Opioid epidemic gap analysis: Pinellas County

Evaluation and gap analysis of the current state of the opioid epidemic and abatement programming in Pinellas County to inform use of opioid abatement funds

October 2024

Contents

Foreword

This report (the Report) was prepared by Ernst and Young LLP (EY) at the request of Pinellas County leadership. The Pinellas County Board of County Commissioners (BCC), upon recommendation of the Pinellas County Opioid Abatement Funding Advisory Board (OAFAB), engaged EY to perform the gap analysis and study of leadership, planning, and coordination opportunities related to opioid abatement services and supports.

The views and insights expressed in the Report were produced by EY and informed by qualitative research insights from interviews, listening sessions, and site visits, as well as quantitative insights from secondary research and thousands of survey responses.

Limitations and restrictions

The Report is not an audit of the services offered in Pinellas County, nor an assessment of the organizations providing care or any services therein. The Report summarizes findings and analysis of the system of care for opioid use disorder (OUD), identifies gaps and defines allowable recommendations to address those gaps. The Report is not an evaluation of behavioral health or mental health services in Pinellas County. As OUD and other behavioral and mental health disorders often co-occur, the Report identifies behavioral health services that are not limited to OUD, however, it does so only in the context of co-occurrence with OUD.

Throughout the gap analysis project and despite the stated willingness of stakeholders to collaborate, the EY team experienced some notable challenges, particularly with data access and acquisition. Issues with timeliness and in some cases complete non-receipt of data were frequent; reasons included but may not be limited to perceived ownership, policy restrictions or the absence of the data itself. In some cases, stakeholders declined to engage. For example, surveys that Pinellas County Human Services distributed to hospital leadership and to employer networks only received n = 5 and n = 3 responses, respectively. These challenges and limitations have shaped the recommendations in the Report, reflecting the realities of the system-level data in the county.

While the Report may provide advice and recommendations to the OAFAB, under the authority of the BCC, the Pinellas County government is responsible for any prioritization, decision to execute or implement any such advice or recommendation, the actual execution or implementation of any thereof, and the results of such implementation. EY makes no representation, warranty or other statement as to whether the advice, recommendations or any strategies contained therein may be effectively or successfully implemented by Pinellas County government, or with respect to any results thereof.

Section 1

Executive summary

The opioid epidemic is a public health crisis across the United States. In 2022, nearly 500 Pinellas County (the county) residents lost their lives to a fatal opioid-related overdose.

Pinellas County has invested significant resources and efforts in aligning programming, services and capabilities to meet the needs of individuals with Opioid Use Disorder (OUD) in an effort to reduce overdoses and deaths across the county.

In 2023, Pinellas recorded a 21% decline in the number of overdose fatalities.[1] Notably, this is the first decline in overdose deaths since 2018. While it may be too early to establish these results as a trend, they are indeed positive.

As a condition of settlement agreements from thousands of lawsuits against manufacturers, pharmacies and other groups associated with the prescription opioid epidemic, Florida will receive more than $3 billion dollars in funding over the next two decades. In 2021, the Florida legislature established a funding framework for how these settlement dollars will flow to counties and cities.[2]

Pinellas County is slated to receive more than $100 million through two sets of funds over the next 18 years. This gap analysis and strategic prioritization focuses on the Regional Funds, which Pinellas County received through its status as a Qualified County in the Florida Opioid Allocation and Statewide Response Agreement.

As of April 2023, Pinellas County has access to $13 million of Regional Funds.[3] The Opioid Abatement Funding Advisory Board (OAFAB), under the authority of the Board of County Commissioners (BCC), is responsible for directing the Regional settlement funds to make the most significant impact for Pinellas County. The OAFAB commissioned a scope of work to identify the needs of the community, gaps in services, and identify leading or emerging practices being recommended by academic organizations, government agencies, non-governmental organizations, and other counties. This Report is the output of that work.

This gap analysis and needs assessment Report includes findings from multiple research efforts, including:

- Analysis of services available across Pinellas County for individuals with OUD
- Qualitative research insights from hundreds of hours of interviews, listening sessions, and site visits
- Thousands of responses to a survey that was fielded between June and July of 2024 to collect the voice of residents (including those with lived experience), family members and visitors to Pinellas County

This Report, organized into discrete sections, outlines the information and feedback of the community, summarizes the identified gaps, identifies leading and emerging practices, and presents recommendations for Pinellas County's consideration for use of the opioid abatement funds. EY also moderated a session in which a group of participants (including community stakeholders) prioritized these recommendations. These priorities informed aspects of the analysis to assist the OAFAB and BCC in prioritizing initial funding allocations.

This community input is particularly relevant. Pinellas County, with a transparent approach to public participation in government, is among the leading counties around the country in initiating proactive, participatory, and specific engagements of different stakeholders. This engagement establishes the fact-base

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[1] Pinellas County Medical Examiner
[2] National Opioid Settlement (2021)
[3] Regional funding is overseen by the OAFAB. Separate city/county funding has been allocated to municipalities and the county government. The city/county funding today is being used to fund Pinellas Matters, a hospital bridge program discussed at several points in this report.

and needs for where and how to direct opioid abatement funds. Indeed, in a report by the Kaiser Family Foundation, it was noted that in some cases state opioid abatement councils (or equivalent) routinely block public participation, limit video use, meet in private, or do not engage public stakeholders for input on needs or spending discussions. [4]

This Report is intended to serve as a foundational point of understanding, at a point in time (current as of October 2024), regarding the current state of services, needs, and opportunities for opioid abatement in and across Pinellas County from the perspectives of providers, families, individuals with lived experience, and the broad constituency.

It should be noted that this Report is not an audit of the services offered in Pinellas County, nor an assessment of the organizations providing care or any services therein. This Report summarizes findings and analysis of the system of care for OUD, identifies gaps and defines allowable recommendations (within the approved uses as defined by the Florida Attorney General's Office, legislatures, and/or local ordinance as relevant) to address those gaps.

This Report is not an evaluation of behavioral health or mental health services in Pinellas County. As OUD and other mental health disorders often co-occur, this Report identifies behavioral health services that are not limited to OUD; however, it does so only in the context of co-occurrence with OUD.

Lastly, there are many indications throughout the Report that highlight data received from providers or other groups which limit the interpretability or may be incomplete. This is particularly true for the inventory of services research. EY identified approximately 60 providers/organizations that were believed to provide some level of service directly to individuals with OUD and sought to validate that through a questionnaire. The questionnaire was sent to identified contact information obtained through public sources. The response rate confirmation was very low (<20%). In other cases, despite requests for access, information collected at the county level through various organizations was not available for further analysis or comparison — including requests to the state-contracted managing entity of public behavioral health services and relevant state agencies.[5]

The following pages describe the work performed, which culminated in a set of 16 recommendations for the OAFAB and BCC's consideration. EY conducted an inventory of services, sourced leading practices, interviewed stakeholders, surveyed residents, and held listening sessions in order to inform a gap analysis. This gap analysis then informed recommendations, which have been further prioritized and refined with constituent engagement.

Inventory of services

EY collected and aggregated information regarding services and practices in Pinellas County. This inventory of the OUD-related programs, facilities, housing providers, and health service providers in Pinellas County provides a view of services available to residents.

Developing the inventory required extensive secondary research collecting data and information through state licensing lists, third-party aggregators and other publicly available reports. Following introductions from Pinellas County Human Services (PCHS), EY also conducted interviews with providers, program leaders, and funders to better understand the services offered, who has access (including eligibility or exclusion considerations), and how the service may meet individual needs, such as care for co-occurring conditions.

The inventory of services was a multiple-month, broad documentation effort; in conducting this analysis, EY also identified difficulties that individuals (families, caregivers, providers, individuals with OUD) experience when seeking care or information about available services.

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[4] Pattani et al. (2024)

[5] State agencies, including the Managing Entity, did sometimes share data. However, it was almost always simple and aggregated, making it useful for a high-level view but not more. More information about data shared is available in the Appendix.

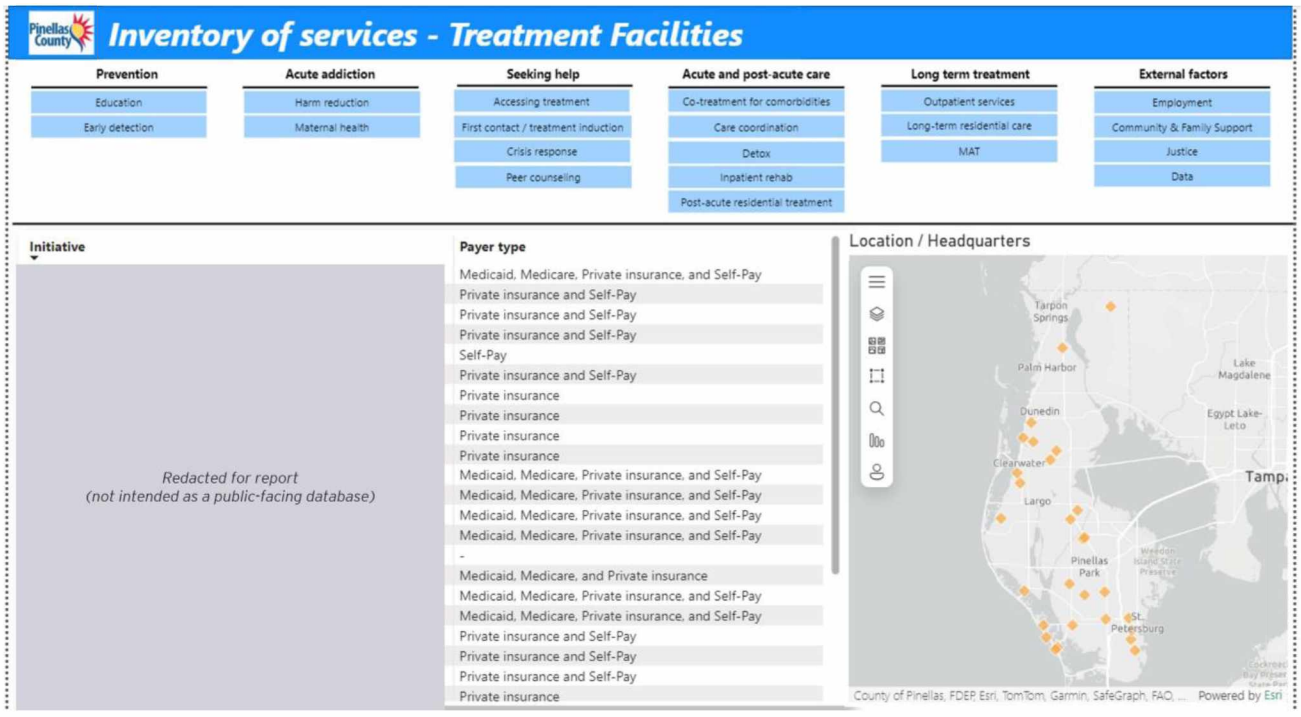
The information regarding all identified services was aggregated into a working document and shared with Pinellas County Human Services (PCHS). The information was also converted into a more dynamic and visual user interface using Microsoft Power BI (see Exhibit 1 with an illustrative screenshot). Visual mapping and selecting of specific service categories or provider types enabled additional insight and hypotheses explored in the interview programs, site visits, and community listening sessions.

While EY sought to confirm service inventory data over a period of several months, responses were insufficient to suggest the completeness and accuracy of all information. Due to these challenges, current materials are not considered a complete or exhaustive inventory of services in Pinellas County.

The inventory identified ~55 health service providers and facilities, after which EY approached all of these organization seeking to verify each location's services, eligibility criteria, payment type accepted, and bed capacity, as well as other information that was listed in the public domain. Only 30% of health service providers and facilities (accounting for ~33% of locations) verified their services despite repeated phone and email-based outreach. The lack of validation meant that the inventory was used as a qualitative resource instead of a systematic, quantitative, method to identify gaps.

Throughout this process, challenges were encountered when trying to confirm service details via desk research (e.g., going into providers' websites and/or using third-party service aggregator websites). Of note, a public, validated information portal that could be used by providers and/or residents was identified as a point of need and value during subsequent research performed in this assessment.

Exhibit 1: Sample output of service inventory, treatment facilities redacted



The index of health service providers, facilities, programs and housing providers can be found in Appendix B (Inventory of Services).

Leading practices

The leading practices index represents information collected from academic and non-academic sources including peer-reviewed publications and reports from leading organizations, think tanks, academic groups, and other reputable sources. These recommended practices were aggregated in a single catalog for reference.

The literature review approach relies on reputable organizations that have legacy expertise in SUD treatment and supports. These reports are shown fully in Table 2 in Section 2 but draw heavily from authoritative sources such as Substance Abuse and Mental Health Services Administration (SAMHSA), National Institute on Drug Abuse (NIDA), the American Society of Addiction Medicine (ASAM), and the Centers for Disease Control and Prevention (CDC). Together, these reports reflect system-level inputs regarding leading practices.

EY also evaluated additional peer-reviewed publications and scanned public reports and interviews to identify emerging practices that delivered positive outcomes in other counties, states, and countries. These emerging practices, which constitute new(er) or innovative programs that have not been widely recognized as evidence-based practice, were sourced through secondary research and public reports. These practices were identified as part of city, county, state, and even international initiatives and added as a secondary layer of practices, complementary to the leading practices index. The sources include peer-reviewed journals such as the *Journal of the American Medical Association, Journal of Substance Use and Addiction Treatment, Harm Reduction Journal*, and *Drug and Alcohol Dependence*, among several others. The full citation list of publications used to develop the summary of leading practices is found in Appendix A (Literature review and citations).

This literature scan and analysis yielded more than 100 leading and emerging practices across the Continuum of Care (CoC) that suggested potential for positive impact in Pinellas County through further understanding of existing services, needs, and gaps. The CoC is an organizing framework that represents the non-linear journey of an individual with OUD and is discussed in greater detail in Section 4.[6] The identified practices were then used to generate hypotheses and questions that directed the qualitative and quantitative research efforts in Pinellas County, including the interviews and surveys. A full list of leading practices can be found in Section 5.

[6] Note that Continuum of Care here and throughout the remainder of the report refers to the framing device introduced in the *Overview of Gaps and Recommendations* section above, and further described in the *Introduction to the Continuum of Care* section below. It does not, unless specified, refer to the Homeless Leadership Alliance's Continuum of Care program.

Trade-offs between leading practices

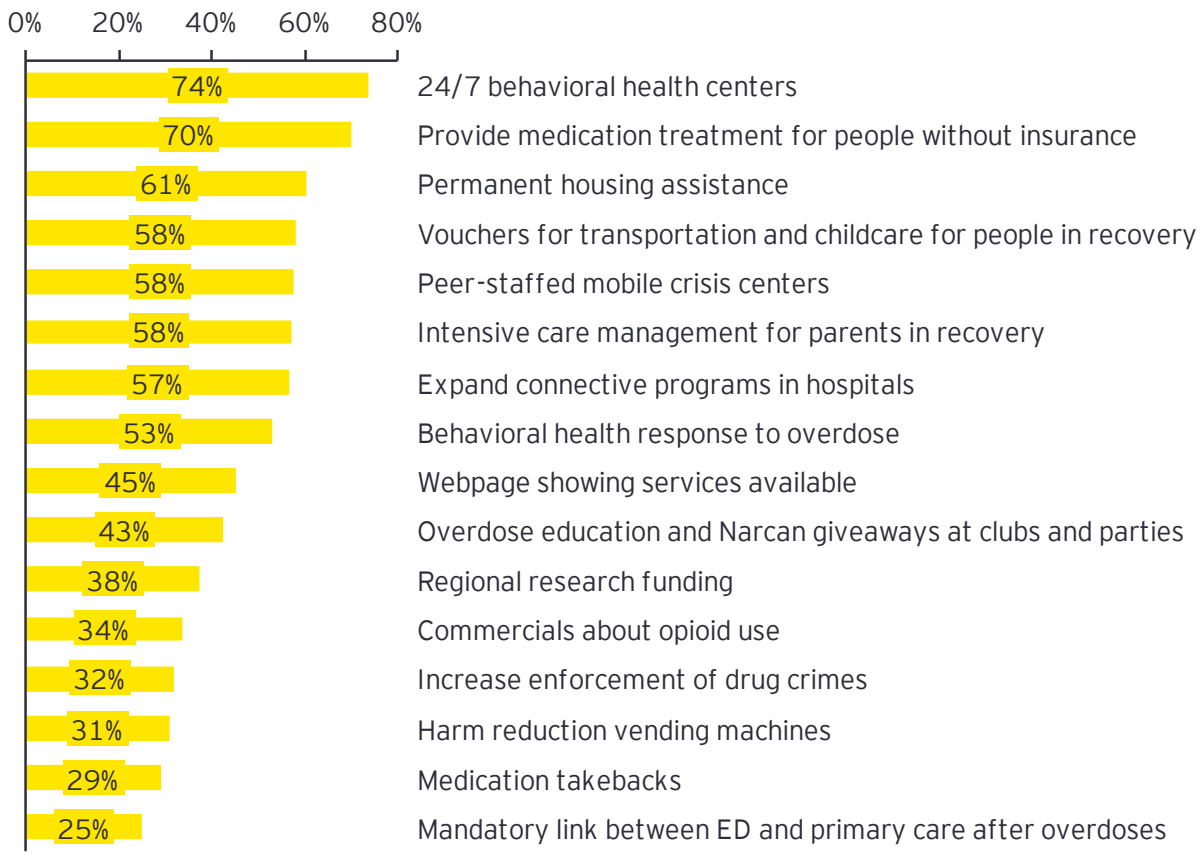
Initial survey responses and interviews narrowed the list of ~100 leading practices into a short list of 16 regularly cited leading practices for constituents to evaluate in the survey. These practices include innovations currently in Pinellas County (e.g., providing medication treatment for people without insurance), concepts that are new to the county (e.g., harm reduction vending machines), and expansion of existing programs (e.g., behavioral health response to overdoses).

In the constituent survey, respondents were presented with a randomized sample of two leading practices (from the short list of 16) and asked to state their preference between the two. Each respondent had the opportunity to answer this question for two pairs of practices. Since the survey was open to anyone in Pinellas County, regardless of SUD knowledge, the question came with a detailed explanation of each choice. There were more than 1,500 responses to this question, the results of which are displayed in Exhibit 2.

Aggregated responses offer a view into which practices were preferred on a relative basis, because every possible combination of two practices were shown to roughly the same number of respondents. Practices associated with clinical care score highest, followed by wraparound services. Leading practices associated with harm reduction or general healthcare were less preferred.

These preferences and trade-offs provided additional insight for the gap analysis as another data point regarding constituent preference and need. For areas where data was difficult to access (such as the usage of transit and childcare subsidies), the relative demand for practices like "vouchers for transportation and childcare for people in recovery" provided important evidence that a gap exists.

Exhibit 2: Constituent preferences in leading practices (n = 1,510)



Summary of gaps and recommendations

The gap analysis presented is grounded in a Continuum of Care relevant to OUD, which serves as the consistent framework throughout this Report. This continuum does not represent a linear journey that all individuals with OUD progress through sequentially but is instead a framework to encompass and categorize the range of relevant services and supports across prevention, treatment, and recovery. The CoC is shown in Exhibit 3:

Exhibit 3: Continuum of Care and supporting factors

Continuum of Care

Prevention

Education
- Enhancing individuals' knowledge and behaviors regarding opioid use, harms, and prevention tactics; includes programs directed towards youth, adults, and professionals in relevant fields

Early detection
- Creating proactive strategies and tools that identify the risk of opioid overdose early on; identifying common triggers and precursors to OUD with high-risk individuals

Acute addiction

Harm reduction
- Minimizing potential health risks and social harms linked to opioid use; improving the health of people who are actively using illicit opioids

Maternal health
- Meeting the unique needs of pregnant women and new mothers in the context of OUD

Seeking help

First contact / treatment induction
- Treatment referrals initiated by providers, law enforcement, or other groups besides the patient

Crisis response
- Caring for an individual in crisis, either through proactively helping someone in need or responding to a call for help

Peer specialists
- Outreach, support, mentorship, and guidance provided by certified individuals with lived experiences of addiction and recovery

Access to treatment
- Widening the reach of effective OUD treatment services; leveraging moments of crisis to offer care, such as emergency department visits

Acute and post-acute care

Care coordination
- Personalized and actively managed programs that combine acute care from different sources (e.g., social work, public assistance, Medication-Assisted Treatment (MAT))

Detox and inpatient rehab
- Programs aimed at managing withdrawals or a transition to sober life, generally shorter term (<30 days) and reserved for medically unstable individuals

Post-acute residential treatment
- Programs providing OUD-related care in a facility in which the patient lives, frequently for 30 days or longer and with varying levels of supervision

Co-treatment for comorbidities
- Treating other illnesses (e.g., HIV, Hep-C, mental illnesses) under the same roof as ongoing Substance Use Disorder (SUD) / OUD treatment

Long-term maintenance treatment and recovery

Medication-Assisted Treatment
- Prescribed medication to treat OUD (MOUD), along with appropriate medical supervision

Outpatient services
- Programs occurring outside of inpatient settings aimed at maintaining an individual's recovery, including regular outpatient services, in-home services, and intensive outpatient services (>10 hours / week)
- Includes MAT, behavioral therapy and counseling

Long-term residential support
- Post-acute-treatment residential facilities that support recovery by providing a safe, drug-free living space specifically for individuals in recovery

External supporting factors

Housing
- Housing support for those recovering from addiction, returning from prison, and / or experiencing homelessness, including emergency shelters, transitional housing, permanent supportive housing, and subsidized housing

Community & family support
- Community, friends, and family involvement to help with recovery; services can involve assistance in accessing healthcare, housing, etc., as well as mutual support groups

General healthcare
- Non-OUD-specific healthcare (e.g., primary care, hospital care, etc.) for individuals with OUD

Mobility
- Transportation support to help people in recovery access jobs, treatment, community, and family; services can look like actual mobility or transit-oriented development and care

Employment
- Job training, placement assistance, and career counseling for people searching for a job; services can include support groups to help maintain a stable job or legal assistance if needed

Justice
- Improved conditions in correctional facilities to spur better health, safety, and treatment; pathways towards alternative justice (e.g., drug courts), notably for populations like veterans or individuals with OUD or mental illness

System-level considerations

Governance
- Governance model to guide abatement strategy; includes accountability decision-making models

Data
- Process improvements to effect changes in the continuum of care and in external supports

Identified gaps

The landscape analysis and stakeholder research identified multiple gaps along the Continuum of Care. After confirming the existence of each gap through multiple points of evidence and cataloguing the effects of the gap; each gap was then aligned to a category of the CoC.

Still, the "organizing framework" of the CoC does not always extend to the gaps. The Report aims to represent gaps in discrete sections, but the gaps may have relationships in or with more than one of the CoC domains. The Report notes that distilling the OUD experience into a multi-category CoC may not be reflective of every potential individual experience, and that the OUD user journey is not linear. Accordingly, the findings in this Report are a representative and robust set of information on gaps that exist in the Pinellas County system of care that have been summarized and matched to the most appropriate area of the CoC.

Several themes appear across gaps in different categories of the CoC, while other themes are notably less present. For example, gaps in clinical service affordability are present across several areas of the CoC, from when an individual is first seeking help to long-term recovery. Other systemic issues such as care coordination create gaps in clinical and non-clinical care.

Some hypothesized gaps at the beginning of the research were observed less frequently. In the gap analysis, the quality of clinical care is consistently regarded as high, and the only quality gap cited multiple times is specific to behavioral health.[7] Maternal health is also a notable area of strength in the county; clinical care and wraparound services are regarded as successful, and gaps in maternal health were only related to willingness to access care. While individuals with OUD face difficulty in accessing non-OUD healthcare like dental care and primary care, these challenges were not reported to be greater than those experience by other individuals of similar socioeconomic backgrounds.

Gaps summary

Prevention

There is a gap in public awareness and understanding of the opioid epidemic in Pinellas County, with a particularly pronounced lack of familiarity among younger and older residents. There is a deficiency in both the knowledge of how to access prevention resources and the perceived effectiveness of existing programs. This hinders the community's ability to support individuals in navigating care and treatment options, and also exacerbates the stigma associated with OUD.

Acute addiction

Broad adoption of naloxone is a gap, despite high distribution rates and significant growth in the distribution of naloxone kits. While those with lived experience are more likely to access free naloxone, there is a need for wider availability in high-risk settings, increased public education on its use, and legal protections for those administering it in emergencies. Additionally, the county's sole syringe service program (SSP) faces geographical and operational limitations due to restrictive local and state regulations, impacting its reach and effectiveness. Fentanyl test strips, a newer harm reduction tool, are not yet widely distributed, with varying opinions on their utility. Lastly, maternal healthcare use is hindered by fears of stigmatization and child removal among mothers with OUD, despite the availability of supportive programs and a decline in neonatal abstinence syndrome (NAS) rates that indicates progress around maternal health for OUD.

Seeking help

There are several gaps in the initial contact and entry into care for individuals with OUD in Pinellas County. Providers and community-based organizations (CBOs) face challenges in connecting individuals to the necessary care before a crisis occurs, with barriers such as lengthy screening and administrative processes deterring or delaying care entry. Research also identified a gap in

[7] EY interviews

front-line physician training, with primary care physicians (PCPs) often hesitant to engage in opioid-related treatments due to a lack of training and resources. The implementation of the Marchman Act, intended for immediate involuntary crisis care, is limited by the absence of a non-jail receiving facility. Peer supports, recognized for their unique ability to foster trust and hope and provide empathetic guidance, are underutilized due to hiring and retention challenges. Public awareness of available services remains low, impacting individuals' ability to seek help. Affordability issues further hinder access to care, particularly for the uninsured and underinsured; however, those who would like to pay out of pocket may also be prevented from receiving care if they are unable to fully fund the treatment. Finally, perceptions of waitlists by both the public and professionals alike, which may or may not exist depending on the provider and facility, result in limiting access to care.

Acute and post-acute care

Quick Response Teams (QRTs) show limited impact in connecting individuals to follow-up treatment after an overdose, with structural limitations and operational differences affecting their success rates. Health information sharing among providers is inconsistent (constrained by regulatory concerns or perceptions), which impacts care coordination and leads to redundant screenings and delays in treatment. The cost of detox and inpatient services poses a significant barrier, especially for low-income individuals, due to limited subsidized options and the perceived expense of available programs. Research indicated there is a need for more low-cost or subsidized residential treatment capacity for post-acute care, as current facilities either have waitlists or are too expensive. Lastly, the treatment of co-occurring conditions is not consistently provided in a co-located manner, despite the benefits of integrated care for engagement, satisfaction, and patient outcomes.

Long-term maintenance treatment and recovery

The analysis identified several gaps in MAT and medication for opioid use disorder (MOUD), outpatient services and long-term residential care in Pinellas County. High costs of care, both direct and indirect, are cited as the most common barrier to accessing MAT/MOUD, with many individuals unable to afford the daily expenses associated with treatment. Stigma toward MOUD, particularly methadone, persists among healthcare workers, some sober housing providers, and within the community, discouraging individuals from seeking evidence-based medication treatments. In Pinellas County Jail, incarcerated individuals are generally unable to receive MOUD, leading to painful withdrawal and increased overdose risk upon release. Assertive Community Treatment (ACT) teams are under-resourced and limited in number, unable to meet the demand for intensive in-home care. Barriers to behavioral healthcare include long wait times, high costs, and perceived low quality of services. A shortage of high-quality recovery housing, with limited spaces in accredited facilities and financial barriers to placement is also noted, highlighting the need for more accessible, affordable, and stigma-free housing options for those recovering from SUD.

External supporting factors

External supports for individuals with OUD in Pinellas County include broad, macro-themes that relate to individual independence and success. Gaps in these supports highlight needs related to housing; community connections, including areas specifically for individuals in recovery; accessible childcare; grief support services, transportation; employment assistance; and increased utilization of diversion programs.

Housing access

There is a significant barrier to stable housing for those with OUD, with a lack of access across various housing types, including transitional, permanent supportive, and subsidized housing. High housing costs, limited capacity in transitional and permanent supportive housing, and closed waitlists for subsidized housing are examples, particularly affecting those with lower incomes or in recovery.

Community and family supports

There is a need for more social and communal spaces for individuals recovering from OUD to build supportive networks, with existing spaces like recovery housing and Alcoholics Anonymous (AA)/Narcotics Anonymous (NA) groups not being universally accessible or appealing. Access to childcare is also significant barrier to treatment participation for parents with OUD, with issues related to childcare center location concentration and financial constraints. Pinellas County also lacks widespread grief support services for those impacted by overdoses, with existing services not well-known.

General healthcare

While this study did not find specific gaps in general healthcare in Pinellas County, there are some areas where general healthcare for individuals with SUD is lacking due to state-level decisions. For example, Florida's lack of Medicaid expansion under the Affordable Care Act affects access to healthcare for nonelderly adults with low income, as this group is disproportionately represented in populations experiencing SUD. However, Pinellas has several places of strength in general healthcare, such as a high density of primary care providers. And as shown in Exhibit 10, Pinellas County has a strength in access to physical activities and health/wellness options, both relative to Florida and the nation.

Mobility

Transportation barriers hinder access to services for individuals without cars in a community where public transit is limited, resulting in lengthy travel times and/or costly expenses. Solutions like transit-oriented development, co-located services, and mobile health units are suggested to alleviate these challenges.

Employment support

Finding employment is difficult for individuals with OUD. This is often due to stigma, difficulties in balancing treatment appointments with employment work schedules, and/or past justice involvement. Employment services and anti-stigma campaigns are needed, along with support for those employed but facing health or privacy challenges.

Justice

Criminal justice diversion programs and alternatives to incarceration programs in Pinellas County, such as the Adult Drug Court, have opportunities to engage more individuals to expand within the current capacity. Increased awareness and encouragement to participate could help keep more individuals with OUD out of incarceration.

System-level considerations

In Pinellas County, the efforts to combat OUD are limited by a lack of centralized governance and strategic coordination. Research identified many organizations operating in "silos" without a unified approach or an authorized body that organizes system-level efforts. This fragmentation results in misalignment, redundancy, and/or potential gaps in service. Additionally, the effectiveness of these efforts is impacted by limited data sharing between organizations, thereby challenging a comprehensive, systems-level understanding and view of the situation in Pinellas County. Currently, there is no ability to explore the application of advanced analytics to target service delivery, develop risk pools, or determine the true impact of specific strategies or targeted interventions. Previous PCHS efforts to do modeling and analysis of this type have acknowledged challenges in interpreting their results due to data sharing limitations in the region.[8]

[8] See Johnson et al. (2024) for a peer-reviewed study centering on Pinellas County that acknowledges data limitations when working with some local stakeholders.

Prioritized recommendations

Recommendations were developed by aligning gaps to identified leading practices, emerging practices, and insights from other research workstreams. In total, 16 recommendations were aligned to gaps across the CoC for consideration. These recommendations were not initially presented in order of priority. PCHS invited key stakeholders from the Pinellas County opioid abatement community to participate in a ranking session and provide their perspectives for Pinellas County's prioritization. The resulting prioritization recommendations are noted below, with more details available in Section 6.

1 Improve access to safe and high-quality housing for individuals in recovery [prioritized]

Housing is prohibitively difficult to access for people in recovery, as they are actively working to "recover" resources that maintain and improve their personal health and wellbeing. Market-rate housing prices in Pinellas County are rising faster than inflation and wages, and supportive housing options like transitional housing and permanent supportive housing are often at capacity.

To address the shortage of supportive and recovery housing in Pinellas County, stakeholders recommend increasing access across the spectrum of recovery-specific housing, from respite housing to independent living. Community stakeholders believe that a reasonable goal is tripling the number of high-quality recovery beds within five years. This could be accomplished by supporting operators to achieve Florida Association of Recovery Residences (FARR) accreditation through financial and technical assistance. These residences could be tailored to individuals with SUD and provide an alternative entry point to the existing process managed by the Homeless Leadership Alliance. Building more recovery-specific beds could increase the quality of the recovery housing supply but may require coordinating with an oversight agency for operational guidance.

2 Enhance care coordination and individual-level data management [prioritized]

Pinellas County stakeholders suggest funding to explore the requirements of a technology platform that functions as a single access point to care with coordinating information and (potentially) individual-level interaction data. Community stakeholders suggested continued review and potential expansion of the recent "Care About Me" program through enhancements to service connection and tracking.

The proposed platform could address current gaps by simplifying access to treatment, consolidating case management, and providing real-time information on service availability. The platform could enable better linkage to services and improve health outcomes. Integrating case management, service navigation, and data analysis into one platform could also result in cost savings and better support for individuals across the CoC, while aiding oversight agencies in creating more responsive care improvements.

3 Expand the role of peer specialists [prioritized]

Peer specialist roles could be redefined to better serve the specialists and individuals in recovery, enhancing treatment outcomes and improving job sustainability in the peer role. Stakeholders suggest that abatement funding should facilitate easier access to certification, particularly for those with prior justice involvement, and encourage employers to reimagine peer roles for long-term engagement.

Funding could improve workplace conditions for peer specialists, ensuring equal treatment and career progression opportunities, with the potential for better care continuity and economic benefits for the community. Additionally, there are opportunities to integrate peer specialists more fully throughout the CoC (e.g., in Crisis Stabilization Units (CSUs), QRTs, emergency departments (EDs), etc.) and other public-facing roles (e.g., outreach), as seen in other jurisdictions, to maximize their impact along the CoC.

4 Expand harm reduction opportunities across the CoC, with a focus on training medical providers [prioritized]

There is a continuous need for expanding harm reduction programs, and the community specifically advocated for training medical providers in harm reduction techniques to address substance use more effectively and to combat stigma faced by individuals in active use or recovery. These providers would include those who often meet individuals who have OUD, including non-physician providers in places like methadone clinics. Proposed additional initiatives include raising awareness of Good Samaritan laws, public overdose education, distribution of fentanyl test strips, and high-impact naloxone distribution.

5 Establish long-term funds to pay for OUD care [prioritized]

Individuals with OUD who are uninsured or underinsured face expensive treatment, waitlists for subsidized services, and difficulty coordinating care. Stakeholders believe that abatement funds could help establish a long-term fund for OUD care. This fund could be similar to the Ryan White funding model for HIV, which provides funding for coordinated care to individuals with HIV who cannot pay out of pocket, along with funding external needs like transportation and housing. This OUD-specific funding could be more expansive than clinical care alone and be organized and distributed through PCHS or a contracted third-party managed by PCHS.

The funding should be flexible, for the individual to use as needed on various expenses including treatment, transportation, housing, childcare or other associated expenses. This recommendation should involve some oversight or reporting; it could fit within the existing capabilities of PCHS or could be overseen by another contracted body. This fund could provide services — such as MAT, detox, transportation, or outpatient treatment — to as many people as funding allows. Based on benchmarking analysis, foundational funding could start at $20,000–$30,000 per individual per year.[9] The positive effects of this recommendation, which focus on improving treatment access, recovery, and retention, are likely to also be magnified if the care coordination recommendation (Recommendation 2) is funded and operationalized.

6 Re-organize the coordinating body to establish a single point of authority for abatement efforts in Pinellas County [prioritized]

Stakeholders perceive that no single person or entity is viewed as the authority for organizing abatement efforts in Pinellas County, either for settlement funding or broader abatement goals. This new coordinating body could have a single leader with behavioral health and substance use expertise, and preferably relationships and experience in Pinellas County, including with communities with lived experience. The entity could be responsible for policy prioritization, meeting with decision-makers, strategy, oversight, and being the public face of abatement efforts. A small, dedicated team could support the leader with opioid abatement programming, advocacy and policy initiatives, and facilitate cross-entity collaboration on key initiatives such as data sharing, coordination, education, and other strategic priorities.

7 System-level data governance and data capabilities [prioritized]

Data-sharing between provider organizations, community organizations, and funders is often sporadic. If Pinellas County created a "Data Governance Council" — perhaps through the new coordinating body — those organizations could be brought together to develop a data-sharing framework for agreement and governance at a system level. Pinellas should also fund a "Data Capabilities Team," which could oversee data collection, insight generation, and progress reporting for organizations in the county that need assistance with data management. This team could be focused on helping smaller organizations that require support to build IT

[9] See Barocas et al. (2022) and Recommendation 5 for details.

systems or that need help with grant-writing capabilities. Given that the Data Capabilities Team and the Governance Council could work closely together, it will be crucial to establish that the appropriate members are selected for both so that frequently collected data would be used promptly and appropriately.

8 Expand access to programming in justice settings

Justice settings are often associated with diminished health outcomes. By increasing early diversion programs, making MOUD available in jails to others besides pregnant females, and providing naloxone upon release from carceral settings, jails and justice affiliates could improve those outcomes. These stakeholders could assess existing alternatives to incarceration to expand eligibility and assess success. Implementing MOUD in jails would allow for treatment continuity and prevent painful withdrawal in jail. Providing naloxone upon release could reduce post-release overdose fatalities. Expanding specialty drug courts and focusing on alternatives to incarceration could require substantial investment but could lead to reduced incarceration and recidivism.

9 Launch a broad prevention campaign to raise awareness about the epidemic

There is a public awareness gap regarding the opioid epidemic, with a significant portion of residents lacking familiarity with the issue and existing efforts to combat it. To address this, county agencies could launch a comprehensive, multi-platform media campaign to educate the public, particularly targeting high-risk groups and ensuring inclusivity across demographics. The campaign could build upon existing anti-substance education and naloxone training in schools, expanding these efforts to include opioid-specific content and making them accessible to the wider community. Implementing overdose education in multiple languages and in the workplace could further bridge the awareness gap.

10 Enhance OUD-related training for providers, beyond harm reduction

Front-line providers could enhance their capabilities for effectively triaging and referring individuals with OUD. Due to a knowledge gap and the scarcity of addiction-certified professionals, there is a need for training a wide range of healthcare providers in "MAT-first" approaches and pain management leading practices. Additionally, the County could pioneer local clinical treatment guidelines for OUD, like those for other medical emergencies like strokes or cardiac arrest. These guidelines could standardize the treatment process for opioid overdose, establishing that all providers follow a consistent protocol. This initiative may require collaboration with medical stakeholders to develop and implement these innovative guidelines at the county level.

11 Expand syringe services programming

Syringe services programs (SSPs) are currently limited in scope and operating hours. SSPs are crucial in reducing needle reuse and the transmission of bloodborne diseases, distributing harm reduction supplies, providing co-occurring care and serving as non-judgmental spaces for individuals seeking to transition into care. To improve access, the County should consider increasing the number of fixed SSP locations. Additionally, adopting mobile SSPs could offer flexibility and reach to engage underserved groups. State-level considerations must be taken into account, as syringe services programs are not currently fundable with abatement settlement funding due to the Florida Attorney General's interpretation of current Florida law.

12 Establish a Marchman receiving facility

Family members of individuals with OUD often express desire for a local treatment facility of "last resort," which Pinellas County does not currently have. The county could partner with a crisis center to open a

designated Marchman Act receiving facility that offers comprehensive, long-term care for individuals with SUD. This facility should be equipped to re-evaluate the necessity of involuntary treatment, maximizing use of existing healthcare facilities to maintain continuity of care following stabilization. Training for law enforcement and first responders on the appropriate and inappropriate use of the Marchman Act, along with the option for walk-in admissions, could minimize misuse and provide a more effective alternate pathway to incarceration or emergency care. By integrating a full suite of SUD-specific treatments, the facility could serve as a critical resource for high-quality intervention and ongoing recovery support.

13 Construct a social center for the recovery community

Pinellas County could benefit from expanding social and communal spaces to support individuals in recovery from OUD, providing structured environments that encourage social support, employment, and community integration. The Clubhouse model could offer a blueprint for activities and roles that foster independence and teamwork among members. It includes employment supports across three tiers: transitional employment for short-term positions, supported employment for permanent roles with clubhouse assistance, and independent employment where members engage in competitive job markets with off-site clubhouse support. Additionally, integrating behavioral health services within these social spaces, or providing linkages to such services, could enhance access to care and create a comprehensive ecosystem that supports recovery. While the integration of behavioral health services adds complexity, the primary focus on community and vocational supports remains crucial for the recovery process.

14 Create new community support teams that focus specifically on substance use disorders

Pinellas County's Assertive Community Teams (ACT teams), which offer integrated support for substance use and mental health, are not directly targeted at individuals with SUD. They focus on individuals with severe mental and behavioral health needs; while some people with SUD are included in that group, many more do not need the high level of care associated with ACT treatment. There is an opportunity for more targeted community support teams (CSTs) that provide a level of care higher than traditional case management but a lower level of care than ACT service. These CSTs could reduce ACT waitlists, as ACT patients with SUD could be transitioned to these teams if clinically indicated. If CSTs hired specialized staff, they could effectively serve individuals with OUD and allow non-specialized teams to attend to other clients. These teams could leverage strategies used by QRTs to work with clients who are leaving residential treatment or detox.

15 Create additional behavioral health services in the style of Certified Community Behavioral Health Clinics

Community Behavioral Health Clinics (CCBHCs) provide essential services for co-occurring treatment by facilitating 24/7 care access and behavioral health screening while overcoming barriers like waitlists and cost. That said, the existing CCBHC in Pinellas County uses a third-party provider for SUD services, which can lead to gaps in treatment and case management. Though Pinellas County likely cannot fund additional CCBHCs on its own, there are opportunities to expand the services offered at the existing CCBHC to incorporate mental health and substance use treatment in one location.

16 Enhance Quick Response Teams

Pinellas County's Quick Response Teams are successful in contacting individuals but face challenges in transitioning those contacts into treatment, with a treatment initiation rate of about 13%. To enhance the QRTs' effectiveness, Pinellas could conduct research to understand the reasons behind the underperformance and identify opportunities for improvement. Insights from this research could lead to the adoption of emerging

practices that have proven successful elsewhere, such as incorporating peer specialists into QRTs, broadening the sources of inbound referrals, and implementing proactive outreach strategies for individuals at risk. This approach could likely improve not only contact rates but also linkages to treatment and other appropriate services.

More detailed and supporting information that extends beyond this Executive Summary can be found in the subsequent sections of the Report.

Section 2: Approach and methodology

This section explains the approach taken to constructing this Report, providing an overview of each phase of the research that grounds the Report. Explanations of why each phase was conducted and the research activities undertaken during each phase are available in this section. Research activities encompassed reviews of key reports, interviews with stakeholders across Pinellas County, listening sessions and surveys to gather constituent input, EY tools and internal expertise, data collection and analysis, and secondary research.

Section 3: Current state of the opioid epidemic in Pinellas County

This section provides an overview of the historical context and current state of the opioid epidemic in Pinellas County, highlighting demographic groups and geographic areas in Pinellas County that are most affected.

Section 4: Gap analysis

This section explains the 34 identified gaps in Pinellas County through the approach and methodology described in Section 2 of the Report. It also contains a detailed overview of the CoC used in this work. Gaps are organized according to where they most directly relate to the CoC for an individual with OUD.

Section 5: Leading practices

As part of the research for this project, EY reviewed leading practices for opioid abatement as well as interventions showing initial positive results both within Florida's counties and beyond. This research leveraged a variety of sources, including government reports, academic studies, and think tank publications, yielding over 100 evidence-based leading practices supported by an authoritative source, such as the Substance Abuse and Mental Health Services Administration (SAMHSA) and National Institute on Drug Abuse (NIDA), as well as emerging practices that have shown promise in the areas where they have been employed but have not yet been thoroughly tested. This section provides an overview of these leading and emerging practices.

Section 6: Recommendations

EY developed recommendations that address one or more gaps identified through this research. Each recommendation can be executed with one or more leading and/or emerging practices that support the recommendation. In August 2024, PCHS invited key community stakeholders to participate in a workshop and provide perspectives for Pinellas County's prioritization. The Report presents these recommendations in prioritization order. Further details on each recommendation, including related case studies and implementation considerations, are found in Section 6.

Section 2

Approach and methodology

The analysis presented in this Report represents the findings and analysis from multiple phases of research. EY's workstreams catalogued existing services, held interviews, led listening sessions, surveyed the community, aggregated leading opioid abatement practices, and benchmarked programs and efforts by other states, counties, and even international entities. These findings were aligned and organized to identify gaps along the Continuum of Care for OUD in Pinellas County. The workstreams are shown in Exhibit 4 below.

Exhibit 4: EY research activities

Illuminate critical gaps; identify leading practice(s) for potential remediation

1. **Mobilize and Inventory**
   - Researched demographic, economic, social, and environmental factors, uncovering gaps and needs in services that impact the Pinellas community
   - Documented comprehensive inventory of existing services and programs
2. **Leading Practices Identification**
   - Reviewed and summarized abatement recommendations from academic, non-profit, and public sector entities
   - Researched financial, operational, administrative, and stakeholder requirements for areas of particular interest
3. **Health & Community Needs**
   - Conducted 48 interviews with stakeholders for "on the ground" abatement experience, surveyed 1,500+ Pinellas County residents, and led 13 community listening sessions, to capture the voice of Pinellas residents from all backgrounds
4. **Gap Analysis**
   - Identified 30+ critical gaps, by leveraging the findings in the inventory and needs analyses
   - Prepared a summary of findings regarding the most pressing areas of need, linking them to leading practices
5. **Recommendations**
   - Collaborated with Pinellas County leadership to develop a framework to assess the costs and benefits of recommendations, alongside goals for execution
   - Worked with key stakeholders in their prioritization of areas within the Continuum of Care that present the greatest gaps

Throughout the five research workstreams, stakeholders were directly and actively engaged to collect and represent the voice of diverse constituent groups: providers, clinical practitioners, residents and visitors to Pinellas County, family members and individuals with lived experience. This was accomplished through interviews, surveys, listening sessions, and workshops over the course of four months.

1 Mobilize and inventory

EY collected and aggregated information regarding services and practices in Pinellas County. This inventory of the OUD-related programs, treatment facilities, housing providers, and health service providers in Pinellas County provides a view of services available to residents.

Given that existing reference lists for these services were not consistent, EY compiled an initial list though extensive secondary research that encompassed reviews of third-party aggregators and existing resource lists.

EY also conducted select interviews with service providers, program providers, and funders to better understand the programs and services offered, who has access (including eligibility or exclusion considerations), and how the service may meet individual needs, such as care for co-occurring conditions.

Identified initiatives are categorized as "programs," "facilities," "housing providers," and "health services." There were 81 programs identified providing OUD-related services, 29 facilities that clinically treated OUD (including all inpatient facilities), 44 housing providers, and 26 health service organizations, which can be seen organized by the CoC in Table 1. For more details about the CoC, see Exhibit 3.

- **Programs** are defined as initiatives that community-based organizations deliver as part of their offerings to serve individuals with SUD or OUD. For example, Personal Enrichment through Mental Health Services (PEMHS) runs several categorized programs, including their Pinellas Integrated Care Team (PIC Team), their Mobile Crisis Response Team, and their H.O.M.E. navigation. Some catalogued programs target a broader behavioral health population but are included if research determined they commonly serve individuals with OUD. All programs are executed or operated by a larger organization.
- **Treatment facilities** offer intensive treatment with a residential component. These facilities include crisis receiving facilities and inpatient rehabilitation centers but exclude supportive housing where individuals could stay for months or years. These treatment facilities may have services that are available to people who do not reside there. For example, three of Operation PAR's locations are categorized as facilities because they have an inpatient program, but others can use those locations for services such as MAT and counseling.
- **Housing providers** are defined as any place that operates housing, but which has service offerings that are not specific to SUD/OUD. These facilities are typically not comprehensive in delivering treatment and recovery services as a core component of the revenue model. For example, Operation PAR's campus in Largo is defined as a facility even though they have a supportive housing "Village." Meanwhile, WestCare Gulf Coast's Mustard Seed Inn is defined as a housing provider because it is primarily transitional housing, even though they also offer treatment for OUD.
- **Health services** are defined as providers that offer clinical services such as counseling, prescriptions for medication, and telehealth appointments. Examples include Advantage Mental Health Center in Clearwater and Caring Community Counseling in St. Petersburg. Some of these providers are SAMHSA-certified Opioid Treatment Programs.

Table 1: Summary of programs, facilities, housing, and health services as part of the Inventory of Services

CoC area	Category	Programs	Facilities	Housing providers	Health services
Prevention	Education	20			
	Early detection	3			
Acute addiction	Harm reduction	15			
	Maternal health	4	1		1
Seeking help	Treatment access improvements	6			
	First contact	11	1	2	3
	Crisis response services	10	7	1	
	Peer counselors	6	1	2	5
Acute and post-acute care	Co-treatment for comorbidities	1	20	2	10
	Care coordination	21	8	11	12
	Detox and inpatient rehab		13		
	Post-acute residential treatment		14		
Long-term treatment, recovery, and maintenance	Behavioral health/counseling	17	29	6	26
	Outpatient services	16	26	1	20
	Long-term residential support			12	
	MAT		8	1	6
External factors	Housing linkages only			9	1
	Emergency shelter			8	
	Transitional housing			26	
	Permanent supportive housing			3	
	Employment	6		6	
	General healthcare				
	Community & family support	7			
	Justice	9			1
	Data	3			

Of note, the number of services does not assess capacity, service level, or service quality; the count denotes the existence of a program or service designed or directed to serve individuals with SUD/OUD.

The inventory of services was a multiple-month, broad documentation effort; in conducting this analysis, EY also identified difficulties that individuals (families, caregivers, providers, individuals with OUD) experience when seeking care or information about available services.

Throughout this process, challenges were encountered when trying to validate service details via desk research (e.g., going into providers' websites and/or using third-party service aggregator websites). As a result, ~35 clinical service providers accounting for a total of ~60 locations across the county were approached to verify each locations' services, eligibility criteria, payment type accepted, bed capacity, and other metrics.

EY conducted this outreach following introductions from Pinellas County Human Services in most cases. Only 30% of providers (accounting for ~33% of locations) verified their services despite repeated phone and email-based outreach. For an example of an attempt to validate services, see Exhibit 5. Accordingly, the inventory of services reflects a multi-month, multi-source documentation effort, but also reflects the navigational difficulties that individuals face when seeking care.

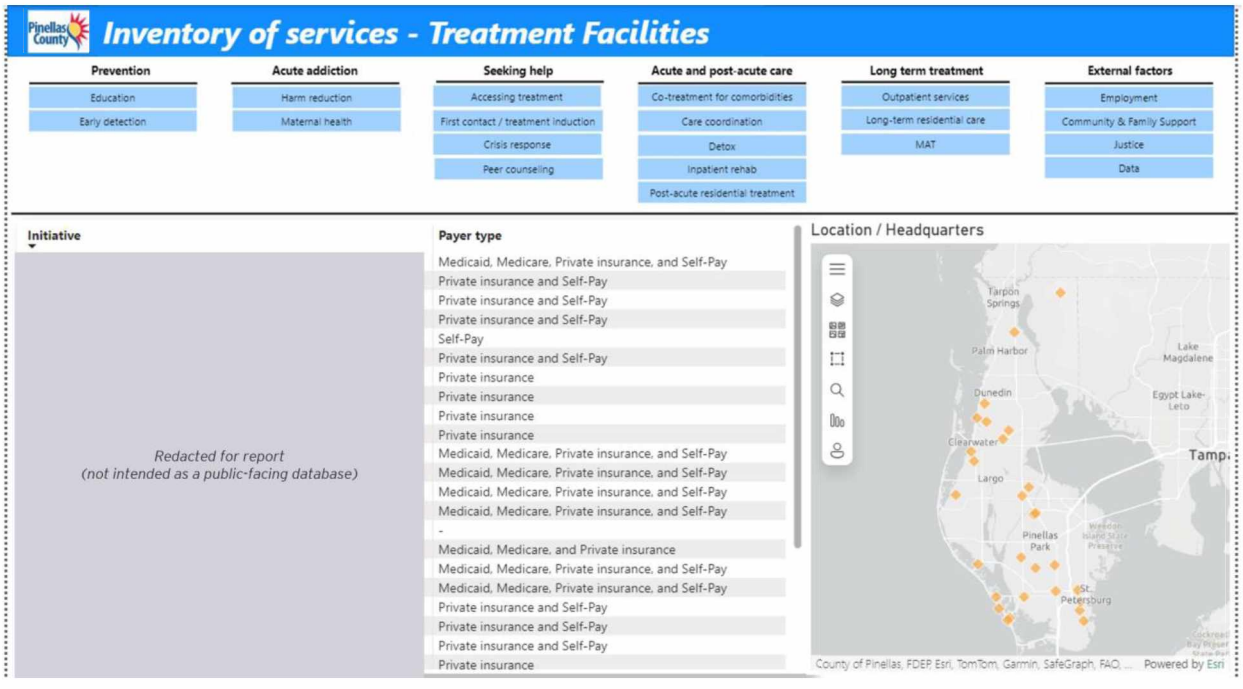
Exhibit 5: Sample form sent to validate information for treatment facilities

Organization type	
Private for-profit	
Private non-profit	Yes
Public non-profit	
Payer type accepted	
Medicaid	
Medicare	
Private insurance	
Self-Pay	Yes

					Long-term treatment, recovery, and maintenance					External factors
							Medication			
Location	Eligibility criteria	Bed capacity	DCF licensed?	Individualized services?	Behavioral health counseling	Intensive outpatient	Methadone	Buprenorphine	Naltrexone	Housing
Location 1	Adults 18 and over needing housing and recovery support, including MAT.	68	No	Yes	Yes	No	No	Yes	Yes	Yes
Location 2	Adults 18 and over needing outpatient level of care for substance use and co-occurring disorders, including MAT.	N/A	Yes	Yes	Yes	No	No	Yes	Yes	Yes
Location 3	Adults 18 and over who are homeless requiring housing, outreach and stabilization, and intervention, and MAT.	65	Yes	Yes	Yes	No	No	Yes	Yes	Yes
Location 4	Adults 18 and over needing residential level of care that includes MAT.	266	Yes	Yes	Yes	No	No	Yes	Yes	Yes

The inventory was captured in a Power BI database (see Exhibit 1 below with an illustrative screenshot) and used to better understand services available during the gap analysis efforts. Due to the challenges and limitations described above, this output is not intended to produce a database for future reference or use given that information was not fully validated by providers.

Exhibit 1 (reprinted): Sample output of service inventory, treatment facilities redacted



The index of providers, programs and housing facilities can be found in Appendix B (Inventory of services).

2 Leading practices identification

Leading practices research included national and international examples that have shown positive outcomes in opioid abatement, many of which were included as case studies in the recommendations.

This analysis began with reviewing several research compendiums of leading practices and evidence-based practices, listed below. These sources were augmented with government reports, academic studies, and think tank publications. In total, this research yielded a list of 100+ leading practices supported by an authoritative body like SAMHSA or NIDA, as well as several emerging practices, which have shown initial positive results but have not been rigorously tested. The reports listed in Table 2 represent system-level inputs regarding leading practices. Alongside this research, efforts from peer counties[10] and other relevant benchmarks within Florida were identified to provide a comprehensive understanding of the landscape and inform the recommendations.

Table 2: Leading practices reports

Author/Group	**Report title** *(publication year)*
Substance Abuse and Mental Health Services Administration, National Institute on Drug Abuse, National Institute of Health	Opioid overdose reduction: A continuum of care approach *(2023)*
National Governors Association	Implementing best practices across the continuum of care to prevent overdose: a roadmap for governors *(2023)*
National Council for Mental Wellbeing/Centers for Disease Control & Prevention	Overdose prevention in community corrections: an environmental scan *(2022)*
Arnold Ventures (With experts at RAND, Harvard Medical School, Johns Hopkins School of Public Health, and others.)	Evidence-based strategies for Abatement of Harms from the opioid epidemic *(2020)*
American Society of Addiction Medicine	National practice guideline for the treatment of opioid use disorder *(2020)*
Centers for Disease Control and Prevention	Evidence-based strategies for overdose prevention *(2018)*

The initial leading practices were then augmented with research from peer-reviewed journals such as the Journal of the American Medical Association, Journal of Substance Use and Addiction Treatment, Harm Reduction Journal, and Drug and Alcohol Dependence, among several others. These articles, in addition to supplemental sources (public reports and direct interviews), were used to identify leading and emerging

[10] Peer counties are based on a statistical modeling of population factors through multiple sources, including the U.S. Census to enable a "like to like" comparison of residents in a given county, using available data for all 3,141 counties in the United States. EY Impact is a proprietary EY tool used for this statistical modeling. For more information, please contact EY.

practices with positive results in other counties, states, and countries. The full citation list of publications used to develop the summary of over 100 leading practices is found in Appendix A (Literature review and citations).

Emerging practices, which constitute new(er) or innovative programs that have not been widely adopted or recognized as evidence-based practice, were sourced through secondary research and public reports. These practices were identified through research of city, county, state, and even international initiatives and added as a secondary layer of practices, complementary to the leading practices index.

The two layers of leading and emerging practices created a base understanding, but further research was needed to connect them to Pinellas County. To do so, EY asked about leading practices in nearly all interviews. These interviews typically asked stakeholders about leading practices in their immediate domain (e.g., emergency medicine for hospitalists with addiction training), as well as three broad questions:

- What leading practices are taking place in Pinellas County?
- What leading practices have been attempted but could be better implemented in Pinellas County?
- What leading practices are taking place elsewhere but not in Pinellas County?

While interviewees had varying definitions of leading practices, practices identified in the research were consistently identified and discussed during the interviews.

Similarly, the Clinical Supports and Services survey distributed at the Behavioral Health System of Care meeting included questions on which leading practices respondents knew about and wished to see in Pinellas County. The responses (n=96) across the group were varied; the most consistent responses focused on mobile MAT services and innovative ways of delivering MAT. These responses were validated through supplemental research, resulting in small number of additional practices being added to the index.

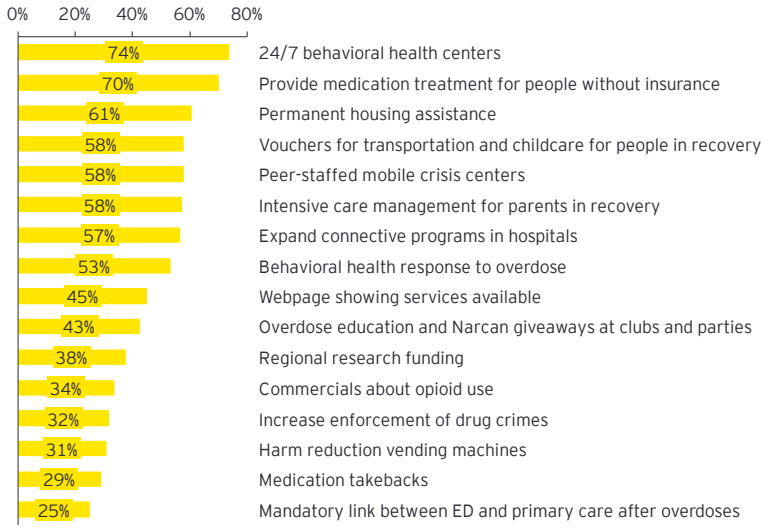
The final list of leading practices had over 100 practices. This sum was too broad to test which practices were most appealing to the community; accordingly, EY asked constituents about a shorter set of 16 leading practices based on frequent mention and alignment to needs in Pinellas County. These practices included innovations currently in Pinellas County (e.g., providing medication treatment for people without insurance), concepts that are new to the county (i.e., harm reduction vending machines), and expansion of existing programs (e.g., behavioral health response to overdoses).

Trade-offs between leading practices

In the constituent survey, respondents were presented with a randomized sample of two leading practices (from the 16 selected above) and asked to state their preference. Since the survey was open to anyone in Pinellas County, regardless of SUD knowledge, the question came with a detailed explanation of each choice. Each respondent was asked this question twice, so there were more than 3,000 responses to this question from n=1,510 individuals.

Aggregated responses offer a view into which practices were preferred more (or less) on a relative basis; see Exhibit 6 for an example of the leading practices aligned to the CoC. Practices associated with clinical care score

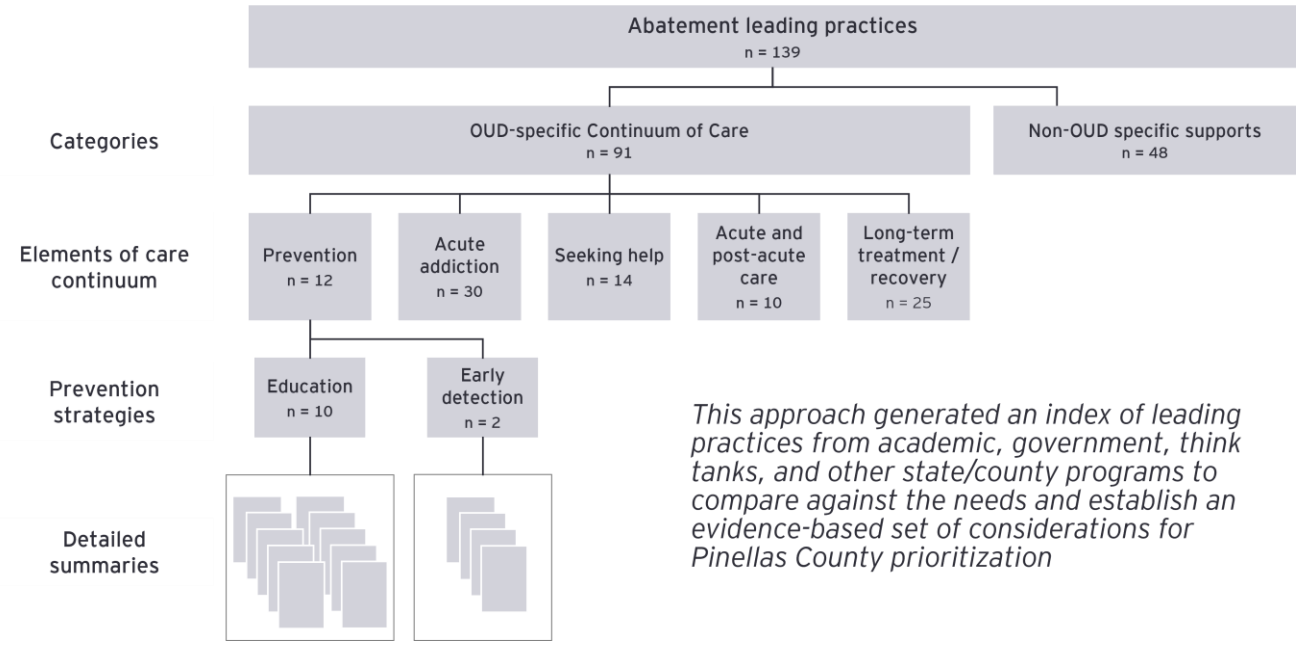
Exhibit 2 (reprinted): Constituent preferences in leading practices (n = 1,510)



highest, following by wraparound services. Leading practices associated with harm reduction or general healthcare were less preferred.

Leading practices tested in the survey were a small portion of all leading practices. As shown in Exhibit 6, the larger body of leading practices were categorized according to the Continuum of Care for use in the gap analysis and recommendations.

Exhibit 6: Leading practices by area of the Continuum of Care



Emerging practices

"Emerging practices," which are innovative initiatives other jurisdictions are actively executing or piloted, were also catalogued. These emerging practices have not been endorsed by a reputable entity or thorough peer review, but were identified through interviews, listening sessions, peer county analysis, or survey responses. EY then collected more information through different research approaches including desk research and stakeholder interviews of program and/or government leaders to understand the objectives, practices, funding requirements, implementation considerations, timing, impact, and other parameters that are important for consideration in another jurisdiction. While the scope of research was global, some programs identified as successful outside the United States are executed in a very different healthcare paradigm and less transposable to Pinellas County (healthcare delivery system, reimbursement framework, and policy being key factors that impacted applicability).

Some emerging practices arose locally. For example, there are several ways to implement an involuntary treatment program under laws like the Marchman Act; one stakeholder alerted EY to a program in Manatee County where new Marchman arrivals are re-evaluated at their treatment facility. For some new arrivals, the re-evaluation results in their Marchman order being rescinded and the client can choose between voluntary detox, voluntary admission into residential treatment, or discharge.[11] Since the Marchman Act is limited and

[11] EY interviews and research

specific to Florida, practices related to it are not broadly implemented and fit in the emerging practices initiative set.

Emerging practices and relevant OUD-related programs were also sourced through analysis of peer counties. Peer counties are similar-sized counties, with comparable population, education, economic, and demographic composition to Pinellas County. EY conducted three interviews with peer counties, discussing both leading practices and recommendations.

Finally, leading and emerging practices were mapped to recommendations for use in the prioritization session. During the prioritization session, case studies associated with leading practices were presented to participants. These case studies covered leading and emerging practices across prevention, treatment, and recovery, and focused on the key implementation strategies necessary to action the recommendation. Case studies, such as the Marchman re-evaluation example above, were presented alongside estimates of impact, cost, resources required, and lessons learned.

Before the prioritization session, participants reviewed the recommendations with an understanding of which leading and emerging practices could be used to action each recommendation. Each recommendation was presented alongside one or several leading or emerging practices, which are shown in Appendix C (Leading and emerging practices for each recommendation).

3 Health and community needs

This workstream highlighted the perspectives of individuals with lived experience, their families, frontline workers, and the broader community in Pinellas County. Recognizing that these voices are critical for understanding the real-world impact of substance use, stakeholders from across the county were engaged in order to gain insights into Pinellas County's unique challenges and barriers. Through this inclusive process, key services and programs were identified, along with their offerings.

Research activities included 48 interviews with 73 participants, several surveys targeting both residents and service providers, and 13 community listening sessions across the county. Interviewees included service providers, people with personal experiences of addiction, government officials, emergency responders, educators, and representatives from employer and employee groups.

Interviews

Many of these interviews yielded feedback and insights about the "on the ground" experience related to service levels, client/caregiver experience, level of integration across service providers, and collaboration among public service groups. Interviews explored several questions, such as:

- Where does the interviewees' organization fall along the CoC? What services do they provide, and why?
- To what extent are Pinellas clinical services designed for individuals with OUD (vs. other residents)?
- What is the state of the epidemic in Pinellas? How do the interviewees' positions inform their perspective on their answers?
- What is their perspective on existing County abatement programs and services? What is working? What has not worked? Why?
- What are the interviewee's observations about the "on the ground" experience of the opioid epidemic in Pinellas County?

Interviews were conducted with individuals associated with the following organizations and/or programs:

- Agency for Community Treatment Services (ACTS)
- Associated Recovery Communities Clearwater
- BayCare
- Bayside Health Clinic
- Boley Centers
- Central Florida Behavioral Health Network (CFBHN)
- EvalCorp
- Family Support Services
- Florida Agency for Healthcare Administration
- Florida Department of Children & Families
- Florida Harm Reduction Collective
- Gulf Coast Jewish Family and Community Services (JFCS)
- Healthy Start Coalition
- Homeless Leadership Alliance (HLA) Continuum of Care
- Juvenile Welfare Board
- Live Tampa Bay
- Narcotics Overdose Prevention & Education (NOPE) of Pinellas
- National Alliance on Mental Illness (NAMI)
- New Seasons
- Northwestern University, School of Medicine, Department of Psychiatry and Behavioral Sciences
- Operation PAR
- Opioid Abatement Funding Advisory Board (OAFAB) & Statewide Opioid Council
- Opioid Task Force
- People Empowering & Restoring Communities (PERC)
  - IDEA Exchange Pinellas
- Personal Enrichment Through Mental Health Services (PEMHS)
- Pinellas County Department of Health
- Pinellas County Human Services
- Pinellas County Medical Examiner
- Pinellas County Safety & Emergency Services
  - Pinellas County Emergency Management Services
- Pinellas County Schools
- Pinellas County Sheriff's Office
- Pinellas Matters
- Real Recovery Sober Living Clearwater
- Recovery Epicenter Foundation
  - The Catcher's Mitt
- Sixth Judicial Circuit Adult Drug Court
- St. Pete Free Clinic
- Suncoast Centers
- University of South Florida, College of Behavioral and Community Sciences, Department of Mental Health Law and Policy
- Vincent House
- West Care/GulfCoast Florida, Inc.
  - Mustard Seed Inn

Surveys

While interviews captured the voice of local experts, surveys were used to capture broader sentiment from the community. The Clinical Services and Supports survey targeted healthcare professionals attending the Pinellas County Behavioral Health System of Care meeting (n=96; see Exhibit 7 on the following page), and a second targeted the general population. The latter survey reached over 1,500 people, with over 90% of them Pinellas County residents. The remaining 10% consisted primarily of individuals who work in but do not reside in Pinellas County, as shown in Exhibit 8 on the following page.

Exhibit 7: Clinical Services survey respondents by role

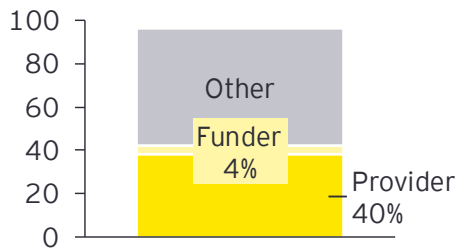
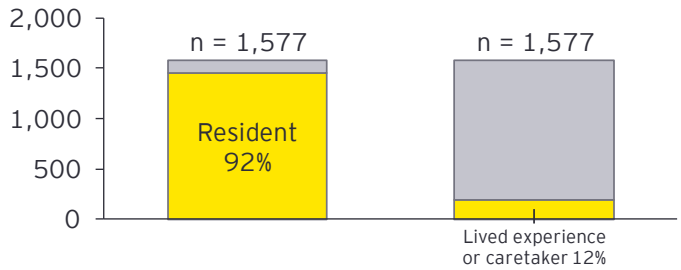


Exhibit 8: Constituent survey respondents by residence and OUD experience



EY also fielded a hospital survey to gather perspectives from hospital administrators and physicians, in addition to an employer survey to gather perspectives from local employers. Surveys were distributed to hospital leadership by the Pinellas County Human Services Department and to physician networks by the Pinellas County Medical Director and the Director of Pinellas County Department of Health. However, limited responses were received from this outreach (n=5 and n=3, respectively).

Listening sessions

EY held 13 community listening sessions in strategic locations across the county, which were shared via several media platforms:

- Clearwater (two sessions)
- St. Petersburg (two sessions)
- East Lake
- Largo
- Seminole
- Lealman
- Pinellas Park
- Ridgecrest
- St. Pete Beach
- Tarpon Springs
- IDEA Exchange Pinellas (St. Petersburg)

Attendance at these listening sessions was more limited than expected, speaking to difficulty in engaging community members around the stigmatized topic. Individuals in active use proved particularly difficult to reach, so EY conducted outreach and visits to harm reduction facilities to talk with those who felt comfortable engaging. EY also visited respite centers, sober living homes, and shelters to listen and learn from center staff, many of whom were in recovery themselves.

4 Gap analysis

The research described previously was synthesized into a gap analysis. Gaps for the purposes of this Report are defined as areas in the CoC where the environment, setting, policies, practices, or services delivered in Pinellas County potentially inhibit the prevention of, treatment of, or recovery from OUD. These identified gaps could be remediated with efforts at the local level by adoption or implementation of leading and emerging practices identified in jurisdictions outside Pinellas County.

As such, funding leading or emerging practices to address the identified gaps could be considered for opioid abatement funding if they are within the approved uses set forth in the multidistrict litigation and within the interpretation of approved use. This analysis also identified gaps relevant to the CoC that are not addressable locally (e.g., Florida state policies for funding syringe services programs or Medicaid expansion); these gaps are noted and acknowledged throughout this Report. These gaps could be addressed in the future as external conditions such as state legislation allow.

