Statewide Drug Policy Advisory Council
2022 Annual Report

To the Governor,

the President of the Senate,

and the Speaker of the
House of Representatives

December 1, 2022

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Acronyms Used in this Report

ACE	Adverse Childhood Experience
AHCA	Agency for Health Care Administration
AMA	American Medical Association
APRN	Advanced Practice Registered Nurse
CBD	Hemp-derived cannabidiol
CDC	Centers for Disease Control and Prevention
CCBHC	Certified Community Behavioral Health Clinics
CEO	Chief Executive Officer
CHD	County Health Department
CHIP	Community Health Improvement Plan
CME	Continuing Medical Education
CORE	Coordinated Opioid Recovery Effort
COVID-19	Coronavirus Disease 2019
DARE	Drug Abuse Resistance Education
DATA 2000	Drug Addiction Treatment Act of 2000
DCF	Florida Department of Children and Families
DDRO	Drug Demand Reduction Outreach Program
DEA	Drug Enforcement Administration
DEN	Drug Epidemiology Networks
DJJ	Florida Department of Juvenile Justice
DOE	Florida Department of Education
DPAC	Statewide Drug Policy Advisory Council
DTO	Drug Trafficking Organizations
ED	Emergency Department
E-FORCSE	Electronic-Florida Online Reporting of Controlled Substance Evaluation Program
EMS	Emergency Medical Services
EMSTARS	Emergency Medical Services Tracking and Reporting System
FAC	Florida Administrative Code
FADAA	Florida Alcohol and Drug Abuse Association
FANA	Florida Association of Nurse Anesthetists
FBHA	Florida Behavioral Health Association
FDA	Food and Drug Administration

FDC	Florida Department of Corrections
FDLE	Florida Department of Law Enforcement
FDOH	Florida Department of Health
FLASH	Florida Access to Syringe and Health Services
FLHealthCHARTS	Florida Community Health Assessment Resource Tool Set
FLNG-CD	Florida National Guard Counterdrug Program
FPQC	Florida Perinatal Quality Collaborative
FQHC	Federally Qualified Health Center
FYSAS	Florida Youth Substance Abuse Survey
GME	Graduate Medical Education
HCA	Hospital Corporation of American
HEROS	Helping Emergency Responders Obtain Support
HIV	Human Immunodeficiency Virus
IDEA	Infectious Disease Elimination Act
MAT	Medication-Assisted Treatment
ME	Medical Examiners
MHPAEA	Mental Health Parity and Addiction Equity Act
MORE	Maternal Opioid Recovery Effort
NAS	Neonatal Abstinence Syndrome
NSDUH	National Survey on Drug Use and Health
OD2A	Overdose Data to Action
ODMAP	Overdose Detection Mapping Application Program
OFR	Overdose Fatality Review
OMNI	Opioid Use Disorder, Maternal Outcomes, and Neonatal Abstinence Syndrome Initiative
ONDCP	Office of National Drug Control Policy
OPP	Overdose Prevention Program
OUD	Opioid Use Disorder
PDMP	Prescription Drug Monitoring Program
RCO	Recovery Community Organization
ROSC	Recovery Oriented System of Care
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SEOW	State Epidemiological Outcomes Workgroup
SEP	Syringe Exchange Program, or SSP Syringe Services Program

SOR	State Opioid Response
SPOT	Special Purpose Outreach Team
STR	State Targeted Response
SUD	Substance Use Disorder
TCO	Transnational Criminal Organization
THC	Tetrahydrocannabinol
U.S.	United States

Message from the State Surgeon General Joseph A. Ladapo, MD, PhD

Dear Colleagues,

Florida faces an ongoing threat from overdose issues, and the Statewide Drug Policy Advisory Council (DPAC) members have worked diligently to address these challenges. Data from the National Center for Health Statistics indicated that nationally, drug overdose deaths increased more than 6.9 percent from April 2021 through April 2022. In Florida, overdose deaths nearly tripled from January 2015 to April 2022, going from 2755 deaths in 2015 to 7,995 deaths in the 12-month period ending April 2022.

The Florida Department of Health continues to partner with state and local agencies both on DPAC and statewide to increase the focus on prevention, improve the number of people with substance use disorder (SUD) who are identified through screening, and expand efforts to reduce overdose deaths through targeted harm reduction programs.

DPAC is reporting substantial progress on the 2021 recommendations and has proposed several significant recommendations to consider for the coming year.

On behalf of DPAC, and as required by section 397.333, Florida Statutes, I am pleased to present the DPAC 2022 Annual Report to Governor Ron DeSantis, Senate President Kathleen Passidomo, and House Speaker Paul Renner. FDOH is honored to serve as the coordinating entity for DPAC, and the annual report provides an update on their ongoing work.

The recommendations in this report reflect the majority vote of DPAC members and do not necessarily reflect the Florida Department of Health's position on all recommendations.

DPAC recognizes the continued support and collaboration of our state legislature and Governor Ron DeSantis. Together, we will continue efforts to reduce the impact of substance use on the health of Floridians.

Joseph A. Ladapo, MD, PhD
State Surgeon General

Summary of 2022 Meetings
Statewide Drug Policy Advisory Council

As required by section 397.333(4)(b), Florida Statutes, Florida's Statewide Drug Policy Advisory Council's (DPAC) 2022 Annual Report analyzes the problem of substance abuse in the state and provides updates on recommendations to the Governor and Legislature for consideration. As required by statute, meetings during 2022 occurred in January, April, July, and October. The topics covered are outlined below

January 25, 2022

- Improvements and challenges to background screening
- University of South Florida secret shopper exercise that assessed issues related to access and quality of care available to pregnant women in Florida with an opioid use disorder.
- Palm Beach County's Overdose Data to Action (OD2A) grant program, which focuses on understanding and tracking the complex and changing nature of the drug overdose epidemic.
- Current efforts to reform and modernize the Baker and Marchman Acts in Florida.

April 19, 2022

- Legislation related to controlled substances, mental health, and SUD via Senate Bill 282, which adds coverage for peer specialists.
- Emerging drug threat of delta-8 tetrahydrocannabinol (THC), hemp-derived cannabidiol (CBD) products being sold throughout the state with a lack of restrictions.
- Standards and instructional support for comprehensive health education that includes substance use and abuse education.
- Drug Abuse Resistance Education (DARE) curriculum to incorporate new information on the dangers related to emerging drugs as well as fentanyl.
- Florida Perinatal Quality Collaborative (FPQC) Maternal Opioid Recovery Effort (MORE), a hospital quality improvement initiative designed to address the needs of pregnant women with SUD.

July 19, 2022

- Coordinated Opioid Recovery Effort (CORE), an evidenced-based program that emphasizes stabilization in an emergency department (ED) and a warm handoff to a long-term treatment facility as well as medication-assisted treatment and uniquely the involvement of first responders.

October 27, 2022

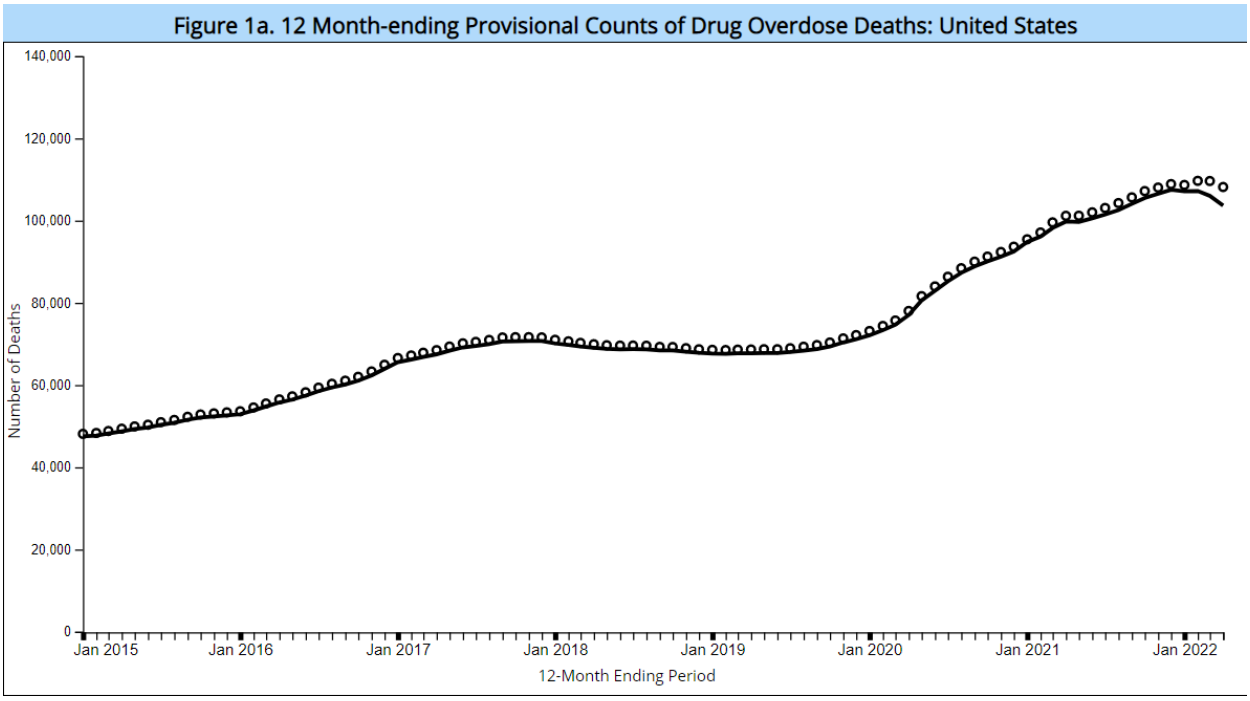
- Applying the Meds-to-Beds Model of Inpatient Dispensing to Naloxone Nasal Spray

Overview

Introduction

Florida and the entire nation face ongoing drug-related threats like the opioid epidemic. Data indicate that our communities are experiencing an increase in drug abuse and overdose during 2020-2022, including a dramatic increase in drugs adulterated with fentanyl. Data from the National Center for Health Statistics indicated that nationally, compared to previous years, drug overdose deaths increased more than 6.9 percent from April 2021 through April 2022.[1] In Florida overdose deaths nearly tripled from January 2015 to April 2022, going from 2,755 deaths in 2015 to 7,995 deaths in the 12-month period ending April 2022 (provisional).

