Florida

UNIFORM APPLICATION
FY 2026/2027 Combined MHBGSUPTRS BG ApplicationBehavioral Health Assessment and Plan

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

OMB - Approved 05/28/2025 - Expires 01/31/2028
(generated on 08/15/2025 5.00.02 PM)

Center for Substance Abuse Prevention
Division of Primary Prevention

Center for Substance Abuse Treatment
Division of State and Community Systems (DSCS)

and

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

State Information

State Information

Plan Year

Start Year	2026
End Year	2027

State SUPTRS BG Unique Entity Identification

Unique Entity ID	GKB5R3B9JGE4

I. State Agency to be the SUPTRS BG Grantee for the Block Grant

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

II. Contact Person for the SUPTRS BG Grantee of the Block Grant

First Name	Bill
Last Name	Hardin
Agency Name	Florida Department of Children and Families
Mailing Address	2415 North Monroe Street Suite 400
City	Tallahassee
Zip Code	32303-4190
Telephone	(850) 491-5356
Fax	
Email Address	William.Hardin@myflfamilies.com

State CMHS Unique Entity Identification

Unique Entity ID	GKB5R3B9JGE4

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

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

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

First Name	Bill
Last Name	Hardin
Agency Name	Florida Department of Children and Families
Mailing Address	2415 North Monroe Street Suite 400
City	Tallahassee
Zip Code	32303-4190
Telephone	(850) 491-5356
Fax	
Email Address	William.Hardin@myflfamilies.com

III. Third Party Administrator of Mental Health Services

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

First Name	Natalie

Last Name	Kelly
Agency Name	Florida Association of Managing Entities
Mailing Address	2415 N. Monroe St Ste#400
City	Tallahassee
Zip Code	
Telephone	8507174410
Fax	
Email Address	

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

From

To

V. Date Submitted

Submission Date

Revision Date

VI. Contact Person Responsible for Application Submission

First Name	Kimberley
Last Name	Brown
Telephone	850-717-4410
Fax	
Email Address	kimberley.brown@myflfamilies.com

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Additional Contact:
Name: Kelly Gergen
Telephone: 850-717-4202
Email: Kelly.Gergen@myflfamilies.com

State Information

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

Fiscal Year 2026

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

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

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

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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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.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

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

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or

attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

State: _____

Name of Chief Executive Officer (CEO) or Designee: Taylor N. Hatch

Signature of CEO or Designee[1]: _____

Title: Secretary

Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

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

Fiscal Year 2026

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Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**

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9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State

management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

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

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

3. Certifications Regarding Lobbying

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

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

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

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

Name of Chief Executive Officer (CEO) or Designee: Taylor N. Hatch

Signature of CEO or Designee[1]: _____

Title: Secretary

Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

Disclosure of Lobbying Activities

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

Name

Taylor N. Hatch

Title

Secretary

Organization

Florida Department of Children and Families

Signature: Date:

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

The Office of Substance Abuse and Mental Health does not engage in lobbying activities.

Signature page is attached.

Planning Steps

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

Narrative Question

Provide an overview of the state's prevention system (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public 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 SMHA, the SSA, and other state agencies with respect to the delivery of mental health and SUD services. States should also include a description of regional, county, tribal, and local entities that provide mental health and SUD services or contribute resources that assist in providing these services. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

1. Please describe how the public mental health and substance use services system is currently organized at the state level, differentiating between child and adult systems.

ORGANIZATIONAL STRUCTURE
STATE LEVEL
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
The Florida Department of Children and Families (the Department) is the statutorily recognized authority for substance use and mental health in Florida and therefore serves as the Single State Authority (SSA) for Substance Use and the State Mental Health Agency (SMHA) for mental health. The Department operates under the direction of a Secretary, who reports directly to the Governor of Florida. The Department serves as the social service agency for the state and oversees the following service areas: Community Services (including Adult Protective Services, Domestic Violence, Homelessness, Hope Florida, and Human Trafficking); the Florida Abuse Hotline, the Office of Child and Family Well-Being; Economic Self-Sufficiency; and Substance Abuse and Mental Health. Each of these areas are managed by Assistant Secretaries who report to the Deputy Secretary of the Department.

SUBSTANCE ABUSE AND MENTAL HEALTH PROGRAM OFFICE
The Substance Abuse and Mental Health (SAMH) Program Office is housed within the Department. SAMH is led by the Assistant Secretary for Substance Abuse and Mental Health who is supported by the Deputy Assistant Secretary for Operations and the Deputy Assistant Secretary for Program Services. SAMH provides oversight for community behavioral health services, State Mental Health Treatment Facilities, and the Sexually Violent Predator Program, and is responsible for behavioral health policy and rule development, grant development and management, contract management, program management, and data collection and analysis. Community SAMH also oversees the Office of Recovery and the Statewide Office for Suicide Prevention.

Regional Operations include six regional SAMH offices, each headed by a Regional Operations Manager who serves as the Department's representative to the community for substance use and mental health within their respective regions. Regional staff are responsible for the dissemination, implementation, and monitoring of the Department's behavioral health goals and statutory duties throughout their regions. This includes oversight of Managing Entity (ME) contracts.

LOCAL LEVEL
MANAGING ENTITIES
In 2013 the Florida Legislature determined that placing responsibility for publicly funded behavioral health services within local entities would expand access to care; increase continuity, efficiency and effectiveness; and streamline administrative processes to create cost efficiencies and better match services with need. As a result, SAMH now contracts with seven Managing Entities (ME) to administer the Department's funding and manage regional behavioral health systems of care throughout the state. MEs are private, non-profit organizations responsible for planning, implementation, administration, monitoring, data collection, reporting, and analysis for behavioral health care in their regions. The MEs contract with network service providers throughout the state.

NETWORK SERVICE PROVIDERS
Network Service Providers are contracted by the MEs to provide prevention, treatment, and recovery support services in their respective catchment areas. These providers are licensed by the Department and are responsible for maintaining licensing requirements in addition to contractual obligations for service provision.

ADULT, CHILDREN AND ADOLESCENT SYSTEM OF CARE
Adult System of Care
Chapter 394, Florida Statutes (F.S.) authorizes and directs "the Florida Department of Children and Families 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." The Department recognizes that the path to treatment and

recovery for behavioral health challenges is unique to the individual. Individuals can choose from a wide array of services developed to meet their behavioral health needs. Decision-making for treatment is shared, and individuals are met where they are to ensure that intervention is person-centered.

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

To ensure that the services for children and adolescents meet the Department's standards, a Children's Behavioral Health Ombudsman was established within the Office of the Secretary. This office receives and manages complaints related to behavioral health services for this population, acts a resource to children, adolescents and their families to identify and explain relevant policies, and provides recommendations to the Department to address systemic issues.

2. Please describe the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and substance use services.

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
The mission of the Florida Department of Children and Families (the Department) 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. In the role of Single State Authority (SSA) for substance use and State Mental Health Agency (SMHA) for mental health, Department staff work in collaboration with business partners and community stakeholders to empower families to achieve positive outcomes.

SUBSTANCE ABUSE AND MENTAL HEALTH PROGRAM OFFICE
The Substance Abuse and Mental Health (SAMH) Program Office serves as the Single State Authority (SSA) for substance use and State Mental Health Agency (SMHA) for mental health led by the Assistant Secretary for Substance Abuse and Mental Health. SAMH staff work in collaboration with business partners and community stakeholders to empower individuals and their families to achieve positive outcomes.

Regional staff are responsible for the dissemination, implementation, and monitoring of the Department's behavioral health goals and statutory duties throughout their regions. This includes oversight of Managing Entity (ME) contracts.

Procurement of the Managing Entity contracts is governed by both ch. 287, F.S., which applies generally to all state contracts, and s. 402.7305, F.S., which applies specifically to Department contracts. In accordance with both Florida and federal law, these contracts require competitive procurement. The statutory authority for the Department to contract with MEs provides for a fixed payment contract, with an advance equivalent to a two-month payment and equal monthly payments thereafter. 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 SAMH contract management staff. In consultation with SAMH program staff to ensure that each ME meets statewide goals and is responsive to the unique conditions of each community it serves.

Managing Entities
Managing Entities, in accordance with both Florida Statute and contract, are required to develop and manage an integrated provider network that meets the behavioral health service needs of the community they serve. The services must be accessible and responsive to individuals, families, and community stakeholders and serve all priority populations as defined in statute and contractual guidance documents.

Network Service Providers
MEs contract with Network Service Providers to provide prevention, treatment, and recovery support services. The Network Service Providers are responsible for providing a comprehensive array of behavioral health services to individuals, including emergency, acute care, residential, outpatient, recovery support, consumer support and prevention services. The service array is included in the community mental health and community substance abuse sections.

STATE AGENCY PARTNERS
In Florida, as with many states, the combined Community Mental Health Services (CMHS) and Substance Use Prevention, Treatments and Recovery Services (SUPTRS) Block Grants do not support the entirety of the publicly funded behavioral health system. Medicaid comprises a significant portion of funding for behavioral health. The Florida Agency for Health Care

Administration (AHCA) serves as Florida's Medicaid authority. The Department, while the single state authority for substance use and mental health, shares administrative responsibility pursuant to Florida Statute with AHCA.

The Florida KidCare program is the umbrella term for Florida's Children's Health Insurance Program (CHIP). Florida KidCare provides a continuum of health insurance coverage to children in families with incomes at or below 250 percent of the federal poverty level. The Florida KidCare program is comprised of four programmatic partners. The Florida Healthy Kids Corporation administers the Florida Healthy Kids program for children ages 5 through 18. AHCA administers the MediKids program for children ages 1 through 4 and effective July 1, 2025, the administration of the Children's Medical Services Managed Care Plan formerly administered by the Department of Health, was moved to AHCA as well. The Department of Children and Families determines eligibility for Medicaid and administers the Behavioral Health Network (BNet) for children ages 5 through 18 with serious emotional disturbances. BNet is a behavioral health services program within the Children's Medical Services Managed Care Plan that is funded by the Children's Health Insurance Program.

In addition to State funding available through the Department and AHCA, Florida's local governments have a statutory vehicle to support behavioral health services through a match requirement based on the amount of state general revenue that a provider receives. This match may be satisfied through cash or in-kind contributions. The authorizing legislation established this as a community issue that is negotiated between local governments and providers. 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 related to the respective agency's service populations. These agencies include:

- Agency for Persons with Disabilities
- Florida Department of Corrections
- Florida Department of Education
- Florida Department of Elder Affairs
- Florida Department of Health
- Florida Department of Juvenile Justice

3. Please describe how the public mental health and substance use services system is organized at the regional, county, tribal, and local levels. In the description, identify entities that provide mental health and substance use services, or contribute resources that assist in providing these services. This narrative must include a description of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

BEHAVIORAL HEALTH SYSTEM OF CARE
As previously stated, Network Service Providers are contracted to provide prevention, treatment, and recovery support services at the local level. Local oversight and management are provided by the regional staff of the Department and the contracted Managing Entity for each catchment area. Services are provided following eligibility and priority criteria in the description below. The description also includes an explanation of community mental health and substance use services provided and those services offered by partner agencies.

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

Priority Populations
Mental Health
Pursuant to s. 394.674, F.S., the following priority populations are established for Department-funded Mental Health Services:

Adults
• Adults who have severe and persistent mental illness. Included within this group are:
o Older adults (aged 65+) in crisis.
o Older adults who are at risk of being placed in a more restrictive environment - due to mental illness.
o Persons deemed incompetent to proceed or not guilty by reason of insanity under chapter 916.
o Other persons involved in the criminal justice system.

• Persons diagnosed as having co-occurring mental illness and substance use disorders.
• Persons who are experiencing an acute mental or emotional crisis.

Children
• Children who are at risk of emotional disturbance.
• Children who have an emotional disturbance.

• Children who have a serious emotional disturbance.
• Children diagnosed as having a co-occurring substance use disorder and emotional disturbance or serious emotional disturbance.

Priority Populations

Substance Use
The following priority populations are established for Department-funded Substance Abuse Services:

Adults
• Adults who have substance use disorders and a history of intravenous drug use.
• Persons diagnosed as having co-occurring substance use and mental health disorders.
• Parents who put children at risk due to a substance use disorder.
• Persons who have a substance use disorder and have been ordered by the court to receive treatment.

Children
• Children at risk for initiating drug use.
• Children under state supervision.
• Children who have a substance use disorder but who are not under the supervision of a court or in the custody of a state agency.

Rural Populations
The Department makes every effort to reach individuals in need of behavioral health services across the state regardless of location. This includes those living in rural areas where a lack of basic resources and transportation make it difficult to access behavioral health services. According to 2020 U.S. Census data, there are 33 counties designated as rural in the state of Florida. Network Service providers are able to serve individuals living in rural areas through telehealth, in-home treatment, outreach, mobile response teams, community partnerships and crisis lines.

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

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

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.
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 Drop-in and self-help centers.
o Income supports.
o Recovery supports.
o Housing supports.
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 Care coordination.
o Intensive case management.
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.
o Advocating on behalf of the person served.

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

Mental health services are also covered services in the State Medicaid Plan. Examples include:
• 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).
• Inpatient services.

In addition to the Medicaid state plan services, managed care providers have an additional array of services they may choose to fund, as long as they are utilized as "in lieu of" services for more restrictive and costly state plan services. Examples of these services include recovery support, wraparound, and early intervention.

Multidisciplinary Teams
The Department funds several team-based community interventions including 39 Florida Assertive Community Treatment (FACT) teams, 73 Community Action Treatment (CAT) teams (a treatment model for children), 15 Community Forensic Multidisciplinary teams, 54 Mobile Response Teams, and 34 Family Intensive Treatment (FIT) teams (a treatment model for caregivers with a substance use condition and at-risk for child welfare involvement. Team-based services aim to divert individuals with significant behavioral health conditions from residential or institutionalized care and support them within their communities. They provide in-home services and supports emphasizing community integration and bolstering family support systems. Additionally, the Department funds 15 Coordinated Specialty Care (CSC) Teams through the Community Mental Health Block Grant set-aside for First Episode Psychosis. CSC Teams in Florida utilize the NAVIGATE and OnTrack NY models.

Suicide Prevention
Pursuant to s. 14.2019, F.S., the Substance Abuse and Mental Health Program Office is mandated to implement suicide prevention efforts through the Statewide Office for Suicide Prevention (SOSP) housed therein. The SOSP collaborated with the Suicide Prevention Coordinating Council (SPCC) and other stakeholders to develop a statewide plan for suicide prevention. The SPCC meets quarterly to discuss suicide prevention efforts, review provisional suicide death data for Florida, and develop the subsequent statewide suicide prevention strategic plans. Suicide Prevention staff also participate in a variety of workgroups, including the Governor's Challenge to combat veteran suicide and a program to address behavioral health conditions for first responders.

Access to Local Crisis Call Centers
The 988 Florida Lifeline comprises 13 local call centers that are nationally accredited by the American Association of Suicidology and provide immediate, free and confidential access to trained crisis counselors. Since data collection began in October 2022 through May 2025, the 988 Florida Lifeline has answered 326,740 calls, made 9,450 referrals to Mobile Crisis Response Teams, referred 136,976 callers to non-acute care in the community, and taken 3,471 calls that were an active suicide attempt in progress that resulted in the caller making it to the next stage of care alive. To date, no suicides have occurred while on the phone with a 988 counselor in Florida. On average, the 988 Florida Lifeline diverts 96% of callers from a higher level of crisis care.

The Department also commits funding to support the Crisis Center of Tampa Bay's Florida Veterans Support Line (www.MyFLVet.com). The Florida Veterans Support Line was launched as a pilot program in 2014, and it has since expanded to every county in Florida. Veterans and their loved ones can call 1-844-MyFLVet and be connected to a peer military veteran who has been trained to provide immediate emotional support, as well as VA and non-VA resources located throughout the community.

Mobile Crisis Response Teams
Mobile Response Teams
Formally established in 2018 to serve individuals aged 0 – 26 and available 24 hours a day, 365 days a year, Mobile (Crisis) Response Teams (MRT) were expanded in 2022 to include individuals of all ages. MRT provide readily available crisis care in the community which increases the individuals that can be stabilized in the least restrictive setting to avoid unnecessary psychiatric hospitalization or emergency department utilization. The Managing Entities contract with local providers for MRT, enabling statewide access to this service across all 67 counties. There are currently 52 MRT in Florida with an average diversion rate of 80% from higher level crisis care.

Short-term Crisis Receiving and Stabilization Centers
Crisis stabilization is an acute care service offered 24 hours a day that provides brief, intensive residential treatment services to meet the needs of individuals experiencing mental health crises who would otherwise require hospitalization. Crisis Stabilization Units (CSU) and Children's Crisis Stabilization Units (CCSU) are residential facilities that conduct voluntary and involuntary

examinations under Florida's Baker Act and serve as alternatives to inpatient hospitalization. In Florida, individuals under involuntarily examination under the Baker Act go to a network of Department "designated" facilities that provide emergency screening, evaluation, and short-term stabilization.

There are 123 designated Baker Act receiving facilities in Florida, including 64 public facilities that have a contract with a Managing Entity and 59 private facilities. Baker Act receiving facilities conduct voluntary examinations and include hospitals licensed under Chapter 395 F.S. and CSUs licensed under Chapter 394 F.S. The Department designates all Baker Act receiving facilities regardless of type. There are also 9 Short-Term Residential Treatment (SRT) facilities in Florida, which provide a step-down for adults in CSUs needing an extended, but less intensive level of treatment. Additionally, these programs were created to step individuals down from CSUs and divert individuals away from State Mental Health Treatment Facilities. Addictions Receiving Facilities (ARF) and Juvenile Addictions Receiving Facilities (JARF) are secure, acute care facilities providing 24-7 emergency screening, evaluation, detoxification, and stabilization services. ARFs and JARFs are designated by the Department to serve individuals with substance impairment who meet placement criteria. Joint CSU/ARFs and joint CCSU/JARFs provide integrated services addressing both substance impairment and mental health crises.

