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 Substance Abuse Block Grant Report

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 03/02/2022 - Expires 03/31/2025
(generated on 11/15/2022 11.23.20 AM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

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.

I: State Information

State Information

I. State Agency for the Block Grant

Agency Name	Department of Children and Families
Organizational Unit	Office of Substance Abuse and Mental Health
Mailing Address	2415 North Monroe St, Suite 400
City	Tallahassee, Florida
Zip Code	32303-4190

II. Contact Person for the Block Grant

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Last Name	Cveticanin
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III. Expenditure Period

State Expenditure Period

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

Block Grant Expenditure Period

From	10/1/2019
To	9/30/2021

IV. Date Submitted

Submission Date	
Revision Date	

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Footnotes:

II: Annual Update

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 servied 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 Prvention 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 1out 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.

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Footnotes:

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 CERTICATION 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) 5. Impact of Substance Use on Families	Understanding Addiction (24 hours)
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 9. Intersection of Harm Reduction and Prevention 10. Integrating Substance Use Prevention with wellness	Prevention Education and Service Delivery (15 hours)
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.

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 (CPSTP) 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-analysis[23] 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 dug 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 Lost 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.

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III: Expenditure Reports

Table 2a - State Agency Expenditure Report

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

Activity (See instructions for entering expenses in Row 1)	A. SA Block Grant	B. MH Block Grant	C. Medicaid (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19[1]	I. ARP[2]
1. Substance Abuse Prevention (Other than Primary Prevention) and Treatment[3]	$78,595,493.00		$0.00	$87,398,220.00	$105,760,353.60	$0.00	$0.00	$42,226,424.00	$0.00
a. Pregnant Women and Women with Dependent Children	$1,597,344.00		$0.00	$0.00	$10,162,927.00	$0.00	$0.00	$0.00	$0.00
b. All Other	$76,998,149.00		$0.00	$87,398,220.00	$95,597,426.60	$0.00	$0.00	$42,226,424.00	$0.00
2. Substance Use Disorder Primary Prevention	$26,261,611.00		$0.00	$5,748,616.00	$436,891.00	$0.00	$0.00	$19,351,401.00	$0.00
3. Tuberculosis Services	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
4. Early Intervention Services Regarding the Human Immunodeficiency Virus (EIS/HIV)[4]	$5,475,111.00		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
5. State Hospital									
6. Other 24 Hour Care									
7. Ambulatory/Community Non-24 Hour Care									
8. Mental Health Primary Prevention									
9. Evidenced Based Practices for First Episode Psychosis (10% of the state's total MHBG award)									
10. Administration (Excluding Program and Provider Level)	$1,376,173.00		$0.00	$5,043,664.00	$6,745,045.00	$0.00	$0.00	$977,098.00	$0.00
11. Total	**$111,708,388.00**	**$0.00**	**$0.00**	**$98,190,500.00**	**$112,942,289.60**	**$0.00**	**$0.00**	**$62,554,923.00**	**$0.00**

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

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

[3] Prevention other than primary prevetion

[4] Only designated states as defined in 42 U.S.C. § 300x-24(b)(2) and 45 CFR § 96.128(b) for the applicable federal fiscal year should enter information in this row. This may include a state or states that were previously considered designated states during any of the three prior federal fiscal years for which a state was applying for a grant. See EIS/HIV policy change in SABG Annual Report instructions.

Please indicate the expenditures are actual or estimated.

(•) Actual ( ) Estimated

0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:
MOE does not include admin from State funds. KG

III: Expenditure Reports

Table 2b - COVID-19 Relief Supplemental Funds Expenditure by Service – Requested

Expenditure Period Start Date 10/1/2021 Expenditure Period End Date 9/30/2022

Service	COVID-19 Expenditures
Healthcare Home/Physical Health	**$0**
Specialized Outpatient Medical Services	
Acute Primary Care	
COVID-19 Screening (e.g., temperature checks, symptom questionnaires)	
COVID-19 Testing	
COVID-19 Vaccination	
Comprehensive Care Management	
Care Coordination and Health Promotion	
Comprehensive Transitional Care	
Individual and Family Support	
Referral to Community Services Dissemination	
Prevention (Including Promotion)	**$0**
Screening with Evidence-based Tools	
Risk Messaging	
Access Line/Crisis Phone Line/Warm Line	
Purchase of Technical Assistance	
COVID-19 Awareness and Education for Person with SUD	
Media Campaigns (Information Dissemination)	
Primary Substance Use Disorder Prevention (Education)	
Primary Substance Use Disorder Prevention (Alternatives)	
Employee Assistance Programs (Problem Identification and Referral)	
Primary Substance Use Disorder Prevention (Community-Based Processes)	

Primary Substance Use Disorder Prevention (Environmental)	
Intervention Services	**$0**
Fentanyl Strips	
Syringe Services Program	
Naloxone	
Overdose Kits/Dissemination of Overdose Kits	
Engagement Services	**$0**
Assessment	
Specialized Evaluations (Psychological and Neurological)	
Services Planning (including crisis planning)	
Consumer/Family Education	
Outreach (including hiring of outreach workers)	
Outpatient Services	**$0**
Evidence-based Therapies	
Group Therapy	
Family Therapy	
Multi-family Therapy	
Consultation to Caregivers	
Medication Services	**$0**
Medication Management	
Pharmacotherapy (including MAT)	
Laboratory Services	
Community Support (Rehabilitative)	**$0**
Parent/Caregiver Support	
Case Management	
Behavior Management	

Supported Employment	
Permanent Supported Housing	
Recovery Housing	
Recovery Supports	**$0**
Peer Support	
Recovery Support Coaching	
Recovery Support Center Services	
Supports For Self-Directed Care	
Supports (Habilitative)	**$0**
Personal Care	
Respite	
Supported Education	
Acute Intensive Services	**$0**
Mobile Crisis	
Peer-based Crisis Services	
Urgent Care	
23-hour Observation Bed	
Medically Monitored Intensive Inpatient for SUD	
24/7 Crisis Hotline	
Other	**$0**
Smartphone Apps	
Personal Protective Equipment	
Virtual/Telehealth/Telemedicine Services	
Purchase of increased connectivity (e.g., Wi-Fi)	
Cost-sharing Assistance (e.g., copayments, coinsurance and deductibles)	
Provider Stabilization Payments	
Transportation to COVID-19 Services (e.g., testing, vaccination)	

Other (please list)	
Total	**$0**

Please enter the five services (e.g., COVID-19 testing, risk messaging, group therapy, peer support) from any of the above service categories (e.g., Healthcare Home/Physical Health, prevention (including promotion), outpatient services, recovery supports) that reflect the five largest expenditures of COVID-19 Relief Supplement Funds.

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Table 3a SABG - Syringe Services Program

Expenditure Start Date: 07/01/2021 Expenditure End Date: 06/30/2022

Syringe Services Program SSP Agency Name	Main Address of SSP	Dollar Amount of SABG Funds Expended for SSP	Dollar Amount of COVID-19[1] Funds Expended for SSP	Dollar Amount of ARP[2] Funds Expended for SSP	SUD Treatment Provider (Yes or No)	# Of locations (Include any mobile locations)	Narcan Provider (Yes or No)	Fentanyl Strips (Yes or No)
No Data Available								

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

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

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Table 3b SABG - Syringe Services Program

Expenditure Start Date: Expenditure End Date:

SABG							
Syringe Services Program Name	**# of Unique Individuals Served**		**HIV Testing** ***(Please enter total number of individuals served)***	**Treatment for Substance Use Conditions** ***(Please enter total number of individuals served)***	**Treatment for Physical Health** ***(Please enter total number of individuals served)***	**STD Testing** ***(Please enter total number of individuals served)***	**Hep C** ***(Please enter total number of individuals served)***
	0	ONSITE Testing	0	0	0	0	0
		REFERRAL to testing	0	0	0	0	0

COVID-19							
Syringe Services Program Name	**# of Unique Individuals Served**		**HIV Testing** ***(Please enter total number of individuals served)***	**Treatment for Substance Use Conditions** ***(Please enter total number of individuals served)***	**Treatment for Physical Health** ***(Please enter total number of individuals served)***	**STD Testing** ***(Please enter total number of individuals served)***	**Hep C** ***(Please enter total number of individuals served)***
	0	ONSITE Testing	0	0	0	0	0
		REFERRAL to testing	0	0	0	0	0

ARP							
Syringe Services Program Name	**# of Unique Individuals Served**		**HIV Testing** ***(Please enter total number of individuals served)***	**Treatment for Substance Use Conditions** ***(Please enter total number of individuals served)***	**Treatment for Physical Health** ***(Please enter total number of individuals served)***	**STD Testing** ***(Please enter total number of individuals served)***	**Hep C** ***(Please enter total number of individuals served)***
	0	ONSITE Testing	0	0	0	0	0
		REFERRAL to testing	0	0	0	0	0

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Table 4 - State Agency SABG Expenditure Compliance Report

This table provides a description of SABG expenditures for authorized activities to prevent and treat SUDs. For detailed instructions, refer to those in BGAS. Only one column is to be filled in each year.

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

Expenditure Category	FY 2020 SA Block Grant Award
1. Substance Abuse Prevention[1] and Treatment	$79,290,625.00
2. Primary Prevention	$27,733,791.00
3. HIV Early Intervention Services[2]	$4,022,100.00
4. Early Intervention Services Regarding the Human Immunodeficiency Virus (EIS/HIV)	$0.00
5. Administration (excluding program/provider level)	$338,799.00
Total	**$111,385,315.00**

[1]Prevention other than Primary Prevention

[2]Only designated states as defined in 42 U.S.C. § 300x-24(b)(2) and 45 CFR § 96.128(b) for the applicable federal fiscal year should enter information in this row. This may include a state or states that were previously considered "designated states" during any of the three prior federal fiscal years for which a state was applying for a grant. See EIS/HIV policy change in SABG Annual Report instructions.

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Table 5a - SABG Primary Prevention Expenditures

The state or jurisdiction must complete SABG Table 5a. There are six primary prevention strategies typically funded by principal agencies administering the SABG. Expenditures within each of the six strategies or Institute of Medicine Model (IOM) should be directly associated with the cost of completing the activity or task. For example, information dissemination may include the cost of developing pamphlets, the time of participating staff and/or the cost of public service announcements, etc. If a state plans to use strategies not covered by these six categories or the state is unable to calculate expenditures by strategy, please report them under "Other" in Table 5a.

