Florida

UNIFORM APPLICATION
FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

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

OMB - Approved 06/12/2015 - Expires 09/30/2020
(generated on 08/16/2017 2.54.15 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

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

Plan Year
Start Year 2018
End Year 2019

State SAPT DUNS Number
Number 604604350
Expiration Date

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

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

State CMHS DUNS Number
Number 604604350
Expiration Date

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

II. Contact Person for the CMHS Grantee of the Block Grant
First Name Ute
Last Name Gazioch
Agency Name Department of Children and Families
Mailing Address 1317 Winewood Blvd., Bldg 6
III. State Expenditure Period (Most recent State expenditure period that is closed out)

From
To

IV. Date Submitted
Submission Date
Revision Date

V. Contact Person Responsible for Application Submission
First Name  Jeffrey
Last Name  Cece
Telephone  850-717-4405
Fax  850-487-2239
Email Address  Jeffrey.Cece@myFLfamilies.com

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

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

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ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

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

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

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

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

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

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

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

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


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

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


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.

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

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

1. CERTIFICATION REGARDING LOBBYING
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 (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)
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 Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. 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, day care, 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.

The authorized official signing for the applicant organization 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 sub-awards which contain provisions for children’s services and that all sub-recipients shall certify accordingly.

The Department of Health and Human 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 DHHS mission to protect and advance the physical and mental health of the American people.

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: Mike Carroll

Signature of CEO or Designee: ________________________________

Title: Secretary, Florida Dept 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.
State Information

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

Fiscal Year 2018

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

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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.

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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.

The authorized official signing for the applicant organization 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 sub-awards which contain provisions for children’s services and that all sub-recipient shall certify accordingly.

The Department of Health and Human 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 DHHS mission to protect and advance the physical and mental health of the American people.

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: Mike Carroll

Signature of CEO or Designee1: 

Title: Secretary, Florida Dept of Children & Families

Date Signed: mm/dd/yyyy

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

### Disclosure of Lobbying Activities

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

**Standard Form LLL (click here)**

<table>
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<tr>
<th>Name</th>
<th>Mike Carroll</th>
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<tbody>
<tr>
<td>Title</td>
<td>Secretary</td>
</tr>
<tr>
<td>Organization</td>
<td>Florida Department of Children and Families</td>
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**Signature:**

**Date:**

**Footnotes:**

Please see attached disclosure form.
Planning Steps

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

Narrative Question:
Provide an overview of the state’s behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health 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 SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

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

Instructions: Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health 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 SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

This narrative must include a discussion of the current service system’s attention to the SABG priority populations: Pregnant Women, Injecting Drug Users, Women with Dependent Children, Persons at Risk for Tuberculosis, Individuals in Need of Primary Substance Abuse Prevention, and, for FY 2018 HIV-designated states, Persons at Risk for HIV.

Organizational Structure

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

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

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

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

Managing Entities

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

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

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

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

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

Figure 1 below is a color-coded map that depicts each ME’s catchment area, start date, and DCF regions and circuits. It also lists each county within each MEs geographic catchment area.
In Florida, as with many states, the CMH and SAPT Block Grants do not support the entirety of the publicly-funded behavioral health system. Medicaid comprises a significant portion of funding for behavioral health. The Florida Agency for Health Care Administration (AHCA) serves as Florida’s Medicaid authority. The Department, while the single state authority for substance abuse and mental health, shares administrative responsibility pursuant to Florida Statute with AHCA.\(^5\) It should be noted that the authority that delegates shared administrative responsibility does not provide for a shared information system between Block Grant funded providers and Medicaid providers.

In 2013, Florida received a federal 1115 waiver to expand a managed care Medicaid pilot statewide, which started in 2006 with five counties. This transitioned Medicaid from a fee-for-service system to the Statewide Medicaid Managed

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Care program. The capitated per-member-per-month rate for a covered individual includes behavioral health services. As of August 2014, AHCA has completed the transition to this full managed care model.

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 that takes into account the state general revenue that a provider receives. This match may be satisfied through cash or include in-kind contributions. The authorizing legislation has set this up as a community issue that is negotiated between local governments and providers. Furthermore, some local governments dedicate additional funding for behavioral health services, while others do not.

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

<table>
<thead>
<tr>
<th>Table 2. Behavioral Health Services at Other State Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Florida Department of Health | • Tobacco Cessation Program  
| | • Positive Youth Development  
| | • School Health Services (including Behavioral Health)  
| | • Infant, Maternal, and Reproductive Health program  
| | • Prescription Drug Monitoring Program  
| | • Children’s Health Insurance Program  
| | • Infectious Disease Surveillance and Control |
| Florida Department of Education | • School based Behavioral Health Services  
| | • Multiagency Network for Students with Emotional or Behavioral Disabilities (SEDNET) |
| Florida Department of Juvenile Justice | • Behavioral Health Services |
| Florida Department of Elder Affairs | • Behavioral Health Services |
| Florida Department of Corrections | • Institutional Behavioral Health Services |

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

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

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

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

Substance Abuse Services

Substance Abuse treatment in Florida is authorized by ch. 397, F.S., and regulated by ch. 65D-30, F.A.C. Florida Statute requires the Department to license substance abuse treatment service components and recognize a certification for clinicians. Chapter 397, F.S., provides for a system of care that is community based, reflecting the principles of recovery and resiliency.

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

The system of care is comprised of the following broad categories of substance abuse services:

• Prevention services, which include:
  o Information dissemination;
  o Education regarding the consequences of substance abuse; alternative drug-free activities;
  o Problem identification;
  o Referral of persons to appropriate prevention programs;
  o Community-based programs that involve members of local communities in prevention activities; and
  o Environmental strategies to review, change, and enforce laws that control the availability of controlled and illegal substances.

• Assessment services, which include the evaluation of individuals and families in order to identify their strengths and determine their required level of care, motivation, and need for treatment and ancillary services.

• Intervention services, which include early identification, short-term counseling and referral, and outreach.

• Rehabilitation services, which include residential, outpatient, day or night, case management, in-home, psychiatric, medical treatment, and methadone or medication management.

• Ancillary services, which include:
  o Self-help and other support groups and activities;
  o Aftercare provided in a structured, therapeutic environment;
  o Supported housing;
  o Supported employment;
  o Vocational services; and
  o Educational services.

Substance Abuse treatment is also a covered service in the State Medicaid Plan. Substance Abuse services that are covered include modalities such as:

• Individual and group therapy;
• Assessment;
• Psychosocial rehabilitation; and
• Medication management.

Mental Health Services

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

As noted earlier, mental health services for children and adults are provided by network service providers through contracts with managing entities, managed care organizations, and local governments. Individuals who require a more 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.

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

The 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:
  o Assessment of personal goals and strengths;
  o Readiness preparation;
  o Specific skill training; and
  o 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:
  o Income supports;
  o Housing supports; and
  o 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:
  o Assessment of the person’s needs;
  o Intervention planning with the person, his or her family, and service providers;
  o Linking the person to needed services;
  o Monitoring service delivery;
  o Evaluating the effect of services and supports; and
  o Advocating on behalf of the person served.

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

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

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

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

The Department also funds team-based community interventions such as Community Action Teams (CATs) and Family Intervention Treatment (FIT) teams that focus on the entire family to prevent out of home placements in the child welfare, behavioral health, and justice systems. CATs provide a community based alternative for children and young adults and their families, with significant behavioral health needs. The goal is to divert these children and youth from residential mental health treatment, foster care, and detention facilities, and to improve their functioning in the community. Children under the age of 11 may be considered for the program if they have two or more of the eligibility criteria. Funding has also been appropriated to Child Welfare Community Based Care agencies to integrate child welfare and behavioral health services.

**Mental Health Treatment Facilities**

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

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

Services include:

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

The state contracts for services at four other sites:

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

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

Service Eligibility

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

Services and Programs

The Department has determined a service array that is allowed to be purchased with Department funds and is outlined in Florida Administrative Code. Table 3 below shows these covered services.

<table>
<thead>
<tr>
<th>Service</th>
<th>Applicable Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aftercare:</td>
<td>• Adult Mental Health</td>
</tr>
<tr>
<td></td>
<td>• Children’s Mental Health</td>
</tr>
<tr>
<td></td>
<td>• Adult Substance Abuse</td>
</tr>
<tr>
<td></td>
<td>• Children’s Substance Abuse</td>
</tr>
<tr>
<td>Assessment:</td>
<td>• Adult Mental Health</td>
</tr>
<tr>
<td></td>
<td>• Children’s Mental Health</td>
</tr>
<tr>
<td></td>
<td>• Adult Substance Abuse</td>
</tr>
<tr>
<td></td>
<td>• Children’s Substance Abuse</td>
</tr>
<tr>
<td>Case Management:</td>
<td>• Adult Mental Health</td>
</tr>
<tr>
<td></td>
<td>• Children’s Mental Health</td>
</tr>
<tr>
<td></td>
<td>• Adult Substance Abuse</td>
</tr>
</tbody>
</table>

Table 3. DCF Covered Services
<table>
<thead>
<tr>
<th><strong>services received.</strong> 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.</th>
<th>• Children’s Substance Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Comprehensive Community Service Team:</strong> This is a bundled service package designed to provide short-term assistance and guide individuals in rebuilding skills in identified roles in their environment through the engagement of natural supports, treatment services, and assistance of multiple agencies when indicated.</td>
<td>• Adult Mental Health • Children’s Mental Health • Adult Substance Abuse • Children’s Substance Abuse</td>
</tr>
<tr>
<td><strong>Crisis Stabilization:</strong> These acute care services, offered twenty-four hours per day, seven days per week, provide brief, intensive mental health residential treatment services. These services meet the needs of individuals who are experiencing an acute crisis and who, in the absence of a suitable alternative, would require hospitalization.</td>
<td>• Adult Mental Health • Children’s Mental Health</td>
</tr>
<tr>
<td><strong>Crisis Support/Emergency:</strong> This non-residential care is generally available twenty-four hours per day, seven days per week, or some other specific time period, to intervene in a crisis or provide emergency care. Examples include: mobile crisis, crisis support, crisis/emergency screening, crisis telephone, and emergency walk-in.</td>
<td>• Adult Mental Health • Children’s Mental Health • Adult Substance Abuse • Children’s Substance Abuse</td>
</tr>
<tr>
<td><strong>Day Care:</strong> Day care services, in a non-residential group setting, provide for the care of children of persons who are participating in mental health or substance abuse services. In a residential setting, day care services provide for the residential and care-related costs of a child living with a parent receiving residential services.</td>
<td>• Adult Mental Health • Adult Substance Abuse</td>
</tr>
<tr>
<td><strong>Day Treatment:</strong> Day Treatment services provide a structured schedule of non-residential services for four or more consecutive hours per day. Activities for children and adult mental health programs are designed to assist individuals to attain skills and behaviors needed to function successfully in living, learning, work, and social environments. Activities for substance abuse programs emphasize rehabilitation, treatment, and education services, using multidisciplinary teams to provide integrated programs of academic, therapeutic, and family services.</td>
<td>• Adult Mental Health • Children’s Mental Health • Adult Substance Abuse • Children’s Substance Abuse</td>
</tr>
<tr>
<td><strong>Drop-in/Self-Help Centers:</strong> These centers are intended to provide a range of opportunities for persons with severe and persistent mental illness to independently develop, operate, and participate in social, recreational, and networking activities.</td>
<td>• Adult Mental Health</td>
</tr>
<tr>
<td><strong>Florida Assertive Community Treatment (FACT) Team:</strong> A FACT team is comprised of slots for participants with a severe and persistent mental illness. Participants are enrolled on a weekly basis. For a provider to identify themselves as a FACT team, the provider must demonstrate adherence to assertive community treatment principles. FACT Teams provide non-residential services that are available twenty-four hours per day, seven days per week. Rehabilitative, support and therapeutic services are provided in the community, by a multidisciplinary team.</td>
<td>• Adult Mental Health • Adult Substance Abuse</td>
</tr>
<tr>
<td><strong>Incidental Expenses:</strong> This reports temporary expenses incurred to facilitate continuing treatment and community stabilization when no other resources are available. All incidental expenses shall be authorized by the Managing Entity. Allowable uses of this Covered Service include: transportation, childcare, housing assistance clothing, educational services, vocational services, medical care, housing subsidies, pharmaceuticals and other incidentals as approved by the department or Managing Entity.</td>
<td>• Adult Mental Health • Children’s Mental Health • Adult Substance Abuse • Children’s Substance Abuse</td>
</tr>
<tr>
<td><strong>Information and Referral:</strong> These services maintain information about resources in the community, link people who need assistance with appropriate service providers, and provide information about agencies and organizations that offer services. The information and referral process involves: being readily available for contact by the individual; assisting the individual with determining which resources are needed; providing referral to appropriate resources; and following up to ensure the individual’s needs have been met, where appropriate.</td>
<td>• Adult Mental Health • Children’s Mental Health • Adult Substance Abuse • Children’s Substance Abuse</td>
</tr>
<tr>
<td><strong>In-Home and On-Site:</strong> Therapeutic services and supports, including early childhood</td>
<td>• Adult Mental Health</td>
</tr>
</tbody>
</table>
mental health consultation, are rendered in non-provider settings such as nursing homes, assisted living facilities, residences, school, detention centers, commitment settings, foster homes, daycare centers, and other community settings.

<table>
<thead>
<tr>
<th>Inpatient:</th>
<th>Inpatient services provided in psychiatric units within hospitals licensed under Chapter 395, F.S. as general hospitals and psychiatric specialty hospitals. They are designed to provide intensive treatment to persons exhibiting violent behaviors, suicidal behaviors, and other severe disturbances due to substance abuse or mental illness.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intensive Case Management:</td>
<td>Case management services consist of 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.</td>
</tr>
<tr>
<td>Intervention:</td>
<td>Intervention services focus on reducing risk factors generally associated with the progression of substance abuse and mental health problems. Intervention is accomplished through early identification of persons at risk, performing basic individual assessments, and providing supportive services, which emphasize short-term counseling and referral. These services are targeted toward individuals and families. 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.</td>
</tr>
<tr>
<td>Medical Services:</td>
<td>Medical services provide primary psychiatric care, therapy, and medication administration provided by an individual licensed under the state of Florida to provide the specific service rendered. Medical services are designed to improve the functioning or prevent further deterioration of persons with mental health or substance abuse problems, including psychiatric mental status assessment. For adults with mental illness, medical services are usually provided on a regular schedule, with arrangements for non-scheduled visits during times of increased stress or crisis.</td>
</tr>
<tr>
<td>Medication-Assisted Treatment:</td>
<td>This provides for the delivery of medications for the treatment of substance use or abuse disorders which are prescribed by a licensed health care professional. Services must be based upon a clinical assessment and provided in conjunction with substance abuse treatment.</td>
</tr>
<tr>
<td>Mental Health Clubhouse Services:</td>
<td>Structured, evidence-based services designed to strengthen and/or regain the individual’s interpersonal skills, provide psycho-social therapy toward rehabilitation, develop the environmental supports necessary to help the individual thrive in the community and meet employment and other life goals and promote recovery from mental illness. Services are typically provided in a community-based program with trained staff and members working as teams to address the individual’s life goals and to perform the tasks necessary for the operations of the program. The emphasis is on a holistic approach focusing on the individual’s strengths and abilities while challenging the individual to pursue those life goals.</td>
</tr>
<tr>
<td>Outpatient:</td>
<td>Outpatient services provide a therapeutic environment, which is designed to improve the functioning or prevent further deterioration of persons with mental health and/or substance abuse problems. These services are usually provided on a regularly scheduled basis by appointment, with arrangements made for non-scheduled visits during times of increased stress or crisis. Outpatient services may be provided to an individual or in a group setting. The group size limitations applicable to the Medicaid program shall apply to all Outpatient services provided by a SAMH-Funded Entity. 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.</td>
</tr>
<tr>
<td>Outreach:</td>
<td>Outreach services are provided through a formal program to both individuals and families. These services are targeted toward individuals and families. 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.</td>
</tr>
</tbody>
</table>

- Children’s Mental Health
- Adult Substance Abuse
- Children’s Substance Abuse
- Adult Mental Health
- Children’s Mental Health
- Adult Mental Health
- Children’s Mental Health
- Adult Mental Health
- Adult Substance Abuse
- Children’s Substance Abuse
- Adult Substance Abuse
- Children’s Substance Abuse
- Adult Mental Health
- Adult Mental Health
- Adult Mental Health
- Adult Substance Abuse
- Children’s Substance Abuse
and the community. Community services include education, identification, and linkage with high-risk groups. Outreach services for individuals are designed to: encourage, educate, and engage prospective individuals who show an indication of substance abuse and mental health problems or needs. Individual enrollment is not included in Outreach services.

| Prevention – Indicated: | Adult Mental Health  
| | Children’s Mental Health  
| | Adult Substance Abuse  
| | Children’s Substance Abuse |

| Prevention – Selective: | Adult Mental Health  
| | Children’s Mental Health  
| | Adult Substance Abuse  
| | Children’s Substance Abuse |

| Prevention – Universal Direct: | Adult Mental Health  
| | Children’s Mental Health  
| | Adult Substance Abuse  
| | Children’s Substance Abuse |

| Prevention – Universal Indirect: | Adult Mental Health  
| | Children’s Mental Health  
| | Adult Substance Abuse  
| | Children’s Substance Abuse |

Recovery Support: These services are designed to support and coach an adult or child and family to regain or develop skills to live, work and learn successfully in the community. Services include substance abuse or mental health education, assistance with coordination of services as needed, skills training, and coaching. This Covered Service shall include clinical supervision provided to a service provider’s personnel by a professional qualified by degree, licensure, certification, or specialized training in the implementation of this service. For Adult Mental Health and Children’s Mental Health Programs, these services are provided by a Certified Family, Veteran, or Recovery Peer Specialist. For Adult and Children’s Substance Abuse programs, these services may be provided by a certified Peer Recovery Specialist or trained paraprofessional staff subject

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Responsibility of care giving. Primary care giver by providing time

Respite Services:

Home/non

Therapeutic Foster Home

Level IV services are the least intensive and restrictive level of residential treatment provided in group or foster home settings, therapeutic foster homes. For children with serious emotional disturbances, Level IV services are programs specifically designed for the purpose of providing intensive therapeutic behavioral and treatment interventions. Therapeutic Group Home, Specialized Therapeutic Foster Home – Level II, and Therapeutic Foster Home – Level 2 are reported under this Covered Service. For substance abuse, Level II services provide a range of assessment, treatment, rehabilitation, and ancillary services in a less intensive therapeutic environment with an emphasis on rehabilitation, and may include formal school and adult education programs.

Residential Level III: These licensed facilities provide twenty-four hours per day, seven days per week, supervision. Level III facilities house persons who have significant deficits in independent living skills and need extensive support and supervision. For children with serious emotional disturbances, Level III services are specifically designed to provide sparse therapeutic behavioral and treatment interventions. Therapeutic Group Home, Specialized Therapeutic Foster Home – Level I, and Therapeutic Foster Home – Level 1 are reported under this Covered Service. For adults with serious mental illness, this Covered Service consists of supervised apartments. For substance abuse, Level III provides a range of assessment, rehabilitation, treatment and ancillary services on a long-term, continuing care basis where, depending upon the characteristics of the individuals served, the emphasis is on rehabilitation or treatment.

Residential Level IV: This type of facility may have less than twenty-four hours per day, seven days per week on-premise supervision. It is primarily a support service and, as such, treatment services are not included in this Covered Service, although such treatment services may be provided as needed through other Covered Services. Level IV includes satellite apartments, satellite group homes, and therapeutic foster homes. For children with serious emotional disturbances, Level IV services are the least intensive and restrictive level of residential care provided in group or foster home settings, therapeutic foster homes, and group care. Regular therapeutic foster care can be provided either through Residential Level IV “Day of Care: Therapeutic Foster Home” or by billing in-home/non-provider setting for a child in a foster home.

Respite Services: Respite care services are designed to sustain the family or other primary care giver by providing time-limited, temporary relief from the ongoing responsibility of care giving.
| **Room and Board with Supervision Level I:** This Covered Service solely provides for room and board with supervision on a twenty-four hours per day, seven days per week basis. It corresponds to Residential Level I as defined in paragraph (4)(aa) of this rule. This Covered Service is not applicable for provider facilities which meet the definition of an Institute for Mental Disease as defined by Title 42 CFR, part 435.1010. | • Adult Mental Health  
• Children’s Mental Health  
• Adult Substance Abuse  
• Children’s Substance Abuse |
|---|---|
| **Room and Board with Supervision Level II:** This Covered Service solely provides for room and board with supervision on a twenty-four hours per day, seven days per week basis. It corresponds to Residential Level II as defined in paragraph (4)(bb) of this rule. This Covered Service is not applicable for provider facilities which meet the definition of an Institute for Mental Disease as defined by Title 42 CFR, part 435.1010. | • Adult Mental Health  
• Children’s Mental Health  
• Adult Substance Abuse  
• Children’s Substance Abuse |
| **Room and Board with Supervision Level III:** This Covered Service solely provides for room and board with supervision on a twenty-four hours per day, seven days per week basis. It corresponds to Residential Level III as defined in paragraph (4)(cc) of this rule. This Covered Service is not applicable for provider facilities which meet the definition of an Institute for Mental Disease as defined by Title 42 CFR, part 435.1010. | • Adult Mental Health  
• Children’s Mental Health  
• Adult Substance Abuse  
• Children’s Substance Abuse |
| **Short-term Residential Treatment:** These individualized, stabilizing acute and immediately sub-acute care services provide short and intermediate duration intensive mental health residential and habilitative services on a twenty-four hours per day, seven days per week basis. These services shall meet the needs of individuals who are experiencing an acute or immediately sub-acute crisis and who, in the absence of a suitable alternative, would require hospitalization. | • Adult Mental Health |
| **Substance Abuse Inpatient Detoxification:** These programs utilize medical and clinical procedures to assist adults, children, and adolescents with substance abuse problems in their efforts to withdraw from the physiological and psychological effects of substance abuse. Residential detoxification and addiction receiving facilities provide emergency screening, evaluation, short-term stabilization, and treatment in a secure environment. | • Adult Substance Abuse  
• Children’s Substance Abuse |
| **Substance Abuse Outpatient Detoxification:** These services utilize medication or a psychosocial counseling regimen that assists recipients in their efforts to withdraw from the physiological and psychological effects of the abuse of addictive substances. | • Adult Substance Abuse  
• Children’s Substance Abuse |
| **Supported Employment:** Supported employment services are evidence-based community-based employment services in an integrated work setting which provides regular contact with non-disabled co-workers or the public. A job coach provides longer-term, ongoing support for as long as it is needed to enable the recipient to maintain employment. | • Adult Mental Health  
• Children’s Mental Health  
• Adult Substance Abuse  
• Children’s Substance Abuse |
| **Supportive Housing/Living:** Supported housing/living is an evidence-based approach to assist persons with substance abuse and mental illness in the selection of permanent housing of their choice. These services also provide the necessary services and supports to assure continued successful living in the community and transitioning into the community. For children with mental health problems, supported living services are a process which assists adolescents in housing arrangements and provides services to assure successful transition to independent living or with roommates in the community. Services include training in independent living skills. For substance abuse, services provide for the placement and monitoring of recipients who are participating in non-residential services; recipients who have completed or are completing substance abuse treatment; and those recipients who need assistance and support in independent or supervised living within a “live-in” environment. | • Adult Mental Health  
• Children’s Mental Health  
• Adult Substance Abuse  
• Children’s Substance Abuse |
| **Treatment Alternatives for Safer Communities:** TASC provides for identification, screening, court liaison, referral and tracking of persons in the criminal justice system with a history of substance abuse or addiction. | • Adult Substance Abuse  
• Children’s Substance Abuse |

Managing entities, by both statute and contract, are required to develop and manage an integrated provider network that meets the behavioral health service needs of the community in which they are located. The services are to be accessible and responsive to individuals, families, and community stakeholders. This includes:
1. All priority populations as defined in statute;
2. Mental Health residents of assisted living facilities;
3. Persons ordered into involuntary outpatient placement;
4. Eligible children referred for residential placement;
5. Inmates approaching the end of their sentences;
6. Individuals that are currently in civil and forensic state Mental Health Treatment Facilities; and
7. Individuals who are at risk of being admitted into a civil or forensic state MH Treatment Facility (including diversionary community treatment and services prior to admission).

