Opioid Crisis

A CONTRA COSTA RESPONSE

A Call to Action

BEHAVIORAL HEALTH DIVISION

Opioid Settlement Funds

CONTRA COSTA HEALTH

MARCH 2025

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Acknowledgments

Contra Costa County's Behavioral Health is grateful to the contributions of the various cities in our county that entrusted us with the allocation of opioid settlement funds. Most importantly, we would like to express our gratitude to all of the residents, parents, youth, prevention and treatment service providers, clients in custody and treatment, medical providers, people in recovery, teachers, counselors, homeless providers, and medical providers whose valuable feedback was instrumental in developing Contra Costa's blueprint for action.

A special thanks to the Latino parents who made time during their busy schedules to participate in Community Conversations, Board members who enthusiastically assisted us to prioritize services to effectively respond to the harms caused by the misuse, access, and availability of opioids in the community. Lastly, Contra Costa could not have accomplished this task without the partnership and ongoing support of the MEDS Coalition.

Executive Summary

Contra Costa Behavioral Health Services (CCBHS) is pleased to present our Opioid Response and Plan of Action, which incorporate the voices, needs, and concerns of residents who participated in regional Listening Sessions, community conversations, and surveys. This plan follows the provisions of the Opioid Settlement Funding and includes a preliminary Plan of Action that will be finalized by Spring 2025. In addition, the Plan of Action will be complemented by an Evaluation Plan, which will be developed at a later time.

Given the urgency to respond to the number of overdoses in our County, the need for education and awareness in the community, and to focus on those populations most impacted by the opioid epidemic, several Opioid Remediation High Impact Abatement Activities (HIAA) are currently underway. All authorized by the Opioid Settlement, the County Administrator's Office, and Contra Costa Health Services, these activities were presented to the Contra Costa Public Managers Association (CCPMA) in late 2022. Immediate actions include expansion of Naloxone distribution, training and education to reverse overdoses. Between the Fall of 2023 and 2024, CCBHS, in collaboration with the MEDS coalition, aggressively pursued education to administer and distribute Naloxone both to the community at large, and also to targeted and populations and locations.

Following the approval of preliminary activities, Behavioral Health proceeded to quickly implement Core Strategies that included: funding to support existing and expansion of substance use disorder (SUD) treatment programs, expansion of Medication Assisted Treatment (MAT) in jails through the purchase of extended-release injectable Medications for Opioid Use Disorders (MOUD), funding syringe exchange programs, deploying public health vending machines to distribute Naloxone, funding for harm reduction training for health professionals, and providing field-based treatment.

In May, Juvenile Probation and Behavioral Health swiftly responded to the needs of one youth who desperately needed residential treatment. Due to the severe history of Opioid Use Disorders (OUD), he was placed at Tarzana located in Los Angeles. Tarzana is the only SUD youth residential facility in California that accepts Medi-Cal. This situation further demonstrated the wide gap and disparity that exists when it comes to youth, and this, too, was later validated by youth at the central county Listening Session.

Consistent with the Final Settlement Opioid Agreements and direction from the Department of Health Care Services (DHCS), Behavioral Health was tasked by the County's Administration Office to work in collaboration with participating subdivisions that received the Opioid Settlement Funds (OSF) to conduct a community engagement process to garner input about the impact of opioids. The community engagement process started in May and successfully concluded in September 2024. Although there are some differences between the activities currently being implemented and the feedback gathered from the community, this document reflects the urgent need to address the devastating effects of opioids in Contra Costa.

About the Opioid Settlement Funds

In 2022, California Attorney General Rob Bonta announced final settlement agreements with prescription opioid manufacturer Janssen Pharmaceuticals and Johnson & Johnson (collectively "Janssen") and pharmaceutical distributors McKesson, Cardinal Health, and AmerisourceBergen (collectively, Distributors). These agreements are part of a broader strategy to resolve litigation regarding the companies' roles in the opioid crisis. In 2023, Attorney General Bonta further announced multistate settlements with opioid manufacturers Teva and Allergan, as well as pharmacies like Walgreens, Walmart, and CVS (collectively, Pharmacies).[1]

These settlements mark the culmination of years of complex negotiations to resolve more than 3,000 opioid-related lawsuits brought by state and local governments across the country. The funds secured through these settlements will provide critical resources to support California's efforts to address the opioid crisis at both the state and local levels. California and its cities and counties stand to receive up to $1.8 billion from opioid manufacturers to be used for substance use prevention, harm reduction, treatment, and recovery services. California is expected to receive up to $2.2 billion from earlier settlements with Janssen Pharmaceuticals. Under the settlement terms, California has worked with its legal counsel to establish a proposed allocation plan, ensuring that the state and its local governments receive maximum benefit. This funding will be pivotal for expanding access to evidence-based treatment, increasing Naloxone distribution, supporting harm reduction initiatives, and enhancing recovery support systems throughout the state. A summary of the allocation can be found in Table 1.

Table 1. California Opioid Settlement Fund Distribution

Fund Type	Recipient(s)	Allowable Uses
CA Abatement Accounts Fund (70%)	CA Participating Subdivisions	Funds must be used for future opioid remediation in one or more of the areas described in Exhibit E of the National Opioid Settlement Agreements; AND No less than 50% of the funds received in each calendar year will be used for one or more High Impact Abatement Activities.
CA Subdivision Fund (15%)	CA Plaintiff Subdivisions	Funds must be used towards future opioid remediation and to reimburse past opioid related expenses, which may include litigation fees and expenses.
California State Fund (15%)	The State of California	Funds must be used for future opioid remediation.

The National Opioid Settlement Administrator, BrownGreer PLC, will distribute payments to the State of California (California State Fund), Participating Subdivisions (CA Abatement Accounts Fund), and Plaintiff Subdivisions (CA Subdivision Fund). To ensure funds are used for opioid response and remediation efforts, California has designated the California Department of Health Care Services (DHCS) as the oversight and monitoring entity for OSF, in accordance with the California State Subdivision Agreements and Government Code, Title 2, Division 3, Part 2, Chapter 6, Article 2, Section 12534.[2] All entities are required to coordinate with Brown Greer and DHCS to ensure the correct distribution and utilization of funds throughout the payment period and up to one year thereafter.

CA ABATEMENT ACCOUNTS FUND ALLOWABLE EXPENDITURES

Figure 1 - Visualization of the funding core strategies

Funds from the settlements must be spent on opioid remediation activities, focusing on prevention, treatment, harm reduction, and recovery services for individuals with an Opioid Use Disorder (OUD) or other Substance Use Disorder (SUD).

Participating Subdivisions shall choose from the abatement strategies listed in Exhibit E[3] of the Final Settlement Agreement (August 2021). Priority should be given to the core abatement strategies as listed under "Core Strategies" in Schedule A of Exhibit E. Exhibit E provides an exhaustive list of eligible opioid remediation activities, including harm reduction services, public health education campaigns, and support for individuals with co-occurring mental health conditions that may be funded through allocations from the CA Abatement Accounts Fund.

Funding Period

The payments will be distributed over time, with schedules varying depending on each settlement, and could extend for up to 18 years.

These funds are allocated explicitly for opioid remediation efforts, which are essential in mitigating the devastating effects of the opioid epidemic on California's communities.

Local Governments may also use a portion of their funds to pay for reasonable administrative expenses related to fund management. However, these expenses must not exceed actual costs or five (5) percent of the total allocation, whichever is less. Indirect costs of more than five (5) percent are not allowed under the California Mallinckrodt Statewide Abatement Agreement.[4] The goal is to ensure that

the majority of the funds are dedicated to direct opioid remediation efforts, ensuring maximum impact.

High Impact Abatement Activities (HIAA)

California state officials, in partnership with counsel representing cities and counties, have agreed to a list of priority abatement activities, referred to as High Impact Abatement Activities (HIAA) [5], to address the opioid crisis within the state. Details of these priorities can be found in Appendix 1. California has joined multiple national lawsuits against manufacturers, distributors, and other responsible entities for the Opioid Epidemic and anticipates receiving funds from future opioid judgments. Most of these funds will be directed towards opioid abatement activities.

Table 2. High Impact Abatement Activities

No.	Activity
1	Provision of matching funds or operating costs for substance use disorder facilities with an approved project within the Behavioral Health Continuum Infrastructure Program (BHCIP)
2	Creating new or expanded substance use disorder (SUD) treatment infrastructure[2]
3	Addressing the needs of communities of color and vulnerable populations (including sheltered and unsheltered homeless populations) that are disproportionately impacted by SUD
4	Diversion of people with SUD from the justice system into treatment, including by providing training and resources to first and early responders (sworn and non-sworn) and implementing best practices for outreach, diversion and deflection, employability, restorative justice, and harm reduction
5	Interventions to prevent drug addiction in vulnerable youth
6	The purchase of naloxone for distribution and efforts to expand access to naloxone for opioid overdose reversals.

Opioid Settlement Oversight

Funds from opioid settlements and bankruptcies are distributed to states, cities, and counties through different Fund Accounts pursuant to the National Opioid Settlement Agreements and National Mallinckrodt Bankruptcy Plan. California has designated the DHCS as the oversight and monitoring entity for these funds. DHCS is responsible for ensuring that funds are allocated in compliance with the settlement agreements, focusing on opioid remediation strategies, proper reporting, and transparency, as well as ensuring that funds are used effectively for prevention, treatment, and recovery efforts.

The Opioid Crisis

The opioid epidemic was declared a national public health emergency in the U.S. in 2017, with 47,600 opioid-related overdose deaths reported that year. In 2017-2022, 70,237 people died due to opioid-related overdoses, with fentanyl accounting for a significant portion of these deaths.[6]

From 1999 to 2021, nearly 645,000 people died in the U.S. from overdoses involving both prescription and illicit opioids.[7,8] The Centers for Disease Control (CDC) has highlighted that the opioid epidemic has evolved through several waves, beginning with the rise of prescription opioid misuse in the late 1990s, followed by a surge in heroin use in 2010, and most recently, a sharp increase in deaths linked to synthetic opioids, particularly fentanyl, beginning in 2013.

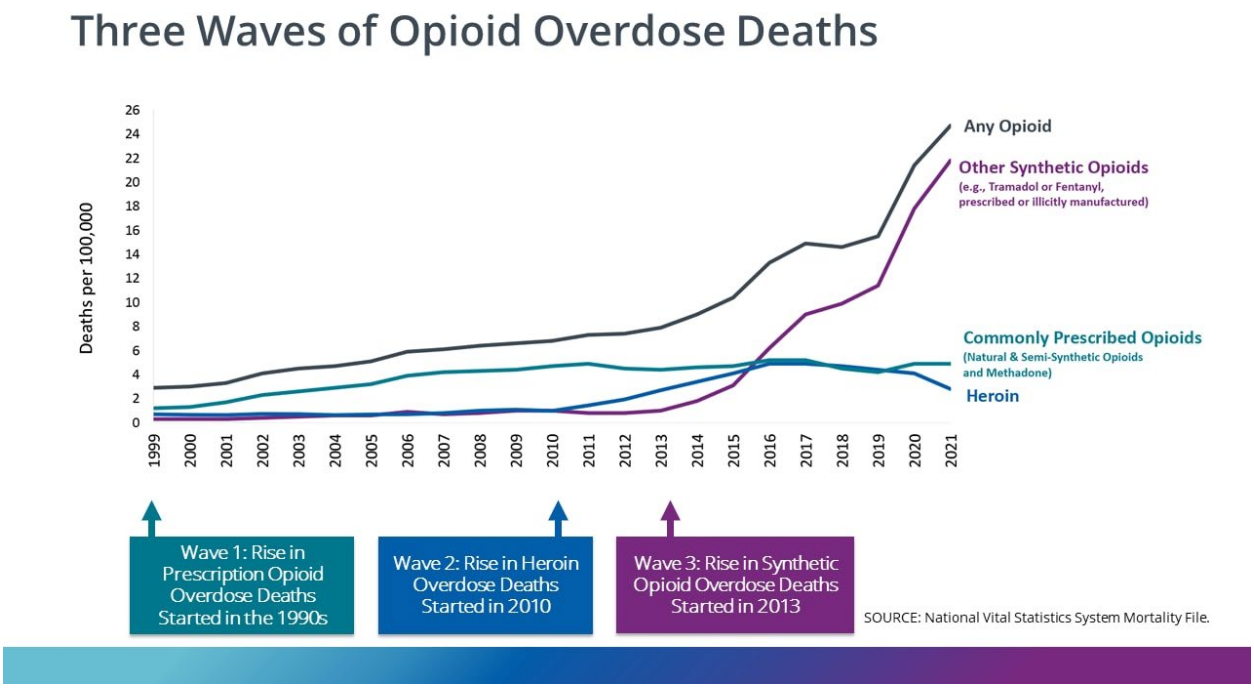


Figure 2 - image source: https://www.cdc.gov/overdose-prevention/media/images/sharable-graphics/overdoseprevention-3-waves-opioid-overdose-deaths-1999-2021.png?CDC_AAref_Val=https://www.cdc.gov/opioids/basics/epidemic.html

California is facing similar challenges, with more than 7,000 opioid-related deaths in 2022, of which 87% involved fentanyl. Also in 2022, the state recorded over 21,000 emergency room visits related to opioid overdoses, indicating the severe toll the epidemic is taking on public health systems. Fentanyl, which is 50 to 100 times more potent than morphine, is increasingly found in counterfeit pills and other illicit drugs, contributing to unintentional overdoses.

The Fourth Wave

Between 2010 and 2021, overdose deaths in the U.S. most commonly involved a synthetic opioid like fentanyl, methamphetamine and other drugs, marking the transition to a "fourth wave" of the opioid crisis.[9] California has also experienced a significant increase in poly-substance overdose deaths, particularly those involving a combination of fentanyl and psychostimulants, primarily methamphetamine.