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

Strategy	IOM Target	SA Block Grant Award	Other Federal	State	Local	Other
Information Dissemination	Selective	$327,115.00				
Information Dissemination	Indicated	$109,038.00				
Information Dissemination	Universal	$654,231.00				
Information Dissemination	Unspecified	$0.00				
Information Dissemination	**Total**	**$1,090,384.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Education	Selective	$2,698,702.00				
Education	Indicated	$899,567.00				
Education	Universal	$5,397,404.00				
Education	Unspecified	$0.00				
Education	**Total**	**$8,995,673.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Alternatives	Selective	$327,115.00				
Alternatives	Indicated	$109,038.00				
Alternatives	Universal	$654,231.00				
Alternatives	Unspecified	$0.00				
Alternatives	**Total**	**$1,090,384.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Problem Identification and Referral	Selective	$1,308,462.00				
Problem Identification and Referral	Indicated	$436,154.00				
Problem Identification and Referral	Universal	$2,616,923.00				
Problem Identification and Referral	Unspecified	$0.00				
Problem Identification and Referral	**Total**	**$4,361,539.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

Community-Based Process	Selective	$3,352,933.00				
Community-Based Process	Indicated	$1,117,644.00				
Community-Based Process	Universal	$6,705,866.00				
Community-Based Process	Unspecified	$0.00				
Community-Based Process	**Total**	**$11,176,443.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Environmental	Selective	$163,558.00				
Environmental	Indicated	$54,519.00				
Environmental	Universal	$327,115.00				
Environmental	Unspecified	$0.00				
Environmental	**Total**	**$545,192.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Section 1926 (Synar)-Tobacco	Selective	$0.00				
Section 1926 (Synar)-Tobacco	Indicated	$0.00				
Section 1926 (Synar)-Tobacco	Universal	$0.00				
Section 1926 (Synar)-Tobacco	Unspecified	$0.00				
Section 1926 (Synar)-Tobacco	**Total**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Other	Selective	$0.00				
Other	Indicated	$0.00				
Other	Universal	$0.00				
Other	Unspecified	$0.00				
Other	**Total**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
	Grand Total	**$27,259,615.00**				

Section 1926 (Synar)-Tobacco: Costs associated with the Synar Program Pursuant to the January 19, 1996 federal regulation "Tobacco Regulation for Substance Abuse Prevention and Treatment Block Grants, Final Rule" (45 CFR § 96.130), a state may not use the SABG to fund the enforcement of its statute, except that it may expend funds from its primary prevention set aside of its Block Grant allotment under 45 CFR §96.124(b)(1) for carrying out the administrative aspects of the requirements, such as the development of the sample design and the conducting of the inspections. States should include any non-SABG funds* that were allotted for Synar activities in the appropriate columns under 7 below.

*Please list all sources, if possible (e.g.., Centers for Disease Control and Prevention, Block Grant, foundations, etc.)

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Table 5b - SABG Primary Prevention Targeted Priorities (Required)

The purpose of the first table is for the state or jurisdiction to identify the substance and/or categories of substances it identified through its needs assessment and then addressed with primary prevention set-aside dollars from the FY 2020 SABG NoA. The purpose of the second table is to identify each special population the state or jurisdiction selected as a priority for primary prevention set-aside expenditures.

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

	SABG Award
Targeted Substances	
Alcohol	☑
Tobacco	☐
Marijuana	☑
Prescription Drugs	☑
Cocaine	☐
Heroin	☑
Inhalants	☐
Methamphetamine	☑
Synthetic Drugs (i.e. Bath salts, Spice, K2)	☐
Targeted Populations	
Students in College	☐
Military Families	☐
LGBTQ+	☐
American Indians/Alaska Natives	☐
African American	☐
Hispanic	☐
Homeless	☐
Native Hawaiian/Other Pacific Islanders	☐
Asian	☐
Rural	☐

Underserved Racial and Ethnic Minorities	☑

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Table 6 - Non Direct Services/System Development

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

Activity	A. SABG Treatment	B. SABG Prevention	C. SABG Integrated[1]
1. Information Systems	$670,410.00	$64,113.00	$0.00
2. Infrastructure Support	$196,472.00	$258,288.00	$0.00
3. Partnerships, community outreach, and needs assessment	$307,573.00	$72,383.00	$0.00
4. Planning Council Activities (MHBG required, SABG optional)	$0.00	$0.00	$0.00
5. Quality Assurance and Improvement	$266,675.00	$33,616.00	$0.00
6. Research and Evaluation	$81,686.00	$18,629.00	$0.00
7. Training and Education	$66,142.00	$27,144.00	$0.00
8. Total	**$1,588,958.00**	**$474,173.00**	**$0.00**

[1]SABG integrated expenditures are expenditures for non-direct services/system development that cannot be separated out of the amounts devoted specifically to treatment or prevention. For Column C, do not include any amounts already accounted for in Column A, SABG Treatment and/or Column B, SABG Prevention.

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Table 7 - Statewide Entity Inventory

This table provides a report of the sub-recipients of SABG funds including community- and faith-based organizations which provided SUD prevention activities and treatment services, as well as intermediaries/administrative service organizations. Table 7 excludes system development/non-direct service expenditures.

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

										Source of Funds SAPT Block Grant					
	Entity Number	I-BHS ID (formerly I-SATS)	ⓘ	Area Served (Statewide or SubState Planning Area)	Provider / Program Name	Street Address	City	State	Zip	A. All SA Block Grant Funds	B. Prevention (other than primary prevention) and Treatment Services	C. Pregnant Women and Women with Dependent Children	D. Primary Prevention	E. Early Intervention Services for HIV	F. Syringe Services Program
	230715301	FL108831	✓	Southeast Region	211 Palm Beach/Treasure Coast Inc	415 Gator Drive	Lantana	FL	33462	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	593087085	FL108581	✓	Northeast	Ability Housing of NE Florida Inc	76 South Laura Street Suite 303	Jacksonville	FL	32202	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	591860626	FL902581	✓	Suncoast Region	Agency for Community Treatment Servs	4612 North 56th Street	Tampa	FL	33610 -7123	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	591162148	FL751459	✓	Northwest	Apalachee Center Inc	2634 Capital Circle NE P.O. Box 1782	Tallahassee	FL	32302 -1782	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	592341993	FL126009	✓	Southeast	Archways Inc	919 NE 13th Street	Fort Lauderdale	FL	33304	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	592301233	FL904041	✓	Central	Aspire Health Partners	1800 Mercy Drive	Orlando	FL	32808	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	273164934	FL111770	✓	Southeast Region	Banyan Detox	225 North Federal Highway	Pompano Beach	FL	33062	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	273164934	FL108216	✓	Southern	Banyan Health Systems	6100 Blue Lagoon Suite 400	Miami	FL	33126	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	591371752	FL104968	✓	Suncoast Region	BayCare Behavioral Health	14527 7th Street	Dade City	FL	33523	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	592462933	FL109039	✓	Southern	Better Way of Miami Inc	800 NW 28th Street	Miami	FL	33127	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	596000531	FL104337	✓	Southeast	Broward Addiction Recovery Center	1000 SW 2nd Street	Fort Lauderdale	FL	33312	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	590624402	FL100761	✓	Southeast	Broward County Commission on SA	1300 South Andrews Avenue	Fort Lauderdale	FL	33316	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	596000524	FL100716	✓	Southeast	Broward County Sheriffs Office	1351 NW 27th Avenue	Pompano Beach	FL	33069	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	592913416	FL112108	✓	Southeast Region	Broward House Inc	1726 SE 3rd Avenue	Fort Lauderdale	FL	33316	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	592274772	FL125985	✓	Southeast	Broward Regional Health	915 Middle River Drive Suite 521	Fort Lauderdale	FL	33304	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	5901086491	FL100848	✓	Suncoast	C E Mendez Foundation Inc	600 North Willow Avenue Suite 301	Tampa	FL	33606	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	650032862	FL112238	✓	Southern	Camillus House	1603 NW 7th Avenue	Miami	FL	33136	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	592564198	FL103908	✓	Southeast	Care Resource Comm Health Ctrs	871 West Oakland Park Boulevard	Fort Lauderdale	FL	33311	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	591279497	FL100152	✓	Southern	Catholic Charities of Miami	7707 NW 2nd Avenue	Miami	FL	33150	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	590143525	FL109021	✓	Northeast	CDS Family/Behavioral Health Servs	3615 SW 13th Street Suite 4	Gainesville	FL	32608	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	510177273	FL900239	✓	Northeast	Centers Inc	3238 South Lecanto Highway	Lecanto	FL	34461	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

