Implementing Best Practices Across the Continuum of Care to Prevent Overdose

A Roadmap for Governors

NATIONAL GOVERNORS ASSOCIATION

O'NEILL INSTITUTE FOR NATIONAL & GLOBAL HEALTH LAW
GEORGETOWN LAW

Table of Contents

Recommendations

The following recommendations represent evidence-based and promising actions states and territories can consider as they work to strengthen the Continuum of Care for people at risk for overdose, including those with Substance Use Disorder (SUD). This Roadmap is a product of guidance and information from more than 30 subject matter experts, including more than 20 states and territories, the O'Neill Institute at Georgetown University Law Center, as well as extensive literature on this topic. These recommendations are oriented from a public health perspective and exclusively focused on overdose prevention. They reflect the current landscape of overdose and risk, which has shifted significantly since the 2016 NGA publication, Finding Solutions to the Prescription Opioid and Heroin Crisis: A Roadmap for States, and is now primarily driven by illicitly manufactured fentanyl rather than prescription opioids.

◆ Foundations

Establish a state government coordinating body to set a statewide vision for overdose prevention.
- Coordinate an all-government approach to addressing overdose by directing cross-agency strategic planning and financial mapping.

Invest in state infrastructure to maximize resources.
- Streamline and create efficient procurement and grant-making processes to ensure funding allocated to overdose prevention has the greatest impact possible.

Seek and include the perspectives and leadership of people with a variety of lived experiences.
- Partner with and solicit input from people with lived and living experience in state planning.
- Streamline and create more efficient procurement and grant-making processes to provide funding and collaboration opportunities for community-based organizations that represent disproportionately impacted populations and that are led by and employ people with lived and living experience.
- Review and revise government hiring policies and practices to enhance employment opportunities for people with lived experience.

Invest in evaluation and test new ideas.
- Continuously monitor population-level data and leverage actionable insights to inform interventions and pivot resource allocation.
- Leverage federal funds to pilot and evaluate community-driven, culturally responsive, and innovative programs, investing in and scaling up those with demonstrated success.
- Invest time and resources into a long-term data strategy to collect accurate, complete, and timely outcome measures from relevant agencies and partners, and continuously evaluate state-funded programs.

Nurture and grow a mental health and substance use workforce that reflects the populations served.

- Leverage recruitment, scholarship, prospective education payments, and loan forgiveness programs to support students enrolled in mental health and substance use-related degrees, particularly those representing disproportionately impacted populations and communities.
- Invest in community-based organization initiatives that expand training capacity for mental health and substance use-related workers.
- Create more opportunities for entry-level mental health and substance use-related roles by establishing training and certification programs.
- Facilitate partnerships between employers and institutions of higher education to provide training and skills-building opportunities for mental health and substance use-related employees to advance their careers.
- Serve as a model for valuing state-employed peers by ensuring equitable pay and acknowledging their contributions.

◆ Prevention

Champion and invest in initiatives that support family cohesion and well-being.

- Ensure that policies do not criminalize prenatal substance use nor deter pregnant and parenting people from accessing health care services.
- Revisit policies and procedures to ensure coordination and collaboration between all relevant agencies in delivering plans of safe care.
- Invest in initiatives that keep families together and healthy by addressing social drivers of health and enhancing employment opportunities, economic health, education, stable housing, and physical and mental health care.
- Leverage the Family First Prevention Services Act to keep families together and prevent foster care placement through access to substance use prevention and treatment, mental health services for parents and children, and parent skill-based programs.

Promote evidence-based requirements for funded prevention initiatives.

- Promote evidence-based primary prevention programming by developing and implementing processes and standards for state-funded substance use and overdose prevention programming.
- Invest in community-driven and culturally responsive interventions and create opportunities to evaluate and scale them.

◆ Harm Reduction

Maximize federal resources and braid funding to promote health and reduce harm for people who use drugs.

- Utilize federal funds available for overdose response to support allowable wrap-around and engagement services at Syringe Services Programs for people who use drugs.
- Review and consider revisions to state laws, regulations, and policies to allow the use of state general funds for harm reduction tools and activities that are part of comprehensive harm reduction services but are without other funding sources.
- Braid state and federal funds to invest in community-based harm reduction programs.

Implement targeted and low-barrier distribution strategies for overdose reversal agents (ORAs) such as naloxone.

- Review and revise internal policies and processes that impede distribution and access.
- Implement universal overdose education and ORA distribution to individuals leaving correctional facilities and those under community supervision.
- Leverage partnerships with community-based organizations, including those led by people with lived and living experience, to reach those most likely to experience or respond to an overdose.
- Champion policies that:
  - Promote overdose education and ORA distribution through entities serving people most likely to experience an overdose.
  - Prioritize ORA distribution to disproportionately impacted populations and people who use drugs.
  - Prohibit life and health insurance discrimination related to ORAs.
  - Require health insurers to cover ORAs, including non-prescription ORAs.
  - Expand Good Samaritan protections for people who experience or respond to an overdose.

Champion changes that allow for the distribution of harm reduction tools.

- Consider levers to establish Syringe Services Programs and protect staff, volunteers, and program recipients from charges related to possession of program supplies
- Consider policy changes to allow possession of harm reduction tools such as drug test strips to detect fentanyl and xylazine, and other risk reduction and participant engagement tools that may be considered paraphernalia under state law.

◆ Treatment

Implement and invest in policies and programs that expand Medication for Opioid Use Disorder access beyond the office setting.

- Implement initiatives that incentivize and/or support emergency departments to provide Medication for Opioid Use Disorder (MOUD) and link individuals to community-based care providers.
- Leverage telemedicine for SUD treatment and invest in efforts to co-locate MOUD via telehealth in community-based settings, including harm reduction and outreach programs.
- Implement and invest in mobile MOUD programs that serve rural areas.
- Expand the scope of practice through collaborative practice agreements to allow pharmacists to initiate MOUD and link patients to community-based providers for maintenance.
- Work with regional DEA offices to ensure that federal rules around MOUD access are applied consistently.
- Implement policies and initiatives to offer SUD treatment, including all MOUD medications, in criminal legal system settings.

Implement and invest in evidence-based treatment and access models.

- Implement a Medication First treatment model and prioritize state and federal resources to programs that align with this model.
- Partner with public safety to implement deflection and diversion programs. Make all MOUD treatment forms available to those involved in the criminal legal system.
- Invest in peer-led post-overdose outreach programs.
- Communicate changes in federal rules to the clinical community and community partners, ensuring they can take advantage of opportunities to expand access.

Maximize federal funding resources for treatment.

- Leverage the telehealth flexibilities given to states to allow for Medicaid coverage of low-barrier MOUD via telehealth; remove state-level requirements for in-person visits associated with telehealth SUD treatment.
- Braid in state funding to optimally implement initiatives not sufficiently covered by federal funding due to limits.
- Take advantage of opportunities to make MOUD and other pre-release services available to incarcerated individuals with SUD through the Medicaid 1115 waiver.

Assess state-level policies that restrict access.

- Support state-level requirements for MOUD that are equivalent to federal requirements after the removal of the DATA 2000 waiver in 2022.
- Remove same-day billing restrictions and prior authorization requirements for MOUD medications from state Medicaid programs.
- Enforce laws ensuring parity in insurance coverage for SUD services.

◆ Recovery

Foster communities that support recovery.

- Incentivize businesses that employ and support staff in recovery.
- Implement certification programs for "recovery ready" workplaces and communities.

Champion changes to policies to establish recovery residence standards.

- Champion changes to policies in order to require that state recovery residences meet national standards.
- Use state funds to support recovery residences that meet national standards.

Invest in small businesses and community-based organizations led by and employing people with lived experience who represent the communities they serve.

- Review and revise state-level processes and provide technical assistance to increase equity in procurement and grant-making for small businesses and community-based organizations.
- Support capacity-building for small businesses and community-based organizations led by people with lived experience who represent the communities they serve.
- Create funding opportunities for and invest in peer recovery organizations.

IT'S TIME TO REFRAME, NOT SHAME

recovery friendly
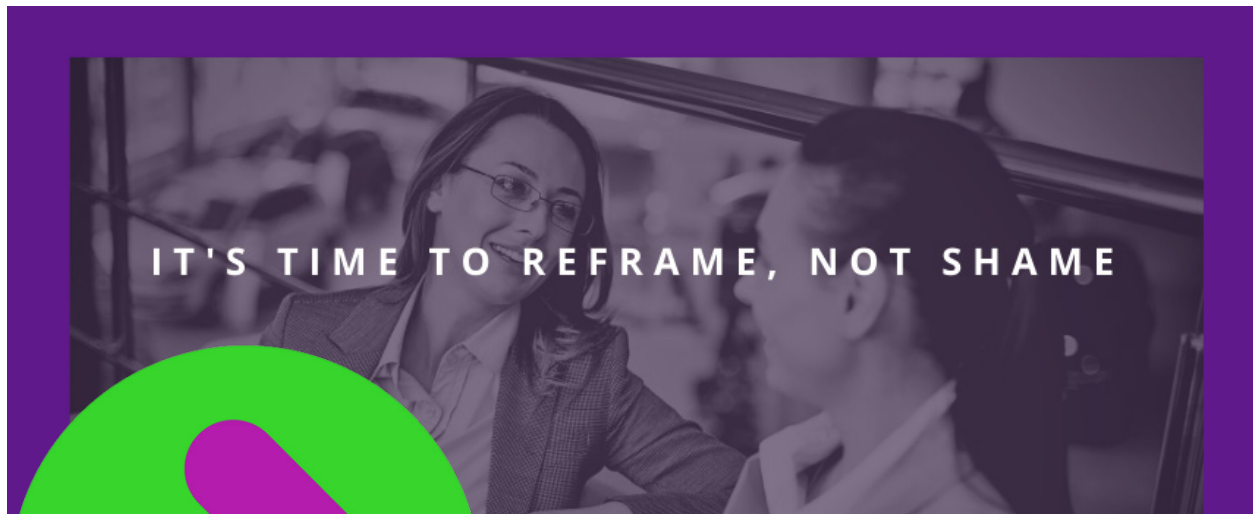
Background and Overview of the Substance Use Landscape

Overdose in the United States

The United States continues to respond to unprecedented opioid overdoses that have claimed nearly 600,000 lives since 1999. The situation has evolved over time, with peaks in overdose deaths characterized by three primary waves. The first wave began in 1999 with widespread access to prescription opioids. As public health, medical communities, and public safety responded, prescription opioids became more difficult to obtain. Subsequently, the second wave was predominately driven by overdose deaths involving heroin, beginning approximately in 2010.

The third and current wave began around 2013. There was increased availability of illicitly manufactured fentanyl, a synthetic opioid, in the drug supply, first as a cutting agent and eventually replacing heroin and becoming ubiquitous nationwide. In 2016, illicitly manufactured fentanyl overcame prescription opioids as the drug most involved in overdose deaths.[1] The COVID-19 pandemic exacerbated many existing challenges, and overdose deaths in many states reached unprecedented highs. From 2019 to 2021, overdose death rates increased in all 50 states; death rates in 40 states increased by more than 25%.[2] The national overdose death rate in 2021 reached 32.4 per 100,000 people, compared to 6.1 in 1999. In the 12-month period ending February 2023, the National Vital Statistics System predicted 109,940 overdose deaths.[3] Early provisional data from 2022 are encouraging, showing that the year-to-year rate of increase may be stabilizing. From 2021 to 2022, overdose deaths increased by 3.6%, compared to 16.2% from 2020 to 2021, and 30% from 2019 to 2020.

Opioid overdose deaths and other substance-use related harms have had a disproportionate impact on Black and Indigenous populations, and the disparities continue to grow. In 2021, the national overdose death rate was highest among Indigenous populations (56.6 per 100,000), followed by Black populations (44.2), compared to 36.8 among White populations; in some states, Hispanic and Latino populations are also disproportionately impacted.[4] Disparities in many individual states are even more profound. The gap has widened in recent years, with overdose deaths among Black persons increasing by 44% and among Indigenous persons by 39% from 2019 to 2020.[5] Black and African American populations experienced the greatest increase in synthetic opioid-related death rates from 2011-2016.[6]

These disparities are interrelated with social and environmental factors. A disproportionate number of Black persons have been incarcerated for drug-related offenses. Of people incarcerated for drug-related offenses, 39% were Black in 2012.[7] Although racial disparity gaps for drug enforcement and incarceration have been declining in recent years, recent incarceration puts individuals at significantly greater risk for overdose. Income inequality is also a factor; overdose death rate disparities were higher in counties with greater income inequality. Unequal access to healthcare and bias in treatment also influence these disparities; among people who died from overdose, evidence of treatment history was

lowest among Black and Indigenous populations. Unstable housing, lack of transportation, lack of health insurance, and socioeconomic status are also factors.

The current highly lethal drug supply means more people than ever are at risk for overdose; for this reason, harm reduction approaches across the Continuum of Care are critical to prevent overdose. Historically, more frequent use over time increased the risk of overdose, and there were more opportunities for behavior change to reduce risk. However, given the prevalence of illicitly manufactured fentanyl, overdose can happen to people using drugs for the first time and to people who use drugs only occasionally. The increased presence of illicitly manufactured fentanyl in pressed pills is also a factor in increased deaths, especially among youth. Overdose deaths among adolescents increased 109% from 2019 to 2021, despite low youth substance use rates; among overdose decedents aged 10-19, two out of three had no history of opioid use.[8]

Opioid overdose can also happen to people who use stimulants in combination with opioids. The use of multiple substances (polysubstance use) is common, which in some cases is intentional and in others is due to contamination and unpredictability of the illicit drug supply.[9] Benzodiazepines, methamphetamine, cocaine, and alcohol are often seen alongside opioids in overdose death toxicology. Fentanyl contamination is related to an increasing number of overdoses among people who use stimulants like methamphetamine and cocaine.[10] Age-adjusted overdose death rates involving stimulants have been increasing since 2012.[11]

Historical Trends in U.S. Opioid-Involved Drug Overdose Deaths - 1999-2021[12]

Almost 645,000 people have died from an opioid-involved drug overdose death since 1999 – including over 80K in 2021 alone

Any Opioid   Percent Rx Opioid   Percent Heroin

Percent Synthetic Opioid excluding Methadone
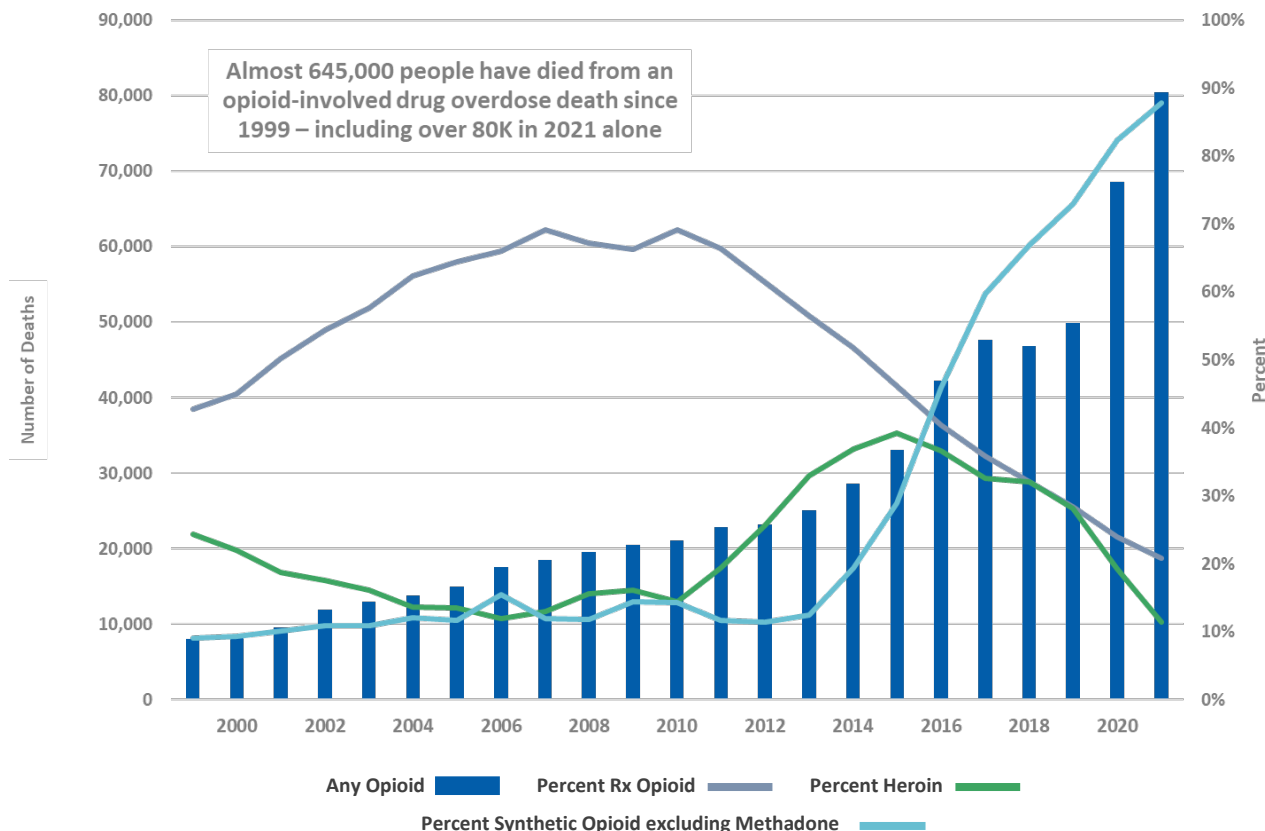
SOURCE: National Vital Statistics System Mortality File

Substance Use Disorder and the Continuum of Care for Overdose Prevention

A Continuum of Care is a spectrum of services, intended to meet the needs of individuals throughout the stages of a health condition—in this case, people with diagnosed Substance Use Disorder (SUD), people who use drugs, and people at risk for overdose. The Diagnostic and Statistical Manual of Mental Disorders (DSM-V) defines SUD using 11 criteria and offers three levels of severity ranging from mild to severe, depending on how many criteria are met. The criteria can be categorized into impaired control (using more of the substance than one wants), social problems (using the substance to the detriment of relationships, responsibilities, other recreation), risky use (using substances in a manner or situation that poses physical hazards), and physical dependence (withdrawal symptoms in the absence of the substance, tolerance).


However, given the wider population of people now at risk, overdose prevention efforts cannot be solely directed toward people with a diagnosed SUD who use opioids, but must also include people who use stimulants and people who use drugs but do not meet criteria for SUD. The pillars of the Continuum of Care, as defined in this document, include prevention, harm reduction, treatment, and recovery, and incorporate overdose prevention strategies that are not exclusive to people diagnosed with SUD. In addition, this document also includes a fifth pillar, the foundation, that grounds implementation of the entire Continuum. Like the foundation of a house, building on these core foundational principles and implementing these strategies will support a stronger system of care for people who use drugs.

Stages of Change

Behavior change is difficult and may be inhibited or facilitated by the social and environmental context in a person's life. In this context, behavior change may mean reducing or stopping substance use, or it may mean taking steps to reduce the risks associated with using substances—e.g., using a sterile syringe or testing the substance for fentanyl prior to use. The Transtheoretical Model, or "Stages of Change," provides a framework for understanding people's decision-making process for behavior change.[13]

The model has been applied to understanding SUD and substance use. People achieve successful, intentional change when they are sufficiently motivated to change, have decided for themselves to change, and believe they can do so—that they have the tools and the personal capacity.

The Continuum of Care presents a comprehensive range of services to support individuals throughout all stages of change, with the understanding that people do not necessarily progress from their first time using substances to developing a SUD or to recovery in a linear fashion. Some people may use substances experimentally and never develop SUD.
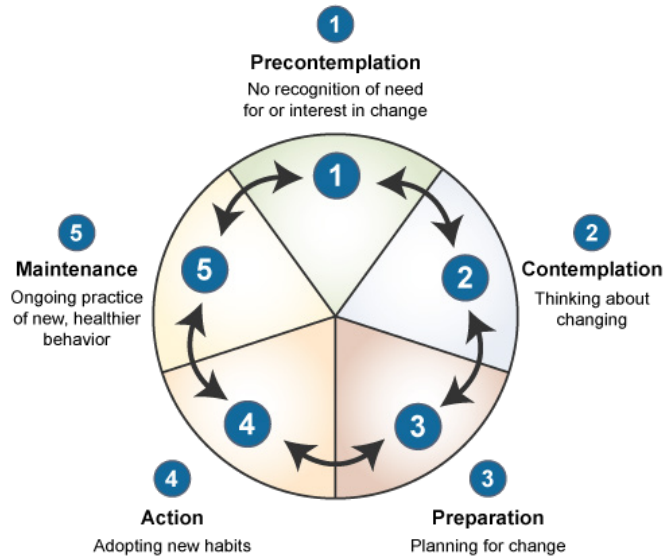
Source: info.nicic.gov/ccar/node/9

Others may achieve abstinence in a recovery process but return to use—sometimes using substances in a way that does not meet the definition of SUD, and other times returning to risky use behaviors. Primary prevention intends to keep a person from using substances and developing SUD to begin with. Harm reduction approaches keep people as safe as possible when they are using substances, provide a support network to connect them to care if they are ready for change, and strengthen confidence in their ability to make a change. Treatment that is available and accessible ensures people can receive high quality, evidence-based medical care that meets their needs and does not present unnecessary hurdles and hardships. Community recovery supports help people to sustain their behavior change, creating an environment that is conducive to maintaining those changes over time. A comprehensive service system supports people, keeping them engaged and maintaining contact as their needs fluctuate. Ideally, a person with SUD would remain connected to some type of service along the Continuum, regardless of whether they are currently using substances.