EY applied a comprehensive approach to define gaps. When available, multiple sources of information (including data analysis, interviews, and surveys) were compared to support or diminish evidence for a gap., For example, when assessing the need for expansion of housing facilities, the analysis combined the capacity data received from housing providers (as available), insights from interviews and listening sessions, survey results regarding housing, and leading practice guidelines for key housing services including peer respite, transitional housing, and permanent supporting housing.

The gap analysis identified 34 gaps across the CoC in Pinellas County; this served as the basis for developing the recommendations represented in this Report. Generally, the gap analysis was informed, but not limited, by existing frameworks or previously published plans (e.g., the Florida settlement agreement or local priority lists).

5 Recommendations

Finally, the analysis focused on identifying strategies to potentially address gaps informed by leading practices and the research. The strategies were assessed to understand how they could address the identified gaps, the specific barriers each strategy could overcome, and how they could meet the community's needs.

The feasibility and potential impact of implementing these strategies was also assessed, including the potential costs and duration of implementation, and the support that may be required from various stakeholders such as community-based organizations, the private sector, and state agencies.

EY and the stakeholders developed 16 recommendations which could remediate the 34 gaps identified. Some of these recommendations cover multiple gaps because of the interconnected nature of the system of care.

These recommendations were discussed during a prioritization workshop in August 2024. This session was a day-long workshop to which 12 key stakeholders from the Pinellas County opioid abatement community were invited to participate. These leaders, listed in Section 6, brought a range of experiences in behavioral health and specifically OUD. Their experiences were both personal and professional and represented different voices impacted by opioids in the county. This collaborative process was designed to incorporate diverse perspectives and help Pinellas County determine how to prioritize these recommendations. Pinellas County's prioritized recommendations, with supporting rationale, are found in Section 6.

A list of resources used in this analysis, including interviews performed and secondary sources, can be found in Section 2 and Appendix A (Literature review and citations), respectively.

Section 3

Current state of the opioid epidemic in Pinellas County

Historical context

While a detailed history of the opioid epidemic in the United States or Pinellas County is outside the scope of this Report, there are sources that provide a substantive overview of its inception and growth.[12] In brief, the opioid epidemic in Pinellas County mirrors national trends that began in the 1990s. During that decade, pharmaceutical manufacturers and distributors worked to substantially increase the prescription and use of addictive opioid pain relievers.[13] As use of these medications became widespread, misuse and addiction grew. When Prescription Drug Monitoring Programs became more widespread and prescriptions began to decline throughout the 2010s, individuals who were addicted turned to illicit and often lethal street opioids like heroin and, in more recent years, fentanyl. [14,15] This third wave resulted in more than 80,000 fatalities across the country due to opioids in 2022 and 2023, largely attributed to fentanyl. [16]

While rarely caused by addictive prescription opioids, these later-wave fatalities have been acknowledged to be downstream of prescription opioid use. Specifically, the actions of various prescribers, pharmaceutical manufacturers, and distributors have been associated with this tragedy.[17] These actions led to the lawsuits from which Pinellas County and its cities have received commitments of over $100 million in funding.

The lethal nature of the third wave of the epidemic is largely due to fentanyl. Fentanyl is a synthetic opioid and common cutting agent for other substances like cocaine, methamphetamine, and MDMA. This contamination has resulted in more fatalities as individuals unknowingly consume drugs contaminated with fentanyl and/or fentanyl analogs. This includes illicit opioids that are manufactured to mimic pharmaceutical-grade substances and are consumed by individuals who are not seeking opioids. Fatalities resulting from this type of contamination can be considered deaths by poisoning, rather than overdose.[18] This Report, following data received from the Pinellas County Medical Examiner, categorizes all opioid-related fatalities as overdoses.

Pinellas County, like many counties in Florida, has experienced a recent rise in opioid-related overdoses. The third wave caused a large increase in opioid-related fatalities in Pinellas County after a decline in the early 2010s.[19] Opioid-related fatalities in the county decreased from roughly 200 in 2011 to fewer than 120 in 2015. As more potent synthetic opioids like fentanyl were introduced into the drug supply, high-prescribing pill mills were closed. Coupled with the effects of the COVID-19 pandemic on individuals (stress, isolation, and economic hardships), more individuals began using illicit opioids, causing more fatalities.[20] However, in Pinellas County, 2023 saw 21% fewer fatalities than prior years, a greater decline than the national average of 4%.[21]

While an encouraging sign of progress, it is too early to draw definitive conclusions about whether this trend could be sustained. Pinellas County medical stakeholders have initial hypotheses that the decline in deaths was

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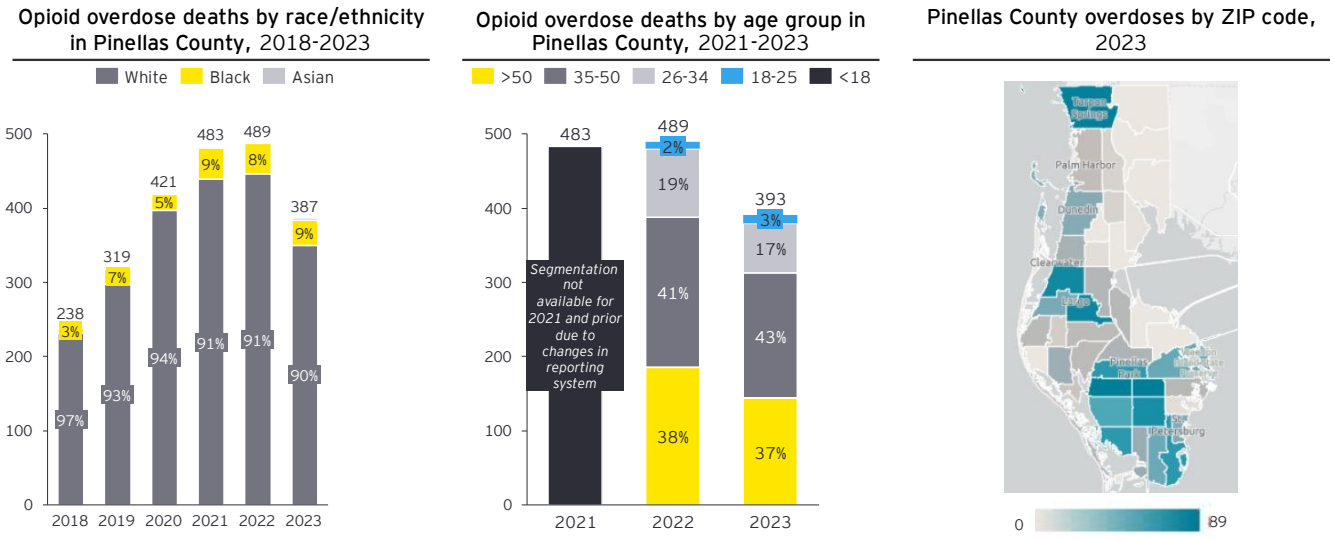
[12] Powell et al. (2022); Congressional Research Service (2022); Macy (2018); Keefe (2021); Quinones (2015); Lembke (2016); Stanford-Lancet commission; Pinellas County Opioid Task Force
[13] Often referred to as the "first wave" of the opioid crisis. See Ciccarone (2019), Saunders et al. (2023), and CDC National Center for Health Statistics for details.
[14] Often referred to as the "second wave," including by the sources cited in prev. footnote
[15] Often referred to as the "third wave," including by the sources cited in prev. footnote
[16] CDC National Center for Health Statistics
[17] Alpert et al. (2018)
[18] Hoffman (2024)
[19] Pinellas County Medical Examiner
[20] CDC National Center for Health Statistics
[21] Pinellas County Medical Examiner; CDC National Center for Health Statistics

in part due to less potent fentanyl contamination, so there remains a large opportunity to fight mortality through prevention, treatment, and recovery services.

Exhibit 9: Overdose deaths in Pinellas County by race/ethnicity, age, and ZIP code[22]



In Pinellas County, opioid overdose fatalities have predominantly affected White individuals. However, the data suggests a rising trend in fatalities among the Black community, with this group accounting for a progressively higher share of overdoses over time. As shown in Exhibit 9, Black individuals now represent 9% of all overdoses. The increase from six deaths in 2018 to 34 deaths in 2023 is a 41% year-over-year increase over the five-year period.

Recent declines in fatal overdoses are comparable across race and ethnic groups. While the decrease is not yet a trend, both White and Black populations have seen similar decreases by percentage.

It is a positive indicator that Pinellas County is experiencing a reduction in fatal overdoses, and also that the share of overdoses caused by opioids has begun to decline. Opioid overdoses rose from 80% of all overdoses in 2018 to 83% of all overdoses in 2020, and now have dropped back to 80% as of 2023.[23]

In Pinellas County, opioid overdose victims are older, as individuals aged 35 and up comprise 80% of fatalities. Only 3% of fatalities in 2023 were attributable to those under 25 years old.

The crisis is most concentrated in and around large population centers like St. Petersburg, Largo, and Clearwater. These cities have high numbers of fatalities and emergency department visits, on both an absolute and relative basis. Other areas with smaller populations including Seminole, West Lealman, Lealman, Tarpon Springs, and Pinellas Park have been heavily impacted by opioid-related fatalities on a per-capita basis, though most of those cities and towns saw their overdose rates regress back toward the county-wide average in 2023.

Most areas saw decreased overdose fatalities in 2023. The only location where overdose deaths rose significantly in 2023 was the 33702 ZIP code. This ZIP code is in unincorporated Pinellas County, north of St. Petersburg and east of Lealman and Pinellas Park. Overdose deaths in this ZIP code rose from 10 in 2021 to 15 in 2022 to 27 in 2023, potentially reflecting a single cluster of overdoses.

[22] Pinellas County Medical Examiner; Pinellas County Opioid Task Force Update
[23] Pinellas County Medical Examiner; Pinellas County Opioid Task Force Update

Comparative health factors

To better understand population health in cities and counties, EY adapted a population health model first developed by researchers at the Centers for Disease Control and Prevention (CDC) that explores the relationship between health factors and health outcomes. The CDC model is now integrated into academic research groups, including the University of Wisconsin Population Health Institute, to advance population health analytics and research.[24] This proprietary platform, EY Impact, establishes quantitative statistical relationships between health factors and outcomes. These health factors span domains of social determinants of health as well as health-related social needs and offer a way to compare outcomes across counties.

For Pinellas County, it enabled the analysis for which health factors were lagging relative to other counties, and supported hypothesis generation to identify potential gaps that were validated through other workstreams. Table 3 reports the relative weights and statistical power for the model.

Table 3: Relative weights in EY Impact health factors

Health factor	Weight	Health factor	Weight
Social and economic factors	**45.5%**	**Health behaviors**	**37.3%**
Injury deaths	13.9%	Adult smoking	14.1%
Children in poverty	10.6%	Excessive drinking	9.0%
Children in single-parent households	7.2%	Sexually transmitted infections	5.7%
Violent crime	3.8%	Teen births	4.4%
Income inequality	2.6%	Adult obesity	1.6%
High school completion	2.5%	Food environment index	1.4%
Unemployment	1.9%	Physical inactivity	0.8%
Social associations	1.7%	Access to exercise opportunities	0.2%
Some college	1.3%	Alcohol-impaired driving deaths	0.1%
Physical environment	**11.1%**	**Clinical care**	**5.9%**
Driving alone to work	6.0%	Mammography screening	2.7%
Long commute - driving alone	3.5%	Preventable hospital stays	1.1%
Drinking water violations	0.7%	Flu vaccinations	0.7%
Severe housing problems	0.7%	Uninsured	0.6%
Air pollution - particulate matter	0.2%	Mental health providers	0.4%
		Primary care physicians	0.3%
		Dentists	0.1%
Root mean square error	0.289	R^2	0.886
Mean absolute error	0.208	Adjusted R^2	0.880

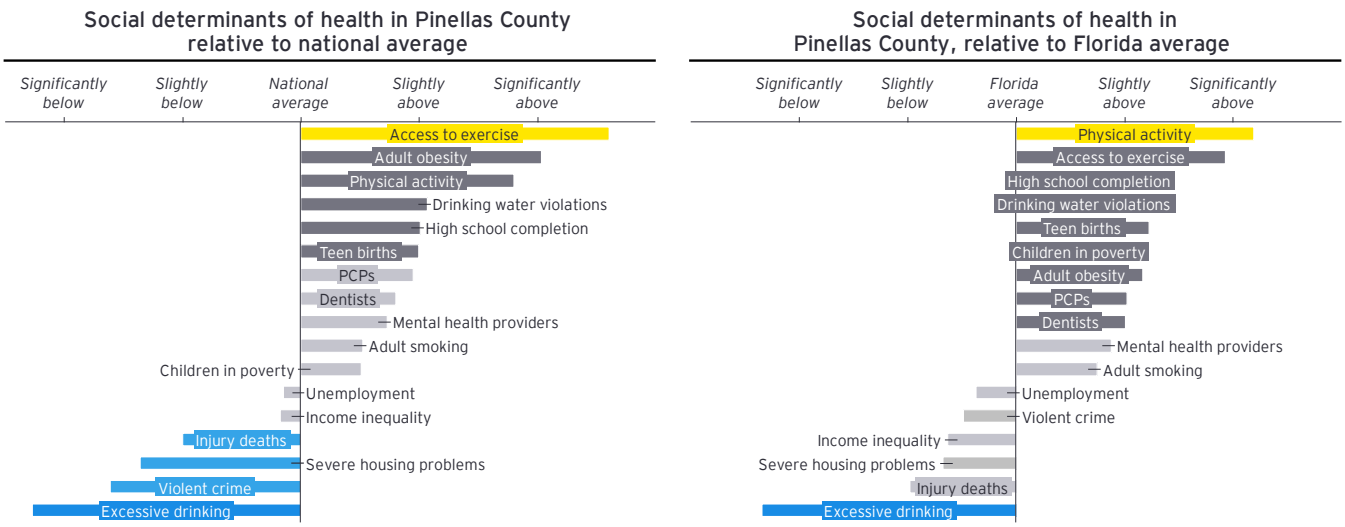
[24] Booske et al. (2010); Hood et al. (2016); Remington et al. (2015)

The platform also enables comparison of all 3,143 counties in the United States by creating "peer groups" using a k-means clustering methodology (similar to unpublished draft clusters by CDC) that utilizes demographic, geographic, economic, and other variables. In establishing peer clusters, EY explored unconstrained and constrained sets to replicate the proposed clusters put forward by CDC.[25]

EY's model differs from the original peer clusters defined by CDC. While the original CDC methodology limited each cluster to 34 or 35 counties with at least three states, the statistical modeling constrained the minimum to be 10 counties, with no maximum and 30 total clusters.

Quantitative comparison to other counties in Florida and around the country is valuable to identify which counties with comparable population composition to Pinellas could have effective strategies that reduce mortality. For this research, the relative ratings of these health factors drive discussions with leaders from Pinellas and other counties leaders on what works, what challenges were faced, and what future considerations include. Exhibit 10 demonstrates the health factors in Pinellas County compared to both national and Florida averages.

Exhibit 10: Health factors in Pinellas County vs. national and Florida averages[26,27]



Overdose risk and fatalities are influenced by environmental, social, and health factors. The relationship between these factors and outcomes (premature death and other quality of life measures) are quantifiable using public data collected by counties and shared with the CDC. Pinellas performs better on many factors such as physical activity, access to exercise, and high school completion.

At the same time, Pinellas performs lower than peers on some health factors related to the opioid epidemic. Injury deaths (a composite factor that includes drug overdose, suicide, motor vehicle crash death, homicide, and other) is one of the lower performing health factors for the county and a key driver of premature death, calculated by years of life lost prior to age 75. This data-driven comparison of Pinellas County to other counties in Florida and across the country identified several areas for opportunity that could expand length and quality

[25] More details on the statistical methods and model fit, including methodology, outputs, and considerations are available on request to EY.
[26] EY Impact. Peer counties are based on a statistical modeling of population factors through multiple sources, including the U.S. Census to enable a "like to like" comparison of residents in a given County, using available data for all 3,143 counties in the United States. EY Impact is a proprietary EY tool used for this statistical modeling.
[27] Pinellas values are compared to population-weighted average of all U.S. counties

of life, independently from opioid abatement planning. (However, there are often connections between OUD/SUD and other health factors such as housing, crime, or other concurrent substance use.)

This comparison informed our gap analysis but was not determinative of any gaps. For example, this comparison and other secondary data identified that Pinellas County had more primary care physicians and mental health providers per capita than many other counties in Florida or around the country. However, that data point alone was not sufficient for insight, and there were several limitations to the data that impacted EY's ability to translate data to insights.

For example, many variables influence clinical practices and may lead to higher counts of PCPs, including geography, covered services, insurance network(s), private practice, and other operational or administrative dimensions. Any insights or inferences from the data through comparison of Pinellas County to other locations were used for hypothesis generation and were rigorously tested through interviews, stakeholder feedback, and other analysis to validate the findings using contemporary and local data.

Efforts to date

Pinellas County has implemented multiple strategies to combat the epidemic. There are many organizations working across the county to support the residents. This Report would not be complete without acknowledging the hard work and contributions that these organizations have made in supporting individuals with OUD. While this section is not meant to be a comprehensive review of all efforts in the county, it highlights the ones encountered during this research.

The inventory of services did not assess program quality, and the gap analysis did not include a detailed quality review of every organization serving individuals with OUD. Therefore, the existence and inventory of these programs should not be taken as a proxy for program quality. In some cases, Pinellas is well-served by programs in part because there are so many (e.g., the county has a strong density of hospitals), and in other cases (e.g., prevention), concerns about quality arose separately from the service inventory.

This research identified 180 unique locations of programs and providers with OUD-related care and housing across the CoC, which can be seen in Exhibit 5. It is important to reiterate the difficulties encountered when requesting data about these services, such that some of the information is unverified by the provider. The programs and treatment centers include:

- 20 programs with an education focus, typically providing information and resources for parents, schools, and community members, with a few focused on early detection and intervention[28]
- 4 maternal health programs with an OUD-specific focus, to support pregnant or new mothers as well as other funded positions in the local birthing hospitals to provide screening at the point of delivery and support connections to community resources
- 13 facilities and three health services providing medically supervised detoxification to those with OUD
- 8 facilities, one housing provider, and six health services providing MAT to reduce dependence on opioids, in combination with therapeutic counseling
- 26 transitional housing services providing temporary supportive accommodation, meant to bridge the gap from homelessness to permanent housing by offering structure, supervision, and supports. This includes recovery housing of which sober-living is a subset

Many of these programs and treatment facility offerings align to leading practices, including:

- Large-scale efforts to expand access to addiction treatment services, most notably through the Central Florida Behavioral Health Network, which funds care for many lower-income individuals. Additionally, Pinellas County Human Services has helped expand access to addiction treatment services with

[28] These counts are non-exhaustive lists, though they reflect a months-long effort to catalog all services from public documents, private documents, interviews, surveys, and other stakeholder engagement.

programs like Pinellas Matters and Care About Me.[29] Pinellas Matters connects individuals in emergency departments who have or are at risk of developing SUD with services. Care About Me is a phone and web-based coordinated access model allowing residents to be screened for a level of care determination, learn about available services, and receive scheduled appointments[30]

- 14 programs, facilities, housing providers and health services that employ peer specialists, which are individuals in recovery from OUD who provide services and supports to individuals in active use, such as outreach
- The Sixth Judicial Circuit Court, which serves Pinellas and Pasco counties, established the Adult Drug Court in 2001, and has since enhanced its set of "Problem Solving" courts that divert qualifying offenders to treatment for drug use instead of jail, leveraging grants in collaboration with Pinellas County Human Services
- Organizations across Pinellas County, with support from the Florida Department of Children and Families (DCF) are distributing naloxone kits to residents[31]
- Pinellas County law enforcement efforts to limit illegal drug trafficking and monitor prescription practices more closely while acknowledging policy as a more effective and sustainable way to address the problem. Federal and state legislation is now in place to limit the over-prescription of opioids and to provide better education for healthcare providers on pain management[32,33, 34]
- The IDEA Exchange Pinellas, the county's only SSP, also helps those with OUD get connected to needed services

Community organizations, healthcare providers, and local government agencies in Pinellas County are convening together to address the epidemic. There is a general culture of willingness to collaborate in Pinellas, although increased collaboration would be of additional significance.

For example, the county shares data from emergency services, hospitals, and law enforcement in different forums (e.g., the Opioid Task Force, Fusion Group, Pinellas County Overdose Fatality Review, and Behavioral Health System of Care) to monitor the crisis and respond accordingly. This data helps to identify trends and areas that need more focused attention. The Strategic Information Partnership (SIP), started in 2018, intends to support real-time data collection from key stakeholders to better articulate the current state of the problem, support cross-system planning and data evaluation, inform policy makers on targeted interventions and leverage scarce resources and avoid duplication of efforts.[35] The SIP project allows for an automated data system between PCHS, Pinellas County Sheriff's Office, Pinellas County Safety and Emergency Services, the local Medical Examiner, the state Prescription Drug Monitoring Program, as well as some provider data. The data architecture surrounding this "data lake" allows for a more real time look at data that is housed and managed by the PCHS team.

Another example of positive data sharing is the Pinellas Integrated Care Alliance, whose PIC teams assist individuals referred by the Sheriff's Mental Health Unit. PIC teams provide an array of services to prevent further contact with law enforcement, crisis stabilization units, and emergency rooms.

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[29] Pinellas Matters is funded through City/County Opioid Settlement dollars that are being directly overseen by the Board of County Commissioners (BCC), not OAFAB-managed regional settlement funding.
[30] Care About Me (CAM) was built on recommendation of the Elevate Behavioral Health Pinellas County strategic review, a similar assessment looking at the behavioral health system in Pinellas County at large.
[31] Naloxone is a medication designed to rapidly reverse opioid overdoses, often known by the brand name Narcan.
[32] Prescription Drug Monitoring Program – Take Control of Controlled Substances
[33] United States Government Accountability Office, n.d.
[34] The E-FORCSE® (Electronic-Florida Online Reporting of Controlled Substance Evaluation Program) is Florida's Prescription Drug Monitoring Program established in 2009 to promote safer controlled substance prescriptions and combat drug use, and federal agencies, including the Department of Justice (DOJ) and Department of Health and Human Services (HHS), have made funding and technical support available to states to help improve integration.
[35] Bureau of Justice Assistance (2018); Pinellas County Opioid Task Force (n.d.); Pinellas County Opioid Task Force (n.d.)

Some institutions have shown success in the past but are being modernized to best serve current county needs. For example, the Pinellas County Data Collaborative is a longstanding initiative to enhance county mental health services by encouraging collaboration among community service providers, government agencies, and educational institutions. In addition to the Florida Mental Health Institute (FMHI), key members of the Collaborative from Pinellas County include the County Commissioners, the Circuit Court, the County Attorney, Sheriff's Office, the Pinellas Department of Social Services, and the Juvenile Welfare Board. Participating state agencies include the Florida Department of Children and Families and the Florida Department of Juvenile Justice. The Policy and Services Research Data Center (PSRDC) at the FMHI compiles and analyzes data shared through the Collaborative for the Pinellas County Blue Ribbon Panel on Mental Health and Substance Abuse and for various other projects.

The program has fostered cross-system data sharing to allow for ad-hoc analyses and reporting on local system involvement and trend questions. The project continues to operate as established; however, recent discussions have focused on a need to modernize the collaboration, architecture, and tools to keep pace with future needs. Pinellas County has recently renewed the signatory agreements for the Data Collaborative and work will be getting underway to assess future needs, modernize the architecture, and update procedures.

By appropriately allocating settlement funding, the county and the community can continue to support the health and wellbeing of its residents while addressing the evolving nature of the crisis.

Section 4

Gap analysis

Introduction to the Continuum of Care

The gap analysis presented in this Report is organized around a Continuum of Care for Opioid Use Disorder. This CoC builds off a Patient Experience Journey published by the Addiction Policy Forum, with support from the National Institute on Drug Abuse (NIDA).[36,] The Addiction Policy Forum also published a "Continuum of Care Approach" document to treating OUD at a systemic level. This "Continuum of Care Approach" is not the basis for the CoC referenced in these pages, though that document is a secondary source incorporated into the catalog of leading practices. The Patient Experience Journey was used because it represents the individual experience and could be modified to represent the specific needs of Pinellas County that were identified during the research.

The Patient Experience Journey is an attempt to represent a nonlinear journey that individuals with OUD are highly likely to progress through. Each individual experiences the journey differently, and this framework is representative of the aggregate experiences. The CoC referenced throughout this document was designed to categorize the relevant services and supports across prevention, treatment, and recovery in Pinellas County.

This process, starting with the foundational framework and supplemented by primary research, was iterative and resulted in multiple additions and refinements to the CoC that are specific to Pinellas County. For example, "Mobility" was added as a key external factor given some of the transportation barriers unique to the county, as well as numerous publications showing how it can be an influencing factor. Other Pinellas-specific additions to the Patient Experience Journey included "Governance" and enhancement of the discussion regarding the clinical experience, to reinforce the difference between acute and post-acute care.

The framework is not exhaustive, nor it is it expected to represent every permutation, or all counties given the focus and orientation in aligning identified gaps to the organizing framework of the CoC. Instead, it serves as a singular organizing structure used throughout this Report for describing the individual barriers, alignment of leading practices, and needs in Pinellas County.

The final CoC represented in this Report also reflects the voice of the Pinellas community, which is a crucial component of this work. Definitions, descriptions, and entries within each of the categories were shaped during the gap analysis by the input of stakeholders with lived experience and expertise who surfaced shared experiences throughout Pinellas County. The individualized approach differs from other secondary sources that attempt to frame this CoC, most notably by cataloguing both evidence-based and innovative practices to address the epidemic.[37]

There are five sections of the CoC, shown below in Exhibit 3. As discussed, the CoC is not a linear path, which means that an individual may experience the sections of the CoC in any order, any number of times, or not at all. Individuals with an active addiction are most likely to use services in the "acute addiction" category (such as harm reduction services) but will interact with services across the CoC if they seek treatment (such as emergency medicine in "Seeking Help" or detox in "Acute and Post-Acute Care."). If individuals experience a relapse, they may move from using services and supports in a category like "Long-term Maintenance

[36]Hulsey & Zawislak (2022).

[37] There are several clear connections between the Patient Journey and the APF's Continuum of Care Approach, and there is some overlap between the CoC used in these pages and the APF's Continuum of Care Approach. A notable area of difference is that the APF's Continuum of Care Approach is limited to evidence-based practices. The individualized approach reflects the reality that people experiencing addiction in Pinellas County will face scenarios for which there is no clear evidence-based solution, or where the evidence-based solution is not immediately feasible.

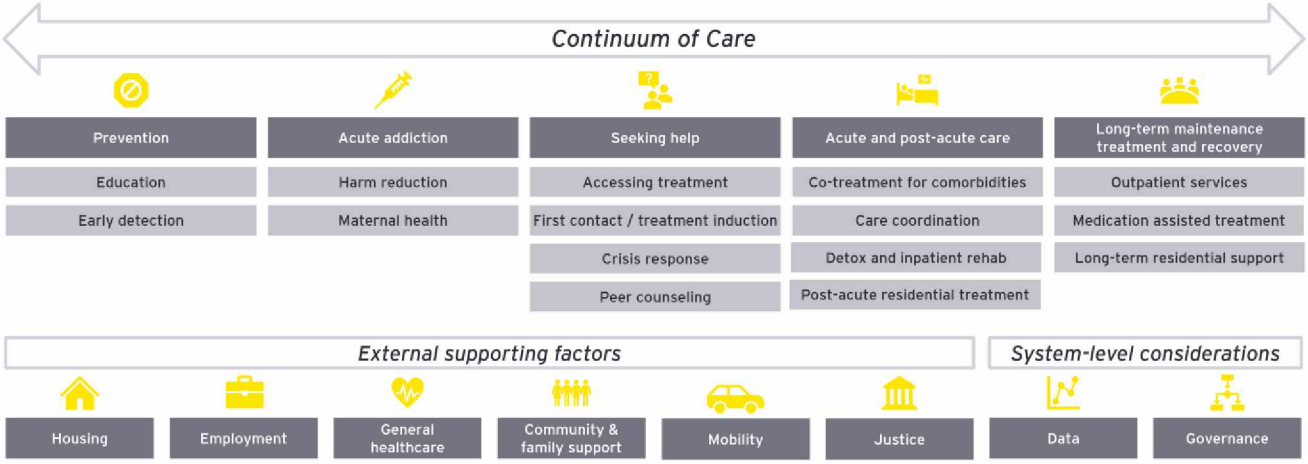
Treatment and Care" back to "Acute Addiction" or "Seeking Help." This dynamic reflects the non-linear nature of the disease.

Additionally, this analysis and framing includes the external supporting factors that influence to OUD-specific care, such as the justice system, given that an individual with OUD or in recovery will not just interact with only clinical services. The discussion of these external supports in this document is limited to how abatement investments could most directly impact someone in recovery. For example, while justice involvement is a primary barrier to many individuals with a history of addiction (and is noted as such throughout this document), the "Justice" category focuses on specific legal pathways for those individuals such as diversion programs.

The CoC is composed of categories and subcategories, shown in Exhibit 3. Each category represents a stage in an individual's journey through OUD and recovery. Each subcategory represents a type of treatment or service that an individual might interact with during the stage represented by the category. The external supporting factors are not tied to a specific category, but often interact with multiple categories and clinical services.

Finally, this Report takes into consideration system-level factors that impact care delivery across the CoC. Each of these categories is described below:

Exhibit 3: Continuum of Care (reprinted)



Prevention[38]

Primary prevention services help individuals avoid risk factors for future opioid use and deter opioid misuse.[39] Prevention services acknowledge that these risk factors often relate to major life events such as trauma, relationships, or finances, which may require extended work for an individual to overcome. The prevention category is composed of two sub-categories:

Education: Enhancing individuals' knowledge and behaviors regarding opioid use, health risks, and prevention tactics; includes programs directed toward youth, adults, and professionals in relevant fields.

Early detection: Creating proactive strategies and tools that identify the risk of opioid overdose early on, including primary care settings; identifying common triggers and precursors to OUD with high-risk individuals.

[38] As discussed, each category of the CoC, such as "Prevention," is constructed based on a Patient Experience Journey Map and adapted to the unique factors of Pinellas County

[39] Secondary prevention, where SUD/OUD is treated and minimized in earlier stages of acuity, is not discussed here as a discrete topic. Components of secondary prevention (as well as tertiary prevention at later stages of acuity) are covered in other sections of the CoC

Acute addiction

Acute addiction services address individuals who are in active use, but not yet seeking help or in treatment. People experiencing acute addiction often use or need services that other individuals in lower stages of acuity (or without addiction) also need, such as primary care, emergency medicine, or external supports. However, those services are covered elsewhere along the CoC. In this Report, acute addiction refers to two types of services for someone further along the pathway of addiction.

Harm reduction: Minimizing potential health risks and social harms linked to opioid use; improving the health of people who are actively using illicit opioids.

Maternal health: Meeting the unique needs of pregnant women and new mothers in the context of OUD.

People experiencing addiction often use other services such as crisis care, inpatient care, or outpatient services, but those services are typically associated with a pathway to recovery. Accordingly, those services are covered in the following section.

Seeking help

Programs and services designed to facilitate an individual's transition between acute addiction and treatment are included in the "Seeking Help" category. There are four sub-categories that cover broad-access care, all of which are not meant to be limited by an individual's ability to pay:

Treatment access: Widening the reach of effective OUD treatment services; leveraging moments of crisis to offer care (such as emergency department visits).

First contact/treatment induction: Treatment referrals initiated by providers, law enforcement, or other groups besides the individual in need of care.

Crisis response: Caring for an individual actively in crisis, either through proactively helping someone in need or responding to a call for help.

Peer counselors: Outreach, support, mentorship, and guidance provided by certified individuals with lived experiences of addiction and recovery.

Acute and post-acute care

Programs and services in the acute and post-acute care category are those that provide the initial medical and behavioral supports required to treat an individual's addiction. Recovery is a lifelong journey, and the longer-term supports required to sustain that journey are housed in the long-term treatment, recovery, and maintenance category. This category is limited to the supports that connect someone to acute care, support that care, and help transition from that care to long-term recovery. There are four subcategories:

Co-treatment for comorbidities: Treating other illnesses (e.g., HIV, Hepatitis C, mental illnesses) most likely to occur alongside substance use disorder (SUD)/OUD.

Care coordination: Personalized and actively managed programs that combine acute care from different sources (e.g., social work, public assistance, Medication-Assisted Treatment (MAT)).

Detox and inpatient rehab: Programs aimed at managing withdrawals or a transition to sober life, generally shorter term (<30 days) and reserved for medically unstable individuals.

Post-acute residential treatment: Programs providing OUD-related care in a facility in which the individual lives, often for 30 days or longer and with varying levels of supervision.

Long-term maintenance treatment and recovery

As stated above, programs and services in this category are designed to support individuals for as long as they need post-completion of acute and post-acute care. The category consists of three subcategories:

Outpatient services: Programs occurring outside of inpatient settings aimed at maintaining an individual's recovery, including regular outpatient services, in-home services, and intensive outpatient services (defined as those occurring for more than 10 hours per week). Includes MAT, behavioral therapy, and counseling.

Medication-assisted treatment/Medication for opioid use disorder: Prescribed medication to treat OUD, along with appropriate medical supervision and accompanying behavioral health care. In this document, the term MOUD specifically refers to medication like methadone, buprenorphine (Subutex), naltrexone (Vivitrol), or a combination of buprenorphine and naloxone (Suboxone). MAT refers to that medication in conjunction with behavioral healthcare such as therapeutic counseling or therapy. Where gaps relate specifically to the physiological dependency and/or euphoric effects of opioids, MOUD is used. Where gaps relate to casual factors associated with cognition, behavior or psychological trauma treatment and where MOUD is subcomponent, the term MAT is used.

Long-term residential support: Long-term homes that support recovery by providing a higher-support safe, drug-free living space specifically for individuals in recovery, typically with staff on site or consistently visiting.

External supporting factors

An individual's experience with OUD recovery is not exclusively defined by the OUD-specific care that they receive. It is also influenced by a range of external factors that inform whether or not that care is accessible, effective, and sustainable. As individuals progress through clinical, psychological, and physical improvements, they often use these external supports to aid in their long-term recovery. For example, employment supports can help provide stability, meaning, sustainable income, and health insurance, all of which may contribute to better outcomes. This Report examines the state of six such factors which Pinellas County stakeholders have consistently mentioned as crucial:

Housing: Housing supports for those recovering from addiction, returning from prison, and/or experiencing homelessness, including various types of transitional housing, supportive housing, and market-rate housing.

Employment: Job training, placement assistance, and career counseling for people searching for a job; services can include support groups to help maintain a stable job or legal assistance if needed.

Social interactions and relationships: Community, friends, and family involvement to help with recovery; services can involve assistance in accessing healthcare, housing, etc., as well as mutual support groups.

Mobility: Transportation support to help people in recovery access jobs, treatment, community, and family; services can look like actual mobility or transit-oriented development and care.

Justice: Improved coordination of care in correctional facilities to spur better health, safety, and treatment; pathways towards alternative justice (e.g., drug courts).

General healthcare: Non-OUD-specific healthcare (e.g., primary care, hospital care, etc.) for people with OUD.

Governance and data

The efficacy of opioid abatement programs is influenced by the efficiency and management of the system in which they operate. This report uses the framework of governance and data to examine the larger abatement system in Pinellas County (i.e., beyond settlement funds)

Governance: Governance model to guide abatement strategy; includes accountability decision-making models.

Data: Process improvements to effect changes in the CoC and in external supports. Key metrics are often measured through the collection of quality data that speaks to all aspects of process improvement.

In the sections following, this Report examines each step of the CoC, including external supporting factors, and describes the gaps identified in them.

Prevention

Prevention efforts aim to reduce stigma, educate communities, and identify the risks and consequences of OUD to prevent individual choices that result in OUD and/or other addictions. Gaps in prevention are believed to indirectly impact ability to "shift the curve" and reduce drug use behaviors upstream of addiction patterns, particularly among younger populations. For example, if prevention messaging is not sufficiently targeted at younger groups, they are likely to be at higher risk of SUD due to biologic and/or socioeconomic factors later in life or be unaware of their current risks. Furthermore, educating parents, educators, and other community leaders about current trends and signs of substance use/OUD may help reduce harmful drug behaviors in youth. Prevention consists of education and early detection.

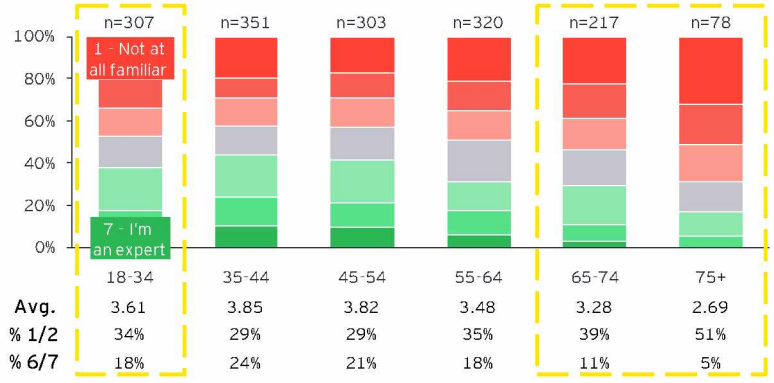
Education

Gap P1: Public awareness of epidemic

The general public in Pinellas County lacks awareness and understanding about the current state of the opioid epidemic.

Survey respondents were asked to rate their familiarity with the opioid epidemic and efforts to stop it in Pinellas County, the results of which are in Exhibit 11.[40,41] Approximately twice as many respondents indicate that they are unfamiliar.[42] More respondents indicate unfamiliarity than familiarity across all age cohorts; this was most pronounced among 18-34-year-old respondents (approximately two times more unfamiliar) and those 55 and older (approximately three times more unfamiliar).

Exhibit 11: Resident familiarity with the opioid epidemic



Generally, low public awareness of the opioid epidemic and related abatement efforts may have downstream effects.

First, residents who are not aware of the scope of the epidemic in Pinellas County and abatement efforts are not likely to know how to navigate the system of care should they need to. As is highlighted in the Seeking help section, surveyed individuals in Pinellas County report low awareness of how to access services related to OUD. Educational efforts aimed at promoting awareness of the epidemic before individuals need services may increase awareness of services and how to access them should the need arise.

Second, low familiarity with the epidemic contributes to stigma towards those with OUD. Residents who attended listening sessions commonly reported that stigma, or fear of stigma, could prevent people with OUD from receiving services. Individuals using substances can find themselves ostracized by friends, family, and peers instead of supported. Educational efforts in Pinellas County aimed towards increasing the public's understanding of addiction as a disease and the prevalence of OUD may work to reduce stigma.

[40] Pinellas County Constituent Survey
[41] On a scale of 1-7, where 1 = "Not at all familiar" and 7 = "I'm an expert"
[42] Unfamiliarity defined as answering 1 or 2, familiarity defined as answering 6 or 7

Gap P2: Access to prevention

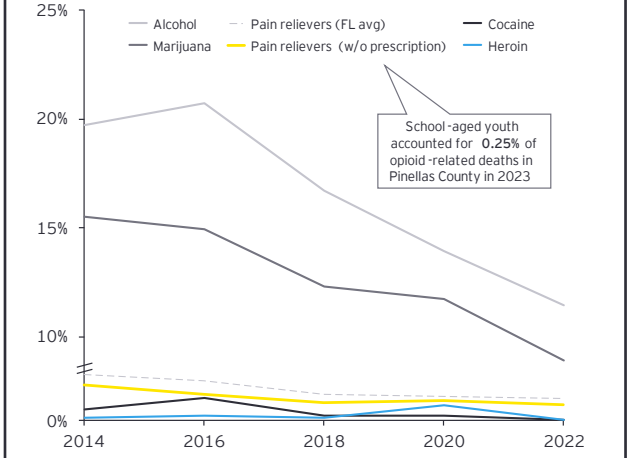
Many individuals in Pinellas County do not know how to access resources to learn more about opioid misuse, and those who do report that resources are not effective.

Surveyed individuals state low awareness for how to access programs that help people make healthy choices around opioid use. Only 20% of surveyed individuals who were unfamiliar with the opioid epidemic in Pinellas County and fewer than 50% of individuals who were familiar with the epidemic felt confident about accessing these programs.[43] Only 11% of surveyed individuals stated they felt that prevention resources were effective.[44]

There are few programs in Pinellas County reaching younger and older populations, the groups with the least familiarity about the epidemic. Several schools have Red Ribbon Campaign weeks, but public materials sent to parents indicate that those weeks are focused on alcohol and marijuana prevention. Boys and Girls Club of the Suncoast is rolling out an opioid-specific prevention program to all 22 Pinellas middle schools, but the program does not have a high school component at the time of writing. Despite seniors' low awareness and high share of opioid overdose fatalities (37% of all opioid overdose deaths in Pinellas County were from those >50 years old), prevention programs specifically targeted at older individuals were not identified through secondary research.

In school settings specifically, research showed that opioid use among students is not as prevalent as the use of other substances (such as alcohol, nicotine, and marijuana; substance use in Pinellas County students is shown in Exhibit 12).[45] However, growing concerns around contamination may warrant more preventive education among youth. Today, every student in Pinellas County Schools (PCSB) interacts with NOPE, a preventive education group,[46] twice over the course of their middle and high school years. The organization has reached ~280,000 students since its founding in 2009.[47] Still, some interviewees would like to see more educational programming, and see it start at a younger age.

Exhibit 12: % of PCSB students using substances, 2014-2022



Second, OUD-related educational efforts in Pinellas County typically focus on harm reduction as opposed to broader prevention enabling safe decisions around opioid use. The Opioid Task Force spearheads educational efforts in Pinellas County, and much of the current effort is directed toward increasing awareness of naloxone availability and usage. In 2023, the OTF organized ~30 community information events, of which approximately five were specifically held to increase awareness about opioid use.[48] Pinellas Prevention Partners is another organization that aims to raise awareness about substance use through educational seminars and related resources, but its efforts are not specific to opioids. NOPE, mentioned above, provides preventive education in school settings as well as to the broader community, but one volunteer-based organization is limited in its reach.

Increasing awareness through prevention efforts across Pinellas County will likely require strategic planning and execution. More specifically, considering the target audience of a given prevention initiative is key to ensuring that awareness campaign efforts and messaging are effective.

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[43] "Unfamiliar" refers to answers of 1/2 to "How familiar are you with the opioid epidemic and efforts to stop it in Pinellas County?" with choices on a 1-7 scale where 7 = "I'm an expert." "Familiar" defined as answering 6/7 to the same question. "Aware" refers to answers of 6/7 to "If you needed prevention services, how confidently could you find them in Pinellas County?", where 7 = "Extremely confident."
[44] "Effective" refers to answers of 6/7 to "How effective are prevention services in Pinellas County?", with choices on a 1-7 scale
[45] 2022 Florida Youth Substance Abuse Survey
[46] Narcotics Overdose Prevention and Education (NOPE) Task Force is a 501(c)(3) offering education and advocacy in Pinellas County
[47] EY interviews and analysis
[48] Opioid Task Force

Acute addiction

Efforts to help people experiencing acute addiction typically focus on harm reduction. Gaps in harm reduction could result in negative healthcare outcomes as individuals may not be able to access life-saving tools such as naloxone or clean syringes. Additionally, mothers experiencing addiction may not be able to access crucial prenatal care.

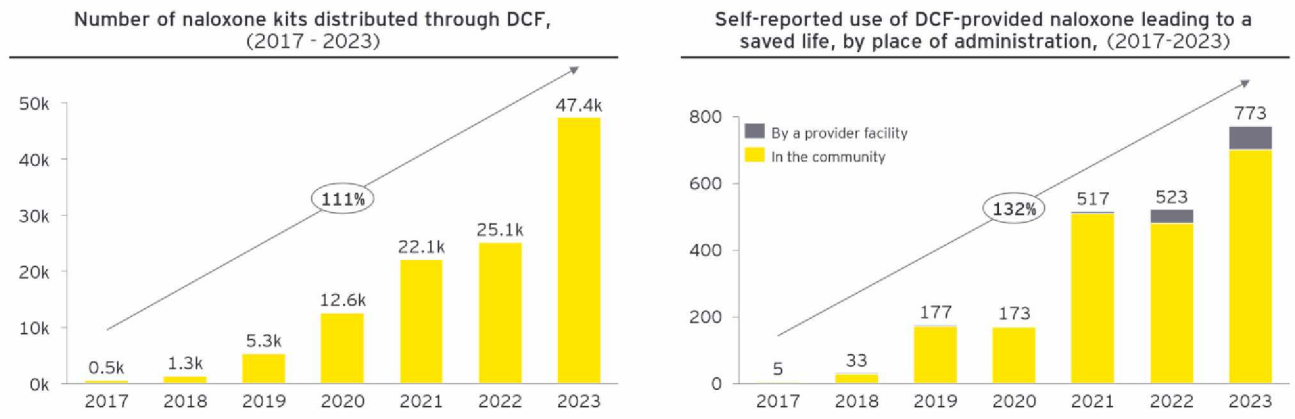
Harm reduction

Gap A1: Naloxone adoption

Populations frequently interacting with opioids (e.g., EMS, first responders, those with lived experience) often have access to naloxone (i.e., Narcan), but broader adoption remains limited.

Pinellas County has a higher rate of naloxone distribution than many Florida counties. In Florida, the Department of Children and Families (DCF) is the primary distributor of free naloxone.[49] In 2023, Pinellas County ranked second in Florida in DCF naloxone kits distributed per capita[50] and fifth in kits distributed per overdose.[51] Between 2017 and 2023, DCF kit distribution grew at a compound annual growth rate (year-over-year rate) of 111%, and self-reported administrations of DCF-provided naloxone leading to a saved life grew at a 132% year-over-year, which can be seen in Exhibit 13. Related to distribution, 75% of surveyed residents indicated that they are either familiar with or have used free naloxone programs in the county.

Exhibit 13: Naloxone distribution through DCF in Pinellas County, 2017-2023

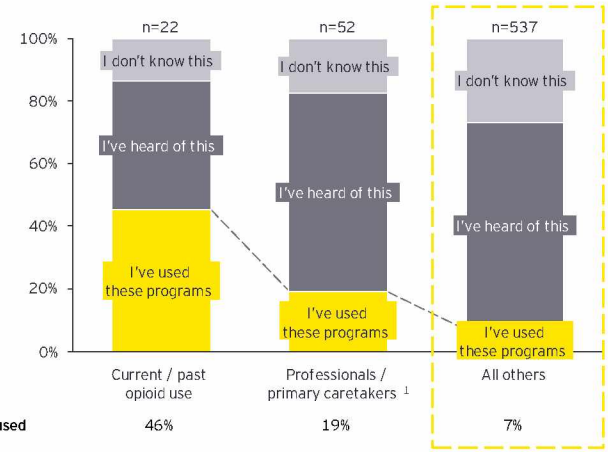


Pinellas County residents state familiarity with naloxone distribution efforts, but interviewees report that residents without lived experience are less familiar with the specifics of access and use (as shown in Exhibit 14). Survey results are consistent with these findings as surveyed residents with lived experience/primary caretakers were more than five times as likely to have accessed free naloxone than other residents.[52]

[49] FL DCF State Opioid Dashboard. Through a state-wide program that begun in 2016, DCF distributes naloxone to organizations that request it. These organizations in turn distribute the naloxone to their staff, clients, and/or the general public. This naloxone distribution is not the source of naloxone used by first responders in their professional work.
[50] Among counties with at least 150,000 residents
[51] Among counties with at least 10 overdoses in 2023
[52] Pinellas County Constituent Survey

There are several places where interviewees believe there would be value in having readily available naloxone, including hospitality venues and high-traffic commercial corridors. 24/7 access points, such as vending machines, were also stated as potentially being valuable for access.

Exhibit 14: Resident awareness and use of free naloxone programs



The need for naloxone availability in non-traditional spaces is underscored by mixed results of naloxone availability in spaces like pharmacies.[53] However, 24/7 options for naloxone dispensation have shown more positive results, with one causal analysis suggesting 40 lives saved in the first year of a program in Clark County, NV (Las Vegas).[54] A study of these vending machines in Hamilton County (Cincinnati) noted that since the vending machine installation, 637 individuals registered with the program, 12% of whom had reportedly never used harm reduction services before. Within its first year of use, the machine dispensed 3,360 naloxone doses and 10,155 fentanyl test strips, more than any other SSP in the county.[55] Partnerships with hospitality venues and other businesses is still a developing practice but has the potential to show positive results.

Despite the fact that less than 1% of OUD-related 911 transports in 2023 involved a transportee under 18 years of age, emergency responders report growing concerns around opioid contamination in marijuana in Pinellas County Schools. Many paired this concern with a desire for naloxone in school settings.[56] In general, interviewees reported that naloxone should be as widely available as other established first-aid tools (e.g., AEDs).

In addition to not knowing where to obtain it, interviewees report that a portion of the general population in Pinellas County likely does not understand what naloxone is, that it is safe, that it is legal, or how to use it. Research identified significant efforts across Pinellas County to raise awareness of naloxone through education, including over 1,300 (and counting) residents trained on what it is and how to use it over the last two years under a targeted grant initiative developed by Pinellas County Human Services and Safety and Emergency through the First Responder Comprehensive Addiction and Recovery Act (FR-CARA) Grant.[57] These trainings initially focused on the first responder population, with expansion to other groups including transit personnel and youth. Interviewees suggest that training more people, including hospitality groups, non-OUD-specific healthcare workers, and the general public could also be beneficial. Key to the success of these engagement efforts is raising awareness of the Good Samaritan law in Florida that provides immunity from civil liability to any person who provides emergency care or treatment in good faith (i.e., administers naloxone in an emergency).[58] That law protects individuals from prosecution for most drug-related offenses discovered as a result of emergency intervention. The trainings mentioned above do usually cover the law; however, these are limited to the groups mentioned above and broader general public awareness is needed.

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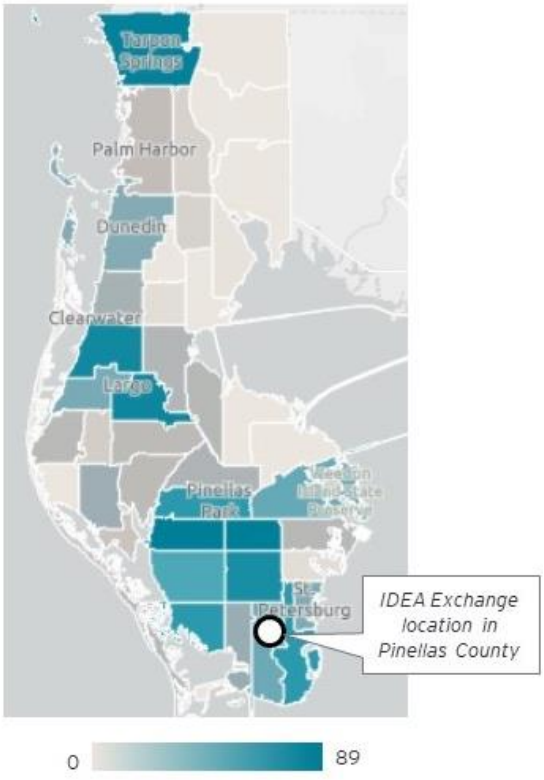
[53] Gallant et al. (2023)
[54] Allen et al. (2022); Arendt (2023)
[55] Arendt (2023)
[56] Figure derived from SES data consisting of random sample of all OUD-related transports in Pinellas County. Sample set consists of approximately 2,300 discrete transports.
[57] Figure reported by interviewee conducting trainings in Pinellas County. Training was done under the FR-CARA grant, which required 500 individuals to be trained; to date, the program has reached over 1,300 people.
[58] Bromley (2021); Minnesota Department of Health

Gap A2: Syringe service programs

Pinellas has only one syringe service program, with only one location. As such, access to it is geographically limited. State and local ordinances also limit available funding streams, distributable supplies, and potential operating models.

At the time of writing, Infectious Disease Elimination Act (IDEA) Exchange Pinellas is the only SSP in Pinellas County, as shown in Exhibit 15. It operates from a strip-mall location in St. Petersburg and is open from 10 a.m.–3 p.m. on Mondays, Wednesdays, and Fridays. During interviews, clinical providers, community organizations, and IDEA Exchange Pinellas clients all expressed that the program is valuable. They perceived IDEA Exchange Pinellas not only as a space specifically for exchanging needles and lowering risk of related illnesses (Hepatitis C, HIV), but also as a space where clients can feel welcome, face no judgement, receive general healthcare like wound care, and be connected to needed services and supports on their own terms. Pinellas County needs avenues through which people with OUD are connected to services and supports before a moment of crisis, and IDEA Exchange Pinellas is one such avenue.

Exhibit 15: IDEA Exchange Pinellas location relative to fatal overdoses (2023)



IDEA Exchange Pinellas has a limited reach due to its single location. Transportation is a key issue for people with OUD in Pinellas County, limiting access to those nearby.[59] There are other pockets of Pinellas County where OUD is prevalent, and residents in these areas do not currently have convenient access to an SSP location and the associated services and supports. As such, only 10% of surveyed residents with lived experience indicate that they have used an SSP in Pinellas County.

Importantly, not all individuals in active use inject opioids. A 2022 study by the CDC analyzing opioid-involved overdoses found that 16% of overdoses had evidence of injection. Smoking was more common, with 23% of overdoses having evidence of smoking. This marks a shift in use since 2020, when injection evidence was found in 23% of cases and smoking evidence in 13% of cases.[60] Furthermore, many individuals who use opioids also use other injectable drugs. For example, 50.1% of cocaine users report using an opioid within the last year,[61] and 53.5% of methamphetamine-related overdoses had opioid involvement.[62] The benefits of SSP services could therefore extend to users of all injectable drugs.

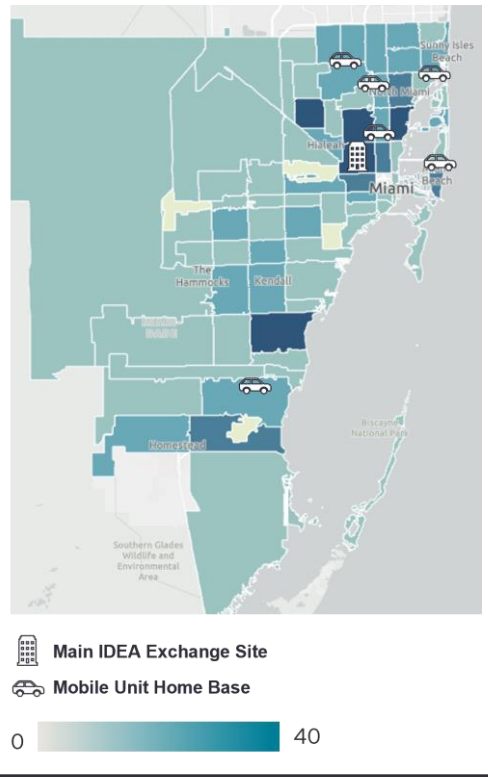
Impact of state and county regulations on SSP operations

The IDEA legislation requires that if a Florida county is to establish an SSP, it must draft and codify an ordinance governing that county's SSPs. Pinellas County's ordinance specifically prohibits SSPs in Pinellas County from carrying "spoons or spoon-like tools, or material for filtration, such as cotton balls, string, bands, or material of a size that allows for use as a tourniquet, lighters, or pipes."[63] These restrictions in Pinellas

[59] See *Mobility* Subsection of *External Supporting Factors* section for further detail. Note that Exhibit 16 shows all overdoses, but a majority of overdoses in Pinellas are from opioids
[60] Tanz et al. (2024)
[61] Cano et al. (2020)
[62] Jones et al. (2021)
[63] Pinellas County Ordinance No. 21-02

County limit the efficacy of syringe service programs in achieving evidence-based outcomes associated with their services, though they were requested in community input sessions held by the Pinellas division of the state Department of Health.[64] Interviewed harm reduction specialists expressed desire to carry these items in order to attract a wider clientele to the SSP, and reduce additional harms associated with use. Tourniquets, for example, enable safer, more accurate injection. Materials for filtration, including cotton swabs, allow users to remove impurities from their supply.[65] Lighters and pipes specifically were cited as an item that could diversify clientele and attract the growing population of individuals who smoke opioids or other substances, who would benefit from the co-occurring care and linkages available at SSPs.

Exhibit 16: IDEA Miami-Dade location relative to fatal overdoses (2022)



The Pinellas County ordinance also prohibits mobile exchange units, the only ordinance in Florida to do so.[66] Miami-Dade operates a combination of mobile and fixed locations, as shown in Exhibit 16.[67] Broward County, Hillsborough County, and Palm Beach County all have mobile syringe service programs,[68] the last of which served 709 clients and distributed 1,368 naloxone kits that directly reversed 935 overdoses in 2021–2022.[69] Orange County, the last county in Florida with an exchange, does not have a mobile unit, but its ordinance allows for them.[70] Additionally, public sentiment supports the use of mobile services in neighboring counties.[71] The CDC recommends that SSP modality be determined through an assessment of community needs, as there are pros and cons to fixed vs. mobile locations. Pinellas County's ordinance does not allow for this, and as such is uniquely restrictive in Florida.[72]

At the state level, the IDEA requires that SSPs operate on a one-to-one needle exchange basis, meaning that participants may only receive one new, sterile needle for every used needle that they bring to the program. Research indicates that needs-based distribution policies reduce syringe reuse and disease risk more effectively than one-to-one policies. Needs-based programs have been shown to lower HIV risk to a greater extent than one-to-one programs, improve syringe coverage, reduce reuse, and increase proper disposal tendencies.[73] Additionally, the act prohibits syringe exchange programs from using state, county, or municipal funds to operate.[74] SSPs must instead rely on federal or private grants and donations. During a Statewide Council on Opioid Abatement in November 2023,[75] Chief Deputy Attorney

[64] Kerr et al. (2010)
[65] National Harm Reduction Coalition
[66] "The Syringe Exchange Program must only operate at one or more fixed locations within Pinellas County." Pinellas County Ordinance No. 21-02.
[67] Exhibit 17 shows all overdoses, but a majority of overdoses in Miami-Dade are from opioids
[68] Florida Harm Reduction Collective
[69] Palm Beach Committee on Behavioral Health, Substance Use and Co-occurring Disorders (2024)
[70] Orange County Ordinance No. 2020-12, § 1, 5-19-20
[71] Sharp et al. (2020)
[72] Javed et al. (2020)
[73] Javed et al. (2020)
[74] "State, county, or municipal funds may not be used to operate an exchange program. Exchange programs shall be funded through grants and donations from private resources and funds." Florida Statute 381.0038.
[75] Statewide Council on Opioid Abatement Virtual Meeting Minutes November 6, 2023

General Guard confirmed that settlement funds are considered state, city, and county funds, and thus Florida law prohibits their use to fund expansion of syringe service programs.

Gap A3: Fentanyl test strips

Fentanyl test strips are not yet widely distributed in Pinellas County.

Decriminalized in June 2023 in Florida, and in January 2024 in Pinellas County,[76] fentanyl test strips have only recently become a viable harm reduction tool in Pinellas County and are not yet widely available.

Stakeholder opinion on the value of the test strips varies, with some citing concerns that substance users are hesitant to expend their substances on testing, that test kits are difficult to use, and that the test strips do not detect some fentanyl analogs or other substance contaminants like xylazine. Xylazine test strips also exist, but, at the time of writing, are not legal in Florida. During the research, several stakeholders noted that test strips are an important tool in a complete harm reduction tool kit, stating that families of those in active use may see value in the strips as a safety mechanism, even if individuals in active use do not.[77] Additionally, recreational drug users — often users of powder-form substances like cocaine and ketamine — often use test strips in nightlife and similar settings. While these strips may not be used broadly, they may be effective among specific groups.

Other Florida counties have made efforts to distribute test strips as part of their harm reduction efforts. In early 2024, Orange County's Office for a Drug-Free Community partnered with local organizations to distribute 6,000 kits, each containing 10 test strips. A portion of this distribution effort targeted music festivals, bars, and similar spaces where recreational drug use is common. Orange County plans to use ~$100,000 of its settlement funding to purchase the strips and support distribution.[78] Outcome metrics for this effort are not yet available, but research has demonstrated that fentanyl test strips positively influence substance use behaviors.[79]

Maternal health

Gap A4: Maternal healthcare utilization

Mothers with OUD can be reluctant to access the services available to them in Pinellas County for fear of receiving poor care or facing repercussions like child separation.

Pinellas County has a well-developed network of supports for pregnant women (e.g., Alpha House, Planned Parenthood, Healthy Start Coalition, Healthy Families[80]), as well as programs specifically dedicated to mothers with OUD (e.g., Parents as Teachers). Prenatal screenings for a range of potential risks, including SUD, are mandated by Florida's 1991 Healthy Start Initiative legislation,[81] and these screenings result in referrals to appropriate programming in Pinellas County. Among this programming is a robust home visit program (Parents as Teachers) specifically designed for women with SUD that offers SUD recovery support alongside care coordination, developmental assessments, health screenings, and family skill building and strengthening training. In 2022–2023, 100% of families served by Parents as Teachers were referred to support services, though participation in these programs is voluntary.[82]

While these support programs exist and do not currently have capacity constraints that could be identified during research, interviewees who work with mothers with OUD suggest a subset of mothers do not access services for two main reasons. There is a fear of stigmatization resulting in poor care from general healthcare

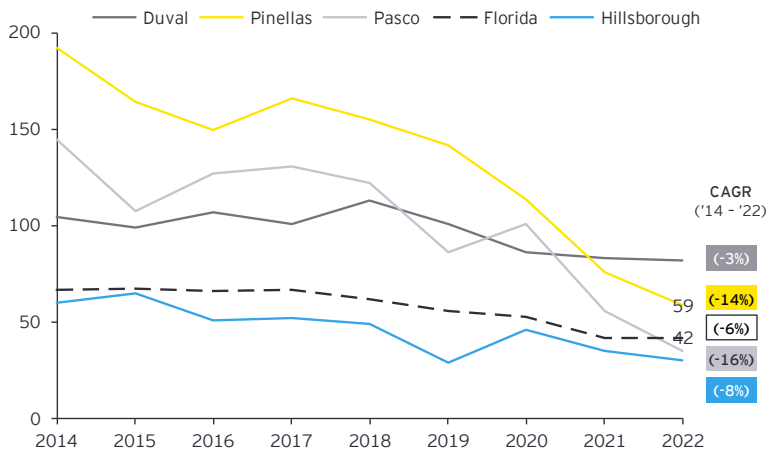
[76] Parseghian (2024)
[77] Claims stemming from feedback after 100 strips were distributed by Pinellas County recovery and harm reduction organization.
[78] Matthews (2024)
[79] Peiper et al. (2019). For more information, see Recommendation 4.
[80] From Healthy Start Pinellas' resource guide
[81] Florida Health (2008)
[82] The Healthy Start Coalition of Pinellas, Inc. (2023)

providers, and a fear of child removal. These fears can prevent mothers from seeking and participating in SUD-specific programming, and even prenatal care altogether.

Consideration: Neonatal abstinence syndrome

The prevalence of neonatal abstinence syndrome, or NAS, is one measure of the impact of maternal opioid use on children. NAS occurs when an infant is exposed to drugs — in particular, opioids — in the womb, and is born into withdrawal. As shown in Exhibit 17, Pinellas County saw approximately 190 cases of NAS per 10,000 births in 2014, almost three times the rate of Florida (~65 cases per 10,000 births). [83] Pinellas was only surpassed in the state by Bradford, Flagler, Manatee, and Putnam counties. By 2022, Pinellas County's NAS incidence rate had declined to 59 cases per 10,000 births. This decline shows signs of progress around prenatal OUD care, but Pinellas' 2022 rate was still above the Florida average of 42 cases per 10,000 births.[84]

Exhibit 17: NAS cases per 10,000 births in selected FL counties, 2014-2022



If Pinellas County experienced a comparable rate of decline (-14%) in the years between 2022–2024 with no other changes, the NAS rate in Pinellas is projected to currently be 44 cases per 10,000 live births (comparable to the state average, assuming stable declines on the statewide level). More recent and granular data was not available over the course of writing this Report, making any assessment of more recent gaps or trends within Pinellas County across geographies and demographic groups unfeasible.

While Pinellas County had higher NAS rates than the state average historically, progress in reducing those rates is a demonstrated success. The programs mentioned above (such as Parents as Teachers and Healthy Families) are believed to have contributed to this success.

[83] Florida Department of Health
[84] *Ibid*

Seeking help

Individuals ready to seek help should have immediate access to services. Delays in treatment can lead to relapse and reduced willingness to pursue care. For example, a one-to-two day wait for detox or inpatient treatment admission can jeopardize long-term recovery and sobriety. Service gaps currently exist in all four subcategories: treatment access, initial contact, crisis response, and peer counseling.

First contact

Gap S1: Care entry

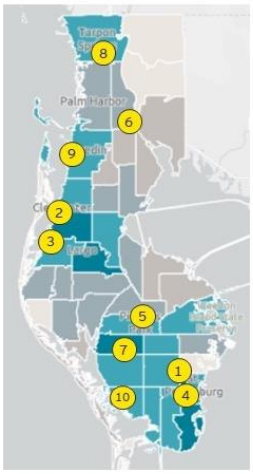
Providers and CBOs who would like to help someone with OUD take initial steps toward accessing care are not always able to connect individuals to the provider/program that the individual needs.

It can be difficult for providers to establish linkages to care before a point of crisis such as arrest or overdose. Many interviewed stakeholders have experience trying to get individuals with OUD connected to the proper care, but those stakeholders report difficulty doing so. They cite barriers like long and intrusive screening processes, which, when completed, do not always result in the individual in question qualifying for the service. When compiling the inventory of services, it was clear that the eligibility criteria for services is not always easy to interpret based on publicly available information. For example, treatment centers may only accept adults who are homeless adults with co-occurring disorders that only meet certain ASAM level criteria, or only accept a certain type of payment. These processes can discourage people ready for care, at best delaying entry and at worst deterring it altogether.[85]

Effective connection to OUD specific treatment after a point of crisis are also not universally available.[86] Interviewees consider the Pinellas Matters program, a hospital bridge program in place at the time of writing in the Bayfront Health St. Petersburg and HCA Northside Hospital emergency departments, to be effective. Pinellas Matters leverages a dedicated care coordinator in the emergency department to connect individuals with follow-up treatment and initiates MOUD induction within the ED and a bridge prescription until their follow-up appointment. This program is planned to expand to HCA Florida Largo. As shown in Exhibit 18, these three locations account for 28% of OUD-related emergency department[87] visits; as the program success is validated through assessment of performance metrics, there may be opportunity for further expansion of Pinellas Matters and/or

Exhibit 18: Emergency departments in Pinellas County

OUD-related ED visits by ZIP code of origin, count, L4Q Q2 2022



Pinellas County EDs, by count and share of OUD-related ED visits, L4Q Q2 2022

Facility name	# of beds	% of cases treated	# of cases treated
1. St Anthonys Hospital	395	20.3%	709
2. Morton Plant Hospital	599	17.8%	622
3. HCA Florida Largo Hospital	455	11.0%	384
4. Bayfront Health St Petersburg	480	9.0%	314
5. HCA Florida Northside Hospital	288	8.1%	281
6. Mease Countryside Hospital	387	6.8%	239
7. HCA Florida St Petersburg	215	6.5%	226
8. AdventHealth North Pinellas	126	4.8%	168
9. Mease Dunedin Hospital	120	4.6%	160
10. HCA Florida Pasadena Hospital	307	2.6%	89
Other		8.5%	298

Existing Pinellas Matters hospital
Planned future Pinellas Matters hospital

[85] Some interviewees report that residents may even choose to use the Baker Act on themselves in order to find care.
[86] Effective hand-offs are typically "warm hand-offs," where referring providers meet in-person with patients and their new providers. These connections increase the likelihood that the individual will successfully receive care from the new provider. See Martin & Krawczyk (2024).
[87] 2023 SG2 emergency department visit data.

similar programs. In Pinellas County, city/county opioid abatement funds have been allocated to fund expansion of Pinellas Matters.[88]

Gap S2: Front-line physician training

Front-line physicians are not appropriately trained to treat individuals with OUD.

PCPs are often the first provider with whom an individual discusses opioid use. In Pinellas County, interviewees indicate that PCPs can be hesitant to provide opioid-related care and are not always effective with triage and referral. This problem is partly a knowledge gap, as addiction-certified MDs/DOs are uncommon in the U.S. healthcare system as well as in Pinellas County. There are ongoing efforts to fund behavioral health teaching hospitals that may help remediate this gap, but the initiative is still in progress.

Research for this Report also identified gaps in starting MOUD-involved care for individuals in emergency and non-OUD specific clinical settings in Pinellas. This is due to both the uncertainty among medical practitioners regarding follow-up care, as well as the limited number of physicians who become MOUD prescribers. Interviewees point out that there is no set of codified procedures related to continued OUD care (as there is with a heart attack, for example), which makes physicians hesitant to begin care as they do not know how it will be continued. Stakeholders also perceive an unwillingness among physicians to access training related to MOUD.

> *"I've heard time and time again how a physician's rotation for mental health was maybe a month long, and their rotation through substance use was a week…it's very minimal if it's not their specialty"*
>
> Clinical service provider

Stakeholders acknowledge that progress on this issue is slow, but improvement efforts can include education on leading practices in referrals, integration into workflows, and additional education on behavioral health supports.

Crisis response

Gap S3: Marchman Act implementation

The Marchman Act aims to remediate a gap in SUD treatment by enabling immediate crisis care. Due to the lack of a state-funded receiving facility other than the jail system, it has not filled that role in Pinellas.

Under Florida state law, individuals at risk of harming themselves or others can be held for an involuntary assessment for mental health or substance use disorders using the Baker Act or Marchman Act, respectively.[89,90] Under these acts, law enforcement agents can forcibly transport individuals to DCF-approved designated receiving facilities for emergency screening, evaluation, and short-term stabilization. Designated receiving facilities (except hospitals subject to the Emergency Medical Treatment and Labor Act) may deny admission of an individual under certain conditions, such as a lack of service capacity or inability to contact the referral source. These facilities are permitted to hold a person on an involuntary basis for screening, and if a Baker or Marchman petition is formally enforced, they may hold a person for treatment. Often, these acts are used with an intention to remediate a gap in timely mental health or substance use treatment.

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[88] Accordingly, recommendations in this document do not discuss expanding Pinellas Matters, since the BCC is allocating City/County Abatement funds to expand this program.

[89] The Baker Act (officially the Florida Mental Health Act of 1971) authorizes the involuntary examination and treatment of individuals experiencing mental health crises for up to 72 hours. Law enforcement officers, physicians, mental health professionals, and judges can initiate this process when an individual displays signs of a mental illness and a substantial likelihood of causing serious bodily harm to themselves or others. See the Florida Department of Children and Families website for further details.

[90] The Marchman Act (the Hal S. Marchman Alcohol and Other Drug Services Act) facilitates the involuntary examination and treatment of individuals struggling with substance abuse within five days. After assessment, the court can order treatment for up to 90 days. Family members, friends, law enforcement officers, and healthcare personnel can enact this process when an individual is proven to be impaired by substance use and unable to exercise control over their use. See the Florida Department of Children and Families website for further details.