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

State Mental Health Treatment Facilities

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

The state directly operates the following three treatment facilities:

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

The state also contracts for services at four other sites:

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

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

SERVICES

Community Substance Use

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

Substance Use Treatment

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

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

- Primary prevention services that prevent or delay substance use and associated problems, which include:
  - o Information dissemination.
  - o Education.
  - o Alternative drug-free activities.
  - o Problem identification and referral.
  - o Community-based processes.
  - o Environmental strategies.
- Intervention services, which are structured services for individuals at risk of substance abuse and focused on outreach, early identification, short-term counseling and referral.

• Clinical treatment, which includes professionally directed services to reduce or eliminate misuse of alcohol and other drugs, such as:
o Outpatient and intensive outpatient treatment.
o Day or night treatment.
o Medication-assisted treatment.
o Residential treatment.
o Intensive inpatient treatment.
o Detoxification.
• Recovery support services are designed to help individuals regain skills, develop natural support systems, and develop goals to help them thrive in the community and promote recovery, such as:
o Aftercare.
o Supported housing.
o Supported employment.
o Recovery support.
• Services that assist individuals discharged from acute care settings, more effectively engage individuals in services, and provide opportunities that support independence and development:
o Drop-in and self-help centers.
o Care coordination
o Intensive case management.

Within this service array, the Department is also implementing specialty programs aimed at the specific needs of certain populations, including:
• Services for pregnant women and mothers through Specific Appropriation 374 of the General Appropriations Act and federal block grant funds.
• Child welfare involved parents/caretakers through Family Intensive Treatment Teams.
• Individuals with opioid misuse and opioid use disorders through federal discretionary grants (i.e., the State Opioid Response grants), and Opioid Settlement funds.

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

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

Overdose Prevention
The Department's Overdose Prevention Program provides free naloxone kits, educational materials, and training to prevent, recognize, and respond appropriately to an opioid overdose. The program targets individuals in the community most likely to experience or witness an overdose through a network of naloxone distribution providers.
Medication Assisted Treatment

The Department funds multiple programs that incorporate medication assisted treatment (MAT) services including:
• Hospital Bridge Programs which include initiating MAT before discharge, engaging with peer support specialists, distributing naloxone nasal spray, and connecting patients to community-based treatment services through warm-handoffs.
• Jail Bridge/Jail-Based MAT offers services to individuals who are currently incarcerated in a county jail diagnosed with opioid use disorder and co-occurring substance use disorder or mental health conditions. Retention in methadone or buprenorphine treatment is often correlated with significantly lower rates of criminal activity. The goal of this initiative is to reduce relapse, recidivism, and contribute to continuity of care.

• Mobile MAT models which provide rapid access through low-barrier treatment to individuals with opioid use disorder through a mobile outreach unit capable of buprenorphine induction and telemedicine. Mobile MAT programs are designed to improve access to treatment for individuals struggling with opioid use disorder.

Recovery Supports

Through a combination of funding through the block grant, State Opioid Response grant, Opioid Settlement, and state general revenue, the Department funds a variety of recovery supports and services, including:

• Recovery support services provided by Certified Recovery Peer Specialists play a vital role. Peers with lived experience and learned skills are credentialed to help others achieve and maintain recovery and wellness from mental health and/or substance use.

• Recovery Community Organizations (RCOs) who work to support individuals in long-term recovery from drug and alcohol use disorders, as well as their family members and friends. Certified Recovery Peer Specialists and RCOs work closely with hospitals and long-term community-based providers participating in the CORE Network and hospital bridge programs.

• Recovery Housing is intended to bolster access to housing to help individuals achieve recovery and reduce overdoses and other adverse health outcomes.

STATE COLLABORATIONS

One of the strengths of the State of Florida's service system is the willingness of lawmakers, stakeholders, advocates and citizens to work together to ensure that the residents of the state receive quality behavioral health care. A few collaborations of note are mentioned below.

Court Diversion

The Department works to partner with court systems and court diversion programs in each circuit throughout Florida to treat individuals with opioid use disorder and co-occurring disorders to divert from jail or prison. He model provides access to treatment and wrap around services for individuals with an opioid use disorder and identified at high risk of being sentenced to jail or prison. The goal is to provide evidence-based treatment services in lieu of sentencing and incarceration.

Commission on Mental Health and Substance Use

The Commission on Mental Health and Substance Use Disorder (Commission) was created in 2021 per Section 394.9086, Florida Statutes and ratified in 2023 to examine current methods of providing mental health and substance use disorder services in the state and to improve the effectiveness of current practices, procedures, programs, and initiatives in providing such services; identify any barriers or deficiencies in the delivery of such services; assess the adequacy of the state's crisis response services; and recommend changes to existing laws, rules, and policies necessary to implement the Commission's recommendations. The Commission is made up of 20 representatives appointed by the Governor and Florida Legislature to represent and speak for every touch point of public behavioral health service delivery in the state. The Commission is responsible for completing an annual report which includes recommendations to be submitted to the Florida Legislature. Recommendations from the Commission were responsible for new legislation that was passed in the 2025 session related to the provision of behavioral health services in the state. This legislation includes Senate Bill 168 (Tristin Murphy Act) which includes a requirement to create the Florida Behavioral Health Care Data Repository and Senate Bill 1620 which includes the requirement of the statewide integration of the Daily Living Activities DLA (20), a functional assessment tool.

CORE Network

The Florida Department of Children and Families, in collaboration with the Department of Health and the Agency for Health Care Administration, launched the Coordinated Opioid Recovery (CORE) Network to implement a comprehensive, statewide system of addiction care. The CORE Network establishes a recovery-oriented continuum of care and support for those seeking treatment and recovery support services for OUD.

This comprehensive approach expands every aspect of overdose response and treats all primary and secondary impacts of substance use disorder. The CORE Network disrupts the revolving door of substance use disorder/opioid use disorders and overdose by providing an evidence based coordinated network of care linking patients to community partners in a continuum from a crisis all the way to lifelong care in a low barrier, sustainable way. It incorporates quality improvement through measure outcomes that help sustain the network locally. Department approval is required before implementing any variation of the CORE Network.

The CORE Network includes the following tiered approach with a warm handoff provided at each level:

1. Rescue response.
2. 24-7 access point for stabilization/ assessment.
3. Receiving clinics for long-term treatment.

Office of Recovery

The Office of Recovery, located within the Substance Abuse and Mental Health (SAMH) Program Office, was established in 2023 through a recurring appropriation. The Office of Recovery is comprised of 22 FTE positions, including research analysts, epidemiologists, clinical evaluators, expert consultants, and associated supervisors. The Office of Recovery administers opioid settlement funds that flow through the Department, analyzes opioid-related trends and conditions, and evaluates the impact of various opioid abatement activities. They provide analytic support to the Statewide Council on Opioid Abatement and are

responsible for compiling the associated Annual Reports. The Office of Recovery is also partnering with Florida State University to build evaluative and predictive models of opioid use disorder and associated fatal and nonfatal opioid overdoses; to conduct simulated patient audits (a.k.a. secret shopper studies); to conduct applied research related to opioid abatement projects; and to establish new data-sharing frameworks for county-level surveillance.

Statewide Council on Opioid Abatement
In 2023, the Statewide Council on Opioid Abatement was established under section 397.335, Florida Statutes, to assess the use of opioid settlement funds and to publish an annual report with recommendations on how future funds should be prioritized and allocated. The Council is chaired by the Attorney General, who currently delegates this responsibility to the Seminole County Sheriff. The Council is comprised of ten members, with appointments made by the Governor, President of the Senate, Speaker of the House, the League of cities, or the Florida Association of Counties. Members serve 2-year terms and are convened on a quarterly basis or at the discretion of the Chair.

The Council is empowered to review data on expenditures and the results achieved, and to develop any metrics or measures needed to assess progress. They advise state and local governments and share information with the Drug Policy Advisory Council, to ensure that recommendations are consistent. Two Annual Reports (for 2023 and 2024) are currently available online. Annual Reports include recommendations for the Governor, the Legislature, and local governments on how to prioritize funding in upcoming years.

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Footnotes:

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system, including state plans for addressing identified needs and gaps with MHBG/SUPTRS BG award(s)

Narrative Question

This narrative should describe your states needs assessment process to identify needs and service gaps for its population with mental or substance use disorders as well as gaps in the prevention system. A needs assessment is a systematic approach to identifying state needs and determining service capacity to address the needs of the population being served. A needs assessment can identify the strengths and the challenges faced in meeting the service needs of those served. A needs assessment should be objective and include input from people using the services, program staff, and other key community stakeholders. Needs assessment results should be integrated as a part of the state's ongoing commitment to quality services and outcomes. The findings can support the ongoing strategic planning and ensure that its program designs and services are well suited to the populations it serves. Several tools and approaches are available for gathering input and data for a needs assessment. These include use of demographic and publicly available data, interviews, and focus groups to collect stakeholder input, as well as targeted and focused data collection using surveys and other measurement tools.

Please describe how your state conducts needs assessments to identify behavioral health needs, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

Grantees must describe the unmet service needs and critical gaps in the state's current systems identified during the needs assessment described above. The unmet needs and critical gaps of required populations relevant to each Block Grant within the state's behavioral health system, including for other populations identified by the state as a priority should be discussed. Grantees should take a data-driven approach in identifying and describing these unmet needs and gaps.

Data driven approaches may include utilizing data that is available through a number of different sources such as the **National Survey on Drug Use and Health (NSDUH)**, **Treatment Episode Data Set (TEDS)**, **National Substance Use and Mental Health Services Survey (N-SUMHSS)**, the **Behavioral Health Barometer**, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the CDC mortality data, and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention, treatment, and recovery support services planning. States with current Strategic Prevention Framework - Partnerships for Success discretionary grants are required to have an active SEOW.

This step must also describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss their plan for implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations listed above, and any other populations, prioritized by the state as part of their Block Grant services and activities are addressed in these implementation plans.

1. Please describe how your state conducts statewide needs assessments to identify needs for mental and substance use disorders, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

The Department of Children and Families (the Department) is routinely tasked with providing analyses of state specific behavioral health statistics and service data to assess service needs and effectiveness. This is accomplished using needs assessments, gap analyses, and reports from service data. The analyses are used to complete legislatively mandated reports that inform members of the legislature and stakeholders of gaps in services, progress on initiatives and the effectiveness of services. The completed analyses are also used to create Legislative Policy Proposals and Legislative Budget Requests (LBR) for funding to implement new initiatives or to expand existing services.

The following reports and data sources in conjunction with current studies and research, are used to identify behavioral health needs, to determine adequacy of current services, and to identify key gaps and challenges in the delivery of quality care and prevention services in Florida.

Assessments of Behavioral Health Services
Assessments of Behavioral Health Services, conducted in partnership with the Managing Entities pursuant to s. 394.4573, Florida Statutes, describe the extent to which designated receiving systems function as no-wrong-door models, the availability of services that use recovery-oriented and peer-involved approaches, and the availability of less-restrictive services. The assessment also considers the availability of and access to coordinated specialty care programs and identifies any gaps in the availability of and access to such programs in the state. Strategies for addressing any identified unmet needs are also included in this annual report. The Department and its contracted Managing Entities identify top unmet system needs in a variety of ways, including analyses of

waitlist records; consumer satisfaction survey results, environmental scans and feedback provided during regional collaborative meetings involving key community stakeholders, and focus groups with consumers, providers, and other community stakeholders.

State of Florida Behavioral Health Gap Analysis
Senate Bill 330 (Behavioral Health Teaching Hospitals) signed by the Governor of Florida in 2024, required the Department to contract for a detailed study of the capacity for inpatient services for adults with serious mental illness and children with serious emotional disturbance or psychosis. The study was commissioned by the Office of Substance Abuse and Mental Health and was completed in January 2025. The completed study was compiled using qualitative and quantitative data specific to the state of Florida and included a gap analysis that evaluated behavioral health care across the state of Florida and projected system of care needs for the next five years.

Financial and Services Accountability Management System (FASAMS)
FASAMS is the Department's uniform data system for use by Department-funded providers of community substance use and mental health treatment and recovery support services. The Department also utilizes auxiliary reporting for supplemental data received from FASAMS.

National Survey on Drug Use and Health (NSDUH)
The National Survey on Drug Use and Health (NSDUH) provides important estimates of substance use, substance use disorders, and other mental illnesses at the national, state, and sub-state levels. NSDUH is an annual survey of the civilian, noninstitutionalized population ages 12 and older, using face-to-face, computer-assisted interviews. NSDUH collects information from residents of households, persons in noninstitutional group quarters (e.g., shelters, rooming/boarding houses, college dormitories, and halfway houses), and civilians living on military bases. Persons excluded from the survey include persons with no fixed household address (e.g., homeless and/or transient persons not in shelters), active-duty military personnel, and residents of institutional group quarters, such as correctional facilities, nursing homes, mental institutions, and long-term hospitals. Usually, there is a lag of two or more years between data collection and publication of state-level estimates.

Uniform Reporting System (URS)
Annually, SAMHSA publishes reports providing output tables from the Uniform Reporting System. States use the URS to report data as part of the Community Mental Health Services Block Grant. URS data includes sociodemographic information, outcomes of care, use of evidence-based practices, client assessment of care, and readmission to psychiatric hospitals, among others, of clients served by the state.

2. Please describe the unmet service needs and critical gaps in the state's current mental and substance use systems identified in the needs assessment described above. The description should include the unmet needs and critical gaps for the required populations specified under the MHBG and SUPTRS BG "Populations Served" above. The state may also include the unmet needs and gaps for other populations identified by the state as a priority.

Prevalence-Mental Health
SMI Population
Adults with serious mental illness (SMI) are defined as persons with a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual (DSM) that results in functional impairment. The 2022-2023 NSDUH estimates that approximately 5.4% of adults in Florida experienced SMI. Further 20% of adults in Florida experienced any mental illness in the past year. Looking more specifically at emerging adults ages 18-25, 34% reported any mental illness in the past year, and 13% had serious thoughts of suicide. According to FY 2023 URS data, 147,870 adults were served in community settings in the state of Florida. This is far less than 5.4% of the estimated 17,338,241 adults residing in the state according to the 2020 United States Census. Additionally, in FY 23-24, there were approximately 1,241 individuals placed on waitlists for community mental health services according to Managing Entity reporting.

SED Population
Children with serious emotional disturbances (SED) have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM that results in functional impairment. The prevalence of serious emotional disturbances (SED) among children was last estimated by the Substance Abuse and Mental Health Services Administration (SAMHSA) in the Federal Register in 1997. The prevalence in Florida was estimated to be between 7% and 13% relying on the lower limit of the range published. According to the 2023 Florida specific Uniform Reporting System (URS) estimates, 137,330 children between the ages of 9-17 in the state of Florida have a Serious Emotional Disturbance. In FY 2023-2024, children with SED comprised 19.5% of individuals served in Florida publicly funded community mental health programs.

Prevalence-Substance Use
According to the most recently published data, Florida-specific estimates from the 2022-2023 NSDUH, approximately 9.2% of children ages 12-17 and 16.4% of adults ages 18 and older experienced a substance use disorder in the past year. With respect to the prevalence of needing but not receiving treatment, in the 2022-2023 report approximately 55% of children ages 12-17 in Florida, and 76% of adults ages 18 and older, needed treatment for substance use but did not receive it. Looking at Floridians ages 18-25, the treatment gap is even higher, with 82% of young adults in Florida needing but not receiving treatment for substance use.

Identified Unmet Needs and Gaps

Assessments of Behavioral Health Services
Although unmet needs and gaps identified in the Assessments of Behavioral Health Services varied by across regions of the state, there were several common needs reported. Housing and housing coordination continues to be the greatest unmet need. The most frequent system gaps for treatment and recovery support services for individuals with SMI, SED, and SUD included care coordination and case management, jail and forensic facility diversion and the expansion of behavioral health services.

State of Florida Gap Analysis
The State of Florida Gap Analysis included qualitative findings from interviews with behavioral health providers, state mental health treatment facilities, government agencies, Managing Entities, and partner health organizations. The unmet needs and gaps identified for treatment included a lack of residential options for short-term and long-term treatment, insufficient community-based services, limited availability of peer support, lack of specialized programs for older adults, limited options for step-down facilities, a lack of affordable housing including assisted living facilities, supportive housing, statewide inpatient psychiatric programs, and long length of stays in civil state mental health facilities. The unmet needs and gaps for recovery support services included limited recovery community organizations.

It is the Department's intention to address all unmet needs identified in its analyses and assessments. However, the priority areas discussed below have been selected for Block Grant reporting.

Early Serious Mental Illness (ESMI)
Coordinated Specialty Care (CSC) Early Serious Mental Illness (ESMI) including First Episodes of Psychosis (FEP)
States are required to expend at least 10% of the Community Mental Health Services Block Grant on Coordinated Specialty Care (CSC) programs for Early Serious Mental Illness (ESMI), including first episodes of psychosis, regardless of the age of the individual at onset. Evidence indicates that a prolonged duration of untreated serious mental illness predicts negative outcomes (e.g., serious impairment, unemployment, homelessness, etc.) across different serious mental illnesses. Earlier treatment and interventions are therefore critical to both reducing acute symptoms and improving long-term outcomes. CSC-ESMI programs are evidence-based and provide comprehensive, coordinated, individualized, and integrated services, including but not limited to intensive case management, individual and group therapy, supported employment, family education and supports, and appropriate psychotropic medication, as indicated. The Department is currently funding 15 CSC-ESMI teams. All teams use either the NAVIGATE or OnTrackNY models.