Public Health Focus

Changes in the composition and supply of the drug market demonstrate the importance of addressing the demand for drugs through the Continuum of Care. This Roadmap was developed with a public health focus and includes policies and interventions that have been shown specifically to prevent overdose death. For many of these strategies, partnership with public safety officials may be important. In those cases, public safety will be listed as a potential partner under the best practice recommendation. However, this document primarily highlights public health strategies and does not elaborate upon specific interdiction or supply-side recommendations.

STIGMA

Defining stigma and its origins

Stigma is ubiquitous across people's experiences of SUD and shows up in many ways that impact the Continuum of Care. Stigma here refers to the underlying beliefs that result in discriminatory behaviors and actions toward people who use drugs and those with SUD.[14] Types of stigma include public (negative attitudes toward people with addiction), structural (exclusion from opportunities and resources), and self-directed (internalized beliefs held by people who use drugs and those with SUD).[15]

People may also experience stigma regarding the use of medications to treat SUD. Past experiences of stigma in healthcare settings and anticipation of how one will be treated keep many people from accessing and staying in treatment for SUD, in addition to other essential healthcare and preventive services.[16]

The problem of stigma is challenging and difficult to measure, and media campaigns alone have not been shown to be effective.[17] Illicit drug use, a behavior symptomatic of SUD, is illegal and criminalized in most places in the United States. SUD and its associated behaviors have historically been viewed as a moral failing and crime rather than a health condition; punishment, including incarceration, has been the response to illicit drug use, with people who use drugs considered criminal offenders.[18] Public health research and evidence now asks that healthcare providers and the public exercise compassion and understand SUD as a health care condition; simultaneously, people are incarcerated for the symptoms of this condition. Amid this incongruence, stigma continues to pervade the public perspective of drug use and SUD. These historical perspectives and approaches are deeply ingrained in individual belief systems and society.
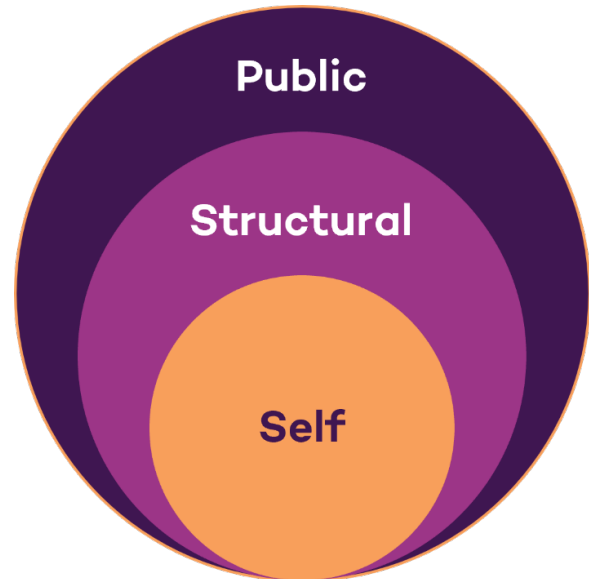
Multiple stigmatized identities

Stigma experienced by people with SUD is also complex. People who use drugs and those with SUD may occupy several stigmatized and marginalized identities that are interrelated and subject them to discrimination in healthcare and other settings. For example, an individual with SUD may also be HIV positive, living in poverty, and have a history of incarceration—all factors that are disproportionately prevalent in Black communities compared to White, adding another layer of potential discrimination.[19] The Black community has experienced a disproportionate impact from drug criminalization and incarceration, disparities in healthcare access, and a shortage of representation among healthcare providers.[20] These examples are limited; other marginalized groups and individuals may have complex experiences of stigma that relate to and intersect with substance use and SUD.

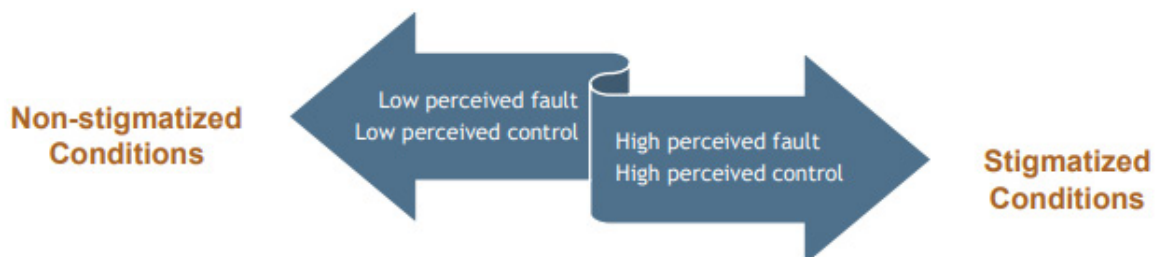### Addressing stigma across the Continuum of Care

Stigma toward SUD is too massive a problem to see significant progress with one particular intervention, particularly amidst incongruent policies in the criminal legal system. However, many of the recommendations throughout the Roadmap can help states work toward reducing stigma indirectly and chip away at the fundamental misperceptions about SUD. Stigma reduction is at the heart of policies and programs that recognize SUD as a health condition, rather than a moral failing, and those that prioritize the autonomy and self-determination of people who use drugs, people with SUD, and people in recovery.

Champions in government leadership positions and in the community have the power to foster empathy, increase awareness, and normalize SUD, treatment, and recovery. Leaders can destigmatize SUD by speaking about personal experiences, such as their own identity as a person in recovery from SUD or the loss of a family member or friend to overdose. Language also plays a key role in maintaining and perpetuating stigmatizing beliefs; state leaders who model non-stigmatizing language can set the standard for treating people with dignity and acknowledging SUD as a health condition. Leaders can describe state-level actions and efforts in terms that extend empathy and align with SUD as a health condition. Similarly, they can avoid language that frames the response to overdose and opioids as a "war," which can position people who use drugs and those with SUD as a targeted enemy.

Resources for addressing stigma

- Disrupting Stigma (National Center on Substance Abuse and Child Welfare)
- Words Matter: How Language Choice Can Reduce Stigma (SAMHSA, 2017)
- Overcoming Stigma Through Language: A Primer
(Canadian Centre on Substance Use and Addiction)
- Change your language (Shatterproof, 2023)
- The Stigmatization of Justice-involved Individuals with Substance Use Disorders
(LAPPA, 2021)

SAMHSA'S CENTER FOR THE APPLICATION OF PREVENTION TECHNOLOGIES

Non-stigmatized Conditions — Low perceived fault, Low perceived control / High perceived fault, High perceived control — Stigmatized Conditions

Utilization of Roadmap

Roadmap Structure, Pillars, and Application

All recommendations included in the Roadmap are evidence-based or promising strategies to prevent overdose deaths. While the recommendations do not include every possible action, the Roadmap prioritizes those with the greatest potential impact. The Roadmap provides a variety of recommendations for states and territories to consider. These recommendations are feasible for most states to implement with the understanding that overdose response strategies are most effective when tailored to the population. States and territories also have varying degrees of readiness for implementing certain approaches and interventions.

There are five pillars of the Continuum of Care included in this roadmap: foundations, prevention, harm reduction, treatment, and recovery. Each pillar includes a background section providing context and grounding information for the pillar. There are two to five recommended "routes," or policy and best practice recommendations for each pillar. The relevant audience may vary for each pillar and may differ based on the organization of each state and territory's substance use-related work and agencies. The foundations pillar may be most relevant to Health Policy Advisors, Governors' offices, and coordinating bodies, while Single State Agencies (SSAs) may find the Prevention and Treatment sections most helpful. The placement of harm reduction work in government agencies across states and territories varies, and thus the audience for this pillar will vary.

Incorporating Roadmap recommendations may begin with an assessment of where the state or territory stands with each aspect. For example, has the recommendation already been implemented? Were suggested partners included, or are there additional opportunities to extend the impact by bringing others in? Which of the state's existing goals align with the Roadmap "destinations," and are there recommendations the state is not yet implementing that would support achievement of that goal? Which of the recommendations reflect the Governor's priorities and preferred approach for addressing substance use and overdose? These are just a few of the questions that states and territories can ask when assessing which Roadmap recommendations to implement. The NGA Center for Best Practices is available to support states and territories in thinking through the application of these recommendations to bolster their overdose response strategies.

Background (Level Setting)
What is our starting point?

These sections characterize the starting point and the landscape to contextualize the recommendations. The background may describe historical trends and relevant context to understand the mechanism of action and potential impact for the recommendations that follow. Background sections may also include equity considerations for each pillar.

Routes (Recommendations)
How do we get to our destination?

These sections include recommendations for states to consider; these recommendations are considered best or promising practices with a strong or emerging evidence base for preventing overdose and reducing substance use-related harms. Each action represents an

actionable, specific, and impactful change that can be made by Governors and executive branch staff. Recommendations are intended to meet a majority of states where they are with regard to readiness for certain types of interventions.

Destination (Objectives)

Where do we want to go?

These sections identify desired outcomes for the named recommendation/ route—objectives that contribute to the larger goal of reducing overdose mortality and improving quality of life for people with SUD, their families, and affected communities.

Passengers (Partners)

Who is on-board with us enroute to our destination?

These sections include information about partnerships and collaborations that are key to implementing the named recommendations. These sections also include considerations around equity and ensuring disproportionately impacted populations and people with lived experience are included in and drivers of various efforts.

Fuel (Funding Sources)

What financial resources are available to support these efforts?

These sections name specific funding sources that may be available for the named best practices. They may also include considerations for sustainability and ensuring continuation of efforts beyond grant periods.

Measures

How do we measure how far we've traveled and determine whether we're going in the right direction?

These sections identify specific measures states may use to evaluate the impact of the recommendations. Available datasets will vary from state to state; these measures are intended as a guide to determine the indicators that might be available.

Resources

What other resources are available?

Resources listed for each best practice may include other publications that take a deeper dive or provide more information and guidance about the recommendation. Resources may also include national datasets that states can use to assess where they stand.

State Spotlights

Which states are implementing innovative programs and policies in this part of the Continuum?

These sections include case studies of states that have implemented programs or policies exemplifying best practices across each pillar of the Continuum.

Considerations for Equity

Each pillar of the Roadmap includes either a breakout section or content throughout that highlights some of the equity considerations applicable to the pillar. These are not comprehensive but serve as a starting point for states to think about disparities that exist in each area and the policies and practices that can move states toward greater equity.

THE ROADMAP

Foundations

Background

A strong foundation is an important starting point to implement an effective and comprehensive Continuum of Care and overdose response strategy. Even an evidence-based intervention may fail to produce the desired outcomes if it is implemented incorrectly, there is an insufficient investment of resources, there is a lack of understanding of which populations are most impacted, or key partners are excluded. This pillar describes principles and strategies that are key to the success of the recommendations throughout the prevention, harm reduction, treatment, and recovery pillars.

Principles

Data-driven and evidence-based

Data is a fundamental tool for states to implement and evaluate an effective overdose response strategy and SUD Continuum of Care. States are custodians of rich datasets that provide extensive information about health and related social and demographic factors. Data in public health can describe the nature of a problem, identify health and service disparities between populations, measure progress, and provide important information to determine whether an intervention is achieving its intended outcomes.

Sharing data across agencies can be complicated and administratively burdensome. Governors who establish a long-term data strategy can bring together interdepartmental and interagency partners to identify and agree on a set of data indicators to collect and measure over time.

Ideally, a multiyear data strategy will clearly outline goals and expectations for sharing information; in addition, states can ensure success by allocating appropriate resources to execute this vision. State governments also face the challenge of inefficient and antiquated data systems. Investing in the right technology can ensure integrity and security, in addition to empowering a workforce that is more efficient in collecting and using data.

Program data and evaluation are also key to an effective overdose response. States and territories that continuously evaluate the effectiveness of their overdose response and programming can identify what works and what does not. Strategies and programs can change over time in response to shifts in the populations most impacted, illicit drug supply trends, and growth of the evidence base around effective interventions.

⟡ *Equity driven and culturally responsive*

The ongoing opioid overdose epidemic has far-reaching impacts felt by most Americans. However, certain populations and communities—particularly, Black, Indigenous, and people of color—have been disproportionately harmed by the devastation of lives lost to overdose, the incarceration of people who use drugs, the disconnecting of families with parental substance use, and the health impacts of substance use-related diseases like HIV and Hepatitis C. These impacts are compounded with other social, economic, and environmental challenges facing certain communities. To address the ongoing opioid epidemic for all residents of their states, Governors and their staff will need to give special attention to those populations and communities that have been hardest hit.

A first step is knowing which racial, ethnic, cultural groups, and which geographic areas have been disproportionately affected in a given state or territory. While national statistics tell one story, states and territories can use disaggregated and geospatial data to understand which populations are impacted by overdose and related health indicators. The states and territories of the US are incredibly diverse, and protective or risk factors for specific groups may vary from one place to another as well; the populations most impacted may also evolve over time. In one state, Indigenous people may bear the burden of overdose and substance use-related harms; in another state it may be a geographically isolated rural community with a shortage of healthcare professionals. Examining the burden of overdose and drug-related harms across ages, genders, and other demographics within these cultural groups may provide additional helpful information.

Equipped with this knowledge, states can include approaches in their overdose response strategy that are specifically tailored to these populations. These approaches can also acknowledge and account for the role of other historical and contemporary challenges impacting the population. Optimal interventions and strategies will originate from and be delivered by the communities and populations they intend to serve; key messaging will be delivered in the language(s) used by the community. In addition, strategies for disproportionately impacted populations cannot be a monolith; while they may experience similar challenges, each group requires its own specific and targeted response and implementation strategy.

⟡ *Grounded in dignity, self-determination, and quality of life outcomes*

The included recommendations are founded on a respect for individual dignity and self-determination of people who use drugs and those with SUD, and their rights to choose their own health and substance use goals. Similarly, the recommendations prioritize quality of life improvements, with the understanding that people deserve access to healthcare and tools to keep themselves as safe as possible, regardless of whether they stop using substances. Across the Continuum, there is an emphasis on minimizing barriers—making it as easy as possible for people to choose safer behaviors and access treatment if desired; for example, participants at Syringe Services Programs are more likely to enter SUD treatment.[21]

Additionally, the recommendations included are most effective when including the input and leadership of people who use or have used drugs and people with SUD.

In addition to the principles, specific strategies that reduce overdose risk across the Continuum are considered foundational because services ideally will engage with individuals as their relationships with substances and desire for change evolves. People with SUD who inject illicit drugs may receive sterile syringes and emergency medication to reverse a potential overdose from a community-based organization. Whether or not they choose to pursue treatment at that time, these supplies keep them from contracting HIV and Hepatitis C and allow them or others to respond in the event of an emergency. This same program can connect that person to SUD treatment, providing a warm hand-off from people they have come to trust. SUD treatment and community recovery supports would ideally help individuals to maintain recovery as they define it. However, return to use is common in SUD. A SUD treatment program attentive to reducing overdose risk would retain the individual in care even if they test positive for illicit substances.

Informed and led by those affected

Another foundational principle is the meaningful inclusion of the impacted population in decision-making about them. This principle underlines a respect for people's rights to be involved in decision-making that affects them. Inclusion must be intentional and meaningful, particularly when dealing with marginalized populations that have been historically excluded. This applies to people who use drugs and those with SUD, who are subject to stigma as well as continued criminalization of their behavior. People may also be part of more than one group that is facing bias and discrimination.

This principle is rooted in respect for people's rights, but it also contributes to a more effective Continuum of Care and overdose response strategy. People who use drugs, people with SUD, and people in recovery have knowledge of the challenges and strengths of their communities; they can inform what will work and what will not, as well as what their communities need. In addition, the qualitative information they provide can supplement and contextualize the quantitative data public health leaders use to drive policy and programs.

Applying this principle requires intentional outreach to gather input, oftentimes via partner organizations that have trusted relationships in the community. Formal settings where state governments gather input are oftentimes not comfortable or convenient settings for community members to provide feedback. Applying this principle also means overcoming barriers and finding ways to compensate people for their time and input. Beyond soliciting input, hiring people with lived or living experience acknowledges their expertise, lends credibility and experience to the work, and supports a more effective response.

Strategies

⟡ *Leverage executive powers to set a unified vision*

Governors are in a unique position to direct their state's overdose response strategy through a variety of levers, including issuing executive orders, convening cross-sector partners to set a statewide vision for overdose response, and through allocating budgetary resources. Governors can also use their platform as a megaphone to destigmatize SUD and set priorities. A holistic overdose response strategy requires collaboration from partners across state government, as well as non-governmental entities. To further ensure that all entities are working toward a singular vision, Governors can establish or revive coordinating entities to oversee state efforts. Coordinating agencies with appointed leadership can help reduce bureaucratic barriers by facilitating cross-agency collaboration on priority projects, in addition to having a designated entity to champion policy priorities on behalf of the Governor. Several states have identified coordinating entities, which can improve efficiencies and reduce duplication of projects across sectors.

⟡ *Tailor the response based on the data*

An effective needs assessment brings together quantitative and qualitative datasets to determine the who, what, when, where, and why of a particular problem. Ideally, a needs assessment is completed regularly or prior to the implementation of interventions to ensure that respective strategies are targeted in areas of greatest need and implemented with cultural sensitivity. Governors can leverage coordinating entities to develop statewide needs assessments to support decision-making if plans do not exist, or to coordinate findings from existing plans that support other state and federal projects.

States can leverage findings from their overdose needs assessments to inform statewide strategic planning. The strategic plan would build on other foundational work to include clearly stated goals and outcomes that are measurable over time, in addition to identifying the respective interventions that tie to the intended goals and outcomes. Through having a centralized strategic plan, states can ensure that statewide policies and programs are being implemented in alignment with the state's vision.

Through the strategic planning process, states can leverage data and literature on interventions that have been shown to be effective or are proving to be promising in reducing overdose. Given that resources to address overdose and SUD are finite, Governors can advocate for state-supported interventions that are data-driven to ensure effective use of funding and to drive intended outcomes.

⟡ *Maximize resources to their fullest potential*

While state-level procurement processes may not be traditionally considered as part of an overdose response strategy, this infrastructure is critical to ensuring states can implement evidence-based strategies and use the resources available to their maximum potential. Internal state grant-making and procurement processes can create difficulties in effectively using federal resources and opioid litigation proceeds. States encounter many challenges

with spending funds, to include federal spending restrictions, state procurement processes that are needlessly complex, a shortage of staff to administer funding, and an insufficient understanding of how funding is being spent across the state. States that focus on these processes and take action to make them run more efficiently may see more effectively implemented programs as well as greater expenditure of federal grants allocated to overdose response.

Effective braiding of funding sources presents another opportunity for states to maximize their federal substance use-related resources. There are numerous federal and state funding streams that support interventions to prevent SUD and overdose. States can consider implementing collaborative funding models, where multiple distinct funding streams work across agencies toward a common goal and allow for increased flexibility. Funds can be braided (each funding system works toward a common goal but maintains its separate identity) or blended (funding systems combine funds under a single set of reporting and other requirements).[22] For example, in Colorado, a children's mental health subcommittee evaluated the funding agencies for children's behavioral health.[23] The evaluation began with comprehensive fiscal mapping and found unclear resource allocation, unnecessary duplication of services, and sparse data collection. It concluded that a system of care grounded in programmatic assignment and coordinated funding streams would lessen client system involvement and improve outcomes, and it made recommendations to consolidate funding streams and service delivery to maximize federal resources.[24]

Invest in the workforce

States and territories require a robust and adequately trained workforce to implement the services across the Continuum of Care. Currently, there are workforce shortages across many industries and professions. Governors are taking actions to address these shortages in a variety of ways. Professions implicated in the SUD Continuum of Care are not exempt—shortages exist among licensed treatment professionals, paraprofessionals, and peer support specialists. Governors can consider the specific needs of the SUD prevention, harm reduction, treatment, and recovery workforces as they act to bolster the workforce more broadly.

◆ Foundation Route 1:
Invest in state infrastructure to maximize resources.

Streamline and create efficient procurement and grant-making processes to ensure funding allocated to overdose prevention has the greatest impact possible.

Context
There are a variety of state and federal funding streams currently available to support overdose response and bolster the SUD Continuum of Care. Significant federal funding resources from SAMHSA, CDC, and other agencies have been deployed in recent years to address the overdose epidemic, and opioid litigation proceeds are now becoming available

in many states as well. While resources are available, many states and territories experience barriers that prevent them from fully expending federal grants. In addition, internal challenges may keep state and territory governments from quickly getting money out the door, which can impede partnerships with the community organizations that represent the "boots-on-the-ground" response to the overdose epidemic.

Successful implementation of many initiatives across the Continuum of Care hinges on the state's procurement and grant-making processes. The overdose epidemic impacts many highly stigmatized and marginalized populations; state overdose responses rely on community-based organizations that serve these populations. Attending to and investing in internal processes that facilitate these partnerships can improve the success of the state's overall overdose response strategy. A large-scale investment could include undertaking a procurement assessment and transformation process, perhaps with outside support.