Pinellas County does not have a designated non-jail Marchman Act receiving facility; candidates for the Marchman Act are either subjected to the Baker Act (which has seven designated receiving facilities in Pinellas) or brought to the County Jail. This system limits the use of the Marchman Act in Pinellas County. While other reports completed for Pinellas County have advised against constructing a new Marchman facility due to the time and resources required to start one, along with unanswered questions about its necessity, there may be an opportunity to contract with an existing provider facility to accomplish the same goal.[91]

Other Florida counties place Marchman Acted individuals into care.[92] Three of Broward County's Marchman facilities are hospitals.[93] Citrus County sends Marchman Acted individuals to a local crisis center (bed space permitting; otherwise, they are transported to another location); after stabilization, they are transported to an affiliated opioid treatment provider (OTP). Desoto County does not have a Marchman receiving facility, opting instead to send indigent individuals to an ACTS facility in Hillsborough County. In Manatee County, individuals are brought to a receiving facility that rescreens them to determine whether the Marchman Act was applied correctly. If the Act is rescinded, the individuals are connected with case managers and linked to appropriate care. If the Act is upheld, the individual is placed into detox and then later transferred to other care.

There is no consensus regarding the utility of the Marchman Act among stakeholders in Pinellas County. Critics of the Marchman Act report that it is a coercive procedure that is also a temporary solution, and that without adequate follow-up care, Marchman Act subjects return to the situations that they were in before the Act was used. A similar concern exists regarding the Baker Act. If Marchman Acts are applied improperly or without sufficient access to individual treatment needs, its application can cause an adversarial relationship with substance use treatment. This uninviting relationship can be counter to meeting a patient's motivational stage of readiness to change. Proponents, including caregivers, state that the Act is still a potentially life-saving tool for "when all else fails" that is not currently usable in Pinellas County.

While Marchman outcomes are not comprehensively tracked, a state-level study conducted in 2012 at the Healthcare Connection of Tampa observed that ~70% of individuals were discharged with medical approval after an average order length of 102 days.[94] This 102-day average includes not only full-time, primary treatment, but also stepped-down transitional care, and, in some cases, aftercare. This study does not discredit Pinellas County stakeholders who criticize the potentially temporary nature of care stemming from the use of the Marchman Act. Instead, it underscores the importance of any use of the Act being tied to the availability of long-term, continued, quality care, with real-time performance measures to confirm program effectiveness.

Peer specialists

Gap S4: Peer supports

Peer supports are underpenetrated across outreach, engagement, community support, and long-term recovery support.

Certified peer recovery specialists are individuals who have been in recovery for at least two years and have completed professional training courses equipping them to aid in other individuals' recovery journeys. Certified peer use is an evidence-based practice growing in popularity around the country, with applications across the CoC ranging from outreach to long-term recovery support. While this gap is introduced in the "Seeking Help" section of this Report, it is important to note that peer recovery specialists can be leveraged in other areas of the CoC as well, including clinical settings.

Interviewees consistently emphasized the importance of peer supports in individuals' recovery journeys. They cited the unique ability of peers to foster trust in the system of care by building personal relationships with individuals navigating the system. They also noted the peers' ability to communicate empathetically, drawing

[91] *Elevate Behavioral Health Pinellas County*
[92] Broward, Citrus, Desoto, and Manatee County websites; EY interviews
[93] Broward Behavioral Health Coalition
[94] Sweeney et al. (2013)

from their lived experience in addition to their training to offer a different approach than clinicians when communicating the value of treatment.

There are headwinds in Pinellas County to growing peer support presence. First, hiring is difficult. Certified peers must either pass state-level criminal background checks or be free of active use for three years for to be eligible for a state-issued level 2 background check waiver.[95] There are several barriers at the state level to receiving these waivers, despite recent legislation meant to smooth the path to passing a background check.[96] The waivers are needed because those in recovery often have backgrounds that reflect the impacts of their mental illness or the disease of addiction which may include histories of incarceration. It is these backgrounds that are often of most value and enable peers to support someone experiencing similar negative circumstances but are determined ineligible per current state backgrounds requirements. Organizations who hire peers are not universally aware of background check waiver availability, with multiple interviewed organizations who employ peers citing background checks as a barrier to hiring. Second, retaining peers is difficult. The high-stress, limited experience of supervisors now responsible for managing these positions, and often low-paying nature of peer support work drives high turnover, and some peers may use specialist work as a stepping-stone to higher-pay, lower-stress employment. As a result, peer specialists are underpenetrated in Pinellas County across the CoC.

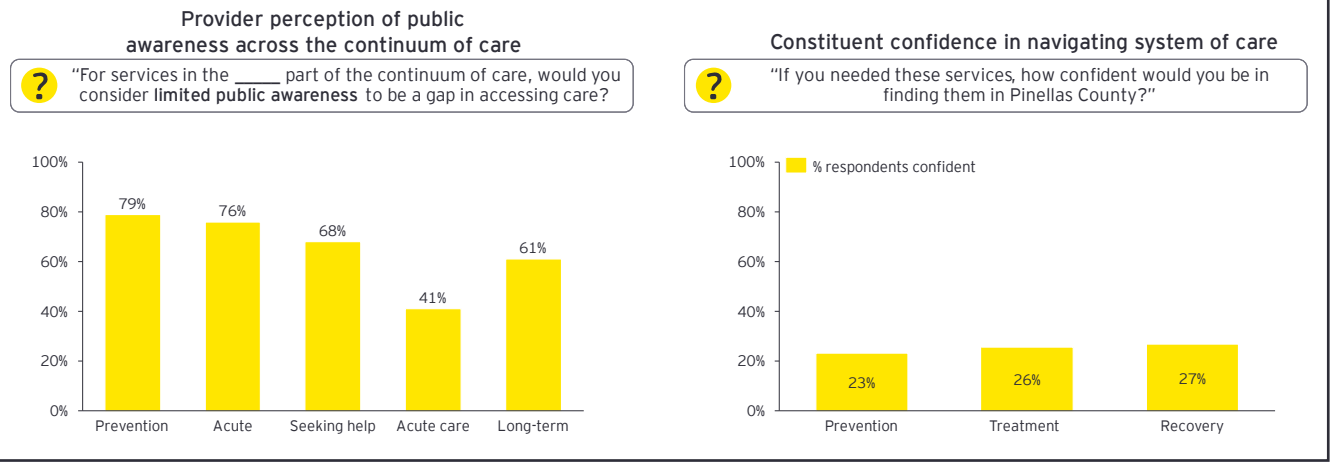
Access to treatment

Gap S5: Service awareness

Individuals with OUD, their caretakers, and their healthcare providers report low awareness of where to go to get help.

Both Pinellas County residents and providers indicate that public awareness of services available in Pinellas County is a gap.[97] Fewer than 25% of surveyed residents indicated that they would be confident finding prevention and treatment-related services in the county if they were to need them,[98] and 27% of respondents indicated confidence in finding recovery services. Seventy-nine percent (79%) of surveyed providers indicate that limited public awareness is a gap to accessing prevention services, 76% indicate it to be a gap to accessing

Exhibit 19: Public awareness of services in Pinellas County, perspectives of providers and constituents



[95] See CS/SB 282 (Chapter 2022-13) for details.
[96] EY interviews and research. See CS/CS/HB 975 for details.
[97] Pinellas County Clinical Services and Support Survey; Pinellas County Constituent Survey
[98] 23% of surveyed respondents; confidence defined as respondents answering 6 or 7 to the question "If you needed these services, how confident would you be in finding them in Pinellas County?" on a scale of 1-7 where 1 = "Not at all" and 7 = "Extremely."

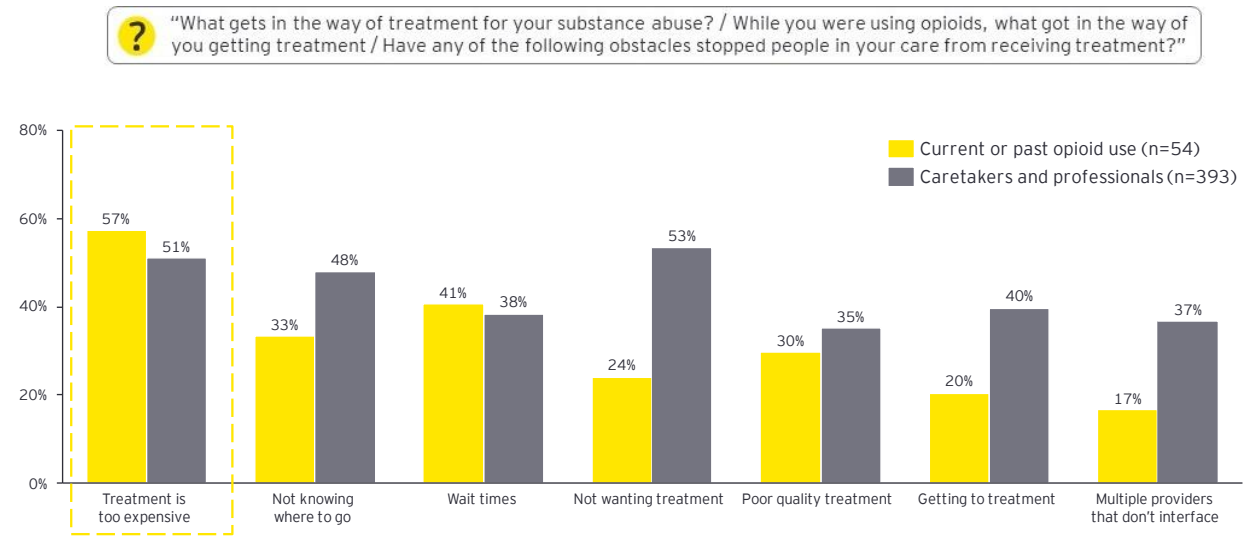
acute addiction services, 68% to seeking help services, 41% to acute addiction services, and 61% to long-term maintenance and recovery services. Survey results can be seen in Exhibit 19.

Resident experience with specific program types is also low, even among surveyed residents with lived experience. The most used service type (of those included in the survey[99]) is behavioral health clinics, with 30% of surveyed residents with lived experience, professional experience, or primary caretaking responsibilities reporting behavioral health clinic use. Only 9% of all surveyed residents without lived experience or primary caretaking responsibility indicated use of these services. Limited use of these services may stem from limited awareness of available services, as not knowing what services are available can lead to frustration when searching for them and even abandoning one's search entirely.

> *"When we go and search for this help, we're all going on Google, right? If we're not getting word of mouth, we're going online. We're looking for it and we're getting hundreds of different options. And the first one that we're going to click on is probably the paid advertisement that we don't realize is a paid advertisement. But it may not actually be the resources that we need. So, we spend all this time trying to figure out if this place can even help us."*
>
> Pinellas Resident

Some organizations in Pinellas County aim to consolidate available services and supports into public-facing resources, but residents express interest in more integrated and user-friendly solutions. Pinellas County Human Services Department has established a centralized, easy-to-use coordinated access model called Care About Me (CAM). CAM assists county residents of all ages, regardless of insurance status, in being screened and scheduled for behavioral health services. The platform includes a searchable database of services for SUD/OUD treatment needs. This is intended to reduce an individuals' time spent searching ad-hoc for services and calling multiple providers to verify eligibility and available capacity. The CAM only launched in May 2024; therefore, current community concerns about navigating these services ad hoc may be reduced if the program is successful. Initial feedback from local stakeholders suggests that CAM is well-received, but it will be important to continually assess awareness and adoption of the program among the broader population to gauge the degree to which CAM fills its intended role.

Exhibit 20: Reported barriers to receiving care in Pinellas County



[99] Survey included syringe services, rehab for opioids, overdose education, housing for people in recovery, free Narcan, behavioral health clinics, mental health crisis treatment, and MOUD.

Gap S6: Affordability

Affordability is a barrier to accessing care, especially for the uninsured and underinsured.

Surveyed residents who are in active use or recovery, are the primary caretaker for someone with OUD, or have professional experience related to OUD were asked what prevents their own treatment or the treatment of those in their care. Fifty-seven percent (57%) of respondents with lived experience (active use and recovery) and 51% of caretakers and professionals indicated that treatment is too expensive, as shown in Exhibit 20. For both populations, this was one of the top two barriers selected.[100] This survey result echoes interviewee sentiment that affordability is a common barrier to accessing care in Pinellas County.

The affordability barrier is particularly applicable to residents in the Pinellas County who are uninsured or underinsured. Because Florida is not a Medicaid expansion state, there is a particularly acute insurance gap for those who make too much to qualify for indigent care (typically above 100% of the federal poverty line) but too little to reliably afford private marketplace healthcare credits (typically below 138% of the federal poverty line). PCHS determines eligibility for indigent care programs and could conduct a study to analyze the costs and benefits of raising the eligibility threshold to a higher figure. However, this is not discussed in the following recommendations, since it would primarily affect other individuals in the county, not just those experiencing OUD.

Even though individuals with OUD are a small proportion of the low-income and uninsured populations (since only a small fraction of people have OUD), individuals with lived experience are still disproportionately likely to be low-income or uninsured. Thirty percent (30%) of surveyed residents with lived experience report being uninsured, with an additional 7% preferring not to disclose their insurance status. The 30% uninsured rate is four times the rate of reported uninsurance by respondents without lived experience, 60% of whom report having some kind of private insurance.[101]

Although Pinellas County has some options to help individuals who cannot pay for services, funding for indigent care in Pinellas County is limited, leading to waitlists for those that cannot pay. This can be attributed in part to Florida's Medicaid expansion status that places the burden of funding indigent care on regional funders and nonprofits. Even where providers have made efforts to maximize out-of-pocket affordability, cost can cause treatment attrition. One interviewed MAT/MOUD provider estimated that, despite the program's daily out of pocket cost being under $20 per day ($620 per month), most individuals who end treatment prematurely do so because they cannot afford to continue as this daily treatment expense is in addition to transportation costs associated with in-person attendance to daily appointments, and other daily costs such as food, medications, rent/mortgage, and other expenses.

Gap S7: Waitlists and treatment immediacy

Waitlists are a barrier to indigent care; self-paying individuals are more likely to have timely access to care. Broadly, waitlist statuses across providers are opaque.

Timely access to treatment is important in making sure that individuals who are ready for care can receive the care that they need. Wait times, whether in the form of formal waiting lists or stemming from long periods between first contact and appointments, can prevent care from taking place. Individuals forced to wait for services can end up changing their minds and forgoing them, with research indicating that wait times have adverse outcomes on treatment retention.[102] In Pinellas County, 41% of surveyed residents report waitlists to be a barrier to accessing care. 85% of interviewed non-providers (e.g., CBOs, government officials, first responders) agree, as do with 68% of surveyed clinical service providers. Survey results can be seen in Exhibit 21.

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[100] Pinellas County Constituent Survey
[101] The balance of respondents without lived experience are on Medicaid (8%), Medicare (20%), or VA benefits (2%).
[102] Hoffman et al. (2011)

In contrast, only 33% of interviewed service providers report that their programs have a waitlist.[103] Data regarding waitlists for all providers was unavailable over the course of this analysis, making it difficult to ascertain the extent of waiting times. However, data shared by a funder for uninsured patients in Pinellas County shows that the average waiting time in 2023 for a large provider for detox was 0.19 days and 19.21 days for MAT (see Exhibit 22), which confirms the existence of waitlists. This funder confirmed that, in the event it is made aware of a waitlist, it searches to see if capacity exists outside of Pinellas County. This is not indicative of patient-centered treatment and may not be feasible for an individual's given variables such as transportation, childcare, employment, and other general healthcare needs. However, if that individual chose not to accept outside care, they may not formally be included as "waitlisted," potentially leading to an undercount of waitlists and less service delivery. (Notably, this is not true for Marchman Act cases — if a Marchman facility existed in Pinellas and the person was identified for an out-of-county provider, they would be detained and transferred to a detox center out of county, regardless of their childcare or employment responsibilities.)

Exhibit 21: Perceptions of waitlists as a problem when accessing intensive or residential care

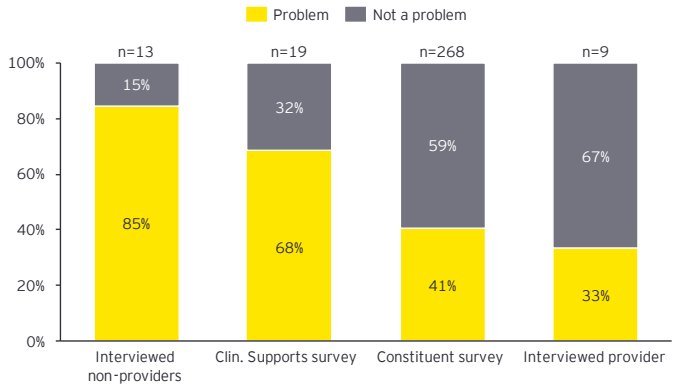
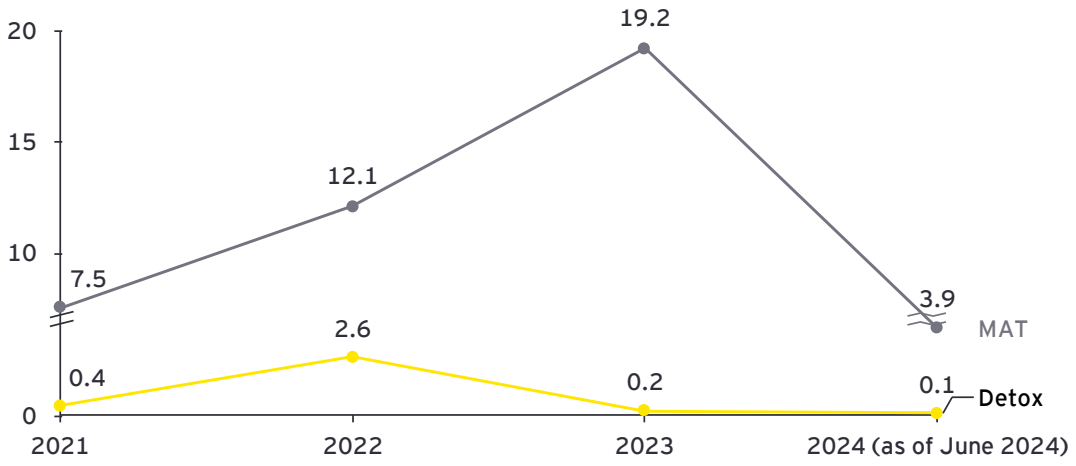


Exhibit 22: Average waiting days for subsidized care at a detox/MAT provider in Pinellas County



[103] Pinellas County Constituent Survey: Pinellas County Clinical Services and Supports Survey; EY interviews. Providers defined as employees of an organization that provides detox, rehab, MAT, or other allopathic care to people with OUD. Constituent survey respondents were asked to select barriers to care for the "Seeking help" section of the CoC; "Wait times" was one of eight options shown. Clinical services and supports respondents were asked "What are the barriers to accessing rehab for opioids?"; "Wait times" was one of nine options shown.

Acute and post-acute care

When an individual receives acute care, they experience a broad array of treatments, from outpatient visits to detoxification, medical treatment, inpatient and outpatient rehab, and post-acute residential care. Coordination efforts between providers to facilitate the individual experience and promote continuity of care are instrumental to long-term recovery. Gaps in acute and post-acute services are likely to result in reduced treatment accessibility, effectiveness, and relapse.

Care coordination

Gap C1: Quick Response Teams

Sustained impact from QRTs is low as providers report reaching very few individuals for follow-up treatment after quick-response team involvement.

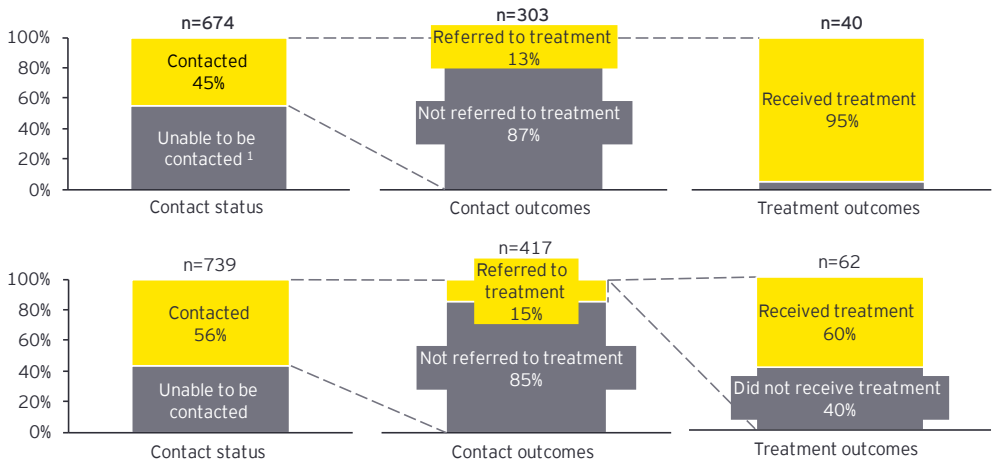
Quick Response Teams are a model of care that provide follow-up to an opioid overdose. These teams make phone calls or visit the home of the person who overdosed and offer connections to treatment. These teams can be composed of a mix of first responders, certified peer specialists, and/or clinicians.

There are two QRTs in Pinellas County. Described here as QRT A and QRT B, the teams have similar scopes but reach individuals through different means. QRT A connects in person with individuals who have had recent interactions with law enforcement for substance use, and QRT B reaches out by telephone to contact individuals who have recently been seen by emergency medical service (EMS) personnel for substance use.

QRTs from around the country use both of these outreach strategies, and benchmarks from other counties show that treatment rates can be high regardless of whether the QRT sourced their contacts from law enforcement or the system of care.

Some interviewees perceived that QRT A could have some structural limitations since justice-involved individuals may be hesitant to talk with someone with connections to law enforcement. However, the two QRTs had similar results regarding outreach, contact outcomes, and treatment outcomes.

Exhibit 23: Patient engagement and treatment outcomes in QRT A (referrals from law enforcement, 2022–present) and QRT B (referrals from EMS, 2021–present)



As indicated in Exhibit 23,[104] QRT A was unable to contact over half (55%) of the individuals to whom the QRT was referred since September of 2022. QRTs in Pinellas County respond to referrals within 72 hours, but, as interviewees overseeing the QRT point out, the often-transient status of these individuals means they may be difficult to find after a day or two has passed.

[104] Information provided by organizations overseeing QRTs

Of those contacted, 13% (38 people) went on to receive treatment. While detailed treatment outcomes are not consistently tracked, QRT A has only tracked one individual as successfully discharged from SUD treatment.

QRT B, in operation since August 2021, reached a slightly higher percentage of referrals by using phone-based outreach instead of visiting in-person. Of clients contacted by telephone, 37 eventually received treatment (9% of all successfully contacted individuals). Interviewees overseeing QRT B cited receiving incorrect contact information (e.g., phone numbers and addresses) as a key barrier to providing individuals with successful linkages to treatment.

Operational differences between the QRTs may explain many of the differences in success rate. QRT A may reach fewer individuals than QRT B if clients are skeptical about follow-up care after a law enforcement interaction. However, QRT A is much more successful in converting treatment referrals to receiving actual treatment. Interviewees perceive that QRT A is more receptive to finding treatment that individuals want (e.g., preferring detox instead of MAT), whereas QRT B tries to match individuals to available services, even if that is not the client's first choice.

Peer counties around the country have seen more positive results around linkages to care through QRTs. Hamilton County, OH, also has a COSSUP-grant-funded QRT in place. It has been able to contact 58% of ED referrals and provide recovery support services to 66% percent of those contacted.[105] It is important to note that while recovery support services include conversations about recovery and safety with the individual, they do not necessarily include substance use treatment.

Gap C2: Health information sharing
Providers face difficulties coordinating care because health information sharing outside the existing health information exchange is limited.

Today, there is one major health information exchange (HIE) in Pinellas County, which is run by an entity contracted by the Florida Agency for Health Care Administration (ACHA). Accordingly, this HIE does not include data on individuals receiving services outside of Medicaid. Florida is a non-Medicaid expansion state and has the fourth highest uninsured rate in the nation, so many individuals are excluded from the HIE, such as those who are incarcerated and those who receive County-funded, grant-funded, or DCF-funded care.[106] This disproportionately affects unhoused populations who often receive this non-Medicaid care.

Data silos emerge as providers in Pinellas County are hesitant to share personal health information with one another, citing the Health Insurance Portability and Accountability Act (HIPAA) and other regulatory requirements as a key limiter. This situation results in significant redundancy and lack of awareness on how individuals encounter different providers. It can negatively impact the individual, such as when they move between providers and experience re-screening, recount trauma(s), and even delay treatment. Even within the existing HIE, there have historically been limitations of sharing behavioral health data.[107]

In February 2024, the Office of Civil Rights (OCR) and SAMHSA finalized modifications to the Confidentiality of SUD Patient Records regulations of 42 CFR to increase coordination among providers treating individuals for SUDs. [108] The modifications enable the use and disclosure of part two records based on a single consent given once for all future uses and disclosures for treatment, payment, and health care operations. The changes aim to strengthen confidentiality protection while simultaneously improving care coordination for individuals and their providers.

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[105] Manchak et al. (2022)
[106] America's Health Rankings (AHR, 2022)
[107] EY interviews
[108] 42 CFR Part 2 imposes restrictions upon the use and disclosure of substance use disorder (SUD) patient records which are maintained in connection with the performance of any part 2 program. The intended purpose is to ensure that a patient receiving treatment for a SUD in a part 2 program is not made more vulnerable by reason of the availability of their record than an individual with a SUD who does not seek treatment.

Awareness of this change at the county level may be limited, and so the benefits of the modifications may not yet be realized. Additionally, system-level data sharing agreements may be necessary to allow for the transfer of any data not related to 42 CFR.

Detox and inpatient rehab

Gap C3: Cost-prohibitive inpatient services

People with low incomes are less able to access detox and inpatient services in Pinellas County because subsidized options are limited.

In Pinellas County, there are 15 medical detox providers. Of these, 13 are inpatient rehabilitations facilities, all of which offer inpatient detox programs. At the time of writing, seven of these facilities reported no waitlist, while the others that provided waitlist information reported a wait of three days or fewer. While this implies available detox and inpatient treatment in Pinellas County, the median costs of these programs are $1,000 per day,[109] while the average income of survey respondents with lived experience is $100-$200 per day. All seven facilities without waitlists are private, and none offer subsidized care options. As such, these programs can be (or are perceived to be) prohibitively expensive to the people who need them. Individuals with less ability to pay often must wait for a bed at one of the two facilities in Pinellas that offer subsidized care, provided that the individual is able to meet medical admission criteria and qualify for the subsidy.[110]

Additionally, the length of stay associated with inpatient programs in Pinellas County can deter people with OUD from participating in them. For programs with available suggested length of stay data, the median recommended length of stay is 28 days. Interviewees report that people can be hesitant to take these month-long sojourns from their daily lives and the jobs, family, and friends contained within them. There may be potential for innovative care models (i.e., part-time residential stays) to help address this issue; the efficacy of such models is yet unproven.

Post-acute residential care

Gap C4: Limited residential care capacity

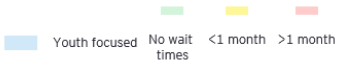
There is need in the county for additional low-cost/subsidized residential treatment capacity.

Residential substance use treatment in Pinellas County follows a similar story to that of detox/inpatient rehab. As shown in Table 4, there are 15 facilities in Pinellas County offering the service, of which six report no wait times. The median cost per month of the facilities with no wait times is $18,000.[111] Operators of residential facilities that offer subsidized care, by contrast, report waitlists. The research also uncovered that other facilities that do not provide a comprehensive residential substance use treatment program end up serving as "landing places" for individuals who cannot access these formal services directly. Recovery Epicenter Foundation's Catcher's Mitt is one such program. These programs often resort to using their own networks to connect clients to treatment.

[109] Data gathered through inquiries to facilities
[110] Interviewees note that there are people with OUD who do not meet indigence and/or income qualification requirements for these programs, but still cannot afford them due to high deductible insurance and/or low maximum income requirements.
[111] Data gathered through inquiries to facilities

Table 4: Post-acute residential treatment facilities in Pinellas County

Facility[112]	Beds	Cost (per month)	Wait times for beds
ACTS Keystone	85	*Unconfirmed*[113]	*Unconfirmed*
Boley Centers (37th St, St. Pete)*	15	90% of income	1-2 months
Boley Centers (32nd Ave South St. Pete)*	15	90% of income	1-2 months
Boley Centers (7th Avenue, S. St. Pete)*	16	90% of income	1-2 months
Boley Centers (5th Ave, North St. Pete)*	14	90% of income	1-2 months
Dr. Paul's at the Bay	*Unconfirmed*	$25,000	None
Footprints (Treasure Island)	7	$18,000	None
Footprints (St. Pete Beach)	8	$18,000	None
Operation PAR (Largo)*	270	$6,000	1-2 weeks
Operation PAR Youth Campus (St. Pete)*[114]	34	$6,000	*N/A*
TB Recovery Center	30	$20,000	None
Tranquil Shores	24	$30,000	None
Transformations by the Gulf	20	$25,000	None
WestCare Gulf Coast (St. Pete)*	266	$75/day	None



Co-treatment for comorbidities

Gap C5: Co-occurring treatment

Treatment centers are not consistently providing co-located co-occurring treatment for co-morbidities.

Organizations that provide co-located treatment of comorbidities in Pinellas County report positive results and a desire to expand.[115] Generally, co-location of care is associated with higher engagement and satisfaction,

[112] Facilities marked with an asterisk have confirmed some of the services they offer. Even in these cases, it is possible that not all of the data was provided or verified.
[113] Facilities marked as "unconfirmed" were not contactable during normal business hours
[114] This facility is closed for three-to-four months at the time of writing
[115] EY interviews

lower wait times, and increased visits to manage comorbidities. In addition to medical conditions such as heart/circulatory disorders and movement disorders,[116] the most common comorbidities are behavioral health (BH)-related. In the United States, 37.9% of adults with SUD have a co-occurring disorder of mental illness.[117] In Pinellas County, Mental health and SUD care are more commonly not integrated, highlighting an opportunity for enhanced clinical integration as it is more likely for mental health and SUD connections to co-occur than not as one of the conditions may be a consequence of the other.

While many treatment facilities in Pinellas County advertise treatment for comorbidities and competencies for co-occurring treatment, it is rare to find comprehensive practices in a single setting. At the time of this Report, only ~25 of the ~55 behavioral health facilities and services tracked in the inventory of services[118] have DCF certifications for addiction-related services. It is likely that some of these facilities have patients with SUD who could be well-served by addiction treatment as about 18.2% of adults with a mental illness also have a SUD.[119] Conversely, many large addiction treatment facilities do have behavioral health treatment. However, smaller ones (such as individual buprenorphine prescribers) are less likely to have behavioral health services on site.[120]

[116] Baumann & Samuels (2022)
[117] Han et al. (2017)
[118] Inventory of services may not include full exhaustive list of behavioral health facilities in Pinellas County; some smaller facilities/providers may not have been captured
[119] Han et al. (2017)
[120] EY interviews

Long-term maintenance treatment and recovery

Long-term maintenance treatment and recovery is composed of outpatient services, MAT/MOUD, and long-term residential care, as an individual's recovery journey might involve accessing these services to sustain their long-term recovery and sober outcome. Gaps in these areas are likely to make recovery more difficult and potentially increase the likelihood of relapse.

MAT/MOUD[121]

Gap L1: MAT cost

Individuals using MAT are burdened by high costs of care.

Surveyed residents with lived experience report cost as the most common barrier to accessing MAT and MOUD. Costs associated with MAT fall into direct and indirect costs, and both are burdensome to lower-income individuals.

Direct costs are composed of the cost of medicine and related counseling services. The Medicare reimbursement rate for medication and related counseling is approximately $20 per day; interviewed providers report charging a similar rate for out-of-pocket payment. For those who pay out-of-pocket, these self-pay rates can be prohibitive. One interviewed full-fee provider estimated that approximately 70% of people who drop out of their treatment program do so because they cannot afford to continue care, and comments from a local subsidized provider at the Opioid Task Force suggest that they face many of the same concerns.[122]

Indirect costs also contribute to this barrier. Indirect costs vary by individual but can consist of all costs outside of the medication itself. Commonly cited external costs include transportation, childcare, and co-pays for those that do have insurance.

There are programs in place in Pinellas County that aim to increase access to MAT for the low-income, indigent, and/or the homeless. The Pinellas County Health Program, in partnership with Operation PAR,[123] provides free MAT for individuals who are uninsured, ineligible for Medicare and Medicaid, and meet federal income guidelines (~$15,000/year for an individual at the time of writing).

The Pinellas County Healthcare for the Homeless program, which has no income eligibility barriers, provides free MAT (in partnership with Operation PAR) for individuals who are uninsured and unhoused or previously unhoused. These programs provide needed options to those who qualify, but many who do not qualify still cannot afford care. Ninety-one percent (91%) of surveyed residents who indicated that cost is a barrier to MAT would not qualify for either program based on their demographic responses. Interviewees echo this, stating that they have encountered disqualifiers like insurance that is not widely accepted, or income slightly over the federal guidelines but not high enough for the individual to afford their care.

Gap L2: MOUD stigma

Despite progress, stigma toward MOUD, and methadone in particular, is still present across groups, including healthcare workers and sober housing providers.

Interviewees report that individuals who could use MOUD as part of their treatment experience are afraid of associated stigma, which prevents them from using medication.

One source of stigma are peers and colleagues. Because MOUD use indicates that one "struggles with addiction" and addiction is highly stigmatized, individuals may worry that being 'found out' by peers or

[121] In this document, the term MOUD specifically refers to medication like methadone, buprenorphine (Suboxone), or naltrexone. MAT refers to that medication in conjunction with behavioral healthcare. Where gaps relate specifically to the medication, MOUD is used. Where gaps relate to treatment more broadly, where MOUD is subcomponent, MAT is used.
[122] September 2024 OTF
[123] Operation PAR offers addiction recovery options such as residential treatment, prevention, outpatient services, MAT, and medical detoxification in Florida. https://www.operationpar.org/

colleagues could cause reputational damage and impacts social or professional standing. This can discourage them from visiting clinics for fear of being seen or accessing insurance benefits for fear of workplace insurance sponsors seeing methadone claims.

A 2019 national survey suggests that these concerns are not confined to Pinellas County. In the study, only 51% of respondents agreed that they would be comfortable being friends with someone in treatment for opioid addiction, and 32% said they would feel uncomfortable seeing a doctor who treated individuals experiencing addiction.[124]

Stigma is not limited to discomfort with addiction at large. Some individuals, both in the recovery space and in the general population, do not believe that MOUD is an appropriate treatment for OUD. In the survey mentioned above, 34% of respondents felt that MOUD substituted one addiction with another.

Interviewees working in the addiction space in Pinellas County also mentioned that because there is potential for MOUD misuse, there have been instances of MOUD hindering recovery in their facilities. As such, many sober living facilities do not permit MOUD use, and are wary about legal or accreditation-based requirements that may require them to do so in the near future. These interviewees often prefer 12-step-style programming that precludes the use not only of MOUD, but also of other DEA-scheduled medications with potential for abuse.

Another source of stigma brought up by interviewees is medical professionals. Interviewees suggest that some healthcare workers are undertrained around how to work with individuals with OUD, and, as a result, can be wary of prescribing MOUD or referring individuals to addiction resources. This stigma also aligns with national trends: a recent survey of individuals using methadone for treatment estimated that 28% hear negative comments about their methadone treatment from their providers.[125]

Organizations in Pinellas County are aware of the pervasiveness of MOUD-related stigma, and efforts combatting it have shown promise. USF's "Stigma lab" roleplays high-stigma situations, helping participants recognize stigmas and biases. LIVE Tampa Bay's Anti-Stigma campaign has engaged 45 large regional employers and made progress in championing MOUD-friendly housing. Still, interviewees, including those aware of the initiatives, indicate there is more work to be done to reduce stigma associated with SUD and MOUD.

Gap L3: MOUD in County Jail

Individuals incarcerated in Pinellas County Jail cannot receive MOUD treatment.

Many incarcerated persons in the United States could benefit from treatment for OUD. Nationwide, 19% of new jail admissions report opioid use, and 30%–45% of people in jail report suffering from "serious withdrawals."[126] Although the Justice Department has filed lawsuits in some jurisdictions claiming that MOUD is "medically necessary," they have not engaged in Florida and the state has not been a party in lawsuits requiring jails to provide MOUD.

Today, only 27 of the 67 counties have MOUD in their jails (see Exhibit 24), but 60% of people in Florida jails are in jails with MOUD access.[127] Pinellas County Jail (PCJ) holds 6% of the state's incarcerated population, and, as such, has the second largest jail population to which MOUD is unavailable.[128] Only pregnant females who test positive for opiates at intake in PCJ are offered MAT treatment (including methadone), and are switched to a short-term buprenorphine tapering dose detox program after the baby is delivered. Today, PCJ does not have the funding, staff, or centralized infirmary required to effectively provide MAT to inmates.

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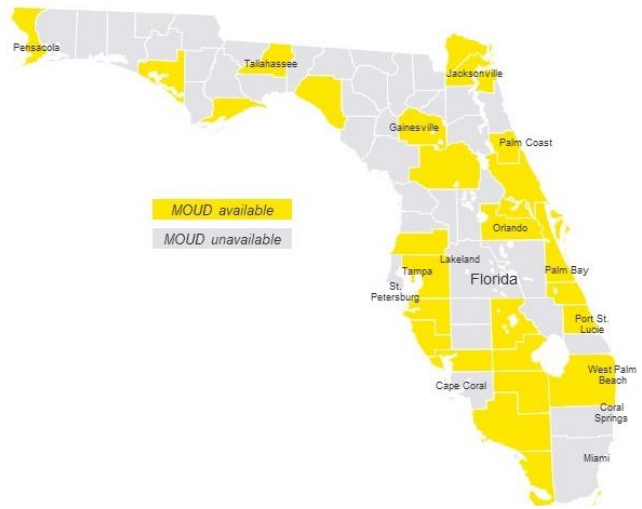
[124] General population survey (n=997) conducted in 2019 and stratified by gender, race, age, education, and income. 21% of respondents reported that they knew someone who had sought treatment for substance use in the past year. The survey author is involved in several large-scale NIH-funded abatement efforts such as HEALing Communities.
[125] Carl et al. (2023). Survey n=247.
[126] Papp (2022)
[127] Prison Opioid Project; Florida Department of Corrections Population Report (May 2024)
[128] Florida Department of Corrections Population Report (May 2024)

The lack of access to medications in jail can cause poor clinical outcomes because individuals are thrown into withdrawal upon incarceration. An interviewed MOUD/MAT provider reported that approximately 15–20 of the provider's (now former) clients are likely undergoing withdrawal that is not supported with medication due to recent arrests.

When individuals with OUD who are not able to receive medication while incarcerated are released, they face elevated mortality risks as they return to their addictions with lowered tolerances and no treatment plan in place to curb cravings or mitigate euphoric effects if use occurs.[129] Nationwide, individuals with OUD released from jails are 10–40 times more likely to overdose in the two weeks immediately following release compared to the general population.[130]

Exhibit 24: MOUD availability in Florida county jails



Outpatient services

Gap L4: ACT teams

Assertive Community Treatment teams, which provide high levels of in-home care, are limited in number and under-resourced in Pinellas County.

ACT teams, colloquially known as FACT (Florida Assertive Community Treatment) teams in Florida, are composed of multidisciplinary behavioral health professionals providing intensive, integrated, and community-based in-home behavioral health care. If staffed to fidelity standards (Tool for Measurement of ACT, or TMACT), these teams are designed to meet people who cannot or otherwise tend not to access care out of their homes, providing a high-quality alternative to out-of-home outpatient or inpatient services. ACT teams can provide co-occurring substance use care but are not necessarily dedicated solely to serving those with substance use disorders. Some interviewees reported that the teams are too high touch for individuals with SUD, indicating that innovation may be required to meet the needs in Pinellas County. When operated according to evidence-based leading practices, these 10- to 12-person teams serve roughly 100 people at a given time.[131]

Pinellas County has three ACT teams funded by CFBHN, with a combined theoretical capacity of 300. Interviewees report this capacity to be insufficient to provide services for all individuals who would benefit from intensive care at home in the county. The presence of a CFBHN-managed[132] waitlist spanning across all three teams supports this anecdotal report. CFBHN provides the priority referrals to all ACT teams in its network. Those referrals are diversion referrals for clients on the State Mental Health Treatment Facilities (SMHTF) waitlist and those clients in the SMHTF discharge-ready list. All other non-priority referrals must be pre-approved by CFBHN before they can be considered for admission. This prioritization system could result in some people not being prioritized who would be a strong fit for ACT treatment. During the research it was reported that one ACT team in Pinellas County is not able to function as designed due to underfunding (and that a 40%+ increase is needed), and the funding issues may also impact the other two teams. Often, one

[129] Hartung et al. (2023)
[130] Hartung et al. (2023)
[131] Capacity figure from interviewee at organization operating team, validated with internal EY experts
[132] CFBHN provided EY information on the expenses associated with each FACT team over the last several fiscal years, though they were unable to provide quantitative information about waitlists, service levels, and co-occurring SUD diagnoses.

organization operates multiple ACT teams, as doing so allows the organization to split administrative load (i.e., prescription, reporting, quality assurance, fidelity measurement) more effectively. In Pinellas County, each team is operated by a different organization. This adds to the financial and operational burdens.

Gap L5: Barriers to behavioral healthcare

People with lived experience report several barriers to behavioral health treatment, most notably wait times, high costs, and low quality.

Residents with lived experience reported several issues with behavioral healthcare in Pinellas County. Wait times are one issue, with 62% of constituent survey respondents with lived experience indicating it as a shortcoming.

There may be misalignment between resident perception and the actual status of waitlists in Pinellas County for behavioral health services, as some large providers stated during multiple interactions that their facilities do not have an active waitlist or are otherwise inhibiting access to behavioral health treatment. One interviewed executive stated that their subsidized low-income provider organization has immediately available services and the ability to hire staff if additional capacity were required. Another interviewed provider hypothesized that this misperception may stem from difficulty accessing smaller, private providers. Resident perception of wait times is potentially conflicting with the findings from the EY Impact health factors data, which show that Pinellas County has better concentration (per capita) of licensed mental health providers when compared to national and state levels. Alternative explanations for this discrepancy (which is not confirmed in this Report) include (1) that individuals licensed in the county may be practicing elsewhere or (2) the individuals that responded to the survey and indicated challenges accessing care may not have the type of insurance coverage that is accepted by necessary providers.

The second reported issue is cost, as 47% of respondents with lived experience indicated it to be a barrier. Cost barriers may follow the logic of Gap S6: 30% of respondents with lived experience report being uninsured, and as such may not be able to either access subsidized treatment or afford out-of-pocket costs for care that is not subsidized. Even for those with insurance, behavioral health care cost burdens may be downstream effects of national trends toward cash payment for behavioral services, especially at smaller, private clinics.

The third reported issue is treatment quality. Forty-four percent (44%) of respondents with lived experience indicate that behavioral healthcare services in Pinellas County are low quality. A common refrain from interviewees was that behavioral clinics were not always caring, with one saying clinics were "all clinical, all tough love, no peer supports."[133] These issues are concentrated in individuals with strong healthcare — the constituent survey found that 50% of people with lived experience on private, VA, or Medicare insurance find behavioral health treatment to be low quality (n=30). Conversely, only 36% of people with lived experience who are uninsured or are on Medicaid report these quality issues.

Complaints about treatment quality are most acute for behavioral health and are not widespread throughout the CoC. For example, only 16% of respondents with lived experience reported the same issues about treatment quality regarding MAT in Pinellas County. Data related to quality of care (e.g., outcomes) was not collected as part of this analysis.

Other interviewees felt that these results resonated with them. Some cite concerns that some behavioral health settings in the county are unwelcoming, lack peers, and that individuals who have spent time in these facilities report an unwillingness to return.

[133] EY interviews

Long-term residential support

Gap L6: Limited high-quality recovery housing
There is insufficient housing for individuals who seek active recovery supports in their living space.

Recovery housing is a broad term, encompassing a range of facility types that offer different levels of care through different organizational structures. This Report uses the four-level framework from the Florida Association of Recovery Residences (FARR) and the National Alliance for Recovery Residences (NARR) to define the types of residences relevant to this section of the Report, which can be seen in Exhibit 25.[134]

This section focuses on the types of residences that fall into Levels I, II, and III. While not all recovery housing in Pinellas County is FARR-accredited, and discussion in this section is not limited strictly to FARR-accredited facilities, the framework is useful for understanding the definitions of the housing discussed.

In the more structured housing settings — Level II and Level III — there is not enough space available in high-quality facilities to meet demand. Of the seven FARR-accredited facilities in this category, only two report no wait time for a bed in their facility. Both facilities prohibit MOUD use, leaving individuals who use MOUD for treatment with no immediately accessible accredited facilities. This may result in residents having to make decisions about whether treatment or housing is their primary need, which may result in unsafe consequences. Although FARR expects recovery residencies to allow individuals on MOUD to reside at their facilities, stakeholders' interviews pointed to residencies utilizing the "undue burden on staff" clause to prohibit MOUD patients from residing at their facilities. This clause will be removed starting January 2025. As mentioned above, not all facilities are FARR-accredited, and interviewees involved in recovery housing report that there are often spaces in non-accredited residences available. Still, these stakeholders also point out that the FARR accreditation promotes quality, and that unaccredited residences that are immediately accessible may be of lower quality.[135] Interviewees also report that FARR accreditation is not adequately incentivized, so many residences in Pinellas County choose to forgo the process and the quality assurance that comes with it.

Exhibit 25: FARR recovery residence framework

	Level I *Peer-Run*	Level II *Monitored*	Level III *Supervised*	Level IV *Service Provider*
Administration	▸ Democratically run ▸ Manual or policy and procedures	▸ House manager or senior resident ▸ Policy and procedures	▸ Organizational hierarchy ▸ Administrative oversight ▸ Policy and procedures	▸ Overseen organizational hierarchy ▸ Clinical and administrative supervision ▸ Policy and procedures
Services	▸ Drug screening ▸ House meetings ▸ Self help meetings encouraged	▸ House rules provide structure ▸ Peer run groups ▸ Drug screening ▸ House meetings ▸ House rules/ drug screening	▸ Life skill development emphasis ▸ Clinical services may be utilized in outside community ▸ House rules/ drug screening	▸ Clients must attend clinical services and programming ▸ Life skill development ▸ House meetings ▸ House rules/ drug screening
Residence	▸ Generally single-family residences	▸ Primarily single-family residences ▸ Possibly apartments or multi-family	▸ Varies – all types of residential settings	▸ Varies – all types of residential settings
Staff	▸ No paid positions within the residence ▸ Perhaps an overseeing officer	▸ A least 1 compensated position ▸ House manager ▸ Peer leader	▸ Facility manager, recovery coach, peer specialist ▸ Certified staff or case managers	▸ Credential staff, case manager, behavioral health tech, housing director, facilities manager

Long-term residential supports

[134] NARR (and by extension FARR) residence levels are based on levels of care published by the American Society of Addiction Medicine (ASAM). Though not a direct comparison, NARR levels II and III loosely correlate to ASAM levels 2.1, 2.5, 3.1, and 3.5. For more information on the ASAM levels of care, see American Society of Addiction Medicine (n.d.).
[135] Note, EY did not assess quality of services as a component of this gap analysis; these statements are reflections of qualitative research conducted with stakeholders familiar with residential facilities across Pinellas County.

Additionally, sober living residences are not considered formal treatment programs under the Affordable Care Act, which means insurance companies are not required to provide coverage for them. This can increase the financial burden on individuals seeking these services, with interviewees often citing move-in fees and first month's rent (typically around ~$1,000 in total)[136] as a barrier to entering recovery housing. There are programs in Pinellas County that offer subsidies to cover these fees, and often several months of rent, but interviewees suggested funding expansion to further improve access.

Stakeholders also report a need for more short-term housing options that serve as a bridge between homelessness and either treatment or recovery housing. Two of the FARR-accredited facilities in the county reported a one-to-two week waiting period for a bed. The Catcher's Mitt, a short-term respite housing facility, offers stays of up to two weeks to support individuals who find themselves in a transition situation such that there is a gap between one facility and the next. The Catcher's Mitt reports an 80%–85% rate of placement into either treatment or housing for individuals who stay in it, indicating effectiveness as a bridge. It is the only facility of its kind, and only has 16 beds, which are typically full at any given time and partially funded by time-limited grants. More facilities (or adoption of bridge-like approaches) may enable increases in positive outcomes for individuals who need such support.

Exhibit 26: Oxford housing vacancy rates in select FL counties, 8/2024

Location	# of locations	# of beds	# of free beds	Vacancy rate
Florida statewide	207	1816	312	17%
Duval	15	130	15	12%
Pasco	4	35	4	11%
Hillsborough	11	97	8	8%
Palm Beach	7	61	4	7%
Pinellas	9	80	4	5%

FARR Level I housing is less structured and enables individuals to create self-sustaining community and build the requisite skills to live on their own. Oxford Housing is one such style of housing, and, in Pinellas County, the vacancy rate is less than one-third of the vacancy rate in Florida at large (5% in Pinellas County vs. 17% in Florida at large; see Exhibit 26).[137] Using Oxford Housing as a proxy for Level I style housing broadly, this indicates a need for more of such housing in Pinellas County. Level I homes are self-governing, and interviewees with knowledge and experience within Pinellas County indicate that quality can vary significantly. Some facilities run well, but others were stated to knowingly permit open drug use. It may be important to consider the role of accreditation and/or other quality control measures when defining the strategy for building additional capacity. SAMHSA recommends the accreditation standards set by the National Alliance for Recovery Residences (NARR) to ensure the home meets organizational, fiscal, operational, property, and recovery support standards.[138]

[136] Figure estimated by interviewee professionally familiar with placing individuals in recovery housing in Pinellas County
[137] From Oxford House vacancy tool
[138] SAMHSA Best Practices for Recovery Housing (2023)

External supporting factors

External supports complement and enable treatment and recovery initiatives across the entire CoC. When these supports are not available, it is more difficult for individuals and/or caregivers to access treatment, connect with the recovery community, and re-integrate into society.

Housing

Gap E1: Housing access
Individuals with OUD and in recovery experience barriers to stable housing.

Interviewees frequently cite access to housing as a problem in Pinellas County broadly, and as an acute barrier to recovery from OUD. While 38% of surveyed individuals in active use and recovery report that housing programs help people achieve sobriety, surveyed individuals in active use and recovery are three times more likely to be housing-insecure than the general public. Nationally, research shows that up to two-thirds of homeless individuals have a history of an alcohol or drug disorder.[139] Interviewees consistently report that it is almost impossible to pause substance use while living on the street. The housing-first approach to this problem has been found to offer greater long-term housing stability, including those experiencing chronic homelessness and intersecting vulnerabilities, compared to the treatment-first approach.[140] Pinellas County recognized this when they adopted Resolution 16-53 in 2016 that endorses a Housing First model.[141] As such, housing is a key supporting factor to recovery.

Pinellas County does have an existing organization dedicated to preventing homelessness and providing care coordination across the CoC for homeless individuals. The Homeless Leadership Alliance (HLA)[142] is responsible for overseeing the types of housing listed below. HLA facilities follow a coordinated entry system, which is a nationwide standardized process to ensure that individuals with housing instability are identified, assessed, and referred to support as necessary.[143] Although the coordinated entry system and the following types of housing may offer resources for individuals with OUD, the primary purpose of both is to support housing stability. As such, individuals who engage with the HLA are generally seeking homelessness services rather than treatment for substance use.

This gap speaks only to access issues for facilities that seek to provide housing stability and are not specific to OUD treatment. Barriers to accessing housing specific to individuals with OUD are addressed in the "Long-term residential support" section above. Importantly, the recovery housing discussed in that section — namely, housing which primarily provides OUD treatment — may not fall under the purview of the HLA or be mandated to follow the local coordinated entry system. That is because those housing opportunities serve individuals for whom residence is a necessary part of their treatment rather than an alleviation of housing insecurity.

Housing supports fall on a spectrum from market-rate housing to heavily supported opportunities.

- **Permanent, market-rate housing** — Housing fully paid for by the occupant, which can be either rented or owned. No services or supports are tied to the housing.
  - **Subsidized housing** — Government or nonprofit-sponsored economic assistance aimed toward alleviating housing costs and expenses (e.g., Department of Housing and Urban Development [HUD] section 8 housing vouchers, state funded housing vouchers).
- **Emergency shelter** — A place for people to live temporarily when they cannot live in their previous residence. An emergency shelter typically specializes in people fleeing a specific type of situation, such

[139] Polcin (2015)
[140] Office of Policy Development and Research, 2023
[141] Justice et al. (2016)
[142] https://www.pinellashomeless.org/
[143] Pinellas County Human Services (n.d.). For more information about the coordinated entry system, see Homeless Leadership Alliance (2023).

as natural or man-made disasters, domestic violence, or victims of sexual abuse, and sometimes facilitate support groups or provide meals.

- **Safe Haven housing** – Supportive, temporary housing that serves hard-to-reach homeless persons with severe mental illness who come primarily from the streets and have been unable or unwilling to participate in other housing or supportive services.
- **Transitional housing** – Supportive, temporary accommodation that is meant to bridge the gap from homelessness to permanent housing by offering structure, supervision, support (for addictions and mental health, for instance), life skills, and in some cases, education and training. Includes recovery housing, of which sober-living is a subset.
- **Permanent supportive housing** – Permanent housing in which housing assistance (e.g., long-term leasing or rental assistance) and supportive services, if needed, are provided to assist households with at least one member (adult or child) with a disability in achieving housing stability.

Market-rate and subsidized housing are not under the purview of the HLA, and there are fewer supports available.

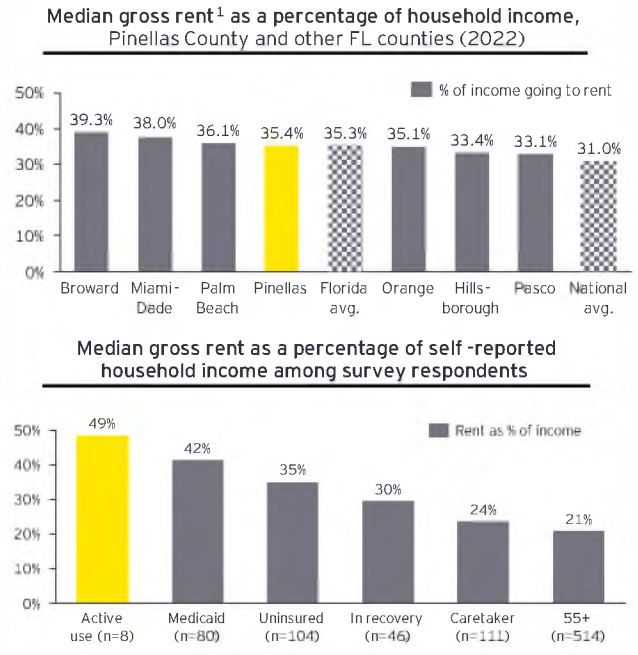
Permanent, market-rate housing

Permanent housing is more difficult to secure for renters across the country in recent years as the cost of housing has increased faster than income since 2020. This is consistent for Pinellas County.

As can be seen in Exhibit 27, renters in 2022 in the US spent an average of 31% of their income on rent. In Pinellas County, renters spent 35.4% of their income on rent, with an average rent of ~$1,500 per month.[145] By comparison, renters in New York County (i.e., Manhattan), spent 29% of their income on rent. This cost pressure makes affording housing in Pinellas County difficult for many residents, regardless of whether they experience OUD.

Residents with OUD may be particularly impacted as the average rent in Pinellas County constitutes ~50% of the average income of a survey respondents in active use.[146] Because the cost of permanent housing is high, accessible housing supports (i.e., emergency shelter, Safe Haven housing, transitional housing, permanent supportive housing – including intensive treatment residential facilities – and subsidized housing) are important. Residents need other housing options when permanent housing is not viable for them, or other temporary financial supports to maintain housing so that permanent housing is not lost.

Exhibit 27: Rent as share of income across FL and for surveyed Pinellas residents[144]

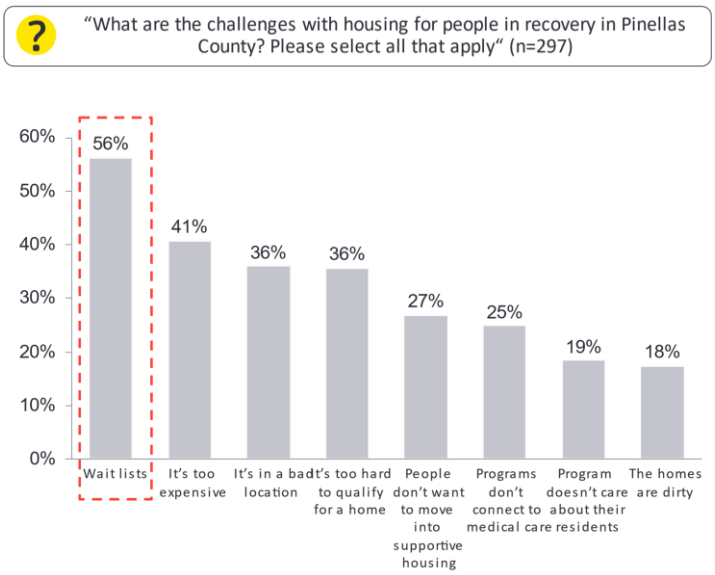


[144] United States Census Bureau
[145] Median gross rent as a percentage of household income from 2022 American Community Survey.
[146] Pinellas County Constituent Survey. Active use n=8. Calculated using median rent in Pinellas County and weighted average of respondent income indicated in survey

Subsidized housing and vouchers

Subsidized housing is not accessible in Pinellas County. Many people with OUD or in recovery would qualify for public housing, as 48% of surveyed respondents with current or past opioid use make under $35,000 per year, which is the qualification threshold for housing vouchers in Pinellas County. One notable exception to the qualification limit is the partnership between HUD and the Department of Veteran Affairs Supportive Housing, called HUD-VASH vouchers.[147] HUD-VASH vouchers, which are paired with case management and supportive services for mental health, substance use, and other concerns, are available to veterans who are United States citizens, not registered in a state sex offender program, and meet the income eligibility requirement.[148] As of August 2024, the initial income eligibility for all HUD-VASH vouchers is 80% of the Area Median Income.[149] With a median household income of ~$71,000,[150] veterans in Pinellas County with an income of ~$57,000 and below would be eligible for the vouchers.

Exhibit 28: Reported challenges for people in recovery



The Pinellas County Housing Authority (PCHA) last opened its waitlist for the housing choice voucher program in 2022, in which 3,000 applicants were selected for the waitlist via a random lottery.[151] At the time of writing, there is no scheduled date to reopen this waitlist.[152] Applications for specific PCHA properties are opened periodically for one to two weeks, and individuals are placed on the waitlist according to date and time of application.[153]

The St. Petersburg and Clearwater Housing Authority also have closed waitlists. Relatedly, as shown in Exhibit 28, 56% of surveyed residents report that waitlists are a challenge experienced by people in recovery.

Individuals with "violent or drug-related criminal activity" within the past five years are disqualified from using the funding of St. Petersburg's public housing agencies, and other local agencies have similar regulations. [154] Individuals with past or current opioid use are frequently justice-involved, leading to disproportionate impact.

There are greater supports available for emergency shelter, safe havens, and other HLA-supported types of housing.

Emergency shelter

At the time of writing, Pinellas County was home to seven organizations operating emergency shelters, listed in Table 5. As of July 30, 2024, these shelters were operating at a combined 75% bed utilization rate, suggesting capacity in the system.[155] A 2024 point-in-time analysis of the Pinellas County homeless population reported

[147] U.S. Department of Veterans Affairs (2023).
[148] U.S. Department of Housing and Urban Development (2021). To receive the vouchers in Pinellas County, veterans must also be eligible for VA Health Care, must have a referral from any Housing Program, and must participate in case management services. For more information on HUD-VASH vouchers in Pinellas County, see Pinellas County Housing Authority (n.d.)
[149] U.S. Department of Housing and Urban Development (2024)
[150] United States Census Bureau (2023)
[151] Hollenbeck (2022)
[152] Pinellas County Housing Authority (n.d.)
[153] For an example of a public notice about a waitlist opening, see Pinellas County Housing Authority (n.d.)
[154] St. Petersburg Housing Authority Public Housing Program Admissions and Continued Occupancy Policy (2020)
[155] Figures from Homeless Leadership Alliance of Pinellas (HLA)

that 66% of the total homeless population in the county is sheltered, with 76% of those individuals residing in emergency shelters at the time of the analysis.[156] This indicates that emergency shelters are capable of housing a large proportion of those that need emergency housing services.

These shelters are concentrated predominantly in St. Petersburg and Clearwater, and as such may not adequately support northern Pinellas County residents. Additionally, interviewees report concerns that a forthcoming state-wide ban on public camping and sleeping (Florida HB 1365, "Unauthorized Public Camping and Public Sleeping") could increase reliance on emergency shelters as unhoused individuals who sleep outside at night of their own volition are no longer able to do so.[157] Further research and monitoring may be relevant to assess the impact of the camping and sleeping ban in October 2024.

Table 5: Emergency shelter availability

Facility	Bed count	Wait times for bed	Max length of stay
Catholic Charities[158]	255	None	90 days
Family Resources SafePlace2B (Clearwater)	12	Days to weeks	30 days
Family Resources SafePlace2B (St. Petersburg)	6	None	30 days
Homeless Empowerment Program (HEP) Emergency Shelters	168	1-2 weeks	90 days
Pinellas Safe Harbor	400	None[159]	*Varies by case*
Salvation Army[160]	113	1-2 days	90 days
St. Vincent de Paul[161]	343	*Varies by program*[162]	*No formal maximum*
WestCare Gulf Coast – Turning Point	65	None	30 days

Safe Haven

Safe Haven housing, a classification defined by HUD, provides homeless individuals with severe and persistent mental illness with shelter and accompanying supports. These programs are specifically designed to support individuals who have been unable or unwilling to access other housing supports.

There are two Safe Haven facilities in Pinellas County today; one (Boley Centers, Safe Haven VA Morningside Mid-County) specifically serves veterans. These can be seen in Table 5. At the time of writing, there is no

[156] Gerhardt (2024)
[157] Governor DeSantis signed Florida HB 1365, titled "Unauthorized Public Camping and Public Sleeping" in March of 2024. The law prohibits counties and municipalities from authorizing or allowing public camping or sleeping on public property.
[158] Includes Hope I Emergency Shelter, Medical Respite Services, and Hope St. Petersburg.
[159] Pinellas Safe Harbor and WestCare GulfCoast – Turning Point do intake once per week.
[160] Includes respite centers, family residential center, and individual residential center.
[161] Bed counts include VA medical respite, VA 20 Emergency Shelter, Center of Hope, City ARPA SEHA, JWB Family Shelter program, Night Shelter, and Pinellas-Clearwater CDBG-CV-SEHA 130 programs. While several of these are in partnership with other organizations, St. Vincent de Paul operates 160 beds in their own programs plus an additional 13 rooms in the family shelter.
[162] Some St. Vincent de Paul programs do not have a waiting list. The Emergency Shelter does not have a wait list, though they state they are "always" at capacity as in their overflow courtyard. VA programs do not have a waiting list. Family shelter waitlists are managed by the HLA, and St. Vincent de Paul is not aware of its length.

capacity available in the second facility.[163] Interviewees indicate that more Safe Haven housing could benefit residents who require more structure and additional care than a shelter or transitional housing program can provide.

Table 6: Safe Havens in Pinellas County

Facility	Occupancy	Capacity	Utilization Rate
Boley Centers Safe Haven South	25	25	100%[164]
Boley Centers, Safe Haven VA Morningside Mid-County	17	20	85%

For veterans 0-50% 51-90% 91-100%

Transitional housing

There are 12 transitional housing facilities in Pinellas County. (Note that FARR-certified recovery housing is covered in the "Long-term treatment maintenance and recovery" section).[165]

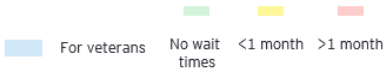
These facilities often serve specific demographic groups. The 12 facilities considered here house groups including pregnant women, domestic abuse survivors, those transitioning out of carceral settings, veterans, as well as people seeking housing more broadly. While these facilities do not cater specifically to people with addiction, people with addiction may use them. Several facilities, though, do not permit MOUD.

Of the 12 transitional housing providers, only five were able to be contacted for research purposes during normal business hours, which points to the difficulty that individuals seeking for help experience when attempting to reach providers. Two of those four providers reported waitlists of a week or longer, and one reported a one-day waitlist, indicating there may be capacity constraints in the system. The transitional housing facilities can be seen in Table 7 on the following page.

[163] From HLA
[164] EY interviews
[165] Pinellas County Homeless Leadership Alliance

Table 7: Transitional housing availability

Facility[166]	Bed count	Wait times for bed	MOUD allowed?
ALPHA House of Pinellas County	16	3 months	No
Boley Centers Jerry Howe VA Housing	18	*Unconfirmed*[167]	*Unconfirmed*[168]
Community Action Stops Abuse (CASA)	130	1 day	Yes
Homeless Empowerment Program (HEP) Transitional Housing	50[169]	*Unconfirmed*	*Unconfirmed*
Kimberly Home Pregnancy Resource Center	~40	1-2 weeks	No
PERC, One Unique Transition (PERC OUT)	21	*Unconfirmed*	*Unconfirmed*
PERC, Continental Housing Program (PERC CHP)	120	*Unconfirmed*	*Unconfirmed*
St. Pete Free Clinic – Baldwin Women's Residence	46	*Unconfirmed*	*Unconfirmed*
St. Pete Free Clinic – Beacon House, Men's Shelter	24	*Unconfirmed*	*Unconfirmed*
St. Vincent de Paul South VA	55	*No wait*	*Unconfirmed*
Salvation Army Hope Crest Transitional Living	62	Days - weeks	*Unconfirmed*



Interviewees suggest capacity constraints as well, consistently citing transitional housing as an area of need for more capacity. These facilities are crucial in an individual's transition between homelessness and self-sufficiency, providing an opportunity for people to increase their independence, find employment, and become self-sustaining. It was noted that one transitional housing provider was able to offer an open bed without a wait list, though they acknowledged that there could be a wait of up to two weeks if the individual was coming out of the justice system.

Permanent supportive housing (PSH)

Permanent supportive housing (PSH) was also frequently cited by interviewees as lacking capacity, largely because there are only three PSH providers in Pinellas County (see Table 8). The two contactable providers

[166] Some sources say they are transitional, but this was contradicted by phone calls to the facility. These sources are not included here.
[167] All "Unconfirmed" entries for wait times reflect organizations that did not respond to attempted contact via general phone number.
[168] All "Unconfirmed" entries for MOUD permissibility reflect organizations that did not respond to attempted contact via general phone number.
[169] Includes 40 VA-specific beds and 10 general beds.

have waiting periods for their facilities, with one reporting a wait time of six months, and the other reporting a wait time of two years. This style of housing offers residents a who need ongoing support for behavioral health issues a place to live at a subsidized rate where they can receive services.

In 2023, PSH funding only came from HUD and only totaled ~$6 million across Pinellas County.[170] This limited funding did not meet county agencies' total request and has resulted in waitlists for this type of housing.[171] While several anecdotes supported the existence of this waitlist for PSH through the HLA's coordinated entry process, it was not possible to confirm its length despite repeated requests by EY and Pinellas County Human Services. PCHS should continue to push for clarification on the length of the waitlist moving forward.

Table 8: Permanent supportive housing in Pinellas County

Facility	Bed count	Wait times for bed
Boley Centers	526	2 years
Catholic Charities	156	6 months
Homeless Empowerment Program (HEP)	59	*Unconfirmed*[172]

No wait times | <1 month | >1 month

In sum, housing in Pinellas County is expensive. Not all of its residents are able to afford places of their own at all times, and the sub-population with OUD and in recovery from OUD feels this acutely. As a result, Pinellas needs a robust system of housing supports so that residents do not have to face the herculean task, and medically unrealistic ability, of achieving and maintaining sobriety while facing housing instability. Housing supports of all types in Pinellas County are unable to provide support to all who need it.

Community and family supports

Gap E2: Case management
Individuals with OUD lack access to individualized and continuous case management support throughout their recovery journey.

Social workers and case managers serve an important role in an individual's recovery journey, coordinating care related to a person's OUD as well as wraparound services like housing, non-OUD medical care, disability support, employment, and more.

In Pinellas County, case management is typically under the purview of a specific provider. As a result, a given case manager only interfaces with a resident while that resident is receiving care from the provider that employs the case manager. This has three consequences:

First is potential for service duplication, as an individual may have multiple case managers because they are treated by multiple providers.

[170] Pinellas Homeless Leadership Alliance
[171] EY interviews
[172] All "Unconfirmed" entries for wait times reflect organizations that did not respond to attempted contact via general phone number.

Second, because case managers do not work with a person across the full length of their treatment (acute and post-acute), gaps in case management can emerge. This constitutes a loss of both a key service and a trusted advisor in care navigation.

Third, because the individual cannot access case management support until they are admitted to treatment services that offer case management services, their condition may further deteriorate while they await admission to treatment.

Stakeholders observe that this system can result in social work roles falling to people outside of formal case manager positions. Referrals to some types of care (e.g., sober living) are perceived to be network-based and centered around whether the person knows a provider, peer supporter, or other party involved in the Pinellas County system of care.

Illustrative example

Employees at the IDEA Exchange often take on de facto case management roles, in addition to conducting outreach, using the network they have developed to place people into the care they need. The IDEA Exchange often serves individuals who, because they have not yet entered treatment, would not otherwise have access to case management services offered by providers.

Importantly, any movement away from a provider-based system could require additional case management capacity as clients who are not currently engaged with a provider may seek case management. Given national trends of low pay and heavy client loads for case managers already, any shift in Pinellas County's case management system should further consider whether there is an adequate supply of case managers available in the area. This may include reallocating those roles away from provider-specific work and into a centralized case management orientation or, if necessary, creating new roles.

Gap E3: Recovery supports
Pinellas County needs more social and communal spaces for individuals recovering from OUD to congregate.

Research has found that hope and meaningful community engagement play significant roles in achieving and/or maintaining a successful recovery.[173] Interviewees in recovery in Pinellas County consistently cited the importance of community in their recovery journeys. People in recovery often build positive networks of like-minded individuals who support one another, keep one another honest, and build friendships. Individuals in recovery may not be able to return to the social groups to which they belonged while in active use, as those environments may not be conducive to continued recovery. As a result, spaces to create new social supports are crucial to a sustained recovery.

Spaces that allow people in recovery to build these new social supports are limited. Some do exist — recovery housing facilities, for example, often work to foster community among their residents. AA/NA and Double Trouble groups do the same, providing structured and consistent peer support. These supports are not universal — not everyone in recovery will live in recovery housing, and not everyone in recovery wants to participate in AA/NA. These resources focus on a shared disease state rather than full social integration. The Catcher's Mitt is another example of a community space for those starting their care journey, but residential space in the program is limited, and its reach is geographically bound because of its single location.

One example of a community support is through Clubhouse International and the clubhouse model, though it primarily serves individuals with severe mental illnesses. A key component of the clubhouse model is fostering community among members. There is one clubhouse in Pinellas County, Vincent House, which provides members with opportunities to build these long-term relationships. The organization also supports members in obtaining employment, education, and housing. Members see a five-times increase in long-term employment rates, and a three-times decrease in hospitalization and incarceration rates.

Vincent House is dedicated to serving those with primary mental health disorder diagnoses. While many of their clients have co-occurring SUD, there is no such concept serving those with SUD specifically. More judgement-

[173] Stevens et al. (2019)

free, casual environments specifically targeted to the recovery community could create needed opportunities for individuals to connect with and support one another.

It is important to note that clubhouses are primarily designed for those with serious and persistent mental illnesses; many individuals with SUD have higher recovery capital and function. Clubhouses are not the only possible social outlet that would remediate this gap.