Although the unmet needs identified were not specific to Coordinated Specialty Care (CSC), this is a priority area as a set-aside for the Community Mental Health Services Block Grant. Based on 2023 URS data, children and adolescents made up 19.5% of the service population for Florida. Approximately 21% of those served were in the 13 to 24 age range for a total of 35,877. The early intervention provided by Coordinated Specialty Care (CSC) increases the odds of better long-term outcomes for those experiencing the first symptoms of what will be a lifelong serious mental illness, reducing repeated utilization of crisis services and the need for higher-end residential care for the individual.

Behavioral Health Crisis Services (BHCS)
BHCS is designated as a priority area by the Community Mental Health Services Block Grant. According to Chapter 65E-14, Florida Administrative Code, Florida's crisis system is composed of crisis stabilization and crisis support/emergency. Crisis stabilization services are acute, intensive residential treatment services offered twenty-four hours per day, seven days per week, that meet the needs of individuals experiencing an acute crisis and who would require hospitalization in the absence of a suitable alternative. Crisis support/emergency services are non-residential care generally available twenty-four hours per day to intervene in a crisis or provide emergency care, such as Mobile Response Teams, the 988 Florida Lifeline, and Crisis Stabilization Units. Crisis services are available statewide. Crisis Stabilization Units, Mobile Response Teams and the 988 Florida Lifeline are all available in every region of the state. In SFY 24-25, 988 call centers operating in Florida reported 181,056 calls received.

(PLACEHOLDER AWAITING 24-25 MRT DATA) In State Fiscal Year 23-24, the MRTs received 31,509 calls, 72% of which met the threshold for an acute face-to-face or telehealth response. Of the 22,609 acute responses, 4,487 calls resulted in an involuntary examination and 18,122 did not result in an involuntary examination. The MRTs had an overall diversion rate of 76%, diverting unique individuals from emergency rooms, hospitals, and juvenile or criminal justice settings.

Pregnant Women and Women with Dependent Children (PWWDC)
The SUPTRS Block Grant designates Pregnant Women and Women with Dependent Children (PWWDC) a priority population. Block Grant regulations stipulate that Florida must expend at least $9.3 million in federal and state funds on services for the PWWDC population. The Department is committed to addressing the unique treatment needs of pregnant women and women with dependent children. Women undertake caregiving roles and responsibilities which often lead to a reluctance or inability to seek treatment. By providing the option to bring children to treatment or to complete intensive outpatient treatment, women are given the flexibility needed to receive the services needed while maintaining other responsibilities. The availability of evidence-based treatments, including medication assisted treatment and recovery support, are crucial to meeting the needs of this population.

Primary Prevention of Substance Use and Substance Use Disorders (PP)
PP is designated as a priority area by the SUPTRS Block Grant. Primary Prevention aims to prevent, delay, or reduce substance use and abuse. The Florida Youth Substance Abuse Survey (FYSAS) provides the state the opportunity to determine the levels of risks and protective factors for youth and then connect those levels to substance use rates. Key survey findings from the 2024 FYSAS

Report are listed below.

• Florida students have reported dramatic long-term reductions in alcohol and cigarette use. Between 2012 and 2024, the prevalence of past-30-day alcohol use declined by 14.4 percentage points, binge drinking declined by 6.9 percentage points, and past-30-day cigarette use declined by 5.5 percentage points.

• Between 2019 and 2024, past-30-day prevalence rates for nicotine vaping and marijuana vaping have declined 5.9 and 2.8 percentage points, respectively.

• In addition to the long-term decline in alcohol use, cigarette use, vaping, and marijuana use, Florida students have reported long-term reductions in the use of illicit drugs other than marijuana. Past-30-day use of any illicit drug other than marijuana dropped from 8.2% in 2012 to 3.7% in 2024.

It is important to note from the report that while alcohol and drug use is down, high-risk drinking behavior continues, with 5.9% of high school students reporting binge drinking and 9.1% reporting blacking out from drinking on one or more occasions.

Persons with Intravenous Drug Use (PWID)
PWID is designated a priority population by the SUPTRS Block Grant. According to the Centers for Disease Control (CDC), persons with intravenous drug use are at risk of contracting infections through contaminated injection drug equipment, unsanitary conditions and other factors. All contracted Network Service Providers are required to meet all federal regulations related to serving the PWID population. In addition to providing services, there is a requirement to monitor waitlists for those who are not immediately provided services and provide interim services until such time as the clinically appropriate level of treatment can be provided. The PWID population must also be designated as a priority population.

Early Intervention Services- HIV (EIS-HIV)
EIS-HIV is designated as a priority area by the SUPTRS Block Grant and is required to spend exactly 5% of the SUPTRS Block Grant award on HIV Early Intervention Services, which includes HIV testing, pre- and post-test counseling, and diagnostic and therapeutic measures related HIV. Block Grant regulations stipulate that these HIV testing services can only be provided to individuals receiving treatment for substance use disorders, at the sites at which they are undergoing treatment. This federal requirement is triggered when a state's AIDS case rate exceeds 10 per 100,000, according to the most recent calendar year for which such data are available. According to the most recently published CDC estimate, Florida's AIDS case rate in 2023 was 11.6 per 100,000. Florida's HIV EIS are delivered onsite through 45 drug treatment programs that collectively tested 14,810 individuals in SFY 23-24. A total of 103 tests were positive for HIV.
(PLACEHOLDER AWAITING 24-25 DATA)

Individuals At-Risk for Tuberculosis (TB)
TB is a priority area designated by the SUPTRS Block Grant. All licensed substance use treatment programs in Florida are required to provide tuberculosis testing to high-risk individuals either directly or through referral. In 2024, 675 tuberculosis (TB) cases were reported in Florida according to the Florida Department of Health data. The 2024 TB incidence rate was 2.9 per 100,000. The following risk factors were identified among the 2023 cases:
• Excess alcohol use in the past year (8%)
• HIV co-infection (6%)
• Illicit drug use within the past year (6%)
• Homelessness (4%)

TB cases where the use of alcohol was identified as a risk factor decreased over the past year, while cases related to illicit drug use did not change. Cases related to the homelessness risk factor also decreased as did those cases with HIV as a co-infection.

Recovery Support Services and Recovery-Oriented Systems of Care (PRSUD)
PRSUD is a priority area designated by the SUPTRS Block Grant. Florida continues to experience a demand for effective, person-centered responses to opioid and substance use disorders, especially in underserved communities and among individuals with high recovery needs. The peer recovery specialist workforce is critical to this effort, individuals with lived experience support others in recovery. Certified recovery peer specialist is an essential component of a coordinated system of care. However, some systemic barriers persist, including navigating the workforce certification process, training access, and background screening regulatory hurdles. These obstacles can contribute to workforce development challenges which include integration of peer-based recovery services. Enhancements to peer services were recommended in the State of Florida Behavioral Health Gap Analysis as well as the Assessment of Behavioral Health Needs.

State Priorities
Housing and Housing Support
A stable living environment is fundamental to recovery from mental disorders and substance use disorders. Unfortunately, housing is among the most consistently identified unmet needs across Florida regions from year-to-year. According to 2024 Point-In-Time counts of individuals who are homeless in Florida, 5,916 individuals surveyed (19%) reported experiencing serious mental illness, while 4,604 individuals (15%) reported experiencing a substance use disorder. According to data included in the 2023 Council on Homelessness Report, the prevalence of SMI among individuals who are homeless was about 20.5 in 2024, 5.35%

higher than 2022. Prevalence of substance use disorders among individuals who are homeless was approximately 15.3% in 2024, 5.6% higher than 2022 according to the same report. The cost of housing from March 2020 to October 2022 increased by 36.1%. Those navigating mental health and substance use challenges may have a harder time securing stable housing.

State Mental Health Treatment Facilities
One of the greatest needs identified relates to serving individuals in community settings instead of State Mental Health Treatment Facilities (SMHTF), which are expensive and highly restrictive. Currently, there is not sufficient capacity in the community for services intensive enough to treat and maintain individuals with serious mental illnesses and complex needs (i.e., co-occurring substance use disorders, co-morbid medical conditions, criminal justice involvement, frequent hospitalizations, etc.). According to the SMHTF's Seeking Placement List Civil and Forensic Report, July 2025, 133 individuals were awaiting discharge from a civil facility (132 have been waiting more than 30 days) and 30 individuals were awaiting discharge from a forensic facility.

Behavioral Health Workforce
The State of Florida, like many other states has experienced shortages the behavioral health workforce. The State of Florida Behavioral Health Gap Analysis report specifically identified a need for psychiatrists in the state but also recommended a services cost rate study and market analysis to assess compensation rates, benefits, and working conditions for behavioral health professionals.

3. Please describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss plans for the implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations and any other populations prioritized by the state as part of the Block Grant services and activities are addressed in the implementation plan.

Early Serious Mental Illness (ESMI)
Coordinated Specialty Care (CSC) Early Serious Mental Illness (ESMI) including First Episodes of Psychosis (FEP)
(PLACEHOLDER AWAITING 24-25 DATA) While there was no specific unmet need identified for Coordinated Specialty Care (CSC) Early Serious Mental Illness (ESMI), there is a corresponding performance indicator. Across teams, the percent of individuals served who experienced improvements in functioning or symptom severity in FY 23-24 was 81.6%. The Department will continue to monitor the progress of service provision and provide technical assistance and training for any barriers or challenges identified.

Pregnant Women and Women with Dependent Children (PWWDC)
The Department will continue to offer services to the PWWDC population as required by federal regulations. The Women's Services Coordinator reviews data submitted by the Managing Entities, addresses discrepancies, facilitates calls to review the performance indicator related to the Block Grant, and shares resources related to PWWDC. The Department continues to contract with the Florida Association of Alcohol and Drug Abuse to provide training and resources that include evidence-based treatment for PWWDC and maintains an online Learning Management System to enhance workforce development.

Primary Prevention of Substance Use and Substance Use Disorders (PP)
The Managing Entities administer funds to providers and community coalitions to implement prevention services in their communities and schools. SAMHSA requires states to fund all six of the following prevention strategies: (1) Information Dissemination; (2) Education;(3) Alternative Recreational Activities; (4) Problem Identification and Referral (excluding assessments for substance use disorders); (5) Community-based Processes (networking, training, and collaborative systems planning); and (6) Environmental Strategies.

The Department will increase the number of prevention strategies provided by the state. Specifically Indicated and Selective strategies. Department staff will meet with Primary prevention providers to discuss barriers and challenges to providing Indicated and Selective level prevention interventions and provide technical assistance as needed. The Department will also continue to monitor the results of the Florida Youth Substance, NSDUH and state reporting for trends in use.

Persons with Intravenous Drug Use (PWID)
The Department will continue to ensure compliance with federal regulations related to the PWID populations including priority designation, waitlist monitoring, and the provision of interim services. Compliance is monitored through administrative processes associated with contract management and reviews are conducted through Independent Peer Reviews.

Early Intervention Services- HIV (EIS-HIV)
The Department's implementation of the Block Grant HIV Early Intervention Services set-aside supports the Department of Health's plan to eliminate HIV transmission and reduce HIV-related deaths. A key component is the implementation of routine HIV screening in health care settings, like substance use disorder treatment facilities. People with HIV who are aware of their status can get HIV treatment, which lowers the level of HIV in the blood, reduces HIV-related illness, and lowers the risk of transmitting HIV to others. Routine and efficient HIV testing through the Department's network of treatment providers helps many at-risk individuals know their status and links individuals who are HIV positive to HIV care. Additionally, the Department's network of behavioral health treatment providers play an important role in helping retain individuals in HIV care and suppressing their viral loads by addressing any unmet needs they might have for addiction treatment, housing, and ancillary support services.

Individuals At-Risk for Tuberculosis (TB)
The Department will continue to track the TB rate for the state and the related risk factors. Network Service providers contracted with the state to provide substance use and mental health services are required to ensure the provision of tuberculosis services in compliance with 65D-30.004(9), F.A.C. Compliance is monitored through administrative processes to monitor contracts. Compliance is also reviewed during independent peer reviews.

Recovery Support Services and Recovery-Oriented Systems of Care (PRSUD)
The Department is investing in targeted innovation initiatives to both study and strengthen the peer recovery workforce. A rigorous, statewide evaluation will identify effectiveness and challenges associated with the use of peer specialists, offering data-driven recommendations for streamlining certification pathways and improving access to training and career development. Simultaneously, an innovation program will be launched to recruit, train, certify, and mentor individuals with lived experience through structured apprenticeships and career pathways. This effort directly addresses critical behavioral health workforce needs and supports a sustainable and responsive peer workforce across Florida.

The Department also funds scholarships for individuals pursuing certifications as Peer Support Specialists and Masters Level Certified Addiction Professionals. The Department plans to increase this training activity, especially for Veteran Peer Specialists and for Peer Specialist Supervisors.

These initiatives will help shape the long-term design and integration of peer recovery supports in Florida, ensuring that lived experience is not only recognized, but effectively mobilized in the service of community recovery. Aligning with Florida's Recovery-Oriented System of Care vision, this work builds on existing infrastructure to include Recovery Community Organizations (RCOs) to advance targeted training and mentoring to existing and emerging RCOs, to build skills in organizational management, advocacy, and sustainability to strengthen the voices of lived experience within behavioral health system and policy development sectors.

Behavioral Health Workforce
The Department currently contracts with the Florida Alcohol and Drug Abuse Association (FADAA), a subsidiary of the Florida Behavioral Health Association, to deliver training and technical assistance to behavioral health Network Service Providers and stakeholders throughout the state of Florida. To further build workforce capacity and improve services, the Department will support development of additional training webinars, workshops, online courses, and toolkits for professionals serving individuals with serious mental illness or emotional disturbance. Providing training and technical assistance for providers and the public offers a more competent workforce for individuals working in the behavioral health field to gain the knowledge and skills necessary to improve themselves and the services they provide.

Additionally, the Florida Legislature passed CS/SB 330 Behavioral Health Teaching Hospitals in 2024. This bill establishes the Florida Center for Behavioral Health Workforce (Center) within the University of South Florida's Louis de la Parte Florida Mental Health Institute. The purpose of the bill is to support an adequate, highly skilled, resilient, and innovative workforce that meets the current and future human resources needs of the state's behavioral health system and develop and disseminate best practices. The Center will:
o Describe and analyze current workforce and possible future workforce demand and produce a statistically valid biennial analysis of the supply and demand of the workforce.
o Expand pathways to behavioral health professions through enhanced educational opportunities and improved faculty development and retention.
o Promote behavioral health professions.
o Convene stakeholders to assist the Center in its work.

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Footnotes:

Planning Tables

Table 1: Priority Area and Annual Performance Indicators

Priority #: 1

Priority Area: Florida Assertive Community Treatment (FACT)

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Increase intensive, team-based services to adults with SMI.

Strategies to attain the goal:

Department staff will work with Managing Entities and providers to identify and address barriers and challenges to reaching capacity in some service areas.

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline measurement (Initial data collected prior to and during 2026): In FY 24-25, XX adults were served by FACT teams.

First-year target/outcome measurement (Progress to the end of 2026): The number of adults served by FACT teams increased by at least 35 compared with the number served in FY 25-26.

Second-year target/outcome measurement (Final to the end of 2027): The number of adults served by FACT teams increased by at least 35 compared with the number served in FY 26-27.

Data Source:

Quarterly Data Reports

Description of Data:

The Department collects a contractually required report which contains the total number of individuals served and performance data. The total served will be calculated on an annual basis.

Data issues/caveats that affect outcome measures:

None

Priority #: 2

Priority Area: Community Action Treatment (CAT) Teams for Children with SED

Priority Type: MHS

Population(s): SED

Goal of the priority area:

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

Strategies to attain the goal:

Department representatives will continue educating various community partners on the eligibility, goals, approach to treatment and the availability of CAT teams to generate more referrals.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of children served by CAT teams.

Baseline measurement (Initial data collected prior to and during 2026): In FY 24-25, XX children were served by CAT teams.

First-year target/outcome measurement (Progress to the end of 2026): The number of children served by CAT teams increased by 25 compared with the number served in FY 25-26.

Second-year target/outcome measurement (Final to the end of 2027): The number of children served by CAT teams increased by 25 compared with the number served in FY 26-27.

Data Source:

CAT Team Supplemental Data Reports, which is submitted monthly.

Description of Data:

The unduplicated total number of young people served across all CAT Teams.

Data issues/caveats that affect outcome measures:

None

Priority #: 3

Priority Area: Mobile Response Teams

Priority Type: BHCS

Population(s): BHCS

Goal of the priority area:

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

Strategies to attain the goal:

The Department will monitor performance of the Mobile Response Teams and offer training and technical assistance resources as needed to maintain performance standards.

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline measurement (Initial data collected prior to and during 2026): In FY 24-25 XX% of MRT providers met the target value for acute call response time.

First-year target/outcome measurement (Progress to the end of 2026): At least 90% of MRT providers met the target value for acute call response time for FY 25-26.

Second-year target/outcome measurement (Final to the end of 2027): At least 95% of MRT providers met the target value for acute call response time for FY 26-27.

Data Source:

MRT Cumulative Tracking Spreadsheet

Description of Data:

The numerator is the number of providers meeting the target value for acute call response time and the denominator is the number of providers responsing to calls requiring an acute response.

Data issues/caveats that affect outcome measures:

None

Priority #: 4

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

Priority Type: ESMI

Population(s): SED, ESMI

Goal of the priority area:

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

Strategies to attain the goal:

The Department will monitor progress, provide opportunities for teams to share barriers and challenges and secure training and technical assistance to address barriers and challenges.