Figure A: Monthly-Ending Provisional Counts of Fatal Drug Overdoses in the United States.



Reported provisional counts are the number of deaths received and processed for the 12-month period ending in the month indicated. Provisional counts are subject to change as more drug overdoses are accounted for after adjusting for incomplete reporting.

Data from the Florida Agency for Health Care Administration (AHCA) and Prehospital EMS Tracking and Reporting System (EMSTARS) indicate there is an increase in substance use in Florida as evidenced by the 11 percent increase in drug-involved ED visits and an 18 percent increase in emergency medical services (EMS) responses to suspected drug overdoses in 2021 compared to 2010. According to data from the FDOH Bureau of Vital Statistics, the number of fatal overdoses increased by 8 percent to more than 8,100 people in 2021, the largest number of annual drug overdose deaths recorded in Florida, compared to the estimated 7,500 in 2020, and 5,500 in 2019.

Preliminary data from January through September of 2022 show a 7 percent decrease in drug-involved ED visits and a 3 percent decrease in EMS responses when compared to the same period in 2021.

Drug Related Deaths

The *Drugs Identified in Deceased Persons* by the Florida Medical Examiners (ME) 2020 Annual Report indicated that there were 7,842 opioid-related deaths reported (which averages more than 21 deaths per day). This is 1,714 more than the previous year, which represents nearly a 28 percent increase. Overall, 9,038 individuals died with one or more prescription drugs in their system, which is more than a 26 percent increase. The drugs were identified as either the cause of death or merely present in the decedent. These drugs may have also been mixed with illicit drugs and/or alcohol. The drugs that caused the most deaths were fentanyl (5,302), cocaine (2,400), ethyl alcohol (1,389), methamphetamine (1,386), benzodiazepines (1,152, including 722 alprazolam deaths), morphine (916), fentanyl analogs (848), amphetamine (768), and heroin (708).[2]

Opioid-related deaths increased again in 2021, according to the *Drugs Identified in Deceased Persons* by the Florida ME (2021 Interim Report). Opioid-related deaths increased by 5.5 percent over the same period (January through June) in 2020; opioid-caused deaths also increased by 4 percent. Deaths involving fentanyl, cocaine, and methamphetamines also increased. The most significant increases were deaths involving fentanyl which increased by 11 percent, and deaths caused by fentanyl increased by 9 percent. Changes were also seen within the prescription opioid category; deaths caused by hydrocodone decreased by 10 percent, deaths caused by oxycodone decreased by 8 percent, and deaths caused by heroin decreased by 44 percent.[3]

Although the majority of overdose deaths are related to opioids, stimulants are responsible for a number of deaths. According to the *Drugs Identified in Deceased Persons* by the Florida ME (2021 Interim Report), deaths from cocaine increased by 3 percent over the same period in 2020. Methamphetamine deaths increased by 44 percent. Deaths from amphetamines also increased by 7 percent. However, many of the amphetamine deaths likely represent methamphetamines that have been metabolized to amphetamine, rather than pharmaceutical amphetamine use.

Expansion of Naloxone Availability

The Florida Department of Children and Families (DCF) has made considerable progress deploying the medications that are proven to reduce opioid-related overdoses and mortality, namely the opioid overdose antidote called naloxone and the two U.S. Food and Drug Administration (FDA) approved agonist maintenance medications for opioid use disorder (OUD), methadone, and buprenorphine. Expanding naloxone availability is the intervention that will reduce the greatest number of opioid overdose deaths.[4] Compelling research demonstrates that opioid overdose mortality is reduced by distributing naloxone to individuals at risk of an overdose and to their peers and family who may witness an overdose, particularly through syringe access programs, treatment programs, re-entry programs, mobile outreach programs, homeless service providers, and other community-based organizations that provide continuous, low-barrier access to naloxone.[5] People who use drugs deploy naloxone to save a life at a rate nearly 10 times that of laypeople who do not use drugs, which substantiates DCF's prioritization of naloxone distribution efforts among people who are not yet engaged in treatment.[6]

Evaluation research confirms that bystander naloxone administration is a safe and effective method for preventing overdose deaths and that the associated education effectively improves overdose recognition and response.[7] Since the inception of DCF's Overdose Prevention Program (OPP), over 373,000 naloxone kits have been distributed. Nearly 22,000 individuals were trained on overdose prevention, recognition, and response and over 23,000 overdose

reversals have been reported. The reporting of reversals is encouraged but not required, which means that the actual number of overdose reversals is considerably higher.

People who present to hospitals for care should be discharged with naloxone kits in hand if they have any risk factors for overdose. Resources and tools are being distributed to hospitals to increase the number of facilities enrolled in the OPP. Naloxone kits will be available to any facility for distribution to people at risk of overdose in their maternity, emergency department, and other inpatient units. DCF is also partnering to provide all 67 county health department clinics with naloxone to be distributed to the community to individuals at risk of experiencing or witnessing an overdose and providing training for all staff to be educated in Overdose Recognition and Response. DCF is also working with the Department of Juvenile Justice (DJJ) to ensure all residential facilities have naloxone on-site, in the event of an overdose. The cross-agency partnerships have been and continue to be extremely important to saving lives in the state of Florida.

Youth Substance Use in Florida

Substance use among students in Florida continues to decline. Among middle and high school students in Florida, between 2010 and 2021, the prevalence of lifetime alcohol use decreased from approximately 52 percent to 33.6 percent and the past-30-day prevalence of alcohol use decreased 15 percentage points, from 29 percent to 14 percent. Regarding binge drinking (in the past 2 weeks), the prevalence decreased from about 14 percent to 7 percent. High schoolers are asked if they ever woke up after a night of drinking and did not remember the things they did or the places they went. The lifetime prevalence of “blacking out” among high schoolers decreased from approximately 19 percent to 14 percent from 2014 (the first year this item appeared on the Florida Youth Substance Abuse Survey (FYSAS) to 2020. Regarding marijuana use, the prevalence of lifetime and past 30-day marijuana use among middle and high school students also decreased between 2010 and 2020. Lifetime prevalence decreased from approximately 24 percent to 20 percent, and past 30-day prevalence decreased from 13 percent to 11 percent.[8]

Trends in early initiation are also encouraging. The percentage of high school youth who started using alcohol (more than a sip) at age 13 or younger decreased from 27 percent to about 16 percent. The percentage who started using marijuana at age 13 or younger decreased from 11 percent to 8 percent. Access to alcohol and marijuana among middle and high school students in Florida continues to decline. Between 2010 and 2020, the percentage of students who said alcohol was “sort of easy” or “very easy” to get decreased from about 46 percent to 31 percent. The percentage of students who said marijuana was “sort of easy” or “very easy” to get also decreased from about 44 percent to 32 percent. These reductions in access may be contributing to the continued decline in alcohol and marijuana use among students in Florida.

With respect to particularly high-risk and antisocial substance-related behaviors, long-term progress in Florida is less dramatic but still encouraging. For example, in 2013 (the first year these questions appeared on the survey in their current form), 6.4 percent of middle and high school students reported using alcohol before or during school (in the past 12 months). Additionally, 9.8 percent smoked marijuana and 3.4 percent used another drug before or during school.[9] Estimates for 2020 reflect minimal progress with respect to these behaviors, with approximately 5.2 percent of students consuming alcohol, 9.5 percent smoking marijuana, and 3.5 percent using other drugs before or during school. Additionally, between 2012 and 2020, the percentage of Florida high school students who reported driving a vehicle after drinking alcohol decreased from 8 percent to 4 percent. The percentage who reported riding in a vehicle driven by someone who had been drinking alcohol decreased from 21 percent to about 15 percent. The percentage who reported driving a vehicle after using marijuana decreased less

dramatically, from 11 percent to 9 percent. The percentage who reported riding in a vehicle driven by someone who had been using marijuana decreased from 25 percent to 22 percent.

Florida's substance use prevention system infrastructure needs to be responsive to childhood trauma as a prominent risk factor for substance use and other problems. In 2020, DCF started collecting data on the prevalence of adverse childhood experiences (ACEs) among high schoolers, through the FYSAS. About 22 percent of Florida high school students reported four or more ACEs, considered a high level of trauma. Examples of ACEs include parental separation/divorce, living with someone who went to jail/prison, and physical and emotional abuse and neglect. Students with four or more ACEs report substance use rates two times higher than students with fewer than four ACEs.

