State Attorney Addiction Recovery Task Force February 6, 2024

STATEWIDE PROGRAMS CERTIFIED (231)

February 2024:

Units: 1,884		
Beds: 9,203		
Levels I, II & III:	**Units: 1,086**	**Beds: 5,940**
Level IV:	**Units: 797**	**Beds: 3,256**

FLORIDA COUNTIES

- **Broward County has 30.3% of the units and 29.5% of the beds.**
- **Palm Beach County has 41.7% of the units and 38.9% of the beds.**

County	Units	Beds	MAT Beds
Alachua	2	10	10
Brevard	8	107	85
Broward	570	2,716	1,138
Clay	1	8	0
Collier	11	75	45
Duval	49	310	211
Escambia	13	60	0
Flagler	6	39	23
Hillsborough	88	501	165
Indian River	11	71	0
Lee	45	299	201
Manatee	22	109	13
Marion	8	40	40

Martin	24	139	50
Miami-Dade	22	172	0
Orange	34	174	76
Osceola	1	12	0
Palm Beach	787	3,576	1,578
Pasco	35	163	36
Pinellas	89	293	156
Polk	1	7	7
Sarasota	31	165	0
Seminole	2	20	10
St. Lucie	12	91	77
Volusia	12	46	46

RUNNING TOTALS

STATE CAPACITY TREND

February 2024

FARR

July	2017	3,280	beds
January	2018	4,153	beds
January	2019	5,786	beds
January	2020	5,781	beds
January	2021	6,715	beds
January	2022	6,872	beds
January	2023	8,122	beds
Sept	2023	8,590	beds
January	2024	9,001	beds
February	2024	9,203	beds

- **7.9% bed capacity Increase since January 2023**

PALM BEACH COUNTY NUMBERS

102 Certified Providers

787 Units, 3,576 Beds (Men: 1,623, Women: 619, Both: 1,310, LGBTQ+: 24)

Level I: 7 Programs, 30 Units, 98 Beds
Level II: 65 Programs, 327 Units, 1,788 Beds
Level III: 5 Programs, 37 Units, 124 Beds
Level IV: 41 Programs, 392 Units, 1,559 Beds

Overdose Numbers

Certified Recovery Residences - Self Reporting

JAN 2023 - JAN 2024 **21.7% Death Rate**

Total	Male	Female	Deaths
46	41	5	10

City Report

Bradenton (2 Overdose) (0 Death)

Boynton Beach (1 Overdose) (0 Death)

Clearwater (1 Overdose) (0 Death)

Coral Springs (2 Overdose) (1 Death)

Delray (8 Overdose) (0 Death)

Fort Lauderdale (8 Overdose) (2 Death)

Hollywood (2 Overdose) (1 Death)

Jacksonville (3 Overdose) (0 Death)

Lake Worth (2 Overdose) (0 Death)

Miami (2 Overdose) (1 Death)

Tampa (2 Overdose) (0 Death)

West Palm Beach (2 Overdose) (0 Death)

Oakland Park (2 Overdose) (0 Death)

Pompano Beach (7 Overdose) (4 Death)

Rockledge (1 Overdose) (1 Death)

St Pete (1 Overdose) (0 Death)

Age Report

Under 20- (0)

20's- (6)

30's- (12)

40's- (3)

50's & Up- (1)

Drug Preference

Opiates/ Fentanyl- (42)

Cocaine-(2)

Alcohol- (2)

Xanax -(0)

Naloxone Dose

1 Dose ()

2 Doses ()

3 Doses ()

4 Doses ()

Unknow (46)

Average Age: 32

Certification Level

Level I- (0)

Level II- (16)

Level III- (0)

Level IV- (6)

State of Origin

NY-(2)

Georgia-(2)

MO-(1)

MA-(0)

Ohio-(1)

NC-(1)

Unknown-(39)

Time in Florida

10 Hours- (0)

3 Months- (1)

1 Year- (0)

2 Years- (0)

Unknown- (45)

FARR

Florida Association of Recovery Residences

COMMITMENT IS THE KEY TO RECOVERY

We are committed to maintaining quality standards, upholding FARR's recovery services and providing effective strategies to meet the expanding needs of our providers.

Mission Statement

01 To create, monitor, evaluate and improve standards for recovery residences in the State of Florida

02 Maintain the standards set forth by NARR (National Association of Recovery Residences)

03 Maintain a forum for exchange of ideas, problem solving and providing guidance for our members

04 To remain ethical in all our endeavors to those we serve

Our Philosophy

We believe in a high quality of care for chemically dependent individuals and other persons needing recovery residence services

We believe that this can best be achieved through maintaining standards of care that are designed for this purpose

We also believe that all people deserve to recover in an atmosphere which meets their special needs as well as their basic right to safety, dignity and respect

NARR Mission

The National Alliance for Recovery Residences (NARR) supports people in recovery from alcohol and other drug use by improving the accessibility, availability and quality of recovery-oriented housing and services.

In support of this mission, we create, evaluate and improve standards and measures of quality for recovery residences. We provide a forum for exchanging ideas, problem solving, technical assistance and training. NARR informs public policy development as recovery experts at the national and regional level.

NARR assists existing regional organizations and fosters the development of stakeholder organizations where none exist. NARR is the national resource on recovery residences for people in recovery, health and recovery professionals, social service agencies, state and local governments and recovery residence providers.

NARR
National Alliance for Recovery Residences

The National Alliance for Recovery Residences (NARR) was formed in 2011 to fill a void in the field of addiction recovery services.

Recovery residences are a vital resource for many along the road to recovery. They have not had a ***national unified resource.***

Until now.

NARR Benefits

- Universally accepted protocol for operating ethical, high quality recovery residences,
- Advice and technical assistance to state and local governments on recovery residence issues,
- Opportunity to effect change through NARR's involvement in professional and policy communities,
- Resource for advocacy, training, technical assistance and information about fair housing rights,
- Latest information, research and policy recommendations on recovery residence conditions, resources and issues impacting people in recovery nationally,
- Participation in discussions and policy formation on issues affecting recovery residences nationally,
- Resource support for local and regional stakeholder organizations seeking to improve the availability, accessibly and quality of recovery residence options.

www.narronline.org

Most Opioid–Caused Deaths by Florida Medical Examiner By District: 2021–2022

6,162 opioid–caused deaths in 2022 (average of 17 per day)

(down 3% from the 6366 opioid–caused deaths in 2021)

Fentanyl caused the death or was present in 5,622 cases (91%)

Fentanyl was the leading cause of drug–caused deaths

- District 4: Pasco/Pinellas Counties: 765 opioid–caused deaths (up 6% from 720 in 2021)
- District 17: Broward County: 568 opioid–caused deaths (down 6% from 613 in 2021)
- District 15:Palm Beach County: 431 opioid–caused deaths (down 17% from 519 in 2021)
- District 4:Clay/Duval/Nassau Counties: 543 opioid–caused deaths (up 1% from 539 in 2021)
- District 13: Hillsborough County: 525 opioid caused–deaths (up 14% from 450 in 2021)
- District 1: Escambia/Okaloosa/Santa Rosa/Walton: 371 opioid (up 13% from 323 in 2021)

2021/2022 PBCME Opiate ODs

- PBC Medical Examiner –2021 – **no pending cases**
  - Total drug overdose cases 657
    - Total opioid OD deaths 519 (79% of total OD cases)
    - Total Fentanyl cause or presence 477 (91%)
    - **Decline in opioid OD deaths 2020/2021 (13%)**

- PBC Medical Examiner –2022 - **no pending cases**
  - Total drug overdose cases 553
    - Total opioid OD deaths 431 (78% of total OD cases)
    - Total Fentanyl & Fentanyl analog cause or presence 391 (93%)**
    - **Decline in Opioid OD deaths - 2021/2022 (17%)**

***** Xylazine: "tranq" non-opioid animal tranquilizer – 40 OD deaths

** New Fentanyl analogues:

- N-Pyrrolidino Etonitazene (NPE) – 20x more potent than Fentanyl – 0/20
- Fleurofentanyl – similar potency to Fentanyl – 6/100

2022/2023 PBCME Opiate OD Deaths

- PBC Medical Examiner –2022 - **no pending cases**
  - Total drug overdose cases 553
    - Total opioid OD deaths 431 (78% of total OD cases)
    - Total Fentanyl & Fentanyl analog cause or presence 391 (93%)**
    - **Decline in Opioid OD deaths - 2021/2022 (17%)**

- **PBC Medical Examiner –2023 (February 2024 snapshot)- 23 pending cases**
  - Total drug overdose cases 529
  - Total opioid OD deaths 399 (75% of total OD cases) - **projected 416 total < 4%**
    - Total fentanyl & fentanyl analog cause or presence 369 (92%)

***** Xylazine: "tranq" non-opioid animal tranquilizer – 2022- 24/ 2023- 31

** New Fentanyl analogues:

- N-Pyrrolidino Etonitazene (NPE) – 20x more potent than Fentanyl – 2022-9/2023-0
- Fleurofentanyl – similar potency to Fentanyl – 2022-87/2023-65

PBCFR TRANSPORTS 2017-2023
January 1 – July 31

YEAR	#CALLS	# PATIENTS	%CHANGE/CALLS
2017	2181	2277	
2018	1207	1233	< 45%
2019	1034	1055	< 14 %
2020	1387	1419	> 26%
2021	1238	1265	< 11%
2022	1130	1153	< 9%
2023	956	980	< 15%

Net change 2017-2023 56% reduction in transports

2022 Medical Examiners Commission Drug Report

Coverage Map

Florida Medical Examiner Districts

371 **District 1**
Escambia
Okaloosa
Santa Rosa
Walton

51 **District 2**
Franklin
Gadsden
Jefferson
Leon
Liberty
Taylor
Wakulla

30 **District 3** *Covered by
Columbia *4
Dixie *8
Hamilton *4
Lafayette *2
Madison *2
Suwannee *2

543 **District 4**
Clay
Duval
Nassau

District 5 **342**
Citrus
Hernando
Lake
Marion
Sumter

District 6 **765**
Pasco
Pinellas

District 7 **295**
Volusia

District 8 **80**
Alachua
Baker
Bradford
Gilchrist
Levy
Union

District 9 **364**
Orange

District 10
Hardee
Highlands **159**
Polk

District 11 **285**
Miami-Dade

District 12 **238**
DeSoto
Manatee
Sarasota

District 13 **525**
Hillsborough

District 14 **71**
Bay
Calhoun
Gulf
Holmes
Jackson
Washington

District 15 **431**
Palm Beach

District 16 **28**
Monroe

District 17 **568**
Broward

District 18 **121**
Brevard

District 19 **154**
Indian River
Martin
Okeechobee
St. Lucie

District 20 **102**
Collier

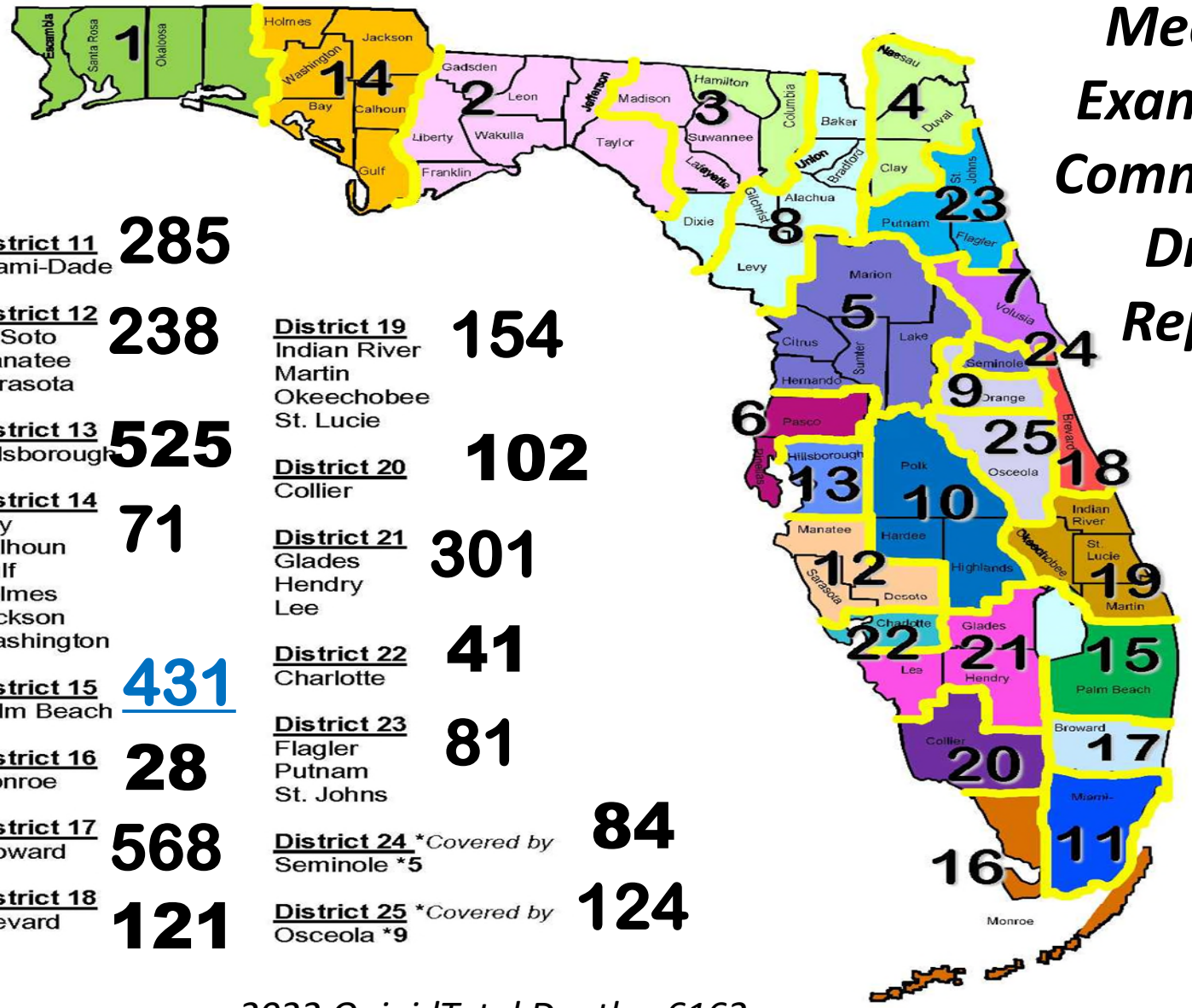
District 21 **301**
Glades
Hendry
Lee

District 22 **41**
Charlotte

District 23 **81**
Flagler
Putnam
St. Johns

District 24 *Covered by **84**
Seminole *5

District 25 *Covered by **124**
Osceola *9



2022 OpioidTotal Deaths 6162
Average 17 Deaths Per Day

2021 Medical Examiners Commission Drug Report

Coverage Map

Florida Medical Examiner Districts

323

District 1
Escambia
Okaloosa
Santa Rosa
Walton

45

District 2
Franklin
Gadsden
Jefferson
Leon
Liberty
Taylor
Wakulla

25

District 3 *Covered by
Columbia *4
Dixie *8
Hamilton *4
Lafayette *2
Madison *2
Suwannee *2

539

District 4
Clay
Duval
Nassau

District 5 328
Citrus
Hernando
Lake
Marion
Sumter

District 6 720
Pasco
Pinellas

District 7 311
Volusia

District 8 63
Alachua
Baker
Bradford
Gilchrist
Levy
Union

District 9 452
Orange

District 10
Hardee
Highlands
Polk
155

District 11 311
Miami-Dade

District 12 281
DeSoto
Manatee
Sarasota

District 13 450
Hillsborough

District 14 84
Bay
Calhoun
Gulf
Holmes
Jackson
Washington

District 15 519
Palm Beach

District 16 26
Monroe

District 17 613
Broward

District 18 260
Brevard

District 19 142
Indian River
Martin
Okeechobee
St. Lucie

District 20 100
Collier

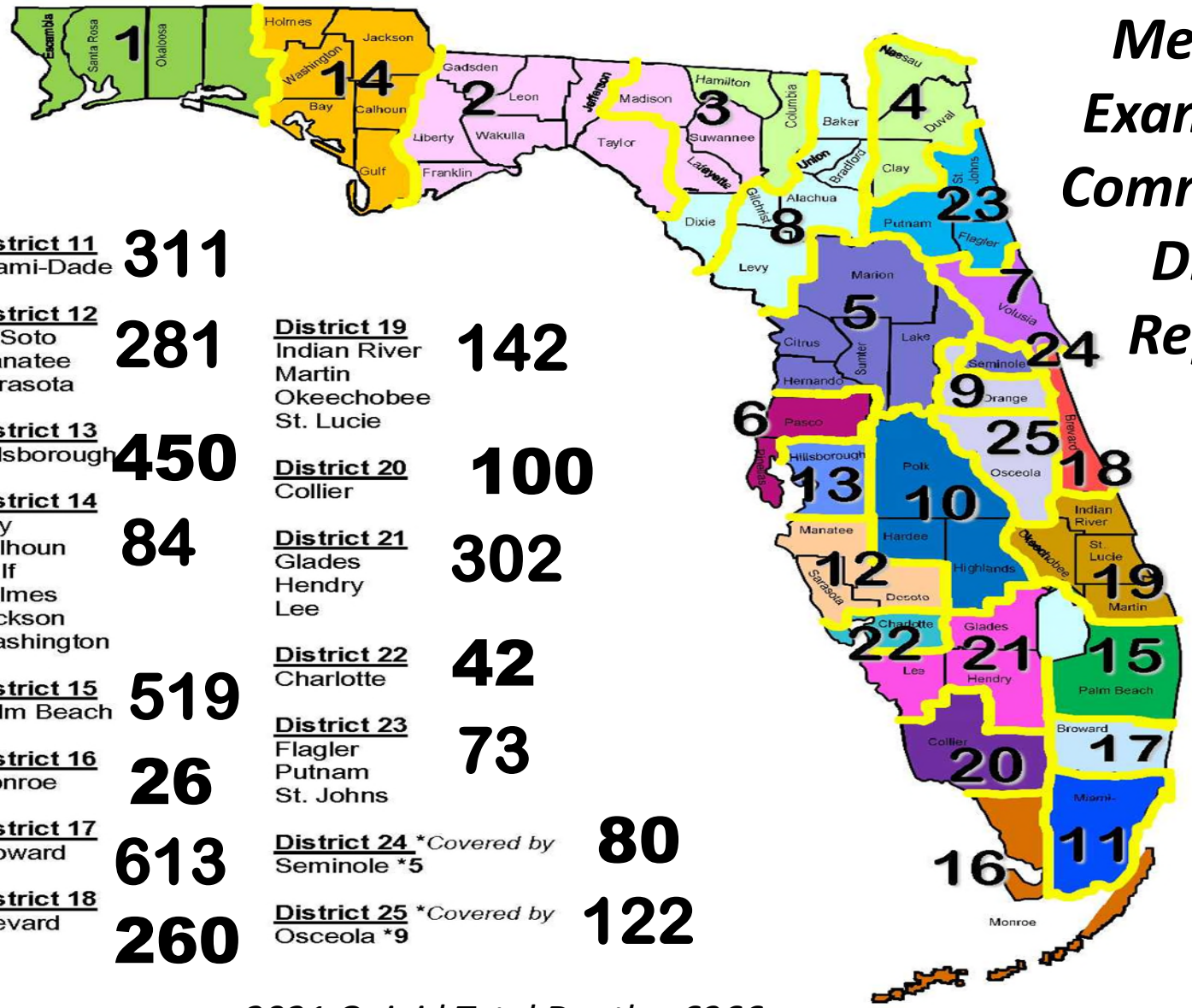
District 21 302
Glades
Hendry
Lee

District 22 42
Charlotte

District 23 73
Flagler
Putnam
St. Johns

District 24 *Covered by 80
Seminole *5

District 25 *Covered by 122
Osceola *9



2021 Opioid Total Deaths 6366
Average 18 Deaths Per Day

Coverage Map

Florida Medical Examiner Districts

2020 Medical Examiners Commission Drug Report

221

District 1
Escambia
Okaloosa
Santa Rosa
Walton

26

District 2
Franklin
Gadsden
Jefferson
Leon
Liberty
Taylor
Wakulla

24

District 3 *Covered by
Columbia *4
Dixie *8
Hamilton *4
Lafayette *2
Madison *2
Suwannee *2

581

District 4
Clay
Duval
Nassau

District 5
Citrus
Hernando
Lake
Marion
Sumter
238

District 6
Pasco
Pinellas
688

District 7
Volusia
304

District 8
Alachua
Baker
Bradford
Gilchrist
Levy
Union
57

District 9
Orange
370

District 10
Hardee
Highlands
Polk
160

District 11
Miami-Dade
332

District 12
DeSoto
Manatee
Sarasota
258

District 13
Hillsborough
409

District 14
Bay
Calhoun
Gulf
Holmes
Jackson
Washington
57

District 15
Palm Beach
604

District 16
Monroe
14

District 17
Broward
662

District 18
Brevard
280

District 19
Indian River
Martin
Okeechobee
St. Lucie
148

District 20
Collier
85

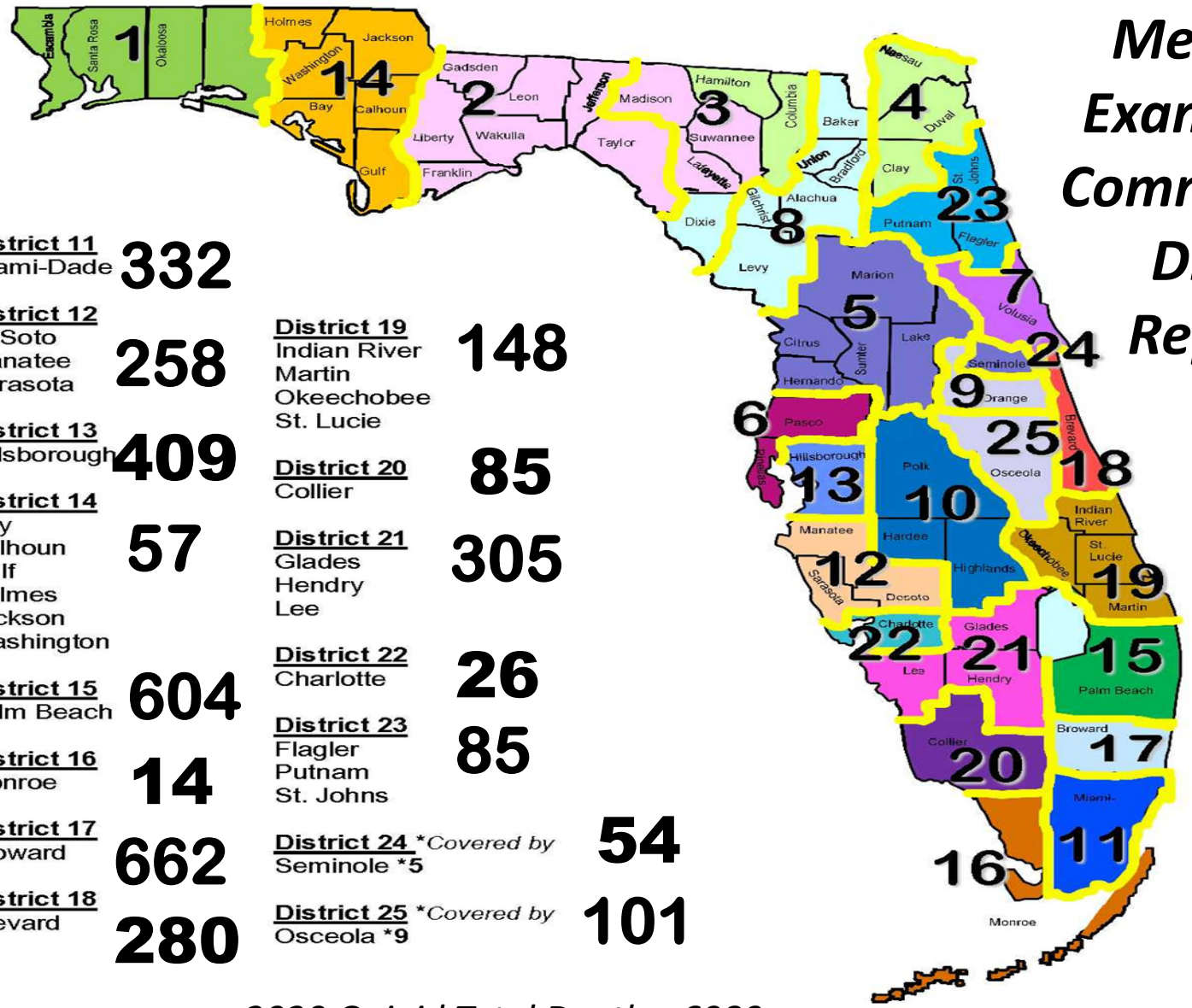
District 21
Glades
Hendry
Lee
305

District 22
Charlotte
26

District 23
Flagler
Putnam
St. Johns
85

District 24 *Covered by
Seminole *5
54

District 25 *Covered by
Osceola *9
101



2020 Opioid Total Deaths 6089
Average 17 Deaths Per Day

Coverage Map

Florida Medical Examiner Districts

2019 Medical Examiners Commission Drug Report

129

District 1
Escambia
Okaloosa
Santa Rosa
Walton

24

District 2
Franklin
Gadsden
Jefferson
Leon
Liberty
Taylor
Wakulla

9

District 3 *Covered by
Columbia *4
Dixie *8
Hamilton *4
Lafayette *2
Madison *2
Suwannee *2

425

District 4
Clay
Duval
Nassau

District 5 195
Citrus
Hernando
Lake
Marion
Sumter

District 6 492
Pasco
Pinellas

District 7 142
Volusia

District 8 32
Alachua
Baker
Bradford
Gilchrist
Levy
Union

District 9 297
Orange

District 10 83
Hardee
Highlands
Polk

District 11 270
Miami-Dade

District 12 182
DeSoto
Manatee
Sarasota

District 13 217
Hillsborough

District 14 51
Bay
Calhoun
Gulf
Holmes
Jackson
Washington

District 15 476
Palm Beach

District 16 14
Monroe

District 17 426
Broward

District 18 265
Brevard

District 19 96
Indian River
Martin
Okeechobee
St. Lucie

District 20 76
Collier

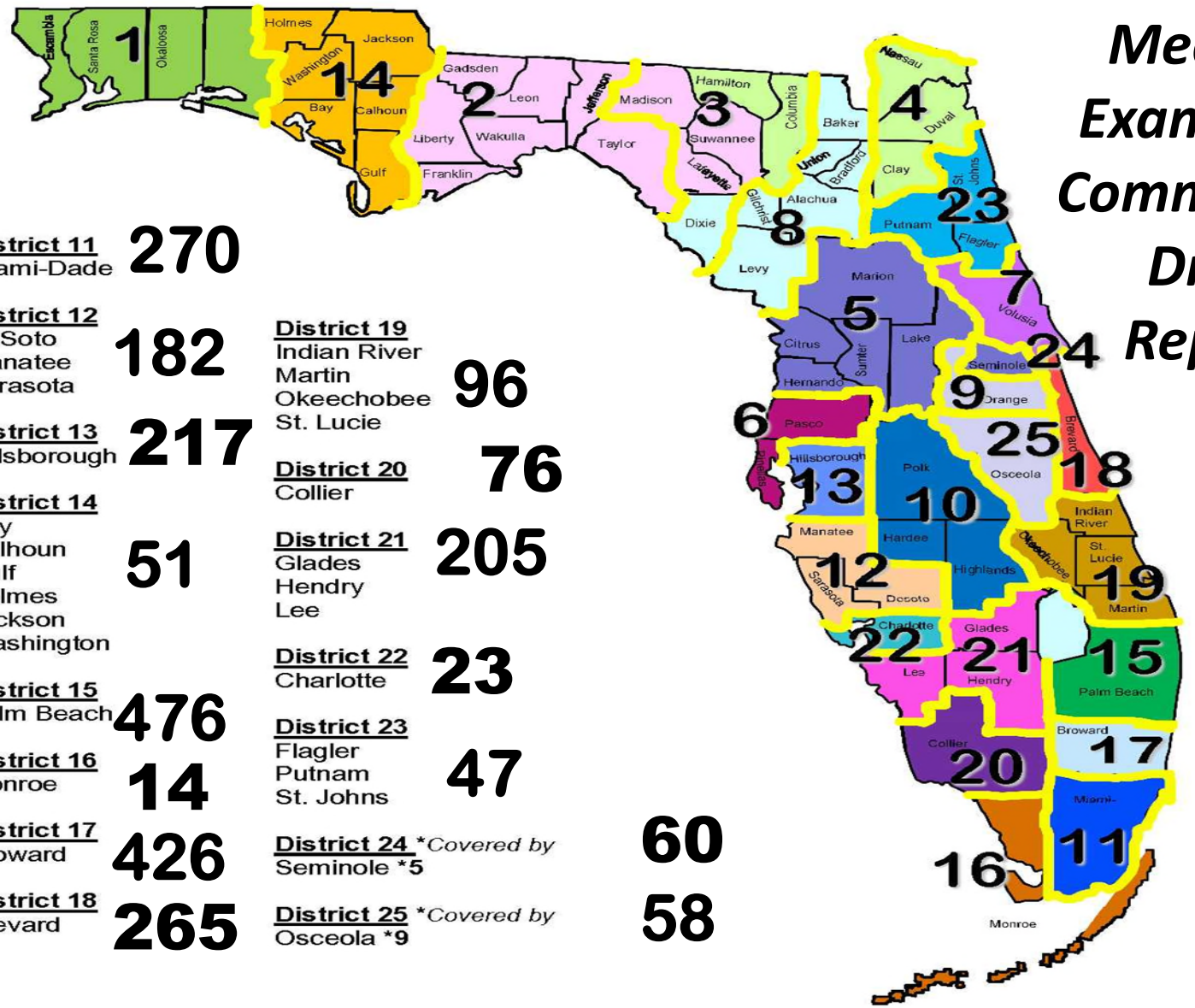
District 21 205
Glades
Hendry
Lee

District 22 23
Charlotte

District 23 47
Flagler
Putnam
St. Johns

District 24 *Covered by 60
Seminole *5

District 25 *Covered by 58
Osceola *9



2019 Opioid Total Deaths 4294
Average 12 Deaths Per Day

Coverage Map

Florida Medical Examiner Districts

2018 Medical Examiners Commission Drug Report

122

District 1
Escambia
Okaloosa
Santa Rosa
Walton

14

District 2
Franklin
Gadsden
Jefferson
Leon
Liberty
Taylor
Wakulla

16

District 3 *Covered by
Columbia *4
Dixie *8
Hamilton *4
Lafayette *2
Madison *2
Suwannee *2

330

District 4
Clay
Duval
Nassau

District 5 **174**
Citrus
Hernando
Lake
Marion
Sumter

District 6 **388**
Pasco
Pinellas

District 7 **149**
Volusia

District 8 **31**
Alachua
Baker
Bradford
Gilchrist
Levy
Union

District 9 **270**
Orange

District 10 **80**
Hardee
Highlands
Polk

District 11 **218**
Miami-Dade

District 12 **132**
DeSoto
Manatee
Sarasota

District 13 **224**
Hillsborough

District 14 **29**
Bay
Calhoun
Gulf
Holmes
Jackson
Washington

District 15 **401**
Palm Beach

District 16 **12**
Monroe

District 17 **370**
Broward

District 18 **216**
Brevard

District 19 **112**
Indian River
Martin
Okeechobee
St. Lucie

District 20 **49**
Collier

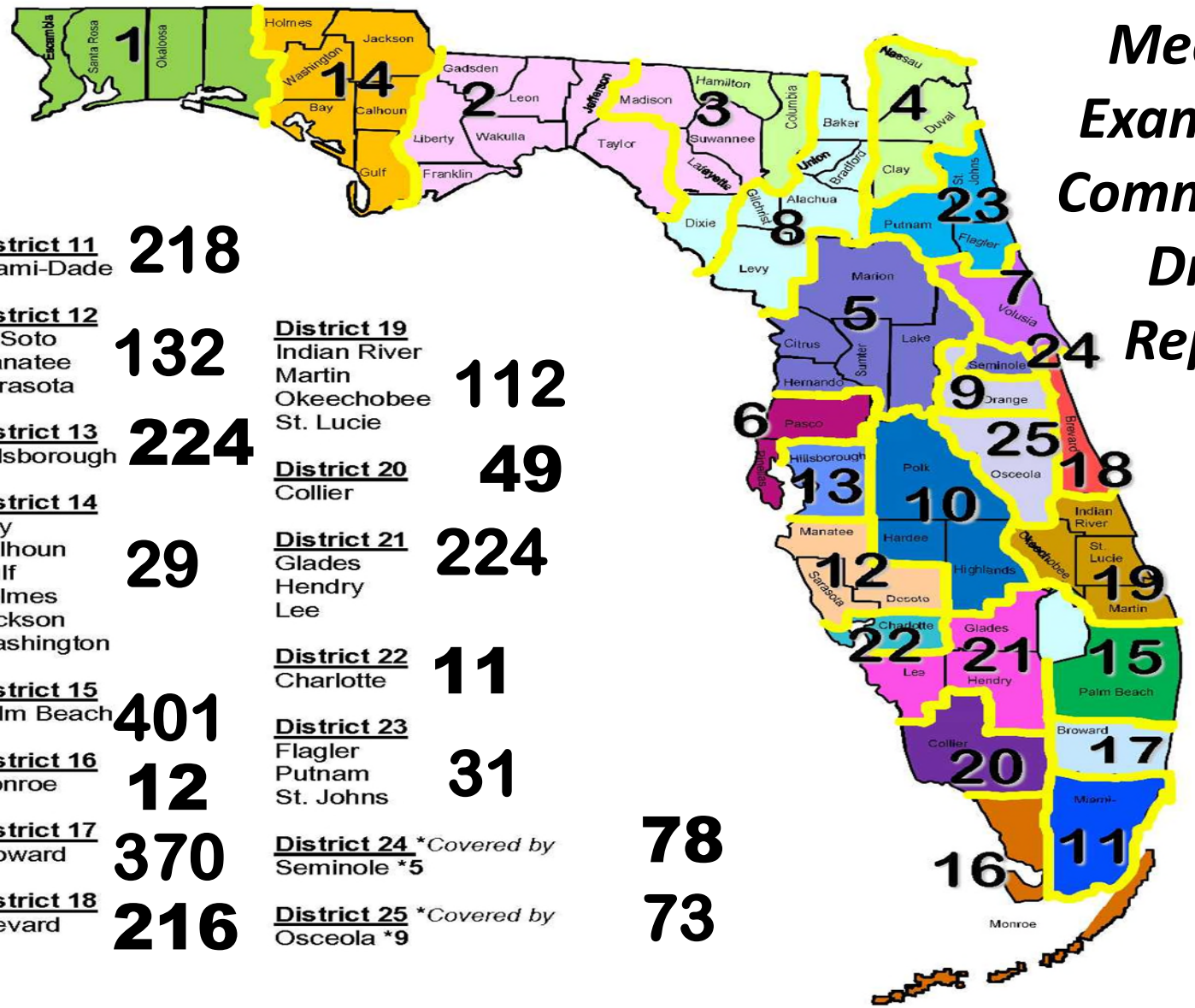
District 21 **224**
Glades
Hendry
Lee

District 22 **11**
Charlotte

District 23 **31**
Flagler
Putnam
St. Johns

District 24 *Covered by **78**
Seminole *5

District 25 *Covered by **73**
Osceola *9



2018 Opioid Total Deaths 3754
Average 10 Deaths Per Day

2017 Medical Examiners Commission Drug Report

Coverage Map

Florida Medical Examiner Districts

District 1 78
Escambia
Okaloosa
Santa Rosa
Walton

District 2 22
Franklin
Gadsden
Jefferson
Leon
Liberty
Taylor
Wakulla

District 3 *Covered by
Columbia *4
Dixie *8
Hamilton *4
Lafayette *2
Madison *2
Suwannee *2
20

District 4 489
Clay
Duval
Nassau

District 5 214
Citrus
Hernando
Lake
Marion
Sumter

District 6 332
Pasco
Pinellas

District 7 129
Volusia

District 8 47
Alachua
Baker
Bradford
Gilchrist
Levy
Union

District 9 239
Orange

District 10 89
Hardee
Highlands
Polk

District 11 315
Miami-Dade

District 12 207
DeSoto
Manatee
Sarasota

District 13 180
Hillsborough

District 14 33
Bay
Calhoun
Gulf
Holmes
Jackson
Washington

District 15 647
Palm Beach

District 16 89
Monroe

District 17 540
Broward

District 18 200
Brevard

District 19 122
Indian River
Martin
Okeechobee
St. Lucie

District 20 41
Collier

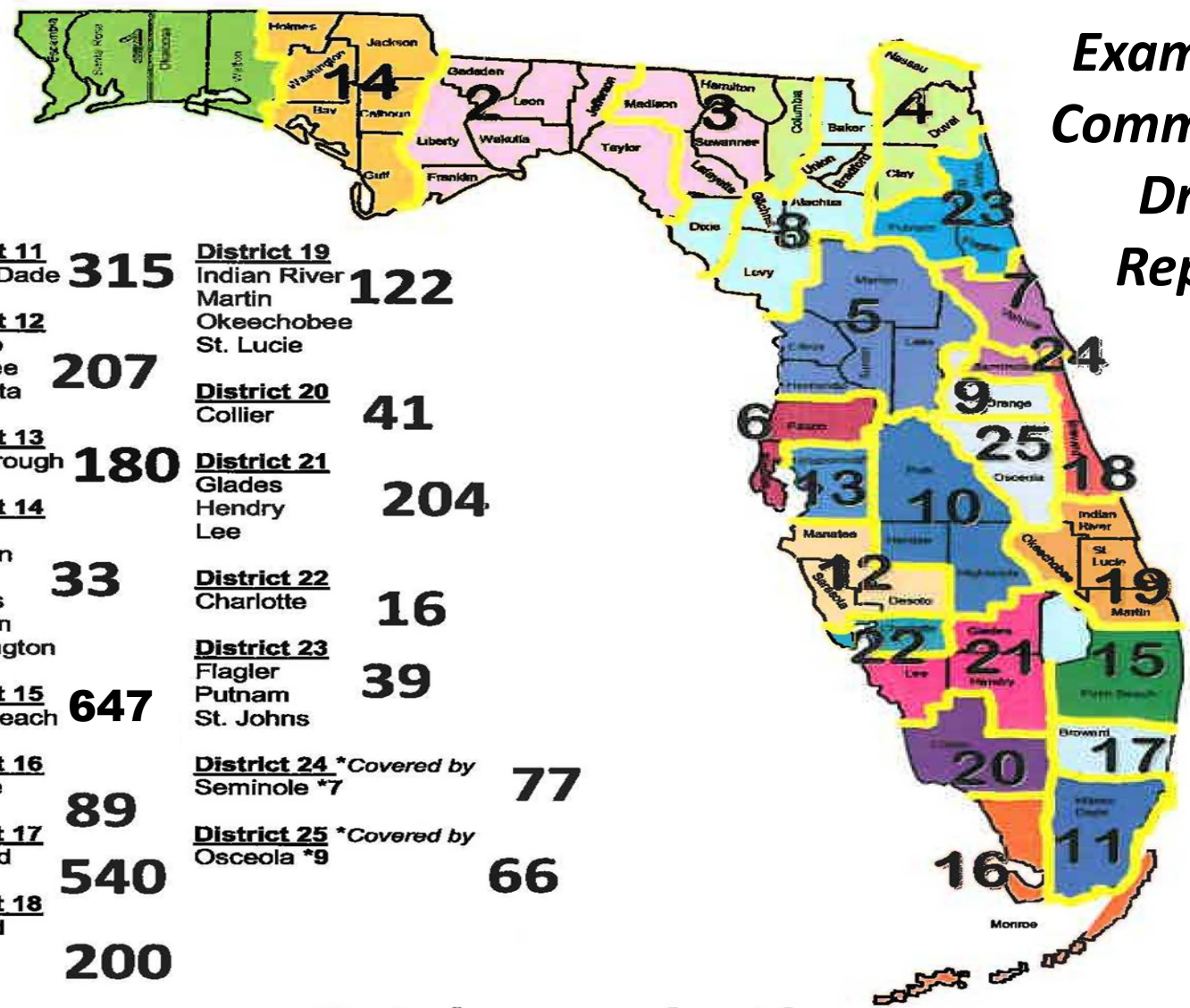
District 21 204
Glades
Hendry
Lee

District 22 16
Charlotte

District 23 39
Flagler
Putnam
St. Johns

District 24 *Covered by 77
Seminole *7

District 25 *Covered by 66
Osceola *9



Total 4279 deaths
Deaths per day 12

2016 Medical Examiners Commission Drug Report

Coverage Map

Florida Medical Examiner Districts

District 1 — 88
Escambia
Okaloosa
Santa Rosa
Walton

District 2 — 28
Franklin
Gadsden
Jefferson
Leon
Liberty
Taylor
Wakulla

District 3 — 15 *Covered by
Columbia *4
Dixie *8
Hamilton *4
Lafayette *2
Madison *2
Suwannee *2

District 4 — 426
Clay
Duval
Nassau

District 5 — 238
Citrus
Hernando
Lake
Marion
Sumter

District 6 — 323
Pasco
Pinellas

District 7 — 78
Volusia

District 8 — 38
Alachua
Baker
Bradford
Gilchrist
Levy
Union

District 9 — 202
Orange

District 10 — 82
Hardee
Highlands
Polk

District 11 — 321
Miami-Dade

District 12 — 229
DeSoto
Manatee
Sarasota

District 13 — 159
Hillsborough

District 14 — 46
Bay
Calhoun
Gulf
Holmes
Jackson
Washington

District 15 — 598
Palm Beach

District 16 — 19
Monroe

District 17 — 453
Broward

District 18 — 139
Brevard

District 19 — 123
Indian River
Martin
Okeechobee
St. Lucie

District 20 — 46
Collier

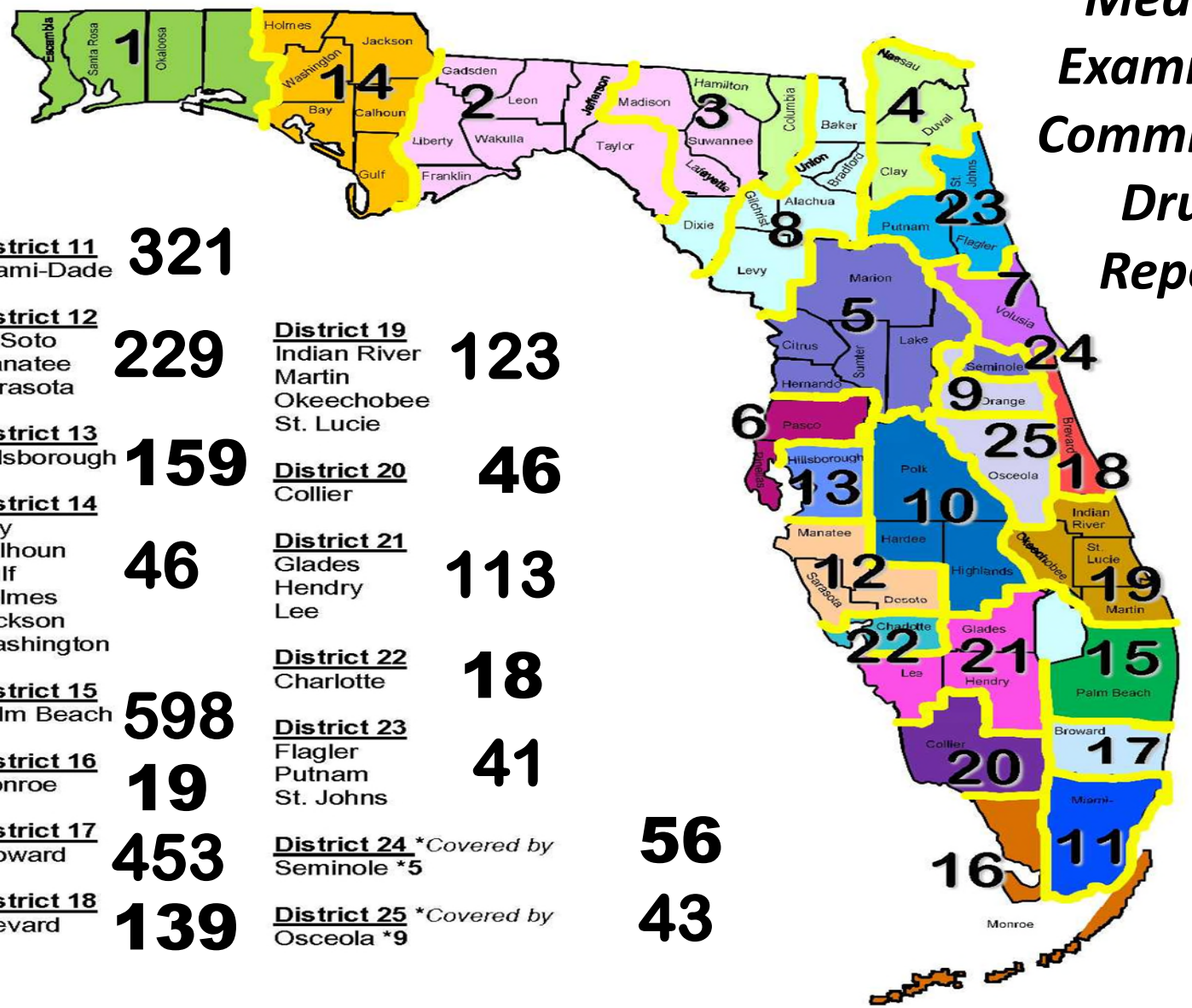
District 21 — 113
Glades
Hendry
Lee

District 22 — 18
Charlotte

District 23 — 41
Flagler
Putnam
St. Johns

District 24 — 56 *Covered by
Seminole *5

District 25 — 43 *Covered by
Osceola *9



2016 Total Deaths 3922
Average 11 Deaths Per Day

Drugs Identified in Deceased Persons by Florida Medical Examiners

2022 Annual Report

FLORIDA DEPARTMENT OF LAW ENFORCEMENT **PUBLISHED JANUARY 2024**

Data Collection

The State of Florida's Bureau of Vital Statistics reported 242,595 deaths in Florida during 2022. Of the 35,429 deaths investigated by Florida's medical examiners, toxicology results determined that the drugs listed below were present at the time of death in 15,592 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 (MEC) 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 15,592 deaths included more than one drug occurrence.

When reporting the data, Florida'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. It 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.

The MEC would like to acknowledge with much appreciation the crucial role of the members of the Quality Assurance Committee.

Data were collected on the following drugs:

Amphetamines
- Amphetamine
- Methamphetamine

Benzodiazepines
- Alprazolam
- Chlordiazepoxide
- Clonazepam
- Diazepam
- Lorazepam
- Midazolam
- Nordiazepam
- Oxazepam
- Temazepam

Ethanol
- Ethyl Alcohol

Hallucinogenics
- Phencyclidine (PCP)/ PCP Analogs
- Phenethylamines/ Piperazines
- Tryptamines

Inhalants
- Halogenated
- Hydrocarbon

Opioids
- Buprenorphine
- Codeine
- Fentanyl
- Fentanyl Analogs
- Heroin
- Hydrocodone
- Hydromorphone
- Methadone
- Morphine
- Oxycodone
- Oxymorphone
- Tramadol
- U-47700

Other
- Cannabinoids
- Carisoprodol/ Meprobamate
- Cathinones
- Cocaine
- Gabapentin
- GHB
- Ketamine
- Mitragynine
- Sympathomimetic Amines
- Synthetic Cannabinoids
- Xylazine
- Zolpidem

Highlights

All comparisons are made to 2021 calendar year data unless otherwise noted.

- ✓ Total drug-related deaths decreased by 3 percent (546 less).
- ✓ 8,012 opioid-related deaths were reported, which is a 5 percent decrease (399 less). The opioids were identified as either the cause of death or merely present in the decedent.
- ✓ 6,157 opioid-caused deaths were reported, which is a 4 percent decrease (285 less).
- ✓ 9,230 (5 percent decrease, 448 less) 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. While fentanyl is a prescription drug, data indicates that at least 87 percent of fentanyl occurrences were illicitly obtained.
- ✓ 6,234 (4.5 percent decrease, 293 less) 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.
- ✓ Benzodiazepines, carisoprodol/meprobamate, zolpidem, gabapentin and all opioids excluding heroin, fentanyl analogs and U-47700 account for 49 percent of all drug occurrences in this report when ethyl alcohol is excluded.
- ✓ The most frequently occurring drugs found in decedents were fentanyl (6,230), ethyl alcohol (6,196), cocaine (3,930), benzodiazepines (3,738, including 1,238 alprazolam occurrences), cannabinoids (3,564), methamphetamine (2,918), amphetamine (2,672), oxycodone (1,014), fentanyl analogs (1,005), gabapentin (967) and morphine (861).
- ✓ The drugs that caused the most deaths were fentanyl (5,622), cocaine (2,598), methamphetamine (2,193), ethyl alcohol (1,364), benzodiazepines (900, including 528 alprazolam deaths), amphetamine (850) and fentanyl analogs (844). Fentanyl (90 percent), fentanyl analogs (84 percent), methamphetamine (75 percent), heroin (73 percent), cathinones (67 percent), cocaine (66 percent), methadone (59 percent), xylazine (57 percent) and mitragynine (56 percent) were listed as causing death in more than 50 percent of the deaths in which these drugs were found.
- ✓ Occurrences of heroin decreased by 51 percent (237 less) and deaths caused by heroin decreased by 55.5 percent (206 less).
- ✓ Occurrences of fentanyl decreased by 3 percent (187 less) and deaths caused by fentanyl decreased by 3 percent (169 less).
- ✓ Occurrences of fentanyl analogs* increased by 40 percent (289 more) and deaths caused by fentanyl analogs* increased by 42 percent (250 more).
- ✓ Occurrences of methadone decreased by 23 percent (90 less) and deaths caused by methadone decreased by 17.5 percent (37 less).
- ✓ Occurrences of hydrocodone decreased by 10 percent (50 less) and deaths caused by hydrocodone decreased by 6 percent (9 less). **These comparisons remove 4-ANPP from occurrences of fentanyl analogs.*

Highlights (continued)

- ✓ Occurrences of oxycodone decreased by 9 percent (97 less) and deaths caused by oxycodone decreased by 14 percent (72 less).
- ✓ Occurrences of buprenorphine decreased by 12 percent (31 less) and deaths caused by buprenorphine decreased by 16 percent (9 less).
- ✓ Occurrences of cocaine decreased by 2 percent (85 less) and deaths caused by cocaine decreased by 3 percent (79 less).
- ✓ Occurrences of morphine decreased by 28 percent (340 less) and deaths caused by morphine decreased by 33.5 percent (165 less).
- ✓ Occurrences of mitragynine increased by 1 percent (3 more) and deaths caused by mitragynine decreased by 8 percent (15 less).
- ✓ Occurrences of gabapentin decreased by 11 percent (124 less) and deaths caused by gabapentin decreased by 0.5 percent (1 less).
- ✓ Alprazolam (Xanax) still dominated the category of benzodiazepines even though occurrences decreased by 21 percent (330 less).
- ✓ Occurrences of methamphetamine decreased by 0.5 percent (16 less) and deaths caused by methamphetamine increased by 4 percent (92 more). Occurrences of amphetamine increased by 1 percent (25 more) and deaths caused by amphetamine decreased by 2 percent (15 less). In the body, methamphetamine is metabolized to amphetamine, thus many occurrences of amphetamine likely represent illicit methamphetamine ingestion rather than pharmaceutical amphetamine use.
- ✓ Occurrences of cathinones increased by 28 percent (119 more) and deaths caused by cathinones increased by 34.5 percent (95 more). The majority of the cathinones reported were N, N-Dimethylpentylone.
- ✓ There were a total of 25 occurrences of Difluoroethane reported from January – December 2022.
- ✓ There was a total of 471 occurrences of Xylazine reported.
- ✓ *NOTE: 4-Anilino-N-phenethylpiperidine (4-ANPP, despropionyl fentanyl) is an intermediate precursor of fentanyl production, as well as a minor metabolite (1%) of fentanyl. 4-ANPP is widely considered to be pharmacologically inactive, and appears to have no significant psychoactive effect. 4-ANPP appears unlikely to be a contributor to morbidity or mortality, but is a valuable indicator of the recent ingestion of illicitly manufactured fentanyl or fentanyl analogs. Accordingly, 4-ANPP will not be listed as a fentanyl analog in drug reports moving forward. However, the Commission continues to request submissions of 4-ANPP occurrences.*

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Coverage Map

Florida Medical Examiner Districts

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Leon
Liberty
Taylor
Wakulla

District 3 **Covered by*
Columbia ***4**
Dixie ***8**
Hamilton ***4**
Lafayette ***2**
Madison ***2**
Suwannee ***2**

District 4
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District 23
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Putnam
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District 24 **Covered by*
Seminole ***5**

District 25 **Covered by*
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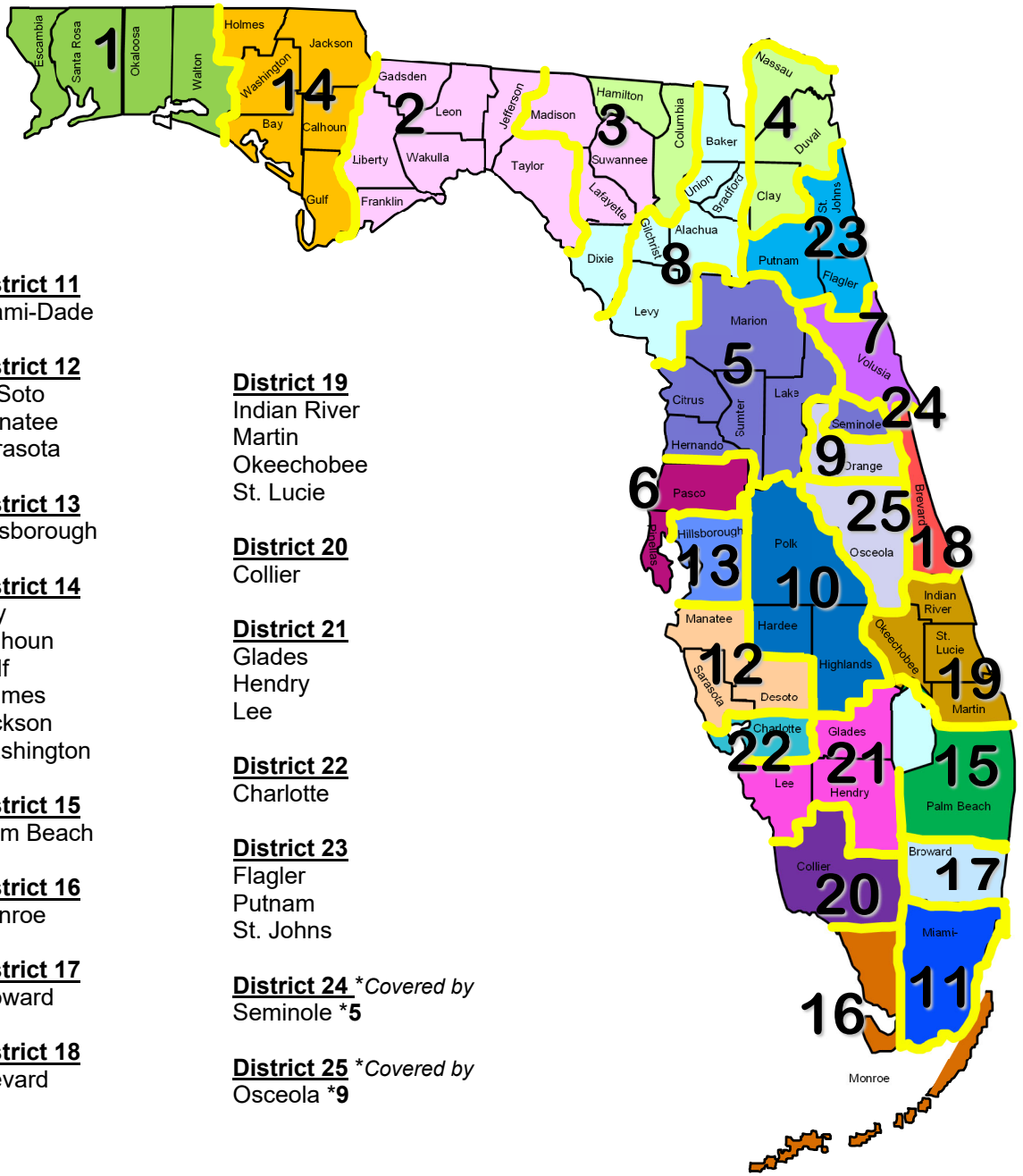


Summary of Drug Occurrences in Decedents
2022

	Drug Present in Body	Cause	Present	Total Occurrences
Amphetamines	Amphetamine	850	1,822	2,672
	Methamphetamine	2,193	725	2,918
Benzodiazepines	Alprazolam	528	710	1,238
	Chlordiazepoxide	20	50	70
	Clonazepam	101	415	516
	Diazepam	142	279	421
	Lorazepam	24	270	294
	Midazolam	3	270	273
	Nordiazepam	35	351	386
	Oxazepam	10	220	230
	Temazepam	37	273	310
Ethanol		1,364	4,832	6,196
Hallucinogenics	Phencyclidine (PCP)/PCP Analogs	0	0	0
	Phenethylamines/Piperazines	53	40	93
	Tryptamines	0	3	3
Inhalants	Halogenated	24	2	26
	Hydrocarbon	1	0	1

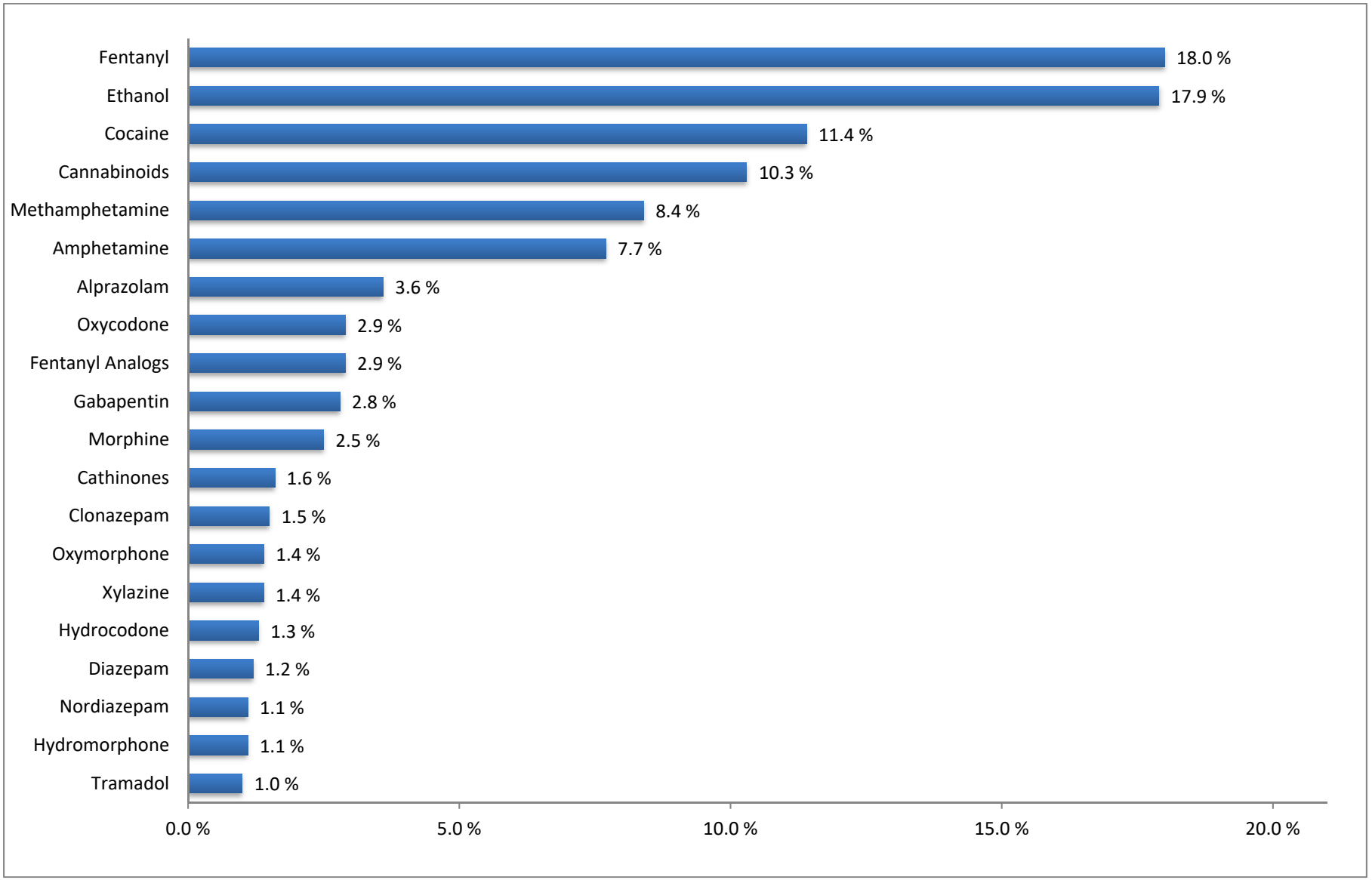
Summary of Drug Occurrences in Decedents (continued)

	Drug Present in Body	Cause	Present	Total Occurrences
Opioids	Buprenorphine	48	179	227
	Codeine	26	150	176
	Fentanyl	5,622	608	6,230
	Fentanyl Analogs	844	161	1,005
	Heroin	165	62	227
	Hydrocodone	133	314	447
	Hydromorphone	77	292	369
	Methadone	175	122	297
	Morphine	328	533	861
	Oxycodone	432	582	1,014
	Oxymorphone	55	419	474
	Tramadol	92	258	350
	U-47700	0	0	0
Other	Cannabinoids	41	3,523	3,564
	Carisoprodol/Meprobamate	13	19	32
	Cathinones	370	179	549
	Cocaine	2,598	1,332	3,930
	GHB	5	3	8
	Gabapentin	179	788	967
	Ketamine	29	185	214
	Mitragynine	172	136	308
	Sympathomimetic Amines	5	19	24
	Synthetic Cannabinoids	9	3	12
	Xylazine	268	203	471
	Zolpidem	39	76	115

Note: Many deaths were found to have several drugs contributing to the death; therefore, the count of specific drugs listed is greater than the number of deaths.

