used as a guide. The CPSTF is an independent panel of 15 public health and prevention experts (appointed by the director of the CDC) “whose members represent a broad range of research, practice, and policy expertise in community preventive services, public health, health promotion, and disease prevention.”² CPSTF’s *Guide to Community Preventive Services* tackles many topics that are directly relevant to the substance use prevention field, namely excessive alcohol consumption, alcohol-related motor vehicle injuries, tobacco use, secondhand smoke exposure, and health communication and information technology. A broad array of interrelated variables that can be considered risk or protective factors for substance use are also addressed by the CPSTF, like mental health (including symptoms of depression and anxiety), exercise and physical activity, parenting skills, intimate partner violence, and other traumatic events. Many of the interventions reviewed are environmental prevention strategies, and some of them have media campaign components, which makes this guide a particularly good resource for anti-drug coalitions that are often trained and directed to implement these kinds of activities.

Table 1: Summary of Environmental Prevention Strategies Used in Florida

Program, Policy, or Campaign	Substance(s) Targeted	Inclusion in Review	Is It Evidence-Based?
Communities Mobilizing for Change on Alcohol	Alcohol	Included	Evidence-Based
Raising the Minimum Legal Sales Age for Tobacco (“Brake the Vape” Advocacy Campaign)	Nicotine	Included	Evidence-Based
Prescription Drug Monitoring Program (PDMP) Utilization	Prescription drugs	Included	Evidence-Based

Drug Take Back Events and Drop Boxes (including “Operation Medicine Cabinet”)	Prescription Drugs and Over-the-Counter	Included	Inconclusive
Drug Deactivation Pouches	Prescription Drugs and Over-the-Counter	Included	Evidence-Based
Responsible Vendor Training	Alcohol	Included	Not Evidence-Based
“Talk It Up, Lock It Up” Campaign (with Lock Box Distribution)	Prescription Drugs, Alcohol, Marijuana, and Tobacco	Included	Insufficient Research
“Lock Your Meds” Campaign	Prescription drugs	Included	Insufficient Research
“Be the Wall” Campaign	Alcohol	Included	Insufficient Research
“At Home” Campaign	Alcohol	Included	Insufficient Research
“No One’s House” and “Not in My House” Campaigns	Alcohol	Included	Insufficient Research
“Know the Law” Campaign	Alcohol	Included	Insufficient Research
“Parents Who Host Lose the Most” Campaign	Alcohol	Included	Insufficient Research
Retailer Compliance Checks	Alcohol, Tobacco	Not Included	Unknown/Not Reviewed
Safe Festival Training	Alcohol	Not Included	Unknown/Not Reviewed
“Use Only as Directed” Campaigns	Prescription Opioids	Not Included	Unknown/Not Reviewed
Safe Use, Safe Storage, and Safe Disposal Campaigns	Prescription Drugs	Not Included	Unknown/Not Reviewed
“We ID” Signage and Checking Guides	Alcohol	Not Included	Unknown/Not Reviewed
“Talk. They Hear You” Campaign	Alcohol	Not Included	Unknown/Not Reviewed
Drug and Drug Paraphernalia Recognition and Detection Training (e.g., “Hidden in Plain Sight”)	Alcohol, nicotine, prescription drugs, Over-the-Counter, and new/emerging psychoactive substances	Not Included	Unknown/Not Reviewed

For the purposes of this report, strategies were evaluated with respect to their ability to reduce access, availability, or supply. Whether observed reductions in access, availability, or supply *cause reductions in consumption* are beyond the scope of this report. Additionally, note that the publication of the SAMHSA Evidence-Based Resource Guide, *Implementing Community-Level Policies to Prevent Alcohol Misuse*³ in November 2022 prompted the Department to revisit this analysis and incorporate the most current findings. The policies and strategies included in this guide address different facets of alcohol availability, including physical availability, financial availability, and social availability. Policies and strategies eligible for inclusion in this guide had to be clearly defined, replicable, evaluated through independent study, currently in use, and supported by implementation guides.

Summary of Findings

Thirteen out of 20 environmental strategies were included in this review. Of those, four were determined to be evidence-based, one not evidence-based, and one inconclusive. Seven strategies could not be evaluated due to insufficient research. The remaining strategies may be included in future reviews.

Communities Mobilizing for Change on Alcohol (CMCA): Communities Mobilizing for Change on Alcohol (CMCA) is a community-based program with a goal to “reduce the number of alcohol outlets that sell to young people; reduce the availability of alcohol from non-commercial sources [...]; and reduce community tolerance for underage purchase and

consumption of alcohol by changing cultural norms that permit and glamorize underage drinking.”⁴ SAMHSA identifies social norms, easy access to alcohol, and weak enforcement of underage drinking laws as risk factors address by CMCA with protective factors that include “policies, practices, and norms that deter underage drinking.”⁵ The intervention involves a community organizing process that follows seven steps: assessing the community, creating a core leadership group, developing a plan of action, building a base of support, implementing and institutionalizing change, and evaluating changes. The creators of CMCA conducted two combination randomized control trial and time series studies that evaluated the progress and impact of the intervention over a span of 2.5-years.

The first trial was conducted from 1992 to 1995 and included 15 school districts in the Midwest. The districts were matched on state, presence of a residential college or university, population, and baseline survey results and then randomly assigned to the treatment (7 districts) or control (8 districts) conditions. Pre- and post-intervention surveys were conducted with high school students, 18-20-year-olds, and alcohol outlet managers as well as underage alcohol purchase attempt surveys. The researchers found significant intervention effects on the practices of “on-sale” alcohol merchants (i.e., locations where alcohol was sold to be consumed on-site; $d = 1.18$) and on the behavior 18-20-year-olds ($d = .76$). When evaluating individual outcomes, the only significant finding was a 17% reduction in 18-20-year-olds in the intervention group providing alcohol to younger individuals. Several outcomes showed substantive changes but failed to reach significance, including increased ID checking and decreased sales to underage appearing individuals in on-sale establishments and decreases in self-reported attempts to buy alcohol and alcohol used in the past 30 days for 18-20-year-olds. There was no significant impact of the intervention on high schoolers reported drinking behaviors.⁶ In a secondary analysis of archival data, the researchers sought to gauge the potential impacts of CMCA on arrests for disorderly conduct, alcohol-related DUIs, single-vehicle nighttime crashes, and police-reported traffic crashes for 18-20-year-olds and 15-17-year-olds. They noted “reductions were observed in all arrest and traffic crash indicators for both age groups.” However, only reductions in DUI arrests for 18-20-year-olds were significant, resulting in a net decrease of 30.3 DUI arrests per 100,000 per year.⁷