According to an analysis of justice-involved youth (n = 65,248) using data from the Florida DJJ, 2.3 percent meet the criteria for past 30-day opioid misuse.[10] The odds of past 30-day opioid misuse among justice-involved children in Florida is 2.5 times higher among those with an ACE score of at least four, compared to those with lower ACE scores.[11]

According to estimates from the 2022 FYSAS, among high schoolers, the lifetime prevalence is 2.8 percent for opioid misuse, 4.1 percent for stimulant misuse, and 5.7 percent for opioid and/or stimulant misuse. The current (past 30 days) prevalence is 1.0 percent for opioid misuse, 1.5 percent for stimulant misuse, and 2.2 percent for opioid and/or stimulant misuse. It is estimated that about 79 percent of high schoolers did not talk with a parent or guardian in the past year about the dangers of taking prescription drugs not prescribed to them.[12]

Adult Substance Use in Florida

The past-year prevalence of substance use disorders among adults in Florida was 14.8 percent in 2019-2020, and the prevalence of needing but not receiving treatment for substance use was 7.5 percent.[13] According to the Florida Association of Managing Entities, 5,117 adults were added to a waitlist for substance use services in FY 20-21.

The most recently published prevalence rates for various substances and substance use disorders among young adults (ages 18-25) and adults in Florida are presented in the table below:

Figure B. Prevalence of Substance Use and Substance Use Disorders in the Past Year, in Florida, by Adult Age Group (2019-2020)

	18 and Older	18-25	26 and Older
Marijuana Use	16.6%	32.9%	14.5%
Cocaine Use	1.7%	4.4%	1.4%
Methamphetamine Use	0.6%	0.6%	0.6%
Heroin Use	0.2%	0.1%	0.2%
Prescription Pain Reliever Misuse	3.6%	4.8%	3.4%
Illicit Drug Use Disorder	7.4%	17.0%	6.2%
Alcohol Use Disorder	9.5%	13.6%	9.0%

Figure C. Prevalence of Cocaine Use, Marijuana Use, and Alcohol Use Disorders in the Past Year Among Adults Ages 18 and Older in Florida (2008-2020)

	2008-2009	2010-2011	2012-2013	2014-2015	2016-2017	2018-2019	2019-2020
Cocaine Use	1.9%	1.7%	1.9%	2.0%	2.1%	1.8%	1.7%
Marijuana Use	9.9%	10.7%	11.2%	12.5%	13.7%	15.0%	16.6%
Alcohol Use Disorder	7.2%	6.1%	6.4%	6.2%	5.6%	4.2%	9.5%

Expanded Access to Medication-Assisted Treatment (MAT)

Methadone, or buprenorphine-assisted maintenance treatment (including psychosocial support as needed and if desired), is the evidence-based standard of care used to treat opioid use disorders. These medications are superior to all other interventions for retaining individuals in care, reducing opioid misuse, and reducing opioid-related mortality, particularly overdose fatalities.[14] According to a recently published network meta-analysis of 72 randomized controlled trials of medications for opioid use disorders, the average percentage of treatment retention across all studies was 64 percent for methadone, 54 percent for buprenorphine, 41 percent for naltrexone (Vivitrol), and 30 percent for nonpharmacological control groups (includes standard of care, usual care, treatment as usual, behavioral counseling, and placebo).[15]

According to an analysis of 25,866 Florida Medicaid enrollees diagnosed with OUD, only about 28 percent go on to initiate medication-assisted treatment. About 56 percent of newly diagnosed individuals who began methadone treatment continued for 180 days, compared to about 19 percent of newly diagnosed individuals who began treatment with buprenorphine. Very few individuals received injectable naltrexone (only 14 during this study period) and none of them received more than the initial dose. Importantly, individuals who remained on medication for 180 days were more likely to survive, exhibiting a 2 percent death rate, while those who did not receive medication-assisted treatment had a death rate five times higher (10%).[16]

In Florida, pharmacies in rural counties are significantly less likely than those in metropolitan counties to have buprenorphine available. Researchers conducted a cross-sectional telephone audit of actively licensed community pharmacies in 11 states, including Florida, to assess the availability of buprenorphine/naloxone films and naloxone nasal spray from May 2020 through April 2021. Florida has the second lowest rate of buprenorphine availability, with only 33 percent of pharmacies making it available. Across all studied states, when buprenorphine was unavailable, only 64 percent of respondents indicated a willingness to order it. Pharmacies in metropolitan Florida counties are significantly more likely than those in rural counties to have buprenorphine available. Naloxone nasal spray is only available in 69 percent of pharmacies in Florida. Another “secret shopper” audit study obtained responses from 200 outpatient pharmacies specifically in Miami-Dade, Broward, and Palm Beach Counties, only 38 percent of which had buprenorphine available. Of these pharmacies that did not have any buprenorphine, only 55 percent would be willing to order.

Syringe Services Programs (SSPs) and Harm Reduction

SSPs are front-line public health interventions that effectively reduce the spread of Human Immunodeficiency Virus (HIV) and hepatitis C by reducing the sharing, reuse, and circulation of syringes and injecting equipment.[17] Research shows that every dollar spent on SSPs saves at least three dollars in averted treatment costs.[18] SSPs provide a range of comprehensive healthcare services including testing and counseling for various infectious diseases, overdose prevention, and vaccinations. SSPs also facilitate recovery by linking people with a SUD to

treatment services.[19] Florida's first legal SSP—called the Infectious Disease Elimination Act (IDEA) Exchange—opened in Miami-Dade County on December 1, 2016. The program provides compassionate and nonjudgmental services, and it empowers people who use drugs to make healthier and safer choices regardless of whether they are ready to stop using drugs. From July 1, 2021, to June 30, 2022, 939 participants were served. During this time, 359 participants were tested for HIV and 347 participants were tested for hepatitis C. In addition, 120 participants entered drug counseling or treatment.[20]

The IDEA, signed in 2019, permits county commissions to authorize the establishment of additional SSPs through county ordinances.[21] The law requires county commissioners to take several steps including enlisting the help of county health departments to provide ongoing advice and recommendations regarding program operation. Additional information can be found at this location: http://www.floridahealth.gov/programs-and-services/idea/exchange.html.

In Florida, there are five approved and currently operational SSPs: The IDEA Exchange (located in Miami-Dade County) operated by the University of Miami Miller School of Medicine, the Special Purpose Outreach Team (SPOT), operated by Care Resource in Broward County, the Florida Access to Syringe and Health Services (FLASH) Exchange (in Palm Beach County), implemented by Rebel Recovery, IDEA Exchange Tampa (Hillsborough County), and IDEA Orlando (Orange County) implemented by Hope and Help. An SSP in Pinellas County will be opening its doors in 2022.

In Florida, counties interested in implementing harm reduction programming through SSPs do not have the support needed to explore, prepare, implement, and sustain efforts. Apart from federal funds, grants and donations are the only authorized funding sources for SSP operations in Florida. The five currently operating SSPs receive funding for harm reduction supplies and services from private donations and foundations. DCF donates naloxone nasal spray kits to the SSPs. All sites reported that the biggest barrier to the effective implementation and operation of their program is funding for harm reduction supplies. Current funding is inadequate to support the foundational operation of the exchanges, with one site reporting continuous supply shortages that have led to the SSP closing on certain days of the week at a time when the program was experiencing rapid growth. Based on current operations, restricted sources of funding, self-reported number of injections per day by clients, and the restrictive 1-for-1 exchange model, Florida SSPs report only meeting about 35 percent of client needs for harm reduction supplies. Because the provision of harm reduction services and low-barrier access to medication-assisted treatment through SSPs is so essential to reducing the opioid-related death rate, expanding the number of operational SSPs throughout Florida is imperative. Research indicates that only 17 percent of Florida counties containing ZIP codes vulnerable to an outbreak of acute hepatitis C virus are currently home to an approved SSP.[22]

SSPs are also effective organizations at saving lives by distributing naloxone directly to people who use drugs. Since the inception of DCF's OPP, the five operational SSPs have distributed over 30,000 naloxone kits and reported 5,602 reversals/rescues. About 29 percent of all reversals/rescues reported to DCF are through the SSPs. Supplying SSPs with naloxone kits, therefore, remains a top priority. As other harm reduction organizations, Recovery Community Organizations, and Peer Networks, expand and evolve in ways that engage and maintain relationships with the hardest-to-reach, most at-risk individuals in their communities, they should also receive priority support for naloxone distribution.

In 2022, the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded Harm Reduction Grant Program funds to Pan American Behavioral Health Services of Florida in Orlando ($398,873) and Lakeview Center in Pensacola ($350,259).[23]

Overdose Data to Action (OD2A) Grant

In September 2019, the FDOH state health office and the Broward, Duval, and Palm Beach CHDs were awarded grant funding through the OD2A grant from the CDC. This now four-year grant provides $58.8 million for surveillance strategies to improve the collection and timely dissemination of actionable overdose data, and prevention strategies implemented at the local level that are informed by more timely data streams. During year three of the grant, the state health office-maintained allocations of $2.2 million in mini-grants to 14 counties as well as allocated $1.2 million to six additional counties to assist local communities experiencing high impacts from the overdose epidemic. All 20 counties received funding to accomplish core surveillance and prevention activities of OD2A. These activities include support for awareness campaigns to highlight the risks of SUD and enhancements to surveillance systems and data collection efforts to assist with monitoring overdose trends, understanding which populations are most at risk to prioritize resources, and evaluating ways to distribute resources. Five counties also received continuous funding to implement evidence-based curriculums in public schools (Brevard, Manatee, Nassau, Pasco, and Sarasota) and efforts increased to three counties receiving funding to support community paramedicine projects to improve patient follow-up among individuals most at risk of overdosing; Clay, Marion, and now Escambia. Forecasting indicates the next phase of OD2A funding will be released in the spring of 2023. This opportunity will allow for continued evidenced-based prevention efforts at the local levels throughout Florida.