Destination

- Increased expenditure of federal grants
- Increased efficiency of grant-making to community organizations
- Improved timeliness of grant administration

Fuel

- State general funds
- In-kind state support

Passengers

- State agency directors:
  - Health and human services
    - Public health
    - Behavioral health and Substance Use Disorder
    - Medicaid
    - Children, youth, and families
  - Public safety and corrections
  - Housing
- Single State Agencies (SSAs)
- Agency procurement officials
- Governor's offices

Measures

- Percent of allocated federal substance use-related grant funds spent/unspent
- Completion of procurement process review, documentation of challenges, and creation of action plan
- Grant cycle timeline

Resources

- Using Government Procurement to Advance Equity (Harvard, 2022)
- Transcending MET (O'Neill Institute, 2023)
- Budgeting to Promote Social Objectives—A Primer on Braiding and Blending (Brookings Institution, 2020)
- Funding Options for States (NASHP, 2022)
- Blending, Braiding, and Block-Granting Funds (NASHP, 2017)
- HHS OIG Report on States' Targeted Response to the Opioid Crisis (2020)
- National Association of State Procurement Officials

◆ ## Foundation Route 2:

Establish a state government coordinating body to set a statewide vision for overdose prevention.

Coordinate an all-government approach to addressing overdose by directing cross-agency strategic planning and financial mapping.

Context

Cross-agency collaboration within state government is critical to identify opportunities to share and maximize resources. Braiding and blending funding sources, even across agencies, also enables a more comprehensive and unified approach to overdose response. Beyond maximizing the use of grants, an all-of-government approach can align strategies, reduce duplication of efforts, and result in a more effective public health response. SUD affects a broad segment of the population, either directly or indirectly; an effective response incorporates government agencies beyond those addressing mental health and substance use. Prevention strategies frequently require the participation of agencies dealing with children, youth, families, and education. Harm reduction strategies are often deployed through infectious disease agencies. Housing agencies play a role in enhancing stable housing as prevention, expanding transitional housing opportunities for people with SUD who are unstably housed, and strengthening the network of recovery housing providers. Statewide coordination can serve to bring these agencies together to conduct assessments of need, identify the various financial resources available holistically, and develop a unified strategy with common goals and input from many internal and external partners. In addition to the resources listed here, state and territory SAMHSA grant reports and local state opioid litigation trackers may be helpful in conducting financial mapping and cross-agency strategic planning.

Destination	Passengers

• Substance use-related work across agencies is guided by an overdose prevention coordinating entity and strategic plan
• The statewide strategic overdose response plan is informed by the statewide needs assessment
• Increased utilization of substance use-related financial resources
• Increased resource-sharing across agencies
	• Coordinating entity
	• State agencies:
	  ▪ Health and human services
	    o Infectious/ communicable disease
	    o Public health
	    o Behavioral health and Substance Use Disorder
	    o Medicaid
	    o Children, youth, and families
	  ▪ Education
	  ▪ Public safety and corrections
	  ▪ Labor
	  ▪ Commerce
	  ▪ Housing
	• Chief Data Officer

Foundation Route 2

Fuel	Measures
• SAMHSA State Opioid Response grant • SAMHSA Substance Use Prevention, Treatment and Recovery Support block grant • Opioid litigation proceeds • State general funds • In-kind state support	• Establishment of a coordinating entity • Completion of a statewide needs assessment for SUD and overdose • Publication of a state overdose prevention strategic plan • Diversity of funding sources supporting state substance use-related programs

Resources

- [Combating the Opioid Crisis: Smarter Spending to Enhance the Federal Response](#) (Bipartisan Policy Center, 2022)

- [Transcending MET](#) (O'Neill Institute, 2023)

- [Strategic Planning Guide](#) (ASTHO)

- [Principles for the Use of Funds from the Opioid Litigation](#) (JHU, 2023)

- [States Should Measure Opioid Use Disorder Treatment to Improve Outcomes](#) (Pew, 2022)

- [Tribal Opioid Response Resource Toolkit](#) (National Indian Health Board)

- [Opioid Overdose Deaths by Race/Ethnicity](#) (KFF 2021)

- [Model Opioid Litigation Proceeds Act](#) (LAPPA, 2021)

Data Resources

- [National Drug Control Budget](#)

- SAMHSA SOR grant reports

- SAMHSA SUPTRS grant state data reports

- State opioid response budgets

- Opioid litigation proceeds tracker

◆ <u>Foundation Route 3:</u>

Seek and include the perspectives and leadership of people with a variety of lived experiences.

3.1 Partner with and solicit input from people with lived and living experience in state planning.

3.2 Adapt procurement and grant-making processes to provide funding and collaboration opportunities for community-based organizations that represent disproportionately impacted populations and are led by and employ people with lived and living experience.

3.3 Review and revise government hiring policies and practices to enhance employment opportunities for people with lived experience.

Context

Including the voices of people impacted in decision-making can result in more effective policies. "Nothing about us without us" was underlined as a core principle in disability activism and applies for policies impacting people with SUD and those who use drugs as well. Individuals with lived experience can see, in a way that others cannot, the barriers that keep them from accessing tools and services to improve their health. However, accessing a platform to provide input is difficult for many reasons, particularly when one's lived experience includes activities that are illegal, i.e., using illicit drugs, and highly stigmatized. In addition, people are better able and willing to provide input when they are compensated for their time and expertise and it reflects value for their input.

Community organizations led by people with lived experience and serving people who use drugs are critical partners in reaching this population and can also be an important channel for input. Grant-making and procurement processes at the state level can often be burdensome and inaccessible for many of these small, community-based organizations. Especially when led by people who reflect the community, these organizations have unique knowledge about the needs of their communities and are well-positioned to provide services that address health disparities. People with lived experience can also provide critical input as employees in state and local government, lending credibility and expertise to overdose response initiatives.

Destination

- More opportunities for people with lived experience to provide input, either directly or through community organizations
- Increased awareness of emerging trends through established community connections and feedback loops
- Increased SUD prevention, harm reduction, and treatment services provided by community organizations that reflect the populations they serve
- Increased state-level funding opportunities for community organizations serving Black, Indigenous, and other historically underserved populations
- Larger proportion of SUD-related positions in state government are filled by people with lived experience
- States engage in data-informed decision-making

Foundation Route 3

Fuel	Passengers

• SAMHSA State Opioid Response grant
• SAMHSA Substance Use Prevention, Treatment and Recovery Support block grant
• State general funds
• Opioid litigation proceeds
	• Single State Agencies (SSAs)
	• State agencies:
	  ○ Health and human services
	  ○ Public safety and corrections
	• State human resources officials
	• Harm reduction organizations
	• People with lived and living experience
	• Agency procurement officials

Measures	**Resources**
• Percent of grantees employing people with lived experience • Hours of technical assistance provided to grant applicants • Population served by race and ethnicity compared to state or territory overdose decedents	• Inclusive Procurement and Contracting (NLC, 2020) • Methods and Emerging Strategies to Engage People with Lived Experience: Improving Federal Research, Policy, and Practice (HHS, 2021) • Participation Guidelines for Individuals with Lived Experience and Family (SAMHSA, 2023) • Meaningful Involvement of People Who Use Drugs (AIDS United, 2021) • Beyond Overdose Prevention: Committing to the Meaningful Inclusion of People Who Use Drugs (RCORP-TA, 2022)

◆ Foundation Route 4:

Invest in evaluation and test new ideas.

4.1 Continuously monitor population-level data and leverage actionable insights to inform interventions and pivot resource allocation.

4.2 Leverage federal funds to pilot and evaluate community-driven, culturally responsive, and innovative programs, investing in and scaling up those with demonstrated success.

4.3 Invest time and resources into a long-term data strategy to collect accurate, complete, and timely outcome measures from relevant agencies and partners, and continuously evaluate state-funded programs.

Context

The ever-changing nature of the ongoing overdose epidemic requires states and territories to be nimble and respond quickly. A strong data strategy can help states stay aware of emerging trends and the evolution of the drug supply and the population's health needs. Data collection that is incomplete, unreliable, and inconsistent has been a challenge for public health and SUD systems over time. A long-term data strategy with sufficient cross-agency collaboration and data-sharing can support a sustainable overdose response strategy and ensure that interventions deployed by the state have a strong evidence base.

There are currently significant federal funding resources and opioid litigation proceeds available that provide an opportunity to align systems and strengthen states' capacity for data integration, analysis, and evaluation. With drastic health disparities in overdose and SUD-related harms impacting Black and Indigenous populations, these funds also offer an opportunity to evaluate culturally responsive interventions that originate in these communities and test new ideas.

Destination	**Passengers**

• Greater evidence base for community-driven and culturally responsive interventions
• Increased sharing of descriptive data relevant to the SUD Continuum of Care across state government agencies
• Greater uniformity in measures used to evaluate SUD Continuum of Care activities across state agencies
• Larger portion of state-supported programs are evidence-based
	• Chief data officers
	• Healthcare systems and health information exchange
	• Single State Agencies (SSAs)
	• State agencies:
	  o Department of health and human services
	    ▪ Behavioral health and Substance Use Disorder
	    ▪ Public health
	    ▪ Medicaid
	    ▪ Infectious/ communicable disease
	  o Public safety and corrections
	• Community-based organizations
	• Medicaid and Medicare officials

Fuel

- CDC grants
- SAMHSA State Opioid Response grant
- SAMHSA Substance Use Prevention, Treatment and Recovery Support block grant
- SAMHSA Harm Reduction grant
- Bureau of Justice Assistance (BJA) grants
- Medicaid Section 1115 Demonstration Project funding
- Opioid litigation proceeds
- State general funds

Foundation Route 4

Measures	Resources
- Percentage of state-funded initiatives that have an evaluation plan - Frequency of State Epidemiological Outcomes Workgroup or other data group meetings - Percentage of pilot initiatives that are community-driven and culturally responsive	- Brandeis Opioid Resource Connector - Data Governance Strategies for States and Tribal Nations (NPHL, 2020) - States Should Measure Opioid Use Disorder Treatment to Improve Outcomes (Pew, 2022) - ODMAP - Federal data resources: - National Survey on Drug Use and Health (NSDUH) - Treatment Episode Data Sets (TEDS) - Monitoring the Future (MTF) - Youth Risk Behavior Survey (YRBS) - Drug Abuse Warning Network (DAWN)

◆ Foundation Route 5:

Nurture and grow a mental health and substance use workforce that reflects the populations served.

5.1 Leverage recruitment, scholarship, prospective education payments, and loan forgiveness programs to support students enrolled in mental health and substance use-related degrees, particularly those representing disproportionately impacted populations and communities.

5.2 Invest in Community-Based Organization initiatives that expand training capacity for mental health and substance use-related workers.

5.3 Create more opportunities for entry-level mental health and substance use-related roles by establishing training and certification programs.

5.4 Facilitate partnerships between employers and institutions of higher education to provide training and skills-building opportunities for mental health and substance use-related employees to advance their careers.

5.5 Serve as a model for valuing state-employed peers by ensuring equitable pay and acknowledging their contributions.

Context

The SUD workforce has sustained staffing shortages that are expected to continue.[25] For example, a majority of high-need areas in the country have low or no access to buprenorphine treatment providers.[26] While eliminating the X-waiver requirement[27] to prescribe buprenorphine may help ease this shortage, too few prescribers know how to treat SUD. Peers are also an important part of the SUD workforce, and their recruitment and retention has challenged many organizations.

State medical specialty societies can consider ways to encourage their members to offer buprenorphine treatment and to publicize its availability in communities. States may encourage their public and private educational institutions to offer training degrees or certificate programs for the treatment workforce, offering incentives (such as student loan assistance repayment programs) or appropriate salaries for commitments to work in places with critical staffing needs. Hiring diverse practitioners who reflect the people and cultures they serve is important, particularly persons with lived experience.[28] Fear of discrimination and stigmatization discourages people with SUD from seeking care and compromises the care they receive when they do seek it.[29]

Destination	Passengers
• Fewer vacancies in mental health and substance use-related positions, including peers • Larger percentage of medical professionals screen and provide treatment for SUD • Eliminate delays from the point of seeking to receiving services for SUD • Increased mental health and substance use-related care providers who are Black, Indigenous, or from other populations historically underrepresented in this field	• Single State Agencies (SSAs) • Colleges and universities • Medical schools • Healthcare administrators • State medical and pharmacy boards • Medical professional societies

Resources

- Behavioral Health Workforce Projections (HRSA)
- Substance Use Disorder Treatment and Recovery Loan Repayment Program (HRSA, 2023)
- Peer Recovery Center of Excellence (2022)
- *Preparing the Next Generation of the Healthcare Workforce: State Strategies for Recruitment and Retention (NGA, 2023)*

Foundation Route 5

Fuel	Measures

• Federal funding sources
   ○ HRSA grants
   ○ SAMHSA State Opioid Response grant
   ○ SAMHSA Substance Use Prevention, Treatment and Recovery Support block grant
• State funding sources
   ○ Opioid litigation proceeds
   ○ State education grants
   ○ State general funds
	• Number of trainings provided to mental health and substance use-related professionals and continuing education hours earned
	• Percent of students pursuing mental health and substance use-related degrees who received scholarships or other financial assistance
	• Number of students pursuing mental health and substance use-related degrees
	• Percent of increase in peer and other mental health and substance use workers

Virginia: FAACT and Cross-Agency Collaboration

The Virginia Framework for Addiction Analysis and Community Transformation, or FAACT, is a **cross-agency data-sharing** initiative that combines data to generate **insights** about contributing factors to the opioid epidemic, deliver actionable intelligence, and enhance timely and effective responses. Managed by the Department of Criminal Justice Services, FAACT began with an initial proof-of-concept grant from the Department of Justice to assess the efficacy of data-sharing as a means to address the opioid epidemic. The initiative was able to grow out of **investments in data-sharing** across agencies, including the creation of the **Chief Data Officer** position and the building of a **data governance infrastructure**. Once the platform was built, funding to grow the project came through the State Opioid Response grant (SOR) managed by the Department of Behavioral Health and Developmental Services (DBHDS) with operational support from the Office of Data Governance and Analytics (ODGA).

Four years in, the platform includes more than **65 unique data sets** from over 20 agencies. The primary benefit of the platform lies in the unique **convergence of multiple public health, public safety, and criminal legal system data sets** that were previously siloed. The project documents as a major outcome the growing number of instances in which data informed on-the-ground **programmatic changes** or helped public health officials communicate the where, what, and why of community-level needs.
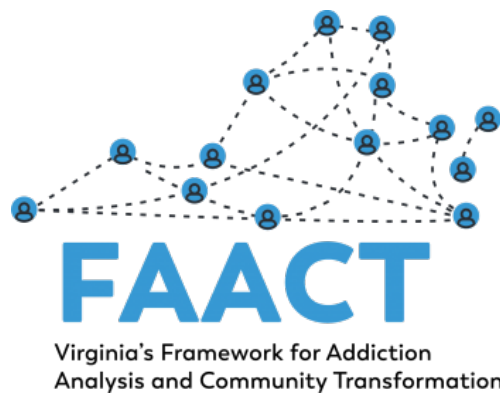
The project has benefited from continuous feedback, improvement, and expansion. The foundation of a strong data governance structure and a cross-agency working group was critical, as was identifying a vendor who was invested in the mission. The overdose epidemic is a key focus area for **Virginia Governor Glenn Youngkin and First Lady Suzanne Youngkin,** and their support of the FAACT initiative has been invaluable. **Governor Youngkin** has continued to bolster the initiative in many ways, including executive orders mandating that certain agencies establish data-sharing plans and participate in FAACT.

The FAACT initiative is reflective of Virginia's **strong relationships across agencies** that support efforts in different areas of need to include treatment, public safety, and overdose prevention efforts. Participants in the NGA project in Virginia noted that engagement with NGA has been one important facilitator of this cross-agency collaboration. Various teams across behavioral health, criminal justice, and corrections recognized years ago that addressing the opioid epidemic in siloed agencies was not getting them where they wanted to go nor leveraging resources to their full extent. While various workgroups and cross-agency initiatives have brought these teams together over time, they **prioritized** their collaborative working relationships and kept meeting on an ad hoc basis, even through administration changes.

These collaborations are driven by the **shared mission** to save lives and help people achieve wellness, as well as an understanding that the work of various agencies is interrelated. These teams are particularly **conscientious** of how their work involves and impacts each other, ensuring they share resources and information and bring each other into the room for new projects and relevant conversations. Finite time as well as administration changes are challenges to maintaining collaboration. However, these collaborative relationships are a priority for all teams involved, so meetings continue even when administrations change and even when attendance must be delegated to different team representatives.

Massachusetts: Single State Agency

Single State Agencies, or SSAs, are the Governor-designated agencies that lead the management of federal substance use prevention, treatment, and recovery funds. Typically, SSAs manage opioid-specific funding and SAMHSA block grants, including data collection and reporting. They work closely with the provider community to ensure **high-quality services** for people who use drugs and people with SUD. SSAs also lead and promote **cross-agency collaboration** across state government to varying degrees, recognizing that substance use touches many sectors and involves many agencies. SSAs may **lead or coordinate** statewide service delivery planning and assessments of need.

Massachusetts' SSA is the Bureau of Substance Addiction Services (BSAS), situated within the Department of Public Health under Health and Human Services. In some other states, a mental health agency oversees or is designated as the SSA. This placement has facilitated a

broad perspective and **innovative approaches** to addressing substance use, focusing on **drug user health** and well-being comprehensively. The SSA's placement alongside the Bureau of Infectious Disease helps to align the work of overdose prevention, SUD treatment and recovery services, and HIV and Hepatitis C prevention and treatment for people who use drugs.

Success for an SSA could be measured in many ways. Massachusetts sees the SSA as a voice for people who use substances and a **leader in implementing evidence-based policies and programs** and coordinating across agencies. BSAS has modeled a **data-driven** and **all-hands-on-deck approach** to addressing overdose, emphasizing the need for involvement of sister agencies. Ensuring equity, centering the voice of living expertise, and emphasizing self-determination are also key responsibilities of Massachusetts's SSA; to this end, BSAS **listens to the communities they serve** and employs people with lived experience. BSAS has built strong relationships with community harm reduction providers.

BSAS highlights many strategies that have been critical in effectively leveraging the leadership of the SSA to implement an SUD Continuum of Care:

- **Invest state dollars**
  - *Don't rely solely on federal grants.*

- **Invest in workforce, both externally and internally**
  - *You can't get money out the door or give technical assistance when you're understaffed.*

- **Listen to your community**
  - *Build trust over time with people who use drugs and the providers who serve them.*

- **Be a voice for your population across departments and agencies**
  - *We can't do this alone.*

- **Consider the context and invest in upstream prevention**
  - *Look at the big picture of what is happening in the community that affects people's lives and impacts their ability to access treatment and stay in care.*

- **Prioritize relationships across agencies**
  - *Bring along neighboring units, even those that are less on board than others.*

Through a special grant program, BSAS is providing capacity-building technical assistance to applicants, convening an advisory board, and leveraging a third-party agency to make grants. This effort reflects their innovative approach, **commitment to equity**, and consideration of context and big picture. This initiative grew from the recognition that navigating the **state procurement system** as a small, community-based organization is a feat; that inequities exist in grant-making systems; and the individuals best equipped to design programs and provide services are those representing the communities they serve.

Prevention

Background

Prevention efforts target the demand for substances amidst a continuously fluctuating and unpredictable illicit drug market—from preventing first use to interrupting the development of SUD. The proliferation of fentanyl and other dangerous substances in the illicit drug market has caused rising overdose deaths among young people, although youth substance use rates are at an all-time low. A larger portion of young people are at risk of overdose—including those using drugs for the first time. First use at an early age is also associated with later problematic drug use and development of SUD, introducing further risk across the lifespan.

Adversity, Protective Factors, and Pathways to SUD

The development of SUD is strongly associated with adversity in childhood, mitigated by protective factors, and influenced by social and environmental influences on health. Adverse Childhood Experiences (ACEs), defined by a landmark research study, are negative events occurring during childhood that increase a person's risk of developing SUD, among many other negative health outcomes.[30] ACEs are cumulative, and their effects are interrelated; the more adversity in childhood, the greater the risk of many poor health outcomes. Outside of those defined in the ACEs study, there are many risk and protective factors at the level of the individual, family, school, and society. The term "social drivers of health" refers to the wider environmental context in which people live that affects their health outcomes. Prevention science recognizes critical periods of development over the span of childhood and young adulthood in which adverse experiences, protective influences, and prevention interventions are most impactful.

SUD also has an intergenerational impact and risk of transmission. Parental substance use is a risk factor for the child's substance use later in life. Parenting style, adversity, child welfare involvement and inequities, and social drivers of health all play a role in the later development of SUD. One in eight children under 17 are living with a parent who has a SUD.[31] Over 240,000 children have lost a parent to opioid overdose and about 325,000 children have been removed from their homes because of parental substance use.[32] Both are traumatic experiences with lifelong impacts on children.

Prevention activities aim to interrupt the pathway for the development of SUD. There are different levels of prevention. Primary prevention interventions reduce the impact of risk factors, promoting positive brain development and coping mechanisms. There are prevention interventions even further upstream that aim to reduce the risk factors that lead to disease in the first place. In addition to preventing and mitigating adversity, both types of prevention seek to enhance protective factors—strengthening coping skills, keeping children with their parents whenever possible, and supporting the health and well-being of families.

