Statewide Drug Policy Advisory Council
2016 Annual Report

December 1, 2016

Rick Scott

Governor

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Surgeon General and Secretary

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EXECUTIVE SUMMARY

PROBLEM STATEMENT

- No sustainable process to compile massive amounts of data and information, perform analysis and develop an evidence-based call to action.
- Many diverse groups and disciplines working on substance abuse issues with no coordinating body.
- Insufficient treatment capacity.
- Restrictions which impact use of beneficial treatments.
- Lack of public knowledge and participation in preventing drug use and abuse.

As the State Surgeon General and Secretary for the Florida Department of Health, it gives me great pleasure to present Florida's Statewide Drug Policy Advisory Council's 2016 Annual Report required by section 397.333(4)(b), Florida Statutes. The report highlights this year's accomplishments by comprehensively analyzing the problems of substance abuse in the state and makes recommendations to the Governor and Legislature for the implementation of a state drug control strategy. The Council exemplifies the Department's mission to protect, promote and improve the health of all people in Florida through integrated state, county and community efforts.

During the course of the year, the Council held three meetings in Tallahassee and two conference calls, hearing testimony from experts in the fields of addiction, drug abuse prevention, substance abuse treatment and agency initiatives. The meetings were held:

- January 29, 2016
- March 11, 2016- conference call
- May 5, 2016
- August 25, 2016
- October 28, 2016- conference call

On March 11, 2016, the Council adopted seven objectives to address the problem areas previously identified in its call to action. The seven objectives were assigned to various agencies for analysis and critique and include:

1. Develop a comprehensive repository of meaningful data and resources related to substance abuse.
2. Develop a process to integrate resources across state agencies to create the biggest impact on substance abuse issues in Florida.
3. Develop a process to research, identify and share best practices from across the nation.
4. Develop an early warning network focused on supply reduction for emerging substances.
5. Provide recommendations to maximize existing resources.
6. Remove barriers to evidence-based treatments.
7. Produce and communicate the action plan.

While promising progress has been made, other concerning aspects of the opioid epidemic have emerged, such as increases in heroin and fentanyl-related deaths. Strong multidisciplinary collaboration is needed to address these challenges and to maintain our progress to reduce misuse and abuse in our great state. The Council proposes 12 recommendations this year focusing on areas to reduce the demand for drugs, reduce the supply of drugs, improve data collection and surveillance, broaden prevention efforts, and expand treatment options.

COSTS AND CONSEQUENCES OF NONMEDICAL OPIOID USE IN FLORIDA

Since 2000, the rate of deaths from drug overdoses has increased 137 percent, including a 200 percent increase in the rate of overdose deaths involving opioids (opioid pain relievers and heroin). In Florida, 1,967 deaths were caused by at least one opioid in 2014. This means that at least five lives per day are lost to opioid overdose in Florida.[1] The number of deaths in 2014 caused by motor vehicle crashes (2,402) and firearms (2,375) were less than deaths caused by prescription drugs, illicit drugs and alcohol detected in 8,587 decedents.[2,3]

From 1999-2014, the national age-adjusted mortality rate for opioid drug overdoses (which includes heroin and pharmaceutical opioids) was 5.8 per 100,000. Florida's rate of 6.8 per 100,000 exceeds the national average. Florida ranks 21st out of all 50 states and the District of Columbia on this measure. Florida's rate almost tripled over this time span, increasing from 2.6 per 100,000 in 1999 to 7.2 per 100,000 in 2014.[4]

Total societal costs of prescription opioid abuse in the United States were estimated at $55.7 billion in 2007 (with workplace costs accounting for 46 percent, health care costs accounting for 45 percent, and criminal justice costs accounting for 9 percent).[5] Prescription opioid overdoses result in 830,652 years of potential life lost before age 65.[6]

In 2011, there were 1,563 instances of newborns diagnosed with drug exposure in Florida, a three-fold increase since 2007 – and neonatal abstinence syndrome (NAS) is still widely believed to be an under reported problem. NAS is a postnatal drug withdrawal syndrome in newborns caused primarily by in utero exposure to opioids. Between 2010 and 2015, the number of cases of NAS in Florida have increased by 86 percent (from 1,336 to 2,487).[7]

In the United States, the incidence of NAS increased 383 percent during 2000–2012, and state Medicaid programs cover an estimated 80 percent of hospital charges for NAS.[8] While the numbers of women in Florida giving birth to drug exposed newborns is still thankfully few as a total percentage of pregnancies, NAS afflicted newborns impose disproportionately higher costs on our health and social service systems compared to healthy deliveries.[9]

