Department of Mental Health and Addiction Services Responses
2025 Appropriations Subcommittee Work Session

1. WHAT IS THE PROGRAMMATIC IMPACT OF REDUCING PREVENTION SERVICES?

The Governor's proposed budget reduces state-funded prevention activities. Table 1 on the following page shows how the $22.4 million prevention budget, including all state, federal, and settlement funds, is broken down by program area.

The proposal reduces prevention-related staffing by 7 positions and the Grants for Mental Health and Substance Abuse Services accounts by $500,000 each. Table 1 illustrates the funding streams these reductions could impact – the yellow highlighted columns encompass all prevention funding expended from the Mental Health and Substance Abuse Services Grants accounts, and the green highlighted column shows how personal services monies are expended across program areas. DMHAS has not finalized a recommendation about where these specific reductions would be made in the identified programs but wanted to illustrate the areas of potential impact.

A detailed description of the prevention program areas follows Table 1.

DMHAS is committed to collaborating with partners to maximize resources to continue investment in the promotion of overall health and wellness of individuals and communities.

Table 1. Prevention Funding SFY 2025

Program Area		General Funds Allocated				Federal Funds	Drug Asset Forfeiture	Cannabis	Juul	Total
		SA Grants	MH Grants	Managed Services	Personal Services					
A. Workforce Development and Support		$100,000				$2,160,941				**$2,260,941**
B. Regional, Community, & Youth Prevention Initiatives	*B1. GPP, RBHAOs, LPCs, RSABs*	$581,065	$218,595	$1,003,395		$7,251,692	$40,000	$1,353,361	$1,500,000	**$11,948,108**
	B2. Statewide Prevention & Cannabis Program Staff				$584,845[i]			$444,330[ii]		**$1,029,175**
	B3. Opioid-Related Prevention					$173,655[iii]				**$173,655**
C. Information Dissemination & Community Engagement		$143,491				$2,255,274		$1,566,309		**$3,965,074**
D. Tobacco Prevention & Enforcement	*D1. FDA Tobacco Program Expenses*					$210,640				**$210,640**
	D2. Synar Amendment				$365,277[iv]					**$365,277**
	D3. FDA Tobacco program staff					$1,318,890[v]				**$1,318,890**
	D4. Youth Investigators						$160,046			**$160,046**
E. Mental Health Promotion & Youth Suicide Prevention						$735,000				**$735,000**
F. Tertiary Prevention/Harm Reduction Supplies						$254,146				**$254,146**
Total		**$824,556**	**$218,595**	**$1,003,395**	**$950,122**	**$14,360,238**	**$200,046**	**$3,364,000**	**$1,500,000**	**$22,420,952**

Yellow Highlighted Columns – Area of potential impact - Governor's Proposed Budget reduces the Grants for Mental Health and Substance Abuse Services accounts by $500,000 each

Green Highlighted Columns – Area of potential impact - Governor's Proposed Budget reduces prevention-related staffing by 7 positions.

[i] Salary for 5 primary prevention FTEs
[ii] Salary & fringe for 3 cannabis-related FTEs
[iii] Salary & fringe for 1 federally funded FTE
[iv] Salary for 4 Synar amendment FTEs – youth access tobacco compliance
[v] Salary & fringe for 5 federally funded FTEs – compliance for FDA tobacco control Act

Detailed Descriptions of Program Areas in Table 1:

A. Workforce Development and Support

- Increase employment opportunities for individuals in recovery
- Provide support and resources to organizations and prevention professionals by offering training programs, technical assistance, resource development and dissemination, and supports
- Monitor, collect, analyze and disseminate behavioral health data to inform prevention services, programs, and the behavioral service system
- Assess the prevention workforce training needs and maintain a statewide workforce development training program
- Track, collect, analyze and disseminate behavioral health data to inform prevention services and programs
- Provide a cloud-based service to meet the state and federal data collection, management, and reporting requirements

B. Regional, Community, & Youth Prevention Initiatives

- *B1*. Assess, plan and provide for the behavioral health needs of children, adolescents and adults across the five regions. Includes Regional Behavioral Health Action Organizations (RBHAOs), Governor's Prevention Partnership, Local Prevention Councils in 169 towns, Regional Suicide Advisory Boards, youth vaping & adult and youth alcohol misuse prevention. Promote youth development and mentoring statewide. Train first responders and other key community sectors on prevention and secondary prevention strategies.
- *B2.* Manage statewide primary prevention, including suicide prevention and postvention, and cannabis programs including coordinating activities for all contracted programs, organizing the Annual CT Prevention Summit and National Prevention Week, and presenting at national and statewide conferences. Includes 5 Primary Prevention FTEs & 3 Cannabis Program FTEs.
- *B3*. Reduce the number of prescription drug/ opioid overdose-related deaths and adverse events among individuals 18 years and older by training first responders and other key community sectors on prevention and secondary prevention strategies. Includes 1 FTE.

C. Information Dissemination & Community Engagement

- Statewide library and resource center that provides information on substance use and mental health, prevention, recovery and treatment. Includes centralized repository of prevention-based curriculum, programs, interventions for educators, students, families, organizations, retailers and communities to mitigate impact of substance use as well as mobile outreach. Media campaign focused on educating adults, parents, and youth.

D. Tobacco Prevention & Enforcement

- *D1.* FDA tobacco program expenses for required compliance with the federal tobacco laws to reduce youth access to tobacco products
- *D2*. 4 FTEs to ensure compliance with the Synar Amendment which aims to reduce youth access to tobacco products
- *D3*. 5 FTEs to conduct inspections of CT tobacco and ENDS merchants for compliance with provisions of the FDA 2010 Tobacco Control Act
- *D4*. Funding for youth investigators between the ages of 16- 20 perform undercover compliance checks at retail establishments to determine if retailers are adhering to state and federal regulations.

E. Mental Health Promotion & Youth Suicide Prevention

- Enhance statewide and community level mental health promotion and suicide prevention, intervention and response capacity among youth age 24 and under.

F. Tertiary Prevention/Harm Reduction Supplies

- Tertiary prevention strategies such as naloxone distribution, leave behind kits for first responders, safe medication storage for individuals and families and other essential resources. These resources empower individuals and families with knowledge and tools needed to respond to substance use related emergencies and make informed health decisions. Additionally, safe medication storage to reduce risk of medication misuse, accidental ingestion and diversion for illicit use.

2. DOES THE PREVENTION SERVICES REDUCTION IMPACT REGIONAL BEHAVIORAL HEALTH ACTION ORGANIZATIONS?

The RBHAOs are recipients of the programs funded by grants that would be impacted by this proposal – they receive $218,595 from mental health grants and $55,677 from substance use grants.