There are two Federally Recognized Indian Tribes in Florida: the Miccosukee Tribe of Indians and the Seminole Tribe of Florida. There are no current activities between the Office of SAMH and the tribes to report. The Department recently sent formal letters to the leaders of the two federally-recognized tribes in Florida requesting consultations. The Department is currently awaiting a response.

The U.S. Census Bureau estimates that Florida’s 2014 population was approximately 55.8% non-Hispanic white, 24.1% Hispanic or Latino, 16.8% black, 2.8% Asian, and 0.5% American Indian and Alaska Native. Although the population of racial/ethnic minorities in Florida is relatively small (comprising only about 44% of the population), these populations are disproportionately impacted by substance use disorders. The National Survey on Drug Use and Health indicates that Hispanics are more likely than non-Hispanics to need drug treatment and they are less likely than non-Hispanics to receive specialty treatment. While blacks are less likely than persons from other racial/ethnic groups to need treatment for alcohol use, they are more likely to need treatment for illicit drug use. American Indians or Alaska Natives are also more likely than persons from other racial/ethnic groups to need treatment.

The prevalence of serious mental illness also varies by race/ethnicity. According to the 2014 NSDUH, the prevalence of past-year serious mental illness is 4.4% among non-Hispanic whites, 3.5% among Hispanics or Latinos, 3.1% among blacks, 2.4% among Asians, 4.0% among American Indians or Alaska Natives, and 8.9% among those who identify as being of two or more races. Furthermore, approximately 72.7% of non-Hispanic whites with serious mental illness received mental health treatment/counseling in the past year, compared to 62.2% of Hispanics or Latinos and 53.7% of blacks.

Approximately 3.5% of adults in Florida identify as lesbian, gay, bisexual, or transgender (LGBT). Rates of past year alcohol and illicit drug dependence are higher among adult males and females who identify as either gay, bisexual, or not sure, than they are among males and females who identify as heterosexual. The prevalence of mood disorders and anxiety disorders also varies by sex and sexual orientation. Florida’s sexual and gender minorities, just like Florida’s racial and ethnic minorities, are expected to have unique needs that must be addressed by the behavioral health service system.

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

In order to ensure that the behavioral health workforce possesses the skills needed to serve Florida’s diverse racial and ethnic minorities and sexual and gender minorities, the Department supports cultural and linguistic competency training. The Director of Florida’s System of Care (SOC) grant and all 40 members of the Cultural and Linguistic Competency Committee have the capacity to conduct trainings. The SOC Director has conducted trainings and provided materials to over 100 healthcare providers in 5 regions of the state. SOC staff partnered with Office of Civil Rights to
distribute educational materials to compliance officers throughout the state. A statewide Cultural and Linguistic Competence Strategic Plan and an assessment of providers were drafted. The Department also provides online training on cultural and linguistic competency and health disparities.

**Services for Early Serious Mental Illness and First Episodes of Psychosis**

In 2014, the U.S. Congress established a new set-aside required under the Community Mental Health Block Grant 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). Evidence indicates that a prolonged duration of untreated mental illness predicts negative outcomes (like serious impairment, unemployment, homelessness, etc.) across different mental illnesses. Earlier treatment and interventions are therefore critical to both reducing acute symptoms and improving long-term outcomes. All states are now required to spend at least 10% of this award on evidence-based services for early serious mental illness. The Department is currently providing set-aside funds to 5 providers who are serving 247 individuals. They all employ the NAVIGATE treatment model, which is a type of coordinated specialty care for early psychosis.

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

In FY 16-17, 1,878 pregnant women received publicly-funded substance abuse treatment services in Florida. There are approximately 104 outpatient programs serving pregnant women and women with dependent children (PWWDC). The Department also funds 361 residential beds specifically for PWWDC. Block Grant regulations stipulate that Florida must expend at least $9.3 million in federal and state funds for PWWDC. In State Fiscal year 2016, Florida expended $11.8 million on PWWDC. The Department, in consultation with the Department of Health and Agency for Health Care Administration, is participating in a Policy Academy for technical assistance from the National Center on Substance Abuse and Child Welfare aimed at improving outcomes for pregnant and postpartum women with opioid use disorders and their infants and families who are involved or at risk of being involved with child welfare services. In partnership with the Florida Association of Alcohol and Drug Abuse and the Florida Certification Board, the Department provides online trainings and resources on evidence-based practices and treatment for PWWDC. The Office of Substance Abuse and Mental Health also recently hired a designated lead for women’s behavioral health services within the Clinical Team. She will work to increase the percent of women served by the Department that are pregnant when they are engaged in services by analyzing current outreach activities and referral networks and implementing recommendations based on the findings.

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

Florida continues to be a “designated” state – and is therefore required to spend 5% of the SABG award on HIV Early Intervention Services (EIS) – due to high AIDS case rates. Florida’s HIV EIS set-aside funds are distributed by the managing entities to 41 providers throughout the state, including 20 that serve rural counties. In FY 15-16, set-aside-funded providers tested over 19,000 individuals. A total of 405 tests were positive for HIV. The Department’s Block Grant coordinator regularly consults with officials from the Department of Health on proposed revisions to rules related to infectious disease control, best practices related to HIV EIS, the development of new needs-based allocation methodologies, standards for programmatic audits, and improvements to each Department’s respective data collection and surveillance systems.

All licensed substance abuse treatment programs in Florida are required to provide tuberculosis testing to high-risk 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. Florida is required to expend at least $1,145 in state funds on tuberculosis services for individuals with substance use disorders who are in treatment. In State Fiscal Year 2016, Florida spent $6.7 million of state funds on tuberculosis services. It is estimated that less than 1% of these expenditures are for services provided to individuals in treatment for substance use disorders, which is still sufficient to consistently meet SAMHSA’s maintenance of effort requirement.
Primary Prevention of Substance Use

Florida regularly expends more than the required minimum of 20% of the Substance Abuse Block Grant funds on primary prevention activities that are directed at individuals who do not require treatment for substance use disorders. All six strategies described by the Center for Substance Abuse Prevention are funded by the primary prevention set-aside. These strategies include information dissemination, education, alternative recreational activities, problem identification and referral, community-based processes, and environmental strategies. The Department recently partnered with the Collaborative Planning Group to conduct the Statewide Substance Abuse Prevention Needs Assessment, which was completed in June 2017. The Department’s Prevention Specialist is in the process of developing an updated state prevention plan and workforce development survey. The Prevention Specialist also manages an Evidence-Based Practice Workgroup that is reviewing standards from various evidence ranking schemes to help inform decisions regarding resource allocations. The Department also recently reinvigorated the State Epidemiological Outcomes Workgroup, which supports state, regional, and local surveillance activities. Its 25 members are epidemiologists and individuals who are knowledgeable about the variables that help document the need for prevention and treatment services. Members include representatives from four of the seven managing entities, the Florida Alcohol and Drug Abuse Association, the Community Coalition Alliance, various prevention and treatment providers, and five state agencies. The SEOW will produce annual reports that will be reviewed by the Department and incorporated into needs assessments and strategic plans for prevention and treatment services as appropriate.

1 S. 394.9082(1), Florida Statutes (F.S.).
2 The Department continues to contract with a few service providers directly when required by the annual General Appropriations Act.
3 Ch. 2013-47, L.O.F., and s. 394.9082(9), F.S.
4 Ibid.
5 S. 394.457, F.S.
6 S. 394.76, F.S.
7 S. 397.311, F.S.
9 The Juvenile Incompetent to Proceed Program offers competency restoration for children who are found incompetent 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.
10 The Statewide Inpatient Psychiatric Program provides residential mental health treatment in a secure setting with intensive treatment and serves children with severe emotional disturbances ages six through seventeen.
12 S. 394.674(1), F.S.
18 Ibid.


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

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

SAMHSA's Behavioral Health Barometer is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the National Survey of Substance Abuse Treatment Services (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the Behavioral Health Barometers. States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

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

Footnotes:

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

Instructions: This step should identify the unmet service needs and critical gaps in the state’s current behavioral health system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state’s behavioral health system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps. The state’s priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state’s unique data system (including community-level data), as well as SAMHSA’s data sets. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorder prevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services.

Need for Services and Receipt of Services among the General Population

According to Florida-specific data from the 2014-2015 National Survey on Drug Use and Health (NSDUH), approximately 2.6% of children ages 12-17 and 6.1% of adults ages 18 and older experienced an alcohol use disorder in the past year.¹ The most recent publicly-available Florida-specific estimates on illicit drug use disorders are from the 2013-2014 NSDUHs because methodological changes apparently preclude the ability to generate these estimates for 2014-2015. According to 2013-2014 NSDUH estimates for Florida, approximately 4.1% of children ages 12-17 and 2.2% of individuals ages 18 and older experienced illicit drug dependence or abuse in the past year.² The vast majority of individuals with substance use disorders did not receive treatment in the past year. It is estimated that 92% of individuals with alcohol use disorders and 87% of individuals with an illicit drug use disorder did not receive treatment.³

The NSDUH estimates that 16.7% of adults in Florida experienced any mental illness in the past year.⁴ Only about 37.3% of these individuals received mental health treatment or counseling.⁵ It is also estimated that 3.6% of adults experienced a serious mental illness in the past year.⁶ Estimates of the percent of these individuals that receive treatment are not publicly available for Florida. Among children ages 12-17, approximately 11.8% experienced a major depressive episode in the past year.⁷ It is estimated that only 33% of these children received treatment for depression.⁸ It is estimated that the prevalence of serious emotional disturbance (SED) among children and adolescents in Florida is between 7% and 13%.⁹

Floridians with No Health Insurance and Living in Poverty

SAMHSA requires that Block Grant funds be used to cover insurance gaps. Block Grant funds should be directed to fund treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time and to fund treatment and support services not covered by Medicaid, Medicare, or private insurance for low-income individuals. These expectations highlight the importance of reviewing data on the prevalence of behavioral health disorders among individuals with no health insurance or who are living in poverty.

According to 5-year (2011-2015) estimates from the American Community Survey, there are approximately 3,017,772 adults (ages 18 to 64 years) with no health insurance coverage (representing about 25.7% of all adults in Florida). It is also estimated that there are 403,993 children (under the age of 18) with no health insurance (representing about 10% of all children in Florida).¹⁰ The American Community Survey also indicates that 24.1% of children and 14.6% of adults live below the poverty level.¹¹

The Prevalence of Behavioral Health Conditions among the Uninsured and Individuals Living in Poverty

Insurance and poverty variables were recently included in a SAMHSA analysis of Florida-specific NSDUH data for adults ages 18-64 using averages from 2010-2014. According to SAMHSA, the findings from this analysis “provide the best...
available guide to the characteristics of the uninsured population.” Among the uninsured population in Florida, 25.8% experienced any mental illness or a substance use disorder in the past year. Approximately 91.2% of these individuals did not receive treatment for their mental illness or substance use. Among the uninsured population with income below 138% of the Federal poverty level (the income limit for Medicaid coverage under expansion), 27.7% experienced any mental illness or a substance use disorder in the past year.12

Nationwide estimates for measures that are not available for Florida are also informative. In 2015, the percentage of adults in the U.S. with past year serious mental illness was significantly higher among those living in households whose income was less than 100% of the poverty level (6.8%) than it was among those living in households whose income was 100% or more of the poverty level (3.5%).13 The prevalence of serious mental illness was 5.1% among uninsured adults, 2.9% among adults with private coverage, 8.4% among adults with Medicaid/CHIP, and 3.8% among adults with other coverage.14 Not surprisingly, adults with serious mental illness are significantly less likely to receive mental health treatment services if they do not have health insurance. About 68.3% of adults with serious mental illness who have insurance receive treatment, compared to 43.5% of adults with serious mental illness who are not insured.15

Nationwide, it is estimated that 7.8% of children below 100% of the Federal Poverty Level experienced past-year alcohol or illicit drug dependence or abuse. Past-year alcohol or illicit drug dependence or abuse is more prevalent among children below 100% of the Federal Poverty Level than among children between 100%-199% of the Federal Poverty Level (7.3%) and children at or above 200% of the Federal Poverty Level (6.7%).16

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

Managing Entities were asked to rank order the top five unmet needs they identified (1=highest need and 5=lowest need). These needs were identified in a variety of different ways, including, but not limited to, analyses of waitlist records, surveys, and focus groups with consumers, providers, and other community stakeholders. This information was requested to help the Department prepare to address s. 394.9082(8), F.S., which requires each Managing Entity, beginning in September 2017, to develop a description of strategies for enhancing services and addressing three to five priority needs. The Department must then compile all of these enhancement plans and evaluate them in accordance with s. 394.4573, F.S. Responses from each of the Managing Entities are presented below.

**Big Bend Community Based Care (BBCBC):**

1. Outpatient services for substance abuse and mental health
2. Residential services for substance abuse
3. Housing options and supported housing for substance abuse and mental health
4. Substance abuse prevention programs for middle and high school students
5. Health Information Exchange platform to help track clients across providers and systems (regardless of payer source)

**Central Florida Behavioral Health Network (CFBHN):**

1. Supportive housing programs
2. Affordable housing
3. Short-term residential beds for state hospital discharges and individuals released from CSUs and jails
4. Psychiatric medical services
5. Service coordination and flexible funding for high utilizers

**Central Florida Cares Health System (CFCHS):**

1. Care coordination with housing assistance
2. Residential treatment for adults with substance use disorders
3. Mental health outpatient treatment for adults
4. Case management for adults

Lutheran Services Florida Health Systems (LSFHS):

1. First Episode of Psychosis Care Teams
2. Short-term residential treatment for civil and forensic populations at risk for admission to state hospitals and individuals who are ready to be discharged from state hospitals
3. Housing for individuals transitioning out of state hospitals, prisons, and jails
4. Project Healthy Homes Teams to provide wraparound services for families involved in the child welfare system
5. Psychiatric care (psychiatrists/ARNPs)

Southeast Florida Behavioral Health Network (SEFBHN):

1. Inpatient detoxification
2. Medication-assisted treatment
3. Supported/transitional housing
4. Crisis support/mobile crisis teams
5. Florida Assertive Community Treatment (FACT) Teams

South Florida Behavioral Health Network (SFBHN):

1. New centralized receiving facilities
2. A permanently funded data analytics team
3. Training in evidence-based practices for criminal justice and child welfare populations
4. Affordable housing
5. Expanded care coordination activities focused on priority populations

Broward Behavioral Health Coalition (BBHC):

1. Permanent and supportive housing, emergency beds, and transitional living
2. Expansion of peer and family specialists and flex funds for transportation, childcare, supported employment, peer specialists, and aftercare planning and support
3. Short term residential treatment (extended acute care beds)
4. Multidisciplinary treatment teams like Community Action Treatment (CAT) Teams, Family Intensive Treatment (FIT) Teams, Florida Assertive Community Treatment (FACT) Teams
5. Integrated primary/behavioral programs and supports for special populations

The Department will address most of these needs by advocating for new state funding. Legislative budget requests will be drafted that describe the nature of these needs in more detail and the benefits associated with addressing them. A performance indicator related to these efforts is included to track progress over the next two years. Additional details regarding the need for supportive housing, medication-assisted treatment, care coordination, and intensive team-based services and an associated performance indicators are described in more detail in a later sections.

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

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

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

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

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

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

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

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

State Mental Health Treatment Facilities Waitlist Reductions

Individuals experiencing a behavioral health crisis may be admitted to a Crisis Stabilization Unit (CSU) for acute care. Some of these individuals may need longer term care and are referred to a State Mental Health Treatment Facility (SMHTF). The process of moving from a CSU to SMHTF and then back to the community is experiencing a bottleneck as individuals waiting to transfer from a CSU to a SMHTF are experiencing delays and persons waiting to be discharged from a SMHTF are remaining on discharge ready status for extended periods. One of the challenges is finding suitable community living arrangements, which the Department will attempt to remedy with a focus on supported housing services and more effective utilization of FACT teams. Furthermore, after a crisis stabilization unit makes a referral to a SMHTF, managing entities will need to work closely with SMHTFs to ensure the timely transfer.

Supported Housing to Reduce Homelessness

The Department’s Council on Homelessness estimates that approximately 34% of homeless individuals in Florida have a mental illness and 33% experience a substance use disorder. A stable living environment is important to recovery and supported housing is needed. Housing was the only need consistently identified by all seven Managing Entities as part of the previously described needs assessment. In order to address this need, all seven managing entities have hired housing/homelessness coordinators, thereby achieving an important performance indicator from the last Block Grant planning period. Clarifying and standardizing their roles and developing outcome measures associated with these positions is the next phase that will be tracked through a proposed performance indicator.
Services for Pregnant Women and Drug Exposed Newborns

The Florida Attorney General’s Statewide Task Force on Prescription Drug Abuse and Newborns identified the need for more services for pregnant women as surveillance reports documented a dramatic increase in the incidence of prescription drug exposed newborns. The number of hospital discharges of newborns diagnosed with neonatal abstinence syndrome increased more than 10-fold in Florida since 1995, far exceeding the three-fold increase observed nationally. In response, the Florida Legislature appropriated funding for an expansion of substance abuse services for pregnant women and their affected families. These services include residential treatment, outpatient treatment with housing support, and post-partum case management supporting both the mother and child consistent with the Task Force’s recommendations. Recent figures indicate that only 22% of the women served through the Department’s special funding allocation for pregnant women and mothers are pregnant when they are engaged in services. This reflects the need for expanded outreach services that reach women earlier in their pregnancies. Outreach efforts to this population must be targeted and address the reasons why women may be reluctant to request assistance.

Prevention System Improvements

The Department partnered with the Collaborative Planning Group to conduct the Statewide Substance Abuse Prevention Needs Assessment, which was completed in June 2017. Focus groups (with participants from managing entities, providers, and coalitions) conveyed an interest in sharing best practices, findings regarding evidence of effectiveness, and challenges. This assessment also determined that coalition leaders need more training in research-based environmental strategies and that all prevention providers need more training on how to properly classify activities in the Performance Based Prevention System that houses the state’s prevention service data. These needs will be addressed through trainings and webinars conducted in partnership with the Florida Alcohol and Drug Abuse Association.

According to an analysis of survey responses received last year from 42 prevention providers, the most commonly implemented opioid misuse prevention activities are designed to reduce the supply of prescription drugs available for theft, diversion, and misuse. These activities include safe storage and disposal campaigns, participation in drug “Take-Back” events, the establishment of prescription drug drop boxes, and the provision of lock boxes and drug deactivation systems. The second most prevalent set of prevention activities are information dissemination and community education. Safe use, safe storage, and safe disposal messages are typical components of these awareness campaigns. Only three prevention providers reported that they were engaged in training and promotional activities related to the opioid overdose reversal medication called naloxone. When surveyed about the kind of infrastructure/capacity improvements needed to more effectively respond to prescription drug abuse and heroin use, the most commonly cited need was training regarding the use of naloxone by paramedics, law enforcement officers, and other first responders, including caregivers.

Research indicates that community-based naloxone distribution can reduce overdose mortality by as much as 37% to 90%. One analysis that focused exclusively on heroin overdoses estimated that naloxone distribution prevents 6.5% of all overdose deaths for each 20% of heroin users reached by the program. Stated another way, it is conservatively estimated that one heroin overdose death will be prevented for every 164 naloxone kits distributed. It should also be noted that there is no evidence indicating that naloxone distribution encourages or increases the use of heroin or other opioids. Rather, studies suggest that increasing health awareness through training programs that accompany naloxone distribution actually reduces the use of opioids and increases users’ desire to seek addiction treatment.

In order to address this critical gap, the Department began implementing an Overdose Prevention Program to support the provision of overdose prevention training and naloxone kits to drug treatment provider staff, community members, law enforcement officers, DCF regional and Managing Entity staff, the recovery community, physicians, nurses, pharmacists, and other health care professionals. A performance indicator related to these trainings activities is included to help maintain the focus on this life-saving initiative.
The State Epidemiological Outcomes Workgroup (SEOW)

Florida’s State Epidemiological Outcomes Workgroup (SEOW) supports state, regional, and local surveillance activities. Its 25 members are epidemiologists and individuals who are knowledgeable about the variables that help document the need for prevention and treatment services. Members include representatives from four of the seven Managing Entities, the Florida Alcohol and Drug Abuse Association, the Community Coalition Alliance, and various prevention and treatment providers. Representatives from the following state agencies also participate: the Department of Children and Families, the Florida Department of Law Enforcement, the Department of Health, the Agency for Health Care Administration, and the Department of Education. In addition, the SEOW’s composition includes a representative from each of the Drug Epidemiology Networks (DENs) that operate across the State of Florida. Through the Florida Partnerships for Success (PFS) project, eight counties were selected for DENs development (Broward, Duval, Franklin, Hillsborough, Manatee, Palm Beach, Washington and Walton). Both the SEOW and the individuals DENs will produce annual reports that will be reviewed by the Department and incorporated into needs assessments and strategic plans for prevention and treatment services as appropriate.