	590100953	FL106985	✓	Suncoast Region	Centerstone of Florida Inc	P.O. Box 9478	Bradenton	FL	34206	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	591234922	FL751244	✓	Suncoast Region	Charlotte Behavioral Healthcare Inc	1700 Education Avenue	Punta Gorda	FL	33950	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	592912345	FL106324	✓	Northwest	Chemical Addictions Recovery Effort	4000 East 3rd Street	Panama City	FL	32404	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	591101553	FL102697	✓	Central	Circles of Care Inc	400 East Sheridan Road	Melbourne	FL	32901	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	591865751	FL904231	✓	Southern	Citrus Health Network Inc	4175 West 20th Avenue	Hialeah	FL	33012	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	592219317	FL101649	✓	Northeast	Clay Behavioral Health Center	1726 Kingsley Avenue Suite 2	Orange Park	FL	32073 -4411	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	591432136	FL902862	✓	Suncoast Region	Coastal Behavioral Healthcare Inc	12497 Tamiami Trail Suite 4	North Port	FL	34287	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	260402611	FL108837	✓	Northeast	Community Coalition Alliance Inc	435 Citrona Drive	Fernandina Beach	FL	32034	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	591380927	FL110805	✓	Northwest	Community Drug and Alcohol Council	803 North Palafox Street	Pensacola	FL	32501	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	591372690	FL750907	✓	Southern	Community Health of South Florida Inc	10300 SW 216th Street	Miami	FL	33190	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	237063810	FL100178	✓	Southern	Concept Health Systems Inc	4850 NE 2nd Avenue	Miami	FL	33137	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	650988051	FL000581	✓	Central Region	Counseling and Recovery Center Inc	P.O. Box 1257	Fort Pierce	FL	34954	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	591514993	FL100566	✓	Suncoast	Cove Behavioral Health	4422 East Columbus Drive	Tampa	FL	33605	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	592323607	FL102117	✓	Southeast	Covenant House Florida	733 Breakers Avenue	Fort Lauderdale	FL	33304	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	592206025	FL112637	✓	Suncoast Region	David Lawrence Center	6075 Bathey Lane	Naples	FL	34116	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	592092715	FL124673	✓	Suncoast Region	Directions for Living	1437 South Belcher Road	Clearwater	FL	33764	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	591491338	FL112744	✓	Northwest	DISC Village Inc	3333 West Pensacola Street Building 300	Tallahassee	FL	32304	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	23070746256O	FL108844	✓	Southeast Region	Drug Abuse Foundation of Palm Beach Co	400 South Swinton Avenue	Delray Beach	FL	33444	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	591363887	FL105814	✓	Southeast Region	Drug Abuse Treatment Association Inc	1016 North Clemons Street Suite 300	Jupiter	FL	33477	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	592551416	FL123568	✓	Suncoast	Eckerd Youth Alternatives Inc	201 Culbreath Road	Brooksville	FL	34602	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	591502582	FL100806	✓	Northeast	EPIC Community Services Inc	17 St. Johns Medical Park Drive	Saint Augustine	FL	32086	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	591466709	FL101777	✓	Southern	Fellowship House	5711 South Dixie Highway	Miami	FL	33143	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	591304472	FL125266	✓	Suncoast Region	First Step of Sarasota Inc	1726 18th Street	Sarasota	FL	34234	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	202630595	FL105315	✓	Southern	Gang Alternative	12000 Biscayne Boulevard	North Miami	FL	33181	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	591881828	FL110457	✓	Northeast	Gateway Community Services Inc	555 Stockton Street	Jacksonville	FL	32204	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	591458324	FL108258	✓	Southern	Guidance Care Center Inc	3000 41st Ocean	Marathon	FL	33050	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	591229354	FL102747	✓	Suncoast Region	Gulf Coast Jewish Family Services Inc	14041 Icot Boulevard	Clearwater	FL	33760	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

	202871945	FL108894	✓	Suncoast Region	Hanley Center Foundation Inc	900 54th Street	West Palm Beach	FL	33407	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	2028719458	FL108894	✓	Suncoast Region	Hanley Center Foundation Inc	900 54th Street	West Palm Beach	FL	33407	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	593163742	FL111814	✓	Northeast	Healthy Start Coalition of Flagler and	109 Executive Circle	Daytona Beach	FL	32114	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	590711167	FL101841	✓	Southeast Region	Henderson Behavioral Health Center Inc	4740 North State Road 7	Fort Lauderdale	FL	33319	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	591298067	FL100236	✓	Southern	Heres Help Inc	15100 NW 27th Avenue	Opa Locka	FL	33054	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	475135700	FL112742	✓	Southern	Hialeah Community Coalition	4708 East 9th Lane	Hialeah	FL	33013	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	710950579	FL751483	✓	Suncoast	Hillsborough County Crisis Center Inc	2214 East Henry Avenue	Tampa	FL	33610 -4497	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	591675284	FL110961	✓	Northeast	House Next Door	804 North Woodland Boulevard	Deland	FL	32720	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	593084953	FL123584	✓	Central	House of Freedom Inc	P.O. Box 42-3202	Kissimmee	FL	34744	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	237014595	FL902946	✓	Southeast	House of Hope	908 Arpeika Street	Fort Lauderdale	FL	33312	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	592704597	FL102707	✓	Southeast Region	Housing Partnership Inc	2001 Blue Heron Boulevard	Riviera Beach	FL	33404	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	237109532	FL110573	✓	Central	IMPOWER	2290 North Ronald Reagan Boulevard Suite 116	Longwood	FL	32750	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	592231894	FL105462	✓	Southern	Informed Families	2490 Coral Way	Miami	FL	33145	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	590866060	FL103541	✓	Southern	Institute for Child and Family Health	15490 NW 7th Avenue	Miami	FL	33169 -6231	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	5901171320	FL104891	✓	Southeast Region	Jerome Golden Ctr for Behav Hlth	1041 43rd Streeet	West Palm Beach	FL	33407	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	591235617	FL115275	✓	Southern Region	Jessie Trice Community Health Ctr	2985 NW 54th Street	Miami	FL	33142	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	590637867	FL106928	✓	Southern	Jewish Community Services of	12000 Biscayne Boulevard Suite 303	Miami	FL	33181	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	590737872	FL100301	✓	Northwest	Lakeview Center Inc	1221 West Lakeview Avenue Building H	Pensacola	FL	32501	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	591561501	FL110456	✓	Northeast	LifeStream Behavioral Center Inc	P.O. Box 491000	Leesburg	FL	34749	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	591906214	FL114070	✓	Northeast	Meridian Behavioral Healthcare Inc	4300 SW 13th Street	Gainesville	FL	32608 -4006	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	596000573	FL750865	✓	Southern	Miami Dade County	111 NW 1st Street Suite 2150	Miami	FL	33128	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	596000573	FL112743	✓	Southern	Miami Dade County	701 NW 1st Court 10th Floor	Miami	FL	33136	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	650440678	FL114245	✓	Southern	New Hope CORPS	1020 North Krome Avenue	Homestead	FL	33030	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	592055751	FL104709	✓	Southern	New Horizons Community MH Ctr	1469 NW 36th Street	Miami	FL	33142	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	596153749	FL114351	✓	Central Region	New Horizons of the Treasure Coast Inc	4500 West Midway Road	Fort Pierce	FL	34981	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	591349234	FL110223	✓	Suncoast Region	Operation Par Inc	6720 54th Avenue North	Saint Petersburg	FL	33709	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	592897172	FL112650	✓	Northeast Region	Outreach Community Care Network	240 North Frederick Avenue	Daytona Beach	FL	32114	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

	591677912	FL102631	✓	Central	Park Place Behavioral Healthcare	206 Park Place Boulevard	Kissimmee	FL	34741	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	590818924	FL102528	✓	Suncoast Region	Peace River Center	P.O. Box 1559	Bartow	FL	33830	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	593153549	FL110448	✓	Suncoast Region	Personal Enrichment Through MH Servs	11254 58th Street North	Pinellas Park	FL	33782	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	593172948	FL111239	✓	Suncoast Region	Phoenix Houses of Florida	510 Vonderburg Drive Suite 301	Brandon	FL	33511	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	5.96000809	FL101181	✓	Central	Polk County Drug Court Treatment Prog	P.O. Box 9000 Drawer J-138	Bartow	FL	33831	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	815190566	FL108840	✓	Southeast Region	Rebel Recovery Lake Worth	1893 Prairie Road	West Palm Beach	FL	33406	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	591952727	FL102142	✓	Northeast Region	River Region Human Services Inc	2055 Reyko Road Building 4700 Suite 101	Jacksonville	FL	32207	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	591287693	FL102538	✓	Suncoast Region	SalusCare	3763 Evans Avenue	Fort Myers	FL	33901	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	590976866	FL102576	✓	Northeast	SMA Adolescent Residential	150 Magnolia Avenue	Daytona Beach	FL	32114	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	596014973	FL106907	✓	Southeast	South Broward Hospital District	3501 Johnson Street	Hollywood	FL	33021	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	596014973	FL111179	✓	Southeast	South Florida Wellness Center	4100 South Hospital Drive Suite 102	Plantation	FL	33317	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	230706196	FL750196	✓	Central	Space Coast Recovery Inc	1215 Lake Drive	Cocoa	FL	32922	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	593029469	FL101869	✓	Northeast	Starting Point Behavioral Healthcare	463142 State Road 200	Yulee	FL	32097	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	630083693	FL122875	✓	Central	STEPS Inc	1033 North Pine Hills Road Suite 400	Orlando	FL	32808	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	650202835	FL101169	✓	Central Region	Substance Abuse Council of IRC	2501 27th Avenue Suite A-7	Vero Beach	FL	32960	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	592092717	FL000464	✓	Suncoast	Suncoast Center Inc	4024 Central Avenue	Saint Petersburg	FL	33711	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	650695313	FL118832	✓	Southeast Region	Sunset House Inc	8589 Sunset Drive	Palm Beach Gardens	FL	33410	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	593218903	FL110095	✓	Central	Transition House Inc	3501 West Vine Street Suite 319	Kissimmee	FL	34741	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	591708182	FL124426	✓	Central	Tri County Human Services Inc	4683 East County Road 540 A	Lakeland	FL	33813	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	590637825	FL101149	✓	Northeast Region	United Way of Northeast Florida	P.O. Box 41428	Jacksonville	FL	32203 -1428	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	591452736	FL103664	✓	Southern	Village South Inc	7867 North Kendall Drive	Miami	FL	33156	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	591590644	FL104901	✓	Southeast Region	Wayside House	328 NE 6th Avenue	Delray Beach	FL	33483	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	593714627	FL106403	✓	Suncoast	Westcare Gulfcoast Florida Inc	2525 South First Avenue	Saint Petersburg	FL	33712	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	591545990	FL124608	✓	Suncoast	Youth and Family Alternatives Inc	5126 School Road	Land O Lakes	FL	34639	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total										$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

*** Indicates the imported record has an error.**

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Footnotes:

III: Expenditure Reports

Table 8a - Maintenance of Effort for State Expenditures for SUD Prevention and Treatment

This Maintenance of Effort table provides a description of non-federal expenditures to include funds appropriated by the state legislature; revenue funds (e.g., alcohol, tobacco, and gambling taxes; asset seizures); state Medicaid match expenditures; and third-party reimbursement (e.g., insurance payments) for authorized activities to prevent and treat SUDs flowing through the Single State Agency (SSA) during the state fiscal year immediately preceding the federal fiscal year for which the state is applying for funds.

