FLORIDA STATEWIDE TASK FORCE ON

OPIOID ABUSE

FINDINGS AND RECOMMENDATIONS OF THE STATEWIDE TASK FORCE ON OPIOID ABUSE

TO THE GOVERNOR
THE PRESIDENT OF THE SENATE AND
THE SPEAKER OF THE
HOUSE OF REPRESENTATIVES

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FLORIDA STATEWIDE TASK FORCE ON OPIOID ABUSE

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FLORIDA STATEWIDE TASK FORCE ON OPIOID ABUSE

INITIAL REPORT

Introduction

In Florida, 15 people die a day due to opioid-involved overdoses.[1] Nationwide, 130 people die a day from opioid-related deaths, amounting to one fatal overdose every 11 minutes.[2] The opioid epidemic is one of the worst drug abuse epidemics in our country's history and was declared a public heath state of emergency both nationally and statewide in 2017.[3]

The opioid crisis took root in the early 1990's when the addictive nature of prescription opioids was minimized by medical literature coupled with a campaign of misrepresentation by pharmaceutical companies.[4] The opioid crisis has progressed in three marked phases: prescription opioid pill abuse and diversion; use of illicit opioids such as heroin; and expansion of fentanyl-laced drugs.[5] While different regions of our state may be experiencing different phases and consequences of the opioid epidemic,[6] projection models show a sharp spike in the use of fentanyl—a potent and deadly form of synthetic opioid.[7] Unless immediate, effective statewide action is taken, the daily death toll from opioid overdoses could dramatically increase.

Statewide Task Force on Opioid Abuse Overview

On April 1, 2019, Governor DeSantis created the Statewide Task Force on Opioid Abuse to Combat Florida's Substance Abuse Crisis (hereinafter "Task Force"). Governor DeSantis appointed Florida Attorney General Ashley Moody as the chair of the Task Force. The charge of the Task Force is to "develop a statewide strategy to identify best practices to combat the opioid epidemic through education, treatment, prevention, recovery and law enforcement. This strategy should include recommendations for how the state can best use resources and funding to combat the opioid epidemic."[8] Finally, the Task Force is to present recommendations to the Governor, the President of the Senate and the Speaker of the Florida House of Representatives.[9]

The Task Force is comprised of 15 gubernatorial appointments; two appointments from the Legislature; and three appointments from the Attorney General. The Task Force is broken into three subcommittees tasked to unpack, discuss and debate general group presentations to then develop recommendations as required by Executive Order 19-97. The subcommittees are organized: 1) prevention/education; 2) law enforcement and 3) treatment/recovery.

The first meeting for the Task Force laid the foundation of the Task Force's mission. Presentations covered an overview of the opioid epidemic; the fiscal response to the opioid crisis

to date; legislative and executive milestones Florida reached to address the opioid crisis; as well as a review of a previous report by the Attorney General's Office to develop recommendations related to the opioid epidemic.

The next meeting focused on treatment of opioid use disorder. This meeting addressed the phases of an opioid overdose from the gurney, to the emergency room, to a warm handoff. There, the Task Force heard presentations on efficacy of medication assisted treatment; the stigma associated with medication assisted treatment and opioid use disorder; differences among the types of medication for opioid use disorder; administration of naloxone; emergency room warm handoff practices; innovative tracking system for treatment beds; and inmate treatment efforts.

The third meeting was recovery themed. Presentations focused on how to achieve long term recovery for individuals with opioid use disorder. Presentations covered: innovative technology aimed at sharing information among the continuum of health care providers and how commercial insurance companies can combat the opioid crisis within their network. The Task Force heard from Project Save Lives from Jacksonville Fire Department on their successful warm handoff and follow-up program with patients discharged from hospitals. A person living in long term recovery discussed barriers she faced in her journey which included background clearance issues and obstacles securing employment. Additional recovery topics covered barriers to treatment; the importance of pain management medicine and the need to revive interdisciplinary pain management as well as Florida's inpatient and outpatient treatment centers.

The fourth meeting focused on law enforcement initiatives to combat the epidemic. The meeting covered: sober home regulation and enforcement; dark web drug trafficking; post office interdiction efforts; best practices with prosecution of opioid overdoses; model law enforcement response practices to overdose calls and DEA-supported regional response teams to highly dangerous investigations.

The Task Force recognizes the urgency of this crisis, and in response, presents preliminary recommendations to the Governor, the President of the Senate and the Speaker of the Florida House. This report is intended to be followed by a final report detailing an opioid abatement strategy. The Task Force has gathered input from local governments and citizens on recommendations to fight the opioid epidemic. The intent of engaging local governments is to shape a ground-up opioid abatement plan to be included in the final report.

The Task Force recognizes that the only way to effectively and quickly abate the opioid epidemic in our state will be through a comprehensive, coordinated and collaborative effort. An all-hands-on-deck approach focuses on cooperation between the medical field, behavioral treatment services, law enforcement agencies, schools, insurance providers, local governments and state agencies. These recommendations propose utilizing all available resources and delivering standard of care as outlined from authoritative entities such as: Substance Abuse and Mental Health Services Administration (SAMHSA), National Institute of Health (NIH), National Institute of Drug Abuse (NIDA), Center for Disease Control (CDC) and others.

This report is based on recommendations developed from deliberation, research and presentations at the general group and subcommittee meetings. The following are the Task Force's recommendations and best practices for a statewide strategy to combat the opioid crisis in our state. Although all recommendations may not have been recommended by every member they represent the general consensus of the Task Force.

EXECUTIVE SUMMARY OF TASK FORCE RECOMMENDATIONS

Each recommendation is further explained and supported following this executive summary. The Task Force has also recommended a prioritized subset of these recommendations which is included following the full report.

TREATMENT & RECOVERY

I. Support and Expand the Infrastructure of the Current System of Care

- Encourage communities to map out local systems of care to assess gaps in care
- Support each level of care and funding for each level
- Increase funding and access to treatment and behavioral health services
- Promote and expand use of peer support services and warm handoffs
- Promote and expand use of medication assisted treatment paired with psychosocial therapy for community and inmate treatment programs
- Support reentry plans for inmates released from jails or prisons
- Support the use of Opioid Mobile Response Teams
- Support the expansion of naloxone (Narcan) availability in communities to include EMS, fire departments, law enforcement, friends and family members
- Utilize drug courts to promote treatment and recovery as they intersect with individuals with opioid use disorder (OUD)
- Enhance coordination with the drug courts to ensure warm handoff from incarceration settings and use court ordered treatment options as conditions of diversion programs or sentencing
- Mitigate treatment barriers like housing instability
- Expand use of telehealth in OUD treatment

II. Support and Expand Access to Medication Assisted Treatment (MAT)

- Ensure access to all Food & Drug Administration (FDA) approved medication for opioid use disorder (MOUD) is available
- Promote MOUD in conjunction with psychosocial interventions (i.e. MAT)
- Reduce barriers to treatment and barriers to obtain medicine for opioid use disorder, including removal of x-waiver requirement to administer buprenorphine

III. Enhance Collection of Deidentified Data

- Improve data collection and data sharing across state agencies
- Provide service provider outcome data to the state and patients and create platform that shares treatment openings available to the public
- Enhance the Opioid Data Dashboard
- Improve real-time information and data analysis from Florida Medical Examiners
- Track recidivism of individuals receiving treatment from jail/prison

PREVENTION & EDUCATION

I. Promote Behavioral Health Integration Including Screening, Brief Intervention & Referral to Treatment (SBIRT)

- Expand implementation of SBIRT in multiple settings, with emphasis on youth and expectant mothers
- Strengthen and expand the Maternal Opioid Recovery Effort (M.O.R.E.)
- Educate physicians on SBIRT billing codes to facilitate coverage by the health plans
- Encourage appropriate state agencies including Florida Office of Insurance Regulation to work with insurance companies in Florida to ensure they are complying with both state and federal parity laws

II. Advance Community Prevention Workforce and Infrastructure

- Facilitate statewide implementation of Substance Abuse Mental Health Services Administration's (SAMHSA) Strategic Prevention Framework
- Designate a regional liaison to coordinate prevention efforts
- Use workforce to enhance protective factors in the communities

III. Strengthen Youth Coalitions & School Education

- Promote Youth Coalitions and Anti-Drug Clubs
- Provide standardized prevention programs about opioids for organizations serving at-risk children/youth including staff training

IV. Engage in Statewide Public Educational Initiative on the Dangers of Prescription Drugs, Safe Storage and Disposal

- Increase participation in Drug Take Back Days
- Identify authorized year-round collectors
- Promote statewide awareness and consider legislation to address safe storage, disposal of prescription opioid drugs and opioid drug deactivation kits

V. Support Comprehensive Community-Based Education Campaigns

- Implement public educational mass media campaign
- Include Florida 211 Network as promoted resource
- Educate public on Good Samaritan immunity (Florida Statute § 893.21)
- Educate first responders on statutory immunity regarding administration of emergency antagonist (Florida Statute § 768.13 & Florida Statute § 381.887)

VI. Build School Prevention Capacity

- Implement Student Assistance Programs (SAP)

- Incentivize schools to implement high quality opioid prevention programs
- Expand the scope of prevention education currently provided in schools
- Implement a social norms media campaign across Florida school districts
- Expand programs, such as EverFi, to all counties training high school students on the perils of prescription drugs and opioids

VII. Expand Education in Medical Field About Pain Management and Opioid Alternatives

- Require continuing medical education (CME) on pain management and opioid alternatives for current medical professionals
- Support expansion of pain management curriculum within medical schools for future medical professionals
- Implement counter-detailing efforts to educate clinicians on pain management and opioid alternatives

LAW ENFORCEMENT

I. Legislative Recommendations

- Expand availability of Narcan for civilians
- Enhance penalties for sale of controlled substance within 1,000 feet of a substance abuse treatment facility
- Analyze the reclassification of Codeine to a Schedule II Controlled Substance

II. Best Practice Recommendations

- Mandate reporting of all overdoses for medical professionals
- Increase High Intensity Drug Targeting Area (HIDTA) group analyst capabilities
- Improve collaboration technologies and deconfliction for law enforcement agencies
- Identify and utilize database software that can maintain and analyze telephone numbers recovered from decedents in fatal overdose cases
- Maximize use and funding of FDLE's Violent Crimes and Drug Control Council (VCDCC)
- Modernize and streamline the Marchman Act
- Improve and support sober home regulation and enforcement
- Provide education, training for prosecutors and cross-designated prosecutors for overdose death prosecutions
- Law Enforcement respond to all overdose calls alongside medical professionals
- Support and partner with US Postal service to maximize interdiction efforts
- Continue to Support the Florida Office of Drug Control

TREATMENT & RECOVERY

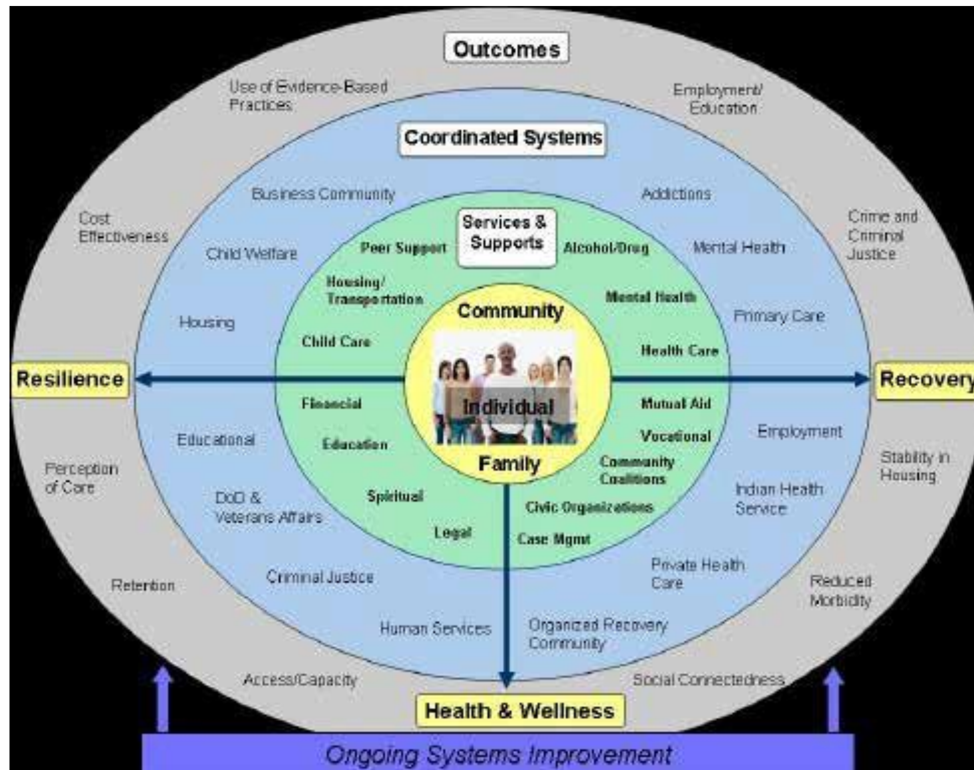
I. SUPPORT AND EXPAND THE INFRASTRUCTURE OF THE CURRENT SYSTEM OF CARE

The Statewide Task Force on Opioid Abuse recommends supporting and expanding Florida's current system of care infrastructure. Chapter 397 of Florida Statutes outlines the critical components of the state's current system of care and focus areas targeting substance abuse in our communities.[10] Pursuant to Florida Statute § 397.305(3), to reduce substance abuse in our state, it is necessary to "provide a comprehensive continuum of accessible and quality substance abuse prevention, intervention, clinical treatment and recovery support services."[11] This system of care, "use[s] the coordination-of-care principles characteristic of recovery-oriented services and include social support services, such as housing support, life skills and vocational training, and employment assistance necessary for persons who have substance use disorders…in their communities."[12] Thus, a system of care must be a seamless, comprehensive continuum addressing all areas of substance abuse from prevention to recovery with the goal of reducing substance abuse and promoting a healthy life style.

A preliminary step forward in improving the state's system of care is identifying detailed system of care that includes all of the critical "touchpoints" where an individual with an opioid use disorder comes into contact with this system of care. For example, the Department of Children and Family Services provides a general framework of a system of care for substance abuse services that includes:

> Primary prevention services that prevent or delay substance use and associated problems, which include: information dissemination, education, alternative drug-free activities, problem identification and referral, community-based processes, environmental strategies.
>
> Intervention services, which are structured services aimed at individuals at risk of substance abuse, focusing on outreach, early identification, short-term counseling and referral.
>
> Clinical treatment, which includes professionally directed services to reduce or eliminate misuse of alcohol and other drugs, such as: outpatient and intensive outpatient treatment, day or night treatment, medication-assisted treatment, residential treatment, intensive inpatient treatment, detoxification.
>
> Recovery support services are designed to help individuals regain skills, develop natural support systems, and develop goals to help them thrive in the community and promote recovery, such as: aftercare, supported housing, supported employment, recovery support.[13]

An example of a system of care is illustrated by SAMHSA's Conceptual Framework of Recovery-Oriented System of Care:[14]



Performing an inventory of a community's system of care highlights the needs, gaps in care, and identifies successful initiatives in the community. "Identifying unmet services needs and a critical gap within the current system"[15] is recommended by the Task Force; it is a SAMHSA Block grant requirement and the next logical step in supporting a system of care infrastructure. The Treatment and Recovery Subcommittee of the Task Force discussed and identified the importance of mapping out a process distinguishing critical touchpoints wherein individuals can receive treatment, obtain referrals, and remain involved in the system of care.[16] System of care mapping focused on a community's opioid crisis, can be accomplished through a community coalition, task force committee or a public safety coordinating council.