Infectious Disease Control and Services for Intravenous Drug Users

Florida continues to be a “designated” state – and is therefore required to spend 5% of the SABG award on HIV Early Intervention Services (EIS) – due to high AIDS case rates. As of June 30, 2017, the Florida Department of Health estimates that there were 4,708 HIV cases diagnosed in Florida in 2015. Intravenous drug use was a suspected risk factor for transmission in 6.1% of these cases. Furthermore, there were 181 cases of co-occurring HIV and hepatitis C diagnosed in 2015. It is estimated that intravenous drug use was a risk factor for transmission in 47.6% of these cases. HIV and hepatitis C cases are increasing in many Florida counties as the crackdown on prescription drug diversion and abuse has contributed to an increase in the injection of opioids. In this context it is increasingly urgent for Florida to ensure that the HIV EIS set-aside funding is used in the most effective and efficient way possible. Preliminary analyses have revealed what appear to be large disparities between providers and managing entities with regard to the number of HIV tests conducted per HIV EIS set-aside dollar expended. This warrants further analyses that are planned through one of the associated performance indicators.

Costs and Consequences of Opioid Abuse in Florida and Gaps in Access to Medication-Assisted Treatment

On May 3, 2017, the Governor of Florida signed an Executive Order (No. 17-146) declaring a state of emergency due to the epidemic of opioid-related deaths. A similar declaration at the federal level was recently announced by the President of the United States. In light of these important developments, additional details regarding the costs and consequences of opioid abuse in Florida and gaps in access to medication-assisted treatment are provided below.

Drug overdose is now the leading cause of injury-related death in the United States. In 2015, over 52,000 deaths in the U.S. were attributed to drug poisoning, and over 33,000 (63%) of these involved some type of opioid (prescription or illicit). Since 2000, drug overdose death rates increased 137%, including a 200% increase in the rate of overdose deaths involving opioids (opiod pain relievers and heroin). In terms of the total number of overdose deaths in 2015, Florida ranked 4th in the nation with 3,228 deaths.²² More specifically, 2,566 deaths were caused by at least one opioid in 2015. This means that at least 7 lives per day are lost to opioid overdose in Florida.²³

From 1999-2014, the national age-adjusted mortality rate for prescription opioid overdoses was 4 per 100,000. Florida’s rate of 5.8 deaths per 100,000 individuals exceeds the national average. Florida ranks 14th out of all 50 states and District of Columbia on this measure. Florida’s rate more than tripled over this time span, increasing from 1.5 per 100,000 in 1999 to 5.8 per 100,000 in 2014. From 1999-2014, the national age-adjusted mortality rate for opioid drug overdoses (which includes heroin and pharmaceutical opioids) was 5.8 per 100,000. Florida’s rate of 6.8 per 100,000 exceeds the national average. Florida ranks 21st out of all 50 states and the District of Columbia on this measure. Florida’s rate more than doubled over this time span, increasing from 2.6 per 100,000 in 1999 to 7.2 per 100,000 in 2014.²⁴
Fentanyl is a synthetic opioid 50-100 times more potent than morphine and approved for the management of surgical/post-operative pain, severe chronic pain, and breakthrough cancer pain. The Drug Enforcement Administration’s National Forensic Laboratory Information System collects drug identification results from drug cases analyzed by federal, state, and local forensic laboratories throughout the United States. During 2013-2014, fentanyl submissions increased 494% in Florida, concurrent with a 115% increase in fentanyl deaths throughout the state. The rapid increase in fentanyl deaths in Florida illustrate the high potency of fentanyl, with the possibility of rapid death, highlighting the importance of quickly recognizing an overdose, calling 911, facilitating rapid administration of one or more doses of naloxone, and the need to expand naloxone availability.

Prescription opioid abuse places a substantial economic burden on society. Societal costs of prescription opioid abuse in the United States totaled $55.7 billion in 2007 (with workplace costs accounting for 46%, health care costs accounting for 45%, and criminal justice costs accounting for 9%). Prescription opioid overdoses result in 830,652 years of potential life lost before age 65. Over the past decade, the annual prevalence of diagnosed opioid abuse more than doubled among both privately insured and Florida Medicaid populations. Researchers compared individuals with opioid abuse and demographically matched controls using privately insured and Florida Medicaid administrative claims data from 2003 to 2007. Individuals with opioid abuse and caregivers had greater resource use in both privately insured and Florida Medicaid populations compared with controls. Mean excess annual cost per privately insured individual was $20,546 and mean excess cost per caregiver was $1,010. Mean excess cost per individual with Florida Medicaid was $15,183.

A recent analysis of 85 million diagnostic and billing records from 302 Florida hospitals from all 67 counties found that costs linked to heroin-related overdoses, hepatitis C, bacterial infections, and neonatal abstinence syndrome now exceed $1.1 billion per year (or $4.1 million per day). Florida’s Medicaid program was billed $2.1 billion as the primary insurer for the hospitalizations over a six-year period. By late 2015, the amount billed averaged roughly $1 million a day more than in 2010. Charges for individuals with hepatitis C who used opiates were $731,000 a day higher in 2015 than in 2010.

SAMHSA recently provided Florida-specific NSDUH estimates of the prevalence of past-year opioid abuse or dependence and the unmet need for treatment. Multiple years of data were pooled to increase the precision of the estimates. The table below depicts an increase in the prevalence of opioid abuse or dependence from 6.7% to 7.8% from 2003-2006 to 2011-2014. The estimated number of individuals with an opioid use disorder that did not receive treatment at a specialty facility was 92,000 for the 2003-2006 period and 101,000 for the 2011-2014 period.

<table>
<thead>
<tr>
<th>Past Year Opioid Abuse or Dependence, and Unmet Treatment Need among Floridians Ages 12 and Older (2003-2014)</th>
<th>2003-2006</th>
<th>2007-2010</th>
<th>2011-2014</th>
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</thead>
<tbody>
<tr>
<td>Opioid Abuse or Dependence</td>
<td>6.7%</td>
<td>7.7%</td>
<td>7.8%</td>
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<tr>
<td>Unmet Need for Treatment</td>
<td>92,000</td>
<td>105,000</td>
<td>101,000</td>
</tr>
</tbody>
</table>

With regard to the existing capacity for MAT, there are 52 methadone clinic sites throughout Florida, including both full clinics and satellite clinics. These clinics serve approximately 19,380 individuals throughout the state according to the most recent census figures. Not-for-profit corporations operate 19 sites and serve 6,861 individuals.

According to an analysis of survey responses from 359 individuals receiving methadone from publicly-funded clinics throughout Florida, the cost of self-pay was the most frequently cited problem that interfered with treatment compliance. Additionally, according to a statewide analysis of 10 years of discharge records there were 3,892 methadone recipients discharged due to inability to pay or loss of insurance coverage (or nearly 390 per year on average). Operation PAR recently reported that there were 903 individuals that were having their doses reduced for discharge because of their inability to pay last year. Lakeview Center reports that there are approximately 150 individuals per year who are unable to begin or continue services due to inability to pay.

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Researchers from the Florida Mental Health Institute analyzed survey responses from 45 professionals who make clinical or administrative decisions regarding service delivery in publicly-funded Opioid Treatment Programs across 12 counties in Florida. About half of the individuals served in these programs were self-pay and about half were covered by Medicaid. Most respondents (88%) reported that their clinic prescribed buprenorphine, but the vast majority (95%) reported that buprenorphine was “rarely/never” prescribed at their site. About 68% reported that when it was prescribed, it was on a case-by-case basis. Approximately 86% of respondents indicated that people do not choose buprenorphine due to the additional personal expense. Qualitative responses reflected the perception that the cost of the medication was the primary barrier to wider adoption by individuals served. According to the authors of this study, “Qualitative responses generated by program staff communicated concern that ‘clients can barely pay $12 a day to dose with self-pay, $2 with Medicaid, and $8 with Medicare. Why would they be able to pay $16+ for alternative medications?’ They added that ‘$28 more per week’ adds up to ‘$1,400 more per year’ and that this additional expense would ‘hinder their ability to provide food and shelter’ and interfere with their ability to cover ‘transportation, childcare, and additional medical expenses.’ Their overwhelming position is that the cost passed on to the client makes it a prohibitive option based on current reimbursement strategies.”

According to a study of 359 individuals receiving methadone at publicly funded clinics in Florida, 26% reported taking buprenorphine at some time in the past, and the majority of these reported they ceased taking it (namely Suboxone) due to the price or limitations of their insurance (particularly Medicaid). Only 5.3% of buprenorphine prescriptions in Florida are funded by Medicaid, giving Florida the third lowest share of buprenorphine prescriptions funded by Medicaid out of all 50 states and the District of Columbia. Nationwide, on average, Medicaid covers about 24% of buprenorphine prescriptions. Another recent study compared the rate of past-year opioid abuse or dependence (using combined 2009 to 2012 restricted-use NSDUH data) among Floridians ages 12 and older (7.7 per 1,000) to the maximum number of individuals who could be treated with buprenorphine in Florida (4.2 per 1,000) and found buprenorphine is potentially available to only about half of the people who might need it.

SAMHSA publishes a list of doctors in Florida who are waivered per the Drug Addiction Treatment Act of 2000 (DATA 2000) to treat opioid use disorders with buprenorphine and who have opted to be publicly listed. Of those doctors listed, only about half are accepting new clients. Therefore, this list has limited utility for individuals seeking services and analysts attempting to gauge system-wide capacity. Notwithstanding these limitations, the number of DATA 2000 waivered and publicly listed physicians with 30 patients increased from 43 in 2002 to 213 in 2016. There were no physicians with 100 patients from 2002 to 2006. In 2007, there were 122 such physicians. The number reached a nadir in 2011 with only 44 physicians and then rebounded back up to 124 in 2015 and 101 in 2016. The total number of waivered Florida physicians listed publicly on SAMHSA’s site is half the number of physicians listed on the www.suboxone.com site maintained by Indivior, Inc. (314 vs. 626). Unfortunately, neither of these resources provides information on the number and location of individuals who are currently being prescribed buprenorphine for opioid use disorders. However, according to a recent analysis of Florida pharmacy claims for buprenorphine formulations (without an FDA indication for treatment of pain) from 2010-2013, the median monthly census among Florida prescribers is 11 individuals. The interquartile range, which describes the range of individuals treated by the middle 50% of the distribution of prescribers, is between 4 and 30 individuals. During this period, waivered physicians were restricted to treating up to 30 individuals concurrently, or after a year, up to 100 individuals upon request (the cap was recently increased to 275). This analysis reveals that Florida prescribers, similar to their counterparts in the rest of the country, tend to treat below regulatory limits.

Finally, research shows that only 40% of individuals that experience an opioid-related hospitalization receive any follow-up services within 30 days. Only 10.7% of individuals receive the recommended combination of both medication and a therapeutic service. These findings only apply to individuals with private insurance, many of whom face obstacles in accessing care as documented in other ways. For example, an analysis of pharmacy claims for individuals with commercial insurance through Florida Blue Cross Blue Shield (BCBS) found that only 29% of BCBS members with an opioid use disorder received medication-assisted treatment in 2016. Post-discharge care coordination is undoubtedly even more challenging for individuals without insurance.
Compared to the use of psychosocial interventions alone, methadone or buprenorphine maintenance is more likely to retain individuals in treatment and reduce heroin use and the use of pharmaceutical opioids. At adequate doses, methadone prevents or reverses withdrawal symptoms and blocks the euphoric effects of heroin. A meta-analysis of eleven randomized clinical trials involving 1,969 heroin dependent participants found that methadone maintenance was more effective than non-pharmacological approaches (placebo medication, drug-free treatment, detoxification, or wait-list control) at retaining individuals in treatment and reducing heroin use (as measured by self-reports and urine/hair analysis).\textsuperscript{40} However, at fixed medium or high doses, buprenorphine appears to be just as effective as methadone in retaining people in treatment and suppressing illicit opioid use.\textsuperscript{41}

With regard to interventions for individuals who are dependent on pharmaceutical opioids (as opposed to heroin), a meta-analysis of six randomized controlled trials involving 607 participants found that maintenance treatment with buprenorphine is more effective than detoxification or psychological treatment (e.g., counseling). This analysis also found that methadone maintenance and buprenorphine maintenance are equally effective at keeping individuals in treatment and reducing opioid use.\textsuperscript{42} Methadone maintenance and buprenorphine maintenance produce consistently superior results compared to short-term withdrawal protocols and dose tapering regimens.\textsuperscript{43}

Researchers analyzed 1,612 opioid users engaged in services funded through Florida’s Access to Recovery grant from 2004 to 2007. They found that 95% of participants engaged in methadone maintenance were retained in care and 100% of participants engaged in buprenorphine maintenance were retained in care, compared to only 58% of participants engaged in nonmaintenance services (psychosocial counseling and/or recovery support services). Additionally, the vast majority (94%) of participants retained in methadone maintenance treatment reported abstinence from opioids. Similar figures for individuals in buprenorphine maintenance were not published due a small number of cases and missing data.\textsuperscript{44}

Methadone and buprenorphine maintenance are the most effective ways to decrease the illicit use of opioids and reduce the risk of overdose. Research shows that the risk of fatal overdoses is at least cut in half when individuals are enrolled in maintenance treatment for opioid dependence.\textsuperscript{45} According to the largest cohort study published to date, individuals who receive only psychological support experience twice the risk of fatal opioid overdose compared to individuals who receive methadone or buprenorphine.\textsuperscript{46} Furthermore, community-level analysis shows that there is a strong and statistically significant association between increases in the number individuals on buprenorphine maintenance and decreases in heroin-related overdose deaths.\textsuperscript{47} Methadone or buprenorphine treatment for opioid-dependent injecting drug users also reduces injecting use and the sharing of injecting equipment. It is also associated with reductions in the proportion of injecting drug users reporting exchanges of sex for drugs or money. The reductions in these risk behaviors translate into reductions in cases of HIV infection.\textsuperscript{48}

These findings are also supported by the most recently published systematic review and meta-analysis of cohort studies. Researchers analyzed all-cause and overdose mortality rates during periods in and out of treatment using 19 cohort studies involving 122,885 individuals treated with methadone and buprenorphine. Time spent in methadone treatment was associated with an average reduction of 25 deaths per 1,000 person years. Mortality risk among opioid users during methadone treatment was less than a third of that expected in the absence of treatment, with the greatest difference observed in deaths from overdose. Buprenorphine maintenance is probably also effective at reducing mortality. Mortality risk while in buprenorphine maintenance treatment (about 4 deaths per 1,000 person years) is less than the mortality risk in the first four weeks after stopping treatment (32 deaths per 1,000 person years).\textsuperscript{49}


Substance Abuse and Mental Health Services Administration. (2017). *Past Year Opioid Use and Abuse or Dependence, and Not Received Treatment at a Specialty Facility and Opioid Abuse or Dependence in Past Year Annual Averages Based on 2003-2006, 2007-2010, and 2011-2014*. Provided by Jonaki Bose (NSDUH Branch Chief) and Deepa Avula (SAMHSA).


Substance Abuse and Mental Health Services Administration. (2016). *Number of DATA-Certified Physicians – Florida*.


Planning Steps

Quality and Data Collection Readiness

Narrative Question:

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

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

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

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

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

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

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

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

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

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

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

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

4. If not, what changes will the state need to make to be able to collect and report on these measures?

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

Footnotes:
Quality and Data Collection Readiness

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

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

Florida’s state data system, SAMHIS, collects data submitted through monthly batch upload from the managing entities, each with their own local data systems. Data are maintained at the state level in a distributed (rather than a centralized) architecture. The monthly file uploads include a client demographic file that is the parent record for all other files, a mental health admission and discharge file, a substance abuse admission and discharge file, a detox admission and discharge file, periodic Functional Assessment Rating Scale files, periodic ASAM placement files, client specific service event file, and a non-client specific service event file. The data dictionary for the specific data elements included in each of these files is available at the following location: www.myflfamilies.com/service-programs/substance-abuse/pamphlet-155-2-v12. The primary key that is unique for each record is a combination of the client, managing entity, and provider identifiers. Client specific data are available at the managing entity, provider, and program levels. Prevention data has historically been maintained in a separate system.

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

SAMHIS is limited Department-funded mental health and substance abuse services. It does not currently include Medicaid data. Currently available data has limited ability to perform invoice reconciliation and SAMHIS does not link to third party liability payor systems. Data from over 300 behavioral health providers is submitted through a variety of means to seven regional managing entities that compile and format all the data for their catchment area and submit monthly files to SAMHIS. The data elements and file parameters are defined in Pamphlet 155-2.

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

Data reported in SAMHIS is at the individual client level. Enhancements to the data system have improved the Department’s ability to uniquely identify individuals that received Department funded services. Florida is not currently able to report on any draft measures that require post-discharge follow-up. Florida is also not currently able to collect and report on the high blood pressure and diabetes measures for individuals with serious mental illness. Furthermore, many of these measures appear to be prevalence estimates that actually use population-level data from nationwide surveillance systems, not individual-level data from service records. This is particularly the case for the prevention measures, most of which are reported at the population-level. SAMHSA should clarify if they expect all of the variables in these measures to be incorporated into each state’s client-level service records or if they expect states to access population-level surveys or insurance claim databases.

If not, what changes will the state need to make to be able to collect and report on these measures?

The funding that would be required to conduct post-discharge follow-up surveys might be a barrier. Also, Florida is not currently able to access private insurance claim databases. Specific technical assistance needs might need to be identified once these measures are articulated in more detail.

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

At this time, no technical assistance is needed.
### Table 1 Priority Areas and Annual Performance Indicators

<table>
<thead>
<tr>
<th>Priority #</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Priority Area:</td>
<td>Funding Priorities Identified by Managing Entities</td>
</tr>
<tr>
<td>Priority Type:</td>
<td>SAT, MHS</td>
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<tr>
<td>Population(s):</td>
<td>SMI, SED, PWWDC, PWID, EIS/HIV</td>
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</table>

**Goal of the priority area:**
Address Unmet Needs Identified by Managing Entities

**Objective:**
1. Draft and submit a legislative budget request to fund new outpatient and residential substance abuse treatment services;
2. Draft and submit a legislative budget request to fund expanded access to methadone and buprenorphine maintenance treatment;
3. Draft and submit a legislative budget request to fund recovery support services and recovery support system enhancements;
4. Draft and submit a legislative budget request to fund care coordination activities for individuals waiting for admission to or discharge from a State Mental Health Treatment Facility, high utilizers of acute care services, parents/caregivers of children involved in the child welfare system, and for individuals involved in the criminal justice system.

**Strategies to attain the objective:**
Ensure that legislative budget requests are data-driven, compelling, and derived from a collaborative approach.

#### Annual Performance Indicators to measure goal success

<table>
<thead>
<tr>
<th>Indicator #:</th>
<th>1</th>
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<tbody>
<tr>
<td>Indicator:</td>
<td>The number of objectives achieved.</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
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</tr>
<tr>
<td>First-year target/outcome measurement:</td>
<td>Achieve two out of the five objectives.</td>
</tr>
<tr>
<td>Second-year target/outcome measurement:</td>
<td>Achieve four out of the five objectives.</td>
</tr>
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**Data Source:**
Legislative budget requests are written documents.

**Description of Data:**
Legislative budget requests are written documents.

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

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<thead>
<tr>
<th>Priority #</th>
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<tr>
<td>Priority Area:</td>
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<td>Priority Type:</td>
<td>MHS</td>
</tr>
<tr>
<td>Population(s):</td>
<td>SMI</td>
</tr>
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**Goal of the priority area:**
Reduce the number of readmissions to acute levels of care among adults with SMI.

**Objective:**
Reduce the number of readmissions to acute levels of care among adults with SMI served in acute levels of care.

**Strategies to attain the objective:**
After discharge from an acute level of care, establish linkages to supportive, community-based services, like outpatient treatment, supported housing, and supported employment.

### Annual Performance Indicators to measure goal success

<table>
<thead>
<tr>
<th>Indicator #: 1</th>
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<tbody>
<tr>
<td>Indicator: The rate readmissions (within 30 days following discharge) to crisis stabilization units among adults with SMI served in crisis stabilization units.</td>
</tr>
<tr>
<td>Baseline Measurement: In FY 16-17, the rate of readmissions (within 30 days following discharge) to crisis stabilization units among adults with SMI served in crisis stabilization units was 15.6%.</td>
</tr>
<tr>
<td>First-year target/outcome measurement: Reduce the readmission rate to 14.6% in FY 17-18.</td>
</tr>
<tr>
<td>Second-year target/outcome measurement: Reduce the readmission rate to 13.6% in FY 18-19.</td>
</tr>
<tr>
<td>Data Source: Substance Abuse and Mental Health Information System (SAMHIS)</td>
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<tr>
<td>Description of Data: This is the total number of persons readmitted within 30 days following discharge from a CSU divided by the total number of CSU discharges. The total number of consumers should be unduplicated. The number of consumers served is across regions and across providers.</td>
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<td>Data issues/caveats that affect outcome measures:</td>
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<tbody>
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<tr>
<td>Priority Type: MHS</td>
</tr>
<tr>
<td>Population(s): SED</td>
</tr>
<tr>
<td>Goal of the priority area: Increase well-being among children served by Community Action Teams (CATs)</td>
</tr>
<tr>
<td>Objective: Increase the percentage of children served by Community Action Teams (CATs) that show improvement in well-being from admission to discharge.</td>
</tr>
<tr>
<td>Strategies to attain the objective: Work with DCF regional staff that manage DCF’s contracts with the MEs to identify opportunities for improvement and best practices.</td>
</tr>
</tbody>
</table>

### Annual Performance Indicators to measure goal success

<table>
<thead>
<tr>
<th>Indicator #: 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator: The percentage of children served by Community Action Teams (CATs) that show improvement in well-being from admission to discharge.</td>
</tr>
<tr>
<td>Baseline Measurement: In FY 16-17, 61% of children served by CATs showed improvement in well-being from admission to discharge.</td>
</tr>
<tr>
<td>First-year target/outcome measurement: Increase the percentage of children served by CATs that show improvement in well-being from admission to discharge to 63%.</td>
</tr>
<tr>
<td>Second-year target/outcome measurement: Increase the percentage of children served by CATs that show improvement in well-being from admission to discharge to 65%.</td>
</tr>
<tr>
<td>Data Source: This information will be reported directly by the CATs.</td>
</tr>
</tbody>
</table>
Description of Data:

This measure is derived from the North Carolina Family Assessment Scale for Reunification.

Data issues/ caveats that affect outcome measures:

Priority #: 4
Priority Area: Early Serious Mental Illness
Priority Type: MHS
Population(s): ESMI

Goal of the priority area:

Increase access to services for ESMI.