While not applicable to everyone in recovery, Pinellas' residents suggest that faith-based organizations could also have a role to play in the recovery community because they are trusted. AA/NA meetings are also frequently held in religious spaces. There are also opportunities in place in other jurisdictions to train faith-based leaders in trauma-informed responses and supports, which may make their organizations more effective participants in fostering community for individuals with OUD and in recovery.

Gap E4: Childcare

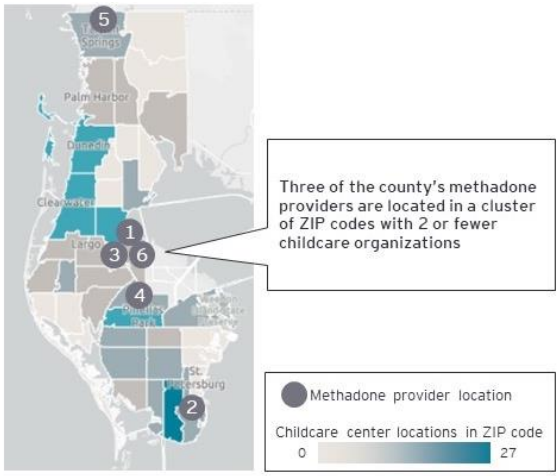
Access to childcare is a barrier to participation in treatment.

OUD treatment requires consistent visits to treatment providers. For individuals in treatment who have children, safe and affordable childcare is a noted barrier.

Several factors may contribute to this barrier. Childcare center operating hours may contribute to difficulties in managing children and treatment. Methadone dosing often occurs before childcare centers open and group meetings may occur after the close childcare centers close. Location may also be a challenge as many childcare centers in Pinellas County are predominantly concentrated in St. Petersburg, Clearwater, and Pinellas Park (see Exhibit 29). Individuals outside of these locales may have difficulty accessing convenient options.

Survey respondents acknowledged this problem as one of the largest in the county. When survey respondents were asked to choose what programs they would like to see, "Vouchers for transportation and childcare" was selected in 58% of instances in which it was shown, the fourth highest rate among the 16 initiatives tested.[174]

Exhibit 29: Childcare density and methadone clinics



Gap E5: Grief supports

Pinellas County lacks grief supports for people impacted by overdoses.

Interviewed residents in Pinellas County state that they would like to see more grief supports. Some operate today (e.g., Empath Health Grief Care, and GriefShare's 13-week support groups) and seem to have capacity. For example, Empath Health grief care in Pinellas and Hillsborough Counties directly served over 20,000 people in 2020,[175] which is well above the number of overdose fatalities in the same year. However, interviewees report these organizations are not well known or widespread in the OUD community.

The opioid epidemic has devastated families across the country. In response, other locales have built programs supporting those who have lost loved ones to overdose. These include providing financial supports to families as well as access to services including grief counseling, legal services, and housing.

[174] Respondents were shown a random pairing of the 16 initiatives and forced to choose one of the pair as preferred.
[175] Empath Health (2021)

General healthcare

The research did not uncover any general healthcare gaps in Pinellas County, though it did reveal several strengths such as density of primary care providers and access to physical activities when compared to Florida and the country as a whole. That said, there are areas in which general healthcare for individuals with SUD is negatively impacted due to state-level decisions.

Consideration: Medicaid in Florida

Florida is one of 10 states that has not adopted the 2014 Medicaid expansion. The expansion opens Medicaid eligibility to nonelderly adults with income up to 138% of the federal poverty line (FPL) and to childless adults.

In Florida today, there is no Medicaid option for non-disabled, non-elderly adults unless they are a caretaker of a related child and earn 27% or less of the FPL.[176] Pinellas County fills some of this uninsurance gap through the Pinellas County Health Program, which offers funded care for uninsured individuals below 100% of the FPL. This income eligibility is the lowest among Florida indigent health care programs and is also below the 138% of Medicaid expansion. As noted in Gap S6 (affordability), this does leave a gap in services for people over 100% of the FPL, though there are opportunities for other subsidized care through groups like CFBHN or free clinics such as the Pinellas County Health Program or the St. Pete Free Clinic. Individuals with OUD are more likely to qualify for those opportunities in part because of the frequent diagnosis of co-occurring disorders which can qualify some for treatment. However, interviewees report that utilization of free clinics remains low, resulting in capacity. It is not fully understood why those who could qualify may not fully utilize accessible services.

Though the Medicaid expansion did not significantly correlate to a reduction in drug-related fatal overdoses, outpatient prescriptions for MAT that were Medicaid-reimbursed rose 43% in expansion states compared to non-expansion states,[177] which indicates that more individuals with SUD were able to access treatment.

Mobility

Gap E6: Mobility

Transportation in Pinellas County presents a significant barrier, as individuals without a car cannot easily and consistently access services.

As discussed above, residents believe that transportation is particularly deserving of abatement dollars. The need for transportation affects individuals with OUD because Pinellas County is a car-centric community. Walk Score, an organization that measures the walkability and transit quality of cities across the country, rates St. Petersburg a 43 in terms of walkability, and 33 in terms of transit quality. (Their metrics are scaled from 0 to 100.) Clearwater scores a walkability score of 42, and a transit score of 29. Pinellas Park scores a 40 on walkability and a 30 on transit.[178] These examples are indicative of the state of the county at large: getting around efficiently requires a car.

Many individuals with OUD do not have vehicles, and as such face significant challenges navigating Pinellas County, typically relying on buses, bikes, or walking.[179] Survey results confirm this challenge, with 40% of individuals who care for someone with OUD citing getting to treatment as a barrier to getting their desired treatment. Similarly, stakeholders express excitement about vouchers or treatment co-location as potential solutions to alleviating transportation burdens.

One type of treatment to which transport barriers are particularly relevant is methadone-based MAT. Geographically accessible methadone treatment is important because the treatment requires daily visits to a clinic for dosing. For example, over half of Pinellas County's overdoses occur in St. Petersburg, but only one

[176] Drake et al. (2024)
[177] Maclean & Saloner (2019)
[178] Walk Score (n.d.)
[179] EY interviews

methadone provider operates there. The overdose hotspot is underserved by methadone clinics, indicating that there is a population of St. Petersburg residents with OUD that may have to travel for their treatment.

Without a car, these residents would need to either rely on buses, bike, ride share, or walk. Interviewees note that buses do not run frequently enough to make this convenient, and the eight miles between St. Petersburg and the next-nearest clinic in Pinellas Park is far for a biker or walker. In the summer, heat can make the median wait time of 10 minutes at unsheltered bus stops dangerous, and there are few opportunities for safely biking.[180] Many individuals resort to ride-sharing services like Uber to effectively access treatment. Uber is expensive in Pinellas County relative to benchmarks[181] and is particularly cost prohibitive. A typical trip from downtown St. Petersburg to the Operation PAR clinic in Pinellas Park is often priced at $18 each way. Over the course of a month, using Uber three times a week could cost over $400.

A peer county with similar issues deliberately placed new low-income housing projects and public health resources along existing transit routes. The residents of these housing projects rely heavily on transit, and this transit-oriented development minimizes the inconvenience associated with using the county's limited transit system.

Co-located services can also help alleviate transportation issues. Co-located behavioral health and primary health care creates easier access to both services. Individuals with OUD needs often do not receive routine primary health care, and having both services in the same physical location simultaneously reduces the transportation barrier and increases access to needed behavioral health and primary health care.

Providers in Pinellas County have explored mobile methadone options as a solution to methadone access specifically; regulatory burdens have led all of them to delay or forgo these plans. More broadly, mobile behavioral health outreach services that come to the individual in their home or community could also lighten transportation burdens. This type of service is already in place to a degree through the Pinellas County Mobile Medical Unit (MMU), with the MMU offering mobile co-located primary care and behavioral health screenings and referrals but not pharmacological treatments for SUD, including MOUD.

Employment

Gap E7: Employment support

Individuals with OUD have trouble finding employment, and those that are employed may not receive employer support as part of their treatment and/or recovery experience.

Being able to work to support oneself is crucial to the goal of self-sufficiency that many individuals in recovery aim to achieve. People with OUD and in recovery have trouble finding employment, and, even when employed, may not receive adequate support for their treatment/recovery journeys compared to other types of addiction because of the stigma associated with opioids.[182, 183]

Finding employment can be challenging for individuals with OUD and in recovery. One in four people with OUD have been involved with the criminal justice system, and employers and employment services often disqualify people who do not pass background checks.[184,185] There are some supports in Pinellas County for justice-involved individuals trying to enter the workforce (i.e., PERC's Career Pathways program), but interviewees report that more such supports are welcome. Even for individuals who are not justice-involved, stigma toward people with addiction, even those in recovery, is prevalent and can comprise another barrier to employment. Interviewees would like to see more anti-stigma campaigns to break down this barrier.

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[180] United States Department of Transportation (2022)
[181] Benchmarks for Uber pricing in places with Pinellas' density are $1–$2 per mile (Helling 2021). For a trip from downtown St. Petersburg to the clinic at Pinellas Park, this equates to an average ride price of $7.90–$15.80.
[182] Rhee & Rosenheck (2019)
[183] Mumba et al. (2022)
[184] Center for Behavioral Health Statistics and Quality (2017)
[185] Scott et al. (2021)

When a person with OUD or in recovery can find work, they may not be adequately supported in their new role. Many of the jobs that people in recovery find through employment services are contract manual labor roles. These jobs may not come with health benefits, and the physical strain associated with them can cause injury and/or relapse as individuals turn to substance use to cope with stress or pain.[186] Those who do procure employer-sponsored health insurance may be hesitant to use it, as these plans can come with limited privacy. An employee in a drug-free workplace may be hesitant to use insurance on SUD-related treatment for fear of being outed. An individual's schedule may not allow them to attend treatment or meetings consistently. Even once hired, individuals with OUD and in recovery report stigma challenges that impact steady employment.

Justice

Gap E8: Diversion program utilization

Pinellas County criminal justice diversion programs could be better leveraged to keep people with OUD from being incarcerated instead of treated.

Pinellas County has several Problem-Solving Courts offering alternatives to incarceration for people with OUD:

Table 9: Problem-solving courts in Pinellas County

Court	Enrollment (2022)	Eligibility criteria	Exclusion criteria
Adult Drug Court	594	▸ Drug charge	▸ History of violent crimes ▸ Judicial discretion
Prison Diversion Program	38	▸ Felony ▸ Facing 12–17 months in prison	▸ More than 60 points in sentencing guidelines
Veterans Treatment Court	118	▸ Veteran ▸ Misdemeanor	▸ History of violent crimes ▸ First or second-degree felony ▸ State Attorney discretion
Dependency Drug Court	61	▸ Child removal with allegations including substance use	▸ Judicial discretion
Early Childhood Court	17 families	▸ Parent of child 0–3 years old	▸ Judicial discretion
Juvenile Drug Court	86	▸ Misdemeanor or felony	▸ Judicial discretion
Mental Health Court	~30	▸ Crime resulting from diagnosed mental health issues	▸ First or second-degree felony ▸ State Attorney's discretion ▸ Victim's discretion

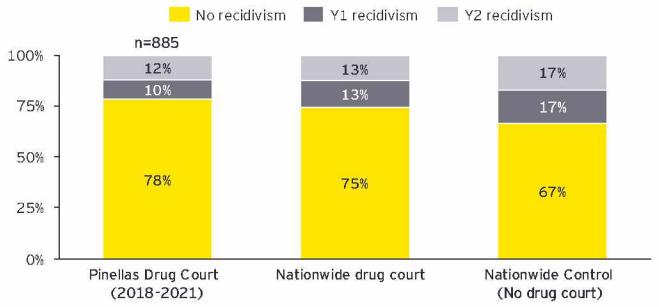
Parent court (total enrollment includes subsidiaries) Subsidiary court

[186] American Addiction Centers (2024)

These courts vary in terms of who qualifies. The Adult Drug Court[187] is for individuals facing drug charges who do not have a history of violent crimes. The Dependency Drug Court[188] is for parents whose children have been removed from their care, have been Court-ordered out of their home, or have been mandated to complete case plans due to substance use. These parents are eligible for the Dependency Drug Court regardless of whether they are facing drug charges. The Juvenile Drug Court is for youth facing either misdemeanor or felony charges. Lastly, the Mental Health Court is for individuals facing charges for criminality stemming from diagnosed mental health disorders. Qualification for all of these courts is subject to judicial discretion, and participation is voluntary.[189]

The Dependency Drug Court currently serves about 35 families per year in Pinellas County and was awarded a $997,000 grant from the United States Department of Justice in 2022 to expand over a period of three years.[190] No capacity target for the end of the grant period has been given. The grant also enabled WestCare GulfCoast to provide recovery services to participants.[191] The program has positive outcomes compared to neighboring counties; for example, Pinellas County has a 76% retention rate and an average final sobriety length of 333 days, while Pasco County only retains 48% of its participants with an average final sobriety length of 238 days.[192] Given this apparent success, current grant funding to expand capacity, and lack of primary evidence indicating lack of access to the program, the Dependency Drug Court is not identified as a gap.

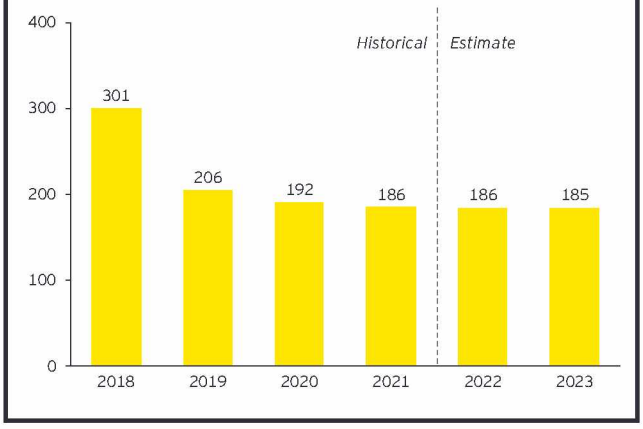
Exhibit 30: All-crime recidivism in two years after drug court, Pinellas County vs. nationwide benchmarks[193]



The Adult Drug Court, the largest diversion court with a 2022 enrollment of ~600, is a program consisting of 19 months of substance use treatment, along with frequent drug tests and checkpoints with a judge. Program completion typically results in dismissed charges or reduced probation timelines. As shown in Exhibit 30, the program is effective for keeping people out of jail and prison, as individuals who complete this program exhibit two-year recidivism rates (22% from 2018-2021) lower than the national average for both drug courts (26%) and for individuals eligible for but not enrolled in drug courts (34%).[194] This program is under capacity. It is scaled to serve 600 participants at a given time, and 1,000 over the course of a year, but, at the time of writing, has 415 active participants.[195]

Capacity only tells one side of the story. Because these courts are voluntary, finding participants requires that qualifying individuals be identified and informed of the court and its potential benefits. To fully assess capacity relative to demand, further analysis into the number of qualifying individuals in Pinellas County who are not made aware of the Adult Drug Court is necessary.

Exhibit 31: Pinellas County Adult Drug Court graduates, 2018-2023[196]



Interviewees familiar with the court report that, among those who are made aware, opt-out rates may be higher today than they were before the COVID-19 pandemic. As a result, the Drug Court may be underutilized even by individuals who are aware of it. Supporting these observations, substance use-related arrests have increased every year since 2020, while the Adult Drug Court has remained the same size (see Exhibit 31). Because this Court is effective in keeping people out of jails and prisons, potential underutilization represents a gap in Pinellas County's justice-related support system.

Governance and data

Systems of care depend on clear coordination between providers, governmental entities, and stakeholder groups to achieve intended outcomes. This can be facilitated by clear operating models, governance structures, and data-sharing agreements to direct and enable participants. Gaps in these areas can lead to silos, misalignment, and/or disagreements about priorities which may increase likelihood of duplication, misalignment, or complete gaps in services.

Governance

Gap G1: Governance

Organizations in Pinellas that provide OUD-related services operate in silos, guided by internally defined priorities, as there is no organization with the authority to oversee and direct opioid abatement efforts at the system level.

Organizations conducting opioid abatement efforts operate in silos because of a lack of system-wide direction from a designated or otherwise delegated authority. Pinellas County lacks a unified, comprehensive, long-term opioid abatement strategy to which organizations should align their efforts.

The county government also lacks an organization with the authority to oversee and direct opioid abatement efforts at the system level. Though the Opioid Task Force is sometimes viewed as that body, it is primarily a group of community partners. The OTF was formed as a collaborative effort in response to sharply increasing numbers of opioid-related fatalities in the county, and now also serves a qualifying body for the county to receive settlement funds. Historically, the OTF saw positive results in leading OUD efforts. More recently, there is less accountability for members to drive programming and direct efforts to stated priority areas.

The Opioid Abatement Funding Advisory Board is also not meant to oversee and direct abatement efforts at a system level. The remit of the OAFAB is strictly limited to the direction of regional opioid abatement settlement funding, as approved by the Board of County Commissioners. It is not intended to deliver services or coordinate system-wide goals. However, because of the existing braided and unstable funding for many SUD-related services, these boards' authority over funds is not comprehensive.

Some other entities see positive results with individual and collaborative efforts. Those groups, including (but not limited to) DCF, PCHS, and the Fusion group,[197] see positive results with individual and collaborative efforts, and even step into coordinating roles with providers. However, these groups are not seen as the authoritative body. Although DCF is the identified authority of the state's mental health and substance use treatment system, it does not operate in this capacity and often refers to its subcontracted managing entity, which is regarded as an entity to manage contracted services rather than a regulator.

The absence of a singular authoritative body means that strategic coordination does not happen today at scale, even though parties are collaborating to push abatement efforts towards various goals. Stakeholders in

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[187] The Prison Diversion Program and Veterans Treatment Courts are specialized subsets of this court. The Prison Diversion Program is for individuals with felony charges facing 12–17 months in prison. The Veterans Treatment Court is for veterans charged with misdemeanors.
[188] The Early Childhood court is a specialized subset of this court for parents with children up to three years old.
[189] Enrollment and criteria from 2022 6th Circuit Court Annual Report
[190] Sixth Judicial Circuit (2022)
[191] Porter (2022)
[192] Sixth Judicial Circuit (2022)
[193] Pinellas County Courts; Mitchell et al. (2012) in *Journal of Criminal Justice*
[194] Pinellas County Courts; Mitchell et al. (2012) in *Journal of Criminal Justice*
[195] Data from Pinellas County Courts. 2022 and 2023 graduate count estimated derived using pre-COVID-19 graduation rates and interviewee-reported program enrollment in 2022 and 2023
[196] Data from Pinellas County Courts. 2022 and 2023 graduate count estimated derived using pre-COVID-19 graduation rates and interviewee-reported program enrollment in 2022 and 2023
[197] The FUSION group was established in 2016. It includes the DOH-Pinellas, PCHS, Pinellas County EMS & Fire Administration, Pinellas County Forensic Laboratory, District 6 Medical Examiner's Office, Pinellas County Sheriff's Office, Pinellas County Poison Control, and other key partners where data is shared, and issues related to community drug trends are discussed.

Pinellas County expressed the need for a body with authority to serve as the "champion" or lead entity to provide oversight and drive accountability at the county-level. This body, if granted the authority, could strategize policy, programs, and financing, and direct stakeholders to individual tasks. If permitted, they could coordinate several groups to deliver mission-oriented outcomes over different time horizons through more active strategic efforts. Counties across the country have implemented similar authoritative coordinating bodies.[198]

Data

Gap G2: Data sharing

Data sharing across stakeholder groups is sparse and limited, which makes it difficult to develop a systems-level perspective and integrated, advanced analytics.

Assembling systems-level data for strategy, operations, and research is a challenge in Pinellas County. There are no system-level data sharing agreements, which is a problem that many county-level governments face. Pinellas has several initiatives with positive initial results, and others that face difficulty in data gathering and sharing.

Efforts like the Optimal Data Set (ODS) initiative are progressing more slowly than many stakeholders expect. The ODS, which was initially conceived with the 2020 *Elevate Behavioral Health* report, and data collection for a collective and standard monitoring program began in early 2023.

This program will provide insight into service access, capacity, and quality, and could be a step toward systems-level data sharing. Although many stakeholders want to collaborate and provide data for this initiative, the lack of data organization and supports (e.g., IT) have hindered progress. Since progress on this initiative is slow, it may require further development alongside cooperation from Pinellas County funders and providers.

As mentioned above in the Efforts to date section, the SIP intended to support timely data collection from key stakeholders to better articulate the current state of the problem and support cross system planning. This data evaluation was intended to better inform policy makers on targeted interventions, leverage scarce resources, and avoid duplication of efforts.[199] However, interviewees reported that discussions during the grant period often got sidetracked into questions about who would own what data.

Academic research groups like the USF and Northwestern collaboration also faced difficulties in assembling representative data required for robust modeling and conclusions. This difficulty stems from providers being hesitant to share potentially sensitive data with researchers and other providers. The researchers point to this in the peer-reviewed publication "Model-driven decision support: A community-based meta-implementation strategy to predict population impact" in the Annals of Epidemiology journal, where they wrote *"Community members may be reluctant to share sensitive data, making data access a challenge initially, as well as over time, as new actors replace existing data providers and data use agreements and privacy are revisited."*

During the time of this gap analysis effort, data owners were often unable to share data for the study even with clear data use agreements available. Some requested data was not available because it is not collected, and some data was simply not made accessible.

Stakeholders have also noted that funders and providers may be hesitant to enter an agreement without reciprocity. Another challenge for data collection and sharing highlighted in stakeholder interviews is the lack of data and technology capabilities, particularly for smaller organizations. This is often due to lack of resources available or dedicated toward data and analytics relative to core competencies and services.

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[198] Erie County, NY, created the Community Opioid Response Director Role to manage the grants, reporting, and communications related to settlement funding. See Buffalo Healthy Living (2024), the Erie County Community Opioid Response Director job posting, and Recommendation 6 for more details.

[199] Bureau of Justice Assistance (2018); Pinellas County Opioid Task Force (n.d.); Pinellas County Opioid Task Force (n.d.)

This gap may be remediated through a data-sharing agreement that evolves into a system of data governance, controls, and maintenance, and through enablement of technical data capabilities in organizations.

It is important to note that some data-collection and data-sharing initiatives in the county are proficient. In fact, there are many cases of leading initiatives, though they are typically smaller scale. For example, the Medical Examiner and Forensic Lab processes cases quicker than peers, typically within 30 days. They actively share data to groups such as the Opioid Task Force and Fusion Group. Additionally, county agencies' ongoing partnership with USF and Northwestern has been helpful in developing predictive modeling tools to assess the potential of abatement interventions. However, even these proficient groups note struggles in accessing and sharing data.

Section 5

Leading practices

As described in Section 2, the leading practices index represents information gathered from multiple academic and non-academic sources including peer-reviewed publications and reports from leading organizations, think tanks, academic groups, and other reputable sources. These research findings from different sources and groups were aligned to the Continuum of Care.

Few leading practices were completely new to Pinellas County stakeholders. While some practices had not been developed (due to barriers like cost, Medicaid expansion status, or local opposition), nearly all had been considered at some point during the opioid epidemic.

Some leading practices that Pinellas County chose not to implement ran into governance barriers. As discussed, the system of care, while robust, is largely decentralized. No single provider, insurer, or funder oversees a majority of individuals with OUD. Since many leading practices require individual-level or system-level data to be shared, and individuals and providers both expressed hesitance about entering in data-sharing agreements, those practices were de-prioritized in favor of ones that could fit into the existing governance structure. Abatement funding offers the opportunity to reimagine those systems, which could unlock several other strategies that are not directly connected to data and governance.

Below is a summary of the leading practices findings by CoC area. Some findings are presented as "primary leading practices" vs. "component leading practices." Component leading practices indicate where a general leading practice (a "primary" practice) can be made more specific. Component leading practices have the same backing and repute as primary leading practices and should be read as options to implement a primary practice.

Emerging practices, which are innovative (but less tested) practices, are not shown in this section. There are more less-tested practices than widely supported practices, so they cannot all be listed in one place. Emerging practices that could support a recommendation are discussed in Section 6 (Recommendations) and Appendix C.

Each leading practice is presented with an approximate yearly cost and an approximate time to implement. Costs and timeline metrics are **estimated** and fluctuate based on scale, local requirements, and funding.

Cost metrics

- Practices with cost below $500,000 per year would typically grow additional services, while:
  - Leveraging existing services *and*
  - Hiring zero or few new FTEs *and*
  - Having no brick-and-mortar construction
- Practices with cost between $500,000 and $1 million would likely require
  - New organization(s) with small headcount *or*
  - Adding FTEs in an existing organization *or*
  - Moderate capital costs (goods or physical presence)
- Practices with cost over $1 million could likely require
  - New organization(s) with small headcount *or*
  - New organization(s) with large headcount *or*
  - New large-scale brick-and-mortar presence

Timeline metrics

- Short timelines reflect initiatives with no structural or legal barriers to implementation. The practice could be operational within months.
- Moderate timelines (two clocks) reflect initiatives with some barriers to implementation. Operations may be contingent on hiring or construction.
- Long timelines (three clocks) have large structural or legal barriers to implementation, possibly requiring legislative approval or permits. These would likely take several years to reach full build-out.

Education

Leading practices in education are needed because there are information gaps among priority populations like youth, adults, first responders and educators. These leading practices create scaled opportunities to alleviate those gaps, reduce stigma against opioid users, and provide an opportunity to upskill community leaders.

These educational leading practices are typically lower-cost and easier to implement, in part because they do not involve changing any clinical care. The targeted populations for these educational efforts include children and young adults transitioning to adulthood, individuals at high risk of opioid misuse, first responders, healthcare providers, and educators.

Leading practice	Description	Feasibility[200] Cost *(est. yearly)*	Feasibility Timeline
Education in school settings	In-school education on OUD, overdose, and the dangers of fentanyl	<$500k	
School nurse/staff trainings[201]	Care provider-specific training, with a focus on OUD detection and overdose response	<$500k	
Anti-stigma trainings for college students	Guided discussion of roots of stigma and strategies to stop it on a college campus	<$500k	
Education in non-English languages	Provide educators with resources to reach non-English speaking participants	<$500k	
Presentation/simulation-based training	Interactive seminars on OUD and appropriate responses to overdose	<$500k	
Trauma-informed care communities	Intentional communities that discuss how trauma can be an OUD trigger	$500k-$1m	
Paid media campaigns to educate the community[202]	Advertisements about OUD, overdoses, fentanyl, and other relevant topics	>$1m	
Education around Good Samaritan laws[203]	Increase community understanding of laws that encourage emergency reports	$500k-$1m	
Encouraging the public to call 911/988	Earned or paid media describing when someone should call 911 or 988	<$500k	
Including opioids in general anti-substance education	Educational programs that situate opioids among other substances to be avoided	<$500k	

Primary leading practice

Component leading practice

Short-term Long-term

[200] Costs are estimated and fluctuate based on scale, local requirements, and available funding. Additional detail available for leading practices included in recommendations.
[201] School nurses would be trained as part of Recommendation 4 and 10, both of which cover provider training.
[202] Paid media campaigns are an integral part of Recommendation 9 (comprehensive media campaigns).
[203] Recommendation 4 could include education around Good Samaritan laws, as explained in Section 6.

Early detection

Early detection enables providers and caregivers to identify the risk of overdose at an early stage. There are few proven interventions besides screening protocols, although there are some technology-enabled emerging practices. The leading screening protocols are brief, and thus fairly simple to incorporate in places that do not have them.

The primary groups for these early detection efforts include individuals with untreated OUD or those at high risk of opioid misuse, healthcare providers, pharmacists, and first responders.

Leading practice	Description	Feasibility[204] Cost *(est. yearly)*	Feasibility Timeline
SBIRT (Screening, Brief Intervention, and Referral to Treatment)	Rapid screening at primary care, federal health centers, schools, or emergency departments with connections to treatment facilities	<$500k	
Screening for ACEs (Adverse Childhood Experiences) in primary/pediatric care	Develop a trauma-informed understanding of a patient population that may be at risk for OUD later in life	<$500k	

Primary leading practice

Component leading practice

Short-term Long-term

[204] Costs are estimated and fluctuate based on scale, local requirements, and available funding. Additional detail available for leading practices included in recommendations.

Harm reduction

Harm reduction leading practices aim to minimize the health risks and social harms associated with opioid use. These strategies are designed to improve the health outcomes of individuals actively using illicit opioids.

The harm reduction practices detailed on this page all concern overdose education and naloxone distribution (OEND). There are several situations where OEND has been shown to be helpful, though OEND is typically more difficult to implement in clinical and carceral settings.

The focus of harm reduction is on individuals actively using opioids, healthcare providers, community health practitioners, and first responders.

Leading practice	Description	Feasibility[205] Cost *(est. yearly)*	Feasibility Timeline
Overdose education and naloxone distribution (OEND)[206]	Distribute naloxone and educate people on its use	$500k-$1m	
OEND for first responders	Equip police officers, firefighters etc. with naloxone and the knowledge to use it	$500k-$1m	
OEND for general public	Make naloxone kits and training available to everyone	<$500k	
OEND in carceral settings	Train prison staff and incarcerated people on naloxone use	$500k-$1m	
OEND in re-entry settings	Equip people leaving prison with naloxone and the skills to use it	$500k-$1m	
OEND in club/party settings	Increase access to naloxone training and kits in high-risk situations	$500k-$1m	
OEND in primary care	Offer naloxone training and access during medical visits	$500k-$1m	
OEND at overdose sites	First responders training those at an active overdose site	$500k-$1m	
Pay people with OUD to do OEND	Employ people in recovery to provide naloxone education	$500k-$1m	

Primary leading practice
Component leading practice

Short-term Long-term

[205] Costs are estimated and fluctuate based on scale, local requirements, and available funding. Additional detail available for leading practices included in recommendations.
[206] Recommendation 4 provides more details about OEND programs.

The harm reduction practices detailed on this page concern practices other than OEND. These practices vary in their scope and cost but are all still targeted at high-risk individuals and people in active use.

Leading practice	Description	Feasibility[207]	
		Cost *(est. yearly)*	Timeline
Double-kit naloxone distribution	Distribute naloxone in larger kits (at least four doses)	$500k-$1m	
Co-prescription for high-risk patients	Prescribe naloxone during medical visits for high-risk individuals	<$500k	
Fentanyl test strip distribution at events	Distribute fentanyl test strips at high-risk events like concerts	<$500k	
Fentanyl test strip distribution in jails	Distribute fentanyl test strips before re-entry	<$500k	
Harm reduction vending machines[208]	Offer naloxone, test strips, or other safe usage tools in vending machines	$500k-$1m	
Supervised consumption sites	Supervise opioid consumption with staff trained to reverse overdoses	>$1m	
Safer supply programs	Prescribe opioids to provide users with an alternative to contaminated street supply	>$1m	
Harm reduction laws and policies	State and national-level laws to further harm reduction goals	*Varies*[209]	*Varies*
Education on infectious disease risks for intravenous drug users	Discuss infectious disease risk during care for someone who uses opioids	<$500k	
Syringe services programs[210]	Offer free hypodermic needles and safe disposal of used needles	$500k >$1m[211]	

Primary leading practice
Component leading practice

Short-term Long-term

[207] Costs are estimated and fluctuate based on scale, local requirements, and available funding. Additional detail available for leading practices included in recommendations.
[208] Recommendation 4 discusses harm reduction tools such as vending machines.
[209] There are several harm reduction laws that could reduce mortality, though they are too numerous to list. As shown, they vary in cost and timeline. Florida has made progress with laws such IDEA (2019), but is generally less mature in passing harm reduction laws than some other states.
[210] See Recommendation 11 for more information about syringe services programs.
[211] Varies from moderate to high based on location and permits required.

Maternal health

Leading practices in maternal health focus on addressing the unique needs of pregnant women and new mothers in the context of opioid use disorder (OUD). Because many leading practices specifically concern reducing neonatal abstinence syndrome, they are often a larger and time-consuming investment.

Key groups targeted by these practices include pregnant women and new parents, childcare providers, and systems that interact with pregnant women, such as obstetricians, WIC administrators, parent support programs, and child welfare organizations.

Leading practice	Description	Feasibility[212] Cost *(est. yearly)*	Feasibility Timeline
General leading practices for treating at-risk mothers	Train providers for unique challenges and opportunities for mothers who use opioids	$500k-$1m	*Varies*
Investments in childcare for parents who have OUD	Provide childcare to create parent time for treatment and/or employment	$500k-$1m	🕐🕐🕐
Initiating SUD treatment with pregnant women	Begin SUD treatment, including MAT, during pregnancy	<$500k	🕐🕐🕐
Treatment for neonatal abstinence syndrome (NAS)	Train healthcare providers to treat high-risk mothers and NAS babies	>$1m	*Varies*
Standardize hospital management of NAS	Create leading practices for NAS treatment within a geographic region	<$500k	🕐🕐🕐
NAS-specific treatment settings	Offer specialized NAS treatment in inpatient settings or NICUs	>$1m	🕐🕐🕐
NAS outpatient opioid weaning	Discharge NAS babies to outpatient care for opioid weaning	$500k-$1m	🕐🕐🕐
SBIRT for parents by pediatricians	Implement SBIRT with high-risk parents at pediatric appointments	<$500k	🕐🕐🕐
Medicaid collaborations after screening pregnant women	Confirm that eligible mothers-to-be are enrolled in Medicaid/using covered services	$500k-$1m	🕐🕐🕐
Integrated SUD treatment with health/family services	Offer SUD treatment at social service centers (e.g., Recovery Community Centers)	$500k-$1m	🕐🕐🕐
Nurse visits to pregnant women's homes	Connect families to medical and social service care during structured home visits	$500k-$1m	🕐🕐🕐

Primary leading practice
Component leading practice

Short-term Long-term

[212] Costs are estimated and fluctuate based on scale, local requirements, and available funding. Additional detail available for leading practices included in recommendations.

Access to treatment and first contact

Treatment can be difficult to access. Since someone's desire for treatment can be sporadic, it is crucial to provide quick access to care. And once received, that "first contact" care is a determinative moment for what someone's long-term treatment journey will look like.

Increasing and sustaining access to treatment can be expensive, and many of the leading practices involve paying for treatment to get around financial barriers. The focus of these efforts is on individuals with OUD, primary care physicians, addiction treatment centers, and emergency department staff.

Leading practice	Description	Feasibility[213] Cost *(est. yearly)*	Feasibility Timeline
Expand access to OUD treatment with ED visits	Offer to begin addiction treatment during emergency care visits for unrelated issues	$500k-$1m	
NIATx (Network for the Improvement of Addiction Treatment)	Operations and process improvement for treatment centers	$500k-$1m	
Investment to offer treatment on demand[214]	Spend money on additional caregivers to make treatment readily available	*Varies*	*Varies*
Subsidize treatment to increase demand	Invest money in detox, rehab, or MAT to alleviate financial concerns for people seeking help	>$1m	
Telehealth options to accelerate access	Allow immediate telehealth treatment for individuals who can't reach in-person care	$500k-$1m	
ED linkages to primary care	Mandate referrals to primary care for potential MAT prescription after ED visit	<$500k	
Short-term inpatient linkage to primary care	Mandate referrals to primary care for potential MAT prescription after inpatient care	<$500k	
SBIRT for patients without insurance	Screen patients for OUD regardless of insurance status	<$500k	
Warm hand-offs into treatment[215]	Facilitate smooth transitions into treatment programs for OUD	$500k-$1m	

Primary leading practice

Component leading practice

Short-term Long-term

[213] Costs are estimated and fluctuate based on scale, local requirements, and available funding. Additional detail available for leading practices included in recommendations.
[214] See Recommendation 5 for more information about treatment on demand and subsidized treatment.
[215] Warm hand-offs can be implemented throughout the CoC, but Recommendation 8 specifically discusses them in carceral settings.

Prevention	Acute addiction	**Seeking help**	Acute and post-acute care	Long-term TX and recovery
Access to treatment	First contact	**Crisis response services**	**Peer specialists**	

Crisis response services and peer specialists

Crisis response services and peer supports both help individuals in crisis. Additionally, there are several emerging practices related to using peers outside of crisis situations. Leading practices can help a moment of crisis become a reason for treatment. These leading practices often require structured teams and approaches, since crises can be such high-leverage situations. This structure typically adds time and expense, though.

These services target all individuals involved in crisis response, particularly people with OUD. Operational improvements can also target first responders.

Leading practice	Description	Feasibility[216] Cost *(est. yearly)*	Feasibility Timeline
Co-responder model to crisis scenarios[217]	Joint law enforcement and clinician response to provide health support	$500k-$1m	
Create and sustain long-term support roles for peers	Create structures for long-term behavioral support/motivation from peers in recovery	$500k-$1m	
Crisis hotline run by peers[218]	Behavioral phone crisis staffed by people with lived OUD experience	$500k-$1m	
Peer-staffed mobile crisis centers	Send teams with lived OUD experience to respond to crises	>$1m	
Adding OUD Tx in places that primarily treat comorbidities	Integrate OUD treatment where people in active use may already receive care	$500k-$1m	
Training care providers about "MAT first" approach[219]	Educate providers on prioritizing MAT as a first-line treatment for OUD	$500k-$1m	

Primary leading practice

Component leading practice

Short-term Long-term

[216] Costs are estimated and fluctuate based on scale, local requirements, and available funding. Additional detail available for leading practices included in recommendations.
[217] This is discussed in Recommendation 16.
[218] Peer counseling and support is discussed in Recommendation 3.
[219] Provider training for MAT is part of Recommendation 10.

Acute and post-acute care

Acute and post-acute care for individuals with OUD involves a comprehensive approach that addresses both the addiction and any coexisting conditions. Leading practices for acute care span a wide range of costs, as some practices offer explicit clinical guidance, and others deal with more tactical care such as warm hand-offs. These practices are meant for individuals with OUD, as well as people involved in care management.

Leading practice	Description	Feasibility[220] Cost *(est. yearly)*	Feasibility Timeline
Immediate integrated treatment	Simultaneous treatment of opioid addiction and other comorbidities from induction	$500k-$1m	
Care coordination in priority settings (EDs, SSPs etc.)[221]	Connect patients with relevant treatment services across EDs, justice systems etc.	$500k-$1m	
Warm handoffs for justice-involved groups[222]	Easing re-entry from justice involvement into treatment programs	$500k-$1m	
Short term detox in CSUs or BHCCs	Offer withdrawal management services in crisis centers	>$1m	
Make detox units into MAT centers	Convert detox centers into MAT-providing centers	$500k-$1m	
Reduce referrals to detox	Divert patients to less-intensive treatment options such as immediate MAT treatment	<$500k	
Recruit staff with demographic similarities to patients	Hire inpatient staff who look like and have had similar experiences to patients	<$500k	
Longer rehab lengths for patients with OUD	Offer longer rehab programs for those struggling with OUD	>$1m	
Increase rehab availability for Medicare/Medicaid patients	Increase the access to rehab covered by Medicare/Medicaid	$500k-$1m	
Induce patients on MAT during rehab	Start MAT within rehab programs	$500k-$1m	

Primary leading practice

Component leading practice

Short-term Long-term

[220] Costs are estimated and fluctuate based on scale, local requirements, and available funding. Additional detail available for leading practices included in recommendations.
[221] Care coordination for individual patients is discussed in Recommendation 2.
[222] Increasing the connection between treatment programs and justice systems is discussed in Recommendation 8.

Long-term maintenance TX and recovery

Outpatient services for OUD provide support for individuals seeking recovery while allowing them to maintain their daily routines. The structured nature of these programs reduces the risk of relapse.

Some of these practices are small changes in clinical care, though they may require work to get providers to adopt them. Some practices shown here represent much larger updates to the system of care. These services support a wide range of individuals, especially those returning from incarceration or inpatient treatment.

Leading practice	Description	Feasibility[223] Cost *(est. yearly)*	Feasibility Timeline
Contingency management	Offer small rewards in treatment (e.g., for behaviors consistent with treatment goals)	$500k-$1m	
Cognitive-behavioral therapy	Offer therapy to change thoughts and behaviors that may reinforce active use	$500k-$1m	
Telehealth therapy	Make therapy available over videochat or telephone	<$500k	
Family therapy	Offer specialized therapy for individuals in recovery with family members	$500k-$1m	
Behavioral therapies for pregnant women	Offer therapy providing the tools to face motherhood and the postpartum period	$500k-$1m	
Long-term peer support[224]	Create structures for long-term behavioral support/motivation from peers in recovery	$500k-$1m	
Certified Community Behavioral Health Clinics[225]	Brick-and-mortar clinics offering comprehensive behavioral health treatment	>$1m	
Use CCBHCs to encourage behavioral health screening	Use shared environments like CCHBCs to encourage broader Bx screening	<$500k	
Substance Abuse Intensive Outpatient (SOAP)	Structured outpatient program that combines treatments multiple times/week	$500k-$1m	
Assertive Community Treatment (ACT) Teams[226]	Team-based approach to provide comprehensive supports and access to substance use and/or psychiatric treatment	>$1m	

Primary leading practice

Component leading practice

Short-term Long-term

[223] Costs are estimated and fluctuate based on scale, local requirements, and available funding. Additional detail available for leading practices included in recommendations.
[224] See Recommendation 3 for more information about the roles of peer specialists.
[225] CCBHCs are discussed in Recommendation 13.
[226] ACT teams are discussed in detail in Recommendation 14.

Prevention	Acute addiction	Seeking help	Acute and post-acute care	**Long-term TX and recovery**
Outpatient services	**Medication-assisted treatment**	Long-term residential support		

Medication-assisted treatment

Medication-assisted treatment for OUD involves the use of prescribed medications, known as medications for opioid use disorder, in combination with medical supervision to support recovery. MAT is one of the few proven treatments for OUD but is costly. Some leading practices here are clinical changes, and others are opportunities to increase access to medication.

MAT services are available to all individuals with OUD, particularly benefiting those who have not found success with other treatment modalities.

Leading practice	Description	Feasibility[227] Cost *(est. yearly)*	Feasibility Timeline
Collaborative decision on which medication to prescribe[228]	Research to define barriers to getting MAT	<$500k	
Patient-provider collaboration	Use data analysis and modeling to identify local hurdles to accessing MAT	<$500k	
Telehealth MAT	Provide take-home MAT through telemedicine	<$500k	
Audio-only telehealth MAT	Provide take-home MAT through audio-only telemedicine	<$500k	
MAT in healthcare settings	Integrate MAT at general healthcare settings (e.g., hospitals, urgent care)	<$500k	
MAT in justice settings[229]	Provide MAT in jails/prisons	>$1m	
Hub-and-spoke	Regional plan to coordinate local MAT treatment after induction	>$1m	
Investing in patient retention	Increase efforts (e.g., mobile, web, digital therapy) to keep patients engaged in MAT	$500k-$1m	
Invest to provide MAT for uninsured population[230]	Cover medication costs for uninsured/ non-Medicaid population in MAT, including above 100% of the federal poverty line	>$1m	

Primary leading practice

Component leading practice

Short-term Long-term

[227] Costs are estimated and fluctuate based on scale, local requirements, and available funding. Additional detail available for leading practices included in recommendations.
[228] Barriers to MAT access are discussed in Recommendation 5 and 10.
[229] Access to OUD-specific medications in prisons and jails is discussed in Recommendation 8.
[230] See Recommendation 5 for more detail.

Long-term residential support

Long-term residential support for individuals in recovery provides post-acute treatment care in dedicated facilities. These facilities offer structure but are often prohibitively expensive for residents, or not high-quality. Leading practices to increase access to recovery housing are accordingly expensive, but there are several more inexpensive options that improve the quality of existing housing.

These residential supports are particularly important for many individuals with OUD who may not have a safe or supportive environment to return to after their initial care. By fostering a sense of community and providing the necessary tools for independence, long-term residential support plays a crucial role in promoting sustained recovery and preventing relapse.

Leading practice	Description	Feasibility[231] Cost *(est. yearly)*	Feasibility Timeline
Offer choice of housing to people entering long-term recovery[232]	Confirm that individuals moving into recovery housing have sufficient options to fit their priorities and current residents' needs	$500k-$1m	
Third-party certification of recovery housing	Incentivize states to acquire third-party (e.g., NARR) certification of meeting nationally recognized standards	<$500k	
Medications in recovery houses	Support use of medications for mental health conditions or substance use disorder within the house	<$500k	
Hire and retain culturally competent staff	Provide cultural competency education to staff (if recovery houses have them)	$500k-$1m	
Evaluate program effectiveness	Work with community supports and government officials to measure the effectiveness of a recovery home on residents	<$500k	
Increase supply of recovery housing (FARR levels I-III)	Work with recovery housing operators to expand houses and beds, while maintaining standard of care	>$1m	
Increase supply of temporary medical respite facilities	Expand temporary medical respite facilities to bridge the gap between homelessness and permanent housing	>$1m	

Primary leading practice

Component leading practice

[231] Costs are estimated and fluctuate based on scale, local requirements, and available funding. Additional detail available for leading practices included in recommendations.

[232] The quality and quantity of recovery housing, housing certifications, housing program effectiveness, and the supply of temporary respite housing are discussed in Recommendation 1.

External supports					
Housing	**Employment**	Community/ family support	Mobility	General healthcare	Justice

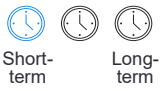
Housing and employment

Individuals with OUD, especially those returning from inpatient treatment, are disproportionately likely to need housing and employment support. Because housing is so expensive, many options require large investments or time. Similar to housing, employment services are essential for helping individuals reintegrate into society, gain self-sufficiency, and reduce the risk of relapse. These practices often require partnerships with employers or other organizations but are less expensive.

Leading practice	Description	Feasibility[233] Cost *(est. yearly)*	Feasibility Timeline
Drug-free housing[234]	Residential programs that enforce abstinence from drugs besides MAT	>$1m	
Pharmacy collaboration for housing supports	Partnerships between pharmacies and housing services to offer consistent care	<$500k	
Permanent supportive housing	Long-term housing with supportive services for the chronically unhoused	>$1m	
Housing support/vouchers	Financial assistance for housing through vouchers or other aid	>$1m	
Workforce training[235]	Skill development and employment readiness for individuals in re-entry or recovery	$500k-$1m	
Individual employment placement	Recovery-specific assists in finding and maintaining employment	$500k-$1m	
Recovery-friendly workplaces[236]	Supportive, non-discriminatory work environments for individuals in recovery	<$500k	
Supportive employment	Supports to help people in recovery find and maintain competitive jobs at market wages	$500k-$1m	
Open additional Clubhouses, or centers providing similar services	Structured social space for people recovering from mental illness or SUD, typically offering jobs in the house or in the community	>$1m	

Primary leading practice

Component leading practice



[233] Costs are estimated and fluctuate based on scale, local requirements, and available funding. Additional detail available for leading practices included in recommendations.
[234] Abstinent housing, permanent supportive housing, and housing support are discussed in Recommendation 1.
[235] Workforce training, transitional employment, recovery-friendly workplaces, and the clubhouse model are discussed in Recommendation 13.
[236]

External supports					
Housing	Employment	**Community/ family support**	**Mobility**	General healthcare	Justice

Community/family support and mobility

Community and family supports play a vital role in the recovery process for individuals with OUD.

By fostering an environment of understanding and support, community and family networks can enhance the effectiveness of recovery efforts and improve outcomes for those affected by OUD. These supports can most help parents, loved ones, and children. These supports typically involve employing care workers and tend to be a larger investment.

Mobility support offers similar benefits, especially for individuals in recovery. Transportation enables them to access jobs, treatment, community resources, and family support. While mobility support is important for all individuals in recovery, the challenges and solutions are particularly acute for those who do not own a car.

Leading practice	Description	Feasibility[237] Cost *(est. yearly)*	Feasibility Timeline
Reduce barriers to transportation and childcare[238]	Provide access to reliable transportation and affordable childcare	$500k-$1m	
Family skills training interventions	Offer skills training to family members of individuals in recovery	$500k-$1m	
Early intervention via justice system	Using specialized courts to monitor treatment for parents with OUD and a child abuse case	>$1m	
IDEA Part C	Using federal grants to support children at risk of delays	$500k-$1m	
Intensive care management for parents	Offer comprehensive, personalized care management for parents in recovery	>$1m	

Primary leading practice

Component leading practice

Short-term Long-term

[237] Costs are estimated and fluctuate based on scale, local requirements, and available funding. Additional detail available for leading practices included in recommendations.
[238] Recommendation 5 discusses reducing barriers such as transportation and childcare.

External supports					
Housing	Employment	Community/ family support	Mobility	**General healthcare**	Justice

General healthcare

General healthcare improvements are fundamental to sustained recovery from OUD. However, since nearly all these supports require clinical care, they are often large investments. These healthcare strategies are beneficial for all individuals, regardless of their stage in the recovery process.

Leading practice	Description	Feasibility[239] Cost *(est. yearly)*	Feasibility Timeline
Academic detailing	Structured visits to providers by dedicated training teams	<$500k	
Collaborative Care Model	Assign a care manager to coordinate behavioral health and primary care	>$1m	
Centralized case management	Centralized, differentiated levels of support to clients, based on need	>$1m	
Nurse Care Model	Assign a nurse to coordinate care after they implement the OUD treatment	$500k-$1m	
Expanding the OUD treatment workforce	Incentivize PCPs to become MAT prescribers and promoting nonphysician providers	>$1m	
Extension for Community Healthcare Outcomes	Assign telehealth patients to remote providers to decrease wait times	<$500k	
Physician-to-physician warm lines	Structured-visit service where providers discuss addiction treatment	<$500k	
Drug supply management policies	Strict limits on dose prescribing (dose limits, lock-ins, utilization reviews)	<$500k	
Provider education on pain management and stigma[240]	Structured education for providers on leading practices in pain management	<$500k	
Clinical guideline enforcement/dissemination	Health care organizations creating guidance on pain management and prescribing	$500k-$1m	
Clinical health system interventions[241]	Interventions to improve painkiller safety (e.g., health record alerts; provider feedback)	>$1m	
Medication takebacks and disposals	Public programs encouraging safe disposal of prescription medicine	$500k-$1m	

Primary leading practice

Component leading practice

Short-term Long-term

[239] Costs are estimated and fluctuate based on scale, local requirements, and available funding. Additional detail available for leading practices included in recommendations.
[240] Provider education and clinical guidelines are discussed in Recommendation 4.
[241] Recommendation 2 discusses care coordination, which includes provider feedback. Further information about data sharing across shareholder systems can be found in Recommendation 6 and 7.

External supports					
Housing	Employment	Community/ family support	Mobility	General healthcare	**Justice**

Justice

Individuals with SUD are often caught in a cycle of arrest and conviction, where treatment options may be more beneficial for both the individual and society. Alternative justice approaches can provide the necessary support and rehabilitation, both in and out of carceral settings.

This page addresses leading practices before the individual arrives in a justice setting. These practices tend to be less cost-efficient, since justice settings often come with increased expense.

Leading practice	Description	Feasibility[242] Cost *(est. yearly)*	Feasibility Timeline
Pre-arrest SUD care and early diversion[243]	Help people with OUD get treatment before potential arrest	>$1m	
Following up on justice referrals to divert patients	Refer potential arrestees with OUD to treatment	$500k-$1m	
Establishing or expanding specialty drug courts	Set up targeted court programs for supervised recovery of incarceration	>$1m	*Varies*
Drug court as an induction mechanism for MAT	Mandate MAT as a condition for drug court enrollment	$500k-$1m	
System of accreditation to improve drug courts	Standardize drug court policies through accreditation	<$500k	
Law enforcement and first responder training on SUD	Educate law enforcement on leading practices when encountering someone with SUD	<$500k	
Establishment or expansion of Veterans' courts	Alternative justice proceedings for veterans	>$1m	*Varies*
Establishment or expansion of mental health treatment courts	Alternative justice proceedings for individuals with diagnosed mental illnesses	>$1m	*Varies*
Medicaid Inmate Exclusion Program	Transition inmates to Medicaid pre-release	<$500k	

Primary leading practice
Component leading practice

Short-term Long-term

[242] Costs are estimated and fluctuate based on scale, local requirements, and available funding. Additional detail available for leading practices included in recommendations.
[243] Early diversion initiation and follow-up, specialty drug courts, and SUD in carceral settings are discussed in Recommendation 8.

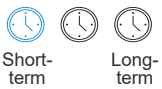
External supports					
Housing	Employment	Community/ family support	Mobility	General healthcare	**Justice**

There are also several leading practices that deal with carceral facilities. While these practices require more investment, they can show significant benefits because of the large numbers of individuals with OUD in jail or prison at a given time.

Leading practice	Description	Feasibility[244]	
		Cost *(est. yearly)*	Timeline
Focus on SUD care in prisons	Confirm that carceral facilities are following evidenced-based practice in treating SUD	>$1m	
Screen for SUD in justice settings[245]	Evaluate for SUD upon jail entry	<$500k	
Specialized caseloads	Equip a subset of correctional officers with SUD-specific tools	$500k-$1m	
Behavioral health centers within correctional facilities	Brick-and-mortar behavioral health centers on or adjacent to jails and prisons	>$1m	
Expand access to treatment in prisons	Increase number of care providers in jails/prisons	>$1m	
Case management for patients in the justice system	Assign case managers for patients with complex conditions like SUD	$500k-$1m	
Medicaid Inmate Exclusion Program	Transition inmates to Medicaid pre-release	<$500k	
Naloxone distribution in carceral settings, especially upon release	Discharge people from jail or prison with naloxone or other harm reduction supplies	<$500k	

Primary leading practice

Component leading practice



[244] Costs are estimated and fluctuate based on scale, local requirements, and available funding. Additional detail available for leading practices included in recommendations.
[245] Screening for SUD and naloxone distribution in carceral settings are mentioned in Recommendation 8.

System-level levers	
Governance	Data

Governance and data

Governance and data play pivotal roles in the strategy to mitigate opioid-related issues. Funders, regulators, local opioid abatement boards or task forces, and state and local elected and bureaucratic officials are all key stakeholders in this governance model. Access to system-level data is also vital for informed decision-making.

These practices aim to streamline governance and data while maintaining crucial elements of community input.

Leading practice	Description	Feasibility[246] Cost *(est. yearly)*	Feasibility Timeline
Regional research funding	Collaborate across county or state lines to develop regionally specific research tools	>$1m	
All-payer reimbursement model	Set equal reimbursement rates for Medicare, Medicaid, CHIP, and third-party insurers	*Varies*	
Value-based reimbursement for privately funded services	Reimburse care at value-based rates (instead of fee-for-service) from non-insurer funders	*Varies*	
Local stakeholder group coordination with state entities	Link state agencies with groups of businesses that provide, fund, or manage people with opioid use disorder	<$500k	
Leveraging local stakeholder groups as a network[247]	Structure local or regional stakeholder groups as an opportunity for all stakeholders to contribute observations and solutions	<$500k	
Leverage local stakeholder groups as a system driver and decision-making entity	Use local stakeholder groups as a more authoritative body that is charged with driving action on a systems level	<$500k	
Apolitical full-time employee to organize local or regional abatement	Hire a single person to coordinate abatement stakeholder groups and the relationship with state agencies	<$500k	

Primary leading practice

Component leading practice

[246] Costs are estimated and fluctuate based on scale, local requirements, and available funding. Additional detail available for leading practices included in recommendations.

[247] Reorganizing the coordinating bodies in Pinellas County is the subject of Recommendation 6.

Section 6

Recommendations

This Report presents 16 recommendations that could potentially address one or more gaps identified through this analysis. The recommendations include expansion of existing efforts that are proven effective as requested by stakeholders, identification of new opportunities to bring leading practices to the county per benchmark research (e.g., housing supports, peer specialists, syringe exchanges), and/or suggestions of emerging practices that may directly or indirectly address gaps (e.g., flexible funds, coordination tech platform). The recommendations are aligned to identified gaps and opportunities to address them.

Each recommendation is associated with one or more leading and/or emerging practices for consideration to execute the recommendation. The recommendation also considers feasibility (e.g., costs, implementation requirements) and potential impact (e.g., target population, measurability).

The County has choices for how to build a sustainable roadmap and promote meaningful and lasting change in combating the opioid epidemic. While the Pinellas regional fund is likely to receive more than $80 million over the next 18 years, only $13 million is available to distribute today.[248] The Opioid Abatement Funding Advisory Board's stated desire for transformative programs of $3 million or more (over one to three years) further narrows the list of fundable opportunities.[249]

These 16 recommendations were prioritized by key Pinellas County stakeholders and informed community input during a prioritization workshop. The workshop resulted in five priority recommendations and two key enablers (Recommendations 1–7; see Table 10), though all 16 recommendations are presented in this report.

Interviews

While developing the recommendations, EY interviewed three individuals from peer counties. These interviews informed the thinking about the leading practices and recommendations, specifically focusing on implementation needs.

Prioritization session

In August 2024, Pinellas County Human Services identified a select group of community members that represent a broad range of constituent groups to assess and prioritize the identified recommendations for Pinellas County's prioritization. Participants represented the voice of individuals with lived experience, those in active use and in recovery, family members, other residents of the county, behavioral health professionals, community leaders, and local officials.

The recommendations included information on short-term and long-term strategies, case studies from

Prioritization session participants

- William Atkinson, CRSS, CRRA
  Recovery Epicenter Foundation
- Joshua Barnett, PhD
  Pinellas County Human Services
- Steve Blank, MHS, ICCDPD, CRC, CEI, CMI
  Opioid Task Force
- Alan Davidson, MA, LMHC
  Central Florida Behavioral Health Network
- Marianne Dean, MS
  Opioid Task Force
- Celeste Fernandez, BS
  Florida Department of Children and Families
- Jim Fogarty
  Pinellas County Safety and Emergency Services
- Gayle Guidash
  DOH-Pinellas
- Heather Henderson, PhD, CAP, CRPS
  University of South Florida
- Krista McElhaney-Isaacs
  Pinellas County Human Services
- Laurie Serra
  NOPE of Pinellas County
- Amanda Sharp, PhD, MPH

[248] EY interviews. This is not inclusive of the expected ~$20m going to the city/county fund.
[249] Opioid Abatement Funding Advisory Board (2024)

other jurisdictions, and considerations for implementation. Where possible, the leading practices and recommendations identified estimated timelines and cost thresholds (e.g., under $500,000, $500,000–$1 million, $1 million+) to inform Pinellas County in their prioritization.

During the session, participants identified long-term treatment and recovery as a focus area in the CoC to prioritize, but they also stressed the need to "think outside the box" and discuss recommendations that span the CoC or even sit outside of it.

When participants were tasked to rank the recommendations that best meet the needs in Pinellas County, these did not align completely to the top prioritized areas of the Continuum of Care. For example, expanding harm reduction services was rated as a priority recommendation, even though "Acute Addiction" was a less-prioritized area of the CoC.

Most of the highest-ranked recommendations spanned the latter stages of OUD acuity, and especially recovery. However, the group also identified system-level recommendations, which, while not ranked highest, were perceived as necessary as key enablers for the highest-ranked recommendations. These enablers had to do with data and governance. While there may not be direct metrics for impacting the opioid epidemic for these enablers, specific progress metrics (e.g., establishing data governance framework, establishing independent coordinating body) can be tracked for progression over time for reporting to OAFAB and the Board of County Commissioners as appropriate.

Table 10: Recommendations with estimated three-year cost ranges

Recommendation	Description	Estimated three-year cost (range)[250]
1	Increase access to safe and high-quality housing for individuals in recovery	$3m–$6m
2	Enhance care coordination and individual-level data management	$2.5m–$8m
3	Expand the role of peer specialists	$3m–$6m
4	Expand harm reduction opportunities across the CoC, with a focus on training medical providers	$3m–$4m
5	Establish long-term funds to pay for OUD care	$3m–$5m
6	Re-organize the coordinating body to establish a single point of authority for abatement efforts	$600k–$3m
7	System-level data governance and data capabilities	$750k–$1.5m
8	Expand access to programming in justice settings	$10m–$15m
9	Launch a broad prevention campaign to raise awareness about the epidemic	$3m–$4m
10	Enhance OUD-related training for providers, beyond harm reduction	$1m–$2.5m
11	Expand syringe services programming	$2m–$4m
12	Establish a Marchman receiving facility	$3m–$5m
13	Construct a social center for the recovery community	$1.5m–$2.5m
14	Create new community support teams that focus specifically on substance use disorders	$3m–$5m
15	Create additional behavioral health services in the style of Certified Community Behavioral Clinics	$1.5m–$15m
16	Enhance Quick Response Teams	$3m–$5m

Level of prioritization
Priority
Key enabler

Cost designations based on midpoint of three-year range
<$1.5m (<$500k/year)
$1.5m–$3m ($500k–$1m/year)
>$3m (>$1m/year)

[250] Estimated costs shown assume all leading and emerging practices associated with the recommendation are funded. Ranges are shown because many practices could be funded to a greater or lesser extent. Further details are included in the "magnitude of investment" section associated with each recommendation.

Recommendation 1: Increase access to safe and high-quality housing for individuals in recovery

Gaps addressed	
L6	Individuals with OUD and in recovery experience barriers to stable housing.
E1	Space in high-quality housing designed to support those in recovery after they exit treatment is limited in Pinellas County.

Context

Our findings indicated that access to high-quality supportive and recovery housing in Pinellas County is difficult. Additionally, research identified barriers to independent living after transitioning from an acute care setting and during long-term recovery.

Housing struggles for individuals in recovery are not limited to homelessness. The majority of individuals with OUD in Pinellas County have access to housing. However, it is disproportionately likely to be unstable.[251] The housed and sheltered population can still benefit from other housing supports as they transition into recovery. There are also opportunities for assisting people with OUD in housing that is not recovery-specific, as market-rate housing is among the most expensive in the state. Community stakeholders and research indicates that landlords may discriminate against people in recovery, particularly if they have prior justice involvement.

Description

Pinellas County should invest to create a supply of several hundred safe and high-quality beds specifically for individuals in recovery. These beds should span the full spectrum of housing types and settings, though the focus should be on lower-support and medium-support recovery housing, as there is the greatest need in that area. Options for types of housing include:

Increasing recovery bed capacity

The top-priority recommendation from the prioritization session was to provide additional funding for medium-support recovery housing (e.g., FARR Level II or Level III) and increase the number of high-quality independent recovery beds (e.g., FARR Level I or Oxford Houses). Between those categories, there are currently 250–350 beds that are known to be high-quality (through FARR or otherwise), but there are hundreds more of uncertain quality.

This recommendation builds on efforts to hold recovery housing providers to high standards of care and lower the cost burden for people in recovery. FARR-accreditation is based on the standards laid out by the National Alliance for Recovery Residences, which are meant to develop and maintain a consistent, high-quality environment across the country. These standards are arranged into four domains, including administrative operations, physical environment, recovery support, and being a good neighbor.[252]

Increasing the supply of high-quality housing would require commensurate funding to enable access. There are several pathways to this, whether through incentivizing private recovery housing operators to operate at a minimum standard of care, creating new beds, or offering housing vouchers as a way to fill vacant beds.

Incentive programs for private recovery housing operators would be a novel way to increase recovery beds, and likely more cost-efficient than new leasing or construction. Other states and counties such as Ohio have incentivized certification through offering technical assistance through their NARR affiliates (i.e., FARR equivalents[253]), or by requiring that houses receive certification to receive public funds. However, investing public funds to bring private recovery residences up to standards would be innovative.

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[251] EY Constituent Survey: interviewees suggest many non-respondents with OUD also have stable housing
[252] National Alliance for Recovery Residences (2018)
[253] Ohio Recovery Housing (n.d.)

Vouchers could offer assistance because this housing is expensive. FARR Level II and Level III typically costs $225 per week.[254] These monthly rents of up to $1,000 are generally prohibitive for people with lived experience.[255] Expanding housing vouchers could help people in recovery have confidence that they could have stable housing for months or years, in turn enabling them to build independence, gain employment and integrate with the community.

Increasing residential peer respite availability

Residential peer respite facilities are places where individuals can stay for short periods of time while being connected to the appropriate next step in their care journey. As a next step, residents may be placed anywhere from acute care to recovery housing depending on their needs. These facilities do not require a medical referral, and often serve as a community center during the day for residents and individuals who are not staying overnight. They are referred to as peer respites because they are typically run by peers or others with lived experience. This type of housing is beneficial because it provides a stopgap between homelessness and care or longer-term housing, providing supports as individuals navigate the system of care and connect with providers.

Currently, there are 16 residential peer respite beds available in Pinellas County. While there is no nationally recognized benchmark for how many respite beds should be available in a county of Pinellas' size, local stakeholders indicate that the demand in the county suggests a need for expansion.

Increasing access to permanent supportive housing

Other leading practices may also enhance the recommendation to increase housing, but attendees focused on specific practices during the ranking session. Permanent supportive housing (PSH) was one such practice. PSH refers to several local programs that offer long-term housing with supports like case management and clinical assistance.

Across the country, programs under the PSH banner operate under varying levels of support. Some programs offer on-site clinical supports multiple times a week, whereas others only have optional case management.

These differing standards reflect different levels of investment that a housing agency can provide. Federal agencies such as the Department of Housing and Urban Development (HUD) fund most PSH programs, though offer few regulations or standards. One of the few consistent standards is a requirement to prioritize families where at least one member has a disability.[256] HUD offers a list of support services that can be funded through PSH funding, though they do not require any specific combination of services.

There are tradeoffs in cost and efficiency for operating a PSH program with lower or higher levels of services, as well as tradeoffs related to how Pinellas County might implement a PSH program. Because there are no clear guidelines on leading practices for implementation, Pinellas should clearly examine the tradeoffs before committing to guidelines and standards when opening a request for proposal (RFP).

There remains community demand for PSH programs. Pinellas County has a long waitlist for HUD-funded PSH, which is managed by the HLA. County agencies could work with housing providers to build more capacity and place some currently waitlisted individuals in PSH, but this option is likely to be more expensive and require coordination with several other agencies.

Other housing options for people in recovery

Another integral part of the care system not addressed in this recommendation is intensive residential treatment. These facilities combine residential support and high-touch clinical care. Based on the interviews and analysis, facilities have ample capacity in Pinellas County; the most significant barrier to access is cost

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[254] EY interviews

[255] EY Constituent Survey showed that people in active use and recovery (n = 54) have average reported income of ~$4700/month before tax.

[256] HUD-funded PSH participants must also meet additional criteria, which can change over time (e.g., chronic homelessness is a current requirement but has not always been a requirement)

(e.g., the median daily out-of-pocket expense in the county is ~$600).[257] People coming out of acute and inpatient care need support to access those services, but that support is largely short-term subsidization rather than increased supply. Since the main barrier for intensive residential treatment is cost instead of supply, strategies to increase access to those programs are addressed in Recommendation 6, which discusses a funding pool for services like intensive residential treatment.

Community members and research also indicated that County officials should investigate ways to support market-rate housing for people in recovery. This could (but would not necessarily need to) take the form of vouchers. A potential solution that does not involve subsidies could be convening a forum of landlords, such as defining a local standard for how they could work toward greater access for people in recovery or establish guidelines that enable access for people with prior justice involvement that meet certain conditions (e.g., number of years in recovery, no new charges). This would be an innovative practice, as there are no past studies of how a consortium like this might affect long-term housing or recovery rates.

Potential impact

Housing issues challenge individuals working to continue their recovery journey in multiple ways:

- Delayed access to an affordable bed in recovery housing with needed supports[258]
- Heightened risk of return to homelessness and consequently risk of relapse[259]
- Exacerbated financial pressures (and potential trade-offs) for treatment co-pays, childcare, daily expenses, and other out-of-pocket costs associated with treatment and recovery[260]
- Accelerated moves to market-rate housing before the individual is ready for full independence[261]

Providing housing for those in recovery through these methods could be a key strategy to improve treatment and recovery outcomes. Of note, opioid-related mortality across metropolitan areas typically falls 0.5% for every 1% decrease in the overall homelessness rate.[262]

The Pinellas HLA counted 300+ homeless individuals with SUD through its 2024 Point In Time report (over 15% of all counted homeless individuals, though this figure is likely an undercount as some people may be hesitant to disclose substance use status).[263] If Pinellas County stably housed 150 currently homeless individuals who are in active use, that would translate to a ~8% decline in the total homeless population. The causal research cited above suggests that this decrease in the homeless population would predict a potential ~4% decline in opioid-related mortality.[264]

Some of the specific housing types referenced have also been studied for potential impact:

Recovery housing

High-standard recovery housing increases the likelihood of long-term recovery. Studies conducted in the nationwide equivalent of Level II and III FARR recovery housing have reported significant improvements in substance use, with alcohol and drug abstinence increasing from 20% at entry to 40% at the six-month follow-up.[265] However, it is important to note that researchers have not tested the impacts of high-quality recovery

[257] Sourced from calling intensive residential treatment providers
[258] Recovery Research Institute (2024)
[259] Wyant et al. (2019)
[260] Pfefferle et al. (2019)
[261] Pfefferle et al. (2019)
[262] Bradford & Lozano-Rojas (2024)
[263] Gerhardt (2024)
[264] By systematically housing individuals with OUD (instead of housing homeless individuals without a substance use disorder), it is possible that the reduction in opioid mortality may be even larger than the cited estimates. However, there is no specific causal evidence showing that increased benefit.
[265] National Alliance for Recovery Residences (2012)

housing vs. low-quality recovery housing, or the impacts of receiving certification from an agency like FARR or NARR.

Residential peer respite

There are few studies of substance use-specific residential peer respite centers. Though the impact of residential peer respite is uncertain, stakeholder interviews point to benefits and successes from the existing one in Pinellas County. Residential peer respite shows promise because there is demand for walk-in short-term housing. Many other short-term housing options require a medical referral, while residential peer respite does not.[266] Medical respite facilities that require a referral are likely to impact a population that already has other connections to care through programs like Pinellas Matters. The walk-in nature of residential peer respite facilities offers crucial first steps to care for individuals who may not get it otherwise.

Permanent Supportive Housing

Though some organizations offer higher support in PSH than others, there are consistent positive results from PSH programs. One study found that homeless individuals with SUD were 30% less likely to experience hospitalization or visit the emergency room if placed in PSH.[267] Generally, PSH helps decrease homelessness, though at a lower level (i.e., every ~10 beds cause one fewer homeless individual in the long term).[268]

Implementation considerations

Standards

Certifying and building more recovery-specific beds could increase the quality of the housing supply and may involve coordination with an oversight agency like FARR. This coordination is necessary because causal studies have shown that providing housing alone does not have meaningful impacts on substance use behaviors.[269] Supportive services are necessary to realize the benefits of stable housing. Organizations like FARR require minimum standards for housing and provide a network that can help recovery homes access the necessary wraparound supports for their residents.

While there are 800 independent recovery beds in Pinellas County now, only about 250 of them are FARR-certified.[270] Stakeholders perceive that the FARR-certified houses are higher quality because of the oversight that FARR provides, which establishes standards of care like an appropriate bedroom-to-bathroom ratio and proper storage and protocols for injectable drugs like insulin (so as not to trigger a resident in recovery from injecting drugs).[271]

Higher-support facilities like respite centers typically have more stringent operating standards than a lower-support recovery home or Oxford House. For example, several standards for medical respite centers should be carried to substance use-specific residential peer respite centers. In 2021, the National Institute for Medical Respite Care published a set of eight standards for medical respite facilities to establish consistent quality. These include guidelines for linkages to and coordination of additional medical services and the quality of the accommodations, environment, and care.[272] These standards include 24-hour bed access for residents,

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[266] For example, medical respite offers a similar short-term housing solution but is typically managed at the provider level. There is one medical respite facility in Pinellas, which is run by a major provider. These facilities have shown positive impacts — for more information, please see National Health Care for the Homeless Council (2017), McCarthy and Waugh (2021), and National Institute of Medical Respite Care (2021). Though medical respite has shown promise, it is not prioritized as a housing solution here because residential peer respite facilities are likely to provide more targeted assistance for individuals with OUD. Medical respite facilities that require a referral are likely to impact a population that already has other connections to care through programs like Pinellas Matters. The walk-in nature of residential peer respite facilities offers crucial first steps to care for individuals who may not get it otherwise.