Several counties are already seeking to identify and close gaps in their system of care.[17] For instance, Palm Beach County, among the most severely impacted communities from the opioid epidemic, adopted a recovery-oriented system of care. Specifically, the Palm Beach County Board of County Commissioners adopted an opioid response plan that provided for a "paradigm shift from a treatment-centric to a person-centered recovery-oriented system of care (ROSC) focused on quality of care and long-term recovery outcome improvements."[18] Likewise, in 2017 Bay County reaffirmed the importance of a strong system of care committee "where stake holders from the judicial system, social services, treatment providers …came together to map out a system of care."[19] A number of other counties have accomplished this through a local coalition or task force and serve as model systems for other communities.[20]

To effectively support and expand the infrastructure of the current system of care, a preliminary step is to encourage each community to map out their county-wide systems of care, which would then subsequently help inform the statewide system of care. Communities can also collaborate with each regions' DCF Managing Entity, which pursuant to Florida Statute § 394.9082, conducts community behavioral health care needs assessments every three years. Some recommended touchpoints for continuum of care analysis include but are not limited to: schools, community outreach organizations, pediatricians, primary care providers, treatment providers, prisons, jails, and reentry support from jails and prisons into community.[21]

Treatment services that weave into our system of care, must be tailor-made to the needs of each individual patient. Levels of care vary from self-help (patient is primarily responsible for their treatment and recovery) to inpatient/residential care (patient needs intensive monitoring). While some patients may be able to succeed with a self-help model and outpatient care, others may need intensive inpatient care that includes a central receiving system, crisis stabilization units, addiction receiving facilities or residential treatment facilities. If funding is allocated, funding allocation based on needs of a region, rather than population, is recommended. Since every patient has different needs, it is important that each level of care receive adequate funding and policy support.

Although there is no one-size-fits-all system of care, there are a few common components that merit focused attention and support. As discussed in more depth below, warm handoffs between touchpoints, peer recovery specialists, opioid mobile response teams, jail or prison treatment and universal access to naloxone are general areas to improve upon to maximize the impact of Florida's system of care.

Warm Handoff

A warm handoff is a "seamless transition for opioid overdose survivors from emergency medical care [or other touchpoints] to specialty substance use disorder treatment that improves their prospects for recovery."[22] Warm handoffs to continued treatment contribute to a seamless system of care. Similar to patients that visit the emergency room (ER) for a medical emergency and require an immediate follow up referral, patients that visit the ER due to a drug-related medical condition or overdose, need immediate follow up for ongoing treatment.[23] A warm handoff model includes peers in the emergency room, with a first dose of medication for opioid use disorder in the hospital and a seamless transition to care management with a hand off to local community behavioral health provider.[24] It is recommended that funding and legislative support is provided to increase the availability of warm handoff programs. This practice, along with associated treatment, has improved outcomes for opioid use disorder.

While models vary on how warm handoffs are implemented, generally, warm handoff programs require cooperation from multiple stakeholders including EMS, law enforcement, hospitals, outpatient services and coalitions.[25] An employee who serves as a case manager works with contract providers, or certified recovery specialists, to provide screening, assessment, treatment and tracking of individuals who receive emergency care for an overdose. These employees can provide direct referrals from the emergency department (ED) to community treatment. Generally, the patient will receive a dose of medication to help mitigate withdrawal and

cravings, while a peer support specialist assists with the transition to treatment for long term recovery.

In 2017 in Florida, 80% of all opioid-related ED visits were released *without* a warm handoff to treatment.[26] Pennsylvania and Florida have state-specific examples of implemented warm handoff programs that have demonstrated a positive impact. In Pennsylvania's warm handoff pilot program, Addition Recovery Mobile Outreach Team ("ARMOT"), 59% of patients that participated in the warm handoff program completed treatment.[27] The warm handoff model is implemented around Pennsylvania's commonwealth and boasts that "counties with successful implementations [of warm handoffs] are seeing a success rate of 90% of overdose survivors directly admitted into drug and alcohol treatment following an overdose."[28]

Project Save Lives is a similar project implemented in Jacksonville, Florida. Project Save Lives "specializes [in] coordinated and seamless service for the treatment of opioid addiction and misuse," providing services that stabilize and treat withdrawal symptoms, connection to a peer recovery specialist, medicated assisted treatment and transfer to an outpatient facility. "From 2017-2018 Project Save Lives experienced a 71% decrease in over-dose related [emergency] responses to participants who accepted services from Project Save Lives."[29]

Peer Recovery Specialists

A peer recovery specialist is an individual working in recovery support services "that has experienced both substance use disorder and recovery."[30] A peer recovery specialist is critical in the treatment and recovery process. Peer recovery specialists foster a "one-on-one relationship in which a peer leader with more recovery experience than the person served; encourages, motivates, and supports a peer who is seeking to establish or strengthen his or her recovery."[31] SAMHSA, CDC, NIH all agree peer support is important for successful completion of treatment and recovery.[32]

Presentations before the Task Force highlighted the benefits of peer support services which have been shown to "reduce symptoms and hospitalizations, increase social support and participation in the community, decrease lengths of hospital stays and costs of services…and encourage more thorough and longer-lasting recoveries."[33] Expanded use of peer support is a way to enhance the system of care and improve our ability to address Florida's opioid epidemic.[34]

Expanding use of peers has been hindered primarily due to barriers created by background checks to qualify for eligible employment. Lee County, for example noted in a survey response that "behavioral health providers… had had some challenges hiring peers due to the regulations related to background checks…"[35] Florida Statute § 397.417 outlines requirements for long term employment as a peer recovery specialist. Specifically, to become a certified peer recovery specialist, you must be in recovery for at least 2 years, or have served as a care giver for 2 years for someone with a substance abuse disorder. An individual may work towards certification for 1 year, under the supervision of a professional or certified peer specialist.[36] Florida has a certification board that provides credentialing services for individuals seeking to serve as a peer recovery specialist or a peer support specialist. The board provides additional requirements like training hours and passing a level 2 background check. The level 2 background screening has been

described as a large barrier to become a peer recovery specialist, since many peers have had encounters with the criminal justice system.[37] This problem is compounded by the requirement for individuals "providing department-funded recovery support services to be certified."[38] In the 2020 Florida Legislative session, the legislature addressed this barrier, however new legislation did not pass.[39] Policy makers should reconsider background barriers for peers to promote more opportunities for peer support in our system of care.

Additionally, to meet the demand for peer specialists, more funding should be dedicated to employ a workforce of peers.[40] For perspective, the International Association of Peer Supporters surveyed peer specialists in 2014 and found the average salary for full time employees making less than $50,000 was $32,628.56.[41] Peer recovery specialists participating in Project Save Lives are paid approximately $36,108 salary.[42] It follows, as part of the mapping for communities' system of care, there should be a gap analysis done for demand for peers in each Managing Entity region and with funding allocated to meet needs identified.

Opioid Mobile Response Teams

Opioid mobile response teams save lives and are cost effective. A mobile response team is a team of specialists responding to an area or an individual in crisis. In Florida, mobile response teams have been closely associated with mental health crisis intervention and have been available to the general public for years. In the aftermath of Marjory Stoneman Douglas School Shooting and as a result of the legislation that followed, additional mobile response team units were organized with a focus to engage school aged children. For example, in "Okaloosa, Walton, Santa Rosa and Escambia counties – all with the ability to … respond to a crisis within one hour of notification and are available 24 hours a day, seven days a week," equipped with "groups of mental health professionals dedicated to responding to people in crisis, in homes or in schools or in workplaces."[43]

Quick (Opioid) Response Teams (QRT) are another type of mobile response effort. QRT consists of a paramedic, law enforcement professional, a recovery coach and, in some instances, someone in the faith community. QRTs serve as "a group of local health experts who [make] contact [with] opioid overdose survivors in an effort to direct them toward treatment."[44]

The QRT model is unique for two reasons: unlike the Mobile Response Team which is related to mental health crisis and responds within an hour, a QRT responds within 24-72 hours after an overdose occurs, for purposes of follow up and referral to treatment. This follow up window of time is critical. The 24-72 hours after a patient is revived from an overdose, is the period of time that the patient is stabilized, has an improved ability to reason more clearly and soon enough after a near-death experience to incentivize them towards treatment.[45]

Secondly, the QRT model is unique since it captures many individuals who are revived at home, as opposed to the emergency room. According to the most recent Patterns and Trends of the Opioid Epidemic in 2017 in Florida, EMS had 15,600 "pre-hospital interactions with individuals experiencing a non-fatal opioid overdose.[46] QRT captures those individuals that do not require an emergency room visit.

QRTs have been implemented in several states including: North Carolina, West Virginia, Ohio, Texas, Indiana, Kentucky, and Pennsylvania.[47] In West Virginia, "since the QRT's founding in 2017, it has come into contact with 720 individuals. Of those, 216 have sought treatment, making up about 30% of those seen. Cabell County's fatal overdose rate fell 24% from 2017 to 2018, according to the most recent CDC data, and nonfatal overdose calls fell 52%, from 1,831 in 2017 to 878 in 2019."[48] Ohio's implementation of QRT units also show impressive results. Between 2015 and 2016, Colerain, Ohio deployed QRTs and conducted 250 "overdose follow-up" investigations.[49] Of the 250 investigations, 80% of the individuals involved, entered in either residential or outpatient treatment, and this translated into a 10% decrease in overdoses in 6 months. [50]

Opioid mobile response, like QRTs, teams save lives and costs are limited. An opioid mobile response team, can enhance the system of care for individuals with opioid use disorder and can fill the gap for individuals that need outreach in the critical days after an overdose. Some communities in Florida are already exploring the benefits of opioid mobile response teams.[51] For example, Bay County Opioid Council aimed to "create a response team for non-fatal overdoses…and offer prevention and treatment services in hopes to break the cycle of addition."[52] QRTs should be supported through funding, policy making and legislation in Florida, in coordination with existing mobile response teams and community services, especially in communities facing high death tolls in the opioid epidemic.

Incarceration, Treatment and Reentry into the Community

Inmate populations are among the most vulnerable for opioid overdose deaths subsequent to release. The statistics are staggering. According to a 2007 study published by the New England Journal of Medicine, "during the first 2 weeks after release, the risk of death among former inmates was 12.7 [] times that among other state residents, with a markedly elevated relative risk of death from drug overdose."[53] The National Institute on Drug Abuse highlighted another study that indicated "14.8% of all former prisoner deaths from 1999 to 2009 were related to opioids" and attributed this "to insufficient pre-release counseling and/or post release follow-up."[54] Inmate treatment and reentry into the community must be a major area of improvement in our system of care.

Nearly half of the county jails offer some sort of inmate treatment services that could range from volunteer-run therapy groups to medication assisted treatment services.[55] According to a recent Florida Alcohol Drug Abuse Association (FADAA) Survey, only 21 jails have medicated assisted treatment out of a total of 67 counties in the state.[56] Additionally, most of the jails that are administering medication assisted treatment are providing only one or two of the three FDA approved medications for opioid use disorder.

Florida Department of Corrections (DOC) does not begin substance abuse intervention for inmates in Florida's prisons until 50 months prior to release. [57] Earlier intervention is difficult due to lack of resources.[58] Notably, since fiscal year, 2016-2017 to fiscal year 2018-2019, there has been a 134% increase in self-reported opioid use disorders from DOC inmates.[59] As of November 2019, Department of Corrections did not offer medication assisted treatment for opioid use disorder, but is in the process of initiating pilot programs with injectable naltrexone programs.[60]

Medication to treat opioid use disorder can save lives for inmates with opioid use disorder. Multiple studies have found that medication assisted treatment (MAT) in correctional facilities is associated with decreased heroin use, decreased levels of syringe sharing, decreased criminal activity, and a significantly higher probability of engaging with treatment upon release.[61] For example, Rhode Island observed a 60% decrease in the proportion of recently incarcerated individuals who suffered a fatal overdose after leaving prison after it adopted a new MAT program. [62] Rhode Island also observed a 12% overall decrease in overdose fatalities compared to the previous year, which can be attributed to the deaths prevented by the prison's MAT program.[63]

A SAMHSA report on the use of medication for opioid use disorder in criminal justice settings, states:

> The impact of opioid use on individuals transitioning from jail or prison back to the community is *overwhelmingly negative*. Outcomes include higher rates of returning to the criminal justice system, harm to families, negative public health effects such as the transmission of infectious diseases, and death. Within 3 months of release from custody, 75 percent of formerly incarcerated individuals with an OUD relapse to opioid use, and approximately 40 to 50 percent are arrested for a new crime within the first year.[64]

In that report, SAMHSA further noted six programs using MAT to treat individuals with opioid use disorder ("OUD") in the correctional system—within jails, prisons, and on reentry to the community. Each of those programs achieved outcomes consistent with the research on the effectiveness of MAT in these settings.[65]

Medication for opioid use disorder has unequivocal positive impacts and saves lives. However, best practices to help inmates suffering from substance abuse disorder while incarcerated, require four main focus areas: medication assisted treatment combined with psychosocial services, reentry plan and peer support. Ideally, medication assisted treatment is introduced prior to release, in conjunction with psychosocial services and a reentry plan that helps the inmate seamlessly continue treatment. There should be some sort of support mechanism from a peer, a probation officer, a judge or all three. An inmate released from custody would have greater likelihood of overdose survival and reaching long term recovery if multiple layers of support are provided.

A best practice system has been modeled by Seminole County Sheriff's Office. Seminole County Sheriff's Office created the Accepting Change Through Treatment Program (ACTT). This program has three levels of intervention: Prevention, Education and Treatment. The prevention component informs the inmate about resources and services in the community. Education portion of the program teaches the inmate population about substance abuse and key factors that contribute to addiction. Finally, the treatment component is aimed to "improve the mental, physical and emotional well-being through MAT, counseling, yoga and mindful [meditation]."[66]

In addition to critical phases that inmates with substance abuse disorder receive in prions, inmates are also offered peer support, release planning and re-entry support as the they transition

back into society. [67] Reentry planning aims to help an individual reintegrate into a community while maintaining treatment and recovery.[68] A unique feature of the ACTT program, is that inmates released *are already* enrolled in medical services and seamlessly transported to the treatment facility upon release. Finally, the inmates who have participated in the ACTT program receive the support of a peer recovery specialist and have a follow up with a Seminole County Opioid Response Effort (SCORE) team member.

The ACTT program is relatively new, but initial data has demonstrated marked success.[69] Specifically, since the program's inception in April 2019, as of November 2019, 60 inmates have graduated from ACTT, with 45 released into treatment or with a treatment plan.[70] Additionally, the program has excellent follow-up and contact statistics—8 out of 10 inmates remain in contact with the sheriff's office.[71] Another positive feature of this program is it did not require additional funding to implement—just a reallocation of resources.

Founded in the evidence-based impact of MAT used in conjunction with psychosocial services in correctional facilities, the importance of a reentry plan and peer support are imperative. It is recommended that resources and legislative focus is directed to support these best practices during and after incarceration. Requested resources would go to providing greater access to MAT qualified physicians available to treatment in the correctional facilities, payment for all medication approved to treat opioid use disorder, such as naloxone, buprenorphine or methadone.[72] These improvements and recommendations would render positive impacts, as shown by the ACTT program in Seminole County, and help save lives among the most vulnerable for overdose death.

Greater Access to Naloxone[73]

Naloxone temporarily reverses the effect of an opioid overdose. Making naloxone available for purchase by the general public will further support of our system of care. The United States Surgeon General, along with countless other public health organizations, has made expanding the awareness and availability of naloxone a key part of the public health response to the opioid epidemic. Research shows that when naloxone and overdose education are available to community members, overdose deaths decrease in those communities. In many states, people who are or who know someone at risk for opioid overdose can go to a pharmacy or community-based program, to get trained on naloxone administration, and receive naloxone.

Pursuant to Florida Statute § 381.887, anyone can obtain naloxone if they have a prescription or if there is a non-patient specific standing order.[74] Florida currently does not have a standing order for any member of the public to purchase naloxone. While there is currently a non-patient specific standing order, it *only* permits emergency responders, which includes law enforcement, firefighters, paramedics and emergency medical technicians, to qualify to receive naloxone without a prescription.[75]

Naloxone is widely used by law enforcement and emergency responders and should continue to be supported through funding and legislation. For instance, in Pasco County Sheriff's Office naloxone deployments increased over three-fold from 2017-2019.[76] Similarly, from 2013-2018, Okaloosa County's Sheriff's Office's witnessed an increase in naloxone deployment resulting in over ten-fold increase in expenditure for the department.[77] Due to existing high volume

use of naloxone by law enforcement, naloxone access and immunity for administration should expanded to include non-sworn civilian employees from law enforcement departments.

Naloxone should also be available for purchase from "behind the counter" to all members of the public, which include friends, family members, caregivers, peer recovery coaches, and others.[78] Many states already have standing orders for the general public to obtain naloxone and Florida should follow suit. Ohio, for example, is a state that has shown a positive impact from greater distribution of Narcan in the community. In Hamilton County, Ohio (Cincinnati), the first-in-the-nation, community-wide infusion of Narcan took place in October 2017. Known as the Narcan Distribution Collaborative (NDC), Adapt Pharma (now BioSolutions) provided 25,000 doses. The supply of Narcan doses increased in Hamilton County by 400% and initially cost about $550,000.