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

Total Single State Agency (SSA) Expenditures for Substance Abuse Prevention and Treatment		
Period **(A)**	**Expenditures** **(B)**	**B1(2020) + B2(2021)** **2** **(C)**
SFY 2020 (1)	$105,282,827.00	
SFY 2021 (2)	$106,530,263.00	$105,906,545.00
SFY 2022 (3)	$106,197,244.00	

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

SFY 2020 Yes **X** No ____

SFY 2021 Yes **X** No ____

SFY 2022 Yes **X** No ____

Did the state or jurisdiction have any **non-recurring expenditures** as described in 42 U.S.C. § 300x-30(b) for a specific purpose which were not included in the MOE calculation?

Yes ____ No **X**

If yes, specify the amount and the State fiscal year: ____

If yes, SFY: ____

Did the state or jurisdiction include these funds in previous year MOE calculations?

Yes ____ No ____

When did the State or Jurisdiction submit an official request to SAMHSA to exclude these funds from the MOE calculations? ____

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

Please provide a description of the amounts and methods used to calculate the total Single State Agency (SSA) expenditures for substance use disorder prevention and treatment 42 U.S.C. §300x-30.
See the attached document entitled 2021-22 SAPT MOE
Methodology. KG

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Footnotes:

2021/22 SAPT MOE Summary

Funding Source	OCA	OCA Name	Expenditure Total
State General Revenue	MS000	ME SA SVCS & SUPPORT	$72,158,162
	MS081	ME EXPAND SA SVCS PREG WOM, MOTHERS & THEIR FAM	$10,162,927
	MSCBS	ME SA COMMUNITY BASED SERVICES	$14,366,427
	PRV00	SA PREVENTION SVCS	$436,891
	SP904	ALCOHOL AND OPIOID DEPENDENCY	$1,818,117
	MS925	ME MCKINSEY SETTLEMENT - SA SERVICES	$7,254,720
Total SAPT MOE Expenditures			$106,197,244

III: Expenditure Reports

Table 8b - Expenditures for Services to Pregnant Women and Women with Dependent Children

This Maintenance of Effort table provides a description of non-federal expenditures to include funds appropriated by the state legislature; revenue funds (e.g., alcohol, tobacco, and gambling taxes; asset seizures); state Medicaid match expenditures; and third-party reimbursement (e.g., insurance payments) for authorized activities to prevent and treat SUDs flowing through the Single State Agency (SSA) during the state fiscal year immediately preceding the federal fiscal year for which the state is applying for funds.

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

Base

Period	Total Women's Base (A)
SFY 1994	$ 9,327,217.00

Maintenance

Period	Total Women's Base (A)	Total Expenditures (B)	Expense Type
SFY 2020		$ 12,555,639.00	
SFY 2021		$ 10,963,856.00	
SFY 2022		$ 11,464,249.00	(•) Actual ( ) Estimated
Enter the amount the State plans to expend in SFY 2023 for services for pregnant women and women with dependent children (amount entered must be not less than amount entered in Section III: Table 8b – Expenditures for Services to Pregnant Women and Women with Dependent Children, Base, Total Women's Base (A) for Period of (SFY 1994)): $ 10000000.00			

Please provide a description of the amounts and methods used to calculate the base and, for 1994 and subsequent fiscal years, report the Federal and State expenditures for such services for services to pregnant women and women with dependent children as required by 42 U.S.C. §300x-22(b)(1). Please see the attached document, SFY 21-22 PWWDC Quarterly Expenditures, outlining the Pregnant and Parenting Women Expenditures. The State of Florida utilizes relevant OCA's (other cost accumulators) from the state accounting system to capture the required total SFY 2022 expenditure. KG

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Footnotes:

Pregnant and Parenting Women Expenditures			
State Fiscal Year 2021/22			
SFY Quarter	**Reporting Period**	**MS027 (Federal)**	**MS081 (State)**
1st	July 1 - Sept 30	$44,004	$1,628,068
2nd	Oct 1 - Dec 31	$534,849	$2,028,626
3rd	Jan 1 - March 31	$299,287	$2,150,906
4th	April 01 - June 30	$719,204	$4,059,305
YTD Total		**$1,597,344**	**$9,866,905**
		$11,464,249	

IV: Population and Services Reports

Table 9 - Prevention Strategy Report

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

Column A (Risks)	Column B (Strategies)	Column C (Providers)
No Risk Assigned	**1. Information Dissemination**	
	1. Clearinghouse/information resources centers	8
	2. Resources directories	9
	3. Media campaigns	28
	4. Brochures	38
	5. Radio and TV public service announcements	21
	6. Speaking engagements	60
	7. Health fairs and other health promotion, e.g., conferences, meetings, seminars	52
	8. Information lines/Hot lines	5
	9. GGC, PS, PBCSAC - Various Print Media Dissemination/ Social Media and Networking/ Community Wide Awareness, SACIRC - Town Halls, Tykes/Teans - Not Specified	20
	2. Education	
	1. Parenting and family management	49
	2. Ongoing classroom and/or small group sessions	68
	3. Peer leader/helper programs	17
	4. Education programs for youth groups	50
	5. Mentors	14
	6. Preschool ATOD prevention programs	6
	7. TGFD, YLS, NHTC - Prevention Training, PBCSAC Gang Prevention/Opioid Training, SACIRC - Generation RX	43
	3. Alternatives	
	1. Drug free dances and parties	23
	2. Youth/adult leadership activities	22
	3. Community drop-in centers	3
	4. Community service activities	21
	5. Outward Bound	1

6. Recreation activities	21
7. TGFD, PS, PBCSAC - Club Quaran Teen Event/Youth Dialogue/Awards Luncheon	14
4. Problem Identification and Referral	
1. Employee Assistance Programs	1
2. Student Assistance Programs	10
3. Driving while under the influence/driving while intoxicated education programs	9
4. TGFD, CMB; Prevention Counseling, assessment and referral; PBCSAC - Adult Focus Groups for Underage Drinking/Marijuana/Teen Focus Group on Marijuanna; Tykes/Teens - Not Specified	30
5. Community-Based Process	
1. Community and volunteer training, e.g., neighborhood action training, impactor-training, staff/officials training	79
2. Systematic planning	63
3. Multi-agency coordination and collaboration/coalition	81
4. Community team-building	63
5. Accessing services and funding	26
6. TGFD, AP, NHTC - Coalition Participation/Coalition Support, PBCSAC - Coalition Task Force Meetings, SACIRC - Workgroup Meeting	36
6. Environmental	
1. Promoting the establishment or review of alcohol, tobacco, and drug use policies in schools	15
2. Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drugs	9
3. Modifying alcohol and tobacco advertising practices	7
4. Product pricing strategies	0
5. 55-a - Environmental Strategies, Illegal Drugs, 55-b - Environmental Strategies, RX or OTC, Hanley - Bus Poster Contest-positive alcohol social norm message, PBCSAC - Environmental Strategies for OTC and illegal drugs	30

Footnotes:

IV: Population and Services Reports

Table 10 - Treatment Utilization Matrix

This table is intended to capture the count of persons with initial admissions and subsequent admission(s) to an episode of care.

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

Level of Care	SABG Number of Admissions ≥ Number of Persons Served		COVID-19 Number of Admissions ≥ Number of Persons Served		SABG Costs per Person			COVID-19 Costs per Person[1]			ARP Costs per Person[2]		
	Number of Admissions (A)	Number of Persons Served (B)	Number of Admissions (A)	Number of Persons Served (B)	Mean Cost of Services (C)	Median Cost of Services (D)	Standard Deviation of Cost (E)	Mean Cost of Services (C)	Median Cost of Services (D)	Standard Deviation of Cost (E)	Mean Cost of Services (C)	Median Cost of Services (D)	Standard Deviation of Cost (E)
DETOXIFICATION (24-HOUR CARE)													
1. Hospital Inpatient	0	0	0	0									
2. Free-Standing Residential	9,681	8,852	8	8									
REHABILITATION/RESIDENTIAL													
3. Hospital Inpatient	0	0	0	0									
4. Short-term (up to 30 days)	530	530	32	32									
5. Long-term (over 30 days)	5,962	5,894	254	254									
AMBULATORY (OUTPATIENT)													
6. Outpatient	21,336	21,336	208	208									
7. Intensive Outpatient	0	0	0	0									
8. Detoxification	36	36	0	0									
OUD MEDICATION ASSISTED TREATMENT													
9. OUD Medication-Assisted Detoxification[3]	15,755	4,581	0	0									
10. OUD Medication-Assisted Treatment Outpatient[4]	20,608	8,835	0	0									

Please explain why Column A (SABG and COVID-19 Number of Admissions) are less than Column B (SABG and COVID-19 Number of Persons Served)

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

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

[3]OUD Medication-Assisted Treatment Detoxification includes hospital detoxification, residential detoxification, or ambulatory detoxification services/settings AND Opioid Medication-Assisted Treatment.

[4]OUD Medication Assisted Treatment Outpatient includes outpatient services/settings AND Opioid Medication-Assisted Treatment.

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Footnotes:

All figures come from the Department's official database for behavioral health records, called the Financial and Services Accountability Management System (FASAMS), with the exception of rows 9 and 10. Figures in rows 9 and 10 are reported directly by the Managing Entities via the Block Grant Reporting Template.

Several factors impacted state Managing Entities' ability to fund services with the COVID-19 Relief supplemental funding, including delayed budget authority and widescale staffing shortages. The Department has submitted a no cost extension for the unspent funds and is waiting for SAMHSA's approval.

IV: Population and Services Reports

Tables 11A, 11B and 11C - Unduplicated Count of Persons Served for Alcohol and Other Drug Use

This table provides an aggregate profile of the unduplicated number of admissions to and persons served in SABG and COVID-19 Relief Supplement funded services.