The second trial investigated CMCA in schools of six communities in the Cherokee Nation with one community assigned the CMCA condition, one community assigned to a screening and brief intervention (SBI) in schools, two communities with both interventions, and two control communities. Data included intervention documentation and quarterly student surveys over 2.5 years. While the article only reports on intervention effects on drinking behavior (i.e., significant reductions in current alcohol use (13%), heavy drinking (12%), and alcohol-related consequences (8%) among high schoolers surveyed in the CMCA-only community),⁸ a secondary analysis showed that “CMCA reduced alcohol acquisition from direct commercial purchase as well as second-hand from social sources—peers and adults.”⁹ Notably, there was an 18% decrease in successful underage purchase attempts. It is important to note that although both trials included longitudinal measures and random assignment, both relied on self-reported data to measure substance use behaviors and smaller sample sizes precluded within-community analyses.

WYSAC proclaimed that “the literature provides varied evidence on the effectiveness of CMCA” as an environmental strategy.¹⁰ Its impact on youth drinking behavior is clear. Although only 18-20-year-olds were affected in the first trial, the second produced evidence of reduced drinking among high schoolers. As an environmental strategy, though, the findings are limited. Decreases in accessibility (i.e., increased ID checking, decreased underaged sales) were only significant in on-site drinking (e.g., bars, restaurants) establishments and not among off-sale (e.g., liquor store, convenience store) locations.

Raising the Minimum Legal Sales Age (MLSA) for Tobacco: On Dec. 20, 2019, the President of the United States signed legislation amending the Federal Food, Drug, and Cosmetic Act, raising the federal minimum age for sale of tobacco products from 18 to 21 years.¹¹ This legislation (known as “Tobacco 21” or “T21”)¹² became effective immediately, and it is now illegal for a retailer to sell any tobacco product to anyone under 21. The new federal minimum age of sale applies to all retail establishments and persons with no exceptions. The T21 law applies to sales of tobacco products – including cigarettes, smokeless tobacco, hookah tobacco, cigars, pipe tobacco, and electronic nicotine delivery systems, including e-cigarettes and e-liquids – to anyone under 21 years of age.

On October 1, 2021, Florida implemented a new statewide law that raised the minimum age to purchase tobacco and nicotine products from 18 to 21 years of age, making it illegal in Florida for anyone under 21 to buy, possess, or smoke tobacco and nicotine products, including e-cigarettes.¹³ The law also banned anyone under 21 from smoking or vaping within 1,000 feet of a school. This aligned Florida's minimum legal age for purchasing these products with federal law.

There is evidence to support that MLSA laws contribute to reductions in youth tobacco use.¹⁴ A March 2015 report by the Institute of Medicine (IOM) that was based on a review of the literature and predictive modeling concluded that raising the tobacco sale age to 21 would significantly reduce the number of adolescents and young adults who start smoking and improve the health of adolescents.¹⁵ The findings included evidence from jurisdictions that had adopted the policy, research on youth and young adult tobacco use and access, and research on industry marketing tactics.

The CPSTF and SAMHSA suggest that minimum legal purchasing age (also known as minimum legal drinking age; MLDA) laws are also effective at reducing youth alcohol availability. In a 2000 systematic review that was last updated in 2018, the CPSTF found evidence to show that raising the MLDA was associated with a median decrease of 16% in crash-related outcomes (i.e., fatal injury, nonfatal injury, and other crash types) across 14 studies.¹⁶ SAMHSA's 2022 guide also found that MLDA laws were associated with decreases in alcohol-related traffic fatalities in addition to reduced consumption among high schoolers and young adults.¹⁷ They categorized MLDA as one of the policies they highlight that "have a strong evidence base" and "affect populations broadly, rather than focus on small groups with a high risk of alcohol-related harm."

Prescription Drug Monitoring Program (PDMP): Prescription Drug Monitoring Programs (PDMPs) are data systems that collect, report, and analyze information on the prescribing and dispensing of controlled substances.¹⁸ SAMHSA issues discretionary grant funds for activities that incorporate PDMPs into the Strategic Prevention Framework by using PDMP data to identify high risk communities and system gaps, improving PDMP partnerships, and increasing the use of PDMP data for surveillance and evaluations.¹⁹ SAMSHA's Center for the Application of Prevention Technologies recommends that prevention practitioners use PDMP data to identify and refine priorities, recruit stakeholders, pin-point geographic "hot spots" for targeted prevention efforts, change prescriber behavior through alerts and comparative "report cards", encourage interagency collaboration around releasing and reporting data, and to track new trends and monitor progress.²⁰

In 2017, researchers published a scoping literature review included an aim to put forth a conceptual model to inform to implementation and evaluation of PDMPs.²¹ The analysis included 11 studies. Studies focused on comparisons between PDMP and non-PDMP states and analyses of data from Florida, New York, and North Carolina. The review's authors posited that the PDMP research assumes an association between increased monitoring and reporting of opioid prescriptions and one or more domains of outcomes: "1) opioid prescribing behavior, e.g., a reduction in opioid prescribing; 2) opioid diversion and supply; 3) opioid misuse; and 4) opioid-related morbidity/mortality, e.g., substance use disorder or overdose."