The Importance of Evidence-Based Approaches

States play an important role in ensuring the policies they enact and programs they invest in will be effective. This is especially important with prevention, where the impact on outcomes such as overdose rates is hard to measure and may not be apparent for many years. Prevention research has validated many interventions across the lifespan and at various points in the potential development of SUD. State-level program registries, requirements, and processes for verifying the evidence base of interventions can help to ensure states are supporting only those interventions with demonstrated success. This is critical to ensure that resources are used for the most effective interventions and do not cause harm.[33]

Root Cause Prevention and Strengthening Family Cohesion

With a better understanding of the impact of adversity and protective factors, the child welfare system nationwide is shifting toward a model that keeps families together and away from surveillance and punishment.[34] [35] Notably, removal of children is traumatic for both parents and children, causing long-term harm to the child's health.[36] Removal is most often the result of neglect, which is recognized as a proxy for poverty in many cases. Significant inequities exist for children and families involved in the child welfare system; Black and Indigenous children are disproportionately removed from their families, more frequently placed in foster care, placed in foster care for longer periods, and less frequently reunited with their families. The Family First Prevention Services Act of 2018 allows child welfare funds to be used to support and keep families together, preventing foster care placement when possible.[37]

These national paradigm shifts reflect the current understanding that prevention is most effective when directed toward root causes and environmental conditions, rather than solely attempting to deter substance use behaviors in youth. Efforts to support families exemplify upstream prevention—preventing adverse events from happening and reducing the impact of those that do happen by enhancing family cohesion and economic well-being. Supporting the parent is supporting the child; ideally, policies treat SUD as a chronic condition and provide access to services such as treatment without the threat of child removal when possible. Evidence-based programs such as home visiting can identify the areas in which families need additional support and connect them with resources; these programs also help identify and resolve potential sources of adversity in the household.[38] Enhancing protective factors can also include economic help and workforce enhancements for low-income families, such as access to high-quality childcare, flexible and consistent work schedules, and paid maternity leave. Research demonstrates that policy-level interventions such as investing in housing support for families and raising the minimum wage can decrease the number of children needing foster care.[39] Additional policy changes might include those that provide employment opportunities, paid time off, tax credits, affordable childcare, education, and stable housing.

Alternatively, policies that criminalize prenatal and parental substance use exacerbate the challenges facing families impacted by SUD, with no demonstrated benefits and many resulting harms.[40] In states where prenatal substance use is criminalized, children are less likely to be reunited with their parents.[41] Punitive parental drug policies have also not reduced neonatal opioid withdrawal syndrome (NOWS).[42] However, punitive policies may deter pregnant people from seeking both routine prenatal care and SUD treatment.[43] [44]

Rising rates of congenital syphilis are attributed to pregnant people who use substances delaying and avoiding prenatal health care, due to stigma and fear of criminal legal and child welfare system consequences.[45] Increases in congenital syphilis rates disproportionately impact Black, Indigenous, and Hispanic and Latino populations.[46] [47]

Sources of Support for Prevention

Federal resources are available to support prevention at various levels. SAMHSA offers the Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) block grant (which has a 20% set-aside for prevention), the State Opioid Response (SOR) grant, and the Strategic Prevention Framework-Partnerships for Success (SPF-PS). SAMHSA previously supported the State Epidemiological Outcomes Workgroups (SEOW), which many states have continued to support with other resources and depend upon as a critical component in prevention and across the Continuum of Care. States can consider maximizing these resources through collaborations with community-based coalitions, schools, and other partners to implement prevention programming. The Family First Prevention Services Act is another opportunity for states, territories, and tribes to implement upstream prevention that supports families, and in doing so, disrupts pathways to SUD in the next generation. States can also consider exploring Medicaid reimbursement options to support pregnant people with SUD.[48]

Interrupting the development of SUD and intergenerational transmission requires long-term, big picture intervention and investments.[49] Prevention science suggests that programming shown to be effective can then be expanded in scope and scale, tailored to the population, and integrated into communities. Effective prevention is also comprehensive, intervening across the lifespan at many points and representing long-term investments. Comprehensive prevention goes beyond individual and school-based programs, and requires environmental, community, and family investments. One program alone, even if evidence-based, will not be sufficient to create long-term and large-scale change.

Equity In Prevention

Exclusively implementing evidence-based and thoroughly researched prevention strategies will ensure the best chance at success in prevention. With overdose disproportionately impacting Black and Indigenous populations, interventions must also be culturally-competent and strategies must be tailored to the community to be effective.[50] However, many evidence-based practices and programs do not originate from diverse communities, and thus require adaptation for many of the populations most impacted by overdose.[51] With a historical dearth of research investment to create an evidence base, many practices and interventions originating from marginalized groups have not had the opportunity to become vetted. This results in an inequity wherein the majority of evidence-based practices were not designed for communities of color.

States can work toward more equity in prevention by creating opportunities for and investing in evaluation of interventions originating from disproportionately impacted populations. This may mean providing pathways for vetting interventions, as well as technical assistance and support for community-based organizations to evaluate practices.

◆ <u>Prevention Route 1:</u>
Champion policies and invest in initiatives that support family cohesion and well-being.

1.1 Ensure that policies do not **criminalize** prenatal substance use nor deter pregnant and parenting people from accessing health care services.

1.2 Revisit policies and procedures to ensure coordination and collaboration between all relevant agencies in delivering plans of safe care.

1.3 Invest in initiatives that keep families together and healthy by addressing social drivers of health and enhancing employment opportunities, economic health, education, stable housing, and physical and mental health care.

1.4 Leverage the Family First Prevention Services Act to keep families together and prevent foster care placement through access to substance use prevention and treatment, mental health services for parents and children, and parent skill-based programs.

Context

The root causes of SUD are attributed to adversity, trauma, and social drivers of health, and intergenerational transmission is common. Risk factors, such as ACEs, and protective factors play a role in the development of SUD. Prevention interventions aim to prevent and mitigate the impact of risk factors and enhance protective factors. Given the rate of intergenerational transmission, upstream prevention includes supporting pregnant people and parents with SUD and keeping families together by reducing unnecessary removals. This national paradigm shift is reflected in the 2018 Family First Prevention Services Act, which provides more opportunities for states to stabilize families and prevent removals. This and other policies and programs that support families' economic health and basic needs can interrupt pathways to SUD development for children.

Alternately, many states currently criminalize substance use by those who are pregnant or parenting in an effort to prevent NOWS. However, current evidence suggests that criminalization does not reduce NOWS and can also produce unintended consequences. Fears of stigma and legal consequences prevent those who are pregnant from seeking prenatal care and MOUD. Substance use and delayed or absent prenatal care have been linked to a national increase in congenital syphilis cases.[52]

Destination

- Disrupt pathways to SUD
  - Mitigate the impact of risk factors (ACEs, trauma)
  - Enhance protective factors (family cohesion and stability, safe housing, family economic health, community health and resources, high-quality education, health care, affordable childcare)
- Prevent intergenerational transmission of SUD
- Reduce incidence of Adverse Childhood Experiences
- Prevent early use and reduce substance use among youth
- Increased access to MOUD and healthcare services for those who are pregnant or parenting

Prevention Route 1

Measures

- Illicit drug use rates among youth statewide compared to national statistics
- Average age of first use among youth
- Family surveillance rates and disparities by race and ethnicity
- Youth overdose mortality rates by substance, by race and ethnicity
- Permanency and reunification rates
- Average length of stay in foster care before exit to reunification, state average compared to national
- Congenital syphilis incidence and rates
- Percent of MOUD providers accepting and prioritizing pregnant people

Passengers

- State agencies:
  - Health and human services
    - Infectious/ communicable disease
    - Public health
    - Behavioral health and Substance Use Disorder
    - Medicaid
    - Children, youth, and families
  - Education
  - Housing

Fuel

- SAMHSA State Opioid Response grant
- SAMHSA Substance Use Prevention, Treatment and Recovery Support block grant
- SAMHSA Strategic Prevention Framework Partnerships for Success
- Families First Prevention Services Act
- Medicaid
- State general funds

Resources

- Monitoring the Future data tables, data sets, and publications (2022)
- Adoption and Foster Care Analysis and Reporting System
- Substance Use During Pregnancy (Guttmacher Institute, 2023)
- State-level Data for Understanding Child Welfare in the United States (Child Trends, 2023)
- Kids Count Data Center (Annie E. Casey Foundation)
- Sexually Transmitted Disease Surveillance 2021, Congenital Syphilis (CDC, 2023)
- Preventing ACES: Leveraging the Best Available Evidence (CDC, 2019)
- Family First Act website and resource database
- The Ripple Effect: The Impact of the Opioid Epidemic on Children and Families (2019)
- Model Substance Use During Pregnancy and Family Care Plans Act (LAPPA, 2023)
- Substance Use Disorder and Pregnancy: Improving Outcomes for Families (ONDCP, 2022)
- Adverse Childhood Experiences (ACEs) in Indian Country (National Indian Health Board)
- Housing Solutions Collaborative (ChangeLab Solutions, 2023)
- Housing Needs by State (National Low Income Housing Coalition, 2023)

◆ Prevention Route 2:

Establish and enforce evidence-based requirements for funded prevention initiatives.

2.1 Promote evidence-based primary prevention programming by developing and implementing processes and standards for state-funded substance use and overdose prevention programming.

2.2 Invest in community-driven and culturally responsive interventions and create opportunities to evaluate and scale them.

Context

States invest millions of dollars in preventing substance use and overdose deaths. Many well-intentioned programs to prevent substance use over the past few decades have been demonstrated as ineffective yet continue to be implemented.[33] Vetting the evidence base of prevention programs can ensure good stewardship of public funds. Internal processes and structures that require initiatives to demonstrate an evidence base can ensure effectiveness.

Many evidence-based practices (EBPs) were not designed for communities of color, and thus require adaptation. There is a lack of research into many cultural adaptations of EBPs. On the other hand, many promising and culturally grounded practices do not have a demonstrated evidence base, due to a lack of research resources and infrastructure.[53] State-level vetting processes can include flexibility and support for evaluating community-driven practices that show promise, in order to promote equity and support culturally responsive programming.

Destination	**Passengers**

• 100% of state-funded programs employ evidence-based practices or support evaluation of practice-based evidence
• Community members have access to resources, technical assistance, and pathways to evaluate culturally responsive interventions
• Dollars invested in prevention represent eventual cost-savings
	• State agencies:
	   ○ Health and human services
	      ▪ Behavioral health and Substance Use Disorder
	   ○ Education
	   ○ Children, youth, and families

Fuel	• Local prevention coalitions • Community-based organizations • Faith-based and cultural leaders • SAMHSA • State Epidemiological Outcomes Workgroup (SEOW)
• SAMHSA State Opioid Response grant • SAMHSA Substance Use Prevention, Treatment and Recovery Support block grant • SAMHSA Strategic Prevention Framework Partnerships for Success • SAMHSA Drug-Free Communities • State general funds	

Prevention Route 2

Measures	Resources
• Percent of funded prevention programs that are evidence-based • Number of technical assistance engagements provided • Number of approved programs on statewide registry • Number of new, community-driven programs undergoing evaluation • Percent of evidence-based funded programs being implemented with culturally responsive adaptations	• Brandeis Opioid Resource Connector • Evidence-Based Practices Resource Center (SAMHSA) • Adapting Evidence-Based Practices for Under-Resourced Populations (SAMHSA, 2022) • An Environmental Scan of Tribal Opioid Overdose Prevention Responses: Community-Based Strategies and Public Health Data Infrastructure (Seven Directions, 2019) • Evidence-Based Tribal Child Welfare Prevention Programs in Washington State (WA Department of Child, Youth, and Family Services, 2020) • Community-Centered Evidence-Based Practice and Building Evidence Toolkit (Esperanza United) • Benefit-Cost Results (Washington State Institute for Public Policy) • Resource Guide on State Actions to Prevent and Mitigate Adverse Childhood Experiences and Trauma (NGA, 2023)

New Jersey: Universal Home Visiting

The New Jersey Universal Home Visiting program, created through legislation in 2021, entitles **all families** throughout the state to receive **free nurse home visits** within the first few weeks following a birth, adoption, and foster home or kinship placement, as well as families who experience a stillbirth. In partnership with **Governor Phil Murphy's** leadership, **New Jersey First Lady Tammy Murphy** championed the legislation and helped develop the program's vision and goal as part of her Nurture NJ initiative to make New Jersey the **safest** and most **equitable** state to deliver and raise a baby. Home visiting strengthens positive **protective factors** for families and promotes health by assessing needs, providing individualized support, and connecting families with community resources.

This state-funded initiative **complements existing investments** in child and family health, building on the statewide infrastructure of Connecting NJ. Community Alignment Specialists help to connect families with services following their home visits and build on the existing Connecting NJ mission to connect expecting and new families with infant and maternal health related services. New Jersey's Family Success Centers serve all families in need in an effort to prevent families from experiencing crisis.

Since initial legislation, the Department of Children and Families has invested significant time and research into developing a strong implementation and communication strategy. The program's **advisory board** brought together healthcare, insurance, and community partners across various workgroups and subcommittees. The resulting design builds on the **evidence-based** Family Connects home visiting model and **follows** in the footsteps of Oregon's home visiting program, learning from their challenges and successes. The Request for Proposals for service providers was issued in May 2023, and service delivery is anticipated to start in January 2024.

While early in implementation, the program credits its initial success to many factors, including **Governor and First Lady Murphy's** advocacy and the support of healthcare providers, communities, and philanthropic partners. It was important to take sufficient **time** to understand the state's landscape and diverse community needs, design a **thoughtful communications strategy**, and explore funding strategies. The state is also investing in **continuous evaluation**, granting support for evaluation to providers and establishing partnerships with academic institutions. The biggest challenge for the state has been navigating the funding and insurance landscape to explore coverage options, keeping in mind **longevity** and the future of this service for all state residents.


Photo Credit: Tom Wiedmann

Utah: Evidence Based Workgroup

The Evidence-Based Workgroup (EBW) was created over a decade ago, growing out of the work of the SAMHSA-funded State Epidemiological Outcomes Workgroup (SEOW) to ensure Utah was implementing evidence-informed prevention initiatives. The EBW was further established by administrative rule and is housed within the Department of Health and Human Services. This workgroup is rooted in a strong **commitment to research and evidence** within Utah's prevention system, which notably represents just one of many areas where Utah is leading in evidence-based policymaking.

The EBW ensures that all state-funded **prevention initiatives** are founded on research evidence and best practices and prevents the state from investing in ineffective interventions. The workgroup oversees a **registry** of curated prevention initiatives that have been vetted and facilitates a **rigorous process** by which new initiatives can be verified and approved as evidence-based. The workgroup's membership includes researchers, academic partners, prevention coordinators, and others, as defined by rule. The group continues to review new applications and benefit from the continued **partnerships** and data collaborations of the SEOW, facilitating technical assistance and connecting applicants to academic partners who can assist in developing **evaluation** plans. The EBW uniquely provides an avenue for local providers to access prevention funding and conduct evaluation, verifying their programming as evidence-based in the process.

> "THE EBW PROVIDES AN OPPORTUNITY TO CONNECT LOCAL ORGANIZATIONS TO LOCAL EVALUATION EXPERTS TO PROVIDE TECHNICAL ASSISTANCE AND EVALUATION EXPERTISE TO IMPLEMENT STRATEGIES THAT ARE INFORMED BY EVIDENCE-BASED PRACTICES."

Applying for and pursuing verification through the EBW offers more than just a stamp of approval. The value also lies in **connecting** community members who are interested in prevention work and providing resources, tools, and connection to the larger **prevention system**. Through these connections, applicants can also receive guidance on adapting and **tailoring** evidence-based interventions to their local populations.

Source: Utah DHHS https://vimeo.com/832353544
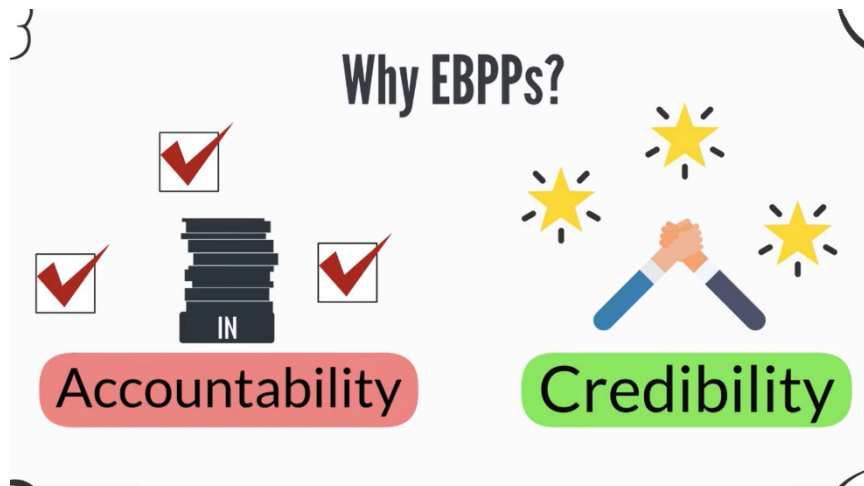
Harm Reduction

Background

Harm Reduction is both a set of practical tools to reduce the risks associated with using substances, as well as an approach to program design and service delivery. The approach prioritizes quality of life above abstinence—at the individual as well as population level. Risks inherent in using substances vary across substances, methods and supplies, environment, individual health and tolerance, and many other factors. Harm reduction recognizes the significant risks and harms that accompany substance use, even with legal substances, and identifies opportunities to reduce these harms as much as possible.

Individual autonomy and dignity are foundational, and harm reduction strategies recognize that people who use drugs can define their own goals and make changes to improve their health. Similarly, people who use drugs and those with a history of drug use are the most effective leaders of harm reduction initiatives. Harm reduction strategies are nonjudgmental and non-coercive. They strive to reduce barriers and empower people to make positive changes toward their goals. The easier it is to make a positive change, the more likely people are to do it—in other words, "meet people where they are."

Foundational harm reduction interventions with a long history of evidence include Syringe Services Programs (SSP), overdose education, Overdose Reversal Agent (ORA) distribution, and drug checking, which can include, but is not limited to, distribution of fentanyl and xylazine test strips.

- **Syringe Services Programs:** These cost-effective programs provide risk reduction counseling and sterile injection and other use supplies that prevent the transmission of infectious diseases, including Hepatitis C and HIV, and reduce the incidence of injection-related wounds and endocarditis.[54][55] These programs also provide linkages to other physical and mental healthcare services, as well safe disposal of used needles and syringes.

- **Overdose Reversal Agent Distribution**: Overdose Reversal Agents (ORAs) such as naloxone have been successfully used for decades to save lives. Distributing these medications to community members allows bystanders to quickly respond in emergencies and prevent overdose deaths. When a geographic area is sufficiently "saturated" with ORAs, and these medications are present at the scene of most overdoses, communities may see a population-level reduction in the number of overdose deaths.[56] To accomplish this, distribution to people who use drugs and their social networks is prioritized, since research indicates this population represents most bystander responders.[57]

- **Drug checking:** Drug checking refers to the use of tools to determine the composition of illicit substances, ideally before using. The distribution of fentanyl test strips, and now xylazine test strips, for harm reduction purposes allows people to test illicitly purchased drugs and determine whether fentanyl or xylazine are present. People can then make informed decisions about whether to use the drug, and how to use more safely. Research has shown that positive test results indicating the presence of fentanyl were significantly associated with behavior change to reduce risk.[58] Building on this concept, more complex types of drug checking, such as the use of spectrometry, can provide information beyond the presence or absence of a specific substance.

Overdose Prevention Centers, or Safer Consumption Sites, which have been implemented in at least ten countries and limited parts of the US, are another harm reduction strategy with many years of evidence. While these programs are not allowed under federal law, two centers currently operate in New York City, and one will soon be implemented in Rhode Island. These programs prevent overdose deaths, reduce public drug use and syringe litter, increase treatment engagement, and prevent the spread of infectious disease by reducing risky use behaviors. [59] [60] [61] The National Institute on Drug Abuse published a report on the evidence base for these programs and other research is underway to evaluate their outcomes.[62]

Harm reduction is foundational to all pillars of the Continuum of Care, and its tenets and strategies may be incorporated throughout many different services. With a dangerous illicit drug supply, prevention interventions based solely on abstaining from substance use are insufficient when overdose risk is present even at first use; access to harm reduction services and tools for young people is critical.[63] Harm reduction in treatment means not requiring abstinence as a condition for receiving services. In practice this may be implementing a Medication First Model, retaining patients regardless of drug screen results, distributing ORAs to patients, and motivational interviewing to guide patient goal setting. Recovery itself is a type of harm reduction, through which people set personal goals to reduce the harms and risks associated with their substance use, oftentimes by pursuing abstinence.

Equity Considerations

As an effective tool in addressing overdose, harm reduction is becoming incorporated into the portfolios of many states' mental health, substance use, and public health agencies. This represents a significant shift from the movement's grass roots and leadership by people with lived experience. Equity is at the core of harm reduction, which works to correct racial health inequities created by drug criminalization and prioritize the voices of those most impacted. It also advances equity by lowering barriers to care and meeting people where they are.

State, territory, and local governments implementing harm reduction practices will need to be mindful of maintaining fidelity to key principles to ensure services are effective and advance equity. Ideally, states and territories will hire people with lived experience to lead state-level harm reduction work. Another key principle is that harm reduction tools are readily available to people regardless of their circumstances; this includes their housing or employment status, whether they are currently using drugs, or their access to mainstream health care and other services. For example, Overdose Reversal Agents that are only available onsite at a health department during business hours are thus only available to people who have transportation, who do not work during business hours, and who feel comfortable walking into a health department building as a person who uses illicit drugs. Similarly, people from marginalized groups may be hesitant to return used syringes for fear of reprisal or incarceration, regardless of Good Samaritan laws or legal protections in place. In addition to people's experiences of stigma related to using drugs, their racial, cultural, and other identities also impact their access to services.