Objective:

(1) Increase access to services for ESMI by drafting and submitting a legislative budget request to fund new coordinated specialty care programs to address early mental illness and first episodes of psychosis; (2) Draft a report summarizing the activities and outcomes associated with the programs currently funded by the Block Grant ESMI set-aside; (3) Implement one new coordinated specialty care program to address early mental illness and first episodes of psychosis using state funds.

Strategies to attain the objective:

Designate a SAMH employee to take ownership of these objectives.

Annual Performance Indicators to measure goal success

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

Data Source:

The Block Grant Coordinator will report progress toward the objectives.

Data issues/ caveats that affect outcome measures:

Priority #: 5
Priority Area: Care Coordination
Priority Type: MHS
Population(s): SMI

Goal of the priority area:

Expedite community reintegration.

Objective:

Increase the 30-day discharge rate.

Strategies to attain the objective:

Designate a SAMH employee to take ownership of these objectives.
After a State Mental Health Treatment Facility identifies a person as ready for discharge to community-based care, the State Mental Health Treatment Facility and managing entities must work closely to ensure the timely transfer.

### Annual Performance Indicators to measure goal success

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator:</td>
<td>The percent of persons discharged from a State Mental Health Treatment Facility within 30 days of being ready to seek community placement.</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
<td>In FY 16-17, 51.7% of persons were discharged from a State Mental Health Treatment Facility within 30 days of being ready to seek community placement.</td>
</tr>
<tr>
<td>First-year target/outcome measurement:</td>
<td>Increase the indicator to 53.7% by FY 17-18.</td>
</tr>
<tr>
<td>Second-year target/outcome measurement:</td>
<td>Increase the indicator to 55.7% by FY 18-19.</td>
</tr>
</tbody>
</table>

**Data Source:**

The seeking placement list.

**Description of Data:**

Numerator includes all persons discharged from a civil State Mental Health Treatment Facility who were on the seeking placement list for more than 30 days; Denominator includes all persons discharged that were on the seeking placement list.

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

Priority #: 6

**Priority Area:** Housing

**Priority Type:** SAT, MHS

**Population(s):** Other (Homeless)

**Goal of the priority area:**

Improve housing.

**Objective:**

1. The Housing Coordination Guidance Document will be revised to clarify and standardize the roles, responsibilities, and expectations associated with the ME Housing Coordinators;
2. All 7 ME Housing Coordinators will publish Department-approved strategic plans;
3. All seven ME Housing Coordinators will implement at least one recommendation for addressing gaps identified in the strategic plan;
4. All seven ME Housing Coordinators will facilitate at least one training event per year with providers on accessing permanent, supportive housing.

**Strategies to attain the objective:**

The Executive Director of the Office on Homelessness and members of the Policy Team within the Office of SAMH will collaborate with the ME Housing Coordinators and monitor progress toward the objectives.

### Annual Performance Indicators to measure goal success

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator:</td>
<td>The number of objectives achieved.</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
<td>Zero objectives achieved.</td>
</tr>
<tr>
<td>First-year target/outcome measurement:</td>
<td>Two out of the four objectives will be achieved.</td>
</tr>
<tr>
<td>Second-year target/outcome measurement:</td>
<td>Three out of the four objectives will be achieved.</td>
</tr>
</tbody>
</table>

**Data Source:**

The Block Grant Coordinator will report progress toward all objectives.

**Description of Data:**

Annual Performance Indicators to measure goal success
Reports, plans, and recommendations will all be in the form of written documents.

Data issues/caveats that affect outcome measures:

Priority #: 7
Priority Area: Services for Pregnant Women and Women with Dependent Children
Priority Type: SAT
Population(s): PWWDC

Goal of the priority area:
Improve outreach activities for pregnant women.

Objective:
Increase the percent of women served through the Department’s special funding allocation that are pregnant when they are engaged in services.

Strategies to attain the objective:
Analyze and describe current outreach activities that target pregnant women with substance use disorders. Analyze and describe current referral sources and processes that link pregnant women with substance use disorders to treatment. Generate a series of recommendations on ways to improve outreach and recruitment activities through revisions to contracts, training materials, guidance documents, or monitoring tools. Draft a legislative budget request for state funding to enhance outreach services for pregnant women with substance use disorders based on the findings from the analyses of outreach activities and referrals sources/processes.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: The percent of women served through the Department’s special funding allocation that are pregnant when they are engaged in services.
Baseline Measurement: Only 22% of women served through the Department’s special funding allocation are pregnant when they are engaged in services.
First-year target/outcome measurement: Increase the indicator to 24% for FY 17-18.
Second-year target/outcome measurement: Increase the indicator to 26% for FY 18-19.
Data Source: The reporting instrument that monitors the Department’s special appropriation for PWWDC.
Description of Data:
Numerator is the number of women served who are pregnant. The denominator is the number of all women served.

Data issues/caveats that affect outcome measures:

Priority #: 8
Priority Area: Prevention Training and Technical Assistance
Priority Type: SAP
Population(s): PP

Goal of the priority area:
Increase prevention workforce in Florida.

Objective:
Increase the knowledge, skills, and abilities of the prevention workforce in Florida.
Strategies to attain the objective:
Survey providers to identify needs and incorporate content in DCF’s contracts with training providers.

### Annual Performance Indicators to measure goal success

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>The number of prevention-related trainings and webinars conducted.</td>
</tr>
<tr>
<td>Baseline Measurement</td>
<td>In FY 16-17, 4 prevention trainings/webinars were conducted.</td>
</tr>
<tr>
<td>First-year target/outcome measurement</td>
<td>Conduct a total of 2 prevention trainings/webinars by June 30, 2018.</td>
</tr>
<tr>
<td>Second-year target/outcome measurement</td>
<td>Conduct a total of 4 prevention trainings/webinars by June 30, 2019.</td>
</tr>
</tbody>
</table>

Data Source:
The FADAA contract manager.

Description of Data:
Prevention trainings/webinars will be clearly identified by the topic addressed.

Data issues/caveats that affect outcome measures:

---

Priority #: 9

Priority Area: Overdose Prevention

Priority Type: SAP

Population(s): PP, PWID

Goal of the priority area:
Reduce the number of opioid overdose deaths.

Objective:
Increase the number of individuals trained in overdose recognition and response.

Strategies to attain the objective:
The Department’s Overdose Prevention Coordinator will stimulate demand for naloxone training by partnering with state agencies and organizations to increase awareness about the opportunity to receive overdose recognition and response training from the Department. Receiving overdose prevention training is also a Department requirement prior to receiving naloxone kits.

### Annual Performance Indicators to measure goal success

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>The number of individuals trained in overdose recognition and response.</td>
</tr>
<tr>
<td>Baseline Measurement</td>
<td>1,400 individuals were trained in FY 16-17.</td>
</tr>
<tr>
<td>First-year target/outcome measurement</td>
<td>Train an additional 1,400 individuals in FY 17-18.</td>
</tr>
<tr>
<td>Second-year target/outcome measurement</td>
<td>Train an additional 1,400 individuals in FY 18-19.</td>
</tr>
</tbody>
</table>

Data Source:
Data will be reported by the Department's Overdose Prevention Coordinator.

Description of Data:
The Department's Overdose Prevention Coordinator documents the number of individuals trained through sign-in sheets at each training. Evaluations are also conducted at each naloxone training and are utilized as a quality improvement measure.

Data issues/caveats that affect outcome measures:
Priority #: 10
Priority Area: Infectious Disease Control and Services for People Who Inject Drugs
Priority Type: SAT
Population(s): PWID, EIS/HIV

Goal of the priority area:
Reduce the spread of infectious diseases.

Objective:
(1) Publish an analysis of the number of HIV tests conducted per HIV EIS set-aside dollar expended among all HIV EIS set-aside-funded providers in Florida; (2) Publish at least three recommendations regarding ways to improve the cost-effectiveness of Florida HIV EIS set-aside-funded programs; (3) Implement at least one of the three recommendations.

Strategies to attain the objective:
The Block Grant Coordinator will collaborate with the managing entities on the analysis and recommendations.

Annual Performance Indicators to measure goal success

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

Data Source:
The Block Grant Coordinator will report progress toward the objectives.

Description of Data:
Analyses and recommendations are written documents.

Data issues/caveats that affect outcome measures:

Priority #: 11
Priority Area: Infectious Disease Control and Services for People Who Inject Drugs
Priority Type: SAT
Population(s): PWID, EIS/HIV, TB

Goal of the priority area:
Reduce the spread of infectious diseases.

Objective:
OBJECTIVES: (1) Collaborate with the Department of Health on an analysis of communities where untreated behavioral health disorders constitute a barrier to adherence to HIV treatment; (2) Conduct an analysis of access to medication-assisted treatment among individuals with opioid use disorders who inject; (3) Publish at least 3 recommendations regarding how to improve behavioral health treatment services for individual who inject; (4) Implement at least one of the three recommendations.

Strategies to attain the objective:
Collaborate with the Department of Health.
Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: The number of objectives achieved.
Baseline Measurement: Zero objectives achieved.
First-year target/outcome measurement: Two objectives achieved.
Second-year target/outcome measurement: Three objectives achieved.

Data Source:
The Block Grant Coordinator will report progress toward the objectives.

Description of Data:
Analyses and recommendations are written documents.

Data issues/ caveats that affect outcome measures:

Priority #: 12
Priority Area: Expanding access to medication-assisted treatment.
Priority Type: SAT
Population(s): PWWDC, PWID

Goal of the priority area:
Expand access to medication-assisted treatment.

Objective:
(1) Draft new contract provisions designed to ensure that all Department-funded behavioral health treatment providers have referral mechanisms in place to link individuals with opioid use disorders to MAT providers; (2) Incorporate the provisions into the Department’s contract with the managing entities; (3) Draft revisions to the Department’s licensure rules to require that MAT providers have overdose prevention plans that address access to naloxone.

Strategies to attain the objective:
The Block Grant Coordinator will collaborate with other teams as necessary.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: The number of objectives achieved.
Baseline Measurement: Zero objectives achieved.
First-year target/outcome measurement: Achieve one out of three objectives.
Second-year target/outcome measurement: Achieve two out of three objectives.

Data Source:
The Block Grant Coordinator will report progress toward the objectives.

Description of Data:
Contracts and licensure rules are written documents.

Data issues/ caveats that affect outcome measures:
### Table 2 State Agency Planned Expenditures [SA]

Planning Period Start Date: 7/1/2017   Planning Period End Date: 6/30/2019

<table>
<thead>
<tr>
<th>Activity (See instructions for using Row 1.)</th>
<th>A. Substance Abuse Block Grant</th>
<th>B. Mental Health Block Grant</th>
<th>C. Medicaid (Federal, State, and Local)</th>
<th>D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), SAMHSA, etc.)</th>
<th>E. State Funds</th>
<th>F. Local Funds (excluding local Medicaid)</th>
<th>G. Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention* and Treatment</td>
<td>$74,254,144</td>
<td>$0</td>
<td>$0</td>
<td>$103,896,657</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>a. Pregnant Women and Women with Dependent Children**</td>
<td>$4,000,000</td>
<td>$0</td>
<td>$0</td>
<td>$10,000,000</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>b. All Other</td>
<td>$70,254,144</td>
<td>$0</td>
<td>$0</td>
<td>$93,896,657</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>2. Primary Prevention</td>
<td>$27,394,940</td>
<td>$0</td>
<td>$0</td>
<td>$1,117,513</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>a. Substance Abuse Primary Prevention</td>
<td>$27,394,940</td>
<td>$0</td>
<td>$0</td>
<td>$1,117,513</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>b. Mental Health Primary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Tuberculosis Services</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>5. Early Intervention Services for HIV</td>
<td>$5,559,049</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>6. State Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Other 24 Hour Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Ambulatory/Community Non-24 Hour Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Administration (Excluding Program and Provider Level)</td>
<td>$1,700,622</td>
<td>$0</td>
<td>$0</td>
<td>$2,421,069</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>10. SubTotal (1,2,3,4,9)</td>
<td>$81,513,815</td>
<td>$0</td>
<td>$0</td>
<td>$106,317,726</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>11. SubTotal (5,6,7,8)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>12. Total</td>
<td>$108,908,755</td>
<td>$0</td>
<td>$0</td>
<td>$107,435,239</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

\* Prevention other than primary prevention

** The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.
## Table 2 State Agency Planned Expenditures [MH]

Planning Period Start Date: 7/1/2017  Planning Period End Date: 6/30/2019

<table>
<thead>
<tr>
<th>Activity (See instructions for using Row 1.)</th>
<th>A. Substance Abuse Block Grant</th>
<th>B. Mental Health Block Grant</th>
<th>C. Medicaid (Federal, State, and Local)</th>
<th>D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)</th>
<th>E. State Funds</th>
<th>F. Local Funds (excluding local Medicaid)</th>
<th>G. Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention and Treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Pregnant Women and Women with Dependent Children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. All Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Primary Prevention</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>a. Substance Abuse Primary Prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Mental Health Primary*</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>3. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)**</td>
<td>$3,339,471</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>4. Tuberculosis Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Early Intervention Services for HIV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. State Hospital</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>7. Other 24 Hour Care</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$12,687,034</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>8. Ambulatory/Community Non-24 Hour Care</td>
<td>$31,160,966</td>
<td>$0</td>
<td>$7,683,697</td>
<td>$78,853,701</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>9. Administration (Excluding Program and Provider Level)</td>
<td>$2,494,063</td>
<td>$0</td>
<td>$0</td>
<td>$314,799</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>10. SubTotal (1,2,3,4,9)</td>
<td>$0</td>
<td>$2,494,063</td>
<td>$0</td>
<td>$0</td>
<td>$314,799</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>11. SubTotal (5,6,7,8)</td>
<td>$0</td>
<td>$34,500,437</td>
<td>$0</td>
<td>$7,683,697</td>
<td>$91,540,735</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>12. Total</td>
<td>$0</td>
<td>$36,994,500</td>
<td>$0</td>
<td>$7,683,697</td>
<td>$91,855,534</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMH or children with SED
** Column 9B should include Early Serious Mental Illness programs funded through MHBG set aside
### Planning Tables

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

<table>
<thead>
<tr>
<th></th>
<th>Aggregate Number Estimated In Need</th>
<th>Aggregate Number In Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant Women</td>
<td>0</td>
<td>423</td>
</tr>
<tr>
<td>Women with Dependent Children</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Individuals with a co-occurring M/SUD</td>
<td>0</td>
<td>20871</td>
</tr>
<tr>
<td>Persons who inject drugs</td>
<td>0</td>
<td>6483</td>
</tr>
<tr>
<td>Persons experiencing homelessness</td>
<td>0</td>
<td>4472</td>
</tr>
</tbody>
</table>

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

SAMHSA only publishes a limited number of state-level estimates on the number of individuals in need of treatment. Estimates for these measures are published according to age group, but not according to priority population status. NSDUH is capable of producing state-level estimates for priority populations, but this requires access to the Restricted-use Data Analysis System (RDAS). According to the most recent correspondence with Carol Place (SAMHDA Help Desk Coordinator), state officials might be able to access the RDAS "later this summer." The 2016 TEDS Admissions Report does not identify women with dependent children.

**Footnotes:**

## Planning Tables

### Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2017    Planning Period End Date: 9/30/2019

<table>
<thead>
<tr>
<th>Expenditure Category</th>
<th>FFY 2018 SA Block Grant Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention and Treatment</td>
<td>$80,486,421</td>
</tr>
<tr>
<td>2. Primary Substance Abuse Prevention</td>
<td>$22,756,120</td>
</tr>
<tr>
<td>3. Early Intervention Services for HIV*</td>
<td>$5,569,030</td>
</tr>
<tr>
<td>4. Tuberculosis Services</td>
<td>$0</td>
</tr>
<tr>
<td>5. Administration (SSA Level Only)</td>
<td>$2,569,030</td>
</tr>
<tr>
<td><strong>6. Total</strong></td>
<td><strong>$111,380,601</strong></td>
</tr>
</tbody>
</table>

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

**Footnotes:**
* Tuberculosis Services in the State of Florida are administered through the Florida Department of Health.
**$2,520,000 of Substance Abuse Prevention and Treatment and $480,000 of Primary Substance Abuse Prevention dollars listed above are planned expenditures for Table 6 Resource Development.
### SABG Primary Prevention Planned Expenditures

**Planning Period Start Date:** 10/1/2017  
**Planning Period End Date:** 9/30/2019

<table>
<thead>
<tr>
<th>Strategy</th>
<th>IOM Target</th>
<th>FY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Information Dissemination</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Universal</td>
<td></td>
<td>$534,628</td>
</tr>
<tr>
<td>Selective</td>
<td></td>
<td>$267,313</td>
</tr>
<tr>
<td>Indicated</td>
<td></td>
<td>$89,104</td>
</tr>
<tr>
<td>Unspecified</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>$891,045</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Universal</td>
<td></td>
<td>$4,410,672</td>
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<tr>
<td>Selective</td>
<td></td>
<td>$2,205,336</td>
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<tr>
<td>Indicated</td>
<td></td>
<td>$735,112</td>
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<tr>
<td>Unspecified</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>$7,351,120</td>
</tr>
<tr>
<td><strong>Alternatives</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Universal</td>
<td></td>
<td>$534,628</td>
</tr>
<tr>
<td>Selective</td>
<td></td>
<td>$267,313</td>
</tr>
<tr>
<td>Indicated</td>
<td></td>
<td>$89,104</td>
</tr>
<tr>
<td>Unspecified</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>$891,045</td>
</tr>
<tr>
<td><strong>Problem Identification and Referral</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Universal</td>
<td></td>
<td>$2,138,508</td>
</tr>
<tr>
<td>Selective</td>
<td></td>
<td>$1,069,253</td>
</tr>
<tr>
<td>Indicated</td>
<td></td>
<td>$356,418</td>
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<tr>
<td>Unspecified</td>
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<td>$0</td>
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<tr>
<td><strong>Total</strong></td>
<td></td>
<td>$3,564,179</td>
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</tbody>
</table>

---

**SA Block Grant Award**

Printed: 8/16/2017 2:54 PM - Florida - OMB No. 0930-0168  Approved: 06/12/2015  Expires: 09/30/2020
<table>
<thead>
<tr>
<th>Community-Based Process</th>
<th>Universal</th>
<th>$5,479,926</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Selective</td>
<td>$2,739,963</td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td>$913,320</td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$9,133,209</strong></td>
</tr>
<tr>
<td>Environmental</td>
<td>Universal</td>
<td>$267,313</td>
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<tr>
<td></td>
<td>Selective</td>
<td>$133,657</td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td>$44,552</td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td>$0</td>
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<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$445,522</strong></td>
</tr>
<tr>
<td>Section 1926 Tobacco</td>
<td>Universal</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Selective</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Other</td>
<td>Universal</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Selective</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>$0</td>
</tr>
</tbody>
</table>

| **Total Prevention Expenditures** | $22,276,120 |
| **Total SABG Award**             | $111,380,601 |

**Planned Primary Prevention Percentage** 20.00%

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

**Footnotes:**
The total for Table 5a of $22,276,120 plus the total amount for the Prevention column on Table 6 of $480,000 should equal the total for Row.
2. Primary Prevention on Table 4 of $22,756,120.
### Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2017  Planning Period End Date: 9/30/2019

<table>
<thead>
<tr>
<th>Activity</th>
<th>FY 2018 SA Block Grant Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal Direct</td>
<td>$7,083,806</td>
</tr>
<tr>
<td>Universal Indirect</td>
<td>$6,281,866</td>
</tr>
<tr>
<td>Selective</td>
<td>$6,682,836</td>
</tr>
<tr>
<td>Indicated</td>
<td>$2,227,612</td>
</tr>
<tr>
<td><strong>Column Total</strong></td>
<td><strong>$22,276,120</strong></td>
</tr>
<tr>
<td><strong>Total SABG Award</strong>*</td>
<td><strong>$111,380,601</strong></td>
</tr>
<tr>
<td><strong>Planned Primary Prevention Percentage</strong></td>
<td><strong>20.00 %</strong></td>
</tr>
</tbody>
</table>

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

**Footnotes:**
The total for Table 5b of $22,276,120 plus the total amount for the Prevention column on Table 6 of $480,000 should equal the total for Row 2, Primary Prevention on Table 4 of $22,756,120.
## Planning Tables

### Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2017  Planning Period End Date: 9/30/2019

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

<table>
<thead>
<tr>
<th>Targeted Populations</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Students in College</td>
<td>b</td>
</tr>
<tr>
<td>Military Families</td>
<td>é</td>
</tr>
<tr>
<td>LGBT</td>
<td>b</td>
</tr>
<tr>
<td>American Indians/Alaska Natives</td>
<td>é</td>
</tr>
<tr>
<td>African American</td>
<td>è</td>
</tr>
<tr>
<td>Hispanic</td>
<td>è</td>
</tr>
<tr>
<td>Homeless</td>
<td>è</td>
</tr>
<tr>
<td>Native Hawaiian/Other Pacific Islanders</td>
<td>è</td>
</tr>
<tr>
<td>Asian</td>
<td>è</td>
</tr>
<tr>
<td>Rural</td>
<td>b</td>
</tr>
<tr>
<td>Underserved Racial and Ethnic Minorities</td>
<td>è</td>
</tr>
</tbody>
</table>
Table 6 Categories for Expenditures for System Development/Non-Direct-Service Activities

Planning Period Start Date: 10/1/2017  Planning Period End Date: 9/30/2019

<table>
<thead>
<tr>
<th>Activity</th>
<th>A. MHBG</th>
<th>B. SABG Treatment</th>
<th>C. SABG Prevention</th>
<th>D. SABG Combined*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information Systems</td>
<td>$0</td>
<td>$1,335,600</td>
<td>$297,600</td>
<td>$0</td>
</tr>
<tr>
<td>2. Infrastructure Support</td>
<td>$250,000</td>
<td>$252,000</td>
<td>$14,400</td>
<td>$0</td>
</tr>
<tr>
<td>3. Partnerships, community outreach, and needs assessment</td>
<td>$0</td>
<td>$327,600</td>
<td>$62,400</td>
<td>$0</td>
</tr>
<tr>
<td>4. Planning Council Activities (MHBG required, SABG optional)</td>
<td>$52,000</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>5. Quality Assurance and Improvement</td>
<td>$0</td>
<td>$352,800</td>
<td>$48,000</td>
<td>$0</td>
</tr>
<tr>
<td>6. Research and Evaluation</td>
<td>$251,509</td>
<td>$100,800</td>
<td>$9,600</td>
<td>$0</td>
</tr>
<tr>
<td>7. Training and Education</td>
<td>$0</td>
<td>$151,200</td>
<td>$48,000</td>
<td>$0</td>
</tr>
<tr>
<td>8. Total</td>
<td>$553,509</td>
<td>$2,520,000</td>
<td>$480,000</td>
<td>$0</td>
</tr>
</tbody>
</table>

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

**Footnotes:**
Based on Managing Entity reporting for previous year.
Environmental Factors and Plan

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

Narrative Question
1. The Health Care System, Parity and Integration

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

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

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care. SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders. The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

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

Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes. SMHAs and SSAs may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations. Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.

