Rock County Opioid Settlement Funds
Report of Recommendations

Presented to the Rock County Board of Supervisors
September 8, 2022

EXECUTIVE SUMMARY

The National Opioid Settlement is a legal agreement reached in February 2022 to resolve all opioid litigation brought by states and local political subdivisions against the three largest pharmaceutical distributors: McKesson, Cardinal Health and AmerisourceBergen, and manufacturer Janssen Pharmaceuticals, Inc. and its parent company Johnson & Johnson. These settlements will provide substantial funds to states and subdivisions for abatement of the opioid epidemic across the country. Wisconsin will receive over $400 million from the settlements. The payments from the distributors will continue over 18 years. The payments from Johnson & Johnson will continue over nine years. Under 2021 Wisconsin Act 57, 30% of the payments are allocated to the State. The other 70% is allocated to communities that joined this litigation. From this distribution it is anticipated that Rock County will receive approximately $8.2 million dollars over 18 years, depending on potential securitization of funds.

In February 2022, an Opioid Settlement Workgroup was formed for Rock County with representatives from the Public Health Department, the Human Services Department, the County Administration, and the Sheriff's Office. This group met every other week from February 28th through June 20th to gather information, collect feedback, and discuss options for the use of the settlement funds.

Information and data sources:

- *Rock County Substance Use Community Assessment* (previously completed)
- Opioid Settlement Survey
- Public listening sessions
- Key informant interviews

Using these sources, a list of recommendations was developed by the group. Once the recommendations were determined, a smaller workgroup at the Public Health Department wrote the following report.

The recommendations for investment of the funds include:

1. Create the equivalent of 1 FTE to oversee the proposed strategies
2. Increase access to sober living
3. Increase access to higher level treatment options located in Rock County (including inpatient, residential, and/or day treatment)
4. Provide evidence-based, youth substance use prevention and/or intervention
5. Provide substance use disorder (SUD) and mental health assessment with rapid access to treatment in the criminal justice system
6. Increased Case Managers/Navigators with access to flex funds
7. Increased Certified Peer Support Specialists
8. Other recommendations (as funds allow):
    a) Transportation and childcare for appointments (therapeutic childcare as possible prevention)
    b) Stigma reduction campaign
    c) Training for law officers about SUD/mental health and resources
    d) Public education and awareness about SUD/Mental Health and available resources

TABLE OF CONTENTS

INTRODUCTION

The National Opioid Settlement presents an opportunity to invest the financial resources available in such a way that addresses the impacts that opioid use has had on Rock County. As the entity receiving the National Opioid Settlement funds, Rock County has a responsibility to ensure that the funds are invested in evidence-based and culturally appropriate strategies that not only address current impacts but work to prevent further negative impacts.

This settlement resolves Rock County's causes of action against the Big Three distributors and Janssen Pharmaceuticals, however the County's causes of action against other defendants in the Opioid Litigation remain unresolved. While the County is set to receive a significant sum from this settlement, it will likely not be sufficient to implement each recommendation to the fullest extent. It is also possible that other funds will be available in the future if the County's other causes of action were to settle or be litigated successfully.

Settlement funds are expected to be spent on strategies related to abatement and prevention. Approved strategies are listed in Exhibit E, located in Appendix F. The recommendations presented in this report have been identified based on their relevance to Rock County, potential impact, and feasibility. In particular, the feasibility of some of the recommendations in this report will also be influenced by the County's decision on whether or not to securitize payments of the opioid settlement. Securitization would provide more funds upfront for investment and would hedge against the future risk that any of the settling entities become insolvent and unable to pay settlement proceeds in the future, but would decrease the overall amount of funds Rock County receives from the settlement. A breakdown of projected settlement payments with and without securitization is available in Appendix E.

Rock County provides some services that align with the recommendations and therefore these services could be enhanced through an additional investment of the settlement funds. Some recommendations in the report are beyond the scope of services provided by the County, and in these situations, it is recommended that the County explore opportunities to contract with reputable service providers and community organizations.

In addition to funding coming directly to Rock County from the settlement, a portion of the settlement funds going to the State of Wisconsin will be made available to local jurisdictions through grants administered by the Wisconsin Department of Health Services (DHS). In the first phase of the state's three-phased plan, DHS plans to increase the availability of Narcan® statewide, create a statewide distribution system for fentanyl test strips, and award grants to local health departments and community organizations to address root causes of substance use. A summary of DHS's proposed plan is on the next page, the full proposal is available online (https://www.dhs.wisconsin.gov/publications/p03288.pdf).

Wisconsin Department of Health Services Proposed Phased Approach for SFY 2023

Phase 1	Increase the availability of Narcan® statewide via the DHS Narcan® Direct Program
	Creation of a statewide distribution system for fentanyl test strips
	Prevention efforts to address root causes of substance use in communities
Phase 2	Allocation of $11 million to support capital projects that expand prevention, harm reduction, treatment, and recovery services statewide
	Funding for Tribal Nations
Phase 3	Enhancement of the DHS overdose central alert system
	K-12 evidence-based substance use prevention curriculums or programs
	Expansion of Medication Assisted Treatment (MAT)
	Funding for room and board costs for residential substance use disorder treatment
	Funding for Family Support Center pilots

BACKGROUND INFORMATION

After decades of malpractice among large pharmaceutical companies regarding opioid marketing and distribution, more than 3,000 state and local governments, including Wisconsin and Rock County, are working to recoup billions in tax dollars spent on the opioid epidemic from opioid manufacturers and distributors.[1] On July 21, 2021, it was announced that agreements were finalized with Johnson & Johnson and three major pharmaceutical distributors resolving legal claims against each company in return for payment of $26 billion and commitments to improve their business practices.[1] As a result, Wisconsin is estimated to receive over $400 million and Rock County is anticipating over $8 million dollars from the settlement to improve opioid treatment and prevention resources across 18 years.

Despite extensive efforts to curb the impact of opioids locally, the opioid epidemic continues to persist in Rock County. With over 200 opioid-involved deaths across the last decade, it is evident that opioids remain a threat to public health in Rock County. To better understand local trends, it's crucial to examine the history of the opioid epidemic and the current state of opioid use and misuse nationally, and in Wisconsin.

Nationally, deaths due to drug overdoses involving opioids have been at the forefront of public health attention for decades. In the United States (U.S.), over 550,000 people have died as a result of an opioid-involved overdose since 1999.[2] With over 130 people dying every day as a result of an opioid overdose, the Centers for Disease Control and Prevention has committed significant time and resources to lessen the impacts of the epidemic through monitoring trends, advancing research, building capacity, and supporting providers.[2] In recent years, opioid-involved overdose deaths, while still very high, remained steady at 47,600 and 46,800 deaths in 2017 and 2018, respectively.[3] However, in 2020, the U.S. experienced 68,630 opioid-involved overdose deaths, or an increase of 44% from 2017.[3]

At the state level, opioid-involved deaths in Wisconsin have increased significantly across the last few years. From 2018-2020, the number of opioid-involved deaths in Wisconsin increased by 46%.[4] Recent data suggests that Wisconsin experienced its highest number of opioid-involved deaths ever recorded in 2021 at 1,401 deaths.[4] In terms of hospitalizations, there were over 3,100 opioid-involved visits to an emergency room throughout the state in 2021.[4] The majority of opioid-involved deaths and hospitalizations throughout the last decade in Wisconsin occurred in the southeast portion of the state, including Rock County and many of its neighboring counties.[4-5]

Locally, Rock County's opioid death rates nearly tripled from 2010-2020. In 2020, Rock County experienced 24.2 opioid-involved deaths per 100,000 people, well above the statewide average rate of 21.1.[5] Rock County also falls into the highest tier of emergency room visits for opioid overdoses. Statewide, the average rate of emergency room visits for opioid overdoses is 53.7 per 100,000 people.[6] Rock County experiences more than double the statewide rate at 127.6 per 100,000 people, marking a significant increase of 23% from 2020.[6] Like Wisconsin, preliminary data indicates that Rock County may have experienced its highest number of overdose deaths ever recorded in 2021.