Over the past decade, the annual prevalence of diagnosed opioid abuse more than doubled among both privately insured and Florida Medicaid populations. Researchers compared opioid abuse patients and demographically matched controls using privately insured and Florida Medicaid administrative claims data from 2003 to 2007. Opioid abuse patients and caregivers had greater resource use in both privately insured and Florida Medicaid populations compared with controls. Mean excess annual cost per privately insured patient was $20,546. Mean excess cost per Florida Medicaid patient was $15,183.[10]

The prescription drug abuse epidemic is fueled in part by a minority of prescribers who over-prescribe or otherwise deviate from standards of practice. Prescribers who deviate from accepted standards of practice or whose prescribing is unusual or uncharacteristic for their specialty are considered at-risk prescribers.[11] In Florida, the top 10 percent of prescribers account for approximately 64 percent of all prescribing.[12]

From 2003-2009, physicians who worked in pain clinics in Florida were prescribing large quantities of opioid analgesics with little medical justification, along with benzodiazepines, and muscle relaxants. In 2010, 98 out of the top 100 U.S. physicians who dispensed the highest quantities of oxycodone were located in Florida. In response, pain clinic regulations were

enacted, law enforcement raids were conducted, and physician dispensing of schedule II or III drugs from their offices was banned. Dispenser reporting to a newly created Prescription Drug Monitoring Program (PDMP) was mandated and additional regulations on wholesale distributors were enacted. Research shows that the implementation of PDMP and "pill mill" regulations resulted in a modest decrease in opioid prescriptions, opioid volume, and mean morphine milligram equivalent (MME) per transaction.[13]

Figure 1 illustrates the percentage of patients with exposure to higher than 100 MME per day and the mean MMEs for patients receiving opioids. The percentage of people prescribed greater than or equal to 100 MME per day among those receiving prescription opioids decreased from 16.8 percent in 4Q 2011 to 9.5 percent in 2Q 2016.[14] During the same period, the mean MME per day decreased by 38.9 percent from 112.2 MME in Q4 2011 to 68.5 MME at the end of Q2 2016.

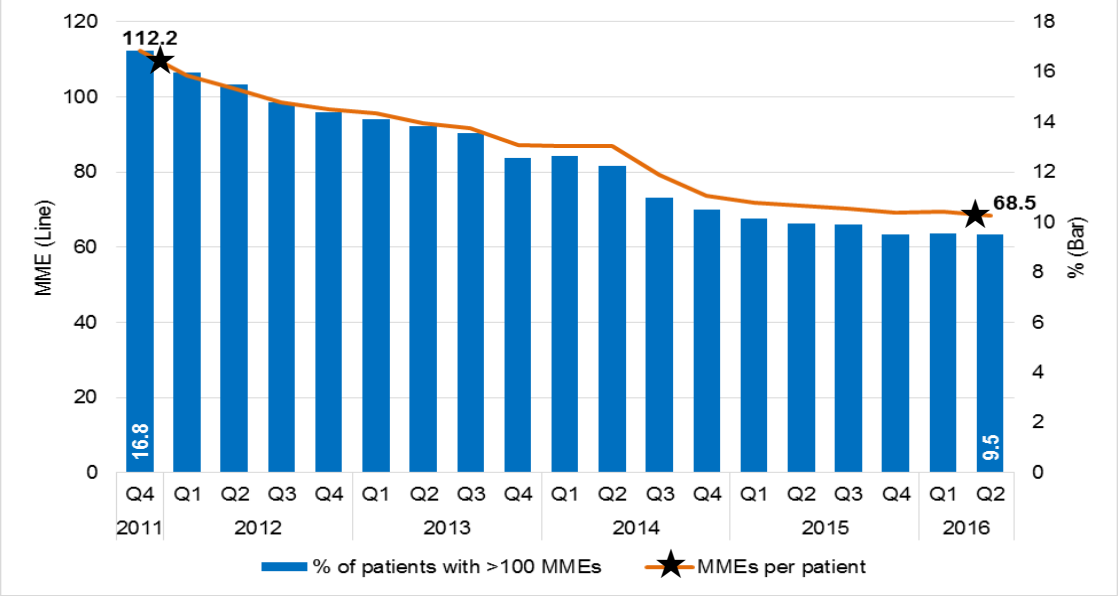

Figure 1. The mean daily dosage per patient in morphine milligram equivalents (MMEs) (line) and the percentage of patients on opioids receiving a dosage >100 MMEs.