One key population of concern is persons who are dually eligible for Medicare and Medicaid. Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible. SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who
experience health insurance coverage eligibility changes due to shifts in income and employment. Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider. SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment. Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

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

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues. Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA’s National Behavioral Health Quality Framework includes core measures that may be used by providers and payers. SAMHSA recognizes that certain jurisdictions receiving block grant funds ? including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs. However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.


29 http://www.samhsa.gov/health-disparities/strategic-initiatives


40 BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs, 2014; 33(4): 700-707


Please respond to the following items in order to provide a description of the healthcare system and integration activities:

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

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

BBBC: BBBC continually moves providers in the direction of integration of mental health and primary health care. Some providers have contracted with local health providers to have a behavioral health professional in their setting and others had health providers in the mental health agencies.

SEFBHN: SEFBHN allows the service providers to ensure a holistic approach in providing treatment for the individuals they serve. Two of our larger behavioral health providers (New Horizons of the Treasure Coast and The Jerome Golden Center) have primary care clinics on site in addition to Memorandums of Understanding (MOU) with Federally Qualified Health Centers (FQHC). Our smaller providers have MOU’s with Federally Qualified Health Centers. It also noted the providers complete health assessments as part of the bio-psychosocial assessment which in turn is used to develop a treatment plan with the individual being served. Additional physical health conditions are monitored for individuals receiving Medication Management services. Their vital, BMI, height and weight are monitored and based on findings they will be referred to primary health care clinic – whether it is on or off-site. Providers will also assist individuals including the parents of minors, in applying for benefits – (Medicaid and Medicare) and in finding a medical home when it is determined they have limited access to primary health care. SEFBHN also employs a SOAR specialist who provides training and technical assistance to our providers on the use of SOAR, thus having a wide ranging impact on the number of individuals who will receive these benefits.

LSFH: Many network service providers deliver an array of services that include both substance abuse and mental health services,
enabling them to address the treatment needs of individuals with co-occurring disorders. Two of our largest providers, Meridian Behavioral Healthcare and Lifestream Behavioral Healthcare, have on-site primary care clinics in one or more locations to integrate behavioral and primary health care. Other providers have agreements with the local Federally Qualified Health Clinics to coordinate the provision of primary and behavioral health care. LSFHS provides a Template for MOUs with FQHCs to aid the network service providers in securing these MOUs.

SFBHN: Since 2014, SFBHN has had a Primary Care/Behavioral Health Integration Committee. The Committee meets to discuss issues surrounding health/behavioral health integration resources and challenges. The Healthcare Integration Committee’s mission is to promote the development of integrated primary and behavioral health services to better address the overall wellness and holistic care needs of individuals, whether seen in behavioral health or primary care provider settings. SFBHN stresses to its providers the importance of primary care integration for the consumers of services. Contract language with the providers requires integration practices that are monitored by the SFBHN CQI Team. SFBHN providers range along a continuum from separate systems and practices to enhanced coordination and collaboration among providers usually involving care or case managers, to co-located care with providers sharing the same office or clinic, and for a few SFBHN providers, to fully integrated care where all providers function as a team to provide joint treatment planning. All providers are striving toward the optimum integrated care goals.

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

BBHC: As a result of receiving a grant from the Health Foundation of South Florida, BBHC has initiated a Health Integration Learning Community. The initial grant was for planning, and BBHC is now in the implementation phase. Selected behavioral health providers in the network have paired with an FQHC or tax-assisted hospital to serve individuals in a holistic manner through sharing clients, electronic health records, and working as a team to address both the primary care and behavioral health needs. It is anticipated that improved outcomes will be achieved through this collaborative effort.

CFCHS: In some of the network provider’s acute care settings, they provide family practice physicians and ARNP’s to evaluate and treat medical conditions and refer to aftercare for follow-up. In substance abuse and mental health residential settings, some providers have both nursing and physician services to monitor medications and identify medical issues. This includes children’s residential facilities, where a physician and a psychiatrist is assigned to every child while they are in the program. The physicians work together to ensure all the needs of the client are covered. When a child is in need of services that are outside of what the doctors can provide, the client is referred out to a specialist. Doctors work with the Director of Nursing to obtain updates on all services the clients are receiving. FACT teams coordinate and ensure appropriate medical, dental and vision services for each person served by the FACT program. This includes individuals with co-occurring mental health and substance use disorders. FACT has developed extensive resources and relationships with healthcare providers in both Brevard and Osceola Counties. This includes: local primary care physicians, Brevard Health Alliance, and the Florida Department of Health in Osceola County. FACT works with the current healthcare providers of each person served or helps the individual find a primary care provider of his/her choice. The FACT team obtains releases of information from the person served to enable the staff to communicate directly with the designated healthcare providers. This collaboration is essential because many of those served by the FACT team have complicated medical problems, often due to years of neglect, substance abuse, or non-compliance with medical treatments in the past. Medical treatments and appointments for each person served is recorded on the person’s schedule and when necessary a FACT staff is assigned to accompany the person to scheduled medical appointments. Any medical conditions requiring ongoing monitoring and treatment are also included on the person’s recovery plan. In cases where funding is an issue, FACT incidental funds may be utilized to ensure healthcare and medication needs are met. Case managers assist in maximizing insurance benefits, setting appointments, transporting and accompanying clients to appointments, following-up on future appointments, and assisting with medication / filling prescriptions. Over the past several years, providers have been attempting to increase communication with clients’ primary care physicians. Providers have MOUs with local Health Care Centers, Orange Blossom Family Health, Winnie Palmer Hospital, etc. Some providers even have primary care clinics embedded in their behavioral health outpatient clinics. Those primary care clinics also serve as intake centers for persons with suspected behavioral health concerns. One network provider reported that their agency promotes the “co-located” model of care whenever possible for mental health, physical health and substance abuse services. For example, they have a relationship with their local FQHC to provide on-site services for residential patients, and other consumers suffering from severe mental illness. Regarding co-occurring disorders, their plan over the last several years has also been to integrate services when possible. As an example, 70% of their CSU patients have a co-occurring disorder. That is addressed by providing efficient access to detox protocols as well as therapeutic co-occurring groups for these patients. Another network provider is part of the Children’s Advocacy Center, which provides a coordinated response to concerns for child abuse that includes medical providers who complete medical evaluations and medical records reviews to ensure not only assessment of child abuse but coordinated care to ensure medical and mental health issues are addressed. Child Advocates connect families to any needed providers to ensure physical and mental health needs are met. That includes connecting families to The Healing Tree to address the impact of child abuse. A complete biopsychosocial evaluation of all participating family members seen at the agency assesses for physical, mental health and substance abuse related needs. They refer to local FQHCs for unmet physical health needs, as well as referring families to their primary care doctors when appropriate. This particular agency provides
evidence-based treatment using a family systems model that addresses the symptoms of the abuse, provides psychoeducation and aids families in supporting their children for a stronger future and reduced long-term consequences of child abuse. If substance abuse issues require further evaluation or specific treatment, we refer families to organizations in the community who specialize in such treatment and then work in a coordinated fashion with those organizations if treatment is occurring in tandem with the work we do with the family at the agency.

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

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

BB CBC: CBC uses several strategies to foster integrated systems of care including sharing of training resources, attending and/or facilitating integration and alliance meetings in the counties and circuits to continually share the message of integration, and through regular monitoring and when needed corrective action plans.

SEFBHN: SEFBHN emphasizes the need for integrated treatment for individuals who have a mental health diagnosis and a substance abuse disorder and has been working with providers to ensure that they are assessing for co-occurring disorders and that they address it through a comprehensive array of services necessary to help clients heal physically, mentally, and emotionally. While our providers understand the validity of assessing and treating co-occurring disorders, it will require them to increase their skill sets as many have traditionally treated only one aspect of a client’s needs – the mental health disorder or the substance abuse disorder. This need to address co-occurring disorder will become particularly important as we implement recent statutory requirements for the provision of acute care through Designated Receiving Systems using a No Wrong Door Practice Model. Providers will need to be prepared to minimally triage and stabilize any individual brought to their facilities regardless of their area of specialization. With that said SEFBHN does have providers (Counseling and Recovery Center, New Horizons of the Treasure Coast, Wayside House and Drug Abuse Foundation) who have primarily treated substance use disorders but are also treating individuals with co-occurring disorders. Services include residential treatment, intensive outpatient therapies, intervention and outreach. SEFBHN also contracts with a provider (The Jerome Golden Center) for an evidence-based, licensed Level II Residential Treatment Facility specifically for adults with concurrent psychiatric and substance abuse diagnoses funded through a legislative appropriation. The program is a short-term (30- to 90-day) structured living environment, and provides residential integrated services where both disorders are primary and treated by one team simultaneously. The program targets individuals experiencing difficulty functioning within the community, as well as individuals who are at risk of being admitted to the state hospital. Funding is provided through a special legislative appropriation and is reimbursed on a daily rate that is inclusive for all services. The program utilizes an evidence-based curriculum for Integrated Combined Therapies, which includes aspects of Motivational Enhancement Therapy (MET), Cognitive Behavioral Therapy, and Twelve Step Facilitation. The therapeutic groups are designed to help enhance residents’ communication and coping skills, develop a relapse prevention plan, and strengthen the daily living skills necessary for their successful functioning in the community.

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

SBFHN: As part of SBFHN’s work towards integration, network providers complete a self-assessment and develop an action plan on an annual basis. These integration activities are incorporated into the agency’s Annual Quality Assurance/Improvement Plans. Agencies’ progress on these activities is monitored through the SBFHN CQI Department. SBFHN has also added contract language that requires network providers to have an MOU with an FQHC. Providers are required to track referrals to the FQHC and document those linkages.

CFBHN: CFBHN provides technical assistance and support for direct service providers. There are ongoing collaboration and training with care providers to enhance treatment for co-occurring mental health and substance abuse issues. Programmatic staff facilitate technical assistance for providers to improve access to quality co-occurring treatments they provide. Staff also frequently have discussions about the most effective means of utilizing funds when it comes to organizations that are balancing limited resources with the needs of persons with a co-occurring disorders.

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

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

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

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

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

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

- Florida Department of Health in Osceola County. MHRC works with the current healthcare providers of each person served or providers in both Brevard and Osceola Counties. This includes: local primary care physicians, Brevard Health Alliance, and the Florida Department of Health in Osceola County. MHRC coordinates and ensures appropriate medical, dental and vision services for each person served by the FACT program. This includes individuals with other services needed or seen as a critical part of the client’s success plan, payment for these services are first explored with funder (CFCHS) to determine if it is an approved incidental expense or if an in-network provider can be utilized from alternative ME funds. Options for mental health and substance abuse services are also explored with local providers, several of which are member agencies of the local CoC. For Prevention education programs at the school, integrated SAMH services are inherent to the program structure, however appropriate open communication is maintained with the host schools to ensure co-occurring substance abuse and mental health concerns are adequately addressed, whether they are presented at referral from the school or arise during prevention education/counseling sessions provided by the Eckerd program.

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

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

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

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

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

- Community Counseling Center of Central Florida - We work with those that we have releases of info to coordinate benefits to make sure all parties are able to bill for appropriate services delivered and prioritized according to safety, need, court order etc.

- Community Treatment Center - Our counselors use a mix of Cognitive Behavior Therapy with a Motivationally Enhanced Treatment approach along with evidence based practices. Our comprehensive, continuous, integrated system of care is recovery oriented, and trauma informed to help identify where the client is and assists to create interventions for motivation and positive behavioral changes. We use cognitive behavior therapy techniques to implement how their thoughts and feelings play a fundamental role in their behavior. Clients often experience thoughts or feelings that reinforce or compound their faulty beliefs. To combat these destructive thoughts and behaviors, we begin by helping the client to identify the problematic beliefs. It is important for the clients to learn how thoughts, feelings and situations can contribute to maladaptive behaviors. We then look at the actual behaviors that are contributing to the problem.

- Mental Health Resource Center - By design, MHRC FACT teams are co-occurring capable. MHRC coordinates and ensures appropriate medical, dental and vision services for each person served by the FACT program. This includes individuals with co-occurring mental health and substance use disorders. MHRC has developed extensive resources and relationships with healthcare providers in both Brevard and Osceola Counties. This includes: local primary care physicians, Brevard Health Alliance, and the Florida Department of Health in Osceola County. MHRC works with the current healthcare providers of each person served or helps the individual find a primary care provider of his/her choice. The FACT team obtains releases of information from the person served to enable the staff to communicate directly with the designated healthcare providers. This collaboration is essential because many of those served by the FACT team have complicated medical problems, often due to years of neglect, substance abuse, or non-compliance with medical treatments in the past. Medical treatments and appointments for each person served is recorded on the person’s schedule and when necessary a FACT staff is assigned to accompany the person to scheduled medical appointments. Any medical conditions requiring ongoing monitoring and treatment are also included on the person’s recovery plan. In cases where funding is an issue, FACT incidental funds may be utilized to ensure healthcare and medication needs are
Aspire Health Partners - Aspire has a full continuum of substance use disorder and mental health treatment. All services are capable of identifying the individual needs of the client through our assessment process. All clinical staff are trained in the identification and treatment of mental illness and underlying substance use disorders as well as substance use manifested due to a mental illness. We employ both psychiatrists and addictionologists physicians who are highly skilled in the practice of treating co-occurring disorders. Aspire's training department provides ongoing training for both clinicians and other staff in the identification and treatment of co-occurring disorders.

LifeStream Behavioral Center - LSBC serves as the health home for its consumers offering both medical and MSHA services in a holistic integrated setting using a common EHR and team approach. Referrals are made from both primary and behavioral health services. An interdisciplinary care coordination team meets weekly to review cases and discuss coordinated treatment plans and outcomes.

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

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

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

6. Do the behavioral health providers screen and refer for:
   a) Prevention and wellness education
   b) Health risks such as
      i) heart disease
      ii) hypertension
      viii) high cholesterol
      ix) diabetes
   c) Recovery supports

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

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services?

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions? The Department is not in a position to identify problems facing the implementation and enforcement of parity provisions.

10. Does the state have any activities related to this section that you would like to highlight?
    Not at this time.
    Please indicate areas of technical assistance needed related to this section
    None.

Footnotes:
Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities, Healthy People, 2020, National Stakeholder Strategy for Achieving Health Equity, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS).

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

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

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA’s and HHS’s attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health 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 SM; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

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

48 http://www.thinkculturalhealth.hhs.gov
51 http://www.whitehouse.gov/omb/fedreg/race-ethnicity
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, LGBT, and age?
   
   a) Race
   
   b) Ethnicity
   
   c) Gender
   
   d) Sexual orientation
   
   e) Gender identity
   
   f) Age

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

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

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

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

6. Does the state have a budget item allocated to identifying and remedialing disparities in behavioral health care?

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

   Please indicate areas of technical assistance needed related to this section

Footnotes:
Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, the 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 behavioral health systems and services.

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

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. NREPP 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. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework. For each intervention reviewed, NREPP publishes a report called a program profile on this website. You will find research on the effectiveness of programs as reviewed and rated by NREPP certified reviewers. Each profile contains easily understandable ratings for individual outcomes based on solid evidence that indicates whether a program achieved its goals. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

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

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

SAMHSA's Treatment Improvement Protocol Series (TIPS) are best practice guidelines for the SUD treatment. The CSAT 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 Informating Transformation (KIT) was developed to help move the latest information available on effective behavioral health 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 behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and
training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

56 http://psychiatryonline.org/
57 http://store.samhsa.gov
58 http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf

Please respond to the following items:

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

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

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

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

Footnotes:
Environmental Factors and Plan

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 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 outcome 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.

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). NIMH sponsored a set of studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP (the RAISE model). 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 CSC model, and have been shown to improve symptoms, reduce relapse, and improved outcomes.

State shall expend not less than 10 percent of the 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 SM I.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)?
2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI?
   If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.
   Providers that receive ESMI set-aside funds from the Department are NAVIGATE model of treatment, which is a form of comprehensive, coordinated, specialty care recommended by SAMHSA.
3. How does the state promote the use of evidence-based practices for individuals with a ESM I and provide comprehensive individualized treatment or integrated mental and physical health services?
   The Block Grant coordinator shares training and technical assistance events and resources with Florida's network of ESMI set-aside funded providers.
4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with a ESM I?
5. Does the state collect data specifically related to ESMI?
6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI?
7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESM I. The NAVIGATE program description has not been recently updated. A detailed description of the NAVIGATE program is available at the following location: http://navigateconsultants.org/how-it-works/.
8. Please describe the planned activities for FFY 2018 and FFY 2019 for your state's ESMI programs including psychosis?
(1) Increase access to services for ESMI by drafting and submitting a legislative budget request to fund new coordinated specialty care programs to address early mental illness and first episodes of psychosis;

(2) Draft a report summarizing the activities and outcomes associated with the programs currently funded by the Block Grant ESMI set-aside;

(3) Implement one new coordinated specialty care program to address early mental illness and first episodes of psychosis using state funds.

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

The Department collects and reports data from ESMI set-aside-funded providers as requested by SAMHSA in Block Grant Reports. The Department plans to draft a report summarizing the activities and outcomes associated with these programs, as noted in the list of objectives above.

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

Diagnostic criteria for mental illnesses are identified in the DSM-V. Providers exclude individuals whose symptoms are substance-induced or due to general medical conditions.

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

No at this time.

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

None.

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

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP 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, family relationships, and treatments are part of a written plan that is consistent with the person’s needs and desires.

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

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

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.
The Department, through our regional managing entities, utilizes several modalities to engage consumers and caregivers. These modalities allow for enhanced communication and assistance in making health care decisions.

By virtue of being team-based, Family Intensive Treatment (FIT) and Florida Assertive Community Treatment (FACT), are able to provide multiple avenues to engage the consumer. Wraparound is predicated on “Family Voice and Choice” in directing the planning process. SOAR enhances financial stability for the consumer, which further empowers their ability to make decisions. Whole Health Action Management (WHAM) and Wellness Recovery Action Plan (WRAP) are both developed by the consumer – recognizing that they know what treatments and supports will work best for them.

In addition to 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 consumers and their family members. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly.

Most notably, the Department has begun incorporating the Recovery Oriented Systems of Care (ROSC) framework throughout the state. The guiding principles of ROSC heavily focus on person-centered decision-making and an established network of peer support, education and advocacy.

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

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

Please indicate areas of technical assistance needed related to this section.
No.

Footnotes:
**Environmental Factors and Plan**

6. **Self-Direction - Requested**

Narrative Question

In self-direction - also known as self-directed care - a service user or "participant" controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. While this is not an allowable use of Block Grant Funds, the practice has shown to provide flexible supports for an individual's service. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual's traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines. The participant is encouraged to think creatively about setting goals and is given a significant amount of freedom to work toward those goals. Purchases can range from computers and bicycles to dental care and outpatient mental health treatment.

Typically, a specially trained coach or broker supports the participant to identify resources, chart progress, and think creatively about the planning and budgeting processes. Often a peer specialist who has received additional training in self-direction performs the broker role. The broker or a separate agency assists the participant with financial management details such as budget tracking, holding and disbursing funds, and hiring and payroll logistics. Self-direction arrangements take different forms throughout the United States and are housed and administered in a variety of entities, including county and state behavioral health authorities, managed care companies, social service agencies, and advocacy organizations.

Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. Hallmarks of self-direction include voluntary participation, individual articulation of preferences and choices, and participant responsibility. In recent years, physical and mental health service systems have placed increasing emphasis on person-centered approaches to service delivery and organization. In this context, self-direction has emerged as a promising practice to support recovery and well-being for persons with mental health conditions. A small but growing evidence base has documented self-direction's impact on quality of life, community tenure, and psychological well-being.

Please respond to the following items:

1. Does your state have policies related to self-direction?  
   - Yes
   - No

2. Are there any concretely planned initiatives in our state specific to self-direction?  
   - Yes
   - No

If yes, describe the currently planned initiatives. In particular, please answer the following questions:

a) How is this initiative financed?

b) What are the eligibility criteria?

c) How are budgets set, and what is the scope of the budget?

d) What role, if any, do peers with lived experience of the mental health system play in the initiative?

e) What, if any, research and evaluation activities are connected to the initiative?

f) If no, describe any action steps planned by the state in developing self-direction initiatives in the future.

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

Please indicate areas of technical assistance needed to this section.

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**Footnotes:**
Environmental Factors and Plan

7. Program Integrity - Required

Narrative Question

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

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

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

Please respond to the following items:

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

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

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

   No.

   Please indicate areas of technical assistance needed to this section

   No technical assistance is need at this time.

Footnotes:
Environmental Factors and Plan

8. 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\(^{59}\) 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.

\(^{59}\) http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?
   The Department recently sent formal letters to the leaders of the two federally-recognized tribes in Florida requesting consultations. The Department is currently still awaiting a response.

2. What specific concerns were raised during the consultation session(s) noted above?
   Consultations have been requested but not yet conducted.
   Does the state have any activities related to this section that you would like to highlight?
   No.
   Please indicate areas of technical assistance needed to this section
   None.

Footnotes:
Environmental Factors and Plan

9. Primary Prevention - Required SABG

Narrative Question

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

- **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;
- **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- **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;
- **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

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

Please respond to the following items

**Assessment**

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)?

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

3. Does your state collect needs assessment data that include analysis of primary prevention needs for the following population groups? (check all that apply)
   - Children (under age 12)
   - Youth (ages 12-17)
   - Young adults/college age (ages 18-26)
   - Adults (ages 27-54)
   - Older adults (age 55 and above)
   - Cultural/ethnic minorities
   - Sexual/gender minorities
   - Rural communities
   - Others (please list)
4. Does your state use data from the following sources in its Primary prevention needs assessment? (check all that apply)
   - Archival indicators (Please list)
   - National survey on Drug Use and Health (NSDUH)
   - Behavioral Risk Factor Surveillance System (BRFSS)
   - Youth Risk Behavioral Surveillance System (YRBS)
   - Monitoring the Future
   - Communities that Care
   - State - developed survey instrument
   - Others (please list)

5. Does your state use needs assessment data to make decisions about the allocation SABG primary prevention funds?
   - Yes
   - No

If yes, (please explain)
Needs assessment data helps the state determine what training and technical assistance activities will be funded. Some managing entities also use needs assessment data when making decisions about which services to fund.