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline measurement (Initial data collected prior to and during 2026): In FY 24-25, XX% of individuals served by CSC-ESMI programs experienced improvements in functioning or symptom severity.

First-year target/outcome measurement (Progress to the end of 2026): In FY 25-26, at least 80% of individuals served by CSC-ESMI programs experienced improvements in functioning or symptom severity.

Second-year target/outcome measurement (Final to the end of 2027): In FY 26-27, at least 80% of individuals served by CSC-ESMI programs experienced improvements in functioning or symptom severity.

Data Source:

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

Description of Data:

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

Data issues/caveats that affect outcome measures:

None

Priority #: 5

Priority Area: : Services for Pregnant Women and Women with Dependent Children (PWWDC)

Priority Type: SUT

Population(s): PWWDC

Goal of the priority area:

Improve outcomes for pregnant women.

Strategies to attain the goal:

Department staff will collaborate with internal system partners on each of the objectives.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of objectives achieved.

Baseline measurement (Initial data collected In FY 24-25, zero objectives were achieved.

prior to and during 2026):

First-year target/outcome measurement (Progress to the end of 2026): In FY 25-26, at least 1 of the 5 objectives is achieved.

Second-year target/outcome measurement (Final to the end of 2027): In FY 26-27, at least 3 of the 5 objectives are achieved.

Data Source:

All updates on objectives will be reported by the Department's Statewide Coordinator of Integration and Recovery Services.

Description of Data:

The data vary by objective and may include narrative or numerical responses.

Data issues/caveats that affect outcome measures:

None

Priority #: 6

Priority Area: : Primary Drug Prevention

Priority Type: SUP

Population(s): PP

Goal of the priority area:

To increase the use of Selective and Indicated prevention interventions,

Strategies to attain the goal:

Department staff will meet with Primary prevention providers to discuss barriers and challenges to providing Indicated and Selective level prevention interventions and provide technical assistance as needed.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of Indicated prevention interventions provided.

Baseline measurement (Initial data collected prior to and during 2026): In FY 24-25, 8,175 Indicated interventions were provided.

First-year target/outcome measurement (Progress to the end of 2026): In FY 25-26, the number of Indicated prevention interventions will increase by 2%.

Second-year target/outcome measurement (Final to the end of 2027): In FY 26-27, the number of Indicated prevention interventions will increase by 2% of FY 25-26 actual.

Data Source:

Performance Based Prevention System (PBPS)

Description of Data:

The total number of Indicated Prevention interventions used.

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: The number of Selective prevention interventions provided.

Baseline measurement (Initial data collected prior to and during 2026): In FY 24-25, 357,509 Selective interventions were provided.

First-year target/outcome measurement In FY 25-26, the number of Selective prevention interventions will increase by 2%.

(Progress to the end of 2026):

Second-year target/outcome measurement (Final to the end of 2027): In FY 26-27, the number of Selective prevention interventions will increase by 2% of FY 25-26 actual.

Data Source:

Performance Based Prevention System (PBPS)

Description of Data:

The number of Selective prevention interventions provided.

Data issues/caveats that affect outcome measures:

None

Priority #: 7

Priority Area:

Priority Type: SUT

Population(s): EIS/HIV

Goal of the priority area:

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

Strategies to attain the goal:

The Department analyses historical provider-level data for variation in test positivity rates to identify factors associated with low and high performance and offers technical assistance if needed. The Department also collaborates with the Florida Department of Health to share relevant resources and training.

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline measurement (Initial data collected prior to and during 2026): In FY 24-25, the percent of HIV-tests that were positive among providers reporting at least one positive test was XX%.

First-year target/outcome measurement (Progress to the end of 2026): In FY 25-26, the percent of HIV-tests that are positive among providers reporting at least one positive test is at least 0.10%.

Second-year target/outcome measurement (Final to the end of 2027): In FY 26-27, the percent of HIV-tests that are positive among providers reporting at least one positive test is at least 0.10%.

Data Source:

Managing Entity Block Grant Data Reporting Template 2

Description of Data:

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

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: The TB case rate per 100,000

Baseline measurement (Initial data collected prior to and during 2026): In Calendar Year 2024 Florida's TB rate is 2.9 per 100,000.

First-year target/outcome measurement In Calendar Year 2025, Florida's TB rate is 5 per 100,000 or lower.

(Progress to the end of 2026):

Second-year target/outcome measurement (Final to the end of 2027): In Calendar Year 2026, Florida's TB rate is 5 per 100,000 or lower.

Data Source:

Tuberculosis cases per 100,000 are taken from the Florida Department of Health.

Description of Data:

For the baseline (Calendar Year 2024), the numerator is 675 tuberculosis cases, and the denominator is 23,058,197 yielding a rate of 2.9 per 100,000.

Data issues/caveats that affect outcome measures:

None

Priority #: 8

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

Priority Type: SUT

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

Goal of the priority area:

Advance Florida's Recovery-Oriented System of Care by expanding peer-led infrastructure, strengthening partnerships, and integrating lived experience to improve recovery outcomes through shared decision-making.

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of objectives achieved.

Baseline measurement (Initial data collected prior to and during 2026): In FY 24-25, zero objectives were achieved.

First-year target/outcome measurement (Progress to the end of 2026): In FY 25-26, at least 1 of the 5 objectives is achieved.

Second-year target/outcome measurement (Final to the end of 2027): In FY 26-27, at least 3 of the 5 objectives are achieved.

Data Source:

All updates on objectives will be reported by the Department's Statewide Coordinator of Integration and Recovery Services.

Description of Data:

The data vary by objective and may include narrative or numerical responses.

Data issues/caveats that affect outcome measures:

None

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Footnotes:

Planning Tables

Table 2: SUPTRS BG Planned State Agency Budget for Two State Fiscal Years (SFY)

ONLY include funds budgeted by the executive branch agency (SSA) administering the SUPTRS BG. This includes only those activities that pass through the SSA to administer substance use primary prevention, substance use disorder treatment, and recovery support services for substance use disorder.

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

Activity	Source of Funds							
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. Bipartisan Safer Communities ACT Funds
1. Substance Use Disorder Prevention[a] and Treatment	$115,469,011.00		$0.00	$172,739,872.00	$229,510,098.00	$0.00	$249,777,660.00	
a. Pregnant Women and Women with Dependent Children (PWWDC)[b]	$4,000,000.00				$20,000,000.00			
b. All Other	$111,469,011.00			$172,739,872.00	$209,510,098.00		$249,777,660.00	
2. Recovery Support Services[c]	$35,037,003.00			$30,483,508.00	$40,501,782.00		$44,078,410.00	
3. Primary Prevention[d]	$46,716,004.00				$16,868,668.00		$44,906,300.00	
4. Early Intervention Services for HIV[e]	$11,679,001.00							
5. Tuberculosis	$0.00							
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award)								
7. State Hospital								
8. Other Psychiatric Inpatient Care								
9. Other 24-Hour Care (Residential Care)								
10. Ambulatory/Community Non-24 Hour Care								
11. Crisis Services (5 percent Set-Aside)								
12. Other Capacity Building/Systems Development[f]	$13,000,000.00							
13. Administration[g]	$11,679,001.00			$14,190,006.00	$48,411,538.00		$14,133,708.00	
14. Total	**$349,049,031.00**		**$0.00**	**$390,153,258.00**	**$564,802,184.00**	**$0.00**	**$602,673,738.00**	

[a] Prevention other than primary prevention.

[b] Grantees must plan expenditures for Pregnant Women and Women with Dependent Children in compliance with Women's Maintenance of Effort (MOE) over the two-year planning period.

[c] This budget category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of planned expenditures allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only plan RSS for those in need of RSS from substance use disorder.

[d] Row 3 should account for the 20 percent minimum primary prevention set-aside of SUPTRS BG funds to be used for universal, selective, and indicated substance use prevention activities.

[e] The most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment.

[f] Other Capacity Building/Systems development include those activities relating to substance use per **45 CFR §96.122 (f)(1)(v)**

[g] Per **45 CFR § 96.135** Restrictions on expenditure of the SUPTRS BG, the state involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

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Footnotes:

In Florida, the agency responsible for Tuberculosis is the Department of Health.

1. When downloaded to PDF, the BGAS system changes the auto-calculated total to an incorrect amount. This is a technical glitch in BGAS. The totals are:

Column A = $233,580,020
Column D = $217,413,386
Column E = $335,292,086
Column G = $352,896,078

Please note that Column G (Other) represents Opioid Settlement funding.

Planning Tables

Table 2: MHBG Planned State Agency Budget for Two State Fiscal Years (SFY)

States are asked to present their projected two-year budget at the State Agency level, including all levels of state and applicable federal funds to be expended on mental health and substance use services allowable under each Block Grant. When planning their budgets, states should keep in mind all statutory requirements outlined in the application Funding Agreement/Certifications and Assurances.

Table 2 addresses funds budgeted to be expended during State Fiscal Years (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027).Table 2 includes columns to capture state planned budget of BSCA funds (MHBG only)

Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

Activity	Source of Funds							
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. Bipartisan Safer Communities ACT Funds[a]
1. Substance Use Disorder Prevention and Treatment								
a. Pregnant Women and Women with Dependent Children (PWWDC)								
b. All Other								
2. Recovery Support Services								
3. Primary Prevention								
4. Early Intervention Services for HIV								
5. Tuberculosis								
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award)[b]		$21,000,000.00						$395,600.00
7. State Hospital				$190,861,998.00	$856,099,786.00			
8. Other Psychiatric Inpatient Care								
9. Other 24-Hour Care (Residential Care)		$13,388,272.00			$127,453,880.00			
10. Ambulatory/Community Non-24 Hour Care		$38,654,993.00			$525,866,052.00			
11. Crisis Services (5 percent Set-Aside)[c]		$64,498,007.00		$12,692,972.00	$404,385,162.00			$2,381,827.00
12. Other Capacity Building/Systems Development								
13. Administration		$4,339,164.00		$5,063,438.00	$4,015,640.00			$27,856.00
14. Total		**$141,880,436.00**	**$0.00**	**$208,618,408.00**	**$1,917,820,520.00**	**$0.00**	**$0.00**	**$2,805,283.00**

[a]The expenditure period for the 3rd and 4th allocations of Bipartisan Safer Communities Act (BSCA) supplemental funding will be from **September 30, 2024 through September 29, 2026** (3rd increment), **September 30, 2025 through September 29, 2027** (4th increment). Column H should reflect the state planned expenditure for this planning period (FY2026 and FY2027) [July 1, 2025 through June 30, 2027, for most states].

[b]Row 6 in Columns B and H: per statute, states are required to set-aside 10 percent of the total MHBG and BSCA awards for evidence-based practices for Early Serious Mental Illness (ESMI), including Psychotic Disorders.

[c]Row 11 in Columns B and H: per statute, states are required to set-aside 5 percent of the total MHBG and BSCA awards for Behavioral Health Crisis Services (BHCS) programs.

[d]Per statute, administrative expenditures for the MHBG and BSCA funds cannot exceed 5 percent of the fiscal year award.

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Footnotes:

Planning Tables

Table 3: Persons in Need of/Receiving SUD Treatment – Required for SUPTRS BG Only

This table allows states to present their estimated current need and baseline reach of the priority populations laid out in the SUPTRS BG statute. This information is intended to assist the state in demonstrating the unmet need of these populations that informs their plans for FY2026 - 2027. The estimates provided should represent the unmet need at the time of the application.

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

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

States should contact their federal points of contact for assistance in drawing these estimates from national and state survey data.

Estimates should utilize the most recent data from NSDUH, TEDS, and other data sources.

	A. Aggregate Number Estimated in Need of SUD Treatment	B. Aggregate Number in SUD Treatment
Pregnant Women	7000	600
Women with Dependent Children	22101	15517
Individuals with a co-occurring M/SUD	1345000	14094
Persons who inject drugs	20001	6982
Persons experiencing homelessness	5604	7659

Please provide an outline of how the state made these estimates, including data sources and values used for each row. For any cell which the state is

unable to estimate the need or number in treatment, please provide an explanation for why these estimates could not be drawn.

1a (Pregnant Women in Need): Estimates of the past-year of prevalence of illicit drug and/or alcohol dependence/abuse from SAMHSA's Restricted Use Data Analysis System (RDAS) using 2015-2018 NSDUH data indicate that 6% of pregnant women in Florida (weighted count = 7,000) experienced past-year illicit drug and/or alcohol dependence/abuse. [SOURCE: Substance Abuse and Mental Health Services Administration. (2021). National Survey on Drug Use and Health: 4-Year RDAS (2015 to 2018). Restricted Online Data Analysis System (RDAS). Row Variable = UDPYILAL; Column Variable = PREGNANT; Control Variable = STNAME (Florida)]. 1b (Pregnant Women in Treatment): FY 22-23 records from the Department's Financial and Services Accountability Management System (FASAMS) 2a (Women with Dependent Children in Need): According to 2021 estimates from the American Community Survey (ACS), there are 409,270 female householders (no spouse/partner present) with children under age 18 in Florida. Additionally, according to 2022-2023 NSDUH estimates, approximately 5.4% of adults in Florida needed treatment for substance use but did not receive it. The aggregate number estimated in need was calculated by applying 5.4% to the number of women with dependent children. [SOURCES: United States Census Bureau. (2021). ACS 1-Year Estimates Data Profiles - Florida. TableID: DP02; Substance Abuse and Mental Health Services Administration. (2021). Table 30: Selected Measures in Florida, Annual Averages Based on 2018-2019 NSDUHs]. 2b (Women with Dependent Children in Treatment): FY 24-25 records from the Department's Financial and Services Accountability Management System (FASAMS) 3a (Individuals with Co-Occurring Disorders in Need): According 2019 NSDUH estimates, approximately 7.4% of adults in the South U.S. experienced past-year co-occurring substance use disorder and any mental illness. This prevalence rate was applied to the number of adults in Florida (18,434,975) to produce the estimated number in need. [SOURCES: Substance Abuse and Mental Health Services Administration. 2021 NSDUH Detailed Tables. Table 6.10B. Retrieved from https://www.samhsa.gov/data/report/2021-nsduh-detailed-tables]; Florida Department of Health. (2021). FLHealthCHARTS Population Query System. 2021 Population by County by Year, Age = 18 and older]. 3b (Individuals with Co-Occurring Disorders in Treatment): FY 24-25 records from the Department's Financial and Services Accountability Management System (FASAMS) 4a (Persons Who Inject Drugs in Need): According to an algorithm-based analysis of hospitalizations for injection-related infections in Florida from 2017, there are 20,001 individuals who inject drugs in Florida [SOURCE: Coye, A. E., et al. (2021). A Missed Opportunity: Underutilization of Inpatient Behavioral Health Services to Reduce Injection Drug Use Sequelae in Florida. Substance Abuse Treatment, Prevention, and Policy, 16(46)]. 4b (Persons Who Inject Drugs in Treatment): FY 24-25 records from the Department's Financial and Services Accountability Management System (FASAMS) 5a (Persons Experiencing Homelessness in Need): According to 2023 Point-In-Time counts of individuals who are homeless, 3,047 individuals (or about 14%) reported experiencing a substance use disorder.[SOURCE: Florida’s Council on Homelessness. (2023). Florida’s Council on Homelessness 2023 Annual Report. Retrieved from https://www.myflfamilies.com/sites/default/files/2023-07/Florida%27s%20Council%20On%20Homelessness%20Annual%20Report%202023.pdf] 5b (Persons Experiencing Homelessness in Treatment): FY 24-25 records from the Department's Financial and Services Accountability Management System (FASAMS)

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Table 4: SUPTRS BG Planned Award Budget by Federal Fiscal Year

In addition to projecting planned budget by State Fiscal Year (Table 2b), states must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations and expenditure categories. Therefore, Plan Table 4b must be completed for the SUPTRS BG awarded for Federal Fiscal Year (FFY) 2026 and FFY 2027. The totals for each FFY planning year should match the SUPTRS BG Final Allotments for the state in that award year.

Note: The FFY presented in the table is that of the award year, however states have up to two years to expend the award received. For example, the FFY 2026 award may be expended from October 1, 2025 through September 30, 2027.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Expenditure Category	FFY 2026 SUPTRS BG Award
1 . Substance Use Disorder Prevention[a] and Treatment	$57,734,504.00
2 . Recovery Support Services[b]	$17,518,502.00
3 . Substance Use Primary Prevention[c]	$23,358,002.00
4 . Early Intervention Services for HIV[d]	$5,839,501.00
5 . Tuberculosis Services	$0.00
6 . Other Capacity Building/Systems Development[e]	$6,500,000.00
7 . Administration[f]	$5,839,501.00
8. Total	$116,790,010.00

[a]Prevention other than primary prevention. The amount in this row should reflect the planned budget for direct services during the planning period. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[b]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of budget allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only present the estimated budget for RSS for those in need of RSS from substance use disorder. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[c]This row should reflect the state's planned budget of direct primary prevention activities that are intended to meet the SUPTRS BG 20 percent set aside. Activities include those used for universal, selective, and indicated substance use prevention activities. The budget for direct activities in this row should match the total budget planned in Table(s) 5a and 5b. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[d]The most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment.

[e]Other Capacity Building/System Development include those activities relating to substance use per **45 CFR §96.122 (f)(1)(v)**. The amount presented here should reflect the total found in Planning Table 6 across treatment, recovery, and primary prevention.

[f]Per **45 CFR §96.135** Restrictions on expenditure of grant, the State involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

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Table 4: MHBG State Agency Planned Budget

Table 4 addresses the planned budget for MHBG. Please use this table to capture your estimated budget for MHBG-funded services and programs over a 24-month period (for most states, it is July 1, 2025 - June 30, 2027).