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

TABLE 11A – SABG Unduplicated Count of Person Served for Alcohol and Other Drug Use

Age	A. Total	B. WHITE		C. BLACK OR AFRICAN AMERICAN		D. NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER		E. ASIAN		F. AMERICAN INDIAN / ALASKAN NATIVE		G. MORE THAN ONE RACE REPORTED		H. Unknown		I. NOT HISPANIC OR LATINO		J. HISPANIC OR LATINO	
		Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
1. 17 and Under	10,038	2,771	2,109	2,449	1,114	15	10	32	22	19	3	319	268	559	348	4,988	3,088	1,176	786
2. 18 - 24	5,072	1,527	1,670	701	471	8	7	11	13	8	5	151	146	186	168	2,078	2,140	514	340
3. 25 - 44	35,251	13,219	13,503	2,865	1,983	88	110	56	47	51	48	867	502	1,142	770	15,460	15,299	2,828	1,664
4. 45 - 64	13,750	6,184	3,819	1,942	627	45	17	34	6	29	27	332	104	417	167	7,658	4,338	1,325	429
5. 65 and Over	1,120	530	250	238	43	2	1	0	0	2	1	17	5	27	4	672	274	144	30
6. Total	**65,231**	**24,231**	**21,351**	**8,195**	**4,238**	**158**	**145**	**133**	**88**	**109**	**84**	**1,686**	**1,025**	**2,331**	**1,457**	**30,856**	**25,139**	**5,987**	**3,249**
7. Pregnant Women	606		466		78		2		3		0		32		25		317		60

Number of persons served who were admitted in a period prior to the 12 month reporting period	18,789
Number of persons served outside of the levels of care described on Table 10	31,425

Are the values reported in this table generated from a client based system with unique client identifiers? (•) Yes ( ) No

TABLE 11B – COVID-19 Unduplicated Count of Persons Served for Alcohol and Other Drug Use

Age	A. Total	B. WHITE		C. BLACK OR AFRICAN AMERICAN		D. NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER		E. ASIAN		F. AMERICAN INDIAN / ALASKAN NATIVE		G. MORE THAN ONE RACE REPORTED		H. Unknown		I. NOT HISPANIC OR LATINO		J. HISPANIC OR LATINO	
		Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
1. 17 and Under	526	195	120	15	15	0	0	0	0	0	0	14	7	98	62	286	189	39	15
2. 18 - 24	158	46	58	16	14	0	0	0	2	0	0	3	3	6	10	63	79	8	8
3. 25 - 44	1,109	409	383	116	94	3	1	1	1	1	4	31	21	23	21	514	478	70	47
4. 45 - 64	406	190	95	68	22	0	0	1	0	2	0	11	2	13	2	253	116	32	5
5. 65 and Over	19	8	2	6	1	0	0	0	0	0	0	0	0	2	0	15	3	1	0
6. Total	**2,218**	**848**	**658**	**221**	**146**	**3**	**1**	**2**	**3**	**3**	**4**	**59**	**33**	**142**	**95**	**1,131**	**865**	**150**	**75**
7. Pregnant Women	61		48		5		0		2		1		4		1		57		4

TABLE 11C – SABG Unduplicated Count of Person Served for Alcohol and Other Drug Use by Sex, Gender Identity, and Sexual Orientation (Requested)

Age	Gender Identity (GI): "Do you think of yourself as:"						Sexual Orientation (SO): "Do you think of yourself as:"				
	Cisgender Male	Cisgender Female	Transgender Man/Trans Man/Female-To-Male	Transgender Woman/Trans Woman/Male-To-Female	Genderqueer/Gender Non-Conforming/Neither Exclusively Male Nor Female	Additional Gender Category (or Other)	Straight or Heterosexual	Lesbian or Gay	Bisexual	Queer, Pansexual, and/or Questioning	Something Else; Please Specify:
1. 17 and Under											
2. 18 - 24											
3. 25 - 44											
4. 45 - 64											
5. 65 and Over											
6. Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Footnotes:

With respect to Row 7 in Table 11a, the count of pregnant women is reported by the Managing Entities through the ME Block Grant Reporting Template. All other figures come directly from the Department's Financial and Services Accountability Management System (FASAMS).

Several factors impacted state Managing Entities' ability to fund services with the COVID-19 Relief supplemental funding, including delayed budget authority and widescale staffing shortages. The Department has submitted a no cost extension for the unspent funds and is waiting for SAMHSA's approval.

The information requested in Table 11c regarding gender identity and sexual orientation is not currently collected in Florida.

IV: Population and Services Reports

Table 12 - SABG Early Intervention Services Regarding the Human Immunodeficiency Virus (EIS/HIV) in Designated States

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

Early Intervention Services for Human Immunodeficiency Virus (HIV)		
1. Number of SAPT HIV EIS programs funded in the State	Statewide: 47	Rural: 8
2. Total number of individuals tested through SAPT HIV EIS funded programs	16,327	
3. Total number of HIV tests conducted with SAPT HIV EIS funds	18,313	
4. Total number of tests that were positive for HIV	163	
5. Total number of individuals who prior to the 12-month reporting period were unaware of their HIV infection	76	
6. Total number of HIV-infected individuals who were diagnosed and referred into treatment and care during the 12-month reporting period	215	
Identify barriers, including State laws and regulations, that exist in carrying out HIV testing services: The most commonly identified barriers are stigma, access to transportation, difficulties due to the COVID-19 pandemic, and client fear/reluctance.		

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Footnotes:

IV: Population and Services Reports

Table 13 - Charitable Choice

Under Charitable Choice Provisions; Final Rule (42 CFR Part 54), states, local governments, and religious organizations, such as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide to all potential and actual program beneficiaries (services recipients) notice of their right to alternative services; (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term "alternative services" means services determined by the state to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider ("alternative provider") to which the program beneficiary (services recipient) has no religious objection. The purpose of this table is to document how the state is complying with these provisions.

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

Notice to Program Beneficiaries - Check all that apply:

- ☐ Used model notice provided in final regulation.
- ☐ Used notice developed by State (please attach a copy to the Report).
- ☐ State has disseminated notice to religious organizations that are providers.
- ☑ State requires these religious organizations to give notice to all potential beneficiaries.

Referrals to Alternative Services - Check all that apply:

- ☐ State has developed specific referral system for this requirement.
- ☑ State has incorporated this requirement into existing referral system(s).
- ☐ SAMHSA's Behavioral Health Treatment Locator is used to help identify providers.
- ☐ Other networks and information systems are used to help identify providers.
- ☐ State maintains record of referrals made by religious organizations that are providers.

2 Enter the total number of referrals to other substance abuse providers ("alternative providers") necessitated by religious objection, as defined above, made during the State fiscal year immediately preceding the federal fiscal year for which the state is applying for funds. Provide the total only. No information on specific referrals is required. If no alternative referrals were made, enter zero.

Provide a brief description (one paragraph) of any training for local governments and/or faith-based and/or community organizations that are providers on these requirements.

One managing entity (Central Florida Cares Health Services) informs patients and staff about patient rights to be transferred or referred due to religious objection. Another managing entity (Northwest Florida Health Network) reported remote training via Zoom or other technologies.

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Footnotes:

V: Performance Data and Outcomes

Table 14 - Treatment Performance Measure Employment/Education Status (From Admission to Discharge)

Short-term Residential(SR)

Employment/Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	0	0
Total number of clients with non-missing values on employment/student status [denominator]	0	0
Percent of clients employed or student (full-time and part-time)	0.0 %	0.0 %

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	0
Number of CY 2021 discharges submitted:	0
Number of CY 2021 discharges linked to an admission:	0
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	0
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	0

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 5/1/2022]

Long-term Residential(LR)

Employment/Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	166	123
Total number of clients with non-missing values on employment/student status [denominator]	1,344	1,344
Percent of clients employed or student (full-time and part-time)	12.4 %	9.2 %

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	3,346
Number of CY 2021 discharges submitted:	1,992
Number of CY 2021 discharges linked to an admission:	1,838
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	1,811

Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	1,344

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 5/1/2022]

Outpatient (OP)

Employment/Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	2,718	1,287
Total number of clients with non-missing values on employment/student status [denominator]	6,423	6,423
Percent of clients employed or student (full-time and part-time)	42.3 %	20.0 %

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	21,152
Number of CY 2021 discharges submitted:	8,661
Number of CY 2021 discharges linked to an admission:	8,321
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	7,926
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	6,423

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 5/1/2022]

Intensive Outpatient (IO)

Employment/Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	27	23
Total number of clients with non-missing values on employment/student status [denominator]	80	80
Percent of clients employed or student (full-time and part-time)	33.8 %	28.8 %

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	379
Number of CY 2021 discharges submitted:	147
Number of CY 2021 discharges linked to an admission:	125
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	112

Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	80

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 5/1/2022]

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Footnotes:

V: Performance Data and Outcomes

Table 15 - Treatment Performance Measure Stability of Housing (From Admission to Discharge)

Short-term Residential(SR)

Clients living in a stable living situation (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients living in a stable situation [numerator]	0	0
Total number of clients with non-missing values on living arrangements [denominator]	0	0
Percent of clients in stable living situation	0.0 %	0.0 %

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	0
Number of CY 2021 discharges submitted:	0
Number of CY 2021 discharges linked to an admission:	0
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	0
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	0

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 5/1/2022]

Long-term Residential(LR)

Clients living in a stable living situation (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients living in a stable situation [numerator]	1,186	1,224
Total number of clients with non-missing values on living arrangements [denominator]	1,645	1,645
Percent of clients in stable living situation	72.1 %	74.4 %

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	3,346
Number of CY 2021 discharges submitted:	1,992
Number of CY 2021 discharges linked to an admission:	1,838
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	1,811
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	1,645

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 5/1/2022]

Outpatient (OP)

Clients living in a stable living situation (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients living in a stable situation [numerator]	6,382	6,420
Total number of clients with non-missing values on living arrangements [denominator]	7,133	7,133
Percent of clients in stable living situation	89.5 %	90.0 %

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	21,152
Number of CY 2021 discharges submitted:	8,661
Number of CY 2021 discharges linked to an admission:	8,321
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	7,926
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	7,133

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 5/1/2022]

Intensive Outpatient (IO)

Clients living in a stable living situation (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients living in a stable situation [numerator]	101	101
Total number of clients with non-missing values on living arrangements [denominator]	105	105
Percent of clients in stable living situation	96.2 %	96.2 %

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	379
Number of CY 2021 discharges submitted:	147
Number of CY 2021 discharges linked to an admission:	125
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	112
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	105

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 5/1/2022]

Footnotes:

V: Performance Data and Outcomes

Table 16 - Treatment Performance Measure Criminal Justice Involvement (From Admission to Discharge)

Short-term Residential(SR)

Clients without arrests (any charge) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	0	0
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	0	0
Percent of clients without arrests	0.0 %	0.0 %
Notes (for this level of care):		
Number of CY 2021 admissions submitted:		0
Number of CY 2021 discharges submitted:		0
Number of CY 2021 discharges linked to an admission:		0
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		0
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):		0

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 5/1/2022]

Long-term Residential(LR)

Clients without arrests (any charge) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	999	1,007
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	1,143	1,143
Percent of clients without arrests	87.4 %	88.1 %
Notes (for this level of care):		
Number of CY 2021 admissions submitted:		3,346
Number of CY 2021 discharges submitted:		1,992
Number of CY 2021 discharges linked to an admission:		1,838
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		1,819

Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	1,143

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 5/1/2022]

Outpatient (OP)

Clients without arrests (any charge) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	4,326	4,476
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	5,406	5,406
Percent of clients without arrests	80.0 %	82.8 %

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	21,152
Number of CY 2021 discharges submitted:	8,661
Number of CY 2021 discharges linked to an admission:	8,321
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	7,979
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	5,406

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 5/1/2022]

Intensive Outpatient (IO)

Clients without arrests (any charge) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	82	82
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	84	84
Percent of clients without arrests	97.6 %	97.6 %

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	379
Number of CY 2021 discharges submitted:	147
Number of CY 2021 discharges linked to an admission:	125
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	114

Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	84

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 5/1/2022]

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Footnotes:

V: Performance Data and Outcomes

Table 17 - Treatment Performance Measure Change in Abstinence - Alcohol Use (From Admission to Discharge)

Short-term Residential(SR)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	0	0
All clients with non-missing values on at least one substance/frequency of use [denominator]	0	0
Percent of clients abstinent from alcohol	0.0 %	0.0 %

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		0
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	0	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		0.0 %

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		0
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	0	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		0.0 %

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	0
Number of CY 2021 discharges submitted:	0
Number of CY 2021 discharges linked to an admission:	0
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	0
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	0

Long-term Residential(LR)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	1,411	1,393
All clients with non-missing values on at least one substance/frequency of use [denominator]	1,811	1,811
Percent of clients abstinent from alcohol	77.9 %	76.9 %

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		52
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	400	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		13.0 %

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		1,341
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	1,411	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		95.0 %

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	3,346
Number of CY 2021 discharges submitted:	1,992
Number of CY 2021 discharges linked to an admission:	1,838
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	1,819
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	1,811

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 5/1/2022]

Outpatient (OP)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	6,906	6,843
All clients with non-missing values on at least one substance/frequency of use [denominator]	7,952	7,952
Percent of clients abstinent from alcohol	86.8 %	86.1 %

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		139
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	1,046	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		13.3 %

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		6,704
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	6,906	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		97.1 %

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	21,152
Number of CY 2021 discharges submitted:	8,661
Number of CY 2021 discharges linked to an admission:	8,321
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	7,979
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	7,952

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 5/1/2022]

Intensive Outpatient (IO)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	94	94
All clients with non-missing values on at least one substance/frequency of use [denominator]	104	104
Percent of clients abstinent from alcohol	90.4 %	90.4 %

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		1
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	10	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		10.0 %

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		93
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	94	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		98.9 %

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	379
Number of CY 2021 discharges submitted:	147
Number of CY 2021 discharges linked to an admission:	125
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	114
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	104

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 5/1/2022]

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Footnotes:

V: Performance Data and Outcomes

Table 18 - Treatment Performance Measure Change in Abstinence - Other Drug Use (From Admission to Discharge)

Short-term Residential(SR)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Drug Abstinence – Clients with no Drug use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	0	0
All clients with non-missing values on at least one substance/frequency of use [denominator]	0	0
Percent of clients abstinent from drugs	0.0 %	0.0 %

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Clients abstinent from Drug at discharge among clients using Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		0
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	0	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		0.0 %

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Clients abstinent from Drug at discharge among clients abstinent from Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		0
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	0	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		0.0 %

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	0
Number of CY 2021 discharges submitted:	0
Number of CY 2021 discharges linked to an admission:	0
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	0
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	0

Long-term Residential(LR)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Drug Abstinence – Clients with no Drug use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	1,053	997
All clients with non-missing values on at least one substance/frequency of use [denominator]	1,811	1,811
Percent of clients abstinent from drugs	58.1 %	55.1 %

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Clients abstinent from Drug at discharge among clients using Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		79
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	758	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		10.4 %

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Clients abstinent from Drug at discharge among clients abstinent from Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		918
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	1,053	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		87.2 %

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	3,346
Number of CY 2021 discharges submitted:	1,992
Number of CY 2021 discharges linked to an admission:	1,838
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	1,819
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	1,811

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 5/1/2022]

Outpatient (OP)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Drug Abstinence – Clients with no Drug use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	5,308	5,334
All clients with non-missing values on at least one substance/frequency of use [denominator]	7,952	7,952
Percent of clients abstinent from drugs	66.8 %	67.1 %

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Clients abstinent from Drug at discharge among clients using Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		348
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	2,644	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		13.2 %

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Clients abstinent from Drug at discharge among clients abstinent from Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		4,986
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	5,308	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		93.9 %

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	21,152
Number of CY 2021 discharges submitted:	8,661
Number of CY 2021 discharges linked to an admission:	8,321
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	7,979
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	7,952

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 5/1/2022]

Intensive Outpatient (IO)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Drug Abstinence – Clients with no Drug use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	75	64
All clients with non-missing values on at least one substance/frequency of use [denominator]	104	104
Percent of clients abstinent from drugs	72.1 %	61.5 %

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Clients abstinent from Drug at discharge among clients using Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		4
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	29	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		13.8 %

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Clients abstinent from Drug at discharge among clients abstinent from Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		60
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	75	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		80.0 %

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	379
Number of CY 2021 discharges submitted:	147
Number of CY 2021 discharges linked to an admission:	125
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	114
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	104

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
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Table 19 - Treatment Performance Measure Change in Social Support Of Recovery (From Admission to Discharge)

Short-term Residential(SR)

Social Support of Recovery - Clients participating in self-help groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients participating in self-help groups (AA NA meetings attended, etc.) [numerator]	0	0
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	0	0
Percent of clients participating in self-help groups	0.0 %	0.0 %
Percent of clients with participation in self-help groups at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	0.0 %	
Notes (for this level of care):		
Number of CY 2021 admissions submitted:		0
Number of CY 2021 discharges submitted:		0
Number of CY 2021 discharges linked to an admission:		0
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		0
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):		0

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 5/1/2022]

Long-term Residential(LR)

Social Support of Recovery - Clients participating in self-help groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients participating in self-help groups (AA NA meetings attended, etc.) [numerator]	340	380
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	1,107	1,107
Percent of clients participating in self-help groups	30.7 %	34.3 %
Percent of clients with participation in self-help groups at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	3.6 %	
Notes (for this level of care):		
Number of CY 2021 admissions submitted:		3,346
Number of CY 2021 discharges submitted:		1,992

Number of CY 2021 discharges linked to an admission:	1,838
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	1,819
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	1,107

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 5/1/2022]

Outpatient (OP)

Social Support of Recovery - Clients participating in self-help groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients participating in self-help groups (AA NA meetings attended, etc.) [numerator]	1,192	1,153
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	5,731	5,731
Percent of clients participating in self-help groups	20.8 %	20.1 %
Percent of clients with participation in self-help groups at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	-0.7 %	

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	21,152
Number of CY 2021 discharges submitted:	8,661
Number of CY 2021 discharges linked to an admission:	8,321
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	7,979
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	5,731

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 5/1/2022]

Intensive Outpatient (IO)

Social Support of Recovery - Clients participating in self-help groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients participating in self-help groups (AA NA meetings attended, etc.) [numerator]	17	16
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	84	84
Percent of clients participating in self-help groups	20.2 %	19.0 %
Percent of clients with participation in self-help groups at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	-1.2 %	

Notes (for this level of care):	
Number of CY 2021 admissions submitted:	379

Number of CY 2021 discharges submitted:	147
Number of CY 2021 discharges linked to an admission:	125
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	114
Number of CY 2021 linked discharges eligible for this calculation (non-missing values):	84

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
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Table 20 - Retention - Length of Stay (in Days) of Clients Completing Treatment

Level of Care	Average (Mean)	25th Percentile	50th Percentile (Median)	75th Percentile
DETOXIFICATION (24-HOUR CARE)				
1. Hospital Inpatient	0	0	0	0
2. Free-Standing Residential	6	2	4	6
REHABILITATION/RESIDENTIAL				
3. Hospital Inpatient	0	0	0	0
4. Short-term (up to 30 days)	0	0	0	0
5. Long-term (over 30 days)	60	17	45	89
AMBULATORY (OUTPATIENT)				
6. Outpatient	57	3	35	82
7. Intensive Outpatient	95	33	84	135
8. Detoxification	1	1	1	1
OUD MEDICATION ASSISTED TREATMENT				
9. OUD Medication-Assisted Detoxification[3]				

Level of Care	2021 TEDS discharge record count	
	Discharges submitted	Discharges linked to an admission
DETOXIFICATION (24-HOUR CARE)		
1. Hospital Inpatient	0	0
2. Free-Standing Residential	3812	3761
REHABILITATION/RESIDENTIAL		
3. Hospital Inpatient	0	0
4. Short-term (up to 30 days)	0	0
5. Long-term (over 30 days)	1992	1838

AMBULATORY (OUTPATIENT)		
6. Outpatient	8661	7988
7. Intensive Outpatient	147	125
8. Detoxification	1	1
OUD MEDICATION ASSISTED TREATMENT		
9. OUD Medication-Assisted Detoxification[3]		

Source: SAMHSA/CBHSQ TEDS CY 2021 admissions file and CY 2021 linked discharge file
[Records received through 5/1/2022]

[1] OUD Medication-Assisted Treatment Detoxification includes hospital detoxification, residential detoxification, or ambulatory detoxification services/settings AND Opioid Medication-Assisted Treatment.