◆ Harm Reduction Route 1:

Maximize federal resources and braid funding to promote health and reduce harm for people who use drugs.

1.1 Utilize federal funds available for overdose response to support allowable wrap-around and engagement services at Syringe Services Programs (SSPs) for people who use drugs.

1.2 Review and consider revisions to policies to allow the use of state general funds for harm reduction tools and activities that are part of comprehensive harm reduction services but are without other funding sources.

1.3 Braid state and federal funds to invest in community-based harm reduction programs.

Context

Federal dollars that are funded through HHS, with the exception of the 2021 SAMHSA Harm Reduction Grant Program, cannot be used to purchase hypodermic needles and syringes. However, federal funding from HHS can support SSPs following a determination of need by the CDC. Federal agencies, including CDC and HRSA, encourage braiding of federal funding sources with state and private funding streams to implement HIV prevention services such as SSPs.[64] Fully leveraging federal resources to support SSPs may require collaboration and coordination across state agencies—for example, between state infectious disease and mental health and substance use-related agencies to implement SSPs using SAMHSA funds.

State general funds can present another opportunity to braid funding and specifically fill gaps where federal funding cannot be used. Some states prohibit the use of state funds for SSPs and/or needles and syringes. States can consider reviewing internal policies to identify state-level restrictions on funding SSPs. Braiding in state funds can allow for comprehensive implementation of SSPs while maximizing federal resources for expenses such as staff and operational needs.

Destination	Passengers

• Decrease incidence of HIV and Hepatitis C
• Increase number of people equipped to respond to an overdose
• Increase number of people who have the tools to detect adulterants in their substances
• Increase the number of people engaged in substance use treatment
• Reduce costs of treating conditions associated with injection drug use (HIV, Hepatitis, endocarditis, wounds)
• Reduce syringe litter
	• State agencies:
	  ○ Health and human services
	    ▪ Infectious/ communicable disease
	    ▪ Behavioral health and Substance Use Disorder
	    ▪ Public Health
	• Community-based organizations

Harm Reduction Route 1

<table>
<tr><td colspan="2" align="center"><u>Fuel</u></td></tr>
<tr>
<td>

SAMHSA State Opioid Response grant
SAMHSA Harm Reduction grant
CDC
HRSA

</td>
<td>

State general funds
Opioid litigation proceeds
North American Syringe Exchange Network
Philanthropic Foundations

</td>
</tr>
<tr>
<td align="center"><u>Measures</u></td>
<td align="center"><u>Resources</u></td>
</tr>
<tr>
<td>

Linkages/ referrals provided to treatment services, including MOUD; HIV, HCV, and STI treatment and care; other health and social services
HIV, HCV, and STI tests conducted
Service encounters
New participants
Syringes distributed and collected
ORAs dispensed
HIV and Hepatitis C incidence
Sexually transmitted infections incidence
Bystander ORA administrations/ overdose reversals
Overdose fatalities

</td>
<td>

Federal Funding for Syringe Services Programs (CDC, 2019)
Summary of state laws (LAPPA, 2022)
National Association of State and Territorial AIDS Directors
Sustainable Funding for Harm Reduction Programs (National Harm Reduction Coalition)
Status neutral approach letter (HRSA & CDC, 2023)
Determination of Need (CDC, 2022)
HepVu
CDC Hepatitis C
AIDSVu
CDC HIV

</td>
</tr>
</table>

◆ Harm Reduction Route 2:

Implement targeted and low-barrier distribution strategies for overdose reversal agents (ORAs) such as naloxone.

2.1 Review and revise internal policies that impede distribution and access.

2.2 Implement universal overdose education and ORA distribution to individuals leaving correctional facilities and those under community supervision.

2.3 Leverage partnerships with community-based organizations, including those led by people with lived and living experience, to reach those most likely to experience or respond to an overdose.

2.4 Champion policies that:

- Promote overdose education and ORA distribution through entities serving people most likely to experience an overdose.

- Prioritize ORA distribution to disproportionately impacted populations and people who use drugs.

- Prohibit life and health insurance discrimination related to ORAs.

- Require health insurers to cover ORAs, including non-prescription ORAs.

- Expand Good Samaritan protections for people who experience or respond to an overdose.

Context

ORAs, and naloxone in particular, have been used for decades by laypersons to respond to emergency overdoses.[65] These medications can be successfully used with brief training.[66] Effective distribution programs leverage partnerships with harm reduction programs and other community-based organizations to get ORAs into the hands of people likely to use them. Sufficient community distribution can reduce overdose fatalities when such distribution prioritizes people who use drugs—as they are the most likely to experience, as well as witness and respond to, an overdose.

Most states use federal funds to purchase ORAs as part of their overdose response strategy. Barriers that can delay and impede sufficient saturation include requirements to have a centralized delivery/pick-up location, collection of data beyond federal and state requirements, and requirements for training to receive or administer. States can improve saturation by examining unnecessary training requirements and burdensome data collection that inadvertently create barriers for distribution sites/ community programs. Ideally, distribution is prioritized for those at highest risk, such as those involved in the criminal legal system.

State law and regulation can facilitate sufficient distribution. Some states, New Mexico and Maryland, for example, have laws mandating ORA dispensing by entities that serve people at high risk for overdose.[67] Other states have addressed life insurance discrimination based on ORAs in one's prescription history.[68] Private insurance coverage and co-payments also pose a barrier.[69] States can consider ways to optimize Medicaid to support naloxone distribution.

Harm Reduction Route 2

Destination	Passengers

• Fewer overdose deaths
 	
• Increased number of people who carry ORAs such as naloxone and know how to respond to an overdose emergency
 	
• Community-level ORA saturation
	• State agencies:
	  o Health and human services
	  o Infectious/ communicable disease
	  o Behavioral health and Substance Use Disorder
	  o Public health
	• Harm reduction organizations
	
	• Community-based organizations
	
	• Legislators

Fuel

• CDC • State general funds • Opioid litigation proceeds • Medicaid and private insurance payers • State in-kind support	• State in-kind support SAMHSA State Opioid Response grant • SAMHSA Substance Use Prevention, Treatment and Recovery Support block grant • SAMHSA Harm Reduction grant

Measures	Resources
• Overdose-related hospital emergency encounters • ORA saturation/ ORA doses distributed to communities at greatest risk • Bystander ORA administrations/ overdose reversals • Overdose deaths	• Naloxone distribution best practices (Harm Reduction Journal, 2022) • Evaluation Profile for Naloxone Distribution Programs (CDC) • Naloxone Insurance Coverage Mandates (NPHL, 2023) • Provisional Drug Overdose Death Counts (NVSS, 2023) • Model Expanded Access to Emergency Opioid Antagonists Act (LAPPA, 2021) • Naloxone Saturation Webinar Series (Opioid Response Network, 2022) • Nonfatal Opioid Overdose Surveillance Dashboard (NEMSIS, 2023)

◆ <u>Harm Reduction Route 3:</u>
Champion changes that allow for the distribution of harm reduction tools.

3.1 Consider levers to establish Syringe Services Programs and protects staff, volunteers, and program recipients from charges related to possession of program supplies.

3.2 Consider policy changes to allow possession of harm reduction tools such as drug test strips to detect fentanyl and xylazine and other risk reduction and participant engagement tools.

Context

State laws often ban or otherwise sanction harm reduction tools, including drug testing strips, syringes and needles, and other drug use supplies that when shared introduce infectious disease transmission risk. Therefore, legislative changes are necessary to effectively implement these public health interventions. States have varied widely in their approaches to this. SSPs can operate through explicit statute authorization or through the exclusion of certain items from the state's drug paraphernalia law. States also vary regarding whether their laws provide protections for SSP participants and staff in possession of syringes, and how they do so. Drug checking equipment legality similarly varies. States have removed drug testing equipment from paraphernalia laws, while others have created exceptions for fentanyl testing strips.

Whatever the mechanism, expanding access to SSPs and drug testing strips has many demonstrated outcomes. Using drug testing strips elicits behavior change and safer use strategies. SSPs decrease equipment sharing behaviors and subsequently reduce injection-related wounds and prevent the spread of infectious diseases. Both interventions engage people who use drugs who otherwise might not access health care services, offering linkage to many other resources including substance use treatment and infectious disease testing and treatment. SSPs also provide safe disposal options and have been associated with decreased syringe litter and fewer needle stick injuries among first responders.[70]

Destination

- Fewer overdose deaths
- Fewer new cases of HIV and HCV
- Increased number of people who have the tools to detect fentanyl and other contaminants in their substances
- Reduced syringe litter

- Increased number of people who know how to reduce risks in response to detecting dangerous contaminants
- Increase the number of people engaged in substance use treatment
- Reduce costs of treating conditions associated with injection drug use (HIV, HCV, endocarditis, wounds)

Fuel	Passengers

• In-kind state support	• State agencies:
	   o Health and human services
	   o Infectious/ communicable disease
	   o Behavioral health and Substance Use Disorder
	   o Public health

Measures • Nonfatal overdose-related hospital emergency encounters • HCV incidence • HCV treatment and cure rates • Sexually transmitted infections incidence • Linkage to treatment from SSPs • Overdose fatalities	• Harm reduction organizations • Community-based organizations • Legislators

Resources

- Summary of state laws (LAPPA, 2022)
- Model Fentanyl Test Strip and Other Drug Checking Equipment Act (LAPPA, 2023)
- Model Syringe Services Program Act (LAPPA, 2021)

Michigan: Syringe Services Programs

The Michigan Department of Health and Human Services leverages state and federal funding to support a network of more than 30 SSPs. These programs build **relationships** with community members who use drugs and serve as an **access point** to many services, including HIV and Hepatitis C (HCV) testing and linkage to care; overdose education and naloxone; Hepatitis A and B vaccines; recovery coaching and linkage to treatment; basic wound care, assistance with accessing medical care; and more.

Expanding SSPs became **urgent** as neighboring states experienced substance use-related HIV and HCV **outbreaks**. Michigan's rising HCV rates and other indicators suggested **vulnerability** to similar outbreaks, and Medicaid **costs** associated with treating HCV were growing significantly. The state applied for a determination of need from the Centers for Disease Control and Prevention (CDC) and engaged in a Policy Academy with the National Governors Association focused on infectious disease and substance use. Michigan public health officials brought their concerns to the Governor's office and the opioid task force, using data to tell the story and pointing to SSPs as a cost-saving solution to address substance use-related HCV. Expansion efforts launched in 2018.

The expansion has been a success, now with more than **30 programs** and many more service sites. SSPs are being integrated as a core component of **comprehensive** community public health services in Michigan, as evidenced by its classification as "**essential**" during the COVID-19 pandemic. Michigan engages a local harm reduction organization to provide technical assistance to SSPs, as well as an advisory committee to inform program development. The state also hosts an annual statewide harm reduction conference. Michigan also established a process for communicating overdose **spike alerts** directly to SSPs to then share with participants. The state has seen recent progress in preventing overdose fatalities, with a rate below the national average, and cites the expansion of harm reduction as a key driver.

Michigan's success in expanding SSPs resulted from many **thoughtful** actions and strategies. Hiring people in key positions who have **lived experiences** accessing SSPs ensured credibility and expertise. The state has exercised **creativity** in blending various federal and state funding streams to support SSPs over time. Prioritizing and investing in data evaluation from the start, Michigan **designed** an encounter-based data collection platform, keeping in mind the population served, barriers data collection can create, and variability across SSPs. **Community engagement** was crucial; the state created opportunities in informal and accessible spaces to garner honest feedback from SSPs and people who use drugs, building **trust** over time by valuing and incorporating **feedback**.

Montana: Infectious Disease Testing Network, Harm Reduction Sites, and Low-Barrier Naloxone

Montana's harm reduction work reflects a syndemic approach by focusing not just on substance use but also Hepatitis C, HIV, and sexually transmitted infections (STI). In alignment with national trends, recent increases in syphilis cases have been highly correlated with substance use and have disproportionately impacted Montana's tribal communities. As a geographically large state with many rural areas, state-driven expansion of services is challenging. Critical access gaps exist, especially in tribal communities where there are healthcare and public health worker shortages and a dearth of harm reduction resources. Limited funding presents a challenge, as well as a lack of support for harm reduction in some areas.

The state works to address these needs by supporting a network of over 30 STI testing partners, a number that continues to increase in response to recent surges in syphilis. A

subset of these partner sites are also harm reduction sites, co-locating SSPs with infectious disease prevention, testing, and treatment. These sites are comprised of a mix of Federally Qualified Health Centers (FQHCs), local health departments, and community-based organizations offering harm reduction services, linkages to care, and other resources to comprehensively address the spectrum of health needs of people who use drugs. Montana braids multiple federal funding sources to support site staff, testing kits, and ancillary supplies—excluding syringes and needles to maintain compliance with federal funding restrictions. Through these sites, Montana is working to meet people where they are in their health journey and help them access community resources.

Montana's harm reduction efforts also include low-barrier naloxone distribution through a broadly written statewide standing order and low-barrier centralized distribution model. Organizations and agencies seeking to distribute naloxone can order the medication with a two-day turnaround through a state naloxone website, launched in 2020 and supported by a contract with a mail-order pharmacy. Since 2020, the state has increased naloxone distribution by 400%, now leveraging Overdose Detection Mapping Application Program (ODMAP) to identify highly impacted areas and gaps for targeted outreach. The state's network of regional overdose prevention hubs is also leading efforts to distribute naloxone in high-impact settings.

> "WHAT WE'VE DONE WITH STATE OPIOID RESPONSE (SOR) GRANT FUNDING ACROSS THE CONTINUUM IS ENGAGED WITH PEOPLE WHO USE DRUGS TO BE A PART OF THE DECISION MAKING—NOT JUST PEOPLE WITH LIVED EXPERIENCES WHO ARE IN RECOVERY."

Strengths of Montana's approach include effective braiding of funding sources, a strong epidemiological foundation, and the state's small government, which facilitates strong relationships and communication across agencies. A partnership with Montana Public Health Institute has also been important for managing opioid-related resources. Montana has also prioritized active engagement of people with lived experience of substance use through focus groups, using feedback to drive strategy and response.

Treatment

Background

⟡ *Historical and regulatory context for current standards of care*

Amidst a paradigm shift in the national perspective on addiction and substance use, the history of substance use treatment in the U.S. provides important context for current challenges. Substance use and SUD have been understood as a moral failing requiring a criminal response, and treatment systems developed outside of mainstream health care have lacked rigorous evidence and evaluation.[71] Return to use can be part of a recovery journey; however, it has been met with punitive responses including loss of housing, jobs, and removal from programs. Treatment systems have begun to shift to view SUD as a health condition, aiming toward the supportive and empathetic medical care expected for other health conditions.[72]

Three medications have been FDA-approved for the treatment of Opioid Use Disorder (OUD): methadone, buprenorphine, and naltrexone. Some non-pharmacological treatments have also been demonstrated as effective in treating SUD, including Cognitive Behavioral Therapy (CBT), Contingency Management, and Motivational Interviewing. Medications for Opioid Use Disorder (MOUD) have specifically been associated with reduced risk of opioid-involved overdoses.

Barriers to these medications have limited access to these life-saving treatments. NSDUH has consistently reported that the number of people who meet criteria for SUD far exceeds the number who access treatment. Among the medications approved for treating OUD, methadone has the longest history of evidence, approved for its current use in 1972.[73] Methadone remains the most highly regulated MOUD and is subject to federal as well as state restrictions; federal regulations restrict methadone dispensing to Opioid Treatment Programs (OTPs).[74] Federal and state regulations require daily, supervised dosing until a patient is deemed stable, along with other requirements that prevent individualized treatment, and create burdensome requirements. During the COVID-19 health emergency, SAMHSA allowed for more flexibility on methadone dispensing; research demonstrated positive patient outcomes, without negative impacts.[75,76] As a result, SAMHSA and HHS have issued proposed rulemaking to modify some requirements for OTPs.[77]

Buprenorphine is a medication that can be prescribed in a doctor's office. The Drug Addiction Treatment Act of 2000 (DATA 2000) allowed prescribers meeting certain requirements to prescribe schedule III-V medications to treat SUD outside of the OTP setting.[78] Until recently, prescribers had to receive an X-waiver with mandatory training to prescribe buprenorphine to more than 30 patients. In 2023, buprenorphine access was further increased with the elimination of the waiver requirement by the Consolidated Appropriations Act, 2023.[79] Naltrexone can also be prescribed outside of OTPs; however, its use requires an individual to have withdrawn from all opioids prior to beginning treatment.

⟡ *State-level and individual barriers to treatment*

Aligning state-level policies with current federal regulations on dispensing buprenorphine can ensure prescribers and patients see the benefits from the X-waiver elimination.[80] An inadequate number of OTPs and prescribers willing to treat individuals with SUD remains a

challenge in many areas, particularly in rural communities; stigma about treating SUD as well as workforce shortages are contributors. MOUD treatment is not widely available in correctional settings due to a number of multi-layered and inter-related challenges.[81] Pharmacy access and insurance coverage restrictions may exacerbate these challenges for buprenorphine, since patients are typically dispensed maintenance doses from their community pharmacies. Fewer than 60% of pharmacies nationally stock buprenorphine, with significant variation from state to state.[82] Pharmacies that are concerned about "suspicious order" reports or "flags" have imposed limits on dispensing controlled substances, including buprenorphine.[83, 84]

Availability and accessibility

States play a role in improving availability of evidence-based medical treatments, especially for populations most at risk of overdose. States that leverage the Medicaid Reentry Section 1115 Demonstration Opportunity can expand MOUD for individuals who are incarcerated—a population at high risk for overdose.[85] Telehealth provides an opportunity for expanding MOUD, particularly in states that do not impose additional barriers beyond federal requirements. Increased telehealth flexibility can allow MOUD to be integrated into community settings that serve people with SUD, such as SSPs.[86] This allows trusted community providers to seamlessly connect patients with treatment in a location they are already frequenting, minimizing the time lapse between treatment readiness and initiation.

Making MOUD accessible to all populations also requires attention to the social drivers of health and conditions of people's day-to-day lives. For example, individuals who are unstably housed may find it difficult to keep medications on hand. Requiring daily morning doses of methadone at an OTP may be challenging for people who are employed and those with childcare responsibilities.[87] Medication First and Certified Community Behavioral Health Clinics (CCBHCs) are two evidence-based approaches that seek to lower the threshold for accessing MOUD. Medication First is an approach that can be integrated with technical assistance and support into existing treatment programs and has shown positive outcomes in treatment utilization, decreased wait time for treatment, and improved treatment retention.[88] CCBHCs are specialized clinics certified by SAMHSA that offer integrated SUD treatment and mental health services, regardless of ability to pay or residence.[89]

Expanding MOUD access points outside of the office setting can give more people with SUD the option to initiate treatment in their community when they are ready. Many hospital emergency departments start patients on buprenorphine and connect them with providers in the community to continue their care—the California Bridge and New Mexico Bridge program are two examples of statewide initiatives. Since states govern the practice of medicine, states may consider expanding the scope of practice laws for healthcare providers. For example, Nurse Practitioners, Physicians Assistants, and other mid-level practitioners are allowed under federal law to prescribe buprenorphine. However, state laws may limit their ability to prescribe. In New Jersey, paramedics can offer patients a first dose of buprenorphine immediately following a non-fatal overdose.[90] Pharmacists offer another untapped opportunity; their scope of practice can be expanded to allow for similar treatment induction and connection to longer-term care; this has been piloted in Rhode Island with success.[91]

◆ <u>Treatment Route 1:</u>

Implement and invest in policies and programs that expand Medication for Opioid Use Disorder (MOUD) access beyond the office setting.

1.1 Implement initiatives that incentivize and/or support emergency departments to provide Medication for Opioid Use Disorder and link individuals to community-based care providers.

1.2 Leverage telemedicine for SUD treatment and invest in efforts to co-locate MOUD via telehealth in community-based settings, including harm reduction and outreach programs.

1.3 Implement and invest in mobile MOUD programs that serve rural areas.

1.4 Expand the scope of practice through collaborative practice agreements to allow pharmacists to initiate MOUD and link patients to community-based providers for maintenance.

1.5 Work with regional DEA offices to ensure that federal rules around MOUD access are applied consistently.

1.6 Implement policies and initiatives to offer SUD treatment, including all MOUD medications, in criminal legal system settings.

Context

Lowering barriers to access and bringing buprenorphine to people in the community can ensure treatment is available when people are ready, without delays in which people might become lost to care. Low-barrier community access to buprenorphine can also work to decrease the current access disparities for Black people with SUD. This requires identifying touchpoints and systems that interact with people with SUD. For example, emergency departments serve many people who have experienced nonfatal overdoses, as well as people with SUD during other types of health emergencies, including injection-related wounds. Correctional facilities provide another opportunity to reach a population at high risk for overdose and high prevalence of SUD. Buprenorphine can be initiated successfully with linkage to community care in many settings such as pharmacies, mobile clinics, and emergency departments. Telehealth and mobile treatment provide opportunities to expand to rural areas as well.