The NDC expanded Narcan to a broader section of the community. New groups receiving Narcan included jails, syringe exchange programs, emergency departments, faith-based groups, and to other locations within reach of people at high risk, or people who have a loved one at high risk, of overdosing. Before this expansion, Hamilton County only distributed naloxone to first responders, treatment agencies, law enforcement and community groups that provided it to the public. Additionally, Hamilton County distributed nearly 25,000 doses of Narcan Nasal Spray 4mg in approximately one year's time. Comparing OUD related statistics for Hamilton County from the 8 months prior to the launch of the NDC to the subsequent 8 months after start of the NDC yields: 42% reduction in emergency department visits; 37% reduction in EMS runs; 31% reduction in opioid overdose deaths. The NDC also frequently provided Narcan to individuals from surrounding counties. Following the start of the NDC, opioid overdose deaths fell by 28% across multiple Ohio counties in Greater Cincinnati receiving Narcan from the NDC.[79]

The Task Force recommends that a standing order is issued by the Department of Health for any member of the public to obtain naloxone. A standing order authorizing pharmacies to provide naloxone to the general public is already authorized by statute and can help save lives. Providing more naloxone to the people that are routinely in contact with individuals with OUD, like caregivers, friends, peer recovery coaches and others have shown marked successes, as illustrated in the case of the NDC in Ohio. Thus, a new standing order should be issued to expand who is eligible to receive naloxone.

Expansion and Support of Drug Courts

According to SAMHSA, the "criminal justice system is the single largest source of referral to substance use disorder treatment," second only to self-referral.[80] Drug courts are "uniquely positioned to deliver solutions to the opioid epidemic."[81] While it has been widely said that "we can't arrest our way out of this epidemic,"[82] when arrests do occur and involve opioid use, drug courts can be a way to "connect people to treatment, issue appropriate consequences, cut the destructive supply, support families, and save lives."[83] As of May 2019, Florida has 92 drug courts in operation, with at least one form of drug court in every county.[84]

A large, longitudinal study by National Institute of Justice Evaluation evaluated impacts of drug courts.[85] The study considered nearly 1,800 drug court and non-drug-court participants and took place over five years.[86] The study revealed:

> Participants reported less criminal activity (40% vs. 53%) and had fewer rearrests (52% vs. 62%) than comparable offenders; Participants reported less drug use (56% vs. 76%) and were less likely to test positive (29% vs. 46%) than comparable offenders; Treatment investment costs were higher for participants, but with less recidivism, drug courts saved an average of $5,680 to $6,208 per offender overall.[87]

Drug courts' positive impacts on reducing criminal activity, recidivism and on drug use is documented. However, drug courts and the intersection with opioid users are a newer phenomenon, which poses new barriers for successful recovery for participants. For example, an estimated 50% of drug courts prohibit the use of the full array of medication assisted treatments because of lack of education about the efficacy and importance of this form of treatment for individuals with opioid use disorder.[88] Additionally, research on MAT with drug court participants currently is scant, but growing.[89]

Florida, however, has been a pioneer in utilizing drug courts and in 1989 was the first to establish a drug court in the country. In 2017, the Florida Supreme Court issued a Best Practice Guide for Adult Courts that addresses the misguided practice of drug courts that disqualify participants with opioid use disorder for using medication for opioid use disorder. Specifically, this bench guide notes:

> [N]umerous controlled studies have reported significantly better outcomes when addicted offenders received medically assisted treatments including opioid antagonist medications such as naltrexone, opioid antagonist medications such as methadone, and partial antagonist medications such as buprenorphine (citation omitted). Therefore, a valid prescription for such medications should not serve as the basis for a blanket exclusion from a drug court. [90]

Accordingly, Florida drug courts should uniformly recognize the benefit of all three types of medication for opioid use disorder; eliminate this as a disqualifier for a drug court program and consult experts on any orders issued related to medication for participants. Drug courts have a unique ability to leverage opioid users towards recovery with sentencing alternatives and are specially situated to monitor, follow up and refer individuals to treatment. There should be greater coordination with problem solving courts like drug courts to support a seamless system of care for individuals with opioid use disorder in the criminal justice system. Additionally, there should be greater focus on educating judges in Florida on best practices for drug courts, such as those published by the Florida Supreme Court. The Office of State Courts should consider how to improve and expand Florida drug courts to better serve participants with opioid use disorder.

<u>Housing and Recovery</u>

Affordable housing is a paramount need for people in recovery. "Without supportive housing, [] individuals and families will continue to cycle endlessly between homelessness and

expensive public [service] delivery systems including, inpatient hospital beds, psychiatric centers, detox services, jails and prisons, at an enormous pubic and human cost."[91] Florida Statute § 397.305(3), highlights "housing support" as a component of Florida's system of care.[92] Considering opioid use disorder is a chronic disease, which may require treatment that could last months to years, stable housing is critical for successful recovery. This key element of our system of care is lacking.

Pursuant to a statewide survey of counties, numerous counties reported a need for affordable housing options for individuals in recovery, [93] while several counties reported little to no available affordable housing options.[94] Housing by non-profits, government housing, sober homes (discussed in-depth in the Law Enforcement section) as well as Oxford Houses are options that can help alleviate the housing concern for individuals in recovery.

Housing by non-profits and government housing should also be explored. For instance, in Hillsborough County, local non-profits like Tampa Crossroads, Agency for Community Treatment Services, DACCO and Gracepoint, provide housing for individuals receiving treatment.[95] In addition to non-profit housing support, there are local government resources to offer individuals in treatment and recovery. But still, even in a community where there are resources which "provide the quantity of affordable housing resources…the need for housing vouchers far exceeds the quantity available." Moreover, it is difficult to find landlords willing to accept the housing voucher since they would be renting the property for less than the fair market value.[96]

Oxford Houses have shown positive results with individuals in treatment. Oxford Houses was singled out as an effective tool for long-term recovery in the U.S. Surgeon General's report: "*Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health, 2016*." Oxford house, Inc., reported the following in their 2018 Annual Report.

- Calendar Year (CY) 2018 # of residents: 40,404 with only 18.9% expelled because of relapse
- $1,895 - Average monthly income of residents
- $132 - Average weekly share of expenses paid by Oxford House residents
- 64% of Oxford House residents had been homeless for an average total period of 5 months
- 76% had done jail time connected to their addiction
- Average length of sobriety of House residents is 12.4 months[97]

However, as of February 2020, there were only 31 registered Oxford Houses in Florida, and those are largely clustered in urban areas.[98] A distinct need in our system of care is affordable and safe housing for individuals in treatment and recovery. It follows, increasing funding for government subsided housing, Oxford Houses or other similar programs offered by non-profits would increase stability, decrease relapse, and likely lead to better outcomes for those recovering from substance abuse.[99]

RECOMMENDATIONS

1. Support community behavioral health providers. Identify gaps in care. provide ongoing support for services integral to address OUD and investment in innovative programs in jails, hospitals and other community settings.

2. Support Recovery Oriented System of Care models.

3. Enhance and Increase the use of ED warm handoff programs.

4. Expand peer support services and re-evaluate barriers for certified peers.

5. Replicate successful in custody treatment programs such as ACTT program in Seminole County, the Vivitrol program in Orange County and the Lifeline program in Bay County.

6. Enhance re-entry programs in the Department of Corrections to administer the first dose of MAT behind the wall; implement transition programs that allow inmates to return to the community gradually with life skills training, MAT, peer support, and job skills.

7. Support the expansion of Mobile Response Teams.

8. Support the expansion of naloxone (Narcan) availability in communities to include EMS, fire departments, law enforcement, friends and family members.

9. Enhance and support coordination with the courts, that includes a warm handoff component, problem solving courts, and sentencing alternatives that include court ordered treatment as an alternative to incarceration.

10. Improve access to affordable housing to alleviate housing instability for individuals and their families in recovery.

II. **CONTINUED SUPPORT AND EXPANSION OF ACCESS TO MEDICATION FOR TREATMENT OF OPIOID USE DISORDER**

Florida Statute § 397.305 recognizes "substance abuse impairment [as] a disease which affects the whole family and the whole society and requires a system of care that includes prevention, intervention, clinical treatment, and recovery support services that support and strengthen the family unit."[100] Medication for opioid use disorder, is considered the gold standard in treating opioid use disorder.[101] "MAT is the use of medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders."[102] The Task Force supports expansion and access to all three FDA approved medications to treat opioid use disorder and submits that barriers to treatment should be dissolved.

Medications for Opioid Use Disorder

The three most commonly used FDA-approved medications to treat opioid use disorder are Methadone, Naltrexone and Buprenorphine.[103] Methadone has the "largest, oldest evidence base of all treatment approaches to opioid addiction."[104] Methadone can be administered only by federal or state designated clinics and must be administered daily. Naltrexone is available in pill or injection form and "is used after detox to prevent relapse."[105] The pill-form naltrexone can be obtained from a traditional pharmacy and is taken daily.[106] The injectable form of naltrexone, also known as Vivitrol, requires detox prior to initiation, is obtained from a *specialty* pharmacy and is administered once a month.[107] Buprenorphine is administered through pill or injection, with the pill taken daily and injection administered once a month.[108]

Each medication is effective in treating opioid use disorder but differ in ease of access. For example, unlike methadone treatment, which must be performed in a highly structured clinic where patients must travel to in order to receive treatment, buprenorphine is the first medication to treat opioid dependency that is permitted to be prescribed or dispensed in physician offices[109] -- *significantly* increasing access to treatment.[110] Although buprenorphine can be administered by a physician on site, it requires a particular DEA waiver. As discussed below, the DEA waiver requirement is a barrier to treatment.

Research shows that a combination of medication and psycho-social therapy can successfully treat OUD disorders, and for some people struggling with addiction, medications can help sustain recovery. Specifically, "[medication for opioid use disorder] decreases opioid use, opioid-related overdose deaths, criminal activity, and infectious disease transmission… and increases social functioning and retention in treatment."[111] Because of the strength of the science, a 2016 report from the Surgeon General[112] urged adoption of medication for OUD along with recovery supports and other behavioral health services throughout the healthcare system.[113]

However, despite the fact that effective treatments for OUD do exist, "MAT is greatly underused."[114] Although there have been "marked increases in opioid abuse, related hospital admissions, and overdose deaths, the majority of individuals in need of treatment do not receive it."[115] For example, "Blue Cross Blue Shield reported a 493% increase in members diagnosed with [opioid use disorder] from 2010 to 2016 but only a 65% increase in the use of medication" to treat the disorder.[116]

Vermont implemented a program aimed to increase access to MAT to address the increasing number of persons suffering from OUD and the shortage of availability of treatment. They called their program the "Hub-and-Spoke" model.[117] The results of the system, which was implemented state-wide, has been associated with substantial increase in the state's OUD treatment capacity. In Vermont, "[t]here was a 64% increase in physicians waivered to prescribe buprenorphine, a 50% increase in patients served per waivered physician, and robust bidirectional transfer of patients between hubs [opioid treatment programs] and spokes [office based opioid treatment settings]."[118] Success in Vermont is one of many examples of the efficacy of MAT in reducing overdose deaths and treating OUD. It follows, this Task Force recommends improved access to medication assisted treatment through improved allocation of any available state resources.[119]

Barriers to Medication for Opioid Use Disorder

Barriers to medication for opioid use disorder should be addressed and eliminated to improve access to treatment. A presentation from Florida Department of Children and Families (DCF) discussed the barriers to treatment such as: location of treatment, stigma, arbitrary provider rules, and the x-waiver requirement for buprenorphine. Relating to the location of treatment barrier, rural counties generally have less access to treatment centers and vivitrol programs or methadone clinics tend to saturate areas with higher populations.[120] One way to address this barrier is to promote the use of telehealth technology[121] by requiring commercial care plans to reimburse for telehealth.

Stigma is another barrier to treatment.[122] Physician's opposition to MOUD can be due to concern for risk of initiating a new addiction. However, physicians and other clinicians should be educated on the benefits of MOUD to address opioid use disorder, which is discussed more fully in the education section of these recommendations. With appropriate education for providers, emergency room doctors and others, MOUD can be more widely administered.

Arbitrary provider rules also create a barrier to treatment. In these circumstances, providers create requirements that individuals with opioid use disorder stop medicine for opioid use disorder, to get psycho-social services.[123] However, according to the National Academy of Science, "[b]ehavioral interventions, in addition to medical management, do not appear to be necessary as treatment in all cases. Some people may do well with medication and medical management alone."[124] Thus, arbitrary provider requirements must be eliminated as a prerequisite to receive services.

Finally, a major barrier to treatment, is the lack of physicians or qualified nurses to meet the demand of patients in need of medication for opioid use disorder,[125] this is especially the case for physicians qualified to prescribe buprenorphine.[126] Attorney General Ashley Moody, among others, has written a letter recognizing the need to re-visit the x-waiver barrier for physicians to administer buprenorphine.[127] As stated above, buprenorphine can be administered on-site, by a clinician, but requires a DEA waiver to administer, also known as an x-waiver. An x-waiver requires 8-hour training for physicians and 24-hour training for nurses or PAs.[128]

For the highest patient quota certification, only 7% of U.S. physicians currently have DEA waivers.[129] As of January 2020, Florida had a total of 3,782 clinicians that could see up to 30 patients; 1,171 clinicians that could see up to 100 patients; and 321 clinicians that could see up to 275 patients.[130] In the 2018 Annual Medical Examiner Drug Report, 5,576 people died from opioid-related deaths.[131] Still, too few providers have obtained the waiver to be able to adequately meet the demands to prescribe buprenorphine. The deficit in doctors obtaining the waiver for this effective medication is due in part to a lack of time and awareness of treating opioid use disorder.[132]

Florida's emergency rooms can and should be equipped with physicians and nurses able and willing to initiate medication assisted treatment. This could be done in connection with educating doctors about safe and responsible opioid prescribing, dosing and tapering patients off opioids, as detailed below. A concerted effort is needed to help remove the x-waiver requirement for physician and physician extenders who want to prescribe medication for opioid use disorder and have the ability to provide the additional counseling that should accompany the medications. The Task Force recommends requiring a continuing medical education for eligibility to administer buprenorphine. This would alleviate the supply and demand gap of clinicians available to administer buprenorphine.

Medications and Psychosocial Therapy

Relapse rates for opioid users are generally very high. "Relapse rate after opioid detoxification ranges from 72% to 88% after 12-36 months."[133] Moreover, "frequent ED visits were predictive of subsequent hospitalizations and near-fatal events."[134] Psychosocial therapy used in conjunction with medications for opioid use disorder, in many cases, is critical and results in better outcomes for long term recovery from opioid addition.[135] Both medication and psychosocial intervention are in many cases, "necessary to normalize brain chemistry, change behavior, and reduce risk for relapse" and using just one or the other is may be insufficient to achieve long term recovery.[136] Psychosocial therapy "seeks to help patients recognize, avoid and cope with the situations in which they're most likely to use drugs."[137]

Additionally, the longer a patient is using medication for opioid use disorder, the more likely they will avoid relapse.[138] For instance, Dr. Debra Barnett, a board certified physician in addiction psychiatry, shared with the Task Force that for patients medicated with buprenorphine: after 6 months there was an 81% decrease in heroin usage; after 12 months there was 90% improvement in drug and crime related problems; and after 2-5 years over 91% of patients tested negative for opioids or cocaine.[139] Thus, while we should avoid provider rules than relegate patients to a form of treatment that is not suitable or necessary for them, a best practice recommendation in most cases is the use of psychosocial therapies in conjunction with long term medication for best outcomes to achieve long-term recovery.

RECOMMENDATIONS

1. Increase funding and access to treatment at each level of care in conjunction with MAT.

2. Support and expand access to all MAT products that are available, efficacious, and have demonstrated outcomes (Methadone, Naltrexone Oral (Vivitrol), Naltrexone XR injectable (Vivitrol), Buprenorphine).

3. Expand use of telehealth in OUD treatment (require commercial managed care plans and public managed care plans (Medicare and Medicaid) to reimburse for telehealth (Florida Medicaid already reimburses for telehealth).

4. Reduce barriers to treatment, particularly workforce barriers due to the limited number of medical providers that can prescribe MAT and the limits on caseload per provider. One solution is to remove the X-waiver requirement for medical professionals and the use of required CME in lieu of X waiver requirement.

5. Use medication for opioid use disorder in conjunction with psychosocial interventions such as counseling, trauma informed care, outpatient therapy services, day treatment, peer support, and utilize models that deploy care management, and care coordination.