Frequency of Occurrence of Drugs in Decedents[1]

January – December 2022



[1]*Drugs not included individually constituted less than one percent of occurrences.*

Note: Percentages may not sum to 100 percent because of rounding.

Comparison of Drug Occurrences in Decedents

2021 to 2022

	Drug Present in Body	2021	2022	Percentage Change
Amphetamines	Amphetamine	2,647	2,672	0.9%
	Methamphetamine	2,934	2,918	-0.5%
Benzodiazepines	Alprazolam	1,568	1,238	-21.0%
	Chlordiazepoxide	65	70	7.7%
	Clonazepam	571	516	-9.6%
	Diazepam	422	421	-0.2%
	Lorazepam	319	294	-7.8%
	Midazolam	285	273	-4.2%
	Nordiazepam	404	386	-4.5%
	Oxazepam	240	230	-4.2%
	Temazepam	321	310	-3.4%
Ethanol		6,511	6,196	-4.8%
Hallucinogenics	Phencyclidine (PCP) / PCP Analogs	3	0	*
	Phenethylamines/Piperazines	115	93	-19.1%
	Tryptamines	12	3	*
Inhalants	Halogenated	45	26	-42.2%
	Hydrocarbon	1	1	0%

**Due to the small number of occurrences, percent changes were not calculated.*

Comparison of Drug Occurrences in Decedents (continued)

	Drug Present In Body	2021	2022	Percentage Change
Opioids	Buprenorphine	258	227	-12.0%
	Codeine	280	176	-37.1%
	Fentanyl	6,417	6,230	-2.9%
	Fentanyl Analogs	716	1,005	40.4%
	Heroin	464	227	-51.1%
	Hydrocodone	497	447	-10.1%
	Hydromorphone	460	369	-19.8%
	Methadone	387	297	-23.3%
	Morphine	1,201	861	-28.3%
	Oxycodone	1,111	1,014	-8.7%
	Oxymorphone	562	474	-15.7%
	Tramadol	541	350	-35.3%
	U-47700	2	0	*
Other	Cannabinoids	3,845	3,564	-7.3%
	Carisoprodol/Meprobamate	43	32	-25.6%
	Cathinones	430	549	27.7%
	Cocaine	4,015	3,930	-2.1%
	GHB	21	8	-61.9%
	Gabapentin	1,091	967	-11.4%
	Ketamine	216	214	-0.9%
	Mitragynine	305	308	1.0%
	Sympathomimetic Amines	25	24	-4.0%
	Synthetic Cannabinoids	24	12	-50.0%
	Xylazine	N/A	471	N/A
	Zolpidem	161	115	-28.6%

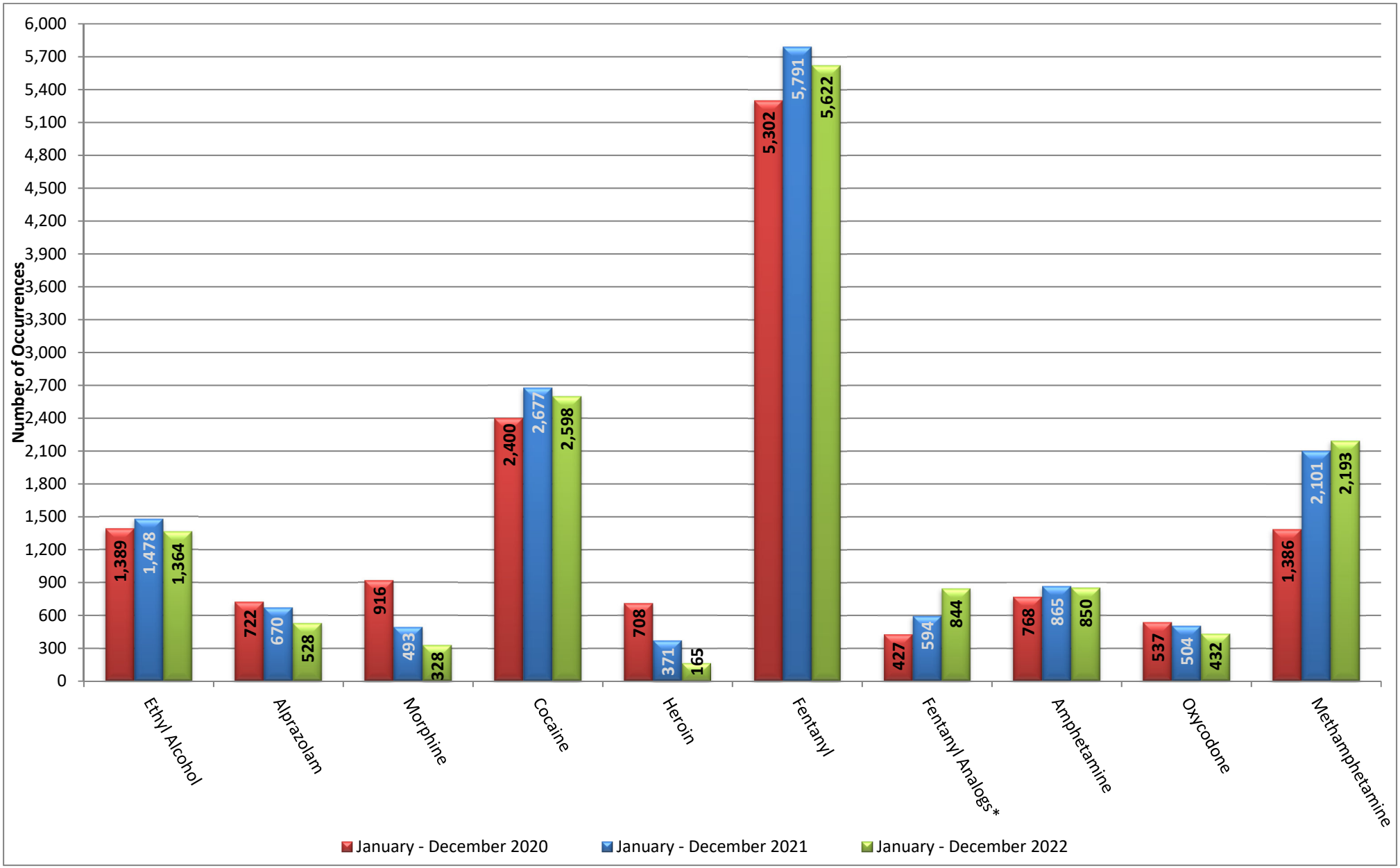
**Due to the small number of occurrences, percent changes were not calculated.*

N/A – Drug was not officially tracked during the previous reporting year.

Note: Many deaths were found to have several drugs contributing to the death; therefore, the count of specific drugs listed is greater than the number of deaths.

Comparison of Drug Caused Deaths

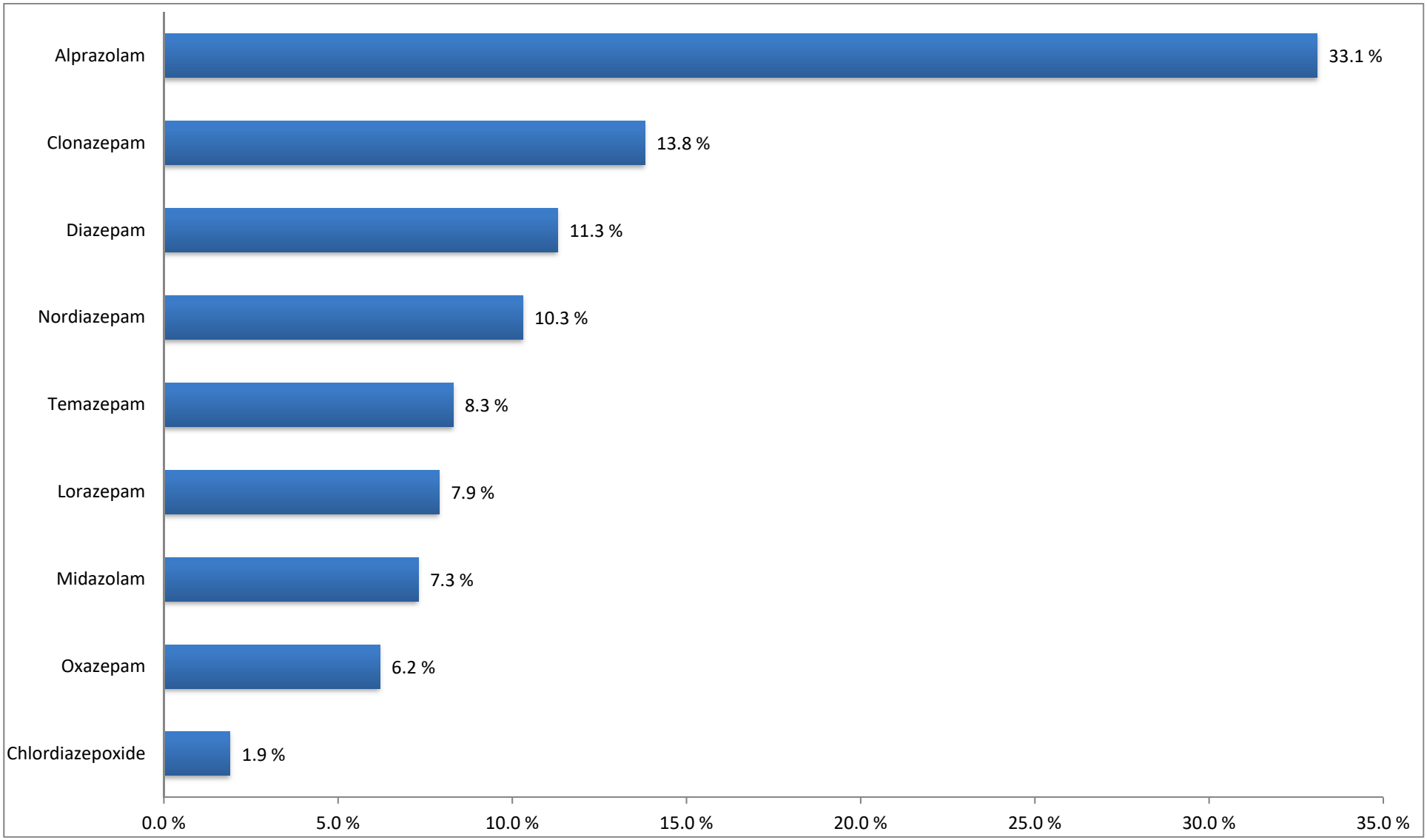
2020 to 2022



** Removed 4-ANPP*

Frequency of Occurrence of Benzodiazepines

January – December 2022



Note: Percentages may not sum to 100 percent because of rounding. Several benzodiazepines (for example, diazepam) 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.

Alprazolam Deaths

January – December 2022

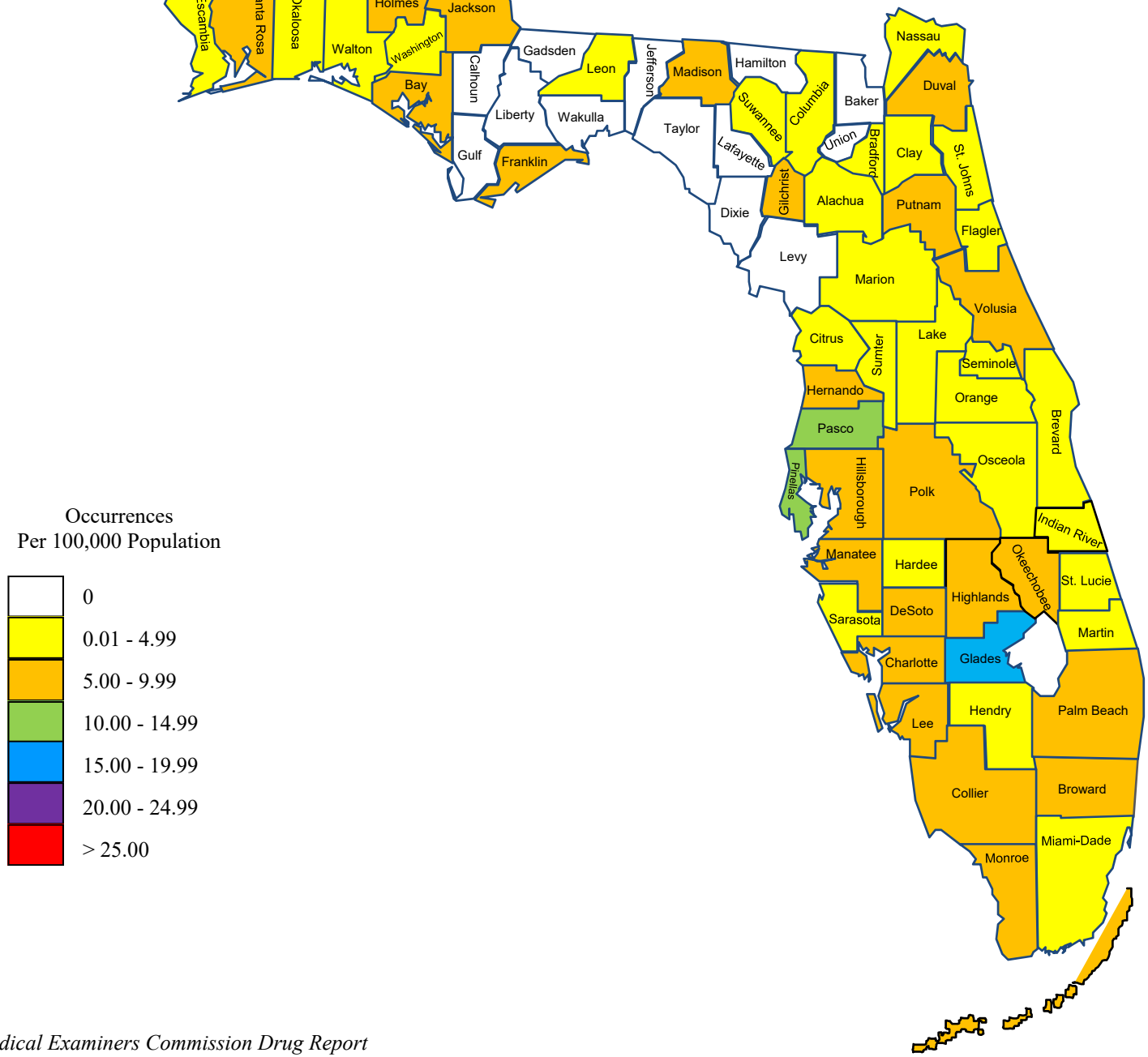
Medical Examiner District and Area of Florida		Total Deaths with Alprazolam			Deaths with Alprazolam Only			Deaths with Alprazolam in Combination with Other Drugs		
District	Area of Florida	Total	Cause	Present	Total	Cause	Present	Total	Cause	Present
1	Pensacola	31	21	10	2	0	2	29	21	8
2	Tallahassee	6	5	1	0	0	0	6	5	1
3	Live Oak	4	2	2	0	0	0	4	2	2
4	Jacksonville	83	28	55	2	0	2	81	28	53
5	Leesburg	49	17	32	5	0	5	44	17	27
6	St. Petersburg	174	114	60	9	2	7	165	112	53
7	Daytona Beach	43	21	22	4	1	3	39	20	19
8	Gainesville	7	2	5	1	0	1	6	2	4
9	Orlando	47	15	32	2	1	1	45	14	31
10	Lakeland	67	16	51	3	0	3	64	16	48
11	Miami	137	33	104	11	1	10	126	32	94
12	Sarasota	40	17	23	6	0	6	34	17	17
13	Tampa	105	65	40	7	0	7	98	65	33
14	Panama City	17	2	15	3	0	3	14	2	12
15	West Palm Beach	143	22	121	12	0	12	131	22	109
16	Florida Keys	8	6	2	1	1	0	7	5	2
17	Ft. Lauderdale	105	68	37	7	1	6	98	67	31
18	Melbourne	13	4	9	1	0	1	12	4	8
19	Ft. Pierce	21	4	17	4	0	4	17	4	13
20	Naples	31	11	20	0	0	0	31	11	20
21	Ft. Myers	54	36	18	3	0	3	51	36	15
22	Port Charlotte	13	6	7	2	0	2	11	6	5
23	St. Augustine	16	4	12	1	0	1	15	4	11
24	Sanford	15	8	7	0	0	0	15	8	7
25	Kissimmee	9	1	8	2	0	2	7	1	6
Statewide Totals		**1,238**	**528**	**710**	**88**	**7**	**81**	**1,150**	**521**	**629**

Alprazolam Deaths by Age

January – December 2022

Medical Examiner District and Area of Florida			Alprazolam Caused Death						Alprazolam Present at Death					
			Age of Decedent						*Age of Decedent*					
District	Area of Florida	Total	Total	<18	18-25	26-34	35-50	>50	Total	<18	18-25	26-34	35-50	>50
1	Pensacola	31	21	0	2	6	9	4	10	0	1	0	3	6
2	Tallahassee	6	5	0	0	2	1	2	1	0	0	0	0	1
3	Live Oak	4	2	0	0	1	0	1	2	0	0	0	2	0
4	Jacksonville	83	28	0	2	8	8	10	55	0	4	11	22	18
5	Leesburg	49	17	0	2	5	3	7	32	0	1	5	9	17
6	St. Petersburg	174	114	0	1	18	41	54	60	0	1	13	18	28
7	Daytona Beach	43	21	0	2	5	7	7	22	0	0	2	6	14
8	Gainesville	7	2	0	1	1	0	0	5	0	1	0	4	0
9	Orlando	47	15	1	2	2	7	3	32	0	1	6	16	9
10	Lakeland	67	16	0	0	3	9	4	51	2	4	12	13	20
11	Miami	137	33	0	1	13	10	9	104	1	9	18	27	49
12	Sarasota	40	17	0	1	5	6	5	23	0	2	3	2	16
13	Tampa	105	65	0	5	20	27	13	40	0	5	5	7	23
14	Panama City	17	2	0	0	1	1	0	15	0	0	3	2	10
15	West Palm Beach	143	22	0	0	4	8	10	121	0	7	17	43	54
16	Florida Keys	8	6	0	0	3	3	0	2	0	0	0	0	2
17	Ft. Lauderdale	105	68	0	3	13	24	28	37	0	2	3	8	24
18	Melbourne	13	4	0	0	1	0	3	9	0	1	2	4	2
19	Ft. Pierce	21	4	0	0	1	2	1	17	0	1	2	2	12
20	Naples	31	11	0	2	3	2	4	20	0	2	5	9	4
21	Ft. Myers	54	36	0	2	9	11	14	18	0	0	2	6	10
22	Port Charlotte	13	6	0	0	0	2	4	7	0	0	1	3	3
23	St. Augustine	16	4	0	1	0	2	1	12	0	1	4	5	2
24	Sanford	15	8	0	1	5	1	1	7	0	0	0	5	2
25	Kissimmee	9	1	0	0	0	1	0	8	0	1	1	3	3
Statewide Totals		**1,238**	**528**	**1**	**28**	**129**	**185**	**185**	**710**	**3**	**44**	**115**	**219**	**329**

Alprazolam Deaths by County
2022



Clonazepam Deaths

January – December 2022

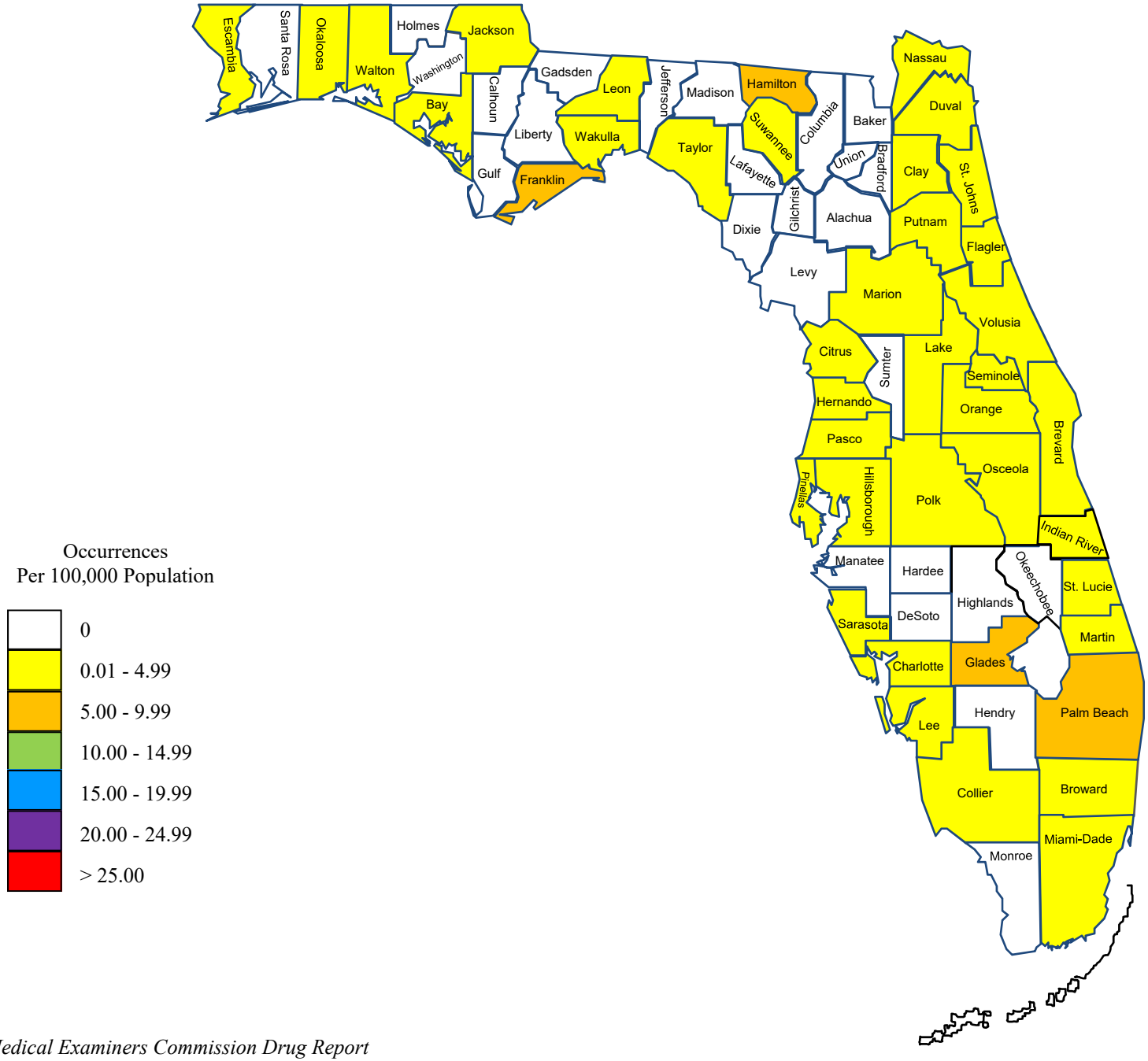
Medical Examiner District and Area of Florida		Total Deaths with Clonazepam			Deaths with Clonazepam Only			Deaths with Clonazepam in Combination with Other Drugs		
District	Area of Florida	Total	Cause	Present	Total	Cause	Present	Total	Cause	Present
1	Pensacola	13	6	7	0	0	0	13	6	7
2	Tallahassee	13	1	12	0	0	0	13	1	12
3	Live Oak	2	0	2	0	0	0	2	0	2
4	Jacksonville	42	7	35	0	0	0	42	7	35
5	Leesburg	14	3	11	0	0	0	14	3	11
6	St. Petersburg	76	21	55	0	0	0	76	21	55
7	Daytona Beach	14	2	12	0	0	0	14	2	12
8	Gainesville	0	0	0	0	0	0	0	0	0
9	Orlando	42	3	39	0	0	0	42	3	39
10	Lakeland	1	1	0	0	0	0	1	1	0
11	Miami	53	6	47	0	0	0	53	6	47
12	Sarasota	1	1	0	0	0	0	1	1	0
13	Tampa	1	0	1	0	0	0	1	0	1
14	Panama City	11	0	11	0	0	0	11	0	11
15	West Palm Beach	88	4	84	0	0	0	88	4	84
16	Florida Keys	0	0	0	0	0	0	0	0	0
17	Ft. Lauderdale	45	24	21	0	0	0	45	24	21
18	Melbourne	11	5	6	0	0	0	11	5	6
19	Ft. Pierce	26	2	24	0	0	0	26	2	24
20	Naples	2	1	1	0	0	0	2	1	1
21	Ft. Myers	29	10	19	0	0	0	29	10	19
22	Port Charlotte	9	2	7	0	0	0	9	2	7
23	St. Augustine	6	0	6	0	0	0	6	0	6
24	Sanford	3	2	1	0	0	0	3	2	1
25	Kissimmee	14	0	14	0	0	0	14	0	14
Statewide Totals		**516**	**101**	**415**	**0**	**0**	**0**	**516**	**101**	**415**

Clonazepam Deaths by Age

January – December 2022

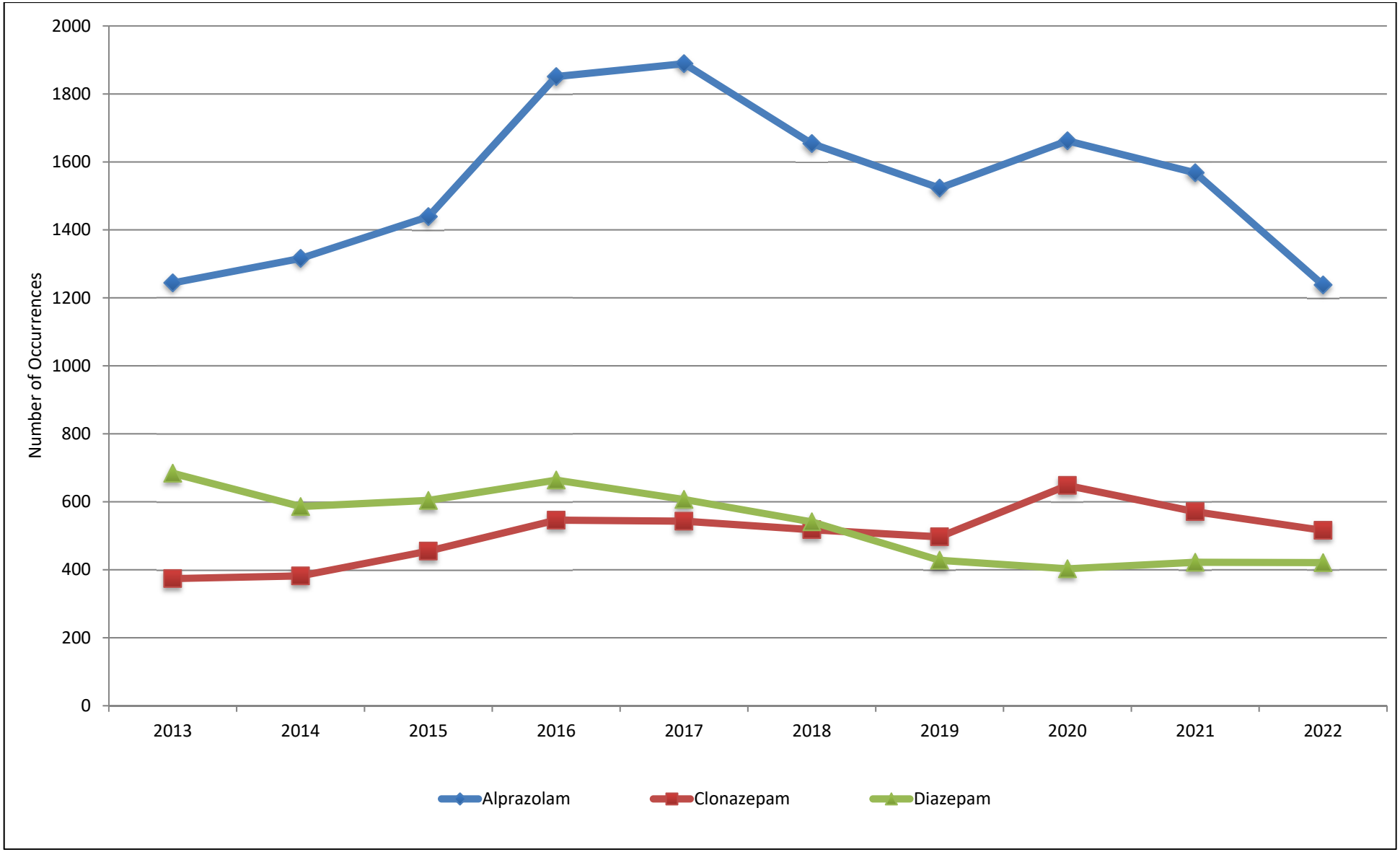
Medical Examiner District and Area of Florida			Clonazepam Caused Death						Clonazepam Present at Death					
			Age of Decedent						*Age of Decedent*					
District	Area of Florida	Total	Total	< 18	18-25	26-34	35-50	>50	Total	<18	18-25	26-34	35-50	>50
1	Pensacola	13	6	0	2	1	2	1	7	0	0	3	2	2
2	Tallahassee	13	1	0	0	0	1	0	12	0	1	2	3	6
3	Live Oak	2	0	0	0	0	0	0	2	0	0	0	1	1
4	Jacksonville	42	7	0	0	1	4	2	35	0	2	8	11	14
5	Leesburg	14	3	0	0	1	0	2	11	0	0	1	6	4
6	St. Petersburg	76	21	0	0	4	11	6	55	0	2	12	19	22
7	Daytona Beach	14	2	0	1	0	0	1	12	0	0	2	6	4
8	Gainesville	0	0	0	0	0	0	0	0	0	0	0	0	0
9	Orlando	42	3	0	0	0	2	1	39	1	7	7	10	14
10	Lakeland	1	1	0	0	0	0	1	0	0	0	0	0	0
11	Miami	53	6	0	1	1	1	3	47	0	1	12	9	25
12	Sarasota	1	1	0	0	0	1	0	0	0	0	0	0	0
13	Tampa	1	0	0	0	0	0	0	1	0	0	0	0	1
14	Panama City	11	0	0	0	0	0	0	11	0	0	3	4	4
15	West Palm Beach	88	4	0	0	0	3	1	84	2	6	19	25	32
16	Florida Keys	0	0	0	0	0	0	0	0	0	0	0	0	0
17	Ft. Lauderdale	45	24	0	0	9	7	8	21	0	2	4	5	10
18	Melbourne	11	5	0	0	0	3	2	6	0	0	1	1	4
19	Ft. Pierce	26	2	0	0	0	0	2	24	0	1	5	5	13
20	Naples	2	1	0	0	0	1	0	1	0	0	0	1	0
21	Ft. Myers	29	10	0	1	1	4	4	19	0	1	2	10	6
22	Port Charlotte	9	2	0	0	1	0	1	7	0	0	0	5	2
23	St. Augustine	6	0	0	0	0	0	0	6	0	0	2	2	2
24	Sanford	3	2	0	1	1	0	0	1	0	0	0	1	0
25	Kissimmee	14	0	0	0	0	0	0	14	0	2	1	5	6
Statewide Totals		**516**	**101**	**0**	**6**	**20**	**40**	**35**	**415**	**3**	**25**	**84**	**131**	**172**

Clonazepam Deaths by County
2022



Historical Overview of Alprazolam, Clonazepam and Diazepam Occurrences

(Present and Cause)
2013 to 2022



Oxycodone Deaths

January – December 2022

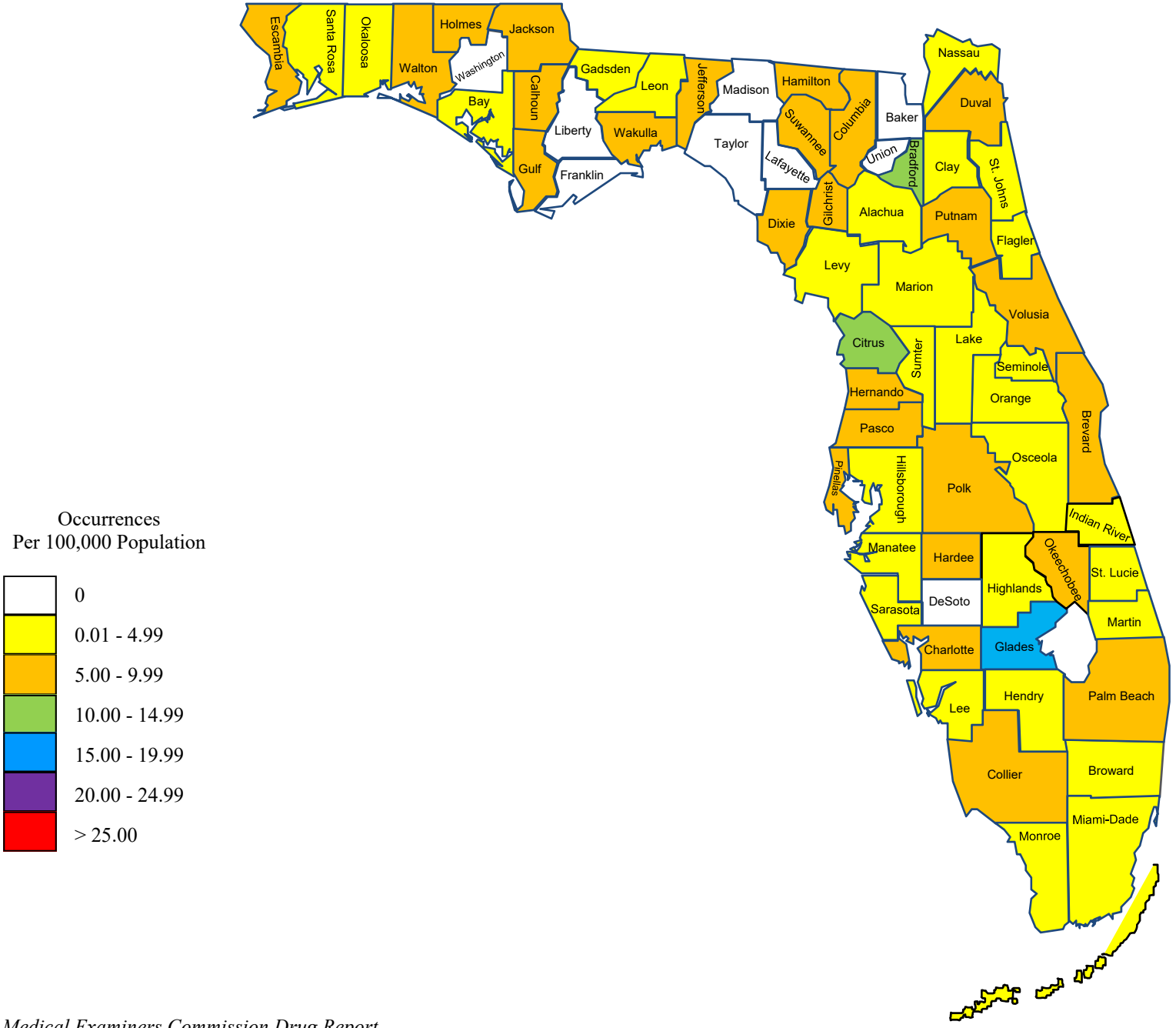
Medical Examiner District and Area of Florida		Total Deaths with Oxycodone			Deaths with Oxycodone Only			Deaths with Oxycodone in Combination with Other Drugs		
District	Area of Florida	Total	Cause	Present	Total	Cause	Present	Total	Cause	Present
1	Pensacola	48	22	26	4	0	4	44	22	22
2	Tallahassee	15	5	10	1	0	1	14	5	9
3	Live Oak	12	2	10	0	0	0	12	2	10
4	Jacksonville	71	28	43	2	0	2	69	28	41
5	Leesburg	62	25	37	10	1	9	52	24	28
6	St. Petersburg	130	75	55	6	1	5	124	74	50
7	Daytona Beach	34	19	15	2	0	2	32	19	13
8	Gainesville	15	4	11	3	0	3	12	4	8
9	Orlando	44	15	29	4	0	4	40	15	25
10	Lakeland	50	13	37	4	2	2	46	11	35
11	Miami	68	24	44	4	0	4	64	24	40
12	Sarasota	32	12	20	2	0	2	30	12	18
13	Tampa	69	48	21	4	0	4	65	48	17
14	Panama City	12	3	9	2	1	1	10	2	8
15	West Palm Beach	102	34	68	1	0	1	101	34	67
16	Florida Keys	4	4	0	0	0	0	4	4	0
17	Ft. Lauderdale	78	39	39	3	1	2	75	38	37
18	Melbourne	33	11	22	4	0	4	29	11	18
19	Ft. Pierce	26	11	15	1	0	1	25	11	14
20	Naples	21	5	16	0	0	0	21	5	16
21	Ft. Myers	43	17	26	4	0	4	39	17	22
22	Port Charlotte	10	3	7	0	0	0	10	3	7
23	St. Augustine	15	4	11	0	0	0	15	4	11
24	Sanford	11	6	5	1	0	1	10	6	4
25	Kissimmee	9	3	6	4	1	3	5	2	3
Statewide Totals		**1,014**	**432**	**582**	**66**	**7**	**59**	**948**	**425**	**523**

Oxycodone Deaths by Age

January – December 2022

Medical Examiner District and Area of Florida			Oxycodone Caused Death						Oxycodone Present at Death					
			Age of Decedent						*Age of Decedent*					
District	Area of Florida	Total	Total	< 18	18-25	26-34	35-50	>50	Total	<18	18-25	26-34	35-50	>50
1	Pensacola	48	22	0	0	4	8	10	26	0	3	0	5	18
2	Tallahassee	15	5	0	0	0	1	4	10	0	1	1	2	6
3	Live Oak	12	2	0	0	0	1	1	10	0	0	1	3	6
4	Jacksonville	71	28	0	0	3	11	14	43	2	4	4	16	17
5	Leesburg	62	25	0	2	4	7	12	37	0	1	0	10	26
6	St. Petersburg	130	75	0	1	7	25	42	55	0	2	7	20	26
7	Daytona Beach	34	19	0	2	2	8	7	15	0	1	0	2	12
8	Gainesville	15	4	0	0	1	1	2	11	0	0	0	5	6
9	Orlando	44	15	0	1	5	7	2	29	0	1	3	7	18
10	Lakeland	50	13	0	0	1	8	4	37	0	4	6	10	17
11	Miami	68	24	0	0	13	5	6	44	0	7	11	9	17
12	Sarasota	32	12	0	0	0	8	4	20	0	1	6	2	11
13	Tampa	69	48	0	4	4	14	26	21	0	0	1	6	14
14	Panama City	12	3	0	0	0	3	0	9	0	0	0	3	6
15	West Palm Beach	102	34	0	1	7	10	16	68	0	4	7	20	37
16	Florida Keys	4	4	0	0	1	1	2	0	0	0	0	0	0
17	Ft. Lauderdale	78	39	0	1	7	9	22	39	1	4	5	7	22
18	Melbourne	33	11	0	1	1	4	5	22	1	1	4	5	11
19	Ft. Pierce	26	11	0	1	0	3	7	15	0	0	2	3	10
20	Naples	21	5	0	0	0	3	2	16	0	0	2	3	11
21	Ft. Myers	43	17	0	2	5	3	7	26	0	0	1	6	19
22	Port Charlotte	10	3	0	0	0	0	3	7	0	0	1	1	5
23	St. Augustine	15	4	0	0	0	1	3	11	0	0	0	3	8
24	Sanford	11	6	0	0	1	0	5	5	0	0	2	2	1
25	Kissimmee	9	3	0	0	0	1	2	6	0	1	0	0	5
Statewide Totals		**1,014**	**432**	**0**	**16**	**66**	**142**	**208**	**582**	**4**	**35**	**64**	**150**	**329**

Oxycodone Deaths by County
2022



Hydrocodone Deaths

January – December 2022

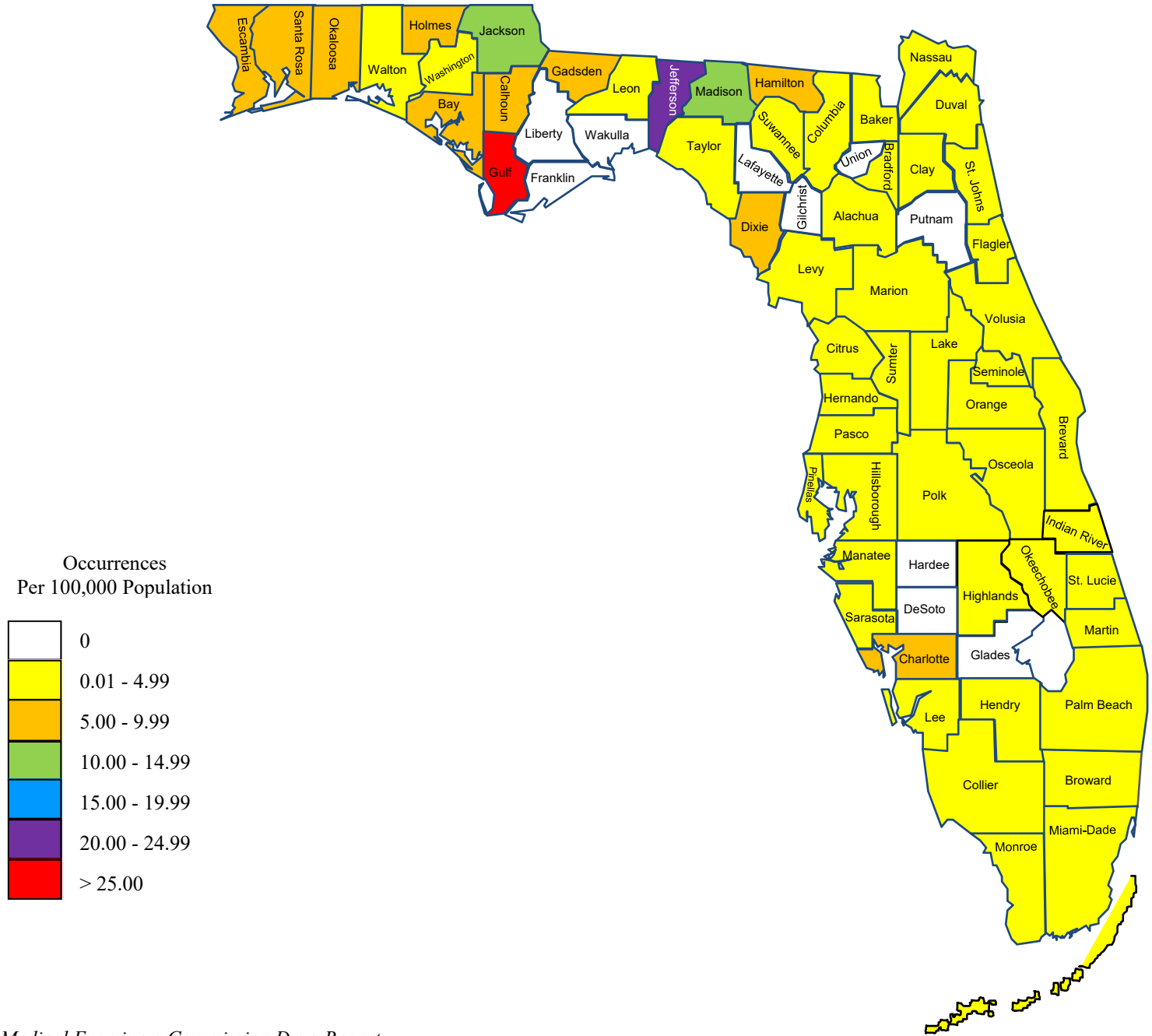
Medical Examiner District and Area of Florida		Total Deaths with Hydrocodone			Deaths with Hydrocodone Only			Deaths with Hydrocodone in Combination with Other Drugs		
District	Area of Florida	Total	Cause	Present	Total	Cause	Present	Total	Cause	Present
1	Pensacola	55	19	36	14	0	14	41	19	22
2	Tallahassee	19	7	12	0	0	0	19	7	12
3	Live Oak	9	1	8	1	0	1	8	1	7
4	Jacksonville	36	11	25	2	0	2	34	11	23
5	Leesburg	24	8	16	4	0	4	20	8	12
6	St. Petersburg	50	20	30	0	0	0	50	20	30
7	Daytona Beach	23	8	15	4	0	4	19	8	11
8	Gainesville	5	1	4	1	0	1	4	1	3
9	Orlando	25	6	19	7	0	7	18	6	12
10	Lakeland	17	4	13	2	1	1	15	3	12
11	Miami	12	4	8	0	0	0	12	4	8
12	Sarasota	14	4	10	5	2	3	9	2	7
13	Tampa	26	10	16	4	1	3	22	9	13
14	Panama City	25	6	19	0	0	0	25	6	19
15	West Palm Beach	22	0	22	1	0	1	21	0	21
16	Florida Keys	2	0	2	0	0	0	2	0	2
17	Ft. Lauderdale	13	6	7	1	0	1	12	6	6
18	Melbourne	10	3	7	4	0	4	6	3	3
19	Ft. Pierce	14	4	10	5	1	4	9	3	6
20	Naples	4	1	3	0	0	0	4	1	3
21	Ft. Myers	11	6	5	2	1	1	9	5	4
22	Port Charlotte	12	3	9	1	0	1	11	3	8
23	St. Augustine	8	0	8	1	0	1	7	0	7
24	Sanford	5	1	4	2	0	2	3	1	2
25	Kissimmee	6	0	6	0	0	0	6	0	6
Statewide Totals		**447**	**133**	**314**	**61**	**6**	**55**	**386**	**127**	**259**

Hydrocodone Deaths by Age

January – December 2022

Medical Examiner District and Area of Florida			Hydrocodone Caused Death						Hydrocodone Present at Death					
			Age of Decedent						*Age of Decedent*					
District	Area of Florida	Total	Total	< 18	18-25	26-34	35-50	>50	Total	<18	18-25	26-34	35-50	>50
1	Pensacola	55	19	0	0	1	12	6	36	0	1	2	10	23
2	Tallahassee	19	7	0	0	0	1	6	12	0	0	0	3	9
3	Live Oak	9	1	0	0	0	0	1	8	0	0	1	1	6
4	Jacksonville	36	11	0	0	2	3	6	25	1	0	4	9	11
5	Leesburg	24	8	0	0	1	3	4	16	0	0	1	1	14
6	St. Petersburg	50	20	0	1	5	4	10	30	0	0	4	6	20
7	Daytona Beach	23	8	0	0	0	3	5	15	0	0	0	3	12
8	Gainesville	5	1	0	0	0	0	1	4	0	0	0	1	3
9	Orlando	25	6	0	0	1	1	4	19	0	0	1	3	15
10	Lakeland	17	4	0	0	0	2	2	13	0	0	1	6	6
11	Miami	12	4	0	0	1	1	2	8	0	2	1	1	4
12	Sarasota	14	4	0	0	0	3	1	10	0	0	2	2	6
13	Tampa	26	10	0	0	0	3	7	16	0	0	1	6	9
14	Panama City	25	6	0	0	0	4	2	19	0	0	1	3	15
15	West Palm Beach	22	0	0	0	0	0	0	22	0	0	2	5	15
16	Florida Keys	2	0	0	0	0	0	0	2	0	0	0	1	1
17	Ft. Lauderdale	13	6	0	0	2	0	4	7	0	0	0	1	6
18	Melbourne	10	3	0	0	0	1	2	7	0	0	0	1	6
19	Ft. Pierce	14	4	0	0	1	0	3	10	0	0	1	1	8
20	Naples	4	1	0	0	0	0	1	3	0	0	1	1	1
21	Ft. Myers	11	6	0	0	0	1	5	5	0	0	0	0	5
22	Port Charlotte	12	3	0	0	0	0	3	9	0	0	0	1	8
23	St. Augustine	8	0	0	0	0	0	0	8	0	1	1	1	5
24	Sanford	5	1	0	0	0	0	1	4	0	0	1	1	2
25	Kissimmee	6	0	0	0	0	0	0	6	0	0	0	2	4
Statewide Totals		**447**	**133**	**0**	**1**	**14**	**42**	**76**	**314**	**1**	**4**	**25**	**70**	**214**

Hydrocodone Deaths by County
2022



Methadone Deaths

January – December 2022

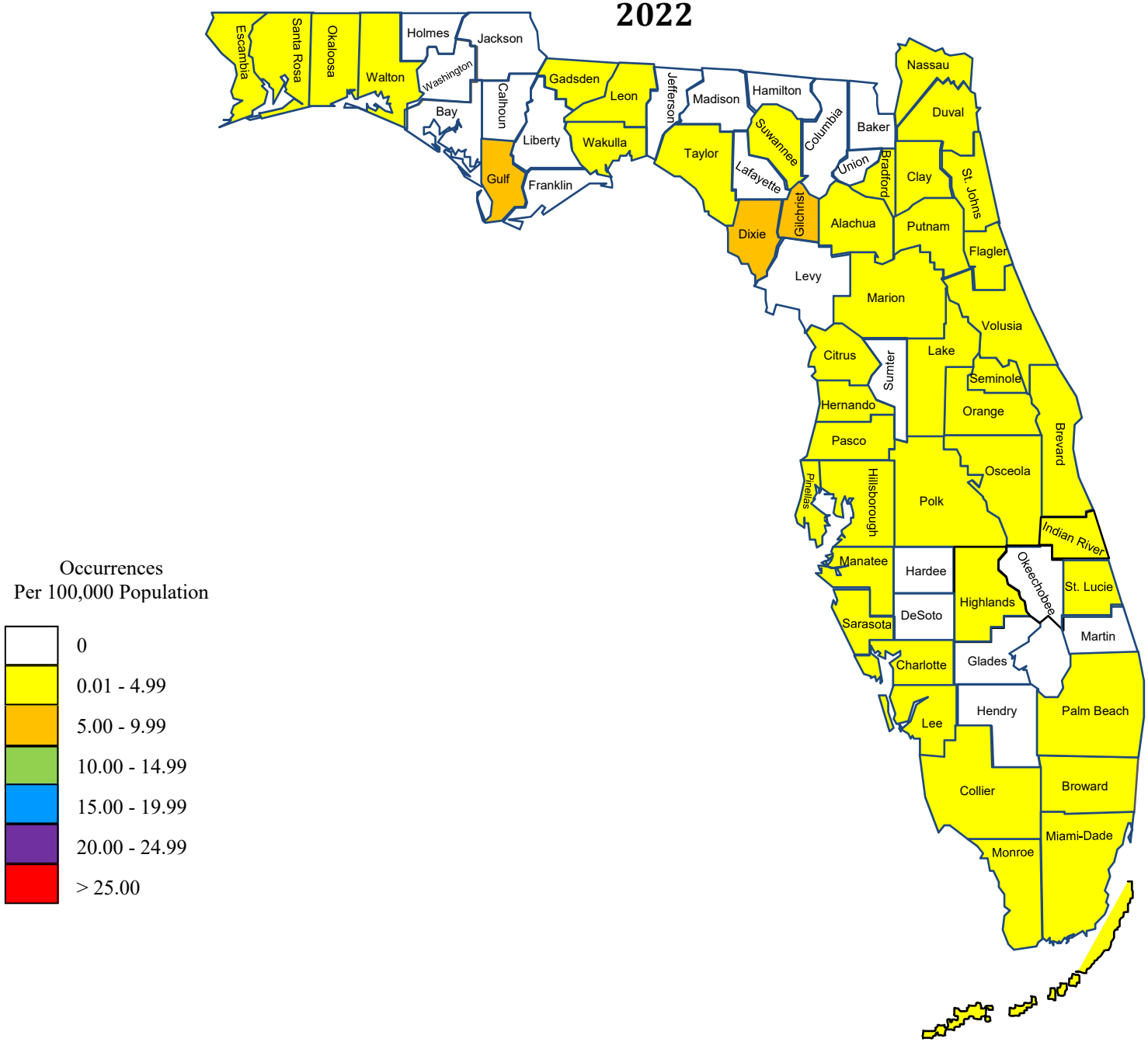
Medical Examiner District and Area of Florida		Total Deaths with Methadone			Deaths with Methadone Only			Deaths with Methadone in Combination with Other Drugs		
District	Area of Florida	Total	Cause	Present	Total	Cause	Present	Total	Cause	Present
1	Pensacola	15	11	4	4	3	1	11	8	3
2	Tallahassee	6	2	4	2	0	2	4	2	2
3	Live Oak	2	0	2	1	0	1	1	0	1
4	Jacksonville	33	19	14	8	6	2	25	13	12
5	Leesburg	19	16	3	3	3	0	16	13	3
6	St. Petersburg	44	33	11	4	1	3	40	32	8
7	Daytona Beach	11	5	6	0	0	0	11	5	6
8	Gainesville	4	2	2	0	0	0	4	2	2
9	Orlando	14	8	6	1	1	0	13	7	6
10	Lakeland	9	5	4	2	1	1	7	4	3
11	Miami	8	2	6	0	0	0	8	2	6
12	Sarasota	19	10	9	5	3	2	14	7	7
13	Tampa	24	18	6	3	1	2	21	17	4
14	Panama City	1	1	0	0	0	0	1	1	0
15	West Palm Beach	28	11	17	1	0	1	27	11	16
16	Florida Keys	1	0	1	0	0	0	1	0	1
17	Ft. Lauderdale	16	12	4	1	1	0	15	11	4
18	Melbourne	7	2	5	0	0	0	7	2	5
19	Ft. Pierce	8	3	5	0	0	0	8	3	5
20	Naples	9	3	6	2	0	2	7	3	4
21	Ft. Myers	3	2	1	1	0	1	2	2	0
22	Port Charlotte	3	2	1	0	0	0	3	2	1
23	St. Augustine	4	2	2	2	1	1	2	1	1
24	Sanford	5	5	0	0	0	0	5	5	0
25	Kissimmee	4	1	3	1	1	0	3	0	3
Statewide Totals		**297**	**175**	**122**	**41**	**22**	**19**	**256**	**153**	**103**

