Please provide any comments and input to stephan.cooley@myflfamilies.com. Any person can provide input both during the development of this Application and after submission to SAMHSA.

Florida

UNIFORM APPLICATION
FY 2024/2025 Combined MHBGSUPTRS BG ApplicationBehavioral Health Assessment and Plan

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

OMB - Approved 04/19/2021 - Expires 04/30/2024
(generated on 08/16/2023 11.55.43 AM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

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

Please provide any comments and input to stephan.cooley@myflfamilies.com. Any person can provide input both during the development of this Application and after submission to SAMHSA.

State Information

State Information

Plan Year

Start Year	2024
End Year	2025

State SAPT Unique Entity Identification

Unique Entity ID	GKB5R3B9JGE4

I. State Agency to be the SAPT Grantee for the Block Grant

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

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

First Name	Christi
Last Name	Anderson
Agency Name	Florida Department of Children and Families
Mailing Address	2415 North Monroe Street Suite 400
City	Tallahassee
Zip Code	32303-4190
Telephone	(850) 717-4288
Fax	
Email Address	Christi.Anderson@myflfamilies.com

State CMHS Unique Entity Identification

Unique Entity ID	GKB5R3B9JGE4

I. State Agency to be the CMHS Grantee for the Block Grant

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

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

First Name	Christi
Last Name	Anderson
Agency Name	Florida Department of Children and Families
Mailing Address	2415 North Monroe Street Suite 400
City	Tallahassee

Zip Code	32303-4190
Telephone	(850)717-4621
Fax	
Email Address	Christi.Anderson@myflfamilies.com

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? (•) Yes ( ) No

First Name	Natalie
Last Name	Kelly
Agency Name	Florida Association of Managing Entities
Mailing Address	122 South Calhoun Street
City	Tallahassee
Zip Code	
Telephone	850-570-5747
Fax	
Email Address	natalie@flmanagingentities.com

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

From	
To	

V. Date Submitted

Submission Date	
Revision Date	

VI. Contact Person Responsible for Application Submission

First Name	Stephan
Last Name	Cooley
Telephone	850-717-4257
Fax	
Email Address	stephan.cooley@myflfamilies.com

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

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

Fiscal Year 2024

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
Section 1923	Intravenous Substance Abuse	**42 USC § 300x-23**
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	**42 USC § 300x-24**
Section 1925	Group Homes for Recovering Substance Abusers	**42 USC § 300x-25**
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	**42 USC § 300x-26**
Section 1927	Treatment Services for Pregnant Women	**42 USC § 300x-27**
Section 1928	Additional Agreements	**42 USC § 300x-28**
Section 1929	Submission to Secretary of Statewide Assessment of Needs	**42 USC § 300x-29**
Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
Section 1931	Restrictions on Expenditure of Grant	**42 USC § 300x-31**
Section 1932	Application for Grant; Approval of State Plan	**42 USC § 300x-32**
Section 1935	Core Data Set	**42 USC § 300x-35**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**

Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

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

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

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

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

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

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

State: _____

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

Signature of CEO or Designee[1]: _____

Title: Secretary, FL Department of Children & Families

Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

RON DESANTIS
GOVERNOR

March 18, 2021

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

To Whom It May Concern:

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

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

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

Sincerely,

Ron DeSantis
Governor

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

State Information

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

Fiscal Year 2024

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
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Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
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Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**
Title XIX, Part B, Subpart III of the Public Health Service Act		
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3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

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

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

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

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

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

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

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

Signature of CEO or Designee[1]: _____

Title: Secretary, FL Department of Children & Families

Date Signed: _____

mm/dd/yyyy

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

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

RON DESANTIS
GOVERNOR

March 18, 2021

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

To Whom It May Concern:

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

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

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

Sincerely,

Ron DeSantis
Governor

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

State Information

Disclosure of Lobbying Activities

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

Name

Shevaun L. Harris

Title

Secretary

Organization

Florida Department of Children and Families

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

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

Planning Steps

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

Narrative Question:

Provide an overview of the state's M/SUD prevention (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.

Further, in support of the **Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government**, SAMHSA is committed to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Therefore, the description should also include how these systems address the needs of underserved communities. Examples of system strengths might include long-standing interagency relationships, coordinated planning, training systems, and an active network of prevention coalitions. The lack of such strengths might be considered needs of the system, which should be discussed under Step 2. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

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

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services.

The description should also include how these systems address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

Organizational Structure

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

The Department operates under the direction of a Secretary, who reports directly to the Governor. SAMH is led by the Assistant Secretary for Substance Abuse and Mental Health who is supported by the Deputy Assistant Secretary for Operations, the Deputy Assistant Secretary for Program Services, the Director of Substance Abuse and Mental Health, the Chief Hospital Administrator, the Director of State Mental Health Treatment Facilities Policies and Programs, the Director of Business Operations, the Director of the Sexually Violent Predator Program, and the Director of SAMH Data and Finance.

SAMH houses the Statewide Office of Suicide Prevention (SOSP), which, in coordination with the Suicide Prevention Coordinating Council (SPCC), develops and implements the *Florida Statewide Strategic Plan for Suicide Prevention* (Strategic Plan) by providing oversight, building capacity, creating policy, and mobilizing communities for suicide prevention. The SOSP and SPCC were established in 2007 pursuant to ch. 14.2019, F.S. The SOSP is overseen by the Director of the Statewide Office of Suicide Prevention who chairs the SPCC and coordinates the state's suicide prevention efforts, including overseeing the development, implementation, and evaluation of the Strategic Plan in partnership with the SPCC. The SPCC consists of 31 voting members who serve as the state's suicide prevention advisory committee. The SPCC meets quarterly and focuses on raising public awareness of policies and best practices for suicide prevention. This year, the SPCC formed the following committees to focus on different tasks relating to suicide prevention:

1. The Planning and Evaluation Committee
2. The Awareness and Marketing Committee
3. The First Responder Mental Wellness and Suicide Deterrence Committee

The Department is decentralized into six regions, which each region representing multiple counties. Each region is somewhat autonomous yet integrated within the broader organization and managed by a Regional Managing Director. The Regional Managing Director reports to the Department's Assistant Secretary for Operations. Each region has a SAMH Director who reports to the Regional Managing Director and serves as the Department's representative to the community for substance use and mental health issues within their respective regions. Department contracts are managed by certified contract managers that serve as single points of contact.

Regional staff is responsible for the implementation of the Department's substance use and mental health funding and statutory duties throughout the state.

Behavioral Health Managing Entities

Although SAMH originally contracted directly with behavioral health providers to implement the Community Mental Health Services (CMHS) and Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grants, the Florida Legislature determined that placing responsibility for publicly-funded behavioral health services within local entities would expand access to care; increase continuity, efficiency and effectiveness; and streamline administrative processes to create cost efficiencies and better match services with need.[1] As a result, SAMH contracts with seven Managing Entities (ME) to administer the Department's funding and manage regional behavioral health systems of care throughout the state. MEs are private, non-profit organizations responsible for planning, implementation, administration, monitoring, data collection, reporting, and analysis for behavioral health care in their regions. Managing Entities contract with local service providers for the provision of prevention, treatment, and recovery support services.

Procurement of the Managing Entity contracts is governed by both ch. 287, F.S., which applies generally to all state contracts, and s. 402.7305, F.S., which applies specifically to Department contracts. In accordance with both Florida and federal law, the contracts were competitively procured. The statutory authority for the Department to contract with MEs provides for a fixed payment contract, with an advance equivalent to a two-month payment and equal monthly payments thereafter.[2] The ME is also permitted to carry up to 8% of state general revenue from fiscal year to fiscal year, for the life of the contract.[3]

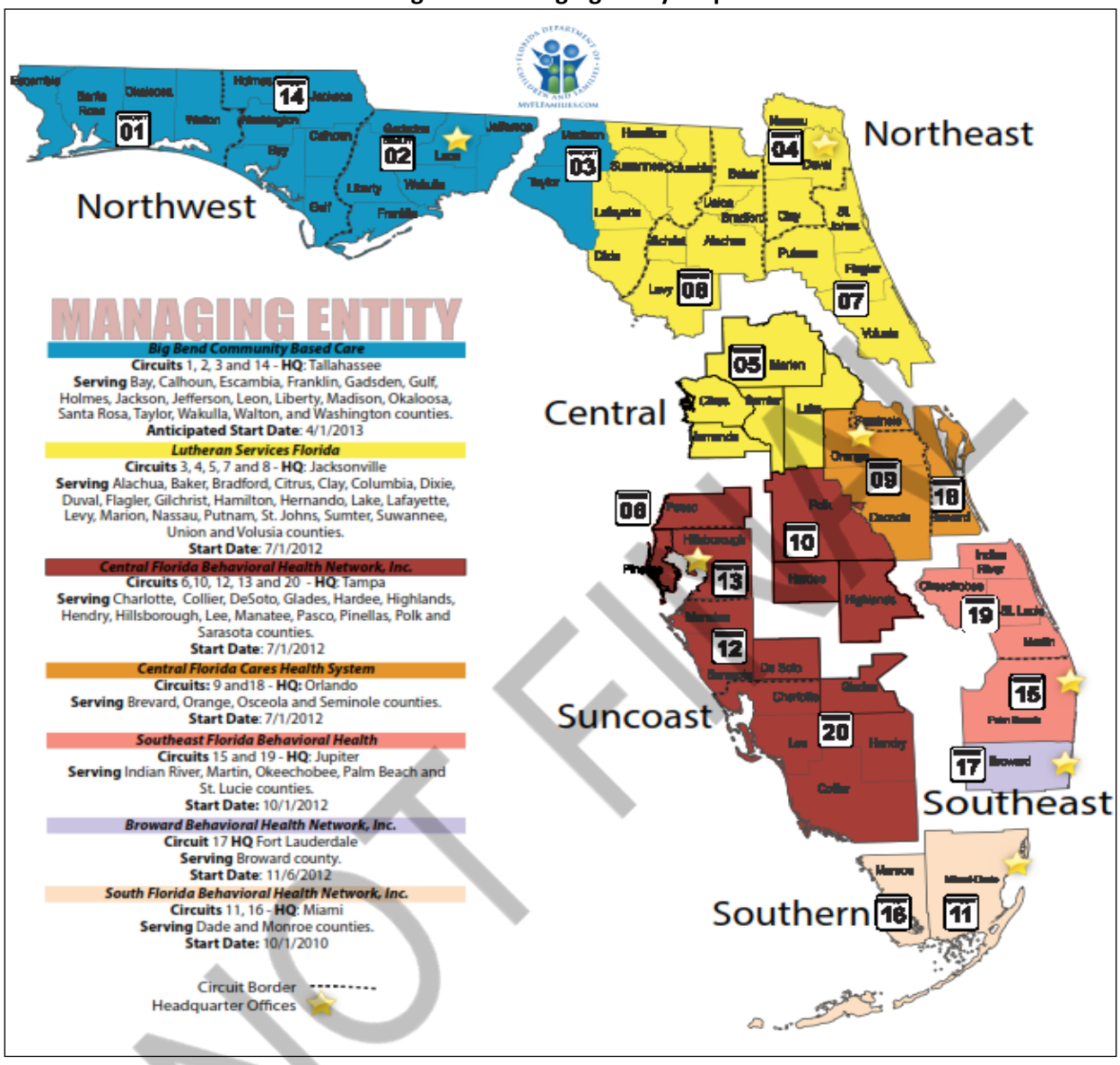
Consistent with the organizational structure of the Department, these contracts are executed, implemented, and managed by the Regional Managing Director and contract management staff. In consultation with SAMH, the Regional SAMH Director ensures that each ME meets statewide goals and is responsive to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

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

Managing Entity	DCF Region(s)	Rural Counties	Non-Rural Counties	Total Counties
Broward Behavioral Health Coalition (BBHC)	Southeast Region	0	1	1
Central Florida Cares Health System (CFCHS)	Central Region	0	4	4
Central Florida Behavioral Health Network (CFBHN)	Suncoast & Central Regions	5	9	14
Lutheran Services Florida Health Systems (LSFHS)	Northwest & Central Regions	10	13	23
Northwest Florida Health Network (NWFHN) / Big Bend Community Based Care (BBCBC)	Northeast & Northwest Regions	13	5	18
South Florida Behavioral Health Network (SFBHN)	Southern Region	1	1	2
Southeast Florida Behavioral Health Network (SEFBHN)	Southeast Region	1	4	5
Entire State of Florida		**30**	**37**	**67**

Figure 1 below is a color-coded map that depicts each ME's catchment area (see Figure 1 for list of counties), start date, and DCF regions and circuits.

Figure 1: Managing Entity Map



Behavioral Health Services

In Florida, as with many states, the CMHS and SUPTRS Block Grants do not support the entirety of the publicly funded behavioral health system. Medicaid comprises a significant portion of funding for behavioral health. The Florida Agency for Health Care Administration (AHCA) serves as Florida's Medicaid authority. The Department, while the single state authority for substance use and mental health, shares administrative responsibility pursuant to Florida Statute with AHCA.[4] It should be noted that the authority that delegates shared administrative responsibility does not provide for a shared information system between Block Grant funded providers and Medicaid providers.

The Florida KidCare program is the umbrella term for Florida's Children's Health Insurance Program (CHIP). Florida KidCare provides a continuum of health insurance coverage to children in families with incomes at or below 250 percent of the federal poverty level. The Florida KidCare program is comprised of four programmatic partners. The Florida Healthy Kids Corporation administers the Florida Healthy Kids program for children ages 5

through 18. AHCA the MediKids program for children ages 1 through 4. The Department of Health administers the Children's Medical Services Managed Care Plan. The Department of Children and Families determines eligibility for Medicaid and administers the Behavioral Health Network (BNET) for children ages 5 through 18 with serious emotional disturbances.[5]

In addition to State funding available through the Department and AHCA, Florida's local governments have a statutory vehicle to support behavioral health services through a match requirement based on the amount of state general revenue that a provider receives.[6] This match may be satisfied through cash or in-kind contributions. The authorizing legislation established this as a community issue that is negotiated between local governments and providers. Furthermore, some local governments dedicate additional funding for behavioral health services, while others do not.

Based on the statutory authority of each state agency, there are a variety of behavioral health services that are offered to more specific segments of the population, as described in Table 2 below:

Table 2. Behavioral Health Services at Other State Agencies

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

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

- For adult mental health services:
    - Adults who have severe and persistent mental illness. Included within this group are:
        - Older adults (aged 65+) in crisis;
        - Older adults who are at risk of being placed in a more restrictive environment due to mental illness;
    - Persons deemed incompetent to proceed or not guilty by reason of insanity under chapter 916;
    - Other persons involved in the criminal justice system;
    - Persons diagnosed as having co-occurring mental illness and substance use disorders; and
    - Persons who are experiencing an acute mental or emotional crisis.

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

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

Substance Use Services

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

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

- Primary prevention services that prevent or delay substance use and associated problems, which include:
    - Information dissemination;
    - Education;
    - Alternative drug-free activities;
    - Problem identification and referral;
    - Community-based processes; and
    - Environmental strategies.
- Intervention services, which are structured services for individuals at risk of substance abuse and focused on outreach, early identification, short-term counseling and referral.
- Clinical treatment, which includes professionally directed services to reduce or eliminate misuse of alcohol and other drugs, such as:
    - Outpatient and intensive outpatient treatment;
    - Day or night treatment;
    - Medication-assisted treatment;
    - Residential Treatment;
    - Intensive inpatient treatment; and
    - Detoxification.
- Recovery support services are designed to help individuals regain skills, develop natural support systems, and develop goals to help them thrive in the community and promote recovery, such as:
    - Aftercare;

    - Supported housing;
    - Supported employment; and
    - Recovery support.
- Services that assist individuals discharged from acute care settings, more effectively engage individuals in services, and provide opportunities that support independence and development:
    - Drop-in and self-help centers;
    - Care coordination; and
    - Intensive case management.

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

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

Mental Health Services

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

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

Part III of Chapter 394, F.S., outlines the guiding principles for child and adolescent mental health services funded by the Department. Florida has adopted a framework that requires services be individualized, culturally competent, integrated, and include the family in all decision-making, grounded in SAMHSA's System of Care principles. These services should ensure a smooth transition for children who will need to access the adult system for continued age-appropriate services and supports. Services must be provided in the least restrictive setting available, including a Department-funded array of formal treatment and informal support services in the home and community. For children who require residential mental health treatment, the Department partners with AHCA to fund and oversee therapeutic group care and the Statewide Inpatient Psychiatric Program. The Statewide Inpatient Psychiatric Program provides residential mental health treatment in a secure setting with intensive treatment for children with severe emotional disturbances ages 6 through 17.

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

- Treatment services intended to reduce or ameliorate the symptoms of mental illness, which include psychiatric medication and supportive psychotherapies;

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

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

Mental health services are also a covered service in the State Medicaid Plan, such as:

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

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

The Department funds several team-based community interventions including 39 Florida Assertive Community Treatment (FACT) teams, 69 Community Action Treatment (CAT) teams, 14 Community Forensic Multidisciplinary teams, 51 Mobile Response Teams, and 28 Family Intensive Treatment (FIT) teams. Team-based services aim to divert individuals with significant behavioral health conditions from residential or

institutionalized care and support them within their communities. They provide in-home services and supports emphasizing community integration and bolstering family support systems.

Access to Local Crisis Call Centers

Florida 2-1-1 is a free, confidential service that connects Floridians with local community-based organizations offering thousands of different programs and services, including food, shelter, disaster resources, and behavioral health crisis services. Individuals can call 2-1-1 or search the Turn to 2-1-1 website for information on more than 40,000 different programs and services throughout Florida. The Florida Alliance of Information and Referral Services (FLAIRS) is the collaborative 2-1-1 association "responsible for studying, designing, implementing, supporting, and coordinating the Florida 211 Network and for receiving federal grants."[7] FLAIRS provides a map of Florida's 2-1-1 network which is comprised of 12 Contact Centers (see Appendix A below). Some centers offer multilingual services 24-hours a day, 365 days per year. Other providers operate more limited in-house schedules and route evening, weekend, and holiday calls to neighboring crisis providers. Some providers have enhanced capacity for web-based interactions and text, chat, or email supports. Local data dashboards, with details on call volume and the type of service requests received by Florida's network of 2-1-1 Centers, are accessible at www.211Counts.org. In FY 22-23, Florida's 2-1-1 Centers reported approximately 1,042,253 requests.[8]

The 988 Suicide and Crisis Lifeline, established in July 2022, is a national network of more than 2000 crisis call centers that connect individuals in crisis with trained crisis counselors and serves as a universal entry point to the continuum of crisis care. The 988 Suicide and Crisis Lifeline comprises 13 call centers in Florida, 10 of which also serve as 2-1-1 centers and three that function as crisis centers or MRT providers. They are nationally accredited by the American Association of Suicidology and answer calls to 988 from their local communities. In SFY 22-23, 988 call centers operating in Florida reported 127,464 calls received. The Department also commits funding to support the Crisis Center of Tampa Bay's Florida Veterans Support Line (www.MyFLVet.com). The Florida Veterans Support Line was launched as a pilot program in 2014 and it has since expanded to every county in Florida. Veterans and their loved ones can call 1-844-MyFLVet and be connected to a peer military veteran who has been trained to provide immediate emotional support, as well as VA and non-VA resources located throughout the community.

Mobile Response Teams

Mobile Response Teams (MRT) provide readily available crisis care in the community and increase opportunities to stabilize individuals in the least restrictive setting to avoid unnecessary psychiatric hospitalization or emergency department utilization. The Managing Entities contract with providers for MRTs, enabling statewide access to this service across all 67 counties. There are currently 51 MRTs. In 2020, House Bill 945 amended s. 394.495, F.S. to add MRT to the child and adolescent mental health system of care, outline programmatic requirements, and expand MRT eligibility to include children that are served by the child welfare system and experiencing or at risk of experiencing placement instability.

Annually, the Department publishes a Guidance Document that identifies eligibility, roles and responsibilities, service components, and output measures for the Managing Entities and MRT service providers. MRT program requirements include:

- Reasonable access to MRT services for all the counties within the Managing Entity's service region
- Established response protocols with local law enforcement agencies, 9-1-1 dispatch, 2-1-1 call centers, 988 Suicide and Crisis Lifeline centers, local community-based care lead agencies, child protective investigators, the Department of Juvenile Justice, and local schools
- Provision of information about MRT services to foster parents

- Service availability 24 hours per day, 7 days a week
- Access to a board-certified or board-eligible psychiatrist or psychiatric nurse practitioner
- MRTs may triage requests to determine the level of severity and provide an in-person response, face-to-face on-location or via telehealth, within 60 minutes when clinical criteria for an immediate response is met
- Availability of an array of crisis response services for individuals and their families, including
    - Evaluation and assessment;
    - Stabilization services;
    - Safety and crisis planning; and
    - Brief care coordination with a warm handoff to another service provider as clinically indicated.

In State Fiscal Year 22-23, the MRTs received 28,394 calls, 71% of which met the threshold for an acute face-to-face or telehealth response. Of the 20,196 acute responses, 3,572 calls (18%) resulted in an involuntary examination and 16,584 did not result in an involuntary examination.

Availability of Short-term Crisis Receiving and Stabilization Centers

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

There are 123 designated Baker Act receiving facilities in Florida, including 64 public facilities that have a contract with a Managing Entity and 62 private facilities. Baker Act receiving facilities conduct voluntary examinations and include hospitals licensed under Chapter 395 F.S. and CSUs licensed under Chapter 394 F.S. The Department designates all Baker Act receiving facilities regardless of type. There are also 9 Short Term Residential Treatment (SRT) facilities in Florida, which provide a step-down for adults in CSUs needing an extended, but less intensive level of treatment. Additionally, these programs were created to step individuals down from CSUs and divert individuals away from State Mental Health Treatment Facilities. Addictions Receiving Facilities (ARF) and Juvenile Addictions Receiving Facilities (JARF) are secure, acute care facilities providing 24-7 emergency screening, evaluation, detoxification, and stabilization services. ARFs and JARFs are designated by the Department to serve individuals with substance impairment who meet placement criteria. Joint CSU/ARFs and joint CCSU/JARFs provide integrated services addressing both substance impairment and mental health crises. The number of designated facilities and beds are presented in the table below. Note that the total number of beds is 5,827 and this reflects the combined total of public beds (2,201) and private beds (3,626). Further disaggregating bed types by category would result in duplication because they serve multiple purposes based on need. For example, beds are used for either children, adults, mental health, or substance impairment, depending on the need.

	CSU	Hospital	CCSU	SRT	Public	Private	Children	Adult
Total Facilities	38	69	7	9	64	59	8	70*
Total Beds	1314	4143	176	194	2201	3626	92	2849

* This figure includes facilities with all population beds.