Destination

- Increased access points for MOUD initiation and linkage to community treatment in a variety of settings
- Buprenorphine and methadone are available in all state correctional facilities with linkages to community care following release
- Increased access to MOUD in rural locations and fewer urban treatment deserts

Treatment Route 1

Fuel	Passengers

• Funding sources:
  o Medicaid
  o SAMHSA State Opioid Response grant
  o SAMHSA Substance Use Prevention, Treatment and Recovery Support block grant
  o Opioid litigation proceeds
• Funding strategies:
  o SSAs work with state Medicaid agencies to identify gaps in coverage for people with SUD who are Medicaid-enrolled or about to lose Medicaid eligibility.
  o States identify opportunities for Section 1115 waivers
	• Single State Agencies (SSAs)
	• Healthcare administrators
	• Medical and pharmacy boards
	• Hospitals and hospital associations
	• Harm reduction organizations
	• Regional DEA offices
	• State agencies:
	  o Health and human services
	  o Infectious/ communicable disease
	  o Public health
	  o Behavioral health and Substance Use Disorder
	  o Medicaid
	  o Public safety and corrections

Measures

- Number of buprenorphine pharmacy prescription fills
- Percent of OTP patients receiving take-home doses of methadone
- Number of providers prescribing buprenorphine

Resources

- State Measures for Improving Opioid Use Disorder Treatment (RTI)
- Report of the Task Force on Medication Assisted Treatment (NABP)
- Model Expanded Access to Emergency Opioid Antagonists Act (LAPPA, 2021)
- Model Access to Medication for Addiction Treatment in Correctional Settings Act (LAPPA, 2020)
- Guidance on Carceral Settings and 1115 Waivers (CMS, 2023)
- A National Snapshot Update: Access To Medications For Opioid Use Disorder In U.S. Jails And Prisons (O'Neill Institute, 2023)
- Buprenorphine use in the Emergency Department Tool (American College of Emergency Physicians, 2018)
- MAT Quick Start Desktop and Mobile Application (Boston Medical Center)
- Practical Tools for Prescribing and Promoting Buprenorphine in Primary Care Settings (SAMHSA, 2021)

State data resources

- National Survey on Drug Use and Health (NSDUH)
- Treatment Episode Data Set (TEDS)
- Data on medications for opioid use disorder (MOUD) availability in state carceral settings
- Bureau of Justice Statistics (BJS) data on SUD, treatment, and withdrawal in carceral populations

◆ <u>**Treatment Route 2:**</u>
Implement and invest in evidence-based treatment and access models.

2.1 Implement a Medication First treatment model and prioritize state and federal resources to programs that align with this model.

2.2 Partner with public safety to implement deflection and diversion programs. Make all MOUD treatment forms available to those involved in the criminal legal system.

2.3 Invest in peer-led post-overdose outreach programs.

2.4 Communicate changes in federal rules to the clinical community and community partners, ensuring they can take advantage of opportunities to expand access.

Context

Many models of treatment and increased access have been deployed throughout the ongoing opioid epidemic. Several of these models demonstrate strong evidence for preventing overdose among populations at highest risk. The Medication First model, with the first state implementation in Missouri, has shown strong outcomes in increasing patient access and retention on buprenorphine treatment. Deflection and diversion programs that make all forms of MOUD available (not just naltrexone) can prevent overdose among a high-risk population. Peer-led overdose outreach programs also reach a high-risk population—people who have survived an overdose—and offer harm reduction tools such as ORAs as well as support accessing treatment.[92] There have been recent changes to buprenorphine federal requirements and imminent changes to OTP requirements that offer potential expansion opportunities. States can best leverage these flexibilities by ensuring community MOUD providers are aware of and understand new changes.

Destination	Passengers

• Increased number of people with SUD initiated on MOUD
• Increased percentage of people retained in MOUD
	• Single State Agencies (SSAs)
	• Healthcare administrators
	• Medical and pharmacy boards
	• Hospitals and hospital associations
	• State agencies:
	  o Health and human services
	  o Infectious/ communicable disease
	  o Public health
	  o Behavioral health and Substance Use Disorder
	  o Medicaid
	  o Public safety and corrections
	• OTPs and community buprenorphine prescribers

Fuel	

• Federal funding sources
  o Medicaid
  o SAMHSA State Opioid Response grant
  o SAMHSA Substance Use Prevention, Treatment and Recovery Support block grant
• Opioid litigation proceeds
• State general funds	

Treatment Route 2

Measures
• Number of people enrolled in state deflection and diversion programs
• Percent of overdose survivors linked to treatment and/ or provided with ORAs
• Percent of MOUD providers statewide adhering to Medication First principles

Resources
• [Community-Based Medication First Model of Care Study](#) (2022)
• [Treatment Improvement Protocol 63: Medications for Opioid Use Disorder](#) (SAMHSA, 2021)
• [Provider Implementation Guide](#) (Missouri Department of Mental Health, 2020)
• [Model Law Enforcement and Other First Responder Deflection Act](#) (LAPPA, 2022)
• [Best Practice Guidance for Post-Overdose Outreach](#) (Grayken Center for Addiction, BMC, 2023)
• [Deflection and Pre-Arrest Diversion to Prevent Opioid Overdose](#) (National Council for Mental Wellbeing, 2023)
• [MAT for OUD in Jails and Prisons](#) (National Council for Mental Wellbeing, 2022) *Data Resources*
• National Survey on Drug Use and Health (NSDUH)
• Treatment Episode Data Set (TEDS)
• Department of Health (Infectious Disease) data

◆ Treatment Route 3:

Maximize federal funding resources for treatment.

3.1 Leverage the telehealth flexibilities given to states to allow for Medicaid coverage of low-barrier MOUD via telehealth; remove state-level requirements for in-person visits associated with telehealth SUD treatment.

3.2 Braid in state funding to optimally implement initiatives not sufficiently covered by federal funding due to limits.

3.3 Take advantage of opportunities to make MOUD and other pre-release services available to incarcerated individuals with SUD through the Medicaid 1115 waiver.

Context

Section 1115 of the Social Security Act provides states the opportunity to pilot innovative programs that align with the objectives of Medicaid. Recently the Centers for Medicare and Medicaid Services issued guidance for states to apply for Section 1115 demonstration projects for healthcare services, including SUD services to people transitioning from carceral settings, pursuant to Section 5032 of the SUPPORT Act.[93] CMS has also issued guidance on

the use of telehealth to provide SUD services, including prescribing of MOUD via telehealth.[94] These exemplify ways states can innovatively use available federal funds to increase MOUD access for populations at high risk for overdose. State funding can supplement federal funds for program expenses that are prohibited, limited, or lacking.

Destination	Passengers
• Increased number of people with SUD initiated on MOUD among incarcerated and recently released population • Increased percentage of people connected and retained in community MOUD care following release from incarceration • Increased options for MOUD available to people in carceral settings	• Single State Agencies (SSAs) • State agencies: o Health and human services o Behavioral health and Substance Use Disorder o Medicaid o Public safety and corrections • OTPs and community buprenorphine prescribers
Fuel	**Measures**
• SAMHSA State Opioid Response grant • SAMHSA Substance Use Prevention, Treatment and Recovery Support block grant • Medicaid • Opioid litigation proceeds • State general funds	• Percent of incarcerated population with diagnosed SUD receiving MOUD • Number of incarcerated people receiving MOUD, by type • Percent of people retained on MOUD with a community provider at a specific number of months following release from incarceration

Resources

- [CMS Guidance on Using Section 1115 Demonstration Projects to Address Opioid Use](#)
- [CMS Guidance on Medicaid SUD Treatment via Telehealth](#)
- [Model Access to Medication for Addiction Treatment in Correctional Settings Act](#) (LAPPA, 2020)
- [The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment and Recovery](#) (US Department of Justice, 2022)
- [Guidelines for Managing Substance Withdrawal in Jails](#) (BJA, 2023)

Data Resources
- State Medicaid data on telehealth funding
- Bureau of Justice Statistics (BJS) data on SUD, treatment, and withdrawal in carceral populations
- State data on MOUD in carceral settings

◆ Treatment Route 4:

Assess state-level policies that restrict access.

4.1 Support state-level requirements for MOUD that are equivalent to federal requirements after the removal of the DATA 2000 waiver in 2022..

4.2 Remove same-day billing restrictions and prior authorization requirements for MOUD medications from state Medicaid programs.

4.3 Enforce laws ensuring parity in insurance coverage for SUD services.

Context

While some federal restrictions on buprenorphine have loosened recently, state-level policies may still reflect the previous requirements. Treating individuals with methadone is also subject to state rules and policies set by state opioid treatment authorities. State-level barriers to MOUD access might also include Medicaid requirements that prohibit same-day billing for physical and behavioral health services or require prior authorization prior to dispensing.[95] Federal laws like the Parity Act[96] require health insurance to cover behavioral health and physical health equally, without imposing undue burdens on behavioral health access that do not exist for other medical care. State-level parity laws may strengthen patient rights even beyond the federal parity law.

Destination	Passengers
• State-level policies do not place additional access barriers to MOUD beyond those at the federal level	• State agencies: ○ Medicaid • Single State Agencies (SSAs) • Healthcare administrators • State insurance commissioners
Fuel	
• SAMHSA State Opioid Response grant	
Measures	**Resources**
• Number of buprenorphine pharmacy prescription fills • Number of providers prescribing buprenorphine • Parity compliance statistics	• [Mental Health and Substance Use Disorder Benefit Resources](#) (HHS, SAMHSA, 2022) • [State Parity Implementation Survey](#) (Parity Track) • [Removal of the X-Waiver Requirement](#) (NPHL, 2023) • [Overview of Opioid Treatment Program Regulations by State](#) (Pew, 2022)

New Mexico: NM Bridge

The New Mexico Bridge supports hospitals in implementing Medication for Opioid Use Disorder (MOUD) programs and dispensing naloxone in acute settings as well as implementing processes that bridge patients to community providers for ongoing treatment. The program builds on and adapts the California Bridge Program, including its implementation science foundation and comprehensive implementation support. The New Mexico Behavioral Health Services Division (BHSD) contracts with the University of New Mexico to administer the State Opioid Response grant, including the NM Bridge program. NM Bridge was developed in collaboration with BHSD and the Bridge Implementation Team, a group with expertise in substance use disorders and evidence-based treatment, implementation science, and hospital emergency departments, as well as experience working with rural communities in New Mexico. Recruitment began with promoting the program widely and sending a survey through the hospital association to assess interest and gauge readiness, including the presence of sufficient community providers.

Establishing a new MOUD program is a significant effort for a hospital, and clinician and staff lack of knowledge and discomfort with prescribing buprenorphine is prevalent; considering this, it was critical that the NM Bridge program offer ongoing training and support for staff and clinicians. Hospital staff want to know that there is support and guidance available and that they will not be left on their own. To this end, the NM Bridge program employs a robust team of medical experts to guide hospitals through implementation. During the first year of engaging with a new hospital, the NM Bridge team usually meets weekly, or as needed, with hospital staff and may provide financial support to fund training and support program champions for one year. NM Bridge also leverages the New Mexico Poison and Drug Information Center to provide 24/7 call support to hospital staff in the program, allowing them to call anytime with specific clinical questions.

In addition to a robust support team, the Blueprint for implementation is the other key component of the NM Bridge program. The Blueprint, developed by the NM Bridge Implementation Team, establishes a timeline and structure for implementation and ensures involvement of all relevant processes and people; it includes plans for everything from building order sets to working with pharmacy to educating nurses, all prior to going live. The Blueprint also acknowledges the reality of provider and staff stigma and includes focused education and discussion to address it.

The NM Bridge Program has successfully partnered with seven hospitals to implement MOUD programs and tracks several key outcomes to evaluate ongoing progress. Given the initiative is funded by State Opioid Response funding, the team leverages the Government Performance Results Modernization Act (GPRA) data collection tools to track providers'

buprenorphine prescribing, naloxone dispensing, and referral to community care. The program also tracks the number of providers and staff trained. Each hospital in the program represents part of the solution to the opioid epidemic, engaging people with SUD in treatment, providing overdose prevention tools, and linking them with community providers.

The NM Bridge team suggests states and territories looking to implement similar programs—"don't let perfect be the enemy of good." Programs can start small, even with one hospital, one department, or one division at a time. States can expect to invest about $200,000 per hospital per year to implement a similarly robust program, including financial and technical support for hospitals and clinicians. Many customizable tools and resources are publicly available on the NM Bridge website.

Missouri: Certified Community Behavioral Health Clinics and Medication First

Certified Community Behavioral Health Clinics

Missouri strives to develop innovative strategies to better support individuals living with behavioral health conditions and was one of eight states participating in a federal demonstration to pilot Certified Community Behavioral Health Clinics (CCHBC) and the prospective payment system (PPS). CCBHCs provide mental health care, substance use care, and care coordination to support access to physical health and social support services, regardless of ability to pay, place of residence, or age. CCBHCs must provide all nine of the required services. Missouri partnered with an initial 15 providers and received approval for a State Plan Amendment in 2022 to add six additional providers for a total of 21 CCBHCs statewide. Missouri provided technical assistance and training, helping providers identify and address areas of improvement needed to meet certification requirements.

Missouri's CCBHCs have seen success in implementation as well as patient outcomes. Implementation of this model brought a 35% increase in access to patient care and 156% increase in access to MOUD from baseline to year five. Hospitalization and emergency department utilization decreased. Missouri credits its success to close partnership with its provider network, as well as practice coaches and tailored technical assistance from the state. Adding new SUD services was a lift for many providers, as was understanding that cost savings might not be initially evident, as

Missourians Served by CCBHCs

119,022 · 123,963 · 140,963 · 146,944 · 152,382 · 160,568

Baseline · Year 1 · Year 2 · Year 3 · Year 4 · Year 5

Source: Missouri CCBHC Impact Report, Year 5

people who may have previously fallen through the cracks instead access services. The CCBHC Demonstration will open to ten additional states every two years beginning in 2024.

Medication First

In addition to CCBHC implementation, Missouri has been a trailblazer of the innovative SUD treatment approach "Medication First" since the initial rollout in 2017. Medication First is premised on four main principles:

1. People with OUD receive pharmacotherapy treatment as quickly as possible, followed by necessary assessments and diagnoses;

2. Maintenance pharmacotherapy is delivered without arbitrary tapering or time limits;

3. Individualized psychosocial services are continually offered but not required as a condition of pharmacotherapy; and

4. Discontinuation of pharmacotherapy occurs only if it is worsening the individual's condition.

The initiative has been supported by SAMHSA STR and SOR funding and facilitated by champions and close partners at the Missouri Institute for Mental Health at University of Missouri at St. Louis. Missouri has funded 69 sites who provide MOUD in alignment with Medication First principles. Extensive technical assistance and supporting compliance with the principles is an ongoing process. Recent programs and initiatives have incorporated and built on the model, including mobile units with telehealth capabilities and care coordination partnerships between FQHCs and SUD providers.

The success of this model in Missouri has been driven by committed champions and academic partners, a technical assistance-heavy approach, and strong relationships with the behavioral healthcare provider community. Missouri's OUD ECHO gives providers additional support. The state has leveraged service data to identify gaps, measure progress, and motivate providers. The administrative burden and insufficient reimbursement have been a challenge, particularly for small agencies; an early analysis of true costs, including administrative, can help surmount this in other states. Missouri advises that states interested in implementing a similar model be committed and prepared for the long term—"It's a marathon, not a sprint."
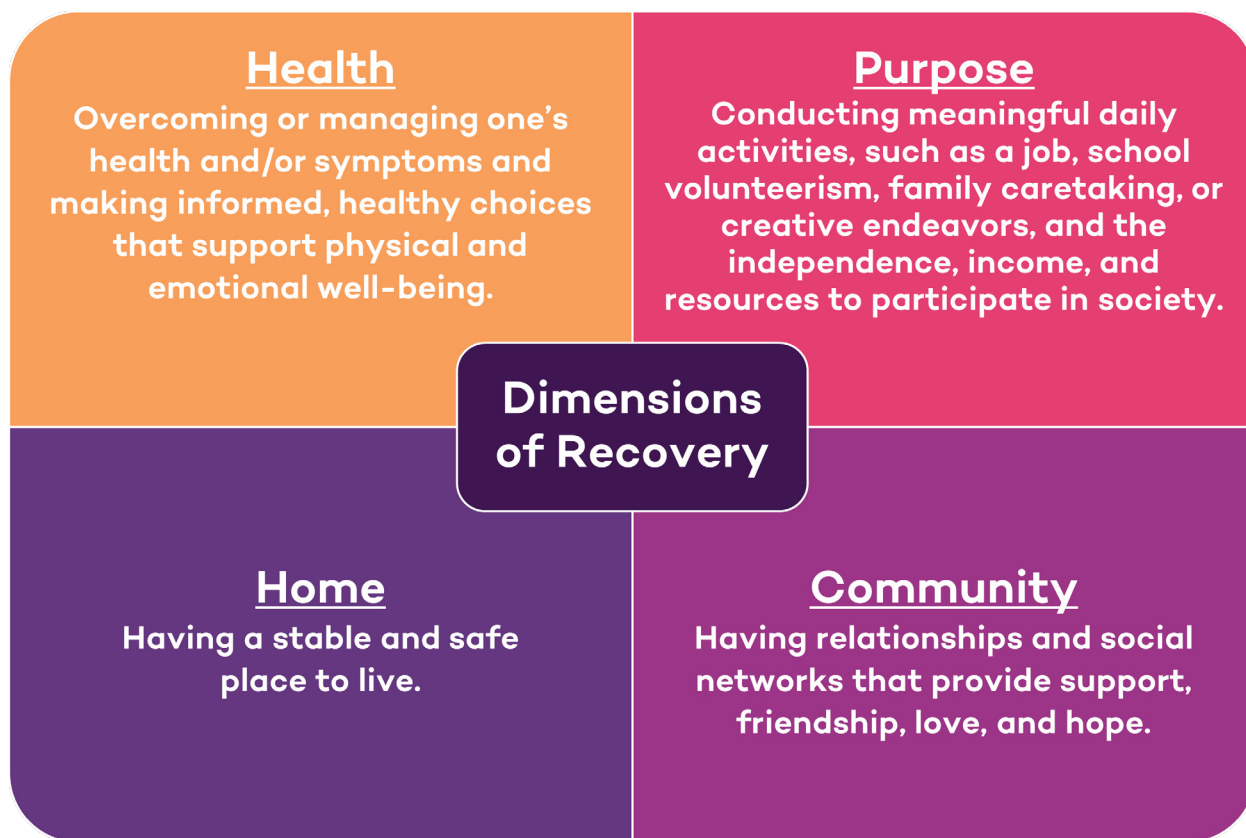
Recovery

Background

SAMHSA's definition of recovery describes a process of behavior change to improve health, wellness, and functioning, with varying pathways and individual-level differences. Supporting people in sustaining their recovery means holistically addressing social drivers of health. SAMHSA defines the dimensions of recovery as Health, Home, Purpose, and Community:[97]

Health
Overcoming or managing one's health and/or symptoms and making informed, healthy choices that support physical and emotional well-being.

Purpose
Conducting meaningful daily activities, such as a job, school volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society.

Dimensions of Recovery

Home
Having a stable and safe place to live.

Community
Having relationships and social networks that provide support, friendship, love, and hope.

Recovery support services cover a gamut of activities and avenues that "wrap around" services. Recovery services play an important part in a state's Continuum of Care and overdose response. A study in Lancet found that recovery supports were part of an effective response to reduce overdose deaths.[98]

Peers play an important role in recovery support services. Peers, sometimes described as Peer Support Specialists or Peer Recovery Specialists, are people with lived experience who have typically undergone a recovery process of their own. Oftentimes peers are people who describe themselves as being in "long-term recovery." As a peer, supporting people to begin and sustain their own recovery process can mean many things. It can be driving someone to an appointment, helping them find and apply for a job, helping them navigate healthcare and social service systems, or simply being available to talk.

The most effective recovery supports are culturally competent, community-based, and led by people who represent the people they serve—which usually means they are staffed and led by people who identify as being in recovery themselves and culturally reflect the community. The type of recovery support needed will differ across environments. Effective recovery supports are also comprehensive, centering the individual and creating continuity in services through trusted relationships.

States and territories can support recovery for people with SUD in a variety of ways. Assessing systems to increase equity in grant-making opportunities can help states better support peer-led and community-based organizations that reflect the communities they serve. States can also champion recovery, hire people with lived experience, and create opportunities for community-based recovery organizations; North Dakota's [Office of Recovery Reinvented](#) is an example of state-level leadership to de-stigmatize recovery. National recovery organizations such as Faces and Voices of Recovery and Black Faces, Black Voices can support states in connecting with local recovery community organizations that are peer-led and reflect the communities they serve. States can also incentivize and support businesses to create employment opportunities for people in recovery; they can even work toward building entire communities that support people with SUD, with infrastructure that supports continuity across the Continuum.

◆ Recovery Route 1:

Foster communities that support recovery

1.1 Incentivize businesses that employ and support staff in recovery.

1.2 Implement certification programs for "recovery ready" workplaces and communities.

Context

Employment can be a critical part of the recovery process, providing purpose, engagement with coworkers, and regular wages. However, employers are sometimes reluctant to hire people in recovery out of concern for return to use or prior unstable job history. States can facilitate more employment opportunities for people in recovery in several ways, including engaging with and educating businesses and employers about hiring and supporting people in recovery. In addition, states can invest in vocational training programs that help people in recovery develop skills and increase their capacity to enter the workforce after an extended absence. Gainful employment can be an important part of maintaining recovery. States can develop community and employer certifications and technical assistance programs that support employers in hiring more people in recovery. More broadly, states can invest in areas that improve people's ability to maintain employment – for example, public education, public transportation, expungement of long-ago nonviolent offenses, and affordable health insurance.

