IN THE CIRCUIT COURT OF THE FIFTEENTH JUDICIAL CIRCUIT
IN AND FOR PALM BEACH COUNTY, FLORIDA

PRESENTMENT OF THE PALM BEACH COUNTY GRAND JURY

REPORT ON THE PROLIFERATION OF FRAUD AND ABUSE IN FLORIDA'S ADDICTION TREATMENT INDUSTRY

FALL TERM A.D. 2016

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December 8, 2016

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TABLE OF CONTENTS

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-

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- -

-

-

-

EXHIBIT LIST
.....
..... 35
LEGAL AUTHORITY
..... 36
DISTRIBUTION REQUEST
..... 38
CERTIFICATE OF PRESENTMENT .....
39

INTRODUCTION

In the midst of the growing national health crisis involving opioid addiction, Dave Aronberg, State Attorney for the Fifteenth Judicial Circuit of Florida, called for this Grand Jury to investigate how government agencies are addressing the proliferation of fraud and abuse occurring within the addiction treatment industry. This Grand Jury was further asked to make appropriate findings and recommendations on how these agencies can better perform their duties to ensure that communities remain safe and individuals with substance use disorders are protected.

"[A] grand jury may investigate the actions .of public bodies and officials concerning the use of public funds." In re Grand Jury Invest. of Fla. Dept. Health & Rehab. Servs., 659 So. 2d 347, 350 (Fla. 1st DCA 1995). Such a grand jury has

the "right to express the view of the citizenry with respect to public bodies and officials in terms of a 'presentment,' describing misconduct, errors, and incidences in which public funds are improperly employed."

Miami Herald Pub. Co. v.

Marko, 352 So. 2d 518, 522 (Fla. 1977). As explained in Kelly v. Sturgis, 453 So.

2d 1179, 1182 (Fla. 5th DCA 1984):

Grand juries have a lawful function to investigate possible unlawful actions for all persons, private citizens and public officials alike, and to return indictments when warranted. As Marko notes, grand juries also have a lawful and proper function to consider the actions of public bodies and officials in the use of public funds and

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report or present findings and recommendations as to practices, procedures, incompetency, inefficiency, mistakes and misconduct involving public offices and public monies. 352 So. 2d at 522. See also Appeal of Untreiner, 391 So. 2d 272 (Fla. 1st DCA 1980).

Kelly v. Sturgis, 453 So. 2d 1179, 1182 (Fla. 5th DCA 1984).
In accepting this important assignment, the Grand Jury reviewed five major areas of concern in regulatory oversight and enforcement: (I) marketing, (2) commercial group housing designed for persons in recovery (also known as recovery residences, sober homes, or halfway houses), (3) the ability of the Department of Children and Families to take action, (4) the strength and clarity of the patient brokering statute, and (5) law enforcement's ability to take action. The Grand Jury heard testimony and received evidence from a wide range of sources, including the Department of Children and Families (DCF), Florida Association of Recovery Residences (FARR), Florida Certification Board (FCB), Florida Alcohol and Drug Abuse Association (F ADAA), Florida Attorney General's Office of Statewide Prosecution, Palm Beach County Fire Rescue, the insurance industry, law enforcement, treatment industry professionals (including a psychiatrist, a licensed clinical social worker, and a marketing director), parents of children victimized by abuses like patient brokering, a City Commissioner, owners of recovery residences, private and municipal attorneys who extensively litigated treatment and recovery housing issues over the past decade, and residents from local communities impacted by the proliferation of recovery residences.
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In this report, we discuss the economic, statutory, and regulatory forces that make Florida the premier medical tourism destination for substance abuse treatment and recovery housing. We identify the main types of fraud and abuse occurring within the treatment industry and how bad actors have managed to avoid detection for so long. We then explain what tools DCF, FARR, and local law enforcement agencies need to provide meaningful oversight in this industry. Finally, we make recommendations on how to clarify and enhance criminal laws to more effectively address the increase in patient brokering, which is one of the most common, damaging, and lucrative ways that this vulnerable class of consumers is being exploited.

3

OVERVIEW
Over the past decade, federal laws have collectively impacted the substance abuse treatment industry in ways that could not have been predicted. First, the Mental Health Parity and Addiction Equity Act of 2008 (Parity Act) placed behavioral health on a par with physical health, which resulted in a drastic increase in coverage for substance abuse treatment.

See 29 U.S.C. § 1185a (2009).

Subsequently, the Patient Protection and Affordable Care Act (ACA) allowed young adults to stay on their parents' policies until age 26, eliminated exclusions for pre-existing conditions, and required treatment for mental health and substance abuse to be included on every insurance policy. See 124 Stat. 119 (2010). These laws inadvertently created a lucrative opportunity for bad actors to exploit a vulnerable class of young adults suffering from addiction.
Addiction is also recognized as a disability under the Americans With Disabilities Act (ADA) and Fair Housing Act (FHA). See 42 U.S.C. § 12101 (2008); 42 U.S.C. § 3602 (2016). Over the past decade, bad actors have been using these laws to hide their exploitation of the very people that these laws were meant to protect. This is especially true in the business of recovery housing, where many unregulated homes have become unsafe and overcrowded "flophouses" where crimes like rape, theft, human trafficking, prostitution, and illegal drug use are commonplace.
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While there is no way to accurately assess the number 1 of these unregulated businesses in Florida, one indication is the number of reasonable accommodation requests made by recovery residences to avoid local zoning restrictions. In one municipality alone, there have been 550 requests by recovery residences for reasonable accommodation. Unfortunately, the most common way of identifying a house as a recovery residence occurs during calls for service. These calls range from overdoses, crimes committed inside the house, or general complaints from the

from overdoses, crimes committed inside the house, or general complaints from the community. These unregulated businesses not only harm their residents directly, but indirectly harm others in recovery by perpetuating a negative stigma. The Grand Jury finds that the problem is the unregulated businesses that house these residents, not the residents themselves.

The average substance use disorder (SUD) patients in Florida are young adults from out-of-state with little to no independent source of income. 2 This demographic has proven to be a critical component of "the Florida model," which is loosely defined as outpatient treatment coupled with recovery housing. The model has proven to be extremely lucrative given the ease of setting up and operating an outpatient treatment center (which can be opened in any strip mall) while warehousing patients off-site in unregulated homes.

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DCF Recovery Residence Report, p.8 (Oct. 1, 2013).

Optum White Paper: Young adults and the behavioral health system, p.4 (2014).

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The problem is that most of these young adult patients from out-of-state cannot afford housing while in treatment. Without a consistent form of patient housing, this model would not work. Currently, patient housing is often paid by treatment providers in exchange for illegal patient referrals.

Out-of-state patients are targeted by Florida treatment providers because they typically have out-of-network plans.

In a recent Optum report, it was

estimated that reimbursement for out-of-network treatment was, on average, three times the amount paid for the same in-network services. 3 Additionally, SUD patients of this demographic are generally unwilling or unable to cooperate with law enforcement.

These characteristics, coupled with impractical privacy

restrictions on oversight, make this patient population exceptionally vulnerable to patient brokering and other forms of exploitation.

The Grand Jury finds that the main criminal and regulatory violations occurring within Florida's substance abuse treatment industry involve deceptive marketing, insurance fraud, and patient brokering. It begins with the deceptive marketing that draws in this vulnerable class of consumers. Online marketers use Google search terms to essentially hijack the good name and reputation of notable treatment providers only to route the caller to the highest bidder, which could

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Optum White Paper: Young adults and the behavioral health system, p.4 (2014).

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simply be another referral agency. Parents acting out of desperation and ignorance are easily convinced to send their young adult children far from home in hopes of effective treatment. The evolution of technology has far surpassed the few laws that exist to govern such conduct.

Insurance fraud is another maJor problem in Florida's substance abuse treatment industry. For example, a point of care (POC) urinalysis (UA) test kit is readily available over the counter and costs under ten dollars. On the other hand, confirmatory and quantitative testing at a lab involves sophisticated instruments, tests for specific and collateral drugs (panels), and results in charges that can exceed five thousand dollars per test. In many cases, confirmatory and quantitative tests are ordered by treatment providers multiple times per week.

Doctors may sign off on such testing as being medically necessary. There are many instances, however, where no prior authorization is required before a claim is paid. As one major insurance carrier explained: claims for confirmatory testing and other treatment are paid without prior doctor authorization based on "access to care" requirements found in federal law. In other words, clinical care is routinely billed and paid without any proof of medical necessity. Some providers bill for services never rendered and others submit falsely labeled samples. Even when confirmatory tests are ordered by a doctor, many are never reviewed, evincing the lack of medical necessity in the first place.

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Although insurance companies generally only pay a percentage of the billed amount for out-of-network services, it is not unusual for treatment providers to receive hundreds of thousands of dollars in insurance payments for confirmatory tests for a single patient over the course of treatment. In one example shown to the Grand Jury, a well-known treatment provider billed a single patient's insurance over $600,000, mainly for drug tests, in just a seven-month period. 4
In addition to deceptive advertising and insurance fraud, patient brokering is a major problem in this industry as well. The Grand Jury heard testimony that the average patient referral fee to a recovery residence from a treatment provider is $500 per week per patient. The more the treatment provider bills, the more the provider can pay in kickbacks to obtain more patients. This leads patients away from quality treatment providers to businesses that are only concerned with billing as much as possible. The amount of patient brokering that occurs in one area can actually be used as a yard-stick to measure the other forms of fraud and abuse occurring within the industry. Meanwhile, treatment suffers and overdose rates
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The 24-year-old Ohio-native who came to Florida to receive this "treatment" died after that seven-month period from a Carfentanil overdose.
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Delray Beach Overdose Statistics (2016); Lake Worth Overdose Statistics (2016); Boynton Beach Overdose Statistics (2016); Zack McDonald, Bay County battles to keep opioid epidemic at bay, Panama City News Herald, Oct. 8, 2016.
8

According to the most recent national statistics, an opioid-related death occurs every 19 minutes. The introduction of Fentanyl, one hundred times more potent than morphine, and Carfentanil, an elephant tranquilizer one thousand times more potent than morphine, have made heroin even deadlier.

FDLE recently

reported a dramatic increase in opioid-related deaths throughout the state 6, and there have been 406 opioid related overdose deaths in Palm Beach County alone through October of this year. Palm Beach County Fire Rescue reported more than 3,000 instances where Narcan, an opioid antidote, was deployed. 7
The Grand Jury finds this type of epidemic to be devastating to local resources. The average cost of a Palm Beach County Fire Rescue response to an overdose is between $1,000 and $1,500. Additionally, Palm Beach County Fire Rescue spent $55,725 on Narcan for the 2015 fiscal year, and another $182,900 in 2016. First responders have also reported higher rates of post traumatic stress disorder (PTSD) based on having to deal with multiple overdose deaths on a daily basis.
To combat the proliferation of fraud and abuse in the treatment industry during the current heroin epidemic, the Grand Jury recommends a number of

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FDLE, 2015 Annual Report, Drugs Identified in Deceased Persons by Florida Medical Examiners (Sept. 2016).
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Palm Beach County Fire Rescue Narcan Use Statistics (1/1116 - 10/24/16).
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legislative and regulatory changes. The Legislature has the ability to act on these recommendations. When it comes to the business of health care, the Legislature has already made statements of intent on its ability to regulate:
[S]uch professions shall be regulated only for the preservation of the health, safety, and welfare of the public under the police powers of the state. Such professions shall be regulated when: (a) Their unregulated practice can harm or endanger the health, safety, and welfare of the public, and when the potential for such harm is recognizable and clearly outweighs any anticompetitive impact

which may result from regulation. (b) The public is not effectively protected by other means, including, but not limited to, other state statutes, local ordinances, or federal legislation. (c) Less restrictive means of regulation are not available.
§ 456.003(1), (2)(a)-(c), Fla. Stat. (2016) (emphasis added).
We find that the unregulated practices within the substance abuse treatment industry and connected business of recovery housing have harmed and endangered the health, safety, and welfare of the public and persons suffering from SUDs. We find that the potential for such harm is recognizable and clearly outweighs any anticompetitive impact that may result from regulation.

We also find that the

public has clearly not been protected by other means, and less restrictive means are not available. This Grand Jury has identified five (5) areas in need of legislative and regulatory change.
First, deceptive marketing should be strictly prohibited, and willful, intentional, and material misrepresentations should be punished with criminal

sanctions. Treatment providers should be held accountable for the conduct of the marketers they employ. Advertising for substance abuse treatment should be held to a higher standard like advertising in other health care fields, and should provide consumers with important information in the form of upfront disclaimers.
Marketing and admissions personnel who have direct contact with this vulnerable class of consumers should also be licensed and/or certified to ensure they possess minimum education, training, and experience.
Second, there should be oversight on businesses designed to provide housing and other services for persons in recovery. At the very least, oversight is needed on businesses that engage in commerce with treatment providers. This can be accomplished by: (1) requiring FARR certification and DCF licensing for certain types of commercial recovery housing, (2) prohibiting treatment providers from referring patients to any uncertified recovery residences, and (3) prohibiting treatment providers from accepting referrals from uncertified recovery residences.
Third, DCF should be adequately funded and staffed to take action against violators and perform inspections with greater depth and frequency. This can be accomplished by treating licenses as a privilege rather than a right, and by providing DCF with the resources it needs to regulate this massive industry. The Grand Jury finds that this can be done in a state revenue neutral manner by raising license and service fees.

Fourth, the patient brokering statute should be clarified and strengthened. Given the great lengths to which patient brokers have gone to creatively disguise their kickbacks as legitimate activities, the patient brokering statute should be amended to prohibit the solicitation or receipt of any "benefit" in exchange for patient referrals or acceptance of treatment. Moreover, serious crimes should have senous consequences.

The Grand Jury finds that patient brokering 1s a very

senous crime, with potentially deadly results.

Penalties for patient brokering

should be enhanced, especially when it involves large-scale brokering. Minimum fines should also be reflective of the outrageous profits made by patient brokers. Additionally, the Florida Attorney General's Office of Statewide Prosecution should be given concurrent jurisdiction with the State Attorney's Offices to assist in the prosecution of patient brokering.
Finally, the Grand Jury recommends that law enforcement be given better tools to deal with the current types of fraud and abuse.

This would include

reducing impractical privacy restrictions that prevent legitimate investigation, and promoting more education among local law enforcement agencies on both state and federal privacy laws. The Grand Jury finds that this can be achieved through better collaboration between government agencies and private business, especially

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FINDINGS AND RECOMMENDATIONS
I.

MARKETING
The Grand Jury finds that people suffering from addiction and their families

are often in an extremely vulnerable position while seeking treatment services. This vulnerable class of consumers is more prone to being victimized by deceptive marketing practices that are harmful to the recovery process. Neither DCF nor any regulatory agency, however, currently provides adequate oversight of the marketing practices of treatment providers. There is even less oversight for online marketing, which is one of the most common methods of marketing used by an industry that draws a majority of its patients from other states.
The Grand Jury has found that a number of harmful marketing practices have become standard practice in Florida's private substance abuse treatment industry. The main abuses consist of: (1) false representation of services, (2) false representation of location, and (3) real-time auctioning of patients through clearing houses, also known as "lead generators."

We heard testimony from industry

professionals with extensive experience in online marketing of addiction treatment services.

One witness demonstrated how online marketers use Google search

terms to essentially hijack the name and reputation of notable treatment providers only to route the caller to another referral agency.

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For example, 8 a person looking for treatment in Seattle types the following search terms into a Google search bar: "Drug Rehab Seattle." A marketer's listing appears in the search results as "Drug Rehab Seattle." The listing purports to be a treatment center in Seattle.

But when the person calls the number listed, the

marketer silently routes the call to one of five different customers of the marketer. Some of those customers are simply other call centers or referral services. Others might be good or bad treatment centers in Florida that have paid the marketer for the referral.
One of the problems with this practice is the monetary conflict of interest created once a "lead" is already paid for. For example, when a treatment center pays $1,000 for a lead, they are compelled to convince that caller to go to their treatment center, regardless of what the caller says or whether that particular treatment is in the caller's best interest. The level of care recommended will also be influenced by this monetary incentive.

A person calling about outpatient

treatment may be urged to get more intensive (and expensive) treatment under this scenario. The Grand Jury finds that deceptive marketing practices like these are detrimental to a patient's chances of receiving quality care and the appropriate level of care.

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These practices are also harmful to the reputation of quality

Deceptive Marketing Exhibit# 1, p.1 (2016).
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treatment providers who have worked hard to establish their reputation.
Accordingly, we make the following recommendations:
A.

Prohibit deceptive advertising

The Grand Jury recommends that materially deceptive advertising for substance abuse treatment be punishable by criminal sanctions.

We also

recommend that treatment providers be held accountable for the actions of the marketers they employ. A provider should not simply pay a flat fee to a marketing company and then look the other way while that company engages in improper conduct like patient brokering. If a marketing agent or entity violates the law, the provider who benefits from such service should be liable as well.
B.

Provide disclaimers and other useful information

The Grand Jury recommends that a marketing entity or agent must be upfront and truthful about who they are, what they do, and where they are located. At the very least, disclaimers should be made to notify patients about material information and other potential conflicts of interest. Material information would include where to report fraud and abuse (as most out-of-state consumers may not even realize that DCF is the agency that regulates substance abuse treatment in Florida) and where to find success rates on providers and recovery residences. We recommend that providers continue to keep consumers informed throughout the continuum of care by making such information readily accessible.
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C.

Require licensing for marketing and admissions

Given the vulnerability of this class of consumers, the Grand Jury finds that marketers and admissions personnel that have direct contact with current and future patients should have minimum education, training, and expenence. Marketers and admissions personnel should be licensed by DCF or certified by a credentialing agency like interventionists who provide similar services, 9 and they should be prohibited from diagnosing or recommending specific levels of care without the appropriate license or certification to do so.

At the very least,

marketing entities operating in Florida should be licensed by a Florida consumer protection agency and have a registered agent located in Florida.
II.

PATIENT HOUSING
The Grand Jury received evidence from a number of sources that recovery

residences operating under nationally recognized standards, such as those created by the National Alliance for Recovery Residences (NARR), are proven to be highly beneficial to recovery. The Florida Association of Recovery Residences (FARR) adopts NARR standards. 10 One owner who has been operating a recovery residence under these standards for over 20 years has reported a 70% success rate

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Carey Davidson, Navigating the Maze ofAddiction Treatment, TogetherAZ Blog: An Ethical Compass, Oct. 31, 2016.
10
NARR/FARR Overview; NARR Quality Standards (July 15, 2015).
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in outcomes. The Grand Jury finds that recovery residences operating under these nationally approved standards benefit those in recovery and, in tum, the communities in which they exist.
In contrast, the Grand Jury has seen evidence of horrendous abuses that occur in recovery residences that operate with no standards. For example, some

occur in recovery residences that operate with no standards. For example, some residents were given drugs so that they could go back into detox, some were sexually abused, and others were forced to work in labor pools. 11

There is

currently no oversight on these businesses that house this vulnerable class. Even community housing that is a part of a DCF license has no oversight other than fire code compliance. This has proven to be extremely harmful to patients.
The Grand Jury also received extensive testimony about many patients' financial need for housing during treatment. Detox, residential treatment, partial hospitalization (PHP), and intensive outpatient (IOP) are time-consuming levels of care, and are not conducive to working normal hours.

Even after finishing

inpatient treatment, most out-of-state, young adult patients don't have local jobs lined up or the resources to afford housing. As a result, patients receiving these levels of care are often unable to afford housing during such treatment.
Given this reality, some type of financial assistance for housing is needed.
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Susan Taylor Martin, Addicts say recovery program stole their money, Tampa Bay Times, Nov. 18, 2012.
17

Currently, this financial assistance for housing is typically paid through patient brokering. A treatment provider pays a patient's rent at a recovery residence in exchange for referring the resident to the provider for treatment. Alternatively, a provider will refer the patient to housing owned by the provider after being discharged from inpatient treatment.

Both treatment providers and recovery

residences offer incentives such as gym memberships, scooters, cigarettes, clothes, and gift cards to keep patients at a particular provider or recovery residence. Brokers known as "body snatchers" approach patients and convince them to move to other recovery residences and/or providers that offer "better stuff." The Grand Jury finds that it would be difficult, if not impossible, to eliminate these practices altogether without addressing the legitimate need for financial assistance with patient housing. Therefore, the Grand Jury makes the following recommendations:
A.

Require DCF licensure and FARR certification of commercial recovery housing, especially when connected to treatment

The Grand Jury recommends that commercial 12 recovery residences be licensed by DCF and certified by FARR. At the very least, commercial recovery residences that contract with treatment providers should be licensed by DCF and certified by FARR. Allowing providers to contract with unregulated sober homes

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Unlike the traditional "Oxford" model that has become a rarity in Florida, commercial recovery residences are for-profit businesses operated by a third party.
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is like allowing hospitals to contract with unlicensed food vendors. The safety concerns for patients are obvious.

A similar law already exists that prohibits

treatment providers from referring clients to non-certified recovery residences. See § 397.407(11), Fla. Stat. (2016).

If a treatment provider is prohibited from

referring a patient to a non-certified home, it should certainly be prohibited from hiring a non-certified home as an independent contractor to provide housing and

other treatment-related services for the patient.
One way to accomplish the oversight needed while also addressing patients'

need for financial assistance with housing would be to create a new DCF license that allows treatment providers to assist PHP and IOP patients with housing by providing a limited, needs-based scholarship for rent. The first and most important requirement for this license would be FARR certification of the housing component in addition to periodic inspections by DCF. This requirement could be waived for publicly funded providers under contract with a Managing Entity. 13 The limitations on this license would also have to be clear and strictly enforced. Patients would have to apply for the scholarship based on financial need. The scholarship would be paid directly to the licensed/certified recovery residence, would be capped at $200 per week for a maximum of 12 weeks, and could only be
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According to DCF, treatment providers that contract with the Managing Entities for public funds are held to higher standards.
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used for rent. This is not only to promote self-sufficient reintegration, but to avoid the strong economic motive to promote a cycle of unnecessary treatment and/or relapse. The Grand Jury heard testimony about countless patients who have fallen prey to this cycle of dependence and its devastating impacts on recovery. It is not uncommon for a person to be in this cycle of treatment/relapse for years. Ultimately, the scholarship amount and time limits could be periodically changed by DCF based on the standard length of time that IOP treatment is designed to last and the fair market value of rent in the area. The Grand Jury finds that this license would properly regulate commerce between the business of recovery housing and treatment while protecting the health, safety, and welfare of the patients in recovery. The Grand Jury finds that the Legislature already requires mandatory licensure for similar group housing for disabled individuals, and the reasoning behind such licensure equally applies to recovery residences. 14

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'"Assisted living facility' means any building ... which undertakes through its ownership or management to provide housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator." § 429.02(5), Fla. Stat. (2015). "'Personal services' means . .. supervision of the activities of daily living and the selfadministration of medication and other similar services ... " § 429.02(17), Fla. Stat. "'Supervision' means reminding residents to engage in activities of daily living and the self-administration of medication, and, when necessary, observing or providing verbal cuing to residents while they perform these activities." § 429.02(24), Fla. Stat. "'Activities of daily living' means functions and tasks for self care ... " § 429.02(1), Fla. Stat.
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purpose of the Assisted Living Facilities Act is:
to promote the availability of appropriate service for ... adults with disabilities in the least restrictive and most homelike environment, to encourage the development of facilities that promote dignity, individuality, privacy, and decision making ability of such persons, to provide for the health, safety, and welfare of residents ... , to promote continued improvement of such facilities, to encourage the development of innovative and affordable facilities particularly for persons with low to moderate incomes, to ensure that all agencies of the state cooperate in the protection of such residents, and to ensure that needed economic, social, mental health, health, and leisure services are made available to residents . . . through the efforts of [AHCA] [DCF], [DOH], assisted living facilities, and other community agencies.
§ 429.01(2), Fla. Stat. (2014) (emphasis added). The Grand Jury believes that disabled individuals living in recovery residences deserve the same type of protection as those living in Assisted Living Facilities or Adult Family Care Homes.
B.

Eliminate loophole that allows for patient referrals to uncertified recovery residences owned by a provider

As discussed above, the Grand Jury finds that there is a need for oversight

on patient housing during PHP and IOP treatment, which most often takes place immediately after discharge from inpatient treatment. Accordingly, the Grand Jury finds that the Legislature should eliminate the loophole found in Florida Statute section 397.407(11) that allows treatment providers to refer patients to uncertified recovery residences that they own.

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This loophole only benefits treatment providers who can afford to own patient housing in addition to an inpatient treatment center, and allows them to refer patients to non-certified recovery residences which have no DCF or FARR oversight. In other words, it allows providers to send patients to unverified and unregulated recovery residences while those patients are in their most vulnerable state of recovery (during or immediately after inpatient treatment).
This is contrary to the purpose of recently enacted section 397.407 (11), which was designed to protect patients from being referred to unregulated recovery residences. The fact that the provider happens to have an ownership interest in the uncertified recovery residence does nothing to protect this vulnerable class of disabled consumers. Therefore, we recommend that this loophole for providerowned referrals be closed.
C.

Prohibit patient referrals from uncertified recovery residences to treatment providers

Additionally, the Grand Jury heard testimony on how patient brokering most often occurs as referrals from the recovery residences to the treatment providers. As a result, we recommend that referrals from uncertified recovery residences to treatment providers be prohibited. The Grand Jury recommends amending section 397.407(11), Fla. Stat. as follows:
Effective July 1, WM 2017, a service provider licensed under this part may not refer a prospective, current or discharged patient to.1
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or accept a referral from, a recovery residence unless the recovery residence holds a valid certificate of compliance as provided in s. 397.487 and is actively managed by a certified recovery residence administrator as provided in 397.4871 or the recovery residence is owned and operated by a licensed service provider or a licensed service provider's wholly owned subsidiary. For purposes of this subsection, the term "refer" means to inform a patient by any means about the name, address, or other details of the recovery residence. However, this subsection does not require a licensed service provider to refer any patient to a recovery residence. This section shall not apply to publicly funded treatment providers, licensed by the Department and under contract to .a Managing Entity.
III.

ENABLE DCF TO TAKE ACTION
The Grand Jury heard testimony from a number of industry professionals on

the inability of DCF to take swift and reasonable action when faced with blatant violations of both DCF regulations and criminal law.

Expensive and time-

consuming procedures like a Chapter 120 administrative hearing are required before DCF can suspend or revoke a license. At best, a treatment provider found in violation of regulations will negotiate a voluntary withdrawal of their license, but then be able to immediately reapply for a new license with no time limit or higher level of scrutiny.

We find that DCF's difficulties in taking reasonable

action stems from the fact that a license to provide substance abuse treatment is treated as a right, rather than a privilege.

This prevents DCF from acting

efficiently for the benefit of the patients who are being exploited and abused across the board. We believe a license for substance abuse treatment should be treated the

same as a license in other health care fields.
The Grand Jury also received extensive testimony and evidence about DCF' s lack of resources. 15 As of August 31, 2016, there were 931 substance abuse treatment providers licensed in Florida, holding 3,417 separate component licenses. The Southeast Region (Palm Beach, Broward and the Treasure Coast) had 321 licensed providers, holding 1,307 component licenses. From April-July, 2016, the Southeast Region alone received 241 Provider Application Packets for the licensure of 606 program components (63 from new providers).
The Southeast Region currently has only 9 licensing specialists. The total number of licensing specialists in the 6 state regions combined is 25. Licensing specialists also have the duty and obligation to perform any monitoring of programs in addition to processing licenses and license renewals. The Grand Jury also heard testimony that these same licensing specialists routinely leave DCF to make more money by working for treatment providers. The Office of Inspector General (OIG) is tasked with providing support, but they also have inadequate resources. Overall, DCF is grossly understaffed and underfunded to regulate this billion-dollar industry.

Therefore, the Grand Jury makes the following

recommendations:

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DCF Response to Sober Homes Task Force Request (Sept. 13, 2016).

A.

Treat license as a privilege instead of a right

The Grand Jury recommends treating the issuance of a license for substance abuse treatment a privilege, rather than a right. This can be done by adopting the language used in the Assisted Living Facilities Act, which states: "The principle that a license issued under this part is a public trust and a privilege and is not an entitlement should guide the finder of fact or trier of law at any administrative proceeding or in a court action initiated by the Agency for Health Care Administration [AHCA] to enforce this part." § 429.01(3), Fla. Stat. (2016). Doing so would allow DCF to adopt a system similar to that used by AHCA, with greater ability to monitor as well as license. For example, anyone can open a substance abuse treatment center. If licenses were treated as a privilege, DCF could require reasonable qualifications for ownership and administration of treatment facilities. Treating licenses as a privilege would also allow DCF greater flexibility to deny or delay the issuance of licenses where there are compliance concerns. The Grand Jury further recommends whenever a license is revoked or surrendered, re-application should require a minimum waiting period and greater scrutiny.
Finally, the Grand Jury heard testimony that an unlimited number of treatment providers have been allowed to open in a given geographical location which has created a supply of treatment services that far outweighs demand. The

Grand Jury heard testimony about how this imbalance in supply and demand encourages patient brokering, poaching, and other forms of abuse by bad actors in the industry. If licenses were treated as a privilege, DCF could counteract this problem by requiring a certificate of need for new treatment facilities to open. The Grand Jury finds that this practice is already done in other health care fields and would be beneficial to the substance abuse treatment industry as well.
B.

Provide better resources by raising licensing and service fees

The Grand Jury finds that DCF's current resources for regulating the substance abuse treatment industry are grossly inadequate. Given the volume of providers, DCF clearly needs more staff and training to achieve meaningful oversight. This can be accomplished in a revenue neutral way. Licensing and service fees should be increased to reflect the lucrative profit margin of a typical treatment provider. Likewise, the Grand Jury has received evidence that FARR,

much like DCF, is grossly underfunded and understaffed to accommodate the needed oversight of recovery residences throughout the State of Florida. Therefore, we recommend that FARR be adequately funded as well by increasing certification and service fees.

Alternatively, if raising fees for both DCF and

FARR are unable to adequately fund the oversight needed for this industry, we urge the Legislature to consider appointing another health agency such as DOH or AHCA to regulate substance abuse treatment.
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IV.

STRENGTHEN PATIENT BROKERING STATUTE
Anti-kickback statutes like Florida's patient brokering statute are designed to

prevent healthcare fraud and abusive practices resulting from provider decisions that are based on self-interest rather than cost, quality of care, or necessity of services. See United States v. Patel, 778 F.3d 607, 612 (7th Cir. 2015). These statutes are also designed to "protect patients from doctors whose medical judgments might be clouded by improper financial considerations." See id.
The Grand Jury heard testimony from victims and families who have been devastated by patient brokering. The Grand Jury also heard testimony from a number of industry professionals who have seen the negative · impacts of patient brokering on recovery. We find that patieht brokering is extremely harmful to recovery, and such practices during the current heroin epidemic have contributed to the exhaustion of public resources, an increase in overdoses, and death. The public has a vested interest in eliminating patient brokering and making sure persons with SUDs are treated successfully.
The Grand Jury also heard testimony from industry professionals who have openly stated that patient brokering is the standard, not the exception, in Florida's substance abuse treatment industry. Over the years, different ways of covering up kickbacks have been developed, such as "case management" contracts between treatment providers and recovery residences. Brokers hide kickbacks in many
27

different ways, such as luxurious amenities, cigarettes, plane flights, scooters, vacations, and gift cards. To combat this elusive and devastating practice, the Grand Jury makes the following recommendations:
A.

Prohibit the solicitation or receipt of any "benefit"

The Grand Jury recommends that Florida's patient brokering statute, § 817.505, Fla. Stat. (2016), be amended to prohibit the solicitation or receipt of any "benefit" in exchange for referring patients to, or accepting treatment from, a particular treatment provider. This would put both patient brokers and legitimate industry professionals on notice that any inducement or reward for the referral or acceptance of patients is clearly prohibited.
B.

Increase criminal penalties and minimum fines

Currently, patient brokering is a third degree felony of the lowest level under the Criminal Punishment Code with no minimum fine. See 817.505(4), Fla. Stat. Given the devastating effects of this crime, the Grand Jury recommends that patient brokering be raised from a level 1 to a level 5 felony. The Grand Jury also recommends that offenders be ordered to pay minimum fines that reflect the high profits of patient brokering.

28

Between California and Florida 16, the average referral fee for a new patient can easily run up to $5,000. A typical patient broker can make up to $500 per week for every patient sent to a provider.

Brokers with multiple recovery

residences make up to $10,000 per week. Currently, there is no minimum fine for patient brokering, no matter how many counts are charged. Meanwhile, there is

currently a minimum $500,000 fine for unlawfully possessing 25 grams or more of oxycodone. See § 893.135(1)(c)3.c., Fla. Stat. (2016). Minimum fines like this should be mandated to provide enough financial deterrent to those who make hundreds of thousands of dollars a year from brokering multiple patients.
C.

Create penalty enhancement for large-scale brokering

For large-scale patient brokering, involving 10 or more patients at a time, the penalty should be increased to a second degree felony, level 7. For large-scale brokering, involving 20 or more patients, the penalty should be increased to a first degree felony, level 8. Recidivist brokers who continue to broker patients should likewise face enhanced penalties. Similar penalty enhancements can also be found in the identity theft statute. See§ 817.568, Fla. Stat. (2016).
D.