Further, the number of calls to the Florida Poison Information Center Network (FPICN) related to prescription opioids decreased from 567 per month in 2010 to 468 per month in 2014. According to the U.S. Centers for Disease Control and Prevention (CDC), Florida experienced a 23 percent decline in drug poisoning deaths from 2010 to 2013, ranking it first among states and one of only two states that experienced a decrease from 2010 to 2014.[15]

During the first quarter of the PDMP's operation (October 1, 2011 to December 31, 2011), PDMP data indicated there were 2,864 individuals who had one or more controlled substance prescription drugs prescribed to them by more than five prescribers and dispensed at more than five pharmacies in a 90-day period. By the end of the second quarter of 2016 (April 1, 2016 to June 30, 2016), there was a 76.2 percent reduction or 682 individuals visiting more than five prescribers and more than five pharmacies within 90 days (Figure 2). During the same initial period, 105 individuals had one or more prescription drugs prescribed to them by more than 10 prescribers and dispensed at more than 10 pharmacies in a 90-day period. By the end of the second quarter of 2016 (April 1, 2016 to June 30, 2016), there was an 80.0 percent reduction or 21 individuals visiting more than 10 prescribers and more than 10 pharmacies within 90 days (Figure 2).[16]

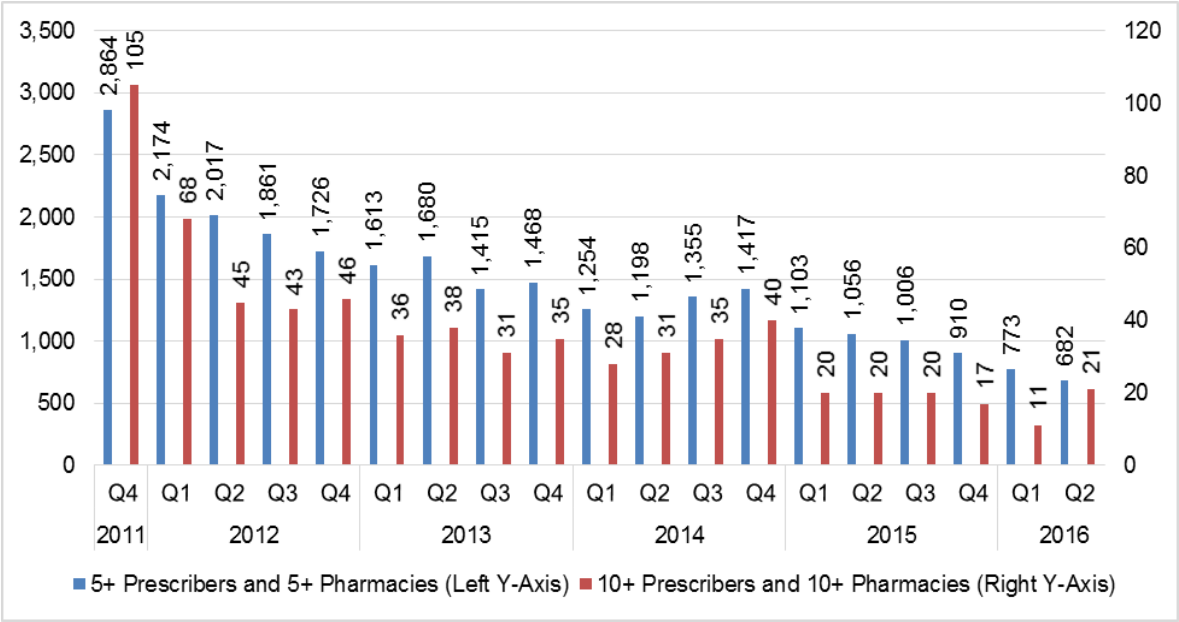

Figure 2. Number of individuals obtaining controlled substance prescriptions in schedules II-IV from 5 (10) or more prescribers and 5 (10) or more dispensers within a 90-day period, December 2011 to June 2016.

Overdose death rates for opioid analgesics and benzodiazepines also declined as a result.[17] For example, from 2010 to 2014, the rate of oxycodone and alprazolam-caused deaths declined 70.6 percent (from 8.0 to 2.4 per 100,000 population) and 45.1 percent (from 5.2 to 2.9 per 100,000 population), respectively.[18] These decreases continued through 2014; however, heroin death rates increased by 462 percent, suggesting that users responded to the reduced availability of prescription opioids by substituting heroin.[19] Research indicates that opioid use is the single most important risk factor for heroin use. People who are addicted to prescription opioid painkillers are 40 times more likely to be addicted to heroin.[20] Over 77 percent of people using both opioid pain relievers and heroin in the past year report using opioid pain relievers prior to heroin initiation.[21]

A growing number of young people who began abusing expensive prescription drugs are switching to heroin, because prescription opioids are far more expensive and harder to buy.[22] The reason may come down to basic economics: illegally obtained prescription pain killers have become more expensive and harder to get, while the price and difficulty in obtaining heroin have decreased. An 80mg OxyContin® tablet runs $60 to $100 on the street. Heroin costs about $9 a hit. Even among heavy heroin abusers, a day's worth of the drug is cheaper than a couple doses of oxycodone.