If no, (please explain) how SABG funds are allocated:

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

Please indicate areas of technical assistance needed related to this section:
None.
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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- **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- **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;
- **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
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### Capacity Building

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

   If yes, please describe

   There are two types of prevention certifications available for the prevention workforce in Florida. The Certified Prevention Specialist (CPS) credential is an entry-level credential for individuals who provide prevention-related services in the area of addiction only. The CPS requires a minimum of a high school diploma or general equivalency degree. The Certified Prevention Professional (CPP) 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.

   Pursuant to section 65D-30.013 of the Florida Administrative Code, the Department also issues Level 1 and Level 2 licenses to organizations for prevention services. The Level 1 license is for services typically directed at the general population or specific subpopulations. The Level 2 license is for services typically directed toward individuals manifesting effects of specific risk factors for substance abuse.

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

   If yes, please describe mechanism used

   The Department provides training and technical assistance to the prevention workforce through a contract with the Florida Alcohol and Drug Abuse Association, through the Block Grant Coordinator upon request, and through SAMHSA’s Center for the Application of Prevention Technologies.

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

   If yes, please describe mechanism used

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

   No.

   Please indicate areas of technical assistance needed related to this section

   None.
Narrative Question

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

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

- **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;

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

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

- **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;

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

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

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

**Planning**

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

   If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan.

   Florida's 5 Year Strategic Plan for Prevention is attached.

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

3. Does your state's prevention strategic plan include the following components? (check all that apply):
   - a) Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
   - b) Timelines
   - c) Roles and responsibilities
   - d) Process indicators
   - e) Outcome indicators
   - f) Cultural competence component
   - g) Sustainability component
   - h) Other (please list):
   - i) Not applicable/no prevention strategic plan

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

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

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

   The Department's EBP Workgroup is in the process of evaluating the current criteria. Currently, in order for a program, practice, or strategy to be considered an EBP, it must meet one of the following options:
Option One: The proposed program or strategy is recognized by a national registry of evidence-based programs and strategies as one that is appropriate for the identified outcome. It is important to note that inclusion within a registry does not reflect a program’s effectiveness. Programs need to be reviewed for the intended target population, demographics, setting, and the research results for each program outcome. Additionally, the rating provided to the program by the registry must be considered prior to selection. Programs deemed not effective or inconclusive should not be selected. The National Registry of Evidence-Based Programs and Practices (NREPP), Blueprints for Healthy Youth Development, the Office of Juvenile Justice and Delinquency Prevention Model Programs Guide, and the National Institute of Justice’s www.CrimeSolutions.gov are all approved registries.

Option Two: The proposed program or strategy is reported in peer-reviewed journals or has documented effectiveness which is supported by other sources of information and the consensus judgment of informed experts. When claiming this option, a provider must include the following:

1. A description of the theory of change and a logic model.

2. A discussion of how the content and structure of this proposed program or strategy is similar to programs or strategies that appear in approved registry or in the peer-reviewed literature, or how it is based on sound scientific principles of community prevention or public health.

3. Documentation that the program or strategy was effectively implemented in the past, with results that show a consistent pattern of credible and positive effects, including the number of times it was implemented, the fidelity with which it was implemented, and the results of any outcome evaluations.

4. 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.

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

Please indicate areas of technical assistance needed related to this section. None.
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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

### Implementation

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

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

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

   a) **Information Dissemination:**
      Social Media (Facebook, Twitter, YouTube), Media Campaigns (Safe Use, Safe Storage, Safe Disposal Campaign; Parents Who Host Lose the Most; Talk - They Hear You), Social Norms Campaigns (Friday Night Done Right, No One’s House), Safe Rx Flyer Distribution, Public Service Announcements, Health Fairs and other Health Promotion (conferences, meetings, seminars), and Information Lines/Hot Lines.
   b) **Education:**
   c) **Alternatives:**
Organized Youth Events, Recreation Centers, Youth and Family Support Groups, Drug Free Dances and Events, and Drug Free Youth (D-Fy) Events.

d) Problem Identification and Referral:
Student Assistance Programs, Brief Strategic Family Assessment, and Student Assessment and Referral.

e) Community-Based Processes:
Coalition and Provider Capacity Building, Community Assessment, Community Mobilization, Community Strategic Planning, Community and Volunteer Training, Recruitment and Engagement of Community Members, Multi-Agency Coordination and Collaboration, Town Hall Meetings, and Youth Coalition Training.

f) Environmental:

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

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 managing entities to specifically track which units are being billed under SABG dollars. The managing entities 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.

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

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

None.
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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

**Evaluation**

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years?  
   - Yes  
   - No
   
   If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan

2. Does your state’s prevention evaluation plan include the following components? (check all that apply):
   - Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
   - Includes evaluation information from sub-recipients
   - Includes SAMHSA National Outcome Measurement (NOMs) requirements
   - Establishes a process for providing timely evaluation information to stakeholders
   - Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
   - Other (please list:)
   
   - Not applicable/no prevention evaluation plan

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

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:
   - 30-day use of alcohol, tobacco, prescription drugs, etc
b) Heavy use
b) Binge use
b) Perception of harm
c) b) Disapproval of use
d) b) Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
e) e) Other (please describe):
Environmental Factors and Plan

10. Statutory Criterion for MHBG - Required MHBG

Narrative Question
Criterion 1: Comprehensive Community-Based Mental Health Service Systems
Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

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

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

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

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

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

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

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

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

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 provide the following services under comprehensive community-based mental health service systems?

a) Physical Health

  j  Yes  j  No
b) Mental Health
   jn Yes jn No

c) Rehabilitation services
   jn Yes jn No

d) Employment services
   jn Yes jn No

e) Housing services
   jn Yes jn No

f) Educational Services
   jn Yes jn No

g) Substance misuse prevention and SUD treatment services
   jn Yes jn No

h) Medical and dental services
   jn Yes jn No

i) Support services
   jn Yes jn No

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

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

Please describe as needed (for example, best practices, service needs, concerns, etc)
N/A

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

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

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

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

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

<table>
<thead>
<tr>
<th>Target Population (A)</th>
<th>Statewide prevalence (B)</th>
<th>Statewide incidence (C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Adults with SMI</td>
<td>3.6%</td>
<td>567,000</td>
</tr>
<tr>
<td>2. Children with SED</td>
<td>7.0%</td>
<td>146,949</td>
</tr>
</tbody>
</table>

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

The most recent state-level estimate of the prevalence of SMI among the non-institutionalized adult household population is based on 2014-2015 NSDUHs. This estimate is published by SAMHSA and retrieved from the following location: [www.samhsa.gov/data/sites/default/files/NSDUHsaeStateTabs2015B/NSDUHsaeSpecificStates2015.htm](http://www.samhsa.gov/data/sites/default/files/NSDUHsaeStateTabs2015B/NSDUHsaeSpecificStates2015.htm).

The most recent state-level estimate of the prevalence of SED among children is from 2015. This estimate was prepared by NRI for SAMHSA in 2016 and was retrieved from the following location: [wwwdasis.samhsa.gov/dasis2/urs/adult_smi_child_sed_prev_2015.xlsx](http://wwwdasis.samhsa.gov/dasis2/urs/adult_smi_child_sed_prev_2015.xlsx). According to the Federal Register (Vol. 62, No. 193), the prevalence of serious emotional disturbance (SED) among children and adolescents in Florida is between 7% and 13%. The figures reported in the table above rely on the lower limit of this range.

This information is occasionally used in conjunction with service figures to produce estimates of the extent to which individuals in need of services for SMI or SED are able to successfully access care.
## Narrative Question

**Criterion 3: Children’s Services**

Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include: social services; educational services, including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.

### Criterion 3

Does your state integrate the following services into a comprehensive system of care?

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
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</thead>
<tbody>
<tr>
<td>a)</td>
<td>Social Services</td>
<td>Yes</td>
</tr>
<tr>
<td>b)</td>
<td>Educational services, including services provided under IDEA</td>
<td>Yes</td>
</tr>
<tr>
<td>c)</td>
<td>Juvenile justice services</td>
<td>Yes</td>
</tr>
<tr>
<td>d)</td>
<td>Substance misuse prevention and SUD treatment services</td>
<td>Yes</td>
</tr>
<tr>
<td>e)</td>
<td>Health and mental health services</td>
<td>Yes</td>
</tr>
<tr>
<td>f)</td>
<td>Establishes defined geographic area for the provision of services of such system</td>
<td>Yes</td>
</tr>
</tbody>
</table>
**Narrative Question**

**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.

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**Criterion 4**

Describe your state's targeted services to rural and homeless populations and to older adults

**Rural Populations:**

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

One particular ME is also working with the Okeechobee County School System to implement services for SED youth and their families through a System of Care Expansion and Sustainability grant. Services include Wraparound Case Management and outpatient therapy, both school and home based. The use of incidental funding will also allow for additional services as identified by the family for their treatment plan. This program will also bring together community stakeholders (law enforcement, child welfare, juvenile justice, primary health care, behavioral health care etc.) to develop a strategic plan designed to create a truly collaborative system of care for vulnerable children and youth in this rural community. The System of Care Expansion and Sustainability grant will also be funding similar activities through three other MEs with significant rural populations.

**Homeless Populations:**

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

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

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

**Elderly Populations:**

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

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

Criterion 5

Describe your state's management systems.

State Financial Resources for Mental Health Service Providers:

In State Fiscal Year 2016, Florida spent $86,141,381 in state dollars on community mental health services for children and adults. This pays for a variety of services, include CAT teams, FACT teams, transitional beds, medications, and competency restoration services.

State Staffing for Mental Health Services Providers:

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

State Training for Mental Health Services Providers:

The Department requests training for mental health service providers through SAMHSA’s TA Tracker System or otherwise provides for these services through contracts. During FY 16-17, the Department worked 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 worked with the Florida Alcohol and Drug Abuse Association on webinars and workshops dealing with topics like Level of Care LOCUS CALOCUS Patient Placement, Treating the LQBT Community, Multidimensional Family Therapy, Trauma Informed Care for Women, DSM-V, Recovery Oriented Systems of Care, and First Episode Psychosis.

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

The Department requests training for providers of emergency mental health services through SAMHSA’s TA Tracker System or otherwise provides for these services through contracts. During FY 16-17, the Department worked 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.

How Florida Intends to Expend the Mental Health Block Grant:

Florida intends to expend $33,160,966 on ambulatory/community-based non-24-hour care and $2,494,063 on administration.
Environmental Factors and Plan

11. Substance Use Disorder Treatment - Required SABG

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

Criterion 1

Improving access to treatment services

1. Does your state provide:
   a) A full continuum of services
      i) Screening  
      ii) Education  
      iii) Brief Intervention  
      iv) Assessment  
      v) Detox (inpatient/social)  
      vi) Outpatient  
      vii) Intensive Outpatient  
      viii) Inpatient/Residential  
      ix) Aftercare; Recovery support  
   b) Are you considering any of the following:
      Targeted services for veterans  
      Expansion of services for:
         (1) Adolescents  
         (2) Other Adults  
         (3) Medication-Assisted Treatment (MAT)
Criterion 2

Criterion 2: Improving Access and Addressing Primary Prevention - See Narrative 9. Primary Prevention-Required SABG.
1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability?

2. Either directly or through and arrangement with public or private non-profit entities make pernatal care available to PWWDC receiving services?

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?

4. Does your state have an arrangement for ensuring the provision of required supportive services?

5. Are you considering any of the following:
   a) Open assessment and intake scheduling
   b) Establishment of an electronic system to identify available treatment slots
   c) Expanded community network for supportive services and healthcare
   d) Inclusion of recovery support services
   e) Health navigators to assist clients with community linkages
   f) Expanded capability for family services, relationship restoration, custody issue
   g) Providing employment assistance
   h) Providing transportation to and from services
   i) Educational assistance

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.

Managing entities conduct annual onsite monitoring of providers using established protocols and tools that address Block Grant regulations regarding pregnant women and women with dependent children.
**Criterion 4, 5 and 6**

**Persons Who Inject Drugs (PWID)**

1. Does your state fulfill the:
   a) 90 percent capacity reporting requirement
   b) 14-120 day performance requirement with provision of interim services
   c) Outreach activities
   d) Syringe services programs
   e) Monitoring requirements as outlined in the authorizing statute and implementing regulation

2. Are you considering any of the following:
   a) Electronic system with alert when 90 percent capacity is reached
   b) Automatic reminder system associated with 14-120 day performance requirement
   c) Use of peer recovery supports to maintain contact and support
   d) Service expansion to specific populations (military families, veterans, adolescents, older adults)

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

   Managing entities conduct annual onsite monitoring of providers using established protocols and tools that address Block Grant regulations regarding individuals who inject drugs.

**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?

2. Are you considering any of the following:
   a) Business agreement/MOU with primary healthcare providers
   b) Cooperative agreement/MOU with public health entity for testing and treatment
   c) Established co-located SUD professionals within FQHCs

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 maintain an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIC in areas that have the greatest need for such services and monitoring the service delivery?

2. Are you considering any of the following:
   a) Establishment of EIS-HIV service hubs in rural areas
   b) Establishment or expansion of tele-health and social media support services
   c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS

**Syringe Service Programs**
1. Does your state have in place an agreement to ensure that SABG funds are not expended to provide individuals with hypodermic needles or syringes (42 U.S.C § 300x-31(a)(1)?

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2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?

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<tr>
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<th>Yes</th>
<th>No</th>
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3. Do any of the programs use SABG funds to support elements of a Syringe Services Program?

<table>
<thead>
<tr>
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<th>Yes</th>
<th>No</th>
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If yes, please provide a brief description of the elements and the arrangement.
Criterion 8, 9 and 10: Service System Needs, Service Coordination, Charitable Choice, Referrals, Patient Records, and Independent Peer Review

Syringe System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state’s approach for improvement?

2. Are you considering any of the following:
   a) Workforce development efforts to expand service access
   b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services
   c) Establish a peer recovery support network to assist in filling the gaps
   d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities)
   e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations
   f) Explore expansion of service for:
      i) MAT
      ii) Tele-Health
      iii) Social Media Outreach

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care?

2. Are you considering any of the following:
   a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services
   b) Establish a program to provide trauma-informed care
   c) Identify current and perspective partners to be included in building a system of care, e.g. FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C. § 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)

2. Are you considering any of the following:
   a) Notice to Program Beneficiaries
   b) Develop an organized referral system to identify alternative providers
   a) Develop a system to maintain a list of referrals made by religious organizations

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs?

2. Are you considering any of the following:
   a) Review and update of screening and assessment instruments
   b) Review of current levels of care to determine changes or additions
c) Identify workforce needs to expand service capabilities

j n Yes j n No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background

j n Yes j n No

Patient Records

1. Does your state have an agreement to ensure the protection of client records?

j n Yes j n No

2. Are you considering any of the following:

a) Training staff and community partners on confidentiality requirements

j n Yes j n No

b) Training on responding to requests asking for acknowledgement of the presence of clients

j n Yes j n No

c) Updating written procedures which regulate and control access to records

j n Yes j n No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure

j n Yes j n 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?

j n Yes j n No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

At this point, 9 Block Grant subrecipients per year are selected to undergo an independent review.

3. Are you considering any of the following:

a) Development of a quality improvement plan

j n Yes j n No

b) Establishment of policies and procedures related to independent peer review

j n Yes j n No

c) Develop long-term planning for service revision and expansion to meet the needs of specific populations

j n Yes j n No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, e.g., Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds?

j n Yes j n 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. Are you considering 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. Are you considering 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

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, which govern the Mental Health and Substance Use Disorder Programs.

Environmental Factors and Plan

12. 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 2016-FFY 2017?

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

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

Footnotes:
Environmental Factors and Plan

13. Trauma - Requested

Narrative Question

Trauma is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive behavioral health care. States should work with these communities to identify interventions that best meet the needs of these residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing “business as usual.” These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma paper.

Footnotes:

60 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.

61 Ibid

Please respond to the following items

1. Does the state have a plan or policy for behavioral health providers that guide how they will address individuals with trauma-related issues?
   - Yes
   - No

2. Does the state provide information on trauma-specific assessment tools and interventions for behavioral health providers?
   - Yes
   - No

3. Does the state have a plan to build the capacity of behavioral health providers and organizations to implement a trauma-informed approach to care?
   - Yes
   - No

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?
   - Yes
   - No

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

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

14. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.62

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.63

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

63 http://csgjusticecenter.org/mental-health/

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to behavioral health services? jn Yes jn No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, behavioral health provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? jn Yes jn No

3. Does the state provide cross-training for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system? jn Yes jn No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address behavioral health and other essential domains such as employment, education, and finances? jn Yes jn No

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

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

Footnotes:

63 http://csgjusticecenter.org/mental-health/
15. Medication Assisted Treatment - Requested

Narrative Question
There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA approved medication treatment should have access to those treatments based upon each individual patient’s needs. In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate. SAMHSA is asking for input from states to inform SAMHSA’s activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders?  
   Yes  No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly, pregnant women?  
   Yes  No

3. Does the state purchase any of the following medication with block grant funds?  
   a) Methadone  
   b) Buprenorphine, Buprenorphine/naloxone  
   c) Disulfiram  
   d) Acamprosate  
   e) Naltrexone (oral, IM)  
   f) Naloxone  
   Yes  No

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately?  
   Yes  No

5. Does the state have any activities related to this section that you would like to highlight?  
Please indicate areas of technical assistance needed to this section.

*Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.

Footnotes:
Environmental Factors and Plan

16. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.64 SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA’s publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises65,

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response. Please check those that are used in your state:

64http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies-SMA14-4848

Please respond to the following items:

1. Crisis Prevention and Early Intervention
   a) Wellness Recovery Action Plan (WRAP) Crisis Planning
   b) Psychiatric Advance Directives
   c) Family Engagement
   d) Safety Planning
   e) Peer-Operated Warm Lines
   f) Peer-Run Crisis Respite Programs
   g) Suicide Prevention

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

3. Post Crisis Intervention/Support
   a) WRAP Post-Crisis
   b) Peer Support/Peer Bridges
c) Family to Family Engagement

d) Follow-up Outreach and Support

e) Connection to care coordination and follow-up clinical care for individuals in crisis

f) Follow-up crisis engagement with families and involved community members

g) Recovery community coaches/peer recovery coaches

h) Recovery community organization

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

Please indicate areas of technical assistance needed to this section.

Footnotes:
Environmental Factors and Plan

17. Recovery - Required

Narrative Question
The implementation of recovery supports and services are imperative for providing comprehensive, quality behavioral health 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 behavioral health treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making.

The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual’s mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, 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. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Clubhouses
- Drop-in centers
- Recovery community centers
- Peer specialist
- Peer recovery coaching
- Peer wellness coaching
- Peer health navigators
- Family navigators/parent support partners/providers
- Peer-delivered motivational interviewing
- Peer-run respite services
- Peer-run crisis diversion services
- Telephone recovery checkups
- Warm lines
- Self-directed care
- Supportive housing models
- Evidenced-based supported employment
- Wellness Recovery Action Planning (WRAP)
- Whole Health Action Management (WHAM)
- Shared decision making
- Person-centered planning
- Self-care and wellness approaches
- Peer-run Seeking Safety groups/Wellness-based community campaign
- Room and board when receiving treatment

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?  
   b) Required peer accreditation or certification?  
   c) Block grant funding of recovery support services.  
   d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state’s M/SUD system?

2. Does the state measure the impact of your consumer and recovery community outreach activity?

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

According to Chapter 65E.14, Florida Administrative Code, “recovery support services are are designed to support and coach an adult or child and family to regain or develop skills to live, work and learn successfully in the community. Services include substance abuse or mental health education, assistance with coordination of services as needed, skills training, and coaching. This Covered Service shall include clinical supervision provided to a service provider’s personnel by a professional qualified by degree, licensure, certification, or specialized training in the implementation of this service. For Adult Mental Health and Children’s Mental Health Programs, these services are provided by a Certified Family, Veteran, or Recovery Peer Specialist.”

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

According to Chapter 65E.14, Florida Administrative Code, “recovery support services are are designed to support and coach an adult or child and family to regain or develop skills to live, work and learn successfully in the community. Services include substance abuse or mental health education, assistance with coordination of services as needed, skills training, and coaching. This Covered Service shall include clinical supervision provided to a service provider’s personnel by a professional qualified by degree, licensure, certification, or specialized training in the implementation of this service…For Adult and Children’s Substance Abuse programs, these services may be provided by a certified Peer Recovery Specialist or trained paraprofessional staff subject to supervision by a Qualified Professional as defined in Rule 65D-30.002, F.A.C. These services exclude twelve-step programs such as Alcoholics Anonymous and Narcotics Anonymous.”

5. Does the state have any activities that it would like to highlight?

Recently, Florida’s System of Care Team received an Excellence in Community Communications and Outreach (ECCO) award. The Substance Abuse and Mental Health Services Administration (SAMHSA) ECCO Recognition Program showcases and celebrates the outstanding achievement of Comprehensive Community Mental Health Services for Children and Their Families Program grantees in the area of social marketing. There are eight categories and there were a total of 63 entries. The System of Care Team received a silver award in the category of Audience - Parents and Caregivers, for the development of a short video titled I Know You Love Me...But for parents and caregivers of youth and young adults with substance abuse and behavioral health conditions. The video features youth in recovery explaining strategies on how to best communicate with them. The youth explain that maintaining an open line of communication has a positive impact in their recovery process. The Federation of Families of Florida and the Palm Beach County Substance Awareness Coalition collaborated with SAMH on the project. Youth in substance abuse recovery were very involved in developing the video from writing the script, acting in the video, to editing. The youth presented the video at the 2016 Florida Behavioral Health Conference.

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

Footnotes:
Environmental Factors and Plan

18. 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 behavioral health 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 behavioral health 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.

Please respond to the following items

1. Does the state's Olmstead plan include:
   - housing services provided. [ ] Yes [ ] No
   - home and community based services. [ ] Yes [ ] No
   - peer support services. [ ] Yes [ ] No
   - employment services. [ ] Yes [ ] No

2. Does the state have a plan to transition individuals from hospital to community settings? [ ] Yes [ ] No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

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

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

Footnotes:
19. Children and Adolescents Behavioral Health Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.

According to data from the 2015 Report to Congress on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health 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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59 The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

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Please respond to the following items:

1. Does the state utilize a system of care approach to support:
   a) The recovery and resilience of children and youth with SED?
   b) The recovery and resilience of children and youth with SUD?

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address behavioral health needs:
   a) Child welfare?
   b) Juvenile justice?
   c) Education?