Figure 3.source: https://www.kron4.com/video/health-officials-host-opioid-listening-sessions-in-concord/9681440/

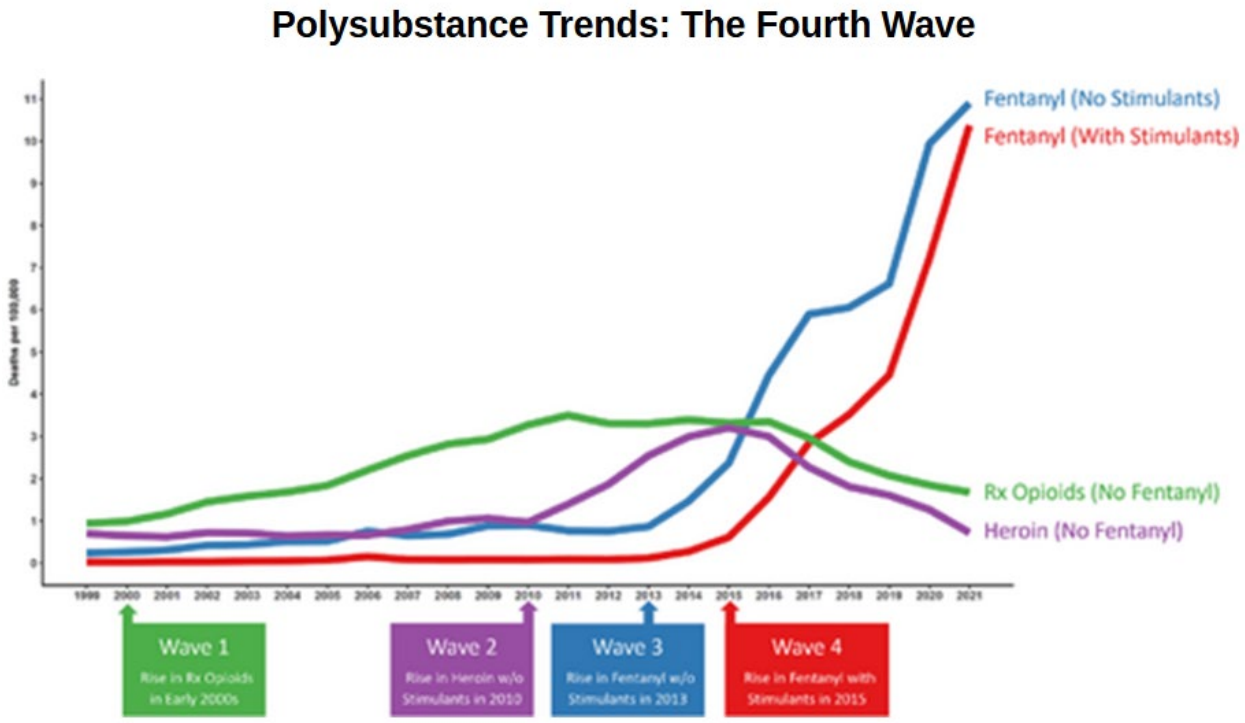


Figure 4. Four waves of overdose mortality in the US.
Image source: Friedman J, Shover CL. Charting the fourth wave: Geographic, temporal, race/ethnicity and demographic trends in polysubstance fentanyl overdose deaths in the United States, 2010–2021. Addiction. 2023; 118(12): 2477–2485. https://doi.org/10.1111/add.16318

Opioid Crisis Timeline

The opioid crisis has claimed more than 564,000 lives in the U.S. due to overdose. Each day, over 150 people lose their lives, primarily from synthetic opioids such as fentanyl. Since 1999, the United States has grappled with a continuously evolving public health emergency centered around opioid addiction, overdose, and fatality.[10]

1990s	Prescription opioids like OxyContin are introduced in the pharmaceutical market as less addictive than older drugs without any scientific evidence, in turn leading to the vast overprescription of opioids and a rise in opioid addiction, overdoses and death
2010	The medical industry begins to realize the dangers of prescription opioids; those suffering from opioid use disorders (OUD) turn to illegal markets like heroin instead; triggering a second wave of overdoses and deaths
2013	Synthetic opioids like fentanyl gain popularity due to their potency and affordability,
2023	Emerging threats include fentanyl being cut with xylazine or mixed with illicit stimulants like methamphetamine or cocaine

Table 3. Opioid Crisis Timeline. Retrieved from https://www.cdph.ca.gov/Programs/CCDPHP/opioids/Pages/landingpage.aspx

COVID-19 and the Opioid Crisis

In 2020, the CDC stated that the U.S. faced two nationwide public health emergencies: the opioid crisis and the COVID-19 pandemic. Data from the CDC identified that nearly 47,000 people died in 2018 from opioid overdoses. In June 2020, more than 120,000 people died from complications related to COVID-19 since the pandemic began. From June 2019 to May 2020, over 81,000 overdose deaths were recorded, marking the highest number ever reported in a 12-month period.[11] This unprecedented increase was primarily driven by synthetic opioids such as fentanyl, exacerbated by disruptions in healthcare delivery, social services, and economic stability caused by the pandemic.

The Office of the Inspector General (OIG), in collaboration with the Substance Abuse and Mental Health Services Administration (SAMHSA), conducted a study in November 2020, to

examine the impact of the pandemic on individuals with OUD. The report highlighted that people with OUD were at a higher risk for severe complications from COVID-19 due to factors such as homelessness, poverty, underlying lung or cardiovascular disease, and being uninsured or underinsured. Individuals with OUD often face significant health and socioeconomic challenges related to their addiction, compounded by co-occurring mental health conditions. The pandemic further exacerbated these challenges. Increased isolation, heightened depression due to stay-at-home orders, fear related to the virus's impact on loved ones, and the effects of social distancing measures likely contributed to a rise in opioid overdoses during this period.[12]

Opioid Overdoses and Vulnerable Populations

Overdoses and Behavioral Health

Drug overdose deaths remain a significant public health crisis in the United States, with 107,000 deaths in 2021 and 108,000 deaths in 2022.[13] Individuals with mental health disorders (MHDs) are at a higher risk of experiencing an overdose. SUDs and MHDs often co-occur, with shared risk factors, complicating the ability to address these challenges in isolation. The CDC's State Unintentional Drug Overdose Reporting System (SUDORS), reporting on characteristics of persons in 43 states and the District of Columbia who died of unintentional or undetermined intent drug overdose, found that. in 2022, 21.9% of overdose victims had a reported MHD. The report uses the Diagnostic *and Statistical Manual of Mental Disorders, Fifth Edition* criteria, and the most frequently reported MHDs were depressive (12.9%), anxiety (9.4%), and bipolar (5.9%) disorders.[13]

Opioids, mainly illicitly manufactured fentanyl, were involved in 82.2% of overdose deaths. Individuals diagnosed with MHDs were more likely to have overdosed on antidepressants (9.7%) and benzodiazepines (15.3%), compared to those without MHDs (3.3% and 8.5%, respectively).[14] Nearly one in four individuals with an MHD had a recent potential opportunity for intervention, such as visits to the emergency department or participation in substance use treatment programs. These findings underscore the need for integrated care approaches that address both mental health and substance use disorders, with particular emphasis on harm reduction and treatment retention strategies to reduce overdose risks.[14]

Opioid Overdoses and Justice-Involved Individuals

Incarcerated individuals face significantly higher risks of opioid overdoses, both during incarceration and upon release. This elevated risk stems from interrupted care, reduced tolerance, and limited access to evidence-based treatment options. Addressing these challenges is

CalAIM Justice Involved – Fact Sheet

People who are currently or have previously been incarcerated in jails, youth correctional facilities, or prisons are at higher risk for poor health outcomes, injury, and death compared to the general population.

» People of color are disproportionately represented in the justice-involved population, driven by systemic inequities in the criminal justice system. They also face a higher likelihood of incarceration due to mental health challenges and the criminalization of substance use disorders.

» The number of incarcerated individuals in California jails with an active mental health case has increased by 63% over the past decade.

» 66% of Californians in jails or prisons have moderate or high need for SUD treatment.

» Overdose is the leading cause of death among individuals recently released from incarceration. In California, people in jails or prisons experience a drug overdose death rate more than **three times** higher than that of incarcerated individuals nationwide.

» In California, **29%** of incarcerated men are Black, despite Black men comprising **5.6%** of the state's total population.

TRANSFORMATION OF MEDI-CAL JUSTICE INVOLVED (DHCS)

critical to reducing overdose fatalities within this vulnerable population.

California addresses these disparities through CalAIM Justice-Involved, an initiative to transform Medi-Cal to better serve justice-involved populations. This program focuses on reducing health inequities and providing continuous care during and after incarceration, particularly for those with mental health and SUD needs.

Culturally competent and client-centered interventions play a vital role in mitigating these risks, particularly among populations that are disproportionately represented in the justice system, such as people of color. These individuals often encounter unique barriers to care, requiring tailored approaches to ensure equitable access to prevention and treatment services. By integrating culturally responsive practices, health systems can more effectively address the diverse needs of justice-involved individuals and improve overall outcomes.

A study published by the National Institute on Drug Abuse (NIDA) found that the leading cause of death in former prisoners was overdose.[15,16] The findings also indicated that women leaving prison are at greater risk for opioid-related death than men, a pattern reflecting evolving demographic trends in substance use complications.[16]

Women also had higher mortality rates than men from overdose of other substances, including cocaine and antidepressants. The study highlighted the need for enhanced overdose education, screening, and continuous drug treatment during incarceration, as well as comprehensive post-release support through community-based mental health services and continuity of care to prevent future mortality.[16] Critical measures include expanding access to Medication-Assisted Treatment (MAT) using methadone or buprenorphine, both during and after incarceration. Unfortunately, many incarcerated individuals do not receive MAT due to administrative prohibitions, exacerbating overdose risks upon release.

In addition, publicly funded overdose education and Naloxone distribution programs have proven to reduce overdose deaths among recently released individuals. Agencies that offer post-release housing and reentry services should integrate strategies to reduce social triggers for drug use among former prisoners with a history of substance dependence, contributing to lower overdose mortality rates.[15,16,17]

Figure 5. Overdose report at Elmwood Correctional Facility. Image source: https://www.ktvu.com/news/multiple-fentanyl-overdoses-at-elwood-correctional-facility

Opioid Overdoses and Vulnerable Populations

Black/African American Communities

Historically, much of the focus on the opioid epidemic has been centered on White suburban and rural communities. However, recent trends show that the crisis is also dramatically affecting Black/African American communities, which have experienced significant increases in opioid misuse and overdose deaths.[18,19] Between 2015 and 2016, opioid overdose deaths among Black/African Americans surged by 40%, compared to a 21% increase in the overall population, making Black/African Americans the group with the fastest-growing rate among all racial and ethnic groups.[18] From 2011 to 2016, Black/African

Americans experienced the highest increase in overdose deaths related to synthetic opioids like fentanyl, far exceeding other racial groups.[18-21]

The historical treatment of Black/African Americans during the crack cocaine epidemic of the 1980s highlights the need to address prevention and treatment services for this community and to work to prevent disparate outcomes and higher rates of imprisonment for substance use than White American. During the cocaine epidemic, Black/African American communities were disproportionately targeted by policies under the "War on Drugs," which emphasized criminalization over treatment. This approach led to widespread incarceration, resulting in long-term damage to families and communities.[20] In 2017, Black/African Americans represented 12% of the U.S. adult population but accounted for nearly 33% of the sentenced prison population, highlighting the enduring effects of these policies on racial inequality in the criminal justice system.[18,20]

A study published by the NIDA found growing racial disparities in opioid overdose death rates, with deaths among African Americans rising faster than among White Americans across the country.[19] The study's authors called for an "antiracist public health approach" to address the crisis in Black communities, recognizing that structural racism exacerbates health disparities. Preliminary data also showed that overall drug overdoses increased during the COVID-19 pandemic, particularly among communities of color.

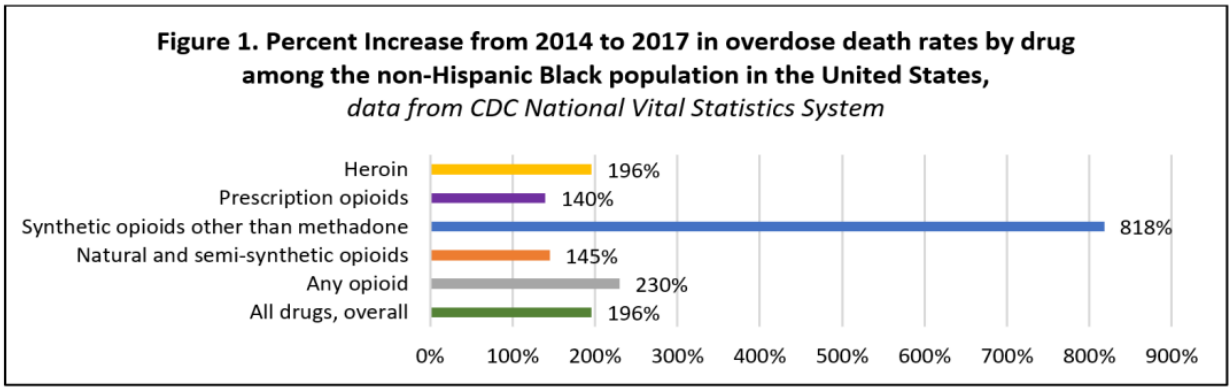


Figure 6 - Figure reprinted from The Opioid Crisis and the Black/African American Population: An Urgent Issue (p. 9), by Substance Abuse and Mental Health Services Administration, 2020. Public domain.

Hispanic/Latino Communities

Hispanic/Latino communities have also been significantly affected by the opioid epidemic, with concerning trends in both youth and general population drug use. Data from the CDC's 2017 Youth Risk Behavior Survey (YRBS) revealed that high school-aged Hispanic youth had the highest prevalence of illicit drug use (16.1%) and prescription opioid misuse (15.1%), surpassing both the total high school youth population and other racial/ethnic groups.[22] NIDA's 2018 Monitoring the Future (MTF) survey found that Hispanic eighth graders had the highest levels of substance misuse, including opioid misuse, compared to their White and

African American peers.[23,24] These findings highlight the urgent need for culturally relevant interventions and prevention programs tailored to vulnerable youth and minority populations.

Data from the SAMHSA's National Survey on Drug Use and Health (NSDUH) shows that the opioid misuse rate (including heroin use and prescription opioid misuse) among Hispanic/Latino populations is similar to the national average of approximately 4%.[23] In 2018, 1.7 million Hispanic/Latino individuals (aged 12 and older) were estimated to have engaged in opioid misuse, compared to 10.3 million people nationally. National data from multiple sources specific to high school-aged youth indicate that Hispanic youth are using drugs at rates that are equivalent or higher compared to their racial/ethnic peers.[23,24]

Given that Hispanic/Latinos are projected to comprise nearly 30% of the U.S. population by 2060,[23] it is important to address the sociocultural factors influencing drug use and access to prevention, treatment, and recovery for this group. This includes reducing barriers to care, increasing education and outreach efforts, and tailoring programs to the specific needs of Hispanic youth and families.

Opioid Crisis in Contra Costa County: Local Data

Contra Costa County Demographics and Relevance to the Opioid Epidemic

According to the 2024 U.S. Census estimates, the population of Contra Costa County is approximately 1,146,626. About 8.3% of residents live in poverty, and 34.3% are enrolled in public health insurance programs, such as Medi-Cal, which provides healthcare coverage for low-income individuals and families. The county's demographics reveal that 22% of the population is under 18 years old, with a median age of 40.9 years. Additionally, 27.3% of residents report being foreign-born, contributing to Contra Costa's diverse cultural makeup. Figure 7 displays the 2020 Census Diversity Index by county, highlighting the region's unique population dynamics.

Understanding these demographics is critical in addressing the opioid epidemic within Contra Costa County. Residents experiencing higher rates of poverty and reliance on public health insurance face significant barriers to accessing quality healthcare. These barriers may include limited availability of providers, transportation challenges, and difficulty navigating complex healthcare systems.

The county's significant proportion of foreign-born residents underscores the need for culturally and linguistically appropriate interventions. Addressing language barriers and cultural differences in healthcare perceptions and utilization is vital to ensure that prevention, treatment, and recovery services are accessible and effective for all communities.