Methadone Deaths by Age

January – December 2022

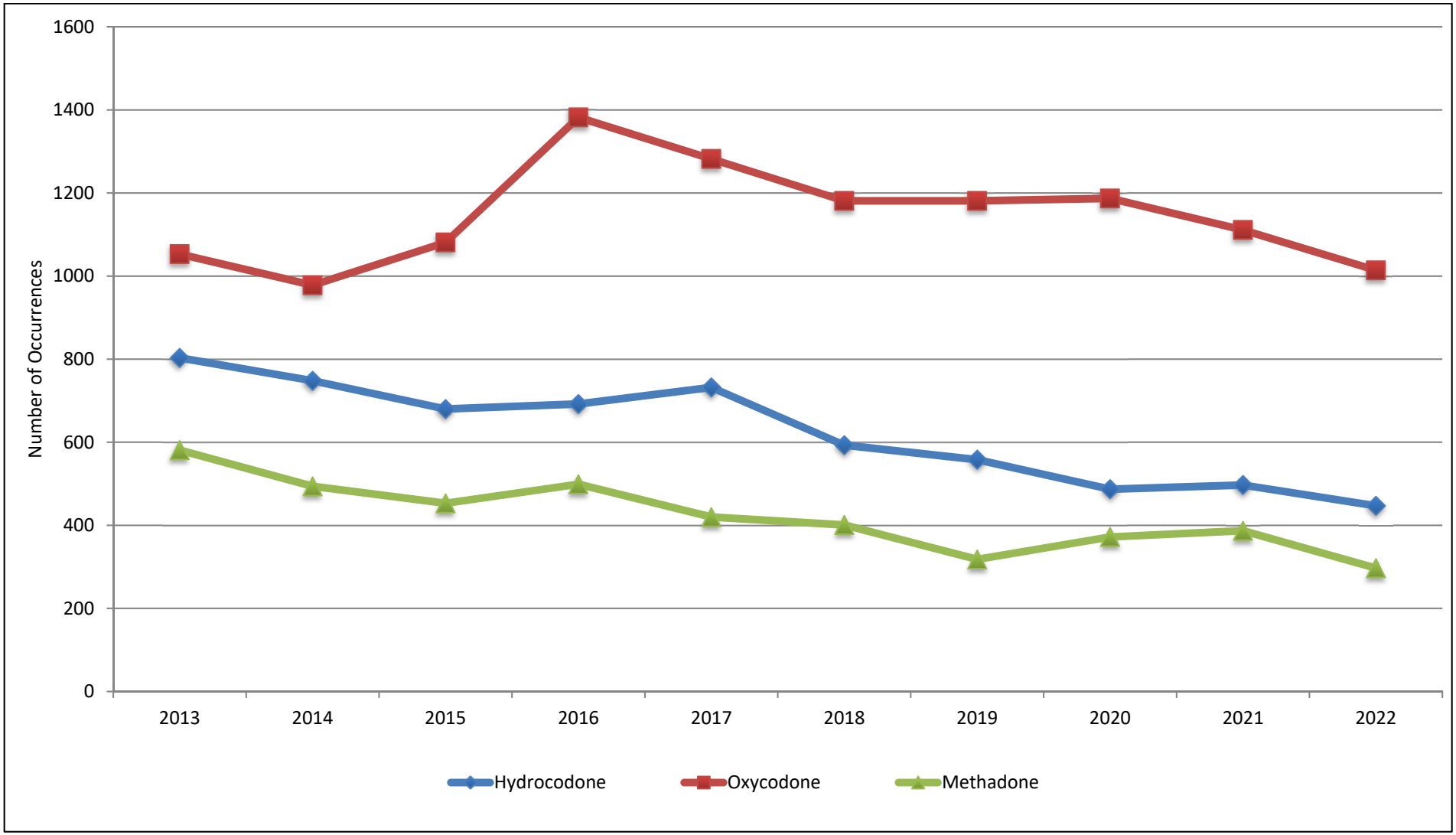
Medical Examiner District and Area of Florida			Methadone Caused Death						Methadone Present at Death					
			Age of Decedent						*Age of Decedent*					
District	Area of Florida	Total	Total	<18	18-25	26-34	35-50	>50	Total	<18	18-25	26-34	35-50	>50
1	Pensacola	15	11	0	0	1	5	5	4	0	0	0	2	2
2	Tallahassee	6	2	0	0	0	1	1	4	0	0	0	2	2
3	Live Oak	2	0	0	0	0	0	0	2	0	0	0	0	2
4	Jacksonville	33	19	0	0	6	7	6	14	0	0	1	8	5
5	Leesburg	19	16	0	0	3	4	9	3	0	0	0	1	2
6	St. Petersburg	44	33	0	1	4	16	12	11	1	0	1	5	4
7	Daytona Beach	11	5	0	0	1	3	1	6	0	1	2	1	2
8	Gainesville	4	2	0	0	1	0	1	2	0	0	0	0	2
9	Orlando	14	8	0	0	2	3	3	6	0	0	0	3	3
10	Lakeland	9	5	0	0	0	3	2	4	0	0	1	1	2
11	Miami	8	2	0	0	0	0	2	6	0	0	2	2	2
12	Sarasota	19	10	0	0	1	3	6	9	0	0	1	4	4
13	Tampa	24	18	0	0	2	8	8	6	0	0	0	2	4
14	Panama City	1	1	0	0	0	0	1	0	0	0	0	0	0
15	West Palm Beach	28	11	0	1	1	4	5	17	0	0	2	4	11
16	Florida Keys	1	0	0	0	0	0	0	1	0	0	0	1	0
17	Ft. Lauderdale	16	12	0	0	1	4	7	4	0	1	0	1	2
18	Melbourne	7	2	0	0	0	1	1	5	1	0	0	2	2
19	Ft. Pierce	8	3	0	0	1	1	1	5	0	0	1	1	3
20	Naples	9	3	0	0	0	1	2	6	0	0	0	2	4
21	Ft. Myers	3	2	0	0	0	1	1	1	0	0	0	0	1
22	Port Charlotte	3	2	0	0	0	2	0	1	0	0	0	0	1
23	St. Augustine	4	2	1	0	0	0	1	2	0	0	0	1	1
24	Sanford	5	5	0	1	0	2	2	0	0	0	0	0	0
25	Kissimmee	4	1	0	0	0	0	1	3	0	0	2	0	1
Statewide Totals		**297**	**175**	**1**	**3**	**24**	**69**	**78**	**122**	**2**	**2**	**13**	**43**	**62**

Methadone Deaths by County
2022



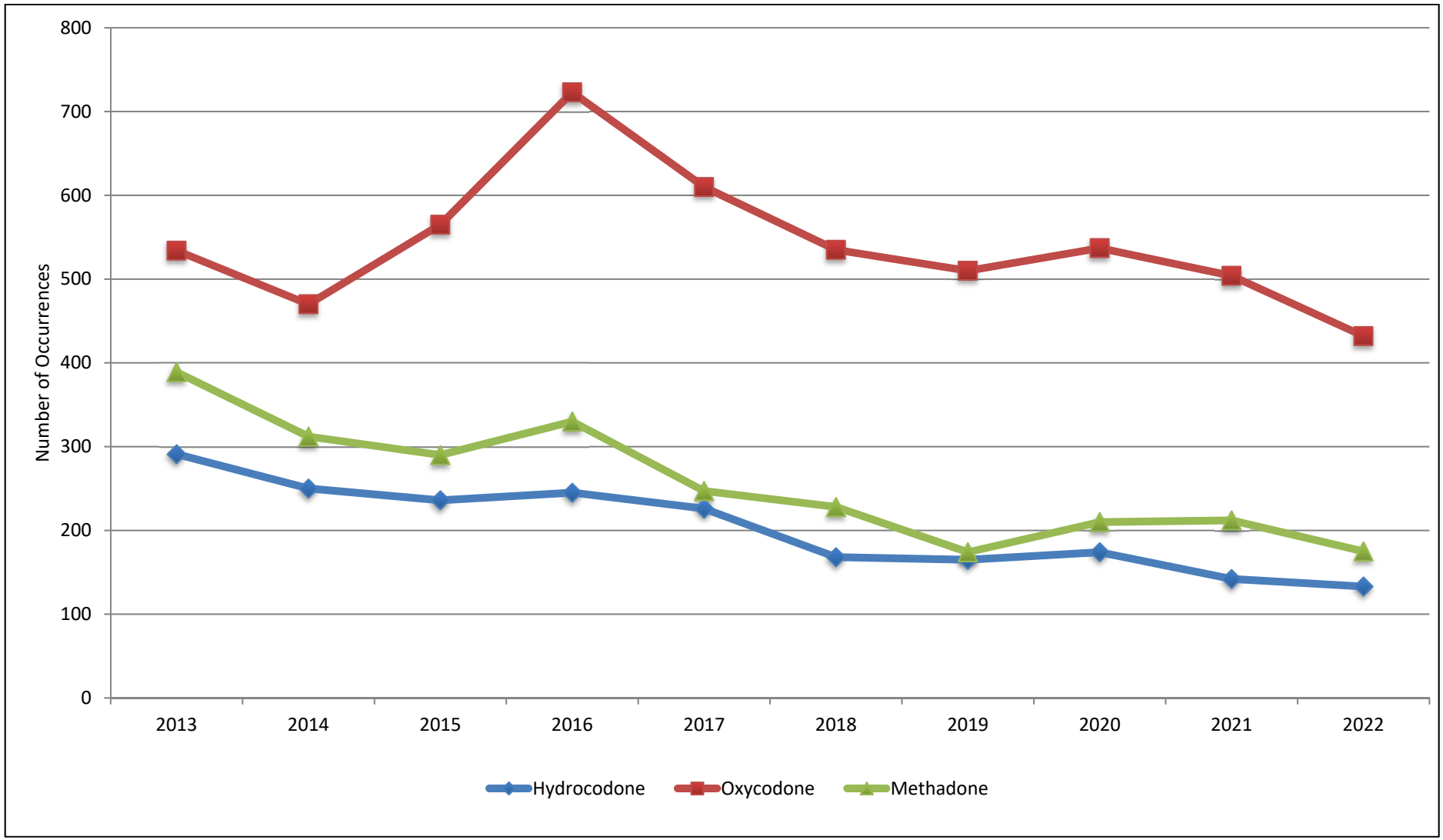
Historical Overview of Hydrocodone, Oxycodone, and Methadone Occurrences

(Present and Cause)
2013 to 2022



Historical Overview of Deaths Caused by Hydrocodone, Oxycodone, and Methadone

2013 to 2022



Morphine Deaths

January – December 2022

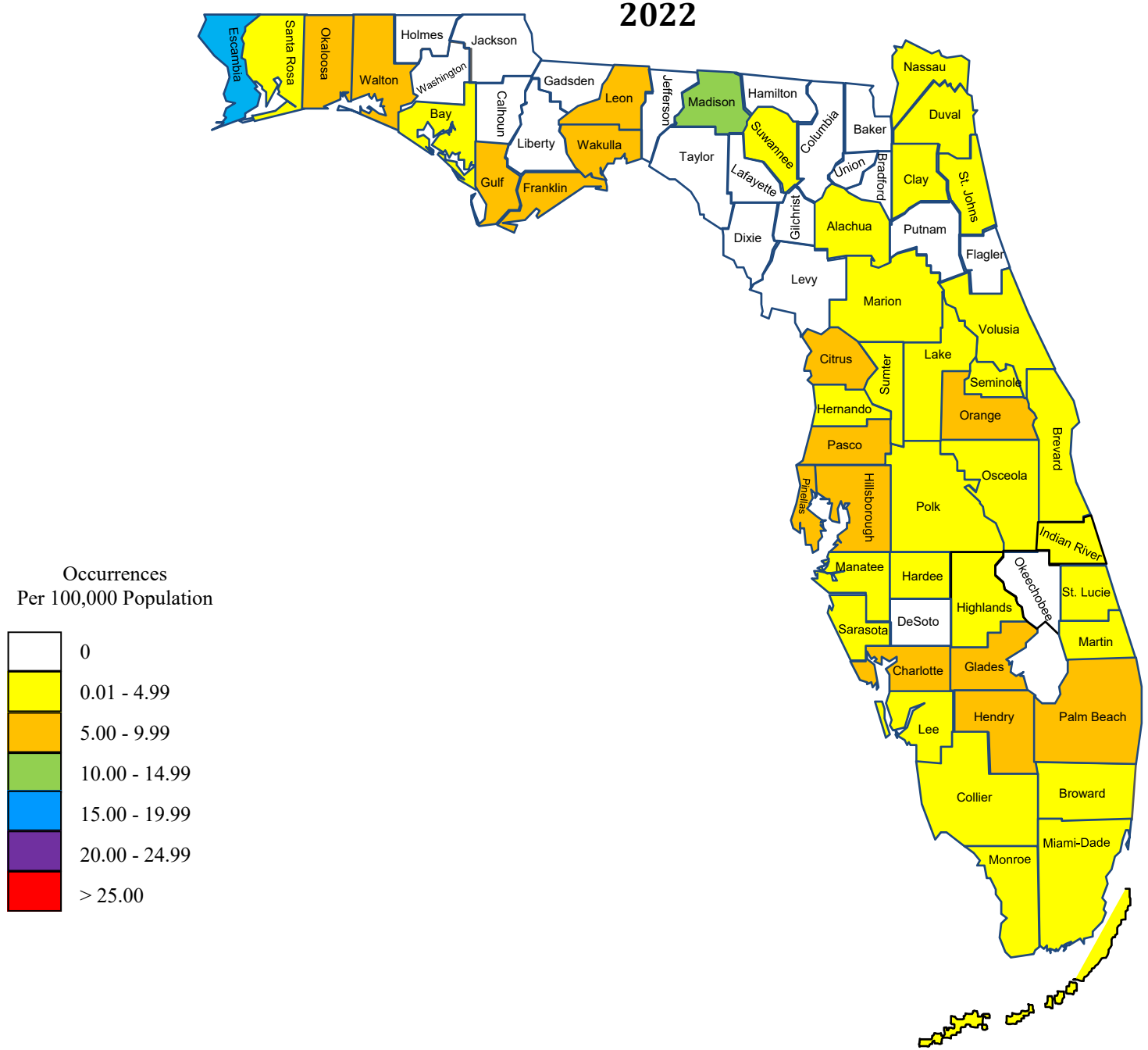
Medical Examiner District and Area of Florida		Total Deaths with Morphine			Deaths with Morphine Only			Deaths with Morphine in Combination with Other Drugs		
District	Area of Florida	Total	Cause	Present	Total	Cause	Present	Total	Cause	Present
1	Pensacola	86	33	53	10	0	10	76	33	43
2	Tallahassee	22	5	17	1	0	1	21	5	16
3	Live Oak	3	0	3	1	0	1	2	0	2
4	Jacksonville	33	14	19	3	0	3	30	14	16
5	Leesburg	37	21	16	1	0	1	36	21	15
6	St. Petersburg	84	49	35	7	2	5	77	47	30
7	Daytona Beach	23	7	16	0	0	0	23	7	16
8	Gainesville	9	2	7	3	1	2	6	1	5
9	Orlando	96	14	82	14	1	13	82	13	69
10	Lakeland	40	5	35	5	0	5	35	5	30
11	Miami	43	11	32	4	0	4	39	11	28
12	Sarasota	20	5	15	3	1	2	17	4	13
13	Tampa	83	56	27	5	0	5	78	56	22
14	Panama City	9	4	5	0	0	0	9	4	5
15	West Palm Beach	105	34	71	1	1	0	104	33	71
16	Florida Keys	1	0	1	0	0	0	1	0	1
17	Ft. Lauderdale	55	22	33	3	1	2	52	21	31
18	Melbourne	12	3	9	1	0	1	11	3	8
19	Ft. Pierce	7	4	3	0	0	0	7	4	3
20	Naples	19	10	9	4	0	4	15	10	5
21	Ft. Myers	33	14	19	6	1	5	27	13	14
22	Port Charlotte	10	2	8	0	0	0	10	2	8
23	St. Augustine	4	3	1	0	0	0	4	3	1
24	Sanford	9	4	5	1	0	1	8	4	4
25	Kissimmee	18	6	12	3	0	3	15	6	9
Statewide Totals		**861**	**328**	**533**	**76**	**8**	**68**	**785**	**320**	**465**

Morphine Deaths by Age

January – December 2022

Medical Examiner District and Area of Florida			Morphine Caused Death						Morphine Present at Death					
			Age of Decedent						*Age of Decedent*					
District	Area of Florida	Total	Total	<18	18-25	26-34	35-50	>50	Total	<18	18-25	26-34	35-50	>50
1	Pensacola	86	33	0	1	7	15	10	53	2	2	1	18	30
2	Tallahassee	22	5	0	1	1	3	0	17	0	2	7	2	6
3	Live Oak	3	0	0	0	0	0	0	3	0	0	1	1	1
4	Jacksonville	33	14	0	0	3	3	8	19	0	1	3	4	11
5	Leesburg	37	21	0	1	1	9	10	16	0	0	0	3	13
6	St. Petersburg	84	49	0	0	4	15	30	35	1	1	4	10	19
7	Daytona Beach	23	7	0	0	2	3	2	16	0	2	2	4	8
8	Gainesville	9	2	0	0	0	0	2	7	0	0	0	2	5
9	Orlando	96	14	1	1	2	5	5	82	0	3	3	6	70
10	Lakeland	40	5	0	0	1	1	3	35	0	1	3	12	19
11	Miami	43	11	0	1	1	4	5	32	1	1	6	8	16
12	Sarasota	20	5	0	0	1	2	2	15	0	0	2	7	6
13	Tampa	83	56	0	0	11	27	18	27	0	0	5	0	22
14	Panama City	9	4	0	0	2	2	0	5	0	0	0	1	4
15	West Palm Beach	105	34	1	4	5	12	12	71	0	2	16	29	24
16	Florida Keys	1	0	0	0	0	0	0	1	0	0	0	0	1
17	Ft. Lauderdale	55	22	0	0	4	5	13	33	0	5	5	9	14
18	Melbourne	12	3	0	0	2	1	0	9	0	2	1	1	5
19	Ft. Pierce	7	4	0	0	0	0	4	3	0	0	1	0	2
20	Naples	19	10	0	1	0	4	5	9	0	1	2	0	6
21	Ft. Myers	33	14	0	1	3	5	5	19	0	0	2	3	14
22	Port Charlotte	10	2	0	0	1	0	1	8	0	0	0	2	6
23	St. Augustine	4	3	0	0	1	0	2	1	0	0	0	0	1
24	Sanford	9	4	0	0	0	3	1	5	0	0	0	1	4
25	Kissimmee	18	6	0	0	0	4	2	12	0	0	0	3	9
Statewide Totals		**861**	**328**	**2**	**11**	**52**	**123**	**140**	**533**	**4**	**23**	**64**	**126**	**316**

Morphine Deaths by County
2022



Occurrences
Per 100,000 Population

- 0
- 0.01 - 4.99
- 5.00 - 9.99
- 10.00 - 14.99
- 15.00 - 19.99
- 20.00 - 24.99
- > 25.00

Fentanyl Deaths

January – December 2022

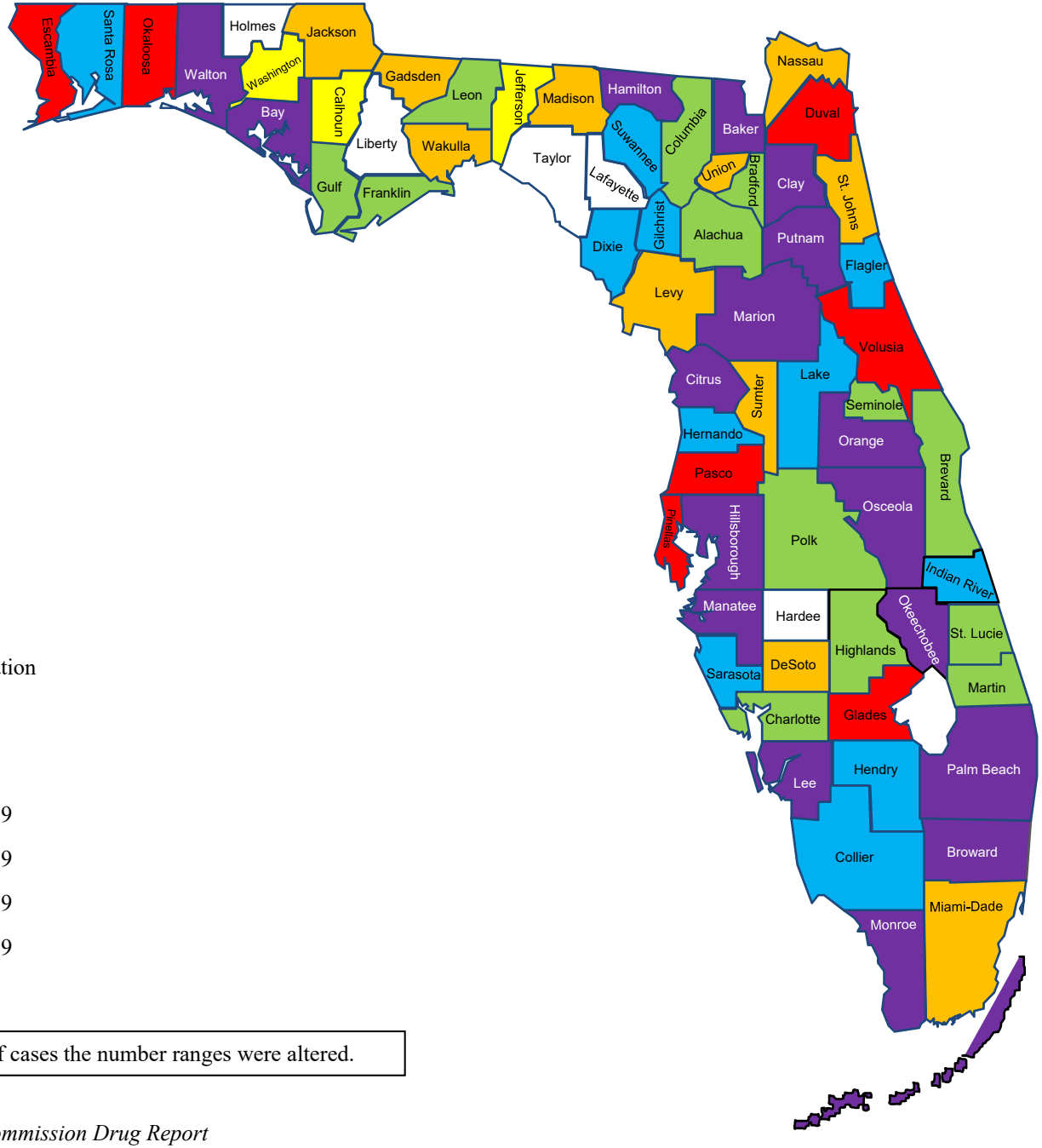
Medical Examiner District and Area of Florida		Total Deaths with Fentanyl			Deaths with Fentanyl Only			Deaths with Fentanyl in Combination with Other Drugs		
District	Area of Florida	Total	Cause	Present	Total	Cause	Present	Total	Cause	Present
1	Pensacola	372	335	37	37	25	12	335	310	25
2	Tallahassee	59	40	19	5	2	3	54	38	16
3	Live Oak	30	25	5	3	3	0	27	22	5
4	Jacksonville	581	504	77	47	34	13	534	470	64
5	Leesburg	332	304	28	30	29	1	302	275	27
6	St. Petersburg	718	680	38	54	51	3	664	629	35
7	Daytona Beach	295	276	19	22	18	4	273	258	15
8	Gainesville	77	73	4	16	15	1	61	58	3
9	Orlando	449	341	108	61	37	24	388	304	84
10	Lakeland	143	135	8	5	5	0	138	130	8
11	Miami	296	267	29	6	3	3	290	264	26
12	Sarasota	233	217	16	14	12	2	219	205	14
13	Tampa	510	480	30	87	83	4	423	397	26
14	Panama City	74	64	10	11	8	3	63	56	7
15	West Palm Beach	468	405	63	25	10	15	443	395	48
16	Florida Keys	24	24	0	1	1	0	23	23	0
17	Ft. Lauderdale	555	526	29	46	41	5	509	485	24
18	Melbourne	120	112	8	10	9	1	110	103	7
19	Ft. Pierce	146	139	7	16	15	1	130	124	6
20	Naples	97	92	5	3	2	1	94	90	4
21	Ft. Myers	304	278	26	30	25	5	274	253	21
22	Port Charlotte	37	33	4	1	1	0	36	32	4
23	St. Augustine	93	84	9	10	7	3	83	77	6
24	Sanford	84	77	7	18	14	4	66	63	3
25	Kissimmee	133	111	22	18	14	4	115	97	18
Statewide Totals		**6,230**	**5,622**	**608**	**576**	**464**	**112**	**5,654**	**5,158**	**496**

Fentanyl Deaths by Age

January – December 2022

Medical Examiner District and Area of Florida			Fentanyl Caused Death						Fentanyl Present at Death					
			Age of Decedent						*Age of Decedent*					
District	Area of Florida	Total	Total	<18	18-25	26-34	35-50	>50	Total	<18	18-25	26-34	35-50	>50
1	Pensacola	372	335	2	17	80	134	102	37	4	2	5	6	20
2	Tallahassee	59	40	0	3	7	19	11	19	1	5	4	4	5
3	Live Oak	30	25	0	2	5	12	6	5	0	0	1	1	3
4	Jacksonville	581	504	2	35	103	226	138	77	2	3	15	33	24
5	Leesburg	332	304	0	16	60	137	91	28	0	2	2	14	10
6	St. Petersburg	718	680	3	22	141	307	207	38	1	0	12	15	10
7	Daytona Beach	295	276	0	16	58	127	75	19	1	1	5	9	3
8	Gainesville	77	73	0	7	10	33	23	4	0	0	1	2	1
9	Orlando	449	341	3	32	64	162	80	108	2	7	13	28	58
10	Lakeland	143	135	0	15	35	55	30	8	0	0	3	4	1
11	Miami	296	267	1	18	58	103	87	29	1	2	6	11	9
12	Sarasota	233	217	0	6	47	105	59	16	0	0	3	9	4
13	Tampa	510	480	0	20	112	225	123	30	1	1	7	12	9
14	Panama City	74	64	2	2	15	31	14	10	0	1	1	2	6
15	West Palm Beach	468	405	2	27	98	179	99	63	3	9	6	24	21
16	Florida Keys	24	24	0	1	6	13	4	0	0	0	0	0	0
17	Ft. Lauderdale	555	526	4	32	139	184	167	29	1	0	8	10	10
18	Melbourne	120	112	1	9	32	35	35	8	0	1	4	1	2
19	Ft. Pierce	146	139	0	7	34	57	41	7	1	1	0	4	1
20	Naples	97	92	0	11	17	49	15	5	0	0	2	1	2
21	Ft. Myers	304	278	2	20	66	123	67	26	2	1	3	9	11
22	Port Charlotte	37	33	0	1	7	15	10	4	0	0	0	1	3
23	St. Augustine	93	84	0	3	21	37	23	9	0	0	3	2	4
24	Sanford	84	77	0	6	24	29	18	7	0	0	1	4	2
25	Kissimmee	133	111	0	8	22	53	28	22	0	0	3	12	7
Statewide Totals		**6,230**	**5,622**	**22**	**336**	**1,261**	**2,450**	**1,553**	**608**	**20**	**36**	**108**	**218**	**226**

Fentanyl Deaths by County
2022



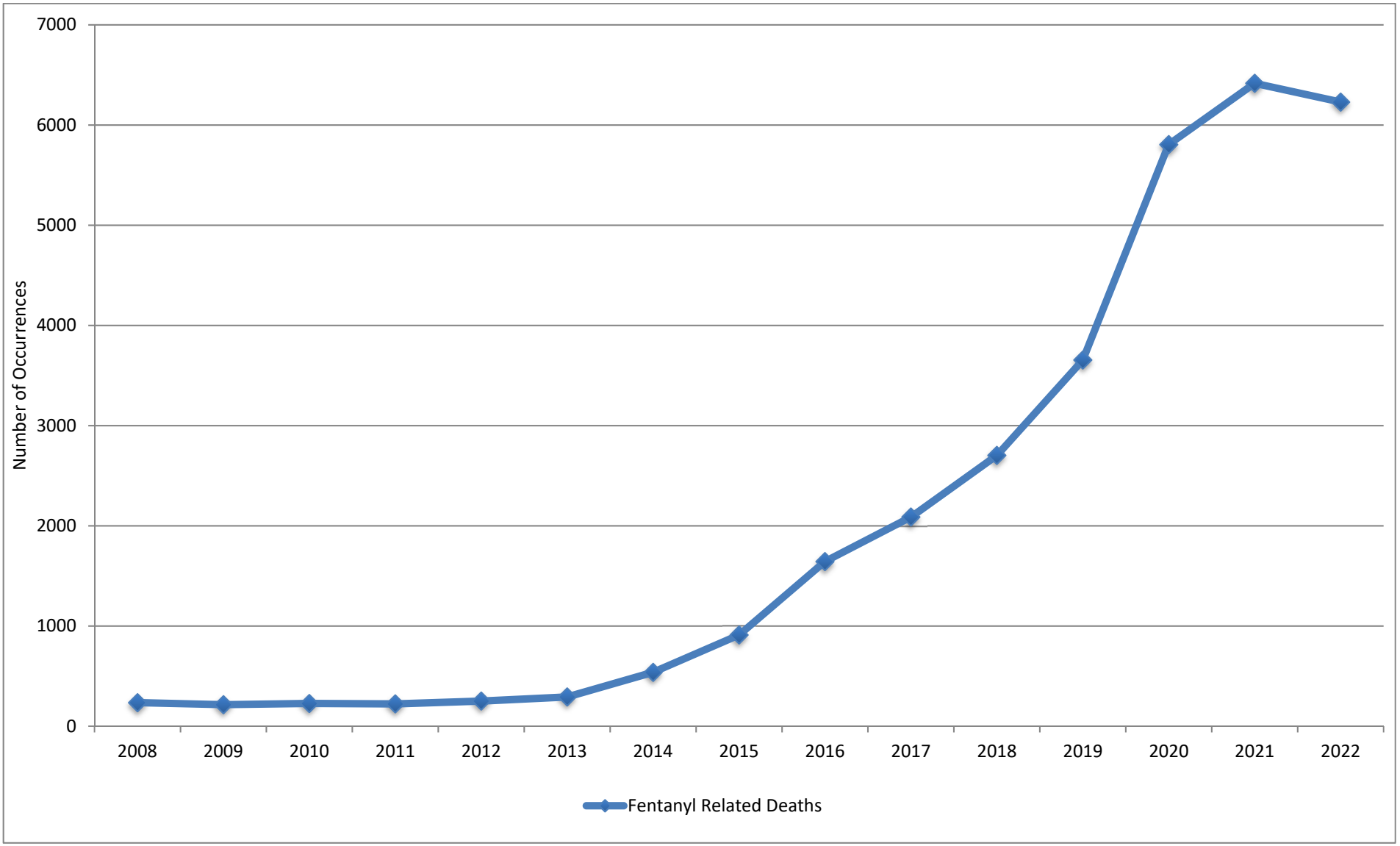
Occurrences
Per 100,000 Population

- 0 - 4.99
- 5.00 - 9.99
- 10.00 - 14.99
- 15.00 - 19.99
- 20.00 - 24.99
- 25.00 - 39.99
- > 40.00

Due to the amount of cases the number ranges were altered.

Historical Overview of Fentanyl Occurrences[1]

(Present and Cause)
2008 to 2022



[1]*Prior to 2016, the number of fentanyl occurrences indicated includes occurrences of fentanyl analogs. Starting in 2016, fentanyl analogs were tracked separately.*

Prescription Drugs in Medical Examiner Deaths

2021 versus 2022

Medical Examiner District and Area of Florida		Total Prescription Drug Deaths in ME Deaths (Present and Cause)			Accidental Deaths with Prescription Drugs (Present and Cause)			Accidental Deaths Caused by Prescription Drugs		
District	Area of Florida	2021	2022	Percent Change	2021	2022	Percent Change	2021	2022	Percent Change
1	Pensacola	487	535	9.9%	375	414	10.4%	322	368	14.3%
2	Tallahassee	97	108	11.3%	62	75	21.0%	41	51	24.4%
3	Live Oak	69	61	-11.6%	33	38	15.2%	23	27	17.4%
4	Jacksonville	778	777	-0.1%	630	621	-1.4%	535	532	-0.6%
5	Leesburg	439	474	8.0%	355	383	7.9%	317	327	3.2%
6	St. Petersburg	954	1,027	7.7%	786	838	6.6%	704	746	6.0%
7	Daytona Beach	406	372	-8.4%	345	320	-7.2%	309	286	-7.4%
8	Gainesville	116	125	7.8%	79	99	25.3%	58	79	36.2%
9	Orlando	790	712	-9.9%	614	557	-9.3%	452	355	-21.5%
10	Lakeland	287	270	-5.9%	209	193	-7.7%	152	143	-5.9%
11	Miami	641	555	-13.4%	432	373	-13.7%	311	278	-10.6%
12	Sarasota	386	328	-15.0%	314	259	-17.5%	279	234	-16.1%
13	Tampa	642	720	12.1%	505	562	11.3%	444	514	15.8%
14	Panama City	168	124	-26.2%	124	94	-24.2%	82	69	-15.9%
15	West Palm Beach	774	718	-7.2%	604	539	-10.8%	514	429	-16.5%
16	Florida Keys	40	39	-2.5%	33	33	0%	28	29	3.6%
17	Ft. Lauderdale	818	730	-10.8%	683	618	-9.5%	622	565	-9.2%
18	Melbourne	385	187	-51.4%	291	130	-55.3%	236	112	-52.5%
19	Ft. Pierce	287	283	-1.4%	188	181	-3.7%	138	150	8.7%
20	Naples	160	155	-3.1%	120	114	-5.0%	104	99	-4.8%
21	Ft. Myers	403	421	4.5%	339	331	-2.4%	302	292	-3.3%
22	Port Charlotte	89	74	-16.9%	59	48	-18.6%	39	40	2.6%
23	St. Augustine	128	135	5.5%	97	104	7.2%	72	83	15.3%
24	Sanford	111	107	-3.6%	87	90	3.4%	77	83	7.8%
25	Kissimmee	223	193	-13.5%	167	149	-10.8%	120	116	-3.3%
Statewide Totals		**9,678**	**9,230**	**-4.6%**	**7,531**	**7,163**	**-4.9%**	**6,281**	**6,007**	**-4.4%**

These tables are based on prescription drugs tracked by the Medical Examiners Commission and reported by Florida Medical Examiners. Do not add across columns.

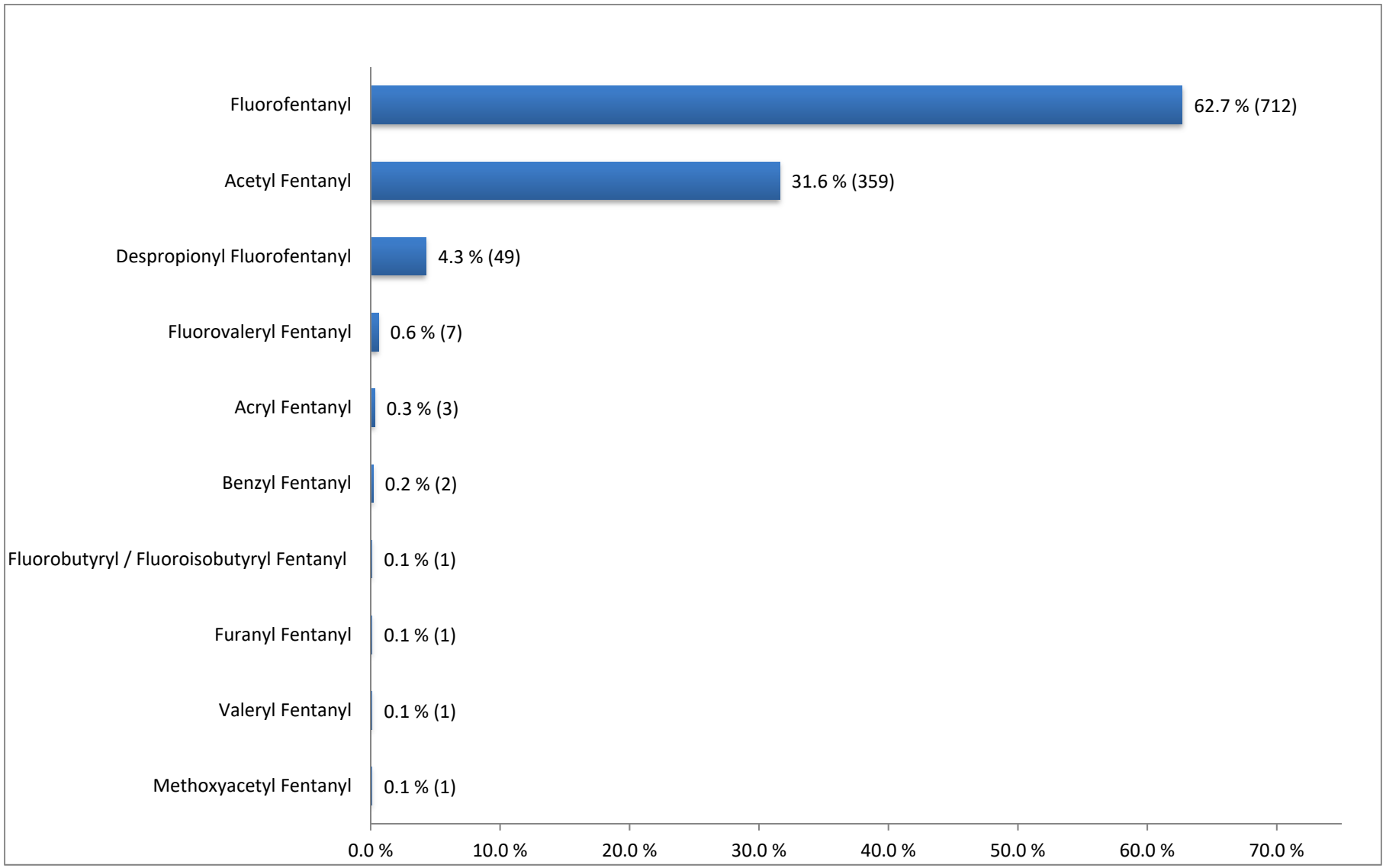
These individuals died with one or more prescription drugs in their system. The drugs were identified as either the cause of death or merely present in the decedent and also may have been mixed with illicit drugs and/or alcohol.

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.

The manner of death for these decedents was reported as accidental. 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.

Frequency of Occurrence of Fentanyl Analogs

January – December 2022



Note: Fluorobutyryl / Fluoroisobutyryl fentanyl includes the analytes para-fluoroisobutyryl fentanyl, para-fluorobutyryl fentanyl, fluoroisobutyryl fentanyl, and fluorobutyryl fentanyl. Fluorofentanyl includes the analytes fluorofentanyl, ortho-fluorofentanyl, and para-fluorofentanyl. Despropionyl fluorofentanyl includes the analytes despropionyl fluorofentanyl, despropionyl ortho-fluorofentanyl, and despropionyl para-fluorofentanyl. Percentages may not sum to 100 percent because of rounding.

Fentanyl Analog Deaths

January – December 2022

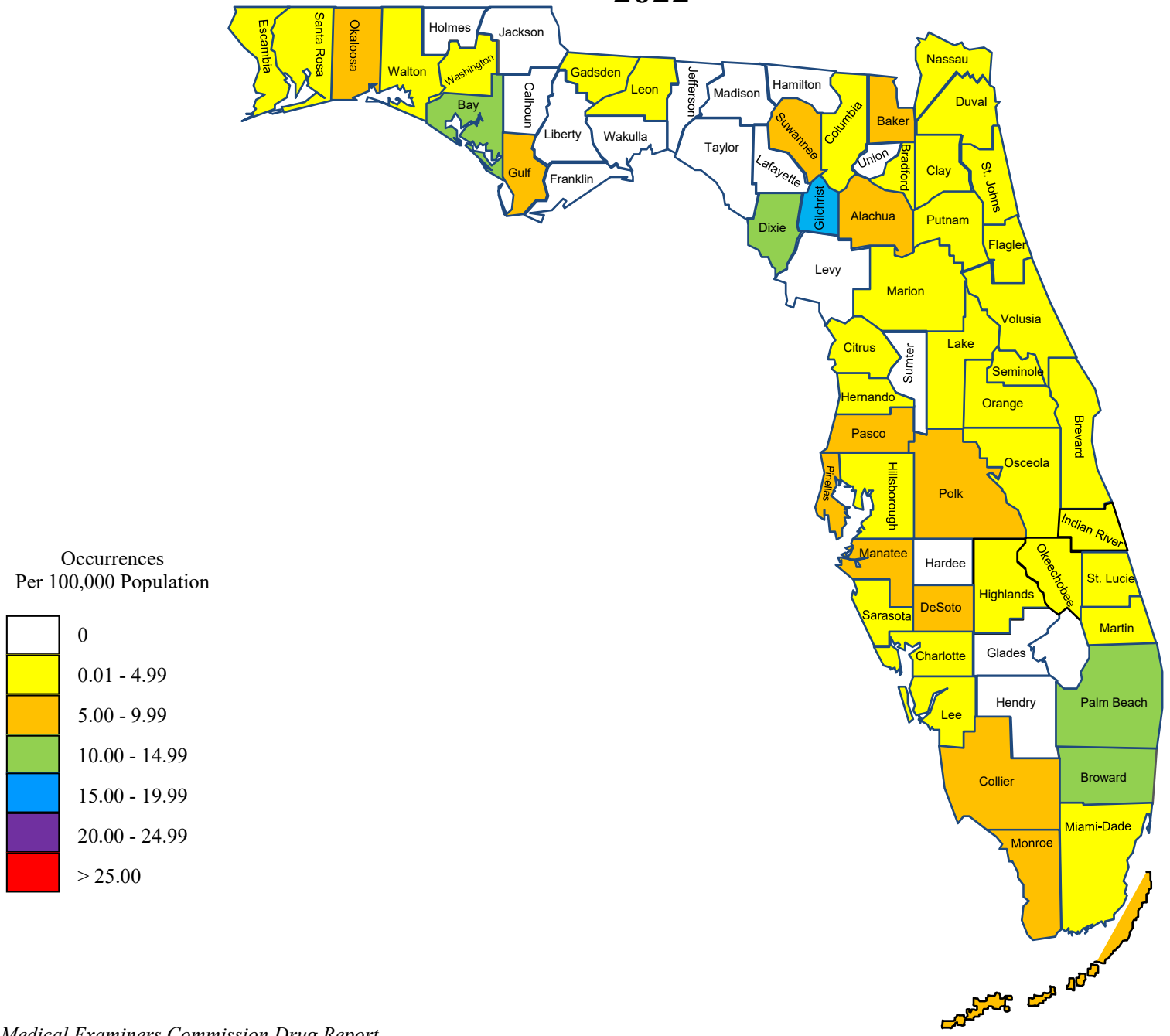
Medical Examiner District and Area of Florida		Total Deaths with Fentanyl Analogs			Deaths with Fentanyl Analogs Only			Deaths with Fentanyl Analogs in Combination with Other Drugs		
District	Area of Florida	Total	Cause	Present	Total	Cause	Present	Total	Cause	Present
1	Pensacola	26	22	4	0	0	0	26	22	4
2	Tallahassee	3	2	1	0	0	0	3	2	1
3	Live Oak	6	6	0	0	0	0	6	6	0
4	Jacksonville	44	41	3	1	1	0	43	40	3
5	Leesburg	14	12	2	0	0	0	14	12	2
6	St. Petersburg	125	96	29	0	0	0	125	96	29
7	Daytona Beach	23	18	5	0	0	0	23	18	5
8	Gainesville	24	16	8	0	0	0	24	16	8
9	Orlando	13	13	0	1	1	0	12	12	0
10	Lakeland	51	27	24	0	0	0	51	27	24
11	Miami	97	77	20	0	0	0	97	77	20
12	Sarasota	53	17	36	0	0	0	53	17	36
13	Tampa	4	4	0	0	0	0	4	4	0
14	Panama City	24	24	0	0	0	0	24	24	0
15	West Palm Beach	169	164	5	0	0	0	169	164	5
16	Florida Keys	7	3	4	0	0	0	7	3	4
17	Ft. Lauderdale	238	228	10	0	0	0	238	228	10
18	Melbourne	5	2	3	0	0	0	5	2	3
19	Ft. Pierce	5	4	1	0	0	0	5	4	1
20	Naples	34	32	2	0	0	0	34	32	2
21	Ft. Myers	25	24	1	0	0	0	25	24	1
22	Port Charlotte	1	1	0	0	0	0	1	1	0
23	St. Augustine	9	7	2	0	0	0	9	7	2
24	Sanford	4	3	1	0	0	0	4	3	1
25	Kissimmee	1	1	0	0	0	0	1	1	0
Statewide Totals		**1,005**	**844**	**161**	**2**	**2**	**0**	**1,003**	**842**	**161**

Fentanyl Analog Deaths by Age

January – December 2022

Medical Examiner District and Area of Florida			Fentanyl Analogs Caused Death						Fentanyl Analogs Present at Death					
			Age of Decedent						*Age of Decedent*					
District	Area of Florida	Total	Total	<18	18-25	26-34	35-50	>50	Total	<18	18-25	26-34	35-50	>50
1	Pensacola	26	22	0	0	6	11	5	4	0	0	2	1	1
2	Tallahassee	3	2	0	0	1	1	0	1	0	0	0	1	0
3	Live Oak	6	6	0	1	0	3	2	0	0	0	0	0	0
4	Jacksonville	44	41	0	3	7	18	13	3	0	0	3	0	0
5	Leesburg	14	12	0	0	0	10	2	2	0	0	1	1	0
6	St. Petersburg	125	96	0	5	28	33	30	29	0	0	8	13	8
7	Daytona Beach	23	18	0	1	2	10	5	5	0	0	2	2	1
8	Gainesville	24	16	0	2	2	7	5	8	0	0	3	3	2
9	Orlando	13	13	0	1	0	10	2	0	0	0	0	0	0
10	Lakeland	51	27	0	2	6	14	5	24	0	3	6	10	5
11	Miami	97	77	0	8	16	27	26	20	0	0	10	6	4
12	Sarasota	53	17	0	0	4	6	7	36	0	1	14	14	7
13	Tampa	4	4	0	0	0	4	0	0	0	0	0	0	0
14	Panama City	24	24	1	0	5	13	5	0	0	0	0	0	0
15	West Palm Beach	169	164	2	11	37	78	36	5	0	0	1	4	0
16	Florida Keys	7	3	0	0	1	0	2	4	0	0	1	3	0
17	Ft. Lauderdale	238	228	1	19	50	80	78	10	0	0	0	7	3
18	Melbourne	5	2	0	0	0	1	1	3	0	0	0	0	3
19	Ft. Pierce	5	4	0	0	2	0	2	1	0	0	1	0	0
20	Naples	34	32	0	1	8	16	7	2	0	1	0	1	0
21	Ft. Myers	25	24	0	0	7	7	10	1	0	0	1	0	0
22	Port Charlotte	1	1	0	0	0	0	1	0	0	0	0	0	0
23	St. Augustine	9	7	0	1	3	1	2	2	0	0	0	2	0
24	Sanford	4	3	0	1	0	2	0	1	0	0	0	1	0
25	Kissimmee	1	1	0	0	0	1	0	0	0	0	0	0	0
Statewide Totals		**1,005**	**844**	**4**	**56**	**185**	**353**	**246**	**161**	**0**	**5**	**53**	**69**	**34**

Fentanyl Analog Deaths by County
2022



Occurrences
Per 100,000 Population

- 0
- 0.01 - 4.99
- 5.00 - 9.99
- 10.00 - 14.99
- 15.00 - 19.99
- 20.00 - 24.99
- > 25.00

Cocaine Deaths

January – December 2022

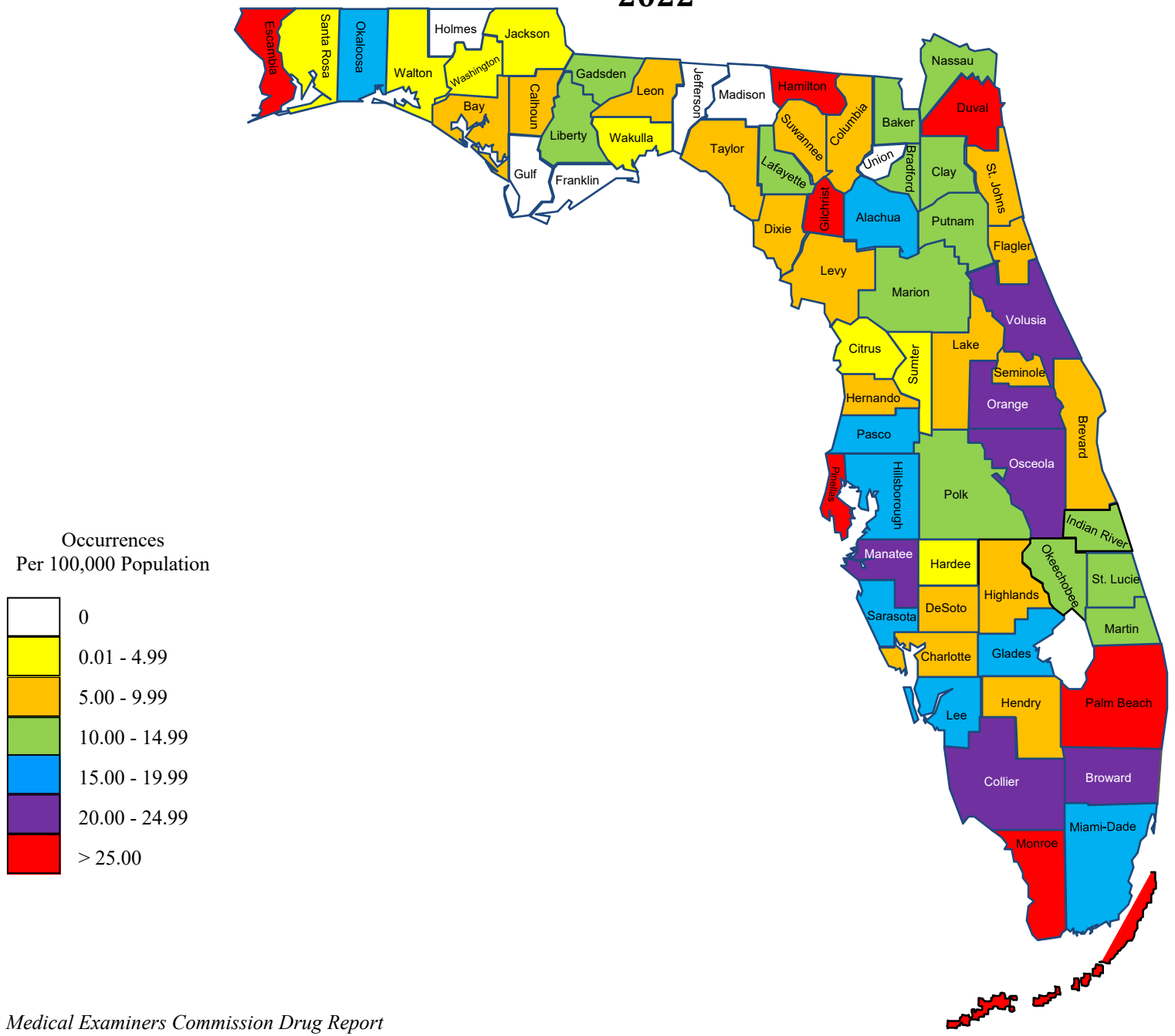
Medical Examiner District and Area of Florida		Total Deaths with Cocaine			Deaths with Cocaine Only			Deaths with Cocaine in Combination with Other Drugs		
District	Area of Florida	Total	Cause	Present	Total	Cause	Present	Total	Cause	Present
1	Pensacola	165	133	32	19	14	5	146	119	27
2	Tallahassee	32	25	7	10	10	0	22	15	7
3	Live Oak	15	6	9	5	2	3	10	4	6
4	Jacksonville	357	273	84	31	16	15	326	257	69
5	Leesburg	110	94	16	11	9	2	99	85	14
6	St. Petersburg	354	247	107	30	19	11	324	228	96
7	Daytona Beach	117	87	30	14	8	6	103	79	24
8	Gainesville	60	34	26	11	4	7	49	30	19
9	Orlando	326	238	88	44	31	13	282	207	75
10	Lakeland	95	65	30	12	9	3	83	56	27
11	Miami	425	268	157	62	30	32	363	238	125
12	Sarasota	174	103	71	9	3	6	165	100	65
13	Tampa	241	168	73	46	17	29	195	151	44
14	Panama City	20	13	7	2	1	1	18	12	6
15	West Palm Beach	429	172	257	27	11	16	402	161	241
16	Florida Keys	29	22	7	1	1	0	28	21	7
17	Ft. Lauderdale	423	304	119	48	28	20	375	276	99
18	Melbourne	58	39	19	6	4	2	52	35	17
19	Ft. Pierce	93	46	47	10	5	5	83	41	42
20	Naples	80	56	24	8	6	2	72	50	22
21	Ft. Myers	134	76	58	13	5	8	121	71	50
22	Port Charlotte	15	8	7	1	0	1	14	8	6
23	St. Augustine	35	8	27	2	1	1	33	7	26
24	Sanford	48	41	7	6	4	2	42	37	5
25	Kissimmee	95	72	23	8	4	4	87	68	19
Statewide Totals		**3,930**	**2,598**	**1,332**	**436**	**242**	**194**	**3,494**	**2,356**	**1,138**

Cocaine Deaths by Age

January – December 2022

Medical Examiner District and Area of Florida			Cocaine Caused Death						Cocaine Present at Death					
			Age of Decedent						*Age of Decedent*					
District	Area of Florida	Total	Total	<18	18-25	26-34	35-50	>50	Total	<18	18-25	26-34	35-50	>50
1	Pensacola	165	133	0	6	23	46	58	32	0	1	5	7	19
2	Tallahassee	32	25	1	0	1	2	21	7	0	0	0	4	3
3	Live Oak	15	6	0	0	0	2	4	9	0	1	2	1	5
4	Jacksonville	357	273	0	7	43	122	101	84	1	2	11	37	33
5	Leesburg	110	94	0	2	11	42	39	16	1	2	3	8	2
6	St. Petersburg	354	247	0	4	46	94	103	107	0	5	22	40	40
7	Daytona Beach	117	87	0	5	20	33	29	30	0	0	6	10	14
8	Gainesville	60	34	0	1	4	13	16	26	0	1	2	10	13
9	Orlando	326	238	1	11	38	115	73	88	1	7	18	36	26
10	Lakeland	95	65	0	4	13	21	27	30	0	2	7	10	11
11	Miami	425	268	1	13	45	92	117	157	1	17	31	55	53
12	Sarasota	174	103	0	4	22	47	30	71	0	4	18	25	24
13	Tampa	241	168	0	6	28	64	70	73	0	5	16	24	28
14	Panama City	20	13	0	0	3	5	5	7	0	0	3	2	2
15	West Palm Beach	429	172	0	8	35	72	57	257	2	20	59	111	65
16	Florida Keys	29	22	0	1	3	13	5	7	0	0	2	3	2
17	Ft. Lauderdale	423	304	1	11	61	111	120	119	0	6	17	52	44
18	Melbourne	58	39	0	2	2	16	19	19	0	1	5	7	6
19	Ft. Pierce	93	46	0	1	9	12	24	47	0	0	9	23	15
20	Naples	80	56	0	2	13	27	14	24	0	4	5	10	5
21	Ft. Myers	134	76	0	6	12	33	25	58	0	3	13	30	12
22	Port Charlotte	15	8	0	0	2	2	4	7	0	0	1	3	3
23	St. Augustine	35	8	0	0	1	4	3	27	0	0	3	15	9
24	Sanford	48	41	0	3	7	15	16	7	0	0	0	5	2
25	Kissimmee	95	72	0	3	10	36	23	23	0	1	6	7	9
Statewide Totals		**3,930**	**2,598**	**4**	**100**	**452**	**1,039**	**1,003**	**1,332**	**6**	**82**	**264**	**535**	**445**

Cocaine Deaths by County
2022



Cocaine Related Deaths by Medical Examiner District

(Present and Cause)

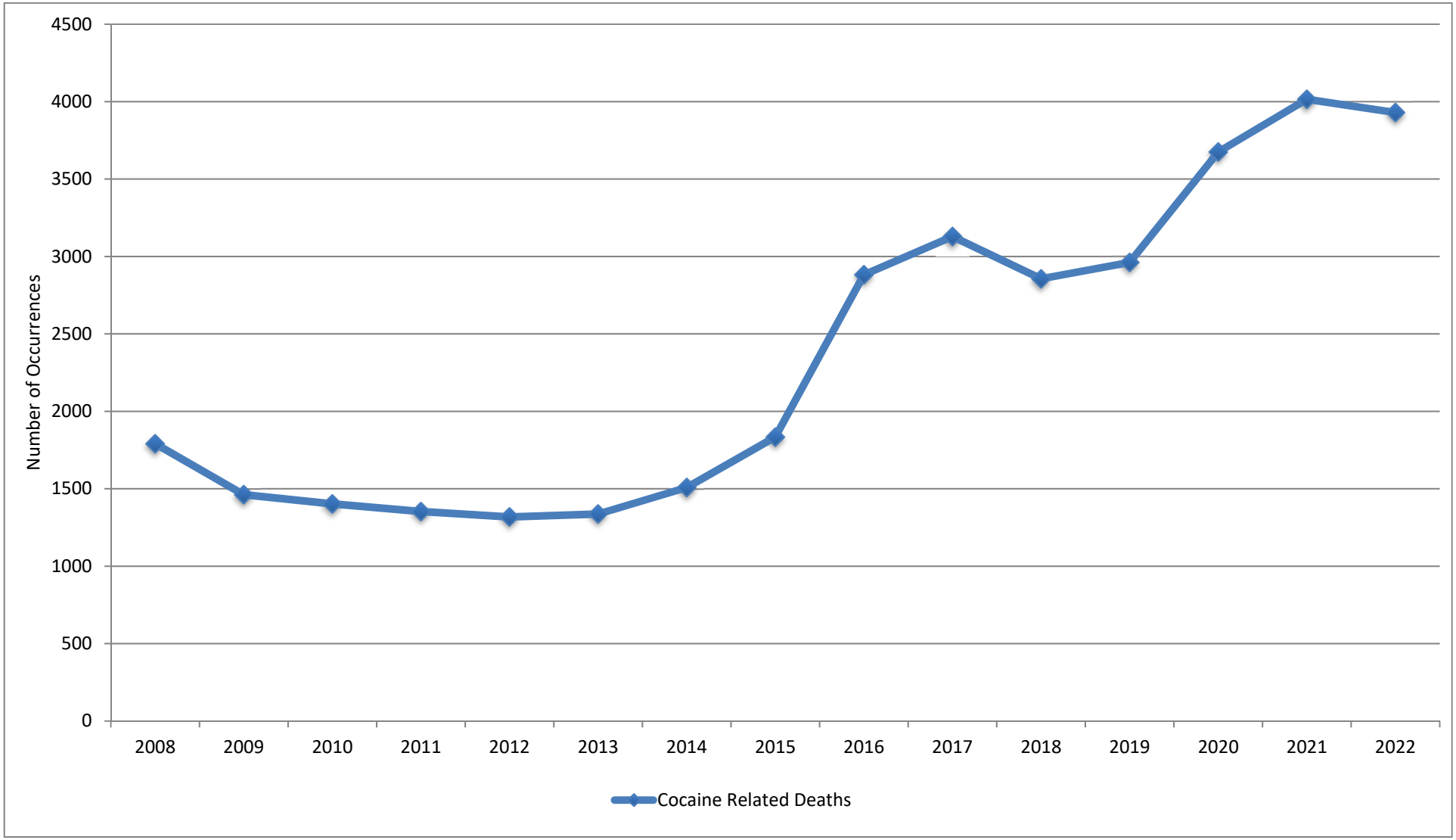
2008 to 2022

District	Area of Florida	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
1	Pensacola	56	33	36	34	34	31	56	80	57	58	71	73	93	120	165
2	Tallahassee	27	30	25	36	25	23	20	18	32	15	11	20	27	26	32
3	Live Oak	13	16	9	8	13	10	6	5	10	4	12	7	6	12	15
4	Jacksonville	165	125	115	113	119	119	107	146	266	359	251	279	335	341	357
5	Leesburg	67	56	52	48	46	57	62	54	128	109	84	77	87	98	110
6	St. Petersburg	154	139	134	112	125	100	98	101	157	187	225	250	284	334	354
7	Daytona Beach	51	58	44	43	36	37	34	37	51	88	102	76	127	130	117
8	Gainesville	32	39	39	34	30	29	30	31	41	43	35	46	48	55	60
9	Orlando	179	145	128	124	120	137	181	203	230	234	266	265	290	364	326
10	Lakeland	40	35	42	29	27	37	33	33	53	70	67	50	77	93	95
11	Miami	201	155	198	184	198	226	234	289	439	401	363	418	449	471	425
12	Sarasota	75	59	57	54	60	60	84	134	147	132	96	117	157	158	174
13	Tampa	146	54	83	96	59	74	65	84	108	109	140	140	216	255	241
14	Panama City	17	20	9	9	10	11	13	15	5	15	20	30	26	22	20
15	West Palm Beach	143	126	106	91	87	105	143	173	405	417	338	343	407	434	429
16	Florida Keys	15	14	11	7	13	4	6	13	20	20	11	15	12	15	29
17	Ft. Lauderdale	146	135	127	115	129	102	99	152	328	321	236	277	427	449	423
18	Melbourne	68	59	49	38	52	53	60	86	103	128	114	130	158	132	58
19	Ft. Pierce	47	35	20	40	24	34	50	49	71	88	69	66	89	102	93
20	Naples	15	21	13	23	16	10	29	23	40	32	45	61	58	78	80
21	Ft. Myers	67	48	53	73	56	51	63	71	99	152	146	98	128	135	134
22	Port Charlotte	14	9	5	7	9	2	10	12	9	13	10	12	17	20	15
23	St. Augustine	27	19	23	15	11	11	1	9	23	39	33	24	53	39	35
24	Sanford	26	32	24	20	19	14	24	16	37	41	50	44	33	40	48
25	Kissimmee									23	54	61	44	71	92	95
Statewide Total		**1,791**	**1,462**	**1,402**	**1,353**	**1,318**	**1,337**	**1,508**	**1,834**	**2,882**	**3,129**	**2,856**	**2,962**	**3,675**	**4,015**	**3,930**