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

Mental Health Treatment Facilities

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

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

The state contracts for services at four other sites:

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

Services are designed to help individuals manage their symptoms and apply skills needed to successfully return to the community. Services include psychiatric assessments, treatment with psychotropic medication, health care services, individual and group therapy, individualized service planning, vocational and educational services, addiction treatment services, rehabilitation therapy, and enrichment activities. For individuals deemed incompetent to proceed, this includes achieving competency and returning to court in a timely manner.

Service Eligibility

In order to be considered eligible for substance use and mental health services funded by the Department, applicants must be a member of at least one of the priority or targeted populations,[10] have an annual gross family income at or below 150% of the Federal poverty Income Guidelines (or a sliding fee scale is applied), have no other payer source, or qualify for a service that Medicaid or other third party payor does not pay. Service providers are required to make reasonable efforts to identify and collect benefits from third party payers when applicable.

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

1. All priority populations as defined in statute;
2. Mental health residents of assisted living facilities;
3. Persons ordered into involuntary outpatient placement;
4. Eligible children referred for residential placement;
5. Inmates approaching the end of their sentences;
6. Individuals that are currently in civil and forensic state Mental Health Treatment Facilities; and

7. Individuals who are at risk of being admitted into a civil or forensic state MH Treatment Facility (including diversionary community treatment and services prior to admission).

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

The distribution of races and ethnicities among Florida's general population is approximately 51.2% White, 14.4% Black, 27.0% Hispanic, 2.8% Asian, 0.1% American Indian/Alaska Native, 0.0% Native Hawaiian/Other Pacific Islander, and 4.6% multiple races.[11] There are two Federally Recognized Indian Tribes in Florida: the Miccosukee Tribe of Indians and the Seminole Tribe of Florida. Members of the Tribes eligible for services through the Department's publicly funded network of providers. The Seminole Tribe also participated in the Department's 9-8-8 Planning Grant coalition. With respect to sexual identity, according to estimates from the 2018-2019 National Survey on Drug Use and Health, approximately 84.7% of Floridians identify as heterosexual, 2.0% identify as lesbian or gay, 3.3% identify as bisexual, and 0.4% don't know.[12]

The Department is committed to ensuring that the behavioral health workforce is prepared to meet the needs of Florida's diverse population. As an example, to become a Certified Addiction Professional in Florida, individuals must demonstrate that they can select and use evidence-based and culturally responsive counseling strategies that are targeted and effective in meeting individuals' needs. They must be able to recognize individual differences between the counselor and person served by gaining knowledge about personality, culture, lifestyles, gender identity, sexual orientation, special needs, and other factors influencing behavior to provide services that are individually tailored and culturally competent. Licensed mental health counselors in Florida are required to have specialized graduate-level course work that includes cultural foundations to improve cultural competence. Emotional and behavioral assessments are also required to assess and address an individual's social, ethnic, and cultural factors.[13] Furthermore, individuals receiving drug treatment services have a guaranteed right to nondiscriminatory services, whereby service providers may not deny an individual access to services solely on the basis of race, gender, ethnicity, age, HIV status, prior service departures against medical advice, disability, or number of relapses.[14] The Department also has agency-wide policies, plans, and procedures that facilitate access to interpretation and translation services to thousands of non-English speakers throughout Florida. Peer specialists in Florida (described in more detail in following sections) are required to complete two hours of cultural and linguistic competence training.

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

States are required to spend at least 10% of the CMHS Block Grant on Coordinated Specialty Care (CSC) programs for Early Serious Mental Illness (ESMI), including first episodes of psychosis, regardless of the age of the individual at onset. A prolonged duration of untreated mental illness predicts negative outcomes (e.g., serious impairment, unemployment, homelessness, etc.) across different mental illnesses. Earlier treatment and interventions are therefore critical to reducing acute symptoms and improving long-term outcomes. CSC programs for ESMI are evidence-based and provide comprehensive, coordinated, individualized, and integrated services, including, but not limited to, intensive case management, individual and group therapy, supported employment, family education and supports, and appropriate psychotropic medication. Three CSC-ESMI teams (Success 4 Kids & Families, David Lawrence Center, and Peace River) use the OnTrackNY treatment model, all the other providers use the NAVIGATE treatment model.

The Department is currently funding the following 16 CSC-ESMI teams:

- Life Management Center serving Bay County
- Lakeview Center serving Escambia County
- Apalachee Center serving Leon County
- Clay Behavioral Health serving Clay and Putnam Counties

- Clay Behavioral Health serving Duval County
- SMA Healthcare serving Volusia County
- Aspire Health Partners serving Orange County
- Success 4 Kids & Families serving Hillsborough County
- David Lawrence Center serving Collier County
- Peace River serving Polk, Highlands, and Hardee Counties
- South County MHC serving Palm Beach County
- Henderson Behavioral Health serving Martin, St. Lucie, Indian River, and Okeechobee Counties
- Henderson Behavioral Health serving Broward County
- Henderson Behavioral Health (2nd team) serving Broward County
- Citrus Behavioral Health serving Miami-Dade County
- Citrus Behavioral Health (2nd team) serving Miami-Dade County

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

Block Grant regulations stipulate that Florida must expend at least $9.3 million in federal and state funds on services for pregnant women and women with dependent children (PWWDC). In SFY 21-22, Florida expended around $11.5 million on services for PWWDC and served 1,338 pregnant women. The most common services were residential treatment, supervised room and board, and case management. The Women's Services Coordinator reviews data submitted by the Managing Entities, addresses discrepancies, completes quarterly reports, facilitating calls to performance, and shares resources related to PWWDC. The Department has also permanently implemented a Substance Exposed Newborn Initiative which is a collaborative effort to intercept families with substance use involvement at the time they are reported to the Florida Abuse Hotline. The goal is to provide a statewide coordinated response across programs for families at risk of or with infants born substance exposed. There are two Statewide Substance Exposed Newborn Care Coordinators responsible for providing guidance to the six regional Substance Exposed Newborn Care Coordinators. The Department continues to contract with the Florida Association of Alcohol and Drug Abuse to provide training and resources that include evidence-based treatment for PWWDC. The Department has also implemented a contract for an online Learning Management System to enhance workforce development.

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

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

Allowable HIV EIS may include one or any combination of the following activities:

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

HIV EIS must be undertaken voluntarily with the informed consent of, the individual and receipt of services may not be requirement for accessing treatment for substance use disorders or other services. HIV-testing and counseling services are confidential and provided in non-group settings, pursuant to the Florida Department of Health's protocol. Florida's HIV EIS are delivered onsite through 47 drug treatment programs that collectively tested 16,327 individuals in SFY 21-22. A total of 163 tests were positive for HIV.

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

Primary Prevention of Substance Use

Florida is required to expend at least 20% of the SUPTRS Block Grant award on primary prevention activities directed at individuals who do not require treatment for substance use disorders. The primary prevention set-aside funds all six strategies described by the Center for Substance Abuse, including information dissemination, education, alternative activities, problem identification and referral, community-based processes, and environmental strategies. The Department licenses prevention service providers; identifies data-driven, statewide strategic priorities; develops competitive applications for prevention grant funding opportunities; provides training on innovative prevention practices; leads data quality improvement initiatives; and collaborates with other state agencies on surveillance and resource coordination. The Department, in partnership with the Department of Education and the Department of Juvenile Justice, also manages the competitive review process for the Block Grant-funded, school-based, Prevention Partnership Grant (PPG) program.[15] The Department's prevention activities are overseen by the Statewide Prevention Coordinator. The Department also manages prevention-specific Legislative appropriations.

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

The prevention system in Florida has a clear directive to be responsive to the needs of diverse racial, ethnic, and gender minorities, as well as American Indian/Alaska Native populations residing in the state. The Department's prevention partners are empowered with flexibility to respond to local needs and conditions. The Department's Prevention Services Guidance Document requires prevention partners conduct data analysis to identify populations to be targeted through culturally appropriate, evidence-based prevention programs.[16] Providers of prevention services are also required to use the planning process known as the Strategic Prevention Framework, which includes cultural competence as a cross-cutting principle that should be integrated into each step (assessment, capacity building, planning, implementation, and evaluation).[17] The Managing Entities monitor and address the needs of the diverse communities they serve in a variety of ways, including inclusive needs assessments that use demographic data throughout the process of writing, reviewing, and negotiating prevention contracts. Efforts are made to ensure that the prevention programs and strategies which are selected will be effective within diverse communities and providers are asked to demonstrate their effectiveness at reaching various demographics.

Data on prevention services is entered in the Department's Performance Based Prevention System (PBPS), which is operated through a contract with Collaborative Planning Group Systems, Inc (CPGSI). In partnership with CPGSI, the Department helps identify and rectify data input errors through training and technical assistance provided to the Managing Entities and prevention services providers. CPGSI provides written recommendations for improvement on an account-by-account basis to each Managing Entity. PBPS was updated to Version 3 in SFY 22-23, which included improved reporting capabilities and functionality to upload guidance documents and other resources. The Department uses PBPS as a primary source for reporting individual- and population-based prevention programs and strategies in the SUPTRS Block Grant annual report to SAMHSA. Ad-hoc reporting and data queries include a variety of data elements and variables, including but not limited to, funding source, substance problem type, strategy type, activity codes, IOM targets, program and campaign names, counties of service, activity counts and descriptions, service recipient demographics (age, race/ethnicity, etc.), outputs types (i.e., media generated, services provided, training provided, community action/change, etc.), and media impressions.

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[1] S. 394.9082(1), Florida Statutes (F.S.).
[2] Ch. 2013-47, L.O.F., and s. 394.9082(9), F.S.
[3] Ibid.
[4] S. 394.457, F.S.
[5] Florida Agency for Health Care Administration. (2021). *Florida KidCare – Title XXI – Children's Health Insurance Program (CHIP)*. Retrieved from https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/program_policy/FLKidCare/index.shtml; Florida KidCare. (2021). *Florida KidCare Partners*. Retrieved from https://www.floridakidcare.org/.
[6] S. 394.76, F.S.
[7] S. 408.918(3), F.S.
[8] 211 Counts. (2023). *Top Service Requests by All Florida Call Centers – Data from July 1, 2022 through June 30, 2023*. Retrieved on July 24, 2023 from www.211counts.org.
[9] Section 65E-14.021(4)(e), Florida Administrative Code.
[10] S. 394.674(1), F.S.
[11] Kaiser Family Foundation. (2021). *Population Distribution by Race/Ethnicity* (Timeframe: 2021). Based on 2008-2021 American Community Survey 1-Year Estimates. Retrieved from https://www.kff.org/statedata/.
[12] Substance Abuse and Mental Health Services Administration. (2021). *National Survey on Drug Use and Health: 2-Year RDAS* (2018- to 2019). Restricted Online Data Analysis System (RDAS). Row Variable = SEXIDENT; Column Variable = STNAME (Florida).
[13] S. 65E-12.107(2)(d), Florida Administrative Code.
[14] S. 397.501(2), F.S.
[15] S. 397.77, F.S. (School Substance Abuse Prevention Partnership Grants).
[16] Florida Department of Children and Families. (2019). *Guidance 10 – Prevention Services*. Retrieved from www.myflfamilies.com/service-programs/samh/managing-entities/2019/IncDocs/Guidance%2010%20Prevention.pdf.
[17] Substance Abuse and Mental Health Services Administration. (2019). *A Guide to SAMHSA's Strategic Prevention Framework*. Retrieved from www.samhsa.gov/sites/default/files/20190620-samhsa-strategic-prevention-framework-guide.pdf.

Planning Steps

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

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system, including for other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps. The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-SSATS), the Behavioral Health Barometer, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the **Uniform Reporting System** (URS), and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States with current Partnership for Success discretionary grants are required to have an active SEOW.

This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the MHBG and SUPTRS BG priority populations, as well as a discussion of the unmet service needs and critical gaps in the current system for underserved communities, as defined under **EO 13985**. States are encouraged to refer to the **IOM reports**, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* and ***The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding***[1] in developing this narrative.

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Footnotes:

This step should identify the unmet service needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system, including for other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps. The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-SSATS), the Behavioral Health Barometer, Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavior Surveillance System (YRBSS), the Uniform Reporting System (URS), and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the MHBG and SUPTRS BG priority populations.

The National Survey on Drug Use and Health (NSDUH) provides important estimates of substance use, substance use disorders, and other mental illnesses at the national, state, and sub-state levels. NSDUH is an annual survey of the civilian, noninstitutionalized population ages 12 and older, using face-to-face, computer-assisted interviews. NSDUH collects information from residents of households, persons in noninstitutional group quarters (e.g., shelters, rooming/boarding houses, college dormitories, migratory worker camps, and halfway houses), and civilians living on military bases. Persons *excluded* from the survey include persons with no fixed household address (e.g., homeless and/or transient persons not in shelters), active-duty military personnel, and residents of institutional group quarters, such as correctional facilities, nursing homes, mental institutions, and long-term hospitals. Traditionally, state- and sub-state level estimates have been based on 2-year or 3-year averages to enhance precision; however, estimates for the most recent year, 2021, are based on a single year due to changes in survey methodology. This change in estimation precludes the ability to make comparisons between current NSDUH estimates and previously published estimates. Usually, there is a lag of two or more years between data collection and publication of state-level estimates.

According to the most recently published data, Florida-specific estimates from the 2021 NSDUH, approximately 7.3% of children ages 12-17 and 15.4% of adults ages 18 and older experienced a substance use disorder in the past year.[1] With respect to the prevalence of needing *but not receiving* treatment, in 2021 approximately 6.7% of children ages 12-17 in Florida, and 13.1% of adults ages 18 and older, needed treatment for substance use but did not receive it. Looking at Floridians ages 18-25, the treatment gap is even higher, with 21.7% of young adults in Florida needing but not receiving treatment for substance use.[2] Importantly, the vast majority (97%) of individuals classified by the NSDUH as needing but not receiving drug treatment also report that they did not feel they needed it. Only about 1% felt they needed treatment and tried to get it.[3]

The NSDUH estimates that 21.0% of adults in Florida experienced any mental illness in the past year.[4] Looking more specifically at young adults ages 18-25, 32.6% reported any mental illness in the past year, and 14.0% had serious thoughts of suicide.[5]

Adults with serious mental illness (SMI) are persons with a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual (DSM) that results in functional impairment. Approximately 5.4% of adults in Florida experienced SMI in 2021.[6] Substate estimates from the 2018-2020 NSDUH are not publicly available “due to methodological concerns with combining 2020 data with data from 2018 and 2019.”[7] Due to the COVID-19 pandemic, “SAMHSA decided to

suspend in-person NSDUH data collection on March 16, 2020." Although a web-based survey was eventually approved for data collection, it was not implemented until the fourth quarter of 2020. Initially, SAMHSA released the 2018-2020 NSDUH substate estimates after assuming that potential affects on the data were similar across different groups of people; however, they noted, "Further analyses that included data from the 2021 NSDUH has shown that this assumption cannot be made. Because of these analyses, along with concerns about the rapid societal changes in 2020, it was determined that averages across the three years maybe misleading. Therefore, as explained above, the substate estimates for 2018-2020 are no longer provided."

Children with serious emotional disturbances (SED) have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM that results in functional impairment. The most recent systematic review and meta-analysis of 12 peer-reviewed studies estimates the prevalence of SED (with domain-specific impairment) at 10.0%.[8] Furthermore, among children ages 12-17 in Florida, approximately 22.2% experienced a major depressive episode in 2021.[9] According to the most recently published 5-year average, only about 38% of children ages 12-17 with a major depressive episode in Florida receive depression care.[10]

Annually, SAMHSA publishes annual reports providing output tables from the Uniform Reporting System (URS). States use the URS to report data as part of the Community Mental Health Services Block Grant. URS data include sociodemographic information, outcomes of care, use of evidence-based practices, client assessment of care, and readmission to psychiatric hospitals, among others, of clients served by the state. In FY 2021, children with SED comprised 18.5% of individuals served in Florida publicly funded community mental health programs.[11]

The prevalence of SED among children was last estimated by the Substance Abuse and Mental Health Services Administration (SAMHSA) in the Federal Register in 1997. The prevalence in Florida was estimated to be between 7% and 13%.[12] These estimates are now over 20 years old and were not based on studies of children in Florida. A search for more current estimates identified a 2018 systematic review and meta-analysis of 12 peer-reviewed studies that estimated the prevalence of SED in the United States.[13] Most of these studies spanned 1989 to 2015 and assessed children ages 8 to 17. The pooled prevalence of SED with domain-specific impairment is 10.0%. Domain-specific impairment indicates substantial disruption in role functioning secondary to a psychiatric disorder in at least one functional domain of family, peers, educational settings, or the community. This definition meets the minimum criteria for SED established by SAMSHA. The pooled prevalence of SED with global impairment is 6.3%. Global impairment is more severe and indicates substantial impairment of role functioning in multiple domains.

States that are not included as part of the regional samples in any of the studies incorporated into the meta-analysis of SED estimates need current state- and sub-state level prevalence estimates. Updates on the next steps related to SED estimation described in the workshop summary from the National Academies' *Standing Committee on Integrating New Behavioral Health Measures into SAMHSA's Data Collection Programs* could inform state-level research plans and proposals to address this knowledge gap.[14] The National Survey on Children's Health (NSCH) is one mechanism explored by the Committee with potential for collecting information on SED among children, though no current items on the survey match SAMHSA's definition of SED. The NSCH is weighted to represent the population of noninstitutionalized children ages 0-17 living in households in Florida and provides data on their physical and emotional health.[15] All information about children's behavioral health from the NSCH is based on parent recollection and is not independently verified.

According to the 2020-2021 NSCH estimates, approximately 11.3% of children in Florida ages 0-17 have any kind of emotional, developmental, or behavioral problem, lasting a year or longer, for which they need treatment or counseling.[16] This estimate varies according to the number of Adverse Childhood Experiences (ACEs) one is

exposed to. The prevalence of emotional, developmental, or behavioral problems requiring treatment is 7.1% among children in Florida with no ACEs, 11.4% among children with one ACE, and 25.0% among children with two or more ACEs.[17] Health care access and quality is another indicator examined by the NSCH. In 2020-2021, approximately 9.9% of children ages 3-17 in Florida received treatment or counseling from a mental health professional in the past year, and an additional 4.0% needed to see a mental health professional but did not.[18] Among children who received or needed mental health treatment, approximately 48.8% did not have difficulty getting it, 28.8% found it was somewhat difficult to get it, and 16.8% found it was very difficult to get it.[19] Among children in Florida who are currently insured and who used behavioral health care, 55.9% have insurance that always offers benefits or covers services that meet their behavioral health needs, 28.4% have insurance that usually offers benefits or coverage that meets those needs, and 15.7% have insurance that sometimes/never offers benefits or coverage that meets those needs.[20]

Unmet needs related to mental health and substance use are also captured through calls to Florida's local crisis call centers: the 988 Suicide and Crisis Lifeline and Florida 2-1-1. In FY 22-23, the 988 Suicide and Crisis Life call centers operating in Florida reported 127,464 calls received. Florida's 2-1-1 Centers reported 1,042,253 requests. Of those, approximately 14 percent of requests were related to mental health needs and addiction, as depicted in the table below.[21]

211 Service Request Category: Mental Health & Addiction	Number of Requests (FY 22-23)
Mental Health Services	90,903
Crisis Intervention and Suicide	38,030
Substance Use and Dependency/Addiction Services	12,364
Mental Health Facilities	4,901
Marriage and Family	1,648
Other Mental Health and Addictions	67
Total:	**147,913**

The Health Resources and Services Administration reports that there are 222 areas experiencing a shortage of mental health professionals in Florida. In Florida, the percent of need met is 21.7%, compared to 27.2% for the entire United States.[22] Statewide, the number of additional practitioners needed to remove the shortage designation is 586. For mental health geographic designations based on the ratio of population to psychiatrist, the designation must have a ratio of 30,000 to 1, while for population designations or geographic designations in areas with unusually high needs, the threshold is 20,000 to 1.

One of the greatest needs identified relates to serving individuals in community settings instead of State Mental Health Treatment Facilities (SMHTF), which are expensive and highly restrictive. Currently, capacity in the community for services intensive enough to treat and maintain individuals with serious mental illnesses and complex needs (i.e., co-occurring substance use disorders, co-morbid medical conditions, criminal justice involvement, frequent hospitalizations, etc.) in the community. These individuals are often ordered into SMHTFs, with challenges discharging them back into the community because of insufficient capacity for necessary services. According to the SMHTF's May 2023 Civil and Forensic Services Report, 91 individuals were awaiting discharge from a civil facility (67 of which were waiting more than 30 days) and 62 individuals were awaiting discharge from a forensic facility.

Lack of Health Insurance, Poverty, and Behavioral Health Conditions

The primary purpose of the Block Grants is to fund services for individuals without insurance or who cycle in and out of health insurance coverage, and to fund treatment and support services not covered by Medicaid, Medicare, or private insurance.[23] According to estimates from the National Survey on Drug Use and Health, approximately 17% of Floridians with substance use disorders are uninsured, and 20% of Floridians needing but

not receiving treatment for substance use are uninsured.[24] Additionally, 19% of adults in Florida with serious mental illness lack health insurance.[25]

According to estimates from the American Community Survey for 2021, uninsured rates vary by race/ethnicity in Florida. The uninsured rate among all nonelderly adult individuals in Florida is 17.9% (compared to 12.2% nationwide). Looking exclusively at children ages 0-18, about 7.3% are uninsured in Florida, compared to 5.4% nationwide. Looking specifically at rates by race/ethnicity, uninsured rates are lower among Whites (9.4%), compared to Blacks (13.9%), Hispanics (17.2%), Asians (9.3%), Native Hawaiians and Pacific Islanders (12.7%), and American Indians/Alaska Natives (26.6%).[26] The poverty rate among all Floridians was about 13.1% in 2021 (compared to 12.8% nationwide). Poverty rates also vary by race/ethnicity in Florida. Breaking it out by race/ethnicity, the poverty rate is 10.3% among Whites, 20.4% among Blacks, % among Hispanics, 10.0% among Asians, 12.4% among Native Hawaiian and Pacific Islanders, 20.9% among American Indian/Alaska Natives, and 14.4% among individuals of multiple races.[27]

The distribution of uninsured individuals in Florida by race/ethnicity is 43.7% White, 38.3% Hispanic, 17.0% Black, 2.2% Asian, 0.1% Native Hawaiian and Pacific Islander, 24.6% multiple races, and 0.6% American Indian/Alaska Native.[28] For comparison, the distribution of races/ethnicities among the general Florida population is approximately 56.1% White, 15.1% Black, 26.8% Hispanic, 2.8% Asian, 0.3% American Indian/Alaska Native, 0.1% Native Hawaiian/Other Pacific Islander, and 19.1% multiple races.[29] For additional comparative purposes, the distribution of race/ethnicity among Floridians *with substance use disorders* is approximately 66% White, 7% Black, 25% Hispanic, and 1% other or multiple races, according to 2018-2019 estimates from NSDUH.[30] Alternatively, the distribution of race/ethnicity among Floridians *needing but not receiving treatment for substance use* is approximately 67% White, 10% Black, 19% Hispanic, and 4% other or multiple races.[31] The distribution of race/ethnicity among adults in Florida with serious mental illness is approximately 72% White, 8% Black, 18% Hispanic, and 3% other or multiple races.[32] According to an earlier analysis of Florida-specific NSDUH estimates, the prevalence of SMI is only about 1.5% higher among uninsured adults than it is among insured adults, whereas the prevalence of substance use disorders among uninsured adults is nearly twice as high as the prevalence among insured adults.[33]

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

Assessments of Behavioral Health Services, conducted in partnership with the Managing Entities pursuant to s. 394.4573, Florida Statutes, describe the extent to which designated receiving systems function as no-wrong-door models, the availability of services that use recovery-oriented and peer-involved approaches, and the availability of less-restrictive services. Managing Entities identify top unmet system needs in a variety of different ways, including analyses of waitlist records; surveys; and focus groups with consumers, providers, and other community stakeholders. Assessments and associated enhancement plans were recently updated to reflect conditions that changed during the pandemic.