[2] OUD Medication-Assisted Treatment included outpatient services/settings AND Opioid OUD Medication-Assisted Treatment.

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Table 21 - Primary Substance Abuse Use Disorder Prevention NOMs Domain: Reduced Morbidity – Abstinence from Drug Use/Alcohol Use Measure: 30-Day Use

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
1. 30-day Alcohol Use	**Source Survey Item:** NSDUH Questionnaire. "Think specifically about the past 30 days, that is, from **[DATEFILL]** through today. During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?[Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used alcohol during the past 30 days.		
	Age 12 - 20 - CY 2019 - 2020		
	Age 21+ - CY 2019 - 2020		
2. 30-day Cigarette Use	**Source Survey Item:** NSDUH Questionnaire: "During the past 30 days, that is, since **[DATEFILL]**, on how many days did you smoke part or all of a cigarette?[Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having smoked a cigarette during the past 30 days.		
	Age 12 - 17 - CY 2019 - 2020		
	Age 18+ - CY 2019 - 2020		
3. 30-day Use of Other Tobacco Products	**Survey Item: NSDUH Questionnaire:** "During the past 30 days, that is, since **[DATEFILL]**, on how many days did you use [other tobacco products][1]?[Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used a tobacco product other than cigarettes during the past 30 days, calculated by combining responses to questions about individual tobacco products (cigars, smokeless tobacco, pipe tobacco).		
	Age 12 - 17 - CY 2019 - 2020		
	Age 18+ - CY 2019 - 2020		
4. 30-day Use of Marijuana	**Source Survey Item: NSDUH Questionnaire:** "Think specifically about the past 30 days, from **[DATEFILL]** up to and including today. During the past 30 days, on how many days did you use marijuana or hashish?[Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used marijuana or hashish during the past 30 days.		
	Age 12 - 17 - CY 2019 - 2020		
	Age 18+ - CY 2019 - 2020		
5. 30-day Use of Illegal Drugs Other Than Marijuana	**Source Survey Item: NSDUH Questionnaire:** "Think specifically about the past 30 days, from **[DATEFILL]** up to and including today. During the past 30 days, on how many days did you use [any other illegal drug]?[2] **Outcome Reported:** Percent who reported having used illegal drugs other than marijuana or hashish during the past 30 days, calculated by combining responses to questions about individual drugs (heroin, cocaine, hallucinogens, inhalants, methamphetamine, and misuse of prescription drugs).		
	Age 12 - 17 - CY 2019 - 2020		

	Age 18+ - CY 2019 - 2020		

[1]NSDUH asks separate questions for each tobacco product. The number provided combines responses to all questions about tobacco products other than cigarettes.
[2]NSDUH asks separate questions for each illegal drug. The number provided combines responses to all questions about illegal drugs other than marijuana or hashish.
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Table 22 - Primary Substance Abuse Use Disorder Prevention NOMs Domain: Reduced Morbidity – Abstinence from Drug Use/Alcohol Use Measure: Perception of Risk/Harm of Use

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
1. Perception of Risk From Alcohol	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?[Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.		
	Age 12 - 20 - CY 2019 - 2020		
	Age 21+ - CY 2019 - 2020		
2. Perception of Risk From Cigarettes	**Source Survey Item: NSDUH Questionnaire:** "How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day? [Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.		
	Age 12 - 17 - CY 2019 - 2020		
	Age 18+ - CY 2019 - 2020		
3. Perception of Risk From Marijuana	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week?[Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.		
	Age 12 - 17 - CY 2019 - 2020		
	Age 18+ - CY 2019 - 2020		

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Table 23 - Primary Substance Abuse Use Disorder Prevention NOMs Domain: Reduced Morbidity – Abstinence from Drug Use/Alcohol Use Measure: Age of First Use

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
1. Age at First Use of Alcohol	**Source Survey Item: NSDUH Questionnaire:** "Think about the first time you had a drink of an alcoholic beverage. How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink. [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of alcohol.		
	Age 12 - 20 - CY 2019 - 2020		
	Age 21+ - CY 2019 - 2020		
2. Age at First Use of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you smoked part or all of a cigarette?[Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of cigarettes.		
	Age 12 - 17 - CY 2019 - 2020		
	Age 18+ - CY 2019 - 2020		
3. Age at First Use of Tobacco Products Other Than Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used [any other tobacco product][1]?[Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of tobacco products other than cigarettes.		
	Age 12 - 17 - CY 2019 - 2020		
	Age 18+ - CY 2019 - 2020		
4. Age at First Use of Marijuana or Hashish	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used marijuana or hashish?[Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of marijuana or hashish.		
	Age 12 - 17 - CY 2019 - 2020		
	Age 18+ - CY 2019 - 2020		
5. Age at First Use Heroin	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used heroin? [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of heroin.		
	Age 12 - 17 - CY 2019 - 2020		
	Age 18+ - CY 2019 - 2020		
6. Age at First Misuse of Prescription Pain Relievers Among Past Year Initiates	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used [specific pain reliever][2] in a way a doctor did not direct you to use it?"[Response option: Write in age at first use.] **Outcome Reported:** Average age at first misuse of prescription pain relievers among those who first misused prescription pain relievers in the last 12 months.		
	Age 12 - 17 - CY 2019 - 2020		

	Age 18+ - CY 2019 - 2020		

[1]The question was asked about each tobacco product separately, and the youngest age at first use was taken as the measure.
[2]The question was asked about each drug in this category separately, and the youngest age at first use was taken as the measure.
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Table 24 - Primary Substance Abuse Use Disorder Prevention NOMs Domain: Reduced Morbidity – Abstinence from Drug Use/Alcohol Use Measure: Perception of Disapproval/Attitudes

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
1. Disapproval of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age smoking one or more packs of cigarettes a day?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.		
	Age 12 - 17 - CY 2019 - 2020		
2. Perception of Peer Disapproval of Cigarettes	**Source Survey Item: NSDUH Questionnaire:** "How do you think your close friends would feel about you smoking one or more packs of cigarettes a day?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent reporting that their friends would somewhat or strongly disapprove.		
	Age 12 - 17 - CY 2019 - 2020		
3. Disapproval of Using Marijuana Experimentally	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age trying marijuana or hashish once or twice?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.		
	Age 12 - 17 - CY 2019 - 2020		
4. Disapproval of Using Marijuana Regularly	**Source Survey Item: NSDUH Questionnaire:** "How do you feel about someone your age using marijuana once a month or more?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.		
	Age 12 - 17 - CY 2019 - 2020		
5. Disapproval of Alcohol	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age having one or two drinks of an alcoholic beverage nearly every day?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.		
	Age 12 - 20 - CY 2019 - 2020		

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Table 25 - Primary Substance Abuse Use Disorder Prevention NOMs Domain: Reduced Morbidity – Abstinence from Drug Use/Alcohol Use Measure: Perception of Workplace Policy

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
Perception of Workplace Policy	**Source Survey Item:** NSDUH Questionnaire: "Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis? Would you say more likely, less likely, or would it make no difference to you?[Response options: More likely, less likely, would make no difference] **Outcome Reported:** Percent reporting that they would be more likely to work for an employer conducting random drug and alcohol tests.		
	Age 15 - 17 - CY 2019 - 2020		
	Age 18+ - CY 2019 - 2020		

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Table 26 - Primary Substance Abuse Use Disorder Prevention NOMs Domain: Reduced Morbidity – Abstinence from Drug Use/Alcohol Use Measure: Average Daily School Attendance Rate

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
Average Daily School Attendance Rate	**Source:** National Center for Education Statistics, Common Core of Data: *The National Public Education Finance Survey* available for download at **http://nces.ed.gov/ccd/stfis.asp**. **Measure calculation:** Average daily attendance (NCES defined) divided by total enrollment and multiplied by 100.		
	School Year 2019		

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Table 27 - Primary Substance Abuse Use Disorder Prevention NOMs Domain: Crime and Criminal Justice Measure: Alcohol Related Fatalities

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
Alcohol-Related Traffic Fatalities	**Source:** National Highway Traffic Safety Administration Fatality Analysis Reporting System **Measure calculation:** The number of alcohol-related traffic fatalities divided by the total number of traffic fatalities and multiplied by 100.		
	CY 2020		

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Table 28 - Primary Substance Abuse Use Disorder Prevention NOMs Domain: Crime and Criminal Justice Measure: Alcohol and Drug-Related Arrests

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
Alcohol- and Drug-Related Arrests	**Source:** Federal Bureau of Investigation Uniform Crime Reports **Measure calculation:** The number of alcohol- and drug-related arrests divided by the total number of arrests and multiplied by 100.		
	CY 2020		

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Table 29 - Primary Substance Abuse Use Disorder Prevention NOMs Domain: Social Connectedness Measure: Family Communications Around Drug and Alcohol Use

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
1. Family Communications Around Drug and Alcohol Use (Youth)	**Source Survey Item:** NSDUH Questionnaire: "Now think about the past 12 months, that is, from [DATEFILL] through today. During the past 12 months, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use? By parents, we mean either your biological parents, adoptive parents, stepparents, or adult guardians, whether or not they live with you.?[Response options: Yes, No] **Outcome Reported:** Percent reporting having talked with a parent.		
	Age 12 - 17 - CY 2019 - 2020		
2. Family Communications Around Drug and Alcohol Use (Parents of children aged 12-17)	**Source Survey Item:** NSDUH Questionnaire: "During the past 12 months, how many times have you talked with your child about the dangers or problems associated with the use of tobacco, alcohol, or other drugs?[1][Response options: 0 times, 1 to 2 times, a few times, many times] **Outcome Reported:** Percent of parents reporting that they have talked to their child.		
	Age 18+ - CY 2019 - 2020		

[1]NSDUH does not ask this question of all sampled parents. It is a validation question posed to parents of 12- to 17-year-old survey respondents. Therefore, the responses are not representative of the population of parents in a State. The sample sizes are often too small for valid reporting.