Prior to 2016, District 9 included Orange and Osceola counties. Both counties enacted Home Rule authority in 2016 and District 9 was split into two districts, with Orange County staying District 9 and Osceola County becoming District 25

Historical Overview of Cocaine Occurrences

(Present and Cause)
2008 to 2022



Heroin Deaths

January – December 2022

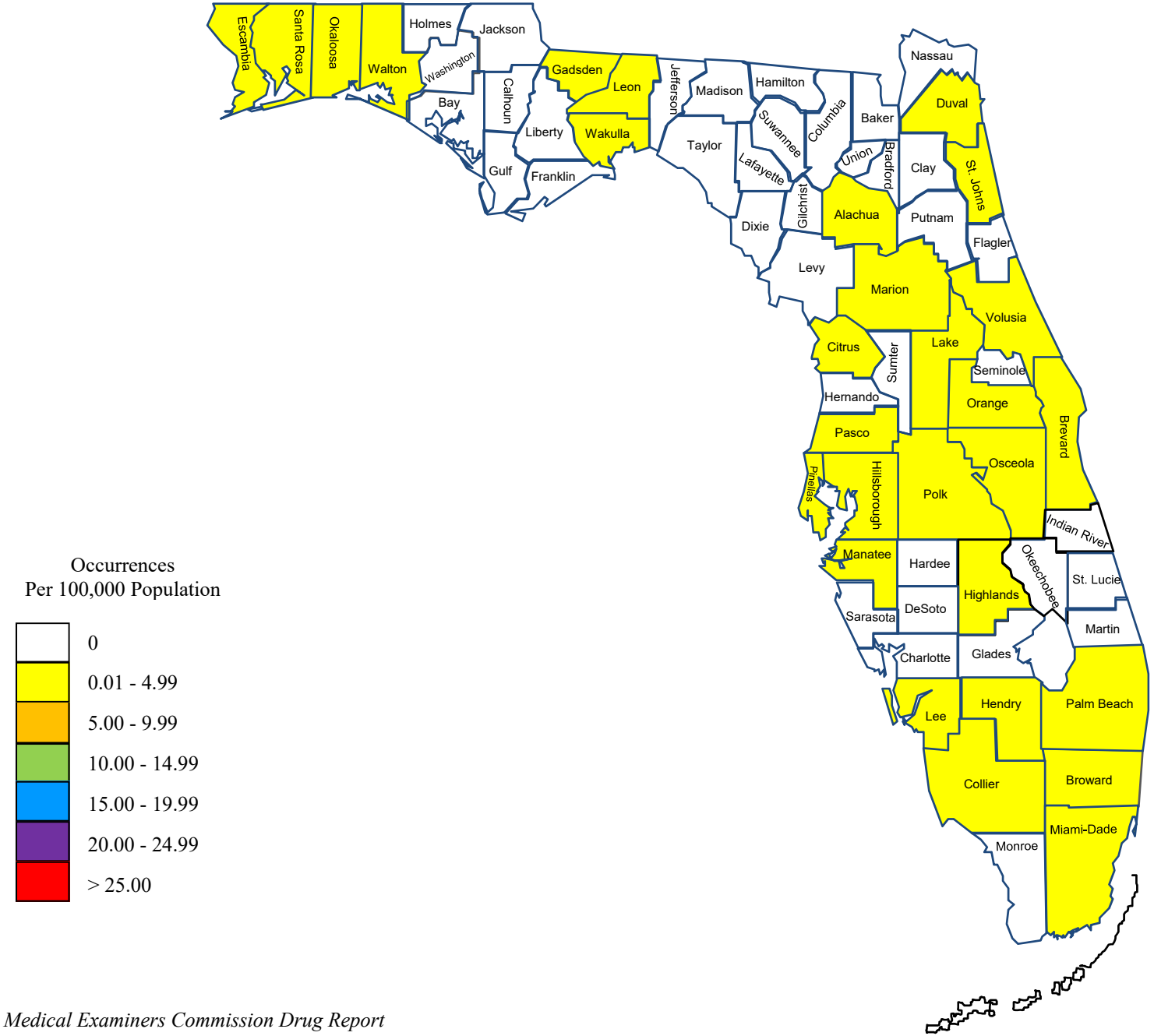
Medical Examiner District and Area of Florida		Total Deaths with Heroin			Deaths with Heroin Only			Deaths with Heroin in Combination with Other Drugs		
District	Area of Florida	Total	Cause	Present	Total	Cause	Present	Total	Cause	Present
1	Pensacola	22	22	0	0	0	0	22	22	0
2	Tallahassee	3	1	2	0	0	0	3	1	2
3	Live Oak	0	0	0	0	0	0	0	0	0
4	Jacksonville	7	7	0	0	0	0	7	7	0
5	Leesburg	12	12	0	0	0	0	12	12	0
6	St. Petersburg	12	9	3	0	0	0	12	9	3
7	Daytona Beach	11	11	0	0	0	0	11	11	0
8	Gainesville	2	2	0	1	1	0	1	1	0
9	Orlando	6	6	0	0	0	0	6	6	0
10	Lakeland	6	5	1	0	0	0	6	5	1
11	Miami	8	8	0	0	0	0	8	8	0
12	Sarasota	1	0	1	0	0	0	1	0	1
13	Tampa	32	32	0	1	1	0	31	31	0
14	Panama City	0	0	0	0	0	0	0	0	0
15	West Palm Beach	59	21	38	0	0	0	59	21	38
16	Florida Keys	0	0	0	0	0	0	0	0	0
17	Ft. Lauderdale	32	15	17	0	0	0	32	15	17
18	Melbourne	1	1	0	0	0	0	1	1	0
19	Ft. Pierce	0	0	0	0	0	0	0	0	0
20	Naples	4	4	0	0	0	0	4	4	0
21	Ft. Myers	3	3	0	0	0	0	3	3	0
22	Port Charlotte	0	0	0	0	0	0	0	0	0
23	St. Augustine	1	1	0	0	0	0	1	1	0
24	Sanford	0	0	0	0	0	0	0	0	0
25	Kissimmee	5	5	0	0	0	0	5	5	0
Statewide Totals		**227**	**165**	**62**	**2**	**2**	**0**	**225**	**163**	**62**

Heroin Deaths by Age

January – December 2022

Medical Examiner District and Area of Florida			Heroin Caused Death						Heroin Present at Death					
			Age of Decedent						*Age of Decedent*					
District	Area of Florida	Total	Total	<18	18-25	26-34	35-50	>50	Total	<18	18-25	26-34	35-50	>50
1	Pensacola	22	22	0	1	0	11	10	0	0	0	0	0	0
2	Tallahassee	3	1	0	0	0	1	0	2	0	0	0	0	2
3	Live Oak	0	0	0	0	0	0	0	0	0	0	0	0	0
4	Jacksonville	7	7	0	1	1	1	4	0	0	0	0	0	0
5	Leesburg	12	12	0	0	1	6	5	0	0	0	0	0	0
6	St. Petersburg	12	9	0	0	1	4	4	3	0	0	1	0	2
7	Daytona Beach	11	11	0	2	3	5	1	0	0	0	0	0	0
8	Gainesville	2	2	0	1	0	1	0	0	0	0	0	0	0
9	Orlando	6	6	0	1	0	4	1	0	0	0	0	0	0
10	Lakeland	6	5	0	0	2	1	2	1	0	0	1	0	0
11	Miami	8	8	0	0	0	2	6	0	0	0	0	0	0
12	Sarasota	1	0	0	0	0	0	0	1	0	0	1	0	0
13	Tampa	32	32	0	0	7	18	7	0	0	0	0	0	0
14	Panama City	0	0	0	0	0	0	0	0	0	0	0	0	0
15	West Palm Beach	59	21	1	4	5	8	3	38	0	1	14	16	7
16	Florida Keys	0	0	0	0	0	0	0	0	0	0	0	0	0
17	Ft. Lauderdale	32	15	0	1	4	4	6	17	0	2	5	5	5
18	Melbourne	1	1	0	0	1	0	0	0	0	0	0	0	0
19	Ft. Pierce	0	0	0	0	0	0	0	0	0	0	0	0	0
20	Naples	4	4	0	0	0	2	2	0	0	0	0	0	0
21	Ft. Myers	3	3	0	1	0	0	2	0	0	0	0	0	0
22	Port Charlotte	0	0	0	0	0	0	0	0	0	0	0	0	0
23	St. Augustine	1	1	0	0	0	0	1	0	0	0	0	0	0
24	Sanford	0	0	0	0	0	0	0	0	0	0	0	0	0
25	Kissimmee	5	5	0	0	0	4	1	0	0	0	0	0	0
Statewide Totals		**227**	**165**	**1**	**12**	**25**	**72**	**55**	**62**	**0**	**3**	**22**	**21**	**16**

Heroin Deaths by County
2022



Heroin Related Deaths by Medical Examiner District

(Present and Cause)

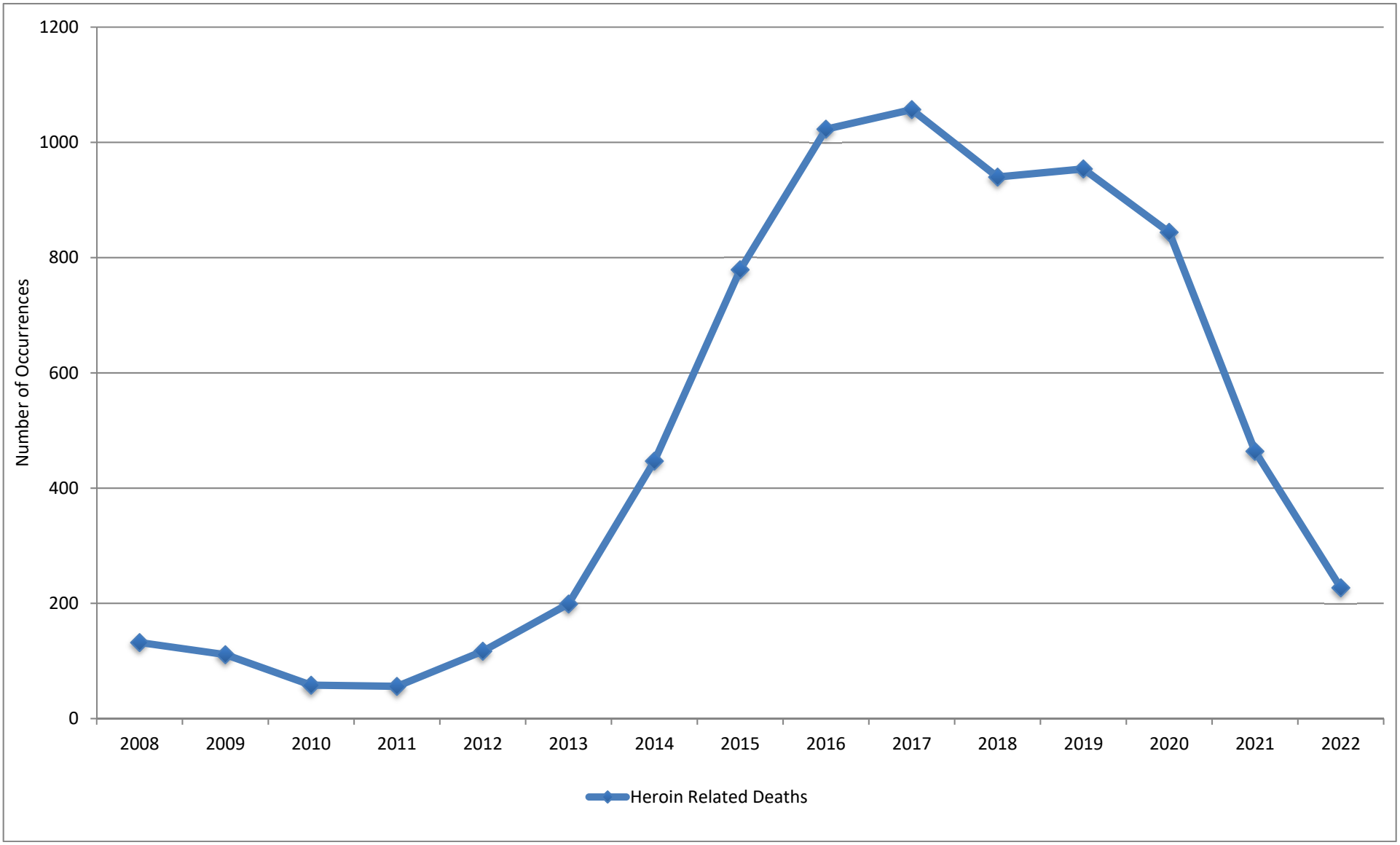
2008 to 2022

District	Area of Florida	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
1	Pensacola	1	2	0	0	1	3	12	28	34	30	35	35	63	46	22
2	Tallahassee	0	0	0	1	0	1	2	0	1	2	1	4	5	4	3
3	Live Oak	0	0	0	0	0	1	0	1	0	2	0	0	5	0	0
4	Jacksonville	3	4	1	3	14	15	16	45	81	98	60	50	35	6	7
5	Leesburg	5	1	0	1	3	2	16	8	40	34	44	56	46	30	12
6	St. Petersburg	5	9	3	1	1	4	7	14	18	22	56	73	55	20	12
7	Daytona Beach	0	3	1	0	1	3	4	20	21	37	75	34	44	21	11
8	Gainesville	0	0	0	0	2	1	2	3	2	4	2	5	4	6	2
9	Orlando	16	24	10	18	26	41	83	108	68	59	54	58	37	17	6
10	Lakeland	0	2	1	0	1	4	7	10	11	10	5	11	19	4	6
11	Miami	38	30	26	15	33	40	60	92	139	97	59	68	43	21	8
12	Sarasota	19	4	2	2	8	19	55	68	32	22	17	20	15	6	1
13	Tampa	5	2	1	2	2	3	22	35	52	75	114	77	119	49	32
14	Panama City	0	0	1	0	0	2	2	4	8	4	7	18	12	8	0
15	West Palm Beach	7	7	4	6	6	20	51	165	205	215	174	205	138	98	59
16	Florida Keys	1	1	0	0	1	1	0	1	7	4	0	1	2	1	0
17	Ft. Lauderdale	17	8	5	3	9	11	28	80	180	186	110	133	118	73	32
18	Melbourne	1	2	0	0	0	2	7	12	21	25	18	8	2	4	1
19	Ft. Pierce	3	1	1	1	2	3	7	8	7	13	4	3	3	1	0
20	Naples	1	0	0	0	0	2	14	11	15	15	14	17	24	18	4
21	Ft. Myers	7	9	0	1	4	12	30	43	30	34	35	22	22	10	3
22	Port Charlotte	0	1	0	0	1	1	3	2	3	1	3	4	3	4	0
23	St. Augustine	0	0	1	0	1	1	1	2	6	14	5	11	9	3	1
24	Sanford	3	1	1	2	1	7	18	19	27	33	31	23	7	5	0
25	Kissimmee									15	21	17	18	14	9	5
Statewide Totals		**132**	**111**	**58**	**56**	**117**	**199**	**447**	**779**	**1,023**	**1,057**	**940**	**954**	**844**	**464**	**227**

Prior to 2016, District 9 included Orange and Osceola counties. Both counties enacted Home Rule authority in 2016 and District 9 was split into two districts, with Orange County staying District 9 and Osceola County becoming District 25.

Historical Overview of Heroin Occurrences

(Present and Cause)
2008 to 2022



Methamphetamine Deaths

January – December 2022

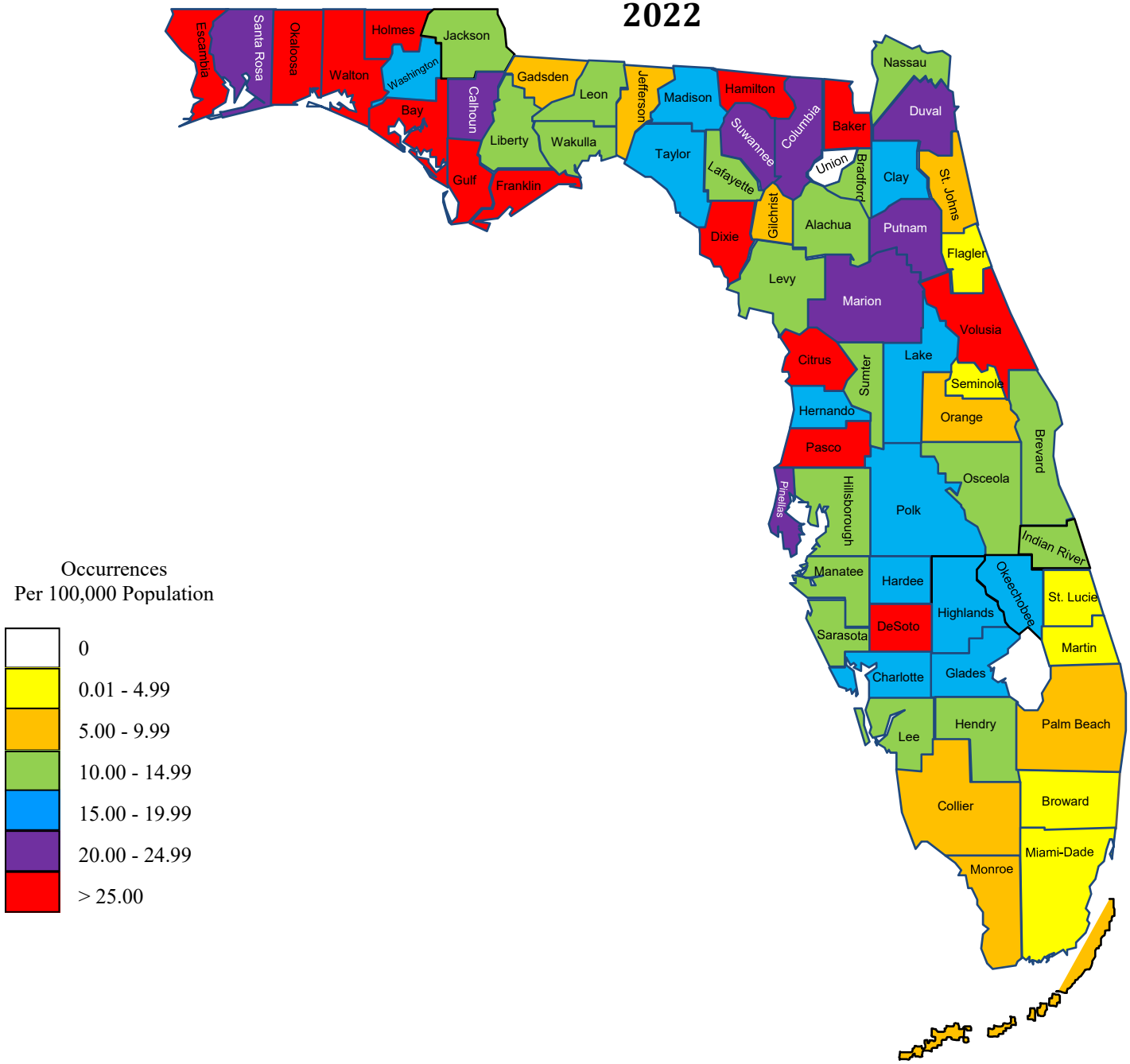
Medical Examiner District and Area of Florida		Total Deaths with Methamphetamine			Deaths with Methamphetamine Only			Deaths with Methamphetamine in Combination with Other Drugs		
District	Area of Florida	Total	Cause	Present	Total	Cause	Present	Total	Cause	Present
1	Pensacola	313	256	57	3	1	2	310	255	55
2	Tallahassee	52	34	18	1	1	0	51	33	18
3	Live Oak	44	25	19	0	0	0	44	25	19
4	Jacksonville	286	202	84	2	0	2	284	202	82
5	Leesburg	253	207	46	4	3	1	249	204	45
6	St. Petersburg	413	359	54	6	4	2	407	355	52
7	Daytona Beach	165	139	26	2	1	1	163	138	25
8	Gainesville	53	31	22	1	0	1	52	31	21
9	Orlando	131	94	37	8	4	4	123	90	33
10	Lakeland	158	128	30	4	3	1	154	125	29
11	Miami	84	54	30	1	1	0	83	53	30
12	Sarasota	112	82	30	5	2	3	107	80	27
13	Tampa	220	168	52	19	12	7	201	156	45
14	Panama City	80	51	29	3	2	1	77	49	28
15	West Palm Beach	79	26	53	2	2	0	77	24	53
16	Florida Keys	5	4	1	0	0	0	5	4	1
17	Ft. Lauderdale	63	41	22	1	1	0	62	40	22
18	Melbourne	63	44	19	1	1	0	62	43	19
19	Ft. Pierce	43	33	10	5	3	2	38	30	8
20	Naples	34	26	8	1	1	0	33	25	8
21	Ft. Myers	124	97	27	1	0	1	123	97	26
22	Port Charlotte	33	25	8	0	0	0	33	25	8
23	St. Augustine	45	22	23	0	0	0	45	22	23
24	Sanford	18	16	2	1	0	1	17	16	1
25	Kissimmee	47	29	18	2	0	2	45	29	16
Statewide Totals		**2,918**	**2,193**	**725**	**73**	**42**	**31**	**2,845**	**2,151**	**694**

Methamphetamine Deaths by Age

January – December 2022

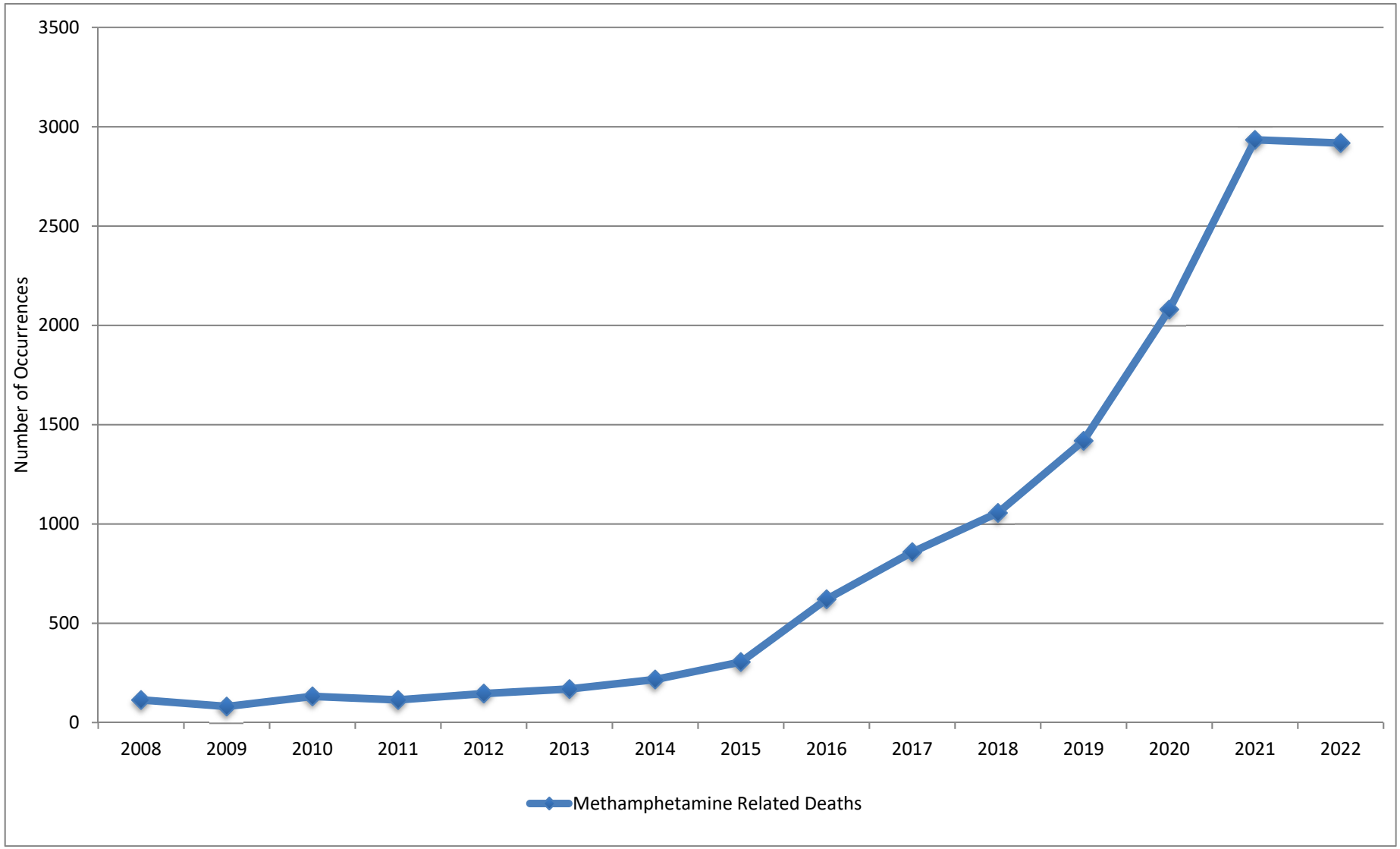
Medical Examiner District and Area of Florida			Methamphetamine Caused Death						Methamphetamine Present at Death					
			Age of Decedent						*Age of Decedent*					
District	Area of Florida	Total	Total	<18	18-25	26-34	35-50	>50	Total	<18	18-25	26-34	35-50	>50
1	Pensacola	313	256	0	12	50	109	85	57	0	3	12	26	16
2	Tallahassee	52	34	0	0	7	16	11	18	0	2	6	5	5
3	Live Oak	44	25	0	0	4	11	10	19	0	0	4	8	7
4	Jacksonville	286	202	1	11	42	100	48	84	0	6	21	44	13
5	Leesburg	253	207	0	4	39	99	65	46	0	1	16	24	5
6	St. Petersburg	413	359	3	15	75	159	107	54	1	2	8	37	6
7	Daytona Beach	165	139	1	4	22	71	41	26	0	0	6	12	8
8	Gainesville	53	31	0	4	2	16	9	22	0	3	5	10	4
9	Orlando	131	94	0	7	14	49	24	37	0	2	8	20	7
10	Lakeland	158	128	2	7	22	44	53	30	0	3	11	10	6
11	Miami	84	54	1	2	15	22	14	30	0	3	7	14	6
12	Sarasota	112	82	0	5	16	33	28	30	0	0	10	10	10
13	Tampa	220	168	0	4	28	94	42	52	0	4	13	26	9
14	Panama City	80	51	0	2	7	27	15	29	1	1	8	11	8
15	West Palm Beach	79	26	0	0	4	15	7	53	0	4	17	25	7
16	Florida Keys	5	4	0	0	3	0	1	1	0	0	1	0	0
17	Ft. Lauderdale	63	41	0	1	10	16	14	22	0	1	5	13	3
18	Melbourne	63	44	2	3	13	15	11	19	0	2	4	7	6
19	Ft. Pierce	43	33	1	3	5	15	9	10	0	1	4	3	2
20	Naples	34	26	0	2	3	12	9	8	0	2	4	1	1
21	Ft. Myers	124	97	0	7	26	48	16	27	0	0	6	17	4
22	Port Charlotte	33	25	0	1	4	12	8	8	0	0	1	5	2
23	St. Augustine	45	22	0	1	6	9	6	23	0	1	8	11	3
24	Sanford	18	16	0	1	4	7	4	2	0	0	1	0	1
25	Kissimmee	47	29	0	0	5	17	7	18	0	0	5	8	5
Statewide Totals		**2,918**	**2,193**	**11**	**96**	**426**	**1,016**	**644**	**725**	**2**	**41**	**191**	**347**	**144**

Methamphetamine Deaths by County
2022



Historical Overview of Methamphetamine Occurrences

(Present and Cause)
2008 to 2022



Xylazine Deaths

January – December 2022

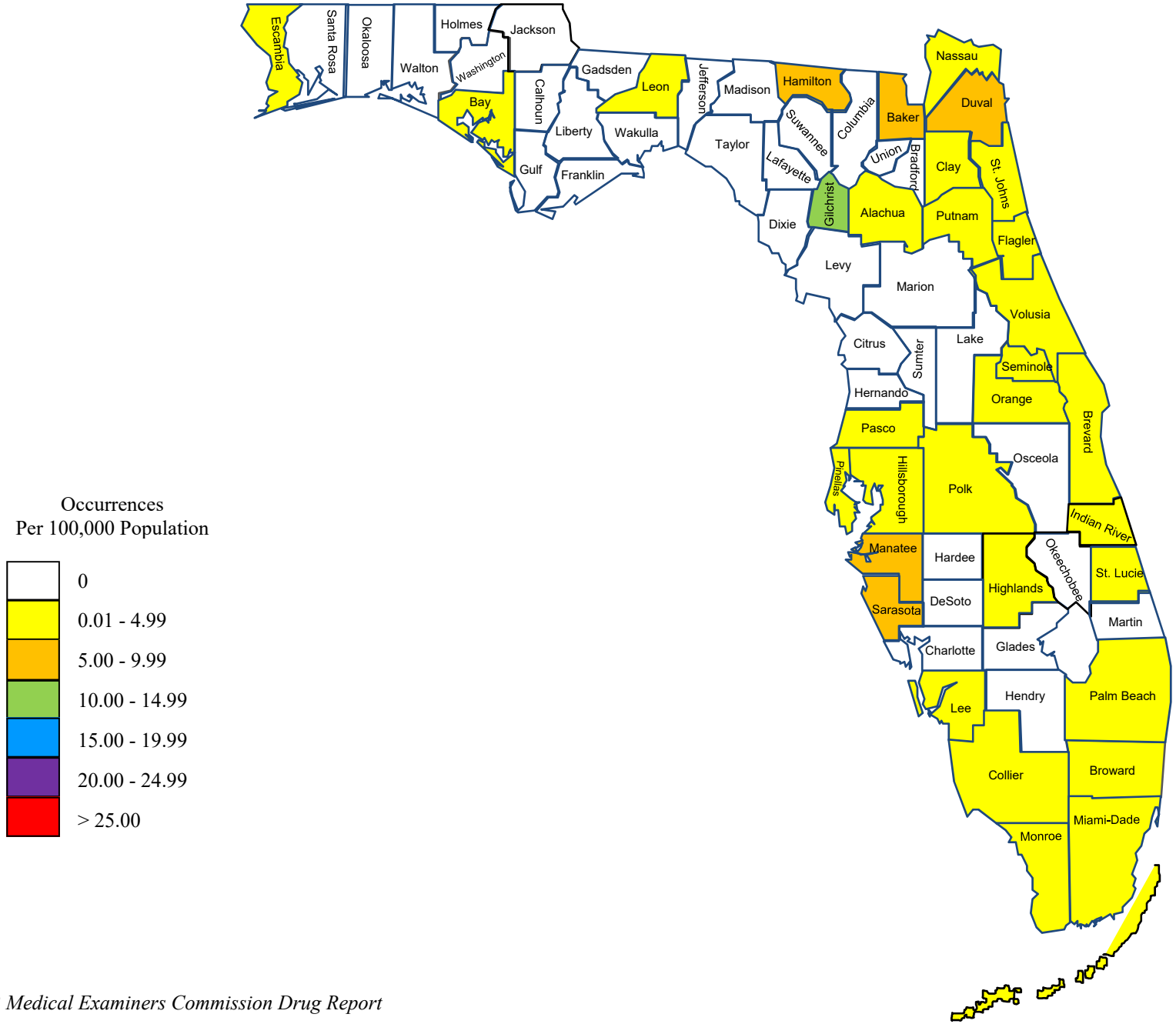
Medical Examiner District and Area of Florida		Total Deaths with Xylazine			Deaths with Xylazine Only			Deaths with Xylazine in Combination with Other Drugs		
District	Area of Florida	Total	Cause	Present	Total	Cause	Present	Total	Cause	Present
1	Pensacola	1	1	0	0	0	0	1	1	0
2	Tallahassee	1	1	0	0	0	0	1	1	0
3	Live Oak	1	0	1	0	0	0	1	0	1
4	Jacksonville	95	52	43	0	0	0	95	52	43
5	Leesburg	0	0	0	0	0	0	0	0	0
6	St. Petersburg	53	18	35	0	0	0	53	18	35
7	Daytona Beach	23	23	0	0	0	0	23	23	0
8	Gainesville	6	1	5	0	0	0	6	1	5
9	Orlando	5	5	0	0	0	0	5	5	0
10	Lakeland	32	16	16	0	0	0	32	16	16
11	Miami	43	32	11	2	0	2	41	32	9
12	Sarasota	76	18	58	0	0	0	76	18	58
13	Tampa	3	2	1	0	0	0	3	2	1
14	Panama City	1	1	0	0	0	0	1	1	0
15	West Palm Beach	44	40	4	0	0	0	44	40	4
16	Florida Keys	1	0	1	0	0	0	1	0	1
17	Ft. Lauderdale	27	21	6	0	0	0	27	21	6
18	Melbourne	1	0	1	0	0	0	1	0	1
19	Ft. Pierce	2	1	1	0	0	0	2	1	1
20	Naples	16	4	12	0	0	0	16	4	12
21	Ft. Myers	25	25	0	0	0	0	25	25	0
22	Port Charlotte	0	0	0	0	0	0	0	0	0
23	St. Augustine	14	6	8	0	0	0	14	6	8
24	Sanford	1	1	0	0	0	0	1	1	0
25	Kissimmee	0	0	0	0	0	0	0	0	0
Statewide Totals		**471**	**268**	**203**	**2**	**0**	**2**	**469**	**268**	**201**

Xylazine Deaths by Age

January – December 2022

Medical Examiner District and Area of Florida			Xylazine Caused Death						Xylazine Present at Death					
			Age of Decedent						*Age of Decedent*					
District	Area of Florida	Total	Total	<18	18-25	26-34	35-50	>50	Total	<18	18-25	26-34	35-50	>50
1	Pensacola	1	1	0	1	0	0	0	0	0	0	0	0	0
2	Tallahassee	1	1	0	0	0	1	0	0	0	0	0	0	0
3	Live Oak	1	0	0	0	0	0	0	1	0	0	1	0	0
4	Jacksonville	95	52	0	4	5	23	20	43	0	1	10	22	10
5	Leesburg	0	0	0	0	0	0	0	0	0	0	0	0	0
6	St. Petersburg	53	18	0	0	7	6	5	35	0	1	8	17	9
7	Daytona Beach	23	23	0	0	3	14	6	0	0	0	0	0	0
8	Gainesville	6	1	0	0	0	0	1	5	0	1	2	2	0
9	Orlando	5	5	0	2	0	3	0	0	0	0	0	0	0
10	Lakeland	32	16	0	4	3	6	3	16	0	3	6	4	3
11	Miami	43	32	0	1	7	16	8	11	0	1	3	4	3
12	Sarasota	76	18	0	0	6	8	4	58	0	2	20	29	7
13	Tampa	3	2	0	0	1	1	0	1	0	0	0	0	1
14	Panama City	1	1	0	0	0	1	0	0	0	0	0	0	0
15	West Palm Beach	44	40	0	2	5	20	13	4	0	0	1	2	1
16	Florida Keys	1	0	0	0	0	0	0	1	0	0	1	0	0
17	Ft. Lauderdale	27	21	1	2	4	7	7	6	0	0	2	2	2
18	Melbourne	1	0	0	0	0	0	0	1	0	0	1	0	0
19	Ft. Pierce	2	1	0	0	0	1	0	1	0	1	0	0	0
20	Naples	16	4	0	0	1	3	0	12	0	1	2	7	2
21	Ft. Myers	25	25	0	0	4	17	4	0	0	0	0	0	0
22	Port Charlotte	0	0	0	0	0	0	0	0	0	0	0	0	0
23	St. Augustine	14	6	0	0	2	2	2	8	0	0	1	4	3
24	Sanford	1	1	0	0	0	1	0	0	0	0	0	0	0
25	Kissimmee	0	0	0	0	0	0	0	0	0	0	0	0	0
Statewide Totals		**471**	**268**	**1**	**16**	**48**	**130**	**73**	**203**	**0**	**11**	**58**	**93**	**41**

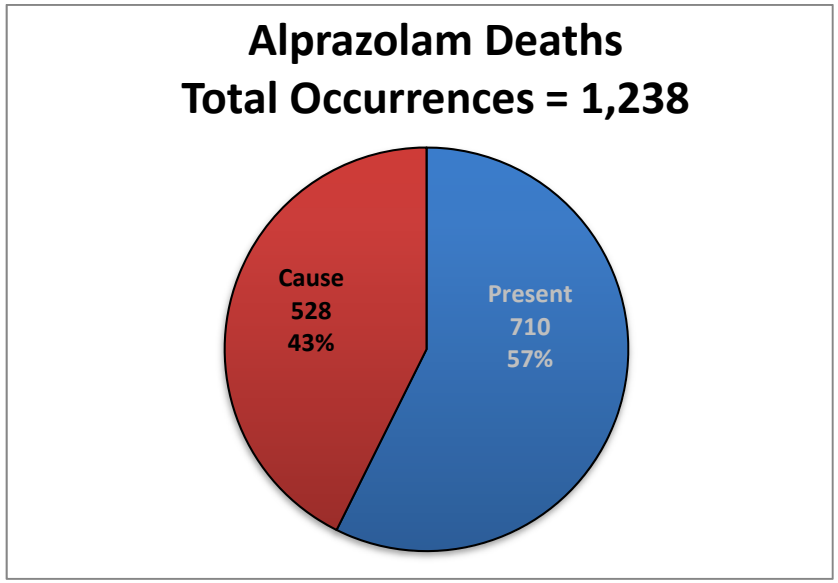
Xylazine Deaths by County
2022

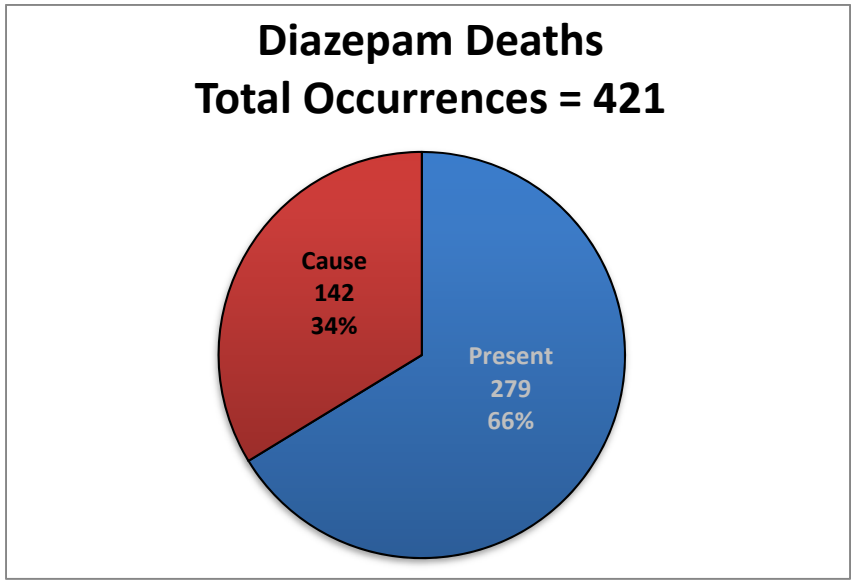


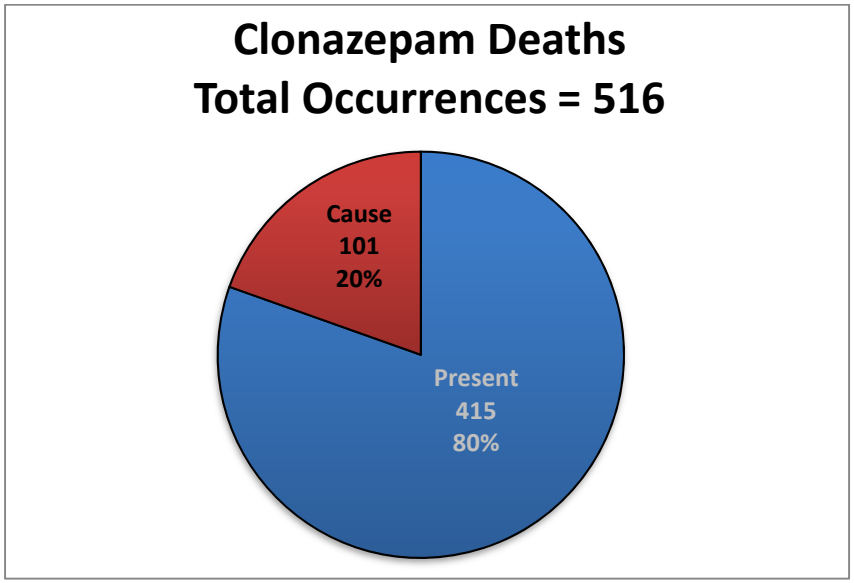
Occurrences
Per 100,000 Population

- 0
- 0.01 - 4.99
- 5.00 - 9.99
- 10.00 - 14.99
- 15.00 - 19.99
- 20.00 - 24.99
- > 25.00

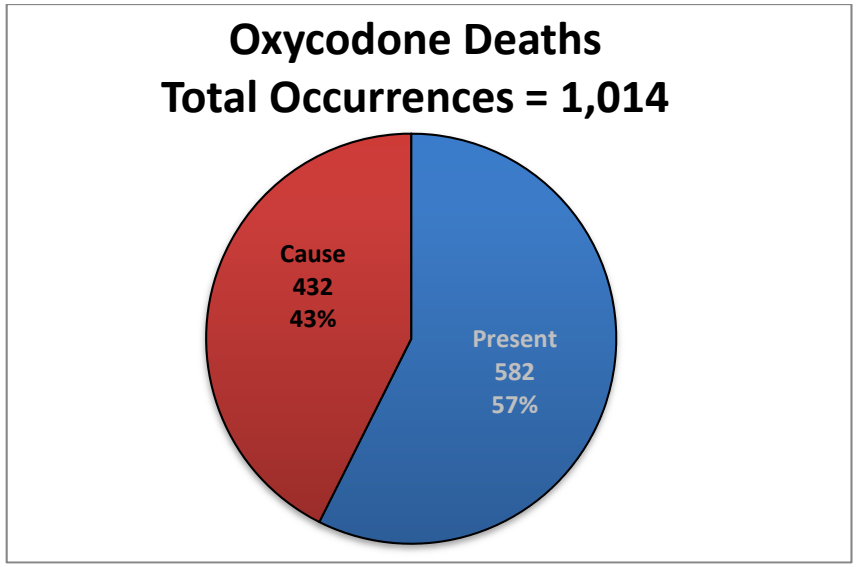
2022 Drug Detected at Death: Cause vs. Present

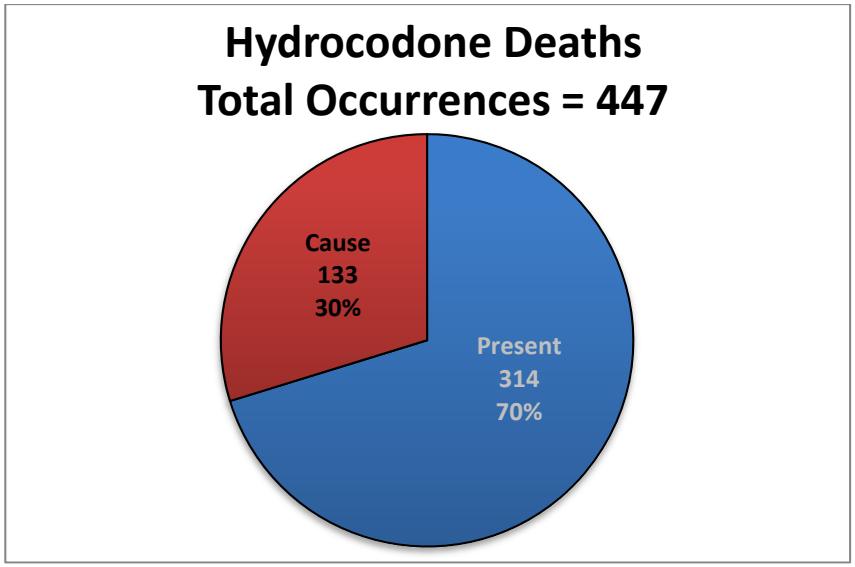


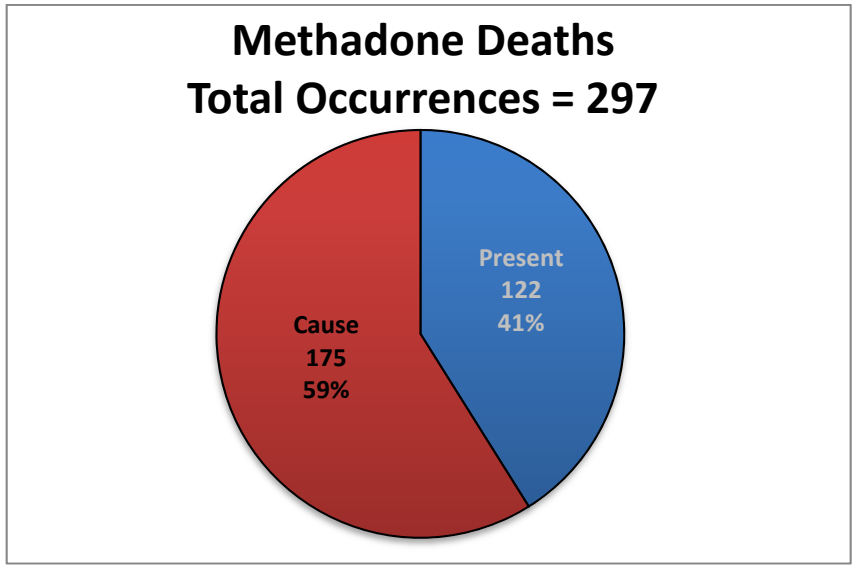


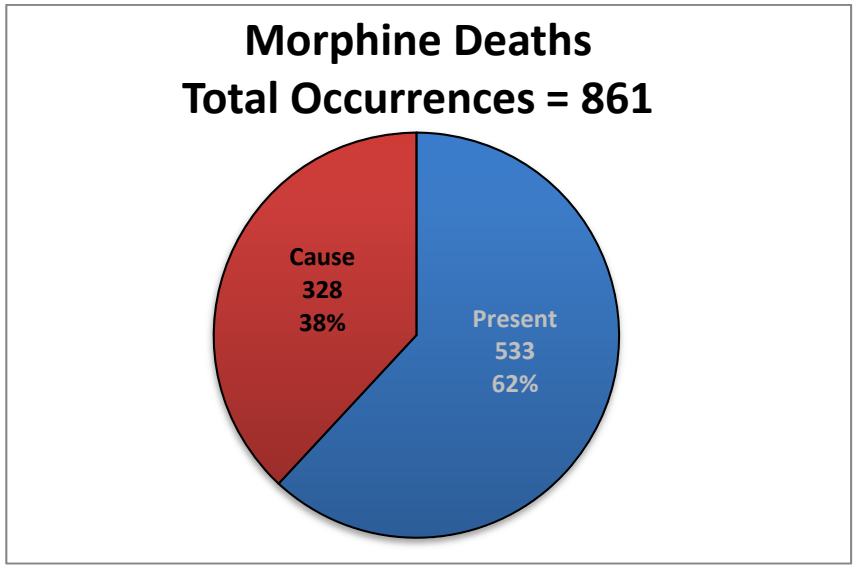


2022 Drug Detected at Death: Cause vs. Present

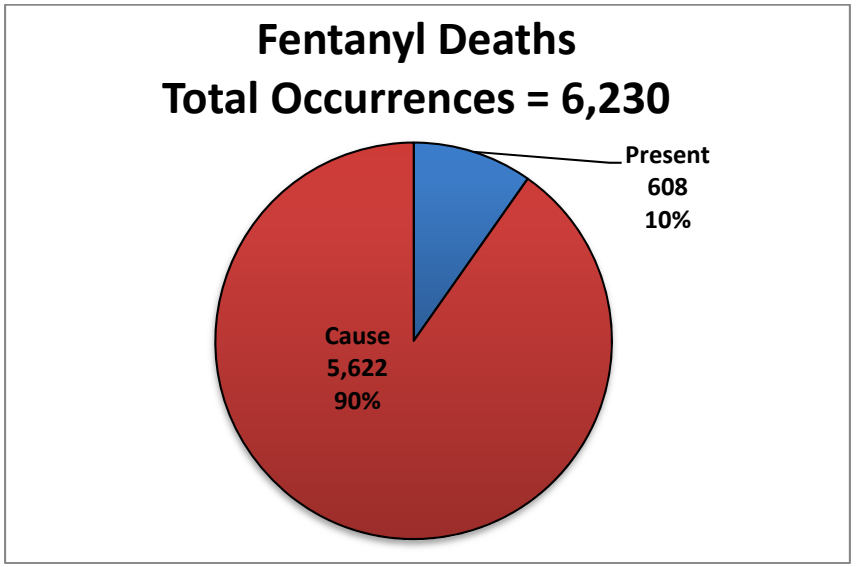


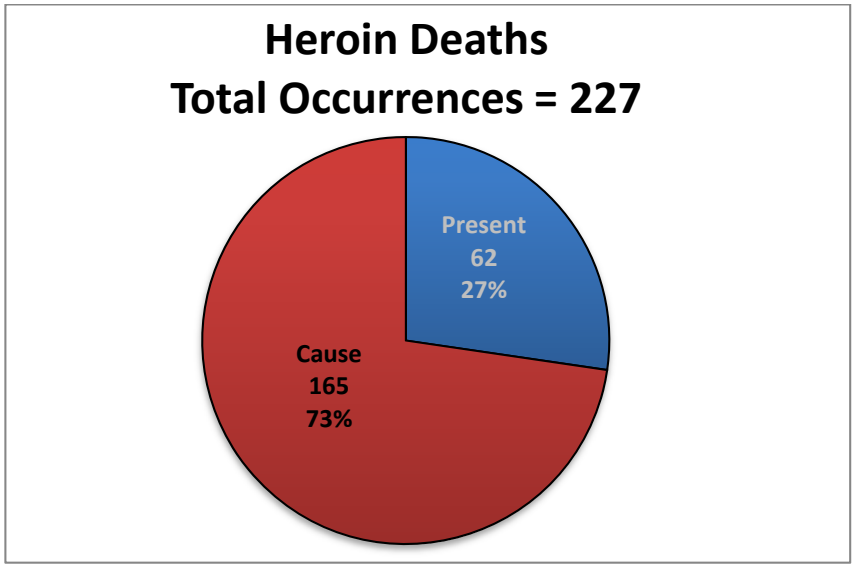


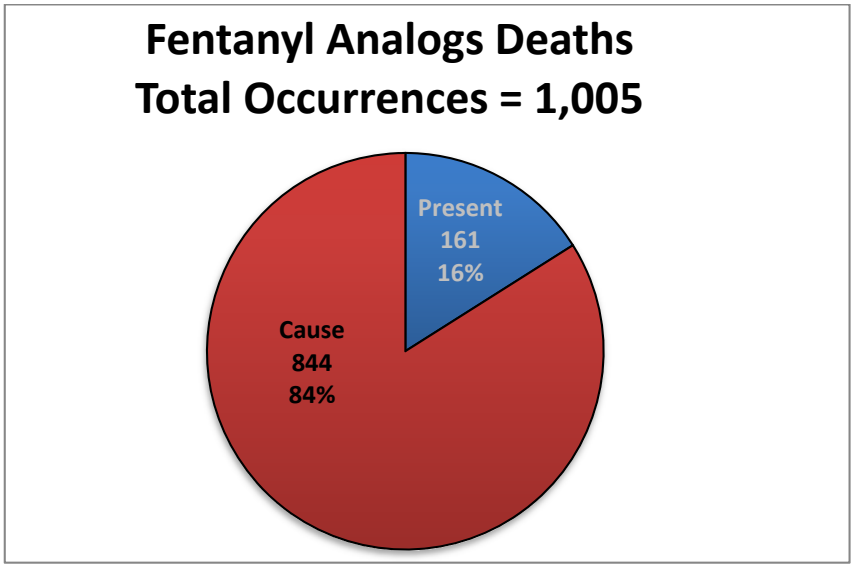




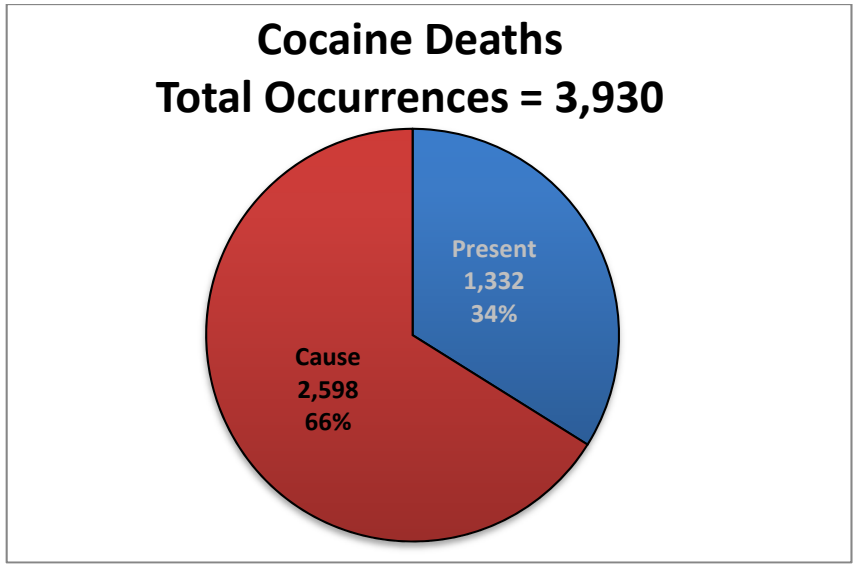
2022 Drug Detected at Death: Cause vs. Present

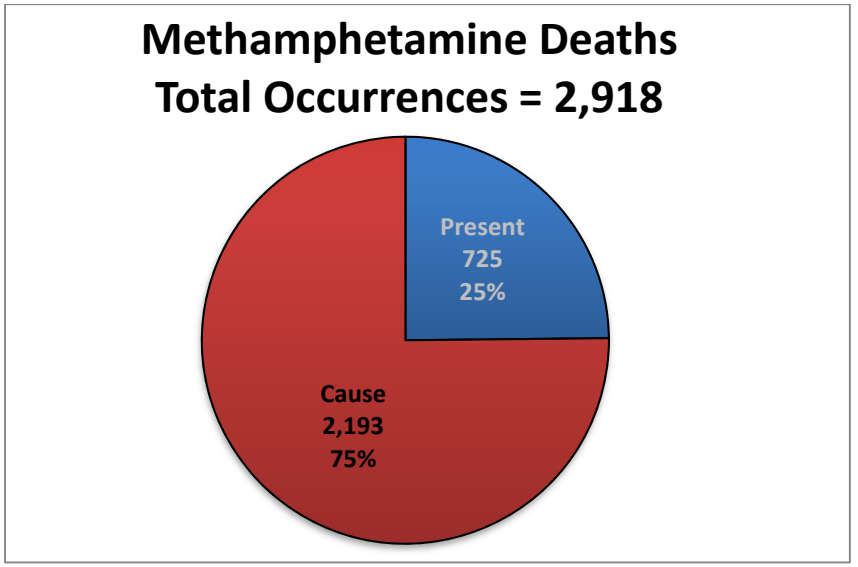


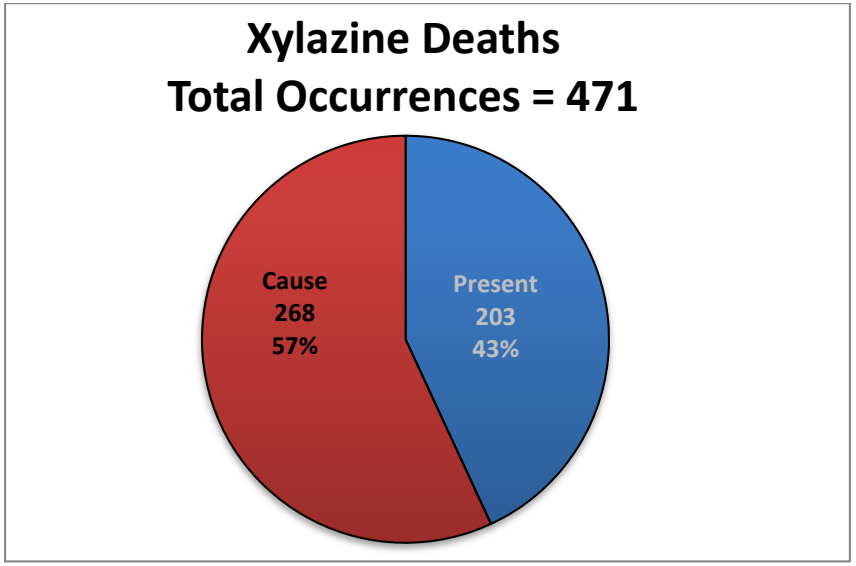




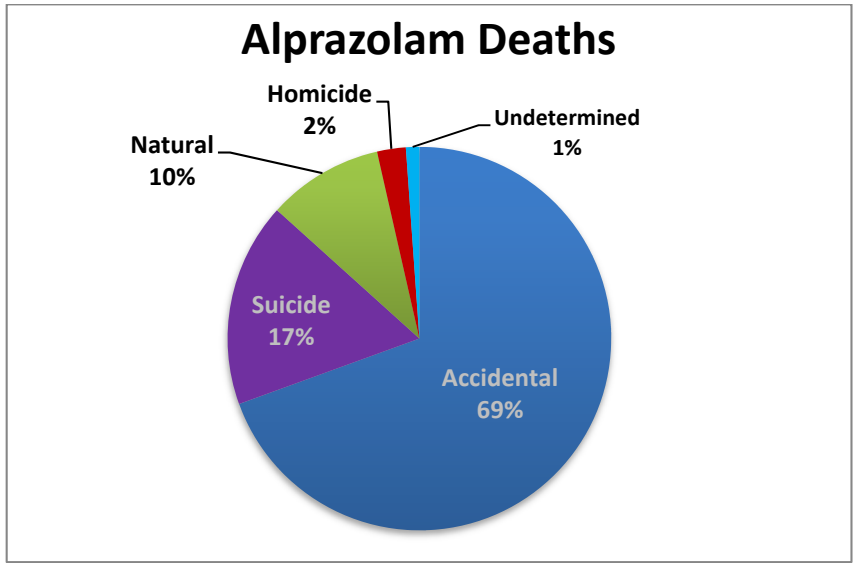
2022 Drug Detected at Death: Cause vs. Present

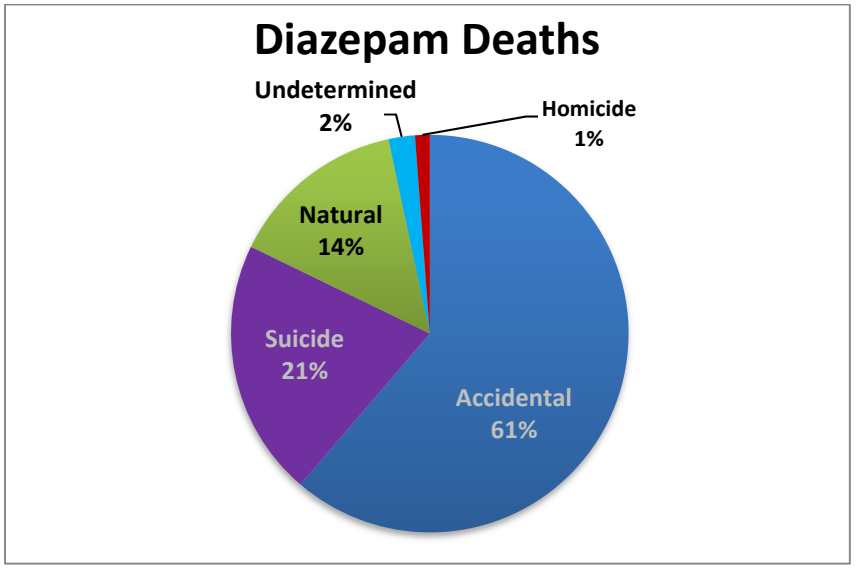


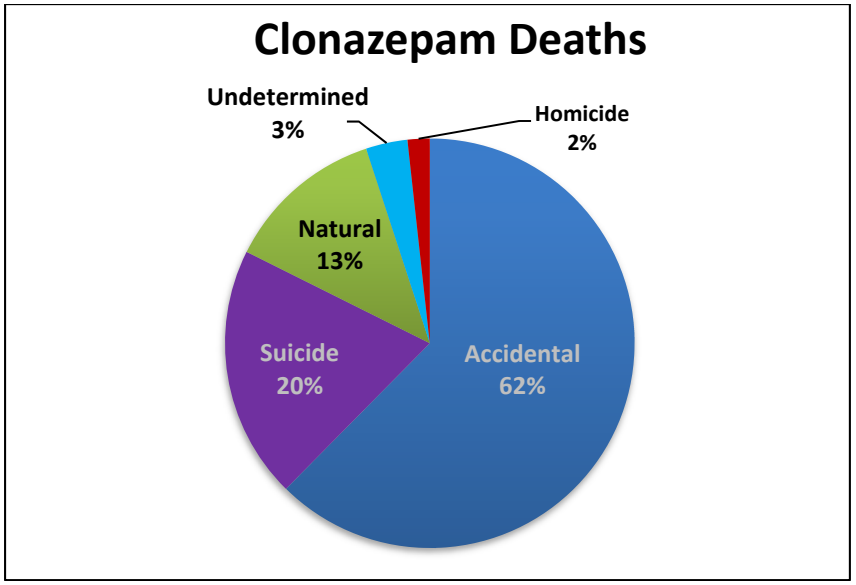




2022 Manner of Death for Reported Drug Occurrences

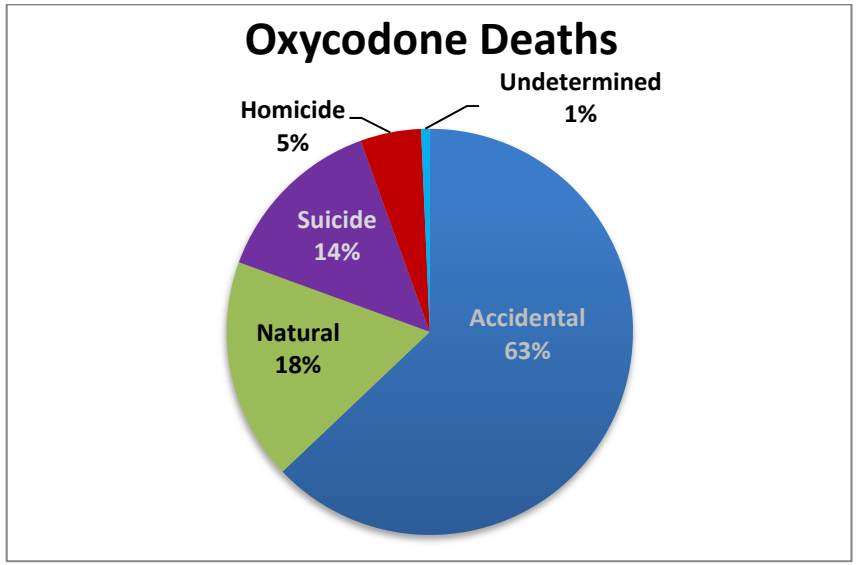


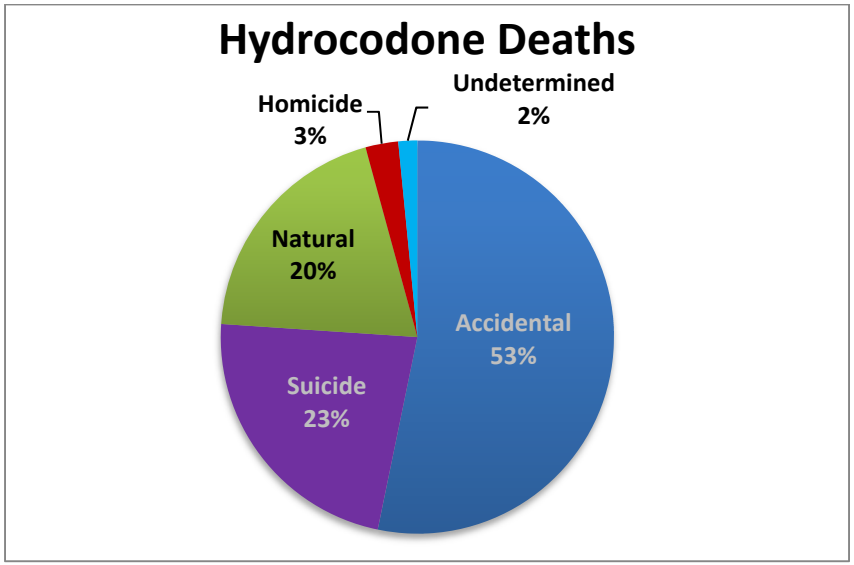


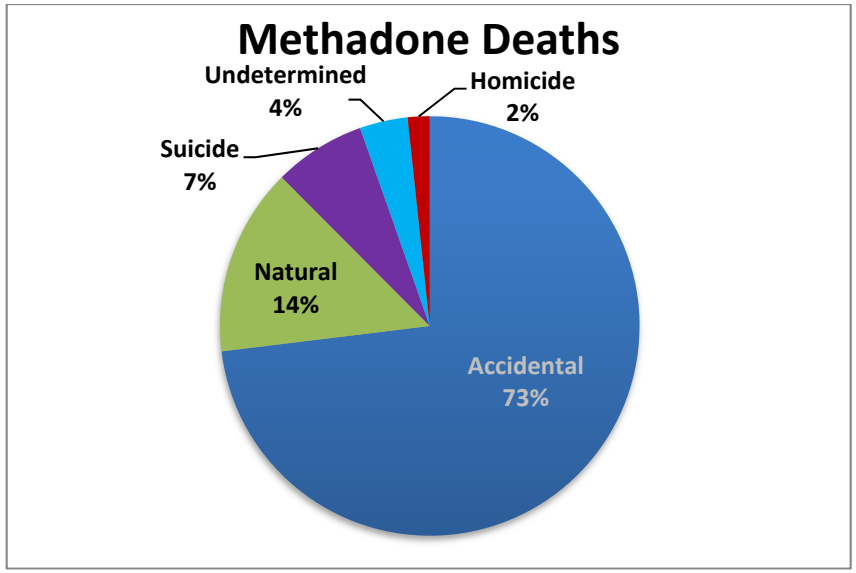


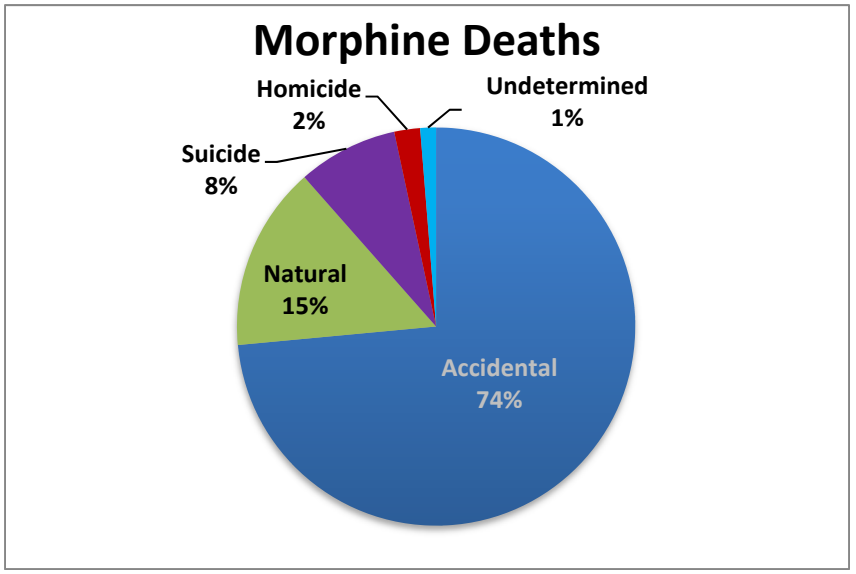
Note: Percentages may not sum to 100 percent because of rounding.

2022 Manner of Death for Reported Drug Occurrences



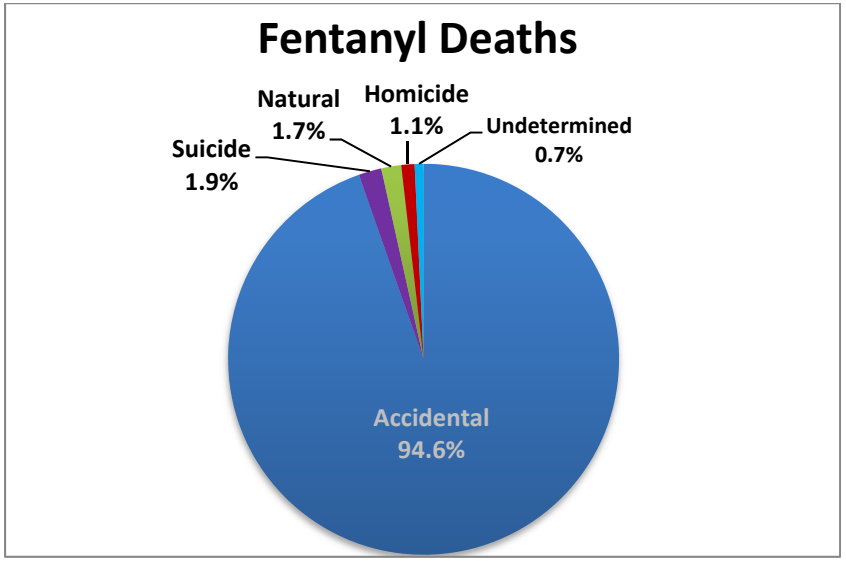


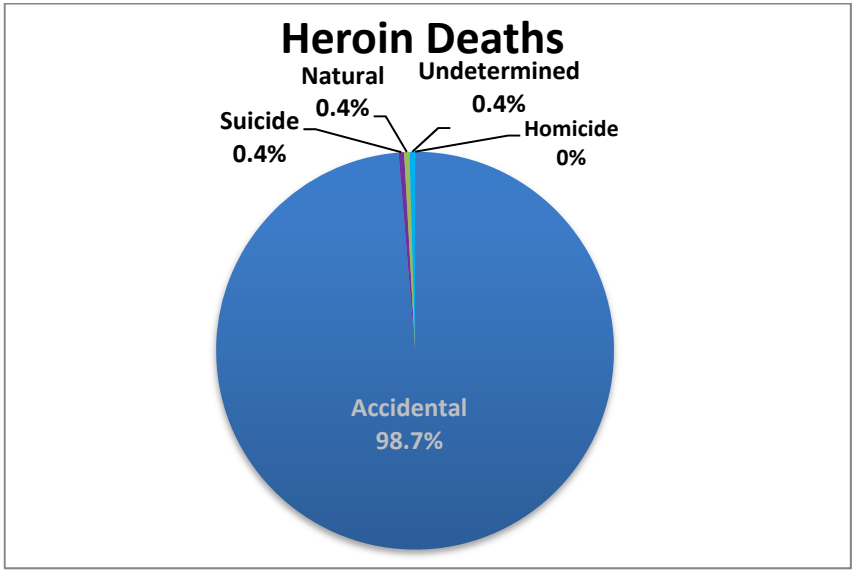


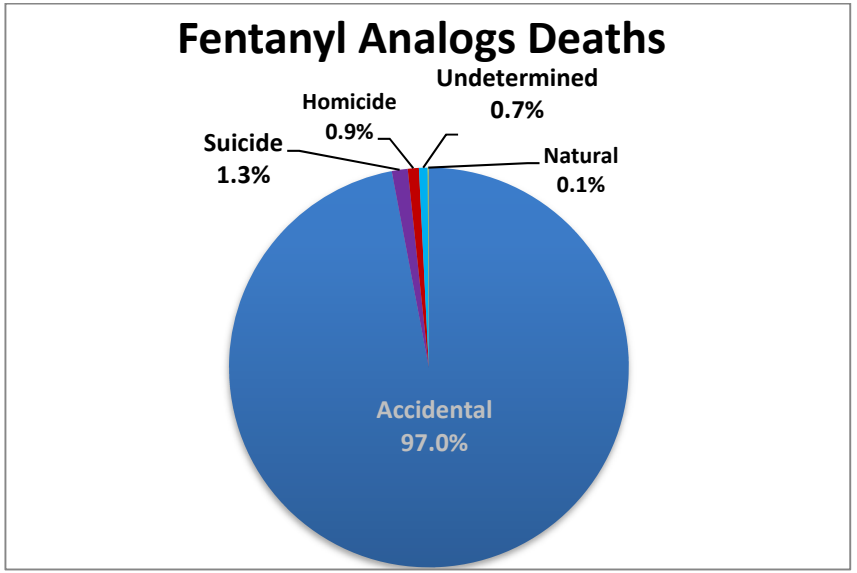


Note: Percentages may not sum to 100 percent because of rounding.

2022 Manner of Death for Reported Drug Occurrences

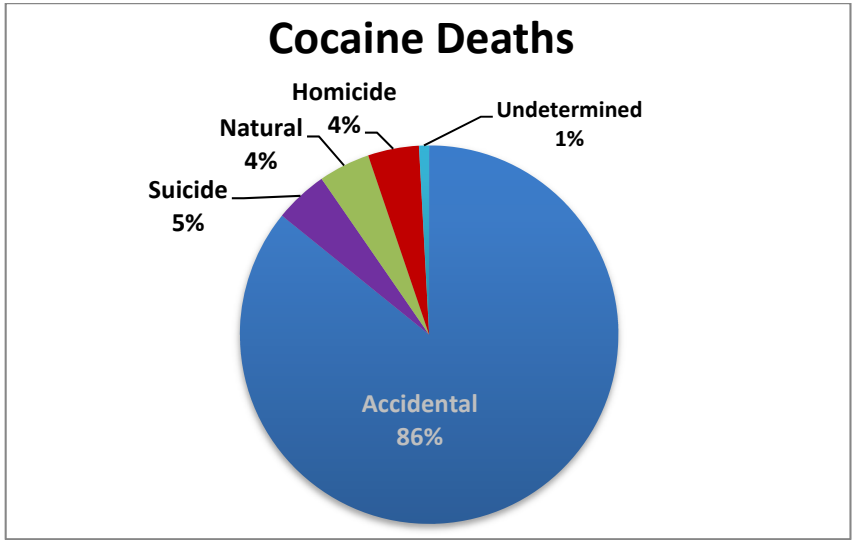


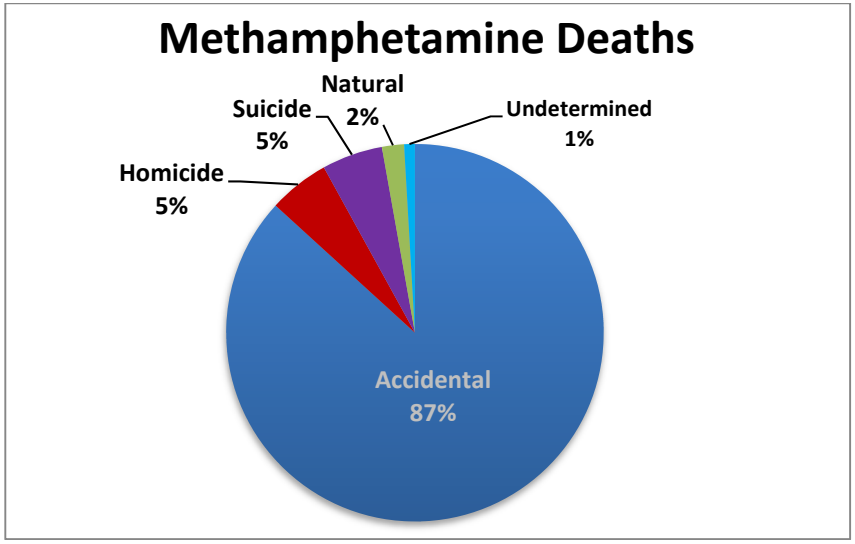


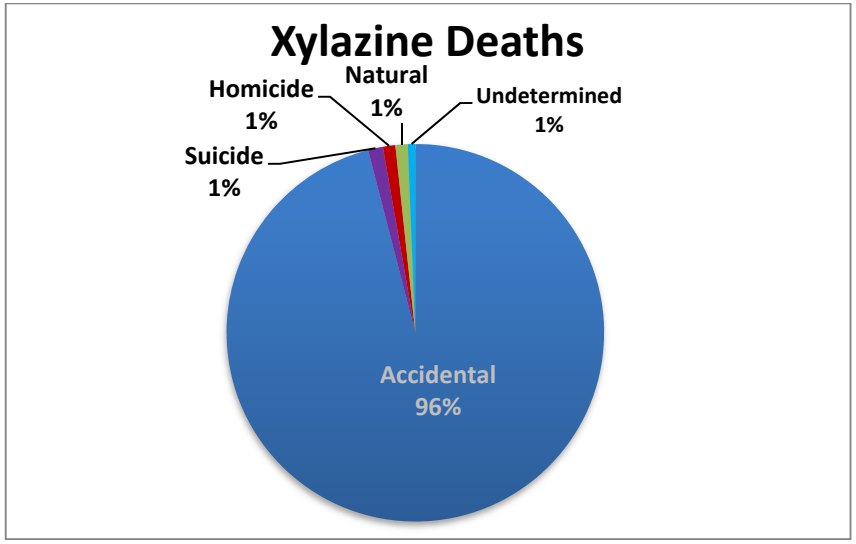


Note: Percentages may not sum to 100 percent because of rounding.

2022 Manner of Death for Reported Drug Occurrences







Note: Percentages may not sum to 100 percent because of rounding.

Analytes

Below are specific analytes that were identified in the decedents:

Cathinones

- N, N-Dimethylpentylone
- Eutylone
- Alpha PiHP
- Alpha PVP
- Pentylone
- N-propyl butylone
- N-Cyclohexylbutylone
- N, N-Dimethylone

Synthetic Cannabinoids

- MDMB-4en-PINACA
- 5-fluoro-MDMB
- ADB-Fubiata
- MDMB-4en-PINACA butanoic acid

Phenethylamines/Piperazines

- 3,4-Methylenedioxyamphetamine
- 3,4-Methylenedioxymethamphetamine

Glossary

4-ANPP (despropionyl fentanyl) – A precursor chemical used in the manufacture of illicit fentanyl. 4-ANPP is also a metabolite of illicit fentanyl and fentanyl-related analogs.

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 MDMA and the amphetamine family of drugs, which includes amphetamine and methamphetamine.

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 most fentanyl occurrences represent the ingestion of illicit fentanyl rather than pharmaceutically manufactured fentanyl.

Glossary (Continued)

Fentanyl Analog – A synthetic opioid structurally similar to fentanyl. Many analogs of fentanyl are pharmacologically more potent than fentanyl. Carfentanil is an analog of fentanyl approved for veterinary use only.

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."

Gabapentin - An anti-epileptic drug also called an anticonvulsant to treat neuropathic pain (nerve pain) caused by herpes virus.

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 "Molly," "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-O," and "5-MEO."

Halogenated Inhalants – Includes, but are not limited to, halogenated hydrocarbons, especially refrigerants such as difluoroethane, which is a component of "compressed air" electronics cleaners; these and similar halogenated substances are 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."

Glossary (Continued)

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 and 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.

Mitragynine – An alkaloid found in the Kratom plant, which is consumed for its stimulant and analgesic (opioid-like) effects. The leaves of the Kratom plant, either whole or crushed, are smoked, chewed or prepared as tea. In addition, plant extract containing mitragynine is available in tablets and capsules.

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 (N2O) – Also known as "laughing gas," 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.”

PCP Analog – A drug structurally related to phencyclidine.

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 manmade 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.”

Glossary (Continued)

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.

U-47700 – A synthetic opioid with a white or light-pink chalky appearance that is found in powder or tablet form. Common street names for this drug include “pink,” “pinky,” or “U4.”

Xylazine - A drug used in veterinary medicine as a sedative with analgesic and muscle relaxant properties. It is often mixed with other drugs such as fentanyl, heroin and cocaine.

Zolpidem – A prescription medication used for the short-term treatment of insomnia; it is commonly known as Ambien.

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LEGISLATIVE ACTION

Senate . House

. . . . .

The Committee on Children, Families, and Elder Affairs (Harrell) recommended the following:

Senate Amendment (with title amendment)

Delete lines 125 - 289
and insert:
Section 3. Paragraph (a) of subsection (2) of section 397.335, Florida Statutes, is amended to read:
397.335 Statewide Council on Opioid Abatement.—
(2) MEMBERSHIP.—
(a) Notwithstanding s. 20.052, the council shall be composed of the following members:

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1. The Attorney General, or his or her designee, who shall serve as chair.

2. The secretary of the department, or his or her designee, who shall serve as vice chair.

3. One member appointed by the Governor.

4. One member appointed by the President of the Senate.

5. One member appointed by the Speaker of the House of Representatives.

6. Two members appointed by the Florida League of Cities who are commissioners or mayors of municipalities. One member shall be from a municipality with a population of fewer than 50,000 people.

7. Two members appointed by or through the Florida Association of Counties who are county commissioners or mayors. One member shall be appointed from a county with a population of fewer than 200,000, and one member shall be appointed from a county with a population of more than 200,000.

8. One member who is either a county commissioner or county mayor appointed by the Florida Association of Counties or who is a commissioner or mayor of a municipality appointed by the Florida League of Cities. The Florida Association of Counties shall appoint such member for the initial term, and future appointments must alternate between a member appointed by the Florida League of Cities and a member appointed by the Florida Association of Counties.

9. Two members appointed by or through the State Surgeon General. One shall be a staff member from the department who has experience coordinating state and local efforts to abate the opioid epidemic, and one shall be a licensed physician who is

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board certified in both addiction medicine and psychiatry.

10. One member appointed by the Florida Association of Recovery Residences.

11. One member appointed by the Florida Association of EMS Medical Directors.

12. One member appointed by the Florida Society of Addiction Medicine who is a medical doctor board certified in addiction medicine.

13. One member appointed by the Florida Behavioral Health Association.

14. One member appointed by Floridians for Recovery.

15. One member appointed by the Florida Certification Board.

16. One member appointed by the Florida Association of Managing Entities.

Section 4. Present paragraphs (c), (d), and (e) of subsection (8) of section 397.487, Florida Statutes, are redesignated as paragraphs (d), (e), and (f), respectively, a new paragraph (c) is added to that subsection, subsections (13) and (14) are added to that section, and paragraph (b) and present paragraphs (c), (d), and (e) of subsection (8) of that section are amended, to read:

397.487 Voluntary certification of recovery residences.—

(8) Onsite followup monitoring of a certified recovery residence may be conducted by the credentialing entity to determine continuing compliance with certification requirements. The credentialing entity shall inspect each certified recovery residence at least annually to ensure compliance.

(b) A certified recovery residence must notify the

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credentialing entity within 3 business days after the removal of the recovery residence's certified recovery residence administrator due to termination, resignation, or any other reason. The certified recovery residence has 90 ~~30~~ days to retain a certified recovery residence administrator. The credentialing entity shall revoke the certificate of compliance of any certified recovery residence that fails to comply with this paragraph.

(c) If a certified recovery residence's administrator has been removed due to termination, resignation, or any other reason and had been previously approved to actively manage more than 50 residents pursuant to s. 397.4871(8)(b), the certified recovery residence has 90 days to retain another certified recovery residence administrator pursuant to that section. The credentialing entity shall revoke the certificate of compliance of any certified recovery residence that fails to comply with this paragraph.

(d) ~~(c)~~ If any owner, director, or chief financial officer of a certified recovery residence is arrested and awaiting disposition for or found guilty of, or enters a plea of guilty or nolo contendere to, regardless of whether adjudication is withheld, any offense listed in s. 435.04(2) while acting in that capacity, the certified recovery residence must ~~shall~~ immediately remove the person from that position and ~~shall~~ notify the credentialing entity within 3 business days after such removal. The credentialing entity may ~~shall~~ revoke the certificate of compliance of a certified recovery residence that fails to meet these requirements.

(e) ~~(d)~~ A credentialing entity shall revoke a certified

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recovery residence's certificate of compliance if the certified recovery residence provides false or misleading information to the credentialing entity at any time.

(f) ~~(e)~~ Any decision by a department-recognized credentialing entity to deny, revoke, or suspend a certification, or otherwise impose sanctions on a certified recovery residence, is reviewable by the department. Upon receiving an adverse determination, the certified recovery residence may request an administrative hearing pursuant to ss. 120.569 and 120.57(1) within 30 days after completing any appeals process offered by the credentialing entity or the department, as applicable.

(13) On or after January 1, 2025, a recovery residence may not deny an individual access to housing solely on the basis that he or she has been prescribed federally approved medication that assists with treatment for substance use disorders by a licensed physician, a physician's assistant, or an advanced practice registered nurse registered under s. 464.0123.

(14) A local law, ordinance, or regulation may not regulate the duration or frequency of a resident's stay in a certified recovery residence located within a multifamily zoning district. This subsection does not apply to any local law, ordinance, or regulation adopted on or before February 1, 2025.

Section 5. Paragraphs (b) and (c) of subsection (6) of section 397.4871, Florida Statutes, are amended, and paragraph (c) is added to subsection (8) of that section, to read:

397.4871 Recovery residence administrator certification.—

(6) The credentialing entity shall issue a certificate of compliance upon approval of a person's application. The

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certification shall automatically terminate 1 year after issuance if not renewed.

(b) If a certified recovery residence administrator of a recovery residence is arrested and awaiting disposition for or found guilty of, or enters a plea of guilty or nolo contendere to, regardless of whether adjudication is withheld, any offense listed in s. 435.04(2) while acting in that capacity, the certified recovery residence must ~~shall~~ immediately remove the person from that position and ~~shall~~ notify the credentialing entity within 3 business days after such removal. The certified recovery residence shall ~~have 30 days to~~ retain a certified recovery residence administrator within 90 days after such removal. The credentialing entity shall revoke the certificate of compliance of any recovery residence that fails to meet these requirements.

(c) A credentialing entity shall revoke a certified recovery residence administrator's certificate of compliance if the recovery residence administrator provides false or misleading information to the credentialing entity at any time.

(8)

(c) Notwithstanding paragraph (b), a Level IV certified recovery residence operating as community housing as defined in s. 397.311(9), which

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

Delete lines 8 - 14

and insert:

"community housing"; amending s. 397.335,

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Children, Families, and Elder Affairs

BILL:	SB 1180
INTRODUCER:	Senator Harrell
SUBJECT:	Substance Abuse Treatment
DATE:	February 5, 2024
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Hall	Tuszynski	CF	**Pre-meeting**
2.			AHS	
3.			AP	

I. Summary:

A recovery residence is a residential dwelling unit, or other form of group housing, that provides a peer-supported, alcohol- and drug-free living environment. Florida has a certification process for a recovery residence meeting certain quality standards and other requirements. If certified, those recovery residences are allowed to receive referrals from treatment and service providers.

SB 1180 amends the definition of certified recovery residence to include standards regarding the level of care provided at those residences. The bill requires four levels of care that distinguish the residences based on their provided care, to include:

- **Level I**: homes that house individuals in recovery who are post-treatment, with a minimum of nine months of sobriety. These homes are run by the members who reside in them.
- **Level II**: homes that provide oversight from a house manager (typically a senior resident). Residents are expected to follow rules outlined in a resident handbook, pay dues, and work toward achieving milestones.
- **Level III**: homes that offer 24-hour supervision by formally trained staff and peer-support services for residents.
- **Level IV**: homes that are offered, referred to, or provided to patients by licensed services providers. The patients receive intensive outpatient and higher levels of outpatient care. These homes are staffed 24 hours a day.

The bill expands the Statewide Council on Opioid Abatement by adding seven additional members beyond the existing membership.

The bill prohibits any recovery residence from denying an individual access to the residence solely on the basis the individual had been prescribed federally approved medication that assists with treatment for substance use disorders by a licensed physician, physician's assistant, or advanced practice registered nurse.

The bill also prohibits a local law, ordinance, or regulation from regulating the duration or frequency of a resident and also exempts certified recovery residences from any transient rental taxes.

The bill has no fiscal impact on state government but may have an indeterminate negative fiscal impact on local government.

The bill provides an effective date of July 1, 2024.

II. Present Situation:

Substance Abuse

Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs.[1] According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), a diagnosis of substance use disorder (SUD) is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.[2] SUD occurs when an individual chronically uses alcohol or drugs, resulting in significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.[3] Repeated drug use leads to changes in the brain's structure and function that can make a person more susceptible to developing a substance abuse disorder.[4]

Among people aged 12 or older in 2021, 61.2 million people (or 21.9 percent of the population) used illicit drugs in the past year.[5] The most commonly used illicit drug was marijuana, which 52.5 million people used.[6] In the past year:[7]

- Nearly 2 in 5 young adults 18 to 25 used illicit drugs;
- 1 in 3 young adults 18 to 25 used marijuana;
- 9.2 million people 12 and older misused opioids;
- 46.3 million people aged 12 and older (16.5 percent of the population) met the applicable DSM-5 criteria for having a substance use disorder, including 29.5 million who were

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[1] The World Health Organization, *Mental Health and Substance Abuse*, available at https://www.who.int/westernpacific/about/how-we-work/programmes/mental-health-and-substance-abuse (last visited January 30, 2024); the National Institute on Drug Abuse (NIDA), *The Science of Drug Use and Addiction: The Basics*, available at https://archives.nida.nih.gov/publications/media-guide/science-drug-use-addiction-basics (last visited January 30, 2024).

[2] The National Association of Addiction Treatment Providers, *Substance Use Disorder*, available at https://www.naatp.org/resources/clinical/substance-use-disorder (last visited January 30, 2024).

[3] The Substance Abuse and Mental Health Services Administrator (The SAMHSA), *Substance Use Disorders*, available at https://www.samhsa.gov/find-help/disorders (last visited January 30, 2024).

[4] The NIDA, *Drugs, Brains, and Behavior: The Science of Addiction*, available at https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/drug-misuse-addiction (last visited January 30, 2024).

[5] U.S. Department of Health and Human Services, *SAMHSA Announces National Survey on Drug Use and Health (NSDUH) Results Detailing Mental Illness and Substance Use Levels in 2021*, available at https://www.hhs.gov/about/news/2023/01/04/samhsa-announces-national-survey-drug-use-health-results-detailing-mental-illness-substance-use-levels-2021.html (last visited January 30, 2024).

[6] *Id.*

[7] *Id.*

classified as having an alcohol use disorder and 24 million who were classified as having a drug use disorder. The percentage was highest among young adults aged 18 to 25.

Substance Abuse Treatment in Florida

In the early 1970s, the federal government enacted laws creating formula grants for states to develop continuums of care for individuals and families affected by substance abuse.[8] The laws resulted in separate funding streams and requirements for alcoholism and drug abuse. In response to the laws, the Florida Legislature enacted chs. 396 and 397, F.S., relating to alcohol and drug abuse, respectively.[9] Each of these laws governed different aspects of addiction, and thus, had different rules promulgated by the state to fully implement the respective pieces of legislation.[10] However, because persons with substance abuse issues often do not restrict their misuse to one substance or another, having two separate laws dealing with the prevention and treatment of addiction was cumbersome and did not adequately address Florida's substance abuse problem.[11] In 1993, legislation was adopted to combine ch. 396 and 397, F.S., into a single law, the Hal S. Marchman Alcohol and Other Drug Services Act (Marchman Act).[12]

The Marchman Act encourages individuals to seek services on a voluntary basis within the existing financial and space capacities of a service provider.[13] However, denial of addiction is a prevalent symptom of SUD, creating a barrier to timely intervention and effective treatment.[14] As a result, treatment typically must stem from a third party providing the intervention needed for SUD treatment.[15]

The Department of Children and Families (DCF) administers a statewide system of safety-net services for substance abuse and mental health (SAMH) prevention, treatment, and recovery for children and adults who are otherwise unable to obtain these services. Services are provided based upon state and federally-established priority populations.[16] The DCF provides treatment for SUD through a community-based provider system offering detoxification, treatment, and recovery support for individuals affected by substance misuse, abuse, or dependence.[17]

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[8] The DCF, *Baker Act and Marchman Act Project Team Report for Fiscal Year 2016-2017*, p. 4-5. (on file with the Senate Children, Families, and Elder Affairs Committee).
[9] *Id.*
[10] *Id.*
[11] *Id.*
[12] Chapter 93-39, s. 2, L.O.F., codified as ch. 397, F.S.
[13] *See* ss. 397.601(1) and (2), F.S., An individual who wishes to enter treatment may apply to a service provider for voluntary admission. Within the financial and space capabilities of the service provider, the individual must be admitted to treatment when sufficient evidence exists that he or she is impaired by substance abuse and his or her medical and behavioral conditions are not beyond the safe management capabilities of the service provider.
[14] Darran Duchene and Patrick Lane, Fundamentals of the Marchman Act, Risk RX, Vol. 6 No. 2 (Apr. – Jun. 2006) State University System of Florida Self-Insurance Programs, available at https://flbog.sip.ufl.edu/risk-rx-article/fundamentals-of-the-marchman-act/ (last visited January 18, 2024)(hereinafter cited as "fundamentals of the Marchman Act").
[15] *Id.*
[16] *See* ch. 394 and 397, F.S.
[17] The DCF, *Treatment for Substance Abuse*, available at https://www.myflfamilies.com/services/samh/treatment (last visited January 18, 2024).

- **Detoxification Services**: Detoxification services use medical and clinical procedures to assist individuals and adults as they withdraw from the physiological and psychological effects of substance abuse.[18]
- **Treatment Services**: Treatment services[19] include a wide array of assessment, counseling, case management, and support that are designed to help individuals who have lost their abilities to control their substance use on their own and require formal, structured intervention and support.[20]
- **Recovery Support**: Recovery support services, including transitional housing, life skills training, parenting skills, and peer-based individual and group counseling, are offered during and following treatment to further assist individuals in their development of the knowledge and skills necessary to maintain their recovery.[21]

Licensure of Substance Abuse Service Providers

The DCF regulates substance use disorder treatment by licensing individual treatment components under ch. 397, F.S., and Rule 65D-30, F.A.C. Licensed service components include a continuum of substance abuse prevention[22], intervention[23], and clinical treatment services.[24]

Clinical treatment is a professionally directed, deliberate, and planned regimen of services and interventions that are designed to reduce or eliminate the misuse of drugs and alcohol and promote a healthy, drug-free lifestyle.[25] "Clinical treatment services" include, but are not limited to, the following licensable service components:

- Addictions receiving facility.
- Day or night treatment.
- Day or night treatment with community housing.
- Detoxification.
- Intensive inpatient treatment.
- Intensive outpatient treatment.
- Medication-assisted treatment for opiate addiction.
- Outpatient treatment.
- Residential treatment.[26]

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[18] *Id.*
[19] *Id.* Research indicates that persons who successfully complete substance abuse treatment have better post-treatment outcomes related to future abstinence, reduced use, less involvement in the criminal justice system, reduced involvement in the child-protective system, employment, increased earnings, and better health.
[20] *Id.*
[21] *Id.*
[22] Section 397.311(26)(c), F.S. "Prevention" is defined as "a process involving strategies that are aimed at the individual, family, community, or substance and that preclude, forestall, or impede the development of substance use problems and promote responsible lifestyles." *See also* The DCF, *Substance Abuse Prevention*, available at https://www.myflfamilies.com/services/samh/substance-abuse-prevention (last visited January 19, 2024).
[23] Section 397.311(26)(b), F.S. "Intervention" is defined as "structured services directed toward individuals or groups at risk of substance abuse and focused on reducing or impeding those factors associated with the onset or the early stages of substance abuse and related problems."
[24] Section 397.311(26), F.S.
[25] Section 397.311(26)(a), F.S.
[26] *Id.*

Recovery Residences

Recovery residences (also known as "sober homes, "sober living homes," "Oxford Houses," or "Halfway Houses") are non-medical settings designed to support recovery from substance use disorders, providing a substance-free living environment commonly used to help individuals transition from highly structured residential treatment programs back into their day-to-day lives (e.g., obtaining employment and establishing more permanent residence).[27] Virtually all encourage or require attendance at 12-step mutual-help organizations like Alcoholics Anonymous (AA) or Narcotics Anonymous (NA), but recovery homes have varying degrees of structure and built-in programmatic elements:[28]

- **Length of Stay**: some may have a limited or otherwise predetermined, length of stay, while others may allow individuals to live there for as long as necessary provided they follow the house rules.
- **Monitoring**: some, but not all, provide monitoring to maintain substance-free, recovery-supportive living environments and help facilitate house members' progress by implementing a number of rules and requirements (i.e., mutual-help organization attendance, attendance at house meetings, curfews, restrictions on outside employment, and limits on use of technology). Typically as individuals successfully follow these rules over time, restrictions become more lenient and individuals have greater latitude in their choices both in and outside of the recovery residence.
- **Size**: while recovery residences range in the number of individuals living there at any given time, there are typically at least 6-8 residents of the same gender.

A recovery residence is defined as "a residential unit, the community housing component of a licensed day or night treatment facility with community housing, or other form of group housing, which is offered or advertised through any means, including oral, written, electronic, or printed means, by any person or entity as a residence that provides a peer-supported, alcohol-free, and drug-free living environment."[29]

Recovery residences can be located in single-family and two-family homes, duplexes, and apartment complexes. Most recovery residences are located in single-family homes, zoned in residential neighborhoods.[30] To live in a recovery residence, occupants may be required to pay a

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[27] Recovery Research Institute, *Recovery Residences*, available at https://www.recoveryanswers.org/resource/recovery-residences/ (last visited January 18, 2024). Substance abuse prevention is achieved through the use of ongoing strategies such as increasing public awareness and education, community-based processes and evidence-based practices. These prevention programs are focused primarily on youth, and, in recent years, have shifted to the local level, giving individual communities the opportunity to identify their own unique prevention needs and develop action plans in response. This community focus allows prevention strategies to have a greater impact on behavioral change by shifting social, cultural, and community environments.

[28] *Id.*

[29] Section 397.311(38), F.S.

[30] Hearing before the Subcommittee on the Constitution and Civil Justice of the Committee on the Judiciary, House of Representatives, One Hundred Fifteenth Congress, Sept. 28, 2018, available at https://www.govinfo.gov/content/pkg/CHRG-115hhrg33123/html/CHRG-115hhrg33123.htm. See also The National Council for Behavioral Health, *Building Recovery: State Policy Guide for Supporting Recovery Housing*, available at https://www.thenationalcouncil.org/wp-content/uploads/2018/05/18_Recovery-Housing-Toolkit_5.3.2018.pdf?daf=375ateTbd56 (last visited January 31, 2024).

monthly fee or rent, which supports the cost of maintaining the home. Generally, recovery residences provide short-term residency, typically a minimum of at least 90 days. However, the length of time a person stays at a recovery residence varies based on the individuals' treatment needs.[31] Because recovery residences essentially provide short-term rental or leasing of living quarters, recovery residences may be classified as transient rental accommodation and subject to taxation of rental fees.

Day or Night Treatment: Community Housing Component

Community housing is a type of group home that provides supportive housing for individuals who are undergoing treatment for substance abuse.

Day or night treatment is one of the licensable service components of clinical treatment services. This service is provided in a nonresidential environment with a structured schedule of treatment and rehabilitative services.[32] Some day or night treatment programs have a community housing component, which is a program intended for individuals who can benefit from living independently in peer community housing which participating in treatment services at a day or night treatment facility for a minimum of five hours a day for a minimum of 25 hours per week.[33]

Prior to 2019, the community housing component of a licensed day or night treatment program was not included in the definition of "recovery residence." After the Legislature amended the definition of "recovery residence" in 2019 to include the community housing component, DCF addressed the statutory change to the definition in a memo. The department stated that, as a result of the change in definition, providers licensed for day or night treatment with community housing must be certified as a recovery residence in order to accept or receive patient referrals from licensed treatment providers or existing recovery residences.[34] The memo did not specifically address whether the community housing component requires certification if the only individuals residing there were clients of the licensed day or night treatment program.

Voluntary Certification of Recovery Residences

A certified recovery residence is a recovery residence that holds a valid certificate of compliance and is actively managed by a certified recovery residence administrator.[35] Florida has a voluntary certification program for recovery residences and recovery residence administrators, implemented by private credentialing entities.[36] Under the voluntary certification program, two DCF-approved credentialing entities administer certification programs and issue certificates: the

[31] American Addiction Center, *Length of Stay at a Sober Living Home*, available at https://americanaddictioncenters.org/sober-living/length-of-stay (last visited January 31, 2024).
[32] Section 397.311(26)(a)2., F.S.
[33] Section 397.311(26)(a)3., F.S.
[34] DCF Memo to Substance Abuse Prevention, Intervention, and Treatment Providers, dated July 1, 2019 (on file with the Senate Children, Families, and Elder Affairs Committee).
[35] Sections 397.487-397.4872, F.S.
[36] *Id.*

Florida Association of Recovery Residences (FARR) certifies the recovery residences and the Florida Certification Board (FCB) certifies recovery residence administrators.[37]

As the credentialing entity for recovery residences in Florida, FARR is statutorily authorized to administer certification, recertification, and disciplinary processes as well as monitor and inspect recovery residences to ensure compliance with certification requirements. FARR is also authorized to deny, revoke, or suspend a certification, or otherwise impose sanctions, if recovery residences are not in compliance or fail to remedy any deficiencies identified. However, any decision that results in an adverse determination is reviewable by the Department.[38]

In order to become certified, a recovery residence must submit the following documents with an application fee to the credentialing entity:[39]

- A policy and procedures manual containing:
- Job descriptions for all staff positions;
- Drug-testing procedures and requirements;
- A prohibition on the premises against alcohol, illegal drugs, and the use of prescription medications by an individual other than for whom the medication is prescribed;
- Policies to support a resident's recovery efforts; and
- A good neighbor policy to address neighborhood concerns and complaints;
- Rules for residents;
- Copies of all forms provided to residents;
- Intake procedures;
- Sexual predator and sexual offender registry compliance policy;
- Relapse policy;
- Fee schedule;
- Refund policy;
- Eviction procedures and policy;
- Code of ethics;
- Proof of insurance;
- Proof of background screening; and
- Proof of satisfactory fire, safety, and health inspections.

There are currently 675 certified recovery residences in Florida.[40] DCF publishes a list of all certified recovery residences and recovery residence administrators on its website.[41]

[37] The DCF, *Recovery Residence Administrators and Recovery Residences*, available at https://www.myflfamilies.com/services/samh/recovery-residence-administrators-and-recovery-residences (last visited January 31, 2024).
[38] Section 397.487, F.S.
[39] *Id*.
[40] DCF, *2024 Agency Bill Analysis SB 1180*, on file with the Senate Children, Families, and Elder Affairs.
[41] Section 397.4872, F.S.

National Alliance for Recovery Residences

The National Alliance for Recovery Residences (NARR) was established to develop and promote best practices in the operation of recovery residences.[42] The organization works with federal government agencies, national addiction and recovery organizations, state-level recovery housing organizations, and state addiction services agencies to improve the effectiveness and accessibility of recovery housing.

In 2011, NARR established the national standard for all recovery residences. This standard defines the spectrum of recovery oriented housing and services and distinguishes four different types, which are known as "levels" or "levels of support." The standard was developed through a strength-based and collaborative approach that solicited input from all major regional and national recovery housing organizations.[43] NARR's levels of support are included in the Substance Abuse and Mental Health Services Administration's Best Practices for Recovery Housing.[44]

NARR Recovery Residence Levels of Support

A recovery residence is a broad term that describes safe and sober living environments that promote recovery from substance use disorders. These residences may also be referred to as halfway houses, three-quarter houses, transitional living facilities, or sober living homes. Since this is a broad term, to help categorize recovery residences into more specific groups, NARR distinguishes these residences based on their levels of care. There are four levels of care for recovery residences: peer-run, monitored, supervised, and service provider. [45]

Level I – Peer-Run
A Peer-Run recovery residence is a home operated by the residents themselves. In this type of residence, there is no external management or oversight from outside sources such as an administrative director. The administration of these facilities is done democratically by the residents. Services may include house meetings for accountability, drug screenings, and self-help meetings. These residences are generally set up in single-family residences like a house.[46]

Level II – Monitored
A monitored recovery residence has an external management structure, usually in the form of an administrative director. The director oversees operations, provides guidance and support, and ensures that all tenants are following rules. These facilities, provide a structured environment with documented rules, policies, and procedures. These residences are typically managed by a house manager or senior resident and may offer peer-run groups, house meetings, drug

[42] NARR, *About Us*, available at https://narronline.org/about-us/ (last visited January 31, 2024).
[43] NARR, *Standards and Certification Program*, available at https://narronline.org/affiliate-services/standards-and-certification-program/ (last visited January 31, 2024).
[44] Substance Abuse and Mental Health Services Administration, *Best Practices for Recovery Housing*, available at https://store.samhsa.gov/sites/default/files/pep23-10-00-002.pdf (last visited January 31, 2024).
[45] NARR, *Recovery Residence Levels of Support*, available at https://narronline.org/wp-content/uploads/2016/12/NARR_levels_summary.pdf (last visited January 31, 2024).
[46] Isaiah House, *NARR Levels of Care for Addiction Recovery Residences*, available at https://isaiah-house.org/narr-levels-of-care-for-addiction-recovery-residences/ (last visited January 31, 2024).

screenings, and involvement in self-help treatment. These facilities are primarily single=family residences, but they may also be apartments or other dwelling types.[47]

Level III – Supervised

Supervised recovery residences have more intense levels of oversight than monitored residences and typically have an on-site staff member who provides 24/7 support to residents. The staff at a Level III residence includes a facility manager and certified staff or case managers. Staff members may also provide counseling services or facilitate group activities. Residents at Level III houses are expected to adhere to a strict set of rules and guidelines while living in this type of residence. Level III residences have an organizational hierarchy with administrative oversight for service providers, and documented policies and procedures. This type of residence emphasizes life skull development. In these residences, services may be utilized in the outside community while service hours may be provided in-house. The type of dwelling for Level III residences varies and may include all types of residential settings.[48]

Level IV – Service Provider

Service provider recovery residences are typically operated by organizations or corporations. These residences offer a wide range of services and activities for residents. Staff levels in Level IV residences are higher than staff levels for Level I-III residences, and the environments are more structured and institutionalized. These residences have an overseen organizational hierarchy. Level IV recovery residence employ credentialed staff and have both clinical and administrative supervision for residents. These residences also provide clinical services and programming in-house and may offer residents life skill development. While Level IV residences may have a more institutionalized environment, all types of residence may be included as a client moves through the care continuum of a treatment center.[49]

NARR National Association of Recovery Residences		RECOVERY RESIDENCE LEVELS OF SUPPORT			
		LEVEL I Peer-Run	LEVEL II Monitored	LEVEL III Supervised	LEVEL IV Service Provider
STANDARDS CRITERIA	ADMINISTRATION	• Democratically run • Manual or P& P	• House manager or senior resident • Policy and Procedures	• Organizational hierarchy • Administrative oversight for service providers • Policy and Procedures • Licensing varies from state to state	• Overseen organizational hierarchy • Clinical and administrative supervision • Policy and Procedures • Licensing varies from state to state
	SERVICES	• Drug Screening • House meetings • Self help meetings encouraged	• House rules provide structure • Peer run groups • Drug Screening • House meetings • Involvement in self help and/or treatment services	• Life skill development emphasis • Clinical services utilized in outside community • Service hours provided in house	• Clinical services and programming are provided in house • Life skill development
	RESIDENCE	• Generally single family residences	• Primarily single family residences • Possibly apartments or other dwelling types	• Varies – all types of residential settings	• All types – often a step down phase within care continuum of a treatment center • May be a more institutional in environment
	STAFF	• No paid positions within the residence • Perhaps an overseeing officer	• At least 1 compensated position	• Facility manager • Certified staff or case managers	• Credentialed staff

[47] *Id.*
[48] *Id.*
[49] *Id.*

FARR Recovery Residence Levels of Support

FARR recognizes four distinct support levels for recovery residences which were developed based on the NARR standards.[50] The levels are not a rating scale regarding the efficacy of valuation of any individual certified recovery residence, but instead offer a unique service structure most appropriate for a particular resident.[51] FARR recovery residence levels of support include:[52]

Level I
Level I residences are structured after the Oxford House model.[53] Individuals who enter FARR Level I homes have a high recovery capital with a minimum of nine months of sobriety and the length of stay is determined by the resident. Level I homes are democratically run by the members who reside in the home through a guided policy and procedure manual or charter.

Level II
Level II residences encompass the traditional perspective of sober living homes. Oversight is provided from a house manager with lived experience, typically a senior resident. Residents are expected to follow the rules outlined in the resident handbook, pay dues, and work on achieving milestones within a chosen recovery path. This level of support is a resident driven length of stay, while providers may suggest a minimum commitment length.

Level III
Level III residences offer higher supervision by staff with formal training to ensure resident accountability. Level III homes offer peer-support services and are staff 24 hours a day. No clinical services are performed at the residence. The services offered usually include life skills, mentoring, recovery planning, and meal preparation. This support structure is most appropriate for residents who require a more structured environment during early recovery from addiction. Length of stay is determined by the resident; however, providers may ask for a minimum commitment length of stay to fully complete programming.

Level IV
A Level IV residence is any recovery residence offered or provided by a licensed service provider that provides housing to patients who are required to reside at the residence while receiving intensive outpatient and higher levels of outpatient care at facilities that are operated by the same licensed service provider or a recovery residence used as the housing component of a day or night treatment with community housing, license issued pursuant to Rule 65D-40.0081, Florida Administrative Code.

[50] FARR, *Levels of Support*, available at https://www.farronline.org/levels-of-support-1 (last visited January 31, 2024).
[51] *Id.*
[52] *Id.*
[53] Oxford House Model is a concept and a system of operating in recovery from drug and alcohol addiction. The concept is that recovering individuals can live together and democratically run an alcohol and drug-free living environment which supports the recovery of every resident. Oxford Houses are one of the largest self-help residential programs in the U.S. *See* Oxford House, *The Purpose and Structure of Oxford House*, available at https://oxfordhouse.org/purpose_and_structure (last visited January 31, 2024) and the National Library of Medicine, *Oxford House Recovery Homes: Characteristics and Effectiveness*, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2888149/ (last visited January 31, 2024).

Opioids

Opioids are a class of medications derived from the opium plant or mimic its naturally occurring substances.[54] Opioids function by binding to specific receptors in the brain that are associated with pain sensation, including pain relief.[55] The opioid family includes several drugs, such as oxycodone, fentanyl, morphine, codeine, and heroin.[56] These drugs are effective at reducing pain; however, they can be highly addictive even when prescribed by a doctor. Over time, individuals who use opioids can develop a tolerance to the drug, a physical dependence on it, and ultimately, succumb to an opioid use disorder. This condition can have grave consequences, including a heightened risk of overdose and even death.

Opioid Overdose

Opioid overdoses result from an overabundance of opioid in the body which leads to suppression of the respiratory system. Opioids account for two thirds of all deaths relating to drug use, most of which are the result of overdoses.[57] More than 106,000 Americans died from drug-involved overdoses in 2021, illicit including illicit drugs and prescription opioids.[58] Opioid-involved overdose deaths increased from 21,088 in 2010 to 47,600 in 2017; the rate of such deaths remained relatively consistent for the next two years with 49,860 opioid-involved overdose deaths in 2019.[59] This was followed by a sharp increase in opioid-involved overdose deaths associated with the COVID-19 pandemic beginning in 2020.[60] Nationally, there were 63,630 reported opioid-involved overdose deaths in 2020 and 80,411 in 2021.[61]

Multistate Opioid Lawsuit and Settlement

In 2018, the Florida Attorney General filed a lawsuit against multiple opioid manufacturers and distributors. The lawsuit was alter expanded to include the pharmacies CVS and Walgreens.[62] The complaint alleged that the defendants caused the opioid crisis by, among other things:[63]

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[54] Johns Hopkins Medicine, *Opioids*, available at https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/opioids (last visited January 31, 2024).
[55] *Id.*
[56] *Id.*
[57] United Nations Office on Drugs and Crime, World Drug Report 2022, *Global Overview: Drug Demand and Drug Supply*, available at https://www.unodc.org/res/wdr2022/MS/WDR22_Booklet_1.pdf (last visited January 31, 2024).
[58] National Institute on Drug Abuse, *Drug Overdose Death Rates*, available at https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates (last visited January 31, 2024).
[59] *Id.*
[60] Ghose, R., Forati, A.M., & Mantsch, J.R., *Impact of the COVID-19 Pandemic on Opioid Overdose Deaths: A Spatiotemporal Analysis*, J Urban Health 99, 316-327 (2022), available at https://link.springer.com/article/10.1007/s11524-022-00610-0 (last visited January 31, 2024).
[61] *Supra*, note 66.
[62] NPR, *Florida Sues Walgreens, CVS for Alleged Role in Opioid Crisis*, available at https://www.npr.org/2018/11/19/669146432/florida-sues-walgreens-cvs-for-alleged-role-in-opioid-crisis (last visited January 31, 2024).
[63] Florida Attorney General, *Florida's Opioid Lawsuit*, available at https://legacy.myfloridalegal.com/webfiles.nsf/WF/MNOS-AYSNED/$file/Complaint%20summary.pdf (last visited January 31, 2024).

- Engaging in a campaign of misrepresentations and omissions about opioid use designed to increase opioid prescriptions and opioid use, despite the risks.
- Funding ostensibly neutral and independent "front" organizations to publish information touting the benefits of opioids for chronic pain while omitting the information about the risks of opioid treatment.
- Paying ostensibly neutral medical experts called "key opinion leaders" who were really manufacturer "mouthpieces" to public articles promoting the use of opioids to treat pain while omitting information regarding the risks.

In 2021, McKesson, Cardinal Health, and AmerisourceBergen, the nation's three largest pharmaceutical distributors, as well as manufacturer Janssen Pharmaceuticals, Inc., agreed to a national settlement in which the distributors agreed to pay $21 billion over 18 years and Janssen agreed to pay $5 billion over nine years.[64] Of the $26 billion available, approximately $22.7 billion was earmarked for use by states that participated in the lawsuit, including Florida.[65]

Florida additionally negotiated individual settlements with multiple other companies including[66]:

- $65 million settlement with Endo Health Solutions;
- $440 million settlement with CVS Pharmacy, Inc.;
- $177,114,999 settlement with Teva Pharmaceuticals Industries, Ltd.;
- $122 million settlement with Allergan Finance, LLC.;
- $620 million settlement with Walgreens Boots Alliance, Inc. and Walgreens, Co.; and
- $215 million settlement with Walmart.

Additionally, Teva Pharmaceuticals has agreed to provide the state with a supply of Naloxone Hydrochloride, an opioid antagonist[67], valued at $84 million.[68]

These settlements will pay out over a period of time ranging from 10 to 18 years. In general, the monies from the settlements must be used for opioid abatement, including prevention efforts, treatment, and recovery services, and to pay litigation fees and costs incurred by the state, cities, and counties.[69]

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[64] National Opioid Settlement, *Executive Summary of National Opioid Settlements*, available at https://nationalopioidsettlement.com/executive-summary/#:~:text=In%20all%2C%20the%20Distributors%20will,additional%20manufacturers%E2%80%94Allergan%20and%20Teva (last visited January 31, 2024).
[65] Office of the Attorney General, *Attorney General Moody Secures Relief for Opioid Crisis*, available at https://www.myfloridalegal.com/opioidsettlement (last visited January 31, 2024).
[66] *Id*.
[67] An opioid antagonist, such as Narcan or Naloxone Hydrochloride, is a drug that blocks the effects of exogenously administered opioids. They are used in opioid overdoses to counteract life-threatening depression of the central nervous system and respiratory system, allowing an overdose victim to breathe normally. *See* Harm Reduction Coalition, *Understanding Naloxone*, available at https://harmreduction.org/issues/overdose-prevention/overview/overdose-basics/understanding-naloxone/ (last visited January 31, 2024).
[68] Office of the Attorney General, *Attorney General Moody Secures Relief for Opioid Crisis*, available at https://www.myfloridalegal.com/opioidsettlement (last visited January 31, 2024).
[69] *Id*.

Florida Opioid Allocation and Statewide Response Agreement

To ensure the settlement proceeds are used to fund opioid and substance abuse education, treatment, prevention, and other related programs and services, the Office of the Attorney General coordinated with certain local governments in the state to enter into the Florida Opioid Allocation and Statewide Response Agreement.[70] The agreement requires the state to establish an opioid abatement task force or council to advise the Governor, the Legislature, DCF, and local governments on the priorities that should be addressed by the expenditure of settlement funds, as well as review the spending of such funds and the results achieved.

The council's membership, administration, and duties are outlined in the agreement.[71] Per the agreement, the Council's membership must consist of ten members equally balanced between state and local government representatives.

Appointments from the local governments must include:
- Two municipality representatives appointed by or through the Florida League of Cities.
- Two county representatives, one appointed from a qualified county and one appointed from a county within the state that is not a qualified county.
- One representative appointment that will alternate every two years between being a county representative appointed by or through the Florida Association of Counties or a municipality representative appointed by or through the Florida League of Cities.

Further, the agreement requires that one municipality representative must be from a city of less than 50,000 people and that one county representative must be from a county of less than 200,000 people and the other county representative must be from a county with a population greater than 200,000 people.

Appointments from the state must include:
- Two members appointed by the Governor.
- One member appointed by the Speaker of the House of Representatives.
- One member appointed by the President of the Senate.
- The Attorney General or a designee.

In 2023, the Florida Legislature established the Statewide Council on Opioid Abatement (hereinafter, "council"). The council is tasked with enhancing the development and coordination of state and local efforts to abate the opioid epidemic and to support the victims and families of the crisis.[72]

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[70] *Florida Opioid Allocation and Statewide Response Agreement Between State of Florida Department of Legal Affairs, Office of the Attorney General and Certain Local Governments in the State of Florida*, available at https://nationalopioidsettlement.com/wp-content/uploads/2021/11/FL-Opioid-AllocSW-Resp-Agreement.pdf (last visited January 31, 2024).
[71] *Id.*
[72] Section 397.335, F.S.

The council has a series of duties associated with the monitoring of the abatement of the opioid epidemic in Florida and a review of settlement fund expenditures associated with opioid litigation.[73]

Transient Rental Accommodations

Under current law, rental charges or room rates paid for the right to use or occupy living quarters or sleeping or housekeeping accommodations for a rental period of six months or less are subject to taxation.[74] Such rentals are often referred to as "transient rental accommodations" or "transient rentals."[75] Examples of transient rentals include hotel and motel rooms, condominium units, timeshare resort units, single-family homes, apartments or units in multiple unit structures, mobile homes, beach or vacation houses, campground sites, and trailer or RV parks.[76]

In Florida, a six percent sales tax, plus any applicable discretionary sales surtax, is assessed on the total rental charges or room rates for transient rental accommodations, unless a statutory exemption applies.[77] Counties may also impose a local option tax on transient rental accommodations, such as the tourist development tax[78], convention development tax[79], tourist impact tax[80], or a municipal resort tax.[81] These taxes are often called local option transient rental taxes and are in addition to the state sales tax.

Currently, transient rentals are potentially subject to the following taxes:

- Local Option Tourist Development Taxes: current law authorizes five separate tourist development taxes on transient rental transactions. Section 125.0104(3)(a), F.S., provides that the local option tourist development tax is levied on the "total consideration charged for such lease or rental."
    - The tourist development tax may be levied at the rate of one or two percent.82 Currently, 62 counties levy this tax at two percent; all 67 counties are eligible to levy this tax.83
    - An additional tourist development tax of one percent may be levied.84 Currently, 56 counties levy this tax; only 59 counties are currently eligible to levy this tax.85

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[73] *Id.*
[74] Section 212.03, F.S.
[75] Department of Revenue, Sales and Use Tax on Rental of Living or Sleeping Accommodations, available at https://floridarevenue.com/Forms_library/current/gt800034.pdf (last visited January 31, 2024).
[76] Section 212.03, F.S.
[77] Rental charges or room rates paid by a person with a written lease longer than six months, a full-time student enrolled in a postsecondary institution offering housing, and military personnel on active duty and present in the community under official orders are exempt. S. 212.03(4) and (7), F.S.
[78] Section 125.0104, F.S.
[79] Section 212.0305, F.S.
[80] Section 125.0101, F.S.
[81] Certain municipalities may impose a municipal resort tax as authorized under chapter 67-930, Laws of Florida. Currently, there are only three municipalities in Miami-Dade County that are eligible to impose the tax.
[82] Section 125.0104(3)(c), F.S.
[83] Florida Revenue Estimating Conference, *2023 Florida Tax Handbook*, available at http://edr.state.fl.us/Content/revenues/reports/tax-handbook/taxhandbook2023.pdf (last visited January 31, 2024).
[84] Section 125.0104(3)(d), F.S.
[85] *Supra*, note 91.

- A professional sports franchise facility tax may be levied up to an additional one percent on transient rental transactions.86 Currently, 46 counties levy this additional tax; all 67 counties are eligible to levy this tax.87
- A high tourism impact county may levy an additional one percent on transient rental transactions.88 Currently, 10 counties levy this tax; only 14 are eligible to levy.89
- An additional professional sports franchise facility tax no greater than one percent may be imposed by a county that has already levied the professional sports franchise facility tax.[90] Out of 65 eligible counties, 36 levy this tax.[91]

- **Local Option Tourist Impact Tax**: the local option tourist impact tax under s. 125.0108, F.S., is levied at the rate of one percent of the total consideration charged. Only Monroe County is eligible and does levy this tax in areas designated as areas of critical concern because they created a land authority pursuant to s. 380.0663(1), F.S.
- **Local Convention Development Tax**: the convention development tax under s. 212.0305, F.S., is imposed on the total consideration charged for the transient rental. Each county operating under a home rule charter, as defined in s. 125.011(1), F.S., may levy the tax at three percent (Miami-Dade County); each county operating under a consolidated government may levy the tax at two percent (Duval County); and each county chartered under Article VIII of the State Constitution that had a tourist advertising district on January 1, 1984, may levy the tax at up to three percent (Volusia County).[92] No county authorized to levy this tax can levy more than two percent of the tourist development tax, excluding the professional sports franchise facility tax.[93]
- **Municipal Resort Tax**: certain municipalities may levy the municipal resort tax at a rate of up to four percent on transient rental transactions. The tourist development tax may not be levied in any municipality imposing the municipal resort tax. The tax is collected by the municipality. Currently, only three municipalities in Miami-Dade County are eligible to impose the tax.
- **State Sales Tax**: the state sales tax on transient rentals under s. 212.03, F.S., is levied in the amount of six percent of the "total rental charged" for the living quarters or sleeping or housekeeping accommodations in, or part of, or in connection with, any hotel, apartment house, rooming house, or tourist or trailer camp.
- **Local Option Discretionary Sales Surtax**: counties have been granted limited authority to levy a discretionary sales surtax for specific purposes on transactions subject to state sales tax.[94] Rates range from 0.5% to 1.5% and are levied by 66 of the 67 counties.[95] Approved purchases include:
  - Operating a transportation system in a charter county;[96]

[86] Section 125.0104(3)(l), F.S.
[87] *Supra*, note 91.
[88] Section 125.0104(3)(m), F.S.
[89] *Supra*, note 91.
[90] Section 125.0104(3)(n), F.S.
[91] *Supra*, note 91.
[92] *Id.*
[93] Section 125.0104(3)(b), (3)(l)4., and (3)(n)2., F.S.
[94] Sections 212.054-055, F.S.
[95]Department of Revenue, *Discretionary Sales Surtax Information for Calendar Year 2024, Form DR-15DSS,* available at https://floridarevenue.com/Forms_library/current/dr15dss.pdf (last visited January 31, 2024).
[96] Section 212.055(1), F.S.

- Financing local government infrastructure projects;[97]
- Providing additional revenue for specified small counties;[98]
- Providing medical care for indigent persons;[99]
- Funding trauma centers;[100]
- Operating, maintaining, and administering a county public general hospital;[101]
- Constructing and renovating schools;[102]
- Providing emergency fire rescue services and facilities;[103] and
- Funding pension liability shortfalls.[104]

Certain rentals or leases are exempt from the taxes; these include rentals to active-duty military personnel, full-time students, bona fide written leases for continuous residence longer than six months, and accommodations in migrant labor camps.[105]

III. Effect of Proposed Changes:

Certified Recovery Residences

Section 2 of the bill amends the definition of "certified recovery residence" in s. 397.311, F.S., to include standards regarding the levels of care offered within those residences. This amendment will help to better align recovery residences in Florida with industry best practices. The levels of care are as follows:

- Level I: these homes house individuals in recovery who are post-treatment, with a minimum of nine months of sobriety. These homes are run by the members who reside in them.
- Level II: these homes have oversight from a house manager (typically, a senior resident). Residents are expected to follow rules outlined in a resident handbook, pay dues, and work toward achieving milestones.
- Level III: these homes offer 24-hour supervision by staff with formal training and peer-support services.
- Level IV: these homes are offered, referred, or provided to patients by licensed service providers. The patients receive intensive outpatient and higher levels of outpatient care. These homes are staffed 24 hours a day.

The bill also defines "community housing" to mean a certified recovery residence offered, referred to, or provided by a licensed service provider that provides housing to its patients who are required to reside at the residence while receiving intensive outpatient and higher levels of outpatient care. The bill also requires a certified recovery residence used by a licensed service

[97] Section 212.055(2), F.S.
[98] Section 212.055(3), F.S. Note that the small county surtax may be levied by extraordinary vote of the county governing board if the proceeds are to be expended only for operating purposes.
[99] Section 212.055(4)(a), F.S. (for counties with more than 800,000 residents); s. 212.055(7), F.S. (for counties with less than 800,000 residents).
[100] Section 212.055(4)(b), F.S.
[101] Section 212.055(5), F.S.
[102] Section 212.055(6), F.S.
[103] Section 212.055(8), F.S.
[104] Section 212.055(9), F.S.
[105] Section 212.03(7), F.S.; *see also* ss.125.0104(3)(a), 125.0108(1)(b), 212.0305(3)(a), F.S.

provider that meets the definition of community housing to be classified as a Level IV level of support.

Section 5 of the bill amends s. 397.487, F.S. to increase the amount of time a certified recovery residence has to retain a certified recovery residence administrator from 30 days to 90 days. The section also requires the recovery residence to retain another administrator within 90 days should the previous administrator, who had been approved to actively manage more than 50 residents pursuant to s. 397.4871(8)(b), be removed due to termination, resignation, or any other reason. Should the certified recovery residence not obtain another administrator within the time allowed, the bill requires the credentialing entity to revoke the residence's certificate of compliance.

The bill prohibits any recovery residence from denying an individual access to the residence solely on the basis the individual had been prescribed federally approved medication that assists with treatment for substance use disorders by a licensed physician, physician's assistant, or advanced practice registered nurse.

The bill also prohibits a local law, ordinance, or regulation from regulating the duration or frequency of a resident's stay at a certified recovery residence located within a multifamily zoning district. This provision does not apply to laws, ordinances, or regulations adopted on or before February 1, 2025.

Section 6 of the bill amends 397.4871, F.S., to allow an increase from 100 residents to 150 residents so long as the following applies:

- The certified recovery residence is a Level IV resident with a community housing component;
- The residence is actively managed by a certified recovery residence administrator, approved for 100 residents;
- The licensed service provider maintains a service provider personnel-to-patient ratio of 1 to 8; and
- Maintains onsite supervision at the residences 24 hours a day, 7 days a week, with a personnel-to-resident ratio of 1 to 10.

The section prohibits a certified recovery residence administrator who has been removed due to termination, resignation, or any other reason from continuing to actively manage more than 50 residents for another service provider or certified recovery residence without being approved by the credentialing entity.

Transient Rental Accommodations

Section 1 of the bill amends s. 212.02, F.S., to exempt recovery residences from any taxes that are imposed on transient accommodations, including transient rental taxes, convention development taxes, tourist development taxes, and tourist impact tax. This may reduce their operating costs.

Statewide Council on Opioid Abatement

Section 4 of the bill amends s. 397.335, F.S., to expand the Statewide Council on Opioid Abatement by adding more members, increasing its membership from 10 to 17. The additional members include:

- Two members appointed by or through the State Surgeon General. One of such members must be from the department with experience coordinating state and local efforts to abate the opioid epidemic; the other must be a licensed physician, board certified in both addiction medicine and psychiatry.
- One member appointed by the Florida Association of Recovery Residences.
- One member appointed by the Florida Association of EMS Medical Directors.
- One member appointed by the Florida Society of Addiction Medicine who is a medical doctor board certified in addiction medicine.
- One member appointed by the Florida Behavioral Health Association.
- One member appointed by Floridians for Recovery.

This will add additional members to represent the providers and clinicians providing behavioral health services, and will expand membership beyond those named in the agreement between the Attorney General and local governments, which included only state and local government representatives.

Other Changes

Section 3 of the bill amends s. 397.321, F.S., to require the DCF to make available, by January 1, 2025, on its website all documents in their Provider Licensure and Designations System pertaining licensure, including:

- Service provider applications for licensure and license renewal.
- Policies and procedures provided by an applicant for licensure or renewal.
- The name and location of each recovery residence in a referral relationship with a service provider/service provider applicant.
- All complaints pertaining to service providers, all investigative reports and findings, whether founded or unfounded.
- Fines assessed for violations.
- All reports or other documents pertaining to license suspensions or revocations.
- All inspection reports for service provider licenses and recovery residences.

Sections 5 and 6 of the bill are amended to make non-substantive style and language changes or conforming changes.

Section 7 of the bill provides for an effective date of July 1, 2024.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

Article VII, s. 18(b) of the Florida Constitution provides that, except upon the approval of each house of the Legislature by a two-thirds vote of the membership, the Legislature

may not enact, amend, or repeal any general law if the anticipated effect of doing so would be to reduce the authority that municipalities or counties have to raise revenue in the aggregate, as such authority existed on February 1, 1989. The mandates provision does not apply to this bill as it affects an optional exemption, rather than requiring the loss of ability to raise revenue.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill will have an indeterminate positive fiscal impact on recovery residences that will no longer be required to pay transient rental taxes. The elimination of the taxes may reduce operational costs for recovery residences.

C. Government Sector Impact:

This bill may have an indeterminate negative fiscal impact on some local governments who will no longer be able to levy local option transient rental taxes on recovery residences.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends ss. 212.02, 397.311, 397.321, 397.335, 397.487, and 397.4871 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

A bill to be entitled

An act relating to substance abuse treatment; amending s. 212.02, F.S.; eliminating certain tax liabilities imposed on certified recovery residences; amending s. 397.311, F.S.; providing the levels of care at certified recovery residences and their respective levels of care for residents; amending s. 397.321, F.S.; requiring the Department of Children and Families to display and make available on its website certain information pertaining to service providers and recovery residences by a specified date; requiring the department to display on its website certain documents pertaining to service providers; amending s. 397.335, F.S.; revising the membership of the Statewide Council on Opioid Abatement to include additional members; amending s. 397.487, F.S.; extending the deadline for certified recovery residences to retain a replacement for a certified recovery residence administrator who has been removed from his or her position; authorizing, rather than requiring, the credentialing entity to revoke the certificate of compliance if a certified recovery residence fails to meet specified standards; requiring certified recovery residences to remove certain individuals from their positions if they are arrested

and awaiting disposition for, are found guilty of, or enter a plea of guilty or nolo contendere to certain offenses, regardless if adjudication is withheld; requiring the certified recovery residence to retain a certified recovery residence administrator if the previous certified recovery residence administrator has been removed due to any reason; prohibiting certified recovery residences, on or after a specified date, from denying an individual access to housing solely for being prescribed federally approved medications from licensed health care professionals; prohibiting local laws, ordinances, or regulations adopted on or after a specified date from regulating the duration or frequency of a resident's stay in a certified recovery residence in certain zoning districts; providing applicability; amending s. 397.4871, F.S.; authorizing, rather than requiring, credentialing entities to revoke a certificate of compliance if a recovery residence fails to meet specified standards; authorizing certain Level IV certified recovery residences owned or controlled by a licensed service provider and managed by a certified recovery residence administrator approved for a specified number of residents to manage a specified greater number of residents, provided that certain

criteria are met; prohibiting a certified recovery residence administrator who has been removed by a certified recovery residence from taking on certain other management positions without approval from a credentialing entity; defines the term "community housing"; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (k) is added to subsection (10) of section 212.02, Florida Statutes, to read:

212.02 Definitions.—The following terms and phrases when used in this chapter have the meanings ascribed to them in this section, except where the context clearly indicates a different meaning:

(10) "Lease," "let," or "rental" means leasing or renting of living quarters or sleeping or housekeeping accommodations in hotels, apartment houses, roominghouses, tourist or trailer camps and real property, the same being defined as follows:

(k) For purposes of this chapter, recovery residences certified pursuant to s. 397.487 which rent properties are not subject to any taxes imposed on transient accommodations, including taxes imposed under s. 212.03; any locally imposed discretionary sales surtax or any convention development tax imposed under s. 212.0305; any tourist development tax imposed

under s. 125.0104; or any tourist impact tax imposed under s. 125.0108.

Section 2. Subsection (5) of section 397.311, Florida Statutes, is amended to read:

397.311 Definitions.—As used in this chapter, except part VIII, the term:

(5) "Certified recovery residence" means a recovery residence that holds a valid certificate of compliance and is actively managed by a certified recovery residence administrator. The levels of care within a certified recovery residence are as follows:

(a) Level I recovery residences that house individuals in recovery who are post-treatment, with a minimum of 9 months of sobriety. Level I certified homes are democratically run by the members who reside in the home.

(b) Level II recovery residences encompass the traditional perspectives of sober living homes. There is oversight from a house manager with lived experience, typically a senior resident. Residents are expected to follow rules outlined in a resident handbook, pay dues, if applicable, and work toward achieving milestones within a chosen recovery path.

(c) Level III recovery residences offer higher supervision by staff with formal training to ensure resident accountability. These homes offer peer-support services and are staffed 24 hours a day. Clinical services are not performed at the residence. The

services offered may include, but are not limited to, life skill mentoring, recovery planning, and meal preparation. This support structure is most appropriate for residents who require a more structured environment during early recovery from addiction.

(d) A Level IV certified recovery residence are dwellings offered, referred to, or provided by, a licensed service provider to its patients who are required to reside at the residence while receiving intensive outpatient and higher levels of outpatient care. Level IV recovery residences are staffed 24 hours a day and combine outpatient licensable services with recovery residential living. Residents are required to follow a treatment plan, attend group and individual sessions, in addition to developing a recovery plan within the social model of recovery spectrum. No clinical services are provided at the residence and all licensable services are provided off-site.

Section 3. Subsection (20) is added to section 397.321, Florida Statutes, to read:

397.321 Duties of the department.—The department shall:

(20) Prominently display and make available on its website no later than January 1, 2025, all documents in the department's Provider Licensure and Designations System pertaining to the following:

(a) Service provider applications for licensure and license renewal.

(b) Policies and procedures provided by the department to

an applicant for service provider licensure or license renewal.

(c) The name and location of each recovery residence engaged in a referral relationship with a licensed service provider or service provider applicant, as required under ss. 397.4104 and 397.403(1)(j).

(d) All complaints pertaining to service providers received by the department, and all investigative reports and findings, whether founded or unfounded. Complainant names and other identifying information shall be redacted.

(e) Fines assessed for violations pursuant to ss. 397.411(7), 397.4104(2), and 397.4873(7).

(f) All reports or other documentation pertaining to service provider license suspension or revocation.

(g) All inspection reports for service provider licenses and recovery residences.

Section 4. Paragraph (a) of subsection (2) of section 397.335, Florida Statutes, is amended to read:

397.335 Statewide Council on Opioid Abatement.—

(2) MEMBERSHIP.—

(a) Notwithstanding s. 20.052, the council shall be composed of the following members:

1. The Attorney General, or his or her designee, who shall serve as chair.

2. The secretary of the department, or his or her designee, who shall serve as vice chair.

3. One member appointed by the Governor.

4. One member appointed by the President of the Senate.

5. One member appointed by the Speaker of the House of Representatives.

6. Two members appointed by the Florida League of Cities who are commissioners or mayors of municipalities. One member shall be from a municipality with a population of fewer than 50,000 people.

7. Two members appointed by or through the Florida Association of Counties who are county commissioners or mayors. One member shall be appointed from a county with a population of fewer than 200,000, and one member shall be appointed from a county with a population of more than 200,000.

8. One member who is either a county commissioner or county mayor appointed by the Florida Association of Counties or who is a commissioner or mayor of a municipality appointed by the Florida League of Cities. The Florida Association of Counties shall appoint such member for the initial term, and future appointments must alternate between a member appointed by the Florida League of Cities and a member appointed by the Florida Association of Counties.

9. Two members appointed by or through the State Surgeon General. One shall be a staff member from the department who has experience coordinating state and local efforts to abate the opioid epidemic, and one shall be a licensed physician who is

board certified in both addiction medicine and psychiatry.

10. One member appointed by the Florida Association of Recovery Residences.

11. One member appointed by the Florida Association of EMS Medical Directors.

12. One member appointed by the Florida Society of Addiction Medicine who is a medical doctor board certified in addiction medicine.

13. One member appointed by the Florida Behavioral Health Association.

14. One member appointed by Floridians for Recovery.

15. One member appointed by the Florida Certification Board.

Section 5. Present paragraphs (c), (d), and (e) of subsection (8) of section 397.487, Florida Statutes, are redesignated as subsections (d), (e), and (f), respectively, and amended, a new paragraph (c) is added to that subsection, subsections (13) and (14) are added to that section, and paragraph (b) of subsection (8) of that section is amended, to read:

397.487 Voluntary certification of recovery residences.—

(8) Onsite followup monitoring of a certified recovery residence may be conducted by the credentialing entity to determine continuing compliance with certification requirements. The credentialing entity shall inspect each certified recovery

residence at least annually to ensure compliance.

(b) A certified recovery residence must notify the credentialing entity within 3 business days after the removal of the recovery residence's certified recovery residence administrator due to termination, resignation, or any other reason. The certified recovery residence has 90 ~~30~~ days to retain a certified recovery residence administrator. The credentialing entity shall revoke the certificate of compliance of any certified recovery residence that fails to comply with this paragraph.

(c) If a certified recovery residence's administrator has been removed due to termination, resignation, or any other reason and had been previously approved to actively manage more than 50 residents pursuant to s. 397.4871(8)(b), the certified recovery residence has 90 days to retain another certified recovery residence administrator pursuant to that section. The credentialing entity shall revoke the certificate of compliance of any certified recovery residence that fails to comply with this paragraph.

(d) ~~(c)~~ If any owner, director, or chief financial officer of a certified recovery residence is arrested and awaiting disposition for or found guilty of, or enters a plea of guilty or nolo contendere to, regardless of whether adjudication is withheld, any offense listed in s. 435.04(2) while acting in that capacity, the certified recovery residence must ~~shall~~

immediately remove the person from that position and ~~shall~~ notify the credentialing entity within 3 business days after such removal. The credentialing entity shall revoke the certificate of compliance of a certified recovery residence that fails to meet these requirements.

(e)~~(d)~~ A credentialing entity shall revoke a certified recovery residence's certificate of compliance if the certified recovery residence provides false or misleading information to the credentialing entity at any time.

(f)~~(e)~~ Any decision by a department-recognized credentialing entity to deny, revoke, or suspend a certification, or otherwise impose sanctions on a certified recovery residence, is reviewable by the department. Upon receiving an adverse determination, the certified recovery residence may request an administrative hearing pursuant to ss. 120.569 and 120.57(1) within 30 days after completing any appeals process offered by the credentialing entity or the department, as applicable.

(13) Effective January 1, 2025, a recovery residence may not deny an individual access to housing solely on the basis that he or she has been prescribed federally approved medication that assists with treatment for substance use disorders by a licensed physician, a physician's assistant, or an advanced practice registered nurse registered under s. 464.0123.

(14) A local law, ordinance, or regulation may not

regulate the duration or frequency of a resident's stay in a certified recovery residence located within a multifamily zoning district. This subsection does not apply to any local law, ordinance, or regulation adopted on or before February 1, 2024.

Section 6. Paragraphs (b) and (c) of subsection (6) of section 397.4871, Florida Statutes, are amended, and paragraph (c) is added to subsection (8) of that section, to read:

397.4871 Recovery residence administrator certification.—

(6) The credentialing entity shall issue a certificate of compliance upon approval of a person's application. The certification shall automatically terminate 1 year after issuance if not renewed.

(b) If a certified recovery residence administrator of a recovery residence is arrested and awaiting disposition for or found guilty of, or enters a plea of guilty or nolo contendere to, regardless of whether adjudication is withheld, any offense listed in s. 435.04(2) while acting in that capacity, the certified recovery residence must ~~shall~~ immediately remove the person from that position and ~~shall~~ notify the credentialing entity within 3 business days after such removal. The certified recovery residence shall ~~have 30 days to~~ retain a certified recovery residence administrator within 90 days after such removal. The credentialing entity shall revoke the certificate of compliance of any recovery residence that fails to meet these requirements.

(c) A credentialing entity may ~~shall~~ revoke a certified recovery residence administrator's certificate of compliance if the recovery residence administrator provides false or misleading information to the credentialing entity at any time.

(8)

(c) Notwithstanding paragraph (b), a Level IV certified recovery residence with a community housing component, which residence is actively managed by a certified recovery residence administrator approved for 100 residents under this section and is wholly owned or controlled by a licensed service provider, may actively manage up to 150 residents so long as the licensed service provider maintains a service provider personnel-to-patient ratio of 1 to 8 and maintains onsite supervision at the residences 24 hours a day, 7 days a week, with a personnel-to-resident ratio of 1 to 10. A certified recovery residence administrator who has been removed by a certified recovery residence due to termination, resignation, or any other reason may not continue to actively manage more than 50 residents for another service provider or certified recovery residence without being approved by the credentialing entity. For purposes of this paragraph, the term "community housing" means a certified recovery residence offered, referred to, or provided by, a licensed service provider that provides housing to its patients who are required to reside at the residence while receiving intensive outpatient and higher levels of outpatient care. A

certified recovery residence as defined in s. 397.311(5) used by a licensed service provider that meets the definition of community housing shall be classified as a Level IV level of support,.

Section 7. This act shall take effect July 1, 2024.

By Senator Harrell

31-00370C-24 20241180__

A bill to be entitled

An act relating to substance abuse treatment; amending s. 212.02, F.S.; eliminating certain tax liabilities imposed on certified recovery residences; amending s. 397.311, F.S.; providing the levels of care at certified recovery residences and their respective levels of care for residents; defining the term "community housing"; amending s. 397.321, F.S.; requiring the Department of Children and Families to display and make available on its website certain information pertaining to service providers and recovery residences by a specified date; requiring the department to display on its website certain documents pertaining to service providers; amending s. 397.335, F.S.; revising the membership of the Statewide Council on Opioid Abatement to include additional members; amending s. 397.487, F.S.; extending the deadline for certified recovery residences to retain a replacement for a certified recovery residence administrator who has been removed from his or her position; requiring certified recovery residences to remove certain individuals from their positions if they are arrested and awaiting disposition for, are found guilty of, or enter a plea of guilty or nolo contendere to certain offenses, regardless if adjudication is withheld; requiring the certified recovery residence to retain a certified recovery residence administrator if the previous certified recovery residence administrator has been removed due to any reason; conforming

provisions to changes made by the act; prohibiting certified recovery residences, on or after a specified date, from denying an individual access to housing solely for being prescribed federally approved medications from licensed health care professionals; prohibiting local laws, ordinances, or regulations adopted on or after a specified date from regulating the duration or frequency of a resident's stay in a certified recovery residence in certain zoning districts; providing applicability; amending s. 397.4871, F.S.; conforming provisions to changes made by the act; authorizing certain Level IV certified recovery residences owned or controlled by a licensed service provider and managed by a certified recovery residence administrator approved for a specified number of residents to manage a specified greater number of residents, provided that certain criteria are met; prohibiting a certified recovery residence administrator who has been removed by a certified recovery residence from taking on certain other management positions without approval from a credentialing entity; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (k) is added to subsection (10) of section 212.02, Florida Statutes, to read:

212.02 Definitions.—The following terms and phrases when used in this chapter have the meanings ascribed to them in this

section, except where the context clearly indicates a different meaning:

(10) "Lease," "let," or "rental" means leasing or renting of living quarters or sleeping or housekeeping accommodations in hotels, apartment houses, roominghouses, tourist or trailer camps and real property, the same being defined as follows:

(k) For purposes of this chapter, recovery residences certified pursuant to s. 397.487 which rent properties are not subject to any taxes imposed on transient accommodations, including taxes imposed under s. 212.03; any locally imposed discretionary sales surtax or any convention development tax imposed under s. 212.0305; any tourist development tax imposed under s. 125.0104; or any tourist impact tax imposed under s. 125.0108.

Section 2. Present subsections (9) through (50) of section 397.311, Florida Statutes, are redesignated as subsections (10) through (51), respectively, a new subsection (9) is added to that section, and subsection (5) of that section is amended, to read:

397.311 Definitions.—As used in this chapter, except part VIII, the term:

(5) "Certified recovery residence" means a recovery residence that holds a valid certificate of compliance and is actively managed by a certified recovery residence administrator.

(a) A Level I certified recovery residence houses individuals in recovery who have completed treatment, with a minimum of 9 months of sobriety. A Level I certified recovery residence is democratically run by the members who reside in the

home.

(b) A Level II certified recovery residence encompasses the traditional perspectives of sober living homes. There is oversight from a house manager who has experience with living in recovery. Residents are expected to follow rules outlined in a resident handbook, which is provided by the certified recovery residence administrator. Residents must pay dues, if applicable, and work toward achieving realistic and defined milestones within a chosen recovery path.

(c) A Level III certified recovery residence offers higher supervision by staff with formal training to ensure resident accountability. Such residences are staffed 24 hours a day, 7 days a week, and offer residents peer-support services, which may include, but are not limited to, life skill mentoring, recovery planning, and meal preparation. No clinical services are performed at the residence. Such residences are most appropriate for persons who require a more structured environment during early recovery from addiction.

(d) A Level IV certified recovery residence is a residence offered, referred to, or provided by, a licensed service provider to its patients who are required to reside at the residence while receiving intensive outpatient and higher levels of outpatient care. Such residences are staffed 24 hours a day and combine outpatient licensable services with recovery residential living. Residents are required to follow a treatment plan and attend group and individual sessions, in addition to developing a recovery plan within the social model of living a sober lifestyle. No clinical services are provided at the residence, and all licensable services are provided off-site.

(9) "Community housing" means a certified recovery residence offered, referred to, or provided by a licensed service provider that provides housing to its patients who are required to reside at the residence while receiving intensive outpatient and higher levels of outpatient care. A certified recovery residence used by a licensed service provider that meets the definition of community housing shall be classified as a Level IV level of support, as described in subsection (5).

Section 3. Subsection (20) is added to section 397.321, Florida Statutes, to read:

397.321 Duties of the department.—The department shall:

(20) Prominently display and make available on its website no later than January 1, 2025, all documents in the department's Provider Licensure and Designations System pertaining to the following:

(a) Service provider applications for licensure and license renewal.

(b) Policies and procedures provided to the department by an applicant for service provider licensure or license renewal.

(c) The name and location of each recovery residence engaged in a referral relationship with a licensed service provider or service provider applicant, as required under ss. 397.4104 and 397.403(1)(j).

(d) All complaints pertaining to service providers received by the department, and all investigative reports and findings, whether founded or unfounded. Complainant names and other identifying information shall be redacted.

(e) Fines assessed for violations pursuant to ss. 397.411(7), 397.4104(2), and 397.4873(7).

(f) All reports or other documentation pertaining to service provider license suspension or revocation.

(g) All inspection reports for service provider licenses and recovery residences.

Section 4. Paragraph (a) of subsection (2) of section 397.335, Florida Statutes, is amended to read:

397.335 Statewide Council on Opioid Abatement.—

(2) MEMBERSHIP.—

(a) Notwithstanding s. 20.052, the council shall be composed of the following members:

1. The Attorney General, or his or her designee, who shall serve as chair.

2. The secretary of the department, or his or her designee, who shall serve as vice chair.

3. One member appointed by the Governor.

4. One member appointed by the President of the Senate.

5. One member appointed by the Speaker of the House of Representatives.

6. Two members appointed by the Florida League of Cities who are commissioners or mayors of municipalities. One member shall be from a municipality with a population of fewer than 50,000 people.

7. Two members appointed by or through the Florida Association of Counties who are county commissioners or mayors. One member shall be appointed from a county with a population of fewer than 200,000, and one member shall be appointed from a county with a population of more than 200,000.

8. One member who is either a county commissioner or county mayor appointed by the Florida Association of Counties or who is

a commissioner or mayor of a municipality appointed by the Florida League of Cities. The Florida Association of Counties shall appoint such member for the initial term, and future appointments must alternate between a member appointed by the Florida League of Cities and a member appointed by the Florida Association of Counties.

9. Two members appointed by or through the State Surgeon General. One shall be a staff member from the department who has experience coordinating state and local efforts to abate the opioid epidemic, and one shall be a licensed physician who is board certified in both addiction medicine and psychiatry.

10. One member appointed by the Florida Association of Recovery Residences.

11. One member appointed by the Florida Association of EMS Medical Directors.

12. One member appointed by the Florida Society of Addiction Medicine who is a medical doctor board certified in addiction medicine.

13. One member appointed by the Florida Behavioral Health Association.

14. One member appointed by Floridians for Recovery.

Section 5. Present paragraphs (c), (d), and (e) of subsection (8) of section 397.487, Florida Statutes, are redesignated as paragraphs (d), (e), and (f), respectively, a new paragraph (c) is added to that subsection, subsections (13) and (14) are added to that section, and paragraphs (b) and present paragraphs (c), (d), and (e) of subsection (8) of that section are amended, to read:

397.487 Voluntary certification of recovery residences.—

(8) Onsite followup monitoring of a certified recovery residence may be conducted by the credentialing entity to determine continuing compliance with certification requirements. The credentialing entity shall inspect each certified recovery residence at least annually to ensure compliance.

(b) A certified recovery residence must notify the credentialing entity within 3 business days after the removal of the recovery residence's certified recovery residence administrator due to termination, resignation, or any other reason. The certified recovery residence has 90 ~~30~~ days to retain a certified recovery residence administrator. The credentialing entity shall revoke the certificate of compliance of any certified recovery residence that fails to comply with this paragraph.

(c) If a certified recovery residence's administrator has been removed due to termination, resignation, or any other reason and had been previously approved to actively manage more than 50 residents pursuant to s. 397.4871(8)(b), the certified recovery residence has 90 days to retain another certified recovery residence administrator pursuant to that section. The credentialing entity shall revoke the certificate of compliance of any certified recovery residence that fails to comply with this paragraph.

(d) ~~(c)~~ If any owner, director, or chief financial officer of a certified recovery residence is arrested and awaiting disposition for or found guilty of, or enters a plea of guilty or nolo contendere to, regardless of whether adjudication is withheld, any offense listed in s. 435.04(2) while acting in that capacity, the certified recovery residence must ~~shall~~

immediately remove the person from that position and ~~shall~~ notify the credentialing entity within 3 business days after such removal. The credentialing entity may ~~shall~~ revoke the certificate of compliance of a certified recovery residence that fails to meet these requirements.

(e)~~(d)~~ A credentialing entity shall revoke a certified recovery residence's certificate of compliance if the certified recovery residence provides false or misleading information to the credentialing entity at any time.

(f)~~(e)~~ Any decision by a department-recognized credentialing entity to deny, revoke, or suspend a certification, or otherwise impose sanctions on a certified recovery residence, is reviewable by the department. Upon receiving an adverse determination, the certified recovery residence may request an administrative hearing pursuant to ss. 120.569 and 120.57(1) within 30 days after completing any appeals process offered by the credentialing entity or the department, as applicable.

(13) On or after January 1, 2025, a recovery residence may not deny an individual access to housing solely on the basis that he or she has been prescribed federally approved medication that assists with treatment for substance use disorders by a licensed physician, a physician's assistant, or an advanced practice registered nurse registered under s. 464.0123.

(14) A local law, ordinance, or regulation may not regulate the duration or frequency of a resident's stay in a certified recovery residence located within a multifamily zoning district. This subsection does not apply to any local law, ordinance, or regulation adopted on or before February 1, 2025.

Section 6. Paragraphs (b) and (c) of subsection (6) of section 397.4871, Florida Statutes, are amended, and paragraph (c) is added to subsection (8) of that section, to read:

397.4871 Recovery residence administrator certification.—

(6) The credentialing entity shall issue a certificate of compliance upon approval of a person's application. The certification shall automatically terminate 1 year after issuance if not renewed.

(b) If a certified recovery residence administrator of a recovery residence is arrested and awaiting disposition for or found guilty of, or enters a plea of guilty or nolo contendere to, regardless of whether adjudication is withheld, any offense listed in s. 435.04(2) while acting in that capacity, the certified recovery residence must ~~shall~~ immediately remove the person from that position and ~~shall~~ notify the credentialing entity within 3 business days after such removal. The certified recovery residence shall ~~have 30 days to~~ retain a certified recovery residence administrator within 90 days after such removal. The credentialing entity shall revoke the certificate of compliance of any recovery residence that fails to meet these requirements.

(c) A credentialing entity shall revoke a certified recovery residence administrator's certificate of compliance if the recovery residence administrator provides false or misleading information to the credentialing entity at any time.

(8)

(c) Notwithstanding paragraph (b), a Level IV certified recovery residence with a community housing component, which residence is actively managed by a certified recovery residence

administrator approved for 100 residents under this section and is wholly owned or controlled by a licensed service provider, may actively manage up to 150 residents so long as the licensed service provider maintains a service provider personnel-to-patient ratio of 1 to 8 and maintains onsite supervision at the residences 24 hours a day, 7 days a week, with a personnel-to-resident ratio of 1 to 10. A certified recovery residence administrator who has been removed by a certified recovery residence due to termination, resignation, or any other reason may not continue to actively manage more than 50 residents for another service provider or certified recovery residence without being approved by the credentialing entity.

Section 7. This act shall take effect July 1, 2024.

Amendments to Senate bill 1180

Section 3, delete lines 125-149 (pertaining to s. 397.321(20): Duties of the department)

Section 4, add the following starting at line 196

15. One member appointed by the Florida Certification Board.

16. One member appointed by the Florida Association of Managing Entities

Section 6, line 289, strike the words "with a community housing component" and replace with "operating as community housing as defined in s. 397.311(9)"

Section 5, s. 397.487, delete lines 218 – 226 (subsection (c))

A bill to be entitled

An act relating to substance use disorder treatment services; creating s. 397.342, F.S.; creating the Substance Use Disorder Housing Advisory Council; providing legislative findings and intent; providing for membership; requiring the University of South Florida College of Public Health to assist the advisory council in conducting a study to evaluate national best practice standards for specified purposes; providing for funding of the study; requiring the advisory council to conduct a review of statewide zoning codes for specified purposes; providing for reports by specified dates; providing for future repeal; amending s. 397.305, F.S.; revising and providing legislative findings and intent; authorizing addiction treatment services to be provided through for-profit providers; amending s. 397.487, F.S.; providing that the certification of recovery residences that meet specified standards protects certain persons; requiring certain recovery residences to keep specified records confidential; prohibiting a local law, ordinance, or regulation from regulating the duration or frequency of resident stay at certain recovery residences; providing applicability; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 397.342, Florida Statutes, is created to read:

397.342 Substance Use Disorder Housing Advisory Council.—

(1) The Substance Use Disorder Housing Advisory Council, an advisory council as defined in s. 20.03(7), is created within the department.

(a) The Legislature finds that the state has a legitimate interest in protecting persons in recovery residences by requiring such homes to meet national best practice standards.

(b) The Legislature intends for this advisory council to ensure state standards for recovery residences conform to national best practice standards to the greatest extent possible and to study local governmental obstructions to achieving these national best practice standards through zoning regulations.

(2) Except as otherwise provided in this section, the advisory council shall operate in accordance with s. 20.052.

(3) The advisory council shall be composed of seven members, to be appointed for staggered terms of not more than 4 years, as follows:

(a) A representative of the Executive Office of the Governor, appointed by the Governor.

(b) A member of the Senate, appointed by the President of

the Senate.

(c) A member of the House of Representatives, appointed by the Speaker of the House of Representatives.

(d) A representative from the department, appointed by the Governor.

(e) A representative from the Agency for Health Care Administration, appointed by the Governor.

(f) A representative of the Florida Association of Recovery Residences, appointed by the Governor.

(g) A representative of the Palm Beach County State Attorney Addiction Recovery Task Force, appointed by the Governor.

(4) The advisory council shall appoint a chair and vice chair from the members of the council and shall meet at least monthly.

(5) Members of the advisory council shall serve without compensation, but shall be entitled to necessary expenses incurred in the discharge of their duties.

(6)(a) The University of South Florida College of Public Health shall assist the advisory council in conducting a study to evaluate the national best practice standards from the Substance Abuse and Mental Health Services Administration, with the goal of removing obstacles to therapeutic housing within this state to be in compliance with the Americans with Disabilities Act of 1990, as amended, 42 U.S.C. ss. 12101 et

seq., and the Fair Housing Amendments Act of 1988. Costs of implementing the study shall be paid by the department from funds appropriated for this purpose.

(b) The advisory council shall also conduct a review of statewide zoning codes to determine what effect, if any, local laws have on the ability of private sector licensed service providers to provide modern, evidence-based, effective treatment and ancillary therapeutic housing to persons in this state.

(c) By June 1, 2027, the department, in conjunction with the Agency for Health Care Administration, shall provide a preliminary report based upon the findings and recommendations of the advisory council to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

(d) By September 1, 2027, the advisory council shall provide a final report based upon the findings and recommendations of the advisory council to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

(7) This section is repealed September 1, 2027, unless reviewed and saved from repeal by the Legislature.

Section 2. Section 397.305, Florida Statutes, is amended to read:

397.305 Legislative findings, intent, and purpose.—

(1)(a) Addiction ~~Substance abuse~~ is a major health problem that affects multiple service systems and leads to such

profoundly disturbing consequences as serious impairment, chronic addiction, criminal behavior, vehicular casualties, spiraling health care costs, AIDS, and business losses, and significantly affects the culture, socialization, and learning ability of children within our schools and educational systems. Addiction ~~Substance abuse impairment~~ is a disease which affects the whole family and the whole society and requires a system of care that includes prevention, intervention, clinical treatment, and recovery support services, including recovery residences, that support and strengthen the family unit. Further, it is the intent of the Legislature to require the collaboration of state agencies, service systems, and program offices to achieve the goals of this chapter and address the needs of the public; to establish a comprehensive system of care for substance use disorder ~~abuse~~; and to reduce duplicative requirements across state agencies. This chapter is designed to provide for public and private substance use disorder treatment ~~abuse~~ services.

(b) The Legislature finds that addiction treatment services are a fully integrated part of the private and public health care system. Further, the Legislature finds that service providers licensed under this chapter and community housing certified under this chapter are deemed a necessary part of the private and public health care system. The Legislature intends to identify and remove barriers that prevent coordinated health care between medical and clinical providers to persons with

substance use disorders.

(2) It is the goal of the Legislature to educate the public about the negative consequences of ~~discourage~~ substance use disorders ~~abuse~~ by promoting healthy lifestyles; healthy families; and drug-free schools, workplaces, and communities.

(3) It is the purpose of this chapter to provide for a comprehensive continuum of accessible and quality addiction ~~substance abuse~~ prevention, intervention, clinical treatment, and recovery support services in the least restrictive environment which promotes long-term recovery while protecting and respecting the rights of individuals~~, primarily~~ through for-profit providers and community-based ~~private~~ not-for-profit providers working with local governmental programs involving a wide range of agencies from both the public and private sectors.

(4) It is the intent of the Legislature that licensed, qualified health professionals be authorized to practice to the full extent of their education and training in the performance of professional functions necessary to carry out the intent of this chapter.

(5) It is the intent of the Legislature to establish expectations that services provided to persons in this state use national best practice standards and the coordination-of-care principles characteristic of recovery-oriented services and include social support services, such as housing support, life skills and vocational training, and employment assistance

necessary for persons who have substance use disorders or co-occurring substance use and mental health disorders to live successfully in their communities.

(6) It is the intent of the Legislature to ensure within available resources a full system of care for substance use disorder treatment ~~abuse~~ services based on identified needs, delivered without discrimination and with adequate provision for specialized needs.

(7) It is the intent of the Legislature to establish services for persons who have ~~individuals with~~ co-occurring substance use ~~abuse~~ and mental health disorders.

(8) It is the intent of the Legislature to provide an alternative to criminal imprisonment for substance ~~abuse~~ impaired adults and juvenile offenders by encouraging the referral of such offenders to service providers not generally available within the juvenile justice and correctional systems, instead of or in addition to criminal penalties.

(9) It is the intent of the Legislature to provide, within the limits of appropriations and safe management of the juvenile justice and correctional systems, addiction treatment ~~substance abuse~~ services to substance ~~abuse~~ impaired offenders who are placed by the Department of Juvenile Justice or who are incarcerated within the Department of Corrections, in order to better enable these offenders or inmates to adjust to the conditions of society presented to them when their terms of

placement or incarceration end.

(10) It is the intent of the Legislature to provide for assisting substance ~~abuse~~ impaired persons primarily through health and other rehabilitative services in order to relieve the police, courts, correctional institutions, and other criminal justice agencies of a burden that interferes with their ability to protect people, apprehend offenders, and maintain safe and orderly communities.

(11) It is the intent of the Legislature that the freedom of religion of all citizens shall be inviolate. ~~Nothing in~~ This act does not ~~shall~~ give any governmental entity jurisdiction to regulate religious, spiritual, or ecclesiastical services.

Section 3. Subsection (1) of section 397.487, Florida Statutes, is amended, and subsections (13) and (14) are added to that section, to read:

397.487 Voluntary certification of recovery residences.—

(1) The Legislature finds that a person suffering from addiction has a higher success rate of achieving long-lasting sobriety when given the opportunity to build a stronger foundation by living in a recovery residence while receiving treatment or after completing treatment. The Legislature further finds that this state and its subdivisions have a legitimate state interest in protecting these persons, who represent a vulnerable consumer population in need of adequate housing, through the certification of recovery residences that meet

national best practice standards. It is the intent of the Legislature to protect persons who reside in a recovery residence.

(13) A recovery residence classified by the credentialing entity as a Level IV residence shall be governed by s. 397.501(7) regarding the right to confidentiality of individual records.

(14) A local law, ordinance, or regulation may not regulate the duration or frequency of resident stay in a certified recovery residence in areas where multifamily uses are allowed. This subsection does not apply to any local law, ordinance, or regulation adopted on or before January 1, 2024.

Section 4. This act shall take effect July 1, 2024.

667440

LEGISLATIVE ACTION

Senate . House

. . . . .

The Committee on Children, Families, and Elder Affairs (Rouson) recommended the following:

Senate Amendment

Delete lines 45 - 62
and insert:
(3) The advisory council shall be composed of the following members, to be appointed for staggered terms of not more than 4 years, as follows:
(a) A representative of the Executive Office of the Governor, appointed by the Governor.
(b) A member of the Senate and a representative of the

667440

Florida Association of Managing Entities, appointed by the President of the Senate.

(c) A member of the House of Representatives and a representative of the Florida Association of Managing Entities, appointed by the Speaker of the House of Representatives.

(d) A representative from the department, appointed by the Governor.

(e) A representative from the Agency for Health Care Administration, appointed by the Governor.

(f) A representative of the Florida Association of Recovery Residences, appointed by the Governor.

(g) A representative of the Palm Beach County State Attorney Addiction Recovery Task Force, appointed by the Governor.

By Senator Gruters

22-01411-24 20241636__

A bill to be entitled

An act relating to substance use disorder treatment services; creating s. 397.342, F.S.; creating the Substance Use Disorder Housing Advisory Council; providing legislative findings and intent; providing for membership; requiring the University of South Florida College of Public Health to assist the advisory council in conducting a study to evaluate national best practice standards for specified purposes; providing for funding of the study; requiring the advisory council to conduct a review of statewide zoning codes for specified purposes; providing for reports by specified dates; providing for future repeal; amending s. 397.305, F.S.; revising and providing legislative findings and intent; authorizing addiction treatment services to be provided through for-profit providers; amending s. 397.487, F.S.; providing that the certification of recovery residences that meet specified standards protects certain persons; requiring certain recovery residences to keep specified records confidential; prohibiting a local law, ordinance, or regulation from regulating the duration or frequency of resident stay at certain recovery residences; providing applicability; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 397.342, Florida Statutes, is created to

read:

397.342 Substance Use Disorder Housing Advisory Council.—

(1) The Substance Use Disorder Housing Advisory Council, an advisory council as defined in s. 20.03(7), is created within the department.

(a) The Legislature finds that the state has a legitimate interest in protecting persons in recovery residences by requiring such homes to meet national best practice standards.

(b) The Legislature intends for this advisory council to ensure state standards for recovery residences conform to national best practice standards to the greatest extent possible and to study local governmental obstructions to achieving these national best practice standards through zoning regulations.

(2) Except as otherwise provided in this section, the advisory council shall operate in accordance with s. 20.052.

(3) The advisory council shall be composed of seven members, to be appointed for staggered terms of not more than 4 years, as follows:

(a) A representative of the Executive Office of the Governor, appointed by the Governor.

(b) A member of the Senate, appointed by the President of the Senate.

(c) A member of the House of Representatives, appointed by the Speaker of the House of Representatives.

(d) A representative from the department, appointed by the Governor.

(e) A representative from the Agency for Health Care Administration, appointed by the Governor.

(f) A representative of the Florida Association of Recovery

Residences, appointed by the Governor.

(g) A representative of the Palm Beach County State Attorney Addiction Recovery Task Force, appointed by the Governor.

(4) The advisory council shall appoint a chair and vice chair from the members of the council and shall meet at least monthly.

(5) Members of the advisory council shall serve without compensation, but shall be entitled to necessary expenses incurred in the discharge of their duties pursuant to s. 112.061.

(6)(a) The University of South Florida College of Public Health shall assist the advisory council in conducting a study to evaluate the national best practice standards from the Substance Abuse and Mental Health Services Administration, with the goal of removing obstacles to therapeutic housing within this state to be in compliance with the Americans with Disabilities Act of 1990, as amended, 42 U.S.C. ss. 12101 et seq., and the Fair Housing Amendments Act of 1988. Costs of implementing the study shall be paid by the department from funds appropriated for this purpose.

(b) The advisory council shall also conduct a review of statewide zoning codes to determine what effect, if any, local laws have on the ability of private sector licensed service providers to provide modern, evidence-based, effective treatment and ancillary therapeutic housing to persons in this state.

(c) By June 1, 2027, the department, in conjunction with the Agency for Health Care Administration, shall provide a preliminary report based upon the findings and recommendations

of the advisory council to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

(d) By September 1, 2027, the advisory council shall provide a final report based upon the findings and recommendations of the advisory council to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

(7) This section is repealed September 1, 2027, unless reviewed and saved from repeal by the Legislature.

Section 2. Section 397.305, Florida Statutes, is amended to read:

397.305 Legislative findings, intent, and purpose.—

(1)(a) Addiction ~~Substance abuse~~ is a major health problem that affects multiple service systems and leads to such profoundly disturbing consequences as serious impairment, chronic addiction, criminal behavior, vehicular casualties, spiraling health care costs, AIDS, and business losses, and significantly affects the culture, socialization, and learning ability of children within our schools and educational systems. Addiction ~~Substance abuse impairment~~ is a disease which affects the whole family and the whole society and requires a system of care that includes prevention, intervention, clinical treatment, and recovery support services, including recovery residences, that support and strengthen the family unit. Further, it is the intent of the Legislature to require the collaboration of state agencies, service systems, and program offices to achieve the goals of this chapter and address the needs of the public; to establish a comprehensive system of care for substance use disorder ~~abuse~~; and to reduce duplicative requirements across

state agencies. This chapter is designed to provide for public and private substance use disorder treatment ~~abuse~~ services.

(b) The Legislature finds that addiction treatment services are a fully integrated part of the private and public health care system. Further, the Legislature finds that service providers licensed under this chapter and community housing certified under this chapter are deemed a necessary part of the private and public health care system. The Legislature intends to identify and remove barriers that prevent coordinated health care between medical and clinical providers to persons with substance use disorders.

(2) It is the goal of the Legislature to educate the public about the negative consequences of ~~discourage~~ substance use disorders ~~abuse~~ by promoting healthy lifestyles; healthy families; and drug-free schools, workplaces, and communities.

(3) It is the purpose of this chapter to provide for a comprehensive continuum of accessible and quality addiction ~~substance abuse~~ prevention, intervention, clinical treatment, and recovery support services in the least restrictive environment which promotes long-term recovery while protecting and respecting the rights of individuals~~, primarily~~ through for-profit providers and community-based ~~private~~ not-for-profit providers working with local governmental programs involving a wide range of agencies from both the public and private sectors.

(4) It is the intent of the Legislature that licensed, qualified health professionals be authorized to practice to the full extent of their education and training in the performance of professional functions necessary to carry out the intent of this chapter.

(5) It is the intent of the Legislature to establish expectations that services provided to persons in this state use national best practice standards and the coordination-of-care principles characteristic of recovery-oriented services and include social support services, such as housing support, life skills and vocational training, and employment assistance necessary for persons who have substance use disorders or co-occurring substance use and mental health disorders to live successfully in their communities.

(6) It is the intent of the Legislature to ensure within available resources a full system of care for substance use disorder treatment ~~abuse~~ services based on identified needs, delivered without discrimination and with adequate provision for specialized needs.

(7) It is the intent of the Legislature to establish services for persons who have ~~individuals with~~ co-occurring substance use ~~abuse~~ and mental health disorders.

(8) It is the intent of the Legislature to provide an alternative to criminal imprisonment for substance ~~abuse~~ impaired adults and juvenile offenders by encouraging the referral of such offenders to service providers not generally available within the juvenile justice and correctional systems, instead of or in addition to criminal penalties.

(9) It is the intent of the Legislature to provide, within the limits of appropriations and safe management of the juvenile justice and correctional systems, addiction treatment ~~substance abuse~~ services to substance ~~abuse~~ impaired offenders who are placed by the Department of Juvenile Justice or who are incarcerated within the Department of Corrections, in order to

better enable these offenders or inmates to adjust to the conditions of society presented to them when their terms of placement or incarceration end.

(10) It is the intent of the Legislature to provide for assisting substance ~~abuse~~ impaired persons primarily through health and other rehabilitative services in order to relieve the police, courts, correctional institutions, and other criminal justice agencies of a burden that interferes with their ability to protect people, apprehend offenders, and maintain safe and orderly communities.

(11) It is the intent of the Legislature that the freedom of religion of all citizens shall be inviolate. ~~Nothing in~~ This act does not ~~shall~~ give any governmental entity jurisdiction to regulate religious, spiritual, or ecclesiastical services.

Section 3. Subsection (1) of section 397.487, Florida Statutes, is amended, and subsections (13) and (14) are added to that section, to read:

397.487 Voluntary certification of recovery residences.—

(1) The Legislature finds that a person suffering from addiction has a higher success rate of achieving long-lasting sobriety when given the opportunity to build a stronger foundation by living in a recovery residence while receiving treatment or after completing treatment. The Legislature further finds that this state and its subdivisions have a legitimate state interest in protecting these persons, who represent a vulnerable consumer population in need of adequate housing, through the certification of recovery residences that meet national best practice standards. It is the intent of the Legislature to protect persons who reside in a recovery

residence.

(13) A recovery residence that meets the criteria of day or night treatment with community housing as defined in s. 397.311(26)(a)3. is governed by s. 397.501(7) regarding the confidentiality of individual records of residents.

(14) A local law, ordinance, or regulation may not regulate the duration or frequency of a resident's stay in a certified recovery residence in areas where multifamily uses are allowed. This subsection does not apply to any local law, ordinance, or regulation adopted on or before January 1, 2024.

Section 4. This act shall take effect July 1, 2024.

JOINT STATEMENT OF THE DEPARTMENT OF JUSTICE AND THE DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

GROUP HOMES, LOCAL LAND USE, AND THE FAIR HOUSING ACT

Since the federal Fair Housing Act ("the Act") was amended by Congress in 1988 to add protections for persons with disabilities and families with children, there has been a great deal of litigation concerning the Act's effect on the ability of local governments to exercise control over group living arrangements, particularly for persons with disabilities. The Department of Justice has taken an active part in much of this litigation, often following referral of a matter by the Department of Housing and Urban Development ("HUD"). This joint statement provides an overview of the Fair Housing Act's requirements in this area. Specific topics are addressed in more depth in the attached Questions and Answers.