A summary of the unmet needs related to treatment and recovery support services for individuals with SMI, SED, and/or SUD is provided below. Each Managing Entity rank-ordered the services and projects according to priority.

NWF Health Network (NWFHN):

1. Establishment of an additional Centralized Receiving Facility
2. Expanded forensic Florida Assertive Community Treatment (FACT) services
3. Expanded family support services

Broward Behavioral Health Coalition (BBHC):

1. Expanded Housing and Care Coordination
2. Family/Peer Navigators
3. Recurring funding to sustain Housing and Care Coordination
4. Establishment of a forensic alternatives center
5. Reduced representation of individuals with SMI and/or SUD in the criminal justice system
6. Development and implementation of Zero Suicide plan
7. Expanded Multi-Disciplinary Treatment teams
8. Sustainment of short-term residential treatment services

Central Florida Behavioral Health Network (CFBHN):

1. Additional Community Action Treatment (CAT) teams
2. Supported Employment
3. Expanded community-based services
4. Expanded Care Coordination
5. Increased number of school-based prevention programs
6. Expanded housing and supported housing options

Central Florida Cares Health System (CFCHS):

1. Expanded telehealth services
2. In-home Family Functional Therapy
3. Wraparound services
4. Expanded short-term residential treatment
5. Expanded peer recovery services through peer recovery respite centers

Luther Services of Florida Health Systems (LSFHS):

1. Implementation of workforce recruitment, retention, and sustainability plan
2. Housing and Care Coordination
3. Behavioral health and law enforcement co-responder teams

Southeast Florida Behavioral Health Network (SEFBHN):

1. Provider workforce stabilization for core outpatient mental health services
2. Expanded wraparound medication management services
3. Expand supported employment services
4. Expand mental health clubhouses
5. Integrated primary care and behavioral health care clinic

South Florida Behavioral Health Network (SFBHN):

1. Expanded supported housing
2. Partnerships with housing providers, organizations, and agencies
3. Managing Entity system-level Care Coordination
4. Enhanced case management
5. Peer-led respite program

Several clear themes emerged from needs assessment data. The most frequent system gaps for treatment and recovery support services for individuals with SMI, SED, and or SUD were related to housing and care coordination, multidisciplinary and team-based services, access to community-based recovery supports (e.g., Peer Navigators, community drop-in centers), and family support services. Team-based services include FACT, CAT, mobile response teams (MRT), Family Intensive Treatment (FIT), and Coordinated Specialty Care for Early Serious Mental Illness (CSC-ESMI). FACT, CAT, MRT, and CSC-ESMI are addressed and prioritized through performance indicators and objectives established in Florida's state plan.

#1 PRIORITY AREA: Mobile Crisis Response Team (MRT) Diversions

Priority Type: Crisis Services (CS)

Required Population: Crisis Services

Goal: Ensure Mobile Response Teams maintain prompt response times for acute call responses.

Objective: Increase number of MRT providers who meet response time target values for acute call responses.

Indicator: The percentage of MRT providers that meet target values for average response time for calls requiring an acute, in-person response.

Baseline (FY 22-23): In FY 22-23, 86.7% of MRT calls requiring an acute response did not result in an involuntary examination.

First Year (FY 23-24) Target: At least 87% of MRT calls requiring an acute response did not result in involuntary examination.

Second Year (FY 24-25) Target: At least 88% of MRT calls requiring an acute response did not result in an involuntary examination.

#2 PRIORITY AREA: Community Action Teams (CAT) for Children with SED

Priority Type: Mental Health Services (MHS)

Required Population: SED

Goal: Expand intensive, team-based services to children with SED.

Objective: Increase the number of children served by CATs.

Indicator: The number of children served by CATs.

Baseline (FY 22-23): In FY 22-23, X,XXX children were served by CATs.

First Year (FY 23-24) Target: The number of children served by CATs increased by XX compared with the number served in FY 22-23.

Second Year (FY 24-25) Target: The number of children served by CATs increased by XX compared with the number served in FY 23-24.

#3 PRIORITY AREA: Florida Assertive Community Treatment (FACT)

Priority Type: Mental Health Services (MHS)

Required Population: SMI

Goal: Expand intensive, team-based services to adults with SMI.

Objective: Increase the number of adults served by FACT teams.

Indicator: The number of adults with SMI served by FACT teams.

Baseline (FY 22-23): In FY 22-23, 3,627 adults were served by FACT teams.

First Year (FY 23-24) Target: The number of adults served by FACT teams increased by 35 compared with the number served in FY 22-23.

Second Year (FY 24-25) Target: The number of adults served by FACT teams increased by 35 compared with the number served in FY 23-24.

Housing and Homelessness

A stable living environment is fundamental to recovery from mental disorders and substance use disorders. Unfortunately, housing is among the most consistently identified unmet needs across Managing Entities from year-to-year. According to 2023 Point-In-Time counts of individuals who are homeless, 5,374 individuals surveyed (17.4%) reported experiencing serious mental illness, while 3,047 individuals (12.2%) reported experiencing a substance use disorder. The prevalence of SMI among individuals who are homeless was about 15.3% in 2022. The prevalence of substance use disorders among individuals who are homeless was approximately 10.9% in 2022.[34]

The needs of people experiencing homelessness often overlap multiple systems, which is why the Department supports collaborative efforts between Managing Entities, Continuums of Care, Public Housing Authorities, Florida Housing Finance Corporation, and other local community-based care providers to enhance the ability to strategically target these multi-system consumers and coordinate housing and services aimed at housing stabilization and retention. In Florida, Continuums of Care (CoC) refer to a group of stakeholders within a geographic area who work together to address homelessness. CoCs are comprised of homeless-serving nonprofits, entities from the philanthropic sector, businesses, local governments, housing developers, realtors, health care systems, and more. These partnerships support a strong system that seeks to incorporate housing and support services funded by a variety of sources, helping to quickly identify, assess, shelter, and permanently house individuals and families experiencing homelessness. Understanding the correlation between recovery and housing, the Office of Substance Abuse and Mental Health spearheaded a Managing Entity Housing Coordination initiative in 2016, establishing partnerships between housing providers, service providers, behavioral health agencies, CoCs, and other systems serving consumers who overlap between these resource-

limited systems. This initiative is focused on ensuring individuals with behavioral health disorders live in the most independent, least restrictive housing possible in their local community and receive services in community-based settings that support wellness, recovery, and resiliency.

The Office of Substance Abuse and Mental Health will continue to support and advocate for affordable and supportive recovery housing and recovery services to aid individuals with substance use, mental health, or co-occurring disorders; those addicted to opiates; and those experiencing or at risk of homelessness. As housing has been clearly demonstrated to be a social determinant of health, the Florida Legislature has focused its efforts on ensuring adequate funding to reduce homelessness in the state. In 2023, the Governor signed the omnibus housing bill, Live Local Act (SB102), which is intended to address Florida's affordable housing crisis. Examples include funding for the State Housing Initiatives Partnership Program (SHIP) and State Apartment Incentive Loan Program (SAIL) and $150 million annually for 10 years for a new program like SAIL. The Legislature also increased their annual appropriation for the Challenge Grant by $16.8 million over the previous year. The Challenge Grant provides funding to support individuals who do not meet the strict eligibility requirements of Federal grant programs.[35]

Pregnant Women and Women with Dependent Children

In SFY 21-22, the Department served 1,338 pregnant women and expended around $11.5 million on services for pregnant women and women with dependent children. The most provided services were residential treatment, medication-assisted treatment, and case management. There were 187 live births reported, 116 of which were born drug free. The Department is committed to addressing the unique treatment needs of pregnant women and women with dependent children. Women are faced with society-defined roles and expectations which often lead to a reluctance to seek treatment. Many must choose between treatment or caretaking. The option to bring children with them to treatment or complete intensive outpatient treatment allows the flexibility needed to receive the services needed while maintaining other responsibilities. The availability of evidence-based treatments, including medication assisted treatment and recovery support, are crucial to meeting the needs of this population.

In FY 22-23, the successful treatment completion rate among pregnant women served was 33.0%. The Department intends to improve successful completion rates among pregnant women through an associated performance measure that calls for a 2-percentage point increase (above the FY 22-23 baseline) each year over the next Block Grant funding cycle. For context, research indicates that pregnant women living in the Northeast U.S. have higher treatment completion rates (56.6%) than those living in the West (49.9%), Midwest (48.1%), and South (36.0%).[36] Improving treatment completion rates may entail focusing on things like stigma, the provision of childcare services, and cultural competence.

#4 PRIORITY AREA: Services for Pregnant Women and Women with Dependent Children (PWWDC)

Priority Type: Substance Use Treatment (SUT)

Required Population: PWWDC

Goal: Improve access to services for pregnant women.

Objective: Increase the rate of successful discharges from services among pregnant women served by the Department.

Indicator: The percent of successful discharges from services among pregnant women.

Baseline (FY 22-23): In FY 22-23, 41.5% of discharges among pregnant women were successful.

First Year (FY 23-24) Target: In FY 23-24, the percentage of successful discharges among pregnant women increased by 2 points.

Second Year (FY 24-25) Target: In FY 24-25, the percentage of successful discharges among pregnant women increased by 2 points.

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

States are required to expend at least 10% of the Community Mental Health Services Block Grant on Coordinated Specialty Care (CSC) programs for Early Serious Mental Illness (ESMI), including first episodes of psychosis, regardless of the age of the individual at onset. Evidence indicates that a prolonged duration of untreated mental illness predicts negative outcomes (e.g., serious impairment, unemployment, homelessness, etc.) across different mental illnesses. Earlier treatment and interventions are therefore critical to both reducing acute symptoms and improving long-term outcomes. CSC-ESMI programs are evidence-based and provide comprehensive, coordinated, individualized, and integrated services, including but not limited to intensive case management, individual and group therapy, supported employment, family education and supports, and appropriate psychotropic medication, as indicated. The Department is currently funding the 16 CSC-ESMI teams, including seven teams established and sustained with Block Grant funding and nine temporary teams funded by Supplemental Block Grant funding. Florida plans to devote a portion of the annual recurring increase of the Community Mental Health Services Block Grant to make all temporary teams permanent. All teams use the NAVIGATE treatment model, except for three teams that use the OnTrackNY model. Across teams, the percent of individuals served who experienced improvements in functioning or symptom severity in FY 20-21 was 80.1%. An associated performance indicator calls for the teams to maintain or exceed an 80% target for individuals experiencing improvement.

#5 PRIORITY AREA: Coordinated Specialty Care for Early Serious Mental Illness (CSC-ESMI) and First Episodes of Psychosis

Priority Type: ESMI

Required Population: SED, ESMI

Goal: Improve functioning or symptom severity among individuals served by Coordinated Specialty Care for Early Serious Mental Illness programs.

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

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

Baseline (FY 22-23): In FY 22-23, XX.X% of individuals served by CSC-ESMI programs experienced improvements in functioning or symptom severity.

First Year (FY 23-24) Target: In FY 23-24, at least 80% of individuals served by CSC-ESMI programs experienced improvements in functioning or symptom severity.

Second Year (FY 24-25) Target: In FY 24-25, at least 80% of individuals served by CSC-ESMI programs experienced improvements in functioning or symptom severity.

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

In 2020, Florida ranked third in the nation in HIV diagnoses and new diagnosis rates per 100,000.[37] In 2021, Florida's HIV case rate was 21.4 with 4,708 new cases of HIV identified.[38] A majority of cisgender male adults who received an HIV diagnosis in 2021 had male-to-male sexual contact as their mode of exposure (76.8%), heterosexual contact (17.6%), male injection drug use (3.3%), and both injection drug use and male to male sexual contact (1.8%). Cisgender women reported exposure through heterosexual contact (91.5%) and injection drug use (8.5%). Black men were six times more likely to get HIV than white men, 93 cases per 100,000 and 16.3 cases per 100,000, respectively. Hispanic men (69.3 cases per 100,000) were four times more likely than white men.[39] Approximately 6.7% of individuals living with an HIV diagnosis in Florida inject drugs.[40] The Department's implementation of the Block Grant HIV Early Intervention Services set-aside supports the Department of Health's plan to eliminate HIV transmission and reduce HIV-related deaths. A key component is the implementation of routine HIV screening in health care settings, like substance use disorder treatment facilities. People with HIV who are aware of their status can get HIV treatment, which lowers the level of HIV in the blood, reduces HIV-related illness, and lowers the risk of transmitting HIV to others.[41] Routine and efficient HIV testing through the Department's network of treatment providers helps many at-risk individuals know their status and links individuals who are HIV positive to HIV care. Additionally, as explained in more detail below, the Department's network of behavioral health treatment providers play an important role in helping retain individuals in HIV care and suppressing their viral loads by addressing any unmet needs they might have for addiction treatment, housing, and ancillary support services.

The chart below depicts the HIV Continuum of Care for people living with HIV and, more specifically, for people who inject drugs living with HIV in Florida. The HIV Continuum of Care reflects the series of steps a person living with HIV takes from initial diagnosis to being retained in HIV care and achieving a very low level of HIV in the body (i.e., viral suppression), which makes transmitting the virus to others less likely. Among HIV-positive individuals who inject drugs in Florida, approximately 75.0% are in HIV care, 68.4% are retained in care (with care documented on two or more occasion at least three months apart), and 60.9% are virally suppressed (HIV-1 RNA load less than 200 copies/mL).[42]

According to an earlier analysis of suboptimal adherence to antiretroviral therapy among individuals living with HIV/AIDS throughout Florida, heavy alcohol consumption is associated with twice the odds of suboptimal HIV viral suppression compared to non-drinkers, even when controlling for other potential confounding variables.[43] Fortunately, most individuals with HIV/AIDS in Florida that need behavioral health services for alcohol and other substance use disorders report that they are able to access them. The Department of Health analyzed responses to an anonymous survey administered in 2019 that was designed to collect information on the met and unmet needs of people living with HIV/AIDS.[44] As depicted in the table below, only about 5% of respondents were unable to get professional mental health counseling and 2% were unable to get professional addiction treatment services:

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

Florida is required to spend exactly 5% of the SAPT Block Grant award on HIV Early Intervention Services, which includes HIV testing, pre- and post-test counseling, and diagnostic and therapeutic measures related HIV. Block

Grant regulations stipulate that these HIV testing services can only be provided to individuals receiving treatment for substance use disorders, at the sites at which they are undergoing treatment. This federal requirement is triggered when a state's AIDS case rate exceeds 10 per 100,000, *according to the most recent calendar year for which such data are available*.[45] According to the most recently published estimate, Florida's AIDS case rate in 2019 was 10.1 per 100,000.[46] SAMHSA allows states that were designated in any of the three years prior to the year for which they are applying for funds to continue to obligate and expend funds for HIV EIS if they so choose. Should Florida's AIDS case rate fall below the cutoff value, analysis of the cost-effectiveness of Florida's HIV EIS programs will help the Department determine the path forward that will make the greatest impact on the health of vulnerable individuals with substance use disorders.

According to recent models, "the path to HIV elimination, given current funding, is one that focuses primarily on prompt diagnosis with sustained treatment of those infected." More specifically, "Given stable funding and the current effectiveness of intervention delivery, sizeable reductions in HIV incidence may be realized by focusing on screening persons at highest risk of HIV, linking the newly diagnosed to care, and supporting those in treatment to achieve and maintain viral suppression."[47] Earlier guidelines suggested that an HIV prevalence of 1% could be used as a general threshold for recommending routine (as compared with targeted) HIV screening in health care settings like drug treatment facilities, while noting that routine screening may be recommended at lower prevalence rates depending on available resources and circumstances. Research now indicates that routine screening is cost-effective if the prevalence of undiagnosed HIV infection is as low as 0.05%.[48] To ensure that HIV EIS set-aside funded providers are providing cost-effective testing services that adequately target high-risk individuals, an associated performance indicator applies a higher standard to the prevalence of HIV positive tests, calling on HIV EIS set-aside funded providers to maintain a 0.10% HIV test positivity rate (among providers reporting positive tests). This is twice the size of the cost-effectiveness standard applied to the prevalence of undiagnosed HIV infections in these settings and may entail more targeted deployment of testing capacity.

#6 PRIORITY AREA: Infectious Disease Control

Priority Type: Substance Use Treatment (SUT)

Required Population: Early Intervention Services – HIV (EIS/HIV)

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

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

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

Baseline (FY 22-23): In FY 22-23, the percent of HIV-tests that were positive among providers reporting at least one positive test was X.XX%.

First Year (FY 23-24) Target: In FY 23-24, the percent of HIV-tests that are positive among providers reporting at least one positive test is at least 0.10%.

Second Year (FY 24-25) Target: In FY 24-25, the percent of HIV-tests that are positive among providers reporting at least one positive test is at least 0.10%.

Individuals At-Risk for Tuberculosis (TB)

All licensed substance use treatment programs in Florida are required to provide tuberculosis testing to high-risk individuals either directly or through referral. In 2022, 535 tuberculosis (TB) cases were reported in Florida.[49] This represents a 7% increase in cases from. The 2022 TB incidence rate was 2.4 per 100,000.[50] The following risk factors were identified among the 2022 cases:

- Excess alcohol use in the past year (9%)
- HIV co-infection (9%)
- Illicit drug use within the past year (6%)
- Homelessness (6%)[51]

TB cases where the use of alcohol and other drugs are identified as risk factors have been declining over the past two decades.[52] Looking more specifically at injection drug use as a risk factor, the Department of Health estimates that only about 1% to 2% of TB cases are associated with injection drug use.[53] The number of HIV diagnoses with TB in Florida has remained relatively stable since 2018, hovering at around 9%.[54]

It is important that people who have TB take medications exactly as prescribed and finish the course of treatment. If they stop too soon, they can become sick and may spread the infection. Furthermore, if they do not take the medicine correctly or receive incomplete treatment, the TB bacteria may develop resistance to those drugs and become harder and more expensive to treat. Fortunately, most individuals with TB in Florida successfully complete treatment, and the expedient provision of behavioral health services and supports helps Florida maintain this rate.[55] Since 2018, the percent of individuals with TB successfully completing treatment is consistently high with 99.2% in 2018, 99.8% in 2019, and 98.9% in 2020.

#7 PRIORITY AREA: Infectious Disease Control

Priority Type: Substance Use Treatment (SUT) and Mental Health Services (MHS)

Required Population: Tuberculosis (TB)

Goal: Prevent the spread of TB through screening of at-risk individuals.

Objective: Maintain a low tuberculosis case rate.

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

Baseline (FY 22-23): In FY 22-23, Florida's TB case rate is 2.4 per 100,000.

First Year (FY 23-24) Target: In FY 23-24, Florida's TB case rate is 2.5 per 100,000 or lower.

Second Year (FY 24-25) Target: In FY 24-25, Florida's TB case rate is 2.5 per 100,000 or lower.

Primary Prevention of Substance Use and Substance Use Disorders

Substance use among students in Florida continues to decline. Among middle and high school students in Florida, between 2010 and 2022, the prevalence of lifetime alcohol use decreased from 51.5% down to 31.0% and the past-30-day prevalence of alcohol use decreased from 28.8% down to 11.8%. Regarding binge drinking (in the past 2 weeks), the prevalence decreased from 14.1% down to 5.6%. High schoolers are asked if they ever woke up after a night of drinking and did not remember the things they did or the places they went. The lifetime prevalence of "blacking out" among high schoolers decreased from 18.9% down to 11.0% from 2014 (the first year this item appeared on the survey) to 2022. Regarding marijuana use, the prevalence of lifetime and past 30-day marijuana use among middle and high school students also decreased between 2010 and 2022. Lifetime prevalence decreased from 23.8% down to 16.0%, and past 30-day prevalence decreased from 13% down to

8.3%. Finally, the lifetime prevalence of the use of any illicit drug *other than marijuana* also decreased from 21% down to 12.3%. Current (past 30-day) use of any illicit drug other than marijuana decreased from 9.3% down to 4.7%. Trends in early initiation are also encouraging. The percent of high school youth that started using alcohol (more than a sip) at age 13 or younger decreased from 27.1% down to 14.1% between 2010 and 2022. The percent that started using marijuana at age 13 or younger decreased from 11.3% down to 6.5%.[56]

With respect to particularly high-risk and antisocial substance-related behaviors, long-term progress in Florida is less dramatic but still encouraging. For example, in 2013 (the first year these questions appeared on the survey in their current form), 6.4% of middle and high school students reported using alcohol before or during school (in the past 12 months). Additionally, 9.8% smoked marijuana and 3.4% used another drug before or during school.[57] Estimates for 2022 reflect moderate progress with respect to these behaviors, with approximately 3.5% of students consuming alcohol, 7.1% smoking marijuana, and 2.4% using other drugs before or during school. Additionally, between 2012 and 2022, the percent of Florida high school students who reported driving a vehicle after drinking alcohol decreased from 8.1% down to 3.3%. The percent who reported riding in a vehicle driven by someone who had been drinking alcohol decreased from 21.4% down to 13.5%. The percent who reported driving a vehicle after using marijuana decreased less substantially, from 11.2% down to 6.4%. The percent who reported riding in a vehicle driven by someone who had been using marijuana decreased from 25.4% down to 17.8%.