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Table 30 - Primary Substance Abuse Use Disorder Prevention NOMs Domain: Retention Measure: Percentage of Youth Seeing, or Listening to a Prevention Message

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
Exposure to Prevention Messages	**Source Survey Item:** NSDUH Questionnaire: "During the past 12 months, do you recall [hearing, reading, or watching an advertisement about the prevention of substance use][1]? **Outcome Reported:** Percent reporting having been exposed to prevention message.		
	Age 12 - 17 - CY 2019 - 2020		

[1]This is a summary of four separate NSDUH questions each asking about a specific type of prevention message delivered within a specific context

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Table 31-35 - Reporting Period - Start and End Dates for Information Reported on Tables 31, 32, 33, 34, and 35

Reporting Period Start and End Dates for Information Reported on Tables 31, 32, 33, 34 and 35

Please indicate the reporting period for each of the following NOMS.

Tables	A. Reporting Period Start Date	B. Reporting Period End Date
1. Table 31 - Primary Substance Use Disorder Prevention Individual-Based Programs and Strategies – Number of Persons Served by Age, Gender, Race, and Ethnicity	1/1/2020	12/31/2020
2. Table 32 - Primary Substance Use Disorder Prevention Population-Based Programs and Strategies – Number of Persons Served by Age, Gender, Race, and Ethnicity	1/1/2020	12/31/2020
3. Table 33 (Optional) - Primary Substance Use Disorder Prevention Number of Persons Served by Type of Intervention	1/1/2020	12/31/2020
4. Table 34 - Primary Substance Use Disorder Prevention Evidence-Based Programs and Strategies by Type of Intervention	1/1/2020	12/31/2020
5. Table 35 - Total Primary Substance Use Disorder Prevention Number of Evidence Based Programs/Strategies and Total SABG Dollars Spent on Primary Substance Use Disorder Prevention Evidence-Based Programs/Strategies	10/1/2019	9/30/2021

General Questions Regarding Prevention NOMS Reporting

Question 1: Describe the data collection system you used to collect the NOMs data (e.g., MDS, DbB, KIT Solutions, manual process).

Providers and coalitions who provide prevention services using SABG funds are required to enter their services information into the Department's Performance Based Prevention System (PBPS). The information collected in PBPS includes, but is not limited to demographics, types of services, outcomes, group sizes, program descriptions and activities, and strategic planning materials. The recorded data are used to track and monitor utilization and performance of the Department-funded prevention strategies. These data are also used to compile Block Grant Reports which explain the services being provided throughout the state. The Department contracts with Collaborative Planning Group Systems, Inc. for the maintenance of PBPS.

Question 2: Describe how your State's data collection and reporting processes record a participant's race, specifically for participants who are more than one race.

Indicate whether the State added those participants to the number for each applicable racial category or whether the State added all those partipants to the More Than One Race subcategory.

When entering data into Florida's Performance Based Prevention System (PBPS), providers must select one of the racial categories identified in Table 31. One of the categories available in PBPS is "More Than One Race." When the data are pulled from PBPS, the totals are based on their selections. Individuals identified as "More Than One Race" are only included in this category and are not added to multiple different racial categories.

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Table 31 - Primary Substance Use Disorder Prevention Individual-Based Programs and Strategies – Number of Persons Served by Age, Gender, Race, and Ethnicity

Category	Total
A. Age	**543,809**
0-4	7,873
5-11	117,427
12-14	154,871
15-17	102,106
18-20	23,183
21-24	12,364
25-44	54,426
45-64	26,355
65 and over	10,007
Age Not Known	35,197
B. Gender	**543,809**
Male	217,630
Female	236,367
Gender Unknown	89,812
C. Race	**543,809**
White	250,654
Black or African American	117,438
Native Hawaiian/Other Pacific Islander	379
Asian	11,443
American Indian/Alaska Native	828
More Than One Race (not OMB required)	126,922

Race Not Known or Other (not OMB required)	36,145
D. Ethnicity	**543,809**
Hispanic or Latino	136,569
Not Hispanic or Latino	296,164
Ethnicity Unknown	111,076

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Table 32 - Primary Substance Use Disorder Prevention Population-Based Programs and Strategies – Number of Persons Served by Age, Gender, Race, and Ethnicity

Category	Total
A. Age	**42087989**
0-4	2146897
5-11	3988908
12-14	1833847
15-17	1957415
18-20	2009164
21-24	2505196
25-44	11269977
45-64	10668090
65 and over	5677177
Age Not Known	31318
B. Gender	**42087989**
Male	20429206
Female	21449395
Gender Unknown	209388
C. Race	**42087989**
White	30494386
Black or African American	6826070
Native Hawaiian/Other Pacific Islander	35866
Asian	1281913
American Indian/Alaska Native	164493
More Than One Race (not OMB required)	1633575

Race Not Known or Other (not OMB required)	1651686
D. Ethnicity	**42087989**
Hispanic or Latino	9996727
Not Hispanic or Latino	32003813
Ethnicity Unknown	87449

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Table 33 (Optional) - Primary Substance Use Disorder Prevention Number of Persons Served by Type of Intervention

Number of Persons Served by Individual- or Population-Based Program or Strategy

Intervention Type	A. Individual-Based Programs and Strategies	B. Population-Based Programs and Strategies
1. Universal Direct		N/A
2. Universal Indirect	N/A	
3. Selective		N/A
4. Indicated		N/A
5. Total	**0**	**$0.00**
Number of Persons Served[1]	**543,809**	**42,087,989**

[1]Number of Persons Served is populated from Table 31 - Primary Substance Use Disorder Prevention Individual-Based Programs and Strategies - Number of Persons Served by Age, Gender, Race, and Ethnicity and Table 32 - Primary Substance Use Disorder Prevention Population-Based Programs and Strategies - Number of Persons Served by Age, Gender, Race, and Ethnicity

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Footnotes:

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Table 34 - Primary Substance Use Disorder Prevention Evidence-Based Programs and Strategies by Type of Intervention

Definition of Evidence-Based Programs and Strategies: The guidance document for the Strategic Prevention Framework State Incentive Grant, Identifying and Selecting Evidence-based Interventions, provides the following definition for evidence-based programs:

- Inclusion in a Federal List or Registry of evidence-based interventions
- Being reported (with positive effects) in a peer-reviewed journal
- Documentation of effectiveness based on the following guidelines:
  - Guideline 1:
    The intervention is based on a theory of change that is documented in a clear logic or conceptual model; and
  - Guideline 2:
    The intervention is similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature; and
  - Guideline 3:
    The intervention is supported by documentation that it has been effectively implemented in the past, and multiple times, in a manner attentive to Identifying and Selecting Evidence-Based Interventions scientific standards of evidence and with results that show a consistent pattern of credible and positive effects; and
  - Guideline 4:
    The intervention is reviewed and deemed appropriate by a panel of informed prevention experts that includes: well-qualified prevention researchers who are experienced in evaluating prevention interventions similar to those under review; local prevention practitioners; and key community leaders as appropriate, e.g., officials from law enforcement and education sectors or elders within indigenous cultures.

1. Describe the process the State will use to implement the guidelines included in the above definition.

Florida implements SAMHSA's EBP guidelines using the following process. First, these guidelines are explicitly included within each Managing Entity contract through Guidance Document 1 (Evidence-Based Guidelines). This guidance document identifies SAMHSA's Evidence-Based Practices Resource Center, Blueprints for Healthy Youth Development, OJJDP's Model Programs, the California Evidence-Based Clearinghouse for Child Welfare, and the University of Washington Alcohol and Drug Abuse Institute's EBP Substance Use Database, as approved registries for identifying and selecting EBPs. Providers who wish to implement a program that is not in one of these registries must document the following: • The theory of change and logic model • How the content and structure is similar to programs or strategies that do appear in the approved registries or in the peer-reviewed literature (or how it is based on sound scientific principles of community prevention or public health) • The number of times it was implemented in the past, the fidelity with which it was implemented, and the results of any outcome evaluations • A review by a panel of informed experts. The Department reviews prevention programs with inconclusive, mixed, or limited findings to determine if they should be added to the list of EBPs in PBPS. To be considered evidence-based, prevention programs must have been evaluated, through a peer-reviewed publication, with an experimental or quasi-experimental research design and found to produce statistically significant reductions in substance use outcomes. An example of three such reviews are included as documentation to support the performance indicator updates.

2. Describe how the State collected data on the number of programs and strategies. What is the source of the data?

Figures used to populate this report were taken directly from ME Block Grant Reporting Templates (Contract Template 2).

Table 34 - SUBSTANCE ABUSE PREVENTION **Number of Programs and Strategies by Type of Intervention**

	A. Universal Direct	B. Universal Indirect	C. Universal Total	D. Selective	E. Indicated	F. Total
1. Number of Evidence-Based Programs and Strategies Funded	79	60	139	44	39	222
2. Total number of Programs and Strategies Funded	82	94	176	48	66	290
3. Percent of Evidence-Based Programs and Strategies	96.34 %	63.83 %	78.98 %	91.67 %	59.09 %	76.55 %

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Footnotes:

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Table 35 - Total Primary Substance Use Disorder Prevention Number of Evidence Based Programs/Strategies and Total SABG Dollars Spent on Primary Substance Use Disorder Prevention Evidence-Based Programs/Strategies

	Total Number of Evidence-Based Programs/Strategies for IOM Category Below	Total SAPT Block Grant Dollars Spent on evidence-based Programs/Strategies
Universal Direct	Total # 106	$8,668,559.00
Universal Indirect	Total # 130	$7,687,212.00
Selective	Total # 45	$8,177,885.00
Indicated	Total # 40	$2,725,962.00
Unspecified	Total # 0	$0.00
	Total EBPs: 321	Total Dollars Spent: $27,259,618.00
Primary Prevention Total[1]	**$27,733,791.00**	

[1]Primary Prevention Total is populated from Table 4 - State Agency SABG Expenditure Compliance Report, Row 2 Primary Prevention.

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The total for Table 35 ($27,259,618) plus the total for Prevention on Table 6 ($474,173) equals the total Primary Prevention reported on Table 4 ($27,733,791).

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Prevention Attachments

Submission Uploads

FFY 2023 Prevention Attachment Category A:

File	Version	Date Added

FFY 2023 Prevention Attachment Category B:

File	Version	Date Added

FFY 2023 Prevention Attachment Category C:

File	Version	Date Added

FFY 2023 Prevention Attachment Category D:

File	Version	Date Added

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Footnotes:

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.