3. Does the state monitor its progress and effectiveness, around:
   a) Service utilization?
   b) Costs?
   c) Outcomes for children and youth services?

4. Does the state provide training in evidence-based:
   a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?
   b) Mental health treatment and recovery services for children/adolescents and their families?

5. Does the state have plans for transitioning children and youth receiving services:
   a) to the adult behavioral health system?
   b) for youth in foster care?

6. Does 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...
Family Intensive Treatment (FIT) teams have been piloted throughout the state to provide specialized treatment for parents with

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 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. As of state fiscal year 2017-18, Florida has implemented 26
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. Of the children served by CAT teams in FY 2014-2015, 87.5 percent were discharged and are living in their
communities. For FY 2015-2016, it was 86.6 percent.

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
primary substance use disorders who come in contact with the child welfare system and who have young children ages birth to eight. FIT is family focused and integrated across the child welfare, behavioral health and judicial systems. Treatment involves joint planning and case management by a team of professionals which include child welfare workers, alcohol and drug treatment professionals, court representatives, and medical professionals. There is cross training and collocation of services. They act as one treatment team with flexible spending, sharing data and accountability. Families are provided wraparound and comprehensive community services to address the multiple needs of parents and children, including parenting skills to increase protective capacity, mental health, health, child care, housing and other services.

Project LAUNCH is a five-year cooperative agreement funded by SAMHSA that seeks to improve the system of care serving children ages 0-8. The project goal is for all children to reach social, emotional, behavioral, physical, and cognitive milestones. Healthy growth in each of these areas builds the foundation for children to thrive in school and beyond. Florida Project LAUNCH, a partnership between the Florida Department of Children and Families and the Florida Department of Health, focuses on Lealman Corridor, an area consisting of five zip codes (33709, 33714, 33771, 33782, and 33781) in Pinellas County. The population of Lealman Corridor faces many early childhood developmental risk factors, such as limited services, high crime, substance use, domestic violence, and high rates of child maltreatment associated with substance use and unemployment. The population of this area also struggles with high rates of poverty, with 19% of individuals living at or below the poverty level. This backdrop creates a difficult environment for healthy child development. Florida Project LAUNCH intends to reduce substance use and other causal issues affecting families and existing child-care bodies so that they can better provide support and care for children.

Project LAUNCH supports two home visitors with Healthy Start of Pinellas County who deliver the Parents as Teachers Plus model to parents identified as having a history of substance use. Many children served over the course of the program have been substance exposed. HSCP receives additional funding from the Health and Human Services-funded Florida Maternal Infant and Early Childhood Home Visiting (MIECHV) initiative. Additional activities in 2017 include an advocacy program directed at improving practices at local birthing hospitals to ensure that appropriate standards of care for pregnant women in recovery and substance exposed newborns are followed.

Project LAUNCH also partners with Operation PAR, Inc, a substance abuse treatment provider in Pinellas County, to provide Nurturing Parenting groups to reduce abusive parenting practices. Among the target population are parents in recovery, some with substance exposed children. With HSCP, PAR is a partner on the local Substance Exposed Newborn Taskforce, which has recently developed an infant safety and care training for other child-serving professionals to improve care for substance exposed newborns. This training is currently offered by two Neonatal Intensive Care Nurses, limiting the training capacity. Project LAUNCH is funding a train-the-trainer to prepare an additional 20 professionals to deliver this training, which includes hands-on breakout sessions for safe sleep, soothing, safety planning, and long-term developmental concerns. In conjunction with this training, PAR will be developing information booklets for parents and other caregivers to ensure they have complete information about the challenges these infants will face across the lifespan. These booklets will be designed to increase understanding of care and safety during infancy and also the developmental challenges substance exposed newborns face as they grow and enter educational environments.

The Florida Healthy Transitions Program strives to achieve policy and funding changes at the state and local level to improve cross-system collaboration, service capacity and workforce expertise; create, implement and expand research-supported services and supports that are culturally competent and youth-guided; and provide for continuity of care between child and adult behavioral health systems, while involving family and community members in the process.

The managing entities and providers who serve older adolescents are expected to provide them with the necessary supports and skills in preparation for coping with life as a young adult and facilitate a smooth transition to the adult mental health system for continuing age-appropriate treatment services, provided they meet the target population for the publicly-funded adult mental health system. Behavioral health services and supports are tailored to address the developmental needs of adolescents and may include supportive housing, supported employment, peer mentoring and education about their behavioral health needs to support wellness management.

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. These services are typically provided within the children’s mental health system and include diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a).

Community-based care organizations are responsible for transition planning with youth served by child welfare, in accordance with the requirements of the Road to Independence. During the 2013 legislative session, the extended foster care bill was passed that allows youth aging out of foster care at age 18 to choose to remain in extended foster care until they turn 21, giving them the option to continue receiving support through this challenging time. The majority of youth served by child welfare receive behavioral health and primary health services through a Medicaid managed care child welfare specialty plan, through the age of 20. However, youth who age out of foster care are eligible for Medicaid until the age of 26, per the guidelines of the Affordable Care Act.

7. Does the state have any activities related to this section that you would like to highlight?
Please indicate areas of technical assistance needed related to this section.

Footnotes:
Environmental Factors and Plan

20. Suicide Prevention - Required MHBG

Narrative Question
Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges behavioral health 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 through the use of MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the behavioral health agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years?  
   Yes  No

2. Describe activities intended to reduce incidents of suicide in your state.
   The Department's Suicide Prevention Specialist and the Suicide Prevention Coordinating Council updated and distributed the Florida Suicide Prevention Plan 2016-2020, which contains additional details about suicide prevention initiatives (see the attachment). They also updated the suicide prevention website and calendar of suicide prevention related activities, held quarterly Suicide Prevention Coordinating Council meetings, assisted with Suicide Prevention Day at the Capitol and the Suicide Prevention Community Summit in Orlando. They are currently planning three additional Suicide Prevention Community Summits in Tallahassee, Tampa, and Fort Lauderdale. Created an awareness for national suicide prevention week 2017.

3. Have you incorporated any strategies supportive of Zero Suicide?  
   Yes  No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments?  
   Yes  No

5. Have you begun any targeted or statewide initiatives since the FFY 2016-FFY 2017 plan was submitted?  
   Yes  No

   If so, please describe the population targeted.
   The targeted populations are members of the military, veterans, and their families.

   Does the state have any activities related to this section that you would like to highlight?
   The Statewide Office for Suicide Prevention created the Service Military, Veterans, and their Families Peer Support Workgroup and Strategic Leadership Workgroup to focus on suicide prevention for service military, veterans, and their families. The Peer Support Workgroup meets monthly and the Leadership Workgroup meets quarterly.

   Please indicate areas of technical assistance needed related to this section.
   None.

Footnotes:
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Appendices

Appendix 1: Categories of organizations that responded to the 2015 Florida suicide prevention survey

Appendix 2: Map of the Department's Geographic Regions
I. Executive Summary

In 2001, the U.S. Surgeon General issued the National Strategy for Suicide Prevention (National Strategy) to launch an organized effort to prevent suicide across the nation. Updated in 2012, the National Strategy represented a new approach to enlisting all Americans in the effort to prevent suicide. In Florida, suicide prevention strategies are developed and implemented in partnership with the Statewide Office for Suicide Prevention (SOSP), the statutorily created Suicide Prevention Coordinating Council (Council), and local communities. The SOSP is administratively housed in the Department of Children and Families’ (Department) Office of Substance Abuse and Mental Health. The Florida Suicide Prevention Plan (Plan) is a joint effort of the Council and SOSP. Section 14.20195(a), F.S., requires the Council to advise the SOSP “regarding the development of a statewide plan for suicide prevention, with the guiding principle being that suicide is a preventable problem”.

In 2014, suicide was the second leading cause of death for individuals ages 25-34 and the third leading cause of death for ages 5-24 in Florida. The purpose of this Plan is to guide statewide efforts to decrease suicide related deaths through a framework of goals and objectives that coordinate suicide prevention efforts at the state and local community levels.

The Department’s mission is to:

- Work in Partnership with Local Communities to Protect the Vulnerable;
- Promote Strong and Economically Self-sufficient Families; and
- Advance Personal and Family Recovery and Resiliency.

To meet the Department’s mission, the SOSP has organized the Plan’s goals into four strategic directions similar to the National Strategy:

- Healthy and Empowered Individuals, Families, and Communities;
- Clinical and Community Preventive Services;
- Treatment and Support Services; and
- Surveillance, Research, and Evaluation.

The Plan describes suicide prevention initiatives at the state and local community levels that aim to decrease suicide related deaths. Suicide prevention initiatives implemented by local communities and a variety of stakeholders provide the foundation that moves Florida’s Plan forward. Section V of this document provides a list of suicide prevention activities and associated resources under each of the Plan’s goals to support statewide implementation by multiple stakeholders. Section V is also available in a brochure format in the Department’s website, at:

II. Current Status

Suicide was Florida’s 10th leading cause of death in 2014, with 2,961 individuals taking their own lives. On average, one Floridian dies by suicide every three hours, and over twice as many die by suicide as by homicide according to the American Foundation for Suicide Prevention. Graph 1 shows an upward trend in the suicide rate from 2005 to 2009. The trend fluctuates from 2009 to 2014. However, it has continually remained above the 2007 rate through 2014.

Graph 1. Suicide Rate per 100,000 Population, Florida (2004 - 2014)


Although suicide data is unavailable for certain populations in Florida, it’s essential to look at the 11 national high risk populations.

Individuals with mental and/or substance use disorders

Individuals with major depressive disorder, bipolar disorder, anxiety disorder, and schizophrenia are at higher risk for suicide. A 2009 to 2013 combined annual average shows that 120,000 adolescents had at least one major depressive disorder per year and 69% did not receive treatment in Florida. It also shows that approximately 525,000 adults had serious mental illnesses per year and 63.7% did not receive treatment.³

Alcohol and substance abuse is a risk factor for suicide; therefore, individuals with substance use disorders are also at high risk for suicide. A 2009 to 2013 combined annual average shows that approximately 124,000 adolescents in Florida reported that they used illicit drugs in the month prior to being surveyed.⁴ Although Florida does not currently report to the National

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Violent Death Reporting System, the CDC found that in 2010, 33.4% of individuals who died by suicide tested positive for alcohol, 23.8% for antidepressants, and 20.0% for opiates, including heroin and prescription pain killers.5

**Men in midlife and older men**

Florida 2013 data shows that the two highest suicide rates were among men at midlife and older men.6 The risk-related behaviors for men in midlife are underreporting of mental health problems, interpersonal violence, economic hardships, not seeking help, dissolution of intimate relationships, and risk factors similar to other age groups such as mental illness, substance abuse, and access to lethal means. The risks for older men are social disconnection, physical illness, functional decline, and mental disorders.

**Members of the Armed Forces and veterans**

As of September 2014, there were a total of 1,584,000 veterans living in Florida, and of that total 794,000 were over 65 years old.7 Although specific suicide data for Florida is unavailable, the Department of Defense reported in 2014, nationally there were 273 suicides for the active component and 170 suicides for the reserve component.8 The active component includes the Air Force, Army, Marine Corps, and Navy while the Reserve component includes Air Force Reserve, Army Reserve, Marine Corps Reserve, Air National Guard, and the Army National Guard. Additionally, the National Strategy states that veterans are approximately 20% of the U.S. suicide deaths as estimated by the Centers for Disease Control and Prevention (CDC).

**Lesbian, gay, bisexual, and transgender (LGBT) populations**

It’s imperative that Florida begins to collect data on LGBT populations due, in part to the fact that gay and bisexual men are at higher risk for suicide attempts before they turn 25 years old. According to a study reported by the CDC, seventh to 12th grade LGB students were more than twice as likely to attempt suicide compared to heterosexual students.9 Additionally, family-rejected LGB youth are 8.4 times as likely to have attempted suicide as LGB peers who reported no or low levels of family rejection.10

**American Indians/Alaska Natives**

Florida suicide data for American Indians/Alaska Natives is available for age-adjusted death rates per 100,000 populations from 2004 to 2010. This data shows that the suicide death rate for American Indians ages 18 to 85 years and older was 6.65. This rate was higher than the 5.30 death rate for all American Indian ages.11 Some risk factors for American Indians/Alaska

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Natives are alcohol and other substance use, discrimination, historical trauma, and limited access and use of mental health services.  

Individuals who have attempted suicide
There is no complete count of suicide attempts in Florida; however, the data shows that the total number of hospital discharges involving suicide and self-inflicted injury has continued to increase from 28,983 in 2007 to 52,391 in 2013. Nationally, females attempt suicide three times more often than males. 25:1 is the estimated ratio of youth suicide attempts to youth suicide deaths. According to research, future attempt reduction is possible if efforts to challenge isolation and provide follow-up support are available after a suicide attempt. 

Individuals bereaved by suicide
Future research is needed on individuals bereaved by suicide in Florida. Someone bereaved by suicide is similar to a survivor of suicide. The CDC defines a survivor as a family member or friend of a person who died by suicide. These individuals experience guilt, anger, abandonment, denial, helplessness, and shock. It is estimated that there are between six and 32 survivors per suicide.

Individuals with medical conditions
Due to various symptoms such as depression, suicide ideation, and level of pain, individuals with medical conditions such as cancers, degenerative diseases of the central nervous system, traumatic injuries and other disorders of the central nervous system, HIV/AIDS, chronic kidney disease, arthritis, migraine, and asthma are at high risk for suicide. Currently, Florida does not capture this type of data.

Individuals in justice and child welfare settings
The Florida juvenile suicide rate for adolescents ages seven to 17, captured from 1990 to 2014, is 20.5 per one million juveniles. A national survey identified 110 juvenile suicides between 1995 and 1999. The study revealed that the majority of suicides occurred in training schools/secure facilities and detention centers; however 15.2% of the suicides occurred in residential treatment centers. A national cohort study found that former child welfare involved

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individuals were four to five times more likely to be hospitalized for suicide attempts than the general population.20

**Individuals who engage in nonsuicidal self-injury (NSSI)**

Nonsuicidal-self injury data is unavailable in Florida. National research shows that self-injury youth who attempt suicide experienced suicidal ideation and depression symptoms compared to youth who self-injure only. Research also indicates that NSSI individuals are at risk of dying by suicide within 10 years.21

### III. Plan Development

In 2015 the SOSP and the Council met quarterly to discuss the Plan’s development. At its March meeting, the Council created a committee to identify the Plan’s goals and objectives. This Committee consisted of Council members and community stakeholders, and met every two weeks through June. The Committee’s efforts to develop the Plan are summarized below:

1. The SOSP distributed a survey to stakeholders asking them to identify local planned programs, opportunities, and resources regarding suicide prevention for 2016-2020. Stakeholders included health care systems, insurers, clinicians, nonprofit agencies, community and faith-based organizations, state and local governments, schools, colleges, universities, and businesses. The SOSP and the Committee used the survey responses to help establish the Plan’s goals and objectives. Appendix 1 summarizes the survey respondents by agency type and the top five initiatives identified statewide; Appendix 2 provides a map of the Department’s six regions.

2. The Committee used information from the National Strategy to further develop goals and objectives and to identify Florida’s strategic directions.

3. The Council created an annual assessment to look at the Plan’s impact on deaths by suicide in Florida, review updated data and resources, and update and revise the plan, as needed. The annual assessment approach will begin in December 2017, and will include:
   - Stakeholder feedback;
   - Data review related to suicide deaths in previous years;
   - Review of Florida Youth Risk Behavior and Florida Substance Abuse surveys; and
   - National data review related to health-seeking behavior, prevalence rates, and treatment utilization to provide context for Florida data.

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IV. Goals

The Plan is organized into four strategic directions, seven goals, and 11 objectives that guide suicide prevention efforts and activities. Additionally, due to the fact that suicide is a public health issue that affects family members, friends, coworkers, and communities, Section V of the Plan details action steps that stakeholders can use to implement suicide prevention efforts and activities in their communities.

<table>
<thead>
<tr>
<th>Strategic Direction</th>
<th>Goal</th>
<th>Objective(s)</th>
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| Healthy and Empowered Individuals, Families, and Communities | 1. Integrate and coordinate suicide prevention activities across multiple sectors and settings | 1.1 Integrate suicide prevention into the values, culture, leadership, and workplace of a broad range of organizations, programs, and schools with a role to support suicide prevention activities  
1.2 Establish effective, sustainable, and collaborative suicide prevention programming at the state, tribal, and local levels |
|                     | 2. Increase public knowledge of the factors that offer protection from suicidal behaviors and promote wellness and recovery | 2.1 Reduce prejudice, stigma, and discrimination associated with suicidal behaviors and mental and substance use disorders |
| Clinical and Community Preventive Services | 3. Implement and monitor effective evidence-based programs to promote wellness and prevent suicide-related behaviors | 3.1 Encourage community-based settings to implement effective evidence-based programs and provide education to promote wellness  
3.2 Intervene to reduce suicidal thoughts and behaviors in populations with suicide risk |
|                     | 4. Provide training on the prevention of suicide and related behaviors to community and clinical service providers | 4.1 Update and modify suicide prevention trainings to meet the provider’s specific needs and roles. |
| Treatment and Support Services | 5. Promote suicide prevention as a core component of health care services | 5.1 Promote timely access to assessment, intervention, and effective care for individuals with heightened risks for suicide  
5.2 Establish linkages between providers of mental health and substance abuse services and primary care and community-based programs, including peer support programs |
|                     | 6. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at-risk for suicidal behaviors | 6.1 Adopt, disseminate and implement guidelines for the assessment of suicide risk among persons receiving care in all settings.  
6.2 Adopt, disseminate, and implement guidelines for clinical practice and continuity of care for providers who treat persons with suicide risk. |
| Surveillance, Research, and Evaluation | 7. Increase the usefulness of national and state level surveillance data to inform suicide prevention efforts | 7.1 Identify available data to guide suicide prevention efforts |
## V. Action Steps

The Action Steps provide resources to support the Plan’s statewide implementation at the community level. To download these steps in a brochure format, visit [http://www.myfffamilies.com/service-programs/mental-health/suicide-prevention](http://www.myfffamilies.com/service-programs/mental-health/suicide-prevention).

<table>
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<tr>
<th>Goal</th>
<th>Action Steps</th>
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</table>
| 1. Integrate and coordinate suicide prevention activities across multiple sectors and settings | **State, Tribal, and Local Governments:**  
- Coordinate efforts through the Office of Substance Abuse and Mental Health. Contact it at 850-487-2920 or email samh@myfffamilies.com  
- The Suicide Prevention Resource Center lists suicide prevention efforts by settings that include juvenile justice, primary care, schools, and the workplace. To learn more visit [http://www.sprc.org/library_resources/sprc](http://www.sprc.org/library_resources/sprc)  
**Businesses and Employers:**  
- Implement organizational changes to promote the mental and emotional health of employees, as well as individuals with behavioral health conditions, across multiple sectors and settings. Examples of organizational change include Zero Suicide, a specific set of strategies and tools to promote suicide prevention. To learn more visit [http://zerosuicide.sprc.org/](http://zerosuicide.sprc.org/)  
- First responders/law enforcement/fire fighter agencies are urged to contact the In Harm’s Way initiative. Training-of-Trainers, Critical Incident Peer Support, and use of the Tool Kit and other resource materials are available at [http://policesuicide.spcollege.edu/](http://policesuicide.spcollege.edu/)  
**Nonprofit, Community-, and Faith-based Organizations:**  
- Implement programs and policies to build social connectedness and promote positive mental and emotional health of individuals, families, and communities. Visit [http://www.sprc.org/bpr/section-i-evidence-based-programs](http://www.sprc.org/bpr/section-i-evidence-based-programs) for a list of evidence-based programs.  
**Health System, Insurers, and Clinicians:**  
- Adopt a No Suicide Tolerance program to improve care and outcomes for individuals at risk of suicide in health care systems by implementing the Zero Suicide Toolkit, available at [http://zerosuicide.sprc.org/toolkit](http://zerosuicide.sprc.org/toolkit)  
**Individuals and Families:**  
- Attend a training/webinar to learn suicide warning signs and how to help/support family and friends who might be at risk for suicide. Visit [http://training.sprc.org/](http://training.sprc.org/) for a list of online trainings. |
<table>
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<tr>
<th>Goal</th>
<th>Action Steps</th>
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<tr>
<td><strong>Goal 1 continued:</strong> Integrate and coordinate suicide prevention activities across multiple sectors and settings</td>
<td>• Contact and join a local community suicide prevention task force for opportunities to become involved with suicide prevention efforts. Visit the Florida Suicide Prevention Coalition at <a href="http://www.floridasuicideprevention.org/">http://www.floridasuicideprevention.org/</a></td>
</tr>
</tbody>
</table>
| 2. Increase public knowledge of the factors that offer protection from suicidal behaviors and promote wellness and recovery | **State, Tribal, and Local Governments:**
• Encourage law enforcement, firefighters, and other first responders to attend a tuition-free 8-hour training titled *Law Enforcement Suicide Prevention Training of Trainers*, which has been designated as a best practice by the National Action Alliance for Suicide Prevention, to learn facts, statistics, truths and myths about suicide, organizational leadership, signs and signals, intervention strategies, and more. For more information email heisler.laura@spcollege.edu or call 727-341-4437.
• Encourage law enforcement, firefighters, and other first responders to visit [http://policesuicide.spcollege.edu/](http://policesuicide.spcollege.edu/) to learn more about trainings and the Law Enforcement Suicide Prevention Tool Kit designed to help them present suicide prevention training within their departments and reduce the stigma associated with seeking help.
• Become familiar with and implement the *Suicide Prevention Protocols for Youth in Contact with the Juvenile Justice System*, a resource from the National Action Alliance for Suicide Prevention’s efforts: [http://actionallianceforsuicideprevention.org/task-force/juvenilejustice](http://actionallianceforsuicideprevention.org/task-force/juvenilejustice)

**Businesses and Employers:**
• Have managers and coworkers visit [http://www.sprc.org/for-professionals](http://www.sprc.org/for-professionals) for information on the roles of the workplace in suicide prevention.