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

MHBG-Funded Services	MHBG Funds Budgeted for This Item
1. Services for Adults	
1a. EBPs for Adults	8903738.00
1b. Crisis Services for Adults	52888366.00
1c. CSC/ESMI program for Adults	16590000.00
1d. Other outpatient/ambulatory services for Adults	17213517.00
1e. *Other Direct Services for Adults	11524700.00
2. Subtotal of Services for Adults	107120321.00
3. Services for Children	
3a. EBPs for Children	8500000.00
3b. Crisis Services for Children	11609641.00
3c. CSC/ESMI program for Children	4410000.00
3d. Other outpatient/ambulatory services for Children	4037738.00
3e. *Other Direct Services for Children	1863572.00
4. Subtotal of Services for Children	30420951.00
5. Other Capacity Building/Systems Development[a]	1304000.00
6. Administrative Costs[b]	4339164.00
7. *Any Other Cost	0.00
8. Total MHBG Allocation[c]	**143184436.00**

Please provide brief explanation for services with an asterisk* below:

*Other Direct Services includes Other 24-Hour Care Residential for adults and children and Transitional Supports for individuals with SMI returning to the community from a state mental health treatment facility.

[a] This row for Other Capacity Building/Systems Development should be equal to the total of your planned budget in Table 6

[b] Administrative Costs should not exceed 5 percent of total MHBG allocation

[c] The total budget should be equal to your MHBG allocation for the next two years.

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Table 5a: SUPTRS BG Primary Prevention Planned Budget by Strategy and Institutes of Medicine (IOM) Categories

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Strategy	IOM Classification	FFY 2026 SUPTRS BG Award
1. Information Dissemination	Universal	$3,630,565
	Selective	$242,550
	Indicated	$80,850
	Unspecified	
	Total	**$3,953,965**
2. Education	Universal	$4,002,083
	Selective	$2,001,041
	Indicated	$667,014
	Unspecified	
	Total	**$6,670,138**
3. Alternatives	Universal	$485,101
	Selective	$242,550
	Indicated	$80,850
	Unspecified	
	Total	**$808,501**
4. Problem Identification and Referral	Universal	$1,940,404
	Selective	$970,202
	Indicated	$323,401
	Unspecified	
	Total	**$3,234,007**
	Universal	$4,972,284
	Selective	$2,486,142

5. Community-Based Processes	Indicated	$828,714
	Unspecified	
	Total	**$8,287,140**
6. Environmental	Universal	$242,551
	Selective	$121,275
	Indicated	$40,425
	Unspecified	
	Total	**$404,251**
7. Section 1926 (Synar)-Tobacco	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
8. Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
Total Prevention Budget		**$23,358,002**
Total Award [a]		**$41,537,004**
Planned Primary Prevention Percentage		**56.23%**

[a] Total SUPTRS BG Award is populated from Plan Table 4 SUPTRS BG Planned Award Budget by Federal Fiscal Year

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Table 5b: SUPTRS BG Planned Primary Prevention Budget by Institutes of Medicine (IOM) Categories

States should identify the planned budget for primary prevention disaggregated by IOM Categories the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 and FFY 2027 SUPTRS BG allotments.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Strategy	FFY 2026 SUPTRS BG Award
1. Universal Direct	$9,573,051
2. Universal Indirect	$5,699,936
3. Selective	$6,063,761
4. Indicated	$2,021,254
5. Column Total	**$23,358,002**
6. Total SUPTRS Award[a]	**$41,537,004**
7. Primary Prevention Percentage	**56.23%**

[a] Total SUPTRS BG Award is populated from Plan Table 4 SUPTRS BG Planned Award Budget by Federal Fiscal Year

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Table 5c: SUPTRS BG Planned Primary Prevention Priorities

States should identify the categories of substances the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 SUPTRS BG award.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Priority Substances	FFY 2026 SUPTRS BG Award
Alcohol	☑
Tobacco/Nicotine-Containing Products	☐
Cannabis/Cannabinoids	☑
Prescription Medications	☑
Cocaine	☑
Heroin	☑
Inhalants	☐
Methamphetamine	☑
Fentanyl or Other Synthetic Opioids	☐
Other	☐
Priority Populations	
Students in College	☐
Military Families	☐
American Indian/Alaska Native	☐
African American	☐
Hispanic	☐
Persons Experiencing Homelessness	☐
Native Hawaiian/Pacific Islander	☐
Asian	☐
Rural	☑

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Table 6: SUPTRS BG Other Capacity Building/Systems Development Activities

Please enter the total amount of the SUPTRS BG budgeted for each activity described above, by treatment, recovery support services and primary prevention. In budgeting for each activity, states should break down the row budget by funds planned for SSA activities and those planned to be contracted out under other subrecipient contracts. States should plan their budgets on a single Federal Fiscal Year (FFY), specified in the table below.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Activity	FFY 2026		
	A. SUPTRS Treatment	B. SUPTRS Recovery Support Services	C. SUPTRS Primary Prevention
1. Information Systems	$1,167,611.00	$0.00	$63,950.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$1,167,611.00	$0.00	$63,950.00
2. Infrastructure Support	$521,098.00	$0.00	$85,755.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$521,098.00	$0.00	$85,755.00
3. Partnerships, community outreach, and needs assessment	$1,556,447.00	$0.00	$2,301,694.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$1,556,447.00	$0.00	$2,301,694.00
4. Planning Council Activities	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
5. Quality Assurance and Improvement	$94,468.00	$0.00	$55,335.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$94,468.00	$0.00	$55,335.00
6. Research and Evaluation	$77,521.00	$0.00	$49,430.00

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a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$77,521.00	$0.00	$49,430.00
7. Training and Education	$82,855.00	$0.00	$443,836.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$82,855.00	$0.00	$443,836.00
8. Total	**$3,500,000.00**	**$0.00**	**$3,000,000.00**

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The State does not currently have any method of separating Recovery Support Services budgeting by other capacity building/systems development activities. KRG 8/15/2025

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Table 6: MHBG Other Capacity Building/Systems Development Activities

MHBG Plan 6 address MHBG funds to be expended on other capacity building /systems development during State Fiscal Year (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027). This table includes columns to capture planned state budget for BSCA supplemental funds. Please use these columns to capture how much the state plans to expend over a 24-month period. Please document the planned uses of BSCA funds in the footnotes section.

MHBG Planning Period Start Date: 07/01/2025 MHBG Planning Period End Date: 06/30/2027

Activity	A. MHBG[1]	B. BSCA Funds[2]
1. Information Systems		
2. Infrastructure Support		
3. Partnerships, Community Outreach, and Needs Assessment		
4. Planning Council Activities	$104,000.00	
5. Quality Assurance and Improvement		
6. Research and Evaluation		
7. Training and Education	$1,200,000.00	
8. Total	**$1,304,000.00**	**$0.00**

[1] The standard MHBG planned expenditures captured in column A should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025 – June 30, 2027**, for most states].

[2] The expenditure period for the 3rd and 4th allocations of the Bipartisan Safer Communities Act (BSCA) funding is **September 30, 2024 – September 29, 2026** (3rd increment) and **September 30, 2025 – September 29, 2027** (4th increment). Column B should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025, through June 30, 2027** for most states].

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Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required for MHBG & SUPTRS BG

Narrative Question

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

A venue for states to advance access to care is by **ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections**. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **The Essential Aspects of Parity: A Training Tool for Policymakers**; **Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States**.

The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1] Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. **States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings**. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

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

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

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

a) Adults with serious mental illness (SMI)

b) Adults with SMI and a co-occurring intellectual and developmental disabilities (I/DD)

c) Pregnant women with substance use disorders

d) Women with substance use disorders who have dependent children

e) Persons who inject drugs

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

g) Persons with substance use disorders in the justice system

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

i) Other adults with substance use disorders

j) Children and youth with serious emotional disturbances (SED) or substance use disorders

k) Children and youth with SED and a co-occurring I/DD

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

Florida's publicly funded system is designed to provide services for mental health disorders, substance use disorders, and co-occurring mental health and substance use disorders and regularly reevaluates the system to ensure access to services for all individuals across Florida.

The Department contracts with seven non-profit Managing Entities to administer the Department's funding and manage regional behavioral health systems of care throughout the state. The Managing Entities ensure funding is used to effectively and efficiently address the gaps and unmet needs of the communities within their catchment areas.
Managing Entities, by contract and statute, are required to develop and maintain provider networks that meet needs of individuals within communities served, including:
• All priority populations as defined in S. 394.674(1), F.S.
• Mental health residents of assisted living facilities.
• Persons ordered into involuntary outpatient placement.
• Eligible children referred for residential placement.
• Inmates approaching the end of their sentences.
• Individuals that are currently in civil and forensic state Mental Health Treatment Facilities.
• 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).
• Adults who have substance use disorders and a history of intravenous drug use.
• Persons diagnosed as having co-occurring substance use and mental health disorders.
• Parents who put children at risk due to a substance use disorder.
• Persons who have a substance use disorder and have been ordered by the court to receive treatment.
• Children at risk for initiating drug use.
• Children under state supervision.
• Children who have a substance use disorder but who are not under the supervision of a court or in the custody of a state agency.

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

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

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

3. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and substance use disorders**, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders.

Florida supports integrated services for individuals with co occurring mental health and substance use disorders through a multi layered system combining state oversight, screening/assessment, coordinated care, evidence based treatment models, and supports. Providers are required to conduct both mental health and substance use disorder assessments as part of the integrated evaluation process. Programs such as Community Action Treatment (CAT) Teams and Family Intensive Treatment (FIT) Teams serve youth and parents with co occurring diagnoses, combining therapy, peer support, case management, child/family services, and recovery-oriented supports in one model.

a. Please describe how this system differs for youth and adults.

In the State of Florida, this system only differs in the source of referral and the choice of evidence-based treatment model, with some models being specific to children and others specific to adults.

b. Does your state provide evidence-based integrated treatment for co-occurring disorders (IT-COD), formerly known as IDDT? Please explain.

Yes. The State of Florida provides team-based approaches to integrated treatment for individuals with co-occurring disorders. These teams provide evidence-based treatment appropriate to various populations, including children/youth.

c. How many IT-COD teams do you have? Please explain.

In total, the State of Florida has 164 teams that provide evidence-based treatment for individuals with co-occurring disorders. 54 teams provide treatment to children/youth, 52 teams provide treatment to families, and 58 teams provide treatment to adults.

d. Do you monitor fidelity for IT-COD? Please explain.

The Department contracts with seven regional Managing Entities, who manage and coordinate the delivery of behavioral health services. These Managing Entities are contractually required to monitor for fidelity to the model.

e. Do you have a statewide COD coordinator? ○ Yes ◉ No

4. Describe how the state **supports integrated behavioral health and primary health care**, including services for individuals with mental disorders, substance use disorders, co-occurring M/SUD, and co-occurring SMI/SED and I/DD. Include detail about:

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

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

c) Efforts to integrate primary care into behavioral health settings

d) How the state provides integrated treatment for individuals with co-occurring disorders

Multidisciplinary teams (e.g., CAT, FACT, CSC-ESMI) and Care Coordination services are important mechanisms for integrating primary care and specialty care for mental health disorders, substance use disorders, and co-occurring mental health and substance use disorders in community-based settings.

Behavioral health care service providers offer primary care directly onsite or through referral arrangements with local clinics and Federally Qualified Health Center (FQHCs). Behavioral health care service providers also offer integrated services for co-occurring disorders, and the networks are required to operate as No Wrong Door models of access with required reporting on the extent to which systems reflect this model. The Department and Managing Entities also provide training and technical assistance on service integration.

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

a) Adults with serious mental illness (SMI)

b) Adults with substance use disorders

c) Adults with SMI and I/DD

d) Children and youth with serious emotional disturbances (SED) or substance use disorders

e) Children and youth with SED and I/DD

The Department funds care coordination with state and federal funds. Florida contracts with seven regional, non-profit Managing Entities (ME) who contract directly with local service providers to administer the funds. Under Section 65E-14.014, Florida Administrative Code, MEs are statutorily required provide assistance to clients who may be eligible for Medicaid or other program benefits when the insurance does not cover the needed service.

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

According to 65E-14.014(1), F.A.C., the care coordination policy must:
• Specify methods used to reduce, manage, and eliminate waitlists for services.
• Promote increased planning, use, and delivery of services to all individuals receiving services, including services for co-occurring mental health and substance use disorders.
• Ensure access to and use of clinically appropriate services using screening, assessment, and placement tools to identify the appropriate level of care within a continuum of services.
• Promote the use of service data to achieve desired outcomes.
• Include methodology to ensure individuals receive the lease restrictive level of care and diverted from higher levels of care when clinically indicated.
• Monitor and implement system changes to promote efficiencies.

Community Action Treatment provides community-based services, including care coordination, to children ages 11 to 21 with SED, I/DD or substance use disorders or co-occurring substance use disorder who meet eligibility criteria established in statute. Other Community Action Treatment services include assessment, intensive case management, crisis support, recovery support, and aftercare, among others.

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

(This question is a duplicate of question #3.)

7. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and intellectual/developmental disorders (I/DD)**, including screening and assessment for co-occurring disorders and integrated treatment that addresses I/DD as well as mental disorders. Please describe how this system differs for youth and adults.

(This question is a duplicate of question #3.)

8. Please indicate areas of **technical assistance needs** related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

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

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among individuals 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 as soon as possible following initial symptoms and reducing possible lifelong negative impacts such as loss of family and social supports, unemployment, incarceration, and increased hospitalizations *[Note: 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 SMI or SED].* The duration of untreated mental illness, defined as the time interval between the onset of symptoms and when an individual gets into appropriate treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be a negative prognostic factor. However, earlier treatment and interventions not only reduce acute symptoms but may also improve long-term outcomes.

The working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5TR (APA, 2022). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic, or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by the 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 experiencing first episode of psychosis (FEP). RAISE was a set of federal government- sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

States shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals experiencing 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.

Please respond to the following items:

1. Please name the evidence-based model(s) for ESMI, including psychotic disorders, that the state implemented using MHBG funds including the number of programs for each.

Model(s)/EBP(s) for ESMI	Number of programs
OnTrackNY	3.00
NAVIGATE	12.00
	0.00
	0.00
	0.00

	0.00

2. Please provide the total budget/planned expenditure for ESMI for FY 26 and FY 27 (only include MHBG funds).

FY2026	FY2027
9,933,480.00	9,933,480.00

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

Coordinated Specialty Care Teams that provide ESMI/FEP services are not billed through Medicaid in Florida. These teams are entirely funded through the Community Mental Health Block Grant. The Department has an established per-team rate that pays the salary of the team members who provide clinical services and peer and family supports. Individuals meeting the eligibility requirements of the program receive services free of charge. This is consistent across most multi-disciplinary teaming models funded through the Department, including (state-funded) Children's Community Action Teams (CAT) and Florida Assertive Community Action Teams (CAT). Referrals to CSC come from a variety of sources including but not limited to, Crisis Stabilization Units, Mobile Response Teams, and schools. The Department is also developing guidance for 988 Lifeline Centers to refer callers as well.

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

The state currently funds the following 15 Coordinated Specialty Care (CSC) for ESMI/FEP teams which utilize the NAVIGATE and OnTrackNY models and serve individuals experiencing the first symptom onset of a serious mental illness that includes psychosis or psychotic features:

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

5. Does the state monitor fidelity of the chosen EBP(s)? ○ Yes ◉ No

6. Does the state or another entity provide trainings to increase capacity of providers to deliver interventions related to ESMI? ○ Yes ◉ No

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

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

8. Please describe the planned activities in FY2026 and FY2027 for your state's ESMI programs.

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

9. Please list the diagnostic categories identified for each of your state's ESMI programs.

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

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

According to the most recent study published in 2017 and titled "First Presentation with Psychotic Symptoms in a Population-Based Sample," the estimated true incidence of FEP is 86 per 100,000 individuals ages 15-29. The estimated true incidence of FEP is

46 per 100,000 individuals ages 30-59. Applying these incidence rates to current Census figures for Florida yields an annual incidence of around 18,524 cases among individuals ages 15-29, and around 9,909 cases among individuals ages 30-59.

11. What is the state's plan to outreach and engage those experiencing ESMI who need support from the public mental health system?

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

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

12. Please indicate area of technical assistance needs related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

3. Person Centered Planning (PCP) – Required for MHBG, Requested for SUPTRS BG

Narrative Question

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

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. PCP resources may be accessed from **https://acl.gov/news-and-events/announcements/person-centered-practices-resources**

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

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

Not applicable

3. Describe how the state engages people with SMI and their caregivers in making health care decisions, and enhances communication.

The Department deploys several modalities to engage consumers and caregivers. These modalities allow for enhanced communication and assistance in making health care decisions. Family Intensive Treatment (FIT) Teams, Community Action Treatment (CAT), and Florida Assertive Community Treatment (FACT) Teams all employ a team-based approach that allows multiple avenues to engage the consumer. In addition, many other modalities are being utilized throughout the state.

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

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

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

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

The annually updated Florida Baker Act Handbook states:

Individuals in a designated receiving facility or State Mental Health Treatment Facility on involuntary status have the right to a representative. This representative may be selected by the individual themselves if competent to provide express and informed consent or through an advance directive. A representative is identified for the individual if he or she is not competent and does not have an advance directive or is competent and refuses to identify anyone.

The individual's representative must receive the same information a competent individual would receive including:
- Prompt notification of the individual's admission, all proceedings, and any restriction of rights.
- A copy of the inventory of personal effects.

The representative must have immediate access to the individual receiving services and is authorized to file a petition for a writ of habeas corpus or right to release on the individual's behalf.