3. WHAT PERCENTAGE OF THE PREVENTION BUDGET DOES THE STATE-FUNDED SERVICES REDUCTION REPRESENT?

The total General Fund prevention budget is $3.0 million (see Table 1). The $1.7M proposed reduction (7 staff and $1M in total from substance use disorder grants and mental health service grants accounts) represents 57% of this amount. The decrease of 7 positions represents 78% of the General-funded prevention staff (total of 9).

4. PLEASE EXPLAIN WHY THE FY 25 PERSONAL SERVICES DEFICIENCY IS NOT ANNUALIZED IN THE PROPOSED BUDGET.

The current Personal Services deficiency outlined in Table 2 below is not annualized in the proposed biennial budget primarily due to two factors: (1) the $7.6 million withhold in FY 2025 is not annualized, and (2) DMHAS anticipates that strategic efforts in overtime reduction, including the successful filling of crucial, overtime-sensitive positions in the current fiscal year, will realize the additional savings.

Table 2. Personal Services Budget

10010 Personal Services	**FY25**	**FY26** (i)	**FY27** (i)
Available Funding	$246,638,398	$246,638,398	$246,638,398
Adjustments			
Wage settlements	$10,479,461	$14,056,165	$14,056,165
Withhold	($7,600,000)	$0	$0
Transfer Position to DOA&DS		($116,146)	($116,146)
Reallocated IT to DAS		($5,389,192)	($5,389,192)
Reduce Office of the Commissioner staff through attrition		($250,000)	($500,000)
Reduce prevention staff / activities		($700,000)	($700,000)
Reduce Overtime due to Kronos		($1,000,000)	($3,000,000)
Revised Funding	$249,517,859	$253,239,225	$250,989,225
Projected Expenditures (ii)	$265,117,859	$253,239,225	$250,989,225
Projected Surplus / (Deficit)	($15,600,000)	$0	$0

(i) Starting point is the FY25 appropriation

(ii) Projected expenditures for FY26 and FY27 reflect the adjustments shown as well as annualization of partial year overtime reductions achieved in FY25

5. PLEASE DETAIL PROFESSIONAL SERVICES EXPENDITURES.

Table 3. Professional Services Expenditures SFY 2024

Account	Purpose	SFY 2024
Temporary Services	Temporary certified staffing (for example: pharmacists, psychiatrists, nurses, doctors, and nurse aids)	$13,345,666
Medical Services	To support client specialized medical needs, for example: dental and medical care and radiological services	$10,488,256
Laboratory Services & Testing	Client laboratory testing, X-rays, ultrasounds, and EKG services	$1,802,914
Transportation Services	Emergency and non-emergency transportation of clients from DMHAS facilities to urgent or emergency medical care and varied appointments.	$414,651
Management Consultant Services	Accreditation, pharmacy and nutritional consultants	$229,595
Total		**$26,281,083**

6. PLEASE PROVIDE HISTORICAL STAFFING LEVELS AND OVERTIME EXPENDITURES (8-10 YEARS IF POSSIBLE) AS WELL AS TOTAL PS EXPENDITURES.

Table 4 below includes, for each DMHAS-operated facility, the total overtime expenditures, the total personal services expenditures, the percentage of overtime expenditures of total personal services expenditures, and full-time filled positions, from FY 2017 to FY 2025 (as of 2/25/25). Please note that this overtime exhibit excludes holiday time.

Table 4. Historical Personal Services Expenditures, Overtime, Total Payroll, and Positions by Facility

Facility	FY17	FY18	FY19	FY20	FY21	FY22	FY23	FY24	FY25 as of 2/25/25
DMHAS OT Hours									
Straight Time	198,769	184,729	183,287	174,639	160,787	159,845	154,192	153,777	86,787
Time and a Half	766,424	739,548	671,545	619,250	594,618	580,011	580,639	732,471	420,923
Double Time	33,494	197,223	158,111	232,326	168,346	228,676	333,156	165,537	82,754
Total OT Hours	**998,687**	**1,121,500**	**1,012,943**	**1,026,215**	**923,751**	**968,532**	**1,067,987**	**1,051,785**	**590,464**
CMHC OT Total ($)	3,407,743	3,358,644	3,548,399	3,547,924	3,287,920	2,812,395	2,691,921	3,182,652	1,666,526
CMHC Total PS ($)	18,641,753	15,988,476	16,730,768	18,220,755	17,086,844	17,234,042	18,767,825	20,163,402	13,995,164
CMHC % OT to Total PS	18%	21%	21%	19%	19%	16%	14%	16%	12%
CMHC Filled Positions	163	156	164	175	170	175	177	213	205
CRMHC OT Total ($)	770,897	577,620	520,051	547,806	1,159,273	1,273,569	1,045,328	1,242,526	403,090
CRMHC Total PS ($)	14,136,424	13,758,126	13,502,818	14,541,244	15,196,300	15,517,110	16,361,337	16,034,899	12,008,845
CRMHC % OT to Total PS	5%	4%	4%	4%	8%	8%	6%	8%	3%
CRMHC Filled Positions	139	148	147	145	139	131	144	167	167
CVH OT Total ($)	30,130,393	29,711,169	23,456,120	24,003,122	19,931,053	23,013,322	28,368,918	26,092,504	15,284,769
CVH Total PS ($)	145,490,701	122,013,932	92,006,340	92,262,122	84,714,177	90,702,924	99,708,826	99,671,007	72,801,435
CVH % OT to Total PS	21%	24%	25%	26%	24%	25%	28%	26%	21%
CVH Filled Positions	1,430	953	981	933	863	945	899	1,001	974
OOC OT Total ($)	1,795,113	1,960,959	1,866,645	1,784,173	1,894,798	1,982,209	2,419,307	2,502,746	1,582,196
OOC Total PS ($)	27,032,626	26,200,513	26,735,383	29,118,836	31,218,799	30,975,391	35,500,112	37,179,922	26,700,003
OOC % OT to Total PS	7%	7%	7%	6%	6%	6%	7%	7%	6%
OOC Filled Positions	297	291	310	333	305	258	302	330	321