Recovery Route 1

Destination

- Increased number of workplaces equipped to support employees in recovery
- Increased employment among people in recovery
- Decrease stigma around SUD and recovery in workplaces
- Increase community-level resources and services to support people in recovery

Passengers

- Private employers
- State labor departments
- Community and business leaders
- State chambers of commerce

Fuel

- SAMHSA State Opioid Response grant
- U.S. Department of Labor grants
- State tax incentives
- Opioid litigation proceeds
- State general funds

Measures

- Number of businesses/ workplaces participating in "recovery ready" programs
- Number of people enrolled in vocational training programs for people in recovery

Resources

- Recovery-Ready Workplace Resource Hub (U.S. Department of Labor)
- Recovery-Ready Communities: A Blueprint to Address the Substance Use Crisis at the Local Level (Young People in Recovery)
- Recovery Friendly Workplace Tax Credit (New York)
- Careers of Substance (MA DPH Bureau of Substance Addiction Services, 2022)
- Jobs & Hope (West Virginia)
- National Survey on Drug Use and Health (SAMHSA)

◆ Recovery Route 2:

Champion changes to policies to establish recovery residence standards.

2.1 Champion changes to policies in order to require that state recovery residences meet national standards.

2.2 Use state funds to support recovery residences that meet national standards.

Context

Recovery housing is widely recognized as an important recovery support system. Housing that supports individuals in recovery fosters improvements in sustained recovery.[99] Yet the lack of standardized criteria for these residences creates the potential for exploitation and can cause harm to individuals in the early stages of recovery. States that adopt certification standards for recovery residences can ensure the use of evidence-based practices and help residents on their personal recovery paths. The National Alliance for Recovery Residences provides a template of such standards.[100] Such standards ideally include allowing individuals to use FDA-approved MOUD, as described in the U.S. Department of Justice guidance.[101]

Destination	Passengers
• Stigma-free, culturally appropriate recovery housing is available in a variety of communities and held to national standards of quality • Recovery housing permits use of MOUD • Stable housing is available for people in recovery	• State and local housing authorities • Single State Agencies (SSAs) • Community leaders • Attorneys general

Measures	Fuel
• Percent of recovery housing statewide that meets national standards • Percent of recovery housing statewide that allows residents receiving MOUD • Number of certified recovery residences available statewide	• State in-kind support • U.S. Department of Housing and Urban Development (HUD) grants • Centers for Medicare & Medicaid Services (CMS) Home and Community-Based Services funding • Opioid litigation proceeds • U.S. Department of Veterans Affairs (VA) funding

Resources

- Standards and Certification Program (NARR)
- Recovery Housing: Best Practices and Suggested Guidelines (SAMHSA)
- Recovery Housing Program (HUD, 2023)
- The Corporation for Supportive Housing
- Health Care Issues: Substance Use and Opioids (National Health Care for the Homeless Council)

Data Resources

- State and local homeless counts
- U.S. Department of Veterans Affairs (VA) data

◆ ## Recovery Route 3:

Invest in small businesses and community-based organizations led by and employing people with lived experience who represent the communities they serve.

3.1 Review and revise state-level processes and provide technical assistance to increase equity in procurement and grant-making for small businesses and community-based organizations.

3.2 Support capacity-building for small businesses and community-based organizations led by people with lived experience who represent the communities they serve.

3.3 Create funding opportunities for and invest in peer recovery organizations.

Context

People with lived experience are crucial partners to those in, or seeking, recovery. Peer recovery support specialists serve both as mentors to those in recovery and proof that recovery is achievable. To truly be effective, service providers must provide culturally appropriate services for their area. States can support recovery in their communities and address disparities by creating funding opportunities specifically for peer recovery organizations, particularly those led by people with lived experience that reflect the racial and ethnic diversity of their communities.

Many community-based organizations serving people with SUD are small, grassroots organizations. They may lack experience applying for complex state-level grant opportunities and managing large federal and state grants with extensive reporting requirements. States can ensure success for these grantees and minimize risk by examining grant-making processes and identifying opportunities to lower barriers while also building capacity and offering robust technical assistance.

Destination	Passengers
• Increased capacity of small, grassroots recovery organizations to apply for, receive, and manage state grants • State-funded recovery organizations provide culturally appropriate services and reflect the communities they serve	• State health and human service agencies • Single State Agencies (SSAs) • Procurement officials • State small business agencies • Community and business leaders • People with lived/living experience • State chambers of commerce

Recovery Route 3

Fuel	Measures
• SAMHSA State Opioid Response grant • SAMHSA Substance Use Prevention, Treatment and Recovery Support block grant • State general funds • Opioid litigation proceeds	• Capacity-building and technical assistance hours provided • Percent of funded community-based organizations led by people with lived experience • Number of state-funded peer recovery organizations

Resources

- National Standards for Recovery Community Organizations (Faces and Voices of Recovery)

- Peer Recovery Center of Excellence (SAMHSA)

- National Association of State Procurement Officials (NASPO)

- Building Capacity Through Community Behavioral Health Organizations to Prevent Overdose (National Council for Mental Wellbeing)

Data Resources

- Small business data

- Qualitative information obtained from communities

Kentucky: Recovery Ready Communities Certification Program

The Kentucky Recovery Ready Communities Certification Program (RRCCP) supports communities to assess their SUD and recovery ecosystem in a framework that is designed to prevent adverse outcomes from substance use and overdose and facilitate remission and recovery. Created by legislation in 2021, the bill establishing the program was championed by leaders in the Office of Drug Control Policy (ODCP) and the business community and was passed with overwhelming **bipartisan support**.

> "THIS HAD BIPARTISAN SUPPORT. PEOPLE RALLIED AROUND PROTECTING OUR NEIGHBORS. PEOPLE ARE TIRED OF SEEING THE SAME BAD OUTCOMES."

The bill establishes a varied and **multidisciplinary advisory council**; members are appointed by the Governor and must represent the diversity of the Commonwealth and include **individuals with lived experience** of substance use, recovery, and criminal legal system involvement. Kentucky ODCP partnered with a nonprofit organization to manage the

initiative. The Council was tasked with establishing the certification program, application process, and guidance. The resulting **certification application process and criteria** provide a framework that guides communities in identifying areas of need and implementing evidence-based programs that support individuals in maintaining their recovery. **Governor Andy Beshear** announced certification of the first Recovery Ready Community this year, and the council has received applications from several communities since.

Leadership, partnership, and collaboration were critical components in establishing the RRCCP. **Governor Beshear's** support was critical, acknowledging milestones and championing the initiative. This endeavor also benefited from a project leader adept at facilitating **cross-agency collaboration**, who championed the idea, brought people together, and ensured that partner voices were heard.

As a result of **strong leadership**, the project proactively engaged the Chamber of Commerce, academic partners, people with lived experience, behavioral health, prevention, and treatment leaders in state government. **Academic and federal partnerships** were particularly foundational to developing criteria that built on existing evidence-based interventions. Academic partners also provided key data resources that supported state leaders and council members.

> "BE COLLABORATIVE, LISTEN. TALK TO PEOPLE IN RECOVERY. TALK TO PEOPLE WHO USE DRUGS. HAVING FOLKS ON THE ADVISORY COUNCIL WITH LIVED EXPERIENCE IS CRUCIAL, AND ON MY TEAM AS WELL… THAT LIVED EXPERIENCE IS ABSOLUTELY VITAL, THAT INPUT IS VITAL."

Founders of the RRCCP recommend **meeting communities where they are**—ensuring that criteria for certification are achievable for smaller communities with less infrastructure, while supporting them in implementing evidence-based interventions and robust community supports. **Recovery advocates** already embedded in communities are key allies for this work. It was important to **take the time to "do it right,"** and to be **flexible** and prepared to pivot along the way. Through **thoughtful implementation**, the program is able to assess community needs and support opportunities in a meaningful way, rather than just being "a rubber stamp."

New Hampshire: Recovery Friendly Workplace Initiative

The idea for the Recovery Friendly Workplace (RFW) initiative began during **Governor Chris Sununu's** previous career as a business owner, where he observed the **challenges facing employees** with SUD. He wanted to **support people** with SUD in the workplace, rather than penalize them and terminate their employment, in turn supporting the business's success by **increasing retention**. Recognizing that, systematically, employers play a key role in supporting employees impacted by SUD (including loved ones who are indirectly impacted), Governor Sununu launched RFW in 2018. RFW is administered by Granite United Way, a non-profit with strong community ties, underscoring the importance of leveraging public-private partnerships to bring public health expertise to the workplace.

RFW provides employers across the state from diverse sectors with **information, education and training,** and connections to **resources** to support their employees. RFW also **builds on the existing system of care**, educating employers on The Doorway NH, another initiative launched by **Governor Sununu**. The Doorway NH interfaces with New Hampshire's 211 number and helps people navigate and access treatment and recovery options. RFW also closely involves community partners such as local Recovery Community Organizations (RCOs) and Public Health Networks to expand employers' access to direct recovery supports and information on a wide array of behavioral health topics and services. Another critical component of RFW is **challenging the stigma** around SUD, normalizing workplace support for employees with SUD and those in recovery. As of June of 2023, around 350 workplaces representing over 95,000 employees are participating.

To make the program meaningful yet feasible for employers, New Hampshire developed a one-page checklist that guides **businesses of all sizes** through the process of becoming an RFW. All assistance, training, and designations are provided to businesses at **no cost**. Upon enrolling, each business is paired with a Recovery Friendly Advisor who provides one-on-one support and technical assistance. The initiative intentionally avoids being overly prescriptive and **meets businesses where they are**, supporting them as they implement evidence-based practices that meet their individualized needs. The program's **advisory council**, which includes business leaders, healthcare professionals, community partners, and people in recovery, has been advantageous from the beginning. The council provides high-level feedback and guidance, providing lived experience insights that help keep the initiative relevant and useful to participating workplaces.

For states and territories interested in replicating the initiative, New Hampshire recommends **involving** businesses who have already implemented strategies to support employees impacted by SUD. These trailblazing businesses can serve as **peer champions** that provide guidance to new businesses. States can also leverage existing partners and resources, including national resources (e.g., the American Foundation for Suicide Prevention), statewide resources (e.g., 211, SUD systems of care, statewide behavioral health organizations), and local resources (e.g., recovery community organizations, public health organizations, and local disabilities rights councils). Partnerships with the Occupational Safety and Health Administration and National Safety Council may be useful in recruiting businesses and sharing the innovative work and successes of the program.

Recognizing the interest in the replicating the initiative, RFW established the nation's first RFW Multi-State **Community of Practice**, which brings states across the country that are (or are interested in) implementing RFW together to share best practices and resources, foster collaboration, and navigate shared challenges. For more information, visit recoveryfriendlyworkplace.com

Funding and Disclaimer Notices

Acknowledgements

States with initiatives featured as "State Spotlights" throughout the Roadmap generously gave their time and shared their experiences. These included Kentucky, Massachusetts, Michigan, Missouri, Montana, New Hampshire, New Jersey, New Mexico, Utah, and Virginia.

Notes

1 Christopher Jones, Emily Einstein, Wilson Compton, "Changes in Synthetic Opioid Involvement in Drug Overdose Deaths in the United States, 2010-2016," *JAMA* 319, 7 (2018): 1819–1821. doi:10.1001/jama.2018.2844

2 "Multiple Cause of Death by Single Race 2018-2021," CDC WONDER Online Database, United States Department of Health and Human Services (US DHHS),Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), released 2022. Data are compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

[3] "Provisional Drug Overdose Data Counts," Centers for Disease Control and Prevention, National Vital Statistics System, last updated February 15, 2023.

4 "Opioid Overdose Deaths by Race/Ethnicity, 2021," KFF, accessed June 2023, https://www.kff.org/other/state-indicator/opioid-overdose-deaths-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

5 Mbabazi Kariisa, Nicole L. Davis, Sagar Kumar, Puja Seth, Christine L. Mattson, Farnaz Chowdhury, and Christopher M. Jones., "Vital Signs: Drug Overdose Deaths, by Selected Sociodemographic and Social Determinants of Health Characteristics — 25 States and the District of Columbia, 2019–2020," *MMWR Morbidity and Mortality Weekly Report* 71 (2022):940–947. DOI: http://dx.doi.org/10.15585/mmwr.mm7129e2.

6 "The Opioid Crisis and The Black/African American Population: An Urgent Issue," Publication No. PEP20-05-02-001, Office of Behavioral Health Equity. Substance Abuse and Mental Health Services Administration, 2020.

7 "Drug Arrests Stayed High Even as Imprisonment Fell From 2009 to 2019," Pew, February 15, 2022, https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2022/02/drug-arrests-stayed-high-even-as-imprisonment-fell-from-2009-to-2019; John Gramlich, "Black imprisonment rate in the U.S. has fallen by a third since 2006," Pew Research Center, May 6, 2020, https://www.pewresearch.org/short-reads/2020/05/06/share-of-black-white-hispanic-americans-in-

prison-2018-vs-2006/; Elizabeth Needham Waddell, Robin Baker, Daniel M. Hartun, Christi J. Hildebran, Thuan Nguyen, Deza'Rae M. Collins, Jessica E. Larsen, Erin Stack, and the ROAR Protocol Development Team, "Reducing overdose after release from incarceration (ROAR): study protocol for an intervention to reduce risk of fatal and non-fatal opioid overdose among women after release from prison," *Health and Justice* 8, 1 (July 10, 2020),: 18. https://doi.org/10.1186/s40352-020-00113-7

8 Lauren J. Tanz, Amanda T. Dinwiddie, Christine L. Mattson, C.L., Julie O'Donnell, Nicole L. Davis, "Drug Overdose Deaths Among Persons Aged 10–19 Years — United States, July 2019–December 2021," *MMWR Morbidity and Mortality Weekly Report 2022* 71 (2022):1576–1582. DOI: http://dx.doi.org/10.15585/mmwr.mm7150a2.

9 "Opioid Overdose Crisis Compounded by Polysubstance Use," Pew, October 8, 2020, https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2020/10/opioid-overdose-crisis-compounded-by-polysubstance-use.

10 "Drug Overdose Death Rates," National Institute on Drug Abuse, June 30, 2023, https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates

11 Merianne Rose Spencer, Arialdi M. Miniño, and Margaret Warner, "Drug overdose deaths in the United States, 2001–2021," *NCHS Data Brief*, no 457. Hyattsville, MD: National Center for Health Statistics, 2022, DOI: https://dx.doi.org/10.15620/cdc:122556.

12 Grant Baldwin,. "The Latest Data and Prevention Opportunities," Optimizing a Continuum of Care and Settlement Funds for Overdose Prevention, Washington, DC. March 23, 2023.

13 James O. Prochaska, Carlo C. DiClemente, and John C. Norcross, "In search of how people change. Applications to addictive behaviors," *The American Psychologist* 47,9 (1992): 1102–1114. https://doi.org/10.1037//0003-066x.47.9.1102

14 National Academies of Sciences, Engineering, and Medicine, Committee on the Science of Changing Behavioral Health Social Norms; Board on Behavioral, Cognitive, and Sensory Sciences; Division of Behavioral and Social Sciences and Education, *Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change*, (Washington DC: National Academies Press, 2016): 2. Available from: https://www.ncbi.nlm.nih.gov/books/NBK384923/

15 "Types of stigma," Shatterproof, accessed June 2023. https://www.shatterproof.org/our-work/ending-addiction-stigma/understanding-addiction-stigma.

16 Brandon Muncan, Suzan M. Walters, Jerel Ezell, Danielle C. Ompad, "'They look at us like junkies": influences of drug use stigma on the healthcare engagement of people who inject drugs in New York City," *Harm Reduction Journal*. 17, 1 (July 31, 2020):53. doi: 10.1186/s12954-020-00399-8. PMID: 32736624; PMCID: PMC7393740.

17 Crystal Welch, Jodi Maiolo, Amber B. Paulus, Lyn O'Connell, Stephen M. Petrany and Shanen Wright, "Addiction is treatable: effectiveness of media toolkits in a public health campaign to reduce stigma toward substance use disorder," *Journal of Substance Use* (2023), DOI: 10.1080/14659891.2023.2223302

18 Shoshana Aronowitz, Zachary F. Meisel, "Addressing Stigma to Provide Quality Care to People Who Use Drugs," *Substance Use and Addiction* 5, 2 (2022):e2146980. doi:10.1001/jamanetworkopen.2021.46980

19 John Gramlich, "Black imprisonment rate in the U.S. has fallen by a third since 2006," *Pew Research Center*, May 6, 2020, https://www.pewresearch.org/short-reads/2020/05/06/share-of-black-white-hispanic-americans-in-prison-2018-vs-2006/; "What is the Impact of HIV on Racial and Ethnic Minorities in the U.S.?" *HIV.gov*, January 20, 2023, https://www.hiv.gov/hiv-basics/overview/data-and-trends/impact-on-racial-and-ethnic-minorities/; John Creamer, "Poverty Rates for Blacks and Hispanics Reached Historic Lows in 2019," United States Census Bureau, September 15, 2020, https://www.census.gov/library/stories/2020/09/poverty-rates-for-blacks-and-hispanics-reached-historic-lows-in-2019.html

20 "Black/African American: Behavioral Health Concerns," SAMHSA, Behavioral Health Equity, last updated May 25, 2023, https://www.samhsa.gov/behavioral-health-equity/black-african-american

21 Alex Wodak and Annie Cooney, "Do needle syringe programs reduce HIV infection among injecting drug users: a comprehensive review of the international evidence," *Substance Use and Misuse* 41,6-7 (2006):777–813; Holly Hagan, James P. McGough, Hanne Thiede, Sharon Hopkins, Jeffrey Duchin, E. Russell Alexander, "Reduced injection frequency and increased entry and retention in drug treatment associated with needle-exchange participation in Seattle drug injectors," *Journal of Substance Abuse Treatment*.19, 3 (2000):247–252; Steffanie A. Strathdee, David D. Celentano, Nina Shah, Cynthia Lyles, Veronica A. Stambolis, Grace Macalino, Kenrad Nelson, and David Vlahov, "Needle-exchange attendance and health care utilization promote entry into detoxification," *Journal of Urban Health* 76, 4 (1999):448-460; Ricky N. Bluthenthal, Aruna Gogineni, Doug Longshore, Michael Stein, "Factors associated with readiness to change drug use among needle-exchange users," *Drug and Alcohol Dependence* 62, 3 (2001):225-230.

22 Beth Howard-Brown and Tara Zuber, "Braiding and Blending Funds: Learning, Collaborating and Understanding," Comprehensive Center Network, March 16, 2022, https://region9cc.org/blog/braiding-and-blending-funds-learning-collaborating-and-understanding

23 "Layering or Blending and Braiding Multiple Funding Streams," Child Care Technical Assistance Network, U.S. Department of Health and Human Services, accessed June 2023, https://childcareta.acf.hhs.gov/systemsbuilding/systems-guides/financing-strategically/maximizing-impact-public-funding/blending; "Serving Colorado's Children: A Financial Map of the Behavioral Health System," Colorado Health Institute and Partners for Children's Mental Health, March 2020. https://pcmh.org/wp-content/uploads/2020/05/Childrens-Behavioral-Health-Financial-Map-Report.pdf

24 Weizman, Shelly, Taleed El-Sabawi, Jennifer Martinez, Daniel Fishbein, and Regina LaBelle, "Transcending MET (Money, Ego, Turf): A Whole Person, Whole Government Approach to Addressing Substance Use Disorder Through Aligned Funding Streams and Coordinated Outcomes," *O'Neill Institute for National and Global Health Law at Georgetown Law Center*, May 2023, 20-22, https://oneill.law.georgetown.edu/wp-content/uploads/2023/06/ONL_Whole_Person_Government_P6r1.pdf.

25 "HRSA Health Workforce Factsheet: Behavioral Health Workforce Projections, 2020-2035," Health Resources and Services Administration, U.S. Department of Health and Human Services, November 2022: 1, https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/Behavioral-Health-Workforce-Projections-Factsheet.pdf.

26 "Geographic Disparities Affect Access to Buprenorphine Services for Opioid Use Disorder, OEI-12-17-00240," Office of the Inspector General, U.S. Department of Health and Human Services, January 2020: 3, https://oig.hhs.gov/oei/reports/oei-12-17-00240.pdf.

27 Consolidated Appropriations Act, 2023, Division FF, Section 1262, Pub. L. 117-328 (Dec. 29, 2022).

28 Alyson Ma, Alison Sanchez, and Mindy Ma, "The Impact of Patient-Provider Race/Ethnicity Concordance on Provider Visits: Updated Evidence from the Medical Expenditure Panel Survey," *Journal of Racial and Ethnic Health Disparities* 6, no. 5 (June 2019): 1011–1020, https://doi.org/10.1007/s40615-019-00602-y.

29 "National Drug Control Strategy 2022", U.S. Office of National Drug Control Policy (ONDCP), Executive Office of the President, The White House, April 21, 2022: 56, https://www.whitehouse.gov/wp-content/uploads/2022/04/National-Drug-Control-2022Strategy.pdf.

30 Vincent J. Felitti, Robert F. Anda, Dale Nordenberg, David F. Williamson, Alison M. Spitz, Valerie Edwards, Mary P. Koss and James S. Marks, "Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study," *American Journal of Preventive Medicine* 14, 4 (1998): 245–258. https://doi.org/10.1016/s0749-3797(98)00017-8

31 Rachel N. Lipari and Struther L. Van Horn, "Children living with parents who have a substance use disorder," The CBHSQ Report: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Rockville, MD, August 24, 2017.