The Fair Housing Act prohibits a broad range of practices that discriminate against individuals on the basis of race, color, religion, sex, national origin, familial status, and disability.[(1)] The Act does not pre-empt local zoning laws. However, the Act applies to municipalities and other local government entities and prohibits them from making zoning or land use decisions or implementing land use policies that exclude or otherwise discriminate against protected persons, including individuals with disabilities.

The Fair Housing Act makes it unlawful --

- To utilize land use policies or actions that treat groups of persons with disabilities less favorably than groups of non-disabled persons. An example would be an ordinance prohibiting housing for persons with disabilities or a specific type of disability, such as mental illness, from locating in a particular area, while allowing other groups of unrelated individuals to live together in that area.

- To take action against, or deny a permit, for a home because of the disability of individuals who live or would live there. An example would be denying a building permit for a home because it was intended to provide housing for persons with mental retardation.

- To refuse to make reasonable accommodations in land use and zoning policies and procedures where such accommodations may be necessary to afford persons or groups of persons with disabilities an equal opportunity to use and enjoy housing.

- What constitutes a reasonable accommodation is a case-by-case determination.

- Not all requested modifications of rules or policies are reasonable. If a requested modification imposes an undue financial or administrative burden on a local government, or if a modification creates a fundamental alteration in a local government's land use and zoning scheme, it is not a "reasonable" accommodation.

The disability discrimination provisions of the Fair Housing Act do not extend to persons who claim to be disabled solely on the basis of having been adjudicated a juvenile delinquent, having a criminal record,

or being a sex offender. Furthermore, the Fair Housing Act does not protect persons who currently use illegal drugs, persons who have been convicted of the manufacture or sale of illegal drugs, or persons with or without disabilities who present a direct threat to the persons or property of others.

HUD and the Department of Justice encourage parties to group home disputes to explore all reasonable dispute resolution procedures, like mediation, as alternatives to litigation.

DATE: AUGUST 18, 1999

Questions and Answers

on the Fair Housing Act and Zoning

Q. Does the Fair Housing Act pre-empt local zoning laws?

No. "Pre-emption" is a legal term meaning that one level of government has taken over a field and left no room for government at any other level to pass laws or exercise authority in that area. The Fair Housing Act is not a land use or zoning statute; it does not pre-empt local land use and zoning laws. This is an area where state law typically gives local governments primary power. However, if that power is exercised in a specific instance in a way that is inconsistent with a federal law such as the Fair Housing Act, the federal law will control. Long before the 1988 amendments, the courts had held that the Fair Housing Act prohibited local governments from exercising their land use and zoning powers in a discriminatory way.

Q. What is a group home within the meaning of the Fair Housing Act?

The term "group home" does not have a specific legal meaning. In this statement, the term "group home" refers to housing occupied by groups of unrelated individuals with disabilities.[(2)] Sometimes, but not always, housing is provided by organizations that also offer various services for individuals with disabilities living in the group homes. Sometimes it is this group home operator, rather than the individuals who live in the home, that interacts with local government in seeking permits and making requests for reasonable accommodations on behalf of those individuals.

The term "group home" is also sometimes applied to any group of unrelated persons who live together in a dwelling -- such as a group of students who voluntarily agree to share the rent on a house. The Act does not generally affect the ability of local governments to regulate housing of this kind, as long as they do not discriminate against the residents on the basis of race, color, national origin, religion, sex, handicap (disability) or familial status (families with minor children).

Q. Who are persons with disabilities within the meaning of the Fair Housing Act?

The Fair Housing Act prohibits discrimination on the basis of handicap. "Handicap" has the same legal meaning as the term "disability" which is used in other federal civil rights laws. Persons with disabilities (handicaps) are individuals with mental or physical impairments which substantially limit one or more major life activities. The term mental or physical impairment may include conditions such as blindness,

hearing impairment, mobility impairment, HIV infection, mental retardation, alcoholism, drug addiction, chronic fatigue, learning disability, head injury, and mental illness. The term major life activity may include seeing, hearing, walking, breathing, performing manual tasks, caring for one's self, learning, speaking, or working. The Fair Housing Act also protects persons who have a record of such an impairment, or are regarded as having such an impairment.

Current users of illegal controlled substances, persons convicted for illegal manufacture or distribution of a controlled substance, sex offenders, and juvenile offenders, are not considered disabled under the Fair Housing Act, by virtue of that status.

The Fair Housing Act affords no protections to individuals with or without disabilities who present a direct threat to the persons or property of others. Determining whether someone poses such a direct threat must be made on an individualized basis, however, and cannot be based on general assumptions or speculation about the nature of a disability.

Q. What kinds of local zoning and land use laws relating to group homes violate the Fair Housing Act?

Local zoning and land use laws that treat groups of unrelated persons with disabilities less favorably than similar groups of unrelated persons without disabilities violate the Fair Housing Act. For example, suppose a city's zoning ordinance defines a "family" to include up to six unrelated persons living together as a household unit, and gives such a group of unrelated persons the right to live in any zoning district without special permission. If that ordinance also disallows a group home for six or fewer people with disabilities in a certain district or requires this home to seek a use permit, such requirements would conflict with the Fair Housing Act. The ordinance treats persons with disabilities worse than persons without disabilities.

A local government may generally restrict the ability of groups of unrelated persons to live together as long as the restrictions are imposed on all such groups. Thus, in the case where a family is defined to include up to six unrelated people, an ordinance would not, on its face, violate the Act if a group home for seven people with disabilities was not allowed to locate in a single family zoned neighborhood, because a group of seven unrelated people without disabilities would also be disallowed. However, as discussed below, because persons with disabilities are also entitled to request reasonable accommodations in rules and policies, the group home for seven persons with disabilities would have to be given the opportunity to seek an exception or waiver. If the criteria for reasonable accommodation are met, the permit would have to be given in that instance, but the ordinance would not be invalid in all circumstances.

Q. What is a reasonable accommodation under the Fair Housing Act?

As a general rule, the Fair Housing Act makes it unlawful to refuse to make "reasonable accommodations" (modifications or exceptions) to rules, policies, practices, or services, when such accommodations may be necessary to afford persons with disabilities an equal opportunity to use or enjoy a dwelling.

Even though a zoning ordinance imposes on group homes the same restrictions it imposes on other groups of unrelated people, a local government may be required, in individual cases and when requested to do so, to grant a reasonable accommodation to a group home for persons with disabilities. For example, it may be a reasonable accommodation to waive a setback requirement so that a paved path of travel can be provided to residents who have mobility impairments. A similar waiver might not be required for a different type of group home where residents do not have difficulty negotiating steps and do not need a setback in order to have an equal opportunity to use and enjoy a dwelling.

Not all requested modifications of rules or policies are reasonable. Whether a particular accommodation is reasonable depends on the facts, and must be decided on a case-by-case basis. The determination of what is reasonable depends on the answers to two questions: First, does the request impose an undue burden or expense on the local government? Second, does the proposed use create a fundamental alteration in the zoning scheme? If the answer to either question is "yes," the requested accommodation is unreasonable.

What is "reasonable" in one circumstance may not be "reasonable" in another. For example, suppose a local government does not allow groups of four or more unrelated people to live together in a single-family neighborhood. A group home for four adults with mental retardation would very likely be able to show that it will have no more impact on parking, traffic, noise, utility use, and other typical concerns of zoning than an "ordinary family." In this circumstance, there would be no undue burden or expense for the local government nor would the single-family character of the neighborhood be fundamentally altered. Granting an exception or waiver to the group home in this circumstance does not invalidate the ordinance. The local government would still be able to keep groups of unrelated persons without disabilities from living in single-family neighborhoods.

By contrast, a fifty-bed nursing home would not ordinarily be considered an appropriate use in a single-family neighborhood, for obvious reasons having nothing to do with the disabilities of its residents. Such a facility might or might not impose significant burdens and expense on the community, but it would likely create a fundamental change in the single-family character of the neighborhood. On the other hand, a nursing home might not create a "fundamental change" in a neighborhood zoned for multi-family housing. The scope and magnitude of the modification requested, and the features of the surrounding neighborhood are among the factors that will be taken into account in determining whether a requested accommodation is reasonable.

Q. What is the procedure for requesting a reasonable accommodation?

Where a local zoning scheme specifies procedures for seeking a departure from the general rule, courts have decided, and the Department of Justice and HUD agree, that these procedures must ordinarily be followed. If no procedure is specified, persons with disabilities may, nevertheless, request a reasonable accommodation in some other way, and a local government is obligated to grant it if it meets the criteria discussed above. A local government's failure to respond to a request for reasonable accommodation or an inordinate delay in responding could also violate the Act.

Whether a procedure for requesting accommodations is provided or not, if local government officials have previously made statements or otherwise indicated that an application would not receive fair consideration, or if the procedure itself is discriminatory, then individuals with disabilities living in a group home (and/or its operator) might be able to go directly into court to request an order for an accommodation.

Local governments are encouraged to provide mechanisms for requesting reasonable accommodations that operate promptly and efficiently, without imposing significant costs or delays. The local government should also make efforts to insure that the availability of such mechanisms is well known within the community.

Q. When, if ever, can a local government limit the number of group homes that can locate in a certain area?

A concern expressed by some local government officials and neighborhood residents is that certain jurisdictions, governments, or particular neighborhoods within a jurisdiction, may come to have more than their "fair share" of group homes. There are legal ways to address this concern. The Fair Housing Act does not prohibit most governmental programs designed to encourage people of a particular race to move to neighborhoods occupied predominantly by people of another race. A local government that believes a particular area within its boundaries has its "fair share" of group homes, could offer incentives to providers to locate future homes in other neighborhoods.

However, some state and local governments have tried to address this concern by enacting laws requiring that group homes be at a certain minimum distance from one another. The Department of Justice and HUD take the position, and most courts that have addressed the issue agree, that density restrictions are generally inconsistent with the Fair Housing Act. We also believe, however, that if a neighborhood came to be composed largely of group homes, that could adversely affect individuals with disabilities and would be inconsistent with the objective of integrating persons with disabilities into the community. Especially in the licensing and regulatory process, it is appropriate to be concerned about the setting for a group home. A consideration of over-concentration could be considered in this context. This objective does not, however, justify requiring separations which have the effect of foreclosing group homes from locating in entire neighborhoods.

Q. What kinds of health and safety regulations can be imposed upon group homes?

The great majority of group homes for persons with disabilities are subject to state regulations intended to protect the health and safety of their residents. The Department of Justice and HUD believe, as do responsible group home operators, that such licensing schemes are necessary and legitimate. Neighbors who have concerns that a particular group home is being operated inappropriately should be able to bring their concerns to the attention of the responsible licensing agency. We encourage the states

to commit the resources needed to make these systems responsive to resident and community needs and concerns.

Regulation and licensing requirements for group homes are themselves subject to scrutiny under the Fair Housing Act. Such requirements based on health and safety concerns can be discriminatory themselves or may be cited sometimes to disguise discriminatory motives behind attempts to exclude group homes from a community. Regulators must also recognize that not all individuals with disabilities living in group home settings desire or need the same level of services or protection. For example, it may be appropriate to require heightened fire safety measures in a group home for people who are unable to move about without assistance. But for another group of persons with disabilities who do not desire or need such assistance, it would not be appropriate to require fire safety measures beyond those normally imposed on the size and type of residential building involved.

Q. Can a local government consider the feelings of neighbors in making a decision about granting a permit to a group home to locate in a residential neighborhood?

In the same way a local government would break the law if it rejected low-income housing in a community because of neighbors' fears that such housing would be occupied by racial minorities, a local government can violate the Fair Housing Act if it blocks a group home or denies a requested reasonable accommodation in response to neighbors' stereotypical fears or prejudices about persons with disabilities. This is so even if the individual government decision-makers are not themselves personally prejudiced against persons with disabilities. If the evidence shows that the decision-makers were responding to the wishes of their constituents, and that the constituents were motivated in substantial part by discriminatory concerns, that could be enough to prove a violation.

Of course, a city council or zoning board is not bound by everything that is said by every person who speaks out at a public hearing. It is the record as a whole that will be determinative. If the record shows that there were valid reasons for denying an application that were not related to the disability of the prospective residents, the courts will give little weight to isolated discriminatory statements. If, however, the purportedly legitimate reasons advanced to support the action are not objectively valid, the courts are likely to treat them as pretextual, and to find that there has been discrimination.

For example, neighbors and local government officials may be legitimately concerned that a group home for adults in certain circumstances may create more demand for on-street parking than would a typical family. It is not a violation of the Fair Housing Act for neighbors or officials to raise this concern and to ask the provider to respond. A valid unaddressed concern about inadequate parking facilities could justify denying the application, if another type of facility would ordinarily be denied a permit for such parking problems. However, if a group of individuals with disabilities or a group home operator shows by credible and unrebutted evidence that the home will not create a need for more parking spaces, or submits a plan to provide whatever off-street parking may be needed, then parking concerns would not support a decision to deny the home a permit.

Q. What is the status of group living arrangements for children under the Fair Housing Act?

In the course of litigation addressing group homes for persons with disabilities, the issue has arisen whether the Fair Housing Act also provides protections for group living arrangements for children. Such living arrangements are covered by the Fair Housing Act's provisions prohibiting discrimination against

families with children. For example, a local government may not enforce a zoning ordinance which treats group living arrangements for children less favorably than it treats a similar group living arrangement for unrelated adults. Thus, an ordinance that defined a group of up to six unrelated adult persons as a family, but specifically disallowed a group living arrangement for six or fewer children, would, on its face, discriminate on the basis of familial status. Likewise, a local government might violate the Act if it denied a permit to such a home because neighbors did not want to have a group facility for children next to them.

The law generally recognizes that children require adult supervision. Imposing a reasonable requirement for adequate supervision in group living facilities for children would not violate the familial status provisions of the Fair Housing Act.

Q. How are zoning and land use matters handled by HUD and the Department of Justice?

The Fair Housing Act gives the Department of Housing and Urban Development the power to receive and investigate complaints of discrimination, including complaints that a local government has discriminated in exercising its land use and zoning powers. HUD is also obligated by statute to attempt to conciliate the complaints that it receives, even before it completes an investigation.

In matters involving zoning and land use, HUD does not issue a charge of discrimination. Instead, HUD refers matters it believes may be meritorious to the Department of Justice which, in its discretion, may decide to bring suit against the respondent in such a case. The Department of Justice may also bring suit in a case that has not been the subject of a HUD complaint by exercising its power to initiate litigation alleging a "pattern or practice" of discrimination or a denial of rights to a group of persons which raises an issue of general public importance.

The Department of Justice's principal objective in a suit of this kind is to remove significant barriers to the housing opportunities available for persons with disabilities. The Department ordinarily will not participate in litigation to challenge discriminatory ordinances which are not being enforced, unless there is evidence that the mere existence of the provisions are preventing or discouraging the development of needed housing.

If HUD determines that there is no reasonable basis to believe that there may be a violation, it will close an investigation without referring the matter to the Department of Justice. Although the Department of Justice would still have independent "pattern or practice" authority to take enforcement action in the matter that was the subject of the closed HUD investigation, that would be an unlikely event. A HUD or Department of Justice decision not to proceed with a zoning or land use matter does not foreclose private plaintiffs from pursuing a claim.

Litigation can be an expensive, time-consuming, and uncertain process for all parties. HUD and the Department of Justice encourage parties to group home disputes to explore all reasonable alternatives to litigation, including alternative dispute resolution procedures, like mediation. HUD attempts to conciliate all Fair Housing Act complaints that it receives. In addition, it is the Department of Justice's

policy to offer prospective defendants the opportunity to engage in pre-suit settlement negotiations, except in the most unusual circumstances.

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1. The Fair Housing Act uses the term "handicap." This document uses the term "disability" which has exactly the same legal meaning.

2. There are groups of unrelated persons with disabilities who choose to live together who do not consider their living arrangements "group homes," and it is inappropriate to consider them "group homes" as that concept is discussed in this statement.

U.S. DEPARTMENT OF JUSTICE
CIVIL RIGHTS DIVISION

U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT
OFFICE OF FAIR HOUSING AND EQUAL OPPORTUNITY

Washington, D.C.
May 17, 2004

JOINT STATEMENT OF
THE DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT
AND THE DEPARTMENT OF JUSTICE

REASONABLE ACCOMMODATIONS UNDER THE
FAIR HOUSING ACT

Introduction

The Department of Justice ("DOJ") and the Department of Housing and Urban Development ("HUD") are jointly responsible for enforcing the federal Fair Housing Act[1] (the "Act"), which prohibits discrimination in housing on the basis of race, color, religion, sex, national origin, familial status, and disability.[2] One type of disability discrimination prohibited by the Act is the refusal to make reasonable accommodations in rules, policies, practices, or services when such accommodations may be necessary to afford a person with a disability the equal opportunity to use and enjoy a dwelling.[3] HUD and DOJ frequently respond to complaints alleging that housing providers have violated the Act by refusing reasonable accommodations to persons with disabilities. This Statement provides technical assistance regarding the rights and obligations of persons with disabilities and housing providers under the Act relating to

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[1] The Fair Housing Act is codified at 42 U.S.C. §§ 3601 - 3619.

[2] The Act uses the term "handicap" instead of the term "disability." Both terms have the same legal meaning. *See* Bragdon v. Abbott, 524 U.S. 624, 631 (1998) (noting that definition of "disability" in the Americans with Disabilities Act is drawn almost verbatim "from the definition of 'handicap' contained in the Fair Housing Amendments Act of 1988"). This document uses the term "disability," which is more generally accepted.

[3] 42 U.S.C. § 3604(f)(3)(B).

reasonable accommodations.[4]

Questions and Answers

1. What types of discrimination against persons with disabilities does the Act prohibit?

The Act prohibits housing providers from discriminating against applicants or residents because of their disability or the disability of anyone associated with them[5] and from treating persons with disabilities less favorably than others because of their disability. The Act also makes it unlawful for any person to refuse "to make reasonable accommodations in rules, policies, practices, or services, when such accommodations may be necessary to afford ... person(s) [with disabilities] equal opportunity to use and enjoy a dwelling."[6] The Act also prohibits housing providers from refusing residency to persons with disabilities, or placing conditions on their residency, because those persons may require reasonable accommodations. In addition, in certain circumstances, the Act requires that housing providers allow residents to

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[4] Housing providers that receive federal financial assistance are also subject to the requirements of Section 504 of the Rehabilitation Act of 1973. 29 U.S.C. § 794. Section 504, and its implementing regulations at 24 C.F.R. Part 8, prohibit discrimination based on disability and require recipients of federal financial assistance to provide reasonable accommodations to applicants and residents with disabilities. Although Section 504 imposes greater obligations than the Fair Housing Act, (*e.g.*, providing and paying for reasonable accommodations that involve structural modifications to units or public and common areas), the principles discussed in this Statement regarding reasonable accommodation under the Fair Housing Act generally apply to requests for reasonable accommodations to rules, policies, practices, and services under Section 504. *See* U.S. Department of Housing and Urban Development, Office of Public and Indian Housing, Notice PIH 2002-01(HA) (www.hud.gov/offices/fheo/disabilities/PIH02-01.pdf) and "Section 504: Frequently Asked Questions," (www.hud.gov/offices/fheo/disabilities/sect504faq.cfm#anchor272118).

[5] The Fair Housing Act's protection against disability discrimination covers not only home seekers with disabilities but also buyers and renters without disabilities who live or are associated with individuals with disabilities 42 U.S.C. § 3604(f)(1)(B), 42 U.S.C. § 3604(f)(1)(C), 42 U.S.C. § 3604(f)(2)(B), 42 U.S.C. § (f)(2)(C). *See also* H.R. Rep. 100-711 – 24 (reprinted in 1988 U.S.C.A.N. 2173, 2184-85) ("The Committee intends these provisions to prohibit not only discrimination against the primary purchaser or named lessee, but also to prohibit denials of housing opportunities to applicants because they have children, parents, friends, spouses, roommates, patients, subtenants or other associates who have disabilities."). *Accord*: Preamble to Proposed HUD Rules Implementing the Fair Housing Act, 53 Fed. Reg. 45001 (Nov. 7, 1988) (citing House Report).

[6] 42 U.S.C. § 3604(f)(3)(B). HUD regulations pertaining to reasonable accommodations may be found at 24 C.F.R. § 100.204.

make reasonable structural modifications to units and public/common areas in a dwelling when those modifications may be necessary for a person with a disability to have full enjoyment of a dwelling.[7] With certain limited exceptions (*see* response to question 2 below), the Act applies to privately and publicly owned housing, including housing subsidized by the federal government or rented through the use of Section 8 voucher assistance.

2. Who must comply with the Fair Housing Act's reasonable accommodation requirements?

Any person or entity engaging in prohibited conduct – *i.e.*, refusing to make reasonable accommodations in rules, policies, practices, or services, when such accommodations may be necessary to afford a person with a disability an equal opportunity to use and enjoy a dwelling – may be held liable unless they fall within an exception to the Act's coverage. Courts have applied the Act to individuals, corporations, associations and others involved in the provision of housing and residential lending, including property owners, housing managers, homeowners and condominium associations, lenders, real estate agents, and brokerage services. Courts have also applied the Act to state and local governments, most often in the context of exclusionary zoning or other land-use decisions. *See e.g.*, City of Edmonds v. Oxford House, Inc., 514 U.S. 725, 729 (1995); Project Life v. Glendening, 139 F. Supp. 703, 710 (D. Md. 2001), aff'd 2002 WL 2012545 (4th Cir. 2002). Under specific exceptions to the Fair Housing Act, the reasonable accommodation requirements of the Act do not apply to a private individual owner who sells his own home so long as he (1) does not own more than three single-family homes; (2) does not use a real estate agent and does not employ any discriminatory advertising or notices; (3) has not engaged in a similar sale of a home within a 24-month period; and (4) is not in the business of selling or renting dwellings. The reasonable accommodation requirements of the Fair Housing Act also do not apply to owner-occupied buildings that have four or fewer dwelling units.

3. Who qualifies as a person with a disability under the Act?

The Act defines a person with a disability to include (1) individuals with a physical or mental impairment that substantially limits one or more major life activities; (2) individuals who are regarded as having such an impairment; and (3) individuals with a record of such an impairment.

The term "physical or mental impairment" includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech and hearing impairments, cerebral palsy, autism, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, Human Immunodeficiency Virus infection, mental retardation, emotional illness, drug addiction (other than addiction caused by current, illegal use of a controlled substance) and alcoholism.

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[7] This Statement does not address the principles relating to reasonable modifications. For further information see the HUD regulations at 24 C.F.R. § 100.203. This statement also does not address the additional requirements imposed on recipients of Federal financial assistance pursuant to Section 504, as explained in the Introduction.

The term "substantially limits" suggests that the limitation is "significant" or "to a large degree."

The term "major life activity" means those activities that are of central importance to daily life, such as seeing, hearing, walking, breathing, performing manual tasks, caring for one's self, learning, and speaking.[8] This list of major life activities is not exhaustive. *See e.g.*, Bragdon v. Abbott, 524 U.S. 624, 691-92 (1998)(holding that for certain individuals reproduction is a major life activity).

4. Does the Act protect juvenile offenders, sex offenders, persons who illegally use controlled substances, and persons with disabilities who pose a significant danger to others?

No, juvenile offenders and sex offenders, by virtue of that status, are not persons with disabilities protected by the Act. Similarly, while the Act does protect persons who are recovering from substance abuse, it does not protect persons who are currently engaging in the current illegal use of controlled substances.[9] Additionally, the Act does not protect an individual with a disability whose tenancy would constitute a "direct threat" to the health or safety of other individuals or result in substantial physical damage to the property of others unless the threat can be eliminated or significantly reduced by reasonable accommodation.

5. How can a housing provider determine if an individual poses a direct threat?

The Act does not allow for exclusion of individuals based upon fear, speculation, or stereotype about a particular disability or persons with disabilities in general. A determination that an individual poses a direct threat must rely on an individualized assessment that is based on reliable objective evidence (*e.g.*, current conduct, or a recent history of overt acts). The assessment must consider: (1) the nature, duration, and severity of the risk of injury; (2) the probability that injury will actually occur; and (3) whether there are any reasonable accommodations that will eliminate the direct threat. Consequently, in evaluating a recent history of overt acts, a provider must take into account whether the individual has received intervening treatment or medication that has eliminated the direct threat (*i.e.*, a significant risk of substantial harm). In such a situation, the provider may request that the individual document

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[8] The Supreme Court has questioned but has not yet ruled on whether "working" is to be considered a major life activity. See Toyota Motor Mfg, Kentucky, Inc. v. Williams, 122 S. Ct. 681, 692, 693 (2002). If it is a major activity, the Court has noted that a claimant would be required to show an inability to work in a "broad range of jobs" rather than a specific job. *See* Sutton v. United Airlines, Inc., 527 U.S. 470, 492 (1999).

[9] *See*, *e.g.*, United States v. Southern Management Corp., 955 F.2d 914, 919 (4th Cir. 1992) (discussing exclusion in 42 U.S.C. § 3602(h) for "current, illegal use of or addiction to a controlled substance").

how the circumstances have changed so that he no longer poses a direct threat. A provider may also obtain satisfactory assurances that the individual will not pose a direct threat during the tenancy. The housing provider must have reliable, objective evidence that a person with a disability poses a direct threat before excluding him from housing on that basis.

Example 1: A housing provider requires all persons applying to rent an apartment to complete an application that includes information on the applicant's current place of residence. On her application to rent an apartment, a woman notes that she currently resides in Cambridge House. The manager of the apartment complex knows that Cambridge House is a group home for women receiving treatment for alcoholism. Based solely on that information and his personal belief that alcoholics are likely to cause disturbances and damage property, the manager rejects the applicant. The rejection is unlawful because it is based on a generalized stereotype related to a disability rather than an individualized assessment of any threat to other persons or the property of others based on reliable, objective evidence about the applicant's recent past conduct. The housing provider may not treat this applicant differently than other applicants based on his subjective perceptions of the potential problems posed by her alcoholism by requiring additional documents, imposing different lease terms, or requiring a higher security deposit. However, the manager could have checked this applicant's references to the same extent and in the same manner as he would have checked any other applicant's references. If such a reference check revealed objective evidence showing that this applicant had posed a direct threat to persons or property in the recent past and the direct threat had not been eliminated, the manager could then have rejected the applicant based on direct threat.

Example 2: James X, a tenant at the Shady Oaks apartment complex, is arrested for threatening his neighbor while brandishing a baseball bat. The Shady Oaks' lease agreement contains a term prohibiting tenants from threatening violence against other residents. Shady Oaks' rental manager investigates the incident and learns that James X threatened the other resident with physical violence and had to be physically restrained by other neighbors to keep him from acting on his threat. Following Shady Oaks' standard practice of strictly enforcing its "no threats" policy, the Shady Oaks rental manager issues James X a 30-day notice to quit, which is the first step in the eviction process. James X's attorney contacts Shady Oaks' rental manager and explains that James X has a psychiatric disability that causes him to be physically violent when he stops taking his prescribed medication. Suggesting that his client will not pose a direct threat to others if proper safeguards are taken, the attorney requests that the rental manager grant James X an exception to the "no threats" policy as a reasonable accommodation based on James X's disability. The Shady Oaks rental manager need only grant the reasonable accommodation if James X's attorney can provide satisfactory assurance that James X will receive appropriate counseling and

periodic medication monitoring so that he will no longer pose a direct threat during his tenancy. After consulting with James X, the attorney responds that James X is unwilling to receive counseling or submit to any type of periodic monitoring to ensure that he takes his prescribed medication. The rental manager may go forward with the eviction proceeding, since James X continues to pose a direct threat to the health or safety of other residents.

6. What is a "reasonable accommodation" for purposes of the Act?

A "reasonable accommodation" is a change, exception, or adjustment to a rule, policy, practice, or service that may be necessary for a person with a disability to have an equal opportunity to use and enjoy a dwelling, including public and common use spaces. Since rules, policies, practices, and services may have a different effect on persons with disabilities than on other persons, treating persons with disabilities exactly the same as others will sometimes deny them an equal opportunity to use and enjoy a dwelling. The Act makes it unlawful to refuse to make reasonable accommodations to rules, policies, practices, or services when such accommodations may be necessary to afford persons with disabilities an equal opportunity to use and enjoy a dwelling.

To show that a requested accommodation may be necessary, there must be an identifiable relationship, or nexus, between the requested accommodation and the individual's disability.

Example 1: A housing provider has a policy of providing unassigned parking spaces to residents. A resident with a mobility impairment, who is substantially limited in her ability to walk, requests an assigned accessible parking space close to the entrance to her unit as a reasonable accommodation. There are available parking spaces near the entrance to her unit that are accessible, but those spaces are available to all residents on a first come, first served basis. The provider must make an exception to its policy of not providing assigned parking spaces to accommodate this resident.

Example 2: A housing provider has a policy of requiring tenants to come to the rental office in person to pay their rent. A tenant has a mental disability that makes her afraid to leave her unit. Because of her disability, she requests that she be permitted to have a friend mail her rent payment to the rental office as a reasonable accommodation. The provider must make an exception to its payment policy to accommodate this tenant.

Example 3: A housing provider has a "no pets" policy. A tenant who is deaf requests that the provider allow him to keep a dog in his unit as a reasonable accommodation. The tenant explains that the dog is an assistance animal that will alert him to several sounds, including knocks at the door, sounding of the smoke detector, the telephone ringing, and cars coming into the driveway. The housing

provider must make an exception to its "no pets" policy to accommodate this tenant.

7. Are there any instances when a provider can deny a request for a reasonable accommodation without violating the Act?

Yes. A housing provider can deny a request for a reasonable accommodation if the request was not made by or on behalf of a person with a disability or if there is no disability-related need for the accommodation. In addition, a request for a reasonable accommodation may be denied if providing the accommodation is not reasonable – *i.e.*, if it would impose an undue financial and administrative burden on the housing provider or it would fundamentally alter the nature of the provider's operations. The determination of undue financial and administrative burden must be made on a case-by-case basis involving various factors, such as the cost of the requested accommodation, the financial resources of the provider, the benefits that the accommodation would provide to the requester, and the availability of alternative accommodations that would effectively meet the requester's disability-related needs.

When a housing provider refuses a requested accommodation because it is not reasonable, the provider should discuss with the requester whether there is an alternative accommodation that would effectively address the requester's disability-related needs without a fundamental alteration to the provider's operations and without imposing an undue financial and administrative burden. If an alternative accommodation would effectively meet the requester's disability-related needs and is reasonable, the provider must grant it. An interactive process in which the housing provider and the requester discuss the requester's disability-related need for the requested accommodation and possible alternative accommodations is helpful to all concerned because it often results in an effective accommodation for the requester that does not pose an undue financial and administrative burden for the provider.

Example: As a result of a disability, a tenant is physically unable to open the dumpster placed in the parking lot by his housing provider for trash collection. The tenant requests that the housing provider send a maintenance staff person to his apartment on a daily basis to collect his trash and take it to the dumpster. Because the housing development is a small operation with limited financial resources and the maintenance staff are on site only twice per week, it may be an undue financial and administrative burden for the housing provider to grant the requested daily trash pick-up service. Accordingly, the requested accommodation may not be reasonable. If the housing provider denies the requested accommodation as unreasonable, the housing provider should discuss with the tenant whether reasonable accommodations could be provided to meet the tenant's disability-related needs – for instance, placing an open trash collection can in a location that is readily accessible to the tenant so the tenant can dispose of his own trash and the provider's maintenance staff can then transfer the trash to the dumpster when they are on site. Such an accommodation would not involve a

fundamental alteration of the provider's operations and would involve little financial and administrative burden for the provider while accommodating the tenant's disability-related needs.

There may be instances where a provider believes that, while the accommodation requested by an individual is reasonable, there is an alternative accommodation that would be equally effective in meeting the individual's disability-related needs. In such a circumstance, the provider should discuss with the individual if she is willing to accept the alternative accommodation. However, providers should be aware that persons with disabilities typically have the most accurate knowledge about the functional limitations posed by their disability, and an individual is not obligated to accept an alternative accommodation suggested by the provider if she believes it will not meet her needs and her preferred accommodation is reasonable.

8. What is a "fundamental alteration"?

A "fundamental alteration" is a modification that alters the essential nature of a provider's operations.

> **Example:** A tenant has a severe mobility impairment that substantially limits his ability to walk. He asks his housing provider to transport him to the grocery store and assist him with his grocery shopping as a reasonable accommodation to his disability. The provider does not provide any transportation or shopping services for its tenants, so granting this request would require a fundamental alteration in the nature of the provider's operations. The request can be denied, but the provider should discuss with the requester whether there is any alternative accommodation that would effectively meet the requester's disability-related needs without fundamentally altering the nature of its operations, such as reducing the tenant's need to walk long distances by altering its parking policy to allow a volunteer from a local community service organization to park her car close to the tenant's unit so she can transport the tenant to the grocery store and assist him with his shopping.

9. What happens if providing a requested accommodation involves some costs on the part of the housing provider?

Courts have ruled that the Act may require a housing provider to grant a reasonable accommodation that involves costs, so long as the reasonable accommodation does not pose an undue financial and administrative burden and the requested accommodation does not constitute a fundamental alteration of the provider's operations. The financial resources of the provider, the cost of the reasonable accommodation, the benefits to the requester of the requested accommodation, and the availability of other, less expensive alternative accommodations that would effectively meet the applicant or resident's disability-related needs must be considered in determining whether a requested accommodation poses an undue financial and administrative

burden.

10. What happens if no agreement can be reached through the interactive process?

A failure to reach an agreement on an accommodation request is in effect a decision by the provider not to grant the requested accommodation. If the individual who was denied an accommodation files a Fair Housing Act complaint to challenge that decision, then the agency or court receiving the complaint will review the evidence in light of applicable law and decide if the housing provider violated that law. For more information about the complaint process, see question 19 below.

11. May a housing provider charge an extra fee or require an additional deposit from applicants or residents with disabilities as a condition of granting a reasonable accommodation?

No. Housing providers may not require persons with disabilities to pay extra fees or deposits as a condition of receiving a reasonable accommodation.

> **Example 1**: A man who is substantially limited in his ability to walk uses a motorized scooter for mobility purposes. He applies to live in an assisted living facility that has a policy prohibiting the use of motorized vehicles in buildings and elsewhere on the premises. It would be a reasonable accommodation for the facility to make an exception to this policy to permit the man to use his motorized scooter on the premises for mobility purposes. Since allowing the man to use his scooter in the buildings and elsewhere on the premises is a reasonable accommodation, the facility may not condition his use of the scooter on payment of a fee or deposit or on a requirement that he obtain liability insurance relating to the use of the scooter. However, since the Fair Housing Act does not protect any person with a disability who poses a direct threat to the person or property of others, the man must operate his motorized scooter in a responsible manner that does not pose a significant risk to the safety of other persons and does not cause damage to other persons' property. If the individual's use of the scooter causes damage to his unit or the common areas, the housing provider may charge him for the cost of repairing the damage (or deduct it from the standard security deposit imposed on all tenants), if it is the provider's practice to assess tenants for any damage they cause to the premises.

> **Example 2:** Because of his disability, an applicant with a hearing impairment needs to keep an assistance animal in his unit as a reasonable accommodation. The housing provider may not require the applicant to pay a fee or a security deposit as a condition of allowing the applicant to keep the assistance animal. However, if a tenant's assistance animal causes damage to the applicant's unit or the common areas of the dwelling, the housing provider may charge the tenant for

the cost of repairing the damage (or deduct it from the standard security deposit imposed on all tenants), if it is the provider's practice to assess tenants for any damage they cause to the premises.

12. When and how should an individual request an accommodation?

Under the Act, a resident or an applicant for housing makes a reasonable accommodation request whenever she makes clear to the housing provider that she is requesting an exception, change, or adjustment to a rule, policy, practice, or service because of her disability. She should explain what type of accommodation she is requesting and, if the need for the accommodation is not readily apparent or not known to the provider, explain the relationship between the requested accommodation and her disability.

An applicant or resident is not entitled to receive a reasonable accommodation unless she requests one. However, the Fair Housing Act does not require that a request be made in a particular manner or at a particular time. A person with a disability need not personally make the reasonable accommodation request; the request can be made by a family member or someone else who is acting on her behalf. An individual making a reasonable accommodation request does not need to mention the Act or use the words "reasonable accommodation." However, the requester must make the request in a manner that a reasonable person would understand to be a request for an exception, change, or adjustment to a rule, policy, practice, or service because of a disability.

Although a reasonable accommodation request can be made orally or in writing, it is usually helpful for both the resident and the housing provider if the request is made in writing. This will help prevent misunderstandings regarding what is being requested, or whether the request was made. To facilitate the processing and consideration of the request, residents or prospective residents may wish to check with a housing provider in advance to determine if the provider has a preference regarding the manner in which the request is made. However, housing providers must give appropriate consideration to reasonable accommodation requests even if the requester makes the request orally or does not use the provider's preferred forms or procedures for making such requests.

Example: A tenant in a large apartment building makes an oral request that she be assigned a mailbox in a location that she can easily access because of a physical disability that limits her ability to reach and bend. The provider would prefer that the tenant make the accommodation request on a pre-printed form, but the tenant fails to complete the form. The provider must consider the reasonable accommodation request even though the tenant would not use the provider's designated form.

13. Must a housing provider adopt formal procedures for processing requests for a reasonable accommodation?

No. The Act does not require that a housing provider adopt any formal procedures for reasonable accommodation requests. However, having formal procedures may aid individuals with disabilities in making requests for reasonable accommodations and may aid housing providers in assessing those requests so that there are no misunderstandings as to the nature of the request, and, in the event of later disputes, provide records to show that the requests received proper consideration.

A provider may not refuse a request, however, because the individual making the request did not follow any formal procedures that the provider has adopted. If a provider adopts formal procedures for processing reasonable accommodation requests, the provider should ensure that the procedures, including any forms used, do not seek information that is not necessary to evaluate if a reasonable accommodation may be needed to afford a person with a disability equal opportunity to use and enjoy a dwelling. See Questions 16 - 18, which discuss the disability-related information that a provider may and may not request for the purposes of evaluating a reasonable accommodation request.

14. Is a housing provider obligated to provide a reasonable accommodation to a resident or applicant if an accommodation has not been requested?

No. A housing provider is only obligated to provide a reasonable accommodation to a resident or applicant if a request for the accommodation has been made. A provider has notice that a reasonable accommodation request has been made if a person, her family member, or someone acting on her behalf requests a change, exception, or adjustment to a rule, policy, practice, or service because of a disability, even if the words "reasonable accommodation" are not used as part of the request.

15. What if a housing provider fails to act promptly on a reasonable accommodation request?

A provider has an obligation to provide prompt responses to reasonable accommodation requests. An undue delay in responding to a reasonable accommodation request may be deemed to be a failure to provide a reasonable accommodation.

16. What inquiries, if any, may a housing provider make of current or potential residents regarding the existence of a disability when they have not asked for an accommodation?

Under the Fair Housing Act, it is usually unlawful for a housing provider to (1) ask if an applicant for a dwelling has a disability or if a person intending to reside in a dwelling or anyone associated with an applicant or resident has a disability, or (2) ask about the nature or severity of such persons' disabilities. Housing providers may, however, make the following inquiries, provided these inquiries are made of all applicants, including those with and without disabilities:

- An inquiry into an applicant's ability to meet the requirements of tenancy;

- An inquiry to determine if an applicant is a current illegal abuser or addict of a controlled substance;

- An inquiry to determine if an applicant qualifies for a dwelling legally available only to persons with a disability or to persons with a particular type of disability; and

- An inquiry to determine if an applicant qualifies for housing that is legally available on a priority basis to persons with disabilities or to persons with a particular disability.

Example 1: A housing provider offers accessible units to persons with disabilities needing the features of these units on a priority basis. The provider may ask applicants if they have a disability and if, in light of their disability, they will benefit from the features of the units. However, the provider may not ask applicants if they have other types of physical or mental impairments. If the applicant's disability and the need for the accessible features are not readily apparent, the provider may request reliable information/documentation of the disability-related need for an accessible unit.

Example 2: A housing provider operates housing that is legally limited to persons with chronic mental illness. The provider may ask applicants for information needed to determine if they have a mental disability that would qualify them for the housing. However, in this circumstance, the provider may not ask applicants if they have other types of physical or mental impairments. If it is not readily apparent that an applicant has a chronic mental disability, the provider may request reliable information/documentation of the mental disability needed to qualify for the housing.

In some instances, a provider may also request certain information about an applicant's or a resident's disability if the applicant or resident requests a reasonable accommodation. See Questions 17 and 18 below.

17. What kinds of information, if any, may a housing provider request from a person with an obvious or known disability who is requesting a reasonable accommodation?

A provider is entitled to obtain information that is necessary to evaluate if a requested reasonable accommodation may be necessary because of a disability. If a person's disability is obvious, or otherwise known to the provider, and if the need for the requested accommodation is also readily apparent or known, then the provider may not request any additional information

about the requester's disability or the disability-related need for the accommodation.

If the requester's disability is known or readily apparent to the provider, but the need for the accommodation is not readily apparent or known, the provider may request only information that is necessary to evaluate the disability-related need for the accommodation.

> **Example 1:** An applicant with an obvious mobility impairment who regularly uses a walker to move around asks her housing provider to assign her a parking space near the entrance to the building instead of a space located in another part of the parking lot. Since the physical disability (*i.e.*, difficulty walking) and the disability-related need for the requested accommodation are both readily apparent, the provider may not require the applicant to provide any additional information about her disability or the need for the requested accommodation.
>
> **Example 2:** A rental applicant who uses a wheelchair advises a housing provider that he wishes to keep an assistance dog in his unit even though the provider has a "no pets" policy. The applicant's disability is readily apparent but the need for an assistance animal is not obvious to the provider. The housing provider may ask the applicant to provide information about the disability-related need for the dog.
>
> **Example 3:** An applicant with an obvious vision impairment requests that the leasing agent provide assistance to her in filling out the rental application form as a reasonable accommodation because of her disability. The housing provider may not require the applicant to document the existence of her vision impairment.

18. If a disability is not obvious, what kinds of information may a housing provider request from the person with a disability in support of a requested accommodation?

A housing provider may not ordinarily inquire as to the nature and severity of an individual's disability (*see* Answer 16, above). However, in response to a request for a reasonable accommodation, a housing provider may request reliable disability-related information that (1) is necessary to verify that the person meets the Act's definition of disability (*i.e.*, has a physical or mental impairment that substantially limits one or more major life activities), (2) describes the needed accommodation, and (3) shows the relationship between the person's disability and the need for the requested accommodation. Depending on the individual's circumstances, information verifying that the person meets the Act's definition of disability can usually be provided by the individual himself or herself (*e.g.*, proof that an individual under 65 years of age receives Supplemental Security Income or Social Security Disability Insurance benefits[10] or a credible statement by the individual). A doctor or other

[10] Persons who meet the definition of disability for purposes of receiving Supplemental Security Income ("SSI") or Social Security Disability Insurance ("SSDI") benefits in most cases meet the definition of disability under the Fair Housing Act, although the converse may not be true. *See e.g.*, Cleveland v. Policy Management Systems Corp., 526 U.S. 795, 797 (1999)

medical professional, a peer support group, a non-medical service agency, or a reliable third party who is in a position to know about the individual's disability may also provide verification of a disability. In most cases, an individual's medical records or detailed information about the nature of a person's disability is not necessary for this inquiry.

Once a housing provider has established that a person meets the Act's definition of disability, the provider's request for documentation should seek only the information that is necessary to evaluate if the reasonable accommodation is needed because of a disability. Such information must be kept confidential and must not be shared with other persons unless they need the information to make or assess a decision to grant or deny a reasonable accommodation request or unless disclosure is required by law (*e.g.*, a court-issued subpoena requiring disclosure).

19. If a person believes she has been unlawfully denied a reasonable accommodation, what should that person do if she wishes to challenge that denial under the Act?

When a person with a disability believes that she has been subjected to a discriminatory housing practice, including a provider's wrongful denial of a request for reasonable accommodation, she may file a complaint with HUD within one year after the alleged denial or may file a lawsuit in federal district court within two years of the alleged denial. If a complaint is filed with HUD, HUD will investigate the complaint at no cost to the person with a disability.

There are several ways that a person may file a complaint with HUD:

- By placing a toll-free call to 1-800-669-9777 or TTY 1-800-927-9275;

- By completing the "on-line" complaint form available on the HUD internet site: http://www.hud.gov; or

- By mailing a completed complaint form or letter to:

Office of Fair Housing and Equal Opportunity
Department of Housing & Urban Development
451 Seventh Street, S.W., Room 5204
Washington, DC 20410-2000

(noting that SSDI provides benefits to a person with a disability so severe that she is unable to do her previous work and cannot engage in any other kind of substantial gainful work whereas a person pursuing an action for disability discrimination under the Americans with Disabilities Act may state a claim that "with a reasonable accommodation" she could perform the essential functions of the job).

Upon request, HUD will provide printed materials in alternate formats (large print, audio tapes, or Braille) and provide complainants with assistance in reading and completing forms.

The Civil Rights Division of the Justice Department brings lawsuits in federal courts across the country to end discriminatory practices and to seek monetary and other relief for individuals whose rights under the Fair Housing Act have been violated. The Civil Rights Division initiates lawsuits when it has reason to believe that a person or entity is involved in a "pattern or practice" of discrimination or when there has been a denial of rights to a group of persons that raises an issue of general public importance. The Division also participates as *amicus curiae* in federal court cases that raise important legal questions involving the application and/or interpretation of the Act. To alert the Justice Department to matters involving a pattern or practice of discrimination, matters involving the denial of rights to groups of persons, or lawsuits raising issues that may be appropriate for *amicus* participation, contact:

U.S. Department of Justice
Civil Rights Division
Housing and Civil Enforcement Section – G St.
950 Pennsylvania Avenue, N.W.
Washington, DC 20530

For more information on the types of housing discrimination cases handled by the Civil Rights Division, please refer to the Housing and Civil Enforcement Section's website at http://www.usdoj.gov/crt/housing/hcehome.html.

A HUD or Department of Justice decision not to proceed with a Fair Housing Act matter does not foreclose private plaintiffs from pursuing a private lawsuit. However, litigation can be an expensive, time-consuming, and uncertain process for all parties. HUD and the Department of Justice encourage parties to Fair Housing Act disputes to explore all reasonable alternatives to litigation, including alternative dispute resolution procedures, such as mediation. HUD attempts to conciliate all Fair Housing Act complaints. In addition, it is the Department of Justice's policy to offer prospective defendants the opportunity to engage in pre-suit settlement negotiations, except in the most unusual circumstances.

U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT
OFFICE OF FAIR HOUSING AND EQUAL OPPORTUNITY

U.S. DEPARTMENT OF JUSTICE
CIVIL RIGHTS DIVISION

Washington, D.C.
November 10, 2016

JOINT STATEMENT OF THE DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT AND THE DEPARTMENT OF JUSTICE

STATE AND LOCAL LAND USE LAWS AND PRACTICES AND THE APPLICATION OF THE FAIR HOUSING ACT

INTRODUCTION

The Department of Justice ("DOJ") and the Department of Housing and Urban Development ("HUD") are jointly responsible for enforcing the Federal Fair Housing Act ("the Act"),[1] which prohibits discrimination in housing on the basis of race, color, religion, sex, disability, familial status (children under 18 living with a parent or guardian), or national origin.[2] The Act prohibits housing-related policies and practices that exclude or otherwise discriminate against individuals because of protected characteristics.

The regulation of land use and zoning is traditionally reserved to state and local governments, except to the extent that it conflicts with requirements imposed by the Fair Housing Act or other federal laws. This Joint Statement provides an overview of the Fair Housing Act's requirements relating to state and local land use practices and zoning laws, including conduct related to group homes. It updates and expands upon DOJ's and HUD's Joint

[1] The Fair Housing Act is codified at 42 U.S.C. §§ 3601–19.

[2] The Act uses the term "handicap" instead of "disability." Both terms have the same legal meaning. *See Bragdon v. Abbott*, 524 U.S. 624, 631 (1998) (noting that the definition of "disability" in the Americans with Disabilities Act

Statement on Group Homes, Local Land Use, and the Fair Housing Act, issued on August 18, 1999. The first section of the Joint Statement, Questions 1–6, describes generally the Act's requirements as they pertain to land use and zoning. The second and third sections, Questions 7–25, discuss more specifically how the Act applies to land use and zoning laws affecting housing for persons with disabilities, including guidance on regulating group homes and the requirement to provide reasonable accommodations. The fourth section, Questions 26–27, addresses HUD's and DOJ's enforcement of the Act in the land use and zoning context.

This Joint Statement focuses on the Fair Housing Act, not on other federal civil rights laws that prohibit state and local governments from adopting or implementing land use and zoning practices that discriminate based on a protected characteristic, such as Title II of the Americans with Disabilities Act ("ADA"),[3] Section 504 of the Rehabilitation Act of 1973 ("Section 504"),[4] and Title VI of the Civil Rights Act of 1964.[5] In addition, the Joint Statement does not address a state or local government's duty to affirmatively further fair housing, even though state and local governments that receive HUD assistance are subject to this duty. For additional information provided by DOJ and HUD regarding these issues, see the list of resources provided in the answer to Question 27.

Questions and Answers on the Fair Housing Act and State and Local Land Use Laws and Zoning

1. How does the Fair Housing Act apply to state and local land use and zoning?

The Fair Housing Act prohibits a broad range of housing practices that discriminate against individuals on the basis of race, color, religion, sex, disability, familial status, or national origin (commonly referred to as protected characteristics). As established by the Supremacy Clause of the U.S. Constitution, federal laws such as the Fair Housing Act take precedence over conflicting state and local laws. The Fair Housing Act thus prohibits state and local land use and zoning laws, policies, and practices that discriminate based on a characteristic protected under the Act. Prohibited practices as defined in the Act include making unavailable or denying housing because of a protected characteristic. Housing includes not only buildings intended for occupancy as residences, but also vacant land that may be developed into residences.

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is drawn almost verbatim "from the definition of 'handicap' contained in the Fair Housing Amendments Act of 1988"). This document uses the term "disability," which is more generally accepted.

[3] 42 U.S.C. §12132.

[4] 29 U.S.C. § 794.

[5] 42 U.S.C. § 2000d.

2. What types of land use and zoning laws or practices violate the Fair Housing Act?

Examples of state and local land use and zoning laws or practices that may violate the Act include:

- Prohibiting or restricting the development of housing based on the belief that the residents will be members of a particular protected class, such as race, disability, or familial status, by, for example, placing a moratorium on the development of multifamily housing because of concerns that the residents will include members of a particular protected class.
- Imposing restrictions or additional conditions on group housing for persons with disabilities that are not imposed on families or other groups of unrelated individuals, by, for example, requiring an occupancy permit for persons with disabilities to live in a single-family home while not requiring a permit for other residents of single-family homes.
- Imposing restrictions on housing because of alleged public safety concerns that are based on stereotypes about the residents' or anticipated residents' membership in a protected class, by, for example, requiring a proposed development to provide additional security measures based on a belief that persons of a particular protected class are more likely to engage in criminal activity.
- Enforcing otherwise neutral laws or policies differently because of the residents' protected characteristics, by, for example, citing individuals who are members of a particular protected class for violating code requirements for property upkeep while not citing other residents for similar violations.
- Refusing to provide reasonable accommodations to land use or zoning policies when such accommodations may be necessary to allow persons with disabilities to have an equal opportunity to use and enjoy the housing, by, for example, denying a request to modify a setback requirement so an accessible sidewalk or ramp can be provided for one or more persons with mobility disabilities.

3. When does a land use or zoning practice constitute intentional discrimination in violation of the Fair Housing Act?

Intentional discrimination is also referred to as disparate treatment, meaning that the action treats a person or group of persons differently because of race, color, religion, sex, disability, familial status, or national origin. A land use or zoning practice may be intentionally discriminatory even if there is no personal bias or animus on the part of individual government officials. For example, municipal zoning practices or decisions that reflect acquiescence to community bias may be intentionally discriminatory, even if the officials themselves do not personally share such bias. (See Q&A 5.) Intentional discrimination does not require that the

decision-makers were hostile toward members of a particular protected class. Decisions motivated by a purported desire to benefit a particular group can also violate the Act if they result in differential treatment because of a protected characteristic.

A land use or zoning practice may be discriminatory on its face. For example, a law that requires persons with disabilities to request permits to live in single-family zones while not requiring persons without disabilities to request such permits violates the Act because it treats persons with disabilities differently based on their disability. Even a law that is seemingly neutral will still violate the Act if enacted with discriminatory intent. In that instance, the analysis of whether there is intentional discrimination will be based on a variety of factors, all of which need not be satisfied. These factors include, but are not limited to: (1) the "impact" of the municipal practice, such as whether an ordinance disproportionately impacts minority residents compared to white residents or whether the practice perpetuates segregation in a neighborhood or particular geographic area; (2) the "historical background" of the action, such as whether there is a history of segregation or discriminatory conduct by the municipality; (3) the "specific sequence of events," such as whether the city adopted an ordinance or took action only after significant, racially-motivated community opposition to a housing development or changed course after learning that a development would include non-white residents; (4) departures from the "normal procedural sequence," such as whether a municipality deviated from normal application or zoning requirements; (5) "substantive departures," such as whether the factors usually considered important suggest that a state or local government should have reached a different result; and (6) the "legislative or administrative history," such as any statements by members of the state or local decision-making body.[6]

4. Can state and local land use and zoning laws or practices violate the Fair Housing Act if the state or locality did not intend to discriminate against persons on a prohibited basis?

Yes. Even absent a discriminatory intent, state or local governments may be liable under the Act for any land use or zoning law or practice that has an unjustified discriminatory effect because of a protected characteristic. In 2015, the United States Supreme Court affirmed this interpretation of the Act in *Texas Department of Housing and Community Affairs v. Inclusive Communities Project, Inc.*[7] The Court stated that "[t]hese unlawful practices include zoning laws and other housing restrictions that function unfairly to exclude minorities from certain neighborhoods without any sufficient justification."[8]

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[6] *Vill. of Arlington Heights v. Metro. Hous. Dev. Corp.*, 429 U.S. 252, 265–68 (1977).
[7] ___ U.S. ___, 135 S. Ct. 2507 (2015).
[8] *Id.* at 2521–22.

A land use or zoning practice results in a discriminatory effect if it caused or predictably will cause a disparate impact on a group of persons or if it creates, increases, reinforces, or perpetuates segregated housing patterns because of a protected characteristic. A state or local government still has the opportunity to show that the practice is necessary to achieve one or more of its substantial, legitimate, nondiscriminatory interests. These interests must be supported by evidence and may not be hypothetical or speculative. If these interests could not be served by another practice that has a less discriminatory effect, then the practice does not violate the Act. The standard for evaluating housing-related practices with a discriminatory effect are set forth in HUD's Discriminatory Effects Rule, 24 C.F.R § 100.500.

Examples of land use practices that violate the Fair Housing Act under a discriminatory effects standard include minimum floor space or lot size requirements that increase the size and cost of housing if such an increase has the effect of excluding persons from a locality or neighborhood because of their membership in a protected class, without a legally sufficient justification. Similarly, prohibiting low-income or multifamily housing may have a discriminatory effect on persons because of their membership in a protected class and, if so, would violate the Act absent a legally sufficient justification.

5. Does a state or local government violate the Fair Housing Act if it considers the fears or prejudices of community members when enacting or applying its zoning or land use laws respecting housing?

When enacting or applying zoning or land use laws, state and local governments may not act because of the fears, prejudices, stereotypes, or unsubstantiated assumptions that community members may have about current or prospective residents because of the residents' protected characteristics. Doing so violates the Act, even if the officials themselves do not personally share such bias. For example, a city may not deny zoning approval for a low-income housing development that meets all zoning and land use requirements because the development may house residents of a particular protected class or classes whose presence, the community fears, will increase crime and lower property values in the surrounding neighborhood. Similarly, a local government may not block a group home or deny a requested reasonable accommodation in response to neighbors' stereotypical fears or prejudices about persons with disabilities or a particular type of disability. Of course, a city council or zoning board is not bound by everything that is said by every person who speaks at a public hearing. It is the record as a whole that will be determinative.

6. Can state and local governments violate the Fair Housing Act if they adopt or implement restrictions against children?

Yes. State and local governments may not impose restrictions on where families with children may reside unless the restrictions are consistent with the "housing for older persons" exemption of the Act. The most common types of housing for older persons that may qualify for this exemption are: (1) housing intended for, and solely occupied by, persons 62 years of age or older; and (2) housing in which 80% of the occupied units have at least one person who is 55 years of age or older that publishes and adheres to policies and procedures demonstrating the intent to house older persons. These types of housing must meet all requirements of the exemption, including complying with HUD regulations applicable to such housing, such as verification procedures regarding the age of the occupants. A state or local government that zones an area to exclude families with children under 18 years of age must continually ensure that housing in that zone meets all requirements of the exemption. If all of the housing in that zone does not continue to meet all such requirements, that state or local government violates the Act.

Questions and Answers on the Fair Housing Act and Local Land Use and Zoning Regulation of Group Homes

7. Who qualifies as a person with a disability under the Fair Housing Act?

The Fair Housing Act defines a person with a disability to include (1) individuals with a physical or mental impairment that substantially limits one or more major life activities; (2) individuals who are regarded as having such an impairment; and (3) individuals with a record of such an impairment.

The term "physical or mental impairment" includes, but is not limited to, diseases and conditions such as orthopedic, visual, speech and hearing impairments, cerebral palsy, autism, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, HIV infection, developmental disabilities, mental illness, drug addiction (other than addiction caused by current, illegal use of a controlled substance), and alcoholism.

The term "major life activity" includes activities such as seeing, hearing, walking breathing, performing manual tasks, caring for one's self, learning, speaking, and working. This list of major life activities is not exhaustive.

Being regarded as having a disability means that the individual is treated as if he or she has a disability even though the individual may not have an impairment or may not have an impairment that substantially limits one or more major life activities. For example, if a landlord

refuses to rent to a person because the landlord believes the prospective tenant has a disability, then the landlord violates the Act's prohibition on discrimination on the basis of disability, even if the prospective tenant does not actually have a physical or mental impairment that substantially limits one or more major life activities.

Having a record of a disability means the individual has a history of, or has been misclassified as having, a mental or physical impairment that substantially limits one or more major life activities.

8. What is a group home within the meaning of the Fair Housing Act?

The term "group home" does not have a specific legal meaning; land use and zoning officials and the courts, however, have referred to some residences for persons with disabilities as group homes. The Fair Housing Act prohibits discrimination on the basis of disability, and persons with disabilities have the same Fair Housing Act protections whether or not their housing is considered a group home. A household where two or more persons with disabilities choose to live together, as a matter of association, may not be subjected to requirements or conditions that are not imposed on households consisting of persons without disabilities.