Facility	FY17	FY18	FY19	FY20	FY21	FY22	FY23	FY24	FY25 as of 2/25/25
RVS OT Total ($)	810,544	767,429	656,848	742,916	954,000	1,087,950	1,193,962	1,357,382	630,341
RVS Total PS ($)	8,261,592	7,761,807	8,406,444	9,097,338	10,684,996	11,285,584	13,580,947	14,312,495	9,631,825
RVS % OT to Total PS	10%	10%	8%	8%	9%	10%	9%	9%	7%
RVS Filled Positions	79	74	76	95	99	104	117	124	126
SMHA OT Total ($)	816,575	575,033	618,229	652,033	730,508	806,152	955,622	771,790	426,977
SMHA Total PS ($)	10,261,063	9,492,221	9,823,600	9,668,209	9,811,384	10,031,243	10,590,586	11,274,388	7,980,316
SMHA % OT to Total PS	8%	6%	6%	7%	7%	8%	9%	7%	5%
SMHA Filled Positions	111	106	104	106	107	108	102	120	122
SWCMHS OT Total ($)	4,464,880	5,544,941	4,906,852	5,371,753	4,594,178	4,064,547	5,032,656	4,845,310	2,691,540
SWCMHS Total PS ($)	35,476,683	30,199,062	30,006,721	30,096,248	30,504,233	31,683,036	34,185,787	34,347,041	25,444,688
SWCMHS % OT to Total PS	13%	18%	16%	18%	15%	13%	15%	14%	11%
SWCMHS Filled Positions	269	254	263	249	259	260	254	292	321
WCMHN OT Total ($)	999,032	689,196	492,740	488,206	549,238	567,869	699,761	634,980	339,804
WCMHN Total PS ($)	13,731,265	11,625,704	12,210,734	11,685,421	12,574,710	12,765,003	13,165,364	13,736,664	9,743,103
WCMHN % OT to Total PS	7%	6%	4%	4%	4%	4%	5%	5%	3%
WCMHN Filled Positions	139	129	129	123	121	123	120	137	141
WFH OT Total ($)	-	5,543,354	11,361,774	13,633,122	16,201,005	13,428,502	16,388,549	16,286,991	10,128,776
WFH Total PS ($)	-	48,728,344	47,427,658	50,771,055	49,301,972	49,036,516	58,796,024	56,916,882	45,190,693
WFH % OT to Total PS	-	11%	24%	27%	33%	27%	28%	29%	22%
WFH Filled Positions		489	499	473	468	449	464	508	493
DMHAS OT Total ($)	43,195,178	48,728,344	47,427,658	50,771,055	49,301,972	49,036,516	58,796,024	56,916,882	33,154,019
DMHAS Total PS ($)	305,005,702	285,768,185	256,850,466	265,461,228	261,093,415	269,230,849	300,656,808	303,636,700	223,496,072
DMHAS % OT to Total PS	14%	17%	18%	19%	19%	18%	20%	19%	15%
DMHAS Filled Positions	2,627	2,600	2,673	2,632	2,531	2,553	2,579	2,892	2,870

ACRONYMS: Connecticut Mental Health Center (CMHC); Capitol Region Mental Health Center (CRMHC); Connecticut Valley Hospital (CVH); Office of the Commissioner (OOC); River Valley Services (RVS); Southeastern Mental Health Authority (SMHA); Southwest Connecticut Mental Health System (SWCMHS); Western Connecticut Mental Health Network (WCMHN); Whiting Forensic Hospital (WFH)

Related to this inquiry, below please find the outpatient client caseload data for Connecticut Mental Health Center (CMHC) for the last three years.

Table 5. CMHC Three-Year Outpatient Client Caseload

CMHC Level of Care Type	2022 Client Count	2023 Client Count	2024 Client Count
Total Outpatient Client Count	1862	1759	1793
Total Research Client Count	351	538	693
Total Outpatient & Research Client Count	2213	2297	2486

7. REGARDING STAFFING REDUCTIONS THROUGH ATTRITION, WHAT RESPONSIBILITIES ARE RELATED TO THESE POSITIONS? HOW WILL THE AGENCY BE IMPACTED?

This reduction represents 5 positions across the Office of Commissioner – for context this represents 1.3% of staff. The actual positions impacted would be determined across the fiscal year, as there is attrition via retirement and voluntary separation and those positions would need to be evaluated as to their criticality and the net salary change of the incumbent vs. replacement.

8. PLEASE DETAIL CURRENT 988 COSTS BY FUNDING SOURCE (FEDERAL, ARPA, GF) AND ESTIMATED COSTS OVER THE BIENNIUM. WHAT IS THE TOTAL COST TO OPERATE 24/7?

Table 6 below details the 988 funding sources and estimated costs over the biennium. The estimated total cost to operate 24/7 in FY 2026 and 2027 is $6.6 million. The Governor's budget proposes $850,000 in each year of the biennium to close the anticipated gap.

Please note that the 988 initiative is funded through numerous sources and relies on a combination of federal awards and state appropriated funding to operate. In our underlying assumptions for the biennium, we assume that certain federal resources (highlighted in yellow below) will continue. DMHAS is currently engaged in contingency planning given the possibility that federal funding may not continue. There is the potential that additional state appropriated resources may be needed in the future to operate 988.

Table 6. 988 Call Center Funding and Estimated Costs

Available Funding for 988 Call Center

Funding	FY25	FY26	FY27
Carryforward	298,684	188,466	-
Base MHBG	698,000	698,000	698,000
SAMHSA 988 Implementation Grant (i)	1,567,893	1,492,206	1,680,345
SAMHSA Safer Communities Grant (i)	222,877	220,643	220,643
General Funds - Managed Services	3,131,996	3,131,996	3,131,996
General Funds - Grants for Sub Abuse Services	17,799	17,799	17,799
Total Funding Amount	**5,937,249**	**5,749,110**	**$5,748,783**
Contract# 25MHA1003	**FY25**	**FY26**	**FY27**
Total Expenditure Amount (ii)	**5,748,783**	**6,598,783**	**6,598,783**
Surplus/(Deficit)	**188,466**	**(849,673)**	**(850,000)**

(i) Assumes continuation of the 988 Implementation and Safer Communities grants.

(ii) FY26 & FY27 projected expenditures include increases of $850K each to reflect anticipated increases in the contract amount.

9. OPIOID SETTLEMENT FUNDS

a. FOR THE PROPOSED USE IN THE BUDGET, PLEASE DETAIL CURRENT FUNDING SOURCE, FUNDING LEVEL, AND PURPOSE

Related to DMHAS, the Governor's biennial budget proposes to fund Adult Mobile Crisis private provider contracts and wrap-around services for 125 individuals in supportive housing.

Purpose: Pursuant to section 17a-485j of the CT general statutes, beginning in FY 2022, DMHAS is required to make adult mobile crisis response services available 24/7 to the public.