[267] Miller-Archie et al. (2019)

[268] Corinth (2017)

[269] Kirst et al. (2015)

[270] EY interviews

[271] There are no direct comparisons of long-term recovery outcomes from being placed in a NARR/FARR home vs. an uncertified one, but stakeholders and research support the results that come from enforcing individual standards.

[272] National Institute for Medical Respite Care (2021)

requirements for individualized care plans like connections to immunization, and annual quality improvement reports for the facility.

Magnitude of investment

Community stakeholders believe that adding 500 high-quality recovery beds within five years is a reasonable target. This is in part because of the low vacancies for recovery homes (as discussed earlier, Pinellas' vacancy rate in Oxford Houses is 5% as compared to a statewide average of 15%) but also because of the need to commit to high standards in homes that have not received certification from an organization like Oxford Houses or FARR. Most of the additional beds would come from bringing existing recovery housing to a common standard, as there are more than 500 beds that have not received certification from FARR as of August 2024.

The high price of housing means that this recommendation could be particularly expensive. An investment of $1 million a year could be expected to serve fewer than 100 individuals.[273] The $225/week price of lower-support recovery housing totals over $10,000/year just for housing one individual alone. PSH is typically more expensive on a per-unit basis than lower-support recovery homes, with typical costs of up to $20,000 per person per year covered.[274] This may be higher for individuals with higher clinical need like those with SUD.

A pilot of this recommendation would be approximately $1 million a year. While there are pathways to implement this recommendation without fully subsidizing long-term housing, there will likely also be significant costs to acquire, renovate, or certify facilities.

Operational suggestions

The providers of housing options discussed in this recommendation would not necessarily be under the oversight of the HLA or the existing coordinated entry system. While any investment in the coordinated entry system (such as emergency shelters, permanent supportive housing, or safe havens) would have to go through the HLA, investments in SUD-specific recovery housing would not.

The oversight required to maintain that quality may also carry some costs; of note, FARR recently received a grant to hire someone to ensure compliance for newly certified homes on Florida's Gulf Coast.[275]

This goal could be accomplished by dedicating financial and technical experts to support operators as they seek FARR accreditation. Importantly, local funders and oversight boards should work with housing providers in the FARR certification process so that the certification process is accessible and would not create barriers to continued operation of smaller recovery homes.

Most importantly, these recommendations may need to be implemented in a way that maintains long-term viability. A pilot of vouchers would not create the stability that the voucher recipients need if funding would expire in two or three years. There may be opportunities to designate shorter-term funding to build or upgrade recovery beds, but there could still be a continuing cost for oversight over newly certified housing facilities.

Case studies

Renovating recovery housing in Massachusetts

There is a long history of public funding for recovery housing, and on some occasions for specific types of recovery housing such as homes that employ peer specialists. One example of long-term support for recovery housing is the Massachusetts Center for Community Recovery Innovations, an organization which works to create and preserve affordable housing for individuals and families in recovery, has awarded more than $15.5 million in grants for substance-free housing to date. [276] These grants funded the creation or renovation of

[273] Housing costs in case studies ranged from $20,000 to $40,000 per person per year, which correlate to 25-50 individuals served. In Pinellas, there may be opportunities to partner with existing organizations to reduce costs.
[274] Jacob et al. (2023)
[275] Stakeholder conversations indicated the existence of this grant, but details are not publicly available as of the time of writing.
[276] MassHousing (2024)

almost 3,000 units of substance-free housing in 54 communities, although the effects on residents' long-term recovery have not been published.

Vouchers for recovery homes in Wisconsin

Several other jurisdictions have used abatement funds for recovery housing. For example, the state of Wisconsin used $2 million of opioid settlement dollars to fund the Recovery Voucher (RV) grant program, where recovery homes employing peer specialists received up to $125,000 each year.[277] At least 70% of the funds must be used for direct client assistance like subsidizing a bed, up to 10% can be used to cover administrative costs such as data management or accounting, and the remaining balance can be used for more direct client assistance or care coordination.

Acquiring recovery houses in Indiana

At the county level, Bartholomew County, Indiana disbursed over $500,000 across five community organizations to increase the supply of recovery homes.[278] For example, one grantee received $160,000 to fund startup costs for three recovery residences for men in the county.

"Tiny home" neighborhoods for PSH

Some states[279] are building neighborhoods of "tiny homes" that offer permanent residences and foster supportive communities. For example, in 2023 Travis County (Austin, TX) used $35 million from the American Rescue Plan Act to build 640 tiny homes in collaboration with a nonprofit partner,[280] and Hawaii currently has 10 operating neighborhoods called "Kauhale" with plans to build more in coming years.[281] Privately held examples of these neighborhoods include several instances of "Casitas" funded by Catholic Charities, such as in Oklahoma City,[282] as well as the Pinellas Hope Cottages in St. Petersburg.

[277] State of Wisconsin Division of Energy, Housing, and Community Resources (2024)
[278] Deprez (2024)
[279] GoLocalProv (2024)
[280] Tompkins (2024)
[281] Statewide Office on Homelessness and Housing Solutions (n.d.)
[282] Archdiocese of Oklahoma City (2024)

Recommendation 2: Enhance care coordination and individual-level data management

Gaps addressed	
S1	Providers and CBOs who would like to help someone with OUD take initial steps toward accessing care are not always able to hand people off to the provider/program that the individual needs.
S7	Waitlists are a barrier to indigent care; self-paying individuals are more likely to have timely access to care. Broadly, waitlist statuses across providers are opaque.
L5	People with lived experience report several barriers to behavioral health treatment, most notably wait times, high costs, and low quality.
E2	Individuals with OUD lack access to individualized case management support throughout their recovery journey.
G2	Data sharing across stakeholder groups is sparse and limited, which makes it difficult to develop a systems-level perspective and integrated, advanced analytics.

Context

The gap analysis identified a need for a platform that combines a single point of entry to the system of care with individualized tracking and centralized care coordination capabilities. In recent months, Pinellas County has made strides toward streamlining the points of entry into their system of care by launching Care About Me, which connects people seeking help with clinical and behavioral support services.

The gaps that this platform could help alleviate span the CoC. First, people who are seeking help for OUD-related treatment struggle to know where to get care. Only 26% of surveyed residents reported that they were confident in finding treatment services in Pinellas County should they need to.[283] Second, individuals in Pinellas County often have multiple case managers, as case managers are often tied to providers instead of individuals. This leads to some service duplication and an inability to track people throughout the system of care. Third, few individuals receiving care or providers in Pinellas have a strong sense of operating hours, availability, or exclusion criteria at local clinics. This platform could pair with service providers to improve knowledge of bed availability.

Description

This recommendation suggests piloting a primary system that identifies individual engagement needs across the system of care. It could help individuals and providers efficiently support individual recovery journeys; this is also expected to reduce the number of people who fail to get care. CAM could serve as a launching pad or a complement to a broader platform that coordinates care and/or tracks individuals in care. It could also help connect individuals to care by monitoring service availability and wait times, expanding on the existing resources for caregivers present in CAM. It is important to note that CAM does not currently track whether individuals continue treatment, which is a feature that could be added to the broader platform.

The platform modules should be complementary as overlap between systems of case management, service navigation, and data collection and analysis can all be built to serve the individual instead of the system. Another benefit to integrating these features into a single platform includes cost savings relative to building multiple (overlapping) platforms. Taken together, this integrated platform could help oversight agencies like the Managing Entity, PCHS, and DCF support individuals across the CoC and create agile care improvements.

Alternative practices to improve care coordination and data management

Community prioritization session discussions focused on mapping the components of this recommended platform, but there may be ways to implement parts of the platform individually. The components are detailed in the following Case Studies section, as the prioritized platform combines several initiatives from around the country that are reporting positive initial results.

[283] EY Constituent Survey

Potential impact

While this recommendation would reimagine the system of care in Pinellas County, there are no benchmarks to quantitatively predict the magnitude of change.

Qualitatively, hospitals and case managers would see the benefits of this platform. For example, hospitals and other clinical providers would receive support to integrate this platform with their existing Electronic Health Record vendor platform. Improved care coordination would likely free up capacity in emergency departments and hospitals, since patients with behavioral or substance use disorders often seek care in hospitals when there are other options available. This new capacity could help other patients receive care quicker. Finally, if the system of case management is moved onto a centralized platform, case managers will have a reduced burden of communicating with each other to coordinate care for a single patient, and individuals in the system of care could also develop stronger patient relationships with their case managers.

Additionally, successful implementation could increase the number of people in the county who feel confident about where to find resources, and especially increase that awareness among families and caregivers of those in active use. People engaged in the system of care may also experience more friction before leaving care, and the amount of people leaving care against medical advice could be likely to decline. Taken together, these factors could increase treatment retention and lower long-term costs of treatment. At a system level, this platform could serve as a model for care management beyond Pinellas County and SUD.

Successful implementation of this recommendation is likely to improve treatment initiation rates, completion rates, and smooth transitions between service sites. Treatment retention rates are also likely to improve through individuals' consistent relationship with case managers, and improved monitoring of people receiving care.

Implementation considerations

Magnitude of investment

Based on similar commercial benchmarks, this platform would be expected to cost over $1 million for licensing and setup and could go higher depending on the complexity (though, likely not over $5 million). Annual ongoing costs are estimated to be between $500,000 and $1 million, pending any additional services or other analytics add-ons and the selected vendor(s) for delivery.

Operational suggestions

This platform would likely require careful consideration for implementations, since it does not exist today. Stakeholders felt that it was worth pursuing given how well it could achieve the broader aims to reduce loss of connection in transition, enable better connectivity, create trust, build relationships, and have better outcomes. However, funding this recommendation would require overcoming several barriers.

- **Technical requirements —** Defining the specifications of the platform and establishing data-sharing requirements and infrastructure are key to implementation. The platform is likely to cost several million dollars to develop and require a technical team to support long-term maintenance; properly scoping the platform could prevent delays and further costs. This platform should adhere to HL7/FHIR standards for ease of operating between multiple providers that may have different electronic health record systems.
- **Data sharing and privacy —** Providers may be hesitant to share data with outside stakeholders except when required. Similarly, Pinellas County residents in care may be hesitant to release private health information, even if it is only used in aggregate. There are several jurisdictions from around the country that have created robust data frameworks (some in the form of Health Information Exchanges) and streamlined the consent process to receive individual health data; these examples may also offer inspiration to Pinellas County.

- **Participation from providers** - Partnership with and participation from providers may also be complicated. One potential approach of a close partnership is explored in Recommendation 6 (creating a single coordinating body) of this Report.

Research and interviews have indicated that the simplest component to independently implement would involve reimagining the case management system. While still transformative, it may be less difficult than building out the entire platform. Community members suggested some current provider-based systems may have the potential to be reworked with similar features such as the single access point, with more moderate changes to employment and a small increase in case managers. There are several third-party case management solutions available for purchase; Pinellas should consider which (if any) are most appropriate for their existing system of care. If the case management system was centralized, the system would need oversight and leadership. This leadership capability would likely be placed under the purview of a single entity in Pinellas County, as decided by the OAFAB.

Case studies

This platform and its components (navigation, caregiver resources, and provider feedback) and features (centralized entry point to care, care coordination, and case management) are innovative. Several jurisdictions, including counties, have created platforms that cover some of these areas, though typically only for Medicaid enrollees.

Service navigation in Connecticut

An example of a technology platform for service navigation over a small geographic area comes from Connecticut. The Connecticut Department of Mental Health and Addiction Services provides a near real-time bed tracker[284] online that allows viewers to see an inventory of inpatient programs with open beds, complete with the program's location, phone number, and date the posting was last updated.

The technology for this tracker could be incorporated into Pinellas County's platform, and there could be a non-public-facing version for providers and/or case managers. End-users would be able to filter for program type (inpatient, intensive, group home, etc.), as well as location and other key characteristics, to ensure their patients' or loved ones' needs are satisfied.

The platform could include a breadth of resources to equip families and caregivers to best serve the needs of individuals with OUD. Examples of helpful features include a searchable map of nearby care facilities, or a user-friendly database providing filterable details on resources and prevention tools to help families and caregivers navigate available support across the CoC.

Provider feedback, care coordination, and case management in California counties

Providers can interface with these platforms in more ways than accessing service availability. In California, the state gave counties grants for data management. Alameda County, which includes Oakland, created a platform which combines data feeds from across 30+ community-based organizations into a community health record to coordinate care, creating a whole-person perspective for each client.[285] The community health record sends real-time alerts to an individual's care manager when the individual is admitted to inpatient programs, when they have entered or are exiting the hospital, and when they have entered or are exiting jail. Given the heightened risk of opioid overdose during transitional periods, these alerts enable providers to monitor patients in times of potential crisis. From 2017–2021, 247,887 individuals were enrolled in the program, 71% of whom eventually disenrolled for reasons such as "Lack of Engagement," "Services No Longer Needed," and "Not Eligible for Medi-Cal." Over half of individuals who disenrolled did not re-enroll, although they were able to do so if they met enrollment criteria at a later date. The average length of enrollment was 14.2 months, with program providers focusing on strategies such as creating multiple points of contact, developing rapport with

[284] Connecticut Department of Mental Health and Addiction Services (n.d.)
[285] Healthcare Innovation (2021)

enrollees, and consistent care coordinator assignment to ensure sustained engagement from the enrollee. Of the enrolled individuals, 91% received care coordination services.[286]

A similar California platform exists in San Joaquin County (Stockton),[287] which used their data grants to partner with a third party to develop a "social health information network." That network expands beyond clinical care to include housing, utility needs, food insecurity, and transportation.

Centralized entry points in Maryland and Washington

Because this platform can build off CAM in Pinellas County, a natural extension could be to make CAM a centralized entry point to the system of care. The Maryland Access Point[288] offers "no wrong door" service to individuals seeking support services such that all physical Access Point sites and the Access Point website connect to state-funded providers. CAM could serve the same purpose for SUD services.

A crucial enabler of this platform is consent from individuals to share data. While there is not a culture of consent in Florida, other jurisdictions have found creative ways to enhance receiving individual consent. Washington State just launched a program called ConsentLink as part of their Medicaid infrastructure, which houses patient consents from across the system of care in one location.[289] The platform is compliant with regulations such as 42 CFR.

Washington was able to pilot the consent navigation system on a small scale — just for substance use, just for Medicaid patients, and just for consent forms. However, they viewed the consent records as a key gating criterion prior to opening the platform up to other crucial tools like data exchange and patient navigation, as Pinellas County might also consider.

[286] Pourat et al. (2022)
[287] Kamyck (2024)
[288] Maryland Department of Aging (n.d.)
[289] Washington State Health Care Authority (n.d.)

Recommendation 3: Expand the role of peer specialists

Gaps addressed	
S4	Peer supports are underpenetrated across outreach, engagement, community support, and long-term recovery support.
E7	Individuals with OUD have trouble finding employment, and those that are employed may not receive employer support as part of their treatment and/or recovery.

Context

Peer specialists help drive positive treatment outcomes but are underpenetrated in Pinellas County; the research identified several barriers to employment and adoption. Peer specialists are currently employed in hospitals, treatment centers, recovery centers, and outreach organizations, but this Report identified opportunities to broaden the settings, attract more peers, and support sustainable employment. Funding could broaden adoption and even reimagine the peer specialist role including how integrated peers are with different teams.

Description

This recommendation suggests funding 10–20 additional peer specialist positions throughout the county. Such an investment is estimated at $1 million to $2 million per year but could likely result in positive recovery outcomes for both the peers and the individuals they engage.

While peers are currently working in treatment facilities, hospitals, and respite/outreach roles, they can be integrated at almost any point within the CoC.[290] There are opportunities for peers to serve in highly structured areas like hospitals through programs like Pinellas Matters; there should be more opportunities to work as a peer in other settings. For example, peers could be more integrated in areas where they are currently either absent or underpenetrated, such as Quick Response Teams, justice settings, and harm reduction efforts. Some jurisdictions also have peers play a more public-facing role via community outreach. For examples, see the Case Studies section.

Funding can be used to increase the number of peer specialists. There are currently 30–50 individuals working as peer specialists in the county, but community members believe nearly as many people would be interested in becoming a peer and ready for employment if there were fewer barriers and more sustainable employment opportunities.[291] Research indicates that peers need better access to certification processes, which could be alleviated by using funding to reduce or remove the $500 fee for the state-sponsored, mandated course as the costs are perceived to be prohibitive. Local peer specialists and peer employers also report that it takes individuals with prior justice involvement months to receive background check approvals, since there are additional steps to pass a background check. Commentary from lawmakers and state employees suggested that delay is not necessary, further supporting the ability to remove barriers to peer specialist certification.[292]

Potential impact

Successful implementation and placement of peer specialists within the CoC is expected to improve communication and engagement with individuals in crisis settings, treatment initiation and retention rates among people who are seeking help, and improve economic outcomes for peers through long-term, sustained employment and professional development.[293] The empathy and trust that peer specialists bring in all these settings cannot be replicated by clinicians, behavioral health professionals or volunteers. Patients who receive

[290] EY interviews: one interviewee noted they believe that ~40% of currently employed peers are currently working in treatment centers, ~40% in respite/outreach positions, and ~20% in hospitals. However, the current number of individuals interested or applying to be a peer is not tracked.
[291] EY interviews
[292] EY interviews
[293] Evans et al. (2016)

peer support are more engaged in OUD recovery services than patients without peer support.[294] Peer support has also been shown to reduce substance use, reduce relapse rates, and increase treatment retention.[295]

It should be noted the effect of peer specialists on treatment outcomes can be inconsistent, and success often reflects how well local leaders place peers in the right roles.[296] Local stakeholder input is crucial to make peer specialist operations as efficient and successful as possible.

The only literature review of randomized controlled trials of peer specialists suggests that peers have a small effect on MOUD initiation, but no effect on MOUD retention.[297] This study notes limitations that could be instructive to local efforts. Specifically, there is very little standardization in peer support certification programs, and peers who undergo standardized training and oversight may create more positive outcomes for the individuals they are supporting.

Few studies have analyzed effects of peer employment on the peers themselves, but initial results are highly positive. Peers typically report a sense of belonging through their employment, and peer specialist roles often have positive impacts on the employed peer. Furthermore, 72% of peer-certified individuals working as peer specialists were employed for at least one year, compared to only 57% of certified individuals employed in non-peer services.[298]

While there are barriers to certification mentioned above, there is little research from other states on how to reduce them, perhaps because other states do not have as stringent requirements for becoming a peer.[299] Further research is necessary to explore why these Florida-specific delays for background checks have persisted.

Implementation considerations

Standards

SAMHSA has published standards for peer specialists to which positions in Pinellas should adhere. These standards denote the five "core competencies" of peer employment as (1) recovery-oriented, (2) person-centered, (3) voluntary, (4) relationship-focused, and (5) trauma-informed.[300]

Magnitude of investment

One important consideration is that a limited number of people in Pinellas County are eligible to become a peer. Individuals who achieve the necessary recovery may not be interested in serving as a peer; this interest limitation applies to eligible family members also.

These structural limitations create a near-term ceiling of how many peer specialists could be hired. A pilot of 10–20 new positions could fit these local labor supply constraints at a reasonable level. One peer county which shared data for this analysis noted that their effort to hire 15 peers led to 11 immediate hires.[301] The funding for those 15 positions totaled roughly $1.4 million for calendar year 2024, or just under $100,000 per employee. Pinellas could start by piloting roles for 10–20 peers and expand the program if it shows initial positive results.

The impact of these 11 hired peers has been large. This peer county planned to have their newly hired peer specialists complete ~1,500 client interactions in calendar year 2024. Initial results are positive, with over 400

[294] Zuccarini & Stiller (2024)
[295] Eddie et al. (2019)
[296] Gormley et al. (2021)
[297] Gormley et al. (2021)
[298] Ostrow et al. (2022); EY interviews
[299] Peer Recovery Center of Excellence (2023)
[300] Substance Abuse and Mental Health Services Administration (n.d.)
[301] Peer County January-June 2024 retrospective

clients served in the first six months who received 1,000 referrals to services in total. Notably, peers were engaged in nearly 50 referrals to MAT treatment and over 150 referrals to detox.[302]

Operational suggestions

Organizations applying for funding to employ peers should be encouraged to be creative in creating roles for peers. Many peer-employing organizations view the job of a peer specialist solely as helping someone with OUD who is in crisis or conducting outreach, but Pinellas community members believe that the peer role is better suited to focus on long-term engagement and continuity of care. Special consideration could be given to employers who are able to support peer specialists who have long-term clinical relationships with clients. Additional prioritization could be given to employers who employ individuals with lived experience in non-peer roles.

Finally, funding could also consider on-the-job experience of peer specialists. Interviews and research suggest that peers in Pinellas County report challenges with stigma, judgement, and access to comparable workplace tools and supports. If employers receive funding, one requirement could be consistent support for peer specialists like other employees. Peer roles should have the opportunity to become a career-track position with progression, professional development, or other benefits (e.g., tuition/loan forgiveness) for individuals that explore additional credentialing beyond the peer certification.

Case studies

Quick Response Teams

One place where peer support could add value is by integrating peers more fully into QRTs. The inclusion of peer specialists on QRTs is not new; for example, the West Virginia Department of Health and Human Resources places a peer specialist on each of its QRTs,[303] and it can be seen in cities such as Milwaukee and Cincinnati. While there is limited specific or causal data regarding the impact of peer specialists on QRTs, there is evidence supporting the overall benefits of peer support in recovery.

Community outreach in Buffalo

In Erie County, NY (Buffalo),[304] the local Department of Health has peers conducting public outreach five days per week, from walking tours to tabling events to community collaboration. In the first six months of 2024, Erie County hosted 93 tabling events, distributed over 23,000 naloxone kits, and gave training sessions to over 2,000 community members.[305] Similarly, the North Carolina Department of Health and Human Services established a peer support helpline in February 2024 which received over 4,000 calls in a one-month period.[306] The "Peer Warmline" collaborates with the 988 Suicide and Crisis Lifeline to provide callers with the option of receiving support from a peer.[307]

Jails and prisons in Florida, Tennessee, New York, and Oregon

The Eleventh Circuit court in Miami, Florida, established the Criminal Mental Health Program to divert individuals with severe mental illnesses from incarceration to community-based treatment.[308] As part of the program, peer specialists assist participants with community reentry and treatment engagement in addition to serving on the crisis intervention team to train law enforcement officers.[309] In an approximately six-year

[302] Peer County January-June 2024 retrospective
[303] Centers for Disease Control and Prevention (2022)
[304] Erie County Department of Health (n.d.)
[305] Erie County Overdose Prevention Task Force (2024)
[306] Knopf (2024)
[307] North Carolina Department of Health and Human Services (2024)
[308] Eleventh Judicial Circuit of Florida (n.d.). For more details, see the Eleventh Judicial Circuit of Florida peer specialist job posting (2024).
[309] National Judicial Task Force to Examine State Courts' Response to Mental Illness (2022)

period, one peer specialist trained over 2,500 police officers and worked with over 1,000 program participants;[310] as of 2022 there were eight peer specialists on staff.[311]

Additionally, there are several out-of-state examples of peer involvement in jails and prisons. Research has shown positive outcomes associated with these programs, including a reduction in risky behaviors.[312] Examples include the West Tennessee State Penitentiary, which runs a year-long educational program for individuals to learn basic skills such as reading and writing and pairs each participant with an incarcerated peer who has become certified as a peer recovery specialist. In Albany County (NY), Catholic Charities' Project Safe Point offers 20 hours of in-jail addiction support (including MAT and harm reduction) each week from two certified peers, which improves inmate morale and reduces anxiety. Lastly, Multnomah County (OR) pairs recently released individuals with peers who can provide connections to resources for recovery, housing, and other basic needs.[313]

Emergency departments

Peers in crisis units and emergency departments can encourage individuals in them to seek care and provide linkages to appropriate services. In a study of over 12,000 patients, researchers found that implementation of peer support programs in EDs was connected to a decrease in medically treated overdoses and increased the probability of MOUD initiation by 45% compared to pre-program levels.[314] This practice is already in place in Pinellas County (e.g., through the Pinellas Matters program) but could be expanded.

Abatement funds and grants for peer specialist programs

Several counties have dedicated opioid settlement funds towards peer specialists. The University of Central Arkansas was awarded over $202,000 in opioid settlement funds from the Arkansas Opioid Recovery Partnership to establish and operate a peer support and recovery specialist program in and around Conway and Faulkner County, Arkansas. The peer recovery specialist program, which is run by two peer support and recovery specialists and graduate-level interns in partnership with the Conway Police Department's Community Crisis Response Team, involves delivering educational activities, prevention, treatment, and recovery to patients in Conway and Faulkner County.[315]

Other areas have taken a less determinative approach to funding peer supports. Indiana requested proposals for provider organizations to have grant-funded peer positions and received 80 responses. The state eventually funded 63 peer positions at 20 employers for two years each, committing over $5 million towards the initiative.[316]

[310] Department of Justice (n.d.)
[311] National Judicial Task Force to Examine State Courts' Response to Mental Illness (2022)
[312] Bagnall et al. (2011)
[313] McCrary et al. (2022)
[314] McGuire et al. (2024)
[315] UCA News
[316] Indiana Family & Social Services Administration (2024)

Recommendation 4: Expand harm reduction opportunities across the Continuum of Care, with a focus on training medical providers

Gaps addressed	
A1	Populations frequently interacting with opioids (e.g., EMS, first responders, those with lived experience) often have access to naloxone (i.e., Narcan), but broader adoption remains limited.
A3	Fentanyl test strips are not yet widely distributed in Pinellas County.

Context

Pinellas County has made strides in harm reduction over the past several years, with Comprehensive Opioid, Stimulant, and Substance Use Program (COSSUP) grants and the OTF helping Pinellas become a leader in naloxone distribution. However, harm reduction efforts are largely limited to naloxone. Other harm reduction policies and initiatives could reduce fatal overdoses. Stakeholders and research suggest training medical providers is a strong first step, and that other harm reduction expansion practices should follow.

Description

There is strong demand for training medical providers on how to integrate harm reduction into practice at their clinics. Stakeholders and peer specialists communicated that clinicians are typically comfortable telling individuals to stop using illicit substances but have less training on how to help individuals reduce dangerous behaviors in their substance use. Accordingly, the county should aim to train 1,000 providers who consistently interface with people in active use on harm reduction techniques within three years.[317] If successful, this training could be expanded in a future funding cycle.

People with lived experience (either current opioid use, past opioid use, or caregiver status) report the current lack of training as stigmatizing. 33% of those individuals thought that employees at behavioral health clinics "don't care about their patients" and 31% thought the same about employees in recovery facilities like rehabilitation centers.[318] But fewer than 15% of respondents with lived experience of opioid use thought that individuals involved in harm reduction efforts (e.g., syringe services or naloxone distribution) did not care about them.[319]

Several other fundable harm reduction initiatives were less prioritized, including:

Education

Efforts could be made to raise awareness of harm reduction tools such as Good Samaritan laws and naloxone to personnel who may interact with OUD, such as law enforcement officers, medical practitioners, individuals who use substances, and the general public. Constituents are often unaware of harm reduction resources, with 48% having never heard of syringe exchanges and 25% having never heard of opportunities for free naloxone.[320] These respondents use these services at an even lower rate. Education efforts should focus on increasing awareness, perhaps targeting small communities during or after a cluster of overdoses.

Naloxone and/or fentanyl test strip distribution

Distribution for harm reduction tools such as fentanyl test strips and naloxone could expand broader community adoption of the tools. These efforts should focus on high-trafficked areas in the general public, via vending machines, public storage receptacles (e.g., NaloxBoxes), or other methods. Since fentanyl test strip distribution has only been legalized recently in Florida, there are few metrics of community awareness. However, it is a reasonable assumption that community awareness and usage of test strips would be lower than naloxone.

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[317] Rationale for goal of 1,000 providers explained in *Potential Impact* section below
[318] EY Constituent Survey (n=45 for behavioral health clinics; n=48 for rehab)
[319] EY Constituent Survey (n=35 for syringe services; n=47 for Narcan distribution)
[320] EY Constituent Survey (n=600 for syringe services; n=611 for naloxone)

Potential impact

The impact of some harm reduction efforts can be directly measured in saved lives. For example, approximately one-fifth of the members of the general public who were trained to use naloxone in one study from 1996 to 2010 ultimately administered it during an overdose.[321] However, some of these efforts promote indirect benefits such as reducing stigma and positively influencing substance use behaviors instead of directly saving lives.

Medical provider training

Training can reduce provider attitudes of stigma towards harm reduction.[322] While not a perfect proxy for harm reduction, providers with a greater knowledge of MOUD displayed more positive attitudes toward patients with OUD.[323]

A higher level of stigma in primary care physicians is also associated with an 11% decrease in OUD medication prescription,[324] and a 2023 survey of patients receiving MOUD reported that 57% of respondents heard "negative comments" about MOUD from their healthcare provider.[325] In addition to negatively impacting the ability to receive treatment, stigma can indirectly undermine recovery due to negative emotions such as low self-efficacy and self-confidence.[326]

Providers are frequently cited as a chief source of stigma that people in active use or recovery face. One national survey showed that perceived judgement by clinicians was the largest barrier to receiving general healthcare for individuals using an SSP. That barrier was cited twice as frequently as any other complaint in the survey.[327]

Providers with less stigma toward harm reduction initiatives should be expected to help their patients receive more harm reduction services, reducing the incidence of infectious disease and overdose. But these patients could also receive more general healthcare services if they felt more comfortable in a clinical setting.

The timeline of this training should involve a year for training creation and pilots, and two to three years for implementation. If Pinellas employs emergency medicine physicians and advanced-practice providers at a similar rate to national benchmarks, there are likely 250–350 of them employed in the county at any given time.[328] There are likely four to six times as many individuals that frequently interact with people with OUD, such as nurses, treatment facility employees, and crisis workers, creating a training target population of several thousand individuals.

Education about Good Samaritan laws

As of 2021, only 10%–30% of overdose witnesses call emergency services.[329] Bystanders are three times more likely to call 911 during an overdose when they are aware of Good Samaritan laws,[330] but many people do not know of or understand the laws in their area.[331] Increased awareness could lead to quicker emergency response times to overdose and a higher likelihood of survival.

Education about other harm reduction opportunities

Overdose education and naloxone distribution (OEND) programs aimed at the general public could also help facilitate treatment during an overdose. Currently, over 75% of individuals in a nationwide survey believe they

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[321] Bennett & Elliott (2021)
[322] Sulzer et al. (2021)
[323] Piscalko et al. (2024)
[324] Stone et al. (2021)
[325] Carl et al. (2023)
[326] Crapanzano et al. (2018)
[327] Miller-Lloyd et al. (2020)
[328] Gettel et al. (2022)
[329] Smart & Davis (2021)
[330] Jakubowski et al. (2018)
[331] Moallef & Hayashi (2021)

could not help an individual experiencing an overdose.[332] Expansion of OEND programs has been shown to produce long-term knowledge improvement about overdoses in addition to sufficiently training participants to manage overdoses, lowering opioid-related mortality.[333] The research cited above found a 20% naloxone usage rate after training, which suggests that training an incremental 1,000 individuals in naloxone use could result in the reversal of 200 overdoses. [334]

Fentanyl test strips also positively influence substance use behaviors, though the effects are less clear. In one statewide study, 43% of substance users changed their substance use patterns while using test strips.[335]

Take-home naloxone programs have been effective in preventing fatal opioid overdoses,[336] and community distribution is a successful strategy due to the capability and willingness of bystanders to administer the treatment.[337] That said, there is little existing guidance on how to evaluate these programs and measurement of naloxone use is challenging, necessitating more research to identify the most effective locations for distribution points.[338]

Implementation considerations

Unlike most other recommendations, this recommendation overlaps with other active initiatives. Specifically, naloxone distribution efforts and other harm reduction trainings are currently under the purview of the Department of Health and the OTF. Local stakeholders believe that current naloxone distribution efforts are strong and well-supported. There is a perception that the recent push toward partnering with businesses (especially in the hospitality industry) for naloxone distribution is appropriate and should continue to be supported. That said, there is still a need for harm reduction tools such as increased public awareness and vending machines.

Due to the perceived strength of naloxone distribution, stakeholders present at the ranking session suggested not using abatement dollars for distribution efforts. As such, the implementation considerations for naloxone distribution listed here may be less applicable to the county's goals.

Standards

There are few nationally recognized standards for fundable harm reduction opportunities. The CDC has published six standards for syringe service program operation, but those are referenced in Recommendation 11, which discusses syringe services at length. The CDC has also a published a guide on efficacy evaluation that could help in the development and refinement of naloxone distribution programs.[339] More generally, the Harm Reduction Coalition has published a guide with leading practices for the development of OEND programs, including suggestions for effective naloxone training.[340]

While there are no formal standards for operating training programs, stakeholders believe that new programs should not adhere to the standards that provider training currently follows. There is a perception that provider training in Pinellas is rarely effective, especially that which counts for continuing medical education. Some trainings, such as the FR-CARA-funded naloxone trainings, are perceived as better, and particularly strong at explaining nuances of laws like Good Samaritan.[341] Training efficacy could be further enhanced through strategies to increase trainee engagement during the sessions.

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[332] Ohio State Health & Discovery (2024)
[333] Razaghizad et al. (2021)
[334] Bennett & Elliott (2021)
[335] Peiper et al. (2019)
[336] Chimbar & Moleta (2018)
[337] Cherrier et al. (2021)
[338] Sugarman et al. (2023)
[339] Centers for Disease Control and Prevention (n.d.)
[340] Wheeler et al. (2012)
[341] EY interviews

Magnitude of investment

The training recommendation is less expensive to implement. However, stakeholders believe that changing interactions with providers, particularly medical doctors, may highlight additional needs for advocacy and partnership. Developing and delivering bespoke trainings may require additional research and/or engagement, and the design of any training materials may take time to complete (particularly if it is intended to be certified for Continuing Medical Education credit).

These trainings can be disseminated widely or narrowly, and the investment will grow or shrink proportionally. One strong parallel is the current FR-CARA naloxone training grant. The current training staff has reached over 1,000 people in three years and expects to reach over 2,000 by the end of the four-year grant, which carried a monetary value of $73,900.

Provider training could be piloted at a similar scope, though likely over a shorter period of time. The training would likely take $100,000–$250,000 to develop over the course of several months and could be rolled out over a 12- or 18-month period for a similar rate to the FR-CARA grant ($25,000–$50,000 per year).

Generally, funding fentanyl test strip or naloxone distribution should be economical, with costs under $500,000 a year. These programs require few or no FTEs and can build off successful programs already in existence. Actual program costs would correlate with the size of the initiative.

Harm reduction vending machines are inexpensive, with one recent grant offering $50,000 to purchase, stock, and maintain a single vending machine.[342]

In total, this recommendation would cost roughly $1 million a year. There would be fewer startup costs, but the benefits may not begin to accrue until the second or third year of funding as training is rolled out.

Operational considerations

This recommendation involves funding and operationalizing harm reduction training and workshops for people across the recovery community. While the initial target group is clinical providers, stakeholders believe expanded training opportunities could be useful for people in the peer specialist community as well. Some peers achieved long-term recovery without the use of harm reduction tools, and so may be hesitant to refer people in active use to places like the IDEA Exchange Pinellas in St. Petersburg. Trainings could give a broader harm reduction background to this group.

Some harm reduction recommendations would be lighter-touch and more appropriate to contract out. For example, vending machines and secured naloxone boxes would not require much work beyond intermittent restocking efforts.

Pinellas County stakeholders felt strongly that existing naloxone distribution efforts should not be transferred under the opioid abatement funding umbrella. However, the focus of the existing efforts has expanded beyond the highest-priority populations over time (e.g., beyond first responders and clinicians), which is a positive step. Future expansions of the county's naloxone distribution program may include some of the innovative practices cited in the case studies below.

Case studies

Based on publicly available data, no jurisdiction has funded training medical providers about harm reduction; however, it is a permissible use of settlement funds.

Some jurisdictions have invested in raising awareness in Good Samaritan laws for people in active use and recovery, but detailed results have not been tracked.[343]

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[342] HealthNet (n.d.)
[343] Moallef & Hayashi (2021); New York Police Department (2017)

Innovative practices for naloxone distribution at the county level

Several counties across the country have funded harm reduction programs, including naloxone distribution through vending machines and syringe services programs. These funded programs are typically under $1 million a year, though the exact amount varies by the size of the county. For example, Hamilton County, OH, has placed a harm reduction vending machine in the same location as their SSP. Since installation, the machine has dispensed 3,360 naloxone doses and 10,155 fentanyl test strips, which is more than any other SSP in the United States. The machine is also associated with a lower rate of fatal overdoses in Hamilton County, reversing at least 78 overdoses in the first year of operation.[344]

There are also emerging practices in harm reduction observed in the private sector or other counties; it is not clear whether these programs are being funded using abatement funding. Pomona Valley Hospital Medical Center engages in combined distribution of harm reduction tools, offering free test kits containing both fentanyl test strips and naloxone in their emergency department.[345] Other counties have explored naloxone distribution in business settings. An IMPACT team in Monroe County, NY installed over 400 naloxone boxes in public areas, with a focus on business settings, and has equipped all parks with naloxone boxes, making harm reduction tools accessible to the general public beyond business settings. [346]

[344] Arendt (2023)
[345] Pomona Valley Hospital Medical Center (2024)
[346] WHAM (2023)

Recommendation 5: Establish long-term funds to pay for OUD care

Gaps addressed	
S6	Affordability is a barrier to accessing care, especially for the uninsured and underinsured.
C3	People with low incomes are less able to access detox and inpatient services in Pinellas County because subsidized options are limited.
C4	There is need in Pinellas County for additional low-cost/subsidized residential treatment capacity.
L1	Individuals using MAT are burdened by high costs of care.
E4	Access to childcare is a barrier to participation in treatment.
E5	Pinellas County lacks grief supports for people impacted by overdoses.
E6	Transportation in Pinellas County presents a significant barrier to individuals without a car consistently accessing services.

Context

Pinellas County is in a unique position where the primary barrier to OUD-related care is the expense of care. Individuals who know where to go for services and who can pay out of pocket (or with high-quality insurance) are able to access services across the CoC. In contrast, people in active use and recovery who are uninsured or underinsured are only able to receive subsidized care from some providers, at some times. Waitlists for some subsidized care stretched up to three weeks in 2023, though there have been some improvements in 2024.[347] Some individuals may choose not to go on a waitlist if care is unavailable. Stakeholders believe that a broad-based fund for subsidizing OUD care will reduce waitlists, reduce the frequency of people declining to join a waitlist, and increase connections to care.

Additionally, some insured people in Pinellas County face large bills for unsubsidized OUD services. This fund could help reduce their financial burden.

Description

Stakeholders believe a solution that overcomes the affordability issue is to create a broad, flexible fund that makes financial resources available to individuals while they navigate their recovery journey. There are instructive lessons to learn from other programs that serve clinical care, housing, transportation, and other supports with funding mechanisms including vouchers.

The funding should be flexible, for the individual to use as needed. Flexible uses for funds may include treatment, transportation, housing, childcare, or other associated expenses. This recommendation would require oversight and reporting on the use of the funding by individuals and in aggregate. Given the broad scope proposed for funding use, it will be important to assess how this oversight capability might fit within the existing capabilities of a funder in Pinellas County such as Human Services (see priority Recommendation 6 below). The OAFAB and fund holder will need to define governance requirements and eligibility criteria, educate individuals around how to use funds, and set provider engagement expectations.

This recommendation is scalable and complementary to other funding sources with the aim of improving recovery rates for residents of Pinellas County. As the fund could finance services and supports based on an annual spending, the OAFAB and BCC could consider the total addressable market for serving as many people as funding and program capacity permits. Based on benchmark analysis, funding could start at $20,000–

[347] Pinellas County Funder; 2023 median wait time for MAT was 19.21 days

$30,000 per individual per year, with analysis in subsequent years to identify the return on investment and key providers or performers that differentiate individual outcomes.[348]

Importantly, this available funding should *supplement* current funding and coverages, not supplant them. If implemented well, the ease of use of these funds could conflict with the responsibility of current payors. This will require significant oversight to confirm that the system actually benefits from this large investment, instead of just shifting the cost burdens of existing care to the abatement fund.

Potential impact

If implemented, this recommendation could lower the financial barriers to treatment and recovery options, as well as to related external factors such as housing, transportation, and childcare. The Medicaid expansion provides a potential example of the positive outcomes associated with increasing OUD treatment accessibility. For example, opioid-related in-patient hospitalizations decreased by 9% post-expansion, possibly because newly insured patients could access outpatient programs.[349] Increased funding could also incentivize treatment initiation: individuals on Medicaid were almost twice as likely to utilize treatment services than patients with private insurance.[350] Additionally, post-expansion prescription rates of buprenorphine and naltrexone per Medicaid enrollee rose 200%,[351] and there was an 8.5% increase in MOUD treatment plans,[352] which indicates that individuals were better able to access medication. Given that MOUD significantly reduces the risk of opioid overdose,[353] enabling more patients to receive this type of treatment may lead to a reduction in fatalities.

From the provider side, this recommendation could create a stronger market dynamic among care providers today. Providers could sign up to receive patients using these services, and patients could take their dollars to any of the enlisted providers. This competition could encourage lower rates for these services, particularly because few clinical care organizations are currently supply-constrained.

The positive effects of this recommendation, including improving treatment access, recovery, and retention, are likely to be magnified if the coordination platform from Recommendation 2 above is also operationalized.

Implementation considerations

Structure

A key gating criterion is deciding which organization will be responsible for operating and administering these funds. This responsibility includes deciding who will be eligible for the pilot program. Accordingly, the most appropriate administrator should be PCHS or a contracted third-party managed by PCHS. Operationally, the funding will follow the individual and support their needs throughout the CoC with the aim of facilitating their recovery and reducing barriers for services and other supports.

Individuals in the pilot program should be able to understand which services are covered (clinical care, housing, transportation, and beyond). Fund administrators should have connections with providers in each of these settings to provide seamless transitions to care or wraparound services.

Magnitude of investment

This transformative investment comes with a higher price tag. The estimated cost of ~$20,000–30,000 per individual per year means that only a small number of individuals will likely be able to enroll for the trial period. An initial cohort of 50 people would allow for enrollment from a wider array of backgrounds and facilitate

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[348] See Barocas et al (2022) for details; this paper estimates that lifetime costs of medication and wraparound services for people who inject opioids are ~$730,000. They suggest that yearly costs of medication and bridge services like addiction consults are ~$14,300. This fund could cover additional services like childcare, transportation, non-medication treatment, so an initial estimate of yearly cost is 50%–100% of the $14,300 estimate (which is only for MAT)

[349] Wen et al. (2020)

[350] Orgera & Tolbert (2019)

[351] Sharp et al. (2018)

[352] Swartz et al. (2023)

[353] Sordo et al. (2017)

easier program evaluation. However, the costs of care for that cohort would accordingly be expected to total $1 million–$1.5 million annually.

Fund administrators will probably have to stand up systems to coordinate this care, but there are examples to follow. One, the Ryan White program, is detailed in the Case Studies section below. The cost of fund administration should remain below $500,000 each year (and potentially significantly less after the startup costs). There may be opportunities to coordinate this care through a new system of case management, if implemented as discussed in Recommendation 2.

Operational suggestions

Individuals enrolled in the pilot should not lose access to services if the program is not renewed. Fund administrators should consider ways to transition these individuals to similarly subsidized treatment after the pilot duration elapses, perhaps through the existing priority system at some programs like the Pinellas County Health Program. Continuity of care is particularly important for individuals receiving long-term care like MAT.

Case studies

No jurisdiction to date has created a pool of flexible funds for people with OUD to use for treatment or other supports such as transportation, food, housing, and/or childcare expenses. That said, Pinellas County does currently offer the Adult Emergency Financial Assistance Program (AEFAP), which can be used by individuals at or below 200% of the FPL for assistance with emergency transportation to medical appointments, unexpected work-related expenses, and some housing expenses such as past-due rent, utilities, and mortgages. However, the AEFAP can only be used once per year by individuals without minor children in the household.[354] Families with children under the age of 18 who are at or below 250% of the FPL may be able to obtain goods and/or services through the Family Services Initiative (FSI), which helps with basic needs such as food, water, rent, transportation, and counseling.[355] Neither AEFAP nor FSI cover OUD treatment, but the systems in place could be leveraged or replicated in service of individuals with OUD. As such, Pinellas County could innovate on existing structures to establish a flexible fund for OUD, define the eligibility requirements, and develop considerations for access.

It is also important to note that the AEFAP, FSI, and OUD flexible fund offer infrequent resource infusions, not long-term care. While they offer vital aid for individuals in emergency situations, it is still necessary to develop them in tandem with other, longer-term supports.

Further examples that can serve Pinellas County as they consider this recommendation can be found in programs that provide funding for people struggling with other diseases, such as HIV.

Ryan White Program

The Ryan White program is a federal program that offers a similar scope of services.[356] Across the country, people with HIV who are unable to pay for care can access services through this funding. The list of approved uses for the Ryan White program, which is controlled at a federal level, is broad and includes wraparound services such as housing and transportation. In Pinellas County, a local Care Council acts as the coordinator for the Ryan White Program. Individual providers, both clinical and those that deliver wrap-around services, could sign up with the Care Council to become approved providers. The council also keeps a list of eligible providers, which the federal government links to a nationwide care database.[357]

[354] Pinellas County (n.d.)
[355] Personal Enrichment through Mental Health Services (n.d.)
[356] Health Resources & Service Administration (n.d.)
[357] Save The Michaels of the World, Inc. (n.d.)

Recommendation 6. Re-organize the coordinating body to establish a single point of authority for abatement efforts in Pinellas County

Gaps addressed	
G1	Organizations in Pinellas that provide OUD-related services operate in silos, guided by internally defined priorities, as there is no organization with the authority to oversee and direct opioid abatement efforts at the system level.
G2	Data sharing across stakeholder groups is sparse and limited, which makes it difficult to develop a systems-level perspective and integrated, advanced analytics.

Context

No single person or entity is viewed as the authority for organizing abatement efforts in Pinellas County. The OAFAB is responsible for the Regional settlement funds; at least two entities have published opioid abatement goals that frame publicly where and how abatement efforts should be directed. Confusion (real or perceived) about the roles and responsibilities of the Opioid Task Force, OAFAB, and other leadership bodies may impact strategic abatement efforts in the future, particularly if there is limited coordination on goals, roles, and priorities.

Description

To address this perceived gap in leadership authority, Pinellas County could create a small, focused entity that has a specific mission and objectives to address the opioid epidemic. This new entity should drive accountability around abatement initiatives and be accountable to funding bodies as well.

A chief responsibility of this entity would be coordinating system-level data-sharing between providers and community organizations. While data-sharing efforts exist in Pinellas County today, they are largely decentralized. Organizations in the county need a standardized data-sharing agreement and a shared understanding of data governance in order to create a system that allows for rapid data-sharing and assurance that these practices would be covered by relevant privacy laws. The details of these data-sharing initiatives are covered in Recommendation 7.

Alternatives to creating a new entity staffed with full-time coordinator(s)

As described in the Case Studies section below, some counties in Florida place their OTF within other county government arms. That Task Force is given the authority to oversee countywide abatement planning. In theory, Pinellas could similarly move its Task Force within a local agency, but it would be complicated to assign part-time responsibility for opioid abatement efforts. For consistency and clarity, a separate organizational structure is recommended.

Potential impact

This coordinating body could reduce silos and allow for clear, action-oriented statements from a unified voice. A small, dedicated team supporting the leader could help establish clear priorities and direction. It could also help align state and county policy by participating in future policy discussions to clearly articulate Pinellas County needs related to opioid abatement efforts. Finally, it could help drive progress by facilitating cross-entity collaboration on key initiatives such as data sharing, coordination, education, and other strategic priorities.

Implementation considerations

Leadership

This entity should identify a leader with behavioral health and substance use expertise, preferably with relationships and experience in Pinellas County. Individuals with lived experience should be encouraged to apply and could be offered preferred consideration. The hiring process could establish that they are

competitively compensated and incentivized to remain in the role through at least one full funding cycle. This position should have clear performance benchmarks that are communicated on hiring and that are evaluated at least once per year.

Magnitude of investment

The minimum investment would be to hire a single coordinating leader. Between salary and fringe benefits, funding this position would likely cost in the range of $200,000–$300,000 per year for an initial tenure of at least three to four years.

The coordinating body could also operate through a more robust structure, with two-to-four employees. This would carry more expense but remain limited to salaries and benefits. Depending on the team structure, a full team cost range might be $350,000–$750,000 a year.

There may be opportunities to grow or streamline this organization after the first funding cycle of three to four years. The 18-year time frame of abatement funding means that someone will likely need to hold coordinating authority for far longer than the first funding cycle. These details of long-term coordination should be resolved after the first funding cycle.

Scope and structure

The entity would be responsible for policy prioritization, meeting with decision-makers, strategy, oversight, and being the public face of abatement efforts. A small, dedicated team supporting the leader is likely to achieve the expected ambition of driving opioid abatement programming, supporting advocacy and policy initiatives, and facilitate cross-entity collaboration on key initiatives such as data sharing, coordination, education, and other strategic priorities.

One local model for organization could be the Homeless Leadership Alliance (HLA). Similar to the HLA model, this coordinating abatement entity could be accountable to local funders but have autonomy over abatement prioritization, strategy, and funding; the entity could also maintain an ability to hold stakeholder organizations accountable for their efforts.

Case studies

Opioid response administration in Florida

Though hiring a full-time team would be novel, other counties have hired administrators or coordinators to oversee opioid response efforts. Within Florida, one of the only counties that has paid staff is Orange County. There is significant overlap between their full-time County Drug Free Initiative and their Opioid Advisory Board (e.g., Task Force). The Advisory Board oversees all abatement efforts and formally sits under the Drug Free Initiative.[358] With this structure, some members of Orange County's Advisory Board may be able to devote part of their time to opioids while drawing on broader SUD expertise.

Coordination in other counties

Outside Florida, several counties have hired individuals to lead abatement efforts and be a key decision-maker for funding. Loudon County (VA) recently hired an Opioid Response Program Administrator from a $360,000 grant.[359] Lake County (IL) allocated $1.5 million toward a round of abatement funding that included endowing an Abatement Coordinator position.[360]

Lastly, Erie County (NY) has employed multiple Opioid Administrators in the past.[361] Erie County has shifted their Opioid Coordinator role in recent years, moving it out from under the umbrella of other local agencies and into a more independent role. Although they receive input from task force groups and a community advisory council, the current appointee now has ultimate authority over fund allocation and implementation. Under their

[358] County Commissioners websites
[359] Virginia Opioid Abatement Authority (2023)
[360] Lake County (2023)
[361] Civil Service Opportunities (2024)

direction, ~$6 million in funds will be distributed to 25 programs through 2024, and a data monitoring dashboard is in progress.

These counties have hired people with substantial expertise in substance use and in the local jurisdiction. Loudon's new Opioid Response Program Administrator has nearly 30 years of prior experience in local government as well as an academic background, while Lake County's new Opioid Coordinator has worked in public health near Loudon for over 20 years.[362]

[362] EY interviews, research, and analysis

Recommendation 7. System-level data governance and data capabilities

Gaps addressed	
G2	Data sharing across stakeholder groups is sparse and limited, which makes it difficult to develop a systems-level perspective and integrated, advanced analytics.

Context

Provider, funder, and community organizations in Pinellas County do not regularly share data such as overdose reports and service utilization with each other. This data, though not private health information, is valuable to developing a community-oriented overdose response.

While some organizations are willing to share data on an ad hoc basis with other groups, and groups such as Fusion have made progress in facilitating data-sharing agreements, Pinellas County lacks a culture of data-sharing at systems and organizational levels. This gap is not unique; many state and county governments around the country struggle to share this type of data.

Description

The path to improved data sharing could run through a "Data Governance Council." This council could be separate from the coordinating body referenced in Recommendation 6. The Data Governance Council would not be an authority figure nor composed of full-time employees focused on abatement. Instead, it includes an identified leader and a representative from each provider and community organization with the goal of defining common data governance and data sharing practices for adoption across public and private provider groups. This system-level data-sharing could result in clear outputs for the coordinating entity and enable prioritization and reporting to funders and the OAFAB with ease.

The Data Governance Council could streamline data-sharing but that may not be directly linked to a measurable output. Indirect measures, such as indicating which programs or initiatives are informed through data-sharing agreements or linked to groups that share data following such agreements could be established. A landscape of increased data sharing would potentially require upskilling community organizations to verify that they can properly manage their data as well as generate insights and measure impact.

To solve the data gap in smaller community organizations, Pinellas could also fund a "Data Capabilities" team, which would oversee data collection, insight generation, and progress reporting for organizations across the county that need assistance with data management and associated capabilities. This team would be focused on helping smaller organizations that require support to build IT systems or that need help with grant-writing capabilities. The Data Capabilities Team could also work closely with the Governance Council to confirm that frequently collected data would be used promptly and appropriately.

Potential impact

This recommendation could improve the agility of the Pinellas County care system. Currently, stakeholders struggle to respond to local trends, because each organization sits in a silo with its own data. In the future state, Pinellas County could expect to see greater flexibility in responding to trends, likely contributing towards better treatment outcomes.

Implementation considerations

Standards

Stakeholders are likely to be concerned about privacy laws when crafting systematic data-sharing agreements. There are several models for agreements that meet 42 CFR part two and HIPAA requirements, especially for when the data being shared is not private health information. These are discussed in the Case Studies section below.

Magnitude of investment

The Data Governance Council would have small startup costs. It may be a responsibility of an FTE employee in the coordinating body (if created via Recommendation 6), but members would join by way of incentives to share data. These incentives could start with — though should not be limited to — funding opportunities specifically for stakeholders who agree to data sharing frameworks and who sit on the Data Governance Council.

The Data Capabilities Team may require a greater investment. If created, this team would be likely to cost from $250,000 to $500,000 or more annually depending on size, scope, and scale of the programming.

Case studies

Data sharing about overdoses in Wisconsin

Wisconsin passed a law in 2021 that mandated data sharing related to opioid and methamphetamine overdoses. Parties bound by this law included hospitals, emergency services, methadone clinics, jails, and state agencies (e.g., the Department of Children and Families).[363] In 2024, Wisconsin distributed a $1.5 million RFP to fund this data collection and sharing. Pinellas County could learn from the early years of Wisconsin's effort to define the requirements and scope anticipated outcomes.

U.S. Department of Transportation data sharing

On a national scale, the U.S. Department of Transportation (DOT) created a data sharing platform called Freight Logistics Optimization Works (FLOW) to help manage the supply chain crisis during the COVID-19 pandemic. The success of FLOW holds several key insights that may be helpful. First, stakeholders were similarly reluctant to share their data with the DOT until realizing that the platform would ultimately create value for the whole community. The DOT was not viewed as a service provider, which made stakeholders wary of sharing data with them. However, extensive outreach from the DOT helped convince other organizations that they would have a use case for the shared data. Journalists covering the implementation after the fact cited these instances of 360-degree data usage as critical to building buy-in.[364]

[363] 2021 Wisconsin Act 181, 2022
[364] Pahlka (2024)

Recommendation 8. Expand access to programming in justice settings

Gaps addressed	
L3	Individuals incarcerated in Pinellas County jail cannot receive MOUD treatment.
E8	Pinellas County criminal justice diversion programs could be better leveraged to keep people with OUD from being incarcerated instead of treated.

Context

Pinellas County has limited OUD-related programming in pretrial and carceral settings. Although the Sixth Circuit pretrial diversion programs perform above national benchmarks, fewer individuals have been enrolled in diversion programs in recent years despite a growing number of drug crimes. Once individuals are in jail, they cannot consistently access MOUD. Pinellas County has the second-largest incarcerated population in a non-MOUD jail in Florida, and Pinellas County Jail has 6% of the state's total incarcerated population.

Upon release, individuals in Pinellas County are at increased risk of relapse because they cannot consistently access MOUD in jails. Additionally, few people leave jail with naloxone or other harm reduction supplies. There is an opportunity to reimagine OUD care in justice settings, bringing Pinellas to the level of other counties in Florida and beyond.

Description

This recommendation suggests improvements to pre-arrest, carceral, and post-release care. Before incarceration, Pinellas should research ways to broaden the pipeline into diversion programs. While Pinellas County has numerous existing diversion programs in place, including Adult Pre-Arrest Diversion and Supervised Release on Recognizance,[365] this recommendation primarily discusses Problem Courts with a focus on the Adult Drug Court (ADC). Pinellas County should have a goal of returning to pre-COVID-19 levels of enrollment in the ADC. This may involve establishing that judicial staff are equipped to identify individuals who are eligible for and could benefit from participation in the ADC or Drug Dependency Court. During incarceration, there should be an opportunity for jails to provide MOUD to all inmates. And during and after release, jails should receive incentives for following best practices in post-release care.

Pre-arrest and pre-incarceration

Expanding early diversion programs would require partnerships with the Sixth Circuit court. Despite a track record of success and existing capacity in the ADC,[366] fewer individuals are being referred into the program: in 2018, more than 300 individuals graduated from the ADC, but only 180–190 have graduated in each of the last three years.[367] This drop occurred even though drug crimes in the county rose during the same period and does not appear to be a capacity issue; the ADC can serve 600 participants at any given time but, at the time of writing, has 415 active participants.[368] While abatement funding cannot and should not change the operations of the court, it could enable County officials and judges to assess why this misalignment is occurring. For example, County leadership could better understand which individuals (if any) would have been referred to diversion programs like the ADC (in 2018, per se) but are not receiving that opportunity today and why.

Research from the Bureau of Justice and the National Institute of Justice has demonstrated that the ideal target population for ADCs are those individuals with a high dependence on substance use and a high risk of recidivism.[369] Current screening procedures for diversion programs in Pinellas County could be examined and

[365] Pinellas County Sheriff's Office (n.d.)
[366] FLHealthCharts
[367] Sixth Circuit Court
[368] Data from Pinellas County Courts
[369] Adult Drug Court Research to Practice Initiative (2022)

refined to establish that they are effectively identifying individuals in this category, and judicial staff could be trained to accurately utilize updated screening criteria.

Finally, efforts could be made to educate eligible individuals about the program and decrease opt-out rates. Other diversion programs such as the Drug Dependency Court have higher retention rates[370] than the ADC and could serve as a reference.

Care in carceral settings

The largest opportunity to improve care in carceral settings is by offering MOUD in Pinellas County Jail. The jail currently only offers methadone and buprenorphine for pregnant inmates, and people who are booked into jail while taking MOUD are tapered off their medication within one week.[371] Noted risks for people who are tapered off MOUD in this manner include painful and uncomfortable withdrawal, and potential to be more susceptible for opioid use in the future (i.e., relapse post release).

While the exact number of jail bookings for persons with OUD is not available for this study, benchmark estimates for medication demand is possible using data from other states. The Rhode Island Department of Corrections reported that 70%–90% of their incarcerated population has SUD, and 20% of these individuals (14%–18% of the total prison population) have OUD.[372] Assuming an estimated 3,000 individuals in Pinellas County jail, this suggests a range of 420–540 people with OUD; there may be more or less depending on local variability.

Benchmarks from pilot studies indicate that ~66% of individuals in jails who would clinically qualify for MOUD choose to take it when offered.[373] Pinellas County could deliver MOUD to 280–360 individuals if available.

Separately, Pinellas should work to establish that all persons entering a justice setting are evaluated for SUD upon entry. These screeners already occur in the jail, but stakeholders report these screenings could be sharpened, professionalized, or expanded with appropriate funding.

Pre/post-release

Pinellas County Jail should have the resources to coordinate transition planning in the pre-release phase. This planning can help provide warm hand-offs for justice-involved groups, and increasing naloxone distribution in carceral settings upon release could mitigate the risk of overdose upon reentry.

As a pilot, the jail should provide naloxone kits to high-risk individuals upon release, such as the estimated 14-18% of individuals in jail with OUD as well as anyone who entered jail for a drug offense. This program could be expanded to the entire incarcerated population if successful.

Potential impact

This recommendation should expand access to programs that reduce incarceration, recidivism, and post-release mortality.

Pre-arrest and pre-incarceration

The success of the Pinellas County ADC offers a clear target for impact. If the program returns to 2018 levels of participation and graduation, an estimated 100 additional individuals will graduate through the program each year, assuming comparable rates of recidivism.[374] As shown in Exhibit 33, Pinellas' diversion graduates have a 22% recidivism rate while national benchmarks are reportedly closer to 33%, suggesting local success with prior efforts that could be assessed for potential expansion.

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[370] Sixth Judicial Court (2022)
[371] EY interviews and research
[372] State of Rhode Island Department of Corrections (n.d.)
[373] Chatterjee et al. (2023)
[374] Current post-graduation recidivism is similar to recidivism rates from prior years when diversion program sizes were larger. This suggests that growing the program may not bring down post-graduation success metrics.

Diversion programs from other jurisdictions show other benefits besides recidivism. For example, participants in a local Law Enforcement Assisted Diversion program that was assessed using causal identification were 46% more likely to be employed, and 33% more likely to be earning an income than individuals who were not in the program.[375]

Care in carceral settings

As discussed above, 280–360 individuals in jail could potentially be inducted on MOUD while incarcerated if the treatment was made available. If they remain on medication until release, they would be less likely to relapse into active use and more likely to transition into long-term recovery.

The potential benefits are noted in various study settings. For example, in one study that assessed individuals one year after release, 25% of individuals who were given MOUD (specifically methadone) and counseling while incarcerated were opioid-positive, compared to 65.6% who received counseling alone and 48.7% who received counseling and a referral to a MOUD treatment center.[376] For Pinellas County, this suggests that MOUD and counseling could result in up to 210–270 individuals stopping opioid use for at least a year after release, assuming comparable performance levels.

A meta-analysis of MOUD programs in prisons also demonstrated that individuals who received methadone while incarcerated were at least eight times more likely to engage in community-based SUD treatment after release than those who did not receive methadone.[377] Additionally, individuals who were given methadone while incarcerated took significantly longer to be rebooked (over nine months) compared to individuals who underwent opioid detoxification (7.75 months).[378]

Pre/post-release

There are some benchmarks from other counties for voluntary "naloxone at release" programs. Approximately 1% of the incarcerated population in the San Francisco County Jail chose to participate in their OEND training, and of these, 67% accepted naloxone upon release. During follow-ups, 32% reported using the naloxone to reverse an overdose, and 44% were tracked as receiving a refill from community-based programs.[379]

If Pinellas had the same uptake and results, it could expect 30 of its current inmates to participate in an OEND program, 20 to accept naloxone upon release, and six to reverse overdoses.

There are opportunities to increase uptake above 1%. For example, the National Commission on Correctional Health Care recommended that these facilities provide naloxone kits to high-risk individuals upon release, train all staff and incarcerated individuals to use naloxone, and keep naloxone kits readily available for all people in the facility.[380]

Implementation considerations

Standards

There are some standards that county organizations should follow throughout the justice process. A key resource comes from SAMHSA, which published a set of 10 guidelines for stakeholders building transition programs for individuals with OUD. These guidelines are organized around assessing individual and community needs, planning for treatment during and after incarceration, identifying post-release services, and coordinating the transition plan to achieve successful implementation.[381]

The National Association of Drug Court Professionals has published standards for adult treatment courts. These standards have been endorsed by SAMHSA and include guidance on topics such as eligibility criteria,

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[375] Collins et al. (2015)
[376] Kinlock et al. (2009)
[377] Moore et al. (2019)
[378] Westerberg et al. (2016)
[379] Wenger et al. (2019)
[380] National Commission on Correctional Health Care (2021)
[381] Substance Abuse and Mental Health Services Administration (2017)

ensuring equity and inclusion, the roles and responsibilities of the judge, and substance use management.[382] Additional resources are offered by the National Treatment Court Resource Center.[383]

Finally, the National Commission on Correctional Healthcare (NCCHC) developed standards for opioid treatment programs in jails and prisons.[384] The NCCHC recommendations are based on the federal guidelines for opioid treatment programs from SAMHSA[385] and adapted for correctional facilities.

Magnitude of investment

Diversion programs

Changes to diversion programs could be implemented, perhaps with little to no additional staff or investment; stakeholders believe that the ADC is set up and staffed to serve over 100 more people than today.[386] At the same time, additional staff may be needed to implement changes within the jail and support operations.

MAT/MOUD

Distributing MOUD in the jail would be one of the most expensive recommendations. If Pinellas County Jail began distributing MOUD, they would likely have to begin dedicated therapy for medication-assisted treatment as well. The jail currently does not provide this service, only offering AA/NA programs.[387] It would not be aligned to evidence-based practice for the jail to offer MOUD without the accompanying counseling and therapy due to the serious risks and corresponding needs of this population.

Local sheriffs in another jurisdiction have partnered with researchers to cost out a new MAT program in a jail, based off real-world observations. This costing exercise assumes, as would likely be the case in Pinellas, that the jail partners with a vendor to dispense the medication and that starting this process takes a considerable amount of employment time.

The budget tool published by these sheriffs and researchers estimates that Pinellas County would have a yearly cost of providing MAT as high as $5 million.[388] Notably, most of this cost would be in labor costs and not the medication itself.

These researchers and the budget tool estimate startup costs (including employee time, additional medication storage, and IT systems) at $50,000.[389] Operational costs, such as annual trainings and the time cost of an advisory team that meets eight hours a month, run $313,000 each year. Labor costs for employees physically running the MAT program (i.e., a new MAT director, four LPNs, and five security personnel) cost ~$3 million between vendor employees and jail employees itself.

Research from pilot programs suggests that ~75% of individuals in jail would choose to take buprenorphine and ~25% would choose to take methadone. [390] If that ratio holds true, the jail pays rates as listed in the budget tool, and ~300 individuals choose to take MOUD in jail as calculated above, then the jail would incur costs of ~$1 million each year in medication. Program induction and counseling requirements would cost an additional ~$500,000 each year.

The experience shows that nearly new 30 FTEs would be required to operate this program. These FTEs are necessary because of the requirements for administering medication (for example, each buprenorphine dosing in a group of 10 requires three observers). However, some of these FTEs could be pulled from existing jail roles, which may lower the cost of labor.

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[382] All Rise (2024)
[383] National Treatment Court Resource Center (n.d.)
[384] National Commission on Correctional Healthcare (2016)
[385] Substance Abuse and Mental Health Services Administration (2015)
[386] EY interviews
[387] EY research and interviews
[388] Ryan et al. (2023)
[389] All operating costs are assumed to be constant for a large jail (such as Pinellas or the sample jail profiled in Ryan et al.), with the exception of MAT, which is costed on a per-person basis.
[390] Chatterjee et al. (2023)

Naloxone upon release

The costs of take-home naloxone for inmates upon release would be much smaller, and likely less than $500,000 a year. The jail could leverage naloxone kits already made by entities like the OTF; even if they gave away 1,000 kits a year, the cost would still barely approach $100,000. It should also be noted that funding for naloxone is currently supported through other funders and may not depend on opioid abatement funding directed to Pinellas County.

Operational suggestions

There are barriers beside policy change to implementing MOUD in the jail system: adopting this standard of care will likely require partnering with jail officials who may be reluctant to offer medication. Pinellas County could look to two other jurisdictions for overcoming this barrier. Those examples of Palm Beach County and Connecticut are covered in the Case Studies section below.

There is also a way of providing MAT without becoming a SAMHSA-certified Opioid Treatment Provider. Some jurisdictions have avoided the lengthy authorization process to become an OTP by partnering with a community healthcare provider that is already certified. The healthcare provider can then offer MOUD to incarcerated individuals, and the relationship facilitates care continuity, medical record exchange, and warm hand-offs when individuals are released.[391]

Alternative funding sources

Other counties have used federal funds, rather than abatement funding, to improve treatment for opioid use disorder within justice systems. Some of these grants are specific to carceral settings, such as when the Massachusetts Department of Correction was awarded over $1.2 million over three years, part of which will be used to deliver enhanced MAT services to individuals nearing their release dates.[392] Locally, Pinellas County has received a total of $7.7 million in recent months in grant funding for mental health and SUD, $4 million of which is earmarked for drug court enhancements.

Case studies

Advocating for MAT in jails in Connecticut

In 2013, Connecticut officials legalized methadone dispensation in state prisons for the first time,[393] after which there was a significant decrease in non-fatal overdoses and a greater probability of resuming methadone treatment post-release.[394] To accomplish that goal, they leaned heavily on a prison medical director to champion that initiative with the state legislature. Pinellas County officials could find a similar advocate.

Warm handoffs after release in Alaska

Several states and counties have eased re-entry with pre-release programs that incorporate warm handoffs. In Alaska, their Department of Corrections employs Institutional Probation Officers with specialized OUD/SUD training, to coordinate care after release.[395] These officers are a subset of the typical probation officer labor force and have a caseload equal to that of other probation officers. Though there are not outcome metrics available, the increased specialization of probation officers should create a consistent knowledge base within the probation officer pool. The only major program costs in this program are the SUD-specific training for those probation officers.

Intensive transition programs in Marion County, Oregon

In Oregon, Marion County has had an "intensive transition program for high-risk men with SUD" for the last decade.[396] Probation officers run this program with individuals who are soon to be released and who have been

[391] Pew Trusts (2020)
[392] Massachusetts Department of Correction (2019)
[393] Williams (2017)
[394] Haas et al. (2021)
[395] Alaska Department of Corrections (n.d.)
[396] Oregon Knowledge Bank (n.d.)

recently released. The program is run in a cohort model, with 25 individuals entering the program every quarter. They note that this program has a positive effect on recidivism, as participants are 30% less likely to be arrested compared to other high-risk males. At the county level, this program has grown to pay for itself due to the decreased recidivism.

Recommendation 9: Launch a broad prevention campaign to raise awareness about the epidemic

Gaps addressed	
P1	The general public in Pinellas County lacks awareness and understanding about the current state of the opioid epidemic.
P2	Many individuals do not know how to access resources to learn more about opioid use; those that do report they are not effective.
A1	Populations frequently interacting with opioids often have access to naloxone, but broader adoption remains limited.
S5	Individuals with OUD, their caretakers, and their healthcare providers report low awareness of where to go to get help.
L2	Stigma towards MOUD, and methadone in particular, is present across groups including healthcare workers.

Context

Pinellas County has a public awareness gap. Fewer than 25% of surveyed residents reported feeling confident in their familiarity of the opioid epidemic and efforts to stop it in Pinellas County, and almost 35% of residents ages 18-34 reported a complete lack of familiarity with the epidemic. Existing overdose education programs are not reaching most people in the county, and survey results across all major demographics report a consistent low level of awareness.

A targeted multi-platform media campaign (print, digital) with strategic communications that aim to reach high-risk groups and span channels to be inclusive of all demographics could increase public awareness of the opioid epidemic in Pinellas County.

Description

Pinellas County should expand the content and reach of opioid overdose education programs, as well as programs that help individuals cope with the lasting effects of the epidemic.

Comprehensive targeted media campaigns could address the public awareness gap. These media campaigns may prime residents for targeted education in places such as work, paving the way for the emerging practice of overdose education in the workplace. Though an older study, research from 2007 reported that a peer-based prevention program in the office reduced injury rates by one-third and provided cost-savings to the employer.[397]

Additionally, these campaigns could be useful platforms to encourage Pinellas County residents to call 911 (for emergencies), 988 (suicide hotline), or the CAM number appropriately and when needed.

Several practices recommended here build upon work Pinellas County is already doing. Efforts to include opioids in general anti-substance education could expand on NOPE's work in middle and high schools, and existing naloxone education programming could be expanded to the general public as discussed in Recommendation 4.

Some practices would be new to Pinellas County, such as providing overdose education in non-English languages or working on targeted media campaigns. While the Opioid Task Force aims to publish a Spanish-language toolkit by the end of 2025, few trainings or events are conducted in Spanish.[398] Most anti-substance education in Pinellas County focuses on alcohol and marijuana. Without education around opioids and OUD, there is limited adoption of naloxone in populations who do not frequently interact with opioid use.

[397] Miller et al. (2007)

[398] None of the 30+ Opioid Task Force events tracked mentioned Spanish-language components, but interviewees occasionally mentioned Spanish-language outreach. One of the EY listening sessions was specifically targeted at Spanish-speaking populations, and Spanish translation support was available at over half of them.

Potential impact

Education campaigns are likely to raise awareness about the epidemic, which in turn could make residents more confident about seeking help for themselves or others. Using leading practices in an education campaign could expand the reach even further. Expanding workforce education about the opioid epidemic could increase community awareness and empower employees to take action in preventing and treating opioid use disorder.

Before starting a campaign, Pinellas County officials could set an awareness target or goal; survey results could inform the baseline awareness. For example, if only 25% of people feel confidently familiar with the epidemic now, an awareness campaign could aim to boost that number to 50% in one or two years.

Other campaigns have shown positive results. One national media campaign targeting opioid dependence in young adults led to decreased OUD stigma and increased intentions to spread information about the opioid epidemic compared to individuals with no exposure to the campaign, indicating that media strategies can influence attitudes.[399] Nearly 74% of individuals with awareness of the campaign perceived opioid use as "high risk," an increase from 66% pre-campaign, and there was a post-campaign 27% reduction in individuals who said they would share prescription opioids with friends.[400]

Implementation considerations

Standards

While there is not a widely recognized list of standards for OUD-specific advertising campaigns, there are targeted suggestions available from the NIH HEALing Communities study and the CDC Rx Awareness campaign. Both campaigns are discussed in more detail in the Case Studies section.

Magnitude of investment

Expanding the awareness campaign could cost more than $1 million per year, but the ease of digital distribution would allow implementation in a matter of months with a measurable response of awareness within the first year. There could be opportunities to invest more money if successful, or to pause investment if not.

Operational suggestions

Pinellas County should reference efforts undertaken by other healthcare organizations when designing a new opioid awareness campaign. The successful CDC campaign against nicotine is one such option. Though conducted on a national scale, the CDC reports that the campaign prompted more than 16.4 million people to attempt to quit smoking from 2012 to 2018, with over one million experiencing successful cessation.

Furthermore, analysis of the campaign audience revealed that fear of death did not motivate users to quit; instead, testimonies about the difficulty of living with long-term negative consequences from smoking (disease, poor family relationships, etc.) were key messaging.[401]

The lessons of some other counties should also illustrate implementation concerns and pitfalls. In Luzerne County (PA), the county cancelled a nearly $1 million contract with a vendor because the vendor's advertising campaign was not sufficiently personalized.[402] County officials felt that the campaign, which would run on cable TV alone, was not distributed enough to reach transition-aged individuals on platforms like TikTok or Snapchat.

Accordingly, if PCHS works with a vendor to implement an educational campaign, vendors should demonstrate qualifications and experience working with groups that are commonly underserved and thereby the most critical to reach. This may involve multiple partnerships or a longer implementation pathway but could lead to a campaign that resonates with more target audiences.

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[399] Rath et al. (2021)
[400] Truth initiative (2020)
[401] Center for Disease Control and Prevention (n.d.)
[402] Riese (2024)

Case studies

There are several leading practices for campaign coordinators to follow. The most instructive ones for Pinellas County increase engagement in advertising campaigns and in the workplace.

A/B testing ads to stimulate demand for naloxone in Kentucky

The NIH HEALing Communities study created several randomized controlled trials to test the efficacy of various advertisements to raise awareness about the epidemic and stimulate demand for naloxone. One key takeaway is that ad campaigns featuring local figures (e.g., county sheriffs) were an effective way to increase community engagement. NIH estimated that using a locally known figure increased community engagement by nearly 150%.[403]

Nationwide prescription opioid awareness campaign

A 2017 pilot of the Rx Awareness campaign from the CDC targeted individuals aged 25–54 in Ohio, Oregon, Rhode Island, and West Virginia who had taken opioids at least once. The campaign utilized testimonials from individuals who struggled with OUD to increase awareness about addiction and decrease opioid use. The materials were placed on billboards, online media, and radio ads, with online media garnering the most attention. Over 70% of participants intended to avoid prescription opioid use for recreational and medical purposes after viewing the campaign. Additionally, the testimonials had a view-through-rate (i.e., viewing from beginning to end) of 25%, above the government benchmark of 20%. This pilot study demonstrates both the effectiveness of media campaigns to influence attitudes towards OUD and the helpfulness of including content from individuals with prior drug experience.[404]

Workforce education programs in Cuyahoga County, Ohio

Similarly, there is growing support for workforce education programs at scale. Following the results of a 2024 Stanford policy brief which revealed that nearly half of workplaces had employees experiencing addiction, the Alcohol, Drug Addiction, and Mental Health Services Board in Cuyahoga County developed several resources for workplace training about SUD.[405] Since this program is new, there are no outcome metrics yet published.

Education and awareness campaigns in Bernalillo County, New Mexico

Other jurisdictions have put large sums of abatement funds into such education and awareness campaigns. For example, Bernalillo County, NM (Albuquerque) invested $975,000 into fentanyl prevention awareness campaigns.[406] This included an 11-month marketing campaign, community awareness training, and an improved website for community resources. This program is also relatively nascent, with no published outcomes yet.

[403] Lefebvre et al, 2020
[404] Center for Disease Control and Prevention (2017)
[405] ADAMHS Board of Cuyahoga County (2024)
[406] Fjeld (2023)

Recommendation 10. Enhance OUD-related training for providers, beyond harm reduction

Gaps addressed	
L2	Despite progress, stigma toward MOUD, and methadone in particular, is still present across groups including healthcare workers and sober housing providers.
S2	Front-line physicians are not appropriately trained to treat individuals with OUD.
A4	Mothers with OUD can be reluctant to access the services available to them in Pinellas County for fear of receiving poor care or facing repercussions like child separation.
C5	Treatment centers are not consistently providing co-located co-occurring treatment for co-morbidities.

Context

Front-line providers for OUD are not always effective with triage and referral in Pinellas County. This problem is partly a knowledge gap, as addiction-certified professionals are uncommon in the US healthcare system.

There are opportunities to train clinicians, including PCPs, emergency medicine physicians, and CSU staffers about the most effective ways to treat OUD.

Description

Currently, medical providers are not adequately trained to diagnose and treat OUD. Medical residency programs are not required to train their physicians about the treatment of addiction, for example, and many practitioners have stigma against patients with OUD and the medications used to treat addiction.[407]

This translates into a treatment barrier, such that only 10% of practicing physicians have completed the training required to prescribe buprenorphine and many pharmacists are reluctant to provide MOUD and naloxone[408] despite evidence that these medications substantially reduce the risk of overdose fatalities.[409] Additionally, over 70% of physicians report that they are reluctant to treat patients with addictions due to a lack of knowledge and/or skill.[410]

Pinellas should explore training for 1,000 to 2,000 workers who frequently interact with people with OUD. This could be accomplished in two to three years, at a similar pace to the successful rollout of Pinellas' naloxone training initiatives. These trainings could be combined with the harm reduction trainings described in Recommendation 4.

Increasing provider awareness regarding "MAT-first" approaches and leading practices in pain management could remove barriers to patient care. These broad skills are appropriate for any provider that might interact with someone who has OUD.

A particularly innovative component to this recommendation that could be funded is addressing the barrier of a lack of institutional support for providing addiction treatment. Research in this Report has suggested that a key driver of institutional hesitancy is a lack of standard practices.[411] Medical stakeholders in the county could benefit from developing and adhering to a consistent set of clinical treatment guidelines, even if they are only adopted locally. For example, the county could create a consistent treatment pathway for OUD that expands off the Pinellas Matters treatment that is currently taking place in some emergency departments.

This would be a novel concept for OUD. Local guidelines could be based off current standards of care and would require providers to follow a standard treatment protocol following acute presentation such as opioid overdose.

[407] Madras et al. (2020)
[408] Madras et al. (2020)
[409] Sordo et al. (2017)
[410] Campopiano von Klimo et al. (2024)
[411] Campopiano von Klimo et al. (2024)

Potential impact

Training

This recommendation should aim to train the providers most likely to interact with people with OUD in a clinical setting (mobile crisis providers, peer specialists, ED physicians and staff) within four years. These trainings would go into detail on MAT, maternal healthcare, and opportunities for co-occurring treatment, with a dual goal of increasing provider knowledge and opportunities for them to expand the scope of their services. Strategies to increase provider engagement during the training sessions, such as minimizing distraction and taking breaks,[412] could also help enhance training impact.

As previously discussed in Recommendation 4, there is a population of at least 2,000 individuals who interact with people who have OUD, and potentially significantly more.[413]

This program is expected to have downstream benefits on individuals that engage with the healthcare system with potential for positive experiences, improve interactions with clinicians, and measurable health outcomes. Enriching the skill and empathy among clinical providers could enhance the quality and focus on individual needs for clinical and non-clinical services.

Local clinical standards

Previous research has demonstrated that adoption of and adherence to standard guidelines improves patient outcomes,[414] though this has yet to be tested for OUD specifically. Similar approaches to supporting individuals at different steps in the CoC with clinical interventions could also have significant benefits, but that alone is not enough to engage clinicians in new behaviors.

The pool of providers who could benefit from training is sizable. While any implementation should prioritize providers most likely to interact with people with OUD in a clinical setting, there could be opportunities for training nurses, PCPs, case managers, and other clinicians in settings like CSUs.

Implementation considerations

Standards

As discussed in Recommendation 4, there is a perception that the current standards for training modules are ineffective. Implementing this recommendation will likely require time to create new training tools, after which there should be a pilot-and-iterate phase.

Resources that could offer guidance as Pinellas County creates new standards of care include an OUD treatment framework for medical personnel from the American Society of Addiction Medicine (ASAM) and the National Academy of Medicine's criteria for developing reliable guidelines. [415, 416] SAMHSA recommends training be provided or approved by one of 14 national organizations such as the ASAM, the American Medical Association, or the American Psychiatric Association. At a minimum, the training should cover four key topics, including diagnosing and managing substance use disorders, effective treatment planning, co-occurring disorders training, and pain management.[417]

Magnitude of investment

Trainings will potentially cost a similar amount as in Recommendation 4. In that recommendation, training 1,000–2,000 people was expected to cost between $300,000 and $500,000 over several years, depending on the complexity of training and number of people employed. A similar figure should hold here.

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[412] Carter et al. (2019)
[413] For example, there is a large number of case managers and clinical social workers who interact with individuals with OUD, but the proportion was not estimated for this project.
[414] Murad (2017)
[415] White et al. (2020)
[416] Graham et al. (2011)
[417] Substance Abuse and Mental Health Services Administration (2023)

Creating new clinical guidelines will likely carry a smaller cost but require a longer timeline. That process could operate by committee, but a full or part-time coordinator may be required to establish that that committee proceeds at a reasonable pace with robust analysis to support any clinical guidelines or recommendations. A single FTE with medical experience could cost $200,000–$300,000 a year, and more if they are an MD.

Operational suggestions

There may be an opportunity to partner with existing medical educators (medical schools or Florida's upcoming investment in behavioral health upskilling) to deliver some of this content. These partnerships should be explored while the content is developed. Furthermore, operation and oversight of the training could be a responsibility of the governing entity discussed in Recommendation 6.

Case studies

Nationwide program to reduce stigma

The benefits of enhancing specialized training for PCPs has long been explored within the field of medical anthropology. One relevant example focuses on stigma against individuals with mental illness, which is a barrier to the integration of mental health services into primary care. To dismantle this stigma, medical anthropologists developed a program called Reducing Stigma among Healthcare Providers (RESHAPE), which is a theoretically grounded intervention addressing the survival, social, and professional threats that fuel this stigma in the medical community. [418] A proof-of-concept study found that healthcare providers experienced increased clinical competency and increased willingness to interact with a person with mental illness after receiving 16 months of RESHAPE training. This study supports the reduction of stigma through the targeted approach of addressing the perceived survival and professional threats commonly seen among providers.

Emerging findings regarding social contact interventions within the field of medical anthropology indicate potential for OUD-related training for providers, expanding beyond harm reduction to address driving forces such as mental illness stigma.[419]

Viewpoints from national organizations

The American Medical Association is a proponent of using abatement funds for training. Specifically, they have urged states and counties to build strong labor pools in addiction medicine and addiction psychiatry.[420] In addition, SAMHSA offers a national program for healthcare and counseling professionals called Providers Clinical Support System — Medications for Opioid Use Disorders. This program trains providers to use medications for OUD and offers a mentorship network.[421]

Drexel University

In Pennsylvania, Drexel University offers a series of courses that teach providers about treatment for co-occurring mental and SUD. The classes cover topics such as integrated care, trauma-informed practices, and crisis intervention to educate providers on best practices in the space.[422] Drexel University is accredited to offer certification as a Certified Co-occurring Disorder Professional for providers who meet the requirements.

[418] Kohrt et al (2020)
[419] Makhmud et al. (2022)
[420] American Medical Association (2022)
[421] Substance Abuse and Mental Health Services Administration (n.d.)
[422] Drexel University College of Medicine (n.d.)

Recommendation 11. Expand syringe services programming

Gaps addressed	
A2	Pinellas has only one syringe exchange program, with only one location. As such, access to it is geographically limited. State and local ordinances also limit available funding streams, distributable supplies, and potential operating models.
A3	Fentanyl test strips are not yet widely distributed in Pinellas County.
C5	Treatment centers are not consistently providing co-located co-occurring treatment for co-morbidities.

Context

Syringe services programs reduce the harm associated with active opioid use through several avenues. However, IDEA Exchange Pinellas is the only SSP in the county. IDEA Exchange Pinellas operates 15 hours per week and has served 200–300 clients since opening in 2023. While successful, the largest gap in programming appears to be the limited geographic coverage. Additional syringe service programs and/or mobile clinics could address this gap.

By reducing needle reuse, SSPs lower the rate of bloodborne disease transmission (e.g., Hepatitis C, HIV). They also typically distribute other harm reduction supplies (naloxone, fentanyl test strips), basic hygiene supplies, and, if available, clothing. They offer co-occurring care like wound care and blood testing. Finally, they provide a non-judgmental, trusted environment that individuals can turn to for connections and hand-offs.

Description

SSP access should exist outside St. Petersburg, either through mobile units or a second IDEA branch.

Importantly, SSPs are not currently fundable with abatement settlement funding. As discussed in Gap A2, the Infectious Disease Elimination Act (IDEA, the namesake legislation governing exchanges in Florida)[423] does not allow SSPs to operate using state, county, or municipal funds. At the time of writing, Florida Attorney General Moody has deemed abatement funding to be state/county/municipal funding. As a result, funding this recommendation would need to be through other funding sources and not from opioid abatement funds. There are indirect methods that could be used to support SSPs. For example, the OAFAB could put out a position statement expressing support for SSPs, which was a recommended action in Palm Beach County (discussed in the Case Studies section below). Abatement funding could also be used for advocacy to amend the IDEA law.

There are two primary implementation pathways for expanding SSPs: growing the current location and adopting mobile programming.

Brick-and-mortar program expansion

IDEA Exchange Pinellas operates out of a fixed location today. As transportation around Pinellas County is often difficult for individuals in active use who may not have access to a car, increasing the number of fixed SSP locations could enhance access to SSP services. As noted by interviewed IDEA Exchange Pinellas clients, there are residents throughout the rest of the county (e.g., Clearwater, North County) that could benefit from SSP access but do not have it today due to location.

Mobile syringe services programs

Mobile programs are another way to increase access to SSPs across Pinellas County. These arrangements allow operators to be agile in choosing where to locate the services and enable them to operate in multiple places using the same infrastructure. Mobile programs come with the tradeoff of more limited hours in a single given location when compared to a brick-and-mortar program. Additionally, mobile programs require separate storage and administrative facilities. As outlined in the case study below, a mix of the two options is perhaps better, as mobile programs work in conjunction with fixed locations. Fixed locations can serve as hubs for

[423] Florida Health (2019)

storage, administration, and more involved services, while mobile programs may be used to target specific populations in need of mobile-friendly services.

Alternative ways to increase SSP utilization

Several interviewees suggested that funding should expand the current operations of IDEA Exchange Pinellas beyond 15 hours/week. However, this may be less impactful than geographic expansion. Conversations conducted with IDEA Exchange Pinellas clients did not demonstrate demand for increased hours – while some of them would come if the clinic was open on Tuesdays or Saturdays, no individual expressed a significant need for increased hours.

Additionally, the current operational success of IDEA Exchange Pinellas is below peer benchmarks. The first year of operations at IDEA Miami-Dade (when they similarly only operated a single site) generated over 500 clients,[424] whereas IDEA Exchange Pinellas was below 200. This occurred even as overdose rates were far lower in Miami during their first year than rates were in St. Petersburg in 2023. This comparison does not mean IDEA Exchange Pinellas is operationally deficient, but rather suggests the existing location may be less accessible. Accordingly, geographic dispersion is preferred over increased hours in the current site.

Potential impact

If implemented, this recommendation could enhance access to SSPs and the services associated with them. Pinellas County could expect to see measurable impact in performance, access and engagement across the CoC. Potential direct and measurable impacts include increased access to co-occurring infectious disease testing and care, increased linkages to SUD services, enhanced harm reduction supply distribution, increased access to wound care, and increased access to related education.

Increasing SSP access will likely increase the number of individuals who already experience the benefits of SSPs at IDEA Exchange Pinellas. As discussed, SSPs offer a range of services to help protect the health of both individuals with OUD and individuals who actively use other injectable drugs such as methamphetamine and cocaine. They have been shown to significantly lower the risk of Hepatitis C (74% risk reduction compared to areas without SSPs) and HIV transmission.[425] These benefits are typically even greater when the client is also taking MOUD.[426] SSP clients are more than five times as likely to enter treatment and three times as likely to stop drug use as individuals who do not use the program.[427] Lastly, SSPs can reduce overdose fatalities through naloxone training and distribution to individuals with OUD.[428] That said, the Florida Drug Policy Advisory Council noted that limited funding and the restrictions of the one-for-one exchange meant SSPs in the state were only meeting about 35% of client needs in 2022.[429]

At a population level, IDEA Exchange Pinellas could expect their client count to trend toward IDEA Miami-Dade over time. While Miami-Dade is a larger county, there is less of an OUD burden there. (In 2022, Miami-Dade County had 393 fatal opioid overdoses, but the larger size of the county made their per-capita rate over five times higher than Pinellas).[430]

IDEA Miami-Dade now serves over 850 unique clients a year and enrolled over 200 new clients in fiscal year 2023.[431] This service-level is possible in part because of six mobile units that complement the brick-and-mortar location.

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[424] Wolfson (2019)
[425] Platt et al. (2017); Des Jarlais et al. (2016)
[426] Platt et al. (2017); Des Jarlais et al. (2016)
[427] Centers for Disease Control and Prevention (2024)
[428] Centers for Disease Control and Prevention (2024)
[429] Florida Medical Examiner; Florida Department of Health (2022)
[430] Florida Department of Health Substance Use Dashboard
[431] Cava (2023)

Implementation considerations

Standards and legal compliance

The CDC has published a technical package that provides guidance on effective strategies for planning, implementing, and sustaining SSPs. Examples of suggestions include collecting data on trends, needs and overall effectiveness of the program; creating a sense of shared purpose through stakeholder engagement; involving individuals with prior drug experience to serve as peers and provide insights into community needs; and providing linkages to care, among others. [432]

As stated, there are legal barriers to directing abatement funding toward SSPs. Some counties have found creative ways to support SSPs through their abatement council; an example from Palm Beach County is detailed in the Case Studies section below. There are also statewide and local barriers to exchange operation that must be considered.

In Florida, IDEA mandates a one-to-one needle exchange policy, meaning that individuals can only receive one needle for each needle that they turn into the exchange. Research suggests needs-based exchanges (which do not limit the needles received to the number turned in) are more effective in lowering needle re-use rates with impact on other measures.[433] If such policy changes are adopted at the state-level, IDEA Exchange Pinellas could consider exploring funding such a program.

Specifically in Pinellas County, there are barriers to implementing mobile units. IDEA requires each county in Florida that implements a syringe program to establish a governing ordinance, and Pinellas County's ordinance currently only allows for fixed locations. Any implementation of mobile units would require amending the ordinance.

Magnitude of investment

New brick-and-mortar and mobile clinics are expensive and have been estimated to cost $1 million–$2 million in the first year of operations.[434] However, long-term operating costs are lower. While one source suggests that a medium-complexity exchange in an urban area (such as IDEA) could cost $1.1 million a year,[435] IDEA Exchange Pinellas receives less than $500,000 in funding now for continued operations. Much of this difference is because IDEA Exchange Pinellas does not have full-time medical staff.

Mobile clinics are presumed to be more expensive than the estimate of $1.1 million each year, especially if staffed with medical personnel.[436]

Case studies

IDEA Exchange growth in Miami-Dade County

Miami-Dade County is home to both the highest rate of HIV in the state of Florida and the first IDEA exchange location in Florida. Today, Miami-Dade houses one brick-and-mortar location and six mobile clinics that serve individuals around the county. These locations are placed in areas with high overdose concentration, and are funded primarily by grants and donations, with the University of Miami contributing significantly. As of July 30, 2023, IDEA Miami-Dade had over 2,200 enrolled participants, collected over 1.6 million used syringes, and performed almost 3,000 HIV tests and over 2,500 Hepatitis C tests. [437] The program had also distributed almost 6,000 boxes of Narcan, responsible for over 3,000 reported reversals. The program linked more than 600 individuals to treatment for SUD (including detox, residential, outpatient, and/or MAT). The program also partners with several healthcare providers (South Florida AIDS Network, Jackson Health System, Florida

[432] Javed et al. (2020)
[433] Mackey et al. (2023)
[434] Teshale et al. (2019); Asher et al. (2021)
[435] Asher et al. (2021)
[436] Asher et al. (2021)
[437] Per 2023 Annual Report

Department of Health) to provide care linkages for individuals who are HIV positive. Altogether, this program exhibits the impact that an expansive syringe program can have in Florida.[438]

Mobile SSPs in Palm Beach County

Palm Beach County is home to a mobile SSP, Florida Access to Syringe and Health Services Exchange (FLASH), operated by the organization Rebel Recovery, an accredited recovery community organization (RCO). The mobile unit's services include syringe exchange, referral to SUD treatment, linkages to peer supports, navigation of community resources, harm reduction training, naloxone training and distribution, HIV/Hepatitis C screening, linkages to HIV supports, trainings around infectious disease prevention, basic wound care, and referrals to community health providers.[439] The mobile unit rotates between five different locations to maximize geographic coverage and consequently access to the broad array of services listed above. In 2021–2022, FLASH served 709 clients, collected 183,150 used syringes, gave 167,670 clean syringes, distributed 1,368 kits of naloxone that reversed 935 overdoses, and linked 269 individuals with treatment.[440] This serves as an example of the types of services that a mobile unit can provide, and how geographic spread can be enabled with a program on wheels.

Supporting SSPs in Palm Beach County

Palm Beach County faces similar restrictions regarding use of abatement funds to fund syringe exchanges. Palm Beach's Opioid Advisory Committee chose to publicly "support syringe exchanges," without intending to allocate funds toward their existing exchange.[441] If the guidance on using abatement funds for SSPs changes in the future, the Palm Beach committee will be on record as having it be a supported service, and it could receive priority in future funding rounds.

[438] Per 2023 Annual Report
[439] Per FLASH website
[440] Palm Beach Committee on Behavioral Health, Substance Use and Co-occurring Disorders (2024)
[441] Diamond (2024)

Recommendation 12. Establish a Marchman receiving facility

Gaps addressed	
S3	The Marchman Act aims to remediate a gap in SUD treatment by enabling immediate crisis care. Due to the lack of a state-funded receiving facility other than the jail system, it has not filled that role in Pinellas.

Context

Under Florida state law, individuals at risk of harming themselves or others due to substance use can be held for detention and transportation to an involuntary assessment for SUD. If the assessment indicates potential harm, those individuals can be held for involuntary treatment via the Marchman Act. Since there is no formal Marchman receiving facility in Pinellas County, the Pinellas County Jail is used as a *de facto* receiving facility. Many residents are hesitant to seek detention for substance use assessment, and the use of the jail is reported to heighten their concern.[442] People perceive that care in the jail is not tailored to SUD, and involuntary referrals are rare since many people believe treatment in jail is not worth the burden of treating someone over their objection.[443]

There is community demand for better "last-resort" treatment options, both voluntary and involuntary. Immediate crisis care is a crucial part of the CoC that is not consistently available. Many crisis care facilities in the county do not target treatment of SUD/OUDs, are costly, and/or have waitlists. While law enforcement often serves as the first point of contact when someone is in crisis, there are reports that they are more familiar with the Baker Act, which further creates a gap in accessing crisis services for people with SUD.[444] A facility that delivers crisis stabilization, de-escalation, screening, assessment, treatment, and linkage to aftercare for persons with SUD/OUD would fill a current gap in Pinellas County. They could treat voluntary or involuntary patients by operating according to leading practices for assessing ongoing treatment needs for voluntary patients or applying civil commitment of involuntary treatment via use of the Marchman Act.

Description

This recommendation suggests subsidizing Marchman beds in an existing treatment facility. The Marchman component of this treatment facility could offer linkages to long-term care after the Marchman duration has expired. Services provided at this facility would be consistent with other Marchman facilities, including screening, assessment, and services for eligible entrants. The facility should be granted appropriate funding and resources to train and support staff, both on general crisis care and Marchman Act-specific actions. For example, a Marchman facility should have the capability to screen involuntary entrants to confirm that the Marchman Act was properly applied. Where appropriate, they would have the ability to rescind the Marchman order and redirect the individual to non-coercive recovery support services. This investment could also be accompanied by enhanced first responder training around proper use of the Marchman Act.

This recommendation carries several benefits relative to the current state, with acknowledgement that coercive treatment should not be over-relied upon or viewed as a substitute for adequate pre-crisis and preventive care. Designating an SUD-specific receiving facility for Marchman Act recipients as described below could divert cases away from the jail, provide safeguards against improper use of the Act, and give concerned loved ones a "last-resort" care option.

There are several possible partnerships with treatment facilities, as described in the Case Studies section below. This facility could be a hospital, crisis stabilization unit, or stand-alone receiving center. It is not recommended for this facility to be a comprehensive behavioral health crisis center, Marchman evaluator, and inpatient treatment location, as separating those components of "last-resort" care reduces unnecessary inpatient care and overapplication of coercive commitment procedures such as the Marchman Act.

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[442] EY interviews
[443] EY interviews
[444] Duchene & Lane (2009)

Constructing a new inpatient facility solely for Marchman beds is also not recommended, as the benefits are very unlikely to outweigh the cost of construction.

Prior research performed on behalf of Pinellas County suggested that county agencies and the BCC should not invest in a new Marchman facility for three reasons:[445]

- Uncertainty over whether there was sufficient demand
- Belief that treatment over objection was "counter to leading practices"
- Perception that there would be a burdensome cost of construction

In the four years since the publication of that report, there is less evidence to support those three reasons.

First, this Report's gap analysis identified that there is currently demand for "last-resort" treatment that would fall under the Marchman Act. Multiple interviewees reported struggles finding a bed for a loved one, some of whom later died. While the Marchman Act would not directly solve this problem, as it would still require detained individuals to find a bed at a treatment facility, a crisis receiving facility could provide a first step during the 72-hour assessment period and provide linkages to beds if the Marchman Act is invoked afterwards. Interviewees also shared anecdotes of individuals going through the Baker Act process to get a loved one care for their substance use, which is not the purpose of the Baker Act.

Second, there is limited research on the effects of involuntary commitment for substance use.[446] While more research is needed on the subject, it is not appropriate to say there is a clear leading practice for individuals who refuse to receive voluntary treatment. There is a large body of evidence showing that involuntary commitment provides poor clinical outcomes compared to voluntary treatment.[447] There can also be detrimental non-clinical outcomes associated with involuntary commitment.[448] However, there are no studies that compare involuntary commitment to *not receiving any treatment*. Research shows that involuntary commitment patients are 40% more likely to die of opioid overdose compared to voluntary patients;[449] it is reasonable to hypothesize potential for clinical benefit from involuntary commitment (versus receiving no treatment), but properly designed clinical research is necessary to confirm. Research and interviews suggest that the population who would disproportionately fill Marchman beds in Pinellas County are that latter group who refuse to receive voluntary treatment.

Third, a Marchman receiving facility could avoid the cost of construction by partnering with and/or expanding other facilities to provide beds when there is a need for inpatient level of care. Interviews and surveys suggest that most inpatient facilities in the county have open beds at most times, which may leave room to set aside some for Marchman admissions. (The prior pilot of a non-jail Marchman facility in the county pursued this partnership model.)

While some hospitals serve as Marchman receiving facilities (as discussed in the Case Studies section below), this is not preferred. Interviewees state that it is best practice for Marchman facilities to not have the incentive of reimbursement for admitting Marchman-Acted individuals into inpatient care. When mobile crisis teams, Marchman evaluators, and inpatient providers of Marchman facilities are all separate organizations, financial incentives to keep individuals in involuntary treatment longer than needed are minimized, as are fears of involuntary commitment from individuals seeking emergency substance use assessment. However, coordinating three separate organizations adds complexity. In other Florida counties (as described below) crisis centers evaluate individuals referred on a Marchman Act but do not provide inpatient treatment. This model of partnership between a crisis facility and an inpatient facility with SUD expertise is likely to best fit Pinellas' existing resources. If multiple services are operationalized under a single provider agency, it will be necessary

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[445] *Elevate Behavioral Health Pinellas County*
[446] Walt et al. (2022)
[447] Patients who are involuntarily committed are 2.2 times more likely to die from an opioid-related overdose then patients who voluntarily commit. See Jain et al. (2018) and Massachusetts Department of Public Health (2016) for more.
[448] For example, trauma from being involuntary commitment in a hospital or carceral setting.
[449] Massachusetts Department of Public Health (2016)

to include contractual benchmarks so that patients are diverted away from inpatient care when it is not needed.

Potential impact

As discussed, there is little research on the impacts of involuntary treatment for a population whose alternative is no treatment at all. However, there are several metrics that Pinellas County could track to measure treatment outcomes and modify operations as appropriate. PCHS and the Marchman operator should analyze the rate at which Marchman Acts are rescinded as well as monitor how frequently the Act is used improperly. More broadly, Pinellas County could potentially expect to observe a decline in individuals with SUD taken to the County Jail, a decline in emergency SUD assessments in hospital emergency departments, and a decline in Baker Acts as people stop using the Baker Act as a stand-in for the Marchman Act.

Implementation considerations

Standards

In addition to SAMHSA's guidelines regarding opioid treatment programs more broadly, some organizations have written standards specifically for involuntary commitment. The National Judicial Opioid Task Force has a list of 11 considerations that court systems should assess before ordering an individual into involuntary commitment, including whether the court personnel are adequately trained, whether the proposed facility has the necessary capacity and resources, and whether committing the individual is the least restrictive means to provide care.[450]

As development of new receiving and treatment settings are being explored, it is important to remain mindful of the spirit of *Olmstead* jurisprudence and the need to operationalize these services close to the individual's community. Implementing a voluntary or involuntary receiving/treatment service that does not create disconnection and is integrated into the community will allow individuals access to their support system and facilitate transition into less intense services to continue their recovery process. It is necessary to operationalize these services in a manner that offers a safe, stabilizing, treating setting. This setting should include opportunities for access to interactions with peers, vocational skill development, and access to green space, along with re-assessment of need and progress toward goals. Lengths of stay should not be excessive and be in accordance with assessed need.

Additionally, the American Psychiatric Association (APA) released a resource document intended to help draft and implement policies related to involuntary commitment. This document covers topics such as ensuring due process, requirements for thorough physical and psychiatric evaluations, and providing medication.[451]

Magnitude of investment

Several components of this recommendation are inexpensive. Law enforcement and first responder training on proper Marchman Act usage (i.e., recognizing when a Marchman Act, Baker Act, or neither is indicated) would be reasonable and relatively simple to implement, costing $500,000 per year or less and requiring minimal additional hiring.

However, expanding crisis services to receive walk-in or voluntary Marchman patients, evaluation capabilities for involuntary patients, and inpatient beds for Marchman-Acted individuals would be a greater investment. There are benefits to walk-in services, namely that individuals experiencing a behavioral health crisis can voluntarily receive a response from practitioners as opposed to law enforcement. Law enforcement can then spend more time on serving and protecting the community.

[450] National Judicial Opioid Task Force (n.d.)
[451] Swartz et al. (2015)

There are benchmarks from other counties that have funded greater levels of Marchman care. Palm Beach County recently costed out a stand-alone full-service behavioral health center; while this operating model is not recommended, the costing exercise contains several relevant comparisons for Pinellas.[452]

While current Marchman Act petition counts were unavailable from Pinellas County Jail, the Palm Beach County benchmark suggests that Pinellas County could expect as many as 300–500 petitions for Marchman Act assessment each year (extrapolated based on population rates).[453]

Since crisis receiving facilities do not currently process Marchman candidates, this capacity would need to be added. If all of these individuals came through a crisis receiving chair for their initial Marchman evaluation (i.e., a "no wrong door" community facility that accepts all referrals for stays of 23 hours or less), Pinellas would only need fewer than five additional crisis receiving chairs under standard assumptions from a leading crisis need calculator (i.e., an average length of stay of 0.8 days, and a targeted occupancy rate of 70%.). [454] Comparisons from other counties suggest that renting these chairs from existing crisis receiving facilities would cost well under $500,000 per year.[455] Subsidizing this care at $1,200/day (the cost of a day of Baker Act care) would cost roughly $500,000 per year.[456]

After an initial 23-hour observation, some Marchman-Acted individuals would need care for the 72-hour duration of the Marchman Act. In Palm Beach, 67% of individuals who had a petition for a Marchman assessment filed were later under petition for involuntary treatment. Under similar standard assumptions for crisis care ($1,200/day cost for a crisis bed, average length of stay of 2.5 days, and a 70% occupancy rate), that would imply a need for fewer than five additional short-term crisis beds. Like the crisis receiving chairs, the cost of renting short-term crisis beds would be well under $500,000 a year. However, the increased length of stay implies a greater cost of care, likely between $500,000 and $1,000,000 each year.

The greatest cost of care for Marchman-Acted individuals would be long-term inpatient care. If half of the individuals who received short-term crisis beds were transitioned to inpatient care, it would cost slightly more than $1 million each year.[457] However, the proportion of Marchman Acts that transition to inpatient is variable and could be lower or higher depending on the partnership between the receiving facility and the inpatient caregivers.

Implementing these leading and emerging practices could require either a new facility or the funding of Marchman beds within an existing one. It could also involve triage and re-assessment of all Marchman admits upon arrival, with options for alternative outpatient services if the Marchman status is rescinded, or in-patient detox programs if the Marchman status is not rescinded. Further information on the staffing and resourcing capacity could be considered as a component of site selection and development.

Operational suggestions

The partnership model that will be crucial to this recommendation is described above, and some examples are detailed in the Case Studies section below.

One consideration that Pinellas County should research more closely (should this recommendation be funded) is walk-in admissions for patients. Stakeholders have expressed interest in enabling walk-in access to a receiving facility. This could reduce improper use of the Act, with on-site screening available. In cases where the Act is being applied directly, it could ease the administrative burden on the person admitting the subject of the Act with staff available to guide people through the paperwork and other associated processes. It could also more easily allow individuals to receive substance use assessment, without requiring detention for transportation to an assessing facility. This operational model would provide an alternative to emergency

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[452] While Palm Beach County has 50% more population than Pinellas, there are also fewer overdoses per capita and likely fewer people experiencing addiction. Thus, Palm Beach numbers could represent a ceiling for Pinellas.
[453] In 2019, Palm Beach County had 392 individuals face petitions for involuntary assessment under the Marchman Act. While Palm Beach County is larger than Pinellas, both counties have similar numbers of Baker Act assessments, suggesting similar needs for "last-resort" crisis care. See O'Brien (2021) and University of South Florida College of Behavioral & Community Sciences (2023) for more details.
[454] Crisis Now (n.d.)
[455] Crisis Now (n.d.)
[456] Crisis Now (n.d.)
[457] Benchmarks from Crisis Now indicate an average cost of $1,200 per day and an average 7.6-day length of stay.

departments, jails, and Baker Act facilities. This walk-in capability could occur with existing community-based crisis centers that offer 23-hour observation.

Furthermore, there are significant reporting requirements for Baker Act cases that were extended to Marchman Act cases in June 2024. As part of the extension, funds were given to the Louis de la Parte Florida Mental Health Institute at the University of South Florida to facilitate data collection for Marchman Act cases.[458] Building on their example, Pinellas County should aim to be seen as a leader in tracking data to enable agile, evidence-based decision-making regardless of whether investment is made in a Marchman Act facility.

Case studies

Marchman implementation in other Florida counties

Other Florida counties have found more consistency and positive results with their Marchman Act procedures, even in cases when their receiving facilities are not local opioid treatment programs.[459] For example, three of Broward County's Marchman receiving facilities are hospitals.[460] Citrus County partners with CSUs and affiliates, sending Marchman patients to a local crisis center when bed space is available, and transfers those patients to an affiliate that offers MAT once the patient has stabilized. Desoto County, which does not have a Marchman receiving facility, sends indigent Marchman patients to an ACTS facility in Tampa. In Sarasota County, a Marchman receiving facility rescreens individuals upon arrival. While fewer than 5% of acts are rescinded, individuals for whom the act is rescinded are referred to the proper level of care.[461]

Involuntary treatment in Washington state

Washington has a similar law to the Marchman Act, known as Ricky's Law. Ricky's Law integrates SUD and mental health involuntary treatment and requires that the individuals subjected to it are evaluated by dedicated behavioral health professionals who determine whether mental health or substance use-related services are more appropriate. If SUD care is appropriate, individuals are placed in dedicated Secure Withdrawal Management (SWMS) facilities for initial detoxification, where they are involuntarily held for up to 120 hours.[462] After that 120-hour period expires, individuals are either discharged without a hearing, discharged on a less-restrictive alternative treatment order, allowed to stay voluntarily, or ordered to an additional 14-day inpatient treatment. The average stay is typically under two weeks. Ricky's Law is not exclusive to OUD but encompasses all cases of SUD. Available data from Q2 2020 indicates that alcohol use disorder accounts for almost half of all admissions, though this proportion may have shifted in the time since.

In 2023, the Washington State Institute for Public Policy published a report examining the difference in outcomes between individuals committed to SWMS facilities, and individuals who received voluntary detox services. The report found that SWMS clients were less likely to receive SUD treatment, experience homelessness, be treated in an ED or be hospitalized, and receive any state financial supports in the six months following their treatment. The report also found that, compared to the voluntary detox group, SWMS returns $0.19 per dollar. This indicates that involuntary treatment may be effective, but, when compared to voluntary SUD treatment in Washington, it is not cost-effective.[463]

Given the lack of a literature consensus on involuntary treatment (discussed in the Description section directly above), these two case studies may be limited in the ability to support a systemic decision.

[458] Ash (2024)
[459] Broward, Citrus, and Desoto County websites; EY interviews
[460] Broward Behavioral Health Coalition
[461] EY interviews
[462] Greenberg (2020)
[463] Miller, M., Spangler, M., Adams, N. & Grob, H. (2023)

Recommendation 13. Construct a social center for the recovery community

Gaps addressed	
L5	People with lived experience report several barriers to behavioral health treatment, most notably wait times, high costs, and low quality.
E3	Pinellas County needs more social and communal spaces for individuals recovering from OUD to congregate.
E7	Individuals with OUD have trouble finding employment, and those who are employed may not receive employer support as part of their treatment and/or recovery experience.

Context

Pinellas County needs more social and communal spaces for individuals recovering from OUD; there is only one peer respite center and one accredited Clubhouse in Pinellas County. Opening additional clubhouses or similar centers could provide structured social spaces for those in recovery from mental illness or SUD and could provide gateways to jobs and a structured path for reintegration into the community.

Individuals in recovery also struggle to find employment and report gaps in employer support for their treatment and/or recovery experience. Many jobs that people in recovery find through employment services are contract jobs for manual labor, which carry risk of relapse due to physical toll and frequently lack insurance benefits. Clubhouses and similar recovery spaces typically include employment supports; such a model is described in more detail in the section that follows. Lastly, social spaces can double as treatment centers, alleviating access barriers to behavioral healthcare. Co-locating behavioral health services and career services in a welcoming, community-based environment can create an ecosystem that encourages care, and the wraparound supports of employment and community.

Description

Clubhouse model with employment supports

This recommendation suggests building an additional clubhouse, potentially near an OUD treatment facility. As with Pinellas' existing clubhouse, it will incorporate needed employment support.

The clubhouse model provides structure and social support, encouraging independence and community simultaneously by allowing members to fulfill roles in keeping the clubhouse operational. While the existing clubhouse in Pinellas County experienced a decline in membership after COVID-19, stakeholders perceive that a new clubhouse could still reach strong membership if it was placed near a clinical setting that attracts individuals with OUD.[464] As any new clubhouse is unlikely to solely focus on individuals with OUD (and is likely to include others, such as people with mental health diagnoses but no SUD), this placement will help target the recommendation towards the population with OUD.

Clubhouses often provide three tiers of employment support: transitional employment (TE), supported employment (SE) and independent employment (IE).[465] Any new clubhouse should incorporate all of these levels of support:

- TE provides clubhouse members with shorter-term (typically nine months or less) positions working for employers with whom the clubhouse has an established relationship. The employer opens a role to the clubhouse, who then assigns a member to fill the role. The clubhouse typically guarantees coverage by staff or another member in case of absence and is typically involved in training and ongoing support. This arrangement can be particularly useful in helping justice-involved individuals gain employment, as TE does not typically require background checks.

[464] EY interviews and research
[465] McKay et al. (2016)

- SE consists of full or part-time permanent roles. The clubhouse will often have a relationship with the employer in these arrangements, but the role is not opened to the clubhouse specifically. Instead, members undergo a competitive interview process and are hired by the employer. The clubhouse then provides on and off-site support as requested by the member.
- IE does not involve a relationship between the clubhouse and the employer. Instead, members go through a fully competitive interview process. This type of employment also precludes on-site support, but off-site support from the clubhouse is available to members in IE roles.

Alternatives to further increase the impact of a clubhouse

While co-located behavioral health services are beyond the scope of a typical clubhouse, there may be opportunity to integrate them into a clubhouse-style environment along with social, educational, and vocational supports (e.g., SUD/OUD peer group). This could create an all-in-one setting that enables easy access to behavioral health services, which residents in Pinellas County indicate can be expensive, hard to get into, and low quality. Bundling behavioral services with other clubhouse amenities could create a welcoming, comfortable environment that holistically supports its membership.

Co-locating behavioral health services could create significant additional complexity, and the broader recommendation should not be discarded if co-located services are not feasible. Community and vocational supports are valuable in and of themselves. If co-located services are not feasible, though, the center could provide linkages to community partners who do offer those services (which is standard practice under a clubhouse model).

Potential impact

If program utilization matches the existing Pinellas County clubhouse, it could be expected to serve 30–50 people in recovery each year. Qualitatively, creating a clubhouse could lead to an increase in job placements for individuals with OUD. Clubhouse operators should measure employment outcomes accordingly (directly and indirectly) across placement types, levels of independence, housing support needed by clubhouse members, or other like metrics.

Research supports the specific impact of clubhouses and employment supports. One study found that 45% of individuals were employed after participating in a clubhouse program, compared to only 34% of sampled individuals who were not in a program.[466] Additionally, clubhouse program members spent less time in the hospital (39 months vs. 50 months) than individuals referred to other services, with only 28% needing to be re-hospitalized after nine months.[467]

Several studies report the importance of employment supports, though they are not specific to clubhouses.

- TE has demonstrated improved employment and earning outcomes. For example, participants in transitional programs in Indianapolis, Syracuse, and Los Angeles were all at least 30% more likely to be employed in the first year than non-participants, and made an average of $3,150, $961, and $2,270 more, respectively.[468]
- SE for individuals with severe mental illness has shown that participants were 1.8 times more likely to be competitively employed, spent more time in competitive employment, and had greater income than individuals did not have supported employment.[469]
- Full employment is often considered an important step for individuals recovering from OUD and can help reduce symptom preoccupation, social isolation, and economic instability. In fact, it is estimated that employment accounts for about 40% of all social determinants of health.[470]

[466] McKay et al. (2016)
[467] McKay et al. (2016)
[468] Cummings & Bloom (2020)
[469] Frederick & VanderWeele (2019)
[470] Mumba et al. (2022)

There is no specific research about the effects of co-locating behavioral health services in a clubhouse because that would be a novel practice, but treatment outcomes could be easily measured.

Implementation considerations

Standards

While the new clubhouse would not need to be certified by Clubhouse International, it could follow the Clubhouse International standards. These standards ask affiliate clubhouses to follow guidelines in eight areas: membership, relationships, space, work-ordered day, employment, education, functions of the house, and funding, governance, and administration. For example, all clubhouses must engage both staff and members in daily tasks required to run the clubhouse, with the intention of building self-worth, confidence, and purpose rather than job-specific training; however, all member participation is entirely voluntary.[471]

Magnitude of investment

Implementing a center as described above could require procuring a space, hiring and training staff, building a membership base, and partnering with local employers to build employment support infrastructure. The Clubhouse International guide to starting a clubhouse notes that a fully functioning clubhouse with average daily attendance would need $500,000 annually.[472] A new-construction clubhouse would likely require several hundred thousand dollars more. Costs could come down if there are little capital or renovation costs associated with building the clubhouse, or if members could assist in construction.

Incorporating co-located behavioral health services could further increase the resources and time estimated, as doing so could functionally require opening and maintaining a new behavioral health clinic that is co-located within the clubhouse.

Case studies

Yahara House in Madison, Wisconsin

Yahara House in Madison, Wisconsin, is an example of a clubhouse with the three levels of employment support described above. Transitional employment placements, in partnership with local employers, do not require resume reviews, and consist of part-time roles ranging from four to 20 hours per week. After transitional employment, Yahara House supports members through supported employment. Here, Yahara House helps members source roles, prepare for interviews, and supports retention. Job coaches are available both on and off-site. Finally, members can graduate to independent employment. Members in this stage source and acquire their own roles but can access support upon request. In 2021, Yahara House placed 43% of their members into the workforce.[473] In addition to supporting employment, Yahara House members and staff work together to run the clubhouse, and the clubhouse provides recreational and social programming. Yahara House does not offer co-located behavioral health services.

Adolescent Recovery Clubhouse, Prince George County, Maryland

Prince George County (MD) has an Adolescent Recovery Clubhouse is a Clubhouse open to youth aged 12–17 with history of SUD and a demonstrated desire to begin the recovery process (through past treatment referral). The Clubhouse is a non-clinical setting aiming to aid its young members in their recovery journeys. The Clubhouse offers case management, support groups, tutoring, computer labs, GED and college prep, vocational training, job readiness coaching, evidence-based life skills programs, and field trips. Overall, the program aims to empower youth in recovery with life skills while maintaining a safe and communal environment.[474]

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[471] Clubhouse International (2019)
[472] Clubhouse International (2016)
[473] More recent data not available
[474] Prince George's County (n.d.)

Faith-based organizations in Hamilton County, Ohio

Faith-based organizations are engaged in other counties around the country, such as in Hamilton County, Ohio (home to Cincinnati). In Cincinnati, faith-based organizations actively provide OUD-related educational programming, building acceptance in their congregations towards OUD.[475]

[475] Practice reported by interviewee in leadership role in Hamilton County

Recommendation 14. Create new community support teams that focus specifically on substance use disorders

Gaps addressed	
C1	Sustained impact from quick-response teams (QRTs) is low, as providers report reaching very few individuals for follow-up treatment after QRT involvement.
L4	Assertive Community Treatment (ACT) teams, which provide high levels of in-home care, are under-resourced in Pinellas County.

Context

Pinellas County currently provides community support treatment through three Assertive Community Treatment teams. These ACT teams are tasked with providing comprehensive support for behavioral health through intensive and integrated treatment. Though ACT teams typically prioritize individuals with chronic behavioral health conditions, they also have shown some benefits in working with populations that have SUD. ACT teams are particularly known for working with hard-to-reach populations, since the teams typically meet their clients at their own homes. These teams have positive effects on continuity of care, and especially treatment like counseling or medication that needs to be consistent.

In Pinellas County, there are some limitations of how ACT teams interact with individuals with SUD. The small number of ACT teams creates waitlists and overburdens existing teams. Stakeholders believe that the ACT teams in Pinellas County are underfunded and overwhelmed trying to meet demand, with lower staff-to-client ratios than clinical recommendations. However, stakeholders also believe that ACT care may be overwhelming for some individuals with SUD, and that many of them may be better served by a less-intense community team that has fewer interactions with clients than ACT teams but more than typical case managers.

Description

Adding one or two community support teams (CSTs) that primarily focus on substance use — with mental health as a crucial but secondary component — would be an innovative investment for Pinellas.

Few CSTs around the country focus on substance use. Most of these teams follow a modified ACT model and primarily focus on mental health conditions. However, a CST could work more efficiently with individuals with SUD if team staff were specialized, including addiction specialists, housing specialists, and case managers. Creating these CSTs could serve people with OUD in a more specialized way, delivering dual-diagnosis and/or SUD-focused supports while freeing up non-specialized ACT staff to focus on other populations.

CSTs could implement some strategies used by QRTs in Pinellas as well. Instead of working with clients who come out of the justice system or emergency care (as QRTs do), these CSTs could work with clients who are transitioning out of residential treatment or detox. Community Support teams could provide in-reach prior to discharge to facilitate engagement and continuity of care. Supports could include SUD/OUD treatment, transitional housing support, and linkage and referral to other services.

Alternative methods of supporting community-based teams

Pinellas County could increase the number of existing ACT teams. These expanded teams would not be focused on OUD but could work to reduce ACT waitlists for individuals with a mental health and/or SUD and lead to greater service access for some people with OUD.

Current waitlists for ACT treatment in Pinellas County are fewer than 100 individuals long, and thus could be served by a single full-fidelity team of 10 staff supporting 100 clients. However, the process of getting on the waitlist is complex and requires receiving behavioral health services from specific providers. Stakeholders believe that there are several hundred individuals who could benefit from frequent care but are not currently connected to services. Some of these individuals would benefit from SUD-specific ACT care.

One outside benchmark suggests that local ACT teams should have the capacity to serve 0.06% of an area's adult population.[476] In Pinellas County, that would consist of 400–500 individuals, or four to five fully staffed, full caseload ACT teams. One or two additional teams would allow Pinellas to meet that minimum standard.

The sponsors of ACT teams could also reimagine the process to become eligible for receiving ACT services. Currently, ACT team eligibility is based on whether an individual has interacted with a certain subset of behavioral health providers. If Recommendations 2 or 7 are implemented, a technology platform could be in place allowing referrals from a broader array of provider organizations and subsequent eligibility determination. Eligibility could be determined through the standards described below (DACTS/TMACT). These technologies could provide a more comprehensive view into individuals eligible to receive ACT treatment.

Potential impact

If implemented, this recommendation could lead to increased delivery of behavioral health services for several individuals with OUD. These CSTs could identify individuals who would benefit from an ACT level of care and those who could be supported at a less-intense level of care. While there are no nationally identified benchmarks for outcome metrics for CSTs, the oversight agency should identify key performance measures (e.g., numbers served, length of enrollment, in-person contacts, re-admission rates). There are national outcomes indicating positive benefits for ACT care. The small number of randomized controlled trials for ACT teams show consistent progress toward long-term recovery (for example, one study showed that the median ACT patient who began treatment in active use showed evidence of reduced substance use for at least a month after three years of ACT treatment).[477]

While some "integrated" ACT teams have substance use treatment components, they are not common practice. The effects of integrated ACT teams on SUD treatment initiation and retention are also understudied. One study from 2011 examined four randomized controlled trials measuring the effects of ACT teams on substance use and found that ACT team participation led to significant decreases in substance use, though not more than a control group receiving case management services without an ACT team.[478] This finding implies a spot in the CoC for these smaller CSTs that merge SUD services and case management. Since there are large gaps in case management services in Pinellas, there may be an opportunity for CSTs to become the most efficient delivery mechanism for SUD treatment.

Implementation considerations

Standards

These CSTs should be guided by the relevant externally validated standards for ACT care such as the DACTS fidelity scale or the TMACT. [479, 480] Of course, not all standards will be applicable for a smaller and lower-touch team. Standards that are likely to still be relevant include maintaining an <20% level of team turnover and employing nurses on teams.

Leading practices for ACT team expansion typically include capping caseloads at 100 clients per 10-member team, or 10 clients per team member. Some ACT teams include peer specialists, though they are often in high demand.

An example of implementation of a CST with agency requirements and standards of operation is found in the State of Georgia, Department of Behavioral Health and Developmental Disabilities provider manual.[481]

[476] Cuddeback et al. (2006)
[477] Essock et al. (2006)
[478] Fries, H. P., & Rosen, M. I. (2011)
[479] Teague et al. (1998)
[480] Monroe-Devita et al. (2011)
[481] Georgia Department of Behavioral Health & Developmental Disabilities (2025)

Magnitude of investment

As with other emerging practices, Pinellas County would have few benchmarks when creating a SUD-specific team. Funders would likely have to coordinate heavily with existing ACT team sponsors to limit service duplication and to share leading practices.

If piloting CSTs that offer services at a lower frequency than ACT teams but a higher frequency than case managers or QRTs, Pinellas should identify a behavioral health provider agency with access to the target population, preferably in an area of the county that has high need as evidenced by discharge/admission rates. This behavioral health provider should have the ability to support the CST staffing needs and develop policy and procedures for oversight and operations.

If expanding formal ACT teams, stakeholders would likely need to consistently work on developing a plan for how to distribute limited ACT resources without overburdening the clinical workers on each team. Each full 10-person team with special expertise in substance use would likely take multiple months to implement and would be a resource-intensive investment costing $1 million/year or more. Allocation of funds to support ACT team expansion should factor in areas of need as evidenced by discharge/admission rates.

Operational considerations

There may be opportunities to use this CST to deliver MAT. Mobile MAT is legal with buprenorphine, though not with methadone. These teams could incorporate the relevant staff to deliver buprenorphine, following existing best practices for home-visit MAT.

Case studies

Combined ACT and Integrated Dually Diagnosed Treatment Teams

Many ACT teams partner with Integrated Dually Diagnosed Treatment teams (IDDT teams), both of which have demonstrated efficacy independently. One study of chronically homeless adults (in an unpublished location) with co-occurring mental health and SUD found improvements in mental health and residential stability after six months in an ACT/IDDT program. Importantly, these researchers did not track long-term outcome metrics, but the short-term improvements are a positive signal.[482] In some states, ACT team members become trained in IDDT techniques and principles and incorporate these tools into their delivery of services and supports for the population of dually diagnosed individuals served.

[482] Young et al. (2014)

Recommendation 15. Create additional behavioral health services in the style of Certified Community Behavioral Health Clinics

Gaps addressed	
S6	Affordability is a barrier to accessing care, especially for the uninsured and underinsured.
C5	Treatment centers are not consistently providing co-located co-occurring treatment for comorbidities.
L5	People with lived experience report several barriers to behavioral health treatment, most notably wait times, high costs, and low quality.

Context

Pinellas County needs comprehensive behavioral health solutions that extend to co-occurring treatment. Providers and residents echo that sentiment, as the most preferred practice in the constituent survey was a "24/7 behavioral health clinic."

Certified Community Behavioral Health Clinics (CCBHCs) are an example of those clinics. The comprehensive nature of CCBHCs addresses the gap of limited co-occurring treatment. Several leading practices related to CCBHCs demonstrate that it is possible to run those clinics with no waitlists for services. Those practices can remediate the gap in which 62% of surveyed individuals with lived experience and caretakers identified waitlists as a common barrier to receiving behavioral health treatment.

Pinellas County has one CCBHC, which is sponsored by the Suncoast Center. The center's services are targeted at individuals with behavioral health disorders, and currently serve over 6,600 of those individuals.[483] That scale implies the center likely treats several hundred individuals with co-occurring SUD. The CCBHC is in a rapidly changing funding environment, and it is important to maintain continuity of services for their population with SUD and OUD. The current funding environment exists because the Suncoast clinic, like most CCBHCs, is funded by the Centers for Medicare and Medicaid Services (CMS) through a demonstration waiver process. The demonstration process does not offer permanent funding; Suncoast would need to receive an extension of this waiver to continue CCBHC funding in perpetuity.

While the existing CCBHC has not publicly tracked many impact metrics for individuals with OUD, stakeholders believe that it offers important services.[484] There are barriers to addiction treatment centers in Pinellas County adding behavioral health as a core competency, and vice versa; only ~25 of the ~55 behavioral health facilities and services tracked in the inventory of services have DCF certifications for addiction-related services.[485] For example, while the existing CCBHC offers in-house mental health services, it contracts all SUD treatment to the third-party provider Operation PAR. The lack of co-occurring competent care on site means that there can be gaps in treatment and case management.

Description

Opening a second CCBHC would likely require significant financial support from the state or CMS. No county has opened a CCBHC by themselves, though states like Texas have self-funded CCBHCs.

Instead, Pinellas County could fund one or several components of the CCBHC model that best fit the county's gaps, such as using shared environments like CCBHCs to facilitate broader behavioral health screening. Additionally, while CCBHCs are required to provide co-occurring treatment, that treatment can be done through partnership with third-party providers. As a result, these facilities do not always meet the benchmarks (i.e., fully in-house, comprehensive, integrated care[486]) for the best practice of co-occurring disorder competency. Rather than increasing the number of CCHBCs, Pinellas County could expand the number of

[483] EY interviews and research
[484] EY interviews
[485] The inventory of services may not include the full exhaustive list of behavioral health facilities in Pinellas County since some smaller facilities/providers may not have been captured.
[486] Substance Abuse and Mental Health Services Administration (2020)

services provided at the existing CCBHC to incorporate both SUD and mental health treatment in one location instead of through third-party partnerships. It should be noted that this Report did not include research into existing services at the existing CCBHC, which considers itself to be a co-occurring disorders provider. Further analysis would be required to identify whether additional in-house services are necessary.

Potential impact

Local impact metrics from the existing CCBHC are not available, but several other states have reported positive results from their CCBHC demonstrations. For example, CCBHC clients use emergency department services (upwards of 20% reduction during the Oklahoma demonstration) and inpatient care (54% decrease in New York, resulting in a 27% decrease in overall costs) far less.[487] States with low MAT utilization have seen it increase, with New Jersey doubling the number of clients receiving MAT within a year.

The results from Pinellas County's CCBHC could be compared to these national benchmarks, which are published by CMS and their research partners. Other key performance indicators could include rates of initiation and follow-up for care as well as several external factors such as the rate of transitioning into stable housing from homelessness.

Implementation considerations

Standards

SAMHSA requires all CCBHCs to provide nine core services, either directly or through partnerships: (1) crisis services, (2) outpatient mental health and substance use services, (3) person- and family-centered treatment planning, (4) community-based mental health care for veterans, (5) peer family support and counselor services, (6) targeted care management, (7) outpatient primary care screening and monitoring, (8) psychiatric rehabilitation services, and (9) screening, diagnosis, and risk assessment.[488] Pinellas County can leverage the CCBHC operator checklist from SAMHSA when seeking certification.[489]

Additionally, SAMHSA's guidelines for co-occurring disorder treatment could provide insight as Pinellas County improves CCBHC services. These include principles such as treating mental illnesses and SUDs concurrently and with multidisciplinary medication as needed, offering addiction counseling, and training providers in the treatment of both mental illnesses and SUDs.[490]

All CCBHCs are required to report the number of clients who receive care within 10 business days, which is the national standard for wait times.[491] As of 2024, 65% of CCHBCs in the United States were able to see patients for routine needs within one week of initiation, and 81% served their median patients within 10 days. Additionally, 53% could provide MOUD within one-to-seven days.[492] CCBHCs in Pinellas should seek to follow these standards.

Magnitude of investment

Expanding existing CCBHC services to integrate treatment for co-occurring disorders potentially costs less than $500,000 per year and could be easier to implement than constructing a new facility. Implementing other CCBHC components would require partnering with the county's existing CCBHC to cost out those services. That said, the capital requirements for this recommendation could be much larger if the CMS demonstration period ends without further funding.

Opening new brick-and-mortar CCBHC clinics are likely to be capital-intensive (likely cost at least $5 million per year or more) and could take years to operationalize. A recent benchmark for costs is a new coordinated receiving facility in Escambia County, which cost $5.4 million to construct and operationalize. The broader

[487] All statistics from National Council on Mental Wellbeing (2022)
[488] Substance Abuse and Mental Health Services Administration (2023)
[489] Substance Abuse and Mental Health Services Administration (2023)
[490] Substance Abuse and Mental Health Services Administration (2020)
[491] National Council for Mental Wellbeing (2024)
[492] National Council for Mental Wellbeing (2024)

array of services at a CCBHC, and the increased cost of labor in Pinellas County, suggest that a new CCBHC is likely to be more expensive than the benchmark.[493]

Operational suggestions

If this recommendation is funded, stakeholders could work closely with existing CCBHC operators to research which services should be integrated into one facility, and which could be performed by third-party providers. Pinellas would need to address these key questions prior to funding a new CCBHC or expanding existing CCBHC services in the county.

- Can the success of CCBHCs be deconstructed if third-party clinics perform part of their services?
- Or, are CCBHCs more successful when comprehensive services are offered in one location?

Case studies

No other abatement funds have publicly directed money to CCBHCs, since they are primarily under the oversight of CMS. Some jurisdictions have specified that CCBHCs are not eligible for funds, like Washoe County (NV).[494] There are several case studies showing positive results from CCBHCs, as discussed in the *Impact* section.

[493] Lakeview Center (2024)
[494] Washoe Opioid Abatement and Recovery Fund (WOARF) Plan 2023-2025, n.d.

Recommendation 16. Enhance Quick Response Teams

Gaps addressed	
C1	Sustained impact from quick-response teams is low as providers report reaching very few individuals for follow-up treatment after Quick Response Team involvement.

Context

Pinellas County's QRTs underperform benchmarks. Both of Pinellas' teams contact a high number of individuals who have recently overdosed, but they struggle in converting those contacts into treatment. Whereas Pinellas County has historically helped about 10% of individuals reach treatment after contact, peer counties have seen treatment initiation rates above 30%. This suggests an opportunity for Pinellas County to improve the operational effectiveness of its QRTs.

Description

Pinellas County should invest in a focused study of why the operational effectiveness of their QRTs is low. The results of that study may indicate opportunities for later improvement, transformation, or expansion.

The research is also likely to offer insights into how to improve contact rates, treatment linkages, and access to services, drawing on successful models from other jurisdictions. Some emerging practices may increase treatment induction rates, such as employing peer specialists on QRTs, expanding inbound referral sources to QRTs, and established proactive outreach for at-risk individuals. Since Pinellas QRTs attempt to contact 300–500 individuals a year (in total), improving operations to meet peer benchmarks described below could result in 100+ more referrals to treatment each year.

Potential impact

If Pinellas County could achieve the treatment initiation rates of Hamilton County QRT contacts and the treatment retention rates of Houston QRT contacts (described in Case Studies section below), Pinellas County could expect to see more than 100 individuals enter treatment each year, several dozen of whom could be expected to remain in treatment.

Entering treatment creates durable outcomes in the long term. For example, long-term MOUD usage with methadone or buprenorphine lowers mortality rates by 50% compared to untreated patients,[495] and each additional month on these medications reduces nonprescription opioid use by 17% and 25%, respectively.[496]

Implementation considerations

Standards

Sustained impact from QRTs in Pinellas County is low. Before deciding on a strategy to improve operational efficiency in the QRTs, an impartial county agency should conduct a needs assessment to define the shortcomings relative to benchmarks. This could be a short assessment conducted by a researcher or a small team and would likely cost the county under $500,000. One place to begin this study is confirming that Pinellas' existing QRTs meet basic operational standards. While there are not wide standards for QRTs, Overdose 2 Action experts have socialized five traits of successful QRTs.[497] These tenets include benchmarking immediate outcomes like response times, engagement rates, and referral rates, as well as building evidence-based models for what local factors create conditions of success for each QRT.[498]

[495] Mancher & Leshner (2019)
[496] Jiang et al. (2024)
[497] Cordata Health (2022)
[498] Cordata Health (2022)

Magnitude of investment

A needs assessment may introduce other potential practices for the QRTs. Most emerging and leading practices for QRTs are fairly inexpensive but could be scaled if the number of QRTs grew. These practices are described in more detail in the Case Studies section below.

Integrating peer specialists more fully into QRTs could be a well-received practice but would pull from the already-small pool of potential peers while likely costing roughly $100,000 per employed peer per year, as discussed in Recommendation 3.[499]

Expanding the inbound referral sources to QRTs and broadening the network of organizations and professionals that refer individuals in crisis to QRTs could help address the gap of poor effectiveness of QRTs by establishing that individuals in crisis receive access to treatment. This strategy could require minimal investment, likely costing less than $500,000 per year, and could be easily implemented through existing support channels and local organizations.

Implementing proactive outreach strategies could help identify and connect with at-risk individuals for early support, which could reduce calls for QRT services in hotspot areas and increase QRT capacity in the long-term. There are no public cost estimates for this strategy, but an expansive proactive outreach structure that partners with several large organizations could require investment of up to $500,000 per year.

Case studies

Team construction in Hamilton County, Ohio

Some county-run QRTs integrate multiple emerging practices in the communities in which they serve. In Hamilton County,[500] which has a high treatment initiation rate among people contacted by QRTs (nearly 80% between 2015 and 2019),[501] they have implemented all three emerging practices mentioned above. QRTs in Hamilton include a diverse array of backgrounds. Typical teams are three-to-four people, with at least one peer specialist and one non-uniformed police officer. Hamilton QRTs also benefits from a wide variety of inbound referrals, both from traditional sources like law enforcement and emergency services, but also public health entities and community-based organizations. Finally, Hamilton County conducts specific proactive outreach to overdose hotspots. While Pinellas has a similar concept in place, Hamilton's is unique in that it targets both geographic hotspots and demographic hotspots. For example, Hamilton recently adopted specific outreach toward African American males, following a cluster of overdoses in that cohort.

Some QRTs highlight proactive outreach through the police department as a precursor to peer support. This practice may be particularly relevant to Pinellas given that one of its two QRTs receives referrals from the justice system.

Hamilton County tracks individuals receiving treatment via billing records, which means that they are likely to capture more individuals receiving treatment than Pinellas County. They also track the number of individuals receiving any recovery support services, which is a much larger number than those who receive treatment (since many successfully contacted individuals are not ready to begin treatment). However, the discrepancy between Hamilton County's figure of 38% of all individuals receiving treatment[502] and Pinellas' 5% (blended average of QRT A and QRT B) is likely too large to explain by data collection practices alone.

Hamilton County's QRT has several operational advantages over Pinellas'. Hamilton's QRT has the capacity to keep in contact with clients who are not initially ready to begin treatment. In these cases, Hamilton's team refers individuals to harm reduction services,[503] keeping them in the county's system of care until the individuals are ready for care. (However, individuals are not tracked as "receiving care" until they access a billable clinical service.) In contrast, QRT A in Pinellas County registered fewer than five referrals to harm reduction services, though this may be an undercount as these referrals are not comprehensively tracked.

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[499] This is an estimate; final numbers will depend on the total number of hired positions.
[500] Manchak et al. (2022)
[501] Firesheets et al. (2022)
[502] 58% contact rate * 66% treatment induction rate for successfully contacted individuals
[503] These referrals are included in the 66% figure.

Another operational advantage is in Hamilton's team composition. Hamilton's QRTs typically consist of law enforcement and peer specialists and can include EMS members as well. QRT A in Pinellas, which is the only one that makes in-person contact, does not have a law enforcement or EMS presence. Interviewees from outside the law enforcement community have stated that law enforcement may be hesitant to participate because standard practice for QRTs is to use nonuniformed police officers. These interviewees have said that Pinellas County law enforcement agencies prefer not to contact constituents out of uniform but noted that these agencies may be more willing to participate in QRTs if they could be credibly convinced that officers would be eligible for worker's compensation if they were injured while out of uniform. Interviewees also noted that EMS professionals in Pinellas County are hesitant to participate in QRTs without law enforcement present.

Law enforcement partnerships in Houston

In Houston, police departments can proactively contact individuals who have recently overdosed. Although this authority comes from the police's arresting power, they instead reach out and offer an optional referral to treatment. The police focus on individuals who have been recently revived with a naloxone intervention. In one illustrative year, 33% of individuals contacted were referred to treatment. For most individuals, that treatment consisted of MAT. More importantly, over half of those individuals remained in treatment for at least 90 days, and there were no observed overdoses or deaths in that 90-day period among the 33% who had started treatment — even if they were no longer in treatment.[504]

[504] Langabeer et al. (2020); Yatsco et al. (2020)

Conclusion

There is hope in Pinellas County as the next chapter unfolds in addressing the opioid epidemic. Recent reductions in fatal overdoses are a testament to the collective leadership of local government, community organizations, and residents. As the Opioid Abatement Funding Advisory Board and the Board of County Commissioners allocate opioid abatement settlement funds in the coming years, strategic investments should reinforce this trend. Individuals on their recovery journeys will see enhanced connections, services, access, and support. This Report should support this mission by providing foundational insights and actionable recommendations, supported by detailed research conducted in and around Pinellas County and informed by representative community voices.

The recommendations provided in this report span the CoC and include advocating for the growth of programs that show success in Pinellas County, adoption/adaptation of leading practices to meet local needs, and exploration of innovative solutions. Community stakeholders played a pivotal role, emphasizing the necessity for systemic transformations and pinpointing key factors that will enable these recommendations. Among the proposed strategies are:

- Enhancing access to safe, quality housing for individuals in recovery, enabling a stable foundation for their journey
- Improving care coordination and data management at the individual level, fostering a more personalized approach to recovery
- Broadening the reach of peer specialist support, offering the invaluable guidance of those who have walked similar paths
- Extending harm reduction initiatives across the CoC, with a focus on equipping medical providers with the necessary training
- Establishing long-term funding mechanisms to maintain the continuity of opioid use disorder care
- Reorganizing the coordinating body to create a centralized authority for abatement efforts
- Advancing the capability for system-level data sharing, promoting transparency and collaboration

These recommendations represent a comprehensive roadmap to meet the diverse and varied needs of the community. Implementation of these initiatives should be approached with necessary planning and evaluation, considering factors such as feasibility, cost-effectiveness, target populations/demographics, and potential for measurement to determine success.

As Pinellas County is preparing to make investments that will affect all residents impacted by opioids, either directly or indirectly, the insights and analyses provided by this Report can serve as a starting point for consistent understanding. The county's leadership, with its commitment to the wellbeing of its residents and focus on addressing the opioid epidemic, is set to embark on a path of informed action.