Florida's substance use prevention system infrastructure must be responsive to childhood trauma as a prominent risk factor for substance use and other problems. In 2020, the Department started collecting data on the prevalence of adverse childhood experiences (ACEs) among high schoolers, through the Florida Youth Substance Abuse Survey (FYSAS). Data analysis is based on 14 items measuring 10 different ACEs. In 2022, about one out of three (32.8%) of Florida high school students reported no ACEs. Conversely, 21.4% of Florida high school students reported four or more ACEs, considered a high level of trauma. Examples of ACEs include parental separation/divorce, living with someone who went to jail/prison, and physical and emotional abuse and neglect. Students with four or more ACEs report substance use rates two times higher than students with fewer than four ACEs. For example, students with fewer than four ACEs report a past-month alcohol use rate of 12.5%, compared to 25.1% for those with four or more ACEs. High-trauma students reported almost three times higher marijuana use, with past 30-day rates of 8.1% among low-trauma students and 24.1% among high-trauma students. White students, female students, and students from low socioeconomic status families are more likely to report high levels of ACEs.[58] In order to prevent ACEs, the Centers for Disease Control and Prevention recommends strengthening economic supports to families, ensuring a strong start for children (with early childhood home visitation, high-quality child care, and preschool enrichment with family engagement), and teaching life skills and parenting skills to bolster resiliency and help parents and children manage stress and emotions.[59]

Shifting focus to adult populations, the table below shows the most recently published NSDUH prevalence rates for various substances and substance use disorders, among three adult age groups in Florida (18 and older, 18-25, and 26 and older).[60]

Prevalence of Substance Use and Substance Use Disorders in the Past Year, in Florida, by Adult Age Group (2021)

	18 and Older	18-25	26 and Older
Pain Reliever Misuse	2.5%	3.0%	2.5%
Heroin Use	0.3%	0.2%	0.3%
Cocaine Use	1.4%	2.8%	1.2%
Methamphetamine Use	0.6%	0.3%	0.6%
Pain Reliever Use Disorder	1.9%	1.2%	2.0%
Illicit Drug Use Disorder	7.7%	14.0%	6.9%
Alcohol Use Disorder	10.4%	13.0%	10.1%

Illicitly manufactured fentanyl is driving an unprecedented opioid overdose crisis which is claiming the lives of about 17 Floridians every day. Pressed pills/tablets are now commonly adulterated with fentanyl and fentanyl analogs, which means that individuals that intend to use prescription stimulants or sedatives are all at-risk of exposure to potentially fatal doses of fentanyl. According to FDLE, the prevalence of counterfeit pills/tablets increased from about 5% in 2018 up to about 44% in 2021, many of which are adulterated with synthetic opioids.[61] As noted by the U.S. Commission on Combating Synthetic Opioid Trafficking, "Expanding traditional prevention messaging to deter initiation, a major focus of conventional prevention efforts, would do little to directly reduce today's appalling death toll, especially among those currently using street-sourced opioids, although it could have long-term benefits for future generations…However, because many people could be misled into using fentanyl disguised as some other drug, educating the public that counterfeit pills can contain a fatal dose of fentanyl is an important potential goal."[62]

According to the 2022 FYSAS, only 22.2% of Middle and High School students talked with a parent or guardian in the past year about the dangers of taking a prescription drug that was not prescribed to them. Without hearing these important messages, it is no surprise that only 67.8% of Middle and High School students perceived great risk of harm in taking a prescription drug without a doctor's order.[63] An associated performance indicator calls for increasing this measure up to 70% by 2024. To help achieve this, the Department will rally prevention partners around "One Pill Can Kill" messaging campaigns. Intermediary progress will be tracked through a new question on the FYSAS that asks high schoolers if they have ever seen or heard the "One Pill Can Kill" message.

#8 PRIORITY AREA: Primary Drug Prevention

Priority Type: Substance Use Prevention (SUP)

Required Population: Primary Prevention (PP)

Goal: Reduce accidental deaths caused by fentanyl and fentanyl analogs through prevention activities.

Objective: Prevent nonmedical prescription drug misuse by increasing perceived risk of harm.

Indicator: The percentage of middle and high school students that perceive great risk of harm in taking a prescription drug without a doctor's orders.

Baseline (FY 22-23): In FY 22-23, 67.8% of middle and high school students in Florida perceived great risk of harm in taking a prescription drug without a doctor's orders.

First Year (FY 23-24) Target: In FY 23-24, at least 69% of middle and high school students in Florida perceived great risk of harm in taking a prescription drug without a doctor's orders.

Second Year (FY 24-25) Target: In FY 24-25, at least 70% of middle and high school students in Florida perceived great risk of harm in taking a prescription drug without a doctor's orders.

Suicide Prevention Through Substance Use Prevention

According to the Florida Department of Health, there were 3,325 deaths due to suicide in 2021, in addition to 7,637 hospitalizations for non-fatal self-inflicted injuries.[64] Suicide is the second leading cause of death for Floridians ages 10 to 34 years old.[65] In 2021, the prevalence of serious thoughts of suicide in the past year was 4.5% among adults 18 and older. Among Floridians ages 18-25, the prevalence of serious thoughts of suicide was 14.0% in 2021.[66] A multivariate analysis of Florida high school students demonstrated that tobacco use, alcohol use, and depressive symptoms were all significantly associated with increased odds of suicidal ideation. Tobacco

use, alcohol use, marijuana use, and depressive symptoms were all significantly associated with increased odds of both suicide planning and suicide attempts. Adverse Childhood Experiences, namely measures of interpersonal violence, were also significantly associated with these measures of suicidality.[67]

According to a meta-analysis of 30 longitudinal studies, there is a positive and significant association between alcohol use and both fatal and nonfatal suicide attempts. Alcohol use increases the probability of suicidal attempts by 110% and the probability of suicide mortality by 65%. However, in this meta-analysis, the association between alcohol and suicide ideation is not significant.[68] According to a more recently published meta-analysis of 48 studies (spanning 1995 to 2020), among patients with substance use disorders, the pooled prevalence of past-year suicide ideations is 35% and the prevalence suicide attempts is 20%. These rates are higher than the rates observed among the general population. Smoking, a history of sexual abuse, depression, and alcohol and cannabis use disorders are significantly associated with suicide ideations. Being female, having a history of physical and sexual abuse, depression, substance use, and polysubstance use are significantly associated with suicide attempts.[69] Given the interrelationship between suicide risk and substance use, reducing the use of alcohol and other drugs is a way to reduce suicide-related experiences. A recently published meta-analysis of individual-level psychological interventions designed to reduce alcohol use revealed a modest decrease in self-harm (encompassing non-suicidal self-injury and attempted suicide), but not suicidal ideation.[70] Another meta-analysis of studies conducted among individuals with substance use disorders found evidence of reduced self-harm following Cognitive Behavioral Therapy and Dialectical Behavioral Therapy interventions.[71] With respect to *population-level* interventions, typically involving restrictions on alcohol availability, a recent systematic literature review showed that most studies found an association with reduced suicides or self-harm, predominantly among males.[72]

According to SAMHSA, "Alcohol and drug misuse are second only to depression and other mood disorders as the most frequent risk factors for suicidal behavior…People at risk for suicide and substance misuse share a number of risk factors that include depression, impulsivity, and thrill-seeking/life threatening behaviors. Because risk and protective factors for the two can overlap, prevention professionals need to be aware of them and to implement prevention programming that reduces risk and enhances protective factors."[73] Substance use is more than a risk factor for suicide, it is a mechanism/means of dying by suicide. For example, according to 2022 interim data from Florida Medical Examiners, approximately 14-22% of deaths caused by sedatives (i.e., alprazolam, diazepam, and clonazepam) in Florida are suicides. With respect to opioids, 13.5% of deaths caused by oxycodone and 19% of deaths caused by hydrocodone are suicides.[74] Prevention efforts targeting access to pharmaceutical sedatives and opioids are therefore part and parcel of reducing suicides by increasing safe storage practices and decreasing access to lethal means.

The Florida Governor's Challenge team is an interdisciplinary team of suicide prevention experts charged with the development and implementation of a state plan to prevent suicide among service members, veterans, and their families. The Governor's Challenge team plan advances the U.S. Department of Veterans Affairs' National Strategy for Preventing Veteran Suicide (2018-2028) and incorporates evidence-based strategies from the CDC's Preventing Suicide: A Technical Package of Policy, Programs, and Practices.[75] Florida is home to 21 military bases and over 1.5 million veterans. According to the most recently published report, 493 Florida veterans died by suicide in 2020. The Florida veteran suicide rate (32.4 per 100,000) is slightly higher than the rate observed among southern states (31.9 per 100,000).[76] The Florida Governor's Challenge Team is prioritizing lethal means safety and safety planning, with a specific goal to increase naloxone (the opioid overdose antidote) distribution and reduce overdoses.[77]

Florida's 2020-2023 Florida Suicide Prevention Interagency Action Plan deployed the Social-Ecological Model for suicide prevention, and identifies four focus areas and eleven strategies to decrease suicide experiences among Floridians. This model targets risk factors for suicide such as easy access to lethal methods, the use of alcohol

and other substances, depression, and a family history of child maltreatment. Strategies include promoting the use of evidence-based interventions that target suicide risk, facilitating interagency collaboration to improve access to mental health care, provision of caring follow-up and support to communities and individuals after a suicide event, and increasing the provision of life skills training programs that address critical thinking, stress management, and coping, to help Floridians safely address stressors and challenges.[78] Another strategy entails increasing awareness of existing behavioral health and suicide prevention resources. Florida's First Lady Casey DeSantis recently announced expansions to the Hope for Healing website: www.HopeForHealingFL.com. Since 2019, the Hope for Healing initiative has helped people access a variety of public and private sector prevention and intervention resources, while addressing the stigma that often deters individuals from seeking help.[79] In 2021, additional resources were added to the website, which now reflects resources from several state agencies, including the Department of Children and Families, Department of Education, Department of Elder Affairs, Department of Veterans' Affairs, Department of Health, and the Division of Emergency Management. First Lady Casey DeSantis' Hope Ambassadors program, which is a critical component of Hope for Healing, is creating settings where students can volunteer, mentor their peers, and develop leadership skills and resiliency. During the initial pilot program, 25 schools started Hope Ambassador clubs in 2020-2021. In December 2021, the program expanded to 100 schools across 39 school districts and continues to grow. Hope Ambassadors topics like homelessness, confronting risks for substance use, and how to ask for help and navigate available resources. The clubs also utilized social media to encourage students to boost and promote healthier conversations.[80]

Recovery Support Services and Recovery-Oriented Systems of Care

The Department supports the provision of peer recovery support services and the development of Recovery Community Organizations (RCOs). In Florida, RCOs organize recovery-focused advocacy activities, carry out recovery-focused community education, outreach, and peer-based recovery support services. They work closely with community treatment providers and other stakeholders to provide harm reduction and recovery support services. RCOs use the Recovery Capital Scale as a component of the recovery planning process. Recovery capital is conceptually linked to natural recovery, solution-focused therapy, strengths-based case management, recovery management, resilience and protective factors, wellness, and sustained recovery. Currently there are 16 existing RCOs in Florida and 10 in the early development phase. RCO development is integral to advancing the vision of a recovery-oriented system of care, which entails a shift from a purely reactive, stabilization-based, acute care model of service delivery to a recovery model, which focuses attention on prevention, early intervention, harm reduction, and wellness.

The Department collaborates with Faces & Voices of Recovery (FAVOR) and the Florida Behavioral Health Association to build the capacity of RCOs through training and technical assistance, virtual RCO mentorship, RCO Bootcamp, and introductions to accreditation standards. FAVOR is a nationally recognized RCO that works to support individuals in long-term recovery from substance use disorders and their family members, friends, and allies in a variety of ways. Services include capacity building in support of the national recovery movement, fighting the stigma of addiction and creating recovery messaging trainings. FAVOR assists local communities of recovery, community partners, and Managing Entities with helping RCOs become accredited through the Council on Accreditation of Peer Recovery. Additionally, Floridians for Recovery, a statewide RCO network, hosted a Statewide Recovery Leadership Summit with over 150 recovery leaders in attendance. The Department also deploys Recovery Oriented Quality Improvement Specialists (ROQIS) – individuals in recovery with lived experience in the behavioral health system of care – to engage in on-going quality assurance and improvement activities, support the implementation and enhancement of recovery approaches and services, and promote effective engagement and care coordination strategies. In addition, ROQIs provide technical assistance and consultation to coordinate the expansion of effective outreach and engagement, medicated assisted treatment, and care coordination services. An associated objective entails examining variation in the use of recovery

support service codes in order to understand the range of peer-based recovery support services provided in the state and ensure the reliability and accuracy of how service codes are being applied for the management and monitoring of these services.

In partnership with the Florida Certification Board, the Department developed a process and protocol for onsite recovery-oriented monitoring, which includes reviews of facilities and medical records, and interviews with employees and persons served. This innovative program uses evidence-based measures of recovery principles and applies these measures to service provider organizations. A recovery-oriented quality improvement component was added to the State's traditional quality improvement monitoring practices for contracted mental health and substance use provider organizations. A blueprint details the rationale, procedures, and tools used for this new component. Clinical record reviews evaluate a source of potential evidence of recovery-oriented principles and practices that are recorded within persons-served clinical charts to identify and measure evidence across 7 domains: Meeting Basic Needs, Medication-Assisted Treatment, Strengths-Based Approach, Customization and Choice, Opportunity to Engage in Self-Determination, Network Supports/Community Integration, and Recovery Focus. The Measuring Recovery-Oriented Principles and Practices Tool breaks down each domain and describes the kind of information that should be present to address that principle. Preliminary analysis of recovery practices documented in medical record reviews shows that providers are scoring highest in the domain of Strength-based Planning (average score of 3.2 on a 5-point scale) and lowest in the domain of Recovery Focus (average score of 2.1 on a 5-point scale). As of July 2023, ROQIs conducted 46 improvement monitoring reviews among Department-funded behavioral health providers and identified an average score of 3.5 across core recovery domains. To bolster ROSC capacity and the quality of data monitoring and reporting, an associated objective calls for the Department to develop and pilot a statewide provider-level tracking system for recovery domain scores obtained during ROQI monitoring visits, in part to see if training and technical assistance are having an impact. Another objective calls for conducting reviews for a sample of direct service providers to establish a baseline score among the latter five recovery domains listed above with an expectation that providers should achieve a score of "4" or higher. The baseline will provide insight into how far we are from the target and where to devote resources to drive improvement. Scores will also be used to help describe and evaluate the impact of Department's contractual guidance on Recovery Management Practices (Guidance Document 35).

The final objective calls for Neonatal Abstinence Syndrome/Substance Exposed Newborn (NAS/SEN) Care Coordinators to provide training on how to link pregnant women with substance use disorders receiving peer recovery support services to resources for NAS/SEN. This may include exploration of the continued role for telehealth in the provision of support services for pregnant and parenting women. Interviews with women who participated in integrated care for substance use disorders reveal that peer support, from a woman with lived experience with a substance use disorder during pregnancy, benefits them by sustaining engagement in treatment, bolstering accountability for participating in treatment, and improving access to well-coordinated medical and social support and resources.[81] The ability to connect with other women who understand both addiction and motherhood was a crucial benefit identified by all participants. This initiative will also mutually support the separate performance indicator that aims to increase rates of successful program completion among pregnant women with substance use disorders.

#9 PRIORITY AREA: Recovery Support Services and Recovery Oriented Systems of Care

Priority Type: Substance Use Treatment (SUT) and Mental Health Services (MHS)

Required Population: PWWDC, PWID, SMI

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

Objectives:

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

2) Establish a baseline score for each of the following domains of recovery from a sample of direct service providers: Strengths-Based Approach, Customization and Choice, Opportunity to Engage in Self-Determination, Network Supports/Community Integration, and Recovery Focus.

4) Analyze and publish a report on the use of recovery support service data codes to identify variations in use among network service providers and ensure reliable, accurate use.

5) Evaluate the Recovery Management Practices Guidance Document 35 and publish a report describing the document's effectiveness with a focus on challenges related to communication and integration of service requirements.

6) Neonatal Abstinence Syndrome/Substance Exposed Newborn (NAS/SEN) Care Coordinators will provide training to RCOs on linking pregnant women with SUD receiving peer recovery services with resources for PWWWDC with NAS/SEN.

Indicator: The number of objectives achieved.

Baseline (FY 22-23): In FY 22-23, zero objectives were achieved.

First Year (FY 23-24) Target: FY 23-24, at least 1 of the 5 objectives is achieved.

Second Year (FY 24-25) Target: In FY 24-25, at least 3 of the 5 objectives are achieved.

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Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Mobile Response Team Diversions

Priority Type: BHCS

Population(s): BHCS

Goal of the priority area:

Ensure Mobile Response Teams maintain prompt response times for acute call responses.

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The percentage of MRT providers that meet the target values for average response time for calls requiring an acute response.

Baseline Measurement: In FY 22-23, 86.7% of MRT calls requiring an acute response did not result in an involuntary examination.

First-year target/outcome measurement: At least 87% of MRT calls requiring an acute response did not result in involuntary examination.

Second-year target/outcome measurement: At least 88% of MRT calls requiring an acute response did not result in an involuntary examination.

Data Source:

MRT Cumulative Data tracking spreadsheet.

Description of Data:

The numerator is the number of calls requiring an acute response that were diverted from an involuntary examination and the denominator is the number of calls requiring an acute response.

Data issues/caveats that affect outcome measures:

None.

Priority #: 2

Priority Area: Intensive Team-Based Services

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Expand intensive, team-based services to children with SED and adults with SMI.

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.

The Department recently implemented a statewide requirement for FACT teams to administer the Assertive Community Treatment Transition Readiness Scale (ATR). The ATR is a standardized measure developed to identify individuals receiving Assertive Community Treatment services who may be ready to transition to less intensive care. Use of the ATR could increase overall capacity for intensive services by transitioning individuals to community-based settings, when appropriate.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of children served by Community Action Teams (CAT)

Baseline Measurement: In FY 22-23, X,XXX children were served by CATs.

First-year target/outcome measurement: The number of children served by CATs increased by XX compared with the number served in FY 22-23.

Second-year target/outcome measurement: The number of children served by CATs increased by XX compared with the number served in FY 23-24.

Data Source:

The data source is the CAT monthly supplemental data reports.

Description of Data:

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

Data issues/caveats that affect outcome measures:

None.

Indicator #: 2

Indicator: The number of adults served by FACT teams.

Baseline Measurement: In FY 22-23, 3,627 adults were served by FACT teams

First-year target/outcome measurement: The number of adults served by FACT teams increased by 35 compared with the number served in FY 22-23.

Second-year target/outcome measurement: The number of adults served by FACT teams increased by 35 compared with the number served in FY 23-24.

Data Source:

Quarterly contract reports.

Description of Data:

The Department collects a quarterly contract report with a total number of individuals served, as well as performance data. The total served will be calculated on an annual basis, based on admissions per team.

Data issues/caveats that affect outcome measures:

None.

Priority #: 3

Priority Area:

Priority Type: SUT

Population(s): PWWDC

Goal of the priority area:

Improve services for pregnant women.

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The percent of successful discharges among pregnant women.

Baseline Measurement: In FY 22-23, 41.5% of discharges among pregnant women were successful.

First-year target/outcome measurement: In FY 23-24, the percentage of successful discharges among pregnant women increased by 2 points compared to the previous year.

Second-year target/outcome measurement: In FY 24-25, the percentage of successful discharges among pregnant women increased by 2 points compared to the previous year.

Data Source:

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

Description of Data:

The numerator is the number of pregnant women discharges reflecting successful completion, comprised of three discharge reason codes: (1) successfully completed treatment, (2) successfully completed transfer to another program/facility, and (3) successfully completed transfer to another program/facility that is not in the reporting system. The denominator is the number pregnant women discharges excluding the following reasons: death, changes of eligibility or funding source, agency closure, or client moved and transferred to another provider.

Data issues/caveats that affect outcome measures:

None.

Priority #: 4

Priority Area: Coordinated Specialty Care for Early Serious Mental Illness (CSC-ESMI) and First Episodes of Psychosis (FEP)

Priority Type: ESMI

Population(s): SED, ESMI

Goal of the priority area:

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

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: XXXX% of individuals served by CSC for ESMI programs experienced improvements in functioning or symptom severity (FY 22-23).

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

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

Data Source:

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

Description of Data:

The numerator is the unduplicated number of the most recent subsequent assessments showing improvements in functioning or symptom severity. The denominator is total number of most recent subsequent assessments conducted during the time period.

Data issues/caveats that affect outcome measures:

None.

Priority #: 5

Priority Area: Infectious Disease Control

Priority Type: SUT, MHS

Population(s): EIS/HIV, TB

Goal of the priority area:

Ensure the cost-effectiveness of services and prevent the spread of infectious diseases through screening of at-risk individuals.

Strategies to attain the goal:

The Department analyzes 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. The Department also collaborates with the Department of Health regarding opportunity to convey behavioral health resources and training opportunities.

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 22-23, the percent of HIV-tests that were positive among providers reporting at least one positive test was X.XX%.

First-year target/outcome measurement: In FY 23-24, the percent of HIV-tests that are positive among providers reporting at least one positive test is at least 0.10%.

Second-year target/outcome measurement: In FY 24-25, the percent of HIV-tests that are positive among providers reporting at least one positive test is at least 0.10%.

Data Source:

EIS/HIV service data reported on the Managing Entity Block Grant Data Reporting Template 2.

Description of Data:

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

Data issues/caveats that affect outcome measures:

None.

Indicator #: 2

Indicator: The TB case rate per 100,000.

Baseline Measurement: In FY 22-23, Florida's TB case rate is 2.4 per 100,000.

First-year target/outcome measurement: In FY 23-24, Florida's TB case rate is 2.5 per 100,000 or lower.

Second-year target/outcome measurement: In FY 24-25, Florida's TB case rate is 2.5 per 100,000 or lower.

Data Source:

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

Description of Data:

For the baseline (Calendar Year 2020), the numerator is 535 tuberculosis cases, and the denominator is 22,329,178 individuals, yielding a rate of 1.9 per 100,000.

Data issues/caveats that affect outcome measures:

None.

Priority #: 6

Priority Area: Primary Drug Prevention

Priority Type: SUP

Population(s): PP

Goal of the priority area:

Reduce accidental deaths caused by fentanyl and fentanyl analogs through prevention activities.

Strategies to attain the goal:

Collaborate with local prevention providers, coalitions, and other stakeholders to increase awareness of the dangers of taking prescription drugs without a doctor's orders.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The percentage of middle and high school students that perceive great risk of harm in taking a prescription drug without a doctor's orders.

Baseline Measurement: In FY 22-23, 67.8% of middle and high school students in Florida perceived great risk of harm in taking a prescription drug without a doctor's orders.

First-year target/outcome measurement: In FY 23-24, at least 69% of middle and high school students in Florida perceived great risk of harm in taking a prescription drug without a doctor's orders.

Second-year target/outcome measurement: In FY 24-25, at least 70% of middle and high school students in Florida perceived great risk of harm in taking a prescription drug without a doctor's orders.