Depending on how the individual's representative is appointed and if authority is granted by the court, the representative may or may not be able to make treatment decisions, access, or release information in the individual's clinical record, or request the transfer of the individual to another facility.

Pursuant to Chapter 59A-3.254(4)(b), Florida Administrative Code individuals in a designated receiving facility or State Mental Health Treatment Facility have the right to have their existing advanced directives honored and develop new advanced directives while receiving services. Familiarity with the individual's advanced directives is important in identifying future decisions made for that individual. Advanced directives must be completed when an individual is competent to provide express and informed consent. Advance directives are employed when an individual becomes incapacitated or incompetent. Advance directives are commonly used to make medical or behavioral health decisions but are also used in financial decision-making.

6. Please indicate areas of technical assistance needs related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

4. Program Integrity – Required for MHBG & SUPTRS BG

Narrative Question

There is a strong emphasis on ensuring that Block Grant funds are expended in amanner consistent with the statutory and regulatory framework. This requires that the federal government and the states have a strong approach to assuring program integrity. Currently, the primary goals of the federal government's 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, states are reminded of restrictions on the use of Block Grant funds outlined in **42 U.S.C. § 300x–5** and **42 U.S.C § 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)**, there are periodic site visits to MHBG and SUPTRS BG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SUPTRS BG funds can only be used for individuals with or at risk for SUD. The 20% minimum primary prevention set-aside of SUPTRS BG funds should be used for universal, selective, and indicated substance use prevention. Guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

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

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

Please respond to the following 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 program requirements, including quality and safety standards? (●) Yes ( ) No

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

None at this time.

4. Please indicate areas of technical assistance needs related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

5. Primary Prevention – Required for SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

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

1. ***Information dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, misuse and substance use disorders on individuals families and communities.
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of priority populations in activities that exclude alcohol, tobacco, and other drug use.
4. ***Problem identification and Referral*** that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions to prevent further use.
5. ***Community-based processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the use 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 serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Assessment

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

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply):

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

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

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

- **a)** ☑ Children (under age 12)
- **b)** ☑ Youth (ages 12-17)
- **c)** ☑ Young adults/college age (ages 18-26)
- **d)** ☑ Adults (ages 27-54)
- **e)** ☑ Older adults (age 55 and above)
- **f)** ☑ Rural communities

i) ☐ Other (please list)

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

a) ☐ Archival indicators (Please list)

b) ☑ National survey on Drug Use and Health (NSDUH)

c) ☑ Behavioral Risk Factor Surveillance System (BRFSS)

d) ☐ Youth Risk Behavioral Surveillance System (YRBS)

e) ☑ Monitoring the Future

f) ☑ Communities that Care

g) ☑ State-developed survey instrument

h) ☐ Other (please list)

5. Does your state use needs assessment data to make decisions about the allocation of SUPTRS BG primary prevention funds? ○ Yes ◉ No

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

b) If no, please explain how SUPTRS BG funds are allocated:

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

Narratve Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

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

1. ***Information dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, misuse and substance use disorders on individuals families and communities.
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6. ***Environmental strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the use 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 serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Building

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

a) If yes, please describe.

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

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

a) If yes, please describe mechanism used.

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

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

a) If yes, please describe mechanism used.

Narratve Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that serve 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 primary prevention that was developed within the last five years? ○ Yes ◉ No

If yes, please attach the plan in WebBGAS

Based on more recent input from various partners, including Managing Entities, prevention providers, and community-based organizations, the following activities are of particular strategic importance to Florida's prevention system:

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

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG?

- ☐ Yes
- ☐ No
- ☑ Not applicable (no prevention strategic plan)

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

- **a)** ☐ Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds
- **b)** ☐ Timelines
- **c)** ☐ Roles and responsibilities
- **d)** ☐ Process indicators

e) ☐ Outcome indicators

f) ☑ Not applicable/no prevention strategic plan

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

a) Does the composition of the Advisory Council represent the demographics of the State? ○ Yes ◉ No

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

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

N/A

Narratve Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

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3. ***Alternative programs*** that provide for the participation of priority populations in activities that exclude alcohol, tobacco, and other drug use.
4. ***Problem identification and Referral*** that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions to prevent further use.
5. ***Community-based processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the use 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 serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

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

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

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

- **a)** Information Dissemination:

  a. Media Campaigns
  b. An Apple a Day
  c. Talk. They Hear You.
  d. Toolkits / Resource Guides
  e. Generation Rx
  f. I Choose Me

g. Natural High
h. Keep a Clear Mind
i. Operation Medicine Cabinet
j. Too Good for Violence
k. Use Only as Directed
l. Teen Intervene
m. Rx Smart
n. Parents Who Host Lose the Most
o. No One's House
p. Lock Your Meds
q. Not in My House
r. Safe Homes/Smart Parties
s. Be the Wall
t. Friday Night Done Right
u. 21MEANS21
v. Opioids 101
w. Know the Law
x. NOPE vigil
y. Naloxone Trainings

b) Education:

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

Student Assistance Program
Strengthening Families
Marijuana And Vaping Prevention
PAX Good Behavior Game (PAX GBG)
Use Only as Directed
Retail Beverage Server Training
Triple P--Positive Parenting Program
Generation Rx
Safe Use, Safe Storage, Safe Disposal
Parent Cafes
Natural High
Opioids 101
CATCH My Breath
Curriculum Based Support Groups (CBSG) Program
Safe Rx
Family Education Program
Youth Messaging Development (YMD)
Be the Wall
21MEANS21
SADD

c) Alternatives:

Friday Night Done Right
Theater Troupe Peer Education Project

d) Problem Identification and Referral:

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

e) Community-Based Processes:

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

f) Environmental:

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

Generation Rx
Hidden in Plain Sight
SPORT Prevention Plus Wellness
Talk. They Hear You.
Marijuana Prevention Plus Wellness
Alcohol Literacy Challenge
Use Only as Directed
STAND

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

a) Yes (if so, please describe)

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

Narratve Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

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

1. ***Information dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, misuse and substance use disorders on individuals families and communities.
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of priority populations in activities that exclude alcohol, tobacco, and other drug use.
4. ***Problem identification and Referral*** that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions to prevent further use.
5. ***Community-based processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the use 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 serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

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

If yes, please attach the plan in WebBGAS

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

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

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

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

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

- **a)** ☑ 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** ☑ Heavy alcohol use
- **c)** ☑ Binge alcohol use
- **d)** ☑ Perception of harm
- **e)** ☑ Disapproval of use
- **f)** ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- **g)** ☐ Other (please describe):

Footnotes:

Environmental Factors and Plan

6. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

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

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-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 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 daily or weekly contact from various FACT Team members depending upon their individual needs. Flexible funding also allows for immediate access to tangible items an individual may need that will also assist with keeping them in the community and minimize the risks of future institutionalization.

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

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

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

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

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

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

Additional services and supports provided to assist in helping individuals with behavioral health disorders to function within the

community are, Vocational Rehabilitation, Supported Employment Programs, Re-entry Services, Case Management, Medication Management.

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

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

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

Not applicable

3. Describe your state's case management services

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

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

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

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

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

5. Please indicate areas of technical assistance needs related to this section.

None at this time.

Criterion 2: Mental Health System Data Epidemiology

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

Criterion 2

1. In order to complete column B of the table, please use the most recent federal prevalence estimate from the National Survey on Drug Use and Health or other federal/state data that describes the populations of focus.

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

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

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	5.38	957,000
2.Children with SED	7.00	137,330

2. 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.

Adults with serious mental illness (SMI) are defined as persons with a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual (DSM) that results in functional impairment. The 2022-2023 NSDUH estimates that approximately 5.4% of adults in Florida experienced SMI. Further 20% of adults in Florida experienced any mental illness in the past year. Looking more specifically at emerging adults ages 18-25, 34% reported any mental illness in the past year, and 13% had serious thoughts of suicide. According to FY 2023 URS data, 147,870 adults were served in community settings in the state of Florida. This is far less than 5.4% of the estimated 17,338,241 adults residing in the state according to the 2020 United States Census. Additionally, in FY 23-24, there were approximately 1,241 individuals placed on waitlists for community mental health services according to Managing Entity reporting.

Children with serious emotional disturbances (SED) have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM that results in functional impairment. According to the 2023 Florida specific Uniform Reporting System (URS) estimates, the prevalence for Serious Emotional Disorder for children 9-17 in the state of Florida is 10%. In FY 2023-2024, children with SED comprised 19.5% of individuals served in Florida’s publicly funded community mental health programs.

3. Please indicate areas of technical assistance needs related to this section.

None at this time.

Criterion 3: Children's Services

Provides for a system of integrated services for children to receive care for their multiple needs.

Criterion 3

1. Does your state integrate the following services into a comprehensive system of care?[1]

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

2. Please indicate areas of technical assistance needs related to this section.

None at this time.

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

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

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

Criterion 4

a. Describe your state's tailored services to rural population with SMI/SED. See the federal **Rural Behavioral Health** page for program resources.

The state of Florida is made up of 67 counties. Of those 67 counties, 33 are considered "rural." A wide variety of outreach methods are employed to target the rural population. Statewide, providers offer telehealth services, satellite offices within rural communities and staff who provide in-home services such as care coordination. In addition, several Managing Entities participate along with service providers to ensure they are involved in rural county community meetings on a regular basis, updating rural communities on any change in services and providing information regarding mental health and/or co-occurring disorders. This is meant to facilitate open dialogue and feedback regarding the types and quality of services offered in each community. Community engagement specialists and trainers work within rural communities to provide training on available resources and how to access those resources, as well as deliver other pertinent training to communities such as Mental Health First Aid and Youth Mental Health First Aid. In addition, assistance in the form of bus passes, gas cards and transportation services are initiated to aid families who may not otherwise be able travel to receive services and supports in an outpatient setting.

b. Describe your state's tailored services to people with SMI/SED experiencing homelessness. See the federal **Homeless Programs and Resources** for program resources[1]

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

There are contracted agencies that offer Supportive Housing/Living services which assist individuals with mental illness and substance abuse in selecting permanent housing in addition to providing services and supports that will enable the individual to maintain their housing so they can continue to live successfully in the community.

The Department also receives funding through the federal Projects for Assistance in Transition from Homelessness (PATH) grant. PATH provides services and supports that may not traditionally supported by mental health programs. The goal is to reduce or eliminate homelessness for adults with serious mental illnesses or co-occurring substance use disorders and who are at risk of or experiencing homelessness.

c. Describe your state's tailored services to the older adult population with SMI. See the federal **Resources for Older Adults** webpage for resources[2]

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

d. Please indicate areas of technical assistance needs related to this section.

None at this time.

[1] **https://www.samhsa.gov/homelessness-programs-resources**

[2] **https://www.samhsa.gov/resources-serving-older-adults**

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

1. Describe your state's management systems.

State Staffing for Mental Health Services Providers:
Community mental health providers are supported by Managing Entities contracted by the Department, as well as Department staff with in the Substance Abuse and Mental Health Program Office who manage funding, collect data, administer programs, develop administrative rule and policy, guidance and contract documents, and provide program monitoring.

State Training for Mental Health Services Providers:
The Department oversees a Learning Management System through a contract with the Florida Alcohol and Drug Abuse Association that provides training, webinars and workshops for behavioral health and related professionals, including free self-paced on-line courses for continuing education credits and an archival training database. The Learning Management System is regularly updated to reflect statutory changes and best practices.

Training of Providers of Emergency Services for Individuals with SMI and SED:
The Department oversees a Learning Management System through a contract with the Florida Alcohol and Drug Abuse Association that provides training, webinars and workshops for behavioral health and related professionals, including free self-paced on-line courses for continuing education credits and an archival training database. The Learning Management System is regularly updated to reflect statutory changes and best practices.

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

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

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

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

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

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

3. Please indicate areas of technical assistance needs related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

7. Substance Use Disorder Treatment – Required for SUPTRS BG

Narrative Question

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

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services (with medications for addiction treatment included in v-x):

i)	Screening	◉ Yes	○ No
ii)	Education	◉ Yes	○ No
iii)	Brief intervention	◉ Yes	○ No
iv)	Assessment	◉ Yes	○ No
v)	Withdrawal Management (inpatient/residential)	◉ Yes	○ No
vi)	Outpatient	◉ Yes	○ No
vii)	Intensive outpatient	◉ Yes	○ No
viii)	Inpatient/residential	◉ Yes	○ No
ix)	Aftercare/Continuing Care	◉ Yes	○ No
x)	Recovery support	◉ Yes	○ No

b) Services for special populations:

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

Criterion 2

Criterion 3

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

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

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

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

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

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

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

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

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

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

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

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

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

i) Educational assistance? (●) Yes ( ) No

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

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

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

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

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

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

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

Florida contracts with seven regional Managing Entities to oversee network service provider compliance with Block Grant rules regarding persons who inject drugs (PWID), which includes preference in admissions. Managing Entities conduct onsite monitoring and desk reviews using Block Grant compliance monitoring tools. Any issues that are found are addressed through Corrective Action Plans (CAPs). Consequences for noncompliance range from remedial (like required training, technical assistance, and policy revisions) to severe (like contract termination).

Tuberculosis (TB)

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

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

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

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

All licensed treatment programs in Florida are required to provide TB testing to high-risk clients either directly or through referral, pursuant to Chapter 65D-30 of the Florida Administrative Code. County Health Departments in Florida offer free TB testing. Managing Entities conduct onsite monitoring and desk reviews using Block Grant compliance monitoring tools. Any issues that are found are addressed through Corrective Action Plans (CAPs). Consequences for noncompliance range from remedial (like required training, technical assistance, and policy revisions) to severe (like contract termination).

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

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

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

a) Establishment of EIS-HIV service hubs in rural areas? ○ Yes ◉ No

b) Establishment or expansion of tele-health and social media support services? ○ Yes ◉ No

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

Hypodermic Needle Prohibition

1. Does your state have in place an agreement to ensure that SUPTRS BG funds are NOT expended to provide individuals with hypodermic needles or syringes for the purpose of injecting illicit substances **(42 U.S.C.§ 300x-31(a)(1)(F))**? ◉ Yes ○ No

Criterion 8,9&10

Service System Needs

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

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

a) Workforce development efforts to expand service access? (●) Yes ( ) No

b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services? ( ) Yes (●) No

c) Establish a peer recovery support network to assist in filling the gaps? (●) Yes ( ) No

d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, persons experiencing homelessness)? (●) Yes ( ) No

e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, such as primary healthcare, public health, VA, and community organizations? (●) Yes ( ) No

Service Coordination

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

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

a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services ( ) Yes (●) No

b) Establish a program to provide trauma-informed care ( ) Yes (●) No

c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice system, adult criminal justice system, and education. (●) Yes ( ) No

Charitable Choice

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

2. Does your state provide any of the following:

a) Notice to Program Beneficiaries? ( ) Yes (●) No

b) An organized referral system to identify alternative providers? ( ) Yes (●) No

c) A system to maintain a list of referrals made by religious organizations? ( ) Yes (●) No

Referrals

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

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

a) Review and update of screening and assessment instruments? (●) Yes ( ) No

b) Review of current levels of care to determine changes or additions? (●) Yes ( ) No

c) Identify workforce needs to expand service capabilities? (●) Yes ( ) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? (●) Yes ( ) No

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

a) Training staff and community partners on confidentiality requirements? ○ Yes ◉ No

b) Training on responding to requests asking for acknowledgement of the presence of clients? ○ Yes ◉ No

c) Updating written procedures which regulate and control access to records? ○ Yes ◉ No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure? ○ Yes ◉ No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? ◉ Yes ○ No

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

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

Seven Block Grant subrecipients are selected to undergo independent peer review per year.

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

a) Development of a quality improvement plan? ○ Yes ◉ No

b) Establishment of policies and procedures related to independent peer review? ○ Yes ◉ No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations? ○ Yes ◉ No

4. Does your state require a Block Grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for Block Grant funds? ○ Yes ◉ No

If Yes, please identify the accreditation organization(s)

i) ☑ Commission on the Accreditation of Rehabilitation Facilities

ii) ☐ The Joint Commission

iii) ☐ Other (please specify)

All of Florida's Managing Entities are required to have accreditation through CARF or an equivalent accrediting body.

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? ○ Yes ◉ No

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

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service? ○ Yes ◉ No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing? ○ Yes ◉ No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state? ◉ Yes ○ No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services? ◉ Yes ○ No

c) Performance-based accountability? ◉ Yes ○ No

d) Data collection and reporting requirements? ◉ Yes ○ No

If the answer is No to any of the above, please explain the reason.