Table 7. Adult Mobile Crisis Private Provider Contracts Funding

	FY 23	FY 24	FY 25	FY26	FY27
General Funds	5,553,323	6,738,008	6,628,158	6,628,158	6,628,158
Mental Health Block Grant	1,265,400	813,845	813,845	813,845	813,845
COVID 19 One-time Block Grants	1,638,664	-	-	-	-
ARPA Privately-Provided Mobile Funds (i)	1,700,000	3,000,000	3,000,000	1,250,000	-
ARPA One-time COLA Funds	124,842	-	177,235	-	-
TOTAL	10,282,229	10,551,853	10,619,238	8,692,003	7,442,003

(i) ARPA Funds will be fully expended by 11/30/25. The Governor proposes to use Opioid Settlement funds of $1.75 million to cover expiring ARPRA funding in FY26, annualized at $3 million in FY27.

Purpose: DMHAS partners with DOH to implement the evidence-based Permanent Supportive Housing initiative, which provides for in-home wrap-around services and rental subsidies to individuals and families who are experiencing homelessness and are diagnosed with a behavioral health disorder. The Governor's budget proposes to use Opioid Settlement dollars to fund wrap-around services for 125 individuals in supportive housing who would otherwise lose services.

Table 8. Supportive Housing Services

	FY 23	FY 24	FY 25	FY26	FY27
General Funds	21,633,579	22,868,458	24,017,231	24,017,231	24,017,231
Housing and Urban Development Funds	2,773,170	4,867,135	4,820,459	4,820,459	4,820,459
ARPA - Supportive Housing Services (i)	562,500	1,125,000	1,125,000	562,500	-
ARPA One-time COLA Funds	740,870		313,868	-	-
Social Services Block Grant Funds	264,477	227,054	227,054	227,054	227,054
TOTAL	25,974,596	29,087,647	30,503,612	29,627,244	29,064,744

(i) ARPA Funds will be fully expended by 12/31/25. The Governor proposes to use Opioid Settlement funds of $562,500 to cover expiring ARPA funding in FY26, annualized at $1.125M in FY27.

b. PLEASE PROVIDE AN OVERVIEW OF CURRENT SETTLEMENT FUNDS

Table 9. Opioid Settlement Advisory Committee Funds Received through 1/31/2025

Opioid Settlement Advisory Committee Funds		
Defendant	**Settlement Description**	**Total Amount Received through 1/31/2025**
Janssen (Johnson & Johnson)	Total award of $59,000,000	$ 37,305,082
McKesson	3 of 18 annual payments received. Total award of $240M	$ 50,879,589
Mallinckrodt	Filed bankruptcy will not receive any more funds	$ 4,332,544
Walgreens	Total award of $67,000,000	$ 7,384,445
CVS	Total award of $62,000,000	$ 6,818,213
Walmart	Total award of $45,000,000	$ 29,760,805
Teva	Total award of $47,000,000	$ 6,511,920
Publicis	Total award received	$ 4,437,769
Allergan	Total award of $28,000,000	$ 6,835,655
Endo	Filed bankruptcy will not receive any more funds	$ 4,098,556
	Total Funds Awarded under OSAC	**$ 158,364,578**

c. PLEASE DETAIL PREVIOUSLY APPROVED FUNDING ALLOCATIONS

Table 10. Opioid Settlement Advisory Committee Approved Funding Allocations

Opioid Settlement Advisory Committee Approved Funding Allocations		
Vendor	**Program**	**Total Approved Initiatives (i)**
Dept of Public Health	Opioid Syringe	2,000,000
Dept of Corrections	Opioid Treatment dosing rooms & medication	416,650
Judicial Branch	CSSD - Treatment Pathway Program	3,840,000
Dept of Public Health	DPH MOU- Vending Machines	2,754,784
Dept of Public Health	Naloxone Purchase	2,323,200
Dept of Public Health	Primary Prevention	1,418,000
Dept of Children & Families	Contingency Management	734,468
UCONN Health Center	Contingency Management	418,349
APT Foundation Inc	Mobile Opioid Treatment Programs	2,000,000
Community Health Resources Inc	Mobile Opioid Treatment Programs	2,000,000
RFP - in process	Contingency Management	1,836,193
Governors Prevention Partnership	Pouches	1,967,650
Connecticut Hospitals	Treatment Bridge Model for Emergency Depts	1,250,000
Odonnell Company	LiveLOUD Expansion	600,000
CTHRA, AFL, Apex, RFP (Bridgeport)	CT Harm Reduction Centers Continuation	6,975,000
Dept of Housing	Supportive Housing as Recovery	58,600,000
Boston Medical Center/SafeSpot Hotline	SafeSpot Overdose Hotline Expansion to CT	1,513,085
Connecticut Clearinghouse	Healthy Campus	631,777
	Total OSAC Funding Allocations	**91,279,156**
	Remaining Available OSAC funds	**67,085,422**

(i) The Governor's Budget includes an additional allocation of $6.4M across the biennium to continue funding the ARPA funded 24/7 mobile crisis services and the ARPA funded wrap-around services for 125 individuals in supportive housing.

d. PLEASE DESCRIBE THE PROCESS TO UTILIZE FUNDS (FROM PROPOSAL TO APPROVAL)

Please see Appendix A – Opioid Settlement Advisory Committee Review Process.

e. PLEASE PROVIDE A LIST OF ALLOWABLE USES (EXHIBIT E)

This link will bring you to Exhibit E, which contains the allowable uses per Opioid Settlement guidelines. It is also included in Appendix B – Exhibit E Opioid Settlement Allowable Uses.