The impact of PDMPs on prescription drug use, the use of other substances (particularly heroin), and associated harms is beyond the scope of this report. The focus here is exclusively related to the impact of PDMPs on measures of supply and/or availability. Although we are interested in the ultimate impact of all the policies reviewed in this report on substance use outcomes, a cursory review of the literature on the effects of PDMPs suggests that it is substantial and complicated, yielding mixed findings from weak studies.²²

A 2021 systematic review and meta-analysis²³ of the impact of PDMP use on clinical decision-making reported that, "The most common clinical decision was in relation to the supply of controlled substances, which was reported in a total of 21 studies, with 10 reporting more than one supply change, including decreased prescribing and dispensing, increased prescribing and dispensing, and prescribing or recommending an alternative medication." All studies were conducted in the U.S. and published between 2005 and 2021. The quality of most studies was low. Researchers were able to perform a meta-analysis using only 15 studies with comparable data on increased/decreased prescribing and prescribing an alternative medication. Two studies reported PDMP use influenced prescribing but did not elaborate on how the supply of medication was altered. The most prevalent clinical decision was *decreased* prescribing. The proportion of prescribers reporting decreased prescribing of controlled substances ranged from 11% to 87%. The pooled prevalence of decreased

prescribing was 53%. In contrast, eight studies reported small *increases* in prescribing or dispensing following PDMP use, with a meta-analysis finding increased prescribing in 19% of cases. The proportion of prescribers reporting an increase ranged from 0.4% to 15%. Any empirical or value-based assessments of the appropriateness of any increases or decreases in prescribing or dispensing are also beyond the scope of this report.

Studies focusing on the impact of Florida's PDMP present promising results. Most studies obtained in our search examined the effects of the implementations of laws requiring PDMP use in combination with other events that happened around the same time, such as new legislation regulating pain clinics and increasing enforcement.²⁴ Researchers in one pair of studies leveraged a comparative interrupted time series design to investigate whether implementation of Florida's pill mill laws and PDMP was associated with reductions in opioid prescribing. In the first study, researchers compared prescribing data from Florida and Georgia, which had not yet enacted PDMP legislation during the data collection period, spanning the 12 months pre-implementation (i.e., July 2010 through June 2011) to an averaged 3-month implementation period (i.e., July 2011 to September 2011) to the 12 months following implementation (i.e., October 2011 to September 2012).²⁵ Data included records for 2.6 million patients, 431,890 prescribers, and 2,829 pharmacies total. Results suggested that implementation of pill mill and PDMP laws in Florida was associated with a reduction of about 2.46 kg of total volume of opioid prescriptions per month and a reduction of about .45 mg per month in mean morphine milligram equivalent (MME) per transaction compared with Georgia over the same period. The researchers noted, however, that the supply reductions identified were mostly limited to the highest baseline opioid users and prescribers. In a follow-up study, the researchers analyzed PDMP data for the same period as above that included 1.13 million Florida patients and 0.54 million Georgia patients with a focus on high-risk users.²⁶ This study confirmed the previous findings of significant reductions in total opioid volume prescribed and MME from pre- to post-implementation when compared with Georgia. When examining groups of high-risk users, they found significant reductions in total opioid volume and opioids prescribed for chronic opioid users and opioid shoppers compared with Georgia.

For the purposes of this report, PDMPs will be considered evidenced-based environmental supply reduction interventions, since decreased prescribing is the most observed result, according to meta-analytic findings from low quality U.S. studies, including studies of Florida's PDMP.

Drug Take Back Events and Drop Boxes (including "Operation Medicine Cabinet"): Drug take-back events are centered around secure drop boxes for unused, expired, or unwanted medications, including prescription and over-the-counter drugs. Organized disposal of controlled medications, such as a [DEA-sponsored prescription drug take-back](#) event, is a widely used prevention strategy to reduce the availability of prescription drugs for diversion or abuse. Drug take-back events provide an opportunity for individuals to safely return unused prescription drugs, including opioids, at specific locations on certain dates. Permanent drug drop boxes are usually placed at locations that are accessible to the public, such as law enforcement offices and pharmacies. Little is known as to whether these prevention strategies reduce the availability of medications for the purposes of diversion or abuse.

A 2021 systematic review of medication disposal interventions assessed the evidence of their effectiveness on disposal-related outcomes in terms of changes in disposal rates of unused prescription opioids.²⁷ The review included 25 studies, 13 of which focused on take-back events, and of those, 12 studies failed to evaluate their effectiveness. These included 12 cross-sectional studies providing counts of medications collected at the take-back events and, in some cases, included survey responses about reasons for disposal. Four of the cross-sectional studies measured controlled substances, including opioids, collected as the percentage of the total medications dispensed and found rates ranging from 3% to approximately 10%. None of the studies investigated the association between the intervention and outcomes nor did they assess the potential impact of confounding variables on disposal. Only one study attempted to evaluate the effectiveness of the take-back events by analyzing the concentration of hydrocodone in the wastewater using a cohort study design. The authors found significant decreases in hydrocodone concentrations following two local take-back events.²⁸

Two of the studies evaluated the use of permanent drug drop boxes, and both studies used a cross-sectional study design to collect information on the quantities of controlled substances collected. The studies examined the number of controlled substance doses collected at drop boxes over different times, of which 62% and 73% were opioid medications, respectively. Like the cross-sectional studies on drug take-back events, however, the drug drop box studies did not control for potential confounds or evaluate the effectiveness of the interventions.

None of the drug take-back or drop box studies identified in this systematic review included an evaluation of the impact of the interventions on diversion of medications. The authors indicated that evidence is lacking on whether the effectiveness of these interventions differs across populations and questioned the accuracy of self-reported disposal. According to this review, many questions on the take-back events remain unanswered, including the intensity of the campaigns prior to the events, the percentage of the target population exposed to the campaigns, the percentage of people moving to action (i.e., disposal at the take-back event) following exposure to the intervention, the disposal rate for people exposed to the campaigns compared to those who are not exposed, the subpopulations reached by the campaigns, and the percentage of unused opioids that are disposed at prescription drug take-back events.

Finally, the large number of medications collected may represent only a small portion of those stored in homes in the U.S. Based on an evaluation of the effectiveness of drug disposal programs in comparison with prescription drug monitoring program data, researchers found that controlled substances collected by take-back events and permanent drug drop boxes constituted a small proportion of the numbers dispensed, accounting for only about 0.3% of the total dispensed.²⁹ Their findings suggest that organized drug disposal efforts may have a minimal impact on reducing the availability of unused medications at a community level; however, the authors emphasized that the study findings do not preclude all possible positive effects of drug take-back programs, adding, “The study was limited in both time and scope; the results might be different in different communities, and over time these programs may influence community norms and behaviors related to storage, disposal and abuse of controlled medications.”³⁰