Appendix

Appendix

Appendix A: Literature review and citations

Key sources

Leading practices compendiums

Barnett, M. L., et al. (2020). *Evidence based strategies for abatement of harms from the opioid epidemic*. Legal Action Center. https://www.lac.org/assets/files/TheOpioidEbatement-v3.pdf

Centers for Disease Control and Prevention. (2024). *Overdose Prevention*. https://www.cdc.gov/overdose-prevention/?CDC_AAref_Val=https://www.cdc.gov/drugoverdose/pdf/pubs/2018-evidence-based-strategies.pdf

National Governors Association & O'Neill Institute for National & Global Health Law. (2023). *Implementing best practices across the continuum of care to prevent overdose: a roadmap for governors*. National Governors Association. https://www.nga.org/wp-content/uploads/2023/08/2023Aug_Roadmap_Best_Practices_Prevent_Overdose.pdf

Peterson, F, et al. (2022). Overdose prevention in community corrections: an environmental scan. National Council for Mental Wellbeing. https://www.thenationalcouncil.org/wp-content/uploads/2022/02/Community-Corrections-Environmental-Scan-22.02.15_Final.pdf?daf=375ateTbd56

Substance Abuse and Mental Health Services Administration. (2023). *Opioid – overdose reduction continuum of care approach (ORCCA) practice guide 2023*. https://store.samhsa.gov/sites/default/files/pep23-06-01-001.pdf

White, et al. (2020). *The ASAM national practice guideline for the treatment of opioid use disorder: 2020 Focused Update*. American Society of Addiction Medicine. https://sitefinitystorage.blob.core.windows.net/sitefinity-production-blobs/docs/default-source/guidelines/npg-jam-supplement.pdf

Academic articles

Allen, S.T., O'Rourke, A., Johnson, J.A., et al. (2022). Evaluating the impact of naloxone dispensation at public health vending machines in Clark County, Nevada. *Annals of Medicine, 54*(1):2692-2700. https://doi.org/10.1080/07853890.2022.2121418

Alpert, A., Powell, D., & Pacula, R.L. (2018). Supply-Side Drug Policy in the Presence of Substitutes: Evidence from the Introduction of Abuse-Deterrent Opioids. *American Economic Journal: Economic Policy, 10*(4):1-35. https://doi.org/10.1257/pol.20170082

Arendt, D. (2023). Expanding the accessibility of harm reduction services in the United States: Measuring the impact of an automated harm reduction dispensing machine. *Journal of the American Pharmacists Association, 63*(1):309-316. https://doi.org/10.1016/j.japh.2022.10.027

Aronowitz, S.V., Engel-Rebitzer, E., Dolan, A., et al. (2021). Telehealth for opioid use disorder treatment in low-barrier clinic settings: an exploration of clinician and staff perspectives. *Harm Reduction Journal*, 18:119. https://doi.org/10.1186/s12954-021-00572-7

Bagnall, A., South, J., Hulme, C., et al. (2015). A systematic review of the effectiveness and cost-effectiveness of peer education and peer support in prisons. *BMC Public Health, 25*(15). https://doi.org/10.1186/s12889-015-1584-x

Bartholomew, T.S., Feaster, D.J., Patel, H., et al. (2021). Reduction in injection risk behaviors after implementation of a syringe services program, Miami, Florida. *Journal of Substance Use and Addiction Treatment,* 127:108344. https://doi.org/10.1016/j.jsat.2021.108344

Bascou, N.A. et al. (2022). Reducing the stigma surrounding opioid use disorder: evaluating an opioid overdose prevention training program. *Harm Reduction Journal,* 19:5. https://doi.org/10.1186/s12954-022-00589-6

Baumann, S. L., & Samuels, W. E. (2022). Comorbidities in older adults with opioid use disorders. *Journal of the American Association of Nurse Practitioners*, *34*(12), 1280–1288. https://doi.org/10.1097/JXX.0000000000000801

Beauchamp, G.A., Cuadrardo, H.M., Campbell, S., et al. (2021). A study on the efficacy of a naloxone training program. *Cureus,* 13(11). https://doi.org/10.7759/cureus.19831

Bennett, A. S., & Elliott, L. (2021). Naloxone's role in the national opioid crisis-past struggles, current efforts, and future opportunities. *Translational research: the journal of laboratory and clinical medicine, 234*:43–57. https://doi.org/10.1016/j.trsl.2021.03.001

Bond, G.R. Drake, R.E., & Campbell K. (2017). Effectiveness of individual placement and support supported employment for young adults. *Early Interv Psychiatry*, 10(4):300-307. https://doi.org/10.1111/eip.12175

Booske, B.C., Athens, J.K., Kindig, D.A., et al. (2010) Different Perspectives for Assigning Weights to Determinants of Health. [Working Paper]. *University of Wisconsin Population Health Institute*. https://www.countyhealthrankings.org/sites/default/files/differentPerspectivesForAssigningWeightsToDeterminantsOfHealth.pdf

Bradford, W.D. & Lozano-Rojas, F. (2024). Higher Rates of Homelessness Are Associated With Increases in Mortality From Accidental Drug And Alcohol Poisonings. *Health Affairs. 43*(2). https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.00951

Broz, D. et al. (2021). Syringe services programs' role in ending HIV epidemic in the U.S.: why we cannot do it without them. *American Journal of Preventive Medicine, 61*(5S1):S118-S129. https://www.ajpmonline.org/article/S0749-3797(21)00389-5/pdf

Campopiano von Klimo, M., Nolan. L., Corbin, M., et al. (2024). Physician Reluctance to Intervene in Addiction: A Systematic Review. *JAMA Netw Open, 7*(7):e2420837. doi:10.1001/jamanetworkopen.2024.20837Cano, M., Oh, S., Salas-Wright, C.P., et al. (2021). Cocaine use and overdose mortality in the United States: Evidence from two national data sources, 2002-2018. *Drug and Alcohol Dependence, 214*, https://doi.org/10.1016/j.drugalcdep.2020.108148

Carl, A., Pasman, E., Broman, M., et al. (2023). Experiences of healthcare and substance use treatment provider-based stigma among patients receiving methadone. *Drug and Alcohol Dependence Reports,* 6:100138. https://doi.org/10.1016%2Fj.dadr.2023.100138

Chatterjee, A., Weitz, M., Savinkina, A., et al. (2023) Estimated Costs and Outcomes Associated With Use and Nonuse of Medications for Opioid Use Disorder During Incarceration and at Release in Massachusetts. *JAMA Netw Open.6*(4):e237036. doi:10.1001/jamanetworkopen.2023.7036

Cherrier, N., Kearon, J., Tetreault, et al. (2022). Community Distribution of Naloxone: A Systematic Review of Economic Evaluations. *PharmacoEconomics - open, 6*(3):329–342. https://doi.org/10.1007/s41669-021-00309-z

Chimbar, L. & Moletta, Y. (2018). Naloxone Effectiveness: A Systematic Review. *Journal of addictions nursing, 29*(3):167–171. https://doi.org/10.1097/JAN.0000000000000230

Ciccarone, D. (2019). The triple wave epidemic: Supply and demand drivers of the U.S. opioid overdose crisis. *International Journal of Drug Policy*, 71:183-188. https://doi.org/10.1016/j.drugpo.2019.01.010

Collins, S. E., Lonczak, H. S., & Clifasefi, S. L. (2019). Seattle's law enforcement assisted diversion (LEAD): program effects on criminal justice and legal system utilization and costs. *Journal of Experimental Criminology, 15*(2), 201–211. https://doi.org/10.1007/s11292-019-09352-7

Cooper-Ohm, S., Habecker, P., Humeniuk, R., et al. (2024). Factors associated with gaps in naloxone knowledge: evidence from a 2022 great plains survey. *Harm Reduction Journal, 21*(37). https://doi.org/10.1186/s12954-024-00954-7

Corinth, K. (2017). The impact of permanent supportive housing on homeless populations. *Journal of Housing Economics, 35*:69-84. https://doi.org/10.1016/j.jhe.2017.01.006

Crapanzano, K. A., Hammarlund, R., Ahmad, B., et al. (2018). The association between perceived stigma and substance use disorder treatment outcomes: a review. *Substance abuse and rehabilitation, 10*:1–12. https://doi.org/10.2147/SAR.S183252

Cuddeback, G.S., Morrissey, J.P., & Meyer, P.S. (2006). How Many Assertive Community Treatment Teams Do We Need? *Psychiatric Services, 57*(12). https://doi.org/10.1176/ps.2006.57.12.1803

Des Jarlais, D. C., Kerr, T., Carrieri, P., et al. (2016). HIV infection among persons who inject drugs: ending old epidemics and addressing new outbreaks. *AIDS (London, England), 30*(6), 815–826. https://doi.org/10.1097/QAD.0000000000001039

Eddie, D., Hoffman, L., Vilsaint, C., et al. (2019). Lived Experience in New Models of Care for Substance Use Disorder: A Systematic Review of Peer Recovery Support Services and Recovery Coaching. *Frontiers in Psychology, 10*, https://doi.org/10.3389/fpsyg.2019.01052

Essock, S.M., Mueser, K.T., Drake, R.E., et al. (2006). Comparison of ACT and Standard Case Management for Delivering Integrated Treatment for Co-occurring Disorders. *Psychiatric Services, 57*(2). https://doi.org/10.1176/appi.ps.57.2.185

Fine, D.R., Lewis, E., Weinstock, K., et al. (2021). Office-based addiction treatment retention and mortality among people experiencing homelessness. *JAMA Network Open, 4*(3). https://doi.org/10.1001/jamanetworkopen.2021.0477

Firesheets, K., Juarez, S., Kopak, A., et al. (2022). Naloxone Plus, Plus Some: Examining Ohio's Quick Response Teams Through the Lens of Deflection. *J Public Health Manag Pract, 28*(Suppl 6):S330-S338. https://pubmed.ncbi.nlm.nih.gov/36194802/

Ford, J.H., Rao, D., Kaur, A., et al. (2022). Wait no longer: reducing medication wait-times for individuals with co-occurring disorders. *Journal of Dual Diagnosis*, 18(2):101–110. https://doi.org/10.1080/15504263.2022.2052225

Frederick, D. E., & VanderWeele, T. J. (2019). Supported employment: Meta-analysis and review of randomized controlled trials of individual placement and support. *PloS one, 14*(2), e0212208. https://doi.org/10.1371/journal.pone.0212208

Friedmann, P.D. & Suzuki, J. (2017). More beds are not the answer: transforming detoxification units into medication induction centers to address the opioid epidemic. *Addiction Science & Clinical Practice,* 12:29. https://doi.org/10.1186/s13722-017-0092-y

Fries, H. P., & Rosen, M. I. (2011). The efficacy of assertive community treatment to treat substance use. *Journal of the American Psychiatric Nurses Association, 17*(1), 45–50. https://doi.org/10.1177/1078390310393509

Gallant, T.L., Gilbert, A.R., Zargham, S., et al. (2023). Impact of California Statute on Naloxone Availability and Opioid Overdose Rates. *AJPM Focus, 2*(3). https://doi.org/10.1016/j.focus.2023.100112

Gettel, C. J., Courtney, D. M., Janke, A. T., et al. (2022). The 2013 to 2019 Emergency Medicine Workforce: Clinician Entry and Attrition Across the U.S. Geography. *Annals of emergency medicine, 80*(3), 260–271. https://doi.org/10.1016/j.annemergmed.2022.04.031

Gormley, M. A., Pericot-Valverde, I., Diaz, L., et al. (2021). Effectiveness of peer recovery support services on stages of the opioid use disorder treatment cascade: A systematic review. *Drug and Alcohol Dependence, 229*, 109123. https://doi.org/10.1016/j.drugalcdep.2021.109123

Greenwald, M.K., Wiest, K.L, Haight, B.R., et al. (2023). Examining the benefit of a higher maintenance dose of extended-release buprenorphine in opioid-injecting participants treated for opioid use disorder. *Harm Reduction Journal,* 20:173. https://doi.org/10.1186/s12954-023-00906-7

Guarino, H., Mateu-Gelabert, P., Quinn, K., et al. (2021). Adverse childhood experiences predict early initiation of opioid use behaviors. *Frontiers in Sociology,* 6. https://doi.org/10.3389/fsoc.2021.620395

Haas, A., Viera, A., Doernberg, M., et al. (2021). Post-incarceration outcomes for individuals who continued methadone treatment while in Connecticut jails, 2014-2018. *Drug and alcohol dependence, 227*, 108937. https://doi.org/10.1016/j.drugalcdep.2021.108937

Haines, M. & O'Byrne, P. (2023). Safer opioid supply: qualitative program evaluation. *Harm Reduction Journal,* 20:53. https://doi.org/10.1186/s12954-023-00776-z

Han, B., Compton, W. M., Blanco, C., et al. (2017). Prevalence, Treatment, And Unmet Treatment Needs Of U.S. Adults With Mental Health And Substance Use Disorders. *Health affairs (Project Hope), 36*(10):1739–1747. https://doi.org/10.1377/hlthaff.2017.0584

Hargons, C.N., Miller-Roenigk, B.D., Malone, N.J., et al. (2022). "Can we get a black rehabilitation center?": factors impacting the treatment experiences of black people who use opioids. *Journal of Substance Abuse and Addiction Treatment,* 142. https://doi.org/10.1016/j.jsat.2022.108805

Hartung, D.M., McCracken, C.M., Nguyen, T., et al. (2023). Fatal and non-fatal opioid overdose risk following release from prison: A retrospective cohort study using linked administrative data. *Journal of Substance Use and Addiction Treatment,* 147:208971. https://doi.org/10.1016%2Fj.josat.2023.208971

Hoffman, K. A., Ford, J. H., Tillotson, C. J., et al. (2011). Days to treatment and early retention among patients in treatment for alcohol and drug disorders. *Addictive behaviors, 36*(6), 643–647. https://doi.org/10.1016/j.addbeh.2011.01.031

Hood, C.M., Gennuso, K.P., Swain, G.R., et al. (2016). County Health Rankings: Relationships Between Determinant Factors and Health Outcomes. *Am J Prev Med, 50*(2):129-135. doi: 10.1016/j.amepre.2015.08.024.

Hulsey, J. & Zawislak, K. (2022). *Patient Journey Map: Substance Use Disorder Treatment and Recovery Experiences.* The Addiction Policy Forum. https://www.addictionpolicy.org/_files/ugd/079eb6_ebb8d5531b0f46a4a85216c199551b54.pdf

Jacob, V., Chattopadhyay, S.K., Atipoe-Dorcoo, S., et al. (2022). Permanent Supportive Housing With Housing First: Findings From a Community Guide Systematic Economic Review. *Am J Prev Med, 62*(3):e188-e201. https://doi.org/10.1016/j.amepre.2021.08.009

Jain, A., Christopher, P., & Appelbaum, P. S. (2018). Civil Commitment for Opioid and Other Substance Use Disorders: Does It Work?. *Psychiatric services (Washington, D.C.), 69*(4), 374–376. https://doi.org/10.1176/appi.ps.201800066

Jakubowski, A. Kunis, H.V., Huxley-Reicher, Z. et al. (2018). Knowledge of the 911 Good Samaritan Law and 911-calling behavior of overdose witnesses. *Substance Use & Addiction Journal, 39*(2), https://doi.org/10.1080/08897077.2017.1387213

Jiang, X., Guy, G.P., Losby, J.L., et al. (2024). Association Between Length of Buprenorphine or Methadone Use and Nonprescribed Opioid Use Among Individuals with Opioid Use Disorder: A Cohort Study. *Substance Use & Addiction Journal, 0*(0). doi:10.1177/29767342241266038

Jilani, S.M. et al. (2022). Standardizing the clinical definition of opioid withdrawal in the Neonate. *The Journal of Pediatrics,* 243:33-9. https://www.jpeds.com/article/S0022-3476(21)01227-0/pdf

Johnson, K. et al. (2024). Model-driven decision support: A community-based meta-implementation strategy to predict population impact. *Annals of Epidemiology,* 95:12-18. https://pubmed.ncbi.nlm.nih.gov/38754571/

Jones, C.M., Houry, D., Han, B., et al. (2022). Methamphetamine use in the United States: epidemiological update and implications for prevention, treatment, and harm reduction. *Ann N Y Acad Sci, 1508*(1), https://doi.org/10.1111/nyas.14688

Kerr, T., Small, W., Buchner, C., et al. (2010). Syringe Sharing and HIV Incidence Among Injection Drug Users and Increased Access to Sterile Syringes. *American Journal of Public Health, 100*(8), 1449–1453. https://doi.org/10.2105/ajph.2009.178467

Kinlock, T. W., Gordon, M. S., Schwartz, R. P., et al. (2009). A randomized clinical trial of methadone maintenance for prisoners: results at 12 months postrelease. *Journal of substance abuse treatment, 37*(3):277–285. https://doi.org/10.1016/j.jsat.2009.03.002

Kirst, M., Zerger, S., Misir, V., et al. (2015). The impact of a Housing First randomized controlled trial on substance use problems among homeless individuals with mental illness. *Drug and Alcohol Dependence, 146*:24-29. https://doi.org/10.1016/j.drugalcdep.2014.10.019

Kohrt, B.A., Turner, E.L., Rai, S., et al. (2020). Reducing mental illness stigma in healthcare settings: Proof of concept for a social contact intervention to address what matters most for primary care providers. *Social Science & Medicine,* 250:112852. https://doi.org/10.1016/j.socscimed.2020.112852

Lancaster, K.E., Cooper, K.L., Browning, C.R., et al. (2020). Syringe service program utilization, barriers, and preferences for design in rural Appalachia: differences between men and women who inject drugs. *Substance Use & Misuse, 55*(14):2268-2277. https://doi.org/10.1080/10826084.2020.1800741

Langabeer, J., Champagne-Langabeer, T., Luber, S.D., et al. (2020). Outreach to people who survived opioid overdose: linkage and retention in treatment. *Journal of Substance Abuse Treatment*, 111:11-15. https://doi.org/10.1016/j.jsat.2019.12.008

Lefebvre, R.C., Chandler, R.K., Helme, D.W., et al. (2020). Health communication campaigns to drive demand for evidence-based practices and reduce stigma in the HEALing communities study. *Drug and Alcohol Dependence,* 217. https://doi.org/10.1016/j.drugalcdep.2020.108338

Louie, D.L., Assefa M.T., & McGovern, M.P. (2019). Attitudes of primary care physicians toward prescribing buprenorphine: a narrative review. *BMC Family Practice,* 20:157. https://bmcprimcare.biomedcentral.com/articles/10.1186/s12875-019-1047-z

Lu, T. et al. (2024). *Treatment of Opioid Use Disorder*. National Center for Biotechnology Information Bookshelf. https://www.ncbi.nlm.nih.gov/books/NBK558319/

Lukowitsky, M.R., Balkoski, V.I., Bromley, N., et al. (2021). The effects of screening brief intervention referral to treatment (SBIRT) training on health professional trainees' regard, attitudes, and beliefs toward patients who use substances. *Substance Abuse, 43*(1):397-407. https://doi.org/10.1080/08897077.2021.1944955

Mackey, K.M., Beech, E.H., Williams, B.E, et al. (2023) Effectiveness of Syringe Services Programs: A Systematic Review. *Washington (DC): Department of Veterans Affairs (U.S.),* https://www.ncbi.nlm.nih.gov/books/NBK598967/

Maclean, J.C. & Saloner, B. (2019). The effect of public insurance expansions on substance use disorder treatment: Evidence from the Affordable Care Act. *Journal of policy analysis and management*, *38*(2), 366–393.

Madras, B.K., Ahmad, N.J., Wen, J., et al. (2020). Improving Access to Evidence-Based Medical Treatment for Opioid Use Disorder: Strategies to Address Key Barriers Within the Treatment System. *NAM Perspectives.* Discussion Paper, Washington, D.C. https://doi.org/10.31478/202004b.

Makhmud, A., Thornicroft, G., & Gronholm, P. C. (2022). Indirect social contact interventions to reduce mental health-related stigma in low- and middle-income countries: systematic review. *Epidemiology and psychiatric sciences, 31*, e79. https://doi.org/10.1017/S2045796022000622

Manchak, S.M. et al. (2022). A data-driven response to the addiction crisis in Hamilton County, Ohio. *Journal of Public Health Management and Practice,* 28(6):S320-325.

Mancher, M., & Leshner, A. (2019). The effectiveness of medication-based treatment for opioid use disorder. In www.ncbi.nlm.nih.gov. National Academies Press (U.S.). https://www.ncbi.nlm.nih.gov/books/NBK541393/

Marsden, J., Anders. P., Shaw, C. et al. (2024). Superiority and cost-effectiveness of individual placement and support versus standard employment support for people with alcohol and drug dependence: a pragmatic, parallel-group, open-label, multicentre, randomised, controlled, phase 3 trial. *EClinicalMedicine*. https://doi.org/10.1016/j.eclinm.2023.102400

Marshall, T., Goldberg, R.W., Braude, L., et al. (2014). Supported employment: assessing the evidence. *Psychiatric Services,* 65(1). https://doi.org/10.1176/appi.ps.201300262

Martin, M. & Krawczyk, N. (2024). Linking Hospitalized Patients With Opioid Use Disorder to Treatment – The Importance of Care Transitions. *JAMA Netw Open, 7*(2), doi:10.1001/jamanetworkopen.2023.56382.

McCarty, D.M., Braude, L., Lyman, D.R., et al. (2014). Substance abuse intensive outpatient programs: assessing the evidence. *Psychiatric Services,* 65(6):718-726. https://doi.org/10.1176%2Fappi.ps.201300249

McCormick, C.L., Hervey, W.M., Monahan, C., et al. (2019). Improved patient outcomes and reduced wait times: transforming a VA outpatient substance use disorder program. *Federal Practitioner,* 36(7):332-338. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6654166/?report=classic

McGuire, A.B., Powell, K.G., Treitler, P.C., et al. (2019). Emergency department-based peer support for opioid use disorders: emergent functions and forms. *Journal of Substance Abuse Treatment,* 108:82-87. https://doi.org/10.1016%2Fj.jsat.2019.06.013

McKay, C., Nugent, K. L., Johnsen, M., et al. (2016). A Systematic Review of Evidence for the Clubhouse Model of Psychosocial Rehabilitation. *Administration and policy in mental health, 45*(1), 28–47. https://doi.org/10.1007/s10488-016-0760-3

Mendel, R. (2022). *Diversion: A Hidden Key to Combating Racial and Ethnic Disparities in Juvenile Justice*. The Sentencing Project. https://www.sentencingproject.org/reports/diversion-a-hidden-key-to-combating-racial-and-ethnic-disparities-in-juvenile-justice/

Milaney, K. et al. (2022). A scoping review of opioid harm reduction interventions for equity-deserving populations. *The Lancet Regional Health – Americas,* 12. https://doi.org/10.1016/j.lana.2022.100271

Miller, T.R., Zaloshnja, E., & Spicer, R.S. (2007). Effectiveness and Benefit-Cost of Peer-Based Workplace Substance Abuse Prevention Coupled with Random Testing. *Accident Analysis & Prevention, 39*(3):565–573.

Miller-Archie, S.A., Walters, S.C., Singh, T.P., et al. (2019). Impact of supportive housing on substance use-related care utilization among homeless persons who are active substance users. *Annals of Epidemiology, 32*:1-6. https://doi.org/10.1016/j.annepidem.2019.02.002

Miller-Lloyd, L., Landry, J., Macmadu, Aet al. (2020). Barriers to Healthcare for People Who Inject Drugs: A Survey at a Syringe Exchange Program. *Substance use & Misuse, 55*(6), 896–899. https://doi.org/10.1080/10826084.2019.1710207

Mistler, C.B., Rosen, A.O., Eger, W., et al. (2021). Fentanyl Test Strip Use and Overdose History among Individuals on Medication for Opioid Use Disorder. *Austin J Public Health Epidemiol., 8*(5):1117. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9249264/

Mitchell, O., Wilson, D.B., Eggers, A., et al. (2012). Assessing the effectiveness of drug courts on recidivism: a meta-analytic review of traditional and non-traditional drug courts. *Journal of Criminal Justice,* 40(1):60-71. https://doi.org/10.1016/j.jcrimjus.2011.11.009

Moallef, S. & Hayashi, K. (2021). The effectiveness of drug-related Good Samaritan laws: A review of the literature. *International Journal of Drug Policy, 90*. https://doi.org/10.1016/j.drugpo.2020.102773

Mohlman, M., Tanzman, B., Finision, K., et al. (2016). Impact of medication-assisted treatment for opioid addiction on Medicaid expenditures and health services utilization rates in Vermont. *Journal of Substance Abuse Treatment,* 67:9-14. http://dx.doi.org/10.1016/j.jsat.2016.05.002

Monroe-DeVita, M., Tague, G.B., & Moser, L. (2011). The TMACT: A New Tool for Measuring Fidelity to Assertive Community Treatment. *Journal of the American Psychiatric Nurses Association, 17*:17. https://doi.org/10.1177/1078390310394658

Moore, K.E., Roberts, W., Reid, H.H., et al. (2019). Effectiveness of medication assisted treatment for opioid use in prison and jail settings: A meta-analysis and systematic review. *Journal of Substance Abuse Treatment, 99*: P32-43. https://www.jsatjournal.com/article/S0740-5472(18)30449-5/fulltext

Moreland, A., Hartley, C., DelMas, S., et al. (2020). Examining stressors and available parenting resources for opioid-using mothers: qualitative findings from an inpatient substance use treatment program. *Community Mental Health Journal,* 56(3):426-434. https://doi.org/10.1007/s10597-019-00478-6

Morgan, J.R., Wang, J., Barocas, J.A., et al. (2020). Opioid overdose and inpatient care for substance use disorder care in Massachusetts. *Journal of Substance Abuse Treatment,* 112:42-48. https://doi.org/10.1016/j.jsat.2020.01.017

Moss, R.B. & Carlo, D.J. (2019). Higher doses of naloxone are needed in the synthetic opioid era. *Substance Abuse Treatment, Prevention, and Policy,* 14:6. https://doi.org/10.1186/s13011-019-0195-4

Moyo, P., Eliot, M., Shah, A., et al. (2022). Discharge locations after hospitalizations involving opioid use disorder among Medicare beneficiaries. *Addiction Science & Clinical Practice,* 17:57. https://doi.org/10.1186/s13722-022-00338-x

Mumba, M. N., Davis, L., Smith, N. L., et al. (2022). Effects of Unemployment on Opioid Use Treatment Trajectories. *Journal of Addictions Nursing, 33*(3), 168–171. https://doi.org/10.1097/jan.0000000000000480

Murad, M.H. (2017). Clinical Practice Guidelines: A Primer on Development and Dissemination. *Mayo Clinic Proceedings, 92*(3), https://www.mayoclinicproceedings.org/article/S0025-6196(17)30025-3/fulltext

Murphy, L. et al. (2022). Opioid utilization and management in the setting of stewardship during inpatient rehab care. *Drug Healthcare and Patient Safety, 14*:161-170. https://doi.org/10.2147/DHPS.S360832

Ostrow, L., Cook, J.A., Salzer, M.S., et al. (2022). Employment Outcomes After Certification as a Behavioral Health Peer Specialist in Four U.S. States. *Psychiatric Services, 73*(11), https://psychiatryonline.org/doi/full/10.1176/appi.ps.202100651

Papp, J. (2022). MOUD in the Criminal Justice Setting: Handoff and Transition of Care upon Release. *MetroHealth.* https://ohsam.org/wp-content/uploads/2022/10/MOUD-Papp.pdf

Patrick, S.W. et al. (2017, March 1). A public health response to opioid use in pregnancy. *American Academy of Pediatrics,* 139(3). https://doi.org/10.1542/peds.2016-4070

Peiper, N.C., Clarke, S.D., Vincent, L.C., et al. (2019). Fentanyl test strips as an opioid overdose prevention strategy: Findings from a syringe services program in the Southeastern United States. *The International journal on drug policy, 63:*122–128. https://doi.org/10.1016/j.drugpo.2018.08.007

Penzenstadler, L., Soares, C., Anci, E., et al. (2019). Effect of Assertive Community Treatment for Patients with Substance Use Disorder: A Systematic Review. *Eur Addict Res 27*, *25* (2): 56–67.

Piscalko, H., Dhanani, L.Y., Brook, D., et al. (2024). Knowledge of medications for opioid use disorder and associated stigma among primary care professionals. *Annals of medicine, 56*(1), 2399316. https://doi.org/10.1080/07853890.2024.2399316

Platt, K., Minozzi, S., Reed, J., et al. (2017). Needle syringe programmes and opioid substitution therapy for preventing hepatitis C transmission in people who inject drugs. *The Cochrane database of systematic reviews, 9*(9), CD012021. https://doi.org/10.1002/14651858.CD012021.pub2

Polcin D. L. (2016). Co-occurring Substance Abuse and Mental Health Problems among Homeless Persons: Suggestions for Research and Practice. *Journal of social distress and the homeless, 25*(1):1–10. https://doi.org/10.1179/1573658X15Y.0000000004

Powell, A.T., Bourgeois, M.M., Lichterman, J., et al. (2022). Opioid-Related Overdose Fatality Cases in Two Florida Counties. *Journal of Emergencies, Trauma, and Shock, 15*(2):83-87. https://doi.org/10.4103/jets.jets_130_21

Raman, S.R., Ford. C.B., Hammill, B.G., et al. (2023). Non-overdose acute care hospitalizations for opioid use disorder among commercially-insured adults: a retrospective cohort study. *Addiction Science & Clinical Practice,* 18:42. https://doi.org/10.1186/s13722-023-00396-9

Rath, J. M., Perks, S. N., Vallone, D. M., et al. (2021). Educating Young Adults about Opioid Misuse: Evidence from a Mass Media Intervention. *International journal of environmental research and public health, 19*(1), *22*. https://doi.org/10.3390/ijerph19010022

Razaghizad, A., Windle, S.B., Filion, K.B., et al. (2021). The Effect of Overdose Education and Naloxone Distribution: An Umbrella Review of Systematic Reviews. *Am J Public Health, 111*(8):e1-e12. https://doi.org/10.2105/AJPH.2021.306306

Reed, M.K., Roth, A.M., Tabb, L.P, et al. (2022). "I Probably Got a Minute": Perceptions of Fentanyl Test Strip Use among People who Use Stimulants. *Int J Drug Policy, 92*. https://doi.org/10.1016/j.drugpo.2021.103147

Remington, P.L., Catlin, B.B., & Gennuso, K.P. (2015). The County Health Rankings: rationale and methods. *Popul Health Metrics* 13 (11). https://doi.org/10.1186/s12963-015-0044-2

Rhee, T. G., & Rosenheck, R. A. (2019). Association of current and past opioid use disorders with health-related quality of life and employment among U.S. adults. *Drug and Alcohol Dependence, 199*, 122–128. https://doi.org/10.1016/j.drugalcdep.2019.03.004

Riazi, F. et al. (2021). Community case study of naloxone distribution by hospital-based harm reduction program for people who use drugs in New York City. *Frontiers in Sociology,* 6:619683. https://doi.org/10.3389%2Ffsoc.2021.619683

Ryan, D. A., Montoya, I. D., Koutoujian, P. J., et al. (2023). Budget impact tool for the incorporation of medications for opioid use disorder into jail/prison facilities. *Journal of substance use and addiction treatment*, *146*, 208943. https://doi.org/10.1016/j.josat.2022.208943

Saunders, M.E., Humphrey, J.L., & Lambdin, B.H. (2023). Spatiotemporal Trends in Three Smoothed Overdose Death Rates in U.S. Counties, 2012-2020. *Preventing Chronic Disease*, 20. http://dx.doi.org/10.5888/pcd20.220316

Scott, C. K., Dennis, M. L., Grella, C. E., et al. (2021). The impact of the opioid crisis on U.S. state prison systems. *Health & Justice, 9*(1), NA–NA. https://doi.org/10.1186/s40352-021-00143-9

Sharp, A., Jones, A., Sherwood, J., et al. (2018). Impact of Medicaid Expansion on Access to Opioid Analgesic Medications and Medication-Assisted Treatment. *American journal of public health, 108*(5): 642–648. https://doi.org/10.2105/AJPH.2018.304338

Sharp, A., Barnett, J., & Vroom, E.B. (2020). Community Perceptions of Harm Reduction and Its Implications for Syringe Exchange Policy. *Journal of Drug Issues, 50*(4), https://doi.org/10.1177/0022042620932289

Smart, R. & Davis, C.S. (2021). Reducing Opioid Overdose Deaths by Expanding Naloxone Distribution and Addressing Structural Barriers to Care. *Am J Public Health, 111*(8):1382-1384. https://doi.org/10.2105/AJPH.2021.306376

Sordo, L., Barrio, G., Bravo, M. J., et al. (2017). Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. *BMJ (Clinical research ed.), 357*, j1550. https://doi.org/10.1136/bmj.j1550

Stein, M.D., Krause, C., Rogers, E., et al. (2023). Lessons learned from developing tailored community communication campaigns in the HEALing communities study. *Journal of Health Communication: International Perspectives,* 28(10):699-705. https://doi.org/10.1080/10810730.2023.2262948

Stevens, E., Guerrero, M., Green, A., et al. (2018). Relationship of hope, sense of community, and quality of life. *Journal of community psychology, 46*(5), 567–574. https://doi.org/10.1002/jcop.21959

Stewart, R.E., Cardamone, N.C., Loscalzo, E., et al. (2023). "There's absolutely no downside to this, I mean, except community opposition:" A qualitative study of the acceptability of vending machines for harm reduction. *Harm Reduction Journal,* 20:25. https://doi.org/10.1186/s12954-023-00747-4

Stone, E.M., Kennedy-Hendricks, A., Barry, C.L., et al. (2021). The role of stigma in U.S. primary care physicians' treatment of opioid use disorder. *Drug Alcohol Depend., 221*. https://doi.org/10.1016/j.drugalcdep.2021.108627

Strang, J. et al. (2003). Loss of tolerance and overdose mortality after inpatient opiate detoxification: follow up study. *BMJ, 326*. https://doi.org/10.1136/bmj.326.7396.959

Sugarman, O.K., Hulsey, E.G., & Heller, D. (2023). Achieving the Potential of Naloxone Saturation by Measuring Distribution. *JAMA Health Forum,* 4(10):e233338. doi:10.1001/jamahealthforum.2023.3338

Sulzer, S. H., Prevedel, S., Barrett, T., Voss, M. W., Manning, C., & Madden, E. F. (2021). Professional education to reduce provider stigma toward harm reduction and pharmacotherapy. *Drugs: Education, Prevention and Policy, 29*(5), 576–586. https://doi.org/10.1080/09687637.2021.1936457

Swartz, N., Odayappan, S., Chatterjee, A., et al. (2023). Impact of Medicaid expansion on inclusion of medications for opioid use disorder in homeless adults' treatment plans. *Journal of Substance Use and Addiction Treatment*, *152*, https://doi.org/10.1016/j.josat.2023.209059

Sweeney, T.J., Strolla, M.P., & Myers, D.P. (2013). Civil commitment for substance use disorder patients under the Florida Marchman Act: demographics and outcomes in the private clinical setting. *Journal of Addictive Diseases,* 32(1):108-15. https://doi.org/10.1080/10550887.2012.759873

Tanz, L.J., Gladden, R.M, Dinwiddie, A.T., et al. (2024). Routes of Drug Use Among Drug Overdose Deaths — United States, 2020–2022. *MMWR Morb Mortal Wkly Rep 73*:124–130. DOI: http://dx.doi.org/10.15585/mmwr.mm7306a2

Teague, G.B., Bond, G.R., & Drake, R.E. (1998). Dartmouth Assertive Community Treatment Scale. *APA PsycTests*. https://doi.org/10.1037/t39988-000

Teshale, E.H., Asher, A., Aslam, M.V., et al. (2019). Estimated cost of comprehensive syringe service program in the United States. *PLoS One*. https://doi.org/10.1371/journal.pone.0216205

Trepman, P. et al. (2020). The association between health insurance and opioid misuse in pregnancy. *Journal of Scientific Innovation in Medicine,* 3(3):23. https://doi.org/10.29024/jsim.46

Walt, G., Porteny, T., McGRegor, A.J., et al. (2022). Clinician's experiences with involuntary commitment for substance use disorder: A qualitative study of moral distress. *International Journal of Drug Policy, 99*. https://www.sciencedirect.com/science/article/abs/pii/S0955395921003704

Watkins, L.E. et al. (2023). Clinical effectiveness of an intensive outpatient program for integrated treatment of comorbid substance abuse and mental health disorders. *Cognitive and Behavioral Practice,* 30(3):354-366. https://doi.org/10.1016/j.cbpra.2022.05.005

Wen, H., Soni., A., Hollingsworth, A., et al. (2020). Association Between Medicaid Expansion and Rates of Opioid-Related Hospital Use. *JAMA Intern Med, 180*(5):753-759. doi:10.1001/jamainternmed.2020.0473

Wenger, L.D., Showalter, D., Lambdin, B., et al. (2019). Overdose Education and Naloxone Distribution in the San Francisco County Jail. *Journal of Correctional Healthcare, 25*(4). https://doi.org/10.1177/1078345819882771

Westerberg, V. S., McCrady, B. S., Owens, M., & Guerin, P. (2016). Community-Based Methadone Maintenance in a Large Detention Center is Associated with Decreases in Inmate Recidivism. *Journal of substance abuse treatment, 70:* 1–6. https://doi.org/10.1016/j.jsat.2016.07.007

Wolfson, M. (2019). 2018-2019 DOCS Annual Report: A Year in Review. *Issuu*. https://issuu.com/umdocs/docs/annual_report_2019_final_compressed

Yatsco, A.J., Garza R.D., & Champagne-Langabeer, J.R.(2020). Alternatives to arrest for illicit opioid use: a joint criminal justice and healthcare treatment collaboration. *Substance Abuse: Research and Treatment,* 14:1-8. https://doi.org/10.1177/1178221820953390

Yeo, E.J., Kralles, H., Sternberg, D., et al. (2021). Implementing a low-threshold audio-only telehealth model for medication-assisted treatment of opioid use disorder at a community-based non-profit organization in Washington, D.C. *Harm Reduction Journal,* 18:127. https://doi.org/10.1186/s12954-021-00578-1

Young, M. S., Barrett, B., Engelhardt, M. A., & Moore, K. A. (2014). Six-month outcomes of an integrated assertive community treatment team serving adults with complex behavioral health and housing needs. *Community mental health journal, 50*(4), 474–479. https://doi.org/10.1007/s10597-013-9692-5

Zhang, A., Balles, J.A., Nyland, J.E., et al. (2022). The relationship between police contacts for drug use-related crime and future arrests, incarceration, and overdoses: a retrospective observational study highlighting the need to break the vicious cycle. *Harm Reduction Journal,* 19:67. https://doi.org/10.1186/s12954-022-00652-2

Zuccarini, M.M. & Stiller, C. (2024). The effect of peer support on treatment engagement for opioid use disorder. *Journal of American Psychiatric Nurses Association, 30*(3):709-715. https://doi.org/10.1177/10783903221128062

Other Secondary Sources

2021 WISCONSIN ACT 181, Wisconsin State Legislature, section 991.11. (2022). https://docs.legis.wisconsin.gov/2021/related/acts/181

2022 Performance Report. (2022). Sixth Judicial Circuit, Florida. https://www.jud6.org/GeneralPublic/AnnualPerformanReports/2023-Perf-Rpt.pdf

211 Tampa Bay Cares. (2024). 211 Tampa Bay.

ADAMHS Board of Cuyahoga County. (2024). ADAMHS Board. https://www.adamhscc.org/home

Addressing homelessness & addiction through recovery housing. (2024). Recovery Research Institute. https://www.recoveryanswers.org/research-post/addressing-homelessness-addiction-through-recovery-housing/

Adult Drug Court Research into Practice Initiative. *Seven Program Design Features: Adult Drug Court Principles, Research, and Practice*. https://ntcrc.org/wp-content/uploads/2022/02/Translating_Drug_Court_Research_Into_Practice.pdf

Alaska Department of Corrections. (n.d.). *Health & Rehabilitation Services*. https://doc.alaska.gov/health-rehab-services

All Rise. (2024). *Adult Treatment Court: Best Practice Standards, 2nd ed*. https://allrise.org/wp-content/uploads/2024/05/Adult-Treatment-Court-Best-Practice-Standards-I-VI_VIII_X-final.pdf

AMA to urge using opioid litigation funds to train physicians in opioid treatment. (2022). American Medical Association. https://www.ama-assn.org/press-center/press-releases/ama-urge-using-opioid-litigation-funds-train-physicians-opioid

American Addiction Centers. (2024). *Alcohol and Drug Abuse Among Blue-Collar Workers*. https://americanaddictioncenters.org/workforce-addiction/blue-collar

American Society of Addiction Medicine. (n.d.). *About the ASAM Criteria*. https://www.asam.org/asam-criteria/about-the-asam-criteria#:~:text=The%20ASAM%20Criteria%E2%80%99s%20strength-based%20multidimensional%20assessment%20takes%20into%20account%20a

America's Health Rankings | AHR. (2022). America's Health Rankings. https://www.americashealthrankings.org/explore/measures/healthinsurance

Archdiocese of Oklahoma City. (2024). *Catholic Charities previews Caritas Casitas*. https://archokc.org/news/catholic-charities-previews-caritas-casitas

Ash, J. (2023). *$50 million proposal for reforming the Baker and Marchman acts awaits the governor's signature*. The Florida Bar. https://www.floridabar.org/the-florida-bar-news/50-million-proposal-for-reforming-the-baker-and-marchman-acts-awaits-the-governors-signature/

Asher, A., Teshale, E., Augustine, R., et al. (2021). Estimating the Cost of a Comprehensive Syringe Services Program in the United States. *National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention*. https://www.inhsu.org/wp-content/uploads/2021/01/11_Alice-Asher.pdf

Behavioral/Mental Health Professionals: Licensed behavioral/mental health professionals per 100k residents. (2024). Florida Health Charts, Florida Department of Health. https://www.flhealthcharts.gov/ChartsDashboards/rdPage.aspx?rdReport=NonVitalIndNoGrp.Dataviewer&cid=9892

Boston Public Health Commission. (2024). *Family overdose support fund to assist families who lost loved ones to overdose*. City of Boston. https://www.boston.gov/news/family-overdose-support-fund-assist-families-who-lost-loved-ones-overdose

Bridge clinic model for methadone initiation leads to high linkage and retention in opioid treatment. (2022). Boston Medical Center. https://www.bmc.org/news/bridge-clinic-model-methadone-initiation-leads-high-linkage-and-retention-opioid-treatment

Bromley, A. (2021). *Recognizing the Human Need for Community Is Essential in Addiction Treatment*. UVAToday, https://news.virginia.edu/content/recognizing-human-need-community-essential-addiction-treatment

Bureau of Justice Assistance. (2018). *Pinellas County Strategic Information Sharing Partnership*. https://bja.ojp.gov/funding/awards/2018-ar-bx-k019

Care About Me: Your Support Starts Here. (2024). Care About Me. https://careaboutme.org/

Carter, J., Varma, R., & Hougaard, R. (2019). *How to Get People to Pay Attention During Corporate Trainings*. Harvard Business Review. https://hbr.org/2019/03/how-to-get-people-to-pay-attention-during-corporate-trainings

Cava, D.L. (2024). Miami-Date County Sterile Needle and Syringe Exchange Program Annual Report. *University of Miami Miller School of Medicine*. https://documents.miamidade.gov/mayor/memos/09.08.23-Miami-Dade-County-Sterile-Needle-and-Syringe-Exchange-Program-Annual-Report.pdf

CBHSQ Data brief: peer services supported through state targeted response to the opioid crisis grants. (2023). Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/opioid-str-peer-support-svcs

Center for Behavioral Health Statistics and Quality. (2017). *RESULTS FROM THE 2016 NATIONAL SURVEY ON DRUG USE AND HEALTH: DETAILED TABLES*. https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2016/NSDUH-DetTabs-2016.pdf

Center for community recovery innovations (CCRI). (2024). MassHousing. https://www.masshousing.com/en/programs-outreach/community-revitalization/ccri

Centers for Disease Control and Prevention. (2017). *Addressing the Prescription Opioid Crisis*. https://www.cdc.gov/rx-awareness/media/pdfs/2024/03/Overview-Rx-Awareness-Resources.pdf

Centers for Disease Control and Prevention. (2022). Overdose Data to Action Case Studies: Public Safety-Led Post–Overdose Outreach. *National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services*. https://www.cdc.gov/ore/pdf/OD2A-public-safety-case-study-508.pdf

Centers for Disease Control and Prevention. (2024). *Safety and Effectiveness of Syringe Services Programs*. https://www.cdc.gov/syringe-services-programs/php/safety-effectiveness.html#cdc_program_profile_policy-implementation-strategies

Centers for Disease Control and Prevention. (n.d.*). Evaluation Profile for Naloxone Distribution Programs*. https://www.cdc.gov/overdose-prevention/media/pdfs/OD2A_EvalProfile_NaloxoneDistributionPrograms_508.pdf

Centers for Disease Control and Prevention. (n.d.). *Tips From Former Smokers: About the Campaign*. https://www.cdc.gov/tobacco/campaign/tips/about/index.html#

Certified peer support professional (CPSP) expansion awardee overview. (2024). Indiana Family & Social Services Administration. https://www.in.gov/recovery/files/Peer-Workforce-Grant-Awardee-Overview.pdf

Cheryll Moore, ECDOH Opioid Program Director, Erie County Department of Health. (2024). New York State Department of Health. https://www.health.ny.gov/prevention/public_health_works/honor_roll/2019/c_moore.htm

Choices *matter: housing models that may promote recovery for individuals and families facing opioid use disorder, Report Highlights*. (2019). Health and Human Services Office of the Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/sites/default/files/private/pdf/261876/ChoicesRH.pdf

Civil Service Opportunities: Community Opioid Response Director. (2024). Erie County, New York. https://www3.erie.gov/employment/posting/community-opioid-response-director

Clubhouse International. (2016). *How to Start a Clubhouse*. https://www.clubhouse-intl.org/documents/starting_a_clubhouse_article_07-08-16.pdf

Clubhouse International. (2019). *International Standards for Clubhouse Programs*. https://clubhouse-intl.org/wp-content/uploads/2019/03/standards_2018_eng.pdf

CMU Home. (2024). Case Management Unit. https://www.cmupa.org/

Colombini, S. (2024). *Recovery advocates are handing out Narcan to Pinellas business and beachgoers*. Health News Florida. https://health.wusf.usf.edu/health-news-florida/2024-04-08/recovery-advocates-are-handing-out-narcan-to-pinellas-businesses-and-beachgoers

Congressional Research Service. (2022). *The Opioid Crisis in the United States: A Brief History*. https://crsreports.congress.gov/product/pdf/IF/IF12260

Connecticut Department of Mental Health and Addiction Services. (n.d.). *Mental Health Services Available*. *https://www.ctmentalhealthservices.com/*

Cordata Health. (2022). *Quick Response Teams: Strategies for Evaluation and Implementation*. https://www.cordatahealth.com/2022/03/22/quick-response-teams-strategies-for-evaluation-and-implementation/

Crisis Now. (n.d.). *Crisis Resources Need Calculator*. https://calculator.crisisnow.com/#/data-insights?chart=SC&geo=State&lob=All&location_key=12103&metric1=bh_high_needs&tab=Map

Cummings, D. (2023*). Effects of the Subsidized and Transitional Employment Demonstration on Earnings After Eight Years*. Office of Planning, Research, and Evaluation. https://www.acf.hhs.gov/sites/default/files/documents/opre/BEES%20STED%20Long-Term%20Brief%20508%20REV.pdf#:~:text=Dozens%20of%20rigorous%20studies%20have%20tested%20the%20effects,potential%20to%20improve%20participants'%20long-term%20employment%20and%20earnings

Cummings, D. & Bloom, D. (2020). *Can Subsidized Employment Programs Help Disadvantaged Job Seekers? A Synthesis of Findings from Evaluations of 13 Programs*. Office of Planning, Research, and Evaluation. https://www.mdrc.org/sites/default/files/sted_final_synthesis_report_feb_2020.pdf

Cuyahoga County Opiate Task Force. (2024). ADAMHS Board of Cuyahoga County. https://www.adamhscc.org/about-us/current-initiatives/task-forces-and-coalitions/cuyahoga-county-opiate-task-force

Department of Justice. (n.d.). *Justin Volpe's Story: "It Stays with You When Someone Treats You with Respect."* Bureau of Justice Assistance, Police-Mental Health Collaboration. https://bja.ojp.gov/program/pmhc/learning/justin-volpes-story#:~:text=Justin%20Volpe%20is%20a%20Certified%20Recovery%20Peer%20Specialist%20for%20Miami-Dade

Deprez, J.C. (2024). *Investing in recovery: Bartholomew County officials start spending opioid settlement funds on treatment, housing and prevention programs*. Indiana Economic Digest. https://indianaeconomicdigest.net/Content/Most-Recent/Health-Care/Article/Investing-in-recovery-Bartholomew-County-officials-start-spending-opioid-settlement-funds-on-treatment-housing-and-prevention-programs/31/91/117066

Diamond, M. (2024). *Opioid settlement money would target recovery-based care under Palm Beach County plan*. The Palm Beach Post. https://www.palmbeachpost.com/story/news/2024/05/24/millions-in-opioid-settlement-money-will-target-recovery-based-care-palm-beach-county-says/73792895007/

Drake, P., Rudowitz, R., Tolbert, J., et al. (2024). *How many uninsured are in the coverage gap and how many could be eligible if all states adopted the Medicaid expansion?* KFF. https://www.kff.org/medicaid/issue-brief/how-many-uninsured-are-in-the-coverage-gap-and-how-many-could-be-eligible-if-all-states-adopted-the-medicaid-expansion/

Drexel University College of Medicine. (n.d.). *Behavioral Healthcare Education Series Information*. *https://drexel.edu/medicine/academics/continuing-education/behavioral-healthcare-education/in-person-*

courses/series-information/#:~:text=Co-Occurring%20Mental%20and%20Substance%20Use%20Disorders%20Series.%20Behavioral%20Healthcare%20Education

Duchene, D. & Lane, P. (2009). *Fundamentals of the Marchman Act*. Risk Rx. https://flbog.sip.ufl.edu/risk-rx-article/fundamentals-of-the-marchman-act/

Duncan, A. (2021). *Mobile medication units help fill gaps in opioid use disorder treatment: New Jersey state official reflects on how services help reach people in need.* The Pew Charitable Trust. https://www.pewtrusts.org/en/research-and-analysis/articles/2021/11/22/mobile-medication-units-help-fill-gaps-in-opioid-use-disorder-treatment

Eleventh Judicial Circuit of Florida. (n.d.). *Jail Diversion Services*. https://www.jud11.flcourts.org/Self-Help-Center/Mental-Health/Jail-Diversion

Eleventh Judicial Circuit of Florida. (2024). *Judicial Support Specialist 1- Peer Specialist (Part-time; 20 hrs/week) – Criminal Mental Health Project – County Criminal Court Operations Division – (County Funded).* https://jobs.jud11.flcourts.org/public/jobdetails.aspx?postingid=405#:~:text=The%20Peer%20Specialist%20works%20as%20a%20member%20of%20the%20Jail

Empath health. (2020). *2020 Community Impact Report*. https://empathhealth.org/wp-content/uploads/2021/02/EMP-20-0441-2020-Annual-Report-Electronic.pdf#:~:text=Empath%20Health%20is%20a%20nonprofit,%20integrated%20network%20of%20care%20in

Engaging Faith Based Communities in the Opioid Pandemic: Multiple Pathways to Recovery. (2023). Minnesota Department of Health. https://www.health.state.mn.us/communities/opioids/communities/faithcommunities.html

Erie County Department of Health. (n.d.) *Peer Navigation & Treatment Support*. https://www3.erie.gov/health/peer-navigation-treatment-support

Erie County Overdose Prevention Task Force. (2024). *Office of Harm Reduction, Erie County Overdose Prevention Task Force: August 2024* [PowerPoint slides]. Erie County Department of Health. https://www3.erie.gov/health/sites/www3.erie.gov.health/files/2024-08/082024-erie-county-overdose-prevention-task-force-mtg-slides.pdf

Evans, A., City of Philadelphia, Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) Strategic Planning Division, et al. (2016). *A Decade of Peer Culture, Support and Leadership: Igniting Behavioral Health Transformation in Philadelphia.* https://peerrecoverynow.org/wp-content/uploads/PCCI_Peer-Culture-Report.pdf

Find a Ryan White HIV/AIDS program medical provider. (2024). HRSA Data Warehouse. https://findhivcare.hrsa.gov/

Fjeld, J. (2023). *BernCo Commission approves $975K for opioid prevention and training*. KOB 4. https://www.kob.com/new-mexico/bernco-commission-approves-975k-for-opioid-prevention-and-training/

Florida Department of Children and Families. (n.d.). *Baker Act. https://www.myflfamilies.com/crisis-services/baker-act*

Florida Department of Children and Families. (n.d.). *Marchman Act*. https://www.myflfamilies.com/crisis-services/marchman-act

Florida Health. (2008). *Chapter 1: The Healthy Start System*. https://www.floridahealth.gov/programs-and-services/childrens-health/healthy-start/_documents/chapter-1-the-healthy-start-system-2008.pdf

Florida Health. (2021). *2021 Physician Workforce Annual Report*. https://www.floridahealth.gov/provider-and-partner-resources/community-health-workers/HealthResourcesandAccess/physician-workforce-development-and-recruitment/2021DOHPhysicianWorkforceAnnualReport-FINALREPORT-10-25-2021.pdf

Florida Health. (2022). Statewide Drug Policy Advisory Council 2022 Annual Report. https://www.floridahealth.gov/provider-and-partner-resources/dpac/_documents/2022_DPAC_Annual_Report.pdf

Franco, C. (2010). *Drug courts: background, effectiveness, and policy issues for congress.* Congressional Research Service. https://sgp.fas.org/crs/misc/R41448.pdf

Georgia Department of Behavioral Health & Developmental Disabilities. (2024). *Provider Manual for Community Behavioral Health providers For the Department of Behavioral Health & Developmental Disabilities*. https://dbhdd.org/files/Provider-Manual-BH.pdf

Gerhardt, T.F. (2024). 2024 Point in Time Count. *Pinellas County, Florida*. https://static1.squarespace.com/static/5c784173a9ab953d5ee017d5/t/66db8751c569805e94f576f2/1725663060073/2024+Pinellas+PIT+Report.pdf

Getting off right: Getting ready: Preparing yourself and your equipment. (2024). National Harm Reduction Coalition. https://harmreduction.org/issues/safer-drug-use/injection-safety-manual/preparing-equipment/

Glorioso, A. & Marchante, M. (2024). *Desantis signs healthcare modernization bills that do little to treat Florida uninsured*. Miami Herald. https://www.miamiherald.com/news/politics-government/article286968125.html

GoLocalProv. (2024). *Pallet Homes: Cost Per Person for First Year Is $66,000*. GoLocalProv News. https://www.golocalprov.com/news/pallet-homes-cost-per-person-for-the-first-year-is-66000

Graham, R., Mancher, M., Wolman, D.M., et al. (2011). *Clinical practice guidelines we can trust*. Institute of Medicine. https://scholar.google.com/scholar?q=Institute+of+MedicineClinical+Practice+Guidelines+We+Can+Trust2011National+Academies+PressWashington%2C+DC

Greenberg, J. (2020). *Bulletin: Changes to the Involuntary Treatment Act (ITA) – Part 1 – Key Changes*. Washington State Hospital Association. https://www.wsha.org/articles/bulletin-changes-to-the-involuntary-treatment-act-ita-part-1-key-changes/#:~:text=Adults%20and%20minors%20may%20be%20held%20for%20an,before%20a%20probable%20cause%20hearing%20must%20be%20held.

Harm Reduction Coalition. (2012). *Guide To Developing and Managing Overdose Prevention and Take-Home Naloxone Projects*. https://harmreduction.org/wp-content/uploads/2020/08/Resource-OverdosePrevention-GuidetoDevelopingandManagingOverdosePreventionandTakeHomeNaloxoneProjects.pdf

Health care for the homeless program. (2023). Pinellas County. https://pinellas.gov/programs/health-care-for-the-homeless-program/

Health Resources & Services Administration. (n.d.). *Ryan White HIV/AIDS Program*. https://ryanwhite.hrsa.gov/about

HealthNet. (n.d.). *HealthNet Announces Harm Reduction Vending Machine Installation*. HealthNet of Rock County. https://healthnet-rock.org/healthnet-announces-harm-reduction-vending-machine-installation/

Healthy start. (2024). Florida Health. https://www.floridahealth.gov/programs-and-services/childrens-health/healthy-start/index.html#:~:text=Florida%27s%20Healthy%20Start%20initiative%20was%20signed%20into%20law,risk%20of%20poor%20birth%2C%20health%2C%20and%20developmental%20outcomes.

Healthy start coalition, Pinellas County. (2022). The Healthy Start Coalition of Pinellas. https://healthystartpinellas.org/Healthy Start Pinellas, Inc. (2023). *2022-2023 Annual Report*. https://healthystartpinellas.org/annual-report/

Helling, B. (2021). *How Much Does Uber Cost? Fare Pricing, Rates, and Cost Estimates Explained.* Rid ester. https://www.ridester.com/uber-rates-cost/

HHS finalizes new provisions to enhance integrated care and confidentiality for patients with substance use conditions. (2024). Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/newsroom/press-announcements/20240208/hhs-finalizes-new-provisions-enhance-intergrated-care-confidentiality-patients-substance-use-conditions

Hoffman, J. (2024). *Overdose or Poisoning? A New Debate Over What to Call a Drug Death.* The New York Times. https://www.nytimes.com/2024/03/11/health/overdose-poison-fentanyl.html

Hollenbeck, S. (2022). *Pinellas County Housing Authority reopened section 8 housing voucher waitlist, received many applications.* ABC Action News. https://www.abcactionnews.com/news/region-pinellas/pinellas-county-reopened-section-8-housing-choice-voucher-waitlist-received-large-number-of-applications#:~:text=If%20you%20applied%20for%20assistance%20through%20Pinellas%20County%20Housing%20Authority%E2%80%99s

Homelessness & Housing. (2024). Office of the Assistant Secretary for Planning and Evaluation. https://www.aspe.hhs.gov/topics/homelessness-housing

Homeless Leadership Alliance. (2023). *Coordinated Entry System Policy & Procedures*. https://static1.squarespace.com/static/5c784173a9ab953d5ee017d5/t/65033f1a007efd319c9278a8/1694711579454/CE+Policies+and+Procedures+09.14.23.pdf#:~:text=Coordinated%20Entry%20(CE)%20improves%20access%20to%20resources%20through%20standardized%20assessments

Hotspotting the overdose epidemic program: a data-driven strategy to end the crisis. (2022). Hotspotting the Overdose Epidemic. https://hotspottingtheoverdoseepidemic.com/

Housing. (2017). People Empowering & Restoring Communities. https://exoffender.org/programs/programs-ex-offenders/housing/

Housing Applicants. (n.d.). St. Petersburg Housing Authority. https://www.stpeteha.org/housing-applicant

HPSA Find. (2024). *Primary care MDs/100k population by Florida County*. Health Resources & Services Administration. https://data.hrsa.gov/tools/shortage-area/hpsa-find

Hub and spoke. (2024). State of Vermont Blueprint for Health. https://blueprintforhealth.vermont.gov/about-blueprint/hub-and-spoke

Illinois Department of Human Services. (2023). *Scattered Site Permanent Supportive Housing.* State of Illinois. https://www.dhs.state.il.us/page.aspx?item=161572

Infectious Disease Elimination Act (IDEA) Exchange. (2019). Florida Health. https://www.floridahealth.gov/programs-and-services/idea/exchange.html

Javed, Z., Pegram, L., Burk, K., et al. (2020). *Syringe Services Programs: A Technical Package of Effective Strategies and Approaches for Planning, Design, and Implementation*. Centers for Disease Control and Prevention. https://www.cdc.gov/overdose-prevention/media/pdfs/Syringe-Services-Programs-SSPs.pdf

Justice, C., Long, J., Eggers, D., et al. (2016). *Minutes -Final Board of County Commissioners.* https://www.mypinellasclerk.gov/Portals/0/Finance-Comptroller/BCC%20Minutes/2016/508_bcc160809_minutes.pdf

Kamyck, D. (2024). *San Joaquin community HIE and activate care partner to connect CBOs, support SDOH and improve outcomes for medicaid patients*. Activate Care. https://blog.activatecare.com/news/san-joaquin-wpc

Keefe, P.R. (2021). *Empire of Pain: The Secret History of the Sackler Dynasty*. Doubleday.

Knopf, T. (2024). *North Carolina to expand peer-led crisis services in push for more mental health support*. NC Health News. https://www.northcarolinahealthnews.org/2024/04/29/north-carolina-to-expand-peer-led-crisis-services-in-push-for-more-mental-health-support/

Lake County. (2023). *Lake County takes steps to address opioid epidemic with settlement funds*. GovDelivery. https://content.govdelivery.com/accounts/ILLAKE/bulletins/36d9b19

Lakeview Center. (2024). *Lakeview Center opening Central Receiving Facility for adults under the Baker Act*. https://elakeviewcenter.org/2024/04/25/lakeview-center-opening-central-receiving-facility-for-adults-under-the-baker-act/

Lembke, A. (2016). *Drug Dealer, MD: How Doctors Were Duped, Patients Got Hooked, and Why It's So Hard to Stop*. Johns Hopkins University Press.

Lewin, K. (2021). *Paramedicine program in Clay aims to reduce overdoses, create coalition to fight epidemic*. The Florida Times-Union. https://www.jacksonville.com/story/news/2021/12/28/community-paramedicine-program-starts-clay-county-combat-opioids/6419989001/

Macy, B. (2018). *Dopesick*. Little, Brown and Company.

Maryland Department of Aging. (n.d.). *Maryland Access Point (MAP)*. *https://aging.maryland.gov/Pages/maryland-access-point.aspx*

Massachusetts Department of Health (2016*). Assessment of Massachusetts Opioid-Related Deaths: Preliminary Findings*. https://d279m997dpfwgl.cloudfront.net/wp/2016/08/DPH-Legislative-Report-Ch.-55-Status-Report.pdf

Massachusetts DOC awarded $1.2m in federal funds to tackle opioid addiction. (2019). Massachusetts Department of Correction. https://www.mass.gov/news/massachusetts-doc-awarded-12m-in-federal-funds-to-tackle-opioid-addiction#:~:text=Online&text=Milford%20%E2%80%94%20The%20Massachusetts%20Department%20of,Mici%20said%20today.

Massachusetts Executive Office of Health and Human Services. (2022). *Notice of Proposed Agency Action*. The Commonwealth of Massachusetts Executive Office of Health and Human Services: Office of Medicaid. https://www.mass.gov/doc/notice-of-proposed-agency-action-masshealth-payment-rates-for-masshealth-substance-abuse-treatment-hospitals-effective-november-1-2022-0/download

Matthews, D. (2024). *Orange County pushes fentanyl testing strips to prevent overdoses*. WFTV 9 Orlando News. https://www.wftv.com/news/local/orange-county-pushes-fentanyl-testing-strips-prevent-overdoses/7LPO7CTFC5CPLPB6HZGYDV4IDM/

Mayor Adams announces city has served over 750 family members of fatal overdose victims through first-in-nation support program. (2024). City of New York City. https://www.nyc.gov/office-of-the-mayor/news/352-24/mayor-adams-city-has-served-750-family-members-fatal-overdose-victims-through

McCarthy, D. & Waugh, L. (2021). *How a Medical Respite Care Program Offers a Pathway to Health and Housing for People Experiencing Homelessness*. The Commonwealth Fund. *https://www.commonwealthfund.org/publications/case-study/2021/aug/how-medical-respite-care-program-offers-pathway-health-housing*

McCrary, H., Etwaroo, E., Marshall, L., et al. (2022). *Peer Recovery Support Services in Correctional Settings*. Bureau of Justice Assistance, U.S. Department of Justice. https://www.cossup.org/Content/Documents/Publications/Altarum_PRSS_in_Correctional_Settings.pdf

Medical Director Options 6.13. (2020). *Leave-behind naloxone*. Massachusetts Department of Public Health Office of Emergency Medical Services. https://www.mass.gov/doc/emergency-release-of-613-leave-behind-naloxone-updated-december-2020/download

Medication assisted therapy. (2024). Clay County, Florida. https://www.claycountygov.com/community/community-paramedicine-program/medication-assisted-therapy

Miller, M., Spangler, M., Adams, N., et al. (2023). *Involuntary treatment for substance abuse: Client outcomes (Document Number 23-06-3401).* Olympia: Washington State Institute for Public Policy. https://wsipp.wa.gov/ReportFile/1766/Wsipp_Involuntary-Treatment-for-Substance-Abuse-Client-Outcomes_Report.pdf

Mobile SSP. (2024). Rebel Recovery. https://pbc.rebelrco.org/syringe/

Moulin, A. & Keating, S. (2021). *Addiction is an emergency: end wait times for services and expand access to life-saving medications.* Health Affairs Forefront. https://www.healthaffairs.org/do/10.1377/forefront.20211208.799414

National Academy of Sciences. (2018). *Permanent supportive housing: evaluating the evidence for improving health outcomes among people experiencing chronic homelessness.* National Library of Medicine: National Center for Biotechnology information. https://www.ncbi.nlm.nih.gov/books/NBK519591/

National Alliance for Recovery Residences. (2012). A Primer on Recovery Residences: from the National Association of Recovery Residences. https://www.farronline.org/_files/ugd/866278_7925ccb7a790400a993e850687f0efd5.pdf

National Archives. (2024). *Title 42, Chapter I, Subchapter A, Part 2 – Confidentiality of Substance Use Disorder Patient Records*. Code of Federal Regulations. https://www.ecfr.gov/current/title-42/chapter-I/subchapter-A/part-2

National Center for Health Statistics. (2024). *U.S. Overdose Deaths Decrease in 2023, First Time Since 2018*. Centers for Disease Control and Prevention (CDC). https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2024/20240515.html

National Commission on Correctional Healthcare. (2016). *Standards for Opioid Treatment Programs*. https://www.ncchc.org/opioid-treatment-programs-standards/

National Commission on Correctional Healthcare. (2021*). Naloxone in Correctional Facilities for the Prevention of Opioid Overdose Deaths.* https://www.ncchc.org/wp-content/uploads/Naloxone-in-Correctional-Facilities-for-the-Prevention-of-Opioid-Overdose-Deaths.pdf#:~:text=In%20accordance%20with%20state%20laws%2C%20naloxone%20kits%20should,risk%20for%20opioid%20overdose%2C%20as%20well%20as%20visitors.13

National Council for Mental Wellbeing. (2024). *2024 CCBHC Impact Report*. file:///C:/Users/DB873AN/Downloads/24.06.3_2024-CCBHC-Impact-Report_FINAL.pdf

National Health Care for the Homeless Council. (2017). *Medical Respite Care: Financing Approaches*. https://nhchc.org/wp-content/uploads/2019/08/policy-brief-respite-financing.pdf

National Institute for Medical Respite Care. (2021). *Medical Respite Literature Review: An Update on the Evidence for Medical Respite Care.* https://nimrc.org/wp-content/uploads/2021/08/NIMRC_Medical-Respite-Literature-Review.pdf

National Institute for Medical Respite Care. (2021). *Standards for Medical Respite Care Programs*. https://nimrc.org/wp-content/uploads/2021/09/Standards-for-Medical-Respite-Programs_2021_final.pdf

National Institute for Medical Respite Care. (2023). *Standard 1: Medical respite program provides safe and quality accommodations.* https://nimrc.org/wp-content/uploads/2023/08/Standard-1-Examples.pdf

National Institute for Occupational Safety and Health (NIOSH). (2024). U.S. Centers for Disease Control and Prevention. https://www.cdc.gov/niosh/index.html

National Institute of Justice. (2012). *NIJ's Multisite Adult Drug Court Evaluation*. https://nij.ojp.gov/topics/articles/nijs-multisite-adult-drug-court-evaluation

National Judicial Task Force to Examine State Courts' Response to Mental Illness. (2022). *Peers in Courts*. https://www.ncsc.org/__data/assets/pdf_file/0029/77690/Peers-in-Courts.pdf#:~:text=Florida%20Criminal%20Mental%20Health%20Project,%20the%20Eleventh%20Judicial%20Circuit%20Miami-Dade

National Judicial Opioid Task Force. (n.d.). *Involuntary Commitment and Guardianship Laws for Persons with a Substance Use Disorder*. https://www.ncsc.org/__data/assets/pdf_file/0028/18478/inv-comm-and-guard-laws-for-sud-final.pdf

National Opioid Settlement. (2021). *Florida Allocation Proposal*. https://nationalopioidsettlement.com/wp-content/uploads/2021/09/Final-Florida-Allocation-Proposal-Revised-with-Exhibits.pdf

National Treatment Court Resource Center. (n.d.). *Best Practice Resources*. https://ntcrc.org/best-practice-resources/

New federal rules make it much easier to expand access to treatment. (2022). Johns Hopkins Bloomberg School of Public Health. https://opioidprinciples.jhsph.edu/new-federal-rules-make-it-much-easier-to-expand-access-to-treatment/

New York Police Department. (2017). *NYPD Launches Public Service Announcement to Increase 'Good Samaritan Law' Awareness*. https://www.nyc.gov/site/nypd/news/pr0623/nypd-launches-public-service-announcement-increase-good-samaritan-law-awareness

North Carolina Department of Health and Human Services. (2024). *NC Launches Additional Phone Support for People Experiencing Mental Illness or Substance Use Disorder*. State of North Carolina. https://www.ncdhhs.gov/news/press-releases/2024/02/19/nc-launches-additional-phone-support-people-experiencing-mental-illness-or-substance-use-disorder

O'Brien, J. (2021). *Marchman Act: A look inside Florida's law forcing some into drug treatment*. CBS 12 News. https://cbs12.com/news/local/marchman-act-a-look-inside-floridas-law-forcing-some-into-drug-treatment

Office of Policy Development and Research. (2023). *Housing First: A Review of the Evidence | HUD USER*. www.huduser.gov. https://www.huduser.gov/portal/periodicals/em/spring-summer-23/highlight2.html

Ohio Recovery Housing. (n.d.). https://www.ohiorecoveryhousing.org/

Ohio State Health & Discovery. (2024). *Do you know how to help someone experiencing an overdose? Most Americans say they don't*. The Ohio State University. https://health.osu.edu/community-health/substance-use/most-americans-dont-know-how-to-help-overdose#:~:text=A%20new%20survey%20indicates%20that%2075%25%20of%20Americans,know%20how%20to%20help%20someone%20experiencing%20an%20overdose.