In this Statement, the term "group home" refers to a dwelling that is or will be occupied by unrelated persons with disabilities. Sometimes group homes serve individuals with a particular type of disability, and sometimes they serve individuals with a variety of disabilities. Some group homes provide residents with in-home support services of varying types, while others do not. The provision of support services is not required for a group home to be protected under the Fair Housing Act. Group homes, as discussed in this Statement, may be opened by individuals or by organizations, both for-profit and not-for-profit. Sometimes it is the group home operator or developer, rather than the individuals who live or are expected to live in the home, who interacts with a state or local government agency about developing or operating the group home, and sometimes there is no interaction among residents or operators and state or local governments.

In this Statement, the term "group home" includes homes occupied by persons in recovery from alcohol or substance abuse, who are persons with disabilities under the Act. Although a group home for persons in recovery may commonly be called a "sober home," the term does not have a specific legal meaning, and the Act treats persons with disabilities who reside in such homes no differently than persons with disabilities who reside in other types of group homes. Like other group homes, homes for persons in recovery are sometimes operated by individuals or organizations, both for-profit and not-for-profit, and support services or supervision are sometimes, but not always, provided. The Act does not require a person who resides in a home for persons in recovery to have participated in or be currently participating in a

substance abuse treatment program to be considered a person with a disability. The fact that a resident of a group home may currently be illegally using a controlled substance does not deprive the other residents of the protection of the Fair Housing Act.

9. In what ways does the Fair Housing Act apply to group homes?

The Fair Housing Act prohibits discrimination on the basis of disability, and persons with disabilities have the same Fair Housing Act protections whether or not their housing is considered a group home. State and local governments may not discriminate against persons with disabilities who live in group homes. Persons with disabilities who live in or seek to live in group homes are sometimes subjected to unlawful discrimination in a number of ways, including those discussed in the preceding Section of this Joint Statement. Discrimination may be intentional; for example, a locality might pass an ordinance prohibiting group homes in single-family neighborhoods or prohibiting group homes for persons with certain disabilities. These ordinances are facially discriminatory, in violation of the Act. In addition, as discussed more fully in Q&A 10 below, a state or local government may violate the Act by refusing to grant a reasonable accommodation to its zoning or land use ordinance when the requested accommodation may be necessary for persons with disabilities to have an equal opportunity to use and enjoy a dwelling. For example, if a locality refuses to waive an ordinance that limits the number of unrelated persons who may live in a single-family home where such a waiver may be necessary for persons with disabilities to have an equal opportunity to use and enjoy a dwelling, the locality violates the Act unless the locality can prove that the waiver would impose an undue financial and administrative burden on the local government or fundamentally alter the essential nature of the locality's zoning scheme. Furthermore, a state or local government may violate the Act by enacting an ordinance that has an unjustified discriminatory effect on persons with disabilities who seek to live in a group home in the community. Unlawful actions concerning group homes are discussed in more detail throughout this Statement.

10. What is a reasonable accommodation under the Fair Housing Act?

The Fair Housing Act makes it unlawful to refuse to make "reasonable accommodations" to rules, policies, practices, or services, when such accommodations may be necessary to afford persons with disabilities an equal opportunity to use and enjoy a dwelling. A "reasonable accommodation" is a change, exception, or adjustment to a rule, policy, practice, or service that may be necessary for a person with a disability to have an equal opportunity to use and enjoy a dwelling, including public and common use spaces. Since rules, policies, practices, and services may have a different effect on persons with disabilities than on other persons, treating persons with disabilities exactly the same as others may sometimes deny them an equal opportunity to use and enjoy a dwelling.

Even if a zoning ordinance imposes on group homes the same restrictions that it imposes on housing for other groups of unrelated persons, a local government may be required, in individual cases and when requested to do so, to grant a reasonable accommodation to a group home for persons with disabilities. What constitutes a reasonable accommodation is a case-by-case determination based on an individualized assessment. This topic is discussed in detail in Q&As 20–25 and in the HUD/DOJ Joint Statement on Reasonable Accommodations under the Fair Housing Act.

11. Does the Fair Housing Act protect persons with disabilities who pose a "direct threat" to others?

The Act does not allow for the exclusion of individuals based upon fear, speculation, or stereotype about a particular disability or persons with disabilities in general. Nevertheless, the Act does not protect an individual whose tenancy would constitute a "direct threat" to the health or safety of other individuals or whose tenancy would result in substantial physical damage to the property of others unless the threat or risk to property can be eliminated or significantly reduced by reasonable accommodation. A determination that an individual poses a direct threat must rely on an individualized assessment that is based on reliable objective evidence (for example, current conduct or a recent history of overt acts). The assessment must consider: (1) the nature, duration, and severity of the risk of injury; (2) the probability that injury will actually occur; and (3) whether there are any reasonable accommodations that will eliminate or significantly reduce the direct threat. See Q&A 10 for a general discussion of reasonable accommodations. Consequently, in evaluating an individual's recent history of overt acts, a state or local government must take into account whether the individual has received intervening treatment or medication that has eliminated or significantly reduced the direct threat (in other words, significant risk of substantial harm). In such a situation, the state or local government may request that the individual show how the circumstances have changed so that he or she no longer poses a direct threat. Any such request must be reasonable and limited to information necessary to assess whether circumstances have changed. Additionally, in such a situation, a state or local government may obtain satisfactory and reasonable assurances that the individual will not pose a direct threat during the tenancy. The state or local government must have reliable, objective evidence that the tenancy of a person with a disability poses a direct threat before excluding him or her from housing on that basis, and, in making that assessment, the state or local government may not ignore evidence showing that the individual's tenancy would no longer pose a direct threat. Moreover, the fact that one individual may pose a direct threat does not mean that another individual with the same disability or other individuals in a group home may be denied housing.

12. Can a state or local government enact laws that specifically limit group homes for individuals with specific types of disabilities?

No. Just as it would be illegal to enact a law for the purpose of excluding or limiting group homes for individuals with disabilities, it is illegal under the Act for local land use and zoning laws to exclude or limit group homes for individuals with specific types of disabilities. For example, a government may not limit group homes for persons with mental illness to certain neighborhoods. The fact that the state or local government complies with the Act with regard to group homes for persons with some types of disabilities will not justify discrimination against individuals with another type of disability, such as mental illness.

13. Can a state or local government limit the number of individuals who reside in a group home in a residential neighborhood?

Neutral laws that govern groups of unrelated persons who live together do not violate the Act so long as (1) those laws do not intentionally discriminate against persons on the basis of disability (or other protected class), (2) those laws do not have an unjustified discriminatory effect on the basis of disability (or other protected class), and (3) state and local governments make reasonable accommodations when such accommodations may be necessary for a person with a disability to have an equal opportunity to use and enjoy a dwelling.

Local zoning and land use laws that treat groups of unrelated persons with disabilities less favorably than similar groups of unrelated persons without disabilities violate the Fair Housing Act. For example, suppose a city's zoning ordinance defines a "family" to include up to a certain number of unrelated persons living together as a household unit, and gives such a group of unrelated persons the right to live in any zoning district without special permission from the city. If that ordinance also prohibits a group home having the same number of persons with disabilities in a certain district or requires it to seek a use permit, the ordinance would violate the Fair Housing Act. The ordinance violates the Act because it treats persons with disabilities less favorably than families and unrelated persons without disabilities.

A local government may generally restrict the ability of groups of unrelated persons to live together without violating the Act as long as the restrictions are imposed on all such groups, including a group defined as a family. Thus, if the definition of a family includes up to a certain number of unrelated individuals, an ordinance would not, on its face, violate the Act if a group home for persons with disabilities with more than the permitted number for a family were not allowed to locate in a single-family-zoned neighborhood because any group of unrelated people without disabilities of that number would also be disallowed. A facially neutral ordinance, however, still may violate the Act if it is intentionally discriminatory (that is, enacted with discriminatory intent or applied in a discriminatory manner), or if it has an unjustified

discriminatory effect on persons with disabilities. For example, an ordinance that limits the number of unrelated persons who may constitute a family may violate the Act if it is enacted for the purpose of limiting the number of persons with disabilities who may live in a group home, or if it has the unjustified discriminatory effect of excluding or limiting group homes in the jurisdiction. Governments may also violate the Act if they enforce such restrictions more strictly against group homes than against groups of the same number of unrelated persons without disabilities who live together in housing. In addition, as discussed in detail below, because the Act prohibits the denial of reasonable accommodations to rules and policies for persons with disabilities, a group home that provides housing for a number of persons with disabilities that exceeds the number allowed under the family definition has the right to seek an exception or waiver. If the criteria for a reasonable accommodation are met, the permit must be given in that instance, but the ordinance would not be invalid.[9]

14. How does the Supreme Court's ruling in *Olmstead* apply to the Fair Housing Act?

In *Olmstead v. L.C.*,[10] the Supreme Court ruled that the Americans with Disabilities Act (ADA) prohibits the unjustified segregation of persons with disabilities in institutional settings where necessary services could reasonably be provided in integrated, community-based settings. An integrated setting is one that enables individuals with disabilities to live and interact with individuals without disabilities to the fullest extent possible. By contrast, a segregated setting includes congregate settings populated exclusively or primarily by individuals with disabilities. Although *Olmstead* did not interpret the Fair Housing Act, the objectives of the Fair Housing Act and the ADA, as interpreted in *Olmstead*, are consistent. The Fair Housing Act ensures that persons with disabilities have an equal opportunity to choose the housing where they wish to live. The ADA and *Olmstead* ensure that persons with disabilities also have the option to live and receive services in the most integrated setting appropriate to their needs. The integration mandate of the ADA and *Olmstead* can be implemented without impairing the rights protected by the Fair Housing Act. For example, state and local governments that provide or fund housing, health care, or support services must comply with the integration mandate by providing these programs, services, and activities in the most integrated setting appropriate to the needs of individuals with disabilities. State and local governments may comply with this requirement by adopting standards for the housing, health care, or support services they provide or fund that are reasonable, individualized, and specifically tailored to enable individuals with disabilities to live and interact with individuals without disabilities to the fullest extent possible. Local governments should be aware that ordinances and policies that impose additional restrictions on housing or residential services for persons with disabilities that are not imposed on housing or

[9] Laws that limit the number of occupants per unit do not violate the Act as long as they are reasonable, are applied to all occupants, and do not operate to discriminate on the basis of disability, familial status, or other characteristics protected by the Act.

[10] 527 U.S. 581 (1999).

residential services for persons without disabilities are likely to violate the Act. In addition, a locality would violate the Act and the integration mandate of the ADA and *Olmstead* if it required group homes to be concentrated in certain areas of the jurisdiction by, for example, restricting them from being located in other areas.

15. Can a state or local government impose spacing requirements on the location of group homes for persons with disabilities?

A "spacing" or "dispersal" requirement generally refers to a requirement that a group home for persons with disabilities must not be located within a specific distance of another group home. Sometimes a spacing requirement is designed so it applies only to group homes and sometimes a spacing requirement is framed more generally and applies to group homes and other types of uses such as boarding houses, student housing, or even certain types of businesses. In a community where a certain number of unrelated persons are permitted by local ordinance to reside together in a home, it would violate the Act for the local ordinance to impose a spacing requirement on group homes that do not exceed that permitted number of residents because the spacing requirement would be a condition imposed on persons with disabilities that is not imposed on persons without disabilities. In situations where a group home seeks a reasonable accommodation to exceed the number of unrelated persons who are permitted by local ordinance to reside together, the Fair Housing Act does not prevent state or local governments from taking into account concerns about the over-concentration of group homes that are located in close proximity to each other. Sometimes compliance with the integration mandate of the ADA and *Olmstead* requires government agencies responsible for licensing or providing housing for persons with disabilities to consider the location of other group homes when determining what housing will best meet the needs of the persons being served. Some courts, however, have found that spacing requirements violate the Fair Housing Act because they deny persons with disabilities an equal opportunity to choose where they will live. Because an across-the-board spacing requirement may discriminate against persons with disabilities in some residential areas, any standards that state or local governments adopt should evaluate the location of group homes for persons with disabilities on a case-by-case basis.

Where a jurisdiction has imposed a spacing requirement on the location of group homes for persons with disabilities, courts may analyze whether the requirement violates the Act under an intent, effects, or reasonable accommodation theory. In cases alleging intentional discrimination, courts look to a number of factors, including the effect of the requirement on housing for persons with disabilities; the jurisdiction's intent behind the spacing requirement; the existence, size, and location of group homes in a given area; and whether there are methods other than a spacing requirement for accomplishing the jurisdiction's stated purpose. A spacing requirement enacted with discriminatory intent, such as for the purpose of appeasing neighbors' stereotypical fears about living near persons with disabilities, violates the Act. Further, a neutral

spacing requirement that applies to all housing for groups of unrelated persons may have an unjustified discriminatory effect on persons with disabilities, thus violating the Act. Jurisdictions must also consider, in compliance with the Act, requests for reasonable accommodations to any spacing requirements.

16. Can a state or local government impose health and safety regulations on group home operators?

Operators of group homes for persons with disabilities are subject to applicable state and local regulations addressing health and safety concerns unless those regulations are inconsistent with the Fair Housing Act or other federal law. Licensing and other regulatory requirements that may apply to some group homes must also be consistent with the Fair Housing Act. Such regulations must not be based on stereotypes about persons with disabilities or specific types of disabilities. State or local zoning and land use ordinances may not, consistent with the Fair Housing Act, require individuals with disabilities to receive medical, support, or other services or supervision that they do not need or want as a condition for allowing a group home to operate. State and local governments' enforcement of neutral requirements regarding safety, licensing, and other regulatory requirements governing group homes do not violate the Fair Housing Act so long as the ordinances are enforced in a neutral manner, they do not specifically target group homes, and they do not have an unjustified discriminatory effect on persons with disabilities who wish to reside in group homes.

Governments must also consider requests for reasonable accommodations to licensing and regulatory requirements and procedures, and grant them where they may be necessary to afford individuals with disabilities an equal opportunity to use and enjoy a dwelling, as required by the Act.

17. Can a state or local government address suspected criminal activity or fraud and abuse at group homes for persons with disabilities?

The Fair Housing Act does not prevent state and local governments from taking nondiscriminatory action in response to criminal activity, insurance fraud, Medicaid fraud, neglect or abuse of residents, or other illegal conduct occurring at group homes, including reporting complaints to the appropriate state or federal regulatory agency. States and localities must ensure that actions to enforce criminal or other laws are not taken to target group homes and are applied equally, regardless of whether the residents of housing are persons with disabilities. For example, persons with disabilities residing in group homes are entitled to the same constitutional protections against unreasonable search and seizure as those without disabilities.

18. Does the Fair Housing Act permit a state or local government to implement strategies to integrate group homes for persons with disabilities in particular neighborhoods where they are not currently located?

Yes. Some strategies a state or local government could use to further the integration of group housing for persons with disabilities, consistent with the Act, include affirmative marketing or offering incentives. For example, jurisdictions may engage in affirmative marketing or offer variances to providers of housing for persons with disabilities to locate future homes in neighborhoods where group homes for persons with disabilities are not currently located. But jurisdictions may not offer incentives for a discriminatory purpose or that have an unjustified discriminatory effect because of a protected characteristic.

19. Can a local government consider the fears or prejudices of neighbors in deciding whether a group home can be located in a particular neighborhood?

In the same way a local government would violate the law if it rejected low-income housing in a community because of neighbors' fears that such housing would be occupied by racial minorities (see Q&A 5), a local government violates the law if it blocks a group home or denies a reasonable accommodation request because of neighbors' stereotypical fears or prejudices about persons with disabilities. This is so even if the individual government decision-makers themselves do not have biases against persons with disabilities.

Not all community opposition to requests by group homes is necessarily discriminatory. For example, when a group home seeks a reasonable accommodation to operate in an area and the area has limited on-street parking to serve existing residents, it is not a violation of the Fair Housing Act for neighbors and local government officials to raise concerns that the group home may create more demand for on-street parking than would a typical family and to ask the provider to respond. A valid unaddressed concern about inadequate parking facilities could justify denying the requested accommodation, if a similar dwelling that is not a group home or similarly situated use would ordinarily be denied a permit because of such parking concerns. If, however, the group home shows that the home will not create a need for more parking spaces than other dwellings or similarly-situated uses located nearby, or submits a plan to provide any needed off-street parking, then parking concerns would not support a decision to deny the home a permit.

20. When does a state or local government violate the Fair Housing Act by failing to grant a request for a reasonable accommodation?

A state or local government violates the Fair Housing Act by failing to grant a reasonable accommodation request if (1) the persons requesting the accommodation or, in the case of a group home, persons residing in or expected to reside in the group home are persons with a disability under the Act; (2) the state or local government knows or should reasonably be expected to know of their disabilities; (3) an accommodation in the land use or zoning ordinance or other rules, policies, practices, or services of the state or locality was requested by or on behalf of persons with disabilities; (4) the requested accommodation may be necessary to afford one or more persons with a disability an equal opportunity to use and enjoy the dwelling; (5) the state or local government refused to grant, failed to act on, or unreasonably delayed the accommodation request; and (6) the state or local government cannot show that granting the accommodation would impose an undue financial and administrative burden on the local government or that it would fundamentally alter the local government's zoning scheme. A requested accommodation may be necessary if there is an identifiable relationship between the requested accommodation and the group home residents' disability. Further information is provided in Q&A 10 above and the HUD/DOJ Joint Statement on Reasonable Accommodations under the Fair Housing Act.

21. Can a local government deny a group home's request for a reasonable accommodation without violating the Fair Housing Act?

Yes, a local government may deny a group home's request for a reasonable accommodation if the request was not made by or on behalf of persons with disabilities (by, for example, the group home developer or operator) or if there is no disability-related need for the requested accommodation because there is no relationship between the requested accommodation and the disabilities of the residents or proposed residents.

In addition, a group home's request for a reasonable accommodation may be denied by a local government if providing the accommodation is not reasonable—in other words, if it would impose an undue financial and administrative burden on the local government or it would fundamentally alter the local government's zoning scheme. The determination of undue financial and administrative burden must be decided on a case-by-case basis involving various factors, such as the nature and extent of the administrative burden and the cost of the requested accommodation to the local government, the financial resources of the local government, and the benefits that the accommodation would provide to the persons with disabilities who will reside in the group home.

When a local government refuses an accommodation request because it would pose an undue financial and administrative burden, the local government should discuss with the requester whether there is an alternative accommodation that would effectively address the disability-related needs of the group home's residents without imposing an undue financial and administrative burden. This discussion is called an "interactive process." If an alternative accommodation would effectively meet the disability-related needs of the residents of the group home and is reasonable (that is, it would not impose an undue financial and administrative burden or fundamentally alter the local government's zoning scheme), the local government must grant the alternative accommodation. An interactive process in which the group home and the local government discuss the disability-related need for the requested accommodation and possible alternative accommodations is both required under the Act and helpful to all concerned, because it often results in an effective accommodation for the group home that does not pose an undue financial and administrative burden or fundamental alteration for the local government.

22. What is the procedure for requesting a reasonable accommodation?

The reasonable accommodation must actually be requested by or on behalf of the individuals with disabilities who reside or are expected to reside in the group home. When the request is made, it is not necessary for the specific individuals who would be expected to live in the group home to be identified. The Act does not require that a request be made in a particular manner or at a particular time. The group home does not need to mention the Fair Housing Act or use the words "reasonable accommodation" when making a reasonable accommodation request. The group home must, however, make the request in a manner that a reasonable person would understand to be a disability-related request for an exception, change, or adjustment to a rule, policy, practice, or service. When making a request for an exception, change, or adjustment to a local land use or zoning regulation or policy, the group home should explain what type of accommodation is being requested and, if the need for the accommodation is not readily apparent or known by the local government, explain the relationship between the accommodation and the disabilities of the group home residents.

A request for a reasonable accommodation can be made either orally or in writing. It is often helpful for both the group home and the local government if the reasonable accommodation request is made in writing. This will help prevent misunderstandings regarding what is being requested or whether or when the request was made.

Where a local land use or zoning code contains specific procedures for seeking a departure from the general rule, courts have decided that these procedures should ordinarily be followed. If no procedure is specified, or if the procedure is unreasonably burdensome or intrusive or involves significant delays, a request for a reasonable accommodation may,

nevertheless, be made in some other way, and a local government is obligated to grant it if the requested accommodation meets the criteria discussed in Q&A 20, above.

Whether or not the local land use or zoning code contains a specific procedure for requesting a reasonable accommodation or other exception to a zoning regulation, if local government officials have previously made statements or otherwise indicated that an application for a reasonable accommodation would not receive fair consideration, or if the procedure itself is discriminatory, then persons with disabilities living in a group home, and/or its operator, have the right to file a Fair Housing Act complaint in court to request an order for a reasonable accommodation to the local zoning regulations.

23. Does the Fair Housing Act require local governments to adopt formal reasonable accommodation procedures?

The Act does not require a local government to adopt formal procedures for processing requests for reasonable accommodations to local land use or zoning codes. DOJ and HUD nevertheless strongly encourage local governments to adopt formal procedures for identifying and processing reasonable accommodation requests and provide training for government officials and staff as to application of the procedures. Procedures for reviewing and acting on reasonable accommodation requests will help state and local governments meet their obligations under the Act to respond to reasonable accommodation requests and implement reasonable accommodations promptly. Local governments are also encouraged to ensure that the procedures to request a reasonable accommodation or other exception to local zoning regulations are well known throughout the community by, for example, posting them at a readily accessible location and in a digital format accessible to persons with disabilities on the government's website. If a jurisdiction chooses to adopt formal procedures for reasonable accommodation requests, the procedures cannot be onerous or require information beyond what is necessary to show that the individual has a disability and that the requested accommodation is related to that disability. For example, in most cases, an individual's medical record or detailed information about the nature of a person's disability is not necessary for this inquiry. In addition, officials and staff must be aware that any procedures for requesting a reasonable accommodation must also be flexible to accommodate the needs of the individual making a request, including accepting and considering requests that are not made through the official procedure. The adoption of a reasonable accommodation procedure, however, will not cure a zoning ordinance that treats group homes differently than other residential housing with the same number of unrelated persons.

24. What if a local government fails to act promptly on a reasonable accommodation request?

A local government has an obligation to provide prompt responses to reasonable accommodation requests, whether or not a formal reasonable accommodation procedure exists. A local government's undue delay in responding to a reasonable accommodation request may be deemed a failure to provide a reasonable accommodation.

25. Can a local government enforce its zoning code against a group home that violates the zoning code but has not requested a reasonable accommodation?

The Fair Housing Act does not prohibit a local government from enforcing its zoning code against a group home that has violated the local zoning code, as long as that code is not discriminatory or enforced in a discriminatory manner. If, however, the group home requests a reasonable accommodation when faced with enforcement by the locality, the locality still must consider the reasonable accommodation request. A request for a reasonable accommodation may be made at any time, so at that point, the local government must consider whether there is a relationship between the disabilities of the residents of the group home and the need for the requested accommodation. If so, the locality must grant the requested accommodation unless doing so would pose a fundamental alteration to the local government's zoning scheme or an undue financial and administrative burden to the local government.

Questions and Answers on Fair Housing Act Enforcement of Complaints Involving Land Use and Zoning

26. How are Fair Housing Act complaints involving state and local land use laws and practices handled by HUD and DOJ?

The Act gives HUD the power to receive, investigate, and conciliate complaints of discrimination, including complaints that a state or local government has discriminated in exercising its land use and zoning powers. HUD may not issue a charge of discrimination pertaining to "the legality of any State or local zoning or other land use law or ordinance." Rather, after investigating, HUD refers matters it believes may be meritorious to DOJ, which, in its discretion, may decide to bring suit against the state or locality within 18 months after the practice at issue occurred or terminated. DOJ may also bring suit by exercising its authority to initiate litigation alleging a pattern or practice of discrimination or a denial of rights to a group of persons which raises an issue of general public importance.

If HUD determines that there is no reasonable cause to believe that there may be a violation, it will close an investigation without referring the matter to DOJ. But a HUD or DOJ

decision not to proceed with a land use or zoning matter does not foreclose private plaintiffs from pursuing a claim.

Litigation can be an expensive, time-consuming, and uncertain process for all parties. HUD and DOJ encourage parties to land use disputes to explore reasonable alternatives to litigation, including alternative dispute resolution procedures, like mediation or conciliation of the HUD complaint. HUD attempts to conciliate all complaints under the Act that it receives, including those involving land use or zoning laws. In addition, it is DOJ's policy to offer prospective state or local governments the opportunity to engage in pre-suit settlement negotiations, except in the most unusual circumstances.

27. How can I find more information?

For more information on reasonable accommodations and reasonable modifications under the Fair Housing Act:

- HUD/DOJ Joint Statement on Reasonable Accommodations under the Fair Housing Act, *available at* https://www.justice.gov/crt/fair-housing-policy-statements-and-guidance-0 or http://www.hud.gov/offices/fheo/library/huddojstatement.pdf.

- HUD/DOJ Joint Statement on Reasonable Modifications under the Fair Housing Act, *available at* https://www.justice.gov/crt/fair-housing-policy-statements-and-guidance-0 or http://www.hud.gov/offices/fheo/disabilities/reasonable_modifications_mar08.pdf.

For more information on state and local governments' obligations under Section 504:

- HUD website at http://portal.hud.gov/hudportal/HUD?src=/program_offices/fair_housing_equal_opp/disabilities/sect504.

For more information on state and local governments' obligations under the ADA and *Olmstead*:

- U.S. Department of Justice website, www.ADA.gov, or call the ADA information line at (800) 514-0301 (voice) or (800) 514-0383 (TTY).
- Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.*, *available at* http://www.ada.gov./olmstead/q&a_olmstead.htm.
- Statement of the Department of Housing and Urban Development on the Role of Housing in Accomplishing the Goals of *Olmstead*, *available at* http://portal.hud.gov/hudportal/documents/huddoc?id=OlmsteadGuidnc060413.pdf.

For more information on the requirement to affirmatively further fair housing:

- Affirmatively Furthering Fair Housing, 80 Fed. Reg. 42,272 (July 16, 2015) (to be codified at 24 C.F.R. pts. 5, 91, 92, 570, 574, 576, and 903).
- U.S. Department of Housing and Urban Development, Version 1, Affirmatively Furthering Fair Housing Rule Guidebook (2015), *available at* https://www.hudexchange.info/resources/documents/AFFH-Rule-Guidebook.pdf.
- Office of Fair Housing and Equal Opportunity, U.S. Department of Housing and Urban Development, Vol. 1, Fair Housing Planning Guide (1996), *available at* http://www.hud.gov/offices/fheo/images/fhpg.pdf.

For more information on nuisance and crime-free ordinances:

- Office of General Counsel Guidance on Application of Fair Housing Act Standards to the Enforcement of Local Nuisance and Crime-Free Housing Ordinances Against Victims of Domestic Violence, Other Crime Victims, and Others Who Require Police or Emergency Services (Sept. 13, 2016), *available at* http://portal.hud.gov/hudportal/documents/huddoc?id=FinalNuisanceOrdGdnce.pdf.

SUMMARY OF KEY POINTS IN NEW JOINT STATEMENT

Below is a summary of key points in the *Joint Statement of the Department of Housing and Urban Development and the Department of Justice: State and Local Land Use Laws and Practice and the Application of the Fair Housing Act*.

Accommodation Requests

As a general rule, a city may deny an accommodation request if granting it would impose an undue financial and administrative burden on local government or would fundamentally alter the city's zoning scheme. Factors to consider include the nature and extent of the potential burden, the cost of the requested accommodation, the financial resources of the local government, and the benefits of the accommodation to the disabled individual. [Pages 14-15] A city can also deny an accommodation if there is no disability-related need for an accommodation because there is no relationship between the accommodation and the disability. [Page 15] The accommodation must actually be *necessary* to afford the disabled individual equal access to housing. A city is well within its rights to ask a requesting person or entity to demonstrate why the accommodation is indeed necessary.

In particular, the new Joint Statement makes clear that, when reviewing a group home's request for an accommodation from an ordinance, **municipalities may take into account concerns about the overconcentration and proximity of group homes to one another.** [Page 12]

While cities must treat equally all homes housing a particular number of unrelated individuals, cities may in some circumstances consider the impact of high-occupancy homes on a community when assessing an accommodation request. For example, when a group home seeks a reasonable accommodation to operate in an area with limited on-street parking, a city may raise concerns that the group home might create too much demand for parking than would a typical family. This could justify denying a reasonable accommodation request. [Page 14]

It is important to keep in mind that a group home must have the opportunity to both apply for a reasonable accommodation and also take part in a back-and-forth

with a municipality to mitigate any burden that fulfilling the request might pose. Requests for accommodation can be either written or oral and can take place at any point.

Preventing De Facto Segregation

The Supreme Court ruled in *Olmstead v. L.C.* that the Americans with Disabilities Act (ADA) prohibits the unjustified segregation of people with disabilities in institutional settings when they could otherwise live in integrated settings. A segregated setting includes congregate settings populated exclusively or primarily by individuals with disabilities. [Page 11] The Joint Statement makes clear that ADA principles such as this can apply in the context of the Fair Housing Act's disability protections. Therefore, it is possible to interpret the ADA prohibition on de facto segregation of congregate living to extend in the FHA context to a community populated primarily by sober homes. In practice, this means that this principle from *Olmstead* may be a defense to denying a group home's accommodation request.

Distance Requirements

Distance or spacing requirements that aim to address group home density are generally inadvisable and may be discriminatory, especially if they aim to discriminate against those with disabilities, but **facially neutral distance requirements *may* be permissible** if they apply equally to all homes with more than a certain number of unrelated individuals, if the city can demonstrate that the requirements are not based on stereotypical fears about living near people with disabilities or motivated by animus against the disabled, and if such distance requirements are the only method to accomplish a city's stated purpose. [Pages 11-12] The burden of demonstrating the need for such distance requirements – such as preventing the fundamental alteration of a municipal zoning scheme – will fall upon the local government. The city could, in theory, incorporate the *Olmstead* argument, that failing to enact distance requirements would necessarily undermine community integration.

Licensing and Registration

Licensing and other requirements for group homes for health and safety purposes ***may* be permitted** if they are not based on stereotypes, equally apply to all homes with a minimum number of unrelated residents, and do not target homes based on the presence of individuals with a disability. For example, **requiring only individuals with disabilities to obtain a license to cohabitate would be discriminatory.** Also, a licensing requirement enacted to address a problem that also could be addressed via less discriminatory means would violate the Fair Housing Act. However, a *necessary* licensing scheme that required all homes that house more than X number of unrelated individuals to obtain a license would not automatically be discriminatory on its face. [12-13] For example, a city might require any landlord renting to more than a certain number of unrelated people to register with the city. That said, the requirements to obtain the license would have to be reasonably possible to be fulfilled.

Incentivizing Group Homes to Locate Elsewhere

The Fair Housing Act allows cities and states to implement strategies to integrate group homes for those with disabilities in neighborhoods where they are not yet located, including via affirmative marketing and incentives. For example, **a city could offer variances or tax incentives to sober homes that locate in neighborhoods where sober homes are not currently located,** rather than in neighborhoods where there are already many sober homes. [Page 13]

People Not Protected by the Fair Housing Act

Not everyone struggling with addiction to drugs or alcohol is protected under the Fair Housing Act. Those currently using illegal drugs are not protected by the Fair Housing Act. However, **the fact that one or more residents of a group home is currently illegally using drugs does not deprive the other residents of Fair Housing Act protections.** [Page 7] In practice, this means that if a sober home resident were to abuse illegal drugs, a city would not be permitted to take an otherwise prohibited action under the Fair Housing Act against the whole sober home, such as revoking its reasonable accommodation or license.

The Fair Housing Act also does not protect people whose tenancy would create a *direct* threat to the health and safety of others or whose tenancy demonstrably would result in substantial physical damage to the property of others. [Page 8]

Preventing Fraud

The Fair Housing Act **does not prevent state or local government from taking action in response to criminal activity,** insurance fraud, Medicaid Fraud, neglect or abuse of residents, or other illegal conduct occurring at group homes. [Page 13]

Treating All Group Homes the Same

The Fair Housing Act treats people who live in sober homes the same as people with disabilities who live in other group homes. Targeting people or homes based on a specific disability is a form of intentional discrimination. [Page 9] This means that **an ordinance may not specifically single out all sober homes in a manner that treats them differently than other homes** housing a large number of unrelated individuals, including other group homes.

Things Cities and States Cannot Do

Cities and states CANNOT:

- **Pass an ordinance prohibiting all group homes or sober homes from being located in single-family neighborhoods.** [Page 7]
- Impose restrictions or conditions on group homes for people with disabilities that are not imposed on other groups of unrelated individuals, for, by example, requiring a permit for the disabled to live in a single-family home or community, while not requiring that of other residents. [Page 2]
- **Impose restrictions on housing based on public safety concerns that are based on stereotypes about residents' disability status,** for, by example, requiring additional security measures because of a belief that those addicted to drugs are more likely to engage in criminal activity. [Page 2]
- Prohibit the development of housing based on a belief that residents will have a disability. For example, a city cannot place a moratorium on the

development of multifamily housing or of group homes because of concern that residents will be disabled. [Page 2]

- Refuse to provide a reasonable accommodation to a law, policy, or ordinance when such accommodation is *necessary* to allow a person with disabilities to have an equal opportunity to use and enjoy a housing unit, subject to reasonable accommodation exceptions noted above. [Page 3]
- **Act because of the fears, prejudices, stereotypes, or unsubstantiated assumptions that community members may have about residents because those residents have a disability, such as addiction.** However, a city council or zoning board is not legally bound by every discriminatory statement said by every person who speaks at a public hearing about a proposed ordinance. [Page 5]
- Cite homes for the disabled with code violations if they do not cite other residences for similar violations. [Page 2]
- Require individuals with disabilities to receive medical or support services they do not need or want as a condition for living in a group home or living in a home located in a particular community. [Page 7]

The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment or Recovery

The opioid crisis poses an extraordinary challenge to communities throughout our country. The Department of Justice (the Department) has responded with a comprehensive approach prioritizing prevention, enforcement, and treatment. This includes enforcing the Americans with Disabilities Act (ADA), which prohibits discrimination against people in recovery from opioid use disorder (OUD) who are not engaging in illegal drug use, including those who are taking legally-prescribed medication to treat their OUD. This guidance document provides information about how the ADA can protect individuals with OUD from discrimination—an important part of combating the opioid epidemic across American communities. While this document focuses on individuals with OUD, the legal principles discussed also apply to individuals with other types of substance use disorders.

1) What is the ADA?

The ADA is a federal law that gives civil rights protections to individuals with disabilities in many areas of life. The ADA guarantees that people with disabilities have the same opportunities as everyone else to enjoy employment opportunities,[1] participate in state and local government programs,[2] and purchase goods and services.[3] For example, the ADA protects people with disabilities from discrimination by social services agencies; child welfare agencies; courts; prisons and jails; medical facilities, including hospitals, doctors' offices, and skilled nursing facilities; homeless shelters; and schools, colleges, and universities.

2) Does an individual in treatment or recovery from opioid use disorder have a disability under the ADA?

Typically, yes, unless the individual is currently engaged in illegal drug use. *See* Question 5.

The ADA prohibits discrimination on the basis of disability.[4] The ADA defines disability as (1) a physical or mental impairment that substantially limits one or more major life activities,

including major bodily functions; (2) a record of such an impairment; or (3) being regarded as having such an impairment.[5]

People with OUD typically have a disability because they have a drug addiction that substantially limits one or more of their major life activities. Drug addiction is considered a physical or mental impairment under the ADA.[6] Drug addiction occurs when the repeated use of drugs causes clinically significant impairment, such as health problems and or an inability to meet major responsibilities at work, school, or home.[7] People with OUD may therefore experience a substantial limitation of one or more major life activities, such as caring for oneself, learning, concentrating, thinking, communicating, working, or the operation of major bodily functions, including neurological and brain functions.[8] The ADA also protects individuals who are in recovery, but who would be limited in a major life activity in the absence of treatment and/or services to support recovery.[9]

3) Does the ADA protect individuals who are taking legally prescribed medication to treat their opioid use disorder?

Yes, if the individual is not engaged in the illegal use of drugs. Under the ADA, an individual's use of prescribed medication, such as that used to treat OUD, is not an "illegal use of drugs" if the individual uses the medication under the supervision of a licensed health care professional, including primary care or other non-specialty providers.[10] This includes medications for opioid use disorder (MOUD) or medication assisted treatment (MAT). MOUD is the use of one of three medications (methadone, buprenorphine, or naltrexone) approved by the Food and Drug Administration (FDA) for treatment of OUD;[11] MAT refers to treatment of OUD and certain other substance use disorders by combining counseling and behavioral therapies with the use of FDA-approved medications.[12]

Example A
A skilled nursing facility refuses to admit a patient with OUD because the patient takes doctor-prescribed MOUD, and the facility prohibits any of its patients from taking MOUD. The facility's exclusion of patients based on their OUD would violate the ADA.

Example B
A jail does not allow incoming inmates to continue taking MOUD prescribed before their detention. The jail's blanket policy prohibiting the use of MOUD would violate the ADA.

4) Does the ADA protect individuals with opioid use disorder who currently participate in a drug treatment program?

Yes. Individuals whose OUD is a disability and who are participating in a supervised rehabilitation or drug treatment program are protected by the ADA if they are not currently engaging in the illegal use of drugs.[13] *See* explanation in Question 5. It is illegal to discriminate against these individuals based on their treatment for OUD.

Example C
A doctor's office has a blanket policy of denying care to patients receiving treatment for OUD. The office would violate the ADA if it excludes individuals based on their OUD.

Example D
A town refuses to allow a treatment center for people with OUD to open after residents complained that they did not want "those kind of people" in their area. The town may violate the ADA if its refusal is because of the residents' hostility towards people with OUD.

5) Does the ADA protect individuals who are currently illegally using opioids?

Generally, no. With limited exceptions, the ADA does not protect individuals engaged in the current illegal use of drugs if an entity takes action against them because of that illegal drug use.[14] "Current illegal use of drugs" means illegal use of drugs that occurred recently enough to justify a reasonable belief that a person's drug use is current or that continuing use is a real and ongoing problem.[15] Illegal use, however, does not include taking a medication, including an opioid or medication used to treat OUD, under the supervision of a licensed health care professional.[16]

Example E
A mentoring program requires its volunteers to provide test results showing that they do not engage in the illegal use of drugs. The program dismisses a volunteer who tests positive for opioids for which the volunteer does not have a valid prescription. This does not violate the ADA because the dismissal was based on current illegal drug use.

In addition, an individual cannot be denied health services, or services provided in connection with drug rehabilitation, on the basis of that individual's current illegal use of drugs, if the individual is otherwise entitled to such services.[17] But a drug rehabilitation or treatment program may deny participation to individuals who engage in illegal use of drugs while they are in the program.[18]

Example F
A hospital emergency room routinely turns away people experiencing drug overdoses, but admits all other patients who are experiencing emergency health issues. The hospital would be in violation of the ADA for denying health services to those individuals because of their current illegal drug use, since those individuals would otherwise be entitled to emergency services.

Example G
A drug rehabilitation program asks a participant to leave because that participant routinely breaks a rule prohibiting the use of illegal drugs while in the program. This is not discrimination under the ADA because the program can require participants to abstain from illegal drugs while in the program.

6) Does the ADA protect individuals with a history of past opioid use disorder, who no longer illegally use drugs?

Yes. The ADA protects individuals with a "record of" disability. As explained above in Question 2, OUD typically qualifies as a disability. Therefore, individuals with a "record of" having OUD usually will be protected under the ADA.[19] Individuals would fall into this category if they have a history of, or have been misclassified as having, OUD.[20]

Example H
A city terminates an employee based on his disclosure that he completed treatment for a previous addiction to prescription opioids. The city may be in violation of the ADA for discriminating against the employee based on his record of OUD.

7) Does the ADA provide any legal protections for individuals who are regarded as having an opioid use disorder, whether or not they actually have an opioid use disorder?

Yes. The ADA protects individuals who are "regarded as" having OUD, even if they do not in fact have OUD.[21]

Example I
An employer mistakenly believes that an employee has OUD simply because that employee uses opioids legally prescribed by her physician to treat pain associated with an injury. The ADA prohibits an employer from firing the employee based on this mistaken belief.

8) Does the ADA protect individuals from discrimination based on their association with individuals who have opioid use disorder?

Yes. The ADA protects individuals from discrimination based on their known association or relationship with an individual who has a disability, such as a friend, coworker, or family member. The ADA also protects organizations, such as OUD treatment clinics, from discriminatory enforcement of zoning rules based on the organization's known association with or relationship to individuals with OUD. [22]

9) Can employers have a drug policy or conduct drug testing for opioids?

Yes. Employers may adopt or administer reasonable policies or procedures, including drug testing, designed to ensure that individuals are not engaging in the illegal use of drugs.[23] However, some individuals who test positive for an opioid, which may include MOUD, will be able to show that the medication is being taken as prescribed or administered and a licensed health care professional is supervising its use. These individuals may not be denied, or fired from, a job for this legal use of medication, unless they cannot do the job safely and effectively, or are disqualified under another federal law.[24]

10) What can I do if I believe I have been discriminated against because of my opioid use disorder or treatment for my opioid use disorder?

Individuals may file a complaint with the Department of Justice if they believe that a public accommodation or a state or local government is discriminating or has discriminated against them because of OUD. Individuals may also bring private lawsuits under the ADA.

Information about filing an ADA complaint with the Department is available at civilrights.justice.gov. More information about the ADA is available by calling the Department's toll-free ADA information line at 800-514-0301 or 800-514-0383 (TTY), or accessing its ADA website at ada.gov.

Complaints about a state or local government's programs, services, or activities relating to the provision of health care and social services can also be filed with the Department of Health and Human Services Office for Civil Rights (HHS OCR). Information about filing an HHS OCR complaint is available at hhs.gov/civil-rights/filing-a-complaint, by email at OCRMail@hhs.gov, by phone at 1-800-368-1019, or at 1-800-537-7697 (TTY).

Complaints about employment discrimination (called "charges") on the basis of disability can be filed with the Equal Employment Opportunity Commission (EEOC). Information about filing an EEOC charge is available at eeoc.gov or 800-669-4000, 800-669-6820 (TTY), or 844-234-5122 (ASL Video Phone). Additional EEOC resources regarding employees and opioid use are available at eeoc.gov/laws/guidance/use-codeine-oxycodone-and-other-opioids-information-employees and eeoc.gov/laws/guidance/how-health-care-providers-can-help-current-and-former-patients-who-have-used-opioids.

Individuals who believe they have been discriminated against under the ADA and would like to file a complaint should file as soon as possible. For instance, there are specific filing deadlines for a charge of employment discrimination, either 180 days or 300 days from the date of the alleged discrimination, depending on the jurisdiction where the charge is filed.

11) Where can I find treatment for opioid use disorder?

Information about treatment for opioid use disorder is available at hhs.gov/opioids, findtreatment.gov, samhsa.gov/medication-assisted-treatment/practitioner-program-data/treatment-practitioner-locator, and dpt2.samhsa.gov/treatment.

Date issued: April 5, 2022

[1] 42 U.S.C. §§ 12111-12117. The Equal Employment Opportunity Commission (EEOC) and the Department of Justice jointly enforce the ADA's ban on employment discrimination. For more information or to file a complaint of employment discrimination, visit eeoc.gov.

[2] *Id.* §§ 12131-12134.

[3] *Id.* §§ 12181-12189.

[4] *Id.* §§ 12112, 12132, 12182.

[5] *Id.* § 12102(1)-(2).

[6] 28 C.F.R. §§ 35.108(b)(2), 36.105(b)(2). Regulations implementing Title I of the ADA define the term "physical or mental impairment" as including "any physiological disorder or condition." 29 C.F.R. § 1630.2(h).

[7] *See* Substance Abuse and Mental Health Services Administration, *Mental Health and Substance Use Disorders*, samhsa.gov/find-help/disorders (last visited Apr. 1, 2022).

[8] 42 U.S.C. § 12102; 28 C.F.R. §§ 35.108(c)(1) (listing examples of major life activities, which include the operation of major bodily functions), 36.105(c)(1) (same).

[9] 28 C.F.R. §§ 35.108(d)(1)(viii), 36.105(d)(1)(viii).

[10] 42 U.S.C. § 12210(d); 28 C.F.R. §§ 35.104, 36.104.

[11] *See* Substance Abuse and Mental Health Services Administration, *TIP 63: Medications for Opioid Use Disorder*, store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP21-02-01-002 (last visited Apr. 1, 2022); *see also* Health Resources and Services Administration, *Caring for Women with Opioid Use Disorder: A Toolkit for Organization Leaders and Providers*, hrsa.gov/sites/default/files/hrsa/Caring-for-Women-with-Opioid-Disorder.pdf (last visited Apr. 1, 2022).

[12] *See* Substance Abuse and Mental Health Services Administration, *Medication-Assisted Treatment (MAT)*, samhsa.gov/medication-assisted-treatment (last visited Apr. 1, 2022); *see also* Substance Abuse and Mental Health Services Administration, *MAT Medications, Counseling, and Related Conditions*, samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions (last visited Apr. 1, 2022).

[13] 42 U.S.C. § 12210(b)(2); 28 C.F.R. §§ 35.131(a)(2)(ii), 36.209(a)(2)(ii).

[14] 42 U.S.C. § 12210(a); 28 C.F.R. §§ 35.131(a)(1), 36.209(a)(1).

[15] 28 C.F.R. §§ 35.104, 36.104.

[16] 42 U.S.C. § 12210(d); 28 C.F.R. §§ 35.104, 36.104.

[17] 42 U.S.C. § 12210(c); 28 C.F.R. §§ 35.131(b)(1), 36.209(b)(1).

[18] 28 C.F.R. §§ 35.131(b)(2), 36.209(b)(2).

[19] 42 U.S.C. § 12102(1)(B); 28 C.F.R. §§ 35.108(a)(1)(ii), 36.105(a)(1)(ii).

[20] 42 U.S.C. § 12102(1)(B); 28 C.F.R. §§ 35.108(e), 36.105(e).

[21] 42 U.S.C. § 12102(1)(C); 28 C.F.R. §§ 35.108(a)(1)(iii), 35.108(f), 36.105(a)(1)(iii), 36.105(f); *see also* 42 U.S.C. § 12201(h); 28 C.F.R. §§ 35.130(b)(7)(ii), 36.302(g); 29 C.F.R. § 1630.2(o)(4) (noting that individuals who meet the definition of "disability" solely because they are "regarded as" disabled are not entitled to reasonable modifications or reasonable accommodations under the ADA).

[22] 42 U.S.C. § 12112(b)(4); 42 U.S.C. § 12182(b)(1)(E); 28 C.F.R. §§ 35.130(g), 36.205; 29 C.F.R. § 1630.8.

[23] 42 U.S.C. §§ 12114(b), 12114(d); 29 C.F.R. §§ 1630.3(c), 1630.16(c); *see also* 42 U.S.C. § 12210(b); 28 C.F.R. §§ 35.131(c), 36.209(c) (drug testing by Title II and Title III entities).

[24] *See, e.g.*, 42 U.S.C. § 12111(3); 29 C.F.R. §§ 1630.2(r), 1630.15(b)(2), 1630.15(e).

The Americans with Disabilities Act authorizes the Department of Justice to provide technical assistance to individuals and entities that have rights or responsibilities under the Act. This document provides informal guidance to assist you in understanding the ADA and the Department's regulations.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way. This document is intended to provide clarity to the public regarding existing requirements under the law or Department policies.

Federal Scientists Recommend Easing Restrictions on Marijuana

In newly disclosed documents, federal researchers find that cannabis may have medical uses and is less likely to cause harm than drugs like heroin.

Trimming a marijuana bud at a dispensary in Massachusetts.Credit...Cindy Schultz for The New York Times

By Christina Jewett and Noah Weiland

Jan. 12, 2024

Marijuana is neither as risky nor as prone to abuse as other tightly controlled substances and has potential medical benefits, and therefore should be removed from the nation's most restrictive category of drugs, federal scientists have concluded.

The recommendations are contained in a 250-page scientific review provided to Matthew Zorn, a Texas lawyer who sued Health and Human Services officials for its release and published it online on Friday night. An H.H.S. official confirmed the authenticity of the document.

The records shed light for the first time on the thinking of federal health officials who are pondering a momentous change. The agencies involved have not publicly commented on their debates over what amounts to a reconsideration of marijuana at the federal level.

Since 1970, marijuana has been considered a so-called Schedule I drug, a category that also includes heroin. Schedule I drugs have no medical use and a high potential for abuse, and they carry severe criminal penalties under federal trafficking laws.

The documents show that scientists at the Food and Drug Administration and the National Institute on Drug Abuse have recommended that the Drug Enforcement Administration make marijuana a Schedule III drug, alongside the likes of ketamine and testosterone, which are available by prescription.

The review by federal scientists found that even though marijuana is the most frequently abused illicit drug, "it does not produce serious outcomes compared to drugs in Schedules I or II."

Marijuana abuse does lead to physical dependence, the analysis noted, and some people develop a psychological dependence. "But the likelihood of serious outcomes is low," the review concluded.

More About Cannabis

With recreational marijuana becoming legal in several states, cannabis products are becoming more easily available and increasingly varied.

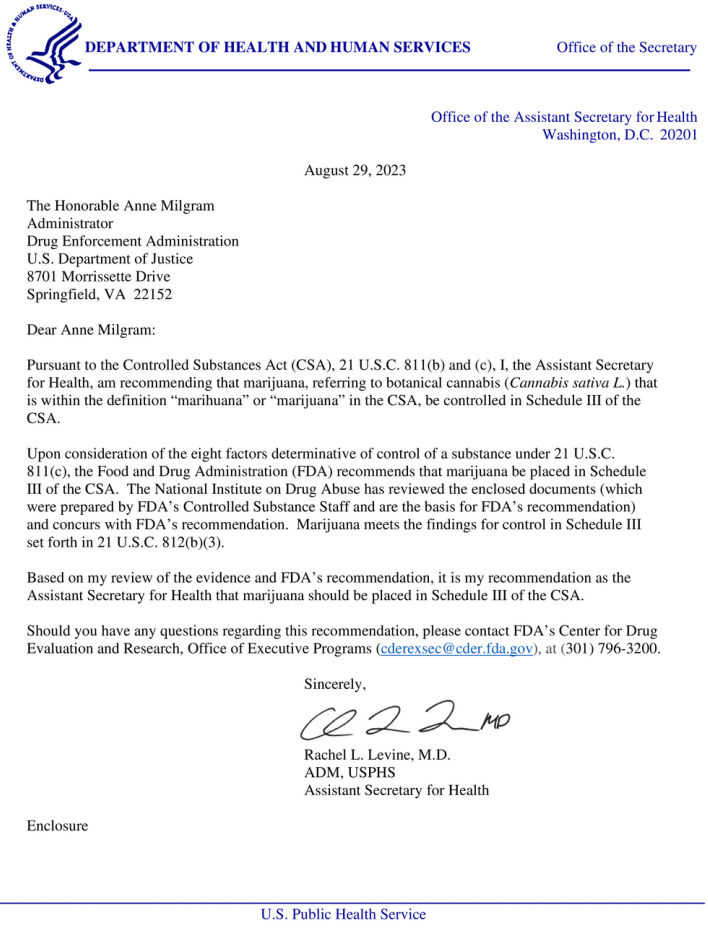
- **A New Heavyweight in the Industry?: The retired boxer** Mike Tyson's foray into the cannabis market in New York is a test of how far a celebrity can carry a brand.
- **Easing Restrictions:** Federal scientists have recommended that the U.S. government remove marijuana from the nation's most restrictive category of drugs.
- **Marijuana or a Gun?:** Legal challenges are pending across the country against a federal law that prevents medical marijuana users from buying or owning firearms.
- **Use Among Older Adults:** Older people are using cannabis more than ever. Here's what to know about the potential medicinal benefits and the side effects.

The review also said there is some "scientific support" for therapeutic uses of marijuana, including treatment of anorexia, pain, and nausea and vomiting related to chemotherapy.

Federal officials cautioned that their analysis was not meant to suggest that they had established the safety and effectiveness of marijuana in a way that would support F.D.A. approval, only that data supported some medical uses of marijuana.

These conclusions apparently led the F.D.A. to break from decades of precedent last August and advise the Drug Enforcement Administration to recategorize marijuana, a move first reported by Bloomberg News.

That recommendation is being considered by the D.E.A., which is expected to formally announce its decision within months. The reclassification will be subject to public comment and debate before it is made final.



DEPARTMENT OF HEALTH AND HUMAN SERVICES — Office of the Secretary

Office of the Assistant Secretary for Health
Washington, D.C. 20201

August 29, 2023

The Honorable Anne Milgram
Administrator
Drug Enforcement Administration
U.S. Department of Justice
8701 Morrissette Drive
Springfield, VA 22152

Dear Anne Milgram:

Pursuant to the Controlled Substances Act (CSA), 21 U.S.C. 811(b) and (c), I, the Assistant Secretary for Health, am recommending that marijuana, referring to botanical cannabis (*Cannabis sativa L.*) that is within the definition "marihuana" or "marijuana" in the CSA, be controlled in Schedule III of the CSA.

Upon consideration of the eight factors determinative of control of a substance under 21 U.S.C. 811(c), the Food and Drug Administration (FDA) recommends that marijuana be placed in Schedule III of the CSA. The National Institute on Drug Abuse has reviewed the enclosed documents (which were prepared by FDA's Controlled Substance Staff and are the basis for FDA's recommendation) and concurs with FDA's recommendation. Marijuana meets the findings for control in Schedule III set forth in 21 U.S.C. 812(b)(3).

Based on my review of the evidence and FDA's recommendation, it is my recommendation as the Assistant Secretary for Health that marijuana should be placed in Schedule III of the CSA.

Should you have any questions regarding this recommendation, please contact FDA's Center for Drug Evaluation and Research, Office of Executive Programs (cderexsec@cder.fda.gov), at (301) 796-3200.

Sincerely,

Rachel L. Levine, M.D.
ADM, USPHS
Assistant Secretary for Health

Enclosure

U.S. Public Health Service

Read the document

Read Document 252 pages

The scientific assessment has prompted tensions between career employees at the D.E.A., a famously conservative law enforcement agency, and the researchers and health officials who support reclassification, according to two senior administration officials.

Xavier Becerra, the health and human services secretary, said in an interview this week that his department had stayed in touch with the D.E.A. about marijuana's status and had "communicated to them our position."

"We put it all out there for them," he said. "We continue to offer them any follow up, technical information if they have any questions."

Advocates for the marijuana industry have hailed a possible rescheduling as highly significant, a powerful way to get marijuana businesses out of the shadows and operating on the same tax footing as other major United States corporations.

Other experts are more circumspect. They note that any long-running study of marijuana that the federal authorities have reviewed may not account for the escalating strength and increasingly frequent use of marijuana, which has been tied to psychiatric problems and chronic vomiting among users in recent years.

For years there was the promise, ultimately unmet, that marijuana could be used to combat opioid abuse or treat mental health problems, said Keith Humphreys, a Stanford health policy professor and a former federal drug policy official.

"As the science has gotten better in the intervening decades, most of the therapeutic claims about cannabis have been debunked," he said.

"And the evidence that cannabis can in fact be quite harmful has gotten stronger — yet it is now that the federal government has decided to call it a medicine."

President Biden urged federal officials to "expeditiously" re-examine marijuana classification in October 2022, when he also issued pardons for those charged with marijuana possession under federal law.

Mr. Biden cited the disproportionate rates of arrest and prosecution of people who are Black and Hispanic for marijuana-related crimes, despite similar rates of use among white people. In December, Mr. Biden again issued pardons for people who had been convicted of simple possession and use of marijuana on federal land.

Federal data shows that marijuana is popular: An estimated 52 million people in the United States reported using it at some point in 2021. Fewer people, about 36 million, reported marijuana use in the previous month, trailing alcohol and tobacco use.

"Decriminalization and legalization is as popular as it ever was," Gov. Jared Polis of Colorado, a Democrat, said in an interview last year regarding his state's early legalization of cannabis.

“None of the horror stories materialized,” he said. “Underage use is down in Colorado. We regulate marijuana like alcohol, effectively. Responsible adults can choose to recreate with alcohol or marijuana in our state as long as they do it in a safe way and don’t drive, don’t show up at work inebriated.”

In 38 states, marijuana is legal for medical use; it’s legal for recreational use in two dozen states and territories. Its pungent scent has become common in many communities, wafting from car windows at intersections in California and hanging over the crowds in Times Square.

Changing the way federal officials regard marijuana has long been a subject of fierce debate.

In 2016, the D.E.A. rejected a petition to reschedule marijuana, citing federal health officials’ stance at the time: “Marijuana has a high potential for abuse, has no accepted medical use in the United States, and lacks an acceptable level of safety for use even under medical supervision.”

Last month, Michael D. Miller, a Justice Department official, defended the D.E.A.’s prerogative in making the final decision on the administration’s position.

“D.E.A. has the final authority to schedule, reschedule, or deschedule a drug under the Controlled Substances Act, after considering the relevant statutory and regulatory criteria and H.H.S.’s scientific and medical evaluation,” he wrote in a letter to Representative Earl Blumenauer, an Oregon Democrat who has pushed the D.E.A. to reconsider marijuana.

Palm Beach Post | Page A02 Saturday, 3 February 2024

Pa. courts to pay $100K in opioid suit

Pennsylvania courts will pay $100,000 to settle a federal lawsuit alleging that people with opioid use disorder under court supervision were prevented from taking prescribed medicine, the U.S. Department of Justice announced Thursday.

Experts say the lawsuit represents a nationwide issue where people with substance use disorders seeking jail alternative programs such as drug court, probation or parole are restricted from using federally approved addiction treatments that contain opioids.

Sally Friedman, senior vice president of legal advocacy at the Legal Action Center, said the lawsuit in Pennsylvania was the first of its kind, noting she has seen similar issues arise in courts across Ohio, South Carolina, Louisiana, New York, Florida and other states.

More than 10 million people in the United States struggle with opioid use, according to the National Center for Drug Abuse Statistics, and opioids are a factor in 72% of all overdose deaths.

'All too often, people taking medication to treat their OUD (opioid use disorder) are subjected to discrimination based on unfounded stigma associated with these medications,' said Jacqueline C. Romero, U.S. attorney for the Eastern District of Pennsylvania. 'It is a violation of the ADA (Americans with Disabilities Act) to deny someone access to programs and services simply because they are taking medication their doctors have prescribed to get and keep their OUD in remission.'

Under the settlement, Pennsylvania state courts were ordered to pay $100,000 to six people in the lawsuit. The agreement also said state court criminal judges and treatment court professionals will receive training on the Americans with Disabilities Act and opioid use disorder medication.

The settlement concluded a yearslong legal battle stemming from a 2018 complaint to the Justice