REPORT ON OPIOID USE DISORDER AS A PUBLIC HEALTH CRISIS

SUBMITTED PURSUANT TO §§174-175 OF PA 25-168

JULY 2026

Mental Health and Addiction Services
Children and Families

Table of Contents

Executive Summary

Sections 174 and 175 of Public Act No. 25-168 established a statutory framework declaring opioid use disorder (OUD) a public health crisis until the Alcohol and Drug Policy Council (ADPC) develops and the state achieves specified goals, to be reported to the General Assembly by July 1, 2026. Unlike traditional emergency declarations, the statute does not confer emergency powers, authorize regulatory waivers, or establish new funding mechanisms. Instead, it creates a structured, outcome-focused process to define measurable statewide goals and track progress over time.

Consistent with the statute's intent, the report identifies opioid-involved mortality as the primary outcome metric for statewide goal development. This measure was selected through an iterative, consensus-based process involving subject matter experts from the Department of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families (DCF), followed by review and refinement by ADPC subcommittee leadership and the full ADPC. This process ensured alignment across prevention, treatment, recovery, and public health stakeholders.

Opioid-involved mortality was selected due to its methodological rigor, consistency over time, and value as a population-level indicator that is not dependent on service utilization, insurance status, or system capacity. It is also the most stable indicator available for long-term trend analysis within Connecticut's surveillance system.

Analysis of Office of the Chief Medical Examiner (OCME) data from 2004 through 2024 demonstrates a clear pre-crisis baseline period (2004–2010), followed by a transition period and subsequent sustained acceleration beginning in the early 2010s. Based on this analysis, the report recommends a statewide goal of reducing opioid-involved mortality to pre-crisis baseline levels (2004–2010 average of 276 deaths annually), sustained for a minimum of five consecutive years. This benchmark is intended to reflect a reversal of the sustained upward trend in opioid-involved mortality and to provide a measurable indicator of long-term system stabilization.

Statutory Mandate

Sections 174 and 175 of Public Act No. 25-168 declared OUD a public health crisis until goals defined by Connecticut's ADPC are met. The ADPC is charged with developing these goals and reporting them to the Public Health Committee by July 1, 2026.

This report fulfills the statutory requirement under subsection (f) of CGS §17a-667a. See Appendix A for the reporting requirement language, as well as the related language in CGS §19a-133f that contains the public health crisis declaration.

Background

Declaring a formal emergency or public health emergency is a tool used by federal, state, and local governments to enable rapid response to urgent public health threats. These declarations are typically designed to address events that are time-sensitive, rapidly evolving, and require immediate system-level flexibility.

At the federal level, a Public Health Emergency (PHE) under Section 319 of the Public Health Service Act authorizes the Secretary of Health and Human Services to determine that a disease or disorder presents an emergency to public health[1]. When declared, a PHE may enable a range of operational flexibilities, including temporary waivers of statutory or regulatory requirements, expanded reimbursement authorities, and accelerated access to federal funding streams.

Similarly, states may declare public health emergencies or disaster emergencies under state statutes[2]. While the legal structures vary by jurisdiction, these declarations generally serve three core functions:

- Mobilization of resources (including state and federal funding streams, where applicable)
- Temporary suspension or modification of regulatory requirements
- Acceleration of administrative processes to support rapid response

Historically, these mechanisms have been most commonly used in the context of:

- Infectious disease outbreaks (e.g., COVID-19, influenza pandemics)
- Biosecurity or environmental exposures
- Natural disasters and mass casualty events
- Other acute, time-limited public health threats requiring surge capacity

In these contexts, emergency declarations are structured around the assumption that the underlying threat is both rapidly evolving and time-bounded, requiring immediate intervention to prevent widespread harm.

---

[1] Administration for Strategic Preparedness & Response (ASPR). Public Health Emergency Declaration. https://aspr.hhs.gov/legal/PHE/Pages/Public-Health-Emergency-Declaration.aspx

[2] Declared States of Emergency – Opioid Crisis. The Network for Public Health Law. January 12, 2018. https://www.networkforphl.org/resources/declared-states-of-emergency-opioid-crisis/

Substance use disorders, including opioid use disorder, present a different policy profile than traditional emergency declaration scenarios. Unlike infectious disease outbreaks or natural disasters, opioid-related mortality trends typically evolve over extended periods and reflect a combination of structural, behavioral, clinical, and supply-related factors.