III. ENHANCE COLLECTION OF DEIDENTIFIED DATA

Data collection, analysis and sharing should be a major focus for our state to address the opioid crisis. The importance of improved data collection, analysis and sharing was repeatedly mentioned and emphasized throughout the Task Force meetings and has been echoed by other state bodies and reports. Indeed, one of the recommendations of the Attorney General's Opioid Working Group was to "create a real-time dashboard system …[to] allow for a collection point of data including medical examiners reports, overdose death rates, overdose locations, ESSENCE-FL data, Neonatal Abstinence Syndrome statistics, ARCOS data, and DEA seizure data. Real-time surveillance and analytics are necessary to monitor trends and metrics."[140] Likewise, Florida's Drug Policy Advisory Council's 2018 and 2019 Annual Reports have recommended enhancement to "data collection systems and [creation of] a state dashboard of substance abuse data."[141]

Two areas of focus for data collection are: 1) real-time collection of data; and 2) timely analysis and distribution of data. Currently there are a number of data collection systems used for tracking overdoses.[142] The legislature, policy makers and state agencies are urged to consider supporting an enhanced opioid dashboard that compiles information from all critical sources like: Overdose Drug Mapping (ODMAP), DEA Analysis and Response Tracking Systems (DARTS), Florida Related Outcomes Surveillance and Tracking System (FROST), ESSENCE-FL data, ARCOS, DEA Deconfliction & Information Endeavor (DICE) data, Prescription Drug Monitoring Program (PDMP), EMSTARS, Medical Examiner Data, ESOOS, Medicaid Claims data, DCF reporting data; hospital discharge data (HDD), Emergency Department (ED) data, Vital Statistics Mortality Data and others.

Data tracking requirements also contemplate recidivism and relapse for inmates that have received treatment. Since the recently-released-inmate population is such a vulnerable population for overdose deaths, jails, prisons, providers and drug courts should develop a system where inmates released are tracked for success in treatment and recidivism. For example, the provider for medication assisted treatment in Bay County tracks a "show rate" of individuals receiving services that appear for treatment pursuant to a court order for follow up for treatment. Since implementing medication for opioid use disorder inside the jails, the "show rate" for individuals appearing for follow up treatment after release, increased from approximately 40% to 70%.[143] A data tracking system for recidivism with inmate treatment programs should be explored and implemented more broadly to help monitor effective programs among our most vulnerable opioid user population.

Although isolated data systems exist, there needs to be an improvement in requiring data entry, consolidation, sharing and analysis of the data collected. For example, the requirement to enter data into EMSTARS is optional, as well as systems like OD-Mapping.[144] Data entry tools help identify hotspot trends of overdoses. For example, pursuant to Florida Statute § 401.256, "in response to an emergency call regarding a suspected or actual overdose...such incidents *may* be reported…"[145] OD-mapping system is an example of an approved reporting system which provides law enforcement with real-time dashboard information about both fatal and non-fatal overdoses.[146] This helps identify "hot spots" of overdoses in an area which will enable law enforcement, peer navigators or mobile response teams to target those areas to help save lives through more proactive efforts.[147] OD-mapping requires a designated administrator[148] for each respective agency and

would require equipment to utilize such as work cell phones. Funding should be dedicated to the training, administration and equipment to utilize OD-Mapping or similar programs.

Data collection can also serve predictive analytics purposes. In this context, information like historical demographic data and claim patterns can be used to predict and intervene with people at high risk of addiction. [149] With this form of data analytics, patients can be flagged, screened and offered opioid prevention coaching. This technology is the same as what is being built in Hillsborough County for child welfare and foster care. Technology involving predictive analytics should be further explored for preventative measures for opioid abuse.

In addition to timely and comprehensive data input, timely data *sharing* is also essential. For example, the Medical Examiners Commission is a governing board that issues the biannual report each year. The report is thorough and provides in depth statistics regarding deaths throughout each jurisdiction. The only area of concern noted is timeliness, especially in relationship to law enforcement and future statewide initiatives. To help data about drug overdose deaths flow more fluidly from the local to the national level and vice versa, CDC's National Center for Health Statistics (NCHS) received funding through the Patient Centered Outcomes Research Trust Fund for a project designed to improve the quality and timeliness of mortality data. Florida was one of six states assembled to collaborate and identify how entities can share real time data, improving responses to public epidemics and allocating resources more effectively. It is recommended that medical examiners contribute real-time data to a statewide system that is akin to the basic analytical functions and trend notifications of OD-Mapping. This will aid criminal justice organizations, medical professionals, and other stakeholders in emerging trends that are presently delayed by a minimum of 6-months to a year.

Data sharing should also apply for treatment providers related to treatment outcomes as well as treatment openings. First, providing data on outcomes help inform the public and supervising state agencies on which providers are effective. Metrics should be developed to gauge treatment outcomes for providers, and the best way to share this information with the public. Secondly, a statewide public platform or phone app should be developed to help individuals accurately identify and easily access where treatment openings are available in their area. Brevard County noted that due to a treatment shortage in their community, "many seeking services are instructed by facilities to call back on certain days to find out if beds are open in detox." Similarly, Orange County shared "many individuals…do not know how or where to find treatment facilities."[150] With a statewide public platform, an individual with OUD would be able to more efficiently identify available treatment options.

RECOMMENDATIONS

1. Improve data collection and data sharing across agencies (law enforcement, hospitals, schools, behavioral health providers, courts, commercial and public insurance providers).

2. Track recidivism of individuals receiving treatment from jail/prison.

3. Enhance the Opioid Data Dashboard to include data from multiple entities.

4. Establish a data sharing outcomes system across the state with providers and patients.

PREVENTION & EDUCATION

I. PROMOTE BEHAVIORAL HEALTH INTEGRATION INCLUDING SCREENING AND REFERRAL TO TREATMENT

Treatment and prevention have tremendous overlap when it comes to screening and referral to treatment. Screening is applicable for both primary prevention purposes and in circumstances where someone's growing addiction must be identified and addressed to avoid financial devastation and personally harmful effects. Referral to treatment is also triggered if there is indication of opioid misuse at the primary prevention stage and beyond. Screening and referral to treatment needs to improve. "In 2017, 80% of all opioid-related ED visits were released under routine discharge (self-care). Of those nearly 12,000 visits, it is unknown how many included naloxone in a discharge package, linkage to treatment, a coordinated care program, or other services."[151] The number captured in the 80% that were released to self-care were missed opportunities for individuals to be screened and referred to treatment. This practice should change by incorporating better screening and referral practices, as outlined below.

Notably, behavioral health integration in primary care and community settings has very strong empirical support for improving prevention of substance use and other behavioral health conditions in youth and adults. Federal agencies that provide evidence, guidance and resources for prevention and treatment of behavioral health recommend integration of behavioral health in primary care including pediatrics (SAMHSA; American Academy of Pediatrics; American Association of Child and Adolescent Psychiatry, NIDA). SBIRT is the primary model for successful behavioral health integration. In Florida, Children's Medical Services (FLDOH) is leading a program to implement behavioral health integration statewide by partnering with key stakeholders throughout the state. The Taskforce recommends expansion, enhancement and continued support for multi-agency and stakeholder collaboration to successfully equip pediatric practices throughout the state to integrate evidence-based approaches to prevent and treat substance use and behavioral health risk in youth, even earlier than school-based programs would detect such risk. The FLODH is similarly developing initiatives to promote behavioral health integration in obstetrics and other prenatal care settings in order to prevent substance use in pregnant and postpartum women and their children.

Screening, Brief Intervention Referral to Treatment (SBIRT)

Screening Brief Intervention and Referral to Treatment (SBIRT) is an evidence-based systematic method to screen for problematic use of all substances and, depending on a cumulative score, follow up with a brief intervention or referral to specialty treatment. Trauma informed care models,[152] such as trauma for domestic violence, adverse childhood experiences and sexual abuse, should also be in place in conjunction with SBIRT. "Because of the significant rates of comorbid mental health disorder and substance-use disorders, cases with opioid-use disorders should be proactively screened and assessed for Post-Traumatic Stress Disorder (PTSD) and those with PTSD should be proactively screened and evaluated for opioid-use disorders."[153]

SBIRT practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs was cited by an Institute of Medicine recommendation that

called for community-based screening for health risk behaviors, including substance use. SBIRT consists of three major components.

- Screening — a healthcare professional assesses a patient for risky substance use behaviors using standardized screening tools. Screening can occur in any healthcare setting.
- Brief Intervention — a healthcare professional engages a patient showing risky substance use behaviors in a short conversation, providing feedback and advice.
- Referral to Treatment — a healthcare professional provides a referral to therapy or additional treatment to patients who screen in need of additional services.[154]

Studies have shown that deploying SBIRT has positive health effects on all groups. There should be referrals to treatment from multiple touchpoints: physicians including specialists like pediatricians or OB/GYNs, schools, EMS, hospital emergency departments, community behavioral health providers and courts. Referrals are most effective at moment of readiness – when the individual is ready to seek treatment, after overdose, or multiple arrests, multiple attempts at treatment, or when court ordered. A Task Force recommendation is to increase the number of communities, schools and medical settings implementing evidence-based systematic screenings for substance use disorder.

Pregnant mothers are a critical target population for SBIRT to prevent infants from experiencing harmful effects of prenatal exposure to opioids. The American College of Obstetricians and Gynecologists (ACOG) issued a committee opinion in 2017 (and reaffirmed in 2019) that early universal SBIRT interventions would improve maternal and infant outcomes.[155] The Centers for Disease Control and Prevention (CDC) and the American Medical Association (AMA) agree.[156] ACOG noted that opioid use escalated dramatically in recent years in pregnant mothers, paralleling the increase in the general population. Likewise, the States with the highest rates of opioid prescribing also have the highest rates of Neonatal Abstinence Syndrome (NAS).[157]

Opioids, Prenatal Care and M.O.R.E.

In 2012 the Florida Legislature created a Statewide Taskforce on Prescription Drug Abuse and Newborns. Some improvements dedicated to tackling the NAS problem included $8.9 million dollars of non-recurring funding dedicated to address the treatment needs for pregnant women suffering from opioid use disorder; a "Born Drug Free Florida" prevention campaign launched; and the prescription drug monitoring program (PDMP) overhauled. While there were marked policy improvements that this task force accomplished prior to its sunset in 2014, the community continues to need resources and a heightened awareness dedicated to combat NAS. According to recent DCF statistics, in "FY 17-18, Florida expended $15.1 million on services for [pregnant women and women with dependent children] and served 1,977 pregnant women. The most commonly provided services were residential treatment, methadone maintenance, day care, and outpatient groups. Among those discharged from services, about 67% successfully completed services."[158]

Most recent Florida statistics reveal that infants diagnosed with NAS has steadily increased since 2010, peaking in 2015 with 1,510 NAS diagnoses and has since decreased to 1,375 infants diagnosed with NAS in 2018. In response to the concerns for pregnant mothers that are navigating

opioid use disorder, the Maternal Opioid Recovery Effort (M.O.R.E.), developed by the Florida Perinatal Quality Collaborative, launched in November of 2019.[159]

M.O.R.E. is a statewide effort providing hospitals resources and tools to educate pregnant women on opioid use with the goal of preventing NAS. Neonatal Abstinence Syndrome is caused by "chronic in utero exposure to opioids."[160] When the opioid-exposed babies are born, they suffer withdrawal symptoms marked by "high-pitched crying, irritability, sleep-wake disturbances, alterations in infant tone and movement, feeding difficulties, or gastrointestinal disturbances," that can last from one to three days.[161] Nineteen Florida hospitals are participating in the M.O.R.E. initiative. M.O.R.E. is targeting at least 50% of pregnant women to receive screening, prevention and treatment services by March of 2021.[162] As part of the standard of care and SBIRT system, it is recommended doctors talk with women of child bearing age about the dangerous of misusing opioids in pregnancy, as an added layer of prevention. Promoting and expanding M.O.R.E. into all hospitals, OB/GYN offices and other touchpoints that can screen for opioid abuse will thereby provide critical education to women about NAS.

SBIRT for Youth

Early application of SBIRT for adolescents is a key component of prevention for opioid use disorder. Florida should examine and consider adopting the Massachusetts model for SBIRT in schools. In 2014, Massachusetts mandated that "each public school shall have a policy regarding substance use prevention and the education of its students about the dangers of substance abuse."[163] Additionally, Massachusetts requires each school district to verbally screen students for substance abuse disorders, on an annual basis.[164] In a recent study of the Massachusetts model, of the students who reported being screened, 97.2% reported answering all/some questions honestly, and over 70% of the students agreed/strongly agreed that they felt comfortable in the screening process, their privacy was protected and the information from the screening was useful.[165] Two-thirds of the participating students agreed they would return to the staff member who screened them with questions.[166]

SBIRT is currently underutilized.[167] SAMHSA noted that one major barrier for greater utilization of SBIRT is a lack of provider comfort in responding to positive screenings; however, having the right training and tools can help providers overcome this challenge and lead to positive health outcomes among patients. One response would be to encourage and promote CME or trainings for providers and clinicians to increase familiarity with SBIRT and implement SBIRT as a mainstay in the standard of care.

SBIRT and Insurance Coverage

Indeed, SBIRT's use across health care settings is dependent on the state's coding and billing policies. Creating codes to facilitate coverage by the health plans, and training physicians in how to bill Medicaid and ACHA for screening and treatment under SBIRT protocols, are key components of improving prevention practices for opioids misuse. To maximize access to SBIRT measures, this Task Force recommends that SBIRT and other best practice behavioral health interventions and treatments are properly covered by health plans and Medicaid.

The Agency for Health Care Administration has made available a "Guide to Utilizing the Screening, Brief Intervention and Referral to Treatment Model for Medicaid Practitioners" along with billable SBIRT codes for physicians.[168] Likewise, billable codes for commercial insurance providers, as well as Medicare and Medicaid are available for practitioners to reference through SAMHSA.[169] However, practitioners may be untrained or unaware that these screening services are covered by Medicaid, which serves as a barrier to prevention. [170] Accordingly, training is recommended for practitioners to improve SBIRT practice and utilization of reimbursement, and thus, remove barriers for effective opioid misuse prevention.

Additional insurance considerations to improve prevention is to encourage appropriate state agencies, including the Florida Office of Insurance Regulation, to work with the insurance companies in Florida to ensure they are complying with both state and federal parity laws, thereby reducing unnecessary emergency room visits and other burdensome costs to the state's other acute systems of care like jails, prisons, child services, etc.

The Federal Mental Health Parity and Addiction Equity Act provides:

> In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that—
>
> (i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and
>
> (ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.[171]

While these laws are on the books, there is concern that insurance companies will "still find ways to short-change coverage" for mental health services,[172] which are often co-morbid conditions of substance abuse. Osceola County noted that health insurance coverage has become a barrier to treatment citing insurance companies' reluctance to pay for long term services and withdrawal management.[173] Likewise, Polk County noted a primary barrier for individuals seeking treatment is "parity in coverage for individuals whose insurance coverage does not cover substance use disorder treatment…"[174] Currently, as it relates to substance abuse coverage requirements in our state, Florida Statute § 627.669 places limits on treatment coverage for substance abuse impaired persons.

Specifically, Florida Statute § 627.669 limits the maximum outpatient visits and detox will not be considered as a benefit under the outpatient program, among other limitations.[175] The Task Force recommends revising and removing limitations on benefits for substance abuse treatment. Likewise, this body encourages state agencies, including the Florida Office of Insurance Regulation, to work with the insurance companies in Florida to ensure they are complying with both state and federal parity laws, thereby reducing unnecessary emergency room visits and other burdensome costs to the state's other acute systems of care (jails, prisons, child services, etc.).[176]

RECOMMENDATIONS

1. Strengthen statewide efforts on integrate behavioral health care in primary care settings including pediatrics and obstetrics.

2. Implement SBIRT and mental health screening tools and systems in our community including, but not limited to, primary care medical settings, pediatricians, etc.

3. Expand the use of Trauma Informed Care models for screening and referrals.

4. Create codes to facilitate coverage by the health plans, and train physicians in how to bill Medicaid and ACHA for screening and treatment under SBIRT protocols.

5. Research the Massachusetts model – with the incorporation of SBIRT within the school system statewide.

6. Encourage state agencies, including Florida Office of Insurance Regulation, to work with the insurance companies in Florida to ensure they are complying with both state and federal parity laws, thereby reducing unnecessary emergency room visits and other burdensome costs to the state's acute systems of care (jails, prisons, child services, etc.).