Heroin has had a resurgence in our nation and Florida is no exception with 779 heroin-related deaths from January to December 2015.[23] Four in five new heroin users began misusing prescription pain medications.[24] Especially hard hit Medical Examiner districts and areas of Florida have been Palm Beach (165), Orange (108) Miami (92), Broward (80), and Sarasota (68) raising fears that heroin will soon ravage the entire state (Table 1). Deaths caused by heroin in 2015 increased a staggering 79.7 percent when compared with 2014.[25] According to the Florida Department of Law Enforcement, heroin was at least partially to blame for 45 deaths in Manatee County in 2015.[26] This year alone, there have been 891 overdoses from heroin and 60 deaths reported by the Manatee County Sheriff's Office.[27]

Table 1. Number of heroin deaths reported by Medical Examiner District and Area of Florida, January to December 2015.

Heroin Deaths
January – December 2015

Medical Examiner District and Area of Florida		Total Deaths with Heroin			Deaths with Heroin Only			Deaths with Heroin in Combination with Other Drugs		
District	Area of Florida	Total	Cause	Present	Total	Cause	Present	Total	Cause	Present
1	Pensacola	28	26	2	0	0	0	28	26	2
2	Tallahassee	0	0	0	0	0	0	0	0	0
3	Live Oak	1	1	0	0	0	0	1	1	0
4	Jacksonville	45	40	5	2	2	0	43	38	5
5	Leesburg	8	8	0	0	0	0	8	8	0
6	St. Petersburg	14	13	1	0	0	0	14	13	1
7	Daytona Beach	20	19	1	0	0	0	20	19	1
8	Gainesville	3	3	0	0	0	0	3	3	0
9	Orlando	108	105	3	0	0	0	108	105	3
10	Lakeland	10	10	0	0	0	0	10	10	0
11	Miami	92	83	9	1	1	0	91	82	9
12	Sarasota	68	61	7	0	0	0	68	61	7
13	Tampa	35	33	2	0	0	0	35	33	2
14	Panama City	4	4	0	0	0	0	4	4	0
15	West Palm Beach	165	158	7	16	16	0	149	142	7
16	Florida Keys	1	1	0	0	0	0	1	1	0
17	Ft. Lauderdale	80	76	4	8	8	0	72	68	4
18	Melbourne	12	11	1	0	0	0	12	11	1
19	Ft. Pierce	8	8	0	0	0	0	8	8	0
20	Naples	11	11	0	0	0	0	11	11	0
21	Ft. Myers	43	40	3	0	0	0	43	40	3
22	Port Charlotte	2	2	0	0	0	0	2	2	0
23	St. Augustine	2	2	0	0	0	0	2	2	0
24	Sanford	19	18	1	0	0	0	19	18	1
Statewide Totals		**779**	**733**	**46**	**27**	**27**	**0**	**752**	**706**	**46**

In addition to the increase in heroin caused deaths in 2015, there has also been an increase in total deaths caused by the synthetic opioid analgesic fentanyl, 911 in 2015 (Table 2).

Table 2. Number of fentanyl caused deaths reported by Medical Examiner District and Area of Florida, January to December 2015.

Fentanyl Deaths
January – December 2015

Medical Examiner District and Area of Florida		Total Deaths with Fentanyl			Deaths with Fentanyl Only			Deaths with Fentanyl in Combination with Other Drugs		
District	Area of Florida	Total	Cause	Present	Total	Cause	Present	Total	Cause	Present
1	Pensacola	30	27	3	0	0	0	30	27	3
2	Tallahassee	5	1	4	1	0	1	4	1	3
3	Live Oak	1	1	0	0	0	0	1	1	0
4	Jacksonville	56	48	8	8	6	2	48	42	6
5	Leesburg	10	7	3	0	0	0	10	7	3
6	St. Petersburg	59	49	10	8	8	0	51	41	10
7	Daytona Beach	26	14	12	1	0	1	25	14	11
8	Gainesville	12	9	3	3	2	1	9	7	2
9	Orlando	105	67	38	13	5	8	92	62	30
10	Lakeland	17	14	3	3	2	1	14	12	2
11	Miami	102	82	20	4	1	3	98	81	17
12	Sarasota	122	111	11	14	13	1	108	98	10
13	Tampa	24	15	9	3	1	2	21	14	7
14	Panama City	10	9	1	2	2	0	8	7	1
15	West Palm Beach	103	90	13	9	8	1	94	82	12
16	Florida Keys	3	3	0	0	0	0	3	3	0
17	Ft. Lauderdale	82	77	5	11	10	1	71	67	4
18	Melbourne	40	26	14	6	3	3	34	23	11
19	Ft. Pierce	25	8	17	1	0	1	24	8	16
20	Naples	10	7	3	1	0	1	9	7	2
21	Ft. Myers	31	19	12	6	1	5	25	18	7
22	Port Charlotte	15	7	8	0	0	0	15	7	8
23	St. Augustine	8	3	5	2	0	2	6	3	3
24	Sanford	15	11	4	3	1	2	12	10	2
Statewide Totals		**911**	**705**	**206**	**99**	**63**	**36**	**812**	**642**	**170**