The opioid epidemic is often described as having three waves, each with its own distinctive characteristic. The first wave of the epidemic began with increased prescribing of opioids in the mid to late 1990s with overdose deaths driven primarily by prescription opioids.[7] Prior to the 1990s, opioids were primarily used

for managing pain during cancer treatments.[8] However, as healthcare organizations and providers began to see the benefits of opioids for pain management, opioid prescriptions were integrated into other standards of care.[8] Concurrently, pharmaceutical companies began to create new opioids, such as oxycodone (OxyContin), that were marketed as less addictive.[8] As a result, more than 260,000 people died in the U.S. from overdoses involving prescription opioids from 1999-2020.[9]

Given the recent emphasis on safe prescribing practices, prescribing rates of opioids has decreased every year in the U.S. since 2013.[10] In 2020, prescriptions of opioids fell to the lowest it has been in the last 15 years at 43.3 prescriptions per 100 people.[10] In Wisconsin, prescribing rates are lower than the national average at 39.6 prescriptions per 100 people.[11] However, many Wisconsin adults still receive opioid prescriptions year to year. In 2019, an estimated 1 in 6 Wisconsin adults were prescribed and used an opioid.[4] This issue is partly fueled by the potential over-prescription of opioids for pain management. Among the pain medications prescribed to Wisconsinites in 2019, over 55% were opioids.[4] Similar to national trends, Rock County has also seen promising opioid prescribing trends across the last few years. From 2015-2020, Rock County's opioid prescription rate dropped from 67.5 per 100 people to 42.3 per 100 people, coming in lower than the 2020 national average.[12] Despite Rock County's decreasing numbers of opioids being prescribed, the County continues to experience high rates of prescription opioid-involved deaths at 12.4 deaths per 100,000 people in 2020, over double the rate seen in Wisconsin during the same year.[5]

The second wave of the opioid epidemic was characterized by sharp rises in heroin-involved overdose deaths in 2010. While prescription opioids were still highly accessible in the mid to late 2000s, the rising costs of the prescriptions lead many to seek a cheaper option in illicit heroin that was and continues to be very accessible.[13] Nearly 143,000 people died from overdoses involving heroin from 1990-2020.[14] However, recent trends indicate that heroin use may be decreasing. From 2019-2020, heroin-involved overdose death rates decreased by nearly 7%.[14] While it is unknown why rates have been decreasing, several factors may be contributing to this decrease including fewer people initiating heroin use, increases in availability of synthetic opioids, increased provision of treatment for those using heroin, and expansion of access to overdose reversal drugs such as naloxone.[14] Though rates have decreased recently, heroin-involved overdose deaths were still over 4 times higher in 2020 than in 2010.[14] At the state level, drug overdose death rates involving heroin decreased every year since 2018.[15] Statewide, the rate of heroin deaths per 100,000 people in 2020 was 4.5.[5] Rock County's rate is lower than the state average at 2.5 heroin deaths per 100,000 people.[5] Rock County's rates of heroin-involved deaths have decreased significantly across the last few years, potentially signifying a shift to other substances, including synthetic opioids.[5]

The third wave of the epidemic began in 2013 as a result of synthetic opioids. Synthetic opioids are substances produced in a laboratory that mimic the properties and effects of natural opioids.[16] While some synthetic opioids are produced legally and used as an anesthetic in medical procedures, overdoses involving synthetic opioids are primarily driven by illicitly manufactured versions of the drug, specifically, fentanyl.[17] Synthetic opioids accounted for over 82%, or 56,000, of the opioid-involved overdose deaths in the U.S. in 2020.[2] Synthetic opioid overdose deaths have been steadily increasing for the greater part of the last decade with death rates more than 18 times higher in 2020 than in 2013.[17] From 2019 to 2020, synthetic opioid-involved death rates increased by over 56%.[17] As in much of the U.S., the majority of overdose deaths in Wisconsin in 2021 involved fentanyl.[5] From 2019-2020, Wisconsin saw an increase of almost 67% in synthetic opioid-involved deaths.[17] Locally, synthetic opioid-involved deaths have increased

significantly the last few years. Rock County's synthetic opioid-involved death rate increased from 2.5 in 2014, to 18 in 2020.[5] Recent data indicates that rates are rising even more quickly due to increases of fentanyl in the drug supply.[18] Similar to trends seen at the national level, the majority of overdose deaths in Rock County in 2021 involved fentanyl, often in combination with other drugs.[5]

Across the last few decades, opioids have had devastating effects on all populations and age groups. However, some groups have been more impacted by the opioid epidemic than others. In general, the White population experiences higher rates of opioid-involved deaths than other races and ethnicities. Throughout the epidemic's history, attention has primarily focused on White suburban and rural communities, as they were the group primarily affected by prescription opioids in the first wave of the epidemic.[19] However, despite the shift to heroin and synthetic opioid misuse that primarily affects people of color, the inequities that continue to elevate opioid-involved deaths among these groups remain unaddressed.[19] In Wisconsin, Black and African Americans and American Indian and Alaska Natives experience higher death rates for every type of opioid than their White counterparts.[5] Following similar national trends, synthetic opioid death rates among people of color in Wisconsin are over double that of the White population; signifying that the inequities seen at the national level may also be playing a role at the state level as well.[5] Unfortunately, local Rock County mortality data stratified by race and ethnicity is unavailable for heroin, prescription opioids, and synthetic opioids. However, given national and state trends, it is likely that similar racial and ethnic disparities are coming into play in Rock County.

While racial and ethnic disparities have fluctuated throughout the opioid epidemic, sex-based disparities have remained consistent throughout the last two decades. In general, men have had consistently higher rates of opioid overdose deaths compared to women.[20] In Wisconsin, men experience over double the rate of heroin-involved and synthetic opioid-involved deaths than women.[5] Locally, Rock County experiences similar trends. In Rock County, the synthetic opioid death rate per 100,000 people in 2020 was 26.5 for men and 9.8 for women.[5] It is important to note that the difference between prescription opioid death rates between men and women is much closer than other opioids at both the state and local level. In Rock County, prescription opioid death rates per 100,000 people are 13.9 and 11.0 for men and women, respectively.[5] It is currently unknown why the difference between prescription opioid death rates among Rock County men and women is much smaller than other opioids. However, national data indicates women are prescribed opioids more frequently than men, which can potentially lead to greater levels of misuse and mortality.[21]

Another disparity seen throughout the opioid epidemic is the differences in opioid mortality among different age groups. Despite a common belief that opioid mortality rates are primarily driven by younger populations, such as those in their teenage years, those 25-34 and 35+ experience the highest rates of opioid-involved deaths.[22] Among all age groups, 25–34-year olds experienced over 18,000 opioid overdose deaths in 2020, followed by 35–44-year olds and those 55+.[22] In Wisconsin, the majority of the opioid-involved deaths experienced in the state are among those 18-44 and 45-64.[5] In 2020, the rate of opioid overdose deaths for 18-44-year olds and 45-64 year olds was 38.8 and 25.4 deaths per 100,000 people, respectively. Comparatively, Wisconsin's opioid death rate among 1–17-year-olds and those 65+ was 0.4 and 4.3 deaths per 100,000. Similar to trends seen at the state level, the majority of opioid-involved deaths in Rock County occurred among age groups 18-44 and 45-64.[5]

When looking at opioid use and misuse in Rock County, the greater context of social and health issues in the County cannot be understated, especially trauma and mental health. One issue of importance,

particularly when analyzing the opioid epidemic, is adverse childhood experiences (ACEs). Children and adolescents in Rock County experience high rates of ACEs, or potentially traumatic events that occur in childhood. Experiencing trauma before the age of 18 increases the risk of opioid misuse in the future.[23] Among all Wisconsin counties, Rock County has the highest proportion of people reporting four or more ACEs at one in four people.[24] Generally, ACEs increase the risk of injection drug use, opioid misuse, opioid overdose, and suicide later in life.[25] ACEs are also associated with using opioids at a younger age.[25] One study indicates that those who experience 5 or more ACEs were 15 times more likely to report opioid misuse than those experiencing no ACEs.[26] Given the significant impacts ACEs can have on future opioid use and misuse, emphasizing early prevention is essential. Adverse childhood experiences are widely preventable, but in order to prevent ACEs at their roots, it's important to understand and address factors that put people at risk of trauma, including mental health.

Mental health is an essential piece of overall health and well-being for those who live in Rock County. As identified in Rock County's 2021 Community Health Assessment, mental health resources are severely lacking in Rock County. While this can have a negative impact on any number of health issues, this has particular significance in the opioid epidemic, as ties between poor mental health and opioid misuse and mortality are well documented. Poor mental health and opioid misuse are often described as having a bidirectional relationship, meaning that symptoms of one issue increases and reinforces the risk of the other.[27] For example, one of the most common mental health issues, depression, is a risk factor for misusing opioids as they can be used to treat insomnia or stress.[27] Conversely, opioid misuse is a common risk factor for many mental health issues like major depressive disorders and anxiety disorders.[28] This relationship is also well documented in data. Of the two million U.S. adults that had an opioid use disorder (OUD) in 2016, over 60% had a co-occurring mental illness.[29] Though the relationship between mental health and opioid misuse is complicated, it can help inform potential prevention strategies aimed at the root causes of each issue.

Mental health, trauma, and opioid misuse and mortality are all heavily interconnected. Addressing just one of these three issues can help decrease the risk of the other two.[30] Given the historical context of the epidemic at the national, state, and local levels, opioid misuse prevention strategies are well documented. Though there are numerous ways to approach preventing future opioid misuse in Rock County, it is crucial that these opioid settlement funds are utilized to address some of the root causes of the opioid epidemic, including mental health and trauma such as ACEs.

METHODOLOGY

Multiple sources of information were used to form the recommendations for the use of the opioid settlement funds presented in this report.