II. ADVANCE COMMUNITY PREVENTION WORKFORCE AND INFRASTRUCTURE

A community prevention workforce is made up of trained professionals that "function in a wide range of prevention, health care, and social services settings."[177] Examples of professionals in the prevention work force include "behavioral health specialists, program specialists, social workers/case managers, and counselors."[178] In Florida, Certified Prevention Professionals (CPP) are also an important entity in the community prevention workforce.[179] The CPP designation is a professional credential for people who work with individuals, families and communities to create environments and conditions that support wellness and the ability of individuals to withstand changes. Prevention professionals are adept at addressing one or more social conditions that affect the well-being of youth and their families, such as substance use, juvenile delinquency, teen pregnancy, and school dropout. The purpose of a community prevention workforce would be to facilitate and enhance prevention infrastructure throughout the state. Coordination between agencies and relationship building requires human capital. Indeed, the need for prevention infrastructure in Florida is high.[180]

Legislative focus and funding should be dedicated to support personnel, in the appropriate government agency, that is wholly dedicated to creating, fostering and managing partnerships between community coalitions, community stakeholders, schools and government agencies. This recommendation is echoed by other local representatives like Manatee County Board of County Commissioners who suggested "professional workforce development to improve co-occurring substance use treatment competencies of both licensed mental health counselors (LMCHs) and other drug treatment professionals." [181] Similar to DCF's regional prevention coordinators, staff would be a point of contact for accountability to implement prevention and education measures in their local communities as well as seeking grant money to further support the prevention workforce. For example, the Health Resources and Services Administration (HRSA) provides grants to "fund paraprofessional and professional training programs to develop and expand the substance abuse behavioral workforce."[182] HRSA has grants narrowly tailored to address support of these work forces, like the Opioid Workforce Expansion Programs for Professionals and Paraprofessional Grant.[183]

Investing in community prevention workforce and prevention programs, helps save money in the long-run. Several studies show net benefits in prevention drug or alcohol abuse versus treating the cost of addiction. For example, in Iowa two programs were evaluated for cost of investing in prevention vs. spending on treatment. In the Iowa's Strengthening Families Program (ISFP) for every dollar spent on prevention $9.60 was saved in intervention costs.[184] Likewise, in Iowa's Guiding Good Choices program, for every dollar spent on prevention, nearly $6 was saved on addressing-addiction costs.[185] An additional earlier study "found that for every dollar spent on drug abuse prevention, communities could save from $4 to $5 in costs for drug abuse treatment and counseling [costs]."[186] Thus, investing in a prevention workforce and infrastructure is worthwhile in long-term fiscal savings for communities.

In addition to the general responsibilities of a community prevention workforce mentioned above, the workforce infrastructure also requires assessing local needs and addressing capacity of local resources to meet prevention needs. With the adequately supported workforce infrastructure,

prevention standards are recommended to be put in place across each region to implement a prevention framework.

SAMHSA's Strategic Prevention Framework

SAMHSA has published a guide to strategic prevention and is helpful to refer to as Florida develops a primary prevention framework. SAMHSA's Strategic Prevention Framework provides five steps for communities to prevent substance abuse: 1) assessing needs; 2) identifying capacity of resources; 3) planning on how to meet identified needs; 4) implementing the plan; and 5) evaluating outcomes.[187] A distinguishing feature of SAMHSA's Strategic Prevention Framework is its focus on data-driven action.[188]

As discussed above, a community prevention workforce would be a large part of assessing needs of communities and the resources available to do so. In addition to those responsibilities, the community prevention workforce would be foundational to facilitate the planning, implementing and evaluation process of a prevention framework.

Specifically related to prevention planning, the prevention workforce develops actionable strategies to address key risk factors for substance abuse.[189] In doing so, communities "replace guesswork and hunches with data-driven decisions."[190] Strategies and policies help create environments that are less conducive to substance abuse. Moreover, the strategies would be aimed to "effectively address the priority substance misuse problem and associated risk and protective factors, and that it is a good fit for the specific community."[191]

When developing strategies to combat the opioid epidemic, it is important to tailor culturally sensitive programs to specific populations. Cultural sensitivity in prevention is recognized by both SAMHSA's prevention framework and the "Drug Free Communities grant under the Office of National Drug Control Policy [who] has recommended using locally driven community-based coalitions to provide locally informed *and culturally sensitive prevention–intervention strategies.*"[192] Providing culturally sensitive substance abuse initiatives is also part of Miami-Dade Opioid Task Force's report.[193] According to SAMHSA "being culturally competent and aware is to be respectful and inclusive of the health beliefs and attitudes, healing practices, and cultural and linguistic needs of different population groups," which can help bring positive change.[194]

Using the Strategic Prevention Framework as a model, communities should then implement their developed strategies and put opioid prevention plans into action. The community workforce along with other key stake holders can implement prevention trainings and coordinate community-based prevention efforts. Finally, the prevention strategies must be subject to evaluation and review process. This will offer stakeholders feedback on planning, implementation and outcome process. The prevention evaluation should include both process evaluation and outcome evaluation. [195]

A 2017 study of the efficacy of SAMHSA's strategic prevention framework revealed positive changes and decreases in substance abuse. Specifically, this study identified two states, Vermont and Washington, that implemented SAMHSA's strategic prevention framework to

reduce underage drinking in their communities. Both states experienced a decline in reported underage drinking. In Vermont, a majority of the participating communities "reported decrease in past 30-day alcohol use by 9-12 graders, with the average use rate decreasing from 41.8% to 35.8%, over the four years of Strategic Prevention Framework implementation at community level."[196]

Likewise, in Washington, 8 of 12 participating communities "saw a small decrease from 22.7% during the pre-intervention period to 19.7% during the post-intervention period."[197] This study noted that the communities in these states which faithfully implemented the Strategic Prevention Framework tended to show a positive correlation with decreases in substances abuse.[198] It follows, that Florida appropriations or grants should therefore seek to expand both the size of the prevention workforce and its responsibilities, to include implementing the Strategic Prevention Framework in communities across Florida.

Enhance Protective Factors

In conjunction with the prevention framework outlined above, based on research from National Institute on Drug Abuse, a main focus of prevention programs are to "enhance protective factors and reverse or reduce risk factors."[199] Protective factors "exert a positive influence or buffer against the negative influence of risk, thus reducing the likelihood that adolescents will engage in problem behaviors."[200] An example of enhancing protective factor is educating parents on how to speak to their children about drug abuse. Other examples of protective factors include: social bonding to family, school, community and peers; healthy beliefs and clear standards for behavior.[201]

Risk factors "challenge an individual's emotional, social and academic development."[202] Prevention programs help identify a community's risk factors to then target, support and enhance that community's protective factors. "For example, if academic failure is identified as an elevated risk factor in a community, then mentoring, tutoring and increased opportunities and rewards for classroom participation can be provided to improve academic performance." It follows, opioid misuse prevention should not only target risk factors like drug availability, but should also capitalize and enhance antidrug use policies.[203]

III. STRENGTHEN YOUTH COALITIONS

A key component of youth prevention are our youth-led, adult-supported youth coalitions. Youth coalitions and youth involvement in the community have positive impacts on prevention for substance abuse.[204] For example, Community Anti-Drug Coalitions of America ("CADCA") is a nonprofit designed to create drug free communities to train youth between ages 13-18 to impact their communities in a positive way.[205] Other examples include Students Against Destructive Decisions (SADD) and Students Working Against Tobacco (SWAT). A key component of a statewide prevention strategy incorporates support and expansion of youth coalitions, representing communities across Florida. A Florida Youth Delegation would bring youth representing these organizations together in a unified fashion, provide a platform to train them on SAMHSA's Strategic Prevention Method (SPF), and facilitate harnessing their ideas, passion and energy to help guide prevention efforts from a youth perspective.

RECOMMENDATIONS

1. Advance community prevention workforce and infrastructure to carry out:

    a) Substance Abuse Prevention Skills Training (SAPST) is an evidence-based curriculum developed by SAMHSA that helps establish a coaching system or at least a review process to offer stakeholders feedback on planning, implementation, and evaluation efforts.

    b) Develop and/or adapt culturally sensitive program efforts tailored to specific populations such as young adults, health care providers and others.

    c) Implement Strategic Prevention Framework (SAMHSA) as a process to guide sustainable data driven actions inclusive but not limited to programs, policy and campaigns.

2. Enhance protective factors.

3. Support and strengthen youth coalitions.

4. Provide standardized prevention programs about opioids for organizations serving at-risk youth including staff training (examples: child welfare, DCF foster care, Boys & Girls Clubs, DJJ, etc.).

IV. CONDUCT A STATEWIDE EDUCATIONAL INITIATIVE ON THE DANGERS OF PRESCRIPTION DRUGS, SAFE STORAGE AND DISPOSAL

Drug Take Back Events and Safe Storage

Drug Take Back Day, organized by the DEA with state and local partners, provides communities a safe and convenient way to dispose of their unneeded prescription drugs, while educating the public about the dangers of drug abuse and misuse. [206] Last year national drug take back days resulted in 71,963 pounds of drugs collected in Florida alone—nearly a 20% increase from the amount collected in 2018.[207] Hosting drug take back events create a variety of benefits including environmental and substance abuse awareness benefits.[208]

According to a recent SAMHSA report, "misuse of prescription pain relievers is, after marijuana use, the second most common form of illicit drug use in the United States."[209] Moreover, "regardless of age, gender, or type of user, most people who misuse prescription pain relievers obtained the drugs from a friend or relative."[210] "Physicians and other medical practitioners may consider talking with their patients or clients about not sharing their prescription medications, preventing others from accessing their medications, and disposing of remaining dosage units."[211] The SAMHSA program advertised promising strategies like drug take back events and safe disposal of medication and did so through community television ads, signs outside of public buildings, pharmacies and through electronic newsletters.[212]

Drug take back campaigns raise awareness of, and participation in, the proper disposal of unused medications.[213] For example, in 2016, New Jersey launched the American Medicine Chest challenge, an "ongoing community based public health initiative, with law enforcement partnership, designed to raise awareness about the dangers of prescription drug misuse and organize a drug take-back collection event…"[214] The study surveyed 906 adults, and 97% of those respondents reported having seen news stories or ads about youth abusing prescription drugs. These advertisements also had tangential impacts like leading people to perform internet searches on safe disposal of prescription drugs, prompting conversations about prevention of prescription drugs abuse, taking an inventory of their own medicine cabinet and disposing of unwanted medication.[215] This study, along with the increasing trend from DEA's Drug Take Back Day, are indicators that drug take back events can educate the public on dangers of prescription medication misuse and the importance of proper disposal, thereby serving as a primary prevention mechanism for potential opioid misuse.

Drug take back events are one form of disposing unwanted medications and raising awareness of the dangers of opioid misuse. Another way to eliminate the danger of prescription opioid misuse, is through at-home drug disposal kits. Drug disposal kits are engineered to permanently alter prescription drugs, rendering them ineffective. In 2019, Florida's Community Coalition Alliance received a grant from Rali Rx, a national organization focused on addressing the nation's opioid crisis, to provide drug disposal kits to households in 23 counties. Similar initiatives have taken place in other states, like Indiana and New Hampshire which distributed nearly 200,000 disposal kits across their state.[216] Alternatively, New Jersey adopted legislation requiring pharmacies make available a consumer method to dispose of prescription drugs. Specifically, New Jersey passed S3933 in January of 2020 which provides:

> A pharmacy practice site that dispenses prescription drugs, other than a long-term care pharmacy, *shall*…make available on-site, for purchase or at no cost to the patient, at least one consumer method for individuals to dispose of unwanted or expired prescription drugs, including, but not limited to over-the-counter [at-home or site of use] solutions…[217]

Because drug take back events educate the public on the dangers of misusing drugs and a major source of drug diversion starts in a home's medicine cabinet, the Task Force recommends increased participation in drug take back days. The Task Force also recommends whether Florida should adopt similar legislation to New Jersey's law requiring pharmacies make drug disposal resources available upon dispensing prescription drug. It is also important to promote wide spread use of drug disposal methods and identification of year-round drug take back collectors through websites like DEA's Controlled Substance Public Disposal Location website and DoseofRealityFl.com;[218] and providing clear and consistent guidance on safe storage and disposal of prescription drugs.

V. SUPPORT COMPREHENSIVE COMMUNITY-BASED EDUCATION CAMPAIGNS AND OTHER COMMUNITY ACTIONS WHICH ARE DATA-DRIVEN AND FOCUS ON PROTECTIVE FACTORS

Educational Campaign Efforts

Mass media campaigns are most effective when they are targeted and supported by comprehensive community-based efforts that coordinate clinical, regulatory, economic, and social strategies. Funding for local prevention initiatives that prevent initiation of a behavior and treatment programs that promote abstinence and recovery, are also-vitally important. A model example of a mass media educational and preventative campaign stems from the *Truth Initiative* Campaign, born from the Tobacco Pilot Program. The Tobacco Pilot Program resulted from the 1997 legal settlement between Florida and tobacco manufactures.[219]

Public awareness campaigns, like the *Truth Initiative*, *The Real Cost* and other state specific campaigns have been proven to be effective in raising awareness and reducing the likelihood of adolescent substance abuse. For example, the *Truth Initiative* Campaign is a long-standing public awareness and prevention campaign that has "helped drive down the youth [traditional cigarette] smoking rate from 23% in 2000 to now just 4.6%."[220] Proudly, Florida was the leading force in this national campaign in 1998. The comprehensive statewide program developed dramatic anti-smoking advertisements, facilitated the youth-led, adult-supported Students Working Against Tobacco (SWAT)[221] and supported community partnerships, enforcement, education and evaluation components.[222] Similarly, within the first year of its launch, 9 out of 10 youth had seen an ad from *The Real Cost* campaign and between 2014-2016, a 30% decrease of smoking initiation for youth between 11-18 years old was reported. [223]

Article X, Section 27 of Florida's Constitution, authorizes a comprehensive statewide tobacco education and prevention program which led to the creation of Tobacco Free Florida.[224] Tobacco Free Florida has proven to be an effective mass media campaign and program.[225] Florida Free Tobacco's campaign must "discourage the use of tobacco and to educate people, especially

youth, about the health hazards of tobacco, which shall be designed to be effective at achieving these goals and shall include, but need not be limited to, television, radio, and print advertising, with no limitations on any individual advertising medium utilized…"[226] Considering this impactful and available infrastructure, resources should be made to adopt or capitalize on the Tobacco Free Florida infrastructure to direct resources to opioid awareness and public education.

Current statewide awareness campaigns include DCF's "Opioid Overdose Prevention Awareness Campaign," launched in November 2018. This campaign "aim[s] to increase awareness of and access to naloxone among people at risk of overdose and their loved ones."[227] This campaign provides digital and print media that were dispersed to major cities across the state, along with social media and radio advertising.