10. CAN YOU PROVIDE AN UPDATE ON POTENTIAL IMPACTS OF CHANGES IN FUNDING/SUPPORT AT THE FEDERAL LEVEL?

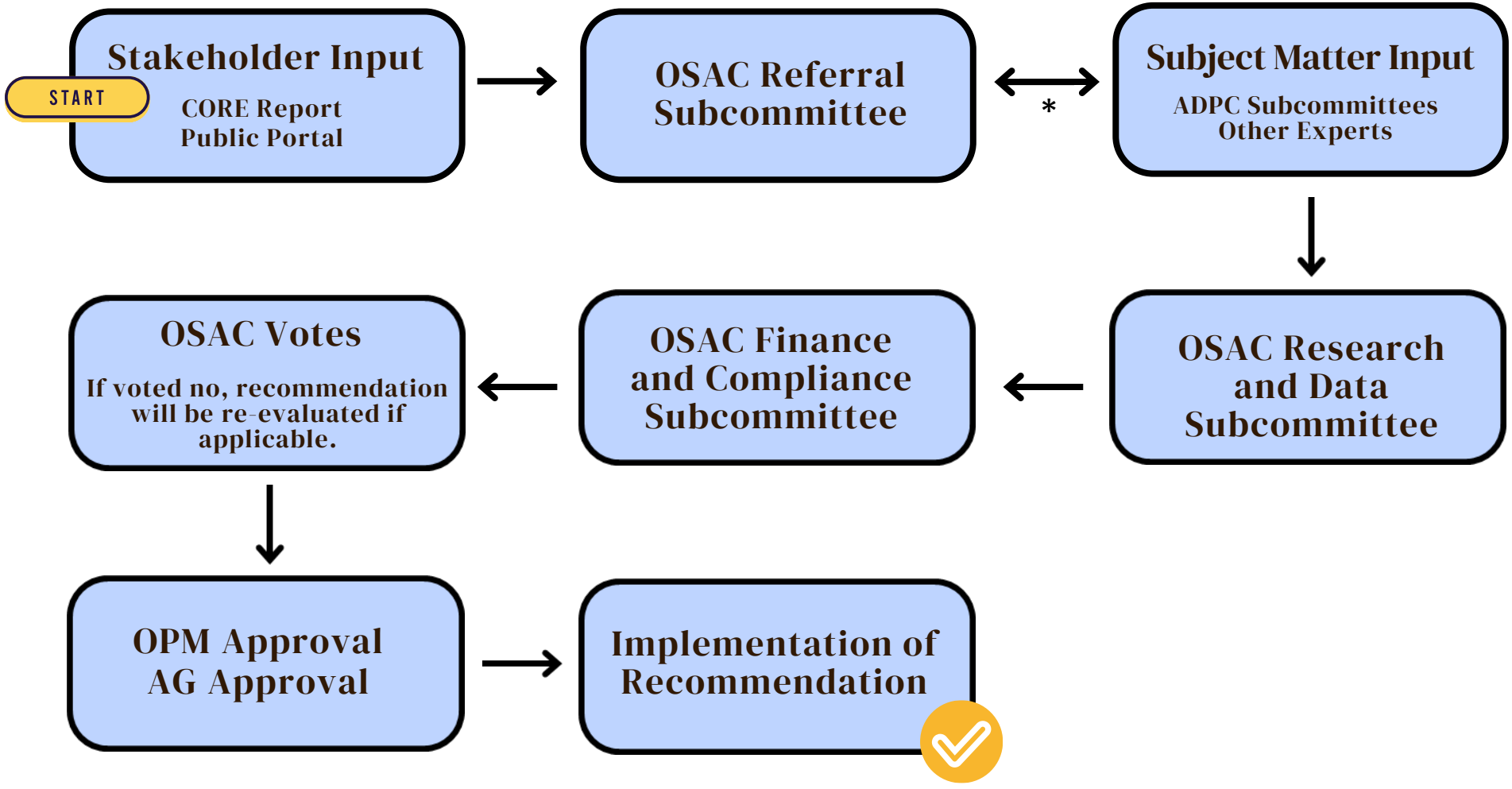
DMHAS is continually monitoring for any potential impacts of changes in funding/support at the federal level. To the extent we have specifics about amounts and timing, we'll develop a response for consideration by the Governor and, to the extent that such response requires action by the General Assembly, we would then bring it to the legislature for consideration.

APPENDIX A

Opioid Settlement Advisory Committee Review Process

OPIOID SETTLEMENT ADVISORY COMMITTEE

Review Process of Opioid Settlement Recommendations



Revised 2.26.2025

* Recommendations may begin the review process with either the OSAC Referral Subcommittee or Subject Matter Experts. Both entities have opportunity for recommendation review and feedback.

APPENDIX B

Exhibit E Opioid Settlement Allowable Uses

EXHIBIT E

List of Opioid Remediation Uses

Schedule A
Core Strategies

States and Qualifying Block Grantees shall choose from among the abatement strategies listed in Schedule B. However, priority shall be given to the following core abatement strategies ("*Core Strategies*").[14]

A. **NALOXONE OR OTHER FDA-APPROVED DRUG TO REVERSE OPIOID OVERDOSES**

1. Expand training for first responders, schools, community support groups and families; and

2. Increase distribution to individuals who are uninsured or whose insurance does not cover the needed service.

B. **MEDICATION-ASSISTED TREATMENT ("*MAT*") DISTRIBUTION AND OTHER OPIOID-RELATED TREATMENT**

1. Increase distribution of MAT to individuals who are uninsured or whose insurance does not cover the needed service;

2. Provide education to school-based and youth-focused programs that discourage or prevent misuse;

3. Provide MAT education and awareness training to healthcare providers, EMTs, law enforcement, and other first responders; and

4. Provide treatment and recovery support services such as residential and inpatient treatment, intensive outpatient treatment, outpatient therapy or counseling, and recovery housing that allow or integrate medication and with other support services.

[14] As used in this Schedule A, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs.

C. **PREGNANT & POSTPARTUM WOMEN**

1. Expand Screening, Brief Intervention, and Referral to Treatment ("*SBIRT*") services to non-Medicaid eligible or uninsured pregnant women;

2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for women with co-occurring Opioid Use Disorder ("*OUD*") and other Substance Use Disorder ("*SUD*")/Mental Health disorders for uninsured individuals for up to 12 months postpartum; and

3. Provide comprehensive wrap-around services to individuals with OUD, including housing, transportation, job placement/training, and childcare.

D. **EXPANDING TREATMENT FOR NEONATAL ABSTINENCE SYNDROME ("*NAS*")**

1. Expand comprehensive evidence-based and recovery support for NAS babies;

2. Expand services for better continuum of care with infant-need dyad; and

3. Expand long-term treatment and services for medical monitoring of NAS babies and their families.

E. **EXPANSION OF WARM HAND-OFF PROGRAMS AND RECOVERY SERVICES**

1. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments;

2. Expand warm hand-off services to transition to recovery services;

3. Broaden scope of recovery services to include co-occurring SUD or mental health conditions;

4. Provide comprehensive wrap-around services to individuals in recovery, including housing, transportation, job placement/training, and childcare; and

5. Hire additional social workers or other behavioral health workers to facilitate expansions above.

F. **TREATMENT FOR INCARCERATED POPULATION**

1. Provide evidence-based treatment and recovery support, including MAT for persons with OUD and co-occurring SUD/MH disorders within and transitioning out of the criminal justice system; and

2. Increase funding for jails to provide treatment to inmates with OUD.

G. **PREVENTION PROGRAMS**

1. Funding for media campaigns to prevent opioid use (similar to the FDA's "Real Cost" campaign to prevent youth from misusing tobacco);

2. Funding for evidence-based prevention programs in schools;

3. Funding for medical provider education and outreach regarding best prescribing practices for opioids consistent with the 2016 CDC guidelines, including providers at hospitals (academic detailing);

4. Funding for community drug disposal programs; and

5. Funding and training for first responders to participate in pre-arrest diversion programs, post-overdose response teams, or similar strategies that connect at-risk individuals to behavioral health services and supports.