**Health System, Insurers, and Clinicians:**
• Visit [http://www.suicidology.org/training-accreditation/rrsr-pc](http://www.suicidology.org/training-accreditation/rrsr-pc) for a training on Recognizing & Responding to Suicide Risk: Essential Skills in Primary Care.
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<th>Goal 2 continued:</th>
<th>Action Steps</th>
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| Increase public knowledge of the factors that offer protection from suicidal behaviors and promote wellness and recovery | **Schools, Colleges, and Universities:**  
- Attend and support the Annual Suicide Prevention Day at the Capitol. Contact Judy Broward gatorjudy2@gmail.com for information.  
- Educators, parents, and students can take the *More than Sad* training by visiting [www.morethansad.org](http://www.morethansad.org)  
- High schools can download *Preventing Suicide: A Toolkit for High Schools* by visiting [http://store.samhsa.gov/product/SMA12-4669](http://store.samhsa.gov/product/SMA12-4669)  
- Download *Youth Suicide Prevention School-based Guide* at [http://theguide.fmhi.usf.edu/](http://theguide.fmhi.usf.edu/)  

**Nonprofit, Community-, and Faith-based Organizations:**  
- Plan, promote, and attend the Suicide Prevention Day at the Capitol. Contact Judy Broward gatorjudy2@gmail.com for information.  
- Become familiar with and implement the *Faith.Hope.Life.* campaign, a resource from the National Action Alliance for Suicide Prevention: [http://actionallianceforsuicideprevention.org/task-force/faith-communities/ylm-home](http://actionallianceforsuicideprevention.org/task-force/faith-communities/ylm-home)  
- Facilitate understanding of risk and resiliency factors in specific cultural groups (e.g., race, ethnicity, faith, sexual orientation, socio-economic status, profession or trade) and utilize data to target suicide prevention and intervention efforts in specific populations. Visit [http://www.myffamilies.com/service-programs/mental-health/suicide-prevention/meetings](http://www.myffamilies.com/service-programs/mental-health/suicide-prevention/meetings) for current data on suicide. The data is included in the Annual Report of the Suicide Prevention Coordinating Council.  

**Individuals and Families:**  
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<th>Goal</th>
<th>Action Steps</th>
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| 3. Develop, implement, and monitor effective evidence-based programs to promote wellness and prevent suicide-related behaviors | **Health System, Insurers, and Clinicians:**  

**Schools, Colleges, and Universities:**  
- Increase school-based and community-based access to mental health and counseling services for individuals at risk of suicide, and encourage the use of those services. Download *The Role of High School Mental Health Providers in Prevention Suicide* by going to [http://www.sprc.org/basics/roles-suicide-prevention](http://www.sprc.org/basics/roles-suicide-prevention)  

**Nonprofit, Community-, and Faith-based Organizations:**  
- Increase awareness of community resources for suicide prevention by providing resources on organization websites.  
- Order free materials from [http://store.samhsa.gov/](http://store.samhsa.gov/)  

| 4. Provide training on the prevention of suicide and related behaviors to community and clinical service providers | **Nonprofit, Community-, and Faith-based Organizations:**  
- Provide suicide prevention trainings to organizations in the health system, insurers, clinicians, police departments, first responders, and schools. For information on webinars and trainings, visit [http://www.sprc.org/training-institute](http://www.sprc.org/training-institute)  

**Schools, Colleges, and Universities:**  
- Educate staff on appropriate available services. Encourage staff to refer those at risk for suicide to these services. To learn about college and university suicide prevention, visit [http://www.sprc.org/collegesanduniversities](http://www.sprc.org/collegesanduniversities)  
- Train relevant school and organization staff to recognize students and employees at potential risk of suicide. For more information visit [http://www.mentalhealthfirstaid.org/cs/take-a-course/course-types/youth/](http://www.mentalhealthfirstaid.org/cs/take-a-course/course-types/youth/)  

| 5. Promote suicide prevention as a core component of health care services | **Businesses and Employers:**  
- Promote the availability of online and phone support services. Visit [http://www.suicidepreventionlifeline.org/](http://www.suicidepreventionlifeline.org/) or share the National Suicide Prevention Lifeline number: 1-800-273-TALK (8255).  
Goal 5 continued:

Promote suicide prevention as a core component of health care services

Nonprofit, Community-, and Faith-based Organizations:
- Coordinate the services of community-based programs by requesting support from local mental health and substance abuse providers.

Individuals and Families:
- Find information to help individuals who are struggling at the following website [http://www.then CSP.org/#!SUPPORT%20A%20FRIEND/c8xp](http://www.then CSP.org/#!SUPPORT%20A%20FRIEND/c8xp)

6. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors

Health System, Insurers, and Clinicians:

7. Increase the usefulness of national and state level surveillance data to inform suicide prevention efforts

State, Tribal, and Local Governments:

VI. Suicide Prevention Resources

In an effort to raise awareness of suicide prevention, information about the risk and protective factors and the warning signs for suicidal behavior are summarized below.

Risk Factors

The Centers for Disease Control and Prevention defines risks as characteristics associated with suicidal behaviors. With risk factor awareness, stakeholders and other interested individuals can assist with recognizing and preventing suicide. Examples of risk factors include:

- Family history of suicide
- Family history of child maltreatment
- Previous suicide attempt(s)
- History of mental disorders, particularly clinical depression
- History of alcohol and substance abuse
- Feelings of hopelessness

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• Impulsive or aggressive tendencies
• Isolation, a feeling of being cut off from other people
• Barriers to accessing mental health treatment
• Loss (relational, social, work, or financial)
• Physical illness
• Easy access to lethal methods
• Unwillingness to seek help because of the stigma attached to mental health and substance abuse disorders or to suicidal thoughts

Warning Signs
The American Association of Suicidology defines warning signs as indicators that a person may be more at risk for suicidal behaviors. Suicide is preventable and increasing awareness of the warning signs is critical to ensuring that individuals in crisis are recognized and receive the help they need. Additionally, awareness of the risk factors and warning signs can reduce the stigma attached to suicide and to individuals exhibiting potential suicidal thoughts or behaviors. The following is a partial list of warning signs from the American Association of Suicidology23:

• Increased substance (alcohol or drug) use
• No reason for living; no sense of purpose in life
• Anxiety, agitation, unable to sleep or sleeping all of the time
• Feeling trapped – like there’s no way out
• Hopelessness
• Withdrawal from friends, family, and society
• Rage, uncontrolled anger, seeking revenge
• Acting reckless or engaging in risky activities, seemingly without thinking
• Dramatic mood changes

Individuals experiencing higher risk of possible suicide may exhibit some or all of the following behaviors:
• Threatening to hurt or kill him/herself, or talking of wanting to hurt or kill him/herself; and/or,
• Looking for ways to kill him/herself by seeking access to firearms, available pills, or other means; and/or,
• Talking or writing about death, dying or suicide, when these actions are out of the ordinary.

Protective Factors
According to the Centers for Disease Control and Prevention, the following list of protective factors may reduce the risks for suicidal thoughts and behaviors:

- Effective clinical care for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support for help seeking
- Family and community support (connectedness)
- Support from ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution, and nonviolent ways of handling disputes

Resources
To get help for yourself or a loved one, contact the following:

1. National Suicide Prevention Lifeline. Provides crisis support 24 hours a day, 7 days a week by phone and live chat. 1 (800) 273-8255. Website: www.suicidepreventionlifeline.org
2. The Veterans Crisis Line. Connects Veterans in crisis and their families and friends with qualified, caring Department of Veterans Affairs responders through a confidential toll-free hotline, online chat, or text. Veterans and their loved ones can call 1-800-273-8255 and Press 1, chat online, or send a text message to 838255 to receive confidential support 24 hours a day, 7 days a week.

To learn more about the risk and protective factors, visit:

1. The American Association of Suicidology. The AAS is a charitable, nonprofit membership organization for all those involved in suicide prevention and intervention, or touched by suicide. AAS is a leader in the advancement of scientific and programmatic efforts in suicide prevention through research, education and training, the development of standards and resources, and survivor support services. http://www.suicidology.org/resources/warning-signs
3. The Florida Suicide Prevention Coalition. The Coalition’s mission is to collaborate with stakeholders to develop and implement suicide prevention, intervention, and postvention strategies and programs. http://www.floridasuicideprevention.org/learn_the_signs.htm

5. The Suicide Prevention Resource Center. The SPRC is the nation’s only federally supported resource center devoted to advancing the National Strategy for Suicide Prevention. It provides technical assistance, training, and materials to increase the knowledge and expertise of suicide prevention practitioners and other professionals serving people at risk for suicide. It also promotes collaboration among a variety of organizations in the field of suicide prevention. [http://www.sprc.org/basics/risk-and-protective-factors](http://www.sprc.org/basics/risk-and-protective-factors)

To learn more about suicide prevention, ways to help, and become involved, visit:


2. The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. Its mission is to reduce the effect of substance abuse and mental illness on America's communities. [http://www.samhsa.gov/](http://www.samhsa.gov/)

3. The Florida Department of Children and Families’ Statewide Office for Suicide Prevention guides suicide prevention efforts in Florida. This Office is also responsible for updating the Statewide Plan and writing an annual report to the Governor’s Office. [http://www.myflfamilies.com/service-programs/mental-health/suicide-prevention](http://www.myflfamilies.com/service-programs/mental-health/suicide-prevention)

4. The Florida Suicide Prevention Coalition collaborates to develop and implement suicide prevention, intervention, postvention strategies, and programs. Additionally, the Coalition, along with other organizations, coordinates the annual Suicide Prevention Day at the Capitol. [http://www.floridasuicideprevention.org/](http://www.floridasuicideprevention.org/)

**VII. Contact**

For more information about the Statewide Plan or suicide prevention efforts, contact the Statewide Office for Suicide Prevention at 850-487-2920 or email samh@myFLfamilies.com. *Florida’s 2016-2020 Statewide Plan for Suicide Prevention* can be accessed at [http://www.myflfamilies.com/service-programs/mental-health/suicide-prevention](http://www.myflfamilies.com/service-programs/mental-health/suicide-prevention)
Appendix 1

CATEGORIES OF ORGANIZATIONS THAT RESPONDED TO THE 2015 FLORIDA SUICIDE PREVENTION SURVEY

<table>
<thead>
<tr>
<th>Region</th>
<th>Health Care Systems, Insurers, and Clinicians</th>
<th>Nonprofit, Community-, and Faith-Based Organizations</th>
<th>State and Local Government</th>
<th>Schools, Colleges, and Universities</th>
<th>Businesses and Employers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northwest Region</td>
<td>9%</td>
<td>56%</td>
<td>2%</td>
<td>33%</td>
<td>0%</td>
</tr>
<tr>
<td>Northeast Region</td>
<td>9%</td>
<td>57%</td>
<td>2%</td>
<td>32%</td>
<td>0%</td>
</tr>
<tr>
<td>Central Region</td>
<td>0%</td>
<td>86%</td>
<td>14%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Southeast Region</td>
<td>30%</td>
<td>50%</td>
<td>0%</td>
<td>20%</td>
<td>0%</td>
</tr>
<tr>
<td>Southern Region</td>
<td>15%</td>
<td>67%</td>
<td>13%</td>
<td>0%</td>
<td>5%</td>
</tr>
<tr>
<td>SunCoast Region</td>
<td>9%</td>
<td>78%</td>
<td>0%</td>
<td>13%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Top Five Suicide Prevention Initiatives Identified by Organization

- **Health Care Systems, Insurers, and Clinicians**
  - Screen for mental health needs/make referrals
- **Nonprofit, Community-, and Faith-Based Organizations**
  - Develop/implement communication strategies that convey messages of help, hope, & resiliency
- **State and Local Government**
  - Assess needs/resources
- **Schools, Colleges, and Universities**
  - Implement programs and policies to build social connectedness and promote positive mental and emotional health
- **Businesses and Employers**
  - Implement organizational changes to promote the mental and emotional health of employees
Environmental Factors and Plan

21. Support of State Partners - Required MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions or consultation on the benefits available to any Medicaid populations;

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period?  
   - Yes  
   - No

   If yes, with whom?
   - None.

2. Has your state identified the need to develop new partnerships that you did not have in place?  
   - Yes  
   - No

   If yes, with whom?
   - None.

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.

   The Department has an interagency agreement with the Agency for Health Care Administration for Pre-Admission Screening and Resident Review to help ensure that individuals are not inappropriately placed in nursing homes for long term care and another agreement to establish jointly-funded Florida Assertive Community Treatment (FACT) teams, which provide comprehensive, multidisciplinary care to help prevent recurrent hospitalization and incarceration. The Department also has an interagency agreement with the Department of Education, Department of Health, and the Agency for Persons with Disabilities to provide transition services, support services, and employment services to students with disabilities. The Department has an interagency agreement with the Department of Juvenile Justice to collaborate on meeting the behavioral needs of children involved in the juvenile justice system. The Department also has an interagency agreement with the Agency for Health Care Administration, Agency for Persons with Disabilities, Department of Juvenile Justice, Department of Education, Department of Health, the Guardian Ad Litem Program, and the Office of Early Learning to coordinate services and supports for children and collaborate on developing the resources necessary for children served by multiple agencies. There is also an agreement with the Department of Corrections to facilitate collaboration to ensure that incarcerated individuals with serious mental illness have access to mental health services upon their release.
The Department also has an agreement with Disability Rights Florida that calls for the Department to develop a pilot project designed to more fully utilize existing FACT resources and create additional opportunities for community integration of individuals being discharged from state mental health treatment facilities (SMHTFs). This component is intended to transition FACT participants to less intensive community based services and supports, allowing persons referred from SMHTFs to fill the vacated slots. This project provides care coordination and vouchers to purchase treatment and support services for adults transitioning from Florida Assertive Community Treatment (FACT) teams, acute crisis services, and institutional settings to independent community living. The Transitional Voucher component is a flexible, consumer-directed voucher system designed to bridge the gap for persons with behavioral health disorders as they transition from acute or more restrictive levels of care to lower levels of care. The intent is to enable individuals to live independently in the community with treatment and support services based on need and choice and build a support system to sustain their independence, recovery, and overall well-being. The project aims to:

• Prevent recurrent hospitalization and incarceration;
• Provide safe, affordable, and stable housing opportunities;
• Maximize use of FACT resources and community supports;
• Increase participant choice and self-determination in their treatment and support service selection; and
• Improve community involvement and overall quality of life for program participants.

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

Please indicate areas of technical assistance needed related to this section.
None.

Footnotes:
Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application - Required MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). 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 BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.\(^72\)

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 behavioral health problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

Please respond to the following items:

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...)
   a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?
      Florida’s Substance Abuse and Mental Health Planning Council is an integrated advisory body that helps the Department plan and implement both mental health services and substance abuse prevention, treatment, and recovery support services.
   b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into i

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguisitc, rural, suburban, urban, older adults, families of young children)?

3. Please indicate 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 the state and the 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.
   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.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.\(^73\)

Footnotes:

\(^{72}\)http://beta.samhsa.gov/grants/block-grants/resources

\(^{73}\)There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.
### Environmental Factors and Plan

#### Behavioral Health Advisory Council Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Type of Membership</th>
<th>Agency or Organization Represented</th>
<th>Address, Phone, and Fax</th>
<th>Email (if available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Dean Aufderheide</td>
<td>State Employees</td>
<td>Department of Corrections</td>
<td>FL, PH: 850-717-3281</td>
<td><a href="mailto:aufderheide.dean@mail.dc.state.fl.us">aufderheide.dean@mail.dc.state.fl.us</a></td>
</tr>
<tr>
<td>Carla Bresnahan</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td>Central Florida Cares Health System</td>
<td>FL, PH: 407-453-2765</td>
<td><a href="mailto:ckbshrink@gmail.com">ckbshrink@gmail.com</a></td>
</tr>
<tr>
<td>Joyce M. Brown</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td>Big Bend Community Based Care</td>
<td>FL, PH: 850-212-8967</td>
<td><a href="mailto:candif@gmail.com">candif@gmail.com</a></td>
</tr>
<tr>
<td>Melanie Brown-Woofler</td>
<td>Others (Not State employees or providers)</td>
<td>Florida Council for Community Mental Health</td>
<td></td>
<td><a href="mailto:melanie@fccmh.org">melanie@fccmh.org</a></td>
</tr>
<tr>
<td>Paul Cassidy</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>Southeast Florida Behavioral Health Network</td>
<td>FL, PH: 850-423-7703</td>
<td><a href="mailto:paul@cassidymsw.com">paul@cassidymsw.com</a></td>
</tr>
<tr>
<td>Justine Castaneda</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>Youth Move Florida</td>
<td>321 SE 15th Ave. Apt. B1 Deerfield Beach FL, 33441 PH: 609-969-1391</td>
<td><a href="mailto:Justine@sfn.org">Justine@sfn.org</a></td>
</tr>
<tr>
<td>Robin H. Cole</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td>South Florida Behavioral Health Network</td>
<td>FL, PH: 518-429-8848</td>
<td><a href="mailto:robinholly@aol.com">robinholly@aol.com</a></td>
</tr>
<tr>
<td>Carmen Dupoint</td>
<td>State Employees</td>
<td>Vocational Rehabilitation</td>
<td>FL, PH: 850-245-3299</td>
<td><a href="mailto:carmen.dupoint@vr.fldoe.org">carmen.dupoint@vr.fldoe.org</a></td>
</tr>
<tr>
<td>Dana Farmer</td>
<td>Others (Not State employees or providers)</td>
<td>Disability Rights Florida</td>
<td>FL, PH: 850-617-9709</td>
<td><a href="mailto:danaf@disabilityrightsflorida.org">danaf@disabilityrightsflorida.org</a></td>
</tr>
<tr>
<td>Mark Fontaine</td>
<td>Others (Not State employees or providers)</td>
<td>Florida Alcohol and Drug Abuse Association (FADAA)</td>
<td></td>
<td><a href="mailto:mfontaine@fadaa.org">mfontaine@fadaa.org</a></td>
</tr>
<tr>
<td>Stephanie Freskos-Wolf</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>Peer Support Coalition of Florida</td>
<td>7101 53rd St. N. 102 Pinellas Park FL, 33781 PH: 727-544-3560</td>
<td><a href="mailto:stephanie.freskos.wolf@gmail.com">stephanie.freskos.wolf@gmail.com</a></td>
</tr>
<tr>
<td>Michael Gomez</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td></td>
<td>1307 E. 127 Ave. Apt. T Tampa FL, 33612 PH: 786-558-6412</td>
<td><a href="mailto:mgomez@s4kf.org">mgomez@s4kf.org</a></td>
</tr>
<tr>
<td>Christine Hurst</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td>Big Bend Community Based Care</td>
<td>FL, PH: 850-774-4741</td>
<td><a href="mailto:cyh089@gmail.com">cyh089@gmail.com</a></td>
</tr>
<tr>
<td>Curtis Jenkins</td>
<td>State Employees</td>
<td>Florida Department of Education</td>
<td></td>
<td><a href="mailto:veree@flfamilies.net">veree@flfamilies.net</a></td>
</tr>
<tr>
<td>Veree Jenkins</td>
<td>Parents of children with SED</td>
<td>Voices and Choices of Florida: Statewide Family and Youth Network</td>
<td></td>
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</tr>
<tr>
<td>Name</td>
<td>Role</td>
<td>Organization</td>
<td>Location</td>
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<tr>
<td>Kristi Krug</td>
<td>Individuals in Recovery</td>
<td>Lutheran Services of Florida</td>
<td>FL</td>
<td>904-742-4681</td>
</tr>
<tr>
<td>Nelson Kull</td>
<td>Individuals in Recovery</td>
<td>Central Florida Cares Health System</td>
<td>FL</td>
<td>407-617-3311</td>
</tr>
<tr>
<td>Bobbie Linkhorn</td>
<td>Parents of children with SED</td>
<td></td>
<td>FL</td>
<td>954-773-6232</td>
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<tr>
<td>Jane H. Manning</td>
<td>Individuals in Recovery</td>
<td>Central Florida Behavioral Health Network</td>
<td>FL</td>
<td>239-728-7106</td>
</tr>
<tr>
<td>Elaine Roberts</td>
<td>State Employees</td>
<td>Florida Housing Finance Corporation</td>
<td>FL</td>
<td>850-488-4197</td>
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<tr>
<td>Mariamee Rodriguez</td>
<td>Parents of children with SED</td>
<td></td>
<td>FL</td>
<td>786-343-1808</td>
</tr>
<tr>
<td>Peggy Scheuermann</td>
<td>State Employees</td>
<td>Florida Department of Health</td>
<td>PH</td>
<td>850-245-4444</td>
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<tr>
<td>Ashley Schwab</td>
<td>State Employees</td>
<td>Florida Department of Juvenile Justice</td>
<td>PH</td>
<td>850-717-2787</td>
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<tr>
<td>Judge Mark Speiser</td>
<td>Others (Not State employees or providers)</td>
<td>Florida Partners in Crisis</td>
<td></td>
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<tr>
<td>James W. Taliaferro, Sr.</td>
<td>Others (Not State employees or providers)</td>
<td>Mental Health America</td>
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<tr>
<td>Richard Wagner</td>
<td>Family Members of Individuals in Recovery</td>
<td>Lutheran Services of Florida</td>
<td>FL</td>
<td>813-695-5490</td>
</tr>
</tbody>
</table>

Footnotes:
## Behavioral Health Council Composition by Member Type

<table>
<thead>
<tr>
<th>Type of Membership</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Membership</strong></td>
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<tr>
<td>Individuals in Recovery* (to include adults with SMI who are receiving, or</td>
<td>7</td>
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<td>have received, mental health services)</td>
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<tr>
<td>Family Members of Individuals in Recovery* (to include family members of</td>
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<tr>
<td>adults with SMI)</td>
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<tr>
<td>Parents of children with SED*</td>
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<tr>
<td>Vacancies (Individuals and Family Members)</td>
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<tr>
<td>Others (Not State employees or providers)</td>
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<tr>
<td><strong>Total Individuals in Recovery, Family Members &amp; Others</strong></td>
<td>20</td>
<td>76.92%</td>
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<td>State Employees</td>
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<td>Providers</td>
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<tr>
<td>Federally Recognized Tribe Representatives</td>
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<tr>
<td>Vacancies</td>
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<td><strong>Total State Employees &amp; Providers</strong></td>
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<td>23.08%</td>
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<td>Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations</td>
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<td>Providers from Diverse Racial, Ethnic, and LGBTQ Populations</td>
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<td><strong>Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations</strong></td>
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<tr>
<td>Persons in recovery from or providing treatment for or advocating for substance abuse services</td>
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* States are encouraged to select these representatives from state Family/Consumer organizations.

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

A briefing on the Block Grant application was provided to the Council by the Department's Block Grant Coordinator on 8/14. A draft of the application was provided via email. No modifications have been recommended by the Council at this time.

### Footnotes:
Environmental Factors and Plan

23. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

   a) Public meetings or hearings?  
   b) Posting of the plan on the web for public comment?  
   c) Other (e.g. public service announcements, print media)

   If yes, provide URL:
   http://www.myffamilies.com/service-programs/substance-abuse/publications

Footnotes:

Please provide comments and input to DCF’s Block Grant Coordinator at Jeffrey.Cece@myFLfamilies.com. Any person can provide input both during the development of this application and after submission to SAMHSA.