Likewise, the Florida Specific *Dose of Reality* website, launched by the Florida Office of Attorney General in September 2019, serves as a one-stop-shop for all opioid related issues. The *Dose of Reality* website, is based on prevention and the media campaign that has been used by at least five other states,[228] provides information on dangers of opioid misuse, safe storage, advice for prescribing providers, students, teachers, parents, veterans, business owners and others.[229] Additionally, this campaign includes information on drug take back days, the Statewide Task Force on Opioid Abuse as well as information to help find treatment. Industry specific downloadable and printable brochures, flyers, and posters are also available on DoseofRealityFL.com. In the first five months, over 2,300 visitors have visited Florida's Dose of Reality website.[230] Other examples of campaigns include *Hope for Healing* by Florida's First Lady, Casey DeSantis, launched in May of 2019.[231]

Community-based media campaigns are also a valuable means to educate the public on prescription drug misuse and our state will benefit from enhanced funding and support. Like the American Medicine Chest Challenge, which implemented a community-based media campaign, there are a number of similar examples that show promising impacts throughout various counties in Florida. For example, Marion County Sheriff's Office implemented a community-based media campaign through coordination with vendors throughout the community to attempt to remove the stigma of opioid addiction and raise public awareness related to successful drug investigations. This community-based media campaign, along with other critical efforts, correlates with a decrease in opioid related overdose deaths, per capita, in Marion County. According to Medical Examiner data, Marion County's per capita death rate for opioid related deaths has steadily decreased by 23% from 2016 to 2018.[232]

Drug Free Manatee, a prevention coalition, is another example of an organization that has launched a community-based media campaign. Drug Free Manatee's Addiction Crisis Task Force (ACT) engages in public awareness and media campaigns which include distribution of safe disposal pouches, pharmacy bag slips with disposal information on them, safe disposal information published in news outlets, community newsletters, a brochures and PSAs on the good Samaritan law,[233] posters, newspaper inserts, a 30-second PSA in movie theater previews and gas pump toppers.[234] The Manatee County's Addiction Crisis Task Force convened in 2015 and Manatee County has experienced nearly a 50% decline in opioid related overdose deaths, per capita from 2016 to 2018. Additional examples of community-based media campaigns are discussed in the Appendix.[235]

Florida's 211 Network

Florida's 211 Network should be promoted and advertised through media campaigns as a free resource for people who need help finding treatment and referral information for OUD.[236] Florida Statute § 408.918 establishes Florida's 211 Network as a "single point of coordination for information and referral for health and human services."[237] This network was created in 2002 and its objectives are to: enhance access to health and human services information; simplify and enhance referral systems; electronically connect local information and referral systems to each other; establish and promote standards for data collection and for distributing information among state and local organizations; promote the use of a common dialing access code; promote visibility and public awareness of the availability of information and referral services; assist in identifying gaps and needs in health and human services programs; and provide a unified system plan for data management and access.[238]

The Florida Alliance of Information and Referral Services manages the Florida 211 Network.[239] Florida's 211 Network addresses public health needs that range from child-care resources, unemployment benefits, or home health needs.[240] 211 is available in all 50 states, and in Florida, there are thirteen 211 regions, each slightly different in organization and funding, that uniformly follow national 211 standards.[241] According to a national survey of 211 networks, in 2018, Florida 211 Network received 885,044 calls; 175,525 emails, texts, chats; 1,060,569 total contacts; and 645,106 website visits. The top two categories for caller needs in 2018 were Housing and Mental Health and Addiction. Of the 200,909 mental health and addiction calls, 3,519 were related to opioid addiction care. [242] The 211 Network is established, codified and free to the public, and thus, needs to be a key feature promoted in media campaigns.

Good Samaritan Law

Education and awareness about the Good Samaritan law should be incorporated into both mass media and community-based media campaigns. Florida Statute § 893.21, popularly known as the 911 Good Samaritan Act**,** grants immunity to individuals in possession of controlled substance or drug paraphernalia.[243] Immunity applies if the individual seeks medical assistance for a drug or alcohol related overdose for themselves or another and does so in good faith.

In 2012, Florida Statute § 893.21 was passed to "encourage a person who is aware of or present during another individual's drug overdose to seek medical assistance for that individual."[244] The legislature noted that in most of the fatal drug overdose cases, someone else was present and in one-third of the cases, believed the decedent was in distress. *Id*. Since "many people cite fear of police involvement or fear of arrest as their primary reason for not seeking immediate help for a person though to be experiencing a drug overdose," the 911 Good Samaritan Act was passed to counter that belief.

In 2019, immunity under the 911 Good Samarian Act was expanded to protect individuals who are on pretrial release, probation or parole from prosecution or arrest for possession of controlled substance or possession of drug paraphernalia.[245] Education and awareness should be raised about the Good Samaritan law, which can help save lives in cases where someone witnesses

an overdose and can call 911. Information about the Good Samaritan law and immunity it provides can be distributed through take home brochures from hospitals, leave behind material for first responders, along with incorporation into media campaigns.

Ideally, community-based media campaigns would educate the public on a range of topics relating to primary prevention of opioid misuse, awareness about neonatal abstinence syndrome, the Good Samaritan law, safe storage and disposal, and de-stigmatize opioid misuse. Legislative support and funding dedicated to mass media awareness campaigns as well as community-based campaigns to address the opioid epidemic and prevent opioid misuse demands immediate attention.[246]

VI. STRENGTHEN SCHOOL EDUCATION ON PREVENTION

"Nothing better guarantees the long-term fulfillment of our drug control goals than a generation grown to adulthood free of substance abuse."[247] The number one priority in Florida's Drug Control Strategy was to "protect Florida's youth from substance abuse."[248] One outcome of this previous, state coordinated, drug-control effort was to institute a reliable baseline of drug use metrics with which to evaluate the success or failure of various drug control and prevention initiatives. This effort resulted in the creation of the *Florida Youth Substance Abuse Survey* (FYSAS).

Since the 1999-2000 school year, Florida has surveyed middle and high school students on topics related to substance abuse. FYSAS represents the collaborative efforts of the Florida Department of Education, Department of Children and Families, Department of Juvenile Justice and Department of Health. The 2019 FYSAS surveyed nearly 10,000 6th through 12th grade students statewide.[249]

The FYSAS captures statistics related to prescription pain killers, which include prescription opioids, as well as illicit drugs such as heroin. Recent FYSAS surveys reveal relatively low youth usage rates for prescription pain killers among our youth. Additionally, youth usage of prescription pain killers has steadily declined from 2008 to 2019.[250] "In 2019, just 0.2% of surveyed Florida students reported the use of heroin in the past 30 days."[251] Correspondingly, in the 2018 Annual Report Medical Examiner Data, there were 11 instances of youth that died of opioid related overdose out of 5,576, of opioid-related fatal overdoses.[252]

While these statistics "compare favorably to national findings,"[253] our state remains vulnerable to deleterious effects of illicit opioids. Among the top four abused substances, two involve smoking or vaping marijuana or hashish.[254] Marijuana laced fentanyl is becoming increasingly more common and often the user is unaware of the fentanyl mix.[255]

As of 2018's annual Medical Examiner Report, the most frequently occurring drugs found in decedents, after alcohol and cocaine, was fentanyl followed by cannabinoids.[256] While correlation does not mean causation in these instances, these trends, associations and statistics are a warning signs of what could develop into a devastating shift in the opioid epidemic as it relates to our youth. Although historically, opioid use disorder has impacted primarily adult, white males, the FYSAS and Medical Examiner information, along with drug trend reporting, shows that the

ground work is being laid for potential harm to our youth as marijuana and fentanyl increasingly overlap. For these reasons, it is imperative our legislature and communities take active and critical steps to focus on youth prevention, particularly as it relates to opioid misuse.

Florida Public Schools and Substance Abuse Education

Florida requires substance abuse education to be part of public health education. A long-standing component of required instruction for public schools includes delivery of 12 components of comprehensive health education which includes substance abuse and mental and emotional health education. These two topics were deemed top priorities for Governor DeSantis, First Lady DeSantis and the Florida Legislature in 2019. To increase support, visibility and accountability for these critical topics, the Florida State Board of Education approved related rules in 2019.

> Florida Administrative Code rule 6A-1.094121, was approved by the State Board of Education on July 17, 2019. This rule establishes a minimum of five hours of required instruction related to mental and emotional health education for students in grades 6-12. [This rule also mandates 10 specific topics to be addressed of which substance use and abuse is included.]
>
> Florida Administrative Code rule 6A-1.094122, was approved by the State Board of Education on August 21, 2019. This rule requires school districts to annually provide instruction to students in grades K-12 related [specifically] to youth substance use and abuse health education.
>
> Content must advance each year through developmentally appropriate instruction and skill building. Decisions about which course(s) will be used to deliver this instruction and curricula used will be determined at the school district level. These rules are in effect for the 2019-2020 school year.[257]

To encourage transparency and school compliance, these rules require school districts to develop and submit a plan on how they will implement these heath education topics in their schools, post on their school district website, and report every July 1st their progress.[258] Thus, public schools are currently engaging in substance use and abuse prevention education and additional support will bolster these efforts and build capacity statewide.

Consideration to advance school prevention funding by the legislature and Department of Education and exploring strategies to incentivize schools to implement high quality opioid prevention programs that focus on opioid use disorders and prescription drugs will further strengthen our state's prevention infrastructure. Florida Administrative Code Rule 6A-1.094122, requiring K-12 planning and implementation of substance abuse education, can be expanded to *require* targeted education on opioid misuse prevention within district's plans. For example, one recommended and cost-free program that can assist districts meet the rule requirements and likewise meet the Task Force's recommendation to expand scope of opioid misuse prevention, is the Prescription Drug Safety Course by EverFi.

EverFi created the Prescription Drug Safety Course, which is a no-cost, digital course that educates students in grades 6-12 on how to make smart and healthy decisions related to prescription medication. Based on EverFi's 2018-2019 Florida Statewide Prescription Drug Safety Course Program Impact Report, the Prescription Drug Safety Course has been administered to 8,744 students in 92 schools.[259] "Students complete an assessment before and after …each module, providing [EverFi] with valuable data on the efficacy of the course."[260] For instance, based on data gathered from student assessments after participating in the course, "14% more students said they could read a prescription drug label effectively; 30% more students said they can identify the signs of prescription drug misuse and abuse;…42% more students said it was their responsibility to prevent prescription drug misuse at their school."[261]

EverFi is one of several examples, that have been recognized by the Florida Department of Education as an accessible and cost-free resource available for school districts to help meet the substance abuse and mental health education requirement.[262] EverFi is unique among the recognized no-cost resources, because EverFi most directly addresses prescription drug abuse, is implemented in a number of Florida districts,[263] effectively collects real-time information. The Task Force recommends advancing more programs like EverFi across the state.

Social Norm Campaign

In conjunction with expanding scope of substance abuse prevention and identifying high quality programs like EverFi's Prescription Drug Safety Course, the legislature and DCF, DOE, DOH and DJJ are urged to consider developing and implementing a social norms media campaign across Florida school districts to improve knowledge about opioid use disorders, dangers of misuse of prescription medications, dispel myths and misperceptions, and reinforce positive choices. Social norm gaps occur when students overestimate "the extent to which their peers endorse negative behaviors and underestimate the extent to which their peers endorse positive behaviors." [264]

The "social norm gap" can keep students from doing the right thing because of a misconception by a student as to what their peers believe. Eliminating negative social norms related to opioid misuse or prescription drug abuse can help promote positive and healthy decision making, and thus, prevent future substance abuse. It is critical for a campaign to be grounded within the schools, since the school environment is among the most common places for students to hear about problems of prescription drug abuse and over 85% of Florida high school students report it being important or very important for schools to address problems of today like drug abuse.[265]

EverFi also assesses social norm gaps impacted by their Prescription Drug Safety Course. This data revealed improvements in students' understanding of what behaviors their peers would endorse, and thus, help empower students to make positive choices. For instance, in EverFi's assessment of social norm categories; after participation in the course; 12% more students believed others would step-in to discourage someone from sharing or selling prescription drugs; 11% more students believed others would avoid misusing prescription drugs if offered; and 10% more students believed others would offer support to a friend who they suspect is abusing prescription drugs.[266] Thus, while EverFi's program offers a good starting point and an evidence-based option of how social norms can be changed through an education program, more can be done to shift the

paradigm of social beliefs related to prescription drug use and opioid misuse among our youth, through a robust comprehensive prevention framework approach.

Student Assistance Programs (SAP)

School level implementation of Student Assistance Programs (SAP) is a powerful and impactful approach to prevention. SAP is "for students who are at risk for substance use, mental health concerns, violence/bullying, academic failure, school suspension, or dropping out." [267] These programs follow a school-based, evidence-informed framework for prevention, early intervention, referral and support for students with identified needs that may prevent them from fully benefitting from their educational experience. SAP has prevention specialists included as the point of contact for students to provide substance abuse or mental health universal prevention as well as services and referrals for more in-depth treatment.[268]

Sarasota County has worked with First Step of Sarasota to implement SAP in five high schools which have shown positive impacts on substance abuse prevention. For instance, in all five high schools with an active SAP, the specialists documented an improvement in attendance outcomes.[269] Additionally, three out of five schools experienced a decrease of in-school suspensions and two out of five schools experienced a decrease of out-of-school suspensions.[270] This is an example of a student assistance program that could be used to target youth that are at risk for opioid misuse and to provide foundational primary prevention. Thus, these school-based evidence-informed programs should be further explored by the Department of Education, Department of Children and Families for implementation in Florida's public-school system.

VII. MEDICAL EDUCATION

Physicians must be educated and well versed in opioid addiction management and alternative pain management practice. Deficient medical education has played a key role in the cause of the opioid epidemic. According to the *2017 Trump Commission Report on Opioids*, "Medical education has been deficient in pain management, opioid prescribing, screening for, and treating addictions."[271] Thus, there is a need for current and future medical service providers to be properly educated in opioid alternatives and pain management.

In 2018, House Bill 21 passed which requires doctors and registrants with the DEA to complete a 2-hour continuing medical education (CME) course to be able to prescribe controlled substances.[272] This was mandated to accomplish what other states have done through counter detailing. For example, a 2013 counter detailing effort in Staten Island suggests that doctors' prescribing patterns can be positively altered by better educating physicians in a systematic manner about the need for opioid prescribing restraint. In the Staten Island study, researchers used a pharmaceutical sales strategy approach to educate health care providers and physicians that: 1) a 3-day supply of opioids is sufficient typically for acute pain; 2) doctors should avoid prescribing opioids for chronic noncancer-related pain; and 3) doctors should avoid prescribing high-dose opioids.[273]

This study successfully demonstrated the ability of a dedicated educational detailing campaign to link health care providers knowledge about opioid prescribing with a decrease in the rate of high-dose opioid prescribing. Substantially curtailing the number of morphine milligram

equivalents prescribed in the country will lead to lower mortality and overdose rates and significantly curb the growth of the OUD population. Thus, while Florida is currently requiring CME's for prescribing patterns, there likewise should be a CME or detailing effort to educate clinicians on pain management and opioid alternatives.

Dr. Mike Kriegel, an expert in the field of pain medicine and interdisciplinary pain management, presented before the Task Force. Dr. Kriegel shared that most physicians only know how to manage pain rather than treat pain. Currently, there is a limited number of options available to treat pain which leads physicians to rely on opioids for patients to manage their pain. Interdisciplinary pain management offers doctors an alternative to opioid prescribing to treat pain for their patients.

Interdisciplinary pain management is "the only field designed to treat pain with the least amount of opioids as possible."[274] Interdisciplinary pain management centers were largely popular in Florida prior to 1999. However, after the 1997 release of timed-release opioids such as Purdue's Oxycontin, third party payers shifted reimbursement away from interdisciplinary pain management services. The rise in use of extended release opioids and absence of third-party payor reimbursement for interdisciplinary pain management services correlated in a rise in opioid deaths. Additionally, as opioid related deaths increased, there was a decline in the number of interdisciplinary pain management centers as well as interdisciplinary pain management clinical education programs for medical students. A return to a robust practice of interdisciplinary pain management within the medical field will help abate the opioid crisis and physicians can be effectively introduced to this field through CMEs. Indeed, this recommendation is already in motion by the HEAL (Helping to End Addiction Long-Term) Initiative created in 2018 through the National Institute of Health to enhance pain management, along with the recommendation to "advance new non-addictive pain treatments through the clinical pipeline."[275]

Medical students should also be exposed to pain management and opioid alternatives in the core components of medical school curricula. In 2018, Florida Medical Schools developed a *Framework for Developing Core Competencies* aiming to "provide a set of core competencies to guide individual medical schools in incorporating this material into their existing curricula as each school deems appropriate and necessary to address the needs of patients experiencing pain, as well as the public health concerns related to opioid abuse."[276] Likewise, the Florida Department of Children and Families is working with medical schools throughout the state to ensure their medical school curriculum addresses medication assisted treatment, substance abuse disorder, OUD, along with information on how to screen, treat and refer for these disorders including a portion on pain management.[277] Medical schools along with other state agencies, are implored to continue working to build sustainable and comprehensive curricula for future physicians and nurses and to strengthen practice areas that promote opioid-alternative approaches to pain medicine.

RECOMMENDATIONS

1. Increase participation in Drug Take Back Days to inform the public about prevention drug screening and treatment services.

2. Identify year-round authorized collectors and increase community events to host additional Drug Take Back Days.

3. Provide clear and consistent guidance on safe storage and disposal of prescription drugs.

4. Increase awareness and provide access to drug deactivation bags.

5. Develop and conduct a statewide educational initiative to raise visibility and provide guidance about the dangers of prescription drugs, safe storage and disposal avenues.

6. Develop and implement a social norms media campaign across Florida school districts to improve knowledge about opioid use disorders, dangers of misuse of prescription medications, dispel myths and misperceptions, de-stigmatizing OUD and reinforce positive choices.

7. Explore strategies to incentivize schools to implement high quality opioid prevention programs and initiatives.

8. Promote pain management and opioid alternatives in the core components of medical school curricula.

9. Expand the scope of prevention education currently provided in the schools to include opioid use disorders and prescription drugs.