Drug Deactivation Pouches: Diversion of prescription drugs, especially opioid pain relievers such as hydrocodone and oxycodone, is an ongoing concern for the prevention and treatment of substance use disorders. The Centers for Disease Control and Prevention reported over 168 million opioid prescriptions were filled in 2018,³¹ and according to the 2020 National Survey on Drug Use and Health (NSDUH), 3% of people aged 12 and over reported using prescription pain relievers for nonmedical purposes in the previous year, representing about 9.3 million people.³² Leftover medication is a primary source of prescription drugs diverted for misuse. Although 42% of the people who reported misusing prescription pain relievers in the previous year obtained them through a prescription from a doctor, 47% indicated they received the drugs from family and friends whether they were given, sold, or stolen.³³

One way to reduce the diversion of prescription drugs is ensure proper disposal of leftover medication. The U.S. Food and Drug Administration (FDA) advises taking unused drugs to drug take back events or prescription drop-off boxes. If those options are not possible, they provide information on home disposal, such as flushing or mixing the medications with an unpalatable substance and throwing them in the trash.³⁴ Concerns exist, however, about the benefit of following these at-home methods. Flushing medications down the toilet could impact the environment, and while mixing the drugs with kitty litter or coffee grounds makes them less attractive, it does not deactivate the substances, leaving them available for misuse. In recent years, drug deactivation products, such as the [Deterra](#) Drug Deactivation System, have come on the market that use activated carbon or another mechanism to deactivate the medications and render them virtually harmless and safe to discard in the trash.³⁵ Studies on the Deterra website present research suggesting the pouches deactivate 99% of drugs exposed to the pouch.³⁶

Researchers have investigated prescription opioid disposal behaviors to identify disposal rates, disposal methods, and factors that may impact decisions to do so. In a national panel survey, Kennedy-Hendricks et al. found that almost half of respondents with leftover opioids (49%) were keeping them for future use while only about two-fifths (39%) disposed or planned to dispose of them.³⁷ One possibility for increasing the rates at which people dispose of leftover medication is

provision of drug deactivation pouches like the Deterra system to individuals being prescribed opioids after surgery. A review of the literature shows significant increases in disposal rates; however, most studies consisted of cross-sectional surveys and single-institution randomized control trials (RCT) that relied on self-report to measure study outcomes.

In a 2021 systematic review of medication disposal interventions, researchers identified these and other weaknesses.³⁸ The review included 25 studies, of which only 12 evaluated effectiveness of interventions and only two examined deactivation pouches, both RCTs. The rest were descriptive studies. In one RCT, researchers randomly assigned adult surgical patients to one of three conditions: usual care, provision of educational materials, or provision of educational materials and a deactivation pouch. They found that 57% of adult surgical patients who received pouches reported disposing of leftover opioids six to eight weeks after surgery versus 33% of the educational materials group and 29% who received usual care.³⁹ In the other RCT, researchers examined the parents or guardians of pediatric surgery patients based on whether they received standard information and instructions to dispose leftover medications at a drop-off box or received a deactivation pouch. Of those that had leftover opioids, 86% of the intervention group reported properly disposing of excess medication (90% of whom used the deactivation pouch) versus 65% of the control group when surveyed six weeks after surgery.⁴⁰ The authors of the 2021 review concluded that both studies showed evidence of intervention effectiveness but expressed concerns that variability in intervention and control group disposal rates between the studies could indicate low generalizability of the findings. Another study from 2021 also investigated the impact of providing parents and guardians of pediatric surgical patients with deactivation pouches. They found that 72% of participants reported disposing of excess opioids compared with 52% of those who received standard educational materials. Interestingly, over 60% of those who had not yet disposed of medications in either group expressed the intention to dispose of the medication in the future.⁴¹ The remaining studies revealed in our review consisted of cross-sectional surveys that reflected those findings, including the variability, with a range of 27% to 88% of adult surgical patients who received deactivation pouches reporting they disposed of unused medications several weeks after discharge.⁴²

Despite the weaknesses noted above, individuals consistently reported higher rates of disposal of excess medications when provided with a deactivation pouch. The RCTs all showed increased likelihood of disposal. The question, however, is whether these findings are generalizable beyond the post-surgical context. All studies investigating the efficacy of providing drug deactivation pouches included surgical patients who were prescribed opioids for postoperative pain management. It is not clear in what contexts would be best to provide the pouches, who would best benefit from the provisions, or whether the pouches would lead to similar levels of reduction of medications at risk of diversion in the prevention population.

Responsible Vendor Training: Responsible Vendor Training, also known as Responsible Beverage Service (RBS) training, is intended to increase safe serving practices and reduce sales to minors among licensed alcohol vendors. Training helps retailers comply with relevant laws against sales to underage individuals or intoxicated individuals. According to the Alcohol Policy Information System, as of January 2021, 39 states and the District of Columbia have laws on the books either requiring training or providing incentives to businesses for completing training.⁴³ Florida passed the voluntary Florida Responsible Vendor Act in 2012 with the intent of eliminating alcohol sales to minors, preventing customer over-service, reducing alcohol-related accidents and injuries, and encouraging beverage vendors to employ responsible serving practices.⁴⁴ Vendors qualified as responsible vendors are exempt from losing their license due to unlawful sales made by trained employees, and status as a responsible vendor is considered in the mitigation of penalties due to unlawful sales by trained employees.⁴⁵ Although there is wide coverage of vendor-related legislation across the U.S., the question remains: is RBS training effective at reducing or eliminating underage alcohol sales or service to intoxicated individuals?

Research on the subject focused almost exclusively on over-service and was ultimately inconclusive. A 2008 systematic review examined 15 studies involving server training interventions ranging in publication from 1987 to 2008. The

authors concluded that “there is conflicting evidence as to whether there is an improvement in server behavior,” citing poor study methodologies, risks of bias, and an inability to evaluate pooled effectiveness due to variation in the range of reported outcomes. Among the finding on server behavior after RBS training interventions, effects on refusal of service to (3 studies) and successful purchases by (2 studies) apparently intoxicated pseudo-patrons were not significant. While three studies reported significant changes in observed server behavior, two other studies report non-significant findings. Similarly, findings related to the patrons were mixed. While two studies reported significant decreases in the percentage of bar patrons with greater than a threshold blood alcohol content (BAC), two studies found no significant change in patron mean BAC. The significant effects were not long lasting with one study showing decay of effects at a 3-month follow-up.