Data Source:

Florida Youth Substance Abuse Survey (FYSAS)

Description of Data:

The FYSAS is an annual survey administered to Florida's middle and high school students each spring. Surveys are administered to a statewide sample of students.

Data issues/caveats that affect outcome measures:

None.

Priority #: 7

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

Priority Type: SUR, MHS

Population(s): SMI, SED, ESMI, PWWDC, PWID, Other

Goal of the priority area:

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

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of objectives achieved.

Baseline Measurement: In FY 22-23, zero objectives were achieved.

First-year target/outcome measurement: FY 23-24, at least 1 of the 5 objectives is achieved.

Second-year target/outcome measurement: In FY 24-25, at least 3 of the 5 objectives are achieved.

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

None.

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SUPTRS]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2024/2025.
SUPTRS BG – ONLY include funds expended by the executive branch agency administering the SUPTRS BG.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	Source of Funds									
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (SUPTRS BG)[b]
1. Substance Use Prevention[c] and Treatment	$163,539,892.00		$0.00	$0.00	$20,000,000.00	$0.00	$0.00		$0.00	$0.00
a. Pregnant Women and Women with Dependent Children[c]	$5,000,000.00				$20,000,000.00					
b. Recovery Support Services	$508,600.00									
c. All Other	$158,031,292.00			$0.00	$0.00					
2. Primary Prevention[d]	$46,725,682.00		$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
a. Substance Use Primary Prevention	$46,725,682.00									
b. Mental Health Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Other Psychiatric Inpatient Care										
5. Tuberculosis Services										
6. Early Intervention Services for HIV	$11,681,420.00									
7. State Hospital										
8. Other 24-Hour Care										
9. Ambulatory/Community Non-24 Hour Care										
10. Crisis Services (5 percent set-aside)										
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately	$11,681,420.00			$13,437,598.00	$3,801,298.00					
12. Total	**$233,628,414.00**	**$0.00**	**$0.00**	**$13,437,598.00**	**$23,801,298.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$13,778,270.00**

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

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

[c] Prevention other than primary prevention

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

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Footnotes:

The figures input into this table represent 2-year budget estimates. KRG 8/11/2023

Row 2a. Substance Use Primary Prevention represents 20% of the award amount (again, 2-year budget estimate), however, a single year estimate will not equal the Substance Use Primary Prevention in Table 4, because the SUPTRS BG Prevention (non-direct services) total has been added to the amount. KRG 8/11/2023

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Table 2 addresses funds to be expended during the 24-month period of July 1, 2023 through June 30, 2025. Table 2 now includes columns to capture state expenditures for COVID-19 Relief Supplemental and ARP funds. Please use these columns to capture how much the state plans to expend over a 24-month period (July 1, 2023 - June 30, 2025). Please document the use of COVID-19 Relief Supplemental and ARP funds in the footnotes.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	Source of Funds										
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (MHBG)[b]	K. BSCA Funds (MHBG)[c]
1. Substance Use Prevention and Treatment											
a. Pregnant Women and Women with Dependent Children											
b. Recovery Support Services											
c. All Other											
2. Primary Prevention											
a. Substance Use Primary Prevention											
b. Mental Health Prevention[d]											
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[e]		$13,241,598.00								$6,300,000.00	
4. Other Psychiatric Inpatient Care											
5. Tuberculosis Services											
6. Early Intervention Services for HIV											
7. State Hospital				$176,448,780.00	$791,933,818.00						
8. Other 24-Hour Care		$12,033,502.00	$12,837,890.00	$5,426,132.00	$153,156,102.00					$172,510.00	
9. Ambulatory/Community Non-24 Hour Care		$80,531,894.00		$36,313,344.00	$1,024,967,764.00					$1,154,490.00	
10. Crisis Services (5 percent set-aside)[f]		$8,922,964.00			$65,780,200.00					$2,027,131.00	
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately[g]		$3,796,616.00		$4,059,290.00	$9,078,102.00						
12. Total	**$0.00**	**$118,526,574.00**	**$12,837,890.00**	**$222,247,546.00**	**$2,044,915,986.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$9,654,131.00**	**$2,777,427.00**

[a]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024, to expend the COVID-19 Relief supplemental funds.

[b]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[c]The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is from **October 17, 2022 thru October 16, 2024** and the expenditure for the 2nd allocation of BSCA funding will be from September 30, 2023 thru September 29, 2025 which is different from the expenditure period for the "standard" MHBG. Column J should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

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

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

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

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

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Footnotes:
The figures input into this table represent 2-year budget estimates. KRG 8/11/2023

Planning Tables

Table 3 SUPTRS BG Persons in need/receipt of SUD treatment

To complete the Aggregate Number Estimated in Need column, please refer to the most recent edition of SAMHSA's National Survey on Drug Use and Health (NSDUH) or other federal/state data that describes the populations of focus in rows 1-5.

To complete the Aggregate Number in Treatment column, please refer to the most recent edition of the Treatment Episode Data Set (TEDS) data prepared and submitted to SAMHSA's Behavioral Health Services Information System (BHSIS).

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	0	0
2. Women with Dependent Children	0	0
3. Individuals with a co-occurring M/SUD	0	0
4. Persons who inject drugs	0	0
5. Persons experiencing homelessness	0	0

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

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Footnotes:

Planning Tables

Table 4 SUPTRS BG Planned Expenditures

States must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations, including the supplemental COVID-19 and ARP funds. Plan Table 4 must be completed for the FFY 2024 and FFY 2025 SUPTRS BG awards. The totals for each Fiscal Year should match the President's Budget Allotment for the state.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	FFY 2024		
Expenditure Category	**FFY 2024 SUPTRS BG Award**	**COVID-19 Award[1]**	**ARP Award[2]**
1 . Substance Use Disorder Prevention and Treatment[3]	$81,515,646.00		$53,967,333.00
2 . Substance Use Primary Prevention	$25,062,841.00		$10,274,476.00
3 . Early Intervention Services for HIV[4]	$5,840,710.00		$2,609,918.00
4 . Tuberculosis Services			
5 . Recovery Support Services[5]	$254,300.00		
6 . Administration (SSA Level Only)	$4,140,710.00		$893,876.00
7. Total	**$116,814,207.00**	**$0.00**	**$67,745,603.00**

[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" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19

Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[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 FY 2024 "standard" SUPTRS BG, which is October 1, 2023 - September 30, 2024. The SUPTRS BG ARP planned expenditures for the period of October 1, 2023 - September 30, 2024 should be entered here in the first ARP column, and the SUPTRS BG ARP planned expenditures for the period of October 1, 2024, through September 30, 2025, should be entered in the second ARP column.

[3]Prevention other than Primary Prevention

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

[5]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023.

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Footnotes:

The amount in Row 2 for the SABG Primary Prevention is the total of Table 5a + Table 6 primary prevention. 8/4/2023 KRG

Recovery Support Services have historically been funded through multiple funding sources, and current planning for this will continue. Including the State Opioid Response Grant and the new Opioid Settlement funds. At this time, Recovery Supports are blended with other recovery services, such as housing, aftercare, respite, etc., and the state needs further guidance from SAMHSA as to which services are being considered eligible for this funding. 8/15/2023 KRG

Planning Tables

Table 5a SUPTRS BG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

A		B		
Strategy	**IOM Target**	**FFY 2024**		
		SUPTRS BG Award	**COVID-19 Award[1]**	**ARP Award[2]**
1. Information Dissemination	Universal	$560,708		$246,587
	Selected	$280,354		$123,294
	Indicated	$93,451		$41,098
	Unspecified			
	Total	**$934,513**	**$0**	**$410,979**
2. Education	Universal	$4,625,843		$2,034,346
	Selected	$2,312,921		$1,017,173
	Indicated	$770,974		$339,058
	Unspecified			
	Total	**$7,709,738**	**$0**	**$3,390,577**
3. Alternatives	Universal	$560,708		$246,587
	Selected	$280,354		$123,294
	Indicated	$93,451		$41,098
	Unspecified			
	Total	**$934,513**	**$0**	**$410,979**
4. Problem Identification and Referral	Universal	$2,242,833		$986,350
	Selected	$1,121,416		$493,175
	Indicated	$373,805		$164,392
	Unspecified			
	Total	**$3,738,054**	**$0**	**$1,643,917**
	Universal	$5,747,259		$2,527,521

5. Community-Based Processes	Selected	$2,873,629		$1,263,761
	Indicated	$957,876		$421,254
	Unspecified			
	Total	**$9,578,764**	**$0**	**$4,212,536**
6. Environmental	Universal	$280,354		$123,294
	Selected	$140,177		$61,647
	Indicated	$46,728		$20,549
	Unspecified			
	Total	**$467,259**	**$0**	**$205,490**
7. Section 1926 (Synar)-Tobacco	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
8. Other	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
Total Prevention Expenditures		**$23,362,841**	**$0**	**$10,274,478**
Total SUPTRS BG Award[3]		**$116,814,206**	**$0**	**$67,745,603**
Planned Primary Prevention Percentage		**20.00 %**		**15.17 %**

[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" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

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

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

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Planning Tables

Table 5b SUPTRS BG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Activity	FFY 2024 SUPTRS BG Award	FFY 2024 COVID-19 Award[1]	FFY 2024 ARP Award[2]
Universal Direct	$7,429,383		$3,267,283
Universal Indirect	$6,588,321		$2,897,402
Selected	$7,008,852		$3,082,343
Indicated	$2,336,285		$1,027,448
Column Total	**$23,362,841**	**$0**	**$10,274,476**
Total SUPTRS BG Award[3]	**$116,814,206**	**$0**	**$67,745,603**
Planned Primary Prevention Percentage	**20.00 %**		**15.17 %**

[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" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

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

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

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Planning Tables

Table 5c SUPTRS BG Planned Primary Prevention Priorities (Required)

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2024 and FFY 2025 SUPTRS BG awards.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
Prioritized Substances			
Alcohol	☑	☑	☑
Tobacco	☐	☐	☐
Marijuana	☑	☑	☑
Prescription Drugs	☑	☑	☑
Cocaine	☐	☐	☐
Heroin	☑	☑	☑
Inhalants	☐	☐	☐
Methamphetamine	☑	☑	☑
Fentanyl	☐	☐	☐
Prioritized Populations			
Students in College	☐	☐	☐
Military Families	☐	☐	☐
LGBTQI+	☐	☐	☐
American Indians/Alaska Natives	☐	☐	☐
African American	☐	☐	☐
Hispanic	☐	☐	☐
Persons Experiencing Homelessness	☐	☐	☐
Native Hawaiian/Other Pacific Islanders	☐	☐	☐
Asian	☐	☐	☐
Rural	☐	☐	☐

Underserved Racial and Ethnic Minorities	☑	☑	☑

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

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

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Footnotes:

Planning Tables

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

Please enter the total amount of the SUPTRS BG, COVID-19, or ARP funds expended for each activity.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Expenditure Category	FFY 2024 A. SUPTRS BG Treatment	B. SUPTRS BG Prevention	C. SUPTRS BG Integrated[1]	D. COVID-19[2]	E. ARP[3]
1. Information Systems	$938,931.00	$184,946.00			
2. Infrastructure Support	$546,231.00	$9,197.00			
3. Partnerships, community outreach, and needs assessment	$609,870.00	$849,986.00			
4. Planning Council Activities (MHBG required, SUPTRS BG optional)					
5. Quality Assurance and Improvement	$152,437.00	$65,421.00			
6. Research and Evaluation	$16,244.00	$35,528.00			
7. Training and Education	$36,287.00	$554,922.00			
8. Total	**$2,300,000.00**	**$1,700,000.00**	**$0.00**	**$0.00**	**$0.00**

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

[2]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[3]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the federal planned expenditure period of October 1, 2023 - September 30, 2025. Please list ARP planned expenditures for each standard FFY period.

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Footnotes:

Planning Tables

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

Please enter the total amount of the MHBG, COVID-19, ARP funds, and BSCA funds expended for each activity

MHBG Planning Period Start Date: MHBG Planning Period End Date:

Activity	FY Block Grant	FY [1] COVID Funds	FY [2] ARP Funds	FY [3] BSCA Funds
.	$	$	$	$
8. Total			**$**	**$**

Please wait while data loads...

[1] The 24-month expenditure period for the COVID-19 Rel **21 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Per the ins res captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for mo oved no cost extension, you have until March 14, 2024 to expend the COVID-19 Relief supplemental funds.

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

[3] The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is **October 17, 2022** thru **October 16, 2024** and for the 2nd allocation will be **September 30, 2023** thru **September 29, 2025** which is different from the expenditure period for the "standard" MHBG. Column D should reflect the spending for the state reporting period. The total may reflect the BSCA allotment portion used during the state reporting period.

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Footnotes:

Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required

Narrative Question

Across the United States, significant percentages of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not access needed behavioral health care. States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001**; **https://store.samhsa.gov/product/Approaches-in-Implementing-the-Mental-Health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the-States/SMA16-4983**. The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1]Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. States should develop systems that vary the intensity of care coordination support based on the severity seriousness and complexity of individual need. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

[1]Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604.Avaiable at: **https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx**

1. Describe your state's efforts to improve access to care for mental disorders, substance use disorders, and co-occurring disorders, including detail on efforts to increase access to services for:

a) Adults with serious mental illness

b) Pregnant women with substance use disorders

c) Women with substance use disorders who have dependent children

d) Persons who inject drugs

e) Persons with substance use disorders who have, or are at risk for, HIV or TB

f) Persons with substance use disorders in the justice system

g) Persons using substances who are at risk for overdose or suicide

h) Other adults with substance use disorders

i) Children and youth with serious emotional disturbances or substance use disorders

j) Individuals with co-occurring mental and substance use disorders

By design, the structure of Florida's publicly funded system to provide services for mental health disorders, substance use disorders, and co-occurring mental and substance use disorders aims to expand access to serve individuals across Florida. The Department contracts with seven non-profit Managing Entities to administer the Department's funding and manage regional behavioral health systems of care throughout the state. The Managing Entities ensure funding is used to effectively and efficiently address the gaps and unmet needs of the communities within their catchment areas.

Managing entities, by contract and statute, are required to develop and maintain provider networks that meet needs of individuals within communities served, including:
1. All priority populations as defined in S. 394.674(1),F.S.;
2. Mental health residents of assisted living facilities;
3. Persons ordered into involuntary outpatient placement;
4. Eligible children referred for residential placement;
5. Inmates approaching the end of their sentences;
6. Individuals that are currently in civil and forensic state Mental Health Treatment Facilities; and
7. Individuals who are at risk of being admitted into a civil or forensic state MH Treatment Facility (including diversionary community treatment and services prior to admission).

Further, Florida is striving to expand access to critical behavioral health services through support, implementation, and expansion of crisis services (i.e., the 988 Suicide and Crisis Lifeline, Mobile Response Teams, and Crisis Stabilization Units) and intensive, team -based services (e.g., Community Action Treatment, Florida Assertive Community Treatment, and Family Intensive Treatment teams).

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance parity enforcement and increase awareness of parity protections among the public and across the behavioral and general health care fields.

The Department is not involved in efforts to advance awareness or enforcement of parity protections. These responsibilities fall under the purview of the Office of Insurance Regulations.

3. Describe how the state supports integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. Include detail about:

a) Access to behavioral health care facilitated through primary care providers

b) Efforts to improve behavioral health care provided by primary care providers

c) Efforts to integrate primary care into behavioral health settings

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

4. Describe how the state provides care coordination, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

a) Adults with serious mental illness

b) Adults with substance use disorders

c) Children and youth with serious emotional disturbances or substance use disorders

The Department funds care coordination with state and federal funds. Florida contracts with seven regional, non-profit Managing Entities (ME) who contract directly with local service providers to administer the funds. Under Section 65E-14.014, Florida Administrative Code, MEs are statutorily required provide assistance to clients who may be eligible for Medicaid or other program benefits.

MEs are also required to develop and implement a care coordination policy applicable to subcontracted services that assures eligibility for services, the appropriateness of services, and the need for services for all individuals with serious mental illness, serious emotional disturbance, or co-occurring mental health and substance use disorders.

5. Describe how the state supports the provision of integrated services and supports for individuals with co-occurring mental and substance use disorders, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

MEs are required to develop and implement a care coordination policy applicable to subcontracted behavioral health services.

According to 65E-14.014(1), F.A.C., the care coordination policy must:
1. Specify methods used to reduce, manage, and eliminate waitlists for services;
2. Promote increased planning, use, and delivery of services to all individuals receiving services, including services for co-occurring

mental health and substance use disorders;
3. Ensure access to and use of clinically appropriate services using screening, assessment, and placement tools to identify the appropriate level of care within a continuum of services;
4. Promote the use of service data to achieve desired outcomes;
5. Include methodology to ensure individuals receive the lease restrictive level of care and diverted from higher levels of care when clinically indicated; and,
6. Monitor and implement system changes to promote efficiencies.

Community Action Treatment provides community-based services, including care coordination, to children ages 11 to 21 with a mental health disorder, including a co-occurring substance use disorder who meet eligibility criteria established in statue. Other Community Action Treatment services include assessment, intensive case management, crisis support, recovery support, and aftercare, among others.

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

None at this time.

Footnotes:

Environmental Factors and Plan

2. Health Disparities - Required

Narrative Question

In accordance with Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Executive Order 13985), Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals (Executive Order 14075), the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[1], **Healthy People, 2030**[2], **National Stakeholder Strategy for Achieving Health Equity**[3], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual orientations, gender identities, races, and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (e.g., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the **Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[4].

Collecting appropriate data are a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[5]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[6]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQI+ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

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

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

[1] **https://www.minorityhealth.hhs.gov/assets/pdf/hhs/HHS_Plan_complete.pdf**

[2] **https://health.gov/healthypeople**

[3] **https://www.mih.ohio.gov/Portals/0/Documents/CompleteNSS.pdf**

[4] **https://thinkculturalhealth.hhs.gov/**

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

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

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

a) Race — (●) Yes ( ) No

b) Ethnicity — (●) Yes ( ) No

c) Gender — (●) Yes ( ) No

d) Sexual orientation — ( ) Yes (●) No

e) Gender identity — ( ) Yes (●) No

f) Age — (●) Yes ( ) No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? — ( ) Yes (●) No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? — (●) Yes ( ) No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? — ( ) Yes (●) No

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

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? — ( ) Yes (●) No

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

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

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

Please indicate areas of technical assistance needed related to this section

None.

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

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

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

SAMHSA anticipates that the movement toward value-based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services. The **National Center of Excellence for Integrated Health Solutions**[1] offers technical assistance and resources on value-based purchasing models including capitation, shared-savings, bundled payments, pay for performance, and incentivizing outcomes.

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

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

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions used with individuals with mental illness and substance use disorders, including youth and adults with substance use disorders, adults with SMI, and children and youth with SED. The recommendations build on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[2], The New Freedom Commission on Mental Health[3], the IOM, NQF, and the **Interdepartmental Serious Mental Illness Coordinating Committee** (ISMICC)[4].

One activity of the EBPRC[5] was a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[6] SAMHSA and other HHS federal partners, including the Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many innovative and promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, evidence is collected to determine their efficacy and develop a more detailed understanding of for who and in what circumstances they are most effective.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[7] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[8] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. Each KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice

demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, for educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is interested with what additional information is needed by SMHAs and SSAs to support their and other purchasers' decisions regarding value-based purchase of M/SUD services.

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[1] **https://www.thenationalcouncil.org/program/center-of-excellence/**

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

[3] The President's New Freedom Commission on Mental Health (July 2003). *Achieving the Promise: Transforming Mental Health Care in America*. Rockville, MD: Department of Health and Human Services, Substance use disorder and Mental Health Services Administration.

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

[5] **https://www.samhsa.gov/ebp-resource-center/about**

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

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

[8] **https://store.samhsa.gov/?f%5B0%5D=series%3A5558**

Please respond to the following items:

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

2. Which value based purchasing strategies do you use in your state (check all that apply):

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

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

Not at this time.

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

None at this time.

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Footnotes:

Environmental Factors and Plan

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

Narrative Question

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

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

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

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

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

Please respond to the following items:

1. Please name the model(s) that the state implemented including the number of programs for each model for those with ESMI using MHBG funds.

Model(s)/EBP(s) for ESMI/FEP	Number of programs
OnTrackNY	3
NAVIGATE	13

2. Please provide the total budget/planned expenditure for ESMI/FEP for FY 24 and FY 25 (only include MHBG funds).

FY2024	FY2025
6300000	6914098

3. Please describe the status of billing Medicaid or other insurances for ESMI/FEP services? How are components of the model currently being billed? Please explain.

In Florida, as with many states, the CMHS and SUPTRS Block Grants do not support the entirety of the publicly funded behavioral health system. Medicaid comprises a significant portion of funding for behavioral health. The Florida Agency for Health Care Administration (AHCA) serves as Florida's Medicaid authority. The Department, while the single state authority for substance use and mental health, shares administrative responsibility pursuant to Florida Statute with AHCA. It should be noted that the authority that delegates shared administrative responsibility does not provide for a shared information system between Block Grant funded providers and Medicaid providers.

The Florida KidCare program is the umbrella term for Florida's Children's Health Insurance Program (CHIP). Florida KidCare provides a continuum of health insurance coverage to children in families with incomes at or below 200 percent of the federal poverty level. The Florida KidCare program is comprised of four programmatic partners. The Florida Healthy Kids Corporation administers the Florida Healthy Kids program for children ages 5 through 18. AHCA administers the MediKids program for children ages 1 through 4. The Department of Health administers the Children's Medical Services Managed Care Plan. The Department of Children and Families determines eligibility for Medicaid and administers the Behavioral Health Network (BNET) for children ages 5 through 18 with serious emotional disturbances.

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI/FEP.

The state currently funds the following 16 Coordinated Specialty Care (CSC) for ESMI/FEP teams:

Life Management Center - Bay County
Lakeview Center - Escambia County
Apalachee Center - Leon County
Clay Behavioral Health - Clay and Putnam Counties
Clay Behavioral Health - Duval County
SMA Healthcare - Volusia County
Aspire Health Partners - Orange County
Success 4 Kids & Families* - Hillsborough County
David Lawrence Center* - Collier County
Peace River* - Polk, Highlands, and Hardee Counties
South County MHC - Palm Beach County
Henderson Behavioral Health - Martin, St. Lucie, Indian River, and Okeechobee Counties
Henderson Behavioral Health - Broward County (two teams)
Citrus Behavioral Health - Miami-Dade County (two teams)

Starred (*) teams use the OnTrackNY treatment model. All other teams use NAVIGATE.

5. Does the state monitor fidelity of the chosen EBP(s)?

(●) Yes ( ) No

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

(●) Yes ( ) No

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI/FEP?