As a result, many states have approached the opioid crisis through a combination of:

- Standing public health authority
- Long-term strategic plans
- Interagency task forces or councils
- Targeted legislation and budget investments
- Data-driven performance frameworks

Rather than relying exclusively on emergency declarations, states have frequently embedded opioid response efforts into ongoing governance structures intended to support sustained system change. Connecticut is one of those states, adopting by statute many provisions that other states adopted years later through emergency declaration actions.[3, 4]

Across states, there is significant variation in whether and how opioid use disorder is framed as a "public health emergency" or "public health crisis," and whether such designations carry independent legal effect. Some common approaches include:

1. Symbolic or declaratory emergency designations
    - Some states have issued executive declarations of a public health emergency related to opioids.
    - These declarations are often used to signal urgency and align stakeholders but may not independently create new funding or regulatory authority unless paired with specific statutory or executive action.

2. Legislatively embedded crisis frameworks

[3] Primer - Opioid Public Health Emergencies 7-30-19. The Network for Public Health Law. https://www.networkforphl.org/wp-content/uploads/2020/01/Primer-Opioid-Public-Health-Emergencies-7-30-19-1.pdf?_gl=1*jexr7o*_ga*MTY4MzQzNTMyLjE3Nzk5OTc5MjQ.*_ga_EZC0V9JM3B*czE3ODE1NjQ1NzAkbzQkZzEkdDE3ODE1NjQ3MjckajIwJGwwJGgw

[4] Connecticut's Opioid Drug Abuse Laws. CT Office of Legislative Research. July 11, 2025. https://cga.ct.gov/2025/rpt/pdf/2025-R-0101.pdf

- Other states have codified opioid response frameworks in statute without formal emergency designation.
- These approaches typically rely on standing agencies and advisory bodies to set goals, monitor outcomes, and coordinate services.

3. Hybrid models
   - Some jurisdictions combine time-limited emergency declarations with longer-term statutory reforms.
   - In these models, emergency authority is used to expand immediate access to treatment or harm reduction tools, while longer-term governance is transitioned to permanent structures.

4. Goal- or metric-driven frameworks
   - A growing number of states have moved toward defining opioid response success through measurable outcomes (e.g., mortality reduction, treatment access, overdose reversal capacity).
   - These frameworks emphasize accountability and performance measurement rather than emergency authority.

Connecticut's approach under Public Act 25-168 differs from traditional emergency declaration frameworks in several key respects. While the statute declares opioid use disorder to be a "public health crisis", it does not define associated emergency powers or authorities, establish new funding mechanisms, or authorize regulatory waivers or expedited processes. Instead, the law requires the ADPC to convene a working group to establish statewide goals and requires reporting of those goals to the General Assembly by July 1, 2026. Accordingly, the statutory framework functions primarily as a goal-setting and reporting mechanism, rather than an emergency authority structure.

Selection of Opioid-Involved Mortality as the Primary Outcome Metric

Process

The selection of opioid-involved mortality as the primary outcome metric for goal development under this statutory requirement reflects both technical considerations and an iterative, consensus-driven process. In addition to its methodological advantages, the metric was refined through consultation with key stakeholders to ensure feasibility, relevance, and shared understanding across systems.

A small internal workgroup composed of subject matter experts from DMHAS and DCF first reviewed potential outcome measures and identified opioid-involved mortality as the most appropriate primary indicator. This initial recommendation was then presented to the chairs of the ADPC subcommittees for feedback and refinement. Following incorporation of that input, the approach was subsequently shared with the full ADPC for broader review and discussion, providing an opportunity for system-wide input and alignment prior to finalization.

This engagement process helped ensure that the selected metric reflects both the statutory intent and the practical considerations of stakeholders across the prevention, treatment, recovery, and public health systems.

Rationale

The selection of opioid-involved mortality as the primary outcome metric for goal development under this statutory requirement is based on considerations of data availability, methodological consistency, policy relevance, and alignment with longstanding public health practice.

Opioid-involved deaths represent the most definitive and consistently defined indicator of the impact of the opioid crisis. Unlike many other measures of substance use disorder burden, mortality is:

- Universally defined and clinically verified through OCME
- Less subject to variation in service utilization patterns or system access changes
- Not dependent on insurance status, treatment engagement, or reporting practices across providers

As a result, mortality data provides a stable, population-level measure that is not influenced by changes in service delivery models or administrative reporting systems. Opioid-involved mortality is also the only core indicator within Connecticut's surveillance system that allows for consistent multi-decade trend analysis.

While OCME did not begin direct classification of opioid involvement in accidental intoxication deaths until 2013, sufficient data exists to construct a consistent historical series through standardized estimation methods. This enables:

- Identification of pre- and post-acceleration trend periods
- Assessment of long-term structural change rather than short-term fluctuations
- Establishment of a stable baseline period for comparative purposes

Other commonly used indicators (e.g., nonfatal overdoses, treatment admissions, or emergency department utilization) are more sensitive to changes in reporting practices, coding standards, and service system capacity, limiting their comparability over time.

Many alternative indicators of opioid crisis severity are influenced by system capacity and utilization patterns, including:

- Availability of treatment slots
- Insurance coverage and reimbursement policy
- Law enforcement activity and diversion practices
- Emergency department coding changes
- Expansion or contraction of harm reduction programs

In contrast, mortality is less directly affected by service system throughput and therefore provides a more stable indicator of underlying population-level risk. However, this **does not diminish the importance of these other measures**; rather, it reflects their role as process and system performance indicators, as opposed to a final outcome indicator. These indicators remain essential for program monitoring and system performance evaluation.

Finally, mortality is widely used in public health as a primary outcome indicator in population health surveillance and long-term trend analysis. Within the context of substance use epidemiology, overdose mortality is routinely treated as the most stable and policy-relevant endpoint for evaluating long-term population impact.

Accordingly, opioid-involved mortality is used as the primary outcome metric for statewide goal development because it represents a stable, comparable, and policy-relevant indicator of population-level impact, while minimizing confounding from system capacity, reporting variability, and service utilization effects. It provides a clear and defensible basis for longitudinal assessment under the statutory framework established.

Data and Observations

Table 1 summarizes accidental intoxication deaths and opioid involvement from 2004 through 2024 as produced by OCME and Table 2 further describes observations and defines tangible time periods based on the analysis of the data.

Table 1. Accidental Intoxication Deaths and Opioid Involvement from 2004-2024

Year	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
# of Accidental Intoxication Deaths	256	291	321	326	323	311	287	324	358	495	568	729	917	1,038	1,017	1,200	1,374	1,524	1,452	1,328	982
Opioid in Any Death	**234**	**265**	**293**	**297**	**295**	**284**	**262**	**296**	**327**	419	513	663	861	961	948	1,127	1,273	1,413	1,339	1,216	845
% Intoxication Deaths with Opioid	**91%**	**91%**	**91%**	**91%**	**91%**	**91%**	**91%**	**91%**	**91%**	85%	90%	91%	94%	93%	93%	94%	93%	93%	92%	92%	86%
% Change Year over Year		*14%*	*10%*	*2%*	*-1%*	*-4%*	*-8%*	*13%*	*10%*	*38%*	*15%*	*28%*	*26%*	*13%*	*-2%*	*18%*	*15%*	*11%*	*-5%*	*-9%*	*-26%*

Methodology: OCME did not start tracking opioids specifically in accidental intoxication deaths until 2013. To obtain an approximate number for 2004 through 2012, DMHAS calculated the average percent of deaths with opioids from 2013 to 2024 (91%) and applied this to the total number of accidental intoxication deaths from 2004 to 2012. Numbers in **bolded red** are based on these assumptions.

Table 2. Observations and Timeline of Opioid Crisis Mortality Statistics from 2004-2024

2004-2010	2011-2012	2013-2016	2017-2021	2022-2024
PRE-CRISIS BASELINE	TRANSITION PERIOD	ABNORMAL ACCELERATION	ELEVATED PLATEAU & SECOND SURGE	DECLINE, BUT STILL ELEVATED
-Values range from 234-297 -Some year-to-year movement, but no sustained acceleration (in fact, deaths decline from 2007 to 2010)	-From 2011 to 2012, there was about a 10% increase -Still within historical range, but upward pressure starts -Early signs of increase appear, but not yet crisis-level	-Multiple consecutive years of 20-30% growth **- Beginning around 2013, opioid-involved deaths entered a period of rapid and sustained acceleration, marking the onset of the crisis phase.**	-High death rate, but volatile -Another sharp rise during COVID years -Peak in 2021 at 1,413	-Declines are meaningful, especially 2024 -However, still well above any pre-crisis level

While opioid-involved deaths in Connecticut fluctuated between 2004 and 2010 without sustained growth, **beginning in 2013 the state experienced a marked and persistent acceleration**. This period represents a clear departure from prior trends.

Recommendation

The statute requires the establishment of a goal that signifies that opioid use disorder no longer constitutes a public health crisis. In this context, the proposed goal is not intended to define an acceptable level of mortality, but rather to establish a measurable benchmark indicating reversal of the sustained upward trend observed since the early 2010s. Accordingly, the report defines the goal as a reduction of opioid-involved mortality to pre-crisis baseline levels (2004–2010 average of 276 deaths per year), sustained for a minimum of five consecutive years.

RECOMMENDATION for Calculation
Baseline: Average of 2004-2010 – *276 deaths a year*
Rationale: The 2004–2010 period represents the last sustained era of relative stability, prior to the onset of abnormal growth in opioid-involved mortality. Using this period as a baseline reflects conditions before the crisis-driven acceleration began.

It is important to note that regardless of which reasonable pre-crisis benchmark is used, current mortality remains multiple times higher than baseline levels. By reversing the post-2011 acceleration in opioid-involved mortality, the state will work toward reducing annual opioid-involved deaths to the average level observed during the 2004–2010 pre-crisis period and maintaining that level, or lower, for at least five consecutive years.

Rationale

From 2004 through 2010, opioid-involved deaths remained relatively stable, fluctuating within a narrow range without sustained year-over-year growth. Beginning in approximately 2011, this pattern begins to shift and then by 2013, changes markedly, with opioid-involved deaths increasing rapidly and persistently for several consecutive years. This shift represents a clear departure from prior trends and marks the onset of the opioid crisis phase. Establishing a goal of returning to pre-crisis baseline levels provides a clear, data-driven benchmark grounded in historical experience rather than an arbitrary target. The baseline reflects conditions that were achievable and sustained prior to the period of abnormal acceleration, making it both ambitious and realistic.

Importantly, the goal emphasizes not only reaching the baseline but sustaining it over multiple years. Short-term declines in opioid-involved deaths can result from

temporary factors, including fluctuations in the drug supply or reporting variability. Sustained maintenance of baseline levels over a defined period indicates that underlying systems—prevention, treatment, harm reduction, and recovery supports—are functioning effectively and durably. A five-year maintenance period provides sufficient time to distinguish lasting progress from short-term variation. It also aligns with planning and evaluation cycles commonly used in public health and allows for assessment across multiple cohorts, funding cycles, and policy implementations.

Considerations

The use of a pre-crisis baseline as a goal does not imply that any level of opioid-involved death is acceptable, nor does it diminish the importance of continued prevention efforts beyond that point. Rather, the baseline functions as a measurable indicator that crisis-level mortality has been reversed and stabilized. Achieving and sustaining this benchmark would represent a significant public health milestone, while continued work to further reduce preventable deaths would remain a core priority.

While the ultimate aim of public health is to prevent all avoidable deaths, setting interim goals grounded in historical data is necessary to guide planning, allocate resources, and evaluate progress. A return to baseline levels is intended as a critical step toward that broader aim, not the endpoint of the work. As such, the baseline should be understood as a diagnostic benchmark rather than a normative standard. It signals the reversal of an abnormal and historically unprecedented escalation, not an acceptable steady state.

In this context, returning to and maintaining pre-crisis levels represents a necessary but not sufficient condition for long-term success. It establishes that the acute crisis has been reversed and creates the conditions for continued, incremental reductions in opioid-involved mortality over time.

Current Trends and Initiatives

In Connecticut, there has been a downward trend in overdose death numbers for the last four consecutive years. One plausible reason for the decline is associated with the saturation of the state with Naloxone (brand name Narcan), an opioid antagonist medication, used as a harm reduction tool to reverse an active overdose. The state has made it a priority to make this life saving medication available to all hospital emergency departments, treatment and recovery support providers, municipalities (first responders), and harm reduction service organizations.

Calendar Year	Drug Overdose Fatalities	DMHAS Naloxone Distribution
2021	1,524	14,986
2022	1,452	29,064
2023	1,329	58,642
2024	989	64,087
2025	836	77,304

Reversing an opioid overdose and saving a life is the first step in the process to recovery and wellbeing. The opioid crisis requires a multifaceted response that includes prevention, recovery support, and treatment interventions. Connecticut, with the infusion of federal and settlement funds, has implemented innovative projects that have collectively contributed to positive outcomes.

Below is a depiction of the projects that DMHAS has funded with the State Opioid Response (SOR) Grant. This grant is administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) to help states reduce unmet treatment and recovery support needs of those at risk for an opioid overdose. Connecticut has received more than $100 million in SOR funding since October 2018, which allowed the department to support many innovative initiatives. The current $15 million per year award will expire in September 2027. See below for a list of initiatives funded.

State Opioid Response Grant Funded Initiatives

- Recovery Coaching (Hospital ED's, Outpatient clinics, Methadone Clinics)
- How Can We Help: Outreach to overdose survivors and family members
- CT Harm Reduction Drop-In Centers
- Imani Breakthrough – faith-based initiative
- Mobile Employment
- Mobile MAT (Medication Assisted Treatment)
- Youth Recovery Services: SMART (Self Management and Recovery Training) groups
- Treatment Program Pathway – recovery coaches at courts
- Early Screening Intervention – Resource Counselors at additional courts
- Sober housing vouchers (Advanced Behavioral Health)

In addition, Connecticut is expected to receive over $600 million over 18 years as part of the nationwide opioid litigation settlement agreements with various pharmaceutic distributors and opioid manufacturers. The Opioid Settlement Advisory Committee (OSAC) was established to ensure the proceeds received by the state are allocated appropriately. The proceeds will be spent on substance use disorder abatement infrastructure, programs, services, supports, and resources for prevention, treatment, recovery, and harm reduction with public involvement, transparency, and accountability.

OSAC is comprised of state and municipality representatives, treatment providers, and persons or family members with lived experience. Opioid Remediation Recommendations are provided by various community organizations and groups, which are then vetted by the Alcohol and Drug Policy Council (ADPC) subcommittees, followed by a vote by OSAC members to approve the recommendations. DMHAS works in partnership with the other state agencies on implementation of the approved recommendations.

Below are links to projects approved through March 2026, categorized by strategy.

OSAC APPROVED INITIATIVES	
TREATMENT	➢ Mobile Opioid Treatment Programs (OTP) ➢ Treatment Bridge Model to Increase MOUD Initiation in CT's Emergency Departments ➢ Department of Correction (DOC) OTP expansion ➢ Contingency Management ➢ Treatment Pathway Program (TPP): Pre-trial Diversionary Program ➢ Opioid Treatment Program Access Expansion ➢ Helping Youth and Parents Enter (HYPE) Recovery
HARM REDUCTION	➢ Syringe Service Program (SSP) Supplies Expansion ➢ Harm Reduction Vending Machines ➢ Naloxone Saturation ➢ SafeSpot Overdose Hotline ➢ Harm Reduction Centers ➢ CT Drug Data Collaborative Dashboard
PREVENTION	➢ LiveLOUD Public Awareness & Education Campaign ➢ Drug Deactivation Mailing ➢ Primary Prevention through Education and Reduction of Opioid Diversion ➢ Collegiate Technical Assistance to Support Opioid Overdose Education
RECOVERY SUPPORT	➢ Supportive Housing ➢ Emergency Department Recovery Coaching ➢ Recovery Centers Continuation

Other settling parties in Connecticut, such as municipalities and tribal governments, receive their proceeds directly from the settlement administrator and report yearly receipts and expenditures to the state to publish on the OSAC website.

Of note, DCF in particular plays a critical role in the state's opioid response through supporting children, youth, and families impacted by substance use disorder. DCF has implemented a series of targeted initiatives focused on child safety, family preservation, prevention, treatment access, and workforce preparedness, including taking steps to strengthen its policies and practices to prevent children from being exposed to fentanyl and opioids in the home. DCF also funds and coordinates an array of recovery-oriented services designed to safely maintain family unity and reduce foster care placements associated with parental substance use.

For more information on specific agency efforts and collaborations with community partners, please see the most recent 2025 Triennial Report, a comprehensive state substance use plan updated every three years that captures information about all of the state operated and funded substance use services across the executive and judicial branches, including: DMHAS, DCF, the Judicial Branch Court Supports Services Division (CSSD), the Department of Public Health (DPH), the Department of Consumer Protection (DCP), the Department of Correction (DOC), the State Department of Education (SDE), and the Department of Social Services (DSS).

The Resources section of this report also includes valuable information about other state initiatives related to addressing opioid use disorder.

Conclusion

Achieving and sustaining the pre-crisis baseline established in this report would represent a significant public health milestone, indicating that opioid-involved mortality has been stabilized at levels consistent with historical experience. However, it should not be interpreted as the endpoint of the state's response.

Progress toward this goal will be monitored and assessed on an ongoing basis through established annual reporting and surveillance processes. Continued work will occur through existing policy and advisory structures, including ADPC and related funding bodies such as Opioid Settlement Advisory Committee, to align system-level strategies, investments, and programmatic priorities in support of sustained reductions in opioid-involved mortality.

Continued effort beyond this threshold will remain necessary to further reduce preventable deaths and strengthen the prevention, treatment, harm reduction, and recovery systems that support long-term population health.

Resources

Substance Use Services Access Line: 1-800-563-4086

The 24/7 Substance Use Services Access Line, operated by Wheeler and funded by DMHAS, facilitates access to Substance Use services for Connecticut residents. Wheeler Staff use a recovery-oriented approach to ask screening questions, and provide callers with education, support, hope and tangible assistance to individuals having difficulty living with substance use issues. Minimally, resource education is provided to each caller on various available treatment options; medications for addiction (e.g., methadone, buprenorphine, naltrexone, naloxone); and various other community programs. The Wheeler staff use the DMHAS CT Addiction website 24/7 to assist callers.

Triennial Report

The DMHAS Triennial Report is mandated by Connecticut legislation to document the state's substance use plan and report on all state-funded substance use services, including those provided by executive and judicial branch agencies. The report highlights achievements over the past three years, identifies emerging substance use trends, and outlines strategies to guide future efforts.

The 2025 Triennial Report is the most updated version; this will be updated in 2028 on the three-year cycle.

LiveLOUD.org

In partnership with DMHAS, the Odonnell Company developed an audience-driven Live Life with Opioid Use Disorder (LiveLOUD) campaign that includes social media posts, place based, bus, and billboard placements, and other tactics. The media campaign is meant to be inclusive, compassionate, and supportive of those who struggle with Opioid Use Disorder and their loved ones.

Naloxone Access

Naloxone, also known as NARCAN® Nasal Spray, is a medication that reverses an opioid overdose. It is a safe and easy to use medication available over the counter at pharmacies and free of cost at many local community organizations.

Naloxone is only effective on opioids (fentanyl, heroin, OxyContin, Vicodin, etc.) and has no misuse potential. Persons given naloxone who have not overdosed on opioids will not be harmed. Persons dependent on opioids who are given naloxone may

experience opioid withdrawal. In any overdose situation, 9-1-1 should be called, and naloxone should be administered.

DMHAS provides Naloxone to numerous community-based entities, including hospital emergency departments, treatment and recovery support providers, municipalities (first responders), and harm reduction service organizations, as well as other state agencies, including DOC. In 2025, DMHAS created a state naloxone saturation plan of distributing at least 77,000 naloxone kits to ensure naloxone is readily available across the state, and distribution has increased steadily since then.

Organizations seeking naloxone to distribute may contact Karolina Wytrykowska at Karolina.Wytrykowska@ct.gov.

Opioid Settlement Advisory Committee

During the 2022 legislative session PA 22-48, An Act Implementing the Governor's Budget Recommendations Regarding the Use of Opioid Litigation Proceeds, was passed into law. PA 22-48 establishes a new Advisory Committee, co-chaired by DMHAS and a representative from the municipalities, to ensure the proceeds received by the state as part of the opioid litigation settlement agreements are allocated appropriately. The Act specifies the proceeds will be spent on substance use disorder abatement infrastructure, programs, services, supports, and resources for prevention, treatment, recovery, and harm reduction with public involvement, transparency, and accountability.

If you have a recommendation for consideration for Opioid Settlement Funding, please submit an approximately 500-word description of your recommendation and an annualized budget to **OSAC@ct.gov**. Please note funding recommendations are not applications for funding and submissions do not guarantee that the submitter will receive funding from the Department. We appreciate your input and will vet it through the following process:

- Recommendations for Opioid Settlement Funding will be sent to the OSAC Referral Subcommittee and/or to the appropriate ADPC subcommittee for review.
- If deemed to be appropriate for Opioid Settlement Funding by the subcommittees, the recommendation will be vetted and voted on by OSAC.
    - *Please note all recommendations are considered funding suggestions, not a funding application or grant proposal. If your recommendation is*

approved by OSAC, it may result in a Request for Proposals, at which time you may apply for funding.

Opioid Settlement Dashboard

This interactive dashboard provides insights into opioid settlement expenditures for the State of Connecticut. Users can explore expenditure data categorized by treatment, recovery, prevention, and harm reduction or Connecticut Opioid Response (CORE) priority. The dashboard features a bar graph that breaks down expenditures by year. Additionally, a detailed table displays each approved project, including project status, funding amount, partners, and brief description.

Department of Public Health Opioid and Drug Overdose Statistics

The Connecticut Department of Public Health (CT DPH) is funded by the CDC to participate in the State Unintentional Drug Overdose Reporting System (SUDORS) to collect comprehensive data on unintentional and undetermined intent overdose deaths within the state. Data is abstracted from multiple data sources including death certificates, medical examiner reports, and postmortem toxicology results.

Connecticut Opioid Response (CORE) Initiative

The Connecticut Opioid Response (CORE) report was commissioned by DMHAS and prepared by the Yale Program in Addiction Medicine. Its primary goal is to inform the **OSAC** on how to strategically use opioid settlement funds to address the state's opioid crisis. The report updates the 2016 CORE report and reflects the evolving opioid landscape, including the rise of fentanyl and other synthetic opioids.

Summary of Connecticut Laws to Reduce and Prevent Opioid Use Disorder

This report highlights provisions of Connecticut law intended to reduce or prevent opioid drug abuse. It does not include all of the laws' provisions; to read the laws in their entirety, visit the Connecticut General Assembly's website.

Youth Recovery CT

Using the Self-Management and Recovery Training (SMART) Recovery approach, Youth Recovery CT works to increase the involvement of youth and families in changing problematic behaviors, reduce the stigma associated with substance use, and increase options and access to recovery supports for young people and their families.

988 Suicide & Crisis Lifeline

In Connecticut, DMHAS and DCF fund the Connecticut 988 Contact Center operated by the United Way of Connecticut. The 988 Contact Center services include rapid 24/7 access to trained crisis contact center staff who can help people experiencing suicidal, substance use and other mental health crises, provide referrals to resources, and perform warm transfers to mobile crisis services or emergency services as needed/desired.

Youth Mobile Crisis Intervention Services

This program is funded by DCF in partnership with the United Way of Connecticut 2-1-1 and the Child Health and Development Institute (CHDI) and is for children and adolescents experiencing a behavioral or mental health crisis that is accessed by calling 2-1-1.

Appendix A

Sec. 19a-133f. Declaration of opioid use disorder as a public health crisis. It is hereby declared that opioid use disorder constitutes a public health crisis in this state and will continue to constitute a public health crisis until each goal reported by the Connecticut Alcohol and Drug Policy Council pursuant to subsection (f) of section 17a-667a is attained.

Sec. 17a-667a. Fact sheet re opioids and opioid use disorder. Marketing campaign and public service announcements. Information portal re detoxification and rehabilitation beds and slots for outpatient treatment. Report. Working groups re disposal of opioid drugs and substance abuse treatment referral programs. Working group to establish goals for combatting opioid use disorder.
(f) The Connecticut Alcohol and Drug Policy Council shall convene a working group to establish one or more goals for the state to achieve in its efforts to combat the prevalence of opioid use disorder in the state. Not later than July 1, 2026, the council shall report, in accordance with the provisions of section 11-4a, to the joint standing committee of the General Assembly having cognizance of matters relating to public health regarding each goal established by the working group.