10. Ensure fidelity of evidence-based prevention programs implemented within the school system.

11. Implement Student Assistance Programs (SAP). SAP is a school-based, evidence-informed framework for prevention, early intervention, referral and support for students with identified needs that may prevent them from fully benefitting from their educational experience.

12. Strengthen and expand the Maternal Opioid Recovery Effort (M.O.R.E.).

13. Raise awareness and education about Good Samaritan Law protections.

LAW ENFORCEMENT

Law enforcement plays a critical role in addressing and responding to the opioid crisis. Law enforcement is often the first to respond to individuals experiencing overdoses and is also responsible for the interdiction of illicit drugs entering our communities. General consensus among the Task Force is that law enforcement will be a critical force in combatting the opioid epidemic, from strengthening enforcement efforts for drug trafficking and improving investigation, reporting and the prosecution of overdose related cases. Law enforcement recommendations include specific statutory changes as well as broader improvements related to the law enforcement community and opioid epidemic.

I. LEGISLATIVE RECOMMENDATIONS

Include Methamphetamines as a Controlled Substance Qualifying for Prosecution

Additionally, this body recommends adding "methamphetamines" as defined in Florida Statute § 893.03(2)(c)5 to be included as a controlled substance to qualify for prosecution under Florida Statute § 782.04(1)(a)(3). Methamphetamine is a Schedule II controlled substance and not an enumerated controlled substance in the felony murder statute. Therefore, under current law, felony murder charges are inapplicable in cases where the victim died of a methamphetamine overdose. Accordingly, Florida Statute § 782.04(1)(a)(3) should be modified to include methamphetamine as a qualifying controlled substance for prosecution under Florida Statute § 782.04(1)(a)(3).

Enhance Penalties for Sale of Controlled Substance Within 1,000 Feet of Substance Abuse Treatment Facilities

Currently, Florida Statute § 893.13 recognizes certain categories of locations that merit additional protections for deterring criminal conduct and provides enhancements for sale of a controlled substance near areas that are deemed particularly vulnerable to illicit drug sale. Generally, depending on the substance, the sale of a controlled substance is considered a third or second degree felony. However, when the sale of an enumerated controlled substance takes place within 1,000 feet of a public university, public elementary, middle, or secondary school, municipal park, community center, church, childcare center, or assisted living facility, the charge is enhanced to a first-degree felony.[279]

The Task Force recommends that the legislature amend Florida Statute § 893.13(h), to include "substance abuse treatment facilities" to serve as a qualifying location for an enhanced penalty. Currently, Florida Statute § 893.13(h) provides an enhanced penalty for sales of a controlled substance within 1,000 feet of an *assisted living facility.* However, no enhancements, and thus no additional deterrents, exist for drug sales near substance abuse treatment facilities. To provide reasonable protection for individuals seeking treatment for substance abuse, Florida Statute § 893.13 should be amended to include enhancements for sale of a controlled substance within 1,000 feet of a substance abuse treatment facility.

Analyze the Reclassification of Codeine-Mixtures as Schedule II-Controlled Substances

Currently, codeine is a Schedule II drug.[280] However, any *mixture* of codeine is either a Schedule III or Schedule V drug.[281] In Central Florida, for example, there has been an increase in cases involving trafficking in cough syrup with codeine because cough syrup is relatively easy to obtain and suspects have been known to travel throughout the state doing so. Traffickers are able to buy large quantities of cough syrup that contain codeine and can avoid trafficking charges simply because cough syrup is a combination or mixture of codeine.[282] Presently, the law enables such a loophole. The Task Force recommends analyzing the benefits of removing all codeine mixtures from Schedule III or Schedule V and reclassify those as Schedule II-Controlled Substances. This potential modification would classify trafficking in codeine or a mixture of codeine categorically as Schedule II and subject violators to more uniform penalties.

Mandatory Reporting Requirement for all Overdoses

As mentioned within the Treatment & Recovery section, accurate and real-time data collection is vital to address the opioid crisis. To bolster statewide efforts for comprehensive data collection, the legislature should adopt a mandatory reporting requirement for clinics, hospitals, doctor's offices or other similar medical facilities to report all overdose incidents to the Florida Department of Health.

Currently, Florida Statute § 401.253(1)(a) provides that in cases where "a basic life support service or advanced life support service which treats and releases, or transports to a medical facility, in response to an emergency call for a suspected or actual overdose of a controlled substance *may* report such incidents to the department." There is no mandatory requirement for overdoses to be reported. Similar to mandatory reporting found in Florida Statute § 39.201 for abuse, abandonment or neglect, mandatory reporting should be required for overdoses. Indeed, there should be mandatory reporting from any medical service touchpoint for individuals that received services for an emergency life-threatening overdose.

Thus, Florida Statute § 401.253 should be amended to include language that mirrors mandatory reporting requirements for children in danger of child abuse, neglect or abandonment. This reporting requirement should be tailored to individuals receiving treatment for life-threatening overdoses. Accordingly, the legislature should consider requiring the Department of Health in each county to be responsible to track and make available data for all overdoses within that community or allow the reporting to likewise be accomplished through a program like EMSTARS. As the information in Florida Statute § 401.253 is currently shared and used to "maximize the utilization of funding programs for licensed basic life support service providers or advanced life support service providers, and for the dissemination of available federal, state, and private funds for local substance abuse services," implementing broader mandatory reporting requirements for overdoses, will reinforce this effort.

I. BEST PRACTICE RECOMMENDATIONS

Law Enforcement Should Respond to all Overdose Calls Alongside Medical Professionals

This Task Force recommends that law enforcement personnel respond to all overdose calls, as resources permit, in conjunction with emergency medical service providers. Specifically,

law enforcement departments should consider adopting Unified Drug Enforcement Strike Team's (UDEST) approach to responding to overdose calls. UDEST implements a rapid response approach to overdose calls that requires officers to "respond to all opioid-related overdose (OD) deaths occurring [within the jurisdiction]. Additionally, UDEST will respond to any OD, not resulting in death, wherein sufficient evidence (opportunity) exists to establish a nexus between the OD victim and the drug dealer supplying the near fatal dosage."[283] This practice has been implemented through collaboration among Marion County, the Ocala Police Department, and North Florida High Intensity Drug Trafficking Area (HIDTA). To date, the model has indicated positive results. [284]

Deconfliction Enhancements Across Florida

The opioid epidemic is not limited to geographic or jurisdictional boundaries. The Task Force recommends increased deconfliction and collaboration between law enforcement agencies to more effectively interdict and target illicit drug sales.[285] Specifically, the HIDTA group analyst capabilities should be increased for both amount of full time employees and in software/database analytics capabilities through a deconfliction tool such as RISS/DICE, to be used by all agencies throughout the state. RISS, for example, deconflicts with HIDTA Case Explorer, which is used by the DEA and all HIDTA groups for target and case management. The implementation of this tool would create greater collaboration and information sharing between local, state, and federal cases under investigation. Another recommendation is to integrate CASE explore to DICE, which is accessible by all state law enforcement agencies.

Forensic Examination of Phones

Cellular phones and similar devices are a tremendous intelligence resource for law enforcement in overdose death investigations because they help link and identify dealers who and supply chains. The DARTS program is a DEA database that serves as a phone number bank to assist in overdose death investigations.[286] This program enables forensic examination of an overdose decedent's phone, upload of information to the system, and identification of telephone numbers that overlap with other cases and well as telephone numbers that are frequently called by the victim, all of which is information helpful in identifying drug dealers by their telephone numbers. Florida's law enforcement agencies are in great need of an analytics software or database that can maintain and analyze the phone numbers recovered from decedents in these cases. The implementation of this platform would require retention schedules and purging capabilities. Resources and funding should be appropriated for law enforcement agencies to fully harness this technology, which will lead to more arrests, prosecutions, and ultimately save lives. The Task Force recommends dedicated resources for state law enforcement to coordinate assisting local law enforcement agencies in recovery and examination of this crucial evidence.

Funding Violent Crime and Drug Control Council

The Violent Crime and Drug Control Council (VCDCC) was created in 1993, originally focused on violent crime control,[287] and expanded in 2001 to also address drug control efforts by state and local law enforcement agencies.[288] This council is an advisory council to the Florida Department of Law Enforcement (FDLE) and was created to "develop and implement a statewide strategy to address violent criminal activity, including crimes committed by criminal gangs, and drug control efforts by state and local law enforcement agencies…"[289] The VCDCC is made up of

14 members who "make recommendations on the development and implementation of initiatives to combat violent crime, drug trafficking, and money laundering."[290]

Although this council was originally funded to support its efforts, as of late, it has "only funded victim/witness protection reimbursement requests" but otherwise has not been funded since 2008.[291] FDLE requested $2.5 million in their FY20/21 legislative budget request and has made funding requests in the past, though none of the funds were awarded. This is an area of funding that could be used to help agencies with investigative expenses as it relates to opioid-related types of investigations. Since the VCDCC already exists and has spending authority in statute and the FDLE is staffed for the Council's operations, the legislature is urged to revive funding for the Violent Crime and Drug Control Council in order to utilize the Council to its intended potential.

Sober Homes Regulation & Enforcement

Sober homes are homes for individuals seeking to live in long-term recovery with others that are also working towards sobriety. Any homeowner can serve as a landlord to tenants who seek long term sobriety. Sober homes enjoy protections from the Fair Housing Act (FHA) and the Americans with Disabilities Act (ADA).[292] "Substance use disorders are a cognizable 'disability' for the purposes of both the FHA and ADA, and individuals suffering from the disorders constitute a 'protected class.'"[293] Sober homes can be a valuable and beneficial housing option for individuals seeking to thrive in long-term recovery. However, sober homes have been a pitfall for individuals striving to live in recovery, because they are not subject to any mandatory registration stemming from protections from the FHA and ADA.

Pursuant to Florida Statute § 397.487, "it is the intent of the Legislature to protect persons who reside in a recovery residence."[294] However, in Florida, sober homes are generally not subject to mandatory certification (i.e. registration with the State). Certification for a recovery residence is voluntary until and unless the residence accepts "referral of a prospective, current or discharged patient [from a service provider]"[295] Essentially, certification requirements are triggered when a financial relationship exists between the licensed service provider and the sober home.[296]

Despite the legislature's good intentions, unchecked sober homes, in many instances, have resulted in harm for the individuals it seeks to rehabilitate. This harm is the result of lack of government oversight and enforcement of current regulations. For example, one sober home operator, Kenneth Chatman, allowed a female resident to be repeatedly sexually abused for his financial gain. Tragically, this resident died of an overdose.[297] This specific operator would also "allow patients to continue using illegal drugs," and "many of the two thousand residents who lived in his facilities died of drug overdoses."[298]

The FDA and FHA protections have served as a barrier for sober home regulation and enforcement is the for individuals.[299] The Florida Legislature should revisit the voluntary certification requirement as outlined in Florida Statute § 397.487, and consider making certification mandatory, to the extent it does not run afoul of federal law. Mandatory certification would serve as a protection "intended to benefit the protected group or respond [] to legitimate safety concerns raised by affected individuals."[300] Moreover, "[t]he voluntary certification process is merely a band-aid on the sober home issues that can be seen in Florida's recovery industry. Whether the answer lies in the form of mandatory certification or not, stronger government oversight is needed in the recovery community to combat the ongoing crisis."[301]

Entire communities have been impacted as a result of the lack of oversight and enforcement for recovery residences. Communities, like Delray Beach, have experienced the deleterious effects of unregulated sober homes. In a recent survey of counties, Palm Beach County shared that "by 2016, about a quarter of the state's 750 drug treatment centers were in the county… Palm Beach County also had twice as many centers as Broward and Miami-Dade combined. The drug-recovery industry was plagued by places that were ignoring addictions and racking up insurance charges."[302] As a result the State Attorneys Office of the 15th Judicial Circuit created the Sober Homes Task Force, aimed to identify, investigate and prosecute patient brokering, fraud and abuse in recovery homes. As of January 2020, this task force has resulted in 100 cases involving the prosecution of 87 people.[303]

While there is legislative work to be done to provide more protection from unscrupulous sober home operators, Palm Beach County's Sober Home Task Force (hereinafter Sober Home Task Force) is a model task force that can help equip other agencies around the state to identify, investigate, and enforce the prohibitions that currently exist. The Sober Home Task Force of the 15th Judicial Circuit was initially funded through a $275,000 appropriation and has since been funded by the State Attorney's Office.

The impact of the sober home task force led many of the unscrupulous treatment facilities to close or move out of the county. Opioid overdose deaths dropped by 40% in 2018 and, based on estimates from code enforcement officers, corrupt sober home operations declined by 50% since 2016.[304] The Task Force recommends a statewide training and partnership with the Attorney General's Office to equip other prosecutors and investigators in these kinds of cases. Additionally, more task forces should be supported and encouraged to help enforce current regulations, prosecute fraudulent recovery residences and provide the protections for individuals in recovery, as intended by the Legislature.

Modernize and Streamline the Marchman Act

For individuals with opioid use disorder, the Marchman Act can be triggered and used to help protect these individuals who may harm or neglect themselves due to their addiction. Pursuant to Florida Statute § 397.675, the Marchman Act is can be invoked when a person has a substance abuse or co-occurring mental health disorder and due to such impairment or disorder that person has lost the power of self-control, the ability to appreciate their need for services and can harm themselves or others.[305] When this Act is coupled with the appropriate plan and resources, it has the potential to help connect individuals to court-ordered services."[306] However, it is often difficult to admit an individual with opioid use disorder into treatment. "Occasionally, the Marchman Act order has elapsed by the time courts have space to admit the individual for treatment… [and] people who are using drugs are often transient so [it is] difficult for the individual to be located and served with a court order."[307] In Miami-Dade County, improved utilization of the Marchman Act by law enforcement has proven effective to help eligible individuals to be linked to treatment "once their treatment episodes end."[308] The Task Force recommends streamlining and modernizing the Marchman Act in order to improve access to treatment for individuals who qualify for involuntarily commitment.

Opioid Overdose Prosecutions

Opioid overdose investigations and prosecutions, as discussed above, face challenges due to the burden of proof and the nexus necessary between the opioid-related drug and cause of death. Opioid overdose death investigations that target drug dealers of the deadly dose, is relatively uncommon. This situation is largely due to the fact that these types of cases are extremely difficult to prove, and most small, rural state attorneys' offices, are ill-equipped and under-resourced for opioid murder investigations and prosecutions.[309] Individuals involved in responding and investigating to overdose scenes, including homicide and narcotic detectives, prosecutors, medical examiners, and first responders should receive increased training about the investigative methods, protocols, and outcomes needed for successful prosecution.

Continued education in this area would be beneficial, as well as creating small working groups with members from each of the respective specialties, in order for everyone to work towards the same goal: better targeting and investigating drug traffickers. As an extension of recognizing the importance of having a skilled prosecutor and investigator for opioid overdose cases, the Task Force also recommends cross-designating more prosecutors. The task force recommends specialized training for skilled investigators and prosecutors in opioid overdose cases.

US Postal Inspection Service

The United States Postal Inspection Service Office (USPIS) is the law enforcement arm of the U.S. Postal Service. The USPIS serves to protect postal employees, investigate illegal narcotics, mail and package theft, identity theft, mail fraud, suspicious packages, global mail security, child exploitation, and cybercrime. The office investigates money laundering and illegally obtained proceeds from narcotic sales. The illegal narcotics section works with the U.S. Customs and Border Patrol seeking to eliminate the mailings of opioids and other illicit drugs. They have developed tools to identify persons on the dark web misusing the postal service, as well as utilizing technology like Advanced Electronic Data (barcodes) and Rapid Substance Identification which helps scan for illegal narcotics. The USPI Office shares real time data with the Drug Enforcement Administration, Customs, and the Organized Crime Fusion Center.

Nationally, from fiscal years 2017-2019 there were 793 synthetic opioid seizures from the postal system totaling 594 pounds of synthetic opioids seized.[310] The agency employs approximately 1,200 Postal Inspectors nationwide, limiting their ability to work interdiction within the facilities. They work in partnerships with US Customs at their five international receiving facilities and need additional funding to support the growing quantity of illegal narcotics being mailed through our postal system. In lieu of additional funding, additional manpower support in the form of task force collaboration should be implemented so that state law enforcement entities can help interdict illicit drug shipments before those shipments reach our communities.