Florida's Prescription Drug Monitoring Program (PDMP)

Florida's PDMP, the Electronic-Florida Online Reporting of Controlled Substance Evaluation Program (E-FORCSE), provides data related to controlled substance prescriptions in the state. From July 1, 2021, to June 30, 2022, there were 30,097,722 controlled substance prescriptions dispensed to Florida patients, a 1.7 percent decrease from the previous year. In addition, 5.06 million people in Florida have been prescribed one or more controlled substances, an increase of 1.2 percent. Alprazolam SA, Oxycodone SA, and Hydrocodone SA were ranked the top three most commonly dispensed controlled substances for the seventh year in a row, together representing 34.9 percent of the total controlled substances dispensed from July 1, 2021, to June 30, 2022. Drugs with the largest year-to-year decreases in dispensing were temazepam (-8.9%), phentermine (-5.4%), and tramadol SA (-4.9%).[i]

Law Enforcement Perspective

Florida law enforcement remains engaged in the current effort to reduce the availability of heroin, fentanyl, fentanyl analogs, and other substances contributing to opioid-involved overdose and overdose deaths. The threats posed by fentanyl have increased in recent years as Mexico-based drug trafficking organizations (DTOs) have been mass-producing illicit fentanyl, mixing fentanyl with other drugs, and manufacturing fentanyl-laced counterfeit pills.

Mexican Transnational Criminal Organizations (TCOs) have become the top producers of fentanyl by obtaining the chemical precursors from China and manufacturing the drug in Mexico. Both heroin and fentanyl typically make their way into the U.S. across the Southwest Border but may also enter via mail or other points of entry and are then distributed by local gangs or DTO's (Drug Enforcement Administration (DEA) 2020 Assessment).[24]

The amount of methamphetamine seized along the U.S. Southwest border increased significantly between 2018 and 2021 as Mexican TCOs continue to smuggle methamphetamine over land routes. These TCOs are able to manufacture high-quality, low-cost methamphetamine

in large quantities. Once inside the U.S., the methamphetamine is typically sold to U.S.-based gangs and DTOs for distribution (DEA Drug Seizure Statistics).[25]

To support emergency responder needs related to increasing numbers of overdoses, the Florida Department of Health HEROS program (Helping Emergency Responders Obtain Support) helps to provide free naloxone to emergency response agencies. Over 455,000 doses have been provided through the HEROS program to emergency response agencies in Florida since 2018. Naloxone can be used to rapidly reverse the effects of an opioid overdose and in turn, save many lives.

Between July 1, 2018, and August 31, 2022, the HEROS program has provided 496,176 doses of naloxone to agencies that employ emergency responders. This includes 386 agencies that employ emergency responders in 64 of 67 Florida counties that are participating in the HEROS program, and 18 agencies are currently completing qualifying HEROS program requirements. In addition, the HEROS program is preparing to host four educational webinars in November and December. Members of the HEROS program meet bi-weekly with the DCF, Office of Substance Abuse and Mental Health's Statewide Overdose Prevention Coordinator, to address issues associated with both programs.

2022 Recommendations

1. State agencies and commercial health plans provided service delivery flexibilities to respond to the challenges related to the delivery of mental health and SUD care during coronavirus disease 2019 (COVID-19). It is recommended that the state agencies, commercial health plans, and other private payors permanently adopt these flexibilities, specifically:

- **Waiving prior authorization requirements and services limits (frequency, duration, and scope) for all behavioral health services (including targeted case management).**
- **Maintaining payment parity for telehealth services by reimbursing services provided via telemedicine at the same rate as face-to-face encounters.**
- **Expanding coverage of telehealth services to include telephone communications but only when rendered by licensed psychiatrists and other physicians, physician extenders, and licensed behavioral health practitioners.**
- **Requiring managed care plans to waive limits on medically necessary services when additional services will maintain the health and safety of enrollees, including when it is necessary to maintain enrollees safely in their homes.**
- **Using audio-only services when video capability is not available, and services can only be provided telephonically, which should be thoroughly documented.**

These flexibilities resulted in continued care, addressed transportation concerns, and allowed access to care that was not previously available. The pandemic has been traumatic and has impacted our collective sense of well-being.[26] The pandemic had a significant impact on the delivery of mental health and SUD prevention, as well as treatment and recovery services across Florida and the country, challenging traditional delivery systems. Assisting this effort was the innovation and waiver of rules authorized by federal and state agencies and commercial health plans to allow flexibilities related to telehealth and audio-only telephonic services. Without these flexibilities, access to services would have been significantly diminished due to social distancing restraints, availability of transportation, stay-in-place orders, and quarantine requirements. Community mental health and SUD service providers report that the flexibilities allowed providers to continue serving clients during a period of increased anxiety, depression, psychosis, and substance abuse directly related to the isolation and economic uncertainty of COVID-19.

- Prior authorization and service limit flexibilities enacted for behavioral health services in response to Florida's COVID-19 state of emergency ended July 1, 2021. AHCA continues to allow most of the flexibilities as outlined at http://portal.flmmis.com/FLPublic/Provider_COVID19/tabId/160/Default.aspx. AHCA will continue to assess the need for continued flexibility in these areas.
- Prior authorization requirements have been reinstated, but the following flexibilities remain in place:
    - Waiving service limits for behavioral health services, including targeted case management.
    - Allowing for behavioral health treatment services to be delivered via telemedicine.

- Allowing for behavioral health services to be delivered via audio-only telemedicine when video capability is not available, and services can only be provided telephonically.

AHCA covers behavioral health evaluation, diagnostic, and treatment recommendation services through telemedicine. AHCA reimburses the behavioral health assessment and medication management screening services through telemedicine, at the same rate detailed on the community behavioral health fee schedule. Providers must perform all service components designated for the procedure code billed. Providers must append the GT modifier in the fee-for-service delivery system to indicate that services were delivered via telemedicine rather than in person.

School districts determine locally whether to offer and implement telehealth in the school setting as a part of the Mental Health Assistance Allocation Plan submitted to the state pursuant to section (s.) 1011.62, Florida Statutes.

2. To effectively address the opioid crisis and the anticipated growth in mental health and SUD service need, it is critical that a vibrant, stable, and well-trained workforce be available to provide prevention, treatment, and recovery services. To address the workforce crisis, the Council recommends adopting changes in payment methods, background screening, exemptions for peer specialist applications, and greater flexibility with telehealth, reimbursing providers the same amount for telehealth and in-person visits.

DPAC recommends:

- Support prospective payment as a critical component of Florida's Certified Community Behavioral Health Clinics (CCBHC) initiative. Authorize the Managing Entities to utilize a prospective payment model.
- Encourage the Florida Legislature to consider modifying background screening legislation related to peer specialists to allow easier access into the workforce. For example, allowing an individual to work prior to full payment of fines and fees if the individual is honoring a payment plan
- Encourage DCF to ensure that the application and instructions for the exemption process are clear and easy to understand for applicants and employers for peer specialist applicants working with adolescents and adults with mental health or a SUD.
- Allow greater flexibility to telehealth services, especially in rural areas of the state. Continue the current flexibilities with telehealth as a mode of service provision and provide payment parity and coverage parity for services provided via telehealth, meaning the behavioral health service is reimbursed for the same amount whether provided via telehealth or in person.

Florida, along with the rest of the country, is experiencing a shortage of healthcare professionals to meet the growing need. For behavioral health professionals, the shortage in Florida is reaching near-critical levels. The shortage has a direct impact on the ability to provide critical treatment and recovery services. The inability to staff critical SUD and mental health services has resulted in a reduction of service availability at the same time the need for services is increasing. The impact of COVID-19 has also added an additional stressor to workforce concerns. While it is anticipated the need for behavioral health services in Florida will increase due to the impact of the pandemic and the continuing opioid crisis, the providers of mental health and SUD services across the state are already struggling to fill existing vacant positions.

Another indication of trouble in the workforce is the turnover rate of existing employees. The Florida Behavioral Health Association conducted a survey of its members in May 2021 and May 2022.[27] The survey indicated the following annual turnover rates on a variety of positions and shows that, apart from Behavioral Health Technicians, turnover rates have essentially remained the same or increased.

Figure D. Turnover Rates for Behavioral Health Professionals (2021-2022)

	2021	2022
Behavioral Health Tech: Certified	-16%	-9%
Clinician: Bachelors, unlicensed	-34%	-43%
Clinician: Masters and unlicensed	-57%	-55%
Licensed Clinical Social Worker	-15%	-33%
Licensed Marriage Family Therapist	-17%	-19%
Licensed Mental Health Counselors	-26%	-43%
Licensed Practical Nurses	-35%	-58%
Peer Specialist	-26%	-27%
Physician: Medical	-19%	-13%
Registered Nurses	-32%	-47%
Senior Clinical Manager: Licensed	-15%	-20%

Along with other economic and industrial sectors, the COVID-19 pandemic seemed to exacerbate workforce shortages experienced by behavioral health providers. Information that Florida Behavioral Health Association gathered from its members in October 2021 showed that both vacancy rates and the average number of days to fill vacant positions have essentially doubled (or more) since before the pandemic for most clinical positions. For example, vacancy rates for Advanced Practice Registered Nurses (APRN) increased from 9 percent to 24 percent and from 19 percent to 38 percent for master's level clinicians. In addition, the average number of days positions are vacant increased from 45 days to 99 days for nurses and from 41 to 97 days for licensed clinicians.