Contracted Assessment
In 2021, the Rock County Human Services Department and local prevention coalitions contracted with Epiphany Community Services to complete an assessment about substance misuse in Rock County. This report, *Rock County Substance Use Community Assessment,* was completed in early 2022 and was included in the formation of the recommendations by the Opioid Settlement Workgroup.

Opioid Settlement Survey
In April of 2022, a survey was created to allow for community input regarding the opioid settlement funds. Information from the *Rock County Substance Use Community Assessment* was utilized for creating the questions in the multiple-choice survey. The survey was emailed directly to stakeholders identified by the Opioid Settlement Workgroup, shared with the public on social media, and featured in a local newspaper. Substance use treatment and harm reduction providers were encouraged to share the survey with people who have lived experience. Over 250 people completed the survey. Survey questions and a summary of the results can be found in Appendix A.

Public Listening Sessions
Opioid Settlement Funds listening sessions were held for the public on May 5 and May 19. Information and feedback on lived experiences were gathered directly from those who currently use or used drugs, from friends and family, and the general public. Notes from the sessions can be found in Appendix B.

Key Informant Interviews
Informal interviews were held with various individuals who work directly with people who use drugs. These interviews were designed to identifying gaps and needs related to treatment and harm reduction in Rock County. Additionally, local prevention coalitions submitted a list of strategies they had identified related to prevention and harm reduction.

RECOMMENDATIONS

1. Create the equivalent of 1 FTE to oversee the proposed strategies
In consideration of the time commitment of overseeing the allocation, administration, and evaluation regarding the use of the opioid settlement funds, it was determined that hiring a full-time staff person would be recommended. This person would be responsible for the Request for Proposals (RFP) process, overseeing contracted services, and the ongoing evaluation of the usage of the funds. In addition to overseeing the aspects of settlement funds coming directly to the County, the position would be responsible for coordinating grant applications for funds that will be available through Wisconsin DHS to local jurisdictions, which would enhance the County's ability to prevent and mitigate the negative impacts of substance use.

2. Increase access to sober living
In the Opioid Settlement Survey, a lack of access to safe and sober living was identified as the top barrier to staying in recovery and maintaining sobriety in Rock County. Key informant interviews indicated there are currently no sober living options located in Rock County for transitional age youth and parents with children. It can be very difficult to achieve and maintain sobriety for individuals in unstable housing. By increasing access to safe, supportive, and stable living environments, the County can improve the likelihood that those who use drugs can maintain sobriety during transitions in housing.

There is ample evidence demonstrating the effectiveness of recovery residences. Research indicates that safe and stable housing is associated with positive recovery outcomes including increased employment, decreased psychiatric symptoms, lower incarceration rates, and decreased rates of substance misuse.[31] Recovery residences that provided access to 12-step meetings improved recovery outcomes.[32] The goal of recovery housing is to increase the stability of individuals suffering from substance use disorders (SUDs) by supporting abstinence through a social model philosophy.

Since Rock County does not have the expertise or capacity to offer sober living as an internal program, it is recommended that funds be made available through a letter of interest, followed by a Request for Proposal (RFP) process. There are established guidelines for qualifying as a sober living or recovery residence. It is requested that in order to qualify for these funds, the requirements set forth in the Recovery Residence Registry must be met.

This recommendation is supported by Exhibit E: List of Opioid Abatement Remediation Uses and is specifically mentioned in Schedule A, B.4. Provide treatment and recovery support services such as residential and inpatient treatment, intensive outpatient treatment, outpatient therapy or counseling, and recovery housing that allow or integrate medication and with other support services.

3. Increase access to higher level treatment options located in Rock County
In the Opioid Settlement Survey, a lack of access to local inpatient treatment was identified as the top barrier to receiving substance misuse treatment in Rock County. In the listening sessions, there was concern about the gap or waiting time between detox and treatment. One parent even reported sending her child out-of-state to find residential treatment in a timely manner. The *Rock County Substance Use Community Assessment* noted a shortage of providers, a shortage of services, limited inpatient treatment, and wait times as challenges in Rock County. There are currently no residential treatment facilities in Rock County and only one day treatment program. It is proposed that funds be used to support the addition of higher-level treatment options including inpatient, residential and/or day treatment programs. By having local access, barriers such as transportation and being away from children and support networks can be

overcome. Increased local access will also reduce wait times and facilitate a more streamlined response for those seeking treatment.

There are several ways to increase access to treatment within Rock County and one strategy is by increasing treatment capacity. A major barrier to treatment is the lack of trained providers in the area that specialize in addiction medicine. The Addiction Solutions Campaign, a consortium of the leading policy, advocacy , education and technical assistance organizations in the addiction field, suggests that funds be used to integrate addiction treatment into hospital and emergency care.[33] An estimated $120 billion per year could be saved if substance misuse was addressed by incorporating addiction treatment into mainstream healthcare.[33] In addition, funds could be used to train and increase the number of providers that would be able to provide medication for opioid use disorder (MOUD)/medication-assisted treatment (MAT) to those suffering from substance addiction. MAT is a combination of behavioral therapy and FDA-approved medications such as methadone, buprenorphine, and naltrexone. Research indicates that MAT interventions are one of the most effective ways of treating opioid use disorder and preventing overdoses. In community-based settings, MAT has been associated with decreasing the transmission of HIV and hepatitis C as well.[34-35] Treatment in primary care settings can also be a critical gateway to improving capacity and access.

This recommendation is supported by Exhibit E: Schedule A, B.4. Provide treatment and recovery support services such as residential and inpatient treatment, intensive outpatient treatment, outpatient therapy or counseling, and recovery housing that allow or integrate medication and with other support services.

4. Provide youth substance use prevention and/or intervention

"*Primary prevention efforts—which are designed to stop use before it starts—can interrupt the pathways to addiction and overdose. Youth primary prevention also reduces the risk of substance use and lessens other negative outcomes, including low educational status, under- and unemployment, unintended parenthood, and an increased risk of death from a variety of causes. Youth prevention programs also have a very favorable return on investment—$18 dollars for every dollar spent by one estimate.*"[36]

Funding prevention is vital to having a long-term impact on reducing the harms of drug use in Rock County. It is recommended that funds from the settlement be used to support youth prevention efforts. The Opioid Settlement Survey indicated that mental health is a top concern regarding prevention efforts. Therefore, it is recommended that the prevention efforts include evidence-based strategies aimed at reducing substance misuse and/or improving mental health for youth.

Rock County currently has several substance use prevention coalitions including Building a Safer Evansville, Janesville Mobilizing 4 Change, Milton Youth Coalition and Youth 2 Youth 4 Change. These groups work collaboratively with Rock County through the Prevention Network. The *Rock County Substance Use Community Assessment* states, "Rock County has successful substance use prevention initiatives that they should continue to support and expand." Drug-Free Communities grants, a major funding source for these coalitions, are limited to 10 years and for most of these coalitions have ended or are near ending. It is recommended that these funds support these coalitions in providing evidence-informed substance use prevention and mental health support strategies.

Research shows that alcohol, tobacco, and illicit drug use can substantially influence the growth and development of youth. It has also been shown that the likelihood of developing a SUD is decreased if substance use is taken up after adolescence.[37] In addition, research indicates that individuals who have experienced trauma and ACEs are at disproportionate risk of substance misuse.[38] Individuals experiencing ACEs such as household dysfunction, childhood neglect, and abuse increases the likelihood of illicit drug

use by 2 to 4-fold.[39] Investing in prevention coalitions will promote the visibility of substance abuse prevention and youth development activities.

This recommendation is supported by Exhibit E: Schedule B, G.5. Funding community anti-drug coalitions that engage in drug prevention efforts. G.6. Supporting community coalitions in implementing evidence-informed prevention such as reduced social access and physical access, stigma reduction--including staffing, educational campaigns, support for people in treatment or recovery, or training of coalitions in evidence-informed implementation, including the Strategic Prevention Framework developed by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA).

5. Provide substance use disorder and mental health assessment with rapid access to treatment for those in the criminal justice system

The criminal justice system is involved with many of the people who are experiencing opioid use disorder (OUD). Meeting the needs of individuals with SUD and co-occurring mental health disorders who are involved with the criminal justice system was identified as a need through key informant interviews. One listening session participant credited jail and drug court with providing what she needed to recover from her addiction.

Research has identified eight criminogenic needs that are dynamic (changeable) risk factors proven to affect recidivism—one of which is substance abuse. Ensuring that justice involved individuals will receive services that address criminogenic needs is critical for managing and reducing any potential risks to the community and improving the lives of the individuals. Interventions should be provided at multiple points in the criminal justice system for maximum effectiveness.[40]

It is recommended that funds be used to establish a more thorough assessment process with rapid access to needed treatment. The criminal justice system has an established contract with a provider of pre-trial assessment and supervision and these services could be expanded to better meet the assessment and referral needs of this population. Once an assessment indicates the need for OUD/SUD treatment, it is vital to have access to the services indicated by the assessment. By increasing treatment options for those involved with the criminal justice system (in jail, pre-trial release, deferred prosecution, other justice system alternatives, etc.), this need will be met.