H. **EXPANDING SYRINGE SERVICE PROGRAMS**

1. Provide comprehensive syringe services programs with more wrap-around services, including linkage to OUD treatment, access to sterile syringes and linkage to care and treatment of infectious diseases.

I. **EVIDENCE-BASED DATA COLLECTION AND RESEARCH ANALYZING THE EFFECTIVENESS OF THE ABATEMENT STRATEGIES WITHIN THE STATE**

Schedule B
Approved Uses

Support treatment of Opioid Use Disorder (OUD) and any co-occurring Substance Use Disorder or Mental Health (SUD/MH) conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

PART ONE: TREATMENT

A. TREAT OPIOID USE DISORDER (OUD)

Support treatment of Opioid Use Disorder ("*OUD*") and any co-occurring Substance Use Disorder or Mental Health ("*SUD/MH*") conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:[15]

1. Expand availability of treatment for OUD and any co-occurring SUD/MH conditions, including all forms of Medication-Assisted Treatment ("*MAT*") approved by the U.S. Food and Drug Administration.

2. Support and reimburse evidence-based services that adhere to the American Society of Addiction Medicine ("*ASAM*") continuum of care for OUD and any co-occurring SUD/MH conditions.

3. Expand telehealth to increase access to treatment for OUD and any co-occurring SUD/MH conditions, including MAT, as well as counseling, psychiatric support, and other treatment and recovery support services.

4. Improve oversight of Opioid Treatment Programs ("*OTPs*") to assure evidence-based or evidence-informed practices such as adequate methadone dosing and low threshold approaches to treatment.

5. Support mobile intervention, treatment, and recovery services, offered by qualified professionals and service providers, such as peer recovery coaches, for persons with OUD and any co-occurring SUD/MH conditions and for persons who have experienced an opioid overdose.

6. Provide treatment of trauma for individuals with OUD (*e.g.*, violence, sexual assault, human trafficking, or adverse childhood experiences) and family members (*e.g.*, surviving family members after an overdose or overdose fatality), and training of health care personnel to identify and address such trauma.

7. Support evidence-based withdrawal management services for people with OUD and any co-occurring mental health conditions.

[15] As used in this Schedule B, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs.

8. Provide training on MAT for health care providers, first responders, students, or other supporting professionals, such as peer recovery coaches or recovery outreach specialists, including telementoring to assist community-based providers in rural or underserved areas.

9. Support workforce development for addiction professionals who work with persons with OUD and any co-occurring SUD/MH conditions.

10. Offer fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.

11. Offer scholarships and supports for behavioral health practitioners or workers involved in addressing OUD and any co-occurring SUD/MH or mental health conditions, including, but not limited to, training, scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas.

12. Provide funding and training for clinicians to obtain a waiver under the federal Drug Addiction Treatment Act of 2000 ("*DATA 2000*") to prescribe MAT for OUD, and provide technical assistance and professional support to clinicians who have obtained a DATA 2000 waiver.

13. Disseminate of web-based training curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service–Opioids web-based training curriculum and motivational interviewing.

14. Develop and disseminate new curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service for Medication–Assisted Treatment.

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

Support people in recovery from OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the programs or strategies that:

1. Provide comprehensive wrap-around services to individuals with OUD and any co-occurring SUD/MH conditions, including housing, transportation, education, job placement, job training, or childcare.

2. Provide the full continuum of care of treatment and recovery services for OUD and any co-occurring SUD/MH conditions, including supportive housing, peer support services and counseling, community navigators, case management, and connections to community-based services.

3. Provide counseling, peer-support, recovery case management and residential treatment with access to medications for those who need it to persons with OUD and any co-occurring SUD/MH conditions.

4. Provide access to housing for people with OUD and any co-occurring SUD/MH conditions, including supportive housing, recovery housing, housing assistance programs, training for housing providers, or recovery housing programs that allow or integrate FDA-approved mediation with other support services.

5. Provide community support services, including social and legal services, to assist in deinstitutionalizing persons with OUD and any co-occurring SUD/MH conditions.

6. Support or expand peer-recovery centers, which may include support groups, social events, computer access, or other services for persons with OUD and any co-occurring SUD/MH conditions.

7. Provide or support transportation to treatment or recovery programs or services for persons with OUD and any co-occurring SUD/MH conditions.

8. Provide employment training or educational services for persons in treatment for or recovery from OUD and any co-occurring SUD/MH conditions.

9. Identify successful recovery programs such as physician, pilot, and college recovery programs, and provide support and technical assistance to increase the number and capacity of high-quality programs to help those in recovery.

10. Engage non-profits, faith-based communities, and community coalitions to support people in treatment and recovery and to support family members in their efforts to support the person with OUD in the family.

11. Provide training and development of procedures for government staff to appropriately interact and provide social and other services to individuals with or in recovery from OUD, including reducing stigma.

12. Support stigma reduction efforts regarding treatment and support for persons with OUD, including reducing the stigma on effective treatment.

13. Create or support culturally appropriate services and programs for persons with OUD and any co-occurring SUD/MH conditions, including new Americans.

14. Create and/or support recovery high schools.

15. Hire or train behavioral health workers to provide or expand any of the services or supports listed above.

C. CONNECT PEOPLE WHO NEED HELP TO THE HELP THEY NEED (CONNECTIONS TO CARE)

Provide connections to care for people who have—or are at risk of developing—OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:

1. Ensure that health care providers are screening for OUD and other risk factors and know how to appropriately counsel and treat (or refer if necessary) a patient for OUD treatment.

2. Fund SBIRT programs to reduce the transition from use to disorders, including SBIRT services to pregnant women who are uninsured or not eligible for Medicaid.

3. Provide training and long-term implementation of SBIRT in key systems (health, schools, colleges, criminal justice, and probation), with a focus on youth and young adults when transition from misuse to opioid disorder is common.

4. Purchase automated versions of SBIRT and support ongoing costs of the technology.

5. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments.

6. Provide training for emergency room personnel treating opioid overdose patients on post-discharge planning, including community referrals for MAT, recovery case management or support services.