Contra Costa stakeholders can better allocate resources, develop targeted prevention initiatives, and design comprehensive treatment programs by aligning public health strategies with the county's demographic profile. These tailored approaches are vital to reducing health disparities and mitigating the impact of the opioid epidemic on the county's most vulnerable populations.

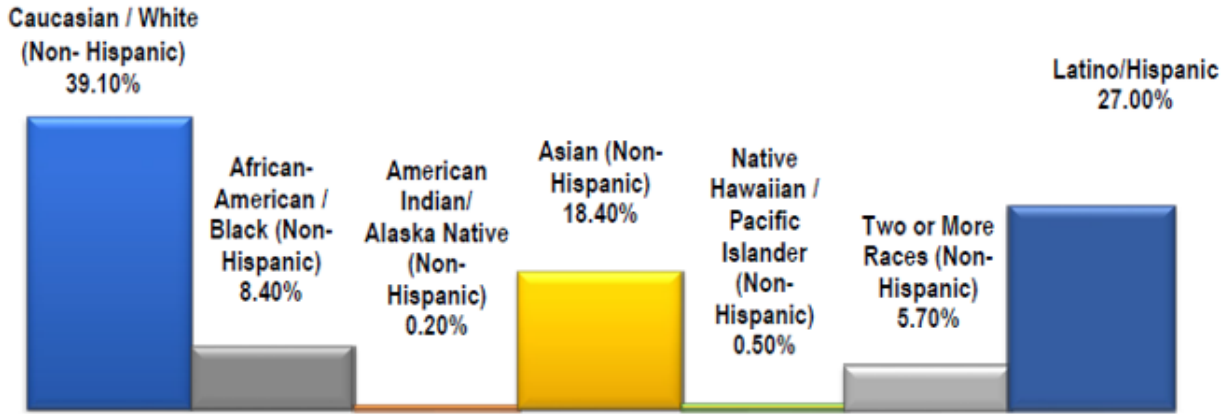
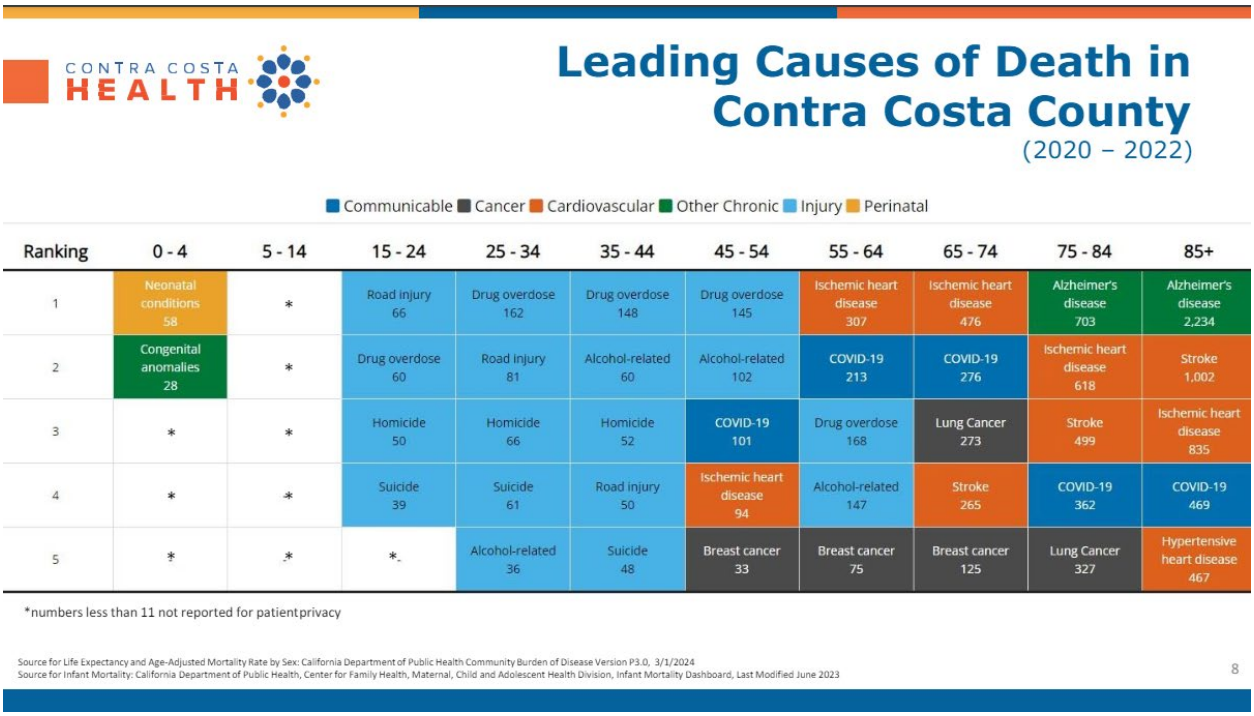


Figure 7. Contra Costa County 2020 Projected Racial/Ethnic Populations

On August 13, 2024, Dr. Ori Tzvieli, Contra Costa County's Health Officer, presented a set of slides to the Board of Supervisors, highlighting mortality data for the county through the newly launched ATLAS dashboard, as illustrated below.



CONTRA COSTA HEALTH

Leading Causes of Death in Contra Costa County

(2020 – 2022)

Communicable | Cancer | Cardiovascular | Other Chronic | Injury | Perinatal

Ranking	0 - 4	5 - 14	15 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65 - 74	75 - 84	85+
1	Neonatal conditions 58	*	Road injury 66	Drug overdose 162	Drug overdose 148	Drug overdose 145	Ischemic heart disease 307	Ischemic heart disease 476	Alzheimer's disease 703	Alzheimer's disease 2,234
2	Congenital anomalies 28	*	Drug overdose 60	Road injury 81	Alcohol-related 60	Alcohol-related 102	COVID-19 213	COVID-19 276	Ischemic heart disease 618	Stroke 1,002
3	*	*	Homicide 50	Homicide 66	Homicide 52	COVID-19 101	Drug overdose 168	Lung Cancer 273	Stroke 499	Ischemic heart disease 835
4	*	*	Suicide 39	Suicide 61	Road injury 50	Ischemic heart disease 94	Alcohol-related 147	Stroke 265	COVID-19 362	COVID-19 469
5	*	*	*	Alcohol-related 36	Suicide 48	Breast cancer 33	Breast cancer 75	Breast cancer 125	Lung Cancer 327	Hypertensive heart disease 467

*numbers less than 11 not reported for patient privacy

Source for Life Expectancy and Age-Adjusted Mortality Rate by Sex: California Department of Public Health Community Burden of Disease Version P3.0, 3/1/2024
Source for Infant Mortality: California Department of Public Health, Center for Family Health, Maternal, Child and Adolescent Health Division, Infant Mortality Dashboard, Last Modified June 2023

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Figure 8. Leading Causes of Death in Contra Costa

Figure 8 presents the leading causes of death across different age groups in Contra Costa County from 2020 to 2022, with an emphasis on various health conditions, including injuries and chronic diseases. In the context of opioid-related concerns, drug overdose is a significant cause of death for specific age groups, particularly young and middle-aged adults.

For individuals aged 15-24, drug overdose is the second leading cause of death, reflecting the serious impact of substance use at a young age. In the 25-34 and 35-44 age groups, drug overdose ranks as the top cause of death, signaling a critical public health issue within these populations. Among those aged 45-54, drug overdose remains a significant concern, ranking as the leading cause of death.

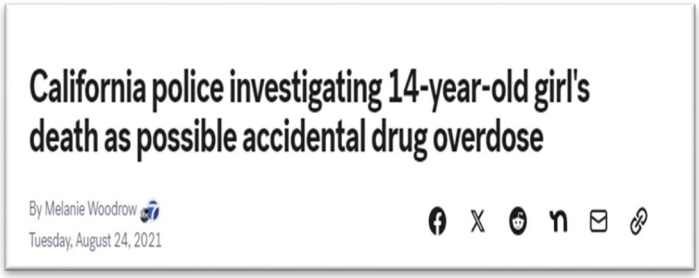


Figure 9.source: https://abc7.com/concord-police-department-death-investigation-high-school-teen-dies-in-overdose/10971559/

This pattern demonstrates the urgent need for targeted interventions to address opioid misuse and prevent overdose fatalities in Contra Costa County. The data highlight young adults as a particularly vulnerable group, emphasizing the importance of opioid response efforts, harm reduction strategies, and preventive measures tailored to reduce the burden of overdose deaths within this community.

California Overdose Surveillance Dashboard

The California Opioid Overdose Surveillance Dashboard serves as an important tool for monitoring opioid-related overdoses across the state, with an emphasis on informing interventions and resource allocation. The dashboard provides granular data on opioid-related overdose trends, enabling a focused view of specific counties and populations disproportionately affected by the crisis.

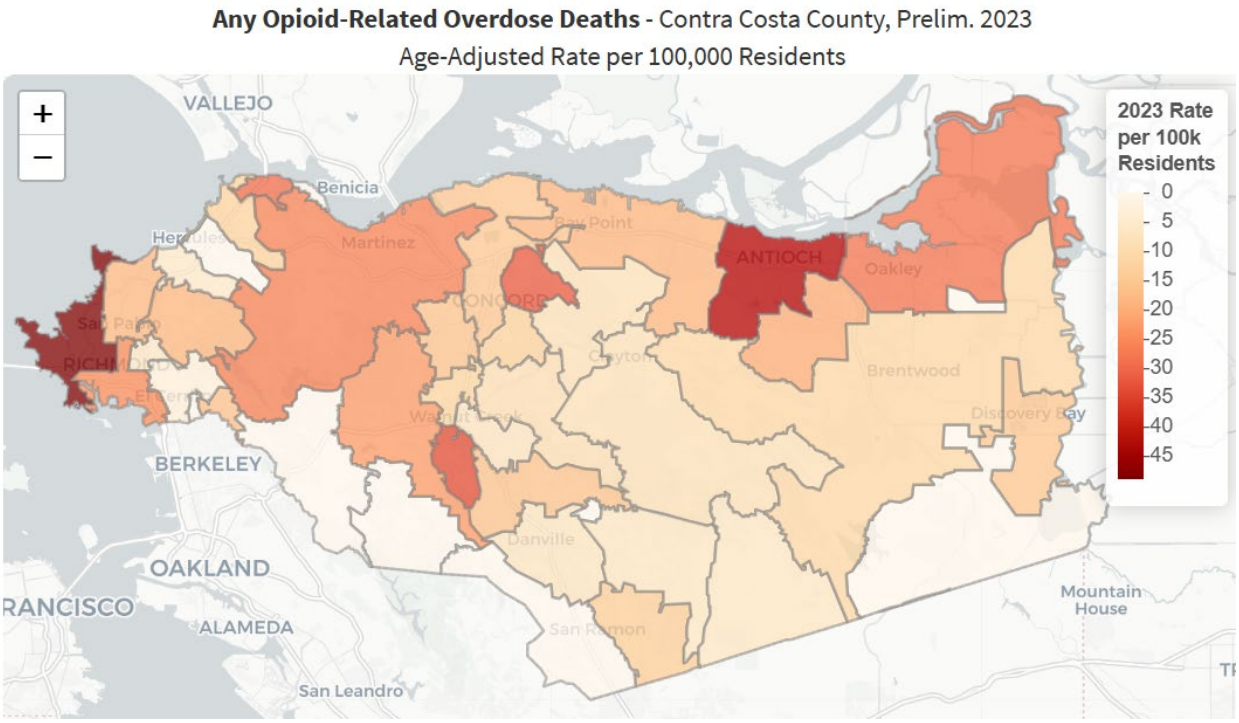
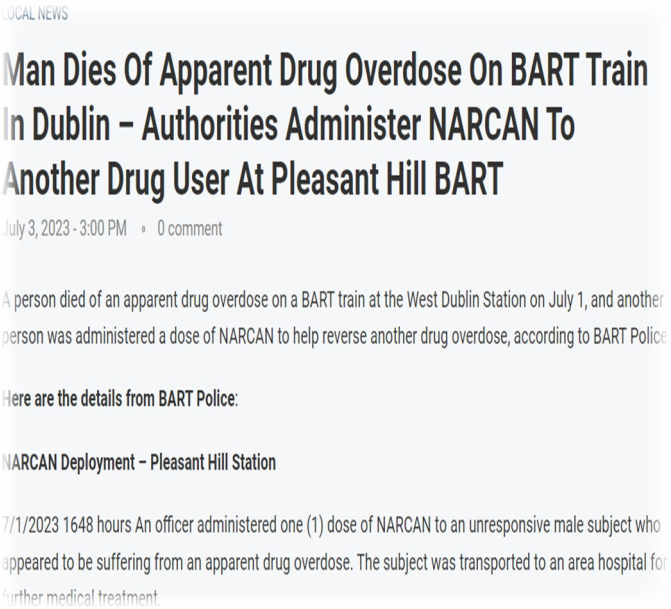


Figure 10. Geographic Distribution of Opioid-Related Overdose Death in Contra Costa County 2023. Source: CDPH Center for Health Statistics and Informatics Vital Statistics - Multiple Cause of Death and California Comprehensive Death Files Prepared by: California Department of Public Health, Substance and Addiction Prevention Branch.

Figure 10 shows a geographic map illustrating the distribution of opioid-related overdose deaths in Contra Costa County for 2023, presented as age-adjusted rates per 100,000 residents. The color gradient, ranging from light to dark shades, indicates the severity of overdose rates in different zip code areas. Darker areas, such as Richmond and Antioch, show significantly higher overdose death rates, highlighting these locations as high-risk zones. In contrast, lighter-colored areas indicate lower overdose rates, suggesting a lesser burden from opioid-related deaths in those regions.



LOCAL NEWS

Man Dies Of Apparent Drug Overdose On BART Train In Dublin – Authorities Administer NARCAN To Another Drug User At Pleasant Hill BART

July 3, 2023 - 3:00 PM • 0 comment

A person died of an apparent drug overdose on a BART train at the West Dublin Station on July 1, and another person was administered a dose of NARCAN to help reverse another drug overdose, according to BART Police.

Here are the details from BART Police:

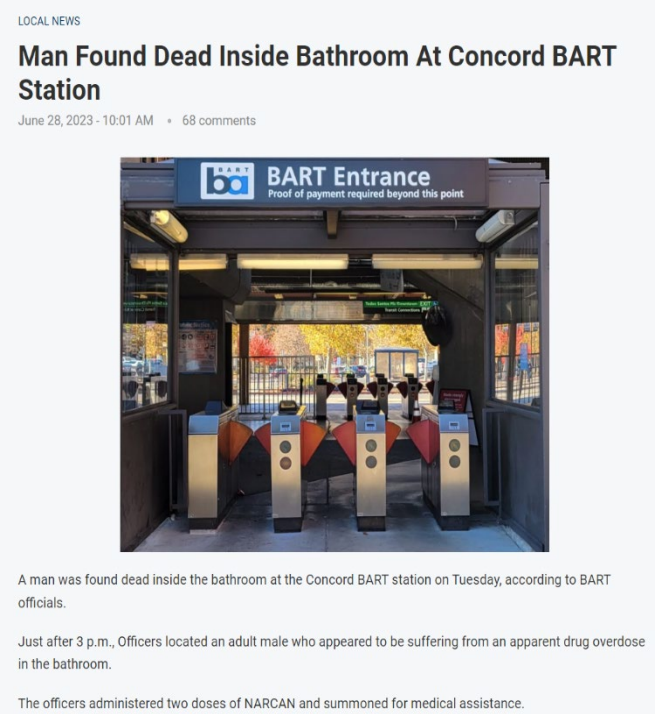
NARCAN Deployment – Pleasant Hill Station

7/1/2023 1648 hours An officer administered one (1) dose of NARCAN to an unresponsive male subject who appeared to be suffering from an apparent drug overdose. The subject was transported to an area hospital for further medical treatment.

Figure 11.Retrieved from https://www.claycord.com/2023/06/28/man-found-dead-inside-bathroom-at-concord-bart-station/

This geographic distribution underscores the importance of age-adjusted rates for analyzing opioid-related overdose trends. An age-adjusted rate is essential for accurately comparing areas with different age distributions. Age adjustment accounts for differences in the population age structure, ensuring that the overdose rate reflects the actual risk within each location rather than being influenced by age-related factors. This adjustment is

particularly relevant because opioid use and overdose risk can vary across age groups. By standardizing the data, Contra Costa Behavioral Health Services (CCBHS) can make fair and meaningful comparisons, identifying areas with genuine disparities in opioid-related outcomes. The statistical approach of using age-adjusted rates provides a more precise view of overdose impacts across Contra Costa County, supporting informed decisions on resource allocation and intervention strategies. This map highlights the need for targeted responses in the most affected areas, emphasizing the importance of focused efforts to reduce overdose rates and address the underlying factors contributing to these high-risk zones.



LOCAL NEWS

Man Found Dead Inside Bathroom At Concord BART Station

June 28, 2023 - 10:01 AM • 68 comments

A man was found dead inside the bathroom at the Concord BART station on Tuesday, according to BART officials.

Just after 3 p.m., Officers located an adult male who appeared to be suffering from an apparent drug overdose in the bathroom.

The officers administered two doses of NARCAN and summoned for medical assistance.

Figure 12. source: https://www.claycord.com/2023/06/28/man-found-dead-inside-bathroom-at-concord-bart-station/

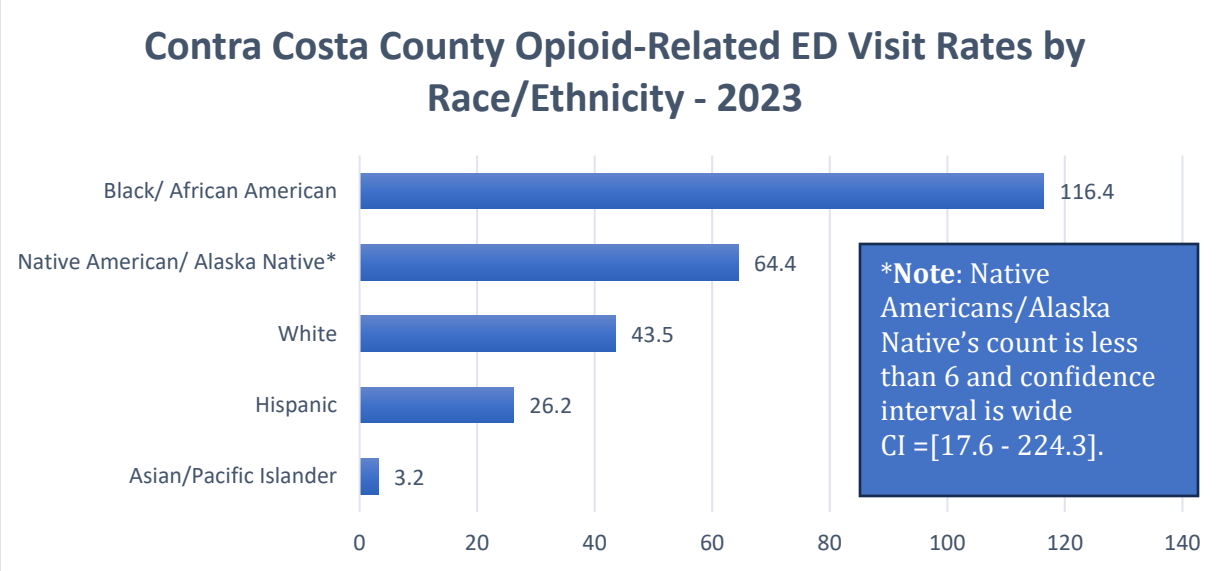


Figure 13. Contra Costa County Opioid-Related ED Visit Rates by Race/Ethnicity - 2023. Source: CDPH Center for Health Statistics and Informatics Vital Statistics - Multiple Cause of Death and California Comprehensive Death Files

The bar graph (Figure 12) displays the opioid-related emergency department (ED) visit rates by race/ethnicity in Contra Costa County for 2023, measured per 100,000 residents. Opioid-related ED visit rates are a critical indicator of the immediate public health impact of opioid misuse, capturing cases of overdose, severe withdrawal, and other acute health issues that require urgent care.

These rates provide timely, accessible data that reflect the burden on healthcare systems and highlight at-risk populations through demographic breakdowns. ED visits also serve as an early warning of escalating trends, allowing for prompt intervention and resource allocation. Monitoring these visits enables public health officials to assess the effectiveness of programs and tailor responses to reduce opioid-related harm in affected communities.

The data reveal stark racial and ethnic disparities in ED visits due to opioid use, with Black/African American residents experiencing the highest rate at 116.4 visits per 100,000 residents. This rate is nearly three times higher than that of White residents, who have a rate of 43.5 per 100,000, indicating a significant public health disparity within the county. Native American/Alaska Native residents also exhibit a high ED visit rate of 64.4 per 100,000, substantially above the county average of 39.0 per 100,000. Hispanic residents have a lower rate of 26.2 per 100,000, while Asian/Pacific Islander residents show the lowest impact, with an ED visit rate of 3.2 per 100,000. These statistics highlight a critical need for targeted public health interventions, particularly within Black/African American and Native American/Alaska Native communities, to address the disproportionate burden of opioid-related health issues. However, because there were fewer than six cases, the wide confidence interval (17.55 to 224.32) suggests considerable uncertainty. This rate should be interpreted cautiously, as small numbers can lead to imprecise estimates. The racial and ethnic disparities observed emphasize the importance of culturally responsive healthcare initiatives, prevention programs, and resource allocation to reduce these rates and support the most impacted populations.

Disparities in Utilization of Services

In Contra Costa County, there are nearly 270,000 residents that are eligible for Medi-Cal services. Data show that of this group, Latino/Hispanic and Asian/Pacific Islander communities, are accessing behavioral health services at lower rates than other ethnic communities.[26]

External Quality Review Organization (EQRO) Penetration Rate (PR) in Substance Use Treatment

CCBHS administers the Drug Medi-Cal Organized Delivery System (DMC-ODS), which operates as a Prepaid Inpatient Health Plan (PIHP). This system provides a comprehensive range of treatment services for individuals diagnosed with SUD, including those with OUD. While DMC-ODS primarily funds treatment services, CCBHS also offers a limited set of prevention services not covered by Drug Medi-Cal but essential for ensuring a continuum of care.

Contra Costa's health system also delivers MAT through its Federally Qualified Health Centers (FQHCs) and public health clinics under the Choosing Change program. This program plays a critical role in expanding access to MAT, which effectively combines medications like buprenorphine and methadone with counseling and behavioral therapies to treat OUD and other SUDs.

Penetration rate (PR) measures the percentage of eligible individuals who receive a specific service within a defined population. In the context of substance use treatment, PR represents the proportion of Medi-Cal-eligible residents who accessed services provided through the DMC-ODS. Higher PRs indicate greater access to care, while lower PRs may highlight gaps in service delivery or barriers to treatment utilization.

Age Groups	# Members Eligible	# Members Served	County PR	County Size Group PR	Statewide PR
Ages 12-17	35,236	122	0.35%	0.29%	0.25%
Ages 18-64	177,604	2,315	1.30%	1.29%	1.19%
Ages 65+	34,052	214	0.63%	0.56%	0.49%
Total	**246,892**	**2,651**	**1.07%**	**1.04%**	**0.95%**

Table 4. Contra Costa DMC-ODS Medi-Cal Eligible Population, Members Served, and Penetration Rates by Age CY 2022

Racial/Ethnic Groups	# Members Eligible	# Members Served	County PR	Same Size Counties PR	Statewide PR
African American	31,665	457	1.44%	1.29%	1.19%
Asian/Pacific Islander	28,883	60	0.21%	0.15%	0.15%
Hispanic/Latino	76,183	396	0.52%	0.74%	0.69%
Native American	628	16	2.55%	2.34%	2.01%
Other	68,336	872	1.28%	1.34%	1.26%
White	41,200	850	2.06%	1.89%	1.67%

Table 5. Contra Costa DMC-ODS Medi-Cal Eligible Population, Members Served, and Penetration Rates by Race/Ethnicity CY 2022

CCBHS Response to the Opioid Crisis

Since 2012, CCBHS has been monitoring the evolving opioid crisis in collaboration with community stakeholders and other county partners. Contra Costa understood then that this urgent public health crisis required a multi-sector approach and a broad solution focus beyond awareness and education. Our interdivisional work involves Public Health, the Health Plan (CCHP), Emergency Medical Technicians (EMTs), the Sheriff-Coroner, Hospitals, and Clinics.

Ongoing efforts to address the Opioid Crisis and Response include reviewing the Morbidity and Mortality Reports from the CDC and the California Department of Public Health Opioid Dashboard to develop a ***Blueprint for Addressing the Opioid Epidemic***. This strategy focuses not only on clinical treatment but also on addressing the underlying social, economic, and health conditions that have exacerbated the opioid crisis over the last decade.

Background History of Opioid Settlement Funds in Contra Costa

On July 13, 2023, Behavioral Health provided an update on the opioid litigation settlement and presented a proposal from Health Services regarding the use of settlement funds to the Contra Costa Public Managers Association alongside County Administration staff. During the presentation, cities were allowed to opt in or out of receiving their respective allocations. The majority of cities, with a few exceptions, chose to delegate their smaller allocations to County Health Services in order to quickly and more effectively respond to the devastating impact of opioids. This decision supported several preliminary activities already approved by the county and implemented by Behavioral Health.

Preliminary Priority Funding Matrix

In November 2021, Contra Costa Health Services proposed a preliminary list of activities for the utilization of Opioid Settlement Funds, contingent on the decision of local cities to defer their allocations to the County. The list of priorities clearly aligned to the Opioid Abatement Activities as defined in the legal agreements as follows:

Treatment				
Status	County Priority Action (1 = Highest; 7=Lowest)	Distributor Agreement	(Min 50%) Must be Used section	Status Note
	Priority 1 Increase contract payment limits for existing SUD providers to expand capacity and/or bolster services to support co-occurring disorders based on quality and performance	Inpatient and outpatient substance use disorder, including recovery support services	The provision of funds towards operating costs for existing substance use disorder facilities within behavioral health	Rates of providers were increased following CalAIM Payment Reform implementation 1 Outpatient provider added in Central Contra Costa 1 Outpatient Provider to be added in West County Increase outpatient services for Latinos – add 4FTE Spanish speaking counselors
	Priority 2 Expand SUD treatment in the jails	Provide treatment for the incarcerated population	Diversion of people with substance use from the justice system into treatment, including providing training and resources to first and early responders (sworn and non-sworn) and implementing best practices for outreach, diversion and deflection, employability, restorative justice Create new programs	Addition of 2 FTE Substance Abuse Counselor to support Spanish speaking clients in the jail Funding of Sublocade, an injectable form of MAT for individuals in jail. Funding to Detention Health
	Priority 3 1 FTE Addiction Medicine Physician to assist with establishment of MAT expansion to include medical treatment for alcohol disorders for clients engaged in treatment.	Establish and expand MAT services	Building the infrastructure of the existing SUD treatment delivery system Create new programs	Participation in the CSAM conference in San Francisco as a vendor to include recruitment efforts.
	Priority 4 Expand Adolescent SUD Treatment (Residential and Outpatient)	Expand screening and intervention for uninsured youth	Addressing needs of communities of color Interventions to prevent substance use in vulnerable youth- harm reduction approaches Create new services	Temporary funding of Tarzana via single service agreement for youth at Juvenile Hall at risk of overdoses. Implementation of contract with The Camp in Santa Cruz. Neither facility accepts Medi-Cal. Propose building a small 6 beds facility through a round 3 BICHIP proposal.

Prevention				
Status	County Priority Action (1 = Highest; 7=Lowest)	Distributor Agreement	(Min 50%) Must be Used section	Status Note
	Priority 5 1 FTE Coordinator/Project Manager to support collaboration and implementation of this program, continue strategic plan and coordinate CCHS's efforts and community stakeholders, and ensure client's voice and lived experience	Provide education and training, facilitate cross divisional coordination	Support infrastructure	1. 1FTE Public Health Service Specialist Hired as of 9/26/2024 2. Fund the MEDS coalition staff to support education and training. Shift to permanent funding

Harm Reduction				
Status	County Priority Action (1 = Highest; 7=Lowest)	Distributor Agreement	(Min 50%) Must be Used section	Status Note
	Priority 6 Increase SUD capacity in existing outreach teams (i.e., Health Care for the Homeless, Mental Health, JI CalAIM, homeless shelters, juvenile hall)	Outreach, expand warm hand-offs and SUD system navigation, naloxone training and distribution	Addressing needs of communities of color, non-insured, harm reduction	Development of the Opioid Response Team. 6 FTE field-based counselors at Touchpoint locations to engage the most vulnerable clients with OUD.

Innovation Quality Fund			
Status	**County Priority Action (1 = Highest; 7=Lowest)**	**Distributor Agreement**	**(Min 50%) Must be Used section**
	Priority 7 Establish an Innovation Quality Fund to Improve quality of services and test new models (3-years cycle)	Implementing best practices, for services to clients with co-occurring, hiring additional workers.	Addressing needs of communities of color, non- insured. Use of wrap around, employability, harm reduction, restorative justice Create new programs

Legend	Completed 	In-progress 	Need Attention 

The proposed activities were designed to be implemented in phases, starting with HIAA, followed by Remediation Core Strategies. The approach emphasized that a robust community engagement process would be essential in tailoring services to meet the unique needs of vulnerable populations. These populations include communities of color, formerly incarcerated or justice-involved individuals, pregnant and parenting women, the unhoused, and those living with co-occurring conditions. The goal is to ensure that these groups receive the targeted support necessary to address their specific challenges within the context of the opioid crisis.

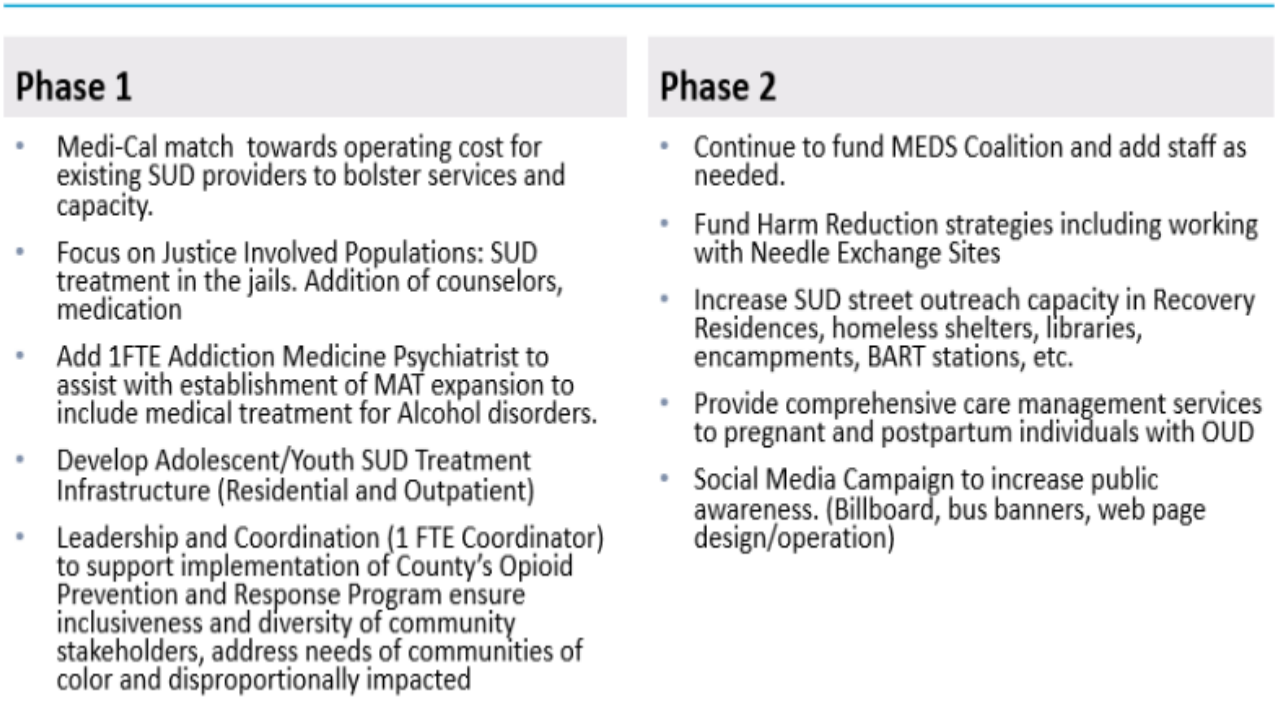


Figure 14. Behavioral Health High Impact Areas

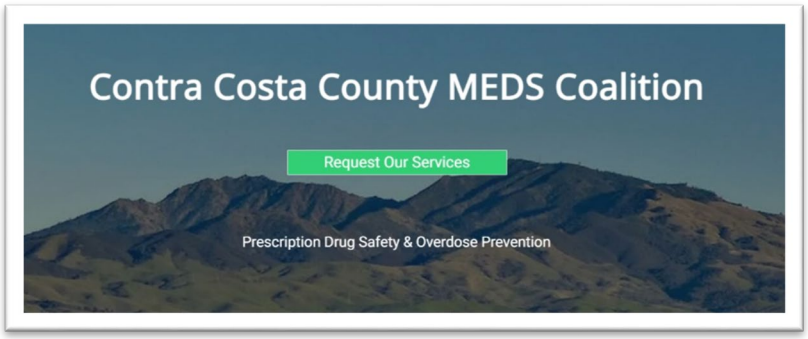


Figure 15. source: https://cccmedscoalition.org/

Collaboration with Other Cities and Local Community Stakeholders

In response to the escalating crisis, it became clear that Contra Costa Behavioral Health Services (CCBHS) needed to focus its initial efforts on outreach, education, and Naloxone training and deployment as the critical first steps in its plan. To broaden the scope and reach of these activities, CCBHS partnered with the MEDS Coalition,

extending efforts across a comprehensive geographic range, including more organizations and communities.

While some cities implemented their abatement activities, Contra Costa Health remains committed to building partnerships and supporting the most vulnerable populations. As part of this commitment, CCBHS continues to collaborate with the Antioch and Richmond Police Departments on initiatives such as Naloxone deployment, training, outreach, and engagement support at homeless encampments, especially during relocation efforts.

Figure 16. source: https://abc7news.com/mt-diablo-unified-school-district-fentanyl-awareness-program-save-a-life-teen-drug-overdoses-narcan/13487726/

Community Outreach Education

For a complete list of agencies with whom we have collaborated please see Appendix 2.

Figure 17. Visualization of stats Jan 2023 - March 2024

To develop the County's Plan of Action, CCBHS partnered with Indigo Project, a local consulting firm, to conduct a series of Listening Sessions to gather community input (see Appendix 3 to see the announcement). The plan for these sessions was presented to the CCBHS Advisory Board on April 23, 2024, and announced during the System of Care meeting for SUD treatment and prevention providers. The sessions' flyers were distributed online and in person at key locations to encourage widespread participation.

The Listening Sessions were held by regions, both in person and virtually, to accommodate different needs. A survey was created in English and Spanish to capture further feedback from the public. SUD prevention providers also integrated opportunities within their existing programs to allow participants to share their opinions and needs regarding opioid prevention and treatment. The goal of the Listening Sessions and surveys was to analyze behavioral health needs and identify priorities and strategies to address these needs effectively.

All Listening Sessions, surveys, and focus groups were completed by June 2024. Members of the CCBHS Advisory Board provided their final input during their monthly board meeting on September 25, 2024.

Methodology

In May 2024, eight in-person and virtual Listening Sessions and community conversations were conducted. These included focus groups that engaged clients in treatment, with sessions available in both English and Spanish (see Appendix 4 for the surveys). Some sessions specifically targeted youth under 18 years of age, and intercept and online surveys were distributed to jail, justice-involved individuals, parents, youth, service professionals, and individuals in treatment and recovery. The sessions were promoted on social media platforms such as Facebook and Instagram by the Health Services Department's Office of Information and Communication. KRON 4 News covered one session held in Concord.

Health officials host opioid listening sessions in Concord

KRON4's Philippe Djegal reports.

www.youtube.com

A brief survey was available in May 2024. It included both a QR code and a survey link for easy access. It was distributed online as well as in paper form at in-person events. In total, 397 responses were received, of which 354 were completed at prevention events, treatment facilities, and jails. Surveys were entered into the system by CCBHS staff, and of the total responses, 81% were completed in English and 19% in Spanish.

In addition to surveys, community input was obtained in person at De Anza High School and through the various regional community forums as follows:

- East County Community Forum
- Central County Community Forum
- West County Community Forum
- Online Community Forum South/Lamorinda Areas
- Focus Groups with Parents at Oak Grove, Riverview, and DeJean Middle Schools
- Focus Group with clients at SUD treatment residential facilities.

Community Input

Participants were encouraged by Indigo consultants to respond to the following questions:

- What are the greatest needs that opioid settlement funds should address?
- What are your priorities for how opioid settlement funds should be spent?
- What specific programs and services would you like to see funded, if any?
- What specific harm reduction programs and connections to treatment would you like to see funded, if any?

- What specific prevention programs and services would you like to see funded, if any?

Participants included Ambulatory Care Clinics or FQHCs, CCBHS Providers, CCRMC ED/PES staff, Child Welfare, CORE Team, Healthcare for the Homeless, and other Homeless Service Providers (HCH), Detention Health, Faith-based and Community Leaders, Law Enforcement, Office of Education, People with Lived Experience, Schools-based clinics and prevention participants.

We placed a big emphasis at eliciting the voices of detention facility staff, Homeless Services/Shelters, clients at Discovery House, Pueblos Del Sol, African American Faith-Based Communities and BAART Clinics.

Community Feedback

Fill-in response question:
What specific programs and services would you like to see funded, if any?

"SLE's for people with MAT services. Most SLE's don't let you live there if you are on MAT services, More residential for mental health, and long term housing."

- Listening Session Survey participant

"We need residential treatment for adolescents ages 12-17, ASAP please!"

- Listening Session Survey participant

"Open 3-4 facilities that support mental health substance abuse residential. There are too many homeless w/severe mental health that do not have any support or anyone to help them."

- Listening Session Survey participant

"[System] is kind of built for us to fail…If outpatient doesn't work for me, residential is the next step. If there is no option, I'm stuck at juvenile hall…People should not have to be institutionalized to get the services they need." - Youth participant

In-County Youth Residential Treatment

What specific programs and services would you like to see funded? What are your priorities for how opioid settlement funds should be spent?

Prevention	Harm Reduction and Connections to Treatment	Treatment
• Improve access to services • Address social determinants, such as housing, income, transportation and childcare • Reduce childhood trauma • Increase awareness amongst parents about opioids • Provide positive activities for youth • Provide drug prevention education for youth • Reduce youth access to alcohol, nicotine, marijuana, and other drugs • Educate and increase public awareness about opioids • Educate healthcare providers • Culturally informed interventions in communities of color • None of these • Other: _____	• Support jail reentry programming for people with substance use disorders • Increase access to peer support for people with substance use disorders • Increase availability of test strips • Increase availability of Narcan • Increase education about safe consumption • Provide overdose education • Increase access to syringe exchange services • Increase opportunities for social connection for people with substance use disorders • None of these • Other: _____	• Increase the availability of treatment services • Increase the availability of outpatient substance use treatment • Increase the availability of residential substance use treatment • Increase the availability of recovery residences • Support innovative programs, such as contingency management • Provide more transportation assistance to care and treatment • Increase the availability of medication assisted treatment • Increase the availability of detoxification • Increase availability of in-custody treatment • Increase field and street-based treatment teams • Improve connections to employment and vocational supports • Build awareness of existing services • None of these • Other: _____

Indigo Project

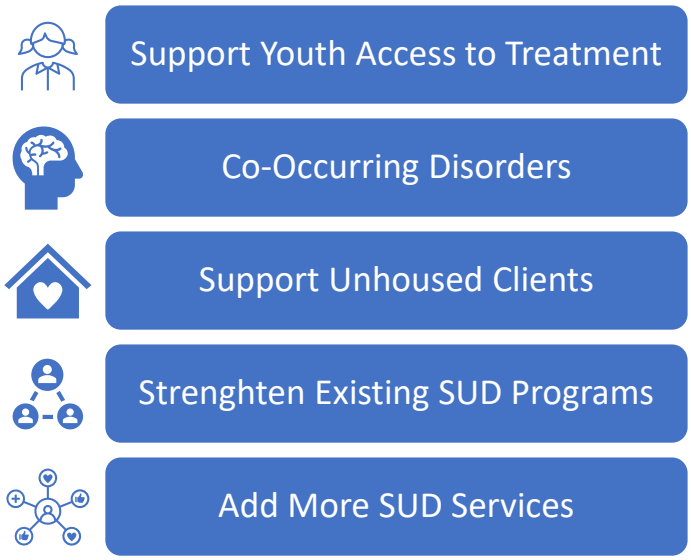
Community Recommendations

On June 2026, Indigo Project presented the results and analysis of community feedback to the CCBHS Advisory Board. Various Board members shared their feedback at the September monthly Board meeting.

The summary below only represents the highest number of responses for the specific questions.

QUESTION ONE

What are the greatest needs that the Opioid Settlement Funds Should Address?



QUESTION TWO

What are your prioritites for how the Opioid Settlement Funds Should Be Spent?

Other responses that received support included: engaging in leadership, planning and coordination, preventing opioid misuse, and supporting first responders. The community also shared recommendations about the type of remediation activities the funds should be spent.

COMMUNITY RECOMMENDED ACTIVITIES WITHIN CORE STRATEGIES

PREVENTION	HARM REDUCTION	TREATMENT
• Improve access to services • Provide drug prevention education to youth • Provide positive activities for youth • Reduce youth access to cannabis, tobacco, alcohol and other drugs • Address social determinants of health: housing, transportation, childcare, etc. • Increase awareness among parents about Opioids • Implement culturally informed interventions in communities of color • Educate health care professionals about MAT & SUD • Increase public awareness about opioids	• Provide overdose education • Support jail reentry programming for people with SUD • Increase availability of Naloxone (Narcan) • Increase access to peer support for people with SUD • Increase opportunities for social connections for people with SUD • Increase education about safe consumption • Increase availability of test strips • Increase access to syringe exchange programs • Support innovative programs such as Contingency Management	• Increase availability of detoxification services in East County • Increase availability of SUD residential treatment for youth • Increase availability of SUD residential and outpatient treatment • Increase availability of recovery residences • Build awareness of existing services • Increase field and street-based treatment teams • Increase availability of in custody SUD treatment • Increase availability of MAT

Gap Analysis

Several gaps are identified through reviewing community feedback, current programs, and resources, particularly in treatment, harm reduction, and prevention services. While the county has existing programs like the Crossroads Program and MAT providers, the feedback highlights a pressing need to expand treatment accessibility, especially in underserved areas such as East County. Many residents reported limited access to detoxification services and a complete lack of youth residential beds for Medi-Cal beneficiaries. There is a significant gap in support for individuals with co-occurring disorders, with limited funding for Spanish-speaking treatment counselors, especially for underserved Latino populations. Expanding SUD treatment for these populations is a crucial next step.

Table 6. Treatment Services Gaps and Opportunities

Category	Community Feedback	Current Programs/Resources	Identified Gaps	Opportunities
Access to Treatment	Expand treatment and recovery services, especially in East County	Crossroads Program, MAT Providers, ORT	Lack of detoxification services, no youth residential beds for Medi-Cal in North/Central Contra Costa	Build more detox centers, develop youth residential programs, increase outreach to underserved areas
Co-occurring Disorders	Increase support for co-occurring disorders	Existing SUD providers, contingency programs (REACH)	Limited funding for Spanish-speaking counselors	Hire more Spanish-speaking counselors, increase funding for culturally sensitive treatment programs
Special Populations	Extend services to undocumented and homeless populations	ORT, Sublocade medication purchase	Limited wrap-around support for uninsured/homeless individuals	Create focused support programs for uninsured/homeless with co-occurring disorders

Harm reduction strategies, including the Opioid Response Team (ORT), partnerships with the Harm Reduction Coalition, and Naloxone distribution efforts, are already in place. However, outreach and support remain insufficient for specific high-risk populations, such as justice-involved individuals and those experiencing homelessness. These groups face barriers in accessing essential harm-reduction tools like Naloxone and fentanyl test strips. Despite the progress made by county partnerships, there is a need to expand touchpoints and implement more community-based distribution models. Increasing initiatives like implementing vending machines for Naloxone distribution in public spaces could be instrumental in reaching these vulnerable populations. Strengthening these efforts would ensure greater access to life-saving resources and help reduce overdose rates within these communities.

Table 7. Harm Reduction Efforts and Gaps

Category	Community Feedback	Current Programs/Resources	Identified Gaps	Opportunities
Naloxone Access	Increase Naloxone availability in more locations	ORT at various touchpoints, Naloxone distribution by CCBHS	Limited distribution in high-risk areas (pregnant women, homeless)	Expand vending machine program for Naloxone, increase distribution points across public spaces
Jail Reentry Programs	Support reentry programming for justice-involved individuals with SUD	ORT support in jails and detention centers	Lack of expanded reentry support for uninsured or non-Medi-Cal recipients	ORT to enhance outreach and post-release care coordination
Peer Support	Increase opportunities for social connection and peer support	ORT and Harm Reduction Coalition (Richmond/Antioch), HEPPAC Contract	Insufficient peer support and social connection programs	Expand peer support programs through partnerships with community organizations

On the prevention side, there is a clear need for broader youth engagement and education on drug prevention, overdose, and recovery resources. The community feedback emphasized the need for more targeted media campaigns to reduce the stigma around opioid use and to inform communities about available resources. While the county's efforts have helped educate students and parents in many areas, East County's participants reported limited outreach and education. Increasing staffing and resources to support these prevention programs will be vital for scaling efforts countywide. Funding should prioritize increasing Spanish-speaking counselors, expanding MAT services, and developing additional detoxification and youth residential beds to address these gaps. Expanding harm reduction services and outreach to include uninsured populations, justice-involved individuals, and homeless communities will be essential. Finally, targeted media campaigns and more robust youth prevention and education outreach programs will help bridge the gap between the community's needs and available services.

Contra Costa Preliminary Action Plan

Treatment			
County Priority Action (1 = Highest; 7=Lowest)	Community Feedback	Current Programs/Resources	Gaps/Opportunities
Priority 1 - Expand/strengthen existing SUD providers to expand capacity to support co-occurring disorders **Focus area (min 50% must be used)** Funds towards operating costs for existing SUD facilities within Behavioral Health **Priority 2** - Support SUD treatment in jail for OUD and MAT to ensure continuity of care **Focus area (min 50% must be used)** a) Transition people with SUD from the justice system into treatment programs by training first responders b) Implement best practices for outreach, diversion and deflection, employability, restorative justice c) Create new programs **Priority 3** - Hire 1 FTE addiction medicine provider to assist with MAT expansion and establishment for clients engaged in SUD treatment **Focus area (min 50% must be used)** a) Build infrastructure of the existing SUD treatment delivery system b) Create new programs **Priority 4** - Expand SUD treatment for youth outpatient/residential **Focus area (min 50% must be used)** a) Address needs of the communities of color b) Harm reduction approaches or Interventions to prevent SU in vulnerable youth c) Create new services	**Access to Treatment** c) Increase the availability of treatment, residential and recovery services, including East County. d) Increase availability of detoxification services, including East County e) Expand SUD adolescent treatment (outpatient/residential) **Treatment and Recovery Services** d) Support individuals with co-occurring disorders e) Strengthen existing programs f) Support people in treatment and recovery g) Treating opioid disorder, including MAT h) Contingency Management i) No youth residential beds in North and Central County for Medi-Cal beneficiaries j) Not enough detoxification beds and limited beds in the East County **Special Populations** a) Connect people who need help with the help that they need b) Support individuals who may be experiencing homelessness c) Extend services to undocumented/Latino populations	1) Sublocade/Suboxone medication purchase 2) County Program a) Crossroads Program b) Treatment/MAT Providers c) Contingency programs (i.e., REACH) 3) ORT	1) Additional allocation to programs that requires more funding (e.g., Nuevos Comienzos or Pueblos Del Sol). 2) ORT a) Support coaches/transition team with ORT. b) ORT can provide training to first responders (collaborate with SUN) c) Expand ORT services to help uninsured navigate the system to receive insurance d) Collaborate with CORE to assist with the homeless population 3) Expand MAT capacities with addiction provider 4) The County has limited detoxification facilities and no youth residential beds. Provide recovery residences for MAT participants and SUD/OUD users. a) Create residential bed programs for youth b) Create more detoxification facilities and/or beds c) East County 5) Jail and detention facility a) Continuing support the Crossroads Programs b) Provide education presentation to justice stakeholders (potentially use innovation funds to garner justice stakeholder's support)

Prevention			
County Priority Action (1 = Highest; 7=Lowest)	Community Feedback	Current Programs/Resources	Gaps/Opportunities
Priority 5 - Hire 1 FTE Coordinator/Project Manager **Focus area (**min 50% must be used) Support infrastructure	**Access to services** a) Supporting youth access to treatment b) Address SoDs to improve access to services and participation (i.e., gift cards, transportation, food, childcare) **Education and Awareness** a) Increase awareness, provide drug/OD education and positive activities for youth (school-based and community) b) Use of incentives or stipends for parents/youth to educate peers (family and community-level interventions) c) Embed CCBHS into family and community programs subtly **Targeted media campaign** a) Receive info about opioid prevention and treatment of communities most impacted b) Promote educational campaigns to counter stigma **Reduce youth access to all substances** a) Prevent OD and deaths	1) MEDS Coalition provides educational outreach and Naloxone training to schools and events across the county 2) CCBHS Staff a) Health Education Specialist/Prevention Coordinator b) Public Health Program Specialist will support infrastructure and coordinate opioid efforts 3) Opioid Response Team (ORT). ORT staff provides education of Naloxone administration, provide help and resources, use of fentanyl strip, and outreach and awareness	1) Communities expressed there are number of schools that were not yet participating and require additional outreach (a) (MEDS) expressed providing education and training to East County is difficult (b) A need for additional staff (e.g., a health educator) to expand outreach and education efforts 2) Integrate CCBHS services into community and family events to reduce stigma 3) Media campaigns can help engage youth and raise awareness of CCBHS services. (a) Billboards (b) Bus wraps (c) Partnership with faith-based communities (d) Ethnic specific media

Harm Reduction			
County Priority Action (1 = Highest; 7=Lowest)	Community Feedback	Current Programs/Resources	Gaps/Opportunities
Priority 6 - Increase SUD capacity in existing outreach teams for harm reduction and abatement (OD prevention) **Focus area (min 50% must be used)** Addressing the needs of communities of color, non-insured populations, and expanding Naloxone distribution.	**Naloxone Access and Distribution** a) Increase Naloxone availability and OD prevention materials in more locations across the county **Supportive Programs** a) Support jail reentry programming for people with SUD b) Increase opportunities for social connection/peer support for people with SUD	1) ORT: Harm reduction (touchpoints). ORT are placed in various touchpoints to provide test strips, Naloxone distribution and harm reduction kits. ORT and counselors (who are also Spanish speakers) are placed in jail and detention facilities who can support individuals receive to connect care upon release. 2) CCBHS oversees Naloxone distribution throughout the county 3) HEPPAC Contract (Antioch)- Syringe Access Program 4) Harm Reduction Coalition (Richmond and Antioch)- Focused on harm reduction initiatives under a 3-year contract.	1) Current ORT target population criteria. ORT services should expand to non-insured people. a) Pregnant women b) Justice-involved c) Unhoused d) SUD/OUD e) No show to MAT appointments and low/no adherence to medication 2) OD prevention initiative with vending machines in libraries and detention centers can serve as a model for increasing access to Naloxone. Expanding this model to more high-traffic or acquiring more locations could enhance Naloxone distribution. 3) Assess the effectiveness of harm reduction coalition and contract of how they are currently addressing the needs of the community.

Overarching		
County Priority Action (1 = Highest; 7=Lowest)	Community Feedback	Gaps/Opportunities
Priority 7 - Establish an innovation quality fund to improve quality of services and test new models (3 years cycle) **Focus area (min 50% must be used)** a) Address needs of community of color, non-insured b) Use of wrap around, employability, harm reduction, restorative justice c) Create new programs via RFP smaller funding allocations	Suggest the County create a pilot contingency management intervention	The Innovation Quality Fund presents an opportunity to address gaps in the current service landscape by enhancing prevention, harm reduction, and treatment services. These funds can be used to build on established programs and explore new, targeted approaches. **Suggestion for Program Development** **1) New Treatment Program for Spanish-Speaking Women** Create outpatient or residential programs specifically designed to meet the needs of Spanish-speaking women, addressing cultural and linguistic barriers to treatment. **2) Media Campaign for Education and Awareness** Launch a countywide media campaign to educate the public about the risks of opioid and substance use, reduce stigma, and promote available prevention and treatment resources. Partner with local organizations, schools, and faith-based groups to ensure messaging resonates with diverse audiences, including youth and communities of color. **3) Pilot Contingency Management Interventions** Develop and pilot an incentive-based program to improve participation in treatment and recovery programs. This intervention could involve small rewards for attendance at therapy sessions or family-oriented recovery events. 4) **Support Program for Non-Insured and Homeless Populations** Establish a wraparound support program for underserved populations, including those who are non-insured, experiencing homelessness, or living with SUD/OUD and co-occurring disorders. Services could include housing support, case management, and access to behavioral health care.

Priority Populations: Addressing Health Inequities and Disproportionate Impacts

The earlier waves of the opioid epidemic primarily affected younger White men and women. However, as the crisis has evolved, shifts in drug use patterns and changes in supply and demand have resulted in a marked increase in overdose rates among Black and Latino populations. This trend underscores the importance of addressing systemic inequities and disparities that leave these communities more vulnerable to the effects of the opioid crisis. From a public health perspective, employing upstream approaches—targeting the root causes of health inequities—is integral to achieving greater equity and reducing the burden of the epidemic on historically underserved populations.

Insights gathered during regional Listening Sessions highlighted the need for culturally and linguistically responsive strategies to engage hard-to-reach populations effectively. Latino and African American groups shared critical lessons from their experiences during the COVID-19 pandemic, emphasizing the importance of trust-building, community partnerships, and tailored messaging to overcome barriers to care.

Stakeholders and community members expressed strong support for prioritizing interventions targeting communities of color, youth, justice-involved individuals, and people with co-occurring disorders. Particular attention was paid to individuals at risk of homelessness after completing SUD treatment, as this group faces compounded challenges that heighten their vulnerability to relapse and overdose.

These priorities underscore the need for a comprehensive and equitable public health response that integrates prevention, treatment, and recovery efforts while addressing the broader social determinants of health. Collaborative strategies that engage community-based organizations, healthcare providers, and public health agencies are necessary to ensure these populations receive the support they need to thrive.

References

1. California Department of Health Care Services (DHCS). (2024). *CA Participating Subdivision Use of OSF Allocated from the CA Abatement Accounts Fund (BHIN 24-002)*. Retrieved from https://www.dhcs.ca.gov/Documents/CSD/BHIN-24-002-CA-Participating-Subdivision-Use-of-OSF-Allocated-from-the-CA-Abatement-Accounts-Fund.pdf

2. California Legislature. (2023). *Government Code Section 12534*. Retrieved from https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=GOV&sectionNum=12534

3. California Department of Health Care Services (DHCS). (2021). *Exhibit E - Final Settlement Agreement*. Retrieved from https://www.dhcs.ca.gov/Documents/CSD/Exhibit-E-Final-Settlement-Agreement-082021.pdf

4. National Opioid Abatement Trust. (2023, December.). *Notice of Filing on Behalf of California (CA) - SAA*. Retrieved from https://www.nationalopioidabatementtrust.com/Home/DownloadDoc?docpath=https://pstoragenationalopioid.blob.core.windows.net/prod/NOAT2/738/738_1213.pdf&docname=8444%20Notice%20of%20Filing%20on%20Behalf%20of%20California%20-%20SAA

5. California Department of Health Care Services (DHCS). (September 2023). *CA OSF Allowable Expenses*. Retrieved from https://www.dhcs.ca.gov/Documents/CSD/CA-OSF-Allowable-Expenses.pdf

6. Wilson N, Kariisa M, Seth P, Smith H IV, Davis NL. Drug and Opioid-Involved Overdose Deaths — United States, 2017–2018. MMWR Morb Mortal Wkly Rep 2020;69:290–297. DOI: http://dx.doi.org/10.15585/mmwr.mm6911a4.

7. **Centers for Disease Control and Prevention (CDC)**. (April, 2024). *Understanding the opioid overdose epidemic*. U.S. Department of Health and Human Services. Retrieved October 23, 2024, from https://www.cdc.gov/overdose-prevention/about/understanding-the-opioid-overdose epidemic.html?CDC_AAref_Val=https://www.cdc.gov/opioids/basics/epidemic.html

8. Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2021. Available at http://wonder.cdc.gov.

9. Friedman J, Shover CL. Charting the fourth wave: Geographic, temporal, race/ethnicity and demographic trends in polysubstance fentanyl overdose deaths in the United States, 2010–2021. *Addiction*. 2023; 118(12): 2477–2485. https://doi.org/10.1111/add.16318

10. Centers for Disease Control and Prevention (CDC). (2023). *Understanding the opioid overdose epidemic*. Retrieved from https://www.cdc.gov/opioids/basics/epidemic.html

11. Ahmad FB, Cisewski JA, Rossen LM, Sutton P. Provisional drug overdose death counts. National Center for Health Statistics. 2024.

12. Office of Inspector General. (2020). Opioid treatment programs reported challenges during COVID-19 pandemic. https://oig.hhs.gov/reports/all/2020/opioid-treatment-programs-reported-challenges-encountered-during-the-covid-19-pandemic-and-actions-taken-to-address-them/

13. Dinwiddie AT, Gupta S, Mattson CL, O'Donnell J, Seth P. Reported Non–Substance-Related Mental Health Disorders Among Persons Who Died of Drug Overdose — United States, 2022. MMWR Morb Mortal Wkly Rep 2024;73:747–753. DOI: http://dx.doi.org/10.15585/mmwr.mm7334a3.

14. Peterson AL. Integrating mental health and addictions services to improve client outcomes. Issues Ment Health Nurs 2013;34:752–6. https://doi.org/10.3109/01612840.2013.809830 PMID:24066651

15. NIDA. 2020, June 1. Criminal Justice DrugFacts. Retrieved from https://nida.nih.gov/publications/drugfacts/criminal-justice on 2024, October 23

16. Binswanger, I. A., Blatchford, P. J., Mueller, S. R., & Stern, M. F. (2013). Mortality after prison release: opioid overdose and other causes of death, risk factors, and time trends from 1999 to 2009. *Annals of internal medicine*, *159*(9), 592–600. https://doi.org/10.7326/0003-4819-159-9-201311050-00005

17. Gicquelais RE, Mezuk B, Foxman B, Thomas L, Bohnert ASB. Justice involvement patterns, overdose experiences, and naloxone knowledge among men and women in criminal justice diversion addiction treatment. *Harm Reduct J.* 2019;16(1):46. Published 2019 Jul 16. doi:10.1186/s12954-019-0317-3

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

19. Marc R. Larochelle, Svetla Slavova, Elisabeth D. Root, Daniel J. Feaster, Patrick J. Ward, Sabrina C. Selk, Charles Knott, Jennifer Villani, and Jeffrey H. Samet, 2021:Disparities in Opioid Overdose Death Trends by Race/Ethnicity, 2018–2019, From the HEALing Communities Study

20. Rosenberg, A., Groves, A. K., & Blankenship, K. M. (2017). Comparing Black and White Drug Offenders: Implications for Racial Disparities in Criminal Justice and Reentry Policy and Programming. *Journal of drug issues*, *47*(1), 132–142. https://doi.org/10.1177/0022042616678614

21. Carson, E. A., & Sabol, W. J. (2015). Prisoners in 2014.

22. Centers for Disease Control and Prevention (CDC). Youth Risk Behavior Survey: Data summary and trends report 2007-2017. [internet]. Atlanta, GA: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention; 2018 Oct 9 [cited 2020 May 28]. Available from: https://www.cdc.gov/healthyyouth/data/yrbs/pdf/trendsreport.pdf

23. Substance Abuse and Mental Health Services Administration: The Opioid Crisis and the Hispanic/Latino Population: An Urgent Issue. Publication No. PEP20-05-02-002. Office of Behavioral Health Equity. Substance Abuse and Mental Health Services Administration, 2020.

24. Centers for Disease Control and Prevention (CDC). Youth Risk Behavior Survey: Data summary and trends report 2007-2017. [internet]. Atlanta, GA: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention; 2018 Oct 9 [cited 2020 May 28]. Available from: https://www.cdc.gov/healthyyouth/data/yrbs/pdf/trendsreport.pdf

25. National Institute on Drug Abuse (NIDA). Monitoring the Future [Internet]. Rockville, MD: NIDA; 2019 [cited 2024 October 23]. Available from: https://www.drugabuse.gov/relatedtopics/trends-statistics/monitoring-future

26. **Contra Costa Health Services**. (2024.). Retrieved October 23, 2024, from https://www.cchealth.org
For a specific document or section

27. Spencer MR, Garnett MF, Miniño AM. Drug overdose deaths in the United States, 2002–2022. NCHS Data Brief, no 491. Hyattsville, MD: National Center for Health Statistics. 2024. DOI: https://dx.doi.org/10.15620/cdc:135849

28. **CalMatters**. (July,2023). *California opioid crisis*. Retrieved October 23, 2024, from https://calmatters.org/explainers/california-opioid-crisis/

Appendices

Appendix 1

High Impact Abatement Activities (HIAA)

On July 21, 2021, California Attorney General Rob Bonta announced the final settlement agreements with prescription opioid manufacturer Janssen Pharmaceuticals and pharmaceutical distributors McKesson, Cardinal Health, and AmerisourceBergen (the Distributors). These were the first of several opioid settlements that will provide substantial funds for the remediation of the opioid crisis in California.

This document is intended to provide guidance for California's cities and counties (otherwise known as Participating Subdivisions) that receive funds from the California Abatement Accounts Fund through current and future California Opioid Settlements.[1]

This resource includes three sections:

- Section 1: Use of California (CA) Abatement Accounts Fund
- Section 2: High Impact Abatement Activities (HIAA)
- Section 3: List of Opioid Remediation Uses (Exhibit E) – Core Strategies and Approved Uses

Questions about the applicability of strategies to expend funds received from the CA Abatement Accounts Fund can be directed to DHCS at OSF@dhcs.ca.gov.

[1] Opioid settlements in this instance refers to final and proposed agreements between the State of California and opioid distributors and manufacturers: Janssen Pharmaceuticals and Johnson & Johnson (collectively "Janssen"); McKesson, Cardinal Health, and AmerisourceBergen (collectively, Distributors); Teva; Allergan; and pharmacies Walgreens, Walmart, and CVS (collectively, The Pharmacies), as well as any future opioid settlement agreements which follow the structure of these agreements.

Section 1: Use of California (CA) Abatement Accounts Fund

Funds from the California Opioid Settlements are intended to support opioid remediation activities. As defined in the National Opioid Settlement Agreements, opioid remediation is the "care, treatment, and other programs and expenditures designed to (1) address the misuse and abuse of opioid products, (2) treat or mitigate opioid use or related disorders, or (3) mitigate other alleged effects of, including on those injured as a result of, the opioid crisis."

Pursuant to the California State-Subdivision Agreements, funds from the CA Abatement Accounts Fund must be used for opioid remediation activities in one or more of the areas described in Exhibit E of the National Opioid Settlement Agreements. Section 3 of this document provides a copy of Exhibit E, which is divided into Schedule A and Schedule B strategies. Schedule A provides a list of core opioid remediation strategies identified through the National Opioid Settlements, while Schedule B provides a list of additional opioid remediation strategies identified through the settlements.

Pursuant to the National Opioid Settlement Agreements, funds from the CA Abatement Accounts Fund may also be used to support reasonable related administrative expenses for opioid remediation activities.

Section 2: High Impact Abatement Activities (HIAA)

California state officials, in partnership with counsel representing cities and counties, have agreed on a list of opioid remediation activities to prioritize within the State of California. These priorities, referred to as High Impact Abatement Activities (HIAA), can be found in the respective California State-Subdivision Agreements. Many of the activities listed in Exhibit E of the National Opioid Settlement Agreements can qualify as HIAA, depending on their focus.

Pursuant to the California State-Subdivision Agreements, **no less than fifty percent (50%)** of the funds received by a Participating Subdivision in each calendar year from the CA Abatement Accounts Fund will be used for one or more of the HIAA listed below:

Table 1: High Impact Abatement Activities (HIAA)

No.	Activity
1	Provision of matching funds or operating costs for substance use disorder (SUD) facilities within the Behavioral Health Continuum Infrastructure Program (BHCIP)
2	Creating new or expanded SUD treatment infrastructure[2]
3	Addressing the needs of communities of color and vulnerable populations (including sheltered and unsheltered homeless populations) that are disproportionately impacted by SUD
4	Diversion of people with SUD from the justice system into treatment, including by providing training and resources to first and early responders (sworn and non-sworn) and implementing best practices for outreach, diversion and deflection, employability, restorative justice, and harm reduction
5	Interventions to prevent drug addiction in vulnerable youth
6	The purchase of naloxone for local entities including for distribution and efforts to expand access to naloxone for opioid overdose reversals.

Section 3: List of Opioid Remediation Uses – Core Strategies and Approved Uses

Participating Subdivisions shall choose from among the opioid remediation strategies listed in "Approved Uses" (Schedule B) of Exhibit E, which are listed below. However, priority should be given to the following core opioid remediation strategies ("Core Strategies" (Schedule A)).

Pursuant to the National Opioid Settlement Agreements, words like "expand," "fund," or "provide" shall not indicate a preference for new or existing programs.

[2] May include cost overrun for BHCIP programs as needed.

Core Strategies (Schedule A)

A. Naloxone or Other FDA-Approved Drug to Reverse Opioid Overdoses

1. Expand training for first responders, schools, community support groups and families; and
2. Increase distribution to individuals who are uninsured or whose insurance does not cover the needed service.

B. Medication-Assisted Treatment (MAT) Distribution and Other Opioid-Related Treatment

1. Increase distribution of MAT to individuals who are uninsured or whose insurance does not cover the needed service;
2. Provide education to school-based and youth-focused programs that discourage or prevent misuse;
3. Provide MAT education and awareness training to healthcare providers, EMTs, law enforcement, and other first responders; and
4. Provide treatment and recovery support services such as residential and inpatient treatment, intensive outpatient treatment, outpatient therapy or counseling, and recovery housing that allow or integrate medication and with other support services.

C. Pregnant and Postpartum Women

1. Expand Screening, Brief Intervention, and Referral to Treatment (SBIRT) services to non-Medi-Cal eligible or uninsured pregnant women;
2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for women with co-occurring Opioid Use Disorder (OUD) and other SUD/Mental Health disorders for uninsured individuals for up to 12 months postpartum; and
3. Provide comprehensive wrap-around services to individuals with OUD, including housing, transportation, job placement/training, and childcare.

D. Expanding Treatment for Neonatal Abstinence Syndrome (NAS)

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

E. Expansion Of Warm Hand-Off Programs and Recovery Services

1. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments;
2. Expand warm hand-off services to transition to recovery services;
3. Broaden scope of recovery services to include co-occurring SUD or mental health conditions;
4. Provide comprehensive wrap-around services to individuals in recovery, including housing, transportation, job placement/training, and childcare; and
5. Hire additional social workers or other behavioral health workers to facilitate expansions above.

F. Treatment for Incarcerated Population

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

G. Prevention Programs

1. Funding for media campaigns to prevent opioid use (similar to the FDA's "Real Cost" campaign to prevent youth from misusing tobacco);
2. Funding for evidence-based prevention programs in schools;
3. Funding for medical provider education and outreach regarding best prescribing practices for opioids consistent with the 2016 CDC guidelines, including providers at hospitals (academic detailing);
4. Funding for community drug disposal programs; and
5. Funding and training for first responders to participate in pre-arrest diversion programs, post-overdose response teams, or similar strategies that connect at-risk individuals to behavioral health services and supports.

H. Expanding Syringe Service Programs

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

I. **Evidence-Based Data Collection and Research Analyzing the Effectiveness of the Abatement Strategies Within the State**

Approved Uses (Schedule B)

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

Part I: Treatment

A. TREAT OPIOID USE DISORDER (OUD)

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

1. Expand availability of treatment for OUD and any co-occurring SUD/MH conditions, including all forms of MAT approved by the U.S. Food and Drug Administration.
2. Support and reimburse evidence-based services that adhere to the American Society of Addiction Medicine (ASAM) continuum of care for OUD and any co-occurring SUD/MH conditions.
3. Expand telehealth to increase access to treatment for OUD and any co-occurring SUD/MH conditions, including MAT, as well as counseling, psychiatric support, and other treatment and recovery support services.
4. Improve oversight of Opioid Treatment Programs (OTPs) to assure evidence- based or evidence-informed practices such as adequate methadone dosing and low threshold approaches to treatment.
5. Support mobile intervention, treatment, and recovery services, offered by qualified professionals and service providers, such as peer recovery coaches, for persons with OUD and any co-occurring SUD/MH conditions and for persons who have experienced an opioid overdose.
6. Provide treatment of trauma for individuals with OUD (*e.g.*, violence, sexual assault, human trafficking, or adverse childhood experiences) and family members (*e.g.*, surviving family members after an overdose or overdose fatality), and training of health care personnel to identify and address such trauma.

7. Support evidence-based withdrawal management services for people with OUD and any co-occurring mental health conditions.
8. Provide training on MAT for health care providers, first responders, students, or other supporting professionals, such as peer recovery coaches or recovery outreach specialists, including tele-mentoring to assist community-based providers in rural or underserved areas.
9. Support workforce development for addiction professionals who work with persons with OUD and any co-occurring SUD/MH conditions.
10. Offer fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.
11. Offer scholarships and supports for behavioral health practitioners or workers involved in addressing OUD and any co-occurring SUD/MH or mental health conditions, including, but not limited to, training, scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas.
12. Provide funding and training for clinicians to obtain a waiver under the federal Drug Addiction Treatment Act of 2000 (DATA 2000) to prescribe MAT for OUD, and provide technical assistance and professional support to clinicians who have obtained a DATA 2000 waiver.
13. Disseminate of web-based training curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service–Opioids web-based training curriculum and motivational interviewing.
14. Develop and disseminate new curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service for Medication– Assisted Treatment.

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

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

1. Provide comprehensive wrap-around services to individuals with OUD and any co-occurring SUD/MH conditions, including housing, transportation, education, job placement, job training, or childcare.
2. Provide the full continuum of care of treatment and recovery services for OUD and any co-occurring SUD/MH conditions, including supportive housing, peer support services and counseling, community navigators, case management, and connections to community-based services.

3. Provide counseling, peer-support, recovery case management and residential treatment with access to medications for those who need it to persons with OUD and any co-occurring SUD/MH conditions.
4. Provide access to housing for people with OUD and any co-occurring SUD/MH conditions, including supportive housing, recovery housing, housing assistance programs, training for housing providers, or recovery housing programs that allow or integrate FDA-approved mediation with other support services.
5. Provide community support services, including social and legal services, to assist in deinstitutionalizing persons with OUD and any co-occurring SUD/MH conditions.
6. Support or expand peer-recovery centers, which may include support groups, social events, computer access, or other services for persons with OUD and any co-occurring SUD/MH conditions.
7. Provide or support transportation to treatment or recovery programs or services for persons with OUD and any co-occurring SUD/MH conditions.
8. Provide employment training or educational services for persons in treatment for or recovery from OUD and any co-occurring SUD/MH conditions.
9. Identify successful recovery programs such as physician, pilot, and college recovery programs, and provide support and technical assistance to increase the number and capacity of high-quality programs to help those in recovery.
10. Engage non-profits, faith-based communities, and community coalitions to support people in treatment and recovery and to support family members in their efforts to support the person with OUD in the family.
11. Provide training and development of procedures for government staff to appropriately interact and provide social and other services to individuals with or in recovery from OUD, including reducing stigma.
12. Support stigma reduction efforts regarding treatment and support for persons with OUD, including reducing the stigma on effective treatment.
13. Create or support culturally appropriate services and programs for persons with OUD and any co-occurring SUD/MH conditions, including new Americans.
14. Create and/or support recovery high schools.
15. Hire or train behavioral health workers to provide or expand any of the services or supports listed above.

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

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

1. Ensure that health care providers are screening for OUD and other risk factors and know how to appropriately counsel and treat (or refer if necessary) a patient for OUD treatment.
2. Fund SBIRT programs to reduce the transition from use to disorders, including SBIRT services to pregnant women who are uninsured or not eligible for Medicaid.
3. Provide training and long-term implementation of SBIRT in key systems (health, schools, colleges, criminal justice, and probation), with a focus on youth and young adults when transition from misuse to opioid disorder is common.
4. Purchase automated versions of SBIRT and support ongoing costs of the technology.
5. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments.
6. Provide training for emergency room personnel treating opioid overdose patients on post-discharge planning, including community referrals for MAT, recovery case management or support services.
7. Support hospital programs that transition persons with OUD and any co-occurring SUD/MH conditions, or persons who have experienced an opioid overdose, into clinically appropriate follow-up care through a bridge clinic or similar approach.
8. Support crisis stabilization centers that serve as an alternative to hospital emergency departments for persons with OUD and any co- occurring SUD/MH conditions or persons that have experienced an opioid overdose.
9. Support the work of Emergency Medical Systems, including peer support specialists, to connect individuals to treatment or other appropriate services following an opioid overdose or other opioid- related adverse event.

10. Provide funding for peer support specialists or recovery coaches in emergency departments, detox facilities, recovery centers, recovery housing, or similar settings; offer services, supports, or connections to care to persons with OUD and any co-occurring SUD/MH conditions or to persons who have experienced an opioid overdose.
11. Expand warm hand-off services to transition to recovery services.
12. Create or support school-based contacts that parents can engage with to seek immediate treatment services for their child; and support prevention, intervention, treatment, and recovery programs focused on young people.
13. Develop and support best practices on addressing OUD in the workplace
14. Support assistance programs for health care providers with OUD.
15. Engage non-profits and the faith community as a system to support outreach for treatment.
16. Support centralized call centers that provide information and connections to appropriate services and supports for persons with OUD and any co-occurring SUD/MH conditions.

D. ADDRESS THE NEEDS OF CRIMINAL JUSTICE-INVOLVED PERSONS

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

1. Support pre-arrest or pre-arraignment diversion and deflection strategies for persons with OUD and any co-occurring SUD/MH conditions, including established strategies such as:
    1. Self-referral strategies such as the Angel Programs or the Police Assisted Addiction Recovery Initiative ("PAARI");
    2. Active outreach strategies such as the Drug Abuse Response Team ("DART") model;
    3. "Naloxone Plus" strategies, which work to ensure that individuals who have received naloxone to reverse the effects of an overdose are then linked to treatment programs or other appropriate services;
    4. Officer prevention strategies, such as the Law Enforcement Assisted Diversion ("LEAD") model;

5. Officer intervention strategies such as the Leon County, Florida Adult Civil Citation Network or the Chicago Westside Narcotics Diversion to Treatment Initiative; or
6. Co-responder and/or alternative responder models to address OUD-related 911 calls with greater SUD expertise.

2. Support pre-trial services that connect individuals with OUD and any co-occurring SUD/MH conditions to evidence-informed treatment, including MAT, and related services.
3. Support treatment and recovery courts that provide evidence-based options for persons with OUD and any co-occurring SUD/MH conditions.
4. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co- occurring SUD/MH conditions who are incarcerated in jail or prison.
5. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co- occurring SUD/MH conditions who are leaving jail or prison or have recently left jail or prison, are on probation or parole, are under community corrections supervision, or are in re-entry programs or facilities.
6. Support critical time interventions ("CTI"), particularly for individuals living with dual-diagnosis OUD/serious mental illness, and services for individuals who face immediate risks and service needs and risks upon release from correctional settings.
7. Provide training on best practices for addressing the needs of criminal justice- involved persons with OUD and any co-occurring SUD/MH conditions to law enforcement, correctional, or judicial personnel or to providers of treatment, recovery, harm reduction, case management, or other services offered in connection with any of the strategies described in this section.

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

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

1. Support evidence-based or evidence-informed treatment, including MAT, recovery services and supports, and prevention services for pregnant women—or women who could become pregnant—who have OUD and any co-occurring SUD/MH conditions, and other measures to educate and provide support to families affected by Neonatal Abstinence Syndrome.
2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for uninsured women with OUD and any co-occurring SUD/MH conditions for up to 12 months postpartum.
3. Provide training for obstetricians or other healthcare personnel who work with pregnant women and their families regarding treatment of OUD and any co- occurring SUD/MH conditions.
4. Expand comprehensive evidence-based treatment and recovery support for NAS babies; expand services for better continuum of care with infant-need dyad; and expand long-term treatment and services for medical monitoring of NAS babies and their families.
5. Provide training to health care providers who work with pregnant or parenting women on best practices for compliance with federal requirements that children born with NAS get referred to appropriate services and receive a plan of safe care.
6. Provide child and family supports for parenting women with OUD and any co- occurring SUD/MH conditions.
7. Provide enhanced family support and child care services for parents with OUD and any co-occurring SUD/MH conditions.
8. Provide enhanced support for children and family members suffering trauma as a result of addiction in the family; and offer trauma-informed behavioral health treatment for adverse childhood events.
9. Offer home-based wrap-around services to persons with OUD and any co- occurring SUD/MH conditions, including, but not limited to, parent skills training.
10. Provide support for Children's Services — Fund additional positions and services, including supportive housing and other residential services, relating to children being removed from the home and/or placed in foster care due to custodial opioid use.

Part II: Prevention

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

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

1. Funding medical provider education and outreach regarding best prescribing practices for opioids consistent with the Guidelines for Prescribing Opioids for Chronic Pain from the U.S. Centers for Disease Control and Prevention, including providers at hospitals (academic detailing).
2. Training for health care providers regarding safe and responsible opioid prescribing, dosing, and tapering patients off opioids.
3. Continuing Medical Education (CME) on appropriate prescribing of opioids.
4. Providing Support for non-opioid pain treatment alternatives, including training providers to offer or refer to multi-modal, evidence-informed treatment of pain.
5. Supporting enhancements or improvements to Prescription Drug Monitoring Programs ("PDMPs"), including, but not limited to, improvements that:
    i. Increase the number of prescribers using PDMPs;
    ii. Improve point-of-care decision-making by increasing the quantity, quality, or format of data available to prescribers using PDMPs, by improving the interface that prescribers use to access PDMP data, or both; or
    iii. Enable states to use PDMP data in support of surveillance or intervention strategies, including MAT referrals and follow-up for individuals identified within PDMP data as likely to experience OUD in a manner that complies with all relevant privacy and security laws and rules.
6. Ensuring PDMPs incorporate available overdose/naloxone deployment data, including the United States Department of Transportation's Emergency Medical Technician overdose database in a manner that complies with all relevant privacy and security laws and rules.
7. Increasing electronic prescribing to prevent diversion or forgery.
8. Educating dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

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

1. Funding media campaigns to prevent opioid misuse.
2. Corrective advertising or affirmative public education campaigns based on evidence.
3. Public education relating to drug disposal.
4. Drug take-back disposal or destruction programs.
5. Funding community anti-drug coalitions that engage in drug prevention efforts.
6. Supporting community coalitions in implementing evidence-informed prevention, such as reduced social access and physical access, stigma reduction—including staffing, educational campaigns, support for people in treatment or recovery, or training of coalitions in evidence-informed implementation, including the Strategic Prevention Framework developed by the U.S. Substance Abuse and Mental Health Services Administration ("SAMHSA").
7. Engaging non-profits and faith-based communities as systems to support prevention.
8. Funding evidence-based prevention programs in schools or evidence-informed school and community education programs and campaigns for students, families, school employees, school athletic programs, parent-teacher and student associations, and others.
9. School-based or youth-focused programs or strategies that have demonstrated effectiveness in preventing drug misuse and seem likely to be effective in preventing the uptake and use of opioids.
10. Create or support community-based education or intervention services for families, youth, and adolescents at risk for OUD and any co- occurring SUD/MH conditions.
11. Support evidence-informed programs or curricula to address mental health needs of young people who may be at risk of misusing opioids or other drugs, including emotional modulation and resilience skills.
12. Support greater access to mental health services and supports for young people, including services and supports provided by school nurses, behavioral health workers or other school staff, to address mental health

needs in young people that (when not properly addressed) increase the risk of opioid or another drug misuse.

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

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

1. Increased availability and distribution of naloxone and other drugs that treat overdoses for first responders, overdose patients, individuals with OUD and their friends and family members, schools, community navigators and outreach workers, persons being released from jail or prison, or other members of the general public.
2. Public health entities providing free naloxone to anyone in the community.
3. Training and education regarding naloxone and other drugs that treat overdoses for first responders, overdose patients, patients taking opioids, families, schools, community support groups, and other members of the general public.
4. Enabling school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support.
5. Expanding, improving, or developing data tracking software and applications for overdoses/naloxone revivals.
6. Public education relating to emergency responses to overdoses.
7. Public education relating to immunity and Good Samaritan laws.
8. Educating first responders regarding the existence and operation of immunity and Good Samaritan laws.
9. Syringe service programs and other evidence-informed programs to reduce harms associated with intravenous drug use, including supplies, staffing, space, peer support services, referrals to treatment, fentanyl checking, connections to care, and the full range of harm reduction and treatment services provided by these programs.
10. Expanding access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use.
11. Supporting mobile units that offer or provide referrals to harm reduction services, treatment, recovery supports, health care, or other appropriate services to persons that use opioids or persons with OUD and any co-occurring SUD/MH conditions.

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

Part III: Other Strategies

I. FIRST RESPONDERS

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

1. Education of law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.
2. Provision of wellness and support services for first responders and others who experience secondary trauma associated with opioid- related emergency events.

J. LEADERSHIP, PLANNING AND COORDINATION

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

1. Statewide, regional, local or community regional planning to identify root causes of addiction and overdose, goals for reducing harms related to the opioid epidemic, and areas and populations with the greatest needs for treatment intervention services, and to support training and technical assistance and other strategies to abate the opioid epidemic described in this opioid abatement strategy list.
2. A dashboard to (a) share reports, recommendations, or plans to spend opioid settlement funds; (b) to show how opioid settlement funds have been spent; (c) to report program or strategy outcomes; or (d) to track, share or visualize key opioid- or health-related indicators and supports as identified through collaborative statewide, regional, local or community processes.
3. Invest in infrastructure or staffing at government or not-for-profit agencies to support collaborative, cross-system coordination with the purpose of preventing overprescribing, opioid misuse, or opioid overdoses, treating those with OUD and any co-occurring SUD/MH

conditions, supporting them in treatment or recovery, connecting them to care, or implementing other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

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

K. TRAINING

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

1. Provide funding for staff training or networking programs and services to improve the capability of government, community, and not-for-profit entities to abate the opioid crisis.
2. Support infrastructure and staffing for collaborative cross-system coordination to prevent opioid misuse, prevent overdoses, and treat those with OUD and any co- occurring SUD/MH conditions, or implement other strategies to abate the opioid epidemic described in this opioid abatement strategy list (*e.g.*, health care, primary care, pharmacies, PDMPs, etc.).

L. RESEARCH

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

1. Monitoring, surveillance, data collection and evaluation of programs and strategies described in this opioid abatement strategy list.
2. Research non-opioid treatment of chronic pain.
3. Research on improved service delivery for modalities such as SBIRT that demonstrate promising but mixed results in populations vulnerable to opioid use disorders.
4. Research on novel harm reduction and prevention efforts such as the provision of fentanyl test strips.
5. Research on innovative supply-side enforcement efforts such as improved detection of mail-based delivery of synthetic opioids.
6. Expanded research on swift/certain/fair models to reduce and deter opioid misuse within criminal justice populations that build upon promising approaches used to address other substances (e.g., Hawaii HOPE and Dakota 24/7).

Appendix 2
Community Partnership

- Partnership with:
  - ✓ CCC MEDS Coalition
  - ✓ Public Libraries
  - ✓ Police Departments & Sheriff's Office
  - ✓ Richmond PD Crime Prevention
  - ✓ County Public Defender's Office
  - ✓ West County Re-entry Center
  - ✓ County Hospital
  - ✓ Healthcare for the Homeless, Homeless Shelter
  - ✓ Office of Consumer Empowerment
  - ✓ Contra Costa Mental Health Specialized Programs
  - ✓ Spanish Specific Training to Latinos
  - ✓ Recovery Residences
  - ✓ Community Based Organizations(CBO) working with homeless encampments
  - ✓ Contra Costa County Clerk Recorder Office
  - ✓ Contra Costa County Office of Education (CCCOE)
  - ✓ Diablo Valley College (Pleasant Hill & San Ramon)
  - ✓ School Districts: Mt. Diablo Unified School District (MDUSD), Pittsburg Unified School District (PUSD)
  - ✓ Samuel Merritt University Nursing Students
  - ✓ Other CBOs: Rubicon, Martinez Boy Scout, Fred Finch
  - ✓ Any many others…

DVC DIABLO VALLEY COLLEGE

MEDS COALITION
CONTRA COSTA COUNTY
Saving Lives Through Collaborative Action

REENTRY SUCCESS CENTER

Appendix 3
Opioid Settlement Funds Listening Session Announcement

Contra Costa Behavioral Health
Alcohol and Other Drugs
Phone: (925) 335-3307
Fax: (925) 335-3311
cchealth.org

May 6, 2024

Dear Community Advocate

California has joined multiple national lawsuits against manufacturers, distributors, and other entities responsible for the opioid epidemic and anticipates receiving funds from future opioid judgments. In Contra Costa, the Behavioral Health Administration (BHA) is directly responsible for the provision of mental health and substance use services and also the designated lead agency to administer the funds.

In alignment to the provisions of the Opioid Settlement Funds (OSF) requirements, BHA will be hosting ***Community Listening Sessions*** throughout the four regions (East, Central, South, and West) in Contra Costa County to gather feedback on how Contra Costa's OSF should be allocated.The majority of this funding will be used for opioid abatement, treatment and prevention activities.

Simultaneously, in our county substance use disorder prevention and treatment providers will gather feedback from clients and participants in different programs and environments. **An online survey is available in both English and Spanish** for feedback on the best use of opioid settlement funds.

Attached please find the flyer to ***Community Listening Sessions*** and online survey**.** Your feedback is important and will help us identify the needs of Contra Costa residents with regards to the impact of the Opioid Epidemic in our communities.

Contra Costa Behavioral Health thanks you for your assistance and feedback.

For more information, please visit California-Opioid Settlements.

For any questions, please contact AODS Program Chief, Fatima Matal Sol at fatima.matalsol@cchealth.org or AODS Prevention Coordinator, Jessica Recinos at Jessica.recinos@cchealth.org.

Appendix 4
Opioid Settlement Funds Survey

Dear Interviewer,

Thank you for being willing to ask your clients/consumers for feedback about how Contra Costa County should spend opiate settlement funds. You are more than welcome to paraphrase the instructions to make it more conversational, if you'd like. There are three questions to be asked, listed below. After each discussion, please jot down a summary of what respondents share. Notes do not need to be word for word. We just need a list of their main ideas or suggestions. Please send notes to roberta@indigoproject.net.

If you have questions, please also contact roberta@indigoproject.net

Best,

Roberta Chambers, PsyD
roberta@indigoproject.net
510-410-5594

Greetings, and thank you for agreeing to provide your perspectives about how Contra Costa County should spend opiate settlement funds across the County. These funds must be spent in accordance with the settlement agreement and address the harms resulting from the opiate epidemic. Your feedback will help Contra Costa County in allocating opioid settlement funds to support our communities. Thank you!

What are the greatest needs that opioid settlement funds should address?

What are your priorities for how opioid settlement funds should be spent?

What specific programs and services would you like to see funded?

Estimado entrevistador:

Le agradecemos su predisposición para solicitar a sus clientes/consumidores comentarios sobre cómo el condado de Contra Costa debe gastar los fondos del acuerdo sobre opioides. Si lo desea, puede parafrasear las instrucciones para hacerlas más amenas. Hay tres preguntas que deben plantearse, enumeradas a continuación. Después de cada evaluación, anote un resumen de lo que comparten los encuestados. No es necesario anotar palabra por palabra. Solo necesitamos una lista de sus principales ideas o sugerencias. Envíe los comentarios a roberta@indigoproject.net.

Si tiene alguna pregunta, póngase en contacto mediante la casilla de correo roberta@indigoproject.net.

Saludos.

Roberta Chambers, PsyD
roberta@indigoproject.net
510-410-5594

Le damos la bienvenida y le agradecemos por aceptar ofrecer sus opiniones sobre la manera en la que el condado de Contra Costa debería gastar los fondos del acuerdo sobre opioides en todo el Condado. Estos fondos deben gastarse de conformidad con el acuerdo de conciliación y abordar los daños resultantes de la epidemia de opioides. Sus comentarios ayudarán a que el condado de Contra Costa asigne fondos del acuerdo sobre opioides para apoyar a nuestras comunidades. ¡Muchas gracias!

¿Cuáles son las necesidades principales que deben abordar los fondos del acuerdo sobre opioides?

¿Cuáles son sus prioridades sobre la manera en la que se deben gastar los fondos del acuerdo sobre opioides?

¿Qué programas y servicios en particular le gustaría que se financiaran?