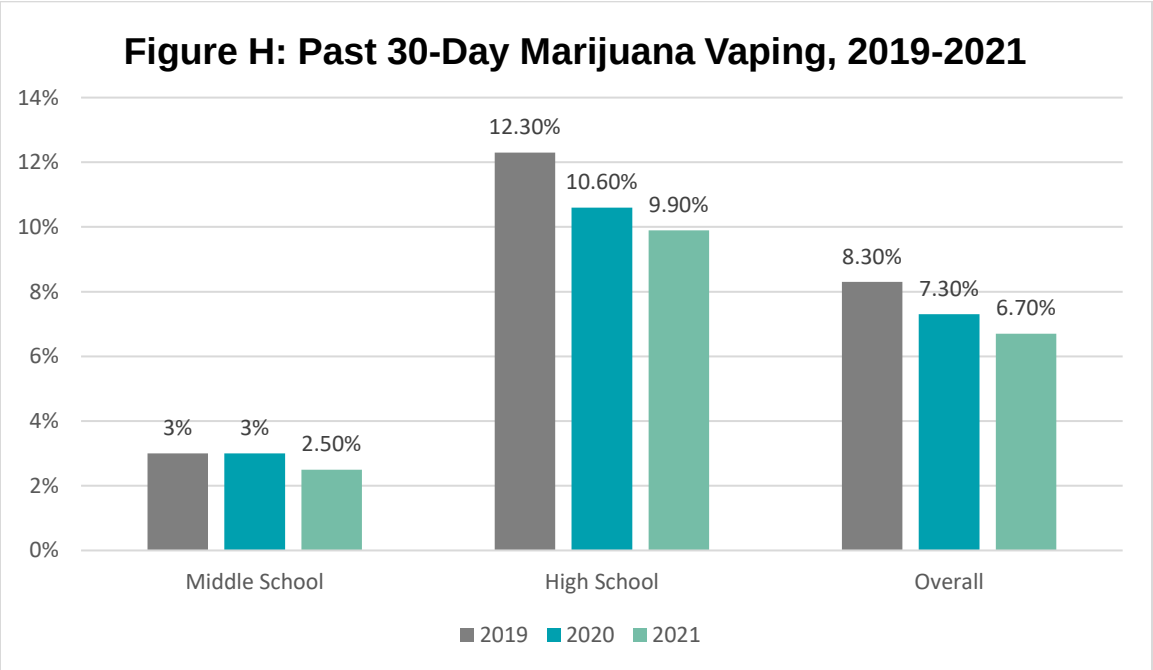
Figure E. Changes in Vacancy Rates for Key Behavioral Health Positions

	Vacancy Rates		Average Number of Days Position Vacant	
	Pre-COVID-19 pandemic	October 2021	Pre-COVID-19 pandemic	October 2021
APRN	9%	24%	50	94
Behavioral Health Technician	16%	28%	34	73
CAP	7%	17%	38	77
Case Manager/Care Coordinator	16%	34%	39	67
Licensed Clinician	19%	38%	41	97
Master's Level Clinician	19%	38%	39	86
Nurse	15%	38%	45	99
Peer Specialist	19%	33%	48	99
Psychiatrist	13%	22%	75	163

While turnover cannot be correlated solely to available funding for salaries, the lack of competitive salaries plays a significant role in the ability to staff safety net providers. Competition for employees from larger health systems, managed care organizations, school districts and federal agencies such as the Veterans Administration is significant. While these systems have more flexibility to set competitive salaries, community providers are often limited by the public resources allocated for services. The CCBHC model being implemented nationally and in Florida has allowed providers to leverage their grant funding and/or Medicaid payment structure to train, recruit and retain highly qualified staff.[28]

3. Develop and implement a substance-use prevention strategy designed to reduce drug use among youth 12–17 years of age. The strategy should focus on: (1) deployment of a unified anti-drug messaging campaign developed around evidence-based practices to ensure good outcomes, (2) increasing/maintaining substance use prevention efforts by securing/sustaining front-end prevention funding that increases screenings and addressing trauma-related issues among youth, and (3) expanding state partnerships with anti-drug coalitions, educational institutions, law enforcement, and other members of the 12 Community Sectors.

In many ways, Florida has made significant gains in preventing substance use among youth. According to the 2021 FYSAS, high school students reported a 19.4 percent reduction in their past 30-day alcohol use and a 10.7 percent reduction in cigarette use as compared to 2010.[29] Despite these gains, new trends demonstrate the need for concern. According to the 2020 Monitoring the Future survey, 24.7 percent of 12th graders have used some form of e-cigarette to consume liquid nicotine within the past 30 days. The Monitoring the Future survey further outlined that 12.2 percent vaped marijuana, 1.8 percent vaped hallucinogens, and another 1.7 percent vaped amphetamines.[30]



Graph highlights “past-30-day marijuana vaping (2019-2021)” trends identified in the 2021 Florida Youth Substance Abuse Survey.

Recognizing vaping as an enduring and significant problem, the FDA expanded their anti-vaping/e-cigarette prevention campaign. The campaign, entitled “The Real Cost,” is part of the FDA’s ongoing effort to protect youth from the dangers associated with e-cigarettes, smoking, and chewing tobacco. The FDA uses a science-based approach to educate young people on the dangers of e-cigarettes and it hopes to reach 10 million students nationally. To deploy its message, the FDA employs television ads, online videos, websites, social media, and printed materials distributed throughout the U.S. at no cost to the end user.[31,32] With the use of a multifaceted drug prevention campaign, Florida can reduce and/or delay the use of alcohol, e-cigarettes, tobacco, and/or other recreational drugs by youth ages 12-17. To maximize impact, community partners such as DCF, Florida Department of Education (DOE), Florida National Guard Counterdrug Program, and other anti-drug organizations should be engaged in the process.

4. Engage in an evidence-based substance use prevention program designed to reduce drug use among youth 12–17 years of age. The curriculum should focus on evidence-based and/or evidence-informed prevention strategies proven to reduce substance use, while also increasing youth resiliency, coping strategies, positive mental health, and responsible decision-making. The end goal is to better link existing prevention education programs with Florida's educators and to reduce substance use and abuse among Florida's youth.

Engagement of an evidence-based and/or evidence-informed prevention strategy, Florida has the opportunity to reduce substance use among youth. Prevention programs such as these have proven to reduce drug use, while also increasing youth resiliency, enhancing their mental health, and providing students with sound protective factors that will aid them in making critical decisions.

Florida’s communities are geographically and culturally unique. Therefore, all evidence-based practices must be flexible and adaptable to the needs of specific populations. These practices must contain a core prevention foundation that remains uniform across the state and provides guidance to administrators on acceptable changes or adaptations in methods of delivery. This process should ensure fidelity and provide measurable, repeatable, and effective outcomes. Collaboration between evidence-based administrators, researchers, and developers would be mandatory. To facilitate this process, SAMHSA has established an evidence-based practice online resource center. The SAMHSA resource center contains a collection of evidence-based resources for a broad range of audiences. These resources include substance use prevention plans, treatment improvement protocols, toolkits, resource guides, clinical practice guidelines, and science-based resources.[33]

Many adult issues, including chronic diseases, substance dependency, depression, and other mental health conditions, are now understood to be negative outcomes of experiencing trauma and toxic stress in childhood. The Centers for Disease Control and Prevention (CDC) Kaiser Permanente Adverse Childhood Experiences (ACE) Study discovered a direct relationship between these “adverse childhood experiences” and lifelong physical and mental health conditions.[34]

The Florida Board of Education adopted Substance Use and Abuse standards for grades 6-12. These standards will provide support and guidance for the teaching of substance use and abuse education in Florida’s schools and were fully implemented beginning with the 2022-2023 school year. This will allow opportunities for students to develop an awareness of the dangers associated with the use and abuse of harmful substances.

Through “The Facts, Your Future.” launched by First Lady, Casey DeSantis, the state of Florida is focusing on supporting students statewide to ensure they receive prevention instruction and encouragement to protect and maintain their health, avoid substance misuse, and discourage risky behaviors so they can thrive and flourish for life. This campaign is an interactive approach to ensure students are informed and can make safe decisions as they grow.

The Red Ribbon Campaign is the oldest and largest anti-drug campaign in the nation. Organized by the National Family Partnership after the murder of DEA Agent Kiki Camarena, the Red Ribbon Campaign recognizes the power and outreach of grassroots citizens and parents to effectively organize communities to change negative social norms.

5. Develop and implement a stigma reduction campaign designed to reduce the negative feelings associated with a SUD and other mental illnesses/injuries. Messaging should increase the awareness of medically assisted treatment options, reduce the stigma associated with addiction, and inform the public of the many benefits that come with obtaining psychiatric, psychological, and/or therapeutic services from a licensed professional.

Individuals with substance use or mental health disorders often experience three forms of stigma. These include structural, public, and self-stigma.[35] Societal norms and attitudes drive the first two types, while the third occurs when individuals internalize these negative opinions. Self-stigma causes lowered self-esteem, decreased self-efficacy, and amplified feelings of embarrassment and shame. As a result, stigma can impede an individual’s willingness to pursue treatment, thus placing them at a higher risk for crisis and/or fatal overdose.[36]

Through a stigma reduction campaign, Florida can (1) educate citizens on the benefits of recovery and (2) guide them in obtaining treatment. Parallel to this effort, Florida should continue to bring awareness to DCF’s naloxone initiative. Naloxone is the medication used to reverse opioid overdose. DCF provides information on where individuals can access this medication within Florida. Targeted audiences for this campaign should include high-risk populations, their friends, and family. Campaign mediums include radio ads, interviews with key stakeholders, printed materials, and a website that allows individuals to search for the nearest naloxone distribution site within their area: https://isavefl.com/. AHCA has been actively working with health plans and external stakeholders to support messaging and awareness of MAT treatment options, as well as working to combat access barriers related to MAT and to encourage additional providers to become MAT prescribers to address any health care gaps for members.

The FLNG-CD Drug Demand Reduction Outreach Program (DDRO) has supported several stigma reduction initiatives by assisting with Opioid Awareness Day ceremonies, Remembrance vigils, social media campaigns, and related articles. Every coalition that FLNG-CD DDRO interacts with implements or supports a mental health/well-being initiative, recognizing the link between mental health and substance misuse and abuse. Several prevention partners experience low community participation. Over time participation has increased as preventions partners become more seasoned with planning and coordination. However, several preventions partners continue to achieve marginal audience attendance or participation.

Florida National Guard will continue to support stigma reduction activities with increased efforts on community involvement. Prevention Partners are efficient at coordinating the events but need further assistance with community engagement.

6. Encourage pharmacies to educate consumers on safe medication storage and disposal procedures when filling prescriptions for controlled substances. Establish a media campaign that incorporates appropriate technology to educate consumers on reasons for safe use, safe storage, and safe disposal as well as the location of safe disposal boxes in each community.

Several resources are available to help people in Florida understand the proper steps to dispose of unused medication:

- The Florida Office of Attorney General's drug abuse prevention site, https://doseofrealityfl.com/drug-take-back.html, offers a link to an interactive map to locate drug take-back locations.
- The Florida Department of Environmental Protection offers information online regarding pharmaceutical waste management for homeowners. The website can be accessed here: https://floridadep.gov/waste/permitting-compliance-assistance/content/pharmaceutical-waste-management.
- The CVS Health locations with drop boxes may be found here: https://www.cvs.com/content/safer-communities-locate.
- The Walgreens locations with drop boxes may be found here: https://www.walgreens.com/topic/pharmacy/safe-medication-disposal.jsp.
- The DEA Diversion Control Unit hosts National Take Back Days (https://takebackday.dea.gov/). There were 1,040 pounds collected in Florida in 2020.
- Through their partnership with Publix, Informed Families also developed a web page focusing on safe disposal locations in Florida, which is consistently updated: https://www.informedfamilies.org/lym/safedisposal.
- Through the State Opioid Response (SOR) grant, DCF is funding a safe use, safe storage, and safe disposal campaign based on the Use Only as Directed initiative from Utah. Over 1 million people have seen or heard a campaign message to date.

Over the past four years, the FLNG-CD DDRO has funded the printing of Rx Drop-Off Location magnets to assist prevention partnerships in supporting Rx safe disposal practices. Additionally, FLNG-CD DDRO supported several coalitions with media campaign efforts in support of semi-annual DEA Take Back Day activities while emphasizing the importance of safe usage, safe storage, and safe disposal.

DEA Take Back events often need additional help from law enforcement. Coalitions are making efforts to advertise, but locations are limited because there must be a law enforcement officer present at each drop-off location to manage the chain of custody and transportation of medication. Florida National Guard will continue to support safe medication and disposal efforts. However, a larger law enforcement presence will give Prevention Partners the capacity to properly coordinate adequate Rx drop-off locations.

7. Establish medical marijuana advertisement standards that restrict the advertising methods of medical marijuana/cannabis evaluation clinics, conveyance shops, and other services or businesses not currently governed by Amendment 2 (section 381.986, Florida Statutes.)

Since the passing of Amendment 2, the Florida medical marijuana initiative in 2016, 22 medical marijuana treatment centers and 486 dispensaries have opened throughout the state. Florida's treatment centers are regulated by laws established under section 381.986, Florida Statutes, and indirectly supported by 2,572 physicians.[37] The physicians have completed the state-

mandated two-hour “Florida Physician Medical Marijuana Course,” which then qualifies them to register their patients into the “Medical Marijuana Use Registry.” The registry is an online database that medical marijuana treatment centers use to validate the patient’s qualifying condition, dosage, and authorized forms of medical marijuana. Prior to adding the patient to the registry, a physician must diagnose the individual’s condition(s) and then determine if the benefit of medical marijuana outweighs the potential health risks associated with use.[38] To accomplish this task, several physicians have opened medical marijuana/cannabis evaluation clinics.

While section 381.986, Florida Statutes, clearly defines the advertising laws that govern treatment centers, no legislation exists to regulate methods used by evaluation clinics. Florida businesses participating in the medical marijuana trade may already be recklessly impacting youth in recreational marijuana use.

FLNG-CD DDRO assisted with the collection of tobacco scans in several counties throughout the state. These scans have included smoke shops which, while principally marketed as being for tobacco and vaping, seem to obviously sell paraphernalia to smoke marijuana/medical marijuana. DDRO South Florida has included pictures specifically of these products when possible (to avoid conflict with store owners) when submitting the respective completed scans along with notes on what was stated by the clerks/owners and to describe the pictures. Several Florida coalitions are actively discussing the issue of city zoning laws to deal with possible medical marijuana dispensaries within the city limits (whether to attempt to prohibit them or how to heavily regulate them).

8. Establish legislation to regulate (1) preparation, distribution, and sale of kratom-based products (Mytragyna Speciosa) that contain the alkaloids mytragynine and/or 7-hydroxymitragynine; (2) prohibit the preparation, distribution, and sale of adulterated or contaminated kratom products; (3) assign authorities and responsibilities to ensure compliance standards are met and/or maintained; 4) incorporate strategies to prohibit market and sale of kratom to minors, and (5) establish corrective actions/penalties for actors/agencies that would violate such legislation.

Kratom (Mytragyna Speciose) is a tropical tree native to Southeast Asia. Consuming kratom can produce both sedative and stimulant effects (dosage dependent) and lead to psychotic symptoms and psychological/physiological dependence.[39] Kratom is typically smoked, brewed into tea, chewed, or ingested through capsules. Kratom has been used in Southeast Asia for many years but has only recently been seen in the U.S. Kratom’s effects on the body include nausea, itching, sweating, dry mouth, constipation, increased urination, tachycardia (rapid heartbeat), vomiting, drowsiness, and loss of appetite. In some cases, kratom users have experienced anorexia, weight loss, insomnia, hepatotoxicity (chemical-driven liver damage), seizures, and hallucinations.

The FDA continues to warn consumers not to use kratom. Research conducted by the FDA, CDC, and various other independent laboratories consistently determines that kratom binds to the same opioid receptors as morphine, which can then lead to addiction, abuse, and dependence.[40] The FDA remains concerned that some kratom producers claim their product contains medical benefits. Many distributors market their products to individuals with SUD as a tool for achieving sobriety from opioids and alcohol. Due largely to these concerns, the FDA has issued warning letters to multiple kratom vendors that have specifically marketed their products to people with SUD advising that their kratom will assist with opiate and alcohol withdrawals. The FDA believes these unsubstantiated claims will potentially delay an individual in need of treatment from entering legitimate recovery programs, thus, significantly increasing their

chances of overdose and death. The FDA does not currently view kratom as a legitimate medication or substance that can assist individuals with SUD in achieving sobriety.[41]

9. Encourage the continued establishment of warm handoff programs, such as the Coordinated Opioid Recovery Network (CORE) from hospital EDs to community OUD treatment providers to address opioid overdoses; issue naloxone to overdose patients before they leave the ED;

The Coordinated Opioid Recovery Network (CORE) is an innovative program currently being launched in 12 counties, with plans to expand to all Florida counties in the next two to three years. CORE is an evidence-based program that emphasizes stabilization in an ED and a warm handoff to a long-term treatment facility, as well as medication-assisted treatment and, uniquely, the involvement of first responders. FDOH and DCF are working together to fund and implement CORE.

The CDC has cited EDs as important centers for OUD interventions and care transitions, including the induction of buprenorphine as part of the overdose protocol. This practice has been shown to be superior to motivational interviewing and referral alone. A 2015 study by researchers at the Yale School of Medicine tested three interventions for opioid-dependent patients who were treated in a hospital ED. The first group was given a handout with contact information for addiction services. The second group received an interview on information about treatment options such as assistance in connecting with treatment. The third group received an interview plus the first dose of buprenorphine, with take-home doses and a scheduled appointment with a primary care provider within 72 hours. The study found that 78 percent of patients in the third group (buprenorphine) were still in treatment 30 days later, compared with 45 percent in the group that only got the interview and 37 percent who only got the handout. [https://www.npr.org/sections/health-shots/2017/08/22/545115225/hospitals-could-do-more-for-survivors-of-opioid-overdoses-study-suggests]

Direct linkage from the ED to a community OUD provider, known as “warm handoffs”, is proving to be a better option to serve this population; however, these interventions are infrequently utilized. According to the Florida Hospital Association, there are 209 EDs in Florida. To date, only a limited number have been identified as having, or are in the process of implementing, a warm handoff protocol.

As the opioid epidemic continues, EDs will play an integral part in mitigating the human toll on many levels through screening and identification of patients at risk for OUD, managing acute opioid withdrawal, initiating MAT and coordinating linkage to outpatient treatment. However, much work remains to be done to create, validate, disseminate, and implement effective evidence-based strategies to accomplish these challenging tasks within the unique care environment of the ED.

As part of AHCA’s Medicaid Quality Bureau initiatives, AHCA requested that each Medicaid health plan develop provider resource guides with direct service lines, escalation contacts, and after-hours instructions covering a wide range of service areas including behavioral health, case management, perinatal care, pharmacy etc. AHCA’s goals with this initiative are to improve communication and coordination between plans and providers generally, and more specifically: to reduce readmissions by improving communication among health plans and providers; to improve members’ access to timely and appropriate services post-discharge; and to streamline the coordination of behavioral health services for members, especially those with SUD and OUD.

Each health plan's resource guide includes a designated OUD/SUD contact person and a direct phone number and/or email address. These designated contacts have been identified by the health plan to assist with a "warm handoff" to coordinate services for members along with the member's case manager.

Additionally, AHCA launched a free continuing medical education (CME) learning opportunity for physicians and physician extenders in October 2021. Providers that complete the CME will learn how to use SBIRT in their daily practices. With this initiative, AHCA aims to reduce the impact of substance use disorders in Florida by increasing the capacity of healthcare providers to screen, briefly intervene, and refer to and treat individuals with substance use.

10. Expand additional fellowship and residency programs for physicians to obtain a specialty in addiction medicine with a goal of increasing physicians with an addiction medicine specialty.

There is an opportunity to expand the subspecialty of addiction medicine to help ensure patients with a SUD are being properly treated by medical professionals. The Accreditation Council for Graduate Medical Education has accredited Florida institutions to sponsor addiction medicine and addiction psychiatry fellowships, which are one-year training programs.

For addiction medicine fellowships, the University of Florida has been approved for seven fellows training in the specialty, the University of South Florida has one fellow, and Larkin Community Hospital has three fellows. For addiction psychiatry fellowships, the University of South Florida has been approved for two positions and none are filled. The University of Miami/Jackson Health System has been approved for three positions and two are filled. [i]

The opioid epidemic in Florida is changing the dynamic of the delivery of SUD treatment and care. The standard for care for an OUD is MAT combined with behavioral counseling. SUD treatment programs across the state have had to add and/or increase medical professionals on treatment teams to evaluate, prescribe, and medically monitor MAT medications. To prescribe buprenorphine, medical personnel must complete a training course and pursue a waiver to prescribe buprenorphine under the Drug Addiction Treatment Act of 2000 (DATA 2000). There is a growing need for physicians certified in addiction medicine.[42] Out of the 52,684 physicians in Florida, only about 0.25 percent—one-quarter of one percent—are certified in addiction medicine.

The American College of Academic Addiction Medicine indicated only three addiction medicine residency programs in Florida: HCA Healthcare/University of South Florida (USF) Morsani College of Medicine GME in Brandon, University of Florida (UF) Addiction Medicine Fellowship Program in Gainesville, and Larkin Community Hospital Palm Springs Campus Addiction Medicine Program in Hialeah. In addition, Florida's physician survey results indicate that 33 more physicians indicated a specialty in Addiction Medicine since last year, bringing the total number to 168. These physicians practice in the areas of Anesthesiology, Family Medicine, Internal Medicine, Neurology, and Psychiatry.

11. Pass model legislation that will align Florida law with the federal Mental Health Parity and Addiction Equity Act (MHPAEA) and require all state health agencies, health plans, and commercial insurance to report annually on the implementation of the parity act in Florida. These reports should be transparent and available to inform the public.

In 2008, the U.S. Congress unanimously approved the Paul Wellstone and Pete Domenici MHPAEA known as the federal parity law. Many state legislatures have passed similar laws to

ensure parity enforcement. The federal law seeks to eliminate discriminatory access to mental health and SUD benefits in health insurance coverage. The federal parity law prohibits plans from applying financial requirements or treatment limitations to mental health and SUD benefits that are more restrictive than those applied to medical/surgical benefits. Treatment limitations and financial requirements to be evaluated include co-pays, deductions, co-insurance, day or visit limits, pre-authorization policies, frequency of treatment limits, fail-first policies, and non-qualitative treatment limitations.

In Florida, the majority of Medicaid recipients receive their services through a managed care plan contracted with AHCA under the Statewide Medicaid Managed Care program. AHCA has multiple avenues for monitoring health plan compliance with parity. These include, but are not limited to, a review of health plan policies and procedures (including utilization management); monitoring of provider and recipient complaints; and monthly submission of complaints, grievances, and appeals reporting. Reports required by AHCA include quantitative treatment limits and non-quantitative treatment limits, in addition to the following:

- AHCA currently meets or exceeds parity standards.
- In November 2020, the managed care plans submitted attestations to confirm their mental health parity procedures for monitoring were in compliance with 42 CFR 438, Subpart K, in accordance with Attachment II, Exhibit-IIA, Section VI.G.2.a. The attestation is required on an annual basis. AHCA's Medicaid Quality Bureau reviewed the attestations to ensure compliance with the contractual requirement.

12. State health agencies, health plans, and commercial insurers should remove prior authorization requirements for evidence-based MAT to allow for use of medications such as buprenorphine, naltrexone, naloxone, and methadone.

Currently, Florida's Medicaid State Plan covers behavioral health medication management services as part of a continuum of care for individuals diagnosed with SUD. MAT is covered in conjunction with psychiatric evaluations, counseling, and behavioral therapies to ensure comprehensive treatment. For example, covered treatment may include monitoring current medication dosage and side effects as well as ensuring concerns or changes in health status are addressed properly. Behavioral health-related medical services such as screenings, verbal interactions, and specimen collection are also covered to assist in drug management and treatment of SUD. MAT services can also include methadone-based treatment. Florida Medicaid covers medication management services in addition to a bundled weekly reimbursement for MAT.

Federal changes in April 2021 enabled more providers to prescribe buprenorphine for up to 30 patients without meeting full waiver training requirements.[43]

Additionally, several health plans provide expanded benefits for substance abuse such as additional behavioral health medical services, substance abuse treatment, and outpatient detoxification services. Expanded benefits are extra benefits above and beyond the minimum required benefits detailed in the Medicaid State Plan. Health plans offer these benefits to their enrollees without a capitation payment from AHCA. A comprehensive listing of expanded benefits by health plan can be located on the website at: http://ahca.myflorida.com/medicaid/statewide_mc/outreach_presentations.shtml.

- AHCA has expanded access to MAT. AHCA has made available buprenorphine tablets, Suboxone film, and Zubsolv tablets through an automated process which looks for a diagnosis of opioid use disorder. If the diagnosis is found, the claim pays at the

pharmacy. If the diagnosis is not found, the pharmacy or physician can call the Florida Medicaid help desk and an override will be entered.

- Other MAT that is covered through Medicaid includes:
    - Naltrexone tablets which are covered without prior authorization through the pharmacy benefit.
    - Vivitrol (naltrexone) injectable can be received at the pharmacy through an automated prior authorization. The pharmacy computer system verifies that the recipient is 18 years of age or older and has a diagnosis of alcohol and/or OUD on file. If both are confirmed, the claim will pay. This automation eliminates the need for prior authorization paperwork submission through the pharmacy benefit. Vivitrol is also available through the medical benefit under J2315 if administered in a medical office setting.
    - Sublocade (buprenorphine) injectable can be received at the pharmacy through an automated prior authorization. When the claim information is entered, the pharmacy computer system verifies that the recipient has received a minimum of seven days of treatment with a buprenorphine-containing oral product. If confirmed, the claim will pay for Sublocade through the pharmacy. Sublocade is also available through the medical benefit under Q9991 and Q9992 if administered in a medical office setting.
    - Methadone tablets are available through methadone clinics.
- For overdoses:
    - Narcan (naloxone) nasal spray, Kloxxado (naloxone) nasal spray, and naloxone vials are covered to treat overdose through the pharmacy benefit and under the medical setting under J2310. Medicaid allows a maximum of two Narcan and Kloxxado kits (four nasal sprays) per year. Additional kits within the same year require prior authorization.

The Medicaid preferred drug list is located at: http://www.ahca.myflorida.com/medicaid/Prescribed_Drug/preferred_drug.shtml. MAT not listed on the preferred drug list does require prior authorizations, which are reviewed within 24 hours of receipt. Medications on the preferred drug list are reviewed at least annually by the Pharmaceutical and Therapeutics Committee, which is composed of physicians and pharmacists.

Prior authorization limitations to MAT for SUD disproportionately affect pregnant and postpartum women and their children due to their vulnerability, especially for low-income populations who have severely limited alternative resources. In 2014, prior authorization for prescription buprenorphine was still required for 35 percent of Health Maintenance Organizations, 36 percent of Preferred Provider Organizations, and more than half of Consumer Driven Products.[44]

During pregnancy, universal screening efforts and enhanced substance abuse services—including accessible MAT for all women who need it—are important goals. At birth, the systematic approach to screening infants, monitoring for withdrawal signs using a scoring tool, and managing care for the mother and infant offer numerous opportunities for improving outcomes including the measured use of MAT.[45]

MAT is considered the standard of care for opioid-dependent pregnant women. Service delivery and treatment capacity should be streamlined to ensure women have access to needed services in a timely manner, whether they are staying in their community or in a medical home whenever possible. Compared to medication-assisted withdrawal, MAT is associated with better relapse prevention, decreased exposure to illicit drugs, and other high-risk behaviors improved

adherence to prenatal care, and improved neonatal outcomes. The goal of MAT is to prevent withdrawal during pregnancy and minimize fetal exposure to illicit substances.[46, 47]

Reducing and eliminating barriers to prescribing buprenorphine to treat OUD is critical to ensure greater access to care and reducing opioid overdose deaths. As noted earlier, prior authorization requirements for buprenorphine represent a common barrier cited by prescribers that can delay or interrupt patient care.

13. Promote legislation that adds the Secretary of AHCA and the Commissioner of the Office of Insurance Regulation as members to the Statewide Drug Policy Advisory Council.

AHCA is a health policy and planning entity for the state of Florida. It serves as the single state agency responsible for the administration of the Florida Medicaid program, authorized under Title XIX of the Social Security Act. AHCA shares similar goals with DPAC and would be a valuable addition to its membership.

The Office of Insurance Regulation is responsible for all activities concerning insurers and other risk-bearing entities, including licensing, rates, policy forms, market conduct, claims, issuance of certificates of authority, solvency, viatical settlements, premium financing, and administrative supervision, as provided under the insurance code or Chapter 636, Florida Statutes The Commissioner of Insurance Regulation who heads the Office of Insurance Regulation would be a valuable member of DPAC since health insurance companies decide upon coverage and formularies affecting all residents of Florida.

14. Continue the statewide Recovery Oriented System of Care (ROSC) initiative designed to promote and enhance recovery efforts in Florida and support the continued development of the Recovery Community Organization (RCO) and a statewide RCO that helps link community initiatives.

Over the past several years, DCF has led an initiative to transform Florida's substance use and mental health system into an ROSC which serves as a framework for coordinating multiple systems, services, and supports that are person-centered, self-directed, and designed to readily adjust to meet the needs of persons served as well as their chosen pathway to recovery.

Across the country, independent, nonprofit organizations that are peer-led and governed by persons in recovery, family members, and recovery allies mobilize resources within the community to make it possible for the over 23 million Americans still struggling with SUD to find long-term recovery. Each organization has a mission that reflects the issues and concerns within its community. These community groups, known as RCOs, share three core principles: recovery vision, the authenticity of voice, and accountability to the recovery community.

There has been a focus on the development of RCOs in Florida over the past several years. As a result of an Aetna Foundation grant to the Florida Alcohol and Drug Abuse Association (FADAA), RCO development activities have taken place in 10 communities across Florida. Six of these organizations have completed the RCO development process and four are continuing to move through the development steps. Two additional communities have expressed a desire to begin the RCO development process. In addition, Floridians for Recovery, the statewide RCO, is working with key stakeholders in Putnam County to develop an RCO. These new and developing RCOs across Florida join the seven already existing RCOs bringing the total number

of RCOs in Florida fully developed or under development to 20. In addition, Floridians for Recovery continues to build its capacity as the statewide RCO for Florida. Over the past year, Floridians for Recovery received a Building Communities of Recovery grant from SAMHSA, and Floridians for Recovery has established a Recovery Leadership Council engaging the leaders from all the RCOs in the state. A map displaying all the RCOs across Florida and an RCO locator with information on each RCO can be found on the Floridians for Recovery website at: https://floridiansforrecovery.org/tst-locator/.[48]

15. Evaluate the impact of Senate Bill 1120 (2020): Substance Abuse Services on agency background screening requirements related to the eligibility of individuals with lived experience/peers attempting to enter the workforce; continue efforts to reduce the administrative burden of the background screening and exemption process; promote consistency among state agencies related to the background screening exemption process; ensure an individual with lived experience is part of the exemption review panel.

The use of peers, or individuals with lived experience, has grown significantly in Florida over the past five years. Research has shown that recovery from SUD or mental illness is facilitated by the use of social support provided by peers.[49] These individuals serve multiple roles which include recovery support navigator by assisting in the transition from institutional setting (jail/prison) to the community; crisis support; peer wellness coach; employment support coach; housing support specialist; and recovery coach.[50] Peers are essential team members of Community Action Teams, Family Intensive Treatment Teams, and Forensic Assertive Community Treatment Teams. In addressing the opioid epidemic, peers serve a key role in warm handoff programs encouraging, and at times transporting, individuals who have overdosed and received treatment in an ED to pursue a treatment intervention. In 2019, the Florida Legislature recognized the role of peers by codifying the definition of peer specialist in section 397.311, Florida Statutes.

To specifically address the challenge that peer specialist candidates often cannot pass background screening requirements, the 2022 Florida Legislature passed SB 282, promoting the use of peer specialists to assist an individual's recovery from substance use disorder or mental illness. Specifically, the legislation adds the use of peer specialists as an essential element of a coordinated system of care and provides legislative findings and intent related to the use of peer specialists in the provision of behavioral health care. It revises background screening requirements for peer specialists and adds offenses for which individuals seeking certification as a peer specialist may seek an exemption from eligibility disqualification. It also allows peer specialists to work with adults with mental health disorders (prior legislation only addressed working for substance disorder providers or recovery residences).

The new law also expands the statutory limit for the number of days during which a service provider can work while a request for exemption from a background check disqualification is pending to 180 days from the current 90 days. It provides that individuals certified as peer specialists by July 1, 2022, will be deemed to have met the requirements for certification under the bill, but will be required to comply with minimum standards and requirements needed to maintain certification. The new law also requires DCF to designate a managing entity with an existing certified recovery peer specialist training program to provide training for persons seeking certification as peer specialists. The managing entity must give preference to trainers who are currently certified peer specialists, and the training program must coincide with a competency exam and be based on current practice standards.

SB 1120 specifically addressed screenings and exemptions processed by DCF of individuals who work with adolescents and peer specialists. This does not affect those positions being screened for AHCA facilities and Medicaid Provider Enrollment. It should be noted that the language of this bill does not provide continuity between background screening requirements and the screening requirements for Medicaid Provider Enrollment. An individual could be approved as a peer specialist and be disqualified for enrollment as a Medicaid Provider based on their background screening result.

SB 282 affects the same programs referenced in SB 1120. SB 282 (Chapter No. 2022-13) amends sections 394.4573, 397.4073, and 397.417, Florida Statutes, revising DCF requirements for certifying and training peer specialists. In addition, the bill establishes unique background screening requirements that peer specialists must meet prior to being able to deliver peer support services. Other changes SB 282 makes include requiring DCF to provide information regarding the use of peer specialists in its annual assessment on behavioral health services in Florida submitted to the Governor and Legislature. The bill also includes language that "grandfathers" current peer specialists who received certification prior to July 1, 2022.

The amended language for section 397.417, Florida Statutes, requires peer specialists to have been in recovery for at least two years, complete DCF's training program, and pass a background screening specific to peer specialists. To implement SB 282's requirements, DCF must either develop a program and train peer specialists or contract with a third-party credentialing entity. In addition to training, the program must provide continuing education and develop an exam that must be passed to obtain certification.

16. The Council recommends the modernization, improvement, and appropriate funding for the Baker and Marchman Acts to increase the effectiveness of the Baker and Marchman Acts to serve the people of Florida.

Passed in 1971 but effective in 1972, exactly fifty years ago, the Florida Legislature enacted a landmark piece of legislation—Chapter 394, Florida Statutes—that revolutionized how Florida cares for individuals struggling with mental illness. It also passed similar legislation in the 1970s—Chapter 397—to help individuals addicted to drugs and alcohol. More commonly known as Florida's Baker and Marchman Acts, these laws have been subject to numerous revisions since their enactments, but their fundamental structure has remained unchanged despite numerous case law and scientific developments. This proposal represents the first comprehensive reform of Florida's civil commitment system to reflect these developments and thus remove structural inefficiencies that are limiting access to treatment and causing state resources to be wasted.

In a study by three authors affiliated with the Department of Mental Health Law and Policy at the University of South Florida, they found that involuntary examinations under the Baker Act "are associated with increased risk of arrest." They concluded that "an involuntary examination is a significant signal that individuals with serious mental illness are at risk of arrest. In fact, each involuntary examination was associated with a 12 percent increase in the risk of arrest. An individual Baker Acted four times in a year has almost a 50 percent chance of being arrested in the near future."[51]

Based on data from the Florida Mental Health Institute at the University of South Florida, there were nearly 211,000 involuntary examinations under the Baker Act in FY 2018–2019.[52] Involuntary Baker Act examinations more than doubled (115.31% increase) in the last 17 years. More than 50 percent (106,327) were initiated by law enforcement. More than half (55.8%) of all involuntary examinations were based on evidence of "harm to self only." One in

five (21.52%) was based on “both harm to self and harm to others.” “Harm to others only” was the evidence for 5.6 percent of all involuntary examinations. In a one-year period, it is typical for 21 percent of people with involuntary (Baker Act) examinations to have two or more involuntary examinations.

While people with two or more involuntary exams in a year account for 21 percent of the people with involuntary exams in that year, their involuntary exams account for 44 percent of the total involuntary exams for the year. While people with five or more involuntary exams account for 2 percent of people with exams in that year, their exams account for 12 percent of the total involuntary exams.

Florida ranks 43rd nationally in access to mental health care, has the 4th highest rate of adults with mental illnesses who are uninsured, and at $39.55 per capita, spending for community-based treatment ranks 49th among all states and the District of Columbia. Ironically, however, Florida is spending inordinate resources on acute mental health services.[53]

The cost to house people with mental illnesses in Florida’s jails, prisons, and forensic treatment facilities is minimally $2.2 million dollars per day or roughly $800 million dollars per year. The state of Florida currently spends 25 percent of its entire mental health services budget ($835,480,828)—approximately $212 million dollars annually—for 1,652 forensic beds in state mental health treatment facilities serving approximately 4,012 individuals; most of whom are receiving services to restore competency so that they can stand trial on criminal charges.[5455]

Given the substantial overlap between mental illness and addiction, many of the changes recommended in the Baker Act reform legislation are also recommended for the Marchman Act.

Further, the recommendation is that similar data be collected by the Florida Mental Health Institute for the Marchman Act as is already collected for the Baker Act.

Improving access to treatment under this proposal will help Florida avoid unnecessary acute care spending and will afford those with serious mental illnesses an opportunity for hope and recovery.

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