Table 2 illustrates the number of fentanyl-caused deaths by Medical Examiner District and Area of Florida from January to December 2015. There have been 642 deaths associated with fentanyl used in combination with other drugs. “Fentanyl is supplied in transdermal patches and also available for oral, nasal, intravenous, and spinal administration. Fentanyl is also produced illicitly, and currently many fentanyl death occurrences represent the ingestion of illicit fentanyl rather than pharmaceutically manufactured fentanyl. Deaths caused by fentanyl increased by 77.6 percent when compared with 2014.”[28]

The observed progress in some prescription drug-related outcomes is a positive development in Florida, but new challenges have emerged. There has been a substantial increase in deaths associated with fentanyl and heroin-related drug use. From January to mid-September 2016, Palm Beach County Fire Rescue reported 1812 opioid overdoses in the county. Also, according the District 15 Medical Examiner there were 234 total opioid related deaths through July 2016.[29]

National concerns have arisen that rapid declines in prescription opioid availability, in the absence of reducing demand driven by opioid use disorders, have resulted in opioid substitutions and other adverse outcomes.[30,31]

EFFECTIVE RESPONSES TO THE OPIOID EPIDEMIC

When used appropriately, prescription opioids can provide pain relief to patients.[32] “However these therapies are often being prescribed in quantities and for conditions that are excessive, and in many cases, beyond the evidence base.”[33] The Council supports efforts to maximize the favorable risk-benefit balance of prescription opioids by optimizing opioid use in circumstances supported by best clinical practice guidelines. Working in collaboration, the Council determined effective responses to the opioid epidemic include: improving prescribing practices, increasing public awareness, expanding the use of naloxone, improve care coordination, strengthening Good Samaritan laws, expanding access to and the use of medication-assisted treatment, and implementing school and family-based prevention programs.

Safe Prescribing Practices: In response to the heroin epidemic, the CDC directs states to reduce prescription opioid painkiller abuse by improving prescribing practices and identifying high-risk individuals early, particularly through the use of prescribing guidelines and PDMPs. Research shows that implementing opioid dosing guidelines is a promising way to reduce the high dosages of prescription opioids and rates of prescription opioid poisoning.[34] The CDC also recommends that PDMPs have the capacity to proactively notify users of high-risk behaviors.[35] Report cards and alerts can increase awareness and help prescribers re-examine their prescribing practices and policies. The CDC also recommends that PDMP data are accessible to public health agencies for tracking trends. Briefing community stakeholders using PDMP data can help highlight unique factors that contribute to local problems, motivate prescribers to utilize the PDMP and improve prescribing practices, and increase community readiness to change.[36] Increasing the dissemination and utilization of PDMP data can help improve Florida’s data infrastructure and increase community readiness. PDMP data can also help opioid addiction treatment programs determine if clients have complied with requirements to disclose the use of other medications and improve patient safety.[37]

Public Awareness: Public education and awareness campaigns are powerful tools that can be difficult to study and measure but like advertising, they encourage people to alter negative behaviors. Altering negative behaviors is a desired outcome.

Increase Access to Naloxone: Naloxone is an opioid antagonist that can reverse opioid respiratory depression. For more than 40 years, naloxone has been FDA approved and used by emergency medical services personnel to reverse opioid overdoses and revive individuals who otherwise might have died without it. Naloxone is remarkably safe and has no potential for abuse. Naloxone is not psychoactive or psychotropic. When given to individuals who are not under the influence of opioids, it produces no harmful effects, even at high doses, and while rapid opioid withdrawal may be unpleasant, it is not life threatening. The FDA has approved injectable naloxone, intranasal naloxone (Narcan® Nasal Spray), and a naloxone auto-injector (Evzio®). The Narcan® Nasal Spray is a pre-filled, needle-free device that requires no assembly, which can deliver a single dose into one nostril. The Evzio® auto-injector is injected into the outer thigh to deliver naloxone to the muscle or under the skin. Both Evzio® and Narcan® Nasal Spray are packaged in a carton containing two doses, to allow for repeat dosing if needed. The currently available intramuscular naloxone kits typically include two vials of naloxone with instructions on how to administer the medication to an overdose victim.