7. Support hospital programs that transition persons with OUD and any co-occurring SUD/MH conditions, or persons who have experienced an opioid overdose, into clinically appropriate follow-up care through a bridge clinic or similar approach.

8. Support crisis stabilization centers that serve as an alternative to hospital emergency departments for persons with OUD and any co-occurring SUD/MH conditions or persons that have experienced an opioid overdose.

9. Support the work of Emergency Medical Systems, including peer support specialists, to connect individuals to treatment or other appropriate services following an opioid overdose or other opioid-related adverse event.

10. Provide funding for peer support specialists or recovery coaches in emergency departments, detox facilities, recovery centers, recovery housing, or similar settings; offer services, supports, or connections to care to persons with OUD and any co-occurring SUD/MH conditions or to persons who have experienced an opioid overdose.

11. Expand warm hand-off services to transition to recovery services.

12. Create or support school-based contacts that parents can engage with to seek immediate treatment services for their child; and support prevention, intervention, treatment, and recovery programs focused on young people.

13. Develop and support best practices on addressing OUD in the workplace.

14. Support assistance programs for health care providers with OUD.

15. Engage non-profits and the faith community as a system to support outreach for treatment.

16. Support centralized call centers that provide information and connections to appropriate services and supports for persons with OUD and any co-occurring SUD/MH conditions.

D. ADDRESS THE NEEDS OF CRIMINAL JUSTICE-INVOLVED PERSONS

Address the needs of persons with OUD and any co-occurring SUD/MH conditions who are involved in, are at risk of becoming involved in, or are transitioning out of the criminal justice system through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:

1. Support pre-arrest or pre-arraignment diversion and deflection strategies for persons with OUD and any co-occurring SUD/MH conditions, including established strategies such as:

    1. Self-referral strategies such as the Angel Programs or the Police Assisted Addiction Recovery Initiative ("*PAARI*");

    2. Active outreach strategies such as the Drug Abuse Response Team ("*DART*") model;

    3. "Naloxone Plus" strategies, which work to ensure that individuals who have received naloxone to reverse the effects of an overdose are then linked to treatment programs or other appropriate services;

    4. Officer prevention strategies, such as the Law Enforcement Assisted Diversion ("*LEAD*") model;

    5. Officer intervention strategies such as the Leon County, Florida Adult Civil Citation Network or the Chicago Westside Narcotics Diversion to Treatment Initiative; or

    6. Co-responder and/or alternative responder models to address OUD-related 911 calls with greater SUD expertise.

2. Support pre-trial services that connect individuals with OUD and any co-occurring SUD/MH conditions to evidence-informed treatment, including MAT, and related services.

3. Support treatment and recovery courts that provide evidence-based options for persons with OUD and any co-occurring SUD/MH conditions.

4. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are incarcerated in jail or prison.

5. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are leaving jail or prison or have recently left jail or prison, are on probation or parole, are under community corrections supervision, or are in re-entry programs or facilities.

6. Support critical time interventions ("*CTI*"), particularly for individuals living with dual-diagnosis OUD/serious mental illness, and services for individuals who face immediate risks and service needs and risks upon release from correctional settings.

7. Provide training on best practices for addressing the needs of criminal justice-involved persons with OUD and any co-occurring SUD/MH conditions to law enforcement, correctional, or judicial personnel or to providers of treatment, recovery, harm reduction, case management, or other services offered in connection with any of the strategies described in this section.

E. ADDRESS THE NEEDS OF PREGNANT OR PARENTING WOMEN AND THEIR FAMILIES, INCLUDING BABIES WITH NEONATAL ABSTINENCE SYNDROME

Address the needs of pregnant or parenting women with OUD and any co-occurring SUD/MH conditions, and the needs of their families, including babies with neonatal abstinence syndrome ("*NAS*"), through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:

1. Support evidence-based or evidence-informed treatment, including MAT, recovery services and supports, and prevention services for pregnant women—or women who could become pregnant—who have OUD and any co-occurring SUD/MH conditions, and other measures to educate and provide support to families affected by Neonatal Abstinence Syndrome.

2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for uninsured women with OUD and any co-occurring SUD/MH conditions for up to 12 months postpartum.

3. Provide training for obstetricians or other healthcare personnel who work with pregnant women and their families regarding treatment of OUD and any co-occurring SUD/MH conditions.

4. Expand comprehensive evidence-based treatment and recovery support for NAS babies; expand services for better continuum of care with infant-need dyad; and expand long-term treatment and services for medical monitoring of NAS babies and their families.

5. Provide training to health care providers who work with pregnant or parenting women on best practices for compliance with federal requirements that children born with NAS get referred to appropriate services and receive a plan of safe care.

6. Provide child and family supports for parenting women with OUD and any co-occurring SUD/MH conditions.

7. Provide enhanced family support and child care services for parents with OUD and any co-occurring SUD/MH conditions.

8. Provide enhanced support for children and family members suffering trauma as a result of addiction in the family; and offer trauma-informed behavioral health treatment for adverse childhood events.

9. Offer home-based wrap-around services to persons with OUD and any co-occurring SUD/MH conditions, including, but not limited to, parent skills training.

10. Provide support for Children's Services—Fund additional positions and services, including supportive housing and other residential services, relating to children being removed from the home and/or placed in foster care due to custodial opioid use.

PART TWO: PREVENTION

F. PREVENT OVER-PRESCRIBING AND ENSURE APPROPRIATE PRESCRIBING AND DISPENSING OF OPIOIDS

Support efforts to prevent over-prescribing and ensure appropriate prescribing and dispensing of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Funding medical provider education and outreach regarding best prescribing practices for opioids consistent with the Guidelines for Prescribing Opioids for Chronic Pain from the U.S. Centers for Disease Control and Prevention, including providers at hospitals (academic detailing).

2. Training for health care providers regarding safe and responsible opioid prescribing, dosing, and tapering patients off opioids.

3. Continuing Medical Education (CME) on appropriate prescribing of opioids.

4. Providing Support for non-opioid pain treatment alternatives, including training providers to offer or refer to multi-modal, evidence-informed treatment of pain.

5. Supporting enhancements or improvements to Prescription Drug Monitoring Programs ("*PDMPs*"), including, but not limited to, improvements that:

1. Increase the number of prescribers using PDMPs;

2. Improve point-of-care decision-making by increasing the quantity, quality, or format of data available to prescribers using PDMPs, by improving the interface that prescribers use to access PDMP data, or both; or

3. Enable states to use PDMP data in support of surveillance or intervention strategies, including MAT referrals and follow-up for individuals identified within PDMP data as likely to experience OUD in a manner that complies with all relevant privacy and security laws and rules.