32 Suzanne C. Brundage, Adam Fifield, and Lee Patridge, "The Ripple Effect: National and State Estimates of the U.S. Opioid Epidemic's Impact on Children," *United Hospital Fund*, November 2019, https://uhfnyc.org/media/filer_public/6e/80/6e80760f-d579-46a3-998d-1aa816ab06f6/uhf_ripple_effect_national_and_state_estimates_chartbook.pdf

33 Steven L. West and Keri K,. "Project D.A.R.E. outcome effectiveness revisited," *American Journal of Public Health* 94,6 (June 2004):1027-9. doi: 10.2105/ajph.94.6.1027. PMID: 15249310; PMCID: PMC1448384; Anthony Petrosino, Carolyn Turpin-Petrosino, Meghan E. Hollis-Peel, Julia G. Lavenberg, and Alexis Stern, "Scared Straight and Other Juvenile Awareness Programs for Preventing Juvenile Delinquency," No. 12 of Crime Prevention Research Review, Washington, DC: Office of Community Oriented Policing Services, 2014, https://portal.cops.usdoj.gov/resourcecenter/ric/Publications/cops-p288-pub.pdf

34 "The State of America's Children 2021," Children's Defense Fund, accessed June 2023, https://www.childrensdefense.org/state-of-americas-children-2021/soac-2021-child-welfare/

35 "Family First Prevention Services Act," Child Welfare Information Gateway, accessed June 2023, https://www.childwelfare.gov/topics/systemwide/laws-policies/federal/family-first/

36 Morgan Cooley, Judy Krysik, "Foster Caregiving and Child Outcomes in relative and non-relative Foster families," *Child and Adolescent Social Work Journal* 39 (2022):539–544. https://doi.org/10.1007/s10560-022-00871-3

37 "Family First Prevention Services Act," https://www.ncsl.org/human-services/family-first-prevention-services-act

38 "What is Home Visiting Evidence of Effectiveness?" U.S. Department of Health and Human Services, Administration for Children and Families, accessed June 2023, https://homvee.acf.hhs.gov/

39 Kerri M. Raissian, Lindsey Rose Bullinger, "Money matters: does the minimum wage affect child maltreatment rates?" *Children and Youth Services Review* 72 (2017):60–70.

40 Laura J. Faherty, Bradley D. Stein, Mishka Terplan, "Consensus Guidelines and State Policies: The Gap Between Principle and Practice at the Intersection of Substance Use and Pregnancy," *American Journal of Obstetrics & Gynecology MFM* Vol. 2, Issue 3, (August 2020):100137. doi: 10.1016/j.ajogmf.2020.100137. Epub 2020 May 17. PMID: 33089133; PMCID: PMC7571448.

41 Maria X. Sanmartin, Mir M. Ali, Sean Lynch, Arda Aktas, "Association Between State-Level Criminal Justice–Focused Prenatal Substance Use Policies in the US and Substance Use–Related Foster Care Admissions and Family Reunification," *JAMA Pediatrics* 174,8 (2020):782–788. doi:10.1001/jamapediatrics.2020.1027

42 Laura J. Faherty, Ashley M. Kran, Joshua Russell-Fritch, Stephen W. Patrick, Jonathan Cantor, Bradley Stein, "Association of punitive and reporting state policies related to substance use in pregnancy with rates of neonatal abstinence syndrome," *JAMA Network Open* 2,11 (2019):e1914078.

43 Cara Angelotta, Carol J. Weiss, John W. Angelotta, Richard A. Friedman, "A Moral or Medical Problem? The Relationship between Legal Penalties and Treatment Practices for Opioid Use Disorders in Pregnant Women," *Women's Health Issues* Volume 26, Issue 6 (2016): 595-601,ISSN 1049-3867, https://doi.org/10.1016/j.whi.2016.09.002.

44 Eunhee Park, Julie Yip, Emily Harville, Marlene Nelson, Gloria Giarrantano, Pierre Buekens, Jennifer Wagman, "Gaps in the congenital syphilis prevention cascade: qualitative findings from Kern County, California," *BMC Infectious Diseases* 22, 129 (2022), https://doi.org/10.1186/s12879-022-07100-3

45 Elaine Y.L. Chan, Carolyn Smullin, Stephanie Clavijo, Melissa Papp-Green, Eunhee Park, Marlene Nelson, Gloria Giarrantano, Jennifer A. Wagman, "A qualitative assessment of structural barriers to prenatal care and congenital syphilis prevention in Kern County, California," *PLoS ON,* 16, 4 (2021): e0249419. https://doi.org/10.1371/journal.pone.0249419

46 Erika G. Martin, Bahareh Ansari, Eli S. Rosenberg, Rachel Hart-Malloy, Dawn Smith, Kyle T. Bernstein, Harrell W. Chesson, Kevin Delaney, Monica Trigg, Thomas L. Gift,. "Variation in Patterns of Racial and Ethnic Disparities in Primary and Secondary Syphilis Diagnosis Rates Among

Heterosexually Active Women by Region and Age Group in the United States," *Sexually Transmitted Diseases* 49, 5 (May 1, 2022):330-337. doi: 10.1097/OLQ.0000000000001607. Epub 2022 Feb 25. PMID: 35121717; PMCID: PMC8994035.

47 "American Indians and Alaska Natives," Centers for Disease Control and Prevention, page last reviewed September 14, 2020. https://www.cdc.gov/nchhstp/healthdisparities/americanindians.html

48 Daniel Tsai, "Improving Maternal Health and Extending Postpartum Coverage in Medicaid and the Children's Health Insurance Program," Centers for Medicare & Medicaid Services, Center for Medicaid & CHIP Services, December 7, 2021, https://www.medicaid.gov/federal-policy-guidance/downloads/sho21007.pdf

49 Fishbein, Diana. "The Science of Prevention and Evidence-Informed Strategies to Disrupt Pathways to Substance Use," Optimizing the Continuum of Care and Settlement Funds for Overdose Prevention, Washington, DC, March 23, 2023.

50 "Adapting Evidence-Based Practices for Under-Resourced Populations," Substance Abuse and Mental Health Services Administration, 2022, Publication No. PEP22-06-02-004.

51 Colleen Connolly, "Path to Federal Foster Care Prevention Funds Overlooks Tribal Programs, Experts Say," *The Imprint*, February 15, 2022, https://imprintnews.org/child-welfare-2/tribal-practices-overlooked-family-first/62641

52 Jeffrey M. Carlson et. al, "Substance Use Among Persons with Syphilis During Pregnancy — Arizona and Georgia, 2018–2021," *MMWR Morbidity and Mortality Weekly Report* 72 (Jan 2023):63–67. DOI: http://dx.doi.org/10.15585/mmwr.mm7203a3.

53 Dolores BigFoot and Jami Bartgis, "Evidence-Based Practices and Practice-Based Evidence," Healthy Indian Country Initiative Promising Prevention Practices Resource Guide, National Indian Health Board, 2010, 7-11, https://ncuih.org/ebp-pbe/#:~:text=Practice%2DBased%20Evidence%3A%20A%20range,the%20local%20society%20and%20traditions

54 Esther J. Aspinall, Dhanya Nambiar, David J. Goldberg, Matthew Hickman, Amanda Weir, Eva Van Velzen, Norah Palmateer, Joseph S. Doyle, Margaret E. Hellard, Sharon J. Hutchinson, "Are needle and syringe programmes associated with a reduction in HIV transmission among people who inject drugs: a systematic review and meta-analysis*," International Journal of Epidemiology* 43,1 (2014): 235-248, doi:10.1093/ije/dyt243

55 Natasha K. Martin, Matthew Hickman, Sharon J. Hutchinson, David J. Goldberg, Peter Vickerman, "Combination interventions to prevent HCV transmission among people who inject drugs: modeling the impact of antiviral treatment, needle and syringe programs, and opiate substitution therapy," *Clinical Infectious Diseases* 57, Suppl 2 (2013): S39-45, doi:10.1093/cid/cit29

56 Sheila M. Bird, Mehesh K. B. Parmar, and John Strang, "Take-home naloxone to prevent fatalities from opiate-overdose: Protocol for Scotland's public health policy evaluation, and a new measure to assess impact," *Drugs (Abingdon, England)* 22, 1 (Feb 2015):66-76. doi: 10.3109/09687637.2014.981509. Epub 2014 Nov 18. PMID: 26045638; PMCID: PMC4438351.https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4438351/

57 Alex S. Bennett, Alice Bell, Maya Doe-Simkins, Luther Elliott, Enrique Pouget and Corey Davis, "From Peers to Lay Bystanders: Findings from a Decade of Naloxone Distribution in Pittsburgh, PA," *Journal of Psychoactive Drugs* 50, 3 (2018): 240-246, DOI: 10.1080/02791072.2018.1430409, https://www.tandfonline.com/doi/abs/10.1080/02791072.2018.1430409?journalCode=ujpd20

58 Maxwell S. Krieger, Willian C. Goedel, Jane A. Buxton, Mark Lysyshyn, Edward Bernstein, Susan G. Sherman, Josiah D. Rich, Scott E. Hadland, Traci C. Green, and Brandon D.L. Marshall,. "Use of rapid fentanyl test strips among young adults who use drugs," *International Journal of Drug Policy* 61 (November 2018):52-58. doi: 10.1016/j.drugpo.2018.09.009, Epub 2018 Oct 18. PMID: 30344005; PMCID: PMC6701177.

[62] Lawrence A. Tabak, "Overdose Prevention Centers," 2021, Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse. https://nida.nih.gov/sites/default/files/NIH-RTC-Overdose-Prevention-Centers.pdf

63 Simeon D. Kimmel, Jessie M. Gaeta, Scott E. Hadland, Eliza Hallett, Brandon D.L. Marshall, "Principles of Harm Reduction for Young People Who Use Drugs," *Pediatrics* 147, Supplement 2 (January 2021): S240–S248. 10.1542/peds.2020-023523G

64 Demetre Daskalakis, Laura W. Cheever and James Macrae, "CDC HRSA Status Neutral Approach Letter," Department of Health and Human Services, January 17, 2023, https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/cdchrsastatusneutralapproachletter-508.pdf

65 "Lifesaving Naloxone," Centers for Disease Control and Prevention, last reviewed April 21, 2023, https://www.cdc.gov/stopoverdose/naloxone/index.html

66 Jermaine D. Jones, Aimee N. Campbell, Laura Brandt, Verena E. Metz, Suky Martinez, Melanie Wall, Thomas Corbeil, Howard Andrews, Felipe Castillo, Joanne Neale, John Strang, Stephen Ross, Sandra D. Comer, "A randomized clinical trial of the effects of brief versus extended opioid overdose education on naloxone utilization outcomes by individuals with opioid use disorder," *Drug and Alcohol Dependence* Volume 237 (2022): 109505, ISSN 0376-8716, https://doi.org/10.1016/j.drugalcdep.2022.109505

67 "Statewide Targeted Overdose Prevention (STOP) Act of 2022," Maryland General Assembly, Legislation, https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/sb0394?ys=2022RS&search=True

68 Martha Bebinger, "Nurse Denied Life Insurance Because She Carries Naloxone," *NPR*, December 13, 2018, https://www.npr.org/sections/health-shots/2018/12/13/674586548/nurse-denied-life-insurance-because-she-carries-naloxone

69 Amy Judd Lieberman, "Fact Sheet: Naloxone Insurance Coverage Mandates," Network for Public Health Law, May 2023, https://www.networkforphl.org/resources/naloxone-insurance-coverage-mandates/

70 "Summary of Information on the Safety and Effectiveness of Syringe Services Programs (SSPs)," last reviewed January 11, 2023, https://www.cdc.gov/ssp/syringe-services-programs-summary.html

71 Maia Szalavitz, *Unbroken Brain: A Revolutionary New Way of Understanding Addiction* (New York: St. Martin's Press. 2016).

72 Nora D. Volkow, "Making Addiction Treatment More Realistic and Pragmatic: The Perfect Should Not Be The Enemy Of The Good," Health Affairs, last modified January 3, 2022: https://www.healthaffairs.org/content/forefront/making-addiction-treatment-more-realistic-and-pragmatic-perfect-should-not-enemy-good

73 Richard A. Rettig and Yarmolinsky, eds., *Federal Regulation of Methadone Treatment* (Washington, DC: National Academies Press, 1995), Executive Summary, https://www.ncbi.nlm.nih.gov/books/NBK232111/

74 "Title 42--the Public Health And Welfare, Chapter I - Public Health Service, Department of Health and Human Services, Part 8 - Medication Assisted Treatment for Opioid Use Disorders, Subpart C—Certification and Treatment Standards for Opioid Treatment Programs, Section 8.11 - Opioid Treatment Program Certification and Section 8.12 – Federal Opioid Treatment Standards," U.S. Code of Federal Regulations, amended June 18, 2015: https://www.govregs.com/regulations/title42_chapterI_part8_subpartC.

75 Kim A. Hoffman, Canyon Foot, Ximena A. Levander, Ryan Cook, Javier Ponce Terashima, John W. McIlveen, P. Todd Korthuis, Dennis McCarty, "Treatment Retention, Return to Use, and Recovery Support Following COVID-19 Relaxation of Methadone Take-Home Dosing in Two Rural Opioid Treatment Programs: A Mixed Methods Analysis," *Journal of Substance Use and Addiction Treatment*, formerly known as Journal of Substance Abuse Treatment 141, (October 2022; published May 08, 2022): 4 – 6, https://www.jsatjournal.com/article/S0740-5472(22)00083-6/fulltext

76 "SAMHSA Proposes Update to Federal Rules to Expand Access to Opioid Use Disorder Treatment and Help Close Gap in Care," U.S. Department of Health and Human Services, December 13, 2022, https://www.hhs.gov/about/news/2022/12/13/samhsa-proposes-update-federal-rules-expand-access-opioid-use-disorder-treatment-help-close-gap-in-care.html

77 "Medications For the Treatment of Opioid Use Disorder", Substance Abuse and Mental Health Services Administration, Department of Health and Human Services, Federal Register 42 CFR Part 8, 87, no. 241, December 16, 2022: 77330 – 77365.

78 "Waiver Elimination (MAT Act)," Substance Abuse and Mental Health Services Administration, Department of Health and Human Services, last updated June 7, 2023: https://www.samhsa.gov/medications-substance-use-disorders/waiver-elimination-mat-act.

79 Anita Silwal et al., "State alignment with federal regulations in 2022 to relax buprenorphine 30-patient waiver requirements," *Drug and Alcohol Dependence Report* 7, art. 100164 (June 2023): 8, https://www.sciencedirect.com/science/article/pii/S2772724623000343.

80 Scott G. Weiner et al., "Pharmacy Availability of Buprenorphine for Opioid Use Disorder Treatment in the US," *Journal of the American Medical Association Network Open* 6, no. 5 (May 2023): 3, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2805329

81 Christine E. Grella et al., "A Scoping Review of Barriers and Facilitators to Implementation of Medications for Treatment of Opioid Use Disorder within the Criminal Justice System," *The International Journal on Drug Policy* 81, article 102768 (July 2020): Abstract, doi: 10.1016/j.drugpo.2020.102768, https://www.sciencedirect.com/journal/international-journal-of-drug-policy/vol/81/suppl/C.

82 Scott G. Weiner et al., "Pharmacy Availability of Buprenorphine for Opioid Use Disorder Treatment in the US*," Journal of the American Medical Association Network Open* 6, no. 5 (May 26, 2023): 2, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2805329.

83 "Suspicious Orders Q&A," Diversion Control Division, Drug Enforcement Administration, U.S. Department of Justice, January 20, 2023: https://www.deadiversion.usdoj.gov/faq/sors_faq.htm

84 Jeffrey Davis, "The X-Waiver is Gone… But There is a Lot More Work to do to Increase Access to Opioid Use Disorder Treatment," Regs & Eggs, American College of Emergency Physicians, March 23, 2023, https://www.acep.org/federal-advocacy/federal-advocacy-overview/regs--eggs/regs--eggs-articles/regs--eggs---march-23-2023

85 "Press Release: HHS Releases New Guidance to Encourage States to Apply for New Medicaid Reentry Section 1115 Demonstration Opportunity to Increase Health Care for People Leaving Carceral Facilities," Centers for Medicare & Medicaid Services, Department of Health and Human Services, April 17, 2023: https://www.cms.gov/newsroom/press-releases/hhs-releases-new-guidance-encourage-states-apply-new-medicaid-reentry-section-1115-demonstration

86 Barrot H. Lambdin, Ricky N. Bluthenthal, Hansel E. Tookes, Lynn Wenger, Terry Morris, Paul LaKosky, Alex H. Kral,, "Buprenorphine implementation at syringe service programs following waiver of the Ryan Haight Act in the United States," *Drug and Alcohol Dependence* 237, art. 109504 (August 2022): 3, https://doi.org/10.1016/j.drugalcdep.2022.109504.

87 Matthew F. McLaughlin, Rick Li, Nicolas Dominguez Carrero, Paul A. Bain, Avik Chatterjee, "Opioid Use Disorder Treatment for People Experiencing Homelessness: A Scoping Review," *Drug and Alcohol Dependence* 224, art. 108717 (July 2021): 8, https://www.sciencedirect.com/science/article/pii/S037687162100212X.

88 Rachel P. Winograd, Claire A. Wood, Erin J. Stringfellow, Ned Presnall, Alex Duello, Phil Horn, and Tim Rudder, "Implementation and Evaluation of Missouri's Medication First Treatment Approach for Opioid Use Disorder in Publicly-Funded Substance Use Treatment Programs," *Journal of Substance Use and Addiction Treatment* 108, (January 2020): 56, DOI: 10.1016/j.jsat.2019.06.015.

89 "Certified Community Behavioral Health Clinics (CCBHCs)," Substance Abuse and Mental Health Services Administration (SAMSHA), Department of Health and Human Services, last updated April 24, 2023: https://www.samhsa.gov/certified-community-behavioral-health-clinics.

90 Lev Facher, "In A Nationwide First, New Jersey Authorizes Paramedics to Start Addiction Treatment at the Scene of an Overdose," *Stat News*, June 26, 2019: https://www.statnews.com/2019/06/26/new-jersey-paramedics-buprenorphine/.

91 Traci C. Green, Rachel Serafinski, Seth A. Clark, Josiah D. Rich, Jeffrey Bratberg, "Physician-Delegated Unobserved Induction with Buprenorphine in Pharmacies," *The New England Journal of Medicine* 388, no. 2 (January 2023): https://doi.org/10.1056/NEJMc2208055, https://opioidcobre.org/physician-delegated-unobserved-induction-with-buprenorphine-in-pharmacies/.

92 Bradley Ray, Jessica McCarthy-Nickila, Nicholas Richardson, and Jeffrey Maahs, "Post-overdose follow-up in the community with peer recovery specialists: The Lake Superior Diversion and Substance Use Response Team," *Drug and Alcohol Dependency Report* 6 (March 2023): 100139. doi: 10.1016/j.dadr.2023.100139. PMID: 36994366; PMCID: PMC10040321.

93 Daniel Tsai, "Letter to State Medicaid Directors SMD #23-003, RE: Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated," Centers for Medicare & Medicaid Services, Department of Health and Human Services, April 17, 2023, https://www.medicaid.gov/federal-policy-guidance/downloads/smd23003.pdf.

94 "CMCS Informational Bulletin, SUBJECT: Rural Health Care and Medicaid Telehealth Flexibilities, and Guidance Regarding Section 1009 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (Pub. L. 115-271), entitled Medicaid Substance Use Disorder Treatment via Telehealth," Centers for Medicare & Medicaid Services, Department of Health and Human Services, April 2, 2020, https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib040220.pdf.

95 Peter Treitler, Molly Nowels, Hillary Samples, and Stephen Crystal, "Buprenorphine Utilization and Prescribing Among New Jersey Medicaid Beneficiaries After Adoption of Initiatives Designed to Improve Treatment Access," *JAMA Network Open* 6, 5 (May 1, 2023):e2312030. doi: 10.1001/jamanetworkopen.2023.12030. PMID: 37145594; PMCID: PMC10163388.

96 "The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)," Pub. L. No. 110-343, 122 Stat. 3881, 2008.

97 "Recovery and Recovery Support," Substance Use and Mental Health Services Administration, n.d. https://www.samhsa.gov/find-help/recovery.

98 Isabelle J. Rao, Keith Humphreys, and Margaret L. Brandeau, "Effectiveness of Policies for Addressing the US Opioid Epidemic: A Model-Based Analysis from the Stanford-Lancet Commission on the North American Opioid Crisis," *The Lancet, Regional Health* 3, 200031 (November 2021): DOI:https://doi.org/10.1016/j.lana.2021.100031

99 Douglas L. Polcin,, Rachael A. Korcha, Jason Bond, and Gantt Galloway, "Sober Living Houses for Alcohol and Drug Dependence: 18-Month Outcomes," *Journal of Substance Use & Addiction Treatment* 38, no. 4 (March 19, 2010): 356–65. https://www.jsatjournal.com/article/S0740-5472(10)00031-0/fulltext.

100 "National Recovery Residence Quality Standards," National Alliance for Recovery Residences, October 7, 2015. https://narronline.org/wp-content/uploads/2015/10/National-Recovery-Residence-Quality-Standards-Oct-7-2015.pdf.

101 "The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment or Recovery," U.S. Department of Justice Civil Rights Division, April 5, 2022. https://archive.ada.gov/opioid_guidance.pdf.