Florida's Emergency Treatment and Recovery Act (2015) allows health care practitioners to prescribe and dispense naloxone to individuals at risk of an opioid overdose and bystanders or caregivers who might witness an overdose. The innovative component of this legislation is the attempt to get naloxone into the hands of patients and caregivers who may witness an overdose. This goal is important because when someone in America overdoses, a call for help occurs less than 50 percent of the time.[38] Even if a call for help is made, it may be too late to save a life by the time the ambulance arrives. When someone is not breathing, every moment counts and the administration of naloxone can mean the difference between life and death (or severe brain damage). This law also extends liability protections to physicians and pharmacists for the prescribing, storing, and dispensing of naloxone to individuals with a prescription. Patients, caregivers, and bystanders in possession of naloxone may administer to a person believed in good faith to be experiencing an opioid overdose. In 2016, the Emergency Treatment and Recovery Act was expanded allowing pharmacists to dispense naloxone under non-patient specific standing orders to individuals at risk of experiencing or witnessing an opioid overdose and became effective July 1, 2016.

Opioid users and their loved ones can be easily trained to respond effectively to an overdose.[39] Since the first opioid overdose prevention program began in Chicago in 1996 with the Chicago Recovery Alliance, over 152,000 people have received training and naloxone kits and over 26,400 overdose reversals have been reported.[40] There is no evidence indicating that naloxone distribution encourages or increases the use of heroin or other opioids. Rather, studies suggest that increasing health awareness through training programs that accompany naloxone distribution actually reduces the use of opioids and increases users' desire to seek addiction treatment.[41]

Research indicates that naloxone distribution can reduce community-level overdose mortality by as much as 37 percent to 90 percent.[42] One analysis that focused exclusively on heroin overdoses estimated that naloxone distribution prevents 6.5 percent of all overdose deaths for each 20 percent of heroin users reached by the program. Stated another way, it is conservatively estimated that one heroin overdose death will be prevented for every 164 naloxone kits distributed.[43]

Improve Care Coordination: Research shows that only 40 percent of patients who experience an opioid-related hospitalization receive any follow-up services within 30 days. Only 10.7 percent of patients receive the recommended combination of both medication and a therapeutic service.[44] These findings only apply to individuals with private insurance. It is reasonable to

assume that post-discharge care coordination is more challenging for individuals without insurance. Providing care coordination that links overdose victims to supportive, evidence-based post-discharge care is critical to stopping the cycle of relapses and overdoses. Preliminary research shows that continuity of care, operationally defined as experiencing an outpatient treatment encounter for a substance use disorder within 14 days after discharge from a residential facility, is associated with significantly lower odds of deaths within a two-year post-discharge period.[45]

The Department of Children and Families (DCF) plans to implement at least two pilot care coordination programs within the high-need urban counties beginning in 2018 that involve at least two hospitals and providers of Medication Assisted Treatment, counseling, recovery peer support, and therapeutic services. Grant funds will be used to support peer recovery specialists who assess, motivate, and link individuals to treatment. Replicable procedures for assessing overdose victims and linking them to treatment and recovery services will be developed, tested, and disseminated if found to be effective.

Strengthen Florida's Good Samaritan Law: Florida's 911 Good Samaritan Act, section 893.21, Florida Statutes, is intended to encourage people to call 911 during suspected overdoses by offering overdose victims and help-seekers limited immunity from being charged for possession of a controlled substance. Unfortunately, this law does not explicitly protect against arrest. As it stands now, people acting in good faith and seeking medical assistance for an overdose victim may not be charged, prosecuted, or penalized for possession of a controlled substance. Until "arrested" is added to the statute, community partners should obtain complete buy-in and cooperation from law enforcement organizations, including prosecutors, before they can disseminate public services announcements saying, "You will not be arrested if you call 911."

Increase Access to Medication-Assisted Treatment: At adequate doses, methadone prevents or reverses withdrawal symptoms and blocks the euphoric effects of heroin. A meta-analysis of 11 randomized clinical trials involving 1,969 heroin dependent participants found that methadone is the most effective way to retain patients in treatment and reduce heroin use (as measured by self-reports and urine/hair analysis).[46] An analysis of 25 studies found that methadone or buprenorphine treatment for opioid-dependent injecting drug users reduces illicit opioid use, injection use, and the sharing of injection equipment. It is also associated with reductions in the proportion of injection drug users reporting exchanges of sex for drugs or money. The reductions in these risk behaviors translate into reductions in cases of HIV and Hepatitis C infections.[47]

"The Florida Legislature has recently supported and funded the utilization of extended-release injectable naltrexone (Vivitrol®) to treat alcohol or opioid addicted individuals in community-based drug treatment programs. The Office of State Courts Administration (OSCA), DCF, and the Department of Corrections have dedicated funding for the distribution of Vivitrol® and the medication is now accessible as a pharmacy benefit in Medicaid.

The initial implementation of the OSCA and DCF Vivitrol® distribution programs was paced and steady. However, the growth of both programs during the last few months of the 2015-2016 fiscal year has been extremely robust in large part because providers have refined and streamlined their processes for engaging and transitioning clients into the program. Individuals in treatment are beginning to experience dramatic changes in their ability to stabilize in recovery while telling others about the effectiveness of the medication. National and state media coverage about medication assisted treatment has increased due to the rise in opioid overdoses

in Florida and across the nation. As a result, more drug courts, behavioral health stakeholders and providers are referring and enrolling patients in the programs.

At the conclusion of this past fiscal year 2015-2016, the number of provider agencies administering medication through the OSCA Vivitrol® distribution program doubled (41 enrolled, 27 delivering medication). For the same period, the number of DCF Vivitrol® distribution program providers administering medication also doubled (25 enrolled, 15 delivering medication). For both programs, the number of injections administered to patients each month and the resulting monthly expenditures increased dramatically. At the current growth rate, the demand for services in both programs will exceed fiscal year 2016-2017 allocated funding."[48]

Evidence-Based School and Family-Based Primary Prevention Programs: The Strengthening Families Program (SFP) is a nationally and internationally recognized parenting and family-strengthening program for high-risk and general population families. SFP is an evidence-based family skills training program found to significantly improve parenting skills and family relationships, reduce problem behaviors, delinquency and alcohol and drug abuse in children and to improve social competencies and school performance.49 Researchers conducted randomized controlled trials of the SFP, and Life Skills Training combined with the SFP, in rural communities and small towns. Despite the fact that these school and family-based interventions did not have any specific content related to the prevention of prescription drug misuse, they demonstrated significant reductions in prescription drug misuse (with relative reduction rates ranging from 20 percent to 65 percent).[50] The combined delivery of Life Skills Training and the Strengthening Families Program appears to be the most cost-effective way to reduce nonmedical opioid use.[51]

Many of the evidence-based strategies described above were incorporated into DCF' application for federal funding. DCF was awarded a Partnership for Success (PFS) grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) on September 30, 2016. The award amount is $1.2 million per year (for a total of $6.1 million over the five-year project period). This project is designed to reduce prescription drug misuse among Floridians ages 12-25 and the nonmedical use of opioids among Floridians ages 26 and older. This project will also reduce the number of accidental and intentional deaths caused by opioids and strengthen prevention capacity and infrastructure at the state and community levels. The sub-recipient communities are five urban counties (Broward, Duval, Hillsborough, Manatee, and Palm Beach) and three rural counties (Franklin, Walton, and Washington). Naloxone promotion, training, and distribution will save lives and strengthen Florida's current infrastructure and capacity to prevent overdose deaths. Care coordination pilot programs will use peer specialists to link overdose victims to drug treatment providers after they are discharged from the hospital. School-based prevention programs that effectively reduce prescription drug misuse will be implemented in rural counties. Local Drug Epidemiology Networks will be developed and integrated into the State Epidemiological Outcomes Workgroup (SEOW). Enhancements to Florida's PDMP will be deployed to provide prescribing alerts to health care practitioners. This Council's role is to serve as the advisory body for the grant.

RECOMMENDATIONS

The Council's purpose, as defined in section 397.333, Florida Statutes, is to conduct a comprehensive analysis of the substance abuse problem in Florida; seek input from a broad spectrum of public and private sector partners; examine outcome measures from existing programs to establish effectiveness; research other state and federal strategies; develop a

compendium of best practices in drug abuse strategies and programs; provide statewide drug control strategy that provides a coordinated, integrated, multidisciplinary response to address substance abuse; and prepare a report with recommendations to the Governor, President of the Senate, and Speaker of the House of Representatives annually.

In a coordinated effort, five recommendations from the Council's 2015 Annual Report were adopted and include the following:

1. The Legislature revised the Florida Comprehensive Drug Abuse Prevention and Control Act by adding twelve new substances and six general substance classes to the list of substances that are classified under Schedule I in section 893.03, Florida Statutes and revised the list of precursor and essential chemicals. The law also revises various criminal penalties that apply to violations of Chapter 893, Florida Statutes. The Florida Drug and Cosmetic Act was also amended to authorize local actions to abate nuisances involving two or more violations within a specified period and specifies additional substances that may be deemed contraband. For the purposes of Florida RICO Act, the law states that crimes involving misbranded drugs are racketeering activity.

2. The Legislature established the Miami-Dade Infectious Disease Elimination Act (IDEA). The IDEA authorizes the University of Miami and its affiliates to establish a needle and syringe exchange pilot program in Miami-Dade County. The pilot program is to offer free, clean, and unused hypodermic needles and syringes in exchange for used needles and syringes to prevent the transmission of blood-borne diseases such as HIV, AIDS, or viral hepatitis among intravenous drug users, their sexual partners, and offspring. The law requires the University of Miami to collect data for reporting purposes, with the final report due August 1, 2021, but prohibits the collection of any personal identifying information. (Section 381.0038, Florida Statutes)

3. The Legislature established the Emergency Treatment and Recovery Act, authorizing certain health care practitioners to prescribe and dispense an emergency opioid antagonist (naloxone) to a patient or caregiver under certain conditions; authorizes storage, possession, and administration by a patient or caregiver and certain emergency responders; provides immunity from liability; and provides immunity from professional sanction or disciplinary action. (Section 381.887, Florida Statutes)

4. The Legislature established the "Victoria Siegel Controlled Substance Safety Education and Awareness Act" requiring Department of Health to develop a written pamphlet relating to controlled substances which includes specific educational information and make available to health care practitioners and entities to disseminate and display. The Department shall also encourage consumers to discuss the risks of controlled substance abuse with their health care providers. (Section 893.30, Florida Statutes)

5. The Department of Children and Families is expanding programs and initiatives that reduce the incidence of heroin overdose-related fatalities through the implementation of the 2016 Partnerships in Success Grant awarded by SAMHSA.

In conclusion, the Council proposes the following recommendations for improving the health and safety of all Floridians by promoting strategic approaches and collaboration to reduce the demand for drugs, reduce the supply of drugs, improve data collection and surveillance, broaden prevention efforts, and expand treatment options.

To reduce the supply of drugs, the Council supports:

1. Amending section 893.055, Florida Statutes, authorizing the integration and interoperability of PDMP data to encourage safer prescribing of controlled substances and reduce drug abuse and diversion within Florida.

2. Increasing outreach and education to health care practitioners to encourage registration and utilization of the PDMP.

3. Updating the Florida Comprehensive Drug Abuse Prevention and Control Act to address the scheduling of new chemical compounds classified under schedule I, and update criminal penalties that apply to violations.

To reduce the demand for drugs, the Council supports:

4. Ensuring providers in the publicly-funded system of behavioral health care present medication assisted treatment as an option to all individuals with opioid use disorders and alcohol use disorders and link these individuals to these services upon request.

5. Increasing funding for extended-release injectable naltrexone to treat alcohol and opioid addicted individuals in community drug treatment programs.

6. Funding pilot programs, in addition to those planned under the Partnerships for Success grant linking individuals hospitalized for overdoses to community-based treatment providers upon discharge.

To improve data collection and surveillance, the Council supports:

7. Amending section 397.333, Florida Statutes, authorizing the Secretary of the Agency for Health Care Administration to serve on the Statewide Advisory Council ensuring all state agencies provide comprehensive recommendations.

8. Amending section 406.13, Florida Statutes, creating a data repository to maintain medical examiner reports to reduce the wait time to obtain and produce invaluable drug related death information.

9. Amending section 893.055, Florida Statutes, expanding authorized use of PDMP to include medical examiners, county coroners, or others authorized to investigate causes of deaths. Expanding access to the PDMP will facilitate the medicolegal death investigation process and certification of the cause and manner of death.

10. Collaborating with other agencies, organizations, and institutions to create a comprehensive statewide strategy addressing the fentanyl and heroin epidemic in the state.

To reduce the harmful consequences of substance use, the Council supports:

11. Amending section 381.887, Florida Statutes, to expand the use of standing orders by community-based organizations and trained outreach workers to distribute naloxone to marginalized, hard-to-reach individuals in the community.

12. Amending section 893.21, Florida Statutes, Florida's 911 Good Samaritan Act by expanding protection to the 911 caller and overdose victim from arrest for possession of drug paraphernalia. Currently, people acting in good faith and seeking medical assistance for an overdose victim may not be charged, prosecuted, or penalized for possession of a controlled substance or drug paraphernalia. Until "arrested" is added to the statute, community partners cannot disseminate public service announcements encouraging individuals to call 911 because the caller or overdose victim are afraid of being arrested.

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