Florida Office of Drug Control

Beginning in 1999, several states established state-level offices modeled after the Office of National Drug Control Policy (ONDCP), with the intent of unifying state-level drug control efforts under one coherent, policy-driven direction. State drug offices have often demonstrated their integral role in collaborating with other state agencies and coordinating substance abuse networks to move policy forward. As policy leaders, drug policy offices are dynamic catalysts for change, and have proven to be effective in the unification of policy efforts. Governor DeSantis reestablished the Florida Office of Drug Control via Executive Order and the reinstatement of this office is a strong step forward in showing the state seriously supports efforts to reverse the tide of the opioid epidemic. The Office of Drug Control will effectively develop, coordinate and implement drug policy for the state. Accordingly, the Task Force supports the Governor's decision to reestablish the Florida Office of Drug Control.

RECOMMENDATIONS

1. Modification of Florida Statute § 381.887: Expansion of Availability of Narcan
2. Modification of Florida Statute § 893.13: Enhanced Penalties for Selling controlled substances Within 1,000 Feet of Substance Abuse Treatment Facilities
3. Analyze whether deleting Florida Statute § 893.03 section(3)(c) and section (5)(a) 1 & 2: Codeine Mixture Schedule III & Schedule V and classifying all forms to Schedule II would be beneficial and impactful
4. Creation of mandatory reporting of overdoses for medical professionals
5. Increase HIDTA group analyst capabilities both in FTE number and in software/database analytics capabilities
6. Increase data sharing by federal and state agencies
7. Ensure funding for statewide law enforcement software and database to assist local law enforcement for investigation efforts.
8. Enable Violent Crimes and Drug Control Council to carry out statutory responsibilities through sufficient funding
9. Law Enforcement respond to all overdose calls along with medical professionals
10. Modernize and streamline Marchman Act to ensure those eligible receive timely treatment
11. Improve sober home regulation and enforcement
12. Provide education and training to prosecutors and investigators for overdose death and sober home prosecutions
13. Support and partner with US Postal Service to maximize interdiction efforts
14. Continue to support the Florida Office of Drug Control

CONCLUSION

While there is no silver bullet to end the opioid crisis in our state, these initial findings of the Task Force provide evidence-informed, best practice recommendations to combat the opioid crisis. Additionally, the Task Force prioritized the aforementioned recommendations, identifying which recommendations should be implemented as soon as possible to make a timely and significant impact on saving lives. These prioritized recommendations found below and are the framework to the statewide strategy to combat the opioid crisis.

PRIORITIZED RECOMMENDATIONS FOR FLORIDA'S STATEWIDE STRATEGY TO COMBAT THE OPIOID CRISIS

TREATMENT & RECOVERY

- Increase funding and access to treatment and behavioral health services
- Create a platform that shares available treatment openings for the public
- Promote and expand use of medication assisted treatment paired with psychosocial therapy for inmate treatment programs
- Support and expand current system of care
- Reduce barriers to treatment and barriers to obtain medicine for opioid use disorder
- Support the use of opioid mobile response teams
- Promote and expand use of peer support services
- Support the expansion of naloxone (Narcan) availability in communities to include EMS, fire departments, law enforcement, friends and family members

PREVENTION & EDUCATION

- Require Continuing Medical Education (CME) for pain management and opioid alternatives
- Promote Behavioral Health Integration including Screening, Brief Intervention & Referral to Treatment (SBIRT)
- Implement public educational mass media campaign
- Advance Community Prevention Workforce and infrastructure
- Engage in statewide educational initiative on the dangers of prescription drugs, safe storage and disposal
- Promote Youth Coalitions

LAW ENFORCEMENT

- Mandate reporting of overdoses by all medical professionals
- Identify and utilize database software that can maintain and analyze telephone numbers recovered from decedents in fatal overdose cases
- Maximize use and funding of the Violent Crimes and Drug Control Council to assist local law enforcement investigative efforts, especially in rural counties
- Increase all federal, state, local and tribal (including HIDTA) analyst capabilities via available technology and training
- Support and partner with US Postal Service to maximize interdiction efforts

[1] FDLE Medical Examiner Report, *Drugs Identified in Deceased Persons by Florida Medical Examiners*, 2018 Annual Report (accessible at: https://www.fdle.state.fl.us/MEC/Publications-and-Forms/Documents/Drugs-in-Deceased-Persons/2018-Annual-Drug-Report.aspx).
[2] *See* CDC, A comprehensive look at drug overdoses in the United States, (accessible at: https://www.cdc.gov/injury/features/prescription-drug-overdose/index.html); see *also* Truth.com (accessible at: https://www.thetruth.com/o/the-facts/fact-1005).
[3] State of Florida, Office of the Governor Executive Order 17-146
[4] *See e.g*. Porter J, Jick H. Addiction rare in patients treated with narcotics. The New England Journal of Medicine. 1980;302:123; see also PRESCRIPTION DRUGS OxyContin Abuse and Diversion and Efforts to Address the Problem. Available at https://www.gpo.gov/fdsys/pkg/GAOREPORTS-GAO-04-110/pdf/GAOREPORTS-GAO-04-110.pdf ("Purdue conducted an extensive campaign to market and promote OxyContin using an expanded sales force to encourage physicians, including primary care specialists, to prescribe OxyContin not only for cancer pain but also as an initial opioid treatment for moderate-to-severe noncancer pain").
[5] See CDC, The Three Waves of Opioid Overdose Deaths, (accessible at https://www.cdc.gov/drugoverdose/epidemic/index.html); *see also* Osceola County Survey Response, Appendix, p.175-76.
[6] *See e.g.* Brevard County Survey Response, Appendix p. 063 (citing economic, workforce and child welfare system impacts from the opioid crisis).
[7] https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm
[8] State of Florida, Office of the Governor Executive Order 19-97.
[9] State of Florida, Office of the Governor Executive Order 19-97.
[10] F.S. § 397.305(2).
[11] F.S. § 397.305(3); *see also* F.S. § 394.4573 (defining and requiring coordinated system of care for mental health).
[12] F.S. § 397.305(5).
[13] FY 2020-2021 Department of Children and Family Services Block Grant Application, p. 26.
[14] Guiding Principles and Elements of Recovery-Oriented Systems of Care: What do we know from the Research? August 2009, U.S. Department of Health and Human Services, p. 3. (accessible at: https://www.samhsa.gov/sites/default/files/partnersforrecovery/docs/Guiding_Principles_Whitepaper.pdf).
[15] FY 2020-2021 Department of Children and Family Services, Block Grant Application, p. 33.
[16] Statewide Task Force on Opioid Abuse Treatment/Recovery Subcommittee Meeting, December 5, 2019.
[17] *See e.g.* Broward County Survey Response, Appendix p. 346 ("Opiate Action Plan was developed through a methodical process of assessment and strategy development. The Commission facilitated a process to collect information from our community's available resources and any activities to address the increasing overdose deaths in Broward County. Assessment results were used to *identify gaps in services* in order to create one unified countywide response.)
[18] Palm Beach County Survey Response, Appendix p. 185; *see also* Miami-Dade County Survey Response, Appendix p. 238.
[19] Treatment/Recovery Subcommittee Meeting December 5, 2019; *see also* Bay County Survey Response, Appendix p. 58. ("Bay County Sheriff's Office (BCSO), other local law enforcement agencies, a representative of the Bay County Commission, Bay County Emergency Services, community groups, social service agencies and medical providers participated in the statewide Recovery Oriented Systems of Care "ROSC" initiative which began on April 21, 2017.")
[20] *See e.g*. Hernando County Survey Response, Appendix, p. 350 (identifying problem-areas in their system of care).
[21] Statewide Task Force on Opioid Abuse Treatment/Recovery Subcommittee Meeting, December 5, 2019.
[22] Spotlight on Pennsylvania's Warm handoff, Addiction Policy Forum, p. 1, (July 2018), Appendix p. 53-54.
[23] *See* Itzkowitz, Matthew, Warm handoffs: A Practical Approach to Improving Opioid Overdose Relapse, American University Washington College of Law, Legislation and Policy Brief, August 20, 2018 (accessible at: http://www.legislationandpolicy.com/3864/warm handoffs-a-practical-approach-to-improving-opioid-overdose-relapse/#_ftn8).
[24] Presentation: Dr. Aaron Wohl: "The Warm handoff: Emergency Department Initiated MAT to Fight Against the Opioid Epidemic," Statewide Task Force on Opioid Abuse Meeting, November 21, 2019.
[25] Spotlight on Pennsylvania's Warm handoff, Addiction Policy Forum, p. 2, (July 2018), Appendix, p. 53-54
[26] Patterns and Trends of the Opioid Epidemic in Florida, Department of Children and Families, Covering Data from Calendar Years 2017-2018, P. 18 (accessible at: http://www.floridahealth.gov/statistics-and-data/e-forcse/fl-seow-annual-report-2018.pdf).

[27] https://www.addictionpolicy.org/hubfs/Pennsylvania%20Warm%20Off_180904.pdf .
[28] Wolf Administration Holds Regional Summit on Warm handoffs for Opioid Overdose Survivors, March 20, 2019 (accessible at: https://www.media.pa.gov/pages/DDAP_details.aspx?newsid=109).
[29] Castleman, David S., City of Jacksonville, Florida Project Save Lives Opioid Epidemic Program, Monthly Status Report, p. 1, August 5, 2019.
[30] Center for Substance Abuse Treatment, "What are Peer Recovery Support Services?" HHS Publication No. (SMA) 09-4454. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2009. P.1.
[31] *Id*. at p. 3.
[32] *See e.g*. https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers; U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. Washington, DC: HHS, November 2016, p.5-12; Centers for Disease Control and Prevention. 2019 Annual Surveillance Report of Drug-Related Risks and Outcomes — United States Surveillance Special Report. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. Published November 1, 2019, p. 42. Accessed [February 4, 2020] from https://www.cdc.gov/drugoverdose/pdf/pubs/2019-cdc-drug-surveillancereport.pdf; Tracy, Kathlene, and Samantha P Wallace. "Benefits of peer support groups in the treatment of addiction." *Substance abuse and rehabilitation* vol. 7 143-154. 29 Sep. 2016, doi:10.2147/SAR.S81535
[33] Presentation: Nyamora, Susan "Utilizing Peer Specialists to Strengthen Recovery," Statewide Task Force on Opioid Abuse Meeting, December 17, 2019.
[34] Presentation: Fontaine, Mark "Substance Use Disorder Treatment in Florida" Statewide Task Force on Opioid Abuse Meeting, December 17, 2019; *see also* Bay County Survey Response, Appendix, p. 102 (Promoting peer support services).
[35] Lee County Survey Response, Appendix, p. 146.
[36] F.S. § 397.417.
[37] *See e.g*. Presentation: Nyamora, Susan, "Utilizing Peer Specialists to Strengthen Recovery, Statewide Task Force on Opioid Abuse Meeting, December 17, 2019.
[38] *See* F. S. § 397.417.
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[234] Manatee County Survey Response, Appendix p. 381.
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[238] *Id*.

[239] F.S. § 408.918(3)

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[258] *See* Florida Administrative Code Rule 6A-1.094122.

[259] Florida Statewide Prescription Drug Safety Course Program Impact Report, Everfi, 2018-2019, p. 8.

[260] *Id*. at 10.

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[262] Mental And Emotional Health Education, Rule 6A-1.09412, F.A.C. Standards Alignment & No-Cost Resources, Sept. 2019.; *See also PlaySmart*, PLAY2PREVENT Lab at the Yale Center for Health & Learning Games (accessible at: https://www.play2prevent.org/our-games/playsmart/) (aiming to teach players the critical skills and knowledge through an engaging and interactive videogame, that targets their perception of risk surrounding opioid misuse, but has not yet launched).

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[264] Florida Statewide Prescription Drug Safety Court Program Impact Report, Everfi, 2018-2019, p. 14.

[265] *See* 2019 Florida Youth Risk Behavior Survey Results (accessible at: http://www.floridahealth.gov/statistics-and-data/survey-data/behavioral-risk-factor-surveillance-system/2019FLHSummaryTables.pdf) *see also* Florida Statewide Prescription Drug Safety Court Program Impact Report, Everfi, 2018-2019, p. 13.
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[267] First Step, Sarasota, Student Assistance Program Post Card, Appendix 55-56.
[268] 2018-2019 First Step of Sarasota, Final Evaluation Report Student Assistance Program, June 2019. p. 2.
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[270] *Id*. at 25.
[271] The President's Commission on Combating Drug Addiction and the Opioid Crisis" p. 46, (2017), p. 22(*citing* Madras BK. 2017, May 1. The Surge of Opioid Use, Addiction, and Overdoses: Responsibility and Response of the US Health Care System. *JAMA Psychiatry.* 74(5):441-442).
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[274] Presentation: Dr. Michael Kriegel, "Interdisciplinary Pain Management," Statewide Task Force on Opioid Abuse Meeting, December 17, 2019.
[275] Hillsborough County Survey Response, Appendix, p. 126; *see also* (https://heal.nih.gov/research/preclinical-translational)
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[277] Statewide Task Force Treatment/Recovery Subcommittee Meeting, December 5, 2019.
[278] *See e.g*. Aumuller v. State, 944 So.2d 1137 (Fla. 2d 2006).
[279] *See generally*, F.S. § 893.13.
[280] F.S. § 893.03(2)(a)(1)(g).
[281] F.S. § 893.03(3)(c)(2); F.S. § 893.03(5)(a)(1).
[282]See F.S.§ 893.135 ("A person who knowingly sells, purchases, manufactures, delivers, or brings into this state, or who is knowingly in actual or constructive possession of, 30 kilograms or more of any morphine, opium, oxycodone, hydrocodone, codeine, hydromorphone, or any salt, derivative, isomer, or salt of an isomer thereof, including heroin, as described in s. 893.03(1)(b), (2)(a), (3)(c) 3., or (3)(c)4., or 30 kilograms or more of any mixture containing any such substance, commits the first degree felony of trafficking in illegal drugs")
[283] *See* UDEST, Appendix p. 012.
[284] Presentation: Taylor, Corey "Unified Drug Enforcement Strike Team" January 10, 2020.
[285] *See* Orange County Survey Response, Appendix p. 170 (supporting joint law enforcement details to reduce the supply of illicit drugs and communications across agencies to interrupt the supply of drugs.)
[286] U.S. Department of Justice, Drug Enforcement Administration, Performance Budget Congressional Submission, FY 2016, p. 98 (last accessed December 2, 2019).
[287] F.S. § 943.031 (1993).
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[289] F.S. § 943.031 (2020).
[290] https://www.fdle.state.fl.us/VCDCC/VCDCC-Home.aspx.
[291] 2019 Annual Report, Violent Crime and Drug Control Council, p. 2.; *see also* Violent Crime and Drug Control Council Laments on funding Shortfall, December 19, 2019. (accessible at: https://floridapolitics.com/archives/313954-violent-crime-and-drug-control-council-laments-funding-shortfall)
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[293] *Id*.
[294] F.S. § 397.487 (2020).
[295] F.S. § 397.4873 (2020).
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[297] Scharf, Hunter, "A rising Florida Epidemic: Big business controls Florida's recovery residence crisis" 44 NOVA LR 91, 101 (2019).
[298] *Id*.
[299] *See e.g.* Presentation: Johnson, Al "Opioid Crisis: Rogue Sober Homes and Treatment Facilities, Law Enforcement Response," Statewide Task Force on Opioid Abuse Meeting, January 10, 2020.

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[301] Scharf, Hunter, "A rising Florida Epidemic: Big business controls Florida's recovery residence crisis" 44 NOVA LR 91, 116 (2019).
[302] Palm Beach County Survey Response, Appendix p. 184.
[303] Palm Beach County Survey Response, Appendix p. 184.
[304] Aronberg, Dave; Johnson, Al; "Best Practices in Creating a Local Opioid/Sober Home Task Force," January 21, 2020. Appendix p. 030.
[305] F.S. § 397.675.
[306] Hillsborough County Survey Response, Appendix p. 128.
[307] Miami-Dade County Survey Response, Appendix p. 235.
[308] Miami-Dade County Survey Response, Appendix p. 338; *see also* Leon County Survey Response, Appendix p. 361 (law enforcement is working with treatment partners to divert individuals with OUD from arrest and into treatment. Officers may initiate a Marchman Act for individuals suspected of an overdose for assessment and treatment)
[309] *See e.g.* Okaloosa County Survey Response, Appendix p. 150 (noting "noticeable absences in aggressive prosecutions regarding drug dealers and related offenders").
[310] United States Postal Inspection Service, The Opioid Epidemic (available at: https//www.uspis.gov/the-opioid epidemic/)