CSC for ESMI/FEP is a multi-disciplinary teaming approach to provide early intervention services to individuals experiencing their first symptoms of serious mental illness. CSC is intended for adolescents and young adults aged 15 – 35. Evidence suggests first symptoms of early serious mental illness generally manifest most frequently between the ages of 15 – 25, therefore, early intervention programs are also designed to bridge existing services for these groups and eliminate gaps between child and adult mental health programs. Referrals to the team are most often made by hospitals, care coordinators, and mobile response teams.

8. Please describe the planned activities for FY 2024 and FY 2025 for your state's ESMI/FEP programs.

CSC-ESMI teams are expected to maintain minimum enrollment numbers and ensure that at least 80% of individuals served experience improvements in functioning or symptom severity.

Florida used a portion of the supplemental CMHS Block Grant funds received through COVID-19 Relief and the American Rescue Plan Act to establish several temporary CSC-ESMI/FEP teams. Florida anticipates allocating the standard Block Grant funding needed to make these teams permanent during this planning period.

9. Please list the diagnostic categories identified for your state's ESMI/FEP programs.

The current diagnoses recognized by providers of Coordinated Specialty Care for ESMI programs includes schizophrenia, schizoaffective disorder, schizophreniform disorder, delusional disorder or psychosis not otherwise specified.

10. What is the estimated incidence of individuals with a first episode psychosis in the state?

SAMHSA recommends that states use the first episode of psychosis (FEP) incidence rates from a 2013 study titled, "An Interactive Tool to Estimate Costs and Resources for a First-Episode Psychosis Initiative in New York State." This publication estimated the incidence of FEP per year to range from 20 cases per 100,000 to 30 cases per 100,000. Applying these incidence rates to current Census figures for Florida yields an annual incidence of between around 4,308 cases and 6,462 cases.

According to a more recent study published in 2017 and titled "First Presentation with Psychotic Symptoms in a Population-Based Sample," the estimated true incidence of FEP is 86 per 100,000 individuals ages 15-29. The estimated true incidence of FEP is 46 per 100,000 individuals ages 30-59. Apply these incidence rates to current Census figures for Florida yields an annual incidence of around 18,524 cases among individuals ages 15-29, and around 9,909 cases among individuals ages 30-59. These findings were derived from an analysis of health care system data from Washington, Colorado, and California.

11. What is the state's plan to outreach and engage those with a first episode psychosis who need support from the public mental health system?

Coordinated Specialty Care for ESMI/FEP clinicians are specially trained to treat clients experiencing early serious mental illness and work with young people and their families to create personal treatment plans as soon as possible after symptoms begin. These specialized teams conduct community outreach and help clients and their families navigate the healthcare system and identify additional community supports and resources. CSC addresses the unique needs of this population, by wrapping the individual and their family in services specifically designed to help the individual and their families understand their condition, learn healthy coping skills, and to keep the individual engaged in the management of their illness, including:

- Case Management
- Medication Management
- Supported Employment and Education
- Family Education and Support
- Psychotherapy
- Peer Support

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

None at this time.

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Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required for MHBG

Narrative Question

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

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. Resources for assessing and developing PCP systems can be found at the National Center on Advancing Person-Centered Practices and Systems **https://ncapps.acl.gov/home.html** with a systems assessment at **https://ncapps.acl.gov/docs/NCAPPS_SelfAssessment_201030.pdf**

1. Does your state have policies related to person centered planning? (●) Yes ( ) No

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

Not applicable.

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

The Department deploys several modalities to engage consumers and caregivers. These modalities allow for enhanced communication and assistance in making health care decisions. Family Intensive Treatment (FIT) Teams, Community Action Treatment (CAT), and Florida Assertive Community Treatment (FACT) Teams all employ a team-based approach that allows multiple avenues to engage the consumer. In addition, many other modalities are being utilized throughout the state. The following is an example of the types of additional consumer and caregiver engagement one of our managing entities employs in their service area.

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

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

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

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as SAMHSA's **A Practical Guide to Psychiatric Advance Directives**)?"

Per 765.101, Florida Statutes, health care facilities must "provide to each patient written information concerning the individual's rights concerning advance directives and the health care facility's policies respecting the implementation of such rights, and shall document in the patient's medical records whether or not the individual has executed an advance directive."

The state convened an Advance Directive Workgroup in 2016. The Workgroup provided the following recommendations:

• Development and use of crisis and personal safety plans should be increased in behavioral health care practice.
• The current Mental Health Advance Directive form found in the 2014 Baker Act Manual should be updated to include substance use disorders.
• Education and training should be provided to providers and persons served on completing and using advanced directives.
• Any advanced directive that address behavioral health conditions and treatment should include:
o The individual's trauma history;
o Identification of a health care surrogate; and,
o Adverse reactions and allergies to medications.
• The use of advance directives should be explained to individuals accessing behavioral health care by their service provider.
• Peer specialists may be best suited to help persons served complete advanced directives.
• Implementation of wallet cards to alert providers that a person served has an advance directive, along with how to locate the document and contact the surrogate.
• The storage of advanced directives should be explored further to ensure that they are readily accessible, while protecting confidentiality.

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

None at this time.

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Footnotes:

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

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

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

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

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

Please respond to the following:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No
2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No
3. Does the state have any activities related to this section that you would like to highlight?

   None at this time.

   Please indicate areas of technical assistance needed related to this section

   None at this time.

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Footnotes:

Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

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

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

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

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

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

There are have been three consultation sessions conducted using Microsoft Teams: December 2022, February 2023, and May 2023. A forth is set to take place August 2023. Additionally, Department staff have corresponded directly with the Community Programs Administrator for the Seminole Tribe of Florida to assist with the development of a list of tribal resources for providers working with Native American clients.

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

The following topics were raised:
-Concern that tribe members are not readily showing love and affection;
-Interest in having an expert speak to tribe members about adverse childhood experiences (ACE) and their impacts;
-Need for resources written in common terms for the layman to encourage buy-in and participation; and,
-Concerns about community buy-in and willingness to participate.

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

The resource list mentioned in question 1 has been drafted, and includes sections for informative articles, webinars, online tools, resources for family members of individuals with SUD, and links to Florida tribe websites. There have also been discussions between the Department and federally recognized tribes in Florida to develop a toolkit for individuals with a high number of ACEs.

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

None at this time.

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Footnotes:

Environmental Factors and Plan

8. Primary Prevention - Required SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

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

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

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

Assessment

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

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) (●) Yes ( ) No

- **a)** [x] Data on consequences of substance-using behaviors
- **b)** [x] Substance-using behaviors
- **c)** [x] Intervening variables (including risk and protective factors)
- **d)** [x] Other (please list)

  Other is collected on current prevention initiatives, strategies, and resources, as well as community-level demographic information (beyond identified risk and protective factors).

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- **a)** [x] Children (under age 12)
- **b)** [x] Youth (ages 12-17)
- **c)** [x] Young adults/college age (ages 18-26)
- **d)** [x] Adults (ages 27-54)
- **e)** [x] Older adults (age 55 and above)
- **f)** [x] Cultural/ethnic minorities
- **g)** [x] Sexual/gender minorities
- **h)** [x] Rural communities
- **i)** [ ] Others (please list)

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

- **a)** ☐ Archival indicators (Please list)
- **b)** ☑ National survey on Drug Use and Health (NSDUH)
- **c)** ☑ Behavioral Risk Factor Surveillance System (BRFSS)
- **d)** ☑ Youth Risk Behavioral Surveillance System (YRBS)
- **e)** ☑ Monitoring the Future
- **f)** ☑ Communities that Care
- **g)** ☑ State - developed survey instrument
- **h)** ☐ Others (please list)

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

- **a)** If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?
- **b)** If no, (please explain) how SUPTRS BG funds are allocated:

  While the Department does not have an EBP workgroup to guide SUPTRS allocations, standards for EBPs are identified in contract documents. The Department's program guidance for Managing Entity contracts considers a program an EBP if it has "demonstrated effectiveness with established generalizability (replicated in different settings and with different populations over time) through research. Managing Entities establish EBP monitoring procedures and ensure that prevention providers address fidelity in provider contracts. EBPs can be identified using appropriate registries. Alternatively, providers claiming EBP designation can provide a description of the theory of change, a logic model, a description of how the content and structure is similar to programs or strategies that appear in approved registries or in the peer-reviewed literature, and documentation that it was effectively implemented in the past, with results that show a consistent pattern of credible and positive effects. They must also include documentation of a review by, and consent of, a Panel of Informed Experts indicating that the implementation of this proposed program or strategy is appropriate for the community and likely to have a positive effect on the identified outcome and what evidence their decision was based upon. Following the selection of an option, the Network Service Provider must maintain sufficient documentation to support the decision.

6. Does your state integrate the National CLAS standards into the assessment step? ◉ Yes ○ No

- **a)** If yes, please explain in the box below.

  The National CLAS standards are already embedded in every step of the Strategic Prevention Framework (SPF) used by Florida and prevention coalitions, including the assessment step. The SPF incudes cultural competence as an integrated, cross-cutting principle. During the assessment step, this entails mapping the cultural landscape to identify different groups in the community as well as key prevention champions within each group. It also entails analysis of assessment findings by subgroup, for example.
- **b)** If no, please explain in the box below.

7. Does your state integrate sustainability into the assessment step? ◉ Yes ○ No

- **a)** If yes, please explain in the box below.

  During the assessment step, prevention stakeholders begin building relationships with data keepers and stakeholders who can play important roles in sustaining local prevention efforts over time.
- **b)** If no, please explain in the box below.

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

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

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Planning

1. Does your state have a statewide licensing or certification program for the substance use primary prevention workforce? (●) Yes ( ) No

a) If yes, please describe.

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

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use primary prevention workforce? (●) Yes ( ) No

a) If yes, please describe mechanism used.

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

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

a) If yes, please describe mechanism used.

4. Does your state integrate the National CLAS Standards into the capacity building step? (●) Yes ( ) No

a) If yes, please explain in the box below.

The National CLAS standards are already embedded in every step of the Strategic Prevention Framework (SPF) used by Florida and prevention coalitions, including the capacity building step. The SPF incudes cultural competence as an integrated, cross-cutting principle. During the capacity building step, this entails sharing and discussing assessment findings throughout the community, inviting interested community members and groups to participate in prevention planning, and making sure that any planning and implementation teams include individuals with strong ties to populations at high risk.

5. Does your state integrate sustainability into the capacity building step? (●) Yes ( ) No

a) If yes, please explain in the box below.

During the capacity building step, prevention partners look to sustain processes that have successfully engaged members of diverse populations. They also look to recruit and engage partners and champions who contribute to the success of prevention efforts, which is essential to sustainability.

b) If no, please explain in the box below.

Narratve Question

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Planning

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

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

The Department partnered with the Collaborative Planning Group to conduct a Statewide Substance Abuse Prevention Needs Assessment, which was completed in June 2017. Focus groups (with participants from Managing Entities, providers, and coalitions) conveyed an interest in sharing best practices, evidence of effectiveness, and challenges. Based on more recent input from various partners, including Managing Entities, prevention providers, and community-based organizations, the following activities are of particular strategic importance to Florida's prevention system:

(1) Targeting prevention resources to individuals and communities identified at the highest risk for substance misuse and substance-related harmful consequences;
(2) Increasing the number of strategic, interagency partnerships;
(3) Attracting, training, and retaining a qualified prevention workforce;
(4) Formalizing opportunities for face-to-face, collaborative planning meetings with various partners; and,
(5) Evaluating prevention programs that have never been tested.

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG? ○ Yes ○ No ◉ N/A

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

- **a)** ☐ Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds
- **b)** ☐ Timelines
- **c)** ☐ Roles and responsibilities
- **d)** ☐ Process indicators
- **e)** ☐ Outcome indicators
- **f)** ☐ Cultural competence component (i.e., National CLAS Standards)
- **g)** ☐ Sustainability component
- **h)** ☐ Other (please list):

i) ☑ Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? ◉ Yes ○ No

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

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

Not applicable.

6. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? ◉ Yes ○ No

7. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? ○ Yes ◉ No

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

Not applicable.

8. Does your state integrate the National CLAS Standards into the planning step? ◉ Yes ○ No

a) If yes, please explain in the box below.

The National CLAS standards are already embedded in every step of the Strategic Prevention Framework (SPF) used by Florida and prevention coalitions, including the planning step. The SPF incudes cultural competence as an integrated, cross-cutting principle. During the planning step, this entails recruiting focus population members to help identify appropriate programs and convening focus groups with diverse community members to obtain their feedback.

b) If no, please explain in the box below.

Not applicable.

9. Does your state integrate sustainability into the planning step? ◉ Yes ○ No

a) If yes, please explain in the box below.

While planning prevention services, the Department and prevention coalitions consider the degree to which interventions fit with local needs, capacity, and culture, because the better the fit, the more likely interventions are to be sustainable.

b) If no, please explain in the box below.

Not applicable.

Narratve Question

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

Implementation

1. States distribute SUPTRS BG primary prevention funds in a variety of different ways. Please check all that apply to your state:

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

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SUPTRS BG primary prevention dollars in at least one of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

Media Campaigns
An Apple a Day
Talk. They Hear You.
Toolkits / Resource Guides
Generation Rx
I Choose Me
Natural High
Keep a Clear Mind
Operation Medicine Cabinet
Too Good for Violence
Use Only as Directed
Teen Intervene

Rx Smart
Parents Who Host Lose the Most
No One's House
Lock Your Meds
Not in My House
Safe Homes/Smart Parties
Be the Wall
Friday Night Done Right
21MEANS21
Opioids 101
Know the Law
NOPE vigil
Naloxone Trainings

b) Education:

Too Good for Drugs
Life Skills Training (Botvin)
Project SUCCESS
New Horizons
An Apple a Day
Too Good for Violence
Teen Intervene
Positive Action
Second Step
Caring School Community
Nurturing Parenting Program
Active Parenting
Theater Troupe Peer Education Project
Ripple Effects Whole Spectrum Intervention System (Ripple Effects)
Peaceful Alternatives to Tough Situations (PATTS)
Alcohol Literacy Challenge
Incredible Years: Child
Keep a Clear Mind
Social Skills Group Intervention (S.S.Grins) 3-5
Brief Strengths Based Case Management (SBCM)
Sanford Harmony
Wise Owl
Living Skills (Adult)
Support for Students Exposed to Trauma (SSET)
Family Life Intervention Program (FLIP)
Project ALERT
Trauma Informed Care Education Series
Know the Law
Parenting Wisely
Creating Lasting Family Connections
InShape Prevention Plus Wellness
Active Parenting of Teens
Guiding Good Choices
CORE Society
Social Norms Campaign
Incredible Years: Parent
Hidden in Plain Sight
Nurturing Fathers
Vaping Prevention Plus Wellness
SPORT Prevention Plus Wellness
Wellness Initiative for Senior Education (WISE)
Incredible Years: Teacher
Naloxone Trainings
Talk. They Hear You.
Student Assistance Program
Strengthening Families
Marijuana And Vaping Prevention
PAX Good Behavior Game (PAX GBG)
Use Only as Directed
Retail Beverage Server Training

Triple P--Positive Parenting Program
Generation Rx
Safe Use, Safe Storage, Safe Disposal
Parent Cafes
Natural High
Opioids 101
CATCH My Breath
Curriculum Based Support Groups (CBSG) Program
Safe Rx
Family Education Program
Youth Messaging Development (YMD)
Be the Wall
21MEANS21
SADD

c) Alternatives:

Friday Night Done Right
Theater Troupe Peer Education Project

d) Problem Identification and Referral:

Teen Intervene
Interactive Journaling
Life Skills Training (Botvin)
Ripple Effects Whole Spectrum Intervention System (Ripple Effects)
Brief Strengths Based Case Management (SBCM)
Living Skills (Adult)
Strengthening Families
Active Parenting of Teens
Team Awareness (Workplace Prevention)

e) Community-Based Processes:

Coalition support, development, and capacity building
Town hall meetings
Communities Mobilizing for Change on Alcohol (CMCA)

f) Environmental:

Project E-FORCSE (Rx drug monitoring program)
Drug Deactivation Packets
Social Norms Campaign
Toolkits / Resource Guides
Environmental Scans
We ID Campaign
Project SUCCESS
Safe Use, Safe Storage, Safe Disposal
Compliance Checks
Communities Mobilizing for Change on Alcohol (CMCA)
Retail Beverage Server Training
Naloxone Kits Distributed
PhotoVoice
Drug Take Backs
Naloxone Trainings
Know the Law
Prescription Drop Boxes
Lock Your Meds
Operation Medicine Cabinet
Drug Free Workplace
Safe Rx
Trauma Informed Care Education Series
I Steer Clear Alcohol and Drug Use Driving Prevention
Community Trials Intervention to Prevent Rx Drug Abuse
Generation Rx
Hidden in Plain Sight
SPORT Prevention Plus Wellness
Talk. They Hear You.
Marijuana Prevention Plus Wellness
Alcohol Literacy Challenge

Use Only as Directed
STAND

3. Does your state have a process in place to ensure that SUPTRS BG dollars are used only to fund primary prevention services not funded through other means? (●) Yes ( ) No

a) If yes, please describe.

To ensure that SABG funds are used only to fund primary substance abuse prevention services which are not funded through other means, different methods are used based on the financial leadership of each Managing Entity. Providers may be instructed to report which budget code they are using to bill for their prevention units. This allows for the MEs to specifically track which units are being billed under SABG dollars. The MEs may also incorporate a written clause into their standard contract for services which will allow for the identification and removal of any sources which are not eligible for payment under the contract. Documentation of financial eligibility may also be reviewed for validation during on-site monitoring.

4. Does your state integrate National CLAS Standards into the implementation step? (●) Yes ( ) No

a) If yes, please describe in the box below.

Multiple organizations throughout the state offer training and certification opportunities for prevention professionals that incorporate National CLAS Standards.

The Florida Certification Board administers credentials for prevention professionals and specialists. The standards and requirements for the Certified Prevention Professional (CPP) and the Certified Prevention Specialist (CPS) include training domains and topics related to sustainability planning and cultural/special population adaptations for services.

Currently, there are two cultural competence online courses available on the Florida Learning Management System for Behavioral Health hosted by the Florida Alcohol and Drug Abuse Association:

1. Understanding Culturally and Linguistically Appropriate Services Standards
This online webinar course (1.5 CEUs) helps providers and agencies to understand the relevance of cultural and linguistic competence, and how the use of the national CLAS standards impacts service delivery.

2. Cultural and Linguistic Competence: Core Concepts and Individual Development
This online course (4.0 CEUs) is designed to introduce the fundamental principles, process, and rationale for cultural and linguistic (CLC) competence. It lays the groundwork for learning to accept and respect differences among the diverse populations.

Our prevention partners, such as the Community Coalition Alliance, offer trainings designed to highlight, discuss, and refresh individual topics from the Substance Abuse Prevention Skills Training (SAPST) curriculum, including cultural awareness and the guiding principles of the Strategic Prevention Framework (SPF), sustainability and cultural competence.

Finally, prevention training opportunities and materials are provided on the Florida Alcohol and Drug Abuse Association (FADAA) Training Calendar, posted in the FADAA Resource Center, and sent to FADAA Prevention Committee members, including Managing Entity Prevention Coordinators, prevention providers, coalition members, and other stakeholders.

b) If no, please explain in the box below.

5. Does your state integrate sustainability into the implementation step? (●) Yes ( ) No

a) If yes, please describe in the box below.

By implementing prevention activities that reflect cultural competence, planners help ensure that prevention services are sustainable by being woven into the fabric of the community.

b) If no, please explain in the box below

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

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

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

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

Evaluation

1. Does your state have an evaluation plan for substance use primary prevention that was developed within the last five years? ○ Yes ◉ No

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

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

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

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

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

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

- **a)** ☑ 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** ☑ Heavy use

c) ☑ Binge use

d) ☑ Perception of harm

e) ☑ Disapproval of use

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

g) ☐ Other (please describe):

5. Does your state integrate the National CLAS Standards into the evaluation step? ◉ Yes ○ No

a) If yes, please explain in the box below.

The National CLAS standards are already embedded in every step of the Strategic Prevention Framework (SPF) used by Florida and prevention coalitions, including the planning step. The SPF incudes cultural competence as an integrated, cross-cutting principle. During the evaluation step this entails demonstrating whether selected programs are having the intended impact on any identified disparities, tracking all cultural adaptations/modifications, and sharing findings with impacted populations.

b) If no, please explain in the box below.

6. Does your state integrate sustainability into the evaluation step? ◉ Yes ○ No

a) If yes, please describe in the box below.

While evaluating prevention services, the Department and prevention coalitions identify what is working well and should be sustained or expanded.

b) If no, please explain in the box below.

Footnotes:

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

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

Please respond to the following items

Criterion 1

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

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

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

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

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

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

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

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

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

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

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

a)	Physical Health	Yes No
b)	Mental Health	Yes No
c)	Rehabilitation services	Yes No
d)	Employment services	Yes No
e)	Housing services	Yes No
f)	Educational Services	Yes No
g)	Substance misuse prevention and SUD treatment services	Yes No
h)	Medical and dental services	Yes No
i)	Support services	Yes No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	Yes No
k)	Services for persons with co-occuring M/SUDs	Yes No

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

Not applicable.

3. Describe your state's case management services

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

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

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

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

Managing Entities work with providers and care coordinators to improve transitions from acute and restrictive to less restrictive community-based levels of care; decrease avoidable hospitalizations, inpatient care, incarcerations, and homelessness; with a focus on an individual's wellness and community integration. Managing Entities and providers statewide work to facilitate the recovery-oriented system of care (ROSC) by coordinating a network of community-based services that are person-centered.

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

None at this time.

Criterion 2: Mental Health System Data Epidemiology

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

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

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

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

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	5.24	901,000
2.Children with SED	7.00	246,468

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

The most recent state-level estimate of the prevalence of SMI among the non-institutionalized adult household population is based on 2021 National Surveys on Drug Use and Health (NSDUH). This estimate is published by SAMHSA and retrieved from Table 30 at the following location:

https://www.samhsa.gov/data/report/2021-nsduh-state-prevalence-estimates

The statewide incidence of adults with SMI is published in Table 29 at the following location:

https://www.samhsa.gov/data/report/2021-nsduh-estimated-totals-state

The prevalence of serious emotional disturbances (SED) among children was last estimated by the Substance Abuse and Mental Health Services Administration (SAMHSA) in the Federal Register in 1997. The prevalence in Florida was estimated to be between 7% and 13%. The figures reported in the table above rely on the lower limit of the range published in the Federal Register.

The 2021 SED incidence figure in the table above comes from the most recently available URS report for SAMHSA prepared using the lower limit estimate for Florida, retrieved from the following location:

https://www.samhsa.gov/data/sites/default/files/reports/rpt39369/adult_smi_child_sed_prev_2021_508.pdf

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

None at this time.