More recent studies have produced more mixed findings and fading effects. One RCT published in 2014 involved providing prevention coalitions with an intervention to improve implementation of RBS training and compliance checks to prevent underage drinking. The intervention included provision of a manual, RBS training, and on-site technical assistance. Although they found that the implementation quality increased compared to control coalitions over the 3-year study, there were no significant differences in self-reported merchant behavior at a 16-month follow-up.⁴⁶

Another community-level study also had mixed findings. Two communities (Monroe County in New York and Cleveland, Ohio) were selected to implement an intervention integrating RBS training and enhanced enforcement. Thirty problem bars in each community were identified and randomly assigned to intervention, control, or alternate groups. Data included trained pseudo-patron purchase attempts, observational bar assessments, actual patron BAC levels, and self-reported behavior among other measures. Training was provided to managers and employees with two enforcement checks with results sent to vendors in the following months. Follow-up data collection was conducted about 6- and 12-months post-intervention. In Monroe County, purchase refusal rates and observed overservice in the intervention bars were too low to analyze. Intervention bars in Cleveland were more likely to refuse service to intoxicate patrons by the first follow-up (4% to 28%); however, refusal rates significantly declined between then and the second follow-up (21%). Neither community had significant reductions in the mean BAC of patrons from baseline to the first follow-up. Monroe County had a significant decline between baseline and the second follow-up. Finally, although the communities showed reductions in the percentage of patrons intoxicated (at least .08 BAC) or highly intoxicated (at least .15 BAC), Cleveland actually had a significant increase in percentage of both intoxicated and highly intoxicated patrons by the second follow-up.⁴⁷

Another study that included 334 bars and restaurants across 15 Midwest communities leveraged an RCT design to assess a hybrid in-person and online RBS training for managers designed to promote and assist development of a policy manual for the establishment. They examined manager surveys to evaluate the impact on adoption of alcohol service policies and their implementation. There were significant increases in the percentage of managers in intervention sites reporting creation of policies from the baseline (62%) to the 1-month follow-up (91%) and 6-month follow-up (95%) compared to the control group. There were also significant increases in reported training on how to refuse intoxicated patrons from baseline to the two follow-ups and training staff to handle fake IDs between the 1-month and 6-month follow ups.⁴⁸ The same researchers also found non-significant decreases in likelihood of selling to intoxicated patrons of 6% and 12% at 1- and 3-month follow-ups, respectively, at intervention bars. By the 6-month mark, however, there were no differences between intervention and control locations in terms of purchase rates. Possible limitations included 30% of intervention establishments failing to complete the online portion of the training and low participation rates compared to total establishments contacted for the study.⁴⁹

One RCT involved providing online RBS training to 152 intervention bars and restaurants and the “usual customary” (i.e., in-person) training for 155 control sites to test the hypothesis that provision of the [Way to Serve](#) training that utilizes multimedia and interactive content would lead to higher server refusal rates to pseudo-patrons trained to act intoxicated. Analysis of the proportion of pseudo-patrons denied service showed significantly higher refusal rates at

intervention sites compared to the control immediately post-intervention (68% vs. 49%) and at a 1-year follow-up (68% vs. 58%); however, there was no significant difference 6-months post-intervention. The researchers highlighted standardization of online training compared to in-person training that could differ depending on the facilitator as possible reasons for the study's success.⁵⁰

Ultimately, a report from the Community Preventive Services Task Force summarizes the state of research evidence supporting responsible vendor training well: "The Community Preventive Services Task Force concludes there is insufficient evidence to determine the effectiveness of responsible beverage service (RBS) training programs for reducing excessive alcohol consumption and related harms at the community level. Although reviewed studies generally showed positive results for the measured outcomes, these results primarily came from academic research studies that evaluated programs focused on individual establishments and were implemented under favorable conditions (e.g., intensive training programs, short follow-up times). Because of these limitations, further evidence is necessary to assess the public health impact of sustainable, community-wide RBS training programs."⁵¹

Social Marketing and Awareness Campaigns: There was insufficient research available to evaluate whether the following media- and marketing-related campaigns are evidence-based.

- **"Talk It Up, Lock It Up" Campaign (with Lock Box Distribution):** This campaign encourages parents to have regular conversations with children about avoiding substance use and encourages parents to monitor, secure, and properly dispose of alcohol, tobacco, marijuana, or prescription drugs. Lock boxes are also distributed.
- **"Lock Your Meds" Campaign:** Lock Your Meds[®] is a national multi-media campaign designed to reduce prescription drug abuse by making adults aware that they are the "unwitting suppliers" of prescription medications being used in unintended ways. Produced by National Family Partnership, it is a multi-media campaign involving posters, interactive video games, and a website.
- **"Be the Wall" Campaign:** The [Be the Wall](#) campaign aims to equip parents with information and skills to host safe parties and limit access to alcohol. Tips related to reducing access to alcohol include keeping an eye on backpacks and purses, discouraging teens from going back and forth from the house to their cars, locking up any alcohol in the home, and avoiding the use of punch bowls, pitchers, and cups.
- **"At Home" Campaign:** This campaign focuses on the legal consequences of providing alcohol to individuals under the age of 21. Some parents in Florida were born and raised in foreign countries with lower minimum legal drinking ages. PSAs in Spanish are aired through Univision.
- **"No One's House" and "Not My House" Campaigns:** No One's House is a Safe Place for Teen Drinking is a social marketing campaign intended to deter parents from allowing underage teens to drink in their homes.⁵² The primary goal of the Not in My House campaign is reducing youth social access to alcohol by raising awareness about social host liability.
- **"Know the Law" Campaign:** This is a social marketing campaign that disseminates information about laws and penalties associated with hosting open house parties and providing alcohol to underage individuals, through booklets, classroom presentations, social media posts, and Public Service Announcements.
- **"Parents Who Host Lose the Most" Campaign:** Parents Who Host Lose the Most is an awareness campaign that educates parents about the laws and penalties associated with hosting open house parties.

Although our literature searches did not result in any studies for these specific campaigns, it might be possible to examine their quality by exploring a few of the common strategies at the core of these and similar campaigns.

¹ Wyoming Survey & Analysis Center. *Environmental Strategies Tool*. University of Wyoming. Retrieved from <https://www.wyomingpreventiondepot.org/strategies/>.

² Guide to Community Preventive Services. *About the Community Preventive Services Task Force*. Retrieved from <https://www.thecommunityguide.org/task-force/about-community-preventive-services-task-force>.

³ Substance Abuse and Mental Health Services Administration. (2022). *Implementing Community-Level Policies to Prevent Alcohol Misuse*. SAMHSA Publication No. PEP22-06-01-006. Rockville, MD.

- ⁴ Wagenaar, A. C., Gehan, J. P., Jones-Webb, R., Toomey, T. L., Forster, J. L., Wolfson, M., & Murray, D. M. (1999). Communities Mobilizing for Change on Alcohol: Lessons and Results from a 15-Community Randomized Trial. *Journal of Community Psychology*, 27, 315-326.
- ⁵ Substance Abuse and Mental Health Services Administration. (2019). *Substance Misuse Prevention for Young Adults*. Publication No. PEP19-PL-Guide-1 Rockville, MD.
- ⁶ Wagenaar, A. C., Murray, D. M., Gehan, J. P., Wolfson, M., Forster, J. L., Toomey, T. L., Perry, C. R., & Jones-Webb, R. (2000). Communities Mobilizing for Change on Alcohol: Outcomes from a Randomized Community Trial. *Journal of Studies on Alcohol*, 61(1), 85-94.
- ⁷ Wagenaar, A. C., Murray, D. M., & Toomey, T. L. (2000). Communities Mobilizing for Change on Alcohol (CMCA): Effects of a Randomized Trial on Arrests and Traffic Crashes. *Addiction*, 95, 209-217.
- ⁸ Wagenaar, A. C., Murray, D. M., & Toomey, T. L. (2000). Communities Mobilizing for Change on Alcohol (CMCA): Effects of a Randomized Trial on Arrests and Traffic Crashes. *Addiction*, 95, 209-217.
- ⁹ Wagenaar, A. C., Livingston, M. D., Pettigrew, D. W., Kominsky, T. K., & Komro, K. A. (2018). Communities Mobilizing for Change on Alcohol (CMCA): Secondary Analyses of a Randomized Controlled Trial Showing Effects of Community Organizing on Alcohol Acquisition by Youth in the Cherokee Nation. *Addiction*, 113, 647-655.
- ¹⁰ Wyoming Survey & Analysis Center. Communities Mobilizing for Change on Alcohol. *Environmental Strategies Tool*. University of Wyoming. Retrieved from <https://www.wyomingpreventiondepot.org/strategies/>.
- ¹¹ Tobacco to 21 Act, H.R.2411 (2019). Retrieved from <https://www.congress.gov/bill/116th-congress/house-bill/2411/text>
- ¹² U.S. Food & Drug Administration. (n.d.) *Tobacco 21*. Retrieved from <https://www.fda.gov/tobacco-products/retail-sales-tobacco-products/tobacco-21>
- ¹³ Tobacco and Nicotine Products, Fla S.B. 1080 (2021). Retrieved from <https://www.flsenate.gov/Session/Bill/2021/1080/?Tab=BillText>
- ¹⁴ Kowitt, S. D., Schmidt, A. M., Myers, A. E., & Goldstein, A. O. (2017). Should the Legal Age for Tobacco Be Raised? Results from a National Sample of Adolescents. *Preventing Chronic Disease*.
- ¹⁵ Institute of Medicine 2015. *Public Health Implications of Raising the Minimum Age of Legal Access to Tobacco Products*. Washington, DC: The National Academies Press.
- ¹⁶ Guide to Community Preventive Services. *Motor Vehicle Injury Alcohol-Impaired Driving: Maintaining Current Minimum Legal Drinking Age (MLDA) Laws*. Retrieved from <https://www.thecommunityguide.org/findings/motor-vehicle-injury-alcohol-impaired-driving-maintaining-current-minimum-legal-drinking-age.html>.
- ¹⁷ Substance Abuse and Mental Health Services Administration (2022). *Implementing Community-Level Policies to Prevent Alcohol Misuse*. SAMHSA Publication No. PEP22-06-01-006. Rockville, MD.
- ¹⁸ Prescription Drug Monitoring Program Training and Technical Assistance Center (PDMP TTAC). (n.d.). *PDMP Policies and Practices*. Retrieved from <https://www.pdmpassist.org/Policies>.
- ¹⁹ Substance Abuse and Mental Health Services Administration. (2021). *Strategic Prevention Framework for Prescription Drugs Funding Opportunity Announcement No. SP-21-001*. Retrieved from <https://www.samhsa.gov/sites/default/files/grants/pdf/fy21-spf-rx-foa.pdf>.
- ²⁰ Prevention Solutions@EDC. (n.d.). *Using Prescription Drug Monitoring Program Data to Support Prevention Planning – At-a-Glance!* Retrieved from https://preventionsolutions.edc.org/sites/default/files/attachments/Using-Prescription-Drug-Monitoring-Program-Data-to-Support-Prevention-Planning_0.pdf.
- ²¹ Finley, E. P., Garcia, A., Rosen, K., McGeary, D., Pugh, M. J., & Potter, J. S. (2017). Evaluating the Impact of Prescription Drug Monitoring Program Implementation: A Scoping Review. *BMC Health Services Research*, 17.
- ²² Fink, D. S., et al. (2018). Association Between Drug Monitoring Programs and Nonfatal and Fatal Drug Overdoses: A Systematic Review. *Annals of Internal Medicine*, 168(11), 783-790.
- ²³ Picco, L., et al. (2021). How Prescription Drug Monitoring Programs Influence Clinical Decision-making: A Mixed Methods Systematic Review and Meta-analysis. *Drug and Alcohol Dependence*, 228, 109090.
- ²⁴ Surratt, H. L., O'Grady, C., Kurtz, S. P., Stivers, Y., Cicero, T. J., Dart, R. C., & Chen, M. (2014). Reductions in Prescription Opioid Diversion Following Recent Legislative Interventions in Florida. *Pharmacoepidemiology and Drug Safety*, 23, 314-320.
- ²⁵ Rutkow, L., Chang, H.-Y., Daubresse, M., Webster, D. W., Stuart, E. A., & Alexander, G. C. (2015). Effect of Florida's Prescription Drug Monitoring Program and Pill Mill Laws on Opioid Prescribing and Use. *JAMA Internal Medicine*, 175, 1642-1649.
- ²⁶ Chang, H.-Y., Murimi, I., Faul, M., Rutkow, L., & Alexander, G. C. (2018). Impact of Florida's Prescription Drug Monitoring Program and Pill Mill Law on High-Risk Patients: A Comparative Interrupted Time Series Analysis. *Pharmacoepidemiology & Drug Safety*, 47, 422-429.
- ²⁷ Schäfer, W. L.A., Johnson, J. K., Wafford, Q. E., Plummer, S. G., & Stulberg, J. J. (2021). Primary prevention of prescription opioid diversion: A systematic review of medication disposal interventions. *The American Journal of Drug and Alcohol Abuse*, 5, 1-12.

- ²⁸ Stoddard, K. I., & Huggett, D. B. (2015). Wastewater Effluent Hydrocodone Concentrations as an Indicator of Drug Disposal Program Success. *Bulletin of Environmental Contamination and Toxicology*, 95, 139-144.
- ²⁹ Egan, K. L., Gregory, E., Sparks, M., & Wolfson, M. (2016). From Dispensed to Disposal: Evaluating the Effectiveness of Disposal Programs through a Comparison with Prescription Drug Monitoring Program Data. *The American Journal of Drug and Alcohol Abuse*, 43, 69-77.
- ³⁰ Ibid.
- ³¹ Centers for Disease Control and Prevention. (2019). *2019 Annual Surveillance Report of Drug-Related Risks and Outcomes — United States Surveillance Special Report*. Retrieved from <https://www.cdc.gov/drugoverdose/pdf/pubs/2019-cdc-drug-surveillance-report.pdf>
- ³² Substance Abuse and Mental Health Services Administration. (2021). Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health (HHS Publication No. PEP21-07-01-003, NSDUH Series H-56). Rockville, MD.
- ³³ Substance Abuse and Mental Health Services Administration. (2021). Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health (HHS Publication No. PEP21-07-01-003, NSDUH Series H-56). Rockville, MD.
- ³⁴ U.S. Food and Drug Administration. (2020). *Disposal of Unused Medicines: What You Should Know*. Retrieved from <https://www.fda.gov/drugs/safe-disposal-medicines/disposal-unused-medicines-what-you-should-know>
- ³⁵ Deterra Drug Deactivation System. (n.d.). *Deterra System Frequently Asked Questions (FAQs)*. Retrieved from <https://deterrasystem.com/science-and-research/faqs/>
- ³⁶ Deterra Drug Activation System. (n.d.). *Case Studies*. Retrieved from <https://deterrasystem.com/resources/case-studies/>
- ³⁷ Kennedy-Hendricks, A., Gielen, A., McDonald, E., McGinty, E. E., Shields, W., & Barry, C. L. (2016). Medication Sharing, Storage, and Disposal Practices for Opioid Medications among US Adults. *JAMA Internal Medicine*, 176, 1027-1029.
- ³⁸ Schäfer, W. L.A., Johnson, J. K., Wafford, Q. E., Plummer, S. G., & Stulberg, J. J. (2021). Primary Prevention of Prescription Opioid Diversion: A Systematic Review of Medication Disposal Interventions. *The American Journal of Drug and Alcohol Abuse*, 5, 1-12.
- ³⁹ Brummet, C. H., Steiger, R., Englesbe, M., Khalsa, C., DeBlanc, J. J., Denton, J. R., & Waljee, J. (2019). Effect of an Activated Charcoal Bag on Disposal of Unused Opioids after an Outpatient Surgical Procedure: A Randomized Clinical Trial. *Jama Surgery*, 154, 558-561.
- ⁴⁰ Lawrence, A. E., Carsel, A. J., Leonhart, K. L., Richards, H. W., Harbaugh, C. M., Waljee, J. F., McLeod, D. J., Walz, P. C., Minneci, P. C., Deans, K. J., & Cooper, J. N. (2019). Effect of Drug Disposal Bag Provision on Proper Disposal of Unused Opioids by Families of Pediatric Surgical Patients: A Randomized Clinical Trial. *JAMA Pediatrics*, 173(8).
- ⁴¹ Cooper, J. N., Lawrence, A. E., Koppera, S., Sebastian, S., Fischer, J. A., Minneci, P. C., & Deans, K. J. (2021). Effect of Drug Disposal Bag Provision on Families' Disposal of Children's Unused Opioids. *Journal of the American Pharmacists Association*, 61, 109-114.
- ⁴² Boitano, T. K. L., Norton, S. B., Shrestha, K. S., Smith, H. J., Leath, C. A., III, & Straughn, J. M., Jr. (2022). Using an Environmentally Friendly Disposal Bag to Discard Leftover Opioids after Gynecologic Surgery. *Obstetrics & Gynecology*, 139, 91-96; Loomis, E. A., McNaughton, D., & Genord, C. (2022). A Quality Improvement Initiative Addressing Safe Opioid Prescribing and Disposal Postcesarean Delivery. *Pain Management Nursing*, 23, 174-179; Ramel, C. L., Habermann, E. B., Thiels, C. A., Dierkhising, R. A., & Cunningham, J. L. (2020). Provision of a Drug Deactivation System for Unused Opioid Disposal at Surgical Dismissal: Opportunity to Reduce Community Opioid Supply. *Mayo Clinic Proceedings: Innovations, Quality & Outcomes*, 4, 357-361.
- ⁴³ Alcohol Policy Information System. (n.d.). *Beverage Service Training and Related Practices*. Retrieved from <https://alcoholpolicy.niaaa.nih.gov/apis-policy-topics/beverage-service-training-and-related-practices/26#page-content>
- ⁴⁴ Section 561.702, Florida Statutes. (2012).
- ⁴⁵ Section 561.706, Florida Statutes. (2012).
- ⁴⁶ Chinman, M., Ebener, P., Burkhart, Q., Osilla, K. C., Imm, P., Paddock, S. M., & Wright, P. A. (2014). Evaluating the Impact of Getting to Outcomes-Underage Drinking on Prevention Capacity and Alcohol Merchant Attitudes and Selling Behaviors. *Prevention Science*, 15, 485-496.
- ⁴⁷ Fell, J. C., Fisher, D. A., Yao, J., McKnight, A. S., Blackman, K. O., & Coleman, H. L. (2017). Evaluation of Responsible Beverage Service to Reduce Impaired Driving by 21- to 34-year-old Drivers (Report No. DOT HS 812 398). Washington, DC: National Highway Traffic Safety Administration.
- ⁴⁸ Lenk, K. M., Erickson, D. J., Nelson, T. F., Horvath, K. J., Nederhoff, D. M., Hunt, S. L., Ecklund, A. M., & Toomey, T. L. (2018). Changes in Alcohol Policies and Practices in Bars and Restaurants after Completion of Manager-Focused Responsible Service Training. *Drug and Alcohol Review*, 37, 356-364.
- ⁴⁹ Toomey, T. L., Lenk, K. M., Erickson, D. J., Horvath, K. J., Ecklund, A. M., Nederhoff, D. M., Hunt, S. L., & Nelson, T. F. (2017). Effects of a Hybrid Online and In-Person Training Program Designed to Reduce Alcohol Sales to Obviously Intoxicated Patrons. *Journal of Studies on Alcohol and Drugs*, 78, 268-275.

⁵⁰ Woodall, W. G., Starling, R., Saltz, R. F., Buller, D. B., & Stanghetta, P. (2018). Results of a Randomized Trial of Web-Based Retail Onsite Responsible Beverage Service Training: WayToServe. *Journal of Studies on Alcohol and Drugs*, 79, 672-679.

⁵¹ Centers for Disease Control and Prevention. (n.d.). Guide to Community Preventive Services. Alcohol – Excessive Consumption: Responsible Beverage Service Training. <https://www.thecommunityguide.org/findings/alcohol-excessive-consumption-responsible-beverage-service-training>.

⁵² Prevention Solutions, Inc. (2020). *No One's House*. Retrieved from <https://www.preventionsolutionsinc.com/no-one-s-house>; Anti-Drug Coalition of Citrus County. (2020). *No One's House*. Retrieved from <https://www.antidrugcitrus.com/anti-drug-coalition-no-ones-house.php>.

NOT FINAL

C. State Agency Expenditure Reports

MHBG Table 3 - Set-aside for Children's Mental Health Services

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

Statewide Expenditures for Children's Mental Health Services			
Actual SFY 1994	Actual SFY 2021	Estimated/Actual SFY 2022	Expense Type
\$39,659,772	\$50,657,831	\$44,094,632	<input checked="" type="radio"/> Actual <input type="radio"/> Estimated

If estimated expenditures are provided, please indicate when actual expenditure data will be submitted to SAMHSA: _____

States and jurisdictions are required not to spend less than the amount expended in FY 1994.

0930-0168 Approved: 03/31/2022 Expires: 03/31/2025

Footnotes:

See the attached document entitled 2021-22 Set-Aside for Children's Mental Health Services. KG

**Community Mental Health Block Grant MOE and Children's Mental Health
Threshold Reporting Methodology for SFY 2021-22**

Adult Mental Health Services

OCA	OCA Title	SFY 21/22 Expenditures
FSH00	FSH INDIGENT DRUG PROGRAM	\$3,266,865
MH072	ME MH COMM FORENSIC BEDS	\$13,944,896
FCTGR	FACT Team Transfer to AHCA	\$4,485,500
MHMCT	ME MH MOBILE CRISIS TEAMS	\$20,400,114
MH0FT	ME FACT Medicaid Ineligible	\$8,608,899
MH076	ME MH INDIG PSYCH MEDS PROGRAM	\$2,169,570
MHTMH	ME MH TRANSITIONAL BEDS FOR MH	\$4,609,570
Total Adult Services		\$57,485,414

Children's Mental Health Services

OCA	OCA Title	SFY 21/22 Expenditures
32N03	JV RESTORATION-INCMPTNT TO PRO	\$8,845,057
MH071	ME MH PRTS EMOT DISTURB CHILD/YOUTH	\$2,201,779
MHCAT	CAT Teams	\$33,047,796
Total Children's Services		\$44,094,632

Total Adult Services	\$57,485,414
Total Children's Set-Aside	\$44,094,632
Total Mental Health MOE	\$101,580,046

C. State Agency Expenditure Reports

MHBG Table 6 - Maintenance of Effort for State Expenditures on Mental Health Services

Period (A)	Expenditures (B)	<u>B1 (2020) + B2 (2021)</u> 2 (C)
SFY 2020 (1)	\$101,079,219	
SFY 2021 (2)	\$101,393,373	\$101,236,296
SFY 2022 (3)	\$101,580,046	

Are the expenditure amounts reported in Column B "actual" expenditures for the State fiscal years involved?

SFY 2020	Yes	<u>X</u>	No	_____
SFY 2021	Yes	<u>X</u>	No	_____
SFY 2022	Yes	<u>X</u>	No	_____

If estimated expenditures are provided, please indicate when actual expenditure data will be submitted to SAMHSA: _____

0930-0168 Approved: 03/31/2022 Expires: 03/31/2025

Footnotes:

See the attached document entitled 2021-22 MHBG MOE and Children's Methodology. KG

**Community Mental Health Block Grant MOE and Children's Mental Health
Threshold Reporting Methodology for SFY 2021-22**

Adult Mental Health Services

OCA	OCA Title	SFY 21/22 Expenditures
FSH00	FSH INDIGENT DRUG PROGRAM	\$3,266,865
MH072	ME MH COMM FORENSIC BEDS	\$13,944,896
FCTGR	FACT Team Transfer to AHCA	\$4,485,500
MHMCT	ME MH MOBILE CRISIS TEAMS	\$20,400,114
MH0FT	ME FACT Medicaid Ineligible	\$8,608,899
MH076	ME MH INDIG PSYCH MEDS PROGRAM	\$2,169,570
MHTMH	ME MH TRANSITIONAL BEDS FOR MH	\$4,609,570
Total Adult Services		\$57,485,414

Children's Mental Health Services

OCA	OCA Title	SFY 21/22 Expenditures
32N03	JV RESTORATION-INCMPTNT TO PRO	\$8,845,057
MH071	ME MH PRTS EMOT DISTURB CHILD/YOUTH	\$2,201,779
MHCAT	CAT Teams	\$33,047,796
Total Children's Services		\$44,094,632

Total Adult Services	\$57,485,414
Total Children's Set-Aside	\$44,094,632
Total Mental Health MOE	\$101,580,046