For out-of-custody justice-involved individuals, treatment court programs such as Drug Court, Operating While Intoxicated (OWI) Court, and Veterans Court can serve high risk individuals with significant substance use disorders. Interventions at earlier stages in the justice system can also reduce recidivism and improve lives. An expansion of the District Attorney's Deferred Prosecution Program could provide comprehensive case management services to participants with opiate use disorders and coordinate their care to meet their needs.

For jail inmates, continuity of care is frequently a problem for those receiving and/or needing OUD/SUD treatment and MAT. It is recommended that these funds be used to increase the capacity of the jail to provide OUD/SUD treatment by adding an SUD counselor. The role of this counselor would be to advocate for MAT use (especially for those already receiving MAT prior to incarceration) and to provide treatment with a warm hand-off to community providers.

MOUD/MAT has been known to be one of the most effective treatments for OUDs. There is ample research demonstrating the use of MAT in correctional facilities and its association with decreased syringe sharing, heroin use, and criminal activity upon release.[41-45] Making MAT available for incarcerated individuals with OUDs and providing the option to initiate MAT in criminal justice settings, has also been

observed to increase the likelihood of adherence to treatment and care in the future.[41] MAT is most effective in the criminal justice system when individuals have access to their choice of the approved medications.[46] In addition, assisting individuals who are expected to be released with provider referrals would help ensure a "warm handoff" so that their treatment remains uninterrupted.[41] A lack of continuity in care after being released from the criminal justice system can lead to withdrawal or additional drug misuse.

Rhode Island was the first state to increase access to MAT in all its adult correctional facilities in 2016. As a result, there was a 60% decrease in the proportion of overdose deaths of those that were recently released in the past year.[47] It was also noted that the program prevented fatal overdoses as the state observed a 12% decrease in overdose deaths as compared to the previous year.[47] Given the evidence, it is recommended that jails and prisons screen incarcerated individuals for OUD and provide tailored MAT and counseling. Additionally, jails and prisons should establish connections with community-based OUD treatment centers to ensure that recently incarcerated individuals with OUD maintain their treatment regimen without disruption. Lastly, jails and prisons must have the capacity and data infrastructure to monitor and evaluate MOUD/MAT outcomes.[48]

This recommendation is supported by Exhibit E: Schedule A, F. 1 & 2. Treatment for incarcerated persons. Schedule B, D.2. Support pre-trial services that connect individuals with OUD and any co-occurring SUD/Mental Health (MH) conditions to evidence-informed treatment, including MAT and related services. D.4. Provide evidence-informed treatment, including MAT, recovery support, harm reduction or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are incarcerated in jail or prison.

6. Increased Case Managers/Navigators with access to flex funds

Three of the needs identified in the Opioid Settlement Survey would be best served by additional recovery case managers to help navigate the system of care. One identified barrier to treatment was a lack of awareness of available services. A lack of help with coordination and navigation of the system was identified as a barrier to recovery and/or staying sober. Additionally, help with linkages to support was identified as a need to prevent overdose deaths. By adding recovery case managers, there will be additional support in overcoming these barriers. It is also recommended that the recovery case managers have access to some flex funding to cover unexpected barriers that may arise for individuals. Many times, specific needs cannot be met by current grant funded programs that are sometime limited. Access to flex funds could make a significant difference in overcoming the barriers that negatively impact people who use drugs in Rock County.

Care coordination has been increasingly recognized as a patient-centered approach to providing medical services. This model has been primarily used for patients with complex healthcare needs in which coordination and communication among providers is essential to manage patients' chronic conditions. There are various models of care coordination, however, many have similar components including the development of an individualized care plan, a primary point of contact, and education and data-sharing for patients and providers.[49] Research has shown that care coordination is associated with decreased hospitalizations, 30-day readmissions, and emergency department visits.[50]

There have been two promising models used for treating OUDs, the nurse care manager (NCM) model and the Medicaid health homes model.[49] The NCM model consists of four stages: screening and assessment, medication initiation, stabilization, and maintenance.[51] In the NCM model, a nurse serves as the primary care coordinator and works with patients in community health centers. The nurse serves as a liaison and educator for the patient and maintains active communication with prescribing providers. This model has

been studied at the Boston Medical Center where researchers found that 95% of the patients who were in treatment for 12 months no longer used illicit opioids.[51]

The Medicaid health homes model utilizes an interdisciplinary team providing behavioral therapy support that can include social workers, behavioral health professionals, physicians, nurse care coordinators, nutritionists, and others that can assist individuals with SUD/OUD with their treatment.[49,52] One well-known and recognized Medicaid health home model is the "hub and spoke" model. Hubs are the lead specialty treatment centers for patients with complex mental health and substance use issues.[49] Hubs are also a place where methadone and buprenorphine can be administered.[49] Spokes are often office-based opioid treatment settings and can be community partners that support hub sites with care management and individuals with recovery.[49] This model was successfully implemented for Vermont's Medicaid population that had SUD/OUD diagnoses.[52-53] As a result of the hub and spoke program, Vermont saw an 89% decrease in emergency department visits, 90% decrease in criminal activity, 92% decrease in injection drug use, and a 96% decrease in opioid use among participants.[52-53] The program served 2,164 patients from 2012-13, and it is estimated that $6.7 million in health care expenses was saved.[52-53]

This recommendation is supported by Exhibit E: Schedule B, B.3. Provide counseling, peer-support, recovery case management and residential treatment with access to medications for those who need it to persons with OUD and any co-occurring SUD/MH conditions.

7. Increased Certified Peer Support Specialists
Peer Support Specialists can be instrumental in providing support and linkages to care to those who use drugs. The Opioid Settlement Survey identified challenges such as stress, stigma, a lack of peer support, and poor access to recovery groups as barriers to recovery and staying sober. Peer Support Specialists would assist individuals in overcoming these barriers and provide linkages to support services. Ideally, a Peer Support Specialist should not be tied to a specific program but should follow the individual even if they drop out of treatment. By continuing to offer support, Peer Support Specialists can connect people with harm reduction services and can encourage re-engagement with treatment.

Social support has been shown to assist those in recovery and Peer Specialists (Peer Provider, Peer Support Specialists, Recovery Coach) are well-positioned to provide this support to those with SUDs.[54] Peer workers have lived experiences that can be of great value for those in recovery. Their first-hand experience with substance use can provide critical support in distinct ways, including informational, emotional, instrumental, and affiliational support.[55] Peer Specialists can serve as mentors and coaches, connect those in recovery with the appropriate resources, facilitate and lead recovery groups, and help build community among those recovering.[55] Research shows that peer support and coaching can increase outpatient treatment engagement, increased satisfaction with life, decreased use of emergency room services and detoxification centers, and decrease the average service costs per person.[56]

This recommendation is supported by Exhibit E: Schedule B, B.3. Provide counseling, peer-support, recovery case management and residential treatment with access to medications for those who need it to persons with OUD and any co-occurring SUD/MH conditions.

8. Other recommendations (as funds allow)
a) Transportation and childcare for appointments was identified as an overwhelming barrier for some people seeking treatment and aftercare. Although this was not one of the top issues identified in the Opioid Settlement Survey, transportation and childcare are often cited as barriers in receiving care. Funding to support transportation to and from counseling, group therapy, and recovery groups would help overcome the transportation barrier. Offering childcare for appointments is not only an opportunity to

support treatment and recovery for parents but can also be an opportunity to offer a supportive or therapeutic time for the children. Children exposed to drug use in the home are at risk for future drug use. An intervention combined with childcare can serve two purposes, helping both generations simultaneously.

This recommendation is supported by Exhibit E: Schedule A, E. 4. Provide comprehensive wrap around services to individuals in recovery including housing, transportation, job placement/training, and childcare.

b) A messaging campaign focused on drug-related stigma was identified as a potential use of settlement funds. One of the themes pulled from the Opioid Settlement Survey was the emotional challenge that stigma presents for those who use drugs. Those who use drugs are often faced with judgement and discrimination that damages their well-being and can even interfere with the quality of care they receive in clinical settings. A campaign focused on reducing stigma in various settings, including healthcare, can help reduce barriers to treatment and recovery to improve the health of those working to achieve and maintain sobriety.

This recommendation is supported by Exhibit E: Schedule B, B.12. Support stigma reduction efforts regarding treatment and support for persons with OUD, including reducing stigma on effective treatment.

c) Substance use and mental health training for law enforcement officers can assist in the response to drug-related calls or emergencies. Law officers are often first on the scene for drug overdoses and mental health crises. Providing law enforcement with the appropriate training and resources to manage these situations can help improve outcomes for both the individual in crisis and the officer on scene. Informational packets or harm reduction kits might also be helpful for law enforcement responding to drug-related calls or emergencies.