Criterion 3

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

a)	Social Services	(•) Yes	( ) No
b)	Educational services, including services provided under IDEA	(•) Yes	( ) No
c)	Juvenile justice services	(•) Yes	( ) No
d)	Substance misuse preventiion and SUD treatment services	(•) Yes	( ) No
e)	Health and mental health services	(•) Yes	( ) No
f)	Establishes defined geographic area for the provision of services of such systems	(•) Yes	( ) No

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

None at this time.

**A system of care is: A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.*
https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf

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

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

Criterion 4

a. Describe your state's targeted services to rural population. **See SAMHSA's Rural Behavioral Health page for program resources**

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

b. Describe your state's targeted services to people experiencing homelessness. **See SAMHSA's Homeless Programs and Resources for program resources**

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

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

c. Describe your state's targeted services to the older adult population. **See SAMHSA's Resources for Older Adults webpage for resources.**

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

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

None at this time.

Criterion 5: Management Systems

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

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic for SAMHSA is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural or underserved areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access, the SAMHSA Evidence Based Resource Guide, **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders**.

Criterion 5

a. Describe your state's management systems.

State Financial Resources for Mental Health Service Providers:
This pays for a variety of services, include CAT teams, FACT teams, transitional beds, medications, and competency restoration services.

State Staffing for Mental Health Services Providers:
Community mental health providers are supported by the Department's Office of Substance Abuse and Mental Health, whose staff members collect and report data, manage finances, develop policies, and administer programs through a Data Team, a Policy Team, a Clinical Team, and Block Grant Coordinators, among others.

State Training for Mental Health Services Providers:
The Department requests training for mental health service providers through SAMHSA or otherwise provides for these services through contracts. The Department works with the Florida Certification Board on webinars, online courses, workshops, and learning collaboratives dealing with topics like the Baker Act, Assessing Suicide Risks, National Cultural Competency Standards, Integration of Peer Services, among others. The Department also works with the Florida Alcohol and Drug Abuse Association on webinars and workshops dealing with various topics related to mental health services.

Training of Providers of Emergency Services for Individuals with SMI and SED:
The Department requests training for providers of emergency mental health services through SAMHSA or otherwise provides for these services through contracts. The Department works with the Florida Certification Board to provide a webinar on Baker Act Procedures for Law Enforcement and online courses on Law Enforcement and the Baker Act and Emergency Medical Treatment: Florida's Baker Act and Marchman Act.

b. Describe your state's current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.

Section 456.47, Florida Statutes, was first enacted in 2019 and authorized Florida-licensed health care providers to use telehealth to deliver health care services within their respective scopes of practice. This telehealth statute defines the term "telehealth" as the use of synchronous or asynchronous telecommunications technology by a telehealth provider to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and professional health-related education; public health services; and health administration. The term does not include audio-only telephone calls, e-mail messages, or facsimile transmissions.

According to the statute, telehealth providers who treat patients located in Florida must be one of the following licensed health care practitioners:
- Behavioral Analysts;
- Allopathic physicians;
- Osteopathic physicians;
- Nurses;
- Psychologists;
- Psychotherapists;
- Clinical Social Workers;

• Marriage and Family Therapists; and
• Mental Health Counselors.

Chapter 2022-36, Laws of Florida, subsequently amended the "Telehealth" definition in Florida's mental health statutes (section 394.455, Florida Statutes), to state: "'Telehealth' has the same meaning as provided in section 456.47, F.S."

Between 2019 and 2020, behavioral health treatment facilities experienced a sharp increase in the number of facilities providing telemedicine. The adoption of telehealth technology was so successful in Florida that, during a rule workshop on Florida licensure for substance use treatment, providers requested that the Department permanently expand the allowance of more types of provider staff to deliver their services through telehealth. The Department agreed that this policy change made sense for all providers, individuals in treatment, and the Department as a funder of the services and the rule revision was adopted in 2023. For Florida mental health rules, the Department recently amended rule 65E-5.2801, of the Florida Administrative Code (regarding Minimum Standards for Involuntary Examination), to clarify that a mental health examination for crisis stabilization can be conducted in person or via telehealth.

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

None at this time.

Footnotes:

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SUPTRS BG

Narrative Question

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

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

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

b) Services for special populations:

i)	Prioritized services for veterans?	Yes / No
ii)	Adolescents?	Yes / No
iii)	Older Adults?	Yes / No

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? (●) Yes ( ) No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? (●) Yes ( ) No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? (●) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? (●) Yes ( ) No

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

a) Open assessment and intake scheduling (●) Yes ( ) No

b) Establishment of an electronic system to identify available treatment slots (●) Yes ( ) No

c) Expanded community network for supportive services and healthcare (●) Yes ( ) No

d) Inclusion of recovery support services (●) Yes ( ) No

e) Health navigators to assist clients with community linkages (●) Yes ( ) No

f) Expanded capability for family services, relationship restoration, and custody issues? (●) Yes ( ) No

g) Providing employment assistance (●) Yes ( ) No

h) Providing transportation to and from services (●) Yes ( ) No

i) Educational assistance (●) Yes ( ) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Florida contracts with seven regional Managing Entities to oversee network service provider compliance with Block Grant rules regarding pregnant women and women with dependent children, which address preference in admissions, the provision of interim services, and the provision of comprehensive services (medical care, prenatal care, pediatric care, gender-specific therapeutic interventions, case management, etc.). Managing Entities conduct onsite monitoring and desk reviews using Block Grant compliance monitoring tools. Any issues that are found are addressed through Corrective Action Plans (CAPs). Consequences for noncompliance range from remedial (like required training, technical assistance, and policy revisions) to severe (like contract termination).

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

- **a)** 90 percent capacity reporting requirement — (●) Yes ( ) No
- **b)** 14-120 day performance requirement with provision of interim services — (●) Yes ( ) No
- **c)** Outreach activities — (●) Yes ( ) No
- **d)** Syringe services programs, if applicable — (●) Yes ( ) No
- **e)** Monitoring requirements as outlined in the authorizing statute and implementing regulation — (●) Yes ( ) No

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

- **a)** Electronic system with alert when 90 percent capacity is reached — ( ) Yes (●) No
- **b)** Automatic reminder system associated with 14-120 day performance requirement — ( ) Yes (●) No
- **c)** Use of peer recovery supports to maintain contact and support — (●) Yes ( ) No
- **d)** Service expansion to specific populations (e.g., military families, veterans, adolescents, LGBTQI+, older adults)? — (●) Yes ( ) No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Florida contracts with seven regional Managing Entities to oversee network service provider compliance with Block Grant rules regarding pregnant women and women with dependent children, which address preference in admissions, the provision of interim services, and the provision of comprehensive services (medical care, prenatal care, pediatric care, gender-specific therapeutic interventions, case management, etc.). Managing Entities conduct onsite monitoring and desk reviews using Block Grant compliance monitoring tools. Any issues that are found are addressed through Corrective Action Plans (CAPs). Consequences for noncompliance range from remedial (like required training, technical assistance, and policy revisions) to severe (like contract termination).

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? — ( ) Yes (●) No

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

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

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

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

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring such service delivery? — (●) Yes ( ) No

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

- **a)** Establishment of EIS-HIV service hubs in rural areas — ( ) Yes (●) No
- **b)** Establishment or expansion of tele-health and social media support services — ( ) Yes (●) No

c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS — ○ Yes ◉ No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SUPTRS BG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)F)? — ◉ Yes ○ No

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

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

If yes, plese provide a brief description of the elements and the arrangement

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — (●) Yes ( ) No

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

- **a)** Workforce development efforts to expand service access — (●) Yes ( ) No
- **b)** Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — ( ) Yes (●) No
- **c)** Establish a peer recovery support network to assist in filling the gaps — (●) Yes ( ) No
- **d)** Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — (●) Yes ( ) No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — (●) Yes ( ) No
- **f)** Explore expansion of services for:
  - **i)** MOUD — (●) Yes ( ) No
  - **ii)** Tele-Health — (●) Yes ( ) No
  - **iii)** Social Media Outreach — ( ) Yes (●) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care? — (●) Yes ( ) No

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

- **a)** Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — (●) Yes ( ) No
- **b)** Establish a program to provide trauma-informed care — (●) Yes ( ) No
- **c)** Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — (●) Yes ( ) No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? — (●) Yes ( ) No

2. Does your state provide any of the following:

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

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — (●) Yes ( ) No

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

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

c) Identify workforce needs to expand service capabilities — (●) Yes ( ) No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — (●) Yes ( ) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — (●) Yes ( ) No

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

a) Training staff and community partners on confidentiality requirements — ( ) Yes (●) No

b) Training on responding to requests asking for acknowledgement of the presence of clients — ( ) Yes (●) No

c) Updating written procedures which regulate and control access to records — ( ) Yes (●) No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure: — ( ) Yes (●) No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — (●) Yes ( ) No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

a) Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

Nine Block Grant subrecipients are selected to undergo independent peer review per year.

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

a) Development of a quality improvement plan — ( ) Yes (●) No

b) Establishment of policies and procedures related to independent peer review — ( ) Yes (●) No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations — ( ) Yes (●) No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — ( ) Yes (●) No

If Yes, please identify the accreditation organization(s)

i) ☐ Commission on the Accreditation of Rehabilitation Facilities

ii) ☐ The Joint Commission

iii) ☐ Other (please specify)

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? ○ Yes ◉ No

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

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service ○ Yes ◉ No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ○ Yes ◉ No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state ◉ Yes ○ No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services ◉ Yes ○ No

c) Performance-based accountability: ◉ Yes ○ No

d) Data collection and reporting requirements ◉ Yes ○ No

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

a) A comprehensive review of the current training schedule and identification of additional training needs ◉ Yes ○ No

b) Addition of training sessions designed to increase employee understanding of recovery support services ◉ Yes ○ No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services ◉ Yes ○ No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort ◉ Yes ○ No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

a) Prevention TTC? ○ Yes ◉ No

b) Mental Health TTC? ○ Yes ◉ No

c) Addiction TTC? ◉ Yes ○ No

d) State Targeted Response TTC? ○ Yes ◉ No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women ○ Yes ◉ No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

a) Tuberculosis ○ Yes ◉ No

b) Early Intervention Services Regarding HIV ○ Yes ◉ No

3. Additional Agreements

a) Improvement of Process for Appropriate Referrals for Treatment ○ Yes ◉ No

b) Professional Development ○ Yes ◉ No

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

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

https://www.flrules.org/gateway/readFile.asp?sid=0&tid=0&cno=65E-14&caid=1528252&type=4&file=65E-14.doc

https://www.flrules.org/gateway/readFile.asp?sid=0&tid=0&cno=65D-30&caid=1553666&type=4&file=65D-30.doc

If the answer is No to any of the above, please explain the reason.

The state is not requesting any waivers for requirements.

Footnotes:

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2022-FFY 2023? ○ Yes ◉ No

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

None at this time.

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Footnotes:

Technically not applicable. Florida dose not currently have a CQI plan.

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma[1] is a common experience for adults and children in communities, and it is especially common in the lives of people with mental and substance use disorders. For this reason, the need to address trauma is increasingly seen as an important part of effective behavioral health care and an integral part of the healing and recovery process. It occurs because of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful and/or life-threatening experiences. Trauma has no boundaries regarding age, gender, socioeconomic status, race, ethnicity, geography, ability, or sexual orientation. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system and children and families in the child welfare system have high rates of mental illness, substance use disorders and personal histories of trauma. Similarly, many individuals in primary, specialty, emergency, and rehabilitative health care also have significant trauma histories, which impacts their health and responsiveness to health interventions. Also, schools are now recognizing that the impact of traumatic exposure among their students makes it difficult for students to learn and meet academic goals. As communities experience trauma, for some, these are rare events and for others, these are daily events. Children and families living in resource scarce communities remain especially vulnerable to experiences of trauma and thus face obstacles in accessing and receiving M/SUD care. States should work with these communities to identify interventions that best meet the needs of their residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink how practices are conducted. These public institutions and service settings are increasingly adopting a trauma-informed approach distinct from trauma-specific assessments and treatments. Trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues with a focus on equity and inclusion. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[2] paper.

[1] Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

[2] *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

1.	Does the state have a plan or policy for M/SUD providers that guides how they will address individuals with trauma-related issues?	○ Yes ◉ No
2.	Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?	◉ Yes ○ No
3.	Does the state provide training on trauma-specific treatment and interventions for M/SUD providers?	◉ Yes ○ No
4.	Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?	○ Yes ◉ No
5.	Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?	◉ Yes ○ No
6.	Does the state use an evidence-based intervention to treat trauma?	○ Yes ◉ No

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

None at this time.

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

None at this time.

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Footnotes:

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than a third of people in prisons and nearly half of people in jail have a history of mental health problems.[1] Almost two thirds of people in prison and jail meet criteria for a substance use disorder.[2] As many as 70 percent of youth in the juvenile justice system have a diagnosable mental health problem.[3] States have numerous ways that they can work to improve care for these individuals and the other people with mental and substance use disorders involved in the criminal justice system. This is particularly important given the overrepresentation of populations that face mental health and substance use disorder disparities in the criminal justice system.

Addressing the mental health and substance use disorder treatment and service needs of people involved in the criminal justice system requires a variety of approaches. These include:

- Better coordination across mental health, substance use, criminal justice and other systems (including coordination across entities at the state and local levels);
- Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups;
- Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system;
- Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community;
- Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems);
- Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, at booking, jails, the courts, at reentry, and through community corrections);
- Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system;
- Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met;
- Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges;
- Partnering with the judicial system to engage in cross-system planning and development at the state and local levels;
- Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system; and
- Supporting court-based programs, including specialty courts and diversion programs that serve people with M/ SUD.
- Addressing the increasing number of individuals who are detained in jails or state hospitals/facilities awaiting competence to stand trial assessments and restoration.

These types of approaches can improve outcomes and experiences for people with M/SUD involved in the criminal justice system and support more efficient use of criminal justice resources. The MHBG and SUPTRS BG may be especially valuable in supporting a stronger array of community-based services in these and other areas. SSAs and SMHAs can also play a key role in partnering with state and local agencies to improve coordination of systems and services. This includes state and local law enforcement, correctional systems, and courts. SAMHSA strongly encourages state behavioral health authorities to work closely with these partners, including their state courts, to ensure the best coordination of services and outcomes, especially in light of health disparities and inequities, and to develop closer interdisciplinary programming for justice system involved individuals. Promoting and supporting these efforts with a health equity lens is a SAMHSA priority.

[1]Bronson, J., & Berzofsky, M. (2017). Indicators of mental health problems reported by prisoners and jail inmates, 2011–12. Bureau of Justice Statistics, 1-16.

[2]Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009. Washington, DC: United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[3]Vincent, G. M., Thomas Grisso, Anna Terry, and Steven M. Banks. 2008. "Sex and Race Differences in Mental Health Symptoms in Juvenile Justice: The MAYSI-2 National Meta-Analysis." Journal of the American Academy of Child and Adolescent Psychiatry 47(3):282–90.

Please respond to the following items

1. Does the state (SMHA and SSA) engage in any activities of the following activities:

- [x] Coordination across mental health, substance use disorder, criminal justice and other systems
- [x] Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups
- [x] Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system, including those related to medications for opioid use disorder
- [x] Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- [x] Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- [x] Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community
- [x] Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems)
- [x] Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, booking, jails, the courts, at reentry, and through community corrections)
- [x] Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system
- [x] Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met
- [x] Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges
- [x] Partnering with the judicial system to engage in cross-system planning and development at the state and local levels
- [x] Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system
- [x] Supporting court-based programs, including specialty courts and diversion programs that serve people with M/SUD
- [x] Addressing Competence to Stand Trial; assessments and restoration activities.

2. Does the state have any specific activities related to reducing disparities in service receipt and outcomes across racial and ethnic groups for individuals with M/SUD who are involved in the criminal justice system? If so, please describe. (●) Yes ( ) No

The Department is working to expand access to all three forms of FDA-approved medications for opioid use disorders through jail -based pilot programs.

3. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? (●) Yes ( ) No

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

None at this time.

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

None at this time.

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Footnotes:

Environmental Factors and Plan

14. Medications in the Treatment of Substance Use Disorders, Including Medication for Opioid Use Disorder (MOUD) – Requested (SUPTRS BG only)

Narrative Question

In line with the goals of the Overdose Prevention Strategy and SAMHSA's priority on Preventing Overdose, SAMHSA strongly request that information related to medications in the treatment of substance use disorders be included in the application.

There is a voluminous literature on the efficacy of the combination of medications for addiction treatment and other interventions and therapies to treat substance use disorders, particularly opioid, alcohol, and tobacco use disorders. This is particularly the case for medications used in the treatment of opioid use disorder, also increasingly known as Medications for Opioid Use Disorder (MOUD). The combination of medications such as MOUD; counseling; other behavioral therapies including contingency management; and social support services, provided in individualized, tailored ways, has helped countless number of individuals achieve and sustain remission and recovery from their substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based, or non-medication inclusive, treatment for these conditions. The evidence base for medications as standards of care for SUDs is described in SAMHSA TIP 49 Incorporating Alcohol Pharmacotherapies Into Medical Practice and TIP 63 Medications for Opioid Use Disorders.

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to offer MOUD and medications for alcohol use disorder or have collaborative relationships with other providers that can provide all FDA-approved medications for opioid and alcohol use disorder and other clinically needed services.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs. States should use Block Grant funds for the spectrum of evidence-based interventions for opioids and stimulants including medications for opioids use disorders and contingency management.

In addition, SAMHSA also encourages states to require equitable access to and implementation of medications for opioid use disorder (MOUD), alcohol use disorder (MAUD) and tobacco use disorders within their systems of care.

SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding the use of medications for substance use disorders? (●) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of medications for substance disorder, including MOUD, within special target audiences, particularly pregnant women? (●) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds?

- **a)** ☑ Methadone
- **b)** ☑ Buprenophine, Buprenorphine/naloxone
- **c)** ☑ Disulfiram
- **d)** ☑ Acamprosate
- **e)** ☑ Naltrexone (oral, IM)
- **f)** ☑ Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based treatment with the use of FDA-approved medications for treatment of substance use disorders is combined with other therapies and services based on individualized assessments and needs? (●) Yes ( ) No

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

There are efforts funded out of the SOR grants to raise awareness about MAT.

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Footnotes:

Environmental Factors and Plan

15. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress to set aside 5 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *....to support evidenced-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to expend some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expanding 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization service to support reducing distress, promoting skill development and outcomes, manage costs, and better invest resources.

SAMHSA developed **Crisis Services: Meeting Needs, Saving Lives**, which includes "**National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit**" as well as an **Advisory: Peer Support Services in Crisis Care** and other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. SAMHSA also developed "**National Guidelines for Child and Youth Behavioral Health Crisis Care**" which offers best practicies, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by this new 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

1. Briefly narrate your state's crisis system. For all regions/areas of your state, include a description of access to the crisis call centers, availability of mobile crisis and behavioral health first responder services, utilization of crsis receiving and stabilization centers.

According to Chapter 65E-14, Florida Administrative Code, Florida's crisis system is composed of crisis stabilization and crisis support/emergency. Crisis stabilization services are acute, intensive residential treatment services offered twenty-four hours per day, seven days per week, that meet the needs of individuals experiencing an acute crisis and who would require hospitalization in the absence of a suitable alternative. Crisis support/emergency services are non-residential care generally available twenty-four hours per day to intervene in a crisis or provide emergency care, such as Mobile Response Teams, the 988 Suicide and Crisis Lifeline, and Crisis Stabilization Units.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the SAMHSA*

guidelines.

*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*

*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Other program implementation data that characterizes crisis services system development.

1. Someone to talk to: Crisis Call Capacity

- *a. Number of locally based crisis call Centers in state*
  - *i. In the 988 Suicide and Crisis lifeline network*
  - *ii. Not in the suicide lifeline network*
- *b. Number of Crisis Call Centers with follow up protocols in place*
- *c. Percent of 911 calls that are coded as BH related*

2. Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)

- *a. Independent of first responder structures (police, paramedic, fire)*
- *b. Integrated with first responder structures (police, paramedic, fire)*
- *c. Number that employs peers*

3. Safe place to go or to be:

- *a. Number of Emergency Departments*
- *b. Number of Emergency Departments that operate a specialized behavioral health component*
- *c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis)*

a. Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to talk to	☐	☐	☐	☐	☐	☑
Someone to respond	☐	☐	☐	☐	☐	☑
Safe place to go or to be	☐	☐	☐	☐	☐	☑

b. Briefly explain your stages of implementation selections here.

Not applicable.

3. Based on SAMHSA's National Guidelines for Behavioral Health Crisis Care, explain how the state will develop the crisis system.

Florida will continue to contribute state and federal funding to develop and expand access to crisis services, including continued support of the 988 Suicide and Crisis Lifeline, Mobile Response Teams, and Crisis Stabilization Units.

4. Briefly describe the proposed/planned activities utilizing the 5 percent set aside.

The 5-percent set-aside will support Mobile Response Teams, crisis stabilization services, short-term residential treatment, and suicide prevention and contribute to sustainment of 988 Suicide and Crisis Lifeline call centers in Florida.

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

None at this time.

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

None at this time.

Footnotes:

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders.

Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery- guided the approach to person-centered care that is inclusive of shared decision-making, culturally welcoming and sensitive to social determinants of health. The continuum of care for these conditions involves psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder, and services to reduce risk related to them. Because mental and substance use disorders can become chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management recovery and personal success over the lifespan.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a)	Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?	(•) Yes ( ) No
b)	Required peer accreditation or certification?	(•) Yes ( ) No
c)	Use Block grant funding of recovery support services?	(•) Yes ( ) No
d)	Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?	(•) Yes ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? (•) Yes ( ) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

According to Chapter 65E-14, Florida Administrative Code, "recovery support services are designed to support and coach an adult or child and family to regain or develop skills to live, work and learn successfully in the community. Services include substance abuse or mental health education, assistance with coordination of services as needed, skills training, and coaching." Recovery services must include clinical supervision provided by a professional qualified by degree, licensure, certification, or specialized training in the implementation of this service. Adult and Child mental health recovery services are provided by a Certified Family, Veteran, or Recovery Peer Specialist.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations

According to Chapter 65E-14, Florida Administrative Code, "recovery support services are designed to support and coach an adult or child and family to regain or develop skills to live, work and learn successfully in the community. Services include substance abuse or mental health education, assistance with coordination of services as needed, skills training, and coaching. This Covered Service shall include clinical supervision provided to a service provider's personnel by a professional qualified by degree, licensure, certification, or specialized training in the implementation of this service...For Adult and Children's Substance Abuse programs, these services may be provided by a certified Peer Recovery Specialist or trained paraprofessional staff subject to supervision by a Qualified Professional as defined in Rule 65D-30.002, F.A.C. These services exclude twelve-step programs, such as Alcoholics Anonymous and Narcotics Anonymous."

