SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

2022 Report to Congress on the State Opioid Response Grants (SOR)

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Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

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Executive Summary

The Substance Abuse and Mental Health Services Administration (SAMHSA) awards states, territories, and the District of Columbia with State Opioid Response (SOR) grants to address the growing opioid and overdose crisis. Initially awarded in fiscal year (FY) 2018, these grants aim to increase access to medications for opioid use disorder (MOUD), reduce unmet treatment need, and reduce opioid-related overdose deaths through the provision of prevention, harm reduction, treatment, and recovery activities. Starting in FY 2020, the SOR program was expanded to support evidence-based prevention, treatment, and recovery support services to address stimulant misuse and use disorders, including cocaine and methamphetamine. This expansion of allowable services continued in FY 2022.

States, territories, and the District of Columbia have used SOR funds to implement evidence-based practices (EBPs) using several effective and innovative approaches. These approaches have resulted in positive outcomes such as: improved access to MOUD via in-person settings, mobile clinics, and/or telehealth; ensured continuity of care through increased utilization of telehealth and telemedicine; increased the number of peer-certified specialists; increased naloxone availability in Opioid Treatment Programs (OTPs) for high-risk clients; improved treatment engagement and attendance, participation in healthy activities, and abstinence from substances; reduced overdose deaths, promoted linkages to care, and facilitated co-location of services as part of a comprehensive, integrated approach; and increased access to naloxone in the community via pharmacy programs, outreach and educational events, vending machines, and technology-based applications (e.g., web-based applications to locate naloxone).

To document these and other outcomes, grantees are required to collect and submit data at the client level. Analysis of these data demonstrate the positive impact SOR grant funds have on individual lives. Positive client outcomes include: an increase in social connectedness, employment, and housing stability; decreases in use of alcohol or illicit drugs; and decreases in reported mental health symptoms (such as depression or anxiety). Also, the number of clients seeking care in an emergency department for mental or emotional difficulties as well as alcohol and/or substance misuse decreased.

SOR funding has increased the amount and availability of the full spectrum of prevention, harm reduction, treatment, and recovery support services in communities across the United States, and its territories, to address the complex and multi-faceted clinical and psychosocial needs of people with opioid use disorder (OUD) and/or stimulant use disorder(s). SOR funding has also increased access to and retention in OUD treatment services, provided support for long-term recovery, and enhanced and implemented preventive services, which have been instrumental in addressing the opioid and overdose crisis. However, these outcomes show a slower rate of positive change among diverse communities, and SAMHSA has undertaken several efforts to address these disparities. SAMHSA will continue to require the use of these life-saving services to provide resources and increase client engagement in under resourced communities and among individuals with diverse racial, ethnic, geographic, and other demographic characteristics.

Congressional Request

As directed by Congress in the fiscal year (FY) 2022 joint explanatory statement accompanying the Consolidated Appropriations Act, 2022 (P.L.117-103), SAMHSA is submitting a report on the SOR grant program. This report includes data collected from SOR grantees in FYs 2020, 2021 and 2022.

Introduction

The SOR grant program aims to increase access to MOUD using the three Food and Drug Administration (FDA) approved medications for the treatment of OUD, reduce unmet treatment need, and reduce opioid-related overdose deaths through the provision of prevention, treatment, and recovery support services for OUD, including prescription opioids, heroin and illicit fentanyl and fentanyl analogs. In FY 2020, the SOR program expanded to allow grantees to use SOR funds to support evidence-based prevention, treatment, and recovery support services to address stimulant misuse and use disorders, including cocaine and methamphetamine. In 2021, the use of SOR funds for harm reduction activities was expanded to include the purchase of fentanyl test strips, if allowed under state law. With SOR funds, grantees are required to develop and implement comprehensive systems of prevention, harm reduction, treatment, and recovery support services.

SOR grants are awarded to states, territories, and the District of Columbia based on a formula which accounts for overdose death rates and treatment need.[1] For the years and cohorts included in this report, the program also included a 15 percent set-aside for the 10 states[2] with the highest mortality rate for drug-related overdose deaths.[3] In FY 2020, 57 SOR grantees were awarded $1.42 billion in grant funding. To date, SOR has been structured as a two-year program.

The SOR program was established and first funded through the Consolidated Appropriations Act, 2018 (P. L. 115-141). Since then, the program has received funding each year from Congress through annual appropriations bills. The program is administered by SAMHSA's Center for Substance Abuse Treatment.

Methods

This report describes SOR program implementation with respect to EBPs used as well as services delivered. Grantees report information to SAMHSA via a variety of sources including SAMHSA's Performance and Accountability System (SPARS), through semi-annual performance progress reports (PPRs), and through routine program monitoring with assigned Government Project Officers (GPOs).

This report highlights SOR program performance including impacts on client outcomes. SAMHSA

[1] SAMHSA is currently reviewing the SOR grant formula methodology to address and mitigate funding cliffs which may result in major decreases in state funding between cohorts.
[2] Fifteen percent set aside was allocated to the following ten states/territories in FY 2020: WV, DE, MD, PA, OH, NH, DC, NJ, MA, and KY.
[3] The current Formula is based on two elements weighted equally: the state's proportion of people who meet criteria for dependence or abuse of heroin or pain relievers who have not received any treatment (NSDUH 2017-2018) and the state's proportion of drug poisoning deaths (CDC, 2018). Drug poisoning mortality data were used as an approximation for opioid overdose given the lack of availability of state-level data on opioid specific deaths.

grantees that provide direct treatment and/or recovery support services are required to submit data using a robust data collection tool designed to collect information on client outcomes, demographic characteristics, services received, substance use behaviors, employment status, housing stability, reduction of criminal justice involvement, and social connectedness.[4] These data are based on elements expected to be collected during any standard assessment of substance use disorder (SUD) treatment and/or recovery needs.

These data are reported in SPARS to ensure that grantees meet compliance requirements under the Government Performance and Results Act (GPRA). SPARS is an online data entry, reporting, technical assistance request, and training system that supports grantees in reporting timely and accurate data to SAMHSA. All data are client reported and collected at intake, six-month follow-up, and client discharge. SOR grantees enter data into the SPARS system on a rolling basis.

This report uses SPARS data collected between March 16, 2021 and April 30, 2022. The SPARS data consists of information from grantees that provided services during this period. This includes 50 FY 2018 grants in no-cost extensions (NCEs) and 57 FY 2020 grants. This report also includes data from grantees' PPRs for the reporting period between September 30, 2020 to March 30, 2022.

Methods used for this report include descriptive statistics (frequencies, percentages, and rate of change). Additionally, data analysis of SOR data was conducted including McNemar Test and Binary Logistic Regressions were performed using IBM Statistical Package for the Social Sciences (SPSS) Statistics 28.0.1.1 for Windows.

Evidence-Based Practices

SOR grantees implement coordinated SUD prevention, harm reduction, treatment, and recovery support efforts to address the opioid and stimulant overdose and addiction crisis. To meet this goal, grantees implement EBPs. EBPs are approaches and strategies shown to be effective in reducing the social, individual health, and population-based impacts of substance use. EBPs commonly implemented by SOR grantees include: MOUD, Cognitive Behavioral Therapy, Motivational Interviewing, Contingency Management, Peer Recovery Support Services, Harm Reduction, and Overdose Education and Naloxone Distribution, specifically.

MOUD, including methadone, buprenorphine products, and naltrexone, serve as the standard of care for the treatment of OUD. All grantees are required to make MOUD available to any individual with an OUD served by the SOR program. These medications are often provided in combination with evidence-based psychosocial services based on individualized assessments. Individuals with OUD primarily access MOUD through OTPs and office-based opioid treatment settings.

OTPs are accredited treatment programs that hold SAMHSA certification and Drug Enforcement Administration (DEA) registration and they administer and dispense medications that are approved by the FDA to treat OUD (i.e., methadone, buprenorphine, and injectable naltrexone). OTPs must have the ability to provide adequate medical, counseling, vocational, educational, mental health and other assessment and treatment services either onsite or by referral to an outside agency or practitioner

[4] For more information on the SAMHSA CSAT Government Performance and Results Act (GPRA) Client Outcome Measures for Discretionary Programs, refer to: https://www.samhsa.gov/grants/gpra-measurement-tools/csat-gpra

through a formal agreement. On July 28, 2021, the DEA published a final rule that permits DEA registrants who are authorized to dispense methadone for OUD to add a "mobile component" to their existing registration. This final rule eliminates the separate registration requirement for OTP mobile medication units.[5] This is an important step as it streamlines the DEA registration process, making it easier for OTPs to meet people where they are and allowing OTPs to provide needed services in remote or under-resourced areas.

Office-Based Opioid Treatment (OBOT) models provide medication for OUD in outpatient settings other than OTPs. The OBOT model of care uses buprenorphine or injectable naltrexone, and providers focus on medication management and treatment of other substance use, mental disorders, medical comorbidities, and psychosocial needs.

Cognitive Behavioral Therapy (CBT) helps individuals learn to identify and correct problematic behaviors by applying a range of different skills that can be used to reduce and cease substance use and address a range of other problems that often co-occur with it. CBT is used by clinicians providing MOUD to help people with OUD understand patterns of their substance use, manage drug cravings, recognize and change thoughts associated with substance use, increase problem solving and decision-making skills, and use alternative coping mechanisms to reduce risk of return to drug use.

Motivational Interviewing (MI) is a clinical approach that helps people with mental and SUD and other chronic conditions make positive behavioral changes to support better health. By exploring ambivalence and highlighting problem areas, providers can help clients discover their own motivations for change.

Contingency Management (CM) is a psychosocial treatment strategy used as a behavior modification intervention to establish a connection between new behaviors of focus and the opportunity to obtain a desired motivational incentive.

Peer Recovery Support Services include a wide range of services provided by peer support specialists. A peer support specialist is someone who combines their own lived experience of recovery with formal training and education to assist others in initiating and maintaining recovery.

Harm Reduction is an approach that emphasizes engaging directly with people who use drugs to prevent overdose and infectious disease transmission, improve the physical, mental, and social wellbeing of those served, and to offer low-threshold options for accessing SUD treatment and other health care services. Evidence-based harm reduction interventions, such as fentanyl test strip distribution and testing and referral to treatment for HIV and viral hepatitis, are critical to keeping people who use drugs alive and as healthy as possible and are a key pillar in the multi-faceted U.S. Department of Health and Human Services' (HHS) Overdose Prevention Strategy.[6]

Opioid Overdose Education and Naloxone Distribution (OEND), entails activities that aim to increase awareness about the use of naloxone and to educate individuals on recognizing

[5] For more information, refer to: https://www.deadiversion.usdoj.gov/fed_regs/rules/2021/fr0628_3.pdf
[6] For more information on the U.S. Department of Health and Human Services' Overdose Prevention Strategy, refer to: https://www.hhs.gov/overdose-prevention/.

potential overdose symptoms. Key components of OEND activities include education and training on recognition and prevention of opioid overdose, opioid overdose rescue response, and distributing naloxone products.

Approaches

Using SOR funds, states and territories have implemented the above EBPs with several effective and innovative approaches.

MOUD

SOR funds have increased access to MOUD in a wide range of settings. Common approaches include the implementation of the "Bridge Clinic" model to provide rapid access to treatment by providing MOUD following hospital emergency department visits. Expanding and enhancing capacity for telehealth has also resulted in increased access to MOUD, particularly in rural and other hard to reach areas. The flexibilities granted during the COVID-19 pandemic regarding the use of telehealth have been particularly effective for continued service provision (see Appendix I for grantee examples) .

Additional approaches to MOUD expansion include a focus on increasing access for special populations, such as incarcerated individuals, pregnant and postpartum women, veterans, and service members. Reported outcomes from states and territories include:

- Improved access to MOUD via in-person visits, mobile clinics, and/or telehealth;
- Increased number of practitioners eligible to prescribe buprenorphine in states and territories;
- Enhanced access to intake, assessment, and medication initiation by expanding hours of service providers;
- Strengthened coordination efforts with various state and local agencies including medical centers, Justice Departments, Departments of Corrections, Departments of Family and Children Services, Federally Qualified Health Centers, community health clinics, universities, and other local health governmental agencies; and
- Significant increase in client engagement, satisfaction, and retention in treatment due to the increased use of telehealth in everyday services.

Twenty-three states and territories reported using SOR funds to implement the "Hub and Spoke" model, which allows each person seeking care for OUD and/or stimulant use disorder(s) to receive an individualized assessment and initiation of treatment at a "hub" location specializing in SUD treatment. Once stabilized, referrals are made to community-based "spokes" for ongoing care to meet client-specific needs.

Although OTPs often serve as "hubs" and OBOTs often serve as "spokes", other common approaches include "hub" locations such as hospital emergency departments, residential treatment providers, or jails. Additional "spoke" settings may include primary care offices, tribal health centers, and community mental health centers. Reported outcomes from states and territories include:

- Improved access to immediate treatment by strategically placing "hub" locations no more

than sixty minutes from a potential client;
- Strengthened collaborations between the rural providers in "spokes" and the MOUD experts in "hubs;"
- Improved transitions for clients reentering communities from criminal justice settings or rehabilitative settings through close partnerships between "hub" locations and "spoke" providers; and
- Continuity of care ensured during COVID-19 through increased utilization of telehealth and telemedicine.

Forty-one states and territories reported using SOR funds to support OTPs. States and territories are establishing new SAMHSA-certified OTPs across the country or enhancing existing OTPs by expanding their hours of operation. For example, the SOR program has funded 24/7 OTPs to provide timely intake, assessment and MOUD initiations. These OTPs are in identified "hotspots" and utilize a "no wrong door" approach. During the COVID-19 pandemic, OTPs continue to be granted additional flexibilities in the dispensing of controlled medications to ensure necessary MOUD remained accessible. Reported outcomes from states and territories include:

- Strengthened networks of MOUD providers through continuous trainings and collaboration in OTPs;
- Increased numbers of "spoke" affiliated DATA-waived practitioners/OBOT providers who provide services in "hub" locations; and
- Increased naloxone availability for OTPs for high-risk clients who have increased take-home doses due to COVID-19 restrictions.

Thirty-nine states and territories reported using SOR funds to provide OBOT services. In addition to OTPs, OBOT providers received flexibilities during the COVID-19 pandemic to avoid disruption of MOUD services. These flexibilities offered eligible practitioners the opportunity to initiate buprenorphine via audio-visual and audio-only telehealth platforms without the statutory requirement of an initial in-person medical evaluation. Reported outcomes from states and territories include:

- Increased outreach and engagement with diverse clinics and facilities acting as OBOT providers, such as Federally Qualified Health Centers, local governing entities, private organizations, and community health centers;
- Improved ability to integrate and provide wrap-around recovery support services not traditionally provided in OBOT settings;
- Expanded outreach and treatment services for pregnant and post-partum people, incarcerated individuals, individuals with co-occurring disorders, individuals experiencing homelessness, and Spanish-speaking individuals; and
- Continued admission of clients into treatment programs offering MOUD despite COVID-19 related challenges.

CBT

Twenty-nine states and territories reported using SOR funds to implement CBT. CBT is often used as a psychosocial support in combination with MOUD. Reported outcomes from states and territories include:

- Developed webinars on topics such as Project ECHO, an educational delivery method to increase the number of providers that can implement CBT;
- Used CBT, in conjunction with MOUD, to address medical issues associated with substance use disorders and to help change thinking and behaviors of individuals involved in the criminal justice system; and
- Increased successful family reunification using a CBT support-group model.

MI

Forty states and territories reported using SOR funds to implement MI. MI is another EBP used as a psychosocial support in combination with MOUD. One approach is utilizing MI for individuals who seek MOUD in hospital emergency departments prior to discharge into the community. Another approach is to use MI in outreach attempts to individuals who have not yet engaged in treatment as a way of eliciting positive behavioral changes. Reported outcomes from states and territories include:

- Increased use of evidence-based behavioral health treatment models and recovery supports;
- Enhanced ability for treatment providers to conduct outreach, brief interventions, and motivational enhancement services; and
- Increased provider support and continuous individualized training on MI.

CM

Forty states and territories reported using SOR funds to implement CM. Reported outcomes from states and territories include:

- Developed outpatient treatment programs to provide buprenorphine and CM for clients aged 18 years or older;
- Improved treatment engagement, attendance, participation in healthy activities, and abstinence from substances; and
- Increased access to care and evidence-based treatment to clients with stimulant use disorder.

Peer Recovery Support Services

Fifty-six states and territories reported using SOR funds to implement Peer Recovery Support Services. In various settings, peers collaborate closely with several stakeholders, including medical professionals, criminal justice personnel, treatment providers, and child welfare workers to provide education, support, and assistance with accessing treatment for OUD and/or stimulant use disorder. A popular collaboration involves peers joining first responders to assist in connecting people to treatment following an overdose in the community. Reported outcomes from states and territories include:

- Increased number of certified peer support specialists in the states and territories, with streamlined application and educational processes for individuals to seek certification;
- Increased access to recovery support services including recovery planning and stabilization, recovery residences, peer services, mutual support groups, employment and housing services, outreach and engagement, treatment support, and linkages to family support services for child reunification efforts; and
- Enhanced transition for individuals re-entering communities from criminal justice settings

or other rehabilitative settings.

Harm Reduction

Fifty-four states and territories reported using SOR funds to provide harm reduction services including but not limited to: access to pre-exposure prophylaxis (PrEP), access to HIV and viral hepatitis testing and treatment, access to certain components of syringe service programs (SSPs) permitted under local state and federal law (see Consolidated Appropriations Act, 2022 (Public Law 117-103) Section 807), fentanyl test strips (FTS), and medical care, including wound care.[7] Reported outcomes from states and territories include:

- Reduced harm-associated with drug use and related behaviors that increase the risk of infectious diseases, including HIV, viral hepatitis, and bacterial and fungal infections;
- Improved connection of individuals to overdose education, counseling, and referral to treatment for infectious diseases and substance use disorders; and
- Reduced overdose deaths promoted linkages to care and facilitated co-location of services as part of a comprehensive, integrated approach.

OEND

OEND remains a large focus of SOR grantees, with fifty-two states and territories implementing these activities. To address the unprecedented increase in preventable overdose deaths, reported outcomes from states and territories include:

- Increased access to naloxone and distribution in the community via pharmacy programs, outreach, and educational events, vending machines, technology-based applications (e.g., web-based applications to locate naloxone), and provision to first responders;
- Enhanced safety for at-risk individuals re-entering communities from criminal justice settings by providing naloxone upon release from incarceration; and
- Increased education and training on overdose awareness and naloxone administration in the community via public service announcements and media campaigns, training of first responders and other community members, outreach activities, and educational events.

For more information on state/territory approaches, highlights, and accomplishments, please refer to Appendix I.

Results

Demographic Profile

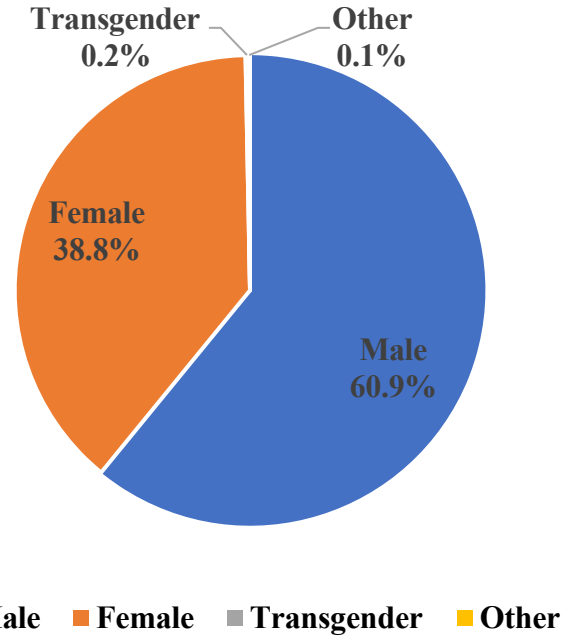
From March 16, 2021 to April 30, 2022, there were 140,623 client-level GPRA intake interviews conducted by SOR grantees. During this same period, grantees conducted six-month follow-up

[7] For more information on allowable harm reduction services and supplies, refer to https://www.samhsa.gov/find-help/harm-reduction

assessments for 53,670 clients.[8] To assess program performance for treatment services provided during the reporting period, SAMHSA identified 34,668 clients that had both an intake and six-month follow-up assessments from March 16, 2021 to April 30, 2022.

Analysis of GPRA intake interview data revealed the demographic characteristics of the clients served by SOR grantees. Most of the clients served by SOR grantees were male. As shown in Figure 1, male clients represent 60.9 percent of all clients served. Clients who identify as female accounted for 38.8 percent (n=54,383) of clients served. However, individuals who identify as transgender or "other" account for less than one percent of (n=430) of all clients served.

Figure 1: Gender



Note: N= 140,623. Clients with missing data or refused to answer the question were excluded (n=415). Data from this figure was accessed from SPARS on June 10, 2022.

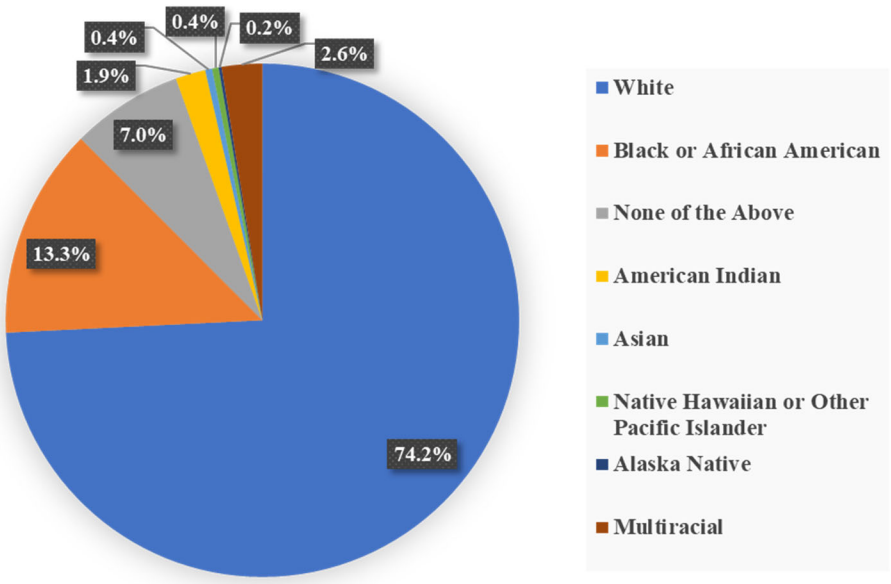
Nearly three out of four clients served identified as White (n= 103,594) (Figure 2). Like race/ethnicity trends in the U.S. population[9], the second highest group were clients who report their race as Black/African American which represented 13.3 percent (n= 18,535) of clients served. Clients who identify as Asian and Native Hawaiian/Other Pacific Islander represented only 0.8 percent (0.4 percent (n= 612) and 0.4 percent (n= 576) of clients served respectively). Over two percent of clients served by SOR grantees self-identified as American Indian or Alaska Native (1.9% (n= 2,633) and 0.2 percent

[8] The difference between the number of clients that had six-month follow-up assessments verse the number of clients included in the outcome analysis found in this report is due to the period of review. From March 16, 2021 to April 30, 2022, 53,670 clients completed a six-month follow-up. However, 19,002 of these clients completed intake assessments outside of the report timeframe. Therefore, program outcome analysis is based on the subset of clients who had both intake and six-month follow-ups within the reporting period or 34,668.

[9] Improved Race and Ethnicity Measures Reveal U.S. Population Is Much More Multiracial: 2020 Census Illuminates Racial and Ethnic Composition of the Country, https://www.census.gov/library/stories/2021/08/improved-race-ethnicity-measures-reveal-united-states-population-much-more-multiracial.html.

(n= 246) respectively)[10].

Figure 2: Race



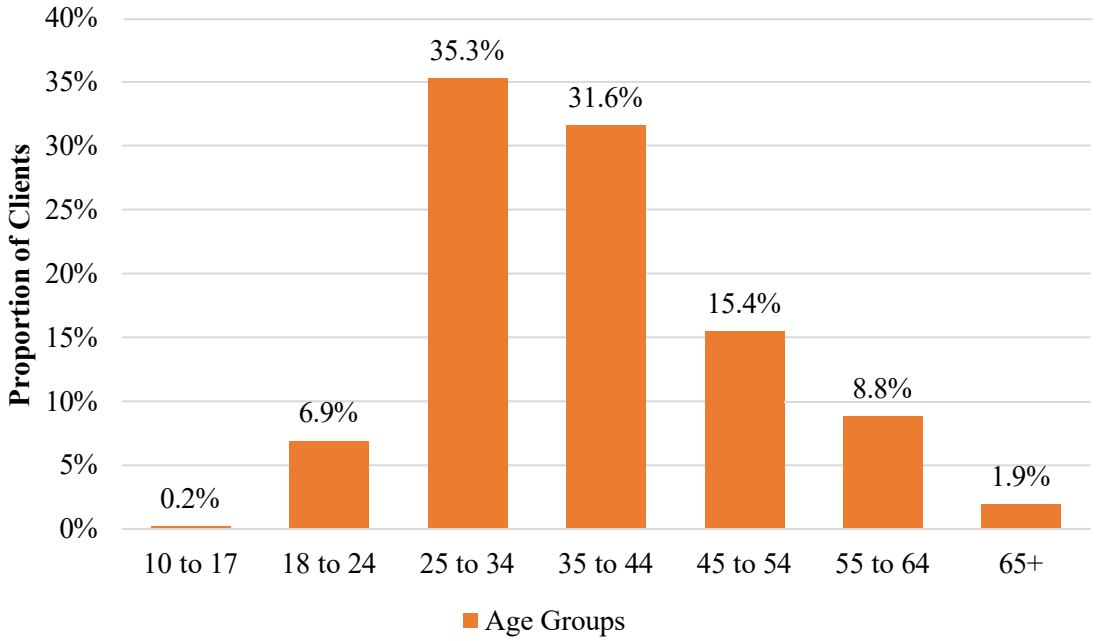
Note: N=140,623. Clients with missing data or refused to answer the question were excluded (n=1,038). Data from this figure was accessed from SPARS on June 10, 2022.

Over two percent (2.6%) of clients treated by SOR grantees identified as Multiracial. Seven percent of clients (n= 9,798) did not identify with the racial options included in the GPRA interviews (i.e., none of the above). In addition, 11.0 percent (n= 15,297) of clients report their ethnicity as Hispanic/Latino/Latina.

SOR grantees served clients across various age groups. Nearly two-thirds of clients served were between the ages of 25 and 44. As shown in Figure 3, among clients served, 35.3 percent (n= 48,126) were between the ages of 25 and 34 and 31.6 percent(n= 43,124) were between the ages of 35 and 44. As it relates to youth and young adults served by SOR grantees, 6.9 percent (n= 9,359) were between the ages of 18 and 24 and 0.2 percent (n= 273) were between the ages of 10 and 17. Conversely, over 26 percent of clients were over the age of 45. Among total clients served, 15.4 percent (n= 21,076) were between the ages of 45 and 54, 8.8 percent (n= 11,995) were between the ages of 55 and 64, and 1.9 percent (n= 2,587) were 65 years or older.

[10] It is important to note that SOR's sister program, the Tribal Opioid Response (TOR) grant program, provides funding to federally recognized American Indian or Alaska Native tribe or tribal organization to provide access to OUD treatment services. Therefore, American Indian or Alaska Natives may be served under the TOR program.

Figure 3: Age Group



Note: Graph based on SPARS data generated on June 10, 2022. N= 140,623. Clients with missing data or refused to answer the question were excluded (n= 4,083).

Naloxone Distribution and Overdose Reversals

Grantees are required to implement prevention and education services. These include: (1) training peers and first responders on recognizing an opioid overdose and the appropriate use of the opioid overdose antidote naloxone, (2) developing evidence-based community prevention efforts such as evidence-based strategic messaging on the consequences of opioid misuse, and (3) purchasing, distributing, and training on the use of naloxone. From April 1, 2021 to March 30, 2022, grantees reported having purchased 2,499,302 naloxone kits and distributed 2,177,367 naloxone kits.[11] Grantees also reported using naloxone to reverse approximately 256,985 overdoses.[12] For more information on the distribution of naloxone across the United States and its Territories by HHS regions, please refer to Appendix II.

MOUD

SAMHSA requires that FDA-approved MOUD be made available through the SOR program to those diagnosed with an OUD. FDA-approved medications include methadone, buprenorphine products, and injectable extended-release naltrexone.

Based on grantees' PPRs, which include a longer period than SPARS data, grantees report 149,770 clients received buprenorphine, 89,662 received methadone, and 12,801 received injectable

[11] Data reported is based on GPRA data generated in SPARs on June 10, 2022, for the number of naloxone kits purchased and distributed.

[12] Data are from the FY 2018 SOR cohort no-cost extensions, Performance Progress Reports (September 30, 2020, to September 29, 2021); and the FY 2020 SOR cohort Performance Progress Reports (September 30, 2020 to March 30, 2022).

naltrexone.[13] Based on PPRs, grantees report 436,761clients received treatment services for OUD[14] and 69,528 clients received treatment services for stimulant use disorder.[15]

Recovery Support Services

In addition to treatment services, grantees are required to employ effective recovery support services to ensure that individuals receive a comprehensive array of services across the spectrum of prevention, harm reduction, treatment, and recovery. Based on the grantees' PPRs, 585,109 individuals received recovery support services.[16] These services included: Recovery Housing, Employment Services,Peer Support, Case Management, Family Services, and Transportation Assistance.

Client Outcomes

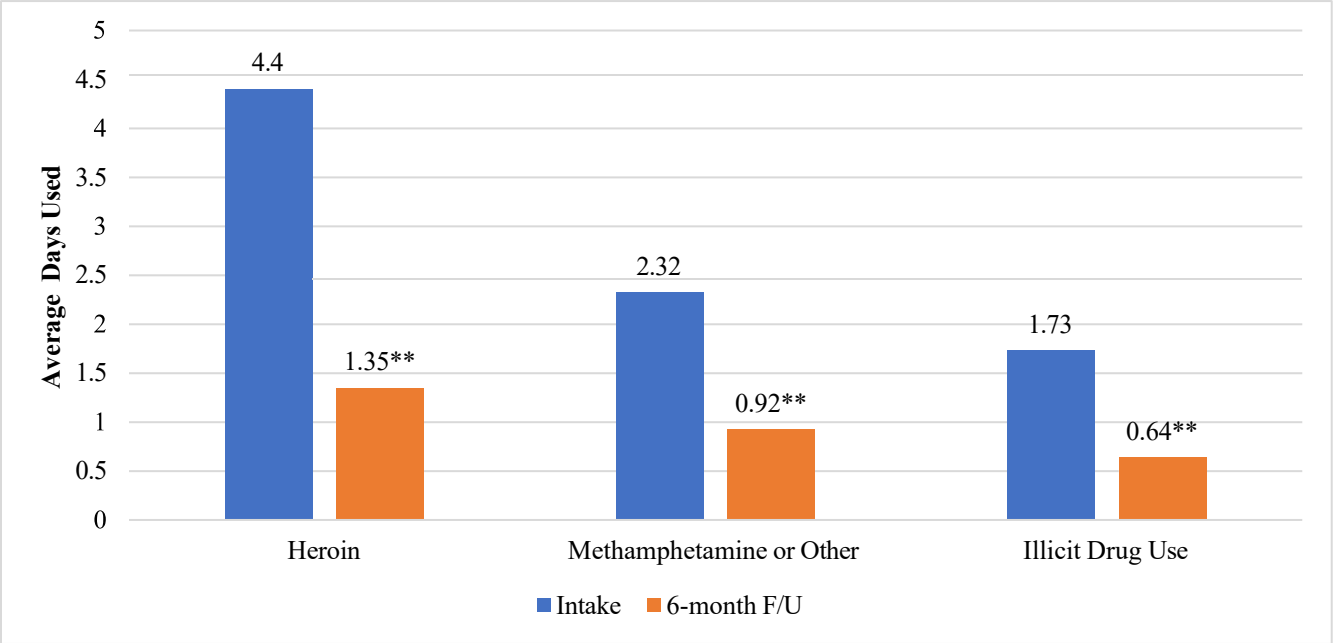
Effectiveness of SAMHSA-funded programs is of critical importance to SAMHSA. As a requirement of the SOR program, grantees must report outcome data at the client level. The collection and submission of these data enable SAMHSA to gauge program effectiveness and determine the extent to which grants programs are improving the lives of individuals served. SAMHSA recognizes the unique impact of substance misuse on an individual's life. However, it is not simply the use of substances that must be addressed. Substance misuse also impacts other aspects of a person's life such as an individual's ability to gain/maintain employment, housing stability, and social connectedness. To assess the impact of the SOR program, SAMHSA analyzed client outcome data for a subset of clients for which intake data was available and six-month follow-ups were conducted during the reporting period (n=34,668).[17]

Opioid Use Among SOR Clients Served

Opioid misuse is a key factor which the SOR program aims to address. For clients in which SPARS outcome data are available, heroin use decreased from an average of 4.40 days of use within the past 30 days prior to intake to an average of 1.35 days of use within the past 30 days prior to the six-month follow-up ($p<.001$). Methamphetamine use decreased from an average of 2.32 days of use within the past 30 days prior to intake to 0.92 days within the past 30 days prior to the six-month follow-up ($p<.001$). The average number of days of other illicit drug use (e.g., fentanyl, cocaine, or Adderall) decreased from 1.73 days within the past 30 days prior to intake to 0.64 days within the past 30 days prior to the six-month follow-up (Figure 4).

[13] Data are from the FY 2018 SOR cohort no-cost extensions, Performance Progress Reports (September 30, 2020, to September 29, 2021); and the FY 2020 SOR cohort Performance Progress Reports (September 30, 2020 to March 30, 2022).
[14] Ibid
[15] Data are from the FY 2020 SOR cohort Performance Progress Reports (September 30, 2020 to March 30, 2022).
[16] Data are from the FY 2018 SOR cohort no-cost extensions, Performance Progress Reports (September 30, 2020, to September 29, 2021); and the FY 2020 SOR cohort Performance Progress Reports (September 30, 2020 to March 30, 2022).
[17] The limitations associated with the following analyses are under the limitations section of this report.

Figure 4: Substance Use Among SOR Clients Served



Notes: The denominator for this figure is N=34,668. Cumulative data from this figure ranges from March 16, 2021- April 30, 2022.
*Notes a p-value <0.05, ** Notes a p-value <0.001

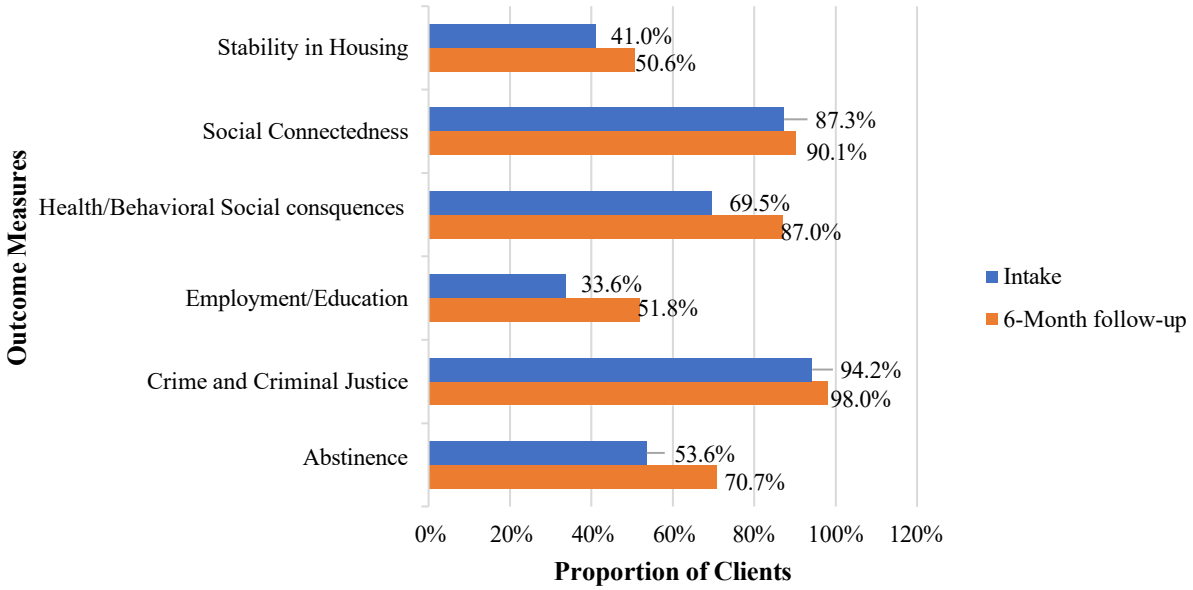
SOR Clients' Performance on National Outcomes Measures (NOMs)

SAMHSA developed NOMs in consultation with states and other stakeholders, to assess performance and improve accountability of SAMHSA programs. NOMs are composed of domains, outcomes, and measures. The domain for each NOM has an expected outcome, as well as treatment and/or prevention measures that are used to determine whether the expected outcome was achieved. The domains are (1) Abstinence: did not use any alcohol or illegal drugs within the past 30 days;[18] (2) Employment/Education: currently employed or attending school; (3) Crime and Criminal Justice: has no past 30 day arrest; (4) Stability in Housing: had a permanent place to live in the community; (5) Social Connectedness: felt socially connected; and (6) Health/Behavioral/Social Consequences: experienced no alcohol or drug related health, behavioral, or social consequences.

Overall, SOR clients saw positive performance between intake and six-month follow-up on all NOMs (Figure 5).

Figure 5: Client Outcomes

[18] Illegal drugs include unprescribed use of prescription medication or misuse of prescribed medication (e.g., taking more than prescribed).



Note: N=34,668, which is based on the number of matched six-month follow-ups. Data from this figure was accessed from SPARS on June 10, 2022

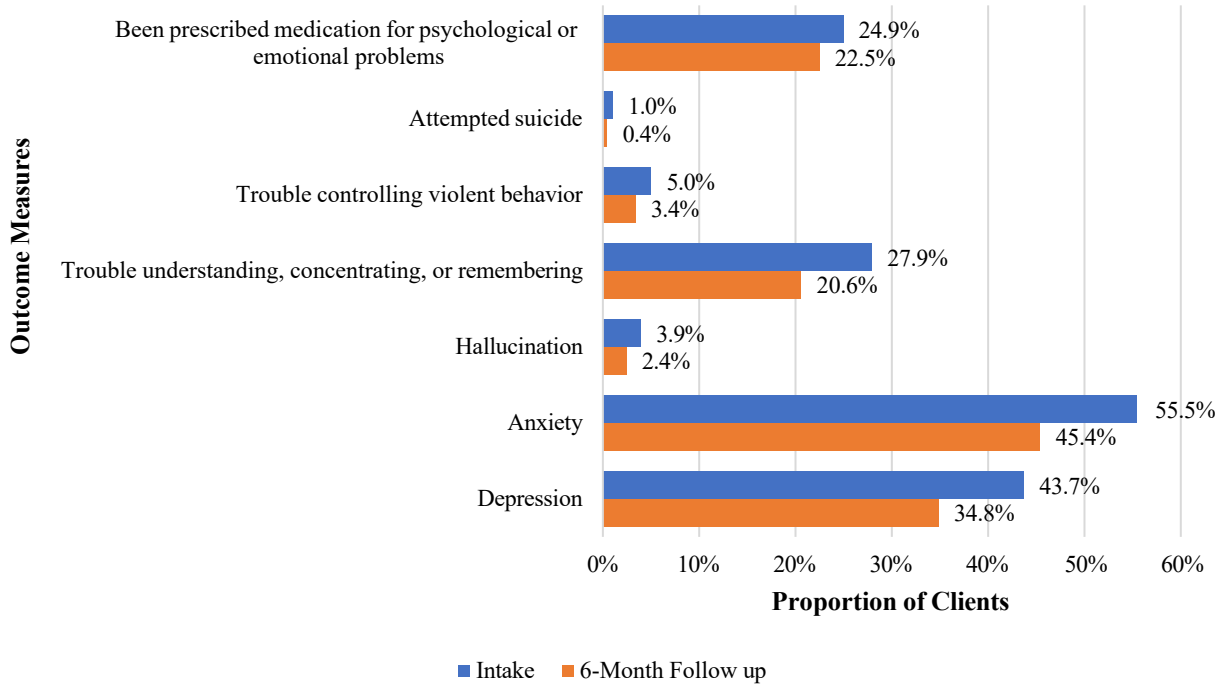
Specifically, the percentage of clients who reported:

- A permanent place to live in the community increased by 23.5 percent.
- Feeling socially connected increased by 3.2 percent.
- Experiencing no alcohol or illegal drug-related health, behavioral or social consequences[19]in the previous 30 days increased by 25.2 percent
- Current employment or school attendance increased by 54.1 percent.
- No past 30 day arrests increased by 4.0 percent and 94.2 percent of clients reported no criminal justice system involvement at intake.
- Abstaining from alcohol or illegal drugs increased by 32.0 percent.

SAMHSA also captures NOMs related to mental health. Clients receiving SOR-supported services also had positive mental health outcomes (Figure 6).

[19] Defined as experiencing stress, reduction or cessation of important activities, and emotional problems because of substance use.

Figure 6: Mental Health Outcomes



Note: N=34,668, which is based on the number of matched six-month follow-ups. Data from this figure was accessed from SPARS on June 10, 2022

The percentage of clients who reported:

- Attempting suicide decreased by 58.6 percent.
- Having trouble controlling violent behavior decreased by 32.7 percent.
- Having trouble understanding, concentrating, or remembering decreased by 26.3 percent.
- Experiencing hallucinations decreased by 38.1 percent.
- Experiencing anxiety decreased by 18.2 percent.
- Experiencing depression decreased by 20.3 percent.
- Being prescribed medication for psychological or emotional problems decreased by 9.8 percent.

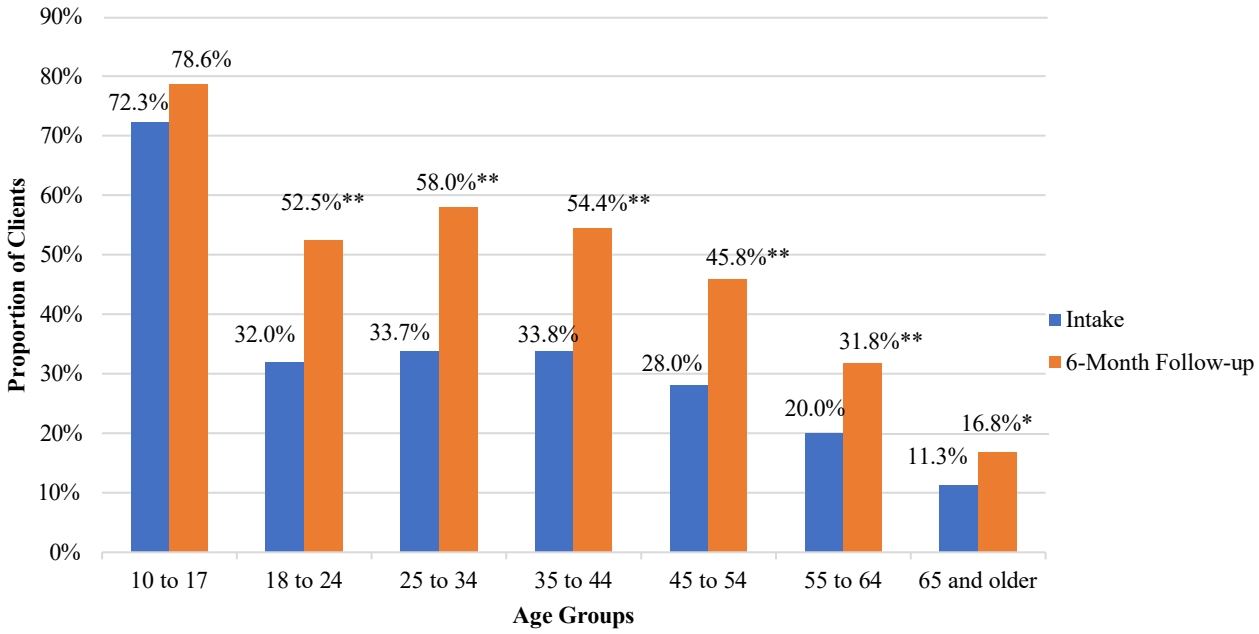
Variation in Client Outcomes on NOMs

As noted in the Demographic Profile section of this report, the population of clients served by the SOR program varied by age, gender, race, and ethnicity. It is important to ensure that the positive impacts of the SOR program were experienced equitably across all clients. To assess whether disparities existed, McNemar Test were conducted between client characteristics (i.e., age, gender, race, and ethnicity) and performance on NOMs measures between intake and six-month follow-up. To conduct this analysis, we identified over 30,000 clients with both intake and six-month follow-up assessment data available.

Variation by Age

Age plays a role in how clients performed on the Employment/Education NOM. The Employment/Education NOM is designed to capture whether the percent of clients that obtain employment or start school increased during the first six-months of receiving SOR supported services. We found that although age was a statistically significant factor on client outcomes related to the Employment/Education NOM, differences in client outcomes between intake and follow-up varied by age group (Figure 7).

Figure 7: NOMs: Employment and Education by Age ǂ



Note: N=34,668, which is based on the number of matched six-month follow-ups. Cumulative data from this figure ranges from March 16, 2021 – April 30, 2022. *p <0.05, **p <0.001, ǂ p <0.001 across all groups.

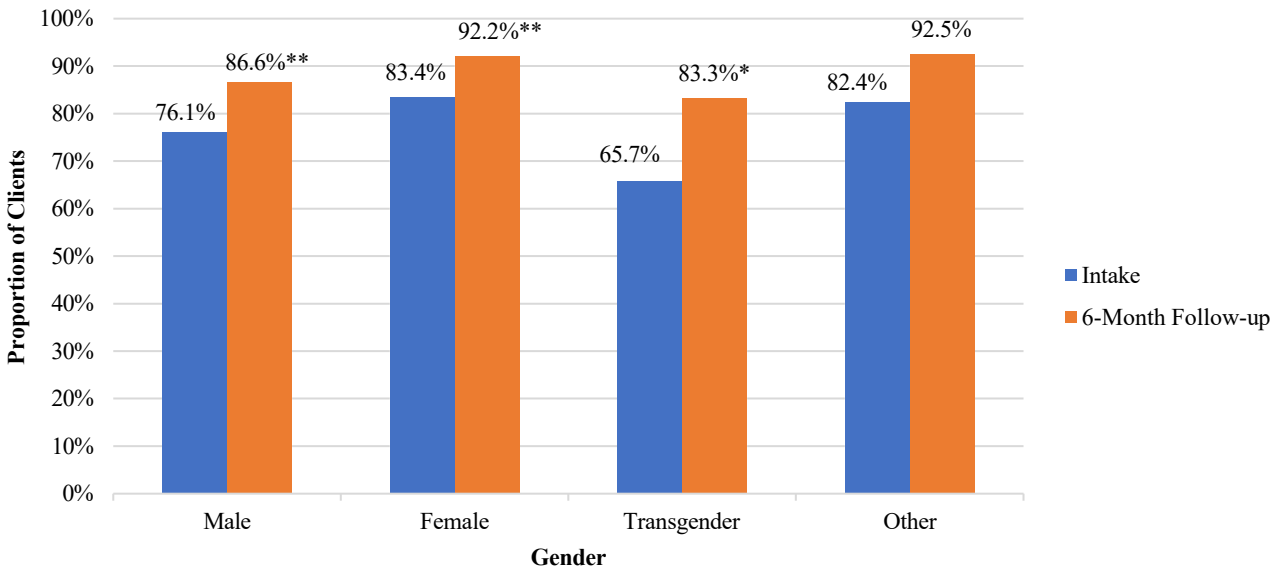
As shown in Figure 7, 58.0 percent of clients between the ages of 25 and 34 reported having current employment at six-month follow-up. This was a statistically significant difference of 24.3 percent from intake (p <0.001). Similarly, clients between the ages of 18-24, 35-44, and 55-64 also showed statistically significant differences between intake and six-month follow-up. For example, clients between the ages of 35 and 44 had a statistically significant difference of 20.6 percent (p <0.001) between intake and six-month follow-up.

However, not all age groups showed significant differences. Clients between ages 10-17 saw no significant difference between intake and six-month follow-up for current employment or school attendance during this reporting period. At six-month follow-up, nearly 8 in 10 clients between the ages of 10-17 were enrolled in school or employed. There was a difference of 6.3 percent between intake and six-month follow-up for this age group. Moreover, although clients 65 and older showed a statistically significant difference between intake and six-month follow-up, the difference was lower than other groups at a 5.5 percent change (p <0.05).

Variation by Gender

Most SOR clients served during this reporting period identified as male (60.9%). The Stability in Housing NOM assesses the percent of clients that have obtained a permanent place to live in the community while receiving treatment. The Social Connectedness NOM is designed to capture the extent to which clients served have a positive social network while obtaining SOR services. We found that although gender was a statistically significant factor on client outcomes related to the Stability in Housing and Social Connectedness NOMs, differences in client outcomes between intake and follow-up varied by gender identity.

Figure 8: NOMs: Stability in Housing by Gender ǂ



Note: N=34,668, which is based on the number of matched six-month follow-ups. Cumulative data from this figure ranges from March 16, 2021 – April 30, 2022. *p <0.05, **p <0.001, ǂ p <0.001 across all groups.

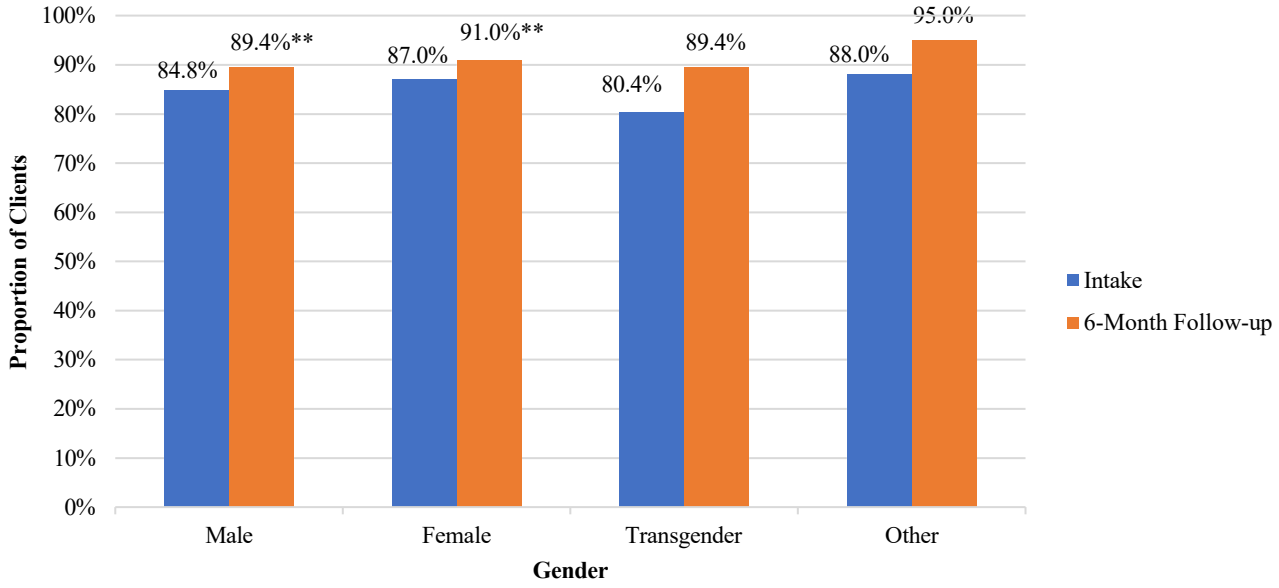
As shown in Figure 8, 86.6 percent of clients who identify as male reported having a permanent place to live in the community at six-month follow-up. This is a 10.5 percent difference (p <0.001) from the intake rate of 76.1 percent. Similarly, over 9 in 10 female clients reported living in a permanent place at six-month follow-up: an 8.8 percent difference (p <0.001) from intake.

Transgender clients also had a difference in the Stability in Housing NOM between intake and six-month follow-up. Over 80 percent of transgender SOR clients reported having stable housing at six-month follow-up compared to 65.7 percent at intake. This was difference of 17.6 percent (p <0.05). However, clients who identified as 'other', had no significant difference between intake and six-month follow-up in the domain of housing stability during this reporting period. At follow-up, over 9 in 10 clients who identified as 'other' had permanent housing.

Like the Stability in Housing NOM, male clients saw a significant difference between intake and six-month follow-up on the Social Connectedness NOM (Figure 9). At six-month follow-up, 89.4 percent of clients reported feeling socially connected. This was a statistically significant difference of 4.6 percent (p <0.001) from the intake rate of 84.8 percent. Clients who identify as female also saw

significant differences between intake and follow-up with 91 percent reporting feeling socially connected at six-month follow-up compared to 87.0 percent at intake.

Figure 9: NOMs: Social Connectedness by Gender ǂ



Note: N=34,668, which is based on the number of matched six-month follow-ups. Cumulative data from this figure ranges from March 16, 2021 – April 30, 2022. *p <0.05, **p <0.001, ǂ p <0.001 across all groups.

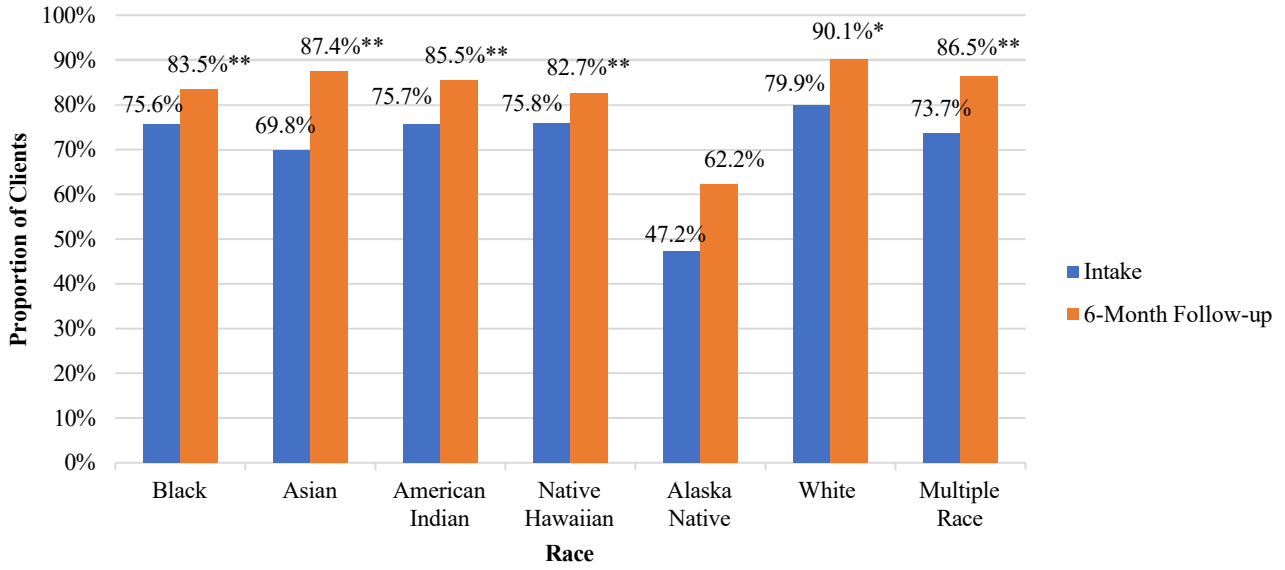
However, transgender clients and clients who identified as 'other' had no significant difference between intake and six-month follow-up during this reporting period for the domain of social connectedness. At six-month follow-up, 95 percent of clients who identified as 'other' reported feeling socially connected. Similarly, 89.4 percent of transgender clients reported feeling socially connected at follow-up.

Variation by Race

Race is also a factor that can impact client NOMs outcomes. In this section we examine variation by race in client outcomes on the Stability in Housing NOM as well as the Abstinence, Crime and Criminal Justice, and Health/Behavioral/Social Consequences NOMs. We found that although race was a statistically significant factor on client outcomes related to the Stability in Housing, Abstinence, Crime and Criminal Justice, and Health/Behavioral/Social Consequences the differences in client outcomes between intake and follow-up varied by race category.

For example, for the Stability in Housing NOM, 83.5 percent of black or African American clients reported having permanent housing at their six-month follow-up (Figure 10). This was a statistically significant difference of 7.9 percent difference compared to intake ($p < 0.001$). Nine in 10 white clients reported having stable housing at their six-month follow-up compared to 79.9 percent at intake. This is a statistically significant difference of 10.2 percent ($p < 0.05$).

Figure 10: NOMs: Stability in Housing by Race ǂ

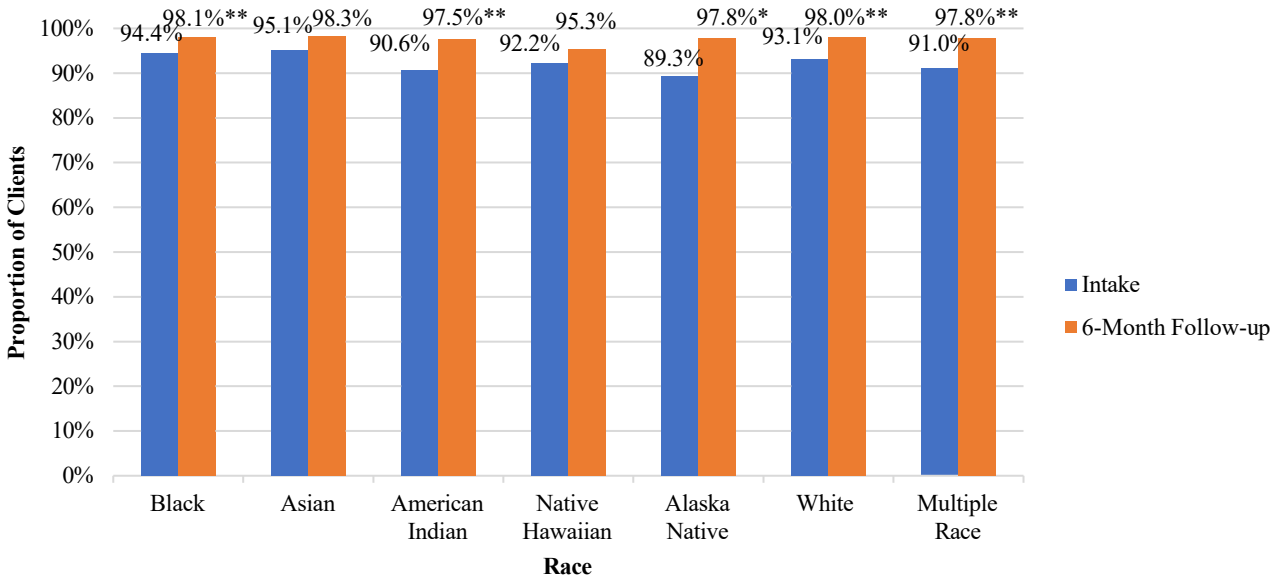


Note: N=34,668, which is based on the number of matched six-month follow-ups. Cumulative data from this figure ranges from March 16, 2021 – April 30, 2022. *p <0.05, **p <0.001, ǂ p <0.001 across all groups.

Asian clients also saw a significant difference between intake and follow-up. At their six-month follow-ups, 87.4 percent of Asian clients reported having stable housing; compared to 69.8 percent at intake. This was a statistically significant difference of 17.6 percent (p <0.001). However, Alaska Native clients had no significant difference between intake and their six-month follow-up during this reporting period for the domain of stable housing. Six in 10 Alaska Native clients reported having permanent housing at six-month follow-up.

As it pertains to the Crime and Criminal Justice NOM, most clients across all racial groups reported no arrests nor criminal justice system involvement at their six-month follow-up (Figure 11). Nearly all black or African American SOR clients reported that they had no past 30 day arrests at their six-month follow-up. This was a statistically significant difference of 3.7 percent (p <0.001) compared to the intake rate of 94.4 percent. Similarly, 98 percent of white clients reported no arrest nor criminal justice system involvement at their six-month follow-up compared to 93.1 percent at intake. However, Asian and Native Hawaiian clients saw no significant differences between intake and their six-month follow-up in this area during this reporting period.

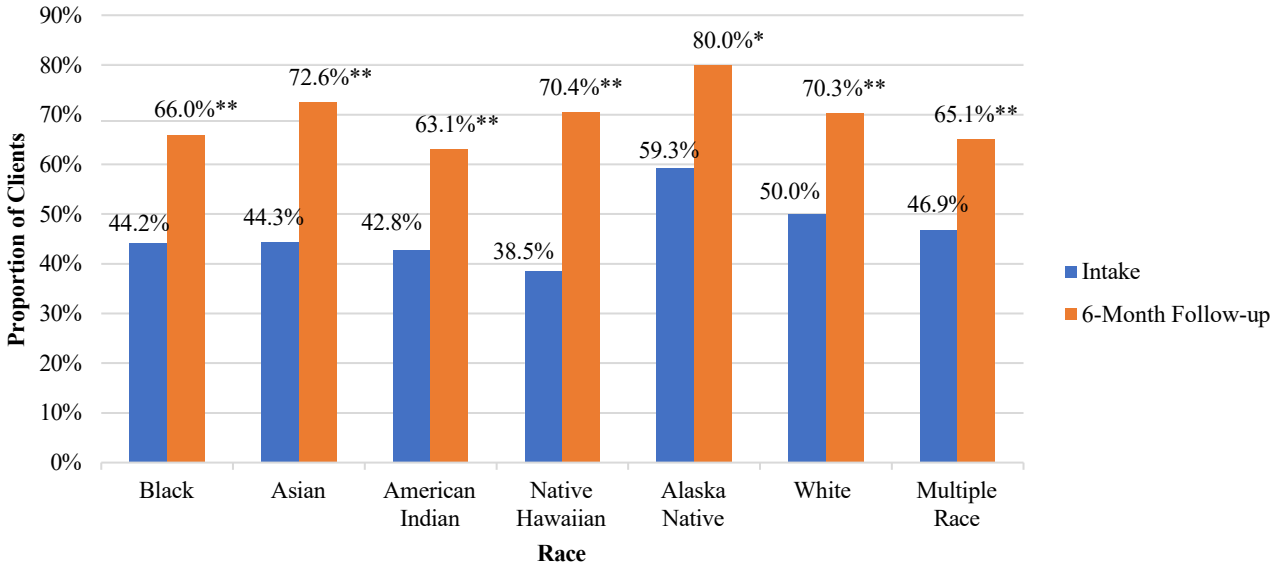
Figure 11: NOMs: Crime and Criminal Justice by Race ǂ



Note: N=34,668, which is based on the number of matched six-month follow-ups. Cumulative data from this figure ranges from March 16, 2021 – April 30, 2022. *p <0.05, **p <0.001, ǂ p <0.001 across all groups. Crime and Criminal Justice variable defined as no past 30 day arrests.

Client outcomes on the Abstinence NOM saw statistically significant differences between intake and their six-month follow-up for all racial groups (Figure 12). For example, 66 percent of black or African American clients reported abstaining from alcohol and illicit drug use at their six-month follow-up. This was a statistically significant difference of 21.8 percent (p <0.001) from the intake rate.

Figure 12: NOMs: Abstaining from Drug and Alcohol Use by Race ǂ

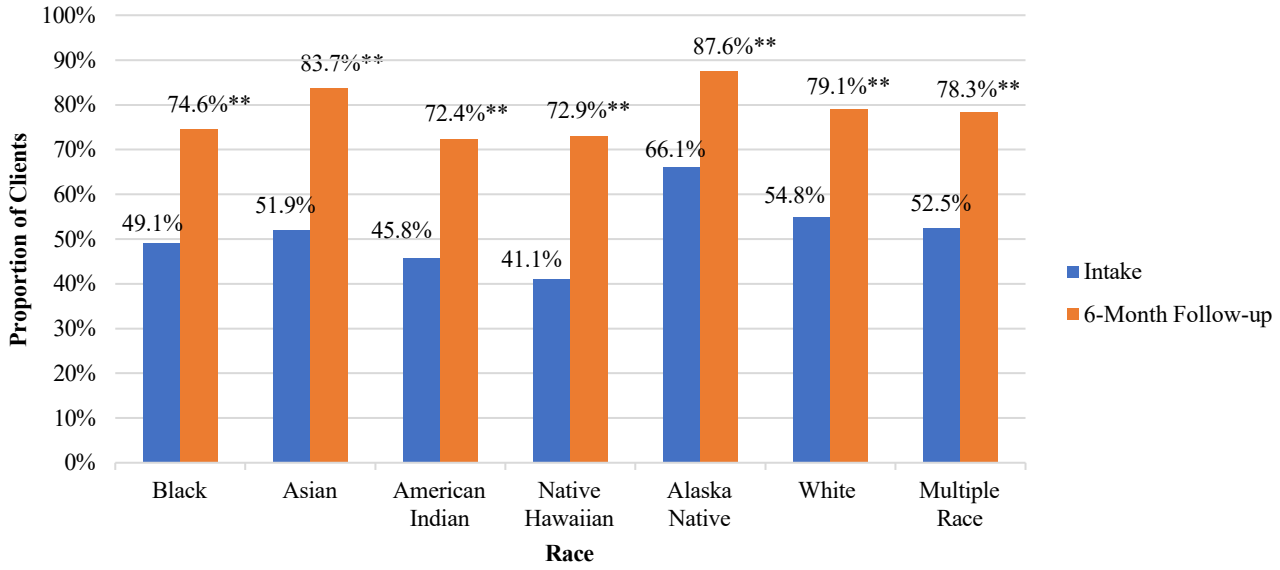


Note: N=34,668, which is based on the number of matched six-month follow-ups. Cumulative data from this figure ranges from March 16, 2021 – April 30, 2022. *p <0.05, **p<0.001, ǂ p <0.001 across all groups.

Nearly 7 in 10 white clients reported abstaining from illicit drugs and alcohol at their six-month follow-up: a statistically difference of 20.3 percent (p <0.001). Asian clients also had a statistically significant difference between intake and their follow-up with a change of 28.3 percent (p <0.001).

Like the Abstinence NOM, client outcomes on the Health/Behavioral/Social Consequences saw statistically significant differences between intake and their six-month follow-up for all racial groups (Figure 13).

Figure 13: NOMs: No Social Consequences by Race ǂ



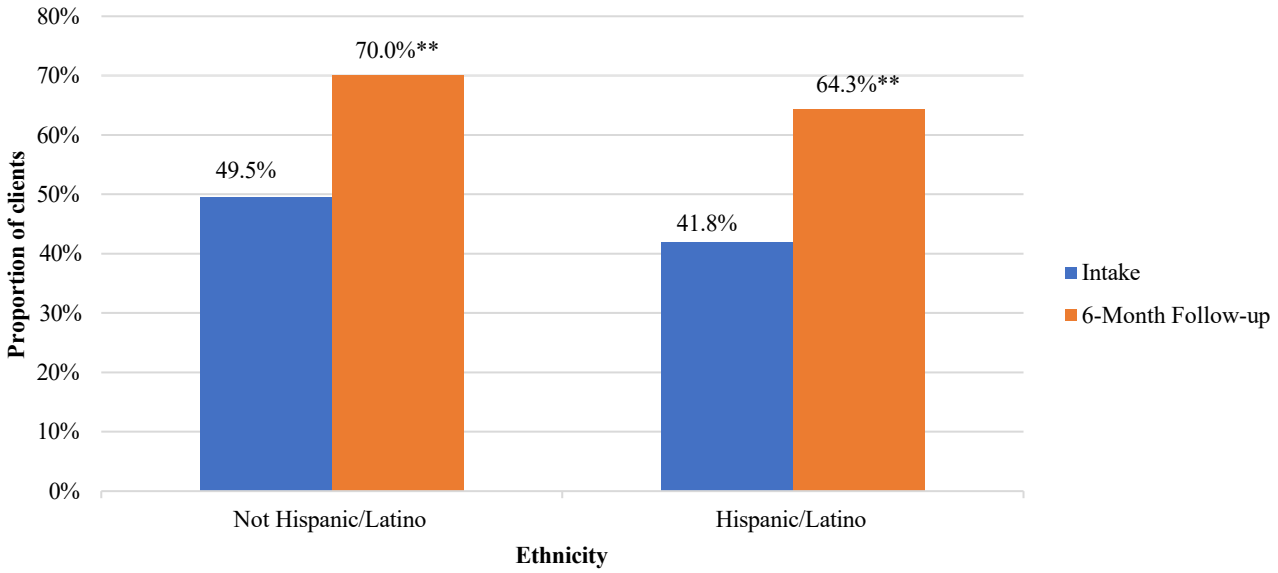
Note: N=34,668, which is based on the number of matched six-month follow-ups. Cumulative data from this figure ranges from March 16, 2021 – April 30, 2022. *p <0.05, **p <0.001, ǂ p <0.001 across all groups.

At their six-month follow-up, over 8 in 10 Asian clients reported not experiencing health, behavioral, and social consequences of substance use in the past 30 days. This was a statistically significant difference of 31.8 percent from the intake rate (p <0.001). Black or African American clients also saw differences. With a change of 25.5 percent (p <0.001). Over 87 percent of Alaska Native clients reported at six-month follow-up not experiencing an alcohol or illicit drug-related health, behavioral or social consequences in the past 30 days. A difference of 21.5 percent compared to the intake rate of 21.5 percent.

Variation by Ethnicity

Ethnicity was a significant factor as it pertains to the Abstinence NOM. Per Figure 14, 64.3 percent of clients that identified as Hispanic or Latino reported abstaining from illicit drugs and alcohol at their six-month follow-up compared to 41.8 percent at intake. This was a statistically significant difference of 22.5 percent (p <0.001). Similarly, 70 percent of non-Hispanic or Latino clients reported abstaining from drugs and alcohol at their six month follow-up. This was a 20.5 percent change from intake (p <0.001).

Figure 14: NOMs: Abstaining from Drug and Alcohol Use by Ethnicity ǂ



Note: N=34,668, which is based on the number of matched six-month follow-ups. Cumulative data from this figure ranges from March 16, 2021 – April 30, 2022. *p <0.05, **p <0.001, ǂ p <0.001 across all groups.

Logistic Regression Analyses with NOMS

To build on variation analysis, binary logistic regressions were conducted between demographic factors and key intake and follow–up measures to assess alcohol and drug use, social consequences, social connectedness, criminal justice involvement, employment and education, and housing stability at the six-month follow-up among over 30,000 clients with matched intake and follow–up assessments. A stepwise approach was taken to ensure that each regression model contained significant variables that may influence the outcome measures at the six-month follow-up. Variables that were not deemed significant were excluded from each model. Additionally, the regression models are limited to client demographic characteristics and variables used to populate the NOMs. SAMHSA will conduct further analyses using additional variables in the future such as sexual orientation, gender identity, and mental health outcomes using data from CSAT's new GPRA client-level tool. The report does not include all data that was collected for this grant program, and only captures a specific timeframe. Please note the data excludes clients who were not due a six-month follow-up during this timeframe.

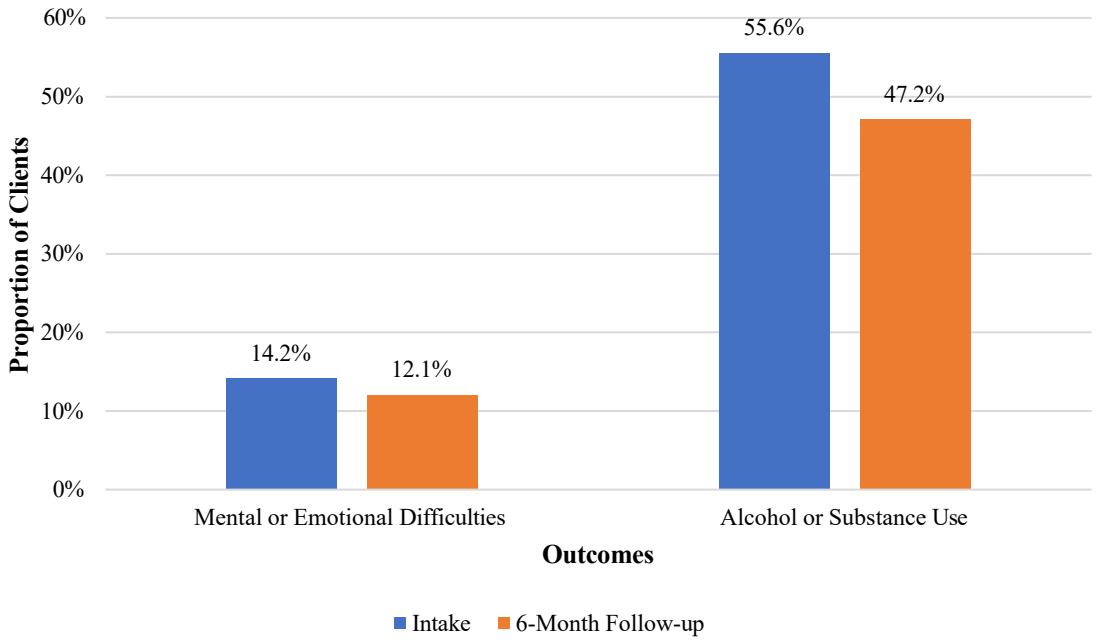
Regarding the Abstinence NOM, after controlling for the respective variables within the regression model, we found that women were 1.209 times more likely to abstain from alcohol and drug use at their six-month follow-up compared to men. Clients who did not identify as Hispanic/Latino were less likely (Odds Ratio (OR)=0.862) to abstain from alcohol and drug use at their six-month follow-up compared to those who identified as Hispanic/Latino. Clients who reported alcohol and drug use at intake were less likely (OR=0.068) to abstain from alcohol and drug use compared to those who reported abstaining from alcohol and drug use at intake. Clients who reported social consequences at intake were 3.131 times more likely to abstain from alcohol and drug use at their six-month follow-up compared to those with no social consequences at intake after controlling for the additional variables within the regression model.

Refer to Appendix III for the full results associated with these analyses.

Hospital or Emergency Department (ED) Visits

Outlined in Figure 15, SOR clients reported decreased use of emergency departments for urgent treatment of mental or emotional difficulties or alcohol and/or substance misuse as well as decreased numbers of hospital admissions for these conditions following six months of program participation.

Figure 15: Change in Hospital or ED Visits from Intake to Six-Months



Note: Graph based on SPARS data generated on June 10, 2022. N= 34,668, which is based on the number of matched six-month follow-ups.

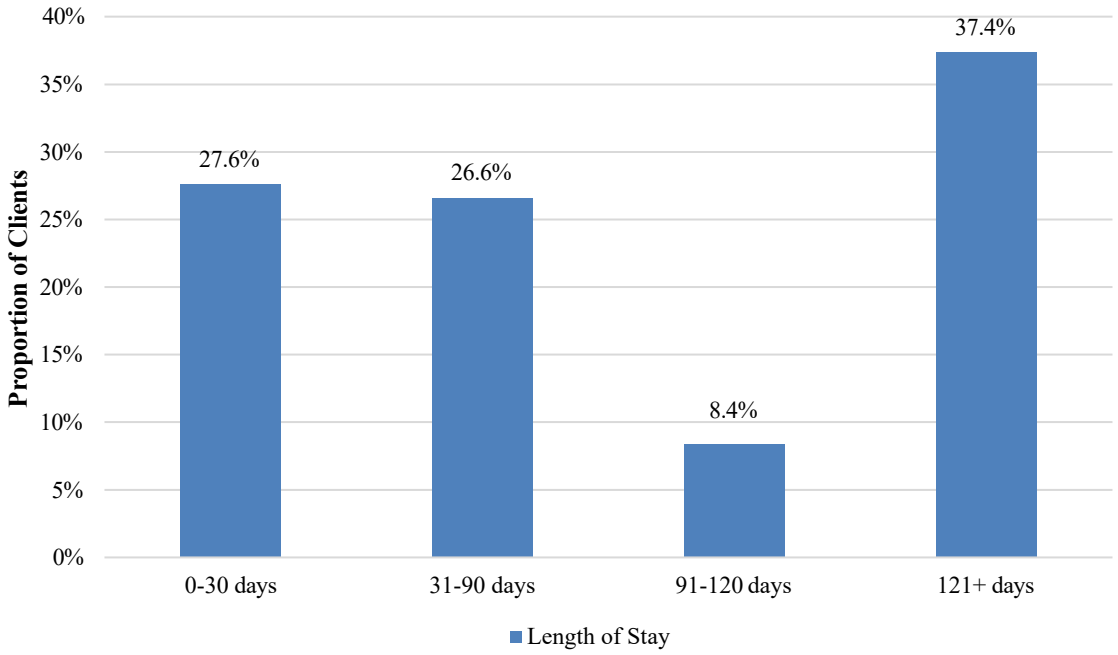
The data below highlights the declines between intake and six-month follow-up.

- The percentage of clients who reported seeking care in a hospital or an emergency department for mental and emotional difficulties decreased from intake to their six-month follow-up by 14.8 percent.
- The percentage of clients who reported seeking care in a hospital or an emergency department for alcohol and/or substance use declined from intake to six-month follow-up by 15.2 percent.

Retention and Length of Stay

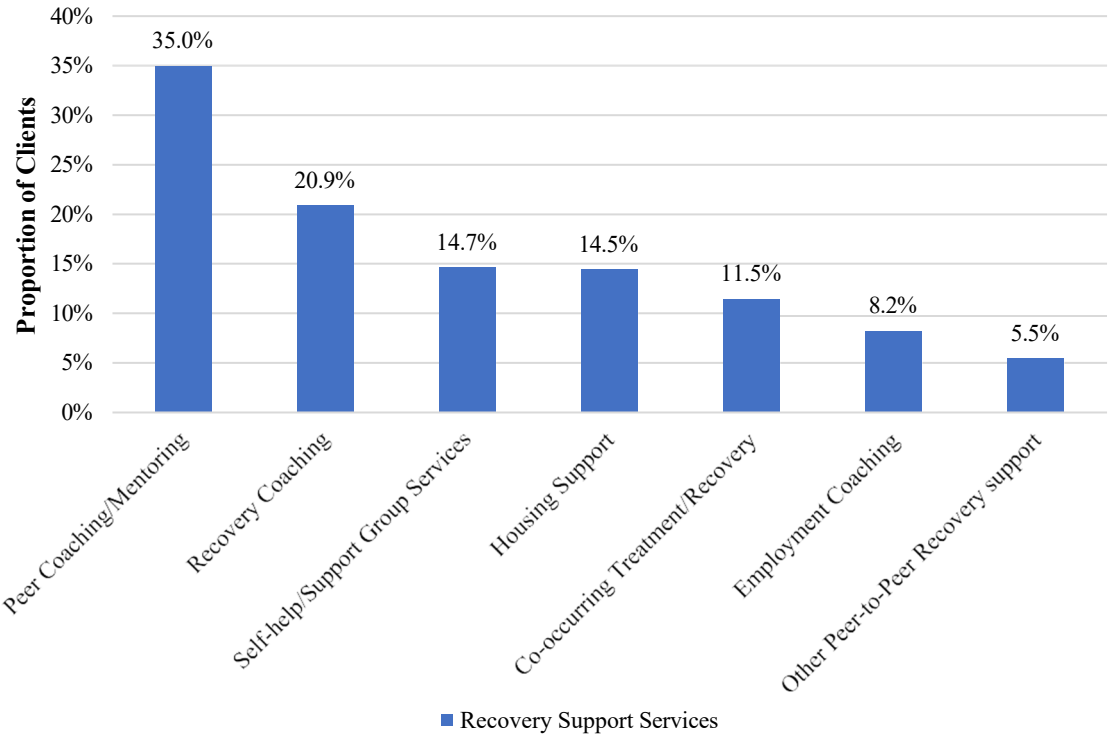
Of the clients served from March 16, 2021 through April 30, 2022, 39,589 client discharges were reported to SPARS. Among the clients discharged, the median length of stay was 79 days compared to the average length of stay of 99.0 days, with a range of 0 to 433 days (Std Dev. 82.1). Over eight percent (N=3,325) stayed in services for 91-120 days. Twenty-eight percent (N=10,928) stayed for 0-30 days, twenty-seven percent (N=10,537) remained in the program for 31-90 days, and approximately 37 percent (N=14,799) of the clients stayed in the program for 121+ days. Figure 16 highlights client retention and length of stay during this reporting period.

Figure 16: Client Retention and Length of Stay



Note: Graph based on SPARS data generated on June 10, 2022. N= 39,589. Treatment modalities include Inpatient/Hospital, Outpatient, Intensive Outpatient, Residential/Rehabilitation, Detoxification, etc.

Figure 17: Recovery Support Services



***Note:** Graph based on SPARS data generated on June 10, 2022. N= 39,589. Clients may receive multiple services prior to discharge.

Among individuals with discharge data available, the SOR program provided its clients with 911,631 days of recovery support services from March 16, 2021 through April 30, 2022. Among these clients, 35 percent (N=13,854) received peer coaching or mentoring, 20.9 percent (N=8,273) received recovery coaching, and 14.7 percent (N=5,800) of clients received self-help and support group services. Additionally, 14.5 percent (N=5,730) received housing support services, 11.5 percent (N=4,542) received co-occurring treatment/recovery services, 8.2 percent (N=3,262) received employment coaching, and 5.5 percent (N=2,189) received other peer-to-peer recovery support services.

Limitations

The SOR FY 2022 Report to Congress uses aggregate data collected and reported by SOR grantees via SPARS and the PPRs. The report highlights selected program-specific indicators including demographic characteristics, the number of clients served, services received, retention and length of stay, and client-level NOMS at intake and at six-month client follow-up. The report does not include all data that was collected for this grant program, and only captures a specific timeframe. The data does not fully recognize grantee challenges related to COVID-19 nor does it account for variable program implementation or differences in service delivery models. Data was downloaded at one point in time (i.e., June 10, 2022); it is possible that additional data for the period covered in this report was submitted into SPARS after the data was accessed. This report is comprised of primarily self-reported data with client data at follow-up included only for clients who responded to the survey after six

months from their initial intake date. As a result, there is the possibility of selection and attrition bias.

In addition, the current version of the CSAT GPRA Client Outcome Measures for Discretionary Program instrument does not account for key client characteristics that will help SAMHSA to better understand outcomes among diverse populations. The new CSAT GPRA tool will be captures key client characteristics such as sexual orientation and gender identity.

Conclusion

SOR funding provides support necessary for states and territories to implement a range of prevention, harm reduction, treatment, and recovery support services for opioid and stimulant use disorders. These services include training on identification of opioid overdose and reversal using the opioid overdose antidote naloxone that has resulted in approximately 256,985 lives saved during this reporting period.

SOR resources have assisted grantees address the complex and multi-faceted clinical and social needs of those with OUD and/or stimulant use disorder(s). Data analyses suggest that clients provided with SOR-funded services achieve positive outcomes including abstinence from substance use, increased employment and education, decreased involvement with the criminal justice system, increases in stable housing and increased social connectedness. Clients served through the SOR program have also reported decreases in hospitalizations and ED visits. If these trends continue, that could translate to substantial cost savings over time for states/territories and communities as we have seen from other research.[20, 21, 22, 23] Despite the COVID-19 pandemic, SOR grantees continue to expand the accessibility of evidence-based services through the utilization of telehealth and telemedicine.

However, the positive outcomes show a slower rate of change by clients demographic characteristics such as race and ethnicity. During the reporting period, 140,623 clients were served and 34,668 clients had a six-month follow-up. Among clients with six-month follow-up interviews, we found that demographic characteristics such as age, race, gender, and ethnicity were associated with client outcomes specifically NOMs. For example, based on SAMHSA's analysis, women were 1.209 times more likely to abstain from alcohol and drug use at their six-month follow-up compared to men (Appendix III). Additionally, we found that Black or African American, Native Hawaiian, Alaska Native, and multiple race clients were less likely to report stable housing at their six-month follow-up compared to White clients. Lastly, as age increased, clients were less likely to feel socially connected at their six-month follow-up. These findings are consistent with disparities reported in previous studies.[24,

[20] Mohlman, Mary Kate et al. (2016) Impact of Medication-Assisted Treatment for Opioid Addiction on Medicaid Expenditures and Health Services Utilization Rates in Vermont *Journal of Substance Abuse Treatment*, Volume 67, 9 - 14 https://doi.org/10.1016/j.jsat.2016.05.002.

[21] Jackson H, Mandell K, Johnson K, Chatterjee D, Vanness DJ. Cost-Effectiveness of Injectable Extended-Release Naltrexone Compared With Methadone Maintenance and Buprenorphine Maintenance Treatment for Opioid Dependence. *Subst. Abus*. 2015; 36(2):226-231. doi:10.1080/08897077.2015.1010031

[22] Ankit Shah, Margaret Duncan, Nipun Atreja, Kei Sing Tai & Mugdha Gore (2018)Healthcare utilization and costs associated with treatment for opioid dependence, Journal of Medical Economics, 21:4, 406-415, DOI: 10.1080/13696998.2018.1427101

[23] Busch, S., et al. (2017) Cost-effectiveness of emergency department-initiated Treatment for opioid dependence Addiction. https://doi.org/10.1111/add.13900

[24] Olivet, J., Wilkey, C., Richard, M., Dones, M., Tripp, J., Beit-Arie, M., Yampolskaya S., & Cannon, R. (2021). Racial

[25, 26, 27, 28]

To address these disparities, SAMHSA is undertaking a number of efforts. FY 2022 state SOR grantees, are required to develop strategic plans to address the needs of diverse populations, underserved populations (e.g., racial/ethnic minorities and LGBTQI+) and older adults with focused interventions, when appropriate, as well as strategies and activities that will be incorporated to promote behavioral health equity. These plans also must address outreach efforts to engage Tribes, Tribal organizations, and urban Indian organizations to ensure that strategies are implemented to meet their needs.

Additionally, SAMHSA continues to promote best practices to reach diverse communities through its ongoing education, technical assistance, and training efforts through the Opioid Response Network (ORN). The ORN was designed to provide technical assistance to SOR grantees. The ORN provides culturally appropriate, evidence-based training and education to address opioid use disorders and stimulant use at the local level.[29] To help reach historically and continually marginalized communities and address health disparities, the ORN has established several workgroups. ORN workgroups are charged with selecting and vetting consultants that facilitate ORN trainings, vetting materials developed for ORN educational activities, creating new material where gaps and needs are determined and conducting community outreach to extend ORN's reach and impact. The following are examples of some of the Workgroup's efforts:

The **ORN Indigenous Communities Workgroup** convened national Tribal technical assistance organizations and stakeholders alongside Gathering of Nations, the largest pow wow in North America. They discussed common interests in assisting Native communities responding to the rise of opioid, stimulant, and polydrug use. The meeting presented an opportunity to share ideas, innovations, and challenges in supporting Native communities to strengthen families, promote generational healing, and provide best practices to counteract the consequences of substance use disorders.

The **ORN Black Communities Workgroup** is engaged in work mapping national organizations to support outreach efforts focused on states with the highest or most disproportionate rates of overdose in Black and African American communities. This work is centered on tailored engagement to meet individual and community identified needs. A virtual outreach event for Fall 2022 is being planned to engage Black community members working in the substance use field across the country.

Members of the **ORN Sexuality and Gender Diversity Workgroup** created a one-of-a-kind web-based training to help substance use disorder treatment providers deliver more affirming care to LGBTQIA+ clients. The training helps participants identify key components of care for LGBTQIA+ people, and how to make the treatment environment and staff interactions more welcoming for

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inequity and homelessness: Findings from the SPARC Study. The ANNALS of the American Academy of Political and Social Science, 693(1), 82-100.

[25] Perissinotto, C., Holt-Lunstad, J., Periyakoil, V. S., & Covinsky, K. (2019). A practical approach to assessing and mitigating loneliness and isolation in older adults. Journal of the American Geriatrics Society, 67(4), 657-662.

[26] Kapadia, F. (2022). Ending Homelessness and Advancing Health Equity: A Public Health of Consequence. American Journal of Public Health.

[27] Mehdipanah R. (2020). Housing as a determinant of COVID-19 inequities. American Journal of Public Health. 2020;110(9):1369–1370.

[28] Versey, H. (2021). The impending eviction cliff: housing insecurity during COVID-19. American Journal of Public Health. 2021;111(8):1423–1427.

[29] For more information on the ORN, refer to https://opioidresponsenetwork.org/

LGBTQIA+ clients. Currently the workgroup is finalizing a Diversity Acknowledgement Checklist, which will be a resource for developing materials that are intersectional, as well as gender and sexuality affirming.

In addition to the resources provided by ORN, SAMHSA funds multiple Centers of Excellence (COE) that develop and disseminate training and technical assistance for healthcare practitioners on issues related to addressing behavioral health disparities. For example, SAMHSA funds the **African American Behavioral Health Center of Excellence (AABH-COE)**. This COE develops and disseminates training, technical assistance, and resources to help healthcare practitioners eliminate behavioral health disparities within this large and diverse population.[30] The **Center of Excellence on LGBTQ+ Behavioral Health Equity (CoE LGBTQ+ BHE)**, provides behavioral health practitioners with vital information on supporting the population of people identifying as lesbian, gay, bisexual, transgender, queer, questioning, intersex, two-spirit, and other diverse sexual orientations, gender identities and expressions (LGBTQ+).[31] The **Engage, Educate, Empower for Equity: E4 Center of Excellence for Behavioral Health Disparities in Aging** (E4) engages, empowers, and educates health care providers and community-based organizations for equity in behavioral health for older adults and their families.[32]

Finally, to address some of the limitations inherent in restricting analyses to a one-year timeframe, SAMHSA plans to conduct and disseminate additional, multi-year analyses disaggregated by race, ethnicity, gender, and age, to further understand issues related to retention and follow-up.

The SOR program continues to help states, territories, and the District of Columbia build robust infrastructures for addressing the overdose crisis by contributing to the increased number of practitioners able to prescribe buprenorphine, and increasing the availability of effective prevention, harm reduction, treatment, and recovery support services. SOR has increased the number of individuals receiving MOUD, enhanced long-term recovery for people with OUD, and enhanced and implemented prevention and harm reduction services, which are instrumental in addressing the opioid crisis. SAMHSA will continue to require the use of these life-saving services to provide resources and increase client engagement among individuals with diverse racial, ethnic, geographic, and other demographic characteristics in future iterations of the SOR program.

[30] For more information on the African American Behavioral Health Center of Excellence, refer to https://www.samhsa.gov/african-american-behavioral-health-center-of-excellence
[31] For more information on The Center of Excellence on LGBTQ+ Behavioral Health Equity, refer to https://www.samhsa.gov/lgbtq-plus-behavioral-health-equity
[32] For more information on the E4 Center of Excellence for Behavioral Health Disparities in Aging, refer to https://www.samhsa.gov/behavioral-health-disparities-in-aging

APPENDIX I: State/Territory Approaches, Highlights, and Accomplishments

State/Territory	Key Accomplishments
Alabama	• Alabama continues to partner with the University of Alabama at Birmingham (UAB) to provide DATA Waiver trainings to increase the number physicians that will continue to be able to provide MOUD after the grant ends. • Providers and Certified Recovery Support Specialists (CRSS) have been able to provide information and referral services to 257 pregnant and post-partum women, 46 of which received treatment services: 302 veterans, 115 received treatment services; and 188 individuals reentering the community from prison, 52 received treatment services. • Alabama partners with the Recovery Organization for Support Specialists (ROSS) and People Engaged in Recovery (PEIR). ROSS and PEIR conduct outreach, hire and train CRSSs, and provide recovery support services. There are currently 381 total active recovery workers with 291 of those working across the entire state that conduct outreach and provide recovery support services in 52 counties.
Alaska	• Alaska continues to increase their continuum of care options for treatment and recovery supports by funding ASAM level 3.3 residential levels of care. Forty-nine individuals received services between October 1, 2020 to March 30, 2022. • The Co-occurring Behavioral Health, Opioid and Stimulant Use Disorders Project ECHO facilitated 10 sessions covering topics related to opioid treatment, stimulant misuse, and challenges in treatment. Two hundred and fourteen individuals, with an average of 21 individuals per session attended sessions between September 30, 2021 and March 30, 2022. • Alaska continues to fund statewide recovery housing residences. SOR funds were provided to eight recovery houses that served 60 new clients; and three rural recovery housing residences located in Wasilla, Homer, and Juneau that served 23 new clients between September 30, 2021 and March 30, 2022.

State/Territory	Key Accomplishments
American Samoa	• American Samoa successfully completed 760 Drug Abuse Screening Tool (DAST) assessments to screen for opioid misuse and assess level of risk for OUD across the community. • Several trainings for the behavioral health workforce were conducted on topics such as: SBIRT, stimulant use disorders, and contingency management. • Brochures, posters, and public service announcements (PSAs) were created to share information on what opioids are and how they affect the brain. American Samoa conducted outreach at youth groups, schools, and other government agencies to educate and inform the community about opioid use and abuse.
Arizona	• Arizona funds four Opioid Treatment Program (OTP) 24/7 access points. These access points serve a critical role in the optimization of MOUD services, allowing for continuous availability in some of the state's most populous areas. In addition to the provision of treatment, staff continue to conduct outreach in the community, targeting high-risk groups by partnering with correctional health facilities, transitional housing programs, and programs for pregnant women with OUD. A total of 6,063 individuals received MOUD services through these sites between September 30, 2020 and March 31, 2022. • SOR-funded street-based outreach targets underserved areas that may have less access to care. Services include the education on and distribution of naloxone, dissemination of hygiene kits, and provision of wound care. The approach for this outreach style is rooted in harm reduction and overdose prevention, often emphasizing education on fentanyl and latest drug trends. Between September 30, 2020 and March 31, 2022, there were 20,321 individuals provided with services and 15,176 naloxone kits distributed. • Working closely with Arizona's prevention coalitions, SOR-funded education and information dissemination efforts resulted in 791 youth directly served with evidence-based prevention programming; 68,704 individuals reached with prevention education; 1,167,609 traditional and social media impressions; and distribution of 417 medication lock boxes, 388 locking caps, and 322 drug disposal bags.

State/Territory	Key Accomplishments
Arkansas	• Collegiate prevention activities supported by a portion of the SOR award focus on distributing naloxone supplies to campuses of participating institutions of higher education throughout the state. Phase one of the program focused on educating students, staff, and faculty members on opioid overdose. Phase two of the program began in March 2022 and included NaloxBoxes and Narcan to be distributed to participating colleges. The state plans to begin distribution in May 2022. • Arkansas is developing a three-tiered credentialing process for Peer Recovery Support Specialists (PRSSs). From September 30, 2021 to March 30, 2022, 35 applications were received for PRSS training at the Core PRSS curriculum level (entry level), 13 applications were received for Advanced PRSS training, and three applications were received for Supervisor training. During the same period, 18 candidates were registered to take Core PRSS credentialing exams, and 7 individuals registered for Advanced PRSS exams. • The Arkansas Community Corrections/Prison-Based Vivitrol Re-Entry Program offers pre-release treatment/recovery services, MOUD, and the option to participate in an injectable naltrexone (Vivitrol) program component, with induction just prior to discharge from incarceration and options to continue during community re-entry. From September 30, 2021 to March 30, 2022, there were 14 MOUD re-entry graduates of the post-release program. Each participant is provided Narcan education prior to community re-entry.
California	• Between September 30, 2020 and December 31, 2021, 566,696 units of naloxone were provided to 1,421 organizations statewide, and 40,215 overdose reversals were reported. • The CA Bridge program continued to expand access to MOUD in hospitals across the state through technical assistance, outreach, education, and pilot initiatives. Between September 30, 2020 and March 30, 2022, the CA Bridge program measured 188 hospital sites providing MOUD, which was a 262 percent increase from the 52 sites during FY18 SOR. • SOR funding was provided to 358 behavioral health organizations to support telehealth infrastructure and equipment. Contractors reported an increase in new admissions, a decrease in appointment no-shows and cancellations, and better client outcomes and completion rates after expanding their telehealth infrastructure.

State/Territory	Key Accomplishments
Colorado	• Using previous SOR funds to stand up the project, the Colorado Naloxone Project (CNP) has 104 hospitals committed to distributing naloxone. • CO-SOR continues their partnership with two of the largest school districts in the state: Denver Public School (DPS) and Jefferson County (JeffCo) School Districts. SOR funding supports a prevention program coordinator embedded within each school district, along with some support staff and administrative costs to provide culturally affirming and strengths-based activities to students and their families. • Six mobile health units (MHU), and two SUVs, are delivering OUD treatment and other resource services to rural Colorado in 54 communities in 31 counties. Additionally, three communities served with an MHU established sustained, substantial demand so they have transitioned to more permanent treatment service locations. This has allowed the MHUs to serve other communities in need, and helps achieve the goal of establishing sustainable, permanent treatment options in previously underserved areas.
Connecticut	• Connecticut continues to fund recovery coaches in 20 hospital emergency departments. Between September 2021 and March 2022, recovery coaches provided services to 2,396 individuals. Individuals were connected to community support, withdrawal management, residential treatment, intensive outpatient programs, outpatient treatment, and MOUD. • Connecticut funds 'The Imani Breakthrough' project, a faith-based intervention for African American and Latino populations. This initiative combines the Yale University Program for Recovery and Community Health (PRCH) Citizenship Model and the World Health Organization's 8 Pillars of Wellness. In partnership with religious leaders, Yale trains peers to educate, outreach, and deliver a 26-week group program to church members seeking recovery, while honoring their multicultural needs. Between September 2021 and March 2022, 44 individuals were served in Latino Imani, and 32 individuals were served in Imani Breakthrough. • In partnership with the Wheeler Clinic and the Connecticut Clearinghouse, Connecticut developed an opioid targeted campaign and website that reaches a variety of audiences including the elderly, construction workers, and realtors. The "Change the Script" public awareness campaign continues to be disseminated via gas station, radio, social media, paratransit advertising, public service announcements (PSAs), and billboards (both print and digital) on major interstates across the state. The drugfreeCT.org website had 28,919 users and 61,142 views between September 2021 and March 2022.

State/Territory	Key Accomplishments
Delaware	• Delaware's Division of Substance Abuse and Mental Health (DSAMH) obtained access to the Drug Enforcement Administration registry in January 2021 and the baseline was 313 qualified practitioners. There were 434 qualified practitioners by September 2021, an approximate 38 percent increase over the baseline. By the end of March 2022, there were 483 prescribers, constituting a 54 percent increase from the baseline. • The Pre-Arrest Diversion Program launched in all three counties and the approved carryover budget has allowed additional expansion, bringing the total to six troops statewide. From launch to March 30, 2022, the program received 784 referrals. Of those, 177 accepted treatment (22.6%), and 158 (89%) were admitted into a treatment program. • DSAMH established the Community Wellbeing Initiative (CWBI) in three zip codes, and in the reporting period of September 30, 2021 to March 30, 2022, 24 Community Wellbeing Ambassadors were trained. Additionally, during this reporting period, 394 individuals were served and received screenings for SUD/OUD, referrals for supports, and naloxone training.
District of Columbia	• In the District of Columbia, seven hospitals have implemented a unified hospital-based peer program that provides recovery support services and connections to treatment in the hospital for patients who screen positive for opioid use disorder (OUD) and/or stimulant use disorder (STUD). During the reporting period of September 30,2021 to March 30, 2022, 112,165 SBIRT screenings were completed, 6,136 patients received brief interventions, and 407 patients eligible to receive MOUD were started in the hospital. • The Text to Live program has been operational on a continuous basis since FY 2021. In February and March of 2022, there were 4.792 million digital media impressions and 370 Text to Live messages received that resulted in 124 naloxone delivery requests. The new marketing campaign will be rolled out on billboards, bikeshare sites, metro liveboards, and television. • Seven Comprehensive Care Management grantees worked to identify the individuals at highest risk for a fatal overdose and/or severe OUD/STUD in the District and to facilitate their engagement in treatment, recovery, harm reduction, and other health services. During the September 30, 2021 to March 30, 2022 reporting period, 889 individuals were contacted through outreach and 125 referrals were made to behavioral health services in which there were 94 successful linkages. There have not been any documented fatal overdoses among care management clients.

State/Territory	Key Accomplishments
Florida	• Prevention Prescription opioid misuse efforts served 26,812 youth through individual-based and group programs • Oxford House, Inc. established 28 recovery houses. • Performance Based Prevention reported 2,407,704 impressions from media campaigns that are designed to prevent prescription opioid or stimulant misuse.
Georgia	• For FY 2021 a targeted media campaign, resulted in 251,139,300 impressions. These are from bus ads, billboards, theater ads, streaming television, YouTube, mobile ads, radio ads, and streaming radio. The state had great success using behavioral health segmentation targeting to zoom in on high-risk demographics. • Three new treatment programs were added. Two of these programs were in areas that did not have any free MOUD for indigent or uninsured clients within a two-hour drive of the clinic locations. • The state has been meeting with and developing an MOU with one of Georgia's two deaf schools to implement Sources of Strength.
Guam	• Guam expanded access to MOUD by funding the Young Adult Program (YAP). YAP is a treatment program for youth adults ages 18-26. Between September 30, 2020 and March 30, 2022, YAP provided MOUD to 22 individuals, and 60 participants received recovery support services, such as peer support, housing services, employment services, transportation services, and social support groups. • TOHGE PRO (Transforming Ourselves, through Healing, Growth & Enrichment – Peer Recovery Organization) trained 12 peers in the Peer Recovery Academy and hired 10 Peer Specialists to provide peer support services to the YAP. The Peer Recovery Specialists (PRS) work closely with clients to help them navigate recovery support services in the community as well as encourage and motivate them to continue their path in recovery through sharing their lived experience. PRS also provide a warmline and SBIRT services in the emergency rooms, receiving an average of 50 calls per day for recovery support services. • One hundred intranasal naloxone kits were distributed to peers who were trained in the peer recovery academy and clients in the YAP.

State/Territory	Key Accomplishments
Hawai'i	• Hawai'i expanded access to the Hawai'i's Community Addiction Resource Entry System (CARES) through implementation of telehealth projects to engage rural and hard to reach Native Hawaiian communities. • Hawai'i continued to train and disseminate naloxone to a wide variety of organizations and communities including first responders, physicians, providers, and families. Between September 30, 2021 and March 30, 2022, 5,930 naloxone kits were distributed. • The SOR-funded Health Enhancement to Reduce Opioid Use Disorder (HERO) Project aims to increase Hepatitis C Virus (HCV) testing and treatment among people who misuse opioids. Between January 2021 and March 2022 there were 686 HCV antibody tests provided, with 28 individuals starting HCV treatment and 21 individuals finishing HCV treatment. There were also 367 individuals who started MOUD.
Idaho	• The Coeur d'Alene tribe's Marimn Health has used SOR funds to provide outreach, education, and awareness on OUD to community members. Between September 2021 and March 2022, Marimn Health referred 71 individuals to MOUD and recovery support services; 199 individuals received naloxone kits and trainings; 205 MOUD/OUD educational materials were distributed; 38 medication locks boxes were distributed; 42 medication disposal bags were distributed; and 53 individuals participated in their contingency management program. • The re-entry program at the Pocatello Women's Correctional Center (PWCC) continues to serve women who are released from prison and returning to the community. PWCC re-entry program served 78 women between September 2021 and March 2022. Case managers and recovery coaches assist women with connections to resources including MOUD, housing, transportation, and other community resources and services as needed. The PWCC re-entry program has shown a 15 percent recidivism rate for women served between January 2020 and January 2022, compared to a 20 percent reduction in the average recidivism rate, and 34 percent based on the Idaho Department of Corrections recidivism rate report. • The Extensions for Community Health Outcomes (ECHO) Idaho, an educational resource designed to create dialogue among healthcare professionals conducted 28 sessions and provided 1,001 contact hours to providers on best practices, and resources for identifying and treating SUD. Additionally, MOUD Office Hours were launched to allow professionals to live stream with MOUD experts and ask questions, and present cases to specialists in the field of MOUD.

State/Territory	Key Accomplishments
Illinois	• The Access to Medication Assisted Recovery (A-MAR) Project uses a "Hub and Spoke" model, the goal of which is to have a substantial population center working with the surrounding "MAR desert" areas (no MAR providers located within their geographic boundaries). For the period September 30, 2021 through March 30, 2022, 179 clients have been admitted to MAR through these service networks. • The state is using grant funds to expand recovery home services for persons with OUD who have unstable living arrangements and are active in some form of MAR. For the period September 30, 2021 through March 30, 2022, 136 clients have been admitted to a recovery home. • The Illinois Opioid Crisis Helpline is a 24-hour, 7-day/week, 365 day/year helpline for persons with OUD-related issues. From September 30, 2021 through March 30, 2022 the helpline received 10,091 calls; 3,803 online service searches; and responded to 448 chats and 170 texts.
Indiana	• Indiana continues to use grant funds for OUD and stimulant use disorder treatment. During the reporting period of September 30, 2021 through March 30, 2022, 85 patients received evidence-based treatment and medication for the treatment of their OUD from 15 different providers. • Contingency Management (CM) training initiatives are underway with three CM/motivational incentive trainings being offered in the state. The training modules are (1) CM for adolescent substance use disorder (SUD) (56 providers have enrolled and begun training); (2) CM for adult SUD (three providers enrolled with more expected before training begins); and (3) treatment for individuals who use stimulants (two applications received so far). • Indiana continues its partnership with Purdue University's Military Family Research Institute (MFRI) to provide trainings for Star Behavioral Health Providers curriculum to licensed behavioral health professionals in Indiana, to address substance misuse, including opioids and stimulants, among military men and women in the state. During the first six months of the grant year (October 2021 through March 2022), MFRI provided trainings to 647 participants. MFRI has also increased the number of registered Star Behavioral Health Providers from Indiana on the national registry to 332 unique individuals; 129 of which provide services at a Community Mental Health Clinic.

State/Territory	Key Accomplishments
Iowa	• Iowa has seen a significant portion of new SOR2 clients with stimulant use disorder. During the September 30, 2021 to March 30,2022 reporting period, 162 individuals had a diagnosis of StimUD out of 390 total new clients. Contingency Management is being implemented by 13 of the 18 contracted agencies, serving 198 clients and many have reported that this modality is assisting in initial engagement. • The Screening, Brief Intervention and Referral to Treatment (SBIRT) program is expanding availability of screening services through the implementation of SBIRT to identify individuals at risk, especially in healthcare facilities. Despite the challenges of COVID-19 reducing the capacity of and access to some healthcare venues, across the three funded programs, there have been 22,632 pre screenings, 2,131 screenings, 484 brief interventions, and 302 referrals to treatment. Of those, 214 received formal SUD assessments and 96 agreed with the recommendations of the assessment. • Five contracted programs have improved coordination of correctional and community services for people re-entering their communities from incarceration. A total of 80 people were served by these enhanced SOR2 services, receiving care coordination, linkages to treatment, MOUD or other services needed for successful recovery and re-entry, as well as assistance with access to naloxone kits: 131 kits or vouchers were provided to clients/family/friends. Across the five service areas, the liaisons' outreach to behavioral and primary healthcare providers as well as jail and corrections staff provided 115 trainings on relevant topics, such as opioids, prescribing guidelines, MOUD, Overdose and Naloxone, etc. to 408 people.

State/Territory	Key Accomplishments
Kansas	• From September 30, 2021 to March 31, 2022, Kansas surpassed their goal of distributing 2,000 Naloxone kits, by reaching a total of 6,905; 64 trainings were held reaching 1,519 persons. The comments from Kansans receiving Naloxone through the SOR program have been tremendously positive with countless success stories shared. • SOR funds have supported treatment and prevention efforts within the Kansas tribal community, Prairie Band Potawatomie Nation reservation. The reservation healthcare clinic, the reservation pharmacy, and the reservation fire department have all participated in SOR activities. These include a culturally sensitive media campaign with brochures, treatment books, billboards, and a social media presence. Transit tickets are provided for treatment purposes and to reduce transportation barriers. Naloxone has been made available for individuals and groups through the reservation pharmacy; trainings have been facilitated through the reservation fire department. • Two Regional Alcohol and Drug Assessment Center (RADAC) sub-grantees have been providing community recovery for OUD and StimUD clients statewide (Substance Abuse Center of Kansas and Heartland). Both cover the entire state of Kansas. From September 2021 to March 31, 2022, they served 330 clients with 202 living in recovery housing, 146 receiving recovery coaching /peer support services, and 149 receiving employment support.
Kentucky	• Sources of Strength is now implemented in 119 schools (22 new, 97 ongoing). 1,771 new peer leaders and 708 new adult leaders were trained to bring 7,369 peers and 2,034 adult leaders trained. Refresher trainings were delivered to 74 schools. The Elementary Sources curriculum is beginning to be implemented in 20 schools with 59 Elementary coaches trained to train the school implementers. Despite school closures, 108 policy and procedure assessment and work plans related to substance use, mental health, stigma, help seeking, and access to resources were completed by schools. • Twenty-two Syringe Services Programs were awarded funding to expand their harm reduction services by purchasing allowable harm reductions supplies (e.g., sharps containers, alcohol swabs), hiring staff to expand operation hours, incorporating peer support, wound care, and implementing outreach campaigns. 1,257 individuals accepted referral to treatment, 4,377 clients received peer support services, 65 educational events were attended by 1,496 individuals, and 117,135 brochures and educational materials were distributed. • NorthKey, a community mental health center in northern Kentucky, has integrated MOUD into their services. They established an office-based opioid treatment hub and spoke model, provided MOUD alongside intensive outpatient, group therapy, individual therapy, case management, peer, and other supportive services. For those referred 21 clients (62%) were scheduled with MOUD prescribers for initial psychiatric and primary care assessments. Of those scheduled, 17 clients (81%) engaged in ongoing services and 11 clients (52%) continued with NorthKey prescribers for MOUD.

State/Territory	Key Accomplishments
Louisiana	• Through agreements with Acadiana Area Human Services District, the Woman's Foundation hosted webinars and provided resources for healthcare professionals and the public on opioid use, MOUD, stigma, stimulant use, and non-drug alternatives to pain management. Through these sessions, 618 persons received education and resources. • In collaboration with the Office of Public Health (OPH) Louisiana Perinatal Quality Collaborative (LaPQC), the Improving Care for the Substance-Exposed Dyad (ICSED) initiative was implemented. This is a limited statewide project focused on improving care for those giving birth, parenting persons, and newborns affected by substance use to improve infant health outcomes. During the reporting period, LaPQC recruited 13 hospitals to participate in the initiative, exceeding the goal of five (5). • Louisiana's Department of Corrections (DOC) provided treatment services to 267 individuals during October 2021 and March 2022.
Maine	• Maine continues to use SOR funding to provide MOUD services to uninsured incarcerated individuals diagnosed with an OUD. Services include medications (i.e., buprenorphine and methadone), drug screen testing, behavioral health therapy, and Narcan training and kits. Three hundred and eleven incarcerated individuals (i.e., 305 individuals received buprenorphine, and 6 individuals received methadone) received MOUD treatment services between September 2021 and March 2022. • SOR continues to fund recovery coaches placed in eight Maine emergency departments that offer rapid MOUD induction to overdose survivors. Between October 2021 and March 2022, 177 individuals were referred for recovery coaching in the emergency department. Of the 177 individuals, 77 individuals accepted/engaged in recovery coaching services. • Maine launched the "Bottled Up" campaign to reduce the use of stimulants among youth between the ages of 13 and 25 years old. Since the campaign was launched in December 2021, there have been 596,000 video views and 1.1 million impressions on YouTube; 1.7 million impressions, 7,000 clicks, and 86,000 Mainers reached through Facebook and Instagram; 1.7 million impressions, and 14,200 clicks via TikTok; and 5,057 website visits.

State/Territory	Key Accomplishments
Maryland	• Crisis walk-in programs have launched and are fully operational. Since the start of SOR II, 4,637 unduplicated individuals were served. From the first six months of SOR II, year two, 1,201 individuals were enrolled, 687 received MOUD, and 1,580 received care coordination. There were 6,003 peer encounters and 899 referrals to residential services. • The Medication-Assisted Treatment (MAT) Re-Entry initiative now allows detention centers across Maryland to understand the risks associated with release from jails and prisons, and re-entry into the community. Since the start of SOR II, MAT Re-Entry programs have enrolled 478 unduplicated individuals. In the first six months of SOR II, year 2, 223 individuals have been enrolled, 207 started receiving MOUD, 287 received care coordination, and 337 individuals received 494 peer encounters. • The Overdose Response Programs report distributing 77,471 doses of naloxone from October 2021 to March 2022, a 44.1percent increase from the same timeframe the prior year (53,751). Additionally, 35,078 individuals received overdose response training or had been trained prior and received refill doses.
Massachusetts	• Massachusetts continues to fund the Access to Recovery (ATR) program, an electronic voucher program that provides vocational training and recovery coaching. One thousand nine hundred and twenty individuals were enrolled in the program between September 30, 2021 and March 30, 2022. Of these individuals, 200 participated in the ATR sober housing support program, and 727 participants attended job training programs (i.e., HVAC/Refrigeration certification, Financial Literacy, Customer Services and Computer Applications, C-Tech certification, and CNC Machining certification). • In collaboration with 29 Opioid Treatment Programs and/or Office-based Opioid Treatment programs, Massachusetts has increased access to treatment and enhanced services to reach and engage underserved or hard to reach populations. Between September 30, 2021 and March 30, 2022, 712 individuals were enrolled. • Massachusetts continues to expand and enhance its overdose prevention education, naloxone distribution and other evidence-based harm reduction services for individuals who use opioids and/or stimulants. Between September 30, 2021 and March 30, 2022, 8,767 individuals received overdose education and naloxone distribution (OEND) services.

State/Territory	Key Accomplishments
Michigan	• For the period of September 30, 2021 to March 30, 2022, the state's Pre-Paid Inpatient Health Plan (PIHP) regions supported 543 naloxone trainings. A total of 5,702 individuals were trained which included individuals in treatment, persons with an Opioid Use Disorder (OUD), law enforcement, restaurant workers, community members, students, inmates, and public-school personnel. The PIHP regions reported distributing 6,020 naloxone kits; 712 were reported used resulting in 530 saves. Additionally, 8,173 fentanyl test strips were distributed during this period. • PIHP regions continue to support the cost of treatment services for uninsured or underinsured individuals. During the first half of Project Year two, September 30, 2021 to March 30, 2022, 1,810 clients received treatment services for OUD and Stimulant Use Disorder. During the same period, 2,544 individuals were served with MOUD, case management, transportation services, cognitive behavioral therapy, motivational interviewing, and web-based treatment services. • The PIHP regions continue to support the cost of overnight recovery home stays for opioid and stimulant using individuals. From the beginning of Project Year 2 of SOR II, 717 individuals received funding for recovery housing.
Micronesia	• Micronesia continues to sustain collaboration with the State Hospital, providing brief but thorough introduction to opioids when an individual receives an opioid prescription. • Micronesia conducted school-based education campaigns on substance use and mental health. Topics included information on tobacco, alcohol, and opioids, as well as introducing students to the availability of community-based services. There have been more than 3,000 individuals reached. • Micronesia conducted 45 prevention activities engaging 2,314 individuals, aiming to reduce perceived acceptability of opioid use and other drug use among youth and the adult population. These activities included education and information dissemination in community-based settings.

State/Territory	Key Accomplishments
Minnesota	• Know the Dangers, the Department of Human Services funded opioid awareness site (https://knowthedangers.com/), has reached over 78,000 visitors over this reporting period. The website has a resource page with fact sheets, a social media toolkit, videos, news stories, the state opioid plan, and treatment and naloxone locators. Know the Dangers added culturally responsive campaigns focused on American Indians and African Americans and were created and produced with the communities they seek to reach. Additionally, a social media generated a reach of more than 3.3 million, with 40,944 individuals engaging (ex. Likes, shares, etc.) and 21,114 visiting the website as a result. A significant success continues to be the addition of the Naloxone locator map which is an interactive online tool enabling those in need of finding locations nearby that offer Naloxone. • Minnesota's Fast Tracker is a real-time, searchable directory of mental health and substance use disorder resources and their availability. During the reporting period of September 30, 2021 through March 30, 2022, the site had 33,171 users, 46,065 sessions, and 123,929 views. • During the period of September 30, 2021 through March 30, 2022, nicotine replacement therapy support was provided to 1,800 clients receiving MOUD. Additionally, training was provided on the impacts of commercial tobacco use to opioid use disorder clients in collaboration with the Lung Mind Alliance, Minnesotans for Smoke Free Generations, Clearway, and the SOR grant manager for nicotine use disorder.
Mississippi	• In FY 2021, Mississippi's Department of Mental Health purchased 14,600 doses of naloxone and distributed all but 573 doses, with 85 different agencies and departments throughout the state receiving naloxone. • The Stand Up, Mississippi website continues to serve as a valuable resource for Mississippians who are looking for opioid and stimulant prevention and treatment services. In FY 2021, the website had 27,586 page views with the Treatment Locator being the most visited portion of the website after the homepage. • Mississippi sub grantees' provided evidence-based treatment access for at least 2,000 residents annually and more than 4,000 individual residents over the life the of the project.

State/Territory	Key Accomplishments
Missouri	• From September 30, 2021 to March 30, 2022, 301 peers completed the Certified Peer Specialist training. This training has continued to be delivered virtually, allowing for more individuals to participate. This has allowed for the expansion of Missouri's peer workforce, resulting in about 1,167 active Certified Peer Specialists through March 31, 2022. • The u-MATr SOR-funded phone application, developed by Washington University, has been expanded to reach any individual living with OUD and/or StimUD. The application is being used in 20 different sites around the state with 501 unduplicated participants, 109 being newly enrolled from September 30, 2021 to March 30, 2022. Additionally, during this period, 249 individuals logged in and used the phone application. • Recovery Housing is provided for individuals with OUD who have gone through withdrawal management but need a safe, healthy environment to support engagement in treatment, including MOUD. As of March 30, 2022, there were 1,619 total recovery housing beds accredited statewide (1,010 for men and 609 for women). Additionally, Missouri Coalition of Recovery Support Providers (MCRSP) continues to provide accreditation for recovery housing providers to ensure they meet national accreditation standards. During this period, MCRSP accredited 18 new recovery houses.
Montana	• In response to an increase in opioid related overdoses on Montana's American Indian Reservations, a formal process was established for Tribes to access SOR funded naloxone for free. The DPHHS Director and Tribal Relations Manager sent letters to tribal councilmen to encourage participation. During FY22, Rocky Boy's, Fort Belknap, the Little Shell Chippewa Tribe, and Confederated Salish Kootenai Tribes have all placed orders through this process. • The inclusion of support for evidence-based treatment and recovery support services to address stimulant misuse and use disorders in the SOR II award is as an important opportunity for Montana to improve access to care for this population. During this reporting period, 92 individuals have initiated the TRUST/ Contingency Management (CM) treatment program. All TRUST/CM providers received training on the administration of GPRA intake, follow-up, and discharge forms to support standardized data collection. In addition to GPRA measures, all sites are collecting data on client outcomes and engagement with TRUST program elements, as well as tracking vouchers. • Between September 30, 2021 and March 30, 2022, Montana provided funding to five providers for the provision of MOUD: Providence – St. Joseph's, Bullhook Community Health Center, One Health, Helena Indian Alliance, and Southwest Montana Community Health Center. These sites are all very stable in their staffing and provision of services with grant dollars, as they have each participated in the grant program for more than three years.

State/Territory	Key Accomplishments
Nebraska	• Nebraska Pharmacists Association (NPA) – Division of Behavioral Health (DBH) funds the permanent disposal boxes at local pharmacies with 296 pharmacies currently participating in drug collection. The pharmacies collected 13,120 pounds of controlled and non-controlled medications between October 2021 and March 2022. • SOR DBH partners with the Nebraska Medical Association (NMA) to coordinate training for treatment of OUD and stimulant use disorder to increase the workforce capacity and enhance behavioral healthcare services. This partnership provides expert consultation support to newly waivered providers on MOUD initiation. As of March 2022, 97 providers are confirmed MOUD prescribers, 127 have completed DATA Waiver training, and 144 participated in MAT 101. • SOR funds support three outreach workers to aid in connecting the OUD population in Oxford House recovery homes across the state. Through the efforts of the three outreach workers funded, 384 individuals have participated in presentations on Oxford Recovery homes from October 2021 to March 2022.
Nevada	• Nevada funds vending machines that distribute naloxone to registered clients in Las Vegas and has been able to place one in the rural community of Hawthorne, NV. Due to the increasing popularity of the vending machines, the state will be placing six new vending machines in a variety of rural and urban locations. • The state increased access to OUD treatment by expanding the number of grant-funded treatment providers. This resulted in 309 individuals receiving withdrawal management, 924 individuals receiving outpatient treatment, and 115 individuals receiving residential treatment during a 12-month period. Positive outcomes were shown in six-month follow-up assessments associated with housing stability, employment/education, and abstinence from illicit substances. • Between September 30, 2021 and March 30, 2022, Nevada distributed 2,600 fentanyl test strips (FTS) through eight distribution sites. Community organizations are also providing training on harm reduction, naloxone, and MAT 101.

State/Territory	Key Accomplishments
New Hampshire	• New Hampshire continues to fund their Doorways System, an access point for SUD services. Through the Doorways, 5,600 individuals were served, 1,853 referrals to treatment were made, 1,624 respite bed nights were provided to more than 600 individuals, and approximately 3,600 calls were referred by 2-1-1 NH to the Doorways between September 30, 2021 and March 30, 2022. • New Hampshire's Recovery Community Organizations (RCOs) provided recovery services to 526 participants: including 291 peer coaching sessions, and 110 Parenting Journey in Recovery sessions between September 30, 2021 and March 30, 2022. SOR funds were used to expand availability of evidence-based prevention strategies for children exposed to adverse childhood experiences because of opioid and/or stimulant misuse. • Adverse Childhood Experiences (ACEs) crisis response teams consist of crisis advocates and police officers providing behavioral therapies, recovery coaching, crisis interventions, peer support groups, and support during court proceedings. Between September 30, 2021 and March 30, 2022, the crisis teams assisted 30 children, including five children under the age of 10.
New Jersey	• The Department of Human Services, Division of Mental Health and Addiction Services (DMHAS), Department of Corrections (DOC) and the Department of Health (DOH) have jointly initiated a program to expand the use of MOUD for inmates with OUD in all but one of New Jersey County jails. The medications prescribed include methadone, buprenorphine, and naltrexone. SOR resources supported the MOUD in four of the State's County jails. One thousand four hundred thirty-two (1,432) inmates received treatment services for OUD and stimulant use disorder during this activity period. Of those individuals, 251 received methadone; 1,063 received buprenorphine; and 58 received injectable naltrexone. Additionally, 245 inmates received recovery support services through the Case Management and peer program. • Oxford House, Inc. (OHI), funded by NJ SOR grant funds recruited, hired, and trained six (6) Oxford House Outreach staff. Outreach workers opened eight (8) new Oxford Houses, providing an additional 63 beds with guidance from OHI Regional Manager, and other senior staff. These Oxford Houses in New Jersey served 73 individuals and sustained an average monthly sobriety rate of 95 percent. • From September 30, 2021 through March 31, 2022, 2,069 unduplicated individuals received peer recovery support services from 10 Community Peer Recovery Centers in New Jersey. CPRCs are a place in the community where individuals can access peer support, information about substance use disorder and MOUD, recovery support services, and information about other community resources in a supportive substance free environment. Most activities and services are held virtually or in-person and are led and driven by peers (i.e., individuals who have experienced substance use disorders and recovery, either directly or indirectly).

State/Territory	Key Accomplishments
New Mexico	• The Lieving Group, LLC continued and expanded activities which included: ongoing local, regional, and statewide capacity building, training of trainers, trainings on the science of fentanyl and its presence in the street drug market, youth and family focused overdose prevention and response trainings, ongoing technical assistance to trained agencies, and the statewide distribution of Narcan Nasal Spray (NNS). During October 2021 and March 2022, The Lieving Group provided training to 1,634 persons and distributed 2,298 nasal naloxone kits. • From October 2021 to March 2022, there were 109 overdose reversals, 6,281 persons trained in Overdose and Narcan Distribution (OEND), and 6,446 Narcan kits distributed. • Sage Neuroscience continues to do outreach and establish connections with rural communities in New Mexico with no or limited MOUD services to provide these to these communities/clients. Sage can do the bulk of this over telemedicine.
New York	• The Office of Addiction Services and Support (OASAS) regional networks have been providing services to at least one underserved community, including those that are homeless or at risk for homelessness, are/have been justice involved, may be pregnant or post-partum, are veterans, or those who identify as LGBTQ+, or are a person of color. Additionally, networks are partnering with other programs (Recovery Community Centers, Health Hubs), providers, and entities (criminal justice facilities, emergency rooms, courts) to establish strong linkages between programs across the spectrum of substance use disorder services, including prevention, harm reduction, treatment, and recovery. • Recovery Community Centers - Fifteen recovery community centers provided recovery/peer support or peer support group services to 4,340 individuals. • New York State (NYS) Department of Health AIDS Institute (AI) Health Hubs - Twelve Health Hubs referred 176 individuals to the OASAS chemical dependence services system providing: ongoing medical, mental health, prevention counseling, and care management to 1,850 individuals. The Hubs also provided buprenorphine induction, prescription, and medical follow up and medication/treatment adherence, and relapse prevention counseling services to 897 individuals.

State/Territory	Key Accomplishments
North Carolina	• Utilizing the Department of Social Services Intensive Family Preservation Services Pilot model, Coastal Horizons Center served 27 families and no children were placed in foster care. This 100 percent rate also applies to the North Carolina Family Assessment Scale, with 100 percent of the families engaged showing improvement in family function • A Peer Support Specialist program was developed to support persons in underserved populations who are transitioning from detention or treatment facilities and enlists the aid of peer support, pastoral ministries, municipal/community organizations, and other agencies/providers who support and assist persons who suffer from OUD. SOR funded the Young Men's Institute Cultural Center which is one of the oldest Black cultural centers in the United States and broadens the reach and increases access to recovery supports. • Cherokee Indian Hospital Authority (CIHA) hired a MOUD Manager to develop an outpatient Methadone treatment program that incorporates daily dosing and uses the clinical programming model for OTP programming and medication administration within the hospital setting. This allows the hospital to use Methadone as an additional option to the CIHA providers and community. By filling this position, they have been able to expand the OTP by adding an additional day of service so that they can administer medication six days per week. A newly hired Grant Coordinator oversees the grant activities allowing for smoother operational functioning. There are currently 141 patients enrolled in the hospital based MOUD clinic and 35 enrolled in the community OTP program (176 total). This is a 27.5 percent increase since the beginning of the grant.
North Dakota	• The North Dakota Department of Human Services' Behavioral Health Division entered a contract with the ND Department of Corrections and Rehabilitation (DOCR) to continue efforts to purchase FDA-approved MOUD to support residents of DOCR who suffer from moderate and severe OUD, especially prior to release. • The ONE program is an innovative approach to screen and educate patients who receive prescribed opioid medications at participating community pharmacies in the state of North Dakota. Addressing opioid use prior to misuse is a cornerstone to help communities. In addition, through patient screening, pharmacists can complete a thorough assessment if a patient is more likely to experience an accidental overdose, even if taking the medication as prescribed. • Because of the rural nature of the state, access to medication take back locations is not always feasible to dispose of unwanted/unneeded medication. Therefore, the state has purchased and distributed the Deterra® Drug Deactivation bags to entities throughout the state to distribute to individuals who do not have access to a medication take back location. There have been 1,344 Deterra bags distributed by community grantees.

State/Territory	Key Accomplishments
Northern Marianas (CNMI)	• The CNMI SOR Recovery Clinic continued to provide services to clients, with 86 individuals receiving intake and assessment, group therapy sessions such as relapse prevention, early recovery skills, social support, and family education through implementation of the Matrix Model. • With adjusting to COVID-19 protocols, policies and procedures, the Peer-Recovery Support Group has been very active in reaching out to the community to help individuals seek treatment. They have formed a non-profit organization and have organized themselves to be an active participant in all community recovery efforts. • As part of National Prevention month, the Substance Abuse Prevention Services Unit facilitated a "Substance Use Disorder" presentation to the Public-School Systems Da'ok Academy. The presentation covered the harmful effects of underage drinking, marijuana, methamphetamine, and prescription medication/opioids. Other topics covered were safety tips on monitoring, securing, and the proper disposal of prescription medication/opioids to prevent a drug overdose. There were 28 participants across two days.
Ohio	• From September 30, 2021 through March 30, 2022, 983 individuals were served through projects with certified behavioral health organizations and recovery houses. Combined, these resources offer services at OTPs, quick response, housing, transportation, peer support, outreach, overdose follow-up, and residential and outpatient treatment. • Through one of its outreach campaigns, the state reported an organization produced 38 new videos of people in recovery, their family members, and allies. That same organization reported 41,616 impressions on YouTube related to the social media outreach campaigns to reduce stigma, 1,015 total views, and 1,285 hours of content watched. The Facebook outreach page has reached 2,442 people with 1,845 likes and 2,416 initial engagement posts. This year, the project has engaged a younger audience through TikTok outreach. This new campaign has 1,352 followers and 4,971 likes so far. • During the period of September 30, 2021 through March 30, 2022, Ohio reported there were 2,811 known overdose reversals as part of the state's grant funded activities to increase the availability of naloxone to prevent overdose deaths.

State/Territory	Key Accomplishments
Oklahoma	• The Substance Use Treatment and Recovery Prenatal clinic provides prenatal services for individuals with substance use disorder specifically opioid and stimulant use disorders, as well as some postnatal care, substance use and co-occurring treatment, and case management. During the reporting period of September 30, 2021 through March 30, 2022, the project exceeded its enrollment goals including for adults (75 enrolled with an enrollment goal of 60) and children (38 enrolled with an enrollment goal of 20). • From September 30, 2021 to December 31, 2021, there were 21 Project ECHO clinics held with 475 total attendees and 133 participating organizations. • The Oxford House, Inc. regional manager and outreach staff in Oklahoma worked to combat the opioid and stimulant epidemic crisis within the existing network of Oxford Houses and throughout the statewide community. During the six-month period from October 2021 through the end of March 2022, 380 members were prescribed MOUD.
Oregon	• The Confederated Tribes of Grand Ronde launched Oregon's first Tribal Opioid Treatment Program OTP) and has provided services to 232 patients between spring of 2021 and the end of March 2022. • Oregon continues prevention efforts which includes 16,064 Naloxone kits purchased of which 6,671 kits were distributed leading to 1,127 overdose reversals reported from October 2021 to March 2022. • From September 30, 2020, to March 30, 2021, there were 393 unduplicated clients who received recovery support services, of which: 80 clients received supportive housing; 322 clients received recovery/peer coaching and 81 clients received employment support.

State/Territory	Key Accomplishments
Pennsylvania	• The Department of Military and Veterans Affairs (DMVA) awarded sub-grants to 11 non-profit organizations serving 44 counties across the Commonwealth to support a variety of existing and new programs tailored to the unique needs of veterans with Opioid and Stimulant Use. During the September 30, 2021 to March 30, 2022 reporting period, accomplishments of the 11 sub-grantees offering Veteran Services include: 79 percent of program participants reported a reduction in substance use, 83 percent of program participants reported an improvement in quality of life, and 38 percent of program participants remained in programming for six months or more. • During the project period of September 30, 2020 to September 29, 2021, Pennsylvania became the fourth state to receive the Vermont Oxford Network's (VON) designation entitled "State of Excellence in Education and Training for Infants and Families Affected by Neonatal Abstinence Syndrome." The award recognizes that at least 85 percent of multidisciplinary care teams participating in the "Neonatal Abstinence Syndrome Collaborative: Improving Care to Improve Outcomes" completed universal training for care of Neonatal Abstinence Syndrome through the Pennsylvania Perinatal Quality Collaborative. • The Department of Corrections (DOC) continued to expand access to MOUD across the State Correctional Institutions (SCIs) by offering both oral and injectable naltrexone and buprenorphine across the SCIs. The Department of Drug and Alcohol Programs, DOC, and all 47 Single Count Authorities worked together to create a discharge and referral process which ensures all inmates started on MOUD during incarceration will continue medications upon their release. The social workers across the DOC system continue to work diligently to make sure each reentrant has services in place before the day of release. This includes housing, Medicaid, therapy, an MOUD prescriber, and a plan to get to the new community provider (bus route, walking directions, provider has van service pick up). Accomplishments achieved by the DOC include: 1,037 individuals were started on an FDA approved form of MOUD, 1,451 individuals were maintained on MOUD while incarcerated, and 1,339 individuals participated in case management and received referrals to treatment while receiving MOUD.

State/Territory	Key Accomplishments
Puerto Rico	• There were 793 overdose reversals reported between September 30, 2020, and March 30, 2022. • SOR treatment providers provided services to 773 individuals. A total of 128 pre-tests of a recovery scale that measures the mood of the participants in the constructs of hope, personal responsibility, self-management, education, and support, showed an average general score of 4.2, out of a maximum of 5 points, which represents full social adaptation. • Between September 30, 2020, and September 29, 2021, there was an increase in Prescription Drug Monitory (PDMP) accounts to serve as a decision-making tool for at least 602 physicians; this represents a 120 percent annual and 60.2 percent cumulative increase.
Rhode Island	• In coordination with the Rhode Island Department of Health, three media campaigns ran statewide during September 30, 2021 to March 30, 2022. The Small Amount – Fentanyl Public Awareness (Contaminated Drugs) campaign had 2,490,311 impressions, with 22,332 clicks, and 750 broadcast spots; Three Words Make a Difference (Anti-Bias) campaign had 2,266,420 impressions, with 11,164 clicks; and Substance Exposed Newborns campaign had 1,809,838 impressions, with 4,047 clicks. • SOR funds were used for Rhode Island's Recovery Friendly Workplace program, that recruits and provide employers training and strategies to create safe and productive working environments for individuals in recovery. Twenty-three employers representing a total workforce of 5,838 employees were designated as a Recovery Friendly Workplace. Of these employees, 4,807 received prevention, treatment, and recovery support services, 92 received Narcan kits, and 107 attended virtual education classes. Additionally, 19 individuals in long-term recovery obtained gainful employment, and 39 persons in positions of leadership received training on how to create a recovery friendly workplace. • Rhode Island continues to fund recovery housing for individuals with an opioid use disorder and stimulant use disorder. Between September 30, 2021 and March 30, 2022, 315 clients were placed into recovery housing.