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

a) A comprehensive review of the current training schedule and identification of additional training needs? ◉ Yes ○ No

b) Addition of training sessions designed to increase employee understanding of recovery support services? ◉ Yes ○ No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services? ◉ Yes ○ No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort? ◉ Yes ○ No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers[1] (TTCs)?

a) Prevention TTC? ○ Yes ◉ No

b) SMI Adviser ○ Yes ◉ No

c) Addiction TTC? ○ Yes ◉ No

d) State Opioid Response Network? ◉ Yes ○ No

e) Strategic Prevention Technical Assistance Center (SPTAC) ○ Yes ◉ No

Waivers

*Upon the request of a state, the Secretary may waive the requirements of all or part of the sections **42 U.S.C.§ 300x-22(b)**,**300x-23**,**300x-24**, and **300x-28** (**42 U.S.C.§ 300x-32(e)**).*

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women (300x-22(b)) ○ Yes ◉ No

2. Is your state considering requesting a waiver of any requirements related to:

a) Intravenous substance use (300x-23) ○ Yes ◉ No

3. Is Your State Considering Requesting a Waiver of any Requirements Related to Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus (300x-24)

a) Tuberculosis ○ Yes ◉ No

b) Early Intervention Services Regarding HIV ○ Yes ◉ No

4. Is Your State Considering Requesting a Waiver of any Requirements Related to Additional Agreements (**42 U.S.C. § 300x-28**)

a) Improvement of Process for Appropriate Referrals for Treatment ○ Yes ◉ No

b) Professional Development ○ Yes ◉ No

c) Coordination of Various Activities and Services ○ Yes ◉ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

CHAPTER 65E-14
COMMUNITY SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES – FINANCIAL RULES
https://www.flrules.org/gateway/readFile.asp?sid=0&tid=0&cno=65E-14&caid=1528252&type=4&file=65E-14.doc

CHAPTER 65D-30
SUBSTANCE ABUSE SERVICES OFFICE
https://www.flrules.org/gateway/readFile.asp?sid=0&tid=0&cno=65D-30&caid=1553666&type=4&file=65D-30.doc

CHAPTER 65E-5
MENTAL HEALTH ACT REGULATION
https://flrules.org/gateway/ChapterHome.asp?Chapter=65E-5

CHAPTER 65E-9
Licensure of Residential Treatment Centers
https://flrules.org/gateway/ChapterHome.asp?Chapter=65E-9

CHAPTER 65E-12
PUBLIC MENTAL HEALTH CRISIS STABILIZATION UNITS AND SHORT-TERM RESIDENTIAL TREATMENT PROGRAMS
https://flrules.org/gateway/ChapterHome.asp?Chapter=65E-12

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[1] **https://www.samhsa.gov/technology-transfer-centers-ttc-program**

Footnotes:

Environmental Factors and Plan

8. Uniform Reporting System and Mental Health Client-Level Data (MH-CLD)/Mental Health Treatment Episode Data Set (MH-TEDS) – Required for MHBG

Narrative Question

Health surveillance is critical to the federal government's ability to develop new models of care to address substance use and mental illness. Health surveillance data provides decision makers, researchers, and the public with enhanced information about the extent of substance use 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. Title XIX, Part B, Subpart III of the Public Health Services Act **(42 U.S.C. §300x-52(a))**, mandates the Secretary of the Department of Health and Human Services to assess the extent to which states and jurisdictions have implemented the state plan for the preceding fiscal year. The annual report aims to provide information aiding the Secretary in this determination.

42 U.S.C. §300x-53(a) requires states and jurisdictions to provide any data required by the Secretary and cooperate with the Secretary in the development of uniform criteria for data collection. Data collected annually from the 59 MHBG grantees is done through the Uniform Reporting System (URS), Mental Health Client-Level Data (MH-CLD), and Mental Health Treatment Episode Data Set (MH-TEDS) as part of the MHBG Implementation Report. The URS is an initiative to utilize data in decision support and planning in public mental health systems, fostering program accountability. It encompasses 23 data tables collected from states and territories, comprising sociodemographic client characteristics, outcomes of care, utilization of evidence-based practices, client assessment of care, Medicaid funding status, living situation, employment status, crisis response services, readmission to psychiatric hospitals, as well as expenditures data. Currently, data are collected through a standardized Excel data reporting template. The MHBG program uses the URS, which includes the National Outcome Measures (NOMS), offering data on service utilization and outcomes. These data are aggregated by individual states and jurisdictions.

In addition to the aggregate URS data, Mental Health Client-Level Data (MH-CLD) are currently collected. SMHAs are state entities with the primary responsibility for reporting data in accordance with the reporting terms and conditions of the Behavioral Health Services Information System (BHSIS) Agreements funded by the federal government. The BHSIS Agreement stipulates that SMHAs submit data in compliance with the Community Mental Health Services Block Grant (MHBG) reporting requirements. The MH-CLD is a compilation of demographic, clinical attributes, and outcomes that are routinely collected by the SMHAs in monitoring individuals receiving mental health services at the client-level from programs funded or provided by the SMHA.

MH-TEDS is focused on treatment events, such as admissions and discharges from service centers. Admission and discharge records can be linked to track treatment episodes and the treatment services received by individuals. Thus, with MH-TEDS, both the individual client and the treatment episode can serve as a unit of analysis. In contrast, with MH-CLD, the client is the sole unit of analysis. The same set of mental health disorders for National Outcome Measures (NOMs) enumerated under MH-CLD is also supported by MH-TEDS. Thus, while both MH-TEDS and MH-CLD collect similar client-level data, the collection method differs.

Please note: *Efforts are underway to standardize the client level data collection by requiring states to submit client-level data through the MH-CLD system. Currently, over three-quarters of states participate in MH-CLD reporting. Starting in Fiscal Year 2028, MH-CLD reporting will be mandatory for all states. States that currently submit data through MH-TEDS are encouraged to begin transitioning their systems now and may request technical assistance to support this transition process*

This effort reflects the federal commitment to improving data quality and accessibility within the mental health field, facilitating more comprehensive and accurate analyses of mental health service provision, outcomes, and trends. This unified reporting system would promote efficiency in data collection and reporting, enhancing the reliability and usefulness of mental health data for policymakers, researchers, and service providers.

Please respond to the following items:

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

The Department implemented FASAMS in January 2019 in compliance with Section 394.77, Florida Statutes, to meet the following statutory requirements:

- A uniform management information and fiscal accounting system for use by providers of community substance abuse and mental health services.
- A uniform reporting system with uniform definitions and reporting categories.

- An integrated system with automated interfaces to Florida Medicaid Management Information System (FMMIS) and Child Welfare (FSFN) systems.

2. Is the SMHA 's current data collection and reporting system specific to mental health services or it is 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.).

The current data collection system is specific to mental health and substance abuse data.

3. What is the current capacity of the SMHA in linking data with other state agencies/entities (e.g., Medicaid, criminal/juvenile justice, public health, hospitals, employment, school boards, education, etc.)?

The current data collection system does not have the capacity to link data with other state agencies. However, recent legislation was passed to begin work on a data repository for state behavioral health data.

4. Briefly describe the SMHA 's ability to report evidence-based practices (EBPs) including Early Serious Mental Illness (ESMI and Behavioral Health Crisis Services (BHCS) outcome data at the client-level.

The Department relies on supplemental reports from the Managing Entities and providers to report evidence-based practices (EBPs) including Early Serious Mental Illness (ESMI and Behavioral Health Crisis Services (BHCS) outcome data at the client-level.

5. Briefly describe the limitations of the SMHA 's existing data system.

The limitation of the existing data system is the inability to link with other internal fiscal systems.

6. What strategies are being employed by the SMHA to enhance data quality?

The Department continuously assesses the quality of data collected through monthly and quarterly data analyses.

7. Please describe any barriers (staffing, IT infrastructure, legislative, or regulatory policies, funding, etc.) that would limit your state from collecting and reporting data to the federal government.

The Department complies with all state and federal regulations related to data collection and reporting, however any substantial changes to data requirements at the federal level do require updates to state reporting systems and mechanisms that may temporarily limit the state's ability to comply.

8. Please indicate areas of technical assistance needs related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

9. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

There is a mandatory 5 percent set-aside within MHBG allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *…….to support evidence-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to fund some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expending 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence-based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

A crisis response system has 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.The expectation is that states will build on the emerging and growing body of evidence, including guidance developed by the federal government, for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization services to support reducing distress, and the promotion of skill development and outcomes, all towards managing costs and better investment of resources.

Several resources exist to help states. These include **Crisis Services: Meeting Needs, Saving Lives**, which consists of the **National Guidelines for Behavioral Health Coordinated System of Crisis Care** as well as an **Advisory: Peer Support Services in Crisis Care** There is also the **National Guidelines for Child and Youth Behavioral Health Crisis Care** which offers best practices, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth, and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by the 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

When individuals experience a crisis related to mental health, substance use, and/or homelessness (due to mental illness or a co-occurring disorder), a no-wrong door comprehensive crisis system should be put in place. Based on the National Guidelines, there are three major components to a comprehensive crisis system, and each must be in place in order for the system to be optimally effective. These three-core structural or programmatic elements are: Crisis Call Center, Mobile Crisis Response Team, and Crisis Receiving and Stabilization Facilities.

Crisis Contact Center. In times of mental health or substance use crisis, 911 is typically called, which results in police or emergency medical services (EMS) dispatch. A crisis call center (which may provide text and chat services as well) provides an alternative. Crisis call centers should be made available statewide, provide real-time access to a live crisis counselor on a 24/7 basis, meet National Suicide Prevention Lifeline operational guidelines, and serve as "Air Traffic Control" to assess, coordinate, and determine the appropriate response to a crisis. In doing so, these centers should integrate and collaborate with existing 911 and 211 centers, as well as other applicable call centers, to ensure access to the appropriate level of crisis response. 211 centers serve as an entry point to crisis services in many states and provide information and referral to callers on where to obtain assistance from local and national social

services, government agencies, and non-profit organizations.

The public has become accustomed to calling 911 for any emergency because it is an easy number to remember, and they receive a quick response. Many of the crisis systems in the United States continue to use 911 for several reasons such as they are still building their crisis systems or because they have no mechanism to fund a call center separate from 911. However, they recognize that the sure way to minimize the involvement of law enforcement in a behavioral health crisis response is to divert calls from 911. There are basically three diversion models in operation at this time: (1) the 911-based system with dispatchers who forward calls to either law enforcement's responder team (law enforcement officer with a behavioral health professional) or to their Crisis Intervention Team (CIT) with law enforcement officers who have received Crisis Intervention Training, including awareness of mental health and substance use disorders, and related symptoms, de-escalation methods, and how to engage and connect people to supportive services; (2) the 911-based system with well-trained 911 dispatchers who triage calls to state or local crisis call centers for individuals who are not a threat to themselves or others; the call centers may then refer appropriate calls to local mobile response teams (MRTs), also called mobile crisis teams (MCTs); and (3) State or local Crisis Contact Centers with well-trained counselors who receive calls directly (without utilizing 911 at all) on their own toll-free numbers.

Mobile Crisis Response Team. Once a behavioral health crisis has been identified and a crisis line has been called, a mobile response may be required if the crisis cannot be resolved by phone alone. Historically, law enforcement has been dispatched to the location of the individual in crisis. But in an effective crisis system, mobile crisis teams, including a licensed clinician, should be dispatched to the location of the individual in crisis, accompanied by Emergency Medical Services (EMS) or police only as warranted. Ideally, peer support professionals would be integrated into this response. Assessment should take place on site, and the individual should be connected to the appropriate level of care, if needed, as deemed by the clinician and response team.

Crisis Receiving and Stabilization Facilities. In a typical response system, EMS or police would transport the individual in crisis either to an ED or to a jail. Crisis Receiving and Stabilization Facilities provide a cost-effective alternative. These facilities should be available to accept individuals by walk-in or drop-off 24/7 and should have a "no wrong door" policy that supports all individuals, including those who need involuntary services. When anyone arrives, including law enforcement or EMS who are dropping off an individual, the hand-off should be "warm" (welcoming), timely and efficient. These facilities provide assessment for, and treatment of mental health and substance use crisis issues, including initiating medications for opioid use disorder (MOUD), and also provide wrap-around services. The multi-disciplinary team, including peers, at the facility can work with the individual to coordinate next steps in care, to help prevent future mental health crises and repeat contacts with the system, including follow-up care.

Currently, the 988 Suicide and Crisis Lifeline (Lifeline) connects with local call centers throughout the United States. Call center staff is comprised of individuals who are trained to utilize best practices in handling behavioral health calls. Local call centers automatically engage in a safety assessment for every call; if an imminent risk exists and cannot be deescalated, they forward the call to either 911 or to a local mobile crisis team for a response. If there is no imminent risk, the call center will work with the individual (or the person calling on their behalf) for as long as needed or, if necessary, dispatch a local MRT.

988 – 3-Digit behavioral health crisis number. The National Suicide Hotline Designation Act (**P.L. 116-172**) provides an opportunity to support the infrastructure, service and long-term funding for community and state 988 response, a national 3-digit behavioral health crisis number that was approved by the Federal Communications Commission in July 2020. In July 2022, the National Suicide Prevention Lifeline transitioned to 988 Suicide & Crisis Lifeline, but the 1-800-273-TALK is still operational and directs calls to the Lifeline network. The 988 transition has supported and expanded the Lifeline network and will continue utilizing the life-saving behavioral health crisis services that the Lifeline and Veterans Crisis Line centers currently provide.

Building Crisis Services Systems. Most communities across the United States have limited, but growing, crisis services, although some have an organized system of services that provide on-demand behavioral health assessment and stabilization services, coordinate and collaborate to divert from jails, minimize the use of EDs, reduce hospital visits, and reduce the involvement of law enforcement. Those that have such systems did not create them overnight, but it involved dedicated individuals, collaboration, considerable planning, and creative methods of blending sources of funding.

1. Briefly describe your state's crisis system. For all regions/areas of your state, include a description of access to crisis contact centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis receiving and stabilization centers.

According to Chapter 65E-14, Florida Administrative Code, Florida's crisis system is composed of crisis stabilization and crisis support/emergency. Crisis stabilization services are acute, intensive residential treatment services offered twenty-four hours per day, seven days per week, that meet the needs of individuals experiencing an acute crisis and who would require hospitalization in the absence of a suitable alternative. Crisis support/emergency services are non-residential care generally available twenty-four hours per day to intervene in a crisis or provide emergency care, such as Mobile Response Teams, the 988 Suicide and Crisis Lifeline, and Crisis Stabilization Units.

Crisis services are available statewide. Crisis Stabilization Units, Mobile Response Teams and the 988 Suicide and Crisis Lifeline are all available in every region of the state.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the published guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the published guidelines.*
*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*
*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to contact	☐	☐	☐	☐	☐	☑
Someone to respond	☐	☐	☐	☐	☐	☑
Safe place to be	☐	☐	☐	☐	☐	☑

3. Briefly explain your stages of implementation selections here.

Someone to Talk to - Since its rollout in July 2022, the Department has overseen the implementation and rapid growth of the 988 Florida Lifeline, which has provided free, 24/7 behavioral health support statewide to 346,896 callers to date. Since that time, the 988 Florida Lifeline has diverted 96% of callers from a higher level of care, made 142,660 referrals to mental health services and saved the lives of 3,566 individuals who called during a suicide attempt in progress. Florida's 988 call centers were able to maintain an 80% answer rate for fiscal year 2024-25, despite an 18% increase in call volume compared to the previous fiscal year. The average speed to answer a call is 29.3 seconds (4 seconds faster than the national average), with some Florida centers answering calls in under 5 seconds. The 988 Florida Lifeline is funded through a combination of Community Mental Health Services Block Grant, Substance Use Prevention, Treatment and Recovery Services Block Grant, Bipartisan Safer Communities Act Supplemental funds, a federal 988 State and Territories Cooperative Agreement Grant, and state general revenue. In June 2025, the Governor signed into law House Bill 1091, which added the 988 Florida Lifeline into Chapter 394 F.S. as an essential part of the crisis system of care, authorized the Department to develop administrative rule, and to establish a workgroup to establish formal protocols for 988/911 interoperability.

Someone to Respond - Mobile Response Teams (MRT) were implemented in 2018 following the Marjorie Stoneman Douglas school shooting. Initial implementation began with 30 teams throughout the state serving individuals 25 and under. Since that time, the Florida Legislature has continued to invest in MRT with increased funding that has allowed the continued expansion of MRT. The MRTs have maintained an 80% diversion from a higher level of care and respond within 30 minutes on average.

(PLACEHOLDER AWAITINH 24-25 DATA) In state fiscal year 2023-24, Florida had 51 teams serving all ages. In state fiscal year 2024-25, the Legislature approved an additional $11 million in recurring general revenue that is currently in the allocation process. MRT exists in all regions of the state covering all 67 counties. (Some counties have shared MRT services due to smaller population size.)

Somewhere to Go – Florida has a long established network of Crisis Stabilization Units that are funded through a combination of state, and federal funds, Medicaid, and billing through private insurance.

4. Based on the National Guidelines for Behavioral Health Crisis Care and the **National Guidelines for Child and Youth Behavioral Health Crisis Care**, explain how the state will develop the crisis system.

Florida's implementation of care coordination in 2016, Mobile Response Teams in 2018, and the 988 Florida Lifeline in 2022 has resulted in an approximate 20% decrease in involuntary examinations under Florida's Baker Act. Florida will continue to build on this success by continuing to contribute state and federal funding to develop and expand access to these vital crisis services.

5. Other program implementation data that characterizes crisis services system development.

Someone to contact: Crisis Contact Capacity

a. Number of locally based crisis call Centers in state
   i. In the 988 Suicide and Crisis lifeline network: 13

ii. Not in the suicide lifeline network: 0

b. Number of Crisis Call Centers with follow up protocols in place

i. In the 988 Suicide and Crisis lifeline network: 13

ii. Not in the suicide lifeline network: 0

c. Estimated percent of 911 calls that are coded out as BH related: 0

Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)

a. Independent of public safety first responder structures (police, paramedic, fire): 67

b. Integrated with public safety first responder structures (police, paramedic, fire): 6

c. Number that utilizes peer recovery services as a core component of the model: 67

Safe place to be

a. Number of Emergency Departments: 0

b. Number of Emergency Departments that operate a specialized behavioral health component: 0

c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis): 123

6. Briefly describe the proposed/planned activities utilizing the 5% set aside. If applicable, please describe how the state is leveraging the CCBHC model as a part of crisis response systems, including any role in mobile crisis response and crisis follow-up. As a part of this response, please also describe any state-led coordination between the 988 system and CCBHCs.

The 5-percent set-aside will support Mobile Response Teams, Crisis Stabilization services, and contribute to sustainment of 988 Suicide and Crisis Lifeline call centers in Florida.