5. Does the state have any activities that it would like to highlight?

From 2017 to 2023, the Department and its partners have expanded statewide capacity of Certified Recovery Peer Specialist from 418 to 914.

The Department has contracted with the Peer Support Coalition since 2019 to provide support for implementation of a Recovery Oriented System of Care, Recovery Oriented Quality Improvement efforts as well as Peer workforce development opportunities. Since 2019, the Peer Support Coalition of Florida has provided more than 40 trainings, including peer supervision, peer specialist certification, facilitator development, and Wellness Recovery Action Planning. Among the various trainings provided, 691 individuals have received training. With support for the Department's contract, the Peer Support Coalition of Florida also support a peer-run Warmline. The Florida Warm Line is for individuals diagnosed with mental health conditions who want to talk with someone who shares personal experience coping with mental health issues.

The Department recognizes the importance of providing ongoing training and technical assistance to support to its peer specialist workforce and enhance quality of peer-based recovery supports. In partnership with the Florida Certification Board, the Department sponsored the development of a free online course, Career Readiness for Peer Specialists. This course is designed for individuals who are currently working at or seeking a position that provides peer support services. The purpose of this course is to help peer specialists gain the essential skills needed to find, acquire, and maintain a job, as well as grow as a successful employee. In addition to providing additional career development opportunities, the Department also began requiring peer specialists providing direct peer-based recovery supports to implement and use of Recovery Capital as a foundation to inform the recovery planning process for individuals receiving peer support. As of June 2023, 330 peer specialist have received this training.

As of June 2023, there were 357 certified peer specialists employed among 115 Department-funded network services providers delivering peer-based recovery support services.

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

None at this time.

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Footnotes:

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Does the state's Olmstead plan include:

Housing services provided	○ Yes	◉ No
Home and community-based services	○ Yes	◉ No
Peer support services	○ Yes	◉ No
Employment services.	○ Yes	◉ No

2. Does the state have a plan to transition individuals from hospital to community settings? ◉ Yes ○ No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

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

The SMHTF staff conducts discharge planning activities in accordance with Chapter 65E-5.1303, F.A.C., available here: www.flrules.org/gateway/readFile.asp?sid=0&tid=12805375&type=1&file=65E-5.1303.doc.

This rule provides that facility staff conduct discharge planning and document consideration of the following for the person:
- Transportation resources;
- Access to stable housing;
- Timely aftercare appointment for needed services, including continuation of prescribed medications and case management;
- Education and written information about his or her illness and psychotropic medications, side effects, and adverse reactions;
- Contact information for community-based peer support services;
- Information and referral to any needed community resources;
- Referrals to substance abuse, trauma or abuse recovery-focused programs, or other self-help groups; and behavioral health systems; and
- Preparation of and use of advanced directives.

This statute provides individuals with rights, including the right to have the opportunity to participate in their treatment and discharge planning. Individuals who are incompetent to consent for treatment are provided with a guardian advocate to help represent their interests throughout their hospital stay. It provides the legislative intent that the least restrictive means of

intervention be employed based on the individual needs of each person, within the scope of available services. The statute includes criteria for individuals to be discharged, and requires that individuals be discharged when they no longer meet the requirements for involuntary inpatient placement. The Department's discharge procedures are also explained in Operating Procedure 155-17. This procedure includes specific action steps for SMHTF staff and the community regarding discharge planning. The facility administrator of a SMHTF or their designee is responsible for discharge planning of civil residents. The SMHTF begins discharge planning at the time of an individual's admission and throughout their stay. The person's recovery plan is developed within 30 days of admission. The resident's recovery team conducts regular reviews of the resident's readiness for discharge.

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

None at this time.

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Footnotes:

Florida does not have a current Olmstead Plan. "No" for the first question above indicates "not applicable."

Environmental Factors and Plan

18. Children and Adolescents M/SUD Services –Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[1]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[2]. For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[4].

Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[5].

According to data from the 2017 Report to Congress[6] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system.
2. improve emotional and behavioral outcomes for children and youth.
3. enhance family outcomes, such as decreased caregiver stress.
4. decrease suicidal ideation and gestures.
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and

employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

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

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

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

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

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

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

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery of children and youth with SED?	(•) Yes	( ) No
b) The resilience of children and youth with SED?	(•) Yes	( ) No
c) The recovery of children and youth with SUD?	(•) Yes	( ) No
d) The resilience of children and youth with SUD?	(•) Yes	( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare?	(•) Yes	( ) No
b) Health care?	(•) Yes	( ) No
c) Juvenile justice?	(•) Yes	( ) No
d) Education?	(•) Yes	( ) No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization?	(•) Yes	( ) No
b) Costs?	(•) Yes	( ) No
c) Outcomes for children and youth services?	(•) Yes	( ) No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?	(•) Yes	( ) No
b) Mental health treatment and recovery services for children/adolescents and their families?	(•) Yes	( ) No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system?	(•) Yes	( ) No
b) for youth in foster care?	(•) Yes	( ) No
c) Is the child serving system connected with the FEP and Clinical High Risk for Psychosis (CHRP) systems?	(•) Yes	( ) No
d) Does the state have an established FEP program?	(•) Yes	( ) No
Does the state have an established CHRP program?	( ) Yes	(•) No
e) Is the state providing trauma informed care?	( ) Yes	(•) No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

The Department is committed to a consistent system of care approach and partnering with all child-serving systems to ensure a youth-guided, family driven, culturally and linguistically responsive, community-based care across the state. Previously, the Department spearheaded the development and continuation of the children's Interagency Agreement. This agreement between all

key child serving agencies established a collaborative process for addressing the needs of children and youth served by multiple agencies. In addition, the agreement established local and state level multiagency teams that identify and address gaps in the system of care. The Interagency agreement requires the system of care values and principles to be practiced throughout all state and local levels.

The Department is also dedicated to person centered planning and has established guidelines to ensure implementation at all levels across the state. Contracted providers are obligated to participate and implement system of care values and principles in their respective regions and ensure sub-provider contracts include these as well, including provision of EBPs and accountability mechanisms.

Assessments focus on evaluating the strengths, needs, vision and culture of the child and their family. The wraparound process is an effective care coordination model to improve the lives of children and their families. Wraparound is an intensive, individualized care planning and management process for children with complex needs due to a serious emotional disturbance. Through structured and creative team meetings, care plans are designed to meet the unique needs of the child, caregivers, and siblings across a range of life domains. This process aims to result in plans that are more effective and more relevant to the recipient and family. In addition, there is an emphasis on integrating the child into the community and building the family's social support network.

The ten principles of wraparound parallel the values of the SOC in that all services must reflect:
• Family voice and choice;
• Natural supports;
• Team based planning;
• Collaboration;
• Community based care;
• Cultural competence;
• Individualized care;
• Strength based approaches;
• Persistence; and
• Outcome accountability.

Florida Law includes a requirement for a community-based system that is child-centered and family driven. This system provides for screening and assessment to promote early identification and treatment. It also provides for individualized, culturally competent, integrated and coordinated care, and a smooth transition to the adult system for continued age-appropriate services and supports. In addition, most provider agencies in the Florida have made advancements over the last few years that enable them to meet the needs of persons with co-occurring disorders.

The Department works collaboratively with all child-serving systems to prevent mental health issues through screening and early intervention to ensure children are equipped with the skills they need to achieve healthy growth and build a foundation to thrive in school and beyond. The Department is home to the Office of Family Safety. This provides an opportunity to harmonize child welfare and behavioral health principles which is especially important because of the traumatizing nature of the child welfare involvement for both children and families. The Department collaborates with the Department of Health's Children's Medical Services division on the development of ways to strengthen the integration of primary care and behavioral health services.

The state of Florida's Interagency Agreement between numerous agencies is designed to address the needs of specific children and families and the gaps in the system of care at the local and state levels through local and state level teams. The community and residential services provided include:

• Medicaid services through AHCA;
• Services to reduce recidivism through the Department of Juvenile Justice (DJJ);
• Educational services through the Department of Education (DOE);
• Residential care in group homes and residential habilitation centers through the Agency for Persons with Disabilities (APD); and
• Advocacy for the rights and best interests of a child involved in a court proceeding through the Guardian ad Litem (GAL) Program.

Effectively addressing the needs of children, adolescents, and their families in the mental health system requires innovative approaches to deliver coordinated, individually tailored, family-focused, and developmentally appropriate services and supports in the community to reduce the need for more restrictive levels of care. Florida has implemented Community Action Teams (CAT) statewide, which utilize a team approach to provide such comprehensive services to children ages 11 to 21 with a mental health diagnosis or co-occurring substance abuse diagnosis who have accompanying characteristics including being at-risk for out-of-home placement, history of hospitalizations, repeated failures in less intensive programs, criminal behaviors, or poor academic performance. Children younger than age 11 may be served if they meet more than one of these characteristics.

The CAT teams provide intensive, wraparound services to children and youths aged 11-21 who have a mental health diagnosis, a substance-use diagnosis or both. They include a psychiatrist or advanced registered nurse practitioner, a nurse, a mental health therapist, a case manager and a mentor. Additionally, someone on the team is available to the family around the clock. The aim of CAT is to stabilize a child's mental illness or substance abuse and divert him or her from the state juvenile justice or child welfare systems.

The primary goals of the CAT program include:
• Improved school attendance, grades and graduation rates
• Decreased out-of-home placements and psychiatric hospitalizations
• Decreased substance use and abuse
• Improved functioning for the child and family

Family Intensive Treatment (FIT) teams have been piloted throughout the state to provide specialized treatment for parents with primary substance use disorders who come in contact with the child welfare system and who have young children ages birth to eight. FIT is family focused and integrated across the child welfare, behavioral health and judicial systems. Treatment involves joint planning and case management by a team of professionals which include child welfare workers, alcohol and drug treatment professionals, court representatives, and medical professionals. There is cross training and collocation of services. They act as one treatment team with flexible spending, sharing data and accountability. Families are provided wraparound and comprehensive community services to address the multiple needs of parents and children, including parenting skills to increase protective capacity, mental health, health, childcare, housing, and other services.

The Florida Healthy Transitions Program strives to achieve policy and funding changes at the state and local level to improve cross-system collaboration, service capacity and workforce expertise; create, implement and expand research-supported services and supports that are culturally competent and youth-guided; and provide for continuity of care between child and adult behavioral health systems, while involving family and community members in the process.

The managing entities and providers who serve older adolescents are expected to provide them with the necessary supports and skills in preparation for coping with life as a young adult and facilitate a smooth transition to the adult mental health system for continuing age-appropriate treatment services, provided they meet the target population for the publicly-funded adult mental health system. Behavioral health services and supports are tailored to address the developmental needs of adolescents and may include supportive housing, supported employment, peer mentoring and education about their behavioral health needs to support wellness management.

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. These services are typically provided within the children's mental health system and include diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a).
medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. These services are typically provided within the children’s mental health system and include diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a).

Community-based care organizations are responsible for transition planning with youth served by child welfare, in accordance with the requirements of the Road to Independence. During the 2013 legislative session, the extended foster care bill was passed that allows youth aging out of foster care at age 18 to choose to remain in extended foster care until they turn 21, giving them the option to continue receiving support through this challenging time. The majority of youth served by child welfare receive behavioral health and primary health services through a Medicaid managed care child welfare specialty plan, through the age of 20. However, youth who age out of foster care are eligible for Medicaid until the age of 26, per the guidelines of the Affordable Care Act.

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

None at this time.

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

None at this time.

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Footnotes:

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death overall, with over 47,000 people dying by suicide in 2021 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following:

1. Have you updated your state's suicide prevention plan in the last 2 years? ○ Yes ◉ No

2. Describe activities intended to reduce incidents of suicide in your state.

The Statewide Office of Suicide Prevention develops and implements the Florida Statewide Strategic Plan for Suicide Prevention by providing oversight, building capacity, creating policy, and mobilizing communities for suicide prevention.

The Suicide Prevention Coordinating Council meets quarterly and focuses on raising public awareness of policies and best practices for suicide prevention.

Example activities include planning and evaluation of suicide prevention activities, awareness and marketing campaigns, and first responder mental wellness and suicide deterrence.

3. Have you incorporated any strategies supportive of Zero Suicide? ◉ Yes ○ No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? ◉ Yes ○ No

If yes, please describe how barriers are eliminated.

This is an issue of critical interest in Florida because of evidence showing that individuals are at a heightened risk of dying by suicide following discharge from an emergency department or inpatient unit. The Statewide Office of Suicide Prevention is developing more robust discharge planning best-practice recommendations.

A significant barrier currently being addressed is a lack of clinicians with CAMS training. CAMS is an evidence-based program for treating suicidality. The Department is currently working to execute a contract to provide this training.

5. Have you begun any prioritized or statewide initiatives since the FFY 2022 - 2023 plan was submitted? ◉ Yes ○ No

If so, please describe the population of focus?

One initiative and priority of Florida's Governor aims to support mental wellness and suicide deterrence for First Responders across the state. This included the creation of the First Responders Suicide Deterrence Taskforce, which was transformed into the First Responder Mental Wellness and Suicide Deterrence Committe of the Suicide Prevention Coordinating Council.

Loss survivors are also expected to be an area of focus in the coming years.

Finally, the Statewide Office of Suicide Prevention is working with the Council to improve and expand suicide prevention best practices to a wider range of individuals served through the work of Council members, including representatives from Guardian ad Litem, Department of Juvenile Justice, and Department of Education, with a focus on children.

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

None at this time.

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Footnotes:

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

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The State Medicaid Authority agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and M/SUD conditions.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- SAMHSA seeks to enhance the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states. In many respects, successful implementation is dependent on leadership and collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? (●) Yes ( ) No

2. Has your state identified the need to develop new partnerships that you did not have in place? ( ) Yes (●) No

If yes, with whom?

Several new partnerships were developed since 2021.

As provided by Section 394.9086, Florida Statutes, the Commission on Mental health and Substance Use Disorder was created in 2021 to examine the current methods of providing mental health and substance use disorder services in the state and to improve the effectiveness of current practices, procedures, programs, and initiatives in providing such services; identify any barriers or deficiencies in the delivery of such services; assess the adequacy of the current infrastructure of Florida's 988 suicide and Crisis Lifeline system and other components of the state's crisis response services; and recommend changes to existing laws, rules, and policies necessary to implement the Commission's recommendations. The Commission has 19 members, including but not limited to representatives from the Agency for Health Care Administration, county school districts, law enforcement, the criminal justice system, and mental health courts. Seats are also designated seats for individuals living with mental illness and family members of consumers of mental health services.

The Department of Children and Families also began partnering with Vocational Rehabilitation in 2021 on an initiative to expand evidence-based Individual Placement and Support (IPS) services. Vocation Rehabilitation (VR), housed within the Florida Department of Education, is a federal-state program that helps individuals with physical and/or mental disabilities find, get, keep, or advance in employment.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

Multi-agency and cross-system collaboration are essential and required elements of the Department's coordinated system of care, as described in s. 394.4573, Florida Statutes (F.S.). This coordinated system features a variety of services that enable consumers to function outside of inpatient or residential institutions, including but not limited to the following:

• Care coordination with other local systems and entities, public and private, such as primary care, child welfare, behavioral health care, and criminal and juvenile justice organizations.
• Outpatient services.
• Aftercare and other post-discharge services.
• Recovery support, including, but not limited to, the use of peer specialists to assist in the individual's recovery from a substance use disorder or mental illness; support for competitive employment, educational attainment, independent living skills development, family support and education, wellness management, and self-care; and assistance in obtaining housing that meets the individual's needs.
• Care plans that assign specific responsibility for initial and ongoing evaluation of the supervision and support needs of the individual and the identification of housing that meets such needs.
• Coordinated specialty care programs for early serious mental illness.

The Department coordinates with other agencies and local organizations, including local school systems, through the statutorily mandated Behavioral Health Managing Entity model. The Legislature "finds that a regional management structure that facilitates a comprehensive and cohesive system of coordinated care for behavioral health treatment and prevention services will improve access to care, promote service continuity, and provide for more efficient and effective delivery of substance abuse and mental health services. It is the intent of the Legislature that managing entities work to create linkages among various services and systems, including juvenile justice and adult criminal justice, child welfare, housing services, homeless systems of care, and health care" (s. 394.9082, F.S.). The Managing Entities are responsible for promoting the development and effective implementation of a coordinated system of care, pursuant to s. 394.9082(5)(d), F.S. Managing Entities and collaborating organizations are also required to document coordination through written memoranda of understanding or other binding arrangements, pursuant to s. 394.4955 (5), F.S. Additionally, Managing Entity governing boards must include consumers and their family members, representatives of local government, area law enforcement agencies, health care facilities, community-based care lead agencies, business leaders, and providers of mental health services, as stipulated by s. 394.9082(4)(c), F.S. Opportunities for multi-agency and cross-system collaboration also reoccur through the Block Grant Planning and Advisory Council (federally required under 42 U.S. Code § 300x–3), the Drug Policy Advisory Council (required by s. 397.333, F.S.), the Commission on Mental Health and Substance Abuse (required by s. 394.9086, F.S.), the Council on Homelessness (required by s. 420.622), the Marjory Stoneman Douglas High School Public Safety Commission (required by s. 943.687, F.S.), and the Children and Youth Cabinet (required by s. 402.56, F.S.).

The Department also supports the development and implementation of a coordinated system of care by requiring each provider that receives state funds through a direct contract with the Department to work with the Managing Entity in the provider's service area to coordinate the provision of behavioral health services as part of the contract with the Department, pursuant to s. 394.9082 (3)(d). The coordinated system of care is also supported through an annual Needs Assessment that considers, at a minimum, the extent to which designated receiving systems function as no-wrong-door models, the availability of treatment and recovery services that use recovery-oriented and peer-involved approaches, the availability of less-restrictive services, and the use of evidence-informed practices, pursuant to s. 394.4573.

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

None at this time.

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Footnotes:

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance use disorder Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SUPTRS BG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[1]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[1] **https://www.samhsa.gov/grants/block-grants/resources [samhsa.gov]**

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc.)

Florida' Substance Abuse and Mental Health Planning and Advisory Council is are asked to review and provide questions, comments, concerns, and feedback on all state plans and annual reports submitted to SAMHSA for the CMHS and SUPTRS Block Grants. Council feedback and acknowledgement of the opportunity to review are formally solicited electronically. All feedback is incorporated into drafts of plans and reports before submission.

The Council is also briefed on upcoming and/or recently submitted state plans and reports at quarterly meetings with opportunities to discuss verbally and via email. These post-submission briefings provide a chance to collect additional feedback to inform future processes for developing and completing Block Grant planning and reporting requirements.

2. What mechanism does the state use to plan and implement community mental health treatment, substance misuse prevention, SUD treatment, and recovery support services?

Florida's Substance Abuse and Mental Health Planning Council is an integrated advisory body that helps the Department plan and implement both mental health services and substance abuse prevention, treatments and recovery support services.

3. Has the Council successfully integrated substance misuse prevention and SUD treatment and recovery or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

4. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? (●) Yes ( ) No

5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The Planning Council reviews the Department's Block Grant applications, plans and reports, and makes recommendations on modifications. The Planning Council also monitors, reviews and evaluates, the allocation and adequacy of mental health services within Florida. The Council advocates for individuals and families through local and statewide efforts. Council members act as a liaison between state and Managing Entities in promoting a recovery oriented system of care. The Council advises the Department on allocation of services and creating a plan that supports the treatments and supports for recovery and a life in the community.

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

None at this time.

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Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.
State Medicaid Agency

Start Year: 2024 End Year: 2025

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Michelle Aguilera	Parents of children with SED			
Melanie Brown Woofter	Others (Advocates who are not State employees or providers)	Florida Behavioral Health Association		
Kayla Califiore	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	South Florida Wellness Network		
Paul Cassidy	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Stephan Cooley	State Employees	Florida Department of Children and Families		
Tony DePalma	Others (Advocates who are not State employees or providers)	Disability Rights Florida		
Glenn East	Parents of children with SED			
Veronica Ebuen	State Employees	Department of Education - Division of Voc Rehab		
Ashley Grimes	Others (Advocates who are not State employees or providers)	NAMI Florida		
Thomas Guerra	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Miami Recovery Project		
Shanette Jackson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Paul Jaquith	Others (Advocates who are not State employees or providers)	Mental Health America		
LaTressa Johnson	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Marq Mitchell	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Chainless Change		

Cheryl Molyneaux	Others (Advocates who are not State employees or providers)	Peer Support Coalition of Florida		
Kim Riley	State Employees	Florida Department of Corrections		
Elaine Roberts	State Employees	Florida Housing Finance Corporation		
Sarah Sheppard	State Employees	Florida Department of Children and Families		
LaNisha Watson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Rosemary Weaver	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			

*Council members should be listed only once by type of membership and Agency/organization represented.

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The Department is currently following procedures outlined in the Substance Abuse and Mental Health Planning and Advisory Council for identifying and appointment representatives from the Agency for Health Care Administration (e.g., agency administering Medicaid), Child Welfare, Department of Juvenile Justice, Department of Education, Department of Elder Affairs, and Department of Health.

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2024 End Year: 2025

Type of Membership	Number	Percentage of Total Membership
Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	7	
Family Members of Individuals in Recovery (to include family members of adults with SMI)	1	
Parents of children with SED	2	
Vacancies (individual & family members)	1	
Others (Advocates who are not State employees or providers)	5	
Total Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services), Family Members and Others	**16**	**59.26%**
State Employees	5	
Providers	0	
Vacancies	6	
Total State Employees & Providers	**11**	**40.74%**
Individuals/Family Members from Diverse Racial and Ethnic Populations	0	
Individuals/Family Members from LGBTQI+ Populations	0	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Youth/adolescent representative (or member from an organization serving young people)	0	
Total Membership (Should count all members of the council)	**27**	

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Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? ○ Yes ◉ No

b) Posting of the plan on the web for public comment? ◉ Yes ○ No

If yes, provide URL:

https://www.myflfamilies.com/services/samh/publications

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

https://www.myflfamilies.com/services/samh/publications

c) Other (e.g. public service announcements, print media) ◉ Yes ○ No

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

None at this time.

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Footnotes:

Environmental Factors and Plan

23. Syringe Services Program (SSP) - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Narrative Question:

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

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

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

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

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

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.samhsa.gov/sites/default/files/grants/ssp-guidance-for-hiv-grants.pdf ,**

2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf,**

3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf ,**

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

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

Future years are subject to authorizing language in appropriations bills.

End Notes

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

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

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

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

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

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

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

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

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

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

HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

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

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Footnotes:

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Syringe Services Program (SSP) Information – Table A - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Dollar Amount of SUBG Funds to be Expended for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone Provider (Yes or No)
No Data Available					

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Footnotes: