Prevention Services and Prevention Partnership Grants (PPG)

Authorities: 42 U.S.C. s. 300x-2
45 C.F.R., pt. 96, sub. L.

S. 397.311(22)(a)9.(c), F. S.

Ch. 65D-30, F.A.C.

Frequency: Ongoing

Due Date: Ongoing

Managing Entity Responsibilities

The Managing Entity shall ensure the administration and provision of evidence-based programs to the target populations indicated in the prevention planning documents

The Managing Entity shall:

1. Collect and analyze data on substance use consumption and consequences to identify the substances of abuse and populations that should be targeted with prevention set-aside funds,
2. Purchase prevention activities and services with Substance Abuse Block Grant funds that are both consistent with the needs assessment data and are not being funded through other public or private sources,
3. Develop capacity throughout the state and Regions to implement a comprehensive approach to substance abuse issues;
4. Collect and analyze outcome data to ensure the most cost-efficient use of substance abuse primary prevention funds,
5. Review community prevention planning documents developed by community coalitions,
6. Purchase substance abuse prevention services, in compliance with 45 C.F.R. pt. 96, sub. L,
7. Contract with and provide oversight of Prevention Partnership Grant (PPG) grantees,
8. Verify delivery of services,
9. Provide technical assistance to subcontracted prevention providers regarding implementation of evidence-based prevention practices; and
10. Provide oversight of prevention services consistent with Block Grant requirements.

Network Service Provider Responsibilities

The Managing Entity shall ensure subcontracted prevention providers and coalitions:

1. Provide culturally appropriate evidence-based programs to the target populations,
2. Deliver prevention programs at the locations specified and in accordance with the Program Description of the strategy,
3. Partner with community coalitions, where available, to obtain their prevention planning documents and confirm that current programs are aligned with community substance abuse problems,

4. Collaborate with partners within the communities and state to focus on prevention,
5. Follow the Center for Substance Abuse Prevention (CSAP) Six CSAP Strategies:
    a. Information Dissemination,
    b. Education,
    c. Alternatives,
    d. Problem Identification and Referral,
    e. Community Based Processes, and
    f. Environmental Strategies.
6. Report prevention services and activities that do not fit under one of the CSAP Strategies under the "Other" category in the ME Block Grant reporting template.
7. Collect and analyze data on substance use consumption and consequences to identify the substances of abuse and populations that should be targeted with prevention set-aside funds,
8. Comply with state reporting requirements,
9. Enter all prevention data monthly into the Department's Performance Based Prevention System (PBPS),
10. Submit the Prevention Program Description using the PBPS format. The Managing Entity shall approve or reject the Program Description before any data submission can be done by the Network Service Provider,
11. Submit prevention data for all program participants, programs and strategies which occurred. Data submitted is consistent with the data maintained in the provider's program documentation, invoicing and sign-in sheets, and
12. Accurately report the following performance measures:
    a. A minimum of ninety percent (90%) of data shall be submitted no later than the 15th of every month.
    b. A minimum of ninety percent (90%) of department-identified errors in data submitted shall be corrected within thirty (30) days of notification.

Defining Prevention

Prevention refers to the proactive approach to preclude, forestall, or impede the development of substance abuse or mental health related problems. These strategies focus on increasing public awareness and education, community-based processes, and incorporating evidence-based practices. Programs designed to prevent the development of *mental, emotional, and behavioral disorders* are commonly categorized in the following manner:

Universal Indirect Prevention

Universal Indirect Preventive services are provided to the general public or a whole population group that has not been identified on the basis of individual risk and is desirable for everyone in that group. Universal indirect services support population-based programs and can include meetings and events related to the design and implementation of components of the strategic prevention framework, including needs assessments, logic models and comprehensive community action plans.

Universal Direct Prevention
Directly serve an identifiable group of participants who have not been identified on the basis of individual risk. This includes interventions involving interpersonal and ongoing or repeated contact such as curricula, programs, and classes.

Selective Prevention
Preventive interventions that are targeted to individuals or to a subgroup of the population whose risk of developing mental, emotional, or behavioral disorders is significantly higher than average. Risk groups may be identified on the basis of biological, psychological, or social risk factors that are known to be associated with the onset of a disorder. Examples include programs offered to children exposed to risk factors, such as parental divorce, parental mental illness, death of a close relative, or abuse, to reduce risk for adverse mental, emotional, and behavioral outcomes.

Indicated Prevention:
Indicated prevention services that are targeted to high-risk individuals who are identified as having minimal but detectable signs or symptoms that foreshadow mental, emotional, or behavioral disorders, as well as, biological markers that indicate a predisposition in a person for such a disorder but who does not meet diagnostic criteria at the time of the intervention. More specifically, indicated populations include individuals without substance use disorders, who may have already initiated substance use, perhaps in risky ways. In other words, indicated prevention services are designed to prevent progression to disorders and associated harmful consequences.

Substance Abuse Prevention and Treatment Block Grant

Federal regulations that apply to the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) require the state to spend at least 20% of the award on services for individuals who do not require treatment for substance abuse. This entails the implementation of a comprehensive primary prevention system which includes a broad array of prevention strategies directed *at* individuals not identified to be in need of treatment.

SAPT Block Grant set-aside funds cannot be used to fund Screening, Brief Intervention, Referral and Treatment (SBIRT) programs. Other examples of strategies that will not be approved for SAPTBG Prevention funding include:

1. Relapse prevention programs,
2. Domestic violence programs
3. Case management for parenting teens,
4. Mental Health First Aid; or
5. Any services provided within prison or jails.

Primary prevention programs can include activities and services provided in a variety of settings for both the general population, and targeted sub-groups who are at high risk for substance abuse and the underlying factors driving a problem. At-risk populations include:

1. Children of substance abusers,
2. Pregnant women/teens,
3. Drop-outs,
4. Individuals exhibiting violent and delinquent behavior,
5. Individuals with mental health problems,
6. Individuals who are economically disadvantaged,
7. Individuals who are physically disabled,
8. Abuse victims,
9. Individuals who are already using substances,
10. Homeless or runaway youth, and
11. Parents who use substances.

Data-Based Decision Making

The Managing Entity shall continue to implement prevention strategies that are research-based and informed by community needs assessments through the subcontracted provider network, in connection with child and youth serving systems (i.e., child welfare providers, school systems, juvenile justice).

The strategic planning process is a conceptual framework that can be used in a variety of different contexts. The Center for Substance Abuse Prevention calls this process the Strategic Prevention Framework (SPF). SPF contains five basic elements[1] and two overarching principles[2] that overlap and interact throughout the process, relying on research and data to determine strategies. Subcontracted prevention providers must engage in this strategic planning process which guides local development of needs assessments, logic models, community action plans, and evaluation plans.

Environmental Strategies and Community Coalitions

Environmental prevention strategies are activities that are intended to reduce or restrict social and retail access to, and economic availability of, alcohol and other drugs by modifying features of the physical environment. Examples include compliance checks, social host laws, restricting alcohol availability at events, increasing prices, and keg registration. The availability of substances at the center of the definition of environmental strategies, and it positions anti-drug coalitions at the helm, since the most recent evaluation of the Drug Free Communities program indicates that the "availability of substances that can be abused" is a risk factor that 86% of anti-drug coalitions throughout the U.S. select for change. Regarding standards of evidence for environmental strategies, several important resources can be consulted, including standards established by the Centers for Disease Control and Prevention and the Society of Prevention Research.

Community Coalitions are local partnerships among multiple sectors of the community that respond to community conditions by developing, implementing, and evaluating comprehensive plans that lead to measurable, population level reductions in drug use and related problems. Scientific studies indicate that the community coalition approach is an effective strategy for addressing alcohol, tobacco and other substance use and misuse-related problems. Coalitions connect multiple sectors of the community to collaborate and develop plans, policies and strategies to achieve reductions in the rates of consumption at the community level, promoting positive well-being. Community coalitions reside at the heart of a proven comprehensive public health approach to support prevention efforts via a structured planning process that promotes civic engagement and the building of social capital.[3]

The Managing Entity shall ensure the administration and provision of evidence-based programs to the target populations indicated in the prevention planning documents. Network Service Providers shall conduct appropriate evidence-based programs that will benefit a community and meet their target population needs. The Network Service Provider shall also perform the following activities:

- Deliver prevention services at the locations specified in, and in accordance with the Program Description of the strategy.
- Partner with community collations to obtain their Needs Assessment Logic Model and confirm that their current programs are aligned with community substance abuse problems and will maintain a formal relationship outlined by an annually negotiated Memorandum of Understanding. This will include:
    - Participate in the SPF process which includes strategic planning, implementation and evaluation.
    - Submit an annual evaluation report to be included in the overall Coalition Evaluation report.
- Implement their scope of work for the target populations indicated in the Coalition Needs Assessment Logic Model.
- Implement evidence-based programs that are culturally appropriate for the target population.
- Encourage providers to participate in the peer-based fidelity assessment process to assess the quality, appropriateness, and efficacy of programs and practices.
- Complete an evidence-based fidelity self-assessment specific to the Evidence Based Practice implemented in the Network Service Provider's approved Program Description.
- Enter all prevention data on a monthly basis into the Department's Performance Based Prevention System (PBPS).

Prevention Data Reporting

The Managing Entity requires:

- Network Service Providers submit the Prevention Program Description. The Managing Entity must approve or reject the Program Description before any data submission can be done by the Network Service Provider.
- Network Service Providers submit prevention data for all program participants, programs and strategies which occurred.
- Network Service Providers submit prevention data into the Department's Performance Based Prevention System (PBPS). Prevention data will be entered into the system by the 8th of each month. Network Service Providers are required to submit additional supporting documentation to the Network Manager upon request.
- Data submitted must be consistent with the data maintained in the Network Service Provider's program documentation, invoicing and sign-in sheets.

Network Service Providers are required to accurately report the following performance measures:

- A minimum of ninety five percent (95%) of data shall be submitted by the 8th of every month.
- A minimum of ninety five percent (95%) of department and managing entity-identified errors in data submitted shall be corrected within ten (10) days of notification.

Suicide Prevention Through and With Substance Use Prevention

Federal law stipulates that the SAPT primary drug prevention set-aside funds must be used for activities that prevent or reduce the risk of substance use (including alcohol and other drugs) among individuals who do not require treatment for substance use disorders. Therefore, it would be impermissible, for example, to use primary prevention set-aside funds on a universal campaign that merely encouraged people experiencing suicidal thoughts to reach out for professional help. In order to be eligible for primary drug prevention set-aside funding, such a campaign would arguably also need to include content designed to prevent or reduce substance use. Also, in order to be eligible for primary drug prevention set-aside funding, such a campaign could target indicated populations (i.e., individuals who have started using substances but not yet escalated to a substance use disorder diagnosis), but it could not target individuals diagnosed with substance use disorders.

A review of the scientific evidence and relevant SAMHSA publications indicates that substance use is an important risk factor for suicide-related thoughts and behaviors. A multivariate analysis of Florida high school students demonstrated that tobacco use, alcohol use, and depressive symptoms were all significantly associated with increased odds of suicide ideation. Tobacco use, alcohol use, marijuana use, and depressive symptoms were all significantly associated with increased odds of both suicide planning and suicide attempts.i According to a meta-analysis of 30 longitudinal studies, there is a positive and significant association between alcohol use and both fatal and nonfatal suicide attempts. Alcohol use increases the probability of suicidal attempts by 110% and the probability of suicide mortality by 65%.ii According to a more recently published meta-analysis of 48 studies (spanning 1995 to 2020), smoking, depression, and alcohol and cannabis use disorders are significantly associated with suicide ideations. Depression, substance use, and polysubstance use are significantly associated with suicide attempts.iii

Given the interrelationship between suicide risk and substance use, reducing the use of alcohol and other drugs is a way to reduce suicide-related experiences. A recently published meta-analysis of individual-level psychological interventions designed to reduce alcohol use revealed a modest decrease in self-harm (encompassing non-suicidal self-injury and attempted suicide), but not suicidal ideation.iv With respect to population-level interventions, typically involving restrictions on alcohol availability, a recent systematic literature review showed that most studies found an association with reduced suicides or self-harm, predominantly among males.v According to SAMHSA, “Alcohol and drug misuse are second only to depression and other mood disorders as the most frequent risk factors for suicidal behavior…People at risk for suicide and substance misuse share a number of risk factors that include depression, impulsivity, and thrill-seeking/life threatening behaviors. Because risk and protective factors for the two can overlap, prevention professionals need to be aware of them and to implement prevention programming that reduces risk and enhances protective factors.”vi

A recently published meta-analysis of 25 studies of longitudinal associations between substance use disorders (SUDs) and suicidality found that SUDs significantly predict subsequent suicidality, and suicidality significantly predicts subsequent SUDs. According to the authors, “Because effects were significant in both directions, results suggest that the bidirectional hypothesis may be the best fit for understanding the association between SUDs and suicidality in youth. Indeed, SUDs and suicidality may be exacerbating each other consistently across development.” They also argue that, “A cross-influence of

SUDs with suicidality could notably be prevented by targeting the mechanisms thought to explain their associations, for example by increasing coping and problem-solving skills. Some programs targeting these skills have already been shown to prevent both substance use and suicidality, and may also prevent co-morbidity when youth already experience one or the other..."[vii]

SAMHSA's evidence-based guide to Treatment for Suicidal Ideation, Self-Harm, and Suicide Attempts also recommends a focus on programs with skill building components: "Skills training during treatment involves youth learning, practicing, and applying a variety of coping skills that help youth better navigate everyday challenges and stressors. Skills training sessions may focus on emotional regulation, distress tolerance, cognitive restructuring, communication skills, help seeking, problem-solving, and/or conflict resolution. This training should be calibrated with what put that youth at risk for suicide. For example, if an adolescent male client tends to experience suicidal thoughts after interpersonal conflicts with his friends, parents, and significant other, a clinician might prioritize different coping skills than for an adolescent female who suffers from perfectionism, anxiety, depression, and feelings of failure."[viii]

Substance use is more than a risk factor for suicide, it is a mechanism/means of dying by suicide. For example, according to 2020 interim data from Florida Medical Examiners, approximately 13-18% of deaths caused by sedatives (i.e., alprazolam, diazepam, and clonazepam) in Florida are suicides. With respect to opioids, approximately 15% of deaths caused by oxycodone and 24% of deaths caused by hydrocodone are suicides.[ix] Prevention efforts targeting access to pharmaceutical sedatives and opioids are therefore part and parcel of reducing suicides by increasing safe storage practices and decreasing access to lethal means.

Resources

Guidance 1 (Evidence-Based Guidelines) (Program Guidance for Managing Entity Contracts)

Guidance 14 (Prevention Partnership Grants – PPG) (Program Guidance for Managing Entity Contracts)

A Guide to SAMHSA's Strategic Prevention Framework
20190620-samhsa-strategic-prevention-framework-guide.pdf

Substance Abuse and Mental Health Services Administration Prevention Resources
https://www.samhsa.gov/prevention-week/toolkit/prevention-resources

Prevention of Substance Use and Mental Disorders Guidance documents to assist communities with prevention planning
https://www.samhsa.gov/find-help/prevention#resources-publications

Florida Administrative Code & Florida Administrative Register Standards for Prevention
https://www.flrules.org/gateway/ruleno.asp?id=65D-30.013&Section=0

National Research Council and Institute of Medicine. (2009). Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. Washington, DC: The National Academies Press.
https://pubmed.ncbi.nlm.nih.gov/20662125

The Prevention Partnership Grants

Prevention Partnership Grants (PPG)[1], established under s. 397.99, F.S., are awarded once every three years. Requirements for the administration of the PPG, for agencies who were awarded the funds, are outlined in specific Attachments to the Network Service Provider contract and according to DCF Guidance 14, which can be found at following link using the applicable fiscal year: http://www.myflfamilies.com/service-programs/samh/managing-entities/.

Definitions

Capacity Building. Efforts that increase or improve the resources available to establish or maintain prevention activities.

Comprehensive Community Action Plan (CCAP). A document that describes and depicts goals and objectives related to the state consumption priorities and the proposed programs and strategies. It also describes and depicts intermediate changes to risk and protective factors and process-based objectives. Applications must include at least one objective that addresses sustainability and at least one objective that addresses capacity building. Goals and objectives are subject to modification during the negotiation process.

Cultural Competence. As defined by SAMHSA at: https://www.samhsa.gov/sites/default/files/20190620-samhsa-strategic-prevention-framework-guide.pdf

Evaluation Plan. A document that explains and describes program assessment, improvement, and strategic management. The assessment portion should address the process for verification and documentation as well as how program activities and their effects will be quantified. Additionally, areas that can be improved or enhanced need to be identified to address areas of weakness. The final piece of strategic management will provide information to help make decisions about how resources should be applied in the future to better serve its mission or goals.

Evidence-Based. Prevention programs or strategies that have been evaluated with an experimental or quasi-experimental research design and found to produce statistically significant reductions in substance use, relative to comparison or control groups, as reported through at least one peer-reviewed journal article. SAMHSA guidance on the selection of evidence-based programs and practices can be accessed at: https://www.samhsa.gov/sites/default/files/ebp_prevention_guidance_document_241.pdf

Grantee. Applicants awarded program funding as a result of this RFA.

Harmful Consequences. Negative effects caused by drug use, such as diseases, fatalities, academic failures, and criminal behavior.

Indicated Prevention. As defined in rule 65E-14.021(4)(v)1., F.A.C.

Managing Entity. As defined in section 394.9082, F.S.

Needs Assessment Logic Model (NALM). A visual depiction of the relationships between risk and protective factors, drug consumption, and harmful consequences. A logic model visually demonstrates

[1] s. 397.99, F.S.

the causal mechanisms and interconnections between variables using arrows to show the direction of influence.

Prevention Data System. An internet-based data system that collects data related to community assessments and plans and substance abuse prevention programs and activities.

Protective Factors. Conditions or variables that reduce the likelihood of drug use.

Risk Factors. Conditions or variables that increase the likelihood of drug use.

Sustainability. As defined by SAMHSA at: https://www.samhsa.gov/sites/default/files/20190620-samhsa-strategic-prevention-framework-guide.pdf

Target Population. The PPG Target Population is students up to 20 years of age. Parents, teachers and other school staff, coaches, social workers, case managers, and other prevention stakeholders may also be the target of proposed activities because of their ability to influence students up to 20 years of age. Activities that target the behavior of these stakeholders for change can be considered process measures. Approved performance measures, on the other hand, must measure improvements in the attitudes and behaviors of students up to 20 years of age.

Objectives

Per Section 2.1 of the RFA, the overall objectives of the PPG program are to:

- Develop effective substance abuse prevention and early intervention strategies for target populations; and
- Conduct prevention activities serving students who are not involved in substance use, intervention activities serving students who are experimenting with substance use, or both prevention and intervention activities, if a comprehensive approach is indicated as a result of a needs assessment.

Network Service Providers must follow the goals, objectives, timelines, tasks and outcomes based on the specifics of the Needs Assessment Logic Model (NALM) and the Comprehensive Community Action Plan (CCAP).

Performance Measures

Per Section 2.3 of the RFA, Network Service Providers must adopt, at a minimum, performance measures to evaluate improvement in those behaviors and attitudes identified in the grantee's application and related to the provider's Evaluation Plan. Pursuant to *s. 397.99(2)(d), F.S.,* performance measures for grant program activities must measure improvements in relevant student behaviors and associated attitudes in the following state priorities for consumption reductions:

- Underage Drinking,
- Marijuana Use, and
- Non-Medical Prescription Drug Use.

The provider will follow performance measures as outlined by LSFHS's As Negotiated Targets document.

Process Measures

Per Section 2.3.1 of the RFA, Network Service Provider must include process measures that quantify the activities of a program or strategy and are designed to evaluate the extent to which a program is implemented as identified in the grantee's application. Process measures may include desirable changes in risk and protective factors that must be modified in order to cause improvements in the attitudes and behaviors of students up to age 20. Process measures may also include changes in the attitudes, beliefs, expectations, and behaviors of other prevention stakeholders if these are necessary preconditions for preventing substance use among students up to age 20.

Reporting

Network Service Providers shall submit the following reports:

- **Program Status Report**
  A detailed report of the services and activities performed and the progress of the program in meeting the performance measures, process measures, goals, objectives and tasks outlined in the subcontract. This report must be submitted quarterly to the Network Manager by the 8th of the month.

- **Financial Report**
  A detailed report of program expenses which are used to track all expenses associated with the grant and reconcile these expenditures with the payments made to the grantee. The financial reports track both grant award-funded and match-funded expenses and encourages program expenditure planning and projection. Pursuant to *Rule 65E-14.021, F.A.C*, this report must be submitted at least annually using the Department's form *CF-MH 1037*.

- **Additional Reporting Requirements**
  Ad Hoc and additional reporting may be required as determined necessary by LSF Health Systems or the Department of Children and Families.

Data Entry

The Network Service Provider must enter all prevention data on a monthly basis into the Department's Performance Based Prevention System (PBPS).

Financial Consequences

Financial consequences may apply if the Network Service Providers fails to perform in accordance with the contract.

Return of Funds

Per Section 2.7 of the RFA, Network Service Providers shall return to the Managing Entity any unused PPG funds and unmatched grant funds, as documented in the Final Financial Report, no later than 60 days following the ending date of the contract.

Staffing

Network Service Providers must incorporate all reasonable, allowable, and necessary elements of the grantee's staffing chart and job descriptions as presented in the grantee's application. Any single revision

the Network Service Provider would like to make to the staffing details; including positions, numbers of FTEs, qualifications and salaries that results in a change to the staffing plan greater than 25% of either the total FTE or total salary costs; presented in their application must be approved by the Managing Entity and the Department.

Funding and Match

Providers must submit a proposed budget and budget narrative, including match commitment, for reasonableness, allowability and necessity to the Managing Entity for review and approval. The Network Service Provider shall ensure they maintain the 25% cash or in-kind match required by *s. 397.99, F.S.*

PPG Network Service Providers

Applicant	**County Coverage**
Meridian Behavioral Healthcare, Inc.	Baker
Hanley Center Foundation, Inc. dba Hanley Foundation	Baker, Bradford, Clay Duval
Meridian Behavioral Healthcare, Inc.	Bradford
Hanley Center Foundation, Inc. dba Hanley Foundation	Putnam
Hanley Center Foundation, Inc. dba Hanley Foundation	Alachua
Hanley Center Foundation, Inc. dba Hanley Foundation	Dixie, Gilchrist, Levy, Lafayette
BayCare Behavioral Health, Inc.	Hernando
CDS Family & Behavioral Health Services, Inc.	Gilchrist, Levy
LifeStream Behavioral Center, Inc.	Sumter
LifeStream Behavioral Center, Inc.	Lake
LifeStream Behavioral Center, Inc.	Marion
Eckerd Youth Alternatives	Citrus
Fresh Ministries	Duval

Monitoring

The Managing Entity shall monitor all PPG grantees in accordance with the terms of **Section C-1.3**. and shall detail the results of all PPG monitoring and any corrective actions implemented as a program-specific element of the Network Service Provider performance report reporting required by **Section C-2.4.6.4**. The Department reserves the right to require additional corrective action for any documented failure of PPG grantees to implement services in accordance with the terms of their PPG applications and their Managing Entity subcontracts.

Invoicing

Invoices for prevention programs are commonly categorized in the following manner:

> <u>Contracted Prevention Provider</u>
> The Contracted Prevention Provider is contracted for prevention services in ASA (MSA25) or CSA (MSC25). This is a fixed price (unit cost) contracted service. The Managing Entity shall pay the Network Service Provider for the delivery of services provided in accordance with the terms and conditions of this contract.

Coalition Provider

The Coalition Provider is contracted for prevention services in ASA (MSA25) or CSA (MSC25). This is a fixed price (unit cost) contracted service. The Managing Entity shall pay the Network Service Provider for the delivery of services provided in accordance with the terms and conditions of this contract.

PPG Provider

The PPG Provider is contracted for prevention services in CSA (MSCPP). This is a fixed price (unit cost) contracted service. The Managing Entity shall pay the Network Service Provider for the delivery of services provided in accordance with the terms and conditions of this contract.

The Invoice template can be found in Exhibit I. The financial rules can be found in 65E-14, F.A.C.

Glossary

- **Community coalitions**

  Local partnerships between multiple sectors of the community that respond to community conditions by developing and implementing comprehensive plans that lead to measurable, population-level reductions in drug use and related problems.

- **Culture**

  The shared values, traditions, norms, customs, arts, history, folklore and institutions of a people unified by race, ethnicity, language, nationality, religion or other factors.[2]

- **Prevention**

  Strategies that take place *prior* to the onset of a disorder and are intended to avert or reduce risk for the disorder.

- **Promotion**

  Strategies to encourage supportive family, school, and community environments and to identify and strengthen protective factors.

- **Protective factor**

  Characteristic at the biological, psychological, family, or community level that is associated with a lower likelihood of problem outcomes or that reduces the negative impact of a risk factor on problem outcomes.[3]

- **Risk factor**

  Characteristic at the biological, psychological, family, or community level that precedes and is associated with a higher likelihood of problem outcomes.[4]

- **Strategic Prevention Framework (SPF)**

[2] National Community Anti-Drug Coalition Institute. (2007). *Cultural Competence Primer: Incorporating Cultural Competence into Your Comprehensive Plan*.
[3] National Research Council and Institute of Medicine. (2009). *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*. Washington, DC: The National Academies Press.
[4] National Research Council and Institute of Medicine. (2009). *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*. Washington, DC: The National Academies Press.

A five-step process to promote youth development, reduce risk-taking behaviors, build assets and resilience, and prevent problem behaviors across the life span.[5]

- **Treatment**

  Services that include assessment, counseling, case management, and support within residential and non-residential settings and recovery support. The intent of these services is aimed to address a specific disorder by reducing or eliminating the symptoms or effects of the disorder or avoiding relapse.

Prevention Services will be administered according to DCF Guidance 10 and Prevention Partnership Grant (PPG) will be administered according to DCF Guidance 14, which can be found at following link using the applicable fiscal year: https://www.myflfamilies.com/services/substance-abuse-and-mental-health/samh-providers/managing-entities.

[i] Evans, D. & Tawk, R. (2016). The Relationship Between Substance Abuse and Suicide Among Adolescents. *Florida Public Health Review, 13* (Article 8).

[ii] Amiri, S. & Behnezhad, S. (2020). Alcohol Use and Risk of Suicide: A Systematic Review and Meta-Analysis. *Journal of Addictive Diseases, 38*(2), 200-213.

[iii] Armoon, B. et al. (2021). Prevalence, Sociodemographic Variables, Mental Health Condition, and Type of Drug Use Associated with Suicide Behaviors Among People with Substance Use Disorders: A Systematic Review and Meta-Analysis. *Journal of Addictive Diseases* (online ahead of print).

[iv] Witt, K. et al. (2021). Effect of Alcohol Interventions on Suicidal Ideation and Behavior: A Systematic Review and Meta-Analysis. *Drug and Alcohol Dependence, 226*(1).

[v] Kolves, K., et al. (2020). Impact of Alcohol Policies on Suicidal Behavior: A Systematic Literature Review. *International Journal of Environmental Research and Public Health, 17*, 7030.

[vi] Substance Abuse and Mental Health Services Administration. (2016). *Substance Use and Suicide: A Nexus Requiring a Public Health Approach*. Retrieved from https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4935.pdf.

[vii] Rioux, C., Huet, A., Castellanos-Ryan, N., Fortier, L., Le Blanc, M., Hamaoui, S., Geoffroy, M., Renaud, J., & Seguin, J. R. (2021). Substance Use Disorders and Suicidality in Youth: A Systematic Review and Meta-Analysis with a Focus on the Direction of the Association. *PLoS ONE, 16*(8), e0255799.

[viii] Substance Abuse and Mental Health Services Administration. (2020). *Treatment for Suicidal Ideation, Self-Harm, and Suicide Attempts Among Youth*. SAMHSA Publication No. PEP20-06-01-002. Retrieved from https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-06-01-002.pdf.

[ix] Florida Department of Law Enforcement, Medical Examiners Commission. (2021). *Drugs Identified in Deceased Persons by Florida Medical Examiners – 2020 Interim Report*. Retrieved from http://www.fdle.state.fl.us/MEC/Publications-and-Forms/Documents/Drugs-in-Deceased-Persons/2020-Interim-Drug-Report-FINAL.aspx.

[5] See http://www.samhsa.gov/spf