7. Please indicate areas of technical assistance needs related to this section.

None at this time.

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Footnotes:

Data for behavioral health related calls to 911 are not available in Florida. The state has 48 traditional MRT Teams and 6 Co-responder Teams. In the communities without Co-responder Teams there is a relationship with law enforcement.

Environmental Factors and Plan

10. Recovery – Required for MHBG & SUPTRS BG

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality behavioral health care. The expansion in access to; and coverage for, health care drives the promotion of 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 health and substance use disorders.

Recovery is supported through the key components of health (access to quality physical health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of a recovery- guided approach to person-centered care is inclusive of shared decision-making, culturally welcoming and sensitive to social needs of the individual, their family, and communities. Because mental and substance use disorders can be chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management of recovery and personal success over the lifespan.

The following working definition of recovery from mental and/or substance use disorders has stood the test of time:

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, there are 10 identified 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 **Working Definition of Recovery.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the several federally supported national technical assistance and training centers. States are strongly encouraged to take proactive steps to implement and expand recovery support services and collaborate with existing RCOs and RCCs. Block Grant guidance is also available at the **Recovery Support Services Table**.

Because recovery is based on the involvement of peers/people in recovery, their family members and caregivers, SMHAs and SSAs should engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing organizations and direct resources for enhancing peer, family, and youth networks such as RCOs and RCCs 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 behavioral health treatment system.

1. Does the state support recovery through any of the following:

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? (●) Yes ( ) No

b) Required peer accreditation or certification? (●) Yes ( ) No

c) Use Block Grant funds for recovery support services? (●) Yes ( ) No

d) Involvement of people with lived experience /peers/family members in planning, implementation, or evaluation of the impact of the state's behavioral health system? (●) Yes ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? (●) Yes ( ) No

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

According to Chapter 65E-14, Florida Administrative Code, "recovery support services are designed to support and coach an adult or child and family to regain or develop skills to live, work and learn successfully in the community. Services include substance abuse or mental health education, assistance with coordination of services as needed, skills training, and coaching." Recovery services must include clinical supervision provided by a professional qualified by degree, licensure, certification, or specialized training in the implementation of this service. Adult and Child mental health recovery services are provided by a Certified Family, Veteran, or Recovery Peer Specialist.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations.

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

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

The state is actively working to expand access to Recovery Community Organization.

6. Please indicate areas of technical assistance needs related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

11. Children and Adolescents M/SUD Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health disorder and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[1] Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[2] For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3]

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started using substances the age of 18. Of people who started using substances before the age of 18, one in four will develop a substance use disorder compared to one in 25 who started using substances after age 21.[4]

Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance use, 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, states are encouraged to designate a point person for children to assist schools in assuring identified children relate to available prevention services and interventions, mental health and/or substance use screening, treatment, and recovery support services.

Since 1993, the federally funded Children's Mental Health Initiative (CMHI) has been used as an approach to build the system of care model 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, states have also received planning and implementation grants for adolescent and transition age youth SUD and MH treatment and infrastructure development. This work has included a focus on formal partnership development across child serving systems and policy change related to 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 functioning of children, youth and young adults in home, school, and community settings. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult, and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[5]

According to data from the 2017 Report to Congress on systems of care, services reach many children and youth typically underserved by the mental health system.

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

The expectation is that states will build on the well-documented, effective system of care approach. 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:

1. 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);
2. supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education

and employment); and

3. residential services (e.g., therapeutic foster care, crisis stabilization services, and inpatient medical withdrawal management).

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[1]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

[2]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[3]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[4]The National Center on Addiction and Substance use disorder at Columbia University. (June, 2011). Adolescent Substance use disorder: America's #1 Public Health Problem.

[5]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery of children and youth with SED? ◉ Yes ○ No

b) The resilience of children and youth with SED? ◉ Yes ○ No

c) The recovery of children and youth with SUD? ◉ Yes ○ No

d) The resilience of children and youth with SUD? ◉ Yes ○ No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? ◉ Yes ○ No

b) Health care? ◉ Yes ○ No

c) Juvenile justice? ◉ Yes ○ No

d) Education? ◉ Yes ○ No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? ◉ Yes ○ No

b) Costs? ◉ Yes ○ No

c) Outcomes for children and youth services? ◉ Yes ○ No

4. Does the state provide training in evidence-based:

a) Substance use prevention, SUD treatment and recovery services for children/adolescents, and their families? ◉ Yes ○ No

b) Mental health treatment and recovery services for children/adolescents and their families? ◉ Yes ○ No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? ◉ Yes ○ No

b) for youth in foster care? ◉ Yes ○ No

c) Is the child serving system connected with the Early Serious Mental Illness (ESMI) services? ◉ Yes ○ No

d) Is the state providing trauma informed care? ◉ Yes ○ No

6. Describe how the state provides integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

Effectively addressing the needs of children, adolescents, and their families in the mental health system requires innovative

approaches to deliver coordinated, individually tailored, family-focused, and developmentally appropriate services and supports in the community to reduce the need for more restrictive levels of care. Florida has implemented Community Action Treatment (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. Florida has adapted the traditional CAT model for youth ages 0-10. There are 5 teams established to serve this younger population.

The CAT teams provide intensive, wraparound services to children and youths aged 11-21 who have a mental health diagnosis, a substance-use diagnosis or both. They include a psychiatrist or advanced registered nurse practitioner, a nurse, a mental health therapist, a case manager and a mentor. Additionally, someone on the team is available to the family around the clock. The aim of CAT is to stabilize a child's mental illness or substance abuse and divert him or her from the state juvenile justice or child welfare systems.

The primary goals of the CAT program include:
• Improved school attendance, grades and graduation rates
• Decreased out-of-home placements and psychiatric hospitalizations
• Decreased substance use and abuse
• Improved functioning for the child and family

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

The 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?

None at this time.

8. Please indicate areas of technical assistance needs related to this section.

None at this time.

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Environmental Factors and Plan

12. Suicide Prevention – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death nationally, with over 49,000 people dying by suicide in 2022 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance use, painful losses, exposure to violence, economic and financial insecurity, and social isolation. Mental illness and substance use are possible factors in 90 percent of deaths by suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, M/SUD agencies are urged to lead in ways that are suitable to this growing area of concern. M/SUD agencies are encouraged to 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 since the FY2024-2025 Plan was submitted? ○ Yes ◉ No

2. Describe activities intended to reduce incidents of suicide in your state.

The Statewide Office of Suicide Prevention develops and implements the Florida Statewide Strategic Plan for Suicide Prevention by providing oversight, building capacity, creating policy, and mobilizing communities for suicide prevention. The Department is currently in the process of writing the new Statewide Strategic Plan.

The Suicide Prevention Coordinating Council meets quarterly and focuses on raising public awareness of policies and best practices for suicide prevention.

Example activities include planning and evaluation of suicide prevention activities, awareness and marketing campaigns, and first responder mental wellness and suicide deterrence.

3. Have you incorporated any strategies supportive of the Zero Suicide Initiative? ◉ Yes ○ No

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

If yes, please describe how barriers are eliminated.

Florida requires care coordination and discharge planning for anyone being discharged from crisis stabilization following a Baker Act. Additionally, Mobile Response Teams are contractually required to provide follow-up services for individuals with suicidal ideation. As part of the 988 network agreement, all 988 Florida Lifeline Centers are also required to provide follow-up services.

5. Have you begun any prioritized or statewide initiatives since the FFY 2024 - 2025 plan was submitted? ◉ Yes ○ No

If so, please describe the population of focus?

The Department published a 988 Florida Lifeline website that included information about 988, and a branding guide and marketing toolkit for partners. Based on new requirements in statute the Department received $50 million dollars in state general revenue to hire additional care coordinators and discharge planners within crisis stabilization units. This also includes coordinating with family members to review the discharge plan. The Department also has a marketing and outreach proposal for suicide prevention, informed by analyses of suicide trends in Florida, that is currently routing for leadership approval. The populations of focus are males aged 45 - 65, veterans, first responders, rural, elderly, and youth. Additionally, the Department's Suicide Prevention webpage, which includes resources for at-risk populations, received over 13,000 views from January to September 2024, and for Suicide Prevention Awareness Month 2024 the Department's social media had 9,000 impressions, and distributed over 5,000 materials with 988 information at events throughout the state.

6. Please indicate areas of technical assistance needs related to this section.

None at this time.

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Environmental Factors and Plan

13. Support of State Partners – Required for MHBG & SUPTRS BG

Narrative Question

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

- The State Medicaid Authority agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations.
- The state 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 prioritize risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of M/SUD, 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 emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults with M/SUD.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and co-occurring M/SUD.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state, and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- Enhancing the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states is crucial to optimal outcomes. In many respects, successful implementation is dependent on leadership and

collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

Please respond to the following items:

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

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

If yes, with whom?

Not applicable.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

Multi-agency and cross-system collaboration are essential and required elements of the Department's coordinated system of care, as described in s. 394.4573, Florida Statutes (F.S.). This coordinated system features a variety of services that enable consumers to function outside of inpatient or residential institutions, including but not limited to the following:

• Care coordination with other local systems and entities, public and private, such as primary care, child welfare, behavioral health care, and criminal and juvenile justice organizations.
• Outpatient services.
• Aftercare and other post-discharge services.
• Recovery support, including, but not limited to, the use of peer specialists to assist in the individual's recovery from a substance use disorder or mental illness; support for competitive employment, educational attainment, independent living skills development, family support and education, wellness management, and self-care; and assistance in obtaining housing that meets the individual's needs.
• Care plans that assign specific responsibility for initial and ongoing evaluation of the supervision and support needs of the individual and the identification of housing that meets such needs.
• Coordinated specialty care programs for early serious mental illness.

The Commission on Mental Health and Substance Use Disorder (Commission) was created in 2021 per Section 394.9086, Florida Statutes and ratified in 2023 to examine current methods of providing mental health and substance use disorder services in the state and to improve the effectiveness of current practices, procedures, programs, and initiatives in providing such services; identify any barriers or deficiencies in the delivery of such services; assess the adequacy of the state's crisis response services; and recommend changes to existing laws, rules, and policies necessary to implement the Commission's recommendations. The Commission is made up of 20 representatives appointed by the Governor and Florida Legislature to represent and speak for every touch point of public behavioral health service delivery in the state. The Commission is responsible for completing an annual report which includes recommendations to be submitted to the Florida Legislature.

4. Please indicate areas of technical assistance needs related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

14. State Planning/Advisory Council and Input on the Mental Health/Substance Use Block Grant Application – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in **42 U.S.C. §300x-3** for adults with SMI and children with SED. To assist with implementing and improving the Planning Council, states should consult the **State Behavioral Health Planning Councils: An Introductory Manual.**

Planning Councils are required by statute to review state plans and annual 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 advocates for individuals with M/SUD. States should include any recommendations for modifications to the application or comments to the annual report that were received from the Planning Council as part of their application, regardless of whether the state has accepted the recommendations. States should also submit documentation, preferably a letter signed by the Chair of the Planning Council, stating that the Planning Council reviewed the application and annual report. States should transmit these documents as application attachments.

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, letter from the Council Chair etc.)

Florida' Substance Abuse and Mental Health Planning and Advisory Council members are asked to review and provide questions, comments, concerns, and feedback on all state plans and annual reports submitted to SAMHSA for the CMHS and SUPTRS Block Grants. Council feedback and acknowledgement of the opportunity to review are formally solicited electronically. All feedback is incorporated into drafts of plans and reports before submission.

The Council is also briefed on upcoming and/or recently submitted state plans and reports at quarterly meetings with opportunities to discuss verbally and via email. These post-submission briefings provide a chance to collect additional feedback to inform future processes for developing and completing Block Grant planning and reporting requirements.

2. Has the state received any recommendations on the State Plan or comments on the previous year's State Report?

a. State Plan — (●) Yes ( ) No

b. State Report — (●) Yes ( ) No

Attach the recommendations /comments that the state received from the Council (without regard to whether the State has made the recommended modifications).

3. What mechanism does the state use to plan and implement community mental health treatment, substance use prevention, SUD treatment, and recovery support services?

Florida's Substance Abuse and Mental Health Planning Council is an integrated advisory body that collaborates with the Department to provide insight related to behavioral health services throughout the state via quarterly council meetings.

4. Has the Council successfully integrated substance use prevention and SUD treatment recovery or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

5. Is the membership representative of the service area population (e.g., rural, suburban, urban, older adults, families of young children?) (●) Yes ( ) No

6. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The Planning Council reviews the Department's Block Grant applications, plans and reports, and makes recommendations on modifications. The Planning Council also monitors, reviews and evaluates, the allocation and adequacy of mental health services within Florida. The Council advocates for individuals and families through local and statewide efforts. Council members act as a liaison between state and Managing Entities in promoting a recovery-oriented system of care.

7. Please indicate areas of technical assistance needs related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Mental Health Agency
State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Medicaid Agency

Start Year: 2026 End Year: 2027

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Michelle Aguilera	Parents of children with SED			
Kimberley Brown	State Employees		2415 N. Monroe St Ste 400 Tallahassee ,	
Melanie Brown-Woofter	Advocates/representatives who are not state employees or providers			
Kayla Califiore	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Paul Cassidy	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Tony DePalma	Advocates/representatives who are not state employees or providers			
Joe Dmitrovic	Providers			
Glenn East	Parents of children with SED			
Veronica Ebuen	State Employees			
Gayle Giese	Advocates/representatives who are not state employees or providers			
Whitney Hughson	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Shanette Jackson	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Paul Jaquith	Providers			
LaTressa Johnson	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			

Cheryl Molyneaux	Providers			
Sharanda Sipe	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Lenisha Watson	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			
Nikki Wotherspoon	State Employees			

*Council members should be listed only once by type of membership and Agency/organization represented.

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Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2026 End Year: 2027

Type of Membership	Number	Percentage of Total Membership
1. Individuals in recovery (including adults with SMI who are receiving or have received mental health services)	5	
2. Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)	2	
3. Parents of children with SED	2	
4. Vacancies (individuals and family members)	13	
5. Total individuals in recovery, family members, and parents of children with SED	**22**	**61.11%**
6. State Employees	3	
7. Providers	3	
8. Vacancies (state employees and providers)	5	
9. Total State Employees & Providers	**11**	**30.56%**
10. Persons in Recovery from or providing treatment for or advocating for SUD services	0	
11. Representatives from Federally Recognized Tribes	0	
12. Youth/adolescent representative (or member from an organization serving young people)	0	
13. Advocates/representatives who are not state employees or providers	3	
14. Other vacancies (who are not individuals in recovery/family members or state employees/providers)	0	
15. Total non-required but encouraged members	**3**	**8.33%**
16. Total membership (all members of the council)	**36**	

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Footnotes:

Environmental Factors and Plan

15. Public Comment on the State Plan – Required for MHBG & SUPTRS BG

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, that 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 the federal government.

Please respond to the following items:

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

a) Public meetings or hearings? Yes No

b) Posting of the plan on the web for public comment? Yes No

If yes, provide URL:

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

c) Other (e.g. public service announcements, print media) Yes No

d) Please indicate areas of technical assistance needs related to this section.

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Footnotes:

Environmental Factors and Plan

16. Syringe Services Program (SSP) – Required for SUPTRS BG if Planning for Approval of SSP

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Narrative Question:
Use of SUPTRS BG funds to support syringe service programs (SSP) is authorized through appropriation acts which provide authority for federal programs or agencies to incur obligations and make payment, and therefore are subject to annual review. The following guidance for the application to budget SUPTRS BG funds for SSPs is therefore contingent upon authorizing language during the fiscal year for which the state is applying to the SUPTRS BG.

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SUPTRS BG to fund elements of an SSP other than to purchase sterile needles or syringes for the purpose of illicit drug use. States interested in directing SUPTRS BG funds to SSPs must provide the information requested below and receive approval from the State Project Officer.

States may consider making SUPTRS BG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SUPTRS BG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to persons who inject drugs (PWID), SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers. Federal funds cannot be supplanted, or in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

The federal government released three guidance documents regarding SSPs, These documents can be found on the **HIV.gov website.**

Please refer to guidance documents provided by the federal government on SSPs to inform the state's plan for use of SUPTRS BG funds for SSPs, if determined to be eligible. The state must follow the steps below when requesting to direct SUPTRS BG funds to SSPs during the award year for which the state is eligible and applying:

Step 1 - Request a **Determination of Need** from the CDC

Step 2 - Include request in the SUPTRS BG Application Plan to expend the funds for the award year which the state is planning support an existing SSP or establish a new SSP. Items to include in the request:

- Proposed protocols, timeline for implementation, and overall budget
- Submit planned expenditures and agency information on Table 16a listed below

Step 3 - Obtain SUPTRS BG State Project Officer Approval

Use of SUPTRS BG funds for SSPs future years are subject to authorizing language in appropriations bills, and must be re-applied for on an annual basis.

Additional Notes:

1. Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (**42 U.S.C.§ 300x-31(a)(1)(F)**) and **45 CFR § 96.135(a)(6)** explicitly prohibits the use of SUPTRS BG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

2. Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (**42 U.S.C. § 300x-24(a)**) and **45 CFR § 96.127** requires entities that receives SUPTRS BG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

3. Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (**42 U.S.C. § 300x-24(b)**) and **45 CFR 96.128** requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SUPTRS BG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (**42 U.S.C. 300x-28(c)**) and **45 CFR 96.132(c)** requires states to ensure that substance use prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to health services.

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Budget of SUPTRS BG for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone or other Opioid Overdose Reversal Medication Provider (Yes or No)
No Data Available					
Totals:		$0.00		0	

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Footnotes:

Florida does not participate in syringe services programs.