Opioid abatement authority announces more than $470,000 in awards. (2023). Virginia Opioid Abatement Authority. https://www.oaa.virginia.gov/media/governorvirginiagov/oaa/pdf/Dec.-7-OAA-Press-Release.pdf

Opioid Abatement Funding Advisory Board. (2024). *Pinellas County Regional Opioid Abatement Funding Priority List*. https://pinellas.gov/wp-content/uploads/2024/06/Pinellas-County-Regional-Opioid-Abatement-Priority-List-FY-24-25.pdf

Opioid remediation settlement advisory committee. (2018). Saint Louis County Minnesota. https://www.stlouiscountymn.gov/departments-a-z/public-health-human-services/boards-committees/opioid-remediation-settlement-advisory-committee

Opioid response program administrator. (2023). Geebo: Leesburg, VA. https://leesburg-va.geebo.com/jobs-online/view/id/1333837116-opioid-response-program-administrator-/

Opioid settlement. (2024). NextLevel Recovery Indiana. https://www.in.gov/recovery/settlement/

Orange County Christian counseling: professional help with faith-based values. (2024). Orange County Christian Counseling. https://orangecountychristiancounseling.com/

Orange County, Florida. (2024). *Orange County Code of Ordinances, Supplement 120*. https://library.municode.com/fl/orange_county/codes/code_of_ordinances

Oregon Knowledge Bank. (n.d.). *Marion County jail Reentry Program. https://okb.oregon.gov/Pages/marion-county-jail-reentry-program.aspx*

Orgera, K. & Tolbert, J. (2019). *The Opioid Epidemic and Medicaid's Role in Facilitating Access to Treatment*. KFF. https://www.kff.org/medicaid/issue-brief/the-opioid-epidemic-and-medicaids-role-in-facilitating-access-to-treatment/#:~:text=Medicaid%20facilitates%20access%20to%20treatment%20by%20covering%20inpatient,to%20expand%20treatment%20options%20for%20enrollees%20with%20OUD.

Pahlka, J. (2024). *Don't Fight Paper With Paper: How To Build a Great Digital Product With the Change in the Couch Cushions*. Eating Policy. https://www.eatingpolicy.com/p/dont-fight-paper-with-paper?utm_source=post-email-title&publication_id=2164237&post_id=148619260&utm_campaign=email-post-title&isFreemail=true&r=9xcw&triedRedirect=true&utm_medium=email

Palm Beach County Advisory Committee on Behavioral Health, Substance Use and Co-Occurring Disorders. (2024). *Behavioral Health and Substance Use Disorder Plan 2024: Advancing a resilience and recovery ecosystem of care*. https://discover.pbcgov.org/communityservices/BHSUCOD/Documents/BHSUCOD2024plan_051324_final.pdf

Parseghian, A. (2024). *No longer 'paraphernalia': Pinellas County advocates say fentanyl testing strips will save lives*. 10 Tampa Bay. https://www.wtsp.com/article/news/local/pinellascounty/fentanyl-testing-strip/67-30d93aab-a6bb-473e-977f-e9fd514f5d7d

Pattani, A., Larweh, H., & Mahon, E. (2024). *Public Voices Often Ignored in States' Opioid Settlement Money Decisions*. KFF HealthNews. https://kffhealthnews-org.cdn.ampproject.org/c/s/kffhealthnews.org/news/article/opioid-settlement-fund-council-meetings-public-comment-closed/amp/

Peer Recovery Center of Excellence. (2023). *Comparative Analysis of State Requirements for Peer Support Specialist Training and Certification in the United States*. https://peerrecoverynow.org/wp-content/uploads/2023-FEB-07-prcoe-comp-analysis.pdf

Perry, M. (2021). *Program to curb Tampa Bay's opioid deaths launches Friday*. Spectrum News. https://baynews9.com/fl/tampa/news/2021/05/20/program-to-curb-tampa-bay-s-opioid-deaths-launches-friday-

Personal Enrichment through Mental Health Services. (n.d.). *Family Services Eligibility Criteria*. https://pemhs.org/fsiconnect/#:~:text=Families%20are%20able%20to%20obtain%20goods%20and/or%20services%20from%20the

Pfefferle, S., Steverman, S., Gault, E., et al. (2019). *Approaches to Early Jail Diversion: Collaborations and Innovations*. Office of the Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/reports/approaches-early-jail-diversion-collaborations-innovations-0#execsum

Pfefferle, S.G., Karon, S.S., & Wyant, B. (2019). *Choice Matters: Housing Models that May Promote Recovery for Individuals and Families Facing Opioid Use Disorder*. Assistant Secretary for Planning and Education. https://aspe.hhs.gov/reports/choice-matters-housing-models-may-promote-recovery-individuals-families-facing-opioid-use-disorder-0#note7

Pinellas County. (n.d.). *Adult Emergency Financial Assistance Program*. https://pinellas.gov/adult-emergency-financial-assistance-program/#:~:text=Emergency%20mortgage%20assistance%20to%20reduce%20the%20risk%20of%20foreclosure.%20Utility

Pinellas County. (n.d.). *Family Housing Assistance Program*. https://pinellas.gov/programs/family-housing-assistance-program/#:~:text=The%20Family%20Housing%20Assistance%20Program%20(FHAP)%20helps%20families%20experiencing%20homelessness

Pinellas County health program. (2023). Pinellas County. https://pinellas.gov/programs/pinellas-county-health-program/

Pinellas County homeless resource guide. (2024). Homeless Leadership Alliance of Pinellas. https://static1.squarespace.com/static/5c784173a9ab953d5ee017d5/t/664e3db06b66925f69fc4bcd/1716403632499/Pinellas+Homeless+Resource+Guide+-+May+2024+-+For+Website+PDF.pdf

Pinellas County Housing Authority. (n.d.). *Housing Choice Voucher (Section 8)*. https://pinellashousing.com/housing-programs/housing-choice-voucher-section-8/

Pinellas County Housing Authority. (n.d.). *HUD-VASH*. https://pinellashousing.com/housing-programs/hud-vash/#:~:text=This%20program%20was%20designed%20to%20address%20the%20needs%20of%20the

Pinellas County Housing Authority. (n.d.). *Lakeside Terrace Apartments Wait List*. https://pinellashousing.com/lakeside-terrace-apartment-opening-wait-list/

Pinellas County Opioid Task Force. (n.d.). *Strategic plan 2020-2022*. Florida Department of Health in Pinellas County. https://pinellas.floridahealth.gov/programs-and-services/wellness-programs/substance-use-prevention/pinellas-county-opioid-task-force/_documents/opioid-task-force-strategic-plan-2.3.pdf

Pinellas County Opioid Task Force. (n.d.). *Strategic plan 2023 – 2027*. Florida Department of Health in Pinellas County. https://pinellas.floridahealth.gov/programs-and-services/wellness-programs/substance-use-prevention/pinellas-county-opioid-task-force/_documents/2023-2027-strategic-plan.pdf

Pinellas County Resource Manual. (2023). The Healthy Start Coalition of Pinellas. https://healthystartpinellas.org/wp-content/uploads/2023/06/Healthy-Start-Manual-2023.pdf

Pinellas County Schools. (2024). Pinellas County Schools. https://www.pcsb.org/

Pinellas County Sheriff's Office. (n.d.). *Alternative Sentencing and Pre-Trial Services*. https://pcsoweb.com/alternative-sentencing#:~:text=Adult%20Pre-Arrest%20Diversion%20Program:%2024%20hours%20/%207%20days%20a

Pinellas Hope. (2024). *Permanent supportive housing*. Catholic Charities, Diocese of St. Petersburg Inc. https://pinellashope.org/permanent-supportive-housing/

Plato Academy. (2023). *Palm harbor*. Plato Academy Schools. https://platoacademy.net/charter-schools/palm-harbor/

Pomona Valley Hospital Medical Center. (2024). *Free Fentanyl Test Strip Kits Now Available at the Emergency Department, 24/7*. https://www.pvhmc.org/blog/2024/august/free-fentanyl-test-strip-kits-now-available-at-t/

Porter, S. (2022). *BCC approves airport, public works, and human services projects*. Tampa Bay Newspapers. https://www.tbnweekly.com/pinellas_county/article_b042cfc8-cc96-11ec-9eed-abc1382d4d74.html

Pourat, N., Chuang, E., O'Masta, B., et al. (2024). *Final Evaluation of California's Whole Person Care (WPC) Program*. UCLA Center for Health Policy Research. https://healthpolicy.ucla.edu/sites/default/files/2024-03/whole-person-care-final-evaluation-report-approved-with-signature_03_11_24.pdf

Prescription Drug Monitoring Program – Take Control of Controlled Substances ▸ #TakeControl. (n.d.). https://flhealthsource.gov/FloridaTakeControl/pdmp/

Prince George's County. (n.d.). *Recovery Clubhouse – Adolescent*. https://www.princegeorgescountymd.gov/departments-offices/health/behavioral-health-services/recovery-clubhouse-adolescent

Quinones, S. (2015). *Dreamland: The True Tale of America's Opiate Epidemic*. Bloomsbury Press.

Raths, D. (2021). *Alameda County's social health information exchange expands*. Healthcare Innovation. https://www.hcinnovationgroup.com/interoperability-hie/health-information-exchange-hie/article/21240807/alameda-countys-social-health-information-exchange-expands

Riese, T. (2024). *Luzerne County steers away from $1M opioid misuse ad campaign*. WVIA. https://www.wvia.org/news/local/2024-07-10/luzerne-county-steers-away-from-1m-opioid-misuse-ad-campaign

Ryan White Care Council. (2024). *HIV/AIDS service providers*. https://thecarecouncil.org/resources/hiv-aids-services/

SAMHSA Best Practices for Recovery Housing. (2023). https://store.samhsa.gov/sites/default/files/pep23-10-00-002.pdf

SAMHSA opioid overdose prevention toolkit: five essential steps for first responders. (2018). Substance Abuse and Mental Health Services Administration. https://store.samhsa.gov/sites/default/files/five-essential-steps-for-first-responders.pdf

Save the Michaels of the World, Inc. (n.d.). *Transportation Aid*. https://www.savethemichaels.org/transportation-aid

Stanford-Lancet Commission on the North American Opioid Crisis. (n.d.). Stanford University. https://opioids.stanford.edu/

State of Rhode Island Department of Corrections. (n.d.) Behavioral Health Services. https://doc.ri.gov/programs-services/healthcare-services/behavioral-health-services

State of Wisconsin Division of Energy, Housing, and Community Resources. (2024). *Recovery voucher grant program (RV)*. Wisconsin.gov. https://energyandhousing.wi.gov/Pages/AgencyResources/RecoveryVoucherGrant.aspx

Staten Island Performing Provider System. (2021). *Hotspotting the overdose epidemic program*. Behavioral Health Programs. https://statenislandpps.org/behavioral-health-programs/hotspotting-the-overdose-epidemic-program/

Statewide Office on Homelessness and Housing Solutions. (n.d.). *Kauhale Initiative*. State of Hawaii. https://homelessness.hawaii.gov/kauhale/

Substance Abuse and Mental Health Services Administration, Office of the Surgeon General. (2016). *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. U.S. Department of Health and Human Services, https://www.ncbi.nlm.nih.gov/books/NBK424857/

Substance Abuse and Mental Health Services Administration. (2015). *Federal Guidelines for Opioid Treatment Programs*. Substance Abuse and Mental Health Services Administration. *https://store.samhsa.gov/sites/default/files/guidelines-opioid-treatment-pep15-fedguideotp.pdf*

Substance Abuse and Mental Health Services Administration. (2017). *Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison: Implementation Guide*. (SMA)-16-4998. https://store.samhsa.gov/sites/default/files/sma16-4998.pdf

Substance Abuse and Mental Health Services Administration. (2020). *Substance Use Disorder Treatment for People With Co-Occurring Disorders.* https://store.samhsa.gov/sites/default/files/pep20-02-01-004.pdf

Substance Abuse and Mental Health Services Administration. (2023). *Harm Reduction Framework*. Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/sites/default/files/harm-reduction-framework.pdf

Substance Abuse and Mental Health Services Administration. (2023). *Recommendations for Curricular Elements in Substance Use Disorders Training.* https://www.samhsa.gov/medications-substance-use-disorders/provider-support-services/recommendations-curricular-elements-substance-use-disorders-training

Substance Abuse and Mental Health Services Administration. (n.d.) *Core Competencies for Peer Workers in Behavioral Health Services*. Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/core-competencies_508_12_13_18.pdf

Substance Abuse and Mental Health Services Administration. (n.d.). *Harm Reduction*. Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/find-help/harm-reduction#:~:text=Harm%20reduction%20plays%20a%20significant%20role%20in%20preventing,chronic%20diseases%20%28such%20as%20HIV%20and%20hepatitis%20C%29.

Substance Abuse and Mental Health Services Administration. (n.d.). *Providers Clinical Support System – Medications for Opioid Use Disorder (PCSS-MOUD).* Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/medications-opioid-use-disorders-pcss-moud

Swartz, M.S., Hoge, S.K., Pinals, D.A., et al. (2015). *Resource document on involuntary outpatient commitment and related programs of assisted outpatient treatment.* American Psychiatric Association. https://www.psychiatry.org/File%20Library/Psychiatrists/Directories/Library-and-Archive/resource_documents/resource-2015-involuntary-outpatient-commitment.pdf

Syringe Services Programs (SSPs). (2024). *Safety and effectiveness of syringe services programs.* U.S. Centers for Disease Control and Prevention. https://www.cdc.gov/syringe-services-programs/php/safety-effectiveness.html?CDC_AAref_Val=https://www.cdc.gov/ssp/syringe-services-programs-summary.html

Syringe Services Programs (SSPs). (2024). *Syringe service programs.* U.S. Centers for Disease Control and Prevention. https://www.cdc.gov/syringe-services-programs/php/index.html?CDC_AAref_Val=https://www.cdc.gov/ssp/docs/SSP-Technical-Package.pdf

Tampa Bay Times Editorial Board. (2024*). Pinellas' smart approach to Florida's homeless camping ban | Editorial.* Tampa Bay Times. https://www.tampabay.com/opinion/2024/07/03/pinellas-smart-approach-floridas-homeless-camping-ban-editorial/

The facts. Your future. (2024). The Facts. Your Future. https://thefactsyourfuture.org/

The Florida senate. (2024). State of Florida. https://m.flsenate.gov/

Tompkins, L. (2024). *Can a Big Village Full of Tiny Homes Ease Homelessness in Austin?* The New York Times. https://www.nytimes.com/2024/01/08/headway/homelessness-tiny-home-austin.html

Tookes, H. (2023). *Miami-Dade County Sterile Needle and Syringe Exchange Program Annual Report.* Retrieved from https://documents.miamidade.gov/mayor/memos/09.08.23-Miami-Dade-County-Sterile-Needle-and-Syringe-Exchange-Program-Annual-Report.pdf

Truth Initiative. (2020). *The Truth About Opioids.* https://truthinitiative.org/sites/default/files/media/files/2020/12/Truth_The%20Truth%20About%20Opioids%20Report_final.pdf

UCA, community partners awarded more than $200,000 in opioid settlement dollars. (2024). University of Central Arkansas, UCA News. https://uca.edu/news/uca-community-partners-awarded-more-than-200000-in-opioid-settlement-dollars/

UNC Institute for Best Practices. (2024). https://www.institutebestpractices.org/

United States Census Bureau. (2023). *Pinellas County, Florida*. https://data.census.gov/profile/Pinellas_County,_Florida?g=050XX00US12103

United States Census Bureau. (2018). *B25064: Median Gross Rent (Dollars).* https://data.census.gov/table?q=B25064:%20Median%20Gross%20Rent%20(Dollars)&g=010XX00US_040XX00US12_050XX00US12033,12057,12101&y=2018

United States Department of Housing and Urban Development. (2024). *Biden-Harris Administration Expands Access to Housing for Veterans*. https://www.hud.gov/press/press_releases_media_advisories/hud_no_24_202#:~:text=Requiring%20public%20housing%20agencies%20(PHAs)%20that%20administer%20HUD-VASH%20to%20set

United States Department of Housing and Urban Development. (2021). *Housing Choice Voucher Program Guidebook: HUD-VASH Vouchers*. https://www.hud.gov/sites/dfiles/PIH/documents/HUD_VASH_HCV_Guidebook_Chapter_July_2021.pdf#:~:text=Through%20the%20HUD-VASH%20program,%20eligible%20homeless%20veterans%20receive%20housing%20assistance

United States Department of Justice. (2024). https://www.justice.gov/

United States Department of Labor. (2024). https://www.dol.gov/

United States Department of Transportation. (2022). *Mobility on Demand (MOD) Sandbox Demonstration: Pinellas Suncoast Transit Authority (PSTA) PublicPrivate-Partnership for Paratransit Evaluation Report [Review of Mobility on Demand (MOD) Sandbox Demonstration: Pinellas Suncoast Transit Authority (PSTA) PublicPrivate-Partnership for Paratransit Evaluation Report].* Federal Transit Administration. https://www.transit.dot.gov/sites/fta.dot.gov/files/2022-04/FTA-Report-No-0213_0.pdf

United States Department of Veterans Affairs. (n.d.). *VA Homeless Programs: Permanent Housing Assistance for Veterans.* https://www.va.gov/homeless/housing.asp

United States Government Accountability Office, U. S. G. A. (n.d.). *Prescription Drug Monitoring Programs: Views on Usefulness and Challenges of Programs.* www.gao.gov. https://www.gao.gov/products/gao-21-22

University of South Florida College of Behavioral & Community Sciences. (2023). *Baker Act Reporting Center Fiscal Year 2022-2023 Report.* Florida Department of Children and Families. https://www.usf.edu/cbcs/baker-act/documents/ba_usf_annual_report_2022_2023.pdf

Vincent House. (2024). Vincent House. https://vincenthouse.org/

Walk Score. (n.d.). *Cities & Neighborhoods.* https://www.walkscore.com/FL/St._Petersburg

Washington State Health Care Authority. (n.d.). *Electronic consent management*. *https://www.hca.wa.gov/about-hca/programs-and-initiatives/clinical-collaboration-and-initiatives/electronic-consent-management*

Washoe Opioid Abatement and Recovery Fund (WOARF) Plan 2023-2025. (n.d.). Office of the County Manager. https://www.washoecounty.gov/mgrsoff/divisions/Community%20Reinvestment/files/Washoe%20Opioid%20Abatement%20and%20Recovery%20Fund%20Plan%202023-2025.pdf

Welcome to the Jail and Prison Opioid Project (JPOP). (2024). Jail & Prison Opioid Project. https://prisonopioidproject.org/

Wellspring Counseling. (2024). Wellspring Counseling. https://www.wellspringmiami.org/

WHAM. (2023). *Naloxone boxes installed at Monroe County-owned parks amid increase in overdoses.* https://13wham.com/news/local/naloxone-boxes-narcan-monroe-county-parks-rochester-opioid-overdoses-michael-fowler-sheriffs-office

What is Live Tampa Bay? (2024). Live Tampa Bay: Presented by the Tampa Bay Partnership. https://livetampabay.org/

Williams, T. (2017). *Opioid Users Are Filling Jails. Why Don't Jails Treat Them?* The New York Times. https://www.nytimes.com/2017/08/04/us/heroin-addiction-jails-methadone-suboxone-treatment.html

Wyant, B.E. et al. (2019). *Housing options for recovery for individuals with opioid use disorder: a literature review.* Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/reports/housing-options-recovery-individuals-opioid-use-disorder-literature-review

The following data from Pinellas County's agencies and other organizations was also used:

6th Judicial Circuit Drug Court: Recidivism data (2018-2022)

Boley Centers: financial data by location (2018 - 2024)

Central Florida Behavioral Health Network (CFBHN) funded programs & amounts (FY2022 - FY2024)

Designation of Baker Act receiving facilities (2022)

Florida Association of Recovery Residences: Levels of support

Florida Association of Recovery Residences: List of accredited recovery residences

Florida Department of Children and Families state Narcan dashboard

Florida Department of Children and Families state Opioid dashboard

Florida Department of Corrections: Monthly statistics report, May 2024

Florida Health Charts youth substance abuse survey results (2014-2022)

Florida Hospital Association: Hometown hero housing program issue brief (2023)

Florida neonatal abstinence syndrome (NAS) case counts and rates by county (2014-2021)

Florida State Medical Examiners Commission: Opioid overdoses by type of drug (2016-2022)

Gulf Coast Jewish Family and Community Services quick response team (QRT) data (2022-2024)

Homeless Leadership Alliance of Pinellas (including 2024 point in time count)

Job Listing: Director of opioid recovery

List of opioid treatment programs (OTPs) in Florida (October 2023)

List of Pinellas County childcare locations (2024)

Operation Parental Awareness and Responsibility (PAR): Detox and inpatient rehab data (2016 - 2024)

Operation Parental Awareness and Responsibility (PAR): Quick Response Team (QRT) licensed staff and patient capacity

Opioid Task Force of Pinellas County survey analysis

Opioid Task Force Outreach Event Log

Orange County Opioid Settlement Funds Advisory Committee: Meeting minutes, May 10, 2024

Overdose heat map: Drug related deaths by demographic information (2021-2023)

Oxford Vacancies website listings

Pinellas County Board of County Commissioners: Meeting minutes, January 16, 2024

Pinellas County human service dashboard (2024)

Pinellas County Opioid Task Force implementation reports (2020-2022, 2023-2027)

Pinellas County Opioid Task Force: Meeting presentation, December 2022

Pinellas County Opioid Task Force: Opioid overdose deaths by race/ethnicity (2014-2022)

Pinellas County resource guide

Program Monitoring Report: Children's Outpatient Program (FY2021, FY2022) (Sent by JWB in their role as funder)

Program Monitoring Report: PAR Motivating New Parents (FY2022) (Sent by JWB in their role as funder)

Program Monitoring Report: PAR Outpatient Service Array (FY2021, FY2022) (Sent by JWB in their role as funder)

Program Monitoring Report: Suncoast Center Family Services (FY2021, FY2022) (Sent by JWB in their role as funder)

Request for quote (RFQ) of bed availability system (2024)

Substance Abuse and Mental Health Services Administration (SAMHSA): Center for Behavioral Health Statistics and Quality (CBHSQ) data brief

Substance Abuse and Mental Health Services Administration (SAMHSA): Evidence-based resource guide series: Use of medication-assisted treatment for opioid use disorder in criminal justice settings

United States emergency department visits and alcohol use disorder prevalence (2018-2022)

U.S. Bureau of Labor Statistics: count of social workers per 100k population, by county

U.S. Census Data: Population distribution by race and age for Pinellas County

U.S. Center for Disease Control: Overdose deaths by city (2018-2024)

Appendix B: Inventory of services

This appendix provides an inventory of existing services (including programs, treatment facilities, housing providers, and health services) in Pinellas County and demonstrates which part of the CoC is addressed by each.

The programs shown in Table B1 are initiatives delivered by community-based organizations that commonly serve individuals with SUD or OUD. These initiatives do not include services that primarily focus on clinical or residential support.

Table B1: Existing programs in Pinellas County

Initiative	Organization	Prevention	Acute addiction	Seeking help	Acute/post-acute care	Long-term maintenance	Employment	General healthcare	Community and family support	Justice
Addiction Recovery Guide	211 Tampa Bay	■		■						
First Responder Hope Line	211 Tampa Bay			■	■					
Crisis Intervention Team (CIT) Training	Directions for Living	■		■						■
988 Lifeline	988 Lifeline			■						
Diversion Program	Advanced Care Physicians Group									■
Florida Assertive Community Treatment (FACT) Team (Boley)	Boley Centers			■	■	■				
Lifesaving Programming for Middle School Children	Boys & Girls Clubs of the Suncoast	■								
Overdose Data to Action	CDC	■								
Parents' Guide to Fentanyl	Central Florida Behavioral Health Network	■								
Talk. They Hear You	Central Florida Behavioral Health Network	■								
Pinellas Support Team Program	Children's Home Network					■				
Mental Health First Aid Training	Clearwater Police Department									■
BabyCAT	Directions for Living				■	■				
Cooperative Agreements to Benefit Homeless Individuals (CABHI)	Directions for Living				■	■				
Early Childhood Consultation	Directions for Living	■								
Family Intensive Treatment Team (FITT)	Directions for Living				■	■				
First Five	Directions for Living	■								
Homebuilders	Directions for Living				■	■				
Homeless Outreach Mobile Engagement (HOME)	Directions for Living				■					
SSI/SSDI Outreach, Access, and Recovery (SOAR)	Directions for Living								■	

Initiative	Organization	Prevention	Acute addiction	Seeking help	Acute/post-acute care	Long-term maintenance	Employment	General healthcare	Community and family support	Justice
Targeted Prevention	Directions for Living				■					
Telehealth Remote Access to Crisis Evaluation (TRACE)	Directions for Living			■						
Opioid Use Prevention Toolkit	Drug Free America Foundation	■	■	■						
Recovery Club House	Dry Dock Center								■	
Sharps Disposal Program	Florida Department of Health in Pinellas County		■							
Workforce Development Program	Florida Dream Center						■			
Naloxone Expansion Initiative (Clearwater)	Florida Harm Reduction Collective				■					
Naloxone Expansion Initiative (Largo)	Florida Harm Reduction Collective				■					
Naloxone Expansion Initiative (Pinellas Park)	Florida Harm Reduction Collective				■					
Naloxone Expansion Initiative (St. Petersburg)	Florida Harm Reduction Collective				■					
Naloxone Expansion Initiative (Tarpon Springs)	Florida Harm Reduction Collective				■					
Regional Harm Reduction Workshops	Florida Harm Reduction Collective				■					
Victory High School	Florida Recovery Schools of Tampa Bay			■		■				
Community Assistance & Life Liaison Program (CALL)	Gulf Coast JFCS			■						
Prevention and Intervention Services	Gulf Coast JFCS	■		■						
Quick Response Team (Gulf Coast JFCS)	Gulf Coast JFCS		■	■	■					
CAPTA	Healthy Start Coalition		■			■				
Fetal Care Program	Johns Hopkins All Children Hospital		■							
Neonatal Follow Up Care Program	Johns Hopkins All Children Hospital		■							
Children's Mental Health Initiative (CMHI)	Juvenile Welfare Board (JWB)	■								
Motivating New Moms	Juvenile Welfare Board (JWB)	■	■							
Medication for Addiction Treatment & Electronic Referrals (MATTERS) Pinellas	MATTERS		■	■	■					
Florida Assertive Community Treatment (FACT) Team (MHRC)	Mental Health Resource Center			■	■	■				
Coping Skills & Substance Misuse Program	Metro Health					■				
Multijurisdictional Counterdrug Task Force Training	Multijurisdictional Counterdrug Task Force Training									■
Crisis Text Line	NAMI Pinellas			■						
School Presentations Program	NOPE of Pinellas	■								
Prevention Services Program	Operation PAR	■								
Quick Response Team (Operation PAR)	Operation PAR		■	■	■					
Needs Assessment Program	People Empowering & Restoring Communities	■		■						

Initiative	Organization	Prevention	Acute addiction	Seeking help	Acute/post-acute care	Long-term maintenance	Employment	General healthcare	Community and family support	Justice
IDEA Exchange Pinellas	People Empowering & Restoring Communities		■		■					
Program for Employers	People Empowering & Restoring Communities						■			
St. Pete Works Employment Link Platform	People Empowering & Restoring Communities						■			
H.O.M.E Navigation	Personal Enrichment Through Mental Health Services				■		■			
IMPACT Team	Personal Enrichment Through Mental Health Services			■	■					
Pinellas Integrated Care Team (PIC)	Personal Enrichment Through Mental Health Services				■					
Pinellas Mobile Crisis Response Team	Personal Enrichment Through Mental Health Services			■		■				
The Community Action Team (CAT)	Personal Enrichment Through Mental Health Services			■	■	■	■		■	
Care About Me (CAM)	Pinellas County Human Services Department			■	■					
Complex Case Reintegration Program	Pinellas County Human Services Department			■	■	■				
Mental Health Court	Pinellas County Human Services Department					■				■
Substance Use Data Reporting Dashboard	Pinellas County Human Services Department									
FACE IT Program	Pinellas County Schools	■								
Narcotics Investigations Program	Pinellas County Sheriff's Office	■								
Pinellas Prevention Partners	Pinellas Prevention Partners	■								
5 % Campaign	Recovery Epicenter Foundation		■							
Florida Harm Reduction Collective - SSP's	Recovery Epicenter Foundation		■	■						
Gideon Narcan Policy	Recovery Epicenter Foundation		■							
Operation Recovery Starters Kit	Recovery Epicenter Foundation								■	
Sober Sports Alliance	Recovery Epicenter Foundation								■	
Adult Drug Court	Sixth Judicial Circuit									■
Addiction Studies Certificate	St. Petersburg College	■								
Mental Health Certificate Program	St. Petersburg College									■
Terra Nova (Pinellas Park)	Terra Nova								■	
THE FACTS. YOUR FUTURE.	THE FACTS. YOUR FUTURE.	■								
The Vincent House Program	Vincent House						■		■	
Camp Mariposa	West Care Gulf Coast	■								
Drug Court Services	West Care Gulf Coast					■				■
Veteran Mentoring Program	West Care Gulf Coast									■

Initiative	Organization	Prevention	Acute addiction	Seeking help	Acute/post-acute care	Long-term maintenance	Employment	General healthcare	Community and family support	Justice
Florida Assertive Community Treatment (FACT) Team (Suncoast Center)	Suncoast Center									
Together We Rise	Directions for Living									

The facilities shown in Table B2 are intensive treatment centers with a residential component and may have services available to individuals who do not live there. They do not include facilities with supportive housing where an individual could stay for months or years.

Table B2: Existing treatment facilities in Pinellas County

Initiative	Organization	Prevention	Acute addiction	Seeking help	Acute/post-acute care	Long-term maintenance	Employment	General healthcare	Community and family support	Justice
Agency for Community Treatment Services - Keystone Residential (Tarpon Springs)	Agency for Community Treatment Services (ACTS)					■	■			
Morton Plant Hospital Baker Act Receiving Facility	BayCare				■	■	■			
St. Anthony's Hospital Baker Act Receiving Facility	BayCare				■		■			
Mease Dunedin Hospital Baker Act Receiving Facility	BayCare				■		■			
Dr. Paul's at The Bay (St. Petersburg)	Dr. Paul's at The Bay					■	■			
Fairwinds Treatment Center (Clearwater)	Fairwinds Treatment Center					■	■			
Footprints Beachside Recovery (St. Pete beach)	Footprints Beachside Recovery					■	■			
Footprints Beachside Recovery (Treasure Island)	Footprints Beachside Recovery					■	■			
HCA Florida Largo Baker Act Receiving Facility	HCA Florida Largo				■		■			
Narconon Suncoast (Clearwater)	Narconon Suncoast					■	■			
Operation PAR (Clearwater)	Operation PAR					■	■			
Operation PAR (Largo)	Operation PAR				■	■	■			
Operation PAR (54th Ave St. Pete)	Operation PAR					■	■			
Crisis Stabilization Unit A	Personal Enrichment Through Mental Health Services				■	■	■			
Crisis Stabilization Unit B	Personal Enrichment Through Mental Health Services				■	■	■			
Tampa Bay Recovery Center (St. Petersburg)	Tampa Bay Recovery Center					■	■			
The WAVE of Clearwater	The WAVE Int						■			
The WAVE of Edgewater	The WAVE Int						■			
Tranquil Shores (St. Petersburg)	Tranquil Shores					■	■			
Transformations by the Gulf (St. Pete Beach)	Transformations by the Gulf			■		■	■			
WestCare Gulf Coast (MLK St St. Pete)	West Care Gulf Coast				■	■	■			
WhiteSands (Clearwater)	WhiteSands					■	■			
WhiteSands (Clearwater)	WhiteSands					■	■			
WhiteSands (Palm Harbor)	WhiteSands					■	■			
WhiteSands (St. Petersburg)	WhiteSands					■	■			

Initiative	Organization	Prevention	Acute addiction	Seeking help	Acute/post-acute care	Long-term maintenance	Employment	General healthcare	Community and family support	Justice
Windmoor Healthcare (Clearwater)	Windmoor Healthcare									
Boley Centers (32nd Ave St. Pete)	Boley Centers									
Boley Centers (7th Ave St. Pete)	Boley Centers									
Boley Centers (5th Ave St. Pete)	Boley Centers									
Boley Centers (37th St St. Pete)	Boley Centers									

The housing providers in Table B3 offer housing supports that are not specific to SUD/OUD. They generally do not offer comprehensive recovery and treatment services as a core component of the revenue model.

Table B3: Existing housing providers for individuals with OUD in Pinellas County[505]

Initiative	Organization	Housing linkages only	Emergency shelter	Transitional housing	Permanent supportive housing	Safe Haven
2-1-1 Tampa Bay Homeless Helpline	211 Tampa Bay	■				
Alpha House Transitional Housing	Alpha House			■		
Associate Recovery Communities (Clearwater)	Associate Recovery Communities			■		
Associate Recovery Communities (St. Petersburg)	Associate Recovery Communities			■		
Boley Centers Permanent Supportive Housing (PSH)	Boley Centers				■	
Community Action Stops Abuse (CASA) Transitional Housing	Community Action Stops Abuse (CASA)			■		
Family Works	Directions for Living	■				
Family Resources Inc (Clearwater)	Family Resources Inc		■			
Family Resources Inc (St. Petersburg)	Family Resources Inc		■			
Footprints Beachside Recovery (St. Pete Beach)	Footprints Beachside Recovery			■		
Tampa Bay Community Re-entry Center	Goodwill industries-Suncoast, Inc.			■		
Supported Housing/Living Program	Gulf Coast JFCS	■				
Homeless Empowerment Program	Homeless Empowerment Program		■		■	
Homeless Leadership Alliance Housing Program	Homeless Leadership Alliance	■				
Homeless Resource Guide	Homeless Leadership Alliance	■				
Kimberly Home Pregnancy Resource Center Transitional Housing	Kimberly Home Pregnancy Resource Center			■		
Koala House (Clearwater)	Koala House			■		
New Motives Sober Living (1/5)	New Motives			■		
New Motives Sober Living (2/5)	New Motives			■		
New Motives Sober Living (3/5)	New Motives			■		
New Motives Sober Living (4/5)	New Motives			■		

[505] Housing linkages connect individuals to housing, but do not provide it themselves.

Initiative	Organization	Housing linkages only	Emergency shelter	Transitional housing	Permanent supportive housing	Safe Haven
New Motives Sober Living (5/5)	New Motives			■		
Continental Housing Program (CHP)	People Empowering & Restoring Communities (PERC)			■		
One Unique Housing (OUT)	People Empowering & Restoring Communities (PERC)			■		
Pinellas Safe Harbor Shelter Program	Pinellas Safe Harbor		■			
Real Recovery Sober Living (Clearwater)	Real Recovery			■		
Real Recovery Sober Living (St. Petersburg)	Real Recovery			■		
Amnesty Program	Recovery Epicenter Foundation	■				
Center of Hope	Saint Vincent De Paul		■	■		
No Child Left Outside	Saint Vincent De Paul	■				
Salvation Army Hope Crest Transitional Housing	Salvation Army			■		
Adult Rehabilitation Centers	Salvation Army			■		
Salvation Army Emergency Shelter	Salvation Army		■			
St. Pete Free Clinic - Baldwin Women's Residence Transitional Housing	St. Pete Free Clinic			■		
St. Pete Free Clinic - Beacon House Men's Residence Transitional Housing	St. Pete Free Clinic			■		
WestCare Gulf Coast - Turning Point	West Care Gulf Coast		■			
Maternal Transitional Living for LGBTQ	-	■				
Catcher's Mitt	Recovery Epicenter Foundation	■				
Boley Centers (Safe Haven – Veterans)	Boley Centers			■		■
Boley Centers (Safe Haven - Unrestricted)	Boley Centers			■		■
Mustard Seed Inn	WestCare Gulf Coast			■		
Emergency Shelter Program (Clearwater)	Pinellas Hope		■			
Permanent Supportive Housing Program	Pinellas Hope				■	

Health services in Table B4 offer clinical services such as counseling, medication, and telehealth appointments.

Table B4: Existing health services for individuals with OUD in Pinellas County

Initiative	Organization	Prevention	Acute addiction	Seeking help	Acute/post-acute care	Long-term maintenance	Employment	General healthcare	Community and family support	Justice
Advanced Care Physicians Group (Seminole)	Advanced Care Physicians Group					■	■			
Advantage Mental Health Center (Clearwater)	Advantage Mental Health Center					■	■			
Affordable Counseling (Indian Shores Beach)	Affordable Counseling by Susan McMillan & Associates						■			
Affordable Counseling (St. Petersburg)	Affordable Counseling by Susan McMillan & Associates						■			
Alternatives in Behavioral Health (Largo)	Alternatives in Behavioral Health						■			
BayCare Life Management Services (Clearwater)	BayCare						■			
Boley Centers (Outpatient Center, 34th Ave St. Pete)	Boley Centers				■		■			
Caring Community Counseling (St. Petersburg)	Caring Community Counseling					■	■			
Center for Rational Living (Clearwater)	Center for Rational Living						■			
Directions for Living (Clearwater)	Directions for Living				■		■			
Directions for Living (Largo)	Directions for Living						■			
Family Resources Inc (St. Petersburg)	Family Resources Inc						■			
Integrity Counseling (East Largo)	Integrity Counseling						■			
MedMark Treatment Centers (Clearwater)	MedMark Treatment Centers			■		■	■			
New Season (Pinellas Park)	New Season				■	■	■			
New Season (Tarpon Springs)	New Season				■	■	■			
Operation PAR (St. Petersburg MLK St St. Pete)	Operation PAR					■	■			
People Empowering & Restoring Communities (Clearwater)	People Empowering & Restoring Communities					■	■			
People Empowering & Restoring Communities (Tarpon Springs)	People Empowering & Restoring Communities					■	■			
Positive Directions Counseling (Clearwater)	Positive Directions Counseling						■			
Solutions Behavioral LLC	Solutions Behavioral Healthcare Consultants						■			
Suncoast Center (Clearwater)	Suncoast Center				■	■	■			
Suncoast Center (Safety Harbor)	Suncoast Center					■				
Suncoast Center (Central Ave St. Pete 1/2)	Suncoast Center				■	■				
Suncoast Center (Central Ave St. Pete 2/2)	Suncoast Center				■	■				
WestCare Gulf Coast (Pinellas Park)	West Care Gulf Coast				■	■				■

Appendix C: Leading and emerging practices for each recommendation

This appendix details the leading and emerging practices associated with each recommendation. It is not a comprehensive list of every practice that could facilitate a recommendation, but rather a list of the practices that best align with the current state of Pinellas County's system of care, gaps, and strengths.

Each recommendation is presented with an approximate yearly cost and an approximate time to implement. Costs and timeline metrics are **estimated** and could fluctuate based on scale, local requirements, and available funding.

Cost metrics

- Practices with cost below $500,000 per year could likely add onto additional services, while:
  - Leveraging existing services and employees *and*
  - Hiring zero or few new FTEs *and*
  - Having no brick-and-mortar construction

- Practices with cost between $500,000 and $1 million could likely require:
  - New organization(s) with small headcount *or*
  - Adding several FTEs onto an existing organization *or*
  - Moderate capital costs (goods or physical presence)

- Practices with cost over $1 million could likely require:
  - New organization(s) with small headcount *or*
  - New organization(s) with large headcount *or*
  - New large-scale brick-and-mortar presence

Timeline metrics

- Short timelines (one clock) reflect initiatives with no structural or legal barriers to implementation. The practice could be operational within months.
- Moderate timelines (two clocks) reflect initiatives with some barriers to implementation. Operations may be contingent on hiring or construction.
- Long timelines (three clocks) have large structural or legal barriers to implementation, possibly requiring legislative approval or permits. These would likely take several years to reach full build-out.

Recommendation 1: Increase access to safe and high-quality housing for individuals in recovery

Gaps addressed	
L6	Individuals with OUD and in recovery experience barriers to stable housing.
E1	Space in high-quality housing designed to support those in recovery after they exit treatment is limited in Pinellas County.

Context

High-quality supportive and recovery housing for people to live independently after transitioning from an acute care setting is difficult to access in Pinellas County; it is expensive and there is not enough affordable housing to meet demand. This challenges individuals working to continue their recovery journey in multiple ways:

- Delays access to an affordable bed in recovery housing with needed supports to continue recovery
- Heightens risk of return of homelessness and consequently risk of relapse
- Exacerbates financial pressures (and potentially trade-offs) for treatment co-pays, childcare, daily expenses, and other out-of-pocket costs associated with treatment and recovery
- Accelerates a move to market-rate housing before the individual is ready for full independence

Without affordable access, housing insecurity is a challenge for many, which puts sustained recovery at risk.

Housing struggles are not limited to recovery housing, as market-rate housing is among the most expensive in the state. Stakeholders state that landlords often discriminate against people in recovery, particularly if they have past justice involvement.

Leading and emerging practices

Component practice	Description	Potential impact and implementation needs	Feasibility	
			Cost* *(est. per year)*	Timing
Increase supply of recovery housing (FARR levels 1-3)	Work with recovery housing operators to expand houses and beds, while maintaining standard of care	▸ May require constructing new houses ▸ Federal or state funds may be available for projects like these	>$1m	
Increase supply of medical respite facilities	Expand temporary respite facilities (that require medical referrals) to bridge the gap between homelessness and permanent housing	▸ Medical facilities are not always standardized, may be difficult to create due to partnerships with providers	>$1m	
Permanent supportive housing	Long-term housing with supportive services for the chronically unhoused	▸ Enhances stability and supports recovery ▸ May require coordination with federally-funded PSH programs	>$1m	
Housing support / vouchers	Financial assistance for housing through vouchers or other aid	▸ Facilitates stable living conditions, aiding in recovery ▸ Barriers may exist in allocating vouchers	>$1m	
Offer "person-centered" choice of housing to people entering long-term recovery	Work towards sufficient housing options for individuals moving into recovery housing, which fit their priorities and current residents' needs	▸ Requires high density of recovery housing ▸ Residences may need to be incentivized to define expectations for group living	$500k - $1m	
Evaluate program effectiveness	Work with community supports and government officials to measure the effectiveness of a recovery home on residents	▸ Likely to make a home eligible for state or federal funding	<$500k	
Increase supply of residential peer respite facilities	Expand temporary respite facilities (that do not require medical referrals) to bridge the gap between homelessness and permanent housing	▸ Typically easier to create or expand than medical respite, but may not have the same clinical benefits or connections	$500k - $1m	

Leading practice (L) Emerging practice (E)

Short-term Long-term

Recommendation 2: Enhance care coordination and individual-level data management

Gaps addressed	
S1	Providers and CBOs who would like to help someone with OUD take initial steps toward accessing care are not always able to hand people off to the provider/program that the individual needs.
S7	Waitlists are a barrier to indigent care; self-paying individuals are more likely to have timely access to care. Broadly, waitlist statuses across providers are opaque.
L5	People with lived experience report several barriers to behavioral health treatment, most notably wait times, high costs, and low quality.
E2	Individuals with OUD lack access to individualized case management support throughout their recovery journey.
G2	Data sharing across stakeholder groups is sparse and limited, which makes it difficult to develop a systems-level perspective and integrated, advanced analytics.

Context

During the prioritization session, community members spoke in favor of investing in platforms that combine a single point of entry to the system of care with individualized tracking and centralized care coordination capabilities. In recent months, Pinellas County has made strides toward streamlining the points of entry into their system of care by launching Care About Me (CAM), but there are still opportunities to further integrate technology.

The gaps that this platform could help alleviate span the CoC. First, people who are seeking help for OUD-related care struggle to know where to get care. Only 26% of surveyed residents reported that they were confident in finding treatment services in Pinellas County should they need to. Second, individuals in Pinellas County often have multiple case managers, as case managers are often tied to providers instead of individuals. This leads to some service duplication and an inability to track people throughout the system of care. Third, few individuals receiving care or providers in Pinellas have a strong sense of operating hours, availability, or exclusion criteria at local clinics. This platform could pair with these service providers to improve the public knowledge of bed availability.

Leading and emerging practices

Component practice	Description	Potential impact and implementation needs	Feasibility	
			Cost* *(est. per year)*	Timing
Warm hand-offs into treatment	Facilitate smooth transitions into treatment programs for OUD	▸ Increases treatment engagement and retention among patients ▸ Requires staffing and training	$500k - $1m	
Collaborative Care Model implementation	Assign a care manager to coordinate behavioral health and primary care	▸ Improves patient retention; helps with early detection in mental health patients	>$1m	
Centralized case management	State-run case management center that provides top-down and differentiated levels of support to clients, depending on need	▸ Helps social workers and case managers clarify services provided to an individual ▸ Requires change to existing services	>$1m	
Platform-enabled solutions that connect between providers (interoperable, SMART on FHIR, HL7-compatible APIs)	Direct connections between providers to disseminate real-time information about availability	▸ Sharpens assessment of level of care needed ▸ May require in-person guides to facilitate use	>$1m	
Linked admission / discharge / transfer (ADT) notifications	Requiring providers to exchange summary of care data, either through a health information exchange or a simpler data-sharing platform	▸ Increases care coordination ▸ Improves provider-to-provider trust ▸ High tech implementation requirements	>$1m	

Leading practice (L) Emerging practice (E)

Short-term Long-term

Recommendation 3: Expand the role of peer specialists

Gaps addressed

- **S4** Peer supports are underpenetrated across outreach, engagement, community support, and long-term recovery support.
- **E7** Individuals with OUD have trouble finding employment, and those who are employed may not receive employer support as part of their treatment and/or recovery.

Context

Community members believe opioid abatement funding could also be directed to expanding and reimagining the role of peer specialists, who are underpenetrated throughout Pinellas County. Peer specialists in the county are currently employed in hospitals, treatment centers, recovery centers, and outreach organizations, but there are opportunities to broaden the settings, attract additional individuals to fulfill the peer role, and make the job more sustainable.

Leading and emerging practices

Component practice	Description	Potential impact and implementation needs	Feasibility	
			Cost* *(est. per year)*	Timing
Create and sustain long-term support roles for peers	Create structures for long-term behavioral support / motivation from peers in recovery	▸ Improves social connection and provides patients with a sense of belonging ▸ Involves recruiting and training peer counselors	**$500k-$1m**	🕐🕐🕐
Certification program for peer specialists	Establish a clear path to certification and employment as a peer specialist	▸ Provides guidance and role models for people in recovery on steps to become a peer specialist ▸ Background checks create regulatory burdens	**<$500k**	🕐🕐
Peer supporters in clinical and non-clinical priority settings (hospital, jail, etc.)	Intentional placement of peers in settings to engage people in active use	▸ Introduces patients to peers in more clinical and non-clinical settings ▸ Non-clinical settings may face difficulties in hiring peers if clinical settings have priority	**$500k-$1m**	🕐🕐
Encourage people with justice involvement to serve as a peer	Encourage people in recovery with a history of justice-involvement to become peer specialists	▸ Since background check policies are often made at the state level, coordination with state agencies may be necessary	**<$500k**	🕐🕐
Identify opportunities for peers to have public-facing outreach	Proactive presentations or presence by peer specialists among the general public or in areas frequented by people in active use	▸ Creates connections to peer supporters and builds a recovery-friendly community ▸ Reduces stigma	**<$500k**	🕐

Leading practice (L) Emerging practice (E)

Short-term Long-term

Recommendation 4: Expand harm reduction opportunities across the Continuum of Care, with a focus on training medical providers

Gaps addressed	
A1	Populations frequently interacting with opioids (e.g., EMS, first responders, those with lived experience) often have access to naloxone (i.e., Narcan), but broader adoption remains limited.
A3	Fentanyl test strips are not yet widely distributed in Pinellas County.

Context

Pinellas County has made strides in harm reduction over the past several years, with COSSUP grants and the Opioid Task Force helping the county become a leader in naloxone distribution. However, harm reduction efforts are largely limited to naloxone, and community members believe that other harm reduction policies and initiatives may facilitate beneficial health outcomes such as reducing fatal overdoses. Because most medical providers receive little training on addiction medicine, many are less familiar with harm reduction in a medical capacity.

Leading and emerging practices

Component practice	Description	Potential impact and implementation needs	Feasibility	
			Cost* *(est. per year)*	Timing
Comprehensive media campaigns to educate the community	Advertisements about OUD, overdoses, fentanyl, and other relevant topics	▸ Disseminates relevant updates to community ▸ Requires multi-channel strategy to reach residents	>$1m	
Including opioids in general anti-substance education	Educational programs that position opioids among other substances to be avoided	▸ Creates more holistic substance-related education ▸ May be included in existing programs	<$500k	
OEND for general public	Proactive efforts to make naloxone kits and training available to everyone	▸ Educates and enables bystanders to intervene in overdoses	<$500k	
Education in non-English languages	Provide educators with resources to reach non-English speaking participants	▸ Broadens trainings to people of all backgrounds ▸ Limited # of non-English speakers in Pinellas	<$500k	
Encouraging the public to call 911 / 988	Earned or paid media describing when someone should 911 or 988	▸ Expands public conception of what 911 / 988 do, esp. for behavioral crises ▸ Ongoing programming	<$500k	
Workforce education	Educational programs about the risks of substance use in the workforce	▸ Media campaigns may prime residents for targeted education in places like work ▸ Workforces are not typical targets of OEND campaigns	<$500k	

Leading practice (L) Emerging practice (E)

Short-term Long-term

Recommendation 5: Establish long-term funds to pay for OUD care

Gaps addressed	
S6	Affordability is a barrier to accessing care, especially for the uninsured and underinsured.
C3	People with low incomes are less able to access detox and inpatient services in Pinellas County, because subsidized options are limited.
C4	There is need in Pinellas County for additional low-cost/subsidized residential treatment capacity.
L1	Individuals using MAT are burdened by high costs of care.
E4	Access to childcare is a barrier to participation in treatment.
E5	Pinellas County lacks grief supports for people impacted by overdoses.
E6	Transportation in Pinellas County presents a significant barrier to individuals without a care consistently accessing services.

Context

Pinellas County is in a unique position because the primary barrier to OUD-related care is expense. Individuals who know where to go for services and who can pay out of pocket (or with high-quality insurance) are able to access services across the CoC. In contrast, people in active use and recovery who are uninsured or underinsured are only able to receive subsidized care from some providers, at some times. Since this group commonly faces waitlists, it can be difficult to coordinate care across providers as they may become eligible for services at different providers at different times.

Leading and emerging practices

Component practice	Description	Potential impact and implementation needs	Feasibility	
			Cost* *(est. per year)*	Timing
Subsidize treatment to increase access	Invest money in detox, rehab, or MAT so people seeking help know that financial concerns will not be a barrier. Include funds for after insurance limit is reached or for items that insurance may consider non-reimbursable	▸ Most jurisdictions already have indigent care management in place with eligibility requirements; these can be repurposed	>$1m	
Invest to provide MAT for uninsured population	Cover medication costs for uninsured / non-Medicaid population in MAT	▸ Increases access to MAT and improves treatment outcomes for a vulnerable pop. ▸ May require program design and regulatory changes	>$1m	
Payments to families of overdose victims	Provide financial compensation to people who have lost a loved one to overdose	▸ Provides a clear way of how abatement dollars help people who were harmed ▸ Requires coordinated grant-funding structure	>$1m	

Leading practice (L) Emerging practice (E)

Short-term Long-term

Recommendation 6: Reorganize the coordinating body to establish a single point of authority for abatement efforts in Pinellas County

Gaps addressed	
G1	Organizations in Pinellas County that provide OUD-related services operate in silos, guided by internally defined priorities, as there is no organization with the authority to oversee and direct opioid abatement efforts at the system level.
G2	Data sharing across stakeholder groups is sparse and limited, which makes it difficult to develop a systems-level perspective and integrated, advanced analytics.

Context

No single person or entity is viewed as the authority for organizing abatement efforts in Pinellas County. The OAFAB is responsible for regional settlement funding but there are two entities that have published broader abatement goals. This situation may impact strategic abatement efforts in the future if there is confusion or limited coordination on goals, roles, and priorities.

Leading and emerging practices

Component practice	Description	Potential impact and implementation needs	Feasibility	
			Cost* *(est. per year)*	Timing
Apolitical full-time employee to organize local or regional abatement	Hire a single person to coordinate abatement efforts and manage relationships with state entities to secure funding, data, and materials in service of abatement objectives	▸ Aims to place one entity in charge with a clear remit ▸ Provides clear decision-making roles	<$500k	
Guiding frameworks for success	Align on a single framework with actionable goals, such as the 90/90/90 framework used in HIV prevention	▸ Creates benchmarks that leaders can be assessed against	<$500k	

Leading practice (L) Emerging practice (E)

Short-term Long-term

Recommendation 7: System-level data governance and data capabilities

Gaps addressed	
G2	Data sharing across stakeholder groups is sparse and limited, which makes it difficult to develop a systems-level perspective and integrated, advanced analytics.

Context

Provider, funder, and community organizations do not often share data like overdose reports and service utilization with each other. This data, though not private health information, is crucial to a community-oriented overdose response.

While some organizations are willing to share data *ad hoc* with other groups, and groups such as FUSION have made progress in facilitating data-sharing agreements, Pinellas County lacks a culture of data-sharing at systems and organizational levels. This gap is not unique; many state and county governments around the country struggle to share this type of data.

Leading and emerging practices

Component practice	Description	Potential impact and implementation needs	Feasibility	
			Cost* *(est. per year)*	Timing
Cross-agency, multi-jurisdictional data-sharing agreements	Template for groups, local agencies, and providers to align on requirements and responsibilities for data-sharing	▸ Requires coordination between all community organizations, providers, and funders who may be privy to shared organizational-level data	**<$500k**	

Leading practice (L) Emerging practice (E)

Short-term Long-term

Recommendation 8: Expand access to programming in justice settings

Gaps addressed	
L3	Individuals incarcerated in Pinellas County jail cannot receive MOUD treatment.
E8	Pinellas County criminal justice diversion programs could be better leveraged to keep people with OUD from being incarcerated instead of treated.

Context

Pinellas County has limited OUD-related programming in pretrial and carceral settings. Although the Sixth Circuit pretrial diversion programs perform above national benchmarks, fewer individuals have been invited to diversion programs in recent years despite a growing number of drug crimes. Once individuals are in jail, they cannot access MOUD. Pinellas County has the second-largest incarcerated population in a non-MOUD jail in Florida, and Pinellas County Jail has 6% of the state's total incarcerated population.

Upon release, individuals in Pinellas are at increased risk of relapse because of the lack of MOUD in jails. Compounding that problem, few people leave jail with naloxone or other harm reduction supplies. There is an opportunity to reimagine OUD treatment in justice settings using the actions of other counties in Florida as benchmarks before considering actions of other counties around the country. Pinellas County could expand access to justice programs and expect to reduce incarceration, recidivism, and post-release mortality.

Leading and emerging practices

Component practice	Description	Potential impact and implementation needs	Feasibility	
			Cost* (est. per year)	Timing
Warm handoffs for justice-involved groups	Easing re-entry from justice involvement into treatment programs	▸ Reduces risk of relapse after re-entry	$500k - $1m	
MAT in justice settings	Provide MAT in jails/prisons	▸ Reduces risk of relapse for a vulnerable population and improves public safety ▸ May require registering jails as SAMHSA-certified OTPs	>$1m	
Pre-arrest SUD care and early diversion	Help people with OUD get treatment before potential arrest	▸ Reduces incarceration for addiction ▸ Requires investment in policing / training at local levels	>$1m	
Naloxone distribution in carceral settings, especially upon release	Discharge people from jail or prison with naloxone or other harm reduction supplies	▸ Mitigates the risk of the first days after release, when someone is most likely to overdose	<$500k	
Establishing or expanding access to specialty drug courts	Set up targeted court programs for supervised recovery instead of incarceration	▸ Offers specialized support and alternatives to incarceration ▸ Requires infrastructure / staff	>$1m	*Varies*
Screen for SUD in justice settings	Evaluate for SUD upon jail entry	▸ Creates opportunities for immediate treatment ▸ May increase treatment costs in jails	<$500k	

Leading practice (L) Emerging practice (E)

Short-term Long-term

Recommendation 9: Launch a broad prevention campaign to raise awareness about the epidemic

Gaps addressed	
P1	The general public in Pinellas County lacks awareness and understanding about the current state of the opioid epidemic.
P2	Many individuals in Pinellas County do not know how to access resources to learn more about opioid misuse, and those that do report that resources are not effective.
A1	Populations frequently interacting with opioids often have access to naloxone, but broader adoption remains limited.
S5	Individuals with OUD, their caretakers, and their healthcare providers report low awareness of where to go to get help.
L2	Stigma toward MOUD, and methadone in particular, is present across groups, including healthcare workers.

Context

Pinellas County has a public awareness gap. Fewer than 25% of surveyed residents felt confident in their familiarity of the opioid epidemic and efforts to stop it in Pinellas County, and almost 35% of residents ages 18–34 reported a complete lack of familiarity with the epidemic. Existing overdose education programs are not reaching most people in the county, and survey results across all major demographics report a consistent low level of awareness.

A targeted multi-platform media campaign (print, digital) with strategic communications that aim to reach high-risk groups and span channels to be inclusive of all demographics could increase public awareness of the opioid epidemic in Pinellas.

Leading and emerging practices

Component practice	Description	Potential impact and implementation needs	Feasibility	
			Cost* *(est. per year)*	Timing
Comprehensive media campaigns to educate the community	Advertisements about OUD, overdoses, fentanyl, and other relevant topics	▸ Disseminates relevant updates to community ▸ Requires multi-channel strategy to reach residents	>$1m	
Including opioids in general anti-substance education	Educational programs that position opioids among other substances to be avoided	▸ Creates more holistic substance-related education ▸ May be included in existing programs	<$500k	
OEND for general public	Proactive efforts to make naloxone kits and training available to everyone	▸ Educates and enables bystanders to intervene in overdoses	<$500k	
Education in non-English languages	Provide educators with resources to reach non-English speaking participants	▸ Broadens trainings to people of all backgrounds ▸ Limited # of non-English speakers in Pinellas	<$500k	
Encouraging the public to call 911 / 988	Earned or paid media describing when someone should 911 or 988	▸ Expands public conception of what 911 / 988 do, esp. for behavioral crises ▸ Ongoing programming	<$500k	
Workforce education	Educational programs about the risks of substance use in the workforce	▸ Media campaigns may prime residents for targeted education in places like work ▸ Workforces are not typical targets of OEND campaigns	<$500k	

Leading practice (L) Emerging practice (E)

Short-term Long-term

Recommendation 10: Enhance OUD-related training for providers, beyond harm reduction

Gaps addressed

- **L2** Despite progress, stigma toward MOUD, and methadone in particular, is still present across groups, including healthcare workers and sober housing providers.
- **S2** Front-line physicians are not appropriately trained to treat individuals with OUD.
- **A4** Mothers with OUD can be reluctant to access the services available to them in Pinellas County for fear of receiving poor care or facing repercussions like child separation.
- **C5** Treatment centers are not consistently providing co-located co-occurring treatment for co-morbidities.

Context

Front-line providers for OUD are not always effective with triage and referral in Pinellas County, often because addiction-certified professionals are uncommon in the US healthcare system. Providers also express concern that other healthcare workers are not familiar with OUD, causing first-contact providers to be conservative in treatment.

There are opportunities to train clinicians, including primary care physicians, emergency medicine physicians, and crisis stabilization unit staffers about the most effective ways to treat OUD.

Leading and emerging practices

Component practice	Description	Potential impact and implementation needs	Feasibility	
			Cost* *(est. per year)*	Timing
Training care providers about "MAT first" approach	Educate providers on prioritizing MAT as a first-line treatment for OUD	▸ Prioritizes evidence-based effective treatment for OUD	$500k-$1m	
Provider education on pain management and addressing stigma	Structured education for providers on how to treat people in pain and in active use, refraining from generalizations about people seeking assistance	▸ Reverses misconceptions about pain management ▸ Requires training staff	<$500k	
Clinical guideline development and enhancement	Health care organizations creating local or regional guidance on pain management and prescribing	▸ Creates a benchmark for local care ▸ Requires a comprehensive study analyzing perceived risk(s) by physicians and the cost of certificates ▸ Also involves adoption / participation from affiliated healthcare workers	$500k-$1m	

Leading practice (L) Emerging practice (E)

Short-term Long-term

Recommendation 11: Expand syringe services programming

Gaps addressed	
A2	Pinellas has only one syringe exchange program, with only one location. As such, access to it is geographically limited. State and local ordinances also limit available funding streams, distributable supplies, and potential operating models.
A3	Fentanyl test strips are not yet widely distributed in Pinellas County.
C5	Treatment centers are not consistently providing co-located co-occurring treatment for co-morbidities.

Context

Syringe services programs (SSPs) reduce the harm associated with active opioid use through several avenues. By reducing needle reuse, these programs lower the rate of bloodborne disease transmission (e.g., Hepatitis C, HIV). They also typically distribute other harm reduction supplies (naloxone, fentanyl test strips), basic hygiene supplies, and, if available, clothing. They offer co-occurring care like wound care and blood testing. Finally, they provide a non-judgmental, trusted environment that individuals who are ready to seek care can turn to for connections and hand-offs. Currently, there is one SSP in Pinellas County (IDEA Exchange St. Petersburg) which operates 15 hours per week. Additional syringe service programs and/or mobile clinics could address the gap in syringe service programming by expanding geographic coverage.

Leading and emerging practices

Component practice	Description	Potential impact and implementation needs	Feasibility	
			Cost* *(est. per year)*	Timing
Syringe services programs	Offer free hypodermic needles and safe disposal of used needles	▸ Mitigates infectious disease risk ▸ Connects high-risk groups with care ▸ Serves as social connector for people in active use ▸ Requires state or local policy changes to fund with abatement dollars	$500k >$1m*	
Mobile syringe services programs	Syringe services programs available in vans that travel to different geographic areas and serve populations at high-risk or in need of services	▸ Typically linked with brick-and-mortar harm reduction organization ▸ Mobile programs must find host sites; SSP operators have found this to be a barrier in the past ▸ Requires state or local policy changes to fund with abatement dollars	>$1m	

* Varies from moderate to high depending on location and permits required

Leading practice (L) Emerging practice (E)

Short-term Long-term

Recommendation 12: Establish a Marchman receiving facility

Gaps addressed	
S3	The Marchman Act aims to remediate a gap in SUD treatment by enabling immediate crisis care. Due to the lack of a state-funded receiving facility other than the jail system, it has not filled that role in Pinellas.

Context

Under Florida state law, individuals at risk of harming themselves or others can be held for detention and transportation to an involuntary assessment for SUD. The individual can then be held for involuntary treatment via the Marchman Act if the assessment indicates potential harm. As Pinellas County does not have a designated non-jail Marchman Act receiving facility, candidates are brought to the County Jail. Residents perceive that treatment in the jail is not tailored to SUD, and as a result involuntary referrals are rare.

There is community demand to improve the "last-resort" treatment options, both voluntary and involuntary. Immediate crisis care is not consistently available, as many crisis facilities in the county do not target SUD/OUD treatment, are costly, and/or have waitlists. A facility that focuses on voluntary and/or involuntary crisis stabilization, de-escalation, brief screening/assessment, treatment, and linkage to aftercare for individuals with SUD/OUD would fill a current gap in Pinellas County.

Leading and emerging practices

Component practice	Description	Potential impact and implementation needs	Feasibility	
			Cost* *(est. per year)*	Timing
Law enforcement and first responder training on SUD	Educate law enforcement on best practices when encountering someone with SUD	▸ Confirms best practices are known, creating ability to monitor interactions	<$500k	
Combined receiving facilities for voluntary and involuntary SUD treatment	Establish a receiving facility with dedicated beds for people experiencing SUD / OUD, arriving via both voluntary and involuntary means	▸ Creates last-resort option for loved ones ▸ Requires extensive coordination with host organization	>$1m	
Use hospitals as receiving facilities for involuntary Tx	Partner with hospitals to reserve beds for involuntary treatment	▸ Streamlines bed holding system ▸ Confirms that the receiving facility is a known community organization	>$1m	
Re-evaluation process of involuntary treatment hold at receiving facility	Establish process at treatment facility to re-evaluate a court's decision to hold a patient involuntarily	▸ Creates off-ramp for improper uses of involuntary treatment	<$500k	

Leading practice (L) Emerging practice (E)

Short-term Long-term

Recommendation 13: Construct a social center for the recovery community

Gaps addressed	
L5	People with lived experience report several barriers to behavioral health treatment, most notably wait times, high costs, and low quality.
E3	Pinellas County needs more social and communal spaces for individuals recovering from OUD to congregate.
E7	Individuals with OUD have trouble finding employment, and those that are employed may not receive employer support as part of their treatment and/or recovery experience.

Context

Pinellas County needs more social and communal spaces for individuals recovering from OUD; there is only one peer respite center and one accredited Clubhouse in Pinellas County. Opening additional Clubhouses or similar centers could provide structured social spaces for those in recovery from mental illness or SUD and could provide gateways to jobs and a structured path for reintegration into the community. Additionally, individuals in recovery struggle to find employment and report gaps in employer support for their treatment and/or recovery experience. Many jobs that people in recovery find through employment services are contract jobs for manual labor, which carry risk of relapse due to physical toll and frequently lack insurance benefits. Clubhouses and similar recovery spaces can include employment supports; such a model is described in more detail in Recommendation 13. Lastly, social spaces can double as treatment centers, alleviating access barriers to behavioral healthcare. Co-locating behavioral health services and career services in a welcoming, community-based environment could create an ecosystem that encourages care, and the wraparound supports of employment and community.

Leading and emerging practices

Component practice	Description	Potential impact and implementation needs	Feasibility	
			Cost* *(est. per year)*	Timing
Open additional Clubhouses, or centers providing similar services	Structured social space for people recovering from mental illness or SUD, typically offering jobs in the house or in the community	▸ Provides gateways to jobs and community ▸ Typically connects to outside medical care	>$1m	
Transitional employment as precursor to supported employment	Leveraging clubhouses as staffing agencies so that members can begin to work without having to go through background checks	▸ Builds work history for employees that may be viewed as a risk to hire	<$500k	

Leading practice (L) Emerging practice (E)

Short-term Long-term

Recommendation 14: Create new community support teams that focus specifically on substance use disorders

Gaps addressed	
C1	Sustained impact from quick-response teams (QRTs) is low, as providers report reaching very few individuals for follow-up treatment after QRT involvement
L4	Assertive Community Treatment (ACT) teams, which provide high levels of in-home care, are limited in number and under-resourced in Pinellas County.

Context

Pinellas County currently has three Assertive Community Treatment (ACT) teams tasked with providing comprehensive support for substance use and/or mental health through intensive and integrated treatment. ACT teams typically prioritize individuals with chronic behavioral health conditions, but they have shown some benefits when working with populations with SUD. The teams have positive effects on continuity of care, particularly with treatment that needs to be consistent, such as medication.

Stakeholders believe that the ACT teams in Pinellas are underfunded and overwhelmed trying to meet demand, with lower staff-to-client ratios than clinical recommendations. However, stakeholders also believe that ACT teams may be overwhelming for some individuals with SUD. These individuals may be better served by a less-intense community team that offers more support than typical case managers but has fewer interactions with clients than ACT teams.

Leading and emerging practices

Component practice	Description	Potential impact and implementation needs	Feasibility	
			Cost* *(est. per year)*	Timing
Assertive Community Treatment (ACT) Teams with SUD-focused staff	Team-based approach to provide comprehensive support and access to substance abuse and / or psychiatric treatment	▸ Requires specialized staff, with typical case load of 10 clients for a multiple-member team ▸ Typical practices include peer supporters, though they are often in high demand	>$1m	

Leading practice (L) Emerging practice (E)

Recommendation 15: Create additional behavioral health services in the style of Certified Community Behavioral Health Clinics

Gaps addressed	
S6	Affordability is a barrier to accessing care, especially for the uninsured and underinsured.
C5	Treatment centers are not consistently providing co-located co-occurring treatment for co-morbidities.
L5	People with lived experience report several barriers to behavioral health treatment, most notably wait times, high costs, and low quality.

Context

Pinellas County needs comprehensive behavioral health solutions that extend to co-occurring treatment. Providers and residents echo that sentiment – in fact, the most preferred practice in the constituent survey was a "24/7 behavioral health clinic."

Certified Community Behavioral Health Clinics (CCBHCs) are an example of those clinics. The comprehensive and around-the-clock nature of CCBHCs addresses the gap of limited co-occurring treatment. Several leading practices related to CCBHCs demonstrate it is possible to run those clinics with no waitlists for services. 62% of surveyed individuals with lived experience identified waitlists as a common barrier to receiving behavioral health treatment, which CCBHCs could help alleviate.

Pinellas County has one CCBHC, which is sponsored by the Suncoast Center. Like most CCBHCs, this clinic is sponsored by the Centers for Medicare and Medicaid Services (CMS) through a demonstration waiver process. Pinellas County would need to receive an extension of this waiver to continue CCBHC funding in perpetuity.

While the Pinellas CCBHC has not publicly tracked many impact metrics, stakeholders believe that it offers important services. There are barriers to addiction treatment centers in Pinellas County adding behavioral health as a core competency, and vice versa; only ~25 of the ~55 behavioral health facilities and services tracked in the inventory of services has DCF certifications for addiction-related services.[506] For example, while the existing CCBHC offers in-house mental health services, it contracts all SUD care to the third-party provider Operation PAR. The lack of on-site co-occurring competent care means that there can be gaps in treatment continuity and case management.

Leading and emerging practices

Component practice	Description	Potential impact and implementation needs	Feasibility	
			Cost* *(est. per year)*	Timing
Open new Certified Community Behavioral Health Clinics	Brick-and-mortar clinics offering comprehensive behavioral health treatment and services	▸ Engages people experiencing OUD into treatment, focusing on vulnerable populations ▸ May require coordination with CMS, who commonly funds CCBHCs	>$1m	
Use CCBHCs to encourage screening by behavioral health providers	Use shared environments like CCBHCs to encourage broader Bx screening	▸ Improves high-level screening for conditions that are billable but under-screened ▸ Requires education and culture shift	<$500k	

Leading practice (L) Emerging practice (E)

Short-term Long-term

[506] The inventory of services may not include the full exhaustive list of behavioral health facilities in Pinellas County since some smaller facilities/ providers may not have been captured

Recommendation 16: Enhance Quick Response Teams

Gaps addressed	
C1	Sustained impact from quick response teams (QRTs) is low, as providers report reaching very few individuals for follow-up treatment after QRT involvement.

Context

Pinellas County's Quick Response Teams underperform benchmarks. Both teams are able to contact a number of individuals, but they struggle in converting those contacts into treatment. Whereas Pinellas County has historically helped about 10% of individuals reach treatment after a successful contact, peer counties have seen treatment initiation rates above 30%. This suggests an opportunity for Pinellas County to improve the operational effectiveness of its QRTs.

Leading and emerging practices

Component practice	Description	Potential impact and implementation needs	Feasibility	
			Cost* *(est. per year)*	Timing
Peer specialists on QRTs	Hire individuals with personal recovery experience to join Quick Response Teams, providing relatable support and guidance during crisis interventions	▸ May require training to align with established protocols and support structures	$500k - $1m	
Expanded inbound referral sources to QRTs	Broaden the network of organizations and professionals that refer individuals in crisis to QTRs	▸ Incorporates QRTs as referral channels to increase their scope and enhance support networks ▸ May require special attention to capacity to manage higher volume of case	<$500k	
Proactive outreach	Implement strategies to identify and connect with at-risk individuals for early intervention and support	▸ Reduce calls for QRT services in hotspot areas by reaching them prior to the immediate need ▸ Local organization partners and coordination required	$500k - $1m	

Leading practice (L) Emerging practice (E)

Short-term Long-term

Disclaimer

This report (the "Report") has been prepared by Ernst & Young LLP ("EY"), from information and material supplied by Pinellas County ("the County"), for the sole purpose of assisting the County and stakeholders in abating the opioid epidemic.

The nature and scope of our services was determined solely by the Agreement between EY and the County dated May 30, 2024 (the "Agreement"). Our procedures were limited to those described in that Agreement. Our work was performed only for the use and benefit of Pinellas County government stakeholders in abating the opioid epidemic. Other persons who read this Report who are not a party to the Agreement do so at their own risk and are not entitled to rely on it for any purpose. We assume no duty, obligation or responsibility whatsoever to any other parties that may obtain access to the Report.

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