State/Territory	Key Accomplishments
South Carolina	• Media efforts began on May 13, 2021, on Facebook, Instagram, Twitter, broadcast and cable television, and over-the-top media. During the first week of the campaign, the videos were viewed over 98,800 times. Paid social ads accounted for the most clicks to the website and over 22,000 engagements. 77 percent of all users who began watching the "Embrace Recovery SC" videos viewed them to completion. To view the PSA and other content developed for the campaign, please visit the website at https://embracerecoverysc.com/. • In May 2021, SAMHSA notified all SOR grantees that the use of SOR funds for the purchase and distribution of fentanyl test strips (FTS) was an allowable activity. South Carolina immediately developed a program that braided FTS distribution with their successful naloxone distribution program. The agency created program guidance documents, education materials on FTS use and interpretation, as well as a training webinar that covered the requirements of the program to ensure compliance with SAMHSA standards and requirements. Since the beginning of the program in May 2021, 34 organizations have contracted with South Carolina to provide FTS in conjunction with the Naloxone programs throughout the state. As of September 29, 2021, 29,036 FTS had been purchased by subgrantees, and 4,371 had been distributed. • South Carolina has a Memorandum of Agreement with the S.C. Department of Corrections (SCDC) to provide funding and services to SCDC through the SOR grant. The funds were used by SCDC to provide treatment transition and coverage for opioid use disorder patients who are re-entering communities from criminal justice settings during the past grant cycle. Additionally, the project provided peer support services to assist with a seamless transition from the state prison system to the community. The project provided inmates with resources to support their recovery efforts in combination with substance use counseling. There have been 130 inmates referred for injectable naltrexone. Of these 130, 65 were enrolled in an injectable naltrexone-focused program, 20 received Cognitive Behavioral Therapy/Certified Peer Support Specialist (CPSS) sessions for stimulant use disorders, and the remaining 45 inmates were linked with CPSS individual support sessions. Thirty-two have received their first extended-release naltrexone injection and were referred to county alcohol and drug authority sites upon release from SCDC. Of these 32, nine have received their second injection. Thirty were employed and 25 were referred to Oxford House to coordinate living arrangements.

State/Territory	Key Accomplishments
South Dakota	• In partnership with the South Dakota GoodHealthTV units in clinics/health centers and tribal schools, South Dakota disseminated culturally responsive prevention campaign materials targeted to American Indians in 29 unique locations across South Dakota. In March 2022, the videos were aired approximately 8,500 times with an estimated 205,000 impressions made, trends which are similar across prior months during the reporting timeframe. Airtime will continue through May 2022. • South Dakota provided treatment cost assistance for MOUD services to 688 unduplicated individuals from October 2021 to March 2022 representing 68 percent of the annual target. South Dakota integrated peer recovery support services for 529 of the 688 individuals that also received treatment cost assistance as part of their care. • South Dakota provided intensive case management services to 39 pregnant or postpartum women in partnership with Bethany Christian Services' ReNEW Program. The ReNEW Program had its first South Dakota graduate in March 2022, a woman who has maintained employment, continues to successfully parent her children without the involvement of CPS, and has maintained sobriety since she began the program. • A total of seven Oxford Homes are established as of the end of this reporting period; the original goal was to establish two new homes each year for a total of four by the end of the grant. Funds are being leveraged to expand into an eighth home within South Dakota in the second half of Year 2, with additional homes being planned through other funding streams based on the successes of SOR-initiated work.
Tennessee	• During the period of September 30, 2020 to September 29, 2021 there were 13,947 overdose reversals reported for naloxone distributed by the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS). • Through SOR II, five new Spoke agencies were added to the current SOR Hub/Spoke system. Three of these providers serve those in rural areas so this has broadened the reach of the SOR HUB and spoke system. That brought the total number of providers that will be implementing the SOR II hub/spoke system to 30. The addition of these new spoke agencies has assisted to further expand access to MOUD, other treatment and recovery services. • Vanderbilt University Medical Center began the Emergency Department Buprenorphine Induction Pilot Program. They provided 26 buprenorphine inductions from July through September 2021. Two social workers were hired to work closely with the nurses and psychiatrists in the emergency department.

State/Territory	Key Accomplishments
Texas	• The state's integrated Opioid Drop-In Centers include walk-in clinics for individuals seeking treatment and locations serving those apprehended by law enforcement. They provide a variety of services, such as primary care, induction onto Buprenorphine, and recovery support services, before referring patients to long-term substance use treatment. In FY22, the drop-in Centers served 4,373 people, referred 71 people to MOUD, provided recovery support services (RSS) to 1,035 participants, and distributed 6,657 naloxone kits. • Through Emergency Medical Services (EMS) Expansion, individuals who have survived an overdose receive a visit 1-3 days post-event from a team, usually a trained first responder (e.g., paramedic) and peer specialist, who offer overdose prevention training and materials, access to treatment and recovery services, and induction onto buprenorphine. The EMS program started in four pilot cities and then expanded in number to 11 locations. In FY22, these sites responded to 839 overdoses, served 991 people, inducted 224 people onto buprenorphine, provided RSS to 447 people, and distributed 925 naloxone kits. • The Texas Opioid Training Initiative continued to provide continuing education to prescribers, pharmacists, and social workers aimed at reducing opioid prescribing and increasing access to naloxone and MOUD. From September 30, 2021 through March 30, 2022, 4,269 people were trained, exceeding the performance measure target.
Utah	• The State of Utah Naloxone program introduced a leave on scene program, a partnership between the Lehi, Mantua, Syracuse fire department and the Lehi police department. The existing program partnerships with four agencies continue to be restocked and supported. Utah Naloxone continued to provide refresher training and Naloxone kits for distribution through multiple county and city libraries in Utah. They have conducted meetings with new libraries, in smaller rural areas of Utah, to ensure there is readiness and support for the librarians to provide and distribute Naloxone to community members who request it. • Syringe Service Programs (SSPs) have increased to nine separate programs that serve 15 areas throughout the state. The providers have been able to distribute 4,187 personal sharps containers. SSPs have provided services, education, and referrals for multiple services to 1,839 individual participants throughout from September 30, 2021 through March 30, 2022. SSPs have agreements with 15 substance use treatment providers for referrals and to support a warm hand off. • The Substance Use Substance Use and Pregnancy- Recovery, Addiction and Dependence (SUPeRAD) team developed a curriculum that offers numerous training sessions with agencies that may encounter pregnant or childbearing aged women with substance use disorders. All presentations can be offered for individuals in the community, local/tribal/state/federal agencies, as well as healthcare staff/employees. During the reporting period there were 46 total participants and findings from the pre- and pos-t survey indicate that 90.9 percent of participants either improved understanding on the topic or it remained the same.

State/Territory	Key Accomplishments
Vermont	• Vermont's Cultural Brokers' program continues to provide integrated prevention, education, and early intervention to new Americans with and at-risk for developing SUD. Six cultural brokers represent the immigrant and refugee communities (e.g., Somali, Somali-Bantu, Congolese, Bhutanese/Nepali), and provide effective liaisons with schools, clinics, community agencies, medical providers, mental health agencies, Juvenile Justice, and Law Enforcement. Additionally, the program provides educational opportunities and information on available SUD community resources. Three hundred and seventy-two individuals (i.e., 36 percent Central African/Congolese, 27 percent Nepali/Bhutanese, 24 percent Somali/Somali Bantu and 13 percent Arabic) were screened for substance use in quarter one (i.e., October 2021 to December 2021). During the same quarter, South Burlington and Colchester Police Department conducted two training and awareness sessions. The first session was on Mental Health Crisis Response, and the second session was on substance use, types of drugs, and impact on youth and young adults. • The Vermont Helplink (Substance Use Disorder Centralized Intake and Resource Center) continues to provide individuals a single point of contact for seeking information and support for substance use treatment services. In 2021, Vermont Helplink received 1,982 calls, 837 referral calls, 295 informational calls, 59,553 website visits, 1,558 direct searches, and conducted 368 web chats. Of the 837 referred calls received, 24.6 percent were referred to SUD outpatient services, 25.8 percent were referred to SUD residential services, 17.8 percent were referred to harm reduction services (i.e., syringe services programs and naloxone), 12.8 percent were referred to MOUD, and 10.3 percent were referred to recovery support services. • In partnership with the Lamoille County Sheriff's Department, Vermont's Drug Disposal Program continues to collect medications dropped off at Sheriff's Department, and secure storage of medications for the annual DEA Take Back Day. Between December 2021 and March 2022, 2,979,261 pounds of medication were collected.

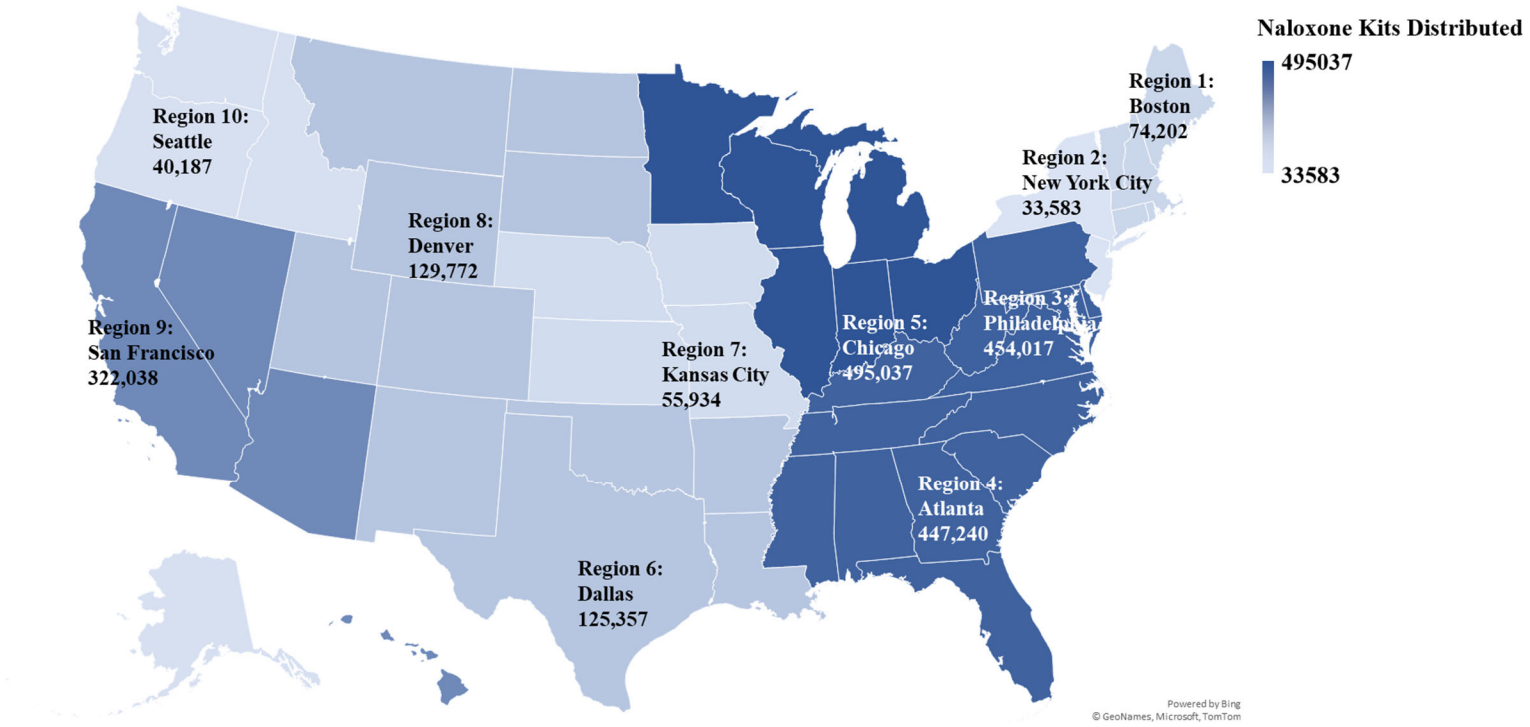
State/Territory	Key Accomplishments
Virginia	• Virginia Commonwealth University's Rams in Recovery Collegiate Recovery Program (CRP) provided 455 hours of support and technical assistance to eight other Virginia universities to expand their programs for students in recovery. CRPs also provided 1,054 individual recovery support sessions, 883 recovery meetings, 109 campus events, and 179 community events during the September 30, 2020 through September 29, 2021 reporting period. • Virginia subgrantees trained 6,117 community members in REVIVE! (Performance Based Prevention System), Virginia's opioid overdose and naloxone training. A total of 12,279 SOR-funded naloxone kits have been distributed during the September 30, 2020 through September 29, 2021 reporting period. • In Virginia, prevention strategies were implemented to reduce access to opioids in communities through proper disposal and storage methods. The following were distributed during the September 30, 2021 to March 30, 2022 reporting period: 8,400 drug deactivation packets, 4,168 lockboxes, and 1,812 smart pill bottles. During this time, more than 26,000 stickers were also distributed for pharmacies to place on prescription bags detailing safe storage and disposal practices. Additionally, one Community Service Board was able to partner with a local pharmacy to ensure that drug deactivation packets were distributed with every opioid prescription filled at that location.
Virgin Islands	• USVI distributed 169 naloxone kits while conducting training on how to use naloxone and signs to look for in an overdose. • USVI provided methadone treatment to 12 individuals and assisted with obtaining housing, education, social service needs, support groups and access to treatment. • Between September 30, 2020, and September 29, 2021, USVI conducted 5 virtual educational prevention outreach events on topics such as opioid/substance misuse to the community reaching 204 participants between the ages of 13-52 years. • SOR-funded radio campaigns aired on three different stations providing information on available services and educational information.

State/Territory	Key Accomplishments
Washington	• SOR II funds contributed to the University of WA weekly TelePain programs, which provide access to a multidisciplinary panel of experts who provide didactic teaching and case consultation to primary care providers to reduce overdose-related deaths by improving the knowledge and prescribing practices of primary care providers. During the period of September 30, 2021 to March 30, 2022, there were 572 attendees which included: 300 Medical Doctors (MD), 36 Doctors of Osteopathic Medicine (DO), 30 Physician Assistants (PA) 24 Doctors of Pharmacy (PharmD), and 35 Nurse Practitioners (NP). • Through the "Hub and Spoke" model, Washington expanded statewide access to MOUD, behavioral health treatment and/or primary healthcare services, wraparound services, and referrals. As of March 2022, 2,858 unique individuals were inducted onto MOUD. Of those individuals, 360 clients received methadone, 2,311 received buprenorphine, and 112 received injectable naltrexone. • In October 2021, Washington's Rx Take Back Program collected over 9,000 lbs. of medication.
West Virginia	• Twelve Peer Recovery Support grants were implemented to aid in MOUD treatment service retention and link individuals in recovery to support services including medical care, housing, employment, and mental health care. There were 78 Peer Recovery Support Specialists (PRSS) who provided services under 12 grants. Between September 30, 2020 and September 29, 2021, 606 clients received peer recovery support services. • Grant funds were used to implement Contingency Management (CM), an evidence-based treatment for Stimulant Use Disorder. Grant funds were made available to incentivize treatment compliance with a maximum contingency value being $15 per contingency and $75 per person per year. For the funding period of September 30, 2020 through September 29, 2021, 149 clients received treatment. • Quick Response Teams (QRTs) identify individuals who have overdosed and promptly engage them in treatment. QRTs are composed of first responders, substance use treatment/recovery providers, law enforcement, and/or faith-based organizations. The QRTs initiate contact with an individual 24-72 hours after being revived from an overdose. The QRTs' goal is to reduce the incidence of repeat overdoses and overdose fatalities. A total of 610 referrals were received by the QRTs for the September 30, 2020 through September 29, 2021 funding period.

State/Territory	Key Accomplishments
Wisconsin	• During the period of September 30, 2021 through March 30, 2022, 20,116 two-dose naloxone kits were purchased and 13,233 two-dose naloxone kits were distributed. Additionally, the NARCAN® Direct Program added an additional 31 distributions sites during the reporting period with 12 of those sites being county jails bringing the total current number of statewide distribution sites to 129. Lastly during the reporting period 7,514 individuals were trained on how to recognize the signs of an overdose, how to administer naloxone, and how to train others to do so as well. • The Wisconsin Addiction Recovery Helpline is a statewide resource that helps individuals find substance use disorder (SUD) treatment and recovery services. During the reporting period the helpline received 3,975 phone calls. Of these calls, 392 individuals received a warm handoff in the form of peer support or recovery coaching beyond the initial contact. Additionally, during the reporting period 8,922 referrals to services were made, 37 new SUD treatment resources were added to the database, and 18,450 Addiction Recovery Helpline cards were distributed. • The state reported the number of individuals receiving treatment services continues to increase over time as the SOR II grantees continue to expand treatment services. During the same reporting period, 47 percent of the SOR II grantees report engaging in community outreach efforts such as: press releases and social media campaigns to raise awareness about services, distributing brochures, business cards, and flyers to families with loved ones that have an SUD, and actively recruiting and locating new referral sources. Furthermore, 36 percent of grantees report strengthening their relationships and collaboration with their community partners and providers, and 17 percent of grantees reported that they began offering a new service.

State/Territory	Key Accomplishments
Wyoming	• Central Wyoming Counseling Center continued its implementation of a Contingency Management Plan and saw positive outcomes in compliance and follow-through with clients engaged in Stimulant Use Disorder (SUD) treatment. Central Wyoming Counseling Center reported that several clients completed the Intensive Outpatient Program (IOP) without an absence from group and were motivated by the support for mental health medication and their mental health. This has decreased barriers and improved overall stability for clients in all areas of their life. • Recover Wyoming continues to successfully implement the state-wide Telephone Recovery Support (TRS) Program utilizing SOR funds. Since its launch, the TRS program has had 70 referrals from agencies and individuals across the state. There are currently 24 active TRS participants receiving recovery check-ins. Most of the referrals came from the SOR subrecipients Southwest Counseling Center and Cody Regional Health for individuals exiting MOUD and stimulant use disorder programs. • Cheyenne Regional Medical Center (CRMC) hospital is a Wyoming SOR Project subrecipient conducting prevention efforts including training and policy changes. Between October 2021 and March 2022, CRMC has provided over1,000 hours of prevention services including various training opportunities, drug disposal education and events, hospital policy changes affecting how pain is treated, and community education focused on opioids and stimulant abuse and disparate populations. • The Northern Arapaho Tribe, White Buffalo Recovery Center (WBRC) received an award to fund recovery residences, peer support, and care coordination. WBRC has provided opioid specific services to 23 individual clients, 10 residential clients. The Northern Arapaho Tribe established a pain management work group that worked on new policies and discussed care coordination. This group included WBRC, the local MOUD provider Wind River Family and Community Health Center, behavioral health providers, general providers, local pharmacy, and local nursing staff. The establishment of this group has been extremely helpful in working with this specific population. The Wind River Family and Community Health Care center now has four providers who can provide MOUD.

APPENDIX II: Naloxone Distribution by Health and Human Services (HHS) Regions



Note: Region 1 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont), Region 2 (New Jersey, New York, and United States Virgin Islands), Region 3 (District of Columbia, Delaware, Maryland, Pennsylvania, Virginia, and West Virginia), Region 4 (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee), Region 5 (Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin), Region 6 (Arkansas, Louisiana, New Mexico, Oklahoma, and Texas), Region 7 (Iowa, Kansas, Missouri,, and Nebraska), Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming), Region 9 (Arizona, Hawaii, California, Guam, Nevada, American Samoa, Northern Mariana Islands, and Federated States of Micronesia), and Region 10 (Alaska, Idaho, Oregon, and Washington).

APPENDIX III: Logistic Regression Analyses with National Outcome Measures

Table 1. Logistic Regression– Abstaining from Drug and Alcohol Use at Six months Health:

In the abstinence regression model, abstaining from alcohol and drug use was coded as Alcohol/Drug use (0) and No Alcohol/Drug Use (1). The Cox & Snell pseudo R^2=0.452, Therefore 45.2 percent of the variance in self–reported alcohol/drug use at six months is explained by the following significant variables: gender, ethnicity, alcohol/drug use at intake, social consequences at intake, crime and criminal justice at intake, employment/education status at intake, housing stability at intake, social connectedness at six month follow–up, social consequences at six month follow–up, crime and criminal justice at six month follow–up, employment/education status at six month follow–up, and housing stability at six month follow–up. The regression equation for the model:

$$Ln\ (Odds) = -1.939 + 0.189_{gender\ (1)} + 0.389_{gender\ (2)} - 0.770_{gender\ (3)} - 0.149_{ethnicity} - 2.695_{alcohol/drug\ intake} + 1.141_{consequences\ intake} + 0.665_{criminal\ justice\ intake} + 0.381_{employment/education\ intake} + 0.372_{housing\ intake} - 0.333_{connectedness\ 6mo} + 4.481_{consequences\ 6mo} - 0.785_{criminal\ justice\ 6mo} - 0.141_{employment/education\ 6mo} + 0.668_{housing\ 6mo}$$

After controlling for the respective variables within the regression model, women were 1.209 times more likely to abstain from alcohol and drug use at six–month follow–up compared to men. Clients who did not identify as Hispanic/Latino were less likely (Odds Ratio (OR)=0.862) to abstain from alcohol and drug use at the six–month follow–up compared to those who identified as Hispanic/Latino. Clients who reported alcohol and drug use at intake were less likely (OR=0.068) to abstain from alcohol and drug use compared to those who reported abstaining from alcohol and drug use at intake. Clients who reported social consequences at intake were 3.131 times more likely to abstain from alcohol and drug use at six–month follow–up compared to those with no social consequences at intake after controlling for the additional variables within the regression model. Those who reported past 30 day arrests at intake were nearly 2 times (1.945) times more likely to abstain from alcohol and drug use at the six–month follow–up compared to those who reported no past 30 day arrests at intake after controlling for respective variables within the regression model. Those who were not employed or enrolled in school at intake were 1.464 times more likely to abstain from drug and alcohol use at six–month follow–up compared to those who were employed or enrolled in a training program at intake. Additionally, those who did not report stable housing at intake were 1.451 times more likely to abstain from alcohol and drug use at the six–month follow–up compared to those with stable housing at intake.