Add brokering to Statewide Prosecution's jurisdiction

Currently, patient brokering is not defined as racketeering activity under the
16

According to one out-of-state industry professional, Palm Beach International Airport is infamous for having patient brokers trolling for new arrivals.
29

RICO statute. See§ 895.02(8)(a), Fla. Stat. (2016). As discussed above, however, patient brokering routinely involves fraud (in disguising kickbacks) and is utilized by those committing other forms of healthcare fraud. As recently observed by the Eleventh Circuit, defendants commit fraud, like falsifying records to justify ordering more than what is necessary to enhance the amount of kickbacks. See

United States v. Vernon, 723 F.3d 1234, 1241 (11th Cir. 2013). Specifically, the Grand Jury received evidence on how kickbacks are increased by billing for unnecessary UA confirmatory and quantitative testing.
The Grand Jury heard testimony from the Florida Attorney General's Office of Statewide Prosecution, which is designed to handle prosecutions of multi-county organized fraud schemes such as this. Statewide Prosecution, however, currently does not have jurisdiction to prosecute patient brokering despite the resources and desire to do so. Accordingly, we recommend that the RICO statute be amended to include patient brokering as a predicate offense, and to amend Florida Statute section 16.56, to give the Office of Statewide Prosecution concurrent jurisdiction with the State Attorney's Offices over patient brokering so that they can assist local law enforcement agencies in the investigation and prosecution of these fraudulent criminal enterprises throughout the state.

30

V.

ENABLE LAW ENFORCEMENT TO TAKE ACTION
The Grand Jury heard testimony from law enforcement with extensive

experience in the field of health care fraud.

One of the biggest hurdles to

investigations in this industry is that the victims of patient brokering (the patients themselves) rarely report these crimes.

In many cases, patients are complicit

because they receive free rent, amenities, and other benefits from engaging in the crime. Moreover, many out-of-state young adult patients have a mistrust of police to begin with.
We also heard that state officials, along with members of the FBI and United States Attorney's Office, have conducted investigations into a number of treatment providers and recovery residences. In doing so, they found that there are privacy laws specific to mental health and substance abuse treatment that are extremely burdensome and impractical in their application. Law enforcement officers face criminal penalties for violating these laws. See 42 C.F .R. § 2.4. One of the most onerous restrictions requires notification for the disclosure of patient records, which could compromise the integrity of ongoing investigations.

As a general matter, confidentiality is paramount to the integrity of an ongoing criminal investigation.

When criminals realize they are being

investigated, they take measures to evade prosecution. Thus, notification of an investigation to the suspected criminals or to persons that would likely advise those
31

criminals of the investigation is harmful to the investigation itself.

Currently,

courts have full discretion whether or not to require patient notification. 42 C.F.R. § 2.66(b).
Under state law, the timing of patient notification is less clear.

Section

397.501 states that protected parties must be given "adequate notice" whenever disclosure is sought. See§ 397.501(7)(h), Fla. Stat. (2016). "Adequate notice" is not defined anywhere in Chapter 397. The State has argued that section 397.501 incorporates the federal confidentiality regulations found in 42 C.F.R. §§ 2.1-2.67, and under those federal confidentiality regulations, "adequate notice" does not mean "prior notice."

At least one Palm Beach County judge has rejected this

argument and refused to authorize disclosure of records without first notifying all protected parties. As a practical matter, the State cannot give notice to patients before the State knows who those patients are, and the State would be violating privacy rights by seeking out information that identified anyone as a patient without prior authorization.

Accordingly, the Grand Jury makes the following

recommendations:
A.

Reduce impractical privacy restrictions on investigation

The Grand Jury recommends that section 397.501(7)(h) expressly permit disclosure of patient records without prior notification under the same circumstances found in section 42 C.F.R. § 2.66(b). This strikes a fair balance
32

between the privacy rights of patients and the need for law enforcement to investigate crimes that are being committed against those same patients.
B.

Promote education and inter-agency collaboration

The Grand Jury also finds that most local law enforcement agencies are lacking in education on how to navigate the many federal and state privacy laws in this industry. Therefore, the Grand Jury recommends more training and education of local law enforcement on how to properly comply with federal and state privacy laws in the course of their investigations.

Agencies like DCF, DOH, AHCA,

FARR, and local law enforcement need to have better protocols in place for sharing information and working together on these types of investigations in the substance abuse treatment industry.
CONCLUSION
The Grand Jury finds a compelling and urgent need for both increased oversight and enforcement in Florida's substance abuse treatment industry. The problems outlined in this report exist throughout our state and continue to spread throughout the country. Although there is no simple answer to these complex problems, we believe our recommendations provide a step in the right direction and can be implemented without any negative fiscal impact on state resources.
The Grand Jury strongly urges the Legislature to consider the recommendations in

this report and take appropriate action before these problems worsen.
-33

SUMMARY OF RECOMMENDATIONS

> Prohibit deceptive advertising and punish with criminal sanctions.
>

Require disclaimers that notify patients and families about material information.

> Require marketers and admissions personnel to be licensed.
> Require

DCF license and FARR certification for commercial recovery
residences, especially those that contract with treatment providers.

> Eliminate

loophole that allows for patient referrals to uncertified recovery
residences owned by a treatment provider.

> Prohibit treatment providers

from accepting patient referrals from uncertified

recovery residences.

> Treat license as a privilege rather than a right.
> Require credentials such as a background check for owning a treatment center.

> Require certificate of need for new treatment providers.
>

Provide adequate resources to DCF and FARR by raising fees.

>

Amend § 817.505, Fla. Stat. to prohibit the solicitation or receipt of any
"benefit" in exchange for referrals or treatment.

> Increase criminal penalties and minimum fines for patient brokering.
> Create penalty enhancements for large-scale patient brokering.
> Enable the Office of Statewide Prosecution to prosecute patient brokering.
>

Amend§ 397.501(7)(h), Fla. Stat. to allow disclosure of patient records without
prior notification under the same circumstances as found in 42 C.F.R. § 2.66(b).

> Educate local law enforcement on privacy laws and promote better inter-agency
collaboration.
34

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DISTRIBUTION REQUEST

The Grand Jury requests this Presentment and Report be furnished to the following:

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Honorable Rick Scott, Governor
Honorable Jeff Atwater, Chief Financial Officer
Honorable Pam Bondi, Attorney General
Honorable Joe Negron, Senate President
Honorable Steve Crisafulli, House Speaker
Honorable Jeff Clemens, State Senator
Honorable Bobby Powell, State Senator
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Honorable Ric L. Bradshaw, Palm Beach County Sheriff
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Honorable Mike Carroll, Dept. of Children and Families Secretary
Honorable Drew Breakspear, Office of Financial Regulation Commissioner
Honorable Dr. Celeste Philip, Dept. ofHealth Surgeon General
Honorable Justin Senior, Agency for Health Care Administration Interim Secretary

Honorable Justin Senior, Agency for Health Care Administration Interim Secretary
Honorable David Altmaier, Office of Insurance Regulation Commissioner
Honorable Rick Swearingen, Florida Dept. of Law Enforcement Commissioner
Honorable Barbara Palmer, Agency for Persons with Disabilities Executive Director
Verdenia C. Baker, Palm Beach County Administrator
Richard Radcliffe, Palm Beach County League of Cities Executive Director
Christina Henson, Palm Beach County Criminal Justice Commission

CERTIFICATE OF PRESENTMENT

The Grand Jury respectfully submits this Presentment this _ _ _ day of December, 2016.

As authorized and required by law, we have advised the Grand Jury returning this presentment.

I, DAVID ARONBERG, State Attorney and Legal Advisor, Palm Beach County Grand Jury - Fall Term 2016, hereby certify that I, as authorized and required by law, have advised the Grand Jury which returned this report on this _ _ _ day of ,2016.

DAYID ARONBERG
State Attorney, Fifteenth Judicial Circuit of Florida
Legal Advisor
Palm Beach County Grand Jury, Fall Term 2016

I, ALAN JOHNSON, Chief Assistant State Attorney and Legal Advisor, Palm Beach County Grand Jury - Fall Term 2016, hereby certify that I, as authorized and re · ed by law2!Q: ~~sed the Grand Jury which returned this on thi day of -M L ·, 2016.

ALAN JOHNSON
Chief Assistant State Attorney
Legal Advisor
Palm Beach County Grand Jury, Fall Term 2016

I, BRIAN L. FERNANDES, Chief Assistant State Attorney and Legal Advisor, Palm Beach County Grand Jury - Fall Term 2016, hereby certify that I, as authorized and required by law, have advised the Grand Jury which returned this S: a_day of ~' --1.-- , 2016. report on this

BRI
L. FERNA
Chief Assistant State f\.ttorney
Legal Advisor
Palm Beach County Grand Jury, Fall Term 2016

I, JUSTIN CHAPMAN, Assistant State Attorney and Legal Advisor, Palm Beach County Grand Jury - Fall Term 2016, hereby certify that I, as authorized and re_quired by law, have advised the Grand Jury which returned this report on this f3"\1!. day , 2016.

Legal Advisor
Palm Beach County Grand Jury, Fall Term 2016

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35

Todays Date 8/3/2016
YTD - 1/1/2016 - 7/31/2016
Total Overdoses - 189 (Including 15 of which resulted with Deaths)

Entered as Crimes	Entered as Non-Crimes	
January		9
February		14
March		30
April		15
May		5
June		0
July		0
TOTAL		73

Total OD's for the Month	Overdoses that Resulted with Deaths
0	1
2	26
17	28
42	116

Month End Summary

(Death #'s are included in Overdose Totals)

(Total CD's/Total Deaths)

9	15
32	41
22	

28
42

0
1
2
1
2
3
6

(9/0}
(15/1)
(32/2)
{41/1)
(22/2)
(28/3)
(42/6)

189

15

(189/15}

Todays Date 7/28/2016
YTD - 1/1/2016 - 7/28/2016
Total Overdoses - 180 (Including 12 of which resulted with Deaths)

Entered
Entered as
as Crimes Non-Crimes
January
February
March
April
May
June
July
(1st-28th)

TOTAL

Total OD's for
the Month

Overdoses that
Resulted with Deaths

Month End Summary

(Death #'s are included in
Overdose Totals)

(Total CD's/Total Deaths)

14
30
15
5
0

0
1
2
26
17
28

9
15

32
41
22
28

0
1
2
1
2
3

{9/0)
(15/1)
(32/2)
(41/1)
(22/2)
(28/3)

0
73

33
107

33

3

(33/3)

180

12

(180/12)

9

Todays Date 8/3/2016
YTD - 1/1/2016 - 7/31/2016
Fatalities From Overdoses - 15
Deceased
(Last
Name/First Name)

Case#

Date/Time

Type/Offense

FEUCHT MIKAYA

16042127

7/30/2016 22:16

DEATH OVERDOSE

Location
THE INN AT BOYNTON BEACH/
480 W BOYNTON BEACH BLVD
tMnQ

STENSON CHRISTOPHER

16042061

7/30/2016 16:20

DEATH OVERDOSE

DEATH OVERDOSE

2724 SW 23RD CRANBROOK DR

ROMEO ANDREW

16041992

7/30/2016 8:08

DEATH OVERDOSE

BORNEMAN DANIEL

16040852

7/23/2016 19:05

DEATH OVERDOSE

HERMAN DUSTIN

16040349

7/21/2016 9:48

DEATH OVERDOSE

3469 S FEDERAL HWY #G

FISHEL RYAN

16039634

7/17/201615:17

DEATH OVERDOSE

105 N BROUGHTON CIR

GAUTHIER EDWARD

16035831

6/27/201618:51

DEATH OVERDOSE

1305 VIA DE PEPI

DAY CHRISTOPHER

16035410

6/25/2016 11:24

DEATH OVERDOSE

220 SE 3RD AVE

BURRUANO MICHAEL

16031007

6/3/2016 11:06

DEATH OVERDOSE

THE INN AT BOYNTON BEACH/
480 W BOYNTON BEACH BLVD

1811 RENAISSANCE COMMONS

BLVD #419
LAS VENTANAS NORTH TOWER
/ 1331 S FEDERAL HWY #216

ltl 1 R

THE INN AT BOYNTON BEACH/
MORA MERYL

16027178

5/14/2016 16:33

DEATH OVERDOSE

DOUGLAS PATRICK

16024735

5/2/2016 12:47

DEATH OVERDOSE

RICE TAYLOR

16021189

4/14/2016 17:37

DEATH OVERDOSE

MC GETIIGAN DENNIS

16017458

3/27/2016 19:06

DEATH OVERDOSE

LABONTE THOMAS

16017453

3/27/2016 18:27

DEATH OVERDOSE

MOLYNEUX MICHAEL

16010741

2/24/2016 15:36

DEATH OVERDOSE

480 W BOYNTON BEACH BLVD
#321
HAMPTON INN/ 1475 W
GATEWAY BLVD #225
315 NW 4TH ST
1410 VIA DE PEPI
ADVANCE TIRE WHOLESALE/
3630 QUANTUM BLVD
533 SE 28TH Cl R

Todays Date 7/28/2016
VTD - 1/1/2016 - 7 /28/2016
Fatalities From Overdoses - 12
Deceased
(Last Name/First Name)

Case#

Date/Time

Type/Offense

Location

16040852

7/23/2016 19:05

DEATH OVERDOSE

TOWER/ 1331 S FEDERAL

LAS VENTANAS NORTH
BORNEMAN DANIEL

HWY#216
HERMAN DUSTIN

16040349

7 /21/2016 9:48

DEATH OVERDOSE

3469 S FEDERAL HWY #G

FISHEL RYAN

16039634

7/17/201615:17

DEATH OVERDOSE

105 N BROUGHTON CIR

GAUTHIER EDWARD

16035831

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DEATH OVERDOSE

1305 VIA DE PEPI

DAY CHRISTOPHER

16035410

6/25/2016 11:24

DEATH OVERDOSE

220 SE 3RD AVE
THE INN AT BOYNTON

BURRUANO MICHAEL

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6/3/2016 11:06

DEATH OVERDOSE

BEACH / 480 W BOYNTON
BEACH BLVD #118

THE INN AT BOYNTON .

MORA MERYL

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5/14/2016 16:33

DEATH OVERDOSE

BEACH / 480 W BOYNTON
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DOUGLAS PATRICK

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DEATH OVERDOSE

HAMPTON INN /1475 W
GATEWAY BLVD #225

RICE TAYLOR

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4/14/2016 17:37

DEATH OVERDOSE

315 NW 4TH ST

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DEATH OVERDOSE

1410 VIADE PEPI

LABONTE THOMAS

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DEATH OVERDOSE

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ADVANCE TIRE WHOLESALE

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TogetherAZ Blog

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Monday, October 31, 2016

An Ethical Compass
Navigating the Maze of Addiction Treatment
By Carey Davidson. MAC, GIP. ICADAC, CAI
At two years sober. I thought I had all the answers. I was heavily involved in my 12 step program and felt incredibly confident in my
recovery. I started to gain notoriety in the recovery community, and when people were in crisis, they knew I was a solid resource to
whom they could turn for help . I was, and still am- passionate about confronting the disease of addiction.
"Why not? ,'' I thought. So, I did it. I printed up cards and called myself an "Interventionist."!! was easy. I recalled when applying for my
real estate license, I was required to be finger printed and participate in a background check. However, all.I needed to do to guide
vulnerable patients and their often desperate families through this life-threatening disease was print up a card .
Without the proper training and certification, I had only one tool- my own recovery experience. I placed many people in treatment,
but I'll never know the extent of damage I may have caused families along the way.

Luckily, after a couple of tough cases in a row. I realized my approach , while legal and extremely common in the field, was not in the best interest of those I served .
Families depended on me to guide them and their loved ones into recovery. The course of their lives would be significantly impacted
.by my gu idance, and the work I had done in my personal recovery program ·could never substitute for the formal education and
clinical training I knew I needed'.
Consequently, I enrolled in the Hazelden Betty Ford Graduate School of Addiction Studies. where on the first day they inform you : "If
you are looking to get your Masters in the 12 steps, you 're in the wrong place ."
To fulfill my passion to helping others I went back to school and earned a Masters Level degree in addiction studies and counseling,
which included rigorous academics and more than 1,200 clinically supervised hours working with patients. I dedicated myself to
education because, although my passion for this field hadn't changed, my responsibilities to struggling families extended far beyond a
simple desire to help people. If I was going to offer myself as a credible resource to the vulnerable. I had to become a trained
professional with a solid clinical background.

One key difference between a trained professional and a layperson is that a layperson works solely from personal
experience and a professional works from an empirically-evidenced theory.

The Families of those in Need
While I can never "undo" what has been done. I have had to own some difficult truths as I've moved forward in the field. I now find
myself hyperaware of the many untrained interventionists around me who, unfortunately, continue to do. harm.
Family can be the most powerful and motivating force in an individual's life. Those traits, amplified in crisis, can be a family's greatest
asset or liability. There are those in this industry who capitalize on this vulnerability in an unethical manner. It is essential families are
able to place their trust in capable, educated, and accountable specialists.
However, because the behavioral health field is so vast, multi-faceted, and unregulated , it's difficult to know where to begin . Let this
article serve as an ethical compass for you to use when navigating the treatment world.

article serve as an ethical compass for you to use when navigating the treatment world .

Questionable Treatment Placement Practices
The point at which your life, or life of someone close to you becomes too unmanageable to handle alone feels unprecedentedly
vulnerable and frightening to most families. You want to trust anyone who promises a treatment or. in some cases. even a miracle
cure. Because you want so desperately to believe what these self-proclaimed "professionals" say, your judgment can understandably
become impaired .

http://stories.togetheraz.com/2016/10/an-ethical-compass.html?m=1

11/8/2016

It is crucial everyone be aware of the many questionable treatment placement practices that currently exist in the U.S. The 2008
Parity Act and Obamacare made treatment for mental health and substance use more accessible for millions of people.
Consultants, patient brokers, marketers, treatment placement specialists, and other creative professions surged, often, without formal
training for those espousing these titles. While these workers are called different names, they serve the same function: to put "heads
in beds." They are people who, t.hrough one method or another, receive kickbacks for getting a patient into a particular facility . These
so-called professionals make their money directly by placing someone into a specific treatment program who pays them a "bounty ," a
"marketing fee," or "reward" for "placing" the person with them . "Patient Brokers," in effect, broker lives for cash .

Interventionists and Treatment Professionals
My intent is not to discredit the challenging and indispensable work of interventionists (or anyone else working in the field). After all, I
am one. I married one . However, it is crucial to know there are individuals without any formal behavioral health education, certification ,
license or clinical tra ining who claim to be "interventionists" or "addiction specialists" that "work" in the addiction field . This is
dangerous. Just because a person has been through recovery and/or has watched every season of Intervention on A&E, it does not
follow they are qualified to be an Interventionist. While unfortunately legal, it is as reckless as watching Grey's Anatomy, buying an
ambulance, and calling oneself an EMT.
When co:isidering employing the services of an interventionist , or ANY TREATMENT "PROFESSIONAL" involved in recommending a '
treatment program and involved with patient care , questions must be asked to ensure you find yourself in capable , educated, and
ethical hands.
What is the professional's relevant education? What are their certifications? Does any board license them? How long have they been
doing what they do? What qualifies them to make recommendations?
For example, if an interventionist is not able to identify and specifically describe what they do or the intervention modalities they
believe would be most effective and why, do not hire them .
If a person who is recommending a treatment center can't give clear criteria as to why they are recommending a particular center, find
out more. Ask if anyone receives any kind of financial compensation or incentives for referrals and/or placement.
Just because someone calls themselves a "professional addiction whatever," does not mean their decisions are not financially
incentivized.

"Kickbacks" have become rampant in the intervention world and can prevent a person from being placed in a program
that's best fit for their needs. Kickbacks can be in the form of money, gifts, or anything that would encourage someone to
recommend one program over another in exchange for compensation .

A Parallel Situation

Your doctor tells you he has discovered a potentially life-threatening tumor in your brain and surgery is required . You panic. You don't know anything about neurology, let alone a good neurologist or neurosurgeon with experience in tumor removal. You want the best option available, so you ask your doctor to recommend the best neurosurgeon in town.
He or she knows of two neurosurgeons who specialize in the type of procedure that could save your life. One does a decent job, but has recently settled a malpractice suit. Due to the lawsuit, this surgeon's referrals have decreased and he's mentioned he would be willing to give your doctor a 'cut of the profits' for any surgery sent his way. The other neurosurgeon is highly respected - one of the best in the field. Her schedule is often full and services are in high demand, but your doctor has a good relationship with her and knows he can ask her to find time to perform the procedure.
Your doctor writes down the name and office number of the first neurosurgeon and tells you, with a reassuring smile, he's the better option. You walk out of his office unaware your wellbeing was just compromised for financial gain.

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This scenario seems almost too ridiculous to take seriously, but why is that? First, this is a violation of Stark Law (starklaw.org) .
Second , it's difficult to fathom a medical professional would compromise the quality of a life-saving decision because of money. Why is mental health and substance abuse any different if we are, in fact, treating a disease?
This happens to families every day. Most states do not have equivalent laws for non-professionals working in the behavioral health field, and those that do rarely enforce them.

Who is paying the Addiction Treatment Professional?
If someone offers their services at no charge, more often than not, this is a red flag .

If someone isn't asking you to compensate them for their seNices, this often means someone else is. They are fully employed, contracted, or financially incentivized by a specific facility, and they have a professional and monetary obligation or "motivation" to recommend clients to a specific program(s).
An independent professional depends upon being fairly compensated or will not mind telling you how they are compensated if it is other than by patients. A best practice wo~ld be to use independent professionals are compensated directly by the families they serve.
Again, I implore you to do your homework. These questions may seem blunt, but a professional worth hiring will not get defensive, will answer directly, and will appreciate your asking.

Levels of Care
Addiction treatment has its own vocabulary, often difficult to decode and understand. There are so many acronyms it often sounds like you're listening to a two-way radio in a police car: IOP, residential treatment, PHP, sober living, OP, extended care, transitional living, day treatment, peer driven care, half way house, gender specific, dual diagnosis, SA, NA, ACOA, trauma informed care, and the list goes on.
Even if you are in a best-case scenario and are sitting across from an ethical professional who is giving you excellent treatment options, it can still feel impossible to make a decision when you don't understand the language. Furthermore, how can you accurately assess the quality of seNices when you have no frame of reference for what the baseline should be?
The following is an overview of levels of treatment care. You can determine how they are differentiated in greater detail by

researching the American Society of Addiction Medicine (www.asam.org) and identify the differences and approaches in each level of
care.

Medically-Managed Intensive Inpatient Services:
This most frequently takes place in the "psych ward" within a hospital setting. If a person has had a suicide attempt, is found to be of
harm to themselves or others and placed on a mandatory hold, or has experienced a psychotic break, this is where they will be
admitted, stabilized and then transported to another facility.

Medically-Monitored Intensive Inpatient Services
Takes place in a residential treatment setting, provides 24 hour care monitored by nurses, physicians, and credentialed clinicians. In
layman's terms, this is what allows some residential programs to be able to provide a safe medical detox program on the same
campus where they provide a residential program. Once a person has been medically cleared and clinically stabilized, they are
phased down to the next level of care.

Clinically-Managed, High Intensity Residential Services
A 24 hour, structured environment. Again, changing levels of care does not always mean changing a physical location. It is entirely
possible to have three levels of care provided within the same campus. The distinctive element to this level of care is that it is nonmedical and clinically managed. The programming provided is focused on maintaining abstinence from substances, delivering
intensive therapy, and developing the skills necessary to accept responsibility and promote positive character change.

Clinically-Managed, Medium-Intensity Residential Services
This is also known as extended care and is used to bridge the gap from an intensive therapy schedule in a residential setting to an
intensive outpatient program (IOP). It maintains a level of care, but with a lesser amount of therapeutic programming.

Partial Hospitalization (PHP)
If someone is enrolled in a Partial Hospitalization (PHP), they require daily monitoring. A person can participate in a PHP while also
living in an extended care facility or sober living home.

Intensive Outpatient Programs (IOP)
Intensive outpatient programs (IOP) requires nine or more hours of structured counseling and education services per week.
Psychiatric and medical services can be scheduled in addition to programming but are used as needed. This level of care can be
utilized at the same time a person is living in a sober living environment. It is best practice for this level of care to follow residential
treatment.

Outpatient Treatment Services
To be designated Outpatient Treatment Services, clinical interaction falls to a level of fewer than nine contact hours per week.

Low-Intensity Residential Services

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OFFENDING COMMAND:

Recovery Residence Report
Fiscal Year 2013-2014 General Appropriations Act
The Office of Substance Abuse and Mental Health
October 1, 2013

 TABLE OF CONTENTS

I.

Summary

2

I. SUMMARY

The 2013-2014 General Appropriations Act (GAA) directed the Department of Children and Families (Department) to submit a report to the legislature by October 1, 2013 about recovery residences in the
state of Florida.
In summary:

- Studies completed by Connecticut, Massachusetts and Hawaii, found that recovery residences are not treatment providers, instead offer housing services to residents .
- There is not a valid methodology, in Florida or the nation, to estimate the number of recovery residences.
- This has been a litigious issue in federal court, because of the federal Fair Housing Act and the
Americans with Disabilities Act.
- local government officials from South Florida expressed frustration as to the regulation of sober
homes in their comments related to public input.
- Public comment included a variety of concerns:
  - o The perception and impact of recovery residences in their neighborhoods;
  - o The risk for the people in recovery; and
  - o The lack of governmental oversight.
- Research suggests that recovery residences may be a valuable component of a community based recovery maintenance system for substance use disorders.

3

II. INTRODUCTION

The 2013-2014 General Appropriations Act (GAA) directed the Department of Children and Families (Department) to develop a plan to determine whether sober homes should be licensed or registered:

From the funds in Specific Appropriations 370 through 380, the department shall develop a plan to determine whether to establish a licensure/registration process relating to residential facilities that provide managed and peer-supported, alcohol-free and drug-free living environments for persons recovering from drug and alcohol addiction, commonly referred to as sober homes. This plan shall identify the number of sober homes operating in Florida, identified benefits and concerns in connection with the operation of sober homes, and the impact of sober homes on effective treatment of alcoholism and on sober house residents and surrounding neighborhoods. The department shall also examine the feasibility, cost, and consequences of licensing, regulating, registering, or certifying sober homes and their operators. The department shall consult with interested parties, including, but not limited to, the Florida Alcohol and Drug Abuse Association, local governments, stakeholders in the chemical abuse treatment community, and operators of sober houses. The plan shall be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives by October 1, 2013. 1

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Ch. 2013-040, L.O.F.

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Ill. GENERAL APPROACH

Sober houses are also known by a variety of names, including; sober living homes, community residences, group homes, halfway houses, recovery residences, or alcohol and drug free housing. These
2
terms are considered synonymous and used interchangeably. For the purposes of this report, the Department has used the term recovery residence.

To receive public input, the Department held public meetings and established an online portal to collect
public feedback. The Department also consulted with interested parties, including the Florida

public feedback. The Department also consulted with interested parties, including the Florida Alcohol
and Drug Abuse Association (FADAA), Florida Association of Recovery Residences (FARR), the Florida
league of Cities (FLC), the Florida Association of Counties (FAC), substance abuse treatment providers,
local governments, owners and operators of recovery residences, and concerned citizens.
To provide a framework to encourage public response, the Department posed the following questions
on its website:

- Should recovery residences be regulated?
- How many recovery residences operate in Florida? What is your methodology for arriving at this number?
- What would be the feasibility, cost and consequence of licensing, regulating, registering, or certifying recovery residences and their operators?
- If there were to be a regulating body, what is the appropriate level of government for it to operate at?
- What should be included in any regulatory framework for a recovery residence?
- Are there any other issues that need to be addressed?

The Department received input from a broad cross section of Florida, including both professional and
private individuals. All public comment is included in this report, both in summary and raw form.

When citing other sources, an attempt is made to use the terminology used by the original authors.

IV. What is a Recovery Residence?

There is no universally accepted definition of a recovery residence, and as such is subject to interpretation. 3 However, researchers have proposed the following essential characteristics of a
recovery residence:

- An alcohol and drug-free living environment for individuals attempting to establish or maintain abstinence.
- No treatment services offered on site, but attendance at self-help groups such as Alcoholics Anonymous and Narcotics Anonymous may be either mandated or strongly encouraged.
- Compliance with house rules. 4
- Resident responsibility for paying rent and other costs.
- No limitations on length of stay as long as residents comply with house rules. 5

These characteristics help distinguish recovery residences from other housing options. For example,
unlike most halfway houses, which receive government funding and limit the length of stays, recovery
residences are financially self-sustaining through rent and fees paid by residents and there is no limit on
length of stay for those who abide by the rules. 6 Furthermore, unlike "wet housing" where residents are
allowed to consume alcohol or other drugs and "damp housing" that discourages but does not exclude
individuals for consuming, recovery residences are abstinence-based environments where consumption
7
of alcohol or other drugs results in eviction .
Other states undertaking similar studies, attempted to define what a recovery residence is in the
context of their respective jurisdictions. A common presentation is the distinction between licensed

substance abuse treatment facilities, and a recovery residence as a housing solution for people in
recovery .
A 2009 Connecticut study noted the following; "Sober houses do not provide treatment, [they are] just a
place where people in similar circumstances can support one another in sobriety. Because they do not
provide treatment, they typically are not subject to state regulation." 8
The Alcohol and Drug Abuse Division of Hawaii's Department of Health recommended the following
definition in a recent Task Force report; "(A] (c]lean and sober home" means a dwelling that is designed
to provide a stable, independent environment of alcohol and drug free living conditions to sustain

3

See e.g., K. Paquette, N. Greene, L. Sepahi, K. Thom, and L. Winn, Recovery Housing in the Stote of Ohio: Findings from an
Environmental Scan, (2013); D. Pofcin, R. Korcha, J. Bond, and G. Galloway, Sober Living Houses for Alcohol and Drug
Dependence: 18-Month Outcome, 38 Journal of Substance Abuse Treatment, 356-365 (2010)
[hereinafter Polcin et. al., 18
Month Outcomes (2010)]; D. Polcin, R. Korcha, J. Bond, W. Lapp and G. Galloway, Recovery from Addiction in Two Types of
Sober Living Houses: 12-Month Outcomes, 18 Addiction Research and Theory, (4), 442-455 (2010)
[hereinafter Polcin et. al., 12
Month Outcomes (2010)].
4
Such as maintaining abstinence, paying rent and other fees on time, participating in house chores and meetings.
5
See, Polcin et. al., 18 Month Outcomes (2010); Polcin et. al., 12 Month Outcomes (2010).
6
See, Polcin et. al., 12 Month Outcomes (2010), at 442-455; Polcin et. al., 18 Month Outcomes (2010),at 352-366.
7
See, L. Jason, A. Mericle, D. Polcin, and W. White, The Role of Recovery Residences in Promoting Long-term Addiction
Recovery, American Journa l of Community Psychology (forthcoming 2013); National Association of Recovery Residences, A
Primer on Recovery Residences: FAQs from
the National Association of Recovery Residences (2012),
www,.narronline.com / NARR. formation website/Recovery%20Residence%20Primer%20-%20Long.odf. site accessed August 14,
2013.
8

See, http://www.cga.ct.gov/2009/rpt/2009-R-0316.htm, site accessed August 18, 2013.

recovery and that is shared by unrelated adult persons who are attempting to maintain a life of sobriety. 9
The Massachusetts Department of Public Health's Bureau of Substance Abuse Services (BSAS) has considered Alcohol and Drug Free Housing as a form of group housing that offers an alcohol and drug
free living environment for individuals recovering from alcohol or substance use disorders and where, as
10
a condition of occupancy, residents agree not to use alcohol or other substances. More specifically,
Alcohol and Drug Free Housing (ADF) refers to:
[T]he variety of group housing arrangements, however designated or legally structured, that provide an alcohol and drug free living environment for people in recovery from substance use disorders. ADF Housing is also referred to as sober housing, alcohol and substance free housing, clean-and-sober housing, alcohol-free or sober-living environments, three-quarter way houses, re-entry homes and other similar names. ADF Housing includes both transitional and permanent housing models which may be operated by a variety of entities, including state and federal government agencies, licensed mental health and addiction treatment agencies, for-profit and non-profit organizations, the occupants themselves, or private landlords. 11

9

St ate of Hawaii, Department of Health, Alcohol and Drug Abuse Division, Relating to the Clean and Sober Homes and Halfway
Houses Task Force. Report to the Twenty-Seventh Legislature, State of Hawaii, 2013. Provided via email from Mardelle Gustil o,
Hawaii State Department of Health, on June 24, 2013, on file with Department Staff.
10
Massachusetts Department of Public Health, Bureau of Substance Abuse Services. Study Regarding Sober (Alcohol and Drug
Free) Housing In Response to Chapter 283, Section 10, of the Acts of 2010, WWY:!'..:.!,1J.lli.:. ({Ov/eohhs/cloc~ubstance-
abuse / aclf-hm1si..llit:Jitudy.rtf, site accessed August 14, 2013.
11 Id.
7

V. Number of Recovery Residences Operating in Florida

Proviso directed the Department to identify the number of recovery residences in the state. To determine the number, the Department used multiple approaches to obtain a valid estimate of the
number of residences in the state. These included:
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Regional Department staff provided an inventory of the facilities known to both them, and the providers they oversee. However, this did not produce a result because the Department did not receive statewide information.
A request to the major advocacy organizations for local governments in the state, to use their networks to assist the Department to provide an estimate. No information was provided.
A request to the advocacy organizations for the industry, to use their networks to assist the Department to provide an estimate. The information provided to the Department was incomplete.

A commonly expressed theme has been that the number is currently unknown, given that the operation
of a recovery residence has not come under the purview of a regulatory entity. A result of this renders
the estimation of a fiscal impact for government action to be a similarly unknown result. In addition,
recovery residences may open or close routinely and the number may vary significantly over short periods of time. It should be noted that this is not a phenomenon unique to Florida; a Massachusetts
official noted the Bureau of Substance Abuse Services had been unable to document the number of
12
sober houses, because even voluntary registration has been struck down by courts.
Despite the absence of absolute data, public comment stated that there has been significant growth in
the number of recovery residences in Florida.
However, at the time of writing, there is an insufficiently valid method from which to identify the
number of recovery residences in the state.

12

www.salemnews.com /local / x1856220496/Training-pro posed-for-sober-house-operators, site accessed September 14, 2013.

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VI. Survey of Legal Authority

This section of the report presents federal and state legal authority related to recovery residences.
Florida Authority

Pursuant to Florida Statute, the Department has statutory authority to license substance abuse
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14

treatment. This includes both service providers, and the programmatic elements of what constitutes
15
substance abuse treatment. In relation to behavioral health, there is currently no provision in Florida
law that contemplates the registration or certification of facilities or providers. As a result, these are
undefined terms in the operation of chapters 394, and 397, F.S.

Federal Authority

There are two federal statutes that are particularly relevant to this report. The Fair Housing Amendment
16
17
Acts of 1988 (FHA), and the Americans with Disabilities Act (ADA). Both of these statutes provide the
federal government with enforcement mechanisms to challenge a housing decision made by other
governmental or private entities. In a private action, a plaintiff may bring suit for actual damages, 18
which include special damages, 19 and general damages for emotional pain and suffering attributable to
20
21
the discriminatory practice. Punitive damages may also be awarded. Equitable remedies are also
22
available to the court. In addition to this, the court also has the discretion to award fees and costs. 23
Specifically, the FHA prohibits discrimination on the basis of disability. This includes people in recovery
24
from substance use disorders. Disability, however, excludes people who continue to abuse substances,
or have been convicted of manufacture or distribution of a controlled substance. 25

See, s. 397.321(6), F.S. Note, the statutory provision requires the Department to license and regulate licensable service
components, which are defined in s. 397.311(18), F.S. The Department has rule-making authority, as it relates to substance
abuse licensing, and has promulgated rules in ch. 650-30, F.A.C.

14 Defined pursuant to s.397.311 (17), F.S.

15 See, s. 397.311(18), F.S.

16 The Fair Housing Act (FHA) was enacted by the Civil Rights Act of 1968, Pub. L. 90-284 (1968), amended by the Fair Housing
Amendments Act of 1988, Pub. L. 100-430 (1988), codified at 42 U.S.C. s. 3601, et. seq. For the purposes of this report, the Fair
Housing Act, and the Fair Housing Amendments Act are referred to as FHA.

17 Title II of The Americans with Disabilities Act (ADA) prohibits the discrimination by public entities as it relates to housing on
the basis of disability. The ADA was enacted by the Americans with Disabilities Act of 1990, Pub. L. 101-336 (1990), amended by
the ADA Amendments Act of 2008, Pub. L. 110-325 (2008), codified at 42 U.S.C. s.12101, et. seq.

18 42 U.S.C. s. 3613(c).

19 See e.g., Douglas v. Metro Rentol Services, Inc., 827 F. 2d 252 (7th Cir. 1987) (Court allowed recovery of expenses to find
alternate residence); Philips v. Hunter Trails Community Ass'n., 685 F. 2d 184, (7th Cir. 1982) (Court allowed recovery of moving
expenses); Moore v. Townsend, 577 F. 2d 424, (7th Cir. 1978)(Court allowed recovery of temporary lodgings); Steele v. Title
Realty Co., 478 F. 2d 380 (10th Cir. 1973) (Court allowed recovery of telephone charges).

20 See e.g., Steele, 478 F. 2d 380.

21 Supra, note 18.

22 Id.
23 Id.
24

The ADA defines disability as :
(A) A physical or mental impairment that substantially limits one or more of the major life activities of such individual;
(B) A record of such impairment; or
(C) Being regarded as having such an impairment. See, 42 U.S.C. s. 3602(h).
The FHA defines disability in the same manner. See, 42 U.S.C. s. 12102(1). Federal courts have required a case by case inquiry as
to the determination of disability. See, Albertson's Inc. v. Kirkingburg, 527 U.S. 555, (1999).

9

The most significant affirmative obligation for a governmental entity of the FHA and ADA requires that a
reasonable accommodation be made, when necessary to allow a person with a qualifying disability, equal opportunity to use and enjoy a dwelling. 26 There is an exception, for the health, safety and
property of others. 27
The FHA provides standing for a person to bring suit if they may be injured by a discriminatory housing
28
practice. Further, a third party may bring suit on behalf of a potential resident in a situation where said
resident may be discriminated against. 29 It should be noted that the FHA does not appear require the
exhaustion of alternative remedies prior to filing suit in federal court. 30 In addition to judicial action, an
administrative complaint may be filed simultaneously with the United States Department of Housing
31
and Urban Development (HUD). HUD may refer cases to the United States Department of Justice (DOJ)
32
to file suit in federal court. The United States Attorney General may also bring an action in situations
where a "pattern of discriminatory practice" may exist, and a private party whose interests have, or may
be harmed, may petition to intervene. 33
34

A violation of the FHA may also constitute a simultaneous violation of the ADA, and the Rehabilitation
35
Act. The ADA also prohibits discrimination on the basis of a substantially limiting impairment.
36
Recovery from a substance use disorder has been considered such an impairment. 37

25

Note, 28 C.F.R. s. 35.131, limits the extension of non-discriminatory practice to a person who may continue to use illicit
substances. This does not include alcohol. A public entity is also permitted to test to verify this.
26
See, 42 U.S.C. s. 3604(f)(3)(B); 42 U.S.C. s. 12131, et. seq., 28 C.F.R. s. 35.130(b)(7). To comply with the reasonable
accommodation provisions of the ADA, regulations have been promulgated for public entities (defined by 28 C.F.R. s. 35.104).
This includes a self-evaluation plan of c'urrent policies and procedures and modify as needed (28 C.F.R. s. 35.105). This is subject
to the exclusions of 28 C.F.R. s. 35.150. For interpretation by the judiciary, see, Oxford House Inc., v. Township of Cherry Hill, 799
F. Supp. 4SO, (D.N.J. 1992) (Court held that a reasonable accommodation means changing some rule that is generally applicable
to everyone so as to make it less burdensome for a protected class).
27
42 u.s.c. s. 3604{f)(9).
28
42 u.s.c. s. 3602{i)

42 u.s.c. s. 3602{i) .
29
See e.g., Brondt v. Viii. of Chebanse, ///.,_82 F.3d 172, {7th Cir.1996); Smith & Lee Assocs., Inc. v. City of Taylor, Mich.,_102 F.3d
781 (6th Cir.1996). But see, Kessler Institute for Rehabilitation, Inc. v. Mayor and Council af Borough of Essex Fells, 876 F. Supp.
641, {D N.J.1995) {Court held that a non-profit advocacy organization lacked standing to intervene).
30
See, e.g., Pu/cine/la v. Ridley Tp., 822 F. Supp. 204, {E.D. Pa . 1993); Oxford House, Inc. v. City of Virginia Beach, Va., 825 F.
Supp. 1251, (E.D. Va. 1993); Oak Ridge Care Center, Inc. v. Racine County, Wis., 896 F. Supp. 867, {E.D. Wis. 1995); Oliver v.
Foster, 524 F. Supp. 927 (S.D. Tex. 1981); Concerned Tenants Ass'n of Indian Trails Apartments v. Indian Trails Apartments, 496
F. Supp. 522 {N.D. Ill. 1980).
31
42 u.s.c. s. 3610.
32
This may occur when HUD refers administrative actions to federal court, 42 U.S.C. s. 3612(a), {o); or in cases that involve
challenges to zoning or land use regulations, 42 U.S.C. s. 3610(g).
33
42 u.s.c. s. 3614.
~ In matters of housing discrimination, federal district courts often analyze an alleged violation of the ADA and the FHA as one.
Caron Foundation of Florido, Inc., v. City of Delray Beach, 879 F. Supp. 2d 1353, (S.D. Fla. 2012) appeal dismissed, (11th Circ.
Aug. 16, 2012).
35
The Rehabilitation Act of 1973 was enacted by the U.S. Rehabilitation Act of 1973, Pub. L. 93-112 {1973), codified at 29 U.S.C.
s. 701 et. seq.
36
S. Res. 933, lOlst Cong. (1990) (enacted), provided clear direction in the title of the ADA as to Congressional intent: " To
establish a clear and comprehensive prohibition of discrimination on the basis of disability."
37
See, 28 C.F.R. s.35.104{4){1)(B){ii).

Authority from Other States

At the time of writing, the Department identified that Idaho, Illinois, Massachusetts, Oregon, and
Tennessee appear to provide a legal basis for the operation of a recovery residence, or an equivalent. 38
There have been a variety of legislative proposals to address regulatory involvement in relation to the
operation of a recovery residence. 39
In 2008, the Massachusetts Bureau of Substance Abuse Services {BSAS) asked sober house operators to
40
voluntarily provide details to a state web-based treatment locator. It should be noted that there does
not appear to have been a statutory or regulatory basis for this request. At the time of publication, 50
facilities in the Commonwealth of Massachusetts have provided such information, with BSAS noting that
the provision of information on its website does not represent a state license, nor endorsement of the
facility. 41
An alternative statutory construction used in Hawaii, Kansas and Oklahoma, is an explicit prohibition on
a local government implementing ordinances or zoning schemes that discriminate against community based housing for people in recovery. 42 Although there is variation between each state, the general
theme has been to define what a recovery residence is, and to statutorily include such as a residence as
a single family dwelling.
Case Law

A review of the website for the Civil Rights Division Housing and Civil Enforcement Section at DOJ
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demonstrates that the FHA and ADA are extensively litigated. For a housing rule, policy or practice to
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be challenged pursuant to the FHA, federal courts have not required that it be facially discriminatory,
but have permitted a challenge on the basis of discriminatory intent, or that it has a disparate impact on
45
people with disabilities. Once a plaintiff has established a prim a facie case of housing discrimination,
38

See, Idaho, IDAHO CODE ANN. 39-302 (11}, (2013); Illinois, 20 ILL. COMP. STAT. 301/15-lO(f) (2013); Massachusetts, MASS. GEN.
ch. lllB, s. 6A, (2013); Oregon, OR. REV. STAT. s. 430.306(7), (2013); Tennessee, TENN . CODE ANN. 33-2-402(2), (2013).
39
See e.g., State Rep. Hennessey and State Sen. Zeldin of New York proposed A06791 and S04697, 2013-14 Sess. (N.Y. 2013), in
the 2013 Legislative Session, a measure which established regulations pertaining to sober living homes. In Hawaii, State Reps.
Carroll, Awana, Brower, Coffman, Evans, Kobayashi, Luke, McKelvey, Morikawa, Nakashima, Nishimoto, Woodson, Rhoads and
Tokioka introduced H.C.R.200 and H161, 27th Sess. (Haw. 2013) in the 2013 Legislative Session to reconvene a taskforce to
examine, among other factors, the impact of criminal justice housing.
•o
www.bostonherald.com/ news opinion / local coverage/ 2007/ 07/ health de pt launches online sober home list,
site
accessed September 14, 2013. See also, supra note 10.
41
See, www.helpline-online.com / re ports/ heloline providers yftytv3ooxy2yfajlmvcfd55.odf, site accessed September 14, 2013.
42
See, Hawaii, HAW. REV. STAT. s. 46-4, (2013); Kansas, KAN. STAT. ANN. s. 12-736, (2013); Oklahoma, OKLA STAT. tit. 43A-3, s.
417.1, (2013).
43
See, www. justice.gov/ crt/ about/ hce/ caselist.php , site accessed August 17, 2013.
44
Specifically, 42 U.S.C. s. 3604(f).
45
See e.g., Bangerter v. Orem City Corp., 46 F.3d 1491, (10th Cir. 1995) (Plaintiff need not prove malice or discriminatory
animus of defendant to make a case of intentional discrimination where the defendant expressly treats someone protected by
the statute in a different manner than others); Thornton v. City of Allegan, 863 F. Supp. 504, (W.D. Mich. 1993) (Not required
that the plaintiff prove discriminatory intent, it is sufficient if the plaintiff proves only that the defendant's action had a
discriminatory impact or effect); Potomac Group Home Corp. v. Montgomery County, Md., 823 F. Supp. 1285, (D. Md. 1993)
(Court held plaintiff may prevail by showing discriminatory intent or by showing discriminatory impact, and that to prove
discriminatory intent, the plaintiff need only show that the handicap of a member of a protected group was in some part the
basis of the policy being challenged). But see, Jeffrey 0. v. City of Boca Raton, 511 F. Supp. 2d 1339, 1352, (S.D. Fla. 2007) (Court
held that the 11th Circuit had not adopted a standard to determine disparate impact, and did not find the city meet the
justifications of Bangerter, 46 F.3d 1491).
LAWS

s.

federal courts shift the burden to the defendant to demonstrate a legitimate, nondiscriminatory reason,
or that the action furthered a legitimate governmental interest, with no alternative. 46 The courts have,
however, held that disability does not require a heightened level of scrutiny for governmental action, in
the context of the FHA. 47
The FHA provides justifications for housing restrictions that federal courts have narrowly construed. A
governmental entity may act on the basis of protecting the public health and safety of other
48
individuals. However, courts have observed that this justification may not be used as a guise to impose additional restrictions on protected classes under the FHA. 49 Additionally, a threat to the public
health and safety, or another's property requires objective evidence that is sufficiently recent to be
50
credible and not unsubstantiated inferences. The action of a governmental entity may also be justified
if the restriction is found to be beneficial or benign. 51
46

See e.g., Tsombandis v. West Haven Fire Dept., 180 F. Supp. 2d 262 (D. Conn. 2001), order aff'd in part, rev'd in part on other
grounds, 352 F.3d 565, (2d Cir. 2003) (Court held that governmental entity engages in discriminatory practice by refusing to
make reasonable accommodations to action); U.S. v. City of Toy/or, Ml., 13 F.3d 920, (6th Cir. 1993), reh'g and suggestion for
reh'g en bane denied, (Mar. 11, 1994) and on remand to, 872 F. Supp. 423, (E.D. Mich. 1995), affd in part on other grounds,
rev'd in part on other grounds, 102 F.3d 781, (6th Cir. 1996) (Court held it is not necessary for plaintiff to prove discriminatory
intent motivated by animus); Human Resource Research and Management Group, Inc. v. County of Suffolk, 687 F. Supp. 2d 237
(E.D. N.Y. 2010) (Plaintiff can establish discrimination in the form of: (1) disparate treatment or intentional discrimination; (2)
disparate impact of a law, practice, or policy on a covered group; or (3) by demonstrating that the defendant failed to make
reasonable accommodation to afford people with disabilities an equal opportunity to live in a dwelling).
47
See e.g., Fomilystyle of St. Paul, Inc. v. City of St. Poul, Minn., 923 F.2d 91 (8th Cir. 1991), reh'g denied, (Feb. 15, 1991) (Court
held that the relevant question is whether legislation is rationally related to legitimate government purpose); Pu/cine/lo, 822 F.
Supp. 204, (Court held that violation of FHAA would not amount to a Constitutional violation, because disability does not give
rise to constitutionally protected class under the Equal Protection or Due Process clause of the Fourteenth Amendment). But
see, Bangerter, 46 F. 3d 1491, (Court held that the inability to assert a right under the Fourteenth Amendment is not of
concern, because the FHA provided a basis to determine the justification of a rest ri ction on housing for the disabled) .
48
42 u.s.c. s. 3604(f)(9) .
49
See e.g., Bongerter, 46 F.3d 1491, (Any requirements placed on housing for a protected class based on the protection of the
class must be tailored to needs or abilities associated with particular kinds of disabilities, and must have a necessary correlation
to the actual abilities of the persons upon whom they are imposed); Association for Advancement of the Mentally Handicapped,
Inc. v. City of Elizabeth, 876 F. Supp. 614, (D.N .J. 1994) (Court held state and local governments have the authority to protect
safety and health, but that authority may be used to restrict the ability of protected classes to live in the community);
Pu/cine/fa, 822 F. Supp. 204, (Special conditions may not be imposed under the pretext of health and safety concerns).
50
See, Oconomowoc Residential Programs, Inc., v. City of Milwaukee, 300 F. 3d 775, (7th Cir. 2002) (Denial for a variance due to

purported health and safety concerns for the disabled adults could not be based on blanket stereotypes); Oxford HouseEvergreen v. City of Plainfield, 769 F. Supp. 1329 (D.N.J. 1991) (Generalized assumptions, subjective fears and speculation are insufficient to prove direct threat to others), Cason v. Rochester Housing Authority, 748 F. Supp . 1002, (W.D.N.Y. 1990). But see, Roe v. Housing Authority of City of Boulder, 909 F. Supp. 814, (D. Colo. 1995) (Court held that no reasonable accommodation could be made to house individual with mental illness, and eviction was justified); Foster v. Tinnea, 705 So. 2d 782 (La . Ct. App. 1st Cir. 1997) (Court upheld an eviction, on the basis of evidence showing that tenants' son posed a threat to others).
s: See e.g., Smith & Lee Associates, Inc. v. City of Taylor, Mich., 102 F.3d 781, (6th Cir. 1996) (Court held that unlawful discrimination often takes the form of special rules that are allegedly designed to benefit handicapped persons); Horizon House Developmental Services, Inc. v. Township of Upper Southampton, 804 F. Supp . 683 (E.D. Pa. 1992), judgment affd without discussion, 995 F.2d 217 (3d Cir. 1993) (Court held that the motives of the drafters of an ordinance which is facially discriminatory, whether benign or evil, are irrelevant to a determination of the lawfulness of the ordinance); Fami/ystyle of St. Paul, Inc, 923 F.2d 91, (The court noted that spacing requirement served a valid and legitimate goal of the state and the city by addressing the need to provide services for the mentally disabled in mainstream community settings and by guaranteeing that facilities are located in the community); Valley Housing LP v. City of Derby, 802 F. Supp. 2d 359 (D. Conn. 2011) (Court held that claim of non-discriminatory zoning enforcement was a pretext for discrimination) ; U.S. v. Borough of Audubon, N.J., 797 F. Supp. 353 (D.N.J. 1991), judgment aff'd without discussion, 968 F.2d 14(3d Cir. 1992) (Court held that a municipality applying restrictive zoning classification to preclude the establishment of a group home for recovering alcoholics and drug users cannot avoid a violation by arguing that its actions were merely a response to community sentiment) . But see, Oxford House-C v. City of St Louis, 843 F. Supp. 1556, (E.D. Mo. 1994), judgment rev' d on other grounds, 77 F. 3d 249, (8th Cir. 1996), cert. denied, 117 S. Ct. 65, (U.S. 1996) (Court upheld legitimate government interest in decreasing congestion, traffic and noise in residential areas).

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As noted, the FHA does not expressly invalidate the action of a governmental entity in relation to
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housing, so long as the action grants, guarantees, or protects the same rights. Federal courts have expressed this rationale in case law, noting that an act, ordinance or zoning decision may not single out the disabled, and apply different and unique rules to housing, when compared to the general population. 53
A Nevada state statute that established a statewide registry for group homes that was intended to be used for emergency services, and would be made available to the public, was invalidated by the
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courts. In addition to state law, federal courts have also invalidated a variety of requirements from local governments that would function essentially as a registry of housing for protected classes, finding that the need to know where such facilities are located is, by itself not a legitimate government interest.ss This has included regulatory devices such as permits, registration requirements, background checks for operators, occupancy restrictions, and inspection requirements . 56
Federal courts have held that the FHA was intended by Congress to have a broad reach for liability. This includes not only the actors directly involved in a real estate transaction, but also actors that affect the
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availability of housing. It should also be noted that federal courts have held governmental officials

personally liable for decisions that violate the FHA. 58
In relation to housing for residents in recovery from substance abuse, or mental illness, federal courts
have found that halfway houses, group homes, sober houses or other community housing arrangements
used as residences were dwellings, and as such protected by the FHA. 59 As a protected class, federal
courts have held that conditions placed on housing for people in recovery from either state or sub-state
42 u.s.c. s. 3615.
See e.g., Bangerter, 46 F. 3d 1491, n. 1., (Invalidating and act and ordinance that facially singles out the handicapped, and
applies different and unique rules to them); Human Resource Research and Management Group, 687 F. Supp. 2d 237, (It is
undisputed that [the ordinance) is discriminatory on its face, in that it imposes restrictions and limitations solely upon a class of
disabled individuals); Potomac Group Home, Inc., 823 F. Supp. 1285, (No other county law or regulation imposed any similar
requirement on a residence to be occupied by adult persons who do not have disabilities) .
54
Nevada Fair Housing Center, Inc., v. Clark County, et. al., 565 F. Supp. 2d 1178, (D. Nev. 2008) (Invalidating state statute
requiring Nevada State Health Department to operate a registry of group homes).
55
See, Human Resource Research and Management Group, 687 F. Supp. 2d 237, (Court held that defendant-city failed to show
that the requirement of registration, inspection and background checks was narrowly tailored to support a legitimate
government interest); Community Housing Trust et. al., v. Department of Consumer and Regulatory Affairs et. al., 257 F. Supp .
2d 208, (D.C. Cir. 2003) (Court held that the zoning administrators classification of plaintiff-facility, requiring a certificate of
occupancy rose to discriminatory practice under FHA) .
56
See, e.g., City of Edmonds v. Oxford House et. al., 574 U.S. 725 (1995) (City's restriction on composition of family violated
FHAA); Safe Haven Sober Houses LLC, et. al., v. City of Boston, et. al., 517 F. Supp. 2d 557, (D. Mass. 2007); United States v. City
of Chicago Heights, 161 F. Supp. 2d 819, (N .D. Ill. 2001)(City violated FHA by requiring inspection for protected class housing
that was not narrowly tailored to the protection of disabled); Human Resource Research and Management Group, 687 F. Supp.
2d 237, (Court held that the city' s purported interest in the number of facilities, in relation to the zoning plan, was not a
legitimate government interest. Further to this, the court found that there was insufficient evidence to justify action by the city
in relation to the protection of this class. The city also failed to justify the requirement for a 24 hour staff member, certified by
the New York State Office of Alcoholism and Substance Abuse Services).
57
See e.g. Michigan Protection and Advocacy Service, Inc. v. Babin, 18 F.3d 337, (6th Cir. 1994), City of Peeskill v. Rehabilitation
Support Services, Inc., 806 F. Supp . 1147, (S.D.N.Y. 1992) (Court held that city seeking to prevent the acquisition of a building to
be used as transitional living violated FHA and state law).
58
See e.g. Samaritan Inns. V. District of Columbia, 114 F. 3d. 1227, (D .C. Cir. 1997) (Court held that officials reversing decision
based on public pressure were not entitled to qualified immunity). But see, O'Neal by Boyd v. Alabama Dept. of Public Health,
926 F. Supp. 1368, (M.D. Ala. 1993) (Court held that state officials are entitled to immunity when conduct does not violate
established statutory or constitutional rights that a reasonable person would have known) .
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See, Connecticut Hosp. v. City of New London, 129 F. Supp. 2d 123, (D. Conn. 2001) .
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entities, such as licenses or conditional use permits, may in application be overbroad and result in

result in
violations of the FHA and ADA. 60 Further to this, federal courts have enjoined state action
that is
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predicated on discriminatory local government decisions. It should be noted, that in the context
of
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deinstitutionalization for people with mental illness, the Eighth Circuit Court of Appeals held
that
Congress did not intend for the FHA to contribute to the segregation of the mentally ill from
mainstream
society. 63 The court further recognized the legitimate and necessary role of the state in
licensing services
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for the mentally ill. However, this recognition was construed within the context of the state's
legitimate interest to place mentally ill people in the least restrictive environment available.
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In Florida, perhaps the most recognized case is that of Jeffrey 0. v. City of Boca Raton. 66 An
ordinance
related to the location of treatment facilities promulgated by the City of Boca Raton, was held
to be
discriminatory to people in recovery for substance use disorders. 67 The court, found that the
city had

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See e.g., Oxford House-C, 843 F. Supp. 1556, (Court held that city singled out plaintiffs for
zoning enforcement and
inspections, on the basis of disability, plaintiff demonstrated city was ignoring zoning
violations from people without
disabilities); Marbrunak v. City of Stow, OH., 947 F. 2d 43, (6th Cir. 1992) (Court held
conditional use permit requiring health
and safety protections was an onerous burden); U.S. v. City of Baltimore, MD, 845 F. Supp. 2d.
640 (D. Md. 2012) (Court held
that conditional ordinance was overbroad and discriminatory); Children 's Alliance v. City of
Bellevue, 950 F. Supp. 1491, (W.D.
Wash. 1997) (Court held zoning scheme establishing classes of facilities was overbroad, and
created an undue burden on a
protected class); Oxford House-Evergreen, 769 F. Supp. 1329, (Court held that refusal to issue
permit was based on opposition
of neighbors, not on protection of health and safety as claimed); Potomac Group Home, Inc., 823
F. Supp. 1285, (Court held that
county requirement for evaluation of program offered at facility at public board. At review
board, decisions were based on nonprogrammatic factors, such as neighbor concerns. Further to
this, the court held that the requirement to notify neighboring
property and enumerated civic organizations violated the FHA). But see, U.S. v. Village of
Palatine, !II, 37 F. 3d 1230, (7th Cir.
1994) (Court held village did not fail to make reasonable accommodation because plaintiff never
applied for a special use
permit); Association for Advancement, 876 F. Supp. 614, (Court dismissed argument that dispersal
requirement protected
governmental interest in preserving residential character of neighborhood) ; Oxford House, Inc.
v. City of Virginia Beach, Va .,
825 F. Supp. 1251, (E.D. Va. 1993) (Court held that public appeal process to denial of permit
was reasonable accommodation),
City of St. Joseph v. Preferred Family Healthcare, Inc., 859 S.W.2d 723, 2 A.D.D. 1335 (Mo. Ct.
App. W.D. 1993), reh'g or transfer
denied, (July 27, 1993) and transfer denied, (Sept. 28, 1993) (Court upheld ordinance limiting
the number of unrelated people
living together, emphasizing ordinance applied equally to all).

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See e.g., Larkin v. State of Mich. 883 F. Supp. 172, (E.D. Mich. 1994), judgment atf' d 89 F. 3
d 285, (6th Cir. 1996) (Court held
there was no rational basis for denial of license on the basis of dispersal requirement, and
local government's refusal to permit.
The court did find, however, that the city was not a party to the law suit because the state
statute did not mandate a variance);
Arc of New Jersey, Inc., v. State of N.J. 950 F. Supp. 637, D.N.J. 1996) (Court held that
municipal land use law, including
conditional use, spacing and ceiling quotas violated FHA) . But see, Charter Tp. of Plymouth v.
Department of Social Services, 503
N.W. 2d 449 (Mich. 1993) (Court held statute did not violate FHA because it did not prohibit

protected class from obtaining
housing); Familystyle of St. Paul, Inc. 923 F. 2d 91, (Court upheld state and local action on the basis of deinstitutionalizing
protected class) . But see, North Shore-Chicago Rehabilitation Inc. v. Village of Skokie, 827 F. Supp. 497, (N .D. Ill. 1993) (Court
held that municipalities could not rely on the absence of a state licensing scheme to deny an occupancy permit); Easter Seal
Sac. of New Jersey, Inc. v. Township of North Bergen, 798 F. Supp. 228 {D.N.J. 1992) (Court held that city denial of permit on the
basis offaiiure to obtain state license was due to the city's discriminatory enforcement of zoning enforcement); Ardmore, Inc. v.
City of Akron, Ohio, 1990 WL 385236 (N .D. Ohio 1990) (Court held granted a preliminary injunction against the enforcement of
an ordinance requiring conditional use permit, even though it was applied to everyone, because Congress intended to protect
the rights of disabled individuals to obtain housing).
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See, Olmstead v. L.C., 527 U.S. 581 (1999) (Court held that unjustified segregation of persons with disabilities constituted
violation of the ADA); Familystyle of St. Paul, Inc. 923 F. 2d 91, 92.
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Familystyle of St. Paul, Inc. 923 F. 2d 91, at 94.
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Id.
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The court noted that deinstitutionalization of mentally ill adults was of special concern to the state of Minnesota. Id, at 92.
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511 F. Supp. 2d 1339, (Note, in this case, the City was held liable for the plaintiff's attorney fees of more than $3 million) .
There are other sober homes in the state that have been litigated, and have included the imposition of damages for local
governments. See also, Tracey P. et. al. v. Sarasota County et. al., 8:05-cv-927-T-27EAJ, (M .D. Fla., 2007) (Settled for $750,000) .
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Specifically the court found that the language singled out recovering individuals who would be residing in a substance abuse
treatment facility. id at 1349.
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not demonstrated that there was no less discriminatory alternative means to further a legitimate
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government interest. Further to this, the court held that the City did not establish a procedure for a
reasonable accommodation to the zoning schema, which pursuant to both the FHA and ADA, it had an affirmative duty to do. 69

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The court held that although the city had a legitimate interest in preservation of residential character, however, it did not
demonstrate that there was a less discriminatory definition of family. Id at 1353.
69
Id. See supra note 26.
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VII. Issues Related to Recovery Residences

To identify issues related to recovery residences, this section presents both a research review as well as
what was identified by members of the public.
At the outset, it should be noted that there is no Florida specific published and peer-reviewed research
that relates to the operation of recovery residences. However, there is a body of relevant research that
has been conducted, that is presented here. These studies are limited by various methodological weaknesses such as small sample sizes or low response rates. Since this report is not intended to
provide a methodological critique of all the relevant literature, readers are advised to consult the

original source material for more detailed discussions of the strengths or weaknesses of the various
research designs. 70
Research Review

In an explanatory study, researchers studied 132 men from eleven recovery residences in Illinois. Initial
interviews were conducted with individuals who had been a resident for at least two weeks, but no
more than six weeks. Only forty-eight participants provided data at a second follow-up interview six
months later. The following general trends were reported with regard to negative experiences by respondents:

- Around a third reported "personality conflicts."
- Approximately twenty percent reported a "lack of cooperation among members ."
- Almost thirteen percent reported "cramped living space."
- Almost thirteen percent reported "personal financial troubles."
- About ten percent reported an "overly structured/authoritarian setting."
- Less than ten percent experienced an "unstructured and poorly governed setting." 71

Researchers interviewed sixty-four individuals from randomly selected houses in northern Illinois that
were in proximity to a recovery residence. Half of the houses were directly next to a recovery residence,
and the other half were one block away. They found that residents in almost seventy percent of houses
next to recovery residence knew of the existence of it, compared to less than ten percent of people
from the houses that were a block away. Qualitative data was collected from the twenty-five residents
who knew of its existence. When asked if they had any concerns about its location in their
neighborhood, the following responses were obtained:
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- Twenty-one said no.
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- Four said yes.

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An epistemological deconstruction of the framework each researcher has used is, for the purposes of this report outside the
scope of proviso. See e.g., I. Vasilachis de Gialdino, Ontological and Epistemological Foundations of Qua/itptive Research, 10,
Forum: Qualitative Social Research, 2, (2009).
71
L. Jason, J. Ferrari, B. Smith, P. Marsh, P. Dvorchak, E. Groessl, M. Pechota, M. Curtin, P. Bishop, E. Kot, and B. Bowdin,
Explanatory Study of Male Recovering Substance Abusers Living in a Self-Help, Self-Governed Setting, 24 Journal of Mental
Health Administration (3), (1997), at 332-339.
72
Neighbors commented, for example: "Guys are friendly ."; "They just proved to be good neighbors."; "No trouble from them ."
L. Jason, K. Roberts, and B. Olson, Attitudes Toward Recovery Homes and Residents: Does Proximity Make a Difference? 33
Journal of Community Psychology (5), (2005), at 529-535. [hereinafter, Jason, Proximity (2005)]
.
73
Neighbors commented, for example: "Sometimes cars block my driveway, only when first opened, no problems now.";
"Sometimes a lot of new faces."; "Louder, more people on street." Id.

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When these residents were asked if they could see any benefits to having the residence in their

neighborhood, they provided the following responses:
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• Seventeen responded yes.
•
Eight did not know of any benefits. 75
Researchers physically inspected eleven recovery residences for women and forty-four for men in 2002
in Virginia, Illinois, and Hawaii. An intoxicated or impaired person present was identified near 76 in less
than two percent of houses and a drug dealer was identified as "present" near less than four percent of
houses. The physical location of bars or pubs nearby occurred in less than a third of houses. 77
In 2008, researchers contacted ninety recovery residence landlords and solicited their participation in a
78
voluntary and anonymous survey. Responses were received from thirty landlords, including eighteen
who rented solely to recovery residences and twelve who rented to both, and other tenants. All
landlords indicated that residents paid rent on time and kept the property in good physical condition
and that recovery residences appeared to be better maintained compared to others on their blocks.
Many of the surveyed landlords indicated that residents built positive relationships with neighbors and
those recovery residences had suitable furnishings and window coverings. Additionally, according to
landlords who were renting to recovery residences and other renters, excessive noise, rent payment,
landlord-tenant communication, and pet problems were less of a problem with them compared to other
renters. The most common negative themes mentioned wear and tear on the property and potential
problems with the neighbors. 79
While not directly related to the question of the impact of a recovery residence, Taniguchi 80 concluded
in the context of a study of the location of alcohol and drug treatment facilities in Philadelphia, PA, that
the answer was at best equivocal.
These findings may not sit well with people looking for clear cut answers regarding the criminogenic impact of treatment facilities. At best, it is possible to say that treatment providers are not unilaterally bad neighbors and that in certain areas these facilities may be associated with lower crime in the surrounding areas. This must be balanced with the fact that these same facilities may, under certain circumstances, also be criminogenic. Further research would be wise to investigate the dynamics that are underlying these
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results.

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Neighbors commented, for example: "Good lookouts, watch everything."; "Upkeep of outside is good."; "No drugs, no parties
going on."; "Take care of property well outside"; "My son plays basketball with guys out in their yard, keeps them out of
trouble."; "Glad to see it's being done to rehabilitate women, especially who have children."; "They keep up the yard better
than last owner." Id.
7S

Id.

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Near was defined as within half a mile. J. Ferrari, L. Jason, R. Blake, M. Davis, and B. Olson, "This is My Neighborhood":
Comparing United States and Australian Oxford House Neighborhoods, 31 Journal of Prevention & Intervention in the
Community, (1/2), (2006), at 41-49. [hereinafter, Jason, et. al., Neighborhood (2006)].
77
Id.
78
J. Ferrari, D. Aase, D. Mueller, and L. Jason, Landlords of Self-Governed Recovery Homes: An Initial Exploration of Attitudes,

Opinions, and Motivation to Serve Others, 41Journal of Psychoactive Drugs,(4),(2009). 349-3S4.
79 Id.
80

T. Taniguchi, and C. Salvatore, Exploring the Relationship Between Drug and Alcohol Treatment Facilities and Violent and
Property Crime: A Socioeconomic Contingent Relationship, 2S Security Journal 2, {2012), 95-115.
81
Id, at 111.

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In a 2010 article dealing with the applicability of the FHA to recovery residences, Gorman has noted that
the implementation of the sober living home model is inherently diverse, and as a result of this, is easily
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abused by landlords. In addition to this, the article observes that a local government must balance
their response to public outrage at the siting of a residence, and proposed steps to limit the establishment of sober living facilities that do not violate the obligation to maintain adequate affordable
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housing. Gorman observes that although much has been "fleshed out" in sober living home litigation,
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however, many questions are still to be answered by judicial interpretation.
In a substantially similar California Bar Journal article, Gorman noted:
[S}ober living facilities typically involve two competing interests: (1) the interests of individuals recovering from addiction, often represented by landowners or organizations which provide addiction recovery services; versus (2) the interests of residents who seek to preserve the "family-friendly" character of their neighborhoods, often represented by city attorneys, county counsel or other public agency attorneys {or attorneys hired by citizen groups opposed to sober living facilities in their neighborhoods.) These disputes arise after a claimed sober living home is established in a single family residential neighborhood, bringing with it unfamiliar and seemingly unrelated faces living together, congregating on porches and front yards, or wandering nearby streets. Disturbances arise, eventually leading to phone calls to the police, complaints to the local officials, and ultimately demands [to] the city or county to intervene and shut down the sober living home. 85
In a 2010 report to the General Court of Massachusetts, in a Legislative requirement to study sober
houses in the Commonwealth, the Massachusetts Bureau of Substance Abuse Services (BSAS) noted that:
[The Bureau] is aware of the numerous complaints received regarding ADF Housing operators. These complaints have been lodged by residents of ADF Housing, neighbors and municipal officials. The nature of complaints range from nuisance complaints (noise) to more serious complaints regarding substandard housing conditions, alcohol and drug use on the property, and fatal and non-fatal overdoses of residents. Although BSAS has received frequent complaints about ADF Housing, the majority of complaints are in reference to only a few ADF homes relative to the number of homes that exist in the Commonwealth. In other words, there are many complaints about a few homes and no complaints about the vast majority of others. 86
BSAS also noted that it was not possible to comprehensively document or quantify the impact of recovery residences on residents, neighborhoods and local municipalities. This is for two reasons:
•
Depending on the nature of the complaint, the avenue for resolution was with various local or state agencies; and
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M. Gorman, A. Marinaccio, and C. Cardinale, Fair Housing for Sober Living : How the Fair Housing Act Addresses Recovery
Homes for Drug and Alcohol Addiction, 42 The Urban Lawyer 3, (Summer 2010), 607-614, at 608.
83
Id, at 614.
84
Id.
85
M. Gorman, A. Marinaccio, and C. Cardinale, Alcoholism, Drug Addiction, and the Right to Fair Housing: How the Fair Housing

Act Applies to Sober Living Homes, 33 The Public Law Journal 2, (Spring 2010): 15-20, at 16.
86
Supra, note 10.
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There is no central repository of substantiated complaints.

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Further to this, it was concluded that it was unlikely a state law requiring registration, or tracking the
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complaints for recovery residences would be permissible pursuant to the FHA.
Florida Public Comment

In public comment directed to the Department, through either email or website, many of the people
responding indicated clearly that there were concerns about recovery residences being sited in their
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neighborhoods. From these comments, there were several themes of concern:
• The safety of residents;
• The safety of neighborhoods; and
• The lack of governmental oversight. 90
At public meetings, participants raised the following concerns:
•
Residents being evicted with little or no notice.
•
Drug testing might be a necessary part of compliance monitoring.
•
Unscrupulous landlords, including an alleged sexual offender who was running a woman's program.
•
Recovery residence owned by a bar owner and attached to the bar.
• Residents dying in recovery residences.
•
Lack of regulation and harm to neighborhoods
• Whether state agencies have the resources to enforce regulations and adequately regulate these homes.
•
Land use problems, and nuisance issues caused by visitors at recovery residences, including issues with trash, noise, fights, petty crimes, substandard maintenance, and parking.
•
Mismanagement of resident moneys or medication .
• Treatment providers that will refer people to any recovery residence.
•
Lack of security at recovery residences and abuse of residents.
• The need for background checks.
• The number of residents living in some recovery residences and the living conditions in these recovery residences.
•
Activities going on in recovery residences that require adherence to medical standards and that treatment services may be provided to clients in recovery residences. This included acupuncture and urine tests.
•
Houses being advertised as treatment facilities and marketed as the entry point for treatment rather than as a supportive service for individuals who are exiting treatment.
•
False advertising.
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Medical tourism.
• The allegation that medical providers capable of ordering medical tests, and billing insurance companies were doing so unlawfully.
•
Lack of uniformity in standards.

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Id.
Id. Refer also to section VI of this report. See e.g., supra note, 54 .
As an illustration, see Appendix 5.
See, Appendix 1.

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Alleged patient brokering, in violation of Florida Statute.

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Concerns were also raised in written responses to the Department. Two cities in South Florida that were
well represented were Port St. Lucie and Delray Beach. According to the city of Port St. Lucie, regulation
or certification is needed to "ensure that operators of the facilities have the adequate training and
experience to provide the services which are needed to assist in the recovery process." They also
indicated that without regulation or certification "some of them will be nothing more than a boarding
house facility." 92
According to the city of Delray Beach, "we have seen far too many of these residents evicted at all
hours, subjected to abusive behavior and worse." The city indicate that recovery residences should be
required to demonstrate "compliance with life safety standards for the residences and have background
check requirements for the operators." They also raised the following concerns:
The lack of state oversight and regulation has made sober house tenants the
target of unscrupulous landlords who prey on tenants/residents by 'flipping' the same
bed, insisting on several months' rent up front, and then evicting someone for rules
violations, and re-renting the same room/bed. Some owners put "rule-breakers" out on
the curb, with no alternative housing, which often leads to an increase in homelessness
and crime. Even worse is that there have been situations where the operator is a newly
recovered individu;al who begins using drugs/alcohol again and the whole house ends up
in disarray. Further, some operators have criminal backgrounds as sexual offenders ... ln
Delray Beach, we had a problem with women being sexually assaulted by the operator
of the house that is supposed to be a safe haven. We also have a sober house attached,
owned, and operated by the same owner as the adjacent bar ... [l]n Delray Beach we
have had people die in sober houses due to lack of state oversight or regulation ... There
seems to be a lot of insurance fraud occurring within these homes whereby they are
charging obscene amounts of money for simple procedures such as urine tests. This is
simply another way that the operators abuse their tenants/patients and use this
vulnerable population to maximize profits. 93

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See, Appendices 1 and 2.
See, Port St. Lucie Response, Appendix 3.
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See, City of Delray Beach Response, Appendix 3.
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VIII. Benefits of Recovery Residences

This section outlines the impact of recovery residences to the treatment of substance use disorders,
and neighborhoods.

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As noted previously, there appears to be no Florida specific published and peer-reviewed research that
relates to recovery residences. However, there is a body of relevant research that has been conducted,
and presented here.

Treatment

A common theme from the definition of recovery residences in other states, and the research, is that
they do not provide substance abuse services on site. As such, this report examines the efficacy of
recovery residences as a component of a continuum to support abstinence and recovery from substance
use disorders. National research has demonstrated that a variety of psychosocial interventions and
medications can effectively treat substance use disorders and reduce use. 95
Jason, Davis, and Ferrari collected baseline data on 897 people from 169 Oxford Houses. 96 They also
collected three subsequent waves of data at four month intervals. Only 607 participants from the initial
measurement wave remained in the study at wave four. Of this group, around fourteen percent
reported having used either drugs or alcohol at the final assessment. The average number of days they
used alcohol was less than four and the number of days they used other drugs was less than six.
Selfefficacy for remaining abstinent from alcohol and other drugs and the percent of participants' social
network members who were abstinent or in recovery increased significantly. Additional models
controlling for a variety of factors found that length of residency in Oxford House was a significant

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Note, the proviso directed the report to examine alcoholism, however, the Diagnostic and Statistical Manual, Fifth Edition
(DSM-5) of the American Psychiatric Association classifies alcohol as a substance in the broader diagnostic cluster of substance
related disorders. American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, (5th. Ed., 2013).
95
See e .g., R. Miller, and P. Wilbourne, Mesa Grande: A Methodological Analysis of Clinical Trials of Treatments for Alcohol Use
Disorders, 97 Addiction (3), (2002) 265-277; A. McRae, A. Budney, and K. Brady, Treatment of Marijuana Dependence: A Review
of the Literature, 24 Journal of Substance Abuse Treatment, (2003) 369-376; M. Prendergast, D. Pod us, E. Chang, and D. Urada,
The Effectiveness of Drug Abuse Treatment: A Meta-Analysis of a Comparison Group Studies, 67 Drug and Alcohol Dependence,
(2002), 53-72; D. Lai, K. Cahill, Y. Qin, and J. Tang, Motivational Interviewing for Smoking Cessation, 1 Cochrane Database of
Systematic Reviews, (2010); E. Whitlock, M. Polen, C. Green, T. Orleans, and J. Klein, Behavioral Counseling Interventions in

Primary Care to Reduce Risky/Harmful Alcohol Use by Adults: A Summary of the Evidence for the U.S. Preventive Services Task
Force, 140 Annals of Internal Medicine(7), (2004), 557-568; L Amato, S. Minozzi, M. Davoli, S. Vecchi, M. Ferri, and S. Mayet,
Psychosocial and Pharmacological Treatments Versus Pharmacological Treatments for Opioid Detoxification, 4 Cochrane
Database of Systematic Reviews, (2009); 0. Mitchell, D. Wilson, and D. MacKenzie, The Effectiveness of Incarceration-Based
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Treatment of Substance Use Disorders: A Meta-Analysis, 101 Addiction, (2006), 1546-1560; J. Irvin, C. Bowers, M. Dunn, and M .
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(2003). 291-303.
L. Jason, M. Davis, and J. Ferrari, The Need for Substance Abuse Aftercare: Longitudinal Analysis of Oxford Hause, 32 Addictive
Behaviors (4), (2007), at 803-818.

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predictor of abstinence and abstinence self-efficacy. Abstinence self-efficacy was a significant predictor
of abstinence. It should be noted that less than a third of the sample remained in an Oxford House
throughout the entire study. The remainder left by waves two, three, or four. Compared to participants
who stayed in Oxford House across all four waves, individuals who left earlier had higher rates of any
substance use over the last ninety days at wave four. This means that over eighty percent of those who
left the house and were interviewed at the final wave remained consistently abstinent. 97
Outcomes Across Wave 1 Through 4

Wave3
Wave 1
Wave 2
% who used alcohol
15.7
10.5
9.7
or other drugs
10.1
5.0
7.7
% who used alcohol
% who used other
9.0
7.0
13.3
drugs
Days consumed
1.8
2.2
1.4
alcohol
Days used other
3.7
2.3
5.5
drugs
Days paid for work
49.8
50.5
42.0
794.0
Employment income
Total monthly
981.8
income
Alcohol abstinence
80.7
80.4
79.3
self-efficacy
Drug abstinence self81.1
80.4
80.8
efficacy
% of social network

abstinent/in
79.0
79.0
75.0
recovery for alcohol
use
% of social network
abstinent/in
94.0%
94.0%
90.%
recovery for drug
use
!IM
** p,::: 0.01, two-tailed, based on repeated measures analyses

Wave4
13.5
10.3
9.8
3.7**
5.6**
48.4**
941.9**
1133.7**
84.6**
84.6**

77.0**

93.0%**

In an Illinois study, researchers noted:
[T]hose in the Oxford Houses ... had significantly lower substance use (31.3% vs. 64.8%), significantly higher monthly income ($989.40 vs. $440.00), and significantly lower incarceration rates (3% vs. 9%). Oxford House participants, by month 24, earned roughly $550 more per month than participants in the usual-care group. In a single year, the income difference for the entire Oxford House sample corresponds to approximately $494,000 in additional production. In 2002, the state of Illinois spent an average of
97
98

Id.
Id.

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 $23,812 per year to incarcerate each drug offender. The lower rate of incarceration among Oxford House versus usual-care participants at 24 months (3% vs . 9%) corresponds to an annual saving of roughly $119,000 for Illinois. Together, the productivity and incarceration benefits yield an estimated $613,000 in savings per year, or an average of $8,173 per Oxford House member. 99
Barkman, Kaskutas, Room, Bryan, and Barrows presented findings from two outcome studies that specifically included social model programs . 100 Both of these studies were published as government
reports. One report examined eighteen-month follow-up data on 198 social model program clients in
San Diego and found that clients who used only the recovery home were the most likely to be abstaining
at follow-up. The other study looked at outcomes among 1,826 clients at social model and nonsocial
model residential programs in California. At the fifteen-month post-treatment follow-up, program graduates from both models reduced the number and frequency of substances used. There was also a relationship between length of stay in social model programs and reductions in substance abuse. For
social model program stays of less than thirty days, there was a thirty-six percent reduction in substance
abuse. For longer stays, there was a fifty-two percent reduction in post-treatment substance abuse. 101
A longitudinal analysis conducted with a national sample of recovering substance abusers living in
Oxford Houses found that persons with psychiatric comorbid substance use disorders, compared to

Oxford Houses found that persons with psychiatric comorbid substance use disorders, compared to those who do not have co-occurring mental illnesses, are not at higher risk for relapse when they reside in self-help residential settings like Oxford House. Furthermore, residents with high psychiatric severity reported decreased psychiatric outpatient treatment utilization over the course of the study.[102] Kaskutas, Ammon, and Weisner conducted a naturalistic, longitudinal comparison of outcomes for[103] individuals in social model programs and clinical programs. Researchers obtained twelve-month follow-up data with 164 social model clients from two public detoxification programs and two public residential recovery homes and 558 clinical model clients from a mix of inpatient and outpatient programs. After controlling for demographics and baseline problem severity, social model program clients were less likely than clinical model clients to report alcohol and other drug problems at the oneyear follow-up. More specifically, fifty-seven percent of social model clients reported no alcohol problems, compared to forty-nine percent of clinical model clients, and fifty-nine percent of social model clients reported having no drug problems, compared to fifty-one percent of clinical model[104] clients.

Data from a randomized controlled study was used to conduct a cost-benefit analysis. Economic cost measures were derived from length of stay at an Oxford House residence, and derived from selfreported measures of inpatient and outpatient treatment utilization . Economic benefit measures were

99

L. Jason, B. Olson, J., Ferrari, and A. Lo Sasso, Communal Housing Settings Enhance Substance Abuse Recovery, 96 American Journal of Public Health (10), (2006), at 1727-1729.

100

T. Berkman, L. Kaskutas, J. Room, K. Bryan, and D. Barrows, An Historical and Developmental Analysis of Socio/ Model Programs, 15 Journal of Substance Abuse Treatment (1), (1998), at 7-17.

101 Id.

102

J. Majer, L. Jason, C. North, J. Ferrari, N. Porter, B. Olson, M. Davis, D. Aase, and J. Molloy, A Longitudinal Analysis of Psychiatric Severity upon Outcomes Among Substance Abusers Residing in Self-Help Settings, 42 American Journal of Community Psychology, (2008), at 145-153.

103

L. Kaskutas, L. Ammon, and C. Weisner, A Naturalistic Comparison of Outcomes at Social and Clinical Model Substance Abuse Treatment Programs, 2 International Journal of Self Help and Self Care (2), (2003-2004), at 111-133.

104 Id.

23

derived from self-reported information on monthly income, days participating in illegal activities, alcohol and drug use, and incarceration. 105

While treatment costs were roughly $3000 higher for the OH group, benefits differed substantially between groups. Relative to usual care, OH enrollees exhibited a mean net benefit of $29,022 per person. The result suggests that the additional costs associated with OH treatment, roughly $3000, are returned nearly tenfold in the form of reduced criminal activity, incarceration, and drug and alcohol use as well as increases in earning from employment... even under the most conservative assumption, we find a statistically significant and economically meaningful net benefit to Oxford House of $17,800 per enrollee over two years. 106

Polcin, Korcha, Bond, and Galloway have undertaken comprehensive studies in California, focusing on Sacramento County and Berkley. In Berkley, fifty-five individuals entering four different sober living[107]

These houses were different from freehomes, operated by a specific provider were reviewed. standing sober living houses because all clients are required to attend outpatient treatment in

order to
be admitted. However, residents can remain at these houses after they complete treatment for as long
as they want as long as they follow the house rules. All participants were interviewed during their first
week of entering the houses between January 2004 and July 2006. 108
Polcin et. al., used generalized estimating equations models in order to include all participants in their
analyses even if they missed follow-up interviews. In the year before entering the program, the most
common substances residents were dependent on were cocaine, alcohol, cannabis, heroin, and
amphetamines. Residents entered the homes with relatively low average Alcohol Severity lndex 109
scores that were generally maintained at follow-up time points. 110 According to the researchers, it is
important to note that residents were able to retain their improvements even after leaving the
residence. 111
As a result
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of the review, Polcin et. al., found that:
Residents at six months were sixteen times more likely to report being abstinent.
Residents at twelve months were fifteen times more likely to report being abstinent.
Residents at eighteen months were six times more likely to report being abstinent. 112

In Sacramento County, 245 individuals entering sixteen sober living homes were reviewed. 113
Participants were recruited and interviewed during their first week of entering the houses between
105

A. Lo Sasso, E. Byro, L. Jason, J. Ferrari, and B. Olson, Benefits and Costs Associated with fv!utual-Help Community-Based
Recovery Homes: The Oxford House Model, 35 Evaluation and Program Planning (1). (2012), at 47-53.

ioG

Id.

107

Polcin et. al., 18 Month Outcomes (2010), at 352-366.
They were interviewed again six-months, twelve-months, and eighteen-months, with follow-up rates of 86%, 76%, and 71%,
respectively.
109
The Addiction Severity Index Ute (AS/) is a standardized, structured interview that assesses problem severity in six areas:
medical, employment/ support, drug/alcohol, legal, family/social, and psychological. The AS/ measures a 30-day period and
provides composite scores between 0 and 1 for each problem area. Id.
110
0.07 (baseline), 0.06 (6 months), 0.5 (12 months), and 0.11 (18 months). The same pattern was observed for drug severity:
0.05 (baseline), 0.03 (6 months), 0.05 (12 months), and 0.11 (18 months). Id.
111
Among the residents contacted for follow up interviews seventy-one percent had left the residence at twelve months and
eighty-six percent had left at eighteen months. Id.
112 Id.

114

January 2004 and July 2006. Among the total sample of 245, almost ninety percent participated in at

least one follow-up interview. Polcin et. al., used the same methodology as with the prior Berkley study.
In the year before entering the program, the most common substances residents were dependent on were methamphetamine and alcohol. Residents entered the homes with low average ASI alcohol scores
that showed significant improvement at six months and then were generally maintained at subsequent
follow-up time points. 115
There was a statistically significant decrease in the number of months they used drugs or alcohol, from
about three out of the six months before entering the sober living houses to about one and a half
months on average. Even among the almost eighty individuals who relapsed, there was a significant
reduction in the intensity of substance use. The number of days of substance use during the month of
heaviest use decreased from an average of twenty-three days at baseline to sixteen days at the sixmonth follow up.. Furthermore, there were significance improvements in the number of days worked,
116
the percent arrested, and the severity of psychiatric symptoms.
Impact on Surrounding Neighborhoods

The American Planning Association's 1997 Policy Guide on Community Residences reviewed more than fifty studies and concluded that community residences such as group homes and halfway houses do not
have an effect on the value of neighboring properties. Reviews also note that community residences are
often the best maintained homes on their block and that many neighbors were not even aware there was such a residence in the neighborhood. Other reviews have found no negative effects on neighborhood safety and that residents of group homes are much less likely to commit a crime of any
sort than the average resident. 117
Community residences have no effect on neighborhood safety. A handful of
studies have also looked at whether community residences compromise neighborhood
safety. The most thorough study, conducted for the State of Illinois, concluded that the residents of group homes are much less likely to commit a crime of any sort than the average resident of Illinois. Community residences do not generate adverse impacts on the surrounding community. Other studies have found that group homes and halfway houses for persons with disabilities do not generate undue amounts of traffic, noise,
.
parking demand, or any other adverse impacts. 118
Researchers reported that, knowledge of the existence of an Oxford House led to improved attitudes
toward those in substance abuse recovery and self-run substance abuse recovery homes. They summarized the major findings as follows:

113

D. Polcin, R. Korcha, J. Bond, and G. Galloway, Sober Living Houses for Alcohol and Drug Dependence: 18 Month Outcomes,
38 Journal of Substance Abuse Treatment, (2010), at 356-365.
114
They were interviewed again at 6-months, 12-months, and 18-months, with follow-up rates of 72%, 71%, and 73%,
respectively. Id.
115
0.16 (baseline), 0.10 (6 months), 0.10 (12 months), and 0.10 (18 months) . The same pattern was observed for drug severity :
0.08 (baseline), 0.05 (6 months), 0.06 (12 months), and 0.06 (18 months). Id.
116
D. Polcin, and D. Hendersen, A Clean and Sober Place to Live: Philosophy, Structure, and Purported Therapeutic Factors in
Sober Living House, 40 Journal of Psychoactive Drugs (2), (2008), at 153-159.
117
See, www.planning.org/policy/guides/pdf/communityresidences.pdf, site accessed August 18, 2013.
ns Id.

The study's major finding was that residents who lived next to an Oxford House versus those who lived a block away had significantly more positive attitudes concerning

the need to provide a supportive environment to those in recovery, the importance of allowing those in substance abuse recovery to live in residential neighborhoods, the need for recovery homes, and the willingness to have a self-run recovery home on their own block ... Another important finding was that there were no significant perceived differences in housing prices for those next to and those a block away from the Oxford Houses. In addition, among those interviewees who knew of the existence of the selfrun recovery home, the values of their houses had actually increased over a mean of 3 years. These findings suggest that the presence of the Oxford Houses did not lead to
119
reduced values for houses in these com munities.
In 2005, researchers surveyed individuals at an annual Oxford House World Convention. Greater than
eighty percent of participants indicated that they thought living in the Oxford House increased their
likelihood of involvement in their neighborhood. Respondents reported around eleven hours of community participation each month, in the following activities:

- Informing or advising agencies or local leaders
- Involvement in community anti-drug campaigns
- Working with youth
- Fundraising
- Attending community meetings
- Volunteering time with community organizations
- Attending public hearings and forums
- Speaking at political events 120

In a mixed-methods study of Oxford House residents, Jason et al., found that the overwhelming majority
of current and alumni members agreed that residents provide support and companionship for each other and that Oxford Houses provide motivation and increase member's sense of responsibility.
121
Both alumni and current residents also reported a variety of formal and informal helping activities in their community outside of Oxford House. Both groups were also similarly likely to respond that they were involved in formal volunteer work in the community and also engaged in informal neighborhood helping such as cleanups ... In the current study, alumni and current residents both tended to spend considerable time each week in neighborhood-helping activities, suggesting that these habits may form earlier in recovery and continue once residents move on to another location. Results from the current study also suggest that alumni and current residents are engaging in processes of change, such as helping relationships (via mutual-help involvement) and social liberation (via ongoing advocacy and community involvement) that are outlined in
122
the transtheoretical model of change for addictive behaviors.

119

Jason, Proximity (2005), at 529-535.
L. Jason, D. Schober, and B. Olson, Community Involvement Among Residents of Second-Order Change Recovery Homes, 20
The Australian Community Psychologist (1), (2008), at 73-83.
121
Jason, et. al., Neighborhood (2006).
122
L. Jason, D. Aase, D. Mueller, and J. Ferrari, Current and Previous Residents of Self-Governed Recovery Homes: Characteristics
of Long-Term Recovery, 27 Alcoholism Treatment Quarterly (4), (2009), at 442-452.
120

Researchers compared crime rates, from 2005, within a two-block radius of forty-two Oxford Houses
and forty-two control houses within the city limits of Portland, Oregon. There were no significant
differences between Oxford Houses and control houses with regard to the amount of any of the

tested
crimes - including assault, arson, burglary, larceny, robbery, homicide, and vehicle theft. 123
Researchers conducted in-depth qualitative interviews with neighbors living near one of the
Clean and
Sober Transitional Living houses in Fair Oaks, California. They found that:
Many of the neighbors also had a limited understanding of SLHs. In some cases,
they had no idea a SLH existed in the neighborhood; it seemed to them like any other
house. For those who were aware that there was a SLH in their neighborhood, there
was often a fairly vague notion of the population served and how the program
operated. Without information, some neighbors expressed fears that the residents
were mostly parolees or that they included sex offenders. They did not seem to be
aware that a minority (about 25%) of residents was referred from the criminal justice
system (i.e., jail or prison) and does not accept individuals convicted of sex offenses. 124
Neighbors who expressed concerns lived in the vicinity of six houses that were densely located
along a
two-block area in one complex. Some complaints related to noise and parking. Furthermore, a few
neighbors expressed fears about safety, the potential for an increase in crime, and declining
values of
houses in the neighborhood. However, when pressed.by the interviewer, they had difficulty
providing
125
examples of these issues.
Concerns about houses appeared to center mostly on issues such as the size and higher density
ofthese
houses in one area, as well as related concerns about noise and traffic. Only a few mentioned
issues
related to resident behavior, such as offensive language and leaving cigarette butts in the
area. 126

123
J. Deaner, L. Jason, D. Aase, and D. Mueller, The Relationship Between Neighborhood Criminal
Behavior and Oxford Houses,
30 Therapeutic Communities(1), (2009), at 89-94.
124
D. Polcin, D. Henderson, K. Trocki, K. Evans, and F. Wittman, Community Context of Sober Living
Houses, 20 Addiction
Research &Theory (6), (2012), 490-491.
125

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IX. Conclusions

This section discusses the feasibility, and consequence of action. As noted in section VI., of
this report,
the intersection of governmental housing action and the operation of the Fair Housing Amendment
Acts
(FHA) have resulted in litigation. This observation was made repeatedly during the collection of
information for this report. This is not a unique phenomenon to Florida, as it has been observed
by the
Connecticut Office of Legal Research, noting that:
Because people with substance abuse disorders are covered by the Americans with
Disabilities Act and the federal Fair Housing Act, state and local zoning and other
requirements meant to regulate them are subject to challenge. 127
In a 2010 report in response to Legislative requirement to study sober houses in the
Commonwealth,
the Massachusetts Bureau of Substance Abuse Services (BSAS) noted that:
The [FHA] limits the Commonwealth's and BSAS' authority to implement mandatory licensure,
regulation, registration or certification requirements directed specifically at ADF Housing
providers and residents. Federal courts have repeatedly rejected state and local efforts to
regulate ADF Housing. 128
In sum, the FHAA imposes a significant complication to local or state governments seeking to
impose licensure, regulatory, registration or certification requirements on ADF Housing. The
Commonwealth and BSAS would need to prove with reliable evidence or studies that any
proposed mandatory licensure, certification or registration requirement (1) benefits the
residents of ADF Housing, or responds to legitimate safety concerns in the community, (2) is
narrowly tailored, and (3) that a nondiscriminatory alternative means of achieving those goals
is

is
not available. 129
In public comment, a common thread running through what was presented was that there were bad actors that needed to be regulated or closed down. The following was presented to the Department, as
it relates to potential action:
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The Department is an appropriate agency to regulate and operate the licensure of recovery residences in the State of Florida. There are processes and procedures in place for the regulation of other similar uses of homes in residential neighborhoods and similar types of services being provided in the home setting environment. The fees for licensure and registrations could also be similar to fees currently being charged to other community residential homes. 130
The State of Florida cannot regulate a relationship between individuals who have a common interest in being sober, agree to live together and share rent . If this is truly the case, people
should not be discriminated against for this. The cost of any license/registration fee should
131
cover the cost of licensing/registering by DCF.

Supra, note 8.
Supra, note 10.

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id.

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See, Port St. Lucie Response, Appendix 3.
See, City of Delray Beach, Appendix 3.

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A certificate of need equivalent for new substance abuse treatment providers was proposed. 132
That the Department licensed substance abuse providers should be restricted to referring clients to recovery residences that are not voluntarily certified. 133
Concern about whether state agencies have the resources to enforce regulations.
There needed to be a market driven solution instead of focusing on a governmental
134
solution, as has been done in other states.

In relation to the cost of any government action, an industry advocacy organization, the National
Association for Recovery Residences (NARR), of which the Florida Association for Recovery Residences is
a member, has observed:
Most recovery residences (particularly levels 1 & 2) are self-funded through resident contribution, but recovery residences with higher levels of support, such as a range of clinical services, often receive other forms of federal, state, and private support. RRs are historically self-funded, eventually become self-sustainable, and utilize community of volunteers. Start-up costs are typically covered by the housing provider, an Angel Investor, or a nonprofit. As a part of their recovery process, residents are expected to work, pay rent, and support the house. In some cases, residents may not be able to fully cover operational costs, so housing providers offer short-term scholarship beds and utilize other financial resources in the community. No RR could financially survive without the use of volunteer staff and peer's cultivating the culture of recovery in homes . Start-up costs of RRs vary across the 4 Levels of Support. Lower Levels of

Support, RR ls and 2s, typically rent residential houses-a practice that avoids the capital cost of purchasing a property. The cost of capital improvements and fully furnishing a household to accommodate on average 10 residents is the largest start-up cost. Marketing, maintenance, and utilities are the largest operational expenses for the lower Levels of Support, RR ls and 2s. Higher Levels of Support, RR 3s and 4s, have higher staffing and administrative expenses as well as higher initial capital outlays. In general, RRs are NOT very profitable. By the time someone is ready to embrace recovery, they have often lost the financial means to afford to live in an RR at any price. Plus, occupancy rates can be inconsistent, and operational costs can be high. It may take several years for an RR to recoup start-up costs and achieve a positive cash flow . As a result, a single financial challenge, like defining housing rights, can easily cause an RR to close. 135

The 2010 Massachusetts Bureau of Substance Abuse Services (BSAS} report is instructive to Florida .

Noting in relation to the impact of BSAS not licensing alcohol and drug free homes (ADF) in Massachusetts:

BSAS has determined that all complaints about ADF homes fall into specific categories and have existing avenues for resolution. For example:

132

See, Alan Stevens, Appendix 3.

See, FARR, Appendix 3.

134

Appendices (2013).

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See, National Association of Recovery Residences . (2012) . A Primer on Recovery Residences : FAQs from the National

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Association of Recovery Residences www.narro nline.com/ NARR formation website/ Recove rv%20Residence%20Primer%20%20Long. pdf

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All nuisance complaints (such as noise), disruptive behavior of residents, and drug use complaints are typically handled by the local police;
Complaints regarding occupancy and substandard living conditions are typically handled by municipal Building and Fire Departments;
Complaints regarding unlicensed substance treatment programs are typically handled by the [Mass.] Department of Public Health, specifically BSAS;
Complaints regarding unfair housing practices, including eviction practices, are typically handled in ... court; and
Complaints regarding unscrupulous ADF Housing operators are typically handled through the [Mass.] Attorney General's Consumer Protection Division within the Consumer Protection and Advocacy Bureau. 136

Until additional independent research is conducted on the outcomes from recovery residences, that is sufficient to conclude which organizational structure is effective, and under what circumstances, the Department is unable to determine the extent to which they contribute to addressing substance use treatment. Absent this determination recovery residences are an issue of community concern similar to other issues related to land use, neighborhood character and, economic impact.

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Supra, note 10.

for 15th Judicial Circuit
SOBER HOME TASK FORCE

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The Following Reports/Statistics have been requested:
Information Requested

1. Number of currently licensed facilities/programs in PBC, Broward County, and state-wide under each category of treatment.

2. Number of licenses suspended or revoked within the last 10 years

3. Number of licenses not renewed within the last 10 years

4. Number of licenses voluntarily surrendered within the last 10 years

5. Of those licenses voluntarily surrendered, Number of providers who have re-applied for licensure.

6. DCF staff dedicated specifically to licensing and oversight of currently active drug treatment providers in PBC, Broward, and statewide. Include staff dedicated to licensure, and staff dedicated to investigation.

7. Number of complaints received in the last 10 years (if possible, breakdown per year). Type of complaints investigated by DCF. Type of complaints not investigated (e.g., referred to another agency)

Response
1 (a): Number of Providers By Region/Statewide
1 (b): Number of Providers for Treasure Coast, Palm Beach and Broward
1 (c): Licensed Components By Region/Statewide
1 (d): Licensed Components for Treasure Coast, Palm Beach and Broward
2 (a): Number of Licenses Revoked by FY 09/10 - FY 16/17
2 (b) : Number of Licenses Revoked by Region
Current Data system does not capture requested information

Page#

2
2

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N/A

4 (a): Number of Licenses voluntarily surrendered by FY 09/10 - FY 16/17

6

4 (b): Number of Licenses voluntarily surrendered by Region

6

N/A

Current Data system does not capture requested information

6 (a): DCF staff dedicated specifically to licensing and oversight of currently active drug treatment providers by Region.
6 (b): DCF staff dedicated specifically to licensing and oversight of currently active drug treatment providers for PBC and Broward
7 (a) - Statewide Number of complaints received in the last 10 years by FY 10/11- FY 16/17
7 (b) - Type of complaints investigated by DCF
7 (c) - Type of complaints not investigated (e.g., referred to another agency)

7

7

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8
8

Information Request: Sober Homes Task Force

llPage

Response: 1 (a)
Number of Providers by Region as of 8/31/2016*
...

Northwest
Northeast
Central
Sun Coast
Southern
Southeast

REGiON
.. ·--

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(

50
108
138
150
115
370

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)

TOTAL

931

Response: 1 (b)
Number of Providers for Treasure Coast, Palm Beach and Broward as of 8/31/2016*
Palm Beach
Broward
Treasure Coast

TOTAL

206

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115
49

321

Information Request: Sober Homes Task Force

21Page

Response: 1 (c)
Number of Licenses per Component by Region as of August 31, 2016*

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Addictions Receiving
Facility
Aftercare
Day or Night Treatment
Day or Night Treatment
with Community
Housing
Intensive Inpatient
Treatment
Intensive Outpatient
Treatment
Intervention - Case
Management

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30

4

2

19

11

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49
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(15GJ

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209
237

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(128)

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502

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118

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205

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24
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41

2

Intervention -TASC

4

Level 1 Prevention

32

21
0
49
2
65

Level 2 Prevention

13

Intervention - EAP
Intervention - General

Medication And
Methadone
Maintenance Treatment
Outpatient
Detoxification
Outpatient Methadone
Detoxification
Outpatient Treatment

0
21

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2

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45

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46

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12

166

164

151

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13

0

354
35
23

Residential - Level 1

2

Residential - Level 2

23

20

29

22

17

Residential - Level 3

1

Residential - Level 4

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1

Residential
Detoxification
Residential Methadone
Detoxification
Satellite Maintenance Medication And
Methadone
Maintenance Treatment

-

28
7

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118
8

Residential - Level 5

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56

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66

134

20
34

3

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(42 }

14

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89

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4

60

*Source: SALIS

Information Request: Sober Homes Task Force

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Response:1(d)
Number of Licenses per Component for Treasure Coast, Palm Beach and Broward as of
August 31, 2016*. ,
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-S.ROWARD
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Addictions Receiving Facility

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1

1

Aftercare

12

22

12

Day or Night Treatment
Day or Night Treatment with Community Housing

105

36

14

69
14

40

19

Intensive Inpatient Treatment

3

4

Intensive Outpatient Treatment

181

77

47

Intervention - Case Management

5

6

1

Intervention - EAP

0
7

0

0

Intervention - General

7

9

Intervention - TASC

1

1

1

Level 1 Prevention

9

14

Level 2 Prevention
Medication And Methadone Maintenance
Treatment
Outpatient Detoxification

3
11
3

5
1

3

3

13

Outpatient Methadone Detoxification

26
0

Outpatient Treatment

178

103

Residential - Level 1

25

5

Residential - Level 2

7

Residential - Level 3

3

Residential - Level 4

3

12
3
1

Residential - Level 5

25
25

14

Residential Detoxification
Residential Methadone Detoxification

2

1

Satellite Maintenance - Medication And
Methadone Maintenance Treatment

0

0

0

9

11
3
70
5
4
0
3
3
6
0
0

*Source: SALIS

Information Request: Sober Homes Task Force

Response: 2 (a)
#Licenses Revoked by FY 09/10- FY 16/17
License Revoked

FY09-10

6

FY 10-11
FY 12-13

5
0
0

FY 13-14

6

FY 14-15
FY 15-16

0
0

FY 16-17

1

FY 11-12

TOTAL

18

*Source: SALIS

Response: 2 (b)
# of Licenses Revoked by Region
FY 09-10

FY 10-11

FY 11-12

FY 12-13

FY 13-14

FY 14-15

FY 15-16

FY 16-17

Northwest
{Circuits 1, 2, 14)

0

0

0

0

0

0

0

0

Northeast {Circuits
3, 4, 7, 8)

4

0

0

0

2

0

0

1

Central {Circuits 5,
9, 10, 18)

2

5

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0

0

0

SunCoast {Circuits
6,12, 13, 20)

0

0

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4

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0

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Southeast {Circuits
15, 17, 19)

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0

0

0

0

0

0

Southern {Circuits
11, 16)

0

0

0

0

0

0

0

0

0

6
18

5

0

0

6

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1

REGION

SUBTOTALS
TOTAL
*Source: SALIS

Response: 3- N/A
Number of licenses not renewed within the last 10 years-Current Data system does not capture requested

information

Information Request: Sober Homes Task Force

SI

Page

Response: 4 (a)
Number of Licenses Voluntarily Surrendered by FY 10/11- FY 16/17
License Voluntarily Surrendered**
FY 10-11

48

FY.11-12

50

FY 12-13

78

FY 13-14

91

FY 14-15

154

FY 15-16

147

FY 16-17

16

584

TOTAL
*Source: SALIS

Response: 4 (b)
Number of Licenses Voluntarily Surrendered by Region
FY 1011

FY 1112

FY1213

FY 1314

FY 1415

FY 1516

FY 1617

Northwest
(Circuits 1, 2, 14)

6

6

13

18

35

24

0

Northeast
(Circuits 3, 4, 7, 8)

7

25

21

38

53

63

5

Central
(Circuits 5, 9, 10, 18)

4

1

5

2

7

2

0

SunCoast
(Circuits 6, 12, 13, 20)

4

6

28

27

46

38

6

Southeast
(Circuits 15, 17, 19)

27

10

10

6

13

9

s

Southern
(Circuits 11, 16)

0

2

1

0

0

11

0

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48

50

78

91

154

147

16

REGION

Total
*Source : SALIS

I

Response: 5- N/A
Of those licenses voluntarily surrendered, # of providers who have re-applied for licensure.
Database does

not capture this data

Information Request: Sober Homes Task Force

6jP a ge

Response: 6 (a)
DCF staff dedicated specifically to licensing and oversight of currently active drug treatment providers by Region.
Office of Substance Abuse and Mental Health Licensing staff. All Licensing staff are involved in licensing and
related activities, as well as involved in conducting and reporting on licensure inspections.

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***No Specific Staff identified for Investigations

Response: 6 (b)
DCF staff dedicated specifically to licensing and oversight of currently active drug treatment providers for PBC and Broward
Nine (9) Licensing Staff Identified in Palm Beach and Broward are involved in licensing and related activities, as
well as involved in conducting and reporting on licensure inspections.

Southeast Region
(Palm Beach County, Broward County, Indian River, Martin, Okeechobee & St. Lucie Counties)

Valerie Allen
Sarah Liccardi
Sha la Brown
Christine Saretto

Alexandra Cadet
Carol Edlund
Max Elhamad

Substance Abuse Coordinator

Substance Abuse
Substance Abuse
Substance Abuse
Substance Abuse

Licensin
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Licensin

Substance Abuse Licensin

Information Request: Sober Homes Task Force

71Page

Response: 7 (a)
Statewide Number of complaints received in the last 10 years by FY 10/11 - FY 16/17
FY 10-11

60

FY 11-12

34

FY 12-13

22
15

FY 13-14
FY 14-15

21

FY 15-16

22
TOTAL

174

*Source: SALIS

Response: 7 (b)
Type of complaints investigated by DCF
•
•
•
•

Dissatisfaction with Treatment
Dissatisfaction with Treatment Cost
Non-Compliant with Licensure Standards
Client Rights Violations

•

Food
•
•
Sanitation, Health and Safety
•
Sexual Abuse
•
Verbal I Emotional Abuse
•
Physical Abuse
•
Inappropriate Behavior Between Clients
Misrepresentation Regarding Service Provided

Response: 7 (c)
Type of complaints not investigated (e.g., referred to another agency)
Each complaint that is received is reviewed to determine issues related to 650-30 F.A.C. substance licensing
standards. In the event that there are issues unrelated to 65D-30 F.A.C. substance licensing standards, they
are advised to contact the appropriate agency to address the identified concern.

Information Request: Sober Homes Task Force

Bl Page

Erroneous/misleading Google Map Business Listing 1

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Source: "Scientology Seeks Captive Converts Via Google Maps, Drug Rehab Centers~ June 27, 2016, (http://krebsonsecurity.com/2016/06/scientology-seeks-captive-converts-via-google-maps-drug-rehab-centers/)

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Erroneous/misleading Google Map Business Listing 2
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Gat&way Community Services Drug

Addiction Treatment Call
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• National call center
• Not associated with Gateway
Community Services
• Not located in Jacksonville
• Refers callers to other unknown centers

Erroneous/Misleading Google Listing
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• National call center

• Not associated with Gosnold
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Recent Media Coverage of Unethical Practices in Addition Treatment
BUZZFEED, MAR 2016
In South Florida's Delray Beach, home to hundreds of rehab facilities and halfway houses, scams abound to profit off of addicts and their insurance policies.
https://www.buzzfeed.com/catferguson/addjction-marketplace?utm term=. rqp3o85ZP9#.rv28yBgvmM
PALM BEACH POST series·INSIDE THE GOLD RUSH
http://www.mypalmbeachpost.com/s/soberhomes/
PALM BEACH POST, SEP 2016
Two years after FBI raids, no indictments against sober home operators
2 years have passed with no arrests of anyone connected with the raided sober homes or any other operators in Palm Beach County. No $100,000 cars seized or property confiscated. The .
epic comeuppance never arrived. Business quietly resumed.
http://www.mypalmbeachpost.com/news/news/state-reqionaVtwo-years-after-fbi-raids-no-indictments-against-s/nsT23/
SUN-SENTINEL, AUG 2016
Community leaders hope a new state law will help curb problems with sober homes, where people transition from rehabilitation facilities to "regular'' life. These homes were not monitored at all
in Florida until July 1, when the state launched a voluntary certification program aimed at tracking and regulating them.
http://www.sun-sentinel.com/news/palm-beach/fl-delray-beach-sober-homes-20150820-storv.html
PALM BEACH POST, AUG 2016
Eric Snyder: Muscle-bound millionaire of addiction treatment under scrutiny
Two years ago, Snyder, 29, caught the attention of a federal task force investigating hundreds of millions of dollars worth of insurance fraud, kickbacks and patient brokering in Palm Beach County's drug treatment industry.
http://insurancenewsnet.com/oarticle/muscle-bound-millionaire-of-addiction-treatment-under-scrutinv
PALM BEACH POST, MAY 2016
Insurer sues lab company, alleging addiction treatment kickbacks
According to a United lawsuit, owners of Florida addiction treatment businesses were invited to invest in Sky's booming lab business. In exchange, they could reap tens of thousands of dollars a month.
http://www.mypalmbeachpost.com/news/news/crime-law/insurer-sues-lab-company-alleging-addiction-treatm/nrGbs/
PALM BEACH POST, MAR 2016
The Florida Legislature responded to corruption in the drug treatment industry that spawned an FBI task force by killing bills by two local lawmakers that would have addressed shady business practices and by de-funding the Florida Association of Recovery Residences - the Boca Raton-based non-profit tasked with creating a voluntary certification program for sober homes.
http://www.mypalmbeachpost.com/news/news/state-regional-govt-oolitics/session-ends-with-sober-home-leqislation-knocked-d/nghBR/
PALM BEACH POST, OCT 2015
Cigna pulls out of Fla. exchange, blames addiction treatment fraud
http://www.mypalmbeachpost.com/news/news/ciqna-pulls-out-of-florida-exchange-blames-addjcti/nn4gx/
BUZZFEED, SEP 2015
Stories abound in Delray Beach of halfway house owners charging insurance companies thousands of dollars a month for simple urine tests, collecting illegal referral fees from rehab programs, and even finding ways to get addicts drugs in hopes that they will relapse.
httos://www buzzfeed,com/catferguson/the-rehab-scam?utm term=.pf8K2eQ3DN#.dmwdK16Xza
PALM BEACH POST, AUG 2015
Palm Beach County's $1 billion gold rush: Addiction treatment draws FBI
http://www.mypalmbeachpost.com/news/news/countys-1-billion-qold-rush-addictjon-treatment-dr/nm9J9/
PALM BEACH POST, DEC 2014
FBI raids two halfway houses in Delray Beach
"20 percent are bad operators and they're giving a bad name to the good operators and making it

difficult for them to compete in the marketplace."
http://www.mypalmbeachpost.com/news/news/crime-law/fbj-rajds-two-halfway-houses-in-delray-beach/njTwS/
HUFFPOST: The Rehab Industry Needs to Clean Up Its Act. Here's How by Maia Szalavitz
!:!ttQ://www.huffinqtonpost.com/the-influence/the-rehab-industrv-needs-clean-up b 9210542.html

DELRAY BEACH POLICI! DEPARTMENT

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2016 OVERDOSES BY TYPE
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 Delray Beach Police Department
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 DELRAY BEACH POLICE DEPARTMENT
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September 2016
Heroin Overdoses Other
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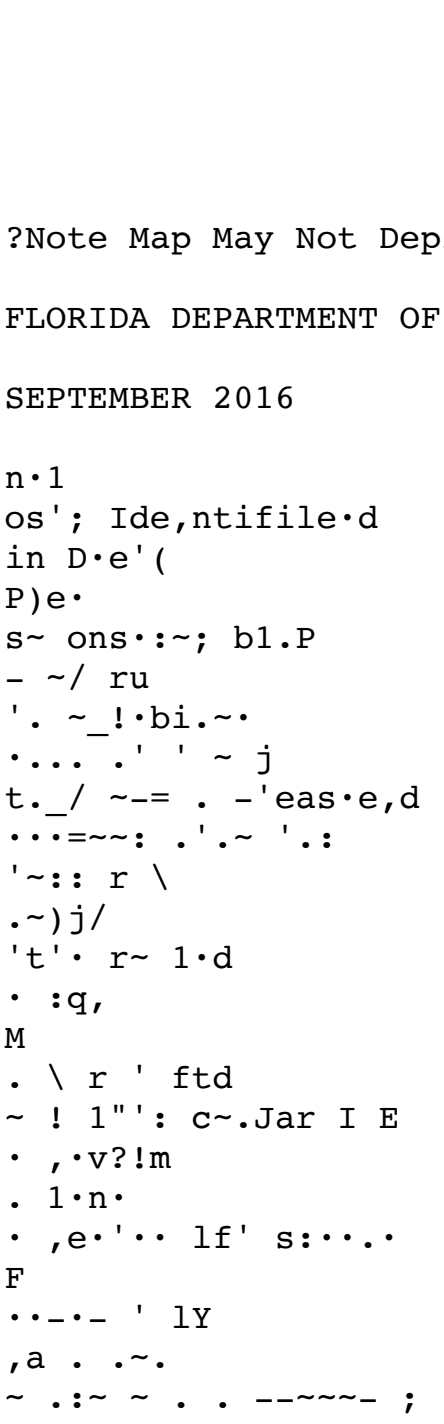
?Note Map May Not Depict All Locations"

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

SEPTEMBER 2016



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Data Collection

The State of Florida's Bureau of Vital Statistics reported 194,304 deaths in Florida during 2015. Of the 24,740 deaths investigated by the state's medical examiners, toxicology results determined that the drugs listed below were present at the time .of death in 9,784 deaths. The medical examiners assessed whether the drug(s) identified was the cause of death or merely present at the time of death. The data were then submitted to the Medical Examiners Commission for presentation in this report. It is important to note that each death is a single case, while each time a drug is detected represents an occurrence. The vast majority of the 9,784 deaths had more than one drug occurrence.

When reporting the data, the state's medical examiners were asked to distinguish between the drugs determined to be the cause of death and those drugs that were present in the body at the time of death. A drug is indicated as the cause of death only when, after examining all evidence, the autopsy, and toxicology results, the medical examiner determines the drug played a causal role in the death. lt is not uncommon for a decedent to have multiple drugs listed as a cause of death. However, a drug may not have played a causal role in the death even when the medical examiner determines the drug is present or identifiable in the decedent. Therefore, a decedent often is found to have multiple drugs listed as present; these are drug occurrences and are not equivalent to deaths.

Data were collected on the following drugs:

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•Midatofam ·

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•Nordiazepam

•Oxazepam
•Temazepam
•Triazolam

2015 Medical Examiners Commission Drug Report

;•Buprenorpl1ine
.•Codeine
;•Fentanyl
•Heroin
•Hydrocodone .
•Hydrornorphone ·
•Meperidine ·
•Methadone
•Morphine ·
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•Tramadol

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•Cathi nones
•·Cocairie
•GHB
•Ketamine
•Sympathomimetic Arntnes
•Synthetic Cannabifloids
•Zolpidem

Highlights
./ Total drug-related deaths increased by 13.9 percent (1,197 more) when compared with 2014 .
./

5,364 (12.4 percent more than 2014) individuals died with one or more prescription drugs in their system. The drugs were identified as either the cause of death or merely present in the decedent. These drugs may have also been mixed with illicit drugs and/or alcohol.

./

2,530 (22.7 percent more than 2014) individuals died with at least one prescription drug in their system that was identified as the cause of death. These drugs may have been mixed with other prescription drugs, illicit drugs, and/or alcohol.

./

Prescription drugs (benzodiazepines, carisoprodol/meprobamate, zolpidem, and all opioids excluding heroin) continued to be found more often than illicit drugs, both as the cause of death and present at death. Prescription drugs account for 67.7 percent of all drug occurrences in this report when ethyl alcohol is excluded .

./ The five most frequently occurring drugs found in decedents were ethyl alcohol (4,762}, benzodiazepines (4,604, including 1,439 alprazolam occurrences), cocaine (1,834), cannabinoids (1,720), and morphine {1,483). The increase in positive cannabinoid findings is due to the increased surveillance by medical examiner offices and not a direct reflection of the increased use of cannabis by decedents .
./ The drugs that caused the most deaths were benzodiazepines (1,140, including 588 alprazolam deaths and 163 diazepam deaths}, cocaine (967), morphine (895), ethyl alcohol (810), heroin (733), fentanyl (705), oxycodone (565), methadone

(290), and hydrocodone (236). Heroin (94.1 percent),
fentanyl (77.4 percent), methadone (64.0 percent), morphine (60.4 percent), cocaine {52.7
percent), and oxycodone (52.3 percent) were listed as
causing death in more than 50 percent of the deaths in which these drugs were found .
./

Occurrences of heroin increased by 74.3 percent and deaths caused by heroin increased by 79.7
percent when compared with 2014 .

./ Occurrences of fentanyl increased by 69.3 percent and deaths caused by fentanyl increased by
77 .6 percent when compared with 2014 .
./

Occurrences of methadone (8.3 percent) and hydrocodone (9.1 percent) decreased when compared
with 2014. Also, deaths caused by methadone (22
less) and hydrocodone (14 less) decreased when compared to 2014 .

./ Occurrences of morphine increased by 24.3 percent and deaths caused by morphine (190 more)
increased when compared to 2014 .
./

Occurrences of oxycodone increased by 10.5 percent and deaths caused by oxycodone increased by
20.2 percent when compared with 2014 .

./ Occurrences of tramadol decreased by 18.9 percent and deaths caused by tramadol (7 less)
decreased when compared to 2014 .
./

Occurrences of cocaine increased by 21.6 percent and deaths caused by cocaine increased by 34.3
percent when compared with 2014 .

./

Alprazolam (Xanax), diazepam (Valium), and nordiazepam dominate the category of benzodiazepines.
Occurrences of alprazolam increased by 9.3
percent, diazepam increased by 3.1 percent, and nordiazepam decreased by 0.9 percent when
compared to 2014. Alprazolam, diazepam, and
nordiazepam are rarely the sole cause of death, but are common as contributing to the cause of
multi-drug deaths. Note that since the drugs diazepam
and chlordiazepoxide (Librium) are normally broken down in the body into the drug nordiazepam,
many occurrences of nordiazepam may represent
ingestion of these other benzodiazepines .

./

Occurrences of methamphetamine (40.6 percent) and amphetamine (26.1 percent) increased when
compared to 2014. Deaths caused by
methamphetamine (68 more than 2014) and amphetamine (20 more than 2014) increased in 2015 .

./

Reporting of occurrences of illicit fentanyl analogs was not specifically requested by the
Commission in 2015. Due to the rapid rise of deaths associated
with fentanyl analogs, many districts voluntarily reported data; however, the data is not
complete. A total of 96 occurrences of fentanyl analogs were
reported for 2015, with the majority identified as acetyl fentanyl (65 percent). Refer to page
34 of the report for a representation of the frequency of
occurrence of fentanyl analogs. Reporting of fentanyl analogs by all districts will begin with
the 2016 Drugs Identified in Deceased Persons Reports.

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20 I 5 Medical Examiners Commission Drug Report

Table of Contents

C-overage Map
Florida Medical Examiner
Districts

District 1
Escambia
Okaloosa
Santa Rosa
Walton
District 2
Franklin
Gadsde_n
Leon
Liberty
Jefferson
Taylor
Wakulla
District 3 *Covered by
Columbia *4
Dixie *8
Hamilton *4
Lafayette *2
Madison *2
Suwannee *2
District 4
Duval
Nassau
Clay

District 5
Citrus
Hernando
Lake
Marion
Sumter
Dist rict 6
Pinellas
Pasco
District 7
Volusia
District 8
Alach ua
Baker
Bradford
Gilchrist
Levy

Union
District 9
Orange
Osceola
District 10
Hardee
Highlands
Polk

2015 Medical Examiners Commission Dntg Report

District 11
Miami-Dade

District 18
Brevard

District 12
DeSoto
Manatee
Sarasota

District 19
Indian River
Martin
Okeechobee
St Lucie

District 13
Hillsborough
District 14
Bay
Calhoun
Gulf
Jackson
Washington
Holmes
District 15
Palm Beach
District 16
Monroe
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Glades
Hendry
Lee
District 22
Charlotte
District 23
Flagler
Putnam
St Johns
District 24
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Summary of Drug Occurrences in Decedents
2015
DRUG PRESENT IN BODY

CAUSE

PRESENT

TOTAL OCCU RRENCES

Amphetamine

87

300

387

Methamphetamine

156

Atpi:azolam

588

851

Chlordiazepoxide

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95

Clona;zepam

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Diazepam

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·P.nenethylamines/Piperazrnes

12

10

22

Tryptamines

2

0

r

236

'

16l.

v::. :.,: '

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.. ~· ' •i
...~'"-

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149

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2015 Medical Examiners Commission J?rug Report

2

Page2

Summary of Drug Occurrences in Decedents (continued)

DRUG PRESENT IN BODY

CAUSE

PRESENT

Halogenated

8

Helium

42
20

Hydrncatbdn

10

Nitrous Oxide

2

,.•¥tr.~!.

Buprenorpl:iine

~~J.o;~j~:l

Codeine

18
73
705
733
236
167
1
290
895
565
105
108
6
35
84
967

•:!~{1 ·,,.~c~. f

~f'-~c-:f:J
:. c,i
_1 c~- >~,...

;-~~-~-~~~,
--~...,

.1

1!L CL . '.;

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9'"'."'"'

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,ll.jt.•. '
'!. . . .MJ:"

·'Iif'~ ?:. : ';_~ .

Feri-taflyl
Heroin

6~·:.p I~~~.• _~:~~ ~ ~~: ·:~~
' .. ; ~:a·j'2.
. 1'~ ?JI,·

Hydromorphone

~~,,a. ·'.''

Meperidine

lo

:0 ;'• .
·~
. ·~

I ~;i~.,_r.:..'·:-£

Hydrocodone

Methadone
Morph·ine

.~~!' '
t-jf ~ ·1_;~3
'4Jl.','11~
. - . ..
. -~,-~:~} _- r-

Oxymorphone

·. ·:·<~

Cannabino•ids

~

'

~~~-:
~

.•r

Oxycodone

__, -~>-
~~~

,f~-..,

r .,.. ....,
~-

.. !

Tramadol

Carisoprodol/Meprobamate
·CathJnones

,, J .';: i.:.·'"

l~

.~
/Wt~-;-:

Cocaine

Syrnpathornimetic Amines

3
6
7

,. •""
!(
·~ ~,:,r,
..:ili

Synthetic Cannabinoids

11
f!!·

Zotpidem

so

$.0

:·

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~

~·..:,,.,~
I~'",

'n'~- ~
-~

.

GHB
Ketamine

0
1
0
53
405
206
46
444
354

TOTAL OCCURRENCES

', 50

..,.

·.· 11 '

~~),..:

..... ?·
'

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il

4'78:.
I""~·

· .!fl:~.;!:

779 .
68((
.~21 ·

• S.

7

4S3~

163
588
516
284
331
1,714
94

1423 ·
· ' ·-•...,:';..!

•

· los:::i.·
.I

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. ~;8~

439

i,no
129
.12.n

139

867
2
40
14
12
152

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· ~

...

. ·20 · ,,

"

' l.;834

5'

46

'•

-- 21
2.3
·

202

Note: The total occurrences for buprenorphine and cannabinoids are under reported due to the variability in analytical protocols in place at medical examiner offices. Medical examiners were asked ta identify any metabolites of parent drugs. Since heroin is rapidly metabolized to morphine, this may lead to a slight over-reporting of morphine-related deaths. Many deaths were found to have several drugs contributing to the death, and therefore, the count of specific drugs listed is greater than the number of deaths.

2015 Medical Examiners Commission Drug Report

Page]

,. ..

Frequency of Occurrence of Drugs in Decedents 1
January - December 2015

r

Amphetamine
Clonazepam
Methamphetamine
1.9%
2.2%
1.s%

Cathinones

I

1.1%"
Cocatne

Diazepam
2.9%

Lorazepam

8.8%
Tramadol

Nordiazepam
3.2%

2.1%"""'.
Oxymorphone_ ••
1.9%

2.0%
Temazepam
2.5%

2.2%

Hydromorphone
2.5%
Codeine
2.3%
L_ _ __

-·--·---------- -------·-··-··--.. -----··---- ·-·--·-···--·-··------

·_

-

1

The following drugs individually constituted less than 1 percent of drug frequencies and are not included: chlordiazepoxide, estazolam, flunitrazepam, flurazepam, midazolam, triazolam, of/ hallucinogenics, all inhalants, buprenorphine, meperidine, carisoprodol/meprobamate, GHB, ketamine, sympathomimetic amines, synthetic cannabinoids, and zo/pidem.
Note: Percentages may not sum to 100 percent because of rounding.

2015 Medical Examiners Commission Drug Report

Page 4

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0

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cu

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0

V)

-s
.E

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cu

iii
.....

..a

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......

.....
C:>
"l

 Comparison of Drug Occurrences in Decedents
2014 to 2015
2014

2015

PERCENTAGE CHANGE

Amphetamine

307

387

26.1%

Metharnphetarnine

217

305

Alprazolam

1,316
92
382
586
2
0
9
191
163
678
385
477

1,439
107
455

1

3

DRUG PRESENT IN BODY

Chlordiazepoxide

·c1onazepam
mazepam

Estazolam
Flunitrazepam
Flurazepam
Lorazepam

Midazolam
Nordiazepam
Oxazepam
Temazeparn

604
2
1
8
236
161
672
405
511

4Ct:6%.

I
'
~

·9,3%
16,3%

–

i9;,:%
:3,.1%
•*

"

'
:

.

~ ~.

...

*.
.. *
23.(3%
–.t;~%

· ~o.:9:%

–

. .
–·
.– –

..

5.f%:
i.I%

*
~'If'

4,270

4,762

Phencyclidine (PCP)

2

2

*

Phenethylami·nes/Piperazines

17

22

*

Tryptamines

1

2

*

11.5%

"Due to the small number of occurrences, percent changes were not calculated.
Note: Many deaths were found to have several drugs contributing to the death, and therefore, the count of specific drugs listed is greater than the number of deaths.

Comparison of Drug Occurrences in Decedents (continued)

"'• ~

2014

2015

Hafr>genated

33
30

50
20

'5,1.$%

16
1
35

11

"'

71

Codeine

304

478

Fentanyl

538
447

911
779

6£h3%

748
444
14
494

680
521
8
453
1,483
1,081

~SL1%

.)

~ :·

! Ill~

, ~, ;;;.-~,

' .'i.-·'

1~,..:: ·-"~- ~": ·

'«,..,._·~o, '. w. ::

.~. J~~;I,

ffn-,J ~ -~t lr,
'\'!9:
. ~

DRUG PRESENT IN BODY

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.....

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'-r

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' .;_~~
~.···

;cl -: ~
•a }>:-

o,,,

Helium
Hydrocarbon
Nitrous Oxide
Buprenorphine

Heroin
Hydrocodone
Hydromorphone
Meperidine
Methadone

.. tfi' ... :-i:~:;-;

·~t!~ ~;~.:

Morphine

:,~ -~t.;";,. ~

Oxycodone

::/" ~~.l~\'!.

Oxymorphone

\Ii ..

.~.'

·'.1c·r1·.~
,~ ;·

/'.I'

·_

·:o,i~

Tramadol
Cannabinoids
Caris.oprodol/Meprobamate

_~
~

f ·~ _~ _'~

Cathinones

..

Cocaine

··~·:,''

..':
··

:·:;

"'.
!:

o.r.'·-

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r.

l,J...,.... - ;:::
of;

0

• 11' 1:·

~

GHB
Ketamine
Sympathomimetic Amines
Synthetic Cannabinoids
Zolpidem

1,193
978
275
541
1,092
198
134
1,508
2
31
25
9
229

PERCENTAGECHANGE
i<

2

389
439
1,720
129
223
1,834
5
46

21
23
202

"''

1oi.9%
;_ ·

··· ,

..

57;2%

7tt:3%'

-~z.,

' 17~3%

. "'
··-8.3%
24.3%:·

i0.s%
4~.!$%

"18.9%
II,

5)7.5~

:34'.a%

..

6fF4%
2LG%
')

~.

48.4.% 1
.*

*
.· -11,8%

•oue to the small number of occurrences, percent changes were nat calculated.
1
The increase in ketamine occurrences is largely due to the clinical use of ketamine as a sedative and anesthetic in the hospital.
Note: Many deaths were found to have several drugs contributing to the death, and therefore, the count of specific drugs listed is greater than the number of deaths.

Comparison of Drug Caused Deaths
2013 to 2015

300
200
100
0

~

q.

~
~

~7
~

co

ir

~

~

~
~

%

%

iii January - December 2013

~

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?(I>

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%

•January - December 2014

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-<'

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oC'!

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~(I>

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co

°O
?(I>

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'?(I>

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O)Q:-

~(I>

uJanuary - December 2015

Note: Not all drugs are included in the above chart.

2015 Medical Examiners Commission Drug Report

Page 7

Frequency of Occurrence of Benzodiazepines
January - December 2015

l

------- -- ---------- - -------- - ----------------··-···--·---···--··---------·------ -------
---·--------·------- ---- - - - - - --- ----- - - - ----1
Temaiepam

11.1%

2.3%

I

l _ __ _
---------- ~~

-

Note: Benzodiozepines not included individually constituted less than 1 percent of occurrences. Percentages may not sum to 100 percent because of rounding. Several benzodiazepines (for example, diozepam) are metabolized to other benzodiazepines in the body (for example, nordiazepam, oxazepam, and temazepam). Thus, occurrences of nordiazepam, oxazepam, and temazepam may be due to the ingestion of diazepam, chlordiazepoxide, and/or temazepam.

2015 Medical Examiners Commission Drug Report

Page8

Alprazolam Deaths
January- December 2015

Meditai Examiaer·Dist*t·
: and Area 'of flo~i;ija
District

1
2
3
4
5
6
7

Total

wttf;iAlpraiolarn

Ar.ea of Florida

Total

Cause

Present

Pensacola

71
9

30
6
8
49
27
58
33
10

29

41
3
5
38
10
78
8
2
27
26
47
44
47
13
56
3
69
30
4
10
10
7
4
6

49
157
36
80
14
33
9
24
40
29
16
22
16
10
23

1,4$~

.5'8'8

851

Tallahassee
Live Oak

13

Jacksonville

S7

Leesburg

37

St. Petersburg

1~6

Daytona Beach

4~

8
9
10

Gainesville

12

Orlando
Lakeland

99

11

Miami

75
204
12
13
14
15

Sarasota

80

Tampa
Panama City
West Palm Beach

127
27

..

!>eat'*~

' 8:9

12

16

Florida Keys

17
18
19
20

Ft. Lauderdale

9$

Melbourne

70

Ft. Pierce
Naples

33
26

21

Ft. Myers

32

22

Port Charlotte

23

23
24

St. Augustine

14

Sanford

Statewh;,te.Totals

2015 Medical Examiners Commission Drug Report

72

Deathls;with Atpr.azolam

ontv

l)eaths with At.pr@zolain 'in
wtth O~ger Qrl!~

C~~bi!)atioo

tota1

Cause

Present

Total

Cau~e

Present

3

11

5

2
3

1
0

2
0
2
1

3
0
1
4
1
12
1
3
7
2
19
5
20
2
0
1
3
4
1

6~

5
1

0
0
0
1
0
25

41
3
5
37
10
73
7
2
25
26
45
43
42
13

88

SS

11

27
6
7
45
26
46
32
7
65
47
138
31
60

60
12
33
8
21
36
28
15
20

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2
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6
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2
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5
4
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118

s
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22

9
1,2
~2

36

119
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9.

90

73
1~~ .
74

102

1

25

2
1
0
3

2;9

26

3
67
30
4
10
9
6
4
6

96

1,.32~

566

813

66
12

21
14

lS
10
20
755

Alprazolam Deaths by Age
January- December 2015
· · . M~diQal EX.9.~iner DiStriet..
an~ Area ef Florida

Al!ilr~zmt~m c;~us¢d o~atb

l

Alprazpla)lil. . Present ~t Deatb

..

Age of Decedent ·

Age of Decedent .

Dist rict

Area of Florida

Total

Total

<18

18-25

26-34

35-50

>SO

Tota.I

<18

18-25

1
2

Pensacola

71

4J,

9

3

3

Live Oak

1.3

5

Jacksonville

87

3$

10
0
0
12

5

Leesburg

37

li.O

6

St. Petersburg

136

7'8

2
0
1
4
2
6
2
0
4
1
7
3

3
0
7
0
11
2
0
1
0
1
0
2
59

17
1
3
10
5
19
4
1
8
10
16
16
21
3
17
3
23
12
2
3
3
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12
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12
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39
2
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3

30

Tallahassee

1

7
8
9

Daytona Beach

41

Gainesville

12
99

10

Lakeland

Orlando

:8
2
27

75
. 204

47

2;@

11

Miami

12
13

Sarasota

80

80

44

Tampa

117

47

14

Panama City

27

13

15
16
17

West Palm Beach

89

5'6

Florida Keys

12
93

18
19

Melbourne

20

Naples

Ft. Lauderdale
Ft. Pierce

21

Ft. Myers

22
23
24

Port Charlotte
St. Augustine
Sanford

State\Nide Totals

3
69
lO

70
33
Zf;l
32

2'3
14
2~
1.4~9

4·

10

10
7

4
6
58.8

2015 Medical Examiners Commission Drug Report

2
14
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0
6
7
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14
9
1
13

0
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7
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125

6
I•

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72
4',9

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9

40'

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3

2'9

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0
0
10

19
0

' 1~9

157

i6
: 22
•. 16

10
23
SSl

4

8
6
3

2
11
8
26
3
10
2
10

0
2
2
5
0

1
0
2
1
113

•, 26-34
4

0
1
10
5
6
5
1
10
8
28
5
9

4
6
3
3
4
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5
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13,1

35-50

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8
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5
12
11
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26

11
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5
20

18
36
8
20
4

9

32
14
7
24
15
65
20
40
4
7
3
13
21

10
3
6
12

11
2
8
7
4
7

11

236

3'61

10
10

8
7

3

Page JO

Alprazolam Deaths by County
2015

Occurrences
Per 100,000 Population

0
0.01 - 4.99
5.00 - 9.99
10.00 - 14.99
15.00 - 19.99

Comer

6!9war-O

20.00 - 24.99

.I

> 25.00

2015 Medical Examiners Commission Drug Report
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crdl" -

;1"'

Page 11

Diazepam Deaths
January- December 2015
Medical
,fixan:iiner
. .
. bistrrct
. '
af\d Area pf Ffodd~
-

'

Area oHiorida

TotEd Death$ wlth · Diiiz:~am

1

Pensacola

' total
21

'2

Tallahassee

8

3
4

Live Oak

4

Jacksonville

61

Leesburg

24

0

St. Petersburg

59
25

41

Gainesville

9

4

47
24
18
22
5

9

Orlando

37

0

37

10
11

Lakeland

13

Miami

s8

1
3

12

Sarasota

13

Tampa

14
15
16
17
18
19
20
21
22
23
24

Panama City

36
30
16
43
8

12
55
18
14
12
28

D:istrict

5
6
7,
8

Daytona Beach

West Palm Beach
Florida Keys

Cau-se

Present

8
1
1
14

13

1

7

0

3

(1)

1

3

18

16
4
15
1

Naples

17

Ft. Myers

18

Sanford

0

0

32

0

0

0

Ft. Pierce

28
32
12
4

0
0

0

10

14

0
0
0
0

14

9

13

St. Augustine

Present

0

19
41

Port Charlotte

0
1

()

0
0
()

6

1
0

1
4
2
1
0
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0

Only.

Cause

13
3

7

Melbourne

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5
5
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Ft. Lauderdale

Statewide TOtats

De~ths--w.tt~ ' Dia~epam

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6

6
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0

Deaths wttbo: Dja~E!pam ln

Cq~~lO.at,on V'lth Qt~~r Qrugs
Cause
Prese.nt
Total
20
8
12
1
7
8
4
1
3
14
46
60
24
24
0
41
17
S'S
22
25
3
4
5
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37
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37
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12
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52
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6
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18
10
41
13
28
32
0
32
5
12
17
18
5
13
1
4
3
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14
14

7

0

7

2

0

2

5

0

5

604

163

441

21

1

20

583

isz

421

2015 Medical Examiners Commission Drug Report

Page 12

Diazepam Deaths by Age
January- December 2015
Medit~I ~1faminer Distri·tt:
. . -an:d-A:rea
of •fto.rida
.
.··:"'.' '"
·.
Area of Florida
Total
District

1

Pensacola

21

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.,.flia~~pa.m ·. Cau,sed ·tl'eath

(

Tallahassee

s

Live Oak

4

4

Jacksonville

61

5

Leesburg

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26·34

35-50

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TQta'i

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18-25

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35.-50

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14
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7

Daytona Beach

25

3

8
9

Gainesville

9

Orlando

3]

10

Lakeland

13

4
0
1

11
12

Miami

58

3

Sarasota

36

18

Tampa

3~

16.

Panama City

1~

West Palm Beach

43
8

· 4

15

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0

17

17

Ft. Lauderdale

19

1
9

1,8

Melbourne

41

13

.o

19

Ft. Pierce

3:2

0

0

20
21
22

Naples

17

18

Port Charlotte

4

23

St. Augustine

24

Sanford

14
7

5
5
1
0
0

604

163

StateW:ide totals

oi~zep.am Pre$~~t ~tiPe~th .
Age of b~cederii

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Ft. Myers

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St. Petersburg

Florida Keys

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Age of Decedent

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20 I 5 Medical Kr.aminers Commission Drug Report

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Page 13

Diazepam Deaths by County
2015

Occurrences
Per 100,000 Population
0

0.01 - 4.99
5.00 - 9.99
10.00 - 14.99
15.00-19.99

Collier

Broward

20.00 - 24.99
> 25.00

2015 Medical Examiners Commission Drug Report

Page 14

Occurrences of Alprazolam and Diazepam
(Present and Cause)
2006 to 2015
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20 I 5 Medical Examiners Commission Drug Report

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Page 15

Oxycodone Deaths
January- December 2015

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and Area o~ Florida
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Area of Florida
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94
32

Gainesville
Orlando

72

Lakeland

Ft. Lauderdale

42
78
47
70
20
80
20
61

Melbourne

76

Ft. Pierce

63

Naples

20

R Myers

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St. Augustine

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Sanford

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2015 Medical Examiners Commission Drug Report

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Port Charlotte

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Florida Keys

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West Palm Beach

41
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18

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Tampa

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13

I · Present

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18
16
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Statewide TQti!lS

Cause

21
8
7
45
22
60

15
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Sarasota

I

34

83
42
106
32
2.5

Miami

Tot:al

Cause

Live Oak

Daytona Beach

·Present

Tota1

Jacksonville

7

8
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12

Deaths with Oxvcoclene in
Oon"tbinati()n with:et.J<l~r l)~fcl~S '

Present

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4

St. Petersburg

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Cause

Tallahassee

Leesburg

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Totall)eat_hs with Oxy:codor.ie

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Oxycodone Deaths by Age
January- December 2015
Ol<Vc~do.n·e ~a1:1$~diDeath ·

Medi~l-EI<ai:nlner

District
· :~nd·Area of'Flpdda .

Total

18-25

26-34

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Area of Florida

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Pensacola

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3

Tallahassee
Live Oak

15
10

4
5
6

Jacksonville

83

45

Leesburg

42
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32

22

St. Petersburg

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7

Daytona Beach

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9

Gainesville

10

Lakeland

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Miami

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13
14

Sarasota
Tampa

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7@

Panama City

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West Palm Beach

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Florida Keys

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Ft Lauderdale

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Melbourne

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Ft. Pierce

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Ft. Myers

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Port Charlotte

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St. Augustine

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Sanford

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Statewide Totals

Tota.I

<18

36
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18

Naples

A9e.of Decedent

< 18

District

Orlando

Q~Y,¢tld0fl.~ ;fr~se,.nt' at ·Death' ·.·

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Ag_e of Decedent

2015 Medical Examiners Commission Drug Report

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Oxycodone Deaths by County
2015

Occurrences
Per 100,000 Population
0
0.01 - 4.99
5.00 - 9.99
10.00 - 14.99
15.00 - 19.99

Broward

20.00 - 24.99

> 25.00

2015 Medical Examiners Commission Drug Report

Page 18

Hydrocodone Deaths
January - December 2015

Medfuai . e~:ar.nhler District
an~, Areaof Florid~

Total Deatbswith··Hydroce~one

Deaths wi:t h f1.ydrocodane Only
. ·.•

Area ofHorida

·rota.1

Cause ·

Present

Total

Pensacola
Tallahassee

45
10

13
3

Live Oak

12

Jacksonville

72
27
65

4
21
12
28

31

9

8

Daytona Beach
Gainesville

32
7
8
51
15
37
22

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4

9

9

Orlando

59

13

10

Lakeland

35

10

11

Miami

34

10

12

Sarasota

28

11

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Tampa

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Panama City

16
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District

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Leesburg

6
7

St. Petersburg

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West Palm Beach

18
26

16

Florida Keys

9
17

Ft. Lauderdale

21;

18

Melbourne

39

19

Ft. Pierce

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Naples

21
22
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24

Ft. Myers

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Port Charlotte

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St. Augustine
Sanford

13

Statewide Total s

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2015 Medical Examiners Commission Drug Report

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Deaths wit h Hydrocodone in
CombiA;ltion With Other Drugs
Total
Cause
Present

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Hydrocodone Deaths by Age
January - December 2015
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and Ariaa of Fl~rid~
District
Area of Florida
Tota:I
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Pensacola
4.5
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Tallahassee
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3
Live Oak
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Jacksonville

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Leesburg
St. Petersburg

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Daytona Beach

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11

Gainesville

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Sarasota

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Tampa

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Panama City
West Palm Beach

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Florida Keys

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Orlando
Lakeland
Miami

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Ft. Lauderdale

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Ft. Myers

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Port Charlotte

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St. Augustine

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Sanford

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St.atewide totals

23-6

2015 Medical Examiners Commission Drug Report

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Hydrocodone Deaths by County
2015

Occurrences
Per 100,000 Population

0
0.01 - 4.99
5.00 - 9.99
I 0.00 - 14.99
15 .00 - 19.99

Collier

Broward

20.00 - 24.99

> 25.00

2015 Medical Examiners Commission Drug Report

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Page 21

Methadone Deaths
January - December 2015
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District .·
Are·a of Flo(lda
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Pensacola
Tallahassee

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Live Oak

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Jacksonville
Leesburg
St. Petersburg
Daytona Beach
Gainesville

9

Orlando

10

Lakeland

11

Miami

12
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17
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Sarasota
Tampa
Panama City
West Palm Beach
Florida Keys

Ft. Lauderdale
Melbourne

19
20
21
22

Port Charlotte

23

St. Augustine

Ft. Pierce

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Naples

Ft. Myers

Sanford

Statewide T~tals

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290

201 5 Medical Examiners Commission Drug Report

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Tota!

Cause

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Death~ with Methadone ·jn

DeathS wi~h Methadc>oe Only

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Total
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Page 22

Methadone Deaths by Age
January - December 2015

Area of floriaa

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Pensacola

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Tallahassee

Total
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Live Oak

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Jacksonville

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Leesburg

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St. Petersburg
Daytona Beach

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Gainesville

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Orlando

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Lakeland

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District

Total

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Miami

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Tampa

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Panama City

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West Palm Beach

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Florida Keys

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Ft. Lauderdale

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Melbourne

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Ft. Pierce

15
23
21

0
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20
2.1
22
23

Naples

5

5

Ft. Myers

HJ

Port Charlotte

5.

Statewide Tetals

18-25

0

Sarasota

Sanford

<18

1

11

4

9
4

3 .

4

20 I 5 Medical Examiners Commission Drug Report

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12

Meth,ad~me ~res_ent at · [)~atl\l
Age of Decedent

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35-50

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0

St. Augustine

18~25

26-34

14
12

12

24

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Meth.:~uilene Caused·!~eatJ:a
Age of Deced<?nt

M~dical b~tniner ~ist~lct ·
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0
4

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0

70

Page 23

Methadone Deaths by County
2015

Occurrences
Per 100,000 Population
0
0.01 - 4.99
5.00 - 9.99
10.00 - 14.99
15.00 - 19.99

Collier

Broward

20.00 - 24.99

> 25 .00

2015 Medical &aminers Commission Drug Report

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r&riP

Page 24

Occurrences of Hydrocodone, Oxycodone, and Methadone
(Present and Cause)
2006 to 2015
--------·-·-···--------··-·------------··------------ ···---·--·-···---·---····-·-------·---
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2014

2015

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0

2006

2007

IL_

2008

2009

...,_Hydrocodone

2010

2011

~Oxycodone

2012

'

2013

Methadone

Deaths Caused by Hydrocodone, O:xycodone, and Methadone
2006 to 2015

1600

I

1400

1200 '

ec 1000
VI

QI

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::J

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0
0
QI

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E
::J

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400

200

0

-1-

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2006

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2007

2008

2009

2010

2011

...._Hydrocodone r .;fEJQxycodone

I_____ _

2012

2013

·----~------- ,

2014

2015

Methadone
'

··----------·-·--·---------·-·----·-------------------------·-------------------------·---·-
···-~-·----~

20 I 5 Medical Examiners Commission Drug Report

Page 26

 Morphine Deaths
January - December 2015
MedicatlE~all'!in~r C>lstrict
~nd)\re{} of'FIO,rj(la · .

Total Deat-hs wtth Morphine

q:~aths
wit~-M.orphime Qnly·
~;

'

Qistrict

Area of Florida

Total

Cause

Present

Total

Cause

1

Pensacola

64

2

Tallahassee

9

Live Oak

5

Jacksonville

100

Leesburg

41

Iii

St. Petersburg

+s

7.
8

Daytona Beach

118
4:S

21
8
3
29
18
58

5
2

3
4
5

17

4

9

Orlando

10

Lakeland

5-0

i1

Miami

12
13
14
15
16
17.

Sarasota

43
1
2
71
23
60
31
8
128
21
94
53
58
4
48
5

1
0
1
0
2
3
2
1
2
1
0
2
4
1
4
1
8
2
1
0
0
0
0
1

Gainesville

25
194

Tampa

157
122
99

Panama City

15

West Palm Beach

64

Florida Keys

lS

Melbourne

7
96
63

19
20

Ft. Pierce

3.8

Naples

21

Ft. Myers

22

Port Charlotte

23
24

St. Augustine

28
66
25
14

44
23
21
46
5
7

35
1,483

895

Ft. Lauderdale

Sanford

Statewide Totals

2015 Medical Examiners Commission Drug Report

77

22

17
66
29
63
69
41

11

16
2
19
19
15
7
20
20
7
13
588

2
4

3

5

14
9
4
10

12
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6
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11

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125

37

Prese:nt
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1
12
2
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8
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neath~ wt~l1

M<it:pttine £'1

C~~binati l:\I:l ~ith~ Oth er Dtt!g~

C binati,i,);3.i ith= 0th_el Dtt:g
Total

Ca1;1se

·Present

59

42
1
1

17
6
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25
17
46
15

7

3·
96
38

.103
44

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180
41
153
112
87
11
58
6

85
58
3}

27
66

3
1
2

22
13

88

~,JS8

32

71

21
57
29
7
126
20
94
51
54

3
44
4
69
42
22
21
46
5

7
21
858

13

54
21
59
61
33
8

14
2
16
16
15
6
20
17
6
11

soo

Morphine Deaths by Age
January - December 2015

.

Morphi.~e;ca$sed G~ath

Medlca·l · lh<alJltn~rb'istdct
a:od Area ·of Florida

Morphine Present at Death

Age of Decedent

Afie of Decedent

Area ofHorida

Total

Tot~

1

Pensacola

64

2

Tallahassee

9

3

Live Oak

4
5

<18

18-25

26-3.4

35-50

>50

Total

<18

1&-25

26-34

35-50

43

1

14

9

21

4

1

8

1

1

6

5

2

3

0

2

1

Jacksonville

100

71

0

22

5

41

i3

0

3

5

6

St. Petersburg

118

7

Daytona Beach

4'8

60
31

0
0

8

Gainesville

25

9

Orlando

194

8
128

0
1

10

18

32

10

Lakeland

so .

21

11

Miami

1$7 ..

94

0
1

Sarasota

122

53

7
8
16

5
12
20

16
40

i2
13
14

Tampa

58

3

10

Panama City

99
15

2

2

15
16.

West Palm Beach

64.

1

5

Florida Keys

7

5

17

Ft. Lauderdale

96

77

0
2
1
13
1
15

15
8
5
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3
0
11
3
1
2
7

5
4
3
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11
5
19
8
7

12

Leesburg

0
0
32
7
19
13
3
52
8
38
17
22
0
18
3
32
18
5
4
10
3
4

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38

Dtstrict

4
48

18

Melbourne

63

44

19

Ft. Pierce

38

23

20

Naples

28

21

46
S.
7

21

Ft. Myers

66

22
23
24

Port Charlotte

25

St. Augustine

14

Sanford

35

22

i,483

895

Statewide Totals

2015 Medical Examiners Commission Drug Report

0

0
0
0
0
0
1
1
0
0
1
0
0
0
6

0
2
4

91

9
6

0
35
3
28
16
15
0
6
1
10
4
9
8
12
1
0
7
211

9
331

11

29

8

18

32
10

58
4

17

27

66

9

29

17

12

63

12

69
41

16
4

11

21
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23

19

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20
7

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588

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8

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22
27
7
8
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3

s

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1
2
1
0

5
1

9
3

10

6

2

16

1

5

3

3

93

160

6
294

Page 28

Morphine Deaths by County
2015

Occurrences
Per 100,000 Population

0
0.01 - 4.99
5.00 - 9.99

10.00 - 14.99
Broward

15.00 - 19.99
20.00 - 24.99

> 25.00

20/ 5 Medical Examiners Commission Drug Report

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rdtiP

Page 29

Fentanyl Deaths
January - December 2015
rviedb:~ .Exa~ine17 i;)istrict

.· .' a!l4 Area of ·~JJ?ri~a

Tl)tal Death,wlth F~taavt
·

District

Area of Florida

Total

Cause

1

Pensacola

30

2

Tallahassee

27
1
1
48

3

Live Oak

5,
1

4
5

Jacksonville

56

Leesburg

6

St. Petersburg

7
8

Daytona Beach

9

Orlando

10
59
26
12
105

10
11
12

Lakeland

li

Miami

102

Sarasota

13

Tampa
Panama City

122
24
10

West Palm Beach

103

14
15

16
17
18
19
20
21
22
23
24

Gainesville

'

·Deaths wltb

fentany~

~

Total

cause

Present

Total

ca1;1se

Present

,Q

0

0

3{)

27

3

4
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8

1
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4

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2
0
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1
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4'8

7

3
10

9

3

8
1
3

67
14
82
111
15
9
90

38

13

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20

3
4

0
2
5
2
1

11

14

13

9
1

3

1

2

13
0

9

2
8

Florida Keys

3

3

82

77

77

Melbourne

26

Ft. Pierce

40
25

Naples

10

Ft. Myers

31
15

8

c;i\>,m:~rnatio~ \yJ~n· O~!:l~i Dpllg~

Present
3

49
14

Ft. Lauderdale

, Deaths with Fentanyf if\

Only
12

5
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17
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92

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82
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67
23
8
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18

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2
17
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7
1
12
0
4

11

16
2

St. Augustine

8

7
19
7
3

6

3

15

11

3

0
1

2

Sanford

5
4

8
3

2

10

2

911

705

2:06

99

63

36

12
812

642

171)

Port Charlotte

Statewide Tetals

2015 Medical Examiners Commission Drug Report

8

0
0

2

9

7

7

Page 30

Fentanyl Deaths by Age
January - December 2015
MediGale~tiiit'ler DiS:trict
.and Area,of.florkla •

F.entan\4 Caus~d Death··

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.Fentanyl.Pres~n'.t at Q~~th,

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Age ofDecedent

Age of Decedent

District

Area ofFloricia

Total

Total

<18

18-25

26c34

35-50

>50

Totad

<18

18-25

26c34

35-50

>50

1
2

Pensacola

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5

27

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Tallahassee

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3

Live Oak

1

4

Jacksonville

56

5
6

Leesburg

:10

1
48
7

St. Petersburg

59

4:9

7
8·
9

Daytona Beach

26

14

West Palm Beach

10
103

1.5
9
90

Florida Keys

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3

3

Ft. Lauderdale

&2

77

Melbourne

40

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Ft. Pierce

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Gainesville

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9

Orlando

105

67

10

Lakeland

11

Miami

12

Sarasota

17
102
122
24

82
111

13

Tampa

14:

Panama City

15
16
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18
19 "

14-

20

Naples

25
10

21

Ft. Myers

31

19

22

Port Charlotte

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st: Augustine

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Sanford

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911

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Stat-e-wide totals

705

2015 Medical Examiners Commission Drug Report

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37
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39
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33
1

28

6

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5
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2
5

7

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17
2
12
4
6

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5
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1
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12

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2

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7
1
8
6
3
4

268

149

lQ6

s

20

34

46

101

5

Page 31

Fentanyl Deaths by County
2015

Occurrences
Per I 00,000 Population

0
0.01 - 4.99
5.00 - 9.99
10.00 - 14.99

Collier

Broward

15.00-19.99
20.00 - 24.99

> 25.00

2015 Medical Examiners Commission Drug Report

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c)ttP

Page 32

Historical Overview of Fentanyl

Occurr~nces 1

(Present and Cause)
2003 to 2015

r ooI

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-

900
800
700

-~---

VI

Q.J

16°0 1
0

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500

0

Qi

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E 400

::J

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300
200
100
0

-------·-·- ----------·--·----------~----··-·--·--·------·-··-·---------·---------------------
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..,_~~~~~~

2003

2004

l

2005

2006

---------r

2007

2008

,

-~-

2009

2010

2011

2012

2013

2014

2015

-..Fentanyl Related Deaths
1

The number of fentany/ occurrences indicated includes occurrences offentanyl analogs.

20 I 5 Medical Examiners Commission Drug Report

Page 33

Frequency of Occurrence of Fentanyl Analogs
Total Occurrences =96
January - December 2015

Butyryl Fentanyl

13

1"3°%

Note: While not officially tracked in 2015, several medical examiner offices voluntarily reported data for occurrences of illicit fentanyl analogs.

2015 Medical Examiners Commission Drug Report

Page 34

Prescription Drugs in Medical Examiner Deaths
2014 versus 2015
Medit~l -£>taroiRer Dis~rict

. ,and Area ofFlPiida

Total Prescription orug Qeaths
i.n ME·Dea.ths
t"rese11~ ~n~ ea1;1s*H

District
Area of Florida

2014

1
2

Pensacola

150
69
36
306
239
479
162
97
506
185
389
217
305
84
350
27
256
211
213
73
203
70
83
64
4:;174

Tallahassee

3

Live Oak

4

Jacksonville

$

Leesburg

6

St. Petersburg

7

Daytona Beach

8

Gainesville

9

Orlando

10
11
12

Lakeland

13

Tampa

14
15
16
17
1$

Miami
Sarasota
Panama City
West Palm Beach
Florida Keys

Ft. Lauderdale
Melbourne

19

Ft. Pierce

20

Naples

- 2.1
22
23
24

Ft. Myers
Port Charlotte
St. Augustine
Sanford

Sanford

s:tatf?wlde Totals
These tables are based on prescription
drugs tracked by the Medical
Examiners Commission and reported
by Florido Medico/ Examiners. Do not
odd ocrass columns.

2015 Medic al

I

2015
208
51
36
355
191
472
174
106
518
199
541
332
360
89
394
52
292
271
197
87
207
70
69
93
S,364

I

PFesqtip~ion Dru~

~Pr~~~'tand (;au~el

.•

Percent
Clll'ai'.lg§!
~~. 7%
.,.z~~i~

0.-0%

. i1?1P%
-~(;>.1,%

-LS.%
7.4%
~.3%

4,43
7.6%
,3~,1%
SJ;(,)%

. 1~.-0%.

G,0%
12,6%
''9:2.6%

· H.1%
28.4% .

-7..5$.

1fil.i %
4•.0%
0~0%

-16.~%
45 .3~ .

12.4~

These individuals died with one or more prescription drugs in their system. The drugs were identified as either the cause of death or merely present in the decedent and also may have been mixed with illicit drugs and/or alcohol.

Examiners Commission Drug Report

Acdde~ilta[P~ths wi.th ·

2014
85
34
16
187
137
277
70
33
272
100
174
126
159
40
201
13
167
115
100
45
101
35
43
38
2,568

I

2015
128
22
22

220
103
278
97
51
307
96

288
224
188

43
251
21
220
161
107
49
118
36
30
44
3,,];04

I Percent
Change

50.6%
~3J»3%

37.5%
'17.6%
-2/l.8~

Q.4%
3'8.f?%
54.5%
12:9%
-4-0%

15:55%
]7;8%

18>
.;2z%
7.$%
i4:su
91.s% ·
3·4j%
f,Q,9%
7.0%

8'9%

i6;8%
2.9,%
-30.2%

t:>.&%
29,;!}%

The manner of death for these decedents was reported as accidental. These individuals died with one or more prescription drugs in their system. The drugs were identified as either the cause of death or merely present in the decedent and also may have been mixed with illicit drugs and/or alcohol.

A¢¢;~~htafDeaths Caused by.
.Pr~scriptioo prug$
2014
62
20
10
134
84
226
43
18
176

48
90
105
114
24
155
9
136

76
64
37
57
12
21
31
1,152

I

2015
91
14
15
161
63
212
69
30
219
58
166
176
134
23
182
12
194
114
69
39
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The manner of death far these decedents was reported as occidental. These individuals died with at least one prescription drug in their system that was identified as causing or contributing to the death. These drugs may also have been mixed with illicit drugs and/or alcohol.

Cocaine Deaths
January- December 2015
MedicalEXarttln'erJ)is·tdct
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District

Area

of Florida

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Cause

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Pensacola

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Tallahassee

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Live Oak

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Jacksonville

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Leesburg

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St. Petersburg

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Daytona Beach
Gainesville

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Orlando

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Lakeland

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Sarasota

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Florida Keys

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Ft. Lauderdale

Naples

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Ft. Myers

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Port Charlotte

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St. Augustine

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Tampa
West Palm Beach

Melbourne

Ft. Pierce

Sanford

Stat¢wide Totals

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2015 Medical Examiners Commission Drug Report

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Page 36

Cocaine Deaths by Age
January - December 2015
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Page 37

Cocaine Deaths by County
2015

Occurrences
Per 100,000 Population

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5.00 - 9.99
10.00 - 14.99
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20.00 - 24.99

> 25.00

2015 Medical Examiners Commission Drug Report

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Page 38

Cocaine Related Deaths by Medical Examiner District
(Present and Cause)
2001 to 2015
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Leesburg
St. Petersburg

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West Palm Beach
Florida Keys
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2015 Medical Examiners Commission Drug Report

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Historical Overview of Cocaine Occurrences
(Present and Cause)
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2015 Medical Examiners Commission Drug Report

Page 40

Heroin Deaths
January- December 2015
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apd Ate.a of Flf.lrida
District

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Area of Florida
Pensacola

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Jacksonville

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Leesburg
St. Petersburg

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Daytona Beach

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Gainesville
Orlando

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Lakeland
Miami
Sarasota

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West Palm Beach

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Florida Keys
Ft. Lauderdale

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Statewide Tatals

2015 Medical Examiners Commission Drug Report

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Page 41

Heroin Deaths by Age
January- December 2015
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2015 Medical Examiners Commission Drug Report

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Heroin Deaths by County
2015

Occurrences
Per 100,000 Population
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10.00 - 14.99
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Heroin Related Deaths by Medical Examiner District1
(Present and Cause)
2001 to 2015

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Area of Florida
Pensacola

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Live Oak
Jacksonville

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Leesburg
St. Petersburg

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Gainesville
Orlando
Lakeland

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Sarasota
Tampa
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West Palm Beach
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Statewide Totals
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58

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117

199

447

779

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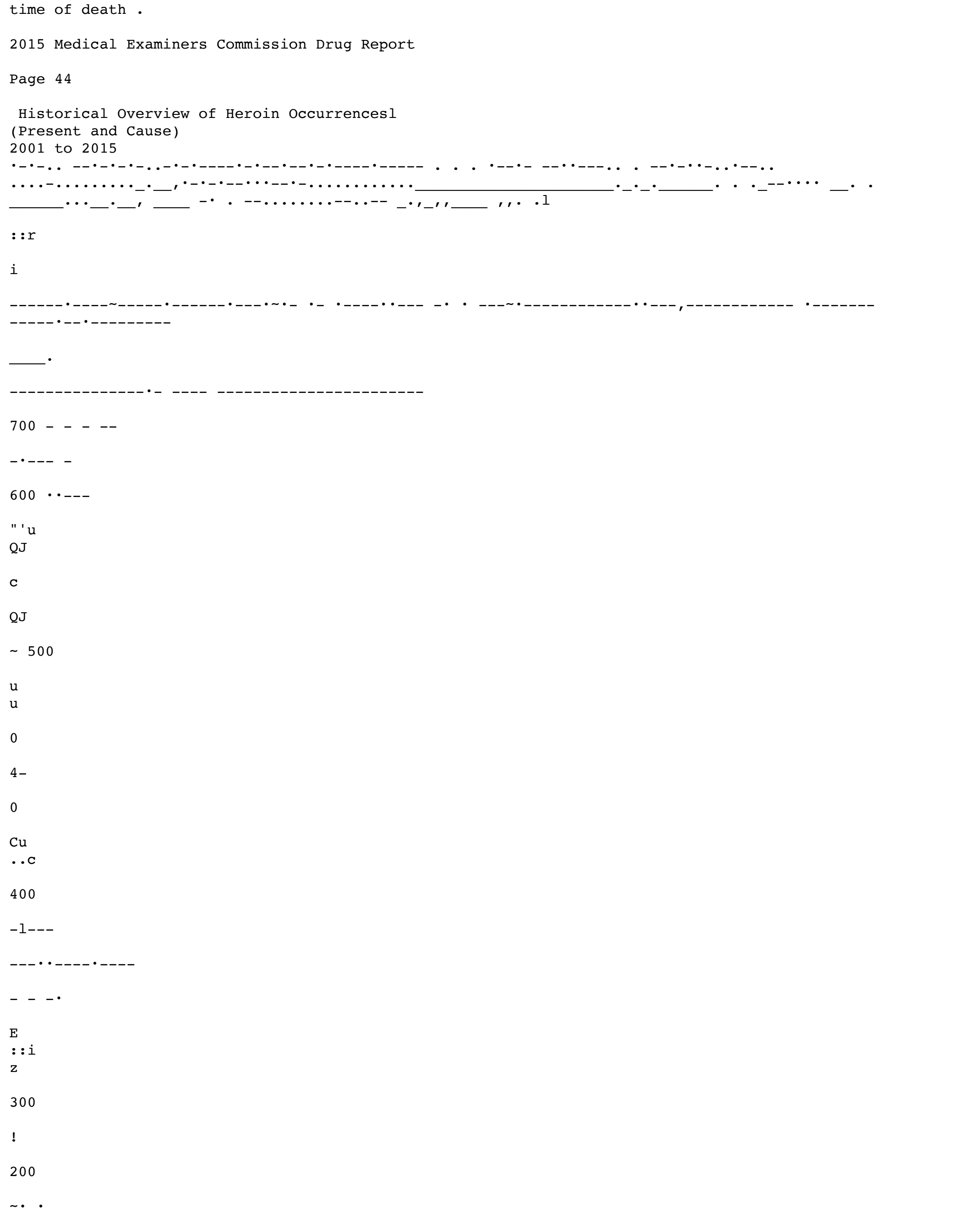
Prior to 2013, only deaths caused by heroin were provided in this chart. The chart has been updated to reflect deaths in which heroin was the cause of deoth or merely present at the

time of death .

2015 Medical Examiners Commission Drug Report

Page 44

Historical Overview of Heroin Occurrencesl
(Present and Cause)
2001 to 2015



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2013

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2015

-C-Heroin Related Deaths
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Prior to 2013, only deaths caused by heroin were provided in this graph. The graph has been updated to reflect deaths in which heroin was the cause of death or merely present at the time of death.

Drug Detected at Death: Cause vs. Present

Diazepam Deaths
Total Occurrences= 604

Alprazolam Deaths
Total Occurrences 1,439

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Morphine Deaths
Total Occurrences= 1,483

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Drug Detected at Death: Cause vs. Present

Oxycodone Deaths
Total Occurrences = 1,081

Hydrocodone Deaths
Total Occurrences = 680

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Methadone Deaths
Total Occurrences= 453

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2015 Medical Examiners Commission Drug Report

Page ./7

Drug Detected at Death: Cause vs. Present

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Cocaine Deaths
Total Occurrences = 1,834

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Heroin Deaths
Total Occurrences= 779

Present
46
6%

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FentanylDeaths
Total Occurrences = 911

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2015 Medical Examiners Commission Drug Report

Page 48

Manner of Death for Cases Reported
(Accidental, Homicide, Natural, Suicide, or Undetermined)

Diazepam Deaths

Alprazolam Deaths
Natural

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Undetermined
2%

12%"'

IHomicide

3%

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Morphine Deaths

2%

2015 Medical Examiners Commission Drug Report

Manner of Death for Cases Reported
(Accidental, Homicide, Natural, Suicide, or Undetermined)

Hydrocodone Deaths

Oxycodone Deaths

Undetermined

1%

Homicide
3%

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3%

Methadone Deaths

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Homicide,
2%

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2015 Medical Examiners Commission Drug Report

Manner of Death for Cases Reported
(Accidental, Homicide, Natural, Suicide, or Undetermined)

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,~s~:=-----Heroin Deaths

Coca ine Deaths

3%

Undetermined

1%

- Undetermined

Natural
\

1% ~

Homicide

1%

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Fentanyl Deaths
Natural

5%/

2015 Medical Examiners Commission Drug Report

Page 51

Glossary
Amphetamines -A group of synthetic psychoactive drugs called central nervous system (CNS) stimulants. The collective group of amphetamines includes amphetamine, dextroamphetamine, and methamphetamine. Methamphetamine is also known as "meth," "crank," "speed," and "tina."
Methamphetamine is metabolized to amphetamine, and thus, occurrences of amphetamine may represent methamphetamine ingestion rather than amphetamine ingestion.
Benzodiazepines -A family of sedative-hypnotic drugs indicated for the treatment of stress, anxiety, seizures, and alcohol withdrawal.
Benzodiazepines are often referred to as "minor tranquilizers." Xanax (alprazolam) and Valium (diazepam) are the most commonly prescribed drugs in this drug class. Many benzodiazepines are interconverted to one another, making occurrences of these drugs difficult to interpret. Exceptions include alprazolam, clonazepam, lorazepam, and midazolam.
Buprenorphine -A semi-synthetic opioid known as Buprenex, Suboxone, and Subutex indicated for the treatment of opioid addiction and moderate to severe pain.
Cannabinoids -A series of compounds found in the marijuana plant, the most psychoactive of which is THC, a strong, illicit hallucinogen. Street names for this drug are often associated with a geographic area from which it came but also include generic names like "ganja," "MJ," "ragweed," "reefer," and "grass."
Carisoprodol - Muscle relaxant indicated for the treatment of pain, muscle spasms, and limited mobility. It is often abused in conjunction with analgesics for enhanced euphoric effect. It is marketed as Soma.
Cathinones -A family of drugs containing one or more synthetic chemicals related to cathinone, an amphetamine-like stimulant found naturally in the Khat plant. They are 'cousins' of the amphetamine family of drugs, which includes amphetamine, methamphetamine, and MDMA (ecstasy). It often goes by the street name of "Molly."
Cocaine -An illicit stimulant. Powdered cocaine goes by many street names including "C," "blow," "snow," and "nose candy," while freebase cocaine is mostly commonly known as "crack."
Ethanol - Ethyl alcohol.
Fentanyl - Synthetic opioid analgesic supplied in transdermal patches and also available for oral, nasal, intravenous, and spinal administration.
Fentanyl is also produced illicitly, and currently many fentanyl occurrences represent the ingestion of illicit fentanyl rather than pharmaceuticallymanufactured fentanyl.

2015 Medical Examiners Commission Drug Report

Page 52

Glossary(Continued)
Flunitrazepam (Rohypnol) - Commonly referred to as a "date rape" drug. It is a sedative-hypnotic drug in the benzodiazepine class. It often goes by the street name "roofies."
Gamma-Hydroxybutyric Acid (GHB}-A depressant, also known as a "date rape" drug. GHB often goes by the street name "easy lay," "scoop," "liquid X," "Georgia home boy," and "grievous bodily harm."
Hallucinogenic Phenethylamines/Piperazines- Includes such drugs as MDMA (Ecstasy, a hallucinogen}, MDA (a psychedelic), MDEA (a psychedelic hallucinogenic}, and piperazine derivatives. Ecstasy has multiple street names including "E,"

"XTC," "love drug," and "clarity." MDMA is often also
known by a large variety of embossed logos on the pills such as "Mitsubishis" and "Killer Bees."
Hallucinogenic Tryptamines - Natural tryptamines are commonly available in preparations of dried or brewed mushrooms, while tryptamine
derivatives are sold in capsule, tablet, powder, or liquid forms. Street names include "Foxy-Methoxy," "alpha-0," and "5-MEO."
Halogenated Inhalants - Includes, but are not limited to, halogenated hydrocarbons, such as Freon, and similar halogenated substances typically used
illicitly as inhalants.
Heroin -An illicit narcotic derivative. It is a semi-synthetic product of opium. Heroin also has multiple street names including "H," "hombre," and
"smack."
Hydrocarbon Inhalants - Includes toluene, benzene, components of gasoline, and other similar hydrocarbons typically used illicitly as inhalants.
Hydrocodone -A narcotic analgesic (pain killer}. Vicodin and Lortab are two common drugs containing hydrocodone.
Hydromorphone -A narcotic analgesic (pain killer} used to treat moderate to severe pain. Marketed under the trade name Dilaudid, it is two to eight
times more potent than morphine. Commonly used by abusers as a substitute for heroin.
Ketamine -An animal tranquilizer and a chemical relative of PCP. Street names for this drug include "special K," "vitamin K," and "cat valium."
Meperidine -A synthetic narcotic analgesic (pain killer) sold under the trade name Demerol, it is used for pre-anesthesia and the relief of moderate to
severe pain.
Methadone -A synthetic narcotic analgesic (pain killer) commonly associated with heroin detoxification and maintenance programs but it is also
prescribed to treat severe pain. It has been increasingly prescribed in place of oxycodone for pain management. Dolophine is one form of methadone.

Glossary (Continued)
Morphine -A narcotic analgesic (pain killer) used to treat moderate to severe pain. MS (Morphine Sulfate), Kadian, and MS-Contin are the tablet
forms; Roxanol is the liquid form. Heroin is metabolized to morphine, and thus, occurrences of morphine may represent heroin ingestion rather than
morphine ingestion.
Nitrous Oxide (N20) - Also known as "laughing gas," this is an inhalant (gas) that produces light anesthesia and analgesia. "Whippets" are a common
form of nitrous oxide.
Oxycodone -A narcotic analgesic (pain killer}. OxyContin is one form of this drug and goes by the street name "OC." Percocet, Percodan, Roxicet,
Tylox, and Roxicodone also contain oxycodone.
Oxymorphone -A narcotic analgesic (pain killer) that is often prescribed as Opana, Numorphan, and Numorphone.
Phencyclidine (PCP) -An illicit, dissociative anesthetic/hallucinogen. Common street names for this drug include "angel dust," "ace," "DOA," and
"wack."
Sympathomimetic Amines ...,-A group of stimulants including phentermine (an appetite suppressant} and other sympathomimetic amines not tracked
elsewhere in this report.
Synthetic Cannabinoids - Synthetic cannabinoids are man-made chemicals that are applied (often sprayed} onto plant material to mimic the effect of
delta-9-tetrahydrocannabinol (THC), the psychoactive ingredient in the naturally grown marijuana plant {cannabis sativa). Synthetic cannabinoids,
commonly known as "synthetic marijuana," "Spice," or "K2," are often sold in retail outlets as "herbal incense" or "potpourri" and are labeled "not for
human consumption."
Tramadol -A synthetic narcotic analgesic sold under the trade name Ultram and Ultracet. Indications include the treatment of moderate to severe
pain. It is a chemical analogue to codeine. Not currently a scheduled drug.
Zolpidem -A prescription medication used for the short-term treatment of insomnia; it is commonly known as Ambien.

APPENDIX B - Heroin Overdose Cases YTD 2016

Average Deaths Per Month = 6
Average Revives Per Month= 22
Average Total Cases Per Month= 28
Total Cases YTD 220

District 14 - City of Lake Worth
Total Overdose Cases 01/01/16-08/31/16

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Jul 2016

Aug 2016

NARR SUPPORT LEVELS
FARR does not offer a rating scale that measures the efficacy or valuation of any individual Certified
Residence. Our mission is to ensure the availability of housing that is:

1. safe and dignified
2.

alcohol and drug free
3. a peer supportive environment
4. a good neighbor and responsible citizen
FARR Standards and the FARR Code of Ethics serve as guides for how best to achieve these four goals
and provide a basis for service provider accountabUity to an independent, non-profit organization
dedicated to upholding the resident's right to access high quality, recovery-oriented housing. Some
support levels are more organically 'peer-supportive' than others and, when selecting a program, individual residents are 'best' served by first gaining a deeper appreciation of defining criteria for each
level.
FARR recognizes four distinct support levels under the singular term Recovery Residence. One level is
not better or more advanced than the others, but instead offers a unique service structure most appropriate for a particular resident. By way of example, Level l residences are perhaps best exemplified by the Oxford House model. This non-profit SOlc (3) program operates nationwide, supports over 1,200 recovery homes that serve more than 24,000 residents annually. Highly regarded by
clinicians, peer specialists and SAMHSA alike, the Oxford House program is documented by evidencedbased studies demonstrating consistently positive outcomes. Many people achieve sustainable recovery
while residing in level 1 residences. Visit ~Y:l,Q.l5fordhouse . org to learn more about this program.
During the first year of my recovery, I resided in a residence that excelled at the aforementioned core
goals. The apartment I occupied was safe and modestly appQinted, dean and adequate to my needs. I
could rely on management to screen anyone whom they, or we residents, suspected was using arid to
immediately and responsibly remove active users from our community. AH my housemates were in recovery and once weekly we convened as a community for a 12 step meeting on property. We were expected t.o attend meetings throughout the remalnder of the week, work with our 12 step sponsor and
take full ownership of our recovery program. This is a basic description of a FARR Le~l 2 residence. The
Social Model might have been embraced more thoroughly to further empower that particular community. However; an argument is just as easily made that the maintenance and development of future resident leadership is primarily the responsibility of the residents themselves.
Management was attentive to neighbor concerns regarding parking, noise and general resident

behavior. Having established good relations, residents took pride in caring for the upkei!p of
the
property. It was one of the nicest homes on the block, complete with the proverbial white picket
fence.
The home supported eleven residents in four attached units. While that community, like so many
others, experienced the typical ebb and flow of casual, short-timers who were uncommitted, I
personally know of at least six housemates who remain clean and sober today. By my unscientific,
outcome measurement, this rates a batting average above .500, which in this world, is a 'hall of
fame'
performance by most standards.

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Thousands of Floridians achieve long-term recovery while residing in level 2 residences ewry
year.
level 1 & 2 residences require residents adhere to a published set of house rules and
consequences,
however; it is generally level 3 residences who offer 24/365 supervision, often by credentialed
staff,
such as behavioral techs. recovery coaches and/or peer specialists to ensure resident
accountability.

Recovery Residence

By design, Level 3 recovery residences are vested in
delivery of only peer-support services. No clinical {medical)
services are performed directly within or by a FARR

Certified Level 3 residence. These services often includes
life skitl mentoring, assistance with crafting an individual
resident's recovery plan, communal meal preparation and
dining, group transportation to self~~lp meetings and
access to recovery coaches. This support is generally more

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appropriate for resldents who require a structured
environment during early recovery from addiction.
Conversely; it is most likely inappropriate for a resident
who has already achieved a solid footing and demonstrates

a personal commitment to their recovery. Residents of a
level 3 residence often independently elect to participate
in external clinical services such as attending an outpatient groups of their choice and/or
engaging a
private therapist for one-on-one counseling. "Independently elect" is a very important
distinction. Many
factors, induding some that meet licensing thresholds, influence the distinction between a Level
3 and

level 4 recovery residence.

level 4 residences incorporate the Medical Model (licensable clinical services) into the Social Mode1 to
varying degrees. In Florida, by virtue of state statute 65.397, Level 4 residences are required to obtain
and maintain appropriate licensure from the Department of Children & Family Services - Substance
Abuse (OCF).

"Florido Moder programs are defined as Partial Hospitalization Programs (PHP) wtt:h day/night community housing.. In Def licensing parlance, these are generally Residential '3 service providers, In
turn, these programs fall under the FARR definition of a Level 4 residence. DCF Residential 4 & 5
programs also meet FARR level 4 criteria. Each of these classiflcations offer varying degrees of cltnlcal
service, provided by credentialed staff, along with a recovery-oriented hoo$ing component. At first

glance, the DCF licensing requ irement coupled with FARR Certification may appear redundant. Nothing
could be farther from the truth .
OCF is our state licensing authority. The Department is tasked with determlning the successful completion of application documentation as it is submitted by substance abuse disorder treatment programs throughout the state. DCF does not have the funding, staff, Infrastructure or appetite to
measure service provider compliance to Standards established to promote high-quality, recoveryoriented housing. This is not a job function the Department considers to fall under their legislative
mandate. Their report to the Florida Senate Appropriations Committee published October 2013 made this fact ab5olutely clear. To download a copy of this study, visit
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As the Florida Affiliate of the National Alliance of Recovery Residences (NARR), FARR offers Level 4

Recovery Residences the opportunity to voluntarily submit for certification to our Standards and Code of
Ethics. This opportunity directly addresses issues of import to the entire continuum. Persons seeking
long-term, residential care and transitional support for themselves or a family member gain free,
reliable access to a published list of programs who have voluntarily sought and secured certification.
This voluntary approach provides a constructive and desirable path to establishing a mechanism for
accountability without running afoul of FHAA and ADA protections. The current NIMBY climate, that
attempts to utilize municipal zoning as an alternative path, amounts to an irresponsible waste of tax
payer dotlars, further dividing communities at a time when there is an ever-increasing need to foster
local resources that address what has now risen to the level of "An Amerlcah Epidemic".

FARR does not measure or evaluate the quality of clinical care. This is outside of our mission and
expertise. Instead, FARR measures accountability to standards designed to ensure the delivery of those
four core goals referenced at the onset of this publication. Peer Support, provided through varying
degrees of Social Model implementation within the residential component of a Level 4 residence is the
guiding consideration. To learn more regarding the Social Model and how this structure is best
embedded ln recovery housing, please visit
htto:L(narronline.org/wpcontent/uploads/2014/09/,Maximizing-Social-Model·Principles-ln-Residential-Recovery -Settings. pdf
The entire continuum of care recognizes an important truth: that the Acute Care model of "28 days
treatment" followed by a graduation ~ebration and the abrupt return of the graduate to the same
environment from which they originated has proven far less effectiVe than has the long-term,
tra nsitiona I approach that gradually "steps the dient up" towards assuming responsibility for their own
chronic disease management. When framed positively, many refer to this achievement as 'Recovery'.
FARR Certified Residences receive our seal of approval. The FARR certification process is rigorous and
subsequent grievances related to mm-compliance are taken very seriously. Our raison d'etre is to
ensure residents have aq:ess to quality, peer--supportive, recovery-oriented housing to assist them along
their journey to secure lastin~ freedom from the bondage of addiction.
For further information, please visit http;LL:fu.rr.q_nline.org/ standards-ethics/ support-levels/,

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FARR C'...ertification & Compliance Agreement

04/2016

NARR Core Principle: Operate with Integrity
I attest and affirm that our organization is .in compliance v.'ith NARR Quality Standards through 05 in their entirety and will remain compliant with same.

01

I attest and affirm that the submission of this application for voluntary certification of compliance with NARR Quality Standards for Recoveiy Residence.s, NARR Code of Ethics arid other criteria as specified by F.S 397,487 truthfully represents full disclosure of facts pertaini11g to ownership, management and staffing of all recovery residence locations operated by our program and that all policies, procedures, and protocols documented by this submission accurately describe the operational practices of our organization, management, staff and volunteers.

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l attest and affirm that, should the FARR Certification Administrator, Compliance Administrator and/or Field Assessor request an opportunity to revie'"" partially or in their entirety, financial records pertaining to the operation of the residence seeking voluntary certification for compliance verification purposes, the requested documents vviH be provided upon request without cost or delay.
I understand and agree that should it be assessed by the FARR Compliance Committee

I understand and agree that should it be assessed by the FARR Compliance Committee,

in their sole determination, that this application does not truthfully and accurately represent full disclosure of facts and operational practices of our organization, sanctions will be applied ""ithout further recourse which may include immediate revocation of our organization's Certificate of Compliance.

NARR Core Principle: Uphold Resident Rights

1
l understand and agree that should it. be assessed by the FARR Compliance Committee, in their sole determination, that this application does not truthfully and accurately represent full disclosure of facts and operational practices of our organization, sanctions will be applied ·without further recourse which may include immediate revocation of our organization's Certificate of Compliance.

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I affirm and attest that our organization's ovmership, management, staff and volunteers uphold the rights of residents as referenced throughout NARR Quality Standards, NARR Code of Ethics and F.S 397-487, placing the rights ofresidents and the rights of the resident community chief among organii.ationa1 priorities.

J attest and affirm that our organizati.on does not subscribe to the "another head to fill a bed" intake philosophy and agree to screen applicants for residency, mindfol of the needs and sensithities of our priority populatfon, to ensure our community is appropriate for the applicant and that the applicant is appropriate for our community.

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I attest and affit·m to thoroughly orient new residents to our community> fully disclosing house rules and consequences, resident right') and responsibilities, phasing and discharge protocols, and all fees and financial commitments, billed directly or indirectly, for 'vhich the resident may potentially become legally accountable as a result of policies, procedures or protocols practiced in the operation of our program.

NARR Core Prindple: Are Recovery Oriented
I attest and affirm that our organization is in compliance \\~th NARR Quality Standards 10 and II in their entirety and will remain compliant with same.

J atte!>'t and affirm that our organization is a recovery-oriented housing provider rather than a "boarding house for persons who do not drink and/or use illicit drugs" and that we take deliberate and intentional steps to encourage and mentor resident participation in a self-directed recovery plan.

NARR Core Principle: Are Peer Staffed and Governed
I attest and affirm that our organization is in compliance with NARR Quality Standards 12 through 17

in their entirety and will remain compliant with same.

I atte.st and affirm that our organization values the resident voice and encourages peer

leadership and accountability by nurturing a community culture that relies on and empowers peers to actively pa1ticipate in community governance.

NARR Core Principle: Promote Health

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I attest and affirm that our organization is in compliance with NARR Quality Standards 18 through 23 in their entirety and wi11 remain compliant with same.

l attest and affirm that our organfaation is a transitional support program for persons in recovery from a substance use disorder and that our primary purpose is to deliver recovery-oriented housing that provides residents with encouragement and support to further develop recovery management skills and recovery capital.

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I attest and affirm our organization's appreciation and understanding that under state law, support levels l 1 II and III are prohibited from directly offe1i.ng clinkal services that require licensure. NARR Support level IV is required by state law to be appropriately licensed by the Department of Children and Families (DCF) Substance Abuse to provide clinical services in accordance with F.S. Chapter 397 and DCF Rule 65D-30.

NARR Core Principle: Provide a Home

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I attest and affirm that our organization is in compliance ·with NARR Quality Standards 24 through 26 in their entirety and will remain compliant with same.

I attest and affirm that our organi7...ation maintains an alcohol and drug-free environment by means of written policies and procedures that are consistent vdth federal and state law.
I attest and affirm that our organization represents a structured home-like environment by means of set parameters that promote acoountability, consideration of others and peer support.
I attest and affirm that our organi7..ation maintains a recovery oriented home-like env;ronment to prote,ct the well-being of the residents, staff and community.

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NARR Core Principle: Inspire Purpose
I attest and affirm that our organization is in compliance with NARR Quality Standard

27 in its entirety and will remain compliant ·with same.

I attest and affirm that our organization is operating a recovery oriented. home with acc~ss to re(•overy programming both inside and outside of the recovery residence.

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I attest and affirm that our organization provides resources for each resident's individual recovery and promotes the individual responsibility of developing recovery capital through measures in compliance with NARR Quality Standard 27.

NARR Core Purpose: Cultivate Community
I attest and affirm that our organization is in compliance with NARR Quality Standards 28 through 30 in their entirety and v.111 remain compliant; including at least 50% of the sub-standards associatt:,'<.l with NARR Quality Standard 28.
I attest and affirm that our organization organizes routine meetings and/or activities that by definition promote a community environment functioning as a family.
I attest and affirm that our organization hosts social activities within the residence and/or ·withjn the broader recovery community that encourage and facilitate resident

bonding and mutual recovery support.
I attest and affirm that the FARR Certification Administrator, Compliance Administrator and/or Field AsseSb'Or is granted a<lvance permission to conduct unannounced resident and/ or staff lntervie'"''S at any time in accordance with F1orida Statute 397487[3]. Failure to comply w-ith thi.<> provision may result in immediate suspension and/or revocation of our Certificate of Complian<.~e.

l attest and affirm that our organization appreciates that residence staff promote recovery through informal and formal intera(,'tions with residents. Peers, including staff, model recovery principles in an interactions with other members of the community. Our organi7.ation attests that all relationships between residents and staff rf'Jlect ethical principles reflected in the Code of Ethics.

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NARR Core Principle~ Promote Recovery
I attest and affirm that our organization is in compliance ,,..;th NARR Quality Standards 31 and 32 in their entirety and will remain compliant "'"ith same.
I attc;>.st and affirm that our organization appreciates that ovt~rcrowding can negatively impact tJie objectives sought through communal living and commits to provide a safe, dignified living environment to each of our residents that indudeA" adequate storage for

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personal belongings, clean and fully functional bathrooms, ldtchen and laundry facilities.

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J attest and affirm that our organization fosters peer leadership within our community to model behaviors that promote orderliness and cleanliness by all residents at all times. Peers hold one another accountable to properly maintain the exterior and interior of the residence. Community pride is promoted and encouraged during scheduled house meetings.

NARR Core Principle: Prolnote Safety

I attest and affirm that our organization is in comp!ian<X~ \\ith NARR Quality Standards 33 and 34 in their entirety and wm remain e-0mpliant \'\ith same.
I attest and affirm that our organization periodically tE'.sts smoke detectors, carbon monoxide.detectors, and fire extinguishers to ensure they are in proper working order.
I attest and affirm that our organization periodically holds community emergency drills to ensure all residents an<l staff are familiar with emergency procedures as established in our policy and procedures.
I attest and affirm that our organization acknowledges that some community members may e_xperience a recurrence of use (relapse) ·while residing in our Iocation(s). Our organization has established, and the community is accountab]e to follow, a discharge protocol designed to achieve an outcome that protects the safety of both the community and the subject resident.
I attest and affirm that we understand that FARR encour-dges all residences to maintain Naloxone on site at each location and train staff in the proper administration of this lifesaving measure in accordance v\!ith F.S. 38i.88 - Emergency treatment for suspected opioid overdose.

NARR Core Principle: Are (}ood Neighbors
I attest and affirm that our organization is in cornplian<:'..e \'<rith NARR Quality

Standards
35 through 37 in their entirety and will remain compliant with same.

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I attest and affirm that every effort is taken to maintain the street appeal of our ptope1ty consistent '·vith other neighboring properties.
I attest and affirm that residents and staff are respectful of neighbor persons and property; making every reasonable effort to blend into the neighborhood .
.

I attest and affirm that our organization is mindful that residents not loiter, use language that may be offensiv€ to others, create parking challenges or othenvise create traffic na\igation issues ·within the neighborhood.
We acknowledge that FARR promotes Good Neighbor Standards, in part, by providing neighbors a conduit to file a formal glievance related to this core principle and that, should FARR receive a Good Neighbor grievance regarding our loc.ation(s), the Compliance Administrator may order a Field Audit to assess compliance/noncompliance in accordance with the Compliance Audit Protocol.

FARR Code of Ethics
I attest and affirm that our organization is in compliance with the FARR Code of Ethics in their entirety and will remain compliant ·with same .

.F.S. 397.487 Voluntary Certification of Recovery Residences
1 attest and affirm that our organization is in compliance with F.S.397-487 in its entirety and '''"ill remain compliant with same.

FARR Certification Protoeols
I attest and affirm that l have read and agree to the terms within the FARR Certification Protocol in its entirety and I ·will sustain compliance thereto.

FARR Compliance Protocols
I attest and affirm that I have read and agree to the terms within the FARR Compliance Protocol in its entirety and I will sustain compliance thereto.

PARR Confidentiality Policy

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 l attest and affirm that 1 have read and agree to the terms within the FARR Confidentially Policy in its entirety and I \Vill sustain compliance thereto.

Notice to Providers \l\lho Seek Volwttary Certification Under F.S. 397.487
Providers seeking Voluntary Certification of Compliam!e with NARR Quality Standards and Code of Ethics and additional criteria specified under F.S 397.487, are advised that FARR Certification and Compliance Administrators are tasked vvith making recommendations of denial, suspension and/ or revocation to the FARR Compliance Committee. In the event of unresolved events of non-compliance, this committee is vested by the FARR Board of Directors to sanction the p.ro\.1der, including but not limited to:
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Dismissal of FARR Certification or Compliance Audit staff recommendation(s)
for sanction(s).
Extension of additional thirty (30) day period during which the subject provider
might achieve compliance.
Schedule a meeting with the Owner(s) and Recovery Residence Administrator(s)
of Record to review the events of non-compliance before making their final
determination.
Suspend certificatjon for a period of no less than 90 days and order a full
compliance audit of all locati.o ns operated by the subject provider; cost of
$300.00 per location to be borne by provider.
Revoke ce1tification based on FARR Compliance Committee assessment that the
specified activities and/or practices represent non-compliance with NARR
Standard 1 Code of Ethics and/or other criteria specified in F.S 397.487, which
may include, but are not limited to;
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Filing a false and/or misleading application for Voluntary Certification
with the Florida Association of Recovery Residences as per F.S 397.487. 8
(d) a credentialing entity shall revoke any Provid~r which e\'idences noncompliance with NARR
Quality Standards Core Principle, Operates \'\rith
Integrity. Standards 01-05 .
Provide residence to a registered sex offender as per non-compliance to
NARR Quality Standards 08.01, 24.02 and F.S 397.487. 5(e)

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Sexual misconduct between provider staff and residents which evidences
non-compliance with NARR Code of Ethics.
o Bullying, physical threats of violence and/or violent behaviors ·which
evidences non-compliance with NARR Quality Standards 24.02, 26.00,
26.01 and Code of Ethics.
o Participation in act(s) of Patient Brokering as defined in F.S 817.505
and/or Insurance Fraud whi<.',h evidences non-compliance with NARR
Quality Standards 02.00 and Code of Ethics.
o Unresolved neighbor grievances deemed by the FARR Compliance
Committee to be non-disc1iminatory and curabie by the provider,
evidencing non-compliancє '"'ith NARR Quality Standards 36.00, 36.01,
36.02, 36.03 sand F.S 397.487 A good neighbor policy to address

neigh.borhood concerns and complaints.
('

Failure of provider to take consistent and demonstrable actions to adhere
to their \Witten policies and procedures as related to sustaining an alcohol
and drug free community for residents \'1, hich evidences non-compliance
with NARR Quality Standards 25.00, 25.oi.A, 25.01.C and C-Ode of Ethics
and F.S 397.487 (a 2, 3)
Failure of the Provider to follow their established protocol(s) to reasonably
ensure the safety of all stakeholders when a resident is discharged as the
result of a reoecurrence of use (relapses). This includes the safety of the
resident, the safety of residence community and the safety of the
surrounding neighborhood. The provider discharge protocol must be
approved by the credentialing entity as a specific requirement of F.S.
397.487 (i) and must be presented at time of application for Voluntary
Certification. Provider failure to implement the approved protocol
evidences non-compliance with NARR Quality Standards 25.01, 26.01 and
Code of Ethics.
Failure of the Owner of Record to notify FARR Certification Staff in
""·riting within seventy~two (72) hours regarding:
Provider changes to approved policies, procedures and/or protocols
Opening and/or closure of provider locations

Opening and/or closure of provider locations
Changes to Ownership, Management and Staff
Life-threatening events and/or deaths of current residents, whether on property or elsewhere
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Criminal charges alleging felony mis<.-onduct by any Owner, Manager or

Staff

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Criminal charges alleging felony misconduct by a qualifying Recovery Residence Administrator
Criminal charges alleging felony misconduct by a current resident

Constitutes an event of non-compliance and may result in suspension and/or revocation of the provider's Certificate of Compliance.
6. Refer grievances filed by stakeholders to external agencies, as determined by the Compliance Audit Administrator, including, but not limited to:
Department of Children and Families - Substance Abuse Li censure Division
o Florida Attorney G-eneral's Office of Consumer Protection
o Florida Department of Lav•.r Enforcement
~1 Local Law Enforcement
o Local Zoning Code Enforcement Depmtments
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Representations and Indemnification
·TI1e undersigned represents and warrants that (a) they have the right and authority to enter into this Agreement and to perform their respective obligations as herein

provided, and (b) their officers, dfrectors, employees and agents will comply \vith all applicable federa.l, state and local laws, codes, rules and regulations. The undersigned ·will indemnify, defend and save harmless FARR arid its respective partners, trustees, beneficiaries, directors, officers, employees, affiliates and agents from and against any and all claims, loss, damage, liability, and expenses (including reasonable attorneys' foes), occasioned by, or arising out of directly or indirectly this Agreement or the breach by the undersigned of any representation or warranty contained in this Agreement, or any act or failure to act by the undersigned in compliance ·witJ1 this Agreement.

Relationship of the Parties
Nothfog in this Agreement shall be construed in any manner to create any of the relationships of employer and employee, principal and agent, joint ·v enturers or pa11ners benveen FARR, on the one hand, and the undersigned, on the other.

Effect and A111endment
This Agreement shall be deemed to supersede and replace any previous documents, correspondence, conversations or other written or oral understandings b(.'1:ween the partie,s hereto related to the subj€.ct matter hereof. No waiver by either party of any breach hereunder shall be deemed a waiver of any other breach. This Agreement cannot he assigned, altered, amended, changed or modified in any respect unless each such assignment, alteration, amendment, change or modification is agreed to in writing, signed and delivered by each patty hereto. This Agreement shall become effective upon signature by you and acceptance by FARR.

Assignment
This Agreement vrill be binding upon and inure to the benefit of you and FARR and their respective successors and assigns; provided, however, that no rights under this Agreement may be assigned by you ";thout the prior written consent of FARR.

Choice of Law
This Agreement will be governed by and construed under the laws of the State of Florida applicable to agreements executed and petformed entirely within the State of Florida. F..ach party hereto submits to the jurisdiction of the state and federal courts in Palm Beach County, Florida for the purpose of resolving any dispute arising out of or resulting from this Agreement.

Headings
The headings of articles of this Agreement are for convenience of reference on]y and shall not be construed to be a substantive part of this Agreement.

National Recovery Residence Quality Standards

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18. Encourage resident5telown thejr recovery

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22. Offer life skills develo~mg11t.i11 a formal..fil:.l.t~

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Adtninistrative and Ope1~ation~l Doniain

Core Principle: Operate with integrity
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As evidenced by:
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a A written mission statement that corresponds with NARR's core
principles
a A vision statement that corresponds wjth NARR's core principles
.02
as stated in this document
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Applied to Levels

Are guided by a mission and vision

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As evi(i~ced by:
0 An affidavit that attests to complying with non-discriminatory state and federal requirements.
.02
0 Marketing materials, claims and advertising that are honest and substantiated as opposed to:
a. False or misleading statement.-; or unfounded claims or exaggerations;
b. Testimonials that do not: really reflect the real opinion of the involved individual;
c. Price claims that are misleading;
d. Therapeutic strategies for which licensure and/or counseling <:ertificatlons are required but not applicable at the site.
e. Misleading representation of outcomes
.03
a Prior to the initial acceptance of any funds, the operator must inform applicants of all fees and charges for which they will be, or could potentially be, responsible. This information needs to be in writing and signed by the applicant.
.04
0 The operator must maintain accurate and complete records of all resident charges, payments and deposits. A resident must be provided with a statement of his/her personal charge and payment history upon request.
.05
a The operator must disclose refund policies to applicants in advance of acceptance into the home, and before accepting any applicant fees.

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Staff must never become involved in residents' personal financial affairs, including lending or borrowing money, or other transactions involving property or services, except that the operator may make agreements with residents with respect to payment of fees.

Policy and procedure that ensures refunds consistent with the terms of a resident agreement are provided within 10 business days, and preferably upon departure from the home.

Applied to Levels

03. Are f"mancially honest and forthright
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As evidenced by:
0 ldentifying the type of accounting system used and its capability to fu1ly document all resident financial transaction, such as foes, payments and deposits
0 Policy and procedure for disclosing to potential residents their financial obligations, including costs for which they might become liable, such as forfeiture of any deposits and fees as a result of prematurely leaving the home
0 Policies about the timing of and requirements for the return of deposit'>, if financial deposits are required
0 The ability to produce clear statements of a resident's financial dealings with the operator (although it's not a requirement that statements be automatically produced)
0 Policie.s and procedures that ensure the follow conditions are met, if the residence provider or a staff member employs, contractors or enters into a paid work agreement with residents:
a. Paid work arrangements are completely voluntary. Residents do not suffer consequences for declining work. Residents who accept paid work are not treated more favorably than residents who do not.
b. Paid work for the operator or staff does not impair participating residents' progress towards their recovery goals.
c. The paid work is treated the same as any other employment situation.
d. Wages are commensurate with marketplace value, and at least minimum wage. The arrangements are viewed by the majority of the residents as fair.
e. Paid work does not confer special privileges on residents doing the work. Work relationships do not negatively affett the recovery environment or morale of the home. Unsatisfact<Jry work relationships are terminated without recriminations that can impair recovery.

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Applied to Levels

4. Collect data for continuous quality improvement
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As evidenced by:
0 Procedures that collect resident's demographic information

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Procedures that collect, evaluate and report accurate process and
outcomes data for continuous quality improvement

As evidenced by:
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Legal business entity documentation e.g. incorporation, LLC
documents or business license
Documentation that the owner/operator ha~ current liability coverage
and other insurance appropriate to their level of support
Written pennission from the owner ofrecord to operate a recovery
residence on the property
Policies and procedures that ensure that background checks are
conducted on all staff, including volunteers that have direct and
regular interaction with residents.

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Applied to Levels

5. Operate with prudence
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Core Principle: Uphold resident rights

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Communicate rights and requirements before agreements are

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Applied m Levels

signed
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As evidenced by:
0 A process that ensures residents receive an orientation on agreements, policies and procedures prior to committing to terms.
.02
Q Written resident's rights and requirements (e.g. House Rules and grievance process) posted in common areas
.03
0 Writt~n resident agreement that includes:
a. Services provided
b. Recovery plan including a move-in (i.e. goals and objectives) and move-out (i.e. contingency) plan

c. Financial terms

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Resident documents that fully disclose policies regarding possessions (personal property) left in a home.

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As evidenced by:
.01
0 Grievance policy and procedures, including the right to take unresolved grievances to the operator's oversight organization

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Policy and procedure for identifying the responsible person{s) in charge to all residents

.03

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Policies and procedures that defend residents' fair housing rights

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Applied to Levels

Support housing choice

As evidenced by:
.01
0 Applicant screening policies and procedures provide current residents a voice in the acceptance of new members.
.02
0 Policies and procedures that promote resident-driven length of stay

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Applied to Levels

Promote self and peer advocacy

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Applied to Levels

9. Protect privacy
As evidenced by:
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Q Policies and procedures that comply with applicable confidentiality

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Policies and procedures that keep resident's records secure, with
access limited to authorized staff only

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Are recovery-oriented
SM 4.0

Applied to Levels

10. View recovery as a person-driven 1 holistic and lifelong process
As evidenced by:
.01
0 Documenting that residents partkipate in the development of their recovery plan including an exit plan and/or lifelong plan
.02
Cl Documenting that the operator cultivates alumni participation

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11. Are (:UJturally responsive and competent
· As evidenced by:
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0 Policies and procedures that identify the priority population, which at

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a minimum includes persons in recovery from substance use but may also include other demographic criterion.
A staffing or leadership plan that reflects the priority population's needs
Documented cultural responsiveness and competence trainings that

are relevant to the priority population.

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Core Principle: Are peer staffed and governed

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Applied to Levels

12. Involve peers in governance in meaningful ways
As evidenced by at least one of the following:
a Some rules made by the residents that the residents (not the staff) enforce?
a A resident council or process is in place that ensures resident's voices can be heard
Q The resident council has a voice in the governance of the home
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Applied. to Levels

13. Use peer staff and leaders in meaningful ways
SM
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As evidenced by:
Q Residents' responsibilities increase with their length of stay or
.01
progress in their recovery.

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Q

Staffing or leadership plan that formally includes a peer component

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Written job description and/or contracts for peer staff and leaders

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SM 3.0

14. Maintain resitlent and staff leadership based on recovery
principles
#12

SM 2.0

As evidenced by:
a Ahome staffing or leadership plan that includes current residents and where possible, former residents that model recovery principles
Q Leader and/or staff job descriptions and selections are based in part
.02
on modeling recovery principles
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15. Create and sustain an atmosphere of recovery support

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As evidenced by:
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0 Integrated recovery support in the daily activity schedule
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a The schedule includes formal and infon11al opportunities for staff and resident interaction in support of recovery

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A)>plled to Levels

16. Ensure staff are trained or credentialed appropriate to their level
As evidenced by:
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Q Written staffing or workforce development plan
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Certification and verification policies and procedures

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Appl!~ to Levels

17. Provide supportive staff supervision
As evidenced by:

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0 Policies and procedures for supervision of staff

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Q Ongoing skills development, oversight and support policies and

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procedures appropriate to staff roles and level of support
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Recovery Support Domain ·.

Core Principle: Promote health
Applied to I.eveJs

18. Encourage residents to own their recovery
As evidenced by:
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Q Policies and procedures that encourage each resident to develop and

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participate in their own personalized recovery plan (Person-driven
recovery)
Q Policies and procedures that encourage residents to make their own
outside appointments

19. Inform and encourage residents to participate in a range of
community-based supports
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As ev.iden-ced by:
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0 Staff that are knowledgeable aboutlocal community-based resources

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Resource directories or similar resources are readily available to
residents

Applled to Levels

20. Offer recovery support in informal social settings
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As evidenced by:
0 Staffing plan that corresponds to the delivery of this service

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Traditions. policies or procedures that foster mutually supportive and
recovery-oriented relationships between residents and/or staff
through peer-based interactions

21. Offers recovery support services in formal settings
As evidenced by:
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Applied to Levels

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Weekly schedule ofrecovery support services recognized by the
respective NARR Affiliate organization

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Weekly schedule of recovery-oriented presentations, group exercises,
and activities
Q Staffing plan that corresponds to the delivery of this service

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22. Offering life skills development services in a formal setting

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As evidenced by:

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Weekly schedule of formal life skills development services or classes
Q Staffing plan that correspDnds to the delivery of this service
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23. Offer cUnJcal services in accordance with State law
As evidenced by:
.01
0 Weekly schedule of clinical services available to residents across all
phases, if multiple phases are used
.02
a Staffing plan that corresponds to the delivery of this service

Core Principle: Provide a home

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Applied to Levels

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24. Provide a physically and emotionally safe, secure and respectful environment
narr 4.01

new

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As evidenced by:
Q Policies and procedures, such as applicant screenings, that establish the home's priority population and cultivate physically and emot1onally safe environments for discussing the needs, feelings and sustaining recovery-supportive connections.
.0 3
0 Policies that promote resident determined lengths of stay that support health and safety of the household/community

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Q Written and enforced policies and procedures that address:

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Applied to Levels

25. Provide an alcohol and illicit drug-free environment

As evidenced by:

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a. Alcohol and/or other prohibited drug-seeking or use;
b. Possession of hazardous and other prohibited items and
associated searches;
c. Drug-screening and or toxicology prntocols; and
d. Prescription and non-prescription medication usage and
storage consistent with the Level of Support and relevant state
law

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4.04

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26. Are cultivated through structure and accountability
As evidenced by:
.01
0 Written resident rights, requirements, agreements, social covenants

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and/or "House Rules"

.02

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Requirements and protocols for peer leadership and/or mentoring
policies that foster individual and community accountability

Core Principle: Inspire purpose
New

Applied to Levels

2 7. Promote meaningful daily activities
As evidenced by:
.01
Q A weekly schedule of the typi<:al resident's activities
.02
0 Are residents encouraged to (at least one of the following) :
a. Work, going to school, or volunteer outside of the residence
community (Level 1, 2 and some 3s)
b. Participate in mutual aid or caregiving (All Levels)
c. Participate in social. physical or creative activities (All Levels)

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 d. Attend daily or weekly programming (All Levels)
.03

Q Person-driven recovery planning & peer governance

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Core Principle: Cultivate community

28. Creating a "fu.nctionally equivalent family" within the household

Applied to Levels

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As evidenced by meeting at least 50% of the following:
0 Are residents involved in food preparation?
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0 Do residents help maintain and clean the home e.g. chores?

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Do residents share in household expenses?

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Family or house meetings at least once a week?

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Do residents have control over who they Hve with?

0 Do residents have access to the common areas of the home?

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29. Foster ethical, peer-based mutually supportive relationships
between residents and/or staff
As evidenced by:
.01
0 Policies and proeedures that encourage residents to engage one
another in informal activities and conversation'?
.02
0 Polides and procedures that encourage staff to engage residents in
informal activities and conversations?
Q Policies and procedures that coordinate community gatherings,
.03
recreational events and/or other social activities amongst residents
and/or staff?

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30. Connect residents to the local (greater) recovery community

Applied to Levels

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As evidenced by at least 5-0% of the following for levels 2 through 4 and at least 1 for level ls:
Q Residents are informed of or Jinked to mutual aid, recovery
.01
community centers, recovery ministries recovery·focused leisure activities and recovery advocacy opportunities;
Q Mutual aid meetings are hosted on site and there are typically
.02
attendees from the greater recovery community

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Q The recovery residence helps participants find a recovery mentor or

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mutual aid sponsor if they are having difficulty finding one
Participants are encouraged to find a recovery mentor or mutual aid sponsor before leaving the recovery residence
Residents are formally linked with the community such as job search, education, family services, health and/or housin.g programs
Residents engage Jn community relations and interactions to promote kinship with other recovery communities and goodwill for recovery services
Sober social events are regularly scheduled (each participant can attend at least one).

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Property and Architect~re Dp1~ain
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Core Principle: Promote recovery

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Applied ro Levels

31. create a home-like environment
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As evidenced by:
Q Furnishing are typical of those found in single family homes or apartments as opposed to institutional settings
Q Entrances and exits that are home-like (vs institutional or clinical)
Q 50+ sq ft per bed per sleeping room
0 One sink, toilet and shower per six residents
a Each resident has personal item storage
Q Each resident has food storage space
Q Laundry services are accessible to all residents

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0 Working appliances

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A staffing plan that pr-0vides for addressing repairs and maintenance
in a timely fashion

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Applied to Levels

32. Promote community
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As evidenced by:
0 Community room (space) large enough to reasonably accommodate community living and meetings.

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.02 A comfortable group area, a living room or sofas, for participants to informaliy socialize

A kitchen and dining area[s} that encourages residents to share meals together

Entertainment or recreational areas and or furnishings that. promote social engagement

Furniture that is in good condition

.03

.04

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Core Principle: Promote health and safety

33. Promote home safety

As evideocecl by:

.01 Cl Affidavit From the owner or operator attesting that the residence meets nondiscriminatory iocai health and safety codes OR document from government agency or credentialed inspector attesting co the property meeting health and safety standards

.02 El Signed and dated safety seliassessmeot checklist which includes

a. Functioning smoke detectors in the sleeping rooms

Functioning carbon monoxide detectors, if there are gas appliances

c. Functic?ming ?re extinguishers in plain sight and/or clearly marked locations

interior and exterior of the property is in a functional. safe and clean condition and free of ?re hazards

.03 Cl Smoke-free living environment policy and/or designated smoking

area outside of the residence.

34. Have an emergency plan
As evidenced by:
.01 13 Post emergency numbers, procedures and evacuation maps in conspicuous locations
.02 13 Collect emergency contact information from residents and orient them to emergency procedures

Good Neighbor Domoin

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Appiied to Levels

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Core PrincipJe: Are good neighbors

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Are compatible with the neighborhood

35.

As evidenced by:
Q If recovery residence is in a residential neighborhood, there are no
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external indications that the property is anything other than a
single family household typical of its neighborhood
The property and its structures are consistently maintained

Applied to Levels

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Applied to Levels

36. Are responsive to neighbor concerns
As evidenced by:
Q Policies and procedures that provide neighbors with the responsible
person(s) contact information upon request
Q Policies and procedures that require Lile responsible person(s) to
.02
respond to neighbor's concerns even if it is not possible to resolve the
issue
Q New resident orientation includes how residents and staff are to greet
.03
and interact with neighbors and/or concerned parties
.01

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As evidenced by:
Q Policies that are responsive or preemptive to neighbor's reasonable

comp1aints regarding
a. Smoking
b. Loitering
c. Parking
d. Noise
e. Lewd or offensive language
f. Cleanliness of public space around the property
Q Parking courtesy rules where street parking is scarce

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37. Rave courtesy rules
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18- to 25-year-olds present a new challenge to a system that is scrambling to meet their needs for mental health and substance use disorder treatment

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White Paper

Young Adults and the Behavioral Health System

More than 3 million 18- to 25-year-olds stayed on their parents' health plans as a result of the Affordable Care Ad (ACA). 1 These young adults, as a group, may have fewer medical expenses than older adults. Their behavioral health costs are another matter.
Political, social and economic forces in the past several years have altered the mental health landscape and dramatically affected young adults.
Today there is an urgent demand for mental health and substance use treatment for young adults - from a system that is frankly strained to provide effective treatment options while managing the costs.
In this paper, we explore the events and trends that have created this situation, and we present some ideas for how to address it

Young Adults Are Bearing the Brunt and Reaping the Benefits - of Recent History
Seminal legislation in health care
Two pieces of federal legislation in two years created a very different health care landscape. Since passage in 2008 of the federal Mental Health Parity and Addiction Equity Act, insurers cannot put limits on substance use disorder coverage or require use of in-network behavioral health providers if the plan includes medical out-of-network benefits. Then, two years later, the Affordable Care Act (ACA) made 18- to 25-yearolds eligible for coverage under their parents' employer-sponsored insurance plans.

Higher rates of mental health and substance use disorder
Many mental health conditions and substance use disorders begin when people are in their teens and 20s.2 At the same time, abuse of prescription medications in the entire population has taken off. The numbers paint a stark picture:
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About one in five - or about 6.4 million - young adults had any mental illness (AMI) in the past year. 3

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The rate of substance use disorder among people age 18 to 25 is twice that of adults 26 and older.4

There was a 346%
•
increase in admissions
for opioid treatment

for opioid treatment
from 2001to2011 .6

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Among 18· to 25-year-olds,

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of those with any •
of those with a
mental illness
severe mental illness
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also have a substance use disorder. 5

White Paper

Health care system caught flat-footed
The fact that many young adults may have lacked health insurance in the past led to lower demand for services. As a consequence there has been, in our opinion, little clinical innovation to address substance use disorders among young adults and not enough attention to defining best practices. Among clinicians who are treating substance use disorders, there is wide variation in their approaches to treatment some driven more by philosophy than evidence of effectiveness.
There are systemic deficiencies, too. For young adults in treatment, there is a drop-off in available services when they reach their 18th birthdays and become "adults." They may be abruptly transitioned into adult treatment settings, few of which have separate quarters and programs for young adults.

MENTAL HEALTH ISSUES OF
18-TO 25-YEAR-OLDS
No mental health issue affects as
many young adults as substance
use disorder.

Substance use disorder
accounted for the majority
of behavioral health claims
costs in 2013.12

Fallout from the 'Great Recession'
Economic circumstances have left many young adults stranded. Students who graduated from college even after the 2007-2009 recession have a higher unemployment rate 7 and generally lower career prospects, delaying them from moving out of their parents' homes arid into their own. 8
Meanwhile, those who are working may be part of the growing "freelance economy" 9 characterized by short-term contractual or hourly jobs without benefits. For those young adults, staying on parents' plans is an attractive option to paying their own health care premiums, putting pressure on the health care costs of their parents' employers.

Significant Increases in Costs for 18- to 25-Year-Olds

6%

Optum analyzed our behavioral health claims for 18- to 25-year-olds in 2011 to 2013 and found a:

EATING DISORDERS

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41 % increase

80% increase

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in per-member/
per-month costs

per-month costs for
substance use disorders10

2%
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MOOD DISORDER
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We can point to three trends that we believe are major cost drivers. They are:

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Substance Use Treatment Is a Particular Concern
Sensing both demand for services and higher rolls of young adults on their parents' insurance, entrepreneurs have opened new centers for treatment of substance use disorders. Many of these are in "destination" locales, in states far from patients' homes. In our estimation, however, those are often not the most appropriate or effective settings for treatment for these reasons:
1. When individuals can be treated for a substance use disorder in or near their home communities, they often stand a better chance of long-term recovery. Their families and close friends can be part of their recovery, and the individuals in treatment learn how to be sober in the surroundings where they will continue their lives.
2. Close analysis of claims from some treatment centers bears witness to questionable practices in treatment protocols and in billing patients, families and their insurance companies.13 A particular area of abuse is in the use of and billing for drug screenings through laboratory tests that are being administered inappropriately, far more frequently than required, at rates well beyond the usual and customary charges.

Florida -

An Expensive Destination for Substance Use Treatment

The climate and natural beauty of Florida make for a prime destination for substance use treatment. When Optum analyzed recent claims for substance use treatment in Florida, however, we found:
The costs of treatment in
out-of-network facilities
were, on average,
three times higher than
the costs of treating at
in-network facilities.14

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Nearly 75 percent of the
cases of young adults
treated in Florida involved
individuals who were not
residents of that state. 15

Individuals from outside the state
treated at out-of-network facilities
were readmitted at highe(rates between 11 percent and 40 percent
higher, depending on level of care
-- than Florida residents who used
in-network facilities .;<>

CLAIMS COSTS FOR SUBSTANCE USE DISORDER TREATMENT IN FLOFllOA
!8- TO

25-~

EAR-OLD DEPENDEfJTS

pi?r rne-mber

$36,645

Out-of-Network
(63% of members)

per mernbcir

(27% of m~rnbers)

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higher cost per member for out-of-network

Figure 1: Florida Example17

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Page 4

Young Adults and t he Behavioral Health System

White Paper

Call to Action: A Collective Response
It will take action from everyone with a stake in this issue - health plans, employers, the behavioral health community, patients and their families - to create better systems for supporting young people in recovery. We believe this collective response should include:

More treatment options within performance-tiered
Providers of substance use treatment must be
closely evaluated and rated according to their effectiveness,
their efficiency and how well they follow evidence-based
practices. In addition, those networks must be broad enough
to include lower-cost options, such as community-based
programs and medication-assisted therapy, to help ensure
continuity of care.
networks -

Better education, guidance and advocacy - Too often young adults or their families select treatment centers in the heat of a crisis. They may not be equipped to ask probing questions about outcomes or the science of treatment before committing to care. They also may not know what treatment and support systems are available to them in or near their home communities . And during recovery, they need access to advocates and peer support.

Vigilance to uncover potential fraud and abuse -

Benefit plan sponsors and payers should implement drug screening and reimbursement codes that follow the recommended guidelines of the Centers for Medicare and Medicaid Services.

Recommitment to this vulnerable population Two-thirds of young adults with mental illness did not receive
mental health services in the past year.18 When they do seek treatment, sometimes it falls well short of evidence-based practices. Young adults can benefit from specialized care management teams of medical staff and behavioral health dinicians to help them navigate their recovery. They need more community-based programs and peer-support networks to support their long-term recovery, too.

About Optum
Optum is a leading information and technology-enabled health services business dedicated to helping the health system work better for everyone.
We're a global team of 40,000 people who collaborate to deliver integrated, intelligent solutions designed to modernize the health system and improve the health of individuals and populations.
Optum leads the industry with unmatched depth and breadth of capabilities, a diverse portfolio of innovative health services and technologies, and the exceptional experience and talents of our people.

Join the Conversation
Optum is interested in your thoughts on this subject.
Email us at engage@optum.com .

Optum Experts in Young Adults and Behavioral Health
Irvin "Pete" Brock Ill, MD
Senior Vice President, Affordability
Optum Behavioral Solutions
Irvin "Pete" Brock Ill, MD, is responsible for Optum initiatives to improve affordability of behavioral health care for employers and commercial and government health plans, including Medicare Advantage and Medicaid plans. He

is board certified in adult and geriatric psychiatry, and he has nearly 40 years of experience in health care, including 20 years while serving in the U.S. Air Force. He is a recipient of the Bronze Star and is a combat veteran of Operation Iraqi Freedom. Dr. Brock received his medical training at the Uniformed Services University of the Health Sciences, Bethesda, Md., with fellowship training in the dementias of aging at Johns Hopkins University. He joined Optum in 2008.

Martin H. Rosenzweig, MD
Medical Director
Optum Behavioral Solutions

Martin H. Rosenzweig, MD, has more than 20 years of experience in behavioral health, and for the past two years he has helped develop the response by Optum to the growing need for substance use treatment and for improving access to quality, evidenced based care for individuals with substance use disorders. Before joining · Optum in 2000, he spent three years as medical director of the counseling program of Pennsylvania Hospital in Philadelphia and six years at the Institute of Pennsylvania Hospital as director of adult treatment services and then director of the mood disorders program. Dr. Rosenzweig is board certified in psychiatry and neurology and is currently a clinical associate in the Department of Psychiatry at the University of Pennsylvania, where he has been on the faculty since 1992. He is a graduate of the University of the Witwatersrand Medical School in Johannesburg, South Africa .

Francisca Azocar, PhD
Vice President, Research and Evaluation
Optum Behavioral Health Sciences

Francisca Azocar, PhD, is a licensed clinical psychologist with extensive experience conducting research in such topics as workplace depression; telephonic care management and outreach to depressed, chronically ill medical patients; and the impact of treatment monitoring and clinician feedback reports on treatment outcomes. Before joining Optum, Dr. Azocar was a faculty member in the Department of Psychiatry at the University of California, San Francisco. She received her doctorate from the University of California, Berkeley, and a National Institute of Mental Health Clinical Services Research post-doctoral fellowship at the University of California, San Francisco. Her work has been published in several scientific, peer-reviewed journals.

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Contact Us:

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Call: 866-386-3408

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Email: resourcecenter@optum.com

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NARCAN USE 1/1/2016 - 10/24/2016

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Incident number

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SIGN UP

"Come join us in recovery!"~ So urged the Web

"Come join us in recovery!" so urged the web
ads for Peachford House, a halfway house
program in Clearwater that promised to help
people addicted to drugs and alcohol.
Peachford would put them up in nice
apartments, find them work and support their
recovery with 12-step meetings. ~ It would turn
around their lives. ~ Instead, residents say,
Peachford employees stole their money, had sex
with clients and turned a blind eye to drugs and
drinking as all semblance of "sober living"
dissolved late last year. The only jobs most
residents got were dead-end day labor. Two
alcoholics say they were put to work selling beer
at Raymond James Stadium.

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TODAY'S TOP STATS

Finally, a few days after Christmas, eviction
notices went up. Peachford had been cramming

six people to an apartment, charging each $135
a week for rent and "program fees," but hadn't
paid the apartment complex in months.
"All Peachford did was provide an over-priced
roof over my head," said Anthony DiGregorio,
one of 40 people who found themselves on their
own when the Clearwater program shut down in
January. "It did absolutely nothing to make me
a better life."

Peachford's parent organization - Sober Living
America - continues to run halfway houses in
Tampa and Jacksonville. As the Tampa Bay

Peachford was started by James deVarennes, a
55-year-old Georgia man who heads the
nonprofit Peachford Ministries.

In 2005, deVarerines incorporated a for-profit company- Peachford House
Clearwater - and started a recovery program in the MacArthur Park
apartments, off U.S. 19. Among the first clients was DiGregorio.
At first the program seemed good, he said. Though most of the jobs were day
labor, requiring clients to be up at 3 a.m., Peachford allowed them to keep
their paychecks. It provided meals. It supported clients' recovery by requiring
them to attend Alcoholics or Narcotics Anonymous meetings.
DiGregorio, addicted to painkillers, acknowledges he wasn't ready for
recovery then. He left the program, spent eight months in state prison for
grand theft, then returned to Peachford a year ago.

Things were far different. Clients had to get their own food. They had to sign
power-of-attorney forms authorizing Peachford to take their paychecks.
"I thought that was crazy," DiGregorio said." I never had to sign anything
like that before."

He was surprised, too, that one of the male directors was having sex with female clients.
And unlike his first time at Peachford, Di Gregorio found virtually no emphasis on recovery.

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"The AA meetings were run by the senior (person) in the apartment, who could have been there two weeks," he said. "It was supposed to be in the AA format but mostly it was people complaining about Peachford and how they didn't have any money."
Clients were paying Peachford $172.50 a week - $135 for "program fees," which were supposed to cover rent and support group meetings, and $7.50 a day for van rides to the labor pool. But Di Gregorio said he and others discovered that not all of their payments were being credited to their accounts.
Complaints that employees were stealing from clients brought deVarennes, Peachford's founder, down from Atlanta in October 2011.
DeVarennes blamed the clients.
"He said we should never have given (the program director) money, we trusted a drug addict with our money," DiGregorio said.
DeVarennes fired a director. He was replaced a few days later by the van driver, a man who watched gay pornography in the office and offered male residents "money to have sex," Di Gregorio said.
Yet Peachford continued to draw clients.
A mental hospital in Pasco County referred 31-year-old Briana Newman to Peachford in November. Within two weeks, she was named "intake coordinator," charged vrith soliciting referrals from detox centers and hospitals that needed some place to send patients after they were discharged.
Once Newman got a discharge planner on the phone, she followed a script that started like this:

Ask this person, 'Have you heard of Peachford Communities?'
If the answer is NO, go into the pitch.
The pitch touted Peachford's "sober clean living, its employment assistance and the most attractive come-on: "Clients without funds are welcomed."
The pitch brought people from as far away as Maine.
"I took on a lot of guilt for sending people here who didn't know what they were getting into," Newman said.
Mass eviction

Three days after Christmas last year, clients were told they had to be out by New Year's Eve.
Peachford was supposed to pay MacArthur Park $1,ooo a month per apartment. By putting six people in a unit and charging each $540 a month, Peachford was collecting as much as $3,240 per apartment yet hadn't made its own rent payments in months.

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Addicts say recovery program stole their money I Tampa Bay Times

With no place to go, many clients relapsed.
"People were just getting loaded," said Jeffry Oliver, a recovering alcoholic who had been at Peachford less than three months. "There was a lot of prescription drug abuse, oxycodone, and people were just running around drunkenly."
Di Gregorio, trying to stay clean, worked long hours at a St. Petersburg sludge incinerator.
"When I got back to Peachford, they wanted those checks," he said. In late December, he left the program and moved in with a friend.

Other clients landed in homeless shelters or shabby motels. Some went to other halfway house programs, including This House II in Clearwater. It was run by Mark Samson, a former Peachford manager accused of stealing from clients.
Samson denied wrongdoing. "The only thing I'm guilty of is trying to give people there a better life."
Allamanno, of the nonprofit Gulfcoast Legal Services, worked with Clearwater detectives to get prosecutors to take action against Peachford. Luring clients to Clearwater with false promises, requiring them to sign over their paychecks - it smacked to Allamanno of human trafficking, but no charges were brought.
DeVarennes, Peachford's founder, did not respond to requests for comment for this story. In a Sept. 5, 2012, letter to Allamanno, he blamed the collapse of Peachford Clearwater on the soured economy and a lender's decision to call in a $550,ooo business loan.
"For over six years, we faithfully served almost 5,000 families in the Pinellas/Hillsborough area with no means to pay," deVarennes wrote. "Unfortunately, when the economy hit bottom, we were unable to afford to keep these self-supporting facilities in operation."
In his letter, deVarennes said he and his wife had recently lost their $450,000 suburban Atlanta home to foreclosure. They still have a $350,000 gulf-front condo in Panama City Beach, records show.
DeVarennes' nonprofit ministry, now called Sober Living America, is soliciting donations on its website for programs to help "homeless and destitute" men in Tampa, Jacksonville and Atlanta.
In Tampa, the program is called How House: Growth in Recovery, and operates out of several apartments in Ashford Place, a run-down complex near the University of South Florida. On a recent day, a man opened the office door, then quickly slammed it when a reporter asked to speak with him.
Outside a few clients milled around the parking lot. They described a familiar -sounding "program:" Seven men crowded into a three-bedroom apartment. Up at 3 a.m. to catch a ride to the labor pool. How House taking their

paychecks, leaving them with little or no money to eventually move out on their own.
The only difference? The program fees. They're now up to $i45 a week.

Times staff writer Lane DeGregory contributed to this story. Susan Taylor Martin can be contacted at susan@tampabay.com.
ABC news investigation

Tune in tonight to WFfS for ABC Action News at 11 p.m. to see more on this joint investigation into halfway houses.
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Addicts say recovery program stole their money 11118112 !Last modified: Monday, November 19, 2012 10:41am}

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Bay County battles to keep opioid epidemic at bay

Bay County battles to keep opioid epidemic at bay
Saturday Posted Oct 8, 2016 at 7:05 PM
Updated Oct 8, 2016 at 7:05 PM

Since March, heroin and fentanyl have claimed the lives
of eight people in Bay County alone.
By Zack McDonald 1747-5071 I @PCNHzack I zmcdonald@pcnh.com

PANAMA CITY - The death toll from overdoses continues to rise in Bay County as the war on opiates rages, according to the Bay County Sheriffs Office. Since more signs of heroin becoming a prevalent drug in Bay County began to emerge at the end of 2014, narcotics officers have made it a priority in their caseloads. Still, the battle against the drug has only increased as more potent forms of opiates, such as fentanyl, find their way into the county and the body count from the drugs increases.
Since March, heroin and fentanyl - a synthetic opioid estimated to be about 80 to 100 times more potent than morphine and 40 to 50 times more potent than pharmaceutical-grade, 100 percent pure heroin - have claimed the lives of eight people in Bay County alone, with countless others being rescued from the edge

of an overdose by emergency responders armed with anecdotes, officials reported.
Despite the growing death toll, though, Lt. Kevin Francis, the head of the narcotics division at BCSO, said the prevalence of the drugs being seen by authorities has leveled out in the recent months. He attributed the stagnation in what had been a blossoming epidemic over the past year to the efforts of narcotics officers.

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'Just like any of the drugs in our community, you have a couple of people dealing them," Francis said. "We'll knock them down and the supply goes down, but soon enough somebody fills that role and it goes back up."
One of the latest developments in the ongoing battle is the appearance of "car fentanyl," Francis said, which is an even more potent opioid than regular fentanyl. Authorities in South Florida are seeing much more of the drug mixed into other narcotics, but BCSO so far only has seized some small amounts. The danger inherent in using the drugs is the unpredictability of their contents because of their clandestine origins, Francis said.
"Some of the stuff we're getting, we've seen heroin with car fentanyl laced in it," he said.
The gradual creep of opioids into Bay County has been attributed to a few causes - among them the vacuum left behind by pill mills. With the absence of medical opiates and the relatively cheap production costs associated with producing heroin, some have turned to opioids to fill the void of prescription pills.
Whatever the cause, in the last decade, heroin abuse has skyrocketed across the country. The rate of heroin-related overdose deaths increased 286 percent between 2002 and 2013, according to figures recently released by the Centers of Disease Control and Prevention. In 2002, 100 people per 100,000 were addicted to heroin, and that number had doubled by 2013.
In February of this year, President Barack Obama asked Congress for $1.1 billion in new funding to address the epidemic of prescription opioid and heroin abuse in this country.
"More Americans now die every year from drug overdoses than they do in motor vehicle crashes," a White House statement noted at the time.
The rise might have been spurred partially by an increase in supply; the amount of heroin seized at the border with Mexico quadrupled by 2013 from the 2000s, making the drug cheaper in the U.S. and more pure.
The South and the West, generally, have been relatively immune from fullblown epidemic status, unlike the Northeast and Midwest. Francis said the main focus for BCSO is keeping the drug at bay in the county.
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"We don't want it to get worse," he said. "We have a small heroin problem. Our No. 1 priority is making sure it doesn't get worse."

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