6. Ensuring PDMPs incorporate available overdose/naloxone deployment data, including the United States Department of Transportation's Emergency Medical Technician overdose database in a manner that complies with all relevant privacy and security laws and rules.

7. Increasing electronic prescribing to prevent diversion or forgery.

8. Educating dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

Support efforts to discourage or prevent misuse of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Funding media campaigns to prevent opioid misuse.

2. Corrective advertising or affirmative public education campaigns based on evidence.

3. Public education relating to drug disposal.

4. Drug take-back disposal or destruction programs.

5. Funding community anti-drug coalitions that engage in drug prevention efforts.

6. Supporting community coalitions in implementing evidence-informed prevention, such as reduced social access and physical access, stigma reduction—including staffing, educational campaigns, support for people in treatment or recovery, or training of coalitions in evidence-informed implementation, including the Strategic Prevention Framework developed by the U.S. Substance Abuse and Mental Health Services Administration ("*SAMHSA*").

7. Engaging non-profits and faith-based communities as systems to support prevention.

8. Funding evidence-based prevention programs in schools or evidence-informed school and community education programs and campaigns for students, families, school employees, school athletic programs, parent-teacher and student associations, and others.

9. School-based or youth-focused programs or strategies that have demonstrated effectiveness in preventing drug misuse and seem likely to be effective in preventing the uptake and use of opioids.

10. Create or support community-based education or intervention services for families, youth, and adolescents at risk for OUD and any co-occurring SUD/MH conditions.

11. Support evidence-informed programs or curricula to address mental health needs of young people who may be at risk of misusing opioids or other drugs, including emotional modulation and resilience skills.

12. Support greater access to mental health services and supports for young people, including services and supports provided by school nurses, behavioral health workers or other school staff, to address mental health needs in young people that (when not properly addressed) increase the risk of opioid or another drug misuse.

H. PREVENT OVERDOSE DEATHS AND OTHER HARMS (HARM REDUCTION)

Support efforts to prevent or reduce overdose deaths or other opioid-related harms through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Increased availability and distribution of naloxone and other drugs that treat overdoses for first responders, overdose patients, individuals with OUD and their friends and family members, schools, community navigators and outreach workers, persons being released from jail or prison, or other members of the general public.

2. Public health entities providing free naloxone to anyone in the community.

3. Training and education regarding naloxone and other drugs that treat overdoses for first responders, overdose patients, patients taking opioids, families, schools, community support groups, and other members of the general public.

4. Enabling school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support.

5. Expanding, improving, or developing data tracking software and applications for overdoses/naloxone revivals.

6. Public education relating to emergency responses to overdoses.

7. Public education relating to immunity and Good Samaritan laws.

8. Educating first responders regarding the existence and operation of immunity and Good Samaritan laws.

9. Syringe service programs and other evidence-informed programs to reduce harms associated with intravenous drug use, including supplies, staffing, space, peer support services, referrals to treatment, fentanyl checking, connections to care, and the full range of harm reduction and treatment services provided by these programs.

10. Expanding access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use.

11. Supporting mobile units that offer or provide referrals to harm reduction services, treatment, recovery supports, health care, or other appropriate services to persons that use opioids or persons with OUD and any co-occurring SUD/MH conditions.

12. Providing training in harm reduction strategies to health care providers, students, peer recovery coaches, recovery outreach specialists, or other professionals that provide care to persons who use opioids or persons with OUD and any co-occurring SUD/MH conditions.

13. Supporting screening for fentanyl in routine clinical toxicology testing.

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

In addition to items in section C, D and H relating to first responders, support the following:

1. Education of law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.

2. Provision of wellness and support services for first responders and others who experience secondary trauma associated with opioid-related emergency events.

J. LEADERSHIP, PLANNING AND COORDINATION

Support efforts to provide leadership, planning, coordination, facilitations, training and technical assistance to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:

1. Statewide, regional, local or community regional planning to identify root causes of addiction and overdose, goals for reducing harms related to the opioid epidemic, and areas and populations with the greatest needs for treatment

intervention services, and to support training and technical assistance and other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

2. A dashboard to (a) share reports, recommendations, or plans to spend opioid settlement funds; (b) to show how opioid settlement funds have been spent; (c) to report program or strategy outcomes; or (d) to track, share or visualize key opioid- or health-related indicators and supports as identified through collaborative statewide, regional, local or community processes.

3. Invest in infrastructure or staffing at government or not-for-profit agencies to support collaborative, cross-system coordination with the purpose of preventing overprescribing, opioid misuse, or opioid overdoses, treating those with OUD and any co-occurring SUD/MH conditions, supporting them in treatment or recovery, connecting them to care, or implementing other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

4. Provide resources to staff government oversight and management of opioid abatement programs.

K. TRAINING

In addition to the training referred to throughout this document, support training to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, those that:

1. Provide funding for staff training or networking programs and services to improve the capability of government, community, and not-for-profit entities to abate the opioid crisis.

2. Support infrastructure and staffing for collaborative cross-system coordination to prevent opioid misuse, prevent overdoses, and treat those with OUD and any co-occurring SUD/MH conditions, or implement other strategies to abate the opioid epidemic described in this opioid abatement strategy list (*e.g.*, health care, primary care, pharmacies, PDMPs, etc.).

L. RESEARCH

Support opioid abatement research that may include, but is not limited to, the following:

1. Monitoring, surveillance, data collection and evaluation of programs and strategies described in this opioid abatement strategy list.

2. Research non-opioid treatment of chronic pain.

3. Research on improved service delivery for modalities such as SBIRT that demonstrate promising but mixed results in populations vulnerable to opioid use disorders.

4. Research on novel harm reduction and prevention efforts such as the provision of fentanyl test strips.

5. Research on innovative supply-side enforcement efforts such as improved detection of mail-based delivery of synthetic opioids.

6. Expanded research on swift/certain/fair models to reduce and deter opioid misuse within criminal justice populations that build upon promising approaches used to address other substances (*e.g.*, Hawaii HOPE and Dakota 24/7).

7. Epidemiological surveillance of OUD-related behaviors in critical populations, including individuals entering the criminal justice system, including, but not limited to approaches modeled on the Arrestee Drug Abuse Monitoring ("*ADAM*") system.

8. Qualitative and quantitative research regarding public health risks and harm reduction opportunities within illicit drug markets, including surveys of market participants who sell or distribute illicit opioids.

9. Geospatial analysis of access barriers to MAT and their association with treatment engagement and treatment outcomes.