At the six–month follow–up, clients who were not socially connected were less likely (OR=0.717) to abstain from alcohol and drug use at the six–month follow–up after controlling for the respective variables within the regression model. Those who reported social consequences at the six–month follow–up were 88.315 times more likely to abstain from alcohol and drug use at the six–month follow–up compared to those with no social consequences when controlling for the respective variables in the regression model. Those who reported past 30 day arrests at the six–month follow–up were less likely to abstain from alcohol and drug use (OR=0.456) compared to those with past 30 day arrests at the six–month follow–up when controlling for the remaining variables in the regression model. Clients who were at employed or enrolled in a training program at the six–month follow–up were less likely (OR=0.868) to abstain from alcohol and drug use compared to those who were employed or enrolled in school at the six–month follow–up. Lastly, those who reported no stable housing at the six–month follow–up were nearly 2 times (OR=1.951) more likely to abstain from alcohol and drug use at the six–month follow–up compared to those who reported stable housing at the six–month follow–up after controlling for the remaining variables within the regression model.

Table 1. Logistic Regression– Abstaining from Drug and Alcohol Use at six months			
Variables	Cox & Snell R squared (0.452)		
	Exp(B)	β	p–value
(Constant)	0.144	–1.939	**<0.001****
Gender:			
Male (REF)			
Female	1.209	0.189	**<0.001****
Transgender	1.476	0.389	0.363
Other	0.463	–0.770	0.094
Ethnicity:			
Hispanic/Latino (REF)			
Non–Hispanic Latino	0.862	–0.149	**0.014***
Alcohol and Drug Use at Intake:			
Abstain from Alcohol or Drug (REF)			
Alcohol or Drug Use	0.068	–2.695	**<0.001****
Social Consequences at Intake:			
No Social Consequences (REF)			
Social Consequences	3.131	1.141	**<0.001****
Criminal Justice Involvement at Intake:			
No past 30 day arrests (REF)			
Past 30 day arrests	1.945	0.665	**<0.001****
Employment/Education at Intake:			
Employed/Enrolled in School (REF)			
Not Employed/Enrolled in School	1.464	0.381	**<0.001****
Housing Stability at Intake:			
Stable Housing (REF)			
No Stable Housing	1.451	0.372	**<0.001****
Social Connectedness at six months:			
Socially Connected (REF)			
Not Socially Connected	0.717	–0.333	**<0.001****
Social Consequences at six months:			
No Social Consequences			
Social Consequences	88.315	4.481	**<0.001****
Crime and Criminal Justice at six months:			
No Criminal Justice Involvement (REF)			
Criminal Justice Involvement	0.456	–0.785	**<0.001****
Employment/Education at six months:			
Employed/Enrolled in School (REF)			
Not Employed/Enrolled in School	0.868	–0.141	**<0.001****
Housing Stability at six months:			
Stable Housing (REF)			
No Stable Housing	1.951	0.668	**<0.001****

Note: *p <0.05, **p <0.001

Table 2. Logistic Regression– No Social Consequences at six months:

Significant variables that influenced social consequences in the regression model include age, race, alcohol, and drug use at intake, housing stability at intake, crime and criminal justice at intake, social consequences at intake, alcohol, and drug use at the six–month follow–up, housing stability at six–month follow–up, crime and criminal justice at six-month follow-up, and social connectedness at the six–month follow–up. In the regression model, the dependent variable was recoded to Social Consequences (0) and No Social Consequences (1). The Cox &

Snell pseudo R^2=0.421. Therefore, 42.1 percent of the variance in social consequences can be explained by the variables in the regression model provided below.

$$Ln\ (Odds)=4.105+0.009_{age}-0.138_{race\ (1)}+0.726_{race\ (2)}-0.179_{race\ (3)}-0.659_{race\ (4)}+0.415_{race\ (5)}+0.264_{race\ (6)}+1.116_{alcohol/drug\ intake}-0.236_{housing\ Intake}+0.178_{criminal\ justice\ intake}-1.996_{consequences\ intake}-4.473_{alcohol/drug\ 6mo}-0.902_{housing\ 6mo}-0.833_{criminal\ justice\ 6mo}-0.490_{connectedness\ 6mo}$$

In the regression model, there was an association with age and social consequences. As age increased by 1 year, the odds for no social consequences at the six–month follow–up increased by approximately one percent (β=0.009) when controlling for the remaining variables in the regression model. Clients who identify as Black were less likely to have no social consequences reported at the six–month follow–up when compared to White clients (OR=0.871). There were no significant differences among the remaining race categories when controlling for the variables in the regression model. Clients who reported alcohol and drug use at intake were 3.054 times more likely to report no social consequences at the six–month follow–up. Those who reported no stable housing at intake were less likely (OR=0.790) to report no social consequences at the six–month follow–up. Clients who reported past 30 day arrests at intake were 1.195 times more likely to report no social consequences at the six–month follow–up when controlling for the remaining variables in the regression model.

At the six–month follow–up, clients who reported alcohol and drug use were less likely (OR=0.011) to report no social consequences at the six–month follow–up after controlling for the variables within the regression model. Additionally, clients who reported no stable housing (OR=0.406), past 30 day arrests(OR=0.453) and those who were not social connected (OR=0.613) were less likely to report no social consequences at the six–month follow–up when compared to their respective reference group and controlling for the variables within the regression model.

Table 2. Logistic Regression– No Social Consequences at six months			
Variables	Cox & Snell R squared (0.421)		
	Exp(B)	β	p–value
(Constant)	60.648	4.105	**<0.001****
Age	1.009	.009	**<0.001****
Race:			
White (REF)			
Black	0.871	–0.138	**0.026***
Asian	2.067	0.726	0.053
American Indian	0.836	–0.179	0.240
Native Hawaiian	0.517	–0.659	0.084
Alaska Native	1.514	0.415	0.377
Multiple Race	1.302	0.264	0.058
Alcohol and Drug Use at Intake:			
Abstain from Alcohol or Drug (REF)			
Alcohol or Drug Use	3.054	1.116	**<0.001****
Housing Stability at Intake:			
Stable Housing (REF)			
No Stable Housing	0.790	–0.236	**<0.001****
Crime and Criminal Justice t at Intake:			
No past 30 day arrests (REF)			
Past 30 day arrests	1.195	0.178	0.051
Social Consequences at Intake:			
No Social Consequences			
Social Consequences	0.136	–1.996	**<0.001****
Alcohol and Drug Use at six months:			
Abstain from Alcohol or Drug (REF)			

Alcohol or Drug	0.011	–4.473	**<0.001****
Housing Stability at six months:			
Stable Housing (REF)			
No Stable Housing	0.406	–0.902	**<0.001****
Crime and Criminal Justice at six months:			
No past 30 day arrests (REF)			
Past 30 day arrests	0.435	–0.833	**<0.001****
Social Connectedness at six months:			
Socially Connected (REF)			
Not Socially Connected	0.613	–0.490	**<0.001****

Note: *p <0.05, **p <0.001

Table 3. Logistic Regression– Social Connectedness at six months:

When assessing social connectedness at the six–month follow–up, age, race, employment/education at intake, social connectedness at intake, alcohol and drug use at the six–month follow–up, housing stability at the six–month follow–up, employment/education at the six–month follow–up, crime and criminal justice at the six–month, and social consequences at the six-month follow-up significantly influenced social connectedness. In the regression model, no social connectedness was recoded to 0 and social consequences recoded to 1. The Cox & Snell pseudo R^2=0.059. Therefore, approximately seven percent of the variance in social connectedness can be explained by the regression model provided.

$$Ln\ (Odds)=3.305 - 0.007_{age} - 0.116_{race\ (1)} - 0.514_{race\ (2)} - 0.077_{race\ (3)} + 1.309_{race\ (4)} + 2.018_{race\ (5)} + 0.139_{race\ (6)} + 0.329_{employment/education\ intake} - 1.438_{social\ connectedness\ Intake} - 0.397_{alcohol/drug\ 6mo} - 0.490_{housing\ 6mo} - 0.518_{employment/education\ 6mo} - 0.343_{criminal\ justice\ 6mo} - 0.468_{consequences\ 6mo}$$

As age increased by 1 year, the odds for social connectedness at the six–month follow–up decreased by nearly one percent (β=0.007) when controlling for the remaining variables within the regression model. Clients who identify as Black were less likely to be socially connected at the six–month follow–up when compared to White clients (OR=0.890). Clients who identify as Native Hawaiian were 3.701 times more likely to be socially connected at the six–month follow–up when compared to White clients, and clients who identify as Alaska Native were 7.525 times more likely to be social connected at the six–month follow–up when compared to White clients. There were no significant differences among the remaining race categories when controlling for the remaining variables in the regression model. Clients who were not employed or enrolled in school at intake were 1.389 times more likely to be socially connected at the six–month follow–up and those who reported no social connectedness at intake were less likely to be socially connected at the six–month follow–up (OR=0.237) when controlling for the remaining variables in the regression model. At the six–month follow–up, clients who reported alcohol and drug use (OR=0.673), no housing stability (OR=0.613), no employment or school enrollment (OR=0.595), past 30 day arrests (OR=0.710), and social consequences (OR=0.626) were all less likely to be socially connected at the six–month follow–up when controlling the variables within the regression model.

Table 3. Logistic Regression– Social Connectedness at six months			
Variables	Cox & Snell R squared (0.059)		
	Exp(B)	β	p–value
(Constant)	27.247	3.305	**<0.001****
Age	0.993	–0.007	**0.001****
Race:			
White (REF)			
Black	0.890	–0.116	**0.043***
Asian	0.598	–0.514	0.071
American Indian	0.926	–0.077	0.596

Native Hawaiian	3.701	1.309	**0.028***
Alaska Native	7.525	2.018	**0.046***
Multiple Race	1.149	0.139	0.345
Employment/Education at Intake:			
Employed/Enrolled in School (REF)			
Not Employed/Enrolled in School	*1.389*	*0.329*	**<0.001****
Social Connectedness at Intake:			
Socially Connected (REF)			
Not Socially Connected	0.237	–1.438	**<0.001****
Alcohol and Drug Use at six months:			
Abstain from Alcohol or Drug (REF)			
Alcohol or Drug Use	0.673	–0.397	**<0.001****
Housing Stability at six months:			
Stable Housing (REF)			
No Stable Housing	0.613	–0.490	**<0.001****
Employment/Education at six months:			
Employed/Enrolled in School (REF)			
Not Employed/Enrolled in School	0.595	–0.518	**<0.001****
Crime and Criminal Justice at six months:			
No past 30 day arrests (REF)			
Past 30 day arrests	0.710	–0.343	**0.002***
Social Consequences at six months:			
No Social Consequences			
Social Consequences	0.626	–0.468	**<0.001****

Note: *p <0.05, **p <0.001

Table 4. Logistic Regression– Crime and Criminal Justice at six months:

Significant variables that influenced crime and criminal justice at the six–month follow–up include age, crime and criminal justice at intake, alcohol, or drug use at the six–month follow–up, housing stability at the six–month follow–up, employment/education at the six–month follow–up, social consequences at the six–month follow–up, and social connectedness at the six–month follow–up. In the regression model, the dependent variable was recoded to past 30 day arrests (0) and no past 30 day arrests (1). The Cox & Snell pseudo R^2=0.029. Therefore, 3 percent of the variance in crime and criminal justice can be explained by the variables provided in the regression model below.

$$Ln\ (Odds) = 4.985 + 0.012_{age} - 1.481_{criminal\ justice\ intake} - 0.873_{alcohol/drug\ 6mo} - 1.258_{housing\ 6mo} - 0.492_{employment/education\ 6mo} - 0.819_{consequences\ 6mo} - 0.236_{connectedness\ 6mo}$$

In the regression model, there was an association with age and crime and criminal justice. As age increased by 1 year, the odds for no past 30 day arrests at the six–month follow–up increased by 1.2 percent (β=0.012) when controlling for the remaining variables. Clients who reported past 30 day arrests at intake were less likely to report no past 30 day arrests at the six–month follow–up (OR=0.227) when controlling for the remaining variables in the regression model.

At the six–month follow–up, clients who reported alcohol or drug use were less likely (OR=0.418) to report no past 30 day arrests after controlling for the variables within the regression model. Additionally, clients who reported no stable housing (OR=0.284), no employment or school enrollment (OR=0.612), social consequences (OR=0.441), and those not socially connected (OR=0.790) were less likely to report no past 30 day arrests at the six–month follow–up, when compared to their respective reference group and controlling for the variables within the regression model.

Table 4. Logistic Regression– Crime and Criminal Justice at six months			
Variables	Cox & Snell R squared (0.029)		
	Exp(B)	β	p–value
(Constant)	146.177	4.985	**<0.001****
Age	1.012	0.012	**<0.001****
Crime and Criminal Justice at Intake:			
No past 30 day arrests (REF)			
Past 30 day arrests	0.227	–1.481	**<0.001****
Alcohol and Drug Use at six months:			
Abstain from Alcohol or Drug (REF)			
Alcohol or Drug Use	0.418	–0.873	**<0.001****
Housing Stability at six months:			
Stable Housing (REF)			
No Stable Housing	0.284	–1.258	**<0.001****
Employment/Education at six months:			
Employed/Enrolled in School (REF)			
Not Employed/Enrolled in School	0.612	–0.492	**<0.001****
Social Consequences at six months:			
No Social Consequences			
Social Consequences	0.441	–0.819	**<0.001****
Social Connectedness at six months:			
Socially Connected (REF)			
Not Socially Connected	0.790	–0.236	**0.027***

Note: *p <0.05, **p <0.001

Table 5. Logistic Regression– Employment/Education at six months:

In the employment and education regression model, gender, race, social connectedness at intake, social consequences at intake, employment or enrollment in school at intake, alcohol or drug use at intake, alcohol and drug use at six–month follow–up, housing stability at the six–month follow–up, crime and criminal justice at the six–month follow–up, social consequences at the six–month follow–up, and social connectedness at the six–month follow–up significantly influenced employment and education at the six–month follow–up. Additionally, employment or enrollment in school was recoded to not employed or in school (0) and employed or in school (1). The Cox & Snell pseudo R^2=0.242. Therefore, 24.2 percent of the variance in employment or enrollment in school at the six–month follow–up is explained by the regression equation below.

$$Ln\ (Odds)=3.054 - 0.24_{age} - 0.380_{gender\ (1)} - 0.188_{gender\ (2)} + 0.522_{gender\ (3)} - 0.216_{race\ (1)} + 0.455_{race\ (2)} - 0.363_{race\ (3)} + 0.326_{race\ (4)} + 0.550_{race\ (5)} - 0.107_{race\ (6)} - 0.182_{connectedness\ Intake} + 0.179_{consequences\ intake} - 1.996_{employment/education\ intake} - 0.382_{alcohol/drug\ intake} - 0.162_{alcohol/drug\ 6mo} - 1.420_{housing\ 6mo} - 0.570_{criminal\ justice\ 6mo} - 0.571_{consequences\ 6mo} - 0.499_{connectedness\ 6mo}$$

In the regression model, there was an association with age and employment or enrollment in school at the six–month follow–up. As age increased by 1 year, the odds for employment or enrollment in school at six–months decreased (OR= 0.977) when controlling for the remaining variables in the model. Compared to men, women were less likely to report employment or enrollment in school at the six–month follow–up after controlling for the variables in the regression model. There were no significant differences with clients who identified as transgender or other. Clients who identify as Black and clients who identify as American Indian were less likely to report employment or school enrollment at the six–month follow–up compared to clients who identify as White (OR= 0.806 and 0.695). However, clients who identify as Asian were 1.576 times more likely to report employment or school enrollment, and Alaska Native clients were 1.733 times more likely to report employment or school enrollment at the six–month follow–up compared to White clients after controlling for the remaining variables in the regression model.

At intake, clients who reported no social connectedness or no employment or school enrollment were less likely to report employment or school enrollment at the six–month follow–up when compared to their respective reference groups and controlling for the variables within the regression model. However, clients who reported social consequences at intake were 1.196 times more likely to report employment or school enrollment at the six–month follow–up compared to those who reported no social consequences at intake when controlling for the variables in the regression model. At the six–month follow–up, clients who reported alcohol or drug use (OR=0.850), unstable housing (OR=0.242), past 30 day arrests (OR=0.566), social consequences (OR=0.565) and those not socially connected (OR=0.607) were less likely to report employment or school enrollment at the six–month follow–up compared to their respective reference groups after controlling for the variables within the regression model.

Table 5. Logistic Regression– Employment/Education at six months			
Variables	Cox & Snell R squared (0.242)		
	Exp(B)	β	p–value
(Constant)	21.193	3.054	**<0.001****
Age	.977	–0.024	**<0.001****
Gender:			
Male (REF)			
Female	0.684	–0.380	**<0.001****
Transgender	0.828	–0.188	0.523
Other	1.686	0.522	0.308
Race:			
White (REF)			
Black	0.806	–0.216	**<0.001****
Asian	1.576	0.455	**0.043***
American Indian	0.695	–0.363	**<0.001****
Native Hawaiian	1.386	0.326	0.173
Alaska Native	1.733	0.550	**0.027***
Multiple Race	0.899	–0.107	0.229
Social Connectedness at Intake:			
Socially Connected (REF)			
Not Socially Connected	0.833	–0.182	**<0.001****
Social Consequences at Intake:			
No Social Consequences			
Social Consequences	1.196	0.179	**<0.001****
Employment/Education at Intake:			
Employed/Enrolled in School (REF)			
Not Employed/Enrolled in School	0.136	–1.996	**<0.001****
Alcohol and Drug Use at Intake:			
Abstain from Alcohol or Drug (REF)			
Alcohol or Drug Use	0.683	–0.382	**<0.001****
Alcohol and Drug Use at six months:			
Abstain from Alcohol or Drug (REF)			
Alcohol or Drug Use	0.850	–0.162	**<0.001****
Housing Stability at six months:			
Stable Housing (REF)			
No Stable Housing	0.242	–1.420	**<0.001****

Crime and Criminal Justice at six months: No past 30 day arrests (REF) Past 30 day arrests	0.566	–0.570	**<0.001****
Social Consequences at six months: No Social Consequences Social Consequences	0.565	–0.571	**<0.001****
Social Connectedness at six months: Socially Connected (REF) Not Socially Connected	0.607	–0.499	**<0.001****

Note: *p <0.05, **p <0.001

Table 6. Logistic Regression– Housing Stability at six months:

In the stable housing regression model, housing was the dependent variable and was recoded to no stable housing (0) and stable housing (1). The Cox & Snell pseudo R^2=0.166. Therefore 16.6 percent of the variance in housing stability is explained by the following significant variables: age, gender, race, alcohol and drug use at intake, housing stability at intake, crime and criminal justice at intake, social connectedness at intake, alcohol and drug use at six month follow–up, employment or school enrollment at the six–month follow–up, crime and criminal justice at the six month follow–up, social consequences at the six–month follow–up, and social connectedness at the six–month follow–up. The regression equation for the model is provided below.

$$Ln\ (Odds)=3.331+0.11_{age}+0.481_{gender\ (1)}+0.190_{gender\ (2)}+0.464_{gender\ (3)}-0.429_{race\ (1)}-0.153_{race\ (2)}-0.199_{race\ (3)}-0.936_{race\ (4)}-1.493_{race\ (5)}-0.277_{race\ (6)}+0.095_{alcohol/drug\ intake}-2.153_{housing\ Intake}-0.746_{criminal\ justice\ intake}-0.157_{connectedness\ intake}+0.745_{alcohol/drug\ 6mo}-1.403_{employment/education\ 6mo}-1.337_{criminal\ justice\ 6mo}-0.845_{consequences\ 6mo}-0.477_{connectedness\ 6mo}$$

As age increased by 1 year, housing stability increased by 11 percent (β= 0.11) when controlling for the remaining variables in the regression model. Black, Native American, Alaska Native, and Multiple Race clients were less likely to report housing stability compared to White clients after controlling for the remaining variables in the regression model. Clients who reported alcohol or drug use at intake were 1.099 times more likely to report housing stability at the six–month follow–up compared to those who abstained from alcohol or drug use at intake when controlling for the remaining variables in the regression model. Those who reported no housing stability at intake more less likely to report housing stability at the six–month follow–up compared to those who reported housing stability at intake when controlling for the remaining variables within the regression model (OR=0.116). Clients who reported past 30 day arrests at intake and clients who were not socially connected at intake were less likely to report stable housing at the six–month follow–up compared to their respective reference groups after controlling for the remaining variables in the regression model.

At the six–month follow–up, clients who reported alcohol or drug use were 2.107 times more likely to report stable housing compared to those who abstained from alcohol or drug use after controlling for remaining variables in the regression model. Additionally, clients who were not employed or enrolled in school (OR=0.246), reported past 30 day arrests (OR=0.263), reported social consequences (OR=0.430) and those who were not social connected (OR=0.621) at the six– month follow–up were less likely to report stable housing at the six–month follow–up after controlling for the remaining variables in the regression model.

Table 6. Logistic Regression– Housing Stability at six months			
Variables	Cox & Snell R squared (0.166)		
	Exp(B)	β	p–value
(Constant)	27.967	3.331	**<0.001****
Age	1.011	0.11	**<0.001****
Gender:			

Male (REF)			
Female	1.618	0.481	**<0.001****
Transgender	1.209	0.190	0.636
Other	1.591	0.464	0.635
Race:			
White (REF)			
Black	0.651	–0.429	**<0.001****
Asian	0.858	–0.153	0.647
American Indian	0.820	–0.199	0.184
Native Hawaiian	0.392	–0.936	**0.002***
Alaska Native	0.225	–1.493	**<0.001****
Multiple Race	0.758	–0.277	**0.032***
Alcohol and Drug Use at Intake:			
Abstain from Alcohol or Drug (REF)			
Alcohol or Drug Use	1.099	0.095	**0.049***
Housing Stability at Intake:			
Stable Housing (REF)			
No Stable Housing	0.116	–2.153	**<0.001****
Crime and Criminal Justice at Intake:			
No past 30 day arrests (REF)			
Past 30 day arrests	0.474	–0.746	**<0.001****
Social Connectedness at Intake:			
Socially Connected (REF)			
Not Socially Connected	0.855	–0.157	**0.006***
Alcohol and Drug Use at six months:			
Abstain from Alcohol or Drug (REF)			
Alcohol or Drug Use	2.107	0.745	**<0.001****
Employment/Education at six months:			
Employed/Enrolled in School (REF)			
Not Employed/Enrolled in School	0.246	–1.403	**<0.001****
Crime and Criminal Justice at six months:			
No past 30 day arrests (REF)			
Past 30 day arrests	0.263	–1.337	**<0.001****
Social Consequences at six months:			
No Social Consequences			
Social Consequences	0.430	–0.845	**<0.001****
Social Connectedness at six months:			
Socially Connected (REF)			
Not Socially Connected	0.621	–0.477	**<0.001****

Note: *p <0.05, **p <0.001