This recommendation is supported by Exhibit E: Schedule A, B.3. Provide MAT education and awareness training to healthcare, EMTs, Law enforcement, and other first responders.

d) Public education about topics such as addiction, treatment, and Good Samaritan laws can help inform Rock County and provide resources to those in need. Many people need assistance but don't know what options are available to them. A comment from the Opioid Settlement Survey stated, *"We need more community awareness of where services are offered. Where are billboards? Where are places people can walk into for help? The common everyday person has no idea where to send a family member or friend."* In one of the listening sessions, a few participants expressed a need for more information about a range of topics for addressing this issue.

This recommendation is supported by Exhibit E: Schedule B, H.6. Public education relating to emergency responses to overdoses. H.7. Public education relating to immunity and Good Samaritan laws.

CONCLUSION

This report aims to serve as a guide to inform and direct the use of the National Opioid Settlement funds. Though the opioid epidemic has had devastating impacts on Rock County, the National Opioid Settlement presents an opportunity to address opioid misuse at its roots and improve the health of the County. By listening to the needs identified in the assessment, building upon evidence-based strategies, initiatives, and programs, and incorporating the identified recommendations, Rock County can utilize these funds to become a healthier, safer community for all residents.

REFERENCES

1. Opioids Investigations, Litigation, and Settlements. (2021). National Association of Attorneys General. https://www.naag.org/issues/opioids/
2. Opioid Data Analysis and Resources. (2022). Centers for Disease Control and Prevention. https://www.cdc.gov/opioids/data/analysis-resources.html
3. Overdose Death Rates. (2022). National Institute on Drug Abuse. https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates
4. Dose of Reality: Opioid Data Summary Dashboard. (2022). Wisconsin Department of Health Services. https://www.dhs.wisconsin.gov/opioids/dashboards.htm
5. Dose of Reality: Opioid Deaths by County Dashboard. (2022). Wisconsin Department of Health Services. https://www.dhs.wisconsin.gov/opioids/deaths-county.htm
6. Dose of Reality: Opioid Hospital Visit Dashboard. (2022). Wisconsin Department of Health Services. https://www.dhs.wisconsin.gov/opioids/hospitalizations-county.htm
7. Understanding the Epidemic. (2021). Centers for Disease Control and Prevention. https://www.cdc.gov/drugoverdose/epidemic/index.html
8. Jones, M. R., Viswanath, O., Peck, J., Kaye, A. D., Gill, J. S., & Simopoulos, T. T. (2018). A Brief History of the Opioid Epidemic and Strategies for Pain Medicine. Pain and Therapy, 7(1), 13–21. https://doi.org/10.1007/s40122-018-0097-6
9. Drug Overdose Overview. (2022). Centers for Disease Control and Prevention. https://www.cdc.gov/drugoverdose/deaths/prescription/overview.html
10. Prescribing Practices. (2019). Centers for Disease Control and Prevention. https://www.cdc.gov/drugoverdose/deaths/prescription/practices.html
11. U.S. Opioid Dispensing Rate Maps. (2021). Centers for Disease Control and Prevention. https://www.cdc.gov/drugoverdose/rxrate-maps/index.html
12. U.S. County Opioid Dispensing Rates. (2022). Centers for Disease Control and Prevention. https://www.cdc.gov/drugoverdose/rxrate-maps/county2020.html
13. National Academies of Sciences, Engineering, and Medicine, Health and Medicine Division, Board on Health Sciences Policy, Committee on Pain Management and Regulatory Strategies to Address Prescription Opioid Abuse, Phillips, J. K., Ford, M. A., & Bonnie, R. J. (2017). Pain Management and the Opioid Epidemic: Balancing Societal and Individual Benefits and Risks of Prescription Opioid Use (1st ed.). National Academies Press.
14. Heroin. (2022). Centers for Disease Control and Prevention. https://www.cdc.gov/opioids/basics/heroin.html
15. Heroin Overdose Data. (2022). Centers for Disease Control and Prevention. https://www.cdc.gov/drugoverdose/deaths/heroin/index.html
16. Synthetic Opioids. (2020). Drug Enforcement Administration. https://www.dea.gov/sites/default/files/2020-06/Synthetic%20Opioids-2020.pdf
17. Synthetic Opioid Overdose Data. (2022). Centers for Disease Control and Prevention. https://www.cdc.gov/drugoverdose/deaths/synthetic/index.html
18. Reported Law Enforcement Encounters Testing Positive for Fentanyl Increase Across US. (2021). Centers for Disease Control and Prevention. https://www.cdc.gov/drugoverdose/deaths/fentanyl-encounters/index.html
19. Larochelle, M. R., Slavova, S., Root, E. D., Feaster, D. J., Ward, P. J., Selk, S. C., Knott, C., Villani, J., & Samet, J. H. (2021). Disparities in Opioid Overdose Death Trends by Race/Ethnicity, 2018–2019, From the HEALing Communities Study. American Journal of Public Health, 111(10), 1851–1854. https://doi.org/10.2105/ajph.2021.306431

20. Mason, M., Soliman, R., Kim, H. S., & Post, L. A. (2022). Disparities by Sex and Race and Ethnicity in Death Rates Due to Opioid Overdose Among Adults 55 Years or Older, 1999 to 2019. JAMA Network Open, 5(1), e2142982. https://doi.org/10.1001/jamanetworkopen.2021.42982
21. Manubay, J., Davidson, J., Vosburg, S., Jones, J., Comer, S., & Sullivan, M. (2015). Sex Differences Among Opioid-Abusing Patients With Chronic Pain in a Clinical Trial. Journal of Addiction Medicine, 9(1), 46–52. https://doi.org/10.1097/adm.0000000000000086
22. Opioid Overdose Deaths by Age Group. (2022). Kaiser Family Foundation. https://www.kff.org/other/state-indicator/opioid-overdose-deaths-by-age-group/
23. Quinn, K., Boone, L., Scheidell, J. D., Mateu-Gelabert, P., McGorray, S. P., Beharie, N., Cottler, L. B., & Khan, M. R. (2016). The relationships of childhood trauma and adulthood prescription pain reliever misuse and injection drug use. Drug and Alcohol Dependence, 169, 190–198. https://doi.org/10.1016/j.drugalcdep.2016.09.021
24. Child Abuse and Neglect Prevention Board. (2021). Wisconsin.Gov. https://preventionboard.wi.gov/Pages/Homepage.aspx
25. Stein, M. D., Conti, M. T., Kenney, S., Anderson, B. J., Flori, J. N., Risi, M. M., & Bailey, G. L. (2017). Adverse childhood experience effects on opioid use initiation, injection drug use, and overdose among persons with opioid use disorder. *Drug and Alcohol Dependence*, *179*, 325–329. https://doi.org/10.1016/j.drugalcdep.2017.07.007
26. Swedo, E. A., Sumner, S. A., de Fijter, S., Werhan, L., Norris, K., Beauregard, J. L., Montgomery, M. P., Rose, E. B., Hillis, S. D., & Massetti, G. M. (2020). Adolescent Opioid Misuse Attributable to Adverse Childhood Experiences. The Journal of Pediatrics, 224, 102–109.e3. https://doi.org/10.1016/j.jpeds.2020.05.001
27. Vekaria, V., Bose, B., Murphy, S. M., Avery, J., Alexopoulos, G., & Pathak, J. (2021). Association of co-occurring opioid or other substance use disorders with increased healthcare utilization in patients with depression. *Translational Psychiatry*, *11*(1). https://doi.org/10.1038/s41398-021-01372-0
28. Rosoff, D. B., Smith, G. D., & Lohoff, F. W. (2021). Prescription Opioid Use and Risk for Major Depressive Disorder and Anxiety and Stress-Related Disorders. *JAMA Psychiatry*, *78*(2), 151. https://doi.org/10.1001/jamapsychiatry.2020.3554
29. Jones, C. M., & McCance-Katz, E. F. (2019). Co-occurring substance use and mental disorders among adults with opioid use disorder. *Drug and Alcohol Dependence*, *197*, 78–82. https://doi.org/10.1016/j.drugalcdep.2018.12.030
30. *Adverse Childhood Experiences, Overdose, and Suicide*. (2022). Centers for Disease Control and Prevention. https://www.cdc.gov/injury/priority/index.html
31. Polcin, D. L., Korcha, R., Bond, J., & Galloway, G. (2010). What did we learn from our study on sober living houses and where do we go from here?. *Journal of psychoactive drugs*, *42*(4), 425–433. https://doi.org/10.1080/02791072.2010.10400705
32. Mericle, A. A., Mahoney, E., Korcha, R., Delucchi, K., & Polcin, D. L. (2019). Sober living house characteristics: A multilevel analyses of factors associated with improved outcomes. *Journal of Substance Abuse Treatment, 98*, 28-38. doi: 10.1016/j.jsat.2018.12.004
33. Addition Solutions Campaign. (2018). *Opioid Settlement Priorities: Recommendations from the Addiction Solutions Campaign.* https://www.lac.org/assets/files/Opioid-Settlement-Priorities_5.17.18.pdf
34. Gowing, L., Farrell, M. F., Bornemann, R., Sullivan, L. E., & Ali, R. (2011). Oral substitution treatment of injecting opioid users for prevention of HIV infection. *The Cochrane database of systematic reviews*, (8), CD004145. https://doi.org/10.1002/14651858.CD004145.pub4
35. Thiede, H., Hagan, H., & Murrill, C. S. (2000). Methadone treatment and HIV and hepatitis B and C risk reduction among injectors in the Seattle area. *Journal of urban health: bulletin of the New York Academy of Medicine*, *77*(3), 331–345. https://doi.org/10.1007/BF02386744

36. Johns Hopkins Bloomberg School of Public Health. (2021). Principles for the Use of Funds from the Opioid Litigation. https://opioidprinciples.jhsph.edu/wp-content/uploads/2022/04/Opioid-Principles-Doc.pdf
37. Rioux, C., Castellanos-Ryan, N., Parent, S., Vitaro, F., Tremblay, R. E., & Séguin, J. R. (2018). Age of Cannabis Use Onset and Adult Drug Abuse Symptoms: A Prospective Study of Common Risk Factors and Indirect Effects. Canadian journal of psychiatry. Revue canadienne de psychiatrie, 63(7), 457–464. https://doi.org/10.1177/0706743718760289
38. Choi, N. G., DiNitto, D. M., Marti, C. N., & Choi, B. Y. (2017). Association of adverse childhood experiences with lifetime mental and substance use disorders among men and women aged 50+ years. International Psychogeriatrics 29(3), 359–372. doi:10.1017/S1041610216001800
39. Dube, S. R., Felitti, V. J., Dong, M., Chapman, D. P., Giles, W. H., Anda, R. F. (2003). Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: the adverse childhood experiences study. Pediatrics 111(3), 564–572.
40. Andrews, D.A., Bonta, J. (2010). *The psychology of criminal conduct* (5th ed). Anderson. https://www.academia.edu/36813114/D_A_Andrews_James_Bonta_The_Psychology_of_Criminal_Conduct_Fifth_Edition_Elsevier_2010_
41. Centers for Disease Control and Prevention. *Evidence-Based Strategies for Preventing Opioid Overdose: What's Working in the United States.* National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, 2018. http://www.cdc.gov/drugoverdose/pdf/pubs/2018-evidence-based-strategies.pdf
42. Dolan, K. A., Shearer, J., MacDonald, M., Mattick, R. P., Hall, W., & Wodak, A. D. (2003). A randomised controlled trial of methadone maintenance treatment versus wait list control in an Australian prison system. *Drug and alcohol dependence*, *72*(1), 59–65. https://doi.org/10.1016/s0376-8716(03)00187-x
43. McKenzie, M., Zaller, N., Dickman, S. L., Green, T. C., Parihk, A., Friedmann, P. D., & Rich, J. D. (2012). A randomized trial of methadone initiation prior to release from incarceration. *Substance abuse*, *33*(1), 19–29. https://doi.org/10.1080/08897077.2011.609446
44. Gordon, M. S., Kinlock, T. W., Schwartz, R. P., Fitzgerald, T. T., O'Grady, K. E., & Vocci, F. J. (2014). A randomized controlled trial of prison-initiated buprenorphine: prison outcomes and community treatment entry. *Drug and alcohol dependence*, *142*, 33–40. https://doi.org/10.1016/j.drugalcdep.2014.05.011
45. Lee, J. D., McDonald, R., Grossman, E., McNeely, J., Laska, E., Rotrosen, J., & Gourevitch, M. N. (2015). Opioid treatment at release from jail using extended-release naltrexone: a pilot proof-of-concept randomized effectiveness trial. *Addiction (Abingdon, England)*, *110*(6), 1008–1014. https://doi.org/10.1111/add.12894
46. Connery H. S. (2015). Medication-assisted treatment of opioid use disorder: review of the evidence and future directions. *Harvard review of psychiatry*, *23*(2), 63–75. https://doi.org/10.1097/HRP.0000000000000075
47. Green, T. C., Clarke, J., Brinkley-Rubinstein, L., Marshall, B., Alexander-Scott, N., Boss, R., & Rich, J. D. (2018). Postincarceration Fatal Overdoses After Implementing Medications for Addiction Treatment in a Statewide Correctional System. *JAMA psychiatry*, *75*(4), 405–407. https://doi.org/10.1001/jamapsychiatry.2017.4614
48. The Pew Charitable Trusts. (2020). Opioid Use Disorder Treatment in Jails and Prisons. https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2020/04/opioid-use-disorder-treatment-in-jails-and-prisons
49. The Pew Charitable Trusts. (2020). Care Coordination Strategies for Patients Can Improve Substance Use Disorder Outcomes. https://www.pewtrusts.org/-/media/assets/2020/04/carecoordinationbrief.pdf

50. Commonwealth Fund. (2019). Quick Reference Guide to Promising Care Models for Patients With Complex Needs. https://www.commonwealthfund.org/publications/2019/feb/care-models-patients-complex-needs
51. LaBelle, C. T., Han, S. C., Bergeron, A., & Samet, J. H. (2016). Office-Based Opioid Treatment with Buprenorphine (OBOT-B): Statewide Implementation of the Massachusetts Collaborative Care Model in Community Health Centers. *Journal of substance abuse treatment*, *60*, 6–13. https://doi.org/10.1016/j.jsat.2015.06.010
52. Brooklyn, J. R., & Sigmon, S. C. (2017). Vermont Hub-and-Spoke Model of Care for Opioid Use Disorder: Development, Implementation, and Impact. *Journal of addiction medicine*, *11*(4), 286–292. https://doi.org/10.1097/ADM.0000000000000310
53. Vermont Department of Health. (2018). Hub & Spoke Model Evaluation. (2017). https://www.healthvermont.gov/sites/default/files/documents/pdf/ADAP_Hub_and_Spoke_Evaluation_Brief_2018_1.pdf
54. McLellan, A.T., Hagan, T.A., Levine, M., Gould, F., Meyers, K. and Ben-civengo, M., et al. (1998). Research report: Supplemental social services improve outcomes in public addiction treatment. *Addiction*, 93(10), 1489-1499. doi: 10.1046/j.1360-0443.1998.931014895.x
55. Center for Substance Abuse Treatment, SAMHSA. (2009). What are Peer Recovery Support Services? HHS Publication No. (SMA) 90-4454. https://dbhds.virginia.gov/assets/doc/recovery/what-are-peer-recovery-support-services-2009.pdf
56. Bringing Recovery Supports to Scale Technical Assistance Center, SAMSHA. (2012). Expert Panel Meeting Report. Equipping Behavioral Health Systems & Authorities to Promote Peer Specialist/Peer Recovery Coaching Services. https://www.peerrecoverynow.org/ResourceMaterials/samsha_2012_expert_panel_meeting_report_-_equipping_behavioral_health.pdf

APPENDIX A: COMMUNITY SURVEY

Opioid Settlement Survey

Last year over 100,000 Americans died from drug overdoses. Rock County has also seen increases in drug overdose deaths throughout the last decade. Due to the National Opioid Settlement, Rock County will be receiving funds to address harm done by the opioid epidemic. In order to determine how to best allocate these funds, we would like to hear from community members impacted by substance misuse and substance use disorders. Please note that individual information provided in this survey will not be shared publicly. Information provided will be used to create a summary report that will guide this effort.

1. Please provide your name. **(optional)**

   Name:

2. How would you describe your connection to the opioid epidemic and primary reason for filling out this survey **(pick one)**.

   - o Substance use disorder treatment provider
   - o Substance use disorder prevention provider
   - o Substance use disorder harm reduction provider
   - o Substance use disorder recovery services provider
   - o Mental health services provider (without substance use treatment)
   - o Law enforcement, corrections, jail, probation, parole
   - o Medical provider-ER, primary care, EMS
   - o Person who uses drugs - current or past
   - o Friend or family member of person who uses or used drugs
   - o Community member
   - o Other (please specify)

3. What are some barriers to receiving substance use treatment in Rock County?

   Select up to 5 options.

   - o Available services are too expensive
   - o There are not enough providers
   - o There are not enough services
   - o The wait times for treatment are too long
   - o Travel and transportation to services
   - o Stigmas associated with substance use
   - o The COVID-19 pandemic
   - o Lack of paid time off work or sick leave
   - o A lack of trust with Rock County providers
   - o Language barriers
   - o Lack of inpatient treatment services
   - o Not aware of available resources in the community

- Other (please specify)

4. Are there specific barriers that make it difficult to maintain recovery/stay sober?

Select up to 5 options.

- Lack of sober living facilities/safe housing
- Lack of peer support/recovery support groups
- Lack of family and friend support
- Lack of aftercare mental health treatment/counseling
- Lack of aftercare substance use disorder treatment/counseling
- Lack of coordination of services, assistance with navigating system
- Emotional challenges such as stress and stigma
- Lack of transportation to appointments
- Lack of paid time off work or sick leave
- Lack of legal help
- Lack of diversity of providers (e.g., race/ethnicity, gender, sexual orientation, etc.)
- Cost of medication to treat substance use disorder
- Lack of health insurance
- Cost of medication to treat mental health
- Other (please specify)

5. Which services would help prevent substance misuse in Rock County?

Select up to 5 options.

- School-based programming
- Increased availability of school-based behavioral health services
- Increased availability of substance use disorder treatment services in the community
- Increased availability of mental health services in the community
- Parenting classes and support
- Anti-bullying campaigns
- Positive activities for youth
- Screening for early identification of substance use disorders
- Grief support for those who lost a loved one to a substance use disorder
- Educational campaigns about drugs
- Other (please specify)

6. In your opinion, what services or programs would reduce overdose deaths in Rock County?

Select up to 5 options.

- Increased availability of Narcan
- Access to supervised/safe injection sites
- Increased availability of substance use disorder treatment services in the community
- Increased availability of medication- assisted treatment (Suboxone, Methadone, etc.)
- Increased availability of mental health treatment services in the community
- Overdose spike alerts when dangerous supplies are identified
- Increased availability of Fentanyl testing strips

- Access to drug testing sites
- Safe prescribing and disposal of medications
- Increased access or linkages to other support (e.g., faith-based organizations, narcotics anonymous, etc.)
- Other (please specify)

7. Please add any comments or questions.

8. If you would like to share additional thoughts on any of the topics above, please provide your phone number or email below.

APPENDIX A: COMMUNITY SURVEY

Opioid Settlement Survey Results
April-May 2022

Most frequently selected answers for each question in rank order.

Barriers to receiving substance use treatment in Rock County

1. Lack of inpatient treatment
2. Not enough providers
3. Not enough services
4. Wait times
5. Too expensive
6. Stigma
7. Awareness of available resources

Specific barriers to recovery/staying sober

1. Sober/safe living
2. Aftercare for mental health
3. Aftercare for SUD
4. Coordination/navigation of system
5. Emotional challenges-stress/stigma
6. Lack of health insurance
7. Lack of peer support/recovery groups

Substance Misuse Prevention Services

1. More mental health services
2. More substance use treatment
3. School-based behavioral health
4. Screening for early identification
5. Positive activities for youth
6. School-based programming
7. Parenting classes and support

Overdose Death Prevention Services

1. More substance use treatment
2. More mental health treatment
3. Medication for treatment of SUD
4. More Narcan
5. More fentanyl test strips (tie with #6)
6. Linkages to support (tie with #5)
7. Overdose spike alerts

Thank you to everyone who completed the survey. The information gathered will help guide the spending of the National Opioid Settlement Funds.

Public Health

APPENDIX B: LISTENING SESSION NOTES

1) **Treatment Options**
    - Treatment is not accessible when it is most needed
        i. Wait times for detoxification and rehabilitation are too long
        ii. Very few options for "urgent" or "walk-in centers" where someone can get help immediately
    - Low-cost options are a necessity
        i. Affordability of services remains an issue
    - Program length is insufficient
        i. Short-term programs (e.g., 3-5 days) do not address the root causes of the issues that led to drug use, often setting up the individual for failure as soon as they leave the program
        ii. Longer term programs can help individuals reach and maintain sobriety
2) **Transitional Care**
    - Gaps in services can have detrimental effects on an individual's recovery
        i. Someone may go through an initial detoxification and the have a 2-week gap before they can be seen for additional treatment
        ii. Gaps in services provides the opportunity for someone to relapse and fall back into the cycle of use
    - There are opportunities to improve service transition
        i. A position that acts as a liaison or a bridge between service to service for individuals throughout the entirety of their care process would prevent gaps in care
            a. An advocate who is familiar with the systems in place would provide an efficient means of care transition that is difficult to coordinate for families and loved ones
3) **Comprehensive Approach**
    - Mental health and substance use disorders are heavily interconnected
        i. Targeting mental health as a way of preventing substance use disorders is a viable method of primary prevention that focuses on the root cause of issue
    - A comprehensive approach to treatment including mental health services (I.e., therapy, support groups, etc.) is essential to achieve and maintain sobriety
4) **Stigma and Substance Use**
    - Stigma continues to persist for those use drugs and their families
        i. Stigma around drug addiction continues to damage the health and well- being of those who use drugs and their family members
        ii. Stigma can also impact the quality of care being received in clinical settings (e.g., pharmacies, emergency rooms, etc.)
5) **Miscellaneous**
    - Support systems are key
        i. Those with good support from their friends and family have a better chance at maintaining sobriety

- Upstream interventions that target the root causes of issues that can lead to drug use is essential
    i. There are opportunities to reach younger populations with resources on coping and communication skills, or plans of action if drug use is a part of their lives
- Overprescribing of opioids in Rock County continues to be an issue
- Hospital policy can be detrimental to the health of those who use drugs
    i. Many emergency rooms will not take someone who uses drugs unless they are suicidal or have a history of mental illness
        a. This further limits who can get help in these settings
    ii. Stigma in hospital settings like emergency rooms is also so severe that those who use drugs may not see them as a viable option for help

APPENDIX C: CURRENT ASSETS AND RESOURCES

Substance Use Providers
(Medication Assisted Treatment provider in BOLD)

AMS of Wisconsin - Janesville, LLC
1312 Barberry Dr Suite 110, Janesville, WI 53545
Phone: 608-758-1944

Beloit Comprehensive Treatment Center
2240 Prairie Avenue, Beloit, WI 53511
Main Tel: 608-361-7200

CleanSlate Outpatient Addiction Medicine
101 E Milwaukee St Suite 315, Janesville, WI 53545
Phone: 608-305-0201

Compass Behavioral Health Clinic
1820 Center Avenue, Suite 170, Janesville, WI 53546
Main Tel: 608-755-1475

Mercyhealth Behavioral Health
903 Mineral Point Avenue, Janesville, WI 53548
Main Tel: 608-756-5555

Rock County Human Services
Rock County Counseling Center
1717 Center Avenue, Janesville, WI 53547
Main Tel: 608-757-5229

Beloit Memorial Hospital
Counseling Care Center
1969 West Hart Road, Beloit, WI 53511
Main Tel: 608-364-5686

Genesis Counseling Services Ltd
1 South Main Street, Suite 250, Janesville, WI 53545
Main Tel: 608-757-0404

Lutheran Social Services of Wisconsin
1850 Cranston Road, Beloit, WI 53511
Main Tel: 608-752-7660
Intake Tel: 608-752-7660 x5110

Lutheran Social Services of Wisconsin
612 North Randall Avenue, Suite A, Janesville, WI 53545
Main Tel: 608-752-7660 x5110

Mercyhealth Behavioral Health
2825 Prairie Avenue, Beloit, WI 53511
Main Tel: 608-756-5555

Mercy Options Behavioral Health
300 Union Street, Evansville, WI 53536
Main Tel: 608-756-5555

Trivium LLC DBA Crossroads Counseling Center
17 South River Street, Suite 254, Janesville, WI 53548
Main Tel: 608-755-5260

Sober Living Providers

The Micah Project
Main Tel: 608-208-2585
"We are a peer supported sober living residence, for women."

The Red Road House
152 S Locust St, Janesville, WI 53545
Main Tel: 608-756-2592
"...to provide safe and structured transitional housing to alcoholic and drug-addicted adults, giving guidance, understanding, respect and dignity to human beings."

Ruth's House
1263 Cherry St, Janesville, WI 53546
"Ruth's House is a spiritual, transitional living facility for women."

Substance Misuse Prevention Coalitions

BASE- Building a Safer Evansville

JM4C- Janesville Mobilizing 4 Change

MCYC- Milton Community Youth Coalition

Y2Y4Change- Youth 2 Youth 4 Change-Beloit

The Prevention Network- Includes the 4 coalitions listed above plus the Rock County Human Services Prevention Unit

APPENDIX D: REQUEST FOR PROPOSALS (RFP) RUBRIC

Criteria	Limited	Needs Improvement	Promising	Excellent
	1	2	3	4
Evidence Base				
Is the strategy grounded in data and evidence-driven/informed?				
Feasibility				
Organizational Capacity: - Do organizations have enough staffing to carry this out?				
Cost: - Will the funding provided cover the entirety of the strategy (start to finish)? - Will the strategy require sustained funding? - Are costs anticipated to increase or decrease at any point in time? - Are there startup costs?				
Legality: - Is the strategy in compliance with DHS and state guidelines? - Is there any activity that is prohibited?				
Scalable: - Can the strategy be implemented to many communities? - How can the strategy by promoted?				
Sustainable: - Does the strategy address short-term outcomes or long-term outcomes? - How will success be measured? - Will the strategy continue to be successful after using the initial funds?				
Fit				
- Does the strategy fit the identified needs and gaps in Rock County?				

- Will it prevent deaths in the long-term?				
Equity				
- Does the strategy consider equity? - Will the strategy address the needs in the community in a fair and equitable way? - Will there be minimal barriers with respect to implementation?				
Reach				
- Will this reach the most vulnerable in the community?				
Scope of Strategy				
Prevention				
Harm Reduction				
Treatment				
Recovery				

APPENDIX E: SECURITIZATION

PMA

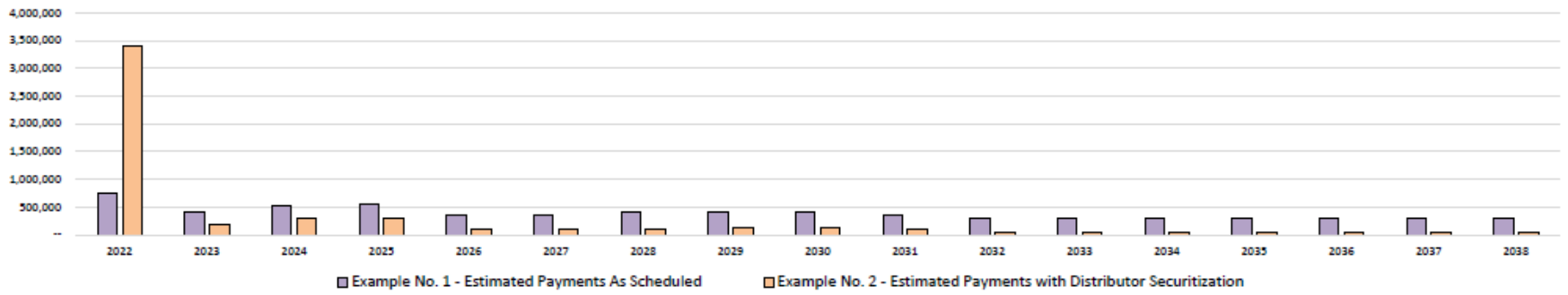
Projected WI LG Settlement Payments (Net of 20% for Legal)
Ex. No. 1 - As Scheduled (No Securitization)
Ex. No. 2 - Distributor Payments Partially Securitized

Rock County

2.947% Share of LG Total

		Example No. 1 - Estimated Payments As Scheduled			
		2.947%	2.947%		
PMT	Year	Janssen Scheduled LG Payment	Distributor Scheduled LG Payment	Total Scheduled LG Payment	Present Value Scheduled PMTs Using USTs
1	2022	81,878	229,991	311,870	311,870
2	2022	191,024	241,710	432,734	432,734
3	2023	152,891	241,710	394,601	386,447
4	2024	234,759	302,534	537,293	510,108
5	2025	260,205	302,534	562,739	518,300
6	2026	46,440	302,534	348,974	312,357
7	2027	46,440	302,534	348,974	303,377
8	2028	46,440	355,816	402,256	339,743
9	2029	59,126	355,816	414,943	340,382
10	2030	59,126	355,816	414,943	331,143
11	2031	59,126	299,099	358,226	278,175
12	2032	--	299,099	299,099	226,045
13	2033	--	299,099	299,099	218,864
14	2034	--	299,099	299,099	211,748
15	2035	--	299,099	299,099	204,703
16	2036	--	299,099	299,099	197,740
17	2037	--	299,099	299,099	190,866
18	2038	--	299,099	299,099	184,088
	Total	1,237,457	5,383,791	6,621,248	5,498,690

		Example No. 2 - Estimated Payments with Distributor Securitization					
		2.947%	2.947%	2.947%	2.947%		
			Distributor LG Payments				
				Securitization			
PMT	Year	Janssen Scheduled LG Payment	Scheduled 2022 PMTs	Proceeds (Est.)	Residual (Est.)	Total Estimated LG Payment	Present Value Estimated PMTs Using USTs
1	2022	81,878	229,991	--	--	311,870	311,870
2	2022	191,024	241,710	2,669,818	--	3,102,552	3,102,552
3	2023	152,891	--	--	40,285	193,176	189,184
4	2024	234,759	--	--	50,422	285,181	270,752
5	2025	260,205	--	--	50,422	310,627	286,097
6	2026	46,440	--	--	50,422	96,862	86,699
7	2027	46,440	--	--	50,422	96,862	84,206
8	2028	46,440	--	--	59,303	105,743	89,310
9	2029	59,126	--	--	59,303	118,429	97,149
10	2030	59,126	--	--	59,303	118,429	94,512
11	2031	59,126	--	--	49,850	108,976	84,624
12	2032	--	--	--	49,850	49,850	37,674
13	2033	--	--	--	49,850	49,850	36,477
14	2034	--	--	--	49,850	49,850	35,291
15	2035	--	--	--	49,850	49,850	34,117
16	2036	--	--	--	49,850	49,850	32,957
17	2037	--	--	--	49,850	49,850	31,811
18	2038	--	--	--	49,850	49,850	30,681
	Total	1,237,457	471,701	2,669,818	818,682	5,197,658	4,935,964
						Difference:	562,726
							89.8%



PMA

Net Distributor Payments to WI LGs (2023-2038)
Ex. No. 1 - As Scheduled (No Securitization)
Ex. No. 2 - Distributor Payments Partially Securitized (No Reinvestment)
Ex. No. 3 - Distributor Payments Partially Securitized (Reinvested)

Rock County

2.947% Share of Total

	Year	Example No. 1 Do Not Securitize Est. Payments	Example No. 2 Securitize - DO NOT Reinvest Est. Cash Flow	Example No. 3 Securitize - Reinvest Est. Cash Flow
	2022	--	2,669,818	--
1	2023	241,710	40,285	241,710
2	2024	302,534	50,422	302,534
3	2025	302,534	50,422	302,534
4	2026	302,534	50,422	302,534
5	2027	302,534	50,422	302,534
6	2028	355,816	59,303	355,816
7	2029	355,816	59,303	355,816
8	2030	355,816	59,303	355,816
9	2031	299,099	49,850	299,099
10	2032	299,099	49,850	299,099
11	2033	299,099	49,850	299,099
12	2034	299,099	49,850	299,099
13	2035	299,099	49,850	96,457
14	2036	299,099	49,850	49,850
15	2037	299,099	49,850	49,850
16	2038	299,099	49,850	49,850
	"Nominal" Total:	4,912,090	3,488,500	3,961,699
	"Nominal" Capture:		71.0%	80.7%
	"Present Value" Total:	3,879,053	3,316,327	3,263,120
	"Present Value" Capture:		85.5%	84.1%
	LG Distributor Payment Risk:	100%	17%	17%

Notes:
Present Value calculations are based on individual U.S Treasury rates over each of the 16 years. (years 2023-2038)
Settlement payments or the securitized proceeds thereof are considered moneys of the local government under S. 66.0603 (1m). (i.e., 7-year maximum maturity)
Investment returns in Example No. 3 are based on (i) 7-year US Treasury over first seven years and (ii) 1.00% thereafter.
In Example No. 3 the County receives the same annual payment for the first 12 years, and receives approximately 20% of scheduled payments in years 13-16.
The 84.1% P.V. Capture in Ex. No. 3 is lower than the 85.5% capture in Ex. No. 2 because investment rate beginning in year 8 (2030) is 1.00%. (lower than current U.S. Treasuries)

EXHIBIT E

List of Opioid Remediation Uses

Schedule A
Core Strategies

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

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

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

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

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

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

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

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

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

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

C. PREGNANT & POSTPARTUM WOMEN

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

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

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

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

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

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

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

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

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

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

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

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

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

F. TREATMENT FOR INCARCERATED POPULATION

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

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

G. PREVENTION PROGRAMS

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

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

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

4. Funding for community drug disposal programs; and

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

H. EXPANDING SYRINGE SERVICE PROGRAMS

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

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

Schedule B
Approved Uses

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

PART ONE: TREATMENT

A. TREAT OPIOID USE DISORDER (OUD)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14. Create and/or support recovery high schools.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. ADDRESS THE NEEDS OF CRIMINAL JUSTICE-INVOLVED PERSONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PART TWO: PREVENTION

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

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

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

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

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

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

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

1. Increase the number of prescribers using PDMPs;

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

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

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

7. Increasing electronic prescribing to prevent diversion or forgery.

8. Educating dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

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

1. Funding media campaigns to prevent opioid misuse.

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

3. Public education relating to drug disposal.

4. Drug take-back disposal or destruction programs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Public education relating to emergency responses to overdoses.

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

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

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

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

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

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

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

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

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

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

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

J. LEADERSHIP, PLANNING AND COORDINATION

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

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

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

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

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

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

K. TRAINING

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

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

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

L. RESEARCH

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

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

2. Research non-opioid treatment of chronic pain